2023-2025 Implementation Strategy

For the 2022 Community Health Needs Assessment

ValleyHealth
War Memorial Hospital

War Memorial Hospital Implementation Strategy Plan

Introduction

The **2022 Community Health Needs Assessment** (CHNA) is a strategic tool that helps Valley Health pursue its mission of serving our community by improving health. The Patient Protection and Affordable Care Act of 2010 requires not-for-profit hospitals to conduct Community Health Needs Assessments every three years. The purpose of the assessment is to identify and prioritize the health needs of the residents of the hospital's service area, particularly those who experience health inequities. After assessments were completed for each Valley Health hospital, an **Implementation Strategy Plan** was developed to address the identified health needs.

The Community Health Needs Assessment involved the contributions of over 2,000 individuals through virtual interviews, surveys, in-person community response sessions, and in-person interviews with vulnerable populations from area homeless shelters and food pantries. Key stakeholder groups included community residents, members of faith-based organizations, health care providers, elected officials, members of the Valley Health Community Advisory Council, health professionals, and leadership from each of Valley Health's six hospitals. The CHNA is a report based on quantitative, qualitative and relative data that assesses health issues in our community and the community's access to services related to those issues. Frameworks of social determinants of health and health equity guided the process of the CHNA.

The Implementation Strategy Plan (ISP) addresses priority needs identified in the CHNA, describing how the hospital intends to respond to the need or identifying it as one that will not be addressed and why. The strategies have been developed with a focus on leveraging Valley Health's programs and resources to achieve sustainable solutions that address health disparities and close gaps in healthcare access. The identified strategies are not intended to be a comprehensive list of all of the many ways the needs of the community are addressed by Valley Health, but rather specific actions the hospital commits to undertaking and monitoring from 2023-2025. Initial collaboration with hospital and community leaders established the impact list and alignment was sought among system leaders to compliment planning efforts around the community health needs. The impact of the chosen strategies will be communicated to the community and further alignment will establish partnerships and related measurable effects.

The hospital may amend the ISP as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs included here. This plan and its strategies will be evaluated annually and may be refocused to account for such changes in the community or health system landscape.

Methodology: Identifying Priority Health Issues

1. **Establish the Assessment Infrastructure**
   A Community Advisory Council (CAC) was established with representation for each of Valley Health's acute care operations, critical care access hospitals, clinical service lines, community members, Finance and Treasury Affairs, and Planning and Business Development. The CAC reviewed Internal Revenue Service and Department of Health requirements and established the project timeline and implementation strategy.

2. **Conduct Community Health Needs Assessment**
   Community health needs for each Valley Health hospital were identified by collecting and analyzing data and information from primary and secondary data sources. Primary data sources included a community health survey, key informant interviews and community response sessions. Demographic, economic, and health data was gathered for the Valley Health service area. Valley Health's internal data was supplemented by data from other governmental and industry sources. The principal findings of recent health assessments conducted by other organizations were reviewed as well.

3. **Analyze Data**
   In July and August 2022, Valley Health led a facilitated process with leadership from each Valley Health hospital, community stakeholders and members of the Community Advisory Council, to understand key health issues identified in the 2022 Community Health Needs Assessment (CHNA). The implementation strategy planning process involved a series of work sessions, including an orientation session and review of the 2022 identified needs, an analysis of internal hospital resources, a review of evidenced-based best practices, a cataloging of potential community partners, and meetings to align the implementation strategies discussed with current planning initiatives throughout the system.

4. **System Prioritization of Community Needs**
   Through a series of over twenty work sessions conducted at all six Valley Health hospitals, priority health needs were identified and solution-driven implementation strategies were developed. The prioritized health needs were grouped into key categories, allowing for a system wide community health improvement plan for those needs that overlap in all six hospital service areas. Targeted strategies for community specific needs are presented in this report. The work group process outlined above served as a means for further understanding what community programs and resources are available and served as a forum for discussing ways to collaborate to better meet the needs identified in the Community Health Needs Assessment.

