# Community Health Needs Assessment Implementation Strategy

2025

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# Cincinnati Children's Overview

## Description of Health System

Established in 1883, Cincinnati Children's Hospital Medical Center is a nonprofit and one of the oldest pediatric health systems in the United States (USA). Cincinnati Children's operates a comprehensive pediatric health system. During the fiscal year (FY) that ended June 30, 2024, Cincinnati Children's had more than 1.7 million patient encounters and served patients from all 50 states and dozens of countries.[1]

## Vision and Mission

Cincinnati Children's vision is to be the leader in improving child health on a local, regional, national, and global scale. The hospital's mission is to improve child health and transform delivery of care through fully integrated, globally recognized research, education, and innovation. For patients from our community, the nation, and the world, the care provided will achieve the best: medical and quality-of-life outcomes, patient and family experience, and value—today and in the future. This vision and mission are realized through three integrated pillars: (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 comprehensive pediatric health systems. 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 locally, regionally, nationally, and internationally. Cincinnati Children's is deeply committed to leading, collaborating, and advocating to measurably improve the health of local children and reduce disparities in health outcomes within our region. Furthermore, Cincinnati Children's has a deep commitment to mental health and is the largest inpatient pediatric mental health provider in the country.

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 scientists work along the full continuum of research—from basic to translational to clinical—with a relentless focus on curing childhood diseases and improving patient outcomes.

This translational research results in innovations that have a direct impact on improving child health for children and youth in the local community and around the world.

Through an academic affiliation dating back to 1926, Cincinnati Children's comprises the Department of Pediatrics at the University of Cincinnati College of Medicine. The nearly 100-year relationship has resulted in numerous joint endeavors, including basic and clinical research, collaboration in patient care, cooperation in education, and training of medical students, doctoral students, residents, and fellows, as well as shared use of facilities and equipment.

# Definition of Community Served

This report assesses the health needs of the children and youth community in the Cincinnati Children's Primary Service Area (PSA), which 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.

## 2025 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 IRS Section 501(r)(3) for all four of Cincinnati Children's hospital facilities – Burnet Campus, Liberty Campus, College Hill Campus, and Lindner Center of HOPE. Utilizing the methodology specified in the 2025 CHNA, child health and health-related needs were identified from primary and secondary data sources. After identifying these needs, a prioritization committee was assembled, comprised of Cincinnati Children's employees representing primary and specialty pediatric care, social work, and Cincinnati Children's regional locations. Committee members were selected based on various factors, including their expertise in child and pediatric health, leadership, roles within the hospital, work with children and families, and experiences collaborating within the community. The prioritization committee reviewed the ranked needs identified during the data collection process and was asked to prioritize the child health and child health-related needs on a 5-point Likert scale based on the following criteria:

- Magnitude of Child Health (Related) Need
- Severity of Child Health (Related) Need
- Community Will and Community Assets to Address Child Health (Related) Need
- Alignment with Cincinnati Children's Pursuing Our Potential Together (POPT) Community Pillar, The Fisher Center, and Population Health Goals
- Alignment with State and National Child Health Priorities and Resources
- Availability of Best Practice Programs and Resources to Address Child Health (Related) Need

After completing the above prioritization process, the following child health needs were selected as the priorities for the 2025 CHNA and Implementation Strategy reports:

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|---|---|
| Child and Youth Mental Health | Child and Youth Chronic Disease |
| Food Insecurity and Poor Nutrition Health Impacts | Child and Youth Injury |

Other health and health-related needs identified by the community were not prioritized as significant child health needs and, therefore, are not covered in the 2025 Implementation Strategy. These other health and health-related needs will be addressed primarily through existing and new community partnerships.

## 2025 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 identified to address the four prioritized significant child health needs.

In accordance with the requirements of the Affordable Care Act of 2010 and IRS Section 501(r)(3), Cincinnati Children's has identified the following strategies addressing the significant child health needs identified in Cincinnati Children's 2025 CHNA.

