Community Health Needs Assessment Implementation Plan

2017-2019

Tri-State Memorial Hospital (TSMH) conducted, in partnership with its community, Community Health Needs Assessments (CHNAs) in 2013 and 2016. In both CHNAs, access to, and the cost of health care, behavioral/mental health, and managing chronic diseases like diabetes were determined by the community to be among its most pressing health needs.

TSMH's 2013-2016 implementation focus was on partnering with community partners in Washington and Idaho to actively increase the number of community members who had health insurance. In Asotin County, this number increased from 83% to 90%. In neighboring Nez Perce County (Idaho), and despite Idaho not being a Medicaid expansion State, it increased from 82% to 86%. TSMH also recruited a number of new primary care and specialty providers and streamlined vaccine distribution in Asotin County by taking responsibility for all immunization services upon request by the Asotin County Health Department.

To address high rates of obesity, which is a risk factor for diabetes, cardiovascular disease and other chronic conditions, TSMH developed and hosted more than 30 community education events.

Building on the efforts to tackle needs identified in 2013, TSMH intends to continue to partner with local public health districts, schools and Healthy Business Partners to design and implement strategies to improve the health needs identified in the 2016 CHNA. To read the complete 2016 CHNA, which was adopted by the TSMH Board of Directors on December 12, 2016, please see this link: http://tristatehospital.org/media/downloads/TriState-CHNA-2016-Final.pdf.

2016 Community Prioritized Health Needs:

Through a combination of meetings held and surveys conducted in 2016, the following areas were identified as the greatest concerns by our community:

- Quality, accessible healthcare

- Greater health insurance coverage
- Behavioral/mental health for adolescents and adults
- Overweight/obesity, chronic diseases (such as diabetes and heart disease)
- Poor nutrition/access to healthy food
- Poor access to exercise options

Figure 1 shows the specific results of each of three means of soliciting community input. Four Community Forums were held in August 2016, and their feedback is summarized in Column A. Column B depicts the community health concerns as ranked by community and business leaders during a meeting and follow-up survey. Column C lists the top three health concerns identified through a 2016 Community Needs Assessment of five counties in North Central Idaho and Asotin County in Washington State.

Figure 1: Community Convening Results

Rank	A TSMH Community Forums	B TSMH Community Leaders	C 2016 Valley-wide CHNA
#1	Access/ shortage of primary care	Behavioral health for adolescents	Overweight/obesity chronic diseases (diabetes, heart disease, obesity)
#2	Need for more specialists locally	Poor nutrition/obesity for adolescents	Health insurance
#3	Affordability of health care	Behavioral health for adults	Mental health
#4	Improved access to healthy food and exercise options		
#5	High behavioral health needs		

TSMH Selected Priorities:

As a 25-bed critical access hospital located on the border of Washington and Idaho, and more than 100 miles from the closest metropolitan area (Spokane, WA), TSMH serves a community where approximately 16% of all people live below the federal poverty level. The hospital is committed to providing the best service to our community and responding to the health needs that are most important to them. As such, the Board of Directors closely considered the community's priorities in developing this CHNA Implementation

Plan. As it was in 2013, TSMH's 2016 overall priority is Support ***healthy families and community by reducing barriers to timely, affordable care.***

The umbrella issue of access to health care (shortage of primary care, need for specialists locally and cost of care) covered three of the top five concerns identified during the community forums. This overwhelming perception of access barriers, even after the addition of several primary care and specialist providers in the last two years, combined with the fact that direct health care provision is TSMH's expertise, prompted the Board to prioritize implementation related to **increasing the availability of high quality, affordable medical services locally.**

Further, and because mental health/behavioral needs were also among the community's top priorities in each of the groups convened and because the data shows that obesity and chronic diseases and the lack of access healthy food and activity are leading to chronic diseases the Board selected **supporting healthy children, families and seniors through education and prevention programs, as its second area of implementation focus.**

Implementation Strategies:

CHNA Board Adopted Priority #1: Quality, Accessible, Affordable Healthcare			
Strategy # 1: Assure an adequate supply of affordable primary care.			
Resource Plan *Resources committed to the success of the health improvement strategy*	Anticipated Impact *How the success of the strategy will improve the health of the community*	Evaluation *How we will determine if we have been successful.*	Planned Collaboration *Community or internal partners*
• Recruit additional primary care providers • Retain providers by: o Maintaining a culture that assures TSMH is supportive, accountable, collaborative and accessible o Provide the infrastructure and continue to implement lean	• Providers employed by Tri-State are engaged and fairly compensated, leading to improved recruitment and retention • Maintaining long-term provider/patient relationships will increase trust and facilitate addressing chronic health conditions	• Number of net additional primary care providers • % of patients who saw their PCP in the last year • Wait times for new patient appointments (all payer classes • Patient satisfaction data • Compare need per study to current	• Internal

culture to mitigate barriers that impact physician productivity and patient access ○ Evaluate recruitment and compensation practices continuously to ensure TSMH remains a competitive employer • Conduct and regularly update physician need study for Service Area • Implement telemedicine and virtual programs • Initiate a gerontology program that focuses on chronic disease management	• Reduce waiting times for new patient appointments • PCPs will be aware of ED visits/ hospital admissions by their patients and follow up as appropriate • PCPs spend more time with patients and less coordinating care	supply with goal of minimizing deficits • Provider satisfaction and provider productivity • Number of seniors with chronic diseases participating in gerontology services.	
Strategy #2: Expand and Integrate behavioral health.			
Resources	Anticipated Impact	Evaluation Plan	Planned Collaboration
• Provide training to providers on BH screening • Screen for behavioral issues upon inpatient or ED admission • Position for Washington's 2019 bi-directional integration of behavioral and	• Better adherence to medical care for those with behavioral health conditions • Reduced readmission rates, ED use and inpatient length of stay for those with underlying BH conditions, including dementia • Reduced depression,	• Patient satisfaction • % of patients receiving BH screening • % patients discharged with a BH referral	• Greater Columbia Behavioral Health Organization • Quality Behavioral Health – Clarkston • Washington Health Care Authority • Greater Columbia Accountable Community of Health (ACH)

physical health • Implement tele-psychiatry	anxiety and suicide rates over time		
CHNA Board Adopted Priority #2: Supporting Healthy Children, Families and Seniors through education and prevention programs			
Strategy #3: Reduce the impact of obesity and other chronic health conditions through the provision of community education classes aimed at healthy lifestyles and managing health conditions, and dissemination and education via active partnership with community organizations			
Resources	Anticipated Impact	Evaluation Plan	Planned Collaboration
• Continue current and expand hospital prevention classes	• More educated and informed residents • Reduced incidence and impact of chronic conditions including obesity, heart disease, and diabetes	• List of curricula provided to each organization • Number of attendees and completed reviews	• Healthy Business Partners • Health Department • Senior Center • School Districts
• Establish Diabetes Prevention Program, follow patients over time	• Reduce the percentage of community residents with at-risk, pre- or full chronic conditions.	• Number of events hosted and # community residents reached • Number of people enrolled in Diabetes Prevention Program (DPP) • Number of people who complete DPP	• Healthy Business partners • Physicians' office • Local Schools