Community Health Needs Assessment Implementation Plan 2013

The Christ Hospital™ Health Network

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The Christ Hospital™ Health Network

EXECUTIVE SUMMARY

The recent passage of the Patient Protection and Affordable Care Act (PPACA) has instituted federal regulations for tax-exempt hospitals to conduct community health needs assessments and develop implementation plans or community health strategies every three years.

In response to this legislation, The Christ Hospital Health Network conducted a community health needs assessment in Fiscal Year 2013 (July 1, 2012 – June 30, 2013) and sought input from a variety of community partners in order to gain valuable insight into the overall health and well-being of the community we serve.

As a first step towards understanding the health needs of our community, The Christ Hospital Health Network analyzed a number of data sources including public health data, health risk factor surveys, socioeconomic needs assessments, environmental standards and existing programs that had been developed for residents in our largest service area, Hamilton County.

The process was designed to identify the most pressing health concerns in Hamilton County with special emphasis on vulnerable populations. The essential components examined in this process include the data indicators compiled on The Christ Hospital Health Network's online community health dashboard of over 100 economical, environmental and health categories; the A.I.M. (Ask. Inform. Make a difference.) Community Health Needs Assessment; the Hamilton County Public Health Department's Community Health Assessment for Hamilton County; the Greater Cincinnati Community Health Status Survey and The United Way of Greater Cincinnati's Bold Goals. Key findings were reviewed with our community partners and internal stakeholders to further identify gaps in existing services.

The prevalent health concerns identified in the Hamilton County area through this needs assessment include:

- Access to Care
- Breast and prostate cancer
- Cardiovascular Disease
  - Hypertension
  - Hyperlipidemia
  - Stroke
  - Congestive Heart Failure
- Behaviors Related to Obesity
- Maternal and Infant Health
  - Low-birth weight babies
  - Infant mortality rates

Through a collaborative and well-thought out process, The Christ Hospital Health Network and its community partners have reviewed the most prevalent health concerns in Hamilton County and have established a course of action as outlined in the following pages. This plan focuses on programs, research and education that specifically targets some of the most pressing health concerns facing the residents of Hamilton County with the hope of making a measurable impact on the health of our community and was approved by The Christ Hospital Health Network Board of Directors on April, 17, 2013.

WHO WE ARE
AND OUR COMMITMENT TO THE COMMUNITY

In 1888, a group of local citizens led by James Gamble—whose soap business eventually became the Procter & Gamble company—invited Isabella Thoburn, a teacher, nurse, and missionary, to come to Cincinnati. They asked her to start a program to train deaconesses and missionaries to carry on religious, educational, and philanthropic work to alleviate the appalling poverty that existed in the city. They could not have imagined the impact that their invitation would have on the city, then and now, more than a century later.

Thoburn accepted the invitation, and after her arrival, soon expanded beyond ministering; in 1889 she opened a 10-bed hospital named Christ's Hospital in the West End at 46 York Street. It was moved to Mount Auburn in 1893, a nursing school was opened in 1902, and the hospital was renamed The Christ Hospital in 1904.

That sense of community and charity that existed in the early days at The Christ Hospital lives on as our mission and in its more than 5,000 employees today, who not only provide the highest quality healthcare while on the job, but also contribute thousands of hours of their own time volunteering to help improve the health of those in Greater Cincinnati and throughout the country *(see Appendix 1)*.

Since our simple beginnings, The Christ Hospital has been a leader in medical excellence. And now, we've grown to become more than a hospital. Today, The Christ Hospital is a vast network of physicians and staff, working together in more than 100 locations throughout the Tristate, to make superior medicine convenient and accessible for the communities it serves. This network – now known as The Christ Hospital Health Network – includes the main Christ Hospital campus in Mt. Auburn, as well as outpatient centers and physician practices all dedicated to providing patients with the same level of high quality care. With a medical staff of more than 1,000 physicians, The Christ Hospital Health Network offers advanced services and technologies in cardiovascular care, orthopaedic and spine treatment, women's health, geriatrics, cancer, major surgery, and a host of outpatient services such as physician practices, imaging, testing, physical and occupational therapy, wound healing, diabetes care, and more.

In addition to providing nationally recognized high acuity healthcare, The Christ Hospital is helping to improve the overall health and access to care in a three state region. The hospital continues its effort to foster healthy individuals and families with its significant commitment to the community through its numerous community benefit activities.

The Christ Hospital provided more than $54 million dollars in community benefit and charity care in fiscal year 2011. However, the true measure of The Christ Hospital's community benefit goes far beyond a balance sheet – it involves patients, caregivers, families, neighbors, local businesses, and a true sense of community. The Christ Hospital launched numerous programs targeting disease management, maintained a number of educational outreach programs, supported other healthcare-related entities, provided leadership and advocacy for the community in which it resides and provided thousands of hours of community volunteerism. While striving to be highly efficient and good stewards of our resources, we are working in a number of creative and collaborative ways to improve the lives of the people we serve.

Part of the hospital's charitable mission includes cash and in-kind donations. Some of the organizations benefiting from such donations include the Center for Respite Care – a non-profit organization that provides care and shelter to homeless patients after they have been discharged from the hospital; the Mt. Auburn Community Council and the Mt. Auburn Chamber of Commerce; Taft Elementary, which serves an underprivileged student population located in the hospital's own urban neighborhood and many more.

Many organizations were provided not only donations, but dedicated (and donated) staff time to assist with other healthcare causes such as the American Heart Association; America Diabetes Association; American Cancer Society; the Arthritis Foundation and The Center for Closing the Health Gap, which works diligently to lead the efforts to eliminate racial and ethnic health disparities in Greater Cincinnati through advocacy, education, and community outreach.

Educational support is an area of community development that continually increases. The Christ Hospital hosted career days for programs like the Medical Explorers, Taft Elementary, and the Hughes High School healthcare curriculum program-most of which allow for students to shadow staff, attend presentations, and watch live surgeries in hopes of attracting the healthcare worker of the future. We also partnered with many undergraduate colleges and universities to provide free internships for radiology, laboratory and other clinical students.

The Christ Hospital hosted more than 100 community health services and educational programs including education events, seminars, and lectures on specific areas of interest including cardiovascular health, colon cancer, obesity, smoking cessation, spine and back health, orthopedic health, vascular disease, family-centered care and many more. In addition, the hospital provided free health screenings and information at various events and locations throughout the Greater Cincinnati region. The hospital also produces several health education publications that are mailed to over 150,000 members of the Greater Cincinnati community quarterly.

The Christ Hospital is also the presenting sponsor for Cincinnati Goes Red, part of the American Heart Association's Go Red for Women Campaign, which encourages women to become more aware of ways to reduce their risk for heart disease and stroke. As part of this program, The Christ Hospital hosted the city's first Girl Scouts Go Red Patch Day, inviting Girl Scout troops to participate in a heart-healthy lifestyle program to educate girls at a young age on ways to prevent heart disease. Girls of all ages — from daisies and brownies to juniors and cadets — got a firsthand look at the importance of a heart-healthy lifestyle, including education on how the heart works, various exercises that contribute to a healthy heart and ways to incorporate a healthy diet into their lives. Each girl received a special Go Red patch to commemorate the day —and as a reminder of their first step in keeping their hearts healthy and strong. The girls — along with their mothers and chaperones — also learned about the symptoms of heart attack in women.

Taking the heart-healthy message even further, The Christ Hospital has partnered with a number of independently-owned restaurants to clearly identify dining options that meet guidelines set by the American Heart Association Step I Heart Healthy Diet. Based on a 2000 calorie-per-day diet, meals must be at or under 650 total calories, 20 g of total fat, 7 g of saturated fat, 100 mg of cholesterol and 850 mg of sodium. Items that meet these guidelines are marked with The Christ Hospital tower, symbolized on the menu.

Additionally, The Christ Hospital, in partnership with The Enquirer and WLWT-TV Channel 5, launched a new city-wide health and wellness initiative designed to help improve the health of our community. This initiative – called Get Healthy Cincinnati – provides Greater Cincinnati residents with resources, interactive tools, and important health information provided by Christ Hospital physicians and experts. These health and wellness messages are delivered through TV commercials on WLWT-TV Channel 5, newspaper ads in the Enquirer, and a new Web site created just for this initiative, www.GetHealthyCincinnati.com. Topics are updated on a monthly basis, and range from back-to-school health, to back and neck pain, to breast health, to diabetes, to weight loss, to many more!

The Christ Hospital opens its doors with free space for self-help programs, and community based support groups like Mended Hearts, pastoral outreach, one time or occasionally held clinics/seminars on topics such as tackling adult and childhood obesity, and quarterly blood drives hosted on site in partnership with Hoxworth Blood Center.

Hospital representatives continue to be very engaged in community building activities and economic development. Many hold board positions on the Mt. Auburn Chamber of Commerce; the American Heart Association; the United Way; Life Center; the Greater Cincinnati Health Council and many other local, non-profit organizations.

As healthcare continues to progress, we look for better ways to meet the ever changing health needs of our community. With new programs such as patient centered medical home and comprehensive primary care, we hope to improve community care coordination pathways to better meet the needs of the community we serve.

The above mentioned activities offer only a glimpse of how we touch and improve the health and the lives of people throughout the region. It's a testimony to the commitment and leadership of our medical staff, Board of Directors, executive team, employees, volunteers and community partners, whose dedication to community service touches many lives and makes our community a better place.

OUR COMMUNITY
HEALTH NEEDS ASSESSMENT

The recent passage of the Patient Protection and Affordable Care Act (PPACA) has instituted federal regulations for tax-exempt hospitals to conduct community health needs assessments and develop implementation plans or community health strategies every three years. To meet this requirement, The Christ Hospital Health Network conducted a community health needs assessment in Fiscal Year 2013 (July 1, 2012 – June 30, 2013) and sought input from a variety of community partners in order to gain valuable insight into the overall health and well-being of the community we serve. The following section of this report provides detailed information on how we conducted our assessment, the methodology we used in analyzing the data we collected and how we identified and plan to address our community's most pressing health needs.

OUR TEAM AND COMMUNITY PARTNERS

Internal Stakeholders

Our initial team consisted of key internal stakeholders that would help us define the scope of our assessment. These members included:

- *Executive Lead* – Heather Adkins, VP, Chief Strategy and Mission Officer
- *Communications Lead* – Patty Thelen, Director, Public Relations and Marketing
- *Community Outreach Lead* – Dona Grant, Senior Consultant, Public Relations and Marketing
- *Community Wellness Lead* – Cheri Miller, Director, Wellness Services
- *Medical Wellness Lead* – Amy Mechley, MD, Medical Director, Wellness Services

Once the scope and data resources were identified, the group expanded to include additional internal and external stakeholders. Those new members included:

- Tim Crowley, Executive Director, Geriatric Services
- Jill Badger, Executive Director, Women's Services
- Deena Casey, Patient Navigator, Oncology Services
- Jeanne Kincaid, RDLDCDE, Manager, Diabetes Education Services
- Stanley Broadnax, MD, Longtime Community Leader and Resident Advocate; the Mt. Auburn Chamber of Commerce and the Mt. Auburn Community Council.
- Renee Harris, VP, The Center for Closing the Health Gap

In addition to these members, input was sought from a variety of internal and external sources including:

- Herb Caillouet, Executive Director, Musculoskeletal Services
- Kimberly Pickens, RN MS NE-BC, Divisional Director
- Jamie Phillips, Controller
- Robert Shoemaker, Director of Finance, The Christ Hospital Physicians
- Jill Loch, Dean, Student Affairs, The Christ College of Nursing and Health Sciences
- Richard Kammerer, President, The Christ Hospital Foundation
- Rajan Lahkia, MD, Assistant Program Director, Internal Medicine Residency Program; Director of Ethics Committee, and Associate Program Director of Palliative Care
- Dianna Dillon, Director, Outpatient Clinic
- Bridgett Fossett, Director of Operations, The Christ Hospital Physicians - Primary Care
- Emily Owens, Manager, Marketing, Cardiovascular Service Line
- Patty Thelen, Director, Marketing, Oncology and Women's Health
- Arin Kraemer, Manager, PR/Marketing, The Christ Hospital Physicians
- The Greater Cincinnati American Heart Association Go Red Program
- The March of Dimes
- The YMCA of Greater Cincinnati
- Greater Cincinnati Health Council CHNA Leadership Committee
- United Way of Greater Cincinnati

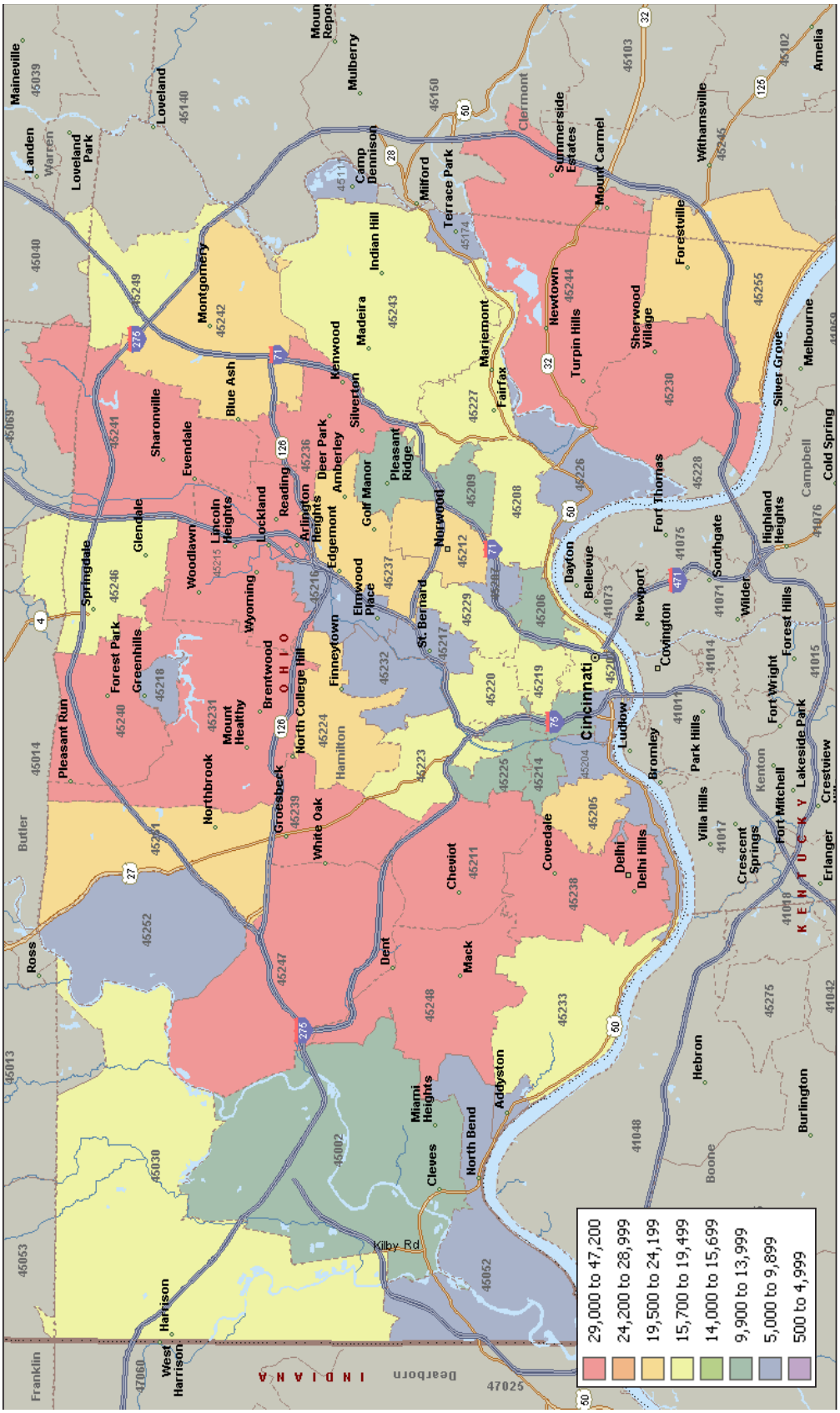
IDENTIFYING OUR COMMUNITY

After determining our objectives for the community health needs assessment, our next step was to define our community. Many definitions of community were explored including specific geographic areas; specific demographics, such as age, race and gender; and specific at-risk populations, such as the uninsured or underinsured. The committee reviewed the hospital's complete geographic primary service area, which includes 14 counties within a three state area *(see Appendix 2)*. Through that analysis, it was determined that the majority of the hospital's patient population reside in Hamilton County, Ohio, with the majority of the hospital's charity care and HCAP usage deriving from the same county.

