christian hospital
FOUNDATION
BJC HealthCare

Community Health Needs Assessment Report and Implementation Plan

Implementation Plan

The North County community has health needs that are different from those of the remainder of the St. Louis County community. While North County residents need a number of different services based upon the rankings, Christian Hospital is positioned to provide excellent healthcare in the top two health needs; Chronic Disease and Access to Care.

A. NEEDS THAT WILL BE ADDRESSED BY CHRISTIAN HOSPITAL

I. CHRONIC DISEASE –DIABETES PREVENTION

Rationale: Diabetes is the leading cause of new cