Upper Valley Medical Center

2025 - 2027 Community Health Improvement Plan

Premier Health

GDAHA
Greater Dayton Area Hospital Association

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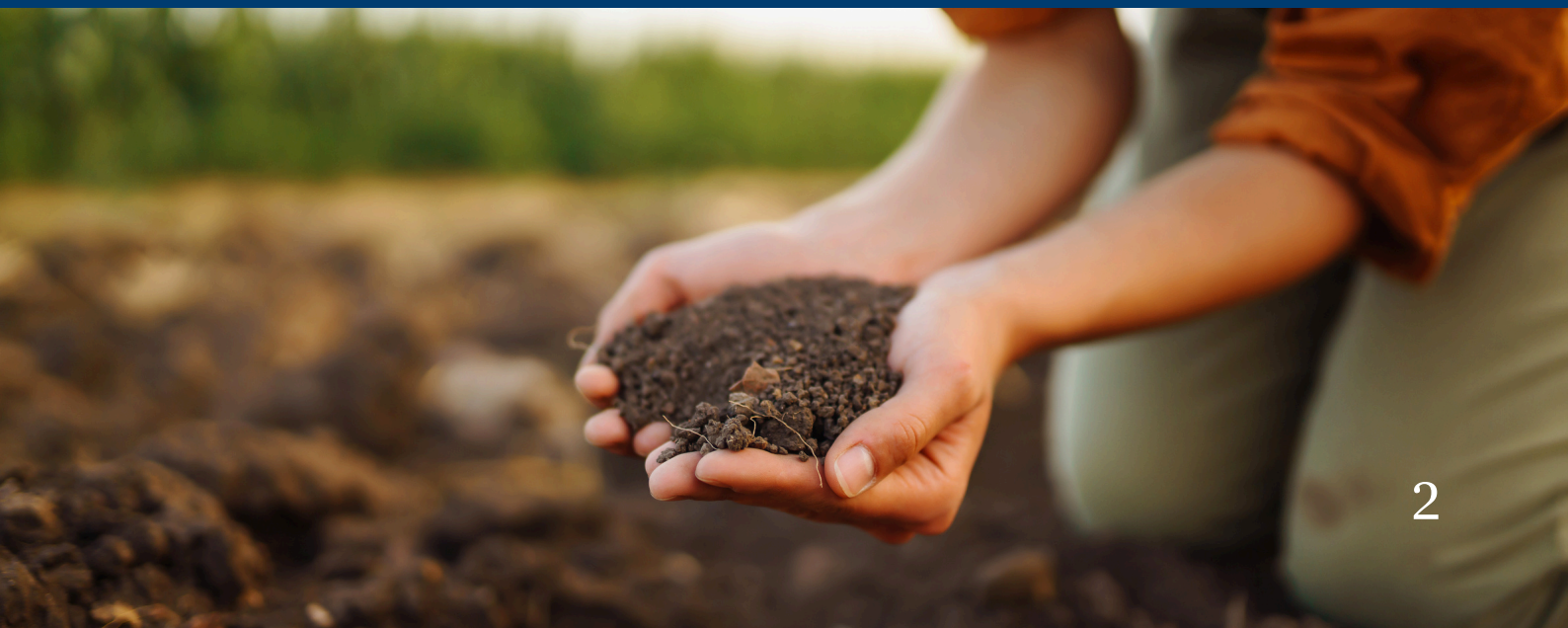


Overview

Program	Description
Community Health Voucher Program	*Provides financial assistance to women who are not eligible for the State program, and it covers diagnostic testing and biopsies*
BCCP Grant Program	*The Breast and Cervical Cancer Project's Patient Navigation Program helps women access cancer screenings, providers, and resources.*
Vaccines for Children Program	*Provides routine childhood immunizations to uninsured, underinsured, and Medicaid-eligible children in underserved communities through mobile clinics at schools and community centers*
Health Partners Free Clinic	*This program continues to provide medical care to uninsured individuals by improving access to care in Troy and surrounding community.*
Miami County Dental Clinic	*Provides access care through the clinic or a mobile dental clinic that goes to schools, homeless shelters, community agencies, etc. to provide dental care to patients in their communities.*
Barbershop Health Initiative	*Provides preventive screenings, education, and resource navigation at barbershops to address health disparities, particularly for African American men at risk for chronic conditions*
Community Health and Mobile Clinic Programming	*Premier Health's Community Health Programming aims to improve cardiovascular and diabetes prevention through screenings, education, and resource navigation for at-risk populations.*
Telehealth Program - Remote Patient Monitoring	*Program improves health outcomes for patients in rural and low-income urban areas by offering continuous monitoring for chronic conditions, reducing hospital readmissions and healthcare disparities*

Overview

Program	Description
Help Me Grow, Brighter Futures	*Help Me Grow Brighter Futures (HMGBF) home visiting is a voluntary, home-based service that provides social, emotional, health-related and parenting support and information to families and links them to appropriate resources.*
Promise to Hope	*The program provides multidisciplinary care for pregnant women with substance use or opiate use disorders to improve maternal and infant health.*
Smoking Cessation Program	*The Smoking Cessation Program provides support on tobacco-related health issues, triggers, and well-being.*
Substance Use Navigators	*Assists emergency department patients with substance use assessments and connects them to treatment.*
Miami County Prenatal Wellness Center	*This program serves as the only prenatal safety net clinic in Miami County, offering both pre and postnatal care to under/uninsured pregnant individuals.*
Tri-County Hope House	*Provides 24/7 support with chemical dependency counselors, along with counseling, case management, life skills training, and recreational activities to promote long-term recovery and independence.*
Community Benefits Grant Program	*Premier Health's grant program supports community health improvement by collaborating with community-based organizations to address access to health services, social determinants, and health disparities.*

Mission:

"We Care. We Teach. We Innovate. We Serve."