After further analysis of the hospital's service areas, it was determined that Hamilton County had the largest population within our service area with more than 800,000 residents[1] with the highest percentage of at-risk populations including African-Americans, Hispanics and the disabled.[2] It was further determined that the residents of Hamilton County would most likely benefit from specific interventions within the first three years of the hospital's implementation plan. Additionally, a significant portion of the services offered by The Christ Hospital Health Network are offered so within Hamilton County, most notably the subsidized clinics where the utilization rate is 89 percent Hamilton County residents.

[1] US Census Bureau, 2010 Census. [2] Observations from Hamilton County Health Assessment, 2011

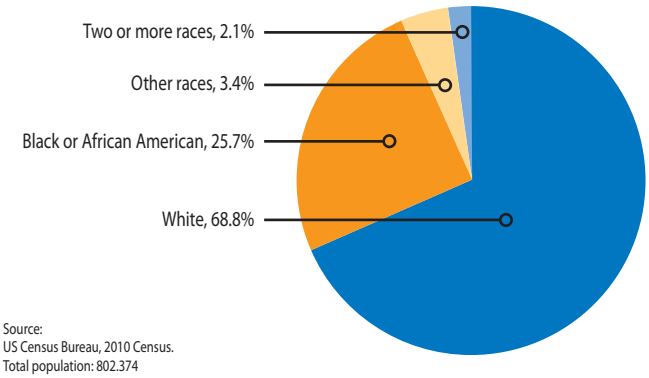
HAMILTON COUNTY 2011 POPULATION BY ZIP CODE



▪ Ohio Hospital Association

HAMILTON COUNTY AT A GLANCE

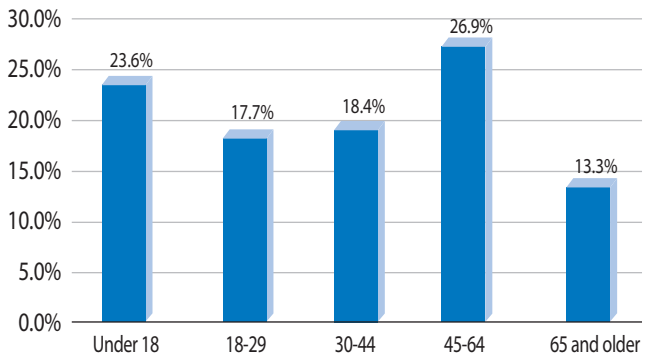
Hamilton County population by race



Source:
US Census Bureau, 2010 Census.
Total population: 802.374

Approximately two-thirds of the population of Hamilton County is white with a little more than 25 percent black or African-American. This compares to Ohio's population of 82.7 percent who are white and 12.2 percent who are black or African-American.

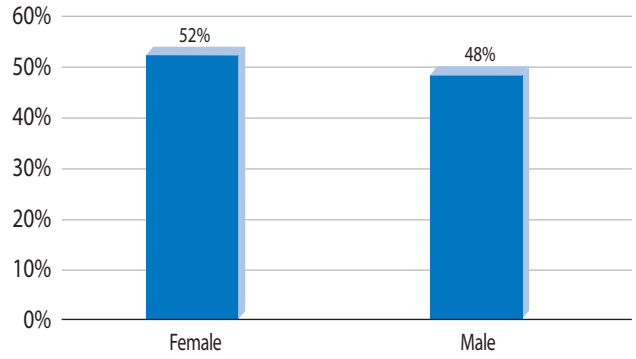
Hamilton County Population by Age



Source: US Census Bureau, 2010 Census

The largest demographic age group in Hamilton County is the 45-64 age range, followed by those under age 18.

Hamilton County Population by Gender



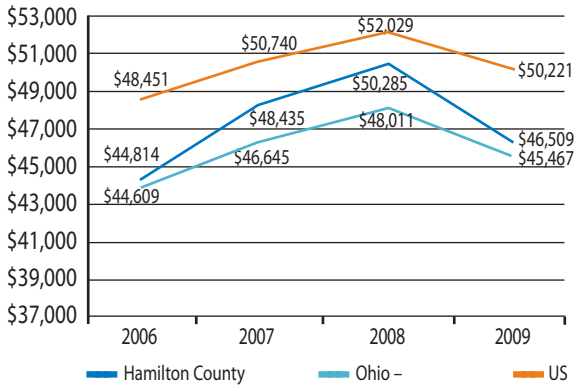
Source: US Census Bureau, 2010 Census

Females only slightly outnumber males in Hamilton County.

HAMILTON COUNTY AT A GLANCE

Hamilton County Median Household Income

Compared to Ohio and US

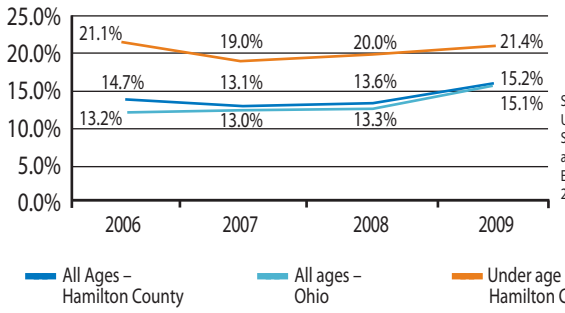


Source: US Census Bureau: Small Area Income and Poverty Estimates, 2006-2009

After showing an increase for three years, the median household income declined in 2009 in Hamilton County to $46,509, mirroring a similar statewide and national decline.

Hamilton County Percent in Poverty

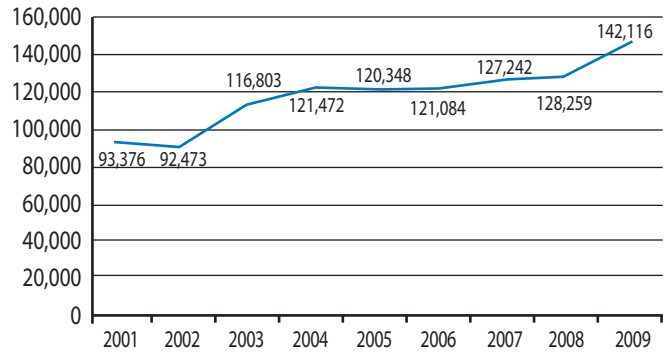
Compared to Ohio



Source: US Census Bureau: Small Area Income and Poverty Estimates, 2006-2009

The percentage of individuals in poverty increased in Hamilton County in 2008 and 2009 to 15.2 percent, which is nearly identical to state numbers.

Hamilton County Medicaid Recipients*



* # of recipients monthly average. Source: Hamilton County Job and Family Services, 2001-2009

The number of Medicaid recipients in Hamilton County was relatively stable for several years after a sharp increase in 2003. Utilization had another sharp increase in 2009 to 142,116 average number of monthly recipients.

DATA COLLECTION AND ANALYSIS

The next step in our community health needs assessment was the collection and analysis of the necessary data sets in order to establish need. In order to accomplish this, we partnered with organizations that could provide us with the tools and necessary collaboration to conduct a thorough assessment.

Health Communities Institute, Inc.

At the recommendation of the VHA, Inc., we partnered with Healthy Communities Institute, Inc. to help us create a comprehensive and accessible electronic community health needs assessment.

By their own definition, the Healthy Communities Institute has designed a system and strategies to help local public health departments, hospitals and community coalitions to measure community health, share best practices, identify new funding sources and drive improved community health. The HCI CHNA System™ is a customizable web-based information system that provides the data, tools and best practices to help hospitals meet Healthcare Reform and IRS 990 requirements for conducting community health needs assessments.

The Christ Hospital Health Network's customized dashboard provides over 100 health and quality of life indicators for Hamilton County and four continuous years of Ohio County hospitalization data from the Ohio Hospital Association *(see Appendix 3)*. These indicators are directly linked to their online sources and are updated in real-time as the source data is updated. Data sources include information from the Center for Disease Control, the Ohio Department of Health and National Cancer Institute on diseases such as diabetes and hypertension to environmental issues such as air quality. In addition to this rich data, this tool also provides us with a large database of promising practices that give us insights into how other healthcare organizations have run successful interventions. Additionally, our dashboard includes the benchmarking goals of the HealthyPeople 2020 program, providing us with tangible national standards to measure these interventions. The Christ Hospital Health Network Community Health Needs Assessment can be accessed at www.thechristhosptial.com/CHNA.

The Greater Cincinnati Health Council

A.I.M. for Better Health Community Health Needs Assessment for Greater Cincinnati

In addition to this abundant source of primary and secondary, data, we also partnered with The Greater Cincinnati Health Council on their first collaborative, community-wide A.I.M. for Better Health Community Health Needs Assessment for Greater Cincinnati. This association provided us with the necessary primary, qualitative data and community collaboration that we needed.

This assessment was conducted in collaboration with Health Care Access Now and numerous other community health providers and healthcare organizations within the Greater Cincinnati region. A.I.M. stands for "Ask. Inform. Make a Difference." It represents a network of public and private organizations that stand for a shared voice and vision of improving population health and wellness in Greater Cincinnati.

In addition to satisfying regulatory requirements of federal and state agencies, this collaborative represents an unprecedented effort and key opportunity to bring together hospital data, mapping, technology and community input to provide a more detailed and complete profile of the community health needs. The data collected were compiled from the most up-to-date publicly available resources and primary research with stakeholders, providers and targeted populations who face more challenges in getting healthcare. It is the goal of this collaboration that the individual hospitals, health and human service organizations represented, as well as the collaborative efforts by the organizations gathered, will work to address the significant needs summarized in this needs assessment both individually and ultimately together. The complete assessment can be found at www.healthcareaccessnow.org/a-i-m-for-better-health. We entered this process after the assessment was complete in order to be part of the implementation and strategy discussions.

Other data was analyzed and reviewed from the United Way of Greater Cincinnati Bold Goals *(see Appendix 4)* and the Community Health Needs Assessment conducted by the Hamilton County Public Health Administration in 2010. More information about these collaborations can be found on page 34.

ANALYSIS

Once both our primary and secondary data sets were collected, a more concentrated group of internal and external stakeholders reviewed the data to determine what unmet health needs existed in Hamilton County. The process for analyzing the data consisted of the following steps:

1. Reviewed online community health dashboard and flagged all health indicators that were in the negative, trending negative and/or at/or below the HealthyPeople 2020 Benchmark *(see Appendix 4)*.
2. Formulated grading matrix based on best practices from reputable sources such as the Catholic Health Association. *(see Figure 2a)*
3. Identified indicators and weighed them based on answers to targeted questions by utilizing knowledge of public health, the services provided by The Christ Hospital Health Network and by reviewing the available data sources, such as the community health dashboard. A.I.M. for Better Community Health Needs Assessment, HealthyPeople 2020 data sources, the United Way Bold Goals and the Community Health Needs Assessment conducted by the Hamilton County Public Health Administration in 2010.

Figure 2a

The Christ Hospital Health Network 2012-13 CHNA Grading Matrix

- **Magnitude of the problem** *(20 percent)*

  On a scale of 1-10, with 10 being the largest, how large is the problem? *(percentage of service area affected)*

- **Severity of the problem** *(20 percent)*

  On a scale of 1-10, with 10 being the most severe, how severe is the problem? *(the degree to which it is worse than national norm)*

- **TCHHN's capacity to act on the issue** *(20 percent)*

  On a scale of 1-10, with 10 being the highest, what is TCHHN capacity to act on the issue? *(existing program, experts, partnerships and budgets)*

- **Likelihood or feasibility of TCHHN having a measurable impact on the issue** *(20 percent)*

  On a scale of 1-10, with 10 being the highest, what is the likelihood TCHHN will have a measurable impact on the issue? (Will our effort be enough?)

- **Affect on other issue** *(20 percent)*

  On a scale of 1-10, with 10 being the highest, what effect does this issue have on other issues *(co-morbidities)*

Once the data was scored by the committee, the top priority areas were agreed upon. Once the priorities were determined, the collaborative created a set of interview questions and obtained input from key stakeholders in the organization and the community to validate the top issues, identify gaps, and suggest evidenced-based and/or promising practices to address the issues. The remaining indicators were identified and labeled as "other unmet needs." These indicators were further analyzed and researched for possible implementation in later years, as well as identifying any community interventions currently available.

KEY FINDINGS
AND OUR RESPONSE TO THE NEED

The review and evaluation of this quantitative and qualitative data combined with community consultation and feedback have enabled us to identify key priority areas in the community that require attention. The findings of this needs assessment can be used to inform strategic planning, decision-making, and resource investments and allocations.

In the next few pages we will highlight the identified needs that The Christ Hospital Health Network plans to focus on over the next three years in order to increase the health and quality of life of residents in Hamilton County. The summaries each include interventions that we feel will have a significant impact on the priority areas. For a more detailed description of the intervention programs, including target populations, please *see Appendix 5*.

Congestive Heart Failure

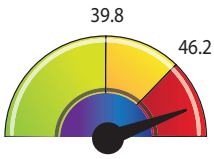
Congestive heart failure (CHF) is a condition in which the heart can't pump enough blood to the body's other organs. This can result from a variety of conditions including coronary artery disease, diabetes, past heart attack, hypertension, heart infections, diseases of the heart valves or muscle, and congenital heart defects. Because the heart is not able to work efficiently, blood backs up in the tissues causing edema or swelling. Edema can occur in the legs and ankles as well as in the lungs, where it causes shortness of breath, especially while lying down. Around 5 million people in the United States have heart failure, and more than 287,000 people in the United States die each year with the disease. The estimated direct cost for heart failure in the U.S. in 2006 was $29.6 billion. According to the National Hospital Discharge Survey, hospitalizations for heart failure have increased from 402,000 in 1979 to 1,101,000 in 2004.

Where we are

Between 2007-2009, Hamilton County had 49.4 hospitalizations per every 10,000 adults *(see Figure 3a)*. The Healthy People 2020 national health target is to reduce the amount of adults age 64-74 to 8.8 hospitalizations per every 1,000 adults; to reduce the amount of adults 75-84 to 20.2 hospitalizations per every 1,000 adults; and to reduce the amount of adults over the age of 85 to 38.6 hospitalizations per every 1,000 adults.

Figure 3a

Age-adjusted hospitaliztion rate due to congestive heart failure



Value	49.4 hospitalizations/10,000 population 18+ years
Measurement period	2007-2009
Location	County: Hamilton
Comparison	OH Counties
Categories	Health/Heart Disease & Stroke

Red > 46.2 Green <= 39.8 In-between = Yellow
Unit: hospitalizations/10,000 population 18+ years

Source: Ohio Hospital Association, 2007-2009

Interventions

By directly addressing risk factors for CHF such as hypertension, hyperlipidemia, diabetes and obesity, we hope to have an impact on the incident rate of CHF in Hamilton County over the next three years. Additionally, in 2007, The Christ Hospital opened The Carl H. & Edyth Lindner Heart Failure Treatment Center that provides specialized care by heart failure specialists to heart failure patients. Here there are dedicated, full-time cardiologists who implement best practice guidelines for heart failure care as well as cutting-edge technologies. It is the only heart failure center in the U.S. to be accredited by both The Joint Commission and the Healthcare Accreditation Colloquium. Additionally, The Christ Hospital is involved in Institutional Review Board-approved, nationally published research of heart failure management and treatment methods, including in the areas of ultrafiltration and implantable devices. In 2008, The Christ Hospital opened a clinic for congestive heart failure patients. The clinic treats the increasing aging population with heart failure, specifically the heart failure patients who do not have any insurance and are at risk because of inability to pay for follow-up appointments or medications. We will continue to monitor progress in this area and evaluate services to address the issue.

Stroke

Why it's important

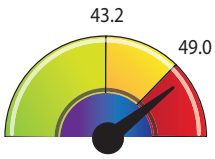
Cerebrovascular diseases rank third among the leading causes of death in the U.S. Cerebrovascular disease can cause a stroke. A stroke occurs when blood vessels carrying oxygen to the brain become blocked or burst, thereby cutting off the brain's supply of oxygen. Lack of oxygen causes brain cells to die which can lead to death or disability. Each year, approximately 795,000 people in the U.S. will suffer a new or recurrent stroke. Although people of all ages may have strokes, the risk more than doubles with each decade of life after age 55. The most important modifiable risk factors for stroke are high blood pressure, high cholesterol and diabetes mellitus.

