# Community Health Needs Assessment 2016

The Christ Hospital™ Health Network

# 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 to start a program to train deaconesses and missionaries to carry on religious, educational and philanthropic work in order to alleviate the appalling poverty that existed in the city. Now, more than a century later, they could not have imagined the impact that invitation would have on the city.

Soon after her arrival, Thoburn's work expanded beyond ministering. In 1889 she opened a 10-bed hospital named Christ's Hospital in the West end, at 46 York Street. In 1893 the facility was moved to Mount Auburn and subsequently opened a nursing school in 1902. In 1904 it was renamed to what we know today, The Christ Hospital.

The Christ Hospital and Subsidiaries' ("The Christ Hospital") is a network of physicians and staff, working together in more than 100 locations throughout Ohio, Kentucky and Indiana. The Christ Hospital, doing business as The Christ Hospital Health Network, includes The Christ Hospital main campus in Mt. Auburn ("the Hospital"), as well as outpatient centers and physician practices. The Network consists of an accredited staff of more than 1,000 physicians, and offers advanced services and technologies through executive leadership of six key service lines: cardiovascular care, orthopaedic and spine treatment, women's health, oncology, special surgery and comprehensive medicine

The Christ Hospital's mission for the last 125 years has been to improve the health of our community and to be a regional exemplar in creating patient value through exceptional outcomes and patient experience, ensuring access to all members of the communities we serve without regard to financial status or other factors such as race, ethnicity, beliefs or gender.

In fiscal year 2015, as disclosed in Schedule H of the 990 Report, The Christ Hospital provided a total of $47 million dollars to the community, including charity care and care provided under governmental assistance programs, medical education for research and innovation, and community health improvement, which all led to better community outcomes. In addition, state regulations require that every three years a comprehensive assessment of the impact we had on community health needs be completed. The rest of this report is dedicated to explaining that impact.

We recognize that community health needs are broad and comprehensive, and while we bring our expertise and leadership to addressing select needs, we also understand that one entity's expertise cannot be broad enough to be the sole answer. Because of this, collaborations and partnerships are key to meeting those needs, and we partner with community organizations that complement our resources. Through these relationships, we increase our effectiveness in providing exceptional care and improved clinical outcomes to the community. For example, The Christ Hospital partners with organizations by means of cash and in-kind donations. Some of the organizations benefiting from such donations include the Center for Respite, the Center for Closing the Health Gap, the American Heart Association, Cradle Cincinnati, The March of Dimes and St. Vincent de Paul Charitable Pharmacy.

The Christ Hospital employees also invest personal hours volunteering with organizations that help to serve the needs of, and improve, the well-being of those in Greater Cincinnati and throughout the region. Some of these organizations include the American Heart Association, American Diabetes Association, American Cancer Society, the March of Dime and Melanoma Know More.

The Christ Hospital also opens its doors to self-help programs and community-based support groups like Mended Hearts and quarterly blood drives hosted on site in partnership with Hoxworth Blood Center, free of charge.

The Christ Hospital's leadership continues 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, LifeCenter, 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. Programs, like Patient Centered Medical Home, which is transforming how primary care is organized and delivered through five functions and attributes: (1) Comprehensive Care; (2) Patient-Centered; (3) Coordinated Care; (4) Accessible Services; and (5) Quality and Safety, and the Comprehensive Primary Care Initiative, which is a four-year multi-payer initiative designed to strengthen primary care by supporting the provision of (1) Risk-stratified Care management; (2) Access and Continuity;

(3) Planned Care for Chronic Conditions and Preventative Care; (4) Patient and Caregiver Engagement; and (5) Coordination of Care across the Medical Neighborhood.

In addition to our work volunteering and with community benefit organizations, The Christ Hospital also invests heavily in a multitude of programs and initiatives that support the community needs. These efforts will be highlighted throughout this document.

The activities mentioned above offer only a glimpse of how we touch and improve the health and the lives of people throughout our community. It's a testament 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.

The 2016 Christ Community Health Needs Assessment report is comprised of five sections:

1. The definition of the community we serve and a description of how the community was determined.
2. A description of the process and methods used to conduct our Community Health Needs Assessment, including how the hospital gathered input from people who represent the broad interests of the community.
3. A prioritized description of the significant health needs that were identified.
4. A description of the resources potentially available to address the significant health needs.
5. An evaluation of the impact of the hospital's 2013 Community Health Needs Assessment.

# DEFINING OUR COMMUNITY

Our first step in conducting our 2016 Community Health Needs Assessment was to define the community we serve. To do so we considered a number of relevant facts and circumstances, including the geographic area we serve, the target populations we serve, and our principle functions as a hospital, which include our service lines. In defining the community we serve, we specifically included the medically underserved, low income and the minority populations who live in the geographic area from which we draw patients. In addition, we included all patients without regard to whether (or how much) they or their insurers pay for care received or whether they are eligible for assistance under our financial assistance policy.

Currently, The Christ Hospital provides services and resources to 14 counties within a three-state area. The committee reviewed this complete geographic primary service area and determined that, for the sake of the Community Health Needs Assessment, it would focus on Hamilton County, Ohio, where the majority of The Christ Hospital's charity care and HCAP usage takes place. Roughly 72 percent of all patient encounters at The Christ Hospital take place in Hamilton County, thus making it a priority for this assessment.

Further analysis to confirm our focus determined that Hamilton County had the largest population within The Christ Hospital's service area. With more than 800,000 residents with the highest at-risk populations, including, African-Americans, Hispanics, and the disabled. Additionally, a significant portion of the services offered by The Christ Hospital are offered within Hamilton County, most notably the subsidized clinics where the utilization rate is 89 percent Hamilton County residents.

# ASSESSING OUR COMMUNITY HEALTH NEEDS

After defining our community, we assessed the health needs of the community in collaboration with other nonprofit hospitals whose communities overlapped with ours and the Health Collaborative. The Health Collaborative is a nonprofit organization serving the Greater Cincinnati area. It works with its member hospitals on health care improvement projects and shares best practices. The Health Collaborative brought 20 hospitals together, including The Christ Hospital, to conduct a comprehensive, collaborative community health needs assessment (Collaborative CHNA).

For a detailed explanation regarding (1) all the processes and methods used to conduct the Collaborative CHNA, (2) descriptions of the data and other information used in the assessment, (3) methods of collecting and analyzing this data and information, and (4) the identities of parties with whom The Christ Hospital collaborated or contracted for assistance in conducting this assessment please see the Collaborative CHNA Report attached here as Appendix 1 and which is incorporated by reference herein.

The Collaborative Report also provides a detailed description of (1) how the Collaborative CHNA Team solicited and took into account input received from persons who represent the broad interests of the community, including those with special knowledge of, or expertise in, public health, (2) how and over what period of time such input was provided, (3) the names of organizations providing input and the nature and extent of the organizations input, (4) descriptions of the medically underserved, low income or minority populations being represented by organizations or individuals that provided input. In addition, The Christ Hospital reviewed any written comments received regarding the 2013 Community Health Needs Assessment and implementation strategy. To date, to the best of our knowledge, no written comments have been received and, thus, written comments were not available for consideration in this assessment.

For ease of reference, the following provides an executive overview of some of the processes, methods and data input collection and analysis used to conduct the Collaborative CHNA.

The Health Collaborative assembled a highly-qualified team which included a consultant with prior community health needs assessment experience and members of the graduate program of Xavier University's Department of Health Services Administration. A Senior Vice President at The Health Collaborative provided executive oversight.

Representatives from 11 healthcare systems (representing 20 hospitals), including The Christ Hospital) met five times and comprised the Collaborative CHNA Committee. This group assisted in process design, provided feedback to the consultant and The Health Collaborative and shared best practices with each other. The Collaborative CHNA Committee also included representatives from the Cincinnati Health Department, Hamilton County Public Health, Interact for Health (a regional philanthropic organization) and a physician/professor from Xavier University.

Consistent sources of comparable data were available only at the state and county levels, and therefore each participating hospital identified which counties contained their services areas. Service areas spanned 19 counties over three states. The Cincinnati-Middletown Metropolitan Statistical Area includes an additional four counties (Bracken, Gallatin, Grant, and Pendleton), and so the Collaborative CHNA assessed the needs of citizens for 23 counties in total. Results in the Collaborative CHNA include data from a structured survey, qualitative data from multiple focus groups, an analysis of available secondary data and findings from health department interviews and surveys.

The CHNA Team collected 106 measures from publicly available sources, starting with the County Health Rankings. Criteria for inclusion included availability of trend data at the county level and ease of comparison and updating.

Primary data collection involved interviews of public health officials; online and paper surveys; and community focus groups. There were four distinct stakeholder groups with separate analysis for comparison: (1) consumers and organizations which attended meetings, (2) individuals surveyed, (3) organizations surveyed and (4) health departments (collectively, Stakeholders). All respondents answered questions about serious health issues, issues handled well, issues not addressed enough, and barriers to care.

Hospitals invited nonprofit agencies and organizations serving the medically underserved, low-income, and minority populations to attend meetings and complete surveys. More than 80 sent representatives to participate in focus groups. Participating organizations provided the name of, and areas served by, their organization. Survey respondents also identified the types of vulnerable populations served. Meeting attendees shared the names of the individuals representing each organization. In total, more than 600 people provided input for the regional Community Health Needs Assessment process.

Importantly, this comprehensive Community Health Needs Assessment was conducted in close coordination with a broader Collective Impact on Health regional effort, also led by The Health Collaborative. Collective Impact on Health included a significant microsimulation modeling process for not only understanding the current state, but also for modeling what the community could hope to accomplish together over a longer period of time to improve health, healthcare and affordability (e.g. the Triple Aim). At present, three action teams are developing prioritized regional interventions strategies and an optimal measure set for assessing progress over time. (For more information on the Collective Impact on Health, see Appendix 3).

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

# IDENTIFYING AND PRIORITIZING
## SIGNIFICANT HEALTH NEEDS OF OUR COMMUNITY

Through the above health needs assessment process, the Collaborative CHNA Team identified and prioritized a variety of significant health needs for a very broad service area or region, a good portion of which overlapped with The Christ Hospital's defined Community. The basis and criteria for the prioritization and identification of certain health needs as significant is set for in detail in the Collaborative CHNA Report.

In sum, The CHNA Team compared the secondary data to what each of the four stakeholder groups identified as priorities and the most serious health issues facing the community. For the secondary data, the criteria for determining priorities included presence of health issues in multiple counties, worsening trends, and rates worse than the state and national rates. For the primary data, the CHNA Team tabulated the votes at the community focus groups and how often phrases and themes recurred in survey and interview responses. Primary input included identification of underserved populations and unmet needs. There were 156 people who voted for their top three priorities in a focus group, and 381 individual consumers whose survey responses were combined to determine the priorities mentioned most frequently. The CHNA Team also analyzed responses from 55 agencies and 24 health departments to identify their consensus on priorities.

The combined priorities across the region reflected the top issues from all four primary sources plus secondary data and are set forth in the Table below.

