COMMUNITY HEALTH IMPROVEMENT PLANRECAP

2014-2016

Premier Health

GOOD SAMARITAN HOSPITAL

Good Samaritan Hospital and Premier Health: Committed to Improving Community Health

Good Samarian Hospital is part of Premier Health, the largest health care system in Southwest Ohio. It is committed to improving the health of the communities it serves through a variety of prevention, health improvement and engagement programs. As part of its overall commitment to the community, Good Samarian Hospital focuses on four areas of service:

- Investing in the community
- Prevention and wellness
- Commitment to the under-served
- Community engagement

Two examples of Good Samaritan Hospital's community health improvement programs include:

The Phoenix Project

As part of Good Samaritan's commitment to give back to the Dayton community, the hospital partnered with the city of Dayton and CityWide Development Corporation for an initiative called the Phoenix Project. Named after the legendary bird that regenerates itself, the Phoenix Project is a comprehensive plan to revitalize the Fairview and Mount Auburn neighborhoods surrounding Good Samaritan Hospital.

The goal is to spur ongoing development and investment to ensure the neighborhood is a safe and attractive urban community for residents and businesses. In an effort to improve homeownership in the area, the project offers low-interest home improvement loans to resident-owners, as well as down-payment help for first-time home buyers. The Phoenix Project also offers a summer day camp for youth and a training and employment program for teenagers to help them learn the skills necessary to find and keep a job.

The Phoenix Project removed more than 100 blighted properties, supported 33 new lease-to-purchase homes and $1 million in private home investment via DPA, Home Improvement Loans, Home Choice and Rebuilding Together.

Health Ministries

Health Ministries provides assistance to faith communities that want to develop and maintain a focused ministry of health and healing for their congregations. Health Ministries emphasizes the wholeness of body, mind and spirit. The Health Ministries program is available to any and all area faith communities interested or involved in such a ministry.

Our Catholic Heritage

In 1932, Good Samaritan Hospital was founded by the Sisters of Charity. Today, it still holds sacred its Catholic heritage and culture. In 1996, Good Samaritan Hospital became a part of Catholic Health Initiatives (CHI), one of the largest Catholic health systems in the country. CHI was formed to advance and strengthen the Catholic health ministry into the 21st century. Today, Good Sam shares CHI's core values with more than 125 organizations nationwide. These values inspire the personal relationships and scientific advances that are the spirit and substance of Good Sam.

Good Samaritan Hospital is part of Premier Health, the largest health care system in Southwest Ohio. This community health improvement plan comes from data gathered through a Community Health Needs Assessment conducted in 2013 on behalf of all the hospitals in the region by the Greater Dayton Area Hospital Association and Wright State University. The service area identified for improvement by that survey is Montgomery County, Ohio.

The priority areas identified for health improvement are:

Priority Area 1: Reduce the proportion of adults with hypertension.
Priority Area 2: Reduce the female breast cancer mortality rate.
Priority Area 3: To reduce the incidence of diabetes in our area and prevent complications in those who have diabetes.

Identified Priorities

Through the assessment, researchers identified priority areas for community health improvement using a variety of criteria. The priorities that are included in the plan – and excluded from it – are outlined here.

Priorities Addressed Through Collaboration

All identified priorities are important in improving the health of our community. In some instances, priorities are already being targeted by collaborative groups of which Good Sam is a part. Additional strategies will not be developed independent of these efforts. Because of the importance of these community-wide efforts, the following identified priorities are not included in the community health improvement plan.

Maternal and Infant Priorities

1. First trimester prenatal care
2. Low birth weight
3. Infant mortality rate

Primary and Chronic Diseases

1. Alcohol and drug discharge diagnosis
2. Mental health disorders

Health Issue	Update
First trimester prenatal care	There has not been a noticeable decrease in the percentage of women receiving late or no prenatal in Montgomery County. In 2007, it was 5.2%; in 2013, 5.3%.
Low birth weight	In 2014, the low birth rate (LBR) was 9.1% in Montgomery County. In 2015, the LBR was 9.6% - a 0.5% increase from the previous year. The LBR for 2016 is 9.5%, which is a 0.1% decrease from the previous year. 2016 – 9.5%, 312 total people who gave birth to babies who were underweight* 2015 – 9.6%, 637 total people who gave birth to babies who were underweight* 2014 – 9.1%, 597 total people who gave birth to babies who were underweight* *Statistics were found on Ohio Department of Health's online database.

