UnityPoint Health

Community Health Needs Assessment and Improvement Plan

2017 -2019

UnityPoint Health - St. Luke's Hospital

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Description and Purpose

Community Health Needs Assessment: Systematic examination of the **health** status indicators for a given population that is used to identify key problems and assets in a **community**.

Community Health Improvement Plan: Long-term **systematic effort** to address **priority** public health issues within a community.

Accountable Care Act Requirements

- ✓ Non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) every three years.
- ✓ *Joint CHNA reports and implementation strategies.*
- ✓ *Input from persons representing the broad interests of the community*
- ✓ *Defining the community*
- ✓ *Health – not just health care – needs.*
- ✓ *Widely available*

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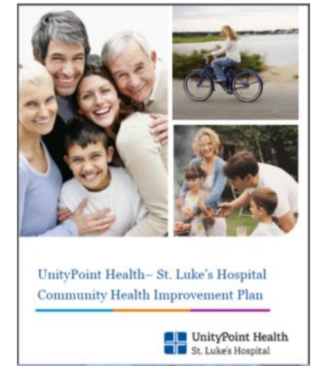
Evaluation of Impact: 2014 – 2016 Plan



- Increased lung check screening from **13 to 120** in one year.
- Surpassed goal of **200 individuals** referred to Quitline Iowa for smoking cessation.
- Collaborated with area schools to implement a **successful skin cancer prevention** social marketing campaign.
- Implemented depression screening in **all UnityPoint primary care clinics**.
- Served **900 new children** in low income families in the Dr. Rhys B. Jones Dental Health Center and performed screening outreach in the majority of Linn County Schools.
- Provided 24 education/outreach sexual health programs reaching over **2000 participating students**.
- Served **10,000 individuals** in helping them navigate Medicaid expansion and Insurance Exchange coverage.

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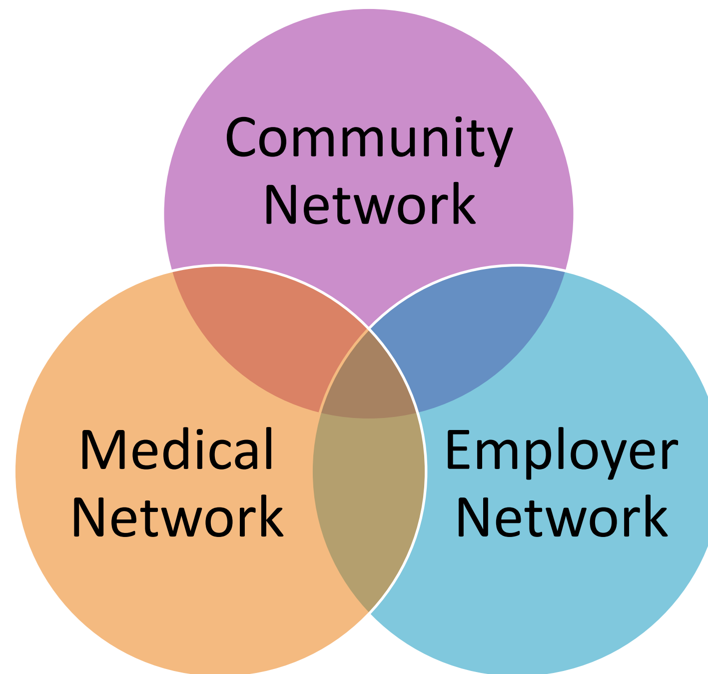
Connection to Mission and Vision

UnityPoint Health Mission: Improve the health of the people and communities we serve.

UnityPoint Health Vision 2020: Effectively partner to manage *the health needs* of a population.



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Joint Process and Community Input

Collaboration

- Joint planning in UnityPoint Health – Cedar Rapids hospital entities
  - *St. Luke's, Continuing Care Hospital, Jones Regional Medical Center and St. Luke's Hospital)*
  - *Consistency and to leverage opportunities*
- Collaborated with public health and other community entities
- Participated in Together! Healthy Linn – Assessment and Improvement Plan
  - *Jointly funded by UnityPoint Health – Cedar Rapids, Linn County Public Health and Mercy*

Process

- Reviewed population health and demographics data – 2014
- Sought additional input through surveys, consumer focus and key stakeholder groups – 2015
- Reviewed service area public health plans for themes
- Aligned strategies with community goals
- Formalized the assessment and improvement plan