These four action statements capture so much of what we do and are about. They support the vision with a strong emphasis on Teaching. Although teaching doctors, nurses, and other clinicians has been a core part of our work from the very beginning, this broadens teaching as an intentional part of our mission

"I CARE" Values:

Integrity
Compassion
Authenticity
Respect
Excellence

Vision:

"To Inspire Better Health."

History of Upper Valley Medical Center

Upper Valley Medical Center (UVMC) is part of a multihospital system known as Premier Health, the largest private, nonprofit, comprehensive healthcare system in Southwest Ohio. In 1986, Miami County, Ohio, had three existing hospitals that merged. Piqua Memorial in Piqua, Stouder Memorial in Troy, and Dettmer Hospital, located midway between Piqua and Troy. As a result of that merger, the Upper Valley Medical Center (UVMC) opened its doors in 1998, consolidating acute-care services to a central location on the 100-acre Dettmer campus. Piqua Memorial and Stouder were closed, and Dettmer remained, housing behavioral medicine programs and various non-clinical services. Increases in patient volumes led to an expansion in 2004, adding 11 inpatient beds and other enhancements in maternity, medical-surgical, and emergency departments. The UVMC Cancer Center on the hospital's west side underwent a major expansion/renovation in 2011-2012. In 2013, an addition to the Physician Office Building, adjacent to the hospital proper, added medical office space, a conference center, and an expanded UVMC Sleep Center.

In 2020, an addition was completed on the south side of the hospital to expand the cardiac and pulmonary rehabilitation program. The addition more than doubled the size of the existing department, provided a separate entrance for participants, and added an employee wellness area for exercise and wellness activities for hospital staff.

Upper Valley Medical Center experienced growth and diversification throughout its first two-plus decades as a result of an ongoing strategic planning process. UVMC has continued to evolve into a comprehensive healthcare provider to better serve the needs of area residents and maintain economic viability.

Over thirty hospitals worked collaboratively to conduct a Community Health Needs Assessment (CHNA) for Greater Dayton Area. The work was led by the Greater Dayton Area Hospital Association in Dayton, Ohio. Local health departments also collaborated to shape the process and share data. Results in the CHNA report include data from a structured survey, qualitative data from multiple focus groups, an analysis of available secondary data, and findings from health departments. Premier Health aims to align its priorities with the top community health needs identified in the CHNA, while providing services that aid in addressing the social determinants of health, structural and systemic barriers that impact the surrounding community.

Geographical Location

Upper Valley Medical Center is located in Troy, Ohio and the county seat for Miami County. The 100-acre campus is next to Interstate 75.

Strategic Planning

Participants invited to the February 6, 2025; meeting included:

- **Dr. Keith Bricking, Executive Vice President & Chief Clinical Officer**
- **Kevin Harlan, President, Atrium Medical Center / Upper Valley Medical Center**
- **Trisha Wackler, Chief Operating Officer & Chief Nursing Officer**
- **Dr. Anna Squibb, Program Director, Addiction Medicine Fellowship, Wright State University**
- **Program Director, Substance Use and Addiction Services**
- **Cheryl Woodward, Site Manager, Public Relations and Community Relations**
- **Dianne Ruhenkamp, Director of Finance**
- **Duanna Osting, President & Executive Director Upper Valley Medical Center Foundation**
- **Frederic Francis, Premier Health Accountant**
- **Jeffrey Smith, Premier Health Accountant**
- **Lisa Henderson, Vice President of Greater Dayton Area Hospital Association, GDAHA**
- **RJ Francisco, System Director-Integrated Care Management**
- **Stephanie Knox, Manager Accounting**
- **Teri Gulker, Director Nurse, Women's Service, Behavioral Health**
- **Janella Straw, Health Promotion & Education Supervisor, Premier Community Health**
- **Sandy Haig, Senior Director Operations, Fidelity Health Care**
- **Lynn Foubert, Director, Premier Community Health and Care Management**
- **Sumayyah Shermadou, Program Coordinator, Community Health Programs, Premier Community Health**
- **Alyssa Morningstar, Community Benefits Coordinator, Premier Community Health**

Executive Summary

Representatives from GDAHA member hospitals and partner agencies convened for a one-day session to define key priorities and strategies for the region's Community Health Improvement Plan (CHIP). Guided by insights from the 2024 Dayton Area Community Health Needs Assessment, this collaborative effort focused on addressing the most pressing health challenges in the region.

The CHIP workgroup identified three overarching priority areas spanning the full continuum of care:

- Barriers to Accessing Care: Addressing systemic and logistical obstacles that prevent individuals from receiving timely and appropriate healthcare.
- Elevating Delivery of Healthcare Services: Enhancing the efficiency, coordination, and quality of healthcare services across the region.
- Wellbeing and Quality of Life: Addressing factors that contribute to long-term physical, mental, and social wellbeing.

For each priority area, targeted strategies were developed to drive meaningful improvements. While many strategies are specific to each focus area, two cross-cutting themes emerged as critical across all priorities: advocacy and social determinants of health (SDOH).

