Borgess Health Implementation Strategy

Implementation Strategy Narrative

Overview

Borgess Medical Center is a 422-bed tertiary care hospital and the flagship of Borgess Health with a continuum of health services from a Level II Trauma Center to primary and specialty care practices throughout southwest Michigan. The majority of Borgess Health inpatient and outpatient services are provided at Borgess Medical Center. Borgess-Pipp Hospital is a 43-bed long-term acute care hospital with an emergency department, diagnostics, rehabilitation services, and an affiliated primary care practice. Borgess at Woodbridge Hills is a large ambulatory care facility with an immediate medical care center, an endoscopy and outpatient surgery center, diagnostics, rehabilitation services, pharmacy and two large primary care practices. Borgess Gardens is a 101-bed skilled nursing and short-stay rehabilitation facility. Borgess Medical Group is a multidisciplinary group of 114 physicians and 71 midlevel providers with practice locations throughout southwest Michigan (excludes hospital based).

Kalamazoo County is at the heart of southwest Michigan and is the most densely populated of the nine counties. Kalamazoo County covers 580 square miles. The neighboring cities of Kalamazoo and Portage, within the county, represent the largest metropolitan area in the region. The estimated total population of Kalamazoo County in 2015 is 260,263. The median income in Kalamazoo County in 2014 was $42,022. The education attainment of the community served is 43% with an Associate degree or higher.

Prioritized Needs

Data collection for the survey came from primary data such as focus groups and key informant interviews with a wide variety of Kalamazoo community members such as leaders from health and human service organizations, government officials, the homeless population, consultants from higher education, public health professionals, faith communities, and hospital personnel.

Secondary data was analyzed from public health data sources such as: Michigan Department of Community Health, US Census Bureau, Michigan Incident Crime Reporting, Center for Disease Control and prevention, US Department of Agriculture, US Department of Health and Human Services as well as Borgess hospital data.

Based on the process and criteria listed above, Borgess Health identified the following priorities for the Implementation Strategy:

Goal 1: Access to Care

Access to Care is an ongoing issue and is listed in the Healthy People 2020 report as one of the leading twelve indicators for the nation to focus on. Healthy People 2020 provides science-based,

10-year national objectives for improving the health of all Americans. As we move into 2016 and the next phase of implementation of the Affordable Care Act, more and more individuals will become insured with Medicaid expansion. Through the Health Insurance Marketplaces (Exchanges) there will still remain the need to support those unfamiliar with the system in navigating the health system, locating a primary care physician, and obtaining support for other non-medical needs that, if not addressed, may present a barrier to Access to Care. The need to address and strengthen Access to Care is an ongoing system-wide initiative through the Ascension Health's Call to Action policy "Healthcare That Leaves No One Behind". The policy represents Ascension Health's commitment to 100% access and coverage for all Americans. Ascension Health has evolved its 2020 destination for "Healthcare That Leaves No One Behind" to describe that all people, particularly those who are poor and vulnerable, can access environments and healthcare that (1) create and support the best journey to improved health status for individuals and communities, and (2) are financed in an adequate and sustainable fashion. The vulnerable people we are focused on serving includes individuals who remain uninsured in a post-reform era, but also includes people who are vulnerable due to factors other than insurance coverage, including their economic situation, citizenship status, geographic location, health status, age, education level or decision-making ability.

Goal 2: Diabetes Prevention

In Michigan, in 2014, an estimated 10.4% of Michigan adults 18 years and older were diagnosed with diabetes. According to the Centers for Disease Control and Prevention (CDC), 27.8% of people of all ages with diabetes are undiagnosed. Also the CDC reported about 37% of adults age 20 years and older were estimated to have pre-diabetes, putting them at high risk for developing type 2 diabetes. However, in 2014, only an estimated 8.2% of Michigan adults reported ever being told that they had pre-diabetes. Michigan ranked 22nd out of 50 states in highest diabetes prevalence among adults 18 years and older in 2013. Diabetes was the seventh leading cause of death in Michigan in 2013 (*Michigan Department of Community Health).* Although reducing incidence of diabetes was a priority area for the 2013 BH CHNA, it remains one of the top causes of hospitalizations and death in Kalamazoo and at BH from 2013 – 2015.

