Implementation Strategy
2013-2015

SUMMA Health System
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The 2013 Community Health Needs Assessment identified a number of health needs within the community we serve. Analysis of the community health needs assessment data provided a way to evaluate and prioritize areas of greatest need. From this prioritized list, a set of implementation plans was developed to address the identified needs within the scope of services provided by each of the Summa Health System hospitals.

**Development of the Implementation Strategy**

In collaboration with Summa Health System internal service line directors and departments, a set of specific objectives and strategies was developed to address each prioritized health need determined to be within the scope of services and aligned with the mission of the system. Progress in achieving the goals of these objectives and strategies will be monitored by the Summa Health System Community Benefit Advisory Council and reported to the Community Benefit Committee. Updates reflecting the status of each prioritized health need will be provided on an annual basis.

The plan to address specific identified health needs, along with the rationale for not addressing a specific identified health need, is presented for each system facility on the following pages of this plan.

**Revisions to the Implementation Strategy**

This implementation strategy specifies community health needs that Summa Health System has determined to meet in whole or in part and that are consistent with its mission. Summa Health System reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

**Summa Akron City and St. Thomas Hospitals**

As a result of the analysis of the data from the community health needs assessment, the adult health needs of asthma, cancer, cardiovascular disease, diabetes, mental health, substance abuse, lifestyle factors, access to care factors, and quality of care factors will be addressed by Summa Akron City and St. Thomas Hospitals in this implementation plan. The child health needs of maternal and infant health and birth risk factors will also be addressed by Summa Akron City and St. Thomas Hospitals. Due to the community resources available to assist individuals in obtaining healthy food, including the Akron Canton Regional Food Bank, Summa Akron City and St. Thomas Hospitals chose not to address this environmental factor health need in this implementation plan. In addition, the community resources available to assist children, specifically Akron Children’s Hospital, in the areas of childhood chronic disease, child development, child lifestyle risk factors, child mental health and substance abuse, child safety, child access to care factors and child environmental risk factors, led to the determination by Summa Akron City and St. Thomas Hospitals to not address these child health needs.
Implementation Strategy

Chronic Disease – Asthma

**Objective 1:** Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations which lead to asthma and/or asthma related disease development. Increase knowledge of the signs and symptoms of asthma and asthma related diseases.

**Strategies:**
1.1. Collaborate with American Lung Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions, which often lead to the development of asthma and asthma related diseases.

1.2. Collaborate with American Lung Association at community outreach events to provide information on the signs and symptoms asthma and asthma related conditions.

**Objective 2:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of asthma and decreasing the incidence of undiagnosed and/or late stage diagnosed asthma with subsequent asthma related complications.

**Strategies:**
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of clients with asthma at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of patients with asthma through continuity of care provided by community based primary care providers.
Implementation Strategy

Chronic Disease – Cancer

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations, which lead to increased incidence of cancer.

Strategies:

1.1. Collaborate with American Cancer Society at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which often lead to the development of cancer.

1.2. Collaborate with American Cancer Society at community outreach events to provide information on the signs and symptoms of cancer.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of cancer and decreasing the incidence of undiagnosed and/or late stage diagnosed cancer with subsequent cancer related complications.

Strategies:

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with cancer at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with cancer through continuity of care provided by community based primary care providers.
**Implementation Strategy**

**Chronic Disease – Cardiovascular Disease**

**Objective 1:** Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations, which lead to cardiovascular disease development.

**Strategies:**

1.1. Collaborate with American Heart Association in utilizing the American Heart Association Family Tree exercise at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of cardiovascular disease.

1.2. Collaborate with American Heart Association at community outreach events to provide instruction and education on cardiopulmonary resuscitation through the CPR Anytime classes.

1.3. Collaborate with American Heart Association at community outreach events to provide information on the signs and symptoms of cardiovascular diseases.

**Objective 2:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of cardiovascular disease and decreasing the incidence of undiagnosed and/or late stage diagnosed cardiovascular disease with subsequent cardiovascular disease related complications.

**Strategies:**

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of clients with cardiovascular disease at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of patients with cardiovascular disease through continuity of care provided by community based primary care providers.
Chronic Disease – Diabetes

**Objective 1:** Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations, which lead to increased incidence of diabetes.

**Strategies:**

1.1. Collaborate with American Diabetes Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of diabetes.

1.2. Collaborate with American Diabetes Association at community outreach events to provide information on the signs and symptoms of diabetes and diabetes related complications.

**Objective 2:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of diabetes and decreasing the incidence of undiagnosed and/or late stage diagnosed diabetes with subsequent diabetes related complications.

**Strategies:**

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with diabetes at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with diabetes through continuity of care provided by community based primary care providers.
Mental Health

**Objective 1:** Improve identification, diagnosis, and treatment of depression.

**Strategies:**
1.1. Provide additional behavioral health care providers in outpatient psychiatry to increase access for patients in behavioral health unit.

1.2. Increase of integrated behavioral health care providers to Internal Medicine and Family Medicine Primary Care Centers at Akron City Hospital to promote early detection, diagnosis and treatment of depression in primary care settings.

**Objective 2:** Improve identification and treatment of patients with suicidal tendencies.

**Strategies:**
2.1. Provide additional behavioral health care providers in outpatient psychiatry to increase access to individuals presenting with suicidal tendencies.

2.2. Provide additional integrated behavioral health care providers to Internal Medicine and Family Medicine Primary Care Centers at Akron City Hospital.

2.3. Provide Psychiatry grand rounds focused on assessment and treatment of suicidal patients.

2.4. In collaboration with Coleman Behavioral Health, provide one Coleman provider to the St. Thomas Hospital Emergency Department to assist in assessment, triage, and to connect patients who present to the emergency department with behavioral health diagnoses to resources.

**Objective 3:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of behavioral health concerns and decreasing the incidence of undiagnosed and/or late stage behavioral health diagnoses with subsequent behavioral health related complications.

