PASSAVANT AREA HOSPITAL
Community Health Need Assessment Implementation Strategy
FY19 October 1, 2018 – September 30, 2019

Passavant Area Hospital – Morgan County, Illinois Passavant Area Hospital is a not-for-profit 131-bed rural community hospital that became affiliated with Memorial Health System in 2014. Passavant Area Hospital (PAH) has been providing healthcare services to the residents of Morgan, Cass, Greene, Scott, Brown, Pike and Macoupin counties in west central Illinois since 1875. In 2018, Passavant Area Hospital completed a community health needs assessment (CHNA) for Morgan County, Ill., as required of nonprofit hospitals by the Affordable Care Act of 2010. The 2018 CHNA was conducted in partnership with the Morgan County Health Department. The hospital completed previous need assessments in 2012 and 2015.

In 2016, the estimated population of Morgan County was 34,277. Race and ethnic breakouts are 91% are white, 6.2% Black, 0.4% American Indian and Alaska Native, 0.6% Asian 0. 1.8% are two or more races, 2.4% Latino or Hispanic. Two point nine percent of Morgan County's population speaks a language other than English in the home. Age groups include 19.5% of the population under the age of 18 and 19.3% over age 65, while 49.5% of the population is female, and 50.5% is male. High school graduates make up 90.6% of the residents (2.7% higher than the Illinois average), and 22.3% hold bachelor's degrees. There are 2,997 United States veterans. The median household income in Morgan County is $45,978. Fourteen point eight percent of people live below the poverty line (1.8% higher than the Illinois average). Thirty six percent of the county residents are rural.

As an affiliate of Memorial Health System (MHS), Passavant Area Hospital (PAH) worked with three other affiliate hospitals on the overall timeline and process steps for the CHNA, but completed its Morgan County assessment independently in collaboration with its local community partners. In order to help narrow down the multiple needs and issues facing the community to a set of final priorities the hospital would address, MHS hospitals agreed to use the same defining criteria throughout the CHNA process.

Defined Criteria

1. Institute of Medicine Triple Aim Impact
    - Improve the care of individuals
    - Improve the health of populations
    - Reduce waste, variation and cost

2. Magnitude of the Issue – How wide an issue is this in the community?
3. Seriousness of the Issue – How related is the issue to the mortality (deaths) of those affected?
4. Feasibility to Address the Issue – Considering available resources to address the issue, how likely are we to make a significant impact on the issue?

Community health needs were prioritized based on reviews of secondary community data, as well as primary data gathered by a Community Advisory Committee comprised of 15 representatives from community organizations. Social determinants of health were included in all data reviews. A community health survey was conducted for Morgan County by the University of Illinois' Survey Research Department. The Community Advisory Committee offered additional input following the survey and helped to prioritize the final issues and which community organizations were best situated to address the issues.

Priorities Not Selected:

Obesity—Passavant will continue offering the Weight Loss & Wellness program along with the Walking for Wellness partnership with Jacksonville High School and First Christian Church. However, the hospital does not have competencies to address this issue as a whole.
Illiteracy/Education—Passavant will work with community partners to provide education related to improving health. The hospital does not have expertise/competencies to address the issue as a whole.
Lice and Bed Bugs—The Morgan County Health Department and Morgan County Housing Association have a plan to address the issue effectively.
Homelessness—New Directions Warming & Cooling Center is working with organizations across the community to address the issue.
Gang/Drug Affiliation/Trafficking/Guns—The Morgan County Sheriff's Department, Jacksonville Police Department and Morgan County probation have a solid plan to address these issues in the community.

Following review of input from the Community Advisory Committee, community forums, the community survey, and Passavant's Core Advisory Team, Passavant selected three priorities to address in its implementation strategy over the next three years, from FY2016-FY2018.

Final Priorities Selected:

1. Access to Care – This is an initiative to address access to care in a vulnerable neighborhood.
2. Mental Health – PAH will expand mental health access in Jacksonville. In addition to specific goals at PAH, Memorial Health System has developed a plan to address this priority across its 4 affiliate hospitals.
3. Substance Abuse – PAH will combat opioid use among its patients. In addition to specific goals at PAH, Memorial Health System has a plan to address this priority across its four affiliate hospitals.

The PAH 2019 Implementation Strategy was approved by the PAH Board on August 15, 2018.

