Potomac Valley Hospital

Community Health Implementation Report

July 19, 2021

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Document Acronyms

The following acronyms are used throughout this document:

Acronym	Definition
CHNA	Community Health Needs Assessment
CHIP	Community Health Implementation Plan
MCRHC	Mineral County Rural Health Clinics
PCP	Primary Care Physician
PVH	Potomac Valley Hospital
WVUHS	West Virginia University Hospital System

1 Health Topic: Obesity and Diabetes

PVH's CHNA leadership team has chosen to prioritize the topics of obesity and diabetes due to strong feedback from primary data collection and the community meeting, evidence from secondary data regarding the area population, and experience in their own clinical and other professional settings. PVH has prioritized these topics during past cycles and has already had programming and community partnerships underway to address these issues. During COVID-19, PVH was able to quickly reconfigure some programming to be offered virtually vs. in-person. This experience has helped prepare them for implementation across a variety of settings during the 2020-22 WVUHS CHNA cycle.

1.1 Strategy #1: Group Lifestyle Balance

PVH plans to host six Group Lifestyle Balance diabetes education classes yearly, open to community participation. PVH's own Diabetes Prevention Coaches will utilize course materials and tools, hosting these classes at and marketing them from the hospital.

Table 1: Group Lifestyle Balance

Group Lifestyle Balance	
Objectives	Hold six Group Lifestyle Balance classes yearly – three every six months.
Activities	• Diabetes Education and Prevention department plan for 3-6 GLB classes yearly, dates/times/location/coaches • Determine location of classes • Marketing • Contact physician referrals and self -referrals • Ground Zero Day- intake of participants • Organize participant materials for distribution • GLB classes consist of 22 educational sessions • Implement SMBP with GLB classes • GLB Coaches provide education sessions, complete BP and weights and review food and exercise journals • GLB Coaches enter data into WV Health Connections Workshop Wizard • Diabetes Education and Prevention submit data to CDC for program recognition requirements • Reports to participants' PCPs • Reports to Diabetes Education Committee
Planning Partners	• PVH Diabetes Prevention Coaches • Family Resource Network
Implementation Partners	• PVH Diabetes Prevention Coaches • WV Health Connection (utilize Workshop Wizard for data collection)

Resources	• Space to hold classes • Materials to purchase: GLB worksheets and notebook, Calorie Kings, pedometers, therabands
Evaluation Activities	# classes held # attendees per class Educational materials provided
Point of Contact	Diabetes Education and Prevention Coordinator

1.2 Strategy #2: Diabetes Support Group

PVH's Diabetes Education Department will host an ongoing Diabetes support group throughout each year. A variety of topics and speakers will be planned.

Table 2: Diabetes Support Group

Diabetes Support Group	
Objectives	Host diabetes support group 6-12 times per year.
Activities	• Marketing • Plan for occasional guest speaker • Plan for topics for sessions • Provide samples as available
Planning Partners	• Marketing • Diabetes Education Department
Implementation Partners	• Marketing • Diabetes Education Department
Resources	• Space for group meeting • Time of facilitator • Educational materials/samples of health and personal hygiene products
Evaluation Activities	# groups held per year # participants per group
Point of Contact	Diabetes Education and Prevention Coordinator

1.3 Strategy #3: Dining with Diabetes

PVH will partner with their local West Virginia University Extension office to offer to the community an existing Dining with Diabetes curriculum/class, as well as two exercise classes along with them. https://extension.wvu.edu/food-health/diabetes/dining-with-diabetes

Table 3: Dining with Diabetes

Dining with Diabetes	
Objectives	Each year, PVH will host one Dining with Diabetes course consisting of four classes.
Activities	• Plan for dates • Marketing Plan • Sign up for participants • BPs and education for participants • 2 exercise class
Planning Partners	• WVU Extension Services • PVH Dietary • PVH Diabetes Education • First United Methodist Church • Marketing
Implementation Partners	• WVU Extension Services • PVH Diabetes Education • First United Methodist Church
Resources	• Space for classes • Print materials from WVU • Food • CDE time
Evaluation Activities	• # classes held • # participants per class • Pre/post survey • Feedback survey
Point of Contact	Diabetes Education and Prevention Coordinator

1.4 Strategy #4: Healthy Hearts for Kids

PVH staff will continue implementation of a successful youth-centric program that was developed and carried out in local schools prior to COVID-19. The program paused when schools closed down during that academic year, but community feedback indicates there are many families and participants who hope it will return. For the upcoming academic years of this cycle, PVH will partner with all Mineral County elementary and middle schools.

Table 4: Healthy Hearts for Kids

Healthy Hearts for Kids	
Objectives	Each month, conduct two sessions at a one school; rotate schools monthly during 2021-2022, 2022-2023, and 2023-2024 academic years.
Activities	• Send confirmation letter to Mineral County School Board (done each year June/July) • Preventive Medicine Staff and Dietician collaborate on activities and education plans • Coordinate with individual principals to plan calendar of programming • Verify that site contact for each school will be present on site to dismiss the students to their caregivers • Develop schedule for Preventive Medicine staff, dietician and ancillary staff for coverage to support the HHK program • Introduction and participation form/letter home to parents • Obtain permission slip signed by parents • Prepare print materials • Gather items for activities with students • Check for food allergies on permission slips/plan healthy snack
Planning Partners	• Mineral County Schools • PVH Dietician • PVH Dietary • Preventive Medicine Department Staff • www.choosemyplate.gov • American Council of Exercise: Operation Fit Kids
Implementation Partners	• Mineral County School Superintendent • Mineral County School Nurses and Teachers • Mineral County Primary and Intermediate School Principals
Resources	• Marketing • Designated space for each school • Snacks for participants • Take-home educational handouts • Props/supplies for physical activities
Evaluation Activities	# after-school classes per school # kids participating per school Feedback surveys
Point of Contact	Preventive Medicine Department Director