- SDOH: such as economic stability, education, and access to nutritious food—profoundly influence patient outcomes and healthcare costs. Hospitals play a vital role in connecting patients to community-based organizations and nonprofit resources that can meet these needs. Addressing SDOH is essential for reducing health disparities, improving preventive care, and fostering a healthier, more equitable Dayton region.
- Advocacy: by championing policies that support equitable healthcare access, funding for public health initiatives, and stronger community partnerships, hospitals and stakeholders can help shape a healthcare environment that better serves the needs of all Dayton residents. Collaborative advocacy efforts will be essential in driving policy changes that support the long-term success of the CHIP.

This CHIP serves as a strategic roadmap for regional collaboration, ensuring that healthcare providers, policymakers, and community partners work together to create sustainable, long-term improvements in health outcomes.

Community Health Needs Assessment

Understanding CHNA/CHIP Requirements

1	2	3	4	5
Provisions in the Affordable Care Act require a tax-exempt hospital facility/System to:	Conduct a CHNA at least every three years	Consider input from persons who represent the broad interests of the community	Consider input from persons with special knowledge of or expertise in public health	Make the CHNA widely available to the public

Community Health Needs Assessment (CHNA) → Community Health Improvement Plan (CHIP)

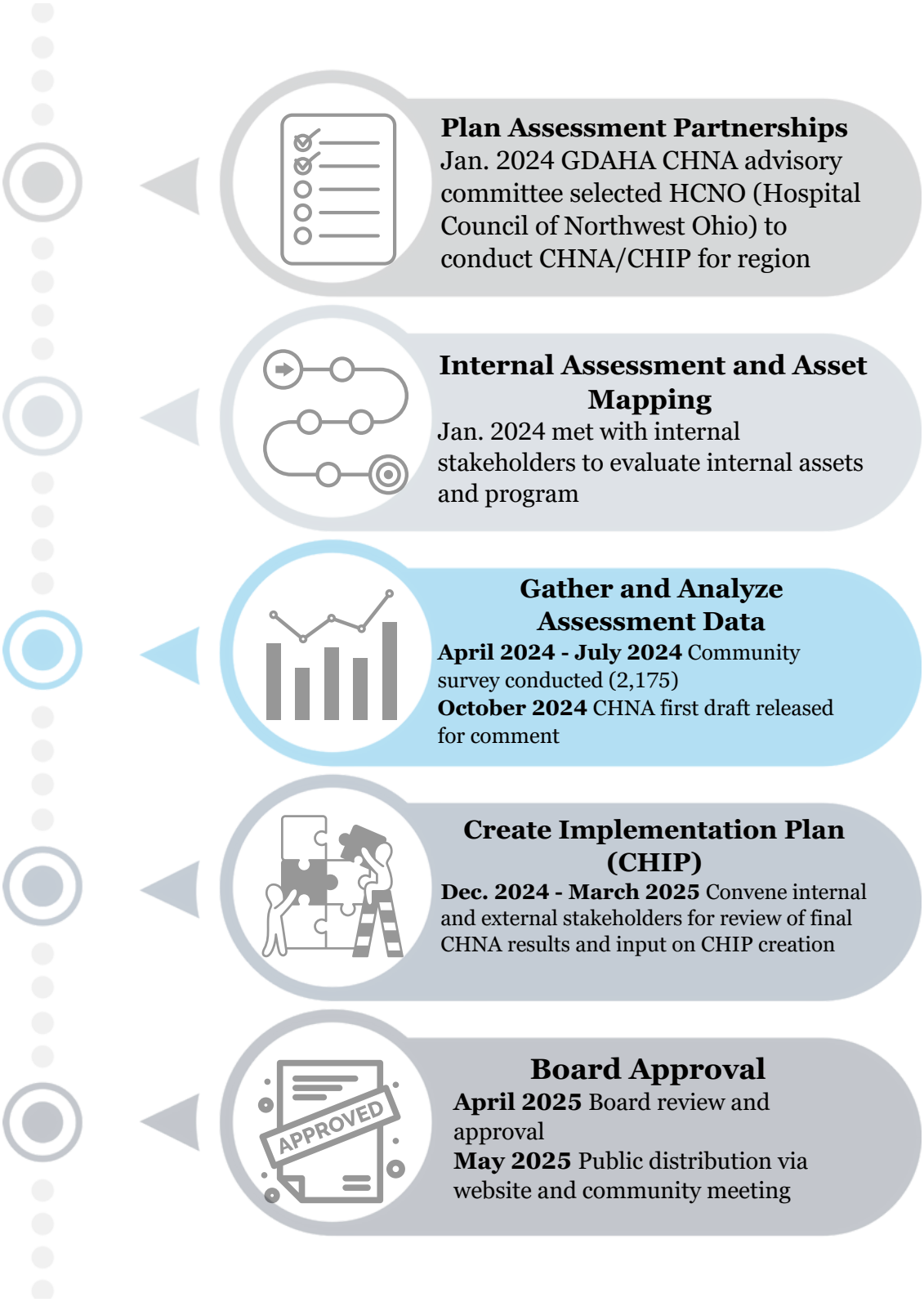
The Collaborative Approach: Greater Dayton Hospital Association

The Community Health Advisory Committee meets regularly, hosts, and facilitates meetings. The Advisory Committee provides expertise on each step of the Regional CHNA including quantitative instrument development, qualitative questions, data collection efforts, reviewing results and report drafts, finalizes, the regional CHNA report, and commits to implementation efforts for their organization to address top needs.

