PUNXSUTAWNEY AREA HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT FY 2018 2019+

Implementation Strategy and Community Benefit Plan

Completed Spring 2018

for 2018-2020

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Completed spring 2018 - June 2018 implementation

In the spring of 2018 a joint Community Health Needs Assessment (CHNA), led by Punxsutawney Area Hospital was conducted for the approximately 50,000 residents in the 3 county service area of Clearfield, Jefferson and Indiana counties. There are several area hospitals in the region and Punxsutawney Area Hospital collaborated with Indiana Regional Medical Center and Clarion Hospital as part of the overall process. Previous CHNAs were completed working directly with a shared process and structure. This 2018 process was completed independently; discussions and planning sessions were held with the 3 hospitals to link the initiatives and strategies.

Punxsutawney Area Hospital is a 49 bed rural, not for profit, community hospital recognized as a regional resource for primary health care. From helping to bring new life into our world to employing state of the art technology to save lives, Punxsutawney Area Hospital has been helping patients and their families for over a century.

To live up to its mission: "Providing excellent primary care to the people in the region", Punxsutawney Area Hospital offers a wide variety of services. From maternity services through critical care and diagnostic testing, Punxsutawney area Hospital has the dedicated professionals, advanced technology and convenient facilities and practices to meet the complex health needs of the region. As the 2nd largest employer in the region, the hospital is recognized not only as the leader in the delivery of health care services, but a significant part of the community's infrastructure. With over 350 employees, we reach beyond the walls of the traditional campus location to be a regional leader for health education, illness prevention and in the promotion of wellness.

This Implementation Strategy and Community Benefit Plan report summarizes how Punxsutawney Area Hospital will develop, conduct and sustain community benefit programs that 1. Address prioritized health needs from previously conducted planning initiatives 2. Respond to other identified community health needs. This is the Implementation plan for FY 2018-2019. Execution will occur in FY 2018/19-FY 2020.

Target Areas and Populations

Given the multi-faceted health needs of our communities we have selected a 3 county target area for our implementation strategy; the prevalence of poor health factors and poor health outcomes compounded by challenging social determinants of health impacting community residents are less than ideal throughout the counties total geographic area.

How the Implementation Strategy and Community Benefit Plan Were Developed- Including How priorities were Established

Punxsutawney Area Hospital identified community health needs through a collaborative process with PMCN (Pennsylvania Mountain Health Care Network) hospitals. Building on past initiatives, the 2018 process included a comprehensive survey, a team prioritization exercise to determine priorities and assessment of past successes and failures.

As the CHNA leveraged and utilized the hospital's planning staff - a multi-part process was employed to develop this implementation strategy and community benefit plan, including

Quantitative data review and analysis, literature reviews completed to identify State and National benchmarks and evidence based strategies that relate to the indicators/metrics. The CHNA teams' utilization of multiple types of research allowed for data collection across a broad range of indicators relating to overall population health, social determinants of health including geographic location differences in health outcomes and the needs of disadvantaged populations including uninsured persons, low income persons and minority groups (including Amish residents) within the region.

In addition to the assessment Punxsutawney Area Hospital's CHNA team also reviewed its existing community benefit activities- both internally and in conjunction with its PMCN partners to assess whether these services were providing value consistent with the needs of the community and its residents. Specifically, these activities considered key health factors and outcomes resultant from associated demographic, social and economic impacts, the physical environment, healthcare access and resource coordination and behavioral trends. Basically, connecting the regions needs to that of the state and nation. With Healthy People 2020 and the CMS Strategy connected to the Pennsylvania Department of Health Priorities, this CHNA is connected to evidence and data based priorities.

Major Health Needs

Criteria included the number of persons affected by the various factors analyzed, the seriousness of the issues (as determined by surveys and data available) whether the health needs particularly affected persons living in poverty or reflected other disparities, and availability of community resources to address the needs. This process identified the following priorities for the community:

Goal 1. Reduce obesity in the community through an increase in physical activity and other wellness/prevention strategies.
Goal 2. Improve preventative care/screenings and educate the community regarding infectious and chronic disease to impact population health.
Goal 3. Increase awareness and prevention of Cardiovascular Disease (heart disease, cholesterol, etc.)
Goal 4. 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 5. Explore tele health/tele medicine to improve access to care issues for rural residents.

Description Of What Punxsutawney Area Hospital Will Do To Address Community Needs: Action Plans

Punxsutawney Area Hospital has worked in partnership with PMCN and other stakeholders (as detailed) to develop the following Action Plans to address our community's needs. The overall goal of the these action plans, which are described below is to improve the overall health factors and behaviors of residents in the region, leading to improvements in resident health outcomes.

