# 2024 Community Health Needs Assessment

## Addendum: University of Cincinnati Medical Center

### Our Purpose

To advance healing and reduce suffering.

### Our Mission

We are committed to  advancing medicine and improving the health of all people – regardless of race, ethnicity, geography or ability to pay by fostering groundbreaking medical research and education, delivering outstanding primary and specialty care services, and building a diverse workforce.

### Our Vision

To use the power of academic medicine to advance the science of discovery and transform the delivery of care.

### Our Values

- People first
- Respect
- Integrity
- Inclusion
- Discovery
- Empathy

# The Facility: UCMC

## The Community We Serve

University of Cincinnati Medical Center is located in ZIP code 45219 in Hamilton County, Ohio. This hospital provides services to patients across the Greater Cincinnati region, with focus on Hamilton, Butler, Clermont, and Warren Counties. The larger 18-County geographic area covered by the Regional Community Health Needs Assessment includes the Primary Service Area of UCMC.

## 2024 Community Health Needs Assessment

Every three years, our health system completes a Community Health Needs Assessment (CHNA) to identify the most significant health needs of our region through comprehensive data review, engagement with community partners, and collective prioritization. In 2024, the University of Cincinnati Medical Center participated, as part of UC Health, in the collaborative development of a Regional CHNA for Greater Cincinnati.

This process, led by the Health Collaborative, incorporated considerable community input. The 2024 Regional CHNA Advisory Committee, along with the Public Health and Special Populations Task Forces, had 45 participating organizations representing diverse populations including 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.

This addendum will be published with the CHNA Report in 2025. The addendum identifies significant regional health needs, and it also updates the status of the prior Implementation Plan.

UC Medical Center has aligned with the region's top priorities as identified in the Regional CHNA, which can be found either on The Health Collaborative's website (https://healthcollab.org/community-health-needs-assessment/) or the UC Health Community Benefit page (https://www.uchealth.com/about/community-benefit/). More details on the CHNA process, methodology, data sources, collaborating partners, and significant health needs of the Greater Cincinnati region can be found in the Regional CHNA document.

## Prioritized CHNA Needs

Priorities

The top priorities for the University of Cincinnati Medical Center are:

1. Mental health treatment and prevention.

2. Assessing for and addressing social drivers of health.

3. Heart disease and stroke prevention and treatment.

Written comments or questions about the CHNA or prioritized needs should be submitted to our feedback from here: CHNA Feedback Form

## Updates on 2022 Implementation Strategies

| PRIORITY/PRIORITIES TARGETED | STRATEGY | PROJECT NAME | PROJECT GOALS | STATUS UPDATE |
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| **Access to Services – Cross-Cutting Strategies** | Expand comprehensive primary care and emergency department care teams to include social workers and community health workers to strengthen the coordination between all care areas. | *Community Health Work Implementation Team* | • Decrease unnecessary ED utilization<br>• Improve compliance with patient medical home care through coordination and connection to community services | • The CHWs in the UCMC ED continue to connect with patients while they are in the ED to provide connections to community resources and primary care options.<br>• The team continues to brainstorm ways to partner with community organizations to provide more resources to our patients, including a clothing closet in partnership with St. Vincent de Paul.<br>• In 2025, the care coordination team in the ED expanded to include ED Case Managers, who will provide additional connections and support to patients. |
| **Access to Services – Behavioral Health** | Provide on-demand crisis intervention services where a behavioral health crisis is occurring. | *Quick Response Team* | • Increase the number of patients that opt-in for QRT follow-up | • The team was working through a process to refer patients to QRT from the ED for follow-up but encountered some barriers in information sharing that prevented a formal partnership.<br>• Between January 2022 and October 2023, almost 1,000 patients were approached about QRT in the UCMC ED.<br>• In 2023, the team attended the Ohio QRT/Deflection Summit to learn best practices and from other organizations. |
| | Coordinate, strengthen, and expand behavioral health services in the region. | *Psychiatry Bridge Clinic* | • Decrease readmissions for psychiatry patients | • The Bridge Clinic team has worked throughout the CHIP timeframe to improve connections with both patients and community partners. They have an ongoing Community Road Show where they visit community mental health providers to ensure seamless hand-offs for continuity of patient care. |

