Community Mercy Health Partners
Springfield Regional Medical Center
A member of Catholic Health Partners
100 Medical Center Drive
Springfield, OH 45504

2014-2016 Community Health Needs Assessment Implementation Plan

Adopted by the Community Mercy Health Partners Board in September, 2013

INTRODUCTION

Springfield Regional Medical Center (SRMC) is a 254-bed Hospital that opened in 2011 providing inpatient, outpatient and ancillary services for residents of Clark County and surrounding communities. This full service hospital offers 24/7 emergency care, maternity services, critical and intensive care, surgery and pediatric care – all provided by skilled doctors and highly trained health professionals. The Cardiac Center houses state-of-the-art catheterization labs, which further enhance its nationally recognized cardiac surgery program. SRMC, along with local health, education, social service, non-profit and governmental agencies participated in a Community Health Needs Assessment ("CHNA") conducted for Clark County and surrounding areas. The detailed process, participants and results are available in SRMC's Community Health Needs Assessment Report which is available on the CMHP website.

This Implementation Plan will detail which community needs SRMC will address and how, as well as which needs SRMC will not address and why. Beyond the programs and strategies outlined in this plan, SRMC will address the needs of the community by continuing to provide care for all individuals regardless of ability to pay.

The strategies and tactics contained within SRMC's Implementation Plan will provide the foundation for addressing the community's needs between 2014 and 2016. However, SRMC anticipates that some of the strategies, tactics and even the needs listed will evolve over that period and as such, SRMC will take a flexible approach that will allow it to adapt to changes and collaborate with other community agencies.

EXECUTIVE SUMMARY

Background and Process

SRMC joined forces with the leadership of the Clark County Combined Health District and 45 community representatives from 35 organizations. These organizations partnered to assess the community's health via rigorous data analysis and to develop evidence-based solutions in response to findings.

The 45 community leaders met to review the results of primary and secondary data analyses on two occasions in winter and spring of 2013. The first session reviewed the results of original data collection, which followed the CDC protocol for the Behavioral Risk Factor Surveillance System (BRF SS), with Wright State University interviewing nearly 1,100 adults. Data from the BRFSS showed greater prevalence for risk behaviors and disease rates in Clark County as compared to Ohio and the nation. This analysis was augmented with extensive secondary data analysis, studying birth and death data including infant mortality, infectious disease rates, cancer rates, and hospital International Classification of Disease (ICD-9) data, along with Youth Risk Behavior Survey results, which are collected by the Clark County Combined Health District every two years. Tests for statistical significance were conducted so as to identify areas of true need. In most cases, it was possible to conduct spatial analysis of disease prevalence to aid the steering committee in determining how to target strategies and consider the allocation of resources.

On April 25, 2013, a data synthesis was presented to the community as the launch of the Community Health Improvement Planning process. At that meeting, the community leaders identified five strategic priorities. The community organized into five task forces that each met two times (offering both on-location and webinar options) between April 25 and June 3, 2013. On June 6, 2013, all the community leaders reconvened to receive and comment on presentations from each of the five task force groups and to make final decisions about strategic health priorities and the plan's management and sustainability.

These community leaders represented elementary schools, institutions of higher education, local health and human services agencies including mental health agencies, community and faith based organizations, public safety, and the health care system. The community determined that a countywide geography was the best way to assemble the resources necessary to respond to strategic priorities. As can be seen from a review of the sectors involved, "Community Health" was broadly defined to include physical health, mental health, substance abuse, support to low income populations, and more.

The initial Community Health Improvement Plan (CHIP) meeting of the steering committee defined the scope of the work, the timeline, and made clear the need for members to champion community priorities identified. The Health District took the lead in providing meeting space and other resource needs. A readiness assessment was conducted in real time at the first steering committee to ensure consensus and resource availability. Guiding assumptions such as the importance of high participation and commitment to priority health issues, once identified, were also addressed at this first meeting.
The process of performing the community health needs assessment, data sources consulted, development of the top priorities and the list of participants is explained in detail in SRMC's CHNA Report which is available at http://www.community-mercy.org/.

Prioritized Needs

As a result of the process, The five strategic priorities were identified as follows:

1. Mental Health
2. Chronic Disease management
3. Substance Abuse
4. Obesity
5. Healthy Births/sexuality

A task force was established for each of the categories led by a collaborating partner. The meetings were held May 13, 14, 15, 17, 23, 29, 30, 31 and June 3, 2013. The detailed results of these meetings were shared and discussed at a gathering of all collaborating partners on June 6, 2013

Implementation Plan

SRMC is continuing to work with other county agencies and is committed to developing a county-wide Community Health Improvement Plan. While that plan is still being finalized, SRMC is committed to addressing the health needs of the community through the strategies and tactics described in this Implementation Plan.

HOSPITAL MISSION STATEMENT

Springfield Regional Medical Center, a member of Catholic Health Partners, has the following Mission:

Springfield Regional Medical Center extends the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and under-served.

SRMC's Mission and culture are expressed through the organizational core values:

Compassion
Our commitment to serve with mercy and tenderness

Excellence
Our commitment to be the best in the quality of our services and the stewardship of our resources

Human Dignity
Our commitment to value the diversity of all persons and to be respectful and inclusive of everyone

Justice
Our commitment to act with integrity, honesty and truthfulness

Sacredness of Life
Our commitment to reverence all life and creation

Service
Our commitment to respond to those in need

COMMUNITY SERVED by HOSPITAL

For the purposes of the CHNA, SRMC is an acute care hospital located in the city of Springfield with 90% of patients served in Clark and Champaign Counties.
Geographic Identifiers: These areas are represented by the following Zip Codes: 45503, 45505, 45506, 45504, 45502, 43078, 45334, 45386, 45369, 45323, 43072, and 43044.

PRIORITIZED COMMUNITY HEALTH NEEDS

The table below lists the community needs that were identified through the community health needs assessment and then subsequently prioritized. The needs that SRMC will address are also noted.

Prioritized Community Health Need	Addressed by SRMC
Mental Health	Yes
Chronic Disease Management	Yes
Substance Abuse	Yes
Obesity	No
Healthy Births/Sexuality	No

2014 – 2016 IMPLEMENTATION STRATEGIES to ADDRESS COMMUNITY HEALTH NEEDS

In 2012, Community Mercy Health Partners (CMHP), which Springfield Regional Medical Center is a part of, provided over $27 million in community benefit – services and activities which benefitted the poor and underserved as well as the broader community. Of the $27 million, almost $24 million was related directly to those living in poverty. Community Mercy Health Partners has supported its Mission for over 125 years, and will continue to provide quality care to the community with emphasis on the poor and under-served.

The strategies defined in the Implementation Plan will supplement the charity care and community benefit already provided by CMHP, and will ensure that focus and resources are being devoted to the highest priority needs of the community.

Addressing the Prioritized Needs of Clark County:
Springfield Regional Medical Center-Community Health Needs Assessment Implementation Plan 2014-2016

Mental Health Wellbeing

Current Situation: Currently, Clark County is working with the State in the area of medical Mental Health Homes and managed care so our focus in on prevention. MHRB advocates adoption of treatment overlay; the FQHC provides mental health services; there is an array of MH providers for adults and youth (Osterlin, Catholic Charities, Well Spring, Rocking Horse—and Medicaid is available through all providers); MHRB is beginning a focus on prevention using the Good Behavior Game (GBG) in local schools, which is also embedded in the local university's education program curriculum; Trauma informed care initiative; Crisis intervention training done by the board on a regular basis to first responders where focus is recognition and referral; The CMHP is supporting a telepsych program in a neighboring county

Goal 1: Promoting the mental health and well-being of youth in Clark County for the near and long-term.

Strategic Issue 1: Implement the Good Behavior Game (GBG)

Strategy: Implement the Good Behavior Game (GBG) eventually in all school buildings in Clark County.

Rationale: In July of 2011, the renowned Washington State Institute for Public Policy reported on return on investments for evidence-based options to improve state-level protective and prevention outcomes. Among all general prevention programs, the Good Behavior Game is the single most cost-efficient strategy, returning $96.80 per dollar spent. The net benefit to the child for his or her lifetime is $10,371 and $4,137 for the taxpayers (see http://www.wsipp.wa.gov/rptfiles/11-07-1201.pdf).

Action Step 1: Create Nurturing Environments – The umbrella under which GBG stands

Action Step 2: Use Kernels (fundamental units of behavioral influence that underlie effective prevention and treatment for the most common and costly problems of behavior and an increase in the prevalence of wellbeing).

Time Frame:

- **12 Month Outcome:** Significant reduction of externalizing problems at the end of the academic year for participating schools. GBG has a data package and districts/partnerships will be required to use that.
- **24 Month Outcome**: More schools participating.
- **Estimated Cost:** The cost per school building is estimated to be $5000 for the toolkit, teacher training, and coaching.

Partnering Agencies: Springfield City Schools, and MHRB

Addressing the Prioritized Needs of Clark County:
Springfield Regional Medical Center-Community Health Needs Assessment Implementation Plan 2014-2016

Goal 2: Redirect EMS frequent users to appropriate care and reduce 911/EMS and SRMC Emergency Department overuse so as to direct resources to where they are more effective.

Strategy: Develop and implement a Hospital/Clinic-EMS data exchange and a better clinical pathway management model.

