Bethesda Butler Hospital

2019 Community Health Needs Assessment

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Community Health Needs Assessment 2019
Bethesda Butler Hospital

Introduction

TriHealth, Inc. and its hospitals joined thirty-one (31) other hospitals in the Greater Cincinnati-Dayton region to sponsor and fund a comprehensive Community Health Needs Assessment (CHNA) Report – the SW Ohio, N Kentucky SE Indiana Community Health Needs Assessment Report 2019 that spans twenty-five (25) counties. The Regional CHNA Report covers Greater Dayton and Greater Cincinnati, which includes Northern Kentucky and Southeastern Indiana. The 2019 CHNA Report shares data for the whole region as well as detailed county-level data. It also added the voice of the Southwest Ohio members of the Association of Ohio Health Commissioners. Developing a broad CHNA helps fulfill the State of Ohio's requirement mandating that health departments and hospitals align their assessments starting in 2020. As a result, the CHNA team has researched more secondary data measures, included hospital utilization data, oversampled vulnerable populations, and engaged more participants. A total of 1,416 people or organizations completed a survey or attended meetings. A key component of the increase was due to local health departments helping to promote and conduct meetings.

There were five different types of source materials: Meeting responses; Consumer survey responses; Agency survey responses; Health Department survey responses; and secondary data for up to 142 publicly available measures. Regional priorities were determined by the number of votes in community meetings, the number of mentions on surveys and data worse than state or national data, trending in the wrong direction, and impacting most of the region's counties (secondary data). This work was also parsed into county specific priorities using the same inputs for each county. The county specific reports comprise the main appendix of the Regional CHNA.

This TriHealth CHNA Report is for Bethesda Butler Hospital ("BBH"). BBH is a general, acute care hospital, located at 3125 Hamilton-Mason Road, Hamilton, Butler County, Ohio 45011. In addition to inpatient care, BBH provides surgery, cardiology, imaging, physical therapy and sleep studies, just to name a few of our services. With operating rooms, endoscopy suites, procedure rooms and a full-service emergency department, the BBH is complemented by additional services and physician offices for primary care, pediatrics and specialty care on campus. BBH is one of four TriHealth hospitals to receive an **'A' for Patient Safety in the Fall 2018 Leapfrog Hospital Safety Grade**. Bethesda North, Good Samaritan, McCullough-Hyde Memorial Hospital and BBH each received the highest mark for their efforts in protecting patients from harm and meeting the highest safety standards in the U.S.

This 2019 CHNA report for BBH is based on the collaborative Regional CHNA Report for the larger region. It will (i) document the Regional CHNA as it applies to Butler County, the primary service area of BBH; (ii) describe the means in which the assessment was taken and data formulated; (iii) describe the significant community health needs identified in the BBH footprint; and (iv) describe the resources available to meet the needs identified. Whereas this report specifically addresses BBH's community, at the same time, it must be noted that several other parts of the TriHealth, Inc. health system provide community benefit programs that are not necessarily included in this report.

For a copy of this CHNA report at no charge, please contact TriHealth Mission and Culture, 625 Eden Park Drive, 9th Floor, Cincinnati, Ohio 45202.

Written comments on this CHNA report and related implementation strategy may be provided to Reverend Frank Nation, Vice President Mission and Culture OR CEO, TriHealth, 625 Eden Park Drive, 9th floor, Cincinnati, Ohio 45202.

Any written comments received will be considered in conducting the next CHNA.

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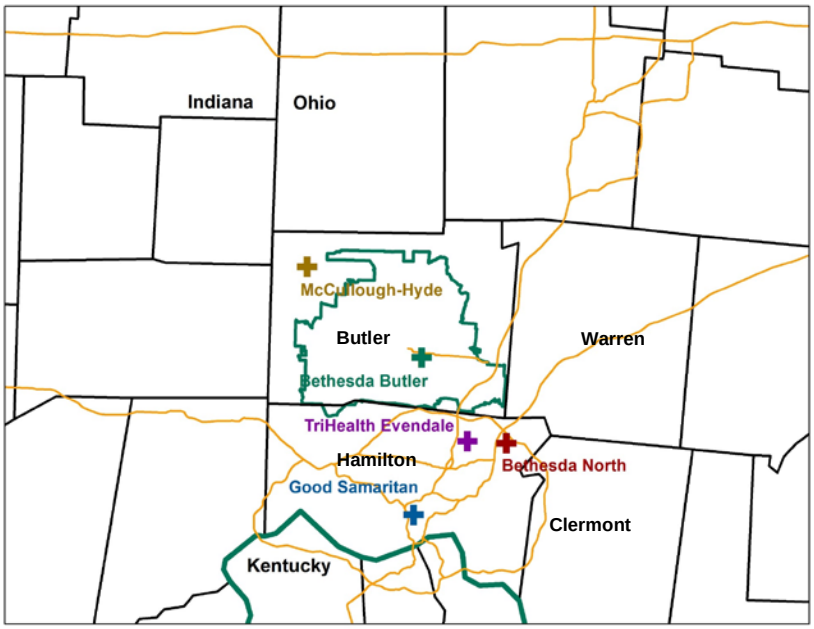
Hospital Service Area

The serviced community for BNH was defined by evaluating the patient origin of BNH's inpatient, ER and outpatient surgery volume. BNH derives more than 90% of its inpatient visits from Butler County Ohio.



Process and Collaborating Partners

BNH/TriHealth and other nonprofit hospitals in the Greater Cincinnati region combined their efforts and resources to produce a comprehensive and collaborative Community Health Needs Assessment (CHNA), the Regional CHNA. Each participating healthcare system designated a representative to join the CHNA Committee. They signed an agreement with their respective member organizations, The Health Collaborative in Cincinnati, to create the process and produce a report. The Southwest District of the Association of Ohio Health Commissioners (AOHC) partnered in the effort. They also provided representatives who could speak on the behalf of the Ohio counties served by the hospitals. All county-level public health departments completed surveys, including some city health departments. The health departments in Southwest Ohio provided additional support, such as secondary data collection and hosting community meetings. In partnership with the Southwest District of the AOHC, all 23 health departments were involved as well as the Northern Kentucky Health Department. Please refer to Chapter 1 of the Regional CHNA for a list of collaborating partners. :**http://healthcollab.org/wp-content/uploads/2019/02/2019-CHNA-Report-2-7-19.pdf**.

Community input was obtained from all required sources, using the processes described in the next section "Description of Methods".

Hospitals

The hospitals agreed to the following:

- Identify a single point-of-contact as a representative on the CHNA Committee;
- Attend quarterly CHNA meetings or send a delegate;
- Participate in planning and design;
- Distribute invitations (by mail, email, in person, social media, and/or on bulletin boards) two weeks in advance of a scheduled meeting; and
- Provide feedback on the draft report.

Public Health Departments

AOHC represented its members by:

- Identifying the Southwest District Director as the single point-of-contact for communication and coordinator;
- Attending the quarterly CHNA Committee meetings;
- Forming an ad hoc working group and convening the region's public health epidemiologists; and
- Sharing minutes and sign-in sheets from meetings.

