Giles Community Health Needs Assessment

HEALTH IMPROVEMENT IMPLEMENTATION STRATEGY

FY 2016 - 2018

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CARILION CLINIC

Carilion Giles Community Hospital
Health Improvement Implementation Strategy
FY 2016 – 2018 Summary

Carilion Clinic is a not–for–profit health care organization based in Roanoke, Va. Through our comprehensive network of hospitals, primary and specialty physician practices, and other complementary services, we work together to provide quality care close to home for nearly 1 million Virginians. With an enduring commitment to the health of our region, we also seek to advance care through medical education and research, help our community stay healthy, and inspire our region to grow stronger.

The ultimate goal of Carilion Clinic is to improve the health of the communities we serve. One of the ways to achieve this goal is through assessing and responding to community health needs. The purpose of this implementation strategy is to describe what Carilion Giles Community Hospital (CGCH) plans to do to address the community health needs identified in the 2015 Giles Community Health Needs Assessment (GCHNA).

CGCH is a non-for-profit, 25-bed critical access hospital located in the town of Pearisburg, the geographic center of Giles County. In the heart of the Appalachian Mountains of southwest Virginia, Giles County is an area of approximately 360 square miles with population of approximately 17,300. A comprehensive replacement facility opened in May 2010, offering 24-hour emergency care, advanced diagnostic procedures, minimally invasive surgery, nuclear medicine studies, comprehensive rehabilitation programs, and a diabetes management program.

Community Served

The target populations for this implementation strategy consist of the following groups: low-income individuals, uninsured and under-insured individuals, those that face barriers to accessing care and available resources, and users of existing health care safety-net organizations.

The service area includes Giles County, Virginia, and Monroe County, West Virginia.

Implementation Strategy Process

CGCH and the New River Valley Partnership for Access to Healthcare (PATH) partnered to conduct the 2015 GCHNA. This process was community-driven and focused on high levels of community engagement involving health and human services leaders, stakeholders, and providers; the target population; and the community as a whole.

Since 1995 the PATH Coalition has served as a collaborative, community-focused alliance of 50+ health and human service organizations, other community organizations, and businesses. The partnership is led by the new River Health District focuses on the localities of Floyd, Giles, Montgomery, and Pulaski counties and the city of Radford. The mission of PATH is to maximize access to health care for all residents of the New River Valley.

A 17- member Community Health Assessment Team (CHAT) oversaw the planning activities for the 2015 GCHNA. The CHAT consisted of health and human service agency leaders, persons with special knowledge of or expertise in public health, the local health department, and leaders, representatives, or members of medically underserved populations, low-income persons, minority populations, and populations with chronic disease. Pease see Appendix 1 for the CHAT Directory.

Beginning in January 2015, primary data collection included a Community Health Survey, focus groups with key stakeholders and providers, and focus groups with target populations. Secondary data was collected including demographic and socioeconomic indicators as well as health indicators addressing access to care, health status, prevention, wellness, risky behaviors and the social environment.

After reviewing the data, CHAT members completed a prioritization activity in June 2015. The 2015 GCHNA was approved by the Carilion Clinic Board of Directors and made publically available in September 2015. This Implementation Strategy was developed by the Carilion Clinic Community Outreach Department based on priority community health needs identified in the 2015 GCHNA, with guidance by the PATH Coalition. This document has been approved by Carilion Clinic Board of Directors.

Prioritized List of Significant Health Needs Identified in the 2015 GCHNA

In June 2015, the CHAT participated in a prioritization activity to determine the greatest needs in the service area based on the primary and secondary data collected during the assessment period. To quantitatively determine health needs, CHAT members were asked to rank the top ten pertinent community needs, with one being the most pertinent. Next, on a scale of 1-5, CHAT members were ask to assign a feasibility and potential impact score for each of the ranked needs. This information is used for CHAT strategic planning in the fall of 2015.

