UC Health

Community Health Needs Assessment

IMPLEMENTATION STRATEGIES

University of Cincinnati Medical Center

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 University of Cincinnati Medical Center (UCMC). Other UC Health facilities include:

- Daniel Drake Center for Post-Acute Care
- West Chester Hospital

Communities Served

Butler, Clermont, Hamilton, and Warren Counties in Ohio

2022 Community Health Needs Assessment Priorities

Priorities

The priorities for the University of Cincinnati Medical Center 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 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: behavioral health, cardiovascular disease, dental, 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 workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.

Significant Health Needs Not Addressed

While UCMC 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 community partners at the Regional level:

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

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 of 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 within the Cincinnati pregnant population, specifically Cincinnati Cradle.

A CHNA Steering Committee was formed to guide and oversee the process development of strategies. The Population Health Team and Community Relations team 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 Interact for Health'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.

Key Stakeholders engaged in the CHNA Steering Committee were:

Name	Position
Dr. Stewart Wright	Chief Medical Officer
Rob Wiehe	Chief Operating Officer, Chief Administrative Officer
Jimmy Duncan	Senior Vice President, Chief Human Resources Officer
Dan Arendt	Pharmacist, Clinical Specialist
Marisa Brizzi	Pharmacist, Clinical Specialist
Dr. Christine Burrows	Medical Director, Internal Medicine and Pediatrics
Suzanne Burgei	AVP, Culture, People, & Technology
Dr. Dustin Calhoun	Director of Emergency Management
Dr. Molly Carey	Medical Director, UC Health Obstetrics and Gynecology
Jeanetta Darno	Chief Diversity, Equity, and Inclusion Officer
Valerie Hoagland-Scarfpin	AVP, Talent Acquisition
Trish Hunter	Interim Director of Population Health
Diva Jonatan	Nurse Practitioner
Dr. Elizabeth Kelly	Vice Chair, Clinical Obstetrics and Gynecology; Medical Director, Women's Community Health Services
Michael Lesko	Manager, Social Services
Dawn Murray	Director of Clinical Operations, UC Health Obstetrics and Gynecology
Dr. Hilja Ruegg	Medical Director, Integrated Mental Health Care
Dr. Rick Ryan	Vice Chair, Emergency Medicine
Candace Sabers	Vice President, Government Relations and Community Relations
Dr. Christine Wilder	Medical Director, Addiction Sciences

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. Opportunity for standardization in practice across the health system
3. Improvement to date if the strategy has been included in previous Community Health Improvement 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: behavioral health, cardiovascular disease, dental, and maternal/infant health.
Cross-Cutting Strategies for Access
• Expand comprehensive primary care and emergency department care teams to include social workers and community health workers, strengthening the coordination between all areas of care.
Behavioral Health Strategies
• Provide on-demand crisis intervention services where a behavioral health crisis is occurring. • Coordinate, strengthen, and expand behavioral health services in the region. • Standardize mental health screening and presence of mental health providers in non-psychiatric clinics. • Expand access to MOUD and harm reduction materials in Ambulatory and community settings.
Cardiovascular Disease Strategies
• Support ongoing efforts to reduce hypertension and stroke in the region through preventative services.
Dental Strategies
• Support ongoing efforts to provide preventative dental services and connection to an established dental home.
Maternal/Infant Health Strategies
• Strengthen and continue to support community collaboratives that impact maternal and infant outcomes. • Participate in statewide initiatives designed to reduce severe maternal morbidity and mortality. • Provide additional support to high-risk pregnant patients through accessible, patient-centered, multimodal educational opportunities. • Expand early access to pregnancy testing and timely connection to care.

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. • Increase the number of CHWs to assist with connecting individuals to resources and program addressing food and housing needs.
Food Security Strategies

• Expand availability of nutritious food through clinical care for high priority populations. • Provide Produce Prescriptions within health systems.

Priority 3: Strengthen 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.
• Increase career exploration work-based learning pathways. • 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

Implementation Strategies to Address Access to Services

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

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 nigh blood pressure or high cholesterol, which a risk factors for cardiovascular disease. Behavioral health-related concerns, such as anxiety and depression, ranked high on the list of most prevalent health conditions with more than a quarter of Cincinnati Metro residents reporting needing treatment within the past year. These conditions were also elevated as areas of unmet need and health outcomes that were significantly impacted by SDoH. Vision and dental were the two areas with the greatest unmet need, which can primarily be attributed to reduced services during the COVID-19 pandemic. Approximately 23% of the Cincinnati Metro population reported that they had vision concerns within the last year but did not seek treatment, and around 20% of residents expressed the same sentiment for dental concerns.

