Community Health Needs Assessment

Top Priority Health Needs

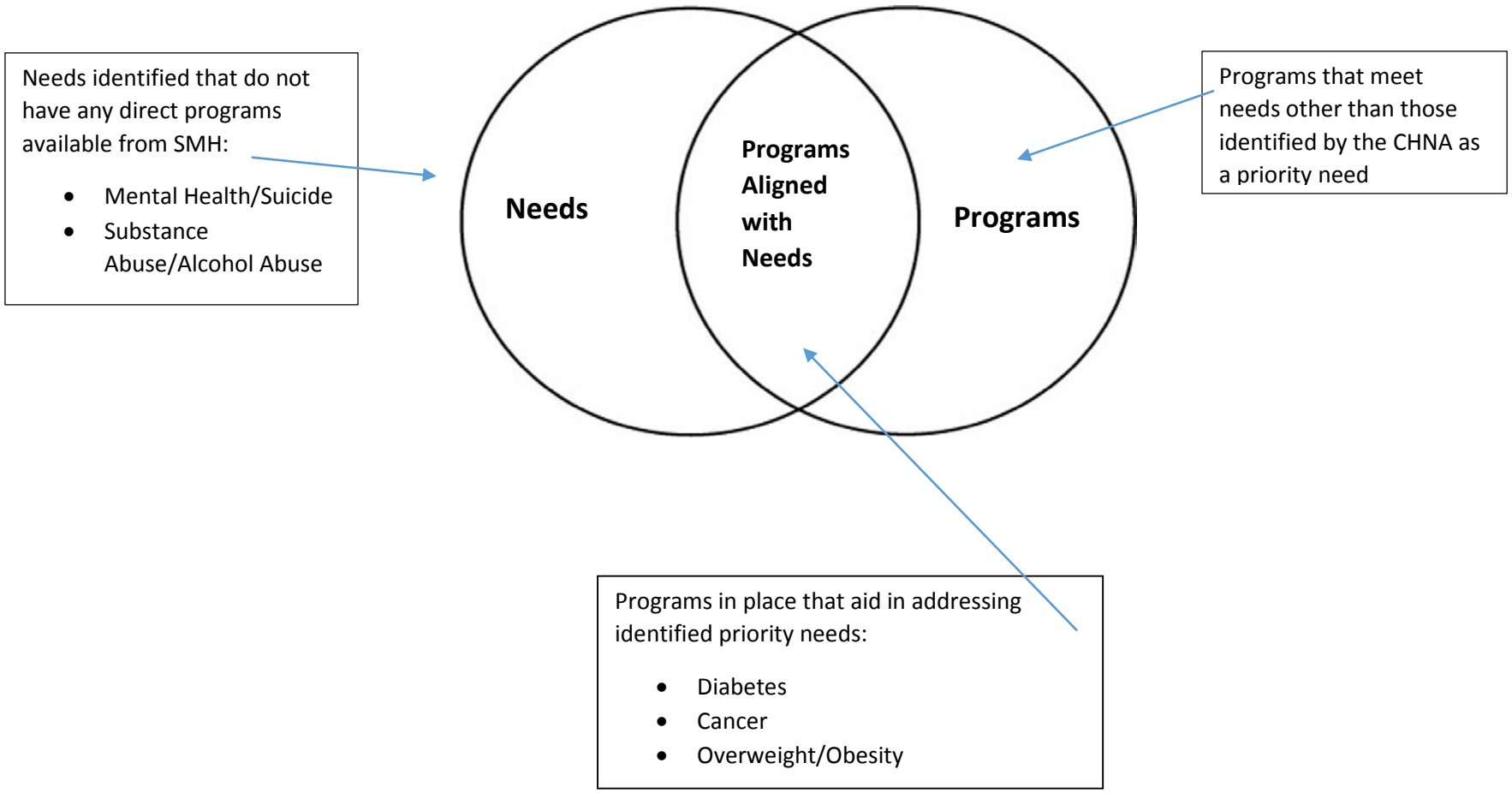
Implementation Plan

2016-2019

Beginning in March 2016, Sturdy Memorial Hospital undertook a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in the Hospital's service areas. This assessment was conducted in an effort to reinforce the Hospital's commitment to the health of its residents while ensuring alignment of health prevention efforts with the community's greatest needs. The CHNA examined a variety of health indicators including chronic health conditions, access to health care and social determinants of health. Sturdy Memorial Hospital contracted with Holleran, a research firm based in Lancaster, Pennsylvania to execute this project.

The completion of the CHNA enabled Sturdy Memorial Hospital to take an in-depth look at its community needs. The findings of the report were utilized by Sturdy to prioritize public health issues and develop an implementation plan focused on meeting the identified community health needs. Sturdy Memorial Hospital is committed to the people it serves and the communities in which they reside. Healthy communities lead to lower health care costs, robust community partnerships and an overall enhanced public health.

As a community Hospital, Sturdy recognizes that there are community health needs, which can be addressed through the Hospital and Associates Practices, while there are other health needs, which will need to be addressed through collaboration and community partnerships. Below represents the prioritized health needs, the Hospital's programs and the programs in place which help address the identified community health needs.



Identified Needs

The Hospital believes that all five identified needs warrant efforts to assist in developing a community with greater population health; however the Hospital understands its limitations and looks forward to collaboration with additional community partners to address those needs that do not have specific programs within the Hospital. Below is the list of identified priority needs. The needs of Mental Health/Suicide and Substance abuse were merged together as the strategies to address these needs are similar. Each Identified need is represented by identified goals, contributing factors, and our strategies to address each of the identified needs.

Identified Need: Cancer

Goals:

- Increase the importance of decreasing cancer risk through the reduction of risk behaviors.
- Increase awareness of the importance of screening and early detection.
- Increase community awareness of the Hospital's Comprehensive Cancer Care Program.
- Minimize treatment impact and improve outcomes.
- Continue to evaluate and expand services offered as needed.

Contributing Factors: Cancer is the leading cause of death in the Hospital's primary service area. Data findings show that females in Norfolk County are more likely to die from breast cancer than females in Bristol County. However, residents of Bristol County are more likely to die from lung and bronchus cancer compared to both Norfolk County and the state and nation as a whole. Contributing to this is the risk behaviors of those in Bristol County where nineteen percent of adults use tobacco.

Strategies:

- Continue to offer early detection and prevention through various screenings, education and support programs.
- Continue to assess smoking habits of inpatients and offer smoking cessation class and/or educational materials to tobacco users.
- Promote Comprehensive Cancer Care through educational columns, community events with oncologists and community collaboration.
- Provide medical navigation for patients through a continuum of care including early screening, intervention and if diagnosed, continue navigation through pre-habilitation, treatment, and post-treatment rehabilitation. In some cases, continue navigation through the palliative care process to remove barriers and provide the needed support.
- Increase appropriate referrals to levels of care, identify and collaborate with appropriate resources both internally and externally.
- Provide education on the importance of healthy lifestyle behaviors and available programs to ensure appropriate referrals.

Identified Need: Diabetes

Goals:

- Increase diabetes self-management education (DSME) for those living with diabetes.
- Increase the number of people to become aware of their risk.
- Improve education around strong glucose monitoring to keep HbA1c at a safe level.
- Educate public around insulin resistance as a cause of Type 2 diabetes and work to remove the stigma around the diagnosis.

Contributing Factors: Being overweight or obese is a major concern as it is one contributing factor toward the development of diabetes, as well as, other health conditions. County Health Rankings data showed that Bristol County has a higher percentage of residents that are obese (28 percent) compared to Norfolk County (20 percent) and the state (24 percent). As the American public ages, Type 2 diabetes can develop as a result of metabolic changes in the body such as the development of insulin resistance.

