



# 2023-2025 Implementation Strategy

For the 2022 Community  
Health Needs Assessment

 **ValleyHealth**  
Warren Memorial Hospital

## Warren Memorial Hospital Implementation Strategy Plan

### Introduction

The **2022 Community Health Needs Assessment (CHNA)** is a strategic tool that helps Valley Health pursue its mission of serving our community by improving health. The Patient Protection and Affordable Care Act of 2010 requires not-for-profit hospitals to conduct Community Health Needs Assessments every three years. The purpose of the assessment is to identify and prioritize the health needs of the residents of the hospital's service area, particularly those who experience health inequities. After assessments were completed for each Valley Health hospital, an **Implementation Strategy Plan** was developed to address the identified health needs.

The Community Health Needs Assessment involved the contributions of over 2,000 individuals through virtual interviews, surveys, in-person community response sessions, and in-person interviews with vulnerable populations from area homeless shelters and food pantries. Key stakeholder groups included community residents, members of faith-based organizations, health care providers, elected officials, members of the Valley Health Community Advisory Council, health professionals, and leadership from each of Valley Health's six hospitals. The CHNA is a report based on quantitative, qualitative and relative data that assesses health issues in our community and the community's access to services related to those issues. Frameworks of social determinants of health and health equity guided the process of the CHNA.

The Implementation Strategy Plan (ISP) addresses priority needs identified in the CHNA, describing how the hospital intends to respond to the need or identifying it as one that will not be addressed and why. The strategies have been developed with a focus on leveraging Valley Health's programs and resources to achieve sustainable solutions that address health disparities and close gaps in healthcare access. The identified strategies are not intended to be a comprehensive list of all of the many ways the needs of the community are addressed by Valley Health, but rather specific actions the hospital commits to undertaking and monitoring from 2023-2025. Initial collaboration with hospital and community leaders established the impact list and alignment was sought among system leaders to compliment planning efforts around the community health needs. The impact of the chosen strategies will be communicated to the community and further alignment will establish partnerships and related measurable effects.

The hospital may amend the ISP as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs included here. This plan and its strategies will be evaluated annually and may be refocused to account for such changes in the community or health system landscape.



## Methodology: Identifying Priority Health Issues

### 1. Establish the Assessment Infrastructure

A Community Advisory Council (CAC) was established with representation for each of Valley Health's acute care operations, critical care access hospitals, clinical service lines, community members, Finance and Treasury Affairs, and Planning and Business Development. The CAC reviewed Internal Revenue Service and Department of Health requirements and established the project timeline and implementation strategy.

### 2. Conduct Community Health Needs Assessment

Community health needs for each Valley Health hospital were identified by collecting and analyzing data and information from primary and secondary data sources. Primary data sources included a community health survey, key informant interviews and community response sessions. Demographic, economic, and health data was gathered for the Valley Health service area. Valley Health's internal data was supplemented by data from other governmental and industry sources. The principal findings of recent health assessments conducted by other organizations were reviewed as well.

### 3. Analyze Data

In July and August 2022, Valley Health led a facilitated process with leadership from each Valley Health hospital, community stakeholders and members of the Community Advisory Council, to understand key health issues identified in the 2022 Community Health Needs Assessment (CHNA). The implementation strategy planning process involved a series of work sessions, including an orientation session and review of the 2022 identified needs, an analysis of internal hospital resources, a review of evidenced-based best practices, a cataloging of potential community partners, and meetings to align the implementation strategies discussed with current planning initiatives throughout the system.

### 4. System Prioritization of Community Needs

Through a series of over twenty work sessions conducted at all six Valley Health hospitals, priority health needs were identified and solution-driven implementation strategies were developed. The prioritized health needs were grouped into key categories, allowing for a system wide community health improvement plan for those needs that overlap in all six hospital service areas. Targeted strategies for community specific needs are presented in this report. The work group process outlined above served as a means for further understanding what community programs and resources are available and served as a forum for discussing ways to collaborate to better meet the needs identified in the Community Health Needs Assessment.

### 5. Identify Resources/Community Collaboration

Valley Health will seek out community partners to address the prioritized health needs. This process will engage both long-standing and new, non-traditional partners in collaborative problem solving. Possible partners may include community and educational organizations, local business, housing and transportation services, and faith-based organizations. Both process and outcome measures will be tracked and reported on a quarterly basis.

