Crittenton Hospital Medical Center Implementation Strategy

Implementation Strategy Narrative

Overview

Crittenton Hospital Medical Center is a 290-bed all inclusive medical facility serving communities in Oakland, Macomb, and Lapeer counties; providing service to both urban and rural areas. In addition to downsizing, many employers are reducing benefits or cost shifting to employees as a means to save costs. This results in higher co-pays and deductibles for the patient. This increase in out-of-pocket expenditures is acting as a deterrent in seeking health care services as a result. Demographically, the population forecast projects minimal growth over the next three years, however, the age of the population continues to rise. The growth of individuals over the age of 55 is projected to grow 20-30%.

Demographically, CHMC serves a population with a median income of $77,000; well above Michigan's median income of $49,000 and the national median of $53,500. The percent of individuals below poverty level is 7.2%; half the state and national level at 16.2% and 14.8% respectfully. The average age of the population served by CHMC is 40 years old and the educational attainment of the community served is 92% earning a high school diploma or higher.

Crittenton Hospital Medical Center resides in a highly competitive market in Southeast Michigan. There are three other hospital systems within a six mile radius that provide competing primary, secondary, and tertiary health care services. CHMC's presence with only 290 beds is substantial in that it captures 34% of the market share in its core service area. As of October 2015, CHMC joined Ascension, the largest not for profit health system in the nation. Its core service area is comprised of three zip codes, and is one of the top three providers in its total service area with 36 zip codes. Key collaborators for CHMC include Ascension Health affiliates in the Michigan Health Ministries throughout St. John Providence Health System and Genesys Health System, in addition to long-standing partnerships with Oakland University School of Nursing and the Wayne State School of Medicine.

The methodology for conducting the survey involved the development of a tool that would assess the needs of the community and the individual needs and health status of the responders. The survey takers were asked to select the health challenges that they face personally and the challenges that they feel their community faces. The overall intent of the survey topic selection was to assess a general overview of the community needs. The deployment of the survey was from September through November 2015.

The online and paper methodology was used to ensure a wide distribution of the survey allowing all community stakeholders the opportunity to participate with both English and Spanish version available. The survey was available on the CHMC website, email invitations were sent to Advisory Board members and all sectors of the community and social media blasts were distributed several times throughout the survey period. Paper surveys, in both English and Spanish, and interactive survey boards were available at

all community events during the months of September through November 2015. In an effort to specifically identify the needs of the underserved population in our community, surveys were also distributed at area mobile food bank locations.

The survey consisted of 8 questions designed to gather information about the specific concerns of the individual, the individual's perception of the needs within the community, general demographic information and where health information is accessed.

In addition to the community survey results, secondary data was analyzed from local, state, and federal community health initiatives. Local data was analyzed from a county-wide assessment, Energizing Connections for Healthier Oakland (ECHO), completed by Oakland County which included a comprehensive Community Health Status Assessment, Community Themes and Strengths Assessment, Local Public Health Assessment and a Forces of Change Assessment from April 2014 through May 2015. Additional local data was analyzed through city and township websites, SocioNeeds Index, and local school district free and reduced lunch price counts. Michigan's Health and Wellness Four Health Behaviors and the national Healthy People 2020 plans were also used as references to community health needs across the broad spectrum of community and to serve as a basis for aligning health needs.

Prioritized Needs

Priority Need #1: Obesity/Overweight: Improve nutrition, diabetes.

Respondents identified several needs related to obesity including concerns to improve nutrition and diabetes. This priority is consistent with Oakland County's Energizing Connections for Healthier Oakland (ECHO) assessment and initiatives, Michigan's Health and Wellness Four Healthy Behaviors initiative and Healthy People 2020 initiatives. Identification of obesity/overweight as a priority community health need aligns CHMC with local, state and national initiatives. In addition, other needs that scored at a moderate level (cancer, high blood pressure, stroke, and heart disease) would reduce risk factors with initiatives that address obesity.

Priority Need #2: Mental Health: Substance abuse (alcohol, drugs, tobacco), mental health services, substance abuse rehabilitation services, teen crisis services.

Respondents identified access to substance abuse treatment (alcohol, drugs, and tobacco), mental health services and suicide as areas of concern. This priority is consistent with Oakland County's Energizing Connections for Healthier Oakland (ECHO) assessment and initiatives, Michigan Department of Community Health Strategic Priorities and Healthy People 2020 initiatives. CHMC is working to strengthen these factors through education classes and youth-led community improvement initiatives.

Priority Need #3: Access to Care: Unable to pay co-pays and deductibles, access to primary care physicians and specialists in a timely manner.

