

# Washington Health System 2022 CHNA Joint Implementation Plan: Washington and Greene Campuses

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## Overview

From February 2021 to June 2022, Washington Health System (WHS) engaged LRF Consulting, LLC (LRF) to complete their Community Health Needs Assessment (CHNA) for the Washington and Greene facilities. During that process, a 2030 Healthy Community Logic Model™ was created to show logical linkages between health factor indicators and final outcomes. This implementation plan completes the logic model by providing the inputs and resources; process goals and objectives; and expected process measures (outcomes) for the two identified, prioritized health needs: colorectal cancer and lung cancer (See Figure 1).

Since some of the other identified needs are interrelated to the two priority ones, they will be addressed to a certain extent by addressing the latter. These include: tobacco quit attempts; food insecurity; meeting recommendations for physical activity and muscle-strengthening exercises; fruit intake; pregnant smoking; youth obesity; and heavy drinking. The rest of the identified health needs will not be addressed in this plan. Reasons why include:

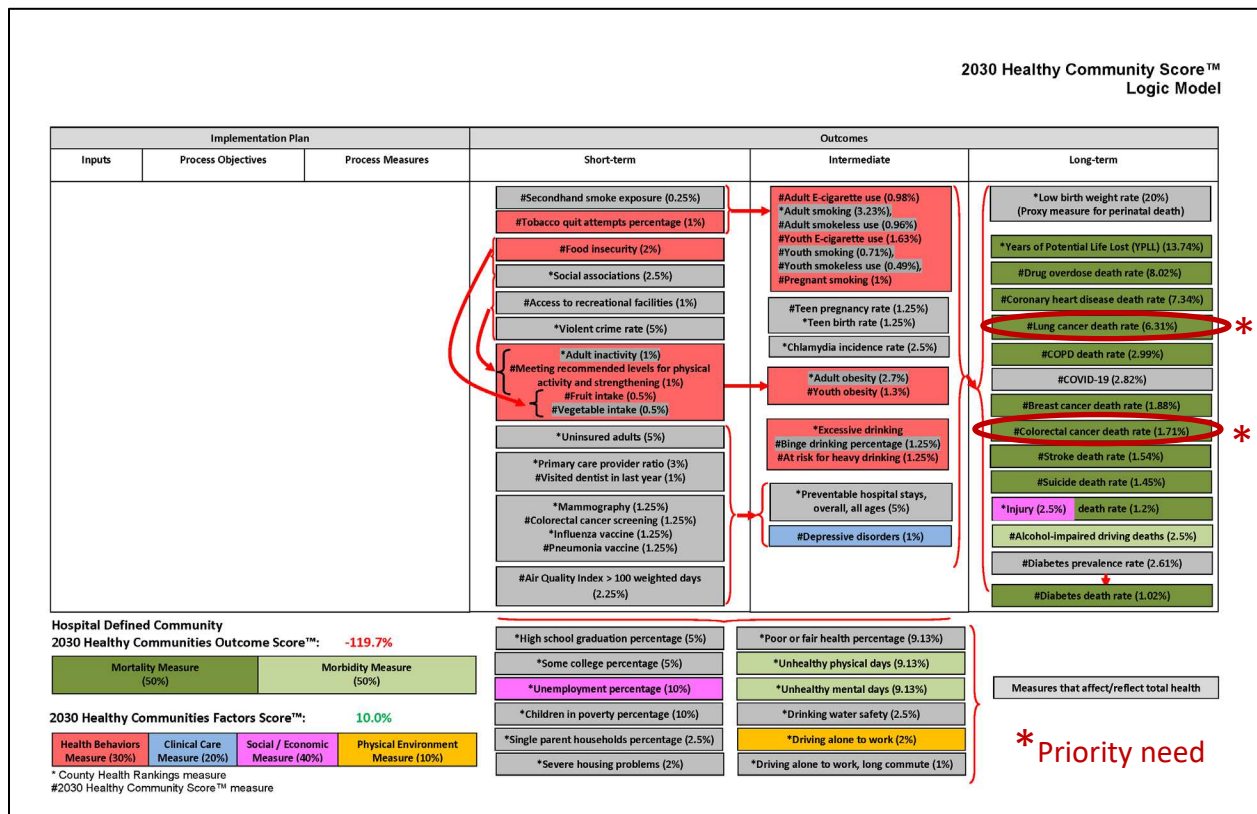
1. Years of Potential Life Lost, Unhealthy physical and mental days—Since these are general measures of health, they are not specific enough to warrant action. That is the reason why specific death rates and other behavioral measures were adding to the model.
2. Drug overdose deaths—these have been addressed for the past three years and the rates, although not in goal range, are static over that time frame.

