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Community Health Needs Assessment
The Implementation Plan

Presented by:

Carolyn St.Charles, RN, BSN, MBA
Regional Chief Clinical Officer, HealthTechS3

FORTY - FIVE YEARS OF
Building Leaders | Transforming Hospitals | Improving Care

Areas of Expertise

Strategy – Solutions - Support

Governance & Strategy

- Executive management & leadership development
- Community health needs assessment
- Lean culture

Finance

- Performance optimization & margin improvement
- Revenue cycle & business office improvement
- AR outsourcing

Recruitment

- Executive and interim recruitment
- CEOs, CFOs, CNOs
- VP and Department Directors

Clinical Care & Operations

- Continuous survey readiness
- Care coordination
- Swing bed consulting

3rd Quarter 2019 Webinars

ALL WEBINARS ARE RECORDED

Understanding the ROI on Advanced Wellness Visits and Advanced Care Planning: Preparing the Right Person for the Job
Host: Faith M Jones, MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3
July 11, 2019 at 12:00 pm CT
https://bit.ly/2Xs2YUN

Using the Concepts of Lean to Improve Swing Bed Documentation
Host: Carolyn St.Charles, RN, BSN, MBA – Chief Regional Clinical Officer, HealthTechS3
July 12, 2019 at 12:00 pm CT
https://bit.ly/2Ju7JmU

Community Health Needs Assessment – The Implementation Plan
Host: Carolyn St.Charles, RN, BSN, MBA – Chief Regional Clinical Officer, HealthTechS3
August 2, 2019 at 12:00 pm CT
https://bit.ly/2xzek9U

Improve your CCM Program Revenue: Incorporate Technology and Resources for Additional Reimbursement
Host: Faith M Jones, MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3
August 15, 2019 at 12:00 pm CT
https://bit.ly/2S08gAC

Swing Bed 101
Host: Carolyn St.Charles, RN, BSN, MBA – Chief Regional Clinical Officer, HealthTechS3
September 6, 2019 at 12:00 pm CT
https://bit.ly/2xHt8Dj

Trends Facing Rural Healthcare Boards
Host: Michael Lieb – Regional Vice President & Director, Practice Management, HealthTechS3
September 13, 2019 at 12:00 pm CT
https://bit.ly/2YJVSaA

INSTRUCTIONS FOR TODAY'S WEBINAR

- You may type a question in the text box if you have a question during the presentation
- We will try to cover all of your questions – but if we don't get to them during the webinar we will follow-up with you by e-mail
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation)
- The webinar will be recorded and the recording will be available on the HealthTechS3 web site: www.healthtechs3.com

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Community Health Needs Assessment

A systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs.

Catholic Health Association
Guide to Assessing and Addressing Community Health Needs
June 2013

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INVEST IN YOUR COMMUNITY

4 Considerations to Improve Health & Well-Being *for All*

WHAT — Know What Affects Health

- 40% SOCIOECONOMIC FACTORS
- 10% PHYSICAL ENVIRONMENT
- 30% HEALTH BEHAVIORS
- 20% CLINICAL CARE

www.countyhealthrankings.org

WHERE — Focus on Areas of Greatest Need

Your zip code can be more important than your genetic code. Profound health disparities exist depending on where you live.

WHO — Collaborate with Others to Maximize Efforts

COLLECTIVE VISION

PEOPLE, COMMUNITY DEVELOPERS, BUSINESSES, EDUCATION, GOVERNMENT, PHILANTHROPISTS & INVESTORS, FAITH-BASED ORGANIZATIONS, HEALTH CARE PROVIDERS, PUBLIC HEALTH, HEALTH INSURANCE, NONPROFITS

HOW — Use a Balanced Portfolio of Interventions for Greatest Impact

- Action in one area may produce positive outcomes in another.
- Start by using interventions that work across all four action areas.
- Over time, increase investment in socioeconomic factors for the greatest impact on health and well-being for all.

