



## 2013 Community Health Needs Assessment

Catholic Health Partners' (CHP) long-standing commitment to the community covers more than 150 years. This commitment has expanded and evolved through considerable thought and care in considering our communities' most pressing health needs. One avenue for examining these needs is through a periodic, comprehensive Community Health Needs Assessment (CHNA) for each CHP hospital. The most recent assessments were completed by teams comprised of CHP and community leaders. They include quantitative and qualitative data that guide both our community benefit and strategic planning.

**Through our CHNA, CHP has identified the greatest needs among each of our hospital's communities. This enables CHP to ensure our resources are directed appropriately toward outreach, prevention, education and wellness opportunities where the greatest impact can be realized.**

The following document is a detailed CHNA for Mercy Health – Clermont Hospital. Mercy Health – Clermont Hospital was established in 1973 and, since that time, has served as Clermont County's leading healthcare provider, offering advanced, convenient medical care. Clermont Hospital features one of the region's newest and largest intensive care units, one of the region's first dedicated wound care centers, 24/7 emergency care and inpatient/outpatient surgery. Founded by the Sisters of Mercy, Clermont is now part of Catholic Health Partners (CHP).

CHP has responded to community health needs as part of a five-year strategic plan that concludes in 2013. Planning also has begun on a five-year plan that will guide CHP through 2018. Recently, CHP has built new hospitals in Cincinnati, Springfield and Willard, all in Ohio, and renovated and expanded facilities in Toledo, Youngstown, Lima and other communities served by CHP. CHP is investing more than \$300 million in an electronic health system as we build integrated networks of care designed to improve the health of communities. We operate health and fitness centers, hospice facilities, outpatient clinics and senior living facilities.

CHP contributes more than \$1 million per day in community benefit services as we carry out our long-standing mission of extending care to the poor and under-served.

Mercy Health – Clermont Hospital strives to meet the health needs of its community. Please read the document's introduction below to better understand the health needs that have been identified.

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## Introduction

### *Community Served by Hospital*

The Mercy Health – Clermont Hospital identified its “community served” as the residents of ZIP code 45103 and contiguous ZIP code areas, which include Clermont County and portions of Adams, Brown, Hamilton, and Highland Counties. This is because the vast majority of patients — the users of the hospital’s services — reside in these areas.

*Geographic Identifiers: Contiguous ZIP codes representing the hospital’s primary service area:*

- 📍 Located in ZIP Code across Clermont, Brown, and Highland Counties: 45118
- 📍 Located in ZIP Code across Clermont and Warren Counties: 45122
- 📍 Located in ZIP Code across Clermont and Brown Counties: 45120, 45121, 45130, and 45176
- 📍 Clermont County ZIP Codes: 45102, 45103, 45106, 45150, 45153, 45157, and 45160
- 📍 Located in ZIP Code across Adams, Brown, and Highland Counties: 45697
- 📍 Located in ZIP Code across Adams and Highland Counties: 45679
- 📍 Brown County ZIP Code: 45168
- 📍 Located in ZIP Code across Brown and Highland Counties: 45154 and 45171
- 📍 Hamilton County ZIP Codes: 45244 and 45245

### *Information and Data Considered in Identifying Potential Need*

*Information and Data Sources: Federal, State or Local Health or Other Departments or Agencies*

The Mercy Health – Clermont Hospital participated in a regional Community Health Needs Assessment process coordinated by the Greater Cincinnati Health Council. It contracted with a local nonprofit organization, Health Care Access Now (HCAN), to prepare *A Community Health Needs Assessment for Southwest Ohio and Southeast Indiana*. HCAN is dedicated to helping establish a high performing, integrated, health care delivery network able to provide access to care for all residents of nine (9) counties of Greater Cincinnati, including Hamilton, Butler, Clermont, Adams, Brown, and Warren in Southwest Ohio. As part of its preparation HCAN performed the following activities:

#### **1. Primary Data Collection Sources:**

- 📍 **Stakeholder Interviews:** The stakeholders selected in each county consisted of one person in the following categories: county health commissioner, county mental health board, United Way, Community Action Agency, community foundation, and colleges/universities. Stakeholders chosen to represent each of the categories were determined through a combination of personal references and online search. A few stakeholders had some overlap in that they represented multiple counties included in the study. Refer to the Community Input section of this report for individuals who participated and the date of the interview.
- 📍 **Direct Service Provider Focus Groups using Group Level Assessment (GLA) method:** Invitations were distributed to target direct service providers/advocacy groups from the county in the following categories: non-English speaking, Federally Qualified Health Center (FQHC)/ free clinics, Visiting Nurses Associations, ex-offenders, seniors, transportation, Chambers of Commerce, schools system, inter-faith, legal aid, area planning, county extension, behavioral health, developmental disabilities, dental care, and primary care. The total number of service providers participating at the county GLA events ranged from as few as nine people to as many as 30 people.

Overall, approximately 200 service providers across the nine counties participated. Refer to the Community Input section of this report for individuals who participated and the date of the focus group participation.

▣ **End-User Surveys:** The University of Cincinnati Action Research Center surveyed populations in the greater Cincinnati region who are more often underserved with a particular focus on health care consumers who are uninsured, underinsured, low socioeconomic status, minority, 65+, or who experience mental health issues. Surveys were administered to more than 1,000 community residents across the nine counties with oversampling of vulnerable groups such as persons over 18 years of age who have a behavioral health disorder; seniors; Hispanic/Latinos; and African immigrants, particularly West African immigrants.

## 2. Secondary Data Collection Sources:

- ▣ A Data Committee led by HCAN's partner, Health Landscape, collected the data from local, state and national sources, for the years of 2005-2011, via online search in order to compile the Community Health Needs Assessment database.
- ▣ Local: Hamilton County Public Health and Jobs/Family Services, Greater Cincinnati Community Health Status Survey, Greater Cincinnati Health Council
- ▣ State: Ohio Dept. of Health, Ohio Family Health Survey
- ▣ National: 2010 Census, Annie E. Casey Foundation, Centers for Disease Control, Homeless Management Information Systems, Small Area Income and Poverty Estimates, Food Environment Atlas

## Process and Methods

### *Process for Gathering and Analyzing Data/Information*

(IRS Notice 2011-52 Section 3.03 (2))

#### **1. Primary Data Collection and Analysis Process:**

☞ **Stakeholder Interviews:** Letters were mailed to 50 stakeholder interview candidates inviting them to participate in a 45-60 minute face-to-face interview. Thirty-two interviews were conducted in-person by the Community Health Needs Assessment Project Manager, Stephanie Marshall. Three out of six requests to complete an available online *Survey Monkey* version were fulfilled. Three individuals declined, and eight individuals were unable to be scheduled due to lack of response. The interview questions were drafted with input from the Community Health Needs Assessment Leadership Team and the University of Cincinnati Action Research Center. They were subsequently narrowed down to a total of 17 questions in five different categories. The interviews were tape recorded with consent and the interviewer took high level notes for each question during the interview process. The invitations, question design, and interviews occurred from July-December 2011.

☞ **Direct Service Provider Focus Group Level Assessments:** The University of Cincinnati Action Research Center team conducted one Group Level Assessment (GLA) in each of the nine counties. Group Level Assessment is a participatory large group approach in which qualitative data is generated about an issue of importance through an interactive and collaborative process (Vaughn et al., 1998). The GLA allows for the identification of needs and priorities within a large group setting where the participants have the knowledge and expertise to inform the research. Approximately 30 pieces of flip chart paper hung on the walls. Each flip chart contained one or more prompts/questions. Sample prompts included:

- “The most pressing health care need in our county is...”
- “If you could change one thing about the health care system in our county....”
- “Health care would be more accessible in our county if...”

As a large group, service providers were instructed to provide responses to each prompt in any order they preferred. After recording their responses, participants were instructed to walk around the room and look at other written responses. Participants then divided into smaller groups and were each given 5-7 flip chart pages. Small groups were instructed to discuss the responses on the charts and to identify 3-5 common themes across the charts. After each small group identified salient themes from their flip charts, the larger group reconvened and each small group reported their findings in a “round-robin” fashion with each group presenting one theme at a time. The primary facilitator recorded the major themes on a flip chart for the larger group to see. Then, participants as a large group discussed overall themes, distilled themes through consensus, and chose the most important priorities regarding health and healthcare in their county. If time permitted, the larger group discussed possible next steps for their county. Meetings lasted approximately 90 minutes to two hours. GLA planning, designing and hosting occurred between September – November 2011.

