2022

Community Health Needs Assessment Implementation Strategy

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Cincinnati Children's Hospital Medical Center Overview

Hospital Description

Cincinnati Children's Hospital Medical Center ("Cincinnati Children's") is a private, not-for-profit 501(c)(3) corporation, which owns and operates a comprehensive pediatric academic medical center located in Cincinnati, Ohio. Cincinnati Children's includes one of the nation's largest pediatric tertiary and quaternary care facilities. During the fiscal year (FY) that ended June 30, 2021, Cincinnati Children's had more than 1.5 million patient encounters and served patients from 65 countries, all 50 states, Washington D.C. and Puerto Rico.[1]

Vision and Mission

Cincinnati Children's was founded in 1883 with the objective to be the premier children's hospital in the region, and its research focus was primarily to support its clinical programs. In the mid-1990s, Cincinnati Children's expanded its vision to be the leader in improving child health on a national and global scale. This vision is accomplished through its three integrated missions: (1) clinical care; (2) research; and (3) medical education. Cincinnati Children's core values include respect for everyone, telling the truth, working as a team, and making a difference.

Cincinnati Children's has grown to become one of the nation's largest pediatric hospital facilities. This growth was achieved through the strengthening of existing programs and the development of new programs for children with targeted diseases and complex disorders, drawing patients regionally, nationally, and internationally. Cincinnati Children's aims to achieve the best medical and quality of life outcomes and patient and family experience at the best value today and in the future for all patients.

In order to live out its mission, Cincinnati Children's is dedicated to advancing medicine and health through research and education. As one of the largest pediatric research programs in the nation, Cincinnati Children's translational research results in innovations that have a direct impact on improving child health for kids in the local community and around the world.

Through an academic affiliation dating back to 1926, Cincinnati Children's serves as the Department of Pediatrics for the University of Cincinnati College of Medicine. As one of the largest pediatric medical education programs in the U.S., Cincinnati Children's provides training to over 1,000 medical residents, postdoctoral fellows, nurses, and other healthcare professionals, as well as training and education to parents, families, and the community.

Definition of Community Served

Cincinnati Children's Primary Service Area (PSA) is an eight-county region in Southwestern Ohio, Northern Kentucky, and Southeastern Indiana. The PSA includes Butler, Clermont, Hamilton, and Warren Counties in Ohio; Boone, Campbell, and Kenton Counties in Kentucky; and Dearborn County in Indiana. Clermont County is classified as part of Appalachia. Within its PSA, Cincinnati Children's operates four hospital facilities and over 20 healthcare facilities.

2022 Community Health Needs Assessment – Prioritized Significant Child Health Needs

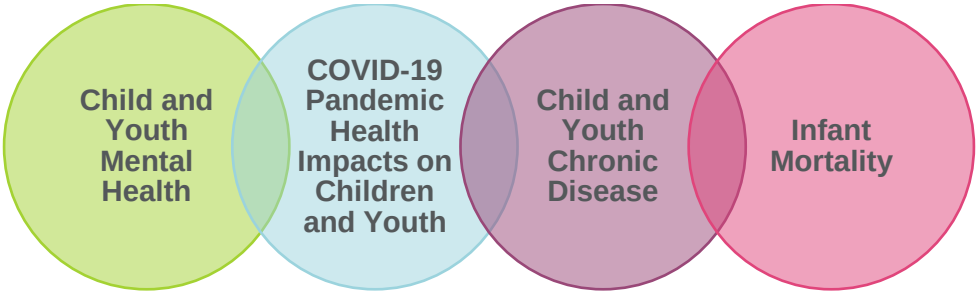
Cincinnati Children's conducted a Community Health Needs Assessment (CHNA) in accordance with the requirements of the Affordable Care Act of 2010 and the IRS Section 501(r)(3) for all four of Cincinnati Children's hospital facilities – Burnet Campus, Liberty Campus, College Hill Campus, and Linder Center of HOPE. Utilizing the methodology specified in the 2022 CHNA, child health and health-related needs were identified from primary and secondary data sources. After identifying these needs, a prioritization committee – comprised of leaders representing primary and specialty pediatric care, social work, and

