COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

Addressing Community Health Needs
2018-2020

Dahl Memorial Healthcare Association, Inc. ~ Ekalaka, Montana

Disclaimer: The Montana Office of Rural Health strongly encourages an accounting professional's review of this document before submission to the IRS. As of this publishing, this document should be reviewed by a qualified tax professional. Recommendations on its adequacy in fulfillment of IRS reporting requirements are forthcoming.

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The Implementation Planning Process

The implementation planning committee – comprised of Dahl Memorial Healthcare Association (DMHA), Inc's leadership team and board members – participated in an implementation planning process to systematically and thoughtfully respond to the issues and opportunities identified through the Community Health Services Development (CHSD)-Community Health Needs Assessment (CHNA) process. The facility conducted the CHSD-CHNA process in conjunction with the Montana Office of Rural Health (MORH).

The CHSD community health needs assessment was performed in the Spring of 2017 to determine the most important health needs and opportunities for Carter County, Montana from its residents' perspective. "Needs" were identified as the top issues or opportunities rated by respondents during the CHSD survey process or during focus groups (see page 10 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.dahlmemorial.com).

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 page 9 for additional information regarding input received from community representatives).

The implementation planning committee determined which needs or opportunities could be addressed considering DMHA'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 relate to the following healthcare issues:

1. Senior Services
2. Access to onsite specialty services
3. Access to telehealth specialty services
4. Workforce development

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In addressing the aforementioned issues, DMHA seeks to:

a) Improve access to healthcare services;
b) Enhance the health of the community;
c) Advance medical or health knowledge;
d) Relieve or reduce the burden of government or other community efforts

Dahl Memorial Healthcare Association, Inc.'s Mission:

Our mission is to improve the lives and health of our community through comprehensive services provided in a professional and dedicated atmosphere of compassion.

We strive to provide a full range of high quality healthcare services your family can depend on. We aim to:

- Serve families as a local, not-for-profit frontier healthcare provider;
- Collaborate with other health care providers and systems and act as an advocate for those in need of their services;
- Promote general health, wellness and the attainment of maximum potential for all.

Implementation Planning Committee Members: Please double check names spelling and titles

- Nadine Elmore – CEO, Dahl Memorial Healthcare Association (DMHA)
- Ed Powell – Board Member, DMHA
- Kathy Wilcox - Performance Improvement, DMHA
- Shauna Kerr – Environmental Services, DMHA
- Melissa Lovec – Human Resources, DMHA
- Roberta Huether – Business Office, DMHA
- Kristy Bruce – Dietary Manager, DMHA
- Melody Loken – Board Member, DMHA
- Linda Cuomo – Lab/x-ray, DMHA
- Alicia Knapp – Purchasing, DMHA
- Patricia Rogers – Director of Nursing, DMHA
- Martha Elmore – Activities Director, DMHA
- Cindy Enos – Social Services, DMHA
- Brittani Brence – Board Chair, DMHA
- Phil Cook – Maintenance, DMHA
- Carla Dowdy – Physician Assistant, DMHA

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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.

Dahl Memorial Healthcare Association's Existing Presence in the Community

- DMHA organizes an annual Health Fair in April. The number of booths has grown from two (2) to eight (8) in the past year. A record number of blood draws (324) were provided in 2014.
- An educational speaker on a healthcare topic is provided at an annual event in early May after the Health Fair. The primary care provider also provides follow-up information concerning lab results for anyone interested.
- The facility provides discounted school physicals annually (in July), as well as year-round Department of Transportation physicals.
- DMHA's provider is trained to conduct impact assessments and training concerning head injuries. The provider also works with local coaches and responders to increase awareness of impact assessments.
- The facility is the Meal on Wheels contractor through the County Council on Aging.
- DMHA is a respite care provider on contract with the County Council on Aging.
- DMHA staff members conduct heart health awareness activities during heart health month each February.
- DMHA assists in coordinating transportation for patient visits outside of the service area through Carter Charter and community volunteers.
- DMHA supports the annual 'Walk for A Cure' and other breast cancer awareness activities each October.
- The facility participates in the local annual parade each August. Health prevention items like lip balm, sunscreen, and water bottles with health messages are distributed.
- DMHA supports the annual 'drug free' week at the school at the same time it encourages reading by purchasing and awarding personal tablets to students to demonstrate a commitment to promoting being drug free throughout the week.
- DMHA participates in an annual Holiday Bazaar and offers free blood draws and flu shots, as well as health planning tools and information.
- At its annual meeting in September, DMHA includes presentations from the departments purposed to update the community on what is happening at the hospital, long term care and clinic locations.

