

# FORT HAMILTON HOSPITAL

## Implementation Strategies 2017 – 2019

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### Mission & Vision

#### Our Mission:

To improve the quality of life of the people in the communities we serve through health care and education.

#### Our Vision:

Kettering Health Network will be recognized as the leader in transforming the health care experience.

#### Our Values:

- Trustworthy
- Innovative
- Caring
- Competent
- Collaborative

### Community Served

Butler County in Ohio

### Prioritized List of CHNA Community Health Needs

#### Criteria

A hospital committee scored the community health needs identified in the CHNA by considering the following criteria:

- Cause of hospitalization/Emergency Department visits (based on hospital utilization data from the Ohio Hospital Association)
- Feasibility and effectiveness of interventions (per The Community Guide; CDC recommendations; and/or recommendations from hospital physicians and/or leaders)
- Hospital's ability to impact effectively (already positioned to make a difference; and/or addressing issue in strategic or community plan)
- Impact on other health outcomes (based on risk factors associated with issue)
- Importance placed by community (based on community priorities in CHNA report)
- Measurable outcome exists (based on CHNA's data sources)
- Opportunities for meaningful collaboration (with current or potential community partners)
- Severity and proportion of population impacted (per incidence rate of new cases; prevalence rate; mortality rate; and/or top cause of death)

- Significant health disparities (by geographic areas of disparity measured by Community Need Index score and/or health issues identified in 2011 and 2013 CDC reports)
- Societal burden (based on education, observation, and/or experience of person scoring)
- Trend: Issue worse over time (based on up to 5 years' trend data collected for CHNA)

### Prioritization Process

There were two meetings held with professional facilitation by a consultant, Gwen Finegan. Kettering Health Network held meetings on April 18 and April 27, 2016 for hospital leaders to convene, discuss, and determine the prioritization process. At a meeting on June 7, 2016 Fort Hamilton Hospital leaders scored the health issues according to criteria determined by consensus at the April meetings.

In order to determine the most significant priorities among all the CHNA issues, Fort Hamilton Hospital used a grid with a scoring scale of 1 to 5. For the CHNA prioritization process, a low numerical score denoted that the criteria did not provide enough reasons to elevate an issue as a significant priority, while a high numerical score meant that the criteria gave evidence of an issue meriting 'high priority.' A blank scoring sheet is provided as an example.

Kettering Health Network's experience with both mental health and substance abuse also led their combination into one category, since mental health issues are a root cause for most substance abuse disorders. In the CHNA cancer, diabetes, heart disease, and obesity were mentioned individually as well as mentioned within the broader category of chronic disease. During the prioritization process, these were considered both together and separately.

### Priorities

- Diabetes
- Mental health/Substance abuse
- Heart disease

### Process for Strategy Development

PJ Brafford, Network Government Affairs Officer, and Lauren Day, Missions Coordinator, convened internal stakeholders to develop strategies. Strategies were discussed in two meetings to identify best-practice and evidence-based responses for the priority areas.

The initial meeting was held on August 3, 2016 and an additional meeting occurred on August 25, 2016. Both meetings were facilitated by an external consultant, Gwen Finegan, who also provided technical assistance in follow-up emails and phone calls. People contributing to strategy development included:

- Phil Boarman, Director, Rehab Administration
- PJ Brafford, Network Government Affairs Officer, Kettering Health Network
- Miriam Cartmell, Executive Director, Women's Services, Kettering Health Network
- Kelli Davis, Community Outreach Coordinator, Kettering Health Network
- Lea Ann Dick, Director, Joslin Diabetes
- Paul Hoover, Strategic Development, Kettering Health Network
- Beverly Knapp, Vice President, Health Outreach, Kettering Health Network
- Sonja Kranbuhl, Director, Fort Hamilton Foundation
- Jennifer Mason, EMS Coordinator, Kettering Health Network
- Aric Merrill, Administrative Director
- Michael Mewhirter, President
- Robert Patterson, Corporate Integrity, Kettering Health Network
- Marcus Romanello, MD, Chief Medical Officer

The hospital team consulted, within Kettering Health Network, topic experts in Diabetes, Cardiovascular Health, Community Paramedicine, Substance Abuse, and Behavioral Health to further refine strategies. Other sources of information about effective strategies were:

- The Centers for Disease Control and Prevention's (CDC) Community Guide
- CDC's Health Disparities and Inequalities 2011 Report and 2013 Supplement
- CDC's Winnable Battles
- Health Policy Institute of Ohio's Guide to Evidence-Based Prevention
- County Health Rankings & Roadmaps' "What Works for Health"
- The Joslin Diabetes Center
- U.S. Preventive Services Task Force of the Agency for Healthcare Research and Quality

Overarching goals were identified to formulate strategies that

- Increased connections with community-based organizations,
- Reflected the values and best practices of Kettering Health Network, and
- Promoted alignment and integration with public health priorities and evidence-based approaches.

