IMPLEMENTATION PLAN

Addressing Community Health Needs

**Big Horn Hospital Association ~ Hardin, Montana**

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# The Implementation Planning Process

The implementation planning committee – comprised of Big Horn Hospital Association’s (BHHA) leadership team – participated in an implementation planning process to systematically and thoughtfully respond to all issues and opportunities identified through the Community Health Services Development (CHSD) needs assessment process. The facility conducted the CHSD process in conjunction with the Montana Office of Rural Health (MORH).

The CHSD community health needs assessment was performed in the spring of 2016 to determine the most important health needs and opportunities for Big Horn County, Montana. “Needs” were identified as the top issues or opportunities rated by respondents during the CHSD survey process or during focus groups (See Page 9 for a list of “Needs Identified and Prioritized”). For more information regarding the needs identified, as well as the assessment process/approach/methodology, please refer to the facility’s assessment report, which is posted on the facility’s website (<http://www.bighornhospital.org>).

The implementation planning committee identified the most important health needs to be addressed by reviewing the CHNA, secondary data, community demographics, and input from representatives representing the broad interest of the community, including those with public health expertise (See 8 for additional information regarding input received from community representatives).

The implementation planning committee determined which needs or opportunities could be addressed considering Big Horn Hospital Association’s parameters of resources and limitations. The committee then prioritized the needs/opportunities using the additional parameters of the organizational vision, mission, and values, as well as existing and potential community partners. Participants then created a goal to achieve through strategies and activities, as well as the general approach to meeting the stated goal (i.e. staff member responsibilities, timeline, potential community partners, anticipated impact(s), and performance/evaluation measures).

The prioritized health needs as determined through the assessment process and which the facility will be addressing relates to the following healthcare issues:

1. Community Health and Wellness
2. Mental and Behavioral Health
3. Aging in Place/Senior Services

In addressing the aforementioned issues, Big Horn Hospital Association seeks to:

1. Improve access to healthcare services;
2. Enhance the health of the community;
3. Advance medical or health knowledge;
4. Relieve or reduce the burden of government or other community efforts

**Big Horn Hospital Association’s Mission:**

* Big Horn Hospital Association provides quality services and promotes responsible choices to enhance

the health of our communities.

**Big Horn Hospital Association’s Vision:**

* Big Horn Hospital Association will individualize the healthcare experience, embodying an organization o

People working together, promoting a culture of personal accountability to improve the health and

Well-being of those we serve.

**Implementation Planning Committee Members:**

* Kristi Gatrell- CEO
* Bill Hodges- Big Horn County Public Health and Hospital Foundation
* Kirsten Willoughby- Director of Nursing
* Paula Small Plenty- Heritage Acres Administrator
* Roxy Cain- Controller
* Tiffany Schubert- Assistant Director of Nursing

# Prioritizing the Community Health Needs

The implementation planning committee completed the following to prioritize the community health needs:

* Reviewed the facility’s presence in the community (i.e. activities already being done to address community need)
* Considered organizations outside of the facility which may serve as collaborators in executing the facility’s implementation plan
* Assessed the health indicators of the community through available secondary data
* Evaluated the feedback received from consultations with those representing the community’s interests, including public health

## Big Horn Hospital Association’s Existing Presence in the Community

* BHHA provides meeting space for AA and ALANON groups
* Big Horn Hospital Association operates an assisted living and nursing home for the senior population in the community.
* The facility hosts a ‘High School Medical Education Day’ in order to promote health careers to youth in the community.
* BHHA sponsors and organizes an annual Rainbow Girls Breast Cancer Walk in order to provide support for the early detection and prevention of breast cancer.
* The facility hosts a ‘Lunch and Learn’ series as an opportunity for community members to learn about certain health issues.
* BHHA is a platinum sponsor for the annual Relay for Life event in the community.
* BHHA coordinates an annual Alzheimer’s Walk for community participation and educational opportunities.
* BHHA is a community stakeholder in a county “Cardiac Readiness” initiative with funding from DPHHS

## List of Available Community Partnerships and Facility Resources to Address Needs

* South Central Mental Health (SCMH) provides access to a Licensed Addiction Counselor (LAC), as well as a Licensed Clinical Professional Counselor (LCPC) for community members on a limited basis as the organization serves eleven other counties.
* The RAM DUI Taskforce, comprised of concerned community members, is charged with the mission of promoting a healthier and safer environment for county residents by reducing the number of alcohol-related traffic crashes through public education, awareness, faith-based community involvement, as well as legislative and enforcement strategies.
* Alcoholics Anonymous (AA) provides assistance and support to those affected by alcoholism.
* The Big Horn Council on Aging and the Big Horn Senior Center provide support and services to the senior population in the county.
* Healthy Harding Coalition supports health and wellness in Big Horn County, promoting safe places to walk and bike, healthy aging in place for seniors, and access to healthy foods.
* The Hardin Food Access Task Force and Big Horn County Extension Service partnered with local government offices to plan and implement a wellness program for County employees.
* Big Horn County installed a walking trail around the fairgrounds for interested community members.
* The Big Horn County Extension Office provides classes to community members on a variety of topics, including nutrition education.
* The Big Horn Valley Health Center (BHVHC) is the community health center that provides community-based, outpatient primary care to Big Horn County on a sliding scale cost basis.
* The Two Rivers Detention Center may have space available to provide for certain community needs when operational.
* The Indian Health Service (IHS) holds education classes/programs to community members on topics such as bike/helmet safety and car/seatbelt safety.
* The local Kiwanis chapter focuses activities on the youth in the community.
* The schools (middle and high school) provide educational programs/presentations to students on a range of topics, such as drug/alcohol awareness.
* The Hardin Community Center provides community members with access to a pool and other exercise equipment.
* The Harding community has access to a FOLF course, tennis courts and the Crow fitness center.
* The Montana Mental Health Trust Settlement awards funds that provide additional mental health education opportunities to providers in Hardin.
* Shape Up Montana is a statewide three-month initiative designed to get Montanans more physically active.
* Instant Recess is a movement of activists dedicated to making America healthier ten minutes at a time through the introduction of brief activity breaks in the middle of the day.
* The Montana Nutrition and Physical Activity program (NAPA) can assist with initiatives associated with health and wellness.
* The Agency for Healthcare Research & Quality (AHRQ) provides research to assist providers and patients with making informed healthcare decisions and improving the quality of healthcare services.
* Montana Office of Rural Health/Area Health Education Center (MORH/AHEC) provides technical assistance to rural health systems and organizations (Med Start and Reach Camps, In-A- Box Curriculum Program etc.)
* The Montana Department of Public Health and Human Services (MT DPHHS) works to protect the health of Montanans.

## Big Horn County Indicators

Low Income Persons

* 29% of persons are below the federal poverty level

Uninsured Persons

* 16.9% of adults less than age 65 are uninsured
* Data is not available by county for uninsured children less than age 18

Leading Causes of Death: Primary and Chronic Diseases

* Heart Disease
* Cancer
* Unintentional Injuries

\* Note: Other primary and chronic disease data is by region and thus difficult to decipher community need.

Elderly Populations

* 10% of Big Horn County’s Population is 65 years and older

Size of County and Remoteness

* 12,841 people in Big Horn County
* 2.6 people per square mile

Nearest Major Hospital

* Billings Clinic Hospital in Billings, MT is 44 miles from Big Horn Hospital Association

## Public Health and Underserved Populations Consultation Summaries

Public Health Consultation [Shelly Sutherland – Big Horn County Public Health – January 26, 2016]

* There are two coalitions in town that are looking into issues specific to community health and lifestyles: Best Beginnings and Healthy Hardin.
* Having services to allow for seniors in the community to age in place is so important.
* Availability of high quality childcare is a high need here- all of the evidence is showing that early childhood is so important for healthy outcomes.
* The community needs more access to healthy foods, safe places to bike/walk, social supports, and public transportation.
* Being active every day and having the ability to walk outside are important for living in a healthy community.

Underserved Population – People with Disabilities [Steve Woodard – LIFTT – January 26, 2016]

* Changes need to be made in town (i.e. sidewalks, streets) to make the community more accessible for those who are disabled.
* Personal care services are a high need and our program provides training so that our clients can help people who do not want to move to a nursing home.

Underserved Population – Senior Citizens

[Shelly Sutherland – Big Horn County Public Health; Steve Woodard-- LIFTT – January 26, 2016]

* Having services to allow for seniors in the community to age in place is so important.
* Personal care services are a high need and our program provides training so that our clients can help people who do not want to move to a nursing home.
* People want to stay in their homes and not be institutionalized, so there should be options for them to age in place.

# Needs Identified and Prioritized

## *Prioritized Needs to Address*

1. 57% of respondents rated their community as “Somewhat healthy.” 32% of respondents felt their community was “Unhealthy” and 7.9% felt their community was “Healthy.”
2. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%)
3. ‘Healthy behaviors and lifestyles (52.2%) was selected as the most important component of a healthy community
4. Interest in the following educational Programs/Classes: ‘Fitness’ (35.3%), ‘Health and wellness’ (33.1%), ‘First aid/CPR’ (29.4%) and ‘Weight loss’ (29.4%)
5. 39.5% of respondents have at least 20 minutes of exercise ‘Daily,’ 6.2% reported ‘No physical activity’
6. 60% of respondents rated their knowledge of health services as “Good,” “Excellent” and “Fair” were both selected by 17.2% each.
7. 16% of respondents reported they experienced periods of feeling depressed on most days for at least three consecutive months
8. In focus groups, community members indicated a need for more resources specific to mental health and substance abuse.
9. Focus group participants indicated that adverse childhood experiences are an issue in the community.
10. Focus group participants indicated there is a need for more senior living options
11. 62% of survey respondents indicated the community needed “Personal care home services.” 53% indicated a need for “Senior retirement housing/community” and 36.8% felt an “Assisted living facility” was needed in the community

