Olathe MEDICAL CENTER

Community Health Improvement Plan (CHIP)

Fiscal Years 2025 - 2027

July 1, 2024, through June 30, 2027

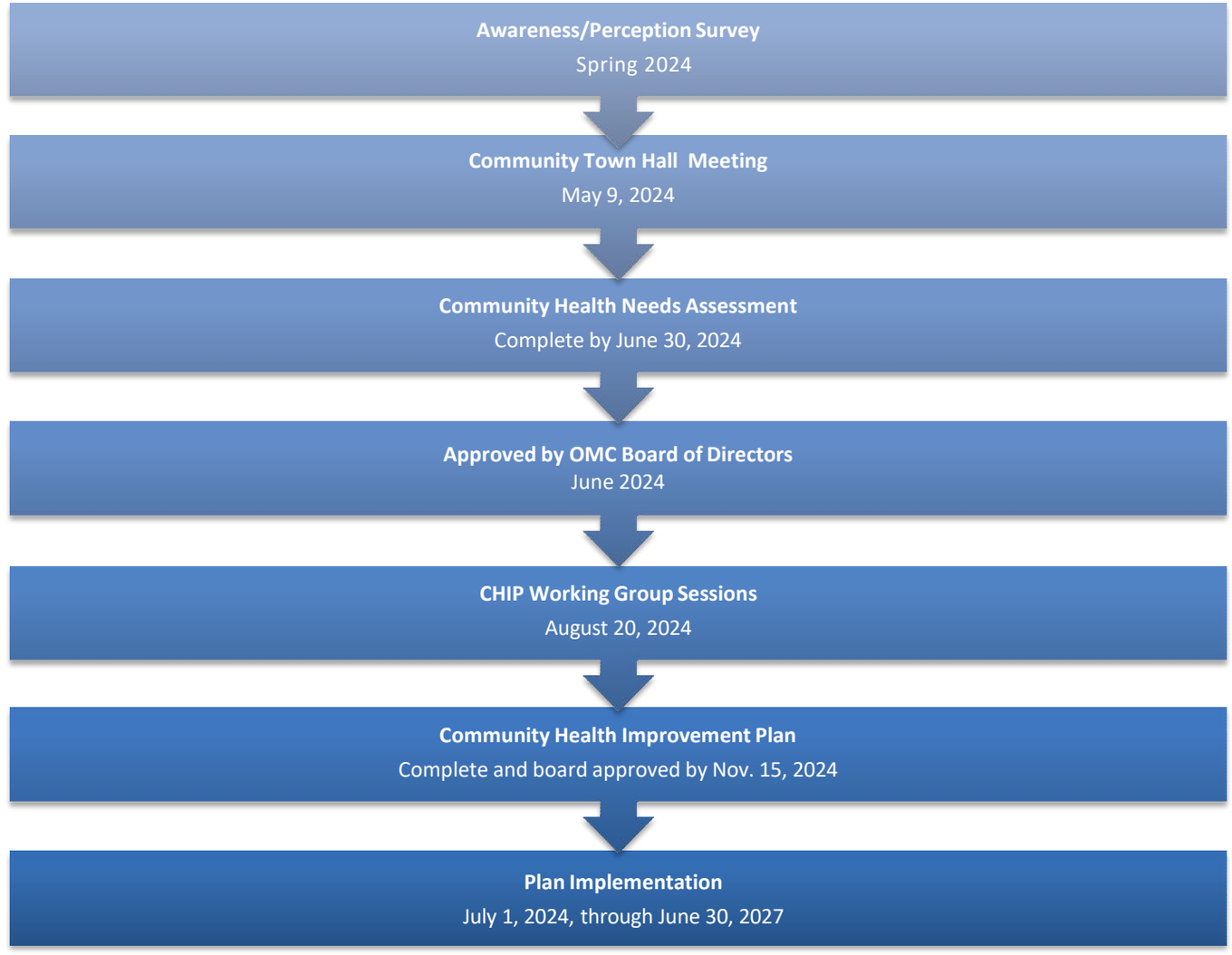
This three-year plan is subject to board approval. Initiatives and tactics may change throughout the three years to better support community engagement, new projects and programs.