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List of Available Community Partnerships and Facility Resources to Address Needs

- Carter County Transportation board and the *Carter Charter* provide low cost transportation for community members throughout the area. The Activities Department at Dahl use these services to transport residents for group outings.
- Powder River Manor provides low income housing for senior citizens in the area.
- Unlicensed Assistance Personnel (UAP) program provides training and student rotations for unlicensed staff.
- Glendive Medical Center (GMC) and Fallon Medical Complex (FMC) provide discounted blood draws, support, and free or discounted mammograms at the annual health fair.
- Montana State University Extension provides unbiased research-based education and information that integrates learning, discovery and engagement to strengthen the social, economic and environmental well-being of individuals, families, and communities.
- The American Cancer Society (ACS) is a nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem.
- The Carter County Public Health Department, housed in DMHA, offers a variety of services (i.e. immunizations, referrals to family planning, walk-in blood pressure checks, and adult day care) to community members, regardless of age or income.
- Life Link, County Cow Belles, and Oxygen suppliers have informational booths at the annual Health Fair Review.
- St Vincent Healthcare in Billings provides e-Emergency services, which links two-way video equipment in rural emergency rooms to emergency-trained physicians and specialists at a central hub. Their Behavioral Health (BH) program also provides access to BH patient care services, professional support and staff education.
- The Eastern Montana Telemedicine Network (EMTN) is a consortium of not-for-profit medical and mental health facilities linking health care providers and their patients throughout Montana and Wyoming.
- The Montana Health Network (MHN) is a consortium of healthcare organizations collaborating to develop products and services needed to make healthcare more stable, efficient and cost effective.
- The Eastern Montana Area Health Education Center (AHEC) is a part of a statewide network of Area Health Education Centers created to train, recruit and retain healthcare professionals in rural/frontier Montana. AHEC also provides pipeline programs for high school students to spark interest in pursuing medical careers and staying locally.
- Montana Geriatric Education Center (MTGEC) is an interdisciplinary center which provides geriatric education and training for Montana health professionals, higher education faculty, and health professions students so that they might better meet the health needs of the older residents of the state.
- St. Vincent Healthcare, Holy Rosary Healthcare, and Billings Clinic provide a variety of clinical specialist telehealth services, health education opportunities on healthy lifestyles and diabetes, as well as professional education opportunities via information technology.
- University of Utah Burn Center has a specialist with privileges at DMHA to provide burn care follow-up via tele-medicine.

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- Action for Eastern Montana, Area I Agency on Aging, and the County Council on Aging sponsor the local Senior Citizens programs and provide a venue for information dissemination as well as informational resources.
- Frontier Community Health Integration Program (FCHIP) provides education, problem-solving support, technical and billing expertise and marketing resources for increasing patient access to telehealth services in our frontier geographic location.
- National Rural Accountable Care Consortium (NRACO) provides education and training, problem-solving support, technical and billing expertise, and marketing materials for increasing Carter County Medicare beneficiaries' to comprehensive health management service integration and coordination.

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Carter County Indicators

Low Income Persons
- 14% of persons are below the federal poverty level

Uninsured Persons
- 23% of adults less than age 65 are uninsured
- Data is not available by county (data is available for some counties) for uninsured children less than age 18

Leading Causes of Death: Primary and Chronic Diseases
- Heart Disease
- Cancer
- Chronic Lower Respiratory Disease

Elderly Populations
- 24.4% of Carter County's population is 65 years and older

Size of County and Remoteness
- 1,169 people in Carter County
- 0.3 people per square mile

Nearest Major Hospital
- Billings Clinic and St. Vincent Healthcare in Billings, MT are 260 miles from DMHA. Medical centers in Bismarck, ND and Rapid City, SD are slightly closer to DMHA but these facilities prove more difficult to refer to due to crossing state lines.

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Public Health and Underserved Populations Consultation Summaries

Public Health Consultation [Patricia Rogers – Public Health Nurse, Dahl Memorial Healthcare Association
Nadine Elmore – CEO, Dahl Memorial Healthcare Association – March 14, 2017]

- The community needs better access to psychiatric care or maybe better advertising of the current way to get that type of care.
- Mental health issues, suicide, drug and alcohol abuse, and domestic violence are important local healthcare issues.
- More outreach could be done to inform the community of the resources available in the region.

Underserved Population – Senior Citizens [Karen Carroll – Senior Citizens Coordinator, Carter County Senior Services
Nadine Elmore – CEO, Dahl Memorial Healthcare Association
Patricia Rogers – Public Health Nurse, Dahl Memorial Healthcare Association – March 14, 2017]

- We see a lot of diabetes, hypertension, cancer, and everything else involving the aging community. Having home health services would help with all of these things. People who only need to be checked on periodically shouldn't have to be considered home bound.
- The long term care services are great.
- We do clinics for blood pressure checkups once a month. Public health does a foot clinic once a month. They have exercise classes twice a week. Hospital does meals on wheels.

