Olathe MEDICAL CENTER

Community Health Improvement Plan (CHIP)

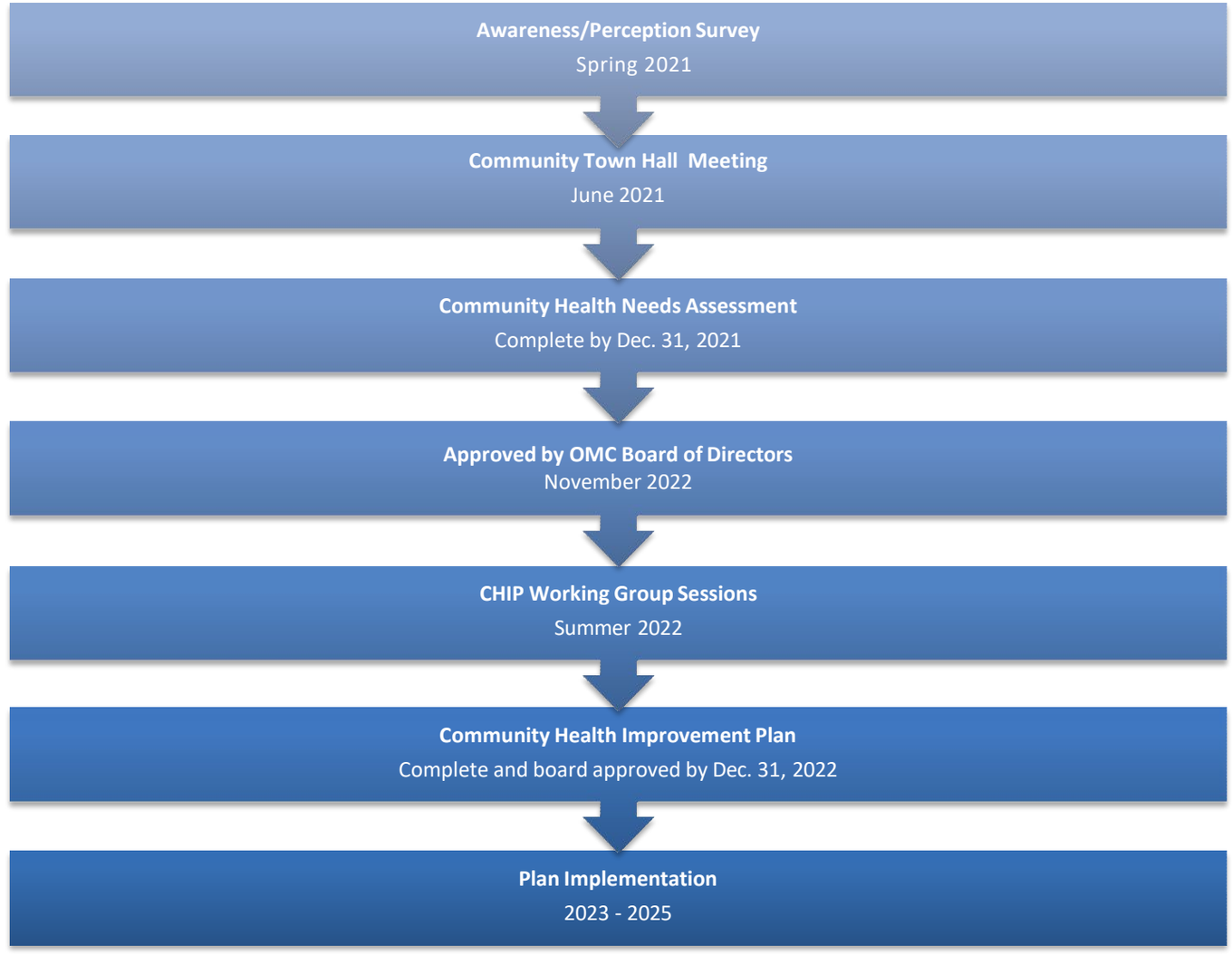
2023 through 2025

Executive Summary

For nearly 70 years, it has been the pleasure and privilege of Olathe Medical Center (OMC) to serve our communities. Our goal of providing the highest possible level of medical expertise, advanced technology, and professional, compassionate care has remained our guiding principal over all those decades, and continues to drive us to provide the very best care for our patients and their families. While OMC is a committed partner, the overall health of our communities is a joint effort. Schools, health-related agencies, local, county and federal government agencies, religious-based groups, health insurers and businesses all play an integral role in meeting the healthcare needs of the residents of our service area.

