Community Health Needs Assessment

Implementation Strategy

FY2019

RUSH

Rush Copley Medical Center

Outline

- Executive Summary
- Health Priorities
- Implementation Strategies

Executive Summary

Executive Summary

In FY2019, Copley Memorial Hospital, otherwise known as Rush Copley Medical Center (RCMC), completed a comprehensive Community Health Needs Assessment (CHNA) process to identify, prioritize, and address the top health issues in the community served.

The hospital is located in the city of Aurora, IL, which is the second largest city in Illinois.

The community served by the hospital includes the geographic area from which approximately 80% of the hospital's patients reside. This area includes Aurora, Sugar Grove, Oswego, Montgomery, North Plainfield, and most of Kendall County.

Process and Methodology

The hospital used four methods for collecting community input and health data, including the following:

- Partnering with the Kane County and Kendall County Health Departments on the development of their respective CHAs/CHIPs (Community Health Assessment & Community Health Improvement Plan)
- Community health survey
- Focus groups
- Extensive secondary data analysis

The hospital established an internal team with health and community expertise to guide the development of the CHNA and establish the implementation strategy.

- The committee reviewed and discussed the findings from the community health survey, focus groups, secondary data analysis, and information from the development of the Kane County and Kendall County CHAs/CHIPs, as well as additional community input.
- Through a defined criteria process, the committee identified and prioritized the top health issues in the community, which are included in this strategy implementation plan.

Executive Summary

Identified and Prioritized Health Needs

Rush Copley identified the following as the top health priorities in the community to be addressed:

1. Inequities caused by the social, economic and structural determinants of health, focusing on reducing inequities in vulnerable populations through improved identification and connection of patients in need to available community resources
2. Mental and behavioral health, focusing on reducing the misuse of opioids and opioid-related deaths
3. Prevent and reduce chronic disease by focusing on risk factors, specifically reducing tobacco usage (including smoking and vaping)

The hospital developed and adopted an implementation strategy to address these community health needs. The CHNA and Implementation Strategy were approved and adopted by the hospital's Board of Directors on March 26, 2019.

The CHNA report, Data and Information Book, and Implementation Strategy are helpful community resources and are widely available to the public at www.rushcopley.com.

Execution of the implementation strategies outlined in this report has begun and will continue over the next three fiscal years.

Health Priorities

Identified and Prioritized Health Needs

- The Rush Copley Community Health Needs Steering Committee identified and prioritized the following community health needs.
- Many of these needs are aligned with the top needs identified in the Kane County, Kendall County, and Rush University community health assessments.

Identified Community Health Needs (listed in order of importance from highest to lowest)
1. Inequities caused by the social, economic and structural determinants of health[1,3] • Inequities in vulnerable populations (children, seniors[2], Spanish speaking, LGBTQ) • Access to transportation to and from health services
2. Mental and Behavioral Health (includes both mental health and substance abuse)[1,2,3] • Access to mental and behavioral health services • Lack of knowledge of the services available in the community and how to access those services • Substance abuse with a focus on opioid misuse and opioid-related deaths
3. Access to care and community services[2,3] • Lack of knowledge of the services available in the community and how to access those services • Insurance access and coverage stability
4. Prevent and reduce chronic disease by focusing on risk factors[1,3] • Obesity due to poor nutrition and physical inactivity • Tobacco usage (including smoking and vaping) • Medication noncompliance

1: Identified as a community health threat in the Kane County 2018-2020 IPLAN
2: Identified as a health priority in the Kendall County 2016-2020 IPLAN
3: Identified as a community health need in the Rush University 2016 and 2019 CHNAs

Identified and Prioritized Health Needs

- Rush Copley discussed and prioritized the list of identified health needs on page 7 to determine the top three needs that the hospital could have a meaningful impact on over the next three years.

