UC Health

Community Health Needs Assessment

IMPLEMENTATION STRATEGIES

Daniel Drake Center for Post-Acute Care

2023 – 2025

UC Health

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Mission and Vision

Mission and Vision

Our Purpose is:
To advance healing and reduce suffering.

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

UC Health Sites

UC Health is a hospital system that is comprised of three 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 Daniel Drake for Post-Acute Care facility. Other UC Health facilities include:

- University of Cincinnati Medical Center (UCMC)
- West Chester Hospital

Communities Served

Butler, Clermont, Hamilton, and Warren Counties in Ohio

2021 Community Health Needs Assessment Priorities

Priorities

The priorities for the Daniel drake Center for Post-Acute Pain align with the top community health needs identified through the Regional CHNA completed in partnership with The Health Collaborative:

1. Increase access to services in order to improve equitable outcomes for the region's top health needs: behavioral health, cardiovascular disease, dental, vision, and maternal/infant health.
2. 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.
3. Strengthen the workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.

Significant Health Needs to be Addressed

As part of the alignment process with the Regional CHNA and resulting Regional Community Health Improvement Plan, participating partners were identified as leads for specific strategies within each priority through which the greatest impact on the community would be achieved. Implementation Strategies, listed on the following pages, will address the following prioritized health needs:

1. Increase access to services in order to improve equitable outcomes for the region's top health needs: cardiovascular disease.
2. 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.
3. Strengthen the workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.

Significant Health Needs Not Addressed

While the Daniel Drake center for Post-Acute Care is able to address many of the identified community needs, there is not currently capacity or infrastructure to address the following needs, which will be taken on by both other UC Health sites and community partners at the regional level:

1. Increase access to services in order to improve equitable outcomes for the region's top health needs: behavioral health, dental, and maternal/infant health.

Process for Strategy Development

Process for Strategy Development
Strategies and Priority Projects were selected to address the needs identified in the UC Health 2021 Community Health Needs Assessment, which can be found here: https://www.uchealth.com/about/community-benefit/.

The 2023-2025 Community Health Needs Assessment and Improvement Plan (CHIP) cycle was the first time that UC Health participated in a regional improvement plan. Facilitated by The Health Collaborative, the Regional CHIP convened stakeholders from across the health ecosystem, including hospital systems, public health entities, and community-based organizations that addressed the areas of greatest need within the Greater Cincinnati and Greater Dayton areas. This was a novel approach on a national scale. The Regional CHIP identified strategies across all the participating institutions that would engage the partners to collaborate and take leadership in those tactics that were targeted within their sphere of influence. UC Health chose to align as closely as possible with the Regional CHIP in order to contribute to addressing the three greatest needs in a collaborative and impactful manner. The Regional CHIP can be found here: https://healthcollab.org/community-health-needs-assessment/.

UC Health chose to add one additional focus area to those selected at the regional level – increasing access to service to improve equitable outcomes for maternal/infant health. This decision was based on the evident need within the population served specifically by UC Health. Additionally, UC Health is engaged in several strong partnerships that are working to address disparities amongst the pregnant population in Cincinnati.

A CHNA Key Stakeholder group was formed to guide and oversee the process development of strategies. The Population Health and Community Relations teams met with both internal and community stakeholders to identify strategies. This team included Cady Cornell, Performance Improvement Specialist, Population Health and Dan Maxwell, Manager, Community Relations. Their activities included:

- Inventory of current strategies worthy of continuation
- Inventory of current activities that may address the targeted needs
- Met with public health agencies to identify additional opportunities to collaborate
- Participated in The Health Collaborative's Regional Implementation Plan Group to discover opportunities for shared strategies
- Met with community-based organizations and other external stakeholders
- 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, participated in discussions between January and August 2022 to generate goals, select priority projects, and ensure alignment to the Regional CHIP. The CHNA team presented an overview of the CHNA Implementation Strategies process during meetings with the Chief Administrative Officers and Chief Medical Officer for final review and approval.

UC Health Key Stakeholders included:

Name	Position
Dr. Stewart Wright	Chief Medical Officer
Rob Wiehe	Chief Operating Officer
Lafe Bauer	Chief Administrative Officer
Estella Neizer-Ashun	Vice President, Chief Nursing Officer
Jimmy Duncan	Senior Vice President, Chief Human Resources Officer
Jenifer Brodsky	Manager, Trauma Program
Suzanne Burgei	AVP, Culture, People, & Technology
Dr. Christine Burrows	Medical Director, Internal Medicine and Pediatrics
Dr. Dustin Calhoun	Director, Emergency Management
Pamela Clinkenbeard	Director, Rehab Services
Jeanetta Darno	Chief Diversity, Equity, and Inclusion Officer
Jennifer Davis	Director, Nursing Administration
Valerie Hoagland-Scarfpin	AVP, Talent Acquisition
Trish Hunter	Interim Director, Population Health
Tamara Lang	Senior Director, Community Relations
Gina Menninger	Coordinator, Trauma Outreach and Prevention