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 within the Cincinnati pregnant population, specifically Cincinnati Cradle.

Primary Goals

- Increase care coordination services
- Increase new patient appointments across Ambulatory Services
- Increase mental health screening in non-psychiatric clinics

Cross-Cutting Strategies for Access

Regional Priority: Establish a consistent continuum of care across health systems that centers the patient and adapts to changing needs across their lifetime.

Strategy: 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.

Priority Project: Community Health Work Implementation Team

The UC Health Social Service team is working to build a team of community healthcare workers that will be integrated throughout the system. This team will be able to specifically identify patients whose care may be hindered by Social Determinants of Health and effectively break down these barriers. They will help patients coordinate care throughout our health system, with other health systems, and with community resources which will lead toward a measurable improvement in overall patient health outcomes.

Objectives	• Connect high-risk patients with community health workers in the UC Health system • Address patient social needs and barriers to care • Connect patients with community resources
Goals	• Decreasing unnecessary ED utilization • Improve compliance with patient medical home care through coordination and connection to community services
Key Metrics	• Clinic no-show rates • ED utilization rates

Behavioral Health

Strategy: Provide on-demand crisis intervention services where a behavioral health crisis is occurring.

Priority Project: Quick Response Teams

To identify and refer patients to the Quick Response Team (QRT) who present to the emergency department for an opioid use disorder related emergency, or an indication of opioid use documented in electronic medical record. The purpose of this referral is to add a layer of support in addition to the linkage to substance use and mental health treatment, linkage to HIV and HCV treatment, peer support, and other community resources provided by the Early Intervention Program. The QRTs provide "in-home" triage assessment, support and linkage of the OUD patients, 3 to 5 days ED visit, with the immediate goal of connecting the overdose victim with the most appropriate treatment specific to their needs.

Objectives	• Track the trends in usage of substance use disorder (SUD) Harm Reduction strategies involving ED referrals to the Hamilton Country Quick Response Team (QRT)
Goals	• Increase number of ED patients that opt-in for QRT follow-up
Key Metrics	• # of patients referred to QRT • # of patients that opt-in for QRT follow-up
Partners	• The HEAL Initiative • The Hamilton County Addiction Response Coalition • Hamilton County QRT Team

Strategy: Coordinate, strengthen, and expand behavioral health services in the region.

Priority Project: Psychiatry Bridge Clinic

UC Health is working toward improvement of "rapid follow-up after mental health discharge (within 7 days of discharge)". This project is intended to help facilitate continuity for psychiatry patients as they continue their treatment journey in the outpatient setting. This project expands the behavioral health services in the region by creating a trusting relationship with patients as they exit inpatient care and maintain the relationship through providing counseling until a long-term provider is established.

Objectives	• Provide follow-up visit with a mental health practitioner to patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.
Goals	• Decrease readmissions for psychiatry patients
Key Metrics	• Patient follow-up completion rate within 7 days of discharge • Patient readmission rates at 30, 60, and 90 days after discharge
Partners	• Greater Cincinnati Behavioral Health

Strategy: Standardize mental health screening and presence of mental health providers in non-psychiatric clinics.

Priority Project: Collaborative Care Model

Collaborative care is a model for integrating mental health care into medical care settings to gain more insight into the individual's concerns and how to best treat them. Through this integrated mental health model, UC Health providers aim to decrease depression levels, improve quality of life, decrease stress, and lower rates of psychiatric hospitalization. The model first requires standardization in screening for mental health concerns, specifically anxiety and depression. Once patients are screened, it is important to have a mental health care manager integrated into non-psychiatric clinics to provide direct care at the time of service, with oversight from the primary medical physician and a consultant psychiatrist. The mental health care manager can assess the needs of the patient and work with them to create an appropriate treatment plan. This model increases access to mental health care by meeting patients where they are already interacting with the health care system. A pilot program is currently operating within some of the UC Health specialty clinics, specifically in clinics that traditionally have higher rates of mental health needs. UC Health also have 17 primary care practices where the model will be rolled out as resources and capacity allows.

Objectives	• Screen patients using the PHQ-9 and GAD 7 with high fidelity • Engage patients in their mental health care through education and communication with their care team • Create a reliable care escalation pathway to connect patients to the appropriate levels of care • Interface collaborative care services with other UC Health support services, such as community health workers and social workers
Goals	• Increase mental health screenings • Increase integration of mental and physical health care in familiar settings
Key Metrics	• Percent of patients who complete a mental health screening at their visit within Ambulatory Services • Percent of patients who screen positive have a visit with a mental health care manager

Strategy: Expand access to medications for opioid use disorder (MOUD) and harm reduction materials in Ambulatory settings.