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Needs Identified and Prioritized

Prioritized Needs to Address

1. Focus group participants indicated that illnesses associated with the aging community (hypertension, diabetes, etc.) are top health concern the community.
2. Survey respondents indicated that the top most serious health concerns were cancer (61.3%) and heart disease (38.7%) alcohol/substance abuse (37%).
3. Focus group participants felt there was a need for more senior services such as an assisted living center and transportation services.
4. Top three components of a healthy community identified were: Access to healthcare and other services (63%), strong family life (44.5%) and healthy behaviors and lifestyles (39.9%).
5. 42.1% of respondents felt the community was 'somewhat healthy'
6. Top community health resources utilized were: Senior center (15.6%), the Carter Charter (12.7%) and the public health nurse (9.2%).
7. Only 41.6% of participants indicated that they had had a routine health checkup in the past year.
8. Focus group participants indicated a need for increased access to mental health services such as psychiatric care.
9. Top suggestions to improve community access to healthcare were: Telemedicine (24.9%) and more specialist (16.8%).
10. Top healthcare services participants would utilize if available locally were: Pharmacy (52%), vision services (44.5%), dental services (40.5%), and prevention/health and wellness (16.2%).
11. 21.1% of the respondents who indicated they did not get or delayed getting needed services because they 'Could not get an appointment' or 'It was too far to go.'
12. The most frequently visited specialist was a "Dentist" (57.4%), "Cardiologist" (27%) and "Dermatologist" (26.2%). Only 12.3% of respondents utilized specialty services at DMHA (including tele video).
13. 30.7% of respondents indicated that they had fair or poor knowledge of available health services at DMHA.

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Needs Unable to Address

(See page 29 for additional information)

1. Focus group participants felt that alcohol and drug abuse was an issue in the community. Additionally, alcohol/substance abuse was selected as a serious health concern by 37% of survey respondents.
2. Of the respondents who indicated they did not get or delayed getting needed services (12.8%), 31.6% selected cost as a barrier to receiving services.
3. Survey respondents indicated an interest in the following educational classes/programs: Weight loss (27.2%), fitness (22.5%) and health and wellness with (22%).
4. 'Outpatient services expanded hours' at 17.7% was a top suggestion to improve community access to healthcare.

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Executive Summary

The following summary briefly represents the goals and corresponding strategies and activities which DMHA will work to execute in order to address the prioritized health needs identified in the assessment (from page 10). For more details regarding the approach and performance measures for each goal, please refer to the Implementation Plan Grid section, which begins on page 15.

Goal 1: Improve access to senior services and resources in Carter County.

Strategy 1.1: Improve access to senior transportation services in Carter County.

Activities:

- Convene Transportation Board to discuss partnership opportunities in assessing and marketing transportation resources.
- Partner with Transportation board in conducting surveys, focus groups, interviews, and/or community meetings to assess transportation needs in Carter County.
- Partner with Transportation Board to publish and disseminate results within community.

Strategy 1.2: Assess and educate community about senior housing options for the community.

Activities:

- Convene meeting with the Carter County Senior Citizens Coordinator to discuss collaborating on an assessment of and education about senior housing resources in Carter County.
- Meet with community to discuss senior housing needs and resources.
- Partner with the local Senior Citizens Coordinator and the MT DPHHS Area Agency on Aging to conduct senior citizens housing needs assessment in Carter County.
- Research various senior housing options and costs associated.
- Assess results of needs assessment and develop publication/ educational materials to discuss results, benefits, and barriers.

Strategy 1.3: Increase marketing and enrollment of beneficiaries in available Medicare Care Management Programs.

Activities:

- Designate staff to connect with all eligible beneficiaries to schedule and provide their Annual Wellness Visit each year.
- Identify and enroll 100% of eligible beneficiaries in the Chronic Care Management Program.

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- Coordinate with the CAH's Acute Care services to identify and appropriately schedule post-discharge Transitional Care Management visits.
- Adapt Medicare Care Management Program materials and the electronic medical record (e-MR) to fit both the requirements of an acceptable CMS Alternative Payment Model and DMHA's care delivery environment.
- Participate in the Montana Health Network's Eastern Mt Chronic Care Coordination (EMC3) project.

Goal 2: Improve access to onsite specialty services at Dahl Memorial Healthcare Association.

Strategy 2.1: Continuously evaluate and implement feasible new specialty care services onsite at DMHA.

Activities:

- Evaluate the feasibility of expanding senior clinical services to include new specialty services (audiology, dental, cardiology, gerontology, behavioral health, outpatient therapies, chiropractic, vision and alternative care services).
- Complete implementation of Outpatient Therapies and Outpatient Pharmacy services.
- Create education/ marketing campaign aimed at educating community members about available and expanding services.

