Strategy: Increase the availability of physician nutrition prescriptions among Lake Health patients with diabetes, heart disease, and/or high blood pressure.					
Aligned to Ohio SHIP ___Yes _X_No			**Aligned to HP 2020 _X_Yes ___No**		
Type of Strategy* ___SDH ___PHS, Pr, & HB _X_HCS & A			**Identified as Likely to Decrease Disparities ___Yes _X_No**		
Lead Agency	**Priority Population**	**Measure of Success**	**Year I Activities**	**Status**	
Lake Health	Lake Health patients with one or more chronic disease, including heart disease, diabetes, and/ or high blood pressure.	Number of patients receiving nutrition prescriptions. Number of patients compliant with nutrition prescriptions. HgA1c reduction to <9	<u>Diabetes patients</u>: Inpatient and PH coordinators implement screening process for assessing nutrition status.	• Baseline population identified, 2/2020 • Focus population selected, 3/2020: Targeting the pre-diabetic patients with elevated A1c during inpatient hospitalization or 90 days prior to inpatient admission. Screening process established and implemented as of 2/2020. • RN Certified Diabetes Instructor placed in acute care setting as of 5/2020	
			Refer patients for nutrition prescriptions that meet criteria.	• January – December, 2020: 2,376 Inpatients screened with 668 appropriate referrals for nutrition prescription for a 28% referral rate.	
			Ambulatory and wellness CDE teams follow referred patients to assess compliance.	• January – December 2020: 42% (279/668) of Lake County community residents Lake contacted joined the nutrition program. This surpasses national enrollment rates of 30%. • January – December 2020: 100% (279/279) of the active community-member participants have care plans in place. This surpasses the national rate of 45%. • January – December 2020: 75% (209/279) compliant with their care plan. This surpasses the national rate of 50%.	
Indicator(s) to Measure Impact of Strategy 1. Fruit and vegetable consumption (BRFSS) 2. Hypertension (BRFSS) .					
Policy Change Necessary for Strategy Success _Yes X No					
Partnering Organizations Motivate Lake County, HChoices					

Lake Health

Strategy: Screen Lake Health patients for food insecurity and provide referrals as appropriate.					
Aligned to Ohio SHIP _X_ **Yes** ___ **No**			**Aligned to HP 2020** _X_ **Yes** ___ **No**		
Type of Strategy* _X_ **SDH** ___ **PHS, Pr, & HB** __ **HCS & A**			**Identified as Likely to Decrease Disparities** _X_ **Yes** __ **No**		
Lead Agency	**Priority Population**	**Measure of Success**	**Year I Activities**	**Status**	
Lake Health	Lake Health patients with one or more chronic disease, including heart disease, diabetes, and/ or high blood pressure.	Number of patients screened for food insecurity. Number of patients screened as high-risk for food insecurity Number of patients referred for post-discharge 2-week meal program.	<u>Diabetes patients:</u> Inpatient and PH coordinators implement screening process to assessing food availability.	• Baseline population identified, 2/2020 • Focus population selected, 3/2020: Targeting the pre-diabetic patients with elevated A1c during inpatient hospitalization or 90 days prior to inpatient admission. Screening process established and implemented as of 2/2020. • RN Certified Diabetes Instructor placed in acute care setting as of 5/2020	
			Refer patients for post-discharge two-week meal program.	On Hold due to COVID in 2020 – moved to 2021 plan	
			Assure qualifying patients receive meals.	On Hold due to COVID in 2020 – moved to 2021 plan	
			Connect patient to community services.	• May – December, 2020: Diabetes Education team identified 761 patients for referral to community services with 517 connections made (68%)	
Indicator(s) to Measure Impact of Strategy 1. Ability to afford food (USDA) 2. Access to grocery store (NHANES) 3. Fruit and vegetable consumption (BRFSS)					
Policy Change Necessary for Strategy Success **Yes** **X No**					
Partnering Organizations Lake County food pantries					

**SDH Social Determinants of Health; PHS, Pr, & HB Public Health System. Prevention, and Health Behaviors; HCS & A Healthcare System and Access.*

Lake Health

Strategy: Lake Health clinician-provided physical activity prescriptions.

Aligned to Ohio SHIP _X_ Yes ___No **Aligned to HP 2020 _X_ Yes ___No**

Type of Strategy* ___SDH ___PHS, Pr, & HB _X_ HCS & A **Identified as Likely to Decrease Disparities ___Yes _X_ No**

Lead Agency	Priority Population	Measure of Success	Year I Activities	Status	
Lake Health	Lake Health patients with one or more chronic disease, including heart disease, diabetes, and/ or high blood pressure.	Number of patients receiving physical activity prescriptions. Number of patients compliant with physical activity prescriptions.	Diabetes patients: Inpatient and PH coordinators implement screening process for assessing physical activity status.	• Baseline population identified, 2/2020 • First CMS Diabetes Prevention Program Cohort kicked off, 2/2020 • Focus population selected, 3/2020: Targeting the pre-diabetic patients with elevated A1c during inpatient hospitalization or 90 days prior to inpatient admission. Screening process established and implemented as of 2/2020. • RN Certified Diabetes Instructor placed in acute care setting as of 5/2020	
			Refer patients meeting criteria to cardiac, pulmonary rehabilitation, and/ or wellness campus for assessment.	• January – December 2020: 209 patients referred to outpatient weight management programs.	
			Provide patient with physical activity prescription.	• January – December 2020: 209 patients referred to outpatient weight management programs.	
			Assess patient compliance.	• January – December 2020: 21% (43/209) participants enrolled in the program lost an average of 5.09 pounds per participant which is a 5% improvement from baseline.	