**Strategies:**
3.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

3.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with behavioral health diagnoses at community outreach events.
Implementation Strategy

Substance Abuse

Objective 1: Decrease adult alcohol abuse.

Strategies: 1.1. Utilization of ongoing Intensive Outpatient Programs for Alcohol and Drug abuse and dependence at St. Thomas Hospital. Intensive programs offered five days per week and three tracks per day.

1.2. Utilization of Inpatient Alcohol Detox Unit at St. Thomas Hospital to provide greater access to individuals requiring intensive inpatient treatment.

1.3. Provide greater access of services by increasing Addiction Medicine Consultation Liaison hours at Akron City Hospital for inpatients who present with alcohol abuse or dependence in non-behavioral health units.

1.4. Develop an Addiction Medicine Fellowship to increase availability and access of trained addiction medicine health care providers.

Objective 2: Decrease adult prescription drug abuse.

Strategies: 2.1. Utilization of ongoing Intensive Outpatient Programs for Alcohol and Drug abuse and dependence at St. Thomas Hospital. Intensive programs offered five days per week and three tracks per day.

2.2. Increase access to services by increasing the number of beds in the Inpatient Alcohol and Drug Detox Unit at St. Thomas Hospital.

2.3. Provide greater access of services by increasing Addiction Medicine Consultation Liaison hours at Akron City Hospital for inpatients who present with alcohol abuse or dependence.

2.4. Develop an Addiction Medicine Fellowship to increase availability and access of trained addiction medicine health care providers.
Objective 3: Decrease adult opioid drug abuse.

Strategies:

3.1. Utilization of three and a half addiction medicine specialists offering Suboxone replacement therapy to assist patients in weaning off of opioids.

3.2. Participate in Summit County ADM Board grant trial of low dose Suboxone replacement therapy with ongoing intensive outpatient programs also available to assist patients as they pursue abstinence from opioid use.

3.3. Provide Psychiatry grand rounds focused on assessment and treatment of patients with opioid dependence and abuse.
Implementation Strategy

Overweight/Obesity

Objective 1: Provide education and resources within the community to assist individuals in obtaining and maintaining healthy weight.

Strategies: 1.1. As noted in implementation plans for chronic diseases and in collaboration with a variety of community partners including the University Park YMCA, educational resources will be made available to address healthy eating, healthy food selection, body mass index, risks for developing obesity, and value of physical exercise at community outreach events.

1.2. Disseminate information regarding available community resources, providers, and facilities for prevention of overweight/obesity conditions and/or weight reduction and weight maintenance approaches.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of obesity and decreasing the incidence of obesity related complications.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with obesity at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with obesity through continuity of care provided by community based primary care providers.
Implementation Strategy

Lifestyle Risk Factors – Smoking

Objective 1: Decrease smoking and tobacco use in adults.

Strategies: 1.1. In collaboration with American Lung Association, American Cancer Society, and American Heart Association, provide education of risk factors for smoking/tobacco use at community health outreach events.

1.2. In collaboration with local public health departments, promote legislation to increase smoke free environments within communities.

1.3. Provide information on available tobacco cessation programs at all community outreach events.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals who are predisposed to smoking/tobacco use or are already engaged in smoking and/or tobacco use behaviors.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals who are predisposed or are exhibiting smoking and or tobacco use behaviors. Inpatients predisposed or currently exhibiting smoking and or tobacco use behaviors will also receive information on available community resources.
**Health Need: Access to Care Factors**

**Objective 1:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring primary care, dental, and mental health providers.

**Strategies:**
1.1. Collaborate with local agencies to assist individuals identified as eligible for health care but need assistance obtaining health care coverage.

1.2. Disseminate information regarding available community resources, providers, and facilities available to assist individuals in connecting with primary care, dental, and mental health providers in their community.

**Objective 2:** Increase access to primary care providers.

**Strategies:**
2.1. In conjunction with Summa Physicians Inc. (SPI), increase the number of primary care providers through targeted recruitment for areas with limited primary care provider availability.

2.2. Enhance utilization of existing primary care medical homes including The Center for Health Equity.

**Objective 3:** Increase access to dental care providers.

**Strategies:**
3.1. Collaborate with local county health department dental task force, mobile dental facility, and Summa Health System Dental Clinic, to identify and begin to link available dental services with population in need.

3.2. Enhance utilization of existing dental services.
Objective 4: Increase access to mental health providers.

Strategies:

4.1. Increase the number of psychiatry and psychology health care providers in both the Psychiatry Department and in two large primary care offices at Akron City Hospital.

4.2. Apply for grant opportunities for telemedicine equipment and add 20 hours of telepsychiatry services to provide psychiatry services to areas with limited access to mental health providers.

4.3. In collaboration with Coleman Behavioral Health, position a Coleman behavioral health provider in the St. Thomas Hospital emergency department to assist in assessment and triage of patients to available behavioral health resources.
Implementation Strategy

Quality of Care Factors – Hospital Readmissions

Objective 1: Decrease hospital readmissions.

Strategies:
1.1. Utilizing community outreach events, increase consumer knowledge of initiatives designed to assist patients to effectively and efficiently transition from inpatient to outpatient/home care.

1.2. During hospital admission and upon discharge, provide education for patients regarding the programs, initiatives, opportunities for assistance with health and health related activities designed to assist patients and families with discharge, transition to home and any home health needs once at home.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring care, increasing the continuity of that care, and working to decrease the opportunities for complications post hospital discharge leading to increased hospital readmissions.

Strategies:
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist individuals in connecting with primary care, dental, and mental health providers in their community.
Quality of Care Factors – Diabetic Screening

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations, which lead to increased incidence of diabetes.

Strategies:
1.1. Collaborate with American Diabetes Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of diabetes.

1.2. Collaborate with American Diabetes Association at community outreach events to provide information on the signs and symptoms of diabetes and diabetes related complications.

