Revised: June 26, 2018

Hospital Name

Community Health Improvement and Health Equity Plan

HEART DISEASE: SMOKING

Outcome: Reduce the incidence of heart disease ________ from the current _____ per 1,000 diagnoses according to the ExploreMOHealth.org database.

Goal: Reduce the smoking rate in ZIP codes ____ in <hospital name> area from _____ to _____ per 1,000 diagnoses by <date> according to the ExploreMOHealth.org database.

	Key Strategies	Key Actions	Internal Lead	Key External Partners[†]	Key Process/Outcome Measures	Timeline
1	Evaluate Existing Programs	**Schools/Youth** • Identify current school tobacco programs and policies • Implement tobacco programs and policies where gaps are identified • Identify efficacy of programs • Maintain active support and partnership with Council for Drug Free Youth, local county health departments to promote tobacco/drug free lifestyles among youth in focused ZIP codes		• School District Officials/Personnel • School Nurses • Health Departments • Council for Drug Free Youth (CDFY) • Substance Abuse Coalitions in this region • Chamber of Commerce Partners in Education	• Increase by at least one school adopting tobacco free school policies • Establish the baseline for "Missouri Student Survey"	
		Employer • Identify existing smoking cessation programs		• Major Local Employers • Health Departments	• Enroll at least one local employer to provide assessments, screenings and education to their employees	
		City and County • Assess current local ordinances[◊] • Engage city and local stakeholders in establishing ordinances		• Health Departments • City Officials	• Increase by at least one passed ordinance in the region	
		Hospital and Medical Group • Develop and offer standardized smoking cessation education and/or facilitate referral to cessation program		• American Heart Association • FQHCs	• Establish the baseline for smoking cessation education rate in <hospital name> patient population	
2	Assess and Screen	**Schools/Youth** • Support the implementation of the "**MOST** Teens Don't Campaign" in school settings Evidence-based programs:		• School District Officials/Personnel • School Nurses • Health Departments	• Establish the baseline for individuals participating in the "**MOST** Teens Don't Campaign" in schools in the region	

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	Key Strategies	Key Actions	Internal Lead	Key External Partners[†]	Key Process/Outcome Measures	Timeline
		Project Toward No Tobacco Use (TNT) A Smoking Prevention Interactive Experience (ASPIRE)		• Council for Drug Free Youth (CDFY) • Substance Abuse Coalitions in this region • Chamber of Commerce Partners in Education		
		Employer • Develop "Worksite Health Promotion Program" based on CDC Worksite Health Scorecard to prevent heart disease, stroke, diabetes and related health conditions https://nccd.cdc.gov/DPH_WHSC/HealthScorecard/Home.aspx • Provide worksite health assessments, screenings and education		• Major Local Employers • Health Departments	• Enroll at least one local employer to provide assessments, screenings and education to their employees • Establish the baseline for participants in the smoking cessation program	
		Community • Provide tools and resources to support screening and for patients and families in need of services for prevention/lifestyle management • Heart disease screening events that include evidence-based tobacco cessation education and screening such as: Hooked on Nicotine Checklist (HONC) Fagerstrom Test for Nicotine Dependence Partnerships with Faith-Based Communities Freedom from Smoking • Missouri specific cessation resources Cancer Information Service - Help For Quitting Become an Ex My Time to Quit • Identify methods to reach Latino and African-Americans (e.g. churches) and convert screening and educational materials to Latino and African-American appeal as needed to improve cultural competency		• FQHCs • Faith-Based Organizations • Chamber of Commerce • American Heart Association • Health Departments • Major Local Employers • City Officials • Compass Health	• Increase number of screening events by one for preventive health • Provide at least one outreach program annually for both Latino and African-American populations	
3	**Advocacy**	**Schools/Youth** • Advocate and adopt tobacco free school policies specifically in the ZIP codes identified to have the		• School District Officials • Health Departments	• Increase by at least one school adopting tobacco free school policies	

