PUNXSUTAWNEY AREA HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT

2017 Update

2017 year-end update -Punxsutawney Area Hospital

Community Health Needs Assessment

A Focus on Population Health. Population health has been defined as "the health outcomes of a group of individuals". It is an approach to health that aims to improve the health of an entire human population- For purposes of Punxsutawney Area Hospital's Community Health Needs Assessment (CHNA), improve the health of the entire population of the Punxsutawney Area Hospital service area.

To date, the hospital's blood screening program is addressing the issue of population health through the ongoing success of this initiative….. In the spring of 2017, more than one thousand people participated in the event. This comprehensive blood screening project is completed in conjunction with community agencies and impacts a significant percentage of the population. Wrap around events to this program are supporting population health for the service area.

Additionally the hospital is looking to partner with tertiary hospitals to address important areas like Diabetes and Heart Disease. In 2017 the hospital was part of a grant submission process to better position the organization to address population health specifically related to Diabetes.

Working in conjunction with Clarion Hospital and Indiana Regional Medical Center, the hospital is collaborating with the Pennsylvania Department of Health and the Healthy People 2020 goals to assure there is an evidence based approach to population health initiatives.

The Opioid Crisis. Punxsutawney Area Hospital like most organizations has been monitoring, reporting and responding to the opioid crisis in Pennsylvania. The hospital is working with law enforcement, and state and national resources to assure the organization is positioned to address this more recently identified population health issue. Initial research and data collection will be part of the 2018/2019 CHNA.

Update on Identified Objectives. The attached document outlines forward progress and strategies achieved by the hospital.

A New Plan for 2018/2019. In the fall of 2017, Punxsutawney Area Hospital in collaboration with Indiana Regional Medical Center and Clarion Hospital began to review current plans and establish timelines and resources for the completion of a new CHNA for 2018. The hospital is embracing technology to reach out to community members to collect data and establish priorities from a myriad of health care and social service providers in the region. Additionally, the community is being surveyed to assure their 'voice' is being heard in the process.

GOAL 1 – Reduce obesity in the community through an increase in physical activity and other wellness/prevention strategies.

Background and rationale

Our data research indicated the largest concern for the primary service area of the hospital, including parts of Clearfield, Indiana and Jefferson counties was high blood pressure/hypertension and obesity. The only way to address these concerns is to get people focused on prevention and exercising. In order to reach large groups of people, we have decided to bring a wellness program into the hospital and later expand to companies in the community.

OBJECTIVE	ACTION STEPS	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2017 Update
Create and lay the groundwork for a Punxsutawney Area Hospital workplace wellness program	Outline what the wellness program will entail and which staff members will be responsible for which pieces and parts	November 2015-January 2016		Workplace wellness program created for a February 1, 2016 kick-off	Year 1 completed in conjunction with Registered Dietician and ER. Year 2 scheduled for completion
Implement the Punxsutawney Area Hospital workplace wellness program	Update the Employee Health Manual	Begin February 1, 2016		25% of target employees participating the first year 50% of target employees participating the second year 75% of target employees participating in the third year Quarterly basis tracking weight loss, BMI reduction and inches lost	Complete 2017 Completed
	Create a STEP Program for Employees utilizing pedometers (goal	February 1, 2016	$500.00	# of pedometers utilized	Not initiated at this time

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OBJECTIVE	ACTION STEPS	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2017 Update
	would be 10,000 steps a day)			# of people who achieve 10,000 steps a day per quarter	
	Offer nutritional education, including monthly skinny recipe renditions	Begin February 1, 2016		# of education classes held a month # of skinny recipes published each year # of participants	Recipes sent to recipients
	Create an e-flyer for all employees to inform about program and sign up			Wellness program and monthly activities will be posted in a weekly calendar emailed to all employees and posted in hospital as well as the hospital's monthly newsletter	Regular updates in place.
	Review/update incentive program of a free blood screening to all participants			Participation % will be evaluated to determine success of current incentive program as well as employee surveys	Input received from participants and program changes put in place based on input
	Tie into the Rails to Trails Punxsutawney for promotional walking event			# people participating # of people intending to change behavior	Not in place at the time of assessment
	Evaluate program to determine goals and expansion for next 3 years			Meet quarterly to assess current program and plan for future	
	Review/update program pre-post tests to measure knowledge and behavior changes			Number and percentage of employees participating in each program and class	Tracking system in place

