Community Health Needs Assessment

Community Health Network

2018

IMPLEMENTATION STRATEGY

Howard Region

About This Document

This document describes how Community Howard Regional Hospital (the hospital) plans to address needs found in the Community Health Needs Assessment (CHNA) published by the hospital on December 31, 2018. See the CHNA report at:

eCommunity.com/community-benefit/archived-reports

The implementation strategy describes how the hospital plans to address significant community health needs in calendar years 2019 through 2021.

The Implementation Strategy for Community Health Network has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code Section 501(r) requiring hospital facilities owned and operated by an organization described in Code Section 501(c)(3) to conduct a CHNA every three years. Secondly, it will adopt an Implementation Strategy to meet the community health needs identified through the Community Health Needs Assessment reports for each hospital facility. The Implementation Strategy will satisfy each of the applicable requirements.

Community Howard Regional Hospital reserves the right to amend this implementation strategy as circumstances warrant. Certain community health needs may warrant increase focus and resources during the next three years. Moreover, other organizations may decide to increase resources devoted to addressing one or more of the significant community health needs, or grant funds that support described initiatives may become unavailable, and as a result the hospital may amend its strategies and focus on other identified needs.

The document contains the following information:

1. About Community Howard Regional Hospital
2. Definition of the Community Served, and Determining Its Needs
3. Implementation Strategy to Address Significant Health Needs
4. Needs Community Howard Regional Hospital Will Not Address
5. Next Steps for Implementation Strategy Adoption

Adopted by the Community Health Network, Inc. Board on: February 28, 2019

About Community Howard Regional Hospital

Community Howard Regional Health (CHRH) is a two-hospital, three-campus system located in Kokomo, Indiana, dedicated to providing exceptional quality patient-centered care. CHRH offers a full spectrum of inpatient and outpatient healthcare services.

Key Statistics

Admissions:	4,864
Emergency room visits:	26,864
Babies born:	383
Surgeries (at hospitals, inpatient and outpatient):	3,291
Physician and Clinic Visits:	126,772

The Community Served and Its Needs

Key Demographic Data

- The current population is 82,363. A five-year trend (2012-2016) shows population at 86,536
- Whites comprised 86.7% of the population, with African-Americans at 6.6%, Hispanic/Latinos at 2.9% and other race or ethnicity at 3.7%
- The fastest growing age group is 65+ at 11.9 %
- The Howard Region will experience 0.5% growth between 2018-2023
- The Howard Region has a household median income of $46,709, with 20% of the households having an annual income of $100,000 or more

Creating the Community Health Needs Assessment

The identification of health needs for CHNw CHRH Region was carried out using two types of data: 1) secondary data from the Healthy Communities Institute (HCI) dashboard and other local and national agencies; and 2) primary data obtained through an online survey of CHNw healthcare providers and a survey of community residents in each CHNw region. To supplement these data and identify population-specific health needs, CHNw directed two focus groups with community stakeholders. Key informant interviews were also conducted with the State of Indiana's top health leaders: Director of the Marion County Public Health Department, the Commissioner for the Indiana State Department of Health, and the Family and Social Services Administration.

Implementation Strategy
To Address Significant Health Needs

This implementation strategy describes how plans to address the significant community health needs identified in the 2018 CHNA. The hospital reviewed the CHNA findings and applied the following criteria to determine the most appropriate needs for the CHRH Region to address:

- The extent to which the hospital has resources and competencies to address the need
- The impact that the hospital could have on the need (i.e., the number of lives the hospital can impact)
- The frequency with which stakeholders identified the need as a significant priority
- The extent of community support for the hospital to address the issue and potential for partnerships to address the issue

By applying these criteria, the hospital determined that it will address the significant health needs identified by Y (for Yes) in the table that follows. Issues identified by N (for No) represent issues that the hospital does not plan to address during the 2019-2021 time-period.

Significant Health Needs Identified in the 2018 CHNA	**Intend to Address**
1. Social Determinant of Health*	Y
2. Mental Health	Y
3. Services for Seniors	N
4. Substance Abuse (Opioids and Other Drugs)	Y
5. Sexually Transmitted Diseases	N
6. Access to Health Services	Y
7. Chronic Disease Management	N
8. Tobacco	Y

*Social Determinant(s) of Health are addressed in Mental Health, Substance Abuse (Opioids and Other Drugs) Access to Health Services and Tobacco.

