2024 Community Health Needs Assessment

Addendum: West Chester Hospital

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: West Chester Hospital

The Community We Serve

West Chester Hospital is located in ZIP code 45069 in Butler 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 West Chester Hospital.

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, West Chester Hospital 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.

West Chester Hospital 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 West Chester Hospital 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
Access to Services – Behavioral Health	Standardize mental health screening and presence of mental health providers in non-psychiatric clinics.	*Collaborative Care Model*	• Increase mental health screenings • 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. • Since 2022, the model has expanded significantly to now include 7 behavioral health care managers c amovering 13 ambulatory clinics across the system, including 4 primary care offices more closely linked with our WCH campus. • 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. • 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.
		Cancer Family Care	• Increase awareness and participation in supportive services available to oncology patients treated at WCH campus as evidenced by participation in programs offered.	• Services provided by the program include counseling, financial assistance, and providing wigs, scarves, hats and accessories to cancer patients or their loved ones. • In FY24, 267 individuals received 333 services through the program. • In FY25, the WCH Cancer Committee integrated with other UC Health cancer committees to form one consolidated, system approach.
	Expand access to MOUD and harm reduction materials in Ambulatory settings.	*MOUD Initiation in the ED*	• Increase MOUD initiation among those with a chief complaint (cc) or discharge diagnosis (ddx) related to opioids • Increase the percentage of ED MOUD patients linked to care within 14 days of ED visit	• The WCH campus has fewer resources solely dedicated to connecting patients to treatment options, but are still able to initiate MOUD in the ED setting. • Since 2023, more than 190 patients have had MOUD initiated in the WCH ED.
Access to Services – Cardiovascular Disease	Equip the community with tools to respond to and reduce harm during a cardiac event**.**	*Stop the Bleed & Take10 CPR*	• To train more people in basic bleeding control techniques in case of emergency • 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. • 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. • Additional partnerships include business safety councils, church safety teams, and the Superseeds youth program. • 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. • In FY25, Take10 CPR trained 545 individuals in 20 classes, which is an improvement on the 100 trainees in 39 classes in FY24.
Access to Services - Dental	Support ongoing efforts to provide preventative dental services and connection to an established dental home.	*ED Dental Referrals*	• Reduce dental-related ED utilization • Increase percent of patients with an established dental home	• This initiative focused on connecting patient who came to the WCH ED with dental pain to a dental home with a nearby clinic. • Leadership turnover both internally and in the partner clinic halted the project, but we were able to refer more than 100 patients in FY24 for follow-up dental care.
Access to Services – Maternal/Infant Health	Provide additional support to high-risk	*Babyscripts App*	• Decrease maternal morbidity and mortality • Decrease infant mortality • Increase adherence to the postpartum visit	• The app provided a personalized approach to perinatal education with resources that discuss the importance of visits,

	pregnant patients through accessible, patient-centered, multimodal educational opportunities.			breastfeeding, medications, and symptoms during pregnancy. • In 2024 more than 700 UC Health patients enrolled in the app. • In 2024, the team focused on using the app to improve home tracking of maternal hypertension. • The system's contract with the Babyscripts App ended with the close of CY24.
		Baby Cafe	• Expand breastfeeding support programming at WCH (i.e. Baby Café).	• The WCH Baby Café group has been consistent throughout the CHIP cycle. • Weekly sessions include 10-20 patients who join for community building, educational discussions, and lactation support. In FY25, 425 patients participated in Baby Café sessions.
Social Determinants of Health	Improve coordination between healthcare systems and social service agencies by establishing a shared mechanism to screen, refer, and follow-up	*Standardization of SDOH Screening*	• Increase standardized screening across all patient care settings • Build community resources in EPIC	• The system SDOH Task Force launched in early 2024, including individuals from WCH. • The Task Force established data tracking by site for regular review of both screening and positivity rates for each SDOH domain. • Members from WCH were key participants of the Community Resources Committee, which worked to update the Epic Community Resource Guide and

	on a patients' health-related social needs.			create alignment on referral processes for the system. • 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. WCH will join the phased Unite Us roll out later in 2025.
	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. • 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.
Workforce Pipeline	Increase career exploration work-based learning pathways.	*Healthcare Career Pathways*	• Give students an understanding of the diversity of careers available in healthcare. • Create opportunities to pursue an education and career in healthcare. • 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. • Activations included high school observations, our weeklong summer observation program, hospiral tours, healthcare

				career panels, and annual collaborative partnerships such as TAP Health. • 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 • 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. • WCH had a training completion rate of 75% 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.