In an effort to improve the health of communities, the Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals nationwide, including OMC, to conduct a Community Health Needs Assessment every three years. Hospitals are then required to develop and execute a Community Health Improvement Plan to meet the needs identified in this assessment. OMC, with the help of VVV Research and Development, conducted the health needs assessment for our service area of Southwest Johnson County and Miami County. This was done by performing research and collecting health data for our area, and actively seeking input from the community through a survey and town hall meetings.

Timeline for CHNA & CHIP



Community Health Needs Priorities

The research and community input helped develop a clearer picture of our service area and the health priorities of residents. The result was a list of ten top health priorities.

1. Mental health, including diagnosis, placement and after care. Need additional providers
2. Health wellness and prevention
3. Alcohol and drug abuse
4. Affordable housing
5. Medicaid Expansion
6. Affordable healthcare services
7. Chronic disease management
8. Mobile health services
9. Transportation, both public and healthcare
10. Homeless

Community Health Needs Priorities

1. Behavioral Health
   A. Mental health, including diagnosis, placement and after-care, need additional providers *(CHNA Priority #1)*
   B. Alcohol and drug abuse *(CHNA Priority #3)*

2. Physical Health
   A. Health wellness and prevention *(CHNA Priority #2)*
   B. Chronic care management (CHNA Priority #7)

3. Access to Care
   A. Affordable housing *(CHNA Priority #4)* and Homeless *(CHNA Priority #10)*
   B. Medicaid expansion *(CHNA Priority #5)*
   C. Affordable healthcare services*(CHNA Priority #6)*
   D. Mobile health services *(CHNA Priority #8)*
   E. Transportation *(CHNA Priority #9)*

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Priority #1A: Increase collective community education, prevention, response and treatment for mental health conditions.

NEED: Our service area lacks adequate behavioral health resources to appropriately care for all residents with behavioral health needs. There is tremendous difficult to identify resources to diagnose and comprehensively treat behavioral health patients. Another barrier to care is the inability for primary care providers to continue treatment once their patient has received care from a behavioral health specialist due to lack of communication.

INITIATIVE: OMC will work with its primary care network to ensure all patients are being screened for depression, and subsequently connecting those who could benefit with the appropriate resources. OMC will also identify a partner to provide behavioral health resources integrated with primary care. This will require breaking down the communication barrier.

ANTICIPATED IMPACT: People who have behavioral health conditions will have more care options, resources and easier access to resources.

Priority #1A: Increase collective community education, prevention, response and treatment for mental health conditions.

Responses	Tactics	2023	2024	2025	KPI's
Through Olathe Health Primary Care Clinics, screen patients during wellness visits using the PHQ-9 depression screening. Continue enhancements to care management for patients with mental illness through implementation of behavioral health care management for patients with mental health conditions.	Assess patients ages 12 and older at least once per year.	X	X	X	75% screening compliance during wellness visits
	In patients who screen positive, increase the number who access services through community partners.	X	X	X	Connect 100% of identified patients with resources. Follow up every three months to confirm follow through.
	If score 5 or above, clinic visit becomes focused on suicidal ideation and one-on-one with the provider.	X	X	X	Develop safety care plan for 100% of identified patients.
Work with community health partners to support patients within the Olathe Health network, specifically focusing on those with depression/anxiety diagnosis, those who have that diagnosis plus a chronic medical condition and those who have more than four chronic conditions.	Identify key community partners and develop process for collaborating to increase access and enhance patient care.	X			Develop cooperative care plans with community partners.
	Increase behavioral health access within Olathe and surrounding communities.	X		X	2023: develop baseline for access 2024: Increase access by 2% over prior year 2025: Increase access by 2% over prior year

Priority #1A: Increase collective community education, prevention, response and treatment for mental health conditions.

