Minnie Hamilton Health System

Community Health Implementation Report

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Prepared for:

Minnie Hamilton Health System
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Document Acronyms

The following acronyms are used throughout this document:

Acronym	Definition
CDC	Centers for Disease Control
CHNA	Community Health Needs Assessment
CHIP	Community Health Implementation Plan
CHW	Community Health Worker
EMR	Electronic Medical Record
FQHC	Federally Qualified Health Center
MAT	Medication Assisted Treatment
MHHS	Minnie Hamilton Health System
PCP	Primary Care Physician
RCORP HRSA	Rural Communities Opioid Response Program, Health Resources & Services Administration
SAMHSA SOR	Substance Abuse and Mental Health Services Administration, State Opioid Response
SUD	Substance Use Disorder
WVUHS	West Virginia University Hospital System

1 Health Topic: Substance Use and Abuse (Including Tobacco and Alcohol)

MHHS's CHNA leadership team has chosen to prioritize the topic of substance use and abuse due to strong feedback from primary data collection and the community meeting, evidence from secondary data regarding the area population, and experience in their own clinical and other professional settings. MHHS has prioritized this topic during past cycles and has already had programming and community partnerships underway to address these issues.

1.1 Strategy #1: Medication Assisted Treatment Program

MHHS has chosen to focus on clinical recovery treatment programs in addition to community-based programs. Their MAT program – currently federally funded at the implementation stage - is open to the community with no referral required. MHHS hopes to continue this intervention for as long as possible to help their community address substance use and opioid dependency.

Table 1: MAT Program – Opioid Dependency Recovery

MAT Program - Opioid Dependency Recovery	
Objectives	This is a comprehensive and multi-component program that utilizes evidence-based behavioral health strategies along with buprenorphine/naloxone medication assistance to improve overall mental and physical health by assisting individuals in reducing and/or discontinuing illicit opioid use. This ongoing program is open to the community and no referral is required.
Activities	• Referral Sources • Continuing Education • Staff Recruitment • Staff Retainment • Marketing/Advertising
Planning Partners	• WVU • SAMHSA SOR Grant program • RCORP HRSA Grant program • University of Charleston - Harm Reduction Support • MHHS
Implementation Partners	• WVU • SAMHSA SOR Grant program • RCORP HRSA Grant program • University of Charleston - Harm Reduction Support • MHHS

(Continuation of MAT Program - Opioid Dependency Recovery)	
Resources	• WVU • SAMHSA SOR Grant program • RCORP HRSA Grant program • University of Charleston - Harm Reduction Support
Evaluation Activities	• # of Participants • # of Groups • Participant Retention • Feedback Surveys
Point of Contact	Laura Simmons --Director of MHHS Behavioral Health MAT/SUD Services

1.2 Strategy #2: Smoking Cessation

Smoking cessation classes will be offered to community members free of charge to support efforts to quit using tobacco or nicotine products.

Table 2 : Smoking Cessation

Smoking Cessation	
Objectives	Group Smoking Cessation Classes will be offered to the community quarterly. These will be held in-person in the MHHS Annex basement lobby 4 times per year.
Activities	• Marketing -Director of Business Development • Contact referrals to sign up for group or individual tobacco cessation—Provider Recommendation • Accept self-referrals from the community • Participants initially meet with a provider then follow up with Education Coordinator for remainder of sessions • NP to follow through with some group sessions as available and as needed
Planning Partners	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers • Designated PCP
Implementation Partners	• Minnie Hamilton Health System • Community Outreach Coordinator • Programs: Freedom from Smoking, Catch my Breath (Vaping Prevention)

(Continuation of Smoking Cessation)	
Resources	EMR-Intake questions—Nurse data collection
Evaluation Activities	• # of classes offered (4) per year • # of referrals for smoking/tobacco cessation (Run report in Athena) • # of participants— (Class size—No limit restrictions) • Feedback Surveys
Point of Contact	• Community Outreach Coordinator • Clinical Care Managers

1.3 Strategy #3: Substance Use Education for Students

MHHS understands the importance of early intervention when it comes to substance use, so they have decided to partner with the local school system to provide education to students over a 3 year period.

Table 3: Substance Use Education for Students

Substance Use Education for Students	
Objectives	Substance Use Education and Prevention displays/presentations will be provided at least 3-5 times over a 3-year time period for both Calhoun and Gilmer County Schools, during school or at school events.
Activities	• Collaborate with community partners • Determine dates, locations, events to schedule the substance use and prevention education sessions • Recruit volunteers (if needed) • Recruit Guest Speakers
Planning Partners	• Calhoun County Schools • Gilmer County Schools • Minnie Hamilton Health System- School Based Health Clinics • Minnie Hamilton Health System- Behavioral Health Clinic • Associate Administrator/System Practice Administrator • Director of Business Development
Implementation Partners	• Calhoun County Schools • Gilmer County Schools • Minnie Hamilton Health System
Resources	• Educational material from CDC, other resource programs • Substance use displays • Location/space for presentations

(Continuation of Substance Use Education for Students)	
Evaluation Activities	• # of presentations • Dates and location of presentations • List of Volunteers and community partners at events • Pre/Post surveys when applicable • Feedback surveys
Point of Contact	• Associate Administrator/System Practice Administrator

2 Health Topic: Mental Health

MHHS's team felt it was necessary to prioritize Mental Health, given clinical knowledge, community feedback, and especially after watching the impacts the COVID-19 pandemic has had on their community. Based on the data collected, many residents reported social isolation and decreased connection to their community. MHHS's data collection also showed that residents would like to see increased access to mental health services in their area. Because of this, MHHS felt it necessary to prioritize this issue for their upcoming implementation cycle.

