

Implementation Strategy

Years 2014 - 2016



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The Implementation Strategy contains the activities that Akron Children's Hospital will conduct from 2014 – 2016 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, Akron General Health System, and Summa Health System collaborated on the development of a CHNA to identify important health needs for children and adults in our community. The Kent State University College of Public Health (KSU-CPH) was hired to help facilitate this process. The CHNA involved reviewing epidemiologic data, interviewing community leaders, and engaging community members. 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 web site.

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 using a SWOT analysis approach. KSU-CPH facilitated this process with the Akron Children's Community Benefit Steering Committee, which is a diverse team representing external stakeholders, such as public health officials, businesses, hospital staff and community leaders. The hospital's Community Benefit Steering Committee then recommended five indicators to the hospital's System Implementation Team, which is a multi-disciplinary team of internal hospital staff. KSU-CPH facilitated another prioritization process with this team, which identified three high-priority health needs for the entire Akron Children's Hospital system. The System Implementation Team also identified staff to serve on three 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.

The three high-priority community health needs addressed in this Implementation Strategy include:

- Asthma
- Diabetes
- Mental Health

Needs Not Addressed

Although all of the community health needs identified by the CHNA and deliberated by our hospital teams are important, three emerged as high-priority areas based on the hospital's current activities, the potential for community impact, and available resources. Consequently, several areas 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:

- Abuse & Neglect
- Access to Health Care
 - Health Insurance Coverage
 - Access to Dental Care
 - Mental Health Insurance Coverage
- Birth Risk Factors
 - Maternal Tobacco Smoking
 - First Trimester Prenatal Care
- Child Development
 - Underweight
- Child Lifestyle Factors
 - Overweight & Obesity
 - Exercise
 - Nutrition
- Environmental Factors
 - Access to Healthy Foods
- Substance Abuse
 - Alcohol Abuse & Excessive Drinking
 - Prescription Drug Abuse
 - Opioid Drug Abuse

Additionally, 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 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 NICU on the Akron campus or NICUs that we operate at Akron General Health System, Summa Health System, and St. Elizabeth Hospital in Youngstown, and the special care nursery at our Mahoning Valley Campus in Boardman.

Data Limitations and Gaps

Due to limited resources and time constraints, 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) are not readily available. Some data are 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. County-wide data that characterize health risk and lifestyle behaviors like nutrition, exercise, and sedentary behaviors are not available for children.
3. 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.
4. 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.
5. County and State-wide chronic disease data are not available for children.
6. Injury data was fragmented and not readily available.

Monitoring the Implementation Strategy

The three 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 System Implementation Team and Community Benefit committee, as well as, an annual report to the hospital board of directors.

Adoption and Approval

Akron Children's Hospital's Board of Directors approved this Implementation Strategy on October 24, 2013.

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, 2016, 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.

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Asthma

Global Aim

In the next 3 years, we aim to substantially reduce the burden of asthma for our patients, their families, and our community.

Specific Aim

Between 1/1/14 and 12/31/16, we will reduce hospitalizations for asthma at Akron Children's Hospital by 10% per year (30% total) and reduce ER visits for asthma by 5% per year (15% total) by implementing guideline based care in the primary care setting, hospital setting, and school setting.

Objective #1	Strategy
Improve asthma identification and care in the primary care setting.	<ul style="list-style-type: none"> • Launch Easy Breathing program in all Akron Children's Hospital Pediatric (ACHP) practices • Enroll >90% of eligible patients • Broadly implement guideline-based severity and control assessment • Implement guideline based therapy to enhance identification of children at risk and those who are poorly controlled • Regional EZB for non ACHP practices, especially hot spots where disease prevalence and severity are high • EZB fully functional within EPIC • All regional asthma patients identified • Asthma dashboard with transparency • Registry to inform Point of Care(POC) • Trigger identification (EZB) • Home inspection for all with severe or high risk asthma • Improve air quality in school • Smoking cessation
Objective #2	Strategy
Improve information systems to allow for registry-informed care.	<ul style="list-style-type: none"> • All regional asthma patients identified • Asthma dashboard with transparency • Registry to inform POC
Objective #3	Strategy
Standardize care in hospital and ambulatory settings	<ul style="list-style-type: none"> • All regional asthma patients identified • Asthma dashboard with transparency • Registry to inform POC • Asthma Pathway fully implemented in the ambulatory practices, in the ED and within the inpatient setting • Follow-up visits scheduled prior to hospital discharge • Guideline based therapy for persistent asthma • Respiratory floor to enhance standardized care • Asthma plan compliance • Trigger identification (EZB) • Home inspection for all with severe or high risk asthma • Smoking cessation

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Objective #4	Strategy
Reduce exposure to acetaminophen (Emphasis to be informed by anticipated studies).	<ul style="list-style-type: none">• Epic Preference list edits• Health Care Provider education• Public Health Campaign• Mobilize social networking and technology
Objective #5	Strategy
Reduce Environmental Triggers	<ul style="list-style-type: none">• Trigger identification (EZB)• Home inspection for all with severe or high risk asthma• Improve air quality in school• Smoking cessation
Objective #6	Strategy
Improve asthma care in the school setting	<ul style="list-style-type: none">• Asthma screening for unidentified asthma• Meds available for all who need them in school• Education for Educators
Objective #7	Strategy
Increase Patient and Family Empowerment	<ul style="list-style-type: none">• Asthma education• Improved use of communication technology• Motivational Interviewing• Leverage Payor Care Coordination and Navigators• Asthma Hotline/Support Groups

Diabetes

Global Aim

To reduce the disease burden and economic impact of Type 2 Diabetes Mellitus (T2DM) on children and families in our community by the prevention, the early detection, and the reversal of T2DM.