5. **Identify Resources/Community Collaboration**
   Valley Health will seek out community partners to address the prioritized health needs. This process will engage both long-standing and new, non-traditional partners in collaborative problem solving. Possible partners may include community and educational organizations, local business, housing and transportation services, and faith-based organizations. Both process and outcome measures will be tracked and reported on a quarterly basis.

The strategy team at each Valley Health hospital worked to prioritize their community's needs using the following criteria:

- Prevalence and degree of need
- Focus on equity and accessibility: understanding the presence of disparities and health issues that disproportionately affect populations by race or ethnicity
- Build on or enhances current work within the system or community and aligns with Valley Health's Strategic Plan
- Ability to demonstrate achievable and measurable outcomes
- Ability to leverage community partnerships

6. Development of Community Health Implementation Strategy Plan

The Implementation Strategy Plan includes a description of identified strategies and how resources will be leveraged through collaborative partnerships across all six Valley Health hospitals. This approach allows Valley Health to leverage resources and opportunities throughout the organization and has the ability to affect change across multiple communities. The collaborative approach enhances Valley Health's ability to address complex needs and engages leaders from marketing, behavioral health, information systems, data analytics, patient experience, care coordination, the medical group, ambulatory services, and EPIC.

To evolve the Implementation Strategy Plan, Valley Health's leaders will align the prioritized needs with best practice models and available resources and define action steps, timelines, and potential partners. The team will continue to focus on health equity to understand the scale and severity of identified needs and their impact on the most vulnerable populations. The identified implementation strategies will utilize system and local resources to improve health for the community with intentional focus on our low-income, underserved, and uninsured populations. Valley Health is approaching these strategies by identifying the drivers behind the health and well-being of our patients throughout the entire patient experience. This focus requires developing strategies that include the social, economic and environmental roots of well-being that are evident at the community level as well as health issues identified in our clinics and hospitals.

7. Plan for Monitoring Progress

Each hospital plan specifies the goals and objectives for addressing the prioritized community health needs. Additionally, each plan identifies the actions to be taken, collaborations that will be instituted, the resources required, and the measures of success. Hospital leadership and the Community Advisory Council will utilize a dashboard with specific measures to gauge progress throughout the three-year duration. The CAC will meet on a quarterly basis to assess progress and make adjustments as required.

8. Board Adoption and Public Availability of the Community Health Needs Assessment/ Community Health Implementation Strategy Plan

The Community Advisory Council that includes Valley Health Board of Trustees representation was engaged throughout the Community Health Needs Assessment process by reviewing progress, providing feedback and endorsing the resulting work product. The Valley Health Board of Trustees adopted the Community Health Needs Assessment final report on December 13, 2022 and the Implementation Strategy Plan report on April 11, 2023. Reports have been published electronically on the Valley Health website with hard copies available upon request at each hospital.

Definition of Prioritized Health Needs for Implementation Strategy Planning

Health needs identified during the community health needs assessment process were grouped into the following categories:

Health Needs Valley Health Will Address

1. **Health Behaviors & Chronic Disease:** Chronic diseases are typically conditions that last one year or more and require ongoing medical treatment or limit activities of daily living or both. Chronic diseases are leading drivers of health care costs and are some of the leading causes of death and disability in the United States. A lack of physical activity is a contributing factor to being overweight and obese, and is connected to a wide range of health problems and chronic diseases among all age groups. The co-occurring health problems and diseases include high cholesterol, hypertension, diabetes, heart disease, stroke, some cancers, and more.

2. **Mental Health & Substance Abuse:** Mental health includes both mental health conditions and behavioral problems. Poor mental health can cause negative outcomes for both those suffering and the people around them. It can impact children's ability to learn in school and adults' ability to be productive in the workplace and provide a stable and nurturing environment for their families. Poor mental or behavioral health frequently contributes to or exacerbates problems with physical health and illness. Substance abuse includes the use of illicit substances; misuse of legal over-the-counter and prescription medications; and abuse of alcohol and tobacco. Substance abuse affects not only substance abusers, but those around them; negatively impacting health, safety and risky behaviors, including violence and crime, adult productivity, students' ability to learn, and families' ability to function.