Where we are

According to 2010 data, Hamilton County had 51 deaths from stroke for every 100,000 adults *(see Figure 4a)*. The Healthy People 2020 national health target is to reduce the stroke deaths to 33.8 deaths per 100,000 population *(see Figure 4b)*.

Figure 4a

Age-adjusted death rate due to cerebrovascular disease (stroke)



Value	51.0 deaths/100,000 population
Measurement period	2010
Location	County: Hamilton
Comparison	OH Counties
Categories	Health/Heart Disease & Stroke Health/Mortality Data

Red > 49.0 Green <= 43.2 In-between = Yellow

Unit: deaths/100,000 population

Source: Ohio Department of Health, Vital Statistics, 2010

Interventions

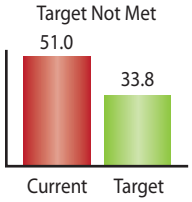
By directly addressing risk factors for stroke such as hypertension, hyperlipidemia, diabetes and obesity, we hope to have an impact on the incident rate of stroke in Hamilton County over the next three years. Additionally, The Christ Hospital Vascular Center offers full-service treatment for vascular disease including: screenings, catheter-based treatment (balloon angioplasty, stents, etc.), medical management, surgical therapy including both traditional and laparoscopic or minimally invasive techniques. The Vascular Center physicians at The Christ Hospital has extensive clinical experience in performing vascular procedures in the Greater Cincinnati region. We will continue to monitor progress in this area and evaluate services to address the issue.

Other Area Resources

The Greater Cincinnati/Northern Kentucky Stroke Team includes stroke neurologists, neurovascular surgeons, emergency medicine physicians, and neuroradiologists backed by a team of researchers and clinical and technical support staff. Based at the University of Cincinnati and UC Health University of Cincinnati Medical Center, the Stroke Team serves as a community resource to all Greater Cincinnati hospitals, while managing the stroke treatment program at University of Cincinnati Medical Center.

Figure 4b

Age-adjusted death rate due to cerebrovascular disease (stroke)



Value	51.0 deaths/100,000 population
Healthy people 2020 target:	33.8 deaths/100,000 population
Measurement period:	2010
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Heart Disease & Stroke Health/Mortality Data

Unit: deaths/100,000 population

CARDIOVASCULAR DISEASE – HYPERLIPIDEMIA

Why it's important

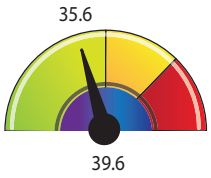
High blood cholesterol is one of the major risk factors for heart disease. Studies show that the higher your blood cholesterol level, the greater your risk for developing heart disease or having a heart attack. Heart disease is the number one killer of men and women in the United States. Every year about 785,000 Americans have a first heart attack. Another 470,000 who have already had one or more heart attacks have another attack. In 2006, over 630,000 Americans died from heart disease. High blood cholesterol does not cause symptoms, so it is important to find out what your cholesterol numbers are. Lowering cholesterol levels lessens the risk for developing heart disease and reduces the chance of having a heart attack. Lowering high cholesterol levels is important for people of all ages, both men and women.

Where we are

According to data from 2009 for Hamilton County, 35.6 percent of adults in Hamilton County have been told their blood cholesterol was high *(see Figure 5a)*.

Figure 5a

High cholesterol prevalence



Value	35.6 percent
Measurement period	2009
Location	County: Hamilton
Comparison	OH State Value
Categories	Health/Heart Disease & Stroke Health/Exercise, Nutrition & Weight
Comparison: 39.6	
Unit: percent	

Source: Behavioral Risk Factor Surveillance System (Centers for Disease Control), 2009

Interventions

The following list of programs have been or will be implemented within The Christ Hospital Health Network. Each program targets a specific patient population and has set individual goals aimed at prevention education and screening for hyperlipidemia, as well as better care coordination for improved disease management. For a complete description of these programs, please *see Appendix 5*.

- Patient Centered Medical Home
- Comprehensive Primary Care
- Clinically Integrated Network
- Community Health Worker Program
- Internal Medicine
- Center for Health And Aging
- Care Transition Project
- The Carl and Edyth Lindner Research Center
- Corporate Wellness Outreach
- Complete Health Improvement Plan and other lifestyle modification and disease prevention programs
- Center for Closing the Health Gap Block by Block and Do Right! Programs
- American Heart Association – Go Red for Women Partnership including many grass-root intiatives such as: Have Faith in Heart; Girl Scout Education Program; Doctors Go Red for Women; Heart Healthy Tailgate and Restaurant program.
- YMCA and Cincinnati Sports Medicine reduced price, physician prescribed exercise programs

Desired Outcomes

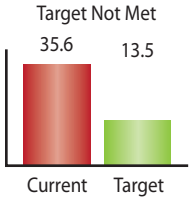
The Christ Hospital Health Network's goal is to align outcomes with those set nationally by HealthyPeople 2020, other national benchmarks as determined by the program and other local benchmarks. Currently, the Healthy People 2020 national health target is to reduce the proportion of adults aged 20 years and older with high total blood cholesterol levels to 13.5 percent *(see Figure 5b)*.

Strategies

Through utilization of the above mentioned programs and in collaboration with other community partners and programs, The Christ Hospital Health Network's desired outcome is to meet the HealthyPeople 2020 benchmark goal for adults with hyperlipidemia. Statistically, this would mean a 22.1 percent decrease over the next seven years in the number of residents with hyperlipidemia. For Hamilton County, this would require approximately 19,000 residents with hyperlipidemia to reverse their blood cholesterol and/or a combination of disease reversal and disease prevention among the adult populations. This is a significant undertaking and will require the input and collaboration of many community partners. It will be attempted through this community collaboration with prevention education and advocacy through programs such as The Center for Closing the Health Gap's Block by Block program *(see Appendix 7)* and increased targeted programs aimed at screening more of the at-risk populations, as well as supporting programs to reduce contributing risk factors directly associated with hyperlipidemia, such as obesity.

Figure 5b

High cholesterol prevalence



Value	35.6 percent
Healthy people 2020 target:	13.5 percent
Measurement period:	2009
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Heart Disease & Stroke Health/Exercise, Nutrition & Weight

Unit: percent

Source: Behavioral Risk Factor Surveillance System (Centers for Disease Control) and HealthyPeople 2020

Why it's important

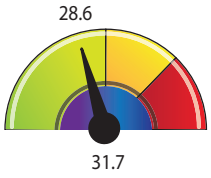
High blood pressure is the number one modifiable risk factor for stroke. In addition to stroke, high blood pressure also contributes to heart attacks, heart failure, kidney failure, and atherosclerosis. The higher your blood pressure, the greater your risk of heart attack, heart failure, stroke, and kidney disease. In the United States, one in three adults has high blood pressure, and nearly one-third of these people are not aware that they have it. Because there are no symptoms associated with high blood pressure, it is often called the "silent killer." The only way to tell if you have high blood pressure is to have your blood pressure checked. High blood pressure can occur in people of any age or sex; however, it is more common among those over age 35. It is particularly prevalent in African Americans, older adults, obese people, heavy drinkers, and women taking birth control pills. Blood pressure can be controlled through lifestyle changes including eating a heart-healthy diet, limiting alcohol, avoiding tobacco, controlling your weight, and staying physically active.

Where we are

According to data from 2009 for Hamilton County, 28.6 percent of adults in Hamilton County have been told they have high blood pressure *(see Figure 6a)*.

Figure 6a

High blood pressure prevalence



Value	28.6 percent
Measurement period	2009
Location	County: Hamilton
Comparison	OH State Value
Categories	Health/Heart Disease & Stroke Health/Exercise, Nutrition & Weight

Comparison: 31.7

Unit: percent

Source: Behavioral Risk Factor Surveillance System (Centers for Disease Control), 2009

Interventions

The following list of programs have been or will be implemented within The Christ Hospital Health Network. Each program targets a specific patient population and has set individual goals aimed at increasing prevention education and screening for hypertension, as well as better care coordination for improved disease management. For a complete description of these programs, please *see Appendix 5*.

- Patient Centered Medical Home
- Comprehensive Primary Care
- Clinically Integrated Network
- Community Health Worker Program
- Internal Medicine & Congestive Heart Failure Outpatient Clinic
- Center for Health And Aging
- Care Transition Project
- The Carl and Edyth Lindner Research Center
- Corporate Wellness Outreach
- Complete Health Improvement Plan and other lifestyle modification and disease prevention programs
- Center for Closing the Health Gap Block by Block and Do Right! Programs
- American Heart Association – Go Red for Women Partnership including many grass-root intiatives such as: Have Faith in Heart; Girl Scout Education Program; Doctors Go Red for Women; Heart Healthy Tailgate.
- YMCA and Cincinnati Sports Medicine reduced price, physician prescribed exercise programs

Desired Outcomes

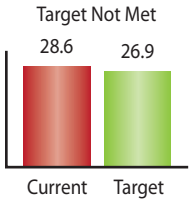
The Christ Hospital Health Network's goal is to align outcomes with those set nationally by HealthyPeople 2020, other national benchmarks as determined by the program and other local benchmarks. Currently, The Healthy People 2020 national health target is to reduce the proportion of adults aged 18 years and older with high blood pressure to 26.9 percent *(see Figure 6b)*.

Strategies

Through utilization of the above mentioned programs and in collaboration with other community partners and programs, The Christ Hospital Health Network's desired outcome is to meet or exceed the HealthyPeople 2020 benchmark goal for adults with high blood pressure. Statistically, this would mean a 1.7 percent decrease over the next seven years in the number of residents with hypertension. For Hamilton County, this would require approximately 1,500 residents with hypertension to reverse their hypertensive state and/or a combination of disease reversal and disease prevention among the adult populations. This will be attempted with community collaboration through education and advocacy with programs such as Go Red for Women and targeted programs like the Complete Health Improvement Program.

Figure 6b

High blood pressure prevalence



Value	28.6 percent
Healthy people 2020 target:	26.9 percent
Measurement period:	2009
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Heart Disease & Stroke Health/Exercise, Nutrition & Weight

Unit: percent

Source: Behavioral Risk Factor Surveillance System (Centers for Disease Control), 2009 and HealthyPeople 2020

Why it's important

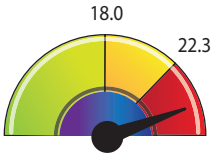
The prevalence of diagnosed Type 2 diabetes increased six-fold in the latter half of the last century according to the CDC. Diabetes risk factors such as obesity and physical inactivity have played a major role in this dramatic increase. Age, race, and ethnicity are also important risk factors. The CDC estimates the direct economic cost of diabetes in the United States to be about $100 billion per year. This figure does not take into account the indirect economic costs attributable to potential work time lost to diabetes- related illness or premature death. Regular A1c screening among diabetics helps assess whether or not the patient is properly managing their disease and is considered the standard of care.

Where we are

According to data from 2009 for Hamilton County, there were 25.3 hospitalizations per 10,000 adults over the age of 18 *(see Figure 7a)*. Additionally, in 2010, 9.2 percent of the entire population had been diagnosed with either Type 1 or Type 2 *(see Figure 7b)*.

Figure 7a

Age-adjusted hospitaliztion rate due to diabetes



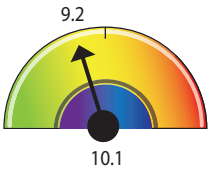
Value	25.3 hospitalizations/10,000 population 18+ years
Measurement period	2007-2009
Location	County: Hamilton
Comparison	OH Counties
Categories	Health/Diabetes

Red > 22.3 Green <= 18.0 In-between = Yellow
Unit: hospitalizations/10,000 population 18+ years

Source: Ohio Hospital Association, 2007-2009

Figure 7b

Adults with diabetes



Value	9.2 percent
Measurement period	2010
Location	County: Hamilton
Comparison	OH State Value
Categories	Health/Diabetes

Comparison: 10.1
Unit: percent

Source: Behavioral Risk Factor Surveillance System (Centers for Disease Control), 2010

Interventions

The following list of programs is currently in place within The Christ Hospital Health Network. Each program targets a specific patient population and has set individual goals aimed at improving education, screenings and improved disease management. For a complete description of these programs, please *see Appendix 5*.

- The Christ Hospital Diabetes and Endocrine Center
- Diabetes Education Services
- Patient Centered Medical Home
- Comprehensive Primary Care
- Clinically Integrated Network
- Community Health Worker Program
- Internal Medicine Outpatient Clinic
- Center for Health And Aging
- Care Transition Project
- The Carl and Edyth Lindner Research Center
- Complete Health Improvement Plan
- American Diabetes Association and JDRF partnerships
- YMCA Diabetes Prevention Program
- Center for Closing the Health Gap Block by Block Program and Do Right!

Desired Outcomes

In response to this public health challenge, Healthy People 2020 has identified goals that aim to "reduce the disease and economic burden of diabetes, and improve the quality of life for all persons who have or are at risk for diabetes." Goals include improved diabetes education, improved compliance with recommended care and screening procedures, and reduced rates of serious complications such as foot ulcers, amputation, and death.

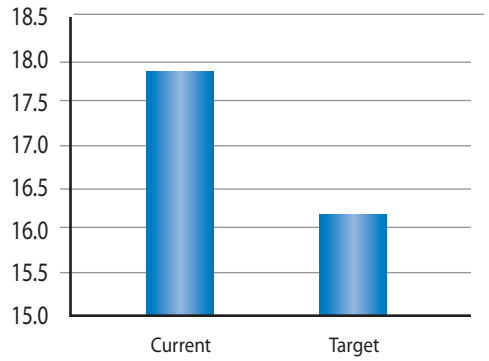
Strategies

The Christ Hospital Health Network recognizes the benefits of each of these goals and suggested interventions and have already begun to align programs and internal benchmarks with those set nationally through programs such as Patient Centered Medical Home (PCMH). Nationally 17.9 percent of adults aged 18 years and older with diagnosed diabetes had an A1c value greater than 9 percent in 2005–08. The Healthy People 2020 national health target is to decrease that rate to 16.1 percent[1] in the next seven years.

Programs such as PCMH are aimed at screening for and monitoring patient's A1c levels and targeting those levels for coordinated care introduction.

Figure 7c

National HP2020 goal for adults with A1c values greater than nine



Source: HealthyPeople 2020. Objectives and Goals - Diabetes. 2012. (www.healthypeople.gov)

[1] HealthyPeople 2020. Objectives and Goals - Diabetes. 2012. (www.healthypeople.gov)

Low Birth Weight Babies and Infant Mortality Rates

Why it's important

Babies born with a low birth weight are more likely than babies of normal weight to require specialized medical care, and often must stay in the intensive care unit. Low birth weight is often associated with premature birth. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability. The most important things an expectant mother can do to prevent prematurity and low birth weight are to take prenatal vitamins, stop smoking, stop drinking alcohol and using drugs, and most importantly, get prenatal care.

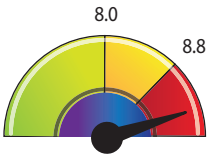
Infant mortality, or the rate of infants who die within the first 12 months of birth, has long been targeted for improvement in the region. Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy.

Where we are

Hamilton County has the highest rate of low birth weight babies and the highest infant mortality rates in the Greater Cincinnati area, showing a steady increasing trend between 2001 and 2008. In 2010, in almost 10 percent of the births in Hamilton County, the newborn weighed less than 2,500 grams (5 pounds, 8 ounces) *(see Figure 8a)*. In 2008, 11.1 infants per 1,000 live births died within their first year of life, an increase of almost 2 percent from 2006 *(see Figure 8b)*. Consequently, though the perception is that access to care is not an issue in Hamilton County, something is preventing women from entering into prenatal care in the first trimester of pregnancy. Women who get prenatal care in the first trimester have better birth outcomes than women who do not.