2.1 Strategy #1: Clinic Education – Mental Health

For this strategy, Community Health Workers will work with FQHC clinic staff, and MHHS Care Managers to provide education in the clinic setting for patients who may present with mental health concerns.

Table 4: Clinic Education - Mental Health

Clinic Education - Mental Health	
Objectives	Utilize Community Health Workers (CHW), RHC/FQHC Clinic Leads, Care Managers, other staff as needed to provide education to all patients that present with any mental health concerns.
Activities	• Run reports: Flags from Intake Questions or noted via providers or behavioral health staff. • Follow up calls to patients • Make follow up appointments as needed • Find community resources as needed • Verify patient understands medications and has new prescriptions • Patient education • Listen to patient concerns if voiced and document as needed in EMR. • Provide notebooks for materials, BP cuffs, bathroom scales and pill organizers as needs identified

(Continuation of Clinic Education – Mental Health)	
Planning Partners	• MHHS Clinical Staff • MHHS Providers • MHHS-Associate Administrator/System Practice Administrator • Director of Business Development • MHHS-Behavioral Health Staff
Implementation Partners	• MHHS-Clinical Staff
Resources	• Patient Education Materials • CHW Time • Funding for Education Materials
Evaluation Activities	• # of patients called monthly by Clinical Staff charted • # of patients called monthly by CHW
Point of Contact	RHC/FQHC Clinical Leads

3 Health Topic: Obesity and Co-Morbid Chronic Disease

During the previous CHNA cycle, obesity and chronic disease appeared among the community's top health concerns and were prioritized by hospital leadership to address through programming. MHHS implemented strategies to address these health topics, and leadership was not surprised to see these prevalent issues rise once again to the top of the list. This cycle, building on experiences from the last and in response to community requests and ideas collected through the survey data, MHHS's team has once again prioritized this topic.

3.1 Strategy #1: FARMACY Program

MHHS has had previous success in the implementation of the FARMACY program, which is designed to improve health and access to fresh fruits and vegetables for patients in need. It is carried out in partnership with Coplin Health System.

Table 5: FARMACY Program

FARMACY Program	
Objectives	Hold (1) FARMACY program per year. FARMACY program consist of (10) weekly sessions.
Activities	• Produce supply—Through Mountaineer Food Bank • Contact referrals with offer and schedule intake appointment if they verbalize commitment to FARMACY program • Confirm location for sessions and put session materials together for participants • Reminder calls for beginning of program • Communicate to providers who of their referrals signed up for FARMACY program • Enter pre/post data into WV Health Connections, Workshop Wizard • Share feedback data to providers • Possible cooking demonstrations (in conjunction with Calhoun County Extension, if possible)
Planning Partners	• FARMACY Program • Mountaineer Food Bank • Minnie Hamilton Health System • Coplin Health System-Sarah Barton • Ritchie Regional • Director of Business Development • Calhoun County Extension (possibly)
Implementation Partners	• Minnie Hamilton Health System • Sarah Barton • Mountaineer Food Bank • Calhoun County Extension (possibly)
Resources	• Produce to participants • Educational print materials • Recipes • Blood pressure cuffs • Notebooks • Logs for weight, blood pressure, and blood sugar • Bathroom scale as needed • Listing of local farmers markets' schedules • Reminder calls

(Continuation of FARMACY Program)	
Evaluation Activities	• # of participants (Year 1-28) Program can have up to 45 participants • Pre/post surveys • Pre/post Hgb, A1c, and cholesterol levels
Point of Contact	• Director of Business Development • Executive Assistant

3.2 Strategy #2: Diabetes Education Support Group

This program supports diabetic patients who are in need of additional education or support after receiving their diagnosis. This program is open to patients of MHHS.

Table 6: Diabetes Education Support Group

Diabetes Education Support Group	
Objectives	Host diabetes support group (1) per month.
Activities	• Marketing • Plan for occasional guest speaker • Plan for topics for sessions • **Would like to expand to offer lunch and learn sessions “Dining with Diabetes” in the future (1) a month at noon.
Planning Partners	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers
Implementation Partners	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers • Executive Assistant
Resources	• Educational materials/samples of health and personal hygiene products • Space for Group Meeting-Annex Basement lobby meeting room.
Evaluation Activities	• # groups held per year - (12) • # participants per group - (10)
Point of Contact	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers • Executive Assistant

3.3 Strategy #3: Wellness – Community Planning

This program is designed to target community members and MHHS employees to support and promote healthy lifestyle choices and to promote education and wellness events.

Table 7: Wellness - Community Planning

Wellness - Community Planning	
Objectives	Provide opportunities for community members and employees to promote healthy lifestyle through education and wellness events.
Activities	• Market Fitness Opportunities (Tracks, Weight Rooms, Swimming Pools, Zumba Dance Classes, etc.). • Monthly Wellness Challenges
Planning Partners	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers • Executive Assistant
Implementation Partners	• MHHS- Director of Business Development • Community Outreach Coordinator • Executive Assistant • Calhoun/Gilmer County Wellness collation • MHHS-Medical Staff
Resources	• Marketing • Incentives for participants' steps/miles goals met • Overall challenge winners' prizes
Evaluation Activities	• # of programs offered • # of participants per activity per month • Participants steps/miles logged monthly with documented proof of step count.
Point of Contact	Community Outreach Coordinator