Priority Project: Naloxone Distribution

Harm reduction resources are distributed to the Greater Cincinnati community through a variety of mechanisms. One particularly successful distribution project is a harm reduction vending machine that provides free naloxone. Naloxone is a life-saving medication that can be administered in the case of an opioid overdose. This vending machine has the highest naloxone distribution volume of any of the S.A.F.E. Syringe service programs in Hamilton County. Pharmacists at UC Health helped develop this partnership and continue to explore mechanisms of increasing access to harm reduction materials.

Objectives	• Provide harm reduction supplies and resources to individuals throughout the greater Cincinnati community who need them, either for themselves or for others
Goals	• To increase access to naloxone
Key Metrics	• # of naloxone doses dispensed
Partners	• University of Cincinnati • Caracole inc.

Priority Project: MOUD Initiation in the ED

The opioid epidemic continues to heavily impact the Greater Cincinnati area. Development of the ED MOUD project since the last Community Health Improvement cycle has significantly increased access to care and initiation of treatment for patients that come to

the University of Cincinnati Medical Center ED. An automated screening process has been developed so that every patient who is seen in the ED is assessed for OUD risk. Between FY20-FY22, 53% of all patients with an opioid related chief complaint or discharge diagnosis was treated with MOUD, and the program is approaching the milestone of treating 1,000 patients for OUD that were identified within the ED. This project continues to grow and evolve, with plans of continued improvement, refinement, and spread throughout the UC Health system.

Objectives	• Provide screening, MOUD (buprenorphine), peer navigation, and linkage coordinators to seamlessly link patients to comprehensive longitudinal care by utilizing the EIP program • Help ensure entrance and continuous recovery at UC Health addiction sciences division or other community resources
Goals	• 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
Key Metrics	• Percent of patients with a cc or ddx who receive MOUD in the ED
Partners	• Brightview • Talbert House • Center for Addiction Treatment

Priority Project: MOUD Initiation in other Ambulatory Settings

UC Health is working to expand access to MOUD in the primary care setting for patients with OUD. This project will provide guidance to primary care providers on how to apply for an x-waiver to prescribe buprenorphine and how to complete the induction process in clinic as well as future monitoring. In addition, we will help individual clinics navigate the licensing requirements from the DEA and State Board of Pharmacy to perform in-office inductions. This project seeks to increase access to treatment by bringing MOUD to patients where they are already interacting with our providers in the system. Testing for this process began in 2022 and spread to additional clinics will be explored as capacity and funding are available.

Objectives	• Increase number of x-waivered providers • Increase number of patients with OUD on buprenorphine • Increase access to primary care providers in patients with OUD
Goals	• Increased MOUD initiation • Reduction in drug overdose deaths
Key Metrics	• Number of patients on buprenorphine/number of patients with opioid use disorder • Number of x-waivered providers/number of UC Health primary care physicians • Number of patients with naloxone prescription/number of patients with OUD diagnosis

Cardiovascular Disease

Strategy: **Support ongoing efforts to reduce hypertension and stroke in the region through preventative services.**

Priority Project: Achieving Cardiovascular Equity (ACE) Hypertension Project

To address hypertension and heart disease disparities, the Ohio Department of Health (ODH) Diabetes and Heart Disease Prevention and Management (DHDPM) Program is implementing a three-year Primary Care Hypertension Quality Improvement Project (QIP) in collaboration with the Ohio Colleges of Medicine Government Resource Center (GRC) and The Ohio State University Wexner Medical Center. The ACE QIP will utilize the Institute for Healthcare Improvement's (IHI) Model for Improvement to identify patients with undiagnosed hypertension, improve management of adults with hypertension, and address social determinants of health among the patient population. Specific interventions will be identified to address disparities at the site level. Through use of these key strategies, the ACE QIP seeks to improve BP control across the patient population, with a specific focus on Black patients, impacting the Healthcare Effectiveness Data and Information Set (HEDIS) score for high blood pressure control, and fostering community partnerships within the Black community. UC Health has four clinics participating in the QIP.

