



TROY HOSPITAL

Community Health Needs Assessment 2020

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Introduction

This Community Health Needs Assessment (CHNA) Report for the new hospital in Troy is based on the collaborative CHNA Report for the larger region. It provides a regional summary that identifies significant community health needs and also 1) documents the CHNA as it applies to Miami County, the primary service area of the Troy Hospital, and 2) identifies the resources available in Miami County to meet the needs identified.

Kettering Health Network and its hospitals joined twenty-seven (27) other hospitals in the Greater Cincinnati-Dayton region to sponsor and fund a comprehensive CHNA for twenty-five (25) counties. The CHNA Report covers Greater Dayton and Greater Cincinnati, which includes Northern Kentucky and Southeastern Indiana. The CHNA Report shares data for the whole region as well as detailed county-level data. It also added the voice of the Southwest Ohio members of the Association of Ohio Health Commissioners. Developing a broad CHNA helps fulfill the State of Ohio's requirement mandating that health departments and hospitals align their assessments starting in 2020. As a result, the CHNA team has researched more secondary data measures (included hospital utilization data), oversampled vulnerable populations, and engaged more participants. A total of 1,416 people or organizations completed a survey or attended meetings. A key component of the increase was due to local health departments helping to promote and conduct meetings.

There were five different types of source materials used for the CHNA Report: Meeting responses; Consumer survey responses; Agency survey responses; Health Department survey responses; and secondary data for up to 142 publicly available measures. Regional priorities were determined by the number of votes in community meetings, the number of mentions on surveys and data worse than state or national data, trending in the wrong direction, and impacting a majority of the region's counties (secondary data).

Priorities

The five identified priorities ranked in the top eight for all primary data sources (meetings and survey from consumers, health departments, and agencies). They are sorted in descending order. These priorities are key findings of the CHNA Report, because they show the areas of agreement between secondary data and all sources of primary data for the region.

- Substance abuse
- Mental health
- Access to care/services
- Chronic disease
- Healthy behaviors

Priorities were determined by the number of votes in community meetings; the number and percentage of mentions on surveys; and, for secondary data, data worse than state or national data, trending in the wrong direction, and impacting at least 16 counties. Here is additional information for each priority area:

Substance abuse

Although Substance Abuse Disorder is a mental health diagnosis, the volume of responses indicated that substance abuse remain a separate category related to the use and abuse of illegal drugs, prescription drugs, alcohol, and addiction in general. Comments about the impact of alcohol on society and families recurred in meetings and on surveys. Multiple people asked for less concentration on drug-specific responses and more approaches that deal with the underlying problems leading to addiction of any kind. The vast majority of responses from surveys or in meetings were the general terms, 'substance abuse,' or 'drug abuse.' Heroin continues to be a source of grave concern throughout the region. In some areas, however, the number of heroin overdoses have declined while the use of other drugs is increasing. Part of the decline is the expanded availability of naloxone throughout the region. Use of methamphetamines (meth) and other illegal drugs is growing.

Mental health

The general term, 'Mental health,' was the most common response in this category. There were also myriad comments about many different types of mental health issues. Depression was cited most often, followed closely by anxiety. Suicide was openly discussed in several meetings, and it was a priority in both LGBTQ+ meetings. Next most commonly mentioned were mood disorders and ADD/ADHD. Self-harming came up several times, as did stigma. Many people mentioned trauma in general, and specifically Adverse Childhood Experiences – both the impact of past experiences on adults and the impact on children living through them now. A disturbing trend was the increase in comments about the need for psychiatric hospital beds for children younger than 12. Related issues included access to mental health providers in the community, insurance for behavioral health treatment, and providers who would accept Medicaid. Secondary data corroborates the lack of providers, and 24 of 25 counties do not have enough mental health providers. The national ratio is one provider for every 470 people. In Ohio, the ratio is 1 per 561. In Miami County, the ratio is 1 per 1,074.

Access to care and/or services

This category received many general 'Access' comments, but also a wealth of specific concerns. The lack of providers was mentioned the most often, 16% of all Access issues. The issues included providers who didn't take Medicaid or other insurance; providers located outside the geographic area; and too few specialists. Other barriers and gaps identified were: no insurance; inadequate insurance coverage; high deductible plans; affordability of care (co-pay and/or out-of-pocket); cost of medication; can't take time off during working hours; no one to watch children; language barrier; and/or lack of local services (e.g., cancer treatment). Transportation was named by consumers in meetings and on surveys. Transportation issues included no public transportation; inadequate transportation; or cost of transportation (bus fare, bus transfers, car ownership and/or gas purchase).

Chronic disease

The most common chronic diseases cited were: heart disease, cancer, and diabetes. Hypertension was commonly cited, and stroke, allergies, and arthritis were mentioned several times. Many responses used the more generic term, 'Chronic disease.' Lung cancer and Type 2 Diabetes significantly impact the region, according to the secondary data. Arthritis, cardiovascular, heart, and respiratory issues were among the top 20 most common diagnoses of hospitalized patients in the region.

Healthy behaviors

This category is the flip side of chronic disease. This is where people described all the habits that they would like to change to avoid illness or increased risk of death. Some people did just answer 'healthy behaviors,' but the most common specific recommendations were: eat healthier; exercise more; quit smoking; and lose weight. This category also captured comments to: quit taking drugs or stop drinking alcohol. Secondary data supports the public perception of needing to address alcohol intake, physical inactivity, smoking, and/or weight.

In answer to the question, "What is your perception of the overall health status of your community," 114 respondents (11.1% of the 1,026 who answered) thought it was very good (7.4%) or excellent (3.7%). Thirty-four percent, or 349, believed it was good. Fifty-five percent, or 563, thought it was poor or fair. The 'Fair' answer attracted the most responses: 413, or 40.3% of the total.

Collaborative Partners

Kettering Health Network and other nonprofit hospitals in Southwest Ohio combined their efforts and resources to produce the comprehensive and collaborative CHNA. Each participating healthcare system designated a representative to join the CHNA Committee. They signed an agreement with their respective member organizations – the Greater Dayton Area Hospital Association (GDAHA) in Dayton and The Health Collaborative (THC) in Cincinnati – to create the process and produce a report. The Southwest District of the Association of Ohio Health Commissioners (AOHC) partnered in the effort. They also provided representatives who could speak on the behalf of the Ohio counties served by the hospitals. All county-level public health departments completed surveys, including some city health departments. The health departments in Southwest Ohio provided additional support, such as secondary data collection and hosting community meetings. In partnership with the Southwest District of the AOHC, all 23 health departments were involved as well as the Northern Kentucky Health Department.

Hospitals

The hospitals agreed to the following:

- Identify a single point-of-contact as a representative on the CHNA Committee;
- Attend quarterly CHNA meetings or send a delegate;
- Participate in planning and design;
- Distribute invitations (by mail, email, in person, social media, and/or on bulletin boards) two weeks in advance of a scheduled meeting; and
- Provide feedback on the draft report.

Public Health Departments

AOHC represented its members by:

- Identifying the Southwest District Director as the single point-of-contact for communication and coordinator;
- Attending the quarterly CHNA Committee meetings;
- Forming an ad hoc working group and convening the region's public health epidemiologists; and
- Sharing minutes and sign-in sheets from meetings.

