# COMMUNITY HEALTH IMPROVEMENT PLAN RECAP

2014-2016

Premier Health

MIAMI VALLEY HOSPITAL

## Miami Valley Hospital and Premier Health: Committed to Improving Community Health

Miami Valley Hospital (MVH) is part of Premier Health, the largest health care system in Southwestern 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, Miami Valley Hospital focuses on four areas of service:

- Investment in the community
- Prevention and wellness
- Commitment to the underserved
- Community engagement

Two examples of Miami Valley Hospital's community health improvement programs include:

### The Genesis Project and Litehouse Development Homes

The Genesis Project is a collaborative effort between the hospital, the University of Dayton, National City Bank, CityWide Development Corporation, County Corp and the City of Dayton. Its mission is to revitalize the Fairgrounds neighborhood, an area near the hospital that had fallen on tough times.

The Genesis Project removed 41 deteriorating structures, rehabilitated 11 existing single-family homes and constructed 23 new houses. Potential buyers received mortgage credit counseling and MVH offered homestead assistance to employees who wanted to move into the neighborhood.

MVH placed a social worker and two community-based police officers in the neighborhood, and crime in the area has decreased by 19 percent.

The Genesis Project won the 2004 Audrey Nelson Community Development Achievement Award from the National Community Development Association for its effective use of a community block grant.

Litehouse Development Homes is following the Genesis Project, with up to 15 additional homes to be built.

### Mahogany's Child

In June 2001, MVH began Mahogany's Child, a health program dedicated to improving the health of African American women. This program educates women on healthy behavior and the importance of early disease detection.

Mahogany's Child's mission is to educate, remove barriers and provide resources to empower African American women to make informed health care decisions and create a healthier lifestyle for themselves and their families.

Since the program's conception in 2001, more than 16,000 women have participated in the Mahogany's Child program.

## Identified Priorities

In the Community Health Needs Assessment, researchers identified priority areas for community health improvement using a variety of criteria. The priorities that are included and excluded in the plan are outlined here. Priorities that are included in the plan are not listed in order of importance.

### Priorities Addressed Through Collaboration

All identified priorities are important elements of improving the health of our community. In some instances, priorities are already being targeted by collaborative groups of which Miami Valley Hospital is a part. Additional strategies will not be developed independent of these efforts. Because of the importance of these collaborative efforts, the following are priorities but are not separated from the existing collaborations as part of this Community Improvement Plan."

*Maternal and Infant Priorities*

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

| Health Issue | Update |
|---|---|
| First trimester prenatal care | There has not been a noticeable decrease in the percent of women who receive late or no prenatal care in Montgomery County. In 2007 it was 5.2% and 2013 it was 5.3%.<br>MVH's Progesterone Project, which was started as an Ohio Perinatal Quality Collaborative (OPQC) project to decrease premature births (the number one cause of infant mortality), and also a Premier Innovate project, has decreased both preterm births less than 37 weeks and 32 weeks in the State of Ohio. That is a real outcome measure where a difference has been made. MVH and Premier Health are active members of the Dayton/Montgomery County Public Health Infant Mortality Coalition, which has several initiatives in place, including: Equity Institute both Ohio and National, Centering Pregnancy, Progesterone (again), and several others aimed at decreasing disparity by addressing social determinants of health – specifically racism and stress. |
| Low birth weight | In 2014 the low birth rate (LBR) was 9.1% in Montgomery County. In 2015, the LBR was 9.6% which is a 0.5% increase since the previous year. The LBR for 2016 is 9.5% which is a 0.1% decrease since the previous year.<br><br>2016 – 9.5%, 312 total people who gave birth to babies who were underweight*<br>2015 – 9.6%, 637 total people who gave birth to babies who were underweight*<br>2014 – 9.1%, 597 total people who gave birth to babies who were underweight*<br><br>*Statistics were found on Ohio Department of Health's web database. |
| Infant mortality rate (IMR) | Premier Health has instituted a system-wide safe sleep program that includes the following aspects:<br>• Educating all maternity patients on the importance of the ABC's of safe sleep |

A= Baby should sleep **ALONE** in bed—do not sleep with parents, siblings, etc.
B= place baby to sleep on his or her **BACK**
C= have a separate **CRIB** in which baby should sleep