*Needs Unable to Address*

*(See Page 32 for additional information)*

1. Majority of respondents indicated a need for ‘Dermatology’ (33.1%), ‘ENT (ear/nose/throat)’ (29.4%), and ‘Ophthalmology’ (25%)
2. Top three suggestions to improve community’s access to healthcare: “Availability of walk-in clinic/longer hours’ (53.7%), ‘Availability of visiting specialists’ (42.6%), and ‘More primary care providers’ (42.6%)
3. 32.5% of respondents indicated that they or a member of their household delayed getting healthcare services when they needed it. Top three reasons cited: ‘It costs too much’ (40%), ‘No insurance’ (32.5%), ‘Could not get an appointment’ (30%)

# Executive Summary

The following summary briefly represents the goals and corresponding strategies and activities which the facility will execute to address the prioritized health needs (from Page 9) For more details regarding the approach and performance measures for each goal, please refer to the Implementation Plan Grid section, which begins on 15.

**Goal 1:** Improve community health and wellness through education and outreach.

**Strategy 1.1:** Educate county commissioners and elected officials about health and wellness needs in the community.

**Activities:**

* + Convene BHHA work group to develop education and outreach materials for elected officials about the health and wellness needs of the community.
  + Develop outreach strategy to deliver health and wellness message with commissioners and elected officials.
  + Hold various meetings with elected officials to present the health and wellness needs and educate on opportunities to improve community health.

**Strategy 1.2**: Educate community on health and wellness needs of the community.

**Activities:**

* + Convene BHHA work group to develop education and outreach materials for community presentations.
  + Develop outreach strategy to deliver health and wellness message with community.
  + Convene community stakeholder groups (i.e. Kiwanis, Chamber of Commerce, schools etc.) to present health needs of the community and opportunities for partnership to improve community health.
  + Hold community forums and meetings to discuss and educate about the health needs of the community.

**Strategy 1.3**: Partner with Healthy Hardin Coalition to develop a health and wellness resource list.

**Activities:**

* Research health and wellness programs and resources available in community.
* Develop a health and wellness resource list.
* Develop marketing pan to advertise programs and resources available in the community (Social media, local paper, newsletters, BHHA website).

**Strategy 1.4**: Continue supporting health in wellness in the community through sponsorship of events and programs.

**Activities:**

* + Continue sponsoring community events centered around health and wellness:
    - Rainbow Walk, Cardiac readiness, Alzheimer’s walk, breast cancer walks, Race for a Cure and EMS classes.
  + Explore enhancing outreach and advertising efforts around existing health and wellness programs.

**Strategy 1.5**: Explore new opportunities for outreach and education

**Activities:**

* + Enhance DPHHS Cardiac Readiness program with testimonies from heart attack survivors who live in the community.
  + Explore partnering with local healthcare organizations to provide a community health fair and blood draws.
  + Partner with schools to discuss the possibility of providing blood pressure checks at parent teacher conferences and high school games.
  + Host a Reach Camp (partner: AHEC).
  + Develop outreach/advertising strategy for all new health and wellness educational programs. (Social media, local paper, newsletters, BHHA website)
  + Check with website IT to make the BHHA website more accessible and visible via Google or other website search mechanisms.

**Strategy 1.6**: Explore expansion of patient navigator position

**Activities:**

* + Conduct feasibility study on expansion of Patient Navigator position.
  + Research and develop job description for desired patient navigator position.

**Goal 2:** Improve access to mental and behavioral health services.

**Strategy 2.1:** Educate staff about existing mental health resources within the community.

**Activities:**

* + Conduct environmental scan of currently available mental health resources in Big Horn County.
  + Develop mental health resource list.
  + Develop an education and dissemination plan for new resource list (ex. nurses meetings).
  + Add mental health resources to website.
  + Enhance outreach and advertising strategies about mental health resources (social media, local paper, poster/bulletins, newsletters etc.)

**Strategy 2.2**: Explore training BHHA staff for critical case management

**Activities:**

* + Develop protocol for critical management training.
  + Hold staff debriefing about protocol
  + Disseminate mental health resource list and refer as necessary.

**Strategy 2.3:** Partner with community organizations related to mental health.

**Activities:**

* + Continue participation on the Hardin Mental Health Advisory Committee.

**Goal 3:** Enhance senior services and outreach to assist Big Horn County’s ageing community to age in place.

**Strategy 3.1:** Enhance senior care training for staff at BHHA.

**Activities:**

* + Research training opportunities regarding dementia/memory education.
  + Develop training schedule for staff.
  + Implement staff training.

**Strategy 3.2:** Continue exploring funding opportunities for expanding senior services.

**Activities:**

* + Research grant funding opportunities and community foundation campaigns etc. for senior living expansion and renovation.
  + Explore providing respite care for low income individuals.

**Strategy 3.3**: Enhance wellness programs and resources for seniors.

**Activities:**

* + Explore supplying a safe trails walking map for seniors.
  + Explore BHHA registered dietitian offering cooking and nutritional classes for seniors.
  + Research potential partnerships for providing senior fall prevention programs.

