Bethesda North Hospital

2022 Community Health Needs Assessment Implementation Plan

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Hamilton County

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TriHealth Review

Over the last year, Bethesda North Hospital (BNH) completed a comprehensive Regional Community Health Needs Assessment (CHNA). The Regional CHNA included input from a wide variety of sources, including, but not limited to customers, community leaders, physicians, county health departments and a paid external consultant.

Through the Regional CHNA, the greatest health needs in the regional community were identified, which will allow BNH to direct our resources appropriately toward education, prevention programs, and wellness opportunities. The significant health needs identified in the Regional CHNA are in order of priority:

1. Cardiovascular Conditions (Hypertension)
2. Mental Health (Depression and Anxiety)
3. Arthritis
4. Lung/Respiratory Health
5. Dental
6. Maternal health concerns
7. Prevention-related needs

BNH carefully considered the health needs identified in the Regional CHNA report for the four-county community served by BNH (Hamilton, Butler, Clermont and Warren Counties, Ohio) and determined that an identified need was significant to the BNH service area if it was represented by the research as particularly acute within BNH's community served.

Process

In order to develop targeted strategies to alleviate problematic issues identified as needs recognized by the Regional CHNA, BNH assembled a TriHealth wide internal work group who represent the programs and services that touch the underserved in the community. This group took the data from the Regional CHNA, the community identified priority needs and their own experience with the underserved and previous programs and recommended the top community health needs for BNH and TriHealth to address.

List of committee members and meetings

- Frank Nation, VP Mission/Culture
- Linda Smith-Berry, Director Community Access Health
- Judy Mitchell, RN, Behavioral Services Executive Director
- Jacqui Appel, Manager TriHealth Breast Care Program
- Anne Siebert, RN, Director of Nursing Bethesda Butler
- Tonya Hurst, Director Perinatal Programs
- Susan Powers, The Cancer Institute Director of Operations
- Tira Williams, RN, Director of Health Equities (Population Health)
- Jeanette Altenau, Director Community and Government Relations
- Tashawna Otabil, Chief Diversity Officer and VP Managed Care
- Sharon Klein, Director Community and Physician Relations, McCullough-Hyde Hospital
- Timothy Hellmann, Tax/Reimbursement Manager
- Lori Baker, Director Ambulatory Care Management/Senior Services/Post-Acute Care
- Chris Swallow, Mobile Mammography/Screening
- Stephanie Lambers and Krista Jones, Community Benefit Consultants

Hospital Presidents:

- Jamie Easterling, President Bethesda North Hospital
- Michael Everett, President Bethesda Butler and McCullough-Hyde Hospitals
- Kelvin Hanger, President Good Samaritan Hospital

This group met on May 24, 2022 to review the finding from the regional Health Needs Assessment that pertains to BNH's service areas. The recommended priorities were then reviewed with the hospital presidents.

Criteria for decision-making

TriHealth chose to continue work with the underserved launched by the 2019 CHNA that is yielding results. Therefore, Substance Abuse and Maternal/Child Health priority work will continue. In addition, the committee assessed the findings considering the below criteria to come to its final recommendations regarding additional priority needs to be addressed in Fiscal Years 2023-2025.

a. Opportunity to build on work already underway in partnership with other community service agencies to address community health needs
b. Potential for community partnership to form a coordinated approach to specific needs or underserved populations
c. Programs that have trackable outcomes
d. Ability to address populations or community health needs that are impactful to future health, not just immediate concerns

Needs identified that were strongly related to others were combined into one.

Based on the process described above, the significant health needs that BNH will address in the implementation strategy are as follows.

Priority Health Needs to be Addressed by BNH

1. Substance Abuse/Mental Health - Given the high prevalence of substance abuse in this area, particularly opioid abuse, the fact that current work is not completed and there are many community partners that are engaging along with TriHealth, substance abuse remains one of the top priority community needs for TriHealth and BNH.
2. Maternal/Child Health - Given the high prevalence in certain geographic areas, the fact that current work is being effective and is not completed and there are many community partners that are engaging along with TriHealth
3. Access to care – Continuing the work of TriHealth/BNH clinics is essential to sustained gains in improving access for un- and underinsured people. There is an opportunity to build on current similar work that funds patients' access via rides to appointments, home from the emergency department and so forth; and
4. Disease Management - Several specific chronic health issues – hypertension, depression, diabetes and cancers resulting from postponed screenings all are affecting black males in the community disproportionally, so were combined into "Disease Management".

