Community Health Needs Assessment (CHNA)

Implementation Plan

Bradford Regional Medical Center

116 Interstate Parkway, Bradford, PA 16701

2016-2019

I. General Information

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Date Written Plan Was Adopted by Organization's Authorized Governing Body: October 28, 2015

Date Written Plan Was Required to Be Adopted: December 15, 2015

Authorizing Governing Body that Adopted the Written Plan: BRMC Board of Directors

Was Written Plan Adopted by Authorized Governing Body by End of Tax Year in Which CHNA was Made Available to the Public? Yes

Address of Hospital Organization: 116 Interstate Parkway, Bradford, PA 16701

Summary

The Bradford Regional Medical Center offers its Community Health Needs Assessment (CHNA) implementation strategy for 2016-2019. The implementation strategy is the result of the hospital's Community Health Needs Assessment adopted by the BRMC Board of Directors in October, 2015. The BRMC CHNA identified 44 health indicators within the community through a thorough process of data analysis, community stakeholder interviews, focus groups, community surveys and community stakeholder committee input. Complete details are available within the BRMC 2015 Community Health Needs Assessment, which may be viewed at www.brmc.com

To arrive at a final set of nine priorities, an implementation plan, members of the BRMC CHNA Steering Committee rated each of the 44 health indicators using a Likert scale of 1 to 10 in the areas of accountable role, magnitude of the problem, impact on other health outcomes and capacity (systems and resources) to implement evidence based solutions. From the 44 initial health indicators, nine final priorities emerged as final priorities for the hospital to address in the next three years. As a result of a growing concern over and epidemic rise in the use of opioids the Bradford Region and the hospital's role in providing behavioral health services, a tenth priority was added to the final list.

The final priorities identified and approved by the BRMC Board of Directors to be addressed over the next three years are:

1. Cardiovascular Disease (heart disease, cholesterol, etc.)
2. Diabetes
3. Obesity
4. Breast Cancer
5. Access to Speciality Medical Care
6. Access to Primary Care Services
7. COPD/Chronic Bronchitis
8. Customer Service in ER/Clinics, Physicians' Offices
9. Lung Cancer
10. Opioid Abuse

An implementation committee made up of hospital administrators and service line managers reviewed the 10 priorities and created four overall implementation goals, grouping the priorities into appropriate and common areas. Within those four goals are specific implementation efforts, either existing or to be developed, which the hospital will budget for, manage, implement and evaluate and report on over the next three years.

Those goals are:

1. Increase Participation in Education, Wellness, Prevention and Screening Services
2. Ensure Local Access to Primary and Secondary Care
3. Improve Health Status through Chronic Disease and Care Management across the Continuum
4. BRMC to Take a Leadership Role in Addressing Opioid Abuse

The Implementation Strategy Action Plan addresses each goal with specific activities, budget and accountability and indicates if activity is currently ongoing or will be developed.

List of Community Health Needs Identified in CHNA Written Report, Ranked by CHNA's Priority:

The Bradford Regional Medical Center (BRMC) Community Health Needs Assessment (CHNA) has nine sections containing both quantitative and qualitative data, as well as Healthy People 2020 indicators. The CHNA summarizes a comprehensive review and analysis of health status indicators, public health, socioeconomic, demographic and other qualitative and quantitative data from the primary service area of BRMC. The data was gathered from multiple sources including a 2015 Community Survey of a representative sample of 508 respondents. The 2015 Community Survey encompassed residents from McKean and Potter Counties in Pennsylvania and Cattaraugus County in New York and was commissioned to update statistics on the health behaviors of residents in the three counties, including BRMC's primary service area of McKean County. Health indicators are reported as individual data points, included in trend analyses, and compared to available state, national, Healthy People 2020, and peer county statistics. The BRMC Steering Committee reviewed the data collected through the CHNA process and, with assistance from Strategy Solutions, Inc., a planning and research firm, who was retained by BRMC, identified forty-four (44) indicators for consideration in the prioritization process. These indicators were organized in a prioritization matrix that included county, state, national, Healthy People 2020, and peer county statistics, identified the indicator as a targeted focus of other organizations, and associated the indicator with disparities. Trending changes were also noted. Qualitative data was compiled from five focus groups conducted throughout McKean County that included participation from experts in numerous disciplines as well as citizens from underrepresented populations. BRMC also conducted twenty-one (21) stakeholder interviews with expertise in the following disciplines and/or organizational affiliations: YMCA/YWCA, transportation, PA Department of Health, school district, Visiting Nurses Association, hospital system, United Way, homelessness/low income community, alcohol and drug abuse, dental services, law enforcement, children and youth, aging population, manufacturing, emergency services and finance services.