- Substance abuse appeared as a top priority across all five sources of information.
- Mental health and access to care each appeared four times.
- Diabetes, obesity, and smoking appeared as priorities three times each.
- Cancer appeared twice, once as lung cancer specifically.
- Healthy behaviors appeared twice. If smoking and obesity were reclassified to fit within the 'healthy behaviors' category, then healthy behaviors would be reflected eight times.

In addition to actively participating in the Collaborative CHNA, the hospital convened an internal task force consisting of a cross section of the hospital's executive leadership to analyze the regionally identified significant health needs in the Collaborative CHNA in relation to our defined community. As a result of this analysis, the task force determined that a strong correlation existed between the significant health needs of the region and our community. By way of example, substance abuse was mentioned by all four groups of Hamilton County Stakeholders. Access to care was a concern at the community meeting and for consumers and agencies responding by survey. Obesity was a top concern from three Stakeholders but not at the community meeting. Agencies and health departments cited Infant mortality and Diabetes as serious issues. Agencies and meeting attendees were concerned about mental health. And Secondary data showed lung cancer to be a top cause of death for our Community.

Table 1, Region: Combined Top Priorities.

| Meetings | Consumers | Agencies | Health Departments | Secondary Data |
|---|---|---|---|---|
| Access to care | Substance abuse | Substance abuse | Substance abuse | Substance abuse |
| Substance abuse | Obesity | Mental health | Obesity | Injuries |
| Healthy behaviors | Access to care/services | Smoking/Tobacco | Smoking | Lung cancer & Respiratory disease |
| Mental health | Cancer | Access to care/services | Communicable disease | Smoking |
| Social determinants | Diabetes | Obesity | Access to affordable care | Diabetes |
| | Mental health | Dental | Access to healthy foods/nutrition | Healthy behaviors |
| | | Diabetes | Mental health | |

# IDENTIFYING AND PRIORITIZING *(continued)*
## SIGNIFICANT HEALTH NEEDS OF OUR COMMUNITY

Based on comprehensive analysis, and numerous Task Force suggestions," we adopted the above listed significant health needs identified in the Collaborative CHNA as the significant health needs facing our community. In an effort to further prioritize these significant health needs, based on our ability to intervene at the prevention or health program level, the task force divided the needs into two groups:

Primary:

- Diabetes
- Access to Healthcare
- Lung Cancer Treatment
- Mental Health
- Obesity
- Infant Mortality

Secondary:

- Substance Abuse
- Smoking Prevention
- Infant Mortality

The significant health needs listed under the Primary heading were prioritized in this manner because these needs align with our core service offerings, and we have the ability to directly impact them. For these Primary needs, The Christ Hospital will assume direct leadership in bringing about desirable outcomes in line with our goals. The priorities listed under the Secondary heading remain significant health needs of our community, but were prioritized in this manner because The Christ Hospital has less ability to directly impact these needs and, therefore, will assume a supportive role to address the needs through our partnerships, including participation in The Collective Impact on Health.

# RESOURCES POTENTIAL AVAILABLE
## TO ADDRESS OUR COMMUNITY'S SIGNIFICANT HEALTH NEEDS

With our Community and its significant health needs identified and prioritized, we will set forth an implementation plan that will drive our efforts to improve the health of our community in 2016 and beyond. That implementation plan will be released, per IRS requirements, by November 2016. In the meantime, the following is a nonexclusive list of resources potentially available to address the significant health needs identified through our 2016 Community Health Needs Assessment.

| Significant Health Need | Resource Potentially Available |
|---|---|
| Diabetes | American Diabetes Association, Juvenile Diabetes Research Foundation |
| Access to Healthcare | Center for Closing the Health Gap, United Way, The Wesley Community, Council on Aging, St. Vincent de Paul Pharmacy |
| Lung Cancer Treatment | American Cancer Society |
| Mental Health | Talbert House, Greater Cincinnati behavioral Health Services, National Alliance on Mental Illness, Council on Aging, Alzheimer's Association |
| Infant Mortality | Cradle Cincinnati |
| Substance Abuse | Talbert House, Greater Cincinnati behavioral Health Services, National Alliance on Mental Illness |
| Smoking Prevention | American Cancer Society, American Lung Association |
| Infant Mortality | Cradle Cincinnati |
| Obesity | Center for Closing the Health Gap, American Heart Association, American Diabetes Association |

# 2013
# WHERE WE WERE, AND WHAT WE ACCOMPLISHED

In response to the passage of the Patient Protection and Affordable Care Act (PPACA), The Christ Hospital conducted a Community Health Needs Assessment during the year 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. In the pages that follow, we will review The Christ Hospital's three-year implementation plan and evaluate our progress based on updated data from 2016.

To create the 2013 Community Health Needs Assessment Implementation Plan, we began by taking steps to better understand the health needs of our community. To do that, we analyzed a number of data sources, including, public health data, health risk factor surveys, socioeconomic needs assessments, environmental standards, and existing programs that have been developed for residents in our largest service area, Hamilton County.

The essential components examined in this process included the data indicators compiled on The Christ Hospital'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.

Through this process, we identified the prevalent health concerns in the Hamilton County that align with our mission and expertise. These were not the only community needs, but they are areas in which we were able to provide direct leadership:

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

Through a collaborative and well-thought-out process, The Christ Hospital and its community partners reviewed the most prevalent health concerns in Hamilton County and established a course of action. The plan focused on programs, research and education that specifically targeted 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. The plan was approved by The Christ Hospital's Board of Directors on April 17, 2013.

In the pages that follow, the 2013 Community Health Needs Assessment action plan results will be reviewed, including an evaluation of our action plan impact on the community during the past three years.

# CONGESTIVE HEART FAILURE

**Why it's important – as noted in the 2013 report**

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 five 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 – as noted in the 2013 report**

Between 2007 and 2009, Hamilton County had 49.4 hospitalizations per every 10,000 adults. The Healthy People 2020 national health target was 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.

**Interventions – as noted in the 2013 report**

By directly addressing risk factors for CHF such as hypertension, hyperlipidemia, diabetes and obesity, the desired outcome was 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 Lindner 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 CHF 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.

**Where we are/CHNA report update**

One of our first priorities was to focus on the advances we've made in heart care. Since 2013, The Christ Hospital's heart failure program continues to be the only heart failure center accredited by both the Joint Commission and the Healthcare Accreditation Colloquium. The Christ Hospital's multidisciplinary team of heart failure specialists have been recognized by The American Heart Association with the Gold Level Get With The Guidelines®–Heart Failure Quality Improvement Award for providing the highest standard of care for heart failure patients. We are also the first non-transplant hospital in Greater Cincinnati to gain insurance coverage by Humana for Left Ventricular Assist Devices ("LVAD") through our LVAD program. This program, which provides care for patients who are potential candidates for heart transplant, also received a Gold Seal of Approval from The Joint Commission.

Critical to the fight against heart disease is establishing a multidisciplinary care model that addresses all aspects of heart disease. To this end, The Christ Hospital started the Heart Link Program, which helps heart failure patients transition from the hospital to home by providing resources, medications and support. The ultimate goal of the program is to insure that patients with heart failure understand their diagnosis and are able to maintain control of their condition. The Heart Link program results indicate a 95% patient coordination of care rate for patients discharged from The Christ Hospital with a primary heart failure diagnosis, and a decrease in readmissions by 33.44 percent. Readmission rates were from a recent sample, but demonstrate how our interventions are impacting outcomes.

The Christ Hospital has also implemented several other programs, among those already mentioned, to address risk factors impacting care coordination. These programs include the 30-day pill project, where The

Christ Hospital enrolled 38 high risk community patients between March 2014 and October 2015 with the goal of preventing hospitalization and reducing readmission. The Heart Failure Network also began a pilot study at a local nursing home to monitor the most vulnerable heart failure patients using tele-health during post-acute care. The study, which included 47 heart failure patients, revealed an exceptional improvement to readmission rates, seeing the number drop from 30 percent to 15 percent. Additionally, The Lindner Research Center has 151 patients currently enrolled in trials to study heart failure treatments that include medications, devices and stem cells.

The Patient Engagement and Community Outreach Committee was put in place to reduce readmissions and align outpatient care with heart failure standards of care. The committee's program includes post-acute care representation and homecare, which helped to reduce heart failure readmissions for both fiscal year 2014 and fiscal year 2015. To properly track these analytics, The Christ Hospital receives regular reports from The Centers for Medicare and Medicaid Services, verifying our performance on readmission reduction. During fiscal years 2015 and 2016, the organization saw improved readmission rates across all monitored patient populations. More specifically, heart failure patients decreased by 15 readmissions between both fiscal years.

# STROKE

**Why it's important – as noted in the 2013 report**

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 – as noted in the 2013 report**

According to 2010 data, Hamilton County had 51 deaths from stroke for every 100,000 adults. The Healthy People 2020 national health target is to reduce the stroke deaths to 33.8 deaths per 100,000 population.

**Interventions – as noted in the 2013 report**

By directly addressing risk factors for stroke such as hypertension, hyperlipidemia, diabetes and obesity, through our Center for Primary Care initiative, as well as others, 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 have 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.

**Collaborative and partnered approaches – as noted in the 2013 report**

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 UC Health - University of Cincinnati Medical Center.

**Where we are/CHNA report update**

Since July of 2013, The Christ Hospital has provided preventative vascular screenings to 3,730 community members in an effort to detect potential health issues such as stroke, before they occur. Since May of 2015, 460 patients have received medical treatment from The Christ Hospital cardiologists, 35 have received a vascular intervention and one received cardiothoracic surgery. This early detection reduces the risk of serious consequences in the future.

The Christ Hospital continued to lead the way in stroke research studies through The Lindner Center for Research (LindnerResearch.com). The Watchman procedure, a new evolution in stroke prevention, was trialed at The Christ Hospital and involved six patients who were implanted prior to 2013. The Watchman has now been approved by the FDA, with four being implanted commercially in 2015. Along with The Watchman, there are currently 14 community patients enrolled in stroke research trials at The Lindner Center for Research (see Appendix 3 for full list of trials). The results of these studies will continue to improve the care patients receive in order to reduce the likelihood of a stroke, or minimize the effects of a stroke.

The Christ Hospital Physicians LLC Advanced Vascular Program has made care for stroke prevention more accessible throughout Hamilton County by offering patients several options in where they are treated. Outpatient care through The Christ Hospital is now available in Anderson, Fort Wright, Green Township, Liberty Township, Madisonville, Montgomery and Mt. Auburn.

Overall, updated data shows that Hamilton County saw an improvement in the death rate of stroke since 2013, from 51 deaths per 100,000 to 48.2 deaths per 100,000. This indicates that The Christ Hospital's intervention and care, alongside that of other community providers, is proving successful. The Christ Hospital will continue to improve the ability to treat the community as we learn more about stroke prevention and recovery.

# HYPERLIPIDEMIA

**Why it's important – as noted in the 2013 report**

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 U.S. 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 – as noted in the 2013 report**

According to data from 2009 for Hamilton County, 35.6 percent of adults in Hamilton County have been told their blood cholesterol was high.

**Interventions – as noted in the 2013 report**

The following list of programs have been or will be implemented within The Christ Hospital. 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 2.

