Hendrick Medical Center
Community Health Needs Assessment
Implementation Plan
2020-2022

Overview:
Hendrick Medical Center ("Hendrick") conducted its third Community Health Needs Assessment ("CHNA") in March through June of 2019, with the assistance of the Crescendo Consulting Group. The assessment determined the most pressing health needs of Taylor County and provided the data and community feedback to create an Implementation Plan for 2020-2022.

Background/Compliance:
The CHNA and the Implementation Plan are required by federal agencies. Specifically, the Affordable Care Act of 2010 requires all U.S. not-for-profit hospitals to complete a CHNA and Implementation Plan every three years.

- In 2019, Hendrick worked with community service leaders, underserved populations, and others to complete its CHNA and identify 34 community health-related needs or service gaps.

- Hendrick prioritized the list using qualitative and quantitative approaches.

- The following Implementation Plan indicates which of the prioritized needs the health system will address and how, and which ones it will not address and why not.

Requirements:
The CHNA and the Implementation Plan are separate but linked requirements.

- CHNA requirements:
  - Define the community served by Hendrick
  - Describe the quantitative and qualitative methodology used to identify and prioritize community needs
  - Include a comprehensive list of community health or health-related resources
  - List the activities conducted since the prior CHNA conducted in order to address the identified needs
  - Prioritize the list of community health needs to be included in the Implementation Plan
- Implementation Plan requirements:
  - Identify which community needs Hendrick will address (and how)
  - Identify which community needs Hendrick will not address (and why not)

This document summarizes the Implementation Plan results.

Methodology:

- Implementation Plan activities (i.e., actions taken to identify which community health needs will be addressed (and how) included the following:

- Conducting in-depth discussions with the Hendrick Project Leadership team to review the needs list and identify ones generally outside of Hendrick's purview to impact

- Developing a matrix that identified existing programs or activities that positively impact one or more of the 34 identified, prioritized community needs

- Working with the Project Leadership team to define for each of the 34 needs the "degree of control that Hendrick has to enact change" and a "potential timeline on which positive change could reasonably be made to address the need"

- Creating this summary document that addresses the project requirements including clear recognition of activities within the hospital's purview to address and if so, how the hospital can best address the need

The final prioritized list of 34 community needs from the CHNA includes:

1.	Primary care services (such as a family doctor or other provider of routine care)
2.	Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers
3.	Crisis or emergency care programs for mental health
4.	Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children
5.	Affordable healthcare services for individuals or families with low income
6.	Services or education to help reduce teen pregnancy
7.	Counseling services for mental health issues such as depression, anxiety, and others for adults
8.	Special care (for example, case workers or "navigators") for people with chronic diseases such as diabetes, cancer, asthma, and others
9.	Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare
10.	Drug and other substance abuse early intervention services
11.	Secure sources for affordable, nutritious food
12.	Drug and other substance abuse treatment services
13.	Drug and other substance abuse education and prevention
14.	Affordable quality childcare
15.	Healthcare services for seniors
16.	Programs for obesity prevention, awareness, and care
17.	Support services for children with developmental disabilities
18.	Social services (other than healthcare) for people experiencing homelessness
19.	Transportation services for people needing to go to doctor's appointments or the hospital
20.	Programs for heart health or cardiovascular health
21.	Programs for diabetes prevention, awareness, and care
22.	Education and job training
23.	Affordable prescription drugs
24.	Programs to help recovering drug and other substance use disorder patients stay healthy
25.	Healthcare services for people experiencing homelessness

26.	Women's health services
27.	Long term care or dementia care for seniors
28.	Support services for adults with developmental disabilities
29.	HIV / AIDS treatment services
30.	General public transportation
31.	HIV / AIDS education and screening
32.	Crisis or emergency care services for medical issues
33.	Parenting classes for the "new Mom" or the "new Dad"
34.	Emergency care and trauma services

Evaluation Criteria and Definitions:
Hendrick has a long-standing commitment to the community on every level. As such, through existing or new programs, the hospital expects to be able to address – to some degree – approximately 66% of the 34 identified needs.

The degree to which the hospital can address the needs is based on the following criteria:

- The CHNA-based priority of the need
- Resources within an existing program or initiative which can be deployed
- Opportunities for collaboration with community partners
- The degree to which the need is within the hospital's purview to address

NOTE: Definition of a "need:" A service gap – or, an inadequately met health issue – that could benefit from additional support from Hendrick or affiliated organizations. For this reason, many chronic disease states such as heart disease, diabetes, cancer, and others – while highly important community health issues – may not be listed as unmet needs because the hospital and others are already highly engaged in these critically important areas.

