DeKalb Medical System

Community Health Needs Assessment: Implementation Plan

DeKalb Medical Hillandale

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Approved by: DeKalb Medical System's Regional Board of Director's Governing, Risk and Compliance Committee in December, 2016
Posted to www.dekalbmedical.org on December 17, 2016. (this date is TBD)

I. Background and Process:

The DeKalb Medical System completed its second community health needs assessment (CHNA) in June 2016. It has now developed this Implementation Plan with strategies to address the heath needs of its communities that were identified in the CHNA. For the 2016 assessment, DeKalb Medical at Hillandale has defined its community as the zip codes of 30034, 30038, 30035 and 30058, all within DeKalb County.

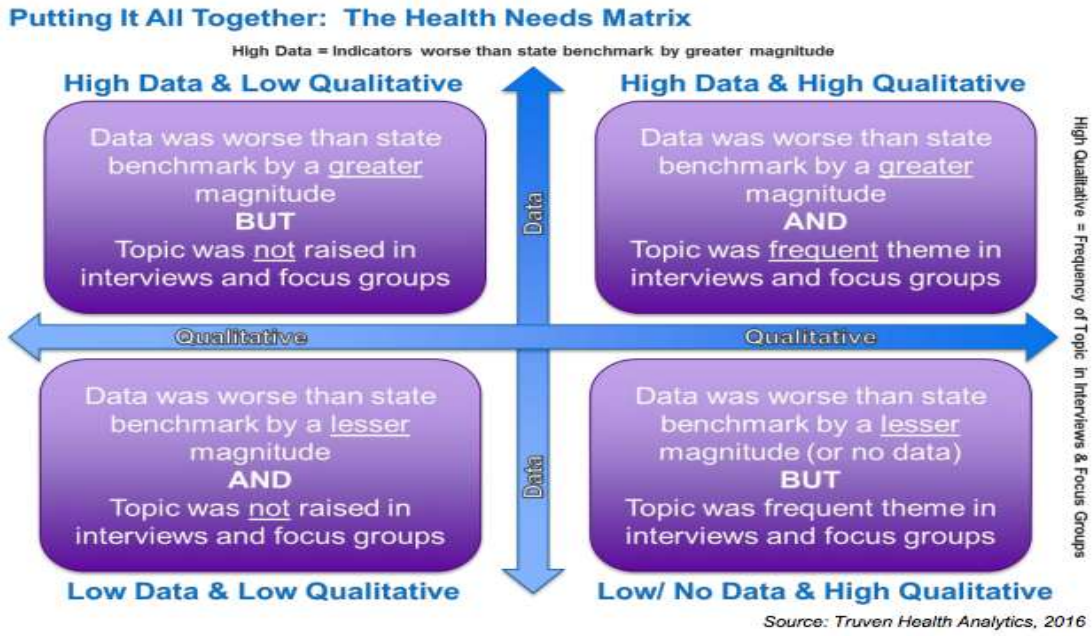
The CHNA was conducted in partnership with Truven Health Analytics, an IBM company. Truven Health Analytics performed a qualitative and quantitative assessment to help identify the health needs of DeKalb Medical at Hillandale's community. More than 100 public health indicators were evaluated during the quantitative analysis. For each indicator, values or scores for the community were compared to that of the state and nation. The qualitative analysis drew input from the community via focus groups comprised of community leaders, public health experts, and those representing the interests of minority, underserved, and indigent populations. The outcomes of these analyses were evaluated to create a comprehensive list of community health needs, which were then reviewed by DeKalb Medical leadership to establish and prioritize the areas of focus for DeKalb Medical.

