Implementation Plan

April 2019 – March 2022

Sheridan Community Hospital

Community Health Needs Assessment (CHNA) Implementation Plan (CHIP)

April 2019 – March 2022

A Community Health Needs Assessment (CHNA) was performed late fall of 2018 in collaboration with Healthy Montcalm Initiative, to determine the most prevalent health needs of the community served by Sheridan Community Hospital.
Sheridan Community Hospital as a collaborative partner, adopts the Healthy Montcalm's Community Health Needs Assessment (CHNA) as its own assessment and will incorporate and adopt pertinent elements of Healthy Montcalm's Community Health Needs Assessment (CHNA) in determining the most prevalent health needs of the community served by Sheridan Community Hospita, and will incorporate findings in to a written Implementation Plan for SCH.

Community Health Needs Assessment Main Findings:

- The number one killer is chronic disease.
    - This includes heart disease, stroke, diabetes and related conditions.
    - People living with these conditions may have poor quality of life and face mounting health care costs.

- Substance abuse is related to many causes of death and sickness.
    - Tobacco and alcohol are still biggest killers.
    - Because of technology changes we have limited ability to prevent access to dangerous substances.

- Poor mental health is intimately connected to poor physical health.
    - Poor mental health is often connected to substance abuse.
    - People with mental health often have worse health outcomes.

- Lower income people and minorities are overwhelming more likely to have poor health
  - Our social and economic polices do not provide an adequate foundation for many people including working families with children.
  - Cost is still a barrier to getting preventive services and health care for many people.
  - Lower income people often have worse mental health.

Key Findings (Significant Health Needs) addressed in Implementation Plan

1. Mental Health
2. Substance Abuse
3. Poor Physical Health

Other Key Findings (Significant Health Needs) identified in the CHNA but not addressed in this plan: Each of the health needs listed below is important and is addressed by numerous programs and initiatives and programs by other hospitals, other organizations and other community partners of Sheridan Community Hospital. However, the Hospital will not address the following key findings identified in the CHNA as part of the CHIP due to limited resources and needs to allocate significant resources to the priority health needs identified above.

1. Health Care Access

2. Maternal, Child and Teen Health

3. Chronic Conditions

Sheridan Community Hospital Health Needs Assessment Implementation Plan April 2019 – March 2022

Mental Health including those with Substance Use Disorder

Health Need	Population Served	Action	Measurable Impact
Mental Health	Residents of Montcalm County and surrounding area	Provide education, awareness and outreach regarding <u>mental health</u> to both community and hospital staff to reduce stigma and better understanding of illness. ○ Free community workshop, "Accessing Mental Health Services in Montcalm County" to be offered April 2019. ○ 100% of all hospital staff will be trained in Mental Health First Aid.	• Number of events provided each year • Number of individuals attending workshops each year. Baseline was 0%. To be completed by 6- 2020
		Provide education and outreach efforts to community about <u>relationship between substance use and mental health.</u> ○ Partner with local substance abuse and mental health experts for free community workshops.	

Mental Health/Substance Abuse/Use	Residents of Montcalm County and surrounding area	Through awarded 2018 Distance Learning and Telemedicine Grant Program: Establish telemedicine access for staff to assist those with mental illness by connecting with behavioral experts outside of SCH facility. Partner with 8th Eighth Circuit Court in Ionia, MI for felons with opioid addiction. Develop primary and behavior options for felons being provided alternative treatment options through Suboxone program with Sheridan Care. Thus allowing them opportunities to stay employed, receive primary care and behavioral care, and meet other court mandates instead of going to prison.	Once program implemented, monitor number of patients referrals. To increase in use by 20% each year. Once program implemented, monitor number of patients referrals. Referrals to increase by 10% each year.
		Implement a community based mental health support group through partnership of local behavioral health organization.	Monitor number of participants. Increase of participation by 10% each year.
Substance use and abuse	Residents of Montcalm County and surrounding area	Increase number of Suboxone provides at Sheridan Care with the Suboxone certification process over a three year period to provide increased access to Suboxone treatment in the community.	Increase Suboxone certification by one provider at Sheridan Care. To be completed by June 2020.Increase of actual number of patients participating in program each year by30%

		Obtain grant funding to support start-up costs for adding one provider To increase the number of Suboxone patients seen at Sheridan Care. ◦ Provider to apply for certificate to increase number of Suboxone patients seen.	
Wellness Ultimately improve the overall health and wellbeing of communities in service area.	Residents of Montcalm County and surrounding area. Local employers' employees	Establish and publish an annual wellness calendar with monthly wellness program presented free of charge. Annual wellness health fair offering free screenings such as BP and cholesterol. Create and implement wellbeing program for local employer groups to promote overall general health. Identify and address health risks and behaviors through offerings of wellness screenings, health risk assessments of employees, implementing wellness education programs and individualized wellness plans for participants.	Monitor number of participants for each monthly program. Monitor number of participants and number of screenings that were done. Increase participation each year by 10%. Implementation of program by January 2020. Increase in participation by 25% January 2021. Monitor number of participants and tracking of identified risks and improvements annually.

		Assist those participants who are identified as not having a primary care provider to find one Expand current exercise program options with implementation of new program options: • Tai-Chi for Health • Walking Club	Monitor number of those identified as needing a PCP and number of those assisted to find a PCP. Monitor number of participants monthly looking for increase in participation by 10% each year.