WOOSTER COMMUNITY HOSPITAL
WOOSTER, OH

2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

APPROVED BY BOARD OF GOVERNORS
DECEMBER 18, 2013
Dear Community Resident:

Wooster Community Hospital (WCH) welcomes you to review this document as we strive to meet the health and medical needs in our community. WCH is organized as a “municipal hospital,” a government organization, and as such, is not required to produce evidence of providing an adequate amount of “community benefit” to justify retention of their not-for-profit tax status. However, WCH has elected to voluntarily complete a Community Health Needs Assessment to assure it is responding to the primary health needs of its residents. This study is designed to comply with standards required of a not-for-profit hospital.

The “2013 Community Health Needs Assessment” identifies local health and medical needs and provides a plan to indicate how WCH will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way that we, WCH, are meeting our obligations to efficiently deliver medical services.

WCH may conduct this effort at least once every three years. As you review this plan, please see if, in your opinion, we have identified the primary needs and if our intended response should make appropriate needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other organizations and agencies, can collaborate to bring the best each has to offer to address the more pressing, identified needs.

The report is a response to a federal requirement of certain not-for-profit hospitals to identify the community benefit it provides in responding to documented community need. Of greater importance, however, is the potential for this report to guide our actions and the efforts of others to make needed health and medical improvements.

Please think about how to help us improve the health and medical services our area needs. I invite your response to this report. We all live and work in this community together and our collective efforts can make living here more enjoyable and healthier.

Thank You
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EXECUTIVE SUMMARY
Executive Summary

Wooster Community Hospital ("WCH" or the "Hospital") is organized as a not-for-profit hospital. A “municipal hospital” is a government organization, and as such, is not required to produce evidence of providing an adequate amount of “community benefit” to justify retention of their not-for-profit tax status. However, WCH has elected to voluntarily complete a Community Health Needs Assessment to assure it is responding to the primary health needs of its residents. This study is designed to comply with standards required of a not-for-profit hospital. We assume WCH acts as a not-for-profit hospital solely for the purposes of producing this report.

In addition to completing a CHNA, and funding necessary improvements, a not-for-profit hospital must document the following:

- Financial assistance policy and policies relating to emergency medical care;
- Billing and collections; and
- Charges for medical care.

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury\(^1\).

Project Objectives

WCH partnered with Quorum Health Resources (QHR) for the following:

- Complete a CHNA report, compliant with the Affordable Care Act; and
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response.

Brief Overview of Community Health Needs Assessment

Prior to the passage of Medicare, charity was generally recognized as care provided to the less fortunate without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- Emergency room open to all, regardless of ability to pay;
• Surplus funds used to improve patient care, expand facilities, train, etc.;

• Controlled by independent civic leaders; and

• All available and qualified physicians are privileged.

Specifically, the IRS requires:

• Effective on tax years beginning after March 23, 2012, each 501(c) (3) hospital facility is required to conduct a CHNA at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment;

• The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations;

• The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues;

• The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment, and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources);

• Each hospital facility is required to make the assessment widely available and ideally downloadable from the hospital website;

• Failure to complete a CHNA in any applicable three-year period results in a penalty to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four); and

• An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.

This report was developed under the guidance of IRS/Treasury 2011-52 as modified by the Draft Federal Regulations published in the April 5, 2013 Federal Register.
APPROACH
Approach

To complete a CHNA, the hospital must:

- Describe the processes and methods used to conduct the assessment;
  - Sources of data and dates retrieved;
  - Analytical methods applied;
  - Information gaps impacting ability to assess the needs; and
  - Identification of with whom the Hospital collaborated.

- The proposed regulations provide that a hospital facility’s CHNA report will be considered to describe how the hospital facility took into account input if the CHNA report:
  1) Summarizes, in general terms, the input provided and how and over what time period such input was provided;
  2) Provides the names of organizations providing input and summarizes the nature and extent of the organization’s input; and
  3) Describes the medically underserved, low income, or minority populations being represented by organizations or individuals providing input.

- Describe the process and criteria used in prioritizing health needs;

- Describe existing resources available to meet the community health needs; and

- Identify the programs and resources the hospital facility plans to commit to meeting each identified need, and the anticipated impact of those programs and resources on the health need.

QHR takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local survey data, and resolve any data inconsistency or discrepancies from the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources to exist in their portion of the county.

Most data used in the analysis is available from public internet sources. Critical data needed to address specific regulations or developed by the individuals cooperating with us in this study is displayed in the report of the appendix. Data sources include:
<table>
<thead>
<tr>
<th>Web Site or Data Source</th>
<th>Data Element</th>
<th>Date Accessed</th>
<th>Data Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.countyhealthrankings.org">www.countyhealthrankings.org</a></td>
<td>Assessment of health needs of Wayne County compared to all OH counties</td>
<td>July 19, 2013</td>
<td>2002 to 2010</td>
</tr>
<tr>
<td><a href="http://www.communityhealth.hhs.gov">www.communityhealth.hhs.gov</a></td>
<td>Assessment of health needs of Wayne County compared to its national set of “peer counties”</td>
<td>July 19, 2013</td>
<td>1996 to 2009</td>
</tr>
<tr>
<td>Truven (formerly known as Thomson) Market Planner</td>
<td>Assess characteristics of the hospital’s primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size, trends, and socio-economic characteristics</td>
<td>July 19, 2013</td>
<td>2012</td>
</tr>
<tr>
<td><a href="http://www.capc.org">www.capc.org</a> and <a href="http://www.getpalliativecare.org">www.getpalliativecare.org</a></td>
<td>To identify the availability of Palliative Care programs and services in the area</td>
<td>July 19, 2013</td>
<td>2012</td>
</tr>
<tr>
<td><a href="http://www.caringinfo.org">www.caringinfo.org</a> and iweb.nhpco.org</td>
<td>To identify the availability of hospice programs in the county</td>
<td>July 19, 2013</td>
<td>2012</td>
</tr>
<tr>
<td><a href="http://www.healthmetricsandevaluation.org">www.healthmetricsandevaluation.org</a></td>
<td>To examine the prevalence of diabetic conditions and change in life expectancy</td>
<td>July 19, 2013</td>
<td>1989 through 2009</td>
</tr>
<tr>
<td><a href="http://www.dataplace.org">www.dataplace.org</a></td>
<td>To determine availability of specific health resources</td>
<td>July 19, 2013</td>
<td>2005</td>
</tr>
<tr>
<td><a href="http://www.cdc.gov">www.cdc.gov</a></td>
<td>To examine area trends for heart disease and stroke</td>
<td>July 19, 2013</td>
<td>2008 to 2010</td>
</tr>
<tr>
<td><a href="http://www.CHNA.org">www.CHNA.org</a></td>
<td>To identify potential needs among a variety of resource and health need metrics</td>
<td>July 19, 2013</td>
<td>2003 to 2010</td>
</tr>
<tr>
<td><a href="http://www.datwarehouse.hrsa.gov">www.datwarehouse.hrsa.gov</a></td>
<td>To identify applicable manpower shortage designations</td>
<td>July 19, 2013</td>
<td>2013</td>
</tr>
</tbody>
</table>
In addition, we deployed a CHNA “Round 1” survey to our local expert advisors to gain local input as to local health needs and the needs of priority populations. Local expert advisors were local individuals selected to conform to the input required by the Federal guidelines and regulations.

We received community input from 23 local expert advisors. Survey responses started Thursday, August 29, 2013 at 2:38 pm and ended with the last response on Friday, September 13, 2013 at 3:15 pm.

Information analysis augmented by local opinions showed how Wayne County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on if they believe certain population groups (or people with certain situations) need help to improve their condition, and if so, who needs to do what.

When the analysis was complete, we put the information and summary conclusions before our local group of experts, who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional statements of need, and new needs did emerge from this exchange. Consultation with 22 local experts occurred again via an internet-based survey (explained below) during the period beginning Thursday, September 19, 2013 at 9:24 am and ending Thursday, October 3, 2013 at 2:26 pm.

With the prior steps identifying potential community needs, the local experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method that relies on a panel of experts. Experts answer questionnaires in a series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provided an anonymous summary of the experts’ forecasts from the previous round, as well as reasons provided for their judgments. The process encouraged experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this process decreases the range of answers and moves the expert opinions toward a consensus "correct" answer. The process stops when we identify the most pressing, highest priority, community needs.

In the WCH process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and challenge conclusions developed from the data analysis. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

We dichotomized the rank order into two groups: high priority needs and low priority needs. The determination of the break point - high as opposed to low - was a qualitative interpretation by QHR and the WCH executive team, where a reasonable break point in rank occurred, indicated by the amount of points each potential need received and the number of local experts allocating any points.
to the need. When presented to the WCH executive team, the divided need rank order identified which needs the Hospital considered high responsibility to respond vs. low responsibility to respond. The result provided a matrix of needs and guided the Hospital in developing its implementation response.

The proposed regulations provide that, in order to assess the community it serves, a hospital facility must identify significant health needs of the community, prioritize them, and then identify potential measures and resources available to address them, such as programs, organizations, and facilities in the community. The proposed regulations clarify a CHNA need only identify significant health needs, and need only prioritize, and otherwise assess, those significant identified health needs. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. By definition, the high priority needs are deemed “significant” needs as defined by the regulations.
FINDINGS
Findings

Definition of Area Served by the Hospital Facility

WCH, in conjunction with QHR, defines its service area as Wayne County in Ohio, which includes the following ZIP codes:

- 44214 Burbank
- 44217 Creston
- 44230 Doylestown
- 44270 Rittman
- 44276 Sterling
- 44280 West Salem
- 44606 Apple Creek
- 44618 Dalton
- 44627 Fredericksburg
- 44645 Marshallville
- 44667 Orrville
- 44676 Shreve
- 44677 Smithville
- 44691 Wooster

In 2011, the Hospital received 83.2% of its patients from this area.