1.5 Strategy #5: PVH Wellness Zone

The PVH Wellness Zone provides monthly educational content, exercise opportunities, nutrition information, and more. The "Cooking for a Healthy Connection" component of this program will be carried out in partnership with local restaurants. Each month a restaurant will host a cooking demonstration of a healthy meal option, and will then offer that meal as part of the menu of their establishment for a month.

Table 5: PVH Wellness Zone

PVH Wellness Zone	
Objectives	Provide monthly schedule of updated educational content, guest speakers, and exercise virtually and live in the community. Events posted on face book site and paper schedule shared by community partners' emails/list servs, PVH clinics, libraries, and churches.

Activities	• Plan monthly schedule:
	  ○ Exercise – 2-4 monthly
	  ○ Healthy Hearts for Kids – 1-2 monthly
	  ○ Nutrition - 1 per month
	  ○ Mental Health - 1 per month
	  ○ 1-2 National Health Observances per month
	  ○ 4-6 guest speakers per year (PVH staff or licensed care providers)
	  ○ 4-6 Cooking Demos per year
	  ○ Cancer Prevention information - 4-6 per year
	• Marketing
	• Recruit guest speakers
	• Obtain space for in-person events

Planning Partners	• Marketing • Preventive Medicine Department Staff • PVH Ancillary Departments • Restaurant partners for "Cooking for a Healthy Connection"
Implementation Partners	• Mineral County Schools • Area Churches • Libraries • PVH Clinics • PVH LCP's • PVH Ancillary Departments • Local restaurant partners
Resources	• Marketing • Educational Handouts

Evaluation Activities	# of monthly virtual events # of in person community events # of guest speakers per year # of cooking demos per year # of nutritional events per year # of Guest Speakers per year # of Mental Health Related post per year # of Cancer Prevention posts per year # of virtual Healthy Hearts for Kids events per year # of followers per year
Point of Contact	Preventive Medicine Department Director

1.6 Strategy #6: PVH Walking Track

PVH's community track, funded by a Take Back Your Health WV grant, offers organized activities for families, employees, and residents of Mineral County and the surrounding area. Group activities boost motivation, promote community engagement, and create support systems. The walking track program goals are to help promote prevention, and for some residents decreases blood pressure, blood sugar, and/or weight. Lastly, the momentum for the use of the track will be encouraged through system/policy change, with PVH clinics using the HER for Physical Activity assessment/referrals/prescriptions. At least 1-2 different walking groups will be implemented by PVH Preventive Medicine Department. Involved staff will advocate for indoor walking space so that Walking for Wellness can continue October-April.

Table 6: PVH Walking Track

PVH Walking Track	
Objectives	Provide motivation for physical activity with organized walking programs offered May through September, twice a week in the morning and afternoon. Track is open for community use.
Activities	• Advertising/marketing walking programs • Find Incentives for participants' steps/miles goals met • Challenges
Planning Partners	• Marketing • Preventive Medicine Department • Take Back Your Health WV – 2020 Grant Administrator
Implementation Partners	• PVH Clinics (Physical Activity Assessments and Physical Activity Prescription and educate patients about PVH track and walking programs available) • Preventive Medicine Staff
Resources	• Marketing

	• Lap Counters • Walking incentives given for steps/miles goals met
Evaluation Activities	# walking programs offered # of participants per month Participants' steps/miles logged
Point of Contact	Preventive Medicine Department Director

1.7 Strategy #7: Supermarket Shopping Tours

PVH will work in conjunction with a local grocer to host 4-6 supermarket shopping tours yearly. Lead by PVH Dietician, available both virtually and in-person, these tours will work to educate participants about healthy nutrition choices.

Table 7: Supermarket Shopping Tours

Supermarket Shopping Tours	
Objectives	Host 4-6 supermarket shopping tours yearly.
Activities	• Determine dates • Schedule dates for Dietician • Identify partner grocer • Order books for participants • Open/market registration • Schedule reminder calls • Tour market with PVH Dietician
Planning Partners	• PVH Dietician • Preventive Medicine Department • Local participating grocer(s) • Marketing
Implementation Partners	• PVH Dietician • Preventive Medicine Department • Local participating grocer(s) • Marketing
Resources	• Marketing (flyers and advertisement) • Super Market Shopping Guide Handout/Booklet • ADA • PVH Dietician
Evaluation Activities	# tours held # participants

	# participating grocers Participant feedback surveys
Point of Contact	Dietician and Preventive Medicine Department

1.8 Strategy #8: Food FARMacy Program

PVH's FARMacy program will operate in conjunction with its Rural Healthcare Clinics. It is anticipated to run for 12 to 15 sessions, and will consist of farm food boxes, cooking demonstrations, healthy lifestyle education, pre/post surveys and pre/post lab and physical measurements.

