# ADDENDUM:

## 2019 Community Health Needs Assessment

## Soin Medical Center

### PRIORITIZATION OF COMMUNITY HEALTH NEEDS

#### Introduction

In 2018 Soin Medical Center participated, as part of the Kettering Health Network, in the collaborative development of a Community Health Needs Assessment (CHNA) for Greater Cincinnati and Greater Dayton. The process obtained considerable community input across 25 counties and involved close cooperation with local health departments. This addendum serves two purposes: to describe the resulting priorities to address significant health needs, and to provide an update from the 2017-2019 implementation strategies. The addendum is considered part of the 2019 CHNA Report for board approval.

#### Criteria

The CHNA considered the health and health-related issues according to the following criteria:

- Community prioritized the issue highly (based on consensus on priorities)
- Public health departments prioritized the issue highly (based on consensus on priorities)
- Nonprofit agencies, representing vulnerable populations, prioritized the issue highly (based on consensus on priorities)
- Secondary data sources reflected that the issue was worse over time (based on up to 5 years' trend data collected for CHNA)
- Proportion of region impacted by worsening trends (based on CHNA data on the number of counties impacted by mortality rate; ratio of providers; and prevalence rate)

#### Process

The hospital's CHNA committee met on May 6, 2019 and June 11, 2019. Their names and titles are provided below. They met to review the priorities and confirmed that the CHNA priorities reflected the significant health needs of the community. Soin Medical Center did not add or omit any priority areas.

**May 6, 2019**

Jared Keresoma, Greene Memorial Hospital Administration
Jeff Jones, Human Resources
Bev Knapp, VP of Clinical Integration and Innovation
Toby Taubenheim, Kettering Behavioral Medicine Center
Lea Ann Dick, Manager of Diabetes and Nutrition
PJ Brafford, Government Affairs Officer
Kelli Davis, Community Benefit Coordinator

Molly Hallock, Community Benefit Coordinator
Gwen Finegan, Consultant

**June 11, 2019**

Rick Dodds, President, Soin Medical Center and Greene Memorial Hospital
Wendi Barber, Chief Financial Officer/Chief Operating Officer
John Nafie, Director, Foundation Administration
Cheyenne Silvers, Community Relations Coordinator
Bev Knapp, VP of Clinical Integration and Innovation
PJ Brafford, Government Affairs Officer
Kelli Davis, Community Benefit Coordinator
Molly Hallock, Community Benefit Coordinator
Gwen Finegan, Consultant

### Top Priorities

There was consistent agreement on the top priorities between the secondary data and all the stakeholder groups who provided input. Respondents included County Health Commissioners, individual consumers, attendees at public meetings, and agencies that represent vulnerable populations. The top priorities identified throughout the region, in descending order, were:

- Substance abuse/Mental health
- Access to care and/or services
- Chronic disease
- Healthy behaviors

## EVALUATION OF IMPACT OF 2017-2019 IMPLEMENTATION STRATEGIES

### Priority Issues: Diabetes, Heart Disease, Obesity

Objective: To increase diabetic screening rates for patients of the Kettering Health Network (KHN) and increase community awareness on diabetes risk factors.

Strategies:
1. Fund and implement PRIME Training & Certification for Primary Care Physicians in KHN.

2. Collaborate with community partners to screen and refer patients at risk for diabetes and educate the community on diabetes prevention.

Status:
1. A total of 24 primary care providers were trained and certified in the PRIME program through 2017. The following health outcomes showed improvement: Glycemic Control in 69.5% of patients; Blood Pressure Control in 77%; Cholesterol Control in 80.4%; Renal Control in 82.6%; and Smoking Control in 87.5%. A total of $3,000 in funding and resources was allocated to this initiative. The contract did not continue for 2018 and 2019.

2. All patients 18+ with a BMI above or equal to 30 were screened for diabetes. All patients deemed high risk were referred through a partnership with Greater Dayton YMCA, Public Health - Dayton & Montgomery County, Dayton Diabetes and Good Neighbor House. The

YMCA's Diabetes Prevention Program conducted 121 A1C screenings in 2017. A partnership was established with Public Health - Dayton & Montgomery County to expand capacity in 2018.

Free community presentations (Duck Diabetes) were provided in a variety of settings to increase public awareness of pre-diabetes. Paper risk assessments were distributed, and information on the community diabetes prevention programs was shared.

Staff from the Diabetes & Nutrition Department provided staffing support at no cost for "Dayton Diabetes" community Diabetes Prevention Program (DPP) in 2019. DPP health coach training and certification was provided 5 times over 3 years at the on-site Diabetes & Nutrition Center to 20 people. A total of $7,200 in funding and resources was allocated to these initiatives.

## Priority Issue: Heart Disease

Objective: To increase cardiovascular disease (CVD) screening and education to improve early detection of the disease.

Strategies:
1. Expand access to preventive clinical services via outpatient and community-based CVD screenings.

2. Fund and host community education events about CVD.

Status:
1. Between 2017 and 2019, 1,070 individuals received CVD screening (a yearly average of 428 screenings). Of these, 29% screened as high risk and were referred for risk factor management. A total of $46,586 in funding and resources was allocated to date.

2. Between 2017 and 2019, a total of 270 individuals attended 8 community education programs (5 heart health displays at community events and 3 education presentations). In addition, 10 Healthy Arteries programs took place in the community. A total of $2,731 in funding and resources was allocated to these programs.

## Priority Issues: Heart Disease and Diabetes

Objective: To increase access to tobacco cessation interventions through collaboration with community agencies.

Strategy: Partner with Greene County Public Health to deliver evidence-based tobacco cessation education to the community.

Status: This hospital partnered with Greene County Public Health to provide a smoking cessation program. Classes were open to the public and advertised throughout the community. In 2019, four separate sessions took place. The format is a five-week program and free Nicotine Replacement Therapy patches are distributed at each class. To date, 22 patients have participated in the program. The resources devoted to this program include over 100 hours from staff as well as the training of three staff to become certified Tobacco Cessation trainers.

## Priority Issue: Mental Health/Substance Abuse

Objective:

1. Integrate behavioral health screenings into primary care processes and train providers on how to use the tools.

2. Hire mental health professionals to provide care in primary care offices with the ability to receive immediate referrals.

Strategies:

1. Create a process and training to integrate evidence-based behavioral health screening tools in primary care practices.

2. Integrate behavioral health professionals into KHN primary care practices.

Status:

1. In 2017, 70,369 PHQ9 screenings were performed on 135,355 patients, with a completion rate of 51.99%. In 2018, 91,622 PHQ9 screenings were performed on 164,949 patients, with a completion rate of 55.55%. In 2019, 90,759 PHQ9 screenings were performed on 163,296 patients, with a completion rate of 55.58%.

2. Three behavioral health professionals were integrated into primary care practices; 1 in 2018 and 2 in 2019. The location are Springboro Health Center, Years Ahead Health Center, and Englewood Health Center.

*__11____/__7____/___2019_____*

*Date adopted by Board of Directors of Kettering Health Network*