☞ **End-User Surveys:** The University of Cincinnati Action Research Center developed a seven page survey instrument using convenience and purposive sampling techniques. The sample size was based on 2010 Census data. Thus, counties with a population up to 50,000 people received 60 surveys. Other counties received a greater number of surveys in relation to increments of ~200,000 people. Most questions tested between a 4th and 6th grade reading level. Pre-testing was conducted with the target population and revealed that there were no significant readability issues. The survey took between 11 and 22 minutes to complete with most completing in less than 15 minutes. A \$5 gift card incentive was provided. This survey was designed to answer questions focused on barriers to care. The survey instrument was a slightly modified Barriers to Care Questionnaire (developed by Michael Seid, 2009) that was originally designed to measure patient reports of difficulties with accessing or using healthcare. The Barriers to Care Questionnaire has a total scale and five subscales: 1) pragmatics — logistical and cost barriers that might prevent or delay appropriate utilization; 2) skills — acquired or learned strategies to navigate

through, manipulate, or function competently within the health care system; 3) expectations of receiving poor quality care; 4) marginalization — the internalization and personalization of negative experiences within the health care system; 5) knowledge and beliefs — lay or popular ideas about the nature and treatment of illness, which may differ from those of mainstream allopathic medicine. The survey includes validated measures including the initial barriers question. Surveys were administered between August 2011 – November 2011.

Data analysis of primary sources was conducted by the Action Research Center and by Stephanie Marshall, HCAN’s Project Manager. The analysis occurred in November and December 2011 and included the following processes and methods:

- **Quantitative Analyses.** Team members from the Action Research Center entered and checked survey data in Excel. To analyze and summarize the survey data, they used SPSS statistical software for descriptive statistics such as percentages and averages. Quantitative survey results are presented in a variety of formats including written summary, pie charts, bar charts, and tables.
- **Qualitative Analyses.** Individual-level qualitative data were generated by each service provider in response to the different prompts during each county GLA. Because the GLA is a participatory process, the participants distilled and summarized themes from the flip charts and prioritized needs for their county during the actual GLA. In the Community Health Needs Assessment report, GLA data is presented both by the individual county and as an aggregate across all nine counties to detect similarities and overlap of priorities.
- As part of the GLA summary, the Action Research Center presented a ROWS analysis. ROWS analysis has been used within the organizational counseling, community consulting, and health promotion and education fields to describe Risks and Opportunities as they pertain to the environment and Weaknesses and Strengths as they pertain to the person (Prilleltensky & Prilleltensky, 2006). ROWS is very similar to SWOT analyses typically used in business to evaluate strengths, weaknesses, opportunities, and threats to a project. The Action Research Center used a modification of ROWS in this project to describe the Risks, Opportunities, Weaknesses, and Strengths as they pertain to health and healthcare in each of the nine counties.
- For the key informant stakeholder interviews, Stephanie Marshall, HCAN’s Project Manager, recorded each

stakeholder’s comments in an Excel spreadsheet. Salient themes were summarized for each question within counties and across all nine counties. The stakeholder interview data was used to support quantitative data findings and assist in the definition of gaps and trends in healthcare in each county and for the region.

- A “Triangulation Summary and Recommendations” report was presented for each of the nine counties, which incorporates and “triangulates” results from both the GLAs and the surveys. Triangulation is an approach that ensures that results are consistent across the GLAs and surveys and allows for identification of areas in which there are differences. The Action Research Center also presented “Overall Recommendations” which combines recommendations across GLAs, surveys, and vulnerable populations.

## **2. Secondary Data Collection and Analysis Process:**

HCAN convened a Data Committee with volunteer representatives from the United Way of Greater Cincinnati, Cincinnati Children’s Hospital Medical Center, Hamilton County Public Health Department, Mental Health Board, Health Care Access Now, Greater Cincinnati Health Council, and the Butler County Educational Service Center. The committee included people with database management and survey experience, planning experience, and knowledge of special population groups. It was chaired by Jene Grandmont of HealthLandscape, one of the Community Health Needs Assessment partners. The Data Committee collected over 300 health-related indicators from secondary data sources via online search and exported available data into one spreadsheet. The secondary data collection occurred over a nine-month period. The Data Committee met monthly from March 2011 – November 2011, when they had finished collecting data for the initial list of indicators. Jene Grandmont continued collecting data when new indicators were requested by HCAN.

The following informational gaps have been identified:

- Indiana county and state-level data
- Rural Ohio counties (Highland and Adams in particular)
- Some state-level benchmark data for Indiana and Ohio
- ZIP-code or neighborhood level data at the county level except for selected indicators as noted in the Assessment report

HCAN was the primary source of information for The Mercy Health – Clermont Hospital’s Community Health Needs Assessment. The county level results of HCAN’s *A Community Health Needs Assessment for Southwest*

*Ohio and Southeast Indiana* were supplemented by the hospital with additional data from the following sources:

- “By the Numbers,” Mental Health Advocacy Coalition, 2011.
- Cancer Incidence and Mortality; Ohio Cancer Incidence Surveillance System, 2008; current data available online as of 6/21/2012.
- Chronic Disease Indicators; State/Area Profile; CDC’s National Center for Chronic Disease Prevention and Health Promotion; <http://apps.nccd.cdc.gov> accessed September 4, 2012.
- Clermont County Vital Statistics; Clermont County General Health District; 2007-2011.
- 2009 Health Assessments, Clermont County Health District.
- County Health Rankings & Roadmaps 2012; [www.countyhealthrankings.org](http://www.countyhealthrankings.org); accessed 8/27/2012.
- Diagnoses for All Hospital Admissions per Service Area (by ZIP code); Ohio Hospital Association, 2011.
- Mercy Health Self-pay and Charity Financial Classes Seen in the Emergency Departments, 2011.
- Policy Brief: Mental Health in Ohio; Health Policy Institute of Ohio, September 2009.
- Top 10 Causes of Death in Cincinnati, 2001-2007, City of Cincinnati.

These sources provided supplemental references and data to inform the ad hoc committee, convened by the hospital and including community leaders, that performed the scoring and prioritizing of community health needs. Local and regional data to determine the severity of a disease or health need was not uniformly available. The county level summaries, below, were prepared by HCAN. Hamilton and Clermont Counties are where the majority of ZIP codes are located for the hospital’s primary service area.

## **Clermont County Summary**

*Summary from HCAN’s A Community Health Needs Assessment for Southwest Ohio and Southeast Indiana*  
In Clermont County, 99 residents completed the CHNA Community Health Survey, and 12 service providers participated in a Group Level Assessment. Most survey respondents were female (72 percent), white (85 percent), reported family incomes below \$40,000 per year (80 percent) and did not have a higher education (62 percent). The majority (70 percent) were not employed full time.

## **Health Care Utilization**

When asked where they most often went for health care for themselves, 70 percent of respondents reported going to private doctors and 62 percent to private dentists. The majority of respondents said they regularly used health care, both to treat illness and for regular check-ups. Clermont respondents were similar to overall CHNA Survey results, averaging 4.0 visits to a doctor’s office or clinic per year, as compared to the overall CHNA survey average of 4.7 visits. Service providers cited access to primary care and specialist physicians for low-income and/or uninsured families as a top issue in Clermont County.

## **Health Behaviors and Beliefs**

Although about 24 percent of respondents have used natural products to treat medical issues, most Clermont County respondents are not regular users of complementary and alternative medicine practices. Like the overall CHNA survey sample, respondents believe health professionals, medication and prayer and/or God are the most important factors in good health. Service providers believe lack of education, difficulty navigating the system and health literacy have a negative impact on health behavior among Clermont County residents.

## **Sources of Health-Related Information**

Survey respondents reported turning most often to health care providers, television and family members to find information about staying healthy. They turned to their health care provider, insurance companies or family members for information about health care and health insurance. Of all hospital-sponsored events, participants most often reported taking advantage of flu shots (23 percent), but no other hospital-sponsored service had more than 10 percent of participants taking advantage of it. Service providers identified several resources for information in Clermont County, but they believe navigating the system to connect to those resources is a significant barrier for consumers.

## **Barriers to Care**

Survey respondents were mostly likely to cite logistical and cost-related barriers to care. Clermont County respondents were somewhat more likely than the overall CHNA sample to report issues such as disagreeing with the doctor’s orders, or that doctors or nurses had different ideas about health care than they did.

These results are consistent with that of service providers, who reported education about prevention and self-care as a major need. About 90 percent of respondents reported

that transportation did not prevent them from seeing a health care professional. Respondents most often reported traveling 2-5 miles to receive various types of health care. Service providers described limited access to primary care and specialty physicians for underinsured and uninsured patients as a top issue in Clermont County.