Implementation Plan

Health Need: Substance Abuse / Mental Health					
Anticipated Impact (Goal)	To improve early identification and treatment, as well as education, to those in our community who need the right care, in the right setting, at the right time regarding substance abuse and mental health to improve health outcomes.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Substance Abuse Treatment Coordinators	• Provide RN/Social Worker with specific substance use training and/or certification at inpatient services and emergency department locations to engage, assess, and provide appointments to treatment within 24-48 hours after discharge.	•	•	•	•
Outpatient Alcohol and Treatment Program	• Offer support and treatment to patients regardless of their ability to pay, in a structured, outpatient setting.	•	•	•	•
Integrated Behavioral Health Model	• Develop a behavioral health care model over the next 18 months to proactively identify patient needs using a comprehensive behavioral health assessment and provide treatment as indicated.	•	•	•	•
Behavioral Health Intake Program	• Refer patients from the emergency department to the appropriate treatment setting and location.	•	•	•	•
BNH Planned Resources	BNH will provide registered nurses, physicians, community health educators, philanthropic cash grants, outreach communication, and program management support for these initiatives				
Planned Collaborators	The hospital will partner with bi3, Addiction Services Council, Brightview, Talbert House, NAMI of Southwest Ohio, Urban Health Project, Center for Addiction Treatment, Good Samaritan Free Health				

Health Need: Substance Abuse / Mental Health	
	Clinic
2022 CHNA Priority Health Needs being Addressed	#2 Priority health need: Mental health related conditions (depression and anxiety disorders) #7 Priority health need: Prevention Services
State Health Improvement Plan (SHIP) 2020-2022 Alignment	Mental health and addiction: Depression • SHIP strategy: Coordinated care for behavioral health • SHIP strategy: Depression screening Mental health and addiction: Drug overdose deaths • SHIP strategy: Culturally competent workforce in underserved communities • SHIP strategy: Recovery communities and peer supports

Health Need: Maternal / Child Health					
Anticipated Impact (Goal)	As TriHealth delivers the most babies in the state, the hospital will reduce infant mortality rates in our service area, as well as improve outcomes for maternal health with emphasis on education, clinical care, and community outreach				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Community	Innovation & Impact
OB Gyn Center	• The Center will provide obstetrics and gynecological services to all, with special attention to health disparities and the underserved improving infant mortality outcomes and women's health.	•	•	•	•
Woman Centered Medical Home model	• Program will provide a complex network of care, delivered by dedicated case managers, social workers, lactation consultants, behavioral health consultants,	•	•	•	•

Health Need: Maternal / Child Health					
	community health workers, financial counselors, and legal aid consultants to provide excellent care while addressing social determinants of health.				
HOPE program	• Program will provide patient-centered care to chemically dependent pregnant women improving birth outcomes and maternal substance-free outcomes.	•	•	•	•
BNH Planned Resources	BNH will provide RNs, dedicated Case Manager, Lactation educator, behavioral health social worker, dieticians, genetic counselors and assistance with transportation, food pantry, home furnishings and baby items.				
Planned Collaborators	Cradle Cincinnati, Urban Health Project, March of Dimes, Talbert House Fatherhood Project, Sweet Cheeks Diaper Bank, Start Strong, Think First for your Baby, Healthy Beginnings, Healthy Moms and Babes, GS Free Clinic, Every Child Succeeds, Cribs for Kids, Childbirth Education Association				
CHNA Priority Health Needs being Addressed	#6 priority health need: Maternal health complications				
State Health Improvement Plan (SHIP) 2020-2022 Alignment	Maternal and infant health: Preterm births, infant mortality, maternal morbidity • SHIP strategy: Care coordination and access to well-woman care • SHIP strategy: Safety and quality improvement				

Health Need: Access To Care		
Anticipated Impact (Goal)	Improve access to care for the underserved populations with emphasis on education, assessment, care delivery and connection to resources within BNH, TriHealth and/or community organizations and programs.	
		Strategic Objectives

