UC Health

Community Health Needs Assessment

Implementation Strategies

University of Cincinnati Medical Center

2026 – 2028

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Our Commitment to Community

At UC Health, and in full partnership with the University of Cincinnati College of Medicine, we are here to transform health and improve life for all. We have been a cornerstone for health and transformation in Greater Cincinnati for more than 200 years as the region's only adult academic health system. We are committed not only to delivering world-class care and research but also to addressing the root causes of health disparities and driving progress that extends far beyond our walls. Grounded in our vision to help shape Cincinnati into the healthiest city in America, we see our role as both a healthcare provider and a catalyst for positive change. With two million patient interactions in FY25, our resolution to work as a team with our local and state partners is steadfast. This Community Health Needs Assessment reflects that commitment, defining how we will align resources, forge partnerships, and invest in solutions that improve access and create lasting impact for generations to come.

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Mission and Vision

Our Purpose is:
Transforming Health, Improving Life.

Our Mission is:
Elevate health for all through life-changing care, innovation and learning.

Our Vision is:
Together, make greater Cincinnati the healthiest city in America.

UC Health Sites

UC Health is a hospital system that is comprised of two separate facilities. Some of the projects listed on the Implementation Plans span multiple sites or are system-wide endeavors. All projects represented on this plan will be implemented at the University of Cincinnati Medical Center (UCMC) or its primary care clinics. UC Health's other hospital facility is West Chester Hospital.

Communities Served

Butler, Clermont, Hamilton and Warren Counties in Ohio. This definition was developed based on historical utilization patterns and alignment with UC Health's strategic service area. UCMC also participated in the Greater Cincinnati Tri-State Regional CHNA, facilitated by The Health Collaborative, which includes broader regional data and priorities. While the regional CHNA covers 18 counties across Ohio, Kentucky, and Indiana, UCMC's implementation strategies are focused on the four-county area where the majority of its patients reside and where its services are concentrated.

2025 Community Health Needs Assessment Priorities
Priorities

The priorities for the University of Cincinnati Medical Center (UCMC) align with the top community health needs identified through the Regional Community Health Needs Assessment (CHNA) completed in partnership with The Health Collaborative:

1. Mental health treatment and prevention.
2. Assessing for and addressing health-related social needs.
3. Heart disease and stroke prevention and treatment.

Significant Health Needs to be Addressed

As part of the alignment process with the Regional CHNA and resulting Regional Collective Health Agenda, participating partners were identified as leads for specific strategies within each priority through which the greatest impact on the community would be achieved. The Regional Agenda narrowed focus on addressing housing and homelessness, but UC Health chose to broaden the scope to standardized screening and referral processes to address the overarching health related social needs of our patients and community. Implementation Strategies, listed on the following pages, will address the following prioritized health needs:

1. Mental health treatment and prevention.
2. Assessing for and addressing health-related social needs.
3. Heart disease and stroke prevention and treatment.

Process for Strategy Development

Strategies and Priority Projects were selected to address the needs identified in the UC Health 2025 Community Health Needs Assessment, which can be found here: https://www.uchealth.com/about/community-benefit/.

The 2026-2028 Community Health Needs Assessment and Improvement Plan (CHIP) cycle was the second time that UC Health participated in a regional improvement plan, this time more narrowly focused to a Collective Health Agenda. Facilitated by The Health Collaborative, the Collective Health Agenda convened stakeholders from across the regional health ecosystem, including hospital systems, public health entities and community-based organizations that addressed the areas of greatest need within the Greater Cincinnati area. The Collective Health Agenda identified the 3 strategies within each priority area with the greatest potential impact, and the sector that could contribute to each strategy. UC Health has aligned with many of the strategies identified for the regional hospitals in order to contribute to the collective momentum. The Regional Collective Health Agenda can be found here: https://healthcollab.org/community-health-needs-assessment/.

The Director of Community and Public Health met with both internal and community stakeholders to identify how UCMC can contribute to addressing these greatest needs of the community. This process included:

- Evaluation of progress on previous CHIP initiatives
- Inventory of current activities that may address the targeted needs.
- Participated in Interact for Health's Collective Health Agenda Steering Committee to discover opportunities for shared strategies.
- Met with UC Health experts and key internal stakeholders to identify and develop responses for the priority areas identified from the Community Health Needs Assessment.

Internal key stakeholders, listed below, provided their input to prioritize strategies and align the Collective Health Agenda to system and department strategic goals. The Director of Community and Public Health presented an overview of the CHNA Implementation Strategies process to the VP of Managed Care and Population Health for final review and approval. UC Health's CHNA Implementation Strategies will be integral for the leadership team steering the new Community Impact strategic pillar for UC Health.

Criteria for Strategy Selection

Our core team collected information on projects throughout the system and assessed them for inclusion based on the following criteria:

1. Alignment with the overarching regional collaborative goals and strategies.
2. Potential for partnership with community organizations to create synergy in approach to greatest needs.
3. Opportunity for standardization in practice across the health system.

4. Improvement to date if the strategy has been included in previous Community Health Improvement Implementation Strategy documents, and potential for continued growth.
5. Potential impact on population within UC Health service area with measurable target.

Implementation Strategies to Address Mental Health

Expected impact: Ongoing integration of mental health care with physical health care to increase early identification of patients with mental health needs, increase access to timely care, and actively improve the models of care to improve health outcomes.

Regional vision: Our vision is to improve mental health treatment and prevention so every community member can be mentally well and live a long, healthy life. This vision will be achieved when everyone in the region is able to thrive in their communities, with access to the mental health services they need.

Mental Health is as equally important as physical health to living a fulfilling life. The Centers for Disease Control (CDC) states that "mental health is not simply the absence of a mental health condition—it is also about the presence of well-being and the ability to thrive." As a system, UC Health will be focused on identifying patients who need mental health support earlier on, so that they can receive the right level of care in a timely manner.

Strategy	Initiative	Goal
1. Identify opportunities to reach people earlier, before they experience a mental health crisis, through consistent screening and intentional quality improvement initiatives.	Utilization of appropriate mental health screening across care settings.	Increase screening for depression and anxiety across care settings to identify patients who need support earlier.
	Bipolar Action Network	Improve care for patients with complex mental health needs like bipolar disorder.
2. Expand capacity to improve timely access to mental health care.	Collaborative Care Model – Integration of Mental Health care into Primary Care	Improve access to mental health services in non-psychiatric care settings.
	Transitional Age Youth Clinic	Improve transitional care from Children's Hospital to adult psychiatry for continuity of care in mental health treatment.
3. Provide on-demand crisis intervention services where a behavioral health crisis is occurring.	Mobile Crisis Team	Meet community members where they are while experiencing a mental health crisis and connect them back to an appropriate level of care.
Implementation Resources		
Resources to implement these initiatives will revolve around our dedicated UC Health staff including social workers, physicians, psychiatrists, counselors, care managers, peer navigators, program administration, data analysts, and IT support.		
Community Collaborations		
UCMC's Psychiatry Department and Psychiatric Emergency Services have extensive partnerships with the region's community mental health agencies: Central Clinic, Talbert House, and Greater Cincinnati Behavioral Health. Other key partnerships for priority initiatives include community-based primary care clinics, Cincinnati Children's Hospital, Hamilton County Mental Health Board, Hamilton County first responders, 9-1-1 Dispatch Cincinnati, Hamilton County Quick Response Team, Addictions Council, Best Point and the nationwide Bipolar Action Network.		
Regional Resources		
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- BIPOC mental and behavioral health provider directory
- Community Mental Health Centers
- Federally Qualified Health Centers
- Foundations
- Hamilton County Addiction Response Coalition
- HEY! (Hopeful Empowered Youth) Cincinnati
- Mental Health America of Northern Kentucky and Southwest Ohio
- Mental Health and Addiction Advocacy Coalition (MHAC)
- Mental Health and Addiction Services Recovery Boards
- MindPeace directory
- National Alliance on Mental Illness (NAMI) Southwest Ohio
- Public Health Departments
- Safety Net Alliances Crisis
- 211 hotline
- Crisis hotlines
- Crisis Receiving Center
- Suicide Prevention Coalitions

Alignments

Additional alignment with the Regional Collective Health Agenda may arise as collective work moves forward.

- Collective Health Agenda 2025 Strategies:
    - Identify opportunities to reach people earlier, before they experience a mental health crisis.
- State Health Improvement Plan (SHIP) 2020-2022 Strategies:
    - MH – Integration of behavioral Health services into primary care
    - MH – Depression screening

Implementation Strategies to Address Health-Related Social Needs

Expected impact: Address access to resources for health-related social needs with a focus on standardized screening and referral processes, as well as the development and strengthening of partnerships and communication between providers and community-based organizations.

Social Drivers of Health (SDoH) are defined by the U.S. Department for Health and Human Services as "the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." These are translated at the individual level to health-related social needs, defined as "social and economic needs that individuals experience that affect their ability to maintain their health and well-being" by the Centers for Medicare and Medicaid Services (CMS). CMS has narrowed focus within health-related social needs to five key domains: housing, food security, transportation, economic stability, and interpersonal violence. The SDoH framework has been elevated in recent years as a mechanism to quantify and operationalize upstream factors that have strongly correlated, long-lasting health effects on those who are most affected.