## Conclusions

Sixty percent of respondents to the CHNA Community Health Survey reported chronic physical illness, in comparison to 44 percent of the overall CHNA survey sample. Similarly, 34 percent of Clermont County respondents said they have a chronic mental illness, a prevalence rate higher than the 20 percent reported in the overall sample. Service providers describe access to care as a primary challenge.

## Recommendations

Service providers emphasized the need for assistance navigating the health care system. The system is complex, and case management services are minimal in Clermont County. Navigation assistance is needed for both consumers and service providers. Particularly with funding structures like Medicaid, service providers reported that rules and systems change so frequently that providers have difficulty knowing how to advise patients. Resources should be provided directly to both consumers to help navigate the system and service providers so they can support consumers in the navigation process.

In terms of strengths, Clermont County appears to have several organizations that serve as important health care resources (e.g., Mercy Health, the county health department, HealthSource, LifePoint Solutions); however, at the Group Level Assessment, some service providers did not know about resources that other group members mentioned. A goal should be to develop enhanced methods to connect residents with existing resources and to connect resources to each other.

Because Clermont County has several health-related agencies, there is potential to mobilize around prevention efforts. Service providers are particularly enthusiastic about a more proactive approach to health care, including general promotion of healthy lifestyles. Future efforts should build on existing programming in order to make the services more widely available to consumers.

Access to dental health professionals, particularly for the underinsured and uninsured, was identified as a major concern of service providers in Clermont County.

One suggestion generated during the GLA was school debt forgiveness as an incentive for dentists to take non-paying patients.

Service providers emphasized drug abuse as a major problem in Clermont County, particularly heroin and a growing problem with bath salts. Limited access to mental health and substance abuse services and cultural resistance to drug abuse treatment were cited as challenges. Future efforts in Clermont County should address community beliefs regarding mental health and drug treatment services and try to de-stigmatize accessing these services, perhaps by offering community-based education with churches and other civic organizations.

## Community Input

*(IRS Notice 2011-52 Section 3.06)*

All of the individuals listed below were identified for participation because they possessed current data or information relevant to the health needs of the community served by the hospital. The staff and officials who, by virtue of their office or position, are considered to have expertise in public health are indicated by an asterisk (\*) after their name.

### Individuals contacted:

Judy Bennington\*, Administrator

Adams County Health Department, 9/14/2011

Mary Ann Miars-Peercy, Executive Director

United Way of Scioto County, 10/4/2011

Alvin Norris, Executive Director, Adams-Brown Counties Economic Opportunities Inc., 8/29/2011

Harold Vermillion\*, Health Commissioner

Brown County Health Department, 8/29/2011

Colleen Chamberlain, Associate Director

Brown County Alcohol, Drug Addiction, Mental Health Services Board, 9/7/2011

Debra Gordon, Area Director

United Way of Greater Cincinnati, 9/19/2011

Jackie Phillips\*, Health Commissioner

Middletown City Health Department, 9/23/2011

Mike Sanders, Executive Director

Middletown Area United Way, 9/7/2011

Jeffery Diver, Executive Director, Butler County Supports to Encourage Low-Income Families, 9/13/2011

John Guidugli, President and Chief Executive Officer  
Hamilton Community Foundation, 9/13/2011

Duane Gordon, Executive Director  
Middletown Community Foundation, 10/10/2011

Karen Scherra, Chief Operating Officer, Clermont County  
Mental Health and Recovery Board, 9/27/2011

Billie Kuntz, Executive Director  
Clermont County Community Services, 9/19/2011

Lisa Jackson, VP Marketing, Development  
HealthSource of Ohio, 12/5/2011

Tim Ingram\*, Health Commissioner  
Hamilton County Public Health, 9/29/2011

Erik Stewart, Vice President of System Performance  
Hamilton County Mental Health and Recovery Services  
Board, 9/19/2011

Barbara Terry, Vice President Community Impact  
Community/Charity United Way of Greater Cincinnati,  
9/8/2011

Will Parr, Agency Director  
Cincinnati/Hamilton Community Action, 10/3/2011

Shiloh Turner, Vice President of Programs  
Greater Cincinnati Foundation, 9/15/2011

H.A. Musser, President and Chief Executive Officer  
Santa Maria Community Services, 12/6/2011

Dr. Jim Vanzant\*, Health Commissioner  
Highland County Health Department, 9/12/2011

Juni Frey, Executive Director, Paint Valley Alcohol,  
Drug Addiction, Mental Health Services Board, 9/22/2011

Duane Stansbury\*, Health Commissioner  
Warren County Combined Health District, 9/12/2011

Brent Lawyer, Executive Director  
Mental Health and Retardation Services of Warren and  
Clinton Counties, 9/7/2011

Karen Hill, Director, Aging Services  
Warren County Community Services Inc., 9/13/2011

Julia Rupp, Chief Operating Officer  
Community Mental Health Center, 8/30/2011

Karen Snyder, Director  
Dearborn County United Way, 9/6/2011

Mark Neff, Coordinator  
Dearborn County Community Foundation, 9/9/2011

David Welsh, M.D. \*, County Health Officer  
Ripley County Health Department, 9/27/2011

Sally Morris, Executive Director  
Ripley County Community Foundation, 8/30/2011

John Joy, Dean  
Southern State Community College, 9/22/2011

Eric Rademacher, PhD, Co-Director University of  
Cincinnati, Institute for Policy Research, 10/20/2011

John Tafaro, President Chatfield College, 8/29/2011

#### **Direct Service Provider Group Level Assessments:**

Becky Basford, Certified Nurse Practitioner, Adams County  
Regional Medical Center (ACRMC), 10/26/2011

Krys Hess, Food Service Supervisor, Adams County Ohio  
Valley School District (ACOVSD), 10/26/2011

Carol Motza\*, Board Member  
Health Department, 10/26/2011

Brian McCord, Sports Medicine Manager, Adams County  
Regional Medical Center (ACRMC), 10/26/2011

Will West, Wal-Mart, 10/26/2011

Farrah Jaquez, Assistant Professor  
University of Cincinnati (UC), 10/26/2011

Shay Beighle, Teacher  
North Adams High School, 10/26/2011

Holly Johnson, Director, Adams County Economic  
Development Council (ACEDC), 10/26/2011

Mike Clinton, 10/26/2011

Karen Ballengee, Treasurer  
Manchester Local School District (MLS), 10/26/2011

Alvis George, Manchester Local School District (MLS),  
10/26/2011

Dane Clark, Assembly and Test Manager/Board of Trustees  
General Electric (GE)/Adams County Regional Medical  
Center, 10/26/2011

Joyce Porter, Director of Human Resources and Risk  
Management, Adams County Regional Medical Center  
(ACRMC), 10/26/2011

Charlie Bess, Volun“teen” Coordinator/Board Member  
Adams County Regional Medical Center (ACRMC)/Adams  
County/Ohio Valley School District (ACOVSD), 10/26/2011

Delora Blymail, Workforce Connections of Adams and Brown Counties, 10/25/2011 Brown Counties, 10/25/2011

Steve Dunkin, Executive Director, Brown County Alcohol, Drug Addiction, Mental Health Board, 10/25/2011

Mary Francis, Director, Assistance for Substance Abuse Prevention Center, 10/25/2011

Erin Holsted, MSW, Licensed Social Worker  
Western Brown School Based Health Center, 10/25/2011

Joan Phillips, Chief Executive Office  
Brown County Hospital, 10/25/2011

Venita Milburn, Brown County Hospital, 10/25/2011

Sue Basta, PhD, RN; Continuing Education Health Promotion Programs, HEALTH-UC/University of Cincinnati Area Health Education Center, 10/25/2011

Ramona Applegate, Adams Brown Early Head Start/  
Adams/Brown County Economic Opportunities, Inc., 10/25/2011

Bonita Haas, BSW, Licensed Social Worker; Assistant Director, Adams Brown High School/Early Head Start/ Help Me Grow/Adams/Brown County Economic Opportunities, Inc., 10/25/2011

Joan Garrett, Pre-K Director, Board Member  
Brown County Educational Service Center, 10/25/2011

Dayne Michael, Supervisor  
Brown County Educational Service Center, 10/25/2011

Margaret Clark, Judge Probate Juvenile Court, 10/25/2011

Randy Allman, Director Regional Services, Brown County Recovery Services (Talbert House), 10/25/2011

David Sharp, Director of Job/Family Services  
Brown County Recovery Services, 10/25/2011