Responses	Tactics	2023	2024	2025	KPI's
Support community initiatives to enhance access to services.	Support the Braden Robertson Fund through the Olathe Public Schools Foundation, which provides access to mental health professionals to underinsured Olathe students in crisis.	X	X	X	$10,000/annually

Priority #1B: Address the rise in abuse and misuse of opioids. Partner with key community entities to reduce the use of alcohol.

NEED: According to analysis of the U.S Bureau of Labor Statistics, U.S. Centers for Disease Control and Prevention and Hospital Industry Data Institute, Johnson County ranked in the middle for opioid dependence per capita. With this data and the national opioid epidemic, participants at the town hall meeting identified this as a top issue in our community. County Health Rankings reports a significantly higher percentage of excessing drinking and alcohol-impaired driving deaths in Johnson County as compared to the state of Kansas and other top performing counties across the United States. The Olathe Communities That Care task force, which OMC plays an active role in, is focused on the use of alcohol and other illegal substances specifically in youth.

INITIATIVE: OMC has created a multi-disciplinary physician team to monitor prescriptive practices. Another main focus for OMC will be to educate residents on resources for safe disposal of unused medications. OMC representatives will also actively participate in the Olathe Communities That Care task force to support education on underage drinking and drug misuse.

ANTICIPATED IMPACT: People who have access to opioids and other unused medications will have the education and access for safe disposal. Parents and local businesses will actively participate in prevention efforts of underage drug and alcohol use.

Priority #1B: Address the rise in abuse and misuse of opioids. Partner with key community entities to reduce the use of alcohol.

Responses	Tactics	2023	2024	2025	KPI's
Engage the OMC Physician Opioid Task Force to review prescription practices and provide appropriate education. *This group has implemented a number of programs to address this priority such as pain management contracts with patients, support KTRACS, intake assessments in clinics, guidelines for dispensing.*	Develop plan and infrastructure to monitor patients who have and do not have a controlled substance agreement. Develop baseline. Develop communication plan to educate providers that includes CME, Rounds, All Provider Meetings, etc.)	X			Reduce number of prescriptions to patients without a controlled substance agreement
	Reduce number of prescriptions to patients without a controlled substance agreement.		X	X	Pending baseline data
Partner with local groups to promote safe drug take back practices.	Host National Take Back event on the Olathe Medical Park campus in April and October.	X	X	X	Host two events and increase pounds collected by 3%.
	Promote local drop-off locations.	X	X	X	Provide annual education to OHP offices.
Actively participate with the Olathe Communities That Care and support their mission to promote a safe and healthy community.	Organize and implement National Family Week campaigns, designed to encourage family time together and conversations about underage drinking.	X	X	X	Increase the number of participants at the Family Day by 3% over prior year.

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Priority #2A: Partner with key community stakeholders to improve opportunities to health and wellness activities to engage and sustain positive behavior change.

NEED: Johnson County is ranked among the healthiest counties in the state. However, there are pockets within the county that lack adequate access to health and wellness activities. Challenges such as food insecurity impact 10.2% of Johnson County residents, having limited access to fresh fruits and vegetables. More than 17% of Johnson County residents reported physical inactivity, which leads to poor health and wellness. Community stakeholders identified food and nutrition services and education as poor in OMC's primary service area. The inventory of health services available in OMC's primary service area identified a number of health wellness and prevention resources.

INITIATIVE: OMC leverage it's community support dollars and resources to address health wellness and prevention activities in the community. OMC will continue to partner with community groups to promote access to wellness and prevention services available throughout the county.

ANTICIPATED IMPACT: People who have access food and nutrition education and wellness activities will promote positive behavior changes and improve overall health.

Priority #2A: Partner with key community stakeholders to improve opportunities to health and wellness activities to engage and sustain positive behavior change.

