ADDENDUM:
2019 CHNA REPORT
SW OHIO | N KENTUCKY | SE INDIANA
CHNA

Wayne HealthCare

INTRODUCTION

For the 2019 to 2021 Community Health Needs Assessment (CHNA), Wayne HealthCare participated in a collaborative CHNA report that served 35 hospitals and 28 local health departments across 3 states and 25 counties.[1] This addendum to the CHNA report:

1. Describes the prioritization process and its results to identify significant health needs specific to Wayne HealthCare;

2. Provides an evaluation of the impact of the actions that were taken, since Wayne HealthCare finished conducting its immediately preceding CHNA, to address the significant health needs that were identified in that CHNA; and

3. Considers written comments received on Wayne HealthCare's most recently conducted CHNA and Implementation Strategy.

The following individuals at Wayne HealthCare participated in the preparation of this Addendum:

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PRIORITIZATION OF COMMUNITY HEALTH NEEDS

The prioritization process and its results to identify significant health needs specific to Wayne HealthCare are set forth in the Wayne HealthCare 2019-2021 Implementation Strategy.[2]

[1] The report may be found at the following link: https://www.waynehealthcare.org/media/file/2019%20CHNA%20Report%201-7-19.pdf.
[2] The report may be found at the following link: https://www.waynehealthcare.org/media/file/Implementation_Strategy%202019_2021_Final.pdf

EVALUATION OF IMPACT OF ACTIONS TAKEN SINCE PRIOR CHNA

Priority Issue	Objective	Strategies	Evaluation of Impact of Actions Taken
Chronic disease prevention & education *Goal: Improve opportunities for chronic disease risk management and support chronic disease prevention and education programming.*	1) By December 2017, increase the number of partners providing health education and promotion services by 2 new partners.	• Inventory existing programs in the community. • Partner with the Health Department, Family Health, the Coalition for a Healthy Darke County, Darke County Recovery and Wellness, and the Department of Job and Family Services to distribute resource guides. • Increase marketing of lifestyle change programs, emphasizing the Group Lifestyle Balance program, to the general public. • Initiate the Healthy Living Series and Invest-in-Your-Health program by December 2017.	• A list of existing health education offerings in the community was created. The majority of health education opportunities for the public were offered by three main entities: Wayne HealthCare, Family Health, and the Darke County Health Department. • The Greenville Public Library and BASF partnered with us in 2017 to provide health education/health promotion programs. These entities expanded the reach of our health education programming outside of our typical demographic. Troy Sunshade partnered with us to provide corporate wellness services in 2017, including a biometric screening and health fair. • Marketing of behavior modification programs expanded to include increased focus on social media. Previously, most marketing efforts focused on local newspapers. The Group Lifestyle Balance Program was a focal point of social media marketing efforts and in-person marketing at other health education sessions to drive participation in that program. • The Healthy Living Series was implemented at the Greenville Public Library, holding sessions each month in 2017. This health education program reached participants that may not have attended hospital-held events, helping us reach a different demographic from our typical health education offerings. • We hosted 14 Healthy Moments events in 2017.
	2) By December 2017, increase participation in risk factor management programs and activities.	• Increase frequency of Healthy Moments program from 4 sessions to 6 sessions, annually. • Increase the number of businesses reached through corporate wellness efforts by partnering with at least one more business by December 2017. • Partner with more organizations to provide information on preventive services and health promotion/education materials at health fairs. • Initiate chronic disease management with inpatients by December 2017.	
	3) By December 2017, increase participation of adults in support groups and counseling programs for those affected by chronic disease.	• Partner with local organizations to provide one-on-one nutrition and exercise counseling. • Market diabetes support groups and Group Lifestyle Balance program to businesses and the community. • Develop and market COPD support group to businesses and the community. • Increase participation in diabetes support groups.	

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		• Initiate one-on-one nutrition/exercise counseling for persons dealing with chronic disease.	• Two primary chronic disease management activities occur with inpatients: pulmonary rehab inpatient education and diabetes education. Pulmonary rehab inpatient education helps patients effectively manage their conditions and adjust lifestyle habits that contribute to poor health outcomes and low quality of life. Diabetes education helps patients better manage their chronic condition and promotes better health outcomes. • Better Breathers COPD support group met in 10 times in 2017 with 15 participants. • County employees were eligible for one-on-one nutrition and exercise health education sessions beginning in 2017.
Coordinated care & coordinated management *Goal: Improve access to care and optimize health care resources by coordinating patient care with all healthcare providers in the*	To reduce hospital readmission and deliver better health outcomes via coordinated care and coordinated management regarding Chronic Obstructive Pulmonary Disease and Congestive Heart Failure by December 2017	1) By December 2017, develop a mechanism to enable care coordination across multiple agencies by using the Darke County Adult Collaborative Care Release form. a. Gain agreement with partners and healthcare providers in Darke County to develop a Darke County Adult Collaborative Care Release form. b. Develop and implement the Darke County Adult Collaborative Care Release form. 2) Identify patients at high risk for readmission and	The Darke County Adult Collaborative Care Release Form was updated in February 2017 and put into use through the Partnership for Patients collaboration. This form was placed on Policy Tech (WH0748HW) so that all departments involved in Care Coordination would have access. Wayne HealthCare worked closely with CHN, Family Health, and Versailles Healthcare to help coordinate post-hospital care efforts. Also, Wayne HealthCare collaborated with the Brethren Retirement Community to

Priority Issue	Objective	Strategies	Evaluation of Impact of Actions Taken
community.		ensure that they get appropriate follow-up care beginning with a pilot demonstration project of a coordination of care data platform to enable connectivity and collaboration across health care and human services organizations. a. Select a vendor with experience and expertise in coordination of care data platforms to guide the pilot demonstration project. b. Conduct a demonstration project focusing on post-discharge care of COPD and CHF patients who are identified as high risk for readmission to the hospital. c. Based on the pilot results, determine the resources required to scale up the project.	communicate discharges from the BRC to recapture patients for the heart failure clinic. The LACE tool was implemented through collaboration with social services to screen for patients at high risk. Civic Health was selected as a vendor and their data platform was purchased. This system did not work well because the patient information needed to be manually entered (no interfaces were purchased). Community partners did not have time to double document everything in two systems. Family Health and Comprehensive Health Network participated in meetings to discuss and develop potential solutions for patients, but patient participation was very low. The project never grew, so the contract with Civic Health was never renewed. The focus shifted to transitional care with a nurse practitioner and serving patients without a primary care provider.

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Mental health & substance Abuse *Goal: Expand assistance and support of the Coalition for a Healthy Darke County to improve access to mental healthcare and substance abuse services.*	By December 2017, increase utilization and awareness of mental health & substance abuse services to enhance the health and wellbeing of individuals, organizations, and workplaces in Darke County.	Strengthen the collaborative partnership with the Coalition for a Healthy Darke County to improve access to mental health and substance abuse services in the community by 2017. a. The VivitrolProject will create a program that provides immediate intervention and treatment for eligible citizens. Wayne HealthCare's role is to partner with the Coalition for a Healthy Darke County to provide Vivitrol case management support. b. The Role Model & Mentoring Project will reach out to high risk groups with role models of healthy, drug and substance free living. Wayne HealthCare's role is to continue providing funding for the Role Model and Mentoring Program for school-aged youth in the community. c. Actively promote the online mental health screening tool provided by the Tri-County Board of Recovery and Mental Health Services during community outreach events.	The Coalition for a Healthy Darke County was developed to understand and promote community decision making, collaboration, and ownership among many different organizations through joint action. The Coalition has identified six collaborative projects for the purpose of addressing mental health and substance abuse issues in the County. These projects include: Vivitrol Project; Role Model & Mentoring; Case Management/ Referral Services/ Outreach; Public & Workforce Education; Funding/ Fundraising; School Resource Officer Program; Making the Healthy Choice the Easy Choice; and Legislative Issues.

09 / 16 / 2020

Date adopted by Board of Directors of Wayne HealthCare

WRITTEN COMMENTS RECEIVED ON IMMEDIATELY PRECEDING CHNA AND IMPLEMENTATION STRATEGY

Wayne HealthCare did not receive any written comments on its immediately preceding CHNA and Implementation Strategy.

Written comments on the current Wayne HealthCare CHNA and Implementation Strategy may be submitted for consideration as follows:

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