Community Health Needs Assessment
2019

The Christ Hospital™
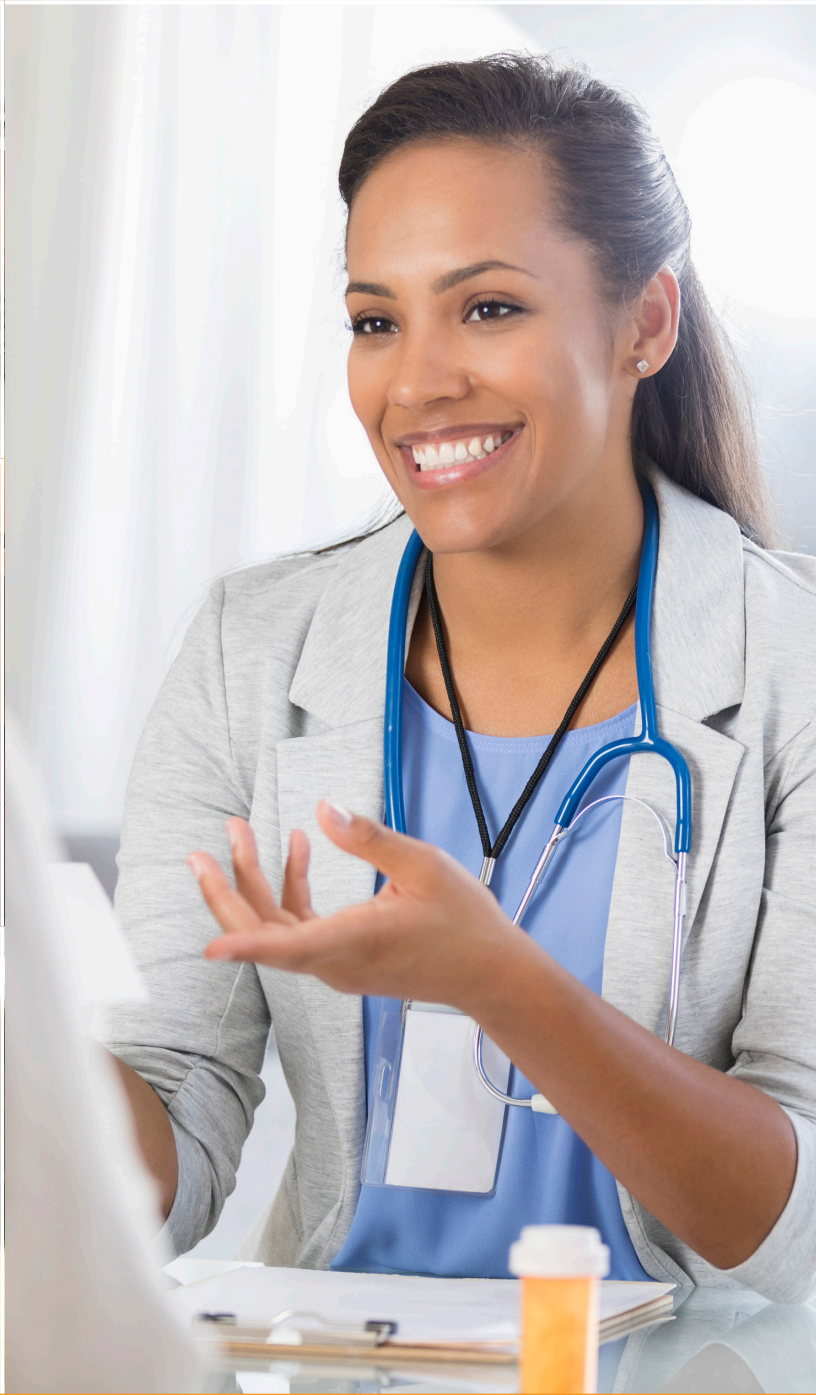Health Network

WHO WE ARE
AND OUR COMMITMENT TO THE COMMUNITY

In 1888, a group of local citizens led by James Gamble – whose soap business eventually became the Procter & Gamble company – invited Isabella Thoburn, a teacher, nurse and missionary, to come to Cincinnati to start a program to train deaconesses and missionaries to carry on religious, educational and philanthropic work in order to alleviate the appalling poverty that existed in the city. Now, more than a century later, they could not have imagined the impact that invitation would have on the city.

