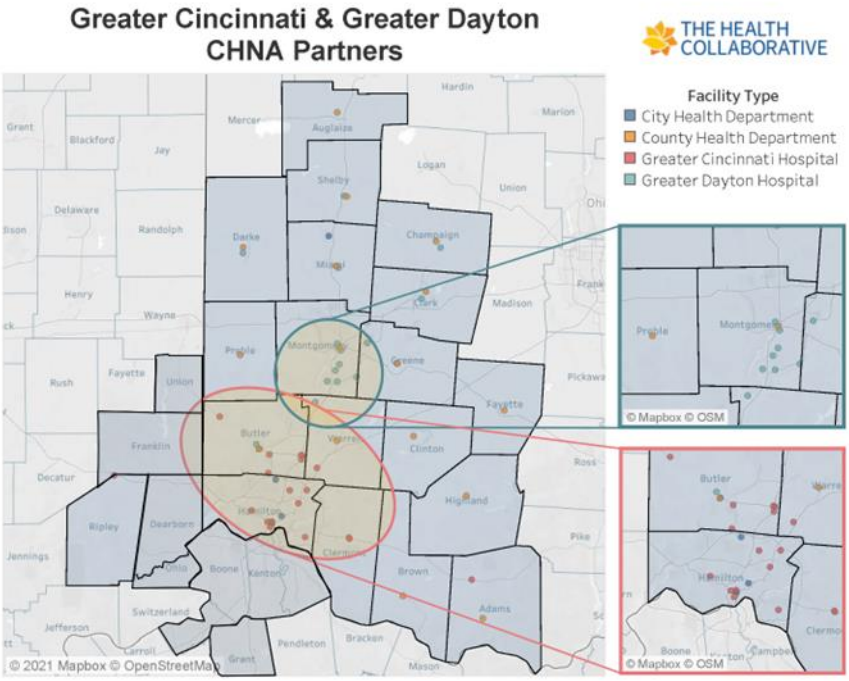
Bethesda North Hospital

2025 Community Health Needs Assessment

10500 Montgomery Road
Cincinnati, Ohio 45242
Hamilton County



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10500 Montgomery Road
Cincinnati, Ohio 45242

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Introduction

Bethesda North Hospital | TriHealth (BNH) continues to grow along with our community and continually assesses the needs of our communities as we develop new programs and services. Over the last year, we have completed a comprehensive Community Health Needs Assessment (CHNA). Our 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.

The following document is a detailed CHNA for BNH, with the main campus located at 10500 Montgomery Road, Cincinnati, Hamilton County, Ohio 45242. BNH is an affiliate with TriHealth, Inc., which is an integrated health care system, whose mission and vision, leadership and resources help us serve our communities. Through our affiliation with TriHealth, Inc. the resources of Good Samaritan Hospital, Bethesda Butler Hospital, and McCullough Hyde Memorial Hospital are also available to our clients.

BNH recognizes that a CHNA is required to meet current government regulations for 501(c)(3) tax exempt hospitals and this assessment is intended to fulfill this purpose. We also recognize the importance of this assessment in helping to meet the needs of our communities.

BNH participated in the broader Regional CHNA process to assess the region's community health needs. The Regional Community Health Needs Assessment 2025 Report is available at https://healthcollab.org/community-health-needs-assessment.

BNH carefully considered the health needs identified in the Regional CHNA for the community served by BNH. This CHNA was completed in 2025, however; all data collection was completed in 2024.

This BNH CHNA is the foundation for our implementation plan as required by the applicable regulations. The question of how the hospital can best use its limited resources to assist communities is addressed in our implementation plan. BNH has taken a leadership role in both the CHNA and in our communities' plans to address the needs identified.

Please contact Frank Nation, VP Mission and Culture, at 513-569-6248 or at Frank_Nation@trihealth.com to obtain a hard copy of the CHNA report at no charge. Written comments regarding this CHNA report and related implementation strategy may be submitted to Frank_Nation@trihealth.com.

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Summary of Regional Approach and Health Findings Introduction

Regional Vision: Every individual and community in the region should have equitable access and support to achieve their desired health outcomes. Achieving this vision requires that communities have what they need to be healthy and that our policies and systems advance health for every individual and family. The Regional Community Health Needs Assessment (CHNA) moves towards this vision by assessing the most significant health needs in the region and defining priorities for collective action.

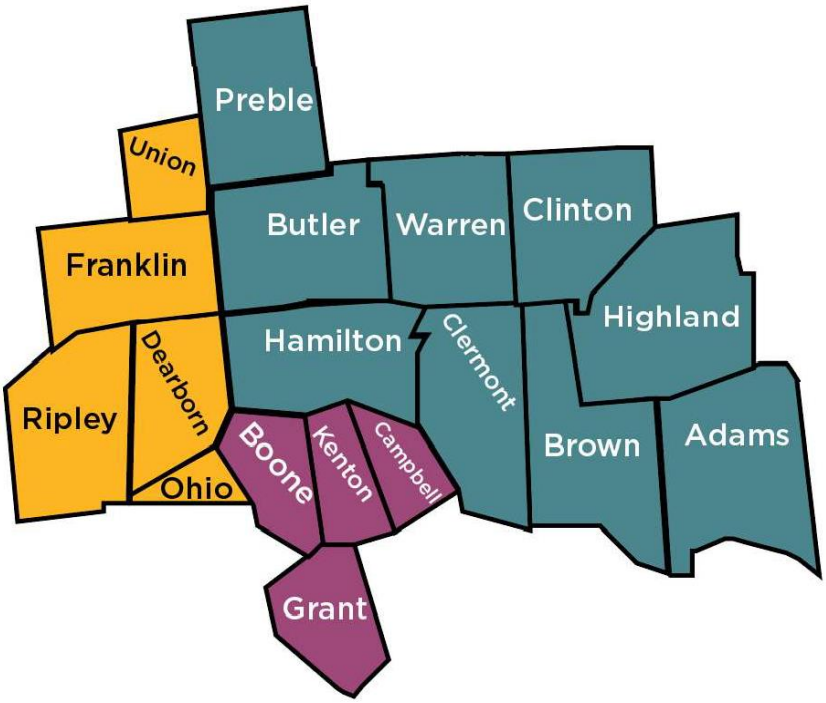
What is the Regional CHNA?

Every three years, the Greater Cincinnati Tri-State Region conducts a Regional CHNA to evaluate the health and well-being of its 18-counties and identify opportunities for collective action. The Regional CHNA is a resource that can be used by partners across sectors and policymakers to increase access to data, guide health improvement, and advance equity.

The Regional CHNA informs the 2025-2027 Collective Health Agenda, a Regional Community Health Improvement Plan (CHIP) and roadmap to advance health and equity in the region. It builds upon progress and lessons learned from the 2021 Regional CHNA and the 2022-2024 Regional CHIP.

The Regional CHNA report:

- Defines regional health priorities
- Describes the factors that shape the region's health and well-being
- Lists the region's significant health needs
- Describes progress made since the previous Regional CHNA and CHIP



Framework for Collective Action

The framework for collective action lays out a comprehensive approach to achieving the region's vision. The approach advances collective action by addressing the factors that shape our health and well-being, measuring if health is improving, and mobilizing community assets and resources.

How was the Regional CHNA developed?

The Regional CHNA by the numbers:

- Compiled 49 secondary, quantitative data metrics from 34 different sources
- Analyzed 18 Ohio Hospital Association data metrics
- Reviewed seven other primary and secondary regional data sources such as community surveys, data from 2-1-1 calls, and recent community reports
- Disaggregated 32 metrics by characteristics such as race, ethnicity, age, and income
- Hosted 12 Advisory Committee meetings and six Task Force meetings, which included 45 total partner organizations

For more detail: Appendix A describes the Community Engagement approach. Appendix B describes the Regional CHNA advisory structure. Appendix C describes the data collection and analysis methodology, and Appendix D describes the prioritization process.

Aligning on principles for collective action

The Regional CHNA's conceptual framework outlines three principles for collective action: equity, collaboration, and community voice. The Regional CHNA put these principles into practice by:

Equity

- Identifying opportunities to foster systems, policies, and beliefs that dismantle systems of power, privilege, and oppression
- Disaggregating data by characteristics such as race, ethnicity, age, and income to identify disparities and inequities
- Defining priority populations for regional priorities with the goal of eliminating disparities across the region

Collaboration

- Building partnerships across health and non-health-specific sectors to lead the CHNA process
- Leaning on alignment and shared decision-making to drive health improvement strategies

Community Voice

- Analyzing primary data, including community surveys, to center lived experiences and perspectives
- Engaging grassroots organizations and others who work directly with priority populations in the advisory structure to guide the CHNA process
- Launching the Community Partnership Network to facilitate bidirectional communication between CHNA partners and community members

Community Partnership Network

The Health Collaborative launched the Community Partnership Network (CPN) in July 2024 to center equity and community voice in the assessment and planning process, increase bidirectional communication on progress, and minimize the burden of "new" data collection. The CPN leverages existing community meetings, momentum, and assets to strengthen connective tissue and partnership to advance shared goals for community health. Currently in an initial pilot phase, existing community partnerships are co-designing a framework for actionability and sustainability of the CPN.

More information on how collaboration and community voice were used to develop the Regional CHNA is provided in Appendix A.

How can I use the Regional CHNA

Partners across the region can use the Regional CHNA to:

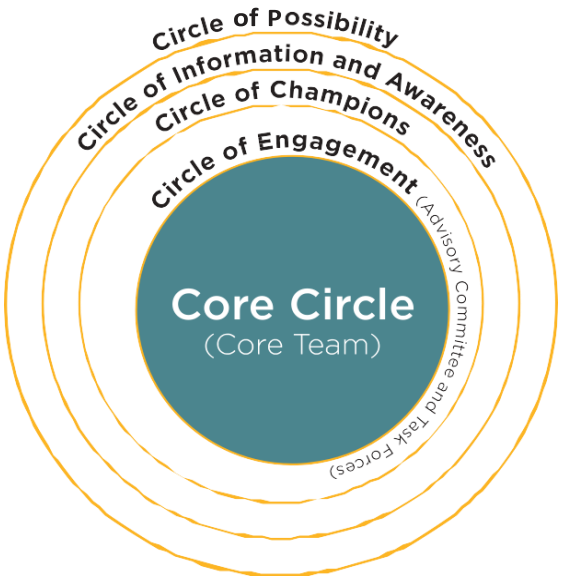
1. **Share data and information.** Post graphics on social media, share data and information in community presentations, and forward the report to partners and community members.
2. **Align health improvement efforts.** Partner and collaborate across and within sectors to improve outcomes in the region.

3. **Advocate for funding and policy change.** Reference the Regional CHNA in research and grant applications and use it in conversations with state and local policymakers.
4. **Advance equity.** Target resources and tailor evidence-based practices to meet the needs of priority populations outlined in the Regional CHNA. Measure progress towards eliminating disparities and inequities in health and well-being across the region using the data provided in the Regional CHNA report.
5. **Inform community investment.** Funders can allocate funding and resources and provide technical assistance related to the priorities outlined in the Regional CHNA.

