



Community Health Needs Assessment Implementation Plan

2016-2018

This assessment was designed to fulfill the requirements of the Federal Patient Protection and Affordable Care Act (PPACA) and to help Copley Hospital to fulfill its mission.

Copley Hospital Community Health Needs Assessment Implementation Plan

Introduction

Copley Hospital conducted a Community Health Needs Assessment in fiscal year 2015. Copley engaged Toby Knox and Associates LLC (TKA) to conduct market research pertaining to this Assessment, which included inviting feedback from community members and stakeholders as well as reviewing relevant data and publications published by government and non-profit agencies from within the Copley community and statewide. Copley Hospital conducted the Assessment in collaboration with the Morrisville District Office of the Vermont Department of Health (VDH), working specifically with Field Director Valerie Valcour and the Copley Hospital Service Area Blueprint for Health Community Health Team. Copley Hospital reviewed secondary data, including reports suggested and provided by the VDH, Blueprint for Health, CommunityCommons.org, and the County Health Rankings for Lamoille County.

This Implementation Plan outlines an action plan as to how Copley Hospital plans to address three key community health priorities for the next three years.

The three identified issues are:

- Reducing the Cost of Healthcare, by reducing preventable hospital visits
- Chronic Health Conditions, with a focus on obesity, diabetes related issues
- Preventive Care, with a focus on alcohol, tobacco, and depression screening

Process, Methods, Decision Makers and Criteria

The Copley Community Health Needs Assessment was reviewed by the Hospital's Senior Leadership Team on September 14, 2015 and posted onto copleyvt.org on September 22, 2015. A copy of the report was emailed to Copley Hospital Board of Trustees and to area social service agencies and providers, including: Lamoille County Mental Health, Community Health Services of Lamoille Valley, Blueprint for Health Copley Hospital Service Area participants, Laraway School, Lamoille Home Health and Hospice, The Manor, The Lamoille Family Center, Green Mountain Services, Central Vermont Council on Aging, United Way of Lamoille County, Lamoille Area Food Share, Lamoille Region Chamber of Commerce, Vermont Department of Health Morrisville District. The hospital presented the report publicly during a community gathering on September 28, 2015. Copley officials presented it to the Morrystown Planning Commission on December 15, 2015.

A Steering Committee was convened to review the Copley Hospital Community Health Needs Assessment and develop this Implementation Plan. The Steering Committee included personnel that collaborated on the Assessment and new clinical leaders at Copley Hospital. Steering Committee members included: Valerie Valcour, Field Director, Morrisville District Office, VT Department of Health; Lori Profota, DNP, RN, NE-BC, Copley Chief Nursing Officer; Joel Silverstein, MD, Copley Chief Medical Officer; Celeste Kane Stebbins, RN, Copley Director of Quality and OneCareVT Unified Clinical Collaborative/Blueprint for Health representative; Nancy Wagner, RD, manager of Copley Wellness Center; Elise McKenna, facilitator, Copley Service Area Blueprint for Health; Kathy Demars, Copley Hospital Board of Trustees and Executive Director Lamoille Home Health & Hospice.

In order to select the Significant Health Needs (SHNs) that Copley Hospital will address 2016-2018, the Steering Committee used the following criteria and considerations:

1. Alignment with existing strategic plans: alignment of addressing the SHN with Copley Hospital's other strategic initiatives, quality improvement initiatives, and clinical strengths;
2. Availability of other resources: the breadth and depth of existing community resources to address the SHN; availability of willing community partners with expertise;
3. Community prioritization: the priority placed on the SHN by the community;
4. Feasibility and effectiveness of possible interventions: the existence of effective strategies to address the SHN and the opportunity to intervene at the prevention level;
5. Copley Hospital resources and expertise: Copley has relevant expertise and sufficient resources to make a meaningful contribution within a reasonable time frame;
6. Health disparities: the health needs disproportionately impacts the health status of one or more vulnerable population groups;
7. Historical trends: whether the SHN has been getting better or worse in the community over time;
8. Severity of the problem: the health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected;
9. Magnitude/scale of the problem: the health need affects a large number of people within the community; and
10. Relationship of the problem to other community issues.

The Steering Committee met on November 19, 2015 to prioritize the issues on which the Implementation Plan would focus. The Steering Committee also reviewed potential programs, events and initiatives as well as identified personnel and resources needed to address the issues. The committee also suggested tools and measurements to track results and, if possible, effectiveness.

Working sub-committees at the hospital were convened. These sub-committees met in December and January to detail initiatives and programs to the three prioritized issues. Each initiative was identified as a level of influence from the Vermont Prevention Model, as developed by the Vermont Department of Health. To have the greatest impact, prevention activities should be addressed from multiple levels, including: individual, relationships, organizational, communities, policies and systems.

The sub-committees' recommendations were reviewed by the hospital's Senior Leadership Team on January 18, 2016, and reviewed and approved by the Steering Committee on January 20, 2016. The Copley Hospital Board of Trustees approved the Implementation Plan on February 8, 2016.