Teams finalized strategy measures and added resource information throughout August and September. Senior leaders at the hospital approved final versions before presenting the implementation strategies to the Board of Directors in November 2016.

Several strategies are contingent on community involvement and partnerships for their eventual success. Hospitals traditionally have not sought to share responsibility for health outcomes with external partners as much as these implementation strategies do. There is a degree of uncertainty about exactly how the collaborations will develop, but the potential of broad-based and tangible improvements is well worth the risk. This level of sharing is the only path forward to improve impact for individuals and for the health of community. With robust community partnerships, another advantage will be the ability to respond as new emerging issues surface.

## Description of Strategies

A table with more details is provided on pages 7 and 8. It includes information about measuring impact, timing, and resources to accomplish the activities.

### Diabetes Education

Issue addressed: Diabetes

Intervention: Increase the number of community educational events to reach more people and improve clinical outcomes in the community. Refer to and partner with the Joslin Diabetes Center.

Background: The Joslin Diabetes Center opened a location in the City of Hamilton in January 2016. The Boston-based Joslin Diabetes Center is one of 11 NIH-designated Diabetes Research Centers in the United States.

Partner: Joslin Diabetes Center in Hamilton, Ohio.

### Syringe Exchange Program

Issue addressed: Substance abuse

Interventions: Expand outreach to intravenous opioid users, provide syringe exchange program to injection drug users, and share information about testing and treatment.

Background: According to the Butler County Mental Health and Addiction Recovery Services Board, “In 2014, 75% of deaths investigated by the Butler County Coroner were heroin-related. And 46% of those treated for substance use in Butler County abused heroin. In 2015 there were 149 total overdose heroin deaths in Butler County. Today that number has grown more than 500% in three years.”

[<http://www.letsfaceheroinbc.org/>, accessed September 20, 2016]. A new syringe exchange program will build on the foundation established with Fort Hamilton Hospital’s Opiate Recovery Taskforce that provides information to addicted patients in the Emergency Department. In the CDC’s document, “Syringe Services Programs (SSPs) - Developing, Implementing, and Monitoring Programs,” the following characteristics of a successful program are provided: “A comprehensive, multi-component, prevention program is the most effective approach for preventing the transmission and acquisition of HIV and other blood-borne infections among drug-using populations. SSPs are an important component of this approach and are particularly key in establishing contact with otherwise hard-to-reach populations to deliver health services, including HIV, sexually transmitted diseases (STD), and viral hepatitis counseling (including for risk reduction) and testing, overdose prevention, and substance use disorder treatment referrals” [<http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-developing-ssp.pdf>, accessed June 27, 2016].

Potential partners: Community Behavioral Health; Genesis Center; Dr. Moss's practice; Hamilton Police Department, EMS, City of Hamilton Health Department; City of Middletown Health Department; and other treatment providers.

#### Tobacco Cessation

Issues addressed: Heart disease and Diabetes

Intervention: Implement initiative to decrease tobacco use.

Background: Comprehensive tobacco control programs have been recommended in 2014 in the CDC’s Guide to Community Preventive Services [[www.communityguide.org](http://www.communityguide.org), accessed January 2016] and scientifically supported in 2014 in County Health Rankings & Roadmaps [[www.countyhealthrankings.org](http://www.countyhealthrankings.org), accessed February 2016]. Coordinated strategies are successful when they combine educational, clinical, regulatory, economic, and/or social approaches. The CDC states that smoking causes Type 2 diabetes and makes it more difficult to control. Smokers with diabetes have higher risk for serious complications such as heart disease. [<http://www.cdc.gov/tobacco/campaign/tips/diseases/diabetes.html>, accessed October 14, 2016].

Potential partners: City of Hamilton; Public Health Departments; Funders; Community-based groups; Pharmacies; and Local employers.

#### Accountability

The Hospital President will be responsible for ensuring progress on the measures used to evaluate the impact of each strategy. Quarterly updates will ensure strategies stay on target. Annually hospital executive and board members will receive progress reports.

### Significant Health Needs Addressed

Implementation Strategies, listed on the following pages, address the prioritized health needs: Diabetes; Mental health/Substance abuse; and Heart disease.

