GDAHA
Greater Dayton Area Hospital Association

# Our Region's Social Determinants of Health

## July 13, 2022

# Agenda

- Healthcare’s Role in Health
- Community Health Needs Assessment (CHNA) 2021
- Dayton Regional Pathways HUB
- Questions

# GDAHA: Hospital and Community Collaboration in the Dayton Region

**AUGLAIZE COUNTY**
Grand Lake Health System (St. Mary's)

**BUTLER COUNTY**
Atrium Medical Center (Middletown)
Ft. Hamilton Hospital (Hamilton)

**CHAMPAIGN COUNTY**
Mercy Health (Urbana)

**CLARK COUNTY**
Mercy Health (Springfield)

**DARKE COUNTY**
Wayne Hospital (Greenville)

**GREENE COUNTY**
Greene Memorial Hospital (Xenia)
Indu & Raj Soin Medical Center (Beavercreek)
Wright-Patterson AFB Medical Center (Fairborn)

**MIAMI COUNTY**
Upper Valley Medical Center (Troy)

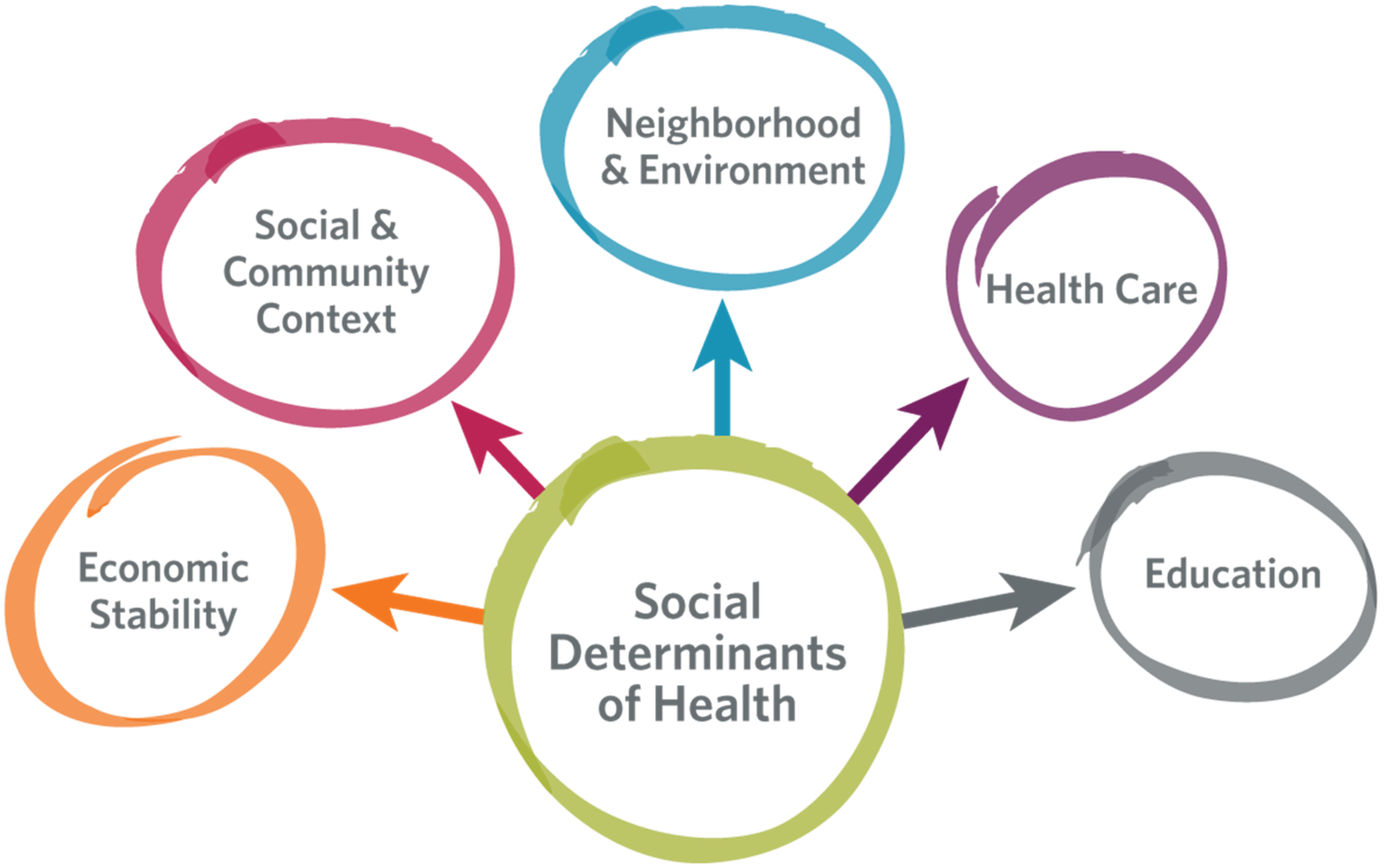
**MONTGOMERY COUNTY**
Access Hospital (Dayton)
Compunet Clinical Laboratories (Dayton)
Dayton Children's Hospital (Dayton)
Department of Veterans Affairs Medical Center
Grandview Hospital (Dayton)
Kettering Medical Center (Kettering)
Kettering - Southview Hospital (Miami Twp.)
Kettering - Sycamore Hospital (Miamisburg)
Kindred Hospital Dayton (Dayton)
PAM Specialty Hospital of Dayton (Miamisburg)
Miami Valley Hospital (Dayton)
Miami Valley Hospital North (Englewood)
Miami Valley Hospital South (Centerville)