Executive Summary

For more than 70 years, it has been the pleasure and privilege of Olathe Medical Center (OMC) to serve our communities. Our goal of providing the highest possible level of medical expertise, advanced technology, and professional, compassionate care has remained our guiding principle over all those decades and continues to drive us to provide the very best care for our patients and their families. While OMC is a committed partner, the overall health of our communities is a joint effort. Schools, health-related agencies, local, county and federal government agencies, religious-based groups, health insurers and businesses all play an integral role in meeting the healthcare needs of the residents of our service area.

To improve the health of communities, the Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals nationwide, including OMC, to conduct a Community Health Needs Assessment every three years. Hospitals are then required to develop and execute a Community Health Improvement Plan to meet the needs identified in this assessment. OMC, with the help of VVV Research and Development, conducted the health needs assessment for our service area of Southwest Johnson County and Miami County. This was done by performing research and collecting health data for our area, and actively seeking input from the community through a survey and town hall meetings.

Timeline for CHNA & CHIP



Community Health Needs Priorities

The research and community input helped develop a clearer picture of our service area and the health priorities of residents. The result was a list of top health priorities.

1. Mental health (diagnosis, placement and after care), access to providers
2. Crisis behavioral healthcare
3. Collaboration of community resources
4. Substance abuse (drugs and alcohol)
5. Housing (accessibility and affordability)
6. Healthcare navigators (coordination of available services)
7. Transportation

Priority #1: Increase collective community education, prevention, response and treatment for mental health conditions. Eliminate barriers to accessing care.

NEED: Our service area continues to lack adequate behavioral health resources to appropriately care for all residents with behavioral health needs. It is very difficult to identify resources to diagnose and comprehensively treat behavioral health patients.

INITIATIVE: OMC will work with its primary care network to ensure all patients are being screened for depression, and subsequently connecting those who could benefit with the appropriate resources. OMC will continue to work with community partners to develop relationships for collective impact and promote existing mental health services.

ANTICIPATED IMPACT: People who have behavioral health conditions will have more care options, resources and easier access to resources.

Priority #1: Increase collective community education, prevention, response and treatment for mental health conditions. Eliminate barriers to accessing care.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Expand capabilities to identify patients with mental health conditions and provide appropriate levels of care.	Through Olathe Health Primary Care Clinics, screen patients during wellness visits using the PHQ-9 depression screening. Continue enhancements to care management for patients with mental illness through implementation of behavioral health care management for patients with mental health conditions.	X	X	X	99% screening compliance during wellness visits. Provide appropriate resources to identified patients.
	Launch behavioral health strategic planning process.		X		Launch and complete a strategic plan for Olathe Medical Center.
	Build and expand telepsych for expanded service offering that are approved by area providers. Explore reimbursement options.			X	Develop implementation plan.

Priority #1: Increase collective community education, prevention, response and treatment for mental health conditions. Eliminate barriers to accessing care.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Continue to develop mental health relationships with key community partners for collective impact. Promote existing mental health services, facilities, and providers.	Support Olathe Communities That Care as they collaborate with community elementary, middle, and high schools to educate students on mental health (de-stigmatize mental health conditions, bullying, suicide prevention and social media bullying).	X			Support Olathe CTC and community partners as they execute communication plans.
	Provide funding to the Braden Robertson Fund through the Olathe Public Schools Foundation, which provides access to mental health professionals to Olathe students in crisis.	X	X	X	Contribute annually to support this fund through the Olathe School District.
Support community initiatives to enhance access to services.	Collaborate with community partners to complete a New Community Inventory Survey to document specific Mental Health service offerings and availability of services by hours & insurance.		X		Complete community inventory and make available to care coordinators, social workers and discharge planners.

Priority #2: Address the rise in crisis behavioral healthcare. Partner with key community entities to identify resources to provide appropriate responses to crises. Educate and train staff to reduce violence in healthcare settings.