- Each County will have their individualized report

Community Health Needs Assessment

CHNA/CHIP Timeline



Plan Assessment Partnerships
Jan. 2024 GDAHA CHNA advisory committee selected HCNO (Hospital Council of Northwest Ohio) to conduct CHNA/CHIP for region

Internal Assessment and Asset Mapping
Jan. 2024 met with internal stakeholders to evaluate internal assets and program

Gather and Analyze Assessment Data
April 2024 - July 2024 Community survey conducted (2,175)
October 2024 CHNA first draft released for comment

Create Implementation Plan (CHIP)
Dec. 2024 - March 2025 Convene internal and external stakeholders for review of final CHNA results and input on CHIP creation

Board Approval
April 2025 Board review and approval
May 2025 Public distribution via website and community meeting

Regional Priorities & Strategies

Priority 1

Barriers to Accessing Care

Strategy #1a:
Educate & inform patients on their health care benefits and options

Strategy #1b:
Increase access & availability of care options, with focus on uninsured and underinsured individuals

Priority 2

Elevating Delivery of Health Care Services

Strategy #2a:
Support chronic disease management

Strategy #2b:
Enhance the quality and accessibility of prenatal care to expectant mothers and educate on its importance

Strategy #2c:
Support mental health & substance use disorder interventions

Priority 3

Wellbeing & Quality of Life

Strategy #3a:
Encourage healthy behaviors & educate on healthy lifestyle

Cross Cutting Strategies: Addressing Social Determinants of Health (SDOH) & Advocacy

Regional Priority #1

Barriers to Accessing Care

Educate & inform patients on their health care benefits and options

This strategy focuses on equipping patients with the knowledge they need to make informed decisions regarding their healthcare plans, services, and coverage. By enhancing patient understanding, we aim to reduce confusion, improve access to care, and increase overall satisfaction with healthcare services.

42%
Cost/No Insurance

40%
Difficult to Get an Appointment

31%
Inconvenient Appointment Times

24%
Could Not Get Time off Work

More than 1 in 5
Greater Dayton Area adults experienced some sort of transportation issue.

Barriers to Accessing Care 1a

Educate & inform patients on their health care benefits and options

Description

This strategy focuses on equipping patients with the knowledge they need to make informed decisions regarding their healthcare plans, services, and coverage. By enhancing patient understanding, we aim to reduce confusion, improve access to care, and increase overall satisfaction with healthcare services.

Dayton region to work collaboratively to:

Outcomes

- Increase the Dayton region's health literacy
- Number of individuals reached through health literacy programming (with an emphasis on underinsured and uninsured populations)

Action Items

- Standardize how health literacy is measured and tracked
- Regional campaign to educate/inform (re: healthcare options, insurance benefits, coverage transitions, etc.)
- Partner with chamber and business community to educate on insurance transitions

Barriers to Accessing Care 1b

Increase access & availability of care options, with focus on uninsured and underinsured individuals

Description

This strategy aims to reduce health care disparities by expanding access to care options and ensuring that these individuals can obtain the services they need, regardless of their insurance status. By focusing on the needs of the underserved populations, we will enhance the availability of essential health care services and support systems that facilitate improved health outcomes.

Dayton region to work collaboratively to:

Outcomes

- Increase health screenings in underserved zip codes

Action Items

Dayton region to work collaboratively to:

- Review and analyze population and visit data to aid in identification of areas with highest need for screening
- Develop alternative models of care (i.e., mobile clinics)
- Focus on availability (i.e., wait times)
- Consider flexible options for care (i.e., urgent, walk-in, etc.) medical, dental, mental health

Strategic Initiatives

Educate & inform patients on their health care benefits and options. Increase access & availability of care options, with focus on uninsured and underinsured individuals

Program	Program Description:	Outcomes	Partners & Resources
Community Health Voucher Program	Provides financial aid for breast and cervical cancer screenings. Eligibility: • Uninsured/underinsured with income ≤ 400% FPL. • Covered Services: Mammograms, biopsies, Pap tests, ultrasounds, and more. Goal: Early cancer detection for successful treatment.	• 3-Year Projection: 150 women system-wide served. • Expansion Efforts: Premier Health working to increase provider contracts for cervical services. • UVMC Estimate: 39 women served. Enrollment Trend: Client numbers steady despite the healthcare Marketplace changes.	Atrium Medical Center Foundation, Good Samaritan Foundation-Dayton, UVMC Foundation, Miami Valley Hospital Foundation (Help Her Fight), Breast Cancer Foundation, Kuhns Brothers and Five Rivers Health Centers Program Sites: Magnolia Women's Health, Five Rivers Health Center, Atrium Medical Center, UVMC, Miami Valley Hospital, Miami Valley North, Miami Valley South
BCCP Grant Program	• The Breast and Cervical Cancer Project's Patient Navigation Program helps women access cancer screenings, providers, and resources. • Assists to answer questions about appointments, insurance, and more. • Improve access for early detection of breast and cervical cancers improves treatment success.	Increase access un-insured and underinsured community members who fall within the eligibility guidelines. (Premier Health provides in-kind support for office space and administrative support.)	Atrium Medical Center Foundation, Good Samaritan Foundation-Dayton, UVMC Foundation, Miami Valley Hospital Foundation (Help Her Fight), Breast Cancer Foundation, Kuhns Brothers and Five Rivers Health Centers Program Sites: Magnolia Women's Health, Five Rivers Health Center, Atrium Medical Center, UVMC, Miami Valley Hospital, Miami Valley North, Miami Valley South

