Hendrick Medical Center

Community Health Needs Assessment
Implementation Plan - 2014-2016

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Overview:

Hendrick Medical Center ("Hendrick") conducted its first Community Health Needs Assessment ("CHNA") in January through June of 2013, with the assistance of BKD, LLP, a CPA and advisory firm. The assessment determined the most pressing health needs of Taylor, Jones and Callahan counties.

Based on current literature and other guidance from the treasury and the IRS, the following steps were taken as part of Hendrick's CHNA:

- The "community served" was defined utilizing inpatient data regarding patient origin.
- Population demographics and socioeconomic characteristics of the community were gathered and reported utilizing various third parties.
- Health status of the community was reviewed.
- An inventory of health care facilities and resources was prepared.
- Community input was provided through key informant interviews of 39 stakeholders.
- 338 individuals completed a community health survey.

The information gathered (see CHNA Assessment) was analyzed and reviewed to identify health issues of un-insured persons, low-income and underserved populations, and the community as a whole.

Overall Goal and Approach to Implementation Plan:

In response to the CHNA, Hendrick developed an implementation plan to address those unmet needs that best utilizes the strengths of Hendrick and the partnerships with community organizations and also aligns with the mission and vision.

The mission of Hendrick is "to provide high, quality healthcare emphasizing excellence and compassion consistent with the healing ministry of Jesus Christ." The vision is "to be a financially stable, regional health system providing comprehensive, quality services with optimal outcomes that meet the evolving needs of the citizens of West Texas." As a faith based, tax-exempt organization, Hendrick embraces its responsibility to invest in programs and facilities to serve the community and to provide community benefit.

Results of the Needs Assessment:

The 2013 CHNA identifies 30 unmet or partially met health needs throughout our service area. Analysis of the CHNA data provided a means to evaluate and prioritize areas of greatest need and how to best use and grow our resources and partnerships. Health needs were ranked based on five factors:

- The size of the problem
- The seriousness of the problem
- The prevalence of common themes
- The impact of the themes on vulnerable populations
- How important the issue is to the community

Selection of Priorities:

The following graphical representations assisted with the identification and selection of health need priority targets for 2014-2016. Chart I-Prioritization of Health Needs shows the order of the needs by ranking the five factors plus Hendrick's ability to impact change. On Chart II-Prioritization of Health Needs, the spheres at the top of the y-axis represent those areas where Hendrick can most address change.

Chart I – Prioritization of Health Needs

Hendrick Medical Center
Prioritization of Health Needs

	How many people are affected by the issue?	What are the consequences of not addressing this problem?	Was the need identified as a health disparity?	How Important is it to the community?	How many sources identified the need?	Total X Axis Rating	Hospital's ability to Impact Change (Y Axis)	Total Score
Lack of access to services (cost)	5	3	5	5	3	**21**	**4**	25
Lack of Primary Care Physicians	5	2	5	5	3	**20**	**5**	25
Uninsured	5	2	5	4	2	**18**	**4**	22
Utilization of Emergency Room for Episodic Care	4	3	5	5	1	**18**	**4**	22
Preterm births/low birth weight	3	4	5	3	2	**17**	**3**	20
Lack of Health Education	3	2	5	4	2	**16**	**4**	20
Heart Disease	4	4	0	3	3	**14**	**5**	19
Obesity	4	4	0	3	3	**14**	**4**	18
Transportation	3	2	5	3	2	**15**	**2**	17
Physical Inactivity	3	4	0	4	3	**14**	**3**	17
Cancer	4	4	0	3	2	**13**	**4**	17
Services for Refugees	2	2	5	3	2	**14**	**2**	16
Adult Smoking	3	4	0	4	1	**12**	**4**	16
Diabetes	2	3	0	4	2	**11**	**5**	16
Poor Nutrition	3	3	0	4	2	**12**	**3**	15
Lack of Mental Health Services	3	3	0	5	1	**12**	**2**	14
Language/Cultural Barriers	2	1	5	2	2	**12**	**2**	14
High Blood Pressure	2	3	0	3	1	**9**	**5**	14
Limited access to Healthy Foods	3	2	0	4	1	**10**	**3**	13
Orthopedic Services	4	1	0	2	1	**8**	**4**	12
COPD/Respiratory Disease	2	3	0	1	1	**7**	**5**	12
Stroke/Cerebrovascular Disease	2	3	0	1	1	**7**	**5**	12
Children in Poverty	2	2	0	2	1	**7**	**2**	9
Mammography screening	1	2	0	1	1	**5**	**4**	9
Children in single-parent households	2	1	0	2	1	**6**	**2**	8
Alcohol Abuse	1	2	0	2	1	**6**	**2**	8
Motor Vehicle Crash Rate	1	2	0	0	1	**4**	**2**	6
Violent Crime Rate	1	1	0	1	1	**4**	**2**	6
Sexually transmitted infections	1	1	0	0	1	**3**	**2**	5
Teen Birth Rate	1	1	0	0	1	**3**	**2**	5

