Community Health Needs Action Plan

2022-2024

Goshen Health

Community Health Needs Action Plan for 2022-2024

Background

Goshen Health, as a 501(c)3 not for profit entity, is required to complete an extensive Community Health Needs Assessment (CHNA) once every three years. That report is presented to the community, and the list of prioritized community health needs established by a community committee is then to be adopted by the board of directors. The institution is then charged to recommend an action plan to the board for approval with the intent to measurably impact these community health needs as one of several ways that this not-for-profit entity directly benefits the community we serve.

2021 Community Health Needs Assessment for the 2022-2024 Action Plan Cycle

The 2021 Community Health Needs Assessment was completed in September and the results were presented to the Goshen Health Board of Directors for adoption on November 17, 2021. Prioritization was established by the Community Advisory Council (CAC) using the Community Health Rankings Model published by the University of Wisconsin and is as follows:

1. **Mental Health**
2. **Diabetes Treatment and Prevention, Poverty**
3. **Obesity/Weight Management**
4. **Lack of Access to Health Care**
5. **Substance Abuse/Addiction, Health Education**

The board directed the executive team to establish an action plan to impact a credible portion of this list, in partnership with other community entities as appropriate, and present it for approval in early 2022. Certain of these health needs have been present in the community over several cycles of CHNA – in cases where Goshen Health is making headway with existing action plans, it was recommended to continue our work in those efforts.

This plan focuses our efforts in three areas. Those areas are Mental Health, Obesity/Nutrition, and Social Determinants of Health (SDOH). While SDOH is not outlined in specific on our priority listing, three of the five social determinants of health as defined by the Centers for Disease Control (CDC) are clearly represented. The CDC specifically identifies Health Care Access, Health Education, Economic Stability (Poverty) within their definition of SDOH, which are "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." The recommended action plans and measures of success are outlined below:

Community Mental Health

The Mental Health Action Plan is formed of 4 Strategies:

1. Integrate mental health service access in support of primary care physicians within Indiana Lakes. This work will relate directly to Oaklawn's access redesign, which intends to enhance outpatient services integration and support for all communities we serve. This program rolls out in July of 2022. Based on the initial outcomes of this platform, Goshen Health will support expansion by Oaklawn with additional resources or implementation of alternative strategies during this action plan.

2. Mental health intervention support for inpatient care will also be investigated for pilot studies. Two different telehealth platforms are under review for implementation. One will be selected and implemented over the next several months, to be tracked and evaluated for meeting our inpatient mental health needs through the years of this action plan.

3. Goshen Health will align the focus our community education and outreach efforts to specifically engage community members and organizations in mental health awareness, education, and prevention tactics in measurable ways. Our efforts to seamlessly engage community partners in successful outreach programs is well demonstrated in obesity/nutrition over the last three years. Our intent is to take that model forward into mental health programming with our school and community partners. Cost of these efforts are already present in our budget.

4. We will support the new Mental Health Urgent Care platform under development by Oaklawn. Goshen Health can best partner with Oaklawn and the City of Goshen as they establish the Crisis Response Center related to medical clearance of individuals who are brought to/enter this de-escalation space. We will aid the development and planning team with medical clearance insight and capabilities and support this important community intervention strategy through implementation. This will provide significant benefit to patients that are currently waiting for evaluation or actively in crisis.

The short-term metrics we will track to determine impact on mental health in our community include time to first visit with a mental health professional, community members served, learner hours/post-interaction knowledge, and any funds used in support of greater community access. Baselines for these action plans will be determined early in roll out or begin at zero and will be reported out annually.

Community Obesity/Nutrition

The Obesity/Nutrition Action Plan is a continuation and expansion of our successful 2019-2021 CHNA Action Plan:

1. Continue engagement with coalitions throughout our service areas that target obesity/nutrition, directly supporting efforts that impact high risk populations, cultural minorities, and children by leveraging community assets and advancing impactful programming choices.