Figure 8a

Babies with low birth weight



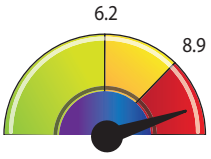
Value	9.6 percent
Measurement period	2010
Location	County: Hamilton
Comparison	OH Counties
Categories	Health/Maternal, Fetal & Infant Health

Red > 8.8 Green <= 8.0 In-between = Yellow
Unit: percent

Source: Ohio Department of Health, Vital Statistics, 2010

Figure 8b

Infant mortality rate



Value	11.1 deaths/1,000 live births
Measurement period	2008
Location	County: Hamilton
Comparison	OH Counties
Categories	Health/Maternal, Fetal & Infant Health Health/Mortality Data

Red > 8.9 Green <= 6.2 In-between = Yellow
Unit: deaths/1,000 live births

Source: Ohio Department of Health, Vital Statistics, 2008

Interventions

The following list of programs is currently in place within The Christ Hospital Health Network. Each program targets expecting/or new mothers in at risk populations and has set individual goals aimed at increasing access and ease of care for expecting mother and increasing the level of education for better outcomes. For a complete description of these programs, please *see Appendix 5*.

- Prenatal Clinic
- Center for Centering Pregnancy
- March of Dimes Partnership – March for Babies
- Community Health Worker Program

Desired Outcomes

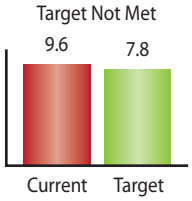
The Christ Hospital Health Network's goal is to align outcomes with those set nationally by HealthyPeople 2020, other national benchmarks as determined by the program and other local benchmarks. Currently, the Healthy People 2020 national health target is to reduce the proportion of infants born with low birth weight to 7.8% *(see Figure 8c)*; additionally the Healthy People 2020 national health target is to reduce the infant mortality rate to 6 deaths per 1,000 live births *(see Figure 8d)*.

Strategies

Through utilization of the above mentioned programs and in collaboration with other community partners and programs, The Christ Hospital Health Network's desired outcome is to meet or exceed the HealthyPeople 2020 benchmark goal for decreasing the amount of babies born below 5 pounds, 8 ounces and the amount of infant deaths within the first year of life. Statistically, this would mean a 2 percent decrease over the next seven years in the number of low birth weight babies and reducing the amount of infant deaths within the first year by five over the next seven years. This will be attempted with community collaboration by utilizing the Pregnancy Pathways/Community Care Coordination model to reach women who are likely to have poor birth outcomes to connect them with a Community Heath Worker and/or utilizing the Center for Centering Pregnancy model to advocate healthy outcomes for pregnancies specifically increased birth weight and gestational age of mothers that deliver preterm. Additionally these goals can be realized with continued support of education, advocacy and other targeted programs through partnerships with organization such as the March of Dimes.

Figure 8c

Babies with low birth weight

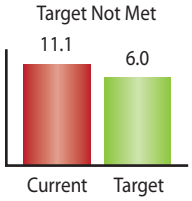


Value	9.6 percent
Healthy people 2020 target:	7.8 percent
Measurement period:	2010
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Maternal, Fetal & Infant Health
Unit: percent	

Source: Ohio Department of Health, Vital Statistics, 2010 and HealthyPeople 2020

Figure 8d

Infant mortality rate



Value	11.1 deaths/1,000 births
Healthy people 2020 target:	6.0 deaths/1,000 births
Measurement period:	2008
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Maternal, Fetal & Infant Health Health/Mortality Data
Unit: deaths/1,000 births	

Source: Ohio Department of Health, Vital Statistics, 2008 and HealthyPeople 2020

BREAST AND PROSTATE CANCER

Why it's important

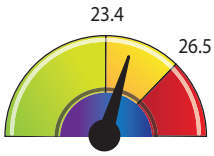
According to the American Cancer Society, breast cancer is the second leading cause of cancer death and the second most common type of cancer among women in the U.S. Additionally, the American Cancer Society also states that prostate cancer is the most commonly diagnosed form of cancer among men in the United States and it is second only to lung cancer as a cause of cancer-related death among men. The two greatest risk factors for prostate cancer are age and race/ethnicity, with men over the age of 65 and men of African descent possessing the highest incidence rates of prostate cancer in the U.S.

Where we are

The indicators for Hamilton County, based on 2009 data, show that 24.9 female patients per 100,000 die from breast cancer every year *(see Figure 9a)*. Additionally, the indicators for Hamilton County, based on 2009 data, show that 26.1 male patients per 100,000 die from prostate cancer every year *(see Figure 9b)*. The rate is almost double for African American males at 48.4 deaths per 100,000 according to the same data *(see Figure 9c)*.

Figure 9a

Age-adjusted death rate due to breast cancer



Value	24.9 deaths/100,000 females
Measurement period	2005-2009
Location	County: Hamilton
Comparison	U.S. Counties
Categories	Health/Cancer Health/Mortality Data Health/Women's Health

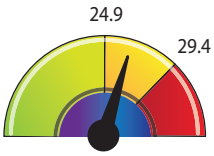
Red < 26.5 Green >= 23.4 In-between = Yellow

Unit: deaths/100,000 females

Source: National Cancer Institute, 2005-2009

Figure 9b

Age-adjusted death rate due to prostate cancer



Value	26.1 deaths/100,000 males
Measurement period	2005-2009
Location	County: Hamilton
Comparison	U.S. Counties
Categories	Health/Cancer Health/Mortality Data Health/Men's Health

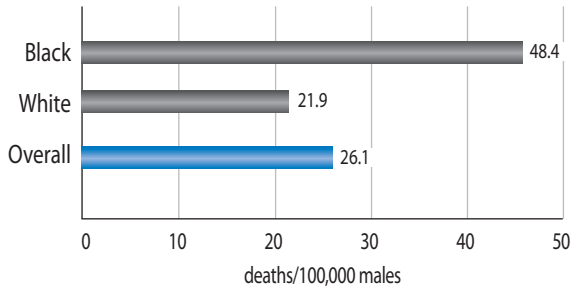
Red > 29.4 Green <= 24.9 In-between = Yellow

Unit: deaths/100,000 males

Source: National Cancer Institute, 2005-2009

Figure 9c

Age-adjusted death rate due to prostate cancer by race/ethnicity



Source: National Cancer Institute, 2005-2009

Interventions

The following list of programs have been or will be implemented within The Christ Hospital Health Network. Each program targets a specific patient population and has set individual goals aimed at improving the outcomes for patients as well increasing the level of education and screenings in the community. For a complete description of these programs, please *see Appendix 5*.

- Subsidized OB/GYN Outpatient Clinic
- Prostate Collaborative Committee
- Breast Cancer Patient Navigator Program
- American Cancer Society Partnership – Making Strides
- Subsidized Mammography Program
- The Christ Hospital Cancer Center Research Center

Desired Outcomes

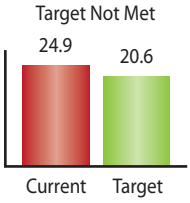
The Christ Hospital Health Network's goal is to align outcomes with those set nationally by HealthyPeople 2020, other national benchmarks as determined by the program and other local benchmarks. Currently, The Healthy People 2020 national health target is to decrease the death rate due to breast cancer to 20.6 per 100,000 females *(see Figure 9d)*. Additionally, the Healthy People 2020 national health target is to reduce the prostate cancer death rate to 21.2 deaths per 100,000 males *(see Figure 9e)*.

Strategies

Through utilization of the earlier mentioned interventions and in collaboration with other community partners and programs, The Christ Hospital Health Network's desired outcome is to meet or exceed the HealthyPeople 2020 benchmark goal for both breast and prostate cancer related deaths. Statistically, this would mean approximately 13 less deaths a year by 2020 for women with breast cancer in Hamilton County. This will be attempted with community collaboration through education, advocacy and targeted programs like the subsidized mammography program that will make access to screenings more readily available and early detection with longer term survival rates more possible.

Figure 9d

HP2020 goal for age-adjusted death rate due to breast cancer



Value	24.9 deaths/100,000 females
Healthy people 2020 target:	20.6 deaths/100,000 females
Measurement period:	2005-2009
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Cancer Health/Mortality Data Health/Women's Health

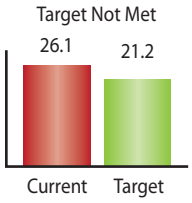
Unit: deaths/100,000 females

Source: National Cancer Institute, 2005-2009 and HealthyPeople 2020, 2012

The numbers are similar for men with prostate cancer. In order to attain the HP2020 benchmark, Hamilton County would need to achieve approximately 15 less deaths a year by 2020 for men with prostate cancer. This reduction will be attempted with community collaboration through education, advocacy and target programs like the Prostate Cancer Collaborative. A concentrated effort in community education will be directed to the most vulnerable population of African American men and those over the age of 65.

Figure 9e

HP2020 goal for age-adjusted death rate due to prostate cancer



Value	26.1 deaths/100,000 males
Healthy people 2020 target:	21.2 deaths/100,000 males
Measurement period:	**2005**-2009
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Cancer Health/Mortality Data Health/Men's Health

Unit: deaths/100,000 males

Source: National Cancer Institute, 2005-2009

Why it's important

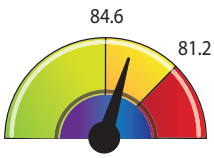
People who lack a regular source of healthcare may not receive the proper medical services when they need them. This can lead to missed diagnoses, untreated conditions, and adverse health outcomes. People without a regular source of healthcare are less likely to get routine checkups and screenings. When they become ill, they generally delay seeking treatment until the condition is more advanced and therefore more difficult and costly to treat. Young children and elderly adults are most likely to have a usual source of care, whereas adults aged 18 to 64 years are the least likely. Maintaining regular contact with a healthcare provider is especially difficult for low-income people, who are less likely to have health insurance. This often results in emergency room visits, which raises overall costs and lessens the continuity of care.

Where we are

The indicators for Hamilton County, based on data from 2008, show that 82.9 percent of the county adult population have identified a usual source of healthcare *(see Figure 10a)*. Additionally, 83.1 percent of the county adult population has some form of health insurance based on data from 2011 *(see Figure 10b)*. It is important to note that African Americans and Latinos with some form of health insurance are lowest at 74.5 and 40.6 percent respectfully *(see Figure 10c)*.

Figure 10a

Adults with a usual source of healthcare



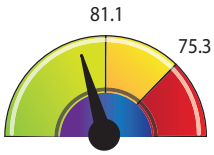
Value	82.9 percent
Measurement period	2008
Location	County: Hamilton
Comparison	Ohio Counties
Categories	Health/Access to Health Services

Red < 81.2 Green >= 84.6 In-between = Yellow
Unit: percent

Source: Ohio Family Survey, 2008

Figure 10b

Adults with health insurance



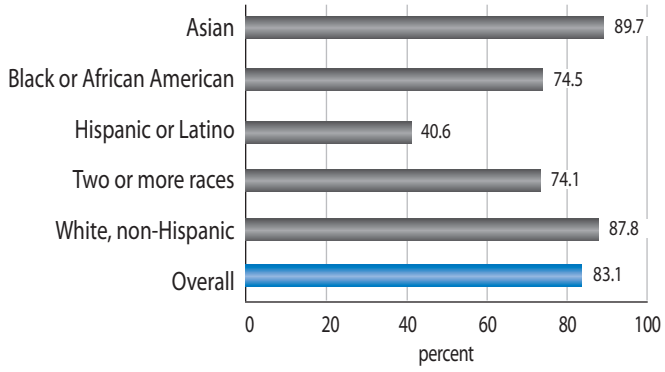
Value	83.1 percent
Measurement period	2011
Location	County: Hamilton
Comparison	U.S. Counties
Categories	Health/Access to Health Services

Red < 75.3 Green >= 81.1 In-between = Yellow
Unit: percent

Source: American Community Survey, 2011

Figure 10c

Adults with health insurance by race/ethnicity



Interventions

The following list of programs have been or will be implemented within The Christ Hospital Health Network. Each program targets a specific patient population and has set individual goals aimed at developing community care coordination pathways and increasing access points for affordable healthcare in addition to other targeted outcomes. For a complete description of these programs, please *see Appendix 5*.

- Patient Centered Medical Home
- Comprehensive Primary Care
- Clinically Integrated Network
- Community Health Worker Program
- Internal Medicine Outpatient Clinic
- Center for Health And Aging
- Care Transition Project
- Prenatal Clinic
- Corporate Wellness Outreach

Desired Outcomes

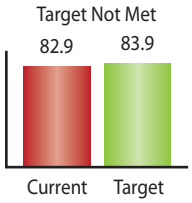
The Christ Hospital Health Network's goal is to align outcomes with those set nationally by HealthyPeople 2020, other national benchmarks as determined by the program and other local benchmarks, such as the United Way Bold Goals. Currently, the Healthy People 2020 national health target for adults with a usual source of healthcare is to increase the proportion of people with a usual primary care provider to 83.9 percent *(see Figure 10d)*; additionally the Healthy People 2020 national health target is to increase the proportion of people with health insurance to 100 percent.

Strategies

Through utilization of the earlier mentioned interventions and in collaboration with other community partners and programs, The Christ Hospital Health Network's desired outcome is to meet or exceed the HealthyPeople 2020 benchmark goal for adults with a usual source of healthcare. Statistically, this would mean a 1 percent increase over the next seven years in the number of residents who have a usual and appropriate source of care. For Hamilton County, this would require 1,143 residents every year to transition into some form of usual care. This will be attempted with community collaboration through education, advocacy and targeted programs like the subsidized services provided by the internal medicine outpatient clinic to the underinsured and uninsured population in Hamilton County, in addition to the many other resources already mentioned. These concentrated efforts are necessary to make access to care easier and the continuum of care more transparent.

Figure 10d

HP2020 goal for adults with a usual source of healthcare



Value	82.9 percent
Healthy people 2020 target:	83.9 percent
Measurement period:	2008
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Access to Health Services

Unit: percent

Source: Ohio Family Survey, 2008 and HealthyPeople 2020, 2012

OBESITY

Why it's important

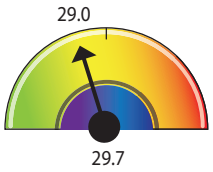
The percentage of obese adults is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions including heart disease, Type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Being obese also carries significant economic costs due to increased healthcare spending and lost earnings.

Where we are

According to data from 2010 for Hamilton County, 29 percent of adults aged 18 and older are obese according to the Body Mass Index (BMI). The BMI is calculated by taking a person's weight and dividing it by their height squared in metric units (BMI = Weight (Kg)/[Height (cm) ^ 2]). A BMI >=30 is considered obese *(see Figure 11a)*.

Figure 11a

Adults who are obese



Value	29.0 percent
Measurement period	2010
Location	County: Hamilton
Comparison	OH State Value
Categories	Health/Exercise, Nutrition & Weight Health/Diabetes Health/Heart Disease & Stroke

Comparison: 29.7

Unit: percent

Source: Behavioral Risk Factor Surveillance System (Centers for Disease Control), 2010

Interventions

The following list of programs is currently in place within The Christ Hospital Health Network. Each program targets a specific patient population and has set individual goals aimed at targeting behaviors that lead to obesity, reducing the amount of adults and children who are currently obese or overweight and managing the comorbidities associated with obesity. For a complete description of these programs, please *see Appendix 5*.

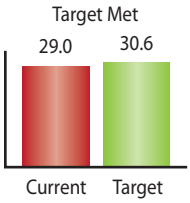
- Patient Centered Medical Home
- Comprehensive Primary Care
- Clinically Integrated Network
- Community Health Worker Program
- Internal Medicine Outpatient Clinic
- Corporate Wellness Outreach
- Complete Health Improvement Plan and other lifestyle modification and disease prevention programs
- Center for Closing the Health Gap Block by Block and Do Right! Programs
- American Heart Association – Go Red for Women Partnership including many grass-root intiatives such as: Have Faith in Heart; Girl Scout Education Program; Doctors Go Red for Women; Heart Healthy Tailgate and Restaurant program.
- YMCA and Cincinnati Sports Medicine reduced price, physician prescribed exercise programs

Desired Outcomes

The Christ Hospital Health Network's goal is to align outcomes with those set nationally by HealthyPeople 2020, other national benchmarks as determined by the program and other local benchmarks. Currently, the Healthy People 2020 national health target is to reduce the proportion of adults aged 20 and older who are obese to 30.6 percent *(see Figure 11b)*.

