University of Cincinnati Medical Center | UC Health

Implementation Strategies 2017 – 2019

Mission & Vision

Our Mission is:

- Advancing education, research and clinical care through a mutual commitment with the University of Cincinnati.
- Delivering outstanding, efficient, compassionate patient-centered care every time.
- Creating innovative advanced specialty services.
- Improving the health of vulnerable populations.
- Leading in preparing a diverse workforce.
- Providing primary care to our local communities.

Our Vision is to be:

Cincinnati's academic health system transforming care by living into our core values of:

- Patients and Families First
- Integrity
- Respect
- Inclusion
- Empathy
- Discovery.

Communities Served

Butler, Clermont, Hamilton, and Warren Counties in Ohio (83% of inpatient and outpatient volume)

Prioritized List of CHNA Community Health Needs

Criteria

An ad hoc CHNA committee scored the community health needs by considering the following criteria:

- Cause of many hospital visits (based on hospital utilization data from the Ohio Hospital Association)
- Clear disparities/inequities (by geographic areas of disparity measured by Community Need Index score and/or health issues identified in 2011 and 2013 CDC reports)
- Collective Impact priority (Collective Impact is a regional multidisciplinary approach to health improvement.)
- Community prioritized it highly (based on consensus on priorities in CHNA) – this criterion was weighted more heavily in order to retain an emphasis on what the community deemed most significant
- Consequences if not addressed (professional judgment)
- Effective/feasible intervention exists (per The Community Guide; CDC recommendations; and/or recommendations from hospital physicians and/or leaders)
- Impact on other health outcomes (based on risk factors associated with issue)
- Issue worse over time (based on up to 5 years' trend data collected for CHNA)

- Measurable outcome exist (based on CHNA's data sources)
- Proportion of population impacted (per incidence rate of new cases; prevalence rate; mortality rate; and/or top cause of death)
- Unique approach to address problem (per recommendations from hospital physicians and/or leaders)

Prioritization Process

There were two meetings held: one on December 17, 2015 to discuss and determine the prioritization process, and one on January 14, 2016 to conduct the scoring of priorities.

The University of Cincinnati Medical Center adapted UC Health's Strategic Project Assessment Form, used to determine priorities for health system initiatives, which has a scoring scale of 1 to 5. For the CHNA prioritization process, a score of '1' denoted 'not a priority,' and a score of '5' meant 'strong priority.' A blank scoring sheet is provided on page 4.

In addition to increasing the weight of the criterion, 'Community prioritized it highly,' two health issues were also weighted. Access to care/services and mental health were both already identified at UC Health as top priorities during its strategic planning process in 2016.

UC Health's experience with both mental health and substance abuse also led their combination into one category, since mental health issues are a root cause for most substance abuse disorders. In the CHNA cancer and obesity were mentioned individually as well as mentioned within the broader category of chronic disease. During the prioritization process, these scores were reflected separately and combined together.

Priorities

- Access to Care
- Chronic Disease
- Mental Health and Substance Abuse

Process for Strategy Development

Laura Allerding, Director of Strategic Planning & Market Research, and Christie Kuhns, Director of Community Strategic Planning, convened internal stakeholders to develop strategies. Strategies were discussed in two meetings to identify responses for all three priority areas identified from the community health needs.

The initial meeting was held on February 4, 2016 and an additional meeting occurred on March 3, 2016 (which included Dr. Diller and Dr. Wilder to obtain physician input and perspective). Both meetings were facilitated by an external consultant, Gwen Finegan, who also provided technical assistance in follow-up emails. Participants included:

- Mary Ahlers, Clinical Coordinator, Air Care & Mobile Care, UC Health
- Laura Allerding, Director, Strategic Planning & Market Research, UC Health
- Philip Diller, MD, PhD, Professor & Director/Chair, UC Family and Community Medicine
- Ted Inman, Vice President, Strategic Planning & Special Projects, UC Health
- Jennifer Jackson, Interim Chief Administrator Officer, UC Medical Center

- Christie Kuhns, Director, Community Strategic Planning, UC Health
- Matt Nealon, Vice President, Finance and Chief Financial Officer, UC Medical Center
- Heena Parvez, Strategic Planning Analyst, UC Health
- Lauren Stenger, Coordinator, Trauma Outreach/Prevention, UC Medical Center
- Christine Wilder, MD, Assistant Professor, UC Psychiatry & Behavioral Neuroscience
- Tracey Zion, Manager of Care Management, UC Medical Center

After team members developed draft strategies, they shared them at a third meeting on March 14, 2016. The revised strategies were presented for review to the Senior Leadership Group on March 30, 2016 and to hospital leaders for final internal refinements on April 14, 2016.

