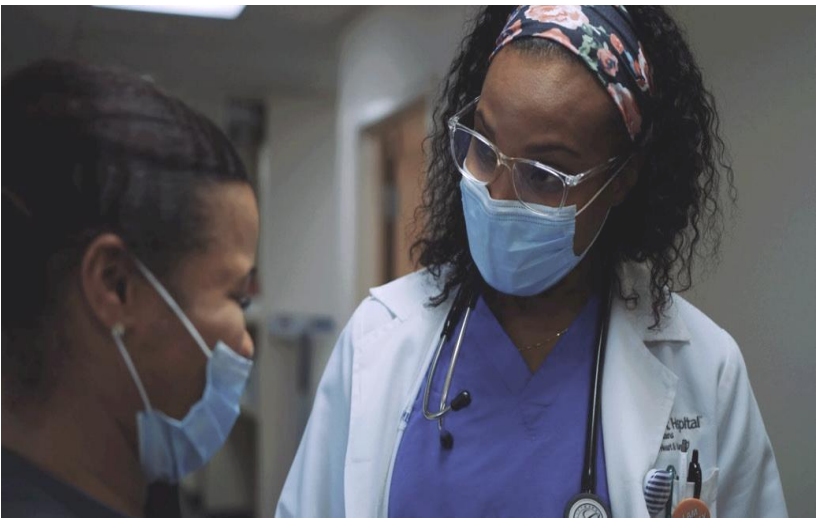
2025 Community Health Needs Assessment



Who We Are and Our Commitment to the Community

In 1888, a group of concerned Cincinnati citizens, led by James Gamble—whose soap business would grow into Procter & Gamble—extended an invitation to Isabella Thoburn, a teacher, nurse, and missionary. Their goal was to address the growing poverty and social inequities in the city through religious, educational, and philanthropic efforts. That invitation marked the beginning of a mission that continues to impact the region today.

Upon her arrival, Thoburn's work quickly expanded beyond ministry. In 1889, she opened a 10-bed facility in the West End, known as Christ's Hospital, located at 46 York Street. Just a few years later, in 1893, the hospital moved to Mount Auburn and, in 1902, established a nursing school. In 1904, the institution adopted its current name: The Christ Hospital.

Our Network and Reach

Today, The Christ Hospital and its subsidiaries—collectively known as *The Christ Hospital Health Network (TCHHN)*—comprise a robust healthcare system serving Ohio, Kentucky, and Indiana through more than 100 locations. Anchored by its flagship campus in Mount Auburn, the Network includes outpatient centers and a growing number of physician practices.

The Health Network features a team of more than 1,000 accredited physicians and offers leading-edge services across six key clinical service lines:

- Cardiovascular Care
- Orthopedic and Spine Treatment
- Women's Health
- Oncology
- Specialty Surgery
- Comprehensive Medicine

For over 125 years, our mission has remained steadfast: to improve the health of our community and to serve as a regional leader in delivering exceptional value through quality outcomes, excellent patient experiences, and accessible care—regardless of a patient's financial status, race, ethnicity, gender, sexual orientation, or beliefs.

Our Impact in FY2024

In fiscal year 2024, as reported in Schedule H of our IRS Form 990, The Christ Hospital contributed $71.4 million to community benefit programs. This total includes:

- Charity care and care provided under government assistance programs
- Investments in medical education, research, and innovation
- Community health improvement initiatives

These efforts have translated into measurable improvements in the overall health and well-being of our region.

Community Health Assessment and Collaboration

Every three years, The Christ Hospital conducts a comprehensive Community Health Needs Assessment (CHNA), as required by state regulations. This assessment guides our strategy in responding to evolving health needs across the region.

We recognize that no single organization can meet every community health need alone. That's why partnerships and collaboration remain central to our approach. Our seven resource groups serve as key drivers of relationship-building, allowing us to align with organizations that share our commitment to health equity and wellness.