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OBJECTIVE	ACTION STEPS	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2017 Update
Expand employee wellness program to other county employers	Meet with Occupational Health to determine list of potential employers	Year 3		Number of employers and employees participating	MOPC has met with employers to assess interests…. Issue identified as priority: drug screening
	Determine how the hospital program would be best implemented with other employers			(all above metrics for each worksite)	"
	Meet with local employers to determine interest in the program			# of employers contacted	"
	Implement program in other sites			# of employers participating in program	
Offer Women's Expo to educate women on health issues	Continue to offer program in October of each year	October each year		# people attending	Women's screening in place.
	Offer educational programs at event to outreach to our female community members			Increase in knowledge of program topic	
	Continue to offer free mammograms and PAP screenings			# of women receiving mammogram # of women receiving PAP screening # of women referred to physician # of women who kept appointment	
Outreach for 3-D mammogram	Communication and outreach to encourage women to seek mammograms			# women receiving 3-D mammogram on a yearly basis	Info being tracked and monitored by PAH
Continue to offer Birthing & Breast Feeding Classes	Outreach to new parents on the importance of parenting a newborn and nutrition with a newborn			# people participating	Classes in place with ongoing monitoring and tracking.

GOAL 2 – Continue to offer preventative care/screenings and educate the community regarding infectious and chronic disease management.

Background and rationale

While the objectives of Goal 1 are being met, the hospital recognizes the importance of preventative care and screenings for the residents of the Punxsutawney Area Hospital's primary service area in order to educate and help prevent chronic diseases, including, but not limited to high blood pressure/hypertension, diabetes, cancer and Lyme disease.

OBJECTIVE	ACTION STEPS	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2017 Update
Flu shot clinic in the community	Partner with a local industry to provide flu shots to their employees	Year 2		# of employees receiving flu shots # of industries flu shot clinic offered to	Flu shots being provided through PAH home care
CPR Training	Open classes that anyone can participate Private industries in the area Collaborative relationship with our local EMS to provide CPR training through referrals			# of people certified every year	Community CPR classes in place with outreach to personal care homes and social service/educational facilities

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OBJECTIVE	ACTION STEPS	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2017 Update
First Aid Training	Open classes that anyone can participate Private industries in the area Collaborative relationship with our local EMS to provide CPR training through referrals Local Nursing Programs			# of people certified each year	Businesses/nursing facilities and personal care homes have participated in training throughout the CHNA implementation period.
Patient Movement Program	Training hospital employees on the proper way to move patients to minimize work-related injuries Create a program with human resources to include the PMP for all new direct care hires.		$8,500.00	By year 1 – all direct care staff will be trained on the PMP By Year 3 have a 50% reduction in patient movement-related injuries By Year 3 see a reduction in the hospital's Work Injury Mod Rate	Completed with all existing clinical staff and new employees Data being tracked Data currently being tracked
Lyme Disease	Continue educational program for informing the community regarding Lyme Disease				
Women's Health Screenings	Offer 3-D Mammography Self-Breast Exam PAP Screening			# of women receiving 3D mammography # of women receiving self-breast exam # of women receiving PAP screening	

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Colorectal Screenings	Continue to offer colorectal screenings			# of people being screened # of people diagnosed with colon cancer	
Skin Screenings	Continue to offer skin screenings			# of people receiving skin screenings # of people sent for referral # of people with skin cancer # of people with skin cancer by stage	
Prostate Screenings	Continue to offer prostate screenings			# of men receiving PSA screening # of men sent for referral # of men with prostate cancer # of men with prostate cancer by stage	
Create a Women's Health Program targeting the Amish population	Increase the gynecological services to the Amish in their communities			# of Amish women receiving services on a yearly basis	
	Increase PAP screenings services to the Amish in their communities			# of Amish women receiving PAP screening	
	Increase prenatal care to the Amish in their Communities			# of Amish women receiving prenatal care	

