Southern Mono Healthcare District
Report to the Board of Directors
Director of Quality Report
June 15, 2017

MAMMOTH HOSPITAL
Elevate Your Health

2015 Press Ganey Pinnacle of Excellence Award Winner

DATE: **June 15, 2017**

TO: **Board of Directors**
Southern Mono Healthcare District

FROM: **Mike Rudolf, Director of Quality**

RE: **Community Health Needs Assessment Report, Regular Meeting of the Board of Directors**

Executive Summary

New Business

1. **Mammoth Hospital Community Health Needs Assessment (CHNA) Annual Report**
    1. **Access To Care**
    2. **Substance Abuse**
    3. **Behavioral Health**
    4. **Chronic Disease**

MAMMOTH HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) ANNUAL REPORT

BACKGROUND: In preparing for the CHNA, individuals who represented the interests of the community and/or had specific expertise regarding the health needs of vulnerable and underserved populations were asked to join the CHNA Steering Committee to identify priority community health needs. Five criteria were used for prioritization: 'Magnitude/scale of the problem'; 'Severity of the problem'; 'Health disparities'; 'Community assets'; 'Ability to leverage' to arrive at four significant health needs to be addressed: 1. Access To Care; 2. Substance Abuse (Drug, ETOH, Tobacco); 3. Behavioral Health; 4. Chronic Disease (Obesity).

In compiling this annual report, our approach centered on the following:

- **A focus on mission, vision and values** as the foundation for integrating key performance and operational requirements within a results-oriented framework that creates a basis for action, feedback, and ongoing success.
    - **Our Mission**: To promote the well-being and improve the health of our residents and guests.
    - **Our Vision**: Meticulous Care - Memorable People - Majestic Location
    - **Our Values**:
        - Excellence - We will provide an experience that surpasses all expectations.
        - Leadership - We believe that effective leadership begins with a commitment to serve others.
        - Empathy - We will look through the lens of others without judgement.
        - Value - We will provide worth that pleases and surprises.
        - Accountability - We will honor and fulfill our agreements and promises.
        - Trust - We will cherish and respect the privilege and responsibility of our calling to serve others.
        - Encouragement - We will inspire courage and confidence to overcome adversity and enable healing.

- **A focus on processes** to assess and improve our processes along four dimensions:
    1. *Approach:* designing and selecting effective processes, methods, and measures.
    2. *Deployment:* implementing our approach consistently across our health care organization.
    3. *Learning:* assessing our progress and capturing new knowledge, including looking for opportunities for improvement and innovation.
    4. *Integration*: aligning our approach with our health care organization's needs; ensuring that our measures, information, and improvement systems complement each other across processes and work units; and harmonizing processes and operations across our health care organization to achieve key organization-wide goals.

- **A focus on results** leading us to examine our results from three viewpoints: the external view (*How do our patients, our community, and other stakeholders view us?*), the internal view (*How efficient and effective are our operations?*), and the future view (*Is our organization learning and growing?*).
    - *Future View*: While the CHNA steering committee will continue to have oversight, we will be merging our four CHNA implementation teams into already established hospital committees to better meet our goals. These committees include Population Health, Chronic Disease Management, Patient and Family Advisory Council, and Patient Experience and will act to operationalize the goals moving forward.

ACCESS TO CARE GOAL

Increase access to our healthcare services. This goal employs five strategies that involve enhanced collaboration among Mono County agencies, providing community education regarding our health care services and availability of financial assistance and the evaluation of additional services and their potential impact on access. Five strategies:

1. Facilitate collaboration among agencies within Mono County.
2. Mammoth Hospital will work with community service organizations to develop a collaborative framework designed to improve access to services through education.
3. Mammoth Hospital will provide community education regarding the availability of financial counseling / assistance.
4. Develop a media campaign describing the health care services available within the service area.
5. Evaluate the effectiveness of the addition of providers in urology, pediatrics, and family practice in 2016 and their effect on access.