Infant mortality rate	Premier Health has instituted a systemwide safe sleep program through which we: • educate all maternity patients on the importance of the ABC's of safe sleep A= sleep **ALONE** in bed—do not sleep with parents, siblings, etc. B= place baby to sleep on the **BACK** C= have baby sleep in a separate **CRIB** • model safe sleep practices in the hospital • use a sleep sack in the hospital • send parents home with a sleep sack for them to use Good Sam facilitated a partnership between the ParentLink program of Catholic Social Services and LifeStages –Samaritan Centers for Women. This joint community outreach project brings support to at-risk pregnant women and teens in the urban Dayton area. The innovative partnership received a three-year grant from Catholic Health Initiative's mission and ministry fund. The medical and social service staffs join together to meet the basic needs of pregnant and parenting mothers who are living in poverty. Our clinic staff, with the assistance of the case manager from Catholic Social Services of the Miami Valley (CSSMV), help young mothers find stable living conditions and gain access to support needed to empower them to keep their infants safe with adequate care, especially emphasizing prenatal care. With the help of ParentLink staff with CSSMV, we provide extended home-based and clinic services, offering up to 18 months of parent education and support. Catholic Social Services seeks to improve the nurturing and care of infants through the ParentLink case management program. By establishing a personal and trusted relationship with young mothers, CSSMV social workers have worked to prevent child abuse and build positive parenting skills. Good Sam and Premier Health collaborate with Five Rivers Health Centers. Five Rivers Health Centers (FRHC) received a 4.9 year grant to improve perinatal health, decrease pre-term births, reduce infant mortality, and reduce infant morbidity. The grant was made by Health Resources Services Administration (HRSA) in the amount of $750,000 each year. Five Rivers Health Centers is one of five Healthy Start recipients in Ohio and one of nine federally qualified health centers nationally receiving this award. This is the first time that anyone from Montgomery County had received this grant. We target the 45402, 45403, 45405,45407, 45414, 45417 and 45426 ZIP codes – which historically have had the highest infant mortality rates in this region. Through this grant, we have achieved the following through a "kitchen sink" approach: • By creating an incentive program for pregnant women and parents, Five Rivers Healthy Start has increased prenatal visits (by 12% from the

previous year) and increased abstinence from smoking and drugs (by 15% from the previous year). It has awarded participants for taking part in classes and other healthy behaviors. Patients see a direct correlation to their healthy behaviors and the rewards (incentives) that they choose.

- The Five Rivers Healthy Start Program includes a program coordinator, three community health workers (who visit patients at their homes), a high-risk nurse educator, tobacco cessation nurse, social worker, data analyst, dietitian, and certified nurse midwife. We contract with Premier Health's Help Me Grow/Nurse Family Partnership, which provides home visits for our high-risk patients. We contract with Samaritan Behavioral Health to provide a part-time behavioral health consultant to provide on-site counseling.

- Upon completion of their prenatal care, post-partum care, and initial well-child visit, families are eligible to receive a $50 gift card, portable crib, layette, and some diapers.

- Five Rivers Health Centers
    - offered 14 Centering Pregnancy groups – with more than 110 participants -- 13% –Low Birth Weight; 13%– Pre-term Rate – 1 infant death (we are the largest program in Ohio).
    - offered two Centering Parenting groups.
    - is one of four federally qualified health centers in Ohio that received a centering grant to expand our current program.
    - created Montgomery County's first diaper bank for parents in targeted ZIP codes. Local community agencies provide these diapers to their patients/clients as well.
    - created a comprehensive patient and provider guide.
    - all Healthy Start patients are visited by the team after they deliver to ensure they have post-partum visits scheduled and infants have scheduled appointments.
    - developed a comprehensive maternity resource guide to be used by community agencies and one for patient use with more than 320 agencies to access.

- Patients see a direct correlation to their healthy behaviors and the rewards (incentives) that they choose

- Five River HS is one of the newest program yet we are exceeding all federal expectations for volume. We served 1,232 participants in our first full year (2015); HRSA's goal had been 500 participants.

- We track more than 500 data points associated with our patients. In 2015:
    - 89% of all women had a documented reproductive life plan – a plan to determine if and when she will be pregnant in the future.
    - 63% of all Healthy Start patients kept their postpartum appointment, up from 52% within our general population.

	• 97% of participants engaged in safe sleep behaviors. • 98% of participants were screened for depression. • FRHC continues to administer progesterone to eligible patients as well. <u>What does all of this mean for the local infant mortality rate?</u> • In 2013, FRHC Center for Women's Health had 11 infants who died. • In 2014, FRHC Center for Women's Health had 15 infants who died. • In 2015, Five Rivers Healthy Start had three infants who died. The Center for Women's Health had four additional infants who died, for a total of seven deaths. This was a 53% decrease from the previous year, but until we get to 0%, we still have a lot more work to do. Future Plans With additional Medicaid funding for two years, FRHC plans to engage with all patients regardless of their ZIP codes to try this same "kitchen sink" approach. Additionally, we will be engaging fathers in parenting through a "Daddy Boot Camp" program and addressing one of the social determinants of health – housing – to improve conditions for pregnant women.

