

**Community Health Implementation Plan**

**QUARTERLY UPDATES**

FY2020-2023

The Community Health Implementation Plan (CHIP) is a list of specific goals and strategies that demonstrate how MVH plans to address the most significant needs identified in the CHNA while also being aligned with Mid Valley’s community health improvement initiatives and national, state and local public health priorities.

Our Annual Marketing Plan, which is derived from our strategic plan, includes community benefit and population health improvement activities.

Based on qualitative and quantitative data collected and analyzed during the CHNA process, MVH’s Implementation Plan remains committed to the goals and strategies identified in the 2016 CNHA.

# Health Priorities FY2020-2023

**The top five priorities:**

1. Access to Care (Behavioral and Physical Health)
2. Affordable Housing
3. Chronic Disease
4. Education
5. Substance Use

**Overarching theme for addressing health priorities:**

1. Reduce barriers to care
2. Improve care coordination
3. Focus on health outreach and education

MVH is engaged in numerous programs addressing the identified needs of Okanogan County. Mid-Valley Hospital and Clinic work to strategically allocate scarce resources to best serve the communities, increase trust and build stronger community partnerships.

The CHIP items which follow, provide action plan strategies and examples of ongoing initiatives that address the identified needs. Strategies emphasize clinical and community partnership development and improved coordination of care. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

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| **Health Need 1: Access to Mental & Physical Health** |
| Goal | Strategies | Metrics | Potential Partnering/ External Organizations |
| ***Goal 1:****Improve access to health care and mental health services for groups of all ages and populations* | **Strategy 1:** Enhance and expand telemedicine opportunities | * Increase total consults
* Identify community partners to strategize on creatively delivering care
 | * Leslie Hite, PMHNP (MVC)
* Terri Greer, PhD
* FHC
* Lifeline
 |
| **Strategy 2:** Enhance awareness of available services | * Resource information distribution
* Participate Community Health Initiative Workgroup
* Informing the community through advertisement for local available services
 | * OBHC
* Public Health
* Colville Confederated Tribe
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| **Strategy 3**: Connect uninsured to private insurance, Medicaid, or other available coverage | * Number of insured patients
 | * HCA
* FHC
* Patient Financial Counselor
 |
| ***Goal 2:****Improve access and integration/ coordination of family health services, mental health and substance abuse services* | **Strategy 1:** Expand program(s) to support ED patients waiting for outpatient mental health and/or substance use disorder treatment | * Number of follow-up phone calls and outreach to patients who have experienced an overdose
* Number of patients served by the Bridge Clinic
 | * Leslie Hite, PMHNP (MVC)
* OBHC
 |
| **Strategy 2:** Improve care coordination for mental health and substance abuse co- occurring conditions through facilitation of direct hand-offs to the next level of care | * Number of patients referred between systems
* Improve access by providing education regarding available resources and services
* Utilize Transitional Care Management and Discharge Planning resources
 | * OBHC
* Physician practices
* Local Health Depts.
* Colville Confederated Tribe
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**ACTIVITIES/INITIATIVE:**

**Education**: To improve access to mental health care for the community providing up to date information on available mental health resources and services.

**Education/Awareness**: Cosponsor the screening “Written Off”: an award-winning documentary about one man’s 10 year struggle with opioid addiction to help community change the way they view America’s opioid crisis and reduce the stigma of addiction.

**Telehealth services** Expand existing programs to outlying facilities as much as possible, increase the number of specialties providing telehealth consultations.

**Transportation**- Work to mitigate transportation barriers by assisting/arranging transportation for patients to travel to medical appointments

**Uninsured/underinsured care -**Inform patients and family members of MVH Financial Assistance Policy, assist with application for financial assistance, and provide financial assistance to eligible patients. Work with patients to determine eligibility for medical assistance, e.g. Medicaid, and other social services.