3. **Access to Primary, Preventive & Clinical Care:** Access to care services through a doctor's or dentist's office, clinic or other appropriate provider is an important element of a community's health care system. Access to health care services is vital to the health of the community's residents. The ability to access care is influenced by many factors including insurance coverage and the ability to afford services, the availability and location of health care providers, understanding where to find services when needed, and reliable personal or public transportation. Place-based solutions bring care to the patient either near or where they reside.

4. **Social & Economic Factors:** Income levels, employment and economic self-sufficiency are all considered social determinants of health and correlate with the prevalence of a range of health problems. People with lower incomes or who are unemployed and underemployed are less likely to have health insurance and are less able to afford out of pocket health care and housing related expenses. Lower income is associated with increased difficulties such as securing reliable transportation for medical care or the ability to purchase an adequate quantity of healthy, fresh food on a regular basis.

Needs Valley Health Will Not Directly Address

No healthcare organization can address all of the health needs present in its community. Valley Health and each of its hospitals are committed to serving the community by adhering to its mission, focusing on core competencies, and using limited resources strategically in order to continue to provide a range of important health care services and community benefits.

To have the greatest impact on the health and wellbeing of the community, Valley Health will be directing its limited resources to the prioritized community health needs. The Implementation Strategy Plan will not address the following identified needs:

1. **Physical Environment:** The physical environment is where individuals live and work. People interact with their physical environment every day through the air they breathe, water they drink, houses they live in, and the transportation they access. Poor physical environment can affect our ability to live long and healthy lives. Physical environment includes looking at the safety of the air and water for a community as well as examining the available transportation and housing burdens, lack of plumbing, internet, and long commutes to work.

2. **Health Outcomes:** Each year over a million people are diagnosed with cancer and the cost of cancer care continues to rise. Some cancers are preventable and there are steps that can be taken to improve the quality of life for cancer survivors and detect cancers in the early and treatable phase. Some risk factors can be reduced to prevent certain types of cancer. Smoking, exposure to the sun and tanning beds, obesity, and excessive alcohol use are all examples of risk factors, which put a person at high risk for developing cancer. Premature death is a long-term health outcome, the effects on which might not be realized until years after a program or policy is implemented. Motor vehicle crashes are one of the leading causes of death in the United States and the lifetime economic costs can be enormous.

3. **Maternal and Child Health:** Maternal and child health indicators, including teen pregnancy and infant mortality, should be considered when evaluating the health of a community. The rate of teen pregnancy is an important health statistic in any community for reasons that include concerns for the health of the mother and child, the financial and emotional ability of the mother to care for the child, and the ability of the mother to complete her secondary education and earn a living.

While these needs are not specifically addressed in the Implementation Strategy Plan, existing Valley Health programs and services impact these areas. Although not ideally suited to be the lead organization in addressing all of the health needs identified by the CHNA, Valley Health will continue to collaborate with community organizations that are more closely aligned and suited to have an impact on these issues.