**SHELBY COUNTY**
Wilson Memorial Hospital (Sidney)

According to the Robert Wood Johnson Foundation,

**Health equity** means that everyone has a **fair and just opportunity to be as healthy as possible.** This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

# Social Determinants of Health



# Healthcare's Role in Health

ADDRESSED BY HUMAN SERVICES

| 20% | 40% | 30% | 10% |
|---|---|---|---|
| **Healthcare** | **Socioeconomic factors** | **Health behaviors** | **Physical environment** |
| Access to care | Education | Tobacco use | Quality of environment |
| Quality of care | Employment | Diet and exercise | Home and built environment |
| | Income | Alcohol use | |
| | Family and social support | Sexual health | |
| | Community safety | | |

# Regional CHNA 2021

All available at: https://gdaha.org/resources/

community health needs assessment (CHNA)

**2021 REPORT**

THE HEALTH COLLABORATIVE
GDAHA Greater Dayton Area Hospital Association
regional community health needs assessment 2021

## Executive Summary

### Vision of Health

We envision a region where everyone has the opportunity to be healthy. To achieve this vision, our region is working on eliminating health disparities by embracing community voice, investing in trusted partnerships, and implementing evidence-based strategies and best practices to achieve equitable health outcomes for all.

### About the Regional CHNA

### The Region's Top Priorities

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THE HEALTH COLLABORATIVE
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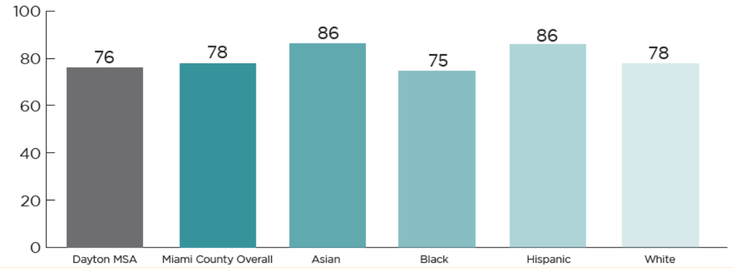
regional community health needs assessment 2021

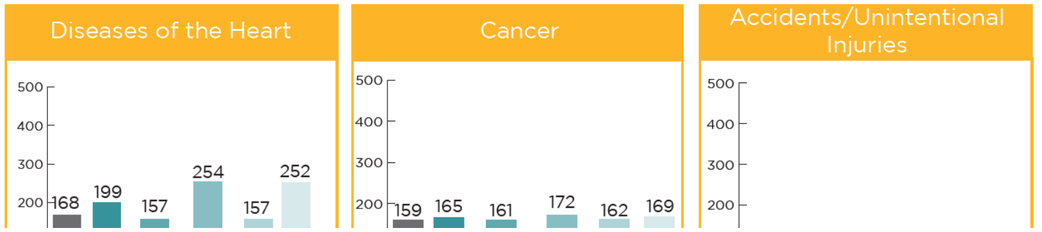
## Miami County

### LOCAL HEALTH INDICATORS
SECONDARY DATA 2019 OR PRIOR (PRE-COVID-19)

**Life Expectancy by Race[1]**
*in Years*




**Cause of Death Summary (by Race) Age-adjusted Mortality Rates[1]**
*Rates per 100,000*



**Populations Experiencing Significant Disparity Related to Multiple SDOH:**

Individuals who identify as:

- Black/African American
- American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander or another race (other than Black, multi-racial or White)
- Individuals with lower levels of education
- Individuals with disabilities
- Individuals without health insurance
- Veteran or active-duty

## Systemic Barriers to Improving Health in the Region

- Structural racism
- High-cost healthcare system
- Structural divide between care systems

## Structural Barriers to Improving Health Throughout the Region

- Limited diversity in workforce
- Lack of cultural relevancy
- Lack of effective cross-sector collaboration
- Community member distrust in the healthcare ecosystem

# SDOH Driving Regional Health

**Education Access and Quality**

- Perceptions of quality of education and childcare available

**Healthcare Access and Quality**

- Perceptions of quality of care available
- Ease of finding desired healthcare professional
- Ease of navigating healthcare costs

**Economic Stability**

- Housing stability
- Food security

**Neighborhood and Built Environment**

- Access to reasonable transportation
- Access to reliable phone/internet
- Access to parks

**Social and Community Context**

- Having someone to talk to
- Feeling connected to community

# Regional Priorities from CHNA

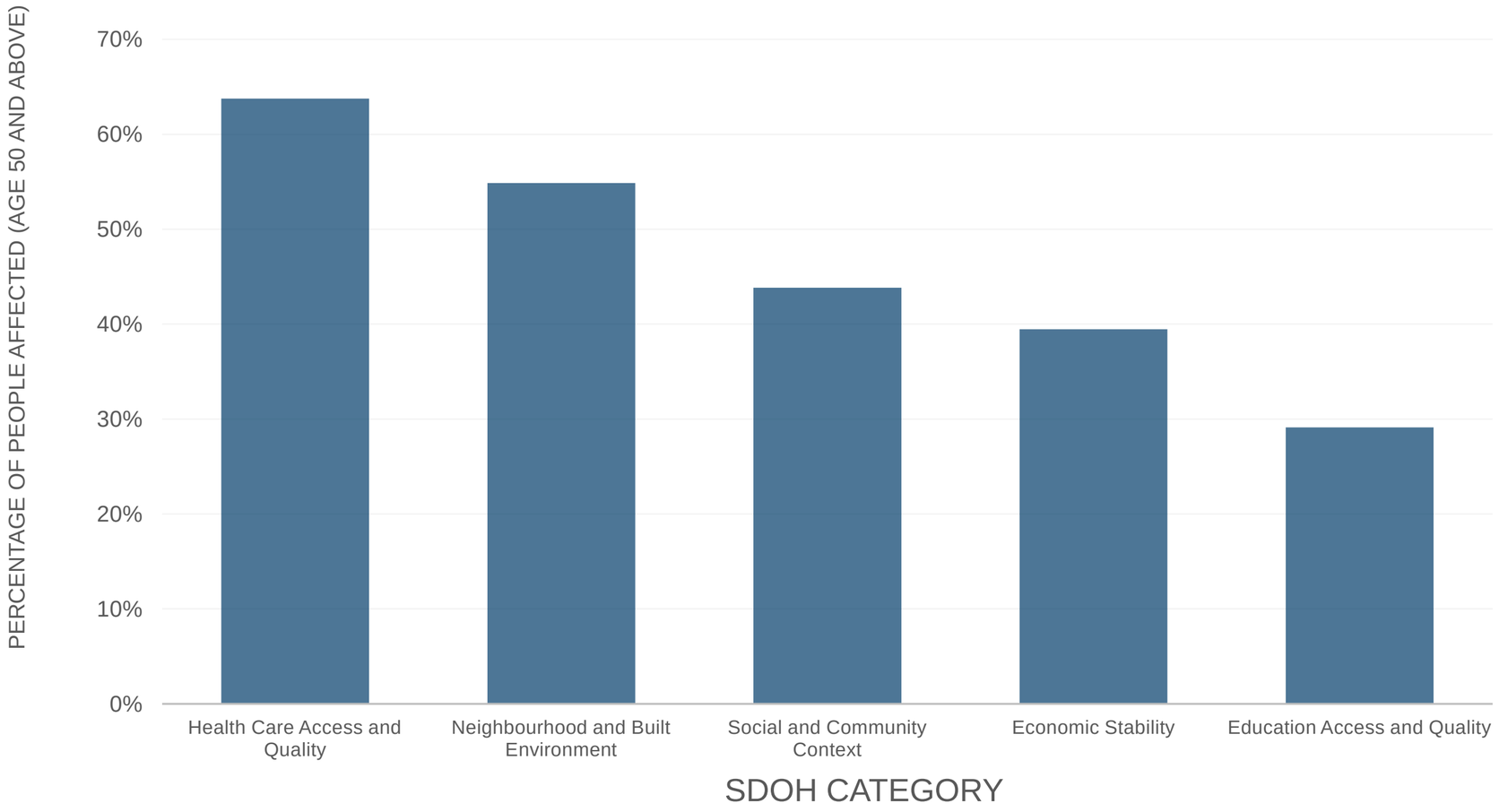
Because physical, environmental, and behavioral factors greatly impact health conditions, this CHNA focused on the SDOH and the underlying structural barriers influencing the SDOH that impact the health of community members.

