2017-2019 Community Health Plan

(Implementation Strategies)

May 15, 2017

Community Health Needs Assessment Process

Central Texas Medical Center (CTMC) conducted a Community Health Needs Assessment (CHNA) in 2016. The Assessment identified the health-related needs of our broad community as well as those of low-income, minority, and medically underserved populations.

In order to assure broad community input, CTMC created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the Assessment and Community Health Plan process. The Committee included representation not only from the Hospital, public health and the broad community, but from low-income, minority and other underserved populations.

The Committee met throughout 2016 and early 2017. The members reviewed the primary and secondary data, reviewed the initial priorities identify in the Assessment, considered the priority-related Assets already in place in the community, used specific criteria to select the specific Priority Issues to be addressed by the Hospital, and helped develop this Community Health Plan (implementation strategies) to address the Priority Issues.

This Community Health Plan lists targeted interventions and measurable outcome statements for each Priority Issue noted below. It includes the resources the Hospital will commit to the Plan, and notes any planned collaborations between the Hospital and other community organizations and hospitals.

Priority Issues that will be addressed by Central Texas Medical Center

Central Texas Medical Center will address the following Priority Issues in 2017-2019.

1. **Educating** the population to better understand the healthcare resources available to them through various channels including those provided by Central Texas Medical Center, Live Oak Health Partners and other entities and a commitment to helping people (including the underserved) navigate those resources;
2. **Healthier management of lifestyle**/making good choices in the areas of nutrition, weight management and exercise;
3. Timely access (including afterhours care) to Healthcare Professionals, especially **primary care**; accessing care close to home when care is needed;
4. Prevalence and/or enhanced outpatient **management of heart disease/congestive heart failure (CHF) and related conditions**/risk factors such as hypertension;
5. Prevalence and/or enhanced **management of mental and behavioral healthcare** options;
6. Prevalence and/or enhanced outpatient **management of diabetes**; programs to address anticipated growth of diabetes and related conditions.

Issues that will not be addressed by Central Texas Medical Center

The 2016 Community Health Needs Assessment also identified the follow community health issues that CTMC will not address. The list below includes these issues and an explanation of why the Hospital is not addressing them.

1. **Prevalence and/or enhanced outpatient management of chronic respiratory diseases**
   While this is an important initiative, beyond adding two pulmonologists to our medical staff in recent months, the committee determined that other needs were more acute and in need of additional focus and resources.
2. **Providing additional dental health resources**
   While serious in nature, Central Texas Medical Center does not currently have the resources to materially impact this community need at this time.
3. **Education and information related to alcohol, tobacco and substance abuse**
   The Committee believed that current programs available in the community were better suited to address the needs related to alcohol, tobacco and substance abuse.

Board Approval

The Central Texas Medical Center Board approved the specific Priority Issues and the full Community Health Needs Assessment in 2016. The Board approved this Community Health Plan prior to May 15, 2017.

Public Availability

This CTMC Hospital Community Health Plan was posted by May 15, 2017 at www.ctmc.org/PopularLInks/CommunityBenefit. A paper copy is available in the Hospital's Finance Department, or you may request a copy from jessica.pizana@ahss.org.

Ongoing Evaluation

Central Texas Medical Center's fiscal year is January-December. For 2017, the Community Health Plan will be deployed beginning May 15 and evaluated at the end of the calendar year. In 2018 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 attached to our IRS Form 990, Schedule H.

For More Information

If you have questions regarding Central Texas Medical Center's Community Health Needs Assessment or Community Health Plan, please contact Community Benefit Manager, Jessica Pizana at jessica.pizana@ahss.org.

Central Texas Medical Center

2014-2017 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**
Timely access (including afterhours care) to Healthcare Professionals, especially primary care; accessing care close to home when care is needed	Increase access to primary care physicians 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 primary care physicians recruited.	Recruit at least 4 primary care physicians.		Recruit at least 3 primary care physicians.		Recruit at least 2 primary care physicians.		$1,260,000		LOHP Practice Administrator
	Increase capacity at Live Oak Health Partners Community Clinic (LOHP-CC) so Medicaid/Low Income/Uninsured (MLIU) and insured patients have access to primary care services.	MLIU and insured residents of Hays and contiguous counties.	Provide community outreach activities that increase awareness of LOHP-CC services and help MLIU and insured patients establish LOHP-CC as their medical home.	Number of encounters per month.	4500 encounters	4800 encounters		5100 encounters			5400 encounters	$1,912,500		LOHP Practice Administrator
	Expand primary care access at the LOHP Walk-in Clinic	Residents of Hays and contiguous Counties.	Hire a primary care physician (PCP) that will establish a patient panel at the LOHP Walk-In Clinic.	Number of patients declaring the LOHP Walk-in Clinic primary care physician as their PCP.	0 encounters	Hire a primary care physician who will establish a patient panel.		300 new patients		600 new patients		$166,000		

