2014-16 Community Health Plan

Posted May 15, 2014

Central Texas Medical Center (CTMC) conducted a Community Health Needs Assessment (CHNA) in 2013. With oversight by a community-inclusive Community Health Needs Assessment Committee, the Assessment looked at the health-related needs of our broad community as well as those of low-income, minority and underserved populations[i]. The Assessment includes both primary and secondary data.

The Community Needs Assessment Committee, hospital leadership and the hospital board reviewed the needs identified in the Assessment. Using the Priority Selection processes described in the Assessment, the Committee identified the following issues as those most important to the communities served by our hospital. The hospital Board approved the priorities and the full Assessment.

1. Accessing the right level of care at the right time/rate of uninsured
2. Healthy Lifestyles: nutrition, weight management, exercise, smoking, alcohol use and sexually transmitted infections (STIs)
3. Management of heart disease/CHF and related conditions/risk factors such as hypertension
4. Management of diabetes and diabetes-related conditions

With a particular focus on these priorities, the Committee helped CTMC develop this Community Health Plan (CHP) or "implementation strategy[ii]." The Plan lists targeted interventions and measurable outcome statements for each effort. Many of the interventions engage multiple community partners. The Plan was posted by May 15, 2014 at the same web location noted below.

CTMC's fiscal year is January-December. For 2014, the Community Health Plan will be deployed beginning May 15, 2014 and evaluated at the end of the calendar year. In 2015 and beyond, the Plan will be implemented and evaluated annually for the 12-month period beginning January 1 and ending December 31. Evaluation results will be posted annually and attached to our IRS Form 990.

If you have questions regarding this Community Health Plan or Community Health Needs Assessment, please contact Ann Berghammer-Miller, Community Benefit Manager, at Ann.BerghammerMiller@ahss.org.

[i] The full Community Health Needs Assessment can be found at www.ctmc.org under the Community Benefit heading.

[ii] It is important to note that this Community Health Plan does not represent all Community Benefit activities. All activities are included on Schedule H of our IRS Form 990.

Central Texas Medical Center

2014-16 Community Health Plan

OUTCOME GOALS						OUTCOME MEASUREMENTS								
CHNA Priority	**Outcome Statement**	**Target Population**	**Strategies/Outputs**	**Outcome Metric**	**Current Year Baseline**	**Year 1 Outcome Goal - #**	**Year 1 Actual**	**Year 2 Outcome Goal - #**	**Year 2 Actual**	**Year 3 Outcome Goal - #**	**Year 3 Actual**	**Hospital $**	**Matching $**	**Comments**
Accessing the right level of care, in the right setting, at the right time; rate of uninsured														
	Increase capacity at Live Oak Health Partners Community Clinic (LOHP-CC) so low-income patients have access to primary care services in a clinic setting vs. accessing non-urgent care via hospital emergency departments.	Uninsured residents of Hays County with specific emphasis on Wimberley, San Marcos and Kyle	Expand clinic hours to include evenings and renovate the clinic in order to accommodate more providers, create improved workflows, reduce wait times, increase patient satisfaction and increase the number of available encounters at LOHP-CC	Number of available encounters per month.	352 available encounters per month	Renovate clinic space; Realize 475 available encounters per month by 3rd quarter		Increase hours to include evenings; Realize 525 available encounters per month by 2nd quarter		550 available encounters per month		$3,331,497	$110,000	LOHP-CC Director
	Develop strategies to improve Live Oak Health Partners - Community Clinic (LOHP-CC) patients access to prescription medications.	Patients served by the Live Oak Health Partners Community Clinic	Increase the number of patients receiving prescription assistance via the Live Oak Health Partners Community Clinic	Number of patients enrolled in the LOHP-CC prescription assistance program.	231 patients enrolled	250 patients enrolled		280 patients enrolled		310 patients enrolled		$233,865	$0	LOHP-CC Director

