ATTACHMENT A

Providence Healthcare Network

2016 Community Health Improvement Plan Implementation Strategy

Formally adopted by Providence Healthcare Network Board of Directors on October 14, 2016.

Formally adopted by the Ascension Texas Ministry on November 15, 2016

About Providence Healthcare Network

A member of Ascension -- the largest non-profit health system in the U.S and the world's largest Catholic health system -- Providence Healthcare Network is dedicated to spiritually centered, holistic care, which sustains and improves the health of individuals and communities. Beginning in 1905 as Waco's first hospital, Providence is now one of the community's largest employers, offering a comprehensive continuum of care to Greater Waco. Ascension's Texas Ministry includes Providence and Seton Healthcare Family in Austin. For more information, go to www.providence.net.

Community Health Needs Assessment (CHNA) Overview

The 2010 Patient Protection and Affordable Care Act included an IRS mandate that changed Community Benefit reporting. Non-profit hospitals must now engage in a three-year cycle of addressing community health needs, beginning with a Community Health Needs Assessment (CHNA) for the communities it serves. Once the CHNA is complete, each hospital must create and adopt an Implementation Strategy that describes the actions the hospital plans to take to address the health needs identified in the Community Health Needs Assessment. These mandates are required as a condition of maintaining the hospital's federal tax exemption status.

CHNA Methodology

In 2016, Providence and its community partners conducted a CHNA for the communities in McLennan County served by Providence Healthcare Network. The methodology for conducting the CHNA included the following components:

(1) The Center for Community Research and Development (CCRD) at Baylor University retained to conduct a CHNA of our community.
(2) Large-Scale Phone Survey conducted
(3) Focus groups and key informant studies conducted in Fall 2015 and compiled by Truven Health Analytics (retained by Baylor Scott & White Hillcrest)
(4) Populations represented: medically underserved; low-income; minorities; populations with chronic disease needs, and; public health representatives

A detailed description of the methodology Providence used to conduct the 2016 CHNA is included in the CHNA report posted on the Providence Healthcare Network website.

CHNA Community Partners

The 2016 Community Health Needs Assessment for McLennan County was prepared by the Center for Community Research and Development (CCRD) at Baylor University in support of the following community partners: Waco-McLennan County Public Health District *; Baylor Scott & White Hillcrest *; Providence Healthcare Network *; Center for Community Research & Development/Baylor University *; City of Waco; Heart of Texas Regional Advisory Council; Veterans Association; Mental Health Mental Retardation Association; Prosper Waco; Family Health Center; and, Texas Area Health Education Centers (TXAHEC).

* *Funding partners*

CHNA Implementation Strategy

Providence has developed six Implementation Strategies (IS); each focused on internal stakeholder efforts with current programs with the intention to continue. Goals and

activities have been planned for next three years. Each plan identifies the programs and actions the service line, with the support of the Network and the community, plans to take to address the priority needs identified in the CHNA. As required by the IRS, the plans also address any needs that will not be met and providing a way to accept public comments.

Prioritized Health Needs for McLennan County

Based on the process and criteria listed above, Providence Healthcare Network created Implementation Strategies that address the following priority needs identified in the 2016 CHNA survey by the use of logic models that identifies:

- Key actions and strategies to address the need
- Available resources
- Potential collaborations
- Describes the anticipated impact of the action

Key Finding #1: Health Concerns and Risks (see action plans below)

1. Priority Need: Diabetes Management
   (Katrina Linthicum/Dir. Of Case Management @ 751-4454)
   Goal: Improvement in self-management in those adults living with diabetes.
   Strategy: Provide diabetes education to activate and empower patients to gain knowledge and make lifestyle changes supporting management of diabetes.

2. Priority Need: Behavioral/Mental Health
   (Vicky Campbell/DePaul Center @ 776-5970)
   Goal: Increase access to psychiatric assessment and care.
   Strategy: Provide Telepsychiatry for patients requiring assessments.

Key Finding #2: Access and Affordability (see action plan below)

1. Priority Need: Access to Care
   Goal: Improve access to care to the identified target population within McLennan County.

a. Strategy #1: Design, develop, and deliver an annual Medical Mission @ Home in Waco.
   (Jay Scherler/VP @ 751-4147; asst. Donna Blansit @ 751-4731)

b. Strategy #2: Assist the Waco-McLennan County Health District in the implementation of the Community Health Worker Initiative.
   (Katrina George/C4T @ 751-4754)

Key Finding #3: Wellness and Prevention (see action plans below)

1. Priority Need: Internal Wellness Initiatives
   (Cate Doerksen/Nutritional Services @ 751-4000 x3054)
   Goal: Improve the health status of associates and visitors.
   Strategy: Increase access to healthier food and beverage options.