- 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 Lindner Center for Research
- 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 initiatives 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 – as noted in the 2013 report**

The Christ Hospital's goal is to align outcomes with those set nationally by Healthy People 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.

**Strategies – as noted in the 2013 report**

Through utilization of the above mentioned programs and in collaboration with other community partners and programs, The Christ Hospital's desired outcome is to meet the Healthy People 2020 benchmark goal for our community patients 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.

**Where we are/CHNA report update**

The Complete Health Improvement Program, which is an educational, intensive lifestyle intervention program designed to prevent, arrest and reverse many chronic diseases, enrolled approximately 260 participants since 2013, including employees and community members. Participants learned to make better choices when grocery shopping, cooking and dining out by learning how to incorporate more plant-based foods into their diets. The program was able to reduce total cholesterol by 8.4 percent, to a desirable range of less than 200. LDL cholesterol levels also saw a decrease by 8.8 percent.

In 2011, Patient Centered Medical Home standards required healthcare providers to identify, and focus on, patients with specific chronic illnesses. These standards were updated in 2014 and The Christ Hospital Physicians LLC chose to focus on their complex patient populations, such as those patients with significant co-morbidities, which can include hyperlipidemia.

The Internal Medicine Outpatient Clinics at The Christ Hospital had a total of 16,802 appointments for medically underserved patients in the surrounding communities. Our physicians in the Clinic continually work to improve the quality of the care they provide to patients with chronic diagnoses. Initiatives such as updating medication refill lists also helps to improve the quality of outcomes on this vulnerable population of community patients. Through The Christ Hospital Physicians LLC Comprehensive Primary Care initiative, patients in the program receive coordinated care, with assistance in pre-visit planning, which ensures patients know about their appointment and helps them to understand what their visit will cover. In addition, CPCi patients who are diagnosed with high cholesterol or hyperlipidemia receive pre-planning reminders asking about medications, and receive screening and education on their condition and on practicing healthy lifestyle changes during their face-to-face appointment.

Through active research conducted at the Lindner Center for Research, there are currently 120 community patients enrolled in clinical trials for cholesterol medication effectiveness studies. Findings from this research will help physicians provide effective care to current and future patients within our community.

Recent data indicates a decrease in Hamilton County's high cholesterol by 1.87 percent, down to 33.7 percent. While the Healthy People 2020 target has not yet been met, these measures are moving in an encouraging direction. The results reinforce the impact of programs like the Community Health Improvement Program and Closing the Health Gap for community members.

# HYPERTENSION

**Why it's important – as noted in the 2013 report**

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 – as noted in the 2013 report**

According to data from 2009 for Hamilton County, 28.6 percent of adults in Hamilton County have been told they have high blood pressure.

**Interventions – as noted in the 2013 report**

The following list of programs have been or will be implemented within The Christ Hospital. 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 2.

- 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 Lindner Center for Research
- 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 initiatives 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 – as noted in the 2013 report**

The Christ Hospital's goal is to align outcomes with those set nationally by Healthy People 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.

**Strategies – as noted in the 2013 report**

Through utilization of the above mentioned programs and in collaboration with other community partners and programs, The Christ Hospital's desired outcome is to meet or exceed the Healthy People 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.

**Where we are/CHNA Report update**

Success in the most recent Complete Health Improvement Program came in the form of approximately 260 participants, which include both employees and community members. The participants, as a group, experienced reduced systolic blood pressure by nine mmHg, and diastolic blood pressure by four mmHg, which reached the goal of blood pressure less than 120/80.

In 2011, Patient Centered Medical Home standards required healthcare providers to identify, and focus on, patients with specific chronic illnesses. These standards have been updated in 2014 and The Christ Hospital Physicians LLC have now chosen to focus on our more complex patients. Complex patients are identified as those with significant co-morbidities, which can include high blood pressure.

In an effort to improve outcomes of patients diagnosed with high blood pressure, among other conditions, the Comprehensive Primary Care initiative works with patients to set goals, personalize a care plan and regularly contact the patient to support recommended lifestyle changes. This program also connects patients to community resources such as the American Heart Association and American Diabetes Association to be educated on other methods for improving their health. Through the Comprehensive Primary Care initiative, patients saw improvements of A1C levels of 8.25 percent, blood pressure control of 2.42 percent and fasting LDL-cholesterol of 3.59 percent.

The Christ Hospital Resistant Hypertension Clinic was developed in 2013 to help patients overcome resistant hypertension through oversight by a cross-disciplinary team of caregivers. Currently, The Christ Hospital is the only Certified Hypertension Center designated by The American Society of Hypertension in Ohio, and one of only eight designated centers in the nation. This designation means that Hamilton County residents and Greater Cincinnati has unique access to the most advanced hypertension care available in the United States.

Overall, Hamilton County's blood pressure prevalence saw an undesirable increase since 2013, however, through the programs described, blood pressure levels of patients at The Christ Hospital decreased. Blood pressure levels were also reviewed in order to understand how our own patients compare to the Healthy People 2020 targets. High blood pressure is defined as a systolic blood pressure greater than 130, and a diastolic blood pressure greater than 89. Patients who visited Christ Hospital Primary Care Physicians between 2013 and 2015 were compared to the Healthy People 2020 target and were shown to not only be meeting, but exceeding the Healthy People 2020 target for blood pressure. Research shows that 17.66 percent of The Christ Hospital population has been diagnosed with high blood pressure, while the Healthy People 2020 target is 26.90 percent.

# DIABETES

**Why it's important – as noted in the 2013 report**

The prevalence of diagnosed Type 2 diabetes increased six-fold in the latter half of the last century according to the Center for Disease Control. 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 – as noted in the 2013 report**

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

**Interventions – as noted in the 2013 report**

The following list of programs is currently in place within The Christ Hospital. 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 2.

- 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 Lindner Center for Research
- 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 – as noted in the 2013 report**

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 – as noted in the 2013 report**

The Christ Hospital recognizes the benefits of each of these goals and suggested interventions and has already begun to align programs and internal benchmarks with those set nationally through programs such as Patient Centered Medical Home. 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 percent1 in the next seven years.

Programs such as Patient Centered Medical Home are aimed at screening for and monitoring patient's A1C levels and targeting those levels for coordinated care introduction.

**Where we are/CHNA Report update**

The Christ Hospital Diabetes and Endocrine Center provides specific services to patients through their Diabetes Education Services. The center experienced 2,720 visits in 2013 and 2,782 visits in 2014.

The YMCA Diabetes Prevention Program also helped to bolster diabetes education of patients at The Christ Hospital. We used an online method to refer patients to the YMCA in order to improve lifestyles through healthier behavior changes.

Chronic disease management, including diabetes, is undergoing research at The Lindner Center for Research.

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

Between 2013 and 2015, 55 patients were enrolled in studies that relate to diabetes, the results of such studies serve to aid the medical community in providing exceptional care to diabetic populations.

The Internal Medicine Outpatient Clinic at The Christ Hospital is actively involved in treating chronic conditions for some of our community's most vulnerable adult populations. The Clinic physicians and medical residents are engaged in promoting programs to meet the needs of the Clinic patients. One such program, established in 2007, is the Diabetic Intake Program, the purpose of which is to reduce the likelihood of hospital inpatient readmissions for those Clinic patients with a diagnosis of diabetes. Between 2013 and 2015, the "Do It" protocol was established in order to improve diabetic management through proper education and a streamlining of the process of patients getting their medication. Phone calls are made to patients to receive blood sugar levels, allowing medications to be adjusted without the need for them to come in for an appointment. These programs help the Clinic continue efforts in targeted diabetic education, and improvement in managing outcomes related to the chronic conditions of diabetes.

The Block-by-Block program, which runs through the Center for Closing the Health Gap, helped 20 participants work toward making healthy lifestyle changes by participating in weekly group meetings and regular follow-up data collection. Evaluation of the program showed that participants had lowered their glucose values to 106.17, a reduction of 8.83.

Between 2014 and 2015, The Christ Hospital Physicians LLC Comprehensive Primary Care initiative established coordinated care for patients with diabetes, which resulted in an improved A1C of less than nine, indicating a positive change due to care management and lifestyle changes. As chronic care management becomes increasingly important, this data is encouraging when it comes to efforts to improve overall patient health.

The Christ Hospital also supports the efforts of the American Diabetes Association, with employees volunteering their time at the Step Out on Diabetes Walk/5K. This support helps the American Diabetes Association continue their research and outreach to the community by providing screenings for at-risk populations in the region. Since 2013, there has been a 3 percent increase of adults with diabetes when compared to Hamilton County and Ohio state values, and continued partnerships are part of The Christ Hospital's plan.

A1C levels of patients seen by The Christ Hospital primary care physicians who have a diabetes diagnoses were reviewed in order to understand how our patients compare to the Healthy People 2020 targets. Of the patients with diabetes who visited our primary care physicians between 2013 and 2015, 11.60 percent of them have A1C levels greater nine, whereas the Healthy People 2020 target is 16.10 percent. As is evident, the number of patients with diabetes and an A1C greater than nine exceeds the Healthy People 2020 target. This positive data is indicative that the exceptional care provided through the programs as described in this report are contributing to better outcomes for our patient community.

## Low Birth Weight Babies and Infant Mortality Rates

**Why it's important – as noted in the 2013 report**

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 – as noted in the 2013 report**

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 (five pounds, eight ounces). In 2008, 11.1 infants per 1,000 live births died within their first year of life, an increase of almost two percent from 2006. 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.

**Interventions – as noted in the 2013 report**

The following list of programs is currently in place within The Christ Hospital. 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 2.

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

**Desired Outcomes – as noted in the 2013 report**

The Christ Hospital's goal is to align outcomes with those set nationally by Healthy People 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 percent; additionally the Healthy People 2020 national health target is to reduce the infant mortality rate to six deaths per 1,000 live births.

**Strategies – as noted in the 2013 report**

Through utilization of the above mentioned programs and in collaboration with other community partners and programs, The Christ Hospital's desired outcome is to meet or exceed the Healthy People 2020 benchmark goal for decreasing the amount of babies born below five pounds, eight ounces and the amount of infant deaths within the first year of life. Statistically, this would mean a two 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 Health 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 organizations Such as the March of Dimes.

**Where we are/CHNA report update**

Through The Christ Hospital Prenatal Clinic, programs like the Center for Centering Pregnancy, offer group classes to patients expecting a child. These classes, provide a safe and comfortable environment where expecting parents can receive valuable education while building support networks in the community. Patients seeking additional resources were also guided to programs such as Pregnancy Pathways, Health Access Now and Every Child Succeeds as part of an increase in the clinic's education referrals. For example, in fiscal year 2015, The Christ Hospital provided more than 1,500 appointments to community patients at the Prenatal Clinic.

In an effort to better assess maternal and infant health in the community, the Prenatal Clinic and Center for Centering Pregnancy closely tracked birth weight, gestational age and breastfeeding for new mothers and babies. Acquiring and analyzing this data allows for a better measure of intervention effectiveness, which is critical to long-term improvements among patients seen at the Prenatal Clinic.