Prioritized Health Need #1: Health Behaviors and Chronic Disease

Key Findings

- Berkeley, Jefferson, Mineral and Morgan counties reported higher percentages of excessive drinking than the state average of 15 percent.
- Alcohol-impaired driving deaths were reported higher than state averages Berkeley, Hampshire, and Morgan counties in West Virginia.
- Teen birth rates were higher in Grant, Hampshire, and Hardy counties than the West Virginia state average.
- In West Virginia, Berkeley and Morgan counties reported higher percentages of excessive drinking than the West Virginia average of 15 percent.
- Alcohol-impaired driving deaths were reported higher than state averages for Berkeley, Hampshire, and Morgan counties in West Virginia.
- Mortality due to cancer, heart disease, chronic lower respiratory diseases, nephritis and nephrosis, influenza and pneumonia, and suicide rates were greater than West Virginia and national averages.
- Berkeley, Hampshire, Mineral and Morgan counties reported unintentional-injury related mortality at a higher rate than both the West Virginia and national averages for that cohort.
- Berkeley, Hampshire and Morgan County residents experienced cancer mortality rates higher than the West Virginia and national averages for colorectal cancer, and for lung and bronchus. Berkeley and Mineral counties showed the highest rates for breast cancer in War Memorial's community.
- Commenting on the contributing factors to poor health status, interview participants mentioned nutrition and diet, low physical activity and exercise, and food insecurity. Many commented on the lack of affordable, healthy food choices in some parts of the community.

Strategy #1: Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

Hospital-based Metrics

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)
- Increase in the number of residency site rotations. (2024-2025)

Community-based Partnership Metrics

- Good Samaritan Health Clinic: Establish additional clinics for nurse education & patient follow-up with increased patient learning about chronic disease management (2023-2024)

Strategy #2: Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

Hospital-based Metrics

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

Strategy #3: Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

Hospital-based Metrics

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

Prioritized Health Need #2: Mental Health and Substance Abuse

Key Findings

- Jefferson, Mineral and Morgan counties reported higher percentages of excessive drinking that the state average of 15 percent.
- In War Memorial's community, all counties are designated as a Medically Underserved Area (MUA), or Medically Underserved Population (MUP). Morgan County reported shortages in all three categories for dental, mental, and primary care services.
- Mental and behavioral health was mentioned as a health status issue by key informants. Interviewees generally reported that the community's mental health needs have grown, while the mental health service capacity has not. Lack of available resources was reported.
- The major concern mentioned by key informants was the need for more providers to care for adults and children with mental and behavioral health issues. Many children are transported out of the community for services.
- Another concern mentioned by key informants was the inability to connect patients with services needed. Wait times for patients to see a clinician are very long, especially for a specialist.
- Alcohol-impaired driving deaths were reported higher than state averages for Berkeley, Hampshire, and Morgan counties in West Virginia.
- Substance abuse was a major concern and mentioned frequently by key informant interview participants. It was portrayed as a growing and serious issue within the community.
- Survey respondents reported substance abuse and mental health as the top most identified health issues for the War Memorial community.

Strategy #1: Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

Hospital-based Metrics

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)

Community-based Partnership Metrics

- Community Health Impact Partner | Morgan County Partnership
  - Provide substance abuse education, SBIRT screenings, and prevention interventions for youth in Morgan County (2023-2024)
  - Provide onsite mental health services and document improvements for children in Morgan County Public Schools (2023-2024)

Strategy #2: Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

Hospital-based Metrics

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

Strategy #3: Establish a behavioral health integration model within the primary care settings with the support of mental health professionals and psychiatric provider consultation as part of a **Behavioral Health Continuum**.

Hospital-based Metrics

- Connect primary care practices with psychiatric consultation capabilities. (2024-2025)
- Establish a standardized assessment tool in practice to monitor patient progress (24 Clinics). (2024-2025)
- Staff will complete psychological safety training as part of annual mandatory review coursework. (2023-2025)