Respondents identified concerns over the inability to pay co-pays and deductibles and the ability to access primary care physicians and specialists. This priority is consistent with Oakland County's Energizing Connections for Healthier Oakland (ECHO) assessment and initiatives, Michigan Department of Community Health Strategic Priorities and Healthy People 2020 initiatives.

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 CHMC 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. Injury prevention scored moderately high but will not be addressed in the CHNA implementation strategy and action plans; CHMC is Level 3 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, CHMC will not address this need as top priority due to the services provided by the Older Person's Commission in the community and the Crittenton Wellness Center located on site.

Summary of Implementation Strategy

Prioritized Need #1: Obesity/Overweight/Nutrition

GOAL: Increase awareness and participation in healthier lifestyle options.

Action Plans

STRATEGY 1: Implement a program in partnership with a community collaboration to address healthy lifestyles that integrates education, physical activity and nutrition.
BACKGROUND INFORMATION: • *This strategy's target population is school-aged children in the community.* • *This policy will address health disparities and barriers to care by providing young children and their families with education and tools to improve health life style.* • *The strategy is informed by evidence found in Oakland County's ECHO Assessment, Michigan's Four x Four, and Healthy People 2020*
RESOURCES: Hospital (H); School District (SD); Community Partners (CP); Families (F); program budget, materials, staff
COLLABORATION: • Rochester Community Schools • Avondale School District

STRATEGY 1: Implement a program in partnership with a community collaboration to address healthy lifestyles that integrates education, physical activity and nutrition.

- Wayne State University
- Gleaner's Food Bank
- Touchpoint Support Services
- Oakland County Health Department
- Macomb County Health Department

ACTIONS:

1. Identify pilot group
2. Create Curriculum
3. By January 2017, train health advisors
4. By January 2017, begin program with pilot group
5. By June 2017, assess effectiveness of curriculum and modify if necessary
6. By September 2017, identify additional group to expand program
7. Ongoing evaluation for effectiveness of program

ANTICIPATED IMPACT:

I. By January 2017, initiate pilot program with one group of school-aged students using approved curriculum and 6 trained health advisors.

II. By January 2018, increase participation in program by one more group of school-aged students with 80% of participants achieving health goals.

III. By December 2019, improve health status of targeted school-aged children with 80% choosing healthier lifestyle options and meeting health goals.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
II, III	Increase education and promotion opportunities around healthy eating. (ECHO –Oakland County CHIP).	By 2017, encourage all school systems to adopt healthy food offerings, healthy behaviors, physical activity programs, and discuss with students the meaning of health as a personal core value. (Michigan Health and Wellness 4 x 4 Plan).	Reduce the proportion of children aged 2-19 years who are considered obese by 10% from 16.1% to 14.5%. (Healthy People 2020 MWS-10.4)

II, III			Help people recognize and make healthy food and beverage choices. (National Prevention Strategy—Healthy Eating).

STRATEGY 2: Implement an evidence-based program (Baby Friendly Hospital) to improve maternity services that protects, promotes and supports breastfeeding.

BACKGROUND INFORMATION:

- *This strategy's target population is mothers and their infants.*
- *This policy will address health disparities and barriers to care by promoting breastfeeding. Evidence shows that successful breastfeeding has an impact on childhood obesity.*
- *The strategy is informed by evidence found in Oakland County's ECHO Assessment, Michigan's Four x Four, and Healthy People 2020.*

RESOURCES:

Hospital (H), Breastfeeding Task Force (BFTF), Organizational Partners (OP), Baby Friendly Hospital Initiative (BFHI), Physician Partners (PP), associates, materials, program budget

COLLABORATION:

- Oakland County Health Department
- Macomb County Health Department
- Physicians
- St. John Providence Hospital

ACTIONS:

1. By December 2016, create Breastfeeding Task Force and hold monthly meetings.
2. By January 2017, identify actions necessary to meet Baby Friendly Hospital designation. Secure funding for application process.
3. By July 2017, register for Baby Friendly Hospital designation.
4. By July 2018, complete required education for appropriate associates and physicians.
5. By July 2018, implement all 10 steps for Baby Friendly Hospital Initiative.
6. By July 2018, schedule Baby Friendly Hospital survey.
7. By June 2019, receive Baby Friendly Hospital designation.

ANTICIPATED IMPACT:

I. By January 2017, identify necessary actions required and secure funding to register for Baby Friendly Hospital designation. By January 2017, initiate pilot program with one group of school-aged students using approved curriculum and 6 trained health advisors.

STRATEGY 2: Implement an evidence-based program (Baby Friendly Hospital) to improve maternity services that protects, promotes and supports breastfeeding.