Cincinnati Children's regional locations – was assembled. Committee members were selected based on their expertise in child and pediatric health, leadership, work with children and families, and experiences collaborating within the community. The prioritization committee reviewed the ranked priorities identified during the data collection process and were asked to prioritize the health needs on a 5-point Likert scale based on the following criteria:

- Magnitude of Child Health Need
- Severity of Child Health Need
- Community Will and Community Assets to Address Child Health Need
- Alignment with Cincinnati Children's Pursuing Our Potential Together (POPT): Community Health strategic plan and Diversity, Equity, and Inclusion (DEI) Goals
  - POPT is Cincinnati Children's Strategic plan to advance care, community, cure, and culture.
- Alignment with State and National Child Health Priorities and Resources
- Availability of Best Practice Programs and Resources to Address Child Health Need

The prioritization committee ranked child health-related needs in order of importance.

After completing the prioritization process detailed above, the following child health needs were prioritized as significant child health needs for the 2022 CHNA and Implementation Strategy reports:



Other health and health-related needs identified by the community were not prioritized as significant child health needs for the purposes and focus of this assessment at this time, and therefore are not covered in the 2022 Implementation Strategy. These other health and health-related needs will be addressed primarily through existing and new community partnerships.

2022 Implementation Strategy Methods

After identifying the four significant child health needs, meetings were conducted with internal experts to gather input on potential strategies to address each of the four significant child health priorities identified in the CHNA. Based on the information gathered during these meetings, strategies, actions, resources, and community collaborations were developed to address the four significant child health needs prioritized.

In accordance with the requirements of the Affordable Care Act of 2010 and the IRS Section 501(r)(3), Cincinnati Children's has developed the following strategies addressing the significant child health needs identified in Cincinnati Children's most recent CHNA.

2022 Implementation Strategies for Prioritized Significant Child Health Needs

The following section provides details on the actions, resources, and planned collaborations for the four 2022 CHNA prioritized significant child health needs. Cincinnati Children's is committed to addressing the significant health needs identified in the 2022 CHNA through programs, resources, collaborations,

and more, as described in the 2022 Implementation Strategy. Cincinnati Children's has programs and resources available to address each child health need. Using evidenced-based approaches, Cincinnati Children's will coordinate both hospital and community resources to ensure that priorities are addressed in an effective and efficient way. Many of the resources listed below target low-income, vulnerable, or underserved populations.

Priority 1: Child and Youth Mental Health

Strategy	Planned Actions	Anticipated Impact
Expand Integrated Behavioral Medicine and Clinical Psychology- clinical psychologists to address both behavioral health promotion and treatment, co-locating them in Cincinnati Children's Primary Care and Community Health Services Network	• Ensure that parents of children ages 0-5 receive guidance that strengthens the parent-child bond and proactively address typical emerging behavioral concerns during this developmental period	• Increase access to behavioral health services for children/pediatric patients and timely behavioral assessment and referral of children/pediatric patients (children) in Cincinnati Children's Primary Care and Community Health Services Network clinics
Expansion of Integrated Behavioral Medicine and Clinical Psychology intervention services into community practices	• Ensure that children receive mental health intervention for emerging and established mental health concerns within their community primary care setting	• Increase access to behavioral health services for children/pediatric patients and timely behavioral assessment and referral of children/pediatric patients in community practices
Implement high-intensity outpatient intervention to manage behavioral and mental health crisis *(Division of Behavioral Medicine and Clinical Psychology)*	• Develop evidence-based interventions to address mental health crisis in children and youth • Implement interventions to address mental health crisis in children and youth	• Reduce Emergency Department utilization by children and youth for mental health crisis
Expand Project ECHO program offerings and audience to increase educational opportunities and reach of program, including the implementation of ECHO Screening	• Expand Project ECHO to offer broader educational topics, including trauma, advanced mental health issues • Expand therapy Project ECHO education to include community mental health providers • Ensure that primary care providers receive training in ECHO to improve the evidence-based behavioral health screening, referrals and care provided to pediatric patients	• Increase access to evidence based behavioral and mental health practices by physicians in primary care and community practices • Improve access to evidence based behavioral and mental health care in the community