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	Key Strategies	Key Actions	Internal Lead	Key External Partners[†]	Key Process/Outcome Measures	Timeline
		highest rates of smoking in the <hospital> region through education and promotional campaigns • Advocate for the implementation of school based curriculum on tobacco prevention through education and promotional campaigns			• Increase by at least one school adopting the tobacco prevention curriculum	
		Employer • Partner with businesses and local employers to become tobacco free places.		• Major Local Employers • City Officials	• Increase by at least one business adopting the tobacco free places	
		State, City and County • Support local tobacco free ordinances across the counties in this region • Advocate and provide education to encourage adoption of smoke free policies and local tobacco free ordinances across the counties in this region (e.g., Tobacco 21, point-of-sale initiatives)		• Health Departments • City Officials • Major Local Employers	• Increase by at least one passed ordinance in the region • Increase by at least one policy adopted in local businesses/restaurants and federally funded housing units	
	Legend	- [†]Key external partner listings are included in appendices. - [◊]Municipalities with smoking ordinances are included in appendices.				
	Notes	- Action items for heart disease takes into account hypertension and cholesterol.				

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Hospital Name

Community Health Improvement and Health Equity Plan

HEART DISEASE: HYPERTENSION

Outcome: Reduce the incidence of heart disease ______________ from the current _____ per 1,000 diagnoses according to the ExploreMOHealth.org database.

Goal: Reduce the hypertension rate in ZIP codes _______________________________ in <hospital name> area from _____ to _____ per 1,000 diagnoses by <date> according to the ExploreMOHealth.org database.

	Key Strategies	Key Actions	Internal Lead	Key External Partners[†]	Key Process/Outcome Measures	Timeline
1	**Assess and Screen**	• Develop Senior Health program including ongoing (at least quarterly) community and minority health screening program for key CVD risk factors such as blood pressure, cholesterol and BMI www.Munroe.Prestige55.org • Host annual community health screening event on "Successful Aging Forum" or "Know Your Numbers" to include CVD profile screenings and facilitate referral or evidence-based interventions when screening positive for risk factor(s) or disease process • Develop "Worksite Health Promotions Program" based on CDC Worksite Health Scorecard to prevent heart disease, stroke, diabetes and related health conditions https://nccd.cdc.gov/DPH_WHSC/HealthScorecard/Home.aspx • Assess <hospital name> Worksite Health utilizing CDC Worksite Health Scorecard and develop action plan including onsite screening event • Increase Medicare annual wellness exams and develop appropriate plan of care for CVD and hypertension • Participate in screening exercises for hypertension including blood pressure, BMI,		• Central Missouri Area Agency on Aging • YMCA • Health Departments • American Heart Association • Major Local Employers • FQHCs	• Establish the baseline for individuals participating in the community and/or worksite risk assessments, screenings and education	

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	Key Strategies	Key Actions	Internal Lead	Key External Partners†	Key Process/Outcome Measures	Timeline
		cholesterol screenings during community events • Promote Community-Based Non-Physician or Self-Screenings performed by other stakeholders • Identify methods to reach Latino and African-Americans (e.g. churches) Evidence-Based Tools and Guidelines: **State Heart Disease and Stroke Prevention Program Addresses High Blood Pressure** Million Hearts® National Heart Disease and Stroke Prevention Program Addresses High Blood Cholesterol WISEWOMEN program **W**ell-**I**ntegrated **S**creening and **E**valuation for **WOM**en **A**cross the **N**ation) Healthy People 2020 CDC Worksite Health Scorecard an assessment tool for employers to prevent heart disease, stroke, and related health conditions			• Provide at least one outreach program annually for Latino and African-American populations	
2	**Access to Care**	• Evaluate existing capacity at clinic locations in the community – hours of operation and number of providers • Identify patients without a primary care provider • Explore and implement telemedicine program (includes remote monitoring) options to improve access to specialist • Increase patient portal access to promote patient communication with care providers, patient access to test results, and patient ability to schedule appointments electronically • Evaluate utilization of Community Health Worker to improve health equity and better serve those with CVD • Identify gaps in transportation		• FQHCs • Other Healthcare Facilities in Community • Health Departments • Department of Health and Human Services / Barbara Brendel • OATS • City Officials	• Establish the baseline for wait time for new patient appointments and established patients • Establish the baseline for same-day appointment fill rate • Establish the baseline of number of appointments scheduled electronically through patient portal • Establish the baseline for utilization of transport services offered in the jurisdiction	