Demographic of the Community

The 2013 population for Wayne County is estimated to be 121,165 and expected to increase at a rate of 0.1%. This is higher than the 0% projected OH growth, but lower than the 3.3% national growth. Wayne County anticipates a population of 121,293 by 2018.
According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2013 median age for the county is 38.1 years, which is younger than the State median age (39 years), but older than the national median age (37.5 years). The 2013 Median Household Income for the area is $43,239 which is lower than the State median income of $44,132 and the national median income of $49,233. Median Household Wealth value is above both the National and the State values. The Median Home Values for the area is $138,022, which is higher than the State value, but lower than the National value. Wayne County’s unemployment rate as of May, 2013 was 5.9%, which is better than the 7% statewide and 7.6% national civilian unemployment rates.

The portion of the population in the county over 65 is 15.3%, above the State average. The portion of the population of women of childbearing age is 18.4%, below the State average of 19.1% and national average of 19.8%. 1.4% of the population is Black non-Hispanic and 94.6% is White non-Hispanic. The Hispanic population comprises 1.7% of the total.
The population also was examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to discern the following table of probable lifestyle and medical conditions present in the population. Items with red text are viewed as statistically important, potentially adverse findings. Other items within the table below are viewed as either not statistically different from the national normal situation, or not considered either favorable or unfavorable in our use of the information.
<table>
<thead>
<tr>
<th>Health Service Topic</th>
<th>Demand as % of National</th>
<th>% of Population Affected</th>
<th>Health Service Topic</th>
<th>Demand as % of National</th>
<th>% of Population Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight / Lifestyle</td>
<td></td>
<td></td>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI: Morbid/Obese</td>
<td>167.1%</td>
<td>27.4%</td>
<td>Routine Screen: Cardiac Stress 2yr</td>
<td>89.9%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Vigorous Exercise</td>
<td>96.5%</td>
<td>56.1%</td>
<td>Chronic High Cholesterol</td>
<td>90.4%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Chronic Diabetes</td>
<td>167.0%</td>
<td>11.2%</td>
<td>Routine Cholesterol Screening</td>
<td>95.1%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Healthy Eating Habits</td>
<td>94.0%</td>
<td>27.2%</td>
<td>Chronic High Blood Pressure</td>
<td>106.4%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Very Unhealthy Eating Habits</td>
<td>167.4%</td>
<td>2.9%</td>
<td>Chronic Heart Disease</td>
<td>109.7%</td>
<td>9.2%</td>
</tr>
<tr>
<td>Behavior</td>
<td></td>
<td></td>
<td>Routine Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Will Travel to Obtain Medical Care</td>
<td>97.1%</td>
<td>29.7%</td>
<td>FP/GP: 1+ Visit</td>
<td>102.8%</td>
<td>99.7%</td>
</tr>
<tr>
<td>I Follow Treatment Recommendations</td>
<td>93.6%</td>
<td>37.7%</td>
<td>Used Midlevel in last 6 Months</td>
<td>102.5%</td>
<td>43.1%</td>
</tr>
<tr>
<td>I Am Responsible for My Health</td>
<td>94.6%</td>
<td>60.3%</td>
<td>OB/Gyn: 1+ Visit</td>
<td>93.1%</td>
<td>42.7%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
<td></td>
<td>Ambulatory Surgery last 12 Months</td>
<td>102.4%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Chronic COPD</td>
<td>110.0%</td>
<td>5.9%</td>
<td>Internet Usage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Use: Cigarettes</td>
<td>114.6%</td>
<td>26.7%</td>
<td>Use Internet to Talk to MD</td>
<td>74.3%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Chronic Allergies</td>
<td>104.0%</td>
<td>22.6%</td>
<td>Facebook Opinions</td>
<td>93.6%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td>Looked for Provider Rating</td>
<td>88.0%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Mammography in Past Yr</td>
<td>96.0%</td>
<td>43.8%</td>
<td>Misc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Screen: Colorectal 2 yr</td>
<td>95.2%</td>
<td>23.3%</td>
<td>Charitable Contrib: Hosp/Hosp Sys</td>
<td>95.3%</td>
<td>22.8%</td>
</tr>
<tr>
<td>Cancer Screen: Pap/Cerv Test 2 yr</td>
<td>94.1%</td>
<td>56.7%</td>
<td>Charitable Contrib: Other Health Org</td>
<td>93.7%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Routine Screen: Prostate 2 yr</td>
<td>94.4%</td>
<td>36.1%</td>
<td>PSA/TSA: Employer Offers</td>
<td>96.5%</td>
<td>48.8%</td>
</tr>
<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
<td>Emergency Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Lower Back Pain</td>
<td>106.1%</td>
<td>23.9%</td>
<td>Emergency Room Use</td>
<td>100.4%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Chronic Osteoporosis</td>
<td>103.4%</td>
<td>10.6%</td>
<td>Urgent Care Use</td>
<td>100.6%</td>
<td>23.8%</td>
</tr>
</tbody>
</table>
Leading Causes of Death

The following table illustrates the leading causes of death for WCH’s service area.

<table>
<thead>
<tr>
<th>OH Rank</th>
<th>Wayne Co. Rank</th>
<th>Condition</th>
<th>Rank among all counties in OH (#1 rank = worst in state)</th>
<th>Rate of Death per 100,000 age adjusted</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Heart Disease</td>
<td>63 of 88</td>
<td>189.7</td>
<td>208.9</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Cancer</td>
<td>61 of 88</td>
<td>190.9</td>
<td>192.4</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>Stroke</td>
<td>17 of 88</td>
<td>41.8</td>
<td>55.6</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>Lung</td>
<td>50 of 88</td>
<td>50.4</td>
<td>50.2</td>
</tr>
<tr>
<td>21,22,24</td>
<td>5</td>
<td>Accidents</td>
<td>57 of 88</td>
<td>32.9</td>
<td>37.9</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>Diabetes</td>
<td>20 of 88</td>
<td>25.7</td>
<td>37.3</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>Alzheimer’s</td>
<td>61 of 88</td>
<td>28.4</td>
<td>20.8</td>
</tr>
<tr>
<td>11</td>
<td>8</td>
<td>Flu - Pneumonia</td>
<td>35 of 88</td>
<td>15.4</td>
<td>19.5</td>
</tr>
<tr>
<td>10</td>
<td>9</td>
<td>Kidney</td>
<td>63 of 88</td>
<td>14.4</td>
<td>12.7</td>
</tr>
<tr>
<td>18</td>
<td>10</td>
<td>Suicide</td>
<td>54 of 88</td>
<td>9.9</td>
<td>10.3</td>
</tr>
<tr>
<td>25</td>
<td>11</td>
<td>Parkinson’s</td>
<td>21 of 88</td>
<td>6.9</td>
<td>8.1</td>
</tr>
<tr>
<td>16</td>
<td>12</td>
<td>Blood Poisoning</td>
<td>69 of 88</td>
<td>11.4</td>
<td>7.7</td>
</tr>
<tr>
<td>8</td>
<td>13</td>
<td>Hypertension</td>
<td>59 of 88</td>
<td>9.5</td>
<td>7.6</td>
</tr>
<tr>
<td>20</td>
<td>14</td>
<td>Liver</td>
<td>77 of 88</td>
<td>8.9</td>
<td>5.1</td>
</tr>
<tr>
<td>33</td>
<td>15</td>
<td>Homicide</td>
<td>44 of 85</td>
<td>4.8</td>
<td>2.2</td>
</tr>
</tbody>
</table>
Primary and Chronic Disease Needs and Health Issues of Uninsured Persons, Low-Income Persons, and Minority Groups

Some information is available to describe the size and composition of various uninsured persons, low income persons, minority groups, and other vulnerable population segments. Specific studies identifying needs of such groups, distinct from the general population at a county unit of analysis, are not readily available from secondary sources.

The National Healthcare Disparities Report results from a Congressional directive to the Agency for Healthcare Research and Quality (AHRQ). This production is an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." The emphasis is on disparities related to race, ethnicity, and socioeconomic status. The directive includes a charge to examine disparities in "priority populations," which are groups with unique healthcare needs or issues that require special attention.

Nationally, this report observes the following trends:

- **Measures for which Blacks were worse than Whites and are getting better:**
  - Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
  - Functional Status Preservation and Rehabilitation - Female Medicare beneficiaries age 65 and over, who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

- **Measures for which Blacks were worse than Whites and staying the same:**
  - Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
  - Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;
  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;

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2 http://www.ahrq.gov/qual/nhdr10/Chap10.htm 2010
• Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;

• Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;

• Timeliness – Adults who needed immediate care for an illness, injury, or condition in the last 12 months, who received care as soon as they wanted; emergency department visits where patients left without being seen; and

• Access – People with a usual primary care provider; people with a specific source of ongoing care.

• Measures for which Asians were worse than Whites and getting better:
  
  o Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  
  o Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.

• Measures for which Asians were worse than Whites and staying the same:
  
  o Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
  
  o Access – People with a usual primary care provider.

• Measures for which American Indians and Alaska Natives were worse than Whites for the most recent year and staying the same:
  
  o Heart Disease – Hospital patients with heart failure who received recommended hospital care;
  
  o HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  
  o Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;
  
  o Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;
  
  o Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home healthcare patients who were admitted to the hospital; and
- Access – People under age 65 with health insurance.

- Measures for which American Indians and Alaska Natives were worse than Whites for the most recent year and getting worse:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient safety – Adult surgery patients who received appropriate timing of antibiotics.

- Measures for which Hispanics were worse than non-Hispanic Whites for the most recent year and getting better:
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
  - Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:
  - Cancer – Women age 40 and over who received a mammogram in the last 2 years; adults age 50 and over who ever received colorectal cancer screening;
  - Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
  - Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;
  - Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  - Lifestyle Modification – Adults with obesity who ever received advice from a health provider to exercise more;
- Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;

- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;

- Timeliness – Adults who needed care right away for an illness, injury, or condition in the last 12 months and got care as soon as wanted;

- Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and

- Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons

- Measures for which Hispanics were worse than non-Hispanic Whites for the most recent year and getting worse:
  - Maternal and Child Health – Children ages 3-6 who ever had their vision checked by a health provider.