# Implementation Plan Grid

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| **Goal 1:** Improve community health and wellness through education and outreach. | | | | | |
| **Strategy 1.1:** Educate county commissioners and elected officials about health and wellness needs in the community. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Convene BHHA work group to develop education and outreach materials for elected officials about the health and wellness needs of the community. | BHHA  Senior Mgmt.  Staff | Ongoing | Hospital  Administrator | Healthy Hardin Coalition, Public Health, BHVC | Scheduling conflicts,  resource limitations |
| Develop outreach strategy to deliver health and wellness message with commissioners and elected officials. | BHHA  Senior Mgmt.  Staff | Ongoing | Hospital Administrator | Healthy Hardin Coalition, Public Health, BHVC | Resource limitations |
| Hold various meetings with elected officials to present the health and wellness needs and educate on opportunities to improve community health. | BHHA  Senior Mgmt.  Staff | Ongoing | Hospital Administrator | Healthy Hardin Coalition, Public Health, BHVC | Scheduling conflicts,  resource limitations |
| **Needs Being Addressed by this Strategy:**   1. 57% of respondents rated their community as “Somewhat healthy.” 32% of respondents felt their community was “Unhealthy” and 7.9% felt their community was “Healthy.” 2. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%) 3. ‘Healthy behaviors and lifestyles (52.2%) was selected as the most important component of a healthy community 4. Most Interest in the following Educational Programs/Classes: ‘Fitness’ (35.3%), ‘Health and wellness’ (33.1%), ‘First aid/CPR’ (29.4%) and ‘Weight loss’ (29.4%) 5. 39.5% of respondents indicated they have at least 20 minutes of exercise ‘Daily’, 6.2% reported ‘No physical activity.’ | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Improved community awareness about health issues in Big Horn County. * Elected officials will consider health and wellness needs of the community in future policies. * Improved health outcomes in Big Horn County. | | | | | |

***Strategy 1.1 Continued on next page…***

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| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Convene BHHA work group 4 times a year to continually evaluate health and wellness needs of the community * Health and wellness educational materials are created * Track number of county commissioners and elected officials who are educated on the health and wellness issues of the community. |
| **Measure of Success:** Hold annual meeting with county commissioners and elected officials to discuss the health and wellness needs of the community. |

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| **Goal 1:** Improve community health and wellness through education and outreach. | | | | | |
| **Strategy 1.2:** Educate community on health and wellness needs of the community. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Convene BHHA work group to develop education and outreach materials for community presentations. | Outreach Director | Ongoing | Hospital Administrator | Public Health, BHVC, Healthy Hardin Coalition, Local Health Clinic | Scheduling conflicts,  resource limitations |
| Develop outreach strategy to deliver health and wellness message with community. | Outreach Director | Ongoing | Hospital Administrator | Healthy Hardin Coalition, Public Schools, Pubic Health, BHVC | Resource limitations, financial limitations |
| Convene community stakeholder groups (i.e. Kiwanis, Chamber of Commerce, schools etc.) to present health needs of the community and opportunities for partnership to improve community health. | BHHA  Senior Mgmt.  Staff | Ongoing | Hospital Administrator | Healthy Hardin Coalition, Public Schools, Pubic Health, Kiwanis, Chamber of Commerce | Scheduling conflicts,  resource limitations |
| Hold community forums and meetings to discuss and educate about the health needs of the community. | Outreach Director | Ongoing | Hospital Administrator | Healthy Hardin Coalition, Public Schools, Pubic Health, Kiwanis, Chamber of Commerce | Scheduling conflicts,  resource limitations |
| **Needs Being Addressed by this Strategy:**   1. 57% of respondents rated their community as “Somewhat healthy.” 32% of respondents felt their community was “Unhealthy” and 7.9% felt their community was “Healthy.” 2. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%) 3. ‘Healthy behaviors and lifestyles (52.2%) was selected as the most important component of a healthy community   ***Strategy 1.2 Continued next page…***   1. Most Interest in the following Educational Programs/Classes: ‘Fitness’ (35.3%), ‘Health and wellness’ (33.1%), ‘First aid/CPR’ (29.4%) and ‘Weight loss’ (29.4%) 2. 39.5% of respondents indicated they have at least 20 minutes of exercise ‘Daily,’ 6.2% reported ‘No physical activity’ 3. 60% of respondents rated their knowledge of health services as “Good,” “Excellent” and “Fair” were both selected by 17.2% percent each. 4. 16% of respondents reported they experienced periods of feeling depressed on most days for at least three consecutive months 5. In focus groups, community members indicated a need for more resources specific to mental health and substance abuse. 6. Focus group participants indicated that adverse childhood experiences are an issue in the community. | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Improved community awareness about health and wellness issues in Big Horn County. * Increased awareness of available programs/resources in the community. * Improved health outcomes. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track number of community presentations * Track number of outreach efforts * Track number of participants at community forum | | | | | |
| **Measure of Success:** Hold 3 community forums to discuss and educate about health and wellness needs/resources. | | | | | |