1.3. Disseminate information regarding available community resources, providers and facilities for diabetes screening, prevention, care, and treatment of clients with a pre-disposition for diabetes or who have been diagnosed with diabetes at community outreach events.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of diabetes and decreasing the incidence of undiagnosed and/or late stage diagnosed diabetes with subsequent diabetes related complications.

Strategies:
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with diabetes at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with diabetes through continuity of care provided by community based primary care providers.
Implementation Strategy

Quality of Care Factors – Elder Care

Objective 1: Inform the community and create community awareness of the health care needs and issues of seniors, how these needs and issues are different than the general adult population and what services are available to meet these needs.

Strategies: 1.1. Provide education through community outreach events to increase awareness of health care issues specific to elder populations.

1.2. Increase awareness of services, providers, and resources available within the community for elder care support through community outreach events.

1.3. Utilization of a trial elder care track within the emergency department to effectively identify elder patients who are exhibiting geriatric syndrome symptoms.

Objective 2: Increase the number of elder individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring care, increasing the continuity of that care, and decreasing the risk of complications from undiagnosed geriatric syndrome symptoms.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist elder individuals in connecting with health care providers.
Implementation Strategy

Maternal and Infant Health – Premature Births and Low Birth Weight Newborns

Objective 1: Decrease the incidence of premature births and low birth weight newborns.

Strategies:

1.1. Increase community knowledge base of risk factors for prematurity and low birth weight infants.

1.2. Provide education through community outreach events, website information, and childbirth education classes.

1.3. Increase awareness of services, providers, and resources available within the community and hospital system for mother/baby prenatal support.

1.4. In collaboration with March of Dimes, provide support services, resources, and programming to assist mothers in understanding the importance of healthy choices and care for themselves during their pregnancies.

Objective 2: Increase the number of women who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for women prior to, during and post pregnancy.

Strategies:

2.1. Collaborate with local agencies to assist women identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist women in connecting with primary care, dental, and mental health providers in their community.
Implementation Strategy

Maternal and Infant Health – Infant/Neonatal/Post-neonatal Mortality

Objective 1: Decrease the incidence of infant/neonatal/post-neonatal mortality.

Strategies:
1.1. Increase community and individual awareness of risks for infant mortality and resources and education available to prevent infant mortality.

1.2. Disseminate information regarding the risks and risky behaviors associated with infant mortality.

1.3. In collaboration with county public health agencies, provide education, resources, and programming through the Safe Sleep program to promote safe sleep methods for newborns.

Objective 2: Increase the number of women and children who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for women and children.

Strategies:
2.1. Collaborate with local agencies to assist women and children identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist women and children in connecting with primary care medical homes.
Implementation Strategy

Birth Risk Factors – Maternal Smoking

Objective 1: Decrease smoking and other forms of tobacco use in women during pre-pregnancy, pregnancy and post partum.

Strategies: 1.1. In collaboration with American Lung Association, and March of Dimes, provide education of risk factors for smoking/tobacco use for women and children at community outreach events.

1.2. In collaboration with local public health departments, promote legislation to increase smoke free environments within communities.

1.3. Provide information on available tobacco cessation programs at all community outreach events.

Objective 2: Increase the number of women who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals who are predisposed to smoking/tobacco use or are already engaged in smoking and/or tobacco use behaviors.

Strategies: 2.1. Collaborate with local agencies to assist women identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of women who are predisposed or are exhibiting smoking and or tobacco use behaviors.
Implementation Strategy

Birth Risk Factors – First Trimester Prenatal Care

Objective 1: Provide support, resources, education, and programming to assist new mothers in developing effective and appropriate parenting skills.

Strategies: 1.1. Disseminate information regarding resources available within the community to assist new mothers with parenting skills at community events and through websites.

1.2. Disseminate standardized preferred infant feeding practices education (as endorsed by World Health Organization) to women, beginning in first trimester and reinforced and enhanced in the second and third trimesters.

Objective 2: Increase the number of women and children who have access to primary care medical homes thereby increasing the opportunities for prevention of and early interventions for birth risk factors in newborns.

Strategies: 2.1. Collaborate with local agencies to assist women and children identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention and early intervention for birth risk factors in newborns.
Summa Barberton Hospital
As a result of the analysis of the data from the community health needs assessment, the adult health needs of asthma, cancer, cardiovascular disease, diabetes, mental health, substance abuse, lifestyle factors, access to care factors, and quality of care factors will be addressed by Summa Barberton Hospital in this implementation plan. Due to the community resources available, including the Akron Canton Regional Food Bank, to assist individuals in obtaining healthy food, Summa Barberton Hospital chose not to address this environmental factor health need in this implementation plan. The child health needs of maternal and infant health and birth risk factors will also be addressed by Summa Barberton Hospital. In addition, the community resources available to assist children health needs, specifically Akron Children’s Hospital, led to the determination by Summa Barberton Hospital to not address the identified child health needs of childhood chronic disease, child development, child lifestyle risk factors, child mental health and substance abuse, child safety, child access to care factors and child environmental risk factors.

Chronic Disease – Asthma

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations which lead to asthma and/or asthma related disease development. Increase knowledge of the signs and symptoms of asthma and asthma related diseases.

Strategies: 1.1. Collaborate with American Lung Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which often lead to the development of asthma and asthma related diseases.

1.2. Collaborate with American Lung Association at community outreach events to provide information on the signs and symptoms asthma and asthma related conditions.
**Implementation Strategy**

**Objective 2:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of asthma and decreasing the incidence of undiagnosed and/or late stage diagnosed asthma with subsequent asthma related complications.

**Strategies:**

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of clients with asthma at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of patients with asthma through continuity of care provided by community based primary care providers.
Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations which lead to increased incidence of cancer.

Strategies: 1.1. Collaborate with American Cancer Society at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which often lead to the development of cancer.