Tammie Keller, Business Manager, Brown County Board of Developmental Disabilities, 10/25/2011

Linda Ondre, Coordinator  
Family Children First Council, 10/25/2011

Angie Devilbliss, Faculty Secretary  
Southern State Community College, 10/25/2011

Heather Wells, MSW, Licensed Social Worker/ Coordinator  
Butler County Family Children First Council, 10/21/2011

Bill Staler, Chief Executive Officer Lifespan, 10/21/2011

Marc Bellijario, Chief Executive Officer  
Primary Health Solutions, 10/21/2011

Yvette Dorsey-Benson\*, Director  
Middletown Health Department Project, 10/21/2011

Carrie Coreen, Butler 211, 10/21/2011

Angie Duncan, Director Butler County Success, 10/21/2011

David Foster, Support Services Director  
Fairfield City Schools, 10/21/2011

Nina Rose, Senior High Students Against Drunk Driving Sponsor, Fairfield City Schools, 10/21/2011

Susie Sheridan, Practice Manager  
Primary Health Solutions, 10/21/2011

Stephanie Johnson, School Nurse, Talawanda School District, Board, Butler County Health Department and Oxford College Corner Free Clinic, 10/21/2011

Linda Kimble, Executive Director, Serve City, 10/21/2011

Cari Wynne, Supervisor  
Educational Service Center – Success, 10/21/2011

Carla Grossman, Counselor  
Mercy Clermont Mental Health, 11/3/2011

Billie Elliot, LifePoint Solutions, 11/3/2011

Deb Spradlin, Director of Behavioral Health Services  
Sisters of Mercy Clermont, 11/3/2011

Marty Lambert\*, Health Commissioner  
Clermont County Health District, 11/3/2011

Julianne Nesbit\*, Assistant Health Commissioner  
Clermont County Health District, 11/3/2011

Karen Balon, LPN; Health Manager  
Child Focus, Inc., 11/3/2011

Peggy Haley, Director Mercy Clermont Outreach, 11/3/2011

Laura Metzler, Director of Community/Volunteer Improvement, American Cancer Society, 11/3/2011

Marty Grove, Director of Nursing Clinical Services – Education, Mercy Clermont, 11/3/2011

Charlotte Goering, Mercy Clermont, 11/3/2011

Ann Lane, Office Manager Emergency Room  
Mercy Clermont, 11/3/2011

Irene Behling, Director of Mission Integration  
Mercy Clermont, 11/3/2011

Carol Muhlenkamp, Director of Patient Care Services  
Nursing – Dearborn County Hospital (DCH), 11/2/2011

Stephanie Craig, Director of Education and Risk Management, Education/Risk Assessment Dearborn County Hospital, 11/2/2011

Mayor Donnie Hastings, Mayor, City of Aurora, 11/2/2011

Tom Talbot, Chief Executive Office  
Community Mental Health Center, Inc., 11/2/2011

Bill Cunningham, Mayor of Lawrenceburg, 11/2/2011

Karl Galey, Superintendent  
Lawrenceburg Schools, 11/2/2011

Cecelia Scudder, Nursing Administration  
Dearborn County Hospital, 11/2/2011

Arn Edwards, Lifetime Resources, 11/2/2011

Lois Franklin\*, Public Health Nurse  
Dearborn County Health Department (DCHD), 11/2/2011

Debbie Fehling\*, RN, Health Educator  
Dearborn County Health Department (DCHD), 11/2/2011

Brenda Coleman, Vice Chairperson on Board  
Health Care Access Now, 11/14/2011

Nancy Carter\*, RDH, MPH Assistant Dental Director  
Cincinnati Health Department, 11/14/2011

Sally Stewart, Chief Executive Officer  
Crossroad Health Center, 11/14/2011

Bill Ebelhar, Director of Outpatient Counseling  
Centerpoint Health, 11/14/2011

Randy Allman, Program Director, Talbert House, 11/14/2011

Sean Kelley, Director of External Relations  
The Health Collaborative, 11/14/2011

Mary Day, Managing LTC Ombudsman  
Pro Seniors, Inc. , 11/14/2011

Shana Trent, Practice Manager  
The Healthcare Connection, 11/14/2011

Sandra Regan, PhD, Research Scientist  
University of Cincinnati Family Residency, 11/14/2011

Judith Warren, Executive Director  
Health Care Access Now, 11/14/2011

Ann Barnum, Officer – Substance Use Disorders  
Health Foundation of Greater Cincinnati Senior Program, 11/14/2011

Stephanie Marshall, Project Manager  
Health Care Access Now, 11/14/2011

Tim Ingram\*, Health Commissioner  
Hamilton County Public Health, 11/14/2011

Terresa Adams, Community Specialist  
Cincinnati Children’s Hospital Medical Center, 11/14/2011

Dolores Lindsay, Chief Executive Officer  
The Healthcare Connection, 11/14/2011

Abda Tall, Interpreter/Patient Advocate  
The Healthcare Connection Lincoln Heights, 11/14/2011

Yolanda Mayweather, Interpreter/Patient Advocate  
The Healthcare Connection, 11/14/2011

Joe Curry, Executive Director  
Everybody Rides Metro, 11/14/2011

Kim Sullivan, Chief Executive Officer/President  
Sincere Home Health Care, 11/14/2011

Tim Sullivan, Sincere Home Health Care, 11/14/2011

Ray Watson, Community Investment Program Officer  
The Greater Cincinnati Foundation, 11/14/2011

Michelle Duff, Caseworker  
Big Brothers Big Sisters, 10/13/2011

Karen McDonald-Myers, Executive Director  
Big Brothers Big Sisters, 10/13/2011

Rita Easday, Superintendent  
Hillsboro City Schools, 10/13/2011

Tony Long, Superintendent  
Southern Ohio Educational Services Center, 10/13/2011

Danielle Ratcliff, FCFC Coordinator  
Family and Children First, 10/13/2011

Juni Frey, Executive Director, Paint Valley Alcohol, Drug Addiction, Mental Health, 10/13/2011

Dana Berryman, Parent Representative, 10/13/2011

Bonnie Cumberland, Parent Representative, 10/13/2011

Heather Gibson, Project Director  
Help Me Grow, 10/13/2011

Shena Weade, Director of Early Childhood Programs  
Highland County Community Action Organization/  
HeadStart/Early Head Start, 10/13/2011

Amanda Robbins, Parent Representative  
Help Me Grow, 10/13/2011

Melody Elliott, Director, FRS Transportation, 10/13/2011

Jehona Preza, Community Outreach  
Molina Healthcare, 10/13/2011

Susan Roades, Case Manager/Social Service Supervisor  
Highland County Job and Family Services, 10/13/2011

Lisa Higley, Health Chck/Pregnancy Related Services  
Highland County Job and Family Services, 10/13/2011

Amy Watson, Nurse, Jac-Cen-Del Nurse, 10/19/2011

Tonya George, Office Manager  
Health Centered Chiropractic, 10/19/2011

Pat Thomas\*, Health Department Director  
Ripley County Health Department, 10/19/2011

Vicky Powell\*, Public Health Nurse  
Ripley County Health Department, 10/19/2011

Gayla Vonderheide, Director of Health Services  
Batesville Community School, 10/19/2011

Appie Thompson, RN  
Milan Community Schools, 10/19/2011

Tony Czack, Manager, Anytime Fitness, 10/19/2011

Geralyn Litzinger, Manager of Occupational Health  
Services, Margaret Mary Community Hospital, 10/19/2011

Cindy Blessing, Wellness Coordinator/Choices Director  
City of Batesville, 10/19/2011

Brenda Wetzler, Board Secretary Osgood Community  
Foundation, 10/19/2011

Laura Rolf, Community Development Director  
Big Brothers/Big Sisters of Greater Cincinnati, 10/19/2011

Trish Hunter, Director of Support Services  
Margaret Mary Community Hospital, 10/19/2011

Kathy Cooley, RD, Dietitian  
Margaret Mary Community Hospital, 10/19/2011

Bonnie Ploeger, Director of Inpatient Care  
Margaret Mary Community Hospital, 10/19/2011

Kathy Newell, Cardiology Director  
Margaret Mary Community Hospital, 10/19/2011

Kevin Knekelen, Neace Luken, 10/19/2011

Angela Hurley, Wellness Director  
Southern Indiana YMCA, 10/19/2011

Amy Ertel, School Nurse, Saint Louis School, 10/19/2011

Angie Johnson, Executive Director  
Southern Indiana YMCA, 10/19/2011

Linda Tuttle, Manager of Social Services Department  
Margaret Mary Community Hospital, 10/19/2011