Soon after her arrival, Thoburn's work expanded beyond ministering. In 1889 she opened a 10-bed hospital named Christ's Hospital in the West end, at 46 York Street. In 1893 the facility was moved to Mount Auburn and subsequently opened a nursing school in 1902. In 1904 it was renamed to what we know today, The Christ Hospital.

The Christ Hospital and Subsidiaries' ("The Christ Hospital") is a network of physicians and staff, working together in more than 100 locations throughout the Ohio, Kentucky, and Indiana Tristate area. The Christ Hospital, doing business as The Christ Hospital Health Network, includes The Christ Hospital main campus in Mt. Auburn ("the Hospital"), as well as outpatient centers and physician practices. The Network consists of an accredited staff of more than 1,000 physicians, and offers advanced services and technologies through executive leadership of six key service lines: cardiovascular care, orthopaedic and spine treatment, women's health, oncology, special surgery, and comprehensive medicine

The Christ Hospital's mission for the last 125 years has been to improve the health of our community and to be a regional exemplar in creating patient value through exceptional outcomes and patient experience, ensuring access to all members of the communities we serve without regard to financial status or other factors such as race, ethnicity, beliefs or gender.

In fiscal year 2018, as disclosed in Schedule H of the 990 Report, The Christ Hospital provided a total of $51.5 million to the community, including charity care and care provided under governmental assistance programs, medical education for research and innovation, and community health improvement, which all led to better community outcomes. In addition, state regulations require that every three years a comprehensive assessment of the impact we had on community health needs be completed. The rest of this report is dedicated to explaining that impact.

We recognize that community health needs are broad and comprehensive, and while we bring our expertise and leadership to addressing select needs, we also understand that one entity's expertise cannot be broad enough to be the sole answer. Because of this, collaborations and partnerships are key to meeting those needs, and we partner with community organizations that complement our resources. Through these relationships, we increase our effectiveness in providing exceptional care and improved clinical outcomes to the community. For example, The Christ Hospital partners with organizations by means of cash and in-kind donations. Some of the organizations benefiting from such donations include the Center for Respite, the Center for Closing the Health Gap, the American Heart Association, Cradle Cincinnati, The March of Dimes and St. Vincent de Paul Charitable Pharmacy.

Christ Hospital employees also invest hours volunteering with organizations that help to serve the needs of, and improve, the well-being of those in Greater Cincinnati and throughout the region. Some of these organizations include the American Heart Association, American Diabetes Association, American Cancer Society, the March of Dime and Melanoma No More.

The Christ Hospital also opens its doors to self-help programs, and community-based support groups like Mended Hearts and quarterly blood drives hosted on site in partnership with Hoxworth Blood Center, free of charge.

The Christ Hospital's leadership continues to be very engaged in community building activities and economic development. Many hold board positions on the Mt. Auburn Chamber of Commerce, the American Heart Association, the United Way, LifeCenter, the Greater Cincinnati Health Council and many other local, non-profit organizations.

As healthcare continues to progress, we look for better ways to meet the ever-changing health needs of our community with new programs. Programs like Patient Centered Medical Home, which is transforming how primary care is organized and delivered through five functions and attributes: (1) Comprehensive Care; (2) Patient-Centered; (3) Coordinated Care; (4) Accessible Services; and (5) Quality and Safety, and the Comprehensive Primary Care Initiative, which is a four-year multi-payer initiative designed to strengthen primary care by supporting the provision of (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventative Care; (4) Patient and Caregiver Engagement; and (5) Coordination of Care access the Medical Neighborhood.

In addition to our work volunteering and with community benefit organizations, The Christ Hospital also invests heavily in a multitude of programs and initiatives that support the community needs. These efforts will be highlighted throughout this document.

The activities mentioned above offer only a glimpse of how we touch and improve the health and the lives of people throughout our community. It's a testament to the commitment and leadership of our medical staff, Board of Directors, executive team, employees, volunteers and community partners, whose dedication to community service touches many lives and makes our community a better place.

