SOIN MEDICAL 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
Clark, Greene, and Montgomery Counties in Ohio

Prioritized List of CHNA Community Health Needs

Criteria
A hospital committee scored the community health needs identified in the 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 Soin Medical Center leaders 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, Soin Medical 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. In the CHNA cancer, diabetes, heart disease, and obesity were mentioned individually as well as mentioned within the broader category of chronic disease. During the prioritization process, these were considered both together and separately.

Priorities

- Obesity
- Diabetes
- Heart disease
- Mental health/Substance abuse

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:

- PJ Brafford, Network Government Affairs Officer, Kettering Health Network
- Jeff Brock, President, Foundation
- Sam Carr, Business Development
- Miriam Cartmell, Executive Director, Women's Services, Kettering Health Network
- Lara Chammas, Administration
- Ron Connovich, Vice President
- Lea Ann Dick, Director, Joslin Diabetes
- Rick Dodds, President
- Ervin Gruia, Business Development
- Paul Hoover, Strategic Development, Kettering Health Network
- Beverly Knapp, Vice President, Health Outreach, Kettering Health Network

- Robert Patterson, Corporate Integrity, Kettering Health Network
- Ron Swiger, Volunteers
- Toby Taubenheim, Director, Behavioral Health, Kettering Behavioral Medicine Center

The hospital team consulted, within Kettering Health Network, topic experts in Diabetes, Cardiovascular Health, Community Paramedicine, Substance Abuse, and Behavioral Health to further refine strategies. Other sources of information about effective strategies were:

- 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"
- The Joslin Diabetes Center
- U.S. Preventive Services Task Force of the Agency for Healthcare Research and Quality
- Montgomery County Community Health Improvement Plan
- Greene 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.

Several 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 pages 7-9. It includes information about measuring impact, timing, and resources to accomplish the activities.

TARGETED DISEASE PREVENTION & EDUCATION STRATEGIES

Community Cardiovascular Disease (CVD) Screenings & Education

Issue addressed: Heart disease
Intervention: Provide access to preventive clinical services with CVD screening and education.
Background: Guidelines emphasize the importance of identifying and treating all adults with, or at high risk for Cardiovascular disease. Identification of at-risk individuals should be a standard practice [Hobbs, F. D. R. (2004). Cardiovascular disease: different strategies for primary and secondary prevention? *Heart*, *90*(10), 1217–1223]. The intervention is intended to detect early CVD risk and improve heart health in the early treatable stages of the atherosclerotic process throughout the community. Historically an average of 39% of screenings at Kettering Health Network hospitals have been identified as high risk.

Potential partners: Benjamin and Marian Schuster Heart Hospital, Physicians, Firefighters/EMS, community-based organizations, parks, and the American Heart Association.

Partnership with Diabetes Prevention Programs

Issue addressed: Diabetes (and other chronic conditions such as Heart disease and Obesity]
Intervention: Refer to and/or partner with CDC's Diabetes Prevention Program offered by community-based organizations.
Background: A recommended intervention by the CDC, this approach offers combined diet and physical activity promotion programs to prevent Type 2 Diabetes among people at increased risk. A sliding scale and/or scholarship will make the program accessible to people of all incomes. Research demonstrated that "The incidence of diabetes was reduced by 58 percent with the lifestyle intervention and by 31 percent with metformin, as compared with placebo" [Diabetes Prevention Program Research Group. (2002). Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin. *N Engl J Med*; 346:393-403].
Potential partners: Joslin Diabetes Center, Public Health departments, YMCAs, Diabetes Dayton, and Good Neighbor House.

MENTAL HEALTH & SUBSTANCE ABUSE STRATEGIES

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 immediately above): Primary Care physicians, Primary Care clinics, Specialty physicians, Public Health departments, Mental health providers, Mental health specialists, ADAMHS Board, and local and/or state government.

CHRONIC DISEASE STRATEGIES

Tobacco Cessation

Issues addressed: Diabetes, Heart disease
Intervention: Implement initiative to decrease tobacco use.
Background: Comprehensive tobacco control programs have been recommended in 2014 in the CDC's Guide to Community Preventive Services [www.communityguide. org, accessed January 2016] and scientifically supported in 2014 in County Health Rankings & Roadmaps [www.countyhealthrankings.org, accessed February 2016]. Coordinated strategies are successful when they combine educational, clinical, regulatory, economic, and/or social approaches. The CDC states that smoking causes Type 2 diabetes and makes it more difficult to control. Smokers with diabetes have higher risk for serious complications such as heart disease. [http://www.cdc.gov/tobacco/campaign/tips/diseases/ diabetes.html, accessed October 14, 2016].
Potential partners: Greater Dayton Area Hospital Association, other hospitals, Public Health departments, funders, community-based groups, pharmacies, and legislators.