CHNA Team

The Health Collaborative ("THC") staff included: Angelica Hardee, PhD, Senior Manager, Gen-H; Colleen O'Toole, PhD, Chief Administrative Officer; Jason Bubenhofer, Manager, Business Intelligence; Emily Kimball, Coordinator, Gen-H; and Lisa Sladeck, Office Manager and Event Administrator. The staff of the Greater Dayton Area Hospital Association included: Shawn Imel, Director, Health Information Technology; Marty Larson, Executive Vice President; and Bryan Bucklew, President and CEO. The Health Collaborative and the Greater Dayton Area Hospital Association contracted with Gwen Finegan as the Lead Consultant. Her team included: Sadie Healy, MPH; Tomika Hedrington, MHRD; Robyn Reepmeyer, MPH; and Amelia Bedri.

Contracted Consultants

Bricker & Eckler LLP/INCompliance Consulting, Jim Flynn and Christine Kenney – located at 100 South Third Street, Columbus, Ohio 43215. Bricker & Eckler LLP / INCompliance Consulting was contracted to review this CHNA report. Jim Flynn is a partner with the Bricker & Eckler's healthcare group, where he has practiced for 28 years. His general healthcare practice focuses on health planning matters, certificates of need, nonprofit and tax-exempt healthcare providers, and federal and state regulatory issues. Mr. Flynn has provided consultation to healthcare providers, including nonprofit and tax-exempt healthcare providers as well as public hospitals, on community health needs assessments. Christine Kenney is the director of regulatory services with INCompliance Consulting, an affiliate of Bricker & Eckler LLP. Ms. Kenney has more than 39 years of experience in healthcare planning and policy development, federal and state regulations, certificate of need regulations, and Medicare and Medicaid certification. She has been conducting CHNAs since 2012, providing expert testimony on community needs and offering presentations and educational sessions regarding CHNAs.

Gwen Finegan Consulting Services, Gwen Finnegan, Principal – located at 4388 Innes Avenue, based in Cincinnati, Ohio. She is an experienced writer and consultant with expertise in the areas of strategic planning, organizational development, community input, and meeting facilitation for healthcare and other nonprofit organizations. She worked for ten years at Mercy Health and was responsible for Community Health Needs Assessments for their six hospitals in 2013. Since 2015, she has been responsible for designing and executing collaborative Community Health Needs Assessments for

hospitals in the Greater Cincinnati and Greater Dayton regions. She also helps develop strategies for improvement and transformation for regional hospitals. She serves as an education consultant and instructor with Mobile CE, where she teaches a virtual course, “Community Health,” in their national Community Paramedic Clinician program. She teaches “Health Data Management” at Xavier University in Cincinnati. She attended the University of Pennsylvania and has a degree in Strategic Organizational Leadership from Wilmington College.

Description of Methods

For the Regional CHNA’s design, the process for gathering primary data, and the process for identifying, collecting, interpreting, and analyzing secondary data, the consultants referenced numerous methods for both qualitative and quantitative data. The consultants sought data that reflected recent as well as emerging issues by people who lived in the hospitals’ service areas, with attention to vulnerable populations and social determinants of health. Secondary data provided information about demographics, health conditions, and health-related issues as of 2016. Primary data reflected the opinions and attitudes of individuals and agencies motivated to attend a meeting or complete a survey. Their passion and level of interest is helpful to hospitals who are contemplating future programs that depend on community support. While not designed to be statistically representative of all 3.3 million residents of the region, there was often remarkable alignment among the top 5-10 priorities from meetings, individual surveys, agency surveys, and health departments. Here is a brief description of the activities and tools utilized most often.

- Analysis of priorities to identify areas of consensus from all data sources
- Communication by email and letter to past and prospective meeting attendees
- Community meetings that included a visual, interactive, and collective multi-voting exercise (3 dots) to identify the top three priorities of residents
- Community Need Index
- Comparison of most frequent topics by geographic area and across data sources
- Consultation with topic experts (i.e., epidemiology, air quality, public health)
- Design and feedback meetings with hospital and health department representatives
- Discourse analysis to categorize and analyze key concepts and topics in all collected responses
- Geographic Information System (GIS) mapping program to identify compelling data and represent data visually
- Marketing materials for hospitals, health departments, and meeting hosts to use or adapt
- Meeting sites, with refreshments, in convenient locations that were welcoming, accessible, and perceived as community asset or resource
- Online databases for researching accurate and reliable data
- Oversampling with vulnerable populations and the general public, including focus groups, use of interpreters and translators, and surveys administered one-to-one in person and via tablet
- Proofreading at least twice of secondary data entry for accuracy and consistency
- Regular communication with hospital and health department representatives
- Review of reports and publications on health, and health-related, topics
- Scripts, handouts, and supplemental materials provided to trained facilitators and scribes
- Shared data at meetings in form of County Snapshots and Community Need Index maps
- Standard set of stakeholder questions (for individual, agency, meeting, health department)
- SurveyMonkey (Gold) for tracking responses at meetings, from interviews, or on surveys, and use of feature to create custom tags for each response
- Tabulation of responses by geographic area and region-wide and for immigrants, children, and urban residents
- Team approach with diverse consultants

- Training, in person and via webinar, for CHNA Team, health departments, hospitals, and nonprofits interested in facilitating and scribing for supplemental meetings to target sub-populations or sub-county geographic areas. This ensured consistent facilitation, process, and recording of meeting comment and priorities.
- Trend analysis that considered local data measures worse that state and/or U.S. measures and/or trending worse than prior years
- Word count to determine frequent categories and to identify dominant topic within a category (e.g., how many times 'heroin' was mentioned within 'Substance abuse' category)

Primary Data Sources

Almost 1,300 people had an opportunity to identify and prioritize health and health-related issues at a meeting or by survey. Twenty-three (23) county- or district-level public health departments responded by survey, and the CHNA Team also received survey responses from 5 city-level health departments. Ninety-six nonprofit organizations completed surveys, and they served residents in every county. Total response far exceeded the level of response experienced three years earlier for the 2016 CHNAs in Cincinnati and Dayton. Primary data was obtained, with a uniform set of questions, via the following:

- There were 42 meetings, held in 23 counties during May – July 2018, which attracted 463 representatives of community organizations, the general public, and/or members of medically underserved and vulnerable populations—to identify barriers to care, give input for current needs assessment, prioritize issues, and identify resources to address health and health-related issues.
- Online surveys of individuals (828), agencies (96), and public health departments (28) throughout the region from June through August 2018.

BBH has not received written comments from the public regarding the 2016 CHNA or its related implementation strategy.