Educate & inform patients on their health care benefits and options. Increase access & availability of care options, with focus on uninsured and underinsured individuals

Program	Program Description:	Outcomes	Partners & Resources
Health Partners Free Clinic	This program continues to provide medical care to uninsured individuals by improving access to care. The goal is to achieve better health outcomes, reduce healthcare disparities, and enhance organizational capacity and efficiency. The program also focuses on expanding the volunteer workforce and engaging the community more actively.	• Increase patient count to 1,000 by April 2025 • Increase volunteer workforce to 75 by April 2025 Hire a case manager to support patients	Miami County Public Health, local churches, local businesses, schools service clubs, local healthcare providers
Vaccines for Children Program	The Premier Community Health Vaccines for Children (VFC) Mobile Program provides routine childhood immunizations to uninsured, underinsured, and Medicaid-eligible children in underserved communities through mobile clinics at schools and community centers. The VFC program targets children (0-18) in underserved areas, addressing access barriers like transportation and cost. Provides education on vaccine safety and immunization schedules and connects families to ongoing healthcare and follow-up support.	• Number of children vaccinated through the mobile program • Increase in immunization rates in target communities • Number of vaccine outreach and education sessions provided • Reduction in school-entry vaccine non-compliance rates • Number of families connected to primary care providers for ongoing preventive care	Area schools, early learning centers, faith-based organizations, and public housing sites

These initiatives are designed to address barriers to accessing essential health care services for underserved communities.

Educate & inform patients on their health care benefits and options. Increase access & availability of care options, with focus on uninsured and underinsured individuals

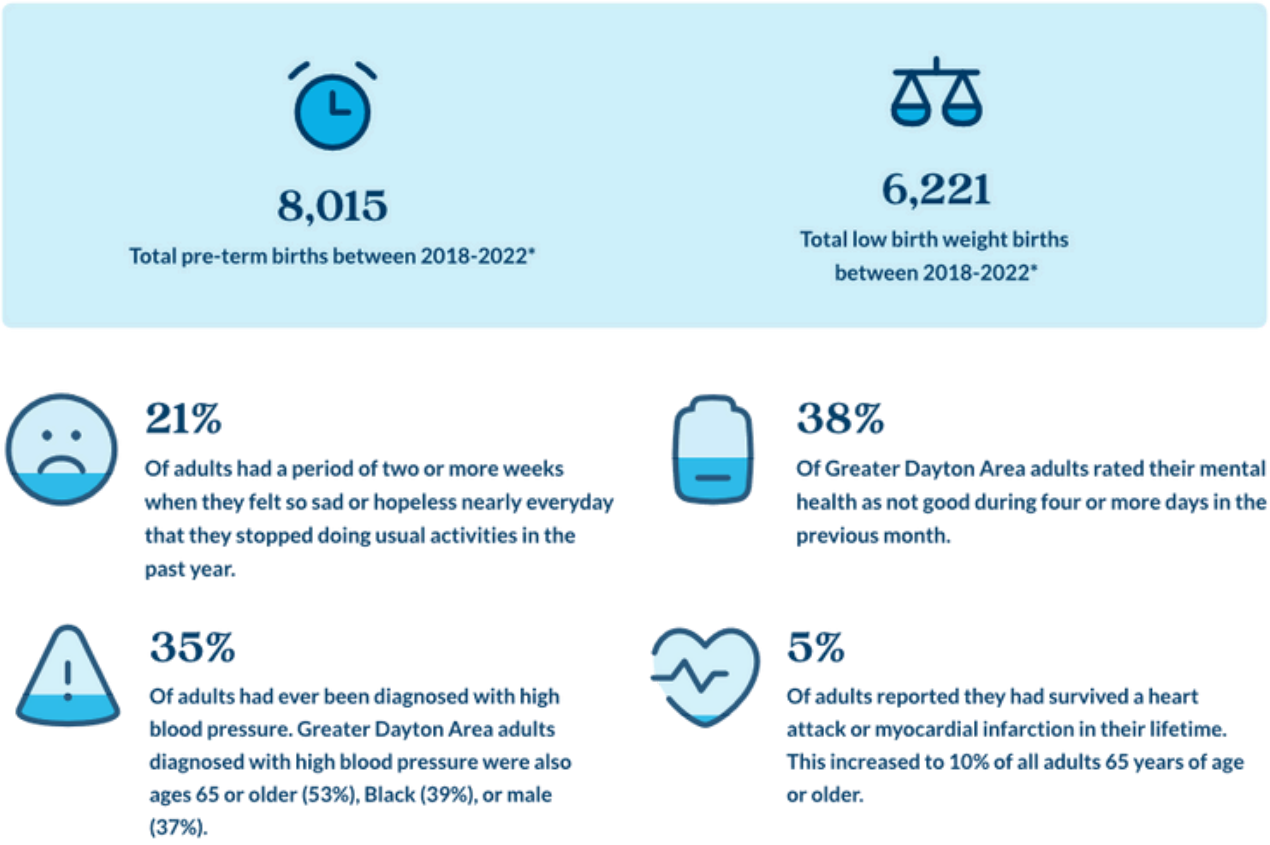
Program	Program Description:	Outcomes	Partners & Resources
Miami County Dental Clinic	Provides access care through the clinic or a mobile dental clinic that goes to schools, homeless shelters, community agencies, etc. to provide dental care to patients in their communities.	The goal is to sustain three fully operational dental chairs with the support of staff and dental students and provide care to at least 500 students in Miami County during the upcoming school year.	Upper Valley Medical Center and Miami County Dental

These initiatives are designed to address barriers to accessing essential health care services for underserved communities.

