2016 Implementation Strategy

Akron Children's Hospital Mahoning Valley
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Akron Children's Hospital

The Implementation Strategy contains the activities that Akron Children's Hospital will conduct from 2017 – 2019 to address the prioritized health needs identified in the Community Health Needs Assessment (CHNA). The development of the Implementation Strategy, the rationale for why certain health needs were selected, and the process for on-going monitoring of the Implementation Strategy are discussed below.

Development of the Implementation Strategy

Earlier this year, Akron Children's Hospital Mahoning Valley hired the Kent State University College of Public Health (KSU-CPH) to conduct a CHNA to identify important health needs for children in our community. The CHNA research methodology involved following recommendations suggested by the Catholic Health Association of the United States in their *Assessing and Addressing Community Health Needs*, second edition. Specifically the process included comparing hospital service-area epidemiologic data to comparable county, state and national benchmarks, supplemented with qualitative data collected by interviewing community leaders, and engaging community members through focus groups. All of the information were compiled and prioritized in order to identify the most important health needs. More information about the CHNA can be found on the hospital's website.

To develop the Implementation Strategy, the health needs identified through the CHNA were evaluated against the hospital's current activities, the potential for community impact, and available resources. KSU-CPH facilitated this process with the Akron Children's Ad-Hoc Committee, which is a multi-disciplinary team of internal hospital staff. The hospital's Ad-Hoc Committee then recommended five health needs to the hospital's Community Benefit and CHNA Steering Committee, which is a diverse team representing external stakeholders, such as public health officials, businesses, hospital staff and community leaders. The Ad-Hoc Committee also identified staff to serve on specific Implementation Teams to develop goals, objectives, and strategies to address the high-priority health needs and to identify potential partners with whom the hospital can collaborate.

Although all of the community health needs identified by the CHNA and deliberated by our hospital teams are important, five health needs emerged as high-priority areas based on the hospital's current activities, the potential for community impact, and available resources. The five high-priority community health needs addressed in this Implementation Strategy include:

- Asthma
- Behavioral Health
- Diabetes
- Infant Mortality
- Injuries

Needs Not Addressed

Several other significant health needs identified in the KSU-CPH research will not be addressed in this Implementation Strategy. These include health areas that ranked lower during the prioritization process, health areas that were beyond the scope of the hospital, and health areas that require more resources than what are available. These include:

- Access to Healthcare
    - Access to dental care
    - Dental insurance coverage
    - Health insurance coverage
    - Mental health insurance coverage
    - Vision insurance coverage
- Child Lifestyle Factors
    - Food insecurity
    - Obesity
- Crime & Violence
    - Child trafficking
- Environmental Factors
    - Elevated blood lead levels

Akron Children's clinicians do not provide care services for pregnant women, other than those whose babies have been diagnosed before birth or prenatally with a condition or disease that must be monitored by our Maternal Fetal Medicine (MFM) Center or Genetics Center. Therefore, we will not be able to impact the service area's rate of infants born at low birth weights or very low birth weights (other than caring for them after birth), the rate of preterm births (other than those mothers and babies being followed by our MFM Center), or the rate of pregnant women, including teens, receiving prenatal care (other than those seen by MFM Center) or the rate of births to women who smoke. We do care for babies born at low and very low birth weights and preterm infants requiring hospitalization in the Neonatal Intensive Care Unit (NICU) on the Akron campus or NICUs that we operate at Cleveland Clinic – Akron General, Summa Health System, St. Elizabeth Hospital in Boardman, and the special care nurseries at our Mahoning Valley Campus in Boardman, St. Joseph Warren Hospital and Wooster Community Hospital.

