

2016 Community Health Needs Assessment

MERCY HEALTH — WEST HOSPITAL, CINCINNATI, OHIO



Mercy Health, formerly Catholic Health Partners, has been committed to the communities it serves for more than 150 years. This long-standing commitment has evolved intentionally, based on our communities' most pressing health needs.

Every three years we evaluate those needs through a comprehensive Community Health Needs Assessment (CHNA) for each of our hospitals. The most recent assessments, completed by Mercy Health and community leaders, include quantitative and qualitative data that guide both our community benefit and strategic planning.

The following document is a detailed CHNA for Mercy Health — West Hospital, which provides quality healthcare to the people in the West Side of Cincinnati.

Mercy Health has responded to community health needs as part of a five-year strategic plan that concludes in 2018. In recent years, Mercy Health has invested in building and renovating hospitals and ambulatory facilities to serve patients and

communities in Ohio and Kentucky. Our ministry continues to invest in our CarePATH electronic health record to ensure seamless and integrated care, no matter the provider or the setting. We also operate health and fitness centers, hospice facilities, outpatient clinics and senior living facilities ... all to improve the health of our communities.

Mercy Health contributes about \$1 million per day in community benefit services as we carry out our Mission of extending care to the poor and under-served.

Mercy Health — West 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.

Written comments regarding the health needs that have been identified in the current CHNA should be directed to <https://www.mercy.com/global/about-us/contact-us>.

Mercy Health has identified the greatest needs among each of our hospital's communities. This ensures our resources for outreach, prevention, education and wellness are directed toward opportunities where the greatest impact can be realized.

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Introduction

COMMUNITY SERVED BY HOSPITAL

T.R. §1.501(r)-3(b)(1)(i) and (3)

Mercy Health — West Hospital is dedicated to continuing the healing ministry of Jesus Christ. As part of the Mercy Health system, West Hospital has been steadfast in its mission of caring for the poor, the elderly and the vulnerable members of the community, and to improving the health of the many communities it serves.

West Hospital strives to ensure residents of Hamilton County, primarily those with in the 45211 ZIP Code and its surrounding area, have access to advanced medical technology and quality care. (ZIP Codes: 45001, 45002, 45030, 45033, 45041, 45052, 45204, 45211, 45214, 45223, 45224, 45231, 45233, 45238, 45239, 45247, 45248, 45251, 45252, 45258)

We're proud to be Mercy Health's newest hospital, opening in 2013. Our services include maternity care, a

cancer center, a heart center with open heart surgery, an orthopaedics center and a women's health center.

West Hospital aims to serve our patients and each other in ways that reflect its core values of Compassion, Excellence, Human Dignity, Justice, Sacredness of Life and Service. Our Mission is to extend the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and under-served.

Each year West Hospital provides millions of dollars in community benefits including the Mercy Action program, Dental Clinic, Call A Nurse, and a variety of community-wide screenings and programs.

The real value of this contribution lies not in dollars, but in the commitment of the staff members, physicians, volunteers, board members and other community leaders who work on behalf of West Hospital ... the people who bring the West Hospital to life.

INFORMATION AND DATA CONSIDERED IN IDENTIFYING POTENTIAL NEED

T.R. §1.501(r)-3(b)(1)(ii) and (5)

Information and data sources: federal, state or local health or other departments or agencies; community input

Public health departments (T.R. §1.501(r)-3(b)(5)(i)(a))		Date of data/information
Hamilton County Health Department		June 2015
Cincinnati Health Department		June 2015
At-risk populations (T.R. §1.501(r)-3(b)(5)(i)(b))		Date of data/information
Community Action Agency		July 2015
Cincinnati Area Senior Services.....		July 2015
Council on Aging of Southwestern Ohio.....		July 2015
St. Vincent de Paul.....		July 2015
Salvation Army		July 2015
Mercy Neighborhood Ministries.....		July 2015
Crossroads Health Center		July 2015
Community Outreach Specialist, Ohio Attorney General		July 2015
The Health Collaborative.....		July 2015
Cincinnati Children's Medical Center.....		July 2015
Additional sources of input (T.R. §1.501(r)-3(b)(5)(ii))		Date of data/information
Meeting with Latinos in the Community.....		2015

Process and methods

PROCESS FOR GATHERING AND ANALYZING DATA/INFORMATION

T.R. §1.501(r)-3(b)(6)(ii)

Process and methods to conduct the community health needs assessment:

T.R. §1.501(r)-3(b)(6)(ii)

Mercy Health – West Hospital participated in a regional Community Health Needs Assessment process coordinated by The Health Collaborative. The Health Collaborative assembled a team which included a consultant with past CHNA experience and two graduate student interns from Xavier University’s Department of Health Services Administration. A Senior Vice President at the Health Collaborative provided executive oversight.