With the aid of a prioritization matrix, members of the BRMC CHNA Steering Committee rated each of the forty-four (44) indicators using a Likert scale of 1 to 10 in the areas of accountable role, magnitude of the problem, impact on other health outcomes and capacity (systems and resources) to implement evidence-based solutions. Scores for each indicator were tallied and ranked. The results rank-ordered the forty-four (44) distinct community needs and issues that demonstrated a disparity, negative trend or gap between the local/regional data and the state, national or Healthy People 2020 Goal and/or that qualitative information suggested that it was a growing need in the community. BRMC leadership and board of directors reviewed the final conclusions and concurred with the priority strategic health issues as the basis for its implementation efforts. Using the methodology, and factoring in the role of the health system, the BRMC Steering Committee selected 11 final priorities listed on page 2.

II. List of Collaborating Organizations

For its 2015 CHNA and in addressing the final IRS CHNA requirements published on December 31, 2014, recommending collaboration with other community entities, BRMC will be working collaboratively with Upper Allegheny Health System, whom BRMC is a part of and certain organizations in the primary service area. These collaborations will be formed to address the seven areas being focused on with the implementation strategy. Possible collaborations include,

but are not limited to, school districts, YMCA, Visiting Nurses Association, and Roswell Park Cancer Institute.

III. Health Needs Planned to Be Addressed By Facility

List of Health Needs the Facility Plans to Address

BRMC, through its mission to provide the highest quality medical services in response to the healthcare needs of the region, to promote community wellness, and to restore health and comfort to patients as swiftly and safely as possible, as well as collaboration with several community partners, has developed strategies to address each of the seven priority health issues.

Chronic Disease Management:

Breast Cancer: Pages 82, 83, 105, 106 and 107 of the BRMC CHNA 2015 Supplemental Data Resource reported that the 2012 breast cancer incidence rates for Potter (52.9) and Cattaraugus (129.5) Counties were above the healthy people 2020 goal (41.0) and that McKean County (40.5) met the Health People goal for 2012. In 2011, the breast cancer mortality rate in McKean County was significantly higher (25.4) than Pennsylvania, and was above the Healthy People 2020 goal of 20.6. The trend for mammogram screenings across all counties is decreasing for the years 2013 through 2015, and all counties (McKean 65.1%, Potter 64.5%, and Cattaraugus 53.1%) are lower than the nation (67.1%) and Healthy People 2020 (81.1%). The BRMC Community Survey reported that over half (53.7%) of the female respondents had a mammogram within the past year. In contrast, 21.2% of respondents have never had a mammogram. Furthermore, the majority of Community Survey female respondents age 18 to 24 (89.5%) and 25 to 34 (85.9%) have never had a mammogram.

Lung Cancer: As described on pages 84 and 85 of the BRMC CHNA 2015 Supplemental Data Resource, the lung cancer incidence rate in McKean County increased between 2011 and 2012 and in 2012 (77.1) was above the nation (73.0) and Pennsylvania (63.9), as well as the Healthy People 2020 Goal (20.6). The rate in Potter County decreased between 2011 and 2012, but remained just above the nation and state in 2012 (73.4). The lung cancer incidence rate in Cattaraugus County has increased the past three years data is available and in 2012 (92.8) was above New York (68.5), as well as the Healthy People 2020 goal. The lung cancer mortality rate in both McKean and Potter counties decreased between 2011 and 2012, although the 2012 rate (50.2, 51.3) remained higher compared to Pennsylvania (46.5). The lung cancer mortality rate in Cattaraugus County has been decreasing over the past three years, but in 2011 (51.5) remained above New York (45.7).

Cardiovascular Disease: As described on pages 93, 94, 95 and 97 of the BRMC CHNA 2015 Supplemental Data Resource and as reported in the BRMC 2015 Community Survey (N=508), the heart disease mortality rates for McKean County has been increasing over the past four years and was significantly higher when compared to Pennsylvania in 2010 through 2012. The rate in Potter County has been decreasing over the past three years and was significantly lower (121.6) compared to Pennsylvania (175.2) in 2012. Cattaraugus County has been decreasing over the past three years, yet still remains above the rate of the nation and New York.

Coronary heart disease mortality rates were again increasing in McKean County over the past four years and in 2011 and 2012 had a rate significantly higher when compared to Pennsylvania. The rate in Potter County had been decreasing from 2008 through 2011 and lower when compared to

Pennsylvania in 2011, although the rate increased in 2012. Cattaraugus County has had a decreasing rate over the past three years, although the rate remains above the nation and New York. Potter County has met and exceeded the Healthy People 2020 goal of 103.4 for four of the five years.

Cardiovascular disease mortality rates for McKean County have been increasing over the past four years, and were significantly higher than the state in 2010 through 2012. Potter County has had a decreasing rate over the last three years and have remained below the Pennsylvania and national rate. Cattaraugus County has also been decreasing over the past three years, but is above the nation and New York. The BRMC Community Survey respondents were asked if they had ever been told they had high blood pressure for those aged 65 and older. Just over half of the community survey respondents (52.4%) had been told they have high blood pressure, while 3.2% had been told they were borderline or pre-hypertensive.

Diabetes: As stated on pages 99-102 and 110-111 of the BRMC CHNA 2015 Supplemental Data Resource and as reported in the BRMC 2015 Community Survey (N=508), the BRMC 2015 Focus Groups and the PRC National Child & Adolescent Health Survey, the diabetes mortality rate in McKean County has been decreasing over the past five years, and in 2012 (22.4) was comparable to Pennsylvania (22.0). The rate in Cattaraugus County nearly doubled between 2011(12.2) and 2012 (23.4) and was above the New York rate in both years where data was available.

Pennsylvania, New York, and the service area counties met and exceeded the Healthy People 2020 goal of 66.6. A very small percentage of the 2015 BRMC Community Survey respondents have ever been told by a doctor that they have diabetes (8.5%). When they were asked the same question, but by age, one in five (20.3%) of those ages 65 to 74 and one in four (27.9) of those 75 and older have been told by a doctor that they have diabetes. According to the PRC National Child & Adolescent Health Survey, twice as many children in the Northeast region (1.4%) have diabetes compared to the United State (0.7%). In the 2015 BRMC Community Survey asking if respondents or their family members were affected by chronic disease problems, 30.7% listed diabetes as the disease that affected them. During the BRMC 2015 Focus groups participants were asked to rate the extent each community health issue was a problem in the local community on a 5 point scale, where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, and 1=Not at all a Problem. Diabetes ranked as the second highest problem with a ranking of 3.4.

Obesity: As depicted on pages 103-104, 110-111 and 141 of the BRMC CHNA 2015 Supplemental Data Resource and as reported in the BRMC 2015 Community Survey (N=508) and the BRMC 2015 Focus Groups, 70.5% of the BRMC Community Survey respondents are considered overweight or obese. Furthermore the survey showed that half of the respondents in each age group are considered overweight or obese, with the highest percentages (78.3%) being between the ages of 18 to 24 and 65 to 74. 44.8% listed obesity and overweight as the chronic disease problem that affected them or a family member on the community survey.

During the BRMC 2015 Focus Groups, participants were asked to rate the extent each community health issue was a problem in the local community on a 5 point scale, where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, and 1=Not at all a Problem. Obesity ranked as number 1 with a rating of 4.0. Compared to Pennsylvania (16.7%) in 2011, McKean County (21.0%) and Potter County (19.2%) had a higher percentage of students considered obese. Cattaraugus County (16.8%) had a lower percentage of obese students than the state (17.2%) for 2012.

Asthma, COPD & Chronic Bronchitis: As illustrated on pages 96, 109, 116, and 123-124 of the BRMC CHNA 2015 Supplemental Data Resource and as reported in the BRMC 2015 Community Survey (N=508), the BRMC 2015 Focus Groups and the PRC National Child & Adolescent Health Survey, the mortality rates for Chronic Lower Respiratory Disease (COPD) have been higher in McKean County when compared to the state in 2008 through 2010 and has steadily been decreasing since then. Potter County rates have fluctuated and were significantly higher compared to the state in 2009 and 2011. Cattaraugus Count has also seen fluctuating rates, but has remained higher than New York. However, the nation, states and service area counties have all met or exceeded the Healthy People 2020 Goal of 102.6.

During the BRMC 2015 Community Survey, respondents were asked to rate the extent each community health issue affected them or their family member when it came to chronic disease. 27.3% reported that they or a family member were affected by Asthma/COPD Related issues. When looking at the rate of asthma hospitalizations for the counties in Pennsylvania in 2010, McKean County (13.4) had a rate slightly higher than Potter County (7.8). The PRC National Child & Adolescent Health Survey showed that one in ten children (10.6%) in the Northeast Region have asthma, which is slightly lower than the nation (11.6%). Furthermore, slightly more than one in four (27.0%) of children in the United State had an Asthma-related visit to the Emergency Room or Urgent Care Facility in 2014. This has been declining between the years 2012 and 2014.

Tobacco: As described on pages 190-200 of the BRMC CHNA 2015 Supplemental Data Resource and as reported in the BRMC 2015 Community Survey (N=508) and the BRMC 2015 Focus Groups, the percentage of adults who reported being a current smoker during 2008-2010 were significantly higher in the McKean County Cluster (29.0%) when compared to Pennsylvania (20.0%). The rate did decrease between 2008-2010 and 2011-2013. Even so, the nation, Pennsylvania and service area counties all exceeded the Healthy People 2020 goal of 12.0%. During 2011 through 2013, the service area counties (52.0%) had slightly fewer adults who reported never being a smoker when compared to the nation (55.0%) and Pennsylvania (53.0%). For the cluster that included McKean County the percentage of adults who reported never being a smoker increased between 2008-2010 and 2011-2013.

When asked in the 2015 Community Survey if the respondent was a current smoker, the overwhelming majority of 85.5% responded that they were not. When respondents who did smoke were asked about the number of cigarettes per day they smoked, almost half (42.9%) respondent that they smoke between 6 to 10 cigarettes, with an additional 33.8% smoking more than 10 cigarettes per day. The percentage of adults who use smokeless tobacco, snuff or snus somewhat or every day was significantly higher for the clusters including Potter (9.0%) and McKean (12.0%) when compared to Pennsylvania (4.0%) for the years 2011-2013. They also have twice the percentage of adults using smokeless tobacco when compared to the nation (4.2%). Furthermore, the percentage of adults ages 18 through 44 during 2011-2013 who report using chewing tobacco, snuff or snus somewhat or every day is higher in the service area clusters that include Potter (13.0%) and McKean (15.0%) counties when compared to Pennsylvania (6.0%). Adults who have quit smoking in the past year between 2008-2010 and 2011-2013 showed a decrease in the service area counties.

During 2011-2013, the service area counties had fewer adults that quit smoking when compared to Pennsylvania. They also were well below meeting the Healthy People 2020 Goal of 80.0% of adults quitting smoking at least one day in the past year. In 2008-2010 the county cluster which includes McKean County (24.0%) had significantly more adults reporting being an every day

smoker when compared to Pennsylvania (15.0%), and was also higher than when compared to other counties, yet decreased the following years. During 2011-2013, the service area counties (19.0% and 18.0%) had higher rates of adults reporting being an everyday smoker when compared to the nation (13.4% and Pennsylvania (16.0%). Community Survey respondents who used chewing tobacco, snuff, or snus reported an overwhelming majority (94.1%) that they do not use any form of smokeless tobacco. Furthermore, slightly less than one in five (17.9%) reported that they or a family member were being affected by tobacco use. During the BRMC 2015 Focus Groups participants were asked to rate the extent each community health issue was a problem in the local community on a 5 point scale, where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, and 1=Not at all a Problem. Smoking (4.1) was identified as a Serious Problem.

Based on this information and the data research that indicated the largest concerns for McKean, Potter and Cattaraugus Counties were cardiovascular disease, diabetes, obesity, cancer and COPD, BRMC is continuing with their workplace wellness program. Screenings, health fairs, education, preventative and support programs and event participation will also be continued during the next three years at the hospital.

Access to Quality Health Care:

As stated on pages 57-59, 63-70, and 76-77 of the BRMC CHNA 2015 Supplemental Data Resource and as reported in the BRMC 2015 Community Survey (N=508), the BRMC 2015 Focus Groups and the PRC National Child & Adolescent Health Survey, there are many barriers to accessing quality health care. The percentage of adults ages 18-64 with no health insurance in the nation, states, and throughout the counties of the service area in 2008-2010 and 2011-2013 all had comparable rates. All of the clusters were above the Healthy People goal of 2020 (0%). The McKean county cluster and Cattaraugus County had lower rates of adults with no personal care provider compared to the state, with adults in the Potter County cluster having the highest rate (15.0%). All of the service area counties and Pennsylvania percentages were below the Healthy People 2020 goal of 16.1%. New York (17.0%) had a higher rate than the Healthy People goal. The rates for those who needed to see a doctor in the last year but could not due to cost showed that the county clusters were comparable to the Pennsylvania (13.0%) and New York (13.8%) rates, and showed decreasing trends in all clusters except for Cattaraugus. The service area counties and state percentages are all above the Healthy People 2020 Goal of 4.2%.

Respondents to the BRMC 2015 Community Survey indicated that 9 out of 10 of them had some type of health insurance, with only 2.4% answering that they did not. The PRC National Child & Adolescent Survey 2014 indicated that more than half of the children in the United States are covered under private insurance (65.3%) and only 6.5% have no insurance or self-pay. Furthermore, the same study showed that 6.6% of children in the Northeast Region are uninsured, which is comparable to the United States (6.5%) but all regions and the nation are above the Healthy People Goal of 100% insured. When respondents were asked if they could not fill a prescription due to cost in the past 12 months, 12.5% of the Community Survey respondents reported that they could not. Furthermore, 14.0% respondents could not seek medical treatment due to cost. Another 2.4% could not get healthcare services due to lack of transportation in the past 12 months.

According to the PRC 2014 National Child & Adolescent Survey, one in four children (24.5%) in the Northeast experienced a delay or barrier in accessing the care they needed, but was still lower

than the nation (29.4%). The majority of the BRMC 2015 Community Survey respondents had a regular health provider, while 5.2% did not. Furthermore, when asked their reasons for experiencing access problems almost a quarter of respondents answered that the availability of specialists/specialty medical care as the main reason. This was followed by access to affordable health care as it relates to co-pays and deductibles (23.8%) and access to insurance coverage (23.5%). The BRMC 2015 Focus groups were asked to share their reasons for not having a health care provider based on a 5-point scale where 5=Very Serious problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem and 1=Not a Problem. Overall, the top five access needs ranked by the Focus Group participants are lack of healthcare coverage in the workplace (4.2), lack of transportation (3.7), access to medical care (3.7), decrease access to specialty care (3.6), and poor dental care (3.5).

Based on this information, BRMC will continue to recruit speciality and primary care physicians, develop procedures for proper Emergency Department utilization, increase utilization of women's health services for low income women and continue to work with the local school districts regarding health professions education.

Mental Health and Substance Abuse:

Western Pennsylvania has experienced an epidemic of heroin and opiate abuse in the past 8-10 years. Pennsylvania now has the 7th highest drug overdose mortality rate in the United States, with over 3,000 deaths being heroin-related overdoses. Drug overdose deaths in Pennsylvania have now exceeded the number of deaths from automobile accidents.

As stated on pages 165, 167, 170and 172 of the BRMC CHNA 2015 Supplemental Data Resource and as reported in the BRMC 2015 Community Survey (N=508) and the BRMC 2015 Focus Groups, the community is concerned about the increasing opioid problem in the hospital's service area. 6.2% of the Community Survey respondents reported that they were affected by prescription drug abuse. In McKean and Potter Counties, prescription narcotic drug use has been increasing with age throughout high school and has been increasing over the past four years. The BRMC 2015 Focus Groups were asked to rate the extent each community health issue was a problem in the local community on a 5-point scale where 5=Very Serious problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem and 1=Not a Problem. Prescription drug abuse (4.2) and substance abuse (4.2) were identified as serious problems.

During the analysis period in 2015 for the CHNA, opioid abuse did not rank among the top ten items identified by the prioritization process. However, since that time, opioid abuse, including the use of heroin, has become a top community and health care concern. Based on this information, BRMC will take a leadership role in addressing opioid abuse in the community.

Identification and Description of How Facility Plans to Address Each Health Need

In response to the identified priority community needs, BRMC has developed four overarching goals and identified specific implementation strategies and programs to address the ten most significant needs in the community. BRMC is committed to achieving the "triple aim:" improved health through better quality of care at lower costs. To that end and to address the needs of the community, BRMC is committed to the following goals and implementation strategies:

Goal 1: Increase Participation in Education, Wellness, Prevention and Screening Services

In order to accomplish the goal to increase participation in education, wellness, prevention and screening services, BRMC is implementing a number of priority programs and initiatives. These include:

1. Continue Breast Cancer Screenings
2. Develop Lung Cancer Screenings
3. Increase immunization rates for children
4. Continue to offer wellness activities
   a. Social Media and Blog Be Well
5. Continue to participate in health fairs
6. Institute smoking cessation program

BRMC will implement these programs over the next three years with and through relationships with various community collaborators, including Upper Allegheny Health System, Roswell Park Cancer Institute, American Lung Association and the YMCA/YWCA. Significant resources and effort will be placed on outreach to the medically underserved through education, wellness, prevention and screenings as these have the potential to impact large numbers of people.

Over the long run, these programs are expected to positively impact overall health status, lifestyle, risk behaviors, and decrease the number of emergency department visits for ambulatory care sensitive conditions. Indicators that will be tracked to evaluate the outcomes and impact of the individual programs will include:

- ☐ Number of events
- ☐ Number of participants in cancer screenings, risk factor screenings and education programs
- ☐ Number of referrals for interventions or higher levels of care based on screening outcomes
- ☐ Number of children immunized
- ☐ Number of people who participated in smoking cessation programs, including number who attended support groups/stopped smoking, number of people diagnosed with smoking-related chronic disease
- ☐ Increase in knowledge, intent to change behavior

Goal 2: Ensure Local Access to Primary and Secondary Care

In order to accomplish this goal, BRMC is implementing a number of priority programs including:

1. Increase utilization of women's health services for low income women
2. Continue to recruit specialty physicians
   a. Recruit General Surgeon
3. Continue to recruit primary care physicians
4. Ensure appropriate Emergency Department utilization

Over the long run, these programs are expected to improve access to primary and secondary care. Indicators that will be tracked to evaluate the outcomes and impacts of the individual programs include:

- ☐ Number of events
- ☐ Number of program participants
- ☐ Number of women utilizing women's health services
- ☐ Recruitment of physicians
- ☐ Number of people utilizing primary care physicians
- ☐ Decrease improper Emergency Department utilization

Goal 3: Improve Health Status through Chronic Disease and Care Management across the Continuum

In order to accomplish this goal, BRMC is implementing a number of priority programs and strategies including:

1. Cardiovascular and Heart Disease
    a. Continue offering the Upbeat Program to cardiovascular and pulmonary rehab patients, as well as people in the community with a doctor's referral
2. Diabetes
    a. Continue hosting monthly Diabetes workshops
    b. Provide community education through presentations to various businesses, community programs and service clubs
    c. Continue to offer nutrition education
3. Obesity
    a. Initiate a weight management program
    b. Offer community exercise classes
    c. Offer educational cooking classes with hospital chef
4. Asthma, COPD and Chronic Bronchitis
    a. Continue Breathe Easy support group
    b. Continue COPD discharge follow-up
    c. Continue Respiratory Education in the lobby
    d. Offer Super Puff Asthma Camp
    e. BRMC Website RT Section
    f. Improve distribution of Pulmonary Newsletter
    g. Continue Healthy Beginnings Plus – asthma education and pulmonary function testing (based on referrals)
    h. Collaboration with a Visiting Nurses Association to streamline the COPD education and inpatient/outpatient COPD and then the VNA can then carry on the streamline to reduce readmissions
    i. Pulmonary Rehab – Upbeat once a month and meet with patients one-on-one
5. Cancer (breast, colorectal and lung)
    a. Continue collaboration with Roswell Park regarding the continuum of care

The strategies were developed and will be implemented in collaboration with BRMC, Upper Allegheny Health System, Visiting Nurses Association and other agencies in the area.