Regional CHNA Methodology

Collaborative Advisory / Work Structure

The advisory structure for the Regional Community Health Needs Assessment (CHNA) was built using the Mobilizing Action through Planning and Partnerships 2.0 (MAPP) Circle of Involvement Framework. This includes the:



See Appendix B for membership.

Community Engagement

Building the assessment and telling the community story

To minimize the burden on community members who report being over-surveyed and assessed, the Advisory Committee decided to leverage recent, existing sources of primary and secondary community data, rather than collecting new primary data. Advisory Committee and Task Force members were invited to share any data they have collected to be included in the Regional CHNA, with a focus on sources that filled data gaps. Seven additional sources of community data were identified and included in the Regional CHNA.

Data Collection and Analysis

The Health Collaborative contracted with the Health Policy Institute of Ohio (HPIO) to develop the Regional Community Health Needs Assessment (CHNA). The analysis was guided by a set of research questions, and consisted of:

- Secondary, quantitative data compilation and analysis
- Additional primary and secondary community data analysis

Research Questions

The Health Collaborative and HPIO developed the following research questions, based on Public Health Accreditation Board (PHAB) and Internal Revenue Service (IRS) requirements, to guide development of this Community Health Needs Assessment:

1. What are the most significant health needs in the region?
2. What populations are experiencing inequities and disparities across health, socio- economic, environmental and quality-of-life outcomes?
3. What are the systems and structures that drive the identified health needs?
4. What strengths and resources does the region have that can address the region's most significant health needs? What resources and assets exist to support communities experiencing inequities and disparities?
5. What progress have partners made on the priorities identified in the last CHNA?

Secondary, quantitative data analysis methodology

How were metrics selected?

HPIO reviewed a wide range of publicly available data sources, including national- and state-based population health surveys, vital statistics, and administrative data from state and federal agencies, among other sources. Using these sources, HPIO compiled a list of 264 metrics for consideration in the Regional CHNA. From this inventory of metrics, The Health Collaborative and HPIO recommended 67 secondary, quantitative metrics using the following criteria approved by the Advisory Committee.

Metric selection criteria

Goal: Identify the **most important** metrics needed to describe the region's significant health needs, including social and structural drivers of health

- **Data availability** — Data available at the county-level that can be assessed for long- term trend (change over time), compared to performance of the U.S. or the state overall, and can be disaggregated to look at disparities and inequities (e.g., by race, ethnicity, household income)
- **Source integrity** — Metrics are recognized as valid and reliable, and data is gathered from reputable sources
- **Face value** — Metrics are easily understood by the public
- **Alignment** — Metrics align with relevant state and local plans
- **Data quality and recency** — Data for the metric is complete, accurate, and most- recent data is from the past three years

See Appendix C for more information.

Regional Priorities

Coming to consensus around shared regional priorities

Throughout the Regional CHNA process, THC emphasized the shared values and principles of collective action for the Advisory Committee and Task Force members. This invited alignment from partners on the significant health needs, potential priorities, and final priorities is described in Appendix D.

To inform the prioritization process, HPIO developed a pre-prioritization survey to be completed by hospitals, local health departments, and other community partners. Of the 47 partners who responded, the largest proportion represented community- based organizations (28%), highlighting the inclusion of community voices through the prioritization process.

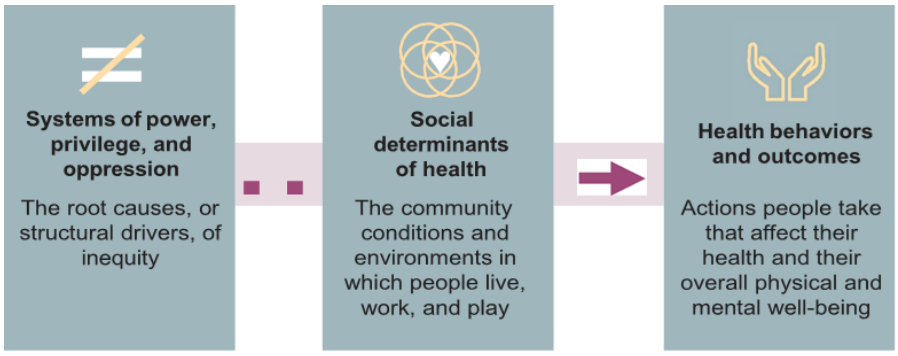
What Shapes the Region's Health and Well-Being?

Many factors lie at the root of the three regional priorities - and our overall health and well-being. One of the biggest factors is related to the conditions of our communities[24]. Also called the social determinants of health, community conditions- like educational opportunities and housing - support our ability to be healthy and make healthy choices.

Those conditions are shaped by systems of power, privilege, and oppression that can unfairly distribute resources and opportunities across groups and communities (as displayed below).

The assessment process for the Regional CHNA was organized and based on these domains using the National Association of County and City Health Officials' (NACCHO) **Mobilizing for Action through Planning and Partnerships (MAPP 2.0)** framework. The following sections outline key findings from each of these domains.

Regional CHNA Domains: The root causes of health outcomes and inequities



Source: Adapted from the NACCHO "Health Equity Action Spectrum"

Significant Health Needs in the Region

The health needs of the region were identified through a robust review of primary and secondary data with community and stakeholder input. Significant health needs are those that rose to the top based on review of the data when looking at prevalence, unmet need, impact, and inequity. Appendix D includes more detail on how significant health needs were identified and used in the prioritization process.

Significant Health Needs in the Region

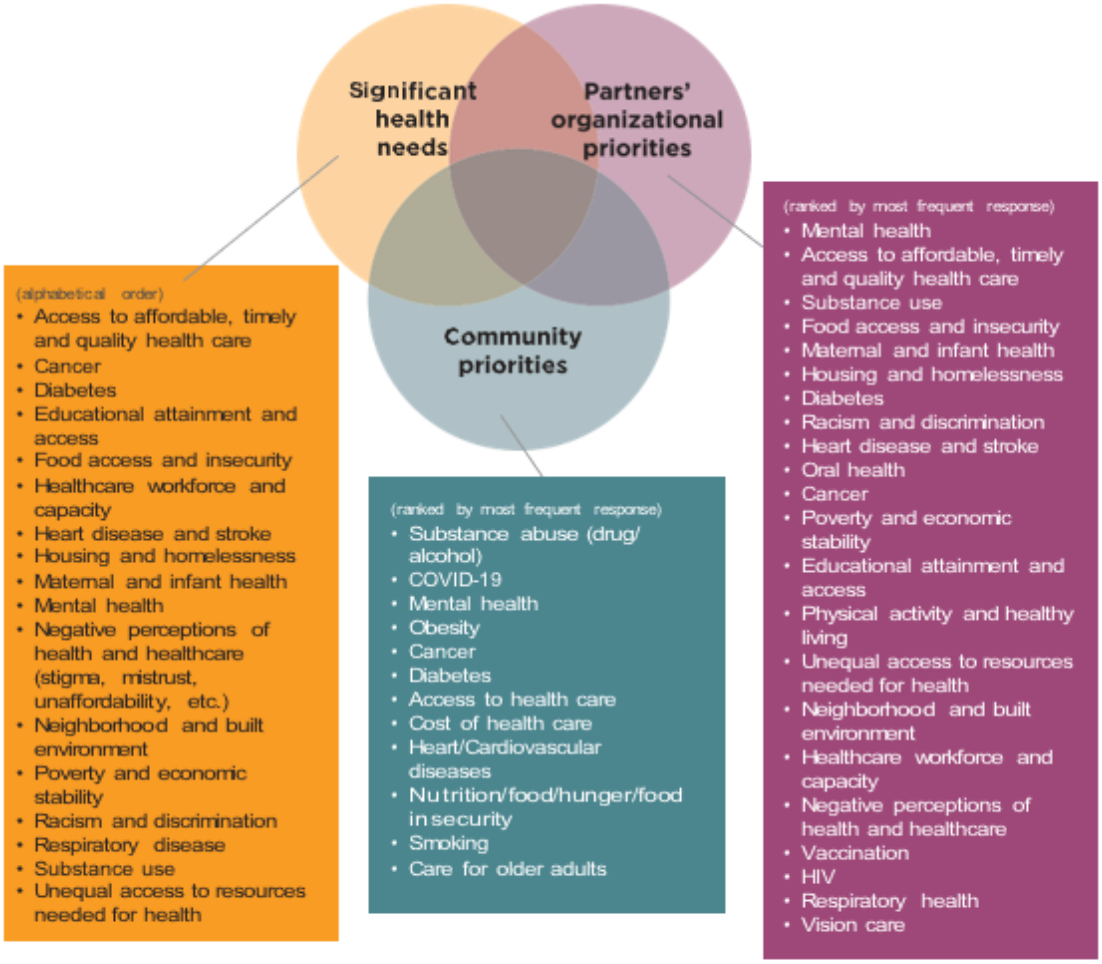
	Healthy People 2030	Ohio SHIP	Kentucky SHIP	Indiana SHIP
Systems of power, privilege, and oppression				
Negative perceptions of health and healthcare (stigma, mistrust, unaffordability, etc.)		✓	✓	✓
Racism and discrimination		✓		
Unequal access to resources needed for health	✓	✓	✓	
Social determinants of health				
Access to affordable, timely and quality health care	✓	✓	✓	✓
Educational attainment and access	✓	✓	✓	✓
Food access and insecurity	✓	✓	✓	✓
Healthcare workforce and capacity	✓	✓	✓	✓
Housing and homelessness	✓	✓	✓	✓
Neighborhood and built environment	✓	✓		✓
Poverty and economic stability	✓	✓	✓	✓
Health behaviors and outcomes				
Cancer	✓	✓	✓	✓
Diabetes	✓	✓	✓	✓
Heart disease and stroke	✓	✓	✓	✓
Maternal and infant health	✓	✓	✓	✓
Mental health	✓	✓	✓	✓
Respiratory disease	✓	✓	✓	✓
Substance use	✓	✓	✓	✓

Note: Icons indicate alignment with State Health Improvement Plans (SHIPs) and Healthy People 2030

Alignment with Community Priorities

There is meaningful alignment between the region's significant health needs, the priorities of community members, and the organizational priorities of Regional CHNA partners. Many people and groups across the region are already taking action to address these challenges and improve health. How the region's significant health needs, partner priorities, and community priorities are aligned is demonstrated below.