We asked a specific question to our local expert advisors about unique needs of priority populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received to identify unique population needs to which we should respond. Specific opinions from the local expert advisors are summarized as follows:

- Cancer, all kinds, heart disease, diabetes, obesity, high blood pressure, mental health issues, dental health

- Access to care and affordability of prescription drugs.

- Routine wellness or preventive health care.

- Addiction and Mental Health

- Very limited mental health resources

Statistical information about special populations follows:
Conclusions from Public Input to Community Health Needs Assessment

Twenty-three area residents participated in a survey asking opinions about their perception of local healthcare needs. In descending order of opinion, eight topics were identified as being of "Major Concern" or "Most Important Issue to Resolve":

1. Affordable health and medical care for all residents of the county;
2. Lack of availability of health care beyond the emergency room for those who are uninsured;
3. Lack of family mental health services in Wayne County;
4. Obesity with an increase of Diabetes Type 2 and Heart Disease, smoking, and alcohol;
5. Resident access to primary care and to dental care;
6. Unhealthy lifestyles precipitating long-term health conditions;
7. More services for the elderly are needed; and
8. Access to comprehensive cancer treatment programs.

Summary of Observations from Wayne County Compared to All Other State Counties, in Terms of Community Health Needs

- In general, Wayne County residents are above average health for State;

- In a health status classification termed "Health Outcomes," Wayne County ranks 16th among 88 counties (best being #1). On measures of morbidity and mortality, Wayne County performs better than the State average and National benchmark for poor physical health days. On all other measures of morbidity and mortality, including premature death (death prior to the age of 75), poor or fair health, poor mental health days, and low birth weight Wayne County performs better than State averages, but does not meet National benchmarks; and

- In another health status classification "Health Factors," Wayne County fares slightly worse, ranking 18th among the 88 counties. The clinical care measures for preventable hospital stays, diabetic screening, and mammography screening are better than State averages, but do not meet National benchmarks. On the clinical measures for uninsured and supply of primary care physicians and dentists, Wayne County performs worse than State averages and does not meet National benchmarks. Conditions where improvement remains to achieving state average rates and then national goals include:
  - Adult smoking;
  - Adult obesity;
  - Higher education (some college);
  - Daily fine particulate matter; and
  - Drinking water safety.

Summary of Observations from Wayne County Peer Comparisons

The federal government administers a process to allocate all counties into "peer" groups. County "peer" groups have similar social, economic, and demographic characteristics. Health and wellness observations when Wayne County is compared to its national set of peer counties and compared to national rates make the following observations:

UNFAVORABLE - observations occurring at rates worse than national AND worse than among peers:

- No care in first trimester
• White non-Hispanic infant mortality;
• Colon cancer;
• Coronary heart disease;
• Lung cancer; and
• Stroke

SOMEWHAT A CONCERN - observations because occurrence is EITHER above national average or above peer group average:

• Infant mortality;
• Post-neonatal infant mortality; and
• Motor vehicle injuries.

BETTER PERFORMANCE – better than peers and national rates:

• Low birth weight (<2500 g);
• Very low birth weight (<1500 g);
• Premature births (<37 weeks);
• Births to women under 18;
• Births to women age 40-54;
• Births to unmarried women;
• Neonatal infant mortality;
• Breast cancer (Female);
• Suicide; and
• Unintentional injury

Conclusions from the Demographic Analysis Comparing Wayne County to National Averages

Wayne County in 2013 comprises 121,165 residents. During the next five years, it is expected to see a population increase of 0.1% to achieve 121,293 residents. These are higher than the anticipated state (0%), but lower than the national growth (3.3%). The population is older than National average, but younger than State average and has a lower median income than state and national comparisons. 15.3% of the population is age 65 or older, higher than OH. 0.8% are non-Hispanic White, Asian, and Pacific Island origin; Hispanics constitute 1.7% of the population; Blacks
comprise 1.4% of the population; Whites 94.6%. Females ages 15 to 44 comprise 18.4% of the population, less than the percentage in OH (19.6%) or the nation (19.8%).

The following areas were identified comparing the county to national averages. Metrics impacting more than 30% of the population and that are statistically significantly different from the national average:

- Personal Responsibility for Health was 5.2% below average, impacting 60.3% - an adverse finding;
- Pap/Cervix Screening was 5.9% below average, impacting 56.7% - an adverse finding;
- OB/GYN 1+ Visit was 6.9% below average, impacting 42.7% - an adverse finding;
- Compliance with Treatment Recommendations was 6.4% below average, impacting 37.7% - an adverse finding;
- Charitable Contributions to Other Health Organizations was 6.3% below average, impacting 36.7% - neither a beneficial nor adverse finding; and
- Routine Screen: Prostate 2 years was 5.6% below average, impacting 30.1% - an adverse finding.

Situations and conditions statistically significantly different from the national average, but impacting less than 30% of the population include:

- Tobacco Use: Cigarettes was 14.5% above average, impacting 29.7% - an adverse finding;
- Chronic High Blood Pressure as 5.4% above average, impacting 27.7% - an adverse finding;
- BMI: Morbid/Obese was 7.1% above average, impacting 27.4% - an adverse finding;
- Healthy Eating Habits was 8.1% below average, impacting 27.2% - an adverse finding;
- Chronic Lower Back Pain was 6.1% above average, impacting 23.9% - an adverse finding;
- Routine Screen: Cardiac Stress Test 2 years was 10.1% below average, impacting 14% - an adverse finding;
- Looked for Provider Rating was 12% below average, impacting 12.7% - neither a beneficial nor adverse finding;
- Chronic Diabetes was 7.8% above average, impacting 11.2% - an adverse finding;
- Use Internet to Talk to MD was 25.7% below average, impacting 10.8% - neither a beneficial nor adverse finding;
- Facebook Opinions was 6.4% below average, impacting 9.6% - neither a beneficial nor adverse finding;
Chronic Heart Disease was 9.7% above average, impacting 9.2% - an adverse finding;

Chronic COPD was 10.9% above average, impacting 5.9% - an adverse finding; and

Very Unhealthy Eating Habits was 7.1% above average, impacting 2.9% - an adverse finding.

Key Conclusions from Consideration of the Other Statistical Data Examinations

Additional observations of Wayne County found:

- Palliative Care programs (programs focused not on curative actions but designed to relieve disease symptoms pain and stress arising from serious illness) one program exists in the county;
- Hospice: Seven programs exist in the county.

Ranking the causes of death in County finds the leading causes to be the following (in descending order of occurrence):

- Heart Disease #1 cause of death statewide and in County - 208.9/100,000 ranking #63 among 88 OH Counties;
- Cancer #2 cause of death statewide and in County - 192.4/100,000 ranking #61 OH County;
- Stroke #3 cause of death in County, statewide #4 - 55.6/100,000 ranking #17 OH County;
- Lung Disease #4 cause of death in County, statewide #3 - 50.2/100,000 ranking #50 OH County - significantly higher than expected;
- Accidents #5 cause of death in County, statewide #21 - 37.9/100,000 ranking #57 OH County - significantly lower than expected;
- Diabetes #6 cause of death in County, statewide #7 - 37.3/100,000 ranking #20 OH County - significantly higher than expected;
- Alzheimer's #7 cause of death in County, statewide #5 - 20.8/100,000 ranking #61 OH County;
- Flu-Pneumonia #8 cause of death in County, statewide #11 - 19.5/100,000 ranking #35 OH County;
- Kidney Disease #9 cause of death in County, statewide #10 - 12.7/100,000 ranking #63 OH County;

- Suicide #10 cause of death in County, statewide #18 - 10.3/100,000 ranking #54 OH County; and

- Among other leading causes of death, Parkinson's is significantly higher than expected. Blood Poisoning, Liver Disease, and Homicide are significantly lower than expected.

The overall, all race incident of Heart Disease death is below both state and national averages. The incident of Heart Disease death for Blacks in Wayne County is also below state and national averages. The overall, all race incidents of Stroke deaths is above both state and national averages. The incident of Stroke deaths among Blacks is above the national average, but below the state average. Diabetes is below state average.

- Life expectancy for Wayne County males in 1989 was 72.8 years, 1.2 years behind the top counties, improving in 2009 to 75.8 years, 2.8 years behind the top counties.

- Life expectancy for Wayne County females in 1989 was 78.5 years, 1.4 years behind the top counties, improving in 2009 to 80.7 years, 2.3 years behind the top counties.
EXISTING HEALTH CARE FACILITIES, RESOURCES AND IMPLEMENTATION PLAN
Significant Health Needs

We used the priority ranking of area health needs by the local expert advisors to organize the search for locally available resources as well as the response to the needs by WCH. The following list includes:

- Identifies the rank order of each identified significant need;
- Presents the factors considered in developing the ranking;
- Establishes a problem statement to specify the problem indicated by use of the significant need term;
- Identifies WCH's current efforts responding to the need;
- Establishes the implementation plan programs and resources WCH will devote to attempt to achieve improvements;
- Documents the leading indicators WCH will use to measure progress;
- Presents the lagging indicators WCH believes the leading indicators will influence in a positive fashion, and;
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, WCH is the major hospital in the service area. WCH is a 172-bed, acute care medical facility located in Wooster, OH. The next closest facilities are outside the service area and include:

- Aultman Orrville Hospital - 25-bed critical access hospital in Orrville, OH; 9.7 miles away from Wooster (19 minutes)
- Lodi Community Hospital - 25-bed critical access hospital in Lodi, OH; 16.2 miles away from Wooster (26 minutes)
- Samaritan Hospital - 50-bed acute care medical facility in Ashland, OH; 25.9 miles away from Wooster (34 minutes)

All data items analyzed to determine significant needs are 'lagging indicators' - measures presenting results after a period of time, characterizing historical performance. Lagging indicators tell you nothing about how the outcomes were achieved. In contrast the WCH implementation plan utilizes 'leading indicators,' which anticipate change in the lagging indicator. Leading indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the lagging indicator. In the QHR application, leading indicators also must be within the ability of the hospital to influence and measure.
Significant Needs

1. MENTAL HEALTH/SUICIDE/SUBSTANCE ABUSE – mental health issues #1 resident concern; Suicide is #10 cause of death in County and statewide #18 - 10.3/100,000 ranking #54 OH County; Local Experts cite mental health access issues.

