

2015 COMMUNITY
HEALTH NEEDS
ASSESSMENT:
**IMPLEMENTATION
PLAN**

October 16, 2015



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2015 Community Health Needs Assessment: Implementation Plan

Introduction

Evangelical Community Hospital, a 132-bed community hospital located in Lewisburg, Pa., in response to its community commitment, contracted once again with Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The community health needs assessment was conducted between October 2014 and March 2015. As a partnering hospital of a regional effort to assess community health needs; Evangelical Community Hospital collaborated with Geisinger Health System and outside organizations in the surrounding region (Juniata, Lycoming, Northumberland, Snyder, and Union Counties) to conduct a detailed community health needs assessment.

2015 Community Health Needs Assessment Planning

In October 2014, Evangelical Community Hospital and Geisinger Health System led the efforts to develop a region health needs assessment. The collaborative also included the following community non-profit organizations located in the surrounding five-county region: Columbia, Montour, Northumberland, Snyder, and Union counties (additional organizations from Juniata and Lycoming counties also provided input for the purpose of the Evangelical service area needs assessment):

- A Community Clinic
- Central PA Food Bank
- CMSU
- Evangelical Community Hospital
- Family Health Council of Central PA-Selinsgrove
- Geisinger Health System
- Greater Susquehanna Valley United Way
- Greater Susquehanna Valley YMCA
- HandUP Foundation
- Higher Hope h2 Church
- Juniata County
- Middlecreek Area Community Center
- PA Dept. of Health
- PA Office of Rural Health
- Penn State Cooperative Extension
- Shikellamy School District
- Snyder County Children and Youth Services
- Snyder/Union Community Action Agency
- St. Paul's UCC
- SUM Child Development Center

- Sunbury YMCA
- Susquehanna University
- Union-Snyder Agency on Aging Inc.
- Williamsport/Lycoming Chamber of Commerce

The Community Health Needs Assessment and this implementation plan fulfill the requirements of the Internal Revenue Code 501(r)(3); a statute established within the Patient Protection and Affordable Care Act (ACA) requiring that non-profit hospitals conduct community health needs assessments every three years and develop an implementation plan to guide its community benefit efforts. The 2015 CHNA was the third community health needs assessment conducted by the Hospital since 2009.

The goal of the 2015 CHNA was to:

- Assure that community members, including underrepresented residents and those with a broad-based racial/ethnic/cultural and linguistic background are included in the needs assessment process. In addition, educators, health-related professionals, media representatives, local government, human service organizations, institutes of higher learning, religious institutions, and the private sector will be engaged at some level in the process.
- Obtain statistically valid information on the health status and socio-economic/environmental factors related to the health of residents in the community and supplement general population survey data that is currently available.
- Develop accurate comparisons to the state and national baseline of health measures utilizing most current validated data. (i.e., 2013 Pennsylvania State Health Assessment).
- Utilize data obtained from the assessment to address the identified health needs of the service area.
- Provide recommendations for strategic decision-making regionally and locally to address the identified health needs within the region to use as a baseline tool for future assessments.
- Developing a CHNA document as required by the Patient Protection and Affordable Care Act (ACA).

Key data sources for the CHNA included: 1) Community health assessment planning; 2) Secondary data; 3) Trending from 2012 community health needs assessment; 4) Interviews with key community stakeholders; 5) Survey of vulnerable populations; 6) Identification of top community health needs; 7) Public comment regarding the 2012 CHNA and implementation plan and; 8) Final Community health Needs Assessment report

Key Community Health Needs

From the review and analysis of key data sources, the following four health needs were identified as top priorities.

- Behavioral health and substance abuse
- Health concerns related to lifestyle
- The impact of socio-economic status on health outcomes

- Access to healthcare

I. Behavioral health and substance abuse

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders, and resident survey respondents:

- Affordable behavioral healthcare options are needed to meet behavioral health needs
- Care coordination is needed among behavioral health, substance abuse, primary care/medical providers
- There are not enough providers to meet the demand and the spectrum of services available in most areas are not comprehensive enough to treat the individual needs
- Substance abuse services are necessary due to the prevalence of substance abuse in local communities
- Residents with a history of behavioral health and/or substance abuse needs often have poor treatment outcomes

Evangelical's Response:

1. Increase care coordination for patients with behavioral health and/or substance abuse needs through screening and referral to internal and/or external behavioral health and/or substance abuse service providers.
2. Collaborate with area agencies to offer the evidence-based strengthening families program PROSPER. PROSPER is a seven-week, interactive program to assist families in reduction of aggressive behaviors, likelihood of substance abuse and tobacco use, increase stress management, and conflict resolution.
3. Support and refer to the Celebrate Recovery program, a 12 step faith-based program to address all types of problems and addictions. Inform and educate all EMSO physician offices, social services, and nursing staff about the program and the referral process.
4. Evaluate the current tele-psychiatric program in-house and through the emergency department, research additional resources and vendors to expand current services to meet the growing demand.
5. Support and participate in the efforts by Communities that Care (CTC) to improve awareness and quality of life for kids in our service area.
6. Develop a regional behavioral health action group to discuss on going issues and concerns. Collaboratively develop policies and procedures among our agencies to better serve the behavioral health and substance abuse population.
7. Work with local law enforcement to deliver the Opioid overdose reversal project in our service area. Secure funding and educate the community.

Timeline/Steps to completion:

December 30, 2015

1. Complete Hospital's Action Plan

July 1, 2016-June 30, 2017

1. Begin execution of Action Plan
2. Secure new tele-psychiatric vendor and have new services in place
3. Establish baseline volumes of patients with behavioral health and/or substance abuse needs through use of screening tools
4. Track referrals for identified patients to internal and/or external behavioral and/or substance abuse services
5. Develop regional behavioral health/substance abuse action group and establish regular meetings
6. Secure funding for a mobile screener
7. Research the opportunity to offer the PROSPER program to an area school district in need
8. Disseminate Opioid overdose reversal kits to law enforcement and safety and security at local colleges and universities.
9. Evaluate the Plain Community program and adjust pricing as needed
10. Establish an annual meeting for participants of plain community program and key hospital representatives
11. Serve on the Communities that Cares board for the Selinsgrove, Shikellamy, and Milton Area school districts.
12. Continue our collaborative efforts with Brighter Dawn clinic by providing primary care support and skill development and education to the Plain Community.
13. Continue to grow our Hospital to Home, para-medicine program to reach an additional demographic each year.

July 1, 2017-June 30, 2018

1. Secure funding for PROSPER program
2. Continue to meet regularly with the behavioral health action group
3. Evaluate new tele-psychiatric program and determine if additional services are needed.
4. Compile summary data to demonstrate needs, frequency of referrals, and unmet needs
5. Monitor frequency of referrals to internal/external behavioral health and/or substance abuse services

6. Provide education to family/friends of at risk persons, local school districts and primary care on what the program is, how it works, and training on how to administer the reversal drug
7. Research additional services for the Plain Community program not offered through ECH, i.e. Home Health
8. Purchase a mobile medical unit. Begin to develop programming and identify locations in need of an on-site screening opportunity
9. Serve on the Communities that Cares board for the Selinsgrove, Shikellamy, and Milton Area school districts
10. Increase program services for the Plain Community program, increase the number of groups utilizing the program, and increase the number of services provided through the program

July 1, 2018-June 30, 2019

1. Increase behavioral health credentialed medical staff at ECH
2. Pilot program established in EMSO for prescribing Opioid overdose reversal kit - Naloxone
3. Establish a pilot site to offer the PROSPER program
4. Continue to meet regularly with the behavioral health action group
5. Serve on the Communities that Cares board for the Selinsgrove, Shikellamy and Milton Area school districts.

Venues: Evangelical Community Hospital, ECH Community Health & Wellness Center, ECH EMSO offices, ECH Emergency Department, ECH Case management, CMSU, White Deer Run treatment Center, Geisinger Health System, Gaudenzia drug and alcohol services, local law enforcement, safety and security at local colleges and universities, local school districts, Penn State Cooperative Extension

Intended Outcome: To improve the care coordination of community members with behavioral health and/or substance abuse issues or concerns.

Measurement:

- 1) Baseline volume of patients with behavioral health issues
- 2) Completion of assessment of services
- 3) Increase behavioral health credentialed medical staff at ECH
- 4) New tele-psychiatric vendor secured and new services in place
- 5) From data and utilization determine effectiveness of services as well as need for expansion of tele-psychiatric services
- 6) Establish a behavioral health work group comprised of CMSU and hospital representatives to address the current needs and develop policies and procedures to better serve this population
- 7) Expansion of tele-psychiatric services as necessary from utilization data
- 8) Purchase of mobile screener

- 9) Offer the PROSPER program in at least one school district in our service area
- 10) Have the Opioid Overdose Reversal program integrated into our community at the law enforcement level, local colleges, and universities and primary care facilities
- 11) Well established behavioral health action group meeting on a regular basis
- 12) Established annual meeting for the Plain community program with current and potential members and key Evangelical Hospital leaders.