Criteria for Strategy Selection

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

1. Alignment with the overarching regional collaborative goals and strategies
2. Opportunity for standardization in practice across the health system
3. Improvement to date if the strategy has been included in previous Community Health Implementation Strategy documents, and potential for continued growth
4. Size of impact on population within UC Health service area

Implementation Strategies

Overview of Implementation Strategies

Priority 1: Increase access to services in order to improve equitable outcomes for the region's top health needs: cardiovascular disease.
Cardiovascular Disease Strategies
• Equip the community with tools to respond to and reduce harm during a cardiac event. • Provide additional access to resources, education, and support services for patients and their families following a cardiopulmonary event.

Priority 2: 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 Determinants of Health Strategies
• Improve coordination between healthcare systems and social service agencies by establishing a shared mechanism to screen, refer, and follow-up on a patients' health-related social needs.

Priority 3: Strengthen the workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.
Workforce Pipeline Strategies
Regional Priority: Expand and diversify the healthcare workforce pipeline through education and hiring opportunities*.
• Collaborate with community-based organizations to connect diverse residents from high-poverty neighborhoods to available frontline positions, and then intentionally to internal career development and advancement opportunities. • Implement and increase diversity, cultural competency, and empathy training of workforce professionals and leadership within health systems.

Key:

 Indicates alignment with the UC Health Strategic Plan

 Indicates alignment with the Regional CHIP

 Indicates alignment with the Ohio State Improvement Plan

Implementation Strategies to Address Access to Services

Increase access to services in order to improve equitable outcomes for the region's top health needs: cardiovascular disease.

Description

The Regional CHNA identified the greater Cincinnati area's most unmet health needs by analyzing and prioritizing a combination of the region's most prevalent health conditions (identified through hospital utilization data, community member surveys, and Center for Disease Control data), most untreated health conditions (identified through community member surveys), and those health conditions most impacted by Social Determinants of Health (SDoH). Through this process, the top needs of behavioral health, cardiovascular conditions, dental, and vision were chosen as regional priorities. As noted in the Regional CHNA, approximately 30% of Cincinnati Metro residents reported high blood pressure or high cholesterol, which are risk factors for cardiovascular disease.

Primary Goals

- Increase care coordination services
- Increase mental health screening in non-psychiatric clinics

Cardiovascular Disease

Strategy: Equip the community with tools to respond to and reduce harm during a cardiac event.

Priority Project: Stop the Bleed & Take10 CPR

The UC Health Department of Trauma has been leading efforts to educate and train Greater Cincinnati first responders, health professionals, teachers, and community members in lifesaving "Stop the Bleed" and "Take10 CPR" techniques.

"Stop the Bleed" is a national preparedness program created after the Sandy Hook Elementary School shooting in December 2012. The goal of "Stop the Bleed" is to reduce the number of people who die from uncontrolled bleeding during mass casualty events, shootings, natural disasters, and everyday emergencies by training ordinary citizens in lifesaving bleeding control techniques. "Stop the Bleed" is provided in communities across the U.S. by the Department of Defense and Homeland Security in partnership with the American College of Surgeons, FEMA, the National Association of EMTs, the U.S. Fire Administration, Prehospital Trauma Life Support, Major Cities Chief's Association, the Hartford Insurance Company, and Johnson and Johnson.

TAKE10 Cincinnati is designed to educate and rally the community around compression-only CPR, an easy-to-learn technique that can save lives. Developed by Take Heart Austin and brought to Cincinnati by UC Health, TAKE10 is a free 10-minute training on the hands-only technique that gives people the confidence to act in an emergency. Increasing the number of people trained to start CPR, before 911 responders arrive, can improve cardiac arrest survival.

Objectives	• To increase the number of people who are trained, equipped, and empowered to help in a bleeding emergency before professional help arrives. • To cultivate and encourage grass roots efforts to provide training. • To provide program support so that trainees are able to identify life-threatening bleeding; use their hands to stop the bleeding; pack a wound; and correctly apply a tourniquet. • To increase the number of people who are trained in compression-only CPR.
Goals	• To train more people in basic bleeding control techniques in case of emergency • To train people in compression-only CPR in case of emergency
Key Metrics	• # of trainings completed • # of people trained
Partners	• Cincinnati Fire Department • Cincinnati Police Department • Cincinnati Health Department • The Health Collaborative • Local Fire and EMS departments

Priority Project: Pulse Point Dispatch Center

This project brings Cincinnati online with the Pulse Point app that has been developed for the purpose of notifying trained users and first responders of a cardiac arrest event so that those trained in CPR can respond quickly. The app also shows the location of the nearest AED, so responders can quickly access this life-saving tool. Research indicates that mobile-phone positioning systems that dispatch CPR-trained volunteers are associated with significantly increased rates of bystander-initiated CPR among persons with out-of-hospital cardiac arrest. Increased bystander CPR rates lead to increased cardiac arrest survival.