Problem Statement: There are insufficient resources in Wayne County to address mental health needs and substance abuse problems.

WCH HEALTH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- Social work evaluations and referrals – connecting patients to available resources
- Employee Assistance Program (EAP) for employees
- Depression Screening in ED and on patient discharge for selected patients

ANTICIPATED RESULTS FROM IMPLEMENTATION PLAN

- WCH can help clinical staff recognize symptoms of mental health issues and substance abuse, and refer to appropriate community resources.
- Increased employee and physician awareness of mental health services and prevention.

LEADING INDICATOR WCH WILL USE TO MEASURE PROGRESS:

- Number of referrals to local mental health resources included in Emergency Department care plans
- Care plans established in prior years which were reviewed and/or revised in 2012:
  - Thirteen (13) individuals were already established with some form of mental health treatment
  - Sixteen (16) individuals were provided information on and/or suggested mental health treatment
- Care plans established in 2012:
  - Six (6) individuals were already established with some form of mental health treatment
  - Four (4) individuals were provided information on and/or suggested mental health treatment

Number and percentage of positive screens (patients scoring five or greater) on the Geriatric Depression Scale. The scale is required for all patients with stroke or CHF as a diagnosis but may be done for others.

- 2012: 311 screenings completed with 88 (28.3%) positive for mild depression
• 2013 (January – September): 188 screenings complete with 46 (24.5%) positive for mild depression

LAGGING INDICATOR WCH WILL USE TO IDENTIFY IMPROVEMENT

• Suicide death rate in Wayne is 10.3 per 100,000.⁴

| OTHER LOCAL RESOURCES IDENTIFIED DURING THE CHNA Process which are believed available to respond to this need include the following: |
|--------------------------------------------------|-----------------|-----------------|
| Your Human Resource Center of Wayne & Holmes Counties | 2587 Back Orrville Rd., Wooster, OH | 330-264-9597 |
| Counseling Center of Wayne and Holmes Counties | 2285 Benden Dr., Wooster, OH | 330-264-9029 |
| Alcoholics Anonymous – Akron Intergroup | 775 N. Main St., Akron, OH | 800-897-6737 |
| Mental Health & Recovery Board of Wayne & Holmes Counties | 2345 Gateway Dr., Wooster, OH | 330-264-2527 |
| STEPS Substance Abuse Treatment Education & Prevention Services | 104 Spink St., Wooster, OH | 330-264-8498 |

2. OBESITY/OVERWEIGHT – Local experts listed nutritional educational needs; Engage in Vigorous Exercise is below avg. impacts 50% of the population.; BMI: Morbid/Obese is 7.1% above average, impacting 27.4% of the population.; Very Unhealthy Eating Habits is 7.1% above average, impacting 2.9% of the population.; Healthy eating habits is 8.1% below average, impacting 27.2% of the population.

Problem Statement: There is a lack of awareness and action of maintaining a healthy weight and lifestyle.

WCH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

• WCH dietitians provide nutritional counseling;
• WCH cafeteria provides healthier food choices;
• WCH Cardiac and Pulmonary Rehab programs;
• WCH physical therapy program.
• WCH health and wellness, exercise and nutrition programs

WCH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

• WCH will explore possibility of an integrated approach to obesity by coordinating its efforts with other local resources on obesity prevention initiatives;

⁴ http://www.worldlifeexpectancy.com/usa/ohio-suicide
WCH provides wellness screenings for their employees and a yearly Health Risk Assessment (HRA) for employees who use the Hospital’s health insurance

WCH participates in multiple health fairs each year for community members;

WCH cafeteria will continue to provide healthier choice options with nutritional content information posted.

**ANTICIPATED RESULTS FROM WCH IMPLEMENTATION PLAN**

WCH anticipates increased community awareness of healthy lifestyle programs by promoting activities of local resources.

**LEADING INDICATOR WCH WILL USE TO MEASURE PROGRESS:**

WCH will determine the number of employees participating in yearly Health Risk Appraisal (HRA)

- Percentage of employees enrolled in WCH insurance plan who participate in the HRA. 2013 = 91%

**LAGGING INDICATOR WCH WILL USE TO IDENTIFY IMPROVEMENT**

Reduction in the percent of Wayne residents having obesity (BMI) value greater than 30. Current value = 32%\(^5\)

<table>
<thead>
<tr>
<th>Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orrville Boys and Girls Club</td>
</tr>
<tr>
<td>Wooster YMCA</td>
</tr>
<tr>
<td>Wooster Parks and Recreation Centers</td>
</tr>
<tr>
<td>Gault Recreation &amp; Fitness Center</td>
</tr>
</tbody>
</table>

3. **AFFORDABILITY** – Local Experts cite lack of access and affordability concerns

**Problem Statement:** Local residents do not have ongoing and integrated access to care because of limited ability to pay and insurance restrictions by some local providers.

**WCH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- WCH business office and financially related policies
- WCH emergency department operates 24/7 and offers a safety net for patients

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- WCH social services and case managers assist patients with obtaining financial assistance and access to the continuum of care
- WCH Patient Navigator helps patients find financial assistance and facilitates applications for such assistance.

**WCH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**
- WCH will continue to refer the uninsured population to Viola Startzman free clinic.
- WCH monitors the adequacy of providers and uses the WCH Foundation to attract and assist new practitioners become established in the county.
- WCH will continue to use 'People to People' for drug assistance.
- WCH will continue to assist in recruiting competent health care professionals that accept Medicaid and Self Pay.
- WCH will encourage enrollment in existing programs such as Medicaid and Health Insurance Exchange via outreach/education and expedited enrollment.
- WCH will initiate the Wooster Care Network

**ANTICIPATED RESULTS FROM WCH IMPLEMENTATION PLAN**
- WCH’s efforts can help address the symptoms of and results from problems of affordability and access in order to have positive impact on the underlying causes.

**LEADING INDICATOR WCH WILL USE TO MEASURE PROGRESS:**
- Number of patients assisted through patient financial assistance efforts should increase. A tracking method to determine the number of patients assisted will be developed and implemented.

**LAGGING INDICATOR WCH WILL USE TO IDENTIFY IMPROVEMENT**
- 2008 Percent of uninsured population in Wayne County was 20.90%6

| Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following: |
|---------------------------------|---------------------|-----------------|
| WCH case management, patient financial services departments | 1761 Beall Avenue, Wooster, OH 44691 | 330-263-8100 |
| Viola Startzman Free Clinic | 1874 Cleveland Rd., Wooster, OH 44691 | 330-262-2500 |
| Local Insurance Agents (Health Exchange enrollment) | Wooster, OH and surrounding area | |

4. **COMPLIANCE BEHAVIOR** – Local experts cite education and prevention as needs; Compliance with Treatment Recommendations was 6.4% below average, impacting 37.7% of the population - an adverse finding; “I am responsible for my health” below average impacts 60.3% of the population.; High School Graduation rate is 88% while Some College is at 46% for Wayne County.

**Problem Statement:** Not enough residents engage in preventative care. One example is immunization compliance, as per the CDC guidelines.

**WCH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- WCH provides public awareness of health prevention and compliance with treatment recommendations through marketing mediums;
- WCH provides influenza vaccinations to patients and staff during flu season as needed
- WCH provides pneumonia vaccines to patients if applicable.

**WCH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- Wooster will increase awareness on Flu and Pneumonia vaccination efforts for community members.
- WCH provides vaccinations thorough their retail pharmacy for the community

**ANTICIPATED RESULTS FROM WCH IMPLEMENTATION PLAN**

- Increased immunization compliance for Wayne County residents.

**LEADING INDICATOR WCH WILL USE TO MEASURE PROGRESS:**

- CMS Core Measure of Preventative Care, percent of patients assessed and given a pneumococcal vaccine.
- WCH’s overall rate for pneumococcal immunization in 2012 was 94.9%. Total eligible cases were 627 with 595 being vaccinated.

**LAGGING INDICATOR WCH WILL USE TO IDENTIFY IMPROVEMENT**

- Cluster profile of “I am responsible for my health” is below average and impacts 60.3% of population

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Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wayne County Health Department</td>
<td>203 S. Walnut Street, Wooster, OH 44691</td>
<td>(330) 264-9590</td>
</tr>
<tr>
<td>Rite Aid Pharmacy</td>
<td>1955 Cleveland Rd Wooster</td>
<td>(330) 262-9045</td>
</tr>
<tr>
<td>CVS Pharmacy</td>
<td>415 N Main St Orrville</td>
<td>(330) 684-2602</td>
</tr>
<tr>
<td>Discount Drug Mart</td>
<td>629 Beall Ave, Wooster</td>
<td>(330) 264-8404</td>
</tr>
<tr>
<td>Buehler's Fresh Foods Wooster Milltown</td>
<td>3540 Burbank Rd, Wooster</td>
<td>(330) 345-5908</td>
</tr>
<tr>
<td>Ritzman Pharmacy</td>
<td>234 N Main St, Rittman</td>
<td>(330) 927-3175</td>
</tr>
<tr>
<td>Local physician practices and clinics</td>
<td><a href="http://www.woosterhospital.org/physicians">http://www.woosterhospital.org/physicians</a></td>
<td></td>
</tr>
</tbody>
</table>

5. PRIORITY POPULATIONS/Services for elderly/disabled – “I follow treatment recommendations” affects 37.7% of the population in Wayne co.; people living in food desert (low healthy food access) is 16.6%, less than OH average; local experts note low income population need better education on healthy food choices and improved services for the elderly and disabled.

Problem Statement: There is a lack of coordination of care for at risk populations and individuals in the county.

