Community Health Needs Assessment

2013 Implementation Plan

LOGANSPORT Memorial HOSPITAL

Community Need: **Access to Care**

To lessen the physical, financial, psychological, socio-cultural and educational barriers to care.

Partners and Resources

Lead Partners: Logansport Memorial Hospital, Area Five, Indiana Health Center

CCRN, Community Health Center, Four County, Mental Health Association, Area Personnel Association, Senior Centers, Churches, Nursing Homes and Assisted Living Centers, Local School Corporations and Educational Institutions, Employer-based Clinics, and Community Pharmacies

Strategy Goal #1: Provide healthcare services where the patient/consumer can easily access them.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Evaluate delivery methods and locations of healthcare services (including the delivery of behavioral health services within traditional medical settings).	Identify services to be provided offsite. Develop list of potential service locations. Meet with potential partners to discuss potential service partnerships.	Expand partnerships and service locations. Decrease the number of persons unable to obtain a medical care appointment due to inconvenient office hours from 6% —> 2%.	95% have a specific source of ongoing care.
Collaborate with key organizations to offer on-site medical services.	Open additional service locations. Evaluate purchase of a mobile healthcare unit.		
Offer non-traditional/extended hours of service.	Decrease the number of persons unable to obtain a medical care appointment due to inconvenient office hours from 7.5% —> 6%.		
Complete ADA evaluations for provider locations.	Conduct ADA audit of all LMPN locations.	Implement ADA recommendations at all LMPN locations resulting from ADA audit. 100% of LMPN and non-LMPN provider locations to be ADA compliant.	
Recruit primary care providers (defined as family medicine, general internal medicine, pediatrics) that match the demographics of the community.	Recruit one PCP provider of Hispanic descent.	Increase the number of PCP providers of Hispanic descent by 10% (or 2 providers).	

Strategy Goal #2: Develop patient materials at appropriate age and reading levels, as well as deliver in English and Spanish.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Develop local healthcare system guide and terms.	Produce healthcare system guide.	Update and maintain healthcare system guide.	
Evaluate reading levels of patient education materials.	Review patient materials or readability at 8th grade level or below.	Rewrite all patient materials at the 8th grade level or below.	
Translate written materials.	Review patient materials for translation.	Translate patient materials.	

Strategy Goal #3: Provide education to patient/consumer on how to access the healthcare system.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Hire a community education navigator.	Collaborate with community organizations to facilitate the hiring of navigator(s).	Achieve Healthy People 2020 target.	100% population with universal coverage.
Provide multiple sign-up locations for healthcare exchanges.	Determine job functions of community education navigator.		
Coordinate financial assistance/planning services for patients in need of healthcare services.	Determine how to fund community education navigator positions. Identify locations for healthcare signups. Reduce percentage of low-income without insurance from 23.9% —> 10%. Reduce percentage of overall population without insurance coverage from 13.6% —> 5%.		

Strategy Goal #4: Utilize technology to improve access to care.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Develop a mobile application.	Identify purpose of mobile application. Identify current mobile applications available that promote healthcare access. Promote mobile applications.	Meet increased demand of healthcare consumers utilizing online/mobile solutions to make informed healthcare choices.	
Incorporate patient education materials onto the LMH website.	Incorporate online health resource library onto LMH website. Link LMH website to partner websites and promote healthcare services and healthcare education.		
Develop a community-wide EMR.	Define data to be shared. Interface with local organizations to share patient information.	Encourage partner organizations to participate in the Indiana Health Information Exchange.	




Community Need: **Chronic Disease Management and Health Screens**

To focus on chronic disease management and whole-person health as a way of providing patient care.

