Implementation Plan for Health Improvement: 2023 – 2026

Marion General Hospital DBA Marion Health understands the importance and necessity of positively transforming the health of the community we serve. We wholeheartedly embrace the opportunities to do so. Determining the health care needs of rural areas such as ours can be difficult. To facilitate community health improvement a Community Benefit Team was created. Comprised of Marion Health, community leaders, we partnered with Indiana Rural Health Association to utilize various needs assessment tools to obtain the necessary primary and secondary data critical to conducting a complex and inclusive data representation of our population. The Community Benefit Team utilized many resource including , Community Health Profile, County Health Rankings and Roadmaps www.countyhealthrankings.org, US and Indiana Census data www.census.gov/quickfacts/fact/table/grantcountyindiana/PST045218, CDC www.cdc.gov , State Department of Health www.in.gov/isdh/, CMS website links www.cms.gov , Community Health Needs Assessment (CHNA) | Hospital in Marion, IN (marionhealth.com) and additional local organizational data to evaluate and create a multi-year strategy to improve health outcomes in our community.

Marion Health has, and is committed to provide the expertise, manpower, and funds to ensure the goal of transforming the health of the community is met.

Implementation Plan

Six areas emerged that were identified in the data: additional interventions, resources, monitoring and education will be focused on the identified areas.

1. Diabetes
2. Nutrition, weight control, and exercise
3. Lung Disease including nicotine prevention and cessation
4. Substance Use Disorder including alcohol, tobacco, opioids, etc.
5. Heart Health
6. Dental Health including low-cost dental care partnerships and primary prevention

A two-pronged community-wide plan was developed:

1. **C**ommunity **E**ducation, **A**wareness, **S**upport and **E**mpowerment (**CEASE**)
2. **I**n **C**ommunity **R**esources, **E**ducation, **A**ssessments, **S**upport and **E**mpowerment (**InCREASE**)

CEASE: Diabetes – 2023-2026

CEASE: Community Education, Community Assessment, Community Support, Community Empowerment

MGH Inpatient Plans	MGH Outpatient Plans	MGH Community Outreach Plans	Community Collaborations Plans
Year 1 1. Review diabetic teaching screen with nursing staff by diabetic educator each year. (Diabetes staff) 2. Increase self-foot check instructions for inpatients admitted with diabetes dx by 5%. (Diabetes Education team) 3. Increase the use of the diabetic teaching tools in the EMR (i.e., foot care, HgbA1c, eye care) by 5%. (Diabetes staff) 4. Determine baseline for diabetic assessments, then increase use by 5%. (IT, Diabetes Team) 5. Utilize one LEAN event to evaluate and improve communications between discharge team, diabetic education staff, primary care office staff, and PACT. (LEAN Team, MH staff) 6. Increase the number of patients seen by the diabetic educator team whose A1C results are above 8 by 3%. (MH providers) 7. Continue Diabetic Quality Management Team reviewing data quarterly. (Diabetes Team) 8. Hire two community health workers to bridge inpatient and outpatient continuum of care for clients with chronic diseases. (Chronic Care Management {CCM} team) 9. Start with baseline of zero for the new Chronic Care Management team increasing inpatient referrals to the program by 20%. (AD of CCM)	**Year 1** 1. Develop and staff a Chronic Care Management (MH Administration) 2. Increase quality measure for HgbA1c > 9 by 3%. (Diabetes Team) 3. Add additional information about diabetes quality measures and tools for on-boarding new PCP providers. (NEO staff) 4. Increase health education for patients with adult kidney disease, diabetes, and high blood pressure by 10%. (MH Staff) 5. Strengthen referral process to dieticians/diabetic team for clients from VAMC, IHC, Meridian, and Optum Network. (Discharge Planners) 5. Continue Lunch and Learn for primary care nursing staff 1- 2 x per year by the dietician/diabetic and chronic care teams 6. Increase formal Diabetes Education Program with provider referral by 5%. 7. Utilize CHW's to evaluate and provide resources to reduce no shows or those not accepting the education program as described in #6. (CCM staff) 8. Increase self-foot check instruction by 5% for patients with diabetes dx providing monofilaments for teaching purposes. (Diabetes Team, IT, PCP Offices) 9. Provide visual tools for health education to re-enforce information in outpatient clinics – Heart Failure, Wound Clinic, Pulmonary Rehab, Cardiac Rehab, Diabetic Program, and Nutritional Services. (Community Outreach)	**Year 1** 1. Provide annual diabetic educational event for parishioners/families dealing with diabetes through the parish nurse program. (Community Outreach, Parish Nursing, Diabetes Team) 2. Offer continuing education for parish nurses and community-based nurses to maintain current standard of care for individuals with diabetes per ADA. (Diabetes Educator, Parish Nurse Program) 3. Highlight current standard of care within MH social media platforms quarterly for clients and families dealing with issues re: diabetes. (Community Outreach) 4. Offer educational info during annual Health Expo. (Community Outreach, MH staff) 5. Provide Lunch and Learn with School nurses re: current standard of care and educational resources 2 x per year. (Community Outreach)	**Year 1** 1. Collaborate with IHC Migrant Camp staff to support diabetes education, monitoring, and support with MH resources. (Community Outreach) 2. Provide health education resources to community agencies annually. (Community Outreach) 3. Offer ongoing education, support, and resources for school nurses and school social workers 1-3 x per year. (Community Outreach) 4. Work with Minority Health Coalition staff to provide and teach self-foot education, eye screenings, and HgbA1c screening annually. (Community Outreach) 5. Collaborate with Bridges to Heath staff for referrals to formal diabetes education at MH. (Community Outreach, Diabetes Team, BTH) 6. Provide visual tools for health education to re-enforce information in outpatient non-MH clinics including VAMC, IHC, Optum, and Meridian. (Community Outreach)

