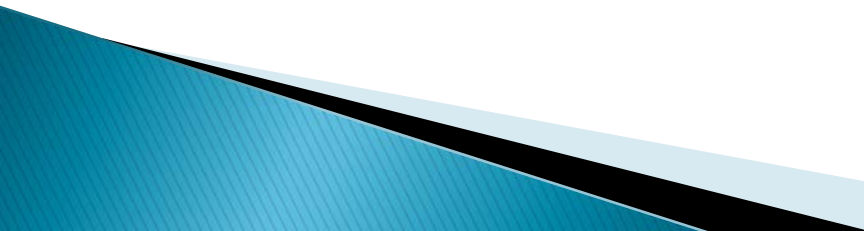



Community Health Needs Assessment Report and Implementation Plan

Labette County
November 21, 2014

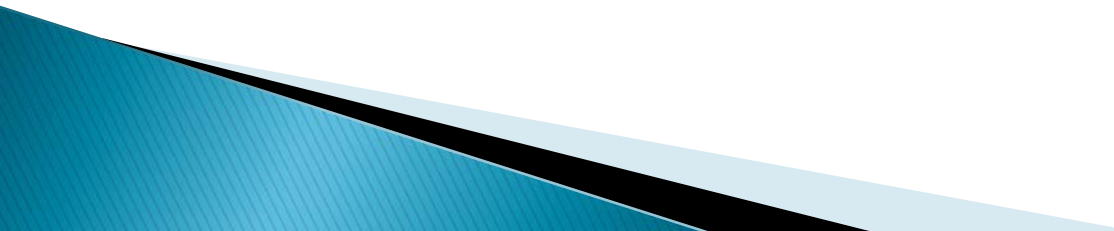
Community Health Needs Assessment Deliverables

- ▶ CHNA Report defining data collected, analysis of county health data, identification of community health gaps and participants in the planning process
 - ▶ Implementation Plan defining local strategies to address remaining community health gaps, based upon historic programming, evidence-based health improvement research and best practices learned from other providers
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Community Health Challenges Identified by Data and Discussion

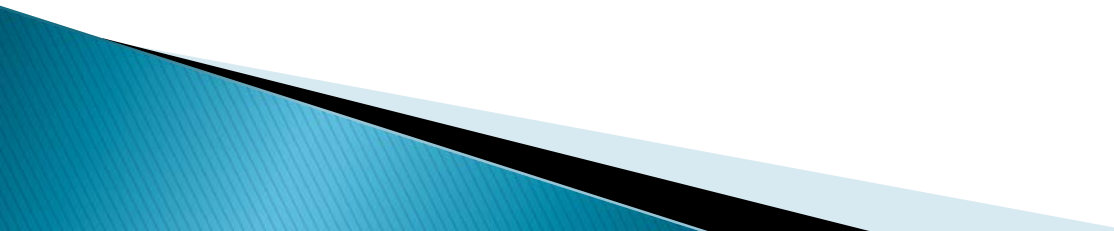
- ▶ Individuals not taking an active role in managing their health
 - ▶ Patients receiving services failing to follow their prescribed care plan
 - ▶ Lack of community-based early detection program for heart disease
 - ▶ Need for expanded early detection of cancer
 - ▶ Community struggling to negotiate the complex health care system
 - ▶ Better understanding of full health care team
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Additional Community Health Gaps

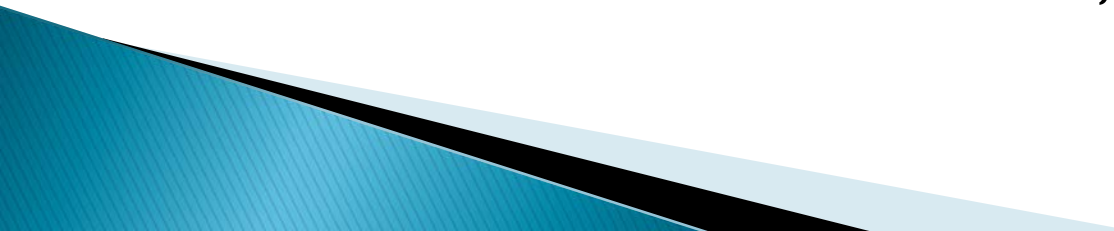
- ▶ Limited transfer of information between community providers
 - ▶ Need for greater access to dental services for uninsured and underinsured
 - ▶ Expanded support services for single parent families
 - ▶ Incentive programs that do not require continued reliance on public assistance
 - ▶ Greater physician involvement in community health activities
- 