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	Improve access to those with limited mobility or lack of transportation to healthcare resources.	Residents lacking transportation within a 15-mile radius of San Marcos.	Work with Texas State University to set-up a program using students to drive patients to medical appointments.	Successful pilot program with expansion to other service lines.	0 service lines	Complete a pilot program with one service line to evaluate feasibility.		Expand to at least 2 service lines (depending on results of pilot program).		Expand to at least 3 service lines (depending on results of pilot program).		$5,400		Administrative Director of Ancillary Services
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 contiguous Counties.	Collaborate with area organizations including churches, civic groups, schools and area employers to offer CREATION HEALTH, an eight-week, faith-based wellness plan with lifestyle seminars and training. Based on 8 principles: choice, rest, environment, activity, trust, interpersonal relations, outlook and nutrition.	Number of CREATION HEALTH workshops	4 CREATION HEALTH workshops.	Offer 4 CREATION HEALTH workshops.		Offer 5 CREATION HEALTH workshops.		Offer 6 CREATION HEALTH workshops.		$7,500		Director of PR and Marketing
	Promote the ideals of healthy living by developing programs built on CREATION HEALTH program.	Residents of Hays and contiguous Counties.	Increase participation in CREATION Health Fitness Day for families and drive participation in fitness challenges at the event.	Number of adults and children participating at the Fitness Day event.	400 participants	425 participants		450 participants		475 participants		$57,000		Director of PR and Marketing

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	Provide low income residents access to basic health screenings to provide baseline for making healthier lifestyle choices.	Residents of Hays and contiguous counties.	Collaborate with local organizations (i.e. government agencies, churches, etc.) to distribute vouchers to the annual CTMC CREATION HealthCheck.	Number of vouchers distributed for HealthCheck blood screenings and number of vouchers redeemed.	Distributed 500 vouchers. 23 vouchers redeemed.	Distribute 300 vouchers. 40 vouchers redeemed.		Distribute 325 vouchers. 60 vouchers redeemed.		Distribute 350 vouchers. 80 vouchers redeemed.		$17,460		Director of PR & Marketing
Prevalence and/or enhanced outpatient management of heart disease/CHF and related conditions/risk factors such as hypertension.	Provide access to unfunded patients who qualify for outpatient cardiac rehab program.	Uninsured residents of Hays and contiguous counties.	Increase capacity of outpatient cardiac rehabilitation program to provide cardiac rehab services to unfunded patients.	Number of patients served.	4 patients	5 patients		5 patients		5 patients		$27,000		Cardiac Rehabilitation Coordinator
	Provide low income residents access to basic health screenings to provide baseline for making healthier lifestyle choices.	Residents of Hays and contiguous Counties.	Offer free blood pressure screenings at CTMC and throughout community with education on hypertension and heart disease.	Number of blood pressure screenings provided annually at CTMC and throughout Hays and contiguous Counties.	382 blood pressure screenings annually	400 blood pressure screenings annually		425 blood pressure screenings annually		450 blood pressure screenings annually		$3,780		CTMC CNO
	Provide low income residents access to basic health screenings to provide baseline for making	Residents of Hays and contiguous Counties.	Collaborate with local organizations (i.e. government agencies, churches, etc.) to distribute vouchers for Carotid Artery and	Number of vouchers distributed for Carotid Artery/ Peripheral Arterial Disease screenings.	0 vouchers provided.	Develop-ment of plan for providing screenings and distributing vouchers.		Distribute 20 Carotid Artery vouchers and 20 Peripheral Arterial Disease vouchers.		Distribute 30 Carotid Artery vouchers and 30 Peripheral Arterial		$9,000		Director of PR & Marketing