CHNA Team

The Health Collaborative staff included: Angelica Hardee, PhD, Senior Manager, Gen-H; Colleen O'Toole, PhD, Chief Administrative Officer; Jason Bubenhofer, Manager, Business Intelligence; Emily Kimball, Coordinator, Gen-H; and Lisa Sladeck, Office Manager and Event Administrator. The staff of the Greater Dayton Area Hospital Association included: Shawn Imel, Director, Health Information Technology; Marty Larson, Executive Vice President; and Bryan Bucklew, President and CEO. The Health Collaborative and the Greater Dayton Area Hospital Association contracted with Gwen Finegan as the Lead Consultant. Her team included: Sadie Healy, MPH; Tomika Hedrington, MHRD; Robyn Reepmeyer, MPH; and Amelia Bedri.

For the Troy Hospital CHNA, Robyn Reepmeyer and Gwen Finegan developed this CHNA with highlights from the regional report and a focus on Miami County, the area to be served by the new hospital opening in 2019.

Community Served

Hospital Service Area

The community served was defined by evaluating the anticipated patient origin for the new Troy Hospital. As the map below shows, the centrally located Troy Hospital expects to derive most of its patients from residents of Miami County in Ohio.



Process and Methods

For the regional CHNA's design, the process for gathering primary data, and the process for identifying, collecting, interpreting, and analyzing secondary data, the consultants referenced numerous methods for both qualitative and quantitative data. The consultants sought data that reflected recent as well as emerging issues by people who lived in the hospitals' service areas, with attention to vulnerable populations and social determinants of health. Secondary data provided information about demographics, health conditions, and health-related issues as of 2016. Primary data reflected the opinions and attitudes of individuals and agencies motivated to attend a meeting or complete a survey. Their passion and level of interest is helpful to hospitals who are contemplating future programs that depend on community support. While not designed to be statistically representative of all 3.3 million residents of the region, there was often remarkable alignment among the top 5-10 priorities from meetings, individual surveys, agency surveys, and health departments.

Here is a brief description of the activities and tools utilized most often.

- Analysis of priorities to identify areas of consensus from all data sources
- Communication by email and letter to past and prospective meeting attendees
- Community meetings that included a visual, interactive, and collective multi-voting exercise (3 dots) to identify the top three priorities of residents
- Community Need Index
- Comparison of most frequent topics by geographic area and across data source
- Consultation with topic experts (i.e., epidemiology, air quality, public health)
- Design and feedback meetings with hospital and health department representatives
- Discourse analysis to categorize and analyze key concepts and topics in all collected responses
- Geographic Information System (GIS) mapping program to identify compelling data and represent data visually
- Marketing materials for hospitals, health departments, and meeting hosts to use or adapt
- Meeting sites, with refreshments, in convenient locations that were welcoming, accessible, and perceived as community asset or resource
- Online databases for researching accurate and reliable data
- Oversampling with vulnerable populations and the general public, including focus groups, use of interpreters and translators, and surveys administered one-to-one in person and via tablet
- Proofreading at least twice of secondary data entry for accuracy and consistency
- Regular communication with hospital and health department representatives
- Review of reports and publications on health, and health-related, topics
- Scripts, handouts, and supplemental materials provided to trained facilitators and scribes

- Shared data at meetings in form of County Snapshots and Community Need Index maps
- Standard set of stakeholder questions (for individual, agency, meeting, health department)
- SurveyMonkey (Gold) for tracking responses at meetings, from interviews, or on surveys, and use of feature to create custom tags for each response
- Tabulation of responses by geographic area and region-wide and for immigrants, children, and urban residents
- Team approach with diverse consultants
- Training, in person and via webinar, for CHNA Team, health departments, hospitals, and nonprofits interested in facilitating and scribing for supplemental meetings to target sub-populations or sub-county geographic areas. This ensured consistent facilitation, process, and recording of meeting comment and priorities.
- Trend analysis that considered local data measures worse than state and/or U.S. measures and/or trending worse than prior years
- Word count to determine frequent categories and to identify dominant topic within a category (e.g., how many times 'heroin' was mentioned within 'Substance abuse' category)

Primary Data

Almost 1,300 people had an opportunity to identify and prioritize health and health-related issues at a meeting or by survey. Twenty-three (23) county- or district-level public health departments responded by survey, and the CHNA Team also received survey responses from 5 city-level health departments. Ninety-six nonprofit organizations completed surveys, and they served residents in every county. Total response far exceeded the level of response experienced three years earlier for the 2016 CHNAs in Cincinnati and Dayton. Primary data was obtained, with a uniform set of questions, via the following:

- There were 42 meetings, held in 23 counties, which attracted 463 representatives of community organizations, the general public, and/or members of medically underserved and vulnerable populations—to identify barriers to care, give input for current needs assessment, prioritize issues, and identify resources to address health and health-related issues.
- Online surveys of individuals (828), agencies (96), and public health departments (28) throughout the region.

Community Meetings

Any individual or agency representative who gave their address during the 2013 or 2016 CHNA process was added to an invite list, and THC mailed them an invitation to the meeting scheduled in their county. The consultants added nonprofit organizations in each county that had either a phone number, street address, or email. THC sent 544 emails and 376 letters by

first-class mail. The consultants made phone calls to agencies that had not previously attended a CHNA meeting as well as to strategic organizations that serve vulnerable populations and/or have a broad reach, e.g., United Way. They followed up with emails. THC sent flyers to hospitals and to meeting host sites for posting and distribution. The consultants also posted upcoming meetings every two weeks in the Interact for Health e-newsletter: Health Watch, which is emailed across 20 counties. The consultants sent flyers to public health departments to post and distribute. Some health departments publicized meetings on their social media pages and held additional meetings. There was a 229% increase in meeting attendance, from 202 for the 2016 cycle to 463 for the 2019 cycle. Part of the increase in attendance is due to the outreach and supplemental meetings held by health departments.

The purpose of the meetings was to solicit public input. The desire was to attract individuals or nonprofit organizations with experience or knowledge to share, especially on emerging issues not captured by the secondary data and from the perspectives of medically underserved, minority, and/or low-income populations.

The objectives were to:

- Share county-level highlights from the secondary data (and city-level for Cincinnati Health Department meetings)
- Gather diverse people to share their ideas -- general public and community leaders
- Receive input from agencies that represent vulnerable populations
- Hear concerns and questions about existing health/health-related issues
- Obtain information about financial and non-financial barriers to health care
- Identify resources available locally to address issues
- Obtain insight into local conditions from local people
- Discover health and health-related priorities of attendees

A group of 2-3 consultants went to each meeting, depending on the number of RSVPs. Each meeting followed the same format and agenda. Refreshments were served, and nametags were used to generate a welcoming atmosphere. Locations were selected for convenience, access, and trusted reputation in the community. The facilitator first shared general Tristate and state-specific health and health-related data to provide context. The survey questions were used, but the first question – about most serious health issues – was asked separately. This technique was intended to capture first thoughts without an opportunity to be influenced by the more specific county-level data or by other attendees. After the first question, the consultants (a meeting facilitator and at least one scribe) shared a profile of the county, including a summary of secondary data. The meetings lasted 90 minutes, of which 60 minutes was devoted to the group's brainstorming. At the end, each person was given 3 colored dots. They placed the dots next to issues they prioritized as most important. The agenda handout contained links to the surveys.