Alignment Between Significant Health Needs and Partners' and Community Priorities



Source: Significant health needs: As defined during the Regional CHNA process; Partners' organizational priorities: "2024 Regional CHNA Pre-Prioritization Survey" administered to Regional CHNA Advisory Committee, Task Forces, and community partners online from September 3 to October 15, 2024; Community priorities: Interact for Health and University of Cincinnati Institute for Policy Research, 2022 Community Health Status Survey

Regional Health Priorities

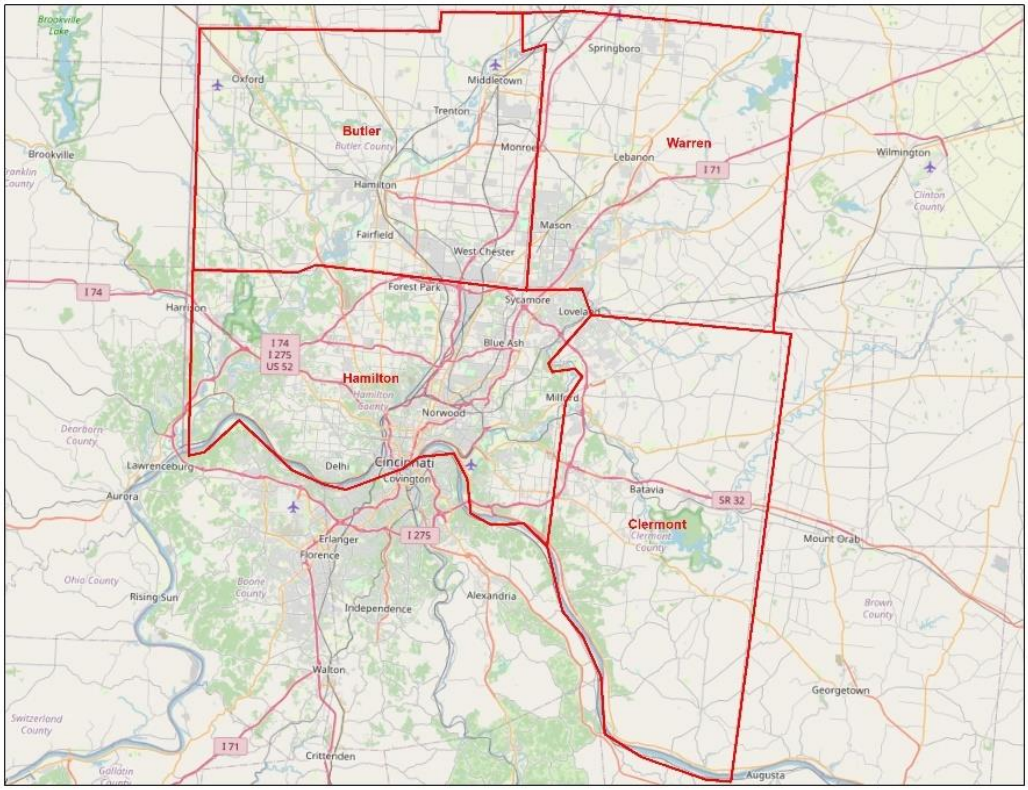
To improve health, address community conditions that undermine health, and tackle the systems that prevent some of our neighbors from living long and healthy lives, CHNA partners selected the following three priorities for collective action:

Regional priorities, informed by data and community voice, were selected by CHNA partners using the following criteria:

1. **Capacity and feasibility:** Does our region have the ability to address this health need?
2. **Connection between factors and outcomes:** To what degree do the prioritized structural/social determinants contribute to prioritized health outcomes?
3. **Equity:** Would addressing this health need significantly address health disparities?
4. **Burden and severity:** Would addressing this health need have an impact on the greatest number of community members?
5. **Ability to track progress:** Are there indicators that can be used to measure progress over time?

Bethesda North Hospital's Service Area

Bethesda North Hospital (BNH) defines its service area to be Hamilton, Butler, Clermont and Warren Counties, Ohio, as determined by the county of origin for inpatients. BNH gets more than 87% of its inpatients from a four-county region in Southwest Ohio.



Community Health Needs Identified by Bethesda North Hospital

Community Health Issues and Disparities

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 and Black populations
6. Diabetes among Hispanic and Black populations
7. Obesity

The Community Needs priorities identified in the Regional CHNA, summarized on page 10, were titrated to the hospital service area and hospital scope, with TWO of the three regional priorities identified by Bethesda North Hospital as key community needs. In addition, Bethesda North Hospital identified several health issues that are specific to its four-county service area.

Regional (18-County) Priority 1: Mental Health treatment and prevention

Populations who face the greatest barriers to mental health treatment and prevention

The following groups and communities in the region often experience policies, practices, and environments that create barriers to mental health treatment and prevention:

- Appalachian and rural communities
- People of color
- LGBTQ+ residents
- People with disabilities
- People with less educational attainment
- People with lower incomes
- Women/female residents
- Youth and young adults

Key insights on mental health outcomes in the region

Regional data on mental health shows:

- The percentage of adults with depression in the region has risen 93% over the last 27 years and nearly 1 in 5 adults report frequent mental distress.[1]
- The number of deaths due to suicide in the region is 10% higher than the national average and 20% higher than the national Healthy People 2030 benchmark.[2]
- Community members often do not have a way to find needed services and to identify trusted mental health providers.[3]
- Barriers to accessing treatment include stigma, lack of insurance coverage, limited availability of providers, and a lack of culturally responsive mental health services.[4]
- As of 2023, only about 18% of residents in the region had heard about the 988 National Suicide Prevention Lifeline.[5]

The percentage of adults in the Greater Cincinnati region with depression nearly doubled between 1995 and 2022.

Depression, 1995 and 2022

Note: The region measured by Interact for Health includes 22 counties across Ohio, Kentucky, and Indiana.
Source: Interact for Health, Our Health, Our Opportunity Report

[1] "About Mental Health." Centers for Disease Control and Prevention, Accessed December 13, 2024. https://www.cdc.gov/ mental-health/about/index.html

[2] "About Mental Health." Centers for Disease Control and Prevention, Accessed December 13, 2024. https://www.cdc.gov/ mental-health/about/index.html

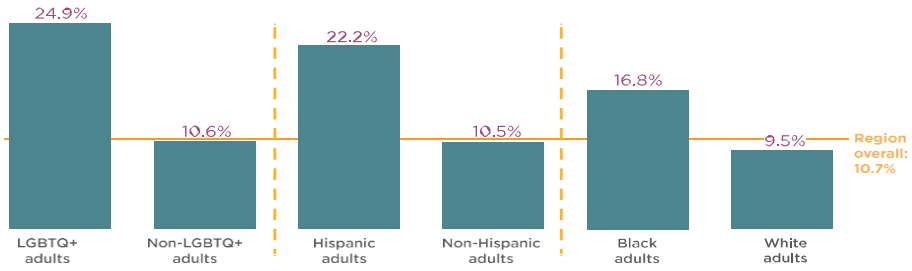
[3] "2021CHNA focus group results." The Health Collaborative and Measurement Resources Company, 2021.

[4] Ibid.

[5] Our Health, Our Opportunity. Cincinnati, OH: Interact for Health, September 2024. https://www.ourhealthouropportunity. org/. Residents surveyed were in the region covered by Interact for Health which serves 20 counties across Ohio, Kentucky, and Indiana.

There are notable disparities in access to mental health treatment by sexual orientation, gender identity, race, and ethnicity in the region.

Access to Mental Health Treatment, By Race, Ethnicity, Sexual Orientation, and Gender Identity, 2022



Note: The region measured by Interact for Health includes 22 counties across Ohio, Kentucky, and Indiana.
Source: Interact for Health and University of Cincinnati Institute for Policy Research, 2022 Community Health Status Survey

How does the region compare to the nation?

The region performs worse than the U.S. overall on measures of frequent mental distress (i.e., the percent of adults who reported 14 or more days of poor mental health per month) and suicide deaths.

National Benchmarks for Mental Health*

	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Frequent mental distress c2021)	17.0%**	14.6%	N/A	Worse	N/A
Suicide deaths c201?-2021)	15.5	14 (2021)	12.8	Worse	Worse

*Benchmark comparisons are a calculation of the difference between the regional value, the value for the U.S. overall, and available national Healthy People 2030 benchmarks. In the Regional CHNA report, metrics that have less than 10% difference between the regional and benchmark values are classified as performing the "same." Metrics that have a difference of 10% or greater are classified as "better" or "worse."

Data note: Regional values ** are the median of all available counties.

Sources: Data for the U.S. overall value for frequent mental distress is from the **CDC BRFSS.** U.S. overall data for suicide deaths is from the **National Institute of Mental Health**

Regional (18-County) Priority 2: Heart Disease and Stroke prevention and treatment

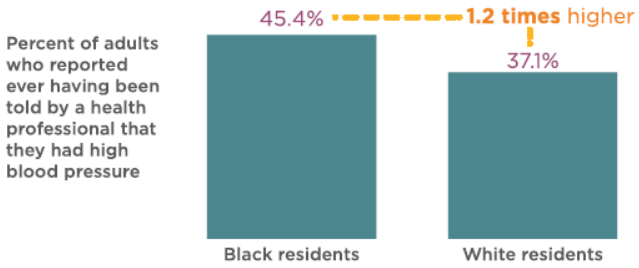
Populations who face the greatest barriers to heart disease and stroke prevention

The following groups and communities in the region often experience policies, practices, and environments that create barriers to heart disease and stroke prevention:

- Appalachian and rural communities
- Black residents
- Older adults
- People with less educational attainment
- People with lower incomes

Forty-five percent of African American residents in the Greater Cincinnati area report having been diagnosed with high blood pressure (i.e., hypertension) by a healthcare provider, compared to 37% of white residents.

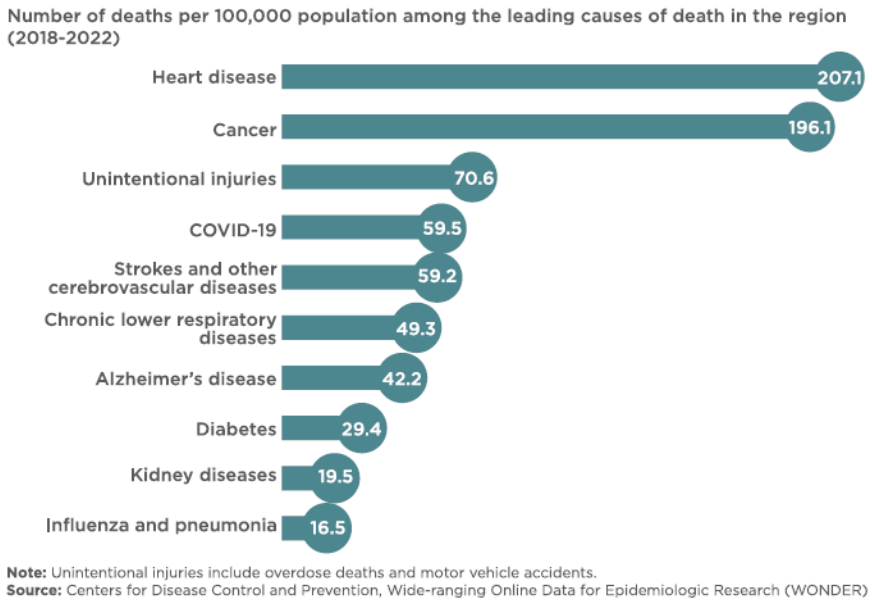
High Blood Pressure, By Race, 2022



Note: The region measured by Interact for Health includes 22 counties across Ohio, Kentucky, and Indiana.
Source: Interact for Health and University of Cincinnati Institute for Policy Research, 2022 Community Health Status Survey

Heart disease and stroke related to hypertension were among the leading causes of death in the region from 2018 to 2022.