MCRHC's LCPs will identify 15 patients with at least one of the following: diabetes, hypertension, obesity and/or elevated lipids. Patients will be educated about the program – its purpose, dates, activities, what is monitored – as well as requirements of commitment and attendance for the entire program. The following will be completed upon registration: WV FARmacy Program Screening Tool, consents for medical tests/services and any additional surveys that may be requested by WVU Extension.

In addition to sign up tools and consent, pre/post screenings will be completed and consist of: FARMacy pre/post survey; pre/post measurements of blood pressure, height, weight; pre/post lab work of: fasting blood sugar, hemoglobin, A1c, and a lipid panel (if not done within past 3 months and no recent med changes). Pre/post labs, measurements, and surveys will be documented in patient's EPIC chart and in WV Health Connection's Workshop Wizard.

During the 12-week period, WVU Extension is a FARMacy community partner and will provide cooking demonstrations and healthy eating education for 6-9 sessions. For the remaining weeks, PVH Preventive Medicine will provide education and/or activities on healthy lifestyles, food benefits, and recipes to promote the message "Food is Medicine".

PVH will provide each participant with a blood pressure cuff. Preventive Medicine staff will provide blood pressure education and complete weekly BP checks. PVH's dietician will offer a supermarket shopping tour opportunity for each participant. The dietician will meet them in small groups at a local market for the tour. Participants will be given a Super Market Tour booklet when attending and a $10 dollar market card to spend on healthy food. In addition, Mineral County's Family Resource Network will be a partner and will provide community resource presentations and have small incentive items to give participants.

During the 12 weeks participants will also be given the PVH Wellness Zone schedule and Facebook site. They will also be encouraged to participate in Walking for Wellness at PVH's Take back Your Health WV grant funded track located on Staggs Lane.

FARMacy boxes will be supplied to PVH's MCRHC weekly for 12 weeks by Flying W Farms. Participants will be given date/time/ location for pickups, BPs and class. Participants will be called the night before for FARMacy date/time reminder. Before the last FARMacy workshop/pickup participants will have repeat labwork, physical measurements, complete post survey forms and feedback survey. Knowing how to prepare the fresh produce as well as the nutritional benefit it provides is an important

educational component that will be covered weekly by combined efforts of PVH staff and WVU Extension staff. The participants will receive support from their LCP and will also have a weekly phone call from a PVH Community Healthcare Worker. The CHW will provide support, motivation, follow up with any questions/concerns, reinforce weekly information provided and magnify the message "Food is Medicine".

In the event any social distancing restrictions should occur, plans are in place for a virtual platform for group classes as well as safe delivery of produce to participants. All PVH and state safety guidelines will be followed. The data collected can be used to encourage continuation of healthy eating, and promote the message that food is medicine. In addition, promoting continuation of any other lifestyle changes that they may have made during the program. Evaluation of data and outcomes will be shared with hospital leadership and healthcare providers. It is important to share data results and the FARMacy concept and effectiveness of connecting patients to healthy affordable food and educational resources to learn more about preparation and nutritional value. This will help with sustainability of future FARMacy programs locally and statewide.

Table 8: Food FARMacy Program

Food FARMacy Program	
Objectives	Hold 1 -2 FARMacy programs per year. FARMacy programs consist of 12-15 weekly sessions.
Activities	• Collaborate with LCP's for referrals for FARMacy • Secure farmer/farmers market for produce supply • Contact referrals with offer and schedule intake appointment if they verbalize commitment to FARMacy program • Confirm location for sessions • Develop schedule with WVU Extension, Mineral County FRN, PVH Preventive Medicine Staff, produce supplier, and PVH Dietician • Copy handouts and put notebooks together for participants • Reminder calls for beginning of program, supermarket shopping tour dates and as needed • Secure market to be used for shopping tours • Order pocket Super Market Tour Guides for handouts • Determine incentives, Farmers Market vouchers, gift cards for participants to use during supermarket shopping tours • Communicate to providers who of their referrals signed up for FARMacy program • Enter pre/post data into WV Health Connections, Workshop Wizard • Remind providers of orders for labs at end of program and schedule with participants • Share feedback data to providers
Planning Partners	• Preventive Medicine Department

	• FARMacy Program/Dr. Carol Greco • Local farmer(s) and markets • WVU Extension Family Nutrition Program • Office of Health Services Research • West Virginia University School of Public Health • WV Health Connections • Mineral County Resource Network • Church(es) for space • Marketing
Implementation Partners	• Preventive Medicine Department staff • LCP's referrals/PVH Rural Healthcare clinics • Farmer(s) • Mineral County FRN • Church partner • WV Health Connections • WVU Extension Agent(s) • AHA/AMA SMBP program • Marketing
Resources	• Produce to participants • Cooking demos • Food samples • Educational print materials • Recipes • Blood pressure cuffs • Notebooks • Logs for weight, blood pressure, and blood sugar • Bathroom scale as needed • Cookbooks • Incentives • Supermarket gift card and/or farmer's market voucher • Listing of local farmers markets' schedules • Reminder calls • Schedules for sessions and Super Market Shopping Tours
Evaluation Activities	# of participants Pre/post surveys Pre/post Hgb, A1c, and cholesterol levels
Point of Contact	Preventive Medicine Department Director

1.9 Strategy #9: Obesity & Nutrition Community Education

Feedback gathered during primary data collection showed repeated requests for community education. This strategy will provide education surrounding obesity, nutrition, and healthy habits no less than once monthly.