Together! Healthy Linn

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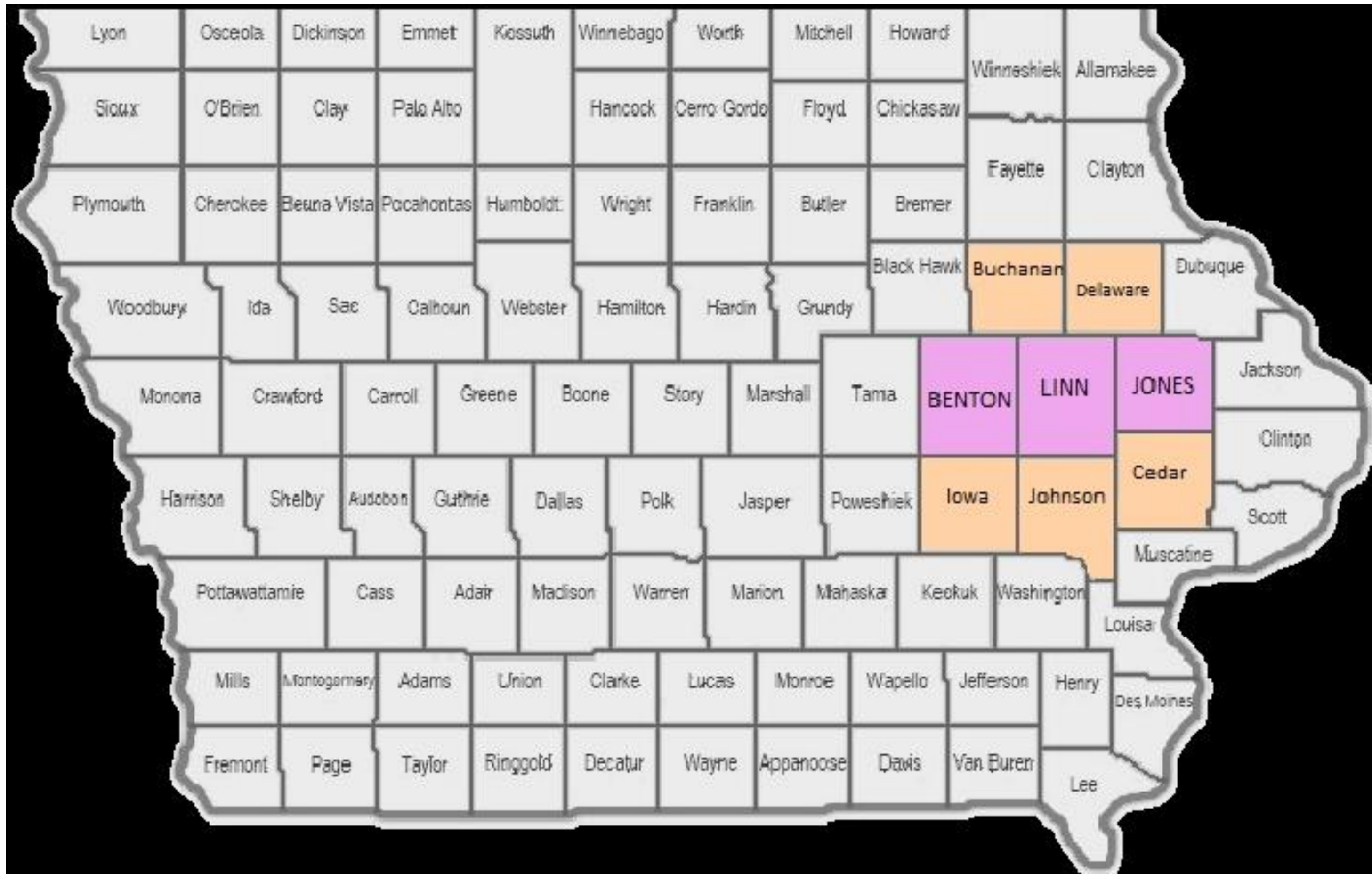
Defining Our Community



Primary Service Area: Linn, Benton and Jones Counties

Secondary Service Area: Buchanan, Delaware, Iowa, Johnson and Cedar

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Community Health Needs

Social Determinants of Health

- Safe and Affordable Housing
- Access to Care and Community Resources
- Adverse Childhood Experiences (ACEs)

Behavioral Health

- Mental Health Services
- Suicide
- Substance Abuse

Health Promotion

- Data Sharing
- Community Education
- Chronic Disease

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Summary of Quantitative Data