II. By July 2018, complete required education for 100% of appropriate associates and physicians.

III. By July 2018, complete required 10 steps to register for Baby Friendly Hospital designation.

IV. By June 2019, receive Baby Friendly Hospital designation improving the health status of women and children by increasing exclusive breastfeeding rate by 80%.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
II, III, IV	Increase education and promotion opportunities around healthy eating. (ECHO –Oakland County CHIP).		Increase the percentage of infants who are ever breastfed from 74% to 81.9% by 2020. (Healthy People 2020 MICH-21.1)

STRATEGY 3: Implement a community-wide campaign that integrates education on nutrition and physical activity to impact healthy lifestyle changes.

BACKGROUND INFORMATION:

- *This strategy's target population is all members of our community.*
- *This policy will address health disparities and barriers to care by promoting healthy lifestyle options.*
- *The strategy is informed by evidence found in Oakland County's ECHO Assessment, Michigan's Four x Four, and Healthy People 2020.*

RESOURCES:

Hospital (H), Physician Partners (PP), Community Partners (CP), associates, materials, program budget

COLLABORATION:

- Oakland County Health Department
- Macomb County Health Department
- Physicians
- Wayne State University
- Gleaner's Food Bank
- Touchpoint Support Services

STRATEGY 3: Implement a community-wide campaign that integrates education on nutrition and physical activity to impact healthy lifestyle changes.

ACTIONS:

1. Each month, conduct phone or in-person meetings that convene partners involved in planning and organizing community campaign.
2. By January 2017, finalize campaign details including educational materials, lecture presentations, and health advisors.
3. By February 2017, use the curriculum to train at least 5 health advisors to provide information, lectures and workshops.
4. By February 2017, create pre and post survey to access participant lifestyle changes
5. By December 2017, distribute educational materials at lecture and workshop.
6. In monthly meetings include data collection and program monitoring as agenda item for group discussion.

ANTICIPATED IMPACT:

I. By January 2017, create community campaign and train health advisors to promote healthy lifestyle changes integrating nutrition and physical activity.

II. By December 2017, implement campaign through educational materials, lectures and workshops to improve at least one healthy lifestyle change in 70% of participants as measured by self-reported survey.

III. By December 2018, improve health status of 85% of participants measured by at least one lifestyle change.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
II, III,	Increase education and promotion opportunities around healthy eating. *(ECHO –Oakland County CHIP).*	Maintain a healthy diet and engage in regular exercise. *(Michigan Health and Wellness 4x4 Plan)*	Increase the proportion of adults at a healthy weight by 10% from 30.8% to 33.9%. *(Healthy People 2020 MWS-8).*
II, III			Help people recognize and make healthy food and beverage choices. *(National Prevention Strategy—Healthy Eating).*

Prioritized Need #2: Mental Health

GOAL: Improve mental health status

Action Plans

STRATEGY 1: Implement a process to identify patients at risk for mental health illness in the outpatient therapy setting.

BACKGROUND INFORMATION:

- *This strategy's target population is patients in the outpatient therapy setting.*
- *This policy will address health disparities of mental illness by providing free screening to all patients in the outpatient therapy setting.*
- *The strategy is informed by evidence found in Healthy People 2020.*

RESOURCES:

Hospital (H); Outpatient Therapy (OT); Community Partners (CP); Social Work (SW); program budget, materials, associates

COLLABORATION:

- Outpatient Physical Therapy
- Catholic Charities of Southeast Michigan
- Oakland County Health Department
- Macomb County Health Department
- Social Workers

ACTIONS:

1. Create designated Task Force to conduct meeting that convene partners involved in planning and organizing the screening tool, referral process and implementation strategy.
2. By April 2017, develop a screening tool to be used in the outpatient therapy setting.
3. By April 2017, identify outpatient therapy sites to utilize screening tool and implement the mental health screening/referral process.
4. By July 2017, develop curriculum to educate and train at least 80% of identified clinical associates responsible for performing the mental health screen and implementing the referral process.
5. By July 2017, initiate screening/referral process on 100% of outpatient therapy population
6. By December 2017, evaluate the process for appropriate referral in 90% of patients identified at risk.