WCH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- Health Fairs for community
- Care Coordination through primary care providers at Bloomington Medical Services
- WCH provides free education and meals via the Senior Partners program
- WCH provides free transportation to local area health providers

WCH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- WCH is developing a community health worker program to address needs of at risk individuals through the Wooster Care Network

ANTICIPATED RESULTS FROM WCH IMPLEMENTATION PLAN

- WCH efforts can help address the symptoms of and results from problems related to healthy food access.
• WCH will continue to explore collaboration efforts with local resources to assist priority populations with health education.

**LEADING INDICATOR WCH WILL USE TO MEASURE PROGRESS:**

• WCH will develop a tracking method for the number of participants through the Wooster Care Network which will be launched in 2014.
  ○ 2013 Participants = 0

**LAGGING INDICATOR WCH WILL USE TO IDENTIFY IMPROVEMENT**

• Percent Population Without Adequate Social/Emotional Support in Wayne County is 19%, as compared to the national average of 20.93%.

| Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following: |
|---|---|---|
| Women Infant and Children (WIC) program | 203 S. Walnut Street, Wooster, OH 44691 | 330-264-9590 |
| Area Agency on Aging | 1550 Corporate Woods Pkwy, Uniontown, OH | 330-563-0310 |
| Meals on Wheels | 2363 Nave St. SE., Massillon, OH | 800-466-8010 |

6. **Coronary Heart Disease** – #1 cause of death statewide and in County - 208.9/100,000 ranking #63 among 88 OH Counties; 9.7% above average, impacting 9.2% of the pop.; Routine Screen: Cardiac Stress Test 2 years was 10.1% below average, impacting 14%.

**Problem Statement:** Wayne County community members have many complications related to heart disease.

**WCH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

• Blood pressure screening by WCH staff and volunteers;

• WCH participates in multiple health fairs with various health measurements;

• WCH has Advanced Cardiac Life Support certified physicians and nursing and other staff, as well as cardiologists on staff, a diagnostic cath lab and cardiovascular services.

• WCH is an American Heart Association Training Center and provides BLS, ACLS, PALS and PEARS training for healthcare professionals throughout the county.

**WOOSTER IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

• WCH participates in programs to screen employees and community members;

• WCH offers free blood pressure screening to community organizations;

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• WCH offers personalized exercise programs to patients enrolled in Cardiac and Pulmonary Rehabilitation and HealthPoint members; and

• WCH provides educational articles on healthy eating and lifestyle.

**ANTICIPATED RESULTS FROM WCH IMPLEMENTATION PLAN**

• Wooster residents will experience lower rates of morbid obesity in the county.

• WCH will help reduce the number of cardiac related complications by providing education.

**LEADING INDICATOR WCH WILL USE TO MEASURE PROGRESS:**

• Number of participants enrolled in Cardiac and Pulmonary Rehab:
  - 2012 Cardiac Rehab participants: 211 Phase II; 31 Phase III
  - 2012 Pulmonary Rehab participants: 61 Phase II; 21 Phase III

**LAGGING INDICATOR WCH WILL USE TO IDENTIFY IMPROVEMENT**

• Wayne County death rate due to heart disease moves closer to the U.S. rate of 193.6 per 100,000.
  - 2012 Wayne County rate: 208.9 per 100,0009

Other local resources identified during the CHNA process which are believed available to respond to this need include the following:

<table>
<thead>
<tr>
<th>Service</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Heart Association</td>
<td>4682 Douglas Cir, NW, Canton</td>
<td>330-478-8383</td>
</tr>
</tbody>
</table>

7. **Diabetes** – #6 cause of death in County and #7 statewide - 37.3/100,000 ranking #20 OH County; Chronic Diabetes is 7.8% above average, impacting 11.2% of population; screening rate is average for state and US goal

**Problem Statement:** There is less compliance of Diabetes self management in Wayne County.

**WCH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

• WCH provides referrals to the Diabetes clinic

• WCH provided diabetic nutritional support for patients on an inpatient and outpatient basis.

**WCH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

• WCH will establish an integrated approach to Diabetes management by exploring efforts to coordinate efforts with other local resources

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9 [www.worldlifeexpectancy.com/usa-health-rankings](http://www.worldlifeexpectancy.com/usa-health-rankings)
• Wooster Care Network’s Health Coaches program will assist identified patients reach their diabetic management goals.

ANTICIPATED RESULTS FROM WCH IMPLEMENTATION PLAN

• Increase in compliance with Diabetes management initiatives.

LEADING INDICATOR WCH WILL USE TO MEASURE PROGRESS:

• WCH will develop a tracking method to measure this progress. Volume of patient interactions should increase from 2013 volumes.
  o 2012 number of outpatients who attend the Diabetic Education Clinic (defined by ADA criteria) = 117
  o 2012 number of units of service to outpatients with diabetes (includes diabetic education, clinic visits and diabetic patients using the Why Weight program) = 2381

LAGGING INDICATOR WCH WILL USE TO IDENTIFY IMPROVEMENT:

• Wayne County death rate due to Diabetes moves closer to the U.S. rate of 22.4 per 100,000.
  o 2012 Wayne County rate: 37.3 per 100,000\(^{10}\)

<table>
<thead>
<tr>
<th>Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WCH Diabetes Clinic</strong></td>
</tr>
<tr>
<td><strong>WCH Home Health Agency</strong></td>
</tr>
<tr>
<td><strong>Wooster Care Network</strong></td>
</tr>
</tbody>
</table>

8. CANCER – # 2 cause of death statewide and in County - 192.4/100,000 ranking #61 OH County. Local experts cite Cancer as a concern also; Obtained a Pap/Cervix test in last 2 years is was 5.9% below average, impacting 56.7% of the pop.; Mammogram screening about avg. impacts 65% of pop.; Unfavorable rates worse than US AND Peers for Breast Cancer, and Lung Cancer.

Problem Statement: Limited access to comprehensive cancer treatment programs.

WCH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

• Cancer committee;
• Tumor board
• COC accreditation

\(^{10}\) www.worldlifeexpectancy.com/usa-health-rankings
• Patient navigator

• WCH provides colonoscopy and mammography screenings. A mechanism to track the number of screening mammography exams exists. A mechanism to better track the number of screening colonoscopies will be developed.

**WCH Implementation Plan Programmatic Initiatives:**

• Coordinating efforts with local resources responding to this need by identifying how WCH services can benefit their initiatives. WCH will initiate efforts by contacting each organization to evaluate opportunities for effort collaboration.

• Cancer navigator/nursing navigator to assist patients with care and financial resources as they cope with cancer.

• Allocating resources to acquire educational material to distribute to patients receiving a cancer diagnosis or interested in the disease

• Wooster Care Network’s Health Coaches.

**Anticipated Results from WCH Implementation Plan**

• An increase in the use of screening and cancer detection services leading to earlier intervention and increased survival.

**Leading Indicator WCH Will Use to Measure Progress:**

• Volume of screening mammography exams done at WCH will be monitored. Overall community volumes should increase from 2012 volumes.
  
  o WCH 2012 screening mammography exams = 3985

• Volume of screening colonoscopy exams done at WCH
  
  o 2012 = 90
  
  o 2013 (January – September) = 91

**Lagging Indicator WCH Will Use to Identify Improvement**

• Wayne County death rate due to Cancer moves closer to the U.S. rate of 186.2 per 100,000.
  
  o 2012 Wayne County rate: 192.4 per 100,000

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Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:

<table>
<thead>
<tr>
<th>American Cancer Society</th>
<th>721 E. Milltown Rd., Wooster 44691</th>
<th>330-287-4605</th>
</tr>
</thead>
</table>

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11 [www.worldlifeexpectancy.com/usa-health-rankings](http://www.worldlifeexpectancy.com/usa-health-rankings)
Other Needs Identified During the CHNA Process

9. **DENTAL** – 36.28% of adult residents have no HX of dental exams, exceeds OH avg.; Dentists to Population Ratio significantly higher (adverse) than OH avg. and US goal

10. **MATERNAL AND INFANT MEASURES** - OB/GYN visit below avg as impacts 42.7% of pop.; Better than Peers and US rates- Low Birth Weight (or Unfavorable rates worse than US - Births to Unmarried Women, Very Low Birth Weight (<1500g); White non Hispanic Infant Mortality; Post-neonatal Infant Mortality

11. **SMOKING/TOBACCO USE** - Tobacco use is 14.5% above average, impacting 29.7% of pop.; above national avg. use for co. and US.

12. **CHRONIC COPD/(LUNG DISEASE)/PULMONARY** - #4 cause of death in County, statewide #3 - 50.2/100,000 ranking #50 OH County - significantly higher than expected; Chronic COPD is above average, impacting 5.9% of the pop.; Chronic allergies above avg. impacts 22.6% of pop.

13. **STROKE** - #3 cause of death in County, statewide #4 - 55.6/100,000 ranking #17 OH County - as expected for Co, and OH

14. **PHYSICIANS** - 91% of pop have used a Primary care physician at least once; Primary Care Physician to Population Ratio significantly higher (adverse) than OH avg. and US goal

15. **BLOOD PRESSURE (High)** - Hypertension 13th cause of deaths in Co., death rate as expected; 5.4% above average, impacting 27.7% of the population

16. **POLLUTION** - Air particulate matter worse than OH avg. and US goal; water, drinking water safety worse than OH and US goal

17. **PALLIATIVE CARE & HOSPICE** - Palliative care programs do not exist in co., 7 facilities provide Hospice services

18. **PREVENTABLE HOSPITALIZATION** - Preventable Hospital Stays avg. for OH but better than US goals

19. **ACCIDENTS** - #5 cause of death in County, statewide #21 - 37.9/100,000 ranking #57 OH County - significantly lower than expected; death rates worse than US AND Peers for Motor Vehicle Injuries; Approximately better than Peers and US rates for Unintentional Injury; Motor Vehicle Crash Death Rate average in OH but higher than US avg.

20. **CHOLESTEROL (HIGH)** - Chronic high cholesterol affects 21.9% of the pop.; Routine cholesterol screening below avg. impacts 48.4% of pop.

21. **EMERGENCY SERVICES** - Emergency Room use above avg. impacts 34.3% of pop.

