Trinity Health System
2019 Community Health Implementation Strategy

Adopted October 2019
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At-a-Glance Summary

Community Served
The Trinity Health System’s primary service area geography is defined as Jefferson County, Ohio. The secondary service area is comprised of Columbiana and Harrison counties in Ohio and Brooke and Hancock counties in West Virginia.

Significant Community Health Needs Being Addressed
The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital’s most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

| Depression | Chronic Disease – Heart Disease |
| Suicides | Chronic Disease - Diabetes |
| Drug Dependency/Abuse | Chronic Disease Overweight/Obesity |
| Drug Overdose Deaths | Maternal and Infant Death |

Strategies and Programs to Address Needs
The hospital intends to take actions and to dedicate resources to address these needs, including:

**Promote well-being and prevent mental health and substance use disorders focusing on depression, suicide, drug dependency/abuse and drug overdose deaths.**

*Depression and suicide strategies and programs to address this focus area include:*

- Hospital and provider offer inpatient, outpatient and intensive outpatient services
- Screenings and referrals for depression
- Offer therapists in the schools and psychiatrists in provider offices
- Hospital will screen for and place patients with co-occurring diagnoses
- Continue to offer safeTALK (suicide alertness for everyone) training

*Drug dependency/abuse and overdose deaths strategies and programs to address this focus area include:*

- Trinity Health System and providers offer both inpatient and outpatient detox programs and counseling
- Hospital will offer a detox residential support unit program for pregnant teens
- Research the feasibility with CMS of increasing the number of licensed mental health bed that the hospital offers.
- Hospital and agencies offer detox programs or referrals – all ages
- Community agencies to continue to offer Narcan training and supply kits through Project DAWN
- Providers to continue to offer Medicated Assisted Treatment (MAT) program
- Provide support groups for substance use dependency as well as loss and grief from drug overdose deaths
## 2019 Community Health Implementation Strategy

**Trinity Health System**

### Promote chronic disease management across the continuum of care, including cardiovascular disease, diabetes and overweight/obesity

*Heart disease, diabetes, and overweight/obesity strategies and programs to address this focus area include:*
- Outreach to community through health fairs, screenings, education, programs
- Research protocol for referrals from hospital to agencies for exercise/nutrition
- Food banks to focus offerings on fresh fruits, vegetables and protein
- Research follow-up protocol with patient providers not affiliated with hospital
- Research hospital cafeteria flagging foods as heart healthy or diabetes-friendly

### Promote women and infant health

*Women and infant health strategies and programs to address this focus area include:*
- Outreach to community through programs, services and referrals to educate on pre-term births, how to reduce low birth weight babies and infant mortality
- Help Me Grow program
- Moms Helping Moms program
- Cribs for Kids© program
- Ohio Partners for Smoke Free Families (OPSFF) program

### Access to health care

*Access to health care strategies and programs to address this focus area include:*
- Continue to assist those patients uninsured or underinsured receive coverage
- Continue to increase access through more providers and increase accessibility

### Anticipated Impact

The hospital’s and communities initiatives to address the four areas of mental health and substance use disorders, chronic disease management, women and infant health, and access to health care are anticipated to improve healthcare outcomes, create stability in a person’s life, ensure that everyone is well and receiving the services they need, and focusing not only on the individual but their entire family as well.

### Planned Collaboration

Trinity Health System will partner with A Caring Place Child Advocacy Center, AIM Women's Center, CHANGE, Inc., Jefferson Behavioral Health System, Jefferson County General Health District, Jefferson County Prevention and Recovery, Ohio Valley Health Center, Urban Mission, Women's Health Center, YMCA. Over the next three years, the hospital will look at other community agencies to partner with as needs arise.

This document is publicly available online at https://trinityhealth.com/. Written comments on this report can be submitted to Trinity Health System’s Mission Integration Department, 4000 Johnson Road, Steubenville, Ohio 43952 or by e-mail to khoanguyen@trinityhealth.com.
Our Hospital and the Community Served

About Trinity Health System

Trinity Health System is a member of Catholic Health Initiatives, which is a part of CommonSpirit Health.

Trinity Health System comprises the most complete health care option in eastern Ohio. The hospital system includes Trinity East and Trinity West which has a combined capacity of over 471 beds and employs more than 1,800 people. Trinity is accredited by the Joint Commission on the Accreditation of Hospitals, a member of the American Hospital Association, Voluntary Hospitals of America and the Catholic Hospital Association. The system offers a full array of acute and outpatient services on two campuses. Trinity also maintains physician offices, Walk-in Lab Draw facilities, the Tony Teramana Cancer Center, WorkCare and the Digestive and Nutrition Center throughout the Tri-State area.

Our Mission

The mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities.

Financial Assistance for Medically Necessary Care

Trinity Health System delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary of the policy are on the hospital’s web site.
Description of the Community Served

Trinity Health System serves Jefferson County as its primary service area. The hospital’s secondary service area is comprised of Columbiana and Harrison counties in Ohio and Brook and Hancock counties in West Virginia.

A summary description of the community is below. Additional details can be found in the CHNA report online.

Jefferson County was named in honor of Thomas Jefferson, the author of the Declaration of Independence and the first United States Secretary of State. Jefferson County is located in the eastern portion of Ohio, and it is in the heart of Appalachia. Its eastern border touches the Ohio River and helps form Ohio’s boundary with West Virginia.

With only 1.5 percent of the county’s 410 square miles deemed to be urban, most residents live in rural areas. The county averages just over 180 people per square mile. The county’s largest community and county seat is Steubenville, which had just over eighteen thousand residents in 2017. Like many of Ohio’s predominantly rural counties, Jefferson County experienced an estimated loss in population between 2010 and 2019. In 2019, 65,632 people resided in the county, a decrease of almost 6% since 2019. Service industries, such as health care, communications, and tourism, and retail positions are the two largest employers in Jefferson County. Farming is a distant fifth behind manufacturing and government positions. During the late nineteenth and early twentieth centuries, coal mining, especially strip mining, were major employers in the county. Now, much of the strip-mined land has been reforested. In 2019, the estimated median household income for Jefferson County residents was approximately $45,000. Approximately 12% of the county’s residents lived in poverty.12

The population in Jefferson County is projected to decrease from 65,632 in 2019 to 64,251 in 2024. There were slightly more females (51.5%) than males (48.5%). The population was predominantly Caucasian (91.1%). The median age was 44.6 and was projected to remain steady. Just under one-third (30.7%) of residents had never been married, while 42.5% were married, 3.7% were separated, 14.9% were divorced and 8.3% were widowed. Just over one in ten residents (11.0%) did not complete high school, while 43.1% were a high school graduate, 10.6% had a bachelor’s degree and 5.4% had an advanced degree. The average household income was $59,124, with 11.8% of families living in poverty. Most (93.5%) of the labor force was employed.