2. Priority Need: Clinic Operations Wellness Assessment Program

(Lesia Holt/Clinic Operations @ 537-6853)

Goal: Increase number of women receiving mammogram in Providence Health Alliance system.

Strategy: Continue collaboration formed with PBHC to capture lives served and streamline the mammogram appointment process for this group.

3. Priority Need: Pink Partner Fund/Free Mammogram Program
   Jennifer Furrer/Breast Health Center @ 537-1711)

   Goal: Expand access to breast health care for the uninsured/underinsured of our community by offering free breast health services through Pink Partner Fund.

   a. Strategy #1: Raise funds for Pink Partner Fund.
   b. Strategy #2: Increase awareness of the fund and importance of early detection.

Key Finding #1.1 – Health Concerns and Risks: Diabetes Management Action Plan

STRATEGY 1: Provide diabetes education to activate and empower patients to gain knowledge and make lifestyle changes supporting management of diabetes.

BACKGROUND INFORMATION:

- The target population is under-served, low-income, uninsured and/or under-insured adults who have diabetes and reside in McLennan and surrounding counties.
- The strategy addresses social determinants of health through the provision of culturally competent services based on both program goals and individualized patient need including language preference, health literacy, psychosocial barriers, lifestyle and environmental considerations.
- The strategy employs evidence-based practices to address patient health literacy, self-management, and quality of life including the Diabetes Self-Management Training model implemented by Certified Diabetes Educators (CDEs) and the scientifically validates Problem Areas in Diabetes Questionnaire (PAID).

RESOURCES:

Strategy source: http://www.cdc.gov/diabetes/prevention/index.html
Staff: CDEs, dieticians, nurse navigators, patient registrars, project coordinator
Equipment: Laptops, glucometers, blood pressure cuffs, scales, monofilaments, standard precautions supplies
Funding: Operational and marketing budgets
Materials: promotional items, teaching aides, marketing materials

COLLABORATION:

Providence Healthcare Network (PHN); regional hospitals in Bosque, Falls, Hill, Limestone, and Coryell counties; community health organizations; endocrinology specialty clinic

ACTIONS:

1. Provide DSMT services to the target population.

STRATEGY 1: Provide diabetes education to activate and empower patients to gain knowledge and make lifestyle changes supporting management of diabetes.

2. Partner with local churches, employers, and community health agencies to conduct diabetes education outreach activities.
3. Create and provide clinical diabetes education for healthcare providers.

ANTICIPATED IMPACT:

1. By June 2019, improve the Problem Areas in Diabetes (PAID) post-scores for those receiving Diabetes Self-Management Training (DSMT) at PHN.
2. By June 2019, increase referrals from regional primary care providers to DSMT.

Key Finding #1.2 – Health Concerns and Risks: Behavioral/Mental Health Action Plan

STRATEGY 2: Provide Telepsychiatry for patients requiring assessment.

BACKGROUND INFORMATION:

- The target population is under-served patients who require a mental health or psychiatric evaluation in McLennan and surrounding counties.
- The strategy addresses social detriments of health through the provision of culturally competent services based on both program goals and individualized patient need including limited access to psychiatric assessment and care/treatment, limited access to medication management, and assistance with appropriate placement and resource referrals.
- There is a national, state, and local shortage of psychiatrists.
- The strategy employs evidence-based practices to address limited access to psychiatric assessment and treatment.

RESOURCES:

Strategy sources:
https://www.cdc.gov/mentalhealth/index.htm
http://www.who.int/topics/mental_disorders/en/
https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives
Staff: Mental health staff, ER staff, MDs, Medicaid Waiver Coordinator
Equipment: TVs, cameras/microphones, secure internet access, tablets, phones and fax machines
Funding: Medicaid 1115 waiver funds

COLLABORATION:

Providence Healthcare Network (PHN); regional hospitals in Bosque, Falls, Hill, Limestone and Coryell counties; DePaul Center

ACTIONS:

1. Develop and implement Telepsychiatry access in PHN Emergency Department (DY2).
2. Implement use at DePaul Center (DY3).

STRATEGY 2: Provide Telepsychiatry for patients requiring assessment.
3. Implement use on medical floors/units at PHC (DY4). 4. Market event to target population.
ANTICIPATED IMPACT: 1. By DY3 (ending September 2014) establish Telepsychiatry equipment and access to contracted provider of services in ERs and provide 1,000 consults or more regionally. 2. By DY4 (ending September 2015) establish Telepsychiatry equipment and access to contracted provider of services at DePaul Center and provide 1,050 consults or more regionally. 3. By DY5 (ending September 2016) establish Telepsychiatry equipment and access to contracted provider of services to medical/surgical floors at Providence Hospitals and provide over 1,500 consults or more regionally.