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	Provide diagnostic support services to Live Oak Health Partners Community Clinic (LOHP-CC) healthcare professionals.	Patients served by the Live Oak Health Partners Community Clinic	Offer discounted lab and radiology diagnostic services at Central Texas Medical Center.	Number of encounters per year.	500 encounters per year	650 encounters per year		700 encounters per year		750 encounters per year		$89,064	$0	CTMC CFO
	Increase participation in the Central Texas Medical Center Hospice Grief Center from the 7 counties served.	Residents of Hays and Caldwell Counties with extended service to Blanco, Guadalupe, Comal, and South Travis Counties who have experienced a loss.	Collaborate with at least 2 area school district counselors for referrals to the Heartsong program.	Increase the number of participants in Camp Heartsong and Camp HeartSong Too offered.	45 in Camp HeartSong and 5 in Camp HeartSong Too! annually.	50 in Camp HeartSong and 7 in Camp HeartSong Too! Annually.		55 in Camp HeartSong and 8 in Camp HeartSong Too! Annually.		61 in Camp HeartSong and 9 in Camp HeartSong Too! Annually.		$0	$47,500	CTMC Hospice Director, Camp HeartSong Directors and CTMC Family Grief Center Coordinator
	Increase participation in the Central Texas Medical Center Hospice Grief Center from the 7 counties served.	Residents of Hays and Caldwell Counties with extended service to Blanco, Guadalupe, Comal, and South Travis Counties who have experienced a loss.	To increase support group access/attendance, will generate press releases in area newspapers, work closely with law enforcement agencies, especially in Comal and Caldwell Counties to identify individuals that would benefit from Grief Center programs.	Increase the number of grief support groups offered.	Offer 6 annual support groups.	Offer 7 support groups annually.		Offer 8 support groups annually.		Offer 9 support groups annually.		$2,880	$3,600	CTMC Hospice Director, Camp HeartSong Directors and CTMC Family Grief Center Coordinator

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	Improved access to mammograms for low-income individuals.	Uninsured residents of Hays and Caldwell Counties with specific emphasis on Lockhart, Wimberley, San Marcos and Kyle	Distribute at least 100 vouchers for a free mammogram; conduct follow-up contact with those receiving a voucher to ensure they access the screening.	Increase the redemption rate of mammogram vouchers.	60 vouchers redeemed	At least 75 vouchers redeemed		At least 80 vouchers redeemed		At least 85 vouchers redeemed		$35,732	$0	CTMC Radiology Director
Timely access (including afterhours care) to Healthcare Professionals, especially primary care; accessing care close to home when care is needed														
	Provide access to a physician (vs. mid-level provider) at Live Oak Health Partners Community Clinic (LOHP-CC) especially for patients that have complex medical needs.	Uninsured residents of Hays County with specific emphasis on Wimberley, San Marcos and Kyle	Partner with at least one physician to provide services at LOHP-CC.	Number of available appointment slots with a physician at LOHP-CC	0 appointments available	Enlist assistance with recruitment firm; initiate search of qualified candidates		Partner with at least one physician to offer at least 20 available appointments per week by 2nd quarter.		Offer at least 30 available appointments per week		$287,000	$0	LOHP Practice Administrator
	Increase access to primary care physicians (family practitioner, internist, OB/GYN), especially for unfunded patients and Medicare and Medicaid beneficiaries.	Residents of Hays and Caldwell Counties.	Recruit primary care physicians to establish a practice within Hays and/or Caldwell Counties.	Number of primary care physicians recruited by CTMC that establish a practice in Hays or Caldwell Counties.	0 PCPs	Enlist assistance with recruitment firm; initiate search of qualified candidates		Recruit at least 1 PCP		Recruit at least 1 PCP		$287,000	$0	CTMC CEO

