Good Samaritan Hospital
2019 Community Health Needs Assessment

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Community Health Needs Assessment 2019
Good Samaritan 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 Good Samaritan Hospital ("GSH"). GSH is a general, acute care hospital, located at 375 Dixmyth Avenue, Cincinnati, Ohio 45220-2475, that is ranked among the best hospitals in the region, providing a range of quality services to patients. GSH a member of Catholic Health Initiatives and is the pre-eminent Catholic hospital in the community, proudly serving all sectors of the population. With many highly respected programs and services, GSH is regularly recognized by Thomson Reuters, U.S. News & World Report and other prestigious publications and research organizations as one of the top hospitals in Greater Cincinnati. Most importantly, the community trusts and relies upon GSH every day to care for loved ones – from birth into the many stages of life. GSH is one of four TriHealth hospitals to receive an **'A' for Patient Safety in the Fall 2018 Leapfrog Hospital Safety Grade**. TriHealth's Bethesda North, Good Samaritan, McCullough-Hyde Memorial Hospital and Bethesda Butler Hospitals 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 GSH is based on data and inputs captured in the Health Collaborative's Regional CHNA Report for the larger region. It will (i) document the Regional CHNA as it applies to Butler, Clermont, Hamilton, and Warren Counties, the primary service area of GSH; (ii) describe the means in which the assessment was taken, and data formulated; (iii) describe the significant community health needs identified in the GSH footprint; and (iv) describe the measures and resources available to meet the needs identified. Whereas this report specifically addresses GSH's community benefit activities, 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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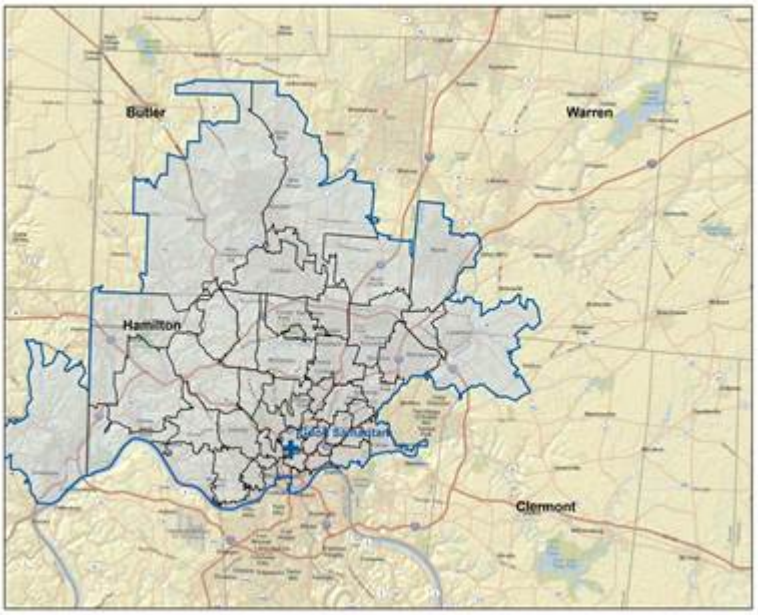
Hospital Service Area

The serviced community was defined by evaluating the patient origin for GSH's inpatient, ER and outpatient surgery volume. GSH derives more than 90% of this volume from zip codes that comprise four counties in Ohio (in descending order of population): Hamilton, Butler, Clermont and Warren.



Process and Collaborating Partners

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 comprehensive 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.
- GSH 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 most recent 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 Stastics (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 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.

Priorities for Hospital Service Area

On the next page 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.

County Profiles

The Appendix **4** contains county profiles for Butler, Clermont, Hamilton, and Warren Counties. The following grid summarizes the common themes expressed across Hamilton, Butler, Clermont and Warren Counties, and it identifies areas of consensus among primary and secondary data sources.

Summary of Priorities for Counties in GSH Service Area

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
Clermont	Substance abuse Access to care Healthy food/ Nutrition Mental health Tie: Healthy behaviors & SDHs	Substance abuse Access to care Cancer	Substance abuse SDHs Chronic disease Access to care Tie: Healthy Food/Nutrition & Infant mortality	Substance abuse Child welfare Obesity Access to care Mental health Tobacco	Cancer Mortality Lung Cancer Mortality
Hamilton	SDHs Mental health Access to care Healthy food/ Nutrition Health education	Substance abuse Chronic disease Access to care Mental health Healthy behaviors	Substance abuse Chronic disease SDHs Infant mortality Access to care	Addiction Tie: Mental health, Infant mortality, Chronic disease & Access	Diabetes % Cancer Mortality Lung Cancer Mortality
Warren	Substance abuse Mental health Healthy food/ Nutrition Tie: Parenting & SDHs	Substance abuse Chronic disease Healthy behaviors Tie: Access, Care for children & Mental health	Infant mortality Mental health Substance abuse Tie: Access, Collaboration & Chronic disease	Access to behavioral health Access to primary care for people with behavioral health issues	Diabetes % Lung Cancer Mortality

SDH=Social Determinants of Health

Progress on 2016 Areas of Focus

During the 2016 Community Needs Assessment process, the significant health needs for GSH's community served were prioritized as follows:

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 – 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. Narcan is currently distributed in the emergency departments at GSH, Western Ridge Hospital, and Bethesda North Hospital. This is funded through a grant with Hamilton County at no or limited cost to the patient. In 2018 which was the first year, TriHealth Emergency Rooms used 31 doses of Narcan for patients that had no insurance. Narcan is also available at the GSH and Bethesda North outpatient pharmacy. This initiative has expanded to Butler, McCullough-Hyde Memorial Hospital (MHMH) and Arrow Springs on January 3rd, 2019. 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 Jan/Feb 2019, the SUTC role expanded to the GSH Emergency Department through a grant our partner Brightview obtained from the Hamilton County Mental Health and Addiction Board.

- TriHealth submitted a grant proposal to Bethesda Foundation to expand the SUTC role to Bethesda North Hospital as a platform for utilizing Telehealth for further expansion to Arrow Springs, McCullough Hyde Memorial Hospital.

- 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 Inpatient Renovation

- GSH has embarked on a twenty month, three phased $6.5 million renovation of its inpatient psych units, to be completed April 2020. This renovation will provide a safe environment for our patients, visitors and team members.

Outpatient Alcohol and Drug Treatment Program

- GSH Foundation provided the much-needed funding for relocation and renovation of program to the Clifton campus Medical Office Building

Behavioral Health Intake

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

Behavioral Health Consultations

- Provides upwards of 2000 behavioral health consultations to nonbehavioral health inpatient units at GSH and Bethesda North Hospital

Project HOPE: TriHealth MidWives provided weekly prenatal care in FMC for pregnant mothers with history of addiction, seeing 400-420 patients per year.

GSH also sponsors the Urban Health project through providing office space for its base of operations – placing medical students in the community to provide services to the underserved, including the homeless, mentally ill, at risk youth and other underserved populations. The Good Samaritan Free Health Clinic offers mental health counseling to over 1000 people every year (FY17: 1011, FY18:1146, FY19 through March: 762).

TriHealth also provides financial and clinical support resources to:

- Fernside Children and Family Bereavement Center
- Urban Health Project
- United Way Support
- NAMI Southwest Ohio (major sponsor for the past 3 years
- CAT Fest, hosted by the Center for Addiction Treatment (Major sponsor Alcohol and Drug Addiction Program)
- Family Nurturing Center

2. Infant mortality - GSH provides obstetric (“OB”) and gynecological services to all comers via its OB Clinics. The OB Clinic had just under 50,000 patient visits during Calendar Years 16 -18. The OB Clinics have adopted an innovative Woman Centered Medical Home model meant to reinforce compliance with pregnant patient office visits and follow up care. GSH provides a Breastfeeding

Support line free to the community that has fielded almost 2000 calls per year, donating approximately 270 hours of time per year to do so during each of the last 3 years (FY16 – 18).