The strategy team at each Valley Health hospital worked to prioritize their community's needs using the following criteria:

- Prevalence and degree of need
- Focus on equity and accessibility: understanding the presence of disparities and health issues that disproportionately affect populations by race or ethnicity
- Build on or enhances current work within the system or community and aligns with Valley Health's Strategic Plan
- Ability to demonstrate achievable and measurable outcomes
- Ability to leverage community partnerships

## **6. Development of Community Health Implementation Strategy Plan**

The Implementation Strategy Plan includes a description of identified strategies and how resources will be leveraged through collaborative partnerships across all six Valley Health hospitals. This approach allows Valley Health to leverage resources and opportunities throughout the organization and has the ability to affect change across multiple communities. The collaborative approach enhances Valley Health's ability to address complex needs and engages leaders from marketing, behavioral health, information systems, data analytics, patient experience, care coordination, the medical group, ambulatory services, and EPIC.

To evolve the Implementation Strategy Plan, Valley Health's leaders will align the prioritized needs with best practice models and available resources and define action steps, timelines, and potential partners. The team will continue to focus on health equity to understand the scale and severity of identified needs and their impact on the most vulnerable populations. The identified implementation strategies will utilize system and local resources to improve health for the community with intentional focus on our low-income, underserved, and uninsured populations. Valley Health is approaching these strategies by identifying the drivers behind the health and well-being of our patients throughout the entire patient experience. This focus requires developing strategies that include the social, economic and environmental roots of well-being that are evident at the community level as well as health issues identified in our clinics and hospitals.

## **7. Plan for Monitoring Progress**

Each hospital plan specifies the goals and objectives for addressing the prioritized community health needs. Additionally, each plan identifies the actions to be taken, collaborations that will be instituted, the resources required, and the measures of success. Hospital leadership and the Community Advisory Council will utilize a dashboard with specific measures to gauge progress throughout the three-year duration. The CAC will meet on a quarterly basis to assess progress and make adjustments as required.

## **8. Board Adoption and Public Availability of the Community Health Needs Assessment/Community Health Implementation Strategy Plan**

The Community Advisory Council that includes Valley Health Board of Trustees representation was engaged throughout the Community Health Needs Assessment process by reviewing progress, providing feedback and endorsing the resulting work product. The Valley Health Board of Trustees adopted the Community Health Needs Assessment final report on December 13, 2022 and the Implementation Strategy Plan report on April 11, 2023. Reports have been published electronically on the Valley Health website with hard copies available upon request at each hospital.

## Definition of Prioritized Health Needs for Implementation Strategy Planning

Health needs identified during the Community Health Needs Assessment process were grouped into the following categories:

### Health Needs Valley Health Will Address

- 1. Mental Health & Substance Abuse:** Mental health includes both mental health conditions and behavioral problems. Poor mental health can cause negative outcomes for both those suffering and the people around them. It can impact children's ability to learn in school and adults' ability to be productive in the workplace and provide a stable and nurturing environment for their families. Poor mental or behavioral health frequently contributes to or exacerbates problems with physical health and illness. Substance abuse includes the use of illicit substances; misuse of legal over-the-counter and prescription medications; and abuse of alcohol and tobacco. Substance abuse affects not only substance abusers, but those around them; negatively impacting health, safety and risky behaviors, including violence and crime, adult productivity, students' ability to learn, and families' ability to function.
- 2. Access to Primary, Preventive & Clinical Care:** Access to care services through a doctor's or dentist's office, clinic or other appropriate provider is an important element of a community's health care system. Access to health care services is vital to the health of the community's residents. The ability to access care is influenced by many factors including insurance coverage and the ability to afford services, the availability and location of health care providers, understanding where to find services when needed, and reliable personal or public transportation. Place-based solutions bring care to the patient either near or where they reside.
- 3. Health Behaviors & Chronic Disease:** Chronic diseases are typically conditions that last one year or more and require ongoing medical treatment or limit activities of daily living or both. Chronic diseases are leading drivers of health care costs and are some of the leading causes of death and disability in the United States. A lack of physical activity is a contributing factor to being overweight and obese, and is connected to a wide range of health problems and chronic diseases among all age groups. The co-occurring health problems and diseases include high cholesterol, hypertension, diabetes, heart disease, stroke, some cancers, and more.
- 4. Social & Economic Factors:** Income levels, employment and economic self-sufficiency are all considered social determinants of health and correlate with the prevalence of a range of health problems. People with lower incomes or who are unemployed and underemployed are less likely to have health insurance and are less able to afford out of pocket health care and housing related expenses. Lower income is associated with increased difficulties such as securing reliable transportation for medical care or the ability to purchase an adequate quantity of healthy, fresh food on a regular basis.

