FirstHealth Moore Regional Hospital – Richmond

Implementation Plan

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For 2019 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, hypertension, diabetes, cancer, diseases of the lung and obesity. FirstHealth Moore Regional Hospital – Richmond Campus will collaborate internally within the health care system and externally with community partners to move forward with implementation plan efforts and community outreach. Through a multifaceted approach of reviewing the PRC assessment data (which was conducted in partnership with the Richmond County Health Department), the First-In-Health 2020 data and health disparities data, FirstHealth Moore Regional Hospital – Richmond Campus has identified health focus areas for implementation plans. These focus areas include:

- *Chronic disease prevention to include diseases such as diabetes, obesity, cardiovascular disease, diseases of the lung and addiction*
    - Although there were improvements in chronic disease outcome measures from 2016 – 2019, rates remain higher the state averages for diabetes prevalence, hypertension, diseases of the lung and obesity, and the community perceives these as health issues. Continuing to address these chronic disease conditions through preventive health programs, evidence-based interventions and health education classes will have an impact on population health outcomes at the patient and community level.
    - The hospital and the community recognize the devastating impact of the opioid epidemic. Organizations, individuals and agencies such as medical providers, health department, treatment facilities, social services, housing authority, and community members at large have joined the Sandhills Opioid Response Consortium. FirstHealth has leveraged several grants to work to increase awareness, increase access to treatment and recovery, increase access to narcan and implement harm reducation strategies to help those individuals struggling with opioid/substance use disorder.

- *Access to care for uninsured*
    - According to the PRC assessment, 22.2 percent of adults ages 18 – 64 are uninsured compared to the state at 18.8 percent. North Carolina did not expand Medicaid coverage. Therefore, there is a portion of the population that does not qualify for the federal marketplace and remain uninsured. 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.

- Given the rural environment and transportation barriers for uninsured and underserved, the hospital will develop a comprehensive telehealth/telemedicine strategy to expand primary and specialty care services to underserved areas in the region.

- *Quality of care (inpatient and outpatient)*
  - FirstHealth of the Carolinas has a strategic goal systemwide to achieve "Zero Harm" with all inpatient quality measures by 2024.
  - FirstHealth Moore Regional Hospital – Richmond Campus will focus on the transition to value based care by focusing on quality care initiatives aligned with value based reimbursement.
  - The hospital will continue to focus on hospital readmissions, enhancing transitions of care for chronically ill patients and recruiting providers to participate in the clinically aligned network (CAN), HealthNC+.
  - The hospital is also working to identify and address social determinants of health to improve population health outcomes with a focus on individuals with high hospital readmission rates and/or high utilization of the emergency department due to unmanaged chronic conditions.

Chronic Disease Prevention

FirstHealth recognizes the value of health education and wellness programs. As such, in the next three years FirstHealth Moore Regional Hospital – Richmond Campus will link patients with chronic disease conditions to community-driven, education and wellness programs:

- At least 150 patients will be referred to diabetes self-management and nutrition services per year; diabetes will develop telehealth technology to expand the reach of services
- In partnership with the health department, 500 individuals will participate in glucose screening events to detect unmanaged diabetes and prediabetes.
- Seventy-five individuals will complete the evidence-based Centers for Disease Control National Diabetes Prevention Program, Prevent T2 (curriculum is one year in length)
- Three hundred individuals/patients, with a priority of reaching individuals at 200 percent of less the federal poverty level, will participate in nutrition education and physical activity programs such as Healthier You and Exercise is Medicine
- In partnership with the Richmond First-In-Health 2020 Task Force, the hospital will continue to facilitate the Healthy People, Healthy Carolinas initiative with a focus on increasing access to healthy foods and increasing levels of physical activity. Partners will continue to implement The Daily Mile (impacting every elementary student in Richmond County Schools), healthy corner store initiative, healthy vending initiative and the "red tablecloth" initiative. The partnership will work to implement a healthy food pantry initiative, a

discharge pantry/food box initiative and walking classroom. The hospital in partnership with the school system will continue to support open use of The Daily Mile walking trails at all seven elementary schools.

- The hospital will partner with Discovery Place Museum to expand "The Daily Mile" concept into community settings, such as the downtown area of City of Rockingham.
- FirstQuit (the tobacco cessation program) will provide inpatient tobacco consultations with serve 50 individuals through the community-based quit-tobacco program per year
- FirstHealth Moore Regional Hospital – Richmond campus employees who utilize tobacco products will be assessed a surcharge for health insurance premium rates each pay period
- The hospital 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 150 children and 1,100 adults will be reached through these events annually
- The hospital will support referrals to the low-dose CT scan program to detect lung cancer in current and former smokers
- The hospital will actively engage in the Sandhills Opioid Response Consortium that is focused on increasing access to treatment via increasing DATA waivered providers to offer medication assisted treatment, implementing a countywide peer support program, increasing the level of awareness through stigma education for providers and community, increasing access to harm reduction, implementing a rapid overdose response team and providing case management for patients struggling with opioid use disorder
- The hospital will contribute to linking at least 50 individuals in the region to treatment/recovery resources, decrease overdose rates (13 in 2016/2017) and decrease emergency department visits for all medications and drug poisoning by 10 percent (baseline 167 in 2017)
- In addition, the hospital will partner with law enforcement and support local Operation Medicine Drop events and promote local Drop Boxes

