

Borgess-Lee Memorial Hospital Implementation Strategy

Implementation Strategy Narrative

Overview

The Borgess-Lee Memorial Hospital (BLMH) is located in Southwest Michigan and is comprised of a nine-county region that borders Indiana. Cass County is located in southwest Michigan and borders the State of Indiana. It covers about 491 square miles with a total population of 51,910. The area was originally inhabited by three bands of Potawatomi Indians. During the Civil War, Cass County played a major role in the Underground Railroad which resulted in the settling of many black families in the area.

Three characteristics combine to make Cass County somewhat unique, especially as it relates to serving health needs. The first is the county's rather large, rural/agriculture base. About 60% of Cass County is farm land, ranking it 15th out of Michigan's 83 counties. Much of the farm land is used for growing seasonal fruits and vegetables which require migrant farm laborers to harvest. This results in a heavy influx of mostly Hispanic families which in turn impacts the need and delivery of health care services.

The second characteristic relates to the significant recreational opportunities that abound in Cass County. It has over 250 lakes and the county's close proximity to major population centers in Indiana and Illinois makes a regional recreational "mecca". During the summer, the population around the lakes grows significantly. Both the summer and full-time lake residents tend to be very affluent. While most of the health care needs of the summer residents are served by out-of-state providers, these people do impact the area's health care service delivery, especially emergency room and fast track primary care services.

The third characteristic is the large blue-collar population in the county's two largest population centers-Dowagiac and Cassopolis. The City of Dowagiac is the county's largest city. It has about 2,400 households with a total population of 5,879. Median household income is \$31,329 and per capita income is \$17,739. Both are well below the county and state averages. The Village of Cassopolis, the County Seat, ranks even lower. It has about 700 households with a total population of 1,774. Median household income is \$24,781 and per capita income is \$15,114. Almost 30% of the Cassopolis residents fall below the poverty level. All of these factors contribute to the unique cultural diversity of the county.

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-Lee Memorial Hospital identified the following priorities for the Implementation Strategy:

Prioritized Needs

Priority Need #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.

Priority Need # 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 BHS CHNA, hospitalizations it remains one of the top causes of death and hospitalizations in Cass County and at BLMH from 2013 – 2015.

Priority Needs #3 Community Health Education

Through the community engagement process, it was mentioned often that there is very little community health education, both in the school system and in the community. Children in the school system do not receive basic health education as there are limited resources to provide that

education. Community members do not have access to health education either and prevention of chronic disease such as diabetes, obesity, COPD and heart disease can be thwarted through free community health classes.

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 Health 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. The Cass /Van Buren District Health Department provide a number of community services. There is a mental health provider in Cass County, The Woodlands Behavioral Health Care. They provide services to those with mental health needs but there are far more needs in the community than they can provide. Because the demographics of the Cass County is rural coupled with high amount of poverty, there are significant community needs. However, resources are limited as well in this area. BLMH has chosen areas to address where they think they will make the most impact with the resources allotted.

Summary of Implementation Strategy

Prioritized Need #1: Access to Care

GOAL: Expand Access to Mental Health Services
Action Plan

STRATEGY 1: Create an FTE position to add additional providers for expansion of Tele-Psychiatric Services

BACKGROUND INFORMATION:

- Target Population: This affects all populations, especially the poor population with no access to mental health care providers.
- This will expand the outreach of tele-psychiatric services to 40 hours a week.
- Mental health was the primary need discovered through the CHNA. This affects all populations, especially the poor population.
- *Strategy source:*
- MHMD-1 Reduce the suicide rate (*Healthy People 2020*)
- MHMD-5 Increase the proportion of primary care facilities that provide mental health treatment on-site or by paid referral (*Healthy People 2020*)
- MHMD-11 Increase depression screening by primary care doctors. (*Healthy People 2020*)

RESOURCES:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN), Community Coalition (CC), The Timbers (T), Cass Family Clinic, (CFC) All Agencies (AA), Borgess marketing dept., program

STRATEGY 1: Create an FTE position to add additional providers for expansion of Tele-Psychiatric Services

budget

COLLABORATION:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN), Community Coalition (CC), The Timbers (T), Cass Family Clinic, (CFC)

ACTIONS:

1. By August 1, 2016, meet with Borgess Leadership and Human Resources to create a position for a mid-level provider with training specific to behavioral health.
2. By September 1, 2016 hire mid-level provider, begin training.
3. By December 30, 2016, offer tele-psychiatric services 40 hours weekly.
4. Continue ongoing data collection to evaluate and determine usage.