# 2025 Implementation Strategies for Prioritized Significant Child Health Needs

## Priority 1: Child and Youth Mental Health

| Strategy | Planned Actions | Anticipated Impact |
|---|---|---|
| Expand Integrated Behavioral Health in community practices and the ability to include mental and behavioral health prevention services | • Ensure that children receive mental health interventions for emerging and established mental health concerns within their community primary care setting<br>• Increase enrollment for eligible patients in OhioRISE | • Improve access to behavioral health services and timely behavioral assessment and referral of children/pediatric patients in community practices<br>• Reduce emergency department utilization for mental health |
| Introduce new clinical services for anxiety and depression (exposure coaching, interventional psychiatry, specialized care pathways) | • Develop and implement innovative evidence-based programs for major mental health disorders | • Improvements in functioning, less disability, and faster return to normal activities |
| System and family navigation program | • Develop and implement family and systems-level navigation program, including healthcare, school, and community partners and systems | • Support access to appropriate mental and behavioral health services |
| Continue implementation of the Zero Suicide program at Cincinnati Children's to improve the detection of suicide risk among patients | • Develop standardized process for screening for suicide risk in patients within outpatient psychiatry<br>• Develop standardized process for safety planning intervention across settings<br>• Lethal Means Training for clinicians on safe storage | • Reduce variation in practice for suicide risk screening and safety planning<br>• Improve detection of patients at risk for suicide<br>• Improve safety planning between levels/settings of care |
| Increase knowledge and confidence of community providers to address mental health concerns (EBCP, PINQ, ECHO) by providing training and evidence-based treatment throughout the region | • Increase participation in behavioral health learning networks focused on expanding evidence-based treatment<br>• Expand Project ECHO class offerings on a variety of mental and behavioral health topics<br>• Implement an evidence-based certification program for community providers<br>• Onboard additional community practices into the PINQ network | • Providers in the community will be better able to identify and treat common mental and behavioral health conditions with evidence-based therapies in their own community practices<br>• Reduce needs for higher acuity care<br>• Reduce burnout/turnover<br>• Reduce emergency department utilization and inpatient stay rates for mental health<br>• Support member engagement (learning network) |
| Create visibility for behavioral health | • Expand behavioral health dashboards and communications | • Support internal and external coordination to drive behavioral health outcomes |

| Strategy | Planned Actions | Anticipated Impact |
|---|---|---|
| Implementation of standardized screening, brief intervention, and referral to treatment for alcohol, substance, or vaping use when needed in priority clinical areas | • Implement screening tool in appropriate clinical areas | • Better identification of adolescent alcohol use, substance use, and vaping<br>• Reduce occurrence of adolescent alcohol use, substance use, and vaping because of brief intervention to encourage adolescents to cut back or quit<br>• Improve connection to providers trained in addiction treatment when substance use disorders are present |

| Hospital Resources | Community Resources and Collaborations |
|---|---|
| • Center for Telehealth<br>• CHECK Foster Care Center*<br>• Community Health Services Network (CHSN)<br>• Division of Adolescent Medicine<br>• Division of Behavioral Medicine and Clinical Psychology (BMCP)*<br>• Division of Child and Adolescent Psychiatry*<br>• Division of Developmental and Behavioral Pediatrics (DDBP)*<br>• Division of General and Community Pediatrics<br>• Emergency Department<br>• James M. Anderson Center for Health Systems Excellence<br>• Mental and Behavioral Health Institute (MBHI)*<br>• Michael A. Fisher Child Health Equity Center*<br>• Multidisciplinary Zero Suicide Team (includes Psychiatry, BMCP, Division of Developmental and Behavioral Pediatrics, Patient Services, and James M. Anderson Center for Health Systems Excellence)<br>• OhioRISE<br>• Patient Services<br>• Population Health Behavioral Health Program*<br>• Population Health School Program | • 1N5*<br>• Cincinnati Public Schools<br>• Community primary care physicians<br>• Community providers<br>• County Coroner offices<br>• MindPeace*<br>• University of Cincinnati Health |

*Strategy Team for this Priority

## Priority 2: Children and Youth Chronic Disease

### Asthma

| Strategy | Planned Actions | Anticipated Impact |
|---|---|---|
| Asthma coordinator and navigator – visit all admitted patients with asthma (1,000 per year) at bedside to complete social needs screening and provide referrals/services and care coordination | • Organize patient-facing materials to ensure consistent approaches and response to screens<br>• Screen all inpatient asthma patients before discharge<br>• Meet with patients who screen positive for needs | • Develop tracking mechanism for regional asthma admissions, including risk stratification tools for clinical team members<br>• Address social/medical needs and medical gaps during a high-risk time (admission event)<br>• Link members of asthma care system |
| Community events to increase awareness and knowledge of asthma education and resources in the community | • Host annual event in the community<br>• Engage families through outreach to attend the event<br>• Distribute asthma kits to the community (e.g., filters, pillowcase covers, pest traps, etc.) | • Improve knowledge and ability for asthma self-management<br>• Connect children and families with regular asthma providers |
| Use data to identify areas in the community that are asthma hot spots. Work with clinical teams, community residents, and leaders to reduce risk in the community. | • Ongoing build of data infrastructure to identify and track asthma hot spots<br>• Sharable dashboard, looking at data on a neighborhood level, heat maps<br>• Identify and build local coalition to address risk/issues | • Build infrastructure to create population-level pattern recognition |