Most Significant Health Improvement Opportunities

- ▶ Labette County ranks in the bottom quartile in the prevalence of:
 - COPD
 - Heart Failure
 - Ischemic Heart Disease
 - Rheumatoid Arthritis/Osteoarthritis

 - ▶ Labette County is not meeting Healthy People 2020 targets in:
 - Infant Mortality
 - Uninsured Adult Population
- 

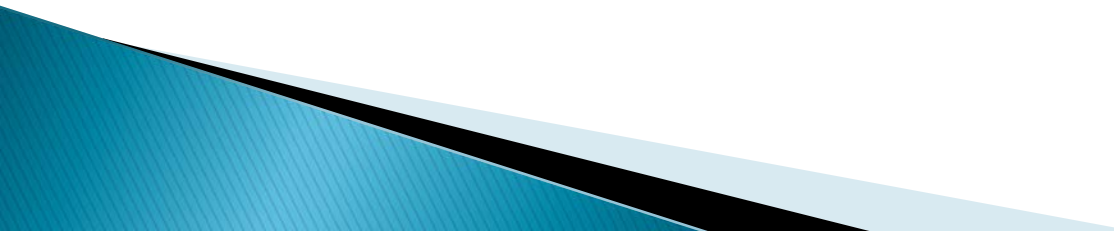
CHNA Implementation Plan

- ▶ What current community health programs can we build upon to continue improvement?
 - ▶ Where are current programs proving too costly or less effective than anticipated?
 - ▶ What new strategies should be considered to address remaining gaps?
 - ▶ What can we learn from other communities in terms of successful initiatives and best practices?
 - ▶ How can we work smarter, not harder?
- 

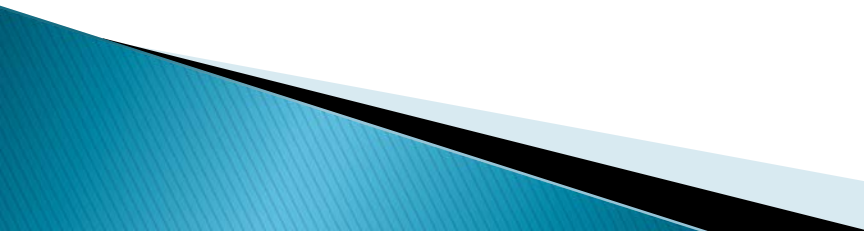
Evidence-based Population Health Resources

- ▶ American Journal of Managed Care
 - ▶ American Hospital Association
 - ▶ Fitness Journal
 - ▶ Jackson Healthcare Awardees
 - ▶ Johns Hopkins Healthcare Solutions
 - ▶ Kansas Department of Health and Environment
 - ▶ Kansas Health Matters
 - ▶ Robert Wood Johnson
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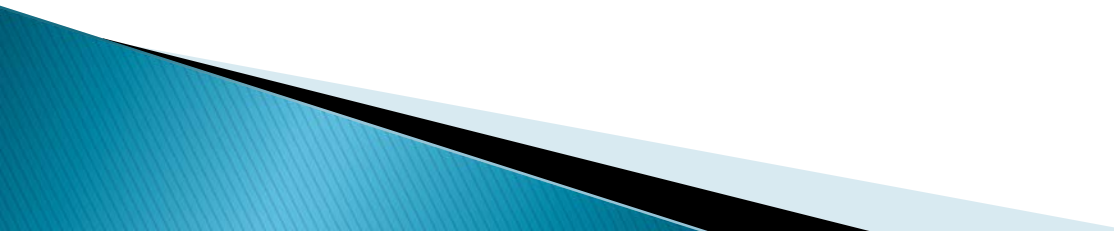
Effective, Proven Options for Improving Community Health

- ▶ Audio recording of discharge conversations, via personal cell phone, shown to measurably improve patient understanding/outcomes.
 - ▶ ExRX – Exercise prescription at-home program with follow-up calls to improve compliance.
 - ▶ KAMP – Kid Asthma Management Program including school screening for asthma, often linked to obesity, and asthma camp.
- 

