2014-16 Community Health Plan

Shawnee Mission Health (SMH) conducted a Community Health Needs Assessment (CHNA) in 2013. With oversight by a community-inclusive Community Health Needs Assessment Committee, the Assessment looked at the health-related needs of our broad community as well as those of low-income, minority and underserved populations[i]. The Assessment includes both primary and secondary data.

The Community Needs Assessment Committee, hospital leadership and the hospital board reviewed the needs identified in the Assessment. Using the Priority Selection processes described in the Assessment, the Committee identified the following issues as those most important to the communities served by our hospital. The hospital Board approved the following priorities and the full Assessment.

1. Expand education on eating habits and nutrition
2. Emphasize physical activity and wellness
3. Develop enhanced behavioral health service delivery system
4. Improve education on proper access to care in the ED

With a particular focus on these priorities, the Committee helped SMH develop this Community Health Plan (CHP) or "implementation strategy[ii]." The Plan lists targeted interventions and measurable outcome statements for each effort. Many of the interventions engage multiple community partners. The Plan was posted by May 15, 2014 at the same web location noted below.

SMH's fiscal year is January-December. For 2014, the Community Health Plan will be deployed beginning May 15, 2014 and evaluated at the end of the calendar year. In 2015 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 posted annually and attached to our IRS Form 990.

If you have questions regarding this Community Health Plan or Community Health Needs Assessment, please contact Shannon Cates, Community Benefit Manager, at shannon.cates@shawnemission.org.

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[i] The full Community Health Needs Assessment can be found at www.shawneemission.org under the Community Benefit heading.

[ii] It is important to note that this Community Health Plan does not include all Community Benefit activities. Those activities are noted on Schedule H of our Form 990.

Shawnee Mission Medical Center

2014-16 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**
Expand education on eating habits and nutrition	Use CREATION Health program to improve and impact the eating habits of individuals in minority populations.	Hispanic church members without other access to health and wellness information.	Train church leaders in the CREATION Health program to allow them to teach the courses in their congregations.	Number of church leaders trained	11 churches trained	6		6		6			N/A	After the initial training of 11 Hispanic churches, the number of congregations lowers each year due to the finite number of churches in the area.
	Use CREATION Health program to improve and impact the eating habits of SMH associates	SMH associates	Train individuals to implement the principles of CREATION Health in their daily lives.	Number of associates educated	90	100		110		120			N/A	
	Class: Detoxification	Community members	Educate about the benefits of cleansing the body	Number of community members educated	10	15		20		25				
	Class: Stop Diabetes Before it Starts	Pre-diabetics in Johnson County	Educate on lifestyle changes that can prevent diabetes	Number of community members educated	10	20		30		40				
	Class: Weight Management University	Community members	Assist in safe weight loss by educating about proper eating habits	Number of community members educated	20	30		35		40				

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
Emphasize physical activity and wellness	Use CREATION Health program to improve and impact the exercise habits of individuals in minority populations.	Hispanic church members without other access to health and wellness information.	Train church leaders in the CREATION Health program to allow them to teach the courses in their congregations.	Number of church leaders trained	11 churches trained	6		6		6			N/A	After the initial training of 11 Hispanic churches, the number of congregations lowers each year due to the finite number of churches in the area.
	Use CREATION Health program to improve and impact the exercise habits of SMH associates	SMH associates	Train individuals to implement the principles of CREATION Health in their daily lives.	Number of associates educated	90	100		110		120			N/A	
	Class: FITMOM 2 BE	Expectant mothers in Johnson County	Educate pregnant women about how to stay active and healthy during pregnancy	Number of women educated	100	120		120		120				
	Class: Tai Chi	Community members	Train individuals in relaxation techniques	Number of community members trained	60	70		80		90				
	Class: Yoga (various forms)	Community members	Train individuals in relaxation techniques	Number of community members trained	120	130		140		150				
	Class: Smoking Cessation	Community members	Assist in quitting smoking	Number of community members trained	40	45		50		55				