- Increase access to services in order to improve equitable outcomes for the region’s top health needs: behavioral health, cardiovascular disease, dental, and vision.
- Address access to and use of resources for food and housing, with a focus on the development and strengthening of partnerships between providers and community-based organizations.
- Strengthen workforce pipeline and diversity, including cultural competence within the healthcare ecosystem.

# Common Social Determinants of Health for Older Adults

Over **60% identified Healthcare Access** as a barrier and **over 50% identified neighborhood and built environment** as a barrier to health.

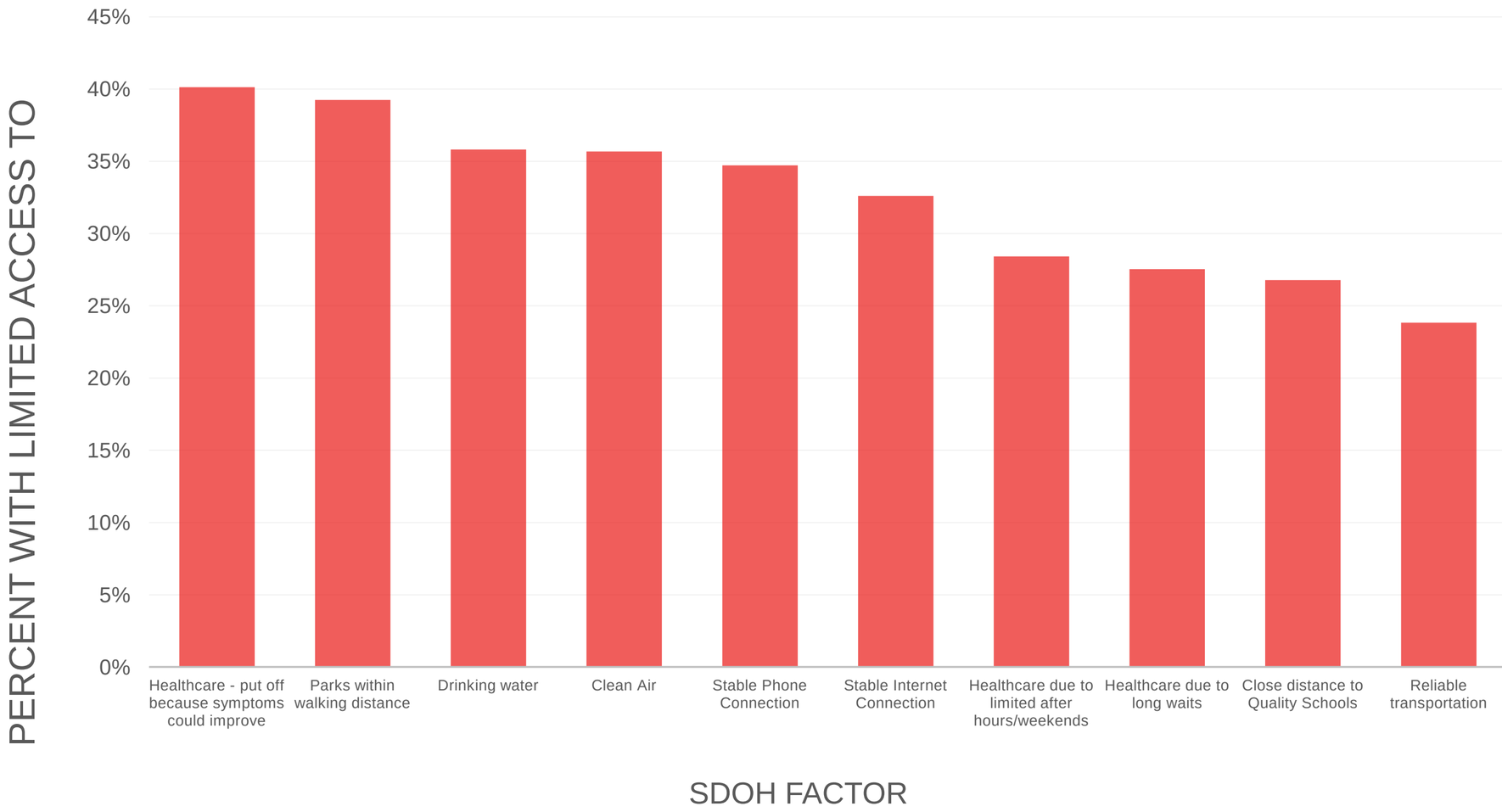
Data gathered from the regional Community Health Needs Assessment, 1460 survey respondents >50 years old