Partners and Resources

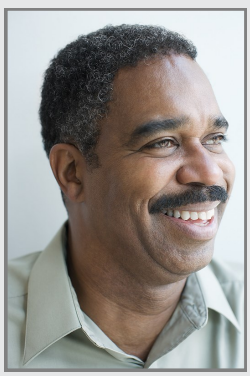
Lead Partners: Logansport Memorial Hospital, Logansport Memorial Physician Network, Cass County Health Department, Indiana Health Center, Four County Counseling Center

Mental Health Association, Nursing Homes and Assisted Living Centers, Local School Corporations and Educational Institutions, and Community Pharmacies

Resources: www.communityguide.org ▪ www.ahrq.gov

Strategy Goal #1: Choose top 3-5 chronic diseases to impact.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Identify team of community practitioners to collaborate for selection of top chronic diseases to address.	Select team to evaluate community chronic disease data.	Percentage improvement in select chronic diseases to be managed for community impact.	5.3% of 50+ population with osteoporosis 26.9% of population with high blood pressure 74.8% with diabetes having annual foot exam 16.1% have a1c value greater than 9% 13.5% of population with high cholesterol
Analyze data.	Determine data to be used for evaluating community chronic disease impact.		
Identify the most effective evidence-based programs for managing disease.	Select best practices to incorporate into healthcare organizations for management of community chronic disease.		
Analyze the role of mental health co-morbidity in each chronic disease state chosen.	Determine improvement goals for chronic disease management.		



Strategy Goal #2: Implement the Medical Home Model.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Monitor patient healthcare needs, required tests/labs and age-appropriate screenings.	Coordinated care resulting in improved quality, satisfaction, and lower costs. Increase the number of patients receiving preventative care.	Percentage improvement in select chronic diseases to be managed for community impact. Point-of-care reports supporting clinical decisions. 2.4% of adult office visits include screening for depression. A behavioral health specialist is part of all primary care office structures.	
Proactively schedule patients for required tests/labs and age-appropriate screenings.			
Develop plan for enhancing integration within and coordination across healthcare settings.			
Develop a community-wide EMR.			
Collaborate with Four County to select common depression and anxiety screening tool.	Implement anxiety screening into primary care visits. Depression screening tool standardized across the community. Increase percentage of providers utilizing mental health/depression/ anxiety screening tools.		
Provide psychiatric medication management.	Increase percentage of patients identified with co-morbidity of chronic health disease and mental disorder. Develop education programs for medication management.		
Number of physicians registered with state INSPECT program (and trained in risk stratification, risk reduction/ management strategies with opioid medications).	Implement evidence-based clinical decision making to address positive depression and anxiety screens within the medical home model.		

Strategy Goal #3: Provide education to patient/consumer on the importance of preventative healthcare services and the impact on chronic disease.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Utilize the LMH website to promote information and education through the online health resource.	Increased number of e-visits/virtual visits (through the patient portal).	Achieve Healthy People 2020 target. Percentage improvement in select chronic diseases to be managed for community impact. Medical Home Model is the standard of practice for all primary care physicians.	95% have a specific source of ongoing care.
Promote the patient portal/LMH website at visits.	Achieve NCQA recognition.		

Strategy Goal #4: Provide community education related to chronic disease management and the role of modifiable health risk behaviors, effective strategies for behavior change, and co-morbidity of mental health/substance abuse.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Develop education programs about mental health/ substance abuse issues.	Improved access to assessment of individuals with possible substance abuse disorders.	Long-term substance abuse facility open in Cass County.	
Develop public service campaigns related to mental health/substance abuse.			
Focus on early intervention and environmental experiences.			
Coordinate with employers to address the impact of substance abuse on the workforce.			
Collaborate with law enforcement to provide education.			

Community Need: **Maternal, Infant, and Child Health**

To increase access to prenatal care.

Partners and Resources

Lead Partners: Logansport Memorial Hospital, Logansport Memorial Physician Network, Area Five, Better Health of Cass County, Cass County Health Department, Indiana Health Center

Local School Corporations and Educational Institutions, Department of Child Services, IHA Midwestern District, and Peak Community Services

Strategy Goal #1: Provide education to patient/consumer on how to access the healthcare system.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Hire a community education navigator.	Collaborate with community organizations to facilitate the hiring of navigator(s). Determine job functions of community education navigator.	Achieve Healthy People 2020 target.	100% population with universal coverage.
Provide multiple sign-up locations for the healthcare exchange.	Identify locations for healthcare exchange sign-ups.		
Coordinate financial assistance/ planning services for patients in need of healthcare services.	Determine how to fund the community education navigator positions. Reduce percentage of low-income without insurance coverage from 23.9% —> 10%. Reduce percentage of overall population without insurance coverage from 13.6% —> 5%.		

