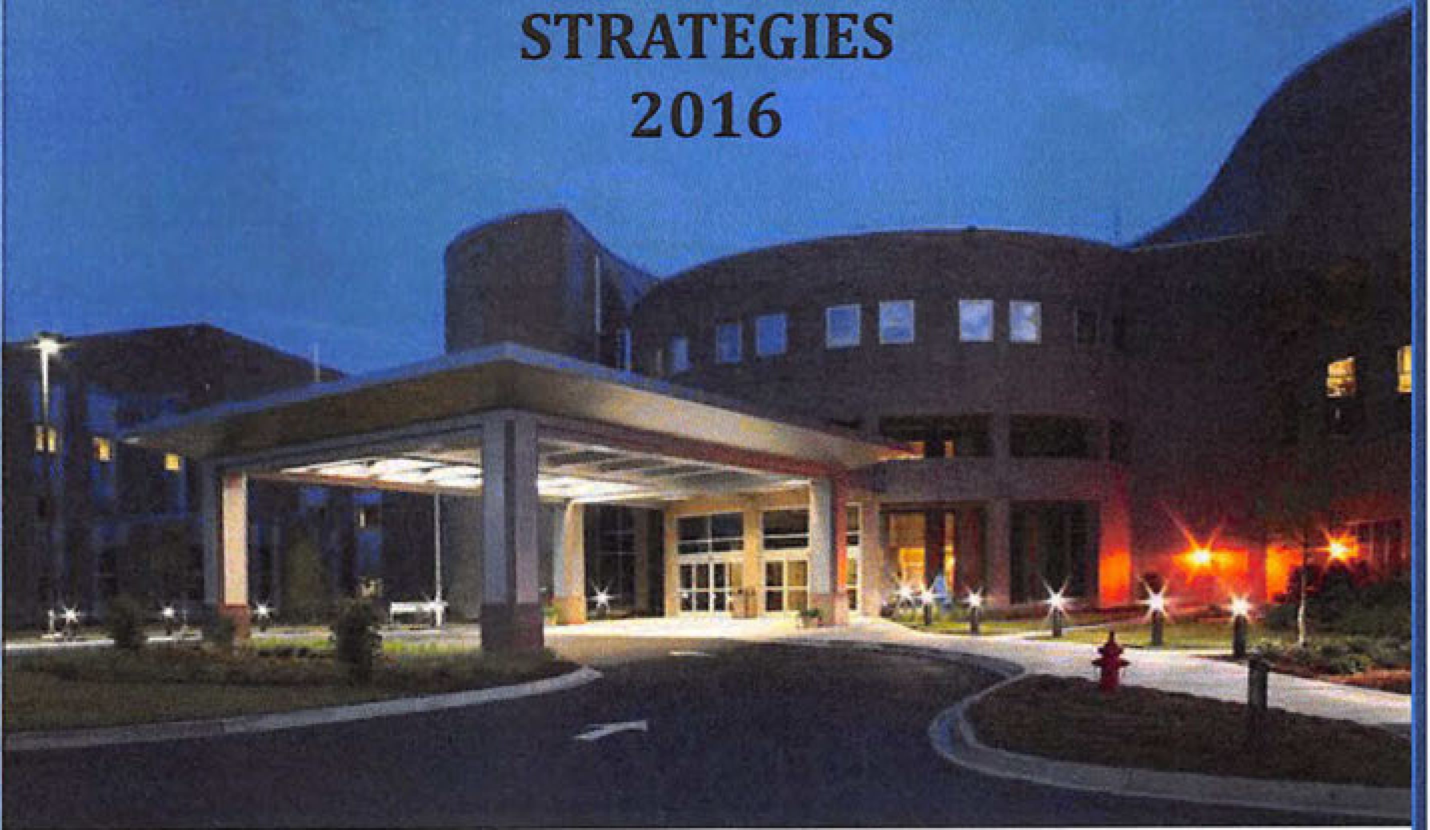
CHNA IMPLEMENTATION STRATEGIES 2016



Implementation Strategies

Conway Medical Center will engage key community partners in implementing evidence-based strategies across the service area. Acknowledging the many organizations and resources in place to address the health needs of our communities, CMC has strategically reviewed both internal and external resources. This portion of the CHNA, the Implementation Strategy, will explain how CMC will address health needs identified in the CHNA by continuing existing programs and services, and by implementing new strategies. It will also explain why the hospitals cannot address all the needs identified in the CHNA, and if applicable, how CMC will support other organizations in doing so.