Draft strategies were removed if they did not have enough detail, did not demonstrate benefit to the community, were part of usual business operations, were still in early planning stages, or would be completed in the current fiscal year. Some removed strategies may still be addressed in the future as part of the University of Cincinnati Medical Center's strategic direction as plans develop. If additional community needs surface in the next three years, the Implementation Strategies can evolve in response.

Significant Health Needs to be Addressed

Implementation Strategies, listed on the following pages, address all three prioritized health needs: Access to Care; Chronic Disease; and Mental Health and Substance Abuse. In addition to the top three priorities, some strategies also address health needs that were not prioritized. For example, expanding access to Ob/Gyn services in the community also addresses the community health issue of Infant Mortality, which was not a top priority.

Accountability

The Chief Administrative Officer will be responsible for ensuring progress on the measures described to evaluate the impact of each strategy. The Director of Community Strategic Planning will convene meetings twice annually with hospital team(s) to track achievements for each strategy. UC Health has selected AchieveIt software to track its strategic initiatives and has committed to spending $30,000 in the next two years on this software. Among other features, the software provides automated reminders for reporting.

Significant Health Needs Not Addressed

Not applicable.

_____/_____/_____

Date approved by Audit and Compliance Committee of UC Health Board of Directors

_____/_____/_____

Date approved by UC Health Board of Directors

Blank Scoring Sheet - CHNA Prioritization

Criteria	Priorities: Access to care/services	Cancer	Chronic disease	Diabetes	Health education	Infant mortality	Mental health	Obesity	Substance abuse, esp. heroin	Systemic socio-economic factors
Issue worse over time										
Community prioritized it highly	*Scores doubled for this criterion*									
Effective/feasible intervention exists										
Cause of many hospital/ED visits										
Consequences if not addressed										
Measurable outcomes exist										
Unique approach to address problem										
Proportion of population impacted										
Impact on other health outcomes										
Clear disparities/inequities										
Collective Impact priority										
TOTAL										

Low				High
1	2	3	4	5
Not a Priority	Low Priority	Neutral	Moderate Priority	Strong Priority

Implementation Strategies

			Resources Required			
Health Issue	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Access to care	Share on website the Community Resource List compiled as part of the CHNA	Post on web site by 12/31/16	No cost.	Requires coordination between Marketing and webmaster	2016	Produced as part of collaborative CHNA process with The Health Collaborative, Xavier University, and 17 other hospitals
Access to care	Increase access to primary care in neighborhoods adjacent to UCMC	Open new health center or primary care office in Avondale	Minimum of $900,000 committed	To be determined	Finalize plans in 2017. Open by 2018.	One potential partner is the Cincinnati Health Department.
Access to care & Chronic disease	Arrange for diabetes education and diabetes management to occur in the community through the Community Health University of the Center for Closing the Health Gap.	Pre- and post-tests for each 6-week course (capacity for 25 people) with follow-up at 3, 6, and 9 months	$115,000 of $200,000 annual support earmarked for this program	Community outreach coordinated by Director, Community Strategic Planning	Agreement can be renewed annually.	Contractual agreement with the Center for Closing the Health Gap to provide the 6-week courses.
Access to care/ services	UC Health will participate in a joint collaboration to improve health in the region, currently under development by The Health Collaborative's Collective Impact Steering Committee. Examples: screening for social determinants of health with referrals to social services; linkages to community resources for health management.	To be determined	To be determined	To be determined	Strategies will start when planning is done in 2017.	The Health Collaborative, community organizations, and participating member hospitals

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Health Issue	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Access to care & Chronic disease	Community health education: 1) Distribute broadly, in community settings, educational materials on topics such as, Caregivers Guide (new); Diabetes and Pregnancy; Diabetes Management; How to Choose the Right Health Care Setting (new); Hypertension; Lung Cancer Screening; and Traumatic Brain Injury and Substance Abuse. 2) Provide classes first at UCMC and eventually extend them to Drake and West Chester on such topics as "Take Ten" CPR. 3) Share educational materials about chronic disease at large-scale community health fair events.	Number of community organizations involved in dissemination; number of classes open to community; community requests for training; 3-4 health fair events per year. Double the number of new patients screened monthly for lung cancer (currently average of 25 new patients per month).	$5,000 is budgeted for the cost of preparing/printing materials. Lung Cancer Screening Program's salary and benefit expenses for fully staffed 3 FTEs are $204,048 annually.	3% of FTE: Community outreach coordinated by Director, Community Strategic Planning. Lung Cancer Screening Program has a nurse coordinator and 1 administrative support person; will recruit to fill vacant position for 2nd nurse coordinator for a total of 3 FTEs.	Extend dissemina-tion of existing information in 2016 to a broader audience, and add new publications for wide release in 2017. Increased lung cancer screening to begin in fall 2016.	Goal to help 10-12 smaller hospitals in the region to set up effective and safe screening for lung cancer.