Access to Care

Although the Affordable Care Act was implemented, according to the assessment data, 22.5 percent of Richmond residents remain uninsured, not to mention the population that remains underinsured. Richmond County continues to struggle with the coverage gap as evidenced by Moore Regional Hospital – Richmond Campus providing $5.4 million in charity care from fiscal year 2016 to fiscal year 2018. Individuals who enrolled in the marketplace are struggling with high deductible plans, making access to care a continued focus area. Furthermore, North Carolina did not expand Medicaid. As a result, individuals who live at or below 133 percent of

the Federal Poverty Level (FPL) do not qualify for the marketplace or Medicaid, which further marginalizes their options for access to care. The hospital is committed to linking low-income, disparate populations with appropriate safety net services in the next three year:

- Discharge planners and nurses in the hospital and the Emergency Department will provide active referrals to the Medication Assistance Program and resources for uninsured and underinsured
- The medication assistance program will request at least 600 medications for low-income and uninsured patients
- The hospital will maintain a strong partnership with Community Care of North Carolina, the Health Department, the Richmond Community Care Clinic (state funded rural health center), the Federally Qualified Health Center, sliding fee scale clinics, rural health clinics, the Department of Social Services and community agencies and partners to continue to ensure referrals to primary care, safety net programs and services for uninsured
- The hospital will continue to support a comprehensive, web-based system, FirstNavistar, to assist patients with navigating health care resources and primary care services
- The hospital will participate in a system-led comprehensive telemedicine plan and continue to support access to specialties such as behavioral health services, neurology and cardiology via telehealth technology
- The hospital will support Teledoc access to primary care and urgent care services initially for employees, with potential to expand to all residents in Richmond
- The hospital will continue to host marketplace navigators in partnership with Legal Aid of North Carolina to assist individuals with marketplace enrollment

Quality of Care

Zero Harm

FirstHealth has a goal of reaching Zero Harm by 2024. In the past, quality data was presented in aggregate versus by specific measure and each hospital site. With a focus on Zero Harm, quality data for all inpatient metrics is shared with leadership and employees with specific numbers per measure per hospital.

- FirstHealth Moore Regional Hospital – Richmond will share reports at each leadership meeting, will encourage accurate reporting and will implement quality improvement initiatives to achieve Zero Harm
- Employees and units will be recognized for areas that achieve Zero Harm on an annual basis

Value Based Care/Value Based Reimbursement

FirstHealth understands the shift in health care to value based reimbursement based on improving population health outcome measures. As such, in 2016, FirstHealth established a

CAN in partnership with local providers, HealthNet+. In order to continue to foster improved quality outcomes and shared savings, over the next three years Moore Regional Hospital – Richmond Campus will support:

- Support providers to join HealthNC+
- Actively monitor quality improvement measurements via electronic medical record reports with a focus on diabetes, hypertension, body mass index and follow-up plan and tobacco usage and counseling.
- Providers will engage a multidisciplinary care team approach and refer unmanaged patients to services such as health coaching for physical activity and nutrition counseling, and health education programs, such as Know It Control It for hypertension, Chronic Disease Self-Management (CDSMP) for individuals with unmanaged chronic conditions and FirstQuit for tobacco users
- Host quarterly meetings of Quality Subcommittee for HealthNC+ members to discuss success and challenges, and share in improving quality measures

Readmission Committee

FirstHealth Moore Regional Hospital – Richmond will continue to implement a multidisciplinary Readmission Prevention Committee led by the quality director to monitor and evaluate the need for care transition services, readmission rates, quality markers and the effectiveness of new service delivery systems.

- Council members will consist of representatives from Quality, Pharmacy, Hospitalist program, Nursing, Home Health, Hospice, Palliative Care, Discharge Planning, Community Health Services, Nutrition Services, Care Transition Nurse and others as deemed necessary.
- The Council will meet at least four times per year to discuss ongoing initiatives, review quality data indicators and determine next steps to improve care transitions and reduce readmissions.
- Care Transition Nurses will focus on patients at high-risk for 30-day readmissions to the hospital and emergency department
- Care Transition Nurses will collect and analyze data on patient encounters and track patient outcomes
- The nurse will link patients to internal and external resources, such as medication assistance, health education/wellness programs and primary care homes

Social Determinants of Health (SDOH)

FirstHealth Moore Regional Hospital – Richmond Campus fully understands that social barriers can often present challenges for individuals struggling to manage chronic conditions. These barriers may include issues such as housing, transportation, access to food, access to care and access to medications. As such, over the next three years, the hospital will engage in developing

a social determinants of health screening and a system of linking patients to services both internally and externally that will ultimately improve population health outcomes to include:

- Establishing the Center for Health and Social Care on the Richmond campus
- Implementing a SDOH screening tool to be utilized inpatient and outpatient that is integrated into the electronic medical record with an identification methodology for patients with needs
- Developing a referral process to the Center for Health and Social Care for patients that need follow-up regarding SDOH needs
- Tracking individual patient level data to intently track improved patient outcomes to support the return on investment for the Center
- Work with community partners such as social services, health department, homeless shelter, Salvation Army, to establish referral patterns to address food insecurity, housing and transportation needs
- Work to ultimately decrease inpatient and emergency room readmissions in a proactive manner through empowering the patient by resolving social barriers

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.