Behavioral Health Primary Care Service Line

Behavioral Health for patients with Diabetes:

Year 1 - Calculate a baseline for patients with diabetes and an A1c greater than 10 seen at Family Medicine Center - Northwood. Track the number of those referred for a behavioral visit.

Year 2 - Add an additional therapist once funding streams have verified payment for Family Medicine Center – South. Track the number of those referred for a behavioral visit.

Year 3 – Offer behavior health referrals for patients who indicate a desire to quit smoking.

Additional Staff for Behavior Health:

Year 1 - Research and prepare to hire one additional masters prepared therapist

Year 2 - Determine the success of those with high A1c's and desire to stop smoking

Year 3 - Add a third masters prepared therapist and continue to monitor cessation rates

Intensive Outpatient Program (IOP) Exploration:

Year 1 - Investigate and gather data and proforma to potentially add an outpatient substance use program, including groups and individual therapy to support the MAT (Medication Assisted Treatment) Clinic program

Year 2 – Based on data and capacity, add an IOP Program

Year 3 - Utilize data from the MAT clinic and first year operation of IOP Program to determine efficiencies and money saved. Evaluate effectiveness of IOP, MAT, and group sessions for whole person wellness

Behavioral Health for patients with Weight Management:

Year 1 - Work with Resident Weight Management Program by adding and tracking behavior health referrals and consultations

Year 2 - Increase the number of patients referred to from the Resident Weight Management Program for Behavior Health by 10%

Year 3 – Track success of interventions by utilizing Resident Weight Management Program data

Healthy Hearts Cardiovascular and Emergency Service Lines

MH Inpatient Plans

- Educate and validate successful return demonstration of 90% of inpatient staff on basics of obtaining a BP including proper placement and proper cuff size.
- Educate 90% of staff on BP result guidelines and when to refer.
- Educate patients regarding proper BP cuff size and placement.
- Review with patient risk factors for cardiovascular disease.

Year 1 – will show a 20% increase of patients presenting with severely elevated BP (≥180/110) will have receive appropriate treatment or medication adjustment.
Measure: last recorded BP of DC to home – percentage receiving intervention

Years 2 & 3 – will show a 20% increase of patients presenting with severely elevated BP (≥180/110) will have receive appropriate treatment or medication adjustment.
Measure: last recorded BP of DC to home – percentage receiving intervention

MH Outpatient Plans

- Educate and validate successful return demonstration of 90% of outpatient staff (ED, Urgent Care, provider offices, etc. on basics of obtaining a BP including proper placement and proper cuff size.
- Educate 90% of staff on BP result guidelines and when to refer.
- Educate patients regarding proper BP cuff size and placement.
- Review with patient risk factors for cardiovascular disease.

MH Community Outreach Plans

- Second Harvest Food Bank: provide education during blood pressure screenings regarding proper BP cuff placement and size.
- Provide information on risk factors for cardiovascular disease
- Measure: number of contacts

Year 1 – will show a 20% increase of patients presenting with severely elevated BP (≥180/110) will have receive appropriate treatment or medication adjustment.
Measure: last recorded BP of DC to home – percentage receiving intervention

Years 2 & 3 – will show a 20% increase of patients presenting with severely elevated BP (≥180/110) will have receive appropriate treatment or medication adjustment.
Measure: last recorded BP of DC to home – percentage receiving intervention

Community Collaboration

- Educate Parish Nurses and Bridges to Health employees on the basics of obtaining a BP including proper placement and proper cuff size.

Measure: number of competent staff

- Through Outreach programs, if elevated BP noted, required information will be obtained to make a follow-up appointment with Primary Care Practices.

Measure: follow-up completed.

Marion Health Outpatient Pharmacy

Year 3 - Outpatient Pharmacy implementation

- Bedside medication delivery program. Outpatient pharmacy can bring medications prior to discharge. Ensures medications are picked up and counseled appropriately
    - Track reduction of readmissions with the same condition.
- Getting Primary Care and outpatient providers enrolled in 340B as child sites
    - Allows pharmacy to provide medications at reduced cost for uninsured and underinsured community members
        - Measure # of RX filled under the 340B plan name

    - Measure % of providers 340B eligible
- Pharmacy can collaborate with local health centers- IHC, Meridian Health, and Bridges. Refer community members to any of these resources for reduced or free treatment. Refer to Meridian for dental, IHC for low-cost Dr clinics, Bridges2 Health for free medications
    - Track # of referrals
- Create an income-based patient assistance program, can give medications at no cost after applying and approved
    - # enrolled in patient assistance
- Having low-cost OTC naloxone for sale at the outpatient. Most insurance will not cover naloxone, and we want to provide this for the community at low cost. The pharmacist will educate on the proper technique and how to use naloxone as well.
    - # sold
- Utilizing the community foundation. Setting up a set # free flu shot vouchers for uninsured patients the hospital would be willing to administer—> could add in other vaccines like PNA or shingles if we wanted, or RSV for uninsured pregnant women from September through February months
    - # vaccines given with foundation donation

Tobacco/Nicotine Prevention

Year 1:

- Contact schools in Blackford and Jay counties for introductions and class presentations.
- Begin introductions and offer services (event tabling, presentations) to organizations within Blackford and Jay counties.
- Invite new connections to coalition meetings.
- Reconnect with schools and organizations for continued presentations, events, and coalition meetings.
- Create HUB commercial for a tobacco/nicotine-focused event (No Menthol Sunday, Great American Smoke Out, etc.)
- Create an incentivized survey on thoughts about tobacco/nicotine for MH employees.
- Presentation on tobacco/nicotine education and terminology for medical staff.
- Collaborate with Family Birthing on resources, education, and follow-up services.
- End-of-year survey for those who participated in presentations (i.e., teachers who allowed me to present, school admin, etc.)

