Implementation Plan for Needs Identified in the 2016 Community Health Needs Assessment for Harrisburg Medical Center

HARRISBURG MEDICAL CENTER

Harrisburg Medical Center is a 77 bed nonprofit Sole Community Hospital licensed by the Illinois Department of Public Health and is a member of the Illinois Hospital and Health Systems Association. The organization is accredited by The Joint Commission. Patient care is provided by professional staff skilled in the assessment of patients and development of a care plan based on findings from those assessments.

Harrisburg Medical Center's Mission

The mission of Harrisburg Medical Center is to maintain and improve the health of the communities we serve. This Community Health Needs Assessment Implementation Plan provides the groundwork for Harrisburg Medical Center, and along with other local organizations to create a blueprint for the provision of services to improve the health of our community. This Implementation Plan is designed ensure that efforts are not duplicated and that the correct organizations to handle specific issues are involved in the process of the needs identified.

The top four priority health needs Identified for Harrisburg Medical Center that are addressed in this implementation plan are:

- **Mental Health**
  Focus on Access to and Treatment of individuals having mental health issues other than the Emergency Room.

- **Chronic Diseases**
  Encourage healthy lifestyles and provide educational activities to elementary school age children to help prevent Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) Diabetes and Obesity in later life.

- **Substance Abuse**
  Focus on the development of a hospital provided Inpatient Medical Stabilization related withdrawal from substance abuse/addiction and a strong outpatient network of programs and providers for treatment of patients with substance abuse/addiction related to drugs and alcohol.

Harrisburg Medical Center 2016 Health Improvement Process Implementation Plan

PRIORITY AREA 1: **MENTAL HEALTH**

Rationale: Throughout the Community Health Needs Assessment, there was overwhelming evidence of the need for increased awareness, education, and access related to mental health issues in our community. Support for our community members and their impacted families who suffer with mental health issues was noted extensively throughout the assessment.

TARGET POPULATION: Individuals and their families within our community that suffer with mental health issues.

GOAL: Decrease emergency room use related to mental health issues and readmission to the inpatient Behavioral Health Unit by increasing the awareness and use of various outpatient services that are available in our community to those who suffer with these issues.

PERFORMANCE MEASURES

Short Term Indicator 1: **Increase awareness of community resources**

- Partner with our behavioral health community to identify additional public locations for resource guide distribution.
- Create community resource guide and expand/enhance presence on HMC Web site.
- Raise awareness of resources with community leaders.
- Partner with local libraries to make resource information publicly available.

Possible partners: local community libraries, mental health agencies, local health departments

Short Term Indicator 2: **Develop stronger relationships with organizations that provide services and resources that are culturally educationally appropriate to community members**

- Research and identify resources available from the professional community with like strategic priorities and identify ways we can work together.
- Conduct interviews with support agencies and community groups to identify how HMC can develop/expand relevant programming for our community.

Possible partners: local health departments, local mental health agencies

Short Term Indicator 3: **Establish Outpatient appointments current baseline volumes for 3 months data;**

- Initial Outpatient appointments at identified local mental health agencies
  Related to the percentage of Initial Outpatient appointments made and kept at EPC and Behavioral Health Inpatient referrals appointments made for post discharge
- BH patients discharged from ER with follow-up appointments
  Related to the percentage of Initial Outpatient appointments made and kept for patients seen and discharged from HMC ER.
- Patients discharged from the BH inpatient unit

Related to the percentage of Initial Outpatient appointments made and kept by patients referrals following discharge from Behavioral Health inpatient status.

Short Term Indicator 4: Establish current baseline volumes for 3 months data related to;

- Patients seen in the ER for Behavioral Health issues monthly
- Patients re-admitted to inpatient Behavioral Health Unit

Long Term Indicators

- Increase in outpatient appointments monthly at identified local mental health agencies
  Compared to the monthly baseline
- Decrease in emergency room visits for psychiatric care
  Compared to the monthly baseline
- Decrease in Behavioral Health inpatient re-admissions for psychiatric care
  Compared to the monthly baseline

Implementation Plan Data

Short-Term Indicators

- Establish a baseline from 3 months data related to the percentage of Initial Outpatient appointments made and kept at; EPC, Behavioral Health Inpatient referrals post discharge, post BH patients ER visit discharge follow-up appointments.
- Establish a baseline from 3 months data related to the volume of patients seen in the ER related to behavioral health issues
- Establish a baseline from 3 months data related to the number of patients that are re-admitted as inpatients to the Behavioral Health Unit

- Once the baseline is established, monthly tracking shall be compared to the baseline

Long-Term Indicators

- Increase in the number of outpatient visits related to behavioral health issues
- Decrease in the number of patients seen monthly in the ER for related behavioral health issues
- Decrease in the number of patient re-admitted to the inpatient Behavioral Health Unit

PRIORITY AREA 2: **Childhood Obesity/Overweight**

Rationale: The rates of obesity and related chronic diseases are on the rise nationally, and the state of Illinois and our community are no exception. Illinois adult obesity rate has increased by nearly 250% in 23 years which has created an increase in patients affected by diabetes, heart disease, hypertension, COPD and obesity related cancer. Childhood obesity has more than tripled since 1980. The National Center for Health Statistics states that nearly 17%, or close to 12.5 million youth age 2-19 in the United States are obese. It has been identified that losing weight and maintaining a healthy weight through physical activity and healthy eating can help to prevent and control these diseases.