Through both cash and in-kind donations, we support a wide array of partners, including:

- Center for Respite Homeless Medical Recovery
- The Abercrumbie Group
- Sister Accord Foundation
- Big Brothers Big Sisters of Cincinnati
- Center for Closing the Health Gap
- American Heart Association
- Cradle Cincinnati
- ArtsWave
- United Way
- March of Dimes
- Arthritis Foundation
- Collective Impact
- Health Connections (Lincoln Heights, Mt. Healthy & Forest Park Health Centers)
- Giving Voice Foundation
- The Sam Hubbard Foundation
- Making Strides
- St. Vincent de Paul Charitable Pharmacy

In addition to financial contributions, our team members devote countless hours volunteering for these and other local causes—demonstrating our commitment not only through funding, but also through personal service and engagement.

Opening Our Doors to the Community

We actively welcome community-based organizations into our facilities to advance shared missions. For example, we support and host efforts led by:

- Cincinnati Works
- Hoxworth Blood Center
- Mt. Auburn Garden Initiative Collaborative
- Mended Hearts

Leadership at The Christ Hospital is also deeply embedded in broader community and economic development initiatives. Many of our leaders serve on the boards of influential organizations such as:

- Mt. Auburn Chamber of Commerce
- American Heart Association
- United Way
- LifeCenter
- Greater Cincinnati Health Council

These roles amplify our influence and help shape healthier, more resilient communities.

A Lasting Commitment

While this document offers just a snapshot of our contributions, it underscores the deep and enduring commitment of our medical staff, executive team, Board of Directors, team members, volunteers, and partners. Together, we continue to deliver on our mission to elevate health, empower lives, and enrich the communities we serve across the Greater Cincinnati region.

The 2024 Christ Hospital Community Health Needs Assessment (CHNA) report is organized into five key sections:

1. **Community Definition** – An overview of the geographic area and population served by The Christ Hospital, including the criteria used to define the community.
2. **Assessment Methodology** – A detailed description of the process and methods used to conduct the CHNA, including how input was gathered from individuals and organizations representing the broad interests of the community.
3. **Identified Health Needs** – A prioritized list and description of the significant health needs identified through the assessment.
4. **Available Resources** – A summary of existing healthcare and community resources that have the potential to address the identified health needs.
5. **Impact Evaluation** – An evaluation of the progress made in addressing the health priorities outlined in the Hospital's 2022 CHNA.

Defining Our Community

The first step in conducting the 2024 Community Health Needs Assessment (CHNA) was to clearly define the community we serve. This process involved evaluating several key factors, including the geographic areas in which we operate, the populations we serve, and the Hospital's primary service lines and clinical functions.

In identifying our community, we intentionally included medically underserved, low-income, and minority populations residing within our service area. We also considered all patients, regardless of their ability to pay, insurance status, or eligibility for financial assistance under our Financial Assistance Policy. This inclusive approach reflects our mission to provide equitable care and improve health outcomes across all populations.

Currently, The Christ Hospital Health Network serves a 14-county region spanning Ohio, Kentucky, and Indiana. While we acknowledge the full breadth of our reach, for the purposes of this assessment, we have chosen to focus specifically on Hamilton County, Ohio. This decision was based on multiple factors:

- Over 50% of our patient population resides in Hamilton County.
- Hamilton County accounts for most of the Hospital's charity care and Hospital Care Assurance Program (HCAP) utilization.
- It is the most populous county within our service area, home to more than 830,000 residents, including many of the region's most at-risk populations.

These at-risk groups include African Americans, Hispanic/Latino populations, LGBTQ+ individuals, women, and people with disabilities. Focusing on Hamilton County allows us to direct our efforts and resources where the need—and potential for impact—is greatest.

Assessing Our Community Health Needs

Assessment Process and Methodology

We partnered with The Health Collaborative (THC) to conduct a comprehensive and collaborative Community Health Needs Assessment (CHNA). This regional effort was facilitated by THC and included the participation of 21 hospitals and 10 health departments, spanning 18 counties across Greater Cincinnati, southeastern Indiana, and northern Kentucky.

The success of this CHNA was made possible through the active engagement of local community leaders, strategic partners, and champions across the region who supported outreach, community engagement, and data collection efforts.