Key Finding #2.1.a – Access and Affordability: Medical Mission @ Home Action Plan

STRATEGY 1: Design, develop, and deliver a Medical Mission at Home in Waco, Texas.

STRATEGY 1: Design, develop, and deliver a Medical Mission at Home in Waco, Texas.

BACKGROUND INFORMATION:

- Specify the target population: Uninsured, underinsured and working poor in McLennan County, Texas
- The uninsured and under-insured often do not have access to the comprehensive, quality health care services necessary for the achievement of health equity and a healthy life. Delivering a Medical Mission at Home will assist those who do not have full access to health care by providing:
    - Access to medical care provided by physicians, mid-level practitioners, and nurses who will volunteer to address basic health needs.
    - Access to free prescription medication as determined necessary by the provider.
    - Access to dental services, including extractions, for those in need.
    - Access to vision screenings, as well as free reading or prescription glasses when determined necessary by the provider.
    - Access to influenza vaccines to prevent illness.
    - Access to breast health screenings and mammography if appropriate.
    - Access to spiritual care and prayer as desired.
    - Access to foot cleaning and care, delivered with a spiritual, healing touch.
    - Access to free shoes for those in need.
    - Access to healthy food items to be given throughout the day and at discharge from the event.
    - Access and connection to resources available in the community in order to assist the population in continuing their health and social services after the event.

RESOURCES:

Strategy source: http://providence.net/medicalmissionathome

Providence Healthcare Network: associates, volunteers, all departments within our network (facilities, lab, pharmacy, environmental services, receiving, admitting, IT)

COLLABORATION:

Providence Healthcare Network (PHN); community health partners; churches; ISD's; county and city leadership.

ACTIONS:

1. Develop an internal multi-disciplinary team at Providence Healthcare Network dedicated to the planning and implementation of a Medical Mission at Home. Establish weekly meetings.
2. Develop strategies for community outreach to ensure public awareness of Medical Mission at Home event. Establish weekly meetings.
3. Deliver a Medical Mission at Home to the Waco, Texas community in FY17.

ANTICIPATED IMPACT:

1. By June 30, 2017, develop and deliver a Medical Mission @ Home event in Waco.

Key Finding #2.1.b – Access and Affordability: Community Health Worker Initiative
Action Plan

STRATEGY 2: Assist the Waco-McLennan County Public Health District in the implementation of the Community Health Worker Initiative.

BACKGROUND INFORMATION:

- The target population is under-served, low-income, uninsured and/or under-insured adults who reside in zip codes 76704, 76705, 76706, and 76707.
    - The strategy addresses the various cultural and social factors influencing access to care by using a trusted member of the community to serve as a liaison between the community and health and/or social service to facilitate access to services.

RESOURCES:

Strategy source: Prosper Waco: McLennan County Community Health Worker Initiative – Strategy Proposal. March 2016
Staff: (1) Community Health Worker Coordinator, (12) Community Health Workers
Funding: Salary for Coordinator with benefits, training costs, travel costs for site visits, stipend for 12 Community Health Workers
Materials: Pre and post surveys

COLLABORATION:

Community partners: Providence (PHN); Waco-McLennan County Public Health District, Prosper Waco, Baylor Scott & White, Family Health Center, Texas-AHEC East

ACTIONS:

1. Deliver Community Health Worker intervention.

ANTICIPATED IMPACT:

1. Six months post implementation; pilot participants will demonstrate an 8% increase in the proportion of adults ages 18-64 who have a specific source (primary care location) where they receive ongoing care.
2. HEALTHY PEOPLE 2020/OTHER NATIONAL OBJECTIVES: https://www.healthypeople.gov/2020/leading-health-indicators/Leading-Health-Indicators-Development-and-Framework

Key Finding #3.1 – Wellness and Prevention: Internal Wellness Initiatives Action Plan

STRATEGY 1: Increase access to healthier food and beverage options.

BACKGROUND INFORMATION:

- In 2015, the adult obesity rate for McLennan County was 28.6%.
- Providence Healthcare Network is one of the largest employers in Waco and one of two community hospitals that serves McLennan County.
- The target population is the associates of Providence Healthcare Network, hospital visitors and community members.
- The strategy addresses access to healthier food options at worksites and within health care organizations and the real and perceived cost barriers to healthy eating.

RESOURCES:

Strategy source:
Dietary Guidelines for Americans 2015-2020: http://www.cnpp.usda.gov/dietary-guidelines
Providence Healthcare Network (PHN), TouchPoint (TP), PHN and TP staff, operational budget, printing, marketing materials

COLLABORATION:

Internal collaboration with multiple departments.