Other Best Practices

- ▶ Men's University – screenings/education at male-oriented events i.e. car shows.
 - ▶ Nutrition Center – school-based snack tastings with fruits, Lots-to-Gardens veggie sharing program, bulk rate fresh produce through hospital vendor partnership with churches/social organizations.
 - ▶ Our Money Place – teaches management of finances including credit and debt counseling and screening for public benefits.
- 

More Best Practice Recommendations

- ▶ Snak Packs – weekend healthy food packs for children at risk of going hungry, through partnership with hospital food vendor.
 - ▶ Voucher Program – grant through Delta Dental to reimburse for basic dental care.
 - ▶ Uninsured Care Coordination program, including psycho-social assessment to connect with community resources i.e. transportation, medication assistance, housing and employment options, funded through hospital charity care savings.
- 

Proposed Strategic CHNA Implementation Plan

- ▶ Access for uninsured/underinsured
 - Seek expansion of Kansas Department of Health and Environment Bureau of Primary Care Grant to extend Community Clinic hours.
 - Expand Community Clinic primary care provider referral program for uninsured with chronic illness including diabetes, heart failure, COPD, asthma and arthritis.
 - Market sliding fee scale access to clinics across the county participating in the primary care program.
 - Promote Foundation's grant-funded mammograms.

Implementation Plan Recommendations

- ▶ Dental Shortage Area designation
 - Provide Labette County residents with transportation to annual Mission of Mercy free dental clinic through hospital/foundation shuttles.
 - Submit Delta Dental Foundation grant application to replicate Community Clinic medical provider referral program for dental patients.
- 


Implementation Plan

Recommendations


- ▶ Engage community in management of their own care
 - Expand blood pressure check sites and frequency.
 - Establish Healthcare Hotline to match individual care needs with local resources.
 - Implement Medicare Care Transitions Program.
 - Explore Community Paramedic Program, based upon Colorado model, as state law allows.
 - Build upon Dr. Pai's annual Men's Health checks with additional screenings, locations and prize drawings tailored to male interests.

Implementation Plan

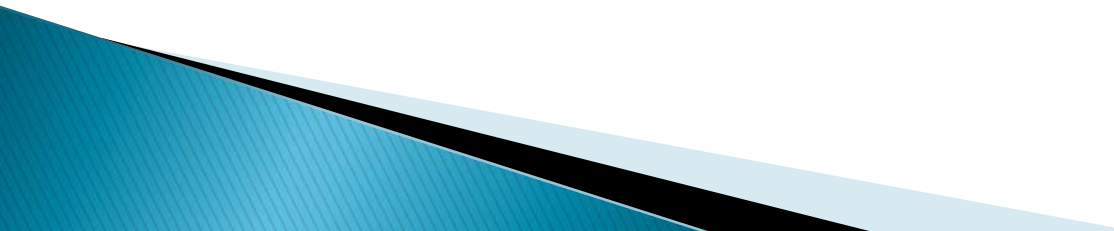
Recommendations

- ▶ Heart disease screening and early detection
 - Establish quarterly, hospital-based screening programs to replace outside mobile services, providing poor quality images and limited follow-up, with a comprehensive and coordinated program.
 - Re-establish Cardiac Rehabilitation Program to assist patients in recovery and on-going management of heart disease.
 - Launch marketing campaign to educate community on the warning signs and symptoms of cardiac disease and stroke.
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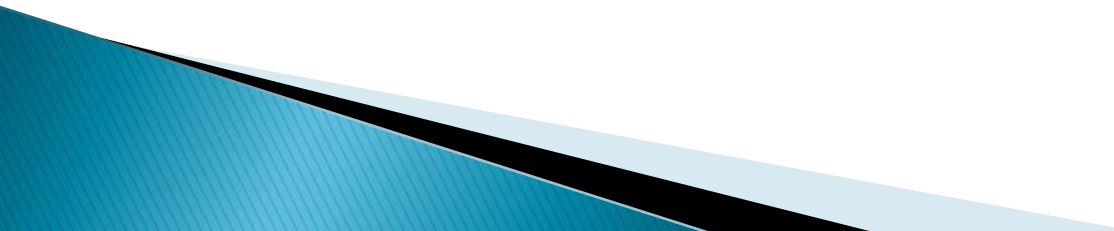
Implementation Plan Recommendations