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

Cradle Cincinnati is 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. Cradle programs/assistance helped 5000+ women a year during the last 3 years who delivered at Good Samaritan – including those who are economically underserved.

Healthy Beginnings, which provides comprehensive pre-natal care to the underserved. GSH through TriHealth donated $100,000 in FY16; $60,000 in FY17; and $80,000 in FY18 and the GSH midwives donated 1600 – 1900 hours per year during these three years.

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

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

- 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

- OB High Risk clinic, staffed by a High Risk RN Case Manager and TriHealth Maternal-Fetal Medicine providers. Patients form a relationship with the RN Case Manager and are followed throughout their pregnancy. They can contact their Case Manager by phone anytime with questions and concerns. More than 47,000 patients were served in the Good Samaritan service area.

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

Other partners include March of Dimes, Sweet Cheeks Diaper Bank.
Finally, GSH also provides financial support to other organizations that focus resources on infant mortality and maternal health:

- Urban Health Project
- OB Clinics
- OB Woman Centered Medical Home Model
- Funding for Cradle Cincinnati Neighborhood Based Woman Centered Medical Home
- Good Samaritan Free Health Clinic
- Healthy Beginnings
- Health Moms and Babes
- Think First For Your Baby
- Start Strong
- March of Dimes
- Sweet Cheeks Diaper Bank

3. Obesity: Given the multiple factors driving obesity, GSH has 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. GSH/TriHealth also supports the Clifton Market, a coop to increase access to healthy food, by providing nutrition information signage to support healthy food choices.

   GSH offers free diabetes education – both classes and on line. The classes are held for up to 60 people per month on the campus of GSH.

   GSH 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). GSH, through TriHealth, provides financial support to exercise related public events and programs:
   - funded a splash park in Cheviot in 2018
   - sponsors over a dozen walks and runs in the greater Cincinnati area (Thanksgiving Day Race, March for Babies with March of Dimes, Hike for Hospice, Making Strides [American Cancer Society], Matt Haverkamp Foundation, Heart Mini [with American Heart Association], Downe Syndrome Buddy Walk, Walk to Cure Arthritis, Great River Swim [underserved children swim program culmination]).

4. Cancer: GSH through TriHealth sponsors free screenings and follow ups at many public community events:
    - TCI (TriHealth Cancer Institute) Gynecology Oncology Physicians participated in Su Casa Health Fair on 4/17/18.providing free Pap smears. There were 11 women screened (3 for the first time), with 2 abnormal results. These women were referred to the Bethesda North GYN Clinic for management. Another screening and prevention event was held 9/15/2018. Update posted online 12/20/2018 https://www.trihealth.com/hospitals-and-practices/tristate-gynecologic-oncology/community-service

    - Genetics, physicians, nursing, and mammography participated in the First Ladies Family Health Day on 10/14 at Corinthian Baptist Church and Rockdale Elementary. There was education provided on genetic counseling and cancer family history, prostate cancer, lung cancer and screening, breast cancer and screening. Five patients had PSA drawn with three referred to PCP and Urology for slightly elevated results. Update posted online 12/20/018 https://www.trihealth.com/institutes-and-services/trihealth-cancer-institute/general-cancer-care/family-health-day-screenings

    - The TCI lung program administrator is now offering a free 4-week American Cancer Society smoking cessation class. A referral is available in Epic with 38 referrals for the initial class. Twelve have registered and five completed the first class. Classes are offered on two campuses one at Bethesda North in the BNOI and Good Samaritan Western Ridge.

    - 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, 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 regularly does screening in high need areas within Hamilton county e.g. Avondale, Butler County, i.e. Hamilton and TriHealth facility/practice locations. Volumes and results follow:

Mobile Van Mammographies	**CY16**	**CY17**	**CY18**
Community	471	623	646
Healthy Women/Healthy Lives	238	133	31
GSH Free Health Center	71	104	101
Cancers Identified	14	12	13

    - All screenings were open to the community. Volunteers from each organization included dermatologists, nurses, medical students, and the community.

Given GSH's dedication to Women's services, it partners with The Ovarian Alliance to raise funds for ovarian cancer research, sponsoring or cosponsoring 6 events per year.

GSH funds the GSH Free Health Clinic and provides gynecological and mammography screening services to patients with no insurance coverage 6 times per year via the TriHealth mobile mammography van. Approximately 100 patients per year are screened, with 20 in total over three years referred on for further evaluation and treatment. Patients with positive results are referred to TriHealth providers and obtain coverage from state funded Breast and Cervical Cancer Prevention (BCCP) funding.

GSH via TriHealth has also just begun to partner with the Erica Holloman Foundation to educate and screen primarily African American women at risk for a particular kind of breast cancer.

GSH's focus on prevention is 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 – through TriHealth - to the American Cancer Society and American Lung Association, and cosponsors – also through TriHealth – 3 major events (Real Men Wear Pink, Blue Ribbon Girls, Pink Football Award at the Cancer NFL game) per year that raise awareness and money for American Cancer Society to fund non-reimbursable costs for cancer patients, including housing and transportation.

Appendix 1: Meeting Attendees - Agencies

First & Last Name	Organization Name and Purpose	City	County
Eileen Turain	Envision Partnerships (Substance Abuse/ Behavioral Health)	Hamilton	Butler
Ben Verdow	Miami University (Students)	Hamilton	Butler
Sharman Willmore	Miami University (Students)	Oxford	Butler
Karen Scherra	Clermont County Mental Health and Recovery Board	Batavia	Clermont
Jackie Lindner	Clermont County Public Health	Batavia	Clermont
Sharon Richmond	Clermont Developmental Disabilities	Batavia	Clermont
Margaret Jenkins	OSU Extension (diet, nutrition, diabetes)	Batavia	Clermont
Sharron DiMario	UC Area Health Education Center (social determinants of health)	Batavia	Clermont
Stacey Sandfoss	Fitzgerald's Pharmacy (pharmacy needs)	Bethel	Clermont
Jen Patrick	HealthSource of Ohio (all underserved)	Milford	Clermont
Becky Fiscus	OSU Extension	Owensville	Clermont
Ashley Colmenero	Phamily (care coordination in the community)	Blue Ash	Hamilton
James S. Berrens	Crossroad Health Center (multiple)	Cincinnati	Hamilton
Jordan Oberndorfer	Crossroad Health Center (multiple)	Cincinnati	Hamilton
Alfonso Cornejo	Hispanic Chamber (Hispanics)	Cincinnati	Hamilton
Robert Brown	Homeless Coalition	Cincinnati	Hamilton
Marla Morse	Oral Health Ohio	Cincinnati	Hamilton
Jayvon Howard	Women Helping Women	Cincinnati	Hamilton
Kristin S. Shrimplin	Women Helping Women	Cincinnati	Hamilton
Jorge Perez	YMCA	Cincinnati	Hamilton
Miriam Crenshaw	WinMed Health Services (multiple, FQHC)	Cincinnati	Hamilton
Yvette Casey-Hunter MD	WinMed Health Services (multiple, FQHC)	Cincinnati	Hamilton
Kayla Eaton	Santa Maria Community Services (Hispanic_	Cincinnati	Hamilton
Corinya Pitts	J-RAB (Jurisdiction-wide Resident Advisory Board) (Public Housing)	Cincinnati	Hamilton
Diamond Bradford	J-RAB (Jurisdiction-wide Resident Advisory Board) (Public housing)	Cincinnati	Hamilton
Andrea Brooks	City Link (low income)	Cincinnati	Hamilton
Janice Sowell	Seven Hills Neighborhood Houses	Cincinnati	Hamilton
Keith Schomaker	Higher Education Mentoring Initiative	Cincinnati	Hamilton
Jayson Douglas	University of Cincinnati LGBTQ Center	Cincinnati	Hamilton
Steve Sunderland	Cancer Justice Network	Cincinnati	Hamilton
Billy Golden	Caracole (HIV)	Cincinnati	Hamilton
Brittany Richardson	Caracole (HIV)	Cincinnati	Hamilton
Alicia Tidwell	Health Care Access Now	Cincinnati	Hamilton
Prencis Wilson	City of Cincinnati Primary Care	Cincinnati	Hamilton