Della Menchhofer  
Osgood Community Foundation, 10/19/2011

Denise Roark, School Nurse  
Milan Elementary, 10/19/2011

Debbie Blank, Reporter, The Herald-Tribune, 10/19/2011

Jean Dorgan, Abuse Rape Crisis Shelter, 11/2/2011

Jerri Langworthy, Volunteer Resource Center Director/  
Community Building, Warren County United Way, 11/2/2011

Kathy Michelich, Educator and Director  
Ohio State University Extension, 11/2/2011

Sue Miller, Family Services Director  
Warren County Community Services, 11/2/2011

Sharon Moeller, School Nurse/Safety Officer  
Warren County Career Center, 11/2/2011

Marilyn Singleton, Site Manager, TriHealth, 11/2/2011

Sandy Smoot, Coordinator  
Family & Children First Council, 11/2/2011

Duane Stansbury\*, Health Commissioner  
Health District (Health Department), 11/2/2011

Judy Webb, Director, Elderly Services Program  
Warren County Community Services, 11/2/2011

The focus group participants, listed above, included representatives of community, consumer, and educational organizations as well as service and health providers. The stakeholder interviews and the focus group participants identified community needs. For the prioritizing of community health needs, the hospital convened a one-time committee and invited community leaders from the hospital's service area to participate in discussing, evaluating, scoring, and prioritizing the health needs identified through both the HCAN report and the supplemental data provided by the hospital.

The following community forums were open to the general public. They were also promoted to interviewees and focus group participants and their organizations, including representatives who work daily with low-income residents, people with chronic diseases, the elderly, young people, disabled populations, people with mental health and/or substance abuse, and minority populations. At each forum, CDs containing HCAN's report were given away for public dissemination. The forums were organized by HCAN and the Action Research Center, and the hospital was not privy

to their communications plan. Not all participants in community forums provided their titles and affiliations.

## Community Forums

*Description prepared on July 2, 2012 by Action Research Center team members and HCAN staff & consultants*

In order to disseminate results of the community health needs assessment (CHNA) and begin the conversation about next steps, five community forums were organized by HCAN and the University of Cincinnati Action Research Center. The forums were held at accessible sites across the nine county region:

▨ Forum 1: Adams, Brown, and Highland Counties, June 11, 2012

Location: Brown County Fairgrounds in Georgetown, OH  
16 Attendees: Jim Settles, Ripley; Rose Merkowitz, Wilmington; Jim Merkowitz, Washington Court House; Steve Dunkin, Georgetown; Denise Neu, Georgetown; Sharon Ashley, Blue Creek; Saundra Stevens, West Union; Sherry Stout, Winchester; Elizabeth Pendell, Peebles; Nancy Darby, West Union; Kathy Jelley, Georgetown; Penny Condo, Georgetown; Amy Habig, Hillsboro; Cheryl Williams, Georgetown; Brian Peck, Georgetown; and Mary Bailey, Georgetown.

▨ Forum 2: Dearborn and Ripley Counties, June 12, 2012

Location: Southeast Indiana YMCA in Batesville, IN  
24 Attendees: Vicky Powell, Batesville; Tom Talbot, Greendale; Kim Inscho, MMCH; Frank Goodpaster, Osgood; Paula Goodpaster, Versailles; Kim Linkel, Batesville; Luree Ketcham, Lawrenceburg; Ruth Wright, Lawrenceburg; Jennifer Mehlon, Batesville; Diane Raver, Batesville; Ashley Morris, Batesville; GERALYN LITZINGER, Batesville; Stephanie Craig, Lawrenceburg; Angie Johnson, Batesville; Connie DeBurger, Versailles; Rae Lynn DeAngelis, Lawrenceburg; Paula Bruner, Lawrenceburg; Jane Yorn, Batesville; Lisa Werner, Batesville; Laura Rolf, Lawrenceburg; Kathy Newell, Batesville; Rick Fledderman, Ripley; Kathy Cooley, Ripley; and Rhonda Savage, Batesville.

▨ Forum 3: Butler and Warren Counties, June 25, 2012

Location: Miami University Voice of America Learning Center in West Chester, OH  
18 Attendees: Jennifer Kruger, City of Hamilton; Terry Purdue, Hamilton; Joyce Kachelries, Hamilton; Jane Barnes, Hamilton; Mike Oberdoesk, Cincinnati; Sherry Schilling, Oxford; Dawn Fahner, Oxford; Susan Lipnickey, Oxford; Marc Bellisaro, Hamilton; Heather Wells, Hamilton; Karen Hill, Lebanon; Judy Webb, Lebanon; Sandy Smoot,

Lebanon; Sharon Klein, Oxford; Pat Van Ofen, Fairfield; Lynn Oswald, Mason; Brad Farr, West Chester; and Brent Lawyer, Lebanon.

▨ Forum 4: Clermont and Hamilton Counties, June 26, 2012

Location: Union Township Civic Center in Eastgate area  
7 Attendees: Sue Motz, Mercy Health; Heidi Nykolayko Woods, Recovery Center; Gwen Finegan, Mercy Health; Wendy Hess, TriHealth; Irene Behling, Mercy Health; Gyasi C. Chisley, Mercy Health; and Ruchi Bawa, UC-Clermont.

▨ Forum 5: Hamilton County, June 28, 2012

Location: Health Foundation in Cincinnati, OH  
20 Attendees: Col Owens, Legal Aid Society; Donna Marsh, Marsh Media Group; Ashaki Warren; Monica Roberts, Healing Center Cincinnati; Tony Savicki; Melissa May; Josh Kaufmann, Project Access; Tonda Francis, Greater Cincinnati Health Council; Lee Ann Liska, Mercy Health; Rick Stumpf, University of Cincinnati; Don Rohling, Mercy Health; Mary Beth Meyer, Center for Respite Care; Jeff Armada, Mercy Health; Kathy Lordo, Hamilton County Public Health; Tim Ingram, Hamilton County Health Commissioner; Yousuf Ahmad, Mercy Health; Jill Gorley, Alzheimer's Association; LiAnne Howard, City of Cincinnati; Tori Ames, Cincinnati Children's Hospital Medical Center; Leslie Applegate, University of Cincinnati.

Although these forums were initially designed to include community residents, service providers, and hospital representatives, the majority of attendees were service providers and hospital representatives. Each forum was held for 1.5 hours. At each forum, the same agenda was followed.

- Welcome and Introduction
- Key CHNA Findings and Recommendations (Across Nine Counties and County Specific)
- “Imagining the Future” Exercise (small group county-specific discussions about report recommendations)
- Wrap Up and Next Steps

Overall, the attendees were interested in hearing the results — both nine-county and county-specific. They were engaged in discussing next steps. Attendees offered specific suggestions about how best to move forward.

Based on the discussions and interest expressed by attendees, there appears to be a high level of willingness among attendees to partner with hospitals and other county stakeholders for the development of practical community

health improvement initiatives. The attendees were rather passionate and ready to mobilize for action planning and execution. Attendees were invited to indicate if they would be interested in follow-up for future meetings, action planning and information. The majority of attendees did consent for future follow-up. Therefore, the hospitals would have a core group of county residents and providers to work with in developing their respective community health improvement plans.

### **General Overall Themes from the Group Discussions**

All counties agreed with and identified the need to establish a collaborative health advisory board that includes consumers. Adams County was the only county who felt they already had such a board with their Health and Wellness Coalition. Some of the counties described coalitions and boards already in existence that could be examined and possibly condensed or expanded to better meet communication and resource needs. All counties identified the need to make sure that county and community resources are not only identified, but shared widely so community members know what is available.

Coordination of services (beyond medical health services) was stressed in all forums. Several GLAs and forums were venues of discovery, as participants became aware of services in their county. All county groups noted the importance of assessing the resources available (and whom they serve), as well as collaborating in spreading awareness of those resources. The groups also agreed that it made sense to coordinate efforts to ensure that the people of their counties would have access to needed services. Participants at the community forums were anxious to network and work collaboratively. They often represented the service providers that are already stretched thin in their respective roles. As the Warren County group put it, “Who will take the lead in coordinating these efforts?”

In terms of next steps, several county groups felt that further assessment of needs of vulnerable populations was warranted. For example, Adams County attendees identified that more information on children and the elderly was needed. Other county groups also voiced that continued in-depth needs assessments were important to determine needs and prioritization. One group, however, said that it’s time to take action, rather than continuing to conduct more assessments.