Health Priorities

As afore mentioned in the CHNA report, the following document addresses the needs that Conway Medical Center has chosen to address. The document also outlines why we chose to address this need, how we will address the need, who the responsible party will be, and any goals that will be set forth from the beginning, as well as time frame for achieving those goals.

A priority session was held at the Conway Medical Center with members of senior leadership in September, 2016. The purpose of this session was to discuss data and input and prioritize the needs of the hospital's defined community. Criteria used included importance to the service area, relevance of the health issue to the population served, and the ability of CMC to effectively impact and improve the health issue.

The team discussed strategic action steps and desired outcomes and these serve as a framework of the implementation strategies.

Also, in accordance with IRS proposed regulations, the team identified which priorities would not be addressed in the implementation strategy and why. After discussing these priorities in depth and examining CMC's expertise, the expertise of other community organizations and outreach, and CMC's wide range of services currently available, the following issues were chosen for implementation:

- **Access to PCPs**
- **Discharge Follow-up**
- **Motor Vehicle Accidents**
- **Diabetes**
- **Mammography**

A strategy for each need mentioned above has been provided on the following pages.

Access to Primary Care Physicians – There is a perceived gap in the market for access to PCP providers. CMC will partner with local clinics to continue assisting in providing care at reduced costs through support in areas of rent, utility bills, and hospital services as well as evaluate the opportunities to expand access points for care.

Community Health Need:	Access to Primary Care Physicians		
Goals:	Conway Medical Center will actively assist in providing access to Primary Care Physicians		
Strategy: Ensure each patient admitted to CMC has appropriate follow-up with a provider of choice prior to discharge			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Initial evaluation with patients within 24 hours of admission to discuss current PCP and/or need for PCP	Case Management	Ongoing	Improved amount of patient's that have appropraite PCP follow-up
Assist patient in scheduling a discharge appointment prior to leaving the hospital which includes appropriate insurance coverage, needed documentation for new appointment and any transportation needs for the appointment	Case Management	Ongoing	Increase in patient's with arrange PCP appointments
Provide community clinic information for those patient's who refuse/deny CM assistance with obtaining new PCP	Case Management	Ongoing	Improved access and better coordination of care
Educate the communuity on the importance of regular, Primary Care exams and follow up	Marketing	12 months	Increase community awareness to promote greater PCP utilization
Promote CPG Physicians through various methods	Marketing	12 months	# of New Patients being seen by CPG
Promote CPG Physicians to all patients admitted to the hospital	Marketing	12 months	# of New Patients being seen by CPG
Promote CPG Physicians to all patients discharged through the Emergency Department	Marketing	12 months	# of New Patients being seen by CPG
CPG Primary Care will create quick care/open access, same day, acute care visits in all primary care sites with multiple providers. The goal is to increase access for first the patients of CPG offices and ultimately the community at large.	CPG	24 months	Increasesd access
CPG will expand Primary Care access for patient population by expanding hours, adding providers and new location convenient to patient base.	CPG	Ongoing; as appropriate	Increasesd access
CPG will embrace "Patient Centered Medical Home" to improve access to the appropriate level of care at the appropriate time of need for the patient. It will formally recognize its practices as NCQA level two and three so facilitate cooperation between patients, practices and payers. This will expand the care coordination approach to primary care and collaboration with Hospital and other organizational care providers.	CPG	Ongoing; as appropriate	Increased access and care coordination
CPG will expand access for pediatric patient population by expanding hours, adding providers and new location convenient to patient base.	CPG	24 months	Increased access
CPG will work closely with our patient population who are prescribed opioids with a dedicated opioid nurse navigator who provides care plans and measures to manage the usage of prescriptions.	CPG	By Q4 2017	eliminate inappropriate opioid use

Discharge Follow-up - In order to reduce several health concerns CMC has identified patients not following discharge instructions as a significant community need. It is CMC's intent to establish best practices and education around discharge instructions.