Under the leadership of The Health Collaborative, primary data was obtained through the following methods:

From June 23- July 30, 2015, 156 representatives of community organizations and/or members of medically under-served and vulnerable populations attended 11 community meetings to identify needs and barriers (financial and non-financial), prioritize issues, and name resources to address health and health related needs. Each attendee received three different colored “dots” to apply next to issues they deemed most serious or important, based on discussion at the meeting and their own knowledge.

An online consumer survey regarding community health needs was advertised on Mercy Health’s website, Facebook and Twitter sites. From June 15–Aug.3, 2015, 329 individuals and 55 health-related agencies and organizations in the service area were surveyed and answered a series of questions. Of the individuals and agencies that participated, 303 people and 49 agencies answered the question “What are the most serious health issues facing your community?” The responses mentioned 555 health and/or health-related issues of particular concern to them.

From June 15–Aug.3, 2015, interviews or surveys were conducted with 24 out of the 25 city, county or district health departments in the 23-county region to identify critical health needs and identify community resources to meet those needs. Only one health department did not respond.

In addition, experts on topics such as heroin addiction, environmental health and sexually transmitted diseases were consulted, and county data and Community Need Index maps were referenced. Meetings were also held with hospital representatives in February, May, June, and August 2015. The Community Health Needs team compared the secondary data to the priorities and issues identified through the meetings, surveys and interviews.

External sources

- Behavioral Risk Factor Surveillance System
- Bureau of Labor Statistics
- Business Analyst - ESRI (aka Environmental Systems Research Institute)
- Centers for Disease Control (CDC) - Diabetes Interactive Atlas and WONDER Mortality Database
- Centers for Medicare and Medicaid Services (CMS) - National Provider Identification File
- County Business Patterns
- County Health Rankings
- Dartmouth Atlas of Health Care
- Data.gov
- Delorme Map Data
- Dignity Health and Trueven Analytics
- Environmental Protection Agency
- Enroll America and Civic Health
- Federal Bureau of Investigation (FBI) - Uniform Crime Reporting
- Feeding America - Map the Meal Gap
- Greater Cincinnati Community Health Status Survey
- Health Indicators Warehouse
- Health Resources and Services Administration (HRSA) - Area Health Resource File/American Medical Association
- Health Resources and Services Administration - Area Health Resource File/National Provider Identification File

- Indiana Cancer Consortium
- Indiana State Health Department
- Kentucky Cancer Registry
- Kentucky Department of Public Health
- National Center for Education Statistics
- National Center for Health Statistics
- National Center for HIV/AIDS, Viral Hepatitis, STD, and TB prevention
- National Highway Traffic Safety Administration (NHTSA) - Fatality Analysis Reporting System
- Ohio Department of Health
- Ohio Department of Mental Health
- PreventionFIRST!
- United States Census - American Community Survey
- United States Census - Population Estimates
- United States Census - Small Area Income and Poverty Estimates
- United States Census - Tigerline Files
- United States Department of Agriculture (USDA) - Food Environment Atlas

Collaborating partners

The hospital collaborated with the following organizations as part of the process of conducting the needs assessment.

- Cincinnati Health Department Commissioner
- Hamilton County Public Health Commissioner
- The Health Collaborative

Community input

T.R. §1.501(r)-3(b)(6)(iii)

No written comments were received on the previously completed CHNA.

The CHNA relied heavily on input from local residents and health-related organizations:

- Attendees of the community meetings identified serious issues and financial and non-financial barriers to care, and provided input for assessing current needs, prioritizing issues and locating resources for health-related issues.
- Consumers who responded to the online survey mentioned a total of 555 health and/or health-related issues of particular concern to them.
- Representatives from 55 agencies also completed online surveys.
- Local and county health commissioners (or their delegates) identified critical health needs and community resources to meet these needs.

