ADDENDUM:
2016 GREATER CINCINNATI CHNA

University of Cincinnati Medical Center

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

Introduction

In 2015 the University of Cincinnati Medical Center participated, as part of UC Health, in the collaborative development of a Community Health Needs Assessment (CHNA) for Greater Cincinnati, which incorporated considerable community input. This addendum will be published with the CHNA Report in 2016. The addendum describes the prioritization process and its results to identify significant health needs, and it also updates the status of the prior Implementation Plan.

Criteria

A hospital committee scored the community health needs identified in the CHNA by considering the following criteria:

- Cause of many hospital visits (based on hospital utilization data from the Ohio Hospital Association)
- Clear disparities/inequities (by geographic areas of disparity measured by Community Need Index score and/or health issues identified in 2011 and 2013 CDC reports)
- Collective Impact priority (Collective Impact is a regional multidisciplinary approach to health improvement.)
- Community prioritized it highly (based on consensus on priorities in CHNA)
- Consequences if not addressed (professional judgment)
- Effective/feasible intervention exists (per The Community Guide; CDC recommendations; and/or recommendations from hospital physicians and/or leaders)
- Impact on other health outcomes (based on risk factors associated with issue)
- Issue worse over time (based on up to 5 years' trend data collected for CHNA)
- Measurable outcome exist (based on CHNA's data sources)
- Proportion of population impacted (per incidence rate of new cases; prevalence rate; mortality rate; and/or top cause of death)
- Unique approach to address problem (per recommendations from hospital physicians and/or leaders)

One criterion was weighted more heavily than the other criteria – 'Community prioritized it highly' – in order to retain an emphasis on what the community deemed most significant.

Process

There were two meetings held: one on December 17, 2015 to discuss and determine the prioritization process, and one on January 14, 2016 to conduct the scoring of priorities.

The University of Cincinnati Medical Center adapted UC Health's Strategic Project Assessment Form, used to determine priorities for health system initiatives, which has a scoring scale of 1 to 5. For the CHNA prioritization process, a score of '1' denoted 'not a priority,' and a score of '5' meant 'strong priority.' A blank scoring sheet is provided on page 4.

In addition to increasing the weight of the criterion, 'Community prioritized it highly,' two health issues were also weighted. Access to care/services and mental health were both already identified at UC Health as top priorities during its strategic planning process in 2016.

UC Health's experience with both mental health and substance abuse also led their combination into one category, since mental health issues are a root cause for most substance abuse disorders. In the CHNA cancer and obesity were mentioned individually as well as mentioned within the broader category of chronic disease. During the prioritization process, these scores were reflected separately and combined together.

Participants

The people who scored the community health needs for the University of Cincinnati Medical Center were:

- Mary Ahlers, Clinical Coordinator, Air Care & Mobile Care, UC Medical Center
- Laura Allerding, Director, Strategic Planning & Market Research, UC Health
- Ted Inman, Vice President, Strategic Planning & Special Projects, UC Health
- Christie Kuhns, Director, Community Strategic Planning, UC Health
- Matt Nealon, Vice President, Finance and Chief Financial Officer, UC Medical Center
- Candace Novak, Vice President, Advocacy & Government Relations, UC Health
- Heena Parvez, Strategic Planning Analyst, UC Health
- Don Peak, CPA, Director of Operations Finance, UC Health
- Lauren Stenger, Coordinator, Trauma Outreach/Prevention, UC Medical Center
- Steve Strakowski, MD, Senior Vice President, Strategic Planning, UC Health
- Tracey Zion, Manager of Care Management, UC Medical Center

Consideration of community input

The University of Cincinnati Medical Center committee received detailed information about the health issues identified in Butler, Clermont, Hamilton, and Warren Counties by Health Commissioners, individual consumers, nonprofit agencies serving vulnerable populations, and focus group participants.

The health and health-related issues were:

- Access to care/services
- Cancer
- Chronic diseases
- Diabetes
- Infant mortality
- Mental health
- Obesity
- Health education
- Substance abuse
- Systemic socioeconomic factors

Additional needs considered

The University of Cincinnati Medical Center committee reviewed hospital utilization data, which confirmed that obesity, mental health, and substance abuse were significant issues among its patient population, consistent with the CHNA findings.

Top three priorities

The top priorities for the University of Cincinnati Medical Center were:

- Chronic diseases (score = 2014)
- Mental health & substance abuse (score = 1620.5)
- Access to care (score = 929)

The list of priorities and their scores is provided below.

SIGNIFICANT ISSUE	SCORE BY ISSUE	TOP SCORES
Chronic diseases combined		**2014.00**
Mental health & substance abuse combined		**1620.50**
Access to care (weight x 2)	929.00	**929.00**
Mental health (weight x 2)	1037.00	
Substance abuse	583.50	
Obesity	548.50	
Chronic disease, general	507.50	
Diabetes	500.00	
Systemic socioeconomic factors	468.00	
Cancer	458.00	
Infant mortality	457.00	
Health education	421.00	

Blank Scoring Sheet - CHNA Prioritization

Criteria	Priorities									
	Access to care/services	Cancer	Chronic disease	Diabetes	Health education	Infant mortality	Mental health	Obesity	Substance abuse, esp. heroin	Systemic socio-economic factors
Issue worse over time										
Community prioritized it highly	*Scores doubled for this criterion*									
Effective/feasible intervention exists										
Cause of many hospital/ED visits										
Consequences if not addressed										
Measurable outcomes exist										
Unique approach to address problem										
Proportion of population impacted										
Impact on other health outcomes										
Clear disparities/inequities										
Collective Impact priority										
TOTAL										