Surveys

The consultants developed three types of surveys: Individual Consumer; Agency; and Health Department. The questions remained the same for each survey. The Health Department version also requested the qualifications of the respondents, as required by the Internal Revenue Service. The Individual Consumer survey was also translated into Spanish and adapted for mobile application at community events. The consultants used SurveyMonkey to collect responses, tabulate data, interpret and analyze results, and create categories to track key words and phrases. Paper copies (translated) were used with Spanish-speaking families, refugees from Rwanda, and at treatment facilities.

There were 492 surveys completed by consumers; 223 collected at events; 96 completed by nonprofit agencies serving vulnerable populations; and 113 surveys completed by Latino immigrants and refugees from conflict in Rwanda. Twenty-eight health departments completed 29 surveys.

Analysis of Primary Data

The primary data collection and analysis used the narrative method and specifically the technique of discourse analysis. The focus was on collecting data from individuals based on their experience. There were several important steps to ensure a consistent process:

- Verbatim entry of comments – this happens automatically with the online survey process and scribes were trained to do this at the community meetings
- Creating custom tags to summarize each response, e.g., cancer, diabetes, heart disease
- Creating themes that connect some of the tags, e.g., Chronic disease
- Proofreading each other's tags and analysis, with review by at least 3 different people to ensure overall consistency
- Use of SurveyMonkey's 'Gold' level enabled the creation of custom tags and initial sorting. It also provided a consistent way to compare survey results with meeting responses. It worked for face-to-face verbal encounters, such as in meetings, as well as written responses. Comments made in person were entered into SurveyMonkey, tagged, and themes identified. The lead consultant customized the tagging in SurveyMonkey because she found that its automatic grouping of ideas was not precise enough and could not account for context or adapt when responses used different words for similar concepts.
- Reviewing tags at the county-level, urban level, and regional level was done to ensure that the tags and themes made sense and were applicable at all levels. For example, the consultants created tags for 'addiction,' 'heroin,' 'meth' as subsets of the 'Substance abuse' theme, because of their apparent frequency at the beginning of the tagging process. They counted each tag and saved the count, but none of these tags reached high enough numbers (more than 5% of mentions) to warrant its own category in the final analysis.

- SurveyMonkey’s filter options facilitated the process of sorting and analyzing by county, by groups of counties, by type of survey, and/or by sub-population. This is a useful option to consider context or culture, such as urban respondents or Latino respondents.

Many responses addressed multiple topics; each new idea was tagged. The review process included verifying that each distinct comment, or ‘mention,’ was tagged once. For example, if smoking was clustered under the ‘Healthy behaviors’ theme, then it did not appear as its own category. If transportation was mentioned in more than 5% of all mentions, then it might become its own category, especially if this pattern were evident in a majority of counties. Otherwise it was counted under ‘Access to care/services.’ This method is known as discourse analysis, used with qualitative results (e.g., written narrative, conversations, focus groups). The tool is becoming more widely applied in health care.

The Miami County Profile contains a “Consensus on Priorities” described by the different types of stakeholders. For the community meetings, the top votes (measured by number of dots) determined the priorities. For the survey results, the regional priorities were the issues receiving the most overall mentions. At the county level, the priorities were sorted by county of residence/service. The threshold for including a priority was 5% or more of all mentions, or at least two mentions.

Emerging Issues

Several emerging areas of interest from the qualitative data are worth noting, although they are not yet high priorities. During the last cycle, the emerging ideas were the burden of high-deductible insurance plans and the heroin epidemic. This time around, those are identified as priority areas within Access to care and Substance abuse.

For this cycle, many comments cited the following needs:

- Support for parents and families – especially young parents who may lack the information and/or skills to be proactive in areas of child development, immunization, school attendance, and school readiness. For Miami County, this category was mentioned as the top priority in the community meeting and amongst the top priorities by consumers;
- Care for children – especially the growing number of children whose parents are heroin addicts or have died from a drug overdose;
- Initiatives to combat addiction – They should address all types of addiction, not just heroin; quite a few people mentioned the devastating impact of alcoholism on families, for example; and
- Social/emotional health – including dealing with bullying, coping skills, positive outlook, self-control, stress management, and community activities that bring people together.

Social Determinants of Health

Three years ago, Social Determinants of Health (SDHs) were mentioned many times in the cities, but the results were diluted when combined with all regional responses. This time SDHs became top priorities for people who live in urban areas but also for people considering the child health issues. Healthy People 2020 (HP2020) defines SDHs as the “conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”¹

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

Secondary Data

Data Collection

County Health Rankings (CHR) formed the foundation for data collection with its county-level focus on health outcomes, health factors, health behaviors, quality of life, clinical care, physical environment, and socioeconomic factors. Additional sources supplemented the CHR data. Publicly available health statistics and demographic were obtained at the state and county level. The epidemiologists for Public Health - Dayton & Montgomery County (PHDMC) volunteered to collect data for the State of Ohio and its counties. They included data through 2016. Ohio's 2017 data was not available in time for this report. The number of data measures increased by 33%, from 106 in 2016 to 142 in 2019.

Data Sources

The standards for researching and including data were:

- Comparable (measures with benchmarks such as Healthy People 2020 or state/national rates)
- County-level data (ZIP Code level preferred but rare)
- Focus on health outcome data (preferred over subjective survey data when both were available)

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

- Reproducible (new update available within three years or at 3-year intervals vs. one-time)
- Reputable source
- Trend data available (more than one data point; 3-5 years preferred)

The CHR was an excellent starting point, but the consultants discovered additional sources with more recent data as well as indicators for measures not collected by CHR. The prevalence of certain cancers, the rapid increase of heroin overdose deaths in the region, and additional mortality data are examples of supplemental data. Many excellent sources of information did not have a breakdown below the state level or did not include the entire region. The consultants contacted state health departments, local health departments, and local experts. The biggest change from the prior cycle is that the Department of Health and Human Services no longer maintains the Health Indicators Warehouse as an online source, and it had provided data for eight key measures. PHDMC epidemiologists consulted the Ohio data for data ranges ending with 2016 and one period prior. The data sources are listed below:

- AIDSvu - <http://map.aidsvu.org/map?state=ky>
- American Community Survey (5-year estimate 2012-2016)
- Business Analyst, Delorme map data, ESRI, U.S. Census provided by 2018 County Health Rankings
- Cancer Incidence: Ohio Department of Health, Ohio Cancer Incidence Surveillance System, 2014-2015
- Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. 500 Cities Project Data 2016
- Centers for Disease Control and Prevention, National Center for Health Statistics. CDC WONDER Online Database, Underlying Causes of Death and Multiple Causes of Death
- Centers for Disease Control and Prevention's Division of HIV/AIDS Prevention
- Centers for Disease Control and Prevention's national HIV surveillance program
- Comprehensive Housing Affordability Strategy (CHAS) data
- County Health Rankings 2018 - American Community Survey, 5-year estimates
- County Health Rankings 2018 - Area Health Resource File/American Medical Association
- County Health Rankings 2018 - Area Health Resource File/National Provider Identification File
- County Health Rankings 2018 - Behavioral Risk Factor Surveillance System
- County Health Rankings 2018 - Bureau of Labor Statistics
- County Health Rankings 2018 - Centers for Disease Control and Prevention Diabetes Interactive Atlas
- County Health Rankings 2018 - National Highway Traffic Safety Administration, Fatality Analysis Reporting System