Data Limitations and Gaps

Due to limited resources and time constraints, complete data were not available for every vulnerable population, such as the homeless or refugee populations. Where available, the most current data were used to determine the health needs of the community. Although the data available are rich with information, not surprisingly, data gaps and limitations existed that impacted the ability to conduct a more thorough and rigorous assessment. These include:

1. Pediatric data related to substance abuse (alcohol abuse and excessive drinking, prescription drug abuse and opioid drug abuse) were not readily available for all counties in our primary service area. For Summit County, data from the Ohio Department of Health Youth Risk Surveillance Survey in 2013 was available due to oversampling of the population. For other counties, some data were available through the Ohio Department of Health Youth Risk Surveillance Survey; however, this data is limited and under sampled, not adequately representing the communities or specific populations.
2. Behavioral Health data was provided through the Ohio Hospital Association (OHA). The limitation of this data is that it is only data from reporting OHA hospitals. Therefore, Belmont Pines Hospital, one of the largest behavioral health agencies in the state, does not report data to OHA. Therefore, Belmont Pines' data are not included and the mental health data are skewed especially for Columbiana, Mahoning and Trumbull counties since the Belmont Pines Hospital is located in Youngstown and many local children are referred there.
3. Due to time constraints and limited resources, we were unable to access pediatric Medicaid data that would have allowed us to more specifically target this vulnerable population.
4. County and State-wide chronic disease data are not available for children.

Monitoring the Implementation Strategy

The Implementation Teams will meet no less than quarterly to review and monitor the progress of the plans in this Implementation Strategy. Each team will provide quarterly reports to the Community Benefit and Community Health Needs Assessment Steering Committee.

Adoption and Approval

Akron Children's Hospital's Board of Directors approved this Implementation Strategy on March 30, 2017.

Revisions to the Implementation Strategy

This Implementation Strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this Implementation Strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2019, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

Asthma

Global Aim

In the next 3 years, we aim to reduce further the burden of asthma for our patients, their families, and our community. We propose to do this by implementing and practicing guideline based care in the primary care, hospital, and school settings and by working collaboratively with our community partners engaged in work which can advance this goal.

Specific Aim 1

Between 1/1/17 and 12/31/19, we will reduce hospitalizations for the asthma registry population at Akron Children's Hospital from 2.3% to 1.8% and reduce ER visits for asthma from 5.8% to 4.5%.

Specific Aim 2

Between 1/1/17 and 12/31/19 we will improve the individual and bundled components of Optimal Care for the registry population as follows: ATP from 63% to 90%, ACT from 36% to 90%, flu vaccine from 35% to 60%, and the bundled measure from 14% to 50%.

Specific Aim 3

Between 1/1/17 and 12/31/19 we will meet or exceed all HEDIS measures related to asthma embedded in value based contracts for the system.

Objective #1	Strategy
Continue to improve asthma identification and risk stratification	• Improve screening of eligible patients through EZB from <20% to 50% • Regionalize EZB for non ACHP practices, especially hot spots where disease prevalence and severity are high • Implement robust risk stratification and reporting in the asthma registry. Consider co-morbidities and social determinants of health • Enhance the focus on and services for High-Risk patients • Leverage school health strategies for identification of unidentified and poorly controlled asthmatics

Objective #2	Strategy
Practice guideline–based care throughout the system	• Continue to encourage broad reliance on EZB principles and tools • Continue to request and foster EMR enhancements (Best Practice Alerts, Smartsets, Order sets, etc.) • Continue to use, expand and refine the Asthma Pathways in the ER and In-patient settings • Consider expanding the use of spirometry in the primary care setting • Continue following and reporting Optimal Care statistics • Standardize discharge and follow-up plans from the hospital and ED for asthma patients • Ensure access to asthma medications • Ensure asthma education at discharge and repeatedly through all appropriate contacts with the health system • Enhance reporting, dashboards, and data/outcomes transparency
Objective #3	**Strategy**
Mobilize an Asthma Care Management Team	• Build and implement an Asthma Care Management Team • Identify appropriate patients for Care Coordination • Link high-risk patients to resources across the continuum • Use quality metrics and continuous improvement to refine the activities of the team to focus on the most effective interventions. • Implement social determinants of health screening and amelioration
Objective #4	**Strategy**
Expand Home Health Services and leverage community partnerships to improve the living environment for children with asthma	• Order referrals for home inspection for all with severe or high risk asthma through Akron Children's Hospital Home Care Group or other community based affiliates • Offer smoking cessation education and resources for patients and families • Identify and reduce asthma triggers (EZB, ATP) • Utilize local health department and housing authority services to ameliorate substandard housing • Use Medical Legal Partnership as appropriate for landlord-tenant issues