| Hospital Resources | Community Resources and Collaborations |
|---|---|
| • Community health workers/nurses/providers<br>• Division of Biostatistics and Epidemiology<br>• Division of General and Community Pediatrics*<br>• Division of Hospital Medicine*<br>• Division of Pulmonary Medicine*<br>• HealthVine<br>• James M. Anderson Center for Health Systems Excellence<br>• Michael A. Fisher Child Health Equity Center*<br>• School-based health clinics (Cincinnati Children's) | • CareSource and other insurance providers<br>• Cincinnati Health Department*<br>• Cincinnati Public Schools<br>• City Gospel Mission<br>• Community pharmacies<br>• Hamilton County Public Health<br>• Legal Aid Society of Greater Cincinnati<br>• People Working Cooperatively<br>• School-based health clinics (Community) |

*Strategy Team for this Priority

## Diabetes

| Strategy | Planned Actions | Anticipated Impact |
|---|---|---|
| Expansion of behavioral and psychosocial screening assessment and intervention into additional diabetes clinics | • Explore sustainability options for program<br>• Maintain and expand 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 resources for diabetes patients<br>• Reduce diabetes distress in patients and caregivers<br>• Improve/maintain diabetes quality of life for patients |
| Systematically address barriers to diabetes education and care | • Maintain expansion of social needs screening to Type 2 Diabetes clinics<br>• Develop community connections for diabetes awareness in the community<br>• Maintain education partnership with HealthVine community health workers, providing interventions | • Address disparities in diabetes outcomes and move to reduce disparities in preventable admissions |

| Hospital Resources | Community Resources and Collaborations |
|---|---|
| • Behavioral Medicine and Clinical Psychology<br>• Division of Endocrinology*<br>• HealthVine<br>• James M. Anderson Center for Health Systems Excellence<br>• Michael A. Fisher Child Health Equity Center* | • American Diabetes Association (ADA)<br>• The Leona M. and Harry B. Helmsley Charitable Trust<br>• Type 1 Diabetes Exchange Collaborative |

*Strategy Team for this Priority

## Epilepsy

| Strategy | Planned Actions | Anticipated Impact |
|---|---|---|
| Expanding connection and referrals to community epilepsy resources for patients | • Community engagement specialists work with eligible patients to get connected with local epilepsy resources – on floor once a week | • Improve patient connectivity to the local epilepsy community for information and community support |
| Enrolling eligible patients in HealthVine for case management and Legal Aid for support | • HealthVine – Pilot retroactively enrolling patients in HealthVine case management based on record review<br>• QI project tracking – Nurses calling once a month to track needs – goal is lack of needs in follow-up call<br>• Legal Aid – referrals during clinical appointment | • Reduce barriers to care access and barriers to medication compliance<br>• Improve patient outcomes through addressing social determinants of health |

| Hospital Resources | Community Resources and Collaborations |
|---|---|
| • Division of Behavioral Medicine and Clinical Psychology (BMCP)*<br>• Division of Neurology*<br>• HealthVine<br>• James M. Anderson Center for Health Systems Excellence<br>• Michael A. Fisher Child Health Equity Center*<br>• Social Service | • Epilepsy Alliance<br>• Epilepsy Health Learning System (EHLS)<br>• Legal Aid |

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### Sickle Cell Disease

| 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<br>• Provide counseling and education follow-up services to families with a newborn diagnosed with sickle cell trait | • Improve general awareness of sickle cell disease and sickle cell trait, particularly among at-risk populations<br>• Improve knowledge and awareness of sickle cell trait within families and the community |
| Increase awareness of sickle cell through provider education | • Provide educational training to multidisciplinary providers through a variety of training opportunities | • Improve general awareness of sickle cell disease and sickle cell trait among multidisciplinary providers |
| Increase access to care management for high-risk patients | • Connect patients with care management services to mitigate barriers | • Improve access to care and health outcomes<br>• Support access to ultrasounds for sickle cell patients |

| Hospital Resources | Community Resources and Collaborations |
|---|---|
| • Comprehensive Care for Sickle Cell and Hemoglobin Disorders*<br>• Division of General and Community Pediatrics<br>• Division of Hematology*<br>• HealthVine*<br>• Michael A. Fisher Child Health Equity Center* | • Ohio Department of Health<br>• U.S. Department of Health and Human Services/Health Resources and Services Administration |