ANTICIPATED IMPACT:

I. By April 2017, create a screening tool and identify appropriate outpatient therapy sites to evaluate patients

STRATEGY 1: Implement a process to identify patients at risk for mental health illness in the outpatient therapy setting.
at risk for mental illness. II. By July 2017, educate and train at least 80% of identified clinical associates responsible for performing the mental health screen/referral process. III. By December 2017, improve mental health status of 90% at risk outpatient therapy patients through identification and referral for mental health services.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
II, III	Improve awareness of mental illness and resources. (ECHO –Oakland County CHIP).	Reduce disparities in health outcomes. (Michigan Department of Community Health)	By 2020, reduce the suicide rate by 10% from 11.3 suicides per 100,000 populations to 10.2 per 100,000 populations. (Healthy People 2020 MHMD-1).
		Strengthen mental health, substance abuse, and physical health integration to reduce chronic disease and co-morbidities (Michigan Department of Community Health)	Promote early identification of mental health needs and access to quality services. National Prevention Strategy—Emotional and Mental Well-Being (Surgeon General. National Prevention Council).

STRATEGY 2: Increase involvement in community coalitions to promote healthy lifestyles by preventing and reducing substance abuse and promoting safety across all sectors of the community.

BACKGROUND INFORMATION:

- *This strategy's target population is all sectors of the community primarily focusing on youth.*
- *This policy will address health disparities of mental illness by increasing programs and community involvement in area coalitions.*
- *The strategy is informed by evidence found in Healthy People 2020.*

RESOURCES:

Hospital (H); Coalitions (C); Parents (P); Business (B); School Districts (SD); Religious Organizations (R), Law Enforcement (L); Governmental Agencies (G); Community Partners (CP)

COLLABORATION:

- Rochester Auburn Hills Community Coalition (RAHCC)
- Alliance of Coalitions for Healthy Communities (ACHC)
- Rochester Community Schools
- Avondale School District
- Religious Organizations in Community
- Community Businesses
- City of Rochester, City of Rochester Hills, City of Auburn Hills, Oakland Township
- Local Law Enforcement Agencies
- Community Members

ACTIONS:

1. Establish and maintain presence on the Executive Board of the Rochester Auburn Hills Community Coalition (RAHCC) by attending monthly meetings.
2. By September 2017, collaborate with RAHCC and community partners to provide 3 community programs.
3. By September 2017, collaborate with RAHCC to increase active membership by recruiting 5 new members.
4. By September 2018, collaborate with RAHCC and community partners to provide educational materials to at least 10 area middle school and high schools.
5. By September 2019, collaborate with RAHCC and community partners to increase active membership by recruiting 5 additional members representing all community sectors.

ANTICIPATED IMPACT:

I. By September 2017, collaborate with the community coalition to provide 3 community programs to youth and their families.

II. By September 2017, increase membership in community coalition by 5 members.

III. By September 2018, provide substance abuse educational materials to 10 area middle and high schools in the community.

IV. By September 2019, improve the health status of adolescents in the community by increasing the proportion

STRATEGY 2: Increase involvement in community coalitions to promote healthy lifestyles by preventing and reducing substance abuse and promoting safety across all sectors of the community.
of adolescents never using substances by 10%.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
II, III	Improve awareness of mental illness and resources. (ECHO –Oakland County CHIP).	Within the Michigan Department of Community Health create the infrastructure to support 4 x 4 Plan Implementation, energizing the local coalitions, and partners. (Michigan 4 X 4 Plan -D)	Reduce tobacco use by adolescents (Healthy People 2020 TU-2) Increase the proportion of adolescents never using substances. (Healthy People 2020 SA-2)
II, III		Strengthen mental health, substance abuse, and physical health integration to reduce chronic disease and co-morbidities (Michigan Department of Community Health)	Promote early identification of mental health needs and access to quality services. National Prevention Strategy—Emotional and Mental Well-Being (Surgeon General. National Prevention Council).

STRATEGY 3: Implement a postpartum depression screening process to identify mothers at risk and refer to appropriate mental health services

BACKGROUND INFORMATION:

- *This strategy's target population is patients that deliver at Crittenton.*
- *This policy will address health disparities of mental illness by providing free screening to all postpartum patients.*
- *The strategy is informed by evidence found in Healthy People 2020.*

RESOURCES:

Hospital (H); Community Partners (CP); Social Work (SW); program budget, materials, associates

COLLABORATION:

- Oakland County Health Department
- Macomb County Health Department
- Catholic Charities of Southeast Michigan
- St. John Providence Hospital

ACTIONS:

1. Create a task force for postpartum depression assessment. Conduct monthly meetings.
2. By April 2017, create a screening tool to be utilized for all postpartum patients.
3. By April 2017, create a referral process for patients at risk with at least 5 resources
4. By July 2017, train postpartum staff in postpartum depression risks and use of the assessment tool.
5. By July 2017, initiate process of screening all postpartum patients and providing appropriate follow-up.
6. December 2017, provide referrals for all patients identified at risk for postpartum depression.

