IU Health Goshen CHNA Action Plan: 2016-2018

The mission of IU Health Goshen is to improve the health of our communities, by providing innovative, outstanding care and services through exceptional people doing exceptional work. We pursue this mission every day, in our every interaction with community members. We measure the impact of our efforts in a multitude of ways to stay on track and verify we are going in the right direction – doing our best for those we serve. One of the ways we accomplish this is to step back every three years and evaluate our community health needs. During 2015, this triennial community health needs assessment (CHNA) reached out to some 20,000 residents, analyzed data statewide for context, and sought the input of public health experts. Findings gave a clear view of the issues endangering public health and causing greatest concern among residents. While local health status metrics are generally better than the state of Indiana overall, there are several key areas within which there is significant room to improve. Areas targeted for focus include:

- obesity,
- access to health services,
- access to mental health services,
- treatment of chronic conditions, and
- tobacco use/smoking.

Programs designed to help people manage these conditions, improve individual health, and positively impact the quality of community members' daily lives will be implemented or grown systematically throughout 2016, as outlined below and approved April 21, 2016 by the chief executive officer. Progress will be measured, and findings will be the driving force for annual activity driving community wide improvement until the next CHNA is conducted in 2018. Through the programming detailed below, our exceptional people are doing exceptional work.

Obesity

As a health condition, obesity is challenging for providers of health care services to address with a diverse population in such a way as to make a sizable impact. This condition does not develop in a short period of time, and managing it to a positive and consistent change requires tremendous focus from the *individual* as well as the system. Our organization seeks to impact obesity in our community focusing both on particular interventions we can offer as well as growing and adapting healthy programming already in place to interact with our community at their point of comfort. Success in impacting obesity in the community will come through increased interactions. We interact with community members of all ages and backgrounds through the following efforts:

- **Community Wellness and Education (CWE)** -- This team focuses on the overall health and wellness of our community at large. They will continue to provide diabetes education to both children and adults. The Fit Together program for parents and children looking to prevent type 2 diabetes is offered to appropriate age children at high risk for diabetes. New diabetes education programs are provided for patients of all ages based on their diagnoses (metabolic syndrome, pre-diabetes, type 1, type 2, gestational diabetes, etc.) and this will be expanded to impact more individuals and coordinated through our clinics in alignment with our ACO. We provide direct support to 30 of our local schools with a "Run the Halls" program. Healthy Steps to a Healthy

Weight is a multi-week class series which is provided to offer comprehensive weight management as a part of daily living for adults.

- **Get Fit Get Healthy (GFGH)** -- This worksite wellness program provides onsite screenings, education, and coaching for a large number of companies and their employees. Goal setting, coaching, stress management and other techniques are deployed by a team of more than 20 skilled clinicians to improve the health of these individuals.

- **The Indiana Lakes Accountable Care Organization (ACO) care coordination program** -- Collaborates with our primary care providers to improve the health of high-risk patients within our ACO, currently numbering 10,000. Our nurses and social workers coordinate care across the health continuum to help patients in need access community resources. One of the most significant areas of concern they work with is chronic condition management, including obesity.

- **Nutrition Therapy** -- This department is staffed with registered dietitians who provide training and education to inpatients, outpatients, and the community at large throughout the year. They also bring on dietetic interns to advance education in the broad sense related to healthy eating. The services provided include some of our CWE events and support to a number of our in-house programs.

- **Expansion of our health coach program** -- A few of our primary care practices have espoused the health coach concept for their covered patients. This program has developed into a one-on-one weight management / loss system for patients. The practices also create walking groups and support groups for these patients. Expanding this programming into additional practices will help us touch additional community members with obesity concerns.

- **Team:Bariatrics** -- Is our multi-disciplinary program for weight reduction. They offer both surgical and non-surgical weight loss options. Programs are individually designed for each patient in a team approach. Community education is one of our routine offerings in addition to providing approximately 80 surgical interventions each year.

Access to Care

Elkhart County is designated as a heath care provider shortage area in several regions, including those directly covered by IU Health Goshen Hospital. We are carrying forward three key strategies from 2016 through 2018 to improve our community's ability to access care of the type they need, at the time that they need assistance. Those three strategies include direct physician recruitment, opening an urgent care center with family practice in a key location to address a shortage area, and building further on our platform to provide access to care through the workplace with our Direct Care program.

Our recruitment efforts in 2016 center on family medicine physicians and nurse practitioners to improve community access to primary care. This is a noted shortage in our community, and we are in a position to specifically work to increase available medical providers in a direct way. The Dunlap area was identified as a designated health provider shortage area in our health needs assessment within our county. The providers already located in that area are not accepting new patients. We will be recruiting a number of nurse practitioners to work with two family practice physicians in this facility,

with hours of access including extended hours that support the working well of our community. This facility is slated to open in in late April, 2016. Care will be available in this facility 7 days per week including holidays. Week days include extended hours through 10:00 p.m. The site will address common illnesses, minor injuries, fractures, immunizations/vaccinations, labs, etc. regardless of whether the customer is or is not a patient of the onsite practice.

