

FirstHealth Richmond Memorial Hospital

Implementation Plan



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FirstHealth Richmond Memorial Hospital Implementation Plan For 2013 Community Health Needs Assessment

Summary of Community Health Needs Assessment Results

Richmond County has chronic disease prevalence and mortality rates higher than state averages for heart disease, diabetes, cancer and diseases of the lung. FirstHealth Richmond Memorial Hospital will collaborate internally within the health care system and externally with community partners to move forward with implementation plan efforts and community outreach. Through this multifaceted approach of reviewing the PRC assessment data, the First-In-Health 2020 data, health disparities data and the Richmond County Community Health Assessment data, FirstHealth Richmond Memorial Hospital has identified health focus areas for implementation plans. These focus areas include:

- *Care transitions*
 - FirstHealth Richmond Memorial Hospital will develop an action plan focusing on care transitions for chronically ill patients at high risk for a hospital readmission
- *Wellness and prevention efforts to address chronic diseases such as diabetes, obesity, cardiovascular disease, tobacco use (lung cancer) and prescription drug abuse/misuse*
 - Data demonstrate that Richmond County has higher rates than the state averages for diabetes prevalence, hypertension, diseases of the lung and obesity, and the community perceives these as health issues. Addressing these chronic disease conditions through preventive health programs and health education classes will have an impact on patient and community health outcomes.
 - Feedback from the community, medical providers and law enforcement indicate a need to address prescription drug abuse/misuse issues through policy and outreach efforts.
- *Access to care for uninsured*
 - There are high rates of uninsured in region. The hospital will develop an implementation plan with consideration for increasing access to primary care and developing partnerships to assist with linkages to services and preventive programs.

Care Transition

Care Transition Council

FirstHealth Richmond Memorial Hospital will implement a multidisciplinary Care Transition Council to monitor and evaluate the need for care transition services, readmission rates, quality markers and the effectiveness of new service delivery systems.

- Steering Committee will consist of representatives from Quality, Pharmacy, Hospitalist program, Nursing, Diabetes Self-Management, Home Health, Hospice, Palliative Care,

Discharge Planning, Corporate Education, Community Health Services, Nutrition Services, Cardiovascular and Thoracic Center and others as deemed necessary.

- Steering Committee will meet at least four times per year to discuss ongoing initiatives, review quality data indicators and determine next steps to improve care transitions.

Care Transition Nurses

FirstHealth Richmond Memorial Hospital recognizes the influence of working with chronically ill patients in a one-on-one environment for education and linkage to services. The hospital will develop a care transition nurse strategy to target patient's at high-risk for readmissions related to heart failure, diabetes and chronic obstructive pulmonary disorder.

- Care transition nurses will develop a mainstream system for care transition documentation.
- Care transition nurses will collect data on patient encounters and track patient outcomes.
- Care transition nurses will be responsible for linking patients to internal and external resources, such as medication assistance, wellness programs, and medical access plan.

Care Transition Clinic

FirstHealth Richmond Memorial Hospital will work in partnership with FirstHealth Moore Regional Hospital to refer patients who are at-risk for readmission to the initial Care Transition Clinic, which will be located in Pinehurst, NC. FirstHealth will create a chronic disease-specific, nurse practitioner-led primary care clinic (Transitional Care Clinic) to provide the individualized care that the chronically ill require upon hospital discharge. FirstHealth Richmond Memorial Hospital will:

- Identify patients who are at-risk for re-hospitalization within a 30-day period
- Develop a formal referral process to transition care clinic
- Work directly with patients to determine and resolve transportation barriers
- Reduce 30-day readmission rates by 10 percent
- FirstHealth projects that at least 50 Medicare, Medicaid and uninsured patients from Richmond will access transition care clinic services
- The hospital will study feasibility of establishing care transition clinic in Richmond County based on outcomes from initial clinic model

Wellness and Prevention Efforts

FirstHealth recognizes the value of health education and wellness programs. As such, FirstHealth Richmond Memorial Hospital will link patients with chronic disease conditions to community-driven, education and wellness programs.

- At least 150 inpatients will be referred to diabetes self-management and nutrition services per year; diabetes will develop telehealth technology to expand the reach of services
- 250 individuals and patients will participate in physical activity programs such as People Living Active Year Round and Exercise As Medicine per year

- 250 individuals and patients will learn basic nutrition skills through nutrition programs such as The Happy Kitchen per year
- FirstQuit (the tobacco cessation program) will provide 250 inpatient tobacco consultations with serve 75 individuals through the community-based quit-tobacco process per year
- The health system will adopt a policy change to increase health insurance premium rates for employees who utilize tobacco products per year
- The health system will continue to support local organizations with health fairs and programs through the speakers bureau
- The hospital will continue to offer Kids Day (an event that provides free/reduced-fee screenings for children) and Wellness Screening Day (an event that provides free/reduced-fee health screenings for adults. At least 300 children and 1,800 adults will be reached through these events.
- Mobile Health Services will provide preventive health screenings on a sliding fee scale to include cholesterol, blood pressure, glucose, prostate-specific antigen, osteoporosis and ultrasound screenings for carotid artery disease, peripheral vascular disease and aortic aneurysms with a target of 500 persons screened and referred for follow-up services
- The hospital will develop and implement an affordable low-dose CT scan program to detect lung cancer in current and former smokers
- The hospital will continue to work with the local provider community to adopt the use of the CSRS database for narcotics and implement narcotic contracts for pain management patients (*Note: the hospital implemented an Emergency Department Opiate policy in July 2013*).
- In addition, the hospital will partner with law enforcement and support local Operation Medicine Drop events and promote local Drop Boxes

Access to Care

The hospital recognizes the landscape for access to care will be significantly impacted by health care reform with individuals having increased access to the health care exchange programs; however, the hospital believes in linking low-income, disparate populations with appropriate safety net services:

- The hospital will maintain a strong partnership with Community Care of the Sandhills, the Health Department, the Department of Social Services and community agencies and partners to implement HealthNet (a safety net program for uninsured who live at or below 200 percent of the federal poverty level; services include linkage to primary and specialty care, medication assistance, and chronic disease case management services)
- Discharge planning will provide referrals to HealthNet
- The hospital will implement and support a comprehensive, web-based system, FirstNavistar, to assist patients with navigating health care resources and primary care services

Note: Reference the Community Health Needs Assessment Introduction for additional details on health focus areas identified as needs that other agencies and community partners are currently addressing through programs and interventions.