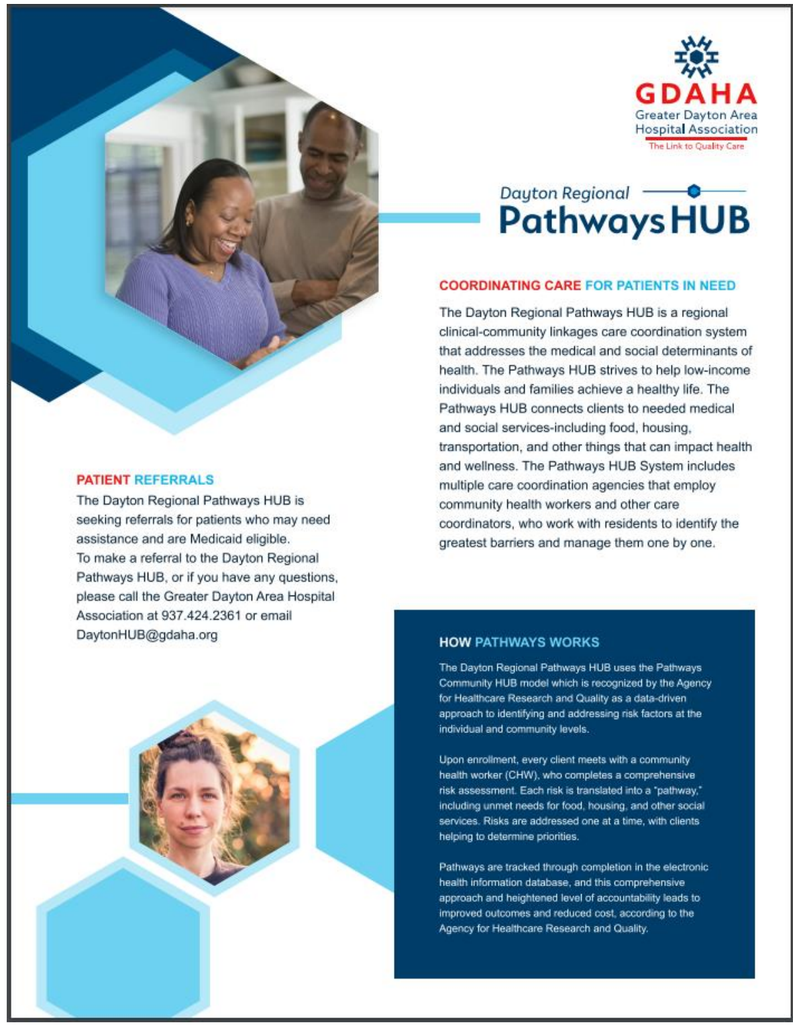
# Common Social Determinants of Health for Older Adults

Over **40% identified Healthcare** as a barrier, citing putting off care in case symptoms improve. **Almost 40% identified proximity to parks, drinking water, clean air all as barriers in their built environment** that impact health.

