



BOCA RATON REGIONAL HOSPITAL



Community Health Needs Assessment Implementation Strategy 2019-2021, Steering Committee Members



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Introduction

Born out of compelling community need in 1967, Boca Raton Regional Hospital is a not-for-profit, advanced tertiary medical center with 400 beds, over 2,100 employees and more than 800 primary and specialty physicians on staff. The Hospital is a recognized leader in Cardiovascular Care, Oncology, Women's Health, Orthopedics, Emergency Medicine and the Neurosciences, all of which offer state-of-the-art diagnostic and imaging capabilities. Boca Raton Regional Hospital is accredited by The Joint Commission and is one of only four hospitals in Palm Beach County to be designated by the Florida Agency for Healthcare Administration (AHCA) as a Comprehensive Stroke Center.

Boca Raton Regional Hospital works closely with an extensive Community Advisory Board in assessing and developing strategies to address the communities unmet health needs including but not limited to local not for profit health care providers, senior services, mental health services, local fire and police and the FAU school of Medicine. The full Community Advisory Board listing can be found here:

<https://www.brrh.com/About/Community-Health-Needs-Assessment.aspx>

Our Mission:

Boca Raton Regional Hospital delivers the highest quality patient care with unrelenting attention to clinical excellence, patient satisfaction and patient safety. Our team of professionals demonstrates unparalleled compassion and commitment to those we serve.

Our Vision:

To be the preeminent regional leader in healthcare delivery and the hospital of choice for patients, physicians, employees and volunteers.

Methodology (How the Implementation Strategy was Developed)

Boca Raton Regional Hospital's Implementation Strategy for 2019-2021 is the result of the hospital's CHNA completed November 2018 and subsequently presented, reviewed and adopted by the board of directors of the hospital on February 28, 2019.

The BRRH CHNA identified 13 Leading, Prioritized Community Needs.

Leading, Prioritized Community Health Needs		
Rank	Health Need	Categorization
1	Behavioral health / mental health services to treat depression, anxiety, or other conditions (excluding substance use)	Behavioral Health, Access to Care
2	Integrated care services for people requiring both behavioral health and medical / physical healthcare services	Coordination of Care, Behavioral Health
3	Affordable healthcare services for people or families with low income	Access to Care
4	Coordination of care between different doctors or other service providers	Coordination of Care
5	Homeless services (healthcare for the homeless)	Access to Care
6	Behavioral health / mental health services for seniors	Behavioral Health
7	Availability of a psychiatrist who can prescribe medications and collaborate with other community physicians	Access to Care
8	Suicide prevention	Behavioral Health
9	End of life issues (including palliative care)	Coordination of Care
10	Transportation services for people needing to go to doctor's appointments or the hospital	Access to Care
11	Substance abuse intervention and treatment (other than opioids)	Behavioral Health
12	Substance abuse of heroin or other opioids services	Behavioral Health
13	Affordable prescription medications for people or families with low income	Access to Care

Prioritized Needs and Areas of Opportunity were based on input from the Leadership Group meetings; analysis of local, State of Florida, and federal quantitative data; community input; and, the needs evaluation process.

The prioritization process included an in-depth workshop-style meeting with over 30 community and hospital leaders.

Prior to the meeting, analysis of the Stage 1 survey (as well as the prior secondary and primary research) led to the categorization of needs into a rank order list and three general clusters or categories.



Access to Affordable Care
Behavioral Health/Mental Health Services
Coordination of Care

The workshop-style meeting embedded activities designed to evaluate the three general clusters or categories, review individual community needs, and – importantly – help develop tactical initiatives by which higher-priority needs can be addressed.

Complete details are available within the Boca Raton Regional Hospital 2019 CHNA, which may be viewed at <https://www.brrh.com/About/Community-Health-Needs-Assessment.aspx>

Implementation Strategy/ Addressing Identified Health Needs

Boca Raton Regional Hospital will work to promote our mission of “delivering the highest quality patient care with unrelenting attention to clinical excellence, patient satisfaction and patient safety” and are committed to the listed strategies to meet the communities identified health needs with unparalleled commitment and compassion.