TARGET POPULATION: Elementary aged school children

GOAL: Reduce the risk factors for obesity by utilization of activities and partnering with area schools and pre-school programs to teach students the importance of good nutrition through a healthy diet and regular physical activity for improved health later in life.

PERFORMANCE MEASURES

Short Term Indicator 1: **Increase awareness of community resources**

- Partner with our community resources related to child development and education for eating a good diet and participating in moderate and vigorous physical activities and muscle strengthening activities to aid in the prevention of overweight and obesity.
- Create a community resource guide and expand/enhance presence of educational material related to the importance of eating five or more servings of fruits and vegetables per day to reduce the risk of many chronic diseases later on in life.
- Raise awareness of resources with community leaders.
- Partner with local libraries to make resource information publicly available.

Possible partners: local community libraries, local health departments, area schools

Short Term Indicator 2: **Develop stronger relationships with organizations that provide educational services and resources that are culturally educationally appropriate to community members**

- Develop a community group involving educational organizations along with as health care organizations involved in children's health and development.
- Research and identify resources available from the professional community with like strategic priorities and identify ways we can work together.
- Conduct interviews with support agencies and community groups to identify how HMC can develop/expand relevant programming for our community in healthier habits in child development.

Possible partners: local health departments, pre-school programs and school programs

Short Term Indicator 3: **Increase the number of schools that participate in the CATCH program**

Short Term Indicator 4: **Establish current baseline volumes for 3 months data related to;**

Long Term Indicators 1: **Reduce the proportion of children in elementary schools who are considered obese.**

PRIORITY AREA 3: **Substance Abuse/Addiction related to Drugs and Alcohol**

Rationale: In the United States, 17.6 million people, or 1 in every 12 adults, suffer from alcohol abuse or dependence. This amounts to 8.3% of the population. An estimated 24.6 million Americans aged 12 or older, or 9.4% of the population, used an illegal drug in the past 30 days. Additionally, the nonmedical use or abuse of prescription drugs--including painkillers, sedatives, and stimulants—is growing, with an estimated 48 million people ages 12 and older having used prescription drugs for nonmedical reasons. This represents approximately 20% of the U.S. population. These are figures from The National Survey on Drug Use and Health. Our primary service area includes the following counties; Saline, Franklin, Gallatin, Hamilton, Hardin, Johnson, Pope, White, and Williamson. In this service area there is a population of 138,017 adults 18 and older. Utilizing the figures stated nationally above, 11,455 people in our service area (8.3%)with alcohol abuse or dependency, 12,973 people (9.4%) who will use illegal drugs and 27,603 (20%) are presently using prescription drugs non-medically.

TARGET POPULATION: Adults 18 years and older with substance abuse/addiction related to drugs and alcohol.

GOAL: Treat those patients who are in need of medical stabilization services who have been drug, alcohol and or other health related issues. To provide appropriate discharge planning assistance in entering into community based programs and services for continued treatment.

PERFORMANCE MEASURES

Short Term Indicator 1: Harrisburg Medical Center and Special Care Hospital Management Corporation begin structure of New Vision services within the hospital.

- Establish New Vision structure
- Develop and improve patient care pathways and protocols
- Develop a Community Outreach and Community Education Plan to increase awareness and managed care awareness of the service
- Define monthly and quarterly goals
- Provide in-service training to hospital staff and selected physicians
- Implement a plan for outreach activity
- Implement policies and procedures
- Implement an outline of daily reporting to Special Care
- Implement monthly reporting to the hospital

Short Term Indicator 2: Development of Service Goals

- Increase community awareness of stabilization service to businesses and agencies with the area
- Recruit new staff/nurses, if needed
- Train and work with nursing staff in development of the service
- Review-assess Community Outreach and Community Education Plan
- Review of billing and collection of accounts receivable
- Begin developing relationships with outpatient referral resources that are substance abuse sites within a 50 mile radius of the hospital's location

Long Term Indicator 1: **Harrisburg Medical Center will develop and provide inpatient medical stabilization and withdrawal symptom management services at the hospital.**

- Harrisburg Medical Center will contract with Special Care Hospital Management Corporation to institute a New Vision Service where patients are screened and admitted for Medical Stabilization and Withdrawal Symptoms Management.

Long Term Indicator 2: **Harrisburg Medical Center through the New Vision Program will develop an internal and external public relations campaign to showcase the Hospital and its New Vision service.**

- Marketing the New Vision Service to people, groups, community agencies, businesses and EAP's, who are most likely to encounter people who need New Vision services, including Business and Industry, Community Groups, Hospital Emergency Rooms and other healthcare practitioners.

Long Term Indicator 3: **Harrisburg Medical Center and Special Care Hospital Management Corporation will develop and implement a quarterly plan which will concentrate on;**

- Increasing community outreach activities and presentations
- Medical chart reviews for compliance with policies and procedures
- Physician recruitment and retention if needed
- Review of Medical Director duties/compliance
- Evaluation of The Joint Commission compliance/state and federal licensure compliance
- Ongoing evaluation of quality of services
- Routine communication with referral sources within the service area
- Communication with the business office to insure billing and collection is appropriate