Table 9: Obesity & Nutrition Community Education

Obesity & Nutrition Community Education	
Objectives	Obesity/nutrition topics will be addressed or a community activity will be provided no less than once per month.
Activities	• Identify speakers • Identify space and dates for community forums/events • Schedule virtual events on PVH Wellness Zone • Monthly PVH Wellness Zone schedule distributed to churches, libraries, food pantries, schools, health clinics, health department and Mineral County FRN and events posted on Facebook • Monthly health observances as related
Planning Partners	• Preventive Medicine Department • WVU Medicine LCPs • Guest speakers/ activity presenter • Marketing PVH Dietician and Dietary Department • Ancillary Staff
Implementation Partners	• Preventive Medicine Department • WVU Medicine LCPs • Guest speakers/ activity presenters • PVH Dietician and Dietary Department • Marketing • Partners for Space for events (schools, churches, parks, Brookedale Farms)
Resources	• National Health Observances - Monthly, Weekly, and days • AHA • WV Health Connections • CDC • WV Division of Health Promotion and Chronic Disease
Evaluation Activities	• Details of activities • Dates • # of people attended • # of Facebook followers of PVH Wellness Zone
Point of Contact	Preventive Medicine Department Director

2 Health Topic: Substance Use, Abuse, and Mental Health

Throught this 2020-22 CHNA's cycle's process, PVH leadership saw issues surrounding substance use and mental health rise to the top of the community's concerns. This was also the case in the previous CHNA cycle, and in anticipation of ongoing concern, PVH has used time and resources to build out infrastructure that will allow them to address these topics to a greater degree in this cycle's implementaiton plan.

2.1 Strategy #1: Smoking Cessation Program

Group smoking cessation classes will be offered to the PVH community four times a year. Participants will be recruited from provider referrals, and classes will also be offered to the community.

Table 10: Smoking Cessation Program

Smoking Cessation Program	
Objectives	Group Smoking Cessation Classes will be offered to the community 4-6 times per year. These will be held in-person and can also be available virtually via Vidyo.
Activities	• Check Preventive Medicine Workquese daily • Marketing to community and PVH Clinics • Contact referrals to sign up for group or individual tobacco cessation • Accept self-referrals from the community • Participants meet with Shannon Sprenkle, NP, then follow up with Preventive Medicine for remainder of sessions • NP to follow through with some group sessions as available and as needed
Planning Partners	• Shannon Sprenkle NP, Certified Tobacco Treatment Specialist • Patricia Barbarito RN, Certified Tobacco Treatment Specialist • Marketing
Implementation Partners	• Preventive medicine Department • Tobacco Treatment Specialist • Marketing
Resources	Preventive Medicine Workquese in EMR
Evaluation Activities	• # of classes offered • # of referrals for smoking/tobacco cessation • # of participants • Feedback Surveys
Point of Contact	Certified Tobacco Treatment Specialists

2.2 Strategy #2: Families Strong

Families Strong is a support group for family members of substance users. The program focuses on helping family members develop self-care, build social supports, and learn effective motivational strategies for interacting with a loved one who is struggling with substance abuse disorder.

Table 11: Families Strong

Families Strong	
Objectives	Host 3-6 Families Strong groups over three years. Each group will meet for nine weeks of closed group session meetings, with each weekly meeting lasting for two hours.
Activities	• Preventive Medicine staff complete Leader training for Families Strong format/content • Advertise • Registrations via Mosaic/PVH • Schedule dates/location • Give schedule of sessions to participants • Complete information needed required by Mosaic
Planning Partners	• Preventive Medicine department • Mosaic • Marketing
Implementation Partners	• Preventive Medicine Department • Mosaic • Marketing
Resources	• Space and/or Vidyo for sessions • Materials copied for participants
Evaluation Activities	# groups # participants Feedback surveys
Point of Contact	Preventive Medicine Department and Mosaic

2.3 Strategy #3: Living a Healthy Life with Chronic Pain

This strategy is an evidence-based self-management program, led by two Preventive Medicine Department staff, and is open to both clinic patients and to the community as a whole.

Table 12: Living a Healthy Life with Chronic Pain

Living a Healthy Life with Chronic Pain	
Objectives	Living a Healthy Life with Chronic Pain- evidenced based self-management program, six-week program. Open to Community and Pain Clinic patients. Offered 4- 6 times per year. Six-week program.
Activities	• Ellen Barnard and Patricia Barbarito complete training at WVSOM • Marketing • Determine space for class, virtual option available with Vidyo • Materials for participants
Planning Partners	• PVH Pain Clinic • Marketing • Preventive medicine department Staff
Implementation Partners	• PVH Pain Clinic • Marketing • Preventive Medicine Department
Resources	• WVSOM Leader training - Living a Healthy Life with Chronic Pain • Dr Soriano, PVH Pain Clinic
Evaluation Activities	# of classes offered # of participants Pre/post Surveys Feedback surveys
Point of Contact	PVH Preventive medicine Department Director

2.4 Strategy #4: Substance Use Education for Schools

In conjunction with Mineral County Schools, provide educational material related to smoking, tobacco, and vaping. Possibly partner with Mineral county Sheriff's Department to provide prevention education about risky behaviors, including substance use, at least twice per year.