Responses	Tactics	2023	2024	2025	KPI's
Enhance food access, including fruits and vegetables, education on how to prepare healthy meals, etc.	Screen Olathe Health Family Medicine patients for food insecurity. Increase number of patients being connected to resources.	X	X	X	Increase by 3% over prior year.
	Collaborate with community partners to educate parents and young families on the importance of a healthy behaviors using the 1-2-3-4-5-Fit-Tastic Program.	X	X	X	Incorporate Fit-Tastic education into five community outreach programs.
	Support Olathe Community Gardens with annual sponsorship for community programming.	X	X	X	Sponsor annual workshop
Maximize community sponsorships to promote physical activity and healthy eating.	Provide community sponsorship dollars and resources to partners with an emphasis on activities that encourage physical activity (ie. Garmin Marathon, Olathe Parks & Recreation signage, etc.).	X	X	X	Support five wellness initiatives each year and add one additional initiative each year.
Encourage communities and employers to support health, wellness and prevention opportunities to improve access.	Partner with 20 local employers and/or community groups to provide preventative health and wellness screenings and/or education.			X	Participate in 10 events, and increase by an additional five each year.
Foster school and employer relationships to host nutrition education.	Host 10 nutritional education programs annually for community and employer groups.			X	Participate in 5 events in 2023, and increase by an additional two-three each year.

Priority #2B: Partner with key community stakeholders to improve access to education and care for people diagnosed with diabetes.

NEED: While the community identified the need for more resources for chronic care management, Olathe Medical Center has chosen to focus its efforts around diabetes care. According to the County Health Rankings, 8% of Johnson County residents have diabetes. This is in line with other top performing counties and slightly lower than the state of Kansas. City health dashboard reveals certain census tracts in close proximity to OMC, along the I-35 corridor, with higher percentage of residents with diabetes.

INITIATIVE: OMC leverage it's community partners to organize, sponsor and promote educational programs for diabetic patients. This will include program for pre-diabetic patients as well. OMC will also work with the Olathe Health Physician Clinics to recruit additional diabetes specialists.

ANTICIPATED IMPACT: People who are diagnosed with diabetes will have access to providers and educational opportunities to better control their diabetes. People who are at risk for developing diabetes or are pre-diabetic will be able to participate in educational opportunities to prolong disease progression.

Priority #2B: Partner with key community stakeholders to improve access to education and care for people diagnosed with diabetes.

Responses	Tactics	2023	2024	2025	KPI's
Increase the number of diabetic patients within the Olathe Health Primary Care clinics who have controlled numbers.	Increase the number of diabetic patients who have a hemoglobin A1C lower than 9 by 3% over previous year's totals.	X	X	X	Increase in managed diabetes care by 2% over previous year.
Identify patients within Olathe Health Primary Care clinics are at-risk of developing diabetes or undiagnosed.	Increase the number of participants in OMC's FREE pre-diabetes education class each month.	X	X	X	Increase the number of participants by 5% over previous year (total participants for 12 months)
Assess barriers to compliance with diabetes management. Then, improve resources to break down barriers for compliance with diabetes management.	Incorporate "Readiness for Change" into care plans for diabetic patients within the Olathe Health Family Medicine clinics who are not appropriately managing their diabetes to identify barriers.	X			Screen "readiness for change" in 80% of patients with unmanaged diabetes.
	Identify resources and work with care coordinators to develop a plan to help connect diabetic patients with the resources they need to manage their chronic condition.	X	X	X	Implement resource plan and increase utilization.
Provide community educational opportunities for people within the community to learn more about diabetes management and nutrition.	Launch partnership with Olathe Public Library to host quarterly public informational sessions that are free of charge.	X	X	X	Launch community program
	Incorporate outpatient dietician specific to diabetes care into at least 5 events throughout the first year; increase by at lease one in subsequent years.	X	X	X	Outpatient dietician at five events in 2023
	Explore additional partnerships within the community to provide pre-diabetes and other diabetes educational opportunities (i.e. Olathe YMCA)		X	X	Specific KPI's are TBD until after partner/program is identified.