Four ACTION Areas: SOCIOECONOMIC FACTORS | PHYSICAL ENVIRONMENT | HEALTH BEHAVIORS | CLINICAL CARE

VISIT **www.cdc.gov/CHInav** FOR TOOLS AND RESOURCES TO IMPROVE YOUR COMMUNITY'S HEALTH AND WELL-BEING

CDC | NATIONAL PREVENTION STRATEGY | Robert Wood Johnson Foundation

MARCH 2015

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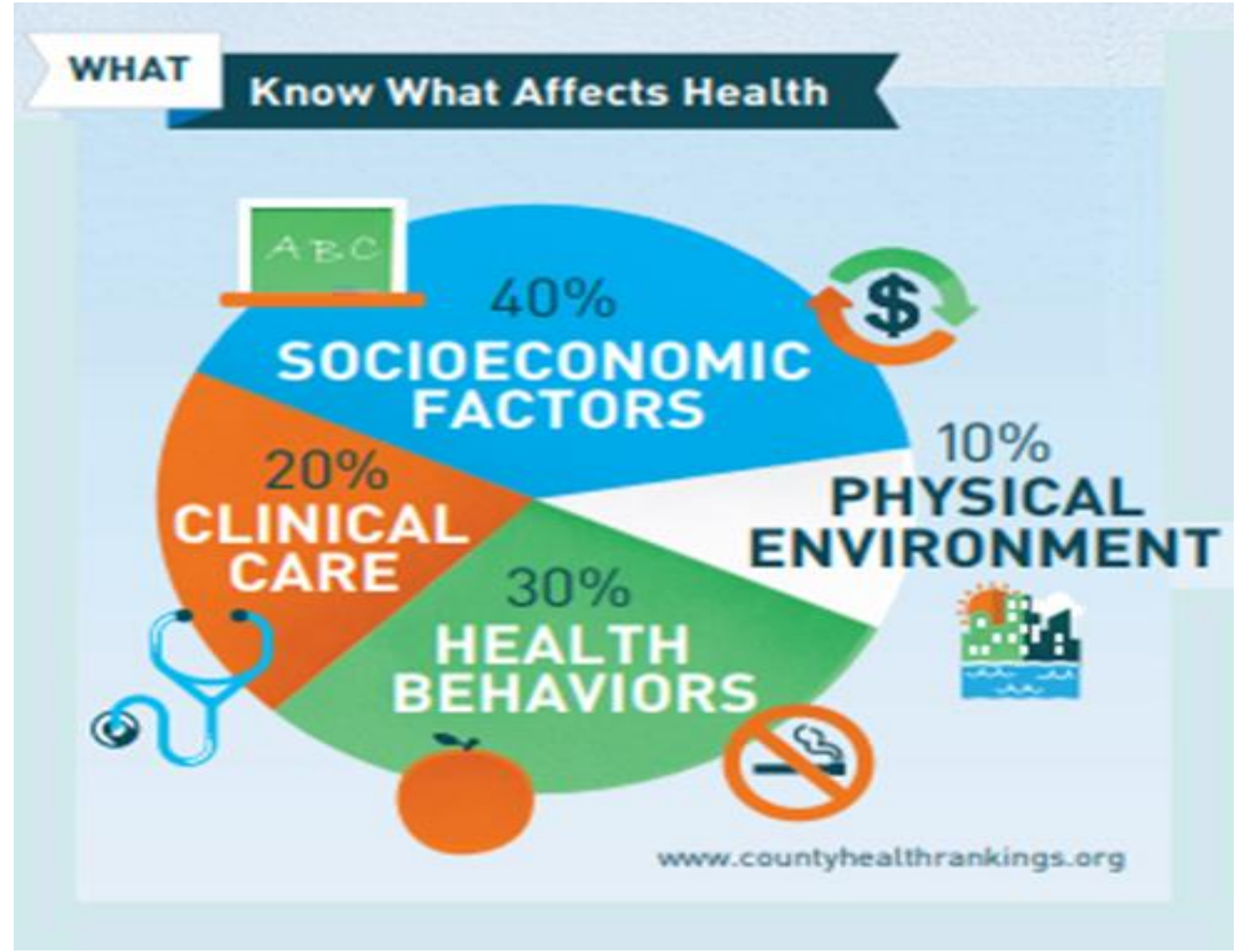