Organizations providing input

Organization providing input	Nature and extent of input	Medically underserved, low-income or minority populations represented by organization
Clermont County Mental Health & Recovery Board	Completed agency survey identifying issues, opportunities and top priorities.	Low income, racial minorities, people with disabilities, children and rural populations.
Childhood Food Solutions	Completed agency survey identifying issues, opportunities and top priorities.	Low income, racial minorities, ethnic minorities, and children.
Children's Advocacy Center of Southeastern Indiana	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low income, racial minorities, ethnic minorities, people with disabilities, children, rural populations and those with alleged abuse.
Churches Active In Northside - CAIN	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, racial minorities, people with disabilities, elderly, children and homeless women.
Cincinnati Children's	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Children and Rural populations.
Community Mental Health Center, Inc.	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, People with disabilities, Elderly, Children, Rural, and those with serious mental illness and substance abuse.
Erlanger-Elsmere Schools	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Children, GLBT youth (or children and youth living in GLBT families), Families who meet the Federal definition of homeless, Children or youth who are exposed to substance abuse.
Family Connections	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities, Children, Rural populations, Pregnant women.
Family Career and Community Leaders of America	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Children and Rural populations.
Freestore Foodbank	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children and Rural populations.

Organizations providing input ...continued

Organization providing input	Nature and extent of input	Medically underserved, low-income or minority populations represented by organization
Good Samaritan Free Health Center	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities, Elderly and Rural populations.
HealthPath Foundation of Ohio	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children, Rural populations and LGBT.
Ivy Tech Community College	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities and People with disabilities.
National Library of Medicine	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, Elderly, Rural.
NKY Health Services	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Ethnic minorities and Children.
Northern Kentucky Health Department	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, People with disabilities, Children, Rural populations, Under insured and Uninsured.
One Community One Family	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Children and Rural populations.
Primary Health Solutions	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children and Suburban without public transportation.
Purdue Extension Services	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children and Rural populations.
Santa Maria Community Services	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly and Children.
SC Ministry Foundation	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children, and Severely challenged children and young adults.

Organizations providing input ...continued

Organization providing input	Nature and extent of input	Medically underserved, low-income or minority populations represented by organization
Southeastern Indiana Economic Opportunity Corporation	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, People with disabilities, Children and Rural populations.
St. Elizabeth Healthcare	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children and Rural populations.
Talbert House	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, People with disabilities, Children and Homeless.
The Greater Cincinnati Foundation	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children and Rural populations.
The Health Collaborative	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Many populations
The HealthCare Connection	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities, Elderly and Children.
Tri-State Eating Disorder Resource Team	Completed agency survey identifying issues, opportunities and top priorities.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children, and Rural populations.
United Way	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Elderly, Children and Rural populations.
YWCA	Completed agency survey identifying issues, opportunities and top priorities. Sent representation to community meetings.	Low-income, Racial minorities, Ethnic minorities, People with disabilities, Children, Rural populations, People with disabilities and LEP.

Executive summary

Significant health needs

T.R. §1.501(r)-3(b)(4)

SUBSTANCE ABUSE

Capacity and adequacy of service levels

- In Hamilton County, heroin overdose deaths are more than twice the state rate (17.9 per 100,000 vs. 8.5) and overall drug-poisoning deaths are higher than the state rate (17 per 100,000 vs. 15).
- While various service providers are available for outpatient services (detoxification, intensive outpatient services, and standard outpatient chemical dependency services), including both voluntary and court-mandated services, there is no organized, voluntary inpatient (hospital-based) detoxification program.
- Wait times for services can range from two weeks to 50 days, indicating that while services are available, they are overtaxed and not capable of meeting the vast community need.

While several organizations provide services, wait times for services can range from 2 weeks to 2 months. This is particularly true for medication-assisted outpatient treatment, for which wait times at toward the higher end of the range, particularly in Hamilton County.

Current service providers

Mercy Health hospitals have Screening, Brief Intervention, and Referral to Treatment (SBIRT) technicians in our emergency departments to identify substance use problems and refer them to local resources. Other service providers include Mercy Health – Clermont Hospital, Talbert House, Central Community Health Board of Greater Cincinnati, BrightView, Greater Cincinnati Behavioral Health Services, Central Clinic, Center for Addiction Treatment, and Addiction Services Council.

MENTAL HEALTH

Capacity and adequacy of service levels

- In Hamilton County, the suicide rate is higher than the state rate (13.3 suicides per 100,000 people vs. 12.9 state rate).
- The mental health provider ratio is 458:1 in Hamilton County. These numbers are a bit misleading, as the access to services is highly dependent on prospective patients' ability to pay-out-of-pocket for services or if they have insurance accepted by the health provider. Many private practitioners do not accept any insurance and only accept out-of-pocket payment.
- Wait times for psychotherapy or counseling average one to two months. Wait times for psychiatric services average three to six months. The wait is longer for specialized populations such as children and adolescents, averaging six months or more for outpatient mental health care.