ANTICIPATED IMPACT:

I. By April 2017, create a screening tool to identify appropriate patients at risk for postpartum depression.

II. By July 2017, educate and train at least 80% of identified clinical associates in risk assessment and referral process.

III. By December 2017, improve the mental health status of 90% at risk postpartum patients through identification and referral for mental health services.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
II, III	Improve awareness of mental illness and resources. (ECHO –Oakland County CHIP).	Reduce disparities in health outcomes. (Michigan Department of Community Health)	By 2020, reduce the proportion of adults age 18 years and older who experience major depressive episodes by 10% from 6.5% to 5.8%. (Healthy People 2020 MHMD-4.2).
II, III		Strengthen mental health, substance abuse, and physical health integration to reduce chronic disease and co-morbidities. (Michigan Department of Community Health)	Promote early identification of mental health needs and access to quality services. National Prevention Strategy—Emotional and Mental Well-Being (Surgeon General. National Prevention Council).

Prioritized Need #3: Access to Care

GOAL: Increase access to mammography services to improve early detection of breast cancer.

Action Plans

STRATEGY 1: Increase access to mammography services to improve early detection of breast cancer.

BACKGROUND INFORMATION:

- *This strategy's target population is low-income, underserved women in our community.*
- *This policy will address health disparities and barriers to care by providing access to mammography services to low-income women.*
- *The strategy is informed by evidence found in Healthy People 2020.*

RESOURCES:
Hospital (H); Physician Partners (PP); Community Partners (CP); Outside Funding (OF); program budget, marketing materials, associates

COLLABORATION:

- Primary Care Physicians
- OB/GYN's
- Radiologists

STRATEGY 1: Increase access to mammography services to improve early detection of breast cancer.
• St. John Providence Health System – Breast Center • Crittenton Hospital Foundation
ACTIONS: 1. Develop criteria for program to identify qualified participants in target population. 2. Create marketing materials highlighting criteria and available services. 3. Educate and train associates and physicians. 4. By December 2017, implement program using funding from 2016 Gourmet Gala. 5. By December 2017, distribute brochures to community and physicians. 6. By December 2019, secure two additional funding sources and expand number of patients served.
I. By February 2017, develop program criteria, brochures, and train (X) of associates and physicians. II. By December 2017, implement program to provide mammography services to qualified low-income women utilizing (x) $. III. By December 2019, reduce the number of women unable to obtain or delay medical care and improve their health status with diagnosis of breast cancer identified through early detection and treatment by 10%.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
II, III	Increase access to health services through policy and system improvements among providers. (ECHO –Oakland County CHIP).	Reduce disparities in health outcomes. (Michigan Department of Community Health)	By 2020, reduce the number of persons who are unable to obtain or delay in obtaining medical care by 10% from 4.7% to 4.2%. (Healthy People 2020 AHS-6.1).

STRATEGY 2: Improve awareness in the community of health care insurance and other health resources.

BACKGROUND INFORMATION:

- *This strategy's target population is all members of our community.*
- *This policy will address health disparities and barriers to care by providing education regarding available resources.*
- *The strategy is informed by evidence found in Healthy People 2020.*

RESOURCES:
Hospital (H); Physician Partners (PP); Community Partners (CP); program budget, marketing materials, associates

COLLABORATION:

- Oakland County Health Department
- Macomb County Health Department
- Wayne State University
- Community Businesses
- Nonprofit Organizations
- Physicians

ACTIONS:

1. Collaborate with community partners to conduct an analysis to identify available community resources.
2. By June 2017, create a campaign that will include 4 different forms of educational materials (i.e. brochures, website, social media, referral call center) for the community to provide health resources
3. By December 2017, create a community outreach calendar that will include 4 free screening health fairs for 2018
4. By January 2018, distribute educational brochures with health resources at community events.
5. By December 2018, provide 2 educational lectures on available health resources for the community.

I. By June 2017, create a campaign to include 4 different forms of educational materials for the community to provide health resources.

II. By December 2017, create community outreach calendar that will include 4 free screening health fairs for 2018.

III. By December 2018, provide 2 educational lectures on available health resources in the community.

IV. By December 2019, improve community access to health resources by increasing utilization of health services and resources by 10%.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
II, III, IV	Increase access to health	Reduce disparities in	By 2020, reduce the number of

	services through policy and system improvements among providers. *(ECHO –Oakland County CHIP).*	health outcomes. *(Michigan Department of Community Health)*	persons who are unable to obtain or delay in obtaining medical care by 10% from 4.7% to 4.2%. *(Healthy People 2020 AHS-6.1).* Support implementation of community-based preventive services and enhance linkages with clinical care. *(National Prevention Strategy-Emotional and Mental Well-Being)*