



2019 Report

The Collaborative Report serves:

- ✓ **35** Hospitals
- ✓ **25** Counties
- ✓ **28** Local Health Departments
- ✓ **3** States

Hospitals

The Christ Hospital Health Network
 Cincinnati Children's Hospital Medical Center
 Clinton Memorial Hospital
 Highpoint Health
 Kettering Health Network
 Fort Hamilton Hospital
 Grandview Medical Center
 Greene Memorial Hospital
 Kettering Behavioral Medic Center
 Kettering Medical Center
 Soin Medical Center
 Southview Medical Center
 Sycamore Medical Center
 Lindner Center of HOPE
 Mercy Health | Cincinnati Region
 Mercy Health - Anderson Hospital
 Mercy Health - Clermont Hospital
 Mercy Health - Fairfield Hospital
 Mercy Health - West Hospital
 The Jewish Hospital – Mercy Health

Mercy Health | Springfield Region
 Mercy Health - Urbana Hospital
 Springfield Regional Medical Center
 Premier Health
 Atrium Medical Center
 Miami Valley Hospital
 Miami Valley Hospital North
 Miami Valley Hospital South
 Upper Valley Medical Center
 TriHealth
 Bethesda Butler Hospital
 Bethesda North Hospital
 Good Samaritan Hospital
 McCullough Hyde Memorial Hospital
 TriHealth Evendale Hospital
 UC Health
 Daniel Drake Center for Post-Acute Care
 University of Cincinnati Medical Center
 West Chester Hospital
 Wayne HealthCare
 Wilson Health

COMMUNITY HEALTH NEEDS ASSESSMENT

Executive Summary

For the third time, The Health Collaborative has convened regional health partners and member hospitals to develop the 2019 Community Health Needs Assessment (CHNA). Hospitals members of the Health Collaborative and Greater Dayton Area Hospital Association (GDAHA) joined the collaboration, and the result is a robust portrait of the larger Southwest Ohio region. The report covers Greater Dayton and Greater Cincinnati, which includes Northern Kentucky and Southeastern Indiana.

The CHNA 2019 report shares data for the whole region as well as detailed county-level data. Service areas of hospitals vary, and this approach provides the most thorough picture of health needs locally and regionally. The 2019 report has added the voice of the Southwest Ohio members of the Association of Ohio Health Commissioners. Developing a broad CHNA helps fulfill the State of Ohio's requirement mandating that health departments and hospitals align their assessments starting in 2020.

As a result, the CHNA team has researched more secondary data measures, included hospital utilization data, oversampled vulnerable populations, and engaged more participants. A total of 1,416 people or organizations completed a survey or attended meetings. A key component of the increase was due to local health departments helping to promote and conduct meetings.

Priorities were determined by the number of votes in community meetings, the number of mentions on surveys and data worse than state or national data, trending in the wrong direction, and impacting at least 16 counties (secondary data). The five identified priorities ranked in the top 8 for all primary data sources (meetings and survey from consumers, health departments, and agencies) see *Table 27*.

The identified priorities are:

1. **Substance abuse**
2. **Mental health**
3. **Access to care/services**
4. **Chronic disease**
5. **Healthy behaviors**

Substance abuse

Although Substance Abuse Disorder is a mental health diagnosis, the volume of responses indicated that substance abuse needs to remain a separate category, due to the current epidemic. This category relates to the use and abuse of illegal drugs, prescription drugs, alcohol, and addiction in general.

Comments about the impact of substance use and abuse on society and families recurred in both meetings and surveys. Respondents asked for less concentration on drug-specific responses and more approaches that explore the underlying problems leading to addiction.

Mental health

'Mental health,' was the most common response in this category. For the first time 'child mental health' was frequently mentioned. Depression was cited most often, followed closely by anxiety. Suicide was openly discussed in several meetings, and it was a priority in both LGBTQ+ meetings. Next most commonly mentioned were mood disorders and ADD/ADHD. Self-harming came up several times, as did stigma. Trauma and specifically Adverse Childhood Experiences – both the impact of past experiences on adults and the impact on children living through them now. A disturbing trend was the increase in comments about the need for psychiatric hospital beds for children younger than 12.

Access to Care/Services

This priority received many 'access' comments. The lack of access to providers was mentioned most often. Including providers being out-of-network for insurance as well as providers located outside the geographic area; and too few specialists. Other barriers and gaps identified included no insurance; inadequate insurance coverage; high deductible plans; affordability of care (co-pay and/or out-of-pocket); cost of medication; can't take time off during working hours; no one to watch children; language barrier; and/or lack of local services (e.g., cancer treatment). Transportation was a total of 7% of all mentions within the Access category.

Chronic disease

The most common chronic diseases cited were: heart disease, cancer, and diabetes. Hypertension was commonly cited, and stroke, allergies, and arthritis were mentioned several times. According to the secondary data, lung cancer and Type 2 Diabetes significantly impact the region. Sixteen counties had high rates of chronic lower respiratory disease deaths for people aged 65 and older. The table on page 92 shows that arthritis, cardiovascular, heart, and respiratory issues were among the top 20 most common diagnoses of hospitalized patients in the region.

Healthy behaviors

This category captured recommendations on building healthy behaviors such as: healthy eating, increasing exercise, quitting unhealthy substances and losing weight. Secondary data supports the public perception of needing to address alcohol intake, physical inactivity, smoking, and/or weight. Twenty-two counties have higher percentages of adults who smoke, compared to the national percentage of sixteen percent. Nineteen counties have more residents who are physically inactive, compared to the national percentage of twenty-five percent. Seventeen counties exceed the national percentage of adults who are obese, nearly thirty percent.

The vulnerable populations who were oversampled in this CHNA were: African-Americans; Elderly residents; Latino residents; LGBTQ+ residents; refugees from Rwanda; and urban residents.

Community Need Index scores were utilized to identify the likelihood of healthcare disparities at the ZIP Code level for all ZIP Codes in 25 counties.

Social Determinants of Health

This report features a new chapter on Urban Health. Three years ago, Social Determinants of Health (SDH) were mentioned many times in the cities, but the results were diluted when combined with all regional responses. This time SDH became top priorities for people who live in urban areas but also for people considering the child health issues. Healthy People 2020 defines SDH as the, "...conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."¹

CHNA participants cited Poverty most often overall as a SDH. The SDH category also included education, employment, environment (living conditions at home and/or hazards in the immediate community such as pollution or crime), violence, race, ethnicity, housing, homelessness, culture, and language. All four primary sources agreed on SDH as a barrier to child wellness. In this context, 80% of the SDH comments specified education. Among urban participants, 11% cited SDH as a top priority; housing and safety were mentioned most often. Although SDH did not emerge as a top regional priority overall, the issue was identified among the top non-financial barriers and the top unmet needs at the regional level.

Emerging Issues

Access to care and Substance abuse were listed most frequently as an emerging issue. For this cycle, many comments cited the following needs:

- Support for parents and families
- Care for children
- Initiatives to combat addiction
- Social/emotional health

Community coalitions that address infant mortality and substance abuse were frequently mentioned as being 'handled well,' but always with the caveat that more remained to be done. Fourteen counties had infant mortality rates greater than the national rate of 5.9 per 1,000 live births. Nine counties had rates exceeding their state's rates. All meeting attendees and survey respondents agreed that these issues were not being handled well or addressed enough: Access to care/Services; Mental health; Social Determinants of Health; and Substance abuse. Transportation made it to both the financial and non-financial list of barriers.

¹ <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>, accessed 12/19/2018.