Regional Priority #2

Elevating Delivery of Health Care Services

Educate & inform patients on their health care benefits and options



Source: 2024 Dayton Area Community Health Needs Assessment

Our Greater Dayton hospitals play a vital role in addressing chronic disease, maternal and infant health, and behavioral health. This priority area will advance the Greater Dayton region's community health through enhanced health care services. It will help patients navigate long-term conditions, reduce preventable complications, ensure healthier pregnancies and births, and address the growing need for comprehensive behavioral health services.

Elevating Delivery of Health Care Services 2a

Support chronic disease management

Description

This strategy supports chronic disease management through a comprehensive approach designed to enhance patient outcomes and encourage self-management.

Outcomes

- Reduce acute care days for chronic disease care (based on most prevalent chronic disease in county)
- Reduce ED admissions relative to chronic disease diagnoses
- Focus on school education and preventative screenings

Action Items

- Share chronic disease management program/service information more broadly across hospitals, public health departments
- Leverage access to regional health care data to inform communities or populations of highest need to inform opportunities for program development or partnership
- Consider remote monitoring or telehealth
- Explore how public health department programming could support chronic disease patients with ongoing management and prevention

Strategic Initiatives

Upper Valley Medical Center is supporting chronic disease management by implementing a range of strategies designed to improve patient outcomes, empower individuals to manage their conditions, and ensure comprehensive, coordinated care.

Support Chronic Disease Management

Program	Program Description	Outcomes	Partners & Resources
Community Health and Mobile Clinic Programming	Premier Health's Community Health Programming aims to improve cardiovascular and diabetes prevention through screenings, education, and resource navigation for at-risk populations. The program provides both in-person and virtual events to promote early detection, lifestyle changes, and chronic disease management in underserved communities. Program Components: • Preventive screenings (blood pressure, BMI, cholesterol, etc.) at community events and via mobile clinic • One-on-one health coaching and group education on chronic disease management. • Community resource navigation for SDOH needs Virtual "Tuesday Talks" health focused webinars on health	• Number of community members screened for cardiovascular and diabetes risk factors • Percentage of high-risk individuals referred to providers • Engagement levels in "Tuesday Talks" virtual education series • Increased health care access for program participants	Local community organizations, churches, senior centers, Middletown Connect walk with a Doc, Community Health Wellness Program, City of Stars Barbershop, Deeez Cuttz Barbershop, Man Up Barbershop, Headliners Barbershop, Nakeda 7 Spa, R. Anthony Hair Salon, Ron West Barbering School, Serenity Salon, Stylzes Barbershop, X-quisite Barbershop & Barbering School

> "The Community Health and Mobile Clinic Program addresses key health priorities, including elevating the delivery of care and reducing barriers to access. It engages directly with the community, promotes health literacy, and connects individuals to essential community resources."

Support Chronic Disease Management

Program	Program Description:	Outcomes	Partners & Resources
Barbershop Health Initiative	The Premier Community Health Barbershop Initiative provides preventive screenings, education, and resource navigation at barbershops to address health disparities, particularly for African American men at risk for chronic conditions. Program Components: • On-site health screenings and coaching • Barber training for health advocacy Culturally tailored education on disease prevention	• Number of barbershops participating in the initiative • Number of individuals screened and referred to follow-up care. • Increase engagement in preventive healthcare and primary care • Improve barbers' engagement and impact as peer health advocates	City of Stars Barbershop, Deeez Cuttz Barbershop, Man Up Barbershop, Headliners Barbershop, Nakeda 7 Spa, R. Anthony Hair Salon, Ron West Barbering School, Serenity Salon, Stylzes Barbershop, X-quisite Barbershop & Barbering School
Telehealth Program - Remote Patient Monitoring	The Remote Patient Monitoring (RPM) Program improves health outcomes for patients in rural and low-income urban areas by offering continuous monitoring for chronic conditions, reducing hospital readmissions and health care disparities. Program Components: • Home monitoring devices, telehealth check-ins, 24/7 monitoring, nurse-led coaching, and support for medication adherence. • Collaboration with community organizations to reach vulnerable populations. Health Equity: Free equipment, multi-lingual support, and digital literacy.	• Reduction in hospital readmissions and emergency department visits • Improvements in patient adherence to medication and care plans • Patient-reported improvements in health status and quality of life	Area hospitals, physicians, community organizations

Elevating Delivery of Health Care 2b

Enhance the quality and accessibility of prenatal care to expectant mothers and educate on its' importance

Description

Enhancing the quality and accessibility of prenatal care is critical for ensuring the health and well-being of both expectant mothers and their babies. A well-rounded strategy to improve prenatal care focuses on providing comprehensive, personalized care, removing barriers to access, and educating mothers about the importance of prenatal care throughout their pregnancy.

Outcomes

- Decrease pre-term births
- Decrease low weight births
- Improved birth outcomes
- Increase # of mothers receiving prenatal care in first trimester

Action Items

- Develop regional resources and best practices to help patients understand importance of maternal and infant health
- Continue to strengthen regional and local partnerships with all levels of care and support for pregnant individuals (i.e. doulas, community organizations, healthcare providers)
- Early screening for high-risk pregnancies
- Nutritional counseling
- Maternal education

Strategic Initiatives

Enhance the quality and accessibility of prenatal care to expectant mothers and educate on its' importance

Upper Valley Medical Center plans to enhance the quality and accessibility of prenatal care and to improve prenatal care by ensuring the health and well-being of both expectant mothers and their babies.

