Sunnyside

COMMUNITY HOSPITAL & CLINICS

COMMUNITY HEALTH NEEDS ASSESSMENT MARCH 2017 IMPLEMENTATION PLAN

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Letter from the CEO

March 20, 2017

Dear Community:

As the Chief Executive Officer at Sunnyside Community Hospital & Clinics, I would like to share our Community Health Needs Assessment Implementation Plan with you. Sunnyside Hospital & Clinics completed a Community Health Needs Assessment (CHNA) in November of 2016.

A multi-faceted approach was used to gather information about the health needs of the community and to develop priorities for health improvement. The process focused on gathering and analyzing secondary data as well as obtaining input from key stakeholders and the community to identify and define significant health needs, issues, and concerns.

A meeting was held on November 15, 2016, with the CHNA steering committee and community representatives to review primary and secondary data and to develop priority community health goals for the next three years. The process, including criteria for selecting community health priorities, is included in the CHNA report.

The following five priorities were selected and approved by the Sunnyside Hospital & Clinics Governing Board:

Priority I: Improve access to primary care including prenatal care in the Sunnyside Hospital & Clinics Service area.

Priority II: Improve access of residents to specialty physicians and to chronic disease management

Priority III: Develop strategies to help reduce obesity

Priority IV: Increase access to mental health services and treatment

Priority V: Increase access to substance abuse services and treatment

The community resources available to meet the priority health needs are included in the CHNA report.

We invite you to work with us as we strive to make our community a better place to live and work for everyone.

Very truly yours,

John Gallagher, CEO

Priority One: Improve access to primary care including prenatal care in the Sunnyside Hospital & Clinics service area.

Background and Rationale

Early and continuous prenatal care is an important strategy for improving the long-term health of the mother and preventing adverse birth outcomes.

Yakima County is not meeting the Healthy People 2020 goal of 77.9% of pregnant women receiving prenatal care in the first trimester. The rate for all women in Yakima County is 63.4%, for women with Medicaid 62%, and for undocumented women 66.1%.[1]

We believe that adding additional primary care providers and providing information about the importance of early prenatal care will increase the percentage of women who are seen within the first trimester.

[1] Healthy People 2020, Accessed October 24, 2016

Objective 1: Increase the number of providers who offer prenatal care

Indicator: Number of providers who provide prenatal care

Target: Increase the number of providers who provide prenatal care from twelve (12) to fourteen (14)

Interventions / Actions	Responsibility	By When
Recruit two (2) additional providers that provide prenatal care	B. Gibbons	December 2017

Objective 2: Provide community resources and education focused on the importance of prenatal care in the first trimester of pregnancy

Indicator: Percentage of pregnant women who are seen by a provider during the first trimester of pregnancy

Target: 77.9% (Healthy People 2020 Target)

Interventions / Actions	Responsibility	By When
Create a parenting resource guide including: Welcome Brochure, Labor & Delivery Booklet, New Mom Handbook, Breastfeeding Guide, and Newborn Testing & Screening	Marketing	December 2017
Distribute parenting resource guide in the Family Birth Center, Sunnyside OB/GYN, and Family Practice Clinics. The parenting resource guide will also be available on-line on the Sunnyside Hospital & Clinics web site.	Marketing	December 2017
Implement a Centering Pregnancy Program. The Centering Pregnancy program is a group care model for 6-10 pregnant women with similar gestational ages. They meet during 10 sessions over 6 months. Educational themes include nutrition, mental health, family planning, stress reduction, and exercise. The Centering Pregnancy model is especially effective for underserved mothers who lack access to comprehensive quality prenatal education.	Marketing Dr. Jessica Bury	2018
Provide flyers and/or information on the importance of prenatal care in the first trimester to all primary care, Pediatric, and OB/GYN offices	Marketing	June 2017
Establish a baseline for the number and percent of pregnant women seen by a provider during the first trimester.	Ruth Stalcup Ismael Almaguer	May 2017
Measure and report number and percent of pregnant women seen by a provider during the first trimester at least twice per year to primary care providers	Ruth Stalcup Ismael Almaguer	December 2017

Priority Two: Improve access of residents to specialty physicians and to chronic disease management

Background and Rationale

More adults who live in Yakima County have been told they have Diabetes and/or Heart Disease than in Washington State.