Current service providers

Mercy Health provides inpatient and outpatient mental health services. Other providers include Talbert House, Central Community Health Board of Greater Cincinnati, Greater Cincinnati Behavioral Health Services, Central Clinic, Child Focus, Inc., and LifePoint Solutions.

ACCESS TO CARE

Capacity and adequacy of service levels

- In Hamilton County, 17.6 % (or 144,813) of the population lives in poverty. And 26% of the children in Hamilton County live in poverty.
- According to the 2015 County health rankings, 17% of the adult population is uninsured in Hamilton County. Cost prevented 12% of the population in Hamilton County from seeing a doctor.

Current service providers

The OB/GYN Clinics provided at Anderson Hospital, Fairfield Hospital, and West Hospital provide free or low-cost care to low-income and uninsured patients. In addition, advocates in our emergency department connect patients without primary care physicians to a medical home. The Mercy Health Partnership Program links the uninsured working poor with physicians in private practice who agree to treat patients for a modest

co-pay. The Mercy Health Partnership Program also provides insurance counseling, medical homes and medication assistance for those without physician connections. Mercy Health also provides school-based clinics, counseling services and behavioral health initiatives that improve residents' access to care. Other resources include HealthCare Connection and 49 local federally qualified health centers (FQHCs).

DIABETES

Capacity and adequacy of service levels

- In Hamilton County, 12% of the population has diabetes.
- In Hamilton County, the death rate due to diabetes is 26.7 per 100,000.

Current service providers

Mercy Health provides education classes and counseling for inpatient diabetic patients and the community at large. YMCA has a diabetes prevention program.

OBESITY

Capacity and adequacy of service levels

- In Hamilton County, 29% of the population of is obese.
- Emergency room costs for overweight patients presenting with chest pain were 22% higher than the cost for patients with a normal weight. Costs were 28% greater for obese patients, and 41% greater for severely obese patients.
- According to the CDC, people who are obese have an increased risk for health disorders and/or death.
- According to a survey conducted by Interact for Health, people who rated their health status fair or good were almost 50% more likely to be overweight or obese than those who rated their health status very good or excellent.

Current service providers

Mercy Health Weight Management Solutions offers surgical and nonsurgical weight loss options, nutritional and behavioral counseling, support group programs, cooking classes and fitness programs at 3 of its Cincinnati hospitals. There are four Mercy HealthPlexes, which

provide training and counseling for reduction of weight and strengthening. YMCA has a pre-diabetes program. Other obesity initiatives focusing on diet, exercise, and healthy choices include “WeTHRIVE” from the Hamilton County Public Health Department, “Gen H” from the Health Collaborative, and “Creating Healthy Communities” from the City of Cincinnati.

LUNG CANCER

Capacity and adequacy of service levels

- In Hamilton County, there are 648 new cases of lung cancer per year.
- In Hamilton County, lung cancer is the 2nd highest cause of death. The scope of lung cancer in Hamilton County is 52 cases per 100,000 with an estimated 418 deaths.

Current service providers

Mercy Health hospitals provide screenings and education for lung cancer. There are also a numerous places providing radiation therapy and education. Mercy Health has smoking cessation initiatives in three of its five hospitals. Mercy Health also provides robust education outreach to the community.

SMOKING

Capacity and adequacy of service levels

- In Hamilton County, 19% of adults smoke.
- Local hospitals, physician practices, and service agencies offer smoking cessation classes and counseling, prescription nicotine replacements, and education services.

Current service providers

All Mercy Health hospitals provide lung cancer screening, diagnosis and treatment. The hospital and other Mercy Health locations often offer free smoking cessation classes in three of its five regional hospitals, as well as community outreach programs.

HEALTHY BEHAVIORS

Capacity and adequacy of service levels

- According to the 2014 Gallup Well-Being Index, residents of the state of Ohio rank 42nd in the nation for overall health. Kentucky residents rank 49th.
- In 2011, the local community spent \$13 billion dollars on health and healthcare.
- The Collective Impact on Health initiative has identified healthy behaviors as a focus for the region. The initiative brings together diverse stakeholders to invest in strategies that encourage healthy eating, active living, healthy coping and smoking cessation.