First & Last Name	Organization Name and Purpose	City	County
Michaela Oldfield	Greater Cincinnati Regional Food Policy Council	Cincinnati	Hamilton
Wade Johnston	Tri-State Trails Green Umbrella (exercise)	Cincinnati	Hamilton
Rashaan Anderson	Center for Closing the Health Gap (health disparities)	Cincinnati	Hamilton
Vanessa Gentry	Center for Closing the Health Gap (Health disparities)	Cincinnati	Hamilton
Barbara Tobias	Health Collaborative	Cincinnati	Hamilton
Jan Harper		Cincinnati	Hamilton
Khrys Styles	The KASSIE Project (sexual and domestic abuse survivors)	Cincinnati	Hamilton
Valerie Walker	NAMI (National Alliance on Mental Illness) - Urban Greater Cinti	Cincinnati	Hamilton
Noah Kling	Proud Scholars (LGBT)	Cincinnati	Hamilton
Brendan Faux	DSA (healthcare access)	Cincinnati	Hamilton
April Moorman	Health Care Access Now	Cincinnati	Hamilton
Ishan Ghildyal	Phamily (care coordination in the community)	Cincinnati	Hamilton
Sara Obando	Su Casa Hispanic)	Cincinnati	Hamilton
Giovanna Alvarez	Su Casa / Catholic Charities Southwest Ohio	Cincinnati	Hamilton
Josh Arnold	Talbert House	Cincinnati	Hamilton
Toni Miller	Walnut Hills Area Council (social determinants, housing)	Cincinnati	Hamilton
Jun Ying	UC College of Medicine (education)	Cincinnati	Hamilton
Tony Fairhead	Childhood Food Solutions	Cincinnati	Hamilton
Jason Harris	LADD (Developmentally disabled)	Cincinnati	Hamilton
Kristin Harmeyer	LADD (Developmentally disabled)	Cincinnati	Hamilton
Maggie Biddle	Health Collaborative	Harrison	Hamilton
Josh Montgomery	Children's Hunger Alliance	Cincinnati	Hamilton
Dan Benson, Sr.	Star Pathways, LLC (behavioral health)	Liberty Township	Hamilton
Jonathan Westendorf	City of Franklin Division of Fire & EMS	Franklin	Warren
Russ Whitman	Franklin Police Department	Franklin	Warren
Brianna Higgins	Miami University	Lebanon	Warren
Jerri Langworthy	United Way Warren County	Lebanon	Warren
Ryan Cook	Warren County Regional Planning Commission	Lebanon	Warren
Julie Knueven	Solutions (behavioral health)	Springboro	Warren
Barbara Adams Marin	Solutions CCRC (Behavioral Health)	Springboro	Warren

Meetings also attended by Public Health department and hospitals

Appendix 2: Survey Respondents - Agencies

(other than Consumers or Public Health)

Organization	Populations Served	County(ies) Served
ABCAP	All	Clermont
Butler County Health Department/ Health District	African American Low income groups. Groups with lower educational status	Butler
Cincinnati Children's Hospital	African Americans	Butler, Clermont, Hamilton
Cincinnati Children's Hospital	Children	Butler, Clermont, Hamilton, Warren
Cincinnati Fire Department	Elderly and children	Hamilton
Colerain Township Department of Fire and EMS	Elderly and undereducated	Hamilton
Council on Aging	African Americans and the poor	Hamilton
Cradle Cincinnati	African Americans	Hamilton
Cradle Cincinnati/Cincinnati Children's Hospital Medical Center	Poor, urban, African-American	Butler, Clermont, Hamilton, Warren
Delhi Township Fire Department	Elderly	Hamilton
Elm Street Clinic	Young and elderly	Hamilton
Envision Partnerships	Poor	Butler
Green Township Fire & EMS	Geriatric	Hamilton
Hamilton County Sheriff's Office	Lower to middle income	Hamilton
HealthSource of Ohio	Poor and rural persons	Clermont
HealthSource of Ohio	Working poor	Clermont, Warren
HealthSource of Ohio	Adults	Clermont
HealthSource of Ohio	Children	Clermont
HealthSource of Ohio	Low income	Clermont, Hamilton
HealthSource of Ohio	Children, senior adults	Clermont, Hamilton
Lighthouse Youth Services	Children	Clermont, Hamilton
Opportunities for Ohioan's with Disabilities	Persons with disabilities, children	Butler
Prevent Blindness, Ohio Affiliate	High risk populations include children <5, seniors, Hispanics, African Americans	Butler, Clermont, Hamilton, Warren
Santa Maria Community Services	African Americans	Hamilton
Solutions CCRC	Elderly, youth	Warren
St. Elizabeth Healthcare	Poor/underserved	Hamilton
The Center for Closing the Health Gap	Low-income African-Americans, Hispanics, and Appalachian	Hamilton
The Salvation Army	Children	Hamilton
University of Cincinnati Medical Center	African-American	Hamilton
YMCA of Greater Cincinnati	Minorities	Clermont, Hamilton
YWCA	Children	Clermont, Hamilton

18 anonymous respondents

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
Allison Franklin/Marilyn Crumpton, MD (answers compiled as a group)	PHAB Accreditation Coordinator	RS / MD	Cincinnati Health Department
Jackie Phillips	Health Commissioner	RN, BSN, MPH	City of Middletown Health District
Julianne Nesbit	Health Commissioner	MPH	Clermont County Public Health
Kay L Farrar	Health Commissioner	BSN	Hamilton City Health Department
Tim Ingram	Health Commissioner	BS and MS, Registered Sanitarian	Hamilton County Public Health
Donna Laake	President of Norwood City Council	RN	Norwood Health Department
Duane Stansbury	Health Commissioner	BS, MPH	Warren County Health District

Appendix 4: 2019 Regional CHNA Summary

(See separate attachment.)