Leading Causes of Death in the Region, 2018-2022



Note: Unintentional injuries include overdose deaths and motor vehicle accidents.
Source: Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research (WONDER)

How does the region compare to the nation?

The region has similar estimated rates of hypertension and stroke compared to the nation but an estimated 50% higher rate of heart disease than the U.S. overall. When looking at rates of death, the region's stroke and cerebrovascular disease death rate is approximately 25% greater than the nation's, and the region's heart disease death rate is more than double the Healthy People 2030 target.

National Benchmarks for Heart Disease and Stroke*

	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Heart disease prevalence (2021)	5.7%**	3.8%	N/A	Worse	N/A
Hypertension prevalence (2021)	32.6%**	32.4%	N/A	Same	N/A
Stroke prevalence (2021)	2.8%**	3%	N/A	Same	N/A
Heart disease deaths (2018-2022)	207.1 per 100,000 population	206.6 per 100,000 population	71.1 per 100,000 population (age-adjusted)	Same	Worse
Stroke and cerebrovascular disease deaths (2018-2022)	59.2 per 100,000 population	47.7 per 100,000 population	33.4 per 100,000 population (age-adjusted)	Worse	Worse

*Benchmark comparisons are a calculation of the difference between the regional value, the value for the U.S. overall, and available national Healthy People 2030 benchmarks. In the Regional CHNA report, metrics that have less than 10% difference between the regional and benchmark values are classified as performing the "same." Metrics that have a difference of 10% or greater are classified as "better" or "worse."
Data note: Regional values ** are the median of all available counties.
Sources: Information on regional values can be found in the data appendix spreadsheet. Data for the U.S. overall value for heart disease prevalence, hypertension prevalence, and stroke prevalence is from the CDC BRFSS. U.S. overall data for heart disease deaths and stroke and cerebrovascular disease deaths is from CDC WONDER.

Bethesda North Hospital Service Area Additional Health Needs

In addition to the two community health needs identified by the regional CHNA that are also prevalent in Bethesda North's service area, Bethesda North assessed data and existing collaborative work in health disparities to identify high needs community health needs applicable to its four county service area.

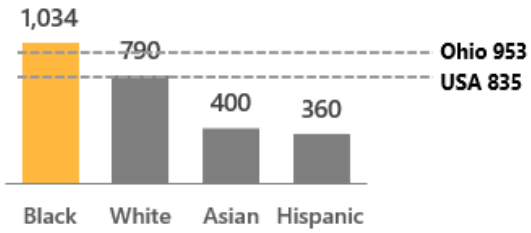
Service Area Health Need: Higher Mortality Rate Among Black Population

~31%

HIGHER MORTALITY RATE

FOR BLACK RESIDENTS THAN FOR WHITE RESIDENTS IN HAMILTON COUNTY

Approximate Age-Adjusted Mortality Rate by Race Rate Per 100,000 Hamilton County Health Equity Report, 2022



Source: Community Health Disparities Report – TriHealth Center for Health Equity

Service Area Health Need: Maternal/Infant Health among Black Women

The infant mortality rate in Hamilton County is now on par with the national average in the aggregrate.*

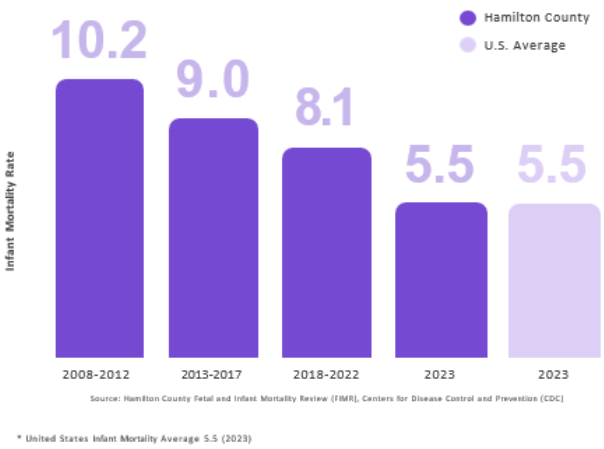
In 2013, Hamilton County set an aspirational goal of achieving an infant mortality rate on par with the national average.

At that time, Hamilton County families were 70% more likely to experience an infant loss than the nation as a whole.

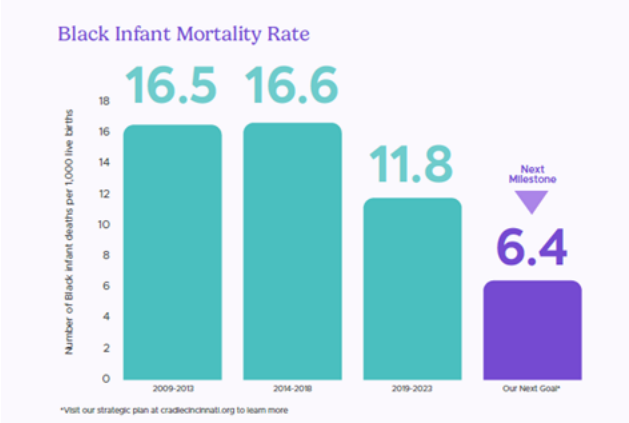
We're pleased to announce the infant mortality rate is on par with the national average – a testament to what can be achieved when a community comes together around a common goal.

We are motivated by our county's progress. ***But there is much more work to be done to ensure every baby born in Hamilton County lives to see their first birthday.***

Source: Cradle Cincinnati, 2023 Hamilton County Maternal and Infant Health



In particular – Black infant mortality remains above the Hamilton County total and above targets.



Leading Causes of Infant Death in Hamilton County 2019-2023		
46%	Preterm Birth-Related Deaths	Complementary medical and community based interventions support the decline in Black infant death.
23%	Sleep-Related Infant Deaths	Sleep-related infant deaths continue to be a stubborn problem. The data calls for innovative interventions.
17%	Birth Defect-Related Deaths	Birth defect data remains consistent with national averages and shows no racial disparities.
14%	Other Deaths	Includes homicides, infections, accidents and other causes.

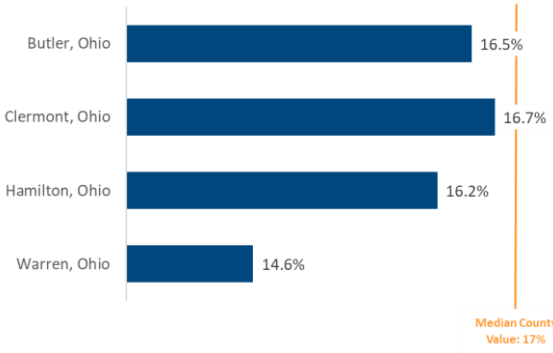
Source: Cradle Cincinnati, 2023 Hamilton County Maternal and Infant Health Report

Key health conditions among low-income population in Bethesda North Hospital's Four-County Service Area that lead to acute hospitalization were also identified in this process, raising three additional community health needs that are prevalent in the low income populations served by Bethesda North Hospital.

Service Area Health Need: Mental Health Issues In the White population

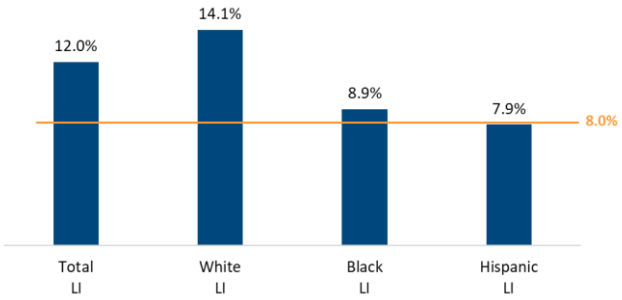
Reinforcing the regional priority - while the service area in the aggregate does not show overly high mental health issues low-income white and black patients experience anxiety and depression at a much higher rate than patients with commercial or Medicare insurance.

Frequent Mental Distress by County, 2021



Source: Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps

Comparative Anxiety & Depression, FY 2024

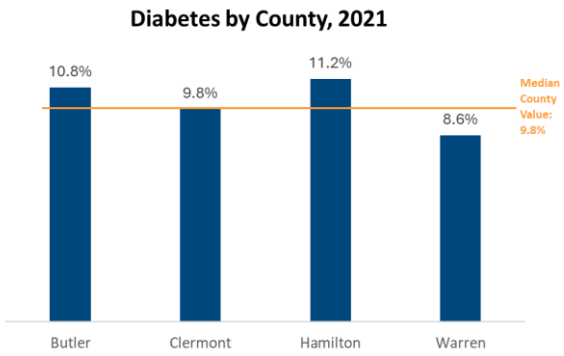


Key:
LI = Low Income = Medicaid & Self Pay

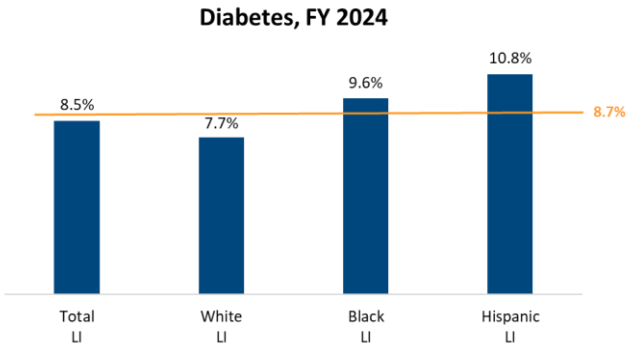
Source: OHA Insight FY24
Definitions:
Low Income (LI) =Medicaid/Self Pay, Admitted Patients 18+ years old
Benchmark= Commercial & Medicare Patients 18+ years old

Service Area Health Need: Diabetes - Hispanic and Black population

Most of the service area has high incidence of diabetes. Low-income Hispanic patients and Black patients have more diabetes than Medicare/Commercial patients.



Source: Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps

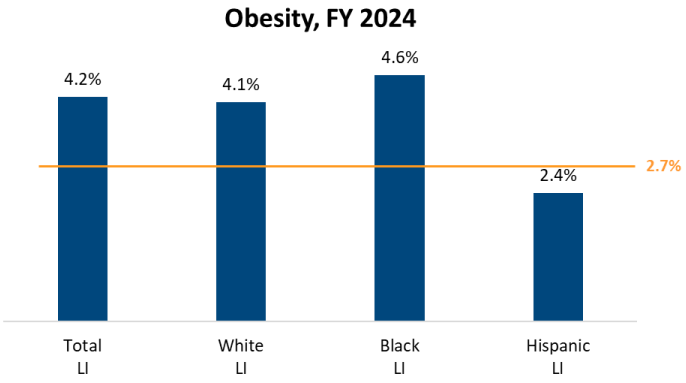


Key:
LI = Low Income = Medicaid & Self Pay

Source: OHA Insight FY24
Definitions:
Low Income (LI) =Medicaid/Self Pay, Admitted Patients 18+ years old
Benchmark= Commercial & Medicare Patients 18+ years old

Service Area Health Need: Obesity

Low income Black and White populations have significantly higher incidence of obesity.