The Christ Hospital believes in a collaborative approach to improving community maternal and infant health, partnering with organizations that are major drivers of infant health improvement. One such organization is the March of Dimes, created by the Prematurity Research Center Ohio Collaborative to coordinate the research of premature babies in order to improve outcomes. Between 2013 and 2015, The Christ Hospital Health Network sponsored activities and donated funds totaling approximately $27,000 to the March of Dimes, including the March for Babies walk and social media campaigns that encouraged people to share their birthing stories, in which The Christ Hospital made a donation for every story received.

In addition, The Christ Hospital has partnered with Cradle Cincinnati, a city-wide collaborative that asks, "what if Hamilton County was one of the healthiest places in the country for pregnant women and babies?" One of the major movements within this organization is the Safe Sleep Program, which seeks to reduce infant mortality rates through education. Among the changes made within The Christ Hospital through the Safe Sleep program is the replacement of blankets in the Birthing Center with safer sleep sacks. The Christ Hospital and Joseph Beth are also sharing the cost of sleep sacks for parents of newborns so that everyone leaves the hospital with new, complimentary sleep sacks. To date, over 1,700 sleep sacks have been provided to new parents, free of charge. The Christ Hospital is also working in collaboration with the Ohio Hospital Association and The Ohio Department of health to frequently assess the safe sleep environment in the Birthing Center and continually update practices accordingly.

Since 2013, Hamilton County has seen an improvement of 0.2 percent for babies born with low birth weight (weighing less than five pounds, eight ounces), when compared to overall data from Ohio. In addition to that figure, The Christ Hospital's rate of babies born at low birth weight were better than Hamilton County as a whole. Not only did The Christ Hospital have fewer babies born at low birth weight, but the percent of babies born at low birth rate continued to decrease from 2013 to 2015. These results indicate that the efforts of the Prenatal Clinic, Center for Centering Pregnancy and others have been instrumental in improving infant health within the community. Hamilton County also saw improvements to the infant mortality rate. Since 2013, infant mortality has dropped from 11.1 deaths per 1,000 live births to 9.1 deaths per 1,000 live births, putting Hamilton County on track to meet the national Healthy People 2020 target.

Infant mortality was identified as the top health priority in the 2013 Community Health Needs Assessment from The Health Collaborative, making this data all the more encouraging as The Christ Hospital continues to improve the health of mothers and infants community.

# BREAST AND PROSTATE CARE

**Why it's important – as noted in the 2013 report**

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 United States. 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 – as noted in the 2013 report**

The indicators for Hamilton County, based on 2009 data, showed that 24.9 female patients per 100,000 die from breast cancer every year. Additionally, the indicators for Hamilton County, based on 2009 data, showed that 26.1 male patients per 100,000 die from prostate cancer every year. The rate was almost double for African American males at 48.4 deaths per 100,000 according to the same data.

**Interventions – as noted in the 2013 report**

The following list of programs were implemented within The Christ Hospital.

Each program targeted a specific patient population and set individual goals aimed at improving the outcomes for patients, as well increase the level of education and screenings in the community. For a complete description of these programs, please see Appendix 2.

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

**Desired Outcomes – as noted in the 2013 report**

The Christ Hospital's goal was to align outcomes with those set nationally by Healthy People 2020, other national benchmarks as determined by the program and other local benchmarks. At that time, The Healthy People 2020 national health target was to decrease the death rate due to breast cancer to 20.6 per 100,000 females. Additionally, the Healthy People 2020 national health target was to reduce the prostate cancer death rate to 21.2 deaths per 100,000 males.

**Strategies – as noted in the 2013 report**

Through utilization of the earlier mentioned interventions and in collaboration with other community partners and programs, The Christ Hospital's desired outcome was to meet or exceed the Healthy People 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 was to be attempted with community collaboration through education, advocacy and targeted programs like the subsidized mammography program that makes access to screenings more readily available and early detection with longer term survival rates more possible.

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

**Where we are/CHNA report update**

Since 2013, The Christ Hospital has treated more than 275 prostate cancer cases and 1,100 breast cancer cases. The nature of treatment at The Christ Hospital means that patients seeking care come at various stages of a cancer care. Both prostate and breast cancer patients are categorized as either analytic or no-analytic. Analytic patients are those who had their initial diagnosis and/or treatment at The Christ Hospital, while nonanalytic patients are those who have been diagnosed, and had their entire first course of treatment elsewhere, before coming to The Christ Hospital for subsequent treatment. Inclusion in the nonanalytic category can either mean a recurrence of their disease or a progression of disease resulting a need for treatment change. There are several programs within The Christ Hospital that help provide the finest patient experience to patients with a cancer diagnosis.

Part of The Christ Hospital's healthcare value proposition is the belief that exceptional treatment should be provided to the community regardless of the ability to pay for that care. Between 2013 and 2014, the American Cancer Society altered a program known as the Subsidized Mammography program, of which The Christ Hospital took part in. During that time, insurance companies also began covering the cost of mammography screenings, Medicare and Medicaid included. This means that patients unable to pay for care could still receive the treatment they needed. In these cases, The Christ Hospital referred patients to the Financial Assistance Policy. This course of action continues today, therefore no formal program was established to replace the subsidy program.

The Christ Hospital's Prostate Cancer Collaborative combines the expertise of physicians, urologists and radiologists to provide exceptional care for patients undergoing treatment for prostate cancer. Between 2013 and 2015, the Prostate Cancer Collaborative added a total of 41 new patients to the program, allowing them to receive focused and innovative care.

The American College of Surgeons mandates the use of cancer programs to provide survivorship plans to patients. A survivorship plan includes specific information about the patient's diagnosis (type of cancer, stage), treatment summary and long term effects of treatments (surgery, chemotherapy, radiation), and recommended surveillance to be done by providers. This program at The Christ Hospital is expanded to also include preventative health screenings and web based resources to read about survivor issues. The program's coordinators also make their contact information public, so patients can call them for referrals for psychological distress.

The Breast Cancer Navigator Program at The Christ Hospital ensures patients have opportunities to ask any questions they may have over the course of their treatment. The program has approximately 100 patient encounters each month, and regularly checks in on patients after imaging (particularly when a breast cancer diagnosis is given), and between chemotherapy and radiation treatments. This program is carried out under the belief that patients who know as much as they can about their treatment and follow through with appointments and treatments will have better outcomes.

Since 2013, The Christ Hospital Cancer Research Center has opened 10 Breast Cancer Trials, seven of which are still active as of spring 2016. There are currently 14 open clinical trials involving every type of cancer research being done on management methods and treatments for cancer. Since 2013 there have been a total of 259 patients enrolled in these trials.

The Christ Hospital also supports cancer research, education and care through targeted efforts like those of the American Cancer Society ("ACS"). The primary goal of the hospital's collaboration with the ACS is to increase awareness and screenings for cancer. 2015 in particular saw many events that helped the community see the importance of breast cancer screenings. These events included collaboration with the University of Cincinnati Health and Wellness Fair, the Paint the Square Pink event, Crucial Catch Day and our own events within the hospital that educated employees and visitors on the importance of breast cancer screenings.

From 2013 to 2015, Hamilton County's age adjusted death rate due to breast cancer saw an unfavorable shift from 24.9 deaths per 100,000 females to 25.2 deaths per 100,000 females. While cancer was not a primary concern of our community in the 2016 Community Health Needs Assessment, The Christ Hospital continues to pursue exceptional outcomes for those within the organization who have been diagnosed with breast cancer.

Conversely, the age adjusted death rate due to prostate cancer improved since the 2013 Implementation Report from 26.1 deaths per 100,000 males to 24.3 deaths per 100,000 males. This new metric is in line with trends towards the Heathy People 2020 target for age adjusted death rate of prostate cancer.

# ACCESS TO CARE

**Why it's important – as noted in the 2013 report**

People who lack 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, which raises overall costs and lessens the continuity of care.

**Where we are – as noted in the 2013 report**

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. Additionally, 83.1 percent of the county adult population has some form of health insurance based on data from 2011. 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.

**Interventions – as noted in the 2013 report**

The following list of programs were implemented within The Christ Hospital. Each program targeted a specific patient population and set individual goals aimed at developing community care and 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 2.

- 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 – as noted in the 2013 report**

The Christ Hospital's goal was to align outcomes with those set nationally by Healthy People 2020, other national benchmarks as determined by the program and other local benchmarks, such as the United Way Bold Goals. At that time, the Healthy People 2020 national health target for adults with a usual source of healthcare was to increase the proportion of people with a usual primary care provider to 83.9 percent; additionally the Healthy People 2020 national health target was to increase the proportion of people with health insurance to 100 percent.

**Strategies – as noted in the 2013 report**

Through utilization of the earlier mentioned interventions and in collaboration with other community partners and programs, The Christ Hospital's desired outcome was to meet or exceed the Healthy People 2020 benchmark goal for adults with a usual source of healthcare. Statistically, this meant a one 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 was to 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 would be necessary to make access to care easier and the continuum of care more transparent.

**Where we are/CHNA Report update**

The Christ Hospital Physicians LLC participate in the Comprehensive Primary Care initiative, of which one goal is to improve access to care and coordination of care for primary care patients in a manner extending beyond their regular appointments with a physician. CPCI activities include pre-visit planning, follow-up calls to patients who have visited the emergency department, and calls to patients who have been discharged from a planned hospital stay. This follow-up allows patients to discuss their treatment with a health professional to ultimately assure the patient is accessing primary care where early interventions and management are delivered, preventing downstream use of the emergency room, and inpatient environment.

Another access to care program instituted in April of 2013 at The Christ Hospital is the Care Transitions Project. This project helps patients receive access to care and information outside of a traditional physician appointment. When this program began in April of 2013, hospital inpatient readmission numbers were regularly around 15 to 20 percent. By 2014, we saw a significant drop in the number of readmissions related to patients in this program, with most months incurring a rate of less than 15 percent, even though the pattern of emergency department admissions remained relatively the same. These outcomes are achieved by linking patients with Care Transitions Coaches, who help patients receive proper follow-up, prescription refills and make sure they have an understanding of their own care plan.

To improve access to care for the communities we serve, over the past three years, The Christ Hospital has expanded the number of providers and specialties across the network and in Hamilton County. This expansion, which includes 42 additional doctors in primary care, means The Christ Hospital currently has 605 providers, 125 physicians in primary care and 480 working in specialties. These additions have increased access to care for patients in the communities served.

In addition to an increase in the number of providers and specialties, The Christ Hospital has also added more outpatient centers in Hamilton County and the surrounding area to reach a greater percentage of the community's population, and to create programs and protocols that have increased the quality of care provided. Increased medication reconciliation efforts, including those in the Prenatal Clinic, have shown improved patient safety. Other efforts provided by these clinics include the development of a Rheumatology Medication Refill list, staff involvement in the Passion Committee for CHF, a new Podiatry Clinic, Palliative Care Support, and involvement in the ODH Breast and Cervical Cancer Project, which is a community collaborative. Coverage for Gardisil and birth control options are also offered to patients. In addition, we participate in a partnership with St. Vincent de Paul Free Pharmacy which assists those who experience barriers in obtaining needed medication.

These efforts not only allow more patients to access The Christ Hospital's services, but they also strengthen the programs offered by the hospital through increased expertise and collaboration. The number of new patients in our primary care space grew by 10,229 in 2013, 9,901 in 2014 and 11,987 in 2015.

