# 2024 - 2026

## Community
## Health Improvement
## Plan
### of
## Regional West
## Medical Center

## PREPARED BY

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## IN COLLABORATION WITH

Rural Nebraska Healthcare Network
Scotts Bluff County Health Department
Box Butte General Hospital
Chadron Community Hospital
Gordon Memorial Hospital
Kimball Health Services
Morrill County Community Hospital
Perkins County Health Services
Regional West Garden County
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**INTRODUCTION**

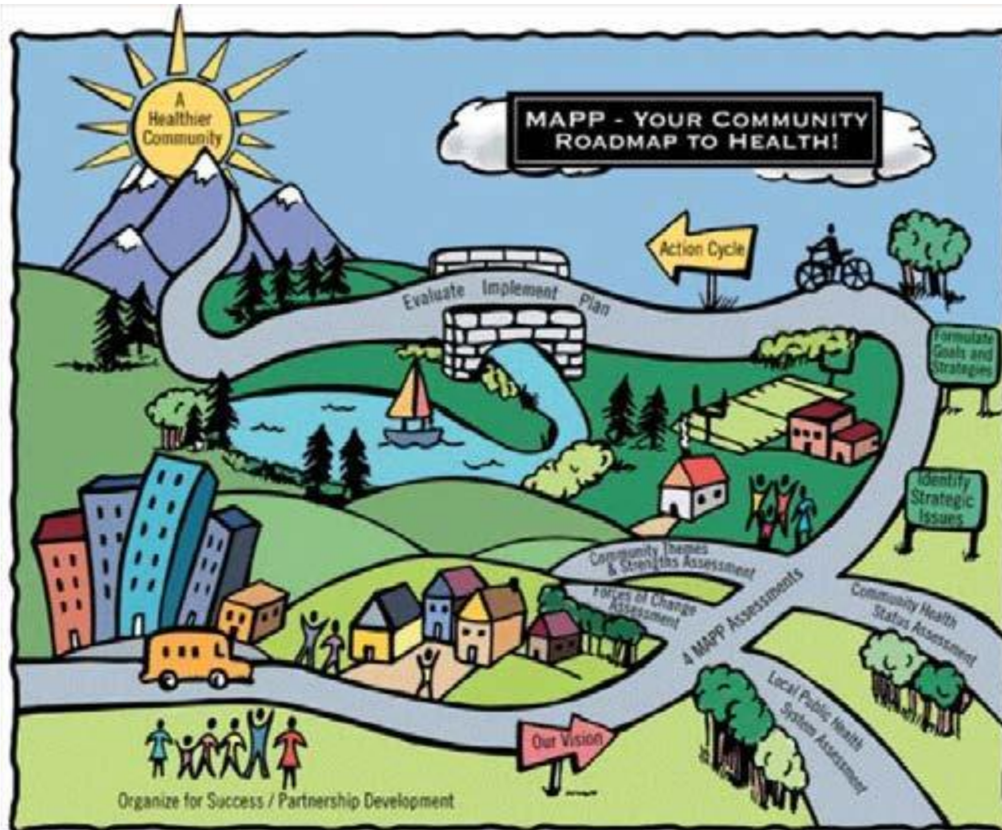
The COVID-19 pandemic limited the regional capacity to attend to the priorities identified in the last cycle. Over the past year and a half, we have been able to grow our capacity and our team witnessed active hope in our partners that is alive and well despite all that has been going on. This cycle (2024-2026) presents an opportunity to make even more movement toward our collective goals. Regional priorities for the Panhandle Public Health District service area (12 counties of the Nebraska Panhandle) were determined prior to priorities for each hospital service area in the district. Every hospital is aligned with the regional goal to improve access to behavioral and mental health. There are pieces of the other regional priorities that can be found in each hospital's plans for the coming years. The spirit of collaboration feels more present than ever.

**THE VISION**

The vision for this cycle of Mobilizing for Action through Planning and Partnerships is:
When we align our resources a safer and healthier Panhandle will be one where wellness and mental well-being are incentivized, there is access to safe and affordable housing, there is increased social connectedness, we have a sustainable workforce and there are development opportunities, the health system collaborations are optimized, there are robust systems to address behavioral health, our community is equitable, we advocate to address access to care, we have resources available, we have safe built environments, and we prevent Adverse Childhood Experiences (ACEs).

