COMMUNITY HEALTH NEEDS ASSESSMENT

2021

2021 Implementation Strategy

GOAL 1 – Increase awareness and prevention of Lyme disease and diabetes

GOAL 1 OBJECTIVE	ACTION STEPS	ACCOUNTABILITY	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	Update
Increase awareness of Lyme Disease and available community resources	Continue educational program for informing the community both in person and virtually	Katie Donald	2-3 Sessions Annually	$1,000	Attendance at events- virtual and in person	
	Connect people to resources	Katie Donald	March-November annually	-	With online resources, we are able to see the traffic to the specific pages on the website through the analytics. Through social media we can also track the amount of people that have been engaged, exposed, etc.	
	Resources available in lobby, website, handed out at events	Katie Donald	March-November annually	$1,000	The measurement will be the rate of the turnover of materials.	
Conduct annual blood screening program	Continue to offer the testing program annually	Katie Donald Ben Hughes Jackie Sansig	1 per year, generally in the spring	$10,000	Completion of Event followed by an evaluation of participants.	
	Identify strategy to track percentage of attendees who follow up with Punxsutawney Area Hospital physicians and results over time	Katie Donald	Annually prior to screening event	-	Evaluation will be completed by referrals based on attendees of the event who sought care from Punxsutawney Area Hospital Physicians.	
	Create an opt out button to gain permission to track data in conjunction with registration.	Katie Donald	Annually prior to screening event	-	When registering participants will have the ability to not participate in our more comprehensive follow up.	

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	Re-establish structural relationships with PCPs for the 1500 blood screening participants.	Katie Donald Abby Caylor	Annually prior to screening event	-	Annually PCP's will be asked to participate in program.	
	Expand current comprehensive blood screening program using evidence-based methodologies to address diabetes, heart disease and obesity rates in the region; by strengthening provider partnerships and targeting education to high risk patients.	Katie Donald Ben Hughes	Annually	-	Attendance at events, number of targeted emails opened, information view on the website.	
	Survey physicians to strengthen collaborative efforts with stakeholders in blood screening program.	Katie Donald Abby Caylor	Annually post screening event.	-	Evaluation of a survey	

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Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)

GOAL 2 OBJECTIVE	ACTION STEPS	ACCOUNTABILITY	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	Update
Decrease readmissions through better chronic care management	Discharge planning – risk factor scores of 10 and above the patient is scheduled for an appointment within 7 days with their primary care provider; they get a discharge phone call within 72 hours – they look at med management, meeting with their physician; any home equipment. If they didn't go home with home health would they benefit for home health.	Robin Moran Patti Dinsmore	Evaluate on a quarterly basis annually.	-	Evaluate follow up measures by direct conversations with patients and document findings.	
	Create a process to track and verify patients participation in their chronic care management with PCP. Validation of participation would be completed by creating a process to track and verify with individual providers in an effective way but timely way. This process would be created to ensure the follow up with patients and their PCP.	Robin Moran Patti Dinsmore		-	Measured by evaluating the process of track/ verify by analysing the data collected.	

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GOAL 2 OBJECTIVE	ACTION STEPS	ACCOUNTABILITY	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	Update
Community Blood Screening	Provide Supplemental information to patients, including blood pressures, heart disease screening questionnaire, provision of nutritional information.	Katie Donald Deanna Beverage	Monthly	$5,000 per year in printing	Rate of disbursement.	
	After event, wrap around events on what did the test results mean, how to lower your cholesterol, diet and nutrition	Katie Donald Deanna Beverage Ben Hughes	Post screening event annually.	-	Identifying key issues and establishing events surrounding the topics.	
	Track the number of users over a five-year period	Katie Donald Ben Hughes	Post screening event annually.	-	Analysing the data collection is complete.	
	Meet 2x annually with PCP to discuss needs of the community based on information gathered from the blood screening.	Katie Donald	2x Annually	-	Completion of meetings.	
Promote the hospital's Congestive Heart Failure Clinic and increase the Number of patients utilizing the clinic annually	Educate hospital staff, physicians and new cardiologist about the benefits of the hospital's Congestive Heart Failure Clinic	Katie Donald Michael Kascmar, CRNP Gary Lewis, M.D. Tom Moore Morgan Janocha	Quarterly Updates, Annually	$1,000 a year for promotional informational printing	Evaluated by the number of connections made to providers and staff regarding the services that are available.	
	Send notice to providersand provide follow up – success stories	Katie Donald	Quarterly Updates, Annually	$1,000 per year in postage	Completing the mailings both email and US Mail.	
Reach out to the American	Create a dialogue and relationship with the regional and national	Katie Donald	Quarterly Connections, Annually	-	Measured by having and analysing the dialogue.	

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Heart Association to support their regional and national initiatives	American Heart Association in order to stay abreast of latest news and offerings					
	Deliver Educational Programs utilizing technology including an introduction to telemedicine.	Katie Donald Michael Kascmar, CRNP Gary Lewis, M.D. Tom Moore Morgan Janocha	Quarterly Programs, Annually	-	Measured by the number of programs that will be available to for patients and community members.	
	Implement the use of the registry of high-risk patients to increase PCP follow-ups.	Katie Donald Abby Caylor	Quarterly Updates, Annually	-	By using clinicians to evaluate and working directly with PCP's, establish a registry. It will be measured by its usefulness and 'completeness'.	
Manage high risk population	Expand participant numbers from 200 to 300 participants in the blood pressure/ high risk monitoring program.	Katie Donald Ben Hughes	During the screening event, Annually	$5,000 per year	Adding additional participants.	
	Increase clinical information provided to referring physicians for patients identified as high risk.	Katie Donald Michael Kascmar, CRNP Gary Lewis, M.D.	Quarterly Updates, Annually	$500 per year	Evaluating the material to send and the amount of times connections were made.	
	Create a tracking system to connect high risk	Ben Hughes Abby Caylor	Quarterly, Annually	-	By using clinicians to evaluate and working directly with PCP's, establish a registry. It	

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	patients with physician follow ups				will be measured by its usefulness and 'completeness'.	

Goal 3: Position the hospital and community to respond to the National Opioid Crisis by using evidence-based practices and research while partnering to ensure efficacy.

GOAL 3 OBJECTIVE	ACTION STEPS	ACCOUNTABILITY	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	Update
Identify health and human service in the local region to partner	Create a resource guide with local contacts for professionals	Katie Donald	Ongoing	-	Measured by the number of materials that created, dispersed, and/or utilized.	
Online resources made available through the hospital's webpage	Redesign of the webpage to adequately provide educational resources.	Katie Donald	Quarterly Updates, Annually	-	The completion of updates on the website of the necessary links.	
	Identify web-based resources	Katie Donald	Quarterly Updates, Annually	-	Find web-based resources and create a connection to them using the pah.org website.	
	Post links through the webpage	Katie Donald	Quarterly Updates, Annually	-	Measured by the engagement of the posts- include post interaction.	

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GOAL 3 OBJECTIVE	ACTION STEPS	ACCOUNTABILITY	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	Update
Connect to regional players for better collaboration of services	Identify key contacts in Law enforcement/Clearfield Jefferson Drug and Alcohol/Punxsutawney EMS, IRMC resources	Katie Donald Ben Hughes	Quarterly Updates, Annually	-	By making the key connections and establishing a relationship.	
Provide resource list physicians and providers in the region	Create a resource list for providers in conjunction with IRMC to establish a cohesive PMCN resource list.	Katie Donald Robin Moran Patti Dinsmore Gary Carnahan	Quarterly Updates, Annually	-	Completion of list creation and assessing its substance.	
State Data provided through the web page and shared with collaborative partners	Notice to collaborative partners of available resources	Katie Donald Robin Moran Patti Dinsmore Gary Carnahan	Quarterly Updates, Annually	$500 per year	Completion of connection being made to partners yearly.	
Collaborative grant identified	Research opportunities with key stakeholders	Katie Donald	Quarterly Updates, Annually	-	Research on a regular basis the grants and funding sources that are available to assist with the goal. Evaluation of	
Create a PMCN strategy to improve regional efforts	PMCN strategic plan to identify opioid as a priority	Ben Hughes Dan Blough Paula Spack Jack Sisk	Annually prior to PMCN reorganizational meeting	-	Confirmation that PMCN has	
Create a Opioid strategy	Planning document created	Paula Spack	Quarterly Updates, Annually	-	Completion of planning documents with is created collaboratively.	

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GOAL 3 OBJECTIVE	ACTION STEPS	ACCOUNTABILITY	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	Update
document to address local needs.	Shared with Collaborative partner and Opioid stakeholders.	Paula Spack	Quarterly Updates, Annually	-		

Goal 4: Improve access to mental health services

GOAL 2 OBJECTIVE	ACTION STEPS	ACCOUNTABILITY	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	Update
ER expansion project	Determine the necessary components needed to assist with the care of mental health patients arriving in the ED	Ben Hughes Patti Dinsmore Katie Donald		$5,000	Evaluate and determine the functionality needed to care for mental health patients through real life visits.	
Develop a database of available community services	Create a database of resources of to assist patients with outpatient and other services.	Patti Dinsmore Juliane Kaza		-	The creation of the database with a comprehensive guide to resources.	