Since 2013, the Internal Medicine Clinic has pursued several changes that have been critical in increasing patient access to healthcare, including improving the management of Chronically Anti-coagulated patients, reviewing immunizations at the time of a patient's visit, developing a Transition of Care process for post-hospitalization follow-up, updating medication refill lists and opening urgent care appointments. These new initiatives not only provide continuity and preventative care for an increased number of patients, they also improve the quality of care those patients receive, which in turn decreases readmissions and adverse outcomes.

# BEHAVIORS RELATED TO OBESITY

**Why it's important – as noted in the 2013 report**

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 – as noted in the 2013 report**

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.

**Interventions – as noted in the 2013 report**

The following programs are currently in place within The Christ Hospital. 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 2.

- 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 initiatives 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 – as noted in the 2013 report**

The Christ Hospital's goal was to align outcomes with those set nationally by Healthy People 2020, other national benchmarks as determined by the program and other local benchmarks. At that time, the Healthy People 2020 national health target was to reduce the proportion of adults aged 20 and older who are obese to 30.6 percent.

**Strategies – as noted in the 2013 report**

Although Hamilton County is currently at the Healthy People 2020 benchmark, it is very important to note that Hamilton County rates sharply increased between 2008 and 2010 by over seven percent. Nationally, African Americans are more likely to be obese than white or Latinos according to Healthy People 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.

**Where we are/CHNA update**

The Patient Centered Medical Home program's most current standards give participating physicians the flexibility to address co-morbidities for their patients, including those conditions that result from a diagnosis of obesity. Since lifestyle changes are the primary modes of treatment for obesity, The Christ Hospital Physicians LLC seek to address these factors in patients who may be at high risk, but may not yet have a specific diagnosis of obesity.

Keeping in line with our mission, The Christ Hospital supports efforts of local organizations seeking to improve the overall health of the community. The Block-by-Block program is a great example of this. The program, which runs through the Center for Closing the Health Gap, helped 20 participants work toward making healthy lifestyle changes. When it was initially

completed in late 2014, 13 of the 20 participants experienced a 0.44 point reduction in their body mass index. A separate program through the Center involved 260 participants working to reduce their body weight and blood glucose levels. Once completed, the participants lost an average of seven pounds, reduced their body mass index by 1.38 and decreased their blood glucose levels by three percent.

The Comprehensive Primary Care initiative has placed an importance on patient goal setting and personal care plan development in an effort to encourage patients to take charge of their own care outside of typical physician appointments. This program provides education to at-risk patients and patients diagnosed with chronic conditions such as obesity so that they understand the critical lifestyle changes they must make as part of their care.

The Complete Health Improvement Program also saw success as approximately 260 participants, including employees and community members, reduced their total body weight by roughly eight pounds and their body mass index by 1.38. This program, which is a 40-hour comprehensive, educationally intense intervention program, was designed to prevent, arrest and reverse essential hypertension, type 2 diabetes, obesity, heartburn, depression, elevated cholesterol and heart disease.

Other partnerships critical to The Christ Hospital improving obesity rates in Hamilton County include the YMCA and Cincinnati Sports Club. These organizations team up with The Christ Hospital to provide physician prescribed exercise programs to patients. Area physicians can refer their patients to this program in order for them to gain more support in health education and lifestyle changes. The goal is to use exercise to reduce levels of obesity in patient populations, while addressing common risk factors. The Cincinnati Sports Club had an enrollment of over 300 patients between 2013 and 2015, who came from a variety of health networks in the city.

Overall, Hamilton County saw an improvement in the "adults who are obese" category of 0.2 percent. At the time of the 2013 Implementation Plan, Hamilton County had already met the Healthy People 2020 target, meaning these improvements in obesity rates help move the county above the national average. The Christ Hospital continues to provide programs and education to the community through these efforts.

# APPENDIX 2
## 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<br>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<br>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<br>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.<br>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<br>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:<br>• Regular prenatal visits<br>• One ultrasound<br>• Delivery at The Christ Hospital<br>• Postpartum care<br>• Normal infant care<br>• Postpartum check up<br><br>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 |

| 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.<br>**Scale to Success** – a seven week weight management program which includes nutritional and exercise coaching.<br>**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.<br>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.<br><br>Targeting tobacco is designed for any individual that uses any type of tobacco products | 10% Decrease in<br>Total Cholesterol<br>HDL<br>LDL<br>Triglycerides<br>Weight<br>Blood pressure<br>Resting heart rate<br>2% decrease in fasting glucose<br><br>Improvement in nutritional habits measured by decrease in animal products and increase in plant based selections<br><br>Scale to Success and average decrease in weight of 2 lbs per week<br><br>Tobacco Cessation by 80% of the class | Pre/Post blood work/ biometrics<br><br>Pre/Post CHIP Intake form for nutritional assessment<br><br>Pre/Post weight measures<br><br>Pre tobacco usage - on enrollment form<br><br>Post tobacco usage - eval form | Chronic Disease Management<br>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<br>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<br>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 |

| 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<br>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.<br>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,<br>patient satisfaction,<br>process management (lean processes for sites for increased patient satisfaction with services) | Electronic medical record | Access to Care<br>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<br>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 |

# Using Collective Impact to Create a Greater Cincinnati-Northern Kentucky Health Improvement Plan

## Background

Collective impact is defined as the commitment of a group of stakeholders from different sectors to a common agenda for solving a specific social problem, using a prescribed form of collaboration. In late 2013 The area's philanthropic community and health systems agreed to financially support and participate in a coalition that would use this model to address health issues in the seven-county region (see image at right). The objective was to create a regional health agenda and drive change. Central to the principles of collective impact, the community is the owner of the agenda and a backbone organization is designated and assigned the responsibilities listed in the graphic below.


**The Seven-County Region**

- **Guide vision and strategy**
- **Support aligned activities**
- **Establish shared measurement practices**
- **Build public will**
- **Advance policy**
- **Mobilize funding**

The Health Collaborative, a regional nonprofit health improvement organization, was selected to function as the backbone organization and began assembling a core group of community leaders. Represented were health systems, community agencies, foundations, public health, employers, commercial payers, and consumers. A steering committee was formed from this group. Together, the committee designed and recruited a forum for broader community participation.[1] They invited over 80 stakeholders to participate in a process to reach consensus as a community on a common health agenda. The goal was to agree on "***A small number of doable things that in combination, had power to drive the triple aim: better health, better care, and lower overall cost.***

## The Process

Central to this process was the use of a multi-variable predictive model to test initiatives and outcomes. The model tool was created by the ReThink Health initiative of the Rippel Foundation. ReThink staff served as consultants. The model was calibrated using local public health and demographic data to reflect our region's unique population and health profile. The model predicted how more than 20 different social changes and health improvement initiatives would perform in isolation or in combination, over eight different variables. The variables included cost of care, deaths, sufficiency of care, equity, workforce productivity, program spending, and net cost. All variables and combinations could be evaluated for impact over time and in many cases there were sub-metrics that allowed for deeper views.

The leadership forum members met the first time on September 12, 2014 to develop a shared understanding of our region's population health profile, health equity issues, provider landscape, and drivers of health cost. They also agreed to the premise that our goal was not simply to improve health, but to do so in a way that improved the experience of care and reduced overall cost.

At the second meeting on November 4, 2014, working in teams of eight, the forum members used the predictive model. Each team tested their own hypotheses about initiatives and combinations that would produce acceptable improvement levels over the elements of the triple aim. Twelve different favored scenarios emerged from this meeting. Forum members were given a chance to study the results on their own time then rank and vote for three scenarios they felt produced the most desirable results. There was no clear winner; however, the voting favored three top scenarios, boxed in blue in the below image.

| 1. Behaviors | 5. Family Pathways | 4. Student Pathways | 16. Care Coordination | 8. Self-care | 15. Medical Homes | 7. Mental Health | 6.Physical Health | 16a. Technology Update | 10. PCP Efficiency | 3. Crime | 2. Environment | 20. Post discharge | 12. Recruit PCPs for FQHCs | Scenario # | Cost % change from baseline) | Deaths % change from baseline | Sufficiency of Care % change from baseline | Inequity % change from baseline | Workforce Productivity % change from baseline | Program Spending in billions | Net Cost Savings (all healthcare costs in baseline and all healthcare and program costs for scenario in billions | Productivity Increase in billions | Contingent Global Payment - Medicare/Medicaid/ Commercial |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| x | 20 | 20 | x | D | x | D | x | x | x | | | | | 1 | -10.90 | -13.00 | 37.40 | -20.20 | 3.10 | $ 9.69 | -$39.47 | $72.67 | 50/50/50 |
| x | 20 | 20 | x | x | x | D | | | | | | | x | 2 | -9.90 | -12.50 | 36.10 | -15.30 | 3.00 | $ 10.20 | -$34.17 | $66.58 | 50/50/50 |
| x | 20 | 20 | x | x | x | x | | | x | | x | | | 3 | -10.50 | -15.00 | 39.40 | -16.40 | 4.20 | $ 13.66 | -$32.33 | $77.33 | 50/50/50 |
| x | 50 | 20 | x | x | x | | | | | | | | x | 4 | -10.20 | -12.00 | 34.60 | -15.10 | 3.70 | $ 12.58 | -$33.37 | $73.42 | 50/50/50 |
| x | 20 | 20 | x | D | x | D | | | x | | | | | 5 | -10.40 | -10.60 | 24.20 | -20.40 | 2.80 | $ 9.29 | -$38.06 | $68.65 | 50/50/50 |
| x | 20 | 20 | x | D | x | x | | x | | | | | | 6 | -11.80 | -11.50 | 27.70 | -19.80 | 4.00 | $ 11.41 | -$42.84 | $85.57 | 80/50/70 |
| x | 20 | 20 | x | D | x | | x | | | | | | | 7 | -9.20 | -12.20 | 34.10 | -16.00 | 2.70 | $ 8.14 | -$32.95 | $61.71 | 50/50/50 |
| x | 20 | 20 | x | x | x | x | | x | x | | | | | 8 | -11.20 | -13.20 | 39.40 | -14.60 | 4.10 | $ 12.47 | -$37.95 | $82.20 | 50/50/50 |
| x | 50 | 20 | x | x | x | x | | x | | | | | | 9 | -11.20 | -13.30 | 39.30 | -17.50 | 5.10 | $ 15.97 | -$34.33 | $89.17 | 50/50/50 |
| x | 100 | | x | x | x | x | | | x | | | | x | 10 | -9.70 | -13.50 | 39.80 | -22.00 | 6.50 | $ 20.95 | -$21.94 | $91.95 | 50/50/50 |
| x | 25 | 25 | x | x | x | x | | x | x | 50/D | | | | 11 | -11.90 | -13.80 | 40.70 | -16.80 | 4.40 | $ 13.59 | -$40.01 | $87.18 | 70/70/70 |
| x | 20 | 20 | x | D | x | D | | | | | | | x | 12 | -11.00 | -10.60 | 23.70 | -20.30 | 2.90 | $ 9.34 | -$41.24 | $72.24 | 50/50/50 |
| x | 20 | 20 | x | | | x | | | (starter scenario) | | | | | S | -8.80 | -8.30 | 13.10 | -8.10 | 3.50 | $9.96 | -$30.45 | $68.10 | 50/50/50 |

Best
Worst
Most spending
D = Disadvantaged Populations Only
**Note:** Far right column showing changes in assumptions on contingent global payment
Any number in columns A-N = % implementation of initiative

The backbone staff then analyzed the results of the three leading scenarios for their points of parity. The favorite scenarios all performed well on net savings, sufficiency of care, health outcomes, equity, and productivity, leading to the conclusion these values were held highly by the forum members. Consultants from ReThink Health provided insights into which of the initiatives selected in the leading scenarios were most important in driving those results. This made it possible for the steering committee to agree to eliminate low impact initiatives and group the high impact initiatives into related categories.