CEASE: Diabetes – 2023-2026 Cont'd.

MGH Inpatient Plans	MGH Outpatient Plans	MGH Community Outreach Plans	Community Collaborations Plans
Years 2 & 3 1. Assess and provide educational resource packets for the ED and discharge planning related to community resources for medication assistance. (BTH Pathway to Medications) 2. Develop a referral/contact process for the CHW (Community Health Worker) in the Chronic Care Management and CHWs in other community settings for support and networking (Bridges to Health, IHC, Meridian, etc.) 2. Empower CHW team to compile and keep up to date a list of the least expensive diabetic medications and supplies through area retailers. (Community Outreach) 3. Offer one 10-minute video and/or education for physicians on social care variables related to many patients in Grant County with diabetes. (David Russell) 4. Provide access and education for PCP office staff for the Asset map and other community resource options. (Community Outreach)	**Years 2 & 3** 1. Track and encourage Medicare Wellness Visits with attention to chronic disease (diabetes) determining Baseline then increase by 10%. (MH Diabetes Team) 2. Evaluate and present quality measure for poor HgbA1c control to determine further interventions needed within primary care practices 1-2x per year. (MH IT, Diabetes Team) 3. Encourage PCP to address diabetic FU with each visit. (David Russell) 4. Do a LEAN event to work with PCP to increase community education and support programs. (LEAN Team) 5. Work with Administration and PCP Director to monitor to make recommendations about ACO measures. (David Russell) 6. Evaluate (through (Diabetic Team) interventions for disease management for adult kidney disease with co-morbidities of diabetes and blood high blood pressure by 5% 3. (Diabetes Team) 7. Continue Lunch and Learn or other educational formats for primary care nursing staff 1-2 x per year. (Diabetes Team, MH Providers) 8. Increase diabetic teaching re-enforced in the outpatient clinics by 5% over last year. (MH Providers, Diabetes Team	**Years 2 &3** 1. Support diabetic screenings and education with the parish nurses and partnering congregations. (PN Staff, Community Outreach) 2. Partner with American Kidney Foundation to provide one KEEP Kidney screening. (Community Outreach) 3. Determine baseline with referral process to the PCP and or the chronic disease clinic when completing education events in the community. (MH staff) 4. Provide visual tools for diabetic teaching for non-MH clinics and PCP. (Community Outreach)	**Years 2 & 3** 1. Work with Indiana Health Center, Grant County Health Department, Optum, IWU Health Center, Bridges to Health, and Purdue Extension annually to provide and teach self-foot care and HgbA1c screening throughout Grant County. (Community Outreach)

