Highlands
HOSPITAL

Community Health Needs Assessment Implementation Plan 2021-2024

Community Health Improvement Plan (CHIP)

In conjunction with its 2021 Community Health Needs Assessment Highlands Hospital developed a system-wide Community Health Improvement Plan (CHIP) to guide community benefit and population health improvement activities across the Highlands' service area.

Highlands' focus will be on Behavioral Health (including Autism and PTSD), Chronic Disease/ Diabetes, Women's Health and Access to Care.

Health Priority: Behavioral Health

Goal: Increase access to behavioral health services with a focus on developing best practices to identify, treat, and refer patients presenting with behavioral health concerns.

Objectives:

1) Restructure the Highlands Hospital Outpatient Behavioral Health Program to increase the number of and the expertise of the program providers
2) Promote the Outpatient Behavioral Health Program restructure to primary care providers, community health providers, community agencies, and community members.
3) Educate providers on the use of the PHQ-9 and Pain Assessment screening tools to identify individuals endorsing depression severity.
4) Promote the Transcranial Magnetic Stimulation (TMS) Program to treat Major Depressive Disorder.
5) Identify community leaders and maintain a strong community presence with local and state officials with the goal of identifying social determinants of health that impede behavioral health diagnosis and treatment.

Target Populations:

- Vulnerable Populations
- Individuals with Behavioral Heath or Substance Abuse Comorbidity
- PTSD/Trauma
- Veterans
- All Socioeconomic Status
- Those with Housing Instability
- Individuals Across All Lifespans to Include Adolescents and Elderly

Strategies:

- Increase access to the restructured Outpatient Behavioral Health Program and the TMS Program by working with primary care and other healthcare providers on the use of the PHQ-9 and Pain Assessment screening tools to identify individuals endorsing depression severity.
- Work closely with primary care and other health providers on identifying, treating, or referring patients with behavioral health concerns or diagnoses.
- Research and develop best practices and expertise in prevention and treatment.
- Utilize the PHQ9 and Pain Assessment tools in Primary Care Practices.
- Promote behavioral health awareness and develop education to decrease stigma related to behavioral health.

Expected impact:

- Collaboration among providers to identify, treat, or refer patients endorsing behavioral health concerns
- Awareness of behavioral health providers and programs to address specific concerns
- Increased use of best practice screening tools
- Increased community and local and state officials involvement due to decreased stigma

Health Priority: Chronic Disease - Diabetes

Goal 1: Decrease preventable chronic disease by ensuring access to resources, knowledge, and opportunities for individuals to adopt healthy behaviors.

Objectives:

1) Increase primary care provider (PCP) adherence to preventive screenings per guidelines for age and risk factors for all individuals.
2) Offer referrals and provide education to high-risk populations.
3) Provide referral to Highland's Diabetes Center for at risk populations and those with pre-diabetes.
4) Screen behavioral health inpatients for diabetes.

Goal 2: Improve management and outcomes for patients diagnosed with Diabetes.

Objectives:

1) Reduce hospital 30-day readmissions rates for diabetes.
2) Increase follow ups per diabetes best practice guidelines and standards of care.
3) Coordinate continuity of care between departments of the hospital system; inpatient, ER, behavioral health, outpatient.
4) Provide access and education for continuous glucose monitors.
5) Increase compliance with patient's obtaining A1c and follow up appointments.

Target Populations:

- Vulnerable Populations
- Individuals with Behavioral Heath or Substance Abuse Comorbidity
- Veterans
- All Socioeconomic Status
- Those with Housing Instability
- Individuals Across All Lifespans to Include Adolescents and Elderly
- Pre-diabetics

Strategies:

- PCP offices to follow diabetes clinical flow chart per standards of care and best practice guidelines
- Provide education to providers and staff on best practices and standards of care in diabetes management and at risk populations
- Increase public awareness and provider awareness of services available at the outpatient diabetes clinic.
- Improve outcomes of high-risk behavioral health patients by screening inpatients for diabetes upon admission
- Consult diabetes educator during inpatient admission for high-risk patients, those with pre-diabetes, and diabetes and direct schedule patients upon discharge from the ER or inpatient to primary care for prompt follow up and diabetes center.
- Direct schedule patients when discharged from the ER or inpatient to primary care for prompt follow up and diabetes center.
- Provide diabetic clinical flow charts highlighting all departments involvement per best practice guidelines.
- Partner with continuous glucose monitor companies and pharmacies to increase access and affordability for patients.
- Increase use of A1c Now meter and standing order sets for obtaining A1c's per diabetic standards of care.