SIGNIFICANT HEALTH NEED ***Mental Health***

Indicator Rankings
The Mental Health indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Pediatric Mental Health
- Adolescent Suicide and Intentional Self-Inflicted Injury
- Mental Health
- Suicide and Intentional Self-Inflicted Injury

Goal: Treatment

Interventions/Recommendations

- Develop Information, Education and Training for Providers (to include the Consult Team) about Medication – Assisted Treatment (MAT) Services
- Develop a Protocol for MAT inductions in the Emergency Department
- Establish a collaborative referral and rapid access into outpatient services
- Evaluate the use of Recovery Coaches in the Emergency Department
- Expand the number of MAT prescribers
- Continued support of the Zero Suicide Initiative. Launched Zero Suicide "Have Hope" initiative within Behavioral Health for Howard Region (Howard, Tipton, & Clinton Counties) in December 2018
- Linking schools and communities to:
    - Coordinate the delivery of educational and mental health services
    - Develop resources to adequately meet the needs of students and families
    - Working with educators to understand family, cultural and community factors affecting students
    - Working with administrators to implement effective prevention programs and policies that address alcohol and drug use, suicide, violence and school safety

Collaborations

- Emergency Room Physicians and Staff
- Family Medical Practice Providers
- Community-based Organizations
- Recovery Housing Organizations
- Faith Based Community Organizations
- Law Enforcement and First Responders
- Turning Point
- GROUPS MAT Partnership
- Internship Partnerships with Academic Institutions (IUK, IWU, Ball State, UIndy, IUPUI)

- Community Hospital North as well as Community Hospital East and providers, in conjunction with Behavioral Health Consult and Liaison team
- Other Community Mental Health Centers and Treatment Providers

Anticipated Impacts

- Reduce recidivism of Emergency Room utilization related to Opioid Use Disorder and IV Drug Use related conditions
- Improve an Individuals Recovery Capital (i.e.: social determinant) to maintain sobriety and reduce relapse
- Increase MAT provider capacity
- Increased access for patients who require acute care services

Evaluation Metrics

- Assess impact during 2021 CHNA
- Growth in the number of MAT providers
- Successful outcomes related to Feedback Informed Treatment measure
- Improvement in Recovery Capital for individuals as measured by the Recovery Capital Scale

SIGNIFICANT HEALTH NEED ***Substance Use Disorders***

Indicator Rankings

The Substance Abuse (Alcohol, Opioids, and other drugs) indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

— Perinatal Substance Use Disorder
— Substance Abuse
— Alcohol Abuse

Goal: Treatment

Interventions

- Expand programming for the continuum of substance use disorders
- Establish a continuing care group for support after the successful completion of treatment
- Continued participation in the Perinatal Substance Use Disorder Program which includes the MOMentum Program
    - Expedited access to evaluation and treatment services based on screening results and referral by the obstetrician.
    - Comprehensive evaluation and medication management by psychiatry.
    - MAT for opiate use.
    - Care coordination with obstetrics including engagement with treatment and psychiatric prescribing.
    - Coordination with other agencies and providers who are involved in service provision to the family including other medical personnel, Department of Child Services (DCS), etc.
    - Intensive outpatient addictions treatment, individual and group therapies as determined to be clinically necessary which includes information that is tailored to their unique needs as a pregnant woman.
- Evaluate embedding a Behavioral Health Consultant (BHC) in the Obstetrics/Gynecologist (OB/GYN) physician office whose role is to detect and address a broad spectrum of behavioral health/substance use needs of the patients with the aim of early identification, quick resolution, long-term prevention and wellness. The BHC will be a Licensed Clinical Social Worker (LCSW) who will provide a comprehensive behavioral health assessment. Based on this assessment, the LCSW determines level of care and service needs and when substance use disorder is a primary concern, refers the case within the addictions programming at CHRH.
- Increase the number of Therapists that can provide co-occurring treatment

Collaborations

- Community-based Organizations
- Schools
- Faith Based Community Organizations

- Law Enforcement and First Responders and Other Governmental Agencies
- Overdose Lifeline

Anticipated Impacts

- Reduce the stigma and increase education around the chronic disease model of addition
- Increase the number of clients who have a Substance Use Disorder in gaining access to care
- Decrease the wait time to access and enter treatment
- Improve health outcomes for Mothers and Infants associated with Neonatal Abstinence Syndrome (NAS)
- Reduce Neonatal Intensive Care Unit length of stay (LOS) related to NAS