## Conclusions

At the third leadership forum meeting on March 19, 2015, members reviewed the results of the polling and parity alignment. The results clearly showed it would not be possible to improve community health by simply spending more on care or expecting better health to happen in the doctor's office. Four strategies for improvement emerged:

## Our Four Action Areas

| | |
|---|---|
| Address the lifestyle behaviors that make the population sick, with special attention to the socio-economic determinants of health. | Create better access to patient centered, coordinated care, including behavioral health, and support for self-management of health goals that extends into the community. |
| Drive a payment system that rewards outcomes more and volume less. | Support community efforts to address poverty and education. |

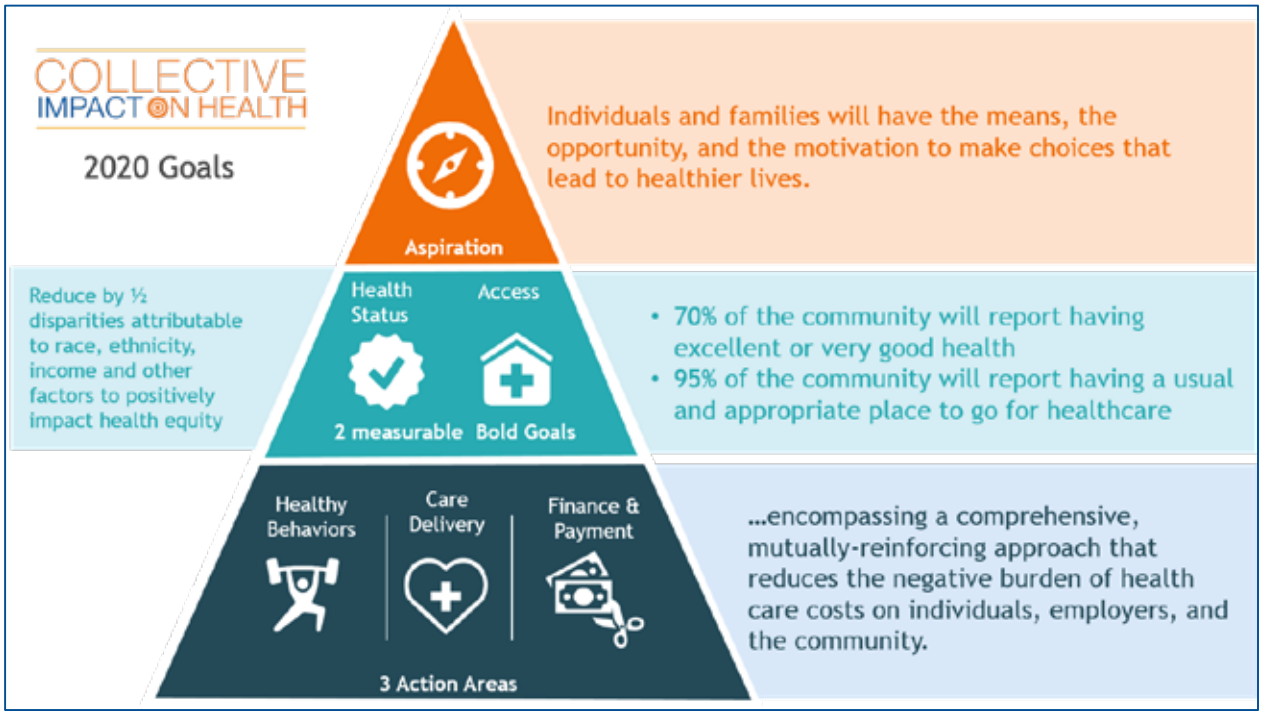
The leadership forum members agreed that it made sense for our community to organize around the first three action areas, while supporting the education and income initiatives already in progress in our community. With that consensus reached, the steering committee reconvened for a series of meetings to set goals, objectives, and metrics.

## Objectives and Metrics

The steering committee concluded that the next phase of work would require more specific expertise from individuals and organizations with knowledge or experience within the action areas. Three action teams were formed. In addition, the backbone began an affiliation with the Greater Cincinnati Foundation, which was convening backbone organizations to create synergies between community work related to income, education, health, and other initiatives.

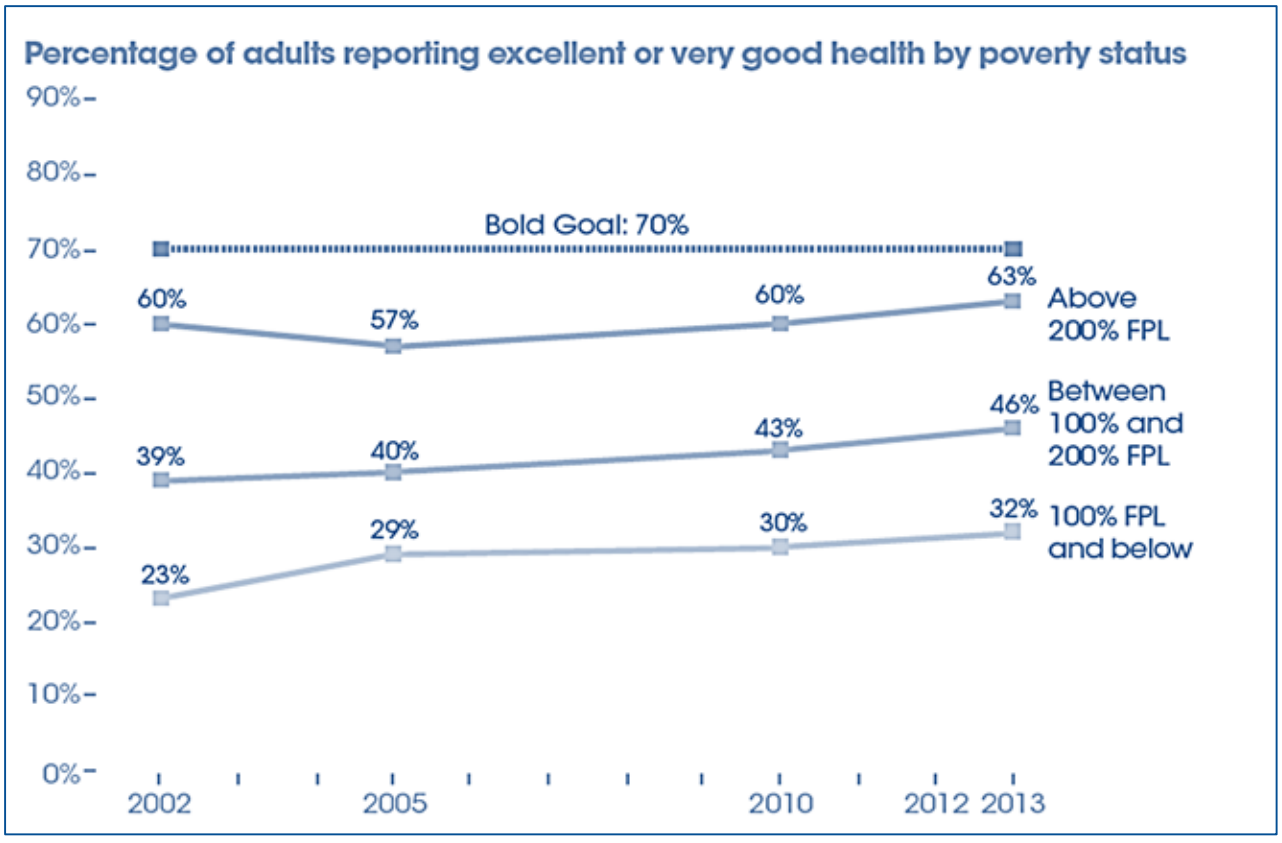
The steering committee stepped back to consider the issue of setting its metrics. After considering other options, members committed to confirming the community bold goals for health established in 2011 through a community process convened by the United Way. These goals had been affirmed by over 250 community organizations as signatories. The heath goals were to have **70% of the community report their health status to be very good or excellent** (currently 52%), and to have **95% report they have access to an appropriate source of medical care** (currently 82%). These metrics are reported every three years on the Community Health Status Survey, a validated and respected tool for local health information.

An analysis of the baseline metrics, last recorded in 2013, revealed large gaps attributable to income and moderate gaps attributable to race. The steering committee committed to reducing those gaps by 50% by 2020. As a result of that decision, the following goal hierarchy was developed:[2]