Table 13: Substance Use Education for Schools

Substance Use Education for Schools	
Objectives	Substance Use Education and Prevention displays/presentations will be provided at least 4-6 times over a 3-year time period, during school or at school events.
Activities	• Collaborate with community partners • Determine dates, locations, events to schedule the substance use and prevention education sessions • Recruit volunteers

	• Recruit guest speakers
Planning Partners	• Mineral County Schools • Potomac Valley Hospital • Mineral County Sheriff's Department • Mineral County Family Resource Network • Mineral County Healthy Lifestyles Coalition
Implementation Partners	• Mineral County Schools • Potomac Valley Hospital • Mineral County Sheriff's Department • Mineral County Family Resource Network • Mineral County Health Department • Mineral County Healthy Lifestyles Coalition
Resources	• Educational material from CDC ACS, SAMSHA, and NIDA • Substance use displays • Location/space for presentations • PVH and community partners' time for planning and presentations • Laptop and projector to take to various locations
Evaluation Activities	# of presentations Dates and location of presentations List of Volunteers and community partners at events Pre/Post surveys when applicable Feedback surveys
Point of Contact	Preventive Medicine Department Director

2.5 Strategy #5: Naloxone Trainings

In conjunction with the Mineral County Health Department, PVH will host at least three Naloxone trainings over a 3-year time period.

Table 14: Naloxone Trainings

Naloxone Trainings	
Objectives	Host at least 3 Naloxone trainings over a 3-year time period
Activities	• Collaborate with Mineral County Health Department, PVH Pharmacy Director, PVH Emergency Department Director/Coordinator • Training for pharmacy and ED staff to lead trainings
Planning Partners	• Mineral County Health Department • PVH Pharmacy

	• Preventive Medicine Department • Emergency Department Director/Coordinator • WVOEM
Implementation Partners	• Mineral County Health Department • PVH Pharmacy • PVH Emergency Department • Preventive Medicine Department
Resources	• Location for training • Funding for Naloxone kits • Trainers' time • Pharmacy's time
Evaluation Activities	# individuals trained Location and date of trainings # kits distributed Post Training Survey
Point of Contact	Pharmacy Director, Emergency Room Director and/or Coordinator

3 Health Topic: Cancer

Cancer is a third topic about which secondary data and community members expressed much concern, and about which PVH leadership saw opportunity to affect health outcomes. PVH will carry on existing programming as well as explore and implement some new strategies to benefit those in their community.

3.1 Strategy #1: Cancer Prevention Education

PVH will promote cancer screenings and raise awareness about prevention and early screenings via community education provided by Preventive Medicine Department and PVH Wellness Zone.

Table 15: Cancer Prevention Education

Cancer Prevention Education	
Objectives	Provide Cancer Prevention Education to the community at least 6 times per year
Activities	• Identify National Observances to coordinate education scheduled • Secure Guest Speaker(s) • Develop Power Points for various Cancer Prevention Education • Cancer Prevention education to be delivered in person, by phone, virtually on PVH Wellness Zone, and at Community Events
Planning Partners	• Infusion Center staff

	• Shania Parsons NP, Infusion Center • Dr. Boyd Sprenkle - Pulmonologist • Dr. Viglianco - Surgeon • Dr. Stephens - Surgeon • PVH Rural Healthcare clinics NPs • Marketing • Preventive Medicine Staff • Radiology Department
Implementation Partners	• Infusion Center staff • Shania Parsons NP, Infusion Center • Dr. Boyd Sprenkle - Pulmonologist • Dr. Viglianco - Surgeon • Dr. Stephens - Surgeon • PVH Rural Healthcare clinics NPs • Marketing • Preventive Medicine St • Radiology Department
Resources	• Time to prepare presentations • Time to develop a schedule for various Cancer Prevention topics • Marketing virtually and in person
Evaluation Activities	# of power point presentations # of guest speakers # of in community presentations
Point of Contact	Preventive Medicine Department and Infusion Center LCP

3.2 Strategy #2: WV Mountains of Hope Cancer Coalition

PVH staff participants attend monthly WV Mountains of Hope Cancer Coalition meetings during their workday to learn about resources available to their patients and to the community, trends in treatment, opportunities for education, and to strengthen new and existing partnerships.

Table 16: WV Mountains of Hope Cancer Coalition

WV Mountains of Hope Cancer Coalition	
Objectives	PVH staff participates in monthly coalition meetings to learn about cancer resources, trends, learning opportunities, and gain community and state connections/partnerships
Activities	• Preventive Medicine staff will become member of WV Mountains of Hope • Goal to have at least one Preventive medicine staff to attend a monthly meeting

	• Use resources to educate community, and PVH Team • Support WV Mountain of Hope by sharing their information and promoting cancer prevention/education
Planning Partners	• MOH • Preventive Medicine Department • Shania Parson NP, PVH Infusion Center
Implementation Partners	• Preventive medicine Department • Shania parsons NP, PVH Infusion Center
Resources	• Time for meetings worked into monthly schedule • PC with camera and headset
Evaluation Activities	• # coalition meetings attended • PVH Staff attended
Point of Contact	• PVH Prevention Departments • Infusion Center LCP

3.3 Strategy #3: Smoking Cessation Program

Group smoking cessation classes will be offered to the PVH community four times a year. Participants will be recruited from provider referrals, and classes will also be offered to the community.