Goal 3: Increase access to specialty services through telehealth.

Strategy 3.1: Improve community outreach and education on available telehealth specialty services.

Activities:

- Provide a telehealth demonstration at the Sept 2018 DMHA Annual Meeting.
- Partner with EMTN to determine feasibility of creating a DMHA telehealth exam demonstration video.
- Distribute marketing and outreach materials of available telehealth services at each inpatient and outpatient discharge home.
- Market telehealth services broadly to community members, Carter County residents and others.

Strategy 3.2: Reduce barriers to use of telehealth services.

Activities:

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- Continue actively participating in the final two years of the three-year FCHIP CMS demonstration grant to enhance tele-health services provided at DMHA.
- Work with the FCHIP Demonstration team, telehealth providers and/or specialty care providers to develop seamless transitions for telehealth appointments and receipt of post-visit notes.
- Update the list of telehealth specialty telehealth providers for DMHA medical staff.
- Develop a procedure for keeping list up to date.

Strategy 3.3: Continuously evaluate and expand specialty care services offered via telehealth whenever possible.

Activities:

- Continuously work with medical and facility staff workgroup to identify potential network partnerships.
- Identify and partner with new telehealth specialists to increase access, including those outside of MT but available through the MT Board of Medicine Licensing Compact states.
- Identify and remove internal and external barriers to new telehealth specialty services.

Goal 4: Continue workforce development efforts to support access to local healthcare services.

Strategy 4.1: Continue to support and actively participate in workforce pipeline efforts.

Activities:

- Continue offering shadowing opportunities for local high school students.
- Continue promoting and participating in MT Area Health Education Center (AHEC) Med Start camps.
- Continue to provide assistance with certification and licensure fees for staff as financially able to do so.
- Continue providing UAP (Unlicensed Assistance Personnel) student rotations.
- Attend the annual *Meet the Residents Program,* sponsored by MHA and the AHEC, when feasible.

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Implementation Plan Grid

Goal 1: Improve access to senior services and resources in Carter County.

Strategy 1.1: Improve access to senior transportation services in Carter County.

Activities	Responsibility	Timeline	Final Approval	Partners	Potential Barriers
Convene Transportation Board to discuss partnership opportunities in assessing and marketing transportation resources.	Activities Dir	3Q 2018	CEO	Transportation Board *Carter Charter* Senior Citizens Coord MT DPHHS Area Agency on Aging	Staff time Scheduling conflicts
Partner with Transportation board in conducting surveys, focus groups, interviews, and/or community meetings to assess seniors' transportation needs in Carter County.	Activities Dir	4Q 2018	CEO	Transportation Board *Carter Charter* Senior Citizens Coord MT DPHHS Area Agency on Aging	Staff time Scheduling conflicts
Partner with Transportation Board to publish and disseminate assessment results within community.	Activities Dir	2Q 2019	CEO	Transportation Board *Carter Charter* Senior Citizens Coord Area Agency on Aging	Staff time Publication costs Scheduling conflicts

Needs Being Addressed by this Strategy:

- #1: Focus group participants indicated that illnesses associated with the aging community (hypertension, diabetes, etc.) are top health concern the community.

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- #3: Focus group participants felt there was a need for more senior services such as an assisted living center and transportation services.
- #4: Top three components of a healthy community identified were: Access to healthcare and other services (63%), strong family life (44.5%) and healthy behaviors and lifestyles (39.9%).
- #6: Top community health resources utilized were: Senior center (15.6%), the Carter Charter (12.7%) and the public health nurse (9.2%).
- #11: 21.1% of the respondents who indicated they did not get or delayed getting needed services because they 'Could not get an appointment' or 'It was too far to go.'

Anticipated Impact(s) of these Activities:

- Improved understanding of transportation needs in Carter County
- Improved access to healthcare services
- Improved community partnerships
- Increased community engagement

Plan to Evaluate Anticipated Impact(s) of these Activities:

- Track number of meetings held and attended in partnership with the Transportation Board.
- Track number of community participants in surveys, focus groups, interviews, and/or-community meetings
- Track assessment progress to completion and publication of results

Measure of Success: Transportation assessment is published by June 30, 2019.

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Goal 1: Improve access to senior services and resources in Carter County.

Strategy 1.2: Assess and educate community about senior housing options for the community.