The top ten priority areas that emerged from these findings include:

1. Tobacco use
2. Lack of exercise / physical activity
3. Access to adult dental care
4. Alcohol and illegal drug use
5. Chronic disease (diabetes, cardiovascular disease, hypertension, asthma)
6. Poor eating habits / lack of nutrient dense foods in diet
7. Stigma with mental health and substance abuse services
8. Prescription drug abuse
9. Value not placed on preventive care and chronic disease management
10. Access to mental health counseling / substance abuse

Significant Health Needs to be Addressed

CGCH plans to address the community health needs identified in the 2015 GCHNA through its community outreach programs, health safety-net partnership, and through support of the PATH Coalition. CGCH plans to address wellness, tobacco use, mental health and substance abuse services, access to adult dental care, and chronic disease management.

A. Wellness:

The Carilion Clinic Community Outreach Department is committed to improving the health of the community by specifically focusing on the needs identified in the 2015 GCHNA. The department is designed to understand the health needs of the population entrusted to Carilion, and to implement programs and approaches that directly impact those conditions. Outreach provides education, flu shots, and community health screenings to the target population. Education available to the community includes free presentations on the topics of cancer prevention, diabetes prevention, fitness/exercise, food safety, health/stroke, healthy lifestyles, nutrition, smoking cessation, and stress. To increase the amount of outreach in the service area, CGCH has allocated .6 FTE to assist in community outreach activities. This is in addition to the full-time community health educator that serves the New River Valley.

CGCH recently added new equipment to the fitness studio to increase physical activity amongst staff. The hospital plans to partner with community organizations to provide additional community health education and screenings with the target population. The hospital will focus on community health education pertaining to physical activity, nutrition tips, and health related events.

B. Tobacco Use:

To address this tobacco use, CGCH will be working closely with the school system and community partners to provide education about tobacco (smoking, e-cigarettes, chewing tobacco) dangers and resources for tobacco cessation. The hospital plans to expand the tobacco cessation program for inpatients. This program will provide education for patients in the Cardiac Rehabilitation program, as well as other patients who are admitted. CGCH will also be partnering with 1-800-QUIT-NOW to obtain tobacco cessation resources for the community. In addition, training will be help with staff and physicians about smoking cessation.

C. Mental health and substance abuse services:

CGCH will provide space for support groups for alcohol and narcotic addicts. Emergency Department doctors will enroll in the state of Virginia's prescription monitoring program, which will provide more detailed information on how narcotics are being distributed. There will also be pain medication management guidelines provided to each patient in discharge paperwork. Narcotic guidelines for prescribing narcotics will be adopted for Emergency Department physicians as well.

CGCH will work with community partners to explore ways to increase access to mental health and substance abuse services as well as decrease the stigma associated with such services.

D. Dental Services:

The CGCH Emergency Department is partnering with the Community Health Center of Giles to increasing referrals for those individuals who aren't able to afford dental care. The hospital will have information for patients about the dental program that is available to them at the Community Health Center.

E. Chronic Disease Management:
The Better Breathers Club will be expanded to the Giles community in March of 2016. This group meets monthly to support patients with COPD, Emphysema, and other respiratory diseases. The group provides education on how to better manage these diseases.

CGCH is actively examining expansion of specialty care services to the local community. It also plans to expand the Diabetes Management Program to the family practice setting.

F. Focused Community Grants and Partnerships:
Community Outreach also addresses community health need through health safety-net partnerships, including financial and in-kind assistance. Carilion Clinic funds health safety-net providers and causes identified through the GCHNA. Requests to fund health safety net programs will be reviewed twice annually and must align with needs in the GCHNA.

G. Implementation and Measurement:
The PATH Coalition in partnership with CGCH will participate in a strategic planning retreat in the spring of 2016 to determine community-wide strategies to address need identified in the 2015 GCHNA. Expected outcomes will be determined and will be monitored and reported by CGCH.