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	Key Strategies	Key Actions	Internal Lead	Key External Partners†	Key Process/Outcome Measures	Timeline
3	**Transitions of Care**	• Coordinate and manage care across the continuum by tracking patients from hospital to post-acute care setting (home, SNF/nursing home, rehab, or palliative) • Utilize EHR quality registries to reduce care gaps • Implement CMS transitional care management (TCM) and chronic care management (CCM) guidelines • Enhance the transitions of care for patients with heart-related diseases to ensure a good connection with post- acute resources and information • Reduce readmissions and preventable hospitalization. Correlate with existing readmission reduction program		• FQHCs • Nursing Homes • Other Post-Acute Care Settings	• Establish the baseline for performance score on "Transition of Care" questions for hospital and medical group patient satisfaction surveys • Continue to reduce preventable readmissions	
4	**Clinical Care/ Pathways**	• Continue to implement evidence-based protocols through EHR to manage care across the continuum related to key metrics of cholesterol, lipids and blood pressure (using CDC guidelines). Correlate with existing programs • Evaluate becoming a Million Hearts® 2022 partner by aligning with the Million Hearts® 2022 priority action guides and protocols • Implement Patient Centered Medical Home Level III Recognition		• American Heart Association • FQHCs • Health Departments • City Officials	• Utilize MIPS measures to improve metrics related to cholesterol, lipids and blood pressure • Align with Million Hearts® 2022 partner goals	
5	**Support Groups and Self-Management**	• Implement a Chronic Disease Self-Management Program that addresses self-management of chronic diseases. i.e., cardiopulmonary, cardiac nutrition https://www.ncoa.org/healthy-aging/chronic-disease/chronic-disease-self-management-programs/ • Promote self-management tools in patient portal to assist patients with recording self-care results such as blood pressure, blood sugar, and weight • Implement Self-Measured Blood Pressure Monitoring (SMBP)		• American Heart Association • FQHCs • YMCA • Central Missouri Area Agency on Aging • Health Departments • Food Pantries	• Establish the baseline for number of participants in the support group	

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	Key Strategies	Key Actions	Internal Lead	Key External Partners[†]	Key Process/Outcome Measures	Timeline
		https://millionhearts.hhs.gov/files/MH_SMBP_Clinicians.pdf • Continue to host or collaborate to provide support groups: Stroke, Mended Hearts, Diabetes				
6	**Education**	• Provide heart disease and diabetes education and awareness via participation in speakers bureaus, etc. • Identify educational material to improve health literacy across different populations with increased focus on Latino and African-Americans • Expand heart disease education across the community in collaboration with other partners through workshops and programs. This includes weight, hypertension, cholesterol, nutrition as well as smoking education. Evidence-based heart disease programs: Cardiovascular Health Education Program (CHEP) Hearts For Life: A Community Program on Heart Health Promotion • Educate providers about the eligibility requirements for WISEWOMAN screenings and referrals • Provide diversity and cultural competency training to providers and staff that increases awareness of health disparities in our region		• American Heart Association • Major Local Employers • School District Officials • YMCA • FQHCs • Health Departments	• Establish the baseline for number of patients who are educated on heart disease, specifically on co-morbidities, cholesterol, blood pressure, diabetes and blood pressure screening • Establish the baseline for hypertension rate for the region identified by ZIP code • Establish the baseline for number of participants in the smoking cessation program • Establish the baseline for number of individuals attending nutrition programs and workshops • Establish the baseline for number of referrals utilizing the Health Department WISEWOMEN program • At least one educational offering provided annually for diversity and cultural competency	

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	Legend	- †Key external partner listings are included in the appendices.
	Notes	- Action items for heart disease takes into account hypertension and cholesterol.
	Additional Resources	Review below evidence-based strategy https://www.ncbi.nlm.nih.gov/pubmed/17102157 https://www.ncbi.nlm.nih.gov/pubmed/11071226 **CDC Guidelines – Evidence-Based Strategy** Clinicians, public health practitioners, health care systems, and individuals Million Hearts Action Guide: Self Measured Blood Pressure Monitoring **Health Education**: Heart Disease **Blood Pressure Know The Facts About Your Blood Pressure**: **CDC** https://www.cdc.gov/bloodpressure/docs/ConsumerEd_HBP.pdf Community Health Worker's Training Resource - A comprehensive training manual to improve skills and competencies of community health workers. Includes a chapter on high cholesterol with information, activities, tip sheets and resources on ways to reduce cholesterol.