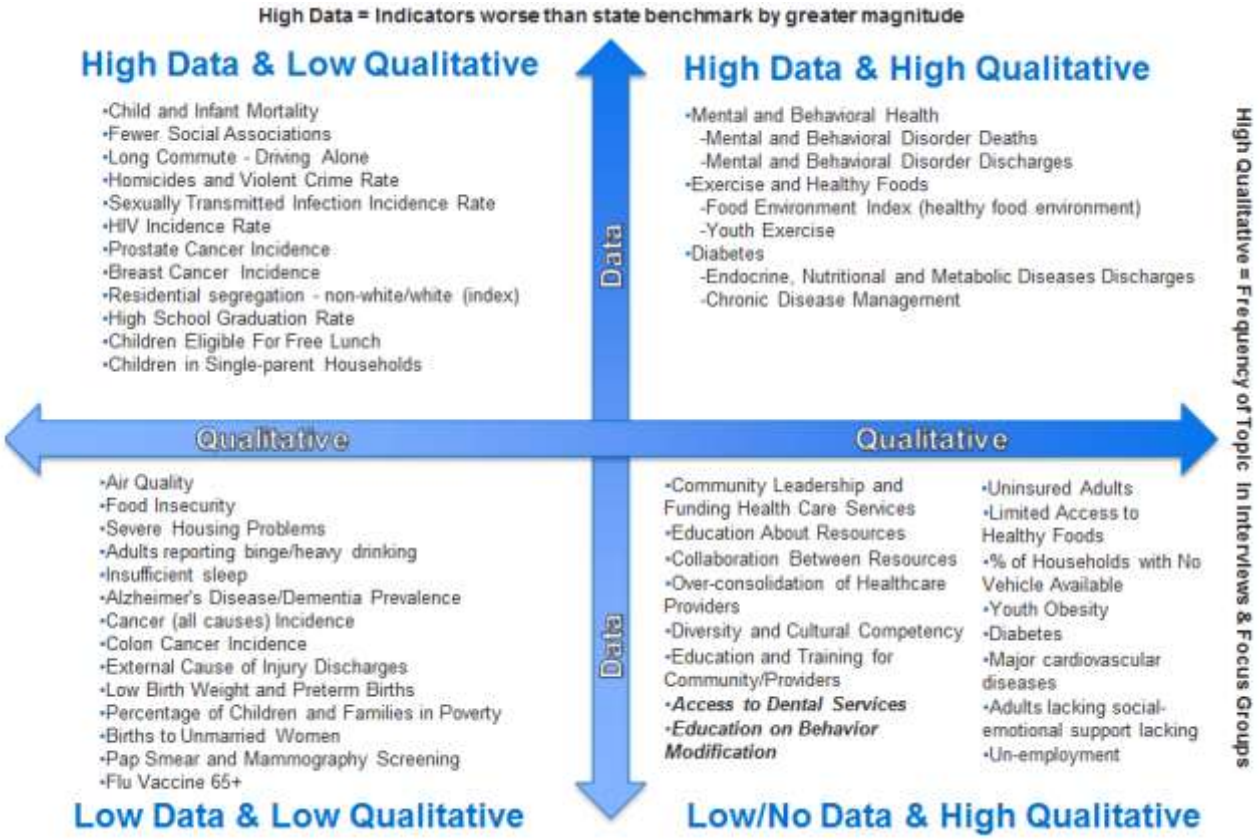
This 2016 Implementation Plan has been prepared to document the efforts of DeKalb Medical at Hillandale to address the community health needs prioritized in the CHNA, and is intended to meet the requirements set forth in federal law by the Internal Revenue Code Section 501(r).

The 2016 CHNA and this Implementation Plan is available for download and can be accessed at www.dekalbmedical.org.

II. Identified Needs and Prioritization:

The quantitative and qualitative data was analyzed and placed into health needs matrix classifying health needs on the basis of quantitative indicator performance and qualitative frequency of the topic in interviews.





In May 2016, DeKalb Medical leadership reviewed the matrix to prioritize and those health needs in the community it would focus its efforts on. Based on feasibility, hospital capacity, ability to measure, and alignment with the health system's strategy, the following needs were identified as the top priorities for DeKalb Medical System to address.

1. Cancer incidence and disease management, with a focus on breast and prostate cancer
2. Education and training of community providers
3. Community health education including available resources.
4. Diabetes incidence and disease management

There are additional areas of need which were identified in the health needs matrix, but not addressed as priority health needs in the 2016 CHNA or Implementation Plan. The needs classified in the bottom left "low data, low qualitative" quadrant were not considered the community's significant health needs. Additionally, while the needs access to dental services and education on behavior modification were classified as "high qualitative", there was no matching quantitative data available. For other needs listed in the matrix, it was determined that DeKalb Medical at Hillandale has limited ability to affect, lacks system resources/data available to influence change, or there are other healthcare and community organizations better aligned to address these priorities. Additionally, many health needs are a result of social, economic, or environmental issues which are outside of the scope of DeKalb Medical's mission and resources.