Over the long run, these efforts are expected to improve chronic disease, including cardiovascular and heart disease, diabetes, obesity, asthma/COPD/ chronic bronchitis, breast cancer, lung

cancer, and colon cancer, as well as care management across the continuum. Indicators will be tracked to evaluate the outcomes and impacts of individual programs including:

- ☐ Number of Upbeat program participants
- ☐ Implementation of ScottCare Cardio Rehab software
- ☐ Number of participants at monthly chronic disease workshops and educational seminars (including Diabetes, Obesity, Asthma/COPD/Chronic Bronchitis, breast cancer, lung cancer and colon cancer)
- ☐ Number of participants attending wellness and nutrition classes
- ☐ Number of participants who lowered A1C levels
- ☐ Number of participants at Super Puff Asthma Camp
- ☐ Successful collaboration with Visiting Nurses Association and Roswell Park

Goal 4: BRMC to Take a Leadership Role in Addressing Opioid Abuse

In order to accomplish the goal of taking a leadership role to address opioid abuse, BRMC is implementing a number of priority programs and initiatives. These include:

1. Offer community education as to the root causes of opioid addiction, including safety advice for patients and family members.
2. Take a leadership role in community task forces and other organized efforts to address opioid abuse.
3. Maximize the clinical capability of the BRMC Behavioral Health Services division to assist the community.
4. Engage Drop Box project with local law enforcement and the District Attorney's office.
5. Connectivity of community and recovering community to expand network of community support.
6. Build on relationships with Bradford Area School Administration to assist student population and family needs.
7. Offer resources for opioid overdose survivors and family members.
8. Link substance abuse patients to effective substance abuse treatment services.

The strategies were developed and will be implemented in collaboration with BRMC, the Task Force for Community Development, Bradford Area School District and other agencies in the area.

Over the long run, these efforts will educate the community on the opioid abuse and the dangers of being addicted to drugs, as well as getting unused medication out of circulation through the Drop Box initiative. Indicators will be tracked to evaluate the outcomes and impacts of individual programs including:

- ☐ Number of attendees at town hall meetings and resource fairs
- ☐ Number of events throughout the community
- ☐ Number of pill bottles and breakdown of type of medication received
- ☐ Number of hits on BRMC's website
- ☐ Number of referrals made linking substance abuse patients to effective substance abuse services

IV. Health Needs Facility Does Not Intend to Address

List of Health Needs the Facility Does Not Plan to Address

During the BRMC CHNA process, the steering committee met several times and identified forty-four (44) health indicators that were then prioritized down to ten (10) high priority strategic health issues during a prioritization meeting held on September 22, 2015 and the completion of a prioritization survey.

The remaining total population of health indicators were not considered a high priority and subsequently not addressed through these implementation strategies because they are already being addressed by the hospital, existing community assets, necessary resources to meet these needs are lacking, or these needs fall outside of the BRMC mission.

There are thirty-four indicators identified by the BRMC CHNA that were not ranked in the top ten priority strategic issues priority list including: mental health services, women's health services, prostate cancer, prenatal care, urgent care services, affordable health care/insurance costs/copays, dental hygiene, tobacco/drug use during pregnancy, prescription drug misuse/abuse, childhood obesity, elder care services, depression, chewing tobacco/snuff/snus, substance abuse rehab/mortality, alcohol abuse, community awareness of services, breastfeeding, smoking, Lyme disease, youth risk behaviors, child abuse, lack of physical activity/recreation, health literacy, nutrition education, sexual abuse, emergency transportation, allergies, chlamydia, asthma, and transportation to /from medical services. The other areas that BRMC has not listed as top ten priorities are the areas of poverty, unemployment, affordable housing and homelessness. While the hospital offers numerous health and wellness programs, addressing the financial needs of McKean, Potter and Cattaraugus County residents is outside the scope of the mission of the hospital.

It is important to note that many of these indicators are currently being addressed by the hospital and will continue to be part of the hospital's service offerings including: mental health services, women's health services, prenatal care, dental hygiene, elder care services and sexual abuse. In addition, health issues which become more critical to community health may also become a higher priority, such as the recent rise in opioid use which is becoming a community crisis.

Appendix A

Bradford Regional Medical Center

Implementation Strategy Action Plan

Bradford Regional Medical Center (BRMC) is committed to achieving the "triple aim:" improved health through better quality of care at lower costs. To that end, to address the needs of the community, BRMC is committed to the strategies outlined below. The BRMC Administration has committed to a budget of $625,000 over the next three years to ensure the achievement of the Implementation Strategy goals outlined here in order to provide the necessary education and services to the community. This three-year budget is broken out by the four goals as follows: Goal 1 $33,300 over three years; Goal 2 $381,600 over three years; Goal 3 $202,000 over three years; and $8,100 over three years.

Goal 1: Increase Participation in Education, Wellness, Prevention and Screening Services
Three-Year Budget: $33,300

1. Continue Breast Cancer Screenings
2. Develop Lung Cancer Screenings
3. Increase immunization rates for children
4. Continue to offer wellness activities
   b. Social Media and Blog Be Well
5. Continue to participate in health fairs
6. Institute smoking cessation program

Goal 2: Ensure local access to primary and specialty care
Three-Year Budget: $381,600

1. Increase utilization of women's health services for low income women
2. Continue to recruit specialty physicians
   a. Recruit General Surgeon
3. Continue to recruit primary care physicians
4. Ensure appropriate Emergency Department utilization
5. Access to Care
6. a. Continue with Patient Center Medical Home certifications

Goal 3: Improve health status through chronic disease and care management across the continuum
Three-Year Budget: $202,000

1. Cardiovascular and Heart Disease
   a. Continue offering the Upbeat Program to cardiovascular and pulmonary rehab patients, as well as people in the community with a doctor's referral
2. Diabetes
   a. Continue hosting monthly Diabetes workshops
   b. Continue to offer nutrition education
3. Obesity
   a. Initiate a weight management program
   b. Offer community exercise classes
   c. Offer educational cooking classes with hospital chef
4. Asthma, COPD and Chronic Bronchitis
   a. Continue Breathe Easy support group
   b. Continue COPD discharge follow-up
   c. Continue Respiratory Education in the lobby
   d. Offer Super Puff Asthma Camp
   e. BRMC Website RT Section
   f. Improve distribution of Pulmonary Newsletter
   g. Continue Healthy Beginnings Plus – asthma education and pulmonary function testing (based on referrals)
   h. Collaboration with a Visiting Nurses Association to streamline the COPD education and inpatient/outpatient COPD and then the VNA can then carry on the streamline to reduce readmissions
   i. Pulmonary Rehab – Upbeat once a month and meet with patients one-on-one
5. Cancer
   a. Continue collaboration with Roswell Park regarding the continuum of care
6. Chronic Care Management
7. a. Implement a module in the EMR

Goal 4: Take a leadership role in addressing opioid abuse. ***Note, this goal is added to the implementation plan in response to the explosion of opioid abuse in the community. During the analysis period in 2015 for the CHNA it did not rank among the top ten items identified. However, since that time opioids, including the use of heroin, has become a top community and healthcare concern.***

Three-Year Goal: $8,100

1. Offer community education as to the root causes of opioid addiction, including safety advice for patients and family members
2. Take a leadership role in community tasks forces and other organized efforts to address opioid abuse
3. Maximize the clinical capability of the BRMC Behavioral Health Services division to assist the community
4. Engage Drop Box project with local law enforcement and district attorney's office
5. Connectivity of community and recovering community, to expand network of community support
6. Build on relationships with Bradford Area School Administration to assist with student population and family needs
7. Offer resources for opioid overdose survivors and Family members
8. Link substance abuse patients to effective substance abuse treatment services