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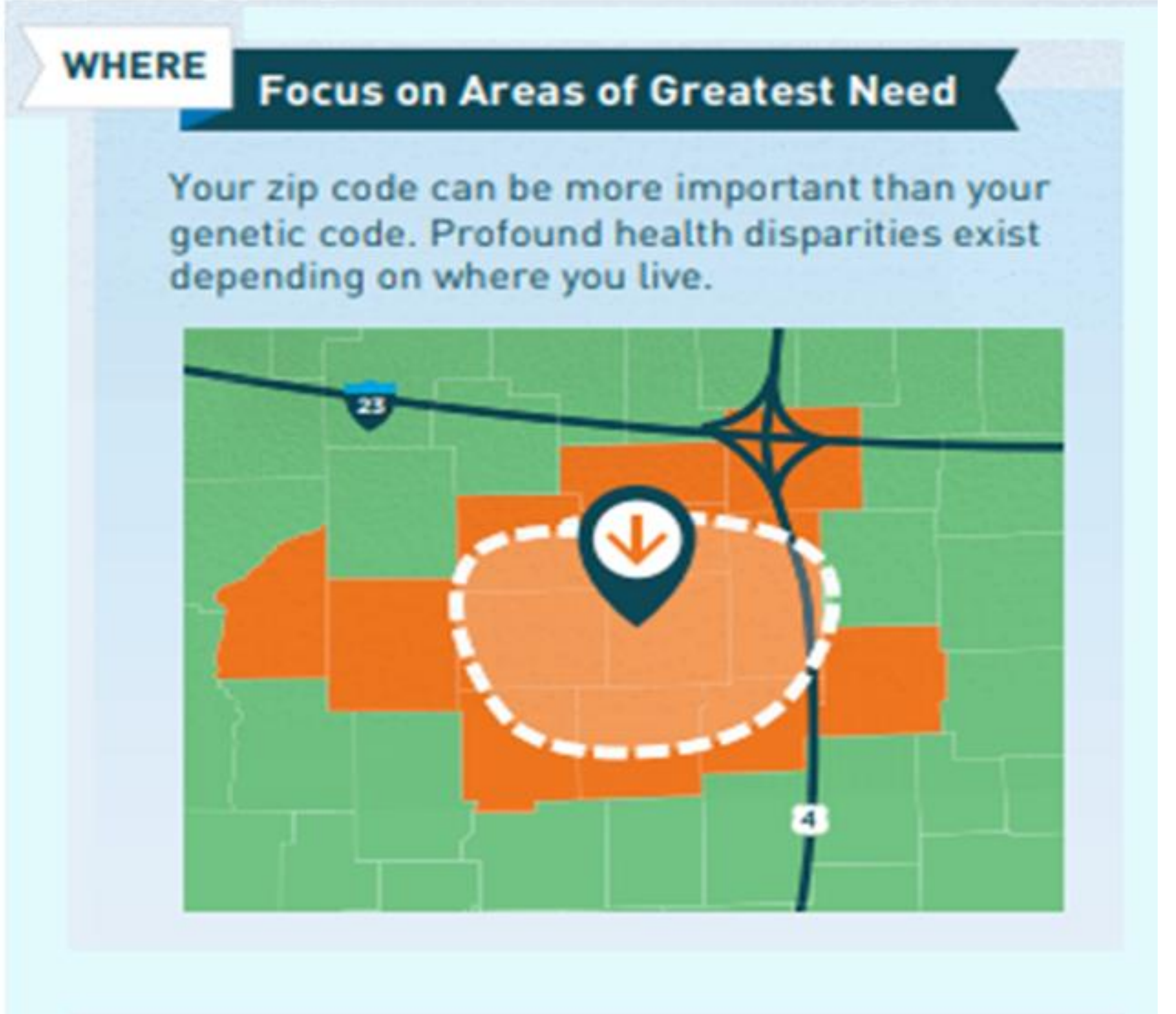