Additional recruitment efforts in 2016 relate to cardiovascular care in our community and improving access to the correct specialists to support our chronic condition management. We have a cardiology program with a substantial wait list for new patients to be referred in for baseline testing. Better provision of primary care access results in additional chronic condition support from our specialists; heart disease and related chronic conditions dominate the community and will be the greatest need as we expand general access across the county. A shortfall that was recognized by the medical community in 2015 but did not make the community health needs assessment is lack of spine surgery case coverage for those patients with a poor payor status or whom are underinsured. We have since in early 2016 contracted with a local spine surgeon to have him cover this patient segment within his practice to better manage spine care in the community.

A prime confounding variable of care access is cost of care/financial access. In 2016, IU Health Goshen is working to reduce the cost of care for several high volume outpatient procedure types in our community. IU Health Goshen Surgery Center will open in June, 2016. Slated outpatient procedures for this facility include colonoscopies, pain procedures, and outpatient orthopedic procedures. Moving the location of service for these episodes of care enables us to reduce the charge rate an average of 45% to the community member. As we remove or reduce the financial barrier to these procedures, we anticipate compliance with colonoscopy guidelines to improve.

We continue to support and develop our partnership with the Maple City Health Care Center as a significant means to provide appropriate access to medical care for our Hispanic/Latino community in south central Elkhart County. This support comes in many different ways, and is measured by achieving more first time patients into their program. Since opening the extension campus in conjunction with IU Health Goshen (Vista Community Health Center) in May of 2015, there have been more than 3,000 visits to the providers onsite. They serve 50-80 new patients per week at this facility! Vista will be adding support services for substance abuse in 2016 with support from IU Health Goshen – which supports our desire to reduce the occurrence of smoking within the population. We continue to support the interests of this community health clinic and its work to improve the health of our community.

Achieving success related to access to care will be measured short term by additional new patients seeking a family practice relationship in 2016 compared to prior years. Long term, it will be documented by a change in the medically underserved status in the hot spots of our community.

Mental Health Access and Coordination

We are seeking to proactively identify depression and other mental health conditions in the community in order to provider intervention and/or support to those in need. Our goal for 2016 is to screen at least 5,000 patients per quarter using a validated screening tool. In addition, we seek to

provide at least 20 hours of free therapy/support services per quarter for patients identified to have need of these services.

We are implementing several different programs to improve access to these screenings as well as to the services physicians indicate are needed for our community members. One such way is through a tele-mental health project, connecting a few primary care locations directly with our primary mental health care provider in the community. It was determined in 2015 that while access to mental health support was low, this organization has a 30% new patient no-show rate. The tele-mental health project addresses both concerns: Existing local offices are convenient to expand points of access and tele-mental health services can be provided in the same visit with other services, thereby driving down no-show rates for additional appointments. As a result we have capacity that can be brought to bear through better coordination, which will palpably improve care for our community. We are also adding depression screening in the emergency department, for inpatients, home care depression screenings, and tracking depression screening throughout our accountable care organization (ACO).

Improve the treatment and management of chronic conditions

Chronic conditions are managed by teams of professionals, all of whom must interact to help a patient maintain or improve their health status. The practitioners who are aligned with IU Health Goshen Hospital are advancing the standards of team based care for chronic condition patients throughout our community. Data is tracked through our employed physician system as well as via Accountable Care Organization data systems. Our goal to improve chronic condition management will be tracked in 2016 through an improvement in 75% of our monitored chronic condition quality metrics within these systems. A number of directives are being put into place, most specialized to the chronic condition metric we are studying. The elements for improvement in 2016 are the following:

Medicare Shared Savings Program (MSSP) Metrics

- Diabetes quality measures
- Heart Failure quality measures
- Depression quality measures
- Coronary Artery Disease (CAD) quality measures
- Ischemic Vascular Disease (IVD) quality measures
- Hypertension (HTN) quality measures

Anthem Accountable Care Organization (ACO)

- Diabetes Management quality measures
- Asthma quality measures

While these measures all relate to a shared savings program of one form or another, the outcome of improvement to these known metrics is better health and management for chronic condition patients. Our goal is to impact positively on 75% of the metrics above. Different tactics will be deployed based on practice, patient cohort, and direct patient feedback throughout the year. Our provider councils will share best practices and improved metric results with one another routinely.

Tobacco Use/Smoking

Tobacco use and/or smoking tobacco products are known to be causative to early loss of life due to preventable conditions. Exposing more of our community to support for reducing these behaviors is the focus of our impact in this area. In 2016, we are expanding access to both our individual tobacco cessation program as well as our group therapy programs. These efforts provide much-needed services for a population within our community while also building positive attitudes and support for those community members working to overcome a challenging addiction. We will also seek to implement remote smoking cessation support, enabling our reach to expand through the community in a mode with higher access possibilities. Finally, we will continue to provide health education in the area of tobacco use. These education programs not only stave off the start of dangerous tobacco use but can also provide impetus to seek help in discontinuing the habit after it has formed. We will measure our impact through number of persons served in these efforts for 2016.