Indicator(s) to Measure Impact of Strategy 1. Physical inactivity (BRFSS) 2. Physical activity during the past 7 days for a total of at least 60 minutes per day (NHANES) LH metrics: Number of patients with physical activity prescriptions; Number of patients compliant with prescriptions; Outcome measures: TBD

Policy Change Necessary for Strategy Success X Yes No

Partnering Organizations Motivate Lake County

**SDH Social Determinants of Health; PHS, Pr, & HB Public Health System. Prevention, and Health Behaviors; HCS & A Healthcare System and Access.*

Lake Health

Strategy: Improve access to comprehensive primary care among Lake Health patients with heart disease, diabetes, high blood pressure, and/or a mental or behavioral health diagnosis.

Aligned to Ohio SHIP _X_ Yes ___No **Aligned to HP 2020 _X_ Yes ___No**

Type of Strategy* ___SDH ___PHS, Pr, & HB _X_HCS & A **Identified as Likely to Decrease Disparities _X_ Yes ___No**

Lead Agency	Priority Population	Measure of Success	Year I Activities	Status
Lake Health	Lake Health patients with one or more chronic disease, including heart disease, diabetes, high blood pressure, and/or a mental behavioral health diagnosis.	Number of uninsured patients presenting to acute care settings. Number of insured patients presenting to acute care settings. List of community-based care coordination services available.	Identify uninsured patients presenting to acute care settings.	272 Behavioral Health Uninsured Patients identified in 2020
			Refer patients to insurance counselors and social workers.	All uninsured patients are contacted by a third party contracted by Lake Health, and assisted with finding and enrolling into a Medicaid product / program, as appropriate
			Assist patients with insurance enrollment and assure completion	Follow-up is completed on those pending approval
			Develop and implement two community-based care coordination strategies.	1. House Calls: In-home Advanced Practice Provider assessment, interventions and care program implemented for house-bound patients. 2. House Calls: COVID-19 Congregate Living Facilities Rapid Response Team implemented in April, 2020.

Indicator(s) to Measure Impact of Strategy 1. Uninsured adults (ACS) 2. Unable to see a doctor due to cost (BRFSS) 3. Regular doctor or healthcare provider (BRFSS)

Policy Change Necessary for Strategy Success Yes X No

Partnering Organizations Lake County Job and Family Services

**SDH Social Determinants of Health; PHS, Pr, & HB Public Health System. Prevention, and Health Behaviors; HCS & A Healthcare System and Access.*

Lake Health

Strategy: Address the Community Needs created as a result of the COVID Pandemic.					
Aligned to Ohio SHIP __Yes _X__No			**Aligned to HP 2020 __Yes _X__No**		
Type of Strategy* ___SDH _X_PHS, Pr, & HB _X_HCS & A			**Identified as Likely to Decrease Disparities __X__Yes ___No**		
Lead Agency	**Priority Population**	**Measure of Success**	**Year I Activities**	**Status**	
• Lake Health • Lake County General Health District	Lake County Residents	• COVID+ Cases • % Lake County Population Vaccinated	**Goal:** Ensure community members have timely access to testing and care to prevent and reduce morbidity and mortality from COVID-19.	• Share resources, donate PPE and other medical supplies, and provide expertise to congregate living facilities, schools, business and to ensure patient/community has access to testing and care. • Provide training and professional development for clinical and non-clinical staff for the COVID-19 response, including preparedness, cross-training, and providing surge support. • Support community-wide COVID-19 education, testing, and vaccination events. • Collaborate with city, county, and state government officials, community organizations, Critical Access Hospitals and other	
			Access to care	Virtual/TeleHealth • Dr. First (Expanding Tele-Health) • COVID Testing (Use of on-line screening tool) • No-Cost COVID-19 virtual triage and screening tool Care Coordination. ▪ The Population Health Team follows all patients that come to the ER with Covid or are referred to by the offices. They follow 6 months to a year and provide educations on COVID-19 and help with any other disease or pre-disease status's they have	

				Home Health. ▪ All patients receive educational information from the CDC regarding COVID – home management, signs and symptoms, prevention, etc. We also encourage follow up with their providers	
			Mental Health Assistance	• Partnership with Crossroads Health for support of Lake Health staff. Connecting with employers and schools. Also COVID Warmline and Hotline via Crossroads. • Partnership with ADAMHS Board with multiple programs to support staff • Dr Lori Stevic-Rust developed a mental health video series for our employees • Integrative Medicine provided multiple sessions on varying topic to assist staff dealing with stress, anxiety, etc… • Developed a relaxation room at multiple locations • Lake Health Behavioral Health Crisis Team Rounding on staff	