***2020 Q1 UPDATE***

**Goal 1: Improve access to health care and mental health services for groups of all ages and populations.**

***Strategy 1:*** *With the COVID-19 pandemic, the Federal Cares Act, which passed March 27t, permitted RHCs and FQHCs during the crisis only to be Distant Site Providers (where the patient is remote and the provider is at the clinic), and not just Originating Site Providers (where the patient comes into the clinic and accesses a provider via telehealth outside of the clinic). In anticipation of the passing of this bill, MVC provided a telemedicine platform, educated staff regarding documentation and consent requirements, and worked with billing and coding to get set up for telemedicine services. Besides Medicare, other insurance carriers are allowing telemedicine services during this Pandemic. Family Practice, Behavioral Health, and Orthopedics are currently providing telemedicine services. The National Assn. of Rural Health Clinics (NARHC) and other rural healthcare organizations are lobbying CMS to allow RHCs to be distant site providers of telemedicine services permanently.*

**Goal 2: Improve access and integration/coordination of family health services, mental health and substance abuse services.**

**Strategy 2:** *MVC has been working with Lifeline to launch joint services. Lifeline, in collaboration and coordination with MVC Behavioral Health, will go to patient’s homes to periodically place eyes on patients with mental illness as needed. Secondly, when a patient either presents to the ER with substance use overdose or complications and are willing to undergo substance use treatment, Lifeline will administer an initial dose of suboxone and then transport the patient to MVC to start the process of Medically Assisted Treatment and care at MVC during normal business hours. This plan has* since been put on hold due to the COVID-19 Pandemic and has not yet been implemented.

**Strategy 3:** We continue to offer each patient information about our financial assistance program. Patients are referred to Maria Davenport, HCA, or to the hospital district’s Self Pay Billers for additional assistance. All of our Healthcare Assistance Program information is available in English and Spanish on the hospital district website.

**2020 Q2 & Q3 Update**

**Goal 1: Improve access to health care and mental health services for groups of all ages and populations.**

***Strategy 1:*** *Received AIMS Premera Integrating Behavioral Health grant in the amount of $245,000. This grant will help develop behavioral health registries, train staff on behavioral health care management, and integration of behavioral health services with primary care.*

**Goal 2: Improve access and integration/coordination of family health services, mental health and substance abuse services.**

**Strategy 2:** *MVC has been working with Lifeline to launch joint services. Lifeline, in collaboration and coordination with MVC Behavioral Health, will go to patient’s homes to periodically place eyes on patients with mental illness as needed. Secondly, when a patient either presents to the ER with substance use overdose or complications and are willing to undergo substance use treatment, Lifeline will administer an initial dose of suboxone and then transport the patient to MVC to start the process of Medically Assisted Treatment and care at MVC during normal business hours. This plan has* since been put on hold due to the COVID-19 Pandemic and has not yet been implemented. **Q2 & Q3:** The substance use disorder MAT Program has been delayed until after completion of the training and implementation of behavioral health integration the AIMS grant.

**Strategy 3:** No new updates. Previous statement still continues.

**2020 Q4 Update**

1. ***Health Need 1: Access to Mental and Physical Health***

***Goal 1:  Improve Access to Health Care and Mental Health services for Groups and Populations***

***Strategy 1:  Enhance and Expand Telemedicine Opportunities***

*Developed telehealth Annual Wellness Visit (AWV) workflow whereby medical assistant contacts patient ahead of visit and completes AWV surveys and prepares list of preventive services and when due.  Provider then conducts telehealth visit with patients going over survey results, needed preventive care, and care plan for patient.*

1. ***Health Need 1: Access to Mental and Physical Health***

***Goal 2:  Improve access and integration/coordination of family health services, mental health, and substance abuse services***

***Strategy 1:****Q4 – Received AIMS Integrated Behavioral Health Grant patient registry software and initial grant funding and began pre-planning meetings with kickoff for training planned for the end of February, 2021.*

***Strategy 2:****Primary care team conducted AMVs via telehealth, often working on unscheduled days to conduct AWV telehealth visits to their patients.*

**2021 Q1 Update**

***Health Need 1, Goal 2, Strategy 2:****Through the Premera/University of WA AIMS integrated Behavioral Health Grant, all primary care providers and Psychiatric Nurse Practitioner received training on the Collaborative Care model in preparation to launch care under the Grant in March.  In addition, Behavioral Health Registry software was included as part of the grant where patients can be tracked who score positive on the PHQ-9 Depression screening, GAD-7 Anxiety screening, and other such screening tools.  Early intervention is promoted through this program, with the help of a Behavioral Health Care Manager (BHCM), who monitors behavioral health patient care, and serves as a liaison between the primary care provider team and Psych consultant.  The actual launch has been postponed until the BHCM position is filled.*