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
	Speaking of Women's Health Annual Conference	Community members	Educate women about various aspects of health, wellness and personal safety	Number of community members educated	1200	1200		1200		1200				
	ASK-A-NURSE Resource Center	Community members	Assist callers with answers to their health-related questions	Number of community members assisted	100,000 per year	100,000		100,000		100,000				
Develop enhanced behavioral health service delivery system - focus on postpartum depression	100% of SMMC Birth Center staff will be very knowledgeable about the symptoms of PPD.	SMMC Birth Center Staff	Purchase the Spectrum Health Toolkit for Health Care Providers; provide training to all SMMC Birth Center staff, including lactation consultants.	Increase of at least 10 points on post-test assessment compared to pre-test prior to training.	200	200		20		22		N/A	N/A	**Assumption:** 10% employee growth in years 2 and 3. Only new employees will be trained in years 2 and 3. Employees trained in year 1 will participate in a Net Learning Computer Based Learning program update.
	150 Postpartum Health support group participants will develop skills for coping with postpartum depression.	Women suffering from postpartum depression (PPD)	Provide weekly curriculum-based support group; screen for PPD every 2 weeks; call participants monthly to evaluate individual progress	Support group participants will "agree" or "strongly agree" with the statement "I have tools to help me deal with postpartum depression"	800 (4,000 births per year, 20% PPD rate, potentially 800 women with PPD)	150		165		170		N/A	N/A	Baselines for years 2 and 3 use an increase in number of deliveries of 3%; program will serve approximately 20% of women with PPD.

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
	90% of support group participants will report improvement of PPD symptoms after 6 weeks of participation	Women suffering from PPD	Provide weekly curriculum-based support group; screen for PPD every 2 weeks; call participants monthly to evaluate individual progress	Reduction of at least 2 points on Edinburgh Postnatal Depression Scale	150	135		149		153		N/A	N/A	
Improve education on proper access to care in the ED	Provide case management with individualized plans for 75 Category 1 frequent users of the ED (Category 1 Frequent User = anyone with 12+ visits in the previous year)	Frequent Users of the SMMC Emergency Department: Individuals who have visited the SMMC Emergency Department 12 or more times in the previous year (Category 1)	Hire two 0.5 FTE (1 FTE total) Community Care Coordinators; one will be a an RN and the other an MSW who will provide one-to-one care and case management services	Number of frequent users who have an individualized case management plan created by an SMMC Community Care Coordinator	104	75		100		100		N/A	N/A	The number of case-managed individuals will be closely monitored. If the program is not on track to meet this outcome, the threshold for number of prior visits will be reduced from 12 to a level that will increase the likelihood of achieving this outcome.

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
	Reduce total ED visits by 25% for case-managed frequent users	Frequent Users of the SMMC Emergency Department: Individuals who have visited the SMMC Emergency Department 12 or more times (Category 1)	Community Care Coordinators will connect individuals with other appropriate resources in the community that will provide consistent care and better management of chronic conditions	Number of ED admissions for case-managed frequent users	1,272	No more than **954** ED visits for the 75 case managed user. *OR* a 25% reduction in the ACTUAL number of visits for the case managed patients in the prior year.		No more than **1,272** ED visits for the 100 case-managed frequent users ****OR**** or a 25% reduction in the actual baseline for the 100 case managed users (See comments for more information about this outcome.)		No more than **1,272** ED visits for the 100 case-managed frequent users ****OR**** or a 25% reduction in the actual baseline for the 100 case managed users (See comments for more information about this outcome.)		N/A	N/A	**Current Year Baseline:** 1768 total ED visits by Category 1 Frequent Users in time period studied. 1768 x 72% = 1272 baseline estimated ED admissions for case managed Category 1 frequent users **Years 2 and 3 Outcome #s:** 1768 x .96 = 1697 baseline estimate of ED admissions for 100 Category 1 Frequent users; 1697 x .75 = 1272 visits

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
	Connect 1/3 of case-managed frequent users who lack an identified medical home to a medical home or primary care provider.	Frequent Users of the SMMC Emergency Department: Individuals who have visited the SMMC Emergency Department 12 or more times (Category 1) or four or more times (Category 2) in the previous 12 months. Primary target is Category 1 users.	Community Care Coordinators will connect individuals with other appropriate resources in the community that will provide consistent care and better management of chronic conditions	Number of case-managed frequent users who are connected with a medical home or primary care provider	75	25		33		33		N/A	N/A	**Assumption:** None of the case-managed frequent users will have a medical home prior to SMMC intervention.