Table 17: Smoking Cessation Program

Smoking Cessation Program	
Objectives	Group Smoking Cessation Classes will be offered to the community 4-6 times per year. In person and can be available virtually via Vidyo
Activities	• Check Preventive Medicine Workquese daily • Marketing to community and PVH Clinics • Contact referrals to sign up for group or individual tobacco cessation • Accept self-referrals from the community • Participants meet with Shannon Sprenkle, NP, then follow up with Preventive Medicine for remainder of sessions • NP to follow through with some group sessions as available and as needed
Planning Partners	• Shannon Sprenkle NP, Certified Tobacco Treatment Specialist • Patricia Barbarito RN, Certified Tobacco Treatment Specialist • Marketing
Implementation Partners	• Preventive medicine Department • Tobacco Treatment Specialists

	• Marketing
Resources	Preventive Medicine Workquese in Electronic Chart
Evaluation Activities	# of classes offered # of referrals for smoking/tobacco cessation # of participants Feedback Surveys
Point of Contact	Certified Tobacco Treatment Specialists

3.4 Strategy #4: PVH Wellness Zone

The PVH Wellness Zone provides monthly educational content, exercise opportunities, nutrition information, and more. The "Cooking for a Healthy Connection" component of this program will be carried out in partnership with local restaurants. Each month a restaurant will host a cooking demonstration of a healthy meal option, and will then offer that meal as part of the menu of their establishment for a month.

Table 18: PVH Wellness Zone

PVH Wellness Zone	
Objectives	Provide monthly schedule of updated educational content, guest speakers, and exercise virtually and live in the community. Events posted on face book site and paper schedule shared by community partners' emails/list serves, PVH clinics, libraries, and churches.

Activities	• Plan monthly schedule:
	  ○ 2-4 exercise per month
	  ○ 1-2 Healthy Hearts for Kids per month
	  ○ Nutrition 1 per month
	  ○ Mental Health 1 per month
	  ○ 1-2 National Health Observances per month
	  ○ 4-6 guest speakers per year (PVH staff or licensed care providers)
	  ○ 4-6 Cooking Demos per year
	  ○ Cancer Prevention information 4-6 per year
	• Marketing
	• Recruit guest speakers
	• Obtain space for in-person events

Planning Partners	• Marketing • Preventive Medicine Department Staff • PVH Ancillary Departments • Restaurant partners for "Cooking for a Healthy Connection"
Implementation Partners	• Mineral County Schools

	• Area Churches • Libraries • PVH Clinics • PVH LCP's • PVH Ancillary Departments • Local restaurant partners
Resources	• Marketing • Educational Handouts
Evaluation Activities	# of monthly virtual events # of in person community events # of guest speakers per year # of cooking demos per year # of nutritional events per year # of Guest Speakers per year # of Mental Health Related post per year # of Cancer Prevention posts per year # of virtual Healthy Hearts for Kids events per year # of followers per year
Point of Contact	Preventive Medicine Department Director

3.5 Strategy #5: Support Services – Advance Directives

This strategy supports patients who may need to complete documents as part of their care, but is also available to the community for those who may need education about the process or help completing it.

Table 19: Support Services - Advance Directives

Support Services – Advance Directives	
Objectives	Assist community members with Advance Directive education and process and assist in completing as needed.
Activities	Place Advance Directive materials in Care Management Department
Planning Partners	• Physicians • PVH Clinics • Care Management
Implementation Partners	• Care Management
Resources	• WV Ethics Committee
Evaluation Activities	# of assisted completion of Advanced Directives # of community events
Point of Contact	Care Management Director

3.6 Strategy #6: Rural Health Clinic Education

This strategy works to provide resources – and connections to needed resources – to patients of PVH rural health clinics and their family members.

Table 20: Rural Health Clinic Education

Rural Health Clinic Education	
Objectives	Educate Rural Health Clinic patients on self-management of chronic disease, need for preventive care and screenings, and more.
Activities	• Community Health Worker, Preventive Medicine Department Director, Coordinator of Rural Health care clinics, and LCP's will collaborate on patient's care plan and education • CHW and/or NN will provide education to Rural Health care clinic patients as identified and as referred to Preventive Medicine Department • CHW will help locate resources for SDOH needs as identified and/or requested by patient and/or RHC clinics
Planning Partners	• PVH Rural Healthcare Clinic Coordinator • PVH Preventive Medicine Department Director • LCP's
Implementation Partners	• Licensed care providers at Rural Healthcare Clinics • Nurse Navigator • Community Healthcare Workers • RHC Clinic Staff • RHC Clinic Coordinator • Preventive Medicine Department Director
Resources	• Notebooks for patients • Educational materials for patients • BP cuffs for patients • Bathroom scales for patients • Pill organizers for patients • Community Resources list of contacts • Laptop for CHW/NN • Mileage for CHW/NN for travel to patient homes
Evaluation Activities	# of patients contact by CHW/NN monthly
Point of Contact	Preventive Medicine Department Director

4 Health Topic: Chronic Disease Management

This topic was among the communiyt's top health concerns along with obesity and diabetes. For the purpose of implemention planning in this CHIP, PVH leadership has chosen to address chronic disease management in its own category.

4.1 Strategy #1: Group Lifestyle Balance

PVH plans to host six Group Lifestyle Balance diabetes education classes yearly, open to community participation. PVH's own Diabetes Prevention Coaches will utilize course materials and tools, hosting these classes at and marketing them from the hospital.