*Highest potential total score = 30

Chart II – Prioritization of Health Needs

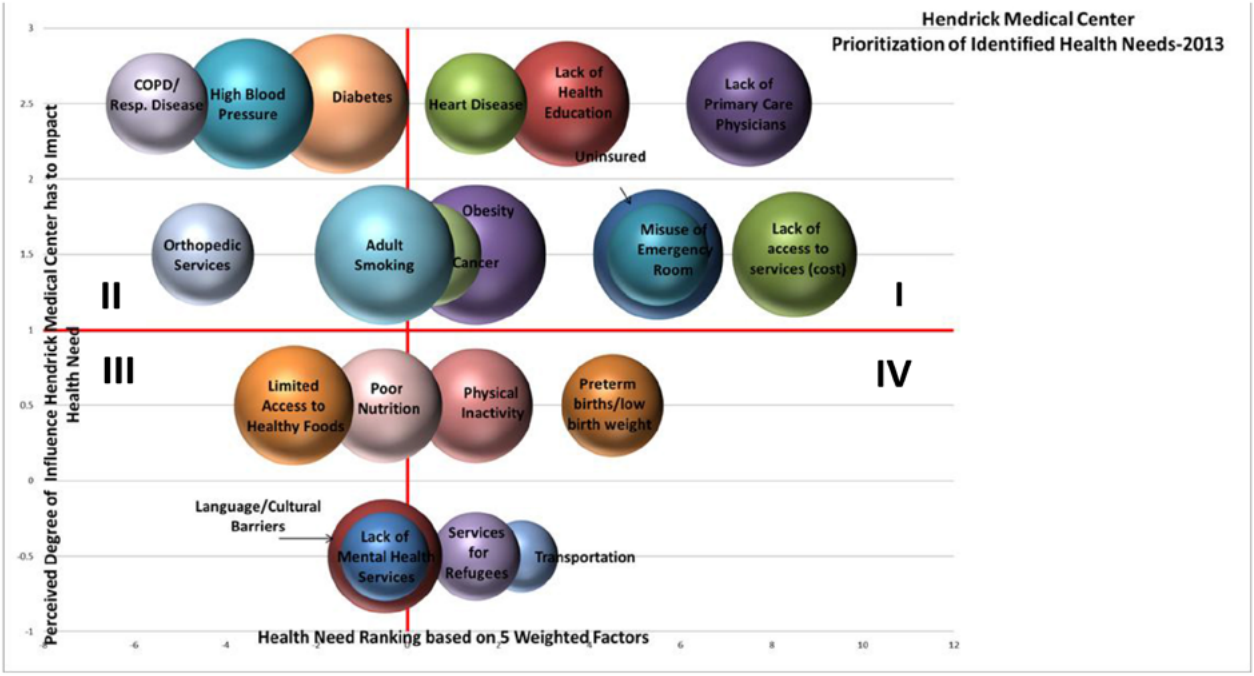

Chart III – Hendrick Medical Center Priority Areas

HMC Priority	Correlated Community Health Needs
Primary Care Physicians	Access to Care Uninsured Population Utilization of ER for Episodic Care Transportation
Health Education	Heart Disease Diabetes COPD/Respiratory Disease Stroke Orthopedic Cancer Wellness: Obesity, Physical Inactivity, Poor Nutrition Refugee Health
Chronic Disease Management	Heart Disease Diabetes COPD/ Respiratory Disease Utilization of ER for Episodic Care

As a result of the analysis, the following "Priorities" were selected:

- Primary Care Physicians
- Health Education
- Chronic Disease Management

Two of the CHNA identified needs, *Lack of Primary Care Physicians* and *Lack of Health Education*, are located in quadrant 1 of *Chart II*. Addressing these needs can have an overarching impact on several of the other listed needs; therefore, were selected as two of the three priorities providing greater opportunity to impact and improve the overall health of the community.