Strategy	Planned Actions	Anticipated Impact
Implement Zero Suicide program at Cincinnati Children's to improve detection of suicide risk among patients	• Develop standardized process for screening for suicide-risk in patients within outpatient psychiatry Develop standardized process for safety planning intervention across settings	• Reduce variation in practice for suicide risk screening and safety planning • Improve detection of patients at risk for suicide Improve safety planning between levels/settings of care
Decrease the number of Adolescent Medicine primary care patients seen in Urgent Care and in the ED for Behavioral Health concerns	• Increase preventative behavioral health screenings during new visits and annual physical exams • Increase the availability for appointments that social workers and psychologists have to meet with and reach out to patients, including the presence of two integrated psychologists in clinic with same day capability Decrease the amount of time between when a patient with acute behavioral concerns is identified and when an integrated psychologist or social worker is able to connect with the patient	• Increase number of patients seen in Adolescent Medicine clinic with acute behavioral health needs • Decrease the number of those being seen in the Urgent Care and ED Identify patients with behavioral health concerns prior to acute crisis
Optimize Psychiatry service lines to connect patients with the appropriate level of mental health care	• Develop plan for service line optimization • Analyzing patient need for different levels of mental health services • Expansion of most needed patient level of mental health care	• Optimize care for patients by connecting patients to the appropriate level of needed mental health care
Enhance Crisis Services to improve access for patients and the community *(Division of Psychiatry)*	• Complete gap analysis between offered services and patient/community need • Implement expansions to the most need service lines, for example Bridge Clinic, Partial Hospitalization Program, or Intensive Outpatient Program • Explore community partnerships to support Mobile Response Stabilization Services (MRSS)	• Improve access to crisis services for patients and the community

Hospital Resources	Community Resources and Collaborations
• All Children Thrive Learning Network • Bridge Clinic • Center for TeleHealth • Community Health Services Network • Division of Behavioral Medicine and Clinical Psychology (BMCP) • Division of Child and Adolescent Psychiatry • Division of General and Community Pediatrics • Division of Social Services/Embedded Social Workers • Emergency Department • HealthVine • James M. Anderson Center for Health Systems Excellence • Multidisciplinary Zero Suicide Team (includes Psychiatry, BMCP, Division of Developmental and Behavioral Pediatrics, Patient Services, and James M. Anderson Center for Health Systems Excellence) • Patient Services	• Cincinnati Public Schools • Community Primary Care Practices • Community Primary Care Physicians and Community-based Therapists • Community Mental Health providers • National Zero Suicide Collaboration • Ohio Medicaid/Ohio Rise • Parents on Point

Priority 2: COVID-19 Pandemic Health Impacts on Children and Youth

Strategy	Planned Actions	Anticipated Impact
Provide child health resources, weekly communications, and education to community providers	• Send regular emails to community providers with short write-ups highlighting specific child health topics and resources • Provide detailed information packets and tools to community providers • Host educational webinars for community providers • Send monthly newsletter to community providers highlighting specific child health topics and resources	• Increase knowledge and resources available for community providers to enhance their patient care.
Increase the percent of primary care patients that are vaccinated against COVID-19	• Offer vaccine in daily workflow & for vaccine only appointment • Partner with community vaccine events • Offer vaccine to household members in addition to patients • Provide vaccine education to providers & staff	• Increase COVID-19 vaccination knowledge and increase the percentage of the pediatric population vaccinated for COVID-19

Strategy	Planned Actions	Anticipated Impact
Recovery of routine childhood vaccine rates to pre-COVID levels	• Convert *ill-visits* to *well visits* to optimize clinical practice and child health • Offer childhood vaccines at all visit types Provide outreach to patients with vaccine care gaps	• Increase knowledge on the importance of childhood vaccinations Increase childhood vaccination rates
Recovery of routine well child care visits to pre-COVID levels to ensure closure of care gaps	• Convert ill-visits to well visits Integrate and promote availability of walk-in well child visits to meet family need	• Increase well child visits completed to ensure children are up-to-date on vaccinations and growth and development milestones Close care gaps among patient population
Address and mitigate Social Determinants of Health identified in Primary Care	• Integrate regular and consistent electronic screening for Social Determinates of Health Provide real time services at time of need identification (i.e. Social Work/Community Engagement Specialist, ChildHelp, Food Pantry, and integrated Mental Health resources)	• Continue identification of Social Determinants of Health Improve health outcomes for patients and families
Increase the percentage of Adolescent Medicine Primary Care patients that have received the COVID-19 vaccine, while meeting their unique adolescent health needs.	• Offer vaccines during scheduled visits to all patients and family members • Offer vaccines during nurse only visit appointments • Provide vaccine education to providers & staff • Provide readily available COVID vaccine resources	• Increase percentage of COVID-19 vaccinations given • Decrease disparities in COVID-19 vaccinations
Increase the number of Adolescent primary care patients who receive annual physical exam within 40 days of annual due date to optimize adolescent health post-COVID pandemic	• Identify patients who are due or overdue for annual physical prior to a scheduled visit • Assign patients so annual physicals can be completed if due or overdue • Educate patients on importance of preventive primary care and annual physical exam	• Increase number of annual physical exams completed within 40 days of due date