PAH 2019 PAH IMPLEMENTATION STRATEGY

PRIORITY 1:	Access To Care
Reasons for priority selection	Morgan County is ranked 77 out of 102 counties in Illinois for overall health as influenced by environment and other factors. Healthy Jacksonville aims to address many factors that influence a person's health that are linked to social issues.

Goal 1: Create a Community Based Health Collaborative	
Target Population	Chosen population was identified through a review of Passavant Emergency Department visits, looking specifically at lower acuity visits and patients who returned to the Emergency Department within three days for follow-up care. Results pointed to a need in northeast Jacksonville
Objective	To Improve the health of people we serve in Jacksonville

Strategy Selected: Healthy Jacksonville

Commitment of Resources: The Passavant Area Hospital Foundation has committed $169,000 to year one of the program. Funding will provide staff and startup costs for office space for Healthy Jacksonville Community Health Workers.

Collaborative Partners: Passavant Area Hospital, SIU Medicine, MacMurray College, Memorial Physician Services

Activity	Timeline	Anticipated Results
1. Create a community health worker (CHW) program.	Q1	• Hire 1 full time program supervisor and 1 part time community health worker
2. Create Healthy Jacksonville Advisory Council	Q1-Q3	• Develop a core group of residents who are interested in providing feedback and gateways to families living in the neighborhood
3. Create Healthy Jacksonville Provider Alliance	Q1-Q3	• Add 5-10 agencies who are providing services to the neighborhood
4. Integrate MOSAIC Program into Jacksonville Middle School	Q1	• LCSW embedded in the school to careen and connect students needing counseling with existing services
3. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Program builds meaningful connections between community residents and social service providers located within the Clay Avenue area; measured by surveys of Advisory Council, Providers Alliance, number of Community Healthy Worker (CHW) program clients due to increased visibility, and number of community outreach events developed and implemented by two or more members of the Providers Alliance.

	• Program identifies Jacksonville, IL residents who will participate in CHW program and increases their access to medical, mental health, and other services; measures to be determined during the first quarter of the program. • Program collaborates with the Memorial Physician Services care coordination program in Jacksonville, IL; measured by referrals between the two programs. • Program collaborates with Memorial Behavioral Health MOSAIC program in Jacksonville, IL; measured by referrals between the two programs.
Long term indicators & source	• Increase the number of participating Jacksonville residents who have a medical home, measured by patient medical records. • Participating residents will decrease their use of hospital emergency departments for non-emergent care and decrease hospitalizations for ambulatory sensitive conditions, measured by hospital electronic health records. • Increase health outcomes and quality of life for program participants. Measures to be determined.

Goal 2: Improve Access through Transportation	
Target Population	Residents of our primary and secondary market communities who need transportation to and from the hospital for medical care.
Objective	Reduce transportation barriers to health services

Strategy Selected: Expand WCMT partnership agreement

Commitment of Resources: PAH invests $37,500 annually to support public transportation services in Morgan and surrounding counties.

Collaborative Partners: Passavant Area Hospital, West Central Mass Transit

Activity	Timeline	Anticipated Results
1. Explore ways to provide rides to PAH campus	Q1	• Process established for qualified riders to attain a ride to the Passavant campus
2. Optimize rides home	Q2	• Patients will receive a free ride home
3. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• More patients will travel to PAH on WCMT as measured by ridership report from WCMT	

Long term indicators & source	• Transportation will be provided for all people who need a ride to and from Passavant.

Goal 3: Prevent, detect and treat sexually transmitted diseases (STDs)	
Target Population	Children in Jacksonville School District 117 and residents of Morgan County
Objective	Prevent people from contracting STDs and reduce prevalence of untreated STD's in Morgan County

Strategy Selected: Support Morgan County Health Department prevention education and STD Clinic.
Commitment of Resources: $9,650

Collaborative Partners: Passavant Area Hospital, Morgan County Health Department, Jacksonville School District 117