Community Meetings

Outreach

Any individual or agency representative who gave their address during the 2013 or 2016 CHNA process was added to an invite list, and THC mailed them an invitation to the meeting scheduled in their county. The consultants added nonprofit organizations in each county that had either a phone number, street address, or email. THC sent 544 emails and 376 letters by first-class mail. The consultants made phone calls to agencies that had not previously attended a CHNA meeting as well as to strategic organizations that serve vulnerable populations and/or have a broad reach, e.g., United Way. They followed up with emails. THC sent flyers to hospitals and to meeting host sites for posting and distribution. The consultants also posted upcoming meetings every two weeks in the Interact for Health e-newsletter: Health Watch, which is emailed across 20 counties. The consultants sent flyers to public health departments to post and distribute. Some health departments publicized meetings on their social media pages and held additional meetings. There was a 229% increase in meeting attendance, from 202 for the 2016 cycle to 463 for the 2019 cycle. Part of the increase in attendance is due to the outreach and supplemental meetings held by health departments. Appendix **1** includes a list of meeting attendees and the organizations each represents.

Purpose of Meetings

The purpose of the meetings was to solicit public input. The desire was to attract individuals or nonprofit organizations with experience or knowledge to share, especially on emerging issues not captured by

the secondary data and from the perspectives of medically underserved, minority, and/or low-income populations. The objectives were to:

- Share county-level highlights from the secondary data (and city-level for Cincinnati Health Department meetings)
- Gather diverse people to share their ideas -- general public and community leaders
- Receive input from agencies that represent vulnerable populations
- Hear concerns and questions about existing health/health-related issues
- Obtain information about financial and non-financial barriers to health care
- Identify resources available locally to address issues
- Obtain insight into local conditions from local people
- Discover health and health-related priorities of attendees

Meeting Facilitation

A group of 2-3 consultants went to each meeting, depending on the number of RSVPs. Each meeting followed the same format and agenda. Refreshments were served, and nametags were used to generate a welcoming atmosphere. Locations were selected for convenience, access, and trusted reputation in the community. The facilitator first shared general Tristate and state-specific health and health-related data to provide context. The survey questions were used, but the first question – about most serious health issues – was asked separately. This technique was intended to capture first thoughts without an opportunity to be influenced by the more specific county-level data or by other attendees. After the first question, the consultants (a meeting facilitator and at least one scribe) shared a profile of the county, including a summary of secondary data. The meetings lasted 90 minutes, of which 60 minutes was devoted to the group's brainstorming. At the end, each person was given 3 colored dots. They placed the dots next to issues they prioritized as most important health conditions or needs of the community. The agenda handout contained links to the surveys.

Surveys

The consultants developed three types of surveys: Individual Consumer; Agency; and Health Department. The questions remained the same for each survey. The agency surveys were pushed out via email as well as the link was shared at the Community Meetings. The Health Department version also requested the qualifications of the respondents, as required by the IRS The Individual Consumer survey was also translated into Spanish and adapted for mobile application at community events. The consultants used SurveyMonkey to collect responses, tabulate data, interpret and analyze results, and create categories to track key words and phrases. Paper copies (translated) were used with Spanish-speaking families, refugees from Rwanda, and at treatment facilities. TriHealth Outreach Ministries gave 40 $10 Kroger gift cards as incentives to the Spanish-speaking community health workers and the community health worker working with the French-speaking refugees from Rwanda (who asked the questions in French but recorded the answers in English). Both TriHealth Outreach Ministries and Santa Maria Community Services provided the answers already translated into English for the consultants. A total of 113 immigrant surveys were completed and returned. See Appendix **2** for the survey respondents who identified themselves. Appendix **3** is a list of health department respondents with their qualifications.

Analysis of Primary Data

The primary data collection and analysis used the narrative method and specifically the technique of discourse analysis. The focus was on collecting data from individuals based on their experience. There were several important steps to ensure a consistent process:

- Verbatim entry of comments – this happens automatically with the online survey process and scribes were trained to do this at the community meetings

- Creating custom tags to summarize each response, e.g., cancer, diabetes, heart disease
- Creating themes that connect some of the tags, e.g., Chronic disease
- Proofreading each other's tags and analysis, with review by at least 3 different people to ensure overall consistency
- Use of SurveyMonkey's 'Gold' level enabled the creation of custom tags and initial sorting. It also provided a consistent way to compare survey results with meeting responses. It worked for face-to-face verbal encounters, such as in meetings, as well as written responses. Comments made in person were entered into SurveyMonkey, tagged, and themes identified. The lead consultant customized the tagging in SurveyMonkey because she found that its automatic grouping of ideas was not precise enough and could not account for context or adapt when responses used different words for similar concepts.
- Reviewing tags at the county-level, urban level, and regional level was done to ensure that the tags and themes made sense and were applicable at all levels. For example, the consultants created tags for 'addiction,' 'heroin,' 'meth' as subsets of the 'Substance abuse' theme, because of their apparent frequency at the beginning of the tagging process. They counted each tag and saved the count, but none of these tags reached high enough numbers (more than 5% of mentions) to warrant its own category in the final analysis.
- SurveyMonkey's filter options facilitated the process of sorting and analyzing by county, by groups of counties, by type of survey, and/or by sub-population. This is a useful option to consider context or culture, such as urban respondents or Latino respondents.

Many responses addressed multiple topics; each new idea was tagged. The review process included verifying that each distinct comment, or 'mention,' was tagged once. For example, if smoking was clustered under the 'Healthy behaviors' theme, then it did not appear as its own category. If transportation was mentioned in more than 5% of all mentions, then it might become its own category, especially if this pattern were evident in a majority of counties. Otherwise it was counted under 'Access to care/services.' This method is known as discourse analysis, used with qualitative results (e.g., written narrative, conversations, focus groups). The tool is becoming more widely applied in health care.

Each County Profile contains a "Consensus on Priorities" described by the different types of stakeholders. For the community meetings, the top votes (measured by number of dots) determined the priorities. For the survey results, the regional priorities were the issues receiving the most overall mentions. At the county level, the priorities were sorted by county of residence/service. The threshold for including a priority was 5% or more of all mentions, or at least two mentions.

Secondary Data Sources

Data Collection

County Health Rankings (CHR) formed the foundation for data collection with its county-level focus on health outcomes, health factors, health behaviors, quality of life, clinical care, physical environment, and socioeconomic factors. Additional sources supplemented the CHR data. Publicly available health statistics and demographic were obtained at the state and county level. The epidemiologists for Public Health - Dayton & Montgomery County (PHDMC) volunteered to collect data for the State of Ohio and its counties. They included data through 2016. Ohio's 2017 data was not available in time for this report. The number of data measures increased by 33%, from 106 in 2016 to 142 in 2019.

Data Sources

The standards for researching and including data were:

- Comparable (measures with benchmarks such as Healthy People 2020 or state/national rates)

- County-level data (ZIP Code level preferred but rare)
- Focus on health outcome data (preferred over subjective survey data when both were available)
- Reproducible (new update available within three years or at 3-year intervals vs. one-time)
- Reputable source
- Trend data available (more than one data point; 3-5 years preferred)

The CHR was an excellent starting point, but the consultants discovered additional sources with more recent data as well as indicators for measures not collected by CHR. The prevalence of certain cancers, the rapid increase of heroin overdose deaths in the region, and additional mortality data are examples of supplemental data. Many excellent sources of information did not have a breakdown below the state level or did not include the entire region. The consultants contacted state health departments, local health departments, and local experts. The biggest change from the prior cycle is that the Department of Health and Human Services no longer maintains the Health Indicators Warehouse as an online source, and it had provided data for eight key measures. PHDMC epidemiologists consulted the Ohio data for data ranges ending with 2016 and one period prior. The data sources and dates are listed below.