- **Rush Copley identified the following as the top health needs in the community to be addressed in the implementation strategy:**

  1. Inequities caused by the social, economic and structural determinants of health, focusing on reducing inequities in vulnerable populations through improved identification and connection of patients in need to available community resources

  2. Mental and behavioral health, focusing on reducing the misuse of opioids and opioid-related deaths

  3. Prevent and reduce chronic disease by focusing on risk factors, specifically reducing tobacco usage (including smoking and vaping)

Identified and Prioritized Health Needs

The following needs will not be addressed in this Implementation Strategy:

Identified Need	Reason why the need will not be addressed through the Implementation Strategy
Mental and Behavioral Health: • Access to mental and behavioral health services • Lack of knowledge of the services available in the community and how to access those services	• As identified during the prioritization exercise, Rush Copley does not provide mental and behavioral health services, and it would not be feasible for the hospital to develop this type of program. Therefore, the hospital would not be able to have a measurable impact on access to mental and behavioral health services. • There are a great number of organizations in the community already addressing this need (as listed in the CHNA). • The hospital and RCMG have implemented a number of mental and behavioral health screenings in order to improve the identification of patients in need and provide referrals to providers in the community. • The hospital currently works closely with behavioral health programs in the community in order to assist patients in accessing care. • Additionally, RCMC anticipates improvement in the knowledge of the mental and behavioral services available in the community and how to access those services through the implementation of strategies related to reducing inequities as described on page 13 of this document.

Inequities:
• Access to transportation to and from health services
	• As identified during the prioritization exercise, Rush Copley does not provide its own transportation services, and it would not be feasible for the hospital to develop this type of program.
	• The hospital continues to address the need for transportation through a number of programs, resources, grants, and outreach activities in the community, including, but not limited to the following:
	  ○ Rush Copley provides cab fare and bus vouchers for patients in need and helps coordinate public transportation. The hospital also helps identify patients appropriate for county funded transportation such as KAT (Kendall Area Transport) and Ride in Kane.
	  ○ Partnership with the American Cancer Society to provide transportation to cancer patients in need of this service.
	  ○ The hospital continues to periodically communicate with PACE to request a second stop on the hospital campus.
	• Additionally, RCMC anticipates that access to transportation services may be improved through the implementation of strategies related to reducing inequities as described on page 13 of this document.

Identified and Prioritized Health Needs

The following needs will not be addressed in this Implementation Strategy:

Identified Need	Reason why the need will not be addressed through the Implementation Strategy

Access to Care:
• Lack of knowledge of the services available in the community and how to access those services
• Insurance access and coverage stability
	• The percent of residents that are uninsured or underinsured is a societal factor that the hospital is not in a position to directly impact as it does not have any control of the insurance system or government regulations.
	• This need is currently being addressed by a number of facilities and resources in the community, including but not limited to, the four Federally Qualified Health Centers (FQHCs) in Kane County and Aurora Primary Care Consortium.
	• Rush Copley offers a generous and comprehensive program of financial assistance in order to serve those who may not have health insurance or other means to pay for their care.
	• The hospital will continue to promote local resources, such as 211, to increase knowledge of the services available in the community.
	• The hospital will continue to provide and promote enhanced education materials regarding appropriate care settings as developed through the FY2016 Implementation Strategy.
	• The hospital will continue (and look to expand) the Care Manager program of scheduling follow-up appointments for patients without a primary care physician. Plans include:
	  ○ Continue to see emergency department patients and inpatients without a primary care physician to help schedule their follow-up appointments before discharge.
	  ○ Enhance follow-up with the VNA for patient referrals to the VNA home program.
	  ○ Contract with Hospice provider to schedule follow-up appointments for hospice and palliative care.