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## Priority 3: Food Insecurity and Poor Nutrition Health Impacts

| Strategy | Planned Actions | Anticipated Impact |
|---|---|---|
| Provide access to food pantry to support a balanced diet for patients with overweight or obesity | • Screen all patients through validated food insecurity screening tool<br>• Nutrition assessment for patients who screen positive for food insecurity | • Meet the needs of patients with food insecurity<br>• Improve food access to support a balanced diet |

| Strategy | Planned Actions | Anticipated Impact |
|---|---|---|
| Pilot cooking classes for patients and families | • Develop course/classes<br>• Pilot monthly cooking classes for patients and caregivers | • Build self-efficacy in patients/families in skills and knowledge to support balanced diets |
| Address food insecurity in primary care clinics through a partnership with regional foodbank that provides free formula and stocks food pantry | • Screen primary care patients for food insecurity during appointments<br>• Refer patients to formula program or pantry | • Reduce food insecurity for primary care patients |

| Hospital Resources | Community Resources and Collaborations |
|---|---|
| • Division of Endocrinology<br>• Division of Gastroenterology, Hepatology & Nutrition<br>• Division of General and Community Pediatrics*<br>• Division of Hospital Medicine<br>• HealthVine<br>• HealthWorks!*<br>• Michael A. Fisher Child Health Equity Center*<br>• Nutrition and Wellness Center<br>• Preventive Cardiology<br>• Social Work* | • Freestore Foodbank*<br>• Legal Aid |

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## Priority 4: Child and Youth Injury

| Strategy | Planned Actions | Anticipated Impact |
|---|---|---|
| Increase awareness and education around car seat safety | • Distribute car seats, host education events | • Reduce child injury related to improper use of car seats or lack of access to a car seat |
| Decrease significant home injuries | • Complete home visits and distribution of safety bundles for home | • Reduce preventable injury within the home |
| Increase the number of child safety technicians in the region | • Offer certification and re-certification courses<br>• Offer continuing education credits to maintain the certification | • Increase accessibility to people who are trained child safety technicians |
| Utilize virtual reality to train clinicians how to engage in firearm injury prevention discussions with patients and families | • Provide virtual reality training to Cincinnati Children's clinicians and medical students nationally, who will educate patients and families | • Improve skills and confidence related to firearm injury prevention counseling among clinicians and students<br>• Improve adoption of firearm safety counseling behaviors in practice among clinicians and students<br>• Reduce firearm-related injuries in the community |

| Hospital Resources | Community Resources and Collaborations |
|---|---|
| • Biomedical Informatics<br>• Center for Simulation and Research<br>• Cincinnati Children's College Hill Campus<br>• Cincinnati Children's Hospital Digital Technologies<br>• Comprehensive Children's Injury Center*<br>• Division of General and Community Pediatrics<br>• Family Resource Center (FRC)<br>• Firearm Safety Task Force*<br>• HealthVine<br>• Newborn Intensive Care Unit (NICU)<br>• Pediatric Intensive Care Unit Innovation Accelerator<br>• Pediatric primary care clinics<br>• Pediatric Residency Program<br>• Perlman Center<br>• Rehabilitation<br>• Transitional Care Center<br>• Trauma Registry | • Buckle UP for Life<br>• Everytown for Gun Safety<br>• Fire stations<br>• Massachusetts General Hospital Center for Gun Violence Prevention<br>• MESSER Construction<br>• Ohio Health Department<br>• Participating institutions<br>• Roll Hill Community Center<br>• The Greater Cincinnati Automobile Dealers Association |

*Strategy Team for this Priority

## Written Comments on 2022 Implementation Strategy

Cincinnati Children's 2022 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, was listed. No comments or questions were received.

## 2025 Implementation Strategy Approval and Adoption

The 2025 Implementation Strategy was adopted by the Board of Trustees on April 29, 2025.

The 2025 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

## References

1. Cincinnati Children's. Data from: Cincinnati Children's Data. 2024.