The 2019 Christ Hospital Community Health Needs Assessment report is comprised of five sections:

1. The definition of the community we serve and a description of how the community was determined.

2. A description of the process and methods used to conduct our community health needs assessment, including how the hospital gathered input from people who represent the broad interests of the community.

3. A prioritized description of the significant health needs that were identified.

4. A description of the resources potentially available to address the significant health needs.

5. An evaluation of the impact of the hospital's 2016 Community Health Needs Assessment.

Our first step in conducting our 2019 Community Health Needs Assessment was to define the community we serve. To do so we considered a number of relevant facts and circumstances, including the geographic area we serve, the target populations we serve, and our principle functions as a hospital, which include our service lines. In defining the community we serve, we specifically included the medically underserved, low income and the minority populations who live in the geographic area from which we draw patients. In addition, we included all patients without regard to whether (or how much) they or their insurers pay for care received or whether they are eligible for assistance under our financial assistance policy.

Currently, The Christ Hospital provides services and resources to 14 counties within a three-state area. The committee reviewed this complete geographic primary service area and determined that, for the sake of the

Community Health Needs Assessment, it would focus on Hamilton County, Ohio, where the majority of the hospital's charity care and HCAP usage takes place. Roughly 72 percent of all patient encounters at The Christ Hospital take place in Hamilton County, thus making it a priority for this assessment.

Further analysis to confirm our focus determined that Hamilton County had the largest population within the hospital's service area. With more than 800,000 residents with the highest at-risk populations, including, African-Americans, Hispanics, and the disabled. Additionally, a significant portion of the services offered by The Christ Hospital Health Network are offered within Hamilton County, most notably the subsidized clinics where the utilization rate is 89 percent Hamilton County residents.

After defining our Community, we assessed the health needs by engaging the Health Collaborative to conduct a comprehensive and collaborative Community Health Needs Assessment. The Health Collaborative is a nonprofit organization serving the Greater Cincinnati area. It works with its member hospitals on health care improvement projects and shares best practices. The Health Collaborative brought 35 hospitals and 28 local health departments together, including The Christ Hospital, to conduct a comprehensive, collaborative community health needs assessment (Collaborative CHNA).

The Executive Summary of the Collaborative CHNA is attached herein as Appendix A. A hyper link is accessible to view the full Collaborative Report, which details all the processes and methods used to conduct the Collaborative CHNA. The Collaborative Report also provides a comprehensive and detailed description of (1) how the Collaborative CHNA Team solicited and took into account input received from persons who represent the broad interests of the community, including those with special knowledge of, or expertise in, public health, (2) how and over what period of time such input was provided, (3) the names of organizations providing input and the nature and extent of the organizations input, (4) descriptions of the medically underserved, low income or minority populations being represented by organizations or individuals that provided input. Collectively within 25 counties over 35 hospitals, 28 health departments, including Hamilton County Department of Health, 100 community groups and organizations, and participation of community members. Over 140 data measures were deployed including primary and secondary data over 1400 qualitative surveys.