Priority Areas Not being Addressed and the Reasons

CGCH uses the CHAT and the prioritization of needs activity to set priority areas. Priority areas not identified by the CHAT will be activity addressed as part of this implementation strategy. Priority areas will be reconsidered every three years as part of the GCHNA process. Please see Appendix 2 for the full prioritization worksheet to see what needs are not being actively addressed.

Please visit www.carilionclinic.org/about/chna to review the 2015 Rockbridge Area Community Health Needs Assessment. Learn more about Carilion Clinic Community Outreach at www.carilionclinic.org/about/community-outreach.

This document was adopted by the Carilion Clinic Board of Directors on 2/15/16.

Appendix 1: Community Health Assessment Team (CHAT) Directory

Name	Organization
Michelle Brauns	Community Health Center for the New River Valley
Susan Dalrymple	Pulaski County United Way
Jeff Dinger	Giles County DSS
Diane Dinger	Pearisburg Farm to Fork
Robert Ferrari	Your Integrated Health
Mary Henderson	Giles County Public Schools
Tina King	NRV Agency on Aging
Holly Lesko	VT Institute for Policy and Governance
Charlie Mullins	Giles County
Kelsey O'Hara	New River Community Action/Family Outreach Connections
Beth O'Connor	Virginia Rural Health Association
Molly O'Dell	NR Health District
Stephanie Spencer	Carilion Giles Community Hospital
Katie Stinnett	Giles County Health Departmen
Rosemary Sullivan	NRV Community Services
Sophie Wenzel	VT Center of Public Health Practice and Research/NRHD
Kristie Williams	Carilion Giles Community Hospital

Appendix 2: 2015 Giles Community Health Needs Assessment Prioritization of Needs

2015 Giles Community Health Needs Assessment Prioritization of Needs	**Rank** *Frequency*	**Rank** *Average*	**Feasibility** *Average*	**Potential impact** *Average*
Tobacco use	8	5.4	2.5	1.4
Lack of exercise / physical activity	7	5	2.1	1.5
Access to adult dental care	5	5.6	2.4	1.7
Alcohol and illegal drug use	5	5.6	3.8	1.5
Chronic disease (diabetes, cardiovascular disease, hypertension, asthma)	5	3.6	2.8	1.5
Poor eating habits / lack of nutrient dense foods in diet	5	5.2	2.2	1.3
Stigma with mental health and substance abuse services	5	2.6	2	1
Prescription drug abuse	4	6.8	3.3	2.5
Value not placed on preventive care and chronic disease management	4	5.3	3	2.3
Access to mental health counseling / substance abuse	3	4	1	3
Inappropriate utilization of ED/urgent care for primary care, dental, and mental health services	3	9.3	3.3	3
Not accessing regular preventive care for primary care	3	5.7	2	1
Access to dental care for children	2	6	3.5	
Access to primary care	2	3.5	2	3
Births without prenatal care	2	10	1	1
Child abuse / neglect	2	6.5	3	3
High cost of services for uninsured	2	6.5	3.5	1
High prevalence of mental health (depression, anxiety) disorders	2	3	3.5	2.5
High prevalence of obesity / overweight individuals	2	5	2	1.5
High prevalence of substance abuse (alcohol, illegal & prescription drugs)	2	1.5	2	3
Lack of knowledge of community resources	2	4	2	1
Lack of reliable transportation	2	7	3.5	3
Not accessing regular preventive care for adult dental care	2	8.5	1.5	2.5
Access to specialty care	1	4	2	
Coordination of care	1	3	2	1
Domestic violence	1	9	3	
Dropping out of school	1	6	3	3
High cost of services for Medications	1	5		
High uninsured population	1	9	4	3
Lack of knowledge of health care	1	10	3	2
Lack of trust in health care services	1	10	3	2
Teenage pregnancy	1	2	3	3
Unsafe sex	1	1	3	3