ACCESS TO CARE

Nearly one of five (18%) Broward County residents and one of seven (16%) Palm Beach residents are without health insurance -- most of whom are under age 65.

One in ten children (each county) is without health insurance – among the highest in the state. Access to affordable care includes a cluster of needs central to the ability of residents to receive health services. The discussion during the prioritization meeting noted that “access” includes at least three components:

- Capacity – An adequate supply of providers, as well as available openings for new and/or existing patients.
- Awareness / prevention – Readily available information regarding health literacy, the impact of health risks and conditions, ways to access the healthcare system, culturally inclusive information, and similar issues.
- Accessibility – The ability to physically avail one’s self of services: transportation, access to care during convenient days / times, childcare (in some cases), multi-lingual resource information, financial aspects (including counseling or other issues related to the availability of financial supports), and others.

Approaches identified by the community and hospital leaders worked to address aspects of these three categories

BRRH Community Advisory Board Proposed Implementation Strategies.

Access to Care

Goals:

1. Identify medical specialties shortage fields and recruit or realign staff, where needed
2. Provide training and resource support to direct care providers to enhance referral efficiency
3. Increase access to care for people with limited transportation abilities by utilizing the BRRH community health van to a greater degree and provide off-site services to underserved and elderly populations.

ACTIONS THE HOSPITAL PLANS TO TAKE TO ADDRESS THIS HEALTH NEED

To address access to affordable care in the community, BRRH plans to implement the following:

Capacity:

- **Identify medical specialties shortage fields and recruit or realign staff, where needed**
BRRH currently has 52 physicians participating in Project Access to provide pro-bono specialty care to the underserved. BRRH and the BocaCare Network will continue recruitment efforts to onboard medical specialties to cover shortages in network coverage. Additionally BRRH will work to close gaps in the specialty charity care network by recruiting identified specialty deficiencies; GYN, GI , Colonoscopy Services, into the Project Access Network.

- **Provide training and resource support to direct care providers to enhance referral efficiency**

The hospital continues to work to assimilate inpatient, outpatient and ER Electronic Medical Record systems to CERNER in an effort to streamline referrals and medical records exchange. Additionally BRRH and our affiliated ambulatory care network, BocaCare will strive to build relationships with area mental health care providers to streamline referrals to behavioral health resources.

Awareness & Accessibility:

- **Increase access to care for people with limited transportation abilities by utilizing the BRRH community health van and mobile mammography van to a greater degree and provide off-site services to underserved and elderly populations.**

The BRRH community health van currently provides regular screenings, education and assistance with navigation to hospital services focused on the underserved population. BRRH Community Outreach team will pursue a partnership with the FAU Charles E. Schmidt College of Medicine internal medicine residents to deploy the community health van to provide primary medical care to underserved populations in underserved locations. Additionally the outreach team will work to expand outreach screening and education in our service area to include Senior Citizens who find challenges in transportation and access to health care services as well as underserved populations in our secondary service area.

RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THIS NEED

BRRH will continue to commit staffing resources to the recruitment and onboarding of primary and specialty care physicians who are committed to providing care for uninsured and underinsured individuals by enrolling in Project Access and expanding the BRRH charity care network resources for underserved patients.

IT staff will continue to support the transition of or outpatient EMR to CERNER, improving referral efficiency and medical record exchange.

BRRH will work to staff and operationalize the community outreach van in an effort to expand its reach in providing care to underserved individuals and isolated senior citizens.

PLANNED COLLABORATION TO ADDRESS THE HEALTH NEED

BRRH has historically, and will continue to collaborate with community organizations including FAU Charles E. Schmidt College of Medicine, BocaCare, Boca Helping Hands, the Volen Center, The Boca Housing Authority, Project Access and The Palm Beach County Medical Society to address access to care in the community.