**2021 Q4 Update**

**Health Need 1: Access to Mental and Physical Health
*Goal 1: Improve Access to Health Care and Mental Health services for Groups and Populations
Strategy 1:*** *Enhance and Expand Telemedicine Opportunities Developed telehealth Annual Wellness Visit (AWV) workflow whereby medical assistant contacts patient ahead of visit and completes AWV surveys and prepares list of preventive services and when due. Provider then conducts telehealth visit with patients going over survey results, needed preventive care, and care plan for patient.*

**Health Need 1: Access to Mental and Physical Health
*Goal 2: Improve access and integration/coordination of family health services, mental health, and substance abuse services

Strategy 1: –*** *Received AIMS Integrated Behavioral Health Grant patient registry software and initial grant funding and began pre-planning meetings with kickoff for training planned for the end of February, 2021.*

***Strategy 2:*** *Primary care team conducted AMVs via telehealth, often working on unscheduled days to conduct AWV telehealth visits to their patients.*

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| **Health Need 2: Affordable Housing** |
| Goal | Strategies | Metrics | Potential Partnering/ External Organizations |
| ***Goal 1:****To increase access to affordable housing* | **Strategy 1**: Be strong partners with Okanogan County Community Action Council and Okanogan County Housing Authority | * MVH while not addressing directly will continue to provide support to local agencies addressing these needs.
 | * Okanogan County Housing Authority
* Okanogan Community Action
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Q1 – Q4 - No updates

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| **Health Need 3: Chronic Disease Management** |
| Goal | Strategies | Metrics | Potential Partnering/ External Organizations |
| ***Goal 1:****Prevent, detect, and manage chronic diseases* | **Strategy 1**: Work with community organizations, congregational networks, and individuals to improve care, management and prevention of chronic diseases | * Number of health education/outreach encounters provided to community-based organizations and churches
* Number of participants in health events and number of screenings performed
* Number of outreach programs
 | * Health Departments
* Community Health Initiative (CHI)
* North Central Accountable Communities of Health (NCACH)
* Confluence
* Family Health Centers
 |
| **Strategy 2:** Screen for barriers/social needs of patients with chronic conditions during transitions to improve ability of patient to manage condition | * Increased transition support available to patients with chronic disease
* Number of patients connected to services addressing social needs
 | * Population Health Nurse
* CHI
 |
| **Strategy 3**: Continue to educate the community about Lung Cancer Screening Program and support programming to reduce use of tobacco products | * Earlier detection of lung cancer
* Improve survival rates
 | * County Health Departments
* Community Providers
* CHI
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**ACTIVITIES/INITIATIVES EXAMPLES:**

### Outreach:

Education, screenings and support groups offered on the following topics/conditions: high blood pressure and heart disease; diabetes; cancer, stroke; hospice services and palliative care; obesity, exercise and nutrition; depression and anxiety

Engage targeted communities on healthy lifestyles: Through sponsorship or provision of:

* Community-wide education
* Store Tours
* Community Screenings & Referrals (Blood pressure, BMI/Weights, & Cholesterol)
* Exercise Demonstrations

### Diabetes

Plan to assess the need for a Diabetic Educator and classes in our community.

### Physician Outreach:

Provide education to community physicians who manage patients with complex chronic conditions

### Stampede Mammography Program

Mid-Valley Hospital & Clinic have teamed up with the Omak Stampede to increase awareness of breast cancer and support uninsured and under-insured patients for prevention and early detection.

Omak Stampede has given a portion of their Friday Night "Tough Enough to Wear Pink" proceeds to Mid-Valley Hospital & Clinic. Funds may be applied to screening or diagnostic mammograms, ultrasounds and distributed as follows:

* Balances owing where a patient has NO insurance coverage may be covered in full.
* Balances owing after insurance has paid may be covered up to $500.

