
Regional Health Needs Assessment Project

Ohio's Critical Access Hospitals

NORTH CENTRAL REGIONAL PLAN

MAY 2012

Funded by Ohio Department of Health's Rural Hospital Flex Program
Prepared by Ohio University's Voinovich School of Leadership and Public Affairs
in partnership with the University of Toledo's Area Health Education Center Program

Preface

Ohio's Flex Program

States with critical access hospitals receive funding from the Medicare Rural Hospital Flex Program (Flex Program) to support quality and performance improvements in critical access hospitals, and the development of cooperative systems of care. The Ohio Department of Health, State Office of Rural Health oversees the Ohio Flex Program.

To be considered a critical access hospital, a hospital has to be located in an area designated as rural, have no more than 25 acute and swing beds, provide 24-hour emergency care and maintain an annual average length of stay of 96 hours. Critical access hospitals are reimbursed by Medicare on a cost plus basis for their inpatient, outpatient and swing bed services. Currently, there are 34 critical access hospitals in Ohio, with the majority located in the northwest and north central areas.

Health Care Needs Assessment

The 2010 Affordable Care Act requires all 501(c)3 hospitals to conduct health needs assessments every three years that consider health needs from the perspective of the community. Ohio's Flex Program awarded a contract to Ohio University's Voinovich School of Leadership and Public Affairs, and project partner, the University of Toledo's Area Health Education Center Program, to facilitate four regional planning processes throughout the state of Ohio. The Ohio Flex Program funded the regional planning process described in this report with the goal of supporting the efforts of individual critical access hospitals to complete their individual needs assessments.

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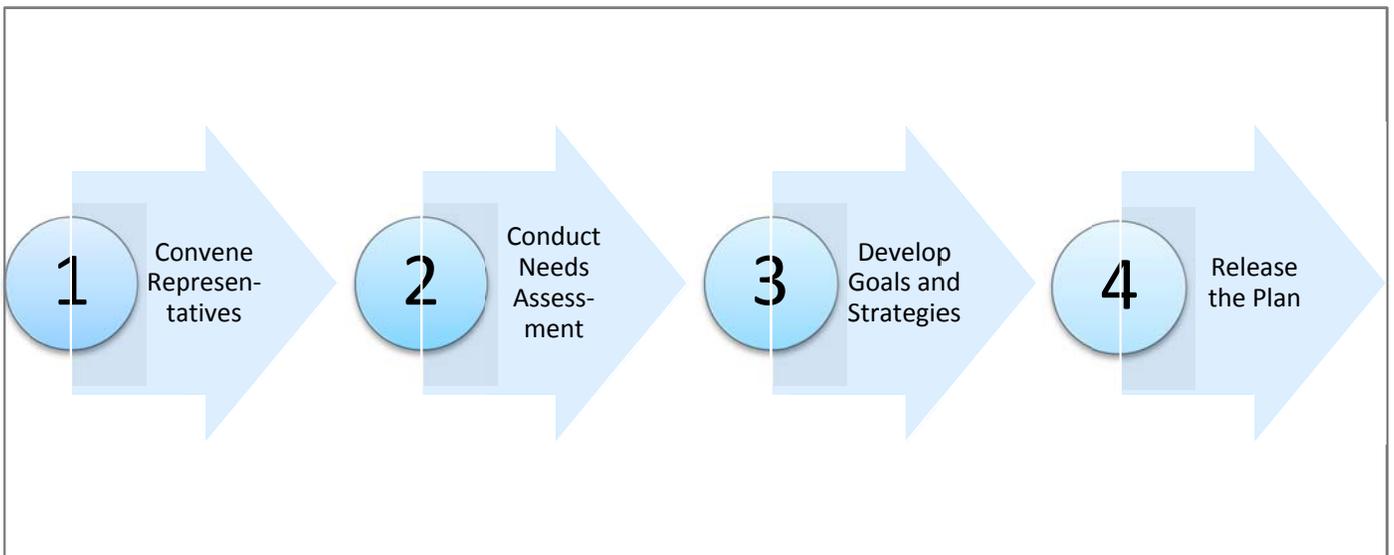
Acknowledgement

A note of gratitude is extended to the hospital and community representatives who participated in this process. Your knowledge and expertise were critical in analyzing the needs and issues in the region and in developing strategies to help address them.

Introduction

With funding from the Ohio Department of Health’s Flex Program, critical access hospitals and community representatives in North Central Ohio met to discuss the health care needs and issues in the region. The process relied on a data-driven, facilitated planning approach, and was conducted between November 2011 and May 2012. This report describes the regional planning process used, along with the goals and strategies developed. The figure below provides an overview of the process utilized, and is followed by a description of each step.