Strategy	Initiative	Goal
1. Standardization of culturally competent assessment of patient health related social needs across all care settings.	UCMC Inpatient & Ambulatory Clinics SDOH Screening Standardization.	Increase reliability of a compassionate and culturally competent SDOH screening process to consistently identify patients with health-related social needs.
2. Develop strategic partnerships to address health-related social needs.	Integration of targeted community partners with enhanced services to support identified health-related social need.	Leverage SDOH screening data to increase innovative and supportive partnerships with community social service agencies.
3. Care coordination between healthcare systems and social service agencies by establishing a clear referral and communication pathway to support patient needs.	Implementation of Standardized Community Referral Pathways.	Increase appropriate referrals and consistent communication with community social service agencies through clear collaboration pathways.
Implementation Resources		
UC Health has partnered with the Unite Us referral platform, which will support the development of bidirectional communication with community social service agencies. Additional resources include supplemental support for the in-clinic food pantries in partnership with FreeStore food bank and key personnel working on these strategies, including both operational leadership and frontline staff such as nurses, social work and care management, clinic managers, data analysts, IT support, and Population Health/Community Health team members.		
Community Collaborations		

UCMC has deep partnership in connection with addressing social drivers of health and will focus on continuing to develop strategic partnerships within each SDOH domain over the CHIP cycle. Current partnerships include Unite Us, United Way 211, FreeStore Food Bank, Last Mile Food Rescue, St. Vincent de Paul, Built for Zero community coalition, YWCA, Council on Aging, NeighborHub Health and many more.

Regional Resources

- Federally Qualified Health Centers (FQHCs)
- Foundations
- Local Initiatives Support Corporation (LISC) Greater Cincinnati
- Public Health Departments
- United Way of Greater Cincinnati
- United Way of Butler County
- United Way of Warren County

Alignments

Additional alignment with the Regional Collective Health Agenda may arise as collective work moves forward.

- Collective Health Agenda 2025 Strategies:
    - Care coordination for those with health-related social needs, including for those experiencing housing instability.
    - Use health data to inform strategy, including housing strategy
- State Health Improvement Plan (SHIP) 2020-2022 Strategies:
    - Addressing community conditions

Implementation Strategies to Address Heart Disease and Stroke Prevention and Treatment

Expected Impact: Increased access to cardiovascular health screening, educations, and wraparound prevention services, in combination with intentional care collaboration and world-class research, will reduce the burden of cardiovascular disease for our community.

Regional Vision: Our vision is to prevent heart disease and stroke so that everyone in the region can live longer, healthier lives. This vision will be achieved when everyone in the region is able to thrive in their community, with access to the resources they need to support their mental and physical well-being.

Given that cardiovascular disease is the leading cause of death in the Greater Cincinnati Region, addressing cardiovascular wellness is essential to decreasing the life expectancy gap between ZIP codes in the area. Screening for and managing hypertension and heart health with wraparound support services is essential for optimal health outcomes.

Strategy	Initiative	Goal
1. Provide access to place-based cardiovascular health education and screening where community members live, work, and play.	513 Relief Bus Partnership	Increase access to preventive care, connection for follow-up, and health education about cardiovascular health and stroke directly to underserved communities.
2. Create shared understanding of the impact of social and structural determinants on cardiovascular disease and stroke.	Coordination of care by Stroke Care Navigators	Improve coordination of care for treatment and recovery from stroke by supporting patient health-related needs.
3. Leverage Quality Improvement methodology to address hypertension management and control in partnership with community.	Southwest Ohio Regional Hub Learning Network – Hypertension Collaborative for primary care practices with >30% of their patients insured by Medicaid.	Improve hypertension control in practices by 10% and increase collaborations with regional practices on QI methodology.
4. Advance innovative approaches to Stroke treatment and prevention through groundbreaking research to improve patient outcomes.	NIH StrokeNet National Coordinating Center	Increase the innovative approaches to Stroke prevention, treatment, and recovery through multi-site clinical trials.
Implementation Resources		
Resources to implement these initiatives will revolve around our dedicated UC Health staff including physicians, stroke coordinators, stroke navigators, program administration, data analysts, nurses, QI coaches, CHWs, dieticians, tobacco cessation specialists, pharmacists. Addition resources include equipment and educational materials for community events with		

the 513 Relief Bus.
Community Collaborations
Key partnerships for these initiatives include Hamilton County, the American Heart Association of Greater Cincinnati, OSU Government Resource Center, community pharmacies, FQHCs, health departments, the Greater Cincinnati Stroke Consortium, and the Board of Ohio Stroke Collaborative.
Regional Resources
• American Heart Association (AHA) Greater Cincinnati • Federally Qualified Health Centers (FQHCs) • HealthPath Foundation • Heart to Heart Home Healthcare • Hospice of Cincinnati Cardiac Care Program • ProjectADAM • Public Health Departments • St. Vincent DePaul Charitable Pharmacy • The Center for Closing the Health Gap • Heart of Northside
Alignments

Additional alignment with the Regional Collective Health Agenda may arise as collective work moves forward.
• Collective Health Agenda 2025 Strategies:
  ○ Create shared understanding of the impact of social and structural determinates on cardiovascular health.
• State Health Improvement Plan (SHIP) 2020-2022 Strategies:
  ○ CC – Hypertension screening and follow up
  ○ CC – Prediabetes screening, testing, and referrals

Accountability

September 11, 2025

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Date approved by Audit and Compliance Committee of UC Health Board of Directors

To obtain a hard copy of this CHNA Implementation Strategies document, please contact: Cady Cornell, Director of Community and Public Health, at cady.cornell@uchealth.com.

Digital copies can be found on UC Health's website: https://www.uchealth.com/about/community-benefit/.

Questions or comments can be submitted to the UC Health Community and Public Health team here: