# Grant Memorial Hospital
# Community Health Needs Assessment
# Implementation Strategy
# October 2016

## EXECUTIVE SUMMARY:

Hospitals are increasingly taking on the challenging work necessary to improve population health by partnering with a diverse group of community stakeholders to address the drivers and conditions identified in their Community Health Needs Assessments (CHNAs). Hospital CHNA Implementation Plans vary based on each hospital's unique characteristics, capabilities and goals.

Grant Memorial Hospital (GMH) has created a plan to enhance existing community benefit programs and hospital services. The plan can be found on GMH website at www.grantmemorial.com that was posted in August, 2016. The focus of this plan is to address major community health priorities that were identified in the June 2016 Grant Memorial Community Health Needs Assessment. This assessment process was designed to extend broadly into the tri-county service area to identify needs, gaps and barriers to health and health services.

The Implementation Strategy will describe GMH's response and strategies that will identify programs and resources to address and respond to the health needs over the next three years. The implementation plan will also describe why an identified health need will not be addressed. Through a process of primary research, data analysis, validation and prioritization, the assessment process identified the following three significant health needs to focus on from 2016-2019:

- **Chronic Disease Management**
  a. Diabetes Mellitus
  b. Heart Disease
- **Unhealthy Lifestyles**
  a. Obesity
  b. Tobacco Use
- **Drug and Alcohol Abuse**

**Priority #1:**
**Chronic Disease Prevention/Management**

**Focus Area:** Increase access to high-quality chronic disease preventive care and management in both clinical and community settings

**Goal:** Increase screening rates for cardiovascular disease and diabetes especially among disparate populations

**Objective:** Increase the percentage of adults (50-75 years) who receive annual screenings

**Disparity:** Provide screening and treatment for lower income patients and those without health insurance

# IMPLEMENTATION STRATEGY

## Health Need Priority: Chronic Disease – Diabetes Mellitus

**Prevention Agenda Linkage:** Prevent Chronic Diseases

**Identified Need:** Diabetes is a chronic disease with many high cost complications. The great need is to promote healthy lifestyles, compliance with clinical practice guidelines and improve access to health care services in order to prevent diabetes and delay its progression once diagnosed.

| GOALS | OBJECTIVES | STRATEGIES |
|---|---|---|
| **Prevention**<br>Increase early detection, awareness and education regarding risk factors as well as prevention strategies for diabetes<br><br>**Diabetes Management**<br>Provide safe, efficacious glycemic management and self-management education throughout the continuum of care<br><br>**Professional Education**<br>Promote healthcare providers knowledge of evidence-based best practice diabetes management | • Increase number of patients attending outpatient and community programming<br>• Increase the number of educational offering to healthcare providers<br>• Continue to target health screenings in targeted underserved areas<br>• Increase the percent of patients with HbA1c measured in past year<br>• Reduce the average HbA1c<br>• Increase the number of patients receiving medical nutrition education/therapy | • Promote and continue "Healthy Lifestyles Balance" classes taught by Registered Dietician and RN<br>• Continue "Healthy Saturdays" Education topics and Blood Screening at minimal cost to the community<br>• Promote GMH ACO Care Coordination for in and out patients through collaboration with physician offices and RN Care Coordinator (includes RN care coordination, Registered Dieticians, Pharmacists and Social Services<br>• Develop/implement educational boards and trainings for all healthcare providers designed to increase their awareness of diabetes standards of care and proven methods for prevention |

## COLLABORATION

**Develop collaborative practices with other community health care providers and health care training programs such as schools of nursing, osteopathic school of medicine, etc.:**

- Eastern Community and Technical College School of Nursing
- Mineral County LPN School
- WV School of Osteopathy
- American Diabetes Association
- Grant/Hardy/Pendleton County Health Departments
- Judy's Drug Store Diabetes Education Program

## INITIATIVES

**Standardize method of treatment of patients diagnosed with diabetes across the continuum**
**Inpatient:**
• Diabetes education for inpatients
• Standardize education materials to be used across continuum including GMH physician offices
• Integrate and standardize policies across hospitals, home care, sub-acute, rehab and continuing care
• Educate health care professionals regarding best practice management of patients with diabetes
**Outpatient:**
• Life Skills Diabetes Management education programs (Balance Lifestyle Classes)
• Individual patient consults as needed with Certified Diabetes Educator (RN, RD)
• Follow-up monitoring of patients attending diabetes management programs
• Integrate GMH ACO Care Coordination Program with other health care primary clinics/offices
**Community:**
• Community screenings and educational sessions through Healthy Saturday program, community health fairs, etc.
• Diabetes screening to include glucose, cholesterol and blood pressure assessments

## Health Need Priority: Chronic Disease – Heart Disease

**Prevention Agenda Linkage:** Prevent Chronic Diseases

**Identified Need:** Significant opportunities continue to exist to educate, treat, and support CHF patients, especially in rural communities, where patients are less compliant with directed medical therapies, and therefore have worse outcomes in key metrics such as mortality and readmission rates

| GOALS | OBJECTIVES | STRATEGIES |
|---|---|---|
| **Prevention**<br>Reduce preventable hospitalizations through disease management<br><br>Provide more comprehensive support and access for rural demographics<br><br>Increase access / reduce disparity | • Reduce Readmission Rates<br>• Improve follow up visit compliance to PCP and Cardiology<br>• Provide more comprehensive support in the home environment | • Promote evidence-based care to manage chronic disease working collaboratively with GMH physicians and WVU Medicine<br>• Programs dedicated to patient access to primary care through the ACO Care Coordinator<br>• More comprehensive home care support, patient navigation, and access to community resources through follow up phone calls/quality impact team (re-admission team)<br>• Better mechanisms for education (Website/pamphlets/ Education boards) |

## COLLABORATION

Grant Memorial Hospital Quality Impact Teams work collaboratively with GMH's Care Coordination programs. The focus of this work is to ensure patients are seamlessly transitioning from GMH to physician offices, home health agencies, and/or home/long term care units and those high- risk patients are able to receive additional support in the physician office setting.

## INITIATIVES

Hospital based nurse manager, responsible for rounding on all CHF patients, educating patients and bedside nurses, and coordinating patients' care throughout the continuum

Continuing Care and Home Care specialized programs and staffing to address CHF patient needs in subacute care facilities and within their homes

Identify opportunities to improve support for CHF patients within the GMH service area

Referral of CHF patients upon admission to GMH ACO care coordinator for follow up

Offer Discharge Bedside Medication Service (Judy's Drug) to patient

GMH RN Follow up phone call within 24 hours after discharge to ensure discharge instructions are understood and appropriate resources are in place

## Priority #2:

## Unhealthy Lifestyle

**Focus Area:** Increase access to dietary and tobacco education and management in both clinical and community settings

**Goal:** Increase the percentage of GMH service area residents that are at a healthy weight through eating a healthy diet and regular physical activity

**Objective:** Increase number of patients attending outpatient and community nutritional and anti-tobacco programming

**Disparity:** Provide screening and treatment for lower income patients and those without health insurance

## Health Need Priority: Unhealthy Lifestyle – Obesity

**Prevention Agenda Linkage:** Unhealthy Lifestyles

**Identified Need:** Significant opportunities continue to exist to reverse the obesity epidemic with community efforts focusing on supporting healthy eating and active living in a variety of settings.

| GOALS | OBJECTIVES | STRATEGIES |
|---|---|---|
| **Prevention**<br>Increase the percentage of GMH service area residents that are at a healthy weight through eating a healthy diet and regular physical activity<br><br>Provide more comprehensive support and access for urban demographics<br><br>Increase access / reduce disparity | • Increase number of patients attending outpatient and community nutritional programming<br>• Continue to target health screenings in targeted underserved areas<br>• Increase the number of patients receiving medical nutrition education/therapy<br>• Increase the number of residents receiving education of the importance of increased physical activity | • Promote and continue "Healthy Lifestyles Balance" classes taught by Registered Dietician and RN<br>• Continue "Healthy Saturdays" Education topics and Blood Screening at minimal cost to the community<br>• Develop/implement educational boards and trainings for all healthcare providers designed to increase their awareness of obesity standards of care and proven methods for prevention<br>• Continue Employee Wellness culture and encourage participation in employee sponsored programs such as gym memberships/healthy meal alternatives<br>• Collaborate with local elementary schools to assist with programs such as "Childhood Obesity Program" |

## COLLABORATION

**Develop collaborative practices with other community health care providers :**

- Local Fitness Centers (Herrick's  Fitness Center and Hardy Co. Wellness Center)
- Civic Organizations such as CEOs, Ruritans
- Grant County Family Issues Task Force
- Grant/Hardy/Pendleton County Schools

## INITIATIVES

• Life Skills education programs (Balance Lifestyle Classes)
• Individual patient consults as needed with Certified Diabetes Educator (RN, RD)
**Community:**
• Community screenings and educational sessions through Healthy Saturday program, community health fairs, etc.
• Develop quarterly information/education opportunities with local elementary schools to incorporate nutrition and increase physical activity incentives
• Collaborate with Grant Co. Family Issues Task Force to promote community awareness of obesity and complications

## Health Need Priority: Unhealthy Lifestyle-Tobacco

**Prevention Agenda Linkage:** Unhealthy Lifestyles

**Identified Need:** Significant opportunities continue to exist to reverse the population's tobacco use

| GOALS | OBJECTIVES | STRATEGIES |
|---|---|---|
| **Prevention**<br>Increase the percentage of GMH service area residents that have quit using tobacco or attempting to quit<br><br>Provide more comprehensive support and access for rural demographics | • Continue to target health screenings in targeted underserved areas<br>• Increase the number of patients receiving tobacco screening/ education<br>• Include smoking prevention initiatives for pregnant population | • Promote and continue tobacco cessation classes in collaboration with local health departments<br>• Promote and offer anti-nicotine patches to inpatients/employees<br>• Continue "Healthy Saturdays" Education topics regarding harm of tobacco use and resources for prevention<br>• Develop/implement educational boards and trainings for all healthcare providers designed to increase their awareness of and proven methods for prevention<br>• Continue Employee Wellness culture and encourage participation in tobacco free lifestyles<br>• Collaborate with local elementary schools to assist with anti-tobacco programs |

## COLLABORATION

**Develop collaborative practices with other community health care providers :**

- Civic Organizations such as CEOs, Ruritans
- Community Health Fairs
- Grant County Family Issues Task Force
- Grant/Hardy/Pendleton County Schools
- Grant/Hardy/Pendleton County Health Departments

## INITIATIVES

• Provide education pamphlets to patients for resources in prevention
• Individual patient consults as needed pharmacist regarding anti-nicotine patches
**Community:**
• Community screenings and educational sessions through Healthy Saturday program, community health fairs, etc.
• Develop quarterly information/education opportunities with local elementary schools to incorporate anti-tobacco programs
• Collaborate with Grant Co. Family Issues Task Force to promote community awareness of tobacco use and complications

### Need(s) That Will Not Be Addressed

In any prioritization, there will be some areas that do not meet as many of the criteria of the priority areas, and will therefore not be addressed in implementation. This is not intended to minimize the importance of a particular health need, it is imperative to the effectiveness of improving the health of the community to create a strategic focus with our plan.

Grant Memorial Hospital's priorities were set so that we could align our resources with the intention to make the most positive impact on our community.
**The need that we chose not to address was drug and alcohol abuse.**

Drug and alcohol abuse is high in West Virginia and poses a problem for our community. Grant Memorial Hospital does not have a detox unit and therefore must transfer all patients to an appropriate detox or behavioral health unit. We will continue to work collaboratively with our local mental health resources including Potomac Highland Health Guild and will review opportunities to expand this service in the future. We will also continue to partner with the WV Hospital Association EDIE project and comply with the Emergency Department Criteria for OPOID Prescription/Use.

## APPROVALS:

The CHNA Implementation Plan was approved by the following groups.

- Senior Leadership – September 25, 2016
- Grant Memorial Strategic Planning Committee – October 10, 2016
- Grant Memorial Hospital Board of Trustees: _____