Health Need: Access To Care					
Strategy or Program	**Summary Description**	Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Planning Grant for expanded Free Clinic Services in Butler County Service Area	• Utilize planning grant to explore providing Free Clinic type access to comprehensive, personalized healthcare services to uninsured patients in unique BNH/Butler County region.	•	•	•	•
Faculty Medical Center	• Program will provide a complex network of care, delivered by providers from our Graduate Medical Education program who are dedicated to providing excellent clinical primary care to the underserved while addressing social determinants of health.	•	•	•	•
TriHealth Outreach Programs Coordination	• Improve coordination of programs directly to the underserved community with connection to TriHealth and community organizations. Program coordination to include mobile mammography, free health screenings, Seniority, Think First education, pharmacy assistance, food programs, legal aid, advocacy, and housing repair.	•	•	•	•
BNH Planned Resources	BNH will provide mammography van, nurses, social workers, physicians, assistance with food, transportation, legal aid, space and resources for clinics, community workers, mental health specialists				
Planned Collaborators	People Working Collaboratively, Legal Aid of Greater Cincinnati, Free Store Foodbank, Greater Cincinnati Foundation, United Way, Health Collaborative, SVDP Charitable Pharmacy, Various Community Organization events.				
CHNA Priority Health Needs being Addressed	#7 Priority health need: Prevention services				
State Health Improvement Plan (SHIP) 2020-2022 Alignment	Access to care: Local access to health care providers • SHIP strategy: Comprehensive and coordinated primary care • SHIP strategy: Culturally competent workforce in underserved communities				

Health Need: Disease Management					
Anticipated Impact (Goal)	Through education, data collection, assessments, interventions, culturally competent care and care management, BNH will address and improve several specific chronic health issues that are impacted by disparities, such as hypertension, depression, diabetes, and cancers.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Health Disparities Data Collection	• Implement a new grant funded program to collect health disparity data regarding chronic disease to assess Social Determinants of Health, assist with interventions and track outcomes.	•	•	•	•
Coordinate existing (and new) chronic health programs with an emphasis on Health Disparities	• Coordinate and assimilate current (and future) programs that address chronic disease in areas of critical need based on zip codes, ethnicity, gender, and other social determinants of health.	•	•	•	•
Diversity, Equity, and Inclusion (DEI) Care Strategy	• Improve the DEI care strategy to focus on accurate DEI documentation in EPIC, Culturally Competent Care Model education, Workforce Diversity, BOLD program, Graduate Medical Education Diversity initiatives, School to Work program, and system DEI training	•	•	•	•
BNH Planned Resources	Newly created Director of Health Equities, Chronic Health Outreach Programs, Community Health Needs Committee, utilization of nurses, physicians, community health educators, philanthropic grants, outreach communication, and program management support for these initiatives				
Planned Collaborators	Bi3, Meharry Medical College (HBCU), Vincent Brown Consulting, Health Collaborative, Interact for Health, United Way, Lumeris, American Heart Association, American Lung Association, NAMI, RideCincinnati				

Health Need: Disease Management	
CHNA Priority Health Needs being Addressed	#1 priority health need: Cardiovascular related conditions (high blood pressure and/or high cholesterol) #2 priority health need: Mental health related conditions (depression and anxiety disorders) #7 priority heath need: Prevention services
State Health Improvement Plan (SHIP) 2020-2022 Alignment	Chronic disease: Heart disease, diabetes • SHIP strategy: Hypertension screening • SHIP strategy: Prediabetes screening, testing and referral to diabetes prevention program Mental health and addiction: Depression • SHIP strategy: Depression screening Access to care: Local access to health care providers • SHIP strategy: Culturally competent workforce in underserved communities

Available Resources to Address Priority Health Needs

Below is a list of community resources and other TriHealth programs available to help address the significant health needs of the community serves

Organization	Role	Focus
Addiction Services Council	Resources	Substance Abuse / Mental Health
American Heart Association	Advocacy, community education	Chronic Conditions, Obesity
American Lung Association	Advocacy, community education	Chronic Conditions, Obesity
bi3	Grant funding in areas of substance abuse and mental health	Substance Abuse / Mental Health
bi3	Grant funding in areas of access to care and health disparities	Access to care
Brightview	Resources, partnership	Substance Abuse / Mental Health
Center for Addiction Treatment	Resources, partnership	Substance Abuse / Mental Health
Childbirth Education Association	Resources, education	Maternal / Child health
Cradle Cincinnati	Neighborhood Based Woman Centered Medical Home - Funding	Infant mortality/ Maternal Health
Cribs for Kids	Resources, supplies, education	Maternal / Child Health
Every Child Exceeds	Resources, education	Maternal / Child Health
Family Nurturing Center	Post treatment support	Mental Health
Fernside	Fernside Children and Family Bereavement Support Groups	Mental Health
Freestore Foodbank	Advocacy, food for pantries	Nutrition Disparities
Greater Cincinnati Foundation	Collective Impact: Grants, support for organizations addressing social determinants of health	Obesity
GSH	Alcohol and Drug Rehab/Treatment	Substance Abuse
GSH	Good Samaritan Free Health Clinic	Chronic Conditions
GSH	Good Samaritan Free Health Clinic	Infant mortality/ Maternal Health
GSH	Good Samaritan Free Health Clinic	Mental Health
GSH	Urban Health Project free office space - medical students were placed in eight-week internships providing service to underserved populations in Greater Cincinnati, including the homeless, mentally ill, disadvantaged women, children, the elderly, at-risk youth, minority populations, refugees, and individuals who struggle with mental disorders or addiction.	Infant mortality/ Maternal Health