II. Reducing the impact of health concerns related to lifestyle

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders, and resident survey respondents:

- Residents need to increase the access and use of healthy options
- Lifestyle has a negative impact on health outcomes

Evangelical's response:

1. Continue to offer a variety of educational programming for the youth in the community at no cost. Evangelical Community Hospital offers a wide variety of educational programs geared toward healthy eating, hygiene, staying active, and living tobacco free. These programs will be offered within our service area and will specifically target local school districts. Additional programming will be added for specific identified populations, i.e. preschools, YMCA's, and other facilities as requested.
2. Continue to offer and improve upon our internal worksite wellness program to improve the health and wellness of our hospital employees and their family members.
3. Continue to increase our external worksite wellness program by adding additional program offering and increasing the number of businesses we work with in our service area.
4. Serve on the North Central Tobacco Coalition. Continue to support efforts and programs to decrease the number of smokers in our service area.
5. Continue to offer the Low Dose CT scans for patients who meet the criteria.
6. Continue to offer tobacco cessation program Freedom from Smoking.
7. Continue to offer the Youth development and educational program, Eat Well, Play Well, Be Well to area youth ages 11-15.
8. Offer free or low-cost adult based programming that will promote a healthy lifestyle and provide educational resources: quarterly healthy eating seminars/demonstrations, group strength training classes, Yoga, Senior Strong program, and strong collaborations with area agencies to assist with educational programming, i.e. Area Agency on Aging, Penn State Cooperative Extension, YMCA, etc.

9. Offer a comprehensive diabetes clinic with a plan to employ an Endocrinologist.
10. Participate in the American Cancer Society Colorectal screening initiative, 80% by 2018.
11. Continue to offer a variety of free or low-cost health screenings to improve awareness and education on “Knowing Your Numbers” and talking with your healthcare provider about your results and how you can improve or reduce your risk factors.

Timeline/Steps to completion:

December 30, 2015

1. Complete Hospital’s Action Plan

July 1, 2016-June 30, 2017

1. Develop Know Your Numbers/Talk to Your Doc educational materials and presentation
2. Evaluate current youth programs, update educational materials, and add additional information related to program content. Develop one new outreach program related to behavioral health/substance abuse issues
3. Offer in collaboration with the American Cancer Society one colorectal screening event to encourage screening and educate community on importance of routine screening
4. Schedule adult health and wellness educational programming monthly
5. Evaluate low dose CT scan program. Determine changes to program deployment and policy and procedural adjustments
6. Begin educational outreach to providers in and out of the Evangelical network related to the low dose CT scan program
7. Add one new worksite wellness program directly related to lifestyle improvement

July 1, 2017-June 30, 2018

1. Collaborate with primary care providers, private practices, and the American Cancer Society to reach the goal of 80% of our patients screened for colorectal cancer
2. Complete construction on the new Diabetes clinic and additional programming developed
3. Complete first round of educational outreach to providers about the low dose CT scan program

July 1, 2018-June 30, 2019

1. Finalize employment of an Endocrinologist or an independent Endocrinologist with privileges at our facility
2. Expand low dose CT scan program to meet any additional needs as determined through evaluation and volumes

3. Add two new worksite wellness clients

Venues: Evangelical Community Hospital, Community Health and Wellness Department, Evangelical EMSO providers, Family Practice Center, local school districts, Greater Susquehanna Valley YMCA (Milton and Sunbury locations), Area Agency on Aging, Penn State Cooperative Extension, Chamber of Commerce, various preschool facilities, boroughs, townships, counties, news media, and social media

Intended Outcomes: To support and educate Evangelical's service area on improving healthy behaviors and health outcomes by providing free or low cost screenings and education on importance of screening compliance, healthy eating, staying active, and living tobacco free.