III. Implementation Plan:

This Implementation Plan was developed based on the findings and top priorities established by the 2016 CHNA and taking into account the quantitative and qualitative data and community stakeholder input. In order to address the priorities, DeKalb Medical at Hillandale leaders identified measurable goals for the management of the identified health needs and outside and inside strategies to address various aspects of the priorities. The accompanying plan outlines those strategies. Measures on the identified needs from DeKalb Medical's fiscal year ending June 30, 2016 are used as baselines and progress goals are set for the three year period. Where projected goals are not available or reasonable for all three years, they will be evaluated each year for the next three years. In addressing the selected priorities, special priority will be placed on building upon existing programs, initiatives, and measures.

I. Cancer

Incidence and disease management of breast and prostate cancer.

Objective 1:

Indicator/Measure	*Baseline Year – 2016*
DeKalb Medical Physicians Group patients receiving mammograms.	53% of total applicable patients – HEDIS percentile: 10%
Projected Goal	*Year*
Increase HEDIS percentile to 50%	2017
Increase HEDIS percentile to 75%	2018
Increase HEDIS percentile to 90%	2019

Actions/Strategies

Initiative in place to centrally schedule mammograms by identifying qualifying patients by payer. This initiative currently comprises commercial/private insurance plans, where mammograms are usually fully covered. Centralized callers contact patients due for mammograms and schedule appointments in an effort to increase screening mammogram acceptance.

Beginning in January 2017, a new population health initiative will be launched. Using MD Insight, a newly implemented system utilizing clinical data to produce dashboards and intelligent reporting, DeKalb Medical Physicians Group physicians are to produce and utilize Patient Care Summary reports for every patient at every visit to ensure any necessary tests, labs, procedures, including mammograms and breast screenings are completed when they are due. The average patient sees their primary care provider four times per year. After the first year of utilizing Patient Care Summaries for every patient at every visit, the aim is that all missing or necessary services and at risk health concerns regarding breast cancer prevention will be addressed.

Also, awareness campaigns and other additional activities will be conducted each October for the next three years for National Breast Cancer Awareness Month to push for breast cancer screenings.

*HEDIS (Healthcare Effectiveness Data and Information Set) is a set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA) utilizing data collected insurance claims for hospitalizations, medical office visits and procedures.

II. Community Health Education

Community health education and available resources

Objective 1:

Indicator/Measure	*Baseline Year – 2016*
Community outreach diabetes programming and events.	42 events total

Projected Goal	*Year*
Increase number of events to 47	2017
Increase number of events to 52	2018
Increase number of events to 57	2019

Actions/Strategies

Community outreach conducts free monthly workshops for diabetes education and health talks at the hospital and in the community on diabetes-related topics. As well as community festivals where diabetes information is distributed and sugar shocker demonstrations are conducted.

Objective 2:

Indicator/Measure	*Baseline Year – 2016*
Community outreach programming for cardiovascular disease and stroke.	23 events total

Projected Goal	*Year*
Increase number of events to 28	2017
Increase number of events to 33	2018
Increase number of events to 38	2019

Actions/Strategies

Programming and events includes American Heart Association Heart Walk and other health talks related to stroke and cardio as well as sleep and heart health. Also includes community festivals where heart health and service line information is distributed.

Objective 3:

Indicator/Measure	*Baseline Year - 2016*
Community outreach cancer programming and events.	15 events total

Projected Goal	*Year*
Increase number of events to 20	2017
Increase number of events to 25	2018
Increase number of events to 30	2019

Actions/Strategies

Community Outreach assists the Cancer staff with such as Cancer Survivor's Day, Relay for Life and Cancer Screening Day. Also includes Community Outreach planned health talks in the community and at the hospital as well community festivals where cancer service line information is distributed.

Also, the Cancer Center focuses on a different malignant disease each year. The focus of 2016 was on breast cancer. 2018 will feature a focus on prostate cancer.

III. Community Providers	
Education and training of community providers.	
Objective 1:	
Indicator/Measure	*Baseline Year – 2016*
Number of nursing students with clinical rotation at DeKalb Medical at Hilllandale measured year over year.	2,908 clinical hours
	Year
7,956 clinical hours	2017
8,353 clinical hours	2018
8,771 clinical hours	2019
Actions/Strategies	
It is a measure of DeKalb Medical's vision to partner with the best providers to prepare students who are in clinical education programs by providing a location for training in a clinical setting. Hospitals are an ideal training location due to the wide range of illnesses and conditions inherent to hospital patients. The DeKalb Medical system has existing agreements to include as a practicum site for nursing students.	