Current service providers

Mercy Health invests in strategies and initiatives that encourage healthy behaviors. Other resources available to address healthy behaviors are The Health Collaborative, United Way of Greater Cincinnati, YMCA, Place Matters Communities – ACDC, The Center for Great Neighborhoods, MCURC, Price Hill Will, Santa Maria Community Services, Walnut Hills Redevelopment Corporation, Seven Hills Neighborhood Houses, Interact for Health, TriHealth, St. Elizabeth, The Christ Hospital, and University of Cincinnati.

INFANT MORTALITY

Capacity and adequacy of service levels

- State-wide sleep related deaths accounted for 13.8% of newborn deaths between 2011 and 2015.
- 28 initiatives driven by partners throughout Ohio resulted in a decline in sleep related deaths in 2014. In 2015, agencies invested less in Safe Sleep messages and initiatives, resulting in an increase in sleep related deaths. The number of sudden infant death syndrome (SIDS) deaths in Ohio in 2015 was 71. The number in Hamilton County was 6.

Current service providers

Mercy Health – Fairfield Hospital OB Clinic and labor and delivery department work with Healthy Moms and Babies, Cradle Cincinnati, the Ohio Department of Health, and other local agencies to educate patients on safe sleep practices and provide safe sleep surfaces.

Prioritization of health needs

As part of the Community Health Needs Assessment, and under the leadership of The Health Collaborative, participants were asked to identify unmet community needs. Health issues discussed during community meetings were prioritized by totaling the number of “dots” each issue received and dividing by the number of total votes. Community health issues noted in online and agency surveys were ranked according to the prevalence of key words and phrases. Rankings of the issues noted by local health department commissioners or their representatives were likewise tabulated and ranked based on prevalence.

The community convener, aggregator and evaluator then combined this data with external secondary data sources. The collective input was aggregated and ordered based on prevalence of response across all areas to produce the combined priorities for the region. The team found that:

- Substance abuse appears as a top priority across all five sources of input.
- Mental health and access to care each appear four times.
- Diabetes, obesity and smoking appear as priorities three times each.
- Cancer appears twice, once as lung cancer specifically.
- Healthy behaviors appear twice. However, if smoking and obesity were included, healthy behaviors would be reflected in eight out of the 31 priorities identified.
- Access to healthy foods/nutrition, communicable disease, dental health, injuries and social determinants each appear once as priorities.

In addition to the combined priorities for the region, infant mortality was identified as a community health need. Infant mortality ranks as one of the top priorities in the Ohio Department of Health’s State Improvement Plan and continues to be an ongoing challenge for both the state of Ohio and City of Cincinnati. Ohio ranks 44th out of 50 states for infant deaths per 1,000 live births.

A core team comprised of leadership from Mercy Health’s Mission Department and the Population and Community Health Institute developed a methodology for weighting the data collected throughout the community health needs assessment and the areas of potential investment identified by Community Benefit Committees within each hospital.

There were four areas of regional input received through the CHNA (Community Meetings, Consumer Surveys, Agency Surveys, and Health Departments). Each area of regional input was assigned a weight of .05 and given a ranking of high, medium or low for a combined regional weight of (.2). The team incorporated local feedback solicited at several county specific meetings into the prioritization process and intentionally weighted this domain higher than the other stakeholder views (.3) to encourage support for a local agenda.

For each area of regional input received and the local feedback solicited, the top three issues identified were assigned a high priority, any issue that was explicitly identified but did not rank within the top three was assigned a medium priority and issues that were not identified were assigned a low priority.

Finally, hospital leaders held Community Benefit Committee meetings and reviewed the community priorities alongside their current service offerings. They determined the areas in which they had the opportunity for the greatest impact. The community health needs were assigned a high, medium or low ranking based on their confidence and capacity to produce measureable outcomes. The hospital input was weighted the highest (.5) to ensure meaningful investments were made within the areas of identified community need.

The weighted averages for regional, local, and hospital input were totaled to identify the top five health priorities as:

Identified Health Need	Regional Weighted Average	Local Weighted Average	Hospital Weighted Average	Total
Access to Care	0.5	0.9	1.5	2.9
Healthy Behaviors	0.35	0.9	1.5	2.75
Infant Mortality	0.2	0.3	1.5	2.0
Substance Abuse	0.6	0.9	0.5	2.0
Diabetes	0.3	0.6	1.0	1.9

Prioritized health needs

Based on all of the above information and processes, the prioritized health needs of the community served by the hospital are listed below.