Figure 11b

Adults who are obese



Value	29.0 percent
Healthy people 2020 target:	30.6 percent
Measurement period:	2010
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Exercise, Nutrition & Weight Health/Diabetes Health/Heart Disease & Stroke

Unit: percent

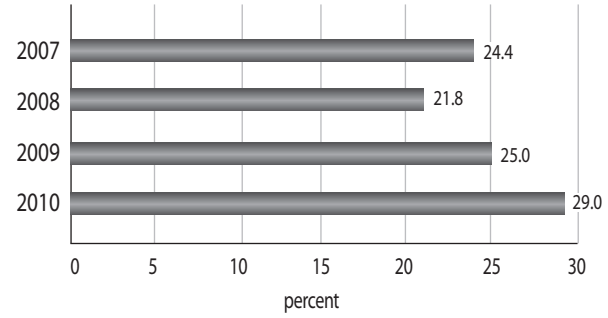
Source: Behavioral Risk Factor Surveillance System (Centers for Disease Control), 2010 and HeathyPeople 2020

Strategies

Although Hamilton County is currently at the HP2020 benchmark, it is very important to note that Hamilton County rates sharply increased between 2008 and 2010 by over 7 percent *(see figure 11c)*. Nationally, African Americans are more likely to be obese than white or Latinos according to HealthyPeople 2020. The complications of obesity are so far-reaching into other disease indicators, it is imperative that communities act now to slow and or reverse the ever-growing trend. In Hamilton county, this will be attempted with significant community collaboration through education on proper nutrition and the benefits of exercise; lifestyle and behavior modification training; advocacy for better food supplies in underserved and at-risk neighborhoods; and better access to fresh foods and exercise facilities.

Figure 11c

Time series data



Source: Behavioral Risk Factor Surveillance System (Centers for Disease Control), 2010

OTHER UNMET COMMUNITY HEALTH NEEDS

Two other areas were identified in Hamilton County by this Community Health Needs Assessment. These areas include sexually transmitted diseases including chlamydia, gonorrhea and syphilis and oral care. While we have chosen to focus the majority of our efforts on the identified Key Findings, we have reviewed all of the indicators and the resources currently available in Hamilton County and plan to continue monitoring each over the next three years for significant changes or developments. Additionally, many of these areas may be addressed in the future through partnerships with area agencies such as Health Care Access Now and The Greater Cincinnati Health Council. The following is a summary of each unmet need and our findings.

Sexually Transmitted Diseases

Why it's important

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24.3. The cost of STDs to the U.S. healthcare system is estimated to be as much as $15.9 billion annually[1]. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the United States.

Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile.

Where we are

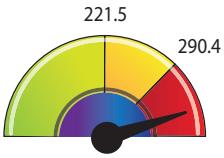
Chlamydia: Data from 2011 show 804.7 cases of chlamydia were reported for every 100,000 people in Hamilton County *(see Figure 12a)*.

Gonorrhea: Data from 2011 show 338.9 cases of gonorrhea were reported for every 100,000 people in Hamilton County *(see Figure 12b)*.

Syphilis: Data from 2011 show 44.9 cases of syphilis were reported for every 100,000 people in Hamilton County *(see Figure 12c)*.

Figure 12a

Chlamydia incidence rate



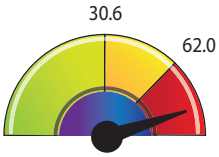
Value	804.7 cases/100,000 population
Measurement period	2011
Location	County: Hamilton
Comparison	OH Counties
Categories	Health/Immunizations & Infectious Diseases

Red > 290.4 Green <= 221.5 In-between = Yellow
Unit: cases/100,000 population

Source: Ohio Department of Health, Infectious Diseases, 2011

Figure 12b

Gonorrhea incidence rate



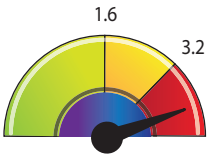
Value	338.9 cases/100,000 population
Measurement period	2011
Location	County: Hamilton
Comparison	OH Counties
Categories	Health/Immunizations & Infectious Diseases

Red > 62.0 Green <= 30.6 In-between = Yellow
Unit: cases/100,000 population

Source: Ohio Department of Health, Infectious Diseases, 2011

Figure 12c

Syphilis incidence rate



Value	44.9 cases/100,000 population
Measurement period	2011
Location	County: Hamilton
Comparison	OH State Value
Categories	Health/Immunizations & Infectious Diseases

Red > 3.2 Green <= 1.6 In-between = Yellow
Unit: cases/100,000 population

Source: Ohio Department of Health, Infectious Diseases, 2011

Conclusions

The Christ Hospital Health Network recognizes that sexually transmitted diseases, such as chlamydia, gonorrhea and syphilis pose a significant problem in Hamilton County and supports the HealthyPeople 2020 objectives to lower STDs nationwide by promoting healthy sexual behaviors, strengthening community

capacity, and increasing access to quality services to prevent sexually transmitted diseases (STDs) and their complications[1]. This is not an area where we have a significant amount of resources and therefore do not believe that we can make enough of an impact on these indicators alone. We will, however, continue to look for ways to support the community in this effort through community collaborations such as The Greater Cincinnati Health Council's A.I.M. for Better Health Collaborative. We will continue to monitor progress in this area and evaluate services to address the issue.

Other Area Resources

There are numerous other area resources in Hamilton County including Planned Parenthood of Southwest Ohio, University of Cincinnati Early Intervention Program and the Cincinnati Health Department.

Oral Health

Why it's important

Oral health has been shown to impact overall health and well-being. Nearly one-third of all adults in the United States have untreated tooth decay, or tooth cavities, and one in seven adults aged 35 to 44 years old has periodontal (gum) disease. Given these serious health consequences, it is important to maintain good oral health. It is recommended that adults and children see a dentist on a regular basis. Professional dental care helps to maintain the overall health of the teeth and mouth, and provides for early detection of pre-cancerous or cancerous lesions. Maintaining good oral health by using preventive dental health services is one way to reduce oral diseases and disorders.

Where we are

According to 2008 data, 12.9 percent of adults in Hamilton County needed dental care but could not get it within the past year *(see Figure 13a)*. The Healthy People 2020 national health target is to reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary dental care to 5 percent. *(see Figure 13b)*.

Conclusions

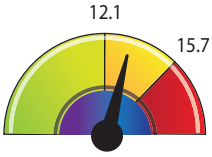
Dental care is central to a person's overall health and well-being and The Christ Hospital Health Network supports the HealthyPeople 2020 goal to prevent and control oral and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental care. This is not an area where we have a significant amount of resources and therefore do not believe that we can make enough of an impact on this indicator alone. We will, however, continue to look for ways to support the community in this effort through community partnerships such as The Greater Cincinnati Health Council's A.I.M. for Better Health Collaborative. We will continue to monitor progress in this area and evaluate services to address the issue.

Other Area Resources

Winton Hills Health Center, West End Health Center, Price Hill Health Center, Northside Health Center, Neighborhood Health Care Dental Center, Options Oral Health Council, University Hospital Oral Surgery Clinic, Elm Street Health Center, Anderson Health Center, Lincoln Heights Healthcare Connections Regional Family Dental Center, Cincinnati Children's Hospital Medical Center Dental Clinic, Dental One Over the Rhine and many others**.**

Figure 13a

Adults who could not receive needed dental care



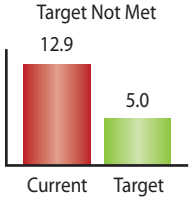
Value	12.9 percent
Measurement period	2008
Location	County: Hamilton
Comparison	OH Counties
Categories	Health/Oral Health Health/Access to Health Services

Red > 15.7 Green <= 12.1 In-between = Yellow
Unit: percent

Source: Ohio Family Survey, 2008

Figure 13b

Adults who could not receive needed dental care



Value	12.9 percent
Healthy people 2020 target:	5.0 percent
Measurement period:	2008
Location	County: Hamilton
Comparison	Healthy People 2020 Target
Categories	Health/Oral Health Health/Access to Health Services

Unit: percent

Source: Ohio Family Survey, 2008 and HealthyPeople 2020, 2012

COMMUNITY COLLABORATION

The community benefit mission of our organizations is to improve access to needed health care services and improve the health of our community by utilizing the information we have found in our community health needs assessment.

Fulfilling this mission is especially important now as we face constant pressure to reduce health care costs and do more with less. To improve community health in this environment, we should consider not only the health problems and risk factors traditionally addressed through our community benefit programs, but also, the economic, social and physical factors that affect the health of people in our community.

This work cannot be done alone. We need to work outside the walls of our facilities and partner with agencies and other community groups. These strategic partnerships can help us align with community-wide health improvement efforts and focus on prioritized needs, share resources and coordinate implementation efforts.

The Christ Hospital Health Network continues to meet with healthcare leaders in the community in order to access and address the health needs of our community. Agencies such as The Greater Cincinnati Health Council, whose efforts have brought together the area's leading healthcare providers to identify the most pressing healthcare issues in the 14 county service area and to work together to identify and implement best practices and solutions.

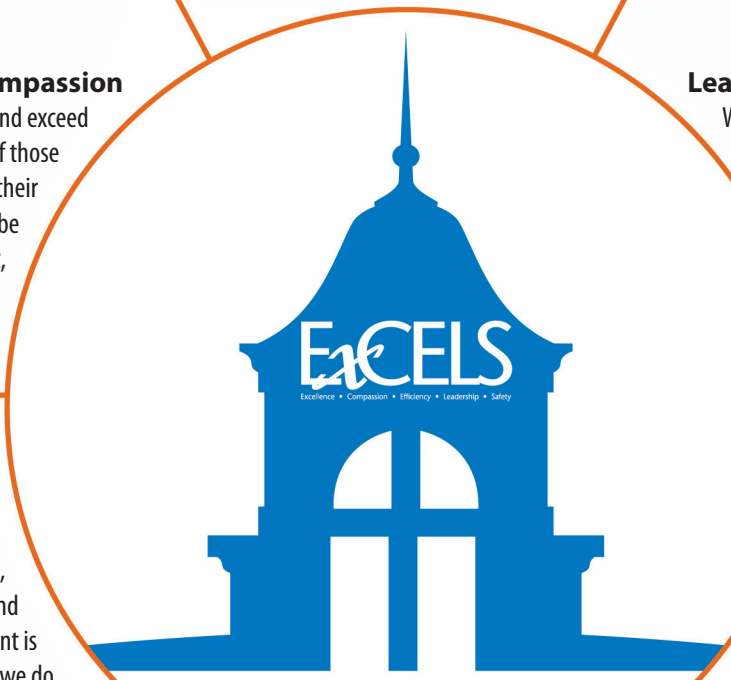
Additionally, we will continue to have dialog with the United Way of Greater Cincinnati to ensure better alignment with and attainment of their Bold Goals for 2020 in healthcare for this region. Further collaboration with the Hamilton County Public Health Administration will continue as we work together to address some of the most pressing issues within Hamilton County. Working together gives us clear objectives, increased collaboration and ultimately better outcomes.

This is often the only way to bring about the policy and system-wide changes that are needed to address the root causes of health problems.

Efficiency
We persistently strive to provide timely and seamless access to services, resulting in high-quality outcomes, strong performance, increased satisfaction and a safe environment.

Compassion
We work to understand and exceed the diverse expectations of those we serve. We understand their most basic expectation is to be treated with courtesy, respect, empathy and dignity.

Leadership
We play an integral role in the progression of the organization. Our words and actions serve as examples to guide others. As leaders, we must constantly grow and pave a path for others to do the same.



Excellence
We are committed to providing the highest quality service to meet the needs of our patients, employees, physicians and community. This commitment is reflected in all that we do.

Safety
We use all resources at our disposal to ensure safety of those we serve.

OUR CORE VALUES

OUR VISION:
We will be a national leader in clinical excellence and patient experience.

OUR MISSION:
To provide the finest patient experience and improve the health of our community.

APPENDIX 2

TCHHN PRIMARY SERVICE AREA MAP

HEALTH	Source
ACCESS TO QUALITY HEALTH SERVICES	
Adults with Health Insurance	American Community Survey
Children with Health Insurance	American Community Survey
Adults with a Usual Source of Health Care	Ohio Family Survey
CHRONIC DISEASES	
Cancer:	
Age-Adjusted Death Rate due to Breast Cancer	National Cancer Institute
Age-Adjusted Death Rate due to Colorectal Cancer	National Cancer Institute
Age-Adjusted Death Rate due to Lung Cancer	National Cancer Institute
Age-Adjusted Death Rate due to Prostate Cancer	National Cancer Institute
Breast Cancer Incidence Rate	National Cancer Institute
Cervical Cancer Incidence Rate	National Cancer Institute
Colorectal Cancer Incidence Rate	National Cancer Institute
Lung Cancer Incidence Rate	National Cancer Institute
Oral Cancer Incidence Rate	National Cancer Institute
Prostate Cancer Incidence Rate	National Cancer Institute
Colon Cancer Screening	Behavioral Risk Factor Surveillance System
Mammogram History	Behavioral Risk Factor Surveillance System
PAP Test History	Behavioral Risk Factor Surveillance System
Diabetes:	
Adults with Diabetes	Behavioral Risk Factor Surveillance System
Age-Adjusted Death Rate due to Diabetes	Ohio Department of Health- Vital Statistics
Diabetic Screening	County Health Rankings
Heart Disease and Stroke:	
Age-Adjusted Death Rate due to Cerebrovascular Disease	Ohio Department of Health- Vital Statistics
Age-Adjusted Death Rate due to Heart Disease	Ohio Department of Health- Vital Statistics
High Blood Pressure Prevalence	Behavioral Risk Factor Surveillance System
Respiratory Diseases	
Adults with Asthma	Behavioral Risk Factor Surveillance System
Children with Asthma	Ohio Family Survey
COMMUNICABLE DISEASES AND IMMUNIZATIONS	
Influenza Vaccination Rate 65+	Behavioral Risk Factor Surveillance System
Pneumonia Vaccination Rate 65+	Behavioral Risk Factor Surveillance System
Chlamydia Incidence Rate	Ohio Department of Health- Infectious Diseases
Gonorrhea Incidence Rate	Ohio Department of Health- Infectious Diseases
Syphilis Incidence Rate	Ohio Department of Health- Infectious Diseases
Tuberculosis Incidence Rate	Ohio Department of Health- Infectious Diseases
Age-Adjusted Death Rate due to Influenza and Pneumonia	Ohio Department of Health- Vital Statistics
HIV/AIDS Prevalence	Ohio Department of Health- Infectious Diseases
DISABILITIES	
Adults with Disability	Behavioral Risk Factor Surveillance System
FAMILY PLANNING	
Teen Birth Rate	Ohio Department of Health- Vital Statistics
Teen Pregnancy	Ohio Department of Health- Vital Statistics
FOOD SAFETY	
Salmonella Incidence Rate	Ohio Department of Health
INJURY AND VIOLENCE PREVENTION	
Age-Adjusted Death Rate due to Unintentional Injuries	Ohio Department of Health- Vital Statistics
Age-Adjusted Death Rate due to Poisoning	Ohio Department of Health- Vital Statistics
Age-Adjusted Death Rate due to Falls	Ohio Department of Health- Vital Statistics

HEALTH	Source
MATERNAL, FETAL, AND INFANT HEALTH	
Mothers who Received Early Prenatal Care	Ohio Department of Health- Vital Statistics
Babies with Low Birth Weight	Ohio Department of Health- Vital Statistics
Infant Mortality Rate	Ohio Department of Health- Vital Statistics
Preterm Births	Ohio Department of Health- Vital Statistics
Mothers who Smoked During Pregnancy	Ohio Department of Health- Vital Statistics
Very Low Birthweight	Ohio Department of Health- Vital Statistics
MENTAL HEALTH AND MENTAL DISORDERS	
Age-Adjusted Death Rate due to Suicide	Ohio Department of Health- Vital Statistics
Frequent Mental Distress	Ohio Family Survey
NUTRITION, PHYSICAL ACTIVITY AND WEIGHT	
Children who are Overweight or Obese: Grade 3	Ohio Department of Health
Adults Overweight or Obese	Behavioral Risk Factor Surveillance System
Adults who are Obese	Behavioral Risk Factor Surveillance System
Adults Engaging in Regular Physical Activity	Behavioral Risk Factor Surveillance System
Teens who are Obese	Ohio Family Survey
Adult Fruit and Vegetable Consumption	Behavioral Risk Factor Surveillance System
ORAL HEALTH	
Adults who Visited a Dentist	Behavioral Risk Factor Surveillance System
Adults with No Tooth Extractions	Behavioral Risk Factor Surveillance System
SUBSTANCE ABUSE AND TOBACCO USE	
Adult Binge Drinking	Behavioral Risk Factor Surveillance System
Adults who Smoke	Behavioral Risk Factor Surveillance System
WELLNESS & LIFESTYLE	
Self-Reported General Health Assessment	Behavioral Risk Factor Surveillance System