Objective #5	Strategy
Improve asthma care in the school setting	• Implement asthma screening for unidentified asthma in a pilot school • Initiate and expand as possible EZB for schools • Leverage the EMR and improve communication with care providers to improve care • Implement a process to assure ATP and medications are available for all children who need them in school • Offer asthma education for children, parents and educators • Raise air quality in schools as an issue of concern
Objective #6	**Strategy**
Increase Patient and Family Empowerment	• Standardize Asthma education across the continuum • Improve the use of technology like MyChart and asthma care apps to improve asthma care adherence • Utilize Payor Care Coordination Services and Navigators • Improve Medication management and compliance through education, care coordination, home health, and technology • Encourage use of motivational interviewing to enhance adherence and outcomes • Continue to optimize the ATP for ease of use and user acceptability

Behavioral Health Access

Global Aim
To expand a collaborative model of behavioral health services in our community

Specific Aim
To collaborate with local mental health agencies and our CHMCA Division resources to integrate behavioral health services in ACHP pediatric offices

Objective #1	Strategy
Increase access to behavioral health services to all ACHP locations within the region from current baseline	• In collaboration with the specific ACHP site, identify the needs of the site for behavioral health services • Develop an ACHP site specific strategy for the provision on-site behavioral health services, utilizing local mental health resources whenever possible • Implement the strategy in each ACHP site in collaboration with the Operations Managers and regulatory bodies • Report number of increased services throughout 2017-2019
Objective #2	**Strategy**
Increase number of patient visits throughout the ACHP locations	• Establish current baseline for 2016 patient visits • Measure increased number in 2017-2019 • Modify existing and future contract language with all community mental health agencies to reflect need to report metrics

Diabetes

Global Aim

To reduce the disease burden of type 1 diabetes on families by helping them progress from diagnosis to adulthood and empowering them to integrate diabetes into their lifestyle

- Programs and interventions will focus on children from birth to 21 years of age;
- Pilot programs will utilize a Lean Six Sigma process to determine greatest impact and value of specific interventions on specific populations

Objective #1	Strategy
Improve education provided to newly diagnosed families at diagnosis	• Develop effective education tools • Educate inpatient nursing on diabetes survival skills • Assess patient education needs • Standardize education between inpatient and outpatient • Measure success of education
Objective #2	**Strategy**
Improve the quality of life for patients with type 1 diabetes	• Working with School Health Services to keep kids in school • Educate families on sick day management to prevent re-admissions for diabetes • Empower families to participate in normal childhood activities and provide them skills to manage diabetes • Utilize technology and community resources to engage adolescents to achieve better compliance in diabetes self-management
Objective #3	**Strategy**
Empower patients with type 1 diabetes to transition successfully to adulthood	• Create a transition plan that can be tailored to meet individual patient needs • Collaborate with adult providers to establish continuity of care for transitioning patients • Implement an educational program for adolescents to prepare them for independence

Infant Mortality – Mahoning Valley

Global Aim

Reduce infant mortality in Mahoning Valley by working collaboratively with our community partners including MY Baby's 1st Mahoning Youngstown Infant Mortality Coalition

Specific Aim

1. Reduce overall infant mortality rates for Mahoning County from 10.9/1000 in 2015 towards the Healthy People 2020 goal of 4.8/1000 of live births
2. Reduce prematurity birth rate for Mahoning County ≤ 37 weeks from 9.4% in 2015 towards the Healthy People 2020 goal of 8.1% live births