The CHNA team reached out to the local health departments in the spring of 2017 to take the first steps towards the State of Ohio's requirement that health departments and hospitals align their assessments starting in 2020. As a result, the CHNA team has researched more secondary data measures, included hospital utilization data, oversampled vulnerable populations, and engaged more participants. A total of 1,416 people or organizations completed a survey or attended a meeting. A significant part of the increase was due to local health departments helping to promote and conduct meetings
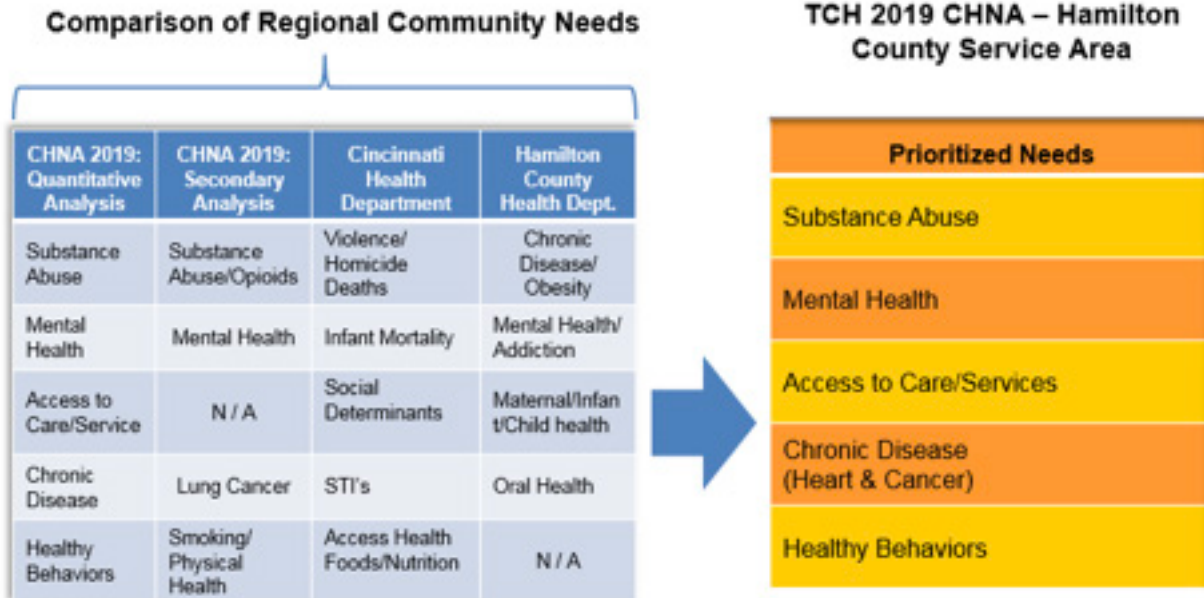
Five top needs were identified and prioritized for The Christ Hospital's defined Community, Hamilton County. These needs were identified in the domains of access, barriers to quality health care, health conditions of the population served and determinants in the population affecting mental health.

The five top identified needs for the 2019 TCH CHNA are:

1. Substance Abuse

2. Mental Health

3. Access to Care/Services

4. Chronic Disease

5. Healthy Behaviors

Table 1, Region: Combined Top Priorities

Comparison of Regional Community Needs

CHNA 2019: Quantitative Analysis	CHNA 2019: Secondary Analysis	Cincinnati Health Department	Hamilton County Health Dept.
Substance Abuse	Substance Abuse/Opioids	Violence/ Homicide Deaths	Chronic Disease/ Obesity
Mental Health	Mental Health	Infant Mortality	Mental Health/ Addiction
Access to Care/Service	N / A	Social Determinants	Maternal/Infant/Child health
Chronic Disease	Lung Cancer	STI's	Oral Health
Healthy Behaviors	Smoking/ Physical Health	Access Health Foods/Nutrition	N / A

TCH 2019 CHNA – Hamilton County Service Area

Prioritized Needs
Substance Abuse
Mental Health
Access to Care/Services
Chronic Disease (Heart & Cancer)
Healthy Behaviors

With our Community and its significant health needs identified and prioritized, we will set forth an implementation plan that will drive our efforts to improve the health of our community in 2019 and for the next three years. The Implementation Plan will be completed and published for approval by July 26, 2019.

Significant Health Need	Resource Potentially Available
Diabetes	American Diabetes Association, Juvenile Diabetes Research Foundation
Access to Healthcare	Center for Closing the Health Gap, United Way, The Wesley Community, Council on Aging, St. Vincent de Paul Pharmacy
Lung Cancer Treatment	American Cancer Society
Mental Health	Talbert House, Greater Cincinnati behavioral Health Services, National Alliance on Mental Illness, Council on Aging, Alzheimer's Association
Infant Mortality	Cradle Cincinnati
Substance Abuse	Talbert House, Greater Cincinnati behavioral Health Services, National Alliance on Mental Illness
Smoking Prevention	American Cancer Society, American Lung Association
Infant Mortality	Cradle Cincinnati
Obesity	Center for Closing the Health Gap, American Heart Association, American Diabetes Association