ACCESS TO CARE

Navigate patients to PCP when their previous choice was West Hospital ED and Queen City ED. Actions include reducing the number of non-emergency visits to both EDs, having a Social Work ED Advocate assist patients in establishing a medical home, piloting test transportation strategies, and working with PCPs to coordinate the transfer of patients.

HEALTHY BEHAVIOR

Improve community heart healthy knowledge and behaviors and remove some of the known obstacles to care. It is a known fact that many people with severe cardiac issues are not knowledgeable and therefore not engaged in their cardiac health. This plan will address education and removal of some significant obstacles for their cardiac improvement. Actions include assisting patients in establishing care with PCP, assisting with insurance (MCD/private) enrollment, removing the barriers of health, providing Heart Health Happy Hours.

INFANT MORTALITY

Address Infant Mortality by reducing the number of low birth weight babies and by providing education on ABC sleep compliance. Under the leadership of the West OB Care Clinic and in collaboration with Healthy Moms and Babes, we plan to reduce low birth weight babies by 25%. The focus will also be on reducing SIDs deaths. Initiatives include providing smoking cessation services, assisting low income patients in navigating all health portals, assisting with enrollment in insurance, and parent education regarding safe sleeping.

SUBSTANCE ABUSE

The epidemic of opioid abuse has become the major cause of accidental death in Southwest Ohio. Patients are more likely to enter rehabilitation following appropriate withdrawal in a monitored setting. An evidence-based opiate withdrawal protocol for patients admitted with medical illness could link them to internal and external medication-assisted therapy. This is key to success and lasting sobriety. Mercy Health partners with Brightview, which is an outpatient addition medicine practice based on clinical best practices and outcomes measures.

DIABETES

Diabetes has become the major cause of death in Southwest Ohio. Diabetes needs are served when community members have access to diagnosis, treatment, and coordination of care for their diabetes.

Resources available

The existing healthcare facilities and other resources within the community that are available to meet the prioritized needs are listed below for each need:

ACCESS TO CARE

Resources available to address access to care in the community include Primary Health Solutions Mercy Health - Fairfield OB Clinic, Mercy Health - West OB Clinic, Mercy Health - West and Queen City EDs, Crossroads Health Center, and HealthCare Connection.

HEALTHY BEHAVIORS

Resources available to address the healthy behaviors of the community include The Health Collaborative, United Way of Greater Cincinnati, YMCA, Place Matters Communities - ACDC, The Center for Great Neighborhoods, MCURC, Price Hill Will, Santa Maria Community Services, Walnut Hills Redevelopment Corporation, Seven Hills Neighborhood Houses, Interact for Health, Mercy Health, TriHealth, St. Elizabeth, The Christ Hospital, and University of Cincinnati.

INFANT MORTALITY

To reduce low birth weights and sudden infant death syndrome (SIDS), the Mercy Health — West Hospital OB Clinic is working with Healthy Moms and Babes. Initiatives include smoking cessation services, care navigation for low-income patients and parent education regarding safe sleeping. Other resources include Cradle Cincinnati, Every Child Succeeds, March of Dimes, Healthy Beginnings, Health Gap, Head Start, and the Cincinnati Children's Medical Center.

SUBSTANCE ABUSE

Resources available to address substance abuse needs of the community include Community Behavioral Health Center, Sojourner Recovery Services, Opiate Task Force, Addiction Services Council, Healthcare for the Homeless, Prevention First, Talbert House, UMADAOP and Crossroads Health Center.

DIABETES

Resources available to address the diabetes needs of the community include Mercy Health, who provides education classes and counseling for inpatient diabetic patients and the community at large. The YMCA also offers a diabetes prevention program.