3. Coronary heart disease deaths—Not enough resources to address need along with the other two prioritized needs and the rates, although not in goal range, are in a decline.
4. COPD deaths—Not enough resources to address need along with the other two prioritized needs and the trend is static.
5. Breast cancer deaths—this has been addressed in past implementation plans and the rates, although not in goal range (since the healthy people 2030 plan has re-benchmarked goals lower this appeared as a need), are static.
6. Stroke deaths—Not enough resources to address need along with the other two prioritized needs and the trend is static.
7. Suicide—need is better addressed by community partners whose focus includes services for this population.
8. Injury deaths—Not enough resources to address need along with the other two prioritized needs.
9. Diabetes-related deaths—this has been addressed in past implementation plans and the rates, although not in goal range (since the healthy people 2030 plan has re-benchmarked goals lower this appeared as a need), are static.
10. Alcohol driving deaths—Not enough resources to address need along with the other two prioritized needs and the trend is static.
11. Depressive disorders—Not enough resources to address need along with the other two prioritized needs and the trend is static.
12. E-cigarette use, Adult and Youth—lack of evidenced-based interventions to decrease access and lack of expertise/control to accomplish progress.
13. Unemployment—need is better addressed by community partners whose focus includes services for this population.
14. Driving alone to work—need is better addressed by community partners and the rates, although not in goal range, are in a decline.

Public health looks at populations and is not used to clinically manage individual patients. This plan is designed with formative evaluation, not summative. This means that the information measured is used to compare where the intervention population is in relation to a "standard;" to investigate reasons behind variation from the "standard;" and to continue to revise the plan and/or interventions based on quality improvement processes.

This plan will detail for each of the prioritized health needs:

- Inputs and resources
- Goals, process objectives and process activities with timeline
- Expected process outcomes and measurements
- How each measure will be collected and by whom
- Into what database the collected information will be entered and who will enter
- How the information will be analyzed and who will perform the analysis
- How and who will communicate the results with timeline



**Figure 1. 2030 Healthy Community Logic Model™ with highlighted needs in color.**

## Inputs and resources

Inputs and resources are the raw materials that are needed to implement the plan. They are determined by the plan’s goals and objectives and include: people; funding; and organizations.

Expected inputs include:

1. Funding from WHS to implement the plan
2. Funding from other entities to implement interventions
3. Appropriate WHS staff to work on the implementation of the plan, including:
  - a. Population Health Team (Social Worker, Pharmacists, 2 RN Care Managers, and 2 RN Quality nurses).
  - b. Lung Screening Navigator and Radiology Department
4. Community organizations such as:
  - a. Washington Physician Hospital Organization
  - b. American Cancer Society,
  - c. Pharmacists
  - d. private physician practices
  - e. employers
  - f. health insurance plans

- g. pharmaceutical companies
  - h. Federally Qualified Health Centers (FQHC)
  - i. faith community and community health workers
5. PA Department of Health representative
  6. people with colorectal or lung cancer
  7. people between the ages of 50 to 77 years at risk of lung cancer
  8. people between the ages of 50 to 75 years at risk of colorectal cancer
  9. Patient Family Center Care Advisors
  10. Health care affordability act mandates
  11. Evidenced-based interventions for colorectal and lung cancer
  12. Community health assessment results

### Goals, process objectives and process activities

Goals identify what is to be accomplished by the end of a specific time period while process objectives specify what is to be accomplished during mile posts within the goals’ timeframes. Process activities map how the objectives will be achieved and are contained within the objective’s time period. An important piece of the activities includes how and who will communicate the results. Since this is a joint implementation plan for both Washington Health System’s (WHS) Washington (W) and Greene (G) Campuses, any differences in process activities, responsible party and/or timeline for completion will be highlighted by being preceded by the letter “W” for Washington and “G” for Greene. Otherwise, it will be assumed that they are identical.