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| **Goal 1:** Improve community health and wellness through education and outreach. | | | | | |
| **Strategy 1.3:** Partner with Healthy Hardin Coalition to develop a health a wellness resource list. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Research health and wellness programs and resources available in community. | Healthy Hardin Coalition | Ongoing | Hospital Administrator | Healthy Hardin Coalition | Resource limitations |
| Develop a health and wellness resource list. | Healthy Hardin Coalition | Ongoing | Hospital Administrator | Healthy Hardin Coalition | Resource limitations |
| Develop marketing plan to advertise programs and resources available in the community. (Social media, local paper, newsletters, BHHA website) | Outreach Director | Ongoing | Hospital Administrator | Healthy Hardin Coalition | Resource limitations, financial limitations |
| **Needs Being Addressed by this Strategy:**   1. 57% of respondents rated their community as “Somewhat healthy.” 32% of respondents felt their community was “Unhealthy” and 7.9% felt their community was “Healthy.” 2. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%) 3. ‘Healthy behaviors and lifestyles (52.2%) was selected as the most important component of a healthy community 4. Most Interest in the following Educational Programs/Classes: ‘Fitness’ (35.3%), ‘Health and wellness’ (33.1%), ‘First aid/CPR’ (29.4%) and ‘Weight loss’ (29.4%) 5. 39.5% of respondents have at least 20 minutes of exercise ‘Daily,’ 6.2% reported ‘No physical activity’ 6. 60% of respondents rated their knowledge of health services as “Good,” “Excellent” and “Fair” were both selected by 17.2% percent each. 7. 16% of respondents reported they experienced periods of feeling depressed on most days for at least three consecutive months 8. In focus groups, community members indicated a need for more resources specific to mental health and substance abuse. | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Increased awareness of available programs/resources in the community. * Increased utilization of preventative health programs and services. * Improved health outcomes. | | | | | |

***Strategy 1.3 Continued on next page…***

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| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track number of meetings held with the Healthy Hardin Coalition. * Track participation in various health and wellness programs before and after implementation of resource list. * Track number of referrals from the resource list. |
| **Measure of Success:** Resource list is created and continually updated to reflect the most current offerings in the community. |

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| **Goal 1:** Improve community health and wellness through education and outreach. | | | | | |
| **Strategy 1.4:** Continue supporting health in wellness in the community through sponsorship of events and programs. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Continue sponsoring community events centered around health and wellness:  Rainbow Walk, Cardiac readiness, Alzheimer’s walk, breast cancer walks, Race for a Cure and EMS classes. | Outreach Director | Ongoing | Hospital Administrator | Healthy Hardin Coalition, DPHHS, Public schools, Council on Aging | Scheduling conflicts,  Resource limitations |
| Explore enhancing outreach and advertising efforts around existing health and wellness programs | Outreach Director | Ongoing | Hospital Administrator | Local newspaper | Resource limitations, financial limitations |
| **Needs Being Addressed by this Strategy:**   1. 57% of respondents rated their community as “Somewhat healthy.” 32% of respondents felt their community was “Unhealthy” and 7.9% felt their community was “Healthy.” 2. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%) 3. ‘Healthy behaviors and lifestyles (52.2%) was selected as the most important component of a healthy community 4. Interest in the following educational Programs/Classes: ‘Fitness’ (35.3%), ‘Health and wellness’ (33.1%), ‘First aid/CPR’ (29.4%) and ‘Weight loss’ (29.4%) 5. 39.5% of respondents have at least 20 minutes of exercise ‘Daily,’ 6.2% reported ‘No physical activity’ | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Increased access to health and wellness events/programs for community members. * Increased participation in health and wellness events/programs. * Improved health outcomes. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track attendance at health and wellness events/programs before and after new outreach strategy is implemented. | | | | | |
| **Measure of Success:** BHHA develops a more robust outreach/advertising protocol regarding health and wellness events/programs. | | | | | |

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| **Goal 1:** Improve community health and wellness through education and outreach. | | | | | |
| **Strategy 1.5:** Explore new opportunities for outreach and education | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Enhance DPHHS Cardiac Readiness program with testimonies from heart attack survivors who live in the community. | Outreach Director | Ongoing | Hospital Administrator | Public School, Public Health, Local Clinics | Scheduling conflicts,  Resource limitations  HIPPA Regulations |
| Explore partnering with local healthcare organizations to provide a community health fair and blood draws. | Outreach Director | Ongoing | Hospital Administrator | Local Clinics | Resource limitations, financial limitations |
| Partner with schools to discuss the possibility of providing blood pressure checks at parent teacher conferences and high school games. | Public Health Nurse | Ongoing | Hospital Administrator | Public Schools | Resource limitations, financial limitations |
| Host a Reach Camp. | Outreach Director | November 2016 | Hospital Administrator | MORH/AHEC | Resource limitations |
| Develop outreach/advertising strategy for all new health and wellness educational programs. (Social media, local paper, newsletters, BHHA website) | BHHA  Senior Mgmt.  Staff, Nurse Health Educator | Ongoing | Hospital Administrator | Public Health, BHVC | Resource limitations, financial limitations |
| Check with website IT to make the BHHA website more accessible and visible via Google or other website search mechanisms. | BHHA IT Staff | Ongoing | Hospital Administrator | BHHA Sr. Management | Resource limitations, financial limitations |
| **Needs Being Addressed by this Strategy:**   1. 57% of respondents rated their community as “Somewhat healthy.” 32% of respondents felt their community was “Unhealthy” and 7.9% felt their community was “Healthy.” 2. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%) 3. ‘Healthy behaviors and lifestyles (52.2%) was selected as the most important component of a healthy community 4. Most Interest in the following Educational Programs/Classes: ‘Fitness’ (35.3%), ‘Health and wellness’ (33.1%), ‘First aid/CPR’ (29.4%) and ‘Weight loss’ (29.4%) 5. 39.5% of respondents indicated they have at least 20 minutes of exercise ‘Daily,’ 6.2% reported ‘No physical activity’   ***Strategy 1.5 Continued on next page…*** | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Increased awareness of health and wellness resources available in the community. * Increased community awareness of chronic health issues. * Increased utilization of preventative health services. * Improved health outcomes. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track student attendance at Reach camps. * Track number of attendees at community health fair. | | | | | |
| **Measure of Success:** BHHA partners with other local health related organizations to hold a community health fair by March 2017. | | | | | |