Strategy #4: Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

Hospital-based Metrics

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

Prioritized Health Need #3: Access to Primary, Preventative, Clinical Care

Key Findings

- The War Memorial community is experiencing lower ratio rates when it comes to the number of primary care physicians per 100,000 populations, number of dentists available within the region: in addition, there is a great need for mental health providers in Hampshire and Morgan counties.
- Primary care physician rates are below West Virginia averages for Hampshire County.
- Access to basic medical care was identified by a vast number of interviewees as an issue. Interviewees indicated that some residents rely on the emergency department as their primary care physician.
- Berkeley, Hampshire, and Morgan counties in West Virginia had uninsured population percentages higher than the West Virginia state average of 5.9%.
- West Virginia's leaders opted to expand Medicaid under the Affordable Care Act (ACA) starting on January 1, 2014, providing coverage to low-income adults, most of whom have jobs but no option for employer-sponsored health insurance. As of May 2022, West Virginia has enrolled 622,788 individuals in Medicaid and CHIP — a net increase of 75.7% since the first Marketplace Open Enrollment Period.
- In WV, the uninsured rate decreased from 6.5 percent to 5.9 percent, and in VA there was a decrease from 9.9 percent to 8.4 percent during the reporting period. Medicaid expansion was adopted for WV counties.
- Berkeley County reported higher flu vaccination rates than the state average of 42 percent in West Virginia.
- Concerns about access to care were the most frequently mentioned factor contributing to poor health, as well as the need for specialty care in key informant interviews.
- Lack of accessible or reliable transportation to health care appointments and a lack of providers who accept new Medicaid and even Medicare patients were the most frequently mentioned specific access to care issues in interviews, especially for low-income individuals and senior citizens.

Strategy #1: Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

Hospital-based Metrics

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)
- Increase in the number of residency site rotations. (2024-2025)

Community-based Partnership Metrics

- Mission Critical Partner | Good Samaritan Free Health Clinic
  - Establish two additional clinics for nurse education & follow-up with increased learning about chronic disease management (2023-2024)
  - Define GSFHC population through use of demographic reporting derived from EMR data (2023-2024)

Strategy #2: Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

Hospital-based Metrics

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

Strategy #3: Establish a behavioral health integration model within the primary care settings with the support of mental health professionals and psychiatric provider consultation as part of a **Behavioral Health Continuum**.

Hospital-based Metrics

- Connect primary care practices with psychiatric consultation capabilities. (2024-2025)
- Establish a standardized assessment tool in practice to monitor patient progress (24 Clinics). (2024-2025)
- Staff will complete psychological safety training as part of annual mandatory review coursework. (2023-2025)

Community-based Partnership Metrics

- Community Health Improvement Partner | Morgan County Partnership
  - Provide substance abuse education, SBIRT screenings, and prevention interventions for youth in MCOPS (2023-2024)
  - Provide mental health services and document improvements for children in Morgan County Public Schools (2023-2024)

Strategy #4: Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

Hospital-based Metrics

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

Prioritized Health Need #4: Social & Economic Factors

Key Findings

- Hampshire and Morgan counties in West Virginia had higher percentages of non-graduates than the state average of 13.8 percent. Berkeley County had the highest percentage of residents who completed a college degree than the state average of 29.1 percent.
- Within the War Memorial community, unemployment rates have decreased in every county for 2017. The most significant decrease in unemployment rates were reported in

both Hampshire County at 0.9 percent, a decrease of 1.1 percent, and Morgan County at 6.1 percent, a decrease of 0.9 percent from the 2016 rate.

- Participants in interviews believe that a lack of low income housing and poverty were the top issues contributing to poor health status and limited care. Other income-related factors include difficulty with securing transportation to medical appointments and homelessness.
- Berkeley and Mineral counties reported the highest percentage of students completing high school.
- Poverty rates were higher than the national average for Hampshire County at 16.9 percent.
- There was a higher percent of children reported in poverty for Berkeley in War Memorial's community.
- Children in single households were reported higher for Mineral County.
- Unemployment rates were shown for December 2019-July 2022. Post-pandemic unemployment rates are higher than pre-pandemic rates across all counties in our region with the exception of Page County.
- Morgan County reported the highest violent crime rates for War Memorial's community.
- In the survey, low income and financial challenges were reported. For survey respondents who reported not being able to get the care they needed, affordability and lack of insurance coverage were the reasons most frequently mentioned.

Strategy #1: Develop Community Collaborations to address disparities involving social determinants of health and health equity.

Hospital-based Metrics

- Increase in collaborative community relationships (2023-2025)

Community-based Partnership Metrics

- Mission Critical Partner | Good Samaritan Free Clinic
  Define GSFHC population through use of demographic reporting derived from EMR data (2023-2024)