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1 https://ohiohistorycentral.org/w/Jefferson_County
2 Claritas – Pop-Facts Premier, 2018 Environics Analytics
Jefferson County has community agencies and organizations providing resources and services to address the following health needs:

- Access to Care
- Behavioral Health
- Disadvantaged Children
- Environmental Conditions
- Heart Disease/Hypertension
- Overall Health Status
- Prevention
- Socio-Economic
- Substance Use Disorder
- Teen Pregnancy

The following programs and services are offered at Trinity Health System:

- Behavioral Medicine
- Breast Cancer Center
- Cardiovascular Services
- Emergency Services
- ExpressCare
- ExpressClinic
- Gastroenterology – Trinity Digestive & Nutritional Center
- Imaging Services – Trinity ExpressCare
- Imaging Services – Trinity West
- Imaging Services – Trinity ExpressClinic
- Imaging Services – Trinity East
- Imaging Services – Trinity West
- Imaging Services – Trinity East
- Laboratory
- Occupational Medicine
- Orthopedics and Sports Medicine
- Pain Management
- Primary Care
- Rehabilitation Services
- Respiratory Services
- School of Medical Laboratory Science
- School of Nursing
- Sleep Disorders Center
- Social Services
- Sports Medicine – Trinity Sports Medicine & Performance Center
- Tony Teramana Cancer Center
- Trinity WorkCare
- Urologic Services
- Women and Children’s Services
- Wound Clinic
Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital’s community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in June 2019. The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://trinityhealth.com/wp-content/uploads/2019/06/Trinity-2019-CHNA-Final-6-25-19.pdf or upon request at the hospital’s Healthy Communities or Community Benefit office.

Significant Health Needs

The community health needs assessment identified the following significant community health needs:

- **Access to Care:** Includes access to health care, lack of specialists (including pediatric specialists), medical providers, affordable health care (including affordable health insurance, medications, deductibles), transportation, dental care, healthy aging, health literacy, and livable wages and poverty
- **Chronic Disease:** Encompasses cancer, heart disease, diabetes, high blood pressure, stroke, obesity/overweight, education on chronic disease management, asthma/COPD, and pain management.
- **Communicable Diseases:** Includes infectious diseases, immunization awareness, HIV/AIDS, sexually transmitted diseases, and Hepatitis C.
- **Mental Health:** Consists of mental health issues, depression, suicide, and lack of mental health services and providers.
- **Substance Use Disorder:** Encompasses opioid and drug use, lack of rehabilitation facilities, alcohol use, and tobacco use.
- **Woman, Infants and Children:** Includes maternal health, prenatal care, infant mortality and miscarriages, smoking during pregnancy, and teen pregnancy.
- **Physical Activity/Nutrition:** Consists of access to healthy foods and outdoor recreation activities.
- **Healthy Environment:** Consists of lack of proper and affordable housing, human trafficking, gun-related injuries and gun violence.
Significant Needs the Hospital Does Not Intend to Address

Trinity Health System is located in Ohio and follows the Ohio State Health Improvement Plan (SHIP). The SHIP is a comprehensive approach to improving Ohio’s greatest health challenges by identifying cross-cutting factors that impact multiple outcomes. The SHIP drives more efficient and effective allocation of resources toward measurable improvements on a manageable number of health outcomes by focusing on three priority topic areas: mental health and addiction, chronic disease, and maternal and infant health. Under these three topic areas, ten priority outcome objectives were identified to reduce: depression, suicide, drug dependence and abuse, drug overdose deaths, heart disease, diabetes, child asthma, preterm births, low birth rate, and infant mortality. All Ohio non-profit hospitals are required to align their implementation strategies to the SHIP.

Although Trinity Health System and community organizations and agencies may have the capacity and resources to address the remaining significant health needs, the hospital is not directly addressing these needs in order to be alignment with the SHIP. These remaining significant health needs not being addressed include: cancer, heart disease, lack of specialists, infectious diseases, high blood pressure, stroke, substance use disorder rehabilitation services, asthma/COPD, immunization awareness, dental care, HIV/AIDS, healthy aging, alcohol use, pain management, health literacy, sexually transmitted diseases, smoking during pregnancy, tobacco use, Hepatitis C, livable wages/poverty, lack of proper and affordable housing, human trafficking, gun-related injuries and violence, and outdoor recreation activities.

Trinity Health System will also continue to seek new partnership initiatives to address priority health issues when there are opportunities to make a meaningful impact on health and quality of life in partnership with others.
2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

This report specifies planned activities consistent with the hospital’s mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital’s limited resources to best serve the community.

The anticipated impacts of the hospital’s activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Implementation Strategy

Trinity Health System is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

On April 15, 2019, the Trinity Health CHNA Steering Committee met to review the primary and secondary data collected through the needs assessment process and discussed needs and issues present in the hospital’s primary service territory. The consulting team from Strategy Solutions, Inc. presented the data to the group and facilitated discussion about the needs of the local area, what the hospital and other providers are currently offering to the community and identified other potential needs that were not reflected in the data collected. A total of 42 possible needs and issues were identified based on disparities in the data (differences in sub-populations, comparison to state, national or Healthy People 2020 goals, negative trends, or growing incidence). Based on this prioritization, the four identified areas of mental health and substance use disorder, chronic disease (focusing on cardiovascular disease, diabetes and overweight/obesity), women, infant and children’s health, and access to health care will be Trinity Health Systems’ focus over the next three years.
On September 12, 2019, an Implementation Strategy Steering Committee was formed to begin the process of identifying the programs and services currently being offered to address the significant needs. Members of this Steering Committee represent the following areas of expertise: Trinity Health System, women’s health, chronic disease management, behavioral health, substance use disorder, children, FQHC, and homeless individuals.

**Strategy by Health Need**

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies’ anticipated impact and any planned collaboration with other organizations in our community.

### Health Need: Mental Health and Substance Use Disorder

<table>
<thead>
<tr>
<th>Strategy or Program Name</th>
<th>Summary Description</th>
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</table>
| Trinity Health System Mental Health Program | • Provide depression screenings and referrals in the ED and direct admissions  
• Provide screenings and placement for patients with co-occurring mental health and substance use disorder diagnoses  
• Research the feasibility with CMS of increasing the number of licensed mental health beds |
| Jefferson Behavioral Health Outpatient Mental Health Program | • Provide psychiatrists to be located within provider offices  
• Provide therapists to schools for students |
| safeTALK Training Program        | • Suicide Alertness for Everyone (safeTALK) is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide.  
• Offer MAT and Vivitrol programs |
<p>| Depression Screenings           | • Various providers and agencies screen for depression and suicide and make referrals as needed. |</p>
<table>
<thead>
<tr>
<th>Strategy or Program Name</th>
<th>Summary Description</th>
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</table>
| Trinity Health System Behavioral Medicine Addiction Recovery Program | • Provide screenings and placement for patients with co-occurring mental health and substance use disorder diagnoses  
• Offer a detox residential support unit program for teen moms  
• Provide detox programs, counseling or referrals – all ages – both inpatient and outpatient |
| Jefferson Behavioral Health Outpatient Addiction Recovery Program      | • Provides a system of quality services including intervention, and recovery to all clients affected by addiction.  
• Provide loss and grief support groups for those losing a loved one to a drug overdose |
| Project DAWN                           | • Project DAWN (Deaths Avoided with Naloxone) is a state program focusing on Naloxone administering training and the handing out of Naloxone kits |
| Medicated Assisted Treatment (MAT) Program | • MAT is a treatment resource for those battling chemical dependency  
• Utilizes specific FDA-approved medications to help patients reduce cravings and mitigate their withdrawal symptoms |

**Anticipated Impact:** The hospital’s and partners’ initiatives to address depression, suicide, drug dependency and overdose deaths are anticipated to result in improved health care outcomes, improved patient linkages to inpatient and outpatient mental health and substance use disorder services, provide a seamless transition of care, and improve care coordination to ensure individuals are connected to appropriate care and can access services, and create a drug-free community.

**Planned Collaboration:** The hospital will partner with local churches, providers, first responders and law enforcement, A Caring Place Child Advocacy Center, Coleman Professional Services, Community Action Counsel, Family Recovery Center, Jefferson Behavioral Health System, Jefferson County General Health District, Jefferson County Prevention and Recovery, Jefferson County School District, Ohio Valley Health Center, Pastoral Care, Urban Mission, Village Network, Women’s Health Center and YMCA.

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### Health Need: Chronic Disease

<table>
<thead>
<tr>
<th>Strategy or Program Name</th>
<th>Summary Description</th>
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| Chronic Disease Community Outreach       | • Outreach to community through hospital participation in health fairs, screenings, education, programs  
• Research the feasibility of having the cafeteria flag menu options that are heart healthy or diabetes friendly for patients, visitors and staff. |
| Chronic Disease Referral System          | • Research protocols for referrals to outside agencies to provide exercise and/or nutrition programs and referrals to non-hospital providers |
| Fresh food offerings at local food banks | • Focus offerings on fresh fruits, vegetables and protein and local food banks |
**Anticipated Impact:** The initiatives and outreach to address this health need by the hospital is anticipated to result in: reduction in hospital readmissions for chronic disease related illnesses, improve the health and quality of life for those who suffer from chronic illness, enable participants to better manage their disease, and create a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.

**Planned Collaboration:** The hospital will partner with local providers and food banks, Jefferson County General Health District, Jefferson County School District, Ohio Valley Health Center, Urban Mission, and YMCA.

<table>
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<tr>
<th>Health Need: Maternal and Infant Health</th>
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<tbody>
<tr>
<td><strong>Strategy or Program Name</strong></td>
</tr>
<tr>
<td>Maternal and Infant Health Community Outreach</td>
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</tbody>
</table>
| Referral Services | • Offer referrals to women and infant health and abuse services  
• Partner with Pittsburgh hospital to have addicted newborns transported down to Pittsburgh for detox |
| Help Me Grow Program | • Help Me Grow is Ohio’s evidenced-based parent support program that encourages early prenatal and well-baby care, as well as parenting education to promote the comprehensive health and development of children. Help Me Grow System includes Central Intake, Help Me Grow Home Visiting and Help me Grow Early Intervention. |
| Moms Helping Moms | • WIC breastfeeding peer helper program  
• WIC mothers supporting new mothers through support and education |
| Cribs for Kids® Program | • Program to provide Cribettes® and safe sleep education to eligible families |
| Ohio Partners for Smoke Free Families (OPSFF) | • A perinatal smoking cessation program to reduce the prevalence of smoking among women of reproductive age, including pregnant women |

**Anticipated Impact:** The initiatives and outreach to address this health need by the hospital is anticipated to result in: reducing the burden of maternal and infant mortality and morbidity and improvement of maternal and newborn health outcomes.

**Planned Collaboration:** The hospital will partner with local providers, A Caring Place Child Advocacy Center, AIM Women’s Services, Jefferson County General Health District, Ohio Valley Health Center, Trinity Health System’s Comprehensive Women’s Care Center, Urban Mission, WIC, and Women’s Shelter Services.
### Health Need: Access to Health Care

<table>
<thead>
<tr>
<th>Strategy or Program Name</th>
<th>Summary Description</th>
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<tbody>
<tr>
<td>Patient Financial Assistance Program</td>
<td>• Continue to offer patient financial assistance to those residents living in Jefferson, Columbiana and Harrison counties in Ohio and Brook and Hancock counties in West Virginia.</td>
</tr>
<tr>
<td>Medical Transition Program</td>
<td>• Program funded by Trinity Health System for Medicaid patients to receive referrals to hospital providers who are under contract to accept patient at no charge.</td>
</tr>
<tr>
<td>Assist Uninsured and Underinsured in Enrolling in Coverage</td>
<td>• Hospital and community agencies assist in enrolling patients/clients to healthcare coverage.</td>
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</table>

**Anticipated Impact:** The initiatives and outreach to address this health need by the hospital is anticipated to result in: reduction in hospital readmissions for chronic disease related illnesses, improve the health and quality of life for those who suffer from chronic illness, enable participants to better manage their disease, and create a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.

**Planned Collaboration:** The hospital will partner with local providers and food banks, Jefferson County General Health District, Jefferson County School District, Ohio Valley Health Center, Urban Mission, and YMCA

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Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.
## Trinity Health System Mental Health Program

| Significant Health Needs Addressed | ✓ Mental Health Issues  
| | ☐ Substance Use Disorder  
| | ☐ Chronic Disease  
| | ☐ Maternal and Infant Health  
| | ✓ Access to Health Care  |

| Program Description | The Mental Health Program at Trinity Health System offers both inpatient and outpatient treatment services, including Intensive Outpatient Mood Disorder, to individuals with psychiatric illnesses. The Mental Health Program is certified by the Ohio Department of Mental Health and Addiction Services. The acute inpatient services are provided to adults 18 years of age and older and non-intensive outpatient services are provided for those individuals ages six and older.  |

| Community Benefit Category | C8 – Subsidized Health Services – Behavioral Health Services  |

### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | Provide immediate access to inpatient, outpatient and intensive outpatient mental health care for those who suffer from this illness, including depression and suicide, and connect them to other available resources that may be appropriate as well as county behavioral services if eligible.  |

| Measurable Objective(s) with Indicator(s) | • # of screenings conducted and % referred for services  
| | • # of patients per year enrolled in inpatient, outpatient or intensive outpatient mental health services  
| | • # and % of referrals being accepted into each program  |

| Intervention Actions for Achieving Goal | Work with providers, emergency department and department floors to educate on the proper tools to administer to their patients to screen for mental health issues, including depression and suicide. Educate on the protocol for referring to an appropriate program.  |

| Planned Collaboration | The hospital will partner with local churches, providers, first responders and law enforcement, Coleman Professional Services, Jefferson Behavioral Health System, Jefferson County General Health District, Jefferson County Prevention and Recovery, Jefferson County School District, Ohio Valley Health Center, Pastoral Care, Urban Mission, Village Network, Women’s Health Center and YMCA.  |
Jefferson Behavioral Health Outpatient Mental Health Program

**Significant Health Needs Addressed**

- ✔ Mental Health Issues
- □ Substance Use Disorder
- □ Chronic Disease
- □ Maternal and Infant Health
- ✔ Access to Health Care

**Program Description**

Outpatient Counseling Services provides various services to individuals three years of age and older who are experiencing emotional distress or are experiencing problems requiring therapeutic interventions and to treat chronic mental illness. Helping individuals improve their coping skills, enhance their self-esteem, eliminating or assisting individuals to minimize stress interfering with their daily functioning are the primary goals of our programs. This program also includes providing psychiatrists to provider offices and therapists in the schools.

**Community Benefit Category**

N/A

**Planned Actions for 2019 - 2021**

**Program Goal / Anticipated Impact**

Provide immediate access to outpatient mental health care for those who suffer from this illness, including depression and suicide, and connect them to other available resources that may be appropriate.

**Measurable Objective(s) with Indicator(s)**

- # of screenings conducted
- # of patients per year in provider offices seeing in-house psychiatrist
- # of referrals to programs
- # and % of referrals being accepted into each program

**Intervention Actions for Achieving Goal**

Work with providers, emergency department and department floors to educate on the proper tools to administer to their patients to screen for mental health issues, including depression and suicide. Educate on the protocol for referring to an appropriate program.

**Planned Collaboration**

| Significant Health Needs Addressed | ✓ Mental Health Issues  
|                                 | ☐ Substance Use Disorder  
|                                 | ☐ Chronic Disease  
|                                 | ☐ Maternal and Infant Health  
|                                 | ☐ Access to Health Care |
| Program Description | SafeTALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide. |
| Community Benefit Category | N/A |
| Planned Actions for 2019 - 2021 | |
| Program Goal / Anticipated Impact | Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors. |
| Measurable Objective(s) with Indicator(s) | After training, participants in the safeTALK program should be able to:  
|                                               | • Challenge attitudes that inhibit open talk about suicide.  
|                                               | • Recognize a person who might be having thoughts of suicide.  
|                                               | • Engage them in direct and open talk about suicide.  
|                                               | • Listen to the person’s feelings about suicide to show that they are taken seriously.  
|                                               | • Move quickly to connect them with someone trained in suicide intervention |
| Intervention Actions for Achieving Goal | Local organizations provide safeTALK training as requested. |
# Depression Screenings

| Significant Health Needs Addressed | ✓ Mental Health Issues  
| | □ Substance Use Disorder  
| | □ Chronic Disease  
| | □ Maternal and Infant Health  
| | □ Access to Health Care |

| Program Description | Providers and local organizations administer a depression screening tool to their patients and refer to appropriate programs and services |

| Community Benefit Category | N/A |

## Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | Conduct screening tool for depression consistently across the service area to identify those patients experiencing depression and refer them to the appropriate services. |

| Measurable Objective(s) with Indicator(s) | • # of screenings conducted  
| | • # and % of those screened being referred to hospital and behavioral health partners  
| | • # and % completing program |

| Intervention Actions for Achieving Goal | Work with providers and local agencies to educate on the proper tools to administer to their patients to screen for mental health issues, including depression. Educate on the protocol for referring to an appropriate program. |

### Significant Health Needs Addressed

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<tbody>
<tr>
<td>Mental Health Issues</td>
<td>✓ Substance Use Disorder</td>
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<tr>
<td>Chronic Disease</td>
<td>☐ Maternal and Infant Health</td>
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</tbody>
</table>
| Access to Health Care |}

### Program Description

The Addiction Recovery Program provides a continuum of care for those patients experiencing substance use disorders.