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| **Goal 1:** Improve community health and wellness through education and outreach. | | | | | |
| **Strategy 1.6:** Explore expansion of patient navigator position | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Conduct feasibility study on expansion of Patient Navigator position. | BHHA  Senior Mgmt.  Staff, Nurse Health Educator | Ongoing | Hospital Administrator | BHHA, BHVC, Hardin Clinic | Financial limitations,  resource limitations |
| Research and develop job description for desired patient navigator position. | BHHA  Senior Mgmt.  Staff, Nurse Health Educator | Ongoing | Hospital Administrator | BHHA, BHVC, Hardin Clinic | Financial limitations,  resource limitations |
| **Needs Being Addressed by this Strategy:**   1. 57% of respondents rated their community as “Somewhat healthy.” 32% of respondents felt their community was “Unhealthy” and 7.9% felt their community was “Healthy.” 2. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%) 3. ‘Healthy behaviors and lifestyles (52.2%) was selected as the most important component of a healthy community 4. Most Interest in the following Educational Programs/Classes: ‘Fitness’ (35.3%), ‘Health and wellness’ (33.1%), ‘First aid/CPR’ (29.4%) and ‘Weight loss’ (29.4%) 5. 39.5% of respondent indicate they have at least 20 minutes of exercise ‘Daily,’ 6.2% reported ‘No physical activity’ 6. 60% of respondents rated their knowledge of health services as “Good” and “Excellent” and “Fair” were both selected by 17.2% each. | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Improved community understanding and utilization of health care services. * Improved access to healthcare services. * Improved health outcomes. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Determine if expansion of Navigator position is possible. * Track number of referrals from patient navigator. | | | | | |
| **Measure of Success:** BHHA will expand patient navigator position by May 2018 | | | | | |

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| **Goal 2:** Improve access to mental and behavioral health services | | | | | |
| **Strategy 2.1:** Educate staff about existing mental health resources within the community. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Conduct environmental scan of currently available mental health resources in Big Horn County. | ESSA, Local Schools, Outreach Director | Ongoing | Hospital Administrator | South Central Mental Health, BHVC, Public Health | Resource limitations |
| Develop mental health resource list. | ESSA, Local Schools, Outreach Director | Ongoing | Hospital Administrator | South Central Mental Health, BHVC, Public Health, AMDD | Resource limitations, Financial Limitations |
| Develop an education and dissemination plan for new resource list (ex. Nurse’s meetings). | ESSA, Local Schools, Outreach Director | Ongoing | Hospital Administrator | South Central Mental Health, BHVC, Public Health, AMDD | Resource limitations, Financial Limitations |
| Add mental health resources to website. | BHHA  Senior Mgmt. | Ongoing | Hospital Administrator | South Central Mental Health, BHVC, Public Health, AMDD | Resource limitations, Financial Limitations |
| Enhance outreach and advertising strategies about mental health resources (social media, local paper, poster/bulletins, newsletters etc.) | ESSA, Local Schools, Outreach Director | Ongoing | Hospital Administrator | Local Media Outlets | Resource limitations, financial limitations |
| **Needs Being Addressed by this Strategy:**   1. 60% of respondents rated their knowledge of health services as “Good,” “Excellent” and “Fair” were both selected by 7.2% each. 2. 16% of respondents reported they experienced periods of feeling depressed on most days for at least three consecutive months 3. In focus groups, community members indicated a need for more resources specific to mental health and substance abuse. 4. Focus group participants indicated that adverse childhood experiences are an issue in the community. | | | | | |
| ***Strategy 2.1 Continued on next page…***  **Anticipated Impact(s) of these Activities:**   * Improved awareness of mental health resources in the community. * Increased referrals of mental health resources. * Increased utilization of mental health resources. * Improved health outcomes. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track number of nurse and physician referrals to mental health services. * Track resource website hits. | | | | | |
| **Measure of Success:** Mental health resource list is created and utilized by hospital staff. | | | | | |