The third priority, *Chronic Disease Management*, was determined by assessing the identification of heart disease, diabetes and chronic obstructive pulmonary disease ("COPD")/respiratory diseases as identified health needs. Because of the broad scope of all three diseases, it was decided that a focus on chronic disease management would be most beneficial to our patient population and also cross over to positively impact the priority of *Health Education* and the correlated community health needs identified in *Chart III – Hendrick Medical Center Priority Areas.*

Health Needs Not Addressed:

There are other needs identified in Chart I that are also important to improving the health of our service area. In the top ten identified needs, there are seven needs not addressed directly in this implementation plan. The explanation for these unaddressed areas is as follows:

Lack of Access to Service (Cost), Uninsured, and Utilization of Emergency Room for Episodic Care

The Presbyterian Medical Care Mission ("Mission") in Abilene is a medical home for patients from the 22 surrounding counties. The patient population is individuals and families at or below 200% of the federal poverty level who do not have Medicaid, Medicare or commercial insurance. The Mission serves as an effective alternative for uninsured patients who would traditionally seek care in the local trauma centers as well as greatly reducing avoidable admissions due to neglected chronic disease and to patients who have no other means of access to primary care.

Hendrick's current 1115 Waiver Project Enhance/Expand Medical Homes gives the Mission additional funding to expand the number of indigent patients served. The Mission currently sees an estimated 9,500 patients per year. By September of 2016, the goal is to serve an additional 3%.

With the potential to increase patient volume at the Mission, coupled with an increase in the community of primary care physicians and chronic disease management addressed in the Hendrick Implementation Plan, the number of episodic emergency room cases should decrease.

Pre-term Births/Low birth rate

The identified need of premature births and low birth rate is already being addressed by a local agency, March of Dimes. March of Dimes is a nationally based non-profit agency with a local office in Abilene that raises awareness and provides education about premature births. March of Dimes is the midst of an intensive, multi-year campaign to raise awareness and find the causes of prematurity.

Transportation

Hendrick is located on the north side of Abilene in close proximity to Interstate-20 providing easy access for surrounding communities. The priority – *Primary Care Physicians* covers an increase of access points for the community by establishing a south side presence for Hendrick, therefore making cross-town transportation less of a deterrent or inconvenience.

For those living within the city limits, but lacking transportation, CityLink is the public transit system for the City of Abilene. Buses travel along twelve weekday routes and seven Saturday routes, which are distributed geographically across the city. Fixed route service is provided Monday through Friday between 6:15 a.m. and 6:15 p.m. and from 7:15 a.m. until 6:15 p.m. on Saturday. All of these routes and times provide easy access to Hendrick and its ancillary services.

Physical Inactivity and Obesity

Hendrick's Wellness Program began as an internal initiative targeting Hendrick employees. Since the program's inception, Hendrick employees have improved as much as 20.3% in areas of overall health such as weight loss, cholesterol, stress management and nicotine use.

Hendrick is now ready to expand the program to the community. The objectives and strategies for this expansion are outlined under the priority - Health Education, which covers the importance of exercise and healthy eating to achieve appropriate body weight. Also, the objectives and strategies in the priority Chronic Disease Management address the detriment of physical inactivity and obesity to heart disease, COPD, and diabetes.

Implementation Plan Goals: The Hendrick Medical Center Board of Trustees determined that to address the priorities identified in the CHNA, over the next three years, Hendrick would meet the following goals:

GOAL 1: Increase access to healthcare;
GOAL 2: Improve through education and disease management the health of our community and surrounding areas;
GOAL 3: Serve as a partner and collaborator to build community healthcare partnerships.

The goals for each priority are the same, but the objectives and strategies for each priority will differ according to the healthcare needs.

PRIORITY: PRIMARY CARE PHYSICIANS

Currently there are 48 internal medicine and family practice physicians serving the Abilene community. These physicians see approximately 120,000 patients each year.