1.2. Collaborate with American Cancer Society at community outreach events to provide information on the signs and symptoms of cancer.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of cancer and decreasing the incidence of undiagnosed and/or late stage diagnosed cancer with subsequent cancer related complications.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with cancer at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with cancer through continuity of care provided by community based primary care providers.
Chronic Disease – Cardiovascular Disease

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations which lead to cardiovascular disease development. Increase knowledge of the signs and symptoms of cardiovascular diseases.

Strategies: 1.1. Collaborate with American Heart Association in utilizing the American Heart Association Family Tree exercise at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of cardiovascular disease.

1.2. Collaborate with American Heart Association at community outreach events to provide instruction and education on cardiopulmonary resuscitation through the CPR Anytime classes.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of cardiovascular disease and decreasing the incidence of undiagnosed and/or late stage diagnosed cardiovascular disease with subsequent cardiovascular disease related complications.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of clients with cardiovascular disease at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of patients with cardiovascular disease through continuity of care provided by community based primary care providers.
Chronic Disease – Diabetes

**Objective 1:** Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations which lead to increased incidence of diabetes.

**Strategies:**

1.1. Collaborate with American Diabetes Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of diabetes.

1.2. Collaborate with American Diabetes Association at community outreach events to provide information on the signs and symptoms of diabetes and diabetes related complications.

**Objective 2:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of diabetes and decreasing the incidence of undiagnosed and/or late stage diagnosed diabetes with subsequent diabetes related complications.

**Strategies:**

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with diabetes at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with diabetes through continuity of care provided by community based primary care providers.
Implementation Strategy

Mental Health

Objective 1: Improve identification, diagnosis, and treatment of depression.

Strategies:

1.1. Provide additional behavioral health care providers in outpatient psychiatry to increase access for patients in behavioral health unit

1.2. Increase of integrated behavioral health providers to Internal Medicine and Family Medicine Primary Care Centers at Akron City Hospital to promote early detection, diagnosis and treatment of depression in primary care settings.

1.3. Provide referral pathways for patients identified in the Summa Barberton region with depression diagnoses for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.

Objective 2: Improve identification and treatment of patients with suicidal tendencies.

Strategies:

2.1. Provide additional behavioral health care providers in outpatient psychiatry to increase access to individuals presenting with suicidal tendencies.

2.2. Provide additional integrated behavioral health care providers to Internal Medicine and Family Medicine Primary Care Centers at Akron City Hospital.

2.3. Provide Psychiatry grand rounds focused on assessment and treatment of suicidal patients.

2.4. In collaboration with Coleman Behavioral Health, provide one Coleman provider to the St. Thomas Emergency Department to assist in assessment, triage, and to connect patients who present to the emergency department with behavioral health diagnoses to resources.

2.5. Provide referral pathways for patients identified in the Summa Barberton region with suicidal tendencies for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.
Implementation Strategy

**Objective 3:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of behavioral health concerns and decreasing the incidence of undiagnosed and/or late stage behavioral health diagnoses with subsequent behavioral health related complications.

**Strategies:**

3.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

3.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with behavioral health diagnoses at community outreach events.
Implementation Strategy

Substance Abuse

Objective 1: Decrease adult alcohol abuse.

Strategies:

1.1. Utilization of ongoing Intensive Outpatient Programs for Alcohol and Drug abuse and dependence at St. Thomas Hospital. Intensive programs offered five days per week and three tracks per day.

1.2. Utilization of Inpatient Alcohol Detox Unit at St Thomas Hospital to provide greater access to individuals requiring intensive inpatient treatment.

1.3. Provide greater access of services by increasing Addiction Medicine Consultation Liaison hours at Akron City Hospital for inpatients who present with alcohol abuse or dependence in non-behavioral health units.

1.4. Develop an Addiction Medicine Fellowship to increase availability and access of trained addiction medicine health care providers.

1.5. Provide referral pathways for patients identified in the Summa Barberton region with alcohol addiction for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.

Objective 2: Decrease adult prescription drug abuse.

Strategies:

2.1. Utilization of ongoing Intensive Outpatient Programs for Alcohol and Drug abuse and dependence at St Thomas Hospital. Intensive programs offered five days per week and three tracks per day.

2.2. Increase access to services by increasing the number of beds in the Inpatient Alcohol and Drug Detox Unit at St. Thomas.

2.3. Provide greater access of services by increasing Addiction Medicine Consultation Liaison hours at Akron City Hospital for inpatients who present with alcohol abuse or dependence.

2.4. Develop an Addiction Medicine Fellowship to increase availability and access of trained addiction medicine health care providers.

2.5. Provide referral pathways for patients identified in the Summa Barberton Hospital region with adult prescription drug addiction for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.
Objective 3: Decrease adult opioid drug abuse.

Strategies:

3.1. Utilization of three and a half addiction medicine specialists offering Suboxone replacement therapy to assist patients in weaning off of opioids.

3.2. Participate in Summit County ADM Board grant trial of low dose Suboxone replacement therapy with ongoing intensive outpatient programs also available to assist patients as they pursue abstinence from opioid use.

3.3. Provide Psychiatry grand rounds focused on assessment and treatment of patients with opioid dependence and abuse.

3.4. Provide referral pathways for patients identified in the Summa Barberton Hospital region with adult opioid drug addiction for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.
Implementation Strategy

Lifestyle Risk Factors – Overweight/Obesity

Objective 1: Provide education and resources within the community to assist individuals in obtaining and maintaining healthy weight.

Strategies:
1.1. As noted in implementation plans for chronic diseases and in collaboration with a variety of community partners, educational resources will be made available to address healthy eating, healthy food selection, body mass index, risks for developing obesity and value of physical exercise at community outreach events.

1.2. Disseminate information regarding available community resources, providers, and facilities for prevention of overweight/obesity conditions and/or weight reduction and weight maintenance approaches.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of obesity and decreasing the incidence of obesity related complications.

Strategies:
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with obesity at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with obesity through continuity of care provided by community based primary care providers.
Implementation Strategy

Lifestyle Risk Factors – Smoking

Objective 1: Decrease smoking and tobacco use in adults.

