ADDENDUM:

2019 Community Health Needs Assessment

Greene Memorial Hospital

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

Introduction

In 2018 Greene Memorial 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 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. Greene Memorial Hospital 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 Medical 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/Greene Memorial Hospital
Wendi Barber, Chief Financial Officer/Chief Operating Officer
John Nafie, Director, Foundation Administration
Cheyenne Silvers, Community Relations Coordinator
PJ Brafford, Government Affairs Officer
Bev Knapp, VP of Clinical Integration and Innovation
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 and improve outcomes of diabetic patients in the community.

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

2. Provide community education on diabetes prevention and risk factors.

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. 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.

Priority Issue: Heart Disease

Objective: Increase cardiovascular disease (CVD) screening and education in the community.

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 early 2017 and June 2019,16 individuals received cardiovascular screening at this hospital. Of these, 56% screened as high risk and were referred for risk factor management. A total of $1,190 in funding and resources was allocated to this effort to date.

2. This hospital supported a Healthy Artery education program annually in the community. Staff provided a heart health display and gave a presentation on heart health at community events. Fifty-eight individuals attended. A total of $840 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: Create community partnerships to deliver coordinated evidence-based tobacco and nicotine cessation education and support.

Status: In partnership with Greene County Public Health, Tobacco Cessation classes at this site started in 2019. Each session included four classes, with free nicotine therapy patches being provided at each. A total of 21 individuals participated in the sessions as of June 2019. Three staff became certified Tobacco Cessation trainers. Starting in November 2019, classes will be condensed into one-hour sessions and take place monthly. All classes held at the Soin Medical Center are promoted to Greene County residents and the community at large.

Priority Issue: Mental Health/Substance Abuse

Objective: Increase access to community mental health and substance abuse treatment for patients.

Strategies:

1. Integrate behavioral health screenings into routine care for cancer patients.

2. Create referral partnerships with community resources: South Community & Beckett Springs.

3. Participate in the County Behavioral Health Task Force to improve access and urgent services for community members suffering from mental health and substance abuse disorders.

4. Build referral partnerships to increase access for patients suffering with substance abuse/addiction disorders.

Status:
1. In January 2019, cancer patients were screened for behavioral health issues at Beavercreek, Greystone, Ollie Davis, and Xenia Family Practice clinics.

2. The referral process is ongoing.

3. The hospital participated in the Behavioral Health Task Force.

4. The Kettering Behavioral Medicine Center opened a Co-Occurring Intensive Outpatient Program in August 2019. An additional 14 bed Co-Occurring mental health/substance abuse use unit opened in November 2019.

Priority Issue: Mental Health/Substance Abuse

Objective: Increase capacity for treatment in Greene County.

Strategies:
1. Join the Collective Impact initiative focused on the county-wide strategy to reduce addiction and overdose deaths.

2. Provide funding to start a Drug Free Coalition in Greene County.

Status:
1. One major focus of the initiative was to determine the feasibility of a county-wide detox center. Working with five county agencies, the group consulted with three 3rd-party detox organizations to provide services, but the process did not progress to implementation.

2. Participation in Drug Free Coalition meetings is ongoing. The hospital donated $20,000 in 2019 for start-up costs and donates catering at meetings, valued at $4,000.

Priority Issues: Diabetes, Heart Disease, Obesity

Objective: Encourage healthy eating by providing prescriptions for healthy foods.

Strategy: Develop a model that incentivizes people with diabetes and/or heart disease to eat more healthy foods.

Status:
This hospital is consulting with the Central State University Land Grant program on the provision of food to satisfy physician prescriptions via their freight farm program. Determination about feasibility of implementation will take place in late 2019.

Priority Issue: Access to Care/Services

Objective: Increase access to primary care in rural areas.

Strategies:

1. Create a residency program for providers interested in practicing in rural areas.

2. Donate land needed to build a community health hub to serve patients in rural parts of the County.

Status:

1. The first class of residents on the Rural Health track will graduate in the summer of 2021. Three residents will be assigned each academic year.

2. Kettering Health Network provided land for the REACH Center in Xenia, which houses health, education, physical fitness, and senior services.

__11____/___7___/___2019_____

Date adopted by Board of Directors of Kettering Health Network