# Bethesda North Hospital

## 2025 Community Health Needs Assessment Implementation Plan

10500 Montgomery Road
Cincinnati, Ohio 45242
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 The Health Collaborative (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 identified below for BNH 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

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, 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 BNH'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 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 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 BNH will address in the implementation strategy are as follows.

## Priority Health Needs to be Addressed by BNH

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 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 and BNH.
3. 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.
4. 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 BNH service areas.

# Implementation Plan

| Mental Health / Substance Abuse | | | | | |
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| **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 | • 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 | • Refer patients from the emergency department to the appropriate treatment setting and location. | • | • | • | • |
| Substance Abuse Treatment Coordinators | • 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 | • Offer support and treatment to patients regardless of their ability to pay, in a structured outpatient setting | • | • | • | • |
| **BNH Planned Resources** | BNH 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)<br>Priority health need: Substance use including alcohol and other drug prevention |
| **State Health Improvement Plan (SHIP) 2020-2022 Alignment** | Mental health and addiction: Depression<br>• SHIP strategy: Coordinated care for behavioral health<br>• SHIP strategy: Depression screening<br>Mental health and addiction: Drug overdose deaths<br>• SHIP strategy: Culturally competent workforce in underserved communities<br>• 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, specifically with the underserved, as well as improve outcomes for maternal health with emphasis on education, clinical care, health disparities and community outreach. | | | | |
| **Strategy or Program** | **Summary Description** | **Strategic Objectives** | | | |
| | | Alignment & Integration | Clinical - Community Linkage | 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, community health workers, financial counselors, and legal aid consultants to provide excellent care while addressing social determinants of health. | ● | ● | ● | ● |
| HOPE Program | ● Program that will provide patient-centered care to chemically dependent pregnant women improving birth outcomes and maternal substance-free outcomes. | ● | ● | ● | ● |
| Perinatal Outreach | ● Maintains several key community partnerships that foster collaboration around social determinants of care to receive referrals to TriHealth and Bethesda North for OB care. | ● | ● | ● | ● |
| **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. | | | | |

| | Health Need: Maternal / Child Health |
|---|---|
| **Planned Collaborators** | Cradle Cincinnati, First Step Home, 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** | Priority health need: Maternal health complications |
| **State Health Improvement Plan (SHIP) 2020-2022 Alignment** | Maternal and infant health: Preterm births, infant mortality, maternal morbidity<br>• SHIP strategy: Care coordination and access to well-woman care<br>• SHIP strategy: Safety and quality improvement |

| Health Need: Chronic Conditions | | | | | |
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| **Anticipated Impact (Goal)** | Through improved education, data collection, assessments, interventions, culturally competent care and care management, BNH 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 | • 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 | • 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 | • 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). | • | • | • | • |
| **BNH Planned Resources** | Center for Health Equities, Chronic Health Outreach Programs, Inclusion and Belonging, ERGs, 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), 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, BN Foundation, Various Community Organizations. |
| **CHNA Priority Health Needs being Addressed** | Priority health need: Cardiovascular related conditions (high blood pressure and/or high cholesterol)<br>Priority health need: Prevention services |
| **State Health Improvement Plan (SHIP) 2020-2022 Alignment** | Chronic disease: Heart disease, diabetes<br>• SHIP strategy: Hypertension screening<br>• SHIP strategy: Prediabetes screening, testing and referral to diabetes prevention program<br>Mental health and addiction: Depression<br>• SHIP strategy: Depression screening<br>Access to care: Local access to health care providers<br>• SHIP strategy: Culturally competent workforce in underserved communities |

| Health Need: Food Access and Insecurities | | | | | |
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| **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 | ● 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 | ● Active partnerships with organizations, such as Shared Harvest, 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 | ● Team Member initiated food drives to support hospital and community partner programs to address food access and insecurities. | ● | ● | ● | ● |
| **BNH 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 | | | | |
| **CHNA Priority Health Needs being Addressed** | Priority health need: Food access and insecurities<br>Priority health need: Education and Resources | | | | |

| | Health Need: Food Access and Insecurities |
|---|---|
| **State Health Improvement Plan (SHIP) 2020-2022 Alignment** | Food Access and Insecurity<br>SHIP strategy: healthy food initiatives in food banks<br>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 BNH will not Address

| Significant Health Need from the 2022 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 |