Strategies:

1.1. In collaboration with American Lung Association, American Cancer Society, and American Heart Association, provide education of risk factors for smoking/tobacco use at community health outreach events.

1.2. In collaboration with local public health departments, promote legislation to increase smoke free environments within communities.

1.3. Provide information on available tobacco cessation programs at all community outreach events.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals who are predisposed to smoking/tobacco use or are already engaged in smoking and/or tobacco use behaviors.

Strategies:

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals who are predisposed or are exhibiting smoking and or tobacco use behaviors. Inpatients predisposed or currently exhibiting smoking and/or tobacco use behaviors will also receive information on available community resources.
Implementation Strategy

Access to Care Factors

Objective 1: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring primary care, dental, and mental health providers.

Strategies: 1.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

1.2. Disseminate information regarding available community resources, providers, and facilities available to assist individuals in connecting with primary care, dental, and mental health providers in their community.

Objective 2: Increase access to primary care providers.

Strategies: 2.1. In conjunction with Summa Physicians Inc. (SPI), increase the number of primary care providers through targeted recruitment for areas with limited primary care provider availability.

2.2. Enhance utilization of existing primary care medical homes including The Center for Health Equity.

Objective 3: Increase access to dental care providers.

Strategies: 3.1. Collaborate with local county health department dental task force, mobile dental facility, and Summa Health System Dental Clinic, to identify and begin to link available dental services with population in need.

3.2. Enhance utilization of existing dental services.
Implementation Strategy

Objective 4: Increase access to mental health providers.

Strategies:

4.1. Increase the number of psychiatry and psychology health care providers in both the Psychiatry Department and in two large primary care offices at Akron City Hospital.

4.2. Apply for grant opportunities for telemedicine equipment and add 20 hours of telepsychiatry services to provide psychiatry services to areas with limited access to mental health providers.

4.3. In collaboration with Coleman Behavioral Health, position a Coleman behavioral health provider in the St. Thomas emergency department to assist in assessment and triage of patients to available behavioral health resources.
Quality of Care Factors – Hospital Readmissions

**Objective 1:** Decrease hospital readmissions.

**Strategies:**

1.1. Utilizing community outreach events, increase consumer knowledge of initiatives designed to assist patients to effectively and efficiently transition from inpatient to outpatient/home care.

1.2. During hospital admission and upon discharge, provide education for patients regarding the programs, initiatives, opportunities for assistance with health and health related activities designed to assist patients and families with discharge, transition to home and any home health needs once at home.

**Objective 2:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring care, increasing the continuity of that care, and working to decrease the opportunities for complications post hospital discharge leading to increased hospital readmissions.

**Strategies:**

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist individuals in connecting with primary care, dental, and mental health providers in their community.
Implementation Strategy

Quality of Care Factors – Diabetic Screening

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations which lead to increased incidence of diabetes.

Strategies: 1.1. Collaborate with American Diabetes Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of diabetes.

1.2. Collaborate with American Diabetes Association at community outreach events to provide information on the signs and symptoms of diabetes and diabetes related complications.

1.3. Disseminate information regarding available community resources, providers and facilities for diabetes screening, prevention, care, and treatment of clients with a pre-disposition for diabetes or who have been diagnosed with diabetes at community outreach events.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of diabetes and decreasing the incidence of undiagnosed and/or late stage diagnosed diabetes with subsequent diabetes related complications.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with diabetes at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with diabetes through continuity of care provided by community based primary care providers.
Quality of Care Factors – Elder Care

**Objective 1:** Inform the community and create community awareness of the health care needs and issues of seniors, how these needs and issues are different than the general adult population and what services are available to meet these needs.

**Strategies:**

1.1. Provide education through community outreach events to increase awareness of health care issues specific to elder populations.

1.2. Increase awareness of services, providers, and resources available within the community for elder care support through community outreach events.

**Objective 2:** Increase the number of elder individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring care, increasing the continuity of that care, and decreasing the risk of complications from undiagnosed geriatric syndrome symptoms.

**Strategies:**

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist elder individuals in connecting with health care providers.
Maternal and Infant Health – Premature Births and Low Birth Weight Newborns

Objective 1: Decrease the incidence of premature births and low birth weight newborns.

Strategies:

1.1. Increase community knowledge base of risk factors for prematurity and low birth weight infants.

1.2. Provide education through community outreach events, website information, and childbirth education classes.

1.3. Increase awareness of services, providers, and resources available within the community and hospital system for mother/baby prenatal support.

1.4. In collaboration with March of Dimes, provide support services, resources, and programming to assist mothers in understanding the importance of healthy choices and care for themselves during their pregnancies.

Objective 2: Increase the number of women who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for women prior to, during and post pregnancy.

Strategies:

2.1. Collaborate with local agencies to assist women identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist women in connecting with primary care, dental, and mental health providers in their community.
Maternal and Infant Health – Infant/Neonatal/Post-neonatal Mortality

Objective 1: Decrease the incidence of infant/neonatal/post-neonatal mortality.

Strategies:
1.1. Increase community and individual awareness of risks for infant mortality and resources and education available to prevent infant mortality.

1.2. Disseminate information regarding the risks and risky behaviors associated with infant mortality.

1.3. In collaboration with county public health agencies, provide education, resources, and programming through the Safe Sleep program to promote safe sleep methods for newborns.

Objective 2: Increase the number of women and children who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for women and children.

Strategies:
2.1. Collaborate with local agencies to assist women and children identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist women and children in connecting with primary care medical homes.
Implementation Strategy

Birth Risk Factors – Maternal Smoking

**Objective 1:** Decrease smoking and other forms of tobacco use in women during pre-pregnancy, pregnancy and post partum.

**Strategies:**
1.1. In collaboration with American Lung Association, and March of Dimes, provide education of risk factors for smoking/tobacco use for women and children at community outreach events.

1.2. In collaboration with local public health departments, promote legislation to increase smoke free environments within communities.