The goal is to reduce risk factors for Type 2 diabetes and provide the tools for those with Type 2 diabetes to have healthier lives

INCREASE: Healthy Eating 2023 - 2026

INCREASE – In Community Resources, Community Education, Community Assessment, Community Support, Community Empowerment

MGH Inpatient Plans	MGH Outpatient Plans	MGH Community Outreach Plans	Community Collaborations Plans
Year 1 1. Provide patient education on risks of overweight and obesity as related to burden of chronic diseases. (Nutritional Team) 2. Research process for developing a "Healthy Weight Resource Team" to support high risk patients. (MH staff, Community Health Workers {CHW}, Nutritional Team) 4. Provide support and on-line resources for staff caring for overweight and obese patients. (MH Education, Nutrition Team) 5. Track number of patients with high BMI to provide additional data for future program interventions. (MH IT) 6. Explore opportunity to temporarily provide healthy foods for patients who are discharged from the hospital to home on a new or extensive therapeutic diet. (Nutrition Team) 7. Offer referral options for bariatric intervention. (Bariatric Team)	**Year 1** 1. Develop a flag system with alert for elevated BMI for outpatient primary care visits through ECW Population Health. (David Russell) 2. Lunch and Learn to physician office staff to reduce stigma in caring for overweight and obese patients. (Nutrition and Bariatric Team) 3. Provide practice education in caring for patients considering bariatric procedures with stigma reduction. (Bariatric Team) 4. Explore opportunity to temporarily provide healthy foods for patients who are living at home on a new or extensive therapeutic diet. (Nutrition Team) 5. Provide Primary care offices info on food pantry locations with best options for healthier less expensive food choices. (Social Services and Community Outreach) 6. Provide information and guidance to PCP re: food as Medicine. (Nutrition Team) 7. Explore malnutrition and food dessert resources. (Nutrition Team and Community Outreach)	**Year 1** 1. Educate within community of bariatric procedure processes 2x per year. (Bariatric Team, Nutrition Team) 2. Promote current weight loss & exercise programs available through Community Outreach, PN and community education series. 3. Provide variety of nutrition education for every community outreach event during summer months. (Community Outreach) 4. Parish Nurse Program will provide Potty Posts and congregational education support for healthy eating. (Community Outreach, PN Program) 5. Promote Real Appeal Program and YMCA membership to MH Employees. (MH HR) 6. Participate in Connections IN Health and IDOH programs including Cardiovascular and Diabetes Coalition of Indiana and Hoosier Health and Wellness Alliance. (Community Outreach)	**Year 1** 1. Offer educational programs and resources to local agencies including the recovery community, transitional housing, Boys & Girls Club, Women's Shelter, Migrant Camps thought IHC, and patients in treatment for mental health. (Community Outreach) 2. Partner with Purdue Extension to promote active community collaboration about healthy eating. (Community Outreach) 3. Provide and maintain Mobile Kitchen for check out by community members and organizations. (Community Outreach and Diabetes Team)

INCREASE: Healthy Eating 2023-2026 (Cont.)