The percentage of adults ages 20 and older in Yakima County who have been told that they have Diabetes is 9.7% compared to 8.17% in the state. The percentage of the Medicare fee-for-service population who have been told they have diabetes in Yakima County is 27.1% compared to 21.7% in Washington State.[2]

The percentage of adults 18 and older who have been told that they have heart disease in Yakima County is 3.0% which is better than the state at 3.8%. However, for the Medicare population, Yakima County is worse than the state, 21.9% compared to 19.3%.[3]

High blood pressure, high LDL cholesterol, and smoking are key risk factors for heart disease. The percent of adults ages 18 and older who have been told they have high cholesterol in Yakima County is higher than the state, 42.6% compared to 39.7%. It is also higher for the Medicare population, 39.4% compared to 34%.[4]

The highest percent of adults not taking medication for their high blood pressure in Washington State (data is not available for Yakima County) is the Hispanic population, 44.94%.[5]

Our approach to chronic disease management will include three strategies:

1. Increasing the number of specialists to improve access
2. Providing diabetes education
3. Increasing the number of Medicare patients enrolled in the Chronic Care Management program

Objective 1: Increase the number of specialists who provide chronic disease management

[2]The State of Obesity, Accessed October 13, 2016
[3] Community Commons, Accessed October 24, 2016
[4] Community Commons, Accessed October 24, 2016
[5] Community Commons, Accessed October 24, 2016

Indicator: Number of specialists who provide chronic care management

Target: Increase the number of specialists who provide chronic disease management by two (2)

Interventions / Actions	Responsibility	By When
Hire one additional cardiologist	B. Gibbons	December 2017
Hire one additional Internal Medicine physician and/or one Pulmonologist	B. Gibbons	December 2017

Objective 2: Provide education and/or counseling for staff and community members that have been diagnosed as pre-diabetic or diabetic

Indicator: Number of classes and support groups

Target: 70 per year

Collaborating Organizations: Nuestra Casa, Sunnyside High School, and Lower Valley Fitness Club

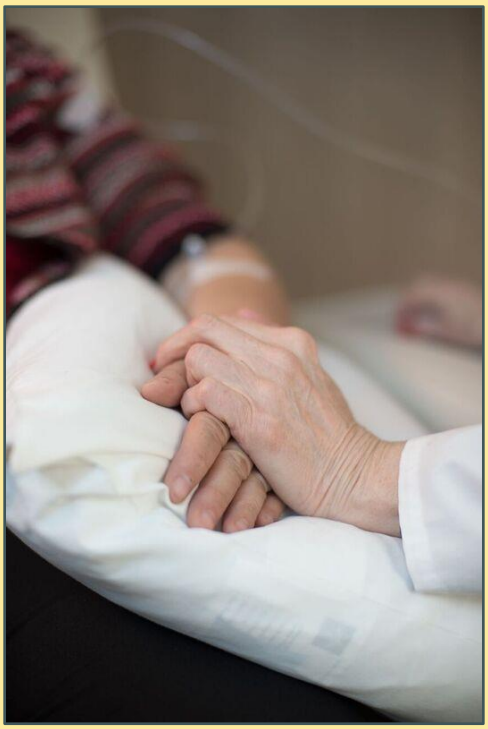
Interventions / Actions	Responsibility	By When
A quarterly series of four (4) diabetic education classes will be held for clients of Nuestra Casa. In addition to education about managing diabetes, the classes will include a blood sugar (finger stick) test prior to the start of the class and after the last class.	Jenny Chavez	Quarterly Classes starting 4th Quarter 2017
Collaborate with the school nurse at the Sunnyside High School to determine interest in offering a Support group for Children and Teens who are Pre-Diabetic, Type 1 Diabetic or Type 2 Diabetic.	Jenny Chavez	April 2017
Offer periodic Lunch and Learn presentations for staff with focus on managing diabetes, healthy food choices, and weight loss (Also included under section on Obesity)	Jenny Chavez Leanna Blue	June 2017 and ongoing
Offer a series of 3-4 Diabetes Self-Management Education classes in English once per month for community members. Weight and blood pressure checks will be included.	Jenny Chavez	January 2017 and Ongoing
Offer a series of 3-4 Diabetes Self-Management Education classes in Spanish once per month for community members. Weight and blood pressure checks will be included.	Jenny Chavez	January 2017 and Ongoing
Offer periodic presentations at the Lower Valley Fitness Club for members and the general community on topics related to managing diabetes, healthy food choices, and weight loss (Also included under section on Obesity)	Jenny Chavez Leanna Blue	April 2017 and ongoing
Provide individualized education and counseling for patients who are diabetic or pre-diabetic referred by a provider or who are self-referred Provide one time individualized education for patients with A1C within normal limits Provide 3-month counseling and follow-up for patients with elevated A1C	Jenny Chavez	January 2017 and ongoing
Evaluate the potential of offering a Centering Diabetes model. The Centering approach for diabetes care and management includes a model where patients come together to meet with their healthcare provider and develop a community that shares information and supports each other in living a healthier lifestyle. They talk about the challenges and triumphs that come with managing a serious chronic illness.	Marketing	2019