IV. Diabetes	
Diabetes prevalence, screening, discharges, and disease management.	
Objective 1:	
Indicator/Measure	*Baseline Year – 2016*
DeKalb Medical Physicians Group diabetic patients' A1C levels less than 9.	HEDIS percentile 50%
Projected Goal	*Year*
Increase HEDIS percentile to 75%	2017
Increase HEDIS percentile to 90%	2018
Maintain HEDIS percentile at 90%	2019
Objective 2:	
Indicator/Measure	*Baseline Year – 2016*
DeKalb Medical Physicians Group diabetic patients' LDL levels less than 100.	HEDIS percentile 25%
Projected Goal	*Year*
Increase HEDIS percentile to 50%	2017
Increase HEDIS percentile to 75%	2018
Increase HEDIS percentile to 90%	2019
Objective 3:	
Indicator/Measure	*Baseline Year – 2016*
DeKalb Medical Physicians Group diabetic patients receiving diabetic eye exams.	HEDIS percentile 10%
Projected Goal	*Year*
Increase HEDIS percentile to 50%	2017
Increase HEDIS percentile to 75%	2018
Increase HEDIS percentile to 90%	2019
Actions/Strategies – Objective 1-3 – Population Health Strategies	
Beginning in January 2017, a new population health initiative will be launched. Using MD Insight, a newly implemented system utilizing clinical data to produce dashboards and intelligent reporting, DeKalb Medical Physicians Group physicians are to produce and utilize Patient Care Summary reports for every patient at every visit to ensure any necessary tests, labs, procedures, etc. are completed when they are due. The average patient sees their primary care provider four times per year. After the first year of utilizing Patient Care Summaries for every patient at every visit, the aim is that all missing or necessary services and at risk health concerns regarding diabetic health will be addressed Also, awareness campaigns and other additional activities will be conducted each November for the next three years for American Diabetes Month to proactively engage diabetic patients to see their doctors to seek routine and necessary care.	

Objective 4:	
Indicator/Measure	*Baseline Year – 2016*
Increasing number of patients/consults in the outpatient diabetes program.	1,150 patients
Projected Goal	*Year*
Increase number of patients/consults to 1,250 patients	2017
Increase number of patients/consults by 5%. ~1,313 patients	2018
Increase number of patients/consults by 5%. ~1,380 patients	2019
Actions/Strategies	
The outpatient diabetes program is referral based and accredited by the American Diabetes Association. Each patient receives a pre-assessment followed by a comprehensive education session. During the on-site session, patients learn diabetic management skills and set personal goals in a group class setting. Patients then receive a 3 month follow up call addressing their diabetic management skills. Questioned topics include A1C level, glucose monitoring, checking feet, physical activity and more.	
Objective 5:	
Indicator/Measure	*Baseline Year – 2016*
Increasing number of patients/consults in the inpatient diabetes program.	748
Projected Goal	*Year*
Increase number of patients/consults to 825 patients	2017
Increase number of patients/consults by 5%. ~866 patients	2018
Increase number of patients/consults by 5%. ~909 patients	2019
Actions/Strategies	
Diabetes educators provide consults to patients who are admitted to the hospital and identified by physicians to need a diabetic consult. These patients may have been newly diagnosed with diabetes or have existing diabetes. Starting October 2016, each educator will identify 5 patients per month to follow up with. These are to be patients who showed great interest in and need for diabetes education as an inpatient. The goal is that they are to obtain referral from their primary care provider to take part in the outpatient program.	

Conclusion

DeKalb Medical at Hillandale's Implementation Plan will help guide efforts towards community health needs that have been identified during the 2016 CHNA. All the needs identified, if unaddressed, have a negative impact on the health and wellness of the people of DeKalb County. For the purposes of this CHNA and the 2016 Implementation Plan, DeKalb Medical at Hillandale has chosen to place its primary focus on the priorities identified above. However, it will continue to address other health issues identified by assisting, where possible, community partners with their endeavors related to these issues.