Program	Program Description	Outcomes	Partners & Resources
Help Me Grow, Brighter Futures	Help Me Grow Brighter Futures (HMGBF) home visiting is a voluntary, home-based service that provides social, emotional, health-related and parenting support and information to families and links them to appropriate resources. Our programs serve families with children up to age three. HMGBF is an operating entity of GDAHA. Premier Health supports this program by providing resources for salary and benefits as a part of a community collaboration.	• Caseload Goal: Serve 1,770 families in 2025. • Infant Mortality: Reduce racial disparities in infant mortality, especially among African American infants.	Greater Dayton Area Hospital Association, Kettering Health Network, Life Stages Centering, Five Rivers Health Centers, Southview Women's Center, Grandview Women's Center, Public Health, physician offices, and a variety of community programs such as the Wesley Center, Elizabeth New Life, Miami Valley Child Development Center, Promise to Hope, Life Resource Center, and Family Service Agency
Miami County Prenatal Wellness Center	This program serves as the only prenatal safety net clinic in Miami County, offering both pre and postnatal care to under/uninsured pregnant individuals. It provides essential nursing and medical care to ensure a healthy pregnancy and postpartum experience for its patients.	Provide care to uninsured and under insured women. Increase access to medical providers and clinical care resources.	United Way of Miami County, Health Partners Free Clinic, Miami County Jail, Help Me Grow, Women, Infants, and Children (WIC) , TCN Behavioral Health, Edison State College, Family Abuse Shelter

Enhance the quality and accessibility of prenatal care to expectant mothers and educate on its' importance

Program	Program Description:	Outcomes	Partners & Resources
Promise to Hope	The program provides multidisciplinary care for pregnant women with substance use or opiate use disorders to improve maternal and infant health. Goals include reducing overdose deaths, supporting successful parenting, and increasing breastfeeding rates for mothers in recovery. Providing Medication Assisted Treatment (MAT), personalized care, recovery support, and prenatal/post-partum services through Promise to Hope. To ensure healthy outcomes, pregnant women with substance use disorder or opiate use disorder require a multidisciplinary approach with connection to community resources.	• Measure the total clients served per year • Reduce overdose deaths • Improve infant health • Increase breast feeding rates for mothers in recovery	ADAMHS Board of Montgomery County, Joshua Recovery Ministries, Brigid's Path, Nova Behavioral Health, Berry Health Center, Family Treatment Court, CareSource, and Fresh Start

Elevating Delivery of Health Care 2c

Support Mental Health & Substance Use Disorder Interventions

Description

Supporting mental health and substance use disorder (SUD) interventions requires a comprehensive, multi-tiered strategy that addresses both the immediate and long-term needs of individuals affected by these issues. The goal is to create an integrated system of care that not only provides treatment for mental health and SUD but also promotes prevention, early intervention, and ongoing support.

Outcomes

- Increase medical provider behavioral health literacy
- Increase number of PCPs screening for behavioral health needs

Action Items

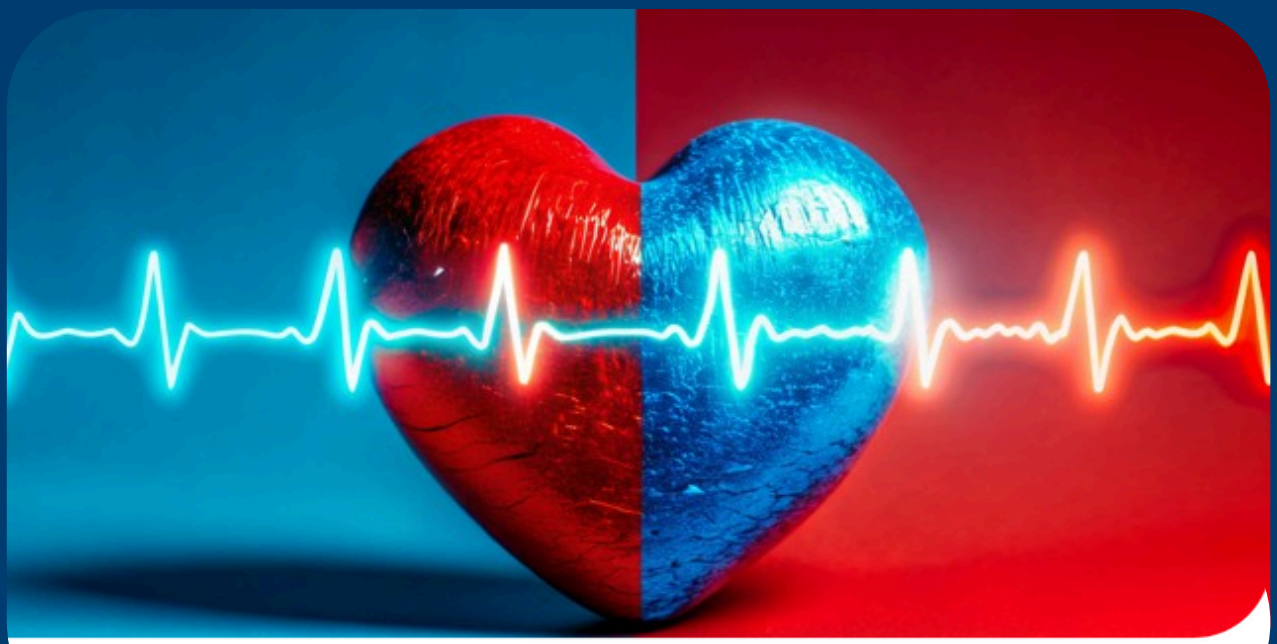
- Standardize screening and data collection/tracking mechanism for mental health across healthcare
- Work with PCPs/medical care providers to integrate behavioral health services
- Create regional best practice for addressing behavioral health alongside medical care
- Consider trauma informed care training for health care providers
- Integrate behavioral health services