- **Inpatient Detox Unit** is licensed to provide detox services to those individuals who exhibit symptoms of withdrawal and who are older than 18 years of age. Nursing care is provided on a 24-hour basis and is supervised by a Certified Addictionologist. Follow-up with intensive treatment after completing detox is required for admission to the detox unit.

- **Outpatient services** are available for individuals ages twelve and older. Outpatient services provided include assessments, intensive outpatient, crisis intervention, group counseling, psycho-education, individual counseling, family education, case management, relapse prevention and aftercare.

- **Transition Program** is a program designed specifically for those women who have addiction issues and are pregnant or recently gave birth, including teen moms.

### Community Benefit Category

C8 – Subsidized Health Services – Behavioral Health Services

### Planned Actions for 2019 - 2021

**Program Goal / Anticipated Impact**

Assist those living with an addiction to drugs and alcohol to complete a program to help them stay sober and create a drug-free community.

**Measurable Objective(s) with Indicator(s)**

- # of patients, including teen pregnancy patients
- # of patients referred
- # and % completing program, including teen patients
- # and % sober at milestones [need to determine these milestones, i.e., 3-months, 6-months, 6-months, etc.]

**Intervention Actions for Achieving Goal**

Work with providers and local agencies to educate on addiction programs and services available at the hospital and throughout the community to refer their clients.

**Planned Collaboration**

# Jefferson Behavioral Health Outpatient Addiction Recovery Program

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<thead>
<tr>
<th>Significant Health Needs Addressed</th>
<th>☐ Mental Health Issues</th>
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<tbody>
<tr>
<td>□ Substance Use Disorder</td>
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<td>□ Chronic Disease</td>
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<td>□ Maternal and Infant Health</td>
<td>✓</td>
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<td>□ Access to Health Care</td>
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## Program Description
Our Community Outreach Recovery Environment (C.O.R.E.) in downtown Steubenville provides a system of quality services including intervention, and recovery to all clients affected by addiction. Clients receive confidential treatment from qualified professionals who understand the dynamics of addiction and the process of recovery.

## Community Benefit Category
N/A

## Planned Actions for 2019 - 2021

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Assist those living with an addiction to drugs and alcohol to complete a program to help them stay sober and create a drug-free community.</th>
</tr>
</thead>
</table>
| Measurable Objective(s) with Indicator(s) | • # of patients  
• # of patients referred  
• # and % completing program  
• # and % sober at milestones (need to determine these milestones, i.e., 3-months, 6-months, 6-months, etc.) |
| Intervention Actions for Achieving Goal | Work with the hospital, providers and local agencies to educate on addiction programs and services available at the agency and throughout the community to refer their clients. |
## Project DAWN

### Significant Health Needs Addressed
- Mental Health Issues
- Substance Use Disorder
- Chronic Disease
- Maternal and Infant Health
- Access to Health Care

### Program Description
Project DAWN (Deaths Avoided with Naloxone) is a state program focusing on Naloxone administering training and the handing out of Naloxone kits.

### Community Benefit Category
N/A

### Planned Actions for 2019 - 2021

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Reduce the number of opioid overdose deaths by offering Naloxone training and Naloxone kits to the community.</th>
</tr>
</thead>
</table>
| Measurable Objective(s) with Indicator(s)                             | • # of trainings offered a year  
|                                                                      | • # trained  
|                                                                      | • # of Naloxone kits distributed  
|                                                                      | • # of patients presenting at the emergency department receiving Naloxone in the field  
|                                                                      | • % decline in overdose deaths |
| Intervention Actions for Achieving Goal                               | Work with the Jefferson County General Health District to increase the number of community members trained in administering Naloxone to reduce the number of overdose deaths. |
## Medicated Assisted Treatment (MAT) Program

| Significant Health Needs Addressed | □ Mental Health Issues  
|                                  | ✓ Substance Use Disorder  
|                                  | □ Chronic Disease  
|                                  | □ Maternal and Infant Health  
|                                  | □ Access to Health Care |

| Program Description | MAT is a treatment resource for those battling chemical dependency that utilizes specific FDA-approved medications to help patients reduce cravings and mitigate their withdrawal symptoms. |

| Community Benefit Category | N/A |

## Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | Reduce the number of people addicted to drugs by offering an FDA-approved MAT program. |

| Measurable Objective(s) with Indicator(s) | • # of patients  
|                                           | • # of patients completing the program  
|                                           | • # and % clean at milestones [need to determine these milestones, i.e., 3-months, 6-months, 6-months, etc.] |

| Intervention Actions for Achieving Goal | Educate providers and community on the availability of the MAT program for referrals in order to reach and assist those struggling with addiction. |

### Chronic Disease Community Outreach

#### Significant Health Needs Addressed

- Mental Health Issues
- Substance Use Disorder
- Chronic Disease
- Maternal and Infant Health
- Access to Health Care

#### Program Description
Provide outreach to the community through hospital participation in health fairs, screenings, education and programs, along with having the cafeteria research the feasibility of flagging menu options that are heart healthy or diabetes friendly for patients, visitors and staff.

#### Community Benefit Category
A1 – Community Health Improvement Services: Community Health Education  
A2 – Community Health Improvement Services: Community Based Clinical Services

#### Planned Actions for 2019 - 2021

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the health and quality of life for those who suffer from a chronic disease (with a focus on cardiovascular disease, diabetes and overweight/obesity) enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable Objective(s) with Indicator(s)</th>
</tr>
</thead>
</table>
| • # of health fairs  
• # of educational sessions conducted  
• # of participants  
• # and % intent to change behavior through pre-post surveys  
• # of screenings conducted  
• # referred to programs and services |

<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach to the community and partner with clinics and other nonprofits to offer health fairs, education, screenings and promote hospital programs. Build community partnerships to expand knowledge on chronic disease management. Continue to promote Heartland Heart Health Fair and Diabetes Day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular, Diabetes, Food Services, Nutrition, Pulmonary, and Sports Medicine Departments at Trinity Health System, providers, food banks, Jefferson County General Health District, Jefferson County Schools, Ohio Valley Health Center, Prime Time Office on Aging, Urban Mission, and YMCA.</td>
</tr>
</tbody>
</table>
## Chronic Disease Referral System