Strategy	Planned Actions	Anticipated Impact
Support return to a healthy communities post-COVID-19	Partner with community organizations, churches, and schools on community health events, including health fairs to increase health education, health screenings, and vaccinations	• Increase access to health screenings and health education materials in the community • Increase access to vaccinations in the community Expand partnerships within schools and communities
Support a healthy return to learning post-COVID-19	• Partner with schools to provide continued guidance through a monthly Return to Learning forum about child health and wellness	• Broaden access to resources and guidance on safe learning environments through the transition from pandemic to endemic • Increase the number of students who are learning in-person verse remotely • Expand partnership within schools and school districts

Hospital Resources	Community Resources and Collaborations
• All Children Thrive Learning Network • Center for Clinical & Translational Science & Training (CCTST) • Clinic-based Food Pantry and KIND Formula distribution • Community Health Services Network • Community Health Team • Community Relations • Division of Adolescent and Transition Medicine • Division of Behavior Medicine and Clinical Psychology • Division of General and Community Pediatrics • Division of Social Services/Embedded Social Workers • Mobile Care Center • Patient and Clinical Services • Pediatric Primary Care Center, Hopple Street Health Center, and Fairfield Primary Care Clinic • Physician Outreach and Engagement Department • Return to Learning Multi-Disciplinary Team and Experts • School-based Health Centers • School Intervention Team	• Black Family Reunion • Cincinnati Health Department • Community Partners, such as the Cincinnati Reds • Community Mental Health Providers • Community Practice Advisory Council • Cincinnati Public Schools • External Behavioral Health Providers • First Ladies for Health • FreeStore Foodbank • Legal Aid • Local schools and school districts within eight-county Primary Service Area • Ohio Medicaid • Ohio Medicaid Providers • Regional and local Health Departments • School-based Health Center partnerships • Shared Harvest • The Center for Closing the Health Gap

Priority 3: Children and Youth Chronic Disease

Asthma

Strategy	Planned Actions	Anticipated Impact
Optimize care management within HealthVine, including establishment of connections with outside general pediatric providers, subspecialty providers, and school nurses	• Identification of high risk asthma patients currently not engaged with HealthVine or General and Community Pediatrics care management • Enhance partnerships and streamlined communication between Care Managers and School-based Health Center providers (testing at specific site) • Develop shared situational awareness regarding high-risk asthma patients between Care Managers, primary and subspeciality providers, and schools	• Enhance situational awareness for population of children with asthma (dashboards illustrating care needs, gaps, patterns of morbidity) • Improve disease control as measured by Asthma Control Test, ED visits, hospital admissions • Narrow the gap of ED Visits and Hospitalizations by race/SES
Identify the social and medical needs of patients using a social screening tool and link them to effective interventions	• Implement reliable screening across all phases of asthma care (inpatient, primary care, outpatient subspecialty care) • Use of the inpatient child asthma risk assessment tool (CARAT) • Expanded use of social needs screening tool across institution • Link to interventions like the CLEAR program (partnership with Cincinnati Health Department focused on healthy housing) and Child HeLP (medical-legal partnership)	• Improve disease control (as noted above) • Address social needs (e.g., improved housing) • Reduce morbidity (ED visits, hospitalizations) • Enhance quality of life (increased days in school)
Complete design session(s) with stakeholders inside and outside Cincinnati Children's in support of population health Quality Improvement (QI)	• Identify key stakeholders including families • Determine number, timing, modality and facilitator of design sessions • Co-produce potential interventions	• Share outcome measures • Share theory for improvement • Complete environmental scan of research and QI ongoing related to asthma