NEED: According to analysis of the County Health Rankings, the average number of mentally unhealthy days has grown since 2021. Through the community health needs assessment process, law enforcement indicated the number of mental health calls coming into the department has also grown, nearly 50% are suicide threats and ideation. This community-based data, along with the number of assaults/injuries to hospital staff due to behavioral health crises, indicates the need for enhanced behavioral health crisis care, both in the healthcare setting and in the community setting.

INITIATIVE: OMC has created opportunities to educate staff with crisis training. Expansion of comprehensive behavioral health treatments plans through multi-disciplinary teams to manage and monitor patients. Continue to support first responders in the community to aid in addressing behavioral health crises.

ANTICIPATED IMPACT: Reduce the number of healthcare staff being assaulted/injured due to this issue and enhance the response mechanisms in the community when a behavioral health crisis is identified.

Priority #2: Address the rise in crisis behavioral health care. Partner with key community entities to identify resources to provide appropriate responses to crises. Educate and train staff to reduce violence in healthcare settings.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Continue and expand mobile crisis response teams that can be dispatched to individuals in crisis to provide on-site stabilization and determine if hospital care is necessary. If hospital care is necessary, provide staff with resources to safely care for patients and successfully discharge them with appropriate follow up care.	Partner with the City of Olathe to support the behavioral health co-responder program. This program deploys a behavioral health specialist alongside an officer to respond to emergency calls where a person is in a behavioral health crisis.	X	X	X	Contribute $50,000 annually to subsidize the salary of the behavioral health specialist employed through the Olathe Police Department.
	Explore protocols for rapid assessment and triage of individuals presenting with behavioral health crises to reduce wait times and improve care outcomes.			X	Create process for rapid assessment and triage of patients in the ER.
	In partnership with Johnson County Mental Health, develop individualized safety plans for patients being discharged from the hospital after a suicidal ideation crisis, including connections to outpatient services, medication management, and follow-up appointments.	X	X	X	Provide 90% of identified patients with safety plan.
Train hospital staff, including security personnel, in crisis intervention techniques to manage behavioral health crises effectively	Develop education plan for staff, non-violent crisis training, trauma informed care, etc. Offer training for unlicensed staff in their respective roles as they interact with patients in crisis (how to recognize escalation).	X	X	X	Launch training opportunities in FY 2025. Continue to train staff as needed.
	Train hospital staff, including security personnel, in crisis intervention techniques to manage behavioral health crises effectively. Offer educational sessions for CEU on related topics including mental health first aid training, bystander training, etc.	X	X	X	Launch training opportunities in FY 2025. Continue to train staff as needed.
	Partner with Johnson County Medical Health to provide mental health first responder resource to staff in the emergency department.	X			Provide document in print and electronic form to the staff in the ER.

Priority #2: Address the rise in crisis behavioral health care. Partner with key community entities to identify resources to provide appropriate responses to crises. Educate and train staff to reduce violence in healthcare settings.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Explore additional ways the hospital and larger health system can support community members in behavioral health crisis.	Advocate with elected officials to support violence against healthcare providers.	X			Host meeting with elected officials focused on the options, processes, and current support available to address healthcare workforce violence and to provide insight into the healthcare community in these difficult situations.
	In partnership with Johnson County Mental Health and the local health department, implement systems for tracking data related to behavioral health crises, including frequency, outcomes, and demographic information, to identify trends and improve services. Use data to continuously evaluate and improve crisis intervention strategies and hospital policies.		X		Develop policy and procedure to track relevant data and improve intervention.
	Explore sustainability of a 24/7 crisis hotline staffed by behavioral health professionals within The University of Kansas Health System/OMC to provide immediate assistance and direct individuals to appropriate care. Ensure the hotline is integrated with hospital services to facilitate seamless transitions from community-based crisis intervention to hospital care.			X	Evaluate process to launch the hotline, identify resources necessary and address barriers.
	Apply for federal, state, and local grants that support behavioral health crisis intervention and care. Continue to develop sustainable financial models for crisis services, including partnerships with insurers and other stakeholders.			X	Identify grants available for this model of care.