**Goal #1 Colorectal Cancer:** To reduce 2020 colorectal cancer death rate in Washington and Greene Counties combined (12.9 per 100,000 population, age-adjusted, with a 95% confidence interval of 9.4-17.4) by 10.1% (to 11.6 per 100,000 population, age-adjusted) as of June 30, 2024.

**Process Objective 1:** To increase the number and percentage of people aged 50-75 years who are screened with a test that fulfills current recommended treatment guidelines in the Washington Health System’s Primary Care Physician offices population from 68.32% in 2021 by 4.2% to 71.2% as of June 30, 2024.

Process Activities:	Responsible Party:	Timeline for completion:
1. New monthly gap reports are pulled from insurers sites. These include patients who are due for or have completed colon screenings.	WHS Population Health Team (PHT) Quality RNs	Monthly, 6-2022 to 6-2024
2. Patients’ charts from this list are reviewed to confirm that those are listed as not being completed do not have the procedure or lab results in their documents. If it is found in patients chart documents this is attached to an order and uploaded to the insurer for patient records.	WHS PHT Quality RNs	Monthly, 6-2022 to 6-2024
3. Lists of patients with confirmed gaps are passed on to the PCP offices.		

<b>Process Activities:</b>	<b>Responsible Party:</b>	<b>Timeline for completion:</b>
4. Patients on the gap list who are scheduled for a visit are flagged by office staff to be addressed at upcoming visit.	WHS PCP office staff	Monthly, 6-2022 to 6-2024
5. Call patients who have not been screened and who did not have a regular visit scheduled during the first nine months of the calendar year to educate on importance of screening and motivate them to be screened.	WHS PCP office staff and WHS PHT	September-December 2022; 2023; 2024
6. Called patients who agree to be screened are sent a FIT; or signed up for Cologuard®; or have an order placed for a colonoscopy.		
7. Provide feedback to providers and staff at least once a year on closing gap effort results	WHS PCP office staff and WHS PHT	5-31-2023 5-31-2024

**Process Objective 2:** WHS PHT to attend at least eight outreach and education events designed to raise awareness of the importance of colorectal cancer screening in people aged 50-75 years from June 30, 2022 to June 30, 2024.

<b>Process Activities:</b>	<b>Responsible Party:</b>	<b>Timeline for completion:</b>
1. Outreach and education events identified and registered to attend (13 senior centers in Washington County, annual senior fair in Greene County on First Friday in October; Different Abilities and Nutrition Security Summit; Washington County Fair Senior Citizens Day).	WHS Population Health Team (PHT) Social Worker, Pharmacists, Care Manager RNs, and Quality RNs	Annually, 6-2022 to 6-2024
2. Members of WHS' PHT attend events and educate target population.		