- American Community Survey (5-year estimate 2012-2016)
- Area Health Resource File provided by RWJF 2018 County Health Rankings (2014, 2015, 2016)
- Business Analyst, Delorme map 2016 data, ESRI, U.S. Census provided by 2018 County Health Rankings
- Cancer Incidence: Ohio Department of Health, Ohio Cancer Incidence Surveillance System, 2014-2015
- Cancer Incidence: Ohio Department of Health, Ohio Cancer Incidence Surveillance System, 2014-2015. Population: Bridged-Race County Population data from National Center for Health Statistics (NCHS), Ohio Department of Health, 2014-2015.
- Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (2011, 2013, 2014, 2015, 2016)
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. 500 Cities Project Data 2016
- Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2016 on CDC WONDER Online Database, released December 2017 (2011-2016)
- Centers for Disease Control and Prevention's Division of HIV/AIDS Prevention
- Centers for Disease Control and Prevention's national HIV surveillance program
- Centers for Medicare & Medicaid Services, National Provider Identification provided by RWJF 2018 Community Health Rankings (2015, 2016, 2017)
- County Health Rankings 2018 - American Community Survey, 5-year estimates
- County Health Rankings 2018 - Area Health Resource File/American Medical Association
- County Health Rankings 2018 - Area Health Resource File/National Provider Identification File
- County Health Rankings 2018 - Behavioral Risk Factor Surveillance System
- County Health Rankings 2018 - Bureau of Labor Statistics
- County Health Rankings 2018 - Centers for Disease Control and Prevention Diabetes Interactive Atlas
- County Health Rankings 2018 - National Center for Education Statistics
- County Health Rankings 2018 - National Center for Health Statistics
- County Health Rankings 2018 - National Center for HIV/AIDS, Viral Hepatitis, STD, and TB prevention
- County Health Rankings 2018 - National Highway Traffic Safety Administration, Fatality Analysis Reporting System
- County Health Rankings 2018 - Small Area Income and Poverty Estimates

- County Health Rankings 2018 - U.S. Census Bureau's Small Area Health Insurance
- Dartmouth Atlas of Healthcare (2013, 2014)
- ED Facts provided by RWJF 2018 County Health Rankings (2012-2013, 2014-2015)
- Environmental Protection Agency. Air Quality System Monitoring Data. State Air Monitoring Data. (2015, 2016)
- Federal Bureau of Investigation (FBI), Uniform Crime Reporting (UCR), Crime in the United States. (2012-2014, 2015)
- Feeding America, Map the Meal Gap. (2014, 2015)
- Greater Cincinnati Community Health Status Survey (2017)
- National Center of Education Statistics (NCES) provided by RWJF 2018 County Health Rankings (2014-2015, 2015-2016)
- National Highway Traffic Safety Administration, Fatality Analysis Reporting System. (2010-2014, 2011-2015)
- Ohio Department of Health 2016 State Health Assessment
- Ohio Department of Health, HIV/AIDS Surveillance Program. Data reported through 6/30/17 for 2016 and 2015.
- Ohio Department of Health, STD Surveillance Program. Data reported through 5/7/2017 for 2016 and 2015.
- Ohio Department of Health: Center for Public Health Statistics and Informatics. Ohio Public Health Information Warehouse. (2012-2014, 2014-2016)
- Ohio Department of Health, Death Certificates (2012-2014, 2015-2016)
- Ohio Emergency Medical Services; Naloxone Administration by Ohio EMS Providers. (2014, 2017)
- PreventionFIRST! Student Drug Use Survey, through 2017
- U.S. Census Bureau, 2010 Census
- U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
- U.S. Census Bureau, County Business Patterns (2014, 2015)
- USDA Food Environment Atlas (2010, 2015)
- U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
- U.S. Census Bureau, County Business Patterns
- U.S. Census Population Estimates
- Uniform Crime Reporting - FBI
- USDA Food Environment Atlas

Analysis of Secondary Data

After assembling data worksheets for up to 142 measures per county, the consultants applied the following criteria to determine the most significant health needs:

- Top causes of death
- Worsening trend
- Lagging national and state measures, and
- To a lesser extent, falling behind a Healthy People 2020 target

Secondary data was prioritized at the county and regional level. The county-level priorities were the data points that met the criteria of being worse than the state and/or national measures and also trending in the wrong direction. The priorities were sorted for analysis by county. For comparison purposes, priorities were rank ordered with the top priority listed first in the Secondary Data column.

Findings

Priorities for Hospital Service Area

Below is a summary table of the priorities by county and by data source. These county priorities were extracted from the appendix and body of the Regional Health Needs Assessment as per the above paragraph.

Summary of Priorities for Butler County

County	Meetings	Consumers	Agencies	Health Depts.	Secondary Data
	(in desc. order)	*(in desc. order)*	*(in desc. order)*	*(not in order))*	*(not in order)*
Butler	Substance abuse Mental health Access to care Tie: Healthy behaviors & Obesity	Substance abuse Chronic disease Mental health Infant mortality	Substance abuse Infant mortality SDHs Tie: Mental health; Chronic disease; & Access to care	Obesity Tie: Addiction, Infant mortality, Health education & Smoking	Diabetes % Cancer Mortality Lung Cancer Mortality

SDH=Social Determinants of Health

County Profiles

Appendix **4** to this report is the county profile for Butler County. The profile summarizes the common themes expressed in Butler County.

Progress on 2016 Areas of Focus

During the 2016 Community Needs Assessment process, the significant health needs for BBH's community served were prioritized as follows and action items for each identified in the related implementation strategy for 2017,2018 and 2019:

1. Substance abuse/mental health – Indicated as concerns in all four counties, high overdose death rates in three of four counties and high suicide rates in Clermont County
2. Infant mortality/Maternal Health –High infant mortality rates in Hamilton and Butler counties, indicated as a concern in Butler county focus group and surveys, and high child poverty rates and teen pregnancy in Hamilton county
3. Obesity – Indicated as a concern by focus groups and survey results in all four counties
4. Cancer – High mortality rates in three of four counties, low mammography screening in Clermont and Warren counties, and indicated as a concern in Butler and Warren counties

1. Substance abuse/mental health - In response to the escalating opioid addiction epidemic in the market served, GSH and TriHealth system engaged the community in an organized and focused set of tactics to address this. Since October 2017, the TriHealth Opiate Steering Committee and the GSH Opiate Pilot have focused on five key areas: Prevention, Treatment, Funding, Community Partnerships and Team Member support. The focus on key areas has helped build the

infrastructure necessary to provide treatment not only at Good Samaritan Hospital but to expand key initiatives to other TriHealth hospitals.