### Lung Cancer Early Screening Program

The low dose computed tomography (LDCT) screening program promotes earlier detection of lung cancer. Eligible patients are the high-risk groups which include those who have smoked a pack of cigarettes daily for two or three decades, who are currently smokers, or those who quit smoking less than 15 years ago to have them screening for lung cancer. Earlier detection promotes better treatment and survival rates.

***2020 Q1 UPDATE***

**Goal 1: Prevent, detect, and manage chronic diseases**

**Strategy 1:** *MVC is working with Lifeline to provide Annual Wellness Visits (AWV) to its Medicare patients in their homes. Lifeline would meet with the patient and go over all the screenings, and then one of MVC’s family practice providers would schedule an afternoon to meet with the patient in their home to go over the screenings with each patient. This will improve the percentage of AWVs which includes screenings for early detection of various health conditions.*

**Strategy 2:** *MVC screens for social determinants of health and refers patients through our patient care coordinator to agencies that can address the patient’s need.*

**Strategy 3**: Ran a 2-month campaign on the new lung cancer screening program and provided physician education.

***2020 Q2 & Q3 Update***

**Goal 1: Prevent, detect, and manage chronic diseases**

**Strategy 1:** *Nursing staff call and screen patients over the phone for annual wellness visits. Providers then call the patient and conducts cognitive screening and reviews the information from the nurse.*

**Strategy 2:** *MVC is working to capture HCC codes. Training has been provided to the Coding Staff on coding documentations of chronic conditions.*

**Strategy 3**: Tobacco screenings are covered at 85-88% of all visits.

***2020 Q4 Update:***

***Health Need 3: Chronic Disease Management***

***Goal 1:  Prevent, detect and manage chronic diseases***

***Strategy 2:****Substantially increased percentage of AWVs conducted in fourth quarter due to conducting visits via telehealth.*

***Strategy2:****Reviewed HCC codes and primary care provider staff concentrated on capturing all chronic diagnoses from previous years in order to most accurately reflect cost of patient’s care.*

*MVC continues to assess diabetic patient care.  For patients with A1C greater than 7, patients are seen quarterly and A1C reviewed until in control (below 7).  Those patients with A1Cs controlled (below 7), are seen every six months.  All diabetic patients have annual foot exams, or more often if needed; and are expected to have annual diabetic retinal exams.  MVC has the instrument to provide diabetic retinol exams in the clinic.*

***2021 Q1 UPDATE***

***Health Need 3, Goal 1, Strategy 1:***  In preparation for conducting Medicare Annual Wellness Exams (AWVs), Staff are researching when patients had their last colorectal screenings and other such health screenings that are not done annually and updating Cerner along with recommendations for when those screenings need to be repeated.  Then, during the AWV encounter, primary care providers review these screening recommendations with the patients and refer for the screening if due.

***Health Need 3, Strategy 2:***  Our Health Information Manager, who was an HCC coder earlier in her career, educated Family Practice providers on HCC coding and how to best document to capture HCC codes accurately to reflect a patient’s health status and cost of care.

***2021 Q4 UPDATE***

**Health Need 3: Chronic Disease Management**

***Goal 1: Prevent, detect and manage chronic diseases***

**Strategy 2:** *Substantially increased percentage of AWVs conducted in fourth quarter due to conducting visits via telehealth.*

**Strategy2:** *Reviewed HCC codes and primary care provider staff concentrated on capturing all chronic diagnoses from previous years in order to most accurately reflect cost of patient’s care.*

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| **Health Need 4: Education**  |
| Goal | Strategies | Metrics | Potential Partnering/ External Organizations |
| ***Goal 1:****Increase health literacy for all age groups.* | **Strategy 1:** Continue to implement new and improve upon existing patient education materials | * Increase total consults
* Identify community partners to strategize on creatively delivering care
 | * FHC
* Confluence Health
* Area hospitals
* School Districts
* Civic Leagues?
 |
| **Strategy 2:** Work with universities to create health literacy programs for K-8 | * Rolling out touch points for healthcare for all grade levels.
* Teddy Bear Clinic
 | * OBHC
* Colville Confederated Tribe
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**ACTIVITIES/INITIATIVE:**

**Education/Awareness**: Reach out to the local school nurses to assess the need for supplemental hospital RN outreach program to assist student health education.

