

Community Health Improvement Plan (CHIP)

2020 through 2022

For more than 20 years, it has been the pleasure and privilege of Miami County Medical Center (MCMC) to serve our communities. Our goal of providing the highest possible level of medical expertise, advanced technology, and professional, compassionate care has remained our guiding principal over all those decades, and continues to drive us to provide the very best care for our patients and their families. While MCMC is a committed partner, the overall health of our communities is a joint effort. Schools, health-related agencies, local, county and federal government agencies, religious-based groups, health insurers and businesses all play an integral role in meeting the healthcare needs of the residents of our service area.

In an effort to improve the health of communities, the Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals nationwide, including MCMC, to conduct a Community Health Needs Assessment every three years. Hospitals are then required to develop and execute a Community Health Improvement Plan to meet the needs identified in this assessment. MCMC, with the help of VVV Research and Development, conducted the health needs assessment for our service area of Miami and Linn counties. This was done by performing research and collecting health data for our area, and actively seeking input from the community through a survey and town hall meetings.

Timeline for CHNA & CHIP



Community Health Needs Priorities

The research and community input helped develop a clearer picture of our service area and the health priorities of residents. The result was a list of ten top health priorities.

1. Mental health, including screening, treatment and after-care
2. Opioid/drug abuse
3. Food Insecurity
4. Suicide prevention
5. Local specialty care, specifically neurology, pulmonology, endocrinology and podiatry
6. Obesity
7. Senior care
8. Safe and affordable housing
9. Healthcare transportation
10. Immunizations

MCMC then conducted additional research to further investigate each priority. This process resulted in combining related initiatives to best allocate our resources and set goals. Below is a summary of the health need priorities in MCMC's service area.

1. Behavioral Health

- A. Mental health, including diagnosis, screening, data, treatment and after-care
(CHNA Priority #1)
- B. Opioid/drug *(CHNA Priority #2)*
- C. Suicide prevention *(CHNA Priority #4)*

2. Physical Health

- A. Food insecurity *(CHNA Priority #3)*
- B. Obesity *(CHNA Priority #6)*
- C. Immunizations *(CHNA Priority #10)*

3. Access to Care

- A. Local specialty care, including neurology, pulmonology, endocrinology and podiatry *(CHNA Priority #5)*
- B. Healthcare transportation *(CHNA Priority #9)*

4. Senior Care *(CHNA Priority #7)*, including safe and affordable housing *(CHNA Priority #8)*

Priority #1A: Increase collective community education, prevention, response and treatment mental health conditions.



| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|---|--|---|------|------|------|--|
| Through Olathe Health Family Medicine Clinics, screen patients during wellness visits using the PHQ-9 depression screening. Continue enhancements to care management for patients with mental illness through implementation of behavioral health care management for patients with mental health conditions. | Assess patients ages 12 and older at least once per year. | MCMC: Joyce Stoughton | X | X | X | 80% screening compliance during wellness visits |
| | In patients who screen positive, increase the number who access services through community partners. | MCMC: Joyce Stoughton | X | X | X | TBD |
| | If score 5 or above, clinic visit becomes focused on suicidal ideation and one-on-one with the provider. | MCMC: Joyce Stoughton | X | X | X | TBD |
| Work with community health partners to support patients within the Olathe Health network, specifically focusing on those with depression/anxiety diagnosis, those who have that diagnosis plus a chronic medical condition and those who have more than four chronic conditions. | Identify key community partners and develop process for collaborating to increase access and enhance patient care. | MCMC: Paul Luce, Joyce Stoughton Community: Leslie Bjork (ELC) | X | | | Develop cooperative care plans with community partners. |
| | Increase behavioral health access within Olathe and surrounding communities. | MCMC: Joyce Stoughton Community: Leslie Bjork | | X | X | 2021: develop baseline for access 2022: Increase access by 3% over prior year |
| Through collaboration with the Culture of Health Workgroup, work with community health partners to offer Mental Health First Aid community program in 2020. Extend program based on demand throughout 2021 and 2022. Consider offering youth-based programming based on the pilot project with Johnson County Mental Health and the Gardner-Edgerton School District. | Co-host/sponsor first program in Spring/Summer 2020. | MCMC: Lacey Kane Community: Kathy Goul (Extension Office) | X | | | Program Held |
| | Increase participation by 3% over 2020 attendees. | Same as above | | X | | Increase Participation |
| | Increase participation by 3% over 2021 attendees. | Same as above | | | | X |

Priority #1A: Collective community education, prevention, response and treatment for mental health conditions.

| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|---|--|----------------------------------|------|------|------|---|
| Develop a localized resource guide with access points for patients, providers, etc. that is easily accessible. | Partner with information sharing resources to localize resources to the MCMC primary service area. (i.e. 2-1-1, etc.) | MCMC: Lacey Kane | X | | | Launch program |
| | Work with community partners to update information available through information sharing resources. Incorporate additional information as appropriate. | MCMC: Lacey Kane | | X | X | Complete annual audits to review and update information. |
| Coordinate with Olathe Health Family Medicine to investigate telemedicine opportunities for behavioral health services. | Develop telemedicine pilot program and infrastructure with community partner. | MCMC: Paul Luce, Joyce Stoughton | X | | | Develop program |
| | Launch pilot program at designated Olathe Health Family Medicine clinic. | MCMC: Paul Luce, Joyce Stoughton | X | X | | Launch program (pending program development, target goal is late 2020/early 2021) |
| | Expand pilot program to other appropriate family medicine clinics as designated based on need. | MCMC: Paul Luce, Joyce Stoughton | | X | X | TBD based on evaluation and review of pilot program. |

Priority #1B: Address the rise in methamphetamines and other illegal drugs, along with abuse and misuse of opioids by partnering with key community entities to reduce the misuse of opioids.

| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|--|---|-----------------------------------|------|------|------|---|
| <p>Engage the Olathe Health Physician Opioid Task Force to review prescription practices and provide appropriate education.</p> <p>This group has implemented a number of programs to address this priority such as pain management contracts with patients, support KTRACS, intake assessments in clinics, guidelines for dispensing.</p> | <p>Develop plan and infrastructure to monitor patients who have and do not have a controlled substance agreement. Develop baseline. Develop communication plan to educate providers that includes CME, Rounds, All Provider Meetings, etc.)</p> | MCMC: James Wetzel, MD | X | | | Reduce number of prescriptions to patients without a controlled substance agreement |
| | <p>Reduce number of prescriptions to patients without a controlled substance agreement.</p> | MCMC: James Wetzel, MD | | X | X | Pending baseline data |
| <p>Partner with local groups to promote safe drug take back practices.</p> | <p>Promote local drop-off locations (i.e. National Drug Take Back Days, etc.).</p> | MCMC: Lacey Kane | X | X | X | Provide annual education to OHP offices. |
| | <p>Provide Olathe Health Family Medicine clinics, and others as identified, with medication disposal systems.</p> | MCMC: Lacey Kane, Joyce Stoughton | | | | 100% of identified clinics have access to these systems on – site. |

Priority #1C: Partner with key community stakeholders to reduce the incidence of suicide and connect those with suicide ideation with the appropriate resources for assistance.

| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|--|--|--|------|------|------|--|
| Work with community partners to develop a rapid response process to help with Olathe Health patients in crisis within our locations. Create resources for crisis management for clinic staff for suicidality including but not limited to iPad assessment in clinics, direct hotline, etc. | Solidify a rapid response process that can be initiated when someone presents to an Olathe Health location and is a danger to themselves or others but not necessarily in need of police involvement. | MCMC: Paul Luce, Joyce Stoughton Community Partners: Leslie Bjork (ELC) | X | | | Create policy |
| | Create additional resources for crisis management within the clinic settings for staff working with suicidal patients. | MCMC: | | X | X | Include resources on community resource page |
| Through collaboration with the Healthy Minds Strong Communities workgroup, support projects and programs to address suicide in youth. | Implement the Yellow Ribbon Project in the communities we serve. Sponsor training days for community, including those who work directly with youth (i.e. non-school based athletic coaches, recreational leaders, etc.) | MCMC: Lacey Kane Community Partner: Kathy Goul (Extension Office) | X | X | X | Implement program and sponsor annual training sessions |
| | Launch community event in Paola, offers breakout sessions about depression/anxiety, trauma, foster care, etc. along with programming specifically for children to teach techniques to enhance resiliency. Consider expanding to additional communities in following years. | MCMC: Lacey Kane Community Partner: Kathy Goul (Extension Office), USD #368 | X | X | X | Sponsor festival and increase participation by 3% over prior year. |

Priority #2A and B: Enhance collaborative communication about accessible health wellness and prevention opportunities to encourage community members to engage and sustain positive behavior change. This includes identifying opportunities to reduce food insecurity and education about how to prepare healthy meal options.



| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|---|--|--|------|------|------|---|
| Encourage communities, insurance companies and employers to support health, wellness and prevention opportunities to improve access. | Partner with 20 local employers and/or community groups to provide preventative health and wellness screenings and/or education. | MCMC: Lacey Kane | X | X | X | Participate in 10 events, and increase by an additional two each year. |
| | Partner with Lockton to develop plan with local employers to encourage wellness and prevention. | MCMC: Darren Odum Community Partners: Lockton | X | X | X | KPI is to be determined based after initial planning with Lockton. |
| Focus on food deserts within our community and enhance access to mobile food pantries and other resources available within the community. | Partner with local food pantry resources and a community organization to host a mobile food pantry in Linn County. | MCMC: Lacey Kane Community Partner: Frannie Eastwood (Extension Office) | X | | | Launch mobile pantry and host regularly throughout the year (specific schedule is TBD). |
| | Expand mobile pantry to other food deserts in the primary service area as appropriate. | MCMC: Lacey Kane | | X | X | |

Priority #2A and B: Enhance collaborative communication about accessible health wellness and prevention opportunities to encourage community members to engage and sustain positive behavior change. This includes identifying opportunities to reduce food insecurity and education about how to prepare healthy meal options.

| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|---|--|---|------|------|------|---|
| Enhance food access, including fruits and vegetables, education on how to prepare healthy meals, etc. | Screen Olathe Health Family Medicine patients for food insecurity. Establish a baseline in 2020 and then increase number of patients being connected to resources. | MCMC: Lacey Kane Community Partners: Local food pantries | X | X | X | Establish baseline and then increase by 3% over prior year. |
| | Collaborate with community partners to educate parents and young families on the importance of a healthy behaviors using the 1-2-3-4-5-Fit-Tastic Program. | MCMC: Lacey Kane Community Partners: School districts, others | X | X | X | Incorporate Fit-Tastic education into five community outreach programs. |
| Identify prescriptive services and partners. | Explore partnerships with local grocery stores and fitness centers to offer prescriptive memberships/services based on provider recommendation. | MCMC: Lacey Kane | | X | | Launch pilot program with local partner in year one. Expand pilot with one additional partner in years two and three. |
| Maximize community sponsorships to promote physical activity. | Provide community sponsorship dollars and resources to partners with an emphasis on activities that encourage physical activity (ie. Paola Pathways, OZone, etc.). | MCMC: Paul Luce and Lacey Kane | X | X | X | Support five wellness initiatives each year and add one additional initiative each year. |

Priority #2C: Assess and understand the barriers to compliance with immunizations. Evaluate how the rural health clinics can partner with the Miami County Health Department to collaborate on this priority.

| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|--|--|---|------|------|------|---|
| Increase the number of pediatric patients within the Olathe Health Family Medicine clinics who are compliant with immunization schedule. | Increase the number of pediatric patients who are compliant with CDC vaccination schedule by 3% over previous year's totals. | MCMC: Joyce Stoughton | X | X | X | Increase in vaccination compliance. |
| | Attend KDHE's annual Immunization Conference. | MCMC: Joyce Stoughton and Lacey Kane | X | X | X | Conference attendance |
| Assess barriers to compliance with vaccinations. Then, improve resources to break down barriers for compliance. | Survey parents of pediatric patients within the Olathe Health Family Medicine clinics who are not compliant with vaccination schedules to identify barriers. | MCMC: Joyce Stoughton | X | | | Launch survey to identified patients and present results. |
| | Launch public awareness campaign about the importance of vaccinations, debunking myths and provide education to parents in the primary service area. | MCMC: Lacey Kane | X | X | X | Annual public awareness campaign to increase education. |
| Partner with Miami County Health Department and others to increase number of children compliant with vaccination schedules. | Host continuing education opportunity to enhance toolkit for providers. | MCMC: Lacey Kane, Traci Lewin, Dr. Patrick Herrick Community Partner: Rita McKoon (MCHD) | X | | | Increase vaccination rate to 60% in Miami County by 2022 (via Kansas Health Matters). |

Priority #3A: Enhance accessibility to specialty care available at Miami County Medical Center through the multispecialty clinic. Priority specialties include dermatology, allergy, gynecology, rheumatology, neurology, nephrology, pulmonology and endocrinology.



| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|---|--|---------------------------------|------|------|------|--|
| Expand Multispecialty Clinic to add specialties and providers in order to provide specialty care close to home. | Add 2 providers per year over four years to expand multi-specialty clinic. | MCMC: Paul Luce and Darren Odum | X | X | X | Two providers added to clinic each year. |

Priority #3B: Healthcare transportation, specifically focused on reducing the number of people who are not able to keep their appointments because of lack of transportation and reduce re-admissions to the hospital because patients are not able to access the resources they need due to lack of transportation.

| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|---|--|--------------------------------|------|------|------|---|
| Identify resources within each community and utilize those resources for patients being discharged from the hospital. | Identify 1 – 2 resources within the community to establish a program to get patients home after discharge. | MCMC: Paul Luce and Lacey Kane | X | | | Launch program. |
| | Expand program into other communities we serve based on need. | MCMC: Paul Luce and Lacey Kane | | X | X | Expand program into two additional communities within our primary service area. |

Priority #4: Enhance resources to help with the health and wellness of the senior population. For the purposes of this CHIP, we are combining this priority with safe and affordable housing options specifically for this population.

| Responses | Tactics | Leaders | 2020 | 2021 | 2022 | KPI's |
|--|--|--------------------------------|------|------|------|--|
| Support My Father's House to coordinate activities to establish emergency shelter. | Collaborate with My Father's House to improve access to emergency shelter. | MCMC: Paul Luce and Lacey Kane | X | X | X | TBD |
| Add senior care/housing on campus by 2022. | Identify partner for on-campus senior housing. | MCMC: Paul Luce | X | | | Open senior care housing unit by 2022. |
| | Construct and open unit. | MCMC: Paul Luce | | | X | |