MGH Inpatient Plans	MGH Outpatient Plans	MGH Community Outreach Plans	Community Collaborations Plans
Year 2 1. Implement a Healthy Weight team to work with patients and staff to address healthy eating choices and preparation including Chronic Care Management team. (Nutrition Department) 2. Provide in-service education about eating disorders to inpatient staff. (Nutrition Department) 3. Update nursing unit staff on current bariatric procedures and benefits. (Bariatric Team)	**Year 2** 1. Develop a nutrition education packet to be used in 50% of provider offices for those with food insecurity or other food inequity. (Nutrition Department) 2. Create E-blast for physician office staff about caring for patients who have an eating disorder or other identified nutritional interest or need. (Nutrition Department) 3. Determine a baseline for nutrition services referrals for healthy eating education in 2-3 offices through ECW population health. (David Russell) 5. Equip lactation consultants on the role that breastfeeding provides for healthy eating and weight control. (FBC)	**Year 2** 1. Offer evidence-based practice resources for weight management, eating disorders, and/or bariatric interventions through the PN Program and Community Outreach events. (Nutrition Department, Community Outreach) 2. Work with Purdue Extension, MH Nutritional Team, and University students to identify the healthiest nutrition options and combinations when using local food pantries. (Nutrition Department, Students, Chronic Care Management team, Community Outreach) 3. Lunch and learn on eating disorders and stigma reduction associated with obesity to the Parish Nursing group. (Nutrition Department, Community Outreach)	**Year 2** 1. Explore access to a best practice youth orientated healthy eating program for adolescents and teens. (Nutrition Department) 2. Partner with Purdue Extension to assist with resources and special speakers for schools and community programs. (Community Outreach) 3. Offer the mobile kitchen to the community for cooking classes and food demos. (Community Outreach)
Year 3 1. Provide in-service education regarding current nutrition and fad diets. (Nutrition Department and Education Department) 2. Continue Years 1 & 2 activities	**Year 3** 1. Provide in-service education regarding current nutrition and fad diets. (Nutrition Department and Education Department) 2. Continue Years 1 & 2 activities	**Year 3** 1. Provide in-service education regarding current nutrition and fad diets to the PN participants and other community groups. (Nutrition Department, Community Outreach, and Education Department) 2. Continue Years 1 & 2 activities	**Year 3** 1. Continue Years 1 & 2 activities.

Goal: Provide opportunities for Grant County residents to have a healthier diet through education, empowerment, and resources

CEASE: Chronic Lung Diseases 2023-2026

CEASE: Community Education, Community Assessment, Community Support, Community Empowerment

MGH Inpatient Plans	MGH Outpatient Plans	MGH Community Outreach Plans	Community Collaborations Plans
Year 1 1. Continue to 1. 800.QUIT Now and EMR data related to identifying 'smoking status'. (Tobacco Treatment Specialist, Chronic Care Management team, PACT Team) 2. Upon discharge, all current nicotine users who desire to quit or reduce receive 1.800 QUIT NOW referral. (MH nursing and provider staff, Tobacco Treatment Specialist {TSS}) 3. All current nicotine users will recieve1.800 QUIT NOW Line information. (MH nursing and provider staff, TTS) 4. All CCD, Med Surg inpatients who identify as nicotine users are referred to the Tobacco Treatment Specialist. (MH Providers) 5. Upon discharge, cessation medication will be available to eligible patients. ((MH nursing and provider staff, TSS) 6. Provide respiratory care with visual teaching tools for Asthma. (Community Outreach) 7. Provide ongoing LEAN events to increase awareness and evidence-based practice. (LEAN team)	**Year 1** 1. Provide Lunch and Learn for 1. 800.QUIT now resources for providers and physician practices (TPC Coordinator) 2. MD/NPs use the 1. 800.QUIT Now referral/resources with TPC program for each nicotine user. (Breathe Easy Tobacco Coordinator) 3. Provide one-on-one preventative care/screening and cessation interventions with each visit for current nicotine users through ECW. (MH Providers and nursing) 4. Promote lung screenings tracking number of screenings and number of referrals from the screening (IT Department) 5. Provide education about lung disease to Wound Clinic, Cardiac Rehab, Chronic Care Management clinic and Heart Failure Clinic. (MH staff) 6. Promote lung screenings (Provider and Office staff)	**Year 1** 1. Promote use of 1. 800.QUIT now phone/Text line (Breathe Easy) 2. Refer to available smoking cessation programs. (Breathe Easy Coordinator) 3. Examine all school policies related to nicotine use on campus. (Breathe Easy Coordinator) 4. PN Lunch to include 1. 800.QUIT Now. (Breathe Easy Coordinator) 5. Parish nursing Potty Posts 2X this year on nicotine use/substance use. (PN Program, Breathe Easy) 6. Community Outreach nursing activities to include tobacco/nicotine related education and 1. 800.QUIT now in ten programs this year. (Breathe Easy Coordinator and Community outreach staff) 7. Education regarding 'Point of Sale' tobacco advertising to increase public awareness. (Tobacco Coalition) 8. Promote lung screenings. 9. Assist Breathe Easy Program 10. Train additional staff for Spirometer screenings (Respiratory Therapy)	**Year 1** **1.** Prioritize greatest areas of impact for community usage of nicotine adding tobacco policy signs if needed. (Breathe Easy Coordinator) **2.** Information to area companies/businesses for employees and clients to use 1. 800.QUIT now resources. (Breathe Easy Coordinator) 3. Promote lung screenings for early detection and connection to care. (Breathe Easy Coordinator, Community Outreach) 4. Increase Grant County residents using 1. 800.QUIT Now by 5%. (Breathe Easy Coordinator) 5. Assist Breathe Easy Coordinator with meeting the deliverable set by the TPC. (Community Outreach, Tobacco Coalition) 6. Provide tools for education and referral options to school nurses for students with asthma. (Community Outreach)