			Resources Required			
Health Issue	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Access to care & Chronic disease	Community health education on fall prevention: 1) Distribute broadly, in community settings, educational materials on fall prevention. 2) Provide classes first at UCMC and eventually extend them to Drake and West Chester on fall prevention. 3) Share educational materials, resource information, assessments, and services at annual Fall Prevention Community Clinic and Healthy Lifestyles Seminar. 4) Develop fall prevention program with local fire departments to identify high-risk fallers and connect them to community resources.	Increase attendance from first Fall Prevention Community Clinic.	UCMC pays $1,000 for expenses not covered by sponsorships.	UCMC provides the speakers for the Fall Prevention Community Clinic. Community outreach coordinated by Injury Prevention Coordinator. 40% of her time is spent organizing, planning, executing, and educating.	Fall Prevention Community Clinic held in fall 2016. Fall prevention program with fire departments developed in 2018.	Molina Healthcare and People Working Collaboratively are partners for Fall Prevention Community Clinic and Seminar. Local fire departments.

			Resources Required			
Health Issue	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Access to care & Infant mortality	Expand Ob/Gyn services in the community: --Adding services at WinMed (Community Action Agency-City West) and Cincinnati Health Department's Walnut Hills Health Center. --Collaborating with Cincinnati Children's Adult Congenital Heart Disease (ACHD) Program with case management of pregnant women. --Collaborating with Cincinnati Public Schools to manage care of pregnant teenage girls in CPS through STEPS (Skills To Ensure Parenting Success) program with UCMC case management. --Future opportunities include: expanding OB/GYN services in Avondale, Walnut Hills/Evanston or in the East End; and/or providing additional sessions in existing Elm Street, Price Hill, Millville, Winton Hills and Walnut Street Health Centers. They would require additional providers and Case Managers.	Walnut Hills OB has 5 patients enrolled as of March 2016; enrollment could increase with 25-30 deliveries per year. ACHD: New program has 8 pregnant women enrolled and case managed. STEPS starting with 12 teens from pilot school, West High	Walnut Hills: $925/4-hour weekly session for annual expense estimated at $48,100. ACHD: $400/monthly session for annual expense estimated at $20,000. STEPS: Estimated annual expense of $7,800 for Nurse Case Manager two hours/week.	Walnut Hills: 0.10 FTE OB provider and 0.10 FTE nurse care manager. ACHD: 0.20 FTE RN Case Manager, WHNP/Maternal Fetal Medicine provider. STEPS: 0.05 FTE RN Case Manager.	Ongoing expansion	Cincinnati Children's; Cincinnati Public Schools; Cincinnati Police Department; Toyota; Cradle Cincinnati; Cincinnati Health Department; Communitiy Action Agency-City West
Mental health & Substance abuse	Improve community treatment capacity for people with substance abuse disorders and co-occurring disorders	Open new Intensive Outpatient (IOP) Clinic, fully operational by 2017. Capacity for daily census of 75 patients, of which 20 will be receiving intensive services.	Total start-up costs of $225,000-$250,000. Annual operating expense in 2017 estimated at $570,312.	Increase staffing from 1.1 now to 4.5 FTE to begin operations. Total eventual staffing need is 7.75 FTE.	Fully operational by 2017.	Deaconess as a main referral source (until services are moved to UCHBC)

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Health Issue	**Strategy**	**Evaluation of Impact**	**Financial**	**Staffing**	**Timing**	**Collaboration**
Mental health & Substance abuse	Continue to grow new Perinatal Addictions Clinic to provide coordinated perinatal, addiction and mental health treatment for women with substance abuse disorders.	Started 1/13/16 with 9 OB patients enrolled to date. Currently offering one 4-hour session/week. Expansion goals would be 3 sessions per week.	Initial expense is $48,100/year. Expansion to 3 sessions/week would require an additional $96,000/year.	Currently 0.10 FTE for OB provider and 0.10 FTE for RN Case Manager. Expansion would require additional 0.40 FTEs.	Fully integrated clinic by 2018	Health Care Access Now to provide biweekly community support; community partners such as First Step Home for residential treatment; and community Ob/Gyn providers
Mental health & Substance abuse	Provide information, as appropriate, about the new methadone clinic in order to connect more people to treatment.	Lindner Center of HOPE reaches its capacity of 400 patients per day.	No significant increase in resources needed.	No significant increase in resources needed.	Lindner Center of HOPE reaches capacity in Spring 2017.	Linder Center of HOPE