- ▶ Infant and Maternal Health
 - Actively support Labette County Public Health Department's March of Dimes prenatal incentive program through coordination with OB clinic.
 - Build upon current breastfeeding expertise through KDHE's education and encouragement program, providing additional resources and training for hospital OB staff.
 - Engage Kansas' private Medicaid Managed Care Organization's in proposed pilot project to expand current prenatal programming into outcomes-based model for reducing complications.
- 

Addressing Environmental Gaps To Improve Community Health

- ▶ Focused ER programs to reduce mortality due to traffic and unintentional injury.
 - ▶ Assistance for those in the “gap” between Medicaid and Healthcare Marketplace participation, i.e. premium support.
 - ▶ Work to expand educational partnership with high schools to promote job skills matching.
 - ▶ Expand local partnership to improve food security, expanding summer children’s program to include weekend packs.
- 

Partnering with Local Health Care Providers To Address Gaps

- ▶ Seek funding to implement “embedding” of behavioral health providers in existing Rural Health Clinics.
 - ▶ Establish linkage with local post–acute providers for expanded Palliative Care and staff training opportunities.
 - ▶ Explore substance abuse partnership options with local law enforcement agencies.
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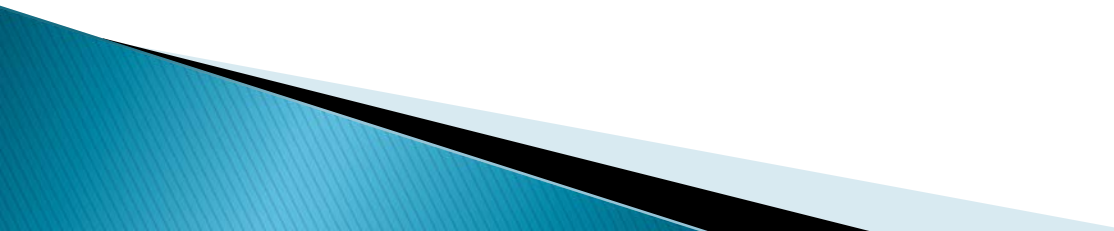
Regional Physician/Provider Need Analysis

- ▶ Regional data includes service areas of the following regional hospitals:
 - Neosho Memorial, Chanute
 - Wilson Medical, Neodesha
 - Fredonia Regional Hospital
 - Allen County Regional Hospital
 - Coffeyville Regional Medical Center
 - Mercy Maude Norton Hospital
- Plus
 - Labette Health
 - Oswego Community Hospital
 - Mercy Hospital Independence

Demographics of Regional Service Area, 2014–2019

▶ Total Population	91,329
▶ Percent Population Change	-2.30%
▶ Net Population Change	-2,149
▶ Population 65+	17,009
▶ Percent Population 65+	19.40%

Five Year Demographic Projections, 2014–2019

- ▶ Percent Female Pop. Change +6%
 - ▶ Median Household Income \$37,807
 - ▶ Projected Income Change -18%
 - ▶ Households Earning <\$25,000 41%
 - ▶ Percent Non-White 12%
- 

Estimated Total Need of Regional Service Area

Specialty	Additional FTE's
Allergy	1.1
Anesthesiology	1.7
Cardiac/Thoracic Surgery	2.3
Cardiology	1.5
Dermatology	2.2
Emergency Medicine	2.8
ENT	2.1
Gastroenterology	3.2

Estimated Additional Need, 2019

▶ Hematology/Oncology	0.3
▶ Infectious Disease	1.3
▶ Internal Medicine	10.1
▶ Nephrology	2.1
▶ Neurology	1.1
▶ Neurosurgery	0.3
▶ Ophthalmology	2.1
▶ Pathology	0.9
▶ Pediatrics	5.2
▶ Physical Medicine/Rehab	0.8

Estimated Additional Need, 2019

▶ Plastic Surgery	1.3
▶ Psychiatry	3.9
▶ Pulmonary Disease	1.3
▶ Radiology	3.5
▶ Rheumatology	1.1

* Additional need estimate assumes current number of providers at 2014 levels, barring retirements/relocations.

Additional Implementation Plan Strategies

- ▶ What gaps does the proposed plan fail to adequately address?
 - ▶ What additional community partnership opportunities should be explored?
 - ▶ Are there more effective strategies to reach our Community Health Improvement goals and where can we learn more?
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