Community Health Needs Assessment

Community Health Network

2018

IMPLEMENTATION STRATEGY

North Region

About This Document

This document describes how Community Hospital North (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 CHNw 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 Hospital North 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 Hospital North
2. Definition of the Community Served, and Determining Its Needs
3. Implementation Strategy to Address Significant Health Needs
4. Needs Community Hospital North Will Not Address
5. Next Steps for Implementation Strategy Adoption

Adopted by the Community Health Network, Inc. Board on: March 11, 2019

About Community Hospital North

Opened in 1985, the North region anchors the organization's largest health care campus that includes Community Hospital North (CHN), Community Heart and Vascular Hospital, Community Rehabilitation Hospital, the Community Cancer Center North affiliated with MD Anderson Cancer Network®, and the Behavioral Health Pavilion.

Key Statistics

Admissions:	24,739
Emergency room visits:	74,474
Babies born:	3,771
Surgeries (at hospitals, inpatient and outpatient):	8,563
Physician & Clinic Visits:	650,852

The Community Served and Its Needs

Key Demographic Data

- The current population is 549,660. A five-year trend (2012-2016) shows population at 519,611.
- Whites comprised 72.5% of the population, with African-Americans at 17.43% and Asians being 4.3%.
- The fastest growing age group is 65+ at 23%
- The North Region will experience 4.9% growth between 2018-2023.
- The North Region has the highest median household income at $77,664, with 365 of the households having an annual income of $100,000 or more.

Creating the Community Health Needs Assessment

The identification of health needs for Community Health Network (CHNw) CHN 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 CHN 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(s) of Health	Y
2. Mental Health	Y
3. Substance Abuse (Alcohol)	N
4. Substance Abuse (Opioids and Other Drugs)	Y
5. Obesity	N
6. Sexually Transmitted Diseases	N
7. Access to Health Services	Y
8. Chronic Disease Management	N
9. Food Insecurity	Y
10. Tobacco	Y

*Social Determinant(s) of Health are addressed in Access to Health Services, Food Insecurity, 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
- Continue support of the Zero Suicide Initiative

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
- Community Hospital East as well as Community Howard Regional Hospital 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 Disorder***

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
— Adults who Drink Excessively
— Substance Abuse

Goal: Treatment

Intervention

- Expand programming for the continuum of substance use disorders
- Establish a continuing care group for support after the successful completion of treatment
- Expand 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, 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.
- Increase the number of Therapists that can provide co-occurring treatment
- Expand access to substance use disorder programming by implantation of the Comprehensive Evaluation Center
- Continue utilization of school based prevention programs for middle and high school students to deliver the "This Is [NOT] About Drugs" prevention programming.

Collaborations

- Community-based Organizations
- Schools
- Faith Based Community Organizations
- Community Health Network Foundation
- 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 NICU length of stay (LOS) related to NAS

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of student 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

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

Goal 1: Access to Health Care Providers

Interventions/Recommendations:

- Continue to recruit Physicians and Advanced Practice Providers.
- Implement nursing triage service for Pediatric and Family medicine practices to improve after hours and weekend care and coordination.
- Continue with centralized Advanced Practice Provider clinic, Community QuickCare, offering care that is an extension of an established patient's office during evenings and weekends.
- Implement Physician well-being initiative to address provider burnout.
- Expand Community Primary Care @ Home program.
- Continue Community Clinics @ Walgreen's clinic offering.

Collaborations

- Walgreens
- TeamHealth
- Vital Work Life

Anticipated Impacts

- Increase health system capacity
- Provide patient education and telephonic care allowing for proper utilization of health care system
- Efficiently provide access to established patients allowing for coordinated care at the proper level
- Address level of physician burnout, maintaining existing workforce
- Provide care and coordination to individuals in their home by an Advanced Practice Provider
- Maintain lower acuity capacity of the health system during evening and weekends in retail settings

Evaluation Metrics

- Number of Physicians actively practicing
- Assess utilization and satisfaction of nursing call service
- Reduce levels of reported Physician burnout
- Assess utilization and effectiveness of Primary Care at Home and its impact on readmissions to hospital
- Monitor utilization of retail settings

Goal 2: 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 CHN's Financial Counselors

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 1: Prevention and Cessation

Intervention

- Implement a Nicotine Dependence Program (NDP) pilot program at Community Heart and Vascular Hospital (CHVH). NDP is a comprehensive program that follows clinical practice guidelines and combines intensive counseling coupled with cessation medications.
- Implement a standardized Nicotine Dependence Program for patient care

Collaborations

- Indiana State Department of Health, Tobacco Prevention Cessation Commission
- University of Texas MD Anderson's End Tobacco Platform and Tobacco Treatment Program
- Indiana Cancer Consortium
- ReThink Tobacco Indiana

Anticipated Impact

- Increase quality of education surrounding tobacco use
- Decrease in tobacco use
- Increase knowledge of existing resources

Evaluation Metrics

- Aim for30% prevention in the use of tobacco by youth

Goal 2: Support Tobacco-Related Community/State Policies

Interventions/Recommendations

- Support State Level Policies such as increase:
  - 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

SIGNIFICANT HEALTH NEED ***Food Insecurity***

Indicator Rankings

The Food Insecurity 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.

— Accessibility to healthy food
— Transportation

Goal: Increase Access to Healthy Food

Interventions/Recommendations

- Educate the community on how to eat healthy, including how fresh produce is grown and how to prepare it. This will be accomplished by hosting workshops and offering cooking demonstrations.
- Continue the Senior Meal Program. This program aims to expand the availability of healthy options for seniors, while also providing opportunities for social engagement through a free membership program.
- Continue partnership with the Cupboard of Lawrence Township in expanding equitable access to healthy, affordable nutritious food to Marion County residents.
- Partner with the Primary Care Navigation Team and Community Health Advocates to get quality food and food education to patients with demonstrated need as a means to improve health outcomes.
- Continue to support the Binford Redevelopment and Growth Farmer's (BRAG) Market from April to October.

Collaborations

- Community Cupboard of Lawrence
- BRAG
- Community Groups
- Food Pantries

Anticipated Impact

- Increase number of people who have access to healthy food
- Increase quality of life by increasing healthy food consumption
- Improve nutrition
- Increase food security

Evaluation Metrics

- Number of Senior Meal vouchers distributed
- Food pantry
    - Number of households
    - Number of individuals
- Track the number of workshops and cooking demonstrations

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 included in the hospital's Implementation Strategy for 2019-2021:

1. Substance Abuse (Alcohol). CHNw will continue course of action in treatment of persons with Substance Abuse (Alcohol).
2. Diabetes/Obesity. CHNw will continue its course of action in treatment of Diabetes/Obesity.
3. Sexually Transmitted Diseases (STD). CHNw will continue course of action in the treatment of STDs.
4. Chronic Disease Management. CHNw will continue its course of action in the treatment of Chronic Diseases.

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