Objective 3: Enroll additional Medicare patients with two (2) qualifying chronic conditions in the Chronic Care Management program

Indicator: Number of Medicare patients enrolled in the Chronic Care Management program

Target: 111 patients enrolled by December of 2017 and 300 patients enrolled by July of 2019

Interventions / Actions	Responsibility	By When
Educate providers and Clinic Referral Coordinators regarding the Chronic Care Management program	Clinic Coordinators	January 2017
Meet with patients who qualify for the Chronic Care Program to establish goals and develop a plan of care	Care Coordinators	January 2017 and ongoing
Monthly follow-up for each patient enrolled in the Chronic Care Management program	Care Coordinators	January 2017 and ongoing
Hire additional care coordinator(s) if necessary to provide services to an expanded panel of patients	Administration	As needed



Priority Three: Develop strategies to help reduce obesity

Background / Rationale

According to the CDC, Obesity is associated with increased health risks including heart disease, stroke, type 2 diabetes, and certain types of cancer.

Washington State has the 15th lowest adult obesity rate in the nation, according to *The State of Obesity: Better Policies for a Healthier America,* released September 2016. Washington's adult obesity rate in 2015 was 26.4%, an increase from 18.4% in 2000 and from10.1% in 1990.[6]

However, the obesity rate in Yakima County and the percentage of adults who are overweight are both higher than the state and the United States.[7] The obesity rate in Washington State is highest for ages 45-64 (31%), Black (32%), Latino (32%), and women (26%).[8]

We will focus on education for staff and the community as well as individualized counseling for patients referred by Sunnyside Clinics. We will assist staff in becoming members of the Lower Valley Fitness Club.

[6] State of Obesity, Accessed October 7, 2016
[7] Community Commons, Accessed October 8, 2016
[8] Community Commons, Accessed October 8, 2016

Objective 1: Provide education for staff and the community regarding healthy eating options and weight loss

Indicator: Education Classes

Target: 20 classes per year

Collaborating Organization: Lower Valley Fitness Club

Interventions / Actions	Responsibility	By When
Increase frequency of community education class, "Healthy Weight for a Life Time" from quarterly to monthly	Leanna Blue	December 2017
Assist employees who use the hospital cafeteria to make healthy food choices including the following strategies: (1) Healthy desserts offered in the cafeteria (2) Provide nutritional calorie content of meals (3) Identify healthy food options in cafeteria line	Leanna Blue	March 2017
Offer periodic presentations at the Lower Valley Fitness Club for members and the general community on topics related to managing diabetes, healthy food choices, and weight loss (Also included in section on Chronic Disease)	Jenny Chavez Leanna Blue	April 2017
Offer periodic *Lunch and Learn* presentations for staff with focus on managing diabetes, healthy food choices, and weight loss (Also included under section on Chronic Disease)	Jenny Chavez Leanna Blue	June 2017 and ongoing
Offer payroll deduction for employees who register to be members of the Lower Valley Health & Fitness	CFO	February 2017

Objective 2: Provide individualized counseling by a registered dietitian for adults with a BMI > 27 and children > 95th percentile for height and weight that are referred by Sunnyside Hospital & Clinics.