ACTIONS:

1. Increase percentage of FIT food items in vending machines.
2. Increase percentage of FIT snack items in cafeteria.
3. Increase percentage of shelf spaced occupied by FIT beverages in cafeteria.
4. Increase FIT entree options.

ANTICIPATED IMPACT:

1. Increase purchases of FIT beverage and food items by 15% by June 2019.
2. Local Community Plan: Prosper Waco: Decrease percent of Waco-area children and adults considered overweight or obese by 5 percent of the baseline http://www.prosperwaco.org/
3. State Plan: Obesity Prevention Strategies https://www.dshs.texas.gov/ObesityNutritionStrategies.aspx
4. Healthy People/Other National Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status

Key Finding #3.2 – Wellness and Prevention: Clinic Ops Wellness Assessment Action Plan

STRATEGY 1: Increase the number of screening mammogram in women ages 40-69yrs old in Providence Health Alliance (PHA).

BACKGROUND INFORMATION:

- The target population is PHA female patients 40-69 years of age at the start of the reporting period that had a mammogram to screen for breast cancer within the past 24 months.

RESOURCES:
Staff: Providers, Nurses, Nurse Navigators
Equipment: EMR
Materials: Marketing Materials, teaching items

COLLABORATION:
Community partner: Providence Breast Health Center

ACTIONS:

1. FY17 Provide mammography to the target population.
2. FY18 Provide mammography to the target population.
3. FY19 Provide mammography to the target population.

ANTICIPATED IMPACT:

1. By June 2019 increase the number of screening mammogram in women ages 40-69 yrs. old in Providence Health Alliance (PHA).

Key Finding #3.3.a – Wellness and Prevention: Pink Partner Fund Action Plan

STRATEGY 1: Raise funds for Pink Partner Fund.

BACKGROUND INFORMATION:

- The target population is PHA female patients 40-69 years of age at the start of the reporting period that had a mammogram to screen for breast cancer within the past 24 months.

RESOURCES: FY16 Community Needs Health Assessment
Staff: breast health coordinator, nurse navigator, Breast Center staff, Providence Foundation staff
Materials: promotional items, teaching aides, marketing materials

COLLABORATION:
Internal partners: Providence Healthcare Network (PHN); Providence Foundation

ACTIONS:

1. Raise $40,000 annually to replenish the fund.

ANTICIPATED IMPACT:

STRATEGY 1: Raise funds for Pink Partner Fund.

1. By end of FY17, raise at least $40,000 through annual associate giving campaign, receptions, direct mail and individual donors.
2. By end of FY18, raise at least $40,000 through annual associate giving campaign, receptions, direct mail and individual donors.
3. By end of FY19, raise at least $40,000 through annual associate giving campaign, receptions, direct mail and individual donors.

Key Finding #3.3.b – Wellness and Prevention: Pink Partner Fund Action Plan

STRATEGY 2: Increase awareness of Pink Partner Fund and the importance of early detection.

BACKGROUND INFORMATION:

- There are a large number of women in our community who are not receiving annual mammograms. According to the most recent CHNA, only 35% of female respondents reported having a mammogram in the past year. From conversations with women in our community, we often hear that barriers include transportation and funding.
- Various funds for free mammograms in our community have diminished over the past several years, especially grants through Susan G. Komen Central Texas Affiliate and grants through Family Health Center. In response, Providence Foundation created an affinity-group-based fund to help support those in our community previously supported through other grants.
- Target population: under-served, low-income, uninsured/under-insured women.

RESOURCES:

FY16 Community Needs Health Assessment
Staff: breast health coordinator, nurse navigator, Breast Center staff, Providence Foundation staff
Materials: promotional items, teaching aides, marketing materials

COLLABORATION:

Internal partners: Providence Healthcare Network (PHN); Providence Foundation

ACTIONS:

1. Participate in 15+ community outreach events annually.
2. Provide Services for 100 patients annually.

ANTICIPATED IMPACT:

1. By end of FY17, participate in at least 15 community events to raise awareness of our fund and provide services to at least 100 people.
2. By end of FY18, participate in at least 15 community events to raise awareness of our fund and provide services to at least 100 people.
3. By end of FY19, participate in at least 15 community events to raise awareness of our fund and provide services to at least 100 people.

Needs Not Addressed in the Implementation Strategy

Providence Healthcare Network will either address all priority needs identified in the 2016 Community Health Needs Assessment or partner with other community organizations to address the priority needs.

Conclusion

Developing the 2016 Community Health Improvement Plan/Implementation Strategy was a collaborative effort. Providence Healthcare Network wishes to thank the many community partners, individuals and experts who participated in the 2016 Community Health Needs Assessment process. We look forward to working together to improve the health of the communities we share and implement the many strategies outlined in this plan.