ADDENDUM:

2019 Community Health Needs Assessment

Fort Hamilton Hospital

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

Introduction

In 2018 Fort Hamilton Hospital 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 8, 2019 and June 10, 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. Fort Hamilton Hospital did not add or omit any priority areas.

May 8, 2019
Ron Connovich, President
Jennifer Shull, Administration
Dr. Marcus Romanello, Chief Medical Officer
Sonja Kranbuhl, Foundation
Teresa Pelfrey, Development Coordinator
PJ Brafford, Government Affairs Officer
Kelli Davis, Community Benefit Coordinator
Molly Hallock, Community Benefit Coordinator
Gwen Finegan, Consultant

June 10, 2019
Ron Connovich, President
Jennifer Shull, Administration
Sonja Kranbuhl, Foundation Director
Miriam Cartmell, Executive Director, Surgical and Women's Service
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 Issue: Diabetes

Objective: To increase the number of community educational events to increase public awareness and improve clinical outcomes.

Strategy: Deliver diabetes education with emphasis on symptoms, impact, and treatment.

Status: 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. The hospital hosts a Diabetes Support Group, a free community program to provide group support, education, and resource connections. Health Fairs with diabetes education components were scheduled for Butler County residents at 5 locations in 2019. Various community events took place in 2019: A to Zumba at East Butler YMCA (diabetes education on prevention, support & heart healthy

eating); Better Sleep - Health Night Out (diabetes education on disease management and effect on sleep); and Move and Groove at the YMCA event with diabetes education.

Priority Issue: Mental Health/Substance Abuse

Objective: To expand outreach to IV Opioid Users in the community.

Strategies:
1.Coordinate the Fort's Opiate Recovery Taskforce (F.O.R.T.) and develop a new Syringe Exchange Program.

2. Support early interventions for overdose victims and the "Golden Ticket" program for immediate admission to rehab facilities.

Status:
1. In 2019, the F.O.R.T. team provided outreach to 329 individuals. The Program Coordinator's lecture was a part of Kettering Health Network's curriculum for Emergency Nursing boot camp and for Butler Tech paramedic classes. Staff participated in five local and regional conferences regarding the F.O.R.T.'s impact. This hospital also advocated for syringe exchange at designated community sites. Butler County, Mercy Fairfield Hospital, and Middletown now offer syringe exchange in the county. With its demonstrated success, the F.O.R.T. program was embraced by the Butler County Police Department, and they now operate the program.

2. The hospital coordinated a process on the KHN Intranet to allow employees to refer an individual who is seeking help with addiction immediately. There is continuing participation at the "Golden Ticket Intervention Meetings." The most common resource used is the Heroin Hopeline, which is supported by Crossroads Church and Beckett Springs. The hospital's EMS Coordinator continues to facilitate requests for release of patient data to treatment facilities. The Nurse Practitioner working with behavioral health patients dedicates time to calling the Heroin Hopeline and making referrals.

Priority Issues: Heart Disease and Diabetes

Objective: To decrease rates of tobacco use in the community utilizing evidence-based programs.

Strategy: Create community partnerships to deliver coordinated, evidence-based tobacco and nicotine cessation programs.

Status: The hospital worked with local leaders to support the City of Hamilton's smoking ban on all campuses, in parks, and other public city-owned properties. Staff met with Butler County Administrators regarding a "Sin Tax" for tobacco and next steps for implementation.

ADDITIONAL ACCOMPLISHMENTS

Access to Care/Mental Health Strategy

In 2019 the hospital placed a social worker in the Emergency Department. To date, the most common patient concern has been the need for connections to community partners for substance abuse interventions.

Heart Disease Strategies

Between 2017 and 2019, 478 individuals received cardiovascular screening at the hospital (yearly average of 191 screenings). Of these, 32% screened as high risk and were referred for risk factor management. A total of $20,056 in funding and resources was allocated to this initiative to date.

Between 2017 and June 2019, a total of 165 individuals attended 9 community education programs hosted by this hospital. In addition, this hospital hosted 19 Healthy Arteries programs in the community. A total of $2,790 in funding and resources were allocated to these programs.

Infant Mortality Strategy

The hospital is funding the annual cost of benefits for two full-time Home Visitor Nurses, who were hired in early 2019. To date, eight patients from this hospital are enrolled and two more are awaiting intake visits. The average new nurse takes 9-12 months to reach a full caseload of 25 patients. A total of $10,000 in annual funding has been allocated to this partnership with Help Me Grow.

In 2018, Primary Health Solutions' patients delivered 225 babies at FHH and in 2019 YTD, patients from this FQHC delivered 118 babies at FHH. Of those babies delivered, 70 were admitted to the specialty care nursery: 45 in 2018 and 25 in 2019 YTD.

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Date adopted by Board of Directors of Kettering Health Network