CEASE Chronic Lung Disease Cont.			
MGH Inpatient Plans	**MGH Outpatient Plans**	**MGH Community Outreach Plans**	**Community Collaborations Plans**
Year 2 1. All inpatients who identify as nicotine users are referred to the Tobacco Treatment Specialist. (Respiratory Therapy, Chronic Care Management team) 2. Continue LEAN QI processes annually. (LEAN Team) 3. Continue Year 1 initiatives **Year 3** 1. Provide staff in-service related to asthma health and preventative education – Education Services 2. Continue with years 1 & 2 activities. 3. Explore a LEAN project for hand-off from discharge to primary care for cessation medication and treatment. 4. Continue Years 1 & 2 initiatives	**Years 2 & 3** 1. Continue #2, #3, #4, and #5 above. 2. PCP Lunch and Learn to identify best practice related to second-hand and third hand exposure. (David Russell, Breathe Easy Coordinator) 3. E-Blasts to PCP on available medical interventions for chronic lung diseases. (David Russell) 4. Health education related to activity tolerance and medication adherence. (Pulmonary Rehab) 5. Explore hand-off from discharge to primary care for cessation medication and treatment with a LEAN event. (LEAN Team, David Russell) 6. Explore process to follow up for ED patients who express interest in quitting nicotine use. (Social Services and discharge planners)	**Years 2 & 3** 1. Continue #2, #3, #4, #8, #9, and #10 above. 2. Develop educational programs/events related to 'gateway' effect of nicotine delivery systems to additional substance use/misuse. (Community Outreach, Breathe Easy Coordinator) 3. Work with school nurses to assist in writing state recognized comprehensive policy regarding nicotine use. (Breathe Easy Coordinator) 4. Promote lung cancer prevention and early detection measuring early dx through the Cancer Registrar. (Community Outreach)	**Year 2** 1. Work with Purdue Extension for School Tobacco/nicotine education. (Breathe Easy Tobacco Coordinator) 2. Investigate smoking concerns of the Rescue Mission residents, transitional housing residents, etc. (Breathe Easy Tobacco Coordinator) **3.** Increase Grant County residents using 1. 800.QUIT Now by an additional 5%. (Breathe Easy Tobacco Coordinator) **4.** Continue with Year 1 initiatives. **Year 3** 1. Explore opportunities to collaborate with Radiant Health, Meridian Health, CMS, and IHC facilities for smoking cessation options. (Breathe Easy Tobacco Coordinator) 2. Increase Grant County residents using 1. 800.QUIT Now by an additional 5%. (Breathe Easy Coordinator) 3. Continue with Year 1 initiatives.

Goals: Increase the health and wellbeing of individuals with chronic lung disease and decrease the risk of individuals beginning to use nicotine delivery systems

CEASE: Substance Abuse 2023-2026

CEASE: Community Education, Community Assessment, Community Support, Community Empowerment