**THE PROCESS**

Mobilizing for Action through Planning and Partnerships (MAPP), a partnership-based framework, has been used for the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) development process in the Panhandle since 2011, and continued to be used for this round of the CHNA and CHIP. MAPP emphasizes the partnership with all sectors of the public health system to evaluate the health status of the region it serves, identify priority areas, and develop plans for implementation.




The MAPP model has six key phases:

1. Organize for success/Partnership development
2. Visioning
3. Four MAPP assessments
    a. Community Themes and Strengths Assessment (CTSA)
    b. Local Public Health System Assessment
    c. Forces of Change Assessment
    d. Community Health Status Assessment
4. Identify strategic issues
5. Formulate goals and strategies
6. Take action (plan, implement, and evaluate)

This document encompasses phases five and six. Phases one through four can be found in the Community Health Needs Assessment.

**GOALS**

The first four phases of the MAPP model are summarized in the CHNA component of this report. For this cycle, the regional priorities were selected first and then the community hospital selected their priorities.

The goals selected for the region are:

Regional West Medical Center chose the following priorities:

# 2024-2026 Regional West Medical Center Community Health Improvement Plan Priority Areas

**ENGAGING THE COMMUNITY**

A survey was created at the end of 2022 and distributed widely online through many email lists and hospital waiting rooms. A postcard with the link to the survey was also sent out to the most isolated communities in the Panhandle (rural counties without hospitals in them, neighborhoods where a high proportion of the residents are non-white, and rural communities that lack common areas for distribution of survey materials). 1100 participants filled out the survey. Community organizations were invited to participate in several meetings throughout 2023 to develop the vision and priorities for the cycle. Community organizations also participated in a survey to describe their gifts that can support community health improvement efforts. Between all of the meetings and surveys, 32 organizations participated.

**ABOUT THE PLAN**

The Regional West Medical Center Community Health Improvement Plan includes goals and objectives for three years and work plans that are intended to be periodically updated. The goals, strategies and objectives are aligned with national initiatives such as Healthy People 2030 and the Panhandle Community Health Improvement Plan. The specific alignments are called out in the Goals and Objectives section. The objectives include quantifiable performance measures based on data included in the CHNA or community feedback surveys conducted throughout the cycle.

Establishing the performance measures for the objectives is done on a three-year cycle. The hospitals operate on three-year CHIP/CHA cycles and data is often not made available until a year or two after it was collected.

Monitoring the CHIP will be done by the hospitals and by the communities of practice. Panhandle Public Health District (PPHD) will collect the data outlined in the CHIP to be presented to the MAPP steering committee and the communities of practice each year. In addition, the party responsible for each activity will present to the committee at least annually to report progress, successes, challenges and needs. The MAPP steering committee meets quarterly and the communities of practice will meet every six months.

The work plan includes activities that community partners have agreed to conduct in the first year of the cycle. The agreements are based on the mission and resources of the agency and are built on evidence-informed best practices. The activities included in the plan include a reference to the best practice and some indication of the agency's ability to support the activity and ongoing needs. The work plan will be reviewed annually to recommit to the activities each hospital and the regional collaboration will complete in that year. With the help of communities of practice and ongoing reviews of the work plans with shorter deadlines, we hope to have more efficient success. Panhandle Public Health District will be responsible for coordinating and scheduling the community of practice and steering committee meetings.

## REGIONAL WEST MEDICAL CENTER COMMUNITY HEALTH IMPROVEMENT PLAN GOAL AND OBJECTIVES

### STRATEGIC GOAL A: IMPROVE ACCESS TO CARE

**Goal A1: Increase the hospital's capacity and availability of services to meet the needs of patients in the regions.**

**Strategy A1.1** Evaluate regional needs to identify priorities for recruitment and retention of key medical specialties.

***Objective A1.1.1***

Engage in active searches for permanent local providers to include Emergency Medicine, Oncology, Psychiatry, and Rheumatology.

**Strategy A1.2** Evaluate staffing models and fast track services to improve access to emergency care.

***Objective A1.2.1***

Reduce wait times and Left Without Being Seen rates in the Emergency Department by at least 10%.

**Goal A2: Increase the hospital's collaboration with area hospitals.**

**Strategy A2.1** Improve relationships with area hospitals through increased collaboration and sharing of telehealth resources.

***Objective A2.1.1***

Regional West will participate in 90% of the MAPP steering committee meetings and will participate in the access to care hospital community collaboration.

### STRATEGIC GOAL B: IMPROVE AVAILABILITY OF MENTAL HEALTH RESOURCES

**Goal B1: Improve regional capacity and support for mental health needs**

**Strategy B1.1** Train nursing staff in the QPR (Question. Persuade. Refer.) program, which is focused on communication for suicide prevention.