Key:
LI = Low Income = Medicaid & Self Pay

Source: OHA Insight FY24
Definitions:
Low Income (LI) =Medicaid/Self Pay, Admitted Patients 18+ years old
Benchmark= Commercial & Medicare Patients 18+ years old

In summary the seven community health needs identified by Bethesda North Hospital to be prioritized for action plans were derived from:

1. The Regional CHNA
2. Bethesda North Hospital's current community benefits work – knowledge of the population and
3. Identifying underlying health conditions among the low income population (Medicaid and self pay used as a surrogate) that are so acute they lead to inpatient hospitalization.

Prior to BNH prioritization work these health conditions are:

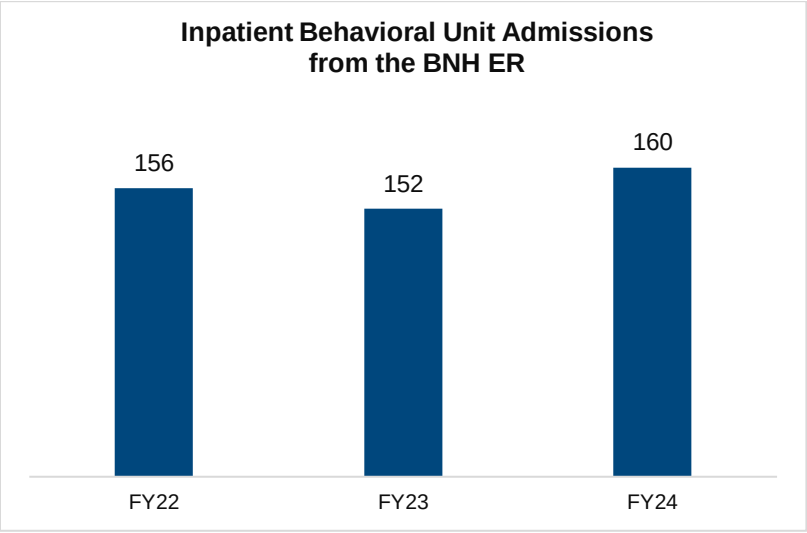
1. Mental Health / Anxiety / Depression – All populations
2. Heart Disease and Stroke / Hypertension
3. Black Mortality Rate
4. Black Infant Mortality
5. Mental Health -Depression and Anxiety among White population
6. Diabetes among Hispanic and Black populations
7. Obesity

Progress Made Since 2022 CHNA

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**	**Progress Made**
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.	● The Substance Use Treatment Coordinators (SUTC) is a team comprising registered nurses and peer recovery support specialists who support Bethesda North Hospital, Bethesda Butler Hospital, and Good Samaritan Hospital's emergency rooms and inpatient services to complete substance use screenings and provide addiction treatment options, with a goal to schedule substance use treatment appointments within 24 hours post discharge. ○ March 2023 – June 30, 2023: Engaged with 200 patients, 28 started MAT during their stay, 148 were referred to treatment at discharge. ● FY2024: Engaged with 678 patients, 4 started MAT during their stay, 539 were referred to treatment at discharge.
Outpatient Alcohol and Treatment Program	● Offer support and treatment to patients regardless of their ability to pay, in a structured, outpatient setting.	● From March 2023 through the end of June 2024, 179 patients were referred from the SUTC team to the Bethesda Program.

Health Need: Substance Abuse / Mental Health		
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.	• TriHealth Behavioral Health has expanded behavioral health access to all pediatric and adult PCP practices via in person or telehealth support. PH-Q screens are completed by PCP offices. Patients can be referred to a: 1. Behavioral Health Consultant (LISW, PHD, LPCC) 2. 12 week collaborative care program 3. BH outpatient clinic
Behavioral Health Intake Program	• Refer patients from the emergency department to the appropriate treatment setting and location.	• Behavioral Health Intake Program provides 24/7 access to Behavioral Health Inpatient Services for TriHealth ERs and TriHealth medical services. 40 percent of these patients are low income [Medicaid or Self Pay]. • The program has stabilized or reduced the time patients need to be admitted to the inpatient unit. See below
BNH Planned Resources	BNH will provide registered nurses, physicians, community health educators, philanthropic cash grants, outreach communication, and program management support for these initiatives	Yes
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 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	

Health Need: Substance Abuse / Mental Health	
	• SHIP strategy: Culturally competent workforce in underserved communities • SHIP strategy: Recovery communities and peer supports

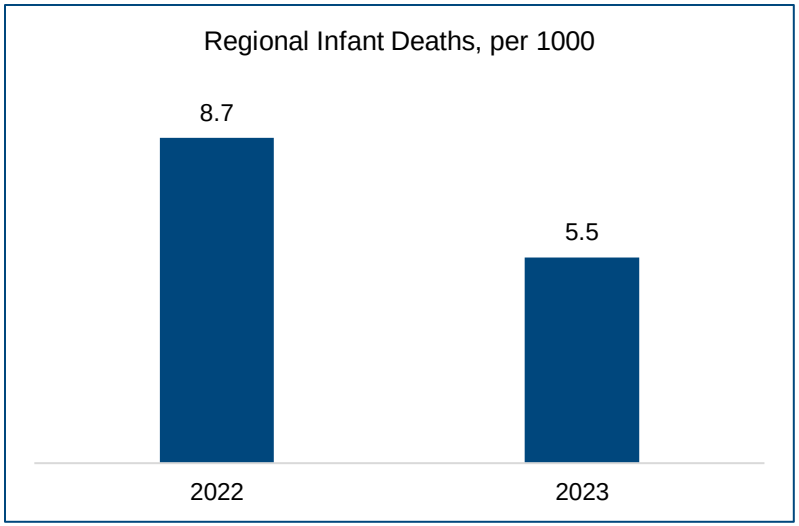


Health Need: Maternal / Child Health		
Anticipated Impact (Goal)	The hospital will reduce infant mortality rates in our service area, as well as improve outcomes for maternal health with emphasis on education, clinical care, and community outreach	
Strategy or Program	**Summary Description**	**Progress Made**
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.	• The OB/Gyn Center at Bethesda North Hospital provides education (self-care, diet, breastfeeding, sleep etc) and care coordination to link patients with the support they need • Two-thirds to three-fourths of their patients are on Medicaid or uninsured – the latter particularly among Hispanic women. • **Centering Pregnancy Program*** - Centering brings pregnant women together for group support, education and discussions about pregnancy. The discussions are focused on pregnancy, birth, nutrition, breastfeeding, child care, safety and new mothering issues. This program is especially beneficial to teens. These focused gatherings, combined with one-on-one time with the provider, empower all women to better understand their physical and emotional journeys through pregnancy and motherhood. **Spanish Centering and Uzbek Centering groups are available - offering classes in the patients' primary language*. • **Key Results** shown below
Woman Centered Medical Home model	• Program will provide a complex network of care, delivered by dedicated case managers, social workers, lactation consultants,	• Team based care is a core element of the Bethesda North OB/Gyn Center's philosophy and operating model – to remove barriers to

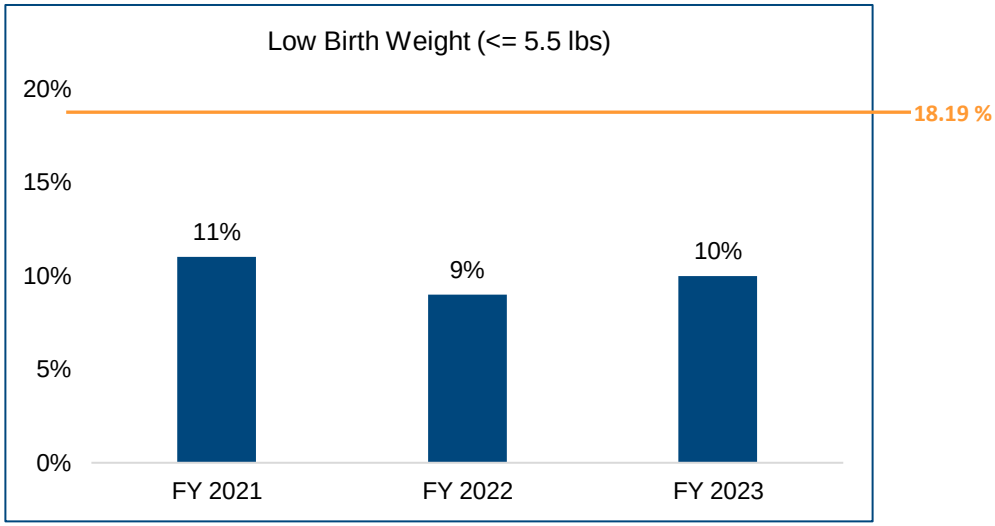
Health Need: Maternal / Child Health		
	behavioral health consultants, community health workers, financial counselors, and legal aid consultants to provide excellent care while addressing social determinants of health.	care and provide a “medical home” for the women who are giving birth.
HOPE program	• Program will provide patient-centered care to chemically dependent pregnant women improving birth outcomes and maternal substance-free outcomes. • The HOPE program is contained within the medical home model at OB/Gyn centers, providing case management until 8 weeks post partum. • The HOPE program is based at Good Samaritan Hospital but does provides oversight and identifies resources for social workers at Bethesda North.	• The program serves the population of substance abusing moms. Most of the population served is low income/on Medicaid. • Targeting fewer babies in the NICU, negative drug screens at delivery, healthier babies and moms. • Other health systems have exited this program, so Good Samaritan Hospital took on those patients. • Includes intake for patients who come to the Center drunk/using drugs; the case management includes inpatient admission for treatment. • The HOPE program treats approximately 50 pts a time and there is high demand/waiting list.
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.	Yes, these resources are provided by BNH to the OB/Gyn center.
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	

Health Need: Maternal / Child Health

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



Source: TriHealth OB Gyn Center FY23 Programming, Volumes and Outcomes



Source: TriHealth OB Gyn Center FY23 Programming, Volumes and Outcomes

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.	
Strategy or Program	**Summary Description**	**Progress Made**
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.	• Completed planning grant funded by bi3 and created plan to target specific high – incidence chronic conditions via the work of the TriHealth Health Equity Institute.
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.	• Fund patients' access via rides to appointments, home from the emergency department and so forth • Eight (8) free food pantries now in place throughout the TriHealth system- serving patients who report food insecurity issues during their Social Determinants of Health intake conversation. • Urban Health Project Medical Student/ Bethesda Family Practice Resident days of service (SERVE Days) where team members and leaders assist low income homeowners with handrail/ramp installation and exterior maintenance yardwork to assist clients (low income seniors, veterans, people with disabilities) for People Working Cooperatively. • Provide Evidence Based Fall Prevention Programs and valuable community resources to area seniors to reduce their barriers to access to care and to promote health, safety and wellness. • Systemwide, comprehensive community

