KETTERING BEHAVIORAL MEDICINE CENTER Implementation Strategies 2017 – 2019

Mission & Vision

Our Mission:
To improve the quality of life of the people in the communities we serve through health care and education.

Our Vision:
Kettering Health Network will be recognized as the leader in transforming the health care experience.

Our Values:
- Trustworthy
- Innovative
- Caring
- Competent
- Collaborative

Communities Served
Montgomery and Warren Counties in Ohio

Prioritization of CHNA Community Health Needs

Criteria
Toby Taubenheim, Director, Behavioral Health, scored the community health needs identified in the Community Health Needs Assessment (CHNA) by considering the following criteria:

- Cause of hospitalization/Emergency Department visits (based on hospital utilization data from the Ohio Hospital Association)
- Feasibility and effectiveness of interventions (per The Community Guide; CDC recommendations; and/or recommendations from hospital physicians and/or leaders)
- Hospital's ability to impact effectively (already positioned to make a difference; and/or addressing issue in strategic or community plan)
- Impact on other health outcomes (based on risk factors associated with issue)
- Importance placed by community (based on community priorities in CHNA report)
- Measurable outcome exists (based on CHNA's data sources)
- Opportunities for meaningful collaboration (with current or potential community partners)
- Severity and proportion of population impacted (per incidence rate of new cases; prevalence rate; mortality rate; and/or top cause of death)

- Significant health disparities (by geographic areas of disparity measured by Community Need Index score and/or health issues identified in 2011 and 2013 CDC reports)
- Societal burden (based on education, observation, and/or experience of person scoring)
- Trend: Issue worse over time (based on up to 5 years' trend data collected for CHNA)

Prioritization Process

There were two meetings held with professional facilitation by a consultant, Gwen Finegan. Kettering Health Network held meetings on April 18 and April 27, 2016 for hospital leaders to convene, discuss, and determine the prioritization process. At a meeting on June 13, 2016 Toby Taubenheim scored the health issues according to criteria determined by consensus at the April meetings.

In order to determine the most significant priorities among all the CHNA issues, Kettering Behavioral Medicine Center used a grid with a scoring scale of 1 to 5. For the CHNA prioritization process, a low numerical score denoted that the criteria did not provide enough reasons to elevate an issue as a significant priority, while a high numerical score meant that the criteria gave evidence of an issue meriting 'high priority.' A blank scoring sheet is provided as an example.

Kettering Health Network's experience with both mental health and substance abuse also led their combination into one category, since mental health issues are a root cause for most substance abuse disorders.

Priority

- Mental health

Process for Strategy Development

PJ Brafford, Network Government Affairs Officer, and Lauren Day, Missions Coordinator, convened internal stakeholders to develop strategies. Strategies were discussed in two meetings to identify best-practice and evidence-based responses for the priority areas.

The initial meeting was held on August 3, 2016 and an additional meeting occurred on August 23, 2016. Both meetings were facilitated by an external consultant, Gwen Finegan, who also provided technical assistance in follow-up emails and phone calls. People contributing to strategy development included:

- Michele Garber, Administration
- Paul Hoover, Strategic Development, Kettering Health Network
- Beverly Knapp, Vice President, Health Outreach, Kettering Health Network
- Toby Taubenheim , Director, Behavioral Health, Kettering Behavioral Medicine Center

The hospital team consulted sources of information about effective strategies, including:

- The Centers for Disease Control and Prevention's (CDC) Community Guide
- CDC's Health Disparities and Inequalities 2011 Report and 2013 Supplement
- CDC's Winnable Battles
- Health Policy Institute of Ohio's Guide to Evidence-Based Prevention
- County Health Rankings & Roadmaps' "What Works for Health"
- U.S. Preventive Services Task Force of the Agency for Healthcare Research and Quality
- Montgomery County Community Health Improvement Plan

Overarching goals were identified to formulate strategies that

- Increased connections with community-based organizations,
- Reflected the values and best practices of Kettering Health Network, and
- Promoted alignment and integration with public health priorities and evidence-based approaches.

Teams finalized strategy measures and added resource information throughout August and September. Senior leaders at the hospital approved final versions before presenting the implementation strategies to the Board of Directors in November 2016.

The hospital provides services for vulnerable populations living in its community. Strategies, such as behavioral health screenings, will have a focus on people who have disproportionate risk of illness or complications because of their socioeconomic status and health disparities.

Strategies are contingent on community involvement and partnerships for their eventual success. Hospitals traditionally have not sought to share responsibility for health outcomes with external partners as much as these implementation strategies do. There is a degree of uncertainty about exactly how the collaborations will develop, but the potential of broad-based and tangible improvements is well worth the risk. This level of sharing is the only path forward to improve impact for individuals and for the health of community. With robust community partnerships, another advantage will be the ability to respond as new emerging issues surface.