Access to care discussions raised issues of transportation with some suggestions for mobile health care (Ripley),

access to transportation (Dearborn) and revised hours or walk in clinics, In the Warren County small group discussion, attendees reiterated that transportation is a challenge within their county. They stated that they must take action to address transportation since they have known it’s a problem and continues to be a problem according to the results of this CHNA.

The lack of specific types of providers was noted in many counties, especially outside the I-275 loop. Primary care, dental, mental health and substance abuse practitioners are lacking in several of the counties. Some suggestions were made for incentivizing practitioners to not only work in outlying areas (Clermont), but to agree to care for the underinsured and uninsured (Hamilton). Participants were aware that funding is part of the equation. Some suggested that loan forgiveness and internships might be incentives for recruitment.

Partnering with business and community leaders was brought up both in direct collaboration and in grants/funding for needed programs.

### ***Community Health Needs***

Priorities were established among identified health needs using a multi-level process incorporating the perspective of major stakeholders in the local community as defined in the IRS Notice and are relevant to the hospital’s defined service area. Local community leaders were invited to join hospital leaders and regional representatives for one scoring session. They were provided a list of health conditions or issues with data from HCAN’s report and the sources above, as relevant, and asked to identify the health needs from the list of health conditions or issues. They prioritized the needs that were identified. The following worksheet was prepared and distributed in advance of the scoring session. Participants added their suggestions to the community capacity column, and they have been incorporated below. The group discussed the conditions and issues for which there was not a lot of data available to measure the degree of severity at the county- or ZIP code-level. In some cases, indicators were included to reflect the dimensions of a condition when prevalence, morbidity, and mortality data, for example, was not available. It was helpful to have hospital personnel and community leaders at the table together to share their experiences and perspectives about how health conditions and issues are demonstrated in the community area served by the hospital.

Based on all of the above information and processes, the prioritized health needs of the community served by the Mercy Health – Clermont Hospital are listed below.

## **Access to Care**

### **Size of Population**

- 16% of the adult population in Clermont County is uninsured = 23,652 people.
- 9.3% live below poverty level.

### **Severity/Significance**

There is a lack of access to care (primary, mental, dental) as a result of un-insurance and under-insurance. Mental Health Provider Ratio is 4885:1 (vs. OH ratio of 2501:1). Dental Provider Ratio is 3886:1 (vs. OH ratio of 2,435:1). 178 physicians are in Clermont County (Clermont County General Health District, CCGHD). Clermont Emergency Department (ED) saw 24.71% self-pay or charity patients in 2011 (Mercy Health, MH). Clermont ED doctor reports that the lack of primary care follow-up is one of the ED's two biggest challenges and reasons for return visits. Many working poor cannot afford co-pays. From Clermont County Health District's 2009 Health Assessment: 82.9% of adults do not have a medical home and 10.9% reported no health insurance.

### **Outcomes to Evaluate Progress**

The metric is the percentage of people with a medical home. United Way's Bold Goal is to reach 95%. As a benchmark, currently 84% in the region have a medical home, per the 2010 Greater Cincinnati Behavioral Health Status Survey (which is repeated every few years).

### **Community Capacity**

HealthSource is local FQHC. 178 physicians in Clermont Co. (per CCGHD). Clermont has Outreach Nurse and Health Partnership program.

## **Cancer**

### **Size of Population**

In Clermont County, female breast cancer affects about 252 women. Lung cancer affects about 188 people and results in 154 deaths.

### **Severity/Significance**

Cancer is a leading cause of death. In Clermont County, the incidence of female breast cancer is 127.9, compared to 121.9 for OH and 126.1 for the U.S. The incidence of lung

cancer is 95.3 per 100,000, compared to 52.9 for OH and 50.6 for the U.S. The mortality rate for lung cancer was 78.2, compared to 60.3 for OH and 54.1 for the U.S.

### **Outcomes to Evaluate Progress**

Lung cancer — Target: Reduce the lung cancer death rate to 45.5 deaths per 100,000 population.  
Female breast cancer — Target: Reduce death rate to 20.6 deaths per 100,000 females. Target: Increase percentage of women aged 50-74 who receive breast cancer screening to 81.1%. (Healthy People, HP, 2020).

### **Community Capacity**

Cancer screening, including mammograms and Pap smears, are offered by hospitals, doctors, and clinics. Mercy Health – Anderson Women's Center helps high risk and low-income women who can't afford breast cancer diagnostics and treatment.

## **Dental Health**

### **Size of Population**

About 31,578 do not have insurance.

### **Severity/Significance**

The dentist ratio is 1 dentist for 3,886 people. There are not enough dentists who will accept self-pay or Medicaid patients.

### **Outcomes to Evaluate Progress**

The benchmark is the ratio of dentists for Ohio of 1 dentist for every 2,435 people.

### **Community Capacity**

This is a priority in the community health needs assessment for Adams County. There is a Clermont County Pediatric Dental Clinic. There is a for-profit Medicaid dental practice for children in Batavia. HealthSource has dental services at its offices in Seaman (Adams Co.), Mt. Orab (Brown Co.), and Eastgate (Clermont Co.).

## **Diabetes**

### **Size of Population**

Diabetes affects about 19,736 people in Clermont County, or 10%. Based on the Ohio mortality rate of 32.7 deaths per 100,000, there would be an estimated 65 deaths.

### **Severity/Significance**

Diabetes is a leading cause of death with 32.7 per 100,000 rate statewide and 23.7 rate nationally. Centers for Disease

Control (CDC). If not treated/controlled, it can lead to amputation and/or blindness. Co-morbidity with depression. From Clermont County Health District's 2009 Health Assessment: 8.3% of adults reported having diabetes.

### **Outcomes to Evaluate Progress**

Aligning Forces For Quality (AF4Q) Public Composite Measures and Goals: A1c<8.0; LDL < 100; BP < 140/90; Non-Smoker; Additional Measures Submitted for Bridges To Excellence (BTE) and National Committee for Quality Assurance (NCQA) Recognition-Ophthalmologic Exam, Nephropathy Assessment

### **Community Capacity**

Diabetes management is tracked on YourHealthMatters.org (AF4Q).

### **Heart Disease**

#### **Size of Population**

Based on the Ohio rate of 265.9 per 100,000, about 525 people are affected with heart disease in Clermont County.

#### **Severity/Significance**

The rate of heart disease in Ohio is 265.9 per 100,000. It is a leading cause of death. The communities with the highest number of hospital admissions for heart disease are: Mt. Orab, Owensville\*, Withamsville, and Williamsburg, based on the southwest Ohio overall rate.

### **Outcomes to Evaluate Progress**

AF4Q Public Composite Measures and Goals: LDL < 100; BP < 140/90; Non-Smoker; Daily Aspirin/Anti-Thrombolytic; Additional Measures Submitted for BTE and NCQA Recognition-Completed Lipid Profile; Smoking Cessation Advice and Treatment

### **Community Capacity**

Cardiovascular health is tracked on YourHealthMatters.org (AF4Q).

### **Infant Mortality**

#### **Size of Population**

There are about 26 deaths for 2,569 live births.

#### **Severity/Significance**

According to the 2012 County Health Rankings, 6.8% of the births in Clermont County are low birth weights. Highland County has an infant mortality rate of 10.1 per 1,000 live births, compared to Ohio average of 7.8.

### **Outcomes to Evaluate Progress**

Healthy People goal of 6.0 infant mortality rate.

### **Community Capacity**

Every Child Succeeds has partners in Adams, Brown & Clermont Counties to make home visits to 1st-time mothers.

### **Safety from Harm**

#### **Size of Population**

Violent Crimes: 117 per 100,000

#### **Severity/Significance**

Adams County has the highest rate of adult protective service orders, both including and excluding self-neglect, in the region. Homicide rate in Adams County is rising; 2nd only to Hamilton County in region. Brown County has a high number of Civil Protection Order Petitions (105.5 per 10,000 adults) compared to benchmark (21.6 per 10,000). The Community Safety ranking for Clermont County is 39th out of 88 counties (2012 Community Health Rankings).

### **Outcomes to Evaluate Progress**

Violent crime rate in OH is 360 per 100,000; U.S. rate is 73.

### **Community Capacity**

Public safety departments and criminal justice system.

### **Vulnerable Seniors**

#### **Size of Population**

There are about 22,697, or 11.5%, people aged 65 or older.

#### **Severity/Significance**

Seniors are vulnerable, especially those who are not yet eligible for Medicare and who do not qualify for Medicaid. They reported higher rates of high blood pressure and diabetes than other vulnerable groups.

