Community Health Needs Implementation Plan, 2017-2019

TriPoint Medical Center Community Health Needs Assessment (CHNA) Implementation Plan —

- *IRS Mandate*
- *The following consists of strategies to address each of the chosen needs identified in the CHNA*
- *This implementation plans is duplicated for both West medical Center and TriPoint Medical Center in an effort to leverage each others strengths*

Community Health Need: DIABETES

Goal: Top Quartile performance in Diabetic Measures for all Lake Health attributed lives in Eastern Lake County

Strategic Objective: Utilize the IPHE Ambulatory Quality Committee and Patient Centered Medical Home leadership to provide oversight, guidance and education to providers and patients regarding Diabetes treatment compliance

Initiative	Lead	Timeline	Measurable Outcome
Initiative #1: Develop Strategies to improve Better Health Partnership and PCMH Diabetes Compliance		YE 2017	HbA1c Completed on high risk patients HbA1c <9 BP< 140/90 Diabetes Foot Exam Completed Diabetic Eye Exam Completed Diabetics 40-70yrs old on a statin ***(Population is all PCP attributed lives in IPHE)***
Action A.1.1 – Convert the inpatient/outpatient traditional approach to Diabetes management to “Comprehensive Diabetes Care Plus”. Expand the Diabetes Education Coordinators role from classroom/instruction focus to patient/family individual focus	J. Taylor		
Action A.1.2 – Primary Care Provider focus on patients at high risk or increasing/rising risk via monitoring HEDIS measures for diabetics and connecting patient/family to ambulatory case management.	Dr. Baniewicz		
Action A.1.3 – Provide Physicians specific diabetic patient rosters and HbA1C scores to target high risk patients for case management	Dr. Baniewicz	YE 2017	Reduction in HbA1C for specific cohort ***(Population is all PCP attributed lives in IPHE)***

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Community Health Need: CONGESTIVE HEART FAILURE			
Goal: Top Quartile performance in CHF Metrics for all Lake Health attributed lives in Eastern Lake County			
Strategic Objective: Through a focus on the Bundled Payment Congestive Heart Failure Steering Committee, provide oversight, guidance and education to providers and patients regarding CHF treatment and protocol compliance			
Initiative	**Lead**	**Timeline**	**Measurable Outcome**
Initiative #1: Reduce readmission rates and ED encounters for patients with Heart Failure	J. Taylor & Dr Baniewicz	YE 2017	***(Population is all LH Patients)*** CHF Readmission Rate
Action A.1.1 – Schedule in-home House Calls visit to occur within 48 hours of patient discharge from the acute care setting.	J. Taylor & Dr Baniewicz		# of House Call Visits/# possible
Action A.1.2 – Conduct risk assessment on patients readmitted to the acute care setting to identify care coordination opportunities for patients/families	J. Taylor & Dr Baniewicz		# of interventions on readmitted patients
Action A.1.3 – Connect patients without a primary care provider to a PCP	J. Taylor & Dr Baniewicz		% of Patients without PCP
Action A.1.4 – Connect patients at high risk for developing or worsening heart failure to an ambulatory care coordinator.	J. Taylor & Dr Baniewicz		# of Patients incorporated into the program

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Community Health Need: HEARTH DISEASE			
Goal: Partner with AHA and Local Schools Eastern Lake County to educate community while focusing physical activity			
Strategic Objective: Utilize Lake Health community opportunities to promote healthy living and its effect on heart disease			
Initiative	**Lead**	**Timeline**	**Measurable Outcome**
Initiative #1: American Heart Association – Utilize “Life is Why” sponsorship and other community activities to maximize general public and student education about heart disease and health living	R. Cicero	YE 2017	# of programs and events sponsored
Action A.1.1 – Utilize Lake Health Running Series to promote physical activity within contracted school systems	R. Cicero/ J.Popely/ J.Smith		# of Community races sponsored & coordinated by Lake Health
Action A.1.2 – Utilize partnership with Lake County Senior Centers to educate membership on Heart Disease and contributing factors	R. Cicero		# of Presentations completed at Senior Centers
Action A.1.3 – Incorporate healthy heart education in the student curriculum with partner schools	R. Cicero/ S. Minjares		# of Healthy Heart Programs provided/taught within Lake County Schools
Action A.1.4 – Conduct/support community lectures, school student presentations and Annual Heart Walk	R. Cicero/ S.Minjares		# of community events sponsored/lead/supported to educate about heart disease

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Community Health Need: HIGH BLOOD PRESSURE			
Goal: Top Quartile performance in managing high blood pressure for Lake Health attributed lives in Eastern Lake County			
Strategic Objective : Through a focus on Community Screening and Patient Centered Medical Homes within Lake Health primary care offices, provide oversight, guidance and education to providers and patients regarding High Blood Pressure treatment and protocol compliance			
Initiative	**Lead**	**Timeline**	**Measurable Outcome**
Initiative #1: Reduce readmission rates and ED encounters for patients with high blood pressure.	J. Taylor & Dr Baniewicz	YE 2018	***(Population is all PCP attributed lives in IPHE)*** Readmission rate for HBP patients
Action A.1.1 – Conduct risk assessment on patients readmitted to the acute care setting to identify care coordination opportunities for patients/families	J. Taylor & Dr Baniewicz		# of HBP patients followed by Care Coordination
Action A.1.2 – Connect patients without a primary care provider to a PCP	J. Taylor & Dr Baniewicz		% of HBP patients w/out a PCP (target 0%)
Action A.1.3 – Schedule in-home House Calls visit to occur within 48 hours of patient discharge from the acute care setting.	J. Taylor & Dr Baniewicz		% of House calls within 48 hrs
Action A.1.4 – Implement medication reconciliation process to assure patients are on the correct medication, correct dosage and correct administration times	J. Taylor & Dr Baniewicz		Reduction in Medication errors
Action A.1,5 – Conduct FREE community and individual BP Screenings at Lake Health Locations – School Partners – Senior Centers – GLM	R. Cicero/ S. Minjares		# of free BP screenings

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Community Health Need: ACCESS TO PREVENTIVE SCREENING			
Goal: Create Multiple Preventive Screening Opportunities for the Eastern Lake County Community			
Strategic Objective: Through a focus on Community Screenings provided to local employers and public community events, provide oversight, guidance and education regarding Heart Disease, Stroke, High Blood Pressure, Weight Management, Tobacco Use and more			
Initiative	**Lead**	**Timeline**	**Measurable Outcome**
Initiative #1: Initiative #1: Leverage Lake Health's participation and sponsorship in community events to increase screening opportunities.		YE 2017	# of events offering screenings # of people screened
Initiative #3: Target current and new Occupational Medicine clients to increase screening opportunities.		YE 2017	# of events offering screenings # of people screened