Prevention

- Narcan Distribution: Narcan serves to block the effects of opioids in case of an accidental overdose. Since January 2019, Narcan is available at all the TriHealth hospital pharmacies, including BBH. Narcan education has been provided to all Pharmacy team members, nurses and Emergency Department team members. TriHealth has committed to $100,000 a year towards this community effort.

Treatment

- Substance Use Treatment Coordinators (SUTC): this is a new role (RN/SW) at GSH inpatient services. A SUTC has specific substance use training, certification and experience in substance use disorders (alcohol, opiates etc.). Between Jan 2018 and December 2018, over 1100 patients have been screened for substance use disorders at Good Samaritan Hospital. The role of the SUTC is to engage, assess and provide an appointment to a treatment program within 24-48 hours after discharge. In collaboration with community partners such as the Addiction Services Council, BrightView, Talbert House Engagement Center, GSH connected over 65% of patients into substance use treatment. Of those, > 65% have appointments within 24 hours, 13% within 48 hours. In addition, 1-5% of patients are referred to a mental health agency each month.

- In December 2018, TriHealth expanded the role of the Substance Use Treatment Coordinator ("SUTC") to Bethesda Butler Hospital through a state grant.

- In 2019 TriHealth expanded the program for ER patients with Substance Use Disorders by adding a Peer Recovery Specialist (defined as a person in sustained recovery) to reach out to patients that might otherwise be reluctant to enter into recovery.

- Tracking Outcomes: The Task Force is finalizing an Opioid Dashboard to track outcomes such as utilization of substance use withdrawal management order sets, Buprenorphine induction (medication used to treat opiate addiction), Narcan dispensing etc. This allows us to monitor the effectiveness of our initiatives.

Behavioral Health Intake – Patients in BBH Emergency Room who need to be admitted have access to a 24/7 intake line.

- Expanded to 24 hr/ 7day operation in 2018
- Responsive to all emergency departments within TriHealth
- Expanded to hospitals in the TriState

BBH through TriHealth provides financial and clinical support resources to:

- Fernside Children and Family Bereavement Center
- United Way Support
- NAMI Southwest Ohio
- Family Nurturing Center

2. Infant mortality/Maternal Health - BBH partners with an area Federally Qualified Health Center ("FQHC") called Primary Health Solutions on a program called PRIM (Partnership to Reduce Infant

Mortality), obtaining an obstetrician/gynecologist for patients that show up in BBH's Emergency Department pregnant and without prenatal care.

TriHealth and thus its hospitals partners with several organizations (providing funding and human/clinical resources) that target infant mortality and child health concerns, including:

Healthy Beginnings, which provides comprehensive pre-natal care to the underserved. TriHealth donated $100,000 in FY16; $60,000 in FY17; and $80,000 in FY18

Healthy Moms and Babes, which provides home services for both pre-natal and post-delivery support for underserved populations. TriHealth donated $125,000 (FY16), $93,000 (FY17) and $100,000 (FY18) to this organization.

TriHealth's Think First for Your Baby is a set of injury prevention programs with a goal to reduce unintentional injuries in infants under the age of one year through prenatal education and post-partum follow-up. In the past three years:

- **300 low income expectant mothers (English and Spanish speaking) reached via the Think First for Your Baby Program** (each mother provided 4 hours of hands on parenting/infant injury prevention education with individual home visit follow up for infant safety and injury prevention, as well as a car seat and childproofing kit)
  Program collaborates with 20 community and maternity clinics and outreach partners for recruitment and resources.

- **600 low income expectant mothers (English and Spanish speaking) and approximately 630 infants reached with the Cribs for Kids Program** (educated on Safe Sleep and provided a portable crib with minimal contribution towards crib from mother to assure Safe Sleep location for infant at home)
  Program collaborates with De Cavel Family Foundation for SIDS, Cradle Cincinnati, Ellies Run Foundation, Charlies Kids Foundation for mutual interest in SIDS prevention.

- **4500 preschool aged children and their parents reached via the Kiwanis Safety Rocks Head Start/preschool program and the Kiwanis Annual Health and Safety Fair** (targeted towards low income families connected to the Hamilton County Education Service Center and their Head Start sites)
  Program collaborates with SouthWest Ohio Kiwanis for Kids, Fire and Police departments, AAA, Hamilton County SAFE Communities Coalition

The outreach work envisioned in the 2016 Implementation Plans for BNH and TEH was centered on the work of the Outreach Ministry nurses. This program does not exist as it did in 2016; resources have been redeployed to Population Health and to the Good Samaritan Free Health Clinic.

Project Purple from the 2016 plan for mothers who have lost infants is no longer a program. There has been a change in focus for all TriHealth towards providing support to women who are pregnant and high risk.

Perinatal Programs and BNH OB-GYN Center team members provide the following support for women that reside in BNH and TEH service areas:

- o CenteringPregnancy groups for pregnant moms, including groups for Spanish speaking patients. CenteringPregnancy has demonstrated a 33% reduced risk of preterm birth (with an even stronger effect in African American women), reduced likelihood of suboptimal prenatal care, and higher rates of breastfeeding (Novik et al., 2017). Centering Pregnancy served 1200 BNH patients between CY16 and 18.

Other partners include March of Dimes and Sweet Cheeks Diaper Bank.

Finally, BBH also provides financial support to other organizations that focus resources on infant mortality and maternal health:

- Free Breastfeeding Support Line
- Healthy Beginnings
- Health Moms and Babes
- Think First For Your Baby
- March of Dimes
- Sweet Cheeks Diaper Bank

3. Obesity: Given the multiple factors driving obesity, BNH and TEH have focused on partnering with existing community organizations to address food/nutrition disparities in its market through Freestore Foodbank and with United Way for a broader set of actions aimed at the underlying causes of obesity. In the 2016 Community Needs Assessment Implementation Plan BBH planned to use Outreach Nurses to visit low income families but these resources were redirected to TriHealth Population Health programs (which are not targeted to the economically underserved) and to the GSH Free Health Clinic, which was experiencing strong growth.

   BBH offers free diabetes education – both classes and on line. The classes are held for up to 40 people per month on the campus of BBH.

   Bethesda Butler recently began a program with Miami University Nursing students, who see patients in the ER, screen them for social determinants of health risk factors, and refer them to community agencies as needed.

   BBH also donates – via TriHealth – funds to organizations that provide education and awareness other conditions that are related to obesity: the American Heart Association ($200,000 per year donation), $10,000 to American Diabetes Association, educational material regarding juvenile diabetes to the Juvenile Diabetes Research Foundation (touches 75,000 people per year). BBH, through TriHealth, provides financial support to exercise related public events and programs in Butler County: Hike for Hospice and Making Strides [American Cancer Society]

4. Cancer: Melanoma Know More (MKM) partnered with TriHealth Cancer Institute and the Good Samaritan Skin Cancer Center using ACS guidelines for melanoma screening and prevention. During the last three calendar years, screenings were held at various rotating TriHealth locations including BBH, open to all comers:

Melanoma Know More	**CY16**	**CY17**	**CY18**
Screenings	149	117	229
Referrals	32	23	53
Melanomas	0	0	8

There is a mobile mammography unit that did periodic screening at 3 locations within Butler County. Mammography screenings in Butler County are on the rise, with 12 in CY16, 45 in CY17 and 97 in CY18, with 5 cancers detected in the last two years.