### **Outcomes to Evaluate Progress**

TBD

### **Community Capacity**

Clermont Senior Services; Council on Aging

### **Other Chronic Disease**

Clermont County — 60% reported chronic physical illness compared to 44% of all regional survey responses. Highland County — Self-pay patients (those who pay

out-of-pocket) account for 14 percent of admissions for chronic conditions in Highland County.

## **Asthma**

### **Size of Population**

Wright State University surveyed 900 adults for Clermont County Public Health and 13.4% reported having asthma.

### **Severity/Significance**

Adams, Brown, Clermont, Highland Counties — 19.2% reported diagnosis of asthma compared to 15.3% for region. From Clermont Co. Health District 2009 Health Assessment: 13.4% of adults have asthma.

### **Outcomes to Evaluate Progress**

TBD — No Healthy People goal.

### **Community Capacity**

TBD

## **Chronic Heart Failure**

### **Size of Population**

Not available

### **Severity/Significance**

The communities with the highest number of hospital admissions for chronic heart failure are: Milford, Owensville\*, and Williamsburg, based on the southwest Ohio overall rate.

### **Outcomes to Evaluate Progress**

TBD — No Healthy People goal.

### **Community Capacity**

Hospitals and doctors' offices

## **COPD**

### **Size of Population**

Not available

### **Severity/Significance**

The communities with the highest number of hospital admissions for COPD are: Mt. Orab, Owensville\*, and Williamsburg, based on the southwest Ohio overall rate.

### **Outcomes to Evaluate Progress**

TBD — No Healthy People goal.

## **Community Capacity**

Hospitals and doctors' offices

## **Hypertension**

### **Size of Population**

Not available

### **Severity/Significance**

Adams, Brown, Clermont, Highland Counties — 42.7% reported diagnosis of high blood pressure or hypertension compared to 33.6% for region. In the Clermont service area, the communities with the highest number of hospital admissions for hypertension are: Mt. Orab, Owensville\*, and Williamsburg.

### **Outcomes to Evaluate Progress**

Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years to 92.6%. Reduce the proportion of adults with hypertension to 26.9%. (HP 2020)

### **Community Capacity**

Hospital, doctors' offices, and Outreach Nurse, Mercy Clermont

## **Mental Health Including Substance Abuse**

### **Size of Population**

25% of American adults suffer from a diagnosable mental disorder in a year. Serious mental illness affects ~6% of American adults, Health Policy Institute of Ohio (HPIO). 7% of Americans have a substance dependence or abuse disorder, Mental Health Advocacy Coalition (MHAC).

### **Severity/Significance**

There is limited access to mental health services. Clermont ED doctor reports that the lack of outpatient mental health follow-up is one of the ED's two biggest challenges and reasons for return visits. 2+ months wait for appointment at LifePoint. Adams County is a HRSA Health Professionals Shortage Area for mental health. Brown County — Access to mental health services is a significant problem. Clermont County — 34% reported a chronic mental illness compared to 20% of all survey responses. Suicide rates are high in this area: Highland County (20.8 per 100,000); Adams (17.5); Brown (16.8); Clermont (14) — compared to the Ohio rate of 11.3 and U.S. rate of 11.4 per 100,000. Medicaid pays for more than 20% of mental health admissions in Brown,

Clermont, and Highland Counties. In Clermont County, the Mental Health Provider Ratio is 4885:1. In Adams County, the Mental Health Provider Ratio is 14092:1. (Ohio's ratio of 2501:1). Vulnerable seniors with mental illness seen at hospital; they try to conceal it. *Substance Abuse:* Alcohol abuse in the overall region is higher than the national rate. 19% of adults reported binge drinking in prior 30 days, compared to the national rate of 15%. There is excessive drug use in Clermont County. Binge drinkers admitted when they have DTs.

### **Outcomes to Evaluate Progress**

Reduce the proportion of adults who experience major depressive episodes (MDE) to 6.1%. Increase the proportion of adults with mental disorders, or serious mental illness, who receive treatment to 64.6%. Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders to 3.3%. Increase the proportion of primary care physician office visits that screen adults aged 19 years and older for depression to 2.4%. (HP 2020)

### **Community Capacity**

LifePoint Solutions, adult mental health (planning to apply to become mental health medical home in summer 2013); Child Focus, child mental health; Clermont Recovery Center, substance abuse; Clermont County National Alliance on Mental Illness, National Alliance on Mental Illness; Clermont FAST TRAC, families and youth. Adams Co. Recovery Center; Coalition for a Drug-free Clermont County; No inpatient detox for Medicaid or self pay. This is a priority area for Adams County.

### **Obesity**

#### **Size of Population**

There are about 18,428 obese 3rd graders in Clermont County.

#### **Severity/Significance**

Adams, Brown, Clermont, Highland Counties: 32.9% of adults are obese. 69.5% of adults are overweight or obese. Obesity in 3rd graders: Adams County — 48.8% obese; Brown County is at 38.1%; Clermont is at 37.2%; Highland is at 39.3%. From Clermont Co. Health District 2009 Health Assessments: 36.4% adults overweight; 30.4% obese. 33.4% have no physical activity; 14.9% of 4th graders are overweight and 13.4% obese.

### **Outcomes to Evaluate Progress**

Obesity rate for region is 30.9% and nation's rate is 27.6%; overweight/obese for the region is 64.2%. Increase the proportion of primary care physicians who regularly measure the body mass index of adult patients to 53.6% and to 54.7% for child/teen patients. Reduce the proportion of adults who are obese to 30.6%. Reduce the proportion of children and adolescents who are considered obese to 9.6%. (HP 2020)

### **Community Capacity**

TBD; This is a priority for Adams County.

### **Smoking**

#### **Size of Population**

27% of adult population (2012 County Health Ranking)

#### **Severity/Significance**

Adams, Brown, Clermont, Highland Counties — 36.6% adults smoke compared to 22.5% for region. From Clermont County Health District's 2009 Health Assessment: 27.6% of adults were current smokers.

### **Outcomes to Evaluate Progress**

Reduce tobacco use by adults to 12% (HP 2020)

### **Community Capacity**

Georgetown physicians offer smoking cessation.

### **Tuberculosis**

#### **Size of Population**

2.1 cases per 100,000 in Adams County

#### **Severity/Significance**

The rate of tuberculosis is considered high in Adams County, with 2.1 cases per 100,000.

### **Outcomes to Evaluate Progress**

Reduce the number of new cases of TB to 1.0 per 100,000 (HP 2020).

### **Community Capacity**

Public Health Departments

*\* There may be data anomalies contributing to the high rates of hospital admissions reported for Owensville.*

The following methodology was used to prioritize the health care needs identified in the assessment. This approach provides a bridge from the assessment findings to the development of the implementation plan.

## *From Needs Assessment To Priorities*

This process involves the scoring of each identified health need based on selected key criteria. Each criterion will also be assigned a weight based on its relative importance in relation to the other key criteria. This scoring method creates a rank order among the identified health needs. The key criteria and scoring method are outlined below.

### **1. Key Criteria and Scoring Definitions**

Key criteria are those measures that best assess the breadth and depth of the impact of the identified health need on the community. These should be limited to the vital few (3 or 4). Key criteria would be scored on a scale of 1 to 5. Key criteria and scoring definitions are as follows:

#### *Size of population affected*

Based on the total population and/or that of an identified cohort in the defined service area for the health needs survey, assess what percent of the community is affected by the identified need.

- 5 =  $\geq 20\%$  of the population is affected
- 4 = 15% to 19%
- 3 = 10% to 14%
- 2 = 5% to 9%
- 1 =  $< 5\%$

#### *Severity of the health need identified*

Degree to which the need causes long-term illness; produces an above average mortality rate; an above average hospitalization rate; has public health implications (These are the ideal measures of severity, but comparable data was not available for all conditions.)

- 5 = Very serious — direct connection to long-term illness and/or other co-morbidity; high mortality; presents a public health issue
- 4 = Serious — indirect link to serious conditions
- 3 = Somewhat serious — can become widespread if not arrested, e.g., lack of vaccinations among children
- 2 = Not very serious — causes illness but no long-term or widespread impact
- 1 = Not a serious health condition

#### *Ability to evaluate outcomes*

For any intervention appropriate to the health need, what is the ability to evaluate outcomes? Data availability, benchmarks, tracking of trends, service counts, etc., would be part of the appraisal.