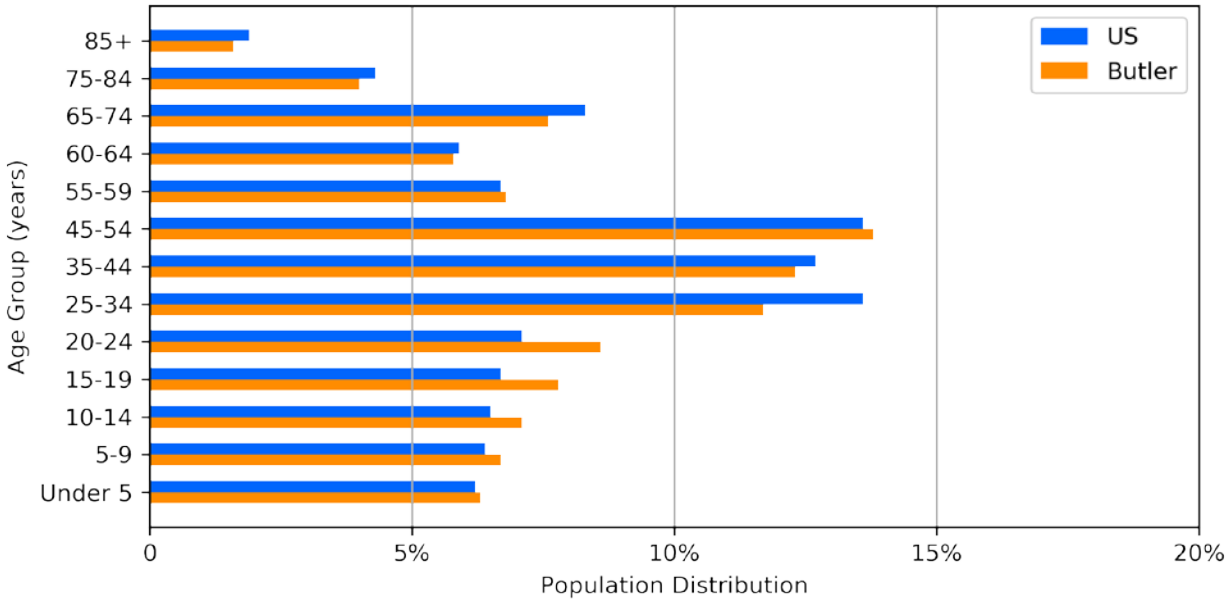
BUTLER COUNTY, OHIO

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.

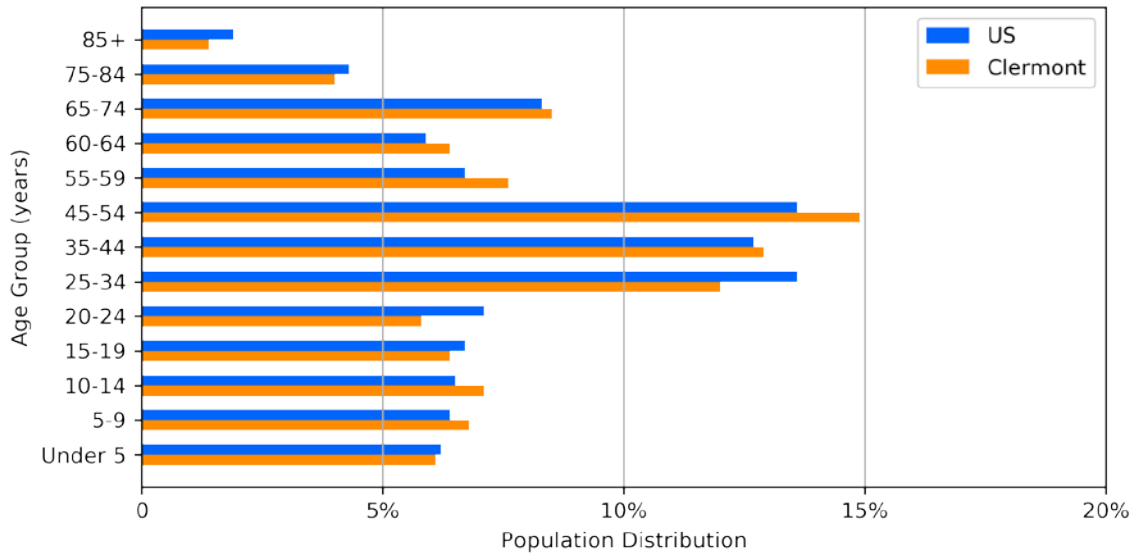
CLERMONT COUNTY, OHIO

Clermont County is a large county with a population of more than 200,000. The County was once mostly rural but has become more suburban. It is one of Ohio's Appalachian counties. The rate of deaths from stroke and the smoking rates are both higher than the U.S. and Ohio rates and increasing. Clermont 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. Clermont County Public Health arranged for meeting space in the county seat, Batavia, and conducted additional community meetings in Felicity and Miami Township on May 1, 2 and 3, 2018. They offered $10 Walmart gift cards as incentives for participation.

Population Chart

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

CLERMONT COUNTY POPULATION



Consensus on Priorities

All four sources of input – meeting, agency survey, consumer survey, and health department – agreed on substance abuse as a top priority. Access to care, especially transportation, was also a priority for all 4 primary sources. Mental health was prioritized by 3 sources: in the meeting, consumer survey, and health department responses. Healthy behaviors was prioritized at the meetings, and that includes use of tobacco/nicotine – a public health priority. They also agreed on obesity. Agencies and meeting attendees agreed on healthy food/nutrition and social determinants of health as priorities.

Top Causes of Death

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

- Lung cancer
- Atherosclerotic heart disease
- Dementia, unspecified
- Accidental poisoning by and exposure to narcotics and hallucinogens

Priorities from Community Meetings on May 1, 2, and 3, 2018

From the three meetings, 17 people contributed their votes to identify their priorities. Below are the topics receiving at least 5% of votes.

CLERMONT COUNTY: MEETING PRIORITIES

Priority	# Votes	% Votes
Substance abuse	10	27.8%
Access (Transportation, 1)	7	19.4%
Healthy food/Nutrition	6	16.7%
Mental health	5	13.9%
Social Determinants of Health	3	8.3%
Healthy Behaviors	3	8.3%
Obesity	2	5.6%

Survey Responses

Below are the most frequent responses from individual consumers, living in Clermont County, who completed a survey between 6/19/18 and 8/3/18. Forty-one people participated. Respondents all answered the question, “Given the health issues facing the community, which ones would be your top priorities?” They mentioned 11 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.

CLERMONT COUNTY: CONSUMER PRIORITIES

Priority	# Mentions	% Mentions
Substance abuse	27	34.5%
Mental health	12	15.8%
Access to care	12	15.8%
Cancer	10	13.2%

Twenty-one organizations serving county residents, especially vulnerable populations, responded with their priorities. The priorities that received more than 5% of mentions are listed below.

CLERMONT COUNTY: AGENCY PRIORITIES

Priority	# Mentions	% Mentions
Substance abuse	13	25%
Social Determinants of Health	11	21%
Chronic disease	10	19%
Access to care (Transportation, 3)	7	13%
Healthy food/Nutrition	3	6%
Infant mortality	3	6%

Response from the Health Department

Clermont County Public Health provided its health priorities for the community:

- Substance Use Disorder (SUD)
- Child welfare associate with SUD
- Obesity
- Access to care
- Mental health
- Tobacco and nicotine use

