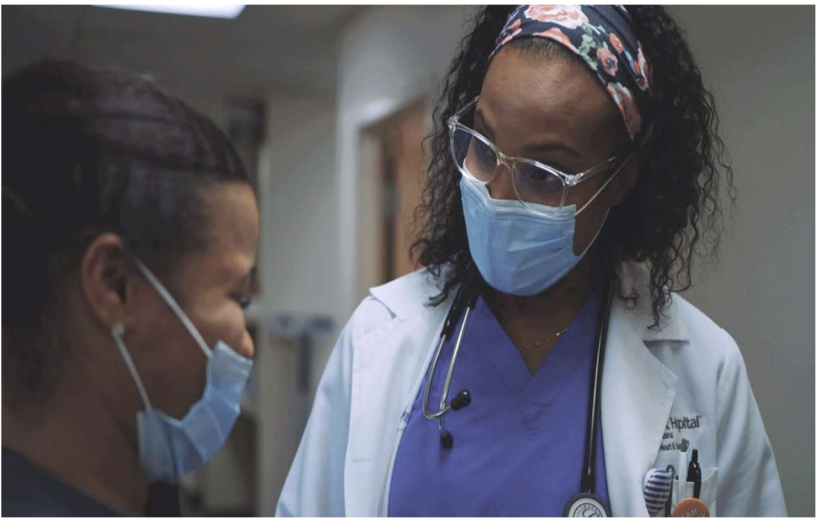
2025 Community Health Implementation Plan



The Christ Hospital Health Network

2025 Community Health Implementation Plan

Executive Summary

As part of the Patient Protection and Affordable Care Act (PPACA), The Christ Hospital Network and other tax-exempt hospitals are required to conduct Community Health Needs Assessments and develop implementation plans or community health strategies every three years. Developing a broad assessment also fulfills the State of Ohio's requirement mandating that health departments and hospitals align their assessments starting in 2020.

In response to this legislation, The Christ Hospital Health Network conducted a Community Health Needs Assessment in Fiscal Year 2022 and again in Fiscal Year 2025 (July 1, 2024 – June 30, 2025). Input from a variety of community partners provided valuable insight into the overall health and well-being of the community we serve.

One of our primary partners was The Health Collaborative, a nonprofit organization that works with its member hospitals on healthcare improvement projects and shares best practices. For the fourth time, The Health Collaborative convened local hospitals and led efforts to better understand community health needs. Their regional report shares data for Southwest Ohio, including the Greater Cincinnati area, Northern Kentucky, and Southeastern Indiana. Because hospital service areas vary, this approach provides the most thorough picture of local and regional health needs.

In addition to The Health Collaborative's data, The Christ Hospital analyzed multiple sources including public health data, health risk factor surveys, socioeconomic needs assessments, environmental standards, and existing programs for residents in the greater Cincinnati region. We also reviewed written comments received from the previous assessment.

For this Implementation Plan, it is imperative to define the community we serve. The Christ Hospital currently provides services and resources to 14 counties within a three-state area. For the purpose of this plan, we are focusing on Hamilton County, Ohio, where the majority of our care occurs.

The priorities were determined by the number of votes in community meetings, the number of mentions in surveys, and data trends that were worse than state or national averages and impacted at least 16 counties (secondary data). The five identified priorities ranked in the top eight across all primary data sources. Prevalent health concerns identified in Hamilton County include:

- Heart Disease and Stroke Prevention
- Mental Health
- Homelessness

Through a collaborative and meticulous process, The Christ Hospital Health Network and its community partners have reviewed these concerns and established a course of action. This plan

focuses on programs, research, and education geared to the community's top identified health concerns. Our goal is to make a measurable impact on community health. We recognize that one entity's expertise cannot be broad enough to address all needs; therefore, collaborations and partnerships are key to meeting them. This Implementation Plan was approved by The Christ Hospital Health Network Board of Directors on 10/22/2025.

Heart Disease and Stroke Prevention and Treatment

Chronic high blood pressure, or hypertension, can lead to heart disease and stroke—serious conditions that rank among the leading causes of death and the most frequent emergency department diagnoses in our region. These conditions are linked to inadequate housing and mental health challenges. Our goal is to continue making an impact on the community through the actions below.

Goal 1: Increase Access to Preventive Screening Services

Actions: Deploy a mobile heart unit to provide vascular screenings directly within the community, removing barriers to care for underserved populations.
Financial Resources: Funding will support acquisition and staffing of the mobile unit.
Manpower: Providers, staff, and leadership will manage and evaluate the program's impact.
Collaboration: Partner with community organizations to engage at-risk individuals for testing.