Data gathered from the regional Community Health Needs Assessment, 1460 survey respondents >50 years old



# Pathways Community HUB



# Pathways Community HUB

### 20 Standard Pathways – Pathways Community HUB

| Pathway | Outcome |
|---|---|
| **Adult Learning** | Confirm that client successfully completes stated education goal:<br>• Course/ class completed<br>• Quarter/ Semester completed<br>• Training program completed |
| **Behavioral Health** | Client has kept 3 scheduled appointments for behavioral health issue(s). |
| **Developmental Referral** | Document the date and results of the completed developmental evaluation. |
| **Developmental Screening** | Child successfully screened using the age-appropriate ASQ or ASQ-SE. |
| **Education** | Client reports that he/she understands the educational information presented (document educational content and format). |
| **Employment** | Client has found consistent source(s) of steady income and is employed over a period of 30 days. |
| **Family Planning** | Confirm that the client has kept appointment and document family planning method:<br>• Completed with permanent sterilization or LARC (long acting reversible contraceptive)<br>• All other methods, completed if client is still successfully using method after 30 days. |
| **Health Insurance** | Completed if client has received health insurance – document plan and insurance number of Pathway and in Client Profile. |
| **Housing** | Confirmation that client and/or family has moved into an affordable suitable housing unit for a minimum of 30 days. |

### 20 Standard Pathways – Pathways Community HUB

| Pathway | Outcome |
|---|---|
| **Immunization Referral** | Client who was behind on immunization has his/her immunization record reviewed and is verified to be up to date. |
| **Immunization Screening** | Client is up to date on all age appropriate immunizations. |
| **Lead** | Confirm that appointment was kept and document results of lead blood tests. |
| **Medical Home** | Confirm that client in need of ongoing primary care has kept first appointment with medical home |
| **Medical Referral** | Verify with health care provider that client has kept appointment. |
| **Medication Assessment** | Verify with provider that medication chart was received (requires chart). |
| **Medication Management** | Verify with provider that client is taking medications as prescribed (requires chart). |
| **Postpartum** | Confirm that client has kept 2 Postpartum appointments. |
| **Pregnancy** | Confirm that client has delivered a healthy baby weighting more than 5 pounds 8 ounces (2500 grams). |
| **Social Service Referral** | Verify that client has kept scheduled appointment with social service provider. |
| **Tobacco Cessation** | Confirm that client has stopped using tobacco products for a minimum of 30 days. |

# Pathways HUB partnerships

Care Coordination Agencies (CCAs) include:

- East End Community Services
- St. Mary Development
- Catholic Social Services
- Community Health Centers of Greater Dayton
- Dayton Children's Hospital
- Goodwill EasterSeals Miami Valley
- Sunlight Village
- Ebenezer Healthcare Access

CCAs employ community health workers (CHWs)

- Over 25 CHWs trained to work with clients to identify their greatest risks and manage them one by one

Contracts with Medicaid Managed Care include CareSource, Buckeye, United Health, Molina and in discussion with all new MCOs going live later in 2022.