Goal 3: Infant Mortality Reduction

For every 1,000 Michigan live births, approximately seven infants die before reaching their first birthday. Michigan's infant mortality rate is consistently higher than the national average. The highest disparity is found among African American infants, which are approximately 13 deaths per 1,000 live births. In comparison with white births, this is three times greater. This has been an area of concern for many years in Kalamazoo County. This situation has not shown any sustainable improvement over the course of time and in fact, has only gotten worse. In fact, for every one death of a Caucasian baby, four black babies die. There is a group working diligently on this problem in Kalamazoo County. Some of the causes are social determinants of health such as poverty and race, as well as safe sleep habits, unintended pregnancy, and previous poor birth outcomes.

Needs That Will Not Be Addressed

Identified needs that will not be addressed were determined by availability of services in the community. Chronic diseases with substantial support in the community such as cancer, lung disease and heart disease are supported by strong Borgess Heath programs with a variety of available resources in addition to the support of the American Cancer Society, American Lung Association and the American Heart Association. Mental Health and lack of providers is certainly a health priority; however, other agencies in the Kalamazoo area have greater resources to address this need. Injury prevention scored moderately high but will not be addressed in the CHNA implementation strategy and action plans; Borgess Health is a Level 2 Trauma Center with very specific requirements for community education, prevention strategies and safety guidelines in place. Finally, senior services scored at a moderate level; however, BHS will not address this need as top priority due to the services provided by the Council on Aging as well as many other organizations in the community.

Summary of Implementation Strategy

Prioritized Need #1: Access to Care

GOAL: Improve Access to Care

Action Plan

STRATEGY 1: Reduce the racial disparity and improve birth outcomes among high risk women in Kalamazoo by increasing their access to prenatal care.

BACKGROUND INFORMATION:

- Target Population: African American women ages 15-44 with incomes at or below the Federal Poverty level in Kalamazoo County.
- Pregnancy-related health outcomes are influenced by factors such as race, ethnicity, age, and income, but most importantly—a woman's health.
- Barriers to be addressed in this project are; access to prenatal care, coordination of care and follow through, referral to community resources, and transportation.
- *Strategy Source:* The California Black Infant Health Model

RESOURCES:

Borgess Hospital, Kalamazoo Infant Mortality Community Action initiative (KIMCAI), YWCA, program budget, printing, hospital staff, volunteers

COLLABORATION:

- Borgess Hospital staff, WMed, YWCA, Kalamazoo Infant Mortality Community Action Initiative, WMed

STRATEGY 1: Reduce the racial disparity and improve birth outcomes among high risk women in Kalamazoo by increasing their access to prenatal care.
ACTIONS: 1. By July 1, 2016, Community Health Worker hired by YWCA (grant partner) and training to begin immediately 2. By September 1, 2016, referral and care coordination of participants to OB care 3. By September 1, 2016, case management to achieve follow through 4. By September 1, 2016, being health education on safe sleep, prenatal & postpartum care 5. By September 1, 2106, use an outreach model that meets the women where they are 6. By September 1, 2106, transportation for prenatal and clinic appointments
ANTICIPATED IMPACT: I. By January, 2017, have 10 women enrolled in project II. By January, 2108, have 40 women receive programs services

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
I.	Reduce the infant mortality rate in racial ethnic minorities to 6.0 (per 1000 births) in Kalamazoo by 2020.	2016 – 2019 Infant Mortality Reduction Plan (State of Michigan Infant Health Plan)	MICH-1 Reduce the rate of fetal and infant deaths

STRATEGY 2: Design, develop and deliver a Medical Mission at Home in downtown Kalamazoo.

BACKGROUND INFORMATION:

Target population: The homeless, uninsured and unemployed residents of Kalamazoo.

- Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone.
    - Through key informant interviews conducted with the missions that serve the homeless population in Downtown Kalamazoo, it was confirmed that most of the homeless population do not have healthcare. The ones who did enroll in Healthy Michigan do not know how to use it. Therefore they do not have a primary care physician and use the ER as their health care provider.
    - A Medical Mission will increase access to medical services as the mission will utilize a downtown location making it easy to walk to as they do not have access to transportation.
    - Access to medical care will be gained as physicians and nurses will volunteer to address basic health needs at the Medical Mission. For example; because this population does not have a home or transportation, they walk everywhere they go. They do not have proper footwear and need podiatry services and/or shoes.
    - Basic screenings will be provided to identify potential health concerns. Referrals will be made in the case that more treatment is needed.
    - A relationship and connection with Borgess healthcare providers will strengthen trust issues this population has.
    - Ideally, mental health services will be present as well to provide screenings and referrals to those in need.
    - Representation from the oral health professions will be present to address lack of dental care.
    - Access to healthy food will be present as giveaways during the day.
    - Access to necessary medications and free prescriptions will be available for those who do not take necessary medications due to cost or lack of provider.