1.3. Provide information on available tobacco cessation programs at all community outreach events.

**Objective 2:** Increase the number of women who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals who are predisposed to smoking/tobacco use or are already engaged in smoking and/or tobacco use behaviors.

**Strategies:**
2.1. Collaborate with local agencies to assist women identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of women who are predisposed or are exhibiting smoking and or tobacco use behaviors.
Implementation Strategy

Birth Risk Factors – First Trimester Prenatal Care

Objective 1: Provide support, resources, education, and programming to assist new mothers in developing effective and appropriate parenting skills.

Strategies:

1.1. Disseminate information regarding resources available within the community to assist new mothers with parenting skills at community events and through websites.

1.2. Disseminate standardized preferred infant feeding practices education (as endorsed by World Health Organization) to women, beginning in first trimester and reinforced and enhanced in the second and third trimesters.

Objective 2: Increase the number of women and children who have access to primary care medical homes thereby increasing the opportunities for prevention of and early interventions for birth risk factors in newborns.

Strategies:

2.1. Collaborate with local agencies to assist women and children identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention and early intervention for birth risk factors in newborns.
Summa Wadsworth-Rittman Hospital
As a result of the analysis of the data from the community health needs assessment, the adult health needs of asthma, cancer, cardiovascular disease, diabetes, mental health, substance abuse, lifestyle factors, access to care factors, and quality of care factors will be addressed by Summa Wadsworth-Rittman Hospital in this implementation plan. Due to the community resources available including the Akron Canton Regional Food Bank, to assist individuals in obtaining healthy food, Summa Wadsworth-Rittman Hospital chose not to address this environmental factor health need in this implementation plan. In addition, the community resources available to assist children health needs, specifically Akron Children’s Hospital and Summa Akron City and St. Thomas Hospitals, led to the determination by Summa Wadsworth-Rittman Hospital to not address child health needs.

Chronic Disease – Asthma

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations which lead to asthma and/or asthma related disease development. Increase knowledge of the signs and symptoms of asthma and asthma related diseases.

Strategies: 1.1. Collaborate with American Lung Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which often lead to the development of asthma and asthma related diseases.

1.2. Collaborate with American Lung Association at community outreach events to provide information on the signs and symptoms asthma and asthma related conditions.
Implementation Strategy

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of asthma and decreasing the incidence of undiagnosed and/or late stage diagnosed asthma with subsequent asthma related complications.

Strategies:

2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of clients with asthma at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of patients with asthma through continuity of care provided by community based primary care providers.
Implementation Strategy

Chronic Disease – Cancer

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations, which lead to increased incidence of cancer.

Strategies:
1.1. Collaborate with American Cancer Society at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which often lead to the development of cancer.

1.2. Collaborate with American Cancer Society at community outreach events to provide information on the signs and symptoms of cancer.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of cancer and decreasing the incidence of undiagnosed and/or late stage diagnosed cancer with subsequent cancer related complications.

Strategies:
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with cancer at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with cancer through continuity of care provided by community based primary care providers
Chronic Disease – Cardiovascular Disease

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations which lead to cardiovascular disease development. Increase knowledge of the signs and symptoms of cardiovascular diseases.

Strategies: 1.1. Collaborate with American Heart Association in utilizing the American Heart Association Family Tree exercise at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of cardiovascular disease.

1.2. Collaborate with American Heart Association at community outreach events to provide instruction and education on cardiopulmonary resuscitation through the CPR Anytime classes.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of cardiovascular disease and decreasing the incidence of undiagnosed and/or late stage diagnosed cardiovascular disease with subsequent cardiovascular disease related complications.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of clients with cardiovascular disease at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of patients with cardiovascular disease through continuity of care provided by community based primary care providers.
Chronic Disease – Diabetes

Objective 1: Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations, which lead to increased incidence of diabetes.

Strategies:
1.1. Collaborate with American Diabetes Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of diabetes.

1.2. Collaborate with American Diabetes Association at community outreach events to provide information on the signs and symptoms of diabetes and diabetes related complications.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of diabetes and decreasing the incidence of undiagnosed and/or late stage diagnosed diabetes with subsequent diabetes related complications.

Strategies:
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with diabetes at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with diabetes through continuity of care provided by community based primary care providers.
Mental Health

Objective 1: Improve identification, diagnosis, and treatment of depression.

Strategies:
1.1. Provide additional behavioral health care providers in outpatient psychiatry to increase access for patients in behavioral health unit

2.2. Increase providers of integrated behavioral health providers to Internal Medicine and Family Medicine Primary Care Centers at Akron City Hospital to promote early detection, diagnosis and treatment of depression in primary care settings.

2.3. Provide referral pathways for patients identified in the Summa Wadsworth Rittman Hospital region with depression diagnoses for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.

Objective 2: Improve identification and treatment of patients with suicidal tendencies.

Strategies:
2.1. Provide additional behavioral health care providers in outpatient psychiatry to increase access to individuals presenting with suicidal tendencies.

2.2. Provide additional integrated behavioral health care providers to Internal Medicine and Family Medicine Primary Care Centers at Akron City Hospital.

2.3. Provide Psychiatry grand rounds focused on assessment and treatment of suicidal patients.

2.4. In collaboration with Coleman Behavioral Health, provide one Coleman provider to the St. Thomas Hospital Emergency Department to assist in assessment, triage, and to connect patients who present to the emergency department with behavioral health diagnoses to resources.

2.5. Provide referral pathways for patients identified in the Summa Wadsworth Rittman Hospital region with suicidal tendencies for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.
Implementation Strategy

**Objective 3:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of behavioral health concerns and decreasing the incidence of undiagnosed and/or late stage behavioral health diagnoses with subsequent behavioral health related complications.

**Strategies:**

3.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

3.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with behavioral health diagnoses at community outreach events.
Implementation Strategy

Substance Abuse

**Objective 1:** Decrease adult alcohol abuse.

**Strategies:**

1.1. Utilization of ongoing Intensive Outpatient Programs for Alcohol and Drug abuse and dependence at St Thomas Hospital. Intensive programs offered five days per week and three tracks per day.