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| | | | • From CY21, the team has increased their connection with patients after discharge from inpatient psychiatric units by 14%.<br>• The team has also seen a decline in the 30-Day readmission rate (7.8% in 2022 to 3.7% median in 2025) and slight decline in 60-Day readmission rate throughout the life of the project. |
| Standardize mental health screening and presence of mental health providers in non-psychiatric clinics. | *Collaborative Care Model* | • Increase mental health screenings<br>• Increase integration of mental and physical health care in familiar settings | • The Collaborative Care team worked with a statewide group over the last 3 years to define a toolkit that will help other systems improve their processes in implementing this model.<br>• Since 2022, the model has expanded significantly to now include 7 behavioral health care managers covering 13 ambulatory clinics across the system. For these clinics, the wait time to see a mental health provider is significantly shorter than for standard mental health referrals.<br>• Throughout the CHIP cycle, the team completed PI testing on specific elements of the model, including patient screening, referral process, and optimization of patient follow-up.<br>• As more resources for follow-up became available, the number of PHQ-2 screenings completed across the system doubled from around 1,200 per month (2022) to more than 2,00 per month (2023). Screening rates and appropriate completion of the PHQ-9 have remained high through 2024 and 2025. |
| Expand access to medications for opioid use disorder (MOUD) and harm reduction materials | *Naloxone Distribution* | • Increase community and patient access to naloxone | • Over the CHIP timeframe, a team of pharmacists has worked to roll out protocol so that high risk opioid prescriptions are accompanied by an offer for a naloxone prescription. Through this |

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| | in Ambulatory settings. | | | automation, over 4,500 naloxone kits were distributed in FY25.<br>• In 2021, our pain stewardship team partnered with Caracole to develop one of the first harm reduction vending machines in the United States, located in the Northside neighborhood of Cincinnati, behind the Caracole office, over 4,000 overdoses have been reversed with naloxone from this machine.<br>• In 2024, UCMC partnered with Hamilton County Public Health to set up another harm reduction vending machine in the ED lobby, which includes boxes of naloxone. Through this vending machine, over 1,600 doses of naloxone have been distributed since February 2024.<br>• Harm reduction materials are also available through community health screening events with the 513 Relief Bus in partnership with Hamilton County. |
| | | *MOUD Initiaiton in the ED* | • Increase MOUD initiation among those with a chief complaint (cc) or discharge diagnosis (ddx) related to opioids<br>• Increase the percentage of ED MOUD patients linked to care within 14 days of ED visit | • The ED SUD team and Early Intervention Program identified and engaged patients with OUD in the ED and improved the treatment uptake from an average of 63% in 2021 to 100% in 2025 at UCMC.<br>• The overdose deaths in Hamilton County saw unprecedented drops during the CHIP timeframe, from 515 in 2021 to 270 in 2024.<br>• The ED SUD team added additional workflows in 2024 to specifically focus on connecting patients with AUD to appropriate medications and treatment options. |
| | | *MOUD Initiation in Ambulatory Settings* | • Increased MOUD initiation<br>• Reduction in drug overdose deaths | • An in initial goal of this project was to increase the number of providers who had an X waiver and therefore could provide MOUD as a treatment option, but this |

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| | | | | requirement was removed in late 2022. This change significantly increased access for patients to receive MOUD as any DEA-licensed prescriber can now provide buprenorphine for OUD.<br>• In December 2023, UCMC opened an addiction recovery clinic within one of their primary care offices every Friday. This significantly reduced the stigma associated with going in to receive treatment and has created a pipeline to train physician residents on how to provide MOUD.<br>• This clinic has provided treatment to more than 120 patients since opening. |
| **Access to Services – Cardiovascular Disease** | Support ongoing efforts to reduce hypertension and stroke in the region through preventative services. | *Achieving Cardiovascular Equity Hypertension Project* | • Reduce the disparity between black patients and non-Hispanic white patients who have controlled their hypertension<br>• Decrease deaths due to myocardial infarction and stroke from cardiovascular disease | • Within the ACE initiative, our teams worked on a medication bundle intervention, outreach to patients that haven't been seen, and repeat BP measurements.<br>• This project was established in partnership with the statewide MedTAPP initiative, which transitioned from ACE to the Hub-and-Spoke model and is still focused on improving hypertension rates, at the end of 2023.<br>• Our UC team is now the Southwest Ohio QI hub, focused on using QI tools across 26 practices in our region, including 9 of the 19 UC Health primary care practices, with plans to spread to 35 clinics by next year.<br>• The QI Hub's goal is to increase blood pressure control by 10% at each clinic. Since this program started, BP control has increased from 69.8% to 73.7% in over 61,000 patients in our region. |

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| | Equip the community with tools to respond to and reduce harm during a cardiac event. | *Stop the Bleed and Take 10 CPR* | • To train more people in basic bleeding control techniques in case of emergency<br>• To train people in compression-only CPR in case of emergency | • In FY24, the project shifted focus to training high school juniors and seniors through Cincinnati Public Schools.<br>• In 2024 and 2025, these programs were also offered in partnership with the Hamilton County 513 Relief Bus to meet community members in the neighborhoods where they work, live and play.<br>• Additional partnerships include business safety councils, church safety teams, and the Superseeds youth program.<br>• In FY25, Stop the Bleed completed 141 training days, with more than 300 classes and 5000 participants trained. This was an improvement on the 130 training days completed in FY24.<br>• In FY25, Take10 CPR trained 545 individuals in 20 classes, which is an improvement on the 100 trainees in 39 classes in FY24. |
| | | *Pulse Point Dispatch Center* | • Improve response time to cardiac events taking place in the community<br>• Increase bystander CPR rates and improve bystander response times | • The team's goal for 2024 and 2025 was to spread awareness about the initiative and increase the number of monthly active users through partnership with the marketing team.<br>• In FY25, there were 2,060 active users on the app, with 873 signed up for CPR alerts.<br>• In FY25, the app resulted in 67 activated events where CPR was initiated following an alert to a trained community member. |
| **Access to Services - Dental** | Support ongoing efforts to provide preventative dental services and connection to an established dental home. | *Pediatric Dental Varnish* | • Increase the number of patients that are established with a dental home | • Providing dental varnish to pediatric patients in need has become part of the clinic's standard practices and workflows.<br>• In 2024, 162 pediatric patients received dental varnish during their primary care visit. |

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| **Access to Services – Maternal/Infant Health** | Strengthen and continue to support community collaboratives that impact maternal and infant outcomes. | *Cradle Cincinnati Collaborative* | • Reduce infant mortality in Hamilton County<br>• Address health disparities in maternal and infant outcomes between black and white pregnant patients | • Cradle Cincinnati continues to be a crucial partner for UC Health in addressing regional infant mortality disparities.<br>• Throughout the CHIP cycle, Cradle rolled out a new Mama Certified program, which is a certification system for hospitals to drive forward commitments to providing equitable care.<br>• UCMC received a leader badges across all areas of care.<br>• UCMC also launched a Queen's Village advisory board to infuse patient voice into work to improve birth outcomes. |
| | Participate in statewide initiatives designed to reduce severe maternal morbidity and mortality. | *OPQC Alliance for Innovation in Medicine Hypertension Collaborative* | • Reduce hypertension-related maternal morbidity and mortality | • The OPQC initiative focusing on maternal hypertension ended in 2023, but work to improve maternal hypertension outcomes continued focused improvement work through FY24 and maintenance/monitoring through FY25.<br>• Through this work, the team was able to significantly improve compliance with the hypertension bundle from 62% to 84% by June 2024. This included providing BP cuffs to patients with severe hypertension, which improved from 20% in 2022 to 96% in 2024.<br>• These improvement results impact the patients we serve by reducing complications and morbidity due to hypertensive disorders of pregnancy.<br>• UC Health Department of Obstetrics and Gynecology is participating in the OPQC Maternal Mental Health QI Project focusing on improving screening for depression and referral to appropriate services in the perinatal period with the global aim of reducing maternal mortality. The team is learning from perinatal psychiatrists across |