Health Need: Access To Care		
		resource list implemented to connect patients, their families and the community at large to Domestic violences resources, Food and housing resources, Insurance and Legal resources, Medication assistance, Mental Health and Substance Abuse, Mobile Crisis information, Social Security, Transportation, Rent and Utility Assistance, Senior Resources, Veterans Resources, Vision and Dental resources • Mobile Mammography is provided to the uninsured population in partnerships with multiple churches and community and community clinics. • The most recent year (2024) it screened 428 uninsured or Medicaid women and connected them as needed with other resources.
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	Providing these resources for targeted high need programs in Maternal/Child Health and access as per the above programs.
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**	**Progress Made**
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.	• The Center for Health Equity developed a dashboard that applies an equity lens on existing TriHealth quality and outcomes metrics. This provides leaders with actionable insights to reduce disparities in care and enhance patient outcomes. Additional data parameters are being developed within the dashboard to monitor health disparities across the system over the next several months.
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.	• The Center for Health Equity deployed key improvement projects that address health disparities across ambulatory care settings. The following are aim statements for each improvement project: ○ Uncontrolled Diabetes: Reduce HbA1C by ≥ 1 percentage point in 75% of Black and Hispanic patients at Bethesda Family Practice with poorly controlled diabetes (HbA1C > 9.0) in the next 6 months. ○ Uncontrolled Hypertension: Decrease systolic blood pressure reading in 90% of Medicaid patients at Heritage Butler with uncontrolled hypertension (BP>140/90) by

Health Need: Disease Management		
		10% in the next 3 months. ○ Maternal Health: Increase hemoglobin concentration in Black pregnant patients by >1 g/dL every 4-6 weeks until target level (>11.0 g/dL) is reached.
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	• Race, Ethnicity and Language (REaL) data is collected in EPIC, stratification of patient experience, culturally competent care model education, Graduate Medical Education Diversity initiatives, School to Work program, and Implicit Bias 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	Yes TriHealth Center for Health Equity created in 2023 includes Chief Health Equity Officer, Director of Health Disparities, DEI+B team and addition support functions: BI Specialist, Communication Specialist, PI Specialist. Other resources: 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, Health Collaborative, Chartis	
CHNA Priority Health Needs being Addressed	#1 priority health need: Cardiovascular related conditions (high blood pressure and/or high cholesterol)	

	Health Need: Disease Management
	#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

Appendices

Appendix A. Community engagement

Development of the Greater Cincinnati Tri-State Region Community Health Needs Assessment (CHNA) was informed by the Advisory Committee and Public Health and Special Populations Task Forces (Appendix B) contains a list of Advisory Committee and Task Force member organizations). Advisory Group and Task Force members were engaged in the process because of their close ties to the communities they live in and serve. They were a valuable source of data and information throughout the assessment process.

Community engagement was brought to the forefront of the Regional CHNA process by building the assessment and telling the community story, coming to consensus around shared regional priorities, and launching a Community Partnership Network to build infrastructure for ongoing, bi-directional communication.

The Health Policy Institute of Ohio (HPIO) and The Health Collaborative (THC) provided regular updates to both the Advisory Committee and Task Forces, including monthly meetings with the Advisory Committee and six meetings with the Task Forces.

Defining community engagement

For the regional CHNA, engagement with community began with clearly defining the community and then establishing intentional, thoughtful, and co-created ways to engage with partners and build trust. Facilitated by THC, community is defined as the 18 county region of southwest Ohio, Northern Kentucky, and Southeast Indiana, and inclusive of health systems and hospitals, public health departments that serve those jurisdictions, and all community-based organizations serving community members. Through specific activities built for a variety of audiences within this community, THC engages partners throughout all phases of the Collective Health Agenda cycle (including the regional CHNA) with convening, stakeholder listening sessions, one- on-one meetings, and in alignment with principles of community based participatory research.

Building the assessment and telling the community story

To minimize the burden on community members who report being over-surveyed and assessed, the Advisory Committee decided to leverage recent, existing sources of primary and secondary community data, rather than collecting new primary data. Advisory Committee and Task Force members were invited to share any data they have collected to be included in the Regional CHNA, with a focus on sources that filled data gaps (described in Appendix C). Seven additional sources of community data were identified and included in the Regional CHNA.

Coming to consensus around shared regional priorities

Throughout the Regional CHNA process, THC emphasized the shared values and principles of collective action for the Advisory Committee and Task Force members. This invited alignment from partners on the significant health needs, potential priorities, and final priorities described in Appendix D.

To inform the prioritization process, HPIO developed a pre-prioritization survey to be completed by hospitals, local health departments, and other community partners. Of the 47 partners who responded, the largest proportion represented community- based organizations (28%), highlighting the inclusion of community voices through the prioritization process.

More information on the results of the pre-prioritization survey can be found in Appendix D.

Launching a Community Partnership Network

The Health Collaborative developed the Community Partnership Network (CPN) to build ongoing community engagement into the work of the Regional CHNA and Collective Health Agenda. The CPN was created based on feedback THC received from partners that the Regional CHNA process for the last several cycles felt very circular, asking the same questions repeatedly to the same communities, with little to no action on issues that arise. Communities and organizations across the region and across sectors expressed concern around the repeated data collection processes, citing the burden it has on community members to discuss problems without seeing any solutions or actions to address community needs.

The CPN will create an opportunity for more regular community engagement, to center community voice and equity in the Regional CHNA, provide space for bidirectional communication between health systems and the community, and reduce "new" data collection (e.g., focus groups and community health needs surveys). The purpose of the CPN is to leverage existing community meetings, momentum, and assets to strengthen connections between partners, including the community, and advance shared goals for community health.

The following community-based organizations have agreed to participate in the CPN:

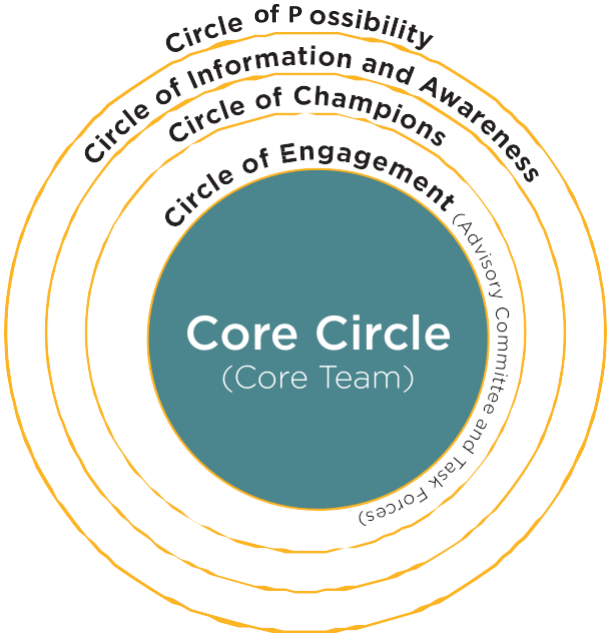
- Cincinnati Compass
- Clermont County Healthy Partners (through the health department)
- Hamilton County Suicide Prevention Coalition
- Black Women Cultivating Change
- Hamilton County Human Services Chamber (HSC)
- Center for Closing the Health Gap

The CPN has met these milestones:

- Attended five meetings to date with CPN partners, with a goal of six meetings. These meetings have included five preparatory meetings and one follow-up.
- Contracted with academic experts to create an infrastructure for THC in partnership with CPN pilot partners.
- Created and co-designed drafts for key CPN infrastructure.

Appendix B. Regional CHNA advisory structure

The advisory structure for the Regional Community Health Needs Assessment (CHNA) was built using the Mobilizing Action through Planning and Partnerships 2.0 (MAPP) Circle of Involvement Framework. This includes the:



Core Circle

The Core Circle (Core Team) met regularly, hosted and facilitated meetings, were responsible for deliverables, and managed day-to-day operations of the project.

Core Team
The Health Collaborative
Butler County General Health District
Health Policy Institute of Ohio

Circle of Engagement

The Circle of Engagement (Advisory Committee and Task Forces) kept the Core Circle accountable for progress, provided expertise on each step of the Regional CHNA including data collection and analysis, reviewed results and report drafts, and approved the final Regional CHNA report. Across the 45 participating organizations in the Advisory Committee and Task Forces, diverse populations were represented that include medically underserved people, Black and African American residents, immigrants and refugees, mothers and babies, Hispanic/Latino residents, people experiencing homelessness, people experiencing mental health challenges, people experiencing food insecurity, people with disabilities, and other marginalized populations.

Advisory Committee
Hospitals and health systems
Adams County Regional Medical Center (ACRMC)
Christ Hospital
Cincinnati Children's Hospital Medical Center
Lindner Center of Hope
Margaret Mary Health
Mercy Health Cincinnati
TriHealth
UC Health
Public health
Butler County General Health District and Southwest Association of Ohio Health Commissioners
Cincinnati Health Department
Clermont County Public Health
Hamilton County Public Health
Community-based organizations
Center for Closing the Health Gap
Hamilton County Human Services Chamber
United Way of Greater Cincinnati
Urban League of Greater Southwestern Ohio
Philanthropy
bi3
Interact for Health
Federally Qualified Health Centers
The HealthCare Connection
HealthSource of Ohio
Payor
CareSource

Task Forces
Public Health Task Force:
Butler County General Health District, Ohio
Cincinnati Health Department, Ohio
Norwood City Board of Health, Ohio
City of Springdale Health Department, Ohio
Clermont County Public Health, Ohio
Clinton County Health District, Ohio
Franklin County Health Department, Indiana
Hamilton County Public Health, Ohio
Ripley County Health Department, Indiana
Warren County Health District, Ohio
Special Populations Task Force:
All-In Cincinnati
Black Women Cultivating Change
Cincinnati Compass
Clermont County Board of Developmental Disabilities
Community Builders
Cradle Cincinnati
Foodbank of Dayton
Freestore Foodbank
Greater Cincinnati Behavioral Health Services
Greater Cincinnati Regional Food Policy Council
Healthcare Access Now
Housing Opportunities Made Equal (HOME)
NAMI Southwest Ohio
Refugee Connect
Santa Maria Community Services
Shared Harvest Food Bank
Su Casa
United Way of Greater Cincinnati

Circles of Champions, Information and Awareness, and Possibility

The Circle of Champions and the Circle of Information and Awareness provided high-level review and oversight of the work on behalf of their organizations.

Finally, the Circle of Possibility represents all the community organizations and community members who can be included in actionable strategies for implementation of the Collective Health Agenda and Community Health Improvement Plans.

Appendix C. Data collection and analysis methodology

The Health Collaborative contracted with the Health Policy Institute of Ohio (HPIO) to develop the Regional Community Health Needs Assessment (CHNA). The analysis was guided by a set of research questions, and consisted of:

- Secondary, quantitative data compilation and analysis
- Additional primary and secondary community data analysis

Research questions

The Health Collaborative and HPIO developed the following research questions, based on Public Health Accreditation Board (PHAB) and Internal Revenue Service (IRS) requirements, to guide development of this Community Health Needs Assessment:

1. What are the most significant health needs in the region?
2. What populations are experiencing inequities and disparities across health, socio-economic, environmental and quality-of-life outcomes?
3. What are the systems and structures that drive the identified health needs?
4. What strengths and resources does the region have that can address the region's most significant health needs? What resources and assets exist to support communities experiencing inequities and disparities?
5. What progress have partners made on the priorities identified in the last CHNA?