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Hospital Name

Community Health Improvement and Health Equity Plan

DIABETES

Outcome: Reduce the incidence of diabetes _____________________ from the current _____ per 1,000 diagnoses according to the ExploreMOHealth.org database.

Goals:

Conduct quarterly screening events in ZIP codes _______________________________________ in <hospital name> area to identify individuals with pre-diabetes and diabetes diagnoses.

Reduce the diabetes diagnoses in ZIP codes __________________________________ in <hospital name> area from _____ to _____ per 1,000 diagnoses by <date> according to the ExploreMOHealth.org database.

	Key Strategies	Key Actions	Internal Lead	Key External Partners[†]	Key Process/Outcome Measures	Timeline
1	Assess and Screen	**Schools/Youth** • Identify children (K-12) that could be at high risk through school health screening • Identify children (K-12) without primary care provider or pediatrician • Partner to support programs that promote physical activity and nutrition (e.g., CEMo WeCan, Boys & Girls Club)		• School Nurse • School District Officials • FQHCs • YMCA • Civic Organizations • City Parks and Recreations	• Establish the baseline for number of screenings completed • Establish the baseline for children without primary care provider or pediatrician • Establish the baseline for children engaging in physical activity	
		Employer • Develop "Worksite Health Promotion Program" based on CDC Worksite Health Scorecard to prevent heart disease, stroke, diabetes and related health conditions. Include spouse and dependents https://nccd.cdc.gov/DPH_WHSC/HealthScorecard/Home.aspx		• Major Local Employers	• Establish the baseline for number of biometric screenings completed	
		City/County and Community • Identify existing screening events offered in the community through local partners		• Health Departments/ Diabetes Educators • Food Pantries • YMCA	• Establish the baseline for number of participants in screening events	

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	Key Strategies	Key Actions	Internal Lead	Key External Partners†	Key Process/Outcome Measures	Timeline
		• Utilize above identified events to have improved coordination of such events and reduce variation • Develop Senior Health program including ongoing (at least quarterly) community and minority health screening program for key diabetes risk factors such as HgA1c, nutrition, physical activity, blood pressure, cholesterol, and BMI (e.g. www.Munroe.Prestige55.org) • Host annual community health education and screening event on "Successful Aging Forum" or "Know Your Numbers" to include diabetes risk health profile screenings and facilitate evidence-based interventions when screening positive for risk factor(s) or disease process. • Identify methods to reach Latino and African-Americans (e.g. churches) • Streamline referral mechanisms to diabetes educators within the community • Implement a referral process for patients within the community or healthcare settings identified with diabetes and develop real time scheduling process for individuals that are identified without a PCP (*refer to access to care section)* • Collaborate with YMCA to establish Diabetes Prevention Program https://www.cdc.gov/diabetes/prevention/index.html http://www.ymca.net/diabetes-prevention/		• American Diabetes Association • Faith-Based Organizations • MHA Diabetes Shared Learning Network	• Establish the baseline for number of prediabetes and diabetes patients identified • Provide at least one outreach program annually for both Latino and African-American populations • Establish the baseline for number of referrals to diabetes educators • Establish the baseline for number of individuals enrolled in DPP program	
		Hospital and Medical Group • Evaluate alignment with AMA/CDC Prevent Diabetes STAT (Screen/Test/Act Today) and M.A.P (Measure/Act/Partner) program guidelines and tool kits https://preventdiabetesstat.org/index.html https://www.stepsforward.org/Static/images/modules/10/downloadable/M.A.P.%20(Measure,%20Act,%20Partner).pdf **Diabetes: Screening Tools**		• Diabetes Educators		