BBH's focus on prevention is also demonstrated via in kind and financial support of Ohio Cancer Research, which is an independent, statewide, nonprofit organization dedicated to the cure and prevention of the many forms of cancer and the reduction of its debilitating effects through aggressive basic seed money research, cancer information, and awareness.

The hospital also provides financial support to the American Cancer Society.

Appendix 1: Meeting Attendees - All Organizations

First & Last Name	Organization Name	City	County
Sister Sharon Wiedmar	Mercy Health	Fairfield	Butler
Mita Patel	Butler County Health Dept.	Hamilton	Butler
Sue Haines	Butler County Health Dept.	Hamilton	Butler
Eileen Turain	Envision Partnerships (Developmental disabilities)	Hamilton	Butler
Ben Verdow	Miami University	Hamilton	Butler
Sharon Klein	McCullough-Hyde Hospital /TriHealth	Oxford	Butler
Sharman Willmore	Miami University	Oxford	Butler

Both hospitals/health systems in above list have interest in health gaps and the drivers of them, and have a history of providing care to underserved populations. The Health Department's interest is care for the economically and physically challenged as well as health issues that are widespread in the county. Miami University's interest is generally for future education and training that is needed but also as a leading corporate "citizen".

Appendix 2: Survey Respondents - Agencies

(other than Consumers or Public Health)

Organization	Populations Served	County(ies) Served
Butler County Health Department/ Health District	African American Low income groups; groups with lower educational status	Butler
Envision Partnerships	Poor	Butler
Opportunities for Ohioan's with Disabilities	Persons with disabilities, children	Butler
Cincinnati Children's Hospital	African Americans	Butler, Clermont, Hamilton
Cincinnati Children's Hospital	Children	Butler, Clermont, Hamilton, Warren
Cradle Cincinnati/Cincinnati Children's Hospital Medical Center	Poor, urban, African-American	Butler, Clermont, Hamilton, Warren
Prevent Blindness, Ohio Affiliate	High risk populations include children <5, seniors, Hispanics, African Americans	Butler, Clermont, Hamilton, Warren

Appendix 3: List of Qualifications of Health Department Respondents

Name	Title of Person Submitting	Qualifications	Health Department/District
Jenny Bailer	Health Commissioner	RN, MS, APHN-BC	Butler County General Health District
Jackie Phillips	Health Commissioner	RN, BSN, MPH	City of Middletown Health District
Kay L Farrar	Health Commissioner	BSN	Hamilton City Health Department

Appendix 4: 2019 Regional CHNA Summary

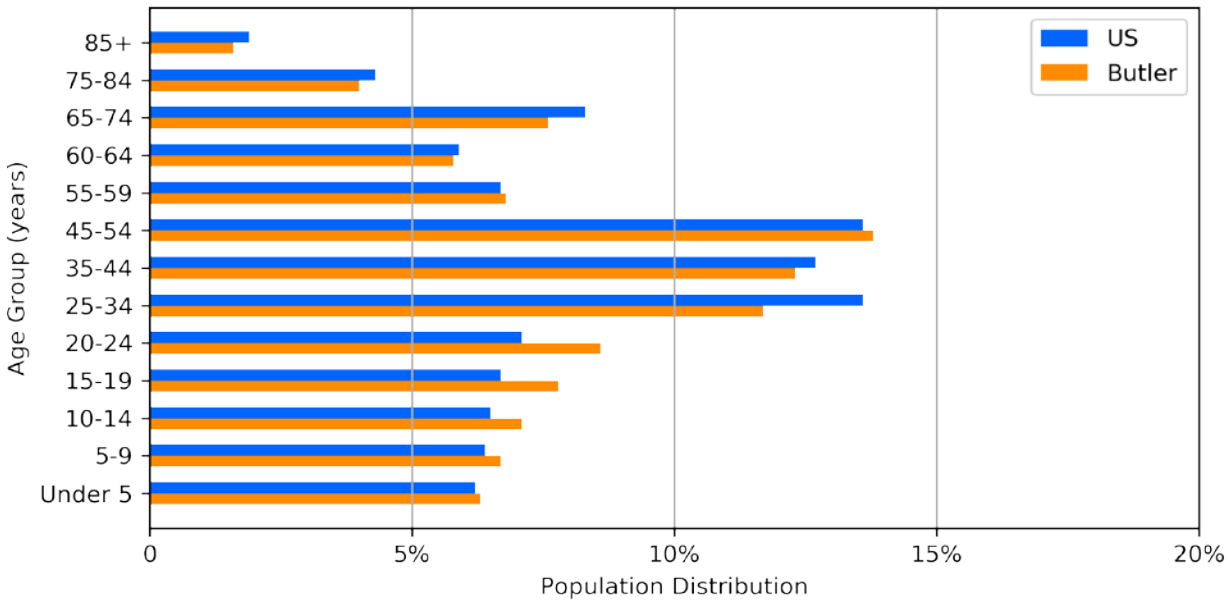
BUTLER COUNTY, OHIO

Butler County is one of the most populated counties in the region and includes the cities of Hamilton and Middletown, former hubs of industry. Many of the cities in the county are experiencing growth, and only about 9% is considered rural. The City of Oxford is located in Butler County and is home to Miami University. Of all the counties, Butler has the highest percentage of households with children (age 0-17). Rates of deaths from heroin poisoning, fentanyl and other prescription opioids are significantly higher than the Ohio and U.S. rates. The suicide rate is below the Ohio and U.S. rate, but increasing. Butler County is one of the 8 counties in the region that experienced an increase in the number of days with an increase in ozone level. There are 12 ZIP Codes in the County; 45015 in Hamilton and 45044 in Middletown have elevated Community Need Index ("CNI") scores, indicating the likelihood of health disparities.

Population Chart

The following is a population chart for Butler County from years 2012-2016.

BUTLER COUNTY POPULATION



Consensus on Priorities

Substance abuse is a major health issue in Butler County and was the top priority mentioned across all sources. Addiction and opioids were mentioned specifically. Mental health was mentioned at meetings and in the consumer and agency surveys. Infant mortality was mentioned in survey responses from consumers, agencies, and the County's health department.

Top Causes of Death

The top causes of death for Butler County for 2016 were, in descending order:

- Lung cancer
- Dementia, unspecified
- Atherosclerotic heart disease

Priorities from Community Meetings

Eleven people contributed votes to identify a total of 8 priorities. Below are the topics receiving at least 5% of votes.

BUTLER COUNTY: MEETING PRIORITIES

Priority	# Votes	% Votes
Substance abuse	11	35.5%
Mental health	7	22.6%
Access (Transportation, 2)	5	16.1%
Healthy Behaviors (Obesity, 2)	4	12.9%

Survey Responses

Below are the most frequent responses from individual consumers, living in Butler County, who completed a survey between 6/19/18 and 8/3/18. Sixty-eight people participated. Respondents all answered the question, “Given the health issues facing the community, which ones would be your top priorities?” They mentioned 91 health and/or health-related issues of particular concern to them. The following table contains the issues that received more than 5% of all mentions.

