regional
community
health
needs
assessment

2021

Executive Summary

Vision of Health

We envision a region where everyone has the opportunity to be healthy. To achieve this vision, our region is working on eliminating health disparities by embracing community voice, investing in trusted partnerships, and implementing evidence-based strategies and best practices to achieve equitable health outcomes for all.

About the Regional CHNA

The 2021 Community Health Needs Assessment (CHNA) is a comprehensive, data-driven, and actionable review of the health of our region. Specifically, this regional, collaborative CHNA provides a summary of:

- The most prevalent health conditions in our community and conditions for which people most commonly did not receive treatment in past year,
- The social determinants of health (SDOH) that impact these poor health outcomes, and
- The systemic barriers that influence health disparities and inequities for our community members.

Because physical, environmental, and behavioral factors greatly impact health conditions, this CHNA focused on the SDOH and the underlying structural barriers influencing the SDOH that impact the health of community members.

The Region's Top Priorities

- Increase **access to services** in order to improve equitable outcomes for the region's top health needs: **behavioral health, cardiovascular disease, dental, and vision**.
- Address access to and use of resources for **food and housing**, with a focus on the development and strengthening of partnerships between providers and community-based organizations.
- Strengthen **workforce pipeline and diversity**, including cultural competence within the healthcare ecosystem.

Tri-State Region

Health Conditions Most Prevalent and Commonly Untreated in Past Year

- **Cardiovascular-related Conditions** (i.e., hypertension)
- **Mental Health** (i.e., Anxiety and Depression)
- **Dental**

Other Prevalent Health Conditions

- **Arthritis**
- **Lung/Respiratory Health**
- **Maternal Health Concerns**
- **Prevention-related Health Needs**

Other Conditions Commonly Untreated in Past Year

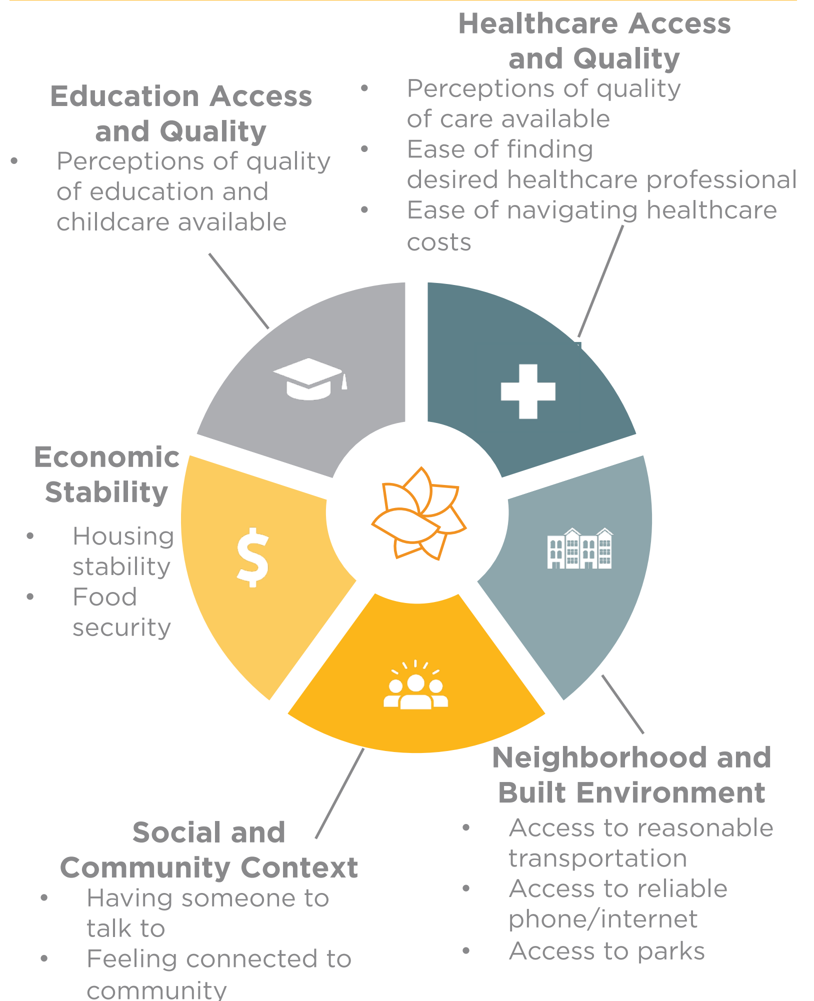
- **Vision**
- **Allergy**
- **Arthritis**
- **Maternal Health Concerns**

Populations Experiencing Significant Disparity Related to Multiple SDOH:

Individuals who identify as:

- Black/African American
- American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander or another race (other than Black, multi-racial or White)
- Individuals with lower levels of education
- Individuals with disabilities
- Individuals without health insurance
- Veteran or active-duty

SDOH Driving Regional Health



Systemic Barriers to Improving Health in the Region

- Structural racism
- High-cost healthcare system
- Structural divide between care systems

Structural Barriers to Improving Health Throughout the Region

- Limited diversity in workforce
- Lack of cultural relevancy
- Lack of effective cross-sector collaboration
- Community member distrust in the healthcare ecosystem

Next Steps

The 2022-2024 Regional Community Health Improvement Plan (CHIP) will align with state and national priorities to achieve a shared vision of improved health for the region. Targeted strategies will be developed by a group of collaborative stakeholders to achieve universal regional health goals. The CHIP will provide an actionable roadmap of evidence-based strategies that cross sectors to address the top health needs and priorities as identified in the CHNA and can be implemented by hospitals, local health departments, community health centers, community-based organizations, and additional sectors in our community.

How the Regional CHNA was Developed

This collaboration was facilitated by The Health Collaborative (THC), in partnership with the Greater Dayton Area Hospital Association (GDAHA) and includes partnership with **36 hospitals, 22 health departments, across 26 counties in Greater Cincinnati and the Greater Dayton Area, southeast Indiana, and northern Kentucky**. The success of this CHNA is a result of the collaboration from local community champions, and strategic partners throughout the region who helped with community engagement and data collection efforts.

Data collection, analysis, and synthesis conducted by Measurement Resources Company (MRC) and subcontractor Scale Strategic Solutions. A comprehensive, inclusive, and balanced mixed-method approach, and best practices in community engagement, were used in data collection to ensure a representative sample of community members, specifically the voices of marginalized populations and the inclusion of providers across health and social services sectors.

The entire process was overseen by an Advisory Committee of 41 members of the community, representing hospitals, public health departments, federally qualified health centers, community-based organizations, public health professional associations, funders, and hospital associations.

Data Collection Results

8,321
online community survey respondents

859
health and social service provider survey respondents

38
interviews with system leaders

51
targeted focus groups

extensive review of current literature and existing community data