### Significant Health Needs Not Addressed

Not applicable.

11 / 3 / 2016

*Date approved by Kettering Health Network Board of Directors*

# Blank Scoring Sheet – CHNA Prioritization

<b>Criteria</b>	<b>Access to care/ services</b>	<b>Cancer</b>	<b>Chronic disease</b>	<b>Diabetes</b>	<b>Heart disease</b>	<b>Infant mortality</b>	<b>Mental health/ Substance abuse</b>	<b>Obesity</b>
Feasibility and Effectiveness of Interventions								
Cause of Hospitalization/ED Visits								
Impact on Other Health Outcomes								
Importance Placed by Community								
KHN/Hospital's Ability to Impact Effectively								
Measurable Outcomes								
Opportunities for Meaningful Collaboration								
Severity & Proportion of Population Affected								
Significant Disparities								
Societal Burden								
Trends: Issue Getting Worse over Time								
<b>TOTAL</b>								

**Low**

**High**

**1**

**2**

**3**

**4**

**5**

**Not a Priority**

**Low  
Priority**

**Mild  
Priority**

**Moderate  
Priority**

**High  
Priority**

## Implementation Strategies

Priority Issue(s)	Strategy	Evaluation of Impact	Resources		Timing	Collaboration
			Financial	Staffing		
Diabetes	Diabetes Education: Increase the number of community educational events to improve clinical outcomes in the community, with emphasis on symptoms, impact, and treatment.	<p>Quadruple the number of educational events in 3 years and the number of people who attend. In 2017 increase by 5% (over 2016) the number of people who seek services at Joslin Center and expand by another 5-10% in 2018 and 2019.</p> <p>Screen up to 400 in 2017 for possible referral to Joslin. Screen up to 500 in 2018, and screen up to 600 in 2019. 70 % of patients at Joslin Diabetes Center will have A1C &lt;8; BP &lt;= 140/90; LDL &lt;100; and eGFR &gt;60.</p>	<p>Annual cost for Paper Risk Assessment Screening: \$1,000. Cost for A1C blood test screening: \$6,000 in 2017; \$7,500 in 2018; and \$9,000 in 2019. Annual labor cost for 0.5 FTE of RN CDE: \$39,520. Total estimated costs in 2017 = \$46,520.</p>	RN/CDE: 0.50 FTE at Joslin to support additional volume	<p>Year 1: 3 events Year 2: 6 events; 10% increase in Joslin volume Year 3: 12 events; 5% increase in Joslin volume</p>	Joslin Diabetes Center in Hamilton OH
Mental health/ Substance abuse	Expand Outreach to IV Opioid Users: Maintain the Fort's Opiate Recovery Taskforce (F.O.R.T.) and develop a new Syringe Exchange Program.	Identify best community solution to provide or connect to services, including delivery of clean needles, to IV drug users. For example, create a mobile needle exchange and/or partner with outside agency to administer the exchange.	\$25,000 pledged annually to F.O.R.T. by Butler County Mental Health Services & Addiction Recovery Services Board. Estimated labor cost = \$17,551 in the first year.	EMS Coordinator: 0.10 FTE; Community Outreach: 0.10 FTE	<p>Year 1: Establish syringe exchange program. Continue F.O.R.T. operations. Year 2: Distribute syringes and connect people to testing, treatment, and other resources. Continue F.O.R.T. operations. Year 3: Expand operations as needed</p>	Community Behavioral Health; Genesis Center; Dr. Moss's practice; Hamilton Police Department, EMS, City of Hamilton Health Department; City of Middletown Health Department; other treatment providers

Implementation Strategies, continued

Priority Issue(s)	Strategy	Evaluation of Impact	Resources		Timing	Collaboration
			Financial	Staffing		
Heart disease (and Diabetes)	Tobacco Cessation: Creation of community partnerships to deliver and coordinate evidence-based tobacco and nicotine cessation efforts through the community.	Creation of community partnerships. Increase pool of eligible applicants for employment (baseline=50%). Increase collaboration with existing partners, e.g., City of Hamilton. Increase level of outreach staffing. Explore external funding for regional efforts, and explore public and private policies to reduce consumption, especially with local employers.	Estimated labor costs = \$30,714 in year one.	Community Benefit Lead: 0.05 FTE; Community Outreach: 0.25 FTE; Ft. Hamilton Coordinator/ Lead: 0.05 FTE	Year 1: Community partnership created Year 2: Full operations underway Year 3: Expanded capacity with additional funding	City of Hamilton; Public Health Departments; Funders; Community-based groups; Pharmacies; Local employers