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HOW

Use a Balanced Portfolio of Interventions for Greatest Impact

- Action in one area may produce positive outcomes in another.
- Start by using interventions that work across all four action areas.
- Over time, increase investment in socioeconomic factors for the greatest impact on health and well-being for all.

Four ACTION Areas

SOCIOECONOMIC FACTORS

PHYSICAL ENVIRONMENT

HEALTH BEHAVIORS

CLINICAL CARE

VISIT www.cdc.gov/CHInav FOR TOOLS AND RESOURCES TO IMPROVE YOUR COMMUNITY'S HEALTH AND WELL-BEING

CDC

NATIONAL PREVENTION STRATEGY

Robert Wood Johnson Foundation

MARCH 2015

Source: https://www.cdc.gov/chinav/index.html

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Developing the Implementation Plan
Association for Community Health Improvement

1. Engage strategic partnerships both within the hospital and with external stakeholders

2. Align strategies with the hospital and other community stakeholder organizations (Population Health, Public Health Initiatives, etc.)

3. Consider the Collective Impact Framework

4. Determine your community assets

- Don't duplicate services or programs
- Develop an asset map

Collective Impact Framework

1. Participants have a common agenda with a joint approach for solving an agreed-upon problem
2. Data and results are measured consistently across participants
3. Action plans have mutually reinforcing activities
4. Open communication is necessary to build trust and ensure mutual objectives
5. A backbone organization coordinates the collaborative effort

The Health Needs identified in your CHNA are likely the result of complex social, economic and environmental factors, making Collective Impact an appropriate model to apply to your implementation strategies.

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Developing the Implementation Plan
Association for Community Health Improvement

5. Identify the drivers of community health improvement

6. Select strategies to address priority needs

- Type of Strategy
  - Practice (way of doing something) – (more sustainable)
  - Intervention (program or initiative)
- Level of Intervention
  - Primary: Targeting an entire population
  - Secondary: Targeting at-risk populations
  - Tertiary: Treating individuals diagnosed with the problem

7. Identify interventions with evidence of success

- What has been successful in the past?
- What does the research suggest is most effective?
- What is feasible to be implemented in our situation and circumstances?
- What research is appropriate to replicate?

The Guide to Community Preventive Services (The Community Guide)

CDC Community Health Improvement Navigator

Examples later!

CDC's 6/18 Initiative: Accelerating Evidence into Action (Targets six common health issues with 18 proven strategies)

County Health Rankings and Roadmaps: What Works for Health

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Developing the Implementation Plan
Association for Community Health Improvement

8. Assess the impact the strategies would have on health in your community

9. Set goals and objectives for implementation strategies
   - **S**pecific
   - **M**easurable
   - **R**ealistic
   - **T**ime-bound

10. Tailor strategies to community culture

11. Consider evaluation from the start

12. Identify funding sources and opportunities

13. Document the implementation strategies

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Interventions with Evidence of Success CDC Community Health Navigator

The database includes seven Target Risk Factors that are related to the leading causes of illness and death in the United States:

- Tobacco Use and Exposure
- Physical Inactivity
- Unhealthy Diet
- High Cholesterol
- High Blood Pressure
- Diabetes
- Obesity

https://www.cdc.gov/chinav/docs/chi_nav_factsheet_database.pdf

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CDC Community Health Navigator