- County Health Rankings 2018 - National Center for Education Statistics
- County Health Rankings 2018 - National Center for Health Statistics
- County Health Rankings 2018 - National Center for HIV/AIDS, Viral Hepatitis, STD, and TB prevention
- County Health Rankings 2018 - Small Area Income and Poverty Estimates
- County Health Rankings 2018 - U.S. Census Bureau's Small Area Health Insurance
- Dartmouth Atlas of Healthcare
- Data USA (Cincinnati) – Access to Care
- ED Facts provided by 2018 County Health Rankings
- Environmental Protection Agency. Air Quality System Monitoring Data. State Air Monitoring Data. Annual PM 2.5 Level (Monitor only). Accessed from Environmental Public Health Tracking Network: www.cdc.gov/ephttracking. Accessed on 03/01/2018
- Environmental Public Health Tracking Network
- Federal Bureau of Investigation (FBI), Uniform Crime Reporting (UCR), Crime in the United States. Available at: <https://ucr.fbi.gov/crime-in-the-u.s/2016/crime-in-the-u.s.-2016/topic-pages/violent-crime>
- Feeding America, Map the Meal Gap, Accessed March 9, 2018
- Greater Cincinnati Community Health Status Survey
- <http://www.governing.com/gov-data/health/county-suicide-death-rates-map.html>
- Indiana State Health Department
- Kentucky Cancer Registry
- Kentucky State Health Department
- kentuckyhealthfacts.org
- Measure of America
- National Center for Health Statistics - Data.CDC.gov
- National Center for Health Statistics - Mortality Files
- National Center for Health Statistics - Natality files
- National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Northern Kentucky Health District
- Ohio Department of Health, Death Certificates
- Ohio Department of Health, HIV/AIDS Surveillance Program. Data reported through 6/30/17
- Ohio Department of Health, STD Surveillance Program. Data reported through 5/7/2017
- Ohio Department of Health: Center for Public Health Statistics and Informatics. Ohio Public Health Information Warehouse
- Ohio Emergency Medical Services; Naloxone Administration by Ohio EMS Providers, accessed at <http://www.ems.ohio.gov/links/emsNaloxoneAdminByCounty2017.pdf> on 2/13/18
- Population: Bridged-Race County Population data from National Center for Health Statistics (NCHS), Ohio Department of Health, 2014-2015

- PreventionFIRST! Student Drug Use Survey, through 2017
- Safe Drinking Water Information System
- U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
- U.S. Census Bureau, County Business Patterns
- U.S. Census Population Estimates
- Uniform Crime Reporting - FBI
- USDA Food Environment Atlas

Analysis of Secondary Data

After assembling data worksheets for up to 142 measures per county, the consultants applied the following criteria to determine the most significant health needs:

- Top causes of death
- Worsening trend
- Lagging national and state measures, and
- To a lesser extent, falling behind a Healthy People 2020 target

Secondary data was prioritized at the county and regional level. The county-level priorities were the data points that met the criteria of being worse than the state and/or national measures and also trending in the wrong direction. The priorities were sorted for analysis by county. For comparison purposes, priorities were rank ordered with the top priority listed first in the Secondary Data column.

Health Disparities

The CNI is a validated high-level assessment of the risk of health disparities. High scores can mean an increased level of health disparities in that area. Across the region sixty-eight ZIP Codes, or 26% of the region's 262 ZIP Codes, had high scores (3.4 to 5.0) indicating a likelihood of disparities in their experience, or lack, of health care. In Miami County, the ZIP Code of 45356 in Piqua has a high CNI score.

Regional Summary

The information below summarizes information and responses from across the entire 25-county region.

Overall, five issues appeared as the region's top priorities overall, across all five sources of input (four primary sources plus the secondary data). They are sorted in descending order according to average placement (in parentheses), where 1 = first place, and 8 = eighth place. These priorities are key findings of the 2019 CHNA Report, because they show the areas of agreement between secondary data and all sources of primary data for the region.

- **Substance abuse (2.2)** (e.g., abuse of alcohol and/or drugs)
- **Mental health (3.2)** (e.g., depression, suicide, lack of providers, # of poor mental health days)
- **Access to care/services (3.8)** (e.g., cost, insurance, lack of providers, transportation)
- **Chronic disease (4.4)** (e.g., cancer, diabetes, heart, respiratory diseases, stroke)
- **Healthy behaviors (6.4)** (e.g., doctor visits, exercise, quit smoking, self-care, weight loss)

Unmet needs

Overview of Significant Needs

Several questions focus attention on what's missing and where there is room for improvement. They include the questions about barriers: financial and non-financial. The question about which issues are not being addressed enough identifies where there are unmet needs. Social Determinants of Health (SDHs) are addressed as one of the top 7 unmet needs. The secondary data and primary data agreed on five issues: Substance abuse; Mental health; Access to care/services; Chronic disease; and Healthy behaviors.

One of the CHNA questions, "What important health issues are not being addressed enough," revealed perceived gaps related to important health and health-related issues. See chart on next page. Four issues emerged as prioritized needs for all respondents: Access to care/services; Mental health; Social determinants of health; and Substance abuse. Within the category of 'Access to care/services,' lack of providers was mentioned the most often, for 16% of all access issues. The issues included providers who didn't take Medicaid or other insurance; providers located outside the geographic area; and too few specialists. Transportation was named by consumers in meetings and on surveys, for a total of 7% of all mentions within the Access category.

Most Frequent Answers to ‘Not Being Addressed Enough’ Question
(in descending order of number of mentions)

Meetings	Consumers	Agencies	Health Depts.
Access to care/services	Substance abuse	Access to care/services	Access to care/services
Social determinants of health	Access to care/services	Substance abuse	Mental health
Mental health	Social determinants of health	Mental health	Substance abuse
Substance abuse	Mental health	Social determinants of health	Social determinants of health

All sources agreed on three additional areas of unmet needs, but these issues did not receive as many mentions: Chronic disease, Health education/Promotion, and Healthy behaviors. Two more areas of unmet needs received mentions by some sources but not all: Healthy food/Nutrition (not mentioned by health departments) and Obesity (not mentioned at the community meetings).