Categorization of the 34 Community Needs Identified in the CHNA

- For each of the 34 needs, Hendrick examined its current programs, outreach efforts, and collaborations, and considered new initiatives such that each of the 34 needs were assigned to one of the following categories:

  - Needs that Hendrick will not address
  - Needs Hendrick is addressing through existing programs and activities: The hospital is already actively providing services to address the community health need
  - Needs for which Hendrick will enhance existing programs or establish new ones: The hospital has current activities that may be able to be modified or expanded to address the community health need; or, newly created activities or initiatives may be required to do so

- The following shows Implementation Plan summary results – "needs that the hospital will address (and how) and which ones it will not address (and why not)" – by category, i.e., the three primary categories noted above plus the "Other community-based programs" category.

Needs that Hendrick Will Not Address:

- The following needs will not be addressed by Hendrick, as they are outside of the Health System's purview – apart from the normal provision of inpatient and outpatient medical care services.

- For each need in the table below, the "Rank" refers to the results of the CHNA ranking / prioritization of community needs.

Rank and Need

(Rank: 6) Services or education to help reduce teen pregnancy
(Rank: 10) Drug and other substance abuse early intervention services
(Rank: 12) Drug and other substance abuse treatment services
(Rank: 13) Drug and other substance abuse education and prevention
(Rank: 14) Affordable quality childcare
(Rank: 15) Healthcare services for seniors (e.g., specialized geriatric care)
(Rank: 17) Support services for children with developmental disabilities
(Rank: 18) Social services (other than healthcare) for people experiencing homelessness
(Rank: 24) Programs to help recovering drug and other substance use disorder patients stay healthy
(Rank: 27) Long-term care or dementia care for seniors
(Rank: 29) HIV / AIDS treatment services
(Rank: 30) General public transportation
(Rank: 31) HIV / AIDS education and screening

Needs Hendrick is Addressing Through Existing Programs and Activities:

- Below is a list of existing Hendrick programs and activities impacting some of the prioritized needs from the CHNA.

- The following pages show the "Needs that Hendrick will address by continuing existing programs and activities."

- The leading "numbers" in the table below (e.g., "1" = MedAssist) are referenced on the following grid:

1	MedAssist	7	Hendrick Women's Services	13	Nurse Aide Classes
2	Meds to Bed Program	8	AMI + Heartsavers	14	Junior Volunteers

3	Diabetes Center	9	Family Practice / Internal Medicine	15	PCT Program
4	Population Health Program	10	Partnership with MHMR/Betty Hardwick	16	Partnership with TTUHSC – Mercy Clinic; Education
5	Emergency Department	11	FollowMyHealth	17	Better Breathers
6	Resource Assistance	12	FQHC Partnership	18	Stroke Support Group

Needs Hendrick is Addressing Through Existing Programs and Activities – CHNA Prioritized Rank 1- 34 (*Note that Multiple Existing Programs are in Place to Address Top Priority Needs)*

- (Rank: 1) Primary care services (such as a family doctor or other provider of routine care) Program (s): 4, 9, 12, 16
- (Rank: 2) Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers - Program(s): 4, 5, 7, 8, 11, 12, 16
- (Rank: 3) Crisis or emergency care programs for mental health - Program(s): 5, 10
- (Rank: 4) Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children - Program(s): 10
- (Rank: 5) Affordable healthcare services for individuals or families with low income - Program(s): 6, 7
- (Rank: 7) Counseling services for mental health issues such as depression, anxiety, and others for adults - Program(s): 10
- (Rank: 8) Special care (for example, case workers or "navigators") for people with chronic diseases such as diabetes, cancer, asthma, and others - Program(s): 1, 2, 3, 4, 5, 7, 8, 17, 18
- (Rank: 9) Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare - Program(s): 6, 7
- (Rank: 11) Secure sources for affordable, nutritious food - Program(s): 3
- (Rank: 16) Programs for obesity prevention, awareness, and care - Program(s): 1, 3
- (Rank: 19) Transportation services for people needing to go to doctor's appointments or the hospital - Program(s): 4, 7
- (Rank: 20) Programs for heart health or cardiovascular health - Program(s): 8
- (Rank: 21) Programs for diabetes prevention, awareness, and care - Program(s): 1, 2, 3
- (Rank: 22) Education and job training - Program(s): 13, 14, 15, 16
- (Rank: 23) Affordable prescription drugs - Program(s): 1,2
- (Rank: 25) Healthcare services for people experiencing homelessness - Program(s): 5
- (Rank: 26) Women's health services - Program(s): 3, 7, 9, 12, 16
- (Rank: 28) Support services for adults with developmental disabilities - Program(s): 10
- (Rank: 32) Crisis or emergency care services for medical issues - Program(s): 5
- (Rank: 33) Parenting classes for the "new Mom" or the "new Dad" - Program(s): 7
- (Rank: 34) Emergency care and trauma services - Program(s): 5