Community Health Need:	Follow-up after Discharge		
Goals:	Establish best practices and education around discharge instructions.		
Strategy: Increase/continue communication with patients within five days of appropriate discharge home			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Hospitals and attending specialists or hospitalists inform and consult with the PCMH Care Coordinator about discharge plans for their patients, and they work together to ensure that discharged patients get appropriate followup care.	CPG	Ongoing	Reduced readmissions and better care coordination
Continue to monitor and increase TCM volume in CPG practices, monitor hospital discharge list and follow up with patients needs after discharge	CPG	Ongoing	Reduced readmissions, better care coordination and patient care
Establish Chronic Care management program for patients with 2 or more chronic conditions to include outreach and education each month, work on ways to decrease re-admissions	CPG	Monthly	Improve patient care, reduce readmissions, reduce ER utilization
Patient will be seen by a member of case management prior to being discharged to home from CMC	Case Management	Ongoing	Decrease of discharge needs after patient is discharged
Patient will be contacted via phone from a member of case management after discharge to home	Case Management	Ongoing	Improved coordination of care
Documentation regarding patient status after hospital stay including medication compliance, home health services, follow-up appointments and/or any other concerns regarding their care	Case Management	Ongoing	Improved coordination of care
Expand utilization of Transitional Care visits post-DC from acute care facilities	CPG	12 months	Increase TCM visits within CPG post-CMC DC
Expand current post-DC Transitional Care program at CMC to include even more value added services and encompass more patients	CMC Case Mgmt	12 months	Expand services to current patients and offer services to a wider patient population

Motor Vehicle Fatalities - According to the Association of State and Territorial Health Officials, crash-related deaths and injuries are largely preventable. States can utilize systems, policy, and programmatic interventions to target and prevent this serious public health problem. CMC will focus its efforts on the trauma side in partnership with local EMS providers.

Community Health Need:	Motor Vehicle Fatalities		
Goals:	Conway Medical Center will provide education and support to assist the community in reducing motor vehicle accidents resulting in disabilities and fatalities.		
Strategy: To reduce motor vehicle accident disabilities and fatalities through community education			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
CPG's Opioid Management program will coordinate care for patients using opioids. This will also decrease the amount of "drugged driving" in our area. With a dedicated nurse coordinator to manage these patients, we are able to provide resources and education of these medications. Several studies have shown that drivers with THC in their blood were roughly twice as likely to be responsible for a deadly crash or to be killed as drivers who had not used drugs or alcohol.	CPG	Ongoing	Creating a safter environment for community
In conjunction with AARP, offer Safe Driver Classes which will focus on: important facts about the effects of medication on driving; How to reduce driver distractions; How to maintain the proper following distance behind another car; Proper use of safety belts, air bags, anti-lock brakes and new technology found in cars today; Techniques for handling left turns, right-of-way, and roundabouts; Age-related physical changes and how to adjust your driving to compensate	Marketing	12 months	Increase # of drivers changing at least one driving habit as a result of what they learned in the class
Provide presentation to area High Schools on the dangers of impaired or distracted driving	Trauma Multidisciplinary Management Committee Multidisciplinary	By September 30, 2018	Increase the awareness of preventable causes of motor vehicle fatalities including, use of alcohol, drugs, distracted or tired driving, and texting.
Collaborate with area police and EMS personnel to provide educational event regarding the dangers of impaired or distracted driving	Trauma Multidisciplinary Management Committee Multidisciplinary Management	By September 30, 2018	Create a working relationship with area governing entities to educate the community regarding preventing motor vehicle accidents from distracted and impaired driving.
Provide public service announcements via radio/television regarding the dangers of impaired or distracted driving	Trauma Multidisciplinary Management Committee Multidisciplinary	By September 30, 2018	Increase the awareness of preventable causes of motor vehicle fatalities including, use of alcohol, drugs, distracted or tired driving, and texting.
Provide information via brochure/pamphlet to patients in waiting rooms at the hospital and CPG offices regarding distracted or impaired driving.	Trauma Multidisciplinary Management	By September 30, 2018	Educate the community regarding preventing motor vehicle accidents from distracted and impaired
Community programs focused around traumatic automobile injuries	Trauma Team	12 months	Increased community awareness of driving habits that lead to increased traumatic MVAs

Diabetes – Diabetes is a major health need across the US and in Horry County. CMC will continue to support and educate medically underserved diabetics in the community.