Additional Efforts in Addressing Maternal and Infant Priorities

Good Sam is involved in several state-wide initiatives addressing maternal and infant issues. The hospital shares the goals and objectives collaboratively developed with these groups for program implementation and measurement.

<u>Ohio Perinatal Quality Collaborative:</u> Good Sam is a non-charter member of this organization as a maternity hospital. The mission of the collaborative is as follows: "Through collaborative use of improvement science methods, reduce preterm births and improve outcomes of pre-term newborns in Ohio as quickly as possible."

Projects of the collaborative include:

- 39 Weeks Delivery Charter Project – to reduce unnecessary elective scheduled births before 39 weeks gestational age, thereby reducing infant mortality and low birth weights.
- 39 Weeks Dissemination and Birth Registry Accuracy Project – to address inaccuracies in birth certificate data within the quality improvement framework.
- Obstetrics Antenatal Corticosteroids Project- to increase the use of antenatal corticosteroids to reduce mortality and morbidity among preterm infants.
- Progesterone Project – to raise awareness about the need for screening and intervention for progesterone; provide support to teams to implement screening, identification and treatment; develop the capacity and capability of skilled ultrasound technicians; and remove administrative barriers to the administration of progesterone. (Reduce infant mortality and low birth weights.)

<u>Ohio Hospital Association (OHA).</u> OHA has developed a plan to reduce infant mortality (which also addresses low infant birth weight and first trimester care) in Ohio. The plan includes:

- safe sleep
- eliminating elective deliveries before 39 weeks
- progesterone for high-risk mothers

- Eliminating health disparities
- Safe spacing (also addresses low birth weight)
- Access to prenatal care (also addresses first trimester care and low birth weight)
- Promote breast milk

Primary and Chronic Diseases

1. Alcohol and drug discharge diagnosis
2. Mental health disorders

In Montgomery County, alcohol and drug abuse services are coordinated by the ADAMHS Board (Alcohol, Drug Addiction and Mental Health Services). The ADAMHS Board administers the planning, development, funding and evaluation of behavioral health services delivered by a network of nearly 30 community-based organizations.

Health Issue	Update
Alcohol and drug discharge diagnosis	Samaritan Behavioral Health, Inc. (SBHI) significantly expanded its substance abuse services in 2014-15 in response to the opiate epidemic plaguing Montgomery County and surrounding counties. This included an increase in its medication-assisted treatment services using: • suboxone and Vivitrol • expanded counseling services • new partnerships with Montgomery County correctional facilities • the development and presentation of a seminar for physicians on 'Improving Opiate Addiction Care' • a new partnership with Miami Valley Hospital to provide opiate addiction care to pregnant women called "Promise to Hope." Access to counseling and psychiatric services was expanded through the opening of a new office in Miami County, where more than 600 patients are now being served. Turning Point offers assessment and treatment for individuals in the Miami Valley who are experiencing problems or concerns over their substance use. We offer opportunities for individuals to learn about their substance use through self-exploration and offer skill-building sessions to assist them with building a life worth living through recovery. Join us in taking the stigma out of substance use and let us begin to give back to our families and communities. During the 2014 year, we worked with 560 individuals and families and provided 4,286 group sessions to assist those suffering from substance use with skills and information to make a positive change in their lives and their communities. During 2015, we assisted some 570 individuals and provided 4,712 skill-building sessions.

Mental health disorders	Access to counseling and psychiatric services was expanded through the opening of a new office in Miami County, where more than 600 patients are now being served. Focusing on early intervention, SBHI opened its "child and family partnership program" for school-aged children struggling in school settings due to behavioral difficulties. In February 2015, SBHI assumed ownership of a Wright State University mental health and substance abuse program at risk of closing. This program, the Consumer Advocacy Model (CAM), serves adults with serious mental illnesses and those with mental illness and co-occurring substance abuse issues and other disabilities, such as hearing impairments and traumatic brain injuries. Our violence prevention program, United Against Violence of Greater Dayton, has developed and implemented strategies to address all forms of violence in Montgomery County. Of particular interest is the United Against Violence-sponsored Second Step program, an empathy-based bullying prevention curriculum that has been taught to hundreds of Dayton area youth. 2014-2015 Substance Use Disorder Community Involvement: • served as content expert for treatment options and readiness for change domains at the Conversation For Change • panelist at the SONK conference, Sigma Theta Tau International-sponsored opiate conference • naloxone training to substance use disorder clients and their families • member, Opiate Coalition, 2011-present (CITAR, WSU, ADAMHS) • expansion of psychiatric consultation team that provides screening, brief intervention, and referral to treatment (SBIRT) for substance use clients • Promise to Hope inception at Miami Valley Hospital: A program designed to link opioid dependent pregnant females to mental health, medication-assisted treatment, and obstetrical care under the supervision of a nurse navigator and collaborative community partnerships • integration into the electronic medical record of COWS, a validated assessment tool intended to capture the severity of opioid withdrawal • routinely expedites bed-to-bed transfers at residential drug and alcohol treatment programs for individuals with medical complications who are ready for change (the highest risk for overdose or death) • partnered with medication-assisted treatment agencies to refer individuals to treatment upon discharge • provides chemical dependency assessments at the bedside of clients with confirmation or suspicion of a substance-use disorder

Additional Efforts in Addressing Alcohol and Drug Discharge Diagnosis and Mental Health Disorders

Good Sam is deeply involved in improving these areas. Samaritan Behavior Health (SBH), a subsidiary of the hospital, provides mental health and substance abuse services for all ages in Southwest Ohio. SBH collaborates with the National Alliance on Mental Illness of Montgomery County, Ohio. It also receives funding from the ADAMHS Board to provide crisis care in the county.

The ADAMHS Collaborative Coalition to Improve Alcohol and Other Drug Abuse and Addiction Services in Montgomery County, Ohio is a plan that includes recommendations for:

- building infrastructure and capacity
- prevention
- building linkages
- treatment
- data sharing

Priorities Included in the Plan

Through the Community Health Needs Assessment, the following priorities were identified for Good Sam, and an improvement plan was put in place. Priorities in the plan are not listed in order of importance. Below are the initiatives and programs instituted in 2014-2016 to address health priorities.

Primary and Chronic Diseases

1. Hypertension — hypertension rates are higher in the service area than in the state and nation. It is the leading inpatient discharge diagnosis and the third leading emergency department discharge diagnosis.

2. Breast cancer — the breast cancer rate is 195.3 per 100,000, and the rate is increasing in comparison to historically prevalent cancers.

3. Diabetes— widespread behavioral risk factors such as obesity and physical activity, and the increasing rate of hospital inpatient diabetes diagnoses, are cause for concern.

Key Health Priorities by Objective

Priority Area 1: Reduce the incidence and complications from adult hypertension.

Blood pressure is how hard blood pushes against the walls of our arteries when our heart pumps blood. When someone has high blood pressure, which is also called hypertension, the increased pressure against the arteries causes damage. Hypertension is called the silent killer because usually those who have it do not feel anything. High blood pressure increases risk for heart disease, stroke, heart failure, kidney disease and blindness.

The percentage of adults who have been told by a primary care provider that they have high blood pressure	
Ohio	31.7%
Montgomery	35.5%

In many cases, hypertension can be prevented by maintaining a healthy weight, being active, eating healthfully, not using tobacco and limiting alcohol. Most people's high blood pressure can be controlled. Those already diagnosed with high blood pressure should take the same steps as those seeking to prevent high blood pressure. If medication is needed, it is imperative to take it every day.

Because of the significant health threat posed by hypertension, a community-focused, population health improvement strategy would benefit all parts of the community.

Priority Area 1: Reduce the proportion of adults with hypertension.
Objective 1.1: Increase the proportion of adults with hypertension whose blood pressure is under control.
Evidence-based Strategies: Coordinate a hypertension education health communications campaign that will include communications tactics; free, community-based screenings and free online education
Update: Through various partnering agencies, Good Sam has conducted 3,100 blood pressure screenings and 1,154 cholesterol screenings from 2014-2016.
Evidence-based Strategies: Promote lectures about high blood pressure prevention and control in worksites, congregations, senior centers and other community based venues.
Update: Good Sam promoted lectures about high blood pressure prevention and control in worksites, congregations and senior centers and other community-based venues. A total of 293 people were served in Montgomery County. • "Women and Stroke" presented by Erin Greene, MS, RN, at Vandalia Senior Center. • "Cardiovascular Disease & You," presented by Dr. Abdul Wase at Earl Heck Community Center in Englewood. • "Handling Hypertension," presented by Dr. Mark Oxman at Vandalia Senior Center. • "Stroke! Think F.A.S.T.," presented by Erin Greene, MS, RN, at Dorothy Lane Optimist in Moraine. • "Handling Hypertension," presented by Dr. Mark Oxman at Earl Heck Community Center in Englewood.
Evidence-based Strategies: Identify or develop a brochure to educate those who already have high blood pressure about the importance of medication adherence and maintaining a healthy lifestyle. Make collateral available through system websites, Facebook pages, employer and community events, and other outlets to be identified. These will include how to get more information by telephone and/or online.
Update: Premier Health has several marketing pieces, including high blood pressure handouts related to the management of high blood pressure and resources to assist in its management. The system also has information available online. Through various print and electronic material (internal and external), Miami Valley Hospital disseminated educational information related to hypertension. Forms of communication included but were not limited to: • the Insider (Weekly hospital/ facility internal newsletter) • Premier Health intranet (internal) • Premier Health internet (external) • social media sites (Facebook, Twitter, YouTube, etc.) Premier Health makes blood pressure experts available to discuss screening, prevention, treatment and management in both public forums and the media.