Partnership with Ohio University for research evaluation

# Pathways HUB in action

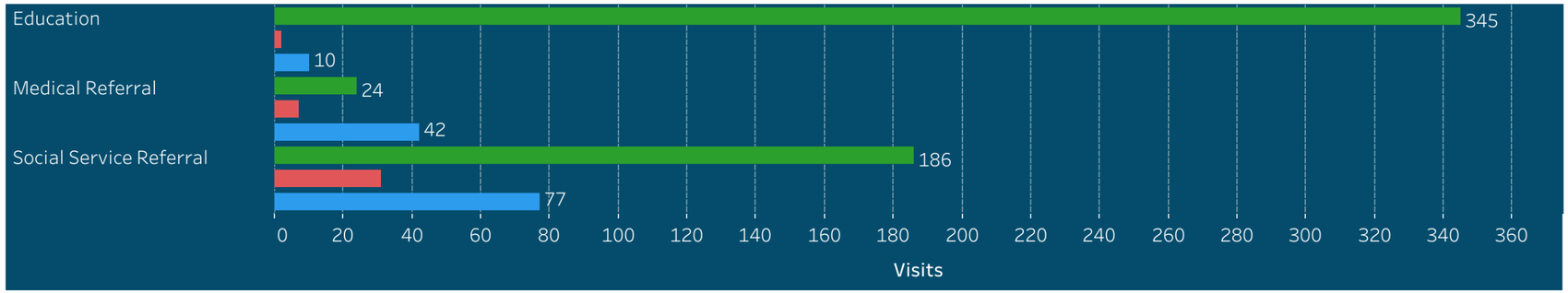
“Lucy” is 68 years old and has been feeling unwell. After some discussion, her Community Health Worker discovers that Lucy hasn’t had a primary care provider in years, most recently because she doesn’t have money to ride the bus to the appointments. The CHW decides that the lack of transportation is Lucy’s primary barrier to care. But Lucy also needs help finding a doctor.

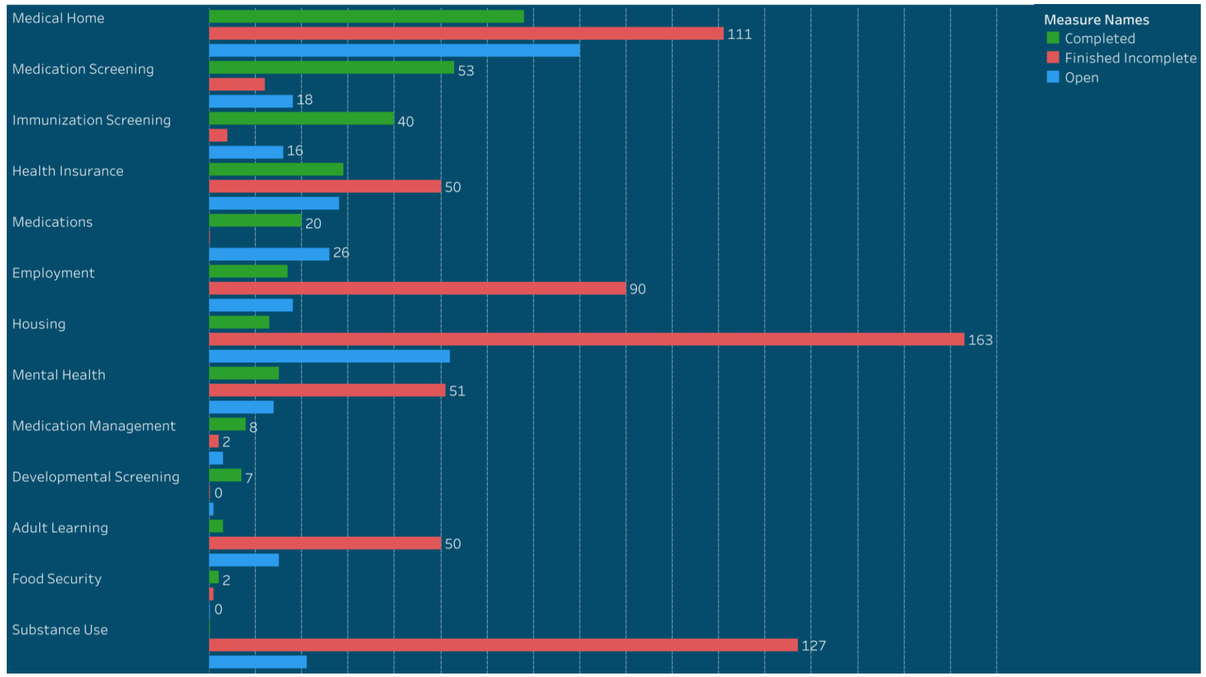
As a plan of action, the CHW identified two pathways that need to be completed:

1. Transportation and
2. Medical Home for primary physician/care

The CHW enters these two pathways into Lucy’s account in the centralized data system. When a solution is found they are marked as completed and the insurance company is billed.

# Pathways Community HUB



# Advance Care Planning

DECIDE to be HEARD.org

NATIONAL HEALTHCARE DECISIONS DAY

★ your decisions matter ★

# Thank you!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