Clermont County Health Snapshot

Pop.: 201,092

Measure/Indicator	County	Trend	State	U.S.
Health Outcomes				
Cancer mortality, Breast (rate per 100,000)	20.5	↑	22.2	20.2
Cancer mortality, Lung (rate per 100,000)	52.6	↓*	48.2	39.4
Cancer mortality, Overall (rate per 100,000)	168	↓	174.3	157.1
Diabetes (%)	9.5	↑	11.1	10.7
Infant Mortality (rate per 1,000 live births)	6.8	-	7.2	5.9
Injury Deaths (rate per 100,000)	76.2	↑*	61.2	45.3
Low birthweight (%)	7.1	↑	8.5	8.2
Preterm Birth (%)	8.8	↑	10.3	9.6
Poor physical health days (last 30 days)	5	↑*	4	3.9
Poor mental health days (last 30 days)	5.5	↑*	4	3.7
Stroke Deaths (rate per 100,000)	55.5	↑*	40.6	37.5
Suicide (rate per 100,000)	14.8	↓*	13.3	13
Health Behaviors				
Adult Obesity (%)	33	↑*	30.6	29.2
Adult Smoking (%)	29.1	↑*	22	16.5
Alcohol-impaired driving deaths (%)	32	↑	34	30
Chlamydia incidence (rate per 100,000)	283.2	↑	521.6	497.3
HIV prevalence (rate per 100,000)	70.9	↑	199.5	305.2
Motor vehicle crash deaths (rate per 100,000)	9.5	↓	10.3	11.5
Naloxone administration rate (per 100,000)	32.2	↑	38.4	NA
Physical inactivity (%)	20.8	↓	26.4	25.2
Substance Abuse/Mental Health				
Depression (%)	26.2*	-	18.5	17.1
Drug poisoning deaths (per 100,000)	43.4*	↑	26.2	14.6
Fentanyl & related drugs overdose deaths (per 100,000)	16.6*	-	9	2.6
Heroin poisoning overdose deaths (per 100,000)	25.5*	↓	10.9	3.5
Prescription Opioid overdose deaths (per 100,000)	9.8*	↑	5.9	4
Access to Clinical Care				
Dentists (ratio)	2640:1	↑*	1656:1	1480:1
Diabetic screening (% HbA1c)	51.2	↓	57.4	57.5
Mammography screening (%)	63.1	↓	73.7	72.7
Mental health providers (ratio)	1880:1	↓*	561:1	470:1
Primary care physicians (ratio)	1430:1	-*	1307:1	1320:1
Uninsured (%)	8.1	↓	7.6	11.8
Socio-Economic/Demographic				
Children in poverty (%)	13.5	↓	22.1	21.2
Population that is 65 and older (%)	14	*	14.5	16
Population below 18 years of age (%)	24.3	*	23	22.3

Source data range: 2014-2018

* = Higher than state and national rates

Top Causes of Death
Lung Cancer
Heart Disease

Injury Deaths
Increasing and > state and national rate

Strokes
Deaths increasing and > state & US
&
Smoking
increasing and > than state and US

Rx Opioid Overdose Deaths
Rate > state and national rates

Depression
Rate > state and national 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. One ZIP Code exceeds a score of 3.4, but it is a statistical anomaly.

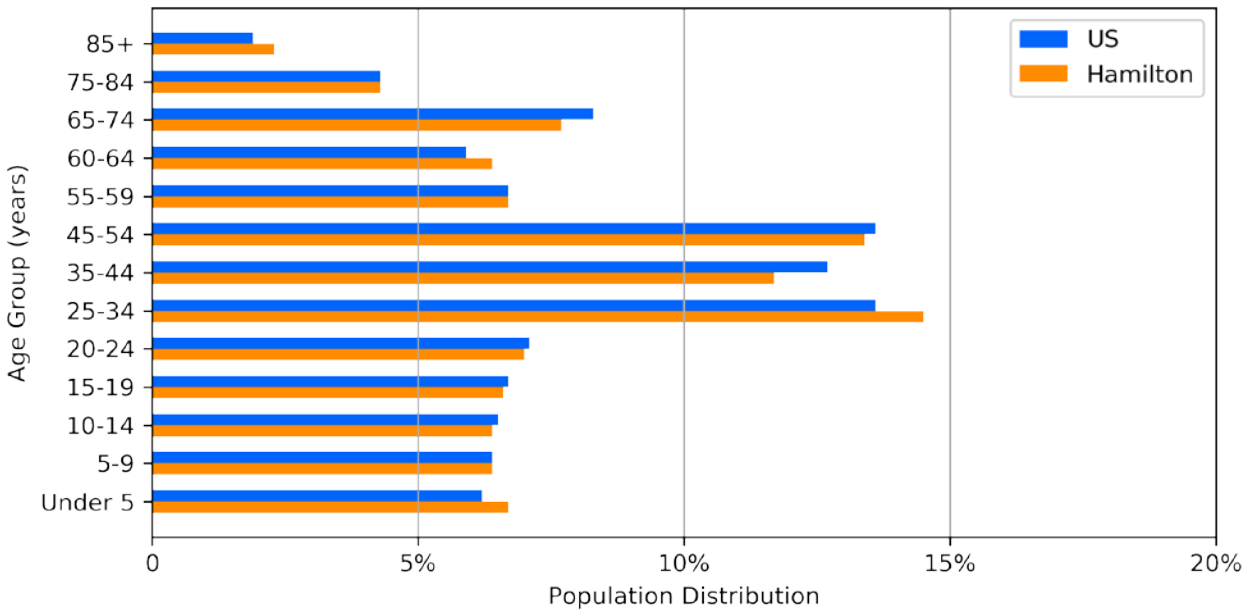
HAMILTON COUNTY, OHIO

Hamilton County is the most populated County in the region and is home to the largest city, Cincinnati. The county continues to struggle with higher than average rates of poverty, infant mortality, homicide, and sexually transmitted diseases. Community collaborations are addressing infant mortality and the heroin epidemic. There is an above average number of children living in the county and a high number of children living in poverty. Hamilton County is one of the 8 counties with an increase in unacceptable ozone levels, from 5 days to 12 days. Of the county's 51 ZIP Codes, 27 have elevated CNI Scores, indicating the likelihood of health disparities. In addition to the community meeting at the Urban League on June 12, 2018, the Cincinnati Health Department hosted 3 additional community meetings June 4 and July 11, 2018, and the CHNA team conducted an additional meeting around LGBTQ+ issues (summarized in the Urban Health chapter) on 7/16/18. Hamilton County Public Health contributed 666 resident surveys as part of its WeTHRIVE! initiative. These residents lived outside the City of Cincinnati but within Hamilton County.

Population Chart

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

HAMILTON COUNTY POPULATION



Consensus on Priorities

For Hamilton County, the consultants had input from 4 health departments and WeTHRIVE! survey respondents as well as the meetings, consumer surveys, and agency surveys. Substance abuse, specifically addiction, was on each group's list of priorities, and it was in top place for each source except the meeting attendees. Mental health was a shared priority at the meeting, on consumer surveys, and with health departments. Access to care was the next highest shared priority for every group, except the WeTHRIVE! respondents. Transportation was a major topic at the meeting. Chronic disease was a top-ranked priority for health departments and on consumer and agency surveys. Social Determinants of Health ("SDH") were discussed broadly at the meeting and echoed on the agency surveys. Some sub-categories of SDHs attracted so many votes at the meeting, that they are listed separately, such as poverty and discrimination. The health of infants concerned both agencies and health departments. Access, availability, and affordability of healthy food and nutrition information were

mentioned on consumer surveys and at the meeting. The discussion included the topics of food insecurity and food deserts.

Top Causes of Death

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

- Lung cancer
- Atherosclerotic heart disease
- Dementia, unspecified
- Accidental poisoning by and exposure to narcotics and hallucinogens, not elsewhere classified
- Alzheimer's disease

Priorities from Community Meeting on June 12, 2018

Twenty-seven people contributed votes to identify a total of 44 priorities. Below are the topics receiving the most votes.

HAMILTON COUNTY: MEETING PRIORITIES

Priority	# Votes	% Votes
Social Determinants of Health (Education/Literacy = 9, Housing = 8, Environment = 6, Employment = 5), not including Poverty or Discrimination	37	18.4%
Mental Health (ACEs = 6, Suicide = 2)	26	12.9%
Access (Transportation = 15)	25	12.4%
Healthy Food/Nutrition	16	8.0%
Discrimination (Racism=6)	14	7.0%
Health education/Promotion	12	6.0%
Poverty	11	5.5%
Substance abuse	8	4.0%

Survey Responses

Below are the most frequent responses from individual consumers, living in Hamilton County, who completed a survey 5/14/18 and 8/3/18. 434 people participated. Respondents all answered the question, “Given the health issues facing the community, which ones would be your top priorities?” They mentioned 68 health and/or health-related issues of concern to them. The following table contains the issues that received more than 5% of all mentions.

