Ellsworth County Medical Center
2013-2015 Implementation Strategy
Community Health Needs Assessment

Overview

Ellsworth County Medical Center (ECMC) initiated its first Community Health Needs Assessment (CHNA) beginning in 2012 and continuing into 2013. The CHNA is designed to reach broadly into the community to identify needs, gaps and barriers to health and health services. Through a

process of primary research, data analysis, validation and prioritization, the assessment process identified the following themes of need:

- **Obesity**
- **Cancer**
- **Diabetes**
- **Mental health**
- **No health insurance**
- **Heart disease**
- **Availability of women's care**
- **Flu/pneumonia**
- **Drug and alcohol issues**
- **Availability of physicians**

ECMC's internal committee reduced the ten prioritized issues into three categories:

1. **Chronic Disease**
    a. **Diabetes**
    b. **Heart Disease**
    c. **Asthma**
    d. **Obesity**
    e. **Cancer**
2. **Behavioral/Mental Health**
    a. **Drug and alcohol abuse services**

b. **Mental health counseling**

3. **Customer service**
    a. **Lack of health insurance**
    b. **Structured wellness/fitness programs**

These identified areas of community health need will be addressed in Ellsworth County Medical Centers' Implementation Strategy for years 2013 through 2015, after which, the next Community Health Needs Assessment will be conducted.

Ellsworth County Medical Center adopted the logic model for implementation of the CHNA Implementation Strategies.

The first four implementation strategies address the Chronic Disease category:

- **Diabetes and Heart Disease (with focus on Metabolic Syndrome)**
- **Hypertension**
- **Colon Cancer, and**
- **Metabolic Syndrome: Metabolic syndrome is a combination of the medical disorders that, when occurring together, increase the risk of developing cardiovascular disease, diabetes and stroke .**

Ellsworth County Medical Center (ECMC) decided to place major emphasis on the above mentioned four chronic diseases, and to continue to address the issue of asthma proactively, with less emphasis as on the aforementioned chronic diseases.

The fifth implementation strategy that ECMC will address is:

- **Behavioral/Mental Health**

Additional Information

ECMC has decided to place less emphasis on, but will continue to address on a daily basis the area of customer service. ECMC will continue to initiate and work with the community concerning the area of structured wellness/fitness programs. In addition, ECMC has a program in place, the Medical Access Card Program (MAC) that addresses the issue of lack of insurance and low income medical assistance.

ECMC Community Health 2013 Logic Model-Implementation Strategy:	
Problem	**Chronic Disease** **Diabetes: 10.2% of adults diagnosed with diabetes in 2009**
Why	General causes of Diabetes include: Diet, hereditary, stress, lack of exercise, limited accessibility to nutritional food, lack of education concerning diabetes.
ECMC Strategies	
How?	1. Awareness: Patient and Staff Education 2. Diagnosis Codes: Used to better monitor disease states 3. Chronic disease management: Implementation of Protocols
ECMC Activities	

How Specifically?	Using Patient Care Summaries, we will improve preventative care opportunities and patient disease management as follows: 1. Establish and oversee system-level aims for improvement, i.e.: utilize MDdatacor for goal setting/monitoring outcomes 2. Establish preventative and disease management protocols to improve health outcomes 3. Establish preventative and disease management improvement goals 4. Establish patient educational opportunities, both for preventative care and disease management 5. Establish staff educational opportunities, both for patient preventative care and disease management 6. Utilize resources to improve patient care outcomes, i.e.: lab fair, MAC, Health Department 7. Integration of acute patients into the disease management process
Outcomes	
Intermediate	Establish diabetic population monitoring tool
Long-Term	Increase the number of adults compliant with diabetic annual well visits by 10%, each year, over the next three years. (Based on MDdatacor totals, i.e.: total diabetic care opportunities divided by completed care opportunities: Current is 797 Completed Care Opportunities. Annual % pulled from non-compliant data) Goal: December, 2014: 819; December, 2015: 839; December 2016: 857
Key Performance Metrics	1. Increase the number of annual HbA1c testing from 50% to 80% by December, 2016. (Based on MDdatacor goal progress report) 2. Increase the number of micro albumin urine creatinine ratio annual testing from 20% to 60% by December, 2016. (Based on MDdatacor goal progress report) 3. Increase % of completed diabetic care opportunities/ "well exams" by 10%, each year, over the next three years. MDdatacor totals, i.e.: total diabetic care opportunities divided by completed care opportunities)
Potential Partnerships	Optometrist, Dentist (2), Podiatrist, Long Term Care/Assisted Living (4), Home Health (2), Ellsworth County Health Department, USD 327, USD 112 and other outside medical care providers or agencies as appropriate
Responsible entity	Ellsworth Rural Health Clinic