Measurable Objectives

The steering committee set measurable objectives for each initiative. These objectives are existing data points collected by government agencies and population health entities, including the Vermont Department of Health, the County Health Rankings, and others. Copley Hospital does not collect health statistics and data so we rely on reputable third parties for these measures. For some initiatives, measurable objectives reflect a target patient population specific to Copley Hospital, with the assumption that improvement in a targeted population could be rolled out to subsequent target populations, and may serve as a stepping stone in improving the overall health of the population. There is shared understanding that measurable improvement in population health takes time, and will be incremental.

Methods for Reporting Progress

Copley will report on the implementation of the initiatives at least annually at the Copley Hospital Board Quality Committee and will be included in the Board Quality Committee Report to the Board of Trustees. Additional forms in which progress may be reported include: the hospital's annual meeting, Blueprint for Health meetings, with civic organizations and via press releases in the hospital newsletter.

Issues Not Addressed

The need for better, more reliable transportation; mental health treatment, the lack of facilities or options for people to exercise and choose healthy eating habits; poverty and the lack of affordable housing, were among other issues also identified. The hospital may monitor, but will not generally address additional issues unless specified in the implementation plan. This is because the hospital does not have the expertise needed, or the necessary actions fall more appropriately to the responsibility of others, or suitable efforts are individuals modifying personal behavior rather than the efforts of a healthcare organization, and/or the hospital's limited resources prevents additional response to other issues.

Implementation Plans: see following pages

Implementation Plan Key:

Blueprint	Copley Hospital Service Area Blueprint for Health Program, includes Morrisville Family Health, Stowe Family Practice, Cambridge Family Practice Associates, Hardwick Area Center, Stowe Natural Wellness, Lamoille County Mental Health, Behavioral Health & Wellness, Northern County Recovery Center, Lamoille Home Health & Hospice, Central Vermont Council on Aging, and more.
Copley	Copley Hospital
CHSLV	Community Health Services of Lamoille Valley (Primary Care Physicians)
CHSLV Care Coord	RNs and Social Workers that serve as Case Managers for CHSLV patients
Cmnty	Community Members
CVCOA	Central Vermont Council on Aging
DVHA	Department of Vermont Health Access
FamCtr	Lamoille Family Center
HLV	Healthy Lamoille Valley
Home Health	Lamoille Home Health & Hospice
JSC	Johnson State College
Law	Law Enforcement
LCMH	Lamoille County Mental Health
LCPC	Lamoille County Planning Commission
Restor	Lamoille Restorative Center
PA	Peoples Academy
UCC	Unified Clinical Collaborative with OneCare Vermont ACO
VDH	Vermont Department of Health

Copley Hospital

Community Need: Reduce Preventable Hospital Visits (Reduce the Cost of Healthcare)

Objectives: Reduce service area's rate of 30-day all-cause readmissions; Reduce # of avoidable visits to the ER; All persons in HSA will have a primary care provider

Measurable Goal:

% 30 day all-cause readmissions for Copley for all payers (Copley)

% 30 day all-cause readmissions for HSA, Medicare only (UCC/OneCare)

% of residents without PCP (VDH)

% of residents without insurance (VDH)

Rate of Medicare enrollees hospitalized for conditions that are Ambulatory Care Sensitive (UCC/OneCare)

Action Item/Specific Tactic	Decision Criteria Willing Partners	Prevention Model:	TimeLine FY16 FY1 FY18	Hospital Resources Needed	Responsible Hospital Dept./Person
Reducing Preventable Hospital Visits		Task Force			
Inpatient Readmissions (Case mgr. doing real time reviews of hospital inpatient readmits within 30 days)	Copley, UCC, allied agencies, discharge planning team. community organizations	Individual, Org., Community	FY16 data collection FY 17 action plan	Clinical Support IT support (McMillian software)	CMO Joel Silverstein, MD,
ER Utilization Follow up w Frequent Users	Copley, UCC, & Blueprint for data; Blueprint Care Coord. at Medical Homes	Individual, Org.	FY16-FY18	Clinical Support, IT Support; Blueprint Care Coordinator support and two-way data sharing; Medical Homes Care Coord work flow	Quality Director Celeste Kane Stebbins, RN

24Hr Hotline ED referral to Home Health	Copley and HomeHealth, UCC	Individual	FY16- FY18	IT Support, Clinical Support, Home Health support; two way data sharing	ED Nurse Director Tracy Webster, RN
Med Reconciliation as part of Hospital Discharge, patients 65+	Copley and Home Health;	Individual, Organization	FY16- FY18	Pharmacy Support Clarification of data being tracked.	Claire Hancock, LCSW
Connect ER patient to PCP (done at registration)	CHSLV Care Coord., Copley Patient Access (Registration),	Individual, Organization	FY16- FY18	Patient Access, Blueprint, two- way data sharing	Krista Gravel, Patient Access
Learning Collaborative through Blueprint: Connecting Frequent Complex Patients with dedicated Care Coord.	Learning Collaborative through Blueprint, UCC, Copley, CHSLV, Home Health, LCMH, DVHA CVCOA	Individual, Organizations	FY16- FY17	Learning Collab Representative; request measurable goals/outcomes from Blueprint	Quality Director Celeste Kane Stebbins, RN
Inclusion in Social Media Marketing Campaign re- education about Advance Directives and Hospice Care	Copley, Home Health, VT Ethics Network	Individual, Organization, Community members	FY16- FY17	Budget: marketing dept	Leah Hollenberger