Draft 6/28/18

The Christ Hospital Health Network

CHNA Implementation Plan: Measures

Access

Measure	Baseline FY '15	Status: FY 2016				Status: FY 2017				Status: FY 2018				Goal FY '18
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Readmission rate - % of patients readmitted more than one time	1.8%	1.7%	1.7%	1.6%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.6%	1.2%	0.1%	1.2%
Patient panel size normalized for average FTE status (0.9)	1634 (2016)		-				1864 (6/26/17)				-			1944

Mental Health

*Partnership exploration in progress

Measure	Baseline FY '15	Status: FY 2016				Status: FY 2017				Status: FY 2018				Goal FY '18
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Partnerships for outpatient care continuity	No	No	No	No	No	No	No	No	No	No	No*	No*	No*	Yes

Obesity & Diabetes

Measure	Baseline FY '15	Status: FY 2016				Status: FY 2017				Status: FY 2018				Goal FY '18
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Diabetes Center patients BMI (average)	33.43	32.79	33.19	33.25	32.90	32.76	32.92	32.98	33.13	33.00	33.71	33.27	33.57	32.65
Diabetes Center patients A1c (average)	7.30%	7.10%	6.95%	7.20%	7.07%	7.07%	7.08%	7.15%	7.17%	7.11%	7.04%	7.11%	7.26%	7.18%
Educational class attendance of Diabetes Center patients (%)	9.3%	11.6%	11.9%	12.2%	12.1%	12.3%	12.1%	12.3%	12.1%	13.1%	13.2%	13.3%	13.9%	12.0%

Lung Cancer

Measure	Baseline FY '15	Status: FY 2016				Status: FY 2017				Status: FY 2018				Goal FY '18
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Number of low-dose CT screenings	21 (Q4)	21	27	43	53	59	131	124	137	158	192	138	167	36/Q
Lung cancer stage at diagnosis (% diagnosed at stage 3 or 4)	62%	58%	70%	61%	83%	63%	52%	64%	84%		-Data Collection Lag-			69%

Infant Mortality

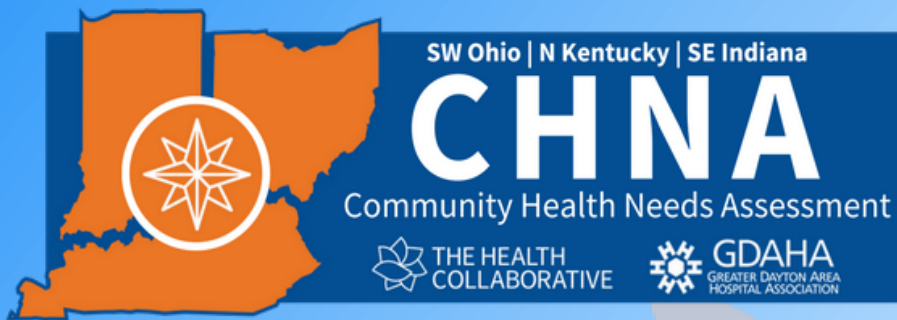| Measure	Baseline FY '15	Status: FY 2016				Status: FY 2017				Status: FY 2018				Goal FY '18
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
TCHHN safe sleep compliance	82% (Q4)	94%	93%	92%	96%	98%	100%	100%	100%	100%	100%	100%	100%	97%

Our 2016 Implementation Plan yielded favorable results. Across all sectors progress was made to meet our goals. Specifically, our diabetes center patients BMI average and A1C scores decreased from fiscal year 15. In the area of Infant Mortality, there was 100% participation in safe sleep practices and techniques in last four quarters of fiscal year 17. This is an 18% increase over fiscal year 15 in our quarter four report and overall has exceed goal by 3%. Moreover, there was an increase in the number of Low Dose CT screenings provided by our Primary Care offices. Although our lung cancer stage at diagnosis numbers are not reflective, due to a lag in our reporting system, a final reflection of our work will be available closer to the end of fiscal year 19. Lastly, a comprehensive mental health program has been established and we will continue to this work in our 2019 TCH Implementation Plan.

1 In addition to actively participating in the Collaborative CHNA, the hospital convened an internal task force consisting of a cross section of the hospital's executive leadership to analyze the regionally identified significant health needs in the Collaborative CHNA in the relation to our defined community. As a result of this analysis, the task force determined that a strong correlation existed between the significant health needs of the region and our community. By way of example, substance abuse was mentioned by all four groups of Hamilton County stakeholders. Access to care was a concern at the community meeting and for consumers and agencies responding by survey. Obesity and healthy behaviors is a concern by all four categories. Additionally, agencies and meeting attendees were concerned about mental health.