PATIENT-FOCUSED PROCESS RESULTS

- Seeking to align our strategic plan with this CHNA, we have aggressively pursued offering Tele-Psychiatry for both our outpatient and emergency services. As of January, we now have an outpatient agreement with UC San Diego through our Clinic as well as an agreement with UC Davis for Tele-Medicine services to our Pediatricians in the areas of Endocrinology and Gastroenterology.

- Also, formal conversations continue with Keck Medicine USC for the provision of part-time clinic services backed up by Tele-Medicine for Pain Management and Neurology. Finally, formal conversations continue with California Emergency Physicians (CEP) to provide emergency tele-psych consults to our Emergency Department which will be paid for by Mono County Behavioral Health.

- In February, the Medical Executive Committee (MEC) met with Senior Managers to begin our five-year Scope of Services Plan. There was strong consensus from MEC to expand our visiting specialist model to include additional specialties such as Neurology, Endocrinology, Infectious Disease, Ophthalmology, Psychiatry, Pain Management, Adult Dental, and others such as the Tele-Medicine services cited above.

- The hospital leadership and staff continue to immerse themselves into Mono County community as evidenced by our relationship with our local schools. As California high schools will soon require a hands-on CPR course for graduation, our Education Coordinator proactively trained 230 students in CPR and AED awareness. This included our growing Athletic Training Program with five trainers supporting the high school student-athletes to aid in preventing injuries as well as treating them. This spring saw a collaboration with our resurging track and field program that saw over twice the team size of any past years, and in partnership with the USATF-certified head coach pilot a 'Food for Sport' program. This included on-the-track education by our Masters-prepared Dietitian and a free nutrition 1:1 consult for all team members.

- Hospital leadership sought the perspective of the Patient and Family Advisory Council (PFAC) in regards to providing community education about our health care services. Following the Council's recommendations, media coverage of services has been expanded with articles written by our CMO and other specialists for the local newspapers and posted on social medial with a link to our hospital website. The PFAC also recommended the creation of a library of professional brochures, describing our services available. Five brochures under development describe Financial Counseling, Behavioral Health Services, Diabetes, Surgical Services, and Cancer Care Services. These brochures are scheduled for publication in 3Q CY–2017 with more created over the next year. They will all be available on-line and promoted via

Facebook with links. Patient and Family-centered Resource Centers are planned for our lobby/waiting areas to provide patients with comprehensive information regarding our services.

SUBSTANCE ABUSE GOALS

1. Provide education and raise awareness of the prevention and treatment of substance abuse (Drug, ETOH, Tobacco) and see an increased number of individuals seeking treatment.
    a. Provide education to the providers and clinical staff.
    b. Provide community education through collaboration.
2. Develop a Pain Management Program to serve the community's chronic pain population and see the number of community members obtaining opioid prescriptions for chronic pain decline.
    a. Develop a Chronic Non-malignant Pain Management Program based on the ICSI Health Care Guidelines: Assessment and Management of Chronic Pain (Project Designated under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program).
    b. Expand the Care Coordination Program.

PATIENT-FOCUSED PROCESS RESULTS

- Family medicine is now distributing the AUDIT and DAST-10 substance abuse screening tools to Medi-Cal patients. Over 170 patients have received screening tools since January 2017.

- Sixteen providers were trained on the PHQ-9 depression tool and the AUDIT/SBIRT (alcohol / drug use) tool at provider trainings during November 2016.

- Thirty-three providers were trained on Southern Mono Healthcare District's (SMHD) Safe Opioid Prescribing Policy in September 2016.

- Twenty-one providers were trained on the Mammoth Hospital Pain Agreement for opioid prescribing in October 2016.

- The first Chronic Pain Multi-disciplinary Committee meeting was held in March 2017. The committee is chaired by our CMO and includes representatives from Physical Therapy, Occupational Therapy, Behavioral Health, Care Coordination, Dietary Services, and Family Medicine. The committee's goal is to review patients on high doses of opioid medication and develop multi-modal treatment plan with an aim toward reducing the dependence on opioids. The committee's second meeting was held in May 2017.

- A Chronic Pain Patient Registry for Medi-Cal patients has been developed and is updated monthly. Patients on the registry with complex health issues are referred to Care Coordination for follow-up. Those on high dosages of opioids are referred to the multi-disciplinary committee for review.

- Our Care Coordination Team was created after Case Managers noticed that several different team members were involved in coordinating a patient's care after discharge. With several different team members involved in coordinating a patient's care after discharge, realistic potential for duplication of work / rework and patients not being followed up. The first Care Coordination Interdisciplinary meeting was held November 23, 2016. Bi-weekly meeting attendees include: CMO (later becomes Physician Advisor), Case Managers, Patient Care Navigator, Chronic Care Manager, Registered Dietician, Spiritual Care / Patient Experience Manager. Discussing care coordination patient referrals in a multidisciplinary environment has been of great value and benefit to the patients and staff. The team looks at each high-risk patient as an individual, always considering how medical advice, nursing education, nutritional

advice, spiritual and emotional support can positively impact their health and wellness. Meetings allow the opportunity to reduce the risk of hospital readmissions by establishing a relationship between patient and both chronic care manager and patient navigator. Ensures local Patient Care Provider (PCP) and that both local and out-of-town follow-up appointments are made and attended. To further

assist in serving our patients through the entire continuum of care, beginning in 2017, a recently retired Case Manager has been calling patients post-discharge. This ensures they understood their discharge instructions (e.g., how to take medications, any special instructions) and to ensure follow-up appointments are made. If needed, patients are referred to the Care Coordination Team or appropriate provider.

- Successfully recruited a Marriage and Family Therapist (MFT) Intern for Mammoth Hospital to expand in-house service capacity.

BEHAVIORAL HEALTH GOALS

1. Increase the awareness of behavioral health resources through education and see an increase number of community members accessing services.
    a. Collaborate with Mono County Behavioral Health to provide community education.
    b. Develop an educational handout for patients and families to be given to patients in the Emergency Department and in the Medical-Surgical Unit.
2. Develop additional behavioral health resources to serve the community and see an increase in the number of individuals accessing services.
    a. Integration of Behavioral Health and Primary Care using the University of Washington Collaborative Care Model (PRIME project).
    b. Investigate the possibility of Tele-psychiatry with an academic medical center.
    c. Investigate the possibility of recruiting a full-time Psychiatrist for the Eastern Sierra.
    d. Recruit a Marriage and Family Counselor for Mammoth Hospital.

PATIENT-FOCUSED PROCESS RESULTS

- Family medicine is now distributing the AUDIT and DAST-10 substance abuse screening tools to Medi-Cal patients. Over 170 patients have received screening tools since January 2017.

- Sixteen providers were trained on the PHQ-9 depression tool and the AUDIT/SBIRT (alcohol / drug use) tool at provider trainings during November 2016.

- PHQ-9s are being administered at Family Medicine for Medicare and Medi-Cal patients. Family Medicine is practicing the “warm hand-off” in which patients with high scores are immediately connected to either behavioral health or care coordination. 472 PHQ-9s have been completed since January (Medicare and Medi-Cal).

- Successfully recruited a Marriage and Family Therapist (MFT) Intern for Mammoth Hospital to expand in-house service capacity.

- Seeking to align our strategic plan with this CHNA, we have aggressively pursued offering Tele-psychiatry for both our outpatient and emergency services. As of January, we now have an outpatient agreement with UC San Diego through our Clinic. Also, formal conversations continue with California Emergency

Physicians (CEP) to provide emergency tele-psych consults to our Emergency Department which will be paid for by Mono County Behavioral Health.

- Our hospital continues to use established social media, hospital web-site as well as traditional radio and newspapers to connect (and keep connected) with our community at-large. Examples range from our raising awareness via all of these various media arenas during Mental Health Month to posting on Facebook about our 'Good Grief Support Group' bi-monthly meetings.