ECMC Community Health 2013 Logic Model-Implementation Strategy:

Problem	**Chronic Disease** **High Blood Pressure: 42% of ECMC RHC Patients have a BP > 140/90 (Data pulled from MDdatacor HTN report)**
Why	General causes of high blood pressure: Obesity, smoking lack physical activity, high sodium intake, stress, genetics, and consumption of alcohol.
ECMC Strategies	
How?	1. Awareness: Patient and Staff Education 2. Diagnosis Codes: Used to better monitor disease states 3. Chronic disease management: Implementation of Protocols
ECMC Activities	
How Specifically?	Using Patient Care Summaries, we will improve preventative care opportunities and patient disease management as follows: 1. Establish and oversee system-level aims for improvement, i.e.: utilize MDdatacor for goal setting/monitoring outcomes 2. Establish preventative and disease management protocols to improve health outcomes 3. Establish preventative and disease management improvement goals 4. Establish patient educational opportunities, both for preventative care and disease management 5. Establish staff educational opportunities, both for patient preventative care and disease management 6. Utilize resources to improve patient care outcomes, i.e.: lab fair, MAC, Health Department 7. Integration of acute patients into the disease management process

Outcomes	
Intermediate	Increase the number of documented blood pressure checks from 80% to 95% by December, 2016. (Based on MDdatacor HTN goal progress report/process compliance)
Long-Term	Establish provider, nurse, patient education tool to be utilized for patients with documented BP > 140/90. (At this point, there is no report to measure/track documented educational opportunities)
Key Performance Metrics	Increase the number of documented BP checks from 80% to 95% by December, 2016. (Based on MDdatacor HTN goal progress report/process compliance)
Potential Partnerships	Ellsworth County Health Department, USD #327, USD #112, KDHE
Responsible entity	ECMC Rural Health Clinic

ECMC Community Health 2013 Logic Model-Implementation Strategy:

Problem	**Chronic Disease** **Colon Cancer is the second leading cause of cancer related deaths in the US.**
Why	Only 23% of the ECMC RHC age eligible patient population has completed the recommended colorectal cancer screening after age 50. (Data provided by MDdatacor)
ECMC Strategies	
How?	1. Awareness: Patient and Staff Education 2. Diagnosis Codes: Used to better monitor disease states 3. Chronic disease management: Implementation of Protocols
ECMC Activities	
How Specifically?	Using Patient Care Summaries, we will improve the % of age eligible patients receiving colorectal cancer screening by using one of the following four criteria for screening: 1. Fecal occult blood test 2. Flexible sigmoidoscopy 3. Double contrast barium enema 4. Colonoscopy
Outcomes	
Intermediate	Improve the % of age eligible patients receiving colorectal cancer screening (based on one of the four criteria listed above) by 10%, each year, for the next three years. (Data from MDdatacor/CRS suite)
Long-Term	1. Improve staff and patient education 2. Improve outreach efforts through mailers, phone calls
Key Performance Metrics	Improve the % of age eligible patients receiving colorectal cancer screening (based on one of the four criteria listed above) from 10% each year for the next three years. (Data from MDdatacor/CRS suite, compliant patients. Annual % pulled from non-compliant data) Goal: December, 2014: 899; December, 2015: 1092; Goal: December 2016: 1266
Potential Partnerships	Health Department