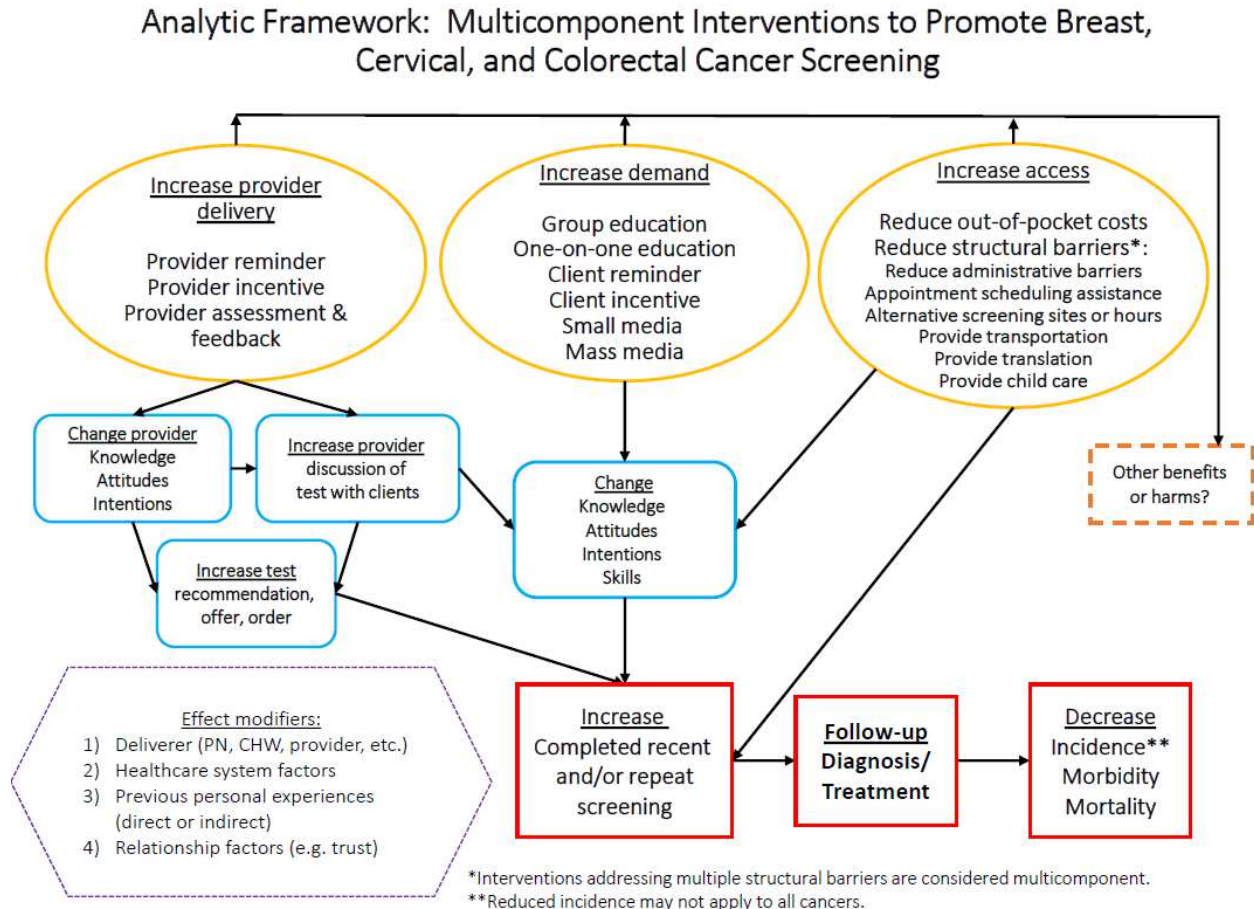
**Goal #2 Lung Cancer:** To reduce the 2020 lung cancer death rate in Washington and Greene Counties combined (40 per 100,000 population, age-adjusted, with a 95% confidence interval of 33.6-46.4) by 8.4% (to 36.7 per 100,000 population, age-adjusted) as of June 30, 2024.

**Process Objective 1:** To increase the number and percentage of people aged 50-77 years who: have a 20 or more pack year history of tobacco smoking; quit smoking tobacco within the last 15 years or are current tobacco users; and are asymptomatic for lung cancer to be screened with low dose computed tomography (LDCT) in WHS PCP offices by 100% from 766 in Fiscal Year 2022 to 1532 as of June 30, 2024.