- Model safe sleep practices in the hospital
  Use a sleep sack in the hospital
  Send parents home with a sleep sack

MVH/Premier Health is a collaborative partner with Five Rivers Health Center (FRHC). Five Rivers Health Centers received a 4.9 year grant to improve perinatal health, decrease pre-term births, reduce infant mortality, and reduce infant morbidity from Health Resources Services Administration (HRSA) for $750,000 per year. Five Rivers Health Centers is one of five Healthy Start recipients in Ohio and one of nine Federally Qualified Health Centers (FQHCs) nationally receiving this award. This is the first time that any organization from Montgomery County had received this grant. We target 45402, 45403, 45405, 45407, 45414, 45417 and 45426 – which historically have the highest infant mortality rates in this area.

Through this grant we have achieved the following accomplishments by taking a "kitchen sink" approach:

- By creating an incentive program for pregnant women and parents, the Five Rivers Healthy Start Program has increased prenatal visits (by 12% from previous year), increased abstinence from smoking and drugs (by 15% from previous year), and awarded participants for participating in classes and other healthy behaviors. Patients see a direct correlation between 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, dietician, and certified nurse midwife. We contract with Premier Health's Help Me Grow/Nurse Family Partnership to provide home visits for our high-risk patients. We contract with Samaritan Behavioral Health to provide a part-time behavioral health consultant for 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 that had 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

- Five Rivers are 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 Five Rivers Healthy Start patients are visited by the team after they deliver to ensure the patient has a post-partum visit scheduled and the infant has a scheduled appointment.

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

- Developed a comprehensive Maternity Resource Guide to be used by community agencies, and a guide for patient use with information on how to access more than 320 agencies.

- Five Rivers Healthy Start is one of the newest programs, yet it is exceeding all of the volume expectations of the federal government – we served 1,232 participants in our first full year (2015); HRSA requirements were for us to serve 500 participants.

- We track over 500 data points regarding our patients, which include the following 2015 data:
  - 89% of all women have a documented Reproductive Life Plan – a plan to determine if and when they 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 engage in infant safe sleep behaviors
  - 98% of participants are screened for depression
- Five Rivers Health Centers continues to administer progesterone to eligible patients, as well.

<u>What does all of this mean for IMR?</u>
In 2013, FRHC Center for Women's Health had 11 infants that died.
In 2014, FRHC Center for Women's Health had 15 infants that died.
In 2015, Five Rivers Healthy Start had 3 infants that died and the rest of the Center for Women's Health had 4 infants that died for a total of 7 deaths. Although this is a 53% decrease from the previous year, until we get to 0%, we still have a lot more work to do.

Future Plans
With additional Medicaid funding for two years, Five Rivers Health Centers 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

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| | Boot Camp" program and addressing housing, one of the social determinants of health, to improve conditions for pregnant women. |

*Additional Efforts in Addressing Maternal and Infant Priorities*

Miami Valley Hospital is involved in several state-wide initiatives addressing maternal and infant priorities. As part of these collaborations, Miami Valley Hospital will share the goals and objectives developed by those groups for program implementation and measurement.

Ohio Perinatal Quality Collaborative. Miami Valley Hospital is a charter member of this organization as a neonatal hospital and as a maternity hospital. Its mission is, "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 elective, unnecessary scheduled births before 39 weeks gestational age. (Reduce infant mortality and low birth weights.)
- 39 Weeks Dissemination and Birth Registry Accuracy Project – This project was to address inaccuracies in birth certificate data within the Quality Improvement framework.
- Obstetrics Antenatal Corticosteroids Project – This project focuses on increasing the use of antenatal corticosteroids to reduce mortality and morbidity among preterm infants. (Reduce infant mortality.)
- Progesterone Project – This project intends to help 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.)

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

- Safe sleep (infant mortality)
- Eliminating elective deliveries before 39 weeks (infant mortality)
- Progesterone for high-risk mothers (infant mortality)
- Eliminating health disparities
- Safe spacing (infant mortality and low birth weight)
- Access to prenatal care (First trimester care, infant mortality and low birth weight)
- Promote breast milk
- These program areas also then address increasing first trimester care, improving low birth weight and decreasing infant mortality.

Ohio Collaborative to Prevent Infant Mortality. This group, which is coordinated by the Ohio Department of Health, works together to formulate a statewide strategic plan to reduce infant mortality and birth outcome disparities. Miami Valley Hospital is part of this collaborative.