Strategic Initiatives

Support Mental Health & Substance Use Disorder Interventions

Program	Program Description:	Outcomes	Partners & Resources
Smoking Cessation Program (Living Smoke Free)	The Smoking Cessation Program provides support on tobacco-related health issues, triggers, and well-being. It meets weekly for five weeks in a group setting providing counseling and support to patients, to help them quit smoking.	• Increase number of participants reporting reduction in nicotine use	Premier Health Physician Network, Community Health Centers, Community Based Organizations
Substance Use Navigators	Premier Health's Substance Use Navigator (SUN) program assists emergency department patients with substance use assessments and connects them to treatment and support services by using navigators experienced in substance use disorder, nursing, or social work.	• Increase number of patients served • Improved connections to ongoing treatment	Area treatment programs, SBHI, Tri County Mental Health Board, County Public Health

Upper Valley Medical Center will continue to support the programs that address both the immediate and long-term needs of individuals affected by these issues



Support Mental Health & Substance Use Disorder Interventions

Program	Program Description:	Outcomes	Partners & Resources
Tri-County Hope House	The Hope House program aims to admit 24 individuals, targeting a 60% successful discharge rate. It offers 24/7 support with chemical dependency counselors, along with counseling, case management, life skills training, and recreational activities to promote long-term recovery and independence.	• Increase number of clients that choose admission • Improve successful discharge rate	Miami County TCN Behavioral Services operates the Hope House and serves Miami, Darke, and Shelby counties. Miami Co Drug Free Coalition. City of Troy, City of Piqua, Local courts and law enforcement, Fire/EMS, Family Abuse Shelter, Recovery and Wellness, St Patrick's Church, New Path, Health Partners, SBHI

Regional Priority #3

Well-being and Quality of Life

Encourage healthy behaviors & educate on a healthy lifestyle

There is an opportunity to proactively support and encourage the wellbeing of those who live in the Greater Dayton area. Wellbeing (or lack thereof) is viewed as an underlying driver of health choices and outcomes. A shared focus on this priority area can encourage individuals to adopt healthier lifestyles, leading to long-term improvements in physical and mental well-being.

45%

Of adults reported that poor mental or physical health kept them from doing usual activities such as self-care, work, or recreation in the past month

Well-being and Quality of Life 3a

Encourage healthy behaviors & educate on a healthy lifestyle

Description

Encouraging healthy behaviors and educating individuals about a healthy lifestyle is key to improving overall public health, preventing chronic diseases, and promoting long-term well-being. The strategy involves a multi-pronged approach that not only provides information but also creates environments and systems that support healthy choices.

Outcomes

- Increasing health literacy in relation to healthy behaviors / making informed decisions about lifestyle choices
- Improve A1Cs and metabolic panel values
- Decrease BMI over all patients

Action Items

- Focus on youth education on healthy behaviors and lifestyles
- Promote exercise, food choices, self-care, mindfulness, youth activities/sports, etc.
- Consider school-based partnerships to educate youth

Strategic Initiatives

Encouraging healthy behaviors and educating individuals about a healthy lifestyle is key to improving overall public health, preventing chronic diseases, and promoting long-term well-being. All the programs listed under previous strategies promote healthy behaviors and incorporate health education as a core component. Additionally, we offer a grant program to support organizations in delivering services that align with our community health improvement strategy.

Encourage healthy behaviors & educate on a healthy lifestyle

Program	Program Description:	Outcomes	Partners & Resources
Community Benefits Grant Program	Premier Health's grant program supports community health improvement and safety by addressing access to health services, social determinants, and health disparities. Grants range from $500 to $8,000 and prioritize projects that align with Premier Health's goals and involve community engagement. • Grants range from $500 to $8,000. • Focus areas include behavioral health, chronic disease, and health equity. Emphasizes community involvement and data-driven, evidence-based solutions.	• Improve health services, public health, and knowledge. • Address root causes like poverty and homelessness	Area nonprofit community-based organizations

> All of the community health initiatives have a core mission to encourage healthy behaviors and educate on healthy lifestyle choices.

Accountability

At the heart of our work is a simple but powerful mission: to inspire better health. This strategic plan reflects our deep and ongoing commitment to improving the health and well-being of every individual in our community. Through strong partnerships, data-driven action, and compassionate service, we are building a healthier, more equitable future—one step, one program, and one person at a time. Together, we will continue to listen, to lead, and to serve—because the health of our community is our shared responsibility and our greatest opportunity.

Accountability

The Executive Community Benefits Committee is responsible for ensuring that strategies occur which meet the community needs, as outlined in this document. The Director for Community Benefits will assist as a community liaison in collaborative efforts and will help coordinate system-wide initiatives.

Significant Health Needs Addressed

Implementation Strategies, listed on the preceding pages, address the prioritized health needs:

- Barriers and Access to Care
- Elevating Healthcare Services
- Well-Being and Quality of Life

Board Approval

Board Approval - Premier Health's Board of Directors approved the Implementation Strategies on March 27, 2025.