Secondary, quantitative data analysis methodology

How were metrics selected?

HPIO reviewed a wide range of publicly available data sources, including national- and state-based population health surveys, vital statistics, and administrative data from state and federal agencies, among other sources. Using these sources, HPIO compiled a list of 264 metrics for consideration in the Regional CHNA. From this inventory of metrics, The Health Collaborative and HPIO recommended 67 secondary, quantitative metrics using the following criteria approved by the Advisory Committee.

Metric selection criteria

Goal: Identify the **most important** metrics needed to describe the region's significant health needs, including social and structural drivers of health

- **Data availability** — Data available at the county-level that can be assessed for long- term trend (change over time), compared to performance of the U.S. or the state overall, and can be disaggregated to look at disparities and inequities (e.g., by race, ethnicity, household income)

- **Source integrity** — Metrics are recognized as valid and reliable, and data is gathered from reputable sources
- **Face value** — Metrics are easily understood by the public
- **Alignment** — Metrics align with relevant state and local plans
- **Data quality and recency** — Data for the metric is complete, accurate, and most- recent data is from the past three years

Figure C.1. displays how the 67 metrics are organized in the Regional CHNA. These metrics were organized based on the domains in the Mobilizing for Action through Planning and Partnership (MAPP 2.0) **framework.**

Figure C.1. **Regional CHNA metric information**

Domain	Total metrics	Metric disaggregated (i.e., broken out by race, ethnicity, age, income or other factor)
Demographics	3	3
Systems of power, privilege, and oppression	3	1
Social determinants of health	26*	10
Health behaviors and outcomes	35*	18
Total	**67**	**32**

*These domains each include a metric that has one or more additional, underlying metrics. These metrics were only counted once for the purpose of these totals.

Data years vary by metric based on the data source. HPIO compiled the most recent year of available data for the Regional CHNA.

Quantitative data analysis methodology

The use of rates, percentages and numbers. To demonstrate the frequency of an event, incident or condition, the Regional CHNA report often uses rates, which are calculated as the "number of incidences, per population." Rates provide standardized measurement for comparison across different groups (e.g., white, compared to Black) or different geographic locations (e.g., Hamilton County as compared to Franklin County). Percentages are often used to represent parts of a whole or express proportions, and are helpful for understanding relative values, or changes over time (e.g., 25% of the total population was impacted). Numbers, which describe absolute values or quantities, are useful for planning purposes but have limitations when comparing across groups of different sizes.

Regional values. Regional data values in this report were calculated one of two ways. If the data source provided a numerator and denominator for all 18 counties in the region, a true regional value was calculated. When a data source did not provide numerators and denominators and/or up to one-third of available counties were missing from the data source, a median value was calculated for the region to serve as the regional value. The median county value in the region was used as a proxy measure for the

region overall value when a regional overall value could not be calculated. These are noted in the tables and graphics where they occur.

Benchmark analysis. Benchmarks, including national data and Healthy People 2030 targets, were identified for all potential priorities (described in Appendix D). The regional value for each potential priority was then compared to the value of the U.S. overall and to applicable national Healthy People 2030 targets, when available. For the Regional CHNA's three priority areas, benchmarks were analyzed to determine if the region performs better, worse, or the same as the rest of the nation and the Healthy People 2030 benchmarks. Metrics that had less than 10% difference between the regional and benchmark values were classified as performing the "same." Metrics that had a difference of 10% or greater were classified as "better" or "worse."

Analysis of populations who face the greatest barriers. The magnitude of disparities across population characteristics such as race and ethnicity, age, and county type were assessed for 12 metrics related to the Regional CHNA's three priorities using disparity ratios. Disparity ratios were calculated by dividing the outcome of each comparison group by the outcome of the rest of the region. The prevalence estimates for each disaggregated metric were calculated for each comparison group. The prevalence for the rest of the region is then re-calculated for each additional breakout group.

When data availability limited the ability to calculate the magnitude of difference between a group and the rest of the region, a median regional value was used. The following measures had missing counties:

- Suicide deaths
- Mental health providers
- Mental health-related hospital encounters
- Depression-related hospital encounters
- Suicide attempt-related hospital encounters

To analyze potential disparities in rural areas, the USDA **Economic Research Service (ERS)** Metropolitan (Metro) and Nonmetropolitan (non-Metro) county type classification was used.

To analyze potential disparities in Appalachian areas, the **Appalachian Regional Commission's** county type classification was used.

When possible, race and ethnicity data were disaggregated, or separated, into the following groups: white (non-Hispanic), Black (non-Hispanic), Asian and/or Pacific Islander (non-Hispanic), Other (non-Hispanic), and Hispanic. When data was not available to classify based on these groups, different racial and ethnic classifications were used based on the data source and data availability.

Once disparity ratios were calculated, any ratio that was at least 10% worse than the rest of the region was elevated as a population who faces the greatest barriers. Because this analysis was limited to metrics with available disaggregated data, the Advisory Committee and Task Forces were consulted to identify other groups experiencing disparities and inequities that were not identifiable in the analyzed data.

Ohio Hospital Association (OHA) data analysis. The Health Collaborative and HPIO analyzed 18 Ohio Hospital Association data metrics on hospital encounters in the region. The methodology used for that data set is available in Appendix D.

Supplemental primary and secondary community data analysis methodology

In analyzing the secondary, quantitative data described above, the following gaps emerged:

- Lack of data for smaller counties, including rural and Appalachian communities
- Lack of data for specific groups, including certain racial and ethnic populations and members of the LGBTQ+ community
- Lack of data on certain social and systemic drivers of health

Seven additional sources of primary and secondary data were identified by THC, HPIO, and the Advisory Committee and Task Forces to fill those data gaps and center community voices and perspectives.

HPIO analyzed the seven sources listed below, which include surveys, focus groups and reports. Key findings from the sources were then themed based on the domains in the MAPP 2.0 **framework.**

The seven sources focused on the Greater Cincinnati Tri-State region, with variation in area of focus, as noted below. Some of these sources included secondary data.

Analysis of this data was limited to available information and not based on the underlying data source.

Sources analyzed include:

- **2-1-1 data.** United Way of Greater Cincinnati and Indiana Family and Social Services Administration, 2024. Area of focus: counties in the greater Cincinnati region, including Ohio, Kentucky and Indiana
- **State of Black Cincinnati report.** Urban League of Greater Southwestern Ohio, 2024. Area of focus: Cincinnati
- **Our Health, Our Opportunity report.** Interact for Health, 2024. Area of focus: Greater Cincinnati region
- **Community Health Status Survey.** Interact for Health and the University of Cincinnati Institute for Policy Research, 2022. Area of focus: 22 counties in the Greater Cincinnati region
- **2021 CHNA provider survey results.** The Health Collaborative and Measurement Resources Company, 2021. Area of focus: 26 counties in the Greater Cincinnati region
- **2021 CHNA focus group results.** The Health Collaborative and Measurement Resources Company, 2021. Area of focus: 26 counties in the Greater Cincinnati region
- **OHA Metrics/Analysis.** The Health Collaborative analyzed 18 Ohio Hospital Association (OHA) data metrics on hospital encounters in the region. The methodology used for that data analysis is included below.

Figure C.2. **Source and theme matrix**

The table below summarizes which sources had key themes in each domain of the Regional CHNA.

	Community strengths and organizational capacities	Systems of power, privilege and oppression	Social determinants of health	Health behaviors and outcomes
2-1-1 data		✓	✓	
State of Black Cincinnati report	✓	✓	✓	✓
Our Health, Our Opportunity report	✓	✓	✓	✓
Community Health Status Survey	✓		✓	✓
2021 CHNA provider survey			✓	
2021 CHNA focus groups			✓	

Limitations of the assessment

The Regional CHNA includes data from a variety of data sources, including publicly available and requested data. It includes survey results, birth records, and administrative data. While care was taken to compile data from credible sources, each source has its own set of limitations, such as self-reported conditions and potential changes in methodology from year to year.

There are several limitations that emerged:

- **Population focus.** The Regional CHNA is focused on adults, ages 18 and over, and families living in the Greater Cincinnati Tri-State Region. Other partners in the region are assessing the health and well-being of children. Only one metric is child- specific (child poverty).
- **County-level data.** HPIO's main level of analysis for secondary, quantitative data analysis for the Regional CHNA was at the county-level. When metrics are disaggregated by county, the sample sizes of the populations can become too small, creating data reliability and suppression issues. In these cases, data values for certain counties could not be reported.
- **Disaggregated data.** Very few data sources allowed for disaggregation of data by county and other demographic categories, such as income, age, or race and ethnicity. In addition, not all sources use mutually exclusive racial and ethnic categories (e.g., Black non-Hispanic and Hispanic, all races) for the disaggregation of data by race and ethnicity. When metrics could be disaggregated by county and another demographic characteristic, the sample sizes of the population groups often became too small, creating data reliability and suppression issues. In these cases, data values could not be reported.

Many data sources often have limited categories for disaggregation and lack the necessary information to break data down by groups such as LGBTQ+ individuals or veterans.

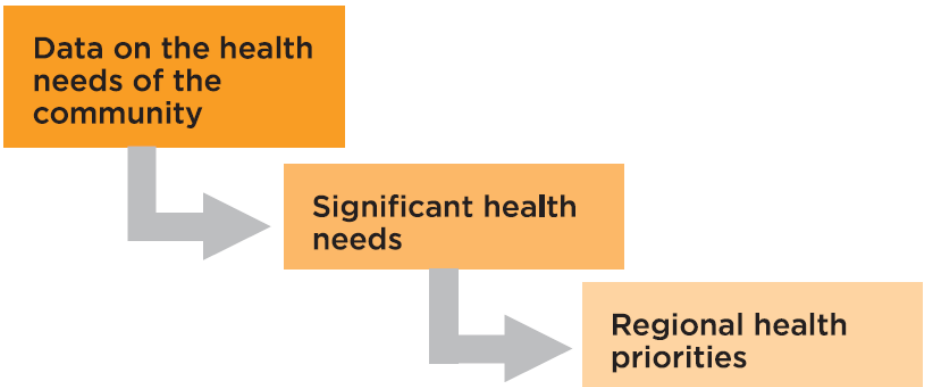
- **Data years.** HPIO provided the most recent year of data for which data was available for the most counties in the region. For data points in the Additional Primary and Secondary Community Data Analysis, consult those sources for more information on their methodology.
- **Access to underlying data for supplemental data analysis.** For the supplemental primary and secondary data analysis (described on pages 51 and 52), HPIO was provided with final reports or summary documents often without access to the underlying data (e.g., sample sizes or raw data values to conduct additional data analysis). Data from those sources are presented as is from the source. For further information on the methodology used by those reports and summaries, please consult the sources listed in figure C2 above.