UC Health has worked collaboratively with Cincinnati Fire Department and Cincinnati Emergency Communications to bring this lifesaving tool to the region and continues to promote expanded use of the app. This partnership is the latest example of how the health system works with first responders to improve prehospital care.

Objectives	• To alert users immediately of a cardiac arrest event • To increase the number of app users and number of AEDs

	registered in the app
Goals	• Improve response time to cardiac events taking place in the community • Increase bystander CPR rates and improve bystander response times
Key Metrics	• Registry number of AEDs • Number of app registrants • Bystander CPR rate
Partners	• Cincinnati Fire Department • Cincinnati Emergency Communications Center • Pulse Point • TAKE10 Cincinnati

Strategy: Provide additional access to resources, education, and support services for patients and their families following a cardiopulmonary event.

Priority Project: Cardiopulmonary Education and Support

The project aims to create standardized, branded educational materials for distribution at cardiopulmonary rehabilitation and the UC Health website. Additionally, content experts from the department will be able to present education to patients and family in a hybrid format to improve knowledge and reduce readmissions. The program will also channel development into its existing support groups to improve community outreach.

Objectives	• Identify educational targets for cardiopulmonary patients • Develop materials to distribute to patients and their families to promote support groups and education • Create hybrid format educational classes for patients, family and their communities to attend
Goals	• Increase knowledge of cardiopulmonary support services provided at UC Health • Increase utilization of cardiopulmonary support services provided at UC Health • Reduce hospital readmissions
Key Metrics	• Attendance rates for classes • Attendance rates for support groups

Implementation Strategies to Address Social Determinants of Health

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.

Description

Health-related social needs, or Social Determinants of Health (SDoH) are defined by the US 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." The Healthy People 2030 framework identified five SDoH categories: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. 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. At the Population Health level, most widespread disparate outcomes are driven by SDoH.

The Regional CHIP assessed the Cincinnati metro community at all levels of the Healthy People 2030 framework and identified food security and housing as the region's most pressing issues. While supportive of initiatives that focus on these two specific needs. UC Health chose to take a broader approach and examine our internal processes for both screening patients for SDoH and connecting them with appropriate and accessible resources. These are truly the first two steps for ensuring that the UC Health patient population is receiving wraparound support that will improve their health outcomes across the board.

Primary Goals

- Increase screening for basic patient social determinants of health
- Standardize referral process to address patient needs with community partners

Strategies for Social Determinants of Health

Strategy: Improve coordination between healthcare systems and social service agencies by establishing a shared mechanism to screen, refer, and follow-up on a patients' health-related social needs.

Priority Project: Standardization of Social Determinants of Health Screening and Referrals to Resources

UC Health Population Health staff are working with an interdisciplinary team to create a structured, standardized method of Social Determinants of Health (SDoH) data collection across all patient care settings. The standardized screenings are being built into the UC Health electronic medical record, EPIC, and will be displayed on all patients charts for ease of access. The screenings that are being standardized across all departments will assess the following needs: food security, housing, mental health, financial resource strain, stress, depression, and social connections. By collecting this crucial information, providers will be able to execute individualized treatment and improve care coordination. Standardized screening will also allow for a better population-level understanding of social and health equity for system administrators. Testing within a select few clinics will begin in Fall of 2022 but will be spread to all patient contact points in the system.

At current state, patient referrals to support services that can address any needs identified by SDoH screening varies across each department. Creation of a referral resource directory within EPIC, UC Health's electronic medical record, will help provide consistent access to resources when patients need them, regardless of where they come in contact with the system. UC Health is working toward establishing means of communication with community-based organizations, with an end goal of establishing closed loops for confirmation of patients engaging with services and ensuring that their needs are met.

UC Health is also committed to collaboration with regional health systems, who also participated in the Regional CHNA, on standardization of referrals and collective support of community-based organizations. Through alignment and partnership across health systems, we hope to build a sustainable regional system that can respond to the changing needs of the community and capacity of the support services.

Objectives	• Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all UC health patients • Establish a resource directory and formalize partnerships with community-based organizations • Provide EPIC support to clinics who do not currently have access to SDoH screeners and chart visualizations • Train clinic staff to increase awareness of updated screening and referral operations
Goals	• Increase standardized screening across all patient care settings • Build community resources in EPIC
Key Metrics	• % of patients who are screened for SDoH on an annual basis
Partners	• The Health Collaborative

Strengthen workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.