Low					**High**
1	**2**	**3**	**4**	**5**	
Not a Priority	**Low Priority**	**Neutral**	**Moderate Priority**	**Strong Priority**	

EVALUATION OF IMPACT OF 2013 IMPLEMENTATION PLAN

Community Health Need	Initiative	Performance Metric(s)	Action Steps	Action Step Completion Date	Status / Notes
Infant Mortality	Execution of collaborative Infant Mortality Project (Infant Mortality Reduction Initiative Project Plan)	Reduce rate of Infant Mortality by 15% (20 deaths/year) in Hamilton County	1. Establish obstetric surveillance data group including UCMC, Christ, Good Samaritan, Bethesda North, and the Mercy Hospitals	June 30, 2014 (Completed)	
			2. Refine the FIMR and the Collaboration with the Perinatal Community Action Team.	June 30, 2014 (Completed)	
			3. Execute Safe Sleep education and media campaign.	June 30, 2014 (Completed)	
			4. Improve coordination and evaluate ongoing efficacy of Pregnancy Pathway Program.	June 30, 2014 (Completed)	
			5. Implement Tobacco Cessation program for pregnant women utilizing established effective interventions, media campaign and development of community resources	June 30, 2014 (Program launched 2/27/15)	
			6. Implement accessible, adequate, standardized and customized pre-natal care	June 30, 2014 (Completed)	

Community Health Need	Initiative	Performance Metric(s)	Action Steps	Action Step Completion Date	Status / Notes
Diabetes / Adult Obesity / Hypertension	Coordinate diabetes care between hospital and primary care settings via the Sweet Transitions patient-centered intervention	--Change in A1C from hospitalization for patients with poorly controlled diabetes --Evidence of testing for diabetes by PCP for hospitalized patients with hyperglycemia --Readmis-sions or ED visits for both patient types --Patient 'activation' & knowledge --Provider satisfaction --Hypogly-cemia	1. Obtain AHRQ grant funding for Sweet Transitions program.	July 2015 (Submitted, but not funded) July 2016 (To be resubmitted)	Grant proposal for Pragmatic Trial arm of Sweet Transitions was submitted to NIDDK in July 2015. A revised proposal will be resubmitted in July 2016.
			2. Establish collaboration & partnerships with stakeholders across academic health center and community.	July 2014 (Completed)	New Collaborators from UC College of Nursing: a. Liaison with primary care practices of FQHCs (Mt. Healthy and Lincoln Heights) to expand underserved patient base for Sweet Transitions. b. Liaison with Greater Cincinnati community-based resources to provide individualized needs-assessment for Sweet Transitions participants and provide diabetes specific education to support community. c. Continued collaboration with UC Department of English and Comparative Literature to revise/refine communication tools and develop EPIC-based components (discharge modules; after-visit summaries; and educational templates).

Community Health Need	Initiative	Performance Metric(s)	Action Steps	Action Step Completion Date	Status / Notes
Diabetes / Adult Obesity / Hypertension	Coordinate diabetes care between hospital and primary care settings via the Sweet Transitions patient-centered inter-vention	continued --Identification of key elements in intervention process that facilitate its implementation across diverse US communities	3. Conduct qualitative evaluation (including patients, community primary care, community health organizations and hospital staff to a) develop communication models and patient-centered intervention, and b) identify key factors that facilitate broad implementation.	Aug. 2016 (Estimated)	
			4. Identify "Found Pilots" - existing initiatives at the University of Cincinnati Medical Center (UCMC) with similar objectives of improving care coordination / transitions in order to leverage resources and prevent 'transformational project overload.'	Aug. 2013 (Completed)	
			5. Establish Sweet Transitions clinical team, design practice operations and implement program in pilot population.	Ongoing	--Sweet Transitions NP and CDE hired and prior positions backfilled Fall 2015. --Obtained additional space and increased number of face-to-face visits with participants --Ongoing collaboration with UCP coding specialist to refine billing strategy in order to facilitate sustainability of program (CMS transition of care codes & traditional E&M codes)

Community Health Need	Initiative	Performance Metric(s)	Action Steps	Action Step Completion Date	Status / Notes
Diabetes / Adult Obesity / Hypertension	Sweet Transitions, continued	Sweet Transitions, continued	6. Engage 50 patients in Sweet Transitions intervention.	Sept. 2015 (Completed)	Enrolled 94 UCMC inpatients with poorly controlled diabetes in Sweet Transitions.
			7. Evaluate effectiveness of Sweet Transitions intervention to improve diabetes outcome (performance metrics).	Aug. 2016 (Estimated)	90-day outcome data for 63 patients enrolled in Sweet Transitions: --Significant decline in HbA1c --Significant decline in 30-day readmissions when compared with controls
Mental Health	Improve access to and create additional capacity to address mental health needs	--Reduce the number of repeat ED visits by mental health patients --Reduce the number of psychiatric transfers between facilities --Reduce the percent of mentally unhealthy days for Clermont and Hamilton Counties to the AIM Benchmark (3.9%)	1. Establish a UCMC Mental Health Clinic staffed by UCP physicians and UCMC psychiatry residents.	Jan. 31, 2016 (Completed)	Development of the Transition Clinic; Expansion of the Resident Mood Clinic; Movement of patients to the Stetson Outpatient Practice
			2. Establish a task force to work with community case management to schedule patients for appointments once they leave the ED systems to decrease the rate of recidivism for ED mental health patients. Collaborate with Keys to Health & Sobriety Center projects.	November 2013 (Completed)	
			3. Optimize telemedicine to collaborate with all internal partners (EDs only).	Feb. 2014 (Completed)	

_____/_____/_____

Date approved by Audit and Compliance Committee of UC Health Board of Directors

_____/_____/_____

Date approved by UC Health Board of Directors