Appendix D. Prioritization process for the Regional CHNA

The Internal Revenue Service (IRS) requires nonprofit hospitals and health systems, as part of the Regional Community Health Needs Assessment (CHNA), to assess the health needs of their communities, identify the significant health needs of their communities, and prioritize those health needs. Similarly, Public Health Accreditation Board (PHAB) standards require local public health departments to create Community Health Assessments (CHAs) that evaluate their communities' health status and needs.

Figure D.1 describes the Regional CHNA prioritization process. Regional CHNA partners began by analyzing data on the health needs of the community, then identified a list of significant health needs based on that data, and finally prioritized a set of those significant health needs for collective action. The following sections describe this process in more detail.

Figure D.1. **Regional CHNA prioritization process**



Data on the health needs of the community

The health needs of the region were identified through a robust review of primary and secondary data. This included 49 secondary, quantitative data metrics, 18 Ohio Hospital Association data metrics, review of seven additional primary and secondary data sources, and primary data from Advisory Committee and Task Force partners (Appendix C provides details on the data analysis methodology). Data was

reviewed by Regional CHNA Advisory Committee and Task Force members during a meaning- making session on August 22, 2024.

Significant Health Needs

To identify significant health needs, the Health Policy Institute of Ohio (HPIO) applied a set of criteria to the health needs that emerged through the data review.

Those criteria were:

- **Prevalence:** Which needs are the most widespread?
- **Unmet need**: Which needs are most unmet and/or untreated?
- **Impact**: Which needs have the greatest impact on health?
- **Inequity**: Which needs are most disparate across populations in the region?

Based on those criteria, the following significant health needs were identified (displayed in figure D.2). Significant health needs were reviewed by Regional CHNA Advisory Committee and Task Force members during a meeting on October 24, 2024.

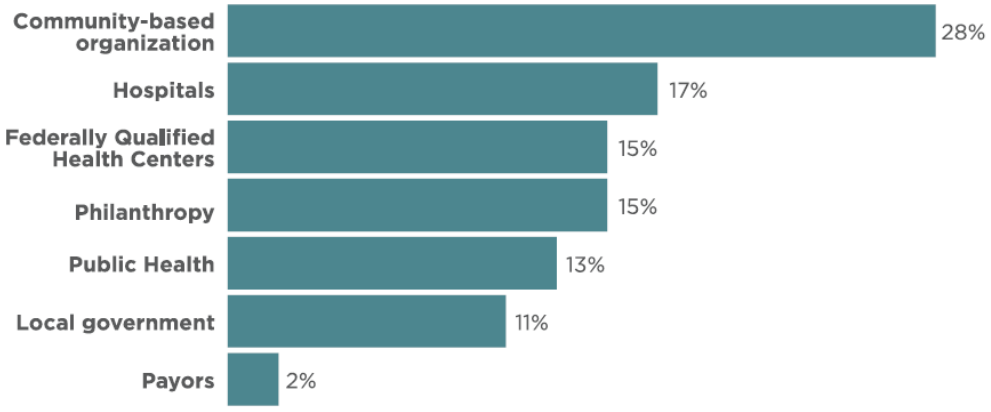
Figure D.2. **Significant health needs**

Systems of power, privilege and oppression
Negative perceptions of health and healthcare (stigma, mistrust, unaffordability, etc.)
Racism and discrimination
Unequal access to resources needed for health
Social determinants of health
Access to affordable, timely and quality health care
Educational attainment and access
Food access and insecurity
Healthcare workforce and capacity
Housing and homelessness
Neighborhood and built environment
Poverty and economic stability
Health behaviors and outcomes
Cancer
Diabetes
Heart disease and stroke
Maternal and infant health
Mental health
Respiratory disease
Substance use

Regional health priorities

To inform prioritization, HPIO administered a "2024 Regional CHNA Pre-Prioritization Survey" to Regional CHNA Advisory Committee members, Task Forces, and community partners online from September 3 to October 15, 2024. The survey gathered information on partners' and the community's priorities and their view of the most pressing health issues in the region. There were 47 responses, with the highest proportion (28%) from community-based organizations, followed by hospitals (17%) (exhibited in figure D.3).

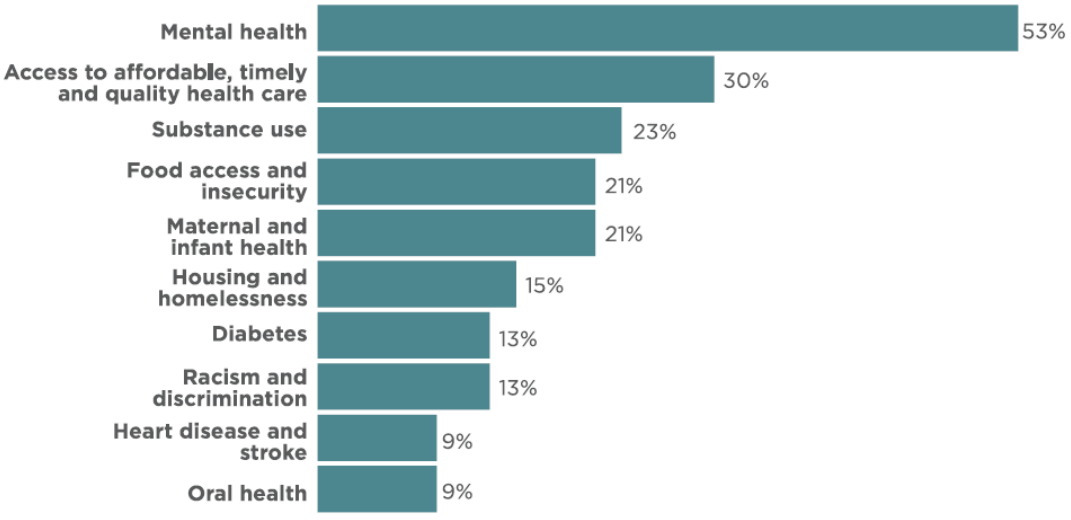
Figure D.3. **Responses to: "What sector does your organization represent?"**



Source: "2024 Regional CHNA Pre-Prioritization Survey"

Question 3 of the survey (shown in figure D.4) explored partners' and community priorities and was used to narrow down the full list of significant health needs to create a list of potential priorities for consideration by Regional CHNA partners. HPIO cross-walked the two lists and identified ten potential priorities (shown in figure D.5) that Regional CHNA Advisory Committee and Task Force members discussed during a meeting on Oct. 24, 2024.

Figure D.4. Responses to: "What are the 1-3 health issues that your organization is most focused on addressing in the region?" (top ten responses)



Source: "2024 Regional CHNA Pre-Prioritization Survey"

Figure D.5. **Potential priorities for discussion**

- **Mental health** service navigation
- **Access** to quality, affordable healthcare
- **Substance use** prevention and treatment
- Access to **healthy and nutritious food**
- **Maternal and infant health** equity
- **Homelessness** prevention and **housing** stability
- **Diabetes** management and prevention
- Collaborative efforts to dismantle **racism and reduce discrimination**
- **Heart disease and stroke** prevention and treatment
- Collaboratively **address data gaps** for underrepresented populations

The Advisory Committee and Task Force members then discussed the data behind each of these potential priorities, including national benchmarks, and applied the following criteria to select the final list of regional health priorities:

1. **Capacity and feasibility:** Does our region have the ability to address this health need?
2. **Connection between factors and outcomes:** To what degree do the prioritized structural/social determinants contribute to prioritized health outcomes?
3. **Equity:** Would addressing this health need significantly address health disparities?
4. **Burden and severity:** Would addressing this health need have an impact on the greatest number of community members?
5. **Ability to track progress:** Are there indicators that can be used to measure progress over time?

Regional CHNA Advisory Committee and Task Force members were then given the opportunity to vote for regional priorities, using the above criteria, on an online survey that was open from Oct. 24 to Nov. 1, 2024. There were 24 total responses; most respondents selected mental health treatment and prevention (75%), followed by homelessness prevention and housing stability (42%), and heart disease and stroke prevention and treatment (33%) as the needs that were most aligned with the prioritization criteria to be prioritized in the Regional CHNA.

Appendix E. Bethesda North Hospital Service Area Demographics

Service Area Demographics

Demographic	Hamilton	Butler	Clermont	Warren
2024 Population	839,511	386,704	222,991	232,955
2029 Projection	845,215	392,395	228,846	244,581
Population by Race				
White	62.7%	74.0%	89.0%	80.0%
African American	24.9%	9.8%	2.0%	4.0%
All Other Races	12.4%	16.2%	9.0%	15.9%
Hispanic (Any Race)	5.3%	7.2%	2.9%	3.7%
Population by Age	**Hamilton**	**Butler**	**Clermont**	**Warren**
<5	5.8%	5.8%	5.6%	5.6%
5-17	15.8%	16.6%	16.4%	17.5%
18-24	9.9%	11.1%	9.0%	9.9%
25-44	27.5%	24.8%	23.6%	22.6%
45-64	22.9%	24.5%	26.0%	27.3%
65+	18.1%	17.3%	19.5%	17.1%
Median Age	39.2	39.3	43.3	41.1

Household Income Below 50k	38.9%	34.0%	30.0%	19.3%
Household Income Below 25k	19.7%	15.1%	13.0%	7.3%

Source: Sg2 Feb 2025

Life Expectancy

County	Overall	Asian	Black	Hispanic	White
Butler	76.4	86.7	74.6	97.8	76.1
Clermont	77.5	98.6	72.9	111.6	77.4
Hamilton	76.4	86.0	72.4	100.1	77.5
Warren	79.2	95.2	78.0	124.4	78.9
4 County Average	77.3	91.6	74.5	108.5	77.4
Ohio Average	76.4	88.3	73.8	89.1	76.7

Source: https://www.countyhealthrankings.org/health-data/ohio/data-and-resources

Contracted Consultants

Bricker & Eckler LLP/INCompliance Consulting, Jim Flynn and Christine Kenney – located at 100 South Third Street, Columbus, Ohio 43215. Bricker & Eckler LLP / INCompliance Consulting was contracted to review this CHNA report. Jim Flynn is managing partner with Bricker & Eckler's healthcare group, where he has practiced for 31 years. His general healthcare practice focuses on health planning matters, certificates of need, nonprofit and tax-exempt healthcare providers, and federal and state regulatory issues. Mr. Flynn has provided consultation to healthcare providers, including nonprofit and tax-exempt healthcare providers as well as public hospitals, on community health needs assessments. Christine Kenney is the director of regulatory services with INCompliance Consulting, an affiliate of Bricker & Eckler LLP. Ms. Kenney has more than 42 years of experience in healthcare planning and policy development, federal and state regulations, certificate of need regulations, and Medicare and Medicaid certification. She has been conducting CHNAs since 2012, providing expert testimony on community needs and offering presentations and educational sessions regarding CHNAs.