South Peninsula Hospital

Community Health Needs Assessment

2020-2023 Implementation Strategy

December 2020

Introduction

From November, 2019 through May, 2020, South Peninsula Hospital conducted a community health needs assessment (CHNA) in the southern Kenai Peninsula. This CHNA was conducted in compliance with IRS Section 501(r), and identified health needs of the 14,000+ residents of the South Kenai Peninsula Hospital Service Area of the Kenai Peninsula Borough.

The final assessment was adopted by the SPH Board of Directors on June 24, 2020 and made available to the public on the organization's website www.sphosp.org free of charge on June 25. The complete CHNA report can be found in the separate document link titled CHNA on the South Peninsula Hospital website www.sphosp.org.

Numerous presentations were made of the report from August - October, including at meetings of the hospital's Board of Directors, publicly elected Service Area Board, Rotary Club of Homer Kachemak Bay, hospital General Medical Staff and *MAPP of the Southern Kenai Peninsula*, the local community health coalition made up of twelve partnering local agencies representing the eight dimensions of wellness.

Health Needs Priorities

South Peninsula Hospital management team reviewed the findings, and considered input and feedback received during presentations, to prioritize the most significant health needs to address. Consideration was given to the magnitude of the issue, consequences if issue was not addressed, and feasibility to affect change. Special consideration was given to the lack of organizational resources due to staff shortages, financial uncertainty and modified access to care due to the COVID-19 pandemic. The health needs priorities are:

1) Health needs of an aging community

- Services for a rapidly growing senior population

2) Strengthen Primary and Preventative Care

- Mental Health and Wellness
- Economic security and social support
- Substance use, misuse and addiction
- Chronic diseases / Obesity
- Interpersonal violence
- Access to Care

3) COVID-19 Pandemic

- Improved emergency preparedness

- Long term consequences to community from one year in conditions of the pandemic (schools closed, job loss, social distancing, quarantines, layoffs, etc.)
- Long term health consequences to individuals from the disease
- Long term health consequences due to individuals delaying care
- Potential impact to staff and organizational systems

Based on these priority needs identified, this document outlines the summary of strategies developed to address these issues affecting the health and wellness of the community. Annual updates will be reported out in the Critical Access Hospital annual program report.

Implementation strategies for 2020-2023

Priority Finding #1: Health needs of an aging community

1. Services for a rapidly growing senior population –
    a) Specialty provider retention and recruitment
    b) Strengthen senior based services, including but not limited to outpatient surgery, rehabilitation, swing bed, home health, etc.
    c) Develop specific senior care offerings within services (i.e., fall risk assessments, senior walking programs, senior promotions, etc.)
    d) Explore alternate funding opportunities such as grants and other means based programs to support equipment and service needs of the growing senior population
    e) Secure space and facilities to support service growth

Priority Finding #2: Strengthen Primary and Preventative Care

1. Mental health and emotional wellness
    a) Recruit and retain ample outpatient and inpatient psychiatric providers
    b) Support wellness programs in the community
    c) Strengthen relations with other providers in the community for seamless transition of care
2. Economic security and social supports
    a) Provide charity care to those in need
    b) Offer promotions and education that help individuals access preventive (free flu shot clinics, sports physical day, vaccine outreach, etc.)

c) Offer insurance consult and enrollment services to residents

d) Explore and apply for alternate funding opportunities such as grants and other needs based programs to support economic and social community programs

e) Ensure financial aid is widely publicized and easy to access

f) Recruit locally for entry level positions

g) Support local workforce development programs

3. Substance use, misuse and addiction

a) Strengthen relations between inpatient, Emergency Department, outpatient clinics and local opioid task force resources to ensure seamless transition of care

b) Provide SPH clinical representation on local MAPP opioid task force

c) Develop and strengthen outpatient addiction services - M.A.T. (alcohol?)

d) Adopt critical recommendations put forth by SPH Substance Use, Misuse and Addiction Task Force which will improve addiction related care and services

e) Support prevention provider practices

f) Explore and apply for alternate funding opportunities such as grants and means based programs to support substance abuse treatment programs, equipment, and support

4. Chronic disease / Obesity

a) Support nutrition education, obesity, diabetes and other related chronic disease care

b) Support and promote physical activity among staff and community residents

c) Support access to good nutrition, education and dietary habits, both as an employer and provider

d) Utilize Health and Wellness to provide outreach to community

e) Ensure inpatient has seamless connection to outpatient referral for chronic disease management needs upon discharge

5. Interpersonal violence

a) Ensure E.R., inpatient and outpatient systems provide necessary safeguards to identify victims of violence

b) Ensure seamless connection to necessary care and services

c) Support local Center of Excellence, continuing SPH role with clinical services and financial support

6. Access to Care

a) Adopt trauma-informed care practices system wide, ensuring all residents feel welcomed seeking services at SPH

b) Review and ensure our services meet the residents where the need is (Homeless Connect, Health Fairs, etc.)

c) Consider or promote flexible hours of operation, such as evenings and weekends

d) Continue to strengthen and promote telehealth services

e) Promote and assist with insurance enrollment, consult and financial aid

Priority Finding #3: COVID-19 Pandemic

1. Improve emergency preparedness readiness
   a) Provide annual training that supports H.I.C.S. event management
   b) Drill and exercise regularly
   c) Maintain relations with local emergency response partners
   d) Develop and train backup staff for key positions in the incident command structure
2. Offer safe, timely, best practices for testing, treatment, patient care and vaccination.
3. Monitor for and respond to Long term consequences in the community due to one year in conditions of the pandemic (schools closed, job loss, social distancing, quarantines, layoffs)
4. Monitor for and respond to long term health consequences to individuals from the disease
   a) Outreach to patients who were confirmed positive for COVID to develop local tracking of long term symptoms and provide necessary support and symptom management
5. Long term health consequences due to individuals delaying care
   a) Promote the importance of regular checkups, and not delaying care
   b) Make systems easy and normal to access care
   c) Use positive language and messaging regarding safe practices and systems
   d) Reach out to those not recently seen for care
6. Monitor for potential impact to staff and organizational systems
   a) Continue close monitoring of all supplies and resources
   b) Provide wellness related services to employees
   c) Focus on employee engagement and maintaining employee morale