Outcome Indicators
Short and Intermediate Term: To have communications at least once a year in existing hospital communications vehicles that highlight hypertension and how it can be prevented/treated successfully.
Update: Through various print and electronic material (internal and external), Miami Valley Hospital disseminated educational information related to hypertension. Forms of communication include but not limited to; • the Insider (weekly hospital/facility internal newsletter) • Premier Health intranet (internal) • Premier Health internet (external) • social media sites (Facebook, Twitter, YouTube) Goal Achieved
Short and Intermediate Term: To conduct at least three lectures per year reaching at least 75 unique individuals.
Update: Good Sam promoted lectures about high blood pressure prevention and control in worksites, congregations and senior centers and other community-based venues. A total of 293 people were served in Montgomery County. Goal Exceeded
Long Term: Increase the proportion of adults with hypertension whose blood pressure is under control.
Update: Efforts to increase adults with hypertension whose blood pressure is under control are ongoing and will continue to be our long-term goal.

Priority Area 1: Reduce the proportion of adults with hypertension.
Objective 1.2: Increase the proportion of adults who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high.
Evidence-based Strategies: Good Sam will conduct blood pressure screenings on at least 1,000 individuals per year at worksites, congregations, senior centers and other community-based venues.
Update: Good Sam has conducted 3,100 blood pressure screenings on members of the community at local venues, free of charge. Additionally, Good Sam has conducted 1,154 free cholesterol screenings at community-based venues at various locations around the community to local citizens. Goal Exceeded
Evidence-based Strategies: Attempt telephone follow-up with 100% of those who have a Stage 2 hypertension result, do not opt out of follow-up and have a working telephone.

Update: Follow-up calls are made with all participants who have a stage 2 hypertension results. Contact is then made with each participant's primary care physician. Additional attempts are made to contact participants via mail if telephone communication was unsuccessful.
Evidence-based Strategies: We will successfully contact at least 45% of those eligible for follow-up.
Update: Follow-ups are made with participants and then contact is made with the primary care physician.
Evidence-based Strategies: If an individual does not have a primary care provider, we will offer to make a referral to the individual that meets their needs.
Update: Referral lists of primary care physicians within our network were given to participants who do not have a physician.
Evidence-based Strategies: If an individual has not seen their primary care provider for three or more years, we will educate them about the importance of seeing their physician regularly to maintain themselves as a patient and encourage them to call their physician to become reestablished with them.
Update: Referral lists of primary care physicians within our network were given to participants who do not have a physician.
Evidence-based Strategies: If an individual uses tobacco, we will educate them about local tobacco cessation services.
Update: In August 2015, the Mayo Clinic Nicotine Dependence Center came to Dayton, Ohio and held a tobacco treatment specialist training program, facilitated by Premier Community Health. As a result, Premier Health now has 26 staff members who are certified tobacco treatment specialists and who can assist individuals and patients quit tobacco. Dr. Michael Johnson, a plastic surgeon and physician champion, has helped promote the program to patients, physicians and other key leadership along the way. The free, five-week group tobacco cessation classes hosted by Premier Community Health are designed to help individuals quit smoking. Our certified tobacco treatment specialists have the training needed to provide counseling and support to those who are ready to stop tobacco use.

Outcome Indicators
Short and Intermediate Term: At least 1,000 unique individuals will receive a blood pressure screening each year in a variety of community-based venues.
Update: More than 3,100 people were screened for their blood pressure each year in a variety of community-based venues. Goal exceeded.
Short and Intermediate Term: We will successfully contact at least 45% of those eligible for follow-up.
Update: At least 45% of people have received follow-up calls and contact has been made to their primary care physicians. If the person did not already have a primary care physician, they were given a referral sheet of physicians within the Premier Health network.
Long Term: Increase the proportion of adults who have had their blood pressure measured during the preceding two years and who can state whether their blood pressure was normal or high.

Update: Efforts to increase the proportion of adults who have had their blood pressure measured during the preceding two years and who can state whether their blood pressure was normal or high is ongoing and continues to be a long term goal.

Priority Area 2: Reduce the female breast cancer mortality rate.