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| **Goal 2:** Improve access to mental and behavioral health services | | | | | |
| **Strategy 2.2:** Explore training BHHA staff for critical case management | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Develop protocol for critical management training. | ESSA, Local Schools, Outreach Director | Ongoing | Hospital Administrator | BHVC, South Central Mental Health, AMDD | Resource limitations  Financial Constraints |
| Hold staff debriefing about protocol | Nurse Health Educator, Outreach Director | Ongoing | Hospital Administrator | BHVC, South Central Mental Health, AMDD | Scheduling conflicts,  resource limitations |
| Disseminate mental health resource list and refer as necessary. | ESSA, Local Schools, Outreach Director | Ongoing | Hospital Administrator | BHVC, South Central Mental Health, AMDD | Scheduling conflicts,  resource limitations |
| **Needs Being Addressed by this Strategy:**   1. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%) 2. 60% of respondents rated their knowledge of health services as “Good,” “Excellent” and “Fair” were both selected by 7.2% each. 3. 16% of respondents reported they experienced periods of feeling depressed on most days for at least three consecutive months 4. In focus groups, community members indicated a need for more resources specific to mental health and substance abuse. 5. Focus group participants indicated that adverse childhood experiences are an issue in the community. | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Enhanced practices regarding critical case management. * Increased access to mental health services. * Improved health outcomes. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Hold 2 staff meetings a year to debrief new and existing employees on critical case management protocol. | | | | | |
| **Measure of Success:** All appropriate staff at BHHA are trained on critical case management protocol. | | | | | |

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| **Goal 2:** Improve access to mental and behavioral health services | | | | | |
| **Strategy 2.3:** Partner with community organizations related to mental health. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Continue participation on the Hardin Mental Health Advisory Committee. | Outreach Director | Ongoing | Hospital Administrator | Hardin Mental Health Advisory Committee | Scheduling conflicts,  Resource limitations |
| **Needs Being Addressed by this Strategy:**   1. Top three health concerns: ‘Alcohol/Substance Abuse’ (88.2%), ‘Diabetes’ (43.4%), and ‘Overweight/obesity’ (42.6%) 2. 60% of respondents rated their knowledge of health services as “Good,” “Excellent” and “Fair” were both selected by 7.2% each. 3. 16% of respondents reported they experienced periods of feeling depressed on most days for at least three consecutive months 4. In focus groups, community members indicated a need for more resources specific to mental health and substance abuse. 5. Focus group participants indicated that adverse childhood experiences are an issue in the community. | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Improved mental health outcomes in community. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track number of Mental Health Advisory Committee meetings/events that a BHHA representative attends. | | | | | |
| **Measure of Success:** A BHHA representative will attend 3 HMHAC meetings a year. | | | | | |

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| **Goal 3:** Enhance senior services and outreach to assist Big Horn County’s ageing community to age in place. | | | | | |
| **Strategy 3.1:** Enhance senior care training for staff at BHHA. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Research training opportunities regarding dementia/memory education. | Heritage Acres Management Staff | Ongoing | Hospital Administrator | Heritage Acres, Local Council On Aging | Resource limitations |
| Develop training schedule for staff. | Heritage Acres Management Staff | Ongoing | Hospital Administrator | Heritage Acres  Management Staff | Scheduling conflicts,  resource limitations |
| Implement staff training. | Heritage Acres Management Staff | Ongoing | Hospital Administrator | Heritage Acres  Management Staff | Scheduling conflicts,  resource limitations |
| **Needs Being Addressed by this Strategy:**   1. Focus group participants indicated there is a need for more senior living options 2. 62% of respondents indicated the community needed “Personal care home services.53% indicated a need for “Senior retirement housing/community” and 36.8% felt an “Assisted living facility” was needed in the community. | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Increased understanding of senior related illnesses for BHHA staff. * Improved quality of care for seniors with dementia or other memory related conditions. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track number of staff who attend training opportunities. | | | | | |
| **Measure of Success:** Appropriate staff at BHHA attend 2 senior care training opportunities a year. | | | | | |

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| **Goal 3:** Enhance senior services and outreach to assist Big Horn County’s ageing community to age in place. | | | | | |
| **Strategy 3.2:** Continue exploring funding opportunities for expanding senior services. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Research grant funding opportunities and community foundation campaigns etc. for senior living expansion and renovation. | BHHA  Senior Mgmt.  Outreach Director | Ongoing | Hospital Administrator | BHHA, DPHHS, HA Auxiliary | Resource limitations, Financial Constraints |
| Explore providing respite care for low income individuals. | BHHA  Senior Mgmt.  Outreach Director | Ongoing | Hospital Administrator | BHHA, DPHHS, HA Auxiliary | Resource limitations, financial limitations |
| **Needs Being Addressed by this Strategy:**   1. Focus group participants indicated there is a need for more senior living options 2. 62% of respondents indicated the community needed “Personal care home services.” 53% indicated a need for “Senior retirement housing/community” and 36.8% felt an “Assisted living facility” was needed in the community | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Increased knowledge about available grant/funding opportunities for improvement of senior living facilities. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track number of grant/funding opportunities that BHHA applies for and any funding awarded. * Determine if expansion of respite care services for low income community members is feasible. | | | | | |
| **Measure of Success:** BHHA will determine feasibility of expanding/renovating senior living options by March 2018. | | | | | |

