

Bethesda Butler Hospital

2025 Community Health Needs Assessment Implementation Plan

3125 Hamilton Mason Road
Hamilton, Ohio 45011
Butler County

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EIN: 31-0537122
Date of Board approval: June 24, 2025
Date of initial posting: July 1, 2025

TriHealth Review

Over the last year, Bethesda Butler Hospital (BBH) 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 The Health Collaborative (a paid external consultant).

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

1. Mental Health/Anxiety/Depression – All Populations
2. Heart Disease and Stroke / Hypertension
3. Black Mortality Rate
4. Black Infant Mortality
5. Mental Health – Depression and Anxiety Among White Populations
6. Diabetes among Hispanic and Black Populations
7. Obesity

BBH carefully considered the health needs identified in the Regional CHNA report for the Butler county community served by BBH and determined that an identified need was significant to the BBH service area if it was represented by the research as particularly acute within the community BBH serves.

Process

In order to develop targeted strategies to alleviate problematic issues identified as needs recognized by the Regional CHNA, BBH 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 BBH and TriHealth to address.

List of committee members and meetings

- Frank Nation, Vice President Mission and Culture
- Linda Smith-Berry, Director Community Health Access/Good Samaritan Health Clinic
- Maria Ashdown, RN, Vice President, Chief Nursing Officer, Behavioral Health Good Samaritan
- Jacqui Appel, Manager TriHealth Breast Care Program
- Joi Lindau, Director School To Work Program
- Anne Siebert, RN, Senior Director of Hospital Operations and Nursing Bethesda Butler Hospital
- Tonya Hurst, Director Perinatal Programs
- Tira Williams, RN, Director of Health Disparities
- Jeanette Altenau, Director Community Relations and Government Affairs
- Katrina Rugless, Inclusion and Belonging Partner, Health Equity, Employee Resource Groups
- Amanda Reiboldt, RN, Director Accreditation, Community and Physician Relations, McCullough-Hyde Hospital
- Timothy Hellmann, Tax/Reimbursement Manager
- Lori Baker, Sr. Director PACE Cincinnati, Population Health Management, Post-Acute Leader
- Chris Swallow, Mobile Mammography/Screening

- Stephanie Lambers and Krista Jones, Community Benefit/Special Projects Consultants

Hospital Presidents:

- Dr. Clint Hutson, President Bethesda North Hospital
- Jeremiah Kirkland, President Bethesda Butler and McCullough-Hyde Hospitals
- Kelvin Hanger, President Good Samaritan Hospital

This group met on May 6, 2025, to review the findings from the regional Health Needs Assessment that pertains to BBH's service area. The recommended priorities were reviewed and accepted by the hospital presidents.

Criteria for decision-making

TriHealth chose to continue work with the underserved launched by the 2022 CHNA that is yielding results. Therefore, Substance Abuse 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 2026-2028.

- 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 BBH will address in the implementation strategy are as follows.

Priority Health Needs to be Addressed by BBH

1. Mental Health/Substance Abuse - Given the high prevalence of depression, anxiety, and substance abuse in this area, and the fact that current work is not completed and there are many community partners that are engaging along with TriHealth, mental health and substance abuse remains one of the top priority community needs for TriHealth and BBH.
2. Chronic Conditions— Heart disease, diabetes, hypertension and other health conditions resulting from postponed screenings, access to care and health education are affecting the community disproportionately has been identified as a top priority community need.
3. Food Access and Insecurity—Given the high prevalence of limited food access and insecurity in the region, it is a critical social determinate of health that contributes and impacts people's physical and mental well-being and is a top need in TriHealth and BBH's service areas.

Implementation Plan


 Mental Health / Substance Abuse					
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 mental health and substance abuse to improve health outcomes.				
Strategy or Program	Summary Description	Strategic Objectives			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Integrated Behavioral Health Model	<ul style="list-style-type: none"> Comprehensive behavioral health care model that proactively identifies patient needs using a comprehensive behavioral health assessment and provide treatment as indicated. 	•	•	•	•
Behavioral Health Intake Program	<ul style="list-style-type: none"> Refer patients from the emergency department to the appropriate treatment setting and location. 	•	•	•	•
Substance Abuse Treatment Coordinators	<ul style="list-style-type: none"> Provide RN/Social Worker with specific substance abuse 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	<ul style="list-style-type: none"> Offer support and treatment to patients regardless of their ability to pay, in a structured outpatient setting 	•	•	•	•
BBH Planned Resources	BBH will provide registered nurses, physicians, community health program, 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, Bethesda Foundation.				