22. **FLU-PNEUMONIA** - #8 cause of death in County, statewide #11 - 19.5/100,000 ranking #35 OH County
23. ALZHEIMER'S - #7 cause of death in County, statewide #5 - 20.8/100,000 ranking #61 OH County; as expected

24. CHRONIC OSTEOPOROSIS (bone disease) - Chronic Osteoporosis above avg. impacts 10% of pop.

25. KIDNEY DISEASE - #9 cause of death in County, statewide #10 - 12.7/100,000 ranking #63 OH County

26. LIFE EXPECTANCY/PREMATURE DEATH - Life expectancy increased but females improved better than males; Premature Death rate (death prior to age 75) in Wayne County is below the state average and higher than the national goal.

27. LOW BACK PAIN – 6.1% above average, impacting 23.9% of the pop. - an adverse finding.

28. NEW Community Health Need which has not been adequately considered or addressed- #1 response “Services-bring them together for information”, #2 – “Explain Community Health”, #3 –“ Service & Support to disabled adults under age 60”

Overall Community Need Statement and Priority Ranking Score:

Significant Needs Where Hospital Has Implementation Responsibility

1. MENTAL HEALTH/SUICIDE/SUBSTANCE ABUSE
2. OBESITY/OVERWEIGHT
3. AFFORDABILITY
4. COMPLIANCE BEHAVIOR/PREDEPOSING CONDITIONS
5. PRIORITY POPULATIONS/Services for elderly/disabled
6. CORONARY HEART DISEASE
7. DIABETES
8. CANCER

Significant Needs Where Hospital Did Not Develop Implementation Plan

None

Other Needs Where Hospital Developed Implementation Plan

None

Other Identified Needs Where Hospital Did Not Develop Implementation Plan

9. DENTAL
10. MATERNAL AND INFANT MEASURES
11. SMOKING/TOBACCO USE
12. CHRONIC COPD/(LUNG DISEASE)/PULMONARY
13. STROKE
14. PHYSICIANS
15. BLOOD PRESSURE (High)
16. POLLUTION
17. PALLIATIVE CARE & HOSPICE
18. PREVENTABLE HOSPITALIZATION
19. ACCIDENTS
20. CHOLESTEROL (HIGH)
21. EMERGENCY SERVICES
22. FLU-PNEUMONIA
23. ALZHEIMER'S
24. CHRONIC OSTEOPOROSIS (bone disease)
25. KIDNEY DISEASE
26. LIFE EXPECTANCY/PREMATURE DEATH
27. LOW BACK PAIN
28. NEW Community Health Need which has not been adequately considered or addressed
APPENDICES
Appendix A – Local Expert Advisor Opinion About Significant Needs

A total of 23 local expert advisors participated in an online survey offering opinions regarding their perceptions of community health needs. The following is an analysis of their responses:

The first question was open-ended. “What do you believe to be the most important health or medical issue confronting the residents of your County?” Answers were placed in a “Word Cloud” format for analysis and generated the following image:

Word Clouds are analytical tools, which give greater visual prominence to words appearing more frequently in the source text. This information visualization establishes a portrait of the aggregate responses, presenting the more frequently used terms with greater text size and distinction in the visual depiction. Common article word (i.e., “a,” “the,” etc.), non-contextual verbs (i.e., “is,” “are,” etc.) and similar words used when writing sentences are suppressed by this application.

Specific verbatim comments received were as follows:

- Care transitions, services for low income
- Access to care in a timely and appropriate manner
- Declining Health as a whole, due to our unhealthy food source, that we continue to consume and think nothing about what it is doing to our health. I think the public is unaware as a whole. We need a lot of educating on proper nutrition. No healthcare system, drugs, or medical field can fix stupid. The best way to lower health care costs is to teach our people how to stay health. I think this may be improving a little, but to make a difference we need the medical field and more Doctors to promote a healthier live style and some already do. Healthcare costs keep going up. I do not think Obama care is a fix for this.
- Cancer, all kinds, heart disease, diabetes, obesity, high blood pressure, mental health issues, dental health

- Access to care by socioeconomics feeding into education, compliance and maintenance of health.

- The high technology of modern day healthcare. Whether in testing, surgery, or treatment, it is readily available. If used it puts a tremendous strain on our funding. If we don’t use it, are we guilty of negligence? Could we be forced? What is the quality of life after? Some of the consequences.

- Wooster is the largest community in Wayne County, however, we need to travel >50 miles to access many medical specialties/specialists. OSU/OARDC, including ATI, represents about 700 Ohio State University employees regionally, but medical access depends upon Wooster Community Hospital for primary health care access beyond general practitioners.

- Access to care and affordability of prescription drugs. There are likely multiple causes and include lack of health insurance, or improper patient understanding of his/her health insurance benefits, transportation difficulties, or prohibitively high cost of many medications. Consequently many patients go without routine wellness or preventive health care. For those patients with chronic medical problems, they may delay or avoid necessary health care provider visits or cease or arbitrarily cut doses of prescription medications because of the relatively high cost of these items (medical debt is now the most common cause of bankruptcy in the United States).

- I believe the most important is obesity and the health complications that follow.

- Due to my position and focus in the community, I believe that Addictions & Mental Health is a critical medical issue confronting the residents of Wayne Co. and the region. The significant increase in the use of opiates (including prescription medications and heroin) has resulted in an increase of children’s placements out of the home (due to parent's addiction), increased Emergency Department waits for psychiatric hospitalizations, an increase in the Emergency Department of drug seeking behavior and the number of deaths from suicides and accidental drug overdoses. A recent survey of our local agency providers reflected a 105% increase in opiate treatment. Nationally, people with mental illness and a major medical illness (such as diabetic, heart disease and COPD) have increased costs & needs. Persons with a Severe and Persistent Mental Illness (SPMI) have a decreased lifespan by 25 years due to co morbidity (medical illnesses and mental illnesses).

- Due to my position and focus, I believe that the integration of Medical Healthcare and Behavioral Health Care, including Addiction and Mental Health, is a critical medical issue confronting the residents of Wayne Co. and the local region. The significant increase in the use of opiates (including prescription pain medications and heroin) has resulted in an
increase of children’s placements out of the home (due to parent's addiction), increased Emergency Department use and wait time for psychiatric hospitalizations, an increase in the Emergency Department of drug seeking behavior, and the number of deaths from suicides and accidental drug overdoses. A recent local survey of our agency behavioral health providers reflected a 105% increase in treatment for opiates & addictions. National data reflects that people experiencing both a mental illness and a major medical illness (including COPD, heart disease & diabetes), have increased needs and medical costs. Persons experiencing a Serious and Persistent Mental Illness experience a 25 year average decrease in lifespan due to the comorbidity of medical illnesses.

- I feel that access to mental health therapy, especially for pediatric patients, is a significant medical issue in our county.

- Access to high quality, affordable primary care which is: 1. Proactive in providing preventative methodologies to avoid or reverse chronic conditions. 2. Accessible in terms of hours of operation, same day appointments and location. 3. Comprehensive in terms of integrated care (behavioral health, physical health, medication compliance and assistance, social service interaction, etc.)

- "Observation stays" at hospitals (keeping the patient under "observation" instead of admitting them) deny patients' ability to utilize their Medicare Part A benefit because they have not had a 3-day qualifying acute care stay. This affects mostly senior citizens; a group who can least afford expensive skilled nursing care.

- Need for urgent care, dental needs, lack of healthcare coverage, opiate addiction issues, and integration of behavioral and physical healthcare

- As a category the greatest health issue would have to be preventative care. Too much of the healthcare system is emergency/urgent response to long term health situations. In specific smoking, obesity, etc. Programs such as Flu Shots and other vaccinations, managing chronic care (Pain, treatment, etc.), early childhood intervention, etc. would all be viable venues for efforts.

- More services for mental health as well as transportation needs for the elderly. Medication assistance.

- Affordable access to care/insurance costs, mental health, obesity and effects of poverty on a child's health and well being

- The most important health issues today that confront the residents in our region is consumer choice, building the middle of the long-term care continuum, and integrating medical and long-term care and social supports. These are also key policy issues that are hopefully going to be addressed with the development of the Integrated Care Delivery System, a program that will integrate services and care for the population of citizens.
receiving Medicare and Medicaid. Managed Care Organizations will integrate medical, behavioral health, social supports and long-term care.

- The most important issue includes the high number of residents who are under insured or without insurance along with insufficient numbers of providers of medical care to provide the quality care necessary for these additional people who are not fully in the system as yet.

- Currently our biggest need in the community is access. We have a very large population who cannot get to and from the hospital with any regularity.

- Family Mental Health - across the life span. The self medication that takes place when individuals in our community try to ameliorate their mental health distress without professional help. This leads to drug/alcohol use, addiction and suicide and countless other medical issues.

- Access to primary care and dental care

Our second question to the local experts was, “Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e. people with certain situations), which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what.”

The responses generated the following image:

Specific verbatim comments received were as follows:
- Better coordination for those individuals with mental health issues and medical problems. These individuals tend to have limited income. It would seem that we would need a collaboration or partnership between the medical community and mental health.

- Yes. Un and under insurer. Poor access and continuity. Very limited mental health resources.

- There will always be poor people that need help. If we want to help, all we have to do is look and we will find people that need help. I do not know of any person, people, or groups that should be helped more than another.

- **Potential needs of specific groups of people:** No insurance, healthy foods, doctors care, education/funds/transportation, assistance to help save for burial/death, senior citizens' office, poor communications and locations of agencies for good directions to find help, need African American nurses, aides, etc. Jobs for all. African American doctors and other health care workers--create identity of all races and creeds and shows that we live up to what we proclaim we do. Work to run drugs out. Black police and firemen. **Who needs to do what:** We all do! City of Wooster, Churches, Community Center, Wooster City Schools, Wooster Police Department, County Commissioners, all schools, Police/Sheriff, Community programs, NAACP, other communities in Wayne County, other ethnic groups. **What we need to do:** Dental care for children, immunizations, more information about environment and disasters, clean up neighborhoods, more information about racial taboos, update about lead in the home, pollution, update on fast foods/healthy food--who knows? Hearing loss, increase in the study of language and speech understanding.