Target Risk Factors
- ❑Tobacco Use and Exposure
- ❑Unhealthy Diet
- ❑High Blood Pressure
- ❑Obesity
- ❑Physical Inactivity
- ❑High Cholesterol
- ❑Diabetes

Target Populations
- ❑Racial/Ethnic Minorities
- ❑Children/Adolescents
- ❑Adults
- ❑Men
- ❑Urban
- ❑Low Income
- ❑Families
- ❑Older Adults
- ❑Women
- ❑Rural

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CDC Community Health Navigator

Target Outcomes or Indicators

- ❑Tobacco Use & Exposure
- ❑Healthy Food/Beverage Intake
- ❑Blood Pressure
- ❑Body Mass Index / Weight
- ❑Mortality

Intervention Settings/Locations

- ❑Business / Worksite
- ❑Childcare Facility
- ❑Community
- ❑Clinic
- ❑Telehealth
- ❑School
- ❑Faith-Based Setting
- ❑Pharmacy
- ❑Hospital

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CDC Community Health Navigator

Intervention Types

- ❑Access to Care
- ❑Disease Management
- ❑Education
- ❑Point-of-Decision Prompt
- ❑Healthy Food/Beverage Provision
- ❑Media/Marketing
- ❑Policy
- ❑Screening
- ❑Counseling
- ❑Program
- ❑Financial Incentive/Offset Costs
- ❑Campaigns
- ❑Changing Physical Environment

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CDC Community Health Navigator

Assets: People or Organizations

- ❑Residents/Community Health Workers
- ❑Payors/Insurers
- ❑Policymakers/Local Council Members
- ❑Voluntary Associations
- ❑Hospitals/Clinicians/Healthcare workers
- ❑Health Department/Public Health Officials
- ❑Local Businesses/Nonprofit Organizations
- ❑Researchers/Evaluators

Assets: Physical or Virtual Space

- ❑Local Institutions
- ❑Website/Community List Serve
- ❑Transportation
- ❑Parks/Community Common Space
- ❑Media: Radio/Tv/Print
- ❑Housing Development/Urban Planning

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CDC Navigator Reviews and Studies

Reviews

Summary recommendations based on systematic review or synthesis of current evidence from multiple studies and other evidence-based sources

Individual Studies

Scientific evaluation of the efficacy of an intervention in a single study

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CDC Study Example

INDIVIDUAL STUDY

Community-Based Multiple Risk Factor Intervention for Cardiovascular Risk

Individual Study Details: Community-Based Multiple Risk Factor Intervention for Cardiovascular Risk

Individual Study Source: Healthy Communities Institute

DESCRIPTION

This program is a community-based multiple risk factor intervention on cardiovascular risk in African American families with a history of premature coronary disease. This program targets the siblings of an individual diagnosed with coronary heart disease under age 60. Participants in the program have a physical examination and medical history taken by a cardiologist. During community-based care visits at an easily accessible nonclinical site, a nurse practitioner performs physical assessments, evaluates patients for pharmacotherapy, and monitors compliance. A community health worker provides dietary counseling, smoking cessation support, and exercise counseling, with follow-up telephone interventions available. Participants requiring pharmacotherapy are given a pharmacy charge services card that allows them to obtain risk factor therapy prescriptions free of charge at any pharmacy. Sibling participants can also attend 2 free exercise sessions per week at the YMCA.

ACTION Areas

- Health Behaviors
- Clinical Care

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Interventions with Evidence of Success CDC 6/18 Initiative

In the 6|18 Initiative, CDC and partners are targeting six common and costly health conditions with 18 proven interventions.

- CDC is collaborating with partners – like healthcare providers, public health workers, insurers, and employers who purchase insurance – to improve health and control healthcare costs by:
- Giving partners rigorous evidence about high-burden health conditions and related interventions.
- Highlighting disease-prevention interventions to increase their coverage, use, and quality.
- Aligning proven preventive practices with value-based ways of paying for healthcare.
- With this information, partners can make decisions that improve people's health and help control costs.