*Primary and Chronic Diseases*

1. Alcohol and drug discharge diagnosis
   In Montgomery County, alcohol and drug abuse services are coordinated by the ADAMHS Board (Alcohol, Drug Addiction and Mental Health Services.) The ADAMHS Board administrates 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 expansion included an expansion of its medication-assisted treatment services using:<br>• suboxone and Vivitrol<br>• expanded counseling services<br>• new partnerships with Montgomery County correctional facilities<br>• the development and presentation of a seminar for physicians on 'Improving Opiate Addiction Care'<br>• New partnership with Miami Valley Hospital to provide opiate addiction care to pregnant women – Promise to Hope.<br><br>Access to counseling and psychiatric services was expanded with the opening of a new office in Miami County, where over 600 patients are now being served.<br><br>Turning Point offers assessment and treatment for individuals in the Miami Valley that are experiencing problems or concerns related to 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. We work to take the stigma out of substance use and give back to our families and communities.<br><br>During the year 2014, we worked with 560 individuals and families, providing 4,286 group sessions to assist those suffering from substance use. We offered skill-building sessions and information to help them make a positive change in their lives and their communities.<br><br>During the 2015 calendar year, we assisted 570 individuals and provided 4,712 skill-building sessions. |

## Priorities Included in the Plan

Through the Community Health Needs Assessment, the following priorities were identified for Montgomery and Greene Counties.

*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 (ED) discharge diagnosis.
2. Breast cancer – The breast cancer rate is 244.8 per 100,000, and the rate is increasing as opposed to historically prevalent cancers.
3. Diabetes – The prevalence of diabetes is substantially greater in the service area compared to the state and nation. It is the third most common inpatient discharge diagnosis and the seventh most common ED discharge diagnosis. Discharge diagnosis rates have increased from 2004 to 2012.

## Key Health Priorities by Objective

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

Blood pressure indicates how hard blood pushes against the walls of the arteries when the heart pumps blood. When someone has high blood pressure, 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 County | 35.5% |
| Greene County | 32.9% |

In many cases hypertension can be prevented by maintaining a healthy weight, being active, eating healthy, not using tobacco, and limiting alcohol. For most people who are diagnosed with high blood pressure, it can be controlled. Those with high blood pressure should take the same steps as individuals who are trying to prevent high blood pressure. If medication is needed, it is imperative to take it every day.

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 ED discharge diagnosis.

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. |
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| **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 and locations, MVH has conducted over 3,300 blood pressure screenings and over 1,600 cholesterol screenings from 2014 to 2016. In addition to health screenings being given, free of charge, presentations have also been held to provide approximately 3000 individuals with information regarding hypertension, its prevention and treatment. These presentations were held at multiple community-based locations around Montgomery and Greene Counties. Highlighted efforts include, but are not limited to, the following:

- Go Red for Women education and blood pressure screening: Sinclair Community College
- Mahogany's Child African-American Wellness Walk: Dayton RiverScape MetroPark
- Stroke and blood pressure screening with Premier Community Health: Miami Valley Hospital South (MVHS)
- Stroke screening and stroke education fairs: MVHS
- Premier Health and Miami Valley Hospital employee health fair, blood pressure screening per request. Premier Health system support, MVH, MVHS
- Second Sunday church blood pressure screenings: Dayton Lutheran Church

**Evidence-based strategies:** Promote lectures about high blood pressure prevention and control in worksites, congregations, senior centers and other community-based venues.

**Update:** Approximately 800 unique individuals participated in presentations regarding hypertension, its prevention and treatment. These presentations were held at multiple community-based locations around Montgomery and Greene Counties. Highlighted efforts include, but are not limited to, the following:

- Stroke update: Education to health providers on the latest methods and trends in stroke and prevention tactics: MVHS and University of Dayton
- Stroke education presentation to health providers: Cedarville, Oakwood Fire Department, University of Dayton
- Second Sunday church blood pressure education: Dayton Lutheran Church

**Evidence-based strategies:** Identify an educational brochure targeted to those who already have high blood pressure that addresses the importance of medication adherence and healthy lifestyle. Make collateral available through system websites, Facebook pages, at employer and community events and other outlets to be identified. All tactics will include instructions on how to get more information by telephone and/or online.