2. Pursue grants for partnership expansion and deeper community reach:
   a. Our communities have several food desert designations. We have written a grant in partnership with Purdue Extension to take our successful Goshen Health garden program out to known sites in our service counties on a small community scale. The goal of this grant is to establish successful community gardens in mobile home parks, senior living communities, low-income housing tracts, and possibly schools. The funds would support a master gardener assisting with site selection, preparation, and resident training.

   b. We have a grant written with partner Cultivate Culinary to expand the School Backpack program they pioneered. Each backpack provided includes 6 nutritionally balanced meals created from locally rescued food. The current program only runs during the school year. This platform costs $12 per pack, and grant funds will be used to expand access through the summer months. With the aid of our additional community partners Elkhart Community Schools, Goshen Community Schools, Wa-nee Community Schools and several others, this program would be folded into our existing Summer Health Lunch Bunch to bridge food insecurity during the summer months for at-risk families.

   c. Expansion of our Move More! Partnership with regional parks departments. This proposal seeks to advance the evidence-based activity and education platform on our greenways and community access activity spaces. It would include additional point-of-decision activity education prompts, as well as a QR-code connection to activity planning. Community-wide public challenges to create awareness and support are included in the grant, as well as universal activity opportunities such as scavenger hunts for all ages to engage physical activity in our amazing green spaces.

The metrics we use for these efforts include participation, specific post-interaction knowledge assessments, measured improvements in physical fitness. In existing programs, we grew community engagement with core programming more than 30% in the first year – carrying over and through a pandemic crisis! The Covid-19 pandemic provided Goshen Health with the opportunity to step into a significant crisis for our community with food stability, health education related to the importance of physical activity, and further partnership with both regional school systems and parks departments to encourage our community to Move More! Our community partnered programs grew from 3 to 7 – and these opportunities to partner around the shared goal to reduce obesity long-term continue to increase. The grant programs above are additional steps Goshen Health will undertake during 2022-2024 to support our community. The impact metrics we have used historically will continue to be used, with growth targets set each year.

Social Determinants of Health

Our Community Health Needs Assessment and Community Advisory Council clearly identified that Social Determinants of Health (SDOH), or the conditions of our community's living environment, are harming their health overall. These environment conditions are highly variable from zip code to zip code, community to community, and household to household. While the scope of this need is enormous, we know certain community members are disproportionately impacted and that we as a health care organization are uniquely positioned to intervene with support. Intervention points where we feel we can make a positive impact are triggered by either an inpatient (acute) experience or an outpatient experience. Our action plans reflect these two trigger points:

1. Establish a pilot program to send community workers into the homes of community members following an acute care visit. This program is designed to send a community health worker directly into the home to assess SDOH, identifying gaps that can be closed. Those gaps are then reported to a coordinating team member who connects the patient to services that are available in the community on their behalf. A form of this pilot has been conducted within our Accountable Care Organization, demonstrating positive impact in a multitude of interventions including but not limited to transportation support, health care access through Medicaid enrollment support, homesite risk assessment and intervention, and addressing food insecurity. This pilot will initially target a defined subset of acute care visits and be limited to $50,000. We will work with a partner, Firefly Health, to provide community health workers for the pilot. Upon pilot completion and evaluation, we intend to seek grants to support this going forward.

2. Primary care providers are uniquely positioned to both identify and flag SDOH within their patient care panels. However, they and their offices need additional support when these needs are outside of routine medical care. To support closing SDOH gaps in the outpatient setting, Goshen Health will expand coordination services for patients with SDOH needs. This expansion plan will take a scaled approach and be implemented through the Indiana Lakes Accountable Care Organization. This intervention may be internally developed or integrated with community partners. We will develop this intervention plan in year two of this community health needs action plan period to permit our experience in the acute care pilot to inform the design.

Social determinants of health are diverse and unique to each person or household. Our strategy embraces the variety of circumstances that exist in the communities we serve. Our experience with care coordination through population health has taught us that going physically into a home, speaking with cohabitants, and observing the physical environment is our best opportunity to identify gaps and establish plans with an individual to close those gaps. These pilots will track several metrics including persons served, intervention plans developed, and plan completion rate.