Goshen Health

Goshen Health CHNA Action Plan: 2019-2021

The mission of Goshen Health is to improve the health of our communities by providing innovative, and outstanding care and services through exceptional people doing exceptional work. To ensure our work is driving our mission, we measure the impact of our efforts to verify that we are doing our very best for those who matter most.

In 2018, once again Goshen Health completed an evaluation of its communities' healthcare needs as required by the Patient Protection and Affordable Care Act. This process continues Goshen Health's long-standing practice of regularly identifying and addressing health needs within its communities.

To identify the health needs for the 2018 Community Health Needs Assessment (CHNA), data were collected from secondary sources and from Latino and non-Latino parents and guardians of school age children, Amish, community leaders, focus groups and key informants from business, not-for-profit and service organizations, health care and mental health workers, and those from or representing vulnerable or medically underserved populations. These data were analyzed to identify and prioritize health needs in the Goshen Health communities.

Based on findings of the 2018 CHNA report, Goshen Health has developed the following action plan that focuses on improving the health of our communities. We look forward to sharing the results with you as we work alongside additional engaged community partners to make a difference in the lives of those we serve.

PRIORITY AREA Obesity/Physical Fitness/Nutrition/Health Education

GOAL Reduce the rate of obesity in the Goshen Health service area through both external and internal programs.

LONG TERM INDICATORS OF IMPACT

	BASELINE VALUES AND SOURCE	FREQUENCY
1. Slow or halt the rapidly accelerating rate of adult obesity within our community	2018 CHNA and 2019 indicators Elkhart County: 32.8%, 11.2% increase over 4 years	Annual
2. Reduce the percent of adults reporting physical inactivity within our community	2018 CHNA: 25.9% reporting physical inactivity in Elkhart County in 2013 2019 indicators Elkhart County: 26.4% from 2014-2018	Annual
3. Increase engagement with health education related to nutrition, physical fitness and obesity within our community, for both adults and children	Community Wellness and Education/Goshen Health engagement data for benchmarking. 2019 is a benchmark year for programming	Annual

STRATEGY #1

Lead a community coalition focused on improving and expanding broad access obesity initiatives with outcomes measures. This group will focus on high risk populations, cultural minorities, leveraging community assets and advancing the role of social determinants of health in programming choices.

TYPE

Community-partner program development and execution

PARTNERS

Elkhart County Health Department, Goshen College, Horizon Education Alliance, Goshen Community Schools, Mayor's Office, Plain Church Group Ministry, Northern Indiana Hispanic Health Coalition and others.

BACKGROUND ON STRATEGY

Evidence of Effectiveness: Social Determinants of Health (SDOH) are published to have a strong impact on both general wellness and obesity in particular within communities. General obesity related programming fails to engage true change in behavior. In order to create lasting improved health status for our community, programs must be built or revised with these SDOH at the forefront. Further, high risk and minority groups differ in how they approach both health education and behavior change. Only by engaging closely with these communities as we seek to provide support for positive change can it be realized successfully.

Bryant, P.H., Hess, A, & Bowen, P. (2015). Social determinants of health related to obesity. The Journal of Nurse Practitioners, 11 (2), 1-7.

Benedict, S., Campbell, M., Doolen, A., Rivera, I., Negussie, T., & Turner-McGrievy, G. (2007). Seeds of hope: A model for addressing social and economic determinants of health in a woman's obesity prevention project in two rural communities. Journal of Women's Health, 16 (8). Doi 10.1089/jwh.2007.CDC9

SHORT TERM INDICATORS

	ANNUAL TARGETS BY DECEMBER 31		
PROCESS INDICATORS	2019	2020	2021
1. Expansion of existing, successful program or development of new programming per year, executed with the coalition's recommendation	2	2	2
2. Number of participants in program(s)	Baseline	Baseline + 10%	Baseline + 20%
IMPACT INDICATORS			
1. Percentage of participants that report positively to established success measures for program	Baseline	Baseline + 10%	Baseline + 20%
2. Percentage of participants that report improved outcomes compared to baseline	Baseline	Baseline + 10%	Baseline + 20%
3. Percentage of participants that demonstrate long term improvement through follow-up surveillance	Baseline	Baseline + 10%	Baseline + 20%

STRATEGY #2

Establish a consistent, evidence based pathway for obese patients within the Accountable Care Organization

TYPE

Clinical Program

PARTNERS

Goshen Physicians, Medical Staff and Referring Providers

BACKGROUND ON STRATEGY

Evidence of Effectiveness: Every patient screened in the ACO medical homes with a BMI over 30 will be engaged through the use of the PAM[1] assessment. The use of a standardized, evidence-based clinical pathway will allow us to connect those patients who are ready to make changes in their lifestyle to health coaches or other specific resources. Patients will be entered into a registry to track outcomes.