	Mental Health / Substance Abuse
CHNA Priority Health Needs being Addressed	Priority health need: Mental health related conditions (depression and anxiety disorders) Priority health need: Substance use including alcohol and other drug prevention
State Health Improvement Plan (SHIP) 2020-2022 Alignment	Mental health and addiction: Depression <ul style="list-style-type: none"> • SHIP strategy: Coordinated care for behavioral health • SHIP strategy: Depression screening Mental health and addiction: Drug overdose deaths <ul style="list-style-type: none"> • SHIP strategy: Culturally competent workforce in underserved communities • SHIP strategy: Recovery communities and peer supports



Health Need: Chronic Conditions


Anticipated Impact (Goal)	Through improved education, data collection, assessments, interventions, culturally competent care and care management, BBH will address and improve specific chronic health conditions that are impacted by disparities, such as hypertension, diabetes, heart disease, stroke and cancers.				
Strategy or Program	Summary Description	Strategic Objectives			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Health Disparities Data Collection	<ul style="list-style-type: none"> Expand program of collecting health disparity data regarding chronic conditions to assess Social Determinants of Health to assist with interventions and track outcomes. 	•	•	•	•
Coordinate existing (and new) chronic health programs with an emphasis on Health Disparities	<ul style="list-style-type: none"> Through the Center for Health Equity, coordinate and assimilate current (and future) programs that address chronic conditions in the areas of critical needs based on zip codes, ethnicity, gender and other social determinants of health. 	•	•	•	•
TriHealth Outreach Programs	<ul style="list-style-type: none"> 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, senior care, ThinkFirst Education, pharmacy assistance, food programs, legal aid, advocacy, housing repair and employee resource groups (ERG). 	•	•	•	•
BBH Planned Resources	Center for Health Equities, Chronic Health Outreach Programs, Inclusion and Belonging, ERGs, Community Health Needs Committee, utilization of nurses, physicians, community health program, philanthropic grants, outreach communication, and program management support for these initiatives				
Planned Collaborators	Bi3, Meharry Medical College (HBCU), American Heart Association, American Lung Association, NAMI, Ride Cincinnati, SVD Charitable Pharmacy, People Working Collaboratively, Legal Aid of				

	Health Need: Chronic Conditions
	Greater Cincinnati, Shared Harvest Foodbank, Greater Cincinnati Foundation, United Way, Health Collaborative, Interact for Health, United Way, Bethesda Foundation, Various Community Organizations.
CHNA Priority Health Needs being Addressed	Priority health need: Cardiovascular related conditions (high blood pressure and/or high cholesterol) Priority health need: Prevention services
State Health Improvement Plan (SHIP) 2020-2022 Alignment	Chronic disease: Heart disease, diabetes <ul style="list-style-type: none"> • SHIP strategy: Hypertension screening • SHIP strategy: Prediabetes screening, testing and referral to diabetes prevention program Mental health and addiction: Depression <ul style="list-style-type: none"> • SHIP strategy: Depression screening Access to care: Local access to health care providers <ul style="list-style-type: none"> • SHIP strategy: Culturally competent workforce in underserved communities



Health Need: Food Access and Insecurities

Anticipated Impact (Goal)	Improve access to food and resources for the underserved populations with emphasis on education, assessment, collaboration, food distribution and integration with clinical care.				
Strategy or Program	Summary Description	Strategic Objectives			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
TriHealth Food Pantries	<ul style="list-style-type: none"> Program that provides screenings, education, food, personal hygiene items, and community resource information for underserved patients who are need that enhances health, mental wellbeing and impacts chronic conditions and health equity. 	•	•	•	•
Partnerships with the Community	<ul style="list-style-type: none"> Active partnerships with organizations, such as Shared Harvest Foodbank, Freestore Foodbank, Hosea House, Last Mile Rescue, and others who contribute to the community with food for homeless, students, mobile markets to addresses food disparities in the underserved communities. 	•	•	•	•
Team Member Engagement Food Drives	<ul style="list-style-type: none"> Team Member initiated food drives to support hospital and community partner programs to address food access and insecurities. 	•	•	•	•
BBH Planned Resources	Facility space, physicians, nurses, team members, community relations director and coordinator				
Planned Collaborators	FreeStore Food Bank, Shared Harvest, Last Mile Rescue, Hosea House, Greater Cincinnati Regional Food Policy Council, Health Collaborative, Interact for Health, Bethesda Foundation				
CHNA Priority Health Needs being Addressed	Priority health need: Food access and insecurities Priority health need: Education and Resources				

	Health Need: Food Access and Insecurities
State Health Improvement Plan (SHIP) 2020-2022 Alignment	Food Access and Insecurity SHIP strategy: healthy food initiatives in food banks SHIP strategy: food insecurity screening and referrals

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
First Step Home	Partner for HOPE programs	Maternal/Child 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
Hosea House	Food Donation to the homeless	Food Access and Insecurity
Interact for Health	Grants, education, policy	Chronic Conditions
Interact for Health	Grants, education, policy	Substance Abuse
Last Mile Food Rescue	Food Donation to the homeless	Food Access and Insecurity
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
Shared Harvest	Food Bank in Butler Co, advocacy, pantries	Food 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

Organization	Role	Focus
TriHealth	HARP - primary care for discharged uninsured patients	Chronic Conditions
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 BBH will not Address

Significant Health Need from the 2025 CHNA that GSH will not Address	Rational for not Addressing the Significant Health Need
Lung/respiratory related conditions, including asthma	Low priority assigned by the GSH workgroup based on criteria for decision-making and the specific GSH community served
Oral/dental disease	Low priority assigned by the GSH workgroup based on criteria for decision-making and the specific GSH community served