Community Health Implementation Plan
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.

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
	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

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.

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

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

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.

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

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.

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

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;

Mid-Valley's Additional Initiative

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