Barriers

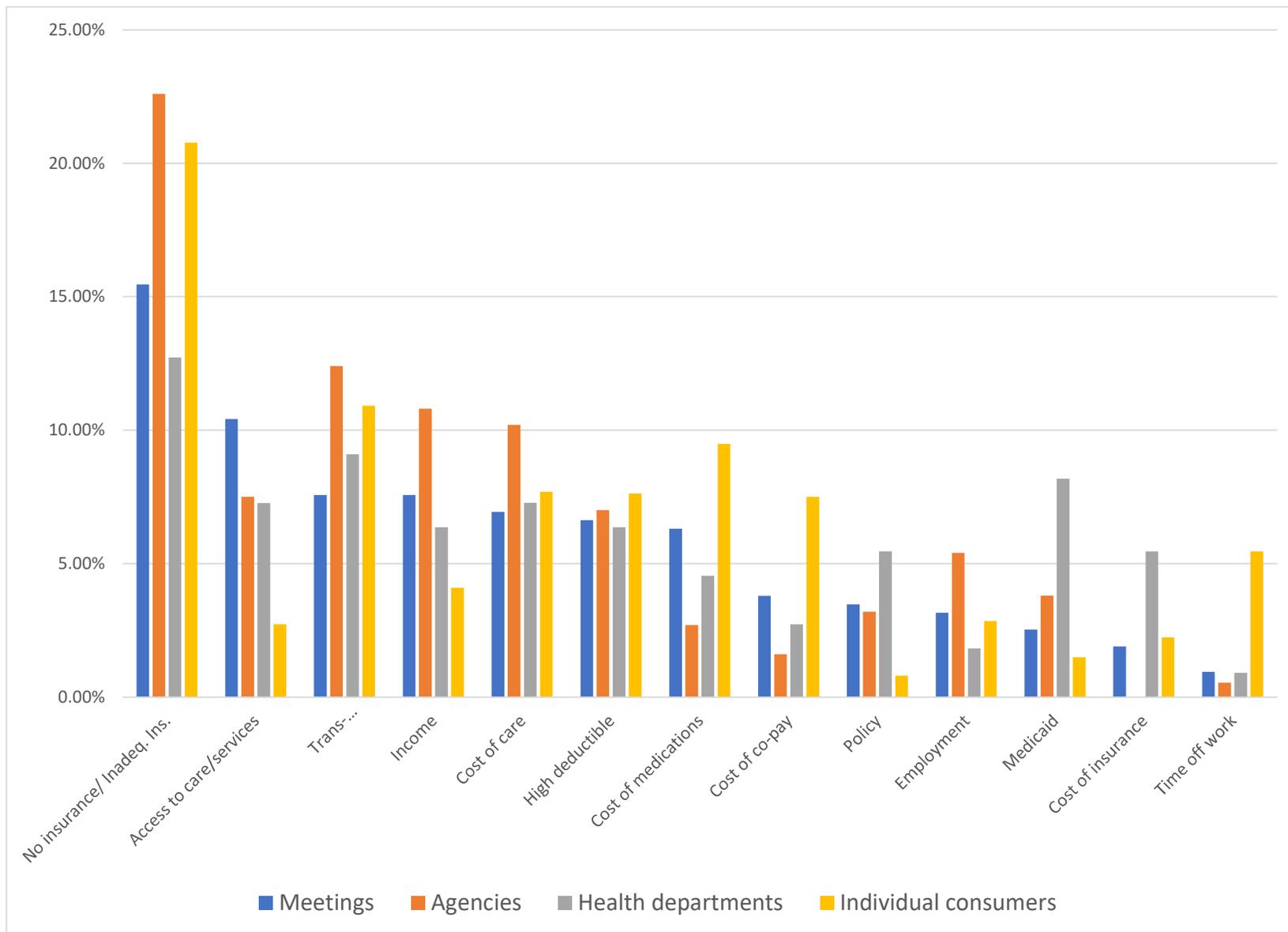
To determine top barriers, the consultants analyzed and compared financial and non-financial barriers to health care that were identified by respondents. Some respondents provided non-financial answers for the ‘Financial Barrier’ question. In some cases, the barrier was the absence of an assigned Medicaid provider near where they lived. In rural counties, the assigned primary care provider might be located out of the county, and there were few specialists. Even with Medicaid, this scenario felt like no coverage. People with commercial insurance also reported the challenge of finding a local provider in their network. The people in these situations felt that they would still have to pay out-of-pocket for care from a provider of their choice, when insurance didn’t cover the services. The lack of providers and/or inadequate insurance coverage became a financial barrier. This is also why ‘cost of care’ is considered a significant barrier, even for those with coverage.

During the 2016 CHNA, participants began bringing up the barrier of co-pays and high-deductible plans. These comments were more frequent and widespread during the 2019 CHNA. Not being able to afford lost wages and (unpaid) time off work seemed less of a barrier this time than the ‘income’ barrier of having a low-paying job and/or needing to work two minimum-wage jobs in order to survive. The cost of prescription medicine remains an ongoing concern.

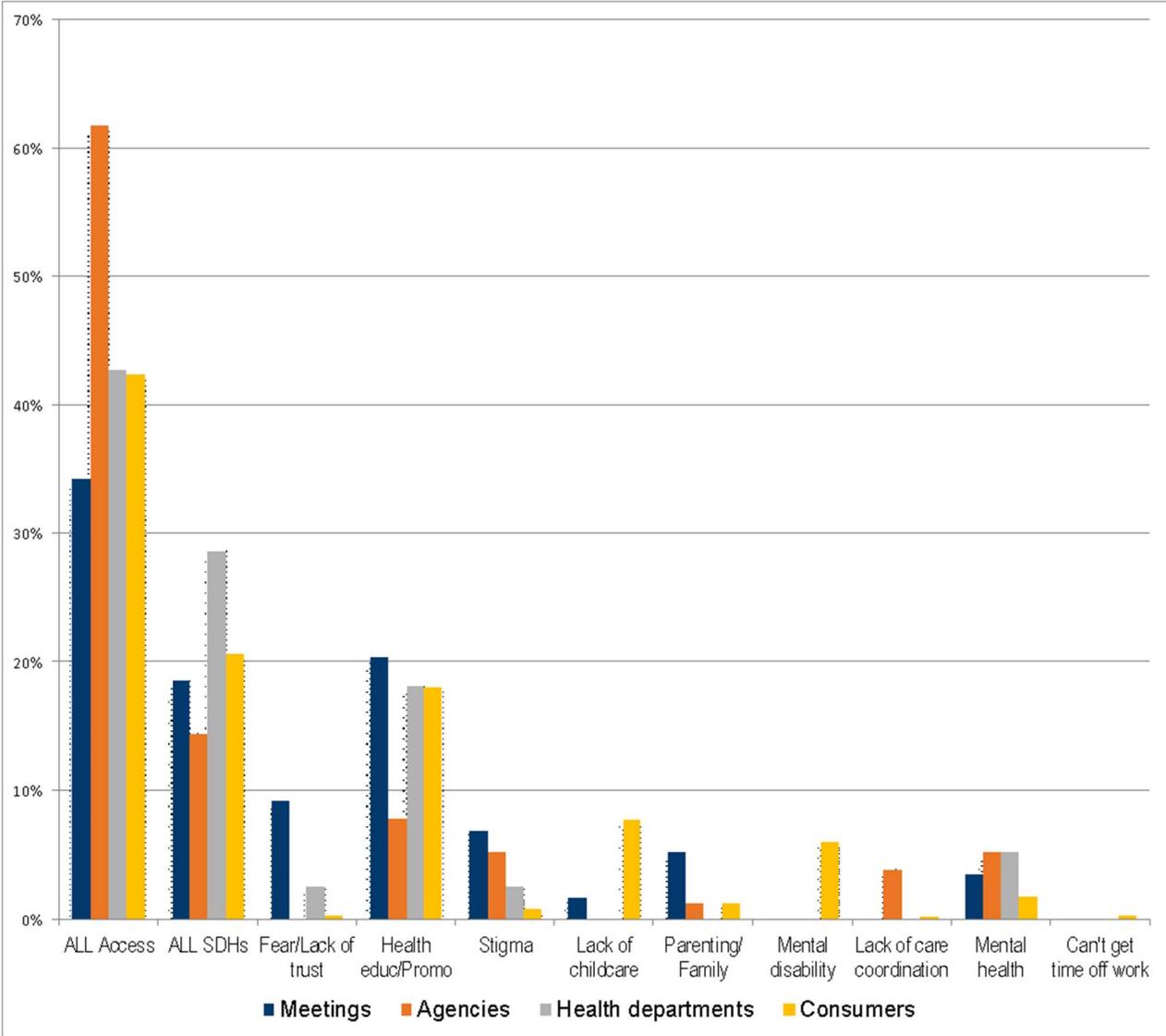
Transportation was mentioned more often this cycle, both as a financial and non-financial barrier. As a financial barrier, it included the rising cost of bus fare and transfers; cost of gas; and not being able to afford the purchase of a car. Many parts of the region have no public transportation, which is reflected in the non-financial barriers. More prominent this cycle were Social Determinants of Health, with sub-categories of race, culture, language, and discrimination receiving many mentions. The figure below shows Access and SDHs were the two largest categories for non-financial barriers, when their sub-categories were combined. Access for people with Mental disability is a new concern voiced by consumers.