- 5 = Excellent ability
- 4 = Good ability — baseline available with some on-going evaluations
- 3 = Some ability — baseline available
- 2 = Little ability — mostly qualitative/primarily perceptions/anecdotal
- 1 = No ability

#### *Current community capacity to address the health care need*

The number of agencies, groups, associations, etc., that offer services for the identified health need. Scoring scale would be reversed as the “highest” score would be assigned to the condition where there is no capacity to address the health care need. The fewer the number of groups, etc. the higher the number.

- 5 = Not currently addressed
- 4 = Need is addressed by efforts outside the community
- 3 = A few independent efforts address the need
- 2 = Community efforts address the need — mostly uncoordinated
- 1 = Community has a well-coordinated approach in place

### **2. Weights**

Although all the criteria are important, not all criteria are of equal importance, e.g., size of the population affected is more important than ability to evaluate outcomes. Assigning weights to each criterion in the evaluative set allows for a more meaningful ranking among the health needs. The Catholic Health Partners’ CHNA Collaborative assigned weights for each of the selected key criteria. Weights are determined by a forced ranking based on the number of items in the data set.

- Size of population weight = 4
- Severity of health need = 3
- Outcomes data = 2
- Community capacity = 1

### **3. Priority Scores**

There was one meeting of an ad hoc committee that included hospital representatives and community leaders. They rated each health need based on the key criteria. Health needs were listed in alphabetical order on the initial worksheet provided to this committee. The chart below illustrates how a single member’s evaluation would be computed.

*Example*

Health Need	Size of Population Affected	Severity of Problem	Ability to Evaluate Outcomes	Community Capacity to Address	TOTAL SCORE
Access to Care	3	5	5	2	15
Obesity	5	4	4	3	16

For each of the needs ranked, the scores assigned by each individual will be aggregated into a composite score on each criterion. All scores from the taskforce would be computed before the weights are applied. The chart provides an example of how the final priority score would be calculated based on 10 evaluations with mixed scores (Assumes half the group scored the variable like the above illustration and the other half was one rating lower):

*Example*

Health Need	Size of Population Affected (Wgt. = 4)	Severity of Problem (Wgt. = 3)	Ability to Evaluate Outcomes (Wgt. = 2)	Community Capacity to Address (Wgt. = 1)	Priority Score
Access to Care	25x4=100	45x3=135	45x2=90	15x1=15	340
Obesity	45x4=180	35x3=105	35x2=70	25x1=25	380

**4. Scoring Participants:**

Kim Patton CEO, Health Source; David Frey, Lawyer and former Mercy Health Board Trustee and Officer; Matt VanZant, CEO, Clermont Chamber of Commerce; Bruce Lunsford, Mayor, Mt. Orab; Marty Lambert, Clermont County Health Commissioner with Julianne Nesbit, her successor in March 2013; Jeff Graham, President and Market Leader; Peggy Haley, Outreach RN; Ann Hoffman-Ruffner, MSW, Behavioral Health; Gayle Heintzelman, Site Administrator; Rob Lambert MD Emergency Department; Irene Behling, Mission Director; Michael Kramer, Vice President, Planning; Richard Perry, Regional Director Business Intelligence and Analytics; Jeffrey Armada, Administrative Fellow, Catholic Health Partners-Mercy Health. The scoring session was facilitated by Gwen Finegan, Regional Director, Community Outreach. Irene Behling, Peggy Haley, Marty Lambert, and Julianne Nesbit had previously participated in a focus group of direct service providers.

**5. Duration and number of meetings:**

Duration and number of meetings: One (1) meeting on November 6, 2012 from 12 noon to 2:00 pm.

**6. Time period for prioritization process:**

Time period for prioritization process: The additional data was compiled into worksheets in July, August, and September, 2012. Scoring occurred in November 2012, and reporting to the board committee occurred on March 28, 2013. The final assessment report will be completed and published in 2013.

Based on all of the above information and processes considered, below is the complete list of the health needs identified in the community, and the top priorities were identified as: Obesity; Mental Health including Substance Abuse; Smoking; Access to Care; and Diabetes.

*Results of Scoring Session with Community Leaders on November 6, 2012*

<b>Health Need</b>	<b>Size of Population Affected</b>	<b>Wgt. Score</b>	<b>Severity of Problem</b>	<b>Wgt. Score</b>	<b>Ability to Evaluate Outcomes</b>	<b>Wgt. Score</b>	<b>Community Capacity to Address</b>	<b>Wgt. Score</b>	<b>Priority Score</b>
Obesity	66	264	58	174	52	104	54	54	596
Mental Health incl. Substance Abuse	64	256	66	198	44.5	89	47	47	590
Smoking	68	272	56	168	50	100	45	45	585
Access to Care	60	240	57	171	47	94	41	41	546
Diabetes	51	204	64	192	56	112	36	36	544
Hypertension	61	244	57	171	44	88	41	41	544
Heart Disease	47	188	61	183	54	108	39	39	518
Dental Health	56	224	56	168	39	78	42	42	512
Cancer	41	164	64	192	51	102	41	41	499
Chronic Heart Failure	41	164	57	171	38	76	45	45	456
COPD	42	168	53	159	35	70	50	50	447
Asthma	45	180	44	132	37	74	48	48	434
Vulnerable Seniors	42	168	48	144	32	64	38	38	414
Infant Mortality	32	128	46	138	55	110	36	36	412
Safety from Harm	30	120	41	123	49	98	37	37	378
Tuberculosis	18	72	41	123	58	116	29	29	340

The hospital's Implementation Plan will detail the specific responses, resources, partners, and timetable (starting 1/1/2014) to address the prioritized needs. The desired outcomes and benchmarks for success will be consistent with external references such as the United Way "Bold Goal" for health, Aligning Forces For Quality targets, and Healthy People goals.

## Collaborating Partners

(IRS Notice 2011-52 Section 3.03 (2))

### The Hospital collaborated with the following partners/funders as part of the process of conducting the needs assessment:

\*Non-funding partners identified with an asterisk

Greater Cincinnati Health Council  
# 100 2100 Sherman Ave, Cincinnati, OH 45212-2775

United Way of Greater Cincinnati  
2400 Reading Road, Cincinnati, OH 45202-1478

Greater Cincinnati Foundation  
200 West Fourth Street, Cincinnati, OH 45202-2775

Hamilton County Public Health  
250 William Howard Taft, 2nd Floor, Cincinnati, OH 45219

Middletown Health Department  
One Donham Plaza, Middletown, OH 45042-1901

Highland County Health Department  
1487 North High Street # 400, Hillsboro, OH 45133-8496

Adams County Regional Medical Center  
19262 Ohio 136, Winchester, OH 45697

Atrium Medical Center  
One Medical Center Drive, Middletown, OH 45005

Cincinnati Children's Hospital Medical Center Innovations\*  
629 Oak Street, Suite 200, MLC 8700  
Cincinnati, OH 45206

Dearborn County Hospital  
600 Wilson Creek Road, Lawrenceburg, IN 47025

Fort Hamilton Hospital  
630 Eaton Avenue, Hamilton, OH 45013

The Cincinnati USA Regional Chamber\*  
441 Vine Street, Suite 300, Carew Tower  
Cincinnati, OH 45202

Health Care Access Now  
8790 Governor's Hill Drive, Suite 200  
Cincinnati, OH 45249

Health Foundation of Greater Cincinnati\*  
3805 Edwards Road, Suite 500, Cincinnati, OH 45209-1948

HealthLandscape\*  
3805 Edwards Road, Suite 500, Cincinnati, OH 45209

Lindner Center of HOPE  
4075 Old Western Row Road, Mason, OH 45040

Margaret Mary Community Hospital  
206 State Road 129 South, Batesville, IN 47006-7694

McCullough-Hyde Memorial Hospital  
110 North Poplar Street, Oxford, OH 45056

Mercy Health  
4600 McAuley Place, Cincinnati, OH 45242

TriHealth  
619 Oak Street, Cincinnati, OH 45206

UC Health  
3200 Burnet Avenue, Cincinnati, OH 45229

United Way of Northern Kentucky\*  
11 Shelby Street, Florence, KY 41042

University of Cincinnati Action Research Center\*  
College of Education, Criminal Justice, and Human  
Services, 51 Goodman Drive, Suite 530  
Cincinnati, OH 45221

### The Hospital contracted with the following third party to assist it in conducting the needs assessment:

Health Care Access Now  
7162 Reading Road, Suite 1120, Cincinnati, OH 45237

A nonprofit organization formed in 2008 to build partnerships among the Greater Cincinnati health care and social service providers that will increase access to care and improve the overall health status of area residents in a cost-effective way.