Chronic Disease: • Obesity due to poor nutrition and physical inactivity • Medication noncompliance	• Over the last six years, the hospital developed and implemented a great number of new programs and resources aimed at reducing obesity in the community. While the development of new strategies for obesity are not included in the FY2019 CHNA Implementation Strategy, the hospital plans to continue many of the programs and resources developed through the previous plans. • Additionally, RCMC plans to continue to look for new opportunities to reduce obesity in the community. • The RCMC Community Care fund remains in place and has expanded to include patients in the “loop hole” or with high out of pocket expenses for their prescriptions. • The onsite Walgreens has been instrumental in researching low cost options for patients even if the patient does not utilize Walgreens for the prescription. • RCMC continues to work with VNA to provide low income or unfunded patients options for their medications. • Additionally, RCMC plans to leverage the new EMR to improve patient’s medication compliance.

Implementation Strategy

Goals and Implementation Strategies Summary

Need	Reduce inequities caused by the social, economic and structural determinants of health	Improve Mental and Behavioral Health Status (includes both mental health and substance abuse)	Prevent and reduce chronic disease by focusing on risk factors
Goal	• Reduce inequities caused by the social, economic and structural determinants of health, focusing on vulnerable populations through improved identification and connection of patients in need to available community resources	• Reduce the misuse of opioids and opioid-related deaths in the community	• Prevent and reduce chronic disease by focusing on risk factors, specifically reducing tobacco usage in the community (including smoking and vaping)
Strategies/Initiatives	1. Identify, measure and mitigate the social determinants of health among those at greatest risk through improving the connection between vulnerable populations and needed socioeconomic resources 2. Provide staff and physician education focused on the unique needs of vulnerable populations 3. Participate in local community health improvement collaborative(s)	1. Reduce the number of opioid prescriptions and quantity prescribed 2. Reduce the amount of opioids already existing in the community 3. Develop and implement community, patient, and care provider education 4. Participate in local community health improvement collaborative(s)	1. Develop/enhance and implement education and resources to help patients and the community quit smoking/vaping 2. Leverage the use of the EMR to improve documentation and reduce tobacco usage 3. Develop/enhance care provider education to increase engagement of tobacco cessation and assessment of willingness to quit 4. Participate in local community and Rush System health improvement collaborative(s)

Three key strategic implementation themes that span each need:

- Leverage capabilities and use of the new EPIC EMR
- Provide new/enhanced community and care provider education
- Participate in local community health improvement collaborative(s)

Reduce Inequities

Goal: Reduce inequities caused by the social, economic and structural determinants of health focusing on vulnerable populations through improved identification and connection of patients in need to available community resources

Strategies and Initiatives:

Strategies	Initiatives

Identify, measure and mitigate the social determinants of health among those at greatest risk through improving the connection between vulnerable populations and needed socioeconomic resources	• In collaboration with Rush University, implement a screening tool for RCMC at-risk/vulnerable patients that will be used to help identify the social, economic and structural determinants of health that could be affecting patient's health
	  ○ Pilot in one department of the hospital or medical group and expand to other departments as possible and meaningful
	  ○ Provide survey in English and Spanish
	• As patient needs are identified through the survey, increase and improve the referral process to care providers, agencies and support services that can help
	• Leverage use of the EPIC medical record throughout the process
	• Enhance and expand the use of Community Care Mangers in RCMG PCP practices to better identify and address the social determinant needs of the patient population
	• Seek grant funding for additional Care Manager/Community Health Navigator support

Provide staff and physician education focused on the unique needs of vulnerable populations	• Develop and implement an education plan regarding social determinants of health to increase knowledge and awareness among care providers • Develop and implement care provider education focused on the unique needs of vulnerable populations, specifically the senior and LGBTQ populations

Participate in local community health improvement collaborative(s)	• Participate in and work with other city and county agencies, health systems, and community organizations, including but not limited to:
	  ○ The Kane Health Counts committee for income, job-ready workforce, and education
	  ○ Oswego Senior Center committee for Senior/dementia-friendly community
	  ○ FUSE (Frequent Users System Engagement) initiative with the City of Aurora

