ADDENDUM:

2019 Community Health Needs Assessment

Southview Medical Center

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

Introduction

In 2018 Southview 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 19, 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. Southview Medical Center did not add or omit any priority areas.

May 6, 2019
Richard Manchur, President of Southview Medical Center
Dr. Paul Martin, Chief Medical Officer
Kelly Fackel, VP of Development
Sheila Roberts, Human Resources
Christie Banford, Cassano Health
Eric Lunde, President, Troy Hospital
PJ Brafford, Government Affairs Officer
Kelli Davis, Community Benefit Coordinator
Molly Hallock, Community Benefit Coordinator
Gwen Finegan, Consultant

June 19, 2019
Becky Lewis, President of Grandview Medical Center
Dr. Paul Martin, Chief Medical Officer
Kelly Fackel, VP of Development
Mark Rita, VP, Clinical Services
Ronda Brandstater, VP Nursing Administration
Sheila Roberts, Human Resources
Bonnie Baker-Tattershall, Administration Fellow
Bev Knapp, VP, Clinical Integration and Innovation
PJ Brafford, Government Affairs Officer
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: Heart Disease and Diabetes

Objective: To implement evidence-based tobacco cessation programs in order to decrease rates of tobacco use in the community.

Strategy: Partner with Public Health - Dayton & Montgomery County to deliver evidence-based tobacco cessation education.

Status: This hospital has partnered with Public Health - Dayton & Montgomery County to provide a smoking cessation program on-site in 2019. This hospital runs two separate five-week sessions. A total of $100 in funding has been allocated to this program.

Priority Issue: Diabetes

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 offer education programs 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 program.

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 conducted 121 A1C screenings in 2017. $7,200 in funding and resources was allocated to this program. 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.

Priority Issue: Mental Health/Substance Abuse

Objective:

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

2. Integrate behavioral health providers into primary care practices.

Strategies:

1. Provide evidence-based screening tools and training for primary care physicians to improve identification of mental health and substance abuse issues.

2. Integrate behavioral health professionals into primary care practice teams.

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 locations are Springboro Health Center, Years Ahead Health Center, and Englewood Health Center.

Priority Issue: Mental Health/Substance Abuse

Objective: Develop a pain management program with a group counseling component.

Strategy: Create a program to reduce chronic pain utilizing non-pharmacological and complementary therapies. In the first year, the goal is to have 15 classes and serve 150 people. Staffing will include a Psychologist and a Pain Specialist. The system is allocating $2,500 for the first year of this program.

Status: During program development, there was not enough demand for feasible implementation and it was not cost-effective, as designed.

ADDITIONAL ACCOMPLISHMENTS

Access to Care and Mental Health/Substance Abuse Strategies

OneFifteen is a new nonprofit health initiative. It is dedicated to the full and sustained recovery of people suffering from opioid addiction. Its campus will expand treatment options in the region, and it will have a treatment center (inpatient and outpatient), rehabilitation housing, and wrap-around services. OneFifteen started seeing patients in 2019. It is the result of a community collaboration with Kettering Health Network, the Greater Dayton Area Health Association, and Premier Health Partners. KHN spent approximately $700,000 in 2019 for development as well as an additional $38,000 of in-kind donations in 2018 and 2019. OneFifteen will be fully operational in 2020.

Diabetes and Heart Disease Strategies

The health system is investing $400,000 to underwrite Gem City Market memberships.

In partnership with a local organization, Kettering Hospital Network will fund a mobile grocery store that will begin operation in 2019 to bring healthy food options into communities located in food deserts.

Heart Disease Strategies

Between 2017 and 2019, 810 individuals (a yearly average of 324) have been screened at this location for CVD with 26% showing high risk. All were referred for risk factor management. A total of $50,723 in funding has been invested in this program to date.

A total of 145 individuals attended five community education programs about CVD. A total of 17 Healthy Arteries programs took place on site. A full-time CT program is available. A total of $1,550 has been invested on these programs since 2017.

Infant Mortality Strategy

In 2019, and on an ongoing basis, the hospital is funding the annual cost of benefits, valued at $10,000, for two full-time Help Me Grow nurse who make home visits to new mothers.

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Date adopted by Board of Directors of Kettering Health Network