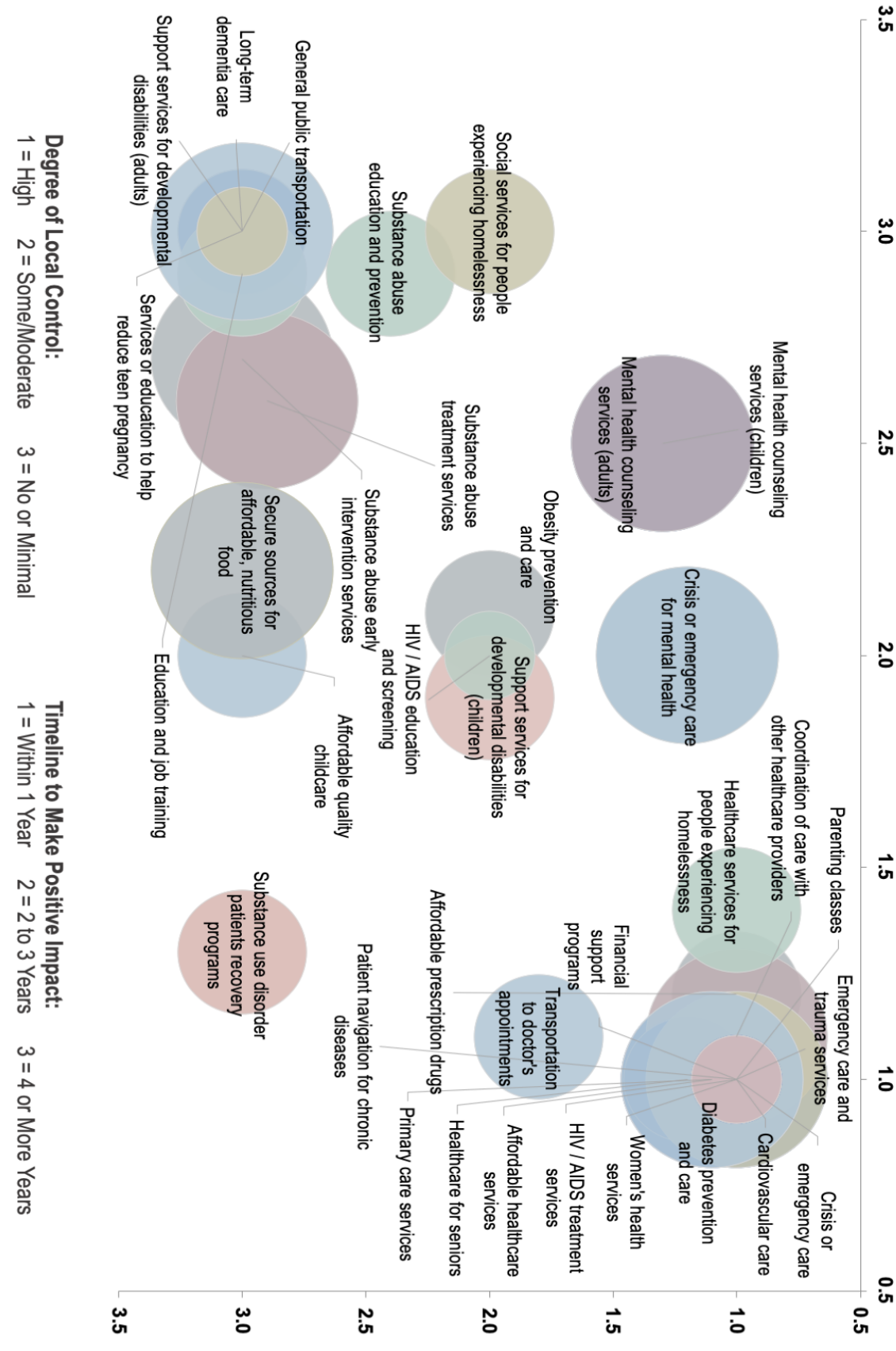
Needs for Which Hendrick Will Enhance Existing Programs or Establish New Ones