An adequate number of primary care physicians to care for a community is a vital component of comprehensive public health. As identified in the CHNA, the lack of primary care providers within the area serviced by Hendrick is a significant community health need.

To receive community input on physician recruitment, Hendrick utilizes a Medical Staff Development Committee comprised of four at-large community members, four members from the Hendrick Board of Trustees, and four physicians. The Medical Staff Development Committee meets as needed with Hendrick's physician recruiter to assess physician recruitment needs in the community and to approve recruitment recommendations.

Hendrick will address the shortage of primary care providers by recruiting additional physicians and increasing provider care at the Mission through Waiver project funds. In addition to recruitment efforts, Hendrick will also focus on access to primary care providers by expanding the number of physicians at a recently established Family Practice office on the Hendrick campus and establishing a new primary care practice location in south Abilene.

Through the establishment of additional primary care offices more geographically accessible to all members of our service area, Hendrick hopes to positively impact other health care needs identified by the CHNA such as the use of emergency room facilities for episodic care by patients without primary care providers, access to care, and transportation. Refer to Chart III.

Objective: Recruit additional physicians to adequately service all populations in our region
Strategies:

- Recruit three family practice physicians by the end of 2014
- Recruit four internal medicine physicians by the end of 2016

Objective: Increase points of access to primary care services
Strategies:

- Expand the newly established (September 2012) Family Practice facility to four physicians by the end of 2014. This facility is easily accessible and within walking distance to other Hendrick medical services that include: hospital, trauma center, laboratory, pharmacy, and specialty physicians
- Establish a Primary Care Clinic in south Abilene in 2015. This clinic will provide primary care and ancillary services to the south Abilene population.

Objective: Assess the market needs for future primary care physician recruitment
Strategy:

- Explore the feasibility of hiring a third party firm to conduct a physician needs assessment tailored to meet the needs of our service area by the end of 2016

Objective: Increase primary care provider capacity at the Mission for patients without Medicaid, Medicare or commercial insurance
Strategy:

- Utilize Waiver Enhance/Expand Medical Home Project funding to recruit and hire additional mid-level providers and support staff at the Mission to service an additional 475 patients by 2016, i.e. an additional full time registered nurse and physician assistant

Objective: Respond to rural community medical needs to provide primary care and other medical services
Strategy:

- Continue networking with regional hospitals, physicians, and community leaders through the Director of Regional Services at Hendrick to gain input into medical needs within Hendrick's service area

PRIORITY: HEALTH EDUCATION

Within Hendrick is a strong team of employees whose goal is to market Hendrick's medical services and programs to Abilene and surrounding communities. This Collaboration Team meets monthly to discuss upcoming health fairs, symposiums, and community events conducive to sharing Hendrick's health education information within Abilene and surrounding communities. Last year the team provided 2,281 hours of community benefit in the areas of diabetes, cancer, heart, pulmonary rehab, stroke, wellness and women's and children's health.

Health Education objectives and strategies for each of these areas are represented on the following chart:

Health Education			
Need	**Objective**	**Strategies**	**Method of Evaluation**
Cancer Education	Increase education and prevention opportunities to rural communities	Collaborate with clinics in Haskell, Stamford, Sweetwater, Colorado City, Breckenridge and Eastland to offer Tobacco Cessation	Offer at least one educational opportunity in each service area annually
		Collaborate with clinics in Haskell, Stamford, Sweetwater, Colorado City, Breckenridge and Eastland to offer "A Taste for Better Living," a nutrition course for cancer patients and their families	Offer at least one educational opportunity in each service area annually
		Collaborate with HMC employees in other health educational areas (Collaboration Team) to coordinate outreach services in Abilene and surrounding communities	Increase participation in health screenings by 20%
	Increase education and cancer prevention screenings	Expand free health screenings for the uninsured to low income neighborhoods	Provide a health screening in one underserved neighborhood each year
Cardiovascular Education	Increase number of people who receive cardiovascular disease prevention education and tools for self management	Increase efficiency of logistical process of screenings for BMI, carotid arteries, cholesterol, glucose and ECGs in HMC's annual cardiac screening events	Increase participants of annual health screenings and educational offerings for the community or communities by 10% within the next three year to 220 participants
		Increase collaboration with non-profits, schools, and support groups to promote prevention and heart disease symptom recognition by offering heart healthy living and cardiac risk factor classes	
		Partner with local and area businesses to provide risk factor and lifestyle modification classes to the employees identified as high risk	
		Collaborate with HMC employees in other health educational areas (Collaboration Team) to coordinate outreach services in Abilene and surrounding communities	