Indicator: Number of referrals

Target: Increase number of referrals from 20 per month to 40 per month by 2019

Interventions / Actions	Responsibility	By When
Individualized weight management counseling by a registered dietitian for Sunnyside Hospital & Clinic patients	Leanna Blue	January 2017 and ongoing
Increase referrals from Sunnyside Hospital & Clinics by faxing / emailing criteria to Clinic referral coordinators at least quarterly	Leanna Blue	March 2017 and ongoing

Priority Four: Increase access to mental health services and treatment

Background and Rationale

Lack of access to mental health services in Yakima County is a significant community health problem.

Yakima County is designated as a Health Professional Shortage Area (HPSA) for Primary Care, Dental, and Mental Health. Yakima County has a ratio of 430:1 mental health providers compared to 380:1 mental health providers in the State.[9]

According to CMS, one in six persons older than 65 years suffers from depression.[10] The US Preventive Services Taskforce (USPSTF) found good evidence that screening improves the accurate identification of depressed patients in primary care settings, and that treating depressed adults and older adults with antidepressants, psychotherapy, or both decreases clinical morbidity.

Strategies to both increase access for inpatient and outpatient treatment as well as early identification of individuals over 65 with depression were developed.

Objective 1: Screen Medicare patients seen at Sunnyside Clinics for depression

Indicator: Percent of Medicare patients screened

Target: Increase the number of Medicare patients screened annually for depression from 20% to 75% by the end of 2019.

Refer 100% of Medicare patients who score High on the depression screening tool to a mental health provider.

Interventions / Actions	Responsibility	By When
Educate providers regarding PHQ-9 Depression Test Questionnaire	Clinic Coordinators	April 2017
Complete depression screening annually with using the PHQ-9 Depression Test Questionnaire for Medicare patients.	Clinic Nursing Staff	April 2017
Refer patients who score High on the PHQ-9 for depression to a mental health provider.	Primary Care Provider	April 2017

[9] Health Resources & Services Administration (HRSA) Data Warehouse, Accessed October 20, 2016
[10] CMS.gov, Decision Memo for Screening for Depression in Adults (CAG-00425N) Wang, *et al.* (2005)

Objective 2: Develop an outpatient behavioral health service

Indicator: Volume of patients served

Target: 3800 visits annually within 24-months of opening

Interventions / Actions	Responsibility	By When
Hire one psychiatrist to work in the Outpatient Behavioral Health Clinic	B. Gibbons	May 2017
Hire one mid-level provider to work in the Outpatient Behavioral Health Clinic	B. Gibbons	May 2017

Objective 3: Develop a ten (10) bed inpatient behavioral health unit

Indicator: Inpatient behavioral health unit design completed

Target: Open by 3rd quarter of 2019

Interventions / Actions	Responsibility	By When
Begin implementation of an inpatient mental health unit.	B. Gibbons	3rd Qtr 2019

Priority Five: Increase access to substance abuse services and treatment.

Background and Rationale

Substance abuse, including alcohol and drug abuse, has a significant impact on health in Yakima County. Although dependence on alcohol or drugs can occur independently, addiction is common in people with mental health problems. Alcohol or drugs may be used to self-medicate and can exacerbate underlying mental disorders.[11]

We will develop a plan for improving access to substance abuse services and treatment over the next 3 years in collaboration with community providers of substance abuse services and providers at the Sunnyside Behavioral Health Clinic.

Objective 1: Assess community need and develop a plan for increasing access to substance abuse services and treatment.

Indicator: Complete assessment and plan

Target: Plan Completed

Interventions / Actions	Responsibility	By When
Complete an assessment of the efficacy and need for providing substance abuse service and treatment	B. Gibbons	December 2017
Develop and implement a program to provide substance abuse services and treatment, as determined by the assessment	B. Gibbons	June 2018

[11] Substance Abuse and Mental Health Issues Joanna Saisan, M.S.W., Melinda Smith, M.A., and Jeanne Segal, Ph.D. Last updated: December 2016.