HAMILTON COUNTY: CONSUMER PRIORITIES

Priority	# Mentions	% Mentions
Substance abuse	72	19.94%
Chronic disease	69	19.11%
Access to care	44	12.19%
Mental health	32	8.86%
Healthy behaviors	22	6.09%
Healthy food/Nutrition	20	5.54%

Hamilton County Public Health shared resident responses from its WeTHRIVE! survey. There were 666 responses of which 558 expressed a health or health-related concern. (Not included were concerns about code enforcement, general civic matters, private property complaints, general public services, or staffing.)

HAMILTON COUNTY: WETHRIVE! RESULTS

Priority	# Mentions	% Mentions
Drugs	202	16%
Crime	147	12%
Recreation activities	108	9%
Care for children	102	8%
Public safety	91	7%
Traffic & sidewalks (with focus on safety)	74	6%

Thirty-four organizations serving county residents, especially vulnerable populations, responded with their priorities. The priorities that received more than 5% of mentions are listed below.

HAMILTON COUNTY: AGENCY PRIORITIES

Priority	# Mentions	% Mentions
Substance abuse	17	21%
Chronic disease	14	17%
Social Determinants of Health	10	12%
Infant mortality	9	11%
Access to care	8	10%

Responses from Health Departments

There were 4 categories where these 4 health departments agreed. The largest area of agreement was addiction. The next 4 were prioritized by 2 health departments: mental health; maternal, infant & child health and/or infant mortality; chronic disease and/or obesity; and access to care (healthcare in general for Springdale and oral health for Hamilton County.)

HAMILTON COUNTY: HEALTH DEPARTMENT PRIORITIES

	Addiction	Mental health	Mat., infant & child health/Infant mortality	Chronic disease/ Obesity	Access to care
Hamilton County	1	1	1	1	1
City of Cincinnati	1	1	1	1	
City of Norwood	1				
City of Springdale	1				1

Hamilton County Health Snapshot

Pop.: 805,965

Measure/Indicator	County	Trend	State	U.S.
Health Outcomes				
Cancer mortality, Breast (rate per 100,000)	24.4	*	22.2	20.2
Cancer mortality, Lung (rate per 100,000)	50.6	-*	48.2	39.4
Cancer mortality, Overall (rate per 100,000)	179.1	-*	174.3	157.1
Cancer mortality, Colon & Rectum (rate per 100,000)	17.3	-*	15.5	14.0
Child mortality (rate per 100,000, 1-17 yrs.)	23.7	*	20.1	19.9
Chronic Lower Respiratory Disease (CLRD) deaths age 65 and up (rate per 100,000)	271.8	-	316.1	270.9
Diabetes (%)	12.1	*	11.1	10.7
Heart Disease Deaths (rate per 100,000)	174.1	-	188.4	167
Infant Mortality (rate per 1,000 live births)	9.0	*	7.2	5.9
Injury Deaths (rate per 100,000)	63.8	-*	61.2	45.3
Low birthweight (%)	9.4	*	8.5	8.2
Preterm Birth (%)	10.7	*	10.3	9.6
Stroke Deaths (rate per 100,000)	49.3	*	40.6	37.5
Health Behaviors				
Adult Obesity (%)	29.1	-	30.6	29.2
Adult Smoking (%)	22.9	*	22.0	16.5
Adults with high blood pressure (% Yes)	34.3	*	33.9	32.0
Alcohol-impaired driving deaths (%)	38.0	-*	34.0	30.0
Chlamydia incidence (rate per 100,000)	858.1	-*	521.6	497.3
Gonorrhea incidence (%)	355.5	-*	176.8	145.8
HIV prevalence (rate per 100,000)	369.1	-*	199.5	305.2
Homicide (rate per 100,000)	9.8	*	5.9	5.5
Motor vehicle crash deaths (rate per 100,000)	7.1	-	10.3	11.5
Physical inactivity (%)	24.5	-	26.4	25.2
Substance Abuse/Mental Health				
Depression (%)	18.5	-	18.5	17.1
Drug poisoning deaths (rate per 100,000)	35.5	-*	26.2	14.6
Fentanyl & related drug OD deaths (rate per 100,000)	15.0	-*	9.0	2.6
Heroin poisoning overdose deaths (rate per 100,000)	21.4	-*	10.9	3.5
Prescription opioid overdose deaths (rate per 100,000)	7.4	*	5.9	4.0
Suicide (rate per 100,000)	12.6	-	13.3	13.0
Access to Clinical Care				
Dentists (ratio)	1380:1	-	1656:1	1480:1
Mammography screening (%)	67.5	-	68.4	65.5
Mental health providers (ratio)	415:1	↓	561:1	470:1
Primary care physicians (ratio)	920:1	↓	1307:1	1320:1
Uninsured (%)	7.9	-	7.6	11.8
Socio-Economic/Demographic				
Children in poverty (%)	26.1	*	22.1	21.2
Hispanic (%)	2.9		3.5	17.3
African American (%)	25.7		12.1	12.3
Population that is 65 and older (%)	14.2		23.0	22.3
Population below 18 years of age (%)	23.3	*	14.5	16.0

* = Higher than state and national rates. Source data range: 2014-2017. U = Unavailable or unreliable data

Top Causes of Death
Lung Cancer
Heart Disease
Dementia

Injury Deaths
Rate is rising and higher than OH and US rates

Drug ODs
Deaths rising and higher than OH and US for drug poisoning, heroin & Fentanyl

STIs
Rising rates of chlamydia, gonorrhea & HIV and > OH & US

Children
Large population under 18 and high percentage living in poverty

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. More than half, or 27, of Hamilton County's 51 ZIP Codes have high scores.

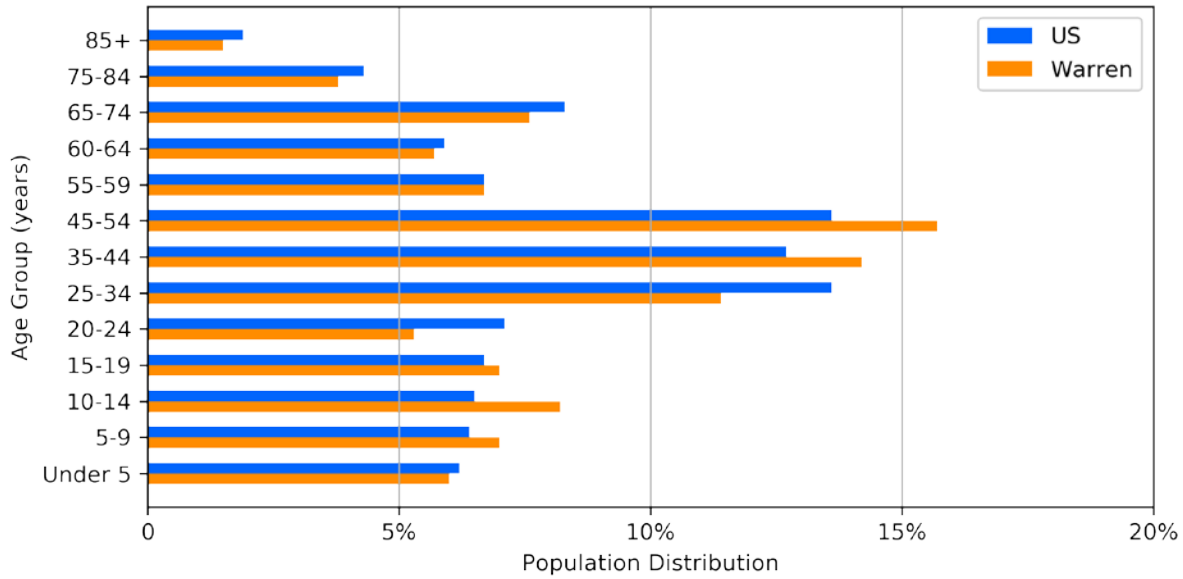
WARREN COUNTY, OHIO

Warren County is one of the fastest growing counties in Ohio, both in residential and commercial growth. The death rate for drug poisoning, fentanyl and prescription opiates are increasing and higher than the Ohio and U.S. rates. The rates of chlamydia, gonorrhea and syphilis are increasing. It is one of the 8 counties with an increase in the number of days with unacceptable ozone levels.