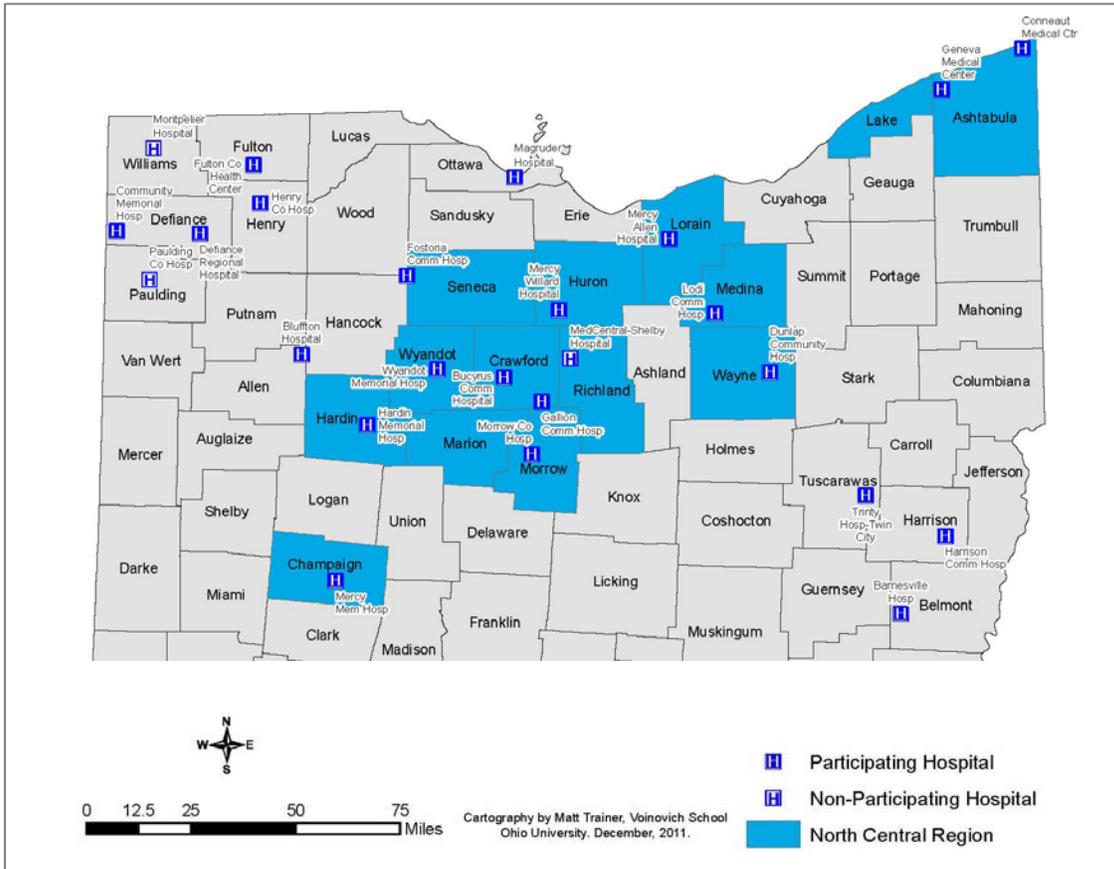
Figure 1. Regional Planning Process



1. Convene Representatives

Critical access hospital representatives met to identify priority health care needs in the region and strategies to address them. The figure on the following page shows the counties identified by hospitals as part of their primary service area. Each hospital recruited a community participant with broad knowledge of the health care needs within their community.

Figure 2. North Central Ohio Needs Assessment Region



2. Conduct Needs Assessment

Critical access hospital and community representatives worked together to analyze the current health care needs in the region. This analysis included reviewing results from a survey of critical access hospitals completed by the hospital representatives. They identified the available and needed inpatient, outpatient and community-based services within their hospital service area. The hospital and community representatives also reviewed health data on the incidence and prevalence of cardiovascular disease, cancer, respiratory disease, diabetes, oral health, perinatal and childhood health, mental health and substance abuse, and a variety of health risk factors. They also considered the region’s demographic composition, educational attainment, poverty status and types of insurance coverage. The reviewed regional needs assessment data is available in a separate report titled, “Regional Health Needs Assessment Project: North Central Ohio Profile” (January 2012).

3. Develop Goals and Strategies

The representatives generated a list of health related needs and issues in the region and then prioritized those issues. Based on the prioritized needs, five key goal areas were developed. For those goal areas, hospital and community representatives brainstormed strategies to address the needs. These strategies were then grouped thematically.

Regional Goal Areas and Strategies

The five goal areas for the North Central region are listed below.