- Diabetes--education pre and post diagnosis; Mental Health--Improved diagnosis and education;
  Obesity--education, dietary options.

- Low insured motorists that have caused accidents. At this time we Amish have several cases like that. We are left with nearly one million in hospital costs. We do not sue anybody. Insurance companies are slow to settle for what they cover. Thus we are threatened for the bills to be turned into collections. Where do we start? I don't know other than increase the minimum legal insurance.

- Yes, poverty/uninsured access to medical care is a concern regionally. We do have the Startzman Free Clinic in Wooster but the long term issues associated with national health care remain unclear. Also, health care costs and restrictions continue to escalate at our institution as they do across our society and, although we are considered a very desirable employer in the community in large part due to employee benefits, the continued rise in health care costs could start to impact our ability to recruit the best people. A strong community hospital is also critical to our future.
One of the most pressing issues, for patients who are uninsured or underinsured, is the high cost of many medications in the treatment of chronic diseases such as diabetes, hypertension and heart disease, chronic lung disease and cancer. Even patients who have health insurance may not fully understand the prescription drug benefit of their insurance plan. For many of my cancer patients, the patient navigator at Wooster Community Hospital has helped them review the drug coverage of their insurance plans or, if they have no insurance, determine their eligibility for Medicaid or prescription drug assistance programs. Insured patients (those with Medicare and/or commercial insurance) may also be eligible for prescription assistance programs but frequently do not realize it or understand how to find out and have benefited from the navigator’s counsel.

Even with implementation of the Affordable Care Act, these problems are not going to disappear. In fact, patients may require more advice/assistance in interpreting their coverage benefits (or lack thereof) for prescription medications and other medical services. In my opinion, the patient navigator is an underutilized service, and it is difficult for individual physician offices to provide this type of service. If more patients were to utilize the services of a navigator type program, it has the potential to help patients reduce their out-of-pocket expenses and potentially increase their compliance with health care visits and proper medication dosing and scheduling.

I think there are many areas where access to care is limited by lack of providers. Most pressing is psychiatry, then endocrinology, also neurology, gastroenterology, and pulmonary.

People with Mental Illness and Addictions experience needs for funding for services, including outpatient & hospitalization benefits for medical and behavioral health treatment. Medicaid Expansion of benefits is needed to provide increased funding availability for access to treatment. Legislative advocacy is needed for provision. Persons with mental illness have chronic disease needs including diabetes, heart, & lung disease health needs and funding to assure treatment access. Adults without children are not eligible for Medicaid and are often uninsured and in need of treatment. Even with the Affordable Care Act this gap will exist if not addressed through Medicaid Expansion.

In analyzing recent data regarding children in poverty by the Family Children’s First Council & Community Health Survey of the Planning Committee, indications were that children in poverty in Wayne Co. who are eligible for Medicaid benefits have decreased utilization. Local providers, including the hospitals, could be made aware to assure that this population in need receives information regarding benefits and eligibility, which would hopefully result in increased medical care for our youth.

Including the Community Health Survey results and priorities per Wayne Co. Family & Children First (FCFC) & Child and Family Health Systems (CFHS) Grant, would integrate these needs and issues.
I think mental health issues continue to affect low-income persons more dramatically than the general population. Part of this problem is substance abuse. Without education that help is available, people will continue to be ill, families will be affected. And the cycle continues.

Many of our low income uninsured persons suffer from severe chronic conditions that are left untreated for many years until they reach a critical life-threatening point. This situation is exacerbated by lack of resources to maintain adequate medication compliance, daily testing and life style modifications needed to aid in their condition. They often lack social resources for support and encouragement. They also frequently face transportation issues which make it difficult to get to numerous office visits. The Free Clinic does its best to meet these needs, but needs assistance from more of the medical community and also financial support to continue what they do and expand to serve more people.

We have worked with our local hospital to place several indigent patients in order to provide care to those in need. Indigent and/or homeless individuals needing medical care have very few resources after their immediate problems are taken care of in the hospital Emergency Department. The expense is almost more than we public health care providers can absorb. This, along with mental health services, should be better funded and supported.

Dental care - expansion at free clinic; Individuals with addiction disease often have diabetes, heart disease, hepatitis etc. with little access to healthcare. There needs to be better integrated care with physical healthcare and behavioral healthcare to treat the "whole person".

Need for urgent care - could be taken care of by hospital or some other healthcare entity
Hospital needs to work more closely with behavioral healthcare providers to provide better integrated care.

The biggest service issue I've observed seems to be a combination of the uninsured and those who simply choose to use urgent/emergency care as a primary care physician. More issues fall to the ER and the hospital because patients don't have primary care options. There are also issues of an aging population needing greater for geriatric care, substance abuse in various age groups, and again early intervention.

Low income residents have difficult time with placement in SNF if only has mcd do to medical cost of supplies and being all included in rate for therapy services and supplies. Cancer treatment cost for pts in very difficult as well.

Low-income (uninsured) families securing timely and affordable care. More strategic and efficient referral systems from schools to health care organizations might benefit families tremendously.
• The ICDS program will address the needs and coordinate the care of the "Duals"—those residents with Medicare and Medicaid. However, there will remain a need for the moderate-income elder, who is not indigent enough for Medicaid yet unable to independently fund his/her own care in the community. Often it is this individual who finds them using a nursing facility for housing when they could easily remain in their home with some assistance. In addition, adequate housing options for older adults remains an issue in every County, and ICDS opens doors for Managed Care Organizations to work with their communities to provide adequate housing and "build the middle" of the long-term care continuum.

• I believe obesity is a primary problem with our population which leads to an epidemic of diabetes which I understand is the most expensive disease in the world. Diabetes increases the risk of heart disease, kidney disease, blindness, stroke, amputations, etc. Obesity also increases the risk of joint problems with the resultant joint replacements and disability. Childhood obesity also needs to be addressed more effectively which will hopefully decrease adult obesity. Today's fast paced life with fattening fast foods, snacks, and sodas really add to the problem. Of course the TV, computer, iPad, and iPhone culture increases the sedentary lifestyle which adds to the obesity problem. I believe the uninsured or inadequately insured often have a higher obesity incidence.

  We need to have more programs to help with the obesity and lack of physical activity problems. However, how will it be financed with the national budget crunch and debt?

• No I don't think we currently have any.

• Poverty's impact on obesity and poor nutrition and vice versa. This combined with comorbidity of poverty with mental health issues with other disabilities combines to become a health crisis of significant economic and resource drain.

• Coordinated management of chronic disease (HBP, COPD, heart disease, etc.); alternatives to emergency room use; expansion of Medicaid should be a priority for Ohio (but it does not seem to be); there is limited access to dental care for low income persons or persons who have Medicaid.
## Appendix B – Process to Identify and Prioritize Community Need

<table>
<thead>
<tr>
<th>Need Candidate</th>
<th>Total Points Allocated</th>
<th>Cumulative Percentage of Response</th>
<th>Number of Local Experts Voting for Need</th>
<th>Point Break from Higher need</th>
<th>Need Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MENTAL HEALTH / SUICIDE / SUBSTANCE ABUSE</td>
<td>247</td>
<td>12.4%</td>
<td>18</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>2. OBESITY / OVERWEIGHT</td>
<td>207</td>
<td>12.2%</td>
<td>18</td>
<td></td>
<td>Significant Needs</td>
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<tr>
<td>3. AFFORDABILITY</td>
<td>206</td>
<td>13.0%</td>
<td>15</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>4. COMPLIANCE BEHAVIOR / PREDEPOSING CONDITIONS</td>
<td>163</td>
<td>41.2%</td>
<td>14</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>5. PRIORITY POPULATIONS / Service for elderly/disabled</td>
<td>117</td>
<td>57.0%</td>
<td>12</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>6. CORONARY HEART DISEASE</td>
<td>103</td>
<td>52.2%</td>
<td>12</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>7. DIABETES</td>
<td>100</td>
<td>57.2%</td>
<td>14</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>8. CANCER</td>
<td>93</td>
<td>61.8%</td>
<td>12</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>9. DENTAL</td>
<td>82</td>
<td>65.9%</td>
<td>12</td>
<td></td>
<td>Significant Needs</td>
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<tr>
<td>10. MATERNAL AND INFANT MEASURES</td>
<td>75</td>
<td>69.7%</td>
<td>12</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>11. SMOKING / TOBACCO USE</td>
<td>72</td>
<td>73.3%</td>
<td>13</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>12. CHRONIC COPD / (LUNG DISEASE) / PULMONARY</td>
<td>67</td>
<td>76.6%</td>
<td>12</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>13. STROKE</td>
<td>60</td>
<td>79.6%</td>
<td>9</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>14. PHYSICIANS</td>
<td>54</td>
<td>82.3%</td>
<td>9</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>15. BLOOD PRESSURE (High)</td>
<td>52</td>
<td>84.9%</td>
<td>10</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>16. POLLUTION</td>
<td>48</td>
<td>87.3%</td>
<td>8</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>17. PALLIATIVE CARE &amp; HOSPICE</td>
<td>41</td>
<td>89.4%</td>
<td>8</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>18. PREVENTABLE HOSPITALIZATION</td>
<td>38</td>
<td>91.3%</td>
<td>6</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>19. ACCIDENTS</td>
<td>36</td>
<td>93.1%</td>
<td>7</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>20. CHOLESTEROL (HIGH)</td>
<td>35</td>
<td>94.8%</td>
<td>9</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>21. EMERGENCY SERVICES</td>
<td>25</td>
<td>96.1%</td>
<td>6</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>22. FLU-PNEUMONIA</td>
<td>20</td>
<td>97.1%</td>
<td>6</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>23. ALZHEIMER’S</td>
<td>13</td>
<td>97.7%</td>
<td>4</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>24. CHRONIC OSTEOPOROSIS (bone disease)</td>
<td>13</td>
<td>98.4%</td>
<td>5</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>25. KIDNEY DISEASE</td>
<td>13</td>
<td>99.0%</td>
<td>4</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>26. LIFE EXPECTANCY / PREMATURE DEATH</td>
<td>12</td>
<td>99.6%</td>
<td>4</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>27. LOW BACK PAIN</td>
<td>6</td>
<td>99.9%</td>
<td>3</td>
<td></td>
<td>Significant Needs</td>
</tr>
<tr>
<td>28. Unified approach to address community health</td>
<td>2</td>
<td>100.0%</td>
<td>1</td>
<td></td>
<td>Significant Needs</td>
</tr>
</tbody>
</table>