<table>
<thead>
<tr>
<th>Significant Health Needs Addressed</th>
<th>Program Description</th>
<th>Community Benefit Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Mental Health Issues</td>
<td>Research protocols for referrals from the hospital to outside agencies to provide exercise and/or nutrition programs, as well as referrals to non-hospital providers.</td>
<td>N/A</td>
</tr>
<tr>
<td>□ Substance Use Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Chronic Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Maternal and Infant Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Access to Health Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Planned Actions for 2019 - 2021

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Measurable Objective(s) with Indicator(s)</th>
<th>Intervention Actions for Achieving Goal</th>
<th>Planned Collaboration</th>
</tr>
</thead>
</table>
| Improve the health and quality of life for those who suffer from a chronic disease (with a focus on cardiovascular disease, diabetes and overweight/obesity) enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital through referrals to continue to assist them in their chronic disease management. | • Referral system established  
• # of agencies participating in the referral system  
• # referred to programs and services  
• # of patients who kept appointment  
• # of patients who completed the program referred to  
• % decrease in readmissions of these referred patients | Outreach to the community and partner with clinics and other nonprofits to create a referral system for chronic disease patients to receive physical and nutritional support from outside agencies. | Cardiovascular, Emergency, Diabetes, Food Services, Nutrition, Pulmonary, and Sports Medicine Departments at Trinity Health System, providers, food banks, Jefferson County General Health District, Ohio Valley Health Center, Prime Time Office on Aging, Urban Mission, and YMCA. |
## Fresh Food Offerings at Local Food Banks

| Significant Health Needs Addressed | □ Mental Health Issues  
| | □ Substance Use Disorder  
| | ✓ Chronic Disease  
| | □ Maternal and Infant Health  
| | □ Access to Health Care |

| Program Description | Focus offerings at the local food banks on fresh fruits, vegetables and protein. |

| Community Benefit Category | E3 – In-Kind Donations |

### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | Improve the health and quality of life for the low income population who suffer from a chronic disease (with a focus on cardiovascular disease, diabetes and overweight/obesity) enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital through healthier offerings at the local food banks of fresh fruits, vegetables and proteins that would otherwise be too expensive to purchase. |

| Measurable Objective(s) with Indicator(s) |  
| | • # of pounds of fresh fruits, vegetables and proteins distributed  
| | • # of individuals referred to their local food bank at discharge  
| | • # of individuals/families participating in the food bank program  
| | • # and % who have increased their intake of fresh foods  
| | • # and % intent to change behavior |

| Intervention Actions for Achieving Goal | Refer patients identified as food insecure to local food banks |

| Planned Collaboration | Cardiovascular, Emergency, Diabetes, Food Services, Nutrition, Pulmonary, and Sports Medicine Departments at Trinity Health System, providers, food banks, Jefferson County General Health District, Ohio Valley Health Center, Prime Time Office on Aging, Urban Mission, and YMCA. |
# Maternal and Infant Health Community Outreach

## Significant Health Needs Addressed
- ☐ Mental Health Issues
- ☐ Substance Use Disorder
- ☐ Chronic Disease
- ✓ Maternal and Infant Health
- ✓ Access to Health Care

## Program Description
Provide outreach to the community through hospital participation in health fairs, screenings, supplies, education and programs on pre-term births, how to reduce low birth weight babies and infant mortality.

## Community Benefit Category
A1 – Community Health Improvement Services: Community Health Education

## Planned Actions for 2019 - 2021

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Decrease pre-term and low birth weight infants in the hospital’s service area, increase the number of mothers receiving adequate prenatal care and decrease infant mortality.</th>
</tr>
</thead>
</table>
| Measurable Objective(s) with Indicator(s) | • # of health fairs  
• # of educational sessions conducted  
• # of participants  
• # and % intent to change behavior through pre-post surveys  
• # referred to programs and services  
• # of patient visits  
• # of prenatal visits  
• Average birth weight of infants  
• Outcomes of births |
| Intervention Actions for Achieving Goal | Outreach to the community and partner with clinics and other nonprofits to offer health fairs, education, screenings, supplies and promote hospital programs. Provide services in areas where zip codes are indicating increased rates of premature birth, low birth weights and higher infant mortality. |
| Planned Collaboration | Trinity Health System, providers, AIM Women’s Center, Jefferson County General Health District, Jefferson County Schools, Ohio Valley Health Center, Urban Mission, and Women’s Health Center. |
### Maternal and Infant Health Referral System

<table>
<thead>
<tr>
<th>Significant Health Needs Addressed</th>
<th>□ Mental Health Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Substance Use Disorder</td>
</tr>
<tr>
<td></td>
<td>□ Chronic Disease</td>
</tr>
<tr>
<td>✓ Maternal and Infant Health</td>
<td>✓ Access to Health Care</td>
</tr>
</tbody>
</table>

| Program Description               | Offer referrals to pregnant or new mothers to connect them to need services including women and infant health and abuse services. |

| Community Benefit Category | N/A |

### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | Decrease pre-term and low birth weight infants in the hospital’s service area, increase the number of mothers receiving adequate prenatal care and decrease infant mortality through referrals to community services. |

| Measurable Objective(s) with Indicator(s) | • Referral system established |
|                                          | • # of agencies participating in the referral system |
|                                          | • # referred to programs and services |
|                                          | • # of patients who kept appointment |
|                                          | • # of patients who completed the program referred to |
|                                          | • Average birth weight of infants |
|                                          | • Outcomes of births |

| Intervention Actions for Achieving Goal | Refer pregnant or new mothers to needed services within the community; create partnerships with community and nonprofits to create a larger referral system. |

| Planned Collaboration                  | Trinity Health System, providers, AIM Women’s Center, Jefferson County General Health District, Jefferson County Schools, Ohio Valley Health Center, Urban Mission, and Women’s Health Center. |
**Help Me Grow Program**

| Significant Health Needs Addressed | □ Mental Health Issues  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Substance Use Disorder</td>
</tr>
<tr>
<td></td>
<td>□ Chronic Disease</td>
</tr>
<tr>
<td></td>
<td>✓ Maternal and Infant Health</td>
</tr>
<tr>
<td></td>
<td>□ Access to Health Care</td>
</tr>
</tbody>
</table>