Population Chart

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

WARREN COUNTY POPULATION



Consensus on Priorities

Mental health was the top priority, shared at the community meetings, in the consumer and agency surveys, and from public health. At the community meetings, childhood trauma emerged specifically. Correspondingly, access to care was mentioned by three sources of input. In particular, the Health District mentioned the access to primary care for those in the behavioral health system. Substance abuse was identified as a priority at community meetings and in consumer and agency surveys. Access to care was an issue on survey results from consumers, agencies, and public health. The agency and consumer survey cited chronic disease as a concern.

Top Causes of Death

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

- Alzheimer's disease, unspecified
- Atherosclerotic heart disease
- Dementia, unspecified

Priorities from Community Meeting on June 19, 2018

The meeting attracted 8 people who gave their detailed responses. There were attendees from Solutions CCRC, the Regional Planning Commission, United Way plus the police chief and fire chief.

WARREN COUNTY: MEETING PRIORITIES

Priority	# Votes	% Votes
Substance abuse	8	40%
Mental health *(Childhood trauma mentioned 3 times)*	4	20%
Healthy food/nutrition	3	15%
Parenting	2	10%
Social determinants of health	2	10%

Survey Priorities

Below are the most common responses from individual consumers, living in Warren County, who completed a survey between 6/19/18 and 8/3/18. There were 27 people who participated, and they all answered the question, "Given the health issues facing the community, which ones would be your top priorities?" They mentioned twenty-eight health and/or health-related issues of particular concern. The following table contains the issues that received more than 5% of all mentions.

WARREN COUNTY: CONSUMER PRIORITIES

Priority	# Votes	% Votes
Substance abuse	10	35.7%
Chronic disease	4	14.3%
Healthy behaviors	4	14.3%
Access to care	2	7.1%
Care for children	2	7.1%
Mental health	2	7.1%

Nine organizations, serving Warren County, responded with their priorities. The priorities that received at least 2 mentions are listed below.

WARREN COUNTY: AGENCY PRIORITIES

Priority	# Votes	% Votes
Infant mortality	3	19%
Mental health	3	19%
Substance abuse	3	19%
Access to care	2	13%
Community collaboration	2	13%
Chronic disease	2	13%

Response from Health Department

The Warren County Health District provided its health priorities for the community:

- Access to behavioral health
- Access to primary care for those in the behavioral health system

Warren County Health Snapshot

Pop.: 222,184

Measure/Indicator	County	Trend	State	U.S.
Health Outcomes				
Cancer mortality, Breast (rate per 100,000)	22.6	-	22.2	20.2
Cancer mortality, Lung (rate per 100,000)	41.9	-	48.2	39.4
Cancer mortality, Overall (rate per 100,000)	153.8	-	174.3	157.1
Cancer mortality, Prostate (rate per 100,000)	19.2	-	19.3	19.1
Child mortality (rate per 100,000, 1-17 yrs.)	11.5	-	20.1	19.9
Chronic Lower Respiratory Disease (CLRD) deaths age 65 and up (rate per 100,000)	260.5	-	316.1	270.9
Diabetes (%)	14.8	-*	11.1	10.7
Heart Disease Deaths (rate per 100,000)	147.5	-	188.4	167
Infant Mortality (rate per 1,000 live births)	3.5	-	7.2	5.9
Injury Deaths (rate per 100,000)	45.4	-	61.2	45.3
Low birthweight (%)	7.4	-	8.5	8.2
Preterm Birth (%)	9.3	-	10.3	9.6
Stroke Deaths (rate per 100,000)	34.0	-	40.6	37.5
Health Behaviors				
Adult Obesity (%)	25.3	-	30.6	29.2
Adult Smoking (%)	10.2	-	22.0	16.5
Adults with high blood pressure (%)	37.8	-*	33.9	32.0
Alcohol-impaired driving deaths (%)	33.0	-	34.0	30.0
Chlamydia incidence (rate per 100,000)	210.3	-	521.6	497.3
Diabetes (%)	14.8	-*	11.1	10.7
Gonorrhea incidence (%)	41.0	-	176.8	145.8
HIV prevalence (rate per 100,000)	68.3	-	199.5	305.2
Total syphilis (rate per 100,000)	4.9	-	13.8	27.4
Substance Abuse/Mental Health				
Depression (%)	17.5	-	18.5	17.1
Drug poisoning deaths (rate per 100,000)	19.2	-	26.2	14.6
Fentanyl & related drug OD deaths (rate per 100,000)	7.1	-	9.0	2.6
Heroin poisoning overdose deaths (rate per 100,000)	7.1	-	10.9	3.5
Prescription opioid overdose deaths (rate per 100,000)	9.2	*	5.9	4.0
Suicide (rate per 100,000)	11.4	-	13.3	13.0
Access to Clinical Care				
Dentists (ratio)	2770:1	-*	1656:1	1480:1
Mammography screening (%)	83.5	-	68.4	65.5
Mental health providers (ratio)	582:1	↓*	561:1	470:1
Primary care physicians (ratio)	1070:1	-	1307:1	1320:1
Uninsured (%)	1.7	-	7.6	11.8
Socio-Economic/Demographic				
Children in poverty (%)	6.5	↑	22.1	21.2
Hispanic (%)	2.5		3.5	17.3
African American (%)	3.4		12.1	12.3
Population that is 65 and older (%)	12.9	↑	23.0	22.3
Population below 18 years of age (%)	25.9	*	14.5	16.0

* = Higher than state and national rates. Source data range: 2014-2017. U = Unavailable or unreliable data

Top Causes of Death
Alzheimer's
Heart Disease
Dementia
Lung Cancer

Drug ODs
Deaths rising for drug poisoning & Fentanyl. Prescription opioid OD death rate is > OH & US

STIs
Rising rates of chlamydia, gonorrhea & syphilis

Chronic Disease
% of people with high blood pressure or diabetes is increasing and > OH & US

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. None of Warren County's 11 ZIP Codes have high scores.

Good Samaritan Hospital

2019 Community Health Needs Assessment Implementation Plan

Mark Clement, CEO TriHealth Inc.
375 Dixmyth Avenue
Cincinnati, Ohio 45220-2475

31-0537486
Date of Board approval:
Date of initial posting:

TriHealth Review

GSH carefully considered the health needs identified in the Regional CHNA report for the community served by GSH and determined that an identified need was significant if it either (i) was represented by the research as severe within a discrete portion of GSH's community served (used 4 county service area with a concentration on the west side), or (ii) was prevalent throughout GSH's community served regardless of severity and identified by more than one of the sources.