Rationale: Data analysis shows that an inordinate number of EMS calls come from a very few number of people. The strategy is to establish a better clinical pathway management model to address the root causes of the frequent calls.

Action Step 1: Establish a better clinical pathway management model vis-à-vis a 911 Emergency Communication Nurse System (ECNS) Nurse Navigator.

Action Step 2: The ECNS takes a more detailed history of the complaint and determines the most appropriate response/destination. Emergency medical dispatchers (EMD), using the computer-assisted medical priority dispatch system, interview callers in order to determine the location, nature, and priority of the caller's situation. The calls are then classified into EMS Event Types. There are 44 different EMS Event Types classified by the medical priority dispatch system.

Action Step 3: Connect with the non-ED partners/services, and specifically with that patient's health network (PCP, medical home, and Urgent care clinics)

Action Step 4: Educate the population about the 911 system. Houston, Texas experienced a measurable impact on call volume from doing so.

Action Step 5: Establish face to face contact by a health and human service team which is shown to permanently reduce calls from frequent users.

Time Frame:

- **12 Month Outcome:** SRMC and EMS data exchange process is developed
- **24 Month Outcome:** Data exchange system is implemented; clinical pathway management model is developed.

Partnering Agencies: Springfield Fire & Rescue, MHRB, and SRMC,

Addressing the Prioritized Needs of Clark County:
Springfield Regional Medical Center-Community Health Needs Assessment Implementation Plan 2014-2016

Chronic Disease Management

Current Situation: It is a struggle to stay on top of disease without a primary care physician (PCP) and without which there is no follow up. A large portion of the city of Springfield is a Health Professionals Shortage Area (HPSA). The County does have an FQHC, but while it does have new physical capacity, the facility has dropped from four physicians to two with one of those two being the medical director. Efforts are underway to increase the number of physicians again.

Strategic Issue: The Task Force determined that there are many challenges in serving people with chronic diseases, and the most important aspect is the management of the various chronic diseases.

Goal: Improve access to care and optimize health care resources by establishing a Chronic Disease Clinic

Rationale: According to the British Medical Journal, today in the United States chronic disease is the major cause of disability, is the main reason why people seek health care, and consumes 70% of healthcare spending. With acute disease, the treatment aims at return to normal. With chronic disease, the patient's life is irreversibly changed. Neither the disease nor its consequences are static. They interact to create illness patterns requiring continuous and complex management. Furthermore, variations in patterns of illness and treatments with uncertain outcomes create uncertainty about prognosis. The key to effective management is understanding the different trends in the illness patterns and their pace. The goal is not cure but maintenance of pleasurable and independent living. (BMJ. 2000 February 26; 320(7234): 526–527)

Action Steps:

- The first year will be dedicated to planning the clinic, beginning with analysis of the data collected for the needs assessment. We will identify community partners and determine feasibility of the clinic, create the clinic structure and find a location.
- Year two we will implement the plan to open the clinic, identify performance metrics to measure the impact of chronic disease in Clark County.
- Year three we will adjust the operating model based on the metric performance and community need as well as create a patient advisory council for real time feedback.

Partnering Agencies: SRMC, CCCHD, and Rocking Horse, FQHC

Addressing the Prioritized Needs of Clark County:
Springfield Regional Medical Center-Community Health Needs Assessment Implementation Plan 2014-2016

Substance Abuse

Current Situation:

Strategic Issue: Model practices from the Strategic Prevention Framework to assess community readiness, determine resources available, and develop a data driven method of reporting outcomes.

Goal: Mobilize a community coalition to address substance use issues in Clark County

Rationale: Clark County, like many communities in the country, is experiencing an increase in the use of heroin among other substance abuse trends. The community determined that the primary barrier to improving substance abuse prevention strategies is the overall lack of capacity in the County. To get to the point of targeting the highest priority strategies, the community first needs to build data collection and analysis capacity. Such capacity will enable the community to make a firm case for the need for more resources, then to obtain additional professionals, and to be able to prioritize and disseminate effective prevention interventions. In terms of community strengths, there is wide community support to follow the Strategic Prevention Framework and to pursue participation by the 12 partnering sectors recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA).

- **Action Step 1:** Assess prevention needs based on epidemiological data. Work toward a central clearinghouse of substance abuse data.
- **Action Step 2:** Form a committee to review mortality data.
- **Action Step 3**: Build prevention capacity by addressing the need for more professionals, more data capacity, and more effective interventions.
- **Action Step 4**: Develop a strategic plan that uses data to inform priority strategies
- **Action Step 5**: Implement effective community prevention programs, policies and practices
- **Action Step 6**: Evaluate efforts for outcomes.