Description of Strategies

A table with more details is provided on page 6. It includes information about measuring impact, timing, and resources to accomplish the activities.

Behavioral Health Screenings in Primary Care Clinics

Issues addressed: Mental health & Substance abuse
Intervention: Provide evidence-based screening tools to PCPs to improve identification of mental health issues and clinical treatment planning.
Background: National statistics forecast an 11% increase in the need for psychiatry/mental health services over the next four years. Acuity will also rise as more patients are managed through outpatient services. This intervention will provide various evidence-based behavioral health screening tools for primary care physicians to incorporate in their practice. There are 48 available screening tools. Examples include Zung Self-Rating Anxiety and Depression Scales; Alcohol Use Disorders Identification Test; Vanderbilt ADHD Diagnostic Parent Rating Scale.

Integration of Behavioral Health Services

Issues addressed: Mental health & Substance abuse
Intervention: Improve integration of behavioral health services in Primary Care Clinics with the addition of referrals by a social worker and evaluation by a nurse practitioner.
Background: Based on screening results, physicians will refer internally to a social worker for further evaluation and referral. A nurse practitioner will provide evaluation and medication management services. Network psychiatrists will be available via Tele-Medicine to provide consultation services as needed. The integration of behavioral health services will improve clinic operations; increase physician capacity to treat medical patients; reduce unnecessary ED visits; and improve the overall quality of patient care.

Potential partners for the two Behavioral Health interventions (described above): Primary Care physicians, Rural Primary Care clinic, Specialty physicians, Public Health departments, Mental health providers, Mental health specialists, ADAMHS Board, and local and/or state government.

Accountability

The Hospital President will be responsible for ensuring progress on the measures used to evaluate the impact of each strategy. Quarterly updates will ensure strategies stay on target. Annually hospital executive and board members will receive progress reports.

Significant Health Needs Addressed

Implementation Strategies, detailed on page 6, address the prioritized health need: Mental health.

Significant Health Needs Not Addressed

Not applicable.

__11___/__3___/___2016_____
Date approved by Kettering Health Network Board of Directors

Blank Scoring Sheet – CHNA Prioritization

Criteria	Access to care/ services	Cancer	Chronic disease	Diabetes	Heart disease	Infant mortality	Mental health/ Substance abuse	Obesity
Feasibility and Effectiveness of Interventions								
Cause of Hospitalization/ED Visits								
Impact on Other Health Outcomes								
Importance Placed by Community								
KHN/Hospital's Ability to Impact Effectively								
Measurable Outcomes								
Opportunities for Meaningful Collaboration								
Severity & Proportion of Population Affected								
Significant Disparities								
Societal Burden								
Trends: Issue Getting Worse over Time								
TOTAL								

Low				**High**
1	**2**	**3**	**4**	**5**
Not a Priority	**Low Priority**	**Mild Priority**	**Moderate Priority**	**High Priority**

Implementation Strategies

			Resources			
Priority Issue	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Mental health	Behavioral Health Interventions: 1) Behavioral Health Screenings in Primary Care Clinics 2) Integration of Behavioral Health Services	Provide evidence-based screening tools to Primary Care physicians (PCPs) to improve identification using objective data of mental health and substance abuse issues for clinical treatment planning. Year 1: 10% (HP2020 goal) of PCPs use screenings covered by insurance, Medicaid and Medicare to include substance abuse, depression, anxiety, ADHD, tobacco use plus other screening options. Years 2 & 3: Increase PCP use of screening tools, measured by number screened and number of participating practices. Advocate for increased funding for treatment, based on screening results. Utilize CNS Vital Signs Company for screening tools. Year 1: Determine clinic site locations for clinical Social Worker/Psychiatric Nurse Practitioner, and develop partnerships and funding models. Years 2 & 3: Establish location(s) and hire staff. Expand capacity to screen, diagnose, evaluate, and refer to treatment and include specialists.	Estimated labor cost = $21,939 in the first year.	Community Benefit Lead: 0.05 FTE; KBMC: 0.10 FTE; Network Physician Lead: 0.05 FTE; Sycamore Coordinator/ Lead: 0.05 FTE	Year 1: PCPs screen for depression, substance abuse, tobacco use, etc. Determine site locations with Kettering Physician Network (KPN) for behavioral health integration; approve staffing model & begin recruiting staff. Years 2 & 3: Increase in PCPs screening and number of screening tools used. Other regional providers collaborate in advocacy. Integrated model expands to include specialists.	Primary care physicians; Rural primary care clinics; Specialty physicians; Public Health Departments; Mental health providers; Mental health specialists; ADAMHS Board; local and/or state government