2 Based on comprehensive analysis and numerous Task Force suggestions, we adopted the above listed significant health needs identified in the Collaborative CHNA as the significant health needs facing our community.

3 The following is a nonexclusive list of resources potentially available to address the significant health needs identified through our 2019 Community Health Needs Assessment

SW Ohio | N Kentucky | SE Indiana

CHNA
Community Health Needs Assessment
THE HEALTH COLLABORATIVE   GDAHA GREATER DAYTON AREA HOSPITAL ASSOCIATION

2019 Report

The Collaborative Report serves:

- ✓ **35** Hospitals
- ✓ **25** Counties
- ✓ **28** Local Health Departments
- ✓ **3** States

Hospitals

The Christ Hospital Health Network
Cincinnati Children's Hospital Medical Center
Clinton Memorial Hospital
Highpoint Health
Kettering Health Network
  Fort Hamilton Hospital
  Grandview Medical Center
  Greene Memorial Hospital
  Kettering Behavioral Medic Center
  Kettering Medical Center
  Soin Medical Center
  Southview Medical Center
  Sycamore Medical Center
Lindner Center of HOPE
Mercy Health | Cincinnati Region
  Mercy Health - Anderson Hospital
  Mercy Health - Clermont Hospital
  Mercy Health - Fairfield Hospital
  Mercy Health - West Hospital
  The Jewish Hospital – Mercy Health

Mercy Health | Springfield Region
  Mercy Health - Urbana Hospital
  Springfield Regional Medical Center
Premier Health
  Atrium Medical Center
  Miami Valley Hospital
  Miami Valley Hospital North
  Miami Valley Hospital South
  Upper Valley Medical Center
TriHealth
  Bethesda Butler Hospital
  Bethesda North Hospital
  Good Samaritan Hospital
  McCullough Hyde Memorial Hospital
  TriHealth Evendale Hospital
UC Health
  Daniel Drake Center for Post-Acute Care
  University of Cincinnati Medical Center
  West Chester Hospital
Wayne HealthCare
Wilson Health

COMMUNITY HEALTH NEEDS ASSESSMENT

Executive Summary

For the third time, The Health Collaborative has convened regional health partners and member hospitals to develop the 2019 Community Health Needs Assessment (CHNA). Hospitals members of the Health Collaborative and Greater Dayton Area Hospital Association (GDAHA) joined the collaboration, and the result is a robust portrait of the larger Southwest Ohio region. The report covers Greater Dayton and Greater Cincinnati, which includes Northern Kentucky and Southeastern Indiana.

The CHNA 2019 report shares data for the whole region as well as detailed county-level data. Service areas of hospitals vary, and this approach provides the most thorough picture of health needs locally and regionally. The 2019 report has added the voice of the Southwest Ohio members of the Association of Ohio Health Commissioners. Developing a broad CHNA helps fulfill the State of Ohio's requirement mandating that health departments and hospitals align their assessments starting in 2020.

As a result, the CHNA team has researched more secondary data measures, included hospital utilization data, oversampled vulnerable populations, and engaged more participants. A total of 1,416 people or organizations completed a survey or attended meetings. A key component of the increase was due to local health departments helping to promote and conduct meetings.

Priorities were determined by the number of votes in community meetings, the number of mentions on surveys and data worse than state or national data, trending in the wrong direction, and impacting at least 16 counties (secondary data). The five identified priorities ranked in the top 8 for all primary data sources (meetings and survey from consumers, health departments, and agencies) *see Table 27.*

The identified priorities are:
1. **Substance abuse**
2. **Mental health**
3. **Access to care/services**
4. **Chronic disease**
5. **Healthy behaviors**

Substance abuse

Although Substance Abuse Disorder is a mental health diagnosis, the volume of responses indicated that substance abuse needs to remain a separate category, due to the current epidemic. This category relates to the use and abuse of illegal drugs, prescription drugs, alcohol, and addiction in general.