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Healthier management of lifestyle/making good choice in the areas of nutrition, weight management, exercise, smoking, alcohol use and sexually transmitted infections (STIs)														
	Promote the ideals of healthy living by developing programs built on the AHS CREATION HEALTH program.	Residents of Hays and Caldwell Counties.	Collaborate with area organizations including churches, civic groups, schools, and area employers etc…to offer CREATION HEALTH workshops and/or encourage participation in the CREATION HEALTH web-based self-assessment.	Number of online self-assessments and CREATION HEALTH workshops	0 workshops and 0 assessments	Offer 2 CREATION HEALTH workshops and completion of 100 on-line assessments		Offer 4 CREATION HEALTH workshops and completion of 200 on-line assessments		Offer 6 CREATION HEALTH workshops and completion of 300 on-line assessments		$60,665	$27,093	Director of PR and Marketing
	Promote the ideals of healthy living by developing programs built on the AHS CREATION HEALTH program.	Residents of Hays and Caldwell Counties.	Increase CREATION Health Fitness Challenge registration to 100 participants over three years by offering at least one additional Challenge event and create a children's component to engage youth participation.	Number of participants	16 participants	32 participants		64 participants		100 participants		$31,841	$7,550	Director of PR and Marketing

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	Provide low-income residents access to basic health screenings.	Residents of Hays and Caldwell Counties.	Collaborate with area organizations that provide health services to distribute free participation vouchers to the annual CTMC CREATION HEALTH HealthCheck health screening event.	Number of vouchers distributed.	0 vouchers distributed.	Distribute 100 vouchers		Distribute 150 vouchers		Distribute 200 vouchers		$39,361	$1,557	Director of PR and Marketing
Prevalence and/or enhanced outpatient management of heart disease/CHF and related conditions/risk factors such as hypertension.														
	Improved management of congestive heart failure (CHF) patients in an outpatient/home setting.	Uninsured and Medicare residents of Hays and Caldwell Counties with at least 1 admission to CTMC annually for CHF or related condition.	Identify CHF inpatients at high risk for potentially preventable hospital readmissions and provide at least one contact per patient.	Number of contacts made with target population.	Initiated program in October 2013. Provided at least one contact for 60% of target population in 4Q 2013.	Provide at least one contact for 85% of target population.		Provide at least one contact for 90% of target population.		Provide at least one contact for 95% of target population.		$112,188	$0	Transitional Care Coordinator
	Improved management of congestive heart failure (CHF) patients in an outpatient/home setting.	Uninsured and Medicare residents of Hays and Caldwell Counties with at least 1 admission to CTMC annually for CHF or related condition.	Initiate referrals to a medical home for unfunded patients.	Number of referrals to a medical home prior to discharge for unfunded patients in target population.	Initiated program in October 2013. Developed a process to initiate referrals to a medical home for unfunded patients.	Ensure 50% of all unfunded patients have a referral to a medical home prior to discharge from CTMC.		Ensure 60% of all unfunded patients have a referral to a medical home prior to discharge from CTMC.		Ensure 75% of all unfunded patients have a referral to a medical home prior to discharge from CTMC.		$13,899	$0	Transitional Care Coordinator

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	Improved management of congestive heart failure (CHF) patients in an outpatient/home setting.	Uninsured residents of Hays and Caldwell Counties with at least 2 admissions to CTMC annually for CHF or related condition and are at high risk for re-admission.	Increase capacity of outpatient cardiac rehabilitation program to provide cardiac rehab services to unfunded patients.	Number of patients served.	0 patients	4 patients		6 patients		8 patients		$19,616	$0	Cardiac Rehabilitation Coordinator
	Provide activities that promote heart healthy living.	All residents in CTMC's primary and secondary service area.	Develop "Walk with a Cardiologist" program and heart healthy living educational programs.	Number of Heart Healthy walks and educational workshops.	0 activities	Hold one Heart Healthy Walk quarterly		Include a Heart Healthy Educational workshop with each quarterly Heart Healthy Walk		Offer a monthly Heart Healthy Walk and corresponding Heart Healthy Workshop quarterly.		$0	$2,000	Cardiac Rehabilitation Coordinator
	Provide individuals diagnosed with CHF, asthma, chronic obstructive pulmonary disease or related condition, and their family members, on-going opportunity foreducation, and accountability and encouragement to adopt and maintain successful self-management strategies	All residents in CTMC's primary and secondary service area with COPD, CHF or related condition.	Develop and implement a free Better Breather's Club (BBC) lead by a American Lung Association BBC certified instructor.	Number of Better Breather's Club meetings held annually.	0 certified instructors/0 meetings	Certify at least one instructor by 3rd quarter. Begin BBC meetings quarterly.		Hold BBC meetings on a quarterly basis.		Hold BBC meetings on a monthly basis.		$10,111	$0	Administrative Director of Ancillary Services