Table 211: Group Lifestyle Balance

Group Lifestyle Balance	
Objectives	Each year, PVH will host one Dining with Diabetes course consisting of four classes.
Activities	• Plan time frame, space, involved PVH staff • Obtain needed materials • Marketing: Facebook, local newspaper, via medical staff meetings, via primary care providers not in WVUH network
Planning Partners	• PVH Diabetes Prevention Coaches • Family Resource Network
Implementation Partners	• PVH Diabetes Prevention Coaches • WV Health Connection (utilize Workshop Wizard for data collection)
Resources	• Space to hold classes • Materials to purchase: GLB worksheets and notebook, Calorie Kings, pedometers, therabands
Evaluation Activities	# classes held # attendees per class Educational materials provided
Point of Contact	Diabetes Education and Prevention Coordinator

4.2 Strategy #2: Better Breathers Support Group

Though this support group was started for patients with COPD, it is open to community as a standing support group for those with breathing issues.

Table 222: Better Breathers Support Group

Better Breathers Support Group	
Objectives	Offer at least 6 Better Breathers Support Group meetings per year.
Activities	• Plan for topics to be discussed at support Group • Marketing of Meetings
Planning Partners	• Cardiopulmonary Department • Pulmonary Rehabilitation Department • Dietary department • Marketing • American Lung association
Implementation Partners	• Pulmonary Rehabilitation and Cardiopulmonary
Resources	• Meeting Space • Staff time for planning and facilitating meetings
Evaluation Activities	• Date/time support groups offered • # of participants per meeting • Feedback surveys
Point of Contact	Better Breathers Facilitator/ CardioPulmonary Rehabilitation Department

4.3 Strategy #3: Rural Health Clinic Education

This strategy is another that reaches individuals when they are patients but provides resources to whole families where needed. .

Table 233: Rural Health Clinic Education

Rural Health Clinic Education	
Objectives	CHW/Nurse Navigator will complete follow up calls on ACO and those at risk for admission/readmission, with a goal to reach as many patients as possible after discharge from PVH Emergency Department and inpatient discharges.
Activities	• Run reports of discharges daily (T-F) from MedSurg and ED • Run reports of past 3 days from MedSurg and ED every Monday • Follow up calls to patients • Make follow up appointments as needed • Find community resources as needed • Verify patient understands discharge instructions

	• Verify patient understands medications and has new prescriptions • Patient education • Listen to patient concerns if voiced and document as needed in event reporting system • When patient gives special recognition of PVH staff document in event reporting system • Home visits as needs identified • Provide notebooks for materials, BP cuffs, bathroom scales and pill organizers as needs identified
Planning Partners	• PVH Nurse Navigator • PVH Community Health Worker • PVH RURAL Healthcare Clinics' staff, LCP and leadership team • PVH Preventive Medicine Department Director
Implementation Partners	• PVH Nurse Navigator • PVH Community Health Worker • PVH RURAL Healthcare Clinics' staff, LCP and leadership team • PVH Preventive Medicine Department Director
Resources	• CHW time • NN Time • Patient education materials • Funding for BP cuffs, bathroom scales, and notebooks and pill organizers
Evaluation Activities	# of patients called monthly by NN # of patients called monthly by CHW # of home visits completed monthly
Point of Contact	Preventive Medicine Department Director

4.4 Strategy #4: Transition of Care Services

This strategy is another that reaches individuals when they are patients but provides resources to whole families where needed.

Table 244: Transition of Care Services

Transition of Care Services	
Objectives	CHW/Nurse Navigator will complete follow up calls on ACO and those at risk for admission/ readmission, with a goal to reach as many patients as possible after discharge from PVH Emergency Department and inpatient discharges.

Activities	• Run reports of discharges daily (T-F) from MedSurg and ED • Run reports of past 3 days from MedSurg and ED every Monday • Follow up calls to patients • Make follow up appointments as needed • Find community resources as needed • Verify patient understands discharge instructions • Verify patient understands medications and has new prescriptions • Patient education • Listen to patient concerns if voiced and document as needed in event reporting system • When patient gives special recognition of PVH staff document in event reporting system • Home visits as needs identified • Provide notebooks for materials, BP cuffs, bathroom scales and pill organizers as needs identified
Planning Partners	• PVH Nurse Navigator • PVH Community Health Worker • PVH RURAL Healthcare Clinics' staff, LCP and leadership team • PVH Preventive Medicine Department Director
Implementation Partners	• PVH Nurse Navigator • PVH Community Health Worker • PVH RURAL Healthcare Clinics' staff, LCP and leadership team • PVH Preventive Medicine Department Director
Resources	• CHW time • NN Time • Patient education materials • Funding for BP cuffs, bathroom scales, and notebooks and pill organizers
Evaluation Activities	# of patients called monthly by NN # of patients called monthly by CHW # of home visits completed monthly
Point of Contact	Preventive Medicine Department Director

5 Health Topic: Poverty and Employment Issues

PVH's primary data collection and community meeting response showed a deep community concern for issues surrounding cost of care, availability of jobs with good wages and benefits, food security, and more. Leadership has chosen to implement some strategies that attempt to offset these systemic issues.