Activities	Responsibility	Timeline	Final Approval	Partners	Potential Barriers
Convene meeting with Action for E MT and Senior Citizens Coordinator to partner on assessment and education on senior housing in Carter County.	Activities Dir SS Director	3Q 2018	CEO	Action for E MT Senior Citizens Coord MT Area Agency on Aging *The Manor*	Staff time Scheduling conflicts
Meet with identified partners to plan for assessing senior housing needs and available resources.	Activities Dir SS Director	4Q 2018	CEO	See above	Staff time Scheduling conflicts
Work with identified partners to conduct housing needs assessment in Carter County.	Activities Dir SS Director	1Q 2019	CEO	See above	Staff time Scheduling conflicts
Research various senior housing improvement options and barriers to meeting identified needs, including projected costs associated with any proposed interventions.	Activities Dir SS Director Business Office, ad hoc	1Q 2019	CEO	See above	Staff time Scheduling conflicts
Develop, publish and disseminate assessment results.	Activities SS Director CEO	2Q 2019	CEO	See above	Staff time Publication costs Scheduling conflicts

Needs Being Addressed by this Strategy:

- #1: Focus group participants indicated that illnesses associated with the aging community (hypertension, diabetes, etc.) are top health concern the community.
- #3: Focus group participants felt there was a need for more senior services such as an assisted living center and transportation services.
- #4: Top three components of a healthy community identified were: Access to healthcare and other services (63%), strong family life (44.5%) and healthy behaviors and lifestyles (39.9%).
- #6: Top community health resources utilized were: Senior center (15.6%), the Carter Charter (12.7%) and the public health nurse (9.2%).
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Anticipated Impact(s) of these Activities:

- Improved understanding of senior housing needs in Carter County
- Improved community partnerships
- Increased community engagement

Plan to Evaluate Anticipated Impact(s) of these Activities:

- Track number of meetings held and attended with identified partners.
- Track number of individual community members participating in the senior housing assessment process.
- Track completion and publication of senior housing assessment results.

Measure of Success: Senior housing assessment is published by June 30, 2019.

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Goal 1: Improve access to senior healthcare services and resources in Carter County.					
Strategy 1.3: Improve marketing and enrollment in Medicare beneficiary healthcare management programs.					
Activities	**Responsibility**	**Timeline**	**Final Approval**	**Partners**	**Potential Barriers**
Support designated staff connecting with eligible Medicare beneficiary patients to schedule and complete Annual Wellness visits each year.	Clinic Nurse Manager & Admin support CEO	Dec 31, 2017 2018 2019 2020	CEO	NRACO/TCPI Our providers Other dept heads Public health Senior Citizens Program	Staff Time Staff buy-in Education- public & staff Transportation to appt Using eMR Scheduling visits Visit time: support patient side of paperwork completion pre-visit Provider coding ed
Identify patients in the Annual Wellness Visit program who qualify and enroll them in the Chronic Care Program Criteria.	Clinic Nurse Manager & Admin support Business Office	Mar 31, 2018 2019 2020	CEO	NRACO/TCPI Our providers Other dept heads Public health Senior Citizens Program MedWorxs	Staff Time Staff buy-in Education- public & staff Using eMR Scheduling contacts Support patient side of paperwork completion Nurse/Provider coding
Identify hospitalized patients who qualify for Transitional Care Management, appropriately schedule the post-discharge clinic TCM visit and bill them as such. ***Continued on next page…***	Clinic Nurse Manager & Admin support ADON Business Office	Mar 31, 2018 2019 2020	CEO	NRACO/TCPI Our providers Other dept heads MedWorxs	No process CAH/Clinic communication Schedule coordination Staff time Provider coding ed

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Research, adapt and implement Chronic Care Program materials, including e-MR documentation and marketing materials, to fit with DMHA model.	Clinic Nurse Manager & Admin Support Business Office IT	Dec 2018	CEO	NRACO/TCPI Our providers Other dept heads MedWorxs	Marketing support Marketing materials MedWorxs forms Integration w/ billing
Participate in the MHN-EM3C Diabetes project.	Providers Clinic Nurse Manager PI	2018 2019 2010	CEO	MHN MHN member facilities MedWorxs	Staff time Staff buy-in Community Ed

Needs Being Addressed by this Strategy:

- 1#: Focus group participants indicated that illnesses associated with the aging community (hypertension, diabetes, etc.) are top health concern the community.
- #2: Survey respondents indicated that the top most serious health concerns were cancer (61.3%) and heart disease (38.7%) alcohol/substance abuse (37%).
- #4: Top three components of a healthy community identified were: Access to healthcare and other services (63%), strong family life (44.5%) and healthy behaviors and lifestyles (39.9%).
- #5: 42.1% of respondents felt the community was 'somewhat healthy'
- #6: Top community health resources utilized were: Senior center (15.6%), the Carter Charter (12.7%) and the public health nurse (9.2%).
- #7: Only 41.6% of participants indicated that they had had a routine health checkup in the past year.