Progress on Health Priorities Identified in the 2013 Health Needs Assessment

MENTAL/BEHAVIORAL HEALTH

Initiatives	Impact
Behavioral health patient visits	During 2015, 353 people visited psychologists in the West Market, and 874 visited psychiatrists in the West Market.
Integration of primary care and behavioral health services	<p>A collaborative care model was implemented to treat a range of behavioral health conditions in the primary care setting. This was chosen over the initially proposed IMPACT model because it offered a broader approach than depression care and also addresses chronic and acute “physical” medical issues. Psychiatrists also now provide direct patient care in the primary care setting in the form of psychiatric evaluation and medication management. Behavioral Health Consultants (BHCs) are now integrated into offices already supported by integrated psychiatrics.</p> <p>To date, several full-time psychiatrists and BHC clinicians have been embedded directly with over 50 PCPs,. Volumes have increased steadily and are indicative of the high unmet demand in our communities. Patients appear to take a common-sense approach to the care model, indicating that a “one-stop shop” is a sensible solution to a longstanding problem. In addition, PCPs and their staff clearly value the presence of experts in human behavior and professionals trained in the use of psychotropic medications in the primary care setting, as evidenced by written survey, verbal report and anecdotal praise.</p>
Mercy Health Partnership Program (MHPP)	<p>MHPP, which was started in 2015, is staffed by Licensed Social Workers who serve the Cincinnati region Mercy Health Physician practices. These social workers compliment the physician practices by providing valuable social assistance to many of their uninsured, underserved and low-income patients.</p> <p>During 2015, the MHPP team followed between 25 and 38 patients and maintained over 91% compliance. The MHPP team tracked PCP office visits kept, prescription medications filled, and PCP notes. Many of the patients come to the MHPP with anxiety, depression, and other mental health concerns and have limited means to treat their diagnoses. Providing access to the PCP and potential prescription interventions has made a huge difference for many of these patients.</p>
Crossroad Health Center rent subsidies	<p>In 2015, Crossroad provided an LISW one day each week for behavioral health for adults, and a counselor from The Children’s Home three days each week for pediatric behavioral health needs. These services are integrated into the primary care services and the teams work collaboratively to meet the needs of the patients. Crossroad practices with two Pediatricians, one Family Practice physician, one Family Nurse Practitioner who sees 70% pediatrics and 30% adults. Crossroad Health Center-West provided 9,306 visits to 2,875 unique patients. In 2014, 2,775 patients were served. In 2013, 1,938 patients were served. The rent subsidies provided by Mercy Health-West Hospital assisted Crossroad Health Center-West in being able to provide the behavioral health services desperately needed in the Westside community and grow the number served by 937 new patients.</p>

Progress on Health Priorities Identified in the 2013 Health Needs Assessment

HEART DISEASE

Initiatives	Impact
Cardiac rehabilitation program	<p>The cardiac rehabilitation program: Helps cardiac patients lead better, healthier lives through education and exercise. Cardiac nurses, dietitians and exercise specialists staff the program. They provide direction and support in exercise, low-fat diets, stress reduction, smoking cessation and other healthful practices. Programs are customized to meet the needs of each patient. The cardiac rehabilitation program is for patients recovering from coronary bypass surgery, angina (chest pain), angioplasty and heart attacks. It's also beneficial for patients dealing with circulation problems, diabetes, lung problems and valve disorders.</p> <p>Phase IV cardiac rehabilitation: This maintenance phase of cardiac rehabilitation emphasizes long-term lifestyle changes to lower the risk of future heart problems by practicing and keeping healthy behaviors and habits. These behaviors include smoking cessation, maintaining a healthy weight, dealing with stress and maintaining a medication regimen.</p> <p>Cardiac phase IV visits: 12,265 in 2014; and 10,581 visits in 2015.</p> <p>Pulmonary rehab phase IV visits: 4,338 in 2014; and 3,415 visits in 2015.</p>
Community programs	<p>Prior to and subsequent to opening Mercy Health — West Hospital, heart disease has been a focus for community seminars, community health fairs and health screening events. In 2015, eight community events were held and three Healthy Happy Hours were held. The Healthy Happy Hours, which attract about 250 people, focus on women's heart health and feature multiple physician speakers. These events are marketed by sending mass mailings to surrounding zip codes. There is no charge to attend. These events have been so successful, we are planning to hold them quarterly in 2016.</p>

ACCESS TO CARE

Initiatives	Impact
Mercy Health Partnership Program (MHPP)	<p>During 2015, the MHPP team provided a total of 2,138 encounters with patients they serve. For the MHPP west region, the team had 1,318 encounters in 2013 and 1,647 encounters in 2014. In 2015, MHPP had 924 encounters. The MHPP works to provide access to Mercy Health Physicians primary care offices by maintaining strong relationships with providers and supporting patients being cared for in those practices. These services include prescription drug support and care to uninsured patients for a modest copay. They also help patients obtain financial aid services, enroll in Medicaid or Marketplace insurance plans, and provide case management services.</p>
Hospital Eligibility Link Program (HELP)	<p>Mercy Health provides financial assistance to uninsured patients through its HELP program. HELP is a free referral service. We assist patients in obtaining medical benefits through federal, state and hospital programs. If the patient cannot afford to pay some or all of their hospital expenses, we will advise where and how to get assistance to pay hospital bills, assist in finding programs for which they qualify, and sign the patient up for state and/or hospital programs that match their needs. During 2015, 6,836 people utilized the HELP services totaling \$298,897 in benefits.</p>

