GVH GRAND VIEW HEALTH

# Community HEALTH

## IMPROVEMENT PLAN 2019


# INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) mandates tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA) every three years. This assessment determines the health needs and gaps in our communities and drives planning, strategy and implementation of initiatives to improve community health. Grand View Health engaged with a collaborative to complete this year's CHNA.

In 2016, Grand View identified 6 priorities for the hospital's three-year improvement plan:

- Obesity
- Diabetes
- Cardiovascular disease
- Lung disease
- Cancer prevention, services and screening
- Behavioral health

The healthcare needs identified during the 2019 CHNA include:

- Behavioral health diagnosis and treatment
- Substance opioid use and abuse
- Chronic disease prevention (cardiovascular, lung, diabetes/obesity, cancer)
- Healthcare and health resource navigation

# IMPLEMENTATION PLAN

## 1 Behavioral Health Diagnosis and Treatment

**Rationale and Statistics:** Behavioral health services were cited by the CHNA as a region-wide, top-priority need. Priority issues for Grand View Health include:

- Limited number of behavioral health providers in the area
- Long wait times for appointments
- Inadequate inpatient resources to provide for psychiatric emergencies
- Difficulty finding pediatric/adolescent behavioral health providers

According to the CHNA data, 1 in 5 adults has a depressive disorder. Undiagnosed and untreated conditions like depression, anxiety, and trauma-related conditions result in high utilization of Emergency Departments (ED), particularly among youth for depressive and mood disorders. The Grand View ED averages 3-4 patients daily for behavioral health needs.

Existing Grand View resources include:

- Crisis workers in the ED to facilitate placement of behavioral health patients
- Referrals to Penn Foundation
- Inpatient psychologist 4 hours per day, Monday-Friday
- Suicide risk assessments and depression screening in the ED, inpatient acute care, and maternal/child health
- Suicide and depression screening by home care with referrals to Montgomery and Lenape Valley Foundation mobile crisis
- Primary care practice depression screening with referrals to nurses, social workers, mobile crisis, ED, or Penn Foundation
- Inpatient case management and social work referrals in ED and inpatient to behavioral and social services
- Home care assessments for social determinants and environment of care referrals to Office of Aging and protective services social workers.

### Objective #1. Increase access to behavioral health services through continued development and growth of community partnerships across the healthcare continuum.

**Action Plan:**

Expansion of improved transitions (warm handoffs) between care managers and behavioral health providers by creating an indexed resource of all social and other services available. This resource will be available to providers, care givers and transitions coaches across the organization via the hospital website to optimize referral opportunities.

## 2 Substance/Opioid Abuse

**Rationale and Statistics:** There are limited substance use disorder providers, and inpatient detox facilities do not always provide ample support after discharge. Patients with substance abuse disorder are being admitted from the ED to inpatient and maternity. Grand View Health hospitalists are able to treat for withdrawal but have limited providers to refer to after discharge.

Existing resources at Grand View include:

- Bucks County Connect Assess Refer Engage Support (BCARES) is a "warm handoff" collaboration between the Grand View ED, inpatient units, and an assigned Certified Recovery Specialist (CRS)
- The hospital's Opioid Stewardship Committee collaborates with HAP to look at recommendations and initiatives for inpatient and outpatient care
- Referrals are made to Penn Foundation for opioid and substance abuse recovery

### Objective #2. Increase access to substance abuse disorder services for recovery and ongoing treatment.

**Action Plan:**

» Reduce prescriptions and utilization of opioids through the work of the opioid stewardship committee.

» Increase warm handoff projects with post-acute and primary practices.

## 3 | Chronic Disease Prevention

**Rationale and Statistics:** Chronic diseases include cardiovascular disease, diabetes, COPD (pulmonary), obesity, and cancer. The CHNA found that overall rates of cardiovascular disease continue to rise. Obesity rates in the Grand View Health community are 26.9% which is down from 30.6% in the 2016 CHNA, but higher than the Bucks County average of 25.1%.

Existing resources include:

***COPD***

- Smoking cessation classes
- Pulmonary specialists
- Pulmonary function testing capabilities, pulmonary rehabilitation, sleep lab, and "Better Breathers" support group
- Low-dose CT scan screening for past and present smokers
- Early palliative care consults for symptom management
- Dietary consults for malnutrition screen and oral intake and BMI monitoring
- Hospice referrals for end-of-life care

***Diabetes/Obesity***

- Dietary support programs on hospital website
- Obesity support groups for diet counseling and teaching
- Diabetic classes for outpatient self-management
- Surgical bariatric and new medical bariatric program with nutritional counseling, classes and support
- Inpatient diabetic teaching by nurses and outpatient by home care and PCP care coordinators

***Cardiovascular***

- Stroke/heart failure coordinator conducts outreach presentations
- Primary care and acute care providers and caregivers refer to cardiac specialists, Grand View cardiac rehabilitation, home care, palliative care, hospice, and nutrition for cardiac patients

***Cancer***

- Nutrition screenings and counseling by dieticians
- Navigators for breast cancer and financial assistance
- Low-dose CT lung scans for early detection and treatment
- Mammograms and colorectal screenings for early detection and screening
- Cancer prevention classes
- Smoking cessation and nutritional classes
- Member of the Penn Cancer Network, working in collaboration with Penn Medicine's Abramson Cancer Center, to provide patients access to the latest research and treatments available

**Objective #3. Increase awareness of the prevention of chronic diseases through healthy lifestyle choices with a combination of education and community outreach.**

**Action Plan:**

» Continue expansion and marketing of wellness programs through education of providers, care givers, and coaches; centralize health and social services resources information on hospital website.

» Explore technology applications for health education and support.

## 4 | Healthcare and Health Resources Navigation

**Rationale and Statistics:** Navigating healthcare services and other health resources, such as enrollment in public benefits and programs, remains a challenge because of a general lack of awareness of what services exist and the fragmented systems.

Financial costs and logistics associated with transportation can be a barrier to accessing healthcare and health resources.

Grand View Health addresses access and navigation with care coordinators in acute care, Emergency Department (ED), primary care practices, and the Grand View Healthcare Partnership.

- Inpatient transitional care handoffs from ED to Primary Care Providers (PCPs) assures patients are seeing a primary care physician within a week of discharge
- ED nurses call patients after discharge that are at-risk for readmission to assure the patients follow-up with prescribed plan of care
- Inpatient care coordinators conduct transitional care handoffs from inpatient to outpatient primary care providers and specialists
- Cardiac rehab nurses call cardiac patients after discharge and follow for 30 days with regular calls and navigation through referrals to primary care and specialty care practices and diagnostics
- Pulmonary rehabilitation respiratory therapists follow at-risk patients after discharge to assure navigation through primary and specialty practices and diagnostics
- Navigators in cancer care follow patients before, during and after treatments to assure ready access to all diagnostics and appointments

**Objective #4: Increase access to healthcare navigators and patient advocates.**

**Action Plan:**
Develop community health resource directories to provide more information about services available to providers, caregivers. and coaches for patient referrals.

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# CONCLUSION

Grand View Health serves more than 10,000 inpatient admissions, 105,000 outpatient visits, and 30,000 Emergency Department visits annually. Many of the health needs identified by the CHNA and prioritized by Grand View and community stakeholders are already being addressed. The CHNA implementation team will meet quarterly to monitor the roll out of the implementation plan over the next 3 years, with the next meeting scheduled for January 2020.