See graphs on the following two pages for a summary of the identified financial and non-financial barriers to receiving care and/or services.

Region: Financial Barriers



Region: Non-Financial Barriers
 (with combined categories for Access and SDHs)



Community Perception

Issues Handled Well

There is more variation among groups of respondents for this question, “Which important health issues are being handled well in your community?” Only two issues had consensus in the top five: Substance abuse and Wellness/Prevention. This is the same result as in 2016.

For Substance abuse, respondents noted that progress was good but more needed to be done. Other issues where groups agreed were: Access to care (in top 4 for Meetings, Consumers, and Agencies); Community collaboration (in 2nd place for Meetings, Agencies, and Health Departments); and Chronic disease (in top 5 for Meetings, Consumers, and Health Departments). Mental health and Healthy food/Nutrition were mentioned by 3 groups but not all 4, and these issues were in 5th to 8th place.

Most Frequent Answers to ‘Important Issues Handled Well’ Question

(in descending order of number of mentions)

Meeting	Consumer	Agency	Health Department
Wellness/Prevention	Substance abuse	Substance abuse	Substance abuse
Community collaboration	Chronic disease	Community collaboration	Community collaboration
Access to care	Access to care	Wellness/Prevention	Chronic disease
Substance abuse	Wellness/Prevention	Access to care	Wellness/Prevention
Chronic disease	Health education/Promotion	Mental health	Health education/Promotion
Healthy food/Nutrition	Healthy behaviors	Infant mortality	Access to care
Infant mortality	Healthy food/Nutrition	Healthy food/Nutrition	Infant mortality
Mental health	Environmental health	Chronic disease	Mental health

Ways to Improve Health

During the 2016 CHNA process, ‘eat healthier’ and ‘exercise more’ comprised 70% of responses. During this cycle, they are still frequent replies but now there are even more answers to the questions, “What can you do to improve your health?” and “What can people, whom your organization serves, do to improve their health?” In the last cycle, ‘Get more information’ received merely 0.9% of mentions. In the top 5 responses for all groups, there was consensus on (in descending order of total mentions):

- Eat healthier foods (172)
- Access health education (157)
- Exercise more (126)
- Receive preventive care (84)

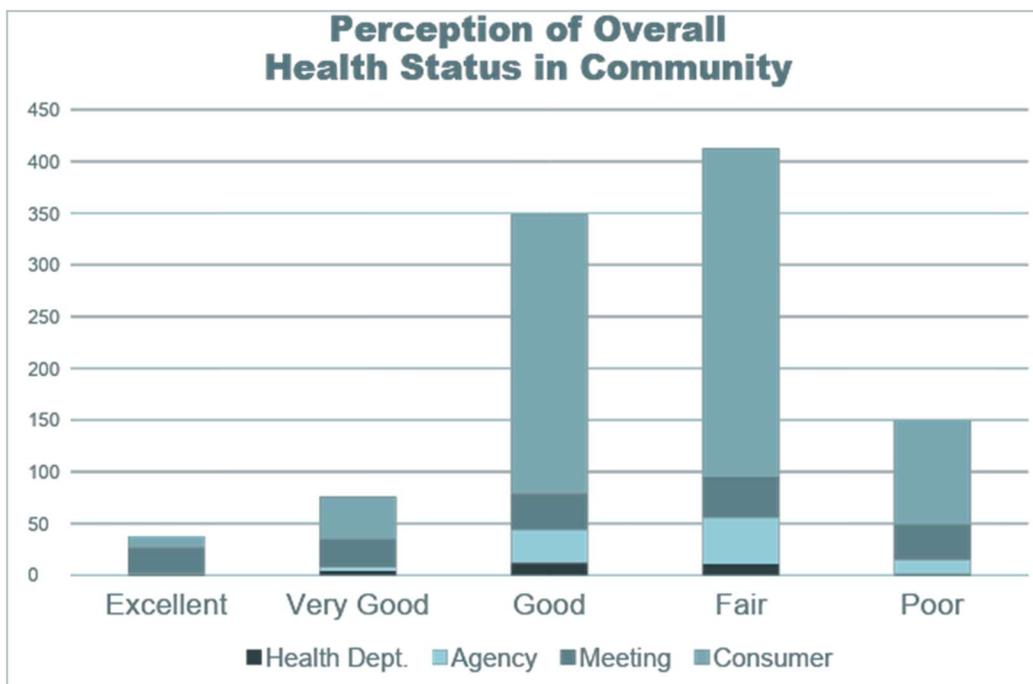
All 4 groups agreed on Get enough sleep but in 9th or 10th place. Other specific ways to improve health that were mentioned by 3 groups, although not all in the top 5, were: Get involved in the community; Drink more water; and Manage stress.

Most Frequent Answers to ‘Ways to Improve Personal Health’ Question (in descending order of number of mentions)

Meeting	Consumer	Agency	Health Department
Exercise more	Make better lifestyle choices	Exercise more	Access health education
Access health education	Access health education	Access health education	Exercise more
Eat healthier foods	Receive preventive care	Eat healthier foods	Receive preventative care
Receive preventive care	Exercise more	Receive preventive care	Eat healthier
Make better lifestyle choices	Eat healthier	Make better lifestyle choices	Manage stress

Perception of Health Status

Another new question this cycle was, “What is your perception of the overall health status of your community?” The graph below shows that the majority of respondents across the region rate the health status of the community as “fair” or “good”.