Objectives	• Identify undiagnosed hypertension • Provide effective treatment for undiagnosed hypertensive patients • Connect patients with supplemental community resources to overcome barriers to optimal health
Goals	• Reduce the disparity between black patients and non-Hispanic white patients who have controlled their hypertension • Decrease deaths due to myocardial infarction and stroke form cardiovascular disease
Key Metrics	• # of patients with controlled hypertension
Disparate Populations	• Black patients
Partners	• Ohio Department of Health • Ohio Government Resource Center

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

Dental

Strategy: Support ongoing efforts to provide preventative dental services and connection to an established dental home.

Priority Project: Pediatric Dental Varnish (pending finalization)

Increase number of patients with an established dental care home through partnership with the Cincinnati Health Department and Cincinnati Children's Hospital.

Objectives	• Screen patients for dental needs • Provide preventative dental care within the primary care setting • Refer patients to external dental providers
Goals	• Increase the number of patients that are established with a dental home
Key Metrics	• Number of pediatric patients who receive bi-annual dental varnish
Partners	• Cincinnati HD • Cincinnati Children's

Maternal/Infant Health 

Strategy: Strengthen and continue to support community collaboratives that impact maternal and infant outcomes.

Priority Project: Cradle Cincinnati Collaborative

UC Health has partnered with Cradle Cincinnati to eliminate infant mortality. Cradle Cincinnati is a collective impact collaborative founded in 2013 through seed funding from UC Health. The leading cause of infant death in Hamilton County is extreme preterm birth which is a maternal health issue. Black women are 2-3 times more likely to experience extreme preterm birth than women of any other race or ethnicity. UC Health and the Department of Obstetrics and Gynecology providers have been active in the collaboration with Cradle Cincinnati. The UC Health team has been actively involved in the Cradle Cincinnati Learning Collaborative which is a network of health care providers who have joined together to address maternal tobacco use, maternal stress, access to first trimester care, and safe sleep education. The community arm of Cradle Cincinnati is Queen's Village. Queen's Village is designed to empower Black women and to provide a venue of support.

UCMC has partnered with Queen's Village in the Center for Women's Health to have a Queen's Village space in the lobby where Black women can directly engage with a Queen's Village staff member.

Objectives	• Work collaboratively with community partners to address key areas that impact preterm births: • Provide resources and support to pregnant patients who use tobacco products • Work to mitigate maternal stress through social support • Increase access to timely prenatal care • Address barriers to safe sleep practices
Goals	• Reduce infant mortality in Hamilton County • Address health disparities in maternal and infant outcomes between black and white pregnant patients
Key Metrics	• Infant mortality rate • Extreme preterm birth rate • # of sleep related deaths
Disparate Population	• Black women of reproductive age
Partners	• Cradle Cincinnati • Queens Village

Strategy: Participate in statewide initiatives designed to reduce severe maternal morbidity and mortality.

Priority Project: Ohio Safety Maternity Quality Improvement Alliance for Innovation in Medicine (AIM) Hypertension Collaborative

UC Health is participating in a statewide collaborative that has the ultimate goal of reducing the rate of hypertension-related maternal morbidity and mortality in Ohio. Through this Quality Improvement partnership, which started a year ago, members of our Women's Health clinic participate in monthly call to share learnings from work within our system and hear best practices established in other health systems. The statewide project has also been able to distribute blood pressure cuffs to participating hospitals. Internally, UC Health staff are ensuring that educational materials are being provided to patients who experience a hypertensive episode, and that appropriate and timely follow-up is completed. Another main component of the project is ensuring appropriate medications are prescribed to address maternal hypertension. AS part of the collaborative, UC Health submits monthly data to track statewide progress on this important issue.

Objectives	• Standardized evidence-based diagnostic and treatment processes for hypertension in pregnancy and postpartum • Screening, identification, and early diagnosis for all women at risk for severe maternal HTN in Pregnancy, with attention to health disparities • Urgent treatment and close follow-up for every pregnant and postpartum woman with new onset severe HTN • Foster a culture of safety, equity, and improvement for care of women with hypertension
Goals	• Reduce hypertension-related maternal morbidity and mortality
Key Metrics	• Timely treatment of severe hypertensive BP • Follow-up in 3 days • Follow-up in 10 days
Partners	• Ohio Government Resource Center • Ohio Department of Health

Strategy: Provide additional support to high-risk pregnant patients through accessible, patient-centered, multimodal educational opportunities.