| Program Description | Help Me Grow is Ohio’s evidenced-based parent support program that encourages early prenatal and well-baby care, as well as parenting education to promote the comprehensive health and development of children. Help Me Grow System includes Central Intake, Help Me Grow Home Visiting and Help Me Grow Early Intervention. |

| Community Benefit Category | N/A |

**Planned Actions for 2019 - 2021**

| Program Goal / Anticipated Impact | Help Me Grow program is required to utilize only evidence-based or innovative, or promising home visiting models to accomplish the following goals:  
1. Improve maternal and child health;  
2. Prevent child abuse and neglect;  
3. Encourage positive parenting;  
4. Promote child development and school readiness |

| Measurable Objective(s) with Indicator(s) | # of agencies participating in the referral system  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># referred to programs and services</td>
</tr>
<tr>
<td></td>
<td># of participants</td>
</tr>
<tr>
<td></td>
<td>Average birth weight of infants</td>
</tr>
<tr>
<td></td>
<td>Outcomes of births</td>
</tr>
</tbody>
</table>

| Intervention Actions for Achieving Goal | Refer patients to this parent support program that encourages early prenatal and well-baby care, as well as parenting education to promote the comprehensive health and development of children. |

| Planned Collaboration | Trinity Health System, providers, AIM Women’s Center, Jefferson County General Health District, Ohio Valley Health Center, Urban Mission, and Women’s Health Center. |
### Moms Helping Moms Program

| Significant Health Needs Addressed | □ Mental Health Issues  
| □ Substance Use Disorder  
| □ Chronic Disease  
| ✓ Maternal and Infant Health  
| □ Access to Health Care |

| Program Description | Moms Helping Moms is a WIC breastfeeding peer help program where WIC mothers are helping other WIC mothers learn to breastfeed by providing support and education. |

| Community Benefit Category | N/A |

### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | This WIC peer program gives a mother:  
| Tips for how to breastfeed comfortably and discreetly, even in public  
| Ways to stay close to your baby through breastfeeding after returning to work or school  
| Ideas for getting support from family and friends  
| Ways to get a good start with breastfeeding  
| Secrets for making plenty of breastmilk for baby  
| Help with breastfeeding concerns |

| Measurable Objective(s) with Indicator(s) | • # of agencies participating in the referral system  
| • # referred to programs and services  
| • # of participants  
| • Average birth weight of infants  
| • Outcomes of births |

| Intervention Actions for Achieving Goal | Refer new moms to this WIC-sponsored program that encourages breastfeeding to promote the comprehensive health and development of children. |

| Planned Collaboration | Trinity Health System, providers, AIM Women’s Center, Jefferson County General Health District, Ohio Valley Health Center, Urban Mission, and Women’s Health Center. |
### Cribs for Kids© Program

| Significant Health Needs Addressed | □ Mental Health Issues  
|                                  | □ Substance Use Disorder  
|                                  | □ Chronic Disease  
|                                  | ✓ Maternal and Infant Health  
|                                  | □ Access to Health Care  |

| Program Description | The Ohio Department of Health, Bureau of Maternal, Child and Family Health partnered with Cribs for Kids© to provide Cribettes© and safe sleep education to eligible families. |

| Community Benefit Category | N/A |

### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | To reduce infant mortality through the promotion of safe sleep with the distribution of Cribettes© kits. |

| Measurable Objective(s) with Indicator(s) | • # of agencies participating in the referral system  
|                                          | • # referred to program  
|                                          | • # of Cribettes© distributed  
|                                          | • % reduction in infant mortality |

| Intervention Actions for Achieving Goal | Refer new moms to this state-sponsored program that encourages safe sleeping practices for infants to reduce infant mortality and promote the comprehensive health and development of children. |

| Planned Collaboration | Trinity Health System, providers, AIM Women’s Center, Jefferson County General Health District, Ohio Valley Health Center, Urban Mission, and Women’s Health Center. |
### Ohio Partners for Smoke Free Families (OPSFF) Program

| Significant Health Needs Addressed | □ Mental Health Issues  
| □ Substance Use Disorder  
| □ Chronic Disease  
| ✓ Maternal and Infant Health  
| □ Access to Health Care |

| Program Description | Sponsored by the Ohio Department of Health, OPSFF is a perinatal smoking cessation program to reduce the prevalence of smoking among women of reproductive age, including pregnant women. |

| Community Benefit Category | N/A |

#### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | Cigarette smoking during pregnancy has been identified as one of the most significant factors contributing to poor pregnancy outcomes. The OPSFF program looks to reduce miscarriage, premature delivery, stillbirth and low birth weight babies. |

| Measurable Objective(s) with Indicator(s) | • # of agencies participating in the referral system  
| • # referred to program  
| • # completing program  
| • # smoke-free  
| • % reduction in miscarriage, premature delivery, stillbirth and low birth weight babies of mothers participating in the program |

| Intervention Actions for Achieving Goal | All providers will screen their reproductive-aged women/pregnant mothers if they smoke and if so, refer to OPSFF. |

| Planned Collaboration | Trinity Health System, providers, AIM Women’s Center, Jefferson County General Health District, Ohio Valley Health Center, Urban Mission, and Women’s Health Center. |
### Patient Financial Assistance Program

| Significant Health Needs Addressed | □ Mental Health Issues  
|                                    | □ Substance Use Disorder  
|                                    | □ Chronic Disease  
|                                    | ✔ Maternal and Infant Health  
|                                    | Access to Health Care  |

| Program Description | Continue to offer patient financial assistance to those residents who are uninsured/underinsured living in Jefferson, Columbiana and Harrison counties in Ohio and Brook and Hancock counties in West Virginia. See Appendix A for Trinity Health System’s Financial Assistance Policy Summary. |

| Community Benefit Category | Financial Assistance: Traditional Charity Care  
|                           | Medicaid and Medicare  |

### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | To provide financial relief to patients who qualify based on a comparison of their financial resources and/or income to Federal Poverty Guidelines. The program is designed specifically for non-elective care patients whose household financial resources and/or income are at or below 300 percent of the Federal Poverty Level. |

| Measurable Objective(s) with Indicator(s) | • # of patients receiving financial assistance  |

| Intervention Actions for Achieving Goal | Screen patients for eligibility to this financial assistance program. Continue to post policy information as required by the IRS.  |

| Planned Collaboration | Trinity Health System and other community agencies.  |
## Medical Transition Program

| Significant Health Needs Addressed | □ Mental Health Issues  
|-----------------------------------|--------------------------------------------------
|                                   | □ Substance Use Disorder  
|                                   | □ Chronic Disease  
|                                   | ✔ Access to Health Care  
| Program Description               | The Medical Transition Program is funded by Trinity Health System for Medicaid patients to receive referrals to hospital providers and specialists who are under contract to accept patients at no charge.  
| Community Benefit Category        | Medicaid  

### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | Serve those uninsured and underinsured individuals by increasing access to providers and specialists to promote well-being and a continuum of care.  
|-----------------------------------|--------------------------------------------------
| Measurable Objective(s) with Indicator(s) | • # patients referred  
|                                          | • # of these patients keeping appointments  
|                                          | • # of follow-up calls made for those no-show patients  
|                                          | • Reduction in hospital readmission rates  
| Intervention Actions for Achieving Goal | Provide a referral system for those uninsured and underinsured patients to receive specialist care, make the referrals for the patient and follow-up with the patient if they no show.  
| Planned Collaboration                | Trinity Health System and providers  

### Assist Uninsured and Underinsured in Obtaining Coverage

| Significant Health Needs Addressed | □ Mental Health Issues  
|                                  | □ Substance Use Disorder  
|                                  | □ Chronic Disease  
|                                  | □ Maternal and Infant Health  
|                                  | ✓ Access to Health Care |

| Program Description | Hospital and community agencies assist in enrolling patients/clients in healthcare coverage including Medicaid, CHIP, or a qualified health plan. |

| Community Benefit Category | Financial Assistance: Traditional Charity Care  
|                            | Medicaid and Medicare |

### Planned Actions for 2019 - 2021

| Program Goal / Anticipated Impact | Reduce the number of uninsured adults and children in the hospital’s service area. |

| Measurable Objective(s) with Indicator(s) |  
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
|                                          | • # of individuals assisted in enrolling in health care coverage  
|                                          | • Provide resources to community agencies and partners regarding enrollment opportunities for their clients  
|                                          | • Attend health events to promote health care coverage  
|                                          | • Collaborate with partners to increase outreach |

| Intervention Actions for Achieving Goal |  
|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
|                                        | • Identify and reach at-risk populations who need health care  
|                                        | • Attend community events  
|                                        | • Collaborate with partners  
|                                        | • Continue to offer financial assistance |

| Planned Collaboration | Trinity Health System, providers, faith-based organizations, AIM Women’s Center, Jefferson County General Health District, Ohio Valley Health Center, Urban Mission, and Women’s Health Center. |
### Hospital Board and Committee Rosters

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linda Bain</td>
<td>Women’s Health Center</td>
<td>Daniel Obertance</td>
<td>Jefferson County Prevention and Recovery</td>
</tr>
<tr>
<td>Nicole Balakos</td>
<td>Jefferson County General Health District</td>
<td>Rob O’Hara</td>
<td>YMCA</td>
</tr>
<tr>
<td>Marisa Bortz</td>
<td>A Caring Place Child Advocacy Center</td>
<td>Anthony Sheposh</td>
<td>Jefferson Behavioral Health System</td>
</tr>
<tr>
<td>Angel Brock</td>
<td>Trinity Health System – Behavioral Health</td>
<td>JoAnne Snodgrass</td>
<td>CHANGE, Inc.</td>
</tr>
<tr>
<td>Carolyn Buchanan</td>
<td>Trinity Health System – Finance</td>
<td>Reverend Ashley Steele</td>
<td>Urban Mission</td>
</tr>
<tr>
<td>Amy DeMattio</td>
<td>Trinity Health System – Diabetes</td>
<td>Douglas Wagstaff</td>
<td>Trinity Health System – Emergency Services</td>
</tr>
<tr>
<td>Allie Gianni</td>
<td>Trinity Health System – MGE</td>
<td>Deacon Paul Ward</td>
<td>Trinity Health System – Chaplain</td>
</tr>
<tr>
<td>Amy Lindsay</td>
<td>Trinity Health System – Emergency Department</td>
<td>Trudy Wilson</td>
<td>Ohio Valley Health Center</td>
</tr>
<tr>
<td>Khoa Nguyen</td>
<td>Trinity Health System – Mission</td>
<td>James Wurzler</td>
<td>AIM Women’s Center</td>
</tr>
</tbody>
</table>
Appendix A – Trinity Health System Financial Assistance Policy

Summary

At Trinity Health System, creating healthier communities and advocating for the poor and vulnerable is both our mission and our passion. One way that we do this is through our Trinity Health System Financial Assistance Program, where we reduce the costs of a patient’s medical bills based on their financial need.

How we can help
We offer free care for emergency, or other medically-necessary, services for our patients who have:

- An annual family income that is less than or equal to 300% of the federal poverty level, as determined by guidelines published annually by the U.S. Department of Health and Human Services (FPL);

- A minimum medical bill account balance of $35.00, for either a single or combined accounts;

- Cooperated with efforts to exhaust all other payment options; and

- Completed a program application and provided supporting documentation to verify income.

NOTE: In some cases, patients may be awarded the financial assistance without a formal application. Details are outlined in the Financial Assistance Policy.

Fees charged patients eligible for financial assistance
Patients eligible for financial assistance will not be expected to pay more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care.

Ready to take the next step?
Complete the application and submit it to Financial Counselor

The Financial Assistance Policy, application and this summary are available at [www.trinityhealth.com](http://www.trinityhealth.com), in English and Spanish. To receive a free copy of these documents by mail or in person, to receive help completing the application, or to request a free copy of these documents translated into a language not described, please contact:

Catholic Health Initiatives
Trinity Health System
Patient Accounting Department: Financial Counselor
4000 Johnson Road, Steubenville, OH 43952
Phone #: 740.283.7261

These documents are also available in the Emergency Room, if any, and admissions areas of the hospital.