## Needs Valley Health Will Not Directly Address

No healthcare organization can address all of the health needs present in its community. Valley Health and each of its hospitals are committed to serving the community by adhering to its mission, focusing on core competencies, and using limited resources strategically in order to continue to provide a range of important health care services and community benefits.

To have the greatest impact on the health and wellbeing of the community, Valley Health will be directing its limited resources to the prioritized community health needs. The Implementation Strategy Plan will not address the following identified needs:

- 1. Physical Environment:** The physical environment is where individuals live and work. People interact with their physical environment every day through the air they breathe, water they drink, houses they live in, and the transportation they access. Poor physical environment can affect our ability to live long and healthy lives. Physical environment includes looking at the safety of the air and water for a community as well as examining the available transportation and housing burdens, lack of plumbing, internet, and long commutes to work.
- 2. Health Outcomes:** Each year over a million people are diagnosed with cancer and the cost of cancer care continues to rise. Some cancers are preventable and there are steps that can be taken to improve the quality of life for cancer survivors and detect cancers in the early and treatable phase. Some risk factors can be reduced to prevent certain types of cancer. Smoking, exposure to the sun and tanning beds, obesity, and excessive alcohol use are all examples of risk factors, which put a person at high risk for developing cancer. Premature death is a long-term health outcome, the effects on which might not be realized until years after a program or policy is implemented. Motor vehicle crashes are one of the leading causes of death in the United States and the lifetime economic costs can be enormous.
- 3. Maternal and Child Health:** Maternal and child health indicators, including teen pregnancy and infant mortality, should be considered when evaluating the health of a community. The rate of teen pregnancy is an important health statistic in any community for reasons that include concerns for the health of the mother and child, the financial and emotional ability of the mother to care for the child, and the ability of the mother to complete her secondary education and earn a living.

While these needs are not specifically addressed in the Implementation Strategy Plan, existing Valley Health programs and services impact these areas. Although not ideally suited to be the lead organization in addressing all of the health needs identified by the CHNA, Valley Health will continue to collaborate with community organizations that are more closely aligned and suited to have an impact on these issues.

## Prioritized Health Need #1: Mental Health and Substance Abuse

### Key Findings

- Page, Rappahannock, Shenandoah, and Warren counties reported higher percentages of excessive drinking than the state average of 17%, and in West Virginia, Berkeley, Jefferson, Mineral and Morgan counties reported higher percentages of excessive drinking than the state average of 15%.
- A measure of alcohol used based on excessive drinking placed for Rappahannock County at 20% higher than the state average, according to 2022 County Health Rankings report
- Three of the four counties within the WMH community have been designated as medically underserved areas.
- Mental and behavioral health was the second most frequently mentioned health status issue by key informants. Interviewees generally reported that the community's mental health needs have grown, while the mental health service capacity has not.
- Substance abuse was a major concern and mentioned frequently by key informant interview participants. It was portrayed as a growing and serious issue.
- The major concern mentioned by key informants was the need for more providers to care for children with mental and behavioral health issues. The WMH community has limited resources for this type of community need.
- Another concern mentioned by key informants was connecting patients with services needed. Wait times are very long for patients to see a clinician for services and medication

**Strategy #1:** Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

#### Hospital-based Metrics

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)
- Improve patient experience related care continuum. (2023-2025)

**Strategy #2:** Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

#### Hospital-based Metrics

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

**Strategy #3:** Establish a behavioral health integration model within the primary care settings with the support of mental health professionals and psychiatric provider consultation as part of a **Behavioral Health Continuum.**