Strategy Goal #2: Provide education to patients that promotes a healthy pregnancy and proper prenatal care.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Develop public service campaigns to target pregnant women at risk of not receiving prenatal care.	70% of females receive prenatal care beginning in the first trimester.	90% of females receive prenatal care beginning in the first trimester.	% no prenatal care in first trimester at 22.1 % of low birth weight births at 7.8
Collaborate with key organizations to facilitate prenatal care.	Reduce the rate of all infant deaths (within one year of life).		
Collaborate with local schools to promote health education for pregnancy prevention services and resource access.	Reduce the Cass County teen pregnancy rate from 63% (in 2009) to less than 60% in 2017.	Reduce the Cass County teen pregnancy rate to below 50% per year by 2020.	
Screen homes for lead, water, and air quality.	Reduce number of reported lead levels by 50%. 90% of the population has a drinking water supply that meets the Safe Drinking Water Act.	No reportable lead level cases. 92% of the population has a drinking water supply that meets the Safe Drinking Water Act.	
Promote Cass County public transit as a transportation resource for patients.	Include public transit contact information in all health resource/ education materials.		

Community Need: **Nutrition, Physical Activity, and Weight**

To improve the quality of life for the population while promoting and engaging participants in healthy lifestyles.

Partners and Resources

Lead Partners: Logansport Memorial Hospital, Better Health of Cass County, Cass County Family YMCA, City of Logansport Parks Department

Indiana Health Center, Four County Counseling Center, Mental Health Association, Local School Corporations and Educational Institutions, ACTS Project—Community Gardening, CCRN, Area Five, Purdue Extension, Cass County Farmer's Market

Strategy Goal #1: Promote availability of healthy food choices.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Promote and support community gardening initiative.	Increase number of community gardens to 10.	Increase from 10 to 20 community gardens.	
Develop food distribution system to ensure excess food reaches community members.	Identify locations for excess food distribution from community gardens. Establish two locations for free food distribution (from community gardens).	Achieve 0% waste from community gardens.	
Collaborate with community partners to offer food education programs (schools, county extension, etc.).	Develop nutrition education programs.		
Educate community on actual compared to perceived cost of fresh and healthy food.	Deliver 4 nutrition education programs per year.	Deliver one nutrition education program per month.	
Work with local restaurants to promote healthy food options.	Identify restaurants that are willing to add and promote healthy food choices to menus.	All restaurants display healthy food choices.	
Promote healthier beverages in vending machines at LMH and other business establishments.	Fill LMH vending machines with healthier beverage choices. Identify 6 businesses willing to convert vending machines to healthier beverage choices.	100% of businesses engaged in health and wellness programs have vending machines that only have healthy beverage choices.	
Incorporate cultural and economic aspects.			

Strategy Goal #2: Promote increased physical activity and exercise for all age groups.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Health communication campaign to make community members aware of various types of physical activity and places they can go to exercise.	5% decrease in Cass County inactivity percentage. Decrease adult obesity rate to 30%.	Achieve the County Health Rankings goal for physical inactivity (21%). Meet the County Health Rankings national benchmark of 25% for adult obesity.	% obese at 30.6 % obese counseled about weight in the past year at 31.8 % children obese at 14.6
Develop a Cass County walking/trails map.	Walking/trail map developed.		
Conduct facility audit to determine available buildings or locations for community activities.			
Work with employers to promote physical activity and exercise at the workplace.			
Work with local government to repair sidewalks, implement safe routes to school, and zoning issues for new development.			
Develop a community family fitness challenge.			
Work with area school districts to promote physical fitness in the schools.	Increase the percentage of youth participating in physical activities.		
Explore the "Complete Streets" program.			

Strategy Goal #3: Engage community partners to examine what actions and policy changes can be taken as a community to influence the overall health of the county.

Outputs	Outcomes—Impact		
Activities	Short Term (1-3 Years)	Long Term (4-7 Years)	Healthy People 2020
Utilize CHNA data and implementation plan to identify community-wide actions to take that will lead to a healthier Cass County.	Common criteria identified to be used for community health decisions.	Rank in the top 25 of the County Health Rankings.	Achieve the top 25% of County Health Rankings.