Comments about the impact of substance use and abuse on society and families recurred in both meetings and surveys. Respondents asked for less concentration on drug-specific responses and more approaches that explore the underlying problems leading to addiction.

Mental health

'Mental health,' was the most common response in this category. For the first time 'child mental health' was frequently mentioned. Depression was cited most often, followed closely by anxiety. Suicide was openly discussed in several meetings, and it was a priority in both LGBTQ+ meetings. Next most commonly mentioned were mood disorders and ADD/ADHD. Self-harming came up several times, as did stigma. Trauma and specifically Adverse Childhood Experiences – both the impact of past experiences on adults and the impact on children living through them now. A disturbing trend was the increase in comments about the need for psychiatric hospital beds for children younger than 12.

Access to Care/Services

This priority received many 'access' comments. The lack of access to providers was mentioned most often. Including providers being out-of-network for insurance as well as providers located outside the geographic area; and too few specialists. Other barriers and gaps identified included no insurance; inadequate insurance coverage; high deductible plans; affordability of care (co-pay and/or out-of-pocket); cost of medication; can't take time off during working hours; no one to watch children; language barrier; and/or lack of local services (e.g., cancer treatment). Transportation was a total of 7% of all mentions within the Access category.

Chronic disease

The most common chronic diseases cited were: heart disease, cancer, and diabetes. Hypertension was commonly cited, and stroke, allergies, and arthritis were mentioned several times. According to the secondary data, lung cancer and Type 2 Diabetes significantly impact the region. Sixteen counties had high rates of chronic lower respiratory disease deaths for people aged 65 and older. The table on page 92 shows that arthritis, cardiovascular, heart, and respiratory issues were among the top 20 most common diagnoses of hospitalized patients in the region.

Healthy behaviors

This category captured recommendations on building healthy behaviors such as: healthy eating, increasing exercise, quitting unhealthy substances and losing weight. Secondary data supports the public perception of needing to address alcohol intake, physical inactivity, smoking, and/or weight. Twenty-two counties have higher percentages of adults who smoke, compared to the national percentage of sixteen percent. Nineteen counties have more residents who are physically inactive, compared to the national percentage of twenty-five percent Seventeen counties exceed the national percentage of adults who are obese, nearly thirty percent.

The vulnerable populations who were oversampled in this CHNA were: African-Americans; Elderly residents; Latino residents; LBGTQ+ residents; refugees from Rwanda; and urban residents.

Community Need Index scores were utilized to identify the likelihood of healthcare disparities at the ZIP Code level for all ZIP Codes in 25 counties.

Social Determinants of Health

This report features a new chapter on Urban Health. Three years ago, Social Determinants of Health (SDH) were mentioned many times in the cities, but the results were diluted when combined with all regional responses. This time SDH became top priorities for people who live in urban areas but also for people considering the child health issues. Healthy People 2020 defines SDH as the, "…conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[1]

CHNA participants cited Poverty most often overall as a SDH. The SDH category also included education, employment, environment (living conditions at home and/or hazards in the immediate community such as pollution or crime), violence, race, ethnicity, housing, homelessness, culture, and language. All four primary sources agreed on SDH as a barrier to child wellness. In this context, 80% of the SDH comments specified education. Among urban participants, 11% cited SDH as a top priority; housing and safety were mentioned most often. Although SDH did not emerge as a top regional priority overall, the issue was identified among the top non-financial barriers and the top unmet needs at the regional level.

Emerging Issues

Access to care and Substance abuse were listed most frequently as an emerging issue. For this cycle, many comments cited the following needs:

- Support for parents and families
- Care for children
- Initiatives to combat addiction
- Social/emotional health

Community coalitions that address infant mortality and substance abuse were frequently mentioned as being 'handled well,' but always with the caveat that more remained to be done. Fourteen counties had infant mortality rates greater than the national rate of 5.9 per 1,000 live births. Nine counties had rates exceeding their state's rates. All meeting attendees and survey respondents agreed that these issues were not being handled well or addressed enough: Access to care/Services; Mental health; Social Determinants of Health; and Substance abuse. Transportation made it to both the financial and non-financial list of barriers.

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[1] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health, accessed 12/19/2018.