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CDC 6/18 Initiative

Reduce Tobacco Use

- Increase access to tobacco cessation treatments, including individual, group, and telephone counseling, and Food and Drug Administration-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guidelines and the 2015 U.S. Preventive Services Task Force recommendations).
- Remove barriers that impede access to covered cessation treatments, such as cost-sharing and prior authorization.
- Promote increased use of covered treatment benefits by tobacco users.

Control High Blood Pressure

- Implement strategies that improve adherence to anti-hypertensive and lipid-lowering prescription medications via expanded access to:
  - low cost medication copayments, fixed dose medication combinations, and extended medication fills;
  - innovative pharmacy packaging;
  - improved care coordination using standardized protocols, primary care teams, medication therapy management programs, and self-monitoring of blood pressure with clinical support.
- Provide home blood pressure monitors to patients with high blood pressure and reimburse for the clinical support services required for self-measured blood pressure monitoring.

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CDC 6/18 Initiative

Prevent Unintended Pregnancy

- Reimburse providers for the full range of contraceptive services (e.g., screening for pregnancy intention; counseling; insertion, removal, replacement, or reinsertion of long-acting reversible contraceptives, and follow-up) for women of childbearing age.
- Reimburse providers for the actual cost of FDA-approved contraceptive methods.
- Unbundle payment for long-acting reversible contraceptives from other postpartum services.
- Remove administrative barriers to receipt of contraceptive services (e.g., pre-approval step therapy restriction, barriers to high acquisition and stocking costs).

Control Asthma

- Use the 2007 National Asthma Education and Prevention Program as clinical practice guidelines.
- Promote strategies that improve access and adherence to asthma medications and devices.
- Expand access to intensive self-management education by licensed professionals or qualified lay health workers for patients whose asthma is not well-controlled with medical management.
- Expand access to home visits by licensed professionals or qualified lay health workers to provide intensive self-management education and reduce home asthma triggers for patients whose asthma is not well-controlled with medical management and self-management education.

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CDC 6/18 Initiative

Improve Antibiotic Use

- Require antibiotic stewardship programs in all hospitals and skilled nursing facilities, in alignment with CDC's Core Elements of Hospital Antibiotic Stewardship Programs and The Core Elements of Antibiotic Stewardship for Nursing Homes.
- Improve outpatient antibiotic prescribing by incentivizing providers to follow CDC's Core Elements of Outpatient Antibiotic Stewardship.

Prevent Type 2 Diabetes

- Expand access to the National Diabetes Prevention Program, a lifestyle change program for preventing type 2 diabetes.

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Building the Implementation Plan

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Look at the Data

Healthy People 2020: Obesity in Adults (NWS-9)

Healthy People 2020 objective NWS-9 tracks the proportion of adults with obesity (BMI ≥ 30).

- HP2020 Baseline: In 2005–2008, the rate of obesity was 33.9% among adults aged 20 years and over (age adjusted).
- Most Recent: In 2013–2016, the rate of obesity was 38.6% among adults aged 20 years and over (age adjusted).

- Males aged 20 years and over had a lower rate of obesity than females (36.5% versus 40.5%, age adjusted) in 2013–2016. The rate for females was 11.0% higher than that for males.

- Among racial and ethnic groups, the non-Hispanic Asian population had the lowest (best) rate of obesity, 12.5% of adults aged 20 years and over (age adjusted) in 2013–2016. Rates (age adjusted) for other racial and ethnic groups were:
  - 48.0% among the non-Hispanic black population; more than 3.5 times the best group rate
  - 44.9% among the Hispanic population; more than 3.5 times the best group rate
  - 37.1% among the non-Hispanic white population; 3 times the best group rate