Priority #2: Address the rise in crisis behavioral health care. Partner with key community entities to identify resources to provide appropriate responses to crises. Educate and train staff to reduce violence in healthcare settings.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Provide education to community about crisis resources available.	Promote 9-8-8 crisis hotline (and like community resources) at community engagement events.	X	X	X	Distribute 9-8-8 educational tools at appropriate community events.
Partner with community providers, Children's Mercy and Camber, to open behavioral health inpatient facility on The University of Kansas Health System - Olathe Campus.	Complete facility upgrades and education of staff at OMC; communication and transportation between the two facilities to provide best outcomes for behavioral health patients with medical needs.	X	X	X	Identify necessary facility upgrades and complete in FY 25. Assure continuity of care between facilities through ongoing performance improvement initiatives.

Priority #3: Enhance collaboration of community resources.

NEED: According to the Robert Woods Johnson Health Rankings, Johnson County is ranked among the healthiest counties in the state. However, there are pockets within the county that lack adequate access to services. Community stakeholders identified one of the strengths in the community as the number of community resources. However, there is a need to enhance collaboration to better identify these resources and provide education on access.

INITIATIVE: OMC will leverage its community support initiatives and relationships to enhance collaboration among entities providing resources to the community. OMC will continue to provide access to education and wellness services within the community through partnerships with government agencies, community and civic groups, and the business community.

ANTICIPATED IMPACT: People who have access to and use community resources available to them will help improve overall health.

Please note: This health need is a community social determinant, thus not part hospital's mission or critical operations. Will partner with others as appropriate.

Priority #3: Enhance collaboration of community resources.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Leverage relationships with community partners to educate the community about availability of resources and how to access them. Continue to work with community organizations to provide patients with referrals to social services that address housing, food insecurity, transportation, and other non-medical needs.	Participate in the Health Equity Network that includes hospitals, local businesses, schools, and community organizations. Regular meetings can help coordinate efforts to address shared challenges like chronic disease management or health disparities.	X	X	X	Attend 90% of regular Health Equity Network meetings.
	Continue to develop a comprehensive directory of all community resources related to behavioral health, including mental health services, substance abuse programs, housing assistance, and peer support groups. Support 1800childrenks.org, United Way 2-1-1, IRIS			X	Review community resources information annually and update as needed.
Partner with community organizations, civic clubs, employers, etc. to offer wellness education and screenings.	Continue partnership with local government agencies to align hospital services with public health initiatives. This can include joint efforts on vaccination drives, mental health awareness, or substance abuse prevention.	X	X	X	Support five wellness initiatives each year and add one additional initiative each year.
	Continue to host regular health fairs in collaboration with local businesses, schools, and churches, offering free screenings and educational workshops. Partner with local experts to provide educational sessions on nutrition, mental health, and chronic disease management.	X	X	X	Participate in 10 events annually to provide access to education, screenings and other health prevention activities.
	Partner with local gyms, parks, and recreation centers to offer discounted or free fitness programs, cooking classes, and wellness workshops to promote healthy living.	X	X	X	Financially support community agencies to subsidize membership and educational opportunities.

Priority #4: Address the rise in substance abuse, including drug and alcohol use; misuse of opioids.

NEED: According to analysis of the U.S Bureau of Labor Statistics, U.S. Centers for Disease Control and Prevention and Hospital Industry Data Institute, Johnson County ranked in the middle for opioid dependence per capita. With this data and the national opioid epidemic, participants at the town hall meeting identified this as a top issue in our community. County Health Rankings reports a significantly higher percentage of excessing drinking and alcohol-impaired driving deaths in Johnson County as compared to the state of Kansas and other top performing counties across the United States. Law enforcement officers also indicated the rise of opioids (pill form) coming from outside the country and are laced with fentanyl.

INITIATIVE: OMC has created a multi-disciplinary physician team to monitor prescriptive practices. Another main focus for OMC will be to educate residents on resources for safe disposal of unused medications. OMC representatives will also actively participate in the Olathe Communities That Care task force to support education on underage drinking and drug misuse.

ANTICIPATED IMPACT: People who have access to opioids and other unused medications will have the education and access for safe disposal. Parents and local businesses will actively participate in prevention efforts of underage drug and alcohol use.