Objective #1	Strategy
Between 1/1/2017 and 12/31/2019 reduce sleep related deaths in Mahoning Valley	• Continue education of health care professionals on safe sleep • Raise community and health care professional awareness through a Safe Sleep Summit Educational program in 3rd quarter 2017 • Collaborate with Safe Kids Mahoning Valley on a pilot program for first responder referral cards and educate first responders on safe sleep guidelines and the referral process to obtain a safe sleep environment • Raise awareness through media messages in periodicals and newspapers, videos on local media and public service announcements • Continue to secure grant funding to provide community education and safe sleep kits for newborns in Mahoning Valley community birth hospitals (5)
Objective #2	**Strategy**
Reduce prematurity birth rate ≤ 37 weeks from 9.4% in 2015 towards 2020 goal of 8.1% live births	• Continue education of Mahoning Valley healthcare professionals on preventing premature birth recurrence through 17 Progesterone education • Continue to educate at least 90% of ACH Mahoning Valley NICU parents on eligibility for 17 Progesterone with next pregnancy • Educate the Mahoning Valley community birth hospitals (5) on 17 Progesterone message for preterm infant parents that deliver in their community birth hospital • Track ACH Mahoning Valley NICU patients eligible for 17 Progesterone who received 17 Progesterone and increase from 54% in 2014 to 64% by 2019 • Collaborate with Mercy Health St. Elizabeth Boardman Hospital and track outcomes of pregnancies eligible for 17 Progesterone

Objective #3	Strategy
Improve Birth Spacing to ≥ 18 months for > 50% of deliveries at Mercy Health St. Elizabeth Boardman Hospital and the Mahoning Valley NICU by year 3	• Continue to educate healthcare professionals on birth spacing and LARC (long acting reversible contraception) • Continue to counsel >90% of ACH Mahoning Valley NICU mothers on birth spacing and LARC • Sponsor a LARC and Birth Spacing webinar for Mahoning Valley healthcare professionals in 1st quarter 2017 • Develop a community hospital message on birth spacing and share with the Mahoning Valley birth hospitals (5) • Track birth spacing for ACH Mahoning Valley NICU patients and Mercy Health St. Elizabeth Boardman Hospital deliveries
Objective #4	**Strategy**
Implement tobacco cessation strategies education for healthcare professionals to reduce prematurity and low birth weight	• Develop a program on smoking cessation strategies and resources available for healthcare professionals to utilize and track in high risk patient settings: o ACH Mahoning Valley NICU o St. Elizabeth Youngstown Hospital Pediatric Clinic o One OB provider in year 2 o Akron Children's Hospital Mahoning Valley Pediatric inpatient unit o Mahoning County Pathways HUB • Measure the prevalence of ACH Mahoning Valley NICU admissions whose mothers admit to historical tobacco use during pregnancy in 2016 and reduce by 10% by 2019 • Develop discharge teaching script for parents in Mahoning Valley community birth hospitals (5) prior to discharge from Well Nursery and ACH Mahoning Valley NICU and offer smoking cessation education and resources available • Partner with the Regional Tobacco Center (RTC) at Mercy Health and measure the number of referrals to RTC from MV zip codes • In collaboration with Mahoning County District Board of Health and MY Baby's 1st, provide outreach to high risk zip codes o 44502 o 44505 o 44506 o 44507 o 44509 o 44512 o 44406

Injuries

Global Aim
Reduce preventable injuries for children and their families.

Specific Aim
Empower our community with knowledge and resources to prevent injuries.

Objective #1	Strategy
Consolidate injury data sources to a common data management program	• Identify and assess current injury data sources • Determine program capable of integrating multiple injury data sources into a user-friendly format • Provide training and support for program
Objective #2	**Strategy**
Define the epidemiology of pediatric injury through data and research	• Prioritize and align pediatric injuries with strategic initiatives within the hospital • Coordinate collaborative injury-related research projects • Develop community-based programs to address top causes of injury
Objective #3	**Strategy**
Increase education and awareness of pediatric injuries in our community	• Partner with Akron Children's Hospital Pediatrics to provide tools and resources about high risk injuries in their communities • Expand CARE Center support to local advocacy centers • Conduct injury prevention programs in high risk communities