Key Health Indicators Trend Summary

Indicator		Race/Ethnicity								Gender		
	Linn County	African American	American Indian/ Alaskan Native	Asian	White	Native Hawaiian/ Pacific Islander	Two+ Races	Other	Hispanic	Female	Male	Healthy People 2020
Health Resource Availability												
Uninsured	⇩	⇩	⇩	⇩	⇩	⇩	⇩	(⇩)	⇩	⇩	(⇩)	Red
Behavioral Risk Factors												
Adult Binge Drinking	⇩	⇩	⇩	↔	⇧	↔	⇩	⇩	(⇧)	(⇧)	⇧	Red
Adult Tobacco Use	⇩	(⇩)	↔	↔	⇩	⇩	⇧	↔	⇧	⇩	(⇩)	Yellow
Adult Overweight	⇧	⇧	(⇧)	⇧	↔	↔	↔	↔	⇧	⇩	(⇧)	*
Adult Obese	⇧	↔	↔	↔	⇧	↔	⇩	(⇧)	⇧	(⇧)	⇧	Red
Adult Physical Inactivity	⇩	⇩	⇩	⇧	⇩	⇩	⇩	(⇔)	⇧	(⇩)	⇩	Red
Social and Mental Health												
Poor Mental Health	↔	⇩	⇩	↔	⇩	↔	(⇧)	↔	⇩	(⇔)	⇩	*
Suicide	⇩	*	*	*	*	*	*	*	*	⇧	(⇩)	Green
Chronic Conditions												
Diabetes	⇧	⇩	⇩	↔	↔	↔	⇧	(⇧)	⇧	⇧	(⇔)	Green
Asthma	⇧	⇩	(⇧)	↔	↔	↔	↔	↔	⇧	(⇩)	⇧	*
Cancer	⇩	(⇩)	*	*	↔	*	*	*	*	⇩	(⇧)	Red

Key

General Trend		Health Inequity		Healthy People 2020 Comparison	
⇧	Getting worse	(⇧)	Largest Inequality, increasing	Worse than LCPH	Red
↔	No Change	(⇔)	Largest inequality, no change	Similar to LCPH	Yellow
⇩	Trend is improving	(⇩)	Largest Inequality, decreasing	Better than LCPH	Green

- Linn County improvements in some areas, but continued work needed in areas of obesity, diabetes, mental health and asthma.
- Continued focus needed on health disparities occurring in Hispanic and Male populations.

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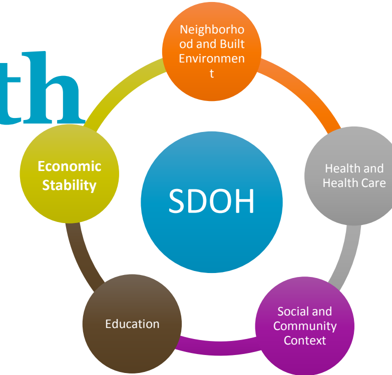
Community Health Improvement Plan

Social Determinants of Health



Access to Care and Community Resources

Goal: Increase access to care and community resources for vulnerable populations

Objectives:

- Certified Application Counselors will **assist 12,000 individuals** navigate opportunities to enroll in Medicaid or other appropriate insurance options.
- Actively **monitor** and respond accordingly to **increases in patient self-pay** related state or national policy changes.
- **Connect 100% of patients** discharged from St. Luke's without a primary care provider to a **primary care provider.**
- Increase access through continued implementation of the UnityPoint Clinic **provider recruitment plan** for additional primary, specialty and mental health access.
- Participate in the Cedar Rapids Community Coalition to develop a **referral system to connect vulnerable populations** with needed resources and support services.

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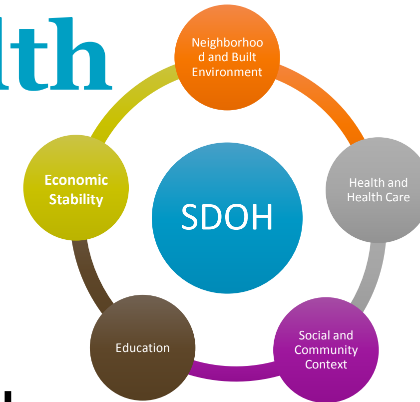
Social Determinants of Health



Adverse Childhood Experiences (ACE)

Goal: Decrease the number of children who are negatively impacted by risk factors associated with Adverse Childhood Experiences (ACE).