- Hospital leadership sought the perspective of the Patient and Family Advisory Council (PFAC) in regards to providing community education about our health care services. Following the Council's recommendations, media coverage of services has been expanded with articles written by our CMO and other specialists for the local newspapers and posted on social medial with a link to our hospital website. The PFAC also recommended the creation of a library of professional brochures, describing our services available. Five brochures under development describe Behavioral Health services, Financial Assistance, Diabetes, Surgical Services, and Cancer Care Services. These brochures are scheduled for publication in 3Q CY–2017 with more created over the next year. Patient and Family-centered Resource Centers are planned for our lobby/waiting areas to provide patients with comprehensive information regarding our services.

CHRONIC DISEASE GOAL

Improve community awareness of the long-term detrimental effects of obesity on health and see individuals with obesity participating in educational programs and seeking care coordination.

1. Develop formal educational programs.
2. Expand the Care Coordination Program.

PATIENT-FOCUSED PROCESS RESULTS

- The Chronic Care Management Program for Medicare patients currently has over 100 patients participating in it. While not obesity-specific, Medicare patients with chronic conditions / complex health needs qualify for this program.

- Forty-four patients have been referred to the Chronic Care Manager for diabetes education.

- A Diabetes Patient Registry for Medi-Cal patients has been developed and is updated monthly. Patients on the registry with uncontrolled diabetes are tracked and referred for diabetes education as appropriate.

- On June 22, the 6-week Stanford University Evidence-Based Chronic Disease Self-Management Workshop is scheduled to begin. The workshop is open to any community member with a chronic condition.

- Our multi-disciplinary Total Joint Replacement Program (TJRP) has established criteria for patient readiness to ensure best practice for safe and optimal outcomes. TJRP patients are evaluated on a multi-disciplinary basis to identify risk behaviors and co-morbidities including, smoking, alcohol and drug use, depression, hypertension, and obesity. For obese patients, i.e. who are above a Body Mass Index (BMI) of 35, they must meet with our Masters-prepared Dietitian and reach the goal of <35 BMI to schedule surgery.

- Our Masters-prepared Dietitian (RD) continues to immerse herself into the Mono County community as evidenced by her ongoing 'Healthy Eating Tips' Facebook post, an elementary school fundraiser (Husky Pup Fundraiser) where she educated students on nutrition and exercise. Partnering with a Physical Therapist, they met with more than 400 Ski Instructors at the Mammoth Mountain Ski area focusing on both nutrition for athletes and injury prevention. Our RD also partnered with the USATF-certified high school track coach to pilot a 'Food for Sport' education program that included a free RD consult for all 23 student-athletes.

- Our Care Coordination Team was created after Case Managers noticed that several different team members were involved in coordinating a patient's care after discharge. With several different team members involved in coordinating a patient's care after discharge, realistic potential for duplication of work / rework and patients not being followed up. The first Care Coordination Interdisciplinary meeting was held November 23, 2016. Bi-weekly meeting attendees include: CMO (later becomes Physician Advisor), Case Managers, Patient Care Navigator, Chronic Care Manager, Registered Dietician, Spiritual Care / Patient Experience Manager. Discussing care coordination patient referrals in a multidisciplinary environment has been of great value and benefit to the patients and staff. The team looks at each high-risk patient as an individual, always considering how medical advice, nursing education, nutritional advice, spiritual and emotional support can positively impact their health and wellness. Meetings allow the opportunity to reduce the risk of hospital readmissions by establishing a relationship between patient and both chronic care manager and patient navigator. Ensures local Patient Care Provider (PCP) and that both local and out-of-town follow-up appointments are made and attended. To further assist in serving our patients through the entire continuum of care, beginning in 2017, a recently retired Case Manager has been calling patients post-discharge. This ensures they understood their discharge instructions (e.g., how to take medications, any special instructions) and to ensure follow-up appointments are made. If needed, patients are referred to the Care Coordination Teamor appropriate provider.