Process

In order to develop targeted strategies to alleviate problematic issues identified as needs recognized by the Regional CHNA, GSH assembled a TriHealth 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 GSH 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 GSH
- Anne Siebert, RN, Chief Nursing Officer Bethesda Butler

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

Criteria for decision-making

The committee assessed the findings considering 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 GSH will address in the implementation strategy are as follows.

Priority Health Needs to be Addressed by GSH

1. Substance abuse - given the high prevalence of substance abuse in this area, particularly opioid abuse, the fact that current work is not completed and there are many community partners that are engaging along with TriHealth, substance abuse remains one of the top priority community needs for TriHealth and GSH.

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, 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 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.

   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 GSH will continue its education of first responders as new information arises and new responders are trained.

   Treatment
   - Substance Use Treatment Coordinators (SUTC): GSH will be picking up the funding for this new role (RN/SW) at GSH inpatient services and ER once the grants expire, and modify responsibilities as needed from the grant learnings. A SUTC has specific substance use training, certification and experience in substance use disorders (alcohol, opiates etc.). 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 will continue to test the efficacy of this role and effectiveness at meeting these targets

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

   - 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.

   - If the Peer Recovery specialist identified in our 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.

   - 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.

Behavioral Health Inpatient Renovation

- Twenty month, three phased 6.5 million dollar renovation underway. To be completed April 2020. This renovation will provide a safe environment for our patients, visitors and team members. GSH is one of the few inpatient units remaining that will take patients regardless of insurance.

Outpatient Alcohol and Drug Treatment Program

- Outpatient Alcohol and Drug Treatment at GSH offers support and treatment to patients in outpatient but structured setting, regardless of their ability to pay.

Behavioral Health Intake designed to get patients to proper treatment setting, location early – once they are in one of the TriHealth/GSH Emergency departments.

- Expanded to 24 hr/ 7day operation
- Responsive to all emergency departments within TriHealth

Behavioral Health Consultations

- Provides upwards of 2000 behavioral health consultations to nonbehavioral health inpatient units at GSH and Bethesda North Hospital

GSH also sponsors the Urban Health project through providing office space for its base of operations – placing medical students in the community to provide services to the underserved, including the homeless, mentally ill, at risk youth and other underserved populations. The Good Samaritan Free Health Clinic will continue to offer mental health counseling to patients who have no insurance.

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 - GSH provides obstetric ("OB") and gynecological services to all comers via its OB Clinics and Family Practice residency programs. The OB Clinics have adopted an innovative Woman Centered Medical Home model meant to reinforce compliance with pregnant patient office visits and follow up care. GSH provides a Breastfeeding Support line free to the community.

   TriHealth will also continue its long time partnership with 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.

   Start Strong is an Avondale-specific outreach (nexus of infant mortality in Hamilton County)

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

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

- Urban Health Project (office space)
- OB Clinics
- OB Woman Centered Medical Home Model
- Funding for Cradle Cincinnati Neighborhood Based Woman Centered Medical Home
- Good Samaritan Free Health Clinic
- Healthy Beginnings
- Health Moms and Babes
- Think First For Your Baby
- Start Strong
- March of Dimes
- Sweet Cheeks Diaper Bank

3. Cancer: GSH 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.

   Given GSH's dedication to Women's services, it will continue to partner with The Ovarian Alliance for monthly ovarian cancer community education events.

   GSH funds the GSH Free Health Clinic and will continue to provide gynecological and mammography screening services to patients with no insurance coverage. Patients with positive results will be referred to TriHealth providers and obtain coverage from state funded Breast and Cervical Cancer Prevention (BCCP) funding.

   GSH partners with the Erica Hall Foundation to screen primarily African American women at risk for a specific kind of breast cancer.

   GGSH'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 also plans to continue its financial support to the American Cancer Society and American Lung Association.

4. Access to Care: Support for the Good Samaritan Free Health Center will continue; this serves only patient who do not qualify for any healthcare coverage – the working poor. Currently GSH provides transportation for needy patients with bus tokens and paid Uber rides. GSH/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 GSH areas of expertise are not found, GSH will focus on 1-3 above.

Available Resources to Address Priority Health Needs

Below is a list of community resources available to help address the significant health needs of the community serves

The following is a list of community resources and other TriHealth programs that TriHealth has worked with in the past. There are others that could be added as needed. As noted, any efforts to expand Access to Care will involve new partners.

Organization	Role	Focus
American Heart Association	Advocacy, community education	Chronic Conditions, Obesity
American Lung Association	Advocacy, community education	Chronic Conditions, Obesity
Cradle Cincinnati	Neighborhood Based Woman Centered Medical Home - Funding	Infant mortality/ Maternal Health
Family Nurturing Center	Post treatment support	Mental Health
Fernside	Fernside Children and Family Bereavement Support Groups	Mental Health
Freestore Foodbank	Advocacy, food for pantries	Nutrition Disparities
Greater Cincinnati Foundation	Collective Impact: Grants, support for organizations addressing social determinants of health	Obesity
GSH	Alcohol and Drug Rehab/Treatment	Substance Abuse
GSH	Good Samaritan Free Health Clinic	Chronic Conditions
GSH	Good Samaritan Free Health Clinic	Infant mortality/ Maternal Health
GSH	Good Samaritan Free Health Clinic	Mental Health
GSH	Urban Health Project free office space - medical students were placed in eight-week internships providing service to underserved populations in Greater Cincinnati, including the homeless, mentally ill, disadvantaged women, children, the elderly, at-risk youth, minority populations, refugees, and individuals who struggle with mental disorders or addiction.	Infant mortality/ Maternal Health
GSH	Urban Health Project free office space - medical students were placed in eight-week internships providing service to underserved populations in Greater Cincinnati, including the homeless, mentally ill, disadvantaged women, children, the elderly, at-risk youth, minority populations, refugees, and individuals who struggle with mental disorders or addiction.	Mental Health
Hamilton Cty Addiction Services Counsel	Identify issues to focus on for Hamilton County residents	Substance Abuse
Healthy Beginnings	OB care for underserved	Infant mortality/ Maternal Health
Healthy Moms and Babes	Home visits and pre-natal services Hamilton County	Infant mortality/ Maternal Health
Interact for Health	Grants, education, policy	Chronic Conditions
Interact for Health	Grants, education, policy	Substance Abuse
March of Dimes	Research and grants to prevent premature birth, birth defects and infant mortality	Infant mortality/ Maternal Health
NAMI Southwest Ohio	Programs, classes and support groups, education/data	Mental Health

Organization	Role	Focus
Ohio Cancer Research	Cancer awareness and seed money research	Cancer
St. Vincent de Paul Pharmacy	Free or low cast medication for underserved	Chronic Conditions
The Ovarian Alliance	Advocacy, Research and survivor programs	Cancer
TriHealth	Bus Tokens	Access to care
TriHealth	Cancer services: social work, nutrition counseling, genetic counseling	Cancer
TriHealth	Diabetic Education Classes open to all	Chronic Conditions
TriHealth	Free Breastfeeding Support Line	Infant mortality/ Maternal Health
TriHealth	HARP - primary care for discharged uninsured patients	Chronic Conditions
TriHealth	OB Clinics	Infant mortality/ Maternal Health
TriHealth	OB Woman Centered Medical Home Model	Infant mortality/ Maternal Health
TriHealth	Resident staffed clinics	Chronic Conditions
TriHealth	Substance Abuse Coordinator in ER	Substance Abuse
TriHealth	Sweet Cheeks Diaper Bank	Infant mortality/ Maternal Health
TriHealth	Think First For Your Baby - violence prevention	Infant mortality/ Maternal Health
United Way	Social agency funding	Mental Health
United Way	Social agency funding	Nutrition Disparities, Obesity
United Way	Social agency funding	Substance Abuse