Strategies:

- Continue inpatient glycemic control protocol with nursing, internal medicine, hospitalist, and pharmacy staff to improve health outcomes. Continue with Diabetes Champions to increase staff awareness of diabetes and our DSME program.
- Continue to offer diabetes support group free of charge as a community benefit.
- Develop a formalized referral process to assist physicians in making appropriate referrals to Sturdy's Diabetes Management Program.
- Develop a formal process to identify patients discharged from Sturdy Memorial Hospital who have an A1C> 6.5 percent and notify their PCP that they are a candidate for our DSME outpatient program.
- Work with local organizations on efforts to refer pre-diabetic patients to the Centers for Disease Control developed Diabetes Prevention Program in conjunction with the nations YMCA's.
- Increase screening for pre-diabetic patients and refer to appropriate resources.
- Continue to remove barriers to care through scholarship efforts for the Diabetes Prevention Program at the YMCA.
- Sturdy's professional staff to serve on local area committees that address diabetes as a health crisis.
- Collaborate with community partners as part a leader of the Healthy Living Consortium to increase education and awareness in the community.

Identified Need: Overweight/Obesity

Goals:

- Increase the availability of resources to help reduce the growing rate of obesity.
- Increase the awareness of programs available to assist in medical weight loss.
- Increase physician awareness of programs in place to aid in weight loss for patients at risk of weight related illness.

Contributing Factors: Bristol County has a higher percentage of residents that are obese (28 percent) compared to both Norfolk County and the state (20 percent and 25 percent, respectively). In addition, County Health Rankings identify that a higher percentage of adults 20 years of age report no leisure time physical activity (27 percent) despite have greater access to exercise opportunities (95 percent). Additionally, the food environment index is worse than the state and nation as a whole.

Strategies:

- Continue to support and expand the newly launched Sturdy Wellness Weight Management Program and ensure physician referrals to appropriate service lines: Cardiac Rehab, Pulmonary Rehab, Wellness Exercise, Medical Weight Management, and Nutrition Counseling.
- Support wellness programming and education for area youth to promote good nutritional and physical activity habits at a young age through the successful HealthyChoices program which targets 5th graders to educate them during an impressionable time.
- Physicians to enhance screening for pre-diabetes and other weight related illnesses, make referrals to appropriate programs.
- Provide healthy cooking demonstrations at the Hospital.
- Collaborate with local experts to promote the importance of physical activity and local resources for such activity.
- Provide education on proper nutrition and physical activity through various mediums including website, and health related newspaper columns.
- Provide educational teaching on healthy eating in areas with poor food environment indexes.
- Collaborate with community partners as part of the Healthy Living Consortium to increase education and awareness within the community.

Identified Need: Mental Health/Suicide and Substance Abuse

Goals:

- Increase proper identification of mental health issues and refer to appropriate, quality mental health services.
- Work to reduce suicide rate by ensuring high risk patients are obtaining proper mental health care.
- Increase patient and community education on opioid prescriptions, their addictive nature and alternative therapies.

Contributing Factors: Mental Health and Substance Abuse almost always result in broader health issues and overall unhealthy lifestyle behaviors. While the suicide rate is lower in the Hospitals' service area, key informants identified Mental Health/Suicide as high priority. With regard to opioid related deaths, the primary service area had a higher crude death rate than the state.

Strategies:

- Develop educational brochures for Associates Practices and waiting areas to highlight the dangers of opioid use as well as provide education on alternatives available for managing pain.

- Develop a comprehensive pain stewardship program to ensure proper internal controls to appropriately manage our patient populations.
- Provide patients with standard patient fact sheets that outline the risks associated with the use of prescription opioids as well as guidance on safe storage and proper disposal of unused prescription medications.
- Develop an internal process to better assure communication and sharing of information about patients' pain management treatment plans following acute level of care to ensure continuity of care.
- Increase public awareness of how to dispose of unused medications, consider development of a program to collect unused medications in a safe and controlled environment.
- Sturdy Memorial Associates medical home physicians to continue use of the PHQ9 Depression Assessment tool and refer as required.
- Collaborate with appropriate community organizations to provide community members with resources.
- Collaborate with community partners as part of the Healthy Living Consortium to increase education and awareness in the community.