Carteret Health Care Implementation Strategy

Carteret Health Care (CHC) will engage key community partners in implementing evidence-based strategies across the service area. The organization has strategically reviewed both internal and external resources to acknowledge the many organizations and resources in place to address the health needs of the community. The implementation strategy explains the actions that CHC will take to address the three priority health needs identified in the CHNA. These actions will identify any programs and resources that CHC plans to commit to address the health need. Also, the anticipated impact of the actions is provided along with an evaluation measure to determine the level of success of each action. Collaboration efforts with various community organizations are specified as well. Over the next three years, Carteret Health Care will work with community partners and health issue experts on the following for each of the approaches to addressing the health needs listed:

- Identify what other local organizations are doing to address the health priority
- Develop support and participation for these approaches to address health needs
- Develop specific and measurable goals so that effectiveness of these approaches can be measured.
- Develop detailed work plans
- Communicate with others involved to ensure appropriate coordination with other efforts to address the issue.

Carteret Health Care will continue to play a leading role in addressing the health needs of those within the community, with a special focus on the underserved. As such, community benefit planning will be integrated into the Hospital's annual planning and budgeting process to ensure the community benefits are supported effectively.

Carteret Health Care and Carteret County Health Department worked collaboratively to collect data and prepare the 2016 Community Health Needs Assessment. Together, three priority areas were identified based on the importance of the health need to the community and feasibility of making an impact on the community. The three identified health priorities include:

- Behavioral Health (including Substance Abuse)
- Access to Care
- Chronic Disease Prevention

Please see next page for implementation strategies developed for each prioritized health need.

Community Health Need:	Behavioral Health (including Substance Abuse)
Specific Needs Identified in the CHNA:	High rates of unintentional injuries/poisoning related deaths (per 100,000); frequently reported concern by citizens regarding mental health issues, suicide, substance abuse and access to behavioral health services
Healthy People 2020 Targets: **Age-Adjusted Death Rate due to Suicide is 10.2 (per 100,000)** **Death Rate due to Drug Poisoning is 13.9 deaths (per 100,000)**	Carteret County: Age Adjusted Death Rate due to Suicide is 17.8 (per 100,000) Carteret County: Death Rate due to Drug Poisoning is 21.9 (per 100,000)
Goals	Reduce deaths associated with unintentional injuries/poisonings and suicide in Carteret County.

Strategy: Align with community partners to increase awareness of mental health and substance abuse issues in Carteret County.

Action Step	Accountability	Timeline	Desired Outcome
1. Actively participate in the Coastal Coalition for Substance Abuse Prevention (CCSAP) in Carteret County and events targeted to improve mental health and decrease substance abuse in Carteret County.	Hospital	Complete and ongoing	Collaboration and Cooperation
2. Refer CA II Medicaid patients who present with overdose and/or mental health issues to outpatient case management through Community Care Plan of Eastern Carolina (CCPEC)	Hospital in Cooperation with the Community	Complete and ongoing	Collaboration and Referral

Strategy: Train a core team of Behavioral Health staff at CHC to effectively interact with behavioral health patients and those suffering from substance abuse.

Action Step	Accountability	Timeline	Desired Outcome
1. Identify a core team of nursing staff who have a desire and aptitude to work with the behavioral health/substance abuse population and provide targeted education and simulations to improve real-life outcomes.	Hospital	Ongoing	Education
2. Facilitate consistent use of CSRS by hospital/ED physicians through education and clinical support	Hospital	Ongoing	Education, Increased identification of patients at risk of misuse
3. Increase availability of Behavioral Health social work and case management in the ED and for patients admitted to CHC to work collaboratively with Bay Area staff	Hospital	Ongoing	Collaboration and Referral

Strategy: Implement new evidence-based practices to reduce deaths due to suicide and substance abuse AND improve access to behavioral health resources.

Action Step	Accountability	Timeline	Desired Outcome
1. Collaborate with Carteret County EMS to implement Community Paramedicine for education and identification of behavioral health conditions and substance abuse concerns and referral to community resources.	Hospital, community, county government	Initial implementation 7/2017	Collaboration, education, referral
2. Consider distribution of Naloxone kits to high-risk patients seen in the ED	Hospital	Ongoing	Education and reduced fatal overdoses
3. Consider hosting a prescription medication drop-off event at CHC	Hospital	2017	Removal of prescription medications to avoid inappropriate use and diversion
4. Offer QPRT (Question, Persuade, Refer and Treat) to hospital clinical staff to aid in the identification of suicidal risk.	Hospital, Health Department	Ongoing	Education and early identification of suicidality
5. Maintain an active list of community resources to distribute to patients and facilitate referral through case management/outpatient care coordination.	Hospital and community	Ongoing	Removal of prescription medications to avoid inappropriate use and diversion.

Community Health Need:	Access to Care
Specific Needs Identified in the CHNA:	According to the US Census Bureau, during 2010-2014, roughly 18% of Carteret County's population was uninsured. During listening sessions and in review of survey results, citizens overwhelming reported the need for health care providers of all specialties who accept all types of insurances.
Healthy People 2020 Target is 100% of adult residents who have health insurance	Carteret County: 82.9% of residents, aged 18-64, who have at least some health coverage Carteret County: 96.7% of children, aged 0-17, who have insurance coverage
Goals:	Increase access to health care for Carteret County residents through collaboration with community partners, recruitment of primary care physicians and specialists, and elimination of barriers, such as transportation and finances.

Strategy: Collaborate with community partners to assure that health care is accessible for the uninsured/underinsured population.

Action Step	Accountability	Timeline	Desired Outcome
1. Continue support of Broad Street Clinic (a local community clinic for patients who are uninsured and have certain chronic health conditions) through the provision of volunteers, pharmaceuticals and diagnostics.	Hospital	Ongoing	Collaboration, increased access to care for the uninsured
2. Identify patients who will benefit from local health department services and refer accordingly to programs such as Adult Health, Child Health, Family Planning, STD screening and treatment, immunizations and communicable disease, and Maternal Health.	Hospital, local health department	Ongoing	Collaboration, increased access to care for the uninsured, underinsured, government payors and private insurances

Strategy: Increase access to and supplement primary care and specialties in the community for patients with all types of insurance and the uninsured

Action Step	Accountability	Timeline	Desired Outcome
1. Recruit physicians to Carteret Medical Group (CMG) to fill gaps in physician specialties (Gastroenterology, Neurology, Infectious Disease, ENT, Endocrinology, etc.)	Hospital, Carteret Medical Group	Ongoing	Increased access to care, reduced travel for patients needing specialty care
2. Extend primary care and specialty medicine to CMG offices in Cedar Point and Sea Level.	Hospital, Carteret Medical Group	Ongoing	Increased access to care
3. Increase access to primary care and specialty medicine through CMG by accepting all payor sources, including self-pay patients	Hospital, Carteret Medical Group	Ongoing	Increased access to care
4. Maximize capacity of new cardiac catherization lab at CHC to offer timely and efficient care in one location.	Hospital	Ongoing	Increased access to specialty services

Strategy: Engage in community benefit activities that increase access to care

Action Step	Accountability	Timeline	Desired Outcome
1. Offer Charity Care assistance to patients as needed, both in the inpatient and outpatient settings, to reduce financial need as a barrier to care.	Hospital	Ongoing	Increased access to care
2. Provide community health screenings (BP, cholesterol, A1C, glucose, skin cancer, breast cancer) throughout the year (May, June, August, October, November). Refer to outpatient hospital programs and/or community partners as needed.	Hospital, community partners	Ongoing	Education, increased access to care
3. Develop relationships with faith communities to assess and utilize available resources (transportation, food banks, utility assistance, caregiving, clothing, shelter, etc.) and to share education with congregations regarding health topics.	Hospital, churches	Ongoing	Collaboration, education, increased access to care and basic needs
4. Utilize resources through the American Cancer Society's "Rebuilding the Road to Recovery" program to assist with transportation to cancer treatments.	Cancer Center	Ongoing	Collaboration, increased access to care
5. Increase referral to CHC's Care Transitions/Telehealth programs for additional support for patients in their homes, following a hospital stay, ED utilization or when referred by primary care provider or specialist.	Care Transitions, Home Health	Ongoing	Collaboration, Education, increased access to care

Community Health Need:	Chronic Disease Prevention
Specific Needs Identified in the CHNA:	Carteret County has age-adjusted death rates due to heart disease and cancer that are higher than the state and national averages. Surveys and listening sessions with Carteret County residents indicate that more information is needed regarding nutrition, exercise, benefit of annual exams and screenings, and stress management. Through education opportunities and community outreach, CHC and local community partners hope to teach prevention of chronic disease.
Healthy People 2020 Target for age-adjusted heart disease deaths is 171.9 (per 100,000) **Healthy People 2020 Target for age-adjusted deaths due to cancer is 161.4 (per 100,000)**	Carteret County: Age-adjusted death rate due to heart disease is 182.1 (per 100,000) Carteret County: Age-adjusted death rate due to cancer is 191.5 (per 100,000)
Goals	Reduce the overall incidence and death rates related to chronic health conditions and cancer through education and screening.

Strategy: Increase awareness of risk factors and preventive efforts related to chronic disease and cancers.