Description

The final piece of community analysis completed for the Regional CHNA was an examination of the healthcare ecosystem's structural barriers to improving the quality of healthcare. Community and healthcare provider surveys and focus groups pointed to a need for increased cultural competency and emphasized the importance of patients' feeling of being "heard" by their providers. Providers also indicated that there is room for greater adoption of several best practice areas specific to cultural competency across the healthcare landscape. Key stakeholders also identified workforce diversity and equitable opportunities for both entering healthcare and advancing along a career path to be barriers to success. At UC Health, many of the strategies suggested by the Regional CHIP are implemented and integrated into regular workflows. Some of these standard practices include, but are not limited to:

- Collect data on workforce gaps and training needs to inform decisions about healthcare workforce development.
- Provide incumbent worker training program opportunities, apprenticeships, and scholarships to assist employees in advancing education and careers in healthcare.

Primary Goals

- Align with regional health system workforce initiatives
- Increase accessible opportunities to enter the healthcare workforce

Workforce Pipeline Strategies

Priority: Expand and diversify the healthcare workforce pipeline through education and hiring opportunities

Strategy: Collaborate with community-based organizations to connect diverse residents from high-poverty neighborhoods to available frontline positions, and then intentionally to internal career development and advancement opportunities.

Priority Project: CityLink

A new partnership between UC Health and CityLink Center will help individuals in the community embark upon medical careers as patient care assistants (PCAs). The PCA Training Program launched August 1, 2022 with a pilot cohort class of 15 students. At the end of the three-week program, graduates will be offered full-time PCA positions at UC Health's Daniel Drake Center for Post-Acute Care. The program also provides graduates with the opportunity to pursue certification as a state tested nurse aide (STNA).

CityLink is a city-wide initiative launched in 2013 that provides integrated services, including career training, to help community members find a path to economic mobility, empowerment and a better future for themselves. CityLink Center partnered with UC Health to develop a solution to employment challenges individuals in our communities are facing. Career paths in the medical field have proven to be sustainable coming out of the pandemic.

Objectives	• To provide students with the opportunity to obtain training and develop skills necessary to enter the healthcare workforce. • Develop a pipeline for PCA employment opportunities at Daniel Drake Center • Support residents by providing individuals with critical training and skills in order to gain sustainable employment.
Goals	• To develop a diverse workforce to meet the healthcare needs of the community. • Increase PCA workforce pipeline
Key Metrics	• Post training evaluation with check in points at week 2, 4 and 8 • Goal to retain at least 80% of hired FTEs cohort • Turnover rates will be measured and tracked through HR dashboard • Increased enrollment in training program (4 cohorts a year)
Partners	• CityLink

Priority Project: Project LIFE

Project LIFE is a combined education and work experience program that is giving high school students and young adult interns with developmental disabilities the opportunity to learn and build skills leading to future employment and a more independent adulthood. Utilizing evidence-based practices proven to get interns on the right track toward independence, Project LIFE has been promoting quality job training partnerships with area businesses in Southwest Ohio for more than 12 years and is now doing the same across the nation.

Daniel Drake Center for Post-Acute Care will develop opportunities and job descriptions for appropriate intern positions within selected hospital departments, coordinate placement, schedules and ongoing requirements with Cincinnati Public Schools Administrations, and complete onboarding and orientation with each intern and adult job coach.

Objectives	• To provide students with developmental disabilities the opportunity to develop job skills and increase their independence. • To support staff in selected Drake departments with additional student resources • To develop a pipeline for entry-level employment opportunities with students who are participating as Project LIFE interns
Key Metrics	• Number of hours served per intern • Number of hours served in each participating department
Partners	• Cincinnati Public Schools

Strategy: Implement and increase diversity, cultural competency, and empathy training of workforce professionals and leadership within health systems.

Priority Project: Diversity, Equity and Inclusion Roadmap to Cultural Competency

The more aware we are of our own unconscious bias and increase our understanding of diversity, equity, and inclusion, the better we can ensure all patients, families and employees feel welcome.
In the Spring on 2021, the UC Health Office of Diversity, Equity, and Inclusion launched four diversity, equity and inclusion (DE&I) training modules across the system. Teams of early adopters volunteered to take the training modules and hold conversations about their learnings.

Beginning in August 2022, all UC Health employees will be part of establishing a common language around how we discuss diversity, equity and inclusion. Employees who have not yet taken the four DE&I modules will be assigned the training modules:

- Module 1 – Diversity and Inclusion Matters
- Module 2 – Basics for Managing an Unconscious Bias
- Module 3 – Hidden Barriers to Inclusion
- Module 4 – Being and Diversity and Inclusion Change Agent
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Objectives	• Build a common language for how employees discuss DE&I • Build a roadmap for building greater cultural competency across the health system
Goals	• Increase staff cultural competency • Create common DE&I language across health system
Key Metrics	• Number of staff to complete all four modules • % Workforce trained

Accountability

September 8, 2022

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