Figure 3. Goal Areas for the North Central Region

- | | |
|--------------|------------------------------------------------------------------------------------------|
| Goal Area 1. | Preventative health education |
| Goal Area 2. | Medication management and reconciliation |
| Goal Area 3. | Help patients with chronic diseases navigate, coordinate and access health care services |
| Goal Area 4. | Immunizations, vaccinations and health screenings |
| Goal Area 5. | Falls and fractures among the elderly |

The remainder of this report outlines the needs and issues related to the five goal areas and the strategies proposed by the hospitals and community representatives to address them. The strategies are presented as examples of ways to accomplish each of the goal areas.

Goal Area 1. Preventative health education

IDENTIFIED HEALTH CARE NEED

Roughly two-thirds of adults in the region are overweight or obese and one in five adults are current smokers. These and other risk factors are linked to higher rates of diabetes, heart disease, stroke, certain cancers and chronic respiratory conditions. Addressing these risk factors could significantly improve health outcomes for area residents.

PROPOSED STRATEGIES

Although a variety of preventative health education initiatives are currently underway, hospital and community representatives identified the need for a more targeted and coordinated approach. In particular, they discussed the need to tailor prevention education and outreach efforts to the interests of specific target populations. Examples of potential strategies include:

Education, Screening and Wellness Programs

- Conduct online wellness screenings and expand lab screenings; develop and deliver targeted information and education programs based on the results of these screenings.
- Utilize social media to reach younger audiences with information and announcements.
- Hold monthly 'Ask the Professional' lunch-and-learns with health professionals.
- Submit weekly newspaper columns written by health care professionals on key health topics.
- Identify evidence-based practices for improving health and wellness and affecting change.
- Incentivize employee wellness programs to encourage healthy lifestyle choices (e.g., Virgin Health Miles). Consider changing employer policies to encourage and incentivize healthy behaviors.

Build Partnerships

Delivering health education in collaboration with public, private and not-for-profit organizations was identified as a key strategy for more effective information dissemination and behavior change. Potential partnerships include:

- YMCAs to conduct monthly meetings and presentations.
- Red Cross and area schools to augment elementary school health education.
- Local health departments to provide parent education seminars; engage parents in taking an early and active role in promoting child health and wellness.
- Faith-based organizations and local health departments to conduct quarterly health and wellness events at local religious institutions.
- Local employers to provide screenings and employee health education. Engage small employers in the coordination and provision of workplace wellness programs.
- Rotary, the Chamber of Commerce and economic development organizations to promote workplace health and wellness, develop workplace incentive programs and make health care more affordable through group purchasing programs.
- Community groups and farmers markets to provide nutritious, seasonal produce to groups.

Goal Area 2. Medication management and reconciliation

IDENTIFIED HEALTH CARE NEED

More than 300,000 individuals in the region have been told they have high blood pressure, while more than 100,000 report having diabetes. In addition, nearly 50,000 area residents report having been diagnosed with angina or coronary heart disease. Individuals with chronic conditions, or those in poor health, may have multiple prescribing providers and are often unable to accurately communicate all the prescriptions they are taking or have had prescribed. The lack of a common electronic medical record system among pharmacies, hospitals and doctors' offices further complicates medication management efforts. The group identified several medication management strategies as well as strategies for reducing medication costs to improve treatment outcomes.

PROPOSED STRATEGIES

Patient Education and Medication Reconciliation

- Develop a standardized medication card to be used by health care providers throughout the community. Encourage each patient to carry their list of medications with them.
- Conduct medication brown bag lunch sessions where individuals bring in all of their medications or a medication list for review by pharmacy students. Provide each participant with a medication card and direct medication concerns to the individual's physician.
- Provide medication management education and medication reconciliation services at health fairs. Provide free pill boxes and show individuals how to sort pills. Include medication "take back" days to allow individuals to dispose of unused medications.
- Conduct medication education sessions on targeted topics such as hypertension, diabetes and congestive heart failure.
- Utilize the "teach back" method by health care providers where they ask the patient to repeat medication instructions at time of discharge.
- Offer discounted subscriptions to electronic medical records systems for affiliate health organizations and area pharmacies to support medication management and reconciliation.

Reduce Medication Cost

- Form a partnership to create charitable community pharmacies that provide free or discounted medications to low-income, uninsured and underinsured individuals. Examples of existing programs include MedAssist of North Carolina and Charitable Pharmacy of Central Ohio.
- Many pharmaceutical companies and pharmacies provide medication vouchers and discounts for low-income individuals; educate social workers and caseworkers about these programs and have them assist with applications for discounted medications.
- Identify other assistance programs which reduce prescription costs; educate patients about these programs.