ANTICIPATED IMPACT: *(List SMART objectives; ensure specific and measurable outcomes, i.e., change(s) in learning, actions and/or conditions):*

- I. By January 1, 2017, have additional mental health therapist hired, trained and fully functional on tele-psychiatric services.
- II. By February, 2017, BLMH has the capacity to offer 40 hours weekly of tele-psychiatric series.

STRATEGY 2: Offer one Mental Health First Aid class in the community.

BACKGROUND INFORMATION:

- Target Population: This affects all populations, especially the poor population with no access to mental health care providers
- Mental health is a significant problem in Cass County. Suicide rates, drug use and domestic violence rates are up. This affects all populations but especially the un-insured and the poor populations.
- This strategy will teach area residents and care-givers how to identify risk of harm or suicide, depression and mood disorders, and substance abuse disorders and encourage treatment of a mental health professional.
- *Strategy source:* Mental Health First Aid, National Council for Behavioral Health

RESOURCES:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN), Community Coalition (CC), The Timbers (T), Cass Family Clinic, (CFC) All Agencies (AA), Borgess marketing dept., program budget

COLLABORATION:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN), Community Coalition (CC), The Timbers (T), Cass Family Clinic, (CFC)

ACTIONS:

1. Meet with community groups; the Community Benefit and Health Needs Committee, Community Health Needs Committee, Rural Health Planning Network to determine date, location, and partnerships to host training
2. Six months prior to event, meet with Borgess Marketing for development of marketing materials for event
3. Three months prior to event, create a marketing strategy to distribute marketing materials to reach schools, businesses, neighboring communities to gain exposure
4. Develop evaluation tool for attendees

ANTICIPATED IMPACT:

- III. By June 30, 2018, host a community Mental Health First Aid event.
- IV. By June 30, 2018, awareness of a mental health situation and how to prevent one will be increased as more community members are exposed to the warnings and triggers and by participation in the education.

STRATEGY 3. Explore Implementing a pilot program of an integrated primary care and behavioral health clinic.

BACKGROUND INFORMATION:

- This model will establish a mental health provider in a primary care setting so that access is easily available during a primary care visit. This will create a continuum of care for the patient in a familiar setting.
- Mental health is a significant problem in Cass County. Suicide rates, drug use and domestic violence rates are up. This affects all populations but especially the un-insured and the poor populations.
- *Strategy source:* Healthy People 2020 has over 12 specific strategies to address mental health.

RESOURCES:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN), Community Coalition (CC), The Timbers (T), Cass Family Clinic, (CFC) All Agencies (AA), Borgess marketing dept., program budget

COLLABORATION:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN), Community Coalition (CC), The Timbers (T), Cass Family Clinic, (CFC)

ACTIONS:

1. By June 30, 2017, meet with community groups; the Community Benefit and Health Needs Committee, Community Health Needs Committee, Rural Health Planning Network to explore feasibility
2. By June 30, 2017, research evidence based models in similar communities.
3. By June 30, 2017, determine possible partners and funding sources
4. By June 30, 2017, determine if a business plan needs to be developed for further consideration and determine a sub-committee to develop a business plan
5. By September 2, 2016, add to meeting agenda for all community groups
6. By January 1, 2018, If all partners are in agreement, proceed with the implementation of the plan setting a concrete start dates, financial approvals by all community partners.

ANTICIPATED IMPACT:

- V. By June 30, 2018, determine whether to move ahead in the pilot project.

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, II, III	N/A	N/A	Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral.