Community Health Need:	Diabetes		
Goals:	Increase/continue diabetes education to improve health status of community. Continue to educate and support people with diabetes in the community		
Strategy: Improve access to diabetes education and increase participation in diabetes education and promote wellness through education			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
CPG will provide diabetes education for its patients in conjunction with its PCMH approach with the addition of CDE to its staffing. The formal diabetes initiative will provide structured care plans, monitoring and case management approach for patients with Type 1 and Type 2 diabetes. It will also develop credentials for existing clinical support staff and will seek reimbursement to support program from payors.	CPG	Ongoing	Increased education and better coordinated care and decreased ER visits
with diabetes and other chronic illnesses. CPG nurse coordinators and diabetic educators help physicians implement and carry out care plans and it is important that they be included as a key member of the Patient Centered Medical Home (PCMH) team.	CPG	Ongoing	Improved knowledge and education for diabetic patients resulting in improved health and less use of acute care
Provide funding for the promotion and education for Diabetes.	CMC Foundation	Continuous	Maintain funding to provide this initiative
Provide funding to Healthreach for outreach screaning of low income individuals and families	CMC Foundation	Continuous	Maintain funding to provide this initiative
Provide funding to Friendship Medical Clinic for outreach screaning and treatment of low income individuals and families.	CMC Foundation	Continuous	Maintain funding to provide this initiative
Continue with free monthly diabetes support group meetings providing education, support and access to community resources	Healthreach	Ongoing	Consistent or increased monthly support group attendance; Increased self-care knowledge of participants; emotional support for participants
Continue to participate in community health fairs to promote diabetes awareness, wellness and access to community resources	Healthreach	Ongoing	Increased awareness of diabetes risk facgtors, need for routine screenings, diabetes wellness, resources available for people with diabetes
Provide diabetes education on an outpatient basis through individual sessions and group sessions on and off campus with physician referral	Healthreach	Ongoing	Increased knowledge, self-care, compliance and health
Continue to provide no-cost glucometers and test strips to uninsured people with diabetes	Healthreach	Ongoing	Increased self-care and health
Educate area healthcare providers on benefits of diabetes education and when to refer patients for diabetes education	Healthreach	Ongoing	Increased patient knowledge, self-care, compliance and improve overall health
Increased participation at Health Fairs, etc. with focus on diabetes education	Healthreach	12 months	Increase community awareness about diabetes
Offer free Hgb A1C screenings to local public	Hospital	12 months	Early identification of pre-DM and DM patients
Offer DM classes and educational sessions throughout local communities using area CPG offices to reach different areas of our county	CMC/CPG	12 months	Bring more DM eduaction to local communities throughout Horry County

Mammography – Provide preventative screenings while finding innovative ways to address financial and transportation barriers of receiving these screenings.

Community Health Need:	Mammography		
Goals:	Increase % of Women with Mammography Screening		
Strategy: Screen and educate the community of mammography screening			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Care Coordination approach in conjuction with PCMH and Breast Health Navigator.	CPG	Ongoing	Improved care coordination
Coordinate with Central Scheduling to provide open access to scheduling Screening Mammography at CMC Diagnostic Center, allowing CPG staff to schedule at time of patient appointment in office.	CPG	Ongoing	Improved access; Increased screenings
Using EMR, send out patient communication to all women over 40 reminding them to schedule their annual mammogram.	CPG	Quarterly	Increased appropriate screenings for women over 40
Promote through various methods our ability to offer screening mammograms without a physician's order	Marketing	12 months	increase % of self referrals
Provide free mammograms to uninsured, low-income women in Horry County area through the Mammography Initiative.	CMC Foundation	Continuous	Maintain funding to provide this initiative
Provide funding to Healthreach for outreach screaning and treatment of low income individuals and families	CMC Foundation	Continuous	Maintain funding to provide this initiative
Provide funding to Friendship Medical Clinic for outreach screaning and treatment of low income individuals and families.	CMC Foundation	Continuous	Maintain funding to provide this initiative

Needs Not Addressed

Priorities not being addressed include:	Reasoning / Explanation
% of Adults Smoking	As part of CMC's 2013 CHNA – CMC included this need in their prioritization planning. CMC actively implemented their action plans. At this time, there are other organizations in the county that are specifically focused on this need. However, CMC will continue to be an advocate of creating smoke free environments.

Board Approval

Treasury Regulation Section 1-501(r)-3(c)(5)(i):

For purposes of paragraph (a)(2) of this section, an authorized body of the hospital facility must adopt the implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA described in paragraph (b)(1) of this section, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.

Conway Medical Center's Board of Directors approves the Implementation Strategy for addressing priorities identified in the most recent Community Health Needs Assessment completed fiscal YE September 30, 2016 and was approved by the Conway Medical Center Board of Directors at its meeting held on September 26, 2016.

Leroy Rainbow, Jr., Chairman

Date February 14, 2017