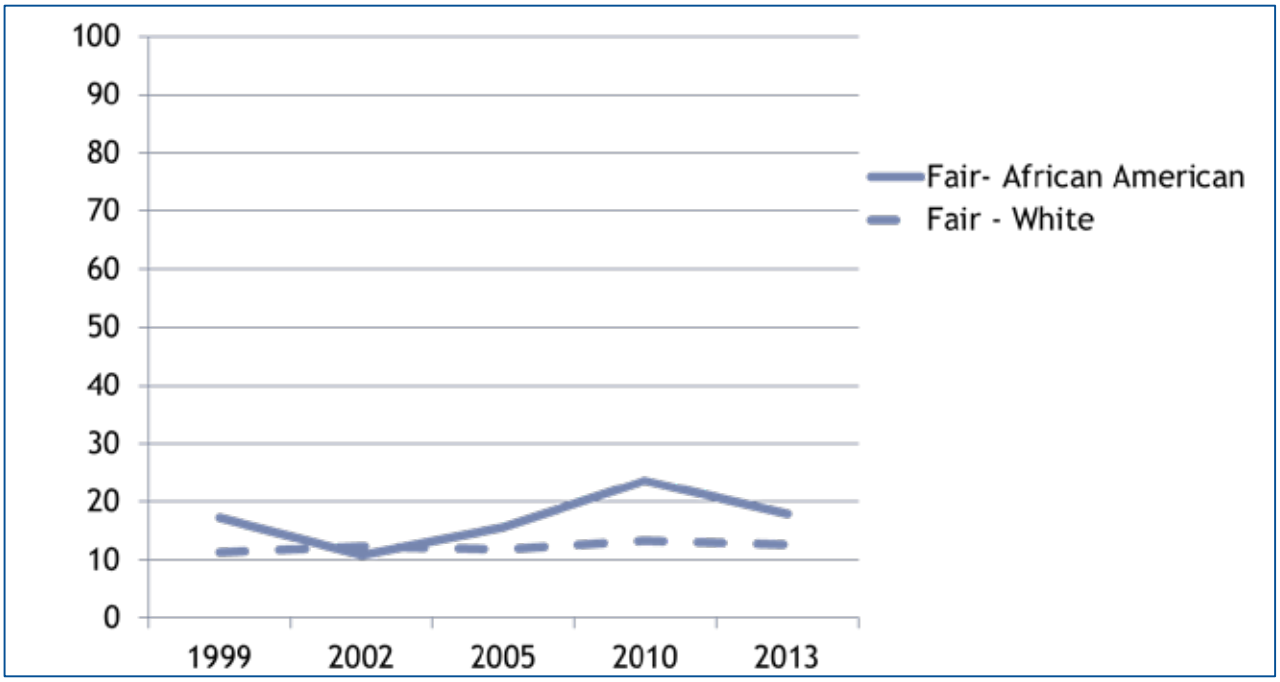



## Adult Self-Reported Health Status

### 2013 By Income: Gap = 29 points  Goal <15 points by 2020

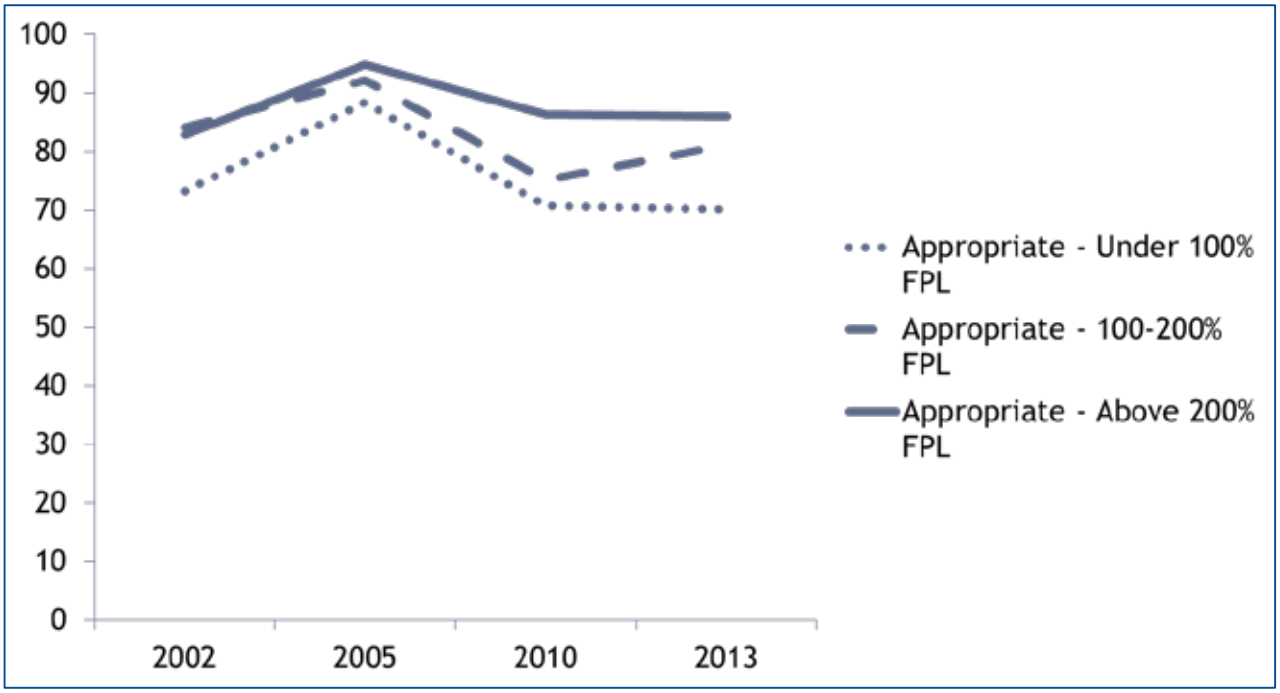


### 2013 By Race: 6-point gap. Goal: <3 points by 2020

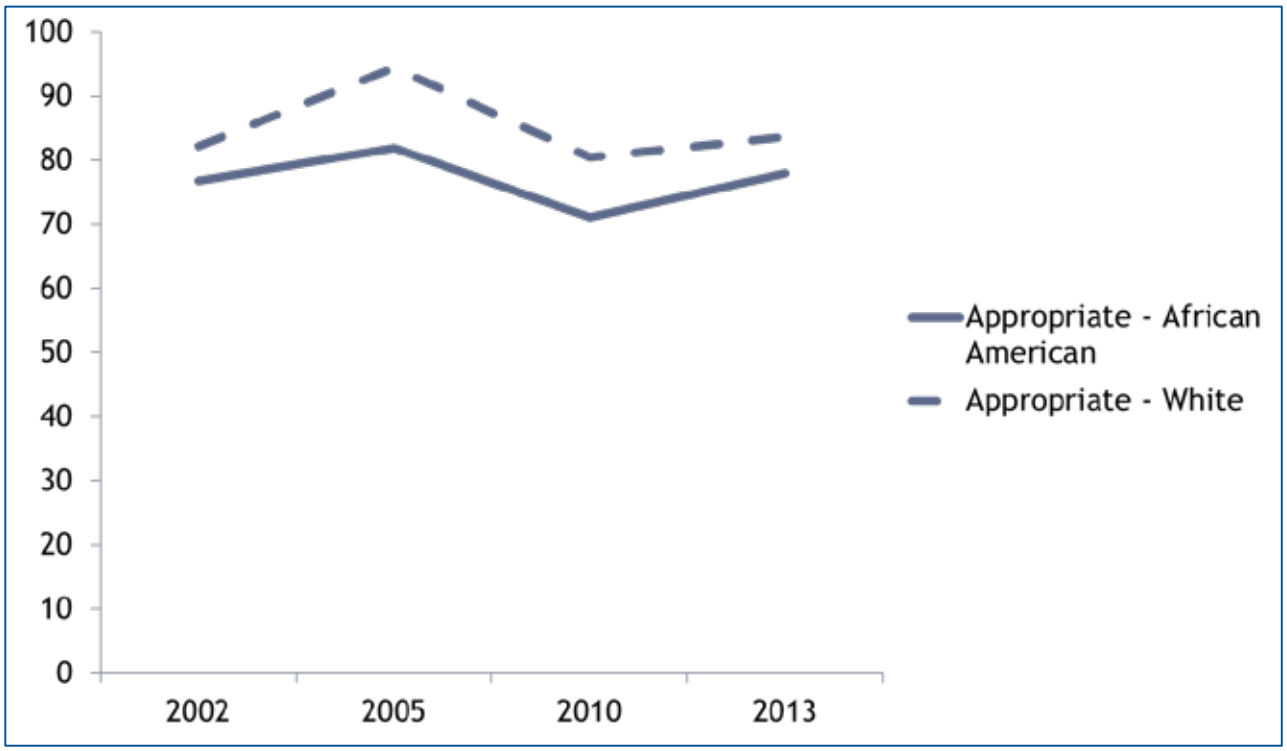



## Adults Reporting a Regular and Appropriate Source of Care

### 2013 By Income: 16-point gap. Goal: <8 points by 2020



### 2013 By Race: 6-point gap. Goal: <3 points by 2020




### 2-Part Goals: Access

| Goal | Disparity reductions |
|---|---|
| 95% reporting regular and appropriate source of care AND Reduce the disparity attributable to race, ethnicity and income by 50% | Reduce by >8 points the gap attributable to income |
| | Reduce by >3 points the gap attributable to race or ethnicity |

### 2-Part Goals: Self-Reported Health Status

| Goal | Disparity Reductions |
|---|---|
| 70% reporting excellent or very good health AND Reduce the disparity attributable to race, ethnicity and income by 50% | Reduce by >15 points the gap attributable to income |
| | Reduce by >3 points the gap attributable to race or ethnicity |

Action teams began to convene to determine what objectives and metrics would be the best indicators of improvement in their areas of focus. Insights from other secondary research suggested respondents who considered their primary barriers to reporting excellent or very good health to be either the existence of a chronic disease, their weight, or poor diet and exercise habits. The strategy began to emerge. **Our opportunity was to focus on the prevention and management of lifestyle modifiable chronic disease, specifically obesity, hypertension, diabetes, and COPD through the following approaches:**

## Objectives of the Four Action Areas

| | |
|---|---|
| Activate a culture of health that values healthy eating, active living, stress management, and tobacco free living. | Leverage changes in the provider environment to support the prevention and management of chronic disease including behavioral health, i.e. care coordination and improved linkages to community support to help patients self-manage their wellness. |
| Address access issues, with particular focus on expanding care options for low income individuals and families. | Develop payment strategies that incent management and prevention of chronic disease, and strategies to encourage efficient utilization of health services. |

Each team developed three to five threads of activity with leading indicators, objectives and baseline metrics. By the close of 2015, work was scheduled to continue in the action teams to bring together a list of strategies, tactics, and partnerships that would be needed to drive progress on the agenda. Strategies may fall into the following categories.

| | |
|---|---|
| Policy change | Influencing governments, schools, employers and organizations to make changes to laws, policies or practices to emphasize healthy choices improve population health |
| Community intervention | Collaborating or creating partnerships with stakeholders to allow individuals and vulnerable populations to overcome barriers to better health and support self-management of health goals |
| Provider intervention | Influencing providers to increase the efficiency and effectiveness of care, support data collection and measurement, and address payment methods that support reducing the prevalence and management of chronic disease |
| Individual change | Enhancing skills, knowledge, attitudes and motivation to make healthy choices |

Going forward, it will be the role of the action teams and steering committee to build community will and help form partnerships with organizations that are interested and able to support the goals through new or existing activities.

- The United Way of Greater Cincinnati has committed to aligning its funding investments in health to support the collective impact on health objectives.
- Interact for Health has also committed to prioritizing its investments based on their alignment with the objectives.
- Greater Cincinnati Foundation continues to support the community of collective impact backbone organizations to leverage alignment and synergy.
- Employers are being asked to participate in an employer council to address workplace approaches to wellness and chronic disease management.
- Hospitals, health systems, and providers are being asked to work together though the backbone organization to identify roles they can play individually and collectively to support the objectives.