Responsible entity	ECMC Rural Health Clinic

ECMC Community Health 2013 Logic Model-Implementation Strategy:	
	Chronic Disease
	Diabetes, Heart Disease,Cancer and Stroke (Metabolic Syndrome Screening)
Why	The risk for heart disease, diabetes, and stroke increases with the number of metabolic risk factors an individual has. In general, a person who has metabolic syndrome is twice as likely to develop heart disease and five times as likely to develop diabetes as someone who doesn't have metabolic syndrome.
ECMC Strategies	
How?	1. Awareness: Patient and Staff Education 2. Diagnosis Codes: Used to better monitor disease states 3. Chronic disease management: Implementation of Protocols

ECMC Activities	
How Specifically?	Identify those patients with Metabolic Syndrome by screening for: • A large waistline. This also is called abdominal obesity or "having an apple shape." Excess fat in the stomach area is a greater risk factor for heart disease than excess fat in other parts of the body, such as on the hips. • A high triglyceride level (or the patient is on medicine to treat high triglycerides). Triglycerides are a type of fat found in the blood. • A low HDL cholesterol level (or patient is on medicine to treat low HDL cholesterol). HDL sometimes is called "good" cholesterol. This is because it helps remove cholesterol from the patients arteries. A low HDL cholesterol level raises the patient's risk for heart disease. • High Blood Pressure (or the patient is on medicine to treat high blood pressure). Blood pressure is the force of blood pushing against the walls of the patient's arteries as the heart pumps. If this pressure rises and stays high over time, it can damage the heart and lead to plaque buildup. • High fasting blood sugar (or the patient is on medicine to treat high blood sugar). Mildly high blood sugar may be an early sign of diabetes.
Outcomes	
Intermediate	Develop and provide Staff Training: Understand Metabolic Syndrome screening tools Develop patient education
Long-Term	Develop protocol for Metabolic Syndrome screening - Develop internal referral process to Registered Dietitian
Key Performance Metrics	Development of a data set concerning the prevalence of Ellsworth County Medical Center Patients exhibiting Metabolic Syndrome.
Potential Partnerships	American Diabetes Association, University of Kansas Medical Center; American Heart Association
Responsible entity	ECMC Rural Health Clinic

ECMC Community Health 2013 Logic Model-Implementation Strategy:	
Problem	**Behavioral/Mental Health** **Drugs, Alcohol and Mental Health**
Why	According to Kansas Health Matters, 28.9% of people over the age of 65 years lived alone during the period of 2007-2011, 7% of the respondents on the 2013 Ellsworth County Medical Center's (ECMC) Community Health Needs Assessment (CHNA) Survey, reported that they have been told by a doctor, that they have a mental/emotional symptoms. 12% of the respondents from the 2013 ECMC's CHNA reported that Mental Health is the top priority of services that are lacking in our community.
ECMC Strategies	
How?	1. Search out potential mental health providers that are willing to work in the Ellsworth County Area.
ECMC Activities	
How Specifically?	1. Contact Central Kansas Mental Health Center, Salina, 2. Contact Counseling Inc. Ellsworth 3. Search out potential Mental Health Professionals
Outcomes	
Intermediate	During years 2013-2014, hold periodic meeting until long term goal achieved
Long-Term	By 2015, have a mental health professional housed at ECMC
Key Performance Metrics	Hold periodic meetings with a potential Mental Health Professional, quarterly, concerning the possibility of having an office located in ECMC.

Potential Partnerships	Central Kansas Mental Health Center, USD #327, USD #112, Ellsworth Good Samaritan Retirement Village, Golden Living Center at Wilson, Ellsworth/Wilson/Holyrood Senior Centers, Optometrist. Dentists, Assisted living centers, Low Income housing: Chisholm Trail, Pines Apartments, Kirkendall Apartments (Ellsworth), Jellison Apartments, Plum Creek Plaza (Holyrood) Pride of the Prairie Apartment, Smoky Villa View (Wilson), Ellsworth County Churches, Ellsworth County Health Department, Home Health Services.
Responsible entity	Administration