Outcomes and Impact Measurement

- **Goal:** Identify and onboard at least 2 additional BRRH on-staff GI and GYN providers in the Project Access network per year 2019-2021.
- Add three additional regular rotation outreach screenings for the underserved, one site providing access for elderly community members. **Goal:** increase outreach by 8 visit annually, 4 screening for seniors, and four for underserved populations by 09/2021.
- Assign a place of service to the Mobile Community Health Van. Develop curriculum with FAU Medical Residents to provide primary care services on the van by 09/2021. **Goal:** Increase access to care to the underserved and isolated by facilitating primary care visits on the mobile health van AEB increased total volume screened and navigated to care.

BEHAVIORAL HEALTH/MENTAL HEALTH SERVICES

Mental health and substance abuse were identified as pressing issues impacting the community in a broad and growing way. The direct impacts on the hospital include the following:

- Increasing need for integrated medical / physical health and mental health care in the inpatient, Emergency Department, and outpatient settings.
- The benefit of having direct care providers more insightful about mental health issues.
- Growing needs for additional engagement of higher-risk groups (e.g., youth, lower-income residents, and seniors).
- The opportunity to work in collaboration with other area service providers to enhance care for patients challenged by mental health and/or substance abuse issues.

Approaches identified by the community and hospital leaders worked to address aspects of these categories.

BRRH Community Advisory Board Proposed Implementation Strategies

Behavioral Health Services

1. Develop a pre-crisis pilot program for deployment via the integrated provider network, urgent care centers, the FAU residency clinic, on-site At Work Care clinic, BocaCare, and community outreach and health screening programs.
2. Enhance education regarding available pre-crisis resources for individuals at moderate to high risk for mental health needs. Make this information available at primary care centers, urgent care centers and other sites of care.
3. Enhance education of providers and first responders including additional CME programs
4. Develop a collaborative care network of mental health providers, including psychiatry, psychologists, mental health social workers, psychiatric nurses and tele-psychiatry and deploy evidence based best practices.

ACTIONS THE HOSPITAL PLANS TO TAKE TO ADDRESS THIS HEALTH NEED

To address Behavioral Health/Mental Health Services to treat depression, anxiety and other disorders not related to substance abuse in the community, BRRH plans to implement the following:

- 1. Implement depression screening throughout the integrated Primary Care provider network, FAU residency clinic and BocaCare Primary Care.**

BRRH is not a mental health receiving facility nor do we have a behavioral health service line. However to better address behavioral health / mental health services to treat depression , anxiety and other conditions excluding substance use, the BRRH primary care network physicians will begin performing a depression screen on all adult patients utilizing the PHQ-9 in an attempt to identify and treat mental health concerns prior to escalation, crisis and hospitalization.

- 2. Enhance education regarding available pre-crisis resources for individuals at moderate to high risk for mental healthcare needs. Make this information available at primary care centers, urgent care centers and other sites of care.**

As an adjunct to the above #1; BRRH will work with local mental health education awareness and resource center, Boca Raton's Promise to enhance education regarding available pre-crisis resources for individuals at moderate to high risk for mental healthcare needs. We will work to improve access to, and make this information available at primary care centers, urgent care centers and other sites of care.

Additionally:

Staff/Patient Education and Safety: In an effort to enhance visibility and education regarding mental health, BRRH will continue our efforts to educate and train staff to identify and respond to mental health concerns; topics included but not limited to:

3. Suicide in Older Adults – Assessing Risk
4. Patient and Family Education: Teaching the Patient with
5. Substance Abuse Disorders
6. Workplace Violence
7. Delirium Prevention and Management
8. De-escalating Challenging Situations
9. Non-violent crisis intervention training
10. Mental Health First Aid

Delirium prevention and management: 31% of BRRH inpatients have a Psychiatric diagnosis, of those approximately 20% have a diagnosis of dementia or delirium. To address this, BRRH will continue work to launch a comprehensive delirium prevention and hospital elder life program. The program currently piloted on 4 inpatient units includes a checklist and supplies clinical staff can use to help minimize and manage delirium in hospitalized older adults. The toolkits have been developed using the latest research on delirium prevention, targeting risk factors including cognitive and sensory impairment, dehydration, immobility, unfamiliar surroundings and sleep deprivation.