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: The strategy will target 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)
- D-1 Reduce the annual number of new cases of diagnosed diabetes in the population (*Healthy People 2020*)

RESOURCES:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN, The Timbers (T),

COLLABORATION:

Community Benefit and Health Needs Committee, Community Health Needs Assessment

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

Committee, Rural Health Planning Network , The Timbers, area churches and community organizations

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: *(List SMART objectives; ensure specific and measurable outcomes, i.e., change(s) in learning, actions and/or conditions):*

- I. By June 30, 2016, meet with Diabetes manager to formulate plan for the IS Diabetes goals
- II. By June 30, 2017 deliver the first diabetes screen and educational program to an area church or organization.
- III. By June 30, 2018, increase knowledge and understanding of how to avoid Type II diabetes.

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

BACKGROUND INFORMATION:

- Target population: The strategy will target 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)
- D-1 Reduce the annual number of new cases of diagnosed diabetes in the population (*Healthy People 2020*)

RESOURCES:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN, The Timbers (T),

COLLABORATION:

Community Benefit and Health Needs Committee, Community Health Needs Assessment Committee, Rural Health Planning Network , The Timbers, area churches and community organizations

ACTIONS:

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

ANTICIPATED IMPACT: *(List SMART objectives; ensure specific and measurable outcomes, i.e., change(s) in learning, actions and/or conditions):*

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

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

goals

- V. By June 30, 2017 deliver the first diabetes screen and educational program to an area church or organization.
- VI. 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)
- D-1 Reduce the annual number of new cases of diagnosed diabetes in the population (*Healthy People 2020*)

RESOURCES:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN, The Timbers (T), All Agencies (AA), program budget

COLLABORATION:

Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN, The Timbers (T)

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:

- VI. By June 30, 2017, increase knowledge of pre-diabetes in the community based on pre and post evaluations.
- VII. By June 30, 2017, increase use of web based pre-diabetes program within one year of implementation base on analytics from the webpage

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):
I, II	N/A	National Diabetes Prevention Program	D-1 Reduce the annual number of new cases of diagnosed diabetes in the population. (Healthy People 2020)

Prioritized Need #3: Community Health Education

GOAL: Increase the quality, availability, and effectiveness of educational and community based programs designed to prevent disease and injury, improve health and enhance the quality of life.

STRATEGY 1: Increase the proportion of elementary, middle and senior high schools that receive health education with classes related to health promotion, disease prevention and mental health.

BACKGROUND INFORMATION:

- Target Population: All school aged children in Cass County school system.
- This strategy will provide free health education to children in Cass County, a rural area of Michigan that has very high poverty levels. Health education is not taught in schools due to lack of funding for it. The prevalence of diabetes, drug use, tobacco use and obesity is very high.
- *Strategy source:* Healthy People 2020 Educational and Community Based programs

RESOURCES:

- Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN), Community Coalition (CC), program budget, The Timbers (T),

COLLABORATION:

- Hospital (H), Community Benefit and Health Needs Committee (CB&HNC), Community Health Needs Assessment Committee (CHNAC) Rural Health Planning Network (RHPN), Community Coalition (CC), The Timbers (T), local schools, local community organizations

ACTIONS:

1. Each month, conduct on phone or in person meetings that convene partners involved in planning and organizing the health education campaign
2. By November 30, 2017, have a draft menu of classes prepared for schools and community to choose from.
3. By November 30, 2017, have a list schools and community agencies ready to schedule trainings.
4. In monthly meetings, develop a data collection and program monitoring agenda item for group discussion.
5. By November 30, 2017, have Borgess Marketing create and brand all marketing materials for distribution.
6. By December 30, 2017, have a schedule of programs confirmed and coordinated for delivery.

ANTICIPATED IMPACT:

- VIII. By January 1, 2018, begin delivering health education programs
- IX. By June 30, 2018, increase the number of community health programs delivered.
- X. By June 30, 2019, decrease number of COPD re-admission at BLMH.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I, II	N/A	N/A	ECBP – 2 Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity
I, II			ECBP-10.4 Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services tobacco use