Anticipated Impact(s) of these Activities:

- Improved access to care
- Increase in knowledge of and participation in Medicare Beneficiary chronic care programs.
- Reduced preventable returns to ED and/or hospital readmission
- Improved health outcomes

Plan to Evaluate Anticipated Impact(s) of these Activities:

- Track number of scheduled senior chronic care clinic visits.
- Track percent qualifying Beneficiaries who receive their Annual Wellness Visit each year.
- Track increased enrollment in Chronic Care Management to an ultimate goal of 100% eligible enrolled.
- Track number of transitional care management visits billed and scheduling opportunities missed.

Measure of Success: DMHA fully implements 3 Medicare Beneficiary healthcare services programs by Dec 31, 2018 and maintains the programs thereafter.

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Goal 2: Improve access to onsite specialty services.

Strategy 2.1: Continuously work to expand feasible onsite specialty services available through DMHA.

Activities	Responsibility	Timeline	Final Approval	Partners	Potential Barriers
Continuously explore feasible approaches for providing new onsite specialty services, including audiology, dental, vision, cardiology, oncology, gerontology, podiatry, therapies, and alternative health provider services.	CEO Providers Dept Heads	2018 2019 2020	CEO	FCHIP, NRACO Regional HC providers MT-BOME MT Compact Participants (9 states)	Specialty providers Staff support time Best available technology Financial limitations
Continue implementation of outpatient therapies and pharmacy services at DMHA.	CEO Providers Dept Heads	2018 2019 2020	CEO	FCHIP, NRACO Regional HC providers MT-BOME MT Compact Participants (9 states)	Licensed staff shortage Support staff time Building space Financial limitations
Update and distribute education/marketing campaign materials aimed at educating community members about available and expanding services.	CEO Providers Dept Heads	2018 2019 2020	CEO	FCHIP, NRACO Regional HC providers MT-BOME MT Compact Participants (9 states)	Staff support time Resource limitations

Needs Being Addressed by this Strategy:

- #1: Survey respondents indicated that the top most serious health concerns were cancer (61.3%) and heart disease (38.7%) alcohol/substance abuse (37%).
- #4: Top three components of a healthy community identified were: Access to healthcare and other services (63%), strong family life (44.5%) and healthy behaviors and lifestyles (39.9%).
- #8: Focus group participants indicated a need for increased access to mental health services such as psychiatric care.

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- #9: Top suggestions to improve community access to healthcare were: Telemedicine (24.9%) and more specialist (16.8%).
- #10: Top healthcare services participants would utilize if available locally were: Pharmacy (52%), vision services (44.5%), dental services (40.5%), and prevention/health and wellness (16.2%).
- #11: 21.1% of the respondents who indicated they did not get or delayed getting needed services because they 'Could not get an appointment' or 'It was too far to go.'
- #12: The most frequently visited specialist was a "Dentist" (57.4%), "Cardiologist" (27%) and "Dermatologist" (26.2%). Only 12.3% of respondents utilized specialty services at DMHA (including tele video).
- #13: 30.7% of respondents indicated that they had fair or poor knowledge of available health services at DMHA.

Anticipated Impact(s) of these Activities:

- Improved access to specialty services
- Improved access to physical therapy and pharmacy services
- Increase in knowledge of available services at DMHA

Plan to Evaluate Anticipated Impact(s) of these Activities:

- Track new onsite consulting specialty services developed.
- Track-elimination of barriers to Outpatient Therapies and Outpatient Pharmacy services.
- Track development and dissemination of new marketing materials

Measure of Success: DMHA fully assesses, develops and implements feasible new onsite specialty services.

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Goal 3: Increase access to specialty services through telehealth services.

Strategy 3.1: Improve community outreach and education about available telehealth services.

Activities	Responsibility	Timeline	Final Approval	Partners	Potential Barriers
Provide a telehealth demonstration at the 2018 Annual Membership Meeting. (September).	DMHA Telehealth staff	Sept 2018	CEO	EMTN MHN Specialty providers	Scheduling conflicts Community participation
Partner with EMTN to determine feasibility of telehealth exam demonstration video.	CEO Telehealth staff Providers All staff	2018 2019	CEO	EMTN MHN Specialty providers	Scheduling conflicts Video expertise Financial limitations
Update marketing and outreach materials of available tele-health services.	CEO	2Q 2018	CEO	FCHIP	Display space Postage costs: postcard mailer
Market telehealth services to community members.	Board CEO Providers Dept Heads All staff	2018 2019 2020	CEO	Regional HC providers EMTN Senior Citizens Program Meals on Wheels Public Health Schools	Human factors

Needs Being Addressed by this Strategy:

- #4: Top three components of a healthy community identified were: Access to healthcare and other services (63%), strong family life (44.5%) and healthy behaviors and lifestyles (39.9%).
- #8: Focus group participants indicated a need for increased access to mental health services such as psychiatric care.
- #9: Top suggestions to improve community access to healthcare were: Telemedicine (24.9%) and more specialist (16.8%).