BUTLER COUNTY: CONSUMER PRIORITIES

Priority	# Mentions	% Mentions
Substance abuse (Addiction, 6 and Opioids, 5)	27	29.7%
Chronic disease (Obesity, 8)	17	18.7%
Mental health	11	12.0%
Infant mortality	6	6.7%

Eighteen organizations serving Butler County residents, especially vulnerable populations, responded with their priorities. The priorities that received more than 5% of mentions are listed below.

BUTLER COUNTY: AGENCY PRIORITIES

Priority	# Mentions	% Mentions
Substance abuse	13	26%
Infant mortality	8	16%
Social Determinants of Health	6	12%
Mental health	5	10%
Chronic disease	5	10%
Access to care	5	10%

Responses from Health Departments

Health Commissioners from Butler County, City of Hamilton, and Middletown City provided the following health priorities for the community.

BUTLER COUNTY: HEALTH DEPARTMENT PRIORITIES

	Addiction	Health education	Infant mortality	Obesity	Smoking
Butler County	1		1	1	
City of Hamilton				1	1
City of Middletown		1			

Butler County Health Snapshot

Pop.: 373,638

Measure/Indicator	County	Trend	State	U.S.
Health Outcomes				
Cancer mortality, Breast (rate per 100,000)	19.8	↓	22.2	20.2
Cancer mortality, Colon & Rectum (rate per 100,000)	15.4	↓	15.5	14.0
Cancer mortality, Overall (rate per 100,000)	168.7	↓	174.3	157.1
Chronic Lower Respiratory Disease (CLRD) deaths age 65+ (rate per 100,000)	306.3	↓	316.1	270.9
Diabetes (%)	10.9	↓	11.1	10.7
Infant Mortality (rate per 1,000 live births)	7.6	*	7.2	5.9
Injury Deaths (rate per 100,000)	83.9	↑*	61.2	45.3
Low birthweight (%)	7.8	—	8.5	8.2
Poor physical health days (last 30 days)	5.0	↑*	4.0	3.9
Poor mental health days (last 30 days)	4.9	*	4.0	3.7
Stroke Deaths (rate per 100,000)	44.0	↓*	40.6	37.5
Suicide (rate per 100,000)	12.9	↑	13.3	13.0
Health Behaviors				
Adult Obesity (%)	31.3	↑*	30.6	29.2
Adult Smoking (%)	22.2	↑*	22.0	16.5
Alcohol-impaired driving deaths (%)	38.0	↓*	34.0	30.0
Chlamydia incidence (rate per 100,000)	370.1	↑	521.6	497.3
HIV prevalence (rate per 100,000)	107.8	↑	199.5	305.2
Motor vehicle crash deaths (rate per 100,000)	9.3	—	10.3	11.5
Naloxone administration rate (per 100,000)	58.5	↑	38.4	U
Physical inactivity (%)	27.6	↑*	26.4	25.2
Violent Crime (rate per 100,000)	354.7	-	300.3	386.3
Substance Abuse/Mental Health				
Depression (%)	19.8	↓*	18.5	17.1
Drug poisoning deaths (per 100,000)	45.2	↑*	26.2	14.6
Fentanyl & related drugs overdose deaths (per 100,000)	18.8	*	9.0	2.6
Heroin poisoning overdose deaths (per 100,000)	22.9	↑*	10.9	3.5
Prescription Opiod overdose deaths (per 100,000)	24.9	*	5.9	4
Access to Clinical Care				
Dentists (ratio)	2090:1	↓	1656:1	1480:1
Diabetic screening (% HbA1c)	55.1	↓	57.4	57.5
Mammography screening (%)	69.1	↑	73.7	72.7
Mental health providers (ratio)	729:1	↓*	561:1	470:1
Primary care physicians (ratio)	1,850:1	-*	1307:1	1320:1
Uninsured (%)	7.0	↓	7.6	11.8
Socio-Economic/Demographic				
Children in poverty (%)	18.6	↓	22.1	21.2
Hispanic (%)	4.4		3.5	17.3
African-American (%)	7.8		12.1	12.3
Population that is 65 and older (%)	13.2	↑	14.5	16.0
Population below 18 years of age (%)	24.2	—	23.0	22.3

U = Unavailable, unreliable, or suppressed due to small numbers. Source data range: 2014-2017

* = Higher than state and national rates

Top Causes of Death
Lung Cancer
Dementia
Heart Disease

Drug Deaths
Rates are higher than OH and US for drug poisoning, heroin, Fentanyl & prescription opioids

Injury Deaths
Increasing & > OH & US rates

Health Behaviors
Obesity, smoking, & physical inactivity rates are worsening and > OH & US rates

Alcohol-Impaired Driving Deaths
Higher than OH & US rates

Community Need Index

A high CNI score (3.4 to 5.0) is an indicator for socioeconomic variation, barriers to care, and an increased need for health care services. Two of the County's 12 ZIP Codes exceed a score of 3.4.

Bethesda Butler Hospital

2019 Community Health Needs Assessment Implementation Plan

Mark Clement, CEO
3125 Hamilton-Mason Road
Hamilton, Ohio 45011

Tax ID # 31-0537122 (same as Bethesda North Hospital)
Date of Board approval:
Date of initial posting:

TriHealth Review

Process

In order to develop targeted strategies to alleviate problematic issues identified as needs recognized by the Regional CHNA, TriHealth assembled a system-wide internal work group who represent the programs and services that touch the underserved in the community. This group took the data from the Regional CHNA, the community–identified priority needs and their own experience with the underserved and previous programs and recommended the top community health needs for BBH and TriHealth to address.

List of committee members and meetings

- Jeremiah Kirkland, Women's Services Executive Director
- Judy Mitchell, RN, Behavioral Services Executive Director
- Candy Hart, Program Coordinator Senior Services
- Jacqui Appel, Manager TriHealth Breast Centers
- Linda Smith-Berry, Manager Good Samaritan Free Health Clinic
- Stephanie Lambers and Krista Jones, Community Benefit Consultants
- Nyota Stoker, Lead Mobile Mammography
- Jamie Easterling, Executive Director Good Samaritan Hospital
- Anne Siebert, RN, Chief Nursing Officer Bethesda Butler

This group met on March 26, 2019 to review the findings from the regional Community Health Needs Assessment that pertain to TriHealth's hospital service areas.

Criteria for decision-making.