Please note: This health need is a community social determinant, thus not part hospital's mission or critical operations. Will partner with others as appropriate.

Priority #4: Address the rise in substance abuse, including drug and alcohol use; misuse of opioids.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Engage the OMC Physician Opioid Task Force to review prescription practices and provide appropriate education. *This group has implemented a number of programs to address this priority such as pain management contracts with patients, support KTRACS, intake assessments in clinics, guidelines for dispensing.*	Continue to monitor patients who have and do not have a controlled substance agreement. Develop baseline. Develop communication plan to educate providers.	X	X	X	Reduce number of prescriptions to patients without a controlled substance agreement.
Partner with local groups to promote safe drug take back practices.	Host National Take Back events on the Olathe Medical Park campus in April and October.	X	X	X	Host two events and increase pounds collected by 3%.
	Promote local drop-off locations, including locations within The University of Kansas Health System (Westwood Medical Pavilion, Bell Hospital Tower and Indian Creek).	X	X	X	Provide annual education to Olathe Health Family Medicine offices.
	Provide fentanyl test strips to patients and families through grant funding from the State of Kansas.	X			Purchase test strips and make available to health system locations.
Actively participate with the Olathe Communities That Care and support their mission to promote a safe and healthy community.	Organize and implement National Family Week campaigns, designed to encourage family time together and conversations about underage drinking.	X	X	X	Increase the number of participants at the Family Day by 3% over prior year.

Priority #5: Increase access to affordable housing solutions.

NEED: In Johnson County, the average per capita income is $56,364 while 5.4% of the population is in poverty. The severe housing problem was recorded at 10.3% compared to the Big KS Norm of 14.2%. Through data collected by Johnson County Department of Health and Environment, 23% of households in Johnson County pay more than 30% of their gross income on housing. And the median monthly housing cost for households in Johnson County has risen 24.4%. National data indicates that rising housing costs differentially impact the health and well-being of those who live in lower income households and renters compared to homeowners with greater income, likely from the increased stress and financial strain that comes from higher housing costs among those with less income.

INITIATIVE: OMC continue to work with community partners and support efforts to expand housing resources.

ANTICIPATED IMPACT: Enhance community knowledge about housing resources and raise awareness with policy makers on the need for more affordable housing.

Please note: This health need is a community social determinant, thus not part hospital's mission or critical operations. Will partner with others as appropriate.

Priority #5: Increase access to affordable housing solutions.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Continue to support community partners and their efforts to expand housing resources and partners.	Participate in a community work group to address this issue and support the homeless community. Support local church Homeless programs. Build "rebound" options for employment.	X	X	X	Participate in bi-annual work group sessions.
Identify patients within Olathe Health Primary Care clinics who are at-risk of being homeless.	Through screening patients for social determinants of health, identify patients at-risk of being homeless. Connect identified patients with community resources.	X	X	X	Complete screening during 100% of annual (wellness/physical) visits within Olathe Health primary care clinics.

Priority #6: Increase access to healthcare navigation.

NEED: Navigating the healthcare delivery system is becoming more complex than ever. In Johnson County, significantly high wait-times for emergency services, the rise in co-morbidities and lack of insurance can make navigating one's healthcare journey even more challenging. Through secondary data, the number of cancer and stroke-related deaths are increasing, as well as the number of adults dealing with high blood pressure. This data indicates those in our community are battling complex health conditions. Community stakeholders cited that within Johnson County, there is a strength in healthcare access, including primary and specialty care, and innovative approaches for access to care. However, there is a lack in coordination of available services and in educating the community on how to access necessary services.

INITIATIVE: OMC will continue and expand resources to help patients navigate the healthcare system and auxiliary resources. OMC will also work with community partners to develop campaigns to raise awareness about the availability of healthcare services and resources.

ANTICIPATED IMPACT: People who have complex medical conditions or have barriers to care (such as language, ability to pay for services, etc.) can access the care and services they need. This will also help reduce the number of re-admissions to the hospital and support an overall healthier community.