<u>GOAL 1</u> – Reduce obesity in the community through an increase in physical activity and other wellness/prevention strategies. (Goal established as part of previous CHNA)

National/State/Local Data -Support of Goal/Objectives

Comments from the PAH CHNA teams online survey identify the need to address the Obesity on the local level.
Pennsylvania Department of Health- 3 County Health profiles support the need to address Obesity on the regional level
Healthy People 2020 identifies Obesity as a national priority

OBJECTIVE	ACTION STEPS	TIMEFRAME-ACCOUNTABLITY	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2019 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 Expand on offerings to local businesses based on their individualized needs. Expand the hospitals' weight loss program to connect with national benchmarking	May 2019 LW AC MJ BH May 2020 January 2019 BH MJ	TBD 400	Planning meeting held in conjunction with the 2019 budget prep. Identification of businesses, initiation of service provision/training/testing Create a listing of evidence based obesity strategies and expand current program to tracking	
Connect with the Punxsutawney School District to assess and establish collaborative goals with healthcare/education.	Assess the schools plans to address childhood obesity in conjunction with athletic training development	December 2019 MG CA		Documents acquired	
Expand employee wellness program to other county employers	Meet with Occupational Health to determine list of potential employers	JAN 2020 MOPC AC BH	PART OF 2020 BUDGET DOCUMENT PLANNING	Number of employers and employees participating	
	Determine how the hospital program would be best implemented with other			TBD	"

OBJECTIVE	ACTION STEPS	TIMEFRAME-ACCOUNTABLITY	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2019 Update
	employers				
	Meet with local employers to determine interest in the program			# of employers contacted	"
	Implement program in other sites			# of employers participating in program	
Connect screenings to Healthy People 2020 initiatives	Continue to offer program in October of each year	October each year LK	1K	# people attending	
	Offer educational programs at event to outreach to targeted community members (EVIDENCE BASED THROUGH HP2020 RESOURCES)	July 2018 BH		Increase in knowledge of program topic	
	Review Healthy People 2020 and connect objectives to national priorities			Review of Healthy People 2020/2030	
	Attend conference to be positioned for Healthy People 2030	May 2018 BH		Attendance by Planning staff	
Hire athletic trainer to work in conjunction with the school – to link hospital and school system priorities.	Create a job description Identify priorities	August 2018 MG DB	40K	Position hired	

<u>GOAL 2</u> – Improve preventative care/screenings and educate the community regarding infectious and chronic disease management.

(Goal established as part of previous CHNA)

National/State/Local Data -Support of Goal/Objectives

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.
Healthy People 2020 identifies Population Health and preventative screenings as a national priority
Stanford School of Medicine Health Disparities and Barriers to Healthcare – supports the need to use screenings to overcome barriers to care for rural residents
Pennsylvania Department of Health- 3 County Health profiles identifies significantly high rates for Lyme's Disease in the region
The existing Community Blood screening program screens 15% of residents annually….. this is statistically significant and creates a foundation to impact change

OBJECTIVE	ACTION STEPS	TIMEFRAME/ ACCOUNTABILITY	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2019 Update
Flu shot clinic in the community	Partner with a local industry to provide flu shots to their employees	Year 2 AB	TBD	# of employees receiving flu shots # of industries flu shot clinic offered to	
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	DEC 2018 LW		# of people certified every year	
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	LW		# of people certified each year	

Lyme Disease	Continue educational program for informing the community regarding Lyme Disease	BH LW NF		Updated web information/links Posted notices on social media Posted local statistics – CREATE AWARENESS	
Women's Health Screenings	Offer 3-D Mammography Self-Breast Exam PAP Screening	LK AC	1k	# of women receiving 3D mammography # of women receiving self-breast exam # of women receiving PAP screening	

Colorectal Screenings	Continue to offer colorectal screenings	LK	1K	# of people being screened # of people diagnosed with colon cancer	
Skin Screenings	Continue to offer skin screenings	LK	1K	# of people receiving skin screenings # of people sent for referral # of people with skin cancer # of people with skin cancer by stage	

Conduct annual multi-phasic blood screening program	Continue to offer the testing program annually	March 2019 DB LK BH JS		# physicians participating	
	Identify strategy to track percentage of attendees who follow up with Punxsutawney Area Hospital physicians and results over time			# people connected to physicians	
	Create an opt out button to gain permission to track data in conjunction with registration.			# 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	Offer annual blood screening for physicians		IK	# physicians participating	
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 LK	1k	# people participating	
				# people referred for follow up with physician	

GOAL 3 – Increase awareness and prevention of Cardiovascular Disease (heart disease, cholesterol, etc.) (Goal established as part of previous CHNA)

National/State/Local Data -Support of Goal/Objectives

Healthy People 2020 identifies heart disease as a national priority
Pennsylvania Department of Health- 3 County Health profiles identifies cardiovascular disease as an outlier.

