

## **Introduction**

Columbus Regional Hospital (CRH) is a community health system located in Columbus, Indiana whose mission is to improve the health and well-being of the people we serve and whose vision is to be, for all those we serve, their health and wellness partner for life.

For over 20 years, CRH has conducted Community Health Needs Assessments periodically to guide its community health promotion activities. CRH's CHNA studies--conducted in 1996, 2000, 2003, 2006, 2009, 2012 and 2015 – employ a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the primary service area of Columbus Regional Hospital. This information is used to inform and determine CRH's CHNA Implementation Strategies.

CRH addresses community health needs primarily through its Healthy Communities Initiative (HCI) organization. Healthy Communities' mission is to achieve radical improvement in our community members' long-term quality of life through local action. HCI accomplishes this by collaborating with a diverse network of partners to develop and respond to data-driven community health priorities.

HCI deploys Action Teams, comprised of paid staff and community volunteers, to address the most urgent community health issues. Healthy Communities' Action Teams address community health issues in three general priority areas: Access to Health Care for All; Promoting Healthy Lifestyles; and Promoting Healthy Relationships. Most HCI Action Teams are standing committees, but from time-to-time, when new community health priorities arise and are identified by the CHNA, new Action Teams are deployed.

Specific activities of the Action Teams are informed by a combination of the CHNA results and a Key Informant Survey and are prioritized by the Healthy Communities Council, a community collaborative comprised of health, civic, business, faith, social service, education, and other leaders from across the community.

**This report is CRH's Community Health Needs Assessment Implementation Strategy for 2017-2019.**

## **CHNA Methodology**

CRH's CHNA incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (a Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey.

### **Community Health Survey**

#### *Survey Instrument*

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the Columbus Regional Hospital and Professional Research Consultants, Inc. and is similar to the previous surveys used in the region, allowing for data trending.

#### *Community Defined for This Assessment*

The study area for the survey effort (referred to as the “Columbus Regional Hospital Service Area” or “CRH Service Area” in this report) includes each of the residential ZIP Codes primarily associated with Bartholomew County, Indiana, as well as ZIP Codes 47274 in Jackson County and 47265 in Jennings County.

### Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Columbus Regional Hospital; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 104 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

<b>Key Informant Type</b>	<b>Number Invited</b>	<b>Number Participating</b>
Community/Business Leaders	93	40
Other Health	46	26
Physicians	15	7
Public Health	36	24
Social Services	13	7

### Information Gaps

While CRH’s CHNA assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community’s health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, the CHNA assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

## **2017-2019 Implementation Strategy Priorities**

Among 13 “Areas of Opportunity” identified by the 2015 CHNA results, wherein local results differed significantly from state and/or national benchmarks, CRH has prioritized 11 priority areas for the 2017-2019 period. The 2 areas not addressed in the implementation strategy (Dementia, including Alzheimer’s Disease deaths and Teen Births) are being addressed by other local social organizations (Just Friends Adult Day Services and Mill Race Center for Active Adults and Pregnancy Care Center.)

### **Areas of Opportunity**

- 1. Access to Healthcare Services (primary care)**
- 2. Cancer (deaths, incidence, screenings)**
- 3. Diabetes (prevalence, kidney disease deaths)**
- 4. Heart Disease & Stroke (stroke deaths, high blood pressure prevalence, overall CV risk)**
- 5. Injury & Violence (unintentional injury deaths, bike helmet usage, firearm deaths, firearm prevalence in homes with children)**
- 6. Mental Health (depression prevalence, suicide deaths)**
- 7. Nutrition, Physical Activity & Weight**
- 8. Infant Mortality**
- 9. Respiratory Diseases (CLRD, COPD & Asthma prevalence)**
- 10. Substance Abuse (disease- and drug-induced deaths)**
- 11. Tobacco Use (cigarette smoking & smokeless tobacco use prevalence)**

## **Priority 1: Primary Care Access**

### **Goal 1: *Increase access to primary health care.***

- a) Increase number of Medicaid and uninsured patients using VIMCare Clinic as their medical home.
- b) Increase net number of primary care physicians in CRH primary and secondary service areas by eight (8).
- c) Continue support for combined Medication Assistance Program (community and VIMCare Clinic patients) at VIMCare.
- d) Implement primary dental care services at VIMCare Clinic.
- e) Continue support for United Way's Premium Link HIP 2.0 and marketplace health insurance subsidy program for low-income people in Bartholomew County.
- f) Continue support for health insurance navigators in the community.