Expected impact:

- Increased primary care provider (PCP) adherence to preventative screenings per guidelines for age and risk factors for all patients
- Increased referrals to outpatient diabetes clinic and increase in quality metrics.
- Enhanced awareness of services available at Highland's Hospital and referrals.
- Identified at risk individuals by screening high risk populations during admission
- Reduced readmissions
- Increased follow up with primary care provider (PCP) per diabetes best practice guidelines and standards of care.
- Enhanced continuity of care between departments of the hospital system; inpatient, ER, behavioral health, outpatient.
- Improved access and use of continuous glucose monitors
- Improved overall health outcomes due to reduction in A1c and increasing access to resources.

Health Priority: Women's Health

Goal: Increase access to women's health care services focusing on development and implementation of best practice standards of care with the overall goal of improving health outcomes for women and families.

Objectives:

1) Increase access to, and utilization of, preventive and well care women's health services
2) Coordinate efforts along multiple continuums to assure that women's heath care needs are being identified and addressed through direct care and through referrals.
3) Increase access to primary care, behavioral health, and women's health by structuring a blended care model to combine services in one location
4) Increase the number of primary care providers and provide education on the integration of women's health care needs and services
5) Promote the Outpatient Behavioral Health Program as restructured to address behavioral health concerns that may prevent access to necessary and appropriate women's health care.

Target Populations:

> Females Across All Lifespans to Include Adolescents and Elderly
> Sexually Active Females
> Minority Women
> Veterans
> Single Mothers
> All Socioeconomic Status
> Those with Behavioral Helath Issues Including:
    - Post-Partum Depression
    - Generalized Depression
    - Anxiety

Strategies:

- Collaborate with primary care and other health providers identifying, treating, or referring patients identified with women's health concerns or diagnoses
- Hire an Advanced Practice Provider (Doctor of Nursing Practice) to build and supervise a Chronic Care Management Program with the goal of developing individualized comprehensive care plans addressing all health issues.
- Increase access to women's health care services
- Engage in the research and development of best practices and expertise in identifying, treating, and referrals of women's health care needs.
- Promote women's health education through healthcare offices, community agencies, and throughout the community.

Expected impact:

- Increased access to care, increased referrals, increase in preventive services
- Increased collaboration and coordination of care
- Expanded access to blended care services to encompass comprehensive care management, decreased barriers to improve health outcomes by increasing access to services
- Increased use of best practices and standards of care
- BH services utilized to promote womens health and wellness

Health Priority: Access to Care

Goal: Improve individual, community and population health by addressing social determinants that create barriers to healthcare and cause disparities inc health outcomes.

Objectives:

1) Identify community leaders and maintain a strong community presence with local and state officials with the goal of identifying social determinants of health that impede healthcare.
2) Partner with the community leaders and community agencies to remove access to treatment barriers and achieve healthier communities.
3) Identify the problems and barriers that prevent vulnerable populations from receiving medical care.
4) Increase access to a full complement of health services with a focus on collaborating with hospital and community providers to develop best practices to identify, treat, and refer patients.
5) Identify structural barriers, to include transportation, to improve health outcomes by increasing access to care and housing instability
6) Provide support to link patients with social services and health initiatives to address barriers and improve outcomes.
7) Identify the barriers that restrict primary care access and lead to primary care treatment being sought through a hospital emergency department.

Target Populations:

- Vulnerable Populations
- Individuals with Behavioral Heath or Substance Abuse Comorbidity
- Veterans
- All Socioeconomic Status
- Those with Housing Instability
- Individuals Across All Lifespans to Include Adolescents and Elderly

Strategies:

- Addressing critical social determinants of health will lead to better health outcomes in local communities.
- Addressing treatment barriers will lead to better health outcomes in local communities.
- Review research that addresses problems that prevent vulnerable populations from receiving medical care.
- Hire an Advanced Practice Provider (Doctor of Nursing Practice) to build and supervise a Chronic Care Management Program with the goal of developing individualized comprehensive care plans addressing all health issues.
- Continue to offer and utilize telehealth to expand access to services and coordinate transportation and housing with community resources
- Provide support to link patients with social services and health initiatives to address barriers and improve outcomes.
- Provide referral to primary care provider to decrease amount of patients who seek primary care treatment through a hospital emergency department.

Expected impact:

- Improved health outcomes
- Decreased barriers and decreased ER utilization
- Increased collaboration and coordination of care
- Improved health outcomes and utlization of services
- Improved health outcomes
- Increased number of PCP referrals and decreased number of ER utilization for primary care needs.