#### **Hospital-based Metrics**

- Connect primary care practices with psychiatric consultation capabilities. (2024-2025)
- Establish a standardized assessment tool in practice to monitor patient progress (24 Clinics). (2024-2025)
- Staff will complete psychological safety training as part of annual mandatory review coursework. (2023-2025)
- Valley Health will operate or collaborate to expand suicide prevention coverage to patient service areas. (2023-2025)

#### **Community-based Partnership Metrics**

- Community Health Impact Partner | Concern Hotline
  - Offer 24 hour, suicide & crisis hotline (2023-2024)
  - Offer community suicide safety trainings with special focus on rural, disadvantaged communities (2023-2024)

**Strategy #4:** Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

#### **Hospital-based Metrics**

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

## **Prioritized Health Need #2: Access to Primary, Preventative, Clinical Care**

### **Key Findings**

- In 2021, the WMH community was estimated to have a population of 117,854 persons. Approximately 27.4 percent of the population resided in the primary service area (Exhibit 1).
- In 2021, the WMH Community collectively accounted for 77 percent of the hospital's inpatients and 88.3 percent of emergency department discharges. The majority (92.9 percent) of the hospital's inpatients originated from the Page County, and 5.9 percent for the secondary service area (Exhibit 2).
- Concerns about access to care were the most frequently mentioned factor contributing to poor health in key informant interviews.
- Lack of accessible or reliable transportation to health care and a lack of providers accepting new Medicaid and Medicare patients were frequently mentioned in interviews, especially for low-income individuals and senior citizens.



- All Virginia counties except Shenandoah County had uninsured rates higher than the commonwealth and national averages. Rappahannock County had the highest rate at 13.4 percent.
- Since January 1, 2019, more adults living in Virginia have access to quality, low-cost, health insurance through Virginia Medicaid. Covered adults include individuals ages 19-64 with income at or below 138% of the federal poverty limit. As of August 2022, there are 679,591 enrolled members in the state of Virginia.
- The WMH community reported Community Need Index scores between 3.2 -4.0 for Page, Rappahannock, Shenandoah, and Warren counties (Exhibit 35). • Three of the four counties within the WMH community have been designated as medically underserved areas (Exhibit 38).
- The WMH community contains Health Professional Shortage Areas for dental, mental, and primary care. Page County reported shortages in dental health. Shenandoah County reported shortages for all three categories for dental, mental and primary care services, whereas, Warren County reported shortages in dental, and primary care services (Exhibit 40).
- The WMH community is experiencing lower ratio rates when it comes to the number of primary care physicians, dentists, and mental health providers per 100,000 populations. Primary care providers and dentists' availability are below the Virginia averages in Page, Rappahannock, and Warren counties. Rappahannock and Warren counties are below the Virginia ratio for dentists according to the 2022 County Health Ranking report (Exhibit 44).
- Preventable hospital stay rate is higher than the state average of (3896) for Page, Shenandoah and Warren counties in VA. Warren Memorial Hospital 12 Produced by P & BD (2022) Community Health Needs Assessment
- The WMH community ranked higher than the state average for five out of the eight metrics for "clinical care" in the 2022 County Health Rankings report. Page County ranked 132 out of 133 VA counties and Rappahannock ranking at 105.

**Strategy #1:** Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

#### **Hospital-based Metrics**

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)
- Improve patient experience related care continuum. (2023-2025)

#### **Community-based Partnership Metrics**

- Mission Critical Partner | St. Luke Community Clinic
  - Patient education and monitoring in order to reduce average blood sugar levels in diabetic patients by measuring A1c & FBG (2023-2024)
  - Patient education and monitoring in order to reduce average Mean Arterial Pressure (2023-2024)

**Strategy #2:** Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

**Hospital-based Metrics**

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

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**Community-based Partnership Metrics**

- Community Health Impact Partner | Concern Hotline
  - Offer 24 hour, suicide & crisis hotline (2023-2024)
  - Offer suicide safety trainings with special focus on rural, disadvantaged communities (2023-2024)