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	Key Strategies	Key Actions	Internal Lead	Key External Partners†	Key Process/Outcome Measures	Timeline
		CDC Guidelines - CDC Prediabetes Screening Test CDC Guideline (Page 9, 10) - Diabetes Risk Test National Institute for Diabetes and Digestive Kidney Diseases – Diabetes Risk Test ADA Diabetes Guidelines - A1c, fasting plasma glucose for diagnostic testing				
2	**Access to Care**	• Evaluate existing capacity at clinic locations in the community – hours of operation and number of providers • Utilize disease registry to identify prediabetes and diabetes patients for internal campaigns • Increase patient portal access to promote patient communication with care providers, patient access to test results, and patient ability to schedule appointments electronically • Explore and implement telemedicine program (includes remote monitoring) options to improve access to specialist • Identify gaps in transportation		• FQHCs • Health Departments • OATS • City Officials	• Establish the baseline for number of days for scheduled new patient appointments and established patients • Establish the baseline for number of individuals through outreach by diabetes health educators • Establish the baseline and increase utilization of patient portal • Establish the baseline for utilization of transport services offered in the jurisdiction	
3	**Transition of Care**	• Coordinate and manage care across the continuum by tracking patients from hospital to post-acute care setting (home, SNF/nursing home, rehab, or palliative) • Utilize EHR quality registries to reduce care gaps • Implement CMS transitional care management (TCM) and chronic care management (CCM) guidelines • Enhance the transitions of care for patients with diabetes to ensure a good connection with post-acute resources and information • Reduce readmissions and preventable hospitalization. Correlate with existing readmission reduction program		• FQHCs • City/County Officials • Case Management/Social Worker/Community Health Worker	• Establish the baseline for performance score on "Transition of Care" questions for hospital and medical group patient satisfaction surveys • Continue to reduce preventable readmissions	

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4	**Clinical Care/ Pathways**	• Improve MIPS Quality Scores for hemoglobin A1c, lipids, blood pressure, neuropathy, fasting plasma glucose testing in an effort to identify patients with prediabetes and maintain control of clinical indicators for existing patients with diabetes • Implement evidence-based diabetes protocols to manage care across the continuum utilizing Million Hearts Action Guide: Self Measured Blood Pressure Monitoring		• FQHCs • Health Departments	• Increase number of patients being tested for A1c during visits	
5	**Support Groups and Self-Management**	• Provide and enroll individuals with prediabetes in Diabetes Self-Management Education Program (DSME) https://www.cdc.gov/learnmorefeelbetter/programs/diabetes.htm • Promote self-management tools in patient portal to assist patients with recording self-care results such as blood pressure, blood sugar, and weight • Continue to host or collaborate to provide support groups: diabetes, cardiac nutrition		• Health Departments • FQHCs • Major Local Employers • Faith-Based Organizations	• Establish the baseline for number of individuals enrolled in DSME program • Establish the baseline for number of patients using patient portal self-management care tools	
6	**Education**	• Provide diabetes education and awareness via participation in speakers bureaus, etc. • Identify educational material to improve health literacy across different populations with increased focus on Latino and African-Americans • Provide and enroll individuals with prediabetes in Diabetes Empowerment Education Program (DEEP) https://www.mhanet.com/mhaimages/sqi/chna/Diabetes%20Empowerment%20Education.pdf • Provide diversity and cultural competency training to providers and staff that increases awareness of health disparities in our region		• Health Departments • FQHCs • Major Local Employers • Faith-Based Organizations	• Establish the baseline for number of individuals enrolled in DEEP program • At least one educational offering provided annually for diversity and cultural competency	

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	Legend	- †Key external partner listings are included in the appendices.
	Note	-
	Additional Resources	Educate diabetics using curriculum provided by the National Diabetes and Education Program (**NDEP**) **Clinical tools and resources** Clinical Diabetes Diabetes Spectrum Review below evidence-based strategy https://www.ncbi.nlm.nih.gov/pubmed/17102157 http://journals.sagepub.com/doi/pdf/10.1177/014572179902500609 http://journal.diabetes.org/diabetesspectrum/00v13n4/page234.asp Community-Based Diabetes Screening and Risk Assessment – Example of a best practice program below http://dx.doi.org/10.1155/2016/2456518

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