Progress on Health Priorities Identified in the 2013 Health Needs Assessment

ACCESS TO CARE

Initiatives	Impact
Obstetrics Clinic	<p>Mercy Health - West Hospital has always had a vision of caring for all patients within the Family Birthing Center. In November of 2013, the Family Birth Center opened its doors to the community on the West Side to bring deliveries back to the hospital. Prematurity births and SIDS continue to be major concerns even in today's world with all the technology. In the clinic, we provide prenatal counseling, social services, ultrasound, financial counseling, lab testing, lactation services and education around prenatal care. There are many barriers these women face everyday, such as language barriers, lack of finances, lack of transportation, lack of a support system, and lack of understanding of what is required to have a healthy full term pregnancy. In 2015, there were 140 births.</p>
School-Based Health Center	<p>Mercy Health developed, as well as runs and supports a school-based health center at Pleasant Hill Academy, a Cincinnati Westside public school. A nurse practitioner provides on-site medical care, including prescriptions, to students and staff. Another Westside school-based health center is planned to open at the beginning of the 2016 school year at the Saylor Park Elementary School.</p>
Healthy Moms & Babes	<p>Mercy Health — West Hospital is a continuing sponsor of this program that is based on the West Side of Cincinnati. This outreach ministry has the mission of increasing infant survival as well as fostering the health of women, children and families. The program offers comprehensive services, including pregnancy testing, prenatal services and a first year of life program offered through both a mobile van and home outreach services. There were 3,007 encounters at Healthy Moms & Babes during 2015.</p>
St. John Case Management	<p>St. John Social Services is located in Over-the-Rhine and serves the social needs of many individuals on the West Side of Cincinnati. These services include rent and utility assistance, clothing and food assistance, and aid in benefit enrollment. Between 2013 and 2015, it also offered access to free-clinic services. In 2013, St. John served 61,268 duplicated individuals. In 2014 and 2015, the team served 6,901 and 9,490 unduplicated clients respectively. Medication assistance Mercy Health — West Hospital provided \$19,885 worth of medications for patients who are poor, to enable them to continue access of primary care.</p>

Progress on Health Priorities Identified in the 2013 Health Needs Assessment

DIABETES

Initiatives	Impact
Mercy Health Partnership Program (MHPP)	The MHPP tracked diabetics and their HgA1C measures (an indication of diabetic control), medication refills, office visits, physician notes regarding compliance, and other interventions like diet counseling, exercise, nurse care coordination intervention, and dietician intervention. The team worked with a Diabetic Nurse Specialist to set up what would be considered “compliance” they measured against those standards. The MHPP team provided the patient with primary care provider access, prescription assistance, case management and referrals for supportive services to stay on a healthier path. During 2015, the MHPP team tracked and monitored 45 diabetics and worked to successfully maintain “compliance” above 89%. This program was started in 2015, so we do not have numbers for 2013 or 2014 for this program.
Pre-diabetes classes	Pre-diabetes is a condition that forms before the onset of diabetes. With pre-diabetes, blood sugar levels are higher than normal, but aren't high enough to be diagnosed as diabetes. Usually a fasting blood sugar level of 100-125 mg/dl indicates pre-diabetes. Pre-diabetes is a warning sign that allows people to take action to prevent or delay the onset of Type 2 diabetes. Diabetes educators who are also registered dietitians teach Mercy Health’s pre-diabetes classes. Each class includes information on making healthy food choices, exercise and blood sugar control, and monitoring blood sugar levels. Participants in pre-diabetes classes during 2015 totaled 45.

DENTAL

Access to dental health services was identified as a priority in the needs assessment. While this was a legitimate community concern, Mercy Health – West Hospital chose not to focus its efforts on this need. Neither access to nor provision of dental care is a core competency of the hospital and should be considered to be outside the hospital’s sphere of community influence. In addition, this need was being addressed by a number of local non-profit agencies.