## **Priorities 2 & 11: Cancer and Tobacco Use**

### **Goal 1: *Increase local cancer treatment options to lower cancer deaths.***

- a) Expand access to local oncology providers and state-of-the-art treatments.

### **Goal 2: *Increase screening for breast cancer.***

- a) Meet mammogram screening goals for under- and uninsured people as outlined in Komen & IBCAT grant awards.

### **Goal 3: *Continue tobacco control efforts to prevent youth initiation.***

- a) Conduct community presentations to educate on other tobacco products and point-of-sale marketing efforts.
- b) Conduct "Getting a Head Start on Living Tobacco Free" training module at Head Start Center, Community Center of Hope, and Bartholomew County's Baby & Me program.
- c) Continue High School Heroes program at local high schools.
- d) Conduct Tobacco Abuse and Consequences presentations at local high schools, including latest information on e-cigarettes.

### **Goal 4: *Increase referrals to Indiana Quitline.***

- a) Beginning with VIMCare Clinic, collaborate with CRH IT department and process into their Electronic Medical Records system.

### **Goal 5: *Increase adult participation in tobacco cessation courses.***

- a) Fully implement US Public Health Service clinical practice guidelines for treating Tobacco Use and Dependence at VIMCare Clinic.
- b) Expand these tobacco USPHS clinical practices among CRHP practices.

## **Priority 3: Diabetes**

**Goal 1:** *Increase prevention behaviors in persons who are at high risk for diabetes or have been diagnosed with pre-diabetes.*

- a) Implement best-practice screening, education, self-management support, and coaching practices for VIMCare Clinic patients in 2017.
- b) Implement best-practice screening, education, self-management support, and coaching practices at other CRHP primary care practices in 2018.
- c) Implement best-practice workplace policies, prevention, and employee self-management supports at CRH in 2018.
- d) Deploy CRH Diabetes Prevention Program certified pre-diabetes coaches to other workplaces in CRH PSA.
- e) Collaborate with other community partners to provide diabetes education in the community, especially to underserved people.
- f) Conduct 2 diabetes screening events in community in 2017 & 2018.

**Goal 2:** *Promote adoption of healthy lifestyle behaviors through efforts that make the healthy choice the easy choice in the workplace, at home, and throughout the community.*

- a) Conduct Complete Health Improvement Program workshops for key CRH stakeholders within the health system and externally in 2017 and 2018.
- b) Adopt policies and practices at CRH that promote healthy eating and beverage consumption among employees and visitors in 2018.
- c) Continue Healthy Lifestyles Action Team leadership in creating a pedestrian and bicycle friendly built environment throughout Bartholomew County.

## **Priority 4: Heart Disease & Stroke**

**Goal 1:** *Increase prevention behaviors in persons who are at high risk for heart disease or stroke.*

- a) See efforts for Diabetes.
- b) Conduct 2 CV and Stroke screening events in community in 2017 & 2018.

**Goal 2:** *Promote adoption of healthy lifestyle behaviors through efforts that make the healthy choice the easy choice in the workplace, at home, and throughout the community.*

- a) See efforts for Diabetes.
- b) Add a CV physician on the Healthy Communities Council in 2017.