Copley Hospital

Community Need: Chronic Conditions: Obesity

Objectives: Reduce the rate of obesity in the Copley Hospital Service Area

Measurable Goal:

% of residents without PCP (VDH)

% of residents without insurance (VDH)

% of adults with hypertension (VDH)

% of adults who are obese (VDH) % of children age 2-5 (in WIC) who are obese (VDH)

% of adults meeting the physical activity guidelines (VDH)

% of adults with diabetes (VDH)

% Copley employees using Copley health insurance who are obese (Copley)

% Copley employees using Copley health insurance with hypertension (Copley)

% Copley employees using Copley health insurance with diabetes (Copley)

Action Item/Specific Tactic <i>(identified during meeting)</i>	Decision Criteria Willing Partners (list or NA)	Prevention Model: Indiv., Relationship, Org., Community, Policy	TimeLine FY16 FY18	Hospital Resources Needed	Responsible Hospital Dept./Person
Copley Employee Wellness Program (target population)	Copley Wellness/Employee Health	Individual, Organization	FY16-FY18	Staff Time	Nancy Wagner, RD
Copley Workplace Wellness Programs (target population)	Copley Workplace Wellness Team	Individual, Organization, Community	FY16-FY18	Staff Time	Nancy Wagner, RD
Copley 5k Run/Walk for the Heart	Copley, Town of Morristown, Sponsoring Organizations	Community	FY16-FY18	Budget: Staff time, Marketing materials	Leah Hollenberger
Bike Share/Bike Racks in Morristown	Copley, Town of Morristown	Community, Policy (Town Plan)	FY16-FY18	Budget: \$1,000 annually	Leah Hollenberger

Targeted Social Media Marketing Campaign re Healthy Living Choices, Preventive Screenings, Healthy Activities in Area	Copley, Healthy Lamoille Valley, VDH, Other community organizations	Community	FY16-FY18	Budget: Marketing dept., \$7K for FY2016	Leah Hollenberger
Advocate for town policies that support healthy lifestyle choices (sidewalks, green space, etc.)	Copley, Healthy Lamoille Valley	Policy	FY16-FY18	Budget: Staff Time	Leah Hollenberger

Copley Hospital

Community Need: Routine Preventive Care: Screenings

Objectives: Targeted Population(s) will receive screening for tobacco, alcohol and depression annually/as appropriate; with appropriate referrals made

Measurable Goal:

- % of Adult Excessive/Binge Drinking (VDH)
- % of Adults who smoke cigarettes (VDH)
- % of Youth (grades 9-12) who smoked cigarettes in last 30 days (VDH)
- % of Students who have misused a stimulant or prescription pain reliever (VDH)
- % of Students who have misused a stimulant or prescription pain reliever in the last 30 days (VDH)
- % of Youth (grades 9-12) who used marijuana in last 30 days (VDH)
- % of Youth Excessive/Binge Drinking (VDH)
- % of Adults with 1+ days mental health “not good” (VDH)

Action Item/Specific Tactic	Decision Criteria Willing Partners (list or NA)	Prevention Model:	TimeLine FY16-FY18	Hospital Resources Needed	Responsible Hospital Dept./Person
Healthy Lamoille Valley / Partnership for Success Advocacy	Copley, VDH, Family Ctr, Restor, LCPC, JSC, Law, PA, Hazen, Cmnty	Community, Policy	FY16-FY18	Budget: \$2,500 in support of HLV operating budget	Leah Hollenberger
Women receiving “Well Woman” exams and/or Pre-Natal Intake at TWC will be screened for Tobacco, Alcohol and Depression; Referrals will be made as needed	The Women’s Center (TWC) Clinicians	Individual, Org.	FY16-FY17	IT support Clinical process support	Michelle McDonald
Expand tobacco/alcohol /depression screening to additional Outpatient Clinic: Cardiology	Copley Outpatient Clinics	Individual, Org.	FY17-FY18	IT Support Clinical process support	Treva Southworth

ER Referrals to Blueprint for Health Opiate Neighborhood Program (MAT)	Copley Emergency Dept.; Blueprint	Individual, Org.	FY16-FY18	IT Support Clinical process support	Tracy Webster, RN
Consider Screening Readiness in Emergency Department	Copley Emergency Dept.	Org.	FY18	Clinical process support; IT Support	Tracy Webster, RN
Inclusion in targeted Social Media Marketing Campaign re Healthy Living Choices, Preventive Screenings, Healthy Activities in Area	Copley, HLV, VDH	Community	FY16-FY18	Budget: Marketing	Leah Hollenberger