SHORT TERM INDICATORS

	ANNUAL TARGETS BY DECEMBER 31		
PROCESS INDICATORS	2019	2020	2021
1. Pilot of pathway/assessment	Execute	Audit	Audit
2. Number of Colleagues with advanced education in PREPARE and lifestyle change training or as health coaches	Baseline	2x Baseline	2x Baseline
3. Number of patients referred to health coaches	Pilot	200% of Pilot	300% of Pilot
IMPACT INDICATORS			
1. Number of new patients who are referred to health coach who attend first visit	Pilot	200% of Pilot	300% of Pilot
2. Improved biometric for patients - weight	Baseline	Baseline + 5%	Baseline + 10%
3. Improved biometric for patients – fasting blood glucose	Baseline	Baseline + 5%	Baseline + 10%

[1] The PAM assessment is an evidence-based tool that addresses an individual's ability to self-manage illness or problems, engage in activities that maintain functioning and reduce health declines, involvement in treatment and diagnostic choices, collaborate with providers, select providers based on performance and quality and navigate the health care system. The survey then determines if the patient is in one of four activation levels including believing the patient role in activation is important, having the confidence and knowledge necessary to take action, proactively taking action to maintain and improve one's health and staying the course even under stress.

STRATEGY #3

Establish an evidence-based pathway for overweight or obese pediatric patients that takes into account SDOH.

TYPE

At risk or acute intervention strategy

PARTNERS

Goshen Physicians

BACKGROUND ON STRATEGY

Evidence of Effectiveness: Use of research supported, evidence-based interventions will advise the selection of process and impact indicators once programming is established. Partner with Horizon Education Alliance, Goshen Community Schools or other organizations to screen and implement evidence-based interventions to decrease the level of obesity in a targeted group of grade levels.

SHORT TERM INDICATORS

	ANNUAL TARGETS BY DECEMBER 31		
PROCESS INDICATORS	2019	2020	2021
1. Establish pilot program based on evidence-based approaches in the pediatric population	Development	Execution	Auditing
2. Number of participants	NA	Pilot	TBD
IMPACT INDICATORS			
1. Percentage of participants that complete program	NA	200% of Pilot	300% of Pilot
2. Percentage of adult caregivers who report improved understanding of care plans for patient	NA	Pilot	TBD
3. Improved biometric for patients - BMI	Baseline	TBD	TBD

PRIORITY AREA
Diabetes/Nutrition/Health Education

GOAL
Reduce the rate of uncontrolled diabetics within the ACO population

LONG TERM INDICATORS OF IMPACT

	BASELINE VALUE, DATE AND SOURCE	FREQUENCY
1. Slow or halt the accelerating rate of Adult Diabetes in our community	ACO Data Set; County Health Rankings, CDC Diabetes Interactive Atlas shows 10.4% in Elkhart County, with an increase of 11.8% over 4 years.	Annual Updates

STRATEGY #1
Establish primary care driven intervention platform for uncontrolled diabetes.

TYPE
Acute intervention, training and education

PARTNERS
Medical Staff

BACKGROUND ON STRATEGY
Evidence of Effectiveness: Use of community-developed, evidence-based MAAP It Out© education strategy that ties patients with A1Cs > 8 on the diabetes registry to ongoing diabetes education should advance disease control. Additional screening of patients with diabetes for engagement level using evidence-based PAM[1] screening system will validate use of resources toward improved outcomes.

SHORT TERM INDICATORS

	ANNUAL TARGETS BY DECEMBER 31		
PROCESS INDICATORS	2019	2020	2021
1. Number of patients on diabetes registry screened for engagement	Baseline	Baseline + 10%	Baseline + 20%
2. Number of patients referred to diabetes education	Baseline	Baseline + 10%	Baseline + 20%
IMPACT INDICATORS			
1. Percentage of patients referred who engage with diabetes education	Baseline	+ 20%	+ 25%
2. Percentage of participants that demonstrate HbgA1C<8 on the registry post education	Baseline	Baseline + 10%	Baseline + 20%

Goshen Health has developed this implementation plan to meet a prioritized need identified through a community health needs assessment process. Goshen Health may refocus resources if necessary to best address the needs of the community as they change over time.