Priority Project: Babyscripts App

Babyscripts is a phone-based app that provides pregnant patients with evidence-based information regarding pregnancy care, a connection to their care team, information about community events, and the opportunity for remote blood pressure monitoring. The importance of attending prenatal care in order to improve health outcomes for both the mom and the baby is highlighted through the educational materials available on the app and communication with the care team. The layout of the app has been revised based on

feedback from a local focus group, in an effort to make the information provided and the feel of the application as patient oriented as possible. Patients are recruited to join the app through a variety of mechanisms, including through partnership with Cincinnati Cradle's Queens Village.

Objectives	• Register patients with an account for the app • Provide patients who are at risk of hypertensive disorders of pregnancy postpartum with home monitoring blood pressure cuffs
Goal	• Increased early access to prenatal care (not sure that this fits with Babyscripts, as the patient does not get the app until they come to the appointment) • Decrease maternal morbidity and mortality • Decrease infant mortality • Increase adherence to the postpartum visit
Key Metrics	• Engagement with the app • Number of registered patients
Partners	• Cradle Cincinnati's Queens Village • Breastfeeding Outreach for Our Beautiful Sisters (BOOBS) • All Moms Empowered to Nurse (AMEN)

Priority Project: CenteringPregnancy

CenteringPregnancy is a model of prenatal care that is group focused and empowers women to make healthy choices through discussion and enhanced learning opportunities. An OB provider and a Centering trained co-facilitator leads the discussion, but pregnant person and their support person guide the dialogue. Patients are grouped based on gestational age, with potential options to be grouped based on neighborhood, primary language or race. The exam, including fundal height check and fetal heart rate, as well as vitals takes place during each session, so patients receive the same evidence-based care as they would in a traditional office visit. By building community, education and support, women are empowered to take control of their health during pregnancy and beyond. Data show Centering is effective in reducing premature birth and racial disparities in preterm birth by more than 35%. By expanding the offering of CenteringPregnancy at UC Health, there is greater opportunity to reduce poor birth outcomes which lead to infant mortality.

Objectives	• To offer CenteringPregnancy to all pregnant patients that seek care at the Center for Women'sHealth at UCMC • Reduce extreme preterm birth • Reduce maternal morbidity and mortality • To empower women to take control of their health during pregnancy and beyond.
Goal	• To reduce the number of extreme pre-term births and small for gestational age infants.
Key Metrics	• Increase number of Centering groups • Reduce disparities for outcomes related to infant mortality: ○ Extreme Preterm birth

	○ Low birth weight ○ Breastfeeding • Sleep-related deaths
Partners	• Cradle Cincinnati

Strategy: Expand early access to pregnancy testing and timely connection to care.

Project: Walk In Pregnancy Testing

Community members will be able to receive a pregnancy test at a time that is most convenient to them through a new walk-in clinic that is currently being developed. This project will allow for timely identification of pregnant patients within the UC Health system and increasing accessing to reliable resources for the community. This project will also increase timely access to an initial prenatal appointment. Positive pregnancy tests will be follow-up with and scheduled for a prenatal care appointment in the days following the positive test. Negative pregnancy test will also be referred to a general gynecology appointment for preventative screenings and services.

Objectives	• Provide accessible connection to care for patients who take a pregnancy test at UC Health
Goal	• Increase early access to pregnancy testing • Increase early access to prenatal care
Key Metrics	• # of walk in pregnancy tests completed • % of walk in positive pregnancy test converted to prenatal appointment

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) 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." There were five SDoH categories identified in the Healthy People 2030 framework: 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 more broad 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
- Increase access to resources that improve food security for patients in need

Social Determinants of Health Strategies

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

Strategy: Increase the number of CHWs to assist with connecting individuals to resources and program addressing food and housing needs.

Priority Project: Health Care Access Now (HCAN) Hub

Health Care Access Now (HCAN) is Cincinnati's Regional Pathways Community Hub. UC Health has a partnership with HCAN, and thus can refer patients for community-based care coordination, which "pairs individual, diverse needs with the complicated matrix of services in our community. Care Coordination services are provided by a specialized workforce – Community Health Workers. Through advocating, educating, connecting and supporting, CHW's are partners with clients and the clinical and social services received in the community." HCAN CHWs provide support to clients for everything from healthcare care coordination, essentials such as food and housing, as well as additional supports like smoking cessation and finding child care.

HCAN is primarily used as an additional resource for clinics who are not able to staff their own internal CHWs or whose CHWs are already at full capacity for their case load. The UC Health Women's Health Clinic has utilized this resource for patients who live outside of the primary service area of UCMC. As we continue to develop our screening processes and identify more patients with wraparound service needs, our need for additional CHW support will grow. We are in alignment with the Regional Community Health Improvement Plan in working to increase referrals to HCAN and further develop our connections with the Pathways Community Hub.