- Programs and interventions will focus on children from birth to 21 years of age;
- Pilot programs will adopt a rapid change cycle/PDSA approach to determine greatest impact and value of specific interventions on specific populations;
- The initial scope of this project will include a four-county region (Summit, Portage, Stark and Mahoning Counties) but program and funding opportunities will be pursued to support further spread.

Objective #1	Strategy
<p>Improve early detection of children, adolescents, and young adults at risk for T2DM</p>	<ul style="list-style-type: none"> • Develop and provide education to primary care physicians to improve their ability to monitor, detect, and treat children and adolescents at risk for T2DM <ul style="list-style-type: none"> ◦ Increase the proportion of children screened for diabetes/pre-diabetes during a primary care visit • Develop new or disseminate existing “tool kits” to support primary care providers who care for children and adolescents at-risk for T2DM • Develop and provide educational programming targeting school districts, social service agencies and other community-based stakeholders in a position to improve the health and, when necessary, screening and early referral of children and adolescents at-risk for T2DM. • Develop and maintain a community resource guide with information on health/nutrition/fitness programming available for individuals and families. • Make recommendations regarding EPIC/EHR enhancements that will support early detection and intervention for at-risk children and adolescents • Promote student wellness in the school setting with a focus on improved lifestyle choices and minimizing risk factors for T2DM
Objective #2	Strategy
<p>Improve access to high quality, evidence-based primary health care for children, adolescents or young adults at risk for pre-diabetes/diabetes</p>	<ul style="list-style-type: none"> • Increase the proportion of children and adolescents with risk factors for pre-diabetes who receive evaluation, monitoring, treatment and follow-up according to published guidelines • Increase awareness of community-based and subspecialty providers of resources available to support outpatient diabetes education and other services • Provide age-specific education and programming to area schools/school districts with a high prevalence of children with/at risk for T2DM • Enhance medical school, nursing and residency curricula emphasizing the new morbidity of T2DM, including the importance of early detection and appropriate prevention/treatment strategies in children and adolescents at

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	<p>risk</p> <ul style="list-style-type: none"> • Coordinate and expand healthy weight/weight management programming in communities and schools • Identify and engage with regional partner agencies (ABIA; Universities; NEOMED; others) to support these initiatives • Increase prevention behaviors and lifestyle modification in persons at risk for diabetes/pre-diabetes: <ul style="list-style-type: none"> ○ Increase the proportion of persons at risk for diabetes/pre-diabetes who report increasing their levels of physical activity to at least 60 minutes each day ○ Increase the proportion of persons at risk for diabetes/pre-diabetes who report efforts to decrease non-academic “screen time” to less than 2 hours each day ○ Increase the proportion of persons at risk for diabetes/pre-diabetes increasing their fruit/vegetable intake to 5 servings each day ○ Increase the proportion of persons at risk for diabetes/pre-diabetes who report eliminating sugar-sweetened beverages
Objective #3	Strategy
<p>Improve health indicators and comorbidities in patients with Type 2 Diabetes Mellitus with the ultimate goal of disease reversal</p>	<ul style="list-style-type: none"> • Improve glycemic control in patients with T2DM <ul style="list-style-type: none"> ○ Increase the proportion of children with T2DM who undergo HbA1C measurement at least twice annually ○ Increase the proportion of patients with T2DM with an HbA1C value of less than 7 percent and decrease the proportion with an HbA1C of greater than 9 percent ○ Increase the proportion of patients with T2DM who undergo blood glucose monitoring according to evidence-based guidelines • Improve lipid control among children with T2DM <ul style="list-style-type: none"> ○ Increase the proportion of patients with T2DM with an LDL cholesterol value of <100 mg/dl • Improve the dental health of children with T2DM <ul style="list-style-type: none"> ○ Increase the proportion of children with T2DM who have an annual dental evaluation • Improve the vision health of children with T2DM <ul style="list-style-type: none"> ○ Increase the proportion of children with T2DM who have an annual vision examination • Increase the proportion of children with T2DM who receive formal diabetes education • Improve lifestyle habits of children with T2DM <ul style="list-style-type: none"> ○ Increase the proportion of children with T2DM who have decreased their BMI (body mass index) • Decrease the number of patients being diagnosed with T2DM

Behavioral Health Access and Integration

Global Aim

To improve access and quality of evidence based behavioral health services for children and adolescents in our community in order to prevent the need for more costly and disruptive inpatient hospitalization.

Specific Aim

To provide evidence based services at the outpatient level which are easy to access, closer to the patient’s home community whenever possible, and integrated into a holistic approach to care.

Objective #1	Strategy
Improve access and quality of care by providing an integrated outpatient service delivery model which incorporates evidence based psychotherapy and medication management treatment in a team based approach	<ul style="list-style-type: none"> • Develop and implement a Center for Anxiety and Mood Management to provide evidence based services to children and adolescents who are diagnosed with mood disorder. • Partner with child psychiatry to provide integrated therapy/medication management for a subset of patients served by the Anxiety and Mood Management Center
Objective #2	Strategy
Partner with regional community mental health agencies to expand access through the use of telepsychiatry services	<ul style="list-style-type: none"> • Develop a strategy for the delivery of mental health services to mental health agencies in the region, utilizing telemedicine capabilities. • Establish collaboration models with mental health agencies. • Assess the need for child mental health services by ACH regional counties.
Objective #3	Strategy
Expand child psychiatry services to the Akron Children’s Hospital Mahoning Valley campus	<ul style="list-style-type: none"> • Increase the number of patient visits • Hire a full-time mental health therapist to provide therapy services to patients seen by the CNS providers • Recruit child psychiatrist

References

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