Strategy source: Ascension Medical Mission Initiative - Healthcare That Leaves No One Behind

RESOURCES:

- Borgess Hospital staff, volunteers, program budget, Downtown missions and faith organizations,

COLLABORATION:

- Hospital staff, volunteers, Downtown missions and faith organizations, community partners

ACTIONS:

1. Develop an internal multi-disciplinary Borgess team dedicated to the planning and implementation of a Medical Mission at home, begin monthly meetings

2. Secure a location, date, timeline, budget, community partners, internal and external partners
3. Develop evaluation and referral tools
4. Market event to target population

ANTICIPATED IMPACT:

III. By July 1, 2016, have a committee of key associates involved first meeting held, subsequent meetings scheduled.

IV. By June 30, 2017, a Medical Mission delivered in downtown Kalamazoo

V. By September 1, 2017, conduct a post-event wrap up meeting, complete evaluation process and determine if another Medical Mission will be delivered and timeline.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
1	N/A	Ascension Medical Mission Initiative - Healthcare That Leaves No One Behind	Ascension Medical Mission Initiative - Healthcare That Leaves No One Behind

Prioritized Need #2: Diabetes

GOAL: Improve the health of those at-risk or living with diabetes

Action Plan

STRATEGY 1: Provide diabetes screenings and education through community groups and local churches

BACKGROUND INFORMATION:

- Target Population: Pre-diabetics with an emphasis on the uninsured and underserved.
- This strategy will deliver community health services, "boots on the ground" in the community where they congregate with family and friends; the churches or community groups. Many ethnic groups will not attend community health screens at the hospital or clinic due to a variety of reasons; trust issues, lack of transportation for example.
    - Taking health care to these hard to reach people removes one more barrier to health for them. Delivering health care in a place where they feel a social connection, a "home", have support systems removes so many "hang-ups" that are inherent to these particular populations.
    - Having a health screen and education in the appropriate language (Spanish for example) will lessen fear factors and give health care providers access to the more vulnerable populations.
    - Using teaching tools with appropriate pictures and language (i.e. Latinos in Spanish) helps alleviate fear and creates trust.
- *Strategy source:* National Diabetes Prevention Program *(NDPP)*

RESOURCES:

- Hospital departments including; (H), Borgess Diabetes department, Borgess Marketing dept., program budget, Community Benefit Advisory Committee (CBAC) volunteers, hospital staff

COLLABORATION:

- Hospital staff, area community churches and organizations

ACTIONS:

1. By July 1, 2016, reach out to local churches and other organizations to being relationship development and determine locations for diabetes education and screening.
2. Create a curriculum by January 2017
3. Develop a pool of educators and screeners for program delivery.
4. Develop data collection and program monitoring tools by March, 2017
5. Create a toolbox for health educators to take with them to on-site locations for program delivery by January, 2017

ANTICIPATED IMPACT:

VI. By June 30, 2016, meet with Diabetes manager to formulate plan for the IS Diabetes goals

VII. By June 30, 2017 deliver the first diabetes screen and educational program to an area

STRATEGY 1: Provide diabetes screenings and education through community groups and local churches
church or organization. VIII. By June 30, 2018, increase knowledge and understanding of how to avoid Type II diabetes.

STRATEGY 2: Design, develop and distribute an online pre-diabetes program based on the CDC recognized Diabetes Prevention Lifestyle change program.

BACKGROUND INFORMATION:

- Target Population: those who have been diagnosed with or may have pre-diabetes with an emphasis on the uninsured and underserved.
- This strategy greatly improves access to much needed health education where it can be delivered through computer or electronic device at any time at any place. It provides 365/24/7 access to life changing health education.
    - There is a disparity in the demographics of populations who will attend a 4 or a 6 week diabetes education classes at the local hospital or clinic. It is uncommon for people of certain cultures or demographics attend such a class. It is also very difficult for those with physical disabilities to attend such a class. Developing a tool that removes the requirement and barrier of a physical presence at a community class will greatly increase access to anyone needing this education.
    - Community members who do not have child care readily available or money to pay for it or transportation or a schedule that will allow regular attendance will benefit from health education that is available via electronic device.
    - Attendance numbers for classes such as a 6 week class have dropped off significantly with the fast paced world of technology. Unless a community member is super motivated, chances of having them attend a class at a hospital for X time for X weeks is diminished. Adding an online component will literally take the education to the community member via phone, tablet or computer. They will have the ability to review the information over and over, access information at any time in case they forget or need to show a family member to help educate them.
    - Distribution of marketing materials with directions on how to access the link for the education will target such locations as community centers, churches, schools, missions, FQHC's, community clinics, PCP's, and so on.