Behavioral Emergency Response Team: As aforementioned BRRH is not a behavioral health facility. To improve both the safety and care of patients and staff, BRRH will continue work to operationalize an interdepartmental, specialized team with the unique skill set and competencies to communicate and safely respond to behavioral health emergencies.

- **Enhance education of providers and first responders including additional CME programs**

BRRH will work with our physicians and staff, as well as local EMS, Fire and Police in collaboration with local mental health education, awareness and resource centers to provide Mental Health First Aid training to physician, staff, first responders and primary health care providers to enhance identification and management of Mental Health concerns.

- **Develop a collaborative care network of mental health providers, including psychiatry, psychologists, mental health social workers, psychiatric nurses and tele-psychiatry and deploy evidence based best practices.**

BRRH physicians, senior leadership, affiliated primary and specialty care network BocaCare and community mental health leaders will work to develop and expand our behavioral health partnerships to more comprehensively address and care for the mental health needs of the community by expanding resources for integrated outpatient mental health care for BRRH patients.

RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THIS NEED

Over the past three years BRRH developed dedicated workgroups whose work focused on the education and safety of staff caring for behavioral health patients and optimizing the navigation and dispositioning of behavioral health patients. Inpatient processes and policies have been assessed and revised to optimize the care, navigation and dispositioning of behavioral health patients. BRRH and our affiliated primary and specialty care network BocaCare will continue to dedicate staff to these efforts as well as work to develop and expand our behavioral health service line. Along with the aforementioned implementation strategies BRRH plans to more comprehensively address the community's behavioral health needs.

PLANNED COLLABORATION TO ADDRESS THE HEALTH NEED

BRRH works closely and will plan to collaborate with local fire, police and first responders as well as community partners like mental health education, awareness and resource center; Boca Raton's promise and the Faulk Center for counseling which provides low-cost programs for counseling, therapy, and support. Additionally BRRH will continue to collaborate with our affiliated primary and specialty care network BocaCare and the FAU Charles E. Schmidt College of Medicine psychiatry residency training program to expand our behavioral health service line to more comprehensively address the community's behavioral health care needs.

Outcomes and Impact Measurement

- **Goal:** Depression screening in BocaCare Primary Care setting to be completed at 80% by 09/2021.
- Delirium Prevention Tool Kits implemented hospital wide by 12/2019. **Goal:** statistically significant decrease in code assist calls on engaged units by 09/2021. 80% of positive CAM screened patients receiving the intervention ultimately decreasing LOS by 09/2021.
- **Goal:** BRRH sponsored Mental Health First Aid training scheduled quarterly 2019-2021 for the following: BRRH Employees, First Responders, PCP's, and Medical Residents.
- **Goal:** Behavioral Emergency Response Team operationalized 9/2020 with measurable decrease in workplace violence incidence by 09/2021.
- Behavioral Health Integrated Care Outpatient Model operationalized 09/2021. **Goal:** Decreased avoidable behavioral health ED visits.

Coordination of Care

Care coordination was identified by community and hospital leaders as a category of services designed to promote more broad-based support for higher-need patients, positively impact community health, and increase the effective and efficient use of health services. Care coordination was recognized as having two aspects:

- **Patient engagement** – Working with higher-risk patients in a culturally sensitive way to provide helpful information, support and guide patients’ lifestyle and healthcare decisions, provide direction regarding ways to optimize access to services, and others.
- **Provider engagement** – Engaging providers and patients in order to coordinate services and share information in a way that reduces service redundancy, improves the efficiency with which complementary services are provided, and strengthens the ability of patients to be highly activated in their own care.

Approaches identified by the community and hospital leaders worked to address aspects of these categories.