Reducing the impact of breast cancer locally will require a diverse strategy. There are several issues to address:

1. More women are diagnosed with later stage breast cancer in our area
2. Mammography rates are lower in our area

At Premier Health, we have the Ohio Region 3 Breast and Cervical Cancer Early Detection Project (BCCP), which is funded by the Centers for Disease Control and Prevention through the Ohio Department of Health. It is estimated that in Ohio, about 0.12% of all women were diagnosed with breast cancer in 2012. Of those served by BCCP throughout Ohio in 2011, 1.9% of screened women learned they had cancer. In Premier's BCCP program in 2013, 2.63% of those screened found out they had breast cancer. While those who participate in this program are at higher risk for breast cancer, this is a large number of women.

Women age 40+ who reported they have had a mammogram in the past two years	
	Yes
Ohio	79.10%
Montgomery	77.30%
BRFSS SMART Data from Premier Oncology Assessment.	

Some identified risk factors for breast cancer are:

- Genetic alterations, including BRCA1 and BRCA2 genes
- Close family history. Having a mother, sister, and/or daughter diagnosed with breast cancer, especially before age 50. Having a close male blood relative with breast cancer.
- Race. While white women are diagnosed with breast cancer more than any other race, African American women die from breast cancer more than any other race.

Source: National Cancer Institute, Breast Cancer Risk in American Women

According to research, a major barrier for screening mammography has been a lack of health insurance. In 2010, only 32% of women age 40 and older with no health insurance had a mammogram in the past two years compared to 71% of those with insurance. Other barriers include the lack of a nearby mammography center, lack of transportation, lack of a primary care provider, no recommendation from a provider to get a screening, lack of awareness of breast cancer risks of screening methods, and cultural and language differences. Studies have also identified a lack of time and perception of pain as barriers.

In Montgomery County, the breast cancer rate is 244.8 per 100,000, and is increasing, in contrast to the trend for historically prevalent cancers.

Priority Area 2: Reduce the female breast cancer mortality rate.
Objective 2.1: Increase the proportion of women who receive breast cancer screening based on the most recent guidelines.
Evidence-based strategies: Offer free mammograms and related services to uninsured, low-income women in our service area. Related services include transportation to and from appointments and help in securing a primary care provider. (This may shift to paying some co-pays for insured women if we see a substantial decline in uninsured women.)

Update: In Montgomery County, Premier Health's mobile mammography unit has enabled us to serve the breast cancer screening needs in our community. This mobile unit has traveled the region, serving more than 450 unique individuals in Montgomery County in 2015-16. Individuals also received prevention education information, as well as resources to further assist them in preventing breast cancer.
Evidence-based strategies: During October, which is Breast Health Month, information about the importance of mammography for women is included in communications campaigns.
Update: Several communication campaigns were held by Good Sam and information was provided about the importance of mammography for women. More than 1,060 women served with education within Montgomery County. • "Winning the Battle Against Breast Cancer," presented by Dr. Thomas Heck at St. Luke Missionary Baptist Church in Dayton (25 attendees present) • "Winning the Battle Against Breast Cancer," presented by Dr. Thomas Heck at Vandalia Butler Chamber of Commerce Women in Networking in Vandalia (33 attendees present) • "Brake for Breakfast," presented by Good Sam at Good Samaritan North Health Center in Englewood. This breast cancer awareness event encouraged women over the age of 40 to get screened for their risk of breast cancer. Materials were distributed to more than 1,000 people.
Evidence-based strategies: Educate women about the provision in the Affordable Care Act that provides screening mammography with no co-pay or deductible for women who meet screening guidelines.
Update: Premier Health educates all patients without insurance about the Affordable Care Act and accessing insurance through the federally operated health insurance marketplace in Ohio. We also inform patients of the many benefits the law has provided, including no co-pay for mammography for women who meet screening guidelines. Financial counselors at each facility are important in this role. Additionally, we educate patients about the Breast and Cervical Cancer Project (BCCP) that could potentially waive the cost for eligible women.
Evidence-based strategies: Continue the Brake for Breakfast educational program in October, offering information about the importance of mammography and breast risk factors with a free breakfast at Good Samaritan North Health Center.
Update: "Brake for Breakfast" presented by Good Sam at Good Samaritan North Health Center in Englewood. This breast cancer awareness event encouraged women over the age of 40 to get screened for their risk of breast cancer. Materials were distributed to 1,000 people.

Objective 2.1: Increase awareness among women of increased risk due to family history and genetics.
Evidence-based strategies: Include information about breast cancer genetic risk in existing community focused communications vehicles.
Update: Premier Health has several marketing pieces, including a cancer brochure and handouts related to mammography and high risk breast cancer that mention genetic counselors. The system also has information available online, including the new Women.Wisdom.Wellnes. website. When available,

Premier Health makes cancer experts available to discuss genetic testing and genetic counseling in both public forums and the media.
Evidence-based strategies: Offer a simple educational piece that includes how to reach genetics counselors.
Update: Same as previous.