## Collective Impact on Health Leadership Forum Event Roster

Attendees for 9/12/14, 11/3/14, 3/19/15 events

| First Name | Last Name | Credentials | Title | Organization | Sector |
|---|---|---|---|---|---|
| Robyn | Chatman | | Physician | Academy of Medicine of Cincinnati | Community Non-Profit |
| Sean | Rugless | | President and CEO | African American Chamber of Commerce | Business-Related Associations |
| Barry | Malinowski | MD | Medical Director, Ohio | Anthem Blue Cross and Blue Shield - Mason | Health Plans/Brokers |
| Sheila | Holmes Howard | | President & Secretary | Avondale Community Council | Other |
| Wonda | Winkler | | Vice President | Brighton Center, Inc | Community Non-Profit |
| Patricia | Burg | | Director of Administration | Butler County Health Department | Public Health Agencies |
| Donald | Wharton | | Ohio Market Medical Director | Caresource Cincinnati | Health Plans/Brokers |
| Brent | Cooper | | President | C-Forward (NKY Chamber of Commerce) | Business-Related Associations |
| Alex | Shirey | | CEO | Champion Window & Patio Room | Employers & Business Interests |
| Gary | Lindgren | | Executive Director | Cincinnati Business Committee | Employers & Business Interests |
| Michael | Fisher | | President and CEO | Cincinnati Children's Hospital Medical Center | Health Systems/Providers |
| Robert | Kahn | MD | Associate Director | Cincinnati Children's Hospital Medical Center | Health Systems/Providers |
| Robert | Shapiro | MD | Director, Child Abuse Team, Mayerson Center for Safe and Healthy Children | Cincinnati Children's Hospital Medical Center | Health Systems/Providers |
| Camille | Jones | MD | Assistant Health Commissioner of Community Health | Cincinnati Health Department | Public Health Agencies |
| Marilyn | Crumpton | | Director, School and Adolescent Health | Cincinnati Public Schools | Education |
| Jean | Chappell | | Dean Health and Public Safety | Cincinnati State Technical & Community College | Education |
| Mary | Stagaman | | VP, Regional Initiatives and Executive Director, Agenda 360 | Cincinnati USA Regional Chamber | Business-Related Associations |
| Sherry | Carran | | Mayor | City of Covington | Local Government |
| Julianne | Nesbit | | Health Commissioner | Clermont County Public Health | Public Health Agencies |
| Suzanne | Burke | | Chief Executive Officer | Council on Aging of Southwestern Ohio | Community Non-Profit |
| Ryan | Adcock | | Executive Director | Cradle Cincinnati | Community Non-Profit |
| Steven | Covington | | Chief Executive Officer | Crossroad Health Center | Health Systems/Providers |
| Greg | Ebel | | Consulting Director | Deaconess Associations Foundation | Foundations |
| Ramsey | Ford | | Co-Founder and Design Director | Design Impact | |
| George | Vincent | | Attorney at Law | Dinsmore & Shohl LLP | Employers & Business Interests |

| First Name | Last Name | Credentials | Title | Organization | Sector |
|---|---|---|---|---|---|
| Amber | Twitty | | President/CEO | Dorothy Grace Consulting | Consumer |
| Gabriela | Alcalde | | Vice President, Policy & Program | Foundation for a Healthy Kentucky | Foundations |
| Michael | Conner | | VP, Human Resources | Frisch's Restaurants, Inc. | Employers & Business Interests |
| Terry | McQuery | | Director, Compensation & Benefits | Frisch's Restaurants, Inc. | Employers & Business Interests |
| Craig | Osterhues | | Executive Director, Regional Health Initiatives | GE Aviation | Employers & Business Interests |
| Todd | Portune | | Hamilton County Commissioner | Hamilton County Board of Commissioners | Local Government |
| Tim | Ingram | | Health Commissioner | Hamilton County Public Health | Public Health Agencies |
| Judith | Warren | | Chief Executive Officer | Health Care Access Now | Community Non-Profit |
| Sharron | DiMario | | Executive Director | Health Careers Collaborative | Consumer |
| Amy | Rohling-McGee | | President | Health Policy Institute Ohio | Other |
| Amy | Stevens | | Director of Prevention and Public Health Policy | Health Policy Institute Ohio | Other |
| Alfonso | Cornejo | | Board President | Hispanic Chamber of Commerce | Business-Related Associations |
| Dan | Cahill | | Vice President, Market Leader | HORAN | Health Plans/Brokers |
| Karen | Mueller | | Executive Vice President | HORAN | Health Plans/Brokers |
| Derek | van Amerongen | | Market Medical Officer | Humana | Health Plans/Brokers |
| Jennifer | Chubinski | PhD | Vice President of Innovation and Learning | Interact for Health | Foundations |
| Jim | Schwab | | President and CEO | Interact for Health | Foundations |
| Susan | Sprigg | | Research Associate | Interact for Health | Foundations |
| Eric | Kearney | Senator | Partner | Kearney & Kearney, LPA | Other |
| Paul | Keck | | President and Chief Executive Officer | Lindner Center of HOPE | Health Systems/Providers |
| Lynn | Oswald | | Executive Vice President | Lindner Center of HOPE | Health Systems/Providers |
| Kathy | Schwab | | Executive Director | Local Initiatives Support Corporations | Community Non-Profit |
| Kristen | Baker | | Senior Program Officer | Local Initiatives Support Corporations (LISC) | Community Non-Profit |
| Aaron | Brock | | Director of Clinical Integration | Mercy Health | Health Systems/Providers |
| Amy | Frankowski | MD | Physician - Internal Medicine | Mercy Health - Blue Ash Primary Care | Health Systems/Providers |
| Karen | Pawsat | | Vice President, Benefits & Compensation | Messer Construction Co. | Employers & Business Interests |
| Laura | Brinson | | Health Educator/Drug Free Communities Coordinator | Northern Kentucky Health Department | Public Health Agencies |

| First Name | Last Name | Credentials | Title | Organization | Sector |
|---|---|---|---|---|---|
| Lynne | Saddler | MD | District Director of Health | Northern Kentucky Health Department Edgewood | Public Health Agencies |
| Adrianne | Lane | PhD | Chair, Advanced Nursing Studies | Northern Kentucky University | Education |
| Joseph | Wind | PhD | Vice President for Government and Community Relations | Northern Kentucky University | Education |
| Owen | Nichols | | President and Chief Executive Officer | NorthKey Community Care | Health Systems/Providers |
| George | Gevas | | Senior Vice President | PNC Bank | Employers & Business Interests |
| Susan | McPartlin | Chair | Market Managing Partner | PricewaterhouseCoopers | Employers & Business Interests |
| Bruce | Brown | | Chief Information Officer (Retired) | Procter & Gamble | Employers & Business Interests |
| Jane | Branscomb | | | ReThink Health | |
| Sherry | Immediato | | Director | ReThink Health | |
| Bobby | Milstein | | Director | ReThink Health | |
| Rebecca | Niles | | Senior Facilitator of System Strategy | ReThink Health | |
| Kristina | Wile | | | ReThink Health | |
| H.A. | Musser | | President & CEO | Santa Maria Community Services Administration | Community Non-Profit |
| Sally | Duffy | SC | President | SC Ministry Foundation | Foundations |
| Nancy | Costello | | Director | Skyward | Business-Related Associations |
| William | Scheyer | | President | Skyward | Community Non-Profit |
| Sarah | Giolando | | Senior Vice President and Chief Strategy Officer | St. Elizabeth Healthcare | Health Systems/Providers |
| Barbara | Terry | | Vice President of Health Care Integration | The Children's Home of Cincinnati | Community Non-Profit |
| Mike | Keating | | President and CEO | The Christ Hospital Health Network | Health Systems/Providers |
| Shelley | Spencer | | VP & Chief Marketing Officer | The Christ Hospital Health Network | Health Systems/Providers |
| Renee | Mahaffey Harris | | Chief Operating Officer | The Ctr for Closing the Health Gap in Gr Cinti | Community Non-Profit |
| Molly | Robertshaw | | Program Officer - Health & Wellness | The Greater Cincinnati Foundation | Foundations |
| Shiloh | Turner | | VP for Community Investment | The Greater Cincinnati Foundation | Foundations |
| Craig | Brammer | | Chief Executive Officer | The Health Collaborative | Backbone Staff |
| Jason | Bubenhofer | | Manager, Business Intelligence | The Health Collaborative | Backbone Staff |
| Amy | Goetz | | Communications Coordinator | The Health Collaborative | Backbone Staff |
| Mary | Maune | | Senior Project Manager Consumer Programs | The Health Collaborative | Backbone Staff |

| First Name | Last Name | Credentials | Title | Organization | Sector |
|---|---|---|---|---|---|
| Laura | Randall | | Senior Vice President, External Affairs | The Health Collaborative | Backbone Staff |
| Richard | Shonk | MD | Chief Medical Officer | The Health Collaborative | Backbone Staff |
| Ruomaio | Wang | | Senior Data Analyst | The Health Collaborative | Backbone Staff |
| Katy | Barclay | | Senior Vice President, Human Resources | The Kroger Company - Vine Street | Employers & Business Interests |
| Jodie | Short | | Business Manager | The Mayerson Center | Other |
| Will | Ziegler | Esq. | President & CEO | The R.C. Durr Foundation, Inc. | Foundations |
| William | Groneman | | Executive Vice President, System Development | TriHealth | Health Systems/Providers |
| John | Prout | | CEO | TriHealth | Health Systems/Providers |
| Richard | Lofgren | | President and CEO | UC Health | Health Systems/Providers |
| Robert | Brown | | Consumer Advocate | UHCAN | Consumer |
| Ross | Meyer | | Vice President Community Impact | United Way of Greater Cincinnati | Community Non-Profit |
| Rob | Reifsnyder | | President and CEO | United Way of Greater Cincinnati | Community Non-Profit |
| Annie | Ryan | | Business Intelligence Analyst | United Way of Greater Cincinnati | Community Non-Profit |
| Alyssa | Spoor | | Community Impact Associate | United Way of Greater Cincinnati | Community Non-Profit |
| Chikere | Uchegbu | | Manager, Strategic Relations & Public Policy | United Way of Greater Cincinnati | Community Non-Profit |
| Kurt | Lewis | | Executive Director | UnitedHealthcare | Health Plans/Brokers |
| Donald | Washington | | SW OH Advocacy Coordinator | Universal Health Care Action Network Ohio | Community Non-Profit |
| Geneva | Miller | | Associate to Senior Vice President for Academic Affairs and Provost | University of Cincinnati | Education/Consumer |
| Thomas | Boat | MD | Dean | University of Cincinnati College of Medicine | Education |
| Christopher | Lindsell | MD | Associate Dean for Clinical Research/Vice-Chair and Professor of Emergency Medicine | University of Cincinnati College of Medicine | Education |
| Karen | Bankston | PhD | Associate Dean Clinical Practice, Partnership and Community Engagement | University of Cincinnati College of Nursing | Education |
| Barbara | Tobias | MD | Professor, Family and Community Medicine, Robert and Myfanwy Smith Chair | University of Cincinnati Department of Family Medicine | Education |
| Patricia | Bready | | Vice President, Youth & Neighborhood Programs | Urban League of Greater Cincinnati | Community Non-Profit |
| Donna | Jones Baker | | President & CEO | Urban League of Greater Cincinnati | Community Non-Profit |
| Rob | Lambert | | Vice President | USI Insurance | Health Plans/Brokers |
| Valerie | Landell | | President/Chief Executive Officer | Visiting Nurse Association of Greater Cincinnati and Nort | Health Systems/Providers |
| Duane | Stansbury | | Health Commissioner | Warren County Health Department Lebanon | Public Health Agencies |

| First Name | Last Name | Credentials | Title | Organization | Sector |
|---|---|---|---|---|---|
| Noreen | Hayes | | Senior Vice President | Western & Southern Financial Group | Employers & Business Interests |
| Bobby | Hilton | | Senior Pastor | Word of Deliverance Ministries for the World, Inc. | Faith-Based Organizations |
| Jenny | King | | Vice President, Human Resources | Xtek Inc | Employers & Business Interests |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