Objectives	• Refer patients to HCAN for CHW services in clinics without internal staffing
Goals	• Increased connection to community resources to address social determinants of health
Key Metrics	• # of patients referred to HCAN for services
Partners	• Health Care Access Now (HCAN)

Food Security Strategies

Strategy: Expand availability of nutritious food through clinical care for high priority populations.

Priority Project: Food is Medicine

UC Health collaboration with The Freestore Foodbank to maintain a food pantry on-site at the Hoxworth General Medicine Primary Care Clinic and Women's Health Clinic. All patients are screened for food insecurity and those who screen positive are eligible to utilize the on-site food pantry. Staff will distribute vouchers for Fresh Vegetables & Fruit Mobile Unit,

provide health education, and connect patients to other food banks and resources if appropriate. Space will be allocated for Foodbank staff to enroll patients in SNAP benefits.

Partnership was expanded to include support from the Sam Hubbard Foundation, providing additional resources to expand the number of individuals served by the food pantry.

Objectives	• To identify and address food insecurity in patient populations • To build on partnership with the Freestore Foodbank • To reduce barriers for patients to access food assistance • To connect patients to benefits and resources to reduce food insecurity
Goals	• Increase access to food resources within the clinical setting
Key Metrics	• # of people screened • # of people receiving food • Pre- and post-surveys • ZIP Code collection • Change in food security status (based on repeat screenings)
Partners	• Freestore Foodbank • Sam Hubbard Foundation

Strategy: Provide Produce Prescriptions within health systems.

Priority Project: Centering Diabetes and Teaching Kitchen

UC Primary Care and Endocrinology patients are invited to participate in a Centering Diabetes Group Session, which uses a curriculum that reflects current evidence and diabetes management practice guidelines, and pair this with a virtual/in-person Teaching Kitchen program guided with certified Chefs in collaboration with a partner organization, La Soupe. This program will include 4 monthly Centering Diabetes Group Sessions and 4 monthly La Soupe Teaching Kitchen classes that take place in tandem. One patient cohort will have a maximum of 12 patients with Diabetes or Pre-Diabetes with known Metabolic Disorder. Patient participants will be combined from the UC Primary care and UC Endocrinology Divisions. Taking into account that patients from the Endocrinology Division may have more complex diabetes care needs with likely more severe comorbidities, all patients from the Endocrinology Division are required to attend at least one session of Diabetes Education class and one session of Medical Nutrition class before program starts.

Objectives	• Improve patients' understanding of healthy eating and attitude toward healthy lifestyle modification. • Provide tools for patients to sustainably address their own barriers to implementing healthy lifestyle modifications.
Goals	• Increase healthy eating habits • Increase diabetes management skills

Key Metrics	• Primary metric: HbA1C • Secondary metrics: Fasting blood glucose, weight, BMI, blood pressure, weight circumference, total cholesterol, LDL cholesterol, triglycerides, healthcare utilization
Partners	• La Soupe

Implementation Strategies to Address Workforce Pipeline

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 healthcare system's structural barriers to improving the quality of healthcare. Both community and healthcare provider surveys and focus groups were completed, with cultural competency and patients feeling "heard" by their providers as two of the emergent themes. At UC Health, many of the strategies suggested by the Regional CHIP are implemented and integrated into regular workflows, so do not have specific projects to track as part of the CHIP. 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 student exposure to healthcare career options and opportunities

Workforce Pipeline Strategies

Strategy: Increase career exploration work-based learning pathways.

Priority Project: Healthcare Career Pathways

To create and expand partnerships with area schools designed to provide students with an opportunity to explore a diversity of career paths within healthcare. Programming will consist of three key components:

Exposure to Healthcare Careers - Professionals from a diverse range of both clinical and non-clinical roles, provide an overview of the various career opportunities in healthcare.

Hands-On Activities - Programming is designed to simulate real-world scenarios and create hands-on patient care skills including learning how to draw blood; how to suture a wound; physical therapy skills, the use of robotics in medicine, and more.

Job-Shadowing - Job shadowing allows students to experience a day-in-the-life of medical professionals from different clinical areas: pharmacy, respiratory, sterile processing, radiology and imaging, physical therapy, the emergency department, and more.

Objectives	• Increased exposure and awareness of healthcare career options and broaden healthcare experience for area students
Goals	• 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
Key Metrics	• # of students participating in programming • # of schools involved
Partners	• Regional school districts

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