Joslin PRIME Training & Certification of Primary Care Practices

Issue addressed: Diabetes (and other chronic conditions such as Heart disease and Obesity)
Intervention: Aligns affiliated and community-based physicians with evidence-based practices through training, education, chart audit, and certification.
Background: Kettering Health Network's Joslin Diabetes and Nutrition Center will maintain, for each practice, baseline data, annual practice data and comparison data as well as Joslin goal for 70% of patients in PCP audit who are in glycemic control (inclusive of all methods of treatment- like no medications, on oral agents, on basal insulin, on basal and bolus insulin and on insulin pumps), blood pressure control, lipid control, renal control and smoking. Joslin Diabetes Center is one of 11 NIH-designated Diabetes Research Centers in the United States [Brown, J. A., Beaser, R. S., Neighbours, J. and Shuman, J. (2011). The integrated Joslin performance improvement/CME program: A new paradigm for better diabetes care. *J. Contin. Educ. Health Prof.*, 31: 57–63].
Partners: Joslin Diabetes Center and Primary Care physicians

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, listed on the following pages, address the prioritized health needs: Obesity, Diabetes, Heart disease, and Mental health/Substance abuse. Chronic diseases are addressed with interventions for Diabetes, Heart disease, and Obesity.

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(s)	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Diabetes, heart disease, obesity	Improvement of Clinical Outcomes: 1) PRIME Training & Certification of Primary Care Physicians 2) Partnership with Diabetes Prevention Programs	3 new physician practices trained in 2017, and then 2 practices annually in 2018 and 2019, for year-long training and chart audit. 4 recruited in 2018; and 5 in 2019. 70% of patients meeting clinical targets Establishment of partnership with YMCA, Public Health, and/or community-based nonprofit Up to 100 people referred to Diabetes Prevention Program (DPP) in 2017; with 150 in 2018; and 200 in 2019. 20 participate in DPP in 2017; 20-40 in 2018; and 40-60 in 2019. % weight loss (7% target) Minutes of physical activity per week (150 target)	PRIME: Annual program costs $7,500. DPP: Printing $1,000; Financial scholarships of $4,000 to support up to 10 people; Labor cost $1,200--for a total annual DPP cost of $6,200.	Shared network staff: Quality Coordinator and RN/CDE staff. Hospital staff support quarterly screenings to identify candidates for DPP referral.	Year 1: Three new physician practices enroll in PRIME ; new community partnership formed with DPPs Year 2 & 3: PRIME practices are certified, renew annually, and report clinical outcomes. Year 2: Recruit 2 practices and retain 4. Year 3: Recruit 2 practices; retain 5. DPPs report on number of hospital referrals and clinical outcomes for their program.	Joslin Diabetes Center; Primary Care physicians; Public Health Departments; YMCAs; Diabetes Dayton; Good Neighbor House
Heart disease	Community CVD Screenings & Education: Provide access to preventive clinical services via outpatient and community-based Cardiovascular disease screening and education services.	41Outreach and education events in community settings annually Two (2) public displays in community every year 500 Screenings annually 39% of screenings showing high risk	Annual screening cost: $22,280. Annual education program cost: $6,710. Total: $28,990	Per year -- 500 screened; 10 Healthy Arteries programs; 10 Lipid with EKG programs; 21 Healthy Heart education programs; 2 displays in com-munity	Year 1: Program planning and coordination with partners. Develop presentations. Ongoing screenings. Years 2 & 3: Respond to new requests for presentations. Outreach and follow-up with worksites.	Benjamin and Marian Schuster Heart Hospital; Physicians; Firefighters/EMS; Community-based organizations; Parks; American Heart Association

			Resources			
Priority Issue(s)	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Heart disease and Diabetes	Tobacco Cessation: Creation of community partnerships (e.g., a hub model) to deliver and coordinate evidence-based tobacco cessation efforts through the community.	Create community partnerships (e.g. a hub model). Increase level of outreach staffing. Explore external funding for regional efforts, and explore policies and/or laws in place to reduce consumption.	Estimated labor cost = $30,714 in the first year.	Community Benefit Lead: 0.05 FTE; Community Outreach: 0.25 FTE; Soin Coordinator/ Lead: 0.05 FTE	Year 1: Partnership created. Year 2: Program(s) begin. Year 3: Expanded capacity with additional funding.	GDAHA and other hospitals; Public Health Departments; Funders; Community-based groups; Pharmacies; Legislators
Mental health/ Substance abuse	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.	Estimated labor cost = $24,133 in the first year	Community Benefit Lead: 0.05 FTE; KBMC: 0.10 FTE; Network Physician Lead: 0.05 FTE; Soin Coordinator/ Lead: 0.05 FTE; Dr. Squibb: 0.025 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

			Resources			
Priority Issue(s)	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Mental health/ Substance abuse	Behavioral Health Interventions	*continued* 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.				