Year 2:

- Engage in summer and back-to-school activities for Grant, Blackford, and Jay Counties.
- Offer no-smoking area signage to businesses and organizations.
- Educational table for Nurses or Hospital week with drawing offer.
- Connecting with businesses about interests in signage for no-smoking and disposal units.

Year 3:

- Contact the Mayor (or whoever is relevant) to discuss placing more signage and/or disposal units around the community.
- Anti-Vape Billboard contests for all three counties.
- Coloring Contest for all three counties
- Use older youth to help educate younger students in a presentation form.

Diabetes Chronic Disease Service Line

Years 1 - 3 MH Inpatient Plans

- Increase the number of patients seen by the Diabetic Educator or team with A1C >8 and/or requiring insulin teaching by 5%
- Review and provide education for staff regarding diabetes and treatment – a minimum of 3x
- Increase Diabetes Nurse Resource Team and develop more opportunities for them to assist with education. As resources are available
- Monitor hyperglycemia and hypoglycemia per Centers for Medicare and Medicaid Service guidelines and implement process to stay within guidelines.
- Explore partnership with Residency program for rotation in Diabetes Education to strengthen diabetes knowledge and confidence with multidisciplinary rounding
- Provide education to all staff regarding insulin pumps.
- Improve education provided to new staff during on-boarding process.

Years 1 -3 MH Outpatient Plans

- Monitor number of referrals for diabetes education vs those who attend and complete classes.
- Explore and develop new plan for diabetes education to better meet the needs of patients.
- Increase the referrals from providers.
- Increase Primary Care Providers awareness and comfort with Omnipod insulin pumps.
- Expand staffing in the Diabetes Education office to allow for better monitoring and tracking of patient data.
- Explore and develop telehealth or video option for diabetes education for those who have transportation issues or are unable to attend in person.

Years 1 – 3 MH Community Outreach

- Provide annual diabetic education to parish nursing and community-based nurses.
- Attend Second Harvest event or other public event as they are available
- Explore opportunities with school nurses and/or local camps for diabetes education.

Years 1 – 3 MH Community Collaborations

- Collaborate with Bridges to Health to improve relationship.
- Offer education to Bridges to Health office/staff/patients twice a year.

- Work with Marion Health inpatient/outpatient pharmacy to assist with prescriptions on discharge.

Maternal Child/Great Beginnings Service Line

Targeted Focus Areas:

- Access to Care: Identifying care deserts for prenatal care, transportation barriers, and insurance disparities.
- Maternal Health/Equity: Addressing disparities in pregnancy-related issues, prenatal care education, prenatal vitamins and mental health support.
- Social Determinants**:** Addressing socioeconomic factors affecting infant nutrition, safe housing, and postpartum support.

Community Collaboration:

- Remote Patient Monitoring
- Work with Indiana Health Center pregnant patients
- Increase prenatal care in underserved areas
- Enhance breastfeeding support. – will offer services through the lactation station at community events

Year 1

- Remote Patient Monitoring - 20% of pregnant patients who are hypertensive will receive remote patient monitoring
- Enhanced breastfeeding support. – will offer services through the lactation station at a minimum of six community events
- Prenatal vitamins will be given to all women coming to the OBGYN office or FBC for pregnancy testing and testing positive – monitor for 100% compliance
- We continue to provide pediatric support – by continuing a pediatric in-patient department.

Year 2

- Remote Patient Monitoring - 40% of pregnant patients who are hypertensive will receive remote patient monitoring
- Will provide education to community organizations to expand remote monitor services and prenatal education
- Enhanced breastfeeding support - will increase by 10% services offered through the lactation station at community events
- Will increase by a minimum of 10% participation in community events and education about services
- Will analyze maternal mortality rates, infant mortality, access to prenatal care, neonatal intensive care unit (NICU) statistics, and birth outcomes of those patients receiving prenatal vitamins at pregnancy testing.
- We continue to provide pediatric support – by continuing a pediatric in-patient department.

Year 3

- Remote Patient Monitoring - 92% of pregnant patients who are hypertensive will receive remote patient monitoring
- Patients in need of blood pressure medications will be provided medications prior to dismissal.
- Will increase by a minimum of 20% participation in community events and education about services
- Enhanced breastfeeding support - will increase by 20% services offered through the lactation station at community events
- Will analyze maternal mortality rates, infant mortality, access to prenatal care, neonatal intensive care unit (NICU) statistics, and birth outcomes of those patients receiving prenatal vitamins at pregnancy testing.
- We continue to provide pediatric support – by continuing a pediatric in-patient department.

All service lines included in the Implementation Plan
are heavily involved with the Indiana Rural Health Association Region 5 Initiatives for improving health.