A summary of the Collaborative CHNA findings is included as Appendix A. The full Collaborative CHNA report offers a detailed account of the following:

1. The process of gathering community input, including contributions from individuals and organizations with special knowledge of, or expertise in, public health.
2. The timeline and methods used to collect community input.
3. The names and roles of participating organizations, as well as the nature and extent of their contributions.
4. Descriptions of medically underserved, low-income, and minority populations represented by participants throughout the process.

Oversight of this process was provided by a diverse Advisory Committee composed of representatives from hospitals, public health departments, federally qualified health centers, community-based organizations, professional associations, funding bodies, and hospital associations. Their leadership ensured that the CHNA process remained inclusive, equitable, and responsive to the needs of the broader community.

The 2024 CHNA was organized and based on domains identified in the National Association of County and City Health Officials (NACCHO) and included assessment of data on systems of power and privilege, social determinants of health, and health behaviors and outcomes.

The assessment also explored the social determinants of health (SDOH) contributing to these outcomes, along with the systemic barriers that drive disparities and health inequities within the community. Recognizing that physical, environmental, and behavioral factors play a critical role in health, the CHNA placed a strong emphasis on understanding the SDOH and the structural issues that shape them—factors that must be addressed to improve health outcomes for all community members.

The Regional CHNA by the numbers:

- Compiled 49 secondary, quantitative data metrics from 34 different sources
- Analyzed 18 Ohio Hospital Association data metrics
- Reviewed seven other primary and secondary regional data sources such as community surveys, data from 2-1-1 calls, and recent community reports
- Disaggregated 32 metrics by characteristics such as race, ethnicity, age, and income
- Hosted 12 Advisory Committee meetings and six Task Force meetings, which included 45 total partner organizations

Identifying and Prioritizing Significant Health Needs of the TCHHN Community

Prioritized Health Needs

The three needs were identified and prioritized for The Christ Hospital's defined community, Hamilton County. The needs identified are Access to Care and Services in order to improve equitable outcomes for the region's top health concerns:

- Heart disease and stroke prevention and treatment
- Mental health treatment and prevention
- Homelessness prevention and housing stability

Criteria for Prioritization

Regional priorities, informed by both data analysis and community voice, were selected by CHNA partners using the following criteria:

1. Capacity and feasibility – Does our region have the ability to address this health need?
2. Connection between factors and outcomes – To what degree do the prioritized structural/social determinants contribute to prioritized health outcomes?
3. Equity – Would addressing this health need significantly reduce health disparities?
4. Burden and severity – Would addressing this health need impact the greatest number of community members?
5. Ability to track progress – Are there indicators that can be used to measure progress over time?

Heart Disease and Stroke Prevention	Mental Health	Homelessness
Of the leading causes of death in the region, heart disease is ranked first, and stroke is ranked fifth.	The percentage of adults with depression in the region has risen by 93% over the last 27 years and an estimated 1 in 5 adults (17%) report frequent mental distress	Housing cost burden (spending 30% or more of income on housing costs) in the region is approximately 45% higher than the Healthy People 2030 benchmark.
Roughly 33% of adults in the region report being told by a doctor or nurse that they had high blood pressure. There are also sizeable racial disparities in hypertension.	The number of deaths due to suicide in the region is approximately 10% higher than the national average and 20% higher than the national healthy People 2030 benchmark.	There are stark disparities in housing outcomes across the region. For example, Black residents and residents with low incomes are more likely to face challenges with housing stability such as homelessness, eviction, and housing cost burden.
Of the top emergency room diagnoses in the region, heart disease is ranked second, heart attack is ranked fifth, and stroke is ranked sixth.	Community members often do not have a way to find needed services and to identify trusted mental health providers	There is a need for homelessness and housing support services, particularly for Black residents, men, and people who have been incarcerated.

Resources Available To Address Our Community's Significant Health Needs

We developed and implemented a strategic action plan to guide our efforts in improving community health throughout 2025 and over the next three years.