## **Priorities 5 & 8: Injury & Violence and Infant Mortality**

**Goal 1:** *Eliminate Shaken Baby Syndrome (unintentional infant injury and deaths to infants resulting from caregivers shaking them.)*

- a) Continue Crying Education to all delivering at the CRH Birthing Center.
- b) Continue providing Period of Purple Crying DVD's to all who give birth at CRH Birthing Center.
- c) Continue cooperative efforts with Family Services in support of home visits to new moms in Bartholomew County.

**Goal 2:** *Increase understanding of safe biking practices.*

- a) Conduct bike safety training in the community.
- b) Support safety initiatives of the Columbus Bike Co-op.

**Goal 3:** *Make Bartholomew County safer for pedestrians and bicyclists.*

- a) CRH HCI staff serves on City of Columbus Bike & Infrastructure Team & CAMPO Citizens Advisory Team.
- b) CRH HCI staff serves on Bartholomew County Safe Routes to Schools Task Force.
- c) Conduct pop-up traffic calming pilots in Columbus in 2017 & 2018.

## **Priorities 6 & 10: Mental Health & Substance Abuse**

**Goal 1:** *Reduce suicide rate.*

- a) Promote universal screening for depression and suicide risk throughout the CRH health system.
- b) Promote standard protocols in the health, school, and criminal justice systems for handling those at risk for suicide.
- c) Spread Counseling on Access to Lethal Means (CALM) training.
- d) Support efforts to introduce QPR training at post-secondary institutions.
- e) Support CRH participation in statewide Zero Suicide Academy.

**Goal 2: *Reduce substance abuse disorder.***

- a) Site visit communities with successful prevention programs in 2017.
- b) Explore how to increase access to detox options in 2017.
- c) Explore how to increase access to medication-assisted treatment options in 2017.

**Goal 3: *Decrease stigma to increase help-seeking behaviors.***

- a) Spread Mental Health First Aid training, partnering with Centerstone.
- b) Conduct a community forum in 2017.

**Goal 4: *Increase local resources for mental health and addiction treatment.***

- a) Implement Collaborative Care Model for Behavioral Health at VIMCare in 2017.
- b) Develop regional resource guide.
- c) Increase access to Recovery Coaches.
- d) Continue Recovery Coach pilot in CRH ED & increase follow-up visit compliance rate.
- e) Determine opportunities for additional financial resources for treatment across the health system.
- f) Explore options for treatment options at the Bartholomew County jail.
- g) Conduct CMEs on mental health topics for primary care providers.

## **Priority 7: Nutrition, Physical Activity & Weight**

**Goal 1: *Increase access to and consumption of plant-based foods throughout the community.***

- a) Support efforts of Bartholomew County Hunger Coalition.
- b) Conduct Fruit & Vegetable spotlight and taste-testing days in schools & community locations.
- c) Support Purdue Extension Service Local Food Summit in 2017.
- d) Explore a local restaurant initiative promoting plant-based options.
- e) Support local school gardens initiative.
- f) Promote senior projects for Smart Snacks at Schools.
- g) See Diabetes, Heart Disease, and Stroke priority area efforts above.

**Goal 2: *Increase initiation and duration of breastfeeding.***

- a) Provide Nurse & Chat program
- b) Educate moms on safe milk storage.
- c) Provide Lactation Station at county fairs.
- d) Develop educational materials for distribution at primary care offices
- e) Support efforts to re-certify CRH's WHO Baby Friendly status.

**Goal 3: *Increase use of bicycling and walking for recreation and routine transportation.***

- a) See efforts above in Injury & Violence.
- b) Participate in Active Transportation Outreach team.
- c) Update and produce Walking and Biking maps.
- d) Conduct Walktober walking promotion activities.
- e) Support and promote Columbike bike share program.
- f) Support community Bike Month promotional efforts.
- g) Promote community Walking Groups.

## **Priority 8: Respiratory Diseases**

**Goal 1: *Decrease prevalence and deaths related to CLRD, COPD, and asthma.***

- a) Increase pulmonary provider access.
- b) Conduct screenings in 2017 and 2018.
- c) See Cancer & Tobacco Use goals and strategies.