**Strategy #4:** Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

**Hospital-based Metrics**

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

## Prioritized Health Need #3: Health Behaviors and Chronic Disease

### Key Findings

- Adult obesity in Page, Shenandoah, and Warren counties in Virginia reported adult obesity rates higher than state average.
- Physical Inactivity was reported higher than the Virginia average of 25% for six out of the seven Virginia counties, and four out of seven counties reported higher than the West Virginia average of 30%.
- Page County reported a higher rate of residents that do not have access to exercise opportunities as reported by 2019 County Health Rankings than the state average.
- Page, Rappahannock, Shenandoah, Warren counties reported higher percentages of excessive drinking than the state average of 17%.
- Mortality due to malignant neoplasms (cancer), chronic lower respiratory disease, influenza/pneumonia, and suicide rates were greater than the state average for six of the seven counties.
- Shenandoah and Warren counties reported unintentional-injury related mortality at a higher rate than both the Virginia and national averages for that cohort. The overall populations of Virginia counties reported higher rates of mortality related to suicide than Commonwealth averages.
- Page and Warren County residents experienced cancer mortality rates higher than the Virginia and national averages for lung and bronchus, breast cancer rates were highest in Shenandoah County. Prostate cancer was reported higher than both the commonwealth and national averages in Shenandoah and Warren counties
- Commenting on the contributing factors to poor health status, interview participants mentioned nutrition and diet, low physical activity and exercise, and food insecurity. Many commented on the lack of affordable, healthy food choices in some parts of the community.
- Interview participants mentioned nutrition and diet, low physical activity and exercise, and food insecurity. Many commented on both the lack of affordable, healthy food choices in some parts of the community. Obesity among children and youth within the community was reported to be a concern

**Strategy #1:** Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

### Hospital-based Metrics

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)
- Increase in the number of residency site rotations. (2024-2025)
- Improve patient experience related care continuum. (2023-2025)

### Community-based Partnership Metrics

- Mission Critical Partner | St. Luke Community Clinic
  - Patient education and monitoring in order to reduce average blood sugar levels in diabetic patients by measuring A1c & FBG (2023-2024)

- Patient education and monitoring in order to reduce average blood sugar levels in diabetic patients by measuring A1c & FBG (2023-2024)

**Strategy #2:** Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

#### **Hospital-based Metrics**

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

**Strategy #3:** Evaluate **Mobile Health** Services for local employers and community members to create a preventive care and screening option that supports the socio-economic needs of the employed, rural, and underserved areas of the community.

#### **Hospital-based Metrics**

- Evaluate mobile care and screening options for the community. (2023-2025)

**Strategy #4:** Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

#### **Hospital-based Metrics**

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

### **Prioritized Health Need #4: Social & Economic Factors**

#### **Key Findings**

- All Virginia counties in the community had a higher percentage than the state average of residents aged 25 and older who did not graduate high school. Page County experienced a slight increase of 20 percent of non-graduates compared to the previous 2019 assessment showing 19.6 percent of non-graduates.
- Rappahannock County reported the highest percentage of student completing high school.
- The highest proportions of households with incomes under \$25,000 in 2021 were located in Page County at 23.5 percent and Shenandoah County at 19.6 percent (Exhibit 15).
- Exhibit 16A shows unemployment rates for December 2019-July 2022. Post Pandemic unemployment rates are higher than pre-pandemic rates across all counties in our region with the exception of Page County.
- The highest percentage of students receiving free or reduced lunches for the WMH community were located in Page County, VA.



- Participants in interviews believe that low income housing, and poverty were the top issues contributing to poor health status and limited care. Other income-related factors noted include difficulty with securing transportation to medical appointments and homelessness.
- From the community health survey, low income and financial challenges were reported. For survey respondents who reported not being able to always get the care they needed, affordability and lack of insurance coverage were the reasons most frequently mentioned.

**Strategy #1:** Develop Community Collaborations to address disparities involving social determinants of health and health equity.

#### **Hospital-based Metrics**

- Increase community collaborative relationships

#### **Community-based Partnership Metrics**

- Mission Critical Partner | Healthy Families Northern Shenandoah Valley
  - Improve maternal health outcomes & child development, through home visiting services & promotion of positive parent-child relationships (2023-2024)
  - Connect families to resources for substance abuse, depression, and food insecurity, fostering health equity (2023-2024)
- Mission Critical Partner | Our Health
  - Assess Unite Us utilization in VH service area, updating the Unite Virginia Referrals Quick Guide and increase partner agencies participating in Unite Us (2023-2024)