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| | | | | Ohio to test and implement best practices at all outpatient locations. |
| | Provide additional support to high-risk pregnant patients through accessible, patient-centered, multimodal educational opportunities. | *Babyscripts App* | • Decrease maternal morbidity and mortality<br>• Decrease infant mortality<br>• Increase adherence to the postpartum visit | • The app provided a personalized approach to perinatal education with resources that discuss the importance of visits, breastfeeding, medications, and symptoms during pregnancy.<br>• In 2024 more than 700 UC Health patients enrolled in the app.<br>• In 2024, the team focused on using the app to improve home tracking of maternal hypertension.<br>• The system's contract with the Babyscripts App ended with the close of CY24. |
| | | *Centering Pregnancy* | • Reduce the number of extreme pre-term births and small for gestational age infants. | • Centering Pregnancy was paused after COVID and re-launched in 2022 with 3, 15-member cohorts.<br>• In 2023, department staffing changes resulted in another pause for the model.<br>• The department plans to re-launch Centering Pregnancy with one cohort by the end of 2025. |
| | Expand early access to pregnancy testing and timely connection to care. | *Walk-In Pregnancy Testing* | • Increase early access to pregnancy testing<br>• Increase early access to prenatal care | • The team transitioned this initiative to developing a process for walk-in initial OB visits.<br>• The Women's Health team has moved forward several initiatives to increase timely connection to prenatal care.<br>• The workflow and processes for walk-in I itial OB visits were developed by the team, but due to department staffing this model was not able to move forward. |
| **Social Determinants of Health** | Improve coordination between healthcare systems and social service agencies by | *Standardization of SDOH Screening* | • Increase standardized screening across all patient care settings | • The system SDOH Task Force launched in early 2024, including individuals from UCMC.<br>• The Task Force established data tracking by site for regular review of both |

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| | establishing a shared mechanism to screen, refer, and follow-up on a patients' health-related social needs. | | • Build community resources in EPIC | screening and positivity rates for each SDOH domain.<br>• Members from UCMC were key participants of the Community Resources Committee, which worked to update the Epic Community Resource Guide and create alignment on referral processes for the system.<br>• In March of 2025, UC Health entered into a partnership with Unite Us, which is an Epic-integrated platform that will allow our system to have closed-loop referrals with community partners. UCMC is the pilot site for rollout of Unite Us. |
| | Increase the number of CHWs to assist with connecting individuals to resources and program addressing food and housing needs. | *Health Care Access Now Hub* | • # of patients referred to HCAN for services | • Several departments worked with HCAN to connect our system CHWs into their hub model as well as refer patients for CHW support in 2023-2024.<br>• As HCAN's model has evolved, so has our relationship with the organization. We now rely on HCAN for training and support with the CHWs hired within our system, instead of relying on referrals to HCAN's CHW team. |
| | Expand availability of nutritious food through clinical care for high priority populations. | *Food is Medicine* | • Increase access to food resources within the clinical setting | • There are now 4 clinics across different specialties who have established food pantries for their patients and offer a variety of goods, including shelf stable foods, produce vouchers for mobile markets, and self care items.<br>• The food pantries within clinics across the system have seen increased needs within the patient populations they serve. One of these clinics had 54% of their patient population identify as needing food support in 2024. Food security is consistently in the top identified SDOH needs for many clinics. |

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| | | | | • In FY25, the four pantries distributed 65,000 pounds of food received from the Freestore Foodbank. |
| | Provide Produce Prescriptions within health systems. | *Centering Diabetes Teaching Kitchen* | • Increase healthy eating habits<br>• Increase diabetes management skills | • The teaching kitchen was able to accommodate 12 patients at each session with a UC Health provider and La Soupe chef in 2023.<br>• In 2023 – 2024, the building where the teaching kitchen was located underwent major renovations to become the new Blood Cancer Healing Center. Renovations are ongoing and a new teaching kitchen will be built and opened for classes again in 2026. |
| **Workforce Pipeline** | Increase career exploration work-based learning pathways. | *Healthcare Career Pathways* | • Give students an understanding of the diversity of careers available in healthcare.<br>• Create opportunities to pursue an education and career in healthcare.<br>• Expand pathways to other area schools | • This initiative shifted from Community Relations to Educational Placements for deeper connection to other education and workforce pipeline initiatives and was re-vamped in 2024.<br>• Activations included high school observations, our weeklong summer observation program, hospiral tours, healthcare career panels, and annual collaborative partnerships such as TAP Health.<br>• In FY25, the team collaborated with 21 schools directly, but interacted with 212 students from 42 schools across the region. |
| | Implement and increase diversity, cultural competency, and empathy training of workforce professionals and leadership within health systems. | *Diversity, Equity, and Inclusion Roadmap* | • Increase staff cultural competency<br>• Create common DE&I language across health system | • The training that was developed for the DEI roadmap was rolled out across all UC Health staff and then integrated into onboarding workflows.<br>• UCMC had a training completion rate of 72% when department restructuring paused the project at the end of FY24. |

*Accountability*

*Date approved by Audit and Compliance Committee of UC Health Board of Directors: 4/18/2025.*