MGH Inpatient Plans	MGH Outpatient Plans	MGH Community Outreach Plans	Community Collaborations Plans
Year 1 1. Complete SUD/alcohol screenings for all inpatients on the EMR. (MH Staff) 2. Refer to social worker and CORE Plus Program per screening guidelines. (MH Staff) 3. CORE Plus Program Peer Support Specialists/Community Health Workers to follow up with referrals per guidelines. (Bridges to Health, MH Social Work, ED staff, Discharge Planners) 4. Provide CORE Peer Support Specialists/Community Health Workers through free health clinic staff to assist Discharge Planning team in addressing social determinants of health resources/interventions. (Bridges to Health)	**Year 1** 1. Update SUD/alcohol screening tools used for new appointments and wellness checks in PCP offices. (David Russell) 2. CORE Plus staff to provide info for E-Blast to PCP offices for new illicit drug trends. (Bridges to Health CHW/PSS staff)	**Year 1** 1. Explore opportunity for Educational Services staff to add trauma informed care and/or Mental Health First Aid to enhance staff capacity and competence with challenging social concerns. (Education Department, Community Outreach) 2. Utilize testimonials of those in recovery to enhance community awareness of SUD/OUD needs and barriers. (Community Outreach) 3. Facilitate a Community Awareness event for overdose deaths and to celebrate those in recovery each August 31. (Community Outreach, Bridges to Health CHW/PSS) 4. Facilitate the CORE Consortium monthly meetings. (Community Outreach) 5. Facilitate monthly the Suicide and Overdose Fatality Review Team in partnership with IDOH. (Community Outreach) 6. Distribute MAT brochures, SUD information, and SDOH resources throughout the community. (Community Outreach, BTH staff)	**Year 1** 1. Explore adding a Narcan resource for the Emergency Department and/or other health care facilities in partnership with CORE Plus, (BTH, Community Outreach) 2. Support faith community recovery activities including pro-social events, family restorative activities, and recovery programs. (Community Outreach, PN Program)

CEASE: Substance Abuse 2023-2026 Cont.			
MGH Inpatient Plans	**MGH Outpatient Plans**	**MGH Community Outreach Plans**	**Community Collaborations Plans**
Years 2 & 3 1. Continue # 1, #2, #3, and #4 above. 2. Provide data compilation obtained from the EMR screenings to MH administration to inform and support adding helpful interventions quarterly. (Community Outreach, BTH, ED) 3. Provide education for MH staff on new and emerging illicit drugs used in the community. (BTH CHW/PSS, House Supervisor, MH Providers)	**Years 2 & 3** 1. Include screening tools on the EMR for routine patient visits for wellness. (David Russell) 2. Provide referral process for CHW/Peer support to PCP offices. (BTH CHW/PSS, Community Outreach) 3. Continue previous year's activities.	**Years 2 & 3** 1. Partner with CORE Plus to Provide education awareness of social determinants of health issues with SUD//Mental health. (BTH CHW/PSS, Community Outreach) 2. Continue Suicide and Overdose Fatality Review Team and CORE Plus Consortium monthly. (BTH staff, Community Outreach) 3. Continue previous year's activities.	**Year 2 & 3** 1. Partner with CORE Plus to identify special speakers and/or programs to address SUD//alcohol/mental health issues for the community. (BTH staff, Community Outreach, CMS, other community organizations) 2. Continue previous year's activities.

Goals: Increase the number of residents who refrain from substance use/misuse and reduce the number of overdoses and overdose fatalities.

INCREASE: Healthy Hearts 2023-2026

INCREASE – In Community Resources, Community Education, Community Assessment, Community Support, Community Empowerment

MGH Inpatient Plans	MGH Outpatient Plans	MGH Community Outreach Plans	Community Collaborations Plans
Year 1 1. Provide ongoing quality improvement through the Lean Process to track efficiency and efficacy across the continuum of care for heart failure patients and other patients with chronic diseases through multi-professional team rounding. (Provider and nursing staff, LEAN Team) 2. Connect patients with the Community Health Worker for the introduction and management of the home monitoring program in collaboration with the Chronic Care Management (CCM) clinic. (Chronic Care Management team, providers, and nursing staff) 3. Track data required by the Health Challenges grant for chronic disease metrics and reporting to the IDOH. (AD for Chronic Care Management clinic)	**Year 1** 1. Track referrals to the Chronic Care Management. (AD of CCM) 2. Work with the PACT team (Post-Acute Care Team) to identify needs for remote monitoring at home and in care facilities. (CCM, PACT Team, Providers, nursing staff) 3. Explore Hospital at Home options for appropriate patients. (MH Administration) 4. Explore increasing access for procedures and specialists offered locally and though remote/telehealth options at the Gas City facility. (MH Administration) 5. Increase individual and family quality of life. (CCM, PACT Team) 6. Chronic Care Management program will be monitoring pre-hypertension and hypertension, A1c, and BMI with reports submitted two times each year to IDOH. (AD for the CCM)	**Year 1** 1. Support education events related to heart health in parish nurse settings, Red Dress event, community festivals/fairs/other community events. (Community Outreach) 2. Promote healthy lifestyles to reduce risks of cardiac complications. (Community Outreach, PN Program) 3. Increase number of blood pressure screenings completed each year. (PN Program and Community Outreach) 4. Promote low-cost cardiovascular screenings throughout the community. (Community Outreach and PN Program) 5. Support community CPR instructor classes and certification throughout the community. (Community Outreach)	**Year 1** 1. Work with area rehab, long term care, and assisted living facilities to improve patient quality of life by reducing visits to the ED and admissions to the hospital. (PACT Team and Chronic Care Management clinic staff and interventions) 2. Provide AHA CPR Support for classes and certifications to multiple organizations and individuals. (Community Outreach)