OBJECTIVE	ACTION STEPS	TIMEFRAME/ ACCOUNTABILITY	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2019 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.	PD		Overall Readmission Rate – less than 14% readmission rate COPD Readmission Rates – less than 12% readmission rate	
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)	PD KL JK		# of readmissions % decline in readmissions CREATION OF DASHBOARD FOR TC TO MONIOR BY LEADERSHIP	

Community Blood Screening	Provide Supplemental information to patients, including blood pressures, heart disease screening questionnaire, provision of nutritional information	DB LK		Maintain the annual participation rate of 75%	
	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	APRIL 2019 LK DB JS		# 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 Send notice to providers and provide follow up – success stories	Ongoing May 2019 NF LK		# of people referred to clinic # of people participating in the clinic # of readmission rates # of patients compliant with their medication	
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	BH JS		Planning documents acquired	

GOAL 4 – 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 established 6/2018)

National/State/Local Data -Support of Goal/Objectives
The National Institutes of Health in response to the opioid crisis is focusing its efforts on 5 priorities: improving access to treatment and recover y services Promoting use of overdose reversing drugs, Strengthening their understanding of the epidemic through better surveillance, support for cutting edge research, and advancing better practices for pain management **Comments from the PAH CHNA teams online survey** identify the need to address the Opioid crisis on the local level.

OBJECTIVE	ACTION STEPS	TIMEFRAME/ACCOUNTABILITY	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2019 Update
Identify health and human service in the local region to partner	Create a resource guide with local contacts for professionals	2/2019 BH LK PS NF	N/A	List of resources created and made available to PAH List made available to residents	
Online resources made available through the hospital's webpage	Redesign of the webpage Identify web based resources Post links through the webpage	3/2019 LK BH	5K	Webpage created Links posted	
Connect to regional players for better collaboration of services	Identify key contacts in law enforcement/Clearfield Jefferson Drug and Alcohol/Punxsutawney EMS	3/2019 NF DN	N/A	Key Players identified	
Provide resource list physicians and providers in the region	Create a resource list for providers.	10/2019 KM LK	N/A MINIMAL PRINTING BUDGET IN CONJUNCTION WITH PAH PR BUDGET	Providers receipt of resource listing.	
State Data provided through the web page and shared with collaborative partners	Notice to collaborative partners of available resources	3/2019 BH NF DN	NA	Notification sent	

Collaborative grant identified	Research opportunities with key stakeholders	6/2019 NF BH BB	N/A	State and Federal opportunities identified- including ARC	
Create a PMCN strategy to improve regional efforts	PMCN strategic plan to identify opioid as a priority	6/2019 JS BH M	TBD	Strategy realized in operations initiatives.	
Create a Opioid strategy document to address local needs.	Planning document created Shared with Collaborative partner and Opioid stakeholders.	12/2019 BH PS NF	N/A	Document created and presented to PMCN/PAH leadership	

GOAL 5 – Explore tele health to improve access to care issues for rural residents. (Goal established 6/2018)

National/State/Local Data -Support of Goal/Objectives

2017 Telemedicine Association 2017Gap Analyses for Pennsylvania
CMS Rural Health Strategy- " Tele health has been identified as a promising solution to meet some of the needs of rural and underserved areas that lack sufficient health care services, including specialty care, and has been shown to improve access to needed care, increase the quality of care and reduce costs by reducing readmissions and unnecessary emergency department visits.
Comments from the PAH CHNA teams online survey identify the need for improved access to specialty care.

OBJECTIVE	ACTION STEPS	TIMEFRAME/ACCOUNTABILITY	BUDGET	IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS	2019 Update
Quantify PMCN Tele health current relationships	Provide written list of each PMCN hospital	12/2018 BH PS	N/A	Document produced	
Apply for telemedicine grant funding	PMCN to engage a consultant and submit	12/2018 5/2019 PMCN BH	10K	Grant submitted Grant received	
Explore national trends and opportunities through CMS	Identify best practices Connect to national governing body Attend national/state conference	BH RM LW	 1K	Online resource files created for PAH leadership Attendance at conference	
Explore changes in tele health funding	Review CMS guidelines/rural health strategy Review private insurance updates Champion tele-health with HAP and political leaders.	12/2019 JS BH PMCN		Provide CMS rural health strategy goals to PAH leadership Connect with HAP to assure strategies are connected.	
Investigate tele-psychiatry and tele stroke for people in the region	Identify best practices Identify functional technology	March 2019 BH LW		Contact identified through tertiary telemedicine departments. HAP/UPMC/AHN/GEISINGER	