Hospital Resources	Community Resources and Collaborations
• All Children Thrive Learning Network • Asthma Improvement Collaborative • Clinic-based Community Health Workers • Community Health Services Network • Community Health Team • Collaboration to Lessen Environmental Asthma Risks (CLEAR) • Division of General and Community Pediatrics • Health Equity Network • HealthVine • Institutional task force on social needs assessment/response • James M. Anderson Center for Health Systems Excellence	• Cincinnati Public Schools • Community Pharmacies • Cincinnati Health Department • Legal Aid Society of Greater Cincinnati

Diabetes

Strategy	Planned Actions	Anticipated Impact
Enhance school nurse Diabetes education program	• Gap analysis of current education program provided • Close the identified gaps to include pre-diabetes, Type 1 Diabetes, and Type 2 Diabetes • Develop curriculum, media, and materials to optimize intervention and prevention strategies	• Increase knowledge of community partners in the schools, which will lead to increased symptom recognition • Improve Diabetes management • Address and reduce stigma related to Diabetes treatment for staff and students • Build and strengthen ongoing partnerships and increasing communication and partnership between schools and the Diabetes Center
Expansion of behavioral and psychosocial screening assessment and intervention into additional Diabetes Clinics	• Develop sustainable practice for expansion of Integrated Behavioral Medicine and Clinical Psychology- clinical psychologists to address both behavioral health promotion and treatment, co-locating them in Diabetes Clinics	• Improve access to psychology for Diabetes patients • Reduce Diabetes distress in patients and caregivers • Improve/Maintain Diabetes Quality of Life for patients
Systematically address barriers to diabetes education and care	• Pilot expansion of social determinants of health screening to Type 2 Diabetes clinics • Pilot diabetes community education • Pilot education partnership with HealthVine Community Health Workers providing interventions	• Address racial and socioeconomic disparities in diabetes outcomes and move to reduce disparities in preventable admissions

Hospital Resources	Community Resources and Collaborations
• Diabetes Management for School Nurses School-Based program • Diabetes Center • Division of Behavioral Medicine and Clinical Psychology • Health Equity Network • Cincinnati Children's Social Determinants of Health Working Group • HealthVine	• American Diabetes Association (ADA) • Juvenile Diabetes Research Foundation (JDRF) • Area School Districts • Type 1 Diabetes Exchange • The Leona M. and Harry B. Helmsley Charitable Trust

Epilepsy

Strategy	Planned Actions	Anticipated Impact
Work with a multidisciplinary team to encourage Epilepsy medication adherence among patients	• Screen patients and families for medication adherence • Partner with Epilepsy psychologists and Social Workers to identify solutions to increase medication adherence among patients	• Improve patient outcomes through increased medication adherence
Optimize epilepsy management for patients through consistent documentation of seizure type and frequency	• Establish documentation protocols for Epic (patient records system) to ensuring notes are consistent between Epilepsy providers • Train Epilepsy providers on documentation protocols	• Improve care coordination for Epilepsy patients

Hospital Resources	Community Resources and Collaborations
• Comprehensive Epilepsy Center • Department of Information Services • Division of Behavioral Medicine Clinical Psychology • Division of Neurology • Scheduling Center Client Management • James M. Anderson Center for Health Systems Excellence	• Epilepsy Health Learning System (EHLS)

Inflammatory Bowel Disease

Strategy	Planned Actions	Anticipated Impact
Optimize treatment through proactive Therapeutic Drug Monitoring for biologic medications	• Utilize QI methodology to determine best practice for managing biologic medications and adjusting therapy to optimize for individualized patient needs • Evaluate the need for more-focused interventions in minority patients • Collaborate with local home care companies and infusion centers for regular labs draws of patients receiving therapy there	• Improve remission rates • Spread best practice of proactive Therapeutic Drug Monitoring across the country through Improve Care Now learning network to other pediatric Inflammatory Bowel Disease centers
Engage patients in regularly scheduled health maintenance visits to improve disease management	• Quarterly reviews of patients not seen in the last 6 months with subsequent follow up to schedule appointments or intervene as needed if social concerns are involved • Dedicated full time social worker to implement self-management and health maintenance program including clinic follow-ups	• Optimize health and disease management • Decrease Emergency Department visits or hospitalizations related to Inflammatory Bowel Disease
Co-Host annual Inflammatory Bowel Disease Education Day	• Provide up-to-date information to patients and families of new developments in the field of Inflammatory Bowel Disease	• Improve Inflammatory Bowel Disease community engagement and health maintenance