Reduce Inequities

(continued)

Anticipated impact:

- Reduce inequities in vulnerable populations in the community
- Improve the referral process for patients needing assistance
- Gain a better understanding of the number of patients needing social and economic service resources (measure and quantify)
- Increase knowledge/awareness of social and economic resources available in the community
- Reduce unnecessary visits to the emergency department and re-admissions
- Improve the awareness of unique healthcare needs of the LGTBQ community, the resources available, and how to access those resources
- Improve awareness of the unique healthcare needs of seniors, the resources available, and how to access those resources

Planned collaboration with other organizations to address this need:

- Rush Copley Medical Group (RCMG)
- Rush Copley Family Practice Residency
- Rush University Medial Center (RUMC)
- Kane County Health Department
- Community agencies, organizations, and health systems participating in Kane Health Counts initiatives
- Kendall County Health Department
- Oswego Senior Center

Improve Mental and Behavioral Health

Goal: Reduce the misuse of opioids and opioid-related deaths in the community

Strategies and Initiatives:

Strategies	Initiatives
Reduce the number of opioid prescriptions and quantity prescribed	• Incorporate intelligent design through the EPIC build and implementation processes that will serve as a tool in the efforts to reduce opioid prescriptions/quantity prescribed. To include the following: ○ Update order sets to optimize pain management while reducing the use of opioids ○ Implement dose warnings for high morphine equivalent per day doses and prescribing advice of Narcan (naloxone) antidote ○ Develop opioid dashboards and reports to track and benchmark opioid use ○ Remove default durations in orders for opioid prescriptions • In partnership with RCMG, implement EPIC enhancements with Best Practice Advisories with MME (Morphine Equivalents) • Develop and implement provider education programs regarding the opioid crisis and ways to optimize pain management
Reduce the amount of opioids already existing in the community	• Assess the feasibility of implementing a prescription drop-off box on site and/or pharmaceutical disposal via mail ○ Additionally, disseminate information to providers, patients, and community on opioid take back locations • Assess the feasibility of distributing Dispose Rx (or similar material) with opioid prescriptions
Develop and implement community, patient, and care provider education	• Develop and implement community and healthcare provider education programs regarding: ○ How to manage pain without medications ○ General education regarding opioid use (dangers of opioids) ○ How to properly dispose of unused medications • Improve discharge instructions and education through EPIC regarding opioid use
Participate in local community health improvement collaborative(s)	• Actively participate in the Kane County Opioid Task Force • Actively participate in the Kane County Behavioral Health Council • Actively participate in the Rush University System for Health Opioid Workforce • Partner with Kendall County to teach Narcan (naloxone) administration to the community

Improve Mental and Behavioral Health

(Continued)

Anticipated impact:

- Decrease in inpatient and outpatient use of opioids at Rush Copley and in the community served
- Decrease in the percent of patients receiving greater than 40 morphine equivalents per day
- Decrease in average duration of opioid prescriptions
- Increased awareness and participation in opioid take back locations
- Reduction in morbidity and mortality related to opioids (Kane and Kendall Counties)
- Reduction in the amount of opioids in the community

Planned collaborations with other organizations to address this need:

- Rush Copley Medical Group (RCMG)
- Rush University Medical Center (RUMC)
- Rush Health
- Kane County Health Department
- Community agencies, organizations, and health systems participating in the Kane County Task Force initiatives
- Kendall County Health Department

Prevent and Reduce Chronic Disease

Goal: Prevent and reduce chronic disease by focusing on risk factors, specifically reducing tobacco usage in the community (including smoking and vaping)

Strategies and Initiatives:

Strategies	Initiatives

Develop/enhance and implement education and resources to help patients and the community quit smoking/vaping	• Develop/enhance and implement education, resources, and/or programs to help the community quit smoking
	  ○ Continue to improve awareness through creating or utilizing materials in both English and Spanish as well as having access to additional resources in other native languages for the patient population at Rush Copley
	  ○ Implement promotion and utilization of Pro-Change for RCMC/RCMG patients and employees (web-based digital coaching for smoking cessation)
	  ○ Host Spanish Freedom From Smoking (FFS) programs in the community
	  ○ Provide the FFS flyer to community partners to distribute among their population that are current smokers
	• Partner with local school districts and health departments to discuss efforts around vaping/e-cigarette prevention and education for pre-teens, adolescents, and parents. This will be done in a way that engages and reaches youth.