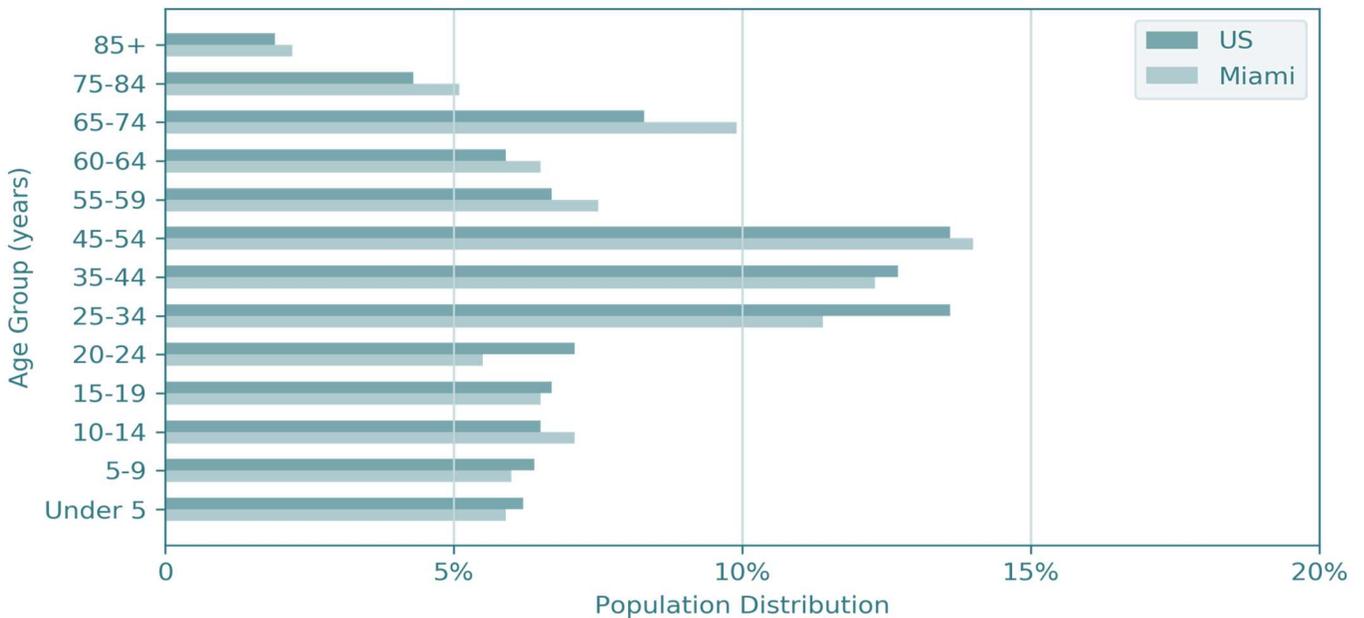
Miami County Profile

The information below summarizes information and responses specific to Miami County.

Miami County is located on the western side of Ohio. The county seat is Troy. Lung, colon and pancreas cancer deaths are rising and higher than the Ohio and U.S. rates. Although the adult smoking and obesity rates are above average, they are declining. The rate of Naloxone administration has increased by 544% in the past three years and is double the Ohio average. Miami County was one of the 8 counties where there was an increase in the number of days with an unacceptable ozone level. It is also one of the few Ohio counties without a 2-1-1 information and referral service. The ZIP Code of 45356 in Piqua has a high CNI score.

The graph below show that Miami County has a higher percentage of people ages 45 and older than the United States. All other age groups, except ages 10-14, have lower percentages.

Miami County Population (2012-2016)



Top Causes of Death

The top causes of death for 2016 were, in descending order:

- Lung cancer
- Dementia, unspecified
- Atherosclerotic heart disease
- Chronic Obstructive Pulmonary Disease

This section will explain the Miami County priorities identified by all sources. The chart below summarizes the Miami County priorities by source. More information about each category follows.

Consensus on Priorities

There is limited consensus on the priorities for Miami County, as the primary sources had a range of responses. The public health, agency, and consumer surveys identified mental health and substance abuse, specifically addiction, as top priorities. Chronic disease was identified on the health department and consumer surveys. Parenting/Family issues were identified as a priority area at the community meeting as well as from the consumer survey. There was considerable discussion at the meeting on the need to educate and support families in order to help their children.

Meetings	Consumers	Agencies	Health Dept.	Secondary Data
<i>(in desc. order)</i>	<i>(in desc. order)</i>	<i>(in desc. order)</i>		<i>(not in order)</i>
Parenting/Family	Chronic disease	Substance abuse	Chronic disease	Substance abuse
Healthy Food/Nutrition	Substance abuse	Access to care	Mental health and addiction	Cancer Mortality overall
	Parenting/Family	Mental health	Maternal and family health	Lung Cancer Mortality

Priorities from Community Meeting on May 10, 2018

Six people identified 2 top priorities at the meeting, which was held at the Piqua YMCA.

Miami County: Meeting Priorities

Priority	# Votes	% Votes
Parenting/Family	7	77.8%
Healthy food/Nutrition	2	22.2%

Survey Responses

Below are the most frequent responses from individual consumers, living in Miami County, who completed a survey between 6/10/18 and 8/3/18. Eleven people participated. Respondents all answered the question, “Given the health issues facing the community, which ones would be your top priorities?” They mentioned 12 health and/or health-related issues of particular concern to them. The following table contains the issues that received more than 2 mentions.

Miami County: Consumer Priorities

Priority	# Mentions	% Mentions
Chronic disease	3	23.08%
Substance abuse	3	23.08%
Parenting/Family	2	15.38%

Seven organizations serving County residents, especially vulnerable populations, responded with their priorities. The priorities that received more than 5% of mentions are listed below.

Miami County: Agency Priorities

Priority	# Mentions	% Mentions
Substance abuse	4	33%
Access to care	3	25%
Mental health	2	17%

Miami County Public Health provided its health priorities for the community:

- Chronic disease
- Mental health and addiction
- Maternal and family health

Miami County Health Snapshot

Pop.: 103,864

Measure/Indicator	County	Trend	State	U.S.
Health Outcomes				
Cancer mortality, Breast (rate per 100,000)	20.0	↓	22.2	20.2
Cancer mortality, Lung (rate per 100,000)	51.4	↑*	48.2	39.4
Cancer mortality, Overall (rate per 100,000)	175.8	↑*	174.3	157.1
Child mortality (rate per 100,000, 1-17 yrs.)	23.3	*	20.1	19.9
Chronic Lower Respiratory Disease (CLRD) deaths age 65 and up (rate per 1000,000)	279.1	↑	316.1	270.9
Diabetes (%)	13.1	↑*	11.1	10.7
Heart Disease Deaths (rate per 100,000)	205.6	↑*	188.4	167
Infant Mortality (rate per 1,000 live births)	3.6	↑	7.2	5.9
Injury Deaths (rate per 100,000)	60.4	↑	61.2	45.3
Low birthweight (%)	5.8	↓	8.5	8.2
Preterm Birth (%)	8.3	↓	10.3	9.6
Poor physical health days (last 30 days)	2.8	-	4	3.9
Poor mental health days (last 30 days)	3.5	↓	4	3.7
Stroke Deaths (rate per 100,000)	43.4	↑*	40.6	37.5
Health Behaviors				
Adult Obesity (%)	31.3	↓*	30.6	29.2
Adult Smoking (%)	23.3	↓*	22.0	16.5
Alcohol-impaired driving deaths (%)	27.0	↑	34.0	30.0
HIV prevalence (rate per 100,000)	61.1	↓	199.5	305.2
Motor vehicle crash deaths (rate per 100,000)	12.3	↑*	10.3	11.5
Physical inactivity (%)	23.7	-	26.4	25.2
Substance Abuse/Mental Health				
Depression (%)	8.2	↓	18.5	17.1
Heroin poisoning overdose deaths (rate per 100,000)	5.5	↑	10.9	3.5
Naloxone administration (rate per 100,000)	72.9	↑*	38.4	U
Suicide (rate per 100,000)	12.9	↓	13.3	13
Access to Clinical Care				
Dentists (ratio)	2090:1	↓*	1656:1	1480:1
Mammography screening (%)	74.3	↑*	68.4	65.5
Mental health providers (ratio)	1074:1	↓*	561:1	470:1
Primary care physicians (ratio)	2170:1	↑*	1307:1	1320:1
Uninsured (%)	5.8	↓	7.6	11.8
Socio-Economic/Demographic				
Children in poverty (%)	15.8	↓	22.1	21.2
Population that is 65 and older (%)	17.2	-	23.0	22.3
Population below 18 years of age (%)	23.2	*	14.5	16