Action Step	Accountability	Timeline	Desired Outcome
1. Collaborate with County wellness to offer education to Carteret County employees regarding chronic disease, risk factors and prevention.	Hospital, county government	Current and Ongoing	Education
2. Offer wellness initiatives and education sessions to hospital employees	Hospital	Current and ongoing	Education
3. Provide education to Carteret County residents regarding prevention of chronic disease and wellness topics in community settings such as the Leon Mann Senior Center, churches, skilled nursing facilities, health fairs	Hospital, local community partners	Current and ongoing	Education
4. Contact other large employers (Walmart, Carteret-Craven Electrical Co-op, West Carteret Water Corp., school system, etc.) in Carteret County to determine interest in education for employees regarding issues related to chronic disease and wellness topics.	Hospital, community partners	Ongoing	Education
5. Work with local skilled nursing facilities to provide education to staff and residents regarding health-related topics,	Hospital, local skilled nursing facilities	Ongoing	Education
6. Increase referrals to the CHC Diabetes Learning Center for education related to diabetes risk factors, prediabetes, type 1 and type 2 diabetes	Hospital, community partners, local physicians	Ongoing	Education
7. Support local community efforts to establish farmers markets, walking trails	Hospital, community partners, faith community	Ongoing	Access to healthy foods and an active lifestyle

Strategy: Offer screenings for risk factors and indicators of chronic disease and cancer in the community.

Action Step	Accountability	Timeline	Desired Outcome
1. Offer health screenings and a community resources fair to the community during Hospital Week (May of each year) to include: BP, cholesterol, A1C and glucose.	Hospital, community partners	May of each year	Education, screening
2. Offer targeted cancer screenings in June (skin cancer) and October (breast cancer).	Hospital, community	June, October of each year	Education, screening
3. Collaborate with Mount Pilgrim to offer a yearly health fair and screenings in August of each year.	Hospital, faith community, community partners	August of each year	Education, screening
4. Offer community screenings for diabetes risk factors, A1C and glucose on ADA Alert Day (late March) and Diabetes Awareness month (November) of each	Hospital	March and November of each year	Education, screening

Strategy: Reduce smoking in the community.			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1. Increase participation in CHC Allwell smoking cessation program by patients, employees and community members	Hospital, community partners, physicians	Ongoing	Collaboration, Education and Referral
2. Promote smoking cessation program at community events.	Hospital	Ongoing	Collaboration, Education and Referral

Please see next page for a list of health needs that will not be addressed by this Implementation Strategy.

The table below is a list of the health needs not addressed by Carteret Health Care's Implementation Strategy. The reasons include: other organizations are already meeting the health need, Carteret County is already meeting targets set by national standards, or a lack of resources for CHC to impact the health need.

Community Needs Not Addressed	
Community Need	**Reasons Needs Not Addressed**
Adults who Drink Excessively	Carteret Health Care has limited resources and ability to impact this need. The Carteret County Substance Abuse Coalition (CCSAP) and local substance abuse providers are trying to address this need.
Adolescent Sexual Health and Pregnancy Prevention	Carteret County Health Department provides these services and has programs to address prevalence.
Adult and Pediatric Asthma	Carteret Health Care offers the Better Breathers support group and a strong partnership with Community Care Plan of Eastern Carolina, who also have their own asthma initiatives for CA II Medicaid patients. Carteret County Health Department monitors the prevalence and causes of asthma in our community. Pediatric and adult clinics within CCHD support and treat.
Alzheimer's Disease	Carteret County's death rate due to Alzheimer's is lower than the state and national averages at 19.9 deaths per 100,000 population.
Communicable Disease Prevention	Carteret Health Care and the Carteret County Health Department work collaboratively to provide these services and have programs to address prevalence.
Dental/Oral Health	Carteret Health Care does not offer dental services. Dental services are offered for school children through the Carteret County Health Department dental bus. Uninsured adults may access dental care through Broad Street Clinic and a collaborative effort between One Harbor Church and Johnson Family Dentistry. Carteret County is well above the national average for number of dentists per 100,000 population (ranked 3rd in North Carolina.
Diabetes	The Carteret County rate of adults with diabetes remains steady at 10.3% of the population, lower than the state and national rates. Carteret Health Care has a diabetes education program for patient education and sponsors a diabetes support group.
HIV and STD's	Carteret County Health Department provides these services and has programs to address prevalence.
Infant Death	Carteret County has programs to address preterm birth and infant mortality. Targeted education is provided to parents in our Maternal Services.
Lack of Jobs/Adequate Pay	Other than being one of the largest employers in Carteret County, Carteret Health Care has limited ability to impact this need.
Motor Vehicle Injuries	Carteret Health Care has limited resources and limited ability to impact this need.
Obesity	Carteret County's rate of obesity among adults is currently 25.8%, lower than the Healthy People 2020 goal of 30.5%.

Pneumonia and Influenza	Carteret County's age-adjusted death rate for pneumonia and influenza are lower than the state and national averages at 14.1 deaths per 100,000 population. Carteret Health Care requires influenza vaccination for all employees and also offers immunizations for these illnesses through its Home Health population.
Unintentional Injuries	Several local agencies (police departments, fire departments, health departments) have educational programs aimed at preventing injuries.