1.2. Utilization of Inpatient Alcohol Detox Unit at St Thomas Hospital to provide greater access to individuals requiring intensive inpatient treatment.

1.3. Provide greater access of services by increasing Addiction Medicine Consultation Liaison hours at Akron City Hospital for inpatients who present with alcohol abuse or dependence in non-behavioral health units.

1.4. Develop an Addiction Medicine Fellowship to increase availability and access of trained addiction medicine health care providers.

1.5. Provide referral pathways for patients identified in the Summa Barberton region with alcohol addiction for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.

**Objective 2:** Decrease adult prescription drug abuse.

**Strategies:**

2.1. Utilization of ongoing Intensive Outpatient Programs for Alcohol and Drug abuse and dependence at St Thomas Hospital. Intensive programs offered five days per week and three tracks per day.

2.2. Increase access to services by increasing the number of beds in the Inpatient Alcohol and Drug Detox Unit at St. Thomas.

2.3. Provide greater access of services by increasing Addiction Medicine Consultation Liaison hours at Akron City Hospital for inpatients who present with alcohol abuse or dependence.

2.4. Develop an Addiction Medicine Fellowship to increase availability and access of trained addiction medicine health care providers.

2.5. Provide referral pathways for patients identified in the Summa Barberton region with adult prescription drug addiction for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.
Objective 3: Decrease adult opioid drug abuse.

Strategies: 3.1. Utilization of three and a half addiction medicine specialists offering Suboxone replacement therapy to assist patients in weaning off of opioids.

3.2. Participate in Summit County ADM board grant trial of low dose Suboxone replacement therapy with ongoing intensive outpatient programs also available to assist patients as they pursue abstinence from opioid use.

3.3. Provide Psychiatry grand rounds focused on assessment and treatment of patients with opioid dependence and abuse.

3.4. Provide referral pathways for patients identified in the Summa Barberton region with adult opioid drug addiction for care on the Summa Akron City and St. Thomas Hospitals campuses as needed.
Lifestyle Risk Factors – Overweight/Obesity

Objective 1: Provide education and resources within the community to assist individuals in obtaining and maintaining healthy weight.

Strategies:
1.1. As noted in implementation plans for chronic diseases and in collaboration with a variety of community partners, educational resources will be made available to address healthy eating, healthy food selection, body mass index, risks for developing obesity, and value of physical exercise at community outreach events.

1.2. Disseminate information regarding available community resources, providers, and facilities for prevention of overweight/obesity conditions and/or weight reduction and weight maintenance approaches.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of obesity and decreasing the incidence of obesity related complications.

Strategies:
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with obesity at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with obesity through continuity of care provided by community based primary care providers.
Lifestyle Risk Factors – Smoking

Objective 1: Decrease smoking and tobacco use in adults.

Strategies:
1.1. In collaboration with American Lung Association, American Cancer Society, and American Heart Association, provide education of risk factors for smoking/tobacco use at community health outreach events.

1.2. In collaboration with local public health departments, promote legislation to increase smoke free environments within communities.

1.3. Provide information on available tobacco cessation programs at all community outreach events.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals who are predisposed to smoking/tobacco use or are already engaged in smoking and/or tobacco use behaviors.

Strategies:
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals who are predisposed or are exhibiting smoking and/or tobacco use behaviors. Inpatients predisposed or currently exhibiting smoking and/or tobacco use behaviors will also receive information on available community resources.
Access to Care Factors

**Objective 1:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring primary care, dental, and mental health providers.

**Strategies:**
1.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

1.2. Disseminate information regarding available community resources, providers, and facilities available to assist individuals in connecting with primary care, dental, and mental health providers in their community.

**Objective 2:** Increase access to primary care providers.

**Strategies:**
2.1. In conjunction with Summa Physicians Inc. (SPI), increase the number of primary care providers through targeted recruitment for areas with limited primary care provider availability.

2.2. Enhance utilization of existing primary care medical homes including The Center for Health Equity.

**Objective 3:** Increase access to dental care providers.

**Strategies:**
3.1. Collaborate with local county health department dental task force, mobile dental facility, and Summa Health System Dental Clinic, to identify and begin to link available dental services with population in need.

3.2. Enhance utilization of existing dental services.
Objective 4: Increase access to mental health providers.

Strategies:

4.1. Increase the number of psychiatry and psychology health care providers in both the Psychiatry Department and in two large primary care offices at Akron City Hospital.

4.2. Apply for grant opportunities for telemedicine equipment and add 20 hours of telepsychiatry services to provide psychiatry services to areas with limited access to mental health providers.

4.3. In collaboration with Coleman Behavioral Health, position a Coleman behavioral health provider in the St. Thomas emergency department to assist in assessment and triage of patients to available behavioral health resources.
Implementation Strategy

Quality of Care Factors – Hospital Readmissions

Objective 1: Decrease hospital readmissions.

Strategies: 1.1. Utilizing community outreach events, increase consumer knowledge of initiatives designed to assist patients effectively and efficiently transition from inpatient to outpatient/home care.

1.2. During hospital admission and upon discharge, provide education for patients regarding the programs, initiatives, opportunities for assistance with health and health related activities designed to assist patients and families with discharge, transition to home and any home health needs once at home.

Objective 2: Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring care, increasing the continuity of that care, and working to decrease the opportunities for complications post hospital discharge leading to increased hospital readmissions.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist individuals in connecting with primary care, dental, and mental health providers in their community.
Quality of Care Factors – Diabetic Screening

**Objective 1:** Increase consumer knowledge base of risk factors, risk behaviors, and genetic considerations, which lead to increased incidence of diabetes.

**Strategies:**
1.1. Collaborate with American Diabetes Association at community outreach events to provide education identifying risk factors, risk behaviors, and genetic conditions which predispose individuals to the development of diabetes.