U = Unavailable, unreliable, or suppressed due to small numbers. Source data range: 2014-2017

* = Higher than state and national rates

Top Causes of Death
Lung Cancer
Dementia
Heart Disease

Poor/Fair Health Responses
Responses increased 84%

Cancer Deaths
Lung, Colon & Pancreas rising & > OH or US rates

Naloxone
544% increase & > OH rate

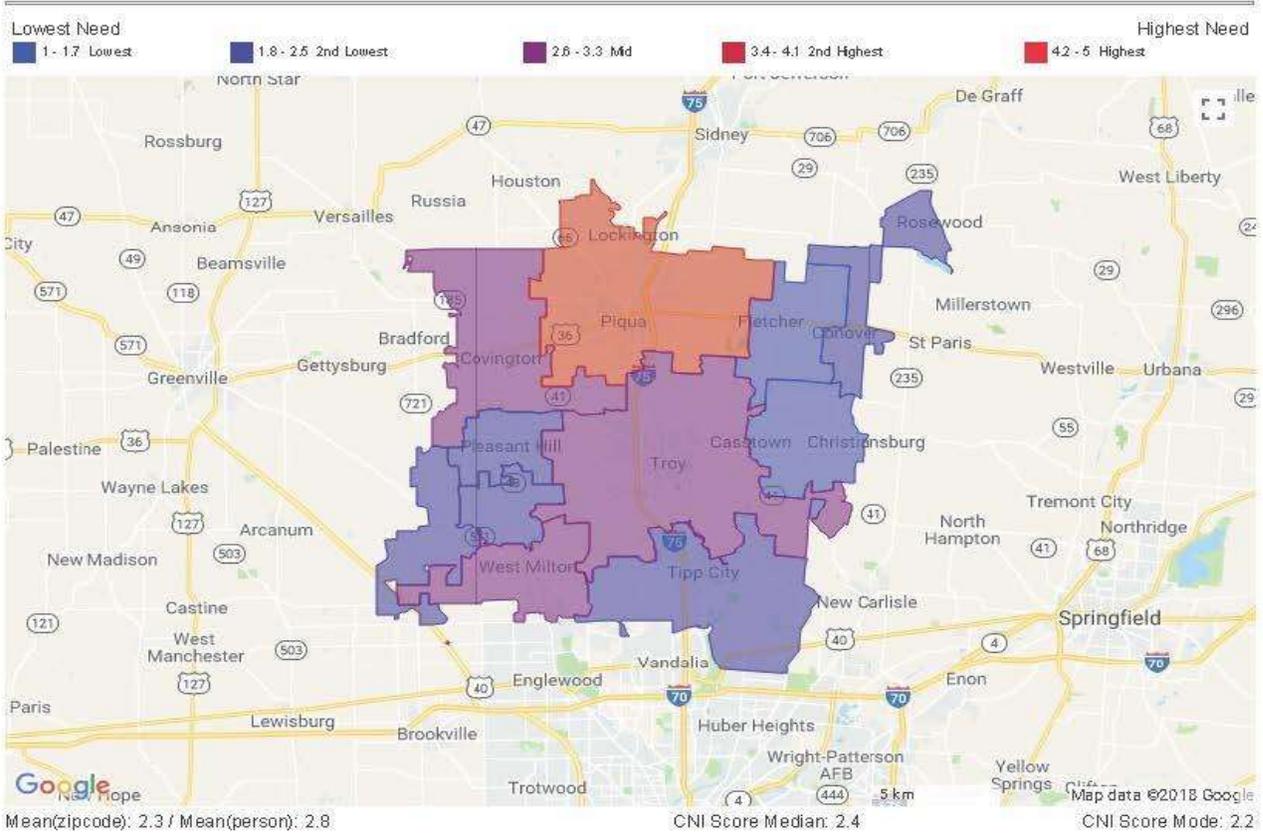
Child Mortality
Higher than OH & US rates

Injury Deaths
20% increase

Community Need Index

A high CNI score (3.4 to 5.0) is an indicator for socioeconomic variation, barriers to care, and an increased need for health care services. One of the County's ZIP codes has a 3.4 score.

Community Need Index – Miami County



Zip Code	CNI Score	Population	City	County	State
45312	1	1711	Casstown	Miami	Ohio
45317	2	1141	Conover	Miami	Ohio
45318	2.8	5401	Covington	Miami	Ohio
45326	1.4	1081	Fletcher	Miami	Ohio
45337	2.4	2043	Laura	Miami	Ohio
45339	2.2	1299	Ludlow Falls	Miami	Ohio
45356	3.4	25331	Piqua	Miami	Ohio
45359	2.2	1791	Pleasant Hill	Miami	Ohio
45371	2.2	19297	Tipp City	Miami	Ohio
45373	3	36579	Troy	Miami	Ohio
45383	2.8	8761	West Milton	Miami	Ohio

Resources

Below is a list of community resources available to help with health and health-related issues in Miami County.

American Red Cross
City of Piqua Health Department
Community Housing of Darke, Miami, and Shelby Co.,Inc, Continuum of Care
Council on Rural Services
Family Abuse Shelter
Fusion Community Learning Center
Future Begins Today
Health Partners Free Clinic
Help Me Grow
Lincoln Community Center
Miami County Recovery Council
Miami County YMCA - Robinson Branch
New Path
OSU Extension Miami County
Partners in Hope
Piqua Compassion Network
Reading for Change
Riverside Developmental Disabilities
Samaritan Behavioral Health
The Troy Rec
Tri-County Board of Recovery & Wellness
Troy-Miami County Library
Veteran's Affairs
WIC
YMCA Troy

Appendix

Community Meeting Attendees (Organizations)

First & Last Name	Organization Name	City	County
Bruce Jamison	Piqua Police	Piqua	Miami
Nancy Horn	Samaritan Behavioral Health	Piqua	Miami
Alisha Barton	OSU Extension	Troy	Miami
Janel Hodges	Miami County Public Health	Troy	Miami
Matthew Ruemping	Joshua Recovery	Troy	Miami, Montgomery
Kim McGuirk	Tri-County Board of Recovery and Wellness	Troy	Miami, Darke and Shelby

Health Department Respondent

Name	Title of Person Submitting	Qualifications	Health Department/District
Janel Hodges	Epidemiologist	RS	Miami County Public Health