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Look at the Data

Indicator	County
Adult BMI 25 or higher (Overweight/Obese)	64.0%
Adult BMI 30 or higher (Obese)	26.0%
Adult (SNAP-Ed eligible) BMI 25 or higher (Overweight / Obese)	57.0%
Adult (SNAP-Ed eligible) BMI 30 or higher (Obese)	26.0%
Indicator	**Rural Health Clinic / Public Health**
Females (SNAP-Ed eligible) with a BMI 25 or higher (Overweight / Obese)	64.0%
Females (SNAP-Ed eligible) BMI 30 or higher (Obese)	36.0%

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Problem – Goal – Partners – Population(s)

Opportunity	Goal	Partners	Population(s)
26% of adults, 36% of females and 43% of Hispanic females over the age of 20 who receive SNAP-ED have a BMI greater than 30	Reduce the percent of Hispanic females over the age of 20 who receive SNAP-ED and have a BMI greater than 30 from 43% to 40% by 2024	Public Health Food Banks in Thurston County Parks & Recreation	Hispanic Females over the age of 20 who receive SNAP-ED Zip code 98501 Patients of Rural Health Clinic

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Identify Drivers (Reasons)

Opportunity	Goal	Partners	Population(s) Zip Code(s)	Drivers			
				Socioeconomic	**Physical Environment**	**Health Behaviors**	**Clinical Care**
26% of adults, 36% of females and 43% of Hispanic females over the age of 20 who receive SNAP-ED have a BMI greater than 30	Reduce the percent of Hispanic females over the age of 20 who receive SNAP-ED and have a BMI greater than 30 from 43% to 40% by 2024	Public Health Food Banks in Thurston County Parks & Recreation	Hispanic Females over the age of 20 who receive SNAP-ED Zip code 98501 Patients of Rural Health Clinic	• Cost of healthy food • Lack of time to prepare healthy food	• Lack of outdoor recreation • Lack of green space • Food Desert	• Diet high in sugar • Failure to follow-thru on provider recomme-ndations	• Lack of counseling / referral by providers • Lack of appointment times with dietitian

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Root Cause

Opportunity	Goal	Partners	Population(s) Zip Code(s)	Drivers			
				Socioeconomic	**Physical Environment**	**Health Behaviors**	**Clinical Care**
26% of adults, 36% of females and 43% of Hispanic females over the age of 20 who receive SNAP-ED have a BMI greater than 30	Reduce the percent of Hispanic females over the age of 20 who receive SNAP-ED and have a BMI greater than 30 from 43% to 40% by 2024	Public Health Food Banks in Thurston County Parks & Recreation	Hispanic Females over the age of 20 who receive SNAP-ED Zip code 98501 Patients of Rural Health Clinic	• Cost of healthy food • Lack of time to prepare healthy food	• Lack of outdoor recreation • Lack of green space • Food Desert	• Diet high in sugar • Failure to follow-thru on provider recommend-dations	• Lack of counseling / referral by providers • Lack of appointment times with dietitian
Ask WHY 5 times				**WHY WHY WHY WHY WHY**	**WHY WHY WHY WHY WHY**	**WHY WHY WHY WHY WHY**	**WHY WHY WHY WHY WHY**

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Maybe One Reason Why!

In a major 2012 study of over 2,200 physicians, for example, researchers found that most doctors harbor significant prejudice against patients with obesity. When researchers surveyed almost 2,500 people about weight discrimination, women reported that doctors were the most common source of stigma about their weight.

And when patients feel judged, they may not trust their doctors — and get the health care they need. Not only are we doctors doing a lousy job helping our patients lose weight, but also our stigmatizing behavior may stop patients with obesity from getting other preventative care.

Teen girls with obesity, for example, are less likely to get the HPV vaccine than normal-weight teens, according to a study published in January 2019. This puts them at an increased risk for cervical cancer. When asked what they would do if a doctor described their child's weight in a stigmatizing way, nearly a quarter of parents in a 2011 study said they would simply avoid future medical appointments.