<b>Process Activities:</b>	<b>Responsible Party:</b>	<b>Timeline for completion:</b>
1. Promote LDCT for appropriate patients to WHS offices by educating PCPs to order screening for new eligible patients and re-order annual re-screening for previously identified eligible patients through a variety of media advertisements, articles and info graphics.	WHS marketing department	On-going, 6-30-2024
2. Follow up with patients who have been ordered LDCT scans to schedule	WHS Lung Screening Navigator	On-going, 6-30-2024
3. Follow up with patients who have been scanned at appropriate intervals based on their lung RADS category		
4. Document scan outcomes in National Radiology Data Registry (NRDR), including those who are diagnosed with lung cancer and at what stage.		
5. Provide statistics on how many patients screened.		
6. Provide statistics on results of lung RADS category; number of patients diagnosed with lung cancer and at what stage.		Monthly, through 6-30-2024
		Yearly, through 6-30-2024

## Expected process outcomes and measurements

Figure 2 illustrates the colorectal cancer intervention population and where areas for policy change and intervention are located<sup>1</sup>. It also provides a framework for defining many of the colorectal cancer screening process measures.

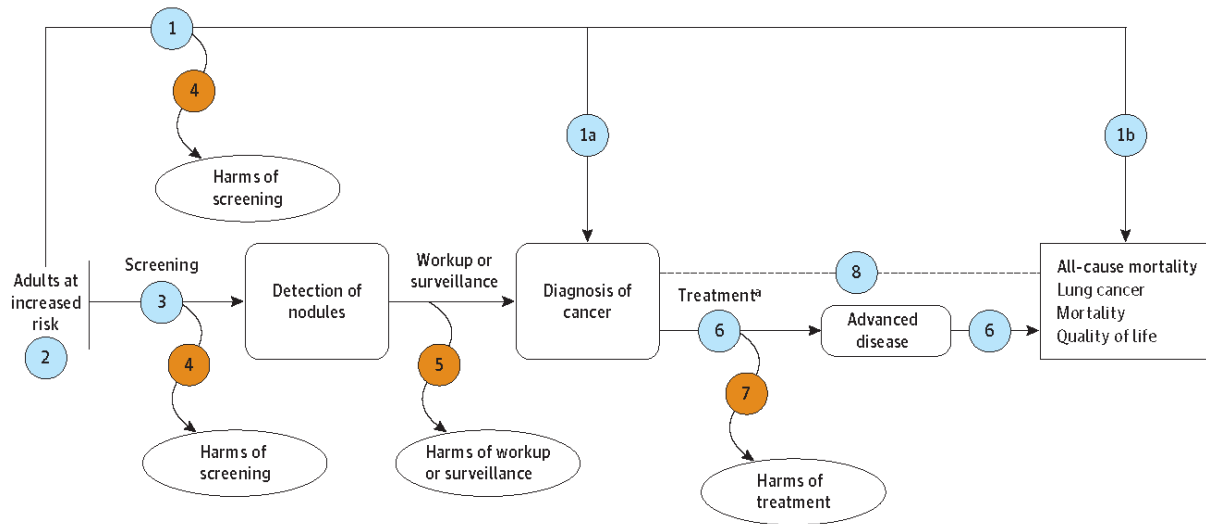


**Figure 2. Analytic Framework for Colorectal Cancer Screening Promotion.**

Figure 3 illustrates the lung cancer intervention population and where areas for policy change and intervention are located.<sup>2</sup> It also provides a framework for defining many of the lung cancer screening process measures.

<sup>1</sup>The Community Guide available online at <https://www.thecommunityguide.org/sites/default/files/assets/AF-multicomponent-cancer-screening.pdf>

<sup>2</sup> Daniel E. Jonas, MD, MPH1,2; Daniel S. Reuland, MD, MPH3,4,5; Shivani M. Reddy, MD, MSc1,6; et al. Screening for Lung Cancer With Low-Dose Computed Tomography; Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. JAMA. 2021;325(10):971-987. doi:10.1001/jama.2021.0377



**Figure 3. Analytic Framework for Lung Cancer Screening Promotion.**



Tables 1 and 2 present recommended process measures for each priority health need (colorectal and lung cancer) that should be collected and analyzed before, during and after interventions. It also identifies how the measure data are collected, who collects it, into what database it is put and who enters or extracts the data for reporting purposes.