COPD Education	Increase awareness of free COPD community resources	Plan a free COPD workshop in November 2014 for COPD Awareness Month to include the community, students and healthcare providers in Abilene and surrounding areas	Increase number of participants in annual COPD workshop and Better Breather monthly meeting by 10%
	Increase COPD awareness by providing additional pulmonary educational materials	Provide downloadable educational material on pulmonary rehab and respiratory care on the HMC website by 2014	Track visits to pulmonary rehab website quarterly
		Provide COPD pocket guides to physicians and respiratory therapists in Abilene and rural communities	Distribute 300 pocket guides by 2016
		Collaborate with HMC employees in other health educational areas (Collaboration Team) to coordinate outreach services in Abilene and surrounding communities	Provide 200 spirometry screenings annually, and increase number of outreach events attended by 10%

Diabetes Education	Educate and provide culturally specific information on risk factors to designated Abilene neighborhoods and rural communities	Distribute culturally appropriate diabetes materials in the 17 counties served to health providers and health organizations	During calendar year 2014, 2015, and 2016, track number of pre-diabetics patients educated
		Host a Pre-Diabetes Workshop	
		Expand venues to market monthly Diabetes Support Group activities to reach underserved areas	
		Collaborate with HMC employees in other health educational areas (Collaboration Team) to coordinate outreach services in Abilene and surrounding communities	
	Educate and empower the culturally diverse diabetic community populations on self-management according to current ADA Standards of Care in the 17 counties served	Collaborate with state experts in the diabetes field on strategies for development of community diabetes education methods and priorities	Arrange meeting by 2014
		Provide annual Diabetes Texas Style Workshop in partnership with the County Extension Agency every November	During calendar year 2014, 2015, and 2016, track number of community members educated or provided resources
	Educate and empower Allied Health students and professionals in the local and regional communities.	Market HMC Diabetes Resource Center to Abilene and surrounding areas	
		Provide education to local higher education facilities with Allied Health professionals programs	
		Provide CME and CNE opportunities to Allied Health professionals	
		Distribute updated information concerning diabetes management standards of care to regional partners	

Orthopedic Education	Develop and initiate educational opportunities through handouts and surveys for Abilene and surrounding areas	Create educational materials and surveys that: 1).Identify risk factors that affect bone health 2).Educate and answer questions to improve bone health 3).Provide additional resources for more information	5% annual increase in number of people reached
		Inform the community of the importance of Joint Venture classes, if surgery has been recommended by a physician	Increase patient participation from 92% to 95% in Joint Venture classes over the next three years
		Collaborate with HMC employees in other health educational areas (Collaboration Team) to coordinate outreach services in Abilene and surrounding communities	5% annual increase in number of people reached

Stroke Education	Increase stroke awareness by providing additional educational materials and community health events	Increase collaboration with non-profits, schools, and support groups to promote prevention and stroke symptom recognition by offering classes about healthy living and stroke risk factors	Increase participants of annual health screenings and educational offerings for the community or communities by 10% within the next three years to 300 participants
		Collaborate with HMC employees in other health educational areas (Collaboration Team) to coordinate outreach services in Abilene and surrounding communities	
		Through ADAM, a web-based educational program, increase awareness of stroke symptoms via Hendrick web page	Promote web information at educational events and annually track number of visits to stroke website

Wellness Education	Provide greater health education to children and families in the community	Expand the Citizens United Against Disproportionality and Disparities (CUADD) Health Equity Committee outreach program to include more schools and additional education on nutrition	Add 2 additional schools to community health education projects each year for the next 3 years
		Create interactive food and drink displays that are fun for children in school and community venues	
		Establish business partnerships in the community to promote wellness	Add 2 additional business partners each year for the next 3 years
		Develop partnership with International Rescue Committee (IRC) to address health needs of refugee population	Offer quarterly health and wellness classes in partnership with the IRC
		Begin Hendrick "Health Minute" educational series incorporating healthy living advice for providers and patients in the region through media, email, or social media by 2014	Track methods utilized and estimated number of people reached
		Collaborate with HMC employees in other health educational areas (Collaboration Team) to coordinate outreach services in Abilene and surrounding communities	Increase participation in health fairs by 10%