**Update:** Premier Health has several marketing pieces, including handouts related to high blood pressure and 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 materials (internal and external), MVH disseminated educational information related to hypertension. Forms of communication include, but are not limited to:

- ***The Insider*** (Weekly hospital/facility internal communication)
- ***Premier Connections*** (Bi-monthly system support internal communication)
- Premier Health intranet (internal)
- Premier Health web site (external)
- Social media sites (Facebook, Twitter, YouTube)

Premier Health makes blood pressure experts available to discuss screening, prevention, treatment and management in both public forums and the media.

| Outcome Indicators |
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| **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 materials (internal and external), MVH disseminated educational information related to hypertension. Forms of communication include, but are not limited to:<br>• ***The Insider*** (Weekly hospital/facility internal communication)<br>• ***Premier Connections*** (Bi-monthly system support internal communication)<br>• Premier Health intranet (internal)<br>• Premier Health web site (external)<br>• Social media sites (Facebook, Twitter, YouTube)<br>Goal achieved. |
| **Short and intermediate term:** To conduct at least three lectures per year reaching at least 75 unique individuals. |
| **Update:** Approximately 800 unique individuals participated in presentations regarding hypertension, its prevention and treatment. Goal exceeded. |
| **Long term:** Increase the proportion of adults with hypertension whose blood pressure is under control. |
| **Update:** Efforts to increase the proportion of 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. |
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| **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:** MVH will conduct blood pressure screenings on at least 1,000 individuals per year at worksites, congregations, senior centers and other community-based venues. |
| **Update:** MVH has conducted over 3,300 blood pressure screenings and over 1,600 cholesterol screenings at community-based venues at various locations around the community to local citizens, free of charge. 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 ups are made with all participants who have a stage 2 hypertension result, and then contact is made with their primary care physician. Additional attempts are made to contact participants via mail if telephone communication was not successful. |

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| **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:** Primary care physician's (PCP) referral lists were given to participants who did not have a PCP. |
| **Evidence-based strategies:** If an individual has not seen his or her primary care provider for three or more years, we will provide education about the importance of seeing a physician regularly to maintain status as a patient. We will encourage them to call their physician to become reestablished as a current patient. |
| **Update:** Primary care physician (PCP) referral lists were given to participants who did not have a PCP. |
| **Evidence-based strategies:** If an individual uses tobacco, we will provide education 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 Certified Tobacco Treatment Specialist (CTTS) staff members who can help individuals and patients at various Premier Health facilities quit tobacco. Dr. Michael Johnson, a plastic surgeon and physician champion, has helped promote the program to patients, physicians and key leadership along the way.<br><br>Premier Community Health hosts free, group tobacco cessation classes that are five weeks long and 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 |
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| **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:** MVH has conducted over 3,300 blood pressure screenings and over 1,600 cholesterol screenings for local citizens at community-based venues, free of charge. 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. Those who did not have a primary care physician 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 within the preceding two years and 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 within the preceding two years and can state whether their blood pressure was normal or high are ongoing and continue to be a long term goal. |

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

Reducing the impact of breast cancer in our area will require a diverse strategy that addresses the following issues:

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

Premier Health participates in the Ohio Region 3 Breast and Cervical Cancer Early Detection Project (BCCP), which is funded by the Centers for Disease Control through the Ohio Department of Health. It is estimated that in Ohio, about .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 Health'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% |
| Greene | 74.20% |
| 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, or 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.

(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 identified 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 or screening methods, and cultural and language differences. Studies have also identified a lack of time and perception of pain as barriers.

Breast cancer rates are high in Greene and Montgomery Counties. Greene County has a breast cancer rate of 151.5 per 100,000. In Montgomery County, the breast cancer rate is 244.8 per 100,000, and is increasing, as opposed to historically prevalent cancers This is significantly higher than the state or other counties in our area.

| Priority Area 2: Reduce the female breast cancer mortality rate. |
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| **Objective 2.1: Increase the proportion of women who receive breast cancer screenings 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 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 over 450 unique individuals in Montgomery County from 2015 to 2016. Individuals also received prevention education information, as well as resources to further assist them in their efforts to prevent breast cancer.

**Evidence-based strategies:** During October, which is breast health month, include information about the importance of mammography for women in communications campaigns.