Priority #6: Increase access to healthcare navigation.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Continue to offer patient navigators, both nursing and care coordinators, to patients with complex medical diagnoses.	Continue to offer OMC patient navigators who can assist individuals in understanding their healthcare options, insurance coverage, and accessing services. These navigators can provide one-on-one guidance throughout the patient's healthcare journey. (i.e.. cancer, cardiology care coordinators in primary care).	X	X	X	Dedicate staff to support the patient population.
	Continue to support bilingual lines. Continue to recruit/work with bilingual community members to uncover best practices for disseminating information.	X	X	X	Ensure 100% of non-English speaking patients have access to bilingual support.
	Continue to educate OMC patients about resources available through Elevate (partner that helps enroll patients in the healthcare marketplace) and consider expanding services to assist with complex patients in the outpatient setting.	X	X	X	Continue to contract with Elevate to support assistance program.
Work with community partners and develop new relationships to educate the community about the availability of healthcare services.	Use local media, social media, and community events to raise awareness about the availability of healthcare services. Continue to develop brochures, infographics, and videos that simplify complex healthcare and insurance concepts. Offer materials in digital / paper formats at the time of visit.			X	Launch campaign to provide general awareness.
	Continue conversations/develop relationships with key community services (community health workers, MH, etc.) to raise awareness of navigation resources.		X	X	Conduct/participate in regular meetings to share knowledge of resources available.

Priority #7: Transportation, specifically healthcare transportation focused on reducing the number of people who are not able to keep their appointments because of lack of transportation and reduce re-admissions to the hospital because patients are not able to access the resources needed due to lack of transportation.

NEED: Availability of public transportation is a considerable issue across the Kansas City Metropolitan Area. OMC's primary service area has even fewer affordable resources and more square mileage to cover. According to the County Health Rankings, we know Johnson County has a higher rate of income inequality, long commute times and traffic volume all of which impact access to affordable transportation options. After OMC's first CHIP, the development of a mobile integrated health program was established. However, that program has reached it's capacity, therefore requiring expansion to continue to serve those with transportation barriers.

INITIATIVE: OMC will continue its financial support of the City of Olathe's Mobile Integrated Health (MIH) Program and work with the MIH team to expand services within the community. OMC will also work with community partners to develop programs to assist those who need affordable transportation services.

ANTICIPATED IMPACT: People who are at risk for hospital readmission due to lack of transportation with have the resources to get to and from their appointments, access to the medications they are prescribed and additional support services to allow them to remain in their home and manage their health conditions.

Please note: This health need is a community social determinant, thus not part hospital's mission or critical operations. Will partner with others as appropriate.

Priority #7: Transportation, specifically healthcare transportation focused on reducing the number of people who are not able to keep their appointments because of lack of transportation and reduce re-admissions to the hospital because patients are not able to access the resources needed due to lack of transportation.

Responses	Tactics	FY 2025	FY 2026	FY 2027	KPI's
Continue to work with community partners to increase awareness and availability of mobile health services and transportation resources.	Continue financial support of the City of Olathe's Mobile Integrated Health (MIH) Program and work with the MIH team to expand services within the community.	X	X	X	Provide financial support to assist with cost of the program, expand program to include a second vehicle and team able to deploy into the community.
	Advocate for and support the expansion of bus routes, especially in underserved areas. Work with local transit authorities to identify gaps in service and areas with high demand.		X	X	Participate in workgroups within the community to provide data and support for this work.
Identify all patients who have lack of transportation that might impact the ability to maintain prescribed follow up care (including recurring medical appointments, visits to the pharmacy and to and from the grocery store). Connect those identified with appropriate resources.	Screen patients for lack of transportation access. Connect identified patients with resources available in the community.	X	X	X	Screen patients during clinic and hospital visits.
	Identify all transportation resources available to OMC patients. Explore partnerships with ride-sharing companies to provide discounted or subsidized rides for patients being discharged from the hospital.	X	X	X	Utilize database of resources. Develop partnership for ride-sharing and/or subsidized rides.
	Explore and apply for additional grants for transportation opportunities to meet needs.	X	X	X	Apply for grants specific to services requiring multiple visits (i.e. cancer).