Objectives:

- Provide **5 ACE education and awareness** programs to associates and clinics.
- Implement an ACE survey for parents in the adolescent behavioral health programs to use as an educational tool to assist/support in **building resiliency**.
- Participate in the Cedar Rapids School District Mental Health Resource Management team, focusing on **ACE and Suicide Prevention with students.**

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Behavioral Health

Mental Health

Goal: Increase access to mental health services.

Objectives:

- Integrate and optimize opportunities through the **Abbe Health affiliation**
- Further tight referral/transition connections to adult and pediatric community **integrated health homes**.
- A **common care plan**, including **depression screening**, will be in place for 100% of high risk hospitalized patients.
- Pediatric and Adult Care Providers will partner with patients and families to promote early identification of depression and care planning as demonstrated by **achieving depression screening targets.**
- Behavioral health therapists will be **integrated in 5 UnityPoint Clinics**.
- Embed a psychiatric nurse in the **Emergency Department.**
- **Eight hundred associates** will be recertified in crisis intervention.

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Behavioral Health

Suicide

Goal: Decrease the rate of suicide.

Objectives:

- Participate in the Suicide Prevention Coalition for Cedar Rapids efforts to become a **Zero Suicide designated city**.
- Implement a **suicide screening assessment and referral process** in the Emergency Department.
- **Incorporate and disseminate research findings** of Foundation 2 Saving Lives Through Follow-up grant to UnityPoint Health system-wide behavioral health group.

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Behavioral Health

Substance Abuse

Goal: Decrease the rate of substance abuse among adults and adolescents.

Objectives:

- Provide **30 education sessions** for UnityPoint associates and community agencies on prevalent substance abuse issues.
- Implement an internship program in the substance abuse department and provide training for **3 interns.**
- Providers will support patients in smoking cessation through collectively achieving established **tobacco assessment and intervention quality targets** each year.

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Health Promotion

Data Sharing

Goal: Increase data sharing and effective use of technology within the local public health system to identify trends and emerging health needs.

Objective:

- **Submit** agreed upon **data** available through the Iowa Hospital Association's population health and geographic mapping program to public health.

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Health Promotion

Community Education

Goal: Decrease preventable diseases through health education in the community.

Objective:

- Participate in **community data collection** efforts to assess the types of **substance abuse education** being provided and the number of individuals reached.
- **Continue close partnerships** and referrals to Linn County Public Health and Eastern Iowa Health Center for services related to sexual health and sexually transmitted diseases.

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Health Promotion

Chronic Disease

Goal: Decrease the incidence of chronic disease in the community (diabetes, heart failure, stroke, obesity).

Objectives:

- Providers of adult care will partner with their patients on healthy behaviors, early prevention and **management for obesity, diabetes and heart failure** as demonstrated by achievement of related yearly quality targets .
- Providers of pediatric care will partner with patients and families to **promote healthy starts and healthy behaviors** as demonstrated by achievement of weight assessment/counseling and well child visit yearly quality targets.
- Evidence based **standardized patient education** will be in place across the continuum for **diabetes, heart failure and stroke**.
- **100% of Care Coordinators** will be trained in motivational interviewing to engage patients in goal setting, prevention and self management including health living and chronic disease management.
- **Partner with employers** to develop applicable healthy living, mental health, caring for the caregiver and disease management sessions for their employees.

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Health Promotion

Chronic Disease (cont.)

Objectives:

- **100% of identified care coordinators** in the hospital and clinic will be trained in standardized diabetes education, including when to refer to the Diabetes Education Center.
- The Diabetes Provider Advisory Group will implement a **provider continuing education** program on the changing diabetes medications.
- Utilize **predictive analytics** to identify individuals with **diabetes** or **heart failure** with a likelihood of an admission within six months and initiate subsequent protocols.
- Continue strong relationships with Critical Access Hospitals on triaging patients with **strokes appropriately and quickly**.

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Collaborating Partners

Community Health Improvement Planning Team
Together! Healthy Linn Steering Committee

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LCPH

Amanda Whitlock
Unity Point

Amy Lepowsky
LCPH

Ana Clymer
UWECI

Ann Hearn
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City of Cedar Rapids

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Denise Bridges
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AmeriCorp/LCPH

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Sarah Bliss
Cedar Valley Friends of the Family

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Mt. Mercy University

Sheree Murphy
EIHC

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LCP&D

Stephanie Neff
Blue Zones Project/CRCSD

Steve Hershner
City of Cedar Rapids

Sister Susan O'Connor
Mercy Medical

Tara Beck
Waypoint

Teri Keleher
Unity Point

Tom Treharne
City of Marion

Tonya Goodburn
Planned Parenthood

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