			COVID Testing	**Testing our Community for Symptomatic and asymptomatic patients**
				• Symptomatic Patients via Urgent Cares
				• OP PCR Testing (Mentor and Willowick) referred by PCPs
				• Preoperative testing, Testing of OB patients, and eventually all Inpatients
				• Fever Clinic within for Peds Offices (Chardon and Madison)
				• Fever Clinic for Adults (LCFP)
				• Rapid Assessment Team
				  • Went to Congregate Living Facilities to test COVID 19 patients
				  • Assisted congregate living facilities asses their facility for best practices during COVID
				  • Rapid Assessment Team supports school districts also.	

			COVID Planning, Guideline Development, and Integration	**Caring for COVID-positive patients:** • Inpatient and Emergency Department care managers are a key part of care teams still providing in person assessment and discharge planning to COVID and non-COVID patients, and participating in daily multidisciplinary rounds • Nurse and social work care managers follow up with individuals who test positive to offer support, navigation and resources – such as home-delivered meals, a referral for caregiver support, assistance on utilities or coping mechanisms • Patient care navigator schedules follow-up visits for individuals who test positive • Updated data and analytics dashboards to track COVID outcomes including test results, admissions, ICU and ventilator, critical supplies and other items **COVID Treatments:** • Convalescent Plasma • Remdesivir • Cohorted COVID Patients • Monoclonal Antibody Infusion Clinic • Dedicated COVID inpatient physician team **<u>Surge Plan Refinement and Implementation</u>** ▪ Pandemic Preparation (Additional Beds; Providers; Facilities) ▪ PPE – Implemented in-house re-sterilization of N95 Masks	

			Public Education	**<u>Patient Education</u>**
				• Timely education of our patients in the community via e-newsletter, press releases and website (done in conjunction with LCGHD and County)
				
				<u>Post-Acute Education</u>
				Coordinated with health district, hospital, and ems assisted local congregate living sites to address the pandemic
				• Formed a congregate living coalition, and playbook..
				• Provided COVID testing, and access to our infection preventionists.
				• Assisted Post-Acute Facilities with obtaining supply needs periodically during the pandemics
				
				<u>Employer/School Education</u>
				• SOS – Safely Opening Schools Program
				• SWAT – Safely Working Again Together
				  • (On-site assessments, Safety Measures, Testing and Wellness Programming)
				• Employer Educational sessions with:
				  ▪ Local Chambers of Commerce as well as employers and Safety Council.
				  ▪ Small Business Expo in conjunction with LCC and the Chambers / Safety Council;
				  • Society for HR Management
				
				<u>Communication and Engagement or Public Education or Community Education</u>
				  • E-Newsletters
				  • Webinars and seminars
				  • Website
				  • Press Release
				  • Social Media	

				<u>Health Education & Wellness</u> To provide accurate, community-relevant information about COVID-19 prevention and support health and well-being, we used a number of communication vehicles including: • E-Newsletter • Webinars • Virtual classes	
			Collaborations	**<u>Community Collaboration</u>** To improve the care ecosystem for our patients and communities Lake Health partnered with Lake County Health District, Lake County EMA, EMS and other non-profit organizations to coordinate a countywide response to COVID-19. Collaborations included: • Communication and education to public, community and patients • Guidance treatment • Integrated partnership with the Senior Care Post-Acute Care Network **<u>Fire/EMS Collaboration</u>** • COVID Testing • Provided PPE to EMS • N95 Fit Testing • RE-sterilization of N-95 for EMS personnel	
			Vaccinations	• Vaccinated healthcare workers • Collaborative Vaccination Clinics with LCGHD, Fire Chiefs & EMA - beginning 1/20/21 and ongoing. ▪ 1B Population (65+) ▪ Development Disability ▪ LHPG 1B Patients • Those with **specific medical conditions** that put them at a **very high risk of dying from COVID-19**	
Indicator(s) to Measure Impact of Strategy 1. COVID-19 Education; COVID-19 Preventable Hospitalization; Mental Health Support for Healthcare Workers; Residents exposed to COVID-19;					

Policy Change Necessary for Strategy Success **Yes** **X No**
Partnering Organizations Lake County General Health District; Emergency Management Agency; ADAMHS Board; Crossroads

**SDH Social Determinants of Health; PHS, Pr, & HB Public Health System. Prevention, and Health Behaviors; HCS & A Healthcare System and Access.*

Strategy: Address the Community Needs created as a result of the COVID Pandemic.				
Aligned to Ohio SHIP __Yes _X__No			**Aligned to HP 2020 __Yes _X__No**	
Type of Strategy* ___SDH _X_PHS, Pr, & HB _X__HCS & A			**Identified as Likely to Decrease Disparities __X__Yes ___No**	
Lead Agency	**Priority Population**	**Measure of Success**	**Year I Activities**	**Status**
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