ECONOMY	Source
Children Living Below Poverty Level	American Community Survey
Families Living Below Poverty Level	American Community Survey
People Living Below Poverty Level	American Community Survey
People Over 65 Living Below Poverty Level	American Community Survey
Per Capita Income	American Community Survey
People Living 200% Above Poverty Level	American Community Survey
Median Household Income	American Community Survey
Minimum Wage Work Hours Needed to Afford 2-Bedroom Apartment	National Low Income Housing Coalition
Renters Spending 30% or More of Household Income on Rent	American Community Survey
Homeownership Rate	American Community Survey
Households with Public Assistance	American Community Survey
Unemployed in Civilian Labor Force	U.S. Bureau of Labor Statistics
Percent Low Income Receiving SNAP (food stamps)	U.S. Department of Agriculture - Food Environment Atlas
SNAP-Authorized Stores per 1,000 pop (food stamps)	U.S. Department of Agriculture - Food Environment Atlas
Percent Students Eligible for Free Lunch	U.S. Department of Agriculture - Food Environment Atlas
Foreclosure Rate	U.S. Department of Housing and Urban Development

EDUCATION	Source
4th grade students proficient in math	Ohio Department of Education
4th grade students proficient in reading	Ohio Department of Education
8th grade students proficient in math	Ohio Department of Education
8th grade students proficient in reading	Ohio Department of Education
Residents > 25 with BA degree or higher	American Community Survey
High School Completion Rate	Ohio Department of Education
Student-to-Teacher Ratio	National Center for Education Statistics

SOCIAL ENVIRONMENT	Source
Child Abuse Rate	Kids Count Data Center
Violent Crime Rate	Ohio Department of Public Safety Office of Criminal Justice Services
Voting Rate	Ohio Secretary of State

BUILT ENVIRONMENT	Source
Grocery Store Density (per 1,000 population)	U.S. Department of Agriculture - Food Environment Atlas
Fast-food Restaurants Density	U.S. Department of Agriculture - Food Environment Atlas
Farmers' Markets Density	U.S. Department of Agriculture - Food Environment Atlas
Recreation & Fitness Facilities Density	U.S. Department of Agriculture - Food Environment Atlas
Percent Low Income & >1 mi to Store	U.S. Department of Agriculture - Food Environment Atlas
Percent Households No Car & > 1 mi to store	U.S. Department of Agriculture - Food Environment Atlas

ENVIRONMENT	Source
Annual Ozone Air Quality	American Lung Association
Annual Particle Pollution	American Lung Association
Daily Ozone Air Quality (Air Monitor Located in Cincinnati)	AIRNow
Daily Particle Pollution (Air Monitor Located in Cincinnati)	AIRNow
Releases of Recognized Carcinogens into Air	Environmental Protection Agency
PBT Released	Environmental Protection Agency

TRANSPORTATION and TRANSPORTATION SAFETY	Source
Mean Travel Time to Work	American Community Survey
Mode of Getting to Work: % Drove Alone	American Community Survey
Mode of Getting to Work: Public Transit	American Community Survey
Age-Adjusted Death Rate Due to Motor Vehicle Collisions	Ohio Department of Health- Vital Statistics

HOSPITALIZATION DATA (analyzed and displayed on Community Dashboard once data file is received)

Inpatient Admission Rates

Hospitalization Rate Due to Adult Asthma	ER Visit Rate Due to Adult Asthma
Hospitalization Rate Due to Asthma	ER Visit Rate Due to Asthma
Hospitalization Rate Due to Alcohol Abuse	ER Visit Rate Due to Alcohol Abuse
Hospitalization Rate Due to Congestive Heart Failure	ER Visit Rate Due to Congestive Heart Failure
Hospitalization Rate Due to COPD	ER Visit Rate Due to COPD
Hospitalization Rate Due to Dehydration	ER Visit Rate Due to Dehydration
Hospitalization Rate Due to Diabetes	ER Visit Rate Due to Diabetes
Hospitalization Rate Due to Hepatitis	ER Visit Rate Due to Hepatitis
Hospitalization Rate Due to Urinary Tract Infection	ER Visit Rate Due to Urinary Tract Infections
Hospitalization Rate Due to Long-term Complications of Diabetes	ER Visit Rate Due to Long-term Complications of Diabetes
Hospitalization Rate Due to Bacterial Pneumonia	ER Visit Rate Due to Bacterial Pneumonia
Hospitalization Rate Due to Short-term Complications of Diabetes	ER Visit Rate Due to Short-term Complications of Diabetes
Hospitalization Rate Due to Uncontrolled Diabetes	ER Visit Rate Due to Uncontrolled Diabetes
Emergency Department Admission Rates	

At or below HP2020 benchmark

Trending even or negative

Access to Care

1. Adults with a usual source of health care
   Hamilton County compared to all Ohio Counties: 82.9 %
   Healthy People 2020 Benchmark: 83.9 percent
   No trend data available

Cancer

1. Age adjusted death rate due to breast cancer
   Hamilton County compared to all US counties: 24.9 deaths/100,000
   Healthy People 2020 Benchmark: 20.6 deaths/100,000
   Trending positive

2. Age adjusted death rate due to prostate cancer
   Hamilton County compared to all US counties: 26.1 deaths/100,000
   Healthy People 2020 Benchmark: 21.2deaths/100,000
   Trending positive

3. Breast cancer incidence rates
   Hamilton County compared to all US counties: 123.2/100,000
   No HP2020 benchmark
   Trending negative

4. Mammogram history
   Hamilton County compared to all Ohio counties: 71.3%
   No HP2020 benchmark
   Trending negative

Diabetes

1. Adults diagnosed with diabetes
   Hamilton County compared to all Ohio counties: 9.2%
   Healthy People 2020 Benchmark: 7.2%
   Trending positive

6. Hospitalization rate due to short term affects of diabetes
   Hamilton County compared to all Ohio counties: 8.7/10,000
   No HP2020 benchmark
   Trending negative

Exercise/Nutrition/Weight

1. Adults who are obese
   Hamilton County compared to all Ohio counties: 29%
   HP2020 benchmark: 30.6
   Trending negative

Heart disease and stroke

1. Age adjusted death rate due to stroke
   Hamilton County compared to all Ohio counties: 46.6/10,000
   HP2020 benchmark: 33.8
   Trending positive

2. High blood pressure prevalence
   Hamilton County compared to all Ohio counties: 28.6%
   HP2020 benchmark: 26.9%
   Trending negative

3. High Cholesterol prevalence
   Hamilton Counties compared to all Ohio counties: 35.6*
   HP2020 benchmark: 13.5%
   Trending positive

Immunizations and infectious diseases

1. Chlamydia Incidence Rate
   Hamilton County compared to all Ohio counties: 804.7/100,000
   No comparative HP2020 benchmark
   Trending negative

2. Gonorrhea Incidence rate
   Hamilton County compared to all Ohio counties: 338.9/100,000
   HP2020 Benchmark: Females 257 new cases
   Trending negative

Maternal, Fetal and Infant Health

1. Babies with low birth weight
   Hamilton County compared to all Ohio counties: 10.2%
   HP2020 benchmark: 7.5%
   Trending even

2. Babies with very low birth weight
   Hamilton County compared to all Ohio counties: 2.1%
   HP2020 benchmark: 1.4
   Trending even

3. Infant mortality rate
   Hamilton County compared to all Ohio counties: 11.1 deaths/1,000
   HP2020 benchmark: 6 deaths/1,000
   Trending negative

4. Mothers who received prenatal care
   Hamilton County compared to all Ohio counties: 60.1%
   HP2020 benchmark: 77.9%
   Trending negative

5. Preterm babies
   Hamilton County compared to all Ohio counties: 13.7%
   HP2020 benchmark: 11.4%
   Trending positive

Oral Health

1. Adults who could not receive needed dental care
   Hamilton County compared to all Ohio counties: 12.9%
   HP2020 benchmark: 5%
   No trend data available

APPENDIX 5
SUMMARY OF THE CHRIST HOSPITAL HEALTH NETWORK'S SIGNIFICANT COMMUNITY HEALTH PROGRAMMING IN RESPONSE TO IDENTIFIED UNMET NEED

TCHHN Program	Brief Description	Demographic/Geographic Target of Program	Desired Outcome	Method of Evaluation	Targeted CHNA Key Finding
Patient Centered Medical Home (PCMH)	National Committee for Quality Assurance (NCQA) program focused on improving patient care in the primary care setting by facilitating partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. Program currently exists in 25 primary care offices of The Christ Hospital Physicians (TCHP), with systematic expansion to all primary care or family medicine practices by Fiscal Year 2015.	Program targets patients in their existing primary care setting who demonstrate specific morbidities that include: hyperglycemia, hypertension and hyperlipidemia.	Improved disease management by lowering blood lipids, sugar and lowering blood pressure rates to manageable levels through education, lifestyle changes and improved continuum of care.	Levels and compliance are measured through electronic medical record (EMR); once patient is identified as meeting PCMH criteria, patient is flagged in electronic medical record; monthly reports are generated and reviewed by clinical management.	Access to Care Chronic Disease Management
Comprehensive Primary Care (CPC)	The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative fostering collaboration between public and private healthcare payers to strengthen primary care. Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients. Out of 75 practices participating in the Ohio/Kentucky region, 16 of those practices are part of TCHHN. Practices were selected through a competitive application process based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by accreditation bodies, service to patients covered by participating payers, participation in practice transformation and improvement activities, and diversity of geography, practice size and ownership structure.	Existing Medicare/Medicaid patients within primary care setting with serious or multiple medical conditions.	Improved disease management by lowering blood lipids, sugar and lowering blood pressure rates to manageable levels through education, lifestyle changes and improved continuum of care.	Customized tracking in electronic medical record (EMR); additional reporting vehicles through CPC program for outcomes. Participation in collaborative community wide electronic communication system called Healthbridge across medical systems and practices for improved continuum of care.	Access to Care Chronic Disease Management
Clinically Integrated Network	The Christ Hospital Clinically Integrated Network brings together more than 400 quality-focused physicians and The Christ Hospital with the focus on better outcomes and more coordinated care at less cost. As a result, patients benefit from more coordinated care, better communication, education and preventative care. With over 100 primary care doctors and nearly 300 specialists in 25 specialties, The Christ Hospital Clinically Integrated Network is the largest physician membership network in the region.	Existing and new patients	Better access to care; better coordinated care across the patient experience; better disease management through universally accepted outcomes and measurements.	Customized tracking in electronic medical record; electronic dashboard	Access to Care Chronic Disease Management

TCHHN Program	Brief Description	Demographic/Geographic Target of Program	Desired Outcome	Method of Evaluation	Targeted CHNA Key Finding
Community Health Worker Program	The Christ College of Nursing and Health Sciences (TCCNHS) was approved by the Ohio Board of Nursing (OBN) to operate its first health science program called the Community Health Worker Program (CHWP). The CHWP at TCCNHS is one of only three of its kind in the Greater Cincinnati area. The CHWP introduces students to community health concepts, resources and skills necessary for a role as a community health worker. The College's CHWP will utilize a competency-based curriculum (130 contact hours) followed by placement in community healthcare setting(s) for 175 hours of practicum experience that includes 165 hours of direct role experiences and10 hours of simulated competency testing. The practicum experience takes advantage of a variety of clinical platforms that expose the student to primary care practices, medical home models of care delivery and home care across the lifespan. CHWs offer a personalized way to support consumers in understanding how to navigate across systems of care, reduce barriers to care, achieve better health status and reduce health costs.	Existing and new patients identified in the primary care settings, as well as other at risk population clinics or clinical settings within the area. CHWs would be integrated into primary care setting with a case load of approximately 30 qualified patients who meet certain criteria such as: chronic inappropriate use of emergency department; chronic non-compliance with disease management such as hypertension, hyperlipidemia; and hyperglycemia.	Better access to care/ more appropriate use of care through improved communication with the patient, family and staff. Better disease management with education, increased communication, lifestyle and behavior modification	Customized tracking in electronic medical record;	Access to Care Chronic Disease Management
Internal Medicine Outpatient Clinic	Physicians and staff at The Christ Hospital are committed to the hospital's mission of providing the best care to the community, regardless of a patient's ability to pay or their insurance coverage. Our Internal Medicine Outpatient Clinic is designed to provide a wide array of healthcare services, at a low cost to those without insurance. Primary care physicians give ongoing medical care several days a week to several thousand patients per year.	Uninsured or underinsured patients of Hamilton County and a limited amount of residents from other counties/zip codes. All patients must meet Department Of Health And Human Services Federal Poverty Guidelines.	Access of care for indigent and at-risk population within Hamilton County; better chronic disease management; targeted diabetes education; subsidized prescription drug program	Electronic medical record; continuum of care coordination through the internal medicine residency program	Access to Care Chronic Disease Management
Center for Health And Aging	Geriatrics at The Christ Hospital is placed among the country's top 50 hospitals in *U.S.News & World Report* because of local and national initiatives currently taking place inside the hospital. The hospital has now extended this service to the community through the region's first outpatient primary care geriatric center. The Christ Hospital Center for Health and Aging provides comprehensive, coordinated care for older adults who have interacting chronic medical conditions while offering support in dealing with the emotional, social and economic strain illness may bring.	At-risk or vulnerable geriatric population.	Provide more comprehensive, streamlined care for the vulnerable geriatric patient to increase better outcomes, facilitate better quality of life and lower costs.	Electronic medical record; comprehensive reporting through center.	Access to Care Chronic Disease Management

TCHHN Program	Brief Description	Demographic/Geographic Target of Program	Desired Outcome	Method of Evaluation	Targeted CHNA Key Finding
Care Transition Project	The Christ Hospital Health Network, in collaboration with the Council on Aging, is participating in the Center for Medicaid and Medicare Services program aimed at helping older adults transition smoothly among different care settings. The funding will allow the collaborative to expand the successful program Council on Aging has started at University Hospital and The Christ Hospital. The funding will allow the collaborative to expand Care Transitions to all Medicare patients hospitalized at the participating hospitals and diagnosed with heart failure, heart attack, pneumonia, or multiple chronic conditions. Centers for Medicare Medicaid Services (CMS) identified the programs and partnerships around the country that have demonstrated effectiveness at reducing harm to older hospital patients, returning them home as quickly as possible, and preventing avoidable and costly readmissions to the hospital. CMS will measure funding recipients on their ability to reduce hospital readmissions, improve patient satisfaction, and generate savings to Medicare	At risk geriatric population with chronic disease condition, heart failure, heart attach or pneumonia; specifically those who receive Medicare benefits.	The program uses coaching, health information technology, help with medications, and chronic disease management to help hospitalized seniors get home and stay home, with reduced readmissions	Electronic medical record; comprehensive reports with care providers and Council on Aging.	Access to Care Chronic Disease Management
Prenatal Clinic	Through the services offered at the Prenatal Clinic, patients can receive the following prenatal care for a set fee, including: • Regular prenatal visits • One ultrasound • Delivery at The Christ Hospital • Postpartum care • Normal infant care • Postpartum check up The Prenatal Clinic is also a designated Center for Centering Pregnancy. Centering Pregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education, and support, into a unified program within a group setting. Through this unique model of care, women are empowered to choose health-promoting behaviors. Health outcomes for pregnancies, specifically increased birth weight and gestational age of mothers that deliver preterm, and the satisfaction expressed by both the women and their providers, support the effectiveness of this model for the delivery of care.	Uninsured or underinsured patients of Hamilton County and a limited amount of residents from other counties/zip codes. All patients must meet DEPARTMENT OF HEALTH AND HUMAN SERVICES Federal Poverty Guidelines	Increase access of care for pregnant mothers; decrease risk of complications due to low birth weight, gestational diabetes, infant mortality and others.	Electronic medical record; comprehensive reporting with the care providers and center coordinators.	Access of care; Maternal and Fetal Health