Outcome Indicators
Short and Intermediate Term: To provide assistance to at least 400 women in Montgomery County to receive a screening mammogram, diagnostic mammogram, ultrasound, clinical breast exam and/or breast biopsy. Because of the overlap in markets, this is a shared objective with Miami Valley Hospital.
Update: In Montgomery County, Premier Health's mobile mammography unit has enabled us to serve the breast cancer screening needs in our community. This mobile unit has traveled the region serving more than 450 unique individuals in Montgomery County in 2015-16. Individuals also received prevention education information as well as resources to further assist them in preventing breast cancer.
Short and Intermediate Term: To serve at least 500 people at the annual Brake for Breakfast at Good Samaritan North Health Center in Englewood.
Update: "Brake for Breakfast" is a breast cancer awareness event that encourages women over the age of 40 to get screened for breast cancer. Materials were distributed to 1,000 people. Goal exceeded.
Long Term: To decrease the number of women in our area who are diagnosed with later stage breast cancers
Update: Efforts to decrease the number of women in our area who are diagnosed with later stage breast cancers is ongoing and continues to be a long-term goal.
Long Term: To increase the number of women age 40 and older who have annual mammograms
Update: Efforts to increase the number of women age 40 and older who have annual mammograms is an ongoing long-term goal at Premier Health.

Priority Area 3: To reduce the incidence of diabetes in our area and prevent complications in those who have diabetes.

Type 2 diabetes is a major public health issue that has reached epidemic proportions worldwide. According to the CDC, 25.8 million people in the United States have diabetes. Of these, 7 million do not know they have it. If the current trend continues, one in three U.S. adults will have diabetes by 2050. Diabetes is the leading cause of blindness, kidney failure and amputations of feet and legs not related to accidents or injury. The majority of people who have Type 2 diabetes also have heart disease.

Research shows making small lifestyle changes can help prevent diabetes. And, if a person has been told by a physician they have diabetes, it can be controlled.

The prevalence of diabetes is substantially greater in Montgomery County, Ohio compared to the state and nation. It is the third most common inpatient discharge diagnosis and the seventh most common emergency department discharge diagnosis. Discharge diagnosis rates have increased from 2004 to 2012.

According to the 2014 County Health Rankings and Roadmaps, the percentage of adults aged 20 and older with diagnosed diabetes is:

Ohio	11%
Montgomery	13%

(Data are for 2011. County Health rankings and Roadmaps collected this data from the National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation.)

As with other health conditions, diabetes rates are higher among nonwhites. Nationally, 10.2% of non-Hispanic whites aged 20 and older have diabetes, both diagnosed and undiagnosed. However, 18.7% of all non-Hispanic blacks aged 20 years and older have diabetes, both diagnosed and undiagnosed.

The American Diabetes Association estimates that 35% of U.S. adults aged 20 or older have prediabetes and 50% of those age 65 years or older have it. Of the 79 million Americans age 20 or older who have prediabetes, only 7.3% have been told they have it. Risk factors for prediabetes include being overweight and having a higher than normal blood glucose.

Montgomery County has higher rates of overweight and obesity than other counties in our market or the state. It would follow that there is increased likelihood of a higher percentage of those with prediabetes in Montgomery County.

Adults who are considered overweight- BMI of 25-29.9

	Male	Female	All
Ohio	43.00%	29.40%	35.90%
Montgomery	46.00%	32.10%	37.80%

Adults who are considered obese- BMI of 30+

	Male	Female	All
Ohio	27.10%	25.60%	26.30%
Montgomery	30.00%	30.40%	31.90%

Priority Area 3: To reduce the incidence of diabetes in our area and prevent complications in those who have diabetes.

Objective 3.1: To prevent diabetes in those who have prediabetes.

Evidence-based Strategies: At community screening events, offer a hemoglobin A1C screening following approved guidelines to find possible prediabetes.

Update: Through various community engagement opportunities, we have served 2,600 people. Those engagements include, but are not limited to, health fairs, group presentations, and material distribution. We were able to facilitate more than 600 foot screenings, 1,000 pre-diabetic screenings, 1,072 HBC1 screenings and 1,000 diabetic risk screenings throughout the Montgomery County area. The following presentations have been given about diabetes, free of charge, with at least 75 people in attendance per event:

- "Diabetes," presented by Becky Harrold, MSN, RN, to Grace Works Lutheran Services
- "Diabetes," presented by Becky Harrold, MSN, RN, to St. Luke Missionary Baptist Church
- Samaritan Diabetes Center provided information and screening for diabetes and prediabetes at Fairview Elementary during an evening celebration.

Evidence-based Strategies: A telephonic follow-up attempt will be made to 100% of those whose hemoglobin A1C falls out of recommended ranges. To be eligible, the participant cannot opt out of follow-up and have a working telephone number.

Update: Follow-ups were made with participants, with contact then made with their primary care physician. If the person did not have a primary care physician, they were given a physician referral list, from within our network, free of charge.

Evidence-based Strategies: We successfully reach at least 45% of those eligible for a follow-up call

Update: Follow ups were made with participants and then contact was made with their primary care physician.

Priority Area 3: To reduce the incidence of diabetes in our area and prevent complications in those who have diabetes.

Objective 3.2: Increase the number of people who are diagnosed with diabetes but do not know they have this disease.

Evidence-based Strategies: At community screening events, offer a hemoglobin A1C screening following approved guidelines to find possible diabetes.
Update: At various community-based venues around Montgomery County, hemoglobin A1C approved guideline diabetic screenings were given, free of charge, to 1,000 local citizens.
Evidence-based Strategies: A telephonic follow-up attempt will be made to 100% of those whose hemoglobin A1C falls out of recommended ranges. To be eligible, the participant cannot opt out of follow-up and have a working telephone number.
Update: Follow-ups were made with participants, with contact then made with each participant's primary care physician. If the person did not have a primary physician, they were given an in-networrrk physician referral list free of charge.
Evidence-based Strategies: We successfully reach at least 45% of those eligible for a follow-up call.
Update: Follow-ups were made with participants, with contact then made with each participant's primary care physician.

Priority Area 3: To reduce the incidence of diabetes in our area and prevent complications in those who have diabetes.
Objective 3.3: Increase the number of those who have diabetes and attend formal diabetes education classes at least every 2 years.
Evidence-based Strategies: Develop strategies to inform those who have diabetes that under the Affordable Care Act, medical nutrition therapy for people with diabetes is covered with no co-pay or deductible.
Update: Premier Health educates all patients without insurance about the Affordable Care Act and accessing insurance through the federally run health insurance exchange in Ohio. We also inform patients of the many benefits the law has provided, including that medical nutrition therapy for people with diabetes is covered with no co-pay or deductible. Our financial counselors at each facility are important in this role.
Evidence-based Strategies: Participate in the annual Diabetes Expo coordinated by Diabetes Dayton.
Update: The Diabetes Coalition has been collaborating with the Center for Global Health and Premier Community Health at Wright State University. The group has specifically targeted work in West Dayton to address food deserts that exist there. The program is still in its early stages; however, significant accomplishments have been made so far. Some efforts include: • Approaching individual small groceries about stocking fresh produce • Assistance by providing the names and addresses of local grocery stores to the Global Health team • Outreach to the African American community about diabetes and other risks to their health.

Outcome Indicators
Short and Intermediate Term: To provide at least 150 hemoglobin A1c screenings in Montgomery County, according to approved guidelines.
Update: Good Sam* has conducted 1,072 AC1 screenings to Montgomery County citizens, free of charge. The screenings conducted were in accordance with approved guidelines.

*(These numbers overlap with Miami Valley Hospital market/numbers.)
Long Term: Increase the number of people who are diagnosed with diabetes but do not know they have this disease.
Update: Efforts to increase the number of people who are diagnosed with diabetes but do not know they have this disease are ongoing and will continue to be our long-term goal.
Long Term: Increase the number of those who have been told by a primary care provider that they have diabetes and attend formal diabetes education classes at least every two years.
Update: The increase in numbers of those who have been told by a primary care provider (PCP) that they have diabetes and attend formal diabetes education classes at least every two years is an ongoing effort and will continue to be a long-term goal for Premier Health.
Ultimate Goal: Decrease the number of people who develop diabetes in our market area and increase the number of people who have diabetes, are well controlled and live healthy, active lives.
Update: Efforts are ongoing to decrease the number of people who develop diabetes in our market area and increase the number of people who have diabetes but have the condition well-controlled and live healthy, active lives. This continues to be a Premier Health goal. However, some strategies are in place with Premier Community Health's collaboration with the Diabetes Coalition, the Center for Global Health and Wright State University on tackling food deserts in West Dayton – specifically within the African American population.

Moving Forward

All Premier Health hospitals have a rich history of working with the communities they serve to improve the health of their citizens. Our work continues with data gleaned from this Community Health Needs Assessment and through a community health improvement plan.

Improving community health is a process of building on traditional and nontraditional partnerships, assuring programs and strategies are evidence-based, building in feedback loops, conducting ongoing evaluation, and measuring if what we are doing is having the intended result. We understand these are issues that cannot be solved by a hospital alone, but take the work of all interested stakeholders in the community. We know we need to develop detailed strategies for the identified targeted areas with in-depth work plans and responsible parties.

As the process continues, we will continue to look at new strategies and opportunities, looking for ways to expand beyond the programs here and reach more people with life-improving and perhaps life-saving education and services.