- Hendrick's Project Leadership team reviewed each of the 34 needs for which Hendrick has, or may establish, programs to address on two scales:
  - The degree of local control (i.e., the amount of influence Hendrick may possess to affect needs).
  - Timeline (i.e., the expected amount of time it would take to impact the need)

- Based on the analysis, Hendrick identified a highly focused list of Program Focus Areas that does the following:
  - (1) Addresses the highest priority needs,
  - (2) Are within Hendrick's' ability to control, and,
  - (3) Are expected to provide positive impact in the "1-year," "two to three-year," and "four years or longer" time frames.

The graph on page 7 assisted with the identification and selection of our health need priority targets for 2020-2022. The chart "Hendrick Community Need Impact" shows the 34 identified needs in correlation to Hendrick's degree of local control and ability to make a positive impact in a one to four-year period. While all needs are important, the spheres in the top right quadrant represent those areas where Hendrick can more readily address the need and impact change in a shorter period of time. The spheres in the middle to lower quadrants will require more extensive community partnerships and several years to make a positive difference.

Hendrick Community Need Impact Chart



Hendrick Priority	Area of Impact
Primary Care Services *(CHNA Rank #1)*	• Increase Access to Care • Utilization of ER for Episodic Care • Transportation services for people needing to go to doctor's appointments or the hospital
Coordination of Patient Care *(CHNA Rank #2)*	• Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers • Patient navigation • Transportation services for people needing to go to doctor's appointments or the hospital • Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare • Education of resources available to make healthcare services more affordable for individuals or families with low income • Women's health services • Affordable prescription drugs
Chronic Disease Prevention and Intervention *(CHNA Rank #8)*	• Patient navigation • Programs for obesity prevention, awareness, and care • Programs for heart health or cardiovascular health • Special care (for example, case workers or "navigators") for people with chronic diseases such as diabetes, cancer, and asthma
Mental Health *(CHNA Rank #3)*	• Crisis or emergency care programs for mental health • Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children • Counseling services for mental health issues such as depression, anxiety, and others for adults • Healthcare services for people experiencing homelessness

Implementation Plan Goals

The Board of Trustees of Hendrick Health System determined that to address the priorities identified in the CHNA, over the next three years, Hendrick would meet the following goals:

GOAL 1: Increase access to healthcare

GOAL 2: Improve through education and disease management the health of our community and surrounding areas

GOAL 3: Serve as a partner and collaborator to build community healthcare partnerships

The goals for addressing each priority are the same, but the objectives and strategies for each priority will differ according to the healthcare needs

Implementation Plan Priorities

PRIORITY 1: Primary Care Services

PRIORITY 2: Coordination of Patient Care

PRIORITY 3: Chronic Disease Prevention and Intervention

PRIORITY 4: Mental Health

Priority 1 – Primary Care Services
Community Needs Addressed
Primary care services (such as a family doctor or other provider of routine care)
Transportation services for people needing to go to doctor's appointments or the hospital

Objective: To recruit additional primary care physicians (PCPs) to serve the Abilene population

Strategy: Recruit 6 primary care physicians by the end of FY 2022

- There are currently 49 primary care physicians serving the Abilene community.

Objective: To increase access to primary care

Strategies:

- Continue offering extended hours at primary care Hendrick clinics. Advanced Practice Providers are available after hours and on weekends to see established Hendrick Provider Network (HPN) patients
- Increase utilization of Advanced Practice Providers
- Establish an Urgent Care location in North Abilene in 2020
    - The Urgent Care facility will be located across from Abilene Christian University, near Hendrick Medical Center.

    - The Urgent Care facility will help to reduce the amount of people who are utilizing the Emergency Department (ED) for episodic care.
- Increase awareness of “Welcome to Medicare” and annual wellness visits at HPN Providers
- Utilize Community Health Workers (CHWs) to help establish care for patients who come through the ED
    - PCPs have 4 designated spots per week available for ED patients without a PCP.