Goal Area 3. Help patients with chronic diseases navigate, coordinate and access health care services

IDENTIFIED HEALTH CARE NEED

As previously noted, a significant number of area residents have been told they have high blood pressure, diabetes or coronary heart disease. Patients with these and other chronic conditions often have complex treatment plans and experience difficulty navigating health care services and managing their condition. The participants identified the following strategies for assisting patients with chronic conditions.

PROPOSED STRATEGIES

- Establish physician-led, multi-disciplinary disease management teams (e.g. dietician, nursing, diabetes educator, etc.) within the critical access hospital.
- Provide patient navigation services to coordinate care of patients with chronic conditions on where and how to access care from multiple providers. Also coach patients on complying with care and help them work through issues that arise. Benefits of a navigator could include reducing health care costs, reducing 30 day readmission rates and improving patient outcomes.
- Develop partnerships with doctors' offices, extended care facilities, public health departments and community, faith-based and not-for-profit organizations to extend care management and education services beyond the hospital. Examples of potential partner organizations and programs include the Parish Nurse Program and the Friendly Neighbor Program.
- Work to improve hospital discharge processes through programs such as Project Re-Engineered Discharge (Project RED) to reduce re-hospitalizations and improve patient outcomes.
- Pursue grant funding for programs which provide in-home, post-care case management services. Provide a home assessment prior to patient discharge from hospital or extended care facility.

Goal Area 4. Immunizations, vaccinations and health screenings

IDENTIFIED HEALTH CARE NEED

In 2010, 34 percent of area residents age 65 and older had not had a flu shot in the past year and 31 percent never had a pneumonia vaccine. In addition, more than 180,000 area residents report never having had their cholesterol checked, and cancer reported screening rates for breast, cervical and colorectal cancer are all below the national rate. Service coordination, low participation rates among subpopulations and issues with information sharing across organizations were all identified as barriers. Examples of strategies for overcoming these barriers and increasing immunization, vaccination and screening rates are below.

PROPOSED STRATEGIES

Coordination and Collaboration

In many communities, multiple not-for-profit and for-profit organizations provide immunization, vaccination and screening services. These services, however, are often not coordinated across organizations, resulting in duplication of services. Furthermore, medical records are not shared across organizations making it difficult to identify those in need of services, as well as those who have already received services. The following strategies were suggested to improve immunization, vaccination and screenings while reducing service duplication.

- Coordinate screening activities across organizations and establish a monthly theme for health screenings and assessments such as diabetes or hypertension.
- Encourage organizations conducting vaccinations and immunizations to have their providers consistently and routinely enter immunization information into the Ohio Impact Statewide Immunization Information System (ImpactSIIS).
- Provide school district immunization rates to school superintendents; work with schools to increase immunization and vaccination rates in districts with low rates.
- Notify primary care physicians when immunizations or vaccinations are administered at a hospital or health department.

Increasing Immunization and Vaccination Rates, Particularly Among Hard-To-Reach Subpopulations

- Establish pediatric clinics; offer sick child and immunization visits at times that are convenient for families.
- Conduct immunization and vaccination clinics or establish satellite offices near popular locations such as Wal-Mart, senior centers and community recreation centers.
- Offer flu vaccinations to emergency department patients.
- Utilize H1N1 funding for mobile units to increase access among hard-to-reach populations.
- Conduct annual vaccination reminder calls.
- Build relationships with leaders in hard-to-reach communities, such as the Amish.

Goal Area 5. Falls and fractures among the elderly

IDENTIFIED HEALTH CARE NEED

Falls can cause moderate to severe injuries among the elderly, such as hip fractures and head traumas, and can increase the risk of early death. Falls and fall-related injuries affect quality of life and increase health care costs. Almost 21 percent of the region's population is over the age of 60. With an aging population, maintaining their safety by preventing falls and fractures become a higher priority.

PROPOSED STRATEGIES

- Include bone density screenings for seniors as part of events, such as health fairs.
- Encourage physical therapists and exercise physiologist to educate patients on daily tasks that can increase bone density (e.g., carrying groceries).
- Implement Repeat Falls Program where first-time fall patients have a home visit from multi-disciplinary health team (e.g., pharmacist, physical therapist, nurse) to prevent repeat falls.
- Develop a check list for discharge to be used by care managers as an assessment of home safety.
- Hold monthly senior forums and periodic seminars or workshops to educate about fall prevention strategies, home safety and exercise.
- Offer physical therapy screenings and assessments that focus on keeping the elderly safe at home. Could be done at health fairs or other health education events.
- Install heated sidewalks in new or facility renovation projects to reduce the risk of inclement weather induced falls