Hospital Resources	Community Resources and Collaborations
• Division of Behavioral Medicine and Clinical Psychology • Division of Social Services/Embedded Social Workers • Division of Nutrition Therapy/Embedded Dietitians • Inflammatory Bowel Disease Center • ImproveCareNow Learning Network	• Crohn's and Colitis Foundation • Local Home Care companies • Local Infusion Centers

Sickle Cell

Strategy	Planned Actions	Anticipated Impact
Increase awareness of Sickle Cell through community education	• Provide educational materials about sickle cell trait and sickle cell disease to community members in targeted areas through health fairs and community events. • Implement faith-based organization educational campaigns in the community (annual statewide Sickle Cell Sabbath and Cincinnat-based First Ladies Initiative) • Provide counseling and education follow-up services to families with a newborn diagnosed with sickle cell trait	• Increase general awareness of Sickle Cell Disease and Sickle Cell Trait, particularly among at-risk populations • Increase knowledge and awareness of Sickle Cell Trait within families and the community
Increase awareness of Sickle Cell through Provider education	• Provide tele-mentoring about evidence-based best practices in Sickle Cell Disease for multidisciplinary providers (i.e. Project ECHO for Sickle Cell Disease; COVID-19 and Sickle Cell Disease ECHO; Health Equity ECHO; School Nurse ECHO) • Provide training at an annual hemoglobinopathy counselor training course • Disseminate an annual newsletter for primary care providers about newborn screening in hemoglobinopathies • Provide educational materials to multidisciplinary providers at statewide professional organization conferences	• Increase general, medical, and psychosocial knowledge and awareness of Sickle Cell Disease and Sickle Cell Trait amoung multidisciplinary providers • Provide continuing education to increase knowledge on newborn screening topics, including, follow-up counseling, referral processes, and education for Sickle Cell Trait and Sickle Cell Disease for community providers • Increase awareness of newborn screening follow-up services, sickle cell clinical services, and multidisciplinary educational resources
Develop and Pilot a Sickle Cell Disease co-management strategy between Hematology and primary care	• Develop a co-management strategy between Cincinnati Children's General and Community Pediatrics and Hematology to care for children with Sickle Cell Disease • Implement as a pilot program	• Improve patients' access to Primary Care • Increase communication between specialty and general practitioners • Decrease healthcare-related inconveniences to families of children with Sickle Cell Disease

Hospital Resources	Community Resources and Collaborations
• Comprehensive Care for Sickle Cell and Hemoglobin Disorders • Division of General and Community Pediatrics • Division of Hematology	• Ohio Department of Health • U.S. Department of Health and Human Services/Health Resources and Services Administration

Priority 4: Infant Mortality

Strategy	Planned Actions	Anticipated Impact
Support families through direct service via Community Health Workers	• Identify and serve women across priority zip codes.	• Reduce extreme preterm birth, sleep related infant deaths and racial disparity in infant deaths.
Amplify Community Voice including addressing racial inequities by empowering Black women to lead	• Engage Black women in community events	
Transform Systems including managing a prenatal care learning collaborative	• Grow our existing 200+ member learning collaborative	
Lead a Collective Impact Collaborative that aligns the Hamilton County maternal and infant health community	• Continue to regularly convene a 40+ member advisory board	

Hospital Resources	Community Resources and Collaborations
• Perinatal Institute	• Cradle Cincinnati Connections

Written Comments on 2019 Implementation Strategy

Cincinnati Children's 2019 CHNA and Implementation Strategy was made widely available to the public on Cincinnati Children's website at http://www.cincinnatichildrens.org/about/community/health-needs-assessment. In addition to posting the 2022 CHNA and Implementation Strategy, contact information including email address and phone numbers were listed. No comments or questions were received.

2022 Implementation Strategy Approval and Adoption

The 2022 Implementation Strategy was adopted by the Board of Trustees on April 26, 2022.

The 2022 CHNA and Implementation Strategy are available at: https://www.cincinnatichildrens.org/about/community/health-needs-assessment. For a printed copy, please contact communityrelations@cchmc.org.