Activity	Timeline	Anticipated Results
1. Support MCHD sex education to 6th grade students which includes STD/STI/HIV/Aids, contraception, pregnancy prevention, and refusal skills.	FY19	• 6th grade students would better understand the consequences of risky behaviors.
2. Provide financial support to maintain the Morgan County STD Clinic at the Morgan County Health Department	FY19	• The Morgan County STD Clinic will continue treating patients for STD's on a walk-in basis at their twice weekly clinic.
3. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Students would receive education. Source: JSD117	
Long term indicators & source	• Fewer students would engage in risky behaviors resulting in fewer students contracting STDs. Fewer teen births would indicate that students are abstaining or using protection against pregnancy and STD. Source: Centers for Disease Control	

PRIORITY 2: Mental Health	
Reasons for priority selection	The demand for mental health services continues to outpace the supply of providers and services. Statistic show all subsets of the population in Morgan County rank higher than stage average for their emergent mental healthcare needs. Three out of five respondents on the community survey ranked mental health as having a significant impact on the health of the county.

Goal 1: Open Partial Hospitalization at PAH	
Target Population	Area residents who need more intensive daytime counseling services including those stepping down from the BHU
Objective	Deter patients from the need for inpatient behavioral health services.

Strategy Selected: Open a day program for behavioral health counseling and group activities

Commitment of Resources: PAH will provide clinic and staff

Collaborative Partners:

Activity	Timeline	Anticipated Results
1. Open Clinic on PAH campus	Q1	• Clinic to begin seeing patients
2. Staff service line	Q1	• Psychiatrist, a psychiatric mental health nurse practitioner, social workers, counselors, registered nurses, behavioral health techs and pastoral care
3. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Clinic will begin seeing patients
Long term indicators & source	• **Fewer patients will be seen in the ED or referred to the BHU**

Goal 2: Support the Children's MOSAIC project in Jacksonville schools.	
Target Population	Children in Morgan County.
Objective	To increase the number of child-serving sites with the capacity to conduct social/emotional screening and to provide mental health services on-site in order to identify children in distress and to increase access to intervention. The screening and early intervention efforts are provided in Springfield Public Schools, physician practices and the community.

Strategy Selected: The Children's MOSAIC Project is a community collaborative transforming the landscape of children's mental health care by moving services out of the clinic and into the community. Under this transformed system of care, children are identified earlier and are quickly engaged in appropriate services and supports in schools, primary care offices, and in the community. Behavioral health integration into schools and primary care practices has been shown to be effective in early identification and treatment of children at risk.

Commitment of Resources: Passavant Area Hospital will help expand and secure the MOSAIC program by providing financial support for the MOSAIC treatment team in Jacksonville School District 117, at Jacksonville Middle School.

Collaborative Partners: Passavant will collaborate with Memorial Behavioral Health, Jacksonville School District 117, SIU School of Medicine, area primary care physicians, area social service providers and Prairieland United Way.

Activity	Timeline	Anticipated Results
1. Implement MOSAIC at one Jacksonville School District 117 site.	FY2019	• Increase access to behavioral health services by integrating services in Jacksonville School District 117. It is anticipated the school in which MOSAIC will be integrated is a middle school.
2. Participate in targeted neighborhood community worker activities		• Increased early identification and intervention within targeted communities
3. Provide ongoing program evaluation of MOSAIC's impact.	FY2019	• Develop a standardized data collection plan for consistent outcomes and targets across all MOSAIC school sites of care. • Design, implementation, and distribution of MOSAIC scorecards for each MOSAIC school on an annual basis.
4. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• MOSAIC program in School District 117 site providing on-site behavioral health intervention • # of client contacts • # of direct client care hours • # of students referred to services • # of students engaged in MOSAIC services • Source: MOSAIC data collection tool, Electronic Health Record, SAEBRS screening reports, school records	
Long term indicators & source	• Increase attendance • Decrease behavior-related office referrals • Increase # of students successfully graduating from MOSAIC • Increase daily living functioning scores • Decrease problem behavior scores • Source: Ohio Youth Scales, functioning assessment tool, school records, Electronic Health Record	

Goal 3: Continue offering Mental Health First Aid training in Morgan county	
Target Population	Community at large
Objective	Step in early to stop the trajectory of issues that lead to mental health issues and the need for psychiatric intervention by providing community education to

	improve mental health literacy, early identification, peer intervention, and referral of community members to available resources if needed.