Total: 2,000

Other Identified Needs
### Individuals Participating as Local Expert Advisors

<table>
<thead>
<tr>
<th>Organization</th>
<th>Position</th>
<th>Area of Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wayne county, Milltown family physicians</td>
<td>Coroner, family physician</td>
<td>Medical care</td>
</tr>
<tr>
<td>Wooster OB/GYN</td>
<td>Physician</td>
<td>Obstetrics/gynecology</td>
</tr>
<tr>
<td>Liberty Center Connections, Inc.</td>
<td>Executive Director</td>
<td>Addiction disease, intimate partner violence and sexual assault</td>
</tr>
<tr>
<td>Wayne Family and children First</td>
<td>Director</td>
<td>General, children to young adults</td>
</tr>
<tr>
<td>LifeCare Hospice (formerly Hospice &amp; Palliative Care of Greater Wayne Co.)</td>
<td>Executive Director</td>
<td>Hospice-end of life care</td>
</tr>
<tr>
<td>Royal Truck Division-Amish Church Fund</td>
<td>Owner</td>
<td>Life resident of Wayne County</td>
</tr>
<tr>
<td>Area Agency on Aging</td>
<td>Director of Provider Relations</td>
<td>Nursing</td>
</tr>
<tr>
<td>Viola Schoolman Free Clinic</td>
<td>Executive Director</td>
<td>Representative of low income uninsured patients</td>
</tr>
<tr>
<td>Springer Health Care</td>
<td>liaison</td>
<td>Skilled nursing representative</td>
</tr>
<tr>
<td>Mental Health &amp; Recovery Board</td>
<td>Executive Director</td>
<td>Mental Health &amp; Substance Abuse</td>
</tr>
<tr>
<td>Orrville Area Boys and Girls Club</td>
<td>Executive Director</td>
<td>Youth, Low to middle income families</td>
</tr>
<tr>
<td>The College of Wooster</td>
<td>Dean of Students</td>
<td>Education</td>
</tr>
<tr>
<td>Trinity Cancer Care</td>
<td>physician</td>
<td>Medical oncology</td>
</tr>
<tr>
<td>Retired</td>
<td>LPN/Social Worker</td>
<td>Nursing, social work, community needs, member of African American population, senior citizen, health care, resident for 65 years</td>
</tr>
<tr>
<td>Amish Church Fund</td>
<td>Chairman</td>
<td>Health care Fund manager</td>
</tr>
<tr>
<td>CCF</td>
<td>Surgeon</td>
<td>Medical staff leadership</td>
</tr>
<tr>
<td>Akron Children's Hospital Pediatrics-Wooster</td>
<td>Pediatrician</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Wayne County Care Center</td>
<td>Administrator</td>
<td>Long-term care</td>
</tr>
<tr>
<td>Ohio State University</td>
<td>Assoc. Vice President-Agriculture</td>
<td>Agricultural Research Director</td>
</tr>
<tr>
<td>The Counseling Center</td>
<td>President/CEO</td>
<td>Behavioral health management</td>
</tr>
<tr>
<td>Cleveland Clinic retired physician</td>
<td>Retired Obstetrician Gynecologist</td>
<td>Retired physician and long term resident</td>
</tr>
<tr>
<td>Wooster City School District</td>
<td>Superintendent</td>
<td>School district superintendent/CEO</td>
</tr>
</tbody>
</table>

12 Wayne Family and children First is Wooster Public Health Department
Advice Received from Local Experts

Q. Do you agree with the observations formed about the comparison of Wayne County to all other State counties?

- Race and color has an important role in the above statements.
- I am not an expert on fine particulate matter or drinking water safety but I find this interesting. I have always used a water filter because I have not been convinced that the water supply was safe. This is true even though information provided by the City of Wooster indicates that it exceeds safety levels. I certainly see smoking and adult obesity as major issues for individuals struggling with behavioral health issues.
- I am not aware of problems with daily fine particulate matter or drinking water safety, but I have not seen any recent data either.
- Poor social support to many of the above topics
- I don't think drinking water is a major issue
- I agree with this information, to the extent that I understand it.
- In general I agree across the county, however, I live in Wooster and none of these indicators really represents this community, which likely exceeds the standards.
- In some areas of the county, water condition is good; while it others it is not. I would think with all of the colleges and branch universities we would do better in terms of the proportion of persons with some college education
- We know that smoking and obesity are linked to major health problems and it only takes a few hours of being out in the public to see that these are real issues in our community.
• First of all, I am not sure if the data is either relevant or credible. For example, how were "poor physical health days" determined? What were the numerators and denominators for the standings? Secondly, I believe the mental health numbers are quite possibly skewed due to a lack of care facilities available to treat the patients. Many of these patients will be not be reported or do not seek medical assistance.

• This sounds about right.

• If it is in that order.

• I do not believe we have a air quality or water quality issue, but I also am not in that field to know that type of information
Q. Do you agree with the observations formed about the comparison of Wayne County to its peer counties?

- Continued good care for new births
- I do not have information or expertise in many of these areas. I do sit on the Family and Children's First Council and know that we have moved backwards in terms of services to pregnant women and new parents. Although the Council has been consistent in their focus on young children and having children ready for school, services have been systematically reduced due to declining funding.
- I only agree because that is the data set; I really have no basis to know either way. The low population level of the county, however, makes access to some health care resources expected in urban centers to be more difficult to obtain.
- I wonder if the assignment of "peer" counties takes into account the Amish population in our area. This special population may impact our infant first trimester care and related items
- Again, difficult to agree with unsupported data. Higher rates of "white, non-Hispanic infant mortality" may, for example, exist due to the lack of a significant "non-white" demographic. This would depend on how the rates are determined.
- I do feel access to mental health still is a concern
• The standard practice for our area may include not seeing pregnant women until they are through the first trimester. I believe our suicide rate has increased dramatically in the past 3 years, even if it has not become an issue in comparison to our peers.

• We have verified this list as well.

• This seems about right, but I do not have the data in front of me to personally compare. Improved sex education, contraceptive availability, general education and training, improved economy all would have a positive effect on the low birth weight and infant mortality. In addition, medical care availability and affordability is critical.
Q. Do you agree with the observations formed about the population characteristics of Wayne County?

- More information for home health care.

- Again, I am not an expert in many of these areas. We do see increased incidence of many of these conditions (tobacco use, high blood pressure, diabetes, back pain, pain COPD, heart disease, unhealthy eating habits) among the populations we serve. I find the lack of taking responsibility for health interesting and would see that as an important area for focus.

- Again, I have to agree if these are the data. Interestingly, I work in an academic environment and would think that our situation would not reflect these data; nor does it reflect the parts of the community in which I live. It may reflect the broader county population.

- Of course, one cannot really disagree with the data -- it is what it is -- but I wonder about the impact of the Amish population on our outcomes. I also think that poverty and lack of health insurance/Medicaid impacts these outcomes.

- From what I see, read and know about this community, I have no doubt that these are true statements.

- I can neither agree nor disagree with all of these findings as I do not have direct involvement in them. The lack of "compliance with treatment recommendations" is quite obvious, which may, in turn lead to other complications noted in the metrics. Perhaps one of the main reasons for non-compliance is cost. Given the choice between buying groceries and having a diagnostic procedure performed is rather simple. The internet/Facebook ratings may be skewed due to lack of availability of these services in our area. Regular health screenings such as stress tests are too costly, even with health insurance assistance, for many "lower
median income" residents. Pap smears and prostate exams may be a result of a lack of understanding in certain demographics.

- Why is routine prostate screening on the list when it is no longer recommended? Not sure internet and Facebook are a quality of care marker!

- However, there have been significant changes in the recommendations for intervals in pap smears in the past few years with the addition of HPV screening so paps are not done as often and the need for paps after 65 and after a hysterectomy for benign disease is not as important. Prostate screening recommendations are in a state of flux also.
Q. Do you agree with the observations formed about the opinions from local residents?


- These are the issues that I see with the populations we serve - those with addiction disease or mental health disorders.

- These seem to be reasonable observations from my perspective. My employer does provide excellent health care coverage for all employees, but low income populations are challenged for the issues listed.

- I am aware of new existing effort to better coordinate mental health and physical health care and of planned service additions in the public mental health system that is underway. However, I am not sure the general community is yet aware. I am not aware of any effort to make dental care more available since those with Medicaid cannot find a provider. I agree with the immunization issue; but again, see this as an area impacted by the Amish population.

- When you look at this list, it covers a lot of different situations/people. I don't this it is possible for one entity to address all the issues. Funding would be an issue as well.
Q. Do you agree with the observations formed about the additional data analyzed about Wayne County?

- I think our community has been changing in recent years and the community has been reluctant to accept this change. We are poorer than we used to be and poor health is typically correlated with poverty.

- Palliative care does exist.

- Seems like a reasonable profile for a somewhat rural county.

- There is a small palliative care program provided by LifeCare Hospice. Patients can be followed in their homes, nursing homes, assisted living in the hospital and for those who are able to get out, there is an outpatient clinic.

- Statement "A" is simply not true in that all hospice organizations provide palliative care options to those patients in need. The perception that palliative care does not exist in our county indicates a great need for education. There are a number of hospice organizations operating in Wayne County, though the perception may be that only one exists.

- I agree other than I thought that Hospice Palliative Care was active in the county. I also believe there are many undiagnosed diabetics in the County.

- I thought Hospice had an ongoing palliative care program. Otherwise I have no information to disagree with the above observations.