Leverage the use of the EMR to improve documentation and reduce tobacco usage	• Improve the assessment and documentation of patients' smoking history by implementing tools in the EPIC EMR to quantify the number of patients that smoke, as well as calculate and document their smoking history (pack year history)
	• Develop and implement a tobacco smart set in the EPIC EMR for both the hospital and RCMG that will:
	  ○ Track provider referrals for Freedom From Smoking program
	  ○ Track provider referrals to the Illinois Tobacco Quitline
	• Participate in the pilot program for the Automation Referral for the Illinois Tobacco Quitline
	• Enhance patient discharge instructions in the EPIC EMR system so that it incorporates and provides tobacco cessation resources for patients (state, local and Rush System resources)

Prevent and Reduce Chronic Disease

(continued)

Strategies and Initiatives (continued):

Strategies	Initiatives

Develop/enhance care provider education to increase engagement of tobacco cessation and assessment of willingness to quit	• Strategically develop staff and physician education around engagement of tobacco cessation and addressing patients' willingness to quit smoking (among current smokers)
	  ○ Begin with education among RCMG practices and then transition into RCMC department education
	  ○ Assess and determine the best teaching methods for each department in order to engage their respective patient population(s) in tobacco cessation discussions and assessment of willingness to quit, which translate into a positive patient experience vs. a negative experience
	• Educate RCMC clinical staff regarding utilization of the Illinois Tobacco Quitline Referral Forms on Policy & Procedures Portal

Participate in local community and Rush System health improvement collaborative(s)	• Join and participate in the newly established Kane County Tobacco Coalition • Continue to collaborate with Rush University's Tobacco Oversight Committee • Become a Rush System partner in supporting Tobacco 21 in IL

Anticipated impact:

- Decrease community smoking rates, which would correlate to a reduction in chronic disease (longer term)
- Decrease the percent of RCMG adult patients that are current smokers
- Each month have an average of 5-10 referrals for the ITQL and FFS from RCMG providers
- Each month connect/refer at least 5 patients from Rush Copley with the ITQL
- Increase participation in the RCMC Freedom From Smoking program
- Increase staff awareness of tobacco cessation resources available for RCMC patients and community members
- Increase knowledge/awareness of pre-teens, adolescents, and parents on the harmful effects of vaping/e-cigarettes among youth
- Decrease pre-teens and adolescents use of vaping/e-cigarettes
- The positive impacts noted above are also anticipated specifically in the Hispanic/Latino community due to targeted efforts for this population

Planned collaborations with other organizations to address this need:

- Rush Copley Medical Group (RCMG)
- Rush University Medial Center (RUMC)
- Rush Health
- Kane County Health Department
- Community agencies, organizations, and health systems participating in the Kane County Task Force initiatives
- Kendall County Health Department
- Local School Districts
- Illinois Tobacco Quitline

Committed Programs and Resources

Rush Copley plans to commit the following resources to implement the strategies and initiatives identified in this plan.

- Management and facilitation of resources needed to implement the described strategies and initiatives
- Existing programs, education, and resources related to the identified health priorities
- Staff resources (both clinical and non-clinical) needed to develop and implement the described strategies and initiatives
- Staff resources needed to seek grant funding to support the described strategies and initiatives
- Leadership and staff resources needed to develop and enhance collaborative relationships with community partners related to the identified health priorities and to seek additional resources needed from the community