***Objective B1.1.1***

Offer QPR training to at least 25% of nurses working in the Emergency Department, Behavioral Health Unit, and the Psychiatric & Behavioral Health Clinic.

**Strategy B1.2** Increase website resources to support mental health access.

***Objective B1.2.1***

The Behavioral Health 360 application (credible minds) will be added to the hospital website and materials will be distributed to patients during visits.

**Goal B2: Increase the hospital's collaboration with area service agencies.**

**Strategy B2.1** Participate in the community solutions for improving mental health support.

***Objective B2.1.1***

Regional West will participate in the regional Situation Table at least once per quarter.

**Strategy B2.2** Engage state resources to assist with addressing lack of mental health services in Western Nebraska

***Objective B2.2.1***

Regional West will actively work with state representatives and the Office or Rural Health to bring awareness and resources to mental health needs in Western Nebraska

## STRATEGIC GOAL C: IMPROVE HEALTH OUTCOMES IN THE REGION THROUGH INCREASED COMMUNITY COLLABORATION & SERVICES, WITH A FOCUS ON HEALTH EQUITY

### Goal C1: Identify and address potential health disparities to improve health equity for the populations we serve.

**Strategy C1.1** Utilize standardized screening and data analysis processes to evaluate health equity and implement action plans as indicated.

***Objective C1.1.1***

Regional West will use electronic health record data to collect, evaluate and act on data related to health disparities

***Objective C1.1.2***

Regional West will use the information gained from looking into the data to determine at least one health equity-focused project per year.

### Goal C2: Increase services related to community health screenings, wellness visits, and health education.

**Strategy C2.1** Increase the number of health screening events offered in the community, such as stroke screening and vascular health.

***Objective C2.1.1***

Increase Regional West offerings of community health screening events.

**Strategy C2.2** Evaluate processes and resources to increase the utilization of wellness visits, with an improved focus on disease prevention, early detection, and effective chronic care management.

***Objective C2.2.1***

Utilize accountable care processes to increase wellness visits and compliance with recommended screening exams and other ACO quality initiatives.

| Year 1 Workplan for Strategic Goal A | | | | |
|---|---|---|---|---|
| **Strategy** | **Activities** | **Responsible** | **Goal #** | **Time Frame** |
| **Access to Care** | Recruit and retain key medical specialties | RWMC Leadership | A1.1 | Jan 2024-Dec 2026 |
| | Improve process efficiencies for emergency care | RWMC Leadership | A1.2 | Jan 2024-Dec 2026 |
| | Participate in 90% of the MAPP steering committee meetings | RWMC Leadership | A2.1 | Jan 2024-Dec 2026 |
| **Community Outreach & Collaboration** | Routine meetings for collaboration between Regional West leadership and CAH leadership | RWMC Leadership | A2.1 | Jan 2024-Dec 2026 |
| | Provide additional health screening events in the community | RWMC Leadership | C2.1 | Jan 2024-Dec 2026 |
| | Train applicable nursing staff in the QPR (Question. Persuade. Refer.) program for suicide prevention. | RWMC Leadership | B1.1 | Jan 2024-Dec 2026 |
| **Mental Health Services** | Add the Behavioral Health 360 application (credible minds) to the Regional West website | RWMC Leadership | B1.2 | Jan 2024-Dec 2026 |
| | Participate in the Situation Tables quarterly | RWMC Leadership | B2.1 | Jan 2024-Dec 2026 |
| | Contact state senators, the Office of Rural Health and other key stakeholders regarding needs for mental health services in Western Nebraska | RWMC Leadership | B2.2 | Jan 2024-Dec 2026 |
| **Health, Wellness & Equity** | Provide additional health screening events in the community | RWMC Leadership | C2.1 | Jan 2024-Dec 2026 |
| | Screen patients and evaluate data to identify and address potential health equity concerns | RWMC Leadership | C1.1 | Jan 2024-Dec 2026 |
| | Improve ACO process through data analysis for enhanced chronic disease management. | RWMC Leadership | C2.2 | Jan 2024-Dec 2026 |
| | Increase wellness visits | RWMC Leadership | C2.2 | Jan 2024-Dec 2026 |
| | Encourage screening programs for early detection | RWMC Leadership | C2.2 | Jan 2024-Dec 2026 |

Sources for Evidence-Based Practices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