TCHHN Program	Brief Description	Demographic/Geographic Target of Program	Desired Outcome	Method of Evaluation	Targeted CHNA Key Finding
March of Dimes	The Christ Hospital Health Network is a sponsor for the March of Dimes – March for Babies each year. Additionally, our Prenatal Clinic is a certified Center for Centering Pregnancy. The March of Dimes mission is to help moms have full-term pregnancies and research the problems that threaten the health of babies. In 2011, through their efforts, measurable headway was made in their national campaign to prevent premature birth. The preterm birth rate dropped for the 4th consecutive year. They expanded their support to families with a baby in newborn intensive care to more than 114 hospitals in different communities in every state. They also e reached out to thousands of moms-to-be with vital information about how to have a healthy pregnancy. Behind the scenes, $31 million was invested in research to further study premature birth, birth defects and infant mortality. By supporting them in their mission, we are working hard to understand why these serious problems happen and to offer treatments and preventions.	At-risk expectant mothers or new mothers and babies in vulnerable populations, such as uninsured, underinsured, African American, Latino and under the age of 18.	To improve the health of babies and support families if something does go wrong.	The Center for Centering Pregnancy program tracks participants in the electronic medical record; comprehensive reporting with the care providers and center coordinators during and following pregnancy.	Maternal and Fetal Health
Outpatient Clinics – other	Physicians and staff at The Christ Hospital are committed to the hospital's mission of providing the best care to the community, regardless of a patient's ability to pay or their insurance coverage. Our Outpatient Clinics are designed to provide a wide array of health care services, at a low cost to those without insurance. Clinics (other than pre-natal and internal medicine) include: Ob/Gyn, Family Medicine; Congestive Heart Failure; Nephrology; Rheumatology; Orthopaedic; and Colorectal	Uninsured or underinsured patients of Hamilton County and a limited amount of residents from other counties/zip codes. All patients must meet DEPARTMENT OF HEALTH AND HUMAN SERVICES Federal Poverty Guidelines	Access of care for indigent population within Hamilton County; better disease management for specific specialties including heart failure, breast and reproductive cancer and colorectal cancer patients	Electronic medical record; comprehensive reporting with the care providers and center coordinators.	Access to Care Chronic Disease Management
The Carl and Edyth Lindner Research Center	The Carl and Edyth Lindner Research Center at The Christ Hospital has participated in over 1000 clinical research trials (130 active trials) and has introduced most of the new techniques in cardiovascular medicine over the past 20 years. These studies have included first-in-man as well as first-in-the-U.S. experiences with leading-edge techniques. A national leader in clinical research, The Lindner Center brings some of the newest and most advanced technologies and treatments to Greater Cincinnati patients - long before they are available to the general public and other physicians.	With support from private industry and the National Institutes of Health, The Lindner Center strives to identify the most promising therapies and provide them at a reduced cost to their patients. The center works hard to establish satisfying relationships with patients and referring physicians.	Cardiovascular disease, musculoskeletal, women's health and other research	Ongoing monitoring is completed on a trial by trial basis.	Access to Care Chronic Disease Management

APPENDIX 5 *(continued)*
SUMMARY OF THE CHRIST HOSPITAL HEALTH NETWORK'S SIGNIFICANT COMMUNITY HEALTH PROGRAMMING IN RESPONSE TO IDENTIFIED UNMET NEED

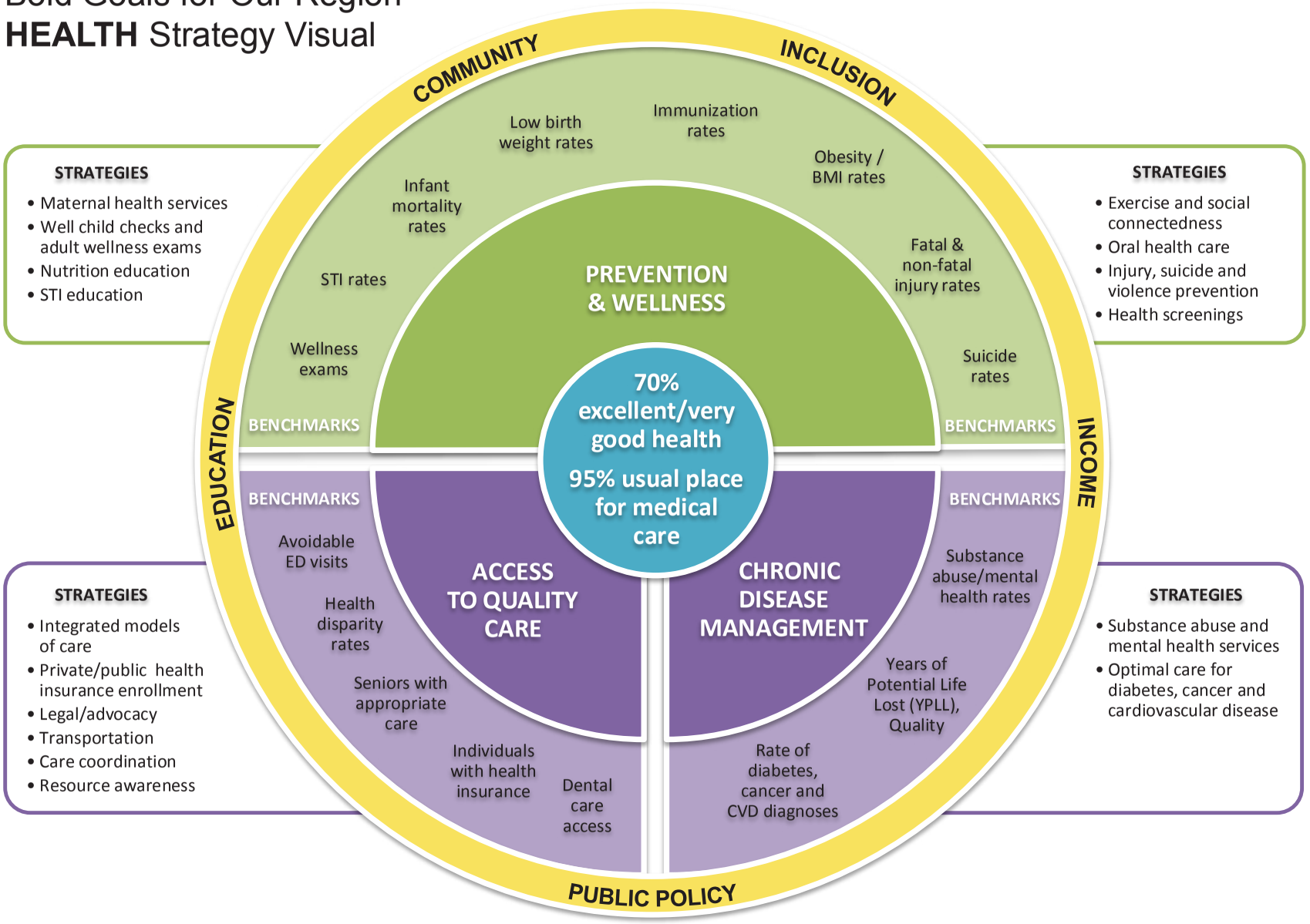
TCHHN Program	Brief Description	Demographic/Geographic Target of Program	Desired Outcome	Method of Evaluation	Targeted CHNA Key Finding
Community Based Lifestyle Modification and Disease Prevention Programs	**Complete Health Improvement Program** - A 40- hour comprehensive, educationally intensive lifestyle intervention program designed to prevent, arrest and reverse essential hypertension, type 2 diabetes, pbesity, heartburn, depression, elevated cholesterol and heart disease. CHIP focuses on an eating plan built on a foundation of a wide variety of nutrient-dense "foods as grown". Through this program you will learn to make better choices when grocery shopping, cooking and when attending parties and dining out. The CHIP motto is "Healthy by Choice, not by Chance." In this program cholesterol levels drop an average of 10-20 percent; weight loss averages seven pounds in 30 days; diabetes and blood pressure medications are often reduced or sometimes eliminated; better sleep and higher energy levels are commonly reported by participants. **Scale to Success** – a seven week weight management program which includes nutritional and exercise coaching. **Targeting Tobacco** - Targeting Tobacco is a six week tobacco cessation wellness coaching program customized to target the triggers that send you back to tobacco use.	CHIP targets those individuals that are at risk or have diabetes, pre-diabetes and heart disease. Scale to Success is designed for those individuals that need 10-30 lbs of weight loss and desire an increased knowledge of nutrition and as well as increased weekly accountability. Targeting tobacco is designed for any individual that uses any type of tobacco products	10% Decrease in Total Cholesterol HDL LDL Triglycerides Weight Blood pressure Resting heart rate 2% decrease in fasting glucose Improvement in nutritional habits measured by decrease in animal products and increase in plant based selections Scale to Success and average decrease in weight of 2 lbs per week Tobacco Cessation by 80% of the class	Pre/Post blood work/ biometrics Pre/Post CHIP Intake form for nutritional assessment Pre/Post weight measures Pre tobacco usage - on enrollment form Post tobacco usage - eval form	Chronic Disease Management Obesity
American Diabetes Association	The American Diabetes Association provides education, advocacy and research to prevent, cure and manage diabetes.	Greater Cincinnati community for education; at-risk population for pre-diabetes or diabetes; existing patients with diabetes	Increase research, screenings for at-risk populations and community awareness through education and advocacy.	Program sponsorship is evaluated annually.	Chronic Disease Management
Center for Closing the Health Gap Block by Block program	Neighborhood health watch pilot program aimed at reducing and preventing obesity among children, adolescents and adults with a block by block model approach using education, advocacy and eliminating barriers to necessary community resources such as access to fresh foods and exercise facilities.	Initial pilot to target at-risk blocks within Mt. Auburn (neighborhood where hospital resides). Household will consist of at least 1 adult and 1 child.	Provide education and resources to engage and empower area residents to relearn behaviors associated with food intake and exercise to decrease obesity and its comorbidities.	Biometric data will be acquired and monitored throughout and beyond process. Continued monitoring of participants as they migrate into other community resources	Chronic Disease Management Obesity
American Heart Association – Go Red Initiative	The Christ Hospital is proud to be the Cincinnati Goes Red presenting sponsor of The American Heart Association's Go Red for Women initiative. Go Red for Women is the American Heart Association's grassroots movement that celebrates the energy, passion, and power of women to band together and wipe out heart disease. Go Red is active in the community year-round educating women about their risk of heart disease and stroke through the Cincinnati Goes Red cause initiative. Community programs include: Have faith in heart, Girl Scout program, Doctors Go Red for Women, Heart Healthy Tailgate, Restaurant Program	Greater Cincinnati community, specifically women and those at-risk for heart disease through advocacy, research, education and screenings.	Decrease and prevent heart disease in men and women; lower mortality rates of women with heart disease;	Sponsorship programs are consistently monitored and tracked for participation and outcomes.	Chronic Disease Management Obesity

TCHHN Program	Brief Description	Demographic/Geographic Target of Program	Desired Outcome	Method of Evaluation	Targeted CHNA Key Finding
YMCA	**Fitness 90 for $90** – Physician prescribed exercise program at any area YMCA at a greatly reduced price. TCHHN works directly with the YMCA to identify and refer at risk patients to this program. **Pre-diabetes program** - the YMCA's Diabetes Prevention Program can participants develop a healthier lifestyle and reduce the risks this condition can pose to their health. Based on effective efforts researched by the National Institutes of Health and the Centers for Disease Control and Prevention, the YMCA's Diabetes Prevention Program will help participants learn about and adopt the healthy eating and physical activity habits that have been proven to reduce the risk of developing Type 2 diabetes. Through the program they will receive support and encouragement from both a trained lifestyle coach and fellow classmates as you develop a plan for improving and maintaining your overall well-being. TCHHN works collaboratively with the YMCA to identify qualified candidates to refer to the program through the primary care providers. Additionally, TCHHN also provides financial support of the program.	Anyone within TCHHN patient population at risk for diabetes or obesity; also, discounts and programs are offered to all of our numerous community and corporate partners.	Through education and lifestyle changes, we hope to reduce the levels of obesity and its common risk factors and comorbidities by encouraging exercise. Additionally, by identifying patients who are at risk for diabetes, we hope to prevent the disease onset through education and lifestyle changes.	Monitoring is completed at the patient/physician level in addition to extensive tracking done by the YMCA	Chronic Disease Management Obesity
Cincinnati Sports Club (CSC)	60 for 60 Program - Physician prescribed exercise program at the CSC facility at a greatly reduced price. TCHHN works directly with CSC to identify and refer at risk patients to this program.	Anyone within TCHHN patient population at risk for obesity; also, discounts and programs are offered to all of our numerous community and corporate partners.	Through education and lifestyle changes, we hope to reduce the levels of obesity and its common risk factors and comorbidities by encouraging exercise.	Monitoring is completed at the patient/physician level	Chronic Disease Management Obesity
American Cancer Society - Making Strides	A powerful and inspiring opportunity to unite as a community to honor breast cancer survivors, raise awareness about steps we can take to reduce the risk of getting breast cancer, and raise money to help the American Cancer Society fight the disease with breast cancer research, information and services, and access to mammograms for women who need them. TCH typically presents as the flagship sponsor of the Cincinnati event.	Tri-state area participates in the yearly Making Strides for Breast Cancer Walk to raise money for treatments, research, etc. for the ACS.	Raise money for research, advocacy and awareness.	Sponsorship is monitored and evaluated annually.	Chronic Disease Management

APPENDIX 5 *(continued)*
SUMMARY OF THE CHRIST HOSPITAL HEALTH NETWORK'S SIGNIFICANT COMMUNITY HEALTH PROGRAMMING IN RESPONSE TO IDENTIFIED UNMET NEED

TCHHN Program	Brief Description	Demographic/Geographic Target of Program	Desired Outcome	Method of Evaluation	Targeted CHNA Key Finding
Subsidized Mammography Screenings	American Cancer Society "BEST Program" – given out on calendar year basis.	TCH serving areas – Hamilton, Butler Counties; specifically the underinsured and uninsured women over 40	Increase access to screenings for at risk populations and navigating the continuum of care for those who present with disease findings.	Monitoring through American Cancer Society and electronic medical record for finding and follow through care	Access to Care Chronic Disease Management – Breast Cancer
Breast Cancer Patient Navigator	Proactive approach to helping patients overcome the barriers of health care system and provide more ease to accessing breast health services at TCH and resources needed in the community. Provide preventative and survivorship resources to increase breast health knowledge and quality of life both during and after treatment. By helping women to navigate the healthcare system, navigators provide the vision that gives women hope, strength, support, guidance, and knowledge to better manage their disease.	Newly diagnosed and existing cancer patients with diagnosis of breast cancer and or entering TCH system for Breast Health Needs. Support not only the patient but his or her family with resources needed that will assist in coping and managing emotions, side effects, etc. during and after treatment.	Increase access, increase TCH service use and or decrease outmigration, patient satisfaction, process management (lean processes for sites for increased patient satisfaction with services)	Electronic medical record	Access to Care Chronic Disease Management
Prostate Cancer Collaborative	Physician led committee designed to improve patient care for prostate patients through better coordination of care and increased access to specialist. Additional resources for increased screenings and education in the community on prevention and treatment.	Existing prostate patients within patient population and Greater Cincinnati community, specifically men within at-risk demographics.	By eliminating barriers and access to healthcare services, the goal is to help the patient navigate the healthcare delivery system more efficiently in order to produce better outcomes, reduce cost and provide a better continuum of care.	Electronic medical record	Access to Care Chronic Disease Management
The Christ Hospital Cancer Center Research	The Christ Hospital offers clinical research study participation opportunities to our extended community in both breast and prostate cancer, in addition to others.. Most commonly, clinical research refers to new drug testing. The clinical testing of experimental drugs is normally done in three phases, each successive phase involving a larger number of people. The center also offers research studies that include dietary effects on disease states and those centered on epidemiology of disease states in certain populations.	The Greater Cincinnati community, specifically those affected with cancer.	Cancer research	Monitoring is completed on a trial by trial basis.	Chronic Disease Management