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Prevalence and /or enhanced outpatient management of diabetes; programs to address anticipated growth of diabetes and related conditions.														
	Increase awareness and early detection of diabetes.	Residents of Hays and Caldwell Counties.	Offer monthly blood glucose screenings and participation in a diabetes risk assessment based on American Diabetes Association guidelines.	Number of blood glucose screenings done monthly.	Average 30 blood glucose screenings and risk assessments monthly at CTMC.	Average 34 blood glucose screenings and risk assessments monthly at CTMC.		Average 36 blood glucose screenings and risk assessments monthly at CTMC. Provide blood glucose screenings and risk assessments in the Lockhart, Wimberley and Kyle communities quarterly.		Average 36 blood glucose screenings and risk assessments monthly at CTMC. Increase participation in quarterly blood glucose screenings and risk assessments in the Lockhart, Wimberley and Kyle communities by 10%.		$2,712	$0	Patient Educator, Diabetes Self-Management Education class coordinator
	Improve compliance with short and long term diabetes control and management strategies.	All residents of Hays and Caldwell Counties that have participated in CTMC Diabetes Education Classes.	Over a 12 month period, provide all CTMC diabetes education class participants with up to 4 individualized, free of charge, follow-up visits with a Diabetes Educator focusing on lifestyle changes.	Percentage of diabetes education class participants that receive at least 2 follow-up visits over a 12 month period.	20% of diabetes education class participants received at least 2 follow-up visits over a 12 month period.	At least 25% of diabetes education class participants receive at least 2 follow-up visits over a 12 month period.		At least 30% of diabetes education class participants receive at least 2 follow-up visits over a 12 month period.		At least 40% of diabetes education class participants receive at least 2 follow-up visits over a 12 month period.		$4,262	$0	Patient Educator, Diabetes Self-Management Education class coordinator

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	Provide individuals diagnosed with diabetes, and their family members, on-going opportunity foreducation, and accountability and encouragement to adopt and maintain successful diabetes management and control strategies.	All residents of Hays and Caldwell Counties with a diagnosis of diabetes or pre-diabetes, especially those participating in CTMC's Diabetes Education Classes and diabetes-related events.	Offer a free, Diabetes Support Group meeting every two weeks.	Average attendance per meeting.	Average 10 participants per meeting.	Average 11 participants per meeting.		Average 12 participants per meeting.		Average 13 participants per meeting.		$16,754	$0	Patient Educator, Diabetes Self-Management Education class coordinator
	Increase access to an endocrinologist, especially for unfunded patients and Medicare and Medicaid beneficiaries.	Residents of Hays and Caldwell Counties.	Recruit an endocrinologist to establish a practice within Hays and/or Caldwell Counties.	Number of endocrinologists recruited by CTMC that establish a practice in Hays or Caldwell Counties.	1 endocrinologist	Enlist assistance with recruitment firm; initiate search of qualified candidates		Continue search of qualified candidates		Recruit 1 endocrinologist		$654,000	$0	CTMC CEO
	Reduce the percentage of LOHP Community Clinic patients with diabetes whose most recent HbA1c level was greater than 9%.	Patients served by the Live Oak Health Partners Community Clinic	Develop and implement strategies that foster compliance with a prescribed diabetes management program.	Achievement of the QISMC Percentile	Program not developed or established.	Identify patients with an HbA1c level > 9%; establish starting baseline percentile; develop and implement strategies to reduce HbA1c level in identified patients.		Reduce number of patients with an HbA1c level > 9% by 5 % over previous year.		Reduce number of patients with an HbA1c level > 9% by 10% over previous year.		$1,046,630	$0	LOHP-CC Director