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OBJECTIVE	ACTION STEPS	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2017 Update
Conduct bi-annual multi-phasic blood screening program	Continue to offer the testing program in May and October each year	Twice a year		# physicians participating	50+
	Identify strategy to track percentage of attendees who follow up with Punxsutawney Area Hospital physicians and results over time			# people connected to physicians	Tracking system not in place at time or assessment
	If you sign up for the hospital wellness weight challenge, we will pay for your blood screening – tying 3 year outcomes into the program			# people completing screening	
				# people identified with high/low levels related to anemia, coronary disease, kidney disease, diabetes, liver disease, thyroid disease	Preliminary planning in place.
				% of participating completing physician office visit within 3 months after report	
Offer physician outreach program	Offer annual blood screening for physicians			# physicians participating	completed
Participate in the annual Groundhog Festival through a Health Fair – this is chronic disease	Continue to offer blood pressure screenings, glucose screenings and cholesterol testing as well as other educational opportunities throughout the week of the fair.	June of each year		# people participating	
				# people referred for follow up with physician	Participation from PAH in place with a variety of departments and strategies.

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OBJECTIVE	ACTION STEPS	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2017 Update
Decrease readmissions through better chronic care management – this is also chronic disease	Discharge planning – risk factor score 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.			Overall Readmission Rate – less than 14% readmission rate COPD Readmission Rates – less than 12% readmission rate	Readmission rates are being evaluated and at the time of assessment PAH has seen a decrease in readmissions.
Decrease readmission rates in the Transitional Care Program – this is also chronic disease	Transitional Care Program to assist with decreasing readmission rates (10-20 day window)			# of readmissions % decline in readmissions	Dashboard completed for the TC program and readmissions are being tracked…. A decrease has been noted.
	Establish baseline for the TCP – create a benchmark for those who can go back home vs. those that would be sent to a long-term skilled nursing facility.			# of patients sent home # of patients sent to long-term skilled nursing facility	complete

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	Identify strategy to track percentage of attendees who follow up with Punxsutawney Area Hospital physicians and results over time			# people connected to physicians	
	If you sign up for the hospital wellness weight challenge, we will pay for your blood screening – tying 3 year outcomes into the program			# people completing screening	
				# people identified with high/low levels related to anemia, coronary disease, kidney disease, diabetes, liver disease, thyroid disease	
				% of participating completing physician office visit within 3 months after report	
Offer physician outreach program - also chronic disease strategy	Offer annual blood screening for physicians			# physicians participating	Complete

GOAL 3 – Increase awareness and prevention of Cardiovascular Disease (heart disease, cholesterol, etc.)

Background and rationale

Cardiovascular Disease (heart disease, cholesterol, etc.) was identified as the third-highest health need in the service area of Punxsutawney Area Hospital. We will expand our continuum of care for persons with cardiovascular disease by collaborating with physician practices and other wellness initiatives

OBJECTIVE	ACTION STEPS	TIMEFRAME	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2017 Update
Community Blood Screening	Provide Supplemental information to patients, including blood pressures, heart disease screening questionnaire, provision of nutritional information			Maintain the annual participation rate of 75%	To be reassessed in 4 2018
	After event, wrap around events on what did the test results mean, how to lower your cholesterol, diet and nutrition			Increase % of people attending the wrap around events # of people attending wrap around events	
	Track the number of users over a five-year period			# of participants each year # of participants that are screened annually that have participated over a five year period	
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	Ongoing		# of people referred to clinic # of people participating in the clinic # of readmission rates # of patients compliant with their medication	Ongoing development of the CHF program has identified opportunities and successes

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Reach out to the American Heart Association to support their regional and national initiatives	Create a dialogue and relationship with the regional and national American Heart Association in order to stay abreast of latest news and offerings				Contacts made