…..participants didn't want their doctors to use words like "obese," "fat" or "extremely obese." Terms like "unhealthy weight" or "high body mass index," however, were more acceptable to families.

Mara Gordon, Family Physician
Health and media fellow at NPR & Georgetown University School of Medicine

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Language Matters

The American Medical Association passed a resolution in 2017 designed to teach health care providers to use "people-first language" that "places the person before the disability or disease." This means, for example, describing a "patient with obesity" rather than an "obese patient."

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Example

Goal: Reduce the percent of Hispanic females over the age of 20 who receive SNAP-ED and have a BMI greater than 30 from 43% to 40% by 2024

Strategies

1. Identify Hispanic female patients with a BMI greater than 30 who are interested in weight loss
2. Provide culturally appropriate education, resources and interventions
3. Educate providers and staff regarding culturally competent care related to weight loss

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Action Plan

1. Identify Hispanic female patients with a BMI greater than 30 who are interested in weight loss			
What	**Who**	**By When**	**Target**
BMI will be calculated for female patients over the age of 20 at every clinic visit	Clinic Nurse	October 1	95%
Patients will be asked if they would like help for their "unhealthy weight" or "high body mass index" by the provider	Provider	October 1	95%
Patients who indicate they are interested in weight loss will receive a follow-up phone call or visit by a Registered Dietitian to discuss weight loss goals and to develop an individualized plan	Dietitian	October 1	95%
Patients who indicate that they are not interested in weight loss will be provided a brochure with information in case they should be willing to discuss weight loss at a later time	Provider or Clinic Nurse	October 1	95%

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Example

2. Provide culturally appropriate education, resources and interventions			
What	**Who**	**By When**	**Target**
Develop and Implement a CDC-Recognized Lifestyle Change Program (Evidence-Based)	Public Health	January 1	100%
Weight loss printed material will be revised, written at the 5th grade level, and printed in English and in Spanish	Public Health	November 1	95%
Food Pantry will highlight healthy foods along with recipes	Food Pantry Dietitian	November 1	95%
Dietitian will be available at food bank two times monthly	Dietitian	November 1	95%
Cooking classes will be held at Food Bank monthly	Dietitian	November 1	95%

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Example

3. Educate providers and staff regarding culturally competent care related to weight loss			
What	**Who**	**By When**	**Target**
All providers and clinic staff will receive a 2-hour educational class at least annually on weight-loss, culturally competent care and CDC Lifestyle change program	Public Health Educator	October 1	95%
Providers and Clinic Staff will receive quarterly reports for each patient in their practice regarding weight loss goals	Dietitian	March 1	95%

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Health

Health is living long and well. It's where we live, work, learn, and play. It's opportunity—for all of us—to strive and thrive.

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care

Health disparities are differences in health or in the key determinants of health, such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

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Final Thoughts

- ✓ A CHNA IS A POPULATION HEALTH STRATEGY
- ✓ Collaborate
- ✓ Leverage
- ✓ Set realistic - but measurable - goals
- ✓ Designate an Owner / Champion for each initiative
- ✓ Ongoing process - not a one-time exercise
- ✓ Report to the governing board at least twice per year
- ✓ Report to the community at least 1 – 2 times per year

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Community Health Needs Assessment Process HealthTechS3

1. Strategy and Planning
2. Qualitative Data Collection and Analysis
3. Quantitative Data Collection and Analysis
4. Facilitation to Develop Priority Community Health Needs
5. Development of Multi-Year Implementation Plan

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HealthTechS3
Value Proposition

- Alignment with your strategic plan and population health strategies
- Diligent research to find the most current data available
- Emphasis on social determinants of health and health disparities
- Highly interactive – it's your plan
- Realistic and actionable goals – not just a paper process
- 3-year follow-up and support
- Compliant with IRC 501(r)

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I hope this information has been helpful

Please contact me if you are interested in a proposal for a Community Health Needs Assessment - or - have questions about the presentation

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