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NEED: Public transportation is a considerable issue across the Kansas City Metropolitan Area. Even more so, OMC's primary service area has even fewer affordable resources and more square mileage to cover. According to the County Health Rankings, we know Johnson County has a higher rate of income inequality, long commute times and traffic volume all impact access to affordable transportation options. After OMC's first CHIP, the development of a mobile integrated health program was established. However, that program has reached it's capacity, therefore requiring expansion to continue to serve those with transportation barriers.

INITIATIVE: OMC will continue it's financial support of the City of Olathe's Mobile Integrated Health (MIH) Program and work with the MIH team to expand services within the community. OMC will also work with community partners to develop programs to assist those who need affordable transportation services.

ANTICIPATED IMPACT: People who are at risk for hospital readmission due to lack of transportation with have the resources to get to and from their appointments, access to the medications they are prescribed and additional support services to allow them to remain in their home and manage their health conditions.

Priority #3A: Continue to grow the Mobile Integrated Health (MIH) Program, a partnership between the Olathe Fire Department, Health Partnership Clinic and Olathe Medical Center. Reach more community members who need these support services.

Responses	Tactics	2023	2024	2025	KPI's
Continue to support the mobile integrated health program through financial contributions and enhance awareness within the community about the program.	Provide annual giving of $125,000 to sustain and expand program.	X			Present check to Chief DeGraffenreid.
	Partner with the MIH program at community events to enhance awareness of the program.		X	X	Partner in at least five events annually with MIH.

Priority #3B: Healthcare transportation, specifically focused on reducing the number of people who are not able to keep their appointments because of lack of transportation and reduce re-admissions to the hospital because patients are not able to access the resources they need due to lack of transportation.

Responses	Tactics	2023	2024	2025	KPI's
Partner with JCDHE to pilot a transportation program supported by grant funding for patients within OMC's primary service areas and fall into one of the categories listed above.	Launch pilot program for identified patients.	X			KPI to be determined once notification of grant approval status.
	Expand pilot program to broader patient population with transportation limitations.		X	X	TBD
	Seek funding to continue program			X	Obtain funding
Explore a partnership with Microtransit to expand services to enhance coverage throughout OMC's primary service area.	Explore and launch the potential for this service to make one stop, ideally for pharmacy, for patients being discharged from OMC or a patient in the Olathe Health Family Medicine clinic who is identified as having a transportation barrier.	X	X	X	Solidify a program by the end of 2023 and launch in 2024. KPI for 2025 would be to connect more patients identified with a transportation barrier with this service.
Increase other transportation services available to residents in primary service area.	Identify all transportation resources available to patients.		X		List of resources identified
	Create community resource page on Olathe Health website and promote in Connected Care and social media channels.			X	Page created

Priority #3C: Increase access to affordable health services by connecting people within our community who do not have health insurance with appropriate services that best fit their needs.

OMC has determined that this initiative is being addressed through other community organizations including the Health Partnership Clinic and others. OMC will continue to support this priority through the following actionable items:

- Provide education about resources available in the community related to health insurance through Olathe Health communication vehicles to communicate about resources available within the community related to health insurance.
    - Create community resource page on Olathe Health website and promote in Connected Care and social media channels.
    - Continue to educate OMC patients about resources available through Resolute Group (partner that helps enroll patients) and consider expanding services to assist with complex patients in the outpatient setting.
- Advocate for Medicaid expansion in Kansas. Research premium assistance programs throughout the state.

This plan will not include specific goals for improvement in this area.

Priority #3D: Increase access to affordable housing and homeless shelters

OMC has determined that this initiative is being addressed through other community organizations including the Olathe School District, Center of Grace, City of Olathe, Johnson County Government, Health Partnership Clinic and others. OMC will continue to support these organizations in their efforts by collaborating to provide volunteers and financial support, as well as leadership to identify resources and partners. OMC is also participating in a community work group to address this issue and support the homeless community. OMC is also providing education to it's providers in an effort to enhance knowledge around the medical needs for the homeless. OMC will continue to partner with Johnson County to promote the health system to attract new residents to the county and advocate for tax incentives and developer incentives.

Other priorities in this plan address enhancing services to this population.

This plan will not include specific goals for improvement in this area.