Women and Children's Education	Develop community partnerships to offer educational classes to previously unreached women in Abilene and surrounding communities	Develop partnership with local Women, Infants, and Children (WIC) office to offer breastfeeding, childbirth, and infant care classes	Offer quarterly educational classes in partnership with WIC
	Provide additional opportunities for outreach and support in the area of pregnancy and childbirth	Develop free Pregnancy and Infant Care classes	Make available to the community by 2014
		Develop a weekly breastfeeding support group	Make available to the community by 2014
		Collaborate with HMC employees in other health educational areas (Collaboration Team) to coordinate outreach services in Abilene and surrounding communities	Increase number of women educated by 10%

PRIORITY: CHRONIC DISEASE MANAGEMENT

Hendrick understands the importance of helping chronically ill patients gain a greater understanding of their own role in staying well and how to successfully self-manage their illness. Recently a committee was formed to address chronic disease management with representation from the diabetes, cardiovascular, pulmonary, admissions, pharmacy and marketing departments. With a focus on preventable readmissions and fewer emergency room visits, the committee's goals include: increasing health education; managing symptoms and medications; initiating a continuum of care; implementing a Palliative Care Program; and exploring more accessible options for treatment for uninsured patients.

Chronic disease management objectives and strategies follow:

Objective: Collaborate with health care providers in Abilene and our region to assure patients have access to Hendrick educational materials and programs.

Strategies:

- Implement a community program for "Risk Factor Identification" by the end of 2015
- Develop a speaker's list for community education by 2014
- Coordinate and offer continuing education programs in our region for the next three years, which address the self-management of chronic diseases. Offer at least one program in each service area by 2016
- Create a comprehensive guide of Hendrick resources to educate health care providers treating patients with chronic diseases by 2015

Objective: Implement a Heart Failure Transition of Care Program

Strategies:

- Initiate a Care Coordination Multidisciplinary team to provide a continuum of care such as (Emergency Room ➔ Inpatient ➔ Outpatient ➔ Palliative Care ➔ Hospice) by 2015
- Explore providing a medically trained advocate who works with patients and physicians to ensure patients stay healthier between appointments and are able to account for their own health by 2015
- Develop a process for follow-up phone calls made to HFC patients by 2014
- Collaborate with case management social worker to track assistance with community resources beginning in 2014
- Increase presence/process of Palliative Care Program beginning in 2014

Objective: Expand inpatient Palliative Care program to create an outpatient program as a way to reach more chronic disease patients in the community

Strategies:

- Present a general palliative care continuing education unit ("CEU") to other health care providers within Hendrick's service area by 2014
- Offer outpatient psycho-social components of palliative care to the community through a collaborative effort with Hendrick Hospice Care beginning in 2014
- Work with Ministerial Alliance to present palliative care programs to area church leadership beginning in 2014

Objective: Increase patient access to prescription medications used to control chronic disease

Strategy:

- To explore the implementation of an "in-house" prescription medication plan for chronic disease patients by 2015
- Provide an initial 30-day supply of covered medications at no charge as part of a "Membership Plan"
- Provide the availability of obtaining subsequent 30-day refills of covered medications for reduced co-pay (amount to be determined)
- Offer "membership" and benefits contingent on meeting certain criteria, such as a monthly face-to-face visit with the pharmacist to ensure compliance and prevent adverse drug events, adherence to care plans, and keeping appointments with clinics or physicians, if applicable

Objective: Explore the development of a nurse driven management clinic (diabetes, heart disease and hypertension) to expand care and access for uninsured patients with chronic diseases by 2016

Strategy:

- Utilize diabetes consultants to assist with the steps necessary to establish a Hendrick clinic

Next Steps:

The Hendrick Medical Center Implementation Plan will be rolled out over the next three years, from FY2014 through the end of FY2016. A committee of members from the Community Health Needs Assessment Committee, Collaboration Team and Chronic Disease Management Committee will work with community partners on the following for each of the priorities addressed in the implementation plan.

- Develop work plans to support effective implementation
- Create mechanisms to monitor and measure outcomes
- Develop a report card to provide on-going status and results of these efforts to improve community health

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