**Update:** During the month of October, and months leading up to October, MVH initiated and participated in various community functions at which breast cancer, mammography education and breast cancer awareness were promoted. Over 3,000 individuals from the community were directly impacted due to these efforts.

- Clemens Cancer Challenge
- Macy's Breast Cancer Awareness
- UD Breast Cancer Awareness Night
- Brake for Breakfast (MVH)
- Brake for Breakfast (MVHS)
- Gyn, Prostate, Breast and Lung Cancer Awareness
- Fairfield Commons Mall Walkers Cancer Awareness
- MVH Fall Cancer Awareness

**Evidence-based strategies:** Educate women about the provision in the Affordable Care Act (ACA) that provides screening mammography with no co-pay or deductible for those who meet screening guidelines.

**Update**: Premier Health educates all patients without insurance about the Affordable Care Act and accessing insurance through the Ohio health insurance exchange marketplace. We also inform patients of the many benefits the ACA has provided, including no co-pay for mammography for women who meet the screening guidelines. Our financial counselors at each facility are important in this effort. Additionally, we educate patience on the Breast and Cervical Cancer Project (BCCP) that could potentially waive the cost for eligible women.

**Evidence-based strategies:** Expand the "Brake for Breakfast" program to Miami Valley Hospital South. This program offers educational information about the importance of mammograms and breast risk factors with a free breakfast.

**Update:** The "Brake for Breakfast" program has been expanded to MVHS since 2014 and has had more than 1500 participates.

Brake for Breakfast synopsis:
Employees offer free breakfast and valuable information about breast health to motorists who drive into the MVHS parking lot. The goal is to encourage more women age 40 and older to get an annual mammogram and to tell their mothers, sisters and daughters to do the same.

| Priority Area 2: Reduce the female breast cancer mortality rate. |
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| **Objective 2.2: Increase awareness among women of elevated 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 Wellness web site. When possible, 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 genetic counselors. |
| **Update:** Same as previous. |

| Outcome Indicators |
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| **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 Good Samaritan Hospital in Dayton. |
| **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 from 2015 to 2016. Individuals also received prevention education information, as well as resources to further assist them in their journey to breast cancer prevention. |
| **Short and intermediate term**: To provide assistance to at least 70 women in Greene County to receive a screening mammogram, diagnostic mammogram, ultrasound, clinical breast exam and/or breast biopsy. |
| **Update:** In Greene 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 200 unique individuals in Greene County from 2015 to 2016. Individuals also received prevention education information, as well as resources to further assist them in their journey to breast cancer prevention. |
| **Short and intermediate term**: In its first year (2014), serve at least 200 people at the Brake for Breakfast program. |
| **Update:** Brake for Breakfast has been expanded to MVHS since 2014 and has had more than 1500 participants.<br>Brake for Breakfast synopsis: Employees offer free breakfast and valuable information about breast health to motorists who drive into the MVHS parking lot. The goal is to encourage more women 40 and older to get an annual mammogram and to tell their mothers, sisters and daughters to do the same. |
| **Long term:** To decrease the number of women in our area who are diagnosed with later-stage breast cancers. |

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| 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. |
| 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 this continues, one in three US 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 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 ER discharge diagnosis. Diabetes discharge diagnosis rates have increased from 2004 to2012.

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

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| Ohio | 11% |
| Montgomery County | 13% |
| Greene County | 10% |

(Data is 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 age 20 and older have diabetes, both diagnosed and undiagnosed. However, 18.7% of all non-Hispanic blacks age 20 years and older have diabetes, both diagnosed and undiagnosed.

The American Diabetes Association estimates that 35% of US adults age 20 or older have prediabetes and 50% of those age 65 years or older also 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 – those with a body mass index (BMI) of 25-29.9

| | Male | Female | All |
|---|---|---|---|
| Ohio | 43.00% | 29.40% | 35.90% |
| Greene County | 42.30% | 26.80% | 34.20% |
| Montgomery County | 46.00% | 32.10% | 37.80% |