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| **Goal 3:** Enhance senior services and outreach to assist Big Horn County’s ageing community to age in place. | | | | | |
| **Strategy 3.3:** Enhance wellness programs and resources for seniors. | | | | | |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers** |
| Explore supplying a safe trails walking map for seniors. | BHHA Representative for Healthy  Hardin Coalition | Ongoing | Hospital Administrator | Senior Center | Resource limitations |
| Explore BHHA registered dietitian offering cooking and nutritional classes for seniors | BHHA  Senior Mgmt.  Outreach Director | Ongoing | Hospital Administrator | Senior Center, MSU Extension | Resource limitations, Staff Availability |
| Research potential partnerships for providing senior fall prevention programs. | Senior Mgmt.  Outreach Director | Ongoing | Hospital Administrator | Senior Center, MSU Extension, Local EMS Staff, BHVC | Resource limitations, Financial Constraints |
| **Needs Being Addressed by this Strategy:**   1. Focus group participants indicated there is a need for more senior living options 2. 62% of respondents indicated the community needed “Personal care home services.” 53% indicated a need for “Senior retirement housing/community” and 36.8% felt an “Assisted living facility” was needed in the community | | | | | |
| **Anticipated Impact(s) of these Activities:**   * Increased senior utilization of walking trails. * Increase in senior knowledge on fall prevention and safety. * Improved health outcomes for seniors. | | | | | |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:**   * Track number of new programs/events offered to seniors. | | | | | |
| **Measure of Success:** BHHA will determine feasibility of offering cooking/nutritional classes for seniors by February 2018. | | | | | |

# Needs Not Addressed and Justification

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| **Identified health needs unable to address**  **by Big Horn Hospital Association** | **Rationale** |
| 1. Majority of respondents indicated a need for ‘Dermatology’ (33.1%), ‘ENT (ear/nose/throat)’ (29.4%), and ‘Ophthalmology’ (25%) | * BHHA offers a variety of traveling specialists at this time including general surgical procedures, but offering additional visiting specialist is not feasible at this time due to low number of patient referrals, and specialized training of staff that is not cost effective. |
| 1. Top three suggestions to improve community’s access to healthcare: “Availability of walk-in clinic/longer hours’ (53.7%), ‘Availability of visiting specialists’ (42.6%) and ‘More primary care providers’ (42.6%) | * BHHA does not offer a “walk in clinic” in its operational matrix. Local Big Horn Valley Health Care Center has expanded walk in hours in previous 60 days. BHHA is not designated as a health care shortage area causing lack of incentives for professional staff acquisition. |
| 1. 32.5% of respondents indicated that they or a member of their household delayed getting healthcare services when they needed it. Top three reasons cited: ‘It costs too much’ (40%), ‘No insurance’ (32.5%), ‘Could not get an appointment’ (30%) | * BHHA offers programs/charity care to assist with paying for healthcare costs at healthcare priced services that are based on current market conditions along with free patient navigator services. |

# Dissemination of Needs Assessment

Big Horn Hospital Association “BHHA” disseminated the community health needs assessment and implementation plan by posting both documents conspicuously on their website (<http://www.bighornhospital.org>)as well as having copies available at the facility should community members request to view the community health needs assessment or the implementation planning documents.

The Steering Committee, which was formed specifically as a result of the CHSD [Community Health Services Development] process to introduce the community to the assessment process, will be informed of the implementation plan to see the value of their input and time in the CHSD process as well as how BHHA is utilizing their input. The Steering Committee, will be encouraged to act as advocates in Big Horn County as the facility seeks to address the healthcare needs of their community.

Furthermore, the board members of BHHA will be directed to the hospital’s website to view the complete assessment results and the implementation plan. BHHA board members approved and adopted the plan on **September 22, 2016**. Board members are encouraged to familiarize themselves with the needs assessment report and implementation plan so they can publically promote the facility’s plan to influence the community in a beneficial manner.

BHHA will establish an ongoing feedback mechanism to take into account any written comments it may receive on the adopted implementation plan document.

***[Please remove the following statement and the disclaimer in the footer once the planning document is finalized]***

*\*Please note that you will need to include information specific to these requirements:*

* *You must post your community health needs assessment (CHNA) and your facility’s implementation plan publicly – both “conspicuously” on your website as well as have a hard copy available at your facility should someone request to view either/both documents.* 
  + *Your documents must remain on the web until two subsequent CHNA reports have been posted*
  + *An individual must not be required to create an account or provide personally identifiable information to access the report*
  + *A paper copy must be available for public inspection without charge*
* *Your facility’s implementation plan must be approved and the plan must document the date upon which the plan was approved/adopted*