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- #11: 21.1% of the respondents who indicated they did not get or delayed getting needed services because they 'Could not get an

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appointment' or 'It was too far to go.'
- #12: The most frequently visited specialist was a "Dentist" (57.4%), "Cardiologist" (27%) and "Dermatologist" (26.2%). Only 12.3% of respondents utilized specialty services at DMHA (including tele video).
- #13: 30.7% of respondents indicated that they had fair or poor knowledge of available health services at DMHA.

Anticipated Impact(s) of these Activities:
- Increased knowledge of available health services
- Increased access to services
- Increased community engagement
- Improved health outcomes

Plan to Evaluate Anticipated Impact(s) of these Activities:
- Track community presentation of telehealth demonstration
- Track telehealth patient utilization pre-post demonstration
- Track telehealth patient utilization pre-post marketing campaign

Measure of Success: Patient healthcare uses of telehealth for accessing specialty care increase by 4Q 2019.

Goal 3: Increase access to specialty services through telehealth services.

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Strategy 3.2: Reduce barriers regarding use of telehealth services.					
Activities	**Responsibility**	**Timeline**	**Final Approval**	**Partners**	**Potential Barriers**
Participate in three-year CMS-FCHIP demonstration project to enhance telehealth services provided at DMHA.	CEO Providers Clinic Nurse Manager & admin support Business Office PI IT/MedWorxs	2018 2019	CEO	FCHIP partners MHA Telehealth providers Regional specialists	Staff time Staff buy-in Telehealth control point(s) Regional specialists buy-in
Engage staff, telehealth providers & FCHIP Demonstration group in problem solving seamless transition for telehealth appointments.	CEO Clinic Nurse Telehealth staff DON Business Office PI Manager	Aug 2018	CEO	FCHIP partners Telehealth providers Regional specialists	Scheduling conflicts Internal & external process variations coming to consensus
Engage staff, telehealth providers & FCHIP Demonstration group in problem solving seamless specialist note to patient home provider after each visit.	CEO Providers Clinic Nurse Telehealth staff Medical Records	Aug 2018	CEO	FCHIP partners Telehealth providers	Staff & provider buy in Scheduling conflicts Internal & external process variations coming to consensus Communication Documentation
Update and distribute telehealth specialists list for DMHA providers. ***Continued on next page…***	Telehealth staff IT	1Q 2018	CEO	EMTN St Vincent HC	Communication
Develop protocol for keeping list up to date.	Telehealth	1Q 2018	CEO	MedWorxs/IT	Technical expertise

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	staff IT				

Needs Being Addressed by this Strategy:

- #4: Top three components of a healthy community identified were: Access to healthcare and other services (63%), strong family life (44.5%) and healthy behaviors and lifestyles (39.9%).
- #9: Top suggestions to improve community access to healthcare were: Telemedicine (24.9%) and more specialist (16.8%).
- #11: 21.1% of the respondents who indicated they did not get or delayed getting needed services because they 'Could not get an appointment' or 'It was too far to go.'
- #12: The most frequently visited specialist was a "Dentist" (57.4%), "Cardiologist" (27%) and "Dermatologist" (26.2%). Only 12.3% of respondents utilized specialty services at DMHA (including tele video).
- #13: 30.7% of respondents indicated that they had fair or poor knowledge of available health services at DMHA.

Anticipated Impact(s) of these Activities:

- Improved access to health services
- Improved knowledge of available services
- Improved health outcomes

Plan to Evaluate Anticipated Impact(s) of these Activities:

- Track # and % ED patients receiving telehealth consult/specialty care at time of their ED visit.
- Track # and % ED and clinic visits where patient received telehealth marketing materials at discharge.
- Track receipt of post-visit note from telehealth specialist visits for inclusion in the patient's medical record.
- Track update of telehealth provider list and implementation of procedure to keep current

Measure of Success: DMHA-demonstrates measurable increase in patient utilization of telehealth visit services by 4Q 2019.