Measurement:

- 1) A new youth educational program related to behavioral health/substance abuse developed and offered to local community agencies and school districts
- 2) A new educational program developed to assist screening participants to understand their "numbers" and how to discuss lifestyle changes or health options with the healthcare provider
- 3) A colorectal screening event in cooperation with the American Cancer Society and their initiative of **80% by 2018**
- 4) Completion of new Outpatient Clinic with a comprehensive diabetes clinic
- 5) An employed Endocrinologist or one working with privileges for the needs of our diabetic patients
- 6) Additional diabetes educational programs developed

III. Increasing access to healthcare

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders, and resident survey respondents:

- Provider to population ratios that are not adequate enough to meet the need
- Limited access to healthcare as a result of the location of providers coupled with transportation issues
- Need to increase of awareness and care coordination

Evangelical's response:

- 1) Continue to provide free or reduced-fee mammography and diagnostic imaging for the un/underinsured population.
- 2) Continue to offer a variety of health screening programs for the community at minimal or no cost. Currently, Evangelical Community Hospital offers a wide variety of health screens within our service area specifically targeted to under and uninsured community members.
- 3) Work directly with our EMSO providers to refer patients to our health education and screening programs as well as offering screening programs on-site at EMSO offices.

- 4) Continue to develop and expand our Community Health Coalition. Invite additional community agencies to assist with meeting the issues surrounding access, i.e. transportation, behavioral health, substance abuse, etc.
- 5) Add an urgent care clinic to assist with access issues and overcrowding of Emergency Department
- 6) Add a mobile medical unit to assist with providing care to individuals and communities in rural areas where transportation is a barrier to care.
- 7) Continue with current provider recruitment efforts to employ necessary specialty and primary care providers to maintain or improve provider to patient ratios.

Timeline/Steps to completion:

December 30, 2015

1. Complete Hospital's Action Plan

July 1, 2016-June 30, 2017

1. Identify additional community agencies as necessary/potential partners of the community health coalition
2. Continue mammography screening program for un/under insured patients continues
3. Educate our EMSO providers of Community Health and Wellness programs, events and screenings offered
4. Evaluate current health screenings being offered and determine need for additional or discontinuation of screening programs, i.e. skin, prostate, etc.
5. Continue to offer free or reduced fee mammography

July 1, 2017-June 30, 2018

1. Open urgent care clinic
2. Secure funding for mobile screener secured

July 1, 2018-June 30, 2019

1. Purchase a mobile screener unit. Begin to develop programming and identify locations in need of on-site screening opportunity
2. Employ an Endocrinologist finalized or an independent Endocrinologist with privileges at our facility

Venues: Evangelical Community Hospital, Community Health and Wellness Department, Evangelical EMSO providers, Family Practice Center, Evangelical Managed Care, Finance and Patient Access departments, various community action agencies, CBH and the Cancer service line, boroughs, townships, counties, news media, and social media

Intended Outcomes: To assist and educate the public, especially those who are un/underinsured on ways in which to access healthcare, as well as available and affordable options.

Measurement:

- 1). Secure an employed Endocrinologist or have one working with privileges for the needs of our diabetic patients
- 2) Purchase a mobile medical unit
- 3) Open urgent care clinic
- 4) Employ an Endocrinologist or private endocrinologist provider with Evangelical privileges
- 5) Meet with EMSO leadership and office supervisors to provide education of programming available to patients through Community Health and Wellness department and collaborations
- 6) Continuation of free or reduce fee mammography program
- 7) Identify additional screening opportunities

IV. The impact of socio-economic status on health outcomes

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders, and resident survey respondents:

- Residents need solutions that reduce the financial burden of health care
- Poverty increases the barriers to accessing healthcare.

As a healthcare organization we will not be responding directly to this identified need as a stand-alone issue, but address it within all three of the aforementioned needs. Through the organizational efforts of the hospital and collaborating agencies, Evangelical can assist with addressing the impact of socio-economic status by:

- 1) Offering educational programming to increase awareness for health insurance options – on going
- 2) Improving health outcomes through free or low cost screenings and education – on going
- 3) Offering a financial assistance program that will assist patients with financial burdens related to healthcare costs – on going
- 4) Opening an urgent care clinic - 2017
- 5) Purchasing a mobile medical unit will allow healthcare to be delivered to pockets of poverty in our community 2018

2015 Community Health Needs Assessment

Evangelical Community Hospital in compliance with federal statutes outlined in PPACA will conduct a community health needs assessment every three years. Planning for the next needs assessment will commence in late 2017 and the assessment will be completed in 2018.

Closing

Evangelical Community Hospital takes seriously its mission as a community provider and seeks to be a source that Valley residents can look to when needing healthcare, health education, and wellness/preventative resources. As a community hospital, the Hospital's outreach to the un/underinsured has been ongoing and steadfast in its approach. More than \$29M in uncompensated care was provided in fiscal year 2015 and that number continues to grow in 2013