Strategy source: National Diabetes Prevention Program *(NDPP)*

RESOURCES:

Hospital departments including; (H), Borgess Diabetes department, Borgess Marketing dept., program budget, Community Benefit Advisory Committee (CBAC) volunteers, hospital staff

COLLABORATION:

Hospital (H), Community Benefit Advisory Committee, area churches and community groups

STRATEGY 2: Design, develop and distribute an online pre-diabetes program based on the CDC recognized Diabetes Prevention Lifestyle change program.

ACTIONS:

1. By August 1, 2016, meet with Borgess Diabetes Manager and Marketing to begin developing materials
2. By March 1, 2107, have an online pre-diabetes program launched
3. By January 1, 2017, develop marketing strategy to disseminate materials
4. By January 1, 2017, develop data collection and program monitoring tools

ANTICIPATED IMPACT:

I. Increased knowledge of pre-diabetes by June 30, 2017
II. Increase use of web based pre-diabetes program within 1 year of implementation based on analytics from the webpage
III. By June 30, 2019, a decrease in incidence of diabetes

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
I	N/A	National Diabetes Prevention Program (NDPM)	D-1 Reduce the annual number of new cases of diagnosed diabetes in the population (*Healthy People 2020)*

Prioritized Need #3: Infant Mortality

GOAL: This project is aimed at reducing the racial disparity and improving birth outcomes among high risk women in Kalamazoo by increasing their access to prenatal care.

Action Plan

STRATEGY 1: Reduce the incidence of infant mortality in Kalamazoo

BACKGROUND INFORMATION:

Target Population:

- Female residents of Kalamazoo County ages 15-44 who are Black
- Female residents of Kalamazoo County ages 15-44 who have incomes at or below FPL
- Female residents of Kalamazoo County ages 15-44 with previous poor birth outcomes
- Female residents of Kalamazoo County ages 15-44 who are high risk (previous miscarriage, history of substance abuse, mental health barriers, etc.)

Barriers to be addressed in this project

- Access to prenatal care
- Coordination of care and follow through
- Referral to community resources
- Transportation
- Being Black and being poor often go together, and they EACH contribute to the risk of premature infant death
- *Strategy source:* California Black Infant Health Program

RESOURCES:

- Hospital (H), Ascension Partnership in Ministry Award (APMA) grant team consisting of Borgess, YWCA and WMed, Kalamazoo Infant Mortality Community Action initiative (KIMCAI), APMA funding for the project, Borgess Foundation as the fiduciary

COLLABORATION:

- Hospital (H), APMA grant team consisting of Borgess, YWCA and WMed, (APMA), Kalamazoo Infant Mortality Community Action initiative (KIMCAI), YWCA, funding for the project, Borgess Foundation as the fiduciary

Actions:

1. By July 1, 2016, begin identification and recruitment of participants
2. By July 5, 2016, begin to develop referral and care coordination

STRATEGY 1: Reduce the incidence of infant mortality in Kalamazoo
of participants for OB care 3. By July 5, 2016, meet with Borgess social workers to discuss referral process 4. Attend Kalamazoo Infant Mortality Community Action Initiative (KIMCAI) meetings 5. By August 1, 2016, develop evaluation plan with external consultant from WMed
ANTICIPATED IMPACT: I. By July 1, 2106, CHW trained and ready to implement program. II. By January 1, 2017, have 10 participants enrolled.in program III. By January 2108, 40 participants reached through the program

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
1	Reduce the infant mortality rate in racial ethnic minorities to 6.0 (per 1000 births) in Kalamazoo by 2020.	2016 – 2019 Infant Mortality Reduction Plan (*State of Michigan Infant Health Plan)*	MICH-1 Reduce the rate of fetal and infant deaths *(Healthy People 2020)*