Heart Disease and Stroke Prevention and Treatment

- American Heart Association (AHA) Greater Cincinnati
- The Christ Hospital Prevention Cardiology Program, The Christ Hospital Women's Heart Center
- TCHNN chronic disease care management team for coordination of care and support
- Ambulatory Pharmacy services manages patients with high cardiac risk with preventative medications
- Pharmacogenomic testing to optimize medications

Mental Health and Treatment Prevention

- Talbert House, Greater Cincinnati behavioral Health Sciences, Sun Behavioral Health
- Behavioral Health Consultants (BHCs) integrated into Primary Care Practices and specific specialty offices
- Psychiatry integrated with Primary Care

Homelessness Prevention & Housing Stability

- Bethany House, Catholic Charities, Central Access Point, Cincinnati Metropolitan Housing Authority, Excel Housing, Legal Aid Society of Greater Cincinnati, Salvation Army, St Vincent DePaul Society, United Way
- TCHHN Social Work and Care Management Teams
- FindHelp – Social care technology connecting people to local resources

2022 Implementation Plan – What We Accomplished

Evaluation of 2022 Implementation Plan

The 2022 Implementation Plan yielded favorable outcomes across multiple focus areas, despite the unprecedented challenges presented by the COVID-19 pandemic. Overall, we made measurable progress toward our goals. Notably, mental health visits through our CPC+ initiative demonstrated consistent growth across most quarters, even during periods when many patients were hesitant to seek in-person care. In the area of Healthy Behaviors, we successfully met our goal of establishing three additional community garden sites, promoting urban gardening and raising awareness about the importance of healthy eating. We also achieved a significant reduction in the number of opioid doses administered across The Christ Hospital Health Network. This progress can be directly attributed to the ongoing efforts of our Opioid Task Force and the implementation of enhanced monitoring of prescribing practices. Additionally, we strengthened our partnership with The Center for Respite Care, ensuring that our most economically and socially vulnerable patients receive continued support and medical care after discharge. Despite the challenges of a global pandemic, we are proud of the meaningful impact achieved through our 2022 Implementation Plan and remain committed to building on this progress in the years ahead.

	Actions	Status
ACCESS TO CARE & SERVICES	Stand up a community cardiovascular clinic in partnership with St. Vincent DePaul to reduce the number of recurring heart related appointments and relatedly reduce the number of deaths from heart disease in the community.	Achieved
	Access to treatment and prevention through the hospital behavioral and mental health Outpatient program.	Achieved through integration of Behavioral Health Counselors in the Primary Care setting
	Become “Mama Certified” so that we continue to address Infant and Maternal mortality within our community.	Achieved
HEALTH RELATED SOCIAL NEEDS	Stand up a formal SDOH screening program in partnership with Aunt Bertha to increase capture of SDOH for primary care patients.	Achieved through, Implementation of annual SDOH screening for all patients in the Primary Care setting with referrals made through FindHelp (formerly Aunt Bertha) Technology
	Expanded access to and referrals to Community-Based Organizations to help stabilize a patient’s socially determined circumstances.	Achieved through FindHelp Technology Implementation, inclusive of closed loop referral coordination
	Prioritize the people and places experiencing significant health disparities and inequities Minority Community Members (black, Asian American, Indian Native), Military (active and veteran), LGBTQ+ individuals, Under insured and uninsured.	Achieved through Care Management Team patient assessment and collaboration with payer partners to provide identified resources
WORKFORCE PIPELINE AND DIVERSITY	Stand up a formal training program and pipeline with an established with a Community Based Organization to reduce vacancy rates for key entry level roles (i.e., Medical Assistants and Phlebotomists)	Achieved in collaboration with The Christ College of Nursing by developing a Medical Assistant and Radiology Technician program. Partnership with Cincinnati Works/NEST program serves as an internal resource for training and career advancement.
	Establish a formal interviewing process that includes a diverse candidate pool and panel interview for management and above roles	Achieved through partnership with national talent acquisition partners to diversify candidate pool for leadership roles
	Provide incumbent worker training program opportunities, apprenticeships, and scholarships to assist employees in advancing education and careers in healthcare.	Achieved through partnerships with local higher learning institutions and internal program development by the workforce optimization team
	Career exploration and work-based learning to include training experiences like an internship required for a credential or entry into an occupation, a clinical experience, or other paid or non-paid work experience.	Achieved through partnerships with local higher learning institutions, Healthcare in One Day Program,