1.2. Collaborate with American Diabetes Association at community outreach events to provide information on the signs and symptoms of diabetes and diabetes related complications.

1.3. Disseminate information regarding available community resources, providers and facilities for diabetes screening, prevention, care, and treatment of clients with a pre-disposition for diabetes or who have been diagnosed with diabetes at community outreach events.

**Objective 2:** Increase the number of individuals who have access to primary care medical homes thereby increasing the opportunities for preventative interventions and early diagnosis of diabetes and decreasing the incidence of undiagnosed and/or late stage diagnosed diabetes with subsequent diabetes related complications.

**Strategies:**
2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities for prevention, care and treatment of individuals with diabetes at community outreach events.

2.3. Increase availability of preventative care, early detection, and maintenance care of individuals with diabetes through continuity of care provided by community based primary care providers.
Implementation Strategy

Quality of Care Factors – Elder Care

Objective 1: Inform the community and create community awareness of the health care needs and issues of seniors, how these needs and issues are different than the general adult population and what services are available to meet these needs.

Strategies: 1.1. Provide education through community outreach events to increase awareness of health care issues specific to elder populations.

1.2. Increase awareness of services, providers, and resources available within the community for elder care support through community outreach events.

Objective 2: Increase the number of elder individuals who have access to primary care medical homes thereby increasing the opportunities for preventative and early interventions for individuals requiring care, increasing the continuity of that care, and decreasing the risk of complications from undiagnosed geriatric syndrome symptoms.

Strategies: 2.1. Collaborate with local agencies to assist individuals identified as eligible for health care coverage but who need assistance obtaining health care coverage.

2.2. Disseminate information regarding available community resources, providers, and facilities available to assist elder individuals in connecting with health care providers.
Implementation Strategy

Summa Rehab Hospital, LLC
Due to the nature of the adult rehabilitation specialty services provided by Summa Rehab Hospital, LLC, the adult identified health need of Quality of Care Factors – Hospital Readmissions will be the only health need addressed by Summa Rehab Hospital, LLC in this implementation plan. The community resources provided by a variety of institutions and agencies including Akron Children’s Hospital and Summa Akron City and St. Thomas Hospitals, Summa Barberton Hospital, and Summa Wadsworth- Rittman Hospital led to the determination by Summa Rehab Hospital, LLC to not address any other identified health need.

Quality of Care Factors – Hospital Readmissions

Objective 1: Decrease hospital readmission by providing transitional care to assist patients in moving from inpatient care to outpatient care effectively and efficiently.

Strategies:
1.1. Assist patients with assessing needs for services including therapies, in-home ADL services, additional social service support, additional outpatient rehabilitation support, additional nutrition supportive services.

1.2. As a part of community education events, provide education regarding services and options designed to assist patients and their families in transitional health needs including both Summa Rehab services and other community services and agencies available to provide therapies and supportive care.

Objective 2: Investigate efforts in providing effective and efficient transitional care services’ effects on readmission rates for the patient population utilizing transitional rehabilitation services.

Strategies:
2.1. Begin to analyze available data to determine if efforts to connect patients with available resources have impacted the readmission rates in this patient population.

2.2. Determine trends of best practices in transitional care that positively impact hospital readmission rates.
Crystal Clinic Orthopaedic Center, LLC

Due to the nature of the adult orthopaedic specialty services provided by Crystal Clinic Orthopaedic Center, LLC, the adult identified health need of Quality of Care Factors – Hospital Readmissions will be the only health need addressed by Crystal Clinic Orthopaedic Center, LLC, in this implementation plan. The community resources provided by a variety of institutions and agencies including Akron Children’s Hospital and Summa Akron City and St. Thomas Hospitals, Summa Barberton Hospital, and Summa Wadsworth-Rittman Hospital led to the determination by Crystal Clinic Orthopaedic Center, LLC to not address any other identified health need.

Health Need: Quality of Care – Hospital Readmissions

Objective 1: Provide education and support for patients at risk for poor bone health.

Strategies:

1.1. Engagement of patient in a 3 month post operative follow up to check patient progress.
1.2. Provide support for patients with nutritional or pharmaceutical needs.
1.3. Proactive evaluation of patients’ needs for physical therapy.
1.4. Provide information and with patient’s primary care provider on on-going bone health care.

Objective 2: Decrease hospital readmissions post bone related procedures.

Strategies:

2.1. Patient education and engagement will prevent complications and improve recovery period post bone related procedures.
2.2. Determining best practices for bone related procedures will allow for improved patient recovery.
Summa Western Reserve Hospital, LLC
As a result of the analysis of the data from the community health needs assessment, a number of needs were identified. While all of these needs were deemed important, due to the variety of institutions and community resources available to address many of the adult health needs and all of the child health needs, including Akron Children’s Hospital, Akron Canton Food Bank, and Summa Akron City and St. Thomas Hospitals, it was determined by Summa Western Reserve Hospital, LLC, to only address the Quality of Care Factor of Hospital Readmissions and the Lifestyle Risk Factor of Smoking in this implementation plan.

Quality of Care Factors – Hospital Readmissions

Objective 1: Decrease hospital readmissions by improving post operative outcomes for patients undergoing joint repairs.

Strategies: 1.1. Develop and implement a Joint Camp Program.

1.2. Monitor length of stay for patients who attended camp versus those who did not attend camp.

Objective 2: Increase consumer knowledge of aspects of preoperative care that improve post operative outcomes and decrease incidence of hospital readmissions.

Strategies: 2.1. Provide education for patients and families preoperatively – at least one class one month prior to surgery date.

2.2. Monitor outcomes of patients who attend preoperative classes versus patients who did not attend any preoperative education.
Implementation Strategy

Lifestyle Risk Factors – Smoking

Objective 1: Increase community awareness regarding the impact of smoking/tobacco use on their health and wellness.

Strategies: 1.1. Develop and implement a smoking/tobacco use cessation program.

1.2. Provide education in the form of educational programming for community groups and schools.