INCREASE: Healthy Hearts 2023 - 2026 Cont.			
MGH Inpatient Plans	**MGH Outpatient Plans**	**MGH Community Outreach Plans**	**Community Collaborations Plans**
Year 2 1. Continue previous year's activities.	**Year 2** 1. Coordinate Pulmonary Clinic, Heart Failure Clinic, Chronic Care Management, and all other outpatient clinics to partner and better utilize all available resources. (All team members) 2. Expand Remote patient monitoring service to at least 50% of patients identified as an appropriate referral. (Chronic Care Management team)	**Year 2** 1. Complete Potty Post each year related to identification of a heart attack, stroke, and other cardiovascular episode. (Parish Nurse staff) 2. Continue previous activities	**Year 2** 1. Continue previous activities.
Year 3 1. Continue above activities. 2. Evaluate though LEAN the hand off process from inpatient to outpatient care for excellence, adherence, and efficacy. (LEAN Team, MH staff)	**Year 3** 1. Provide Million Hearts Campaign information to the PCP offices. (David Russell and Physician Practice Team) 2. Expand tele-monitoring services to 60% of patients identified as an appropriate referral. (AD of CCM clinic) 3. Complete reports on blood pressure results identifying those at high risk to make interventions appropriate to MH educational services. (David Russell and Physician Practice Team)	**Year 3** 1. Develop education blitz across the age continuum about heart health through the Million Hearts Campaign. (Community Outreach) 2. Work with schools to provide educational and activities for all ages to promote heart health through Health Expo. (Health Expo staff, Community Outreach)	**Year 3** 2. Continue previous activities.

Goal: Provide opportunities for Grant County residents to have increased quality and quantity of life through primary prevention and early access to screening, treatment, & referral.

INCREASE: Dental Health 2023-2026

INCREASE – In Community Resources, Community Education, Community Assessment, Community Support, Community Empowerment

MGH Inpatient Plans	**MGH Outpatient Plans**	**MGH Community Outreach Plans**	**Community Collaborations Plans**
Year 1 1. Partner with Bridges to Health and Meridian Services to provide free/lower cost dental treatment tracking though intake records for each referral source. (MH IT Department)	**Year 1** 1. Partner with Bridges to Health and Meridian Services to provide free/lower cost dental treatment from Emergency Department to reduce frequent visits tracking though intake records for each referral source. (MH IT Department)	**Year 1** 1. Complete Potty Post each year related to healthy mouth and preventive care. (Parish Nurse Program) 2. Add dental care education to community outreach events. (Community Outreach)	**Year 1** 1. Partner with Bridges to Health, Meridian Services, MH, and Indiana University School of Dentistry for community cleaning and intervention events. (Community Outreach and other community agencies)
Year 2 & 3 1. Continue activity above.	**Year & 3** 1. Continue activity above.	**Year 2 & 3** 1. Develop education blitz across the age continuum in outpatient clinics about dental health and impacts on overall heath. (Community Outreach and Educational Services) 2. Work with schools to provide educational and activities for all ages to promote healthy oral care. (Community Outreach	**Year 2 & 3** 1. Continue activity above.

Goal: Provide low cost or free services for individuals/families needing dental care.