Strategy Selected: Mental Health First Aid (MHFA) is an evidence-based program that offers a five-day intensive training session to community members to become certified MHFA trainers. These certified trainers in turn go out in the community to provide an eight-hour education session to community members such as teachers, police, first responders, churches, youth leaders and others to teach them how to identify mental health issues, how to refer people to resources, and encourage community support of those struggling with issues that may contribute to mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that leads public health efforts to advance the behavioral health of the nation, endorses MHFA and recently established grant funding for MHFA as part of the President's initiative to increase access to mental health services. MHFA is on the National Registry of Evidence Based Practices (NREPP). All interventions on the registry have been independently assessed and rated for quality of research and readiness for dissemination. MHFA has been shown to increase understanding of mental health disorders, knowledge of available resources, and confidence in and likelihood to help and individual in distress,

Commitment of Resources: MHFA was a program initiated in response to the 2015 CHNA priority of mental health, which was also a final priority of the 2018 CHNA. The MHFA program will continue to be offered to both the community at large and healthcare workers. Memorial Medical Center's Organization Learning Department will oversee the MHFA program. This includes communication about the program, maintaining contact with the network of certified MHFA instructors in Sangamon, Christian, Logan and Morgan counties; overseeing online registration portal for MHFA classes, and ordering program materials.

Collaborative Partners: Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, Memorial Behavioral Health, Sangamon County Department of Public Health, and area social service providers.

Activity	Timeline	Anticipated Results
1. MHFA Coordinator will maintain contact with MHFA certified trainers and assist trainers with program registrations via an online website.	FY2019	Certified MHFA instructors both within MHS and in other community organizations will have support for MHFA promotion, program registration and access to program materials.
2. Promote the program to communities in Morgan county.	FY2019	MHS will create a communication plan to promote MHFA in Morgan county to create awareness of and promote available MHFA courses in their communities.

3. Hold at minimum three MHFA community trainings by certified MHFA instructors Morgan county.	FY2019	Increased number of individuals in Morgan County trained as mental health first aiders.
4. Create program logic model	Completed by Q3	Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Creation of a communication plan for FY19. • Number of MHS-sponsored community training events • Number of overall community MHFA trainings. • Source: MHFA data collection tool	
Long term indicators & source	• Among instructors and first aiders, increases in: mental health literacy, awareness of available resources, and confidence in assisting individuals in distress • Source: MHFA data collection tool.	

Goal 4: Support Girls on the Run of Central Illinois to help participants learn critical life skills to increase their personal confidence in who they are.	
Target Population	Girls in grades three through eight.
Objective	Girls will increase their personal confidence and gain skills to manage emotions and resolve conflict.

Strategy Selected: Girls on the Run is a positive youth development program designed to intentionally teach life skills. PYD programs use the "5 Cs" to measure impact on life skills which include confidence, competence, caring, character and connection. The curriculum teaches skills for girls to build their personal confidence, manage their emotions and resolve conflicts. This program reaches approximately 1,000 girls annually in central Illinois.

Commitment of Resources: PAH will provide $2,500 to support Girls on the Run of Central Illinois. This includes program support and scholarships for low-income girls, with additional support for CPR training for coaches and printing of program materials.

Collaborative Partners: Elementary schools in district #117 and Scott, Cass & Greene counties.

Activity	Timeline	Anticipated Results
1. Girls participate in a 10-week GOTR program, focusing on; two sessions offered annually	Fall 2018 and spring 2019	• 60% or more of participants will increase in personal confidence
2. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.

MEASURES: What will we measure to know the program is making a difference?	
Short term indicators & source	• Coach evaluations will include measures of increases in their team's confidence during the 10-week program. • Parent evaluations will include whether their daughter increased her personal confidence during the 10-week session.
Long term indicators & source	• Coach evaluations will include measures of increases in their team's confidence during the 10-week program. • Parent evaluations will include whether their daughter increased her personal confidence during the 10-week session.

PRIORITY 3:	**SUBSTANCE ABUSE**
Reasons for priority selection	During the 2018 Morgan County Community Health Needs Assessment, substance abuse was the top-ranked issue in the community survey and was a final recommendation from the Community Advisory Committee as a top priority. Substance abuse was noted as a significant contributing problem to many other health and social determinant issues, including mental health issues, crime, child abuse, poor health, education, housing, homelessness, unemployment, accidents, DUIs, suicide and early deaths. Is a drain on available community resources and affects everyone, either directly or indirectly.