Organization	Role	Focus
GSH	Urban Health Project free office space - medical students were placed in eight-week internships providing service to underserved populations in Greater Cincinnati, including the homeless, mentally ill, disadvantaged women, children, the elderly, at-risk youth, minority populations, refugees, and individuals who struggle with mental disorders or addiction.	Mental Health
Hamilton County Addiction Services Counsel	Identify issues to focus on for Hamilton County residents	Substance Abuse
Healthy Beginnings	OB care for underserved	Infant mortality/ Maternal Health
Healthy Moms and Babes	Home visits and pre-natal services Hamilton County	Infant mortality/ Maternal Health
Interact for Health	Grants, education, policy	Chronic Conditions
Interact for Health	Grants, education, policy	Substance Abuse
Legal Aid of Greater Cincinnati	Assist with housing and other health related legal matters	Access
March of Dimes	Research and grants to prevent premature birth, birth defects and infant mortality	Infant mortality/ Maternal Health
Meharry Medical College (HBCU)	Partnership to improved diversity of medical providers	Disease Management
NAMI Southwest Ohio	Programs, classes and support groups, education/data	Mental Health
Ohio Cancer Research	Cancer awareness and seed money research	Cancer
People Working Collaboratively	Assist with housing repairs, ramps, etc.	Access
St. Vincent de Paul Pharmacy	Free or low cost medication for underserved	Chronic Conditions
Start Strong	Resources, education	Maternal / Child Health
Sweet Cheeks Diaper Bank	Resources, supplies, education	Maternal / Child Health
The Ovarian Alliance	Advocacy, Research and survivor programs	Cancer
Think First For Your Baby	Resources, supplies, education	Maternal / Child Health
TriHealth	Bus Tokens	Access to care
TriHealth	Cancer services: social work, nutrition counseling, genetic counseling	Cancer
TriHealth	Diabetic Education Classes open to all	Chronic Conditions
TriHealth	Free Breastfeeding Support Line	Infant mortality/ Maternal Health
TriHealth	HARP - primary care for discharged uninsured patients	Chronic Conditions

Organization	Role	Focus
TriHealth	OB Clinics	Infant mortality/ Maternal Health
TriHealth	OB Woman Centered Medical Home Model	Infant mortality/ Maternal Health
TriHealth	Resident staffed clinics	Chronic Conditions
TriHealth	Substance Abuse Coordinator in ER	Substance Abuse
TriHealth	Sweet Cheeks Diaper Bank	Infant mortality/ Maternal Health
TriHealth	Think First For Your Baby - violence prevention	Infant mortality/ Maternal Health
United Way	Resources, education	Access
United Way	Resources, education	Disease Management
United Way	Social agency funding	Mental Health
United Way	Social agency funding	Nutrition Disparities, Obesity
United Way	Social agency funding	Substance Abuse
Vincent Brown Consulting	Partner to improve diversity education for team members to improve care for health disparities	Access
Vincent Brown Consulting	Partner to improve diversity education for team members to improve care for health disparities	Disease Management

Significant Health Needs that BNH will not Address

Significant Health Need from the 2022 CHNA that BNH will not Address	Rational for not Addressing the Significant Health Need
#3: Arthritis or osteoporosis	Low priority assigned by the BNH workgroup based on criteria for decision-making and the specific BNH community served
#4: Lung/respiratory related conditions, including asthma	Low priority assigned by the BNH workgroup based on criteria for decision-making and the specific BNH community served
#5: Oral/dental disease	Low priority assigned by the BNH workgroup based on criteria for decision-making and the specific BNH community served