**Table 1: Recommended colorectal cancer intervention process measures**

<b>Colorectal cancer process measures</b>	<b>How collected</b>	<b>Who collect</b>	<b>What database</b>	<b>Who enters or extracts information</b>
1. Rate of colorectal cancer deaths for Washington and Greene Counties	Death Certificate	Centers for Disease Control (CDC)	CDC WONDER ICD-10 C18-C21	LRF Consulting, LLC (LRF)
2. Percentage of invasive colorectal cancer incidence for Washington and Greene Counties	Pennsylvania (PA) cancer registry	PA Department of Health (DOH)	PA DOH EDDIE	
3. Percentage of Hospital Defined Community residents who have been screened in the past 12 months for colorectal cancer by a recommended method and time frame (USPSTF)	Community Health Needs Assessment (CHNA )	LRF	SPSS	
4. Number/percent of patients in 50-75 years age group in Washington Health System (WHS) practices	Electronic Medical Record (EMR)	WHS Population Health Team (PHT)	Eagle-Dream	WHS PHT
5. Number/percent of patients aged 50-75 years who have been screened for colorectal cancer by a recommended method and time frame (USPSTF) in WHS practices				
6. Number/percent of patients aged 50-75 years who have NOT been screened for colorectal cancer by a recommended method and time frame in WHS practices	Health Insurance	Health insurances	Health insurances	WHS PHT can extract gap reports
a. Of those not screened, how many contacted	WHS office staff and WHS PHT	WHS office staff and WHS PHT	Hand Tally	WHS office staff and WHS PHT
b. Of those contacted, how many sent Fecal Immunochemical Test (FIT) screening kits or enrolled in Cologuard® or ordered a colonoscopy				
7. Feedback given to providers				
8. Number of outreach/educational events attended	WHS PHT calendars	WHS PHT		WHS PHT

**Table 2: Recommended lung cancer intervention process measures**

<b>Lung cancer process measures</b>	<b>How collected</b>	<b>Who collect</b>	<b>What database</b>	<b>Who enters or extracts information</b>
1. Rate of lung cancer deaths for Washington and Greene Counties	Death Certificate	Centers for Disease Control (CDC)	CDC WONDER ICD-10 C34	LRF Consulting, LLC (LRF)
2. Percent distribution of early vs. late stage lung cancer incidence for Washington and Greene Counties	Pennsylvania (PA) cancer registry	PA Department of Health (DOH)	PA DOH EDDIE	
3. Percentage of Hospital Defined Community residents who fit criteria and have been screened in the past 12 months for lung cancer.	Community Health Needs Assessment (CHNA )	LRF	SPSS	
4. Number/percent of referred patients 50-77 years of age who are asymptomatic for lung cancer, have a 20 pack year or more history of smoking and have either quit in the last 15 years or are current smokers.	By physician referral	WHS Lung Screening Navigator	National Radiology Data Registry (NRDR) NRDR	WHS Lung Screening Navigator
5. Number/percent of above identified in #4 who have been screened for lung cancer by low dose computed tomography scan.	WHS Lung Screening Navigator enters into NRDR			
a. Of those screened, how many in each lung-RADS category				
i. Of those in lung-RADS category 4, how many diagnosed with lung cancer and at what stage				
6. Number/percent of above identified in #4 who have <b>NOT</b> been screened for lung cancer by low dose computed tomography scan.				

## Data Analysis

Specifying how the data will be analyzed is important to show why each piece of information is collected and how it will be used to improve and/or evaluate programs. Identifying who will perform the data analysis defines and clarifies roles. Table 3 provides a summary.

**Table 3: Recommended data analyses**

<b>Analysis</b>	<b>Time periods</b>	<b>Why</b>	<b>Who analyses</b>
2021 baseline data compared with collected program data for 2022, 2023 and 2024. Use calendar year for colorectal cancer screening and fiscal year for lung cancer screening.	quarterly and annually	To identify if and when improvements are occurring	WHS
Comparisons between different intervention sites and/or health care providers and/or data collection methods	quarterly and annually	To provide feedback for improvement and/or encourage compliance	WHS
Population data compared with program data	Annually	To identify how much impact is being made	WHS