ADDENDUM:
2019 COLLABORATIVE CHNA

University of Cincinnati Medical Center

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

Introduction

In 2018 the University of Cincinnati Medical Center participated, as part of UC Health, in the collaborative development of a Community Health Needs Assessment (CHNA) for Greater Cincinnati and Greater Dayton, which incorporated considerable community input. This addendum will be published with the CHNA Report in 2019. The addendum describes the prioritization process and its results to identify significant health needs, and it also updates the status of the prior Implementation Plan.

Criteria

The CHNA considered the health and health-related issues according to the following criteria:

- Community prioritized the issue highly (based on consensus on priorities in CHNA)
- Public health departments prioritized the issue highly (based on consensus on priorities in CHNA)
- Nonprofit agencies, representing vulnerable populations, prioritized the issue highly (based on consensus on priorities in CHNA)
- Secondary data sources reflected that the issue was worse over time (based on up to 5 years' trend data collected for CHNA)
- Proportion of region impacted by worsening trends (based on CHNA data on the number of counties impacted by mortality rate; ratio of providers; and prevalence rate)

Process

UC Health Administration designated Christie Kuhns, Esq., in consultation with key stakeholders across the organization, to recommend priorities for the University of Cincinnati Medical Center. In her role as Chief of Staff and Vice President of Operations & Community Relations, Ms. Kuhns is qualified to select and endorse the priorities from the CHNA report and to allocate resources for implementation strategies. The CHNA identified the following regional priorities:

1. Substance abuse
2. Mental health
3. Access to care/Services
4. Chronic disease
5. Healthy behaviors

Priorities were determined by the number of votes in community meetings; the number and percentage of mentions on surveys; and, for secondary data, data worse than state or national data, and trending in the wrong direction.

UC Health is committed to improving the physical and economic health our community and has prioritized Community Health as one of its Core Four Strategies. Therefore, the University of Cincinnati Medical Center weighted one criterion more heavily than the other criteria – 'Community prioritized it highly' – in order to retain an emphasis on what the community deemed most significant.

In addition to increasing the weight of the criterion, 'Community prioritized it highly,' two health issues were also weighted. Access to care/services and mental health were both already identified at UC Health as top priorities during its strategic planning process in 2016. UC Health's experience with both mental health and substance abuse also led their combination into one category, since mental health issues are a root cause for most substance abuse disorders.

Consideration of community input

Through the CHNA process, the University of Cincinnati Medical Center received detailed information about the health issues identified in Butler, Clermont, Hamilton, and Warren Counties by Health Commissioners, individual consumers, nonprofit agencies serving vulnerable populations, and focus group participants.

Top priorities

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

1. Substance abuse and mental health
2. Access to care/Services
3. Chronic disease
4. Healthy behaviors

EVALUATION OF IMPACT OF 2016 IMPLEMENTATION PLAN

Community Health Need	Strategy	Evaluation of Impact	Status	
Access to care	Share on website the CHNA Resource List.	Post on website before 12/31/16.	Completed.	★
Access to care	Increase access to primary care in neighborhoods adjacent to UCMC.	Open new health center or primary care office in Avondale.	Executed lease & tenant agreement in Oct. 2017. Groundbreaking on Oct. 30, 2017. Working with Cincinnati Health Department on logistics. On target to open in 2019.	In progress
Access to care & Chronic disease	Arrange for diabetes education & diabetes management in community via Community Health University of Center for Closing the Health Gap (CCHG).	Pre- and post-tests for each 6-week course (capacity for 25 people) with follow-up at 3, 6, and 9 months.	48 registrants; 14 program participants. First session held Oct. 4-Nov. 29, 2018.	★
Access to care/ services	UC Health will participate in a joint collaboration to improve health in the region, with The Health Collaborative.	Identify shared regional priority.	As part of the Gen-H Initiative, The Health Collaborative has launched Accountable Health Communities (Aug. 2018) in which UC Health is actively participating in addressing social determinants. Partnership with The Health Collaborative is ongoing to identify a shared priority.	★
Access to care & Chronic disease	Share information and classes on community health education topics: disseminate educ. at community-wide health care events and provide classes.	3-4 health fair events per year. Double the number of new patients screened monthly for lung cancer (avg. 55.4/mo. FY16).	Shared information and screenings health fairs: Midwest Black Family Reunion; CCHG Health Expo; Cincy Cinco; Avondale Festival and Health Fair; First Ladies Health Day; African-American Male Wellness Walk. (Total attendance @ 40,000+.) Education and screenings at Curvy Cardio and Community Conversations on Cancer and on Causes of Infertility.	★