Adults who are considered obese – BMI of 30+

| | Male | Female | All |
|---|---|---|---|
| Ohio | 27.10% | 25.60% | 26.30% |
| Greene County | 25.60% | 25.70% | 25.70% |
| Montgomery County | 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. |
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| **Objective 3.1: To prevent diabetes in those who have prediabetes.** |
| **Evidence-based strategies:** At community screening events, offer a hemoglobin A1C test following approved guidelines to find possible prediabetes. |
| **Update:** At various community-based venues around Montgomery County, hemoglobin A1C approved guideline diabetic screenings were given, free of charge, to more than 1,000 local citizens. |
| **Evidence-based strategies:** Attempt telephone follow-up with 100% of those whose hemoglobin A1C falls out of recommended ranges. To be eligible, the participant cannot opt out of follow-up and must have a working telephone number. |
| **Update:** Follow-ups were made with participants and then contact was 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 reached 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. |
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| **Objective 3.2: Increase the number of people who are diagnosed with diabetes but do not know they have the disease.** |
| **Evidence-based strategies:** At community screening events, offer a hemoglobin A1C test 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 over 1,000 local citizens.<br><br>Every year MVH hosts a diabetes education day. The intended audience is nurses and it is open to all nurses at Premier Health. In 2014, the event included a talk by Dr. Al-Samkari on diabetes during which he discussed the importance of checking the HgbA1c of inpatients to help determine if they are |

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| diabetic or hyperglycemic. At the diabetes education day in 2015, we included several case studies that discussed the importance of the diagnosis of diabetes.<br><br>In May 2016, Dr. Parilo spoke about transitioning the inpatient diabetic patient to home. His talk included the importance of follow-up after discharge, diabetes education classes and obtaining resources for the diabetic patient. |
| **Evidence-based strategies**: Attempt telephone follow-up with 100% of those whose hemoglobin A1C falls out of recommended ranges. To be eligible, the participant cannot opt out of follow-up and must have a working telephone number. |
| **Update:** Follow-ups were made with participants and then contact was made with their primary care physician. If the person did not have a primary 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. |
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| **Objective 3.3: Increase the number of those with diabetes who attend formal diabetes education classes at least every two 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 Ohio health insurance exchange marketplace. We also inform patients of the many benefits the ACA has provided, including medical nutrition therapy for people with diabetes, which is covered with no co-pay or deductible. Our financial counselors at each facility are important in this effort. |
| **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 insecurity that exist there. The program is still in its early stages, however they have made significant accomplishments so far. Some of their efforts include:<br>• Approaching individual small groceries to stock fresh produce<br>• Assistance by providing the Global Health team with the names and addresses of local grocery stores<br>• Reach-out efforts have been made to the African-American community concerning their health and their risks for diabetes. |

| Outcome Indicators |
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| **Short and intermediate term**: To provide at least 150 hemoglobin A1C screenings in Montgomery County, according to approved guidelines. |
| **Update:** MVH* has conducted 1,183 A1C screenings for Montgomery County citizens, free of charge. The screenings conducted were in accordance with the approved guidelines.<br>***(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 attend formal diabetes education classes at least every two years if they have been told by a primary care provider that they have diabetes. |
| **Update**: Increasing the number of individuals who attend formal diabetes education classes at least very two years if they have been told by a primary care provider (PCP) that they have diabetes is an ongoing effort at Premier Health and will continue to be our long term goal. |
| **Ultimate Goal:** Decrease the number of people who develop diabetes in our market area and increase the number of people who live healthy, active lives and whose diabetes is well controlled. |
| **Update:** Efforts to decrease the number of people who develop diabetes in our market area and increase the number of people whose diabetes are well controlled and who live healthy, active lives are ongoing and continue to be a Premier Health goal. Strategies are in place with Premier Community Health's collaboration with the Diabetes Coalition, the Center for Global Health and Wright State University to tackle food deserts in West Dayton, specifically within the African-American population. |

## Moving Forward

All of the hospitals in the Premier Health system have a rich history of working with the communities they serve to improve the health of their citizens. With the data gleaned from this Community Health Needs Assessment and the development of a Community Health Improvement Plan, our work continues.

Improving community health is a multi-step process: continuing to build traditional and nontraditional partnerships; assuring programs and strategies are evidence-based; building in feedback loops; conducting ongoing evaluation; and measuring to ensure that what we are doing is having the intended results. We understand that these issues cannot be solved by one hospital alone – they require 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 look at new strategies and opportunities to expand beyond the programs listed here and to reach more people with life-improving – and perhaps life-saving – education and services.