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of students who receive prevention training
- Increase in the number of therapist who provide co-occurring / Substance Use Disorder treatment
- Increase in the service count related to Substance Use Disorder treatment
- Increase the number of individuals who successfully complete treatment and receive referral into continuing care group
- Zero Suicide Reports will track the Following:
    - Lifetime Columbia score
    - Most recent visit Columbia scores
    - Days since most recent safety plan (percentage of plans in compliance for those on Pathway)
    - Days since most recent Care Contact (percentage of pathway clients receiving care contacts per guideline)
    - Number of clients who enter pathway
    - Number of clients who exit pathway
    - Average number of days on pathway

SIGNIFICANT HEALTH NEED ***Access to Health Care***

Indicator Rankings

The Access to Health Services indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Access to health insurance coverage
- Access to health care providers
- Transportation

Goal 1: Increase Access to Affordable Health Care Coverage

Interventions/Recommendations

- Continue to offer financial counselors for the assessment of the individuals' financial situation to determine if the person qualifies for health insurance coverage, Medicaid, or Medicare. Offer assistance with completing the needed requirements/paperwork for coverage. Assist individuals in completing applications for Food Stamps and Temporary Assistance for Needy Families (TANF).
- Continue to partner/collaborate with community-based organizations to provide education, training and access to healthcare services

Collaborations

- Health Care Providers
- Community-based organizations

Anticipated Impacts

- Increase individuals access to healthcare, Food Stamps, and TANF
- Increase knowledge of existing resources

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of participants assisted by CHRH's Financial Counselors

Goal 2: Increased Access to Health Care Providers

Interventions/Recommendations

- Continued participation in the Para-medicine Program in which Medics work in collaboration with local public health agencies, physicians, nurses and facilities playing an important role in assessing and evaluating community services and systems in order to identify gaps in services between the community and health care systems and services. The service is provided to patients who have been diagnosed with chronic heart failure (CHF) and chronic obstructive pulmonary disease (COPD).
- Continue support of Breastfeeding Program in which new mothers (who have no supplemental formula), upon discharge, are provided donated breast milk.

Anticipated Impacts

- Early Intervention in Care
- Reduce long-term impact of untreated conditions
- Positive impact on infant mortality

Evaluation Metrics

- Assess Impact during 2021 CHNA
- Number of readmissions within 30 days (Para-medicine Program)
- Number of participants in program

SIGNIFICANT HEALTH NEED ***Tobacco Cessation***

Indicator Rankings

The Tobacco Use Indicator ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the Highest Ranking CHNw Health Indicator's table.

- Adults who smoke
- Mothers who smoke during pregnancy
- Babies with low birth weight

Goal: Support Tobacco-Related Community/State Policies

Interventions/Recommendations

- Support State Level Policies such as:
  - Increase in tobacco taxes
  - Increasing legal age to purchase tobacco
  - Smoke Free indoor air policies

Collaborations

- Community-based organizations
- Health care providers
- Local elected officials

Anticipated Impacts

- Reduce long-term impact of tobacco use

Evaluation Metrics

- Assess impact during 2021 CHNA

Health Needs Not Addressed

Health needs not identified as a priority fall into one of three categories:

1. Beyond the scope of CHNw services
2. Needs further intervention, but no plans to expand community benefit services at this time
3. Rely on community partners to lead efforts with expertise in these areas with CHNw in a supporting role

The needs identified below are not specifically included in the hospital's Implementation Strategy for 2019-2021:

1. Sexually Transmitted Diseases (STD). CHNw will continue its course of action in the treatment of STDs.
2. Chronic Disease Management. CHNw will continue its course of action in the treatment of Chronic Diseases. See Para-medicine Program.
3. Services for Seniors. CHNw will continue its course of action for Services for Seniors.

Next Steps for Implementation Strategy Adoption

1. Build consensus around an evaluation plan
2. Decide what goals are most important to evaluate
3. Determine evaluation methods
4. Evaluate current partnerships and create new health-need focused alignment
5. Identify indicators and how to collect data (process and evaluation measures)
6. Identify benchmarks for success
7. Establish data collection and analysis systems
8. Collect credible data
9. Monitor progress toward achieving benchmarks
10. Review evaluation results and adjust programs
11. Share results with CHNw community, and as needed, with the community