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	healthier lifestyle choices.		Peripheral Arterial Disease screenings; including education.							Disease vouchers.				
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 contiguous 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 50 blood glucose screenings and risk assess-ments monthly at CTMC.	Average 52		Average 54		Average 56		$4,205		Patient Educator, Diabetes Self-Management Education class coordinator
	Improved compliance with short and long term diabetes control and management strategies.	All individuals that have participated in a CTMC Diabetes Education Class.	Over a 12-month period, provide all CTMC diabetes education class participants with up to four free, individualized 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.	42.5% of diabetes education participants received at least 2 follow-up visits over a 12-month period.	At least 42.5% of diabetes education participants received at least 2 follow-up visits over a 12-month period.		At least 43.8% of diabetes education participants received at least 2 follow-up visits over a 12-month period.		At least 45% of diabetes education participants received at least 2 follow-up visits over a 12-month period.		$5,672		Patient Educator, Diabetes Self-Management Education class coordinator
	Provide individuals diagnosed with diabetes, and their family members, on-going opportunity for education, and accountability and	All residents of Hays and contiguous Counties with a diagnosis of diabetes or pre-diabetes, especially those participating in CTMC's	Offer a free, Diabetes Support Group meeting every two weeks.	Average attendance per meeting.	Average 9 participants per meeting	Average 10		Average 11		Average 12		$12,303		Patient Educator, Diabetes Self-Management Education class coordinator

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	encouragement to adopt and maintain successful diabetes management and control strategies.	Diabetes Education Classes and diabetes-related events.												
Educating the population to better understand the healthcare resources available to them through various channels including those provided by CTMC, Live Oak Health Partners and other entities and a commitment to helping them navigate those resources.	Improved management of Hospitalized unfunded patients in an outpatient/ home setting.	Uninsured residents of Hays and contiguous counties with an admission to CTMC.	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.	50% of all unfunded patients have a referral to a medical home prior to discharge from CTMC.	75% of all unfunded patients have a referral to a medical home prior to discharge from CTMC.		80% of all unfunded patients have a referral to a medical home prior to discharge from CTMC.		85% of all unfunded patients have a referral to a medical home prior to discharge from CTMC.		$360,000		Case Management Director
	Improve the community's understanding of healthcare resources provided through CTMC, Live Oak Health Partners and associated clinics.	Patients who received care, or their family members, from CTMC or Live Oak Health Partners or any other outpatient clinics within the last 2 years.	Establish a Patient Family Advisory Council (PFAC) that will advocate for community resources based on their experience with CTMC and Live Oak Health Partners and associated clinics.	Successful Patient Family Advisory Council with at least 4 scheduled meetings per year.	Develop-ment of Patient Family Advisory Council.	PFAC members will develop an action plan to address at least one identified CTMC/community need.		PFAC members will develop an action plan to address at least two identified CTMC/community need.		PFAC members will develop an action plan to address at least three identified CTMC/community need.		$2,544		CTMC CNO
	Develop support groups for individuals	All individuals with breast cancer and	Patient Navigator will coordinate/	Number of support groups meetings.	0 support group meetings	Develop a roll-out strategy for		12 meetings		15 meetings		$1,350		CTMC Ancillary

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	facing breast cancer, especially those that are Spanish speaking.	their family members/support system.	facilitate free breast cancer support groups with emphasis on navigation of healthcare resources.			these meetings including locations and frequency.								Services Director
	Improve access to mammograms for low-income individuals.	Uninsured residents of Hays and Caldwell Counties; focus on Kyle, Lockhart, Wimberley, & San Marcos	Expand the timeframe to redeem free mammogram vouchers and conduct follow-ups to ensure they access the screening.	Increase the redemption rate of mammogram vouchers.	49 vouchers redeemed	At least 70 vouchers redeemed		At least 80 vouchers redeemed		At least 100 vouchers redeemed		$16,250		CTMC Ancillary Services Director
Prevalence and/or enhance management of mental and behavioral healthcare options.	Increase coordination of community organizations to better meet the psychiatric needs of the community.	Residents of Hays and contiguous counties.	Develop a cross-functional community committee. Include law enforcement, CTMC, Texas State University, LOHP and local mental health providers.	Number of meetings/year	0 meetings	1 meeting		2 meetings		4 meetings		$630		CTMC CNO
	Provide family members ongoing opportunity for education and encouragement.	Residents of Hays and contiguous counties.	Offer a free support group for families with a loved one with mental/behavioral challenges.	Number of support groups facilitated.	0 support groups	Develop family centered support group for behavioral/ mental health patients.		Facilitate 2 meetings.		Facilitate quarterly meetings.		$360		CTMC CNO

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	Educate community residents about the mental and behavioral healthcare options available.	Residents of Hays and contiguous counties.	Offer free, educational presentations at local churches, businesses, civic groups, etc.	Number of presentations provided in community.	0 presentations	2 presentations		4 presentations		8 presentations		$840		CTMC CNO