Access to care & Chronic disease, *Continued*			Lung cancer screening program fully staffed as of 12/15/2018. Average new people scanned: 81.2/mo. FY17; 101.8/mo. FY18; 127.3/mo. FY19. Helped Margaret Mary Hospital to establish fully operational lung screening program. Formed Community Advisory Committee in Dec. 2017. It meets quarterly to advise on issues of interest with focus on access to high quality care and socioeconomic determinants of health.	★
Access to care & Chronic disease	Provide community health education on fall prevention through dissemination of educational materials; classes; seminars; and partnerships with fire departments.	Increase attendance from first Fall Prevention Community Clinic.	New Trauma Prevention Coordinator in 2018 changed Fall Clinic to community presentations with similar content and reached 215 people in 6 locations. Hosted 2 Senior Wellness/Fall Prevention Fairs in 2018. Ongoing free seminars in Colerain Twp. with screens & medication review. Partnered with Colerain Fire & working with Mason, Liberty, and West Chester Fire & EMS.	★
Access to care & Infant mortality	Expand Ob/Gyn services in the community: Add services at WinMed and Cincinnati Health Department's Walnut Hills Health Center; collaborate with Cincinnati Children's Adult Congenital Heart Disease (ACHD) Program to case manage pregnant women; care for pregnant students of Cincinnati Public Schools (CPS) with STEPS program; and expand services in other community locations.	Increase enrollment at community-based services.	Expansion to 3 new OB clinics with Crossroads in 2018. No longer partner with WinMed. 180 deliveries from community clinics in 2017, 28.5% increase from 140 deliveries in 2016. ACHD manages 5-10 women at a time. Despite CPS discontinuing STEPS due to poor attendance, continued to serve 20 youth in 2017 from CPS & Lighthouse. Received grants for 2 community health workers; Centering Pregnancy; and Infant Vitality Program focused on Winton Hills and North College Hill.	★
Mental health & Substance abuse	Improve community treatment capacity for people with substance abuse disorders and co-occurring disorders.	Open new Intensive Outpatient Clinic by 2017 with capacity for 75 patients; intensive services for 20.	Opened with 40 beds in Oct. 2016. 93 patients have attended with a completion rate of 73%.	★

Mental health & Substance abuse	Continue to grow new Perinatal Addictions Clinic to provide coordinated perinatal, addiction & mental health treatment for pregnant women.	Started Jan. 2016 with 9 OB patients enrolled to date. Expand from 1 to 3 sessions per week.	23 patients served in 2017. 31 patients served in 2018. Centering Care and Recovery – Weekly recovery group with monthly integrative primary care for women with perinatal opioid addiction and their babies. A 2nd recovery group has started with plans for primary care partnership.	★
Mental health & Substance abuse	Connect more people to treatment at new methadone clinic.	Lindner Center of HOPE reaches its capacity of 400 patients per day.	As of July 2017, Lindner was close to 270 patients. UC Opioid Therapy Program received separate Opioid Treatment Program License: July 2018. Accepting third party payment from Medicaid required separate license. UC Opioid Therapy Program has 300 patients, with capacity for 500. Clinic volume has increased by 250% in last 2 years. Screening & referring ED patients to treatment per protocol. UC/UC Health Opioid Task formed Apr. 2017. Active participant in the Hamilton County Heroin Coalition.	★

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