Goal 1: Memorial Health System will develop a system-wide initiative to combat opiod abuse.	
Target Population	All patients provided care within Memorial Health System Healthcare providers within the community.
Objective	MHS will develop a system-wide initiative to reduce unnecessary clinical use of opioids and risk of addiction for patients treated at MHS hospitals, Memorial Physician Services, Memorial Home Services and Memorial Behavioral Health. Additionally, MHS will work with other community healthcare providers on standardizing opiod prescription policies, medication management agreements and increasing awareness of alternative treatments.
Strategy Selected: Using guidelines developed by the Centers for Disease Control and Intermountain Healthcare, Memorial Health System is putting structures in order to develop strategies to address clinical opioid use, among other key factors surrounding the opioid epidemic. An Opioid Stewardship Steering Committee has been formed to create a system-wide strategy to standardize opioid stewardship efforts. This effort is being led by Jennifer Harris, Administrator, Perioperative Services and Tamar Kutz, Administrator, Ambulatory Operations. The group is comprised of key leaders across the system and will oversee the work of four different subgroups focused on: Inpatient Compliance and Operations, Workforce Management, Drug Control & Diversion, and Ambulatory Operations/ Community Partnerships.	

Additionally, MHS will collaborate with other community healthcare providers on reviewing protocols across various physician practices and hospitals, including Southern Illinois University School of Medicine, Springfield Clinic, HSHS Medical Group, local law enforcement, and other community partners.

Commitment of Resources: The Opioid Stewardship Steering Committee is comprised of the following individuals: Kim Bourne, President and CEO, Taylorville Memorial Hospital; Dolan Dalpoas, President and CEO, Abraham Lincoln Memorial Hospital; Harry Schmidt, President and CEO, Passavant Area Hospital; Raj Govindaiah, MD, Senior Vice President and Chief Medical Officer; Marsha Prater, Senior Vice President and Chief Nursing Officer; Jay Roszhart, Vice President, Ambulatory Networks and Clinical Integration; Todd Roberts, Vice President, Quality and Safety; Linda Jones, Vice President, Operations and Administration; Bob Scott, Vice President, Human Resources; Drew Early, Vice President, Operations, Emergency Medical Services; Evan Davis, Administrator, Ortho and Neurosciences; Jan Gambach, System Administrator, Behavioral Health; Tamar Kutz, Administrator, Ambulatory Networks; and Jennifer Harris, Administrator, Perioperative Services.

Collaborative Partners: Memorial Medical Center, Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, Memorial Physician Services, Memorial Home Services and Memorial Behavioral Health. Community partners include SIU School of Medicine, HSHS Medical Group, Springfield Clinic, and local law enforcement agencies.

Activity	Timeline	Anticipated Results
1. Development of charter and goals for Opioid Stewardship Steering Committee	Q1	• Systemized strategy around opioid stewardship throughout Memorial Health System
2. Inpatient Compliance and Operations for Opioid Stewardship	Q1-Q4	• Address Joint Commission standards around pain and compliance
3. Ambulatory Operations and Community Partnerships	Q1-Q4	• Standardized Opioid Prescription Policy with partners • Increase usage of Medication Management agreements • Increase awareness of complementary and alternative treatments
4. Workforce Management	Q1-Q4	• Create a policy and program as it relates to opportunities around workforce management
5. Drug Control and Diversion	Q1-Q4	• Development of opportunities through drug diversion prevention audit
4. In FY19, MHS will participate in the Sangamon County Opioid Task Force convened by Sangamon County Department of Public Health.	Q1-Q4	• Serve on the Education Committee of the Sangamon County Opioid Task Force. • Keep leadership of MHS opioid initiative apprised of work being done by the task force, which includes law enforcement, courts, pharmacies, public health, schools, mental health and others.

5. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
6. Development of Program Measures	Completed by Q3	• Data collection plan
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Usage of Medication Management Agreement by prescribing providers for patients prescribed an opiate prescription. • Usage of Prescription Monitoring Program Site by prescribing providers. • Increased understanding of risks associated with opioid prescriptions by both patients and providers	
Long term indicators & source	Program measures to be fully identified by FY19 Q3.	

Goal 2: MHS will engage in a system-wide initiative to expand access to substance abuse treatment.	
Target Population	Community members who are dealing with a substance abuse issue.
Objective	To develop a strategy to expand substance abuse treatment by creating a system of care that will provide a full continuum of care and treatment options to people in central Illinois.