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Goal 4: Continue workforce efforts to improve access to healthcare services.					
Strategy 4.1: Continue to support workforce pipeline efforts.					
Activities	**Responsibility**	**Timeline**	**Final Approval**	**Partners**	**Potential Barriers**
Continue offering summer job shadowing and school-year *School to Work* program opportunities for local high school students.	Medical staff Nursing Lab X-ray MR-coding Therapies Maintenance Activities Social Services	Marketing by April 2018 Students shadowing June 2018	CEO	School counselors "*School to Work*" AHEC HR Dept Heads Action for E MT - youth program	Staff time Coordination with partners Schedule conflicts HIPAA requirements Current competency lists Current profession flyers Current Licensing requirements
Continue participating in and promoting AHEC Med Start Camps.	CEO Providers	2018 2019 2020	CEO	MHA AHEC	Staff time Coordination with partners Schedule conflicts HIPAA requirements Current competency lists Current profession flyers
Continue to provide assistance with certification and licensure fees for positions targeted by the Board.	CEO HR	2018 2019 2020	CEO	NA	Financial limitations
Continue providing UAP (Unlicensed Assistance Personnel) student rotations.	DON ADON Clinic Nurse	2018 2019 2020	CEO	MHN AHEC	Staff time Scheduling conflicts

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Continued from previous page…	Manager HR				
Explore attending the MHA/AHEC sponsored *Meet the Residents* Program each year and attend when feasible.	CEO Providers	2018 2019 2020	CEO	MHA AHEC	Staff Time Scheduling conflicts Financial limitations

Needs Being Addressed by this Strategy:

- #4: Top three components of a healthy community identified were: Access to healthcare and other services (63%), strong family life (44.5%) and healthy behaviors and lifestyles (39.9%).
- #7: Only 41.6% of participants indicated that they had had a routine health checkup in the past year.
- #8: Focus group participants indicated a need for increased access to mental health services such as psychiatric care.
- #9: Top suggestions to improve community access to healthcare were: Telemedicine (24.9%) and more specialist (16.8%).

Anticipated Impact(s) of these Activities:

- Improved access to health education
- Improved knowledge of health services at DMHA
- Increased community engagement
- Increased access to care

Plan to Evaluate Anticipated Impact(s) of these Activities:

- Track number of high school students participating in job shadowing and *School to Work* programs at DMHA.
- Track community participants in *Med Start Camps* and number UAP student rotations provided each year.
- Track dollar value of professional license and certification fee assistance paid.
- Track attendance at the MHA/AHEC-sponsored annual "*Meet the Residents*" or "*Meet Up*" programs.

Measure of Success: DMHA encourages community members and students to enter a healthcare profession each year.

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Needs Not Addressed and Justification

Identified health needs unable to address by Dahl Memorial Healthcare	Rationale
1. Focus group participants felt that alcohol and drug abuse was an issue in the community. Additionally, alcohol/substance abuse was selected as a serious health concern by 37% of survey respondents.	• Alcohol and drug abuse are specialty healthcare services. DMHA emergency providers appropriately treat emergency patients, however, ongoing treatment is best provided by a specialist. DMHA patients can access ongoing specialty care of these types through our telehealth services.
2. Of the respondents who indicated they did not get or delayed getting needed services (12.8%), 31.6% selected cost as a barrier to receiving services.	• DMHA reviewed and updated its Financial Assistance program less than 2 years ago. Demand for this assistance is low. As our elderly population and healthcare costs both continue to increase, DMHA will continue to work with eligible patients to provide financial assistance as it is able to do so.
3. Survey respondents indicated an interest in the following educational classes/programs: Weight loss (27.2%), fitness (22.5%) and health and wellness with (22%).	• The local Public Health service provides exercise classes twice a week. Public Health and the Senior Citizens programs currently provide education classes related to health and wellness. DMHA staff are focused on meeting the clinical care needs of our inpatient, emergency and outpatient clinic populations. DMHA staff time and financial limitations preclude the provision of these types of health and wellness education services in-house at this time.
4. 'Outpatient services expanded hours' at 17.7% was a top suggestion to improve community access to healthcare.	• Expanding outpatient/clinic service hours beyond keeping the clinic reception desk staffed over the lunch hour is not feasible at this time because DMHA has only 1 full time clinic nurse and 1 full time receptionist to work the entire appointment schedule each week.

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Dissemination of Needs Assessment and Implementation Plan

Dahl Memorial Healthcare "DMHA" disseminated the community health needs assessment and implementation plan by posting both documents conspicuously on their website (http://www.dahlmemorial.com) 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. Hard copies of this needs assessment and implementation plan are available upon request at no charge.

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, has been informed of this implementation plan so they may see the value of their input and time in the CHSD process as well as how DMHA is utilizing their input. The Steering Committee, as well as the Board of Directors, are encouraged to act as advocates in Carter County as the facility seeks to address the healthcare needs of their community.

Furthermore, the DMHA Board of Directors has been directed to the hospital's website to view and familiarize themselves with the complete assessment results and the implementation plan so they can publicly promote the facility's plan to influence the community in a beneficial manner. DMHA board members approved and adopted the plan on October 24, 2017.

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Chairman of the DMHA Board of Directors ***Date***

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