BRRH Community Advisory Board Proposed Implementation Strategies:

Care Coordination

1. Reduce hospital inpatient readmissions by providing post discharge follow-up phone calls to inpatient discharges.
2. Provide additional assistance to higher-need patients requiring help with scheduling appointments and using community resource information.
3. Train and educate staff to help improve patient health literacy and understanding of effective ways to manage their own care, where necessary.
4. Prior to patient discharge, connect inpatient physicians to outpatient care providers in order to enhance effective “hand-offs continuity of care.
5. Review physician education resources that clearly define the impact (e.g., financial, community health, etc.) of inpatient readmissions. Review hospital incentives to help prevent readmissions.

ACTIONS THE HOSPITAL PLANS TO TAKE TO ADDRESS THIS HEALTH NEED

To address access to affordable care in the community, BRRH plans to implement the following:

Patient Engagement:

- **Reduce hospital inpatient readmissions by providing post discharge follow-up phone calls to inpatient discharges.**
- **Provide additional assistance to higher-need patients requiring help with scheduling appointments and using community resource information.**

BRRH population health, patient and guest relations in collaboration with nursing, case management, social work and senior leadership will work to develop, staff and launch a comprehensive discharge follow up program encompassing follow up phone calls, as well as clinical guidance and navigation to resources with assistance finding and scheduling with a provider when required.

A comprehensive discharge education and information folder will be developed and deployed providing access to community resources including but not limited to: prescription medication assistance, medical supplies, mental health resources, transportation, and food assistance. The discharge folder will also provide hospital resources commonly utilized after discharge, including medical records, case management, pharmacy and physician referrals

Provider Engagement:

- **Prior to patient discharge, connect inpatient physicians to outpatient care providers in order to enhance effective “hand-offs and continuity of care.**

BRRH case management and social work staff currently work to ease the transition from inpatient to post-acute resources. The CHNA community advisory group believes that a warm handoff from inpatient to outpatient care providers will enhance the safe and successful transition of patients from inpatient to outpatient care. BRRH will work with case management, patient and guest relations and our BocaCare physician network to begin formalizing the transition of care communications from inpatient physicians to outpatient providers.

RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THIS NEED

The projects described above will likely require additional staffing resources to be committed and or /reallocated to manage the new workflows for transitions of care and discharge follow up.

PLANNED COLLABORATION TO ADDRESS THE HEALTH NEED

As stated above BRRH departments and staff will collaborate with our affiliated physician network and community partners such as the Volen Center for Senior Citizens and 211 Palm Beach County to establish a formalized transition from inpatient to outpatient care providers and resources.

Outcomes and Impact Measurement

- Increase volume of individuals navigated to care by 50% by 9/2021
- Reduction in hospital readmission of target patient populations TBD.
- Volume of post-discharge follow up phone calls and ambulatory network post-acute follow up appointments scheduled at 80% of those with appropriate disposition by 9/2021.

Identified Health Needs Not Addressed

IRS regulations require that the Implementation Strategy include a brief explanation of why a hospital facility does not intend to address any significant health needs identified during the CHNA. BRRH Community Advisory Board identified three significant health needs during the CHNA process— Access to Affordable Care, Behavioral Health Services, and Coordination of Care. BRRH has elected to address each of the three significant health needs in this Implementation Strategy. Other significant health needs identified during the 2018 CHNA included Homeless services, End of life concerns, and Transportation services for people needing to go to doctor's appointments or the hospital. These health needs are already being addressed in some fashion by BRRH or other community service providers or were outside the scope of BRRH's service capabilities.

Conclusions

The aforementioned programs to be implemented as well as those in existence to be continued or expanded demonstrate Boca Raton Regional Hospital's commitment, through the help of its community partners in addressing the unmet health needs of our community. Through the resources and identified collaborations we expect to have a positive impact on the health and wellbeing of the community.

Comments or questions regarding the Community Health Needs Assessments and or Implementation Strategy may be sent to Patrick Mahaney RD LDN, Manager of Community Outreach at pmahaney@brrh.com

Board approval: 02/28/2019