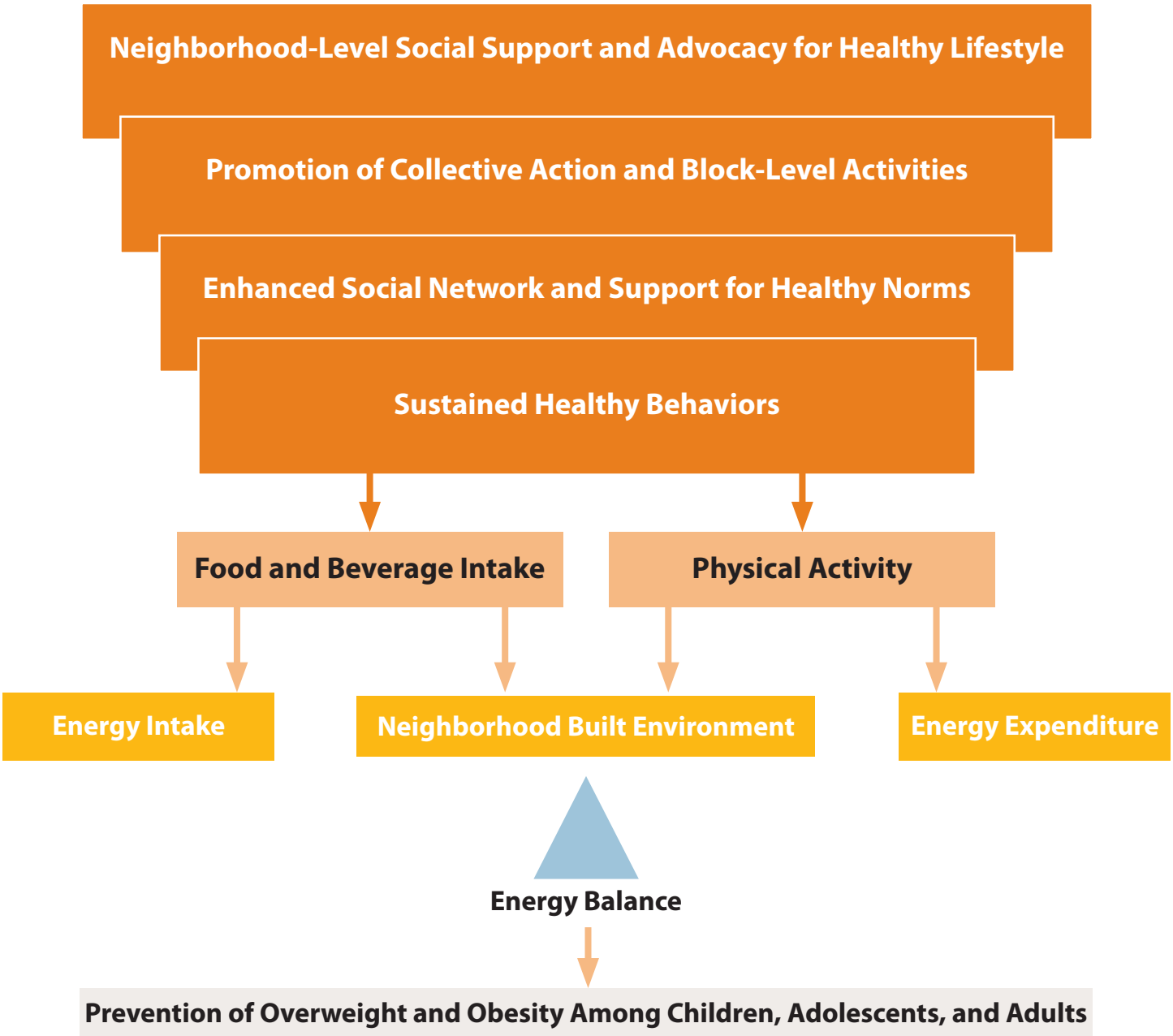
Bold Goals for Our Region
HEALTH Strategy Visual



Note: United Way of Greater Cincinnati convened key stakeholders from throughout the region to develop the Bold Goals and to identify the strategies that we must collectively focus on if we are to achieve these Goals. The Goals and strategies are not solely the responsibility of United Way nor do they represent the totality of the stakeholders' missions.

APPENDIX 7

THE CENTER FOR CLOSING THE HEALTH GAP NEIGHBORHOOD LEVEL CONCEPTUAL MODEL FOR OBESITY PREVENTION



APPENDIX 8
TCHHN CHARITY CARE POLICY

POLICY TITLE	**Financial Assistance Program**
APPROVED BY	**Chief Financial Officer**
ORIGINATED BY	**Director of Patient Financial Services**
REVIEWED/REVISED	**July 1, 2013**

POLICY Financial Assistance Program

PURPOSE

To proactively offer, educate and assist patients and their families with financial assistance options and flexible payment plans. The Christ Hospital recognizes that some uninsured and underinsured patients and their families do not have the ability to pay for their healthcare or can only afford to pay a portion of the charges.

The hospital is committed to helping uninsured and underinsured patients' secure financial assistance through the state Medicaid program, state and local financial assistance programs or flexible payment plans to resolve their hospital bill in a timely manner. The options available to patients are outlined in this policy.

Under the provisions of section 5112 of the Ohio Revised Code (ORC), The Christ Hospital is required to provide basic, medically necessary hospital-level services without charge to Ohio residents whose gross income is at or below the federal poverty guidelines, with the exception of non-covered services. Services must be ordered by an Ohio licensed physician and delivered at a hospital where the physician has privileges. Current recipients of the Disability Assistance Program (DA) are also deemed to qualify for these services.

DEFINITIONS

Medically Necessary Services: All inpatient and outpatient services covered under the Medicaid program

Financial Assistance Application (FAA): A document that must be completed by the patient/guarantor, and accompanied by proof of residency and income, in order to qualify a patient for financial assistance

Federal Poverty Guidelines (FPG): Published yearly by the Department of Health and Human Services and used to determine if a patient is eligible for assistance under a particular program.

Presumptive Charity: The process of proactively classifying charity care patients on the basis of limited financial information.

Family: OAC 5101:3-2-07.17 (B) (1) states "a "family" shall include the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children, natural or adoptive, under the age of eighteen who live in the home.

PROCEDURE

1. The Christ Hospital Interdisciplinary team

   Registration associates

   - Focus on capturing accurate and up to date demographic information (e.g. home address, telephone contact numbers, place of employment);
   - Knowledgeable of financial assistance programs and can refer interested patients to an in-house Financial Counselor; and
   - Request photo ID for proof of identity to protect against identity theft and ensure the application is accurate.

   Financial Counselors

   - Visit patients and their families on the floors as early in the medical visit as is appropriate to help the patient identify which assistance programs he/she is eligible for;
   - If possible, complete, the application process during the patient's stay; and
   - Work closely with an outside service that conducts home visits to housebound patients or will accompany or represent patients at the interview, free of charge to the patient.

   Financial Clearance

   - Pre-registration, insurance verification and certification and pre-service collection of deductibles, copays and uninsured services

Customer Service

- Receive patient phone calls, answers questions about a patient's bill, accept credit card payments, assist patient in completing a Financial Assistance Application, and set up payment arrangement
- Process applications for the state and local Financial Assistance programs
- Proactively call patients to explore financial assistance programs to resolve outstanding balances

2. Financial Assistance Options

a. **Medicare**: Patients 65 years of age or older and patients under 65 with certain medical conditions may be eligible for the Medicare program. Although they cannot act as the patient's representative, the financial counselors will offer education to the patient on how to apply for the Medicare program.

b. **Medicaid**: Medicaid programs are administered by the state in which the patient resides. Eligibility criteria vary from state to state and the application process can be cumbersome and difficult to understand. If during the in-house interview the financial counselor determines the patient may be eligible for Medicaid, they will assist the patient in the application process in the following manner:

- Act as patient's representative by attending Medicaid appointment with or in place of the patient
- Refer an out of state or uncooperative patient to an outside service for assistance in completing a Medicaid application. The outside service will also make home visits if appropriate.
- File an appeal on behalf of the patient if they feel eligibility may have been improperly denied

c. **Hospital Care Assurance Program (HCAP)**: HCAP is available to Ohio residents who are treated at an Ohio facility and whose family income is at or below federal poverty guidelines. HCAP provides free hospital care for medically necessary services. Patients may apply for HCAP if they are a resident of the state of Ohio and are not currently a Medicaid recipient. To apply for HCAP, a patient or family member must complete an application and attest to family income for a minimum of 3 months (up to 12 months) prior to the date of service. In addition, TCH may perform a resource test (see 2 e. Presumptive Charity below) and additional documentation to support income may be requested. Eligibility is based upon income levels that are at or below the Federal Poverty Guidelines. If approved, 100% of the patient portion will be adjusted.

d. **Charity Program**: Patients who do not meet income or residency requirements of other programs may be eligible for assistance with their hospital bill in the following circumstances:

- Patient has cooperated in supplying all information needed for other federal/State healthcare programs and has been denied
- Patient's income is at or below 300% of the federal poverty guidelines
- Patient should complete FAA and cooperate with the hospital.
- Below is the sliding scale income matrix for the hospital's Charity Program:

INCOME RANGE	DISCOUNT %
Income <= 150% FPG	100% Assistance
Income >150% and <=200%FPG	75% Assistance
Income >200% and <=300% FPG	50% Assistance

- For Discounted care of less than 100% Assistance, the hospital will limit amounts charged to uninsured patient to not more than the amounts generally billed (AGB) to individuals who have insurance covering such charges. Historical percentages for the 12 months prior to this policy period for claims paid by both Medicare fee-for-service and all private health insurers as primary payers, together with any associated portions for these claims paid by Medicare beneficiaries or insured individuals in the form of co-payments, co-insurance, or deductibles will be used to calculate amount billed to patient

PATIENT TYPE	% OF GROSS CHARGES
Inpatient	34%
Outpatient	32%

e. Presumptive Charity: Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is incomplete evidence to support a patient's eligibility for charity care, or an attestation has not been obtained, the Hospital could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include: household income and size, asset ownership, ratio to estimated FPL, and other socioeconomic behavior indicators.

- In the absence of information provided by the patient or in cases where the information provided by the patient is incomplete, an assessment process utilizing a predictive model will be deployed to qualify patients for charity care. The predictive model incorporates income and household size estimates, a socio-economic need factor, as well as information on homeownership.
- The application of the predictive scoring process and presumptive charity rules will be deployed for all self pay, out-sourced patients, after the 120 collection cycle consisting of a minimum of 3 statements and 2 calls.
- PARO will be utilized to determine presumptive charity scoring based on the rules below.

Socioeconomic Score ≤ 627 AND Estimated Federal Poverty Level ≤ 248 AND 3rd Party data which is gathered must not indicate that the patient is a homeowner or probable

All three factors must be met in order for the patient to qualify for presumptive charity. If a patient does not qualify under these rules, the patient may engage in the traditional charity policy in order to be considered for charity care.

- Presumptive Charity scores will be noted in patient account notes.
- The Hospital is not obligated to notify the patient that they have received presumptive charity care. The account will be adjusted according to charity policy to reflect the presumptive charity care discount or adjustment.
- Presumptive care is applicable only to the stay or service to which it is associated. Presumptive charity care determination can not be carried forward to future stays or services.
- Upon notice of a patient's death, unless the patient passed away at the hospital, the staff will procure a copy of the death certificate. Account will be reviewed for estate status, assets, or available form of payment prior to being sent to Bad Debt or written off to Charity.

f. Uninsured Discount Program: Uninsured patients not eligible for any of the above programs will receive a discount. See "Uninsured Discount Policy" for more detail.

3. Eligibility:
   a. Medicare/Medicaid determinations are made by the respective government authorities. TCH personnel will assist potential eligible patients with these programs.
   b. HCAP:
      - To apply for HCAP, a patient or their legal designee must complete the application. Patients are instructed to attest to gross income for all family members, for a minimum of three (3) months prior to the date of service or twelve (12) months of income.
      - Upon receipt of the signed application, the information will be reviewed and an eligibility determination will be made. Eligibility is based upon income that is at or below 100% of the Federal Poverty Guidelines. If the patient qualifies for HCAP, the account will be listed for adjustment. For applications taken over the telephone, the patient will be informed that we will be mailing the application to them for their signature. The account will continue through the normal collection process, until we receive the application back from the patient. * No extraordinary collection actions

(ECA) will be undertaken for 120 days post the first billing statement. After this 120 day notification period, the hospital will continue to accept and process the FAA for an additional 120 days. If during this 240 day period, it is determined that the patient is financial aid-eligible, the hospital will seek to reverse all ECAs and promptly refund any overpaid amount.

- Inpatients will be required to complete an application for each admission unless the patient is readmitted within 45 days of discharge for the same underlying condition. Approved outpatient applications are effective for 90 days from initial date of service. An inpatient application can also be used to cover outpatient services for the patient in the 90-day period immediately following the first day of the inpatient admission.
- In all cases, where a patient/applicant reports zero income for the period in question, the hospital will require, at the bottom of the application, the patient/applicant to document how the applicant and his family are surviving.
- All HCAP applicants are run through the Presumptive Charity module: If the patient qualifies for presumptive Charity then the account balance is adjusted off at 100%. If the patient does not meet presumptive Charity criteria, then the applicant may be asked for additional documentation to support income.

c. Charity:
- To apply for FAA, a patient or family member must complete an application including gross income for a minimum of 3 months (up to 12 months) prior to the date of application or date of service. If the patient verbally attests to the income on the application form, the application will be processed with what is on the form.
- Upon receipt of the signed application, the information will be reviewed and an eligibility determination will be made. Eligibility is based upon expanded income levels of up to 300% of the Federal Poverty Guidelines and is prorated on a sliding scale. Approval is based upon the number of family members and family income.
- Inpatients will be required to complete an application for each admission unless the patient is readmitted within 45 days of discharge for the same underlying condition. Approved outpatient applications are effective for 90 days from initial date of service. An inpatient application can also be used to cover outpatient services for the patient in the 90-day period immediately following the first day of the inpatient admission.
- Applications will be valid retrospectively for a period of 3 years prior to the date of application regardless of inpatient or outpatient status.
- If a dependent is handicapped and over the age of eighteen they are included in family size.
- All Charity applicants are run through the Presumptive Charity module: If the patient qualifies for presumptive Charity then the account balance is adjusted off at 100%. If the patient does not meet presumptive Charity criteria, then the applicant may be asked for additional documentation to support income.

4. Financial Assistance Application Disposition Procedure:

a. TCH PFS department or designated contracted vendors will process applications. The information on the application will be cross-referenced to the Federal Poverty Guideline table for the appropriate date of service. Staff will indicate program eligibility, sign and date the form.

b. Account moved to Presumptive Charity work queue:
- If patient qualifies for presumptive charity the account balance is written off at 100%
- If patient does not qualify for presumptive charity the account is moved back to the corresponding charity work queue for follow-up.

c. Actions for approved applications:
- Application and applicable documentation will be scanned into the hospital system;
- Adjustment applied to the account(s) in hospital system;
- Account notes added accordingly; and
- Disposition Notice mailed to patient

d. Actions for denied applications:
   - Application and applicable documentation will be scanned into the hospital system
   - Account notes added accordingly; and
   - Disposition Notice mailed to patient and scanned in to hospital system

e. All HCAP and Charity adjustment will be audited in the hospital system by management prior to the transaction filing to the patient account. If any corrections are needed to the transaction or documentation, the transaction will be deleted and communicated back to the applicable staff accordingly.

f. If insurance has been billed on an account qualifying for assistance, the adjustment will not be taken until after the insurance has made a determination.

g. Accounts that qualify for HCAP or Charity but are pending Medicaid eligibility may be processed for HCAP or Charity adjustment while awaiting a decision. If Medicaid eligibility is later verified, the HCAP or Charity adjustment will be reversed and the account will be billed to the Medicaid program.

h. Patient payments on HCAP or 100% Charity approved accounts will be refunded to the patient. The staff will complete a Refund Request Form and any required documentation. Accounts will be noted accordingly.

The Christ Hospital reserves the right to make exceptions to the above policy. Exceptions must be approved by the PFS Director.

All references to coverage under this policy relate to hospital-level services only and do not include physician-based charges.

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