5.1 Strategy #1: Food FARMacy Program

(See narrative of this program under Obesity Strategy #9)

Table 255: Food FARMacy Program

Food FARMacy Program	
Objectives	Hold 1 -2 FARMacy programs per year. FARMacy programs consist of 12-15 weekly sessions.
Activities	• Collaborate with LCPs for referrals for FARMacy • Secure farmer/farmers market for produce supply • Contact referrals for registration if they verbalize commitment to FARMacy program • Confirm location for sessions • Develop schedule with WVU Extension, Mineral County FRN, PVH Preventive Medicine staff, produce supplier, and PVH Dietician • Assemble print materials and notebooks for participants • Reminder calls for beginning of program • Supermarket shopping tour dates and as needed • Secure market to be used for supermarket shopping tours • Order pocket Super Market Tour Guides for handouts • Determine incentives, farmers market vouchers, grocery gift card for participants to use during supermarket shopping tours • Communicate to providers which referrals signed up for FARMacy program • Enter pre/post data into WV Health Connections, Workshop Wizard • Remind providers of orders for labs at end of program and schedule with participants • Share feedback data to providers
Planning Partners	• Preventive Medicine Department • FARMacy Program/Dr. Carol Greco • Local farmer(s) and farmers markets • WVU Extension Family Nutrition Program • Office of Health Services Research • West Virginia University School of Public Health • WV Health Connections • Mineral County Resource Network

	• Church(es) for space • Marketing
Implementation Partners	• Preventive Medicine Department staff • LCP's referrals/PVH Rural Healthcare clinics • Farmer(s) • Mineral County FRN • Church partner • WV Health Connections • WVU Extension Agent(s) • AHA/AMA SMBP program • Marketing
Resources	• Produce to participants • Cooking demos • Food samples • Educational print materials • Recipes • Blood pressure cuffs • Notebooks • Logs for weight, blood pressure and blood sugar • Bathroom scale as needed • Cookbooks • Incentives • Supermarket gift card and/or farmer's market Voucher • Listing of local farmers markets' schedules • Reminder calls Schedules for sessions and Super Market Shopping Tours
Evaluation Activities	# of participants Pre/post surveys Pre/post Hgb A1c and Cholesterol Level
Point of Contact	Preventive medicine Department Director

5.2 Strategy #2: "Food for Health" Food Boxes

In partnership with Loving Hands and other local pantries, PVH will provide healthy food boxes and educational materials designed to address chronic health issues.

Table 26: "Food for Health" Food Boxes

"Food for Health" Food Boxes	
Objectives	Twice monthly, provide food pantries with ten healthy food boxes prepared with healthier options for participants with diabetes, heart

	disease, hypertension, and/or obesity. Provide related educational information regarding healthy recipes with pantry staples, healthy grocery store options, and health benefits of different foods and of physical activity.
Activities	• Explore ideas or resources available for funding • Develop community partnerships • Collaborate with Dietician for plans for food boxes • Educate Rural Health care clinics of program and Food pantry(ies) participating • Develop Patient education and recipes to add to Food Boxes
Planning Partners	• PVH Dietician • Loving Hands Outreach Center • Mineral County Family Resource Network • Other Community Partners recruits/volunteers • Food Pantries • Preventive Medicine Department
Implementation Partners	• Preventive Medicine Department • Food Pantries • Community partners as available
Resources	• Funding for food • CHW Time • Dietician Time
Evaluation Activities	• # of Food for Health Food Boxes provided per month • Participating Food Pantries • List of Community Partners
Point of Contact	Preventive Medicine Department Director

5.3 Strategy #3: PVH Job Incubator

PVH will be donating space and time for participants to complete online education credentialing and gain on-site job-shadowing experience.

Table 27: PVH Job Incubator

PVH Job Incubator	
Objectives	Job shadowing/training provided for 1-2 clinical position roles yearly.
Activities	• Planning for clinical job shadowing sessions date/time/department/mentors • Plan for space • PVH modified hospital orientation

	• Documentation of participants HIM /vaccine requirements records reviewed by Employee Health Coordinator
Planning Partners	• Marketing • Human Resources • Staff Development Coordinator • Employee Health Coordinator • Mineral County Vocational Technical Center • Allegheny College of Maryland • Potomac State College • Alderson Broadus University • WVSOM • PVH Ancillary Department Leaders
Implementation Partners	• Marketing • Staff Development Coordinator • Employee Health Coordinator • Human Resources • PVH Ancillary Department Leaders • PVH Ancillary Department staff/mentors
Resources	• PVH hospital space for participants • PVH staff time for shadowing/mentoring • Computers
Evaluation Activities	• # of clinical roles supported per year • # of participants per clinical role per year
Point of Contact	Staff Development Coordinator

5.4 Strategy #4: PVH Community Garden

A community garden will be started near PVH's walking track for the 2022 growing season and beyond.

Table 28: PVH Community Garden

PVH Community Garden	
Objectives	A community Garden will be planted yearly at PVH's track, with 3-4 raised beds planted.
Activities	• Construction of raised beds • Recruit volunteers/participants/community partners • Provide education to participants/volunteers • Soil delivered • Seeds/plants planning

	• Planting • Weeding and watering schedule of volunteers/participants • Harvesting • Clearing/cleanup • Distribution of produce to food pantry and/or participants
Planning Partners	• Preventive medicine staff • Community Partners for construction(materials/build) • Food Pantries • Recruits/Volunteers
Implementation Partners	• Preventive medicine staff • Community Partners for construction(materials/build) • Food Pantries • Recruits/Volunteers
Resources	• Preventive Medicine Department time • Ancillary staff time • Soil • Materials for construction • Storage Shed for Community Garden Supplies/tools • Seeds/Plants • Water cost • Water cans/hoses • Gardening tools • Produce baskets • Disposal container for weeding and end of season plants
Evaluation Activities	# of raised beds List of Vegetables grown List of community partners, volunteers/participants List of Produce provided to food pantries and participants
Point of Contact	Preventive Medicine Department