The committee assessed the findings in light of the below criteria to come to its recommendations.

a. Opportunity to build on work already underway in partnership with other community service agencies to address community health needs
b. Potential for community partnership to form a coordinated approach to specific needs or underserved populations
c. Programs that have trackable outcomes
d. Ability to address populations or community health needs that are impactful to future health, not just immediate concerns

Based on the process described above, the significant health needs that BBH will address in the implementation strategy are as follows:

Priority Health Needs to be Addressed by BBH

1. Substance abuse - given the high prevalence in this area, the fact that current work is not completed and there are many community partners that are engaging along with TriHealth,
2. Child health/infant mortality - given the high prevalence in certain geographic areas, the fact that current work is being effective and is not completed and there are many community partners that are engaging along with TriHealth
3. Chronic disease, specifically Cancer – given system wide focus on cancer as well as an opportunity to get more people funding for their treatments through the Breast and Cervical Cancer Project ("BCCP"); and

4. Access to care – There is an opportunity to build on current smaller work that funds poor patients' access via rides to appointments, home from the ER and so forth. As TriHealth moves into more telehealth tools, video visits for home bound patients can be addressed.

Implementation Plan

1. Substance abuse/mental health - In response to the escalating opioid addiction epidemic in the market served, the TriHealth system engaged the community in an organized and focused set of tactics to address this. Since October 2017, the TriHealth Opiate Steering Committee and the GSH Opiate Pilot continues to focus on five key areas: Prevention, Treatment, Funding, Community Partnerships and Team Member support. The focus on key areas has helped build the infrastructure necessary to provide treatment not only at GSH but to expand key initiatives to other TriHealth hospitals, including BBH.

   Prevention
   - Narcan Distribution: Narcan serves to block the effects of opioids in case of an accidental overdose. Narcan will continue to be provided to all ER patients who need it without cost to the patient, and BBH will continue its education of first responders as new information arises and new responders are trained.

   Treatment
   - Substance Use Treatment Coordinators (SUTC): In December 2018, TriHealth expanded the role of the Substance Use Treatment Coordinator ("SUTC") to Bethesda Butler Hospital through a state grant. The role of the SUTC is to engage, assess and provide an appointment to a treatment program within 24-48 hours after discharge. In collaboration with community partners such as the Addiction Services Council, BrightView, Talbert House Engagement Center, TriHealth and BBH will continue to test the efficacy of this role and effectiveness at meeting these targets

   - By July 2019, TriHealth will have a response to a grant proposal it submitted to Bethesda Foundation to expand the SUTC role to Bethesda North Hospital as a platform for utilizing Telehealth for further expansion to Arrow Springs and McCullough Hyde Memorial Hospital (MHMH). MHMH also serves the Butler County population.

   - If the Peer Recovery specialist identified in the Progress Report re: 2016 Priorities is effective in reaching out to patients that might otherwise be reluctant to enter into recovery, this function will be evaluated for expansion to BBH.

   - Tracking Outcomes: The Task Force will be monitoring an Opioid Dashboard to track outcomes such as utilization of substance use withdrawal management order sets, Buprenorphine induction (medication used to treat opiate addiction), Narcan dispensing etc. This allows us to monitor the effectiveness of our initiatives.

   BBH participates in the TriHealth Behavioral Health Intake, designed to get patients to proper treatment settings and locations early – once they are in one of the TriHealth Emergency departments.
   - Expanded to 24 hr/ 7day operation
   - Responsive to all emergency departments within TriHealth

BBH through TriHealth also plans to continue its support for:

- Urban Health Project
- United Way, which funds a number of agencies that aim to get substance abusers back on their feet in society
- NAMI Southwest Ohio
- CAT Fest, hosted by the Center for Addiction Treatment (Major sponsor Alcohol and Drug Addiction Program)

2. Infant mortality – BBH partners directly with an area Federally Qualified Health Center ("FQHC") called Primary Health Solutions on a program called PRIM (Partnership to Reduce Infant Mortality), obtaining an obstetrician/gynecologist for patients that show up in BBH's Emergency Department pregnant and without prenatal care.

   In partnership with Miami University School of Nursing, BBH will continue screening of ER patients for underlying social determinants of health issues and refer them to Primary Health Solutions and/or community agencies that can help with the underlying social issues.

   BNH and TEH – through TriHealth - will also continue its long-time partnership with and funding of several organizations (providing funding and human/clinical resources) that target infant mortality and child health concerns, including;

   Cradle Cincinnati - an organization aimed at reducing infant mortality through education and awareness. Cradle Cincinnati's goals are to prevent premature births, reducing tobacco use and substance abuse, and promoting safe sleep for babies through three approaches: communications, medical, and community.

   Healthy Beginnings, which provides comprehensive pre-natal care to the underserved. Healthy Moms and Babes, which provides home services for both pre-natal and post-delivery support for underserved populations.

   TriHealth's Think First for Your Baby is an injury prevention program with a goal to reduce unintentional injuries in infants under the age of one year through prenatal education and post-partum follow-up.

   Finally, BBH through TriHealth also provide financial support to other organizations that focus resources on infant mortality and maternal health:

   - Good Samaritan Free Health Clinic
   - March of Dimes
   - Sweet Cheeks Diaper Bank

3. Cancer: BBH and TriHealth Cancer Institute will continue the targeted (melanoma, lung) free screenings and follow ups. There is a mobile mammography unit that will continue to do screening in high need areas within Hamilton county e.g. Avondale, and the city of Hamilton in Butler County.

   Patients with positive results identified at the Good Samaritan Free Health Center will continue to be referred to BNH Clinic providers and obtain coverage from state funded Breast and Cervical Cancer Prevention (BCCP) funding.

Cancer screening via the mobile mammography van will continue, with more focus on getting poor patients (below 250% of federal poverty level) with positive results into treatment through the Ohio Department of Health's Breast and Cervical Cancer Project (BCCP).
BBH's and TriHealth's focus on prevention will continue to demonstrate its commitment via in kind and financial support of Ohio Cancer Research, which is an independent, statewide, nonprofit organization dedicated to the cure and prevention of the many forms of cancer and the reduction of its debilitating effects through aggressive basic seed money research, cancer information, and awareness.

The hospital plans to continue financial support to the American Cancer Society and American Lung Association.

4. Access to Care: Currently BBH provides transportation for needy patients with bus tokens and paid Uber rides. BBH/TriHealth will seek new partners and identify other avenues to expand this type of service. It is not something that has a natural connection to a hospital or health system like the other three priorities. If specific actions that are within BBH areas of expertise are not found, BBH will focus on 1-3 above, particularly on Substance Abuse.

Available Resources to Address Priority Health Needs

Below is a list of community resources available to help with health and health-related issues.

American Lung Association
Atrium Medical Center
Bethesda North Hospital
Butler Behavioral Health Services
Butler County Coalition / Mental Health and Addiction Recovery Services
Butler County Educational Service Center
Butler County Families and Children First Council
Butler County Health Department
Catholic Charities of Southwest Ohio
City of Hamilton Health Department
Clifton Market
Coalition for a Healthy, Safe and Drug-Free Greater Hamilton
Community First Pharmacy
Community First Solutions
Healthcare Access Now
Interact for Health
Life Learning Center
McCullough-Hyde Hospital
Middletown City Health Department
Primary Health Solutions
St. Vincent de Paul
Sojourner Recovery Services
Transitional Living
United Way
YWCA Hamilton