- **Time Frame:** SRMC and CCCHD will build an information system. Year one will be in-kind contributions of time.
- **12 Month Outcome:** Build, coalesce, and develop the baseline data to drive insight to interventions needed and build the case for additional local funding
- **24 Month Outcome:** interventions are begun which are data-driven. Measurable outcomes may be available by this time.
- **Estimated Cost:** A person will be needed to manage the Coalition after year one when the coalition moves into selecting and implementing interventions. The data will be used to make the case for funding.

Partnering Agencies: McKinley Hall, Mercy REACH, MHS, Criminal Justice System, CCCHD, and MHRD

Addressing the Prioritized Needs of Clark County:
Springfield Regional Medical Center-Community Health Needs Assessment Implementation Plan 2014-2016

Obesity

Strategic Plan: Implement a child health, multi-dimensional, school-wide, evidence-based program in Lincoln Elementary as a pilot program to determine what works then scale up to additional schools.

Current Situation: the Obesity Task Force determined that a core criterion for their decision was prevention, and therefore their focus is on youth in schools, which also engages parents, via a multidimensional, school-wide, child health evidence-based program.
The competency and capacity assessment revealed that in Clark County, the Health Department measures BMI for the City Schools and conducts a youth risk behaviors survey. Data show that the overweight and obesity problem is worsening. There are many school-based obesity prevention programs being carried out across the country. The strengths assessment pointed out the important coordination role of the Springfield Promise Neighborhoods given its strong relationships with the schools and the neighborhoods. The Task Force prefers presenting the various programs, which have an evidence base of effective outcomes, to school representatives and allowing them to select the program that best suits the school. The Task Force reviewed the "Just for Kids!" program, the CDC's CATCH program, and the Annapolis Valley Health Promoting School Project among other evidence-based programs.
"Just For Kids!" was adapted from the SHAPEDOWN Pediatric Obesity Program, the nation's leading weight management program for children and adolescents. SHAPEDOWN is currently offered in over 400 hospitals, HMO's and clinics, and by hundreds of health professional private practitioners providing pediatric obesity care to families nationwide.

- CATCH stands for a Coordinated Approach To Child Health and is an evidence-based, coordinated school health program designed to promote physical activity, healthy food choices and the prevention of tobacco use in children.
- The CATCH Programs cover kids from preschool through 8th grade and has been implemented in thousands of schools and after-school organizations across America and Canada. For 25 years, the CATCH Programs have guided kids on how to be healthy for a lifetime and it is now the #1 health promotion and childhood obesity prevention program available.
- Annapolis Valley Health Promoting School Project (AVHPSP): Schools are the voice and the leaders in the program. Health Promoting School Teams are formed at each school. These are comprised of a cross-section of people including school staff, food service workers, students, parents, Public Health staff and community members (e.g. recreation directors). Their purpose is to assess needs and develop a plan for their school. At the high school level where Youth Health Centers are being established, the vision is that health promotion will be part of the Youth Health Centre role.

Goal: Change school culture to impact child and family wellness by increasing knowledge about healthy food and exercise choices and modifying systems and programs that can aid such choices in the school.
Partnering Agencies: Springfield Promise Neighborhoods, The OSU Cooperative Extension Service, Clark County Combined Health District (CCCHD), the YMCA, and the School district.

Addressing the Prioritized Needs of Clark County:
Springfield Regional Medical Center-Community Health Needs Assessment Implementation Plan 2014-2016

Healthy Births/Sexuality

Strategic Plan: Increase the focus on outreach and education about early signs of pregnancy, and ways to improve access to testing and services

Current Situation: The gap analysis uncovered the need for better outreach to pregnant women to get them to the FQHC's OB program. A concerning proportion of pregnant women delay prenatal care, and this trend is especially evident among the growing Spanish speaking-only households, where it is not uncommon for pregnant women to get a confirmation of pregnancy at 4-6 months. There are several reasons why pregnant women may not be seen for first trimester care.

- The observation that some Hispanic women did not seem to understand the importance of beginning prenatal care early and attending regular visits
- Many pregnant women work or depend on a working person for transportation.
- There may be a shortage of evening and weekend appointment times.
- Uninsured patients had difficulty paying for ultrasounds and other prenatal testing.
- Very young women deny they are pregnant or they seem not to want to deal with it
- Some women think that their total cost of the birth of the child will be reduced if they see the doctor less. Women don't realize that they would have been eligible for services within the delivery cost.
- The culture thinks you go to prenatal care when something is wrong or in the last trimester. There is a generational lack of understanding of a wellness approach to childbirth.
- Lack of awareness of the Rocking Horse Center (FQHC) OB clinic

Goal: To identify and engage pregnant women in first trimester prenatal care.

Partnering Agencies: Clark County Combined Health District including its WIC program, the Community Foundation, the Pregnancy Resource Center, Clark County Department of Job and Family Services, and Springfield's Women's Network.