Priority 2 – Coordination of Patient Care
Community Needs Addressed
Affordable healthcare services for individuals or families with low income
Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers
Special care (for example, case workers or "navigators") for people with chronic diseases such as diabetes, cancer, asthma, and others
Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare
Transportation services for people needing to go to doctor's appointments or the hospital
Emergency care and trauma services

Coordination of Care & Patient Navigation

Objective: To ensure patients receive the right care at the right place and at the right time

Strategy: Develop a Discharge Navigation Program for patients treated in the ED by August 2020

- Work with current CHW in the ED to further reduce overall readmission rates
- Coordinate with Hendrick Case Management to identify patients with additional needs
- Develop baseline trend of patient post-discharge care coordination

Strategy: Develop an internal one-call scheduling system to coordinate patient care referrals to physician and ancillary services by August 2021

- Explore potential of one centralized call-center for patients with post-care questions
    - Scale-up to include non-employed physician office referrals and direct patient requests for scheduling, when appropriate
- Develop baseline number of calls pending call-center approval
- Increase participation and call volume by 5% annually

Strategy: Explore a partnership with community-based faith organizations to connect patients to needed healthcare resources by August 2020

- Explore feasibility of replicating Baylor Scott and White Community Faith Partners Program
    - Launch program, if approved, with 3 or more community organizations

- Report annually number of meetings exploring the concept, number of contacts regarding the program

Strategy: Investigate the expansion of the CHW Program to include inpatient discharge navigation by August 2021

- Increase CHW contacts and program participants by 5% with a baseline established by August 2020

Transportation to Hospital and Other Physician or Medical Appointments

Objective: To expand access to transportation to and from the hospital, physician offices or other Hendrick services for patients facing transportation issues

Strategy: Expand Lyft transportation services by 5% via Apollo Go to the acute care hospital, HPN clinics and Hendrick outpatient services within Taylor County

Strategy: Explore feasibility of creating a partnership and rural transportation outreach program between Hendrick Health System and regional faith-based organizations

- Partner with Texas Tech University Health Sciences Center School of Public Health students to explore program feasibility
- Consult with local churches and non-profits for possible utilization of the organizations' vans for patient transportation

Affordable Healthcare Services

Objective: To expand community knowledge and use of resource assistance and financial assistance programs at Hendrick over a three-year period

Strategy: Increase public distribution of Open Enrollment opportunities to community members by 25%

- Distribute at least 1,800 in 2019 (1,500 flyers distributed in 2018)
- Hold two Open Enrollment Fairs annually
- Increase patient enrollment by 15% annually (100 patients signed up for insurance at the Marketplace, resulting in $1.4M cost savings in 2018.)

Strategy: Explore opportunity to provide comprehensive information and instructions for Resource Assistance Program prior to hospitalizations and surgical visits.

Priority 3 – Chronic Disease Prevention and Intervention
Community Needs Addressed
Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers
Affordable healthcare services for individuals or families with low income
Special care (for example, case workers or "navigators") for people with chronic diseases such as diabetes, cancer, asthma, and others

Programs for obesity prevention, awareness, and care
Programs for heart health or cardiovascular health
Programs for diabetes prevention, awareness, and care
Affordable prescription drugs
Women's health services

Pharmacy

Objective: To promote chronic disease management by addressing issues related to medication accessibility, adherence and compliance with medication therapy, and/or lack of knowledge or education related to medications

Strategies:

- Increase the number of patients served and prescriptions dispensed by at least 10% annually
- Continue educational and community outreach programs, including one-on-one Medication Therapy Management (MTM) sessions
- Implement new educational programming including quarterly "Pillbox Talks" to senior living centers and churches, and expansion of pharmacist-led educational programs to existing HMC clinics

Heart Failure

Objective: To schedule follow-up appointments for Heart Failure (HF) patients within 7 days of discharge

Strategies:

- Inpatient HP nurse to visit at least 90% of inpatient HF patients
- Make appointments to the HF Clinic within 7 days of discharge for patients without primary care physicians

Objective: To increase community and physician awareness of HF and HF treatment options

Strategies:

- Provide HF education (i.e. risk factors & prevention and treatment options) in varying community settings at least 3 times annually
- Initiate all procedures related to the structural heart program by end of 2020
- Find a HF Physician Educator for grand rounds by end of 2021 to discuss HF, diabetes, new technologies and medications

Objective: To increase access to prescriptions for patients with HF

Strategies:

- Collaborate with Hendrick Professional Pharmacy and HF Medical Director to provide significant savings by filling prescriptions on the 340B program

- Direct patients to Hendrick Professional Pharmacy to fill their prescriptions at a significant savings

Pulmonary Health

Objective: To increase access to prescriptions for patients with pulmonary health issues

Strategies:

- Collaborate with Hendrick Professional Pharmacy and Pulmonary Rehab Medical Director to provide significant savings for at least 10 patients annually by filling prescriptions on the 340B program
- Direct patients to Hendrick Professional Pharmacy to fill their prescriptions at a significant savings

Objective: To partner with Texas Tech University Health Sciences Center School of Pharmacy (TTUHSC-SOP) students

Strategies:

- Schedule bimonthly visits to Pulmonary Rehab for TTUHSC-SOP students
- Complete monthly medication profile reviews and medication reconciliation
- Provide education to Hendrick Pulmonary Rehab patients (current and maintenance patients) by scheduling a quarterly Medication Class

Diabetes Health

Objective: To promote diabetes prevention by extending free prediabetes education to at-risk populations

Strategies:

- Encourage HPN physicians to refer 50% of their prediabetes patient population for the free outpatient class at Hendrick Diabetes Center
- Distribute prediabetes course information brochures to community resource centers including but not limited to Presbyterian Medical Care Mission, MERCY clinic and Abilene Community Health Center

Objective: To explore the development and implementation of weight-loss courses to educate target populations about obesity prevention, awareness and care

Strategies:

- Create a 1-2-hour educational class to educate patients on healthy eating and exercise habits
- Work with community resource centers to establish on-site class classes devoted to weight-loss and management specific to their patient population bi-annually

Objective: To promote diabetes support and education collaborating with community

Strategies*:*

- Continue annual Diabetes Expo open to the community with a maximum capacity of 150 participants
- Continue annual World Diabetes Day health fair and increase participation by 50%
- Utilize communication software to promote monthly Diabetes Support Group meetings and increase attendance by 25%
- Transition from informational to interactive booth models for health fairs

Cancer

Objective: To assign a Nurse Navigator to 85% of new patients at Hendrick Cancer Center

Strategies:

- Assess unmet patient needs through patient interviews and direct to appropriate programs/services
- Provide educational Chemo Class within one week to patients beginning chemotherapy treatment
- Reassess patient needs at 3-month and 12-month post-treatment office visits

Objective: To increase the number unfunded patients assessed for financial assistance with cancer treatment medications to 85%

Strategies:

- Explore available resources for patients needing financial assistance with cancer treatment medications
- Complete patient interviews with a social worker for new, unfunded patients scheduled for cancer treatment

Priority 4 – Mental Health
Community Needs Addressed
Crisis or emergency care programs for mental health
Counseling services for mental health issues such as depression, anxiety, and others for adults
Healthcare services for people experiencing homelessness

Objective: To collaborate with both of Abilene's Crisis Response Teams (CRTs) to assist with appropriate facility referrals for mental health patients

Strategies:

- Provide funding for a second cardiac monitor for use by CRTs that will equip CRTs to differentiate between cardiac health events and other mental health issues
- Decrease the number of ED admissions for suspected cardiac events by utilization of cardiac monitor

- Continue to partner and expand collaborations with mental health facilities via CRTs to direct patients requiring mental care versus healthcare

Objective: To increase points of access for mental healthcare for the homeless population

Strategies:

- Utilize CHWs to help assess care needs of patients who come through the ED presenting with mental health conditions
- Explore collaboration with Texas Tech University Health Sciences Center School of Public Health program to educate agencies working with the homeless population about resources available for individuals in need of mental health care
- Collaborate with agencies addressing alcohol and substance abuse to establish referral system for homeless patients in need of their services

Objective: To continue supporting navigation of mental health patients to the appropriate resources

Strategies:

- Explore expansion of nurse navigation program at the Federally Qualified Health Center to increase capability to direct mental health patients to the mental and medical care needed
- Support the continued growth of Abilene's Jail Navigation Program where trained personnel screen inmates upon intake for acute or chronic mental health needs

Objective: To maintain and expand inpatient and outpatient mental health support services

Strategies:

- Continue tele-psychiatry consultation program for ED and acute patients at Hendrick Medical Center
- Expand partnership with Betty Hardwick Center outpatient mental health support services to include hours for walk-in referrals