***2020 Q1-3 Update:*** Educational materials on Covid-19 have been developed and continue to be disseminated to patients, staff and the community.

***2020 Q4 Update:*** Educational materials on Covid-19 have been developed and continue to be disseminated to patients, staff and the community. **Most activities have been put on hold due to COVID.**

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| **Health Need 5: Substance Use** |
| Goal | Strategies | Metrics | Potential Partnering/ External Organizations |
| ***Goal 1:****Improve access and integration/ coordination substance abuse services* | **Strategy 1**: Provide individual, group, medication assisted treatment, and other mental health services, including prevention and support services | * Decrease re- hospitalization
* Number of patients who accept treatment following an overdose
* Number of adults who utilize services
* Increase family and patient understanding of mental health treatments.
 | * OBHC
* County Health Department
* FHC
 |
| ***Goal 2:*** *Raise awareness and provide education about Substance Use and Cessation* | **Strategy 1**: Connect with local agencies and groups to identify gaps, spread awareness and treatment options for the community | * Identify people seeking these services
* Assess effectiveness of the programs
* Reduced number of ED visits related to Substance use
 | * Local AA group
* Local NA group
* OBHC
* County Health Department
* Okanogan County Jail
* Colville Confederated Tribes
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**ACTIVITIES/INITIATIVE:**

* Work with OBHC to support their efforts and streamline
* Begin to provide: (1) medication administration assistance to complement counseling services currently being offered and to assist post discharge overdose patients;

***2020 Q1-3 Update:*** Continuing to work with OBHC to support their efforts. Providing medication administration assistance to patients, utilizing Psych-NP for med management. Psych-NP has been certified to diagnose autism and is the only behavioral provider in the county that offers behavioral health services to children.

***2020 Q4 Update:*** Working with OBCH on creating a mass communication list to not overlap on outreach, education efforts and grant requests. Also, continuing to work with the Rural Communities Opioid Response Program (RCORP) to bring awareness and education on substance abuse in Okanogan County.

**Mid-Valley’s Additional Initiative**

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| **HEALTH NEED 6: Preventable ER Visits** |
| **Goal** | **Strategies** | **Metrics/What are we measuring** | **Potential Partnering/External Organizations** |
| *Goal: Help patients obtain “The Right Care, at the Right Place, at the Right Time”* | **Strategy 1**: Provide community health education to improve understanding of appropriate use of primary care, urgent care, and emergency department in terms of medical capability and patient needs | * Decrease in unnecessary emergency department visits
* Increase health in literacy
 | * Payers
* Community media outlets
* NCACH
 |
| **Strategy 2:** Improve care coordination, info sharing protocols to achieve safer, more effective care | * Protocols developed
* Chronic disease management
* Transitional Care Coordination
* Assess gaps in the discharge and referral process
 | * Community providers
* County health departments
* social services
* EMS agencies
* Aging agencies
* NCACH
 |

**ACTIVITIES/INITIATIVES:**

### Chronic Disease:

To address chronic disease-related emergency department visits, The Transitional Care Management Program provides continued care coordination for high-risk patients from the beginning of their hospital stay through up to 30-days after discharge. The scope of the discharge planning process has been expanded to include the broader, holistic needs of patients. Discharge planning and the transitional care manager help patients anticipate what their care needs will be in their home environment, connect with the patient’s primary care provider to ensure proper follow-up, and provide links to needed community resources offering services such as transportation, home care, meals, home technologies and social support.

**Identify Metrics to better connect patients to follow up and referrals from ED visits per discharge instructions**

***2020 Q3 Update:***  Working with NCACH, Molina’s Value-based Care Model to provide managed patient care for preventable ER visits. The Transitional Care Management Program works with PCPs to manage patients post discharge from the hospital or ER which prevents reoccurring admissions.

***2020 Q4 Update:***  Launched a three-month “Safely open for care” campaign to educate the community on the dangers of waiting to seek medical attention amidst the pandemic. Media outlets utilized include social media, print (newspaper), email and radio interviews.