Goal 2: Increase Mental Health Support in the Heart Disease Population

Actions: Expand behavioral health consultant support within TCHHN's cardiology service line to integrate mental health care into cardiovascular disease management.
Financial Resources: Funding for additional positions has been allocated to support this expansion.
Manpower: Implemented and monitored by a multidisciplinary team.
Collaboration: Coordinate with community-based mental health services and payor resources to ensure comprehensive, integrated care.

Mental Health

Mental health treatment and crisis prevention are crucial for individuals and communities. Mental health is closely linked to physical health and influenced by relationships, employment, and living environments. Lack of timely, affordable mental health services can contribute to poor outcomes, while supportive communities with access to quality housing, education, and jobs promote positive mental health. We aim to continue making an impact through the actions below.

Goal 1: Expand Access to Behavioral Health Consultants in Ambulatory Specialty Services

Actions: Recruit additional behavioral health consultants within Ambulatory specialty services, focusing on high-risk populations to ensure timely and equitable access.
Financial Resources: Secure funding through internal and external sources to recruit and retain qualified staff.
Manpower: Providers, staff, and leadership will oversee implementation and monitor outcomes.
Collaboration: Strengthen work with community-based mental health services and payor partners to align resources and extend program impact.

Goal 2: Reduce Readmissions Related to Mental Health Diagnoses

Actions: Ensure patients are seen by a provider within seven days of discharge to reduce relapse or readmission and improve continuity of care.
Financial Resources: Targeted funding will support more timely appointments.
Manpower: Providers, staff, and leadership will actively implement and monitor progress.
Collaboration: Partner with community organizations and payors to ensure seamless support during transition from hospital to community care.

Homelessness

Safe, stable housing is essential for health and well-being. Affordable rent, adequate space, and housing stability prevent stressors that can lead to chronic health conditions. High housing costs may limit resources for other necessities such as childcare, nutritious food, and healthcare. Poor-quality housing can increase chronic stress, blood pressure, and mental health risks. We will continue to address these needs through the actions below.

Goal 1: Expand Access to Resources for Patients Facing Housing Crises

Actions: Increase screening for social determinants of health (SDOH) to better identify needs and connect patients to appropriate resources.
Financial Resources: Implement without direct new funding by optimizing existing resources and partnerships.
Manpower: Providers, staff, and leadership will implement and monitor.
Collaboration: Leverage community and payor partnerships to fill gaps in support.

Goal 2: Provide Quality, Holistic Medical Care to People Experiencing Homelessness

Actions: Offer financial support to the Center for Respite Care to allow patients without stable housing to receive needed care in a safe environment while breaking the cycle of homelessness.
Financial Resources: Funded through respite-specific resources.
Manpower: Staff and leadership will oversee implementation to ensure effectiveness.
Collaboration: Ongoing collaboration with the Center for Respite Care will ensure coordinated, comprehensive, and patient-centered services.

Community Health Implementation Plan

	Goals	Actions	Financial Resources	Manpower	Collaboration
Heart Disease and Stroke Prevention	Increase access to cardiovascular disease screening and preventative services	**Deploy mobile heart unit to provide vascular screenings to the community**	Funding for mobile unit and team members	Providers, staff and leadership participation to implement and monitor actions.	Collaborate with community partners to engage at risk population for testing
		Develop community outreach education and initiatives focusing on at risk populations	Funding for screening and educational resources	Providers, staff and leadership participation to implement and monitor actions.	Collaborate with community partners to engage at risk population for testing
	Increase mental health support in heart disease population to improve health outcomes and manage care in the most affordable setting	**Expand behavioral health consultant support to TCHHN cardiology service line**	Funding for additional positions	Providers, staff and leadership participation to implement and monitor actions.	The Christ Hospital collaborates with community based mental health services and payor resources
Mental Health	Expand access to Behavioral Health Consultants in Ambulatory specialty services	**Hire additional behavioral health consultant personnel to support, with prioritization of high-risk populations**	Funding for additional positions	Providers, staff and leadership participation to implement and monitor actions.	The Christ Hospital collaborates with community based mental health services and payor resources
	Reduce readmissions related to Mental Health Diagnosis	**Patients seen by provider within 7 days of discharge**	Funding to support more timely access to appointments	Providers, staff and leadership participation to implement and monitor actions.	
Homelessness	Expand access to resources for patients facing housing crisis	**Increase SDOH screening services to better identify needs**	None	Providers, staff and leadership participation to implement and monitor actions.	Collaborate with community and Payor partners to provide resources
	Provide quality, holistic medical care to people experiencing homelessness who need a safe place to heal, while assisting them in breaking the cycle of homelessness.	**Provide financial support to Center for Respite Care**	Respite program funding	Staff and leadership participation to implement and monitor actions.	Collaborate with Center for Respite Care