Strategy Selected: MHS, along with collaborative partners, will design and implement an integrated, treatment approach to treating co-occurring behavioral health and substance use disorders. According to the 2017 National Survey of Substance Abuse Treatment services, about 37% of individuals in Illinois seeking substance use disorder treatment have been diagnosed as having a co-occurring mental and substance use disorder. The Substance Abuse and Mental Health Services Administration (SAMHSA) supports an integrated treatment approach along a continuum of care. An integrated treatment approach has shown to lower costs and leads to better outcomes.

Commitment of Resources: MHS Substance Use Treatment Steering Committee is comprised of Jay Roszhart, Vice President, Ambulatory Networks and Clinical Integration; Jan Gambach, System Administrator, Behavioral Health; Kari Wolf, MD, Chair of Department of Psychiatry, SIU Medicine; Tamar Kutz, Administrator, Ambulatory Operations; Emily Ebert, Director of Finance, MBH; Heather Sweet, Manager, Behavioral Health Performance Management; and Jeanette Hoelzer, Behavioral Health Consultant. Additional workgroups comprised of affiliate hospitals and local community treatment agencies will be convened as needed during strategic implementation.

Collaborative Partners: Memorial Medical Center, Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, Memorial Physician Services, Memorial Behavioral Health, SIU School of Medicine, SIU Department of Psychiatry, and area social service and substance abuse treatment providers.

Activity	Timeline	Anticipated Results

3. Engage a system-wide steering team, including medical leadership from SIU and other local stakeholders	Q1	• Develop a core committee to work across the region in creating a system-wide treatment approach
4. Identify best practice care continuums that allow for full integration and coordination of care	Q1	• Evidence-based practices for alcohol and opioid use in detoxification, integrated co-occurring treatment models, and medication assisted treatment
5. Conduct regional gap analysis in substance use treatment	Q2-Q3	• Regional maps identifying locations of current substance use treatment resources
6. Develop action items to advance regional capacity	Q3-Q4	• Create multiple and seamless, best-practice, pathways of care from identification of a substance abuse problem, through acute treatment, recovery and aftercare to prevent relapse
5. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Development of regional gap analysis/neighborhood maps • Development of integrated co-occurring treatment model with optimal treatment pathways • Source: MHS system-wide continuum of care model	
Long term indicators & source	• Increase access to substance abuse treatment • Decrease substance use disorder overdoses • Decrease substance use presentations in emergency departments • Source: electronic health records	

Goal 3: PAH will reduce use of prescription opioids	
Target Population	Inpatients and patients of Center for Pain Medicine
Objective	Reduce prescription opioids for pain management

Strategy Selected: Hospitalization frequently requires pain management for trauma-related injuries, for underlying conditions such as cancer or in the post-surgical setting. Opioids have traditionally been used to suppress pain for these patients. The CDC's latest guidelines for opioid prescribing directs doctors to try nondrug treatments first. Measures are being implemented in Nursing practice and the Center for Pain management to introduce alternatives to opioid prescriptions.

Commitment of Resources: PAH will develop the software needed to implement and track the screening for inpatients. PAH pain clinic was developed with a specific goal of utilizing alternative to opioids for pain management.

Collaborative Partners:

Activity	Timeline	Anticipated Results
1. Nursing practice screening and non-pharmaceutical comfort before meds	Q1	• Address opioid addiction for inpatients through screening, nondrug comforts and referral to addiction services upon discharge.
2. Anesthesiologists adding ERAS to reduce post-surgery opioid need.	Q1	• Reduced need for opioid pain relief after surgery
3. Pain Clinic procedures designed to reduce the need for pain medications	Q1	• Fewer prescriptions written for pain medication
4. Utilize urine drug screens to ensure patients are safely using meds.	Q1	• Patients on abnormally high dose medication will be referred to services that aid in reduction measures.
5. Add Social Worker in the Pain Clinic to assist patients with follow up psych and dependency issues.	Q3	• Patients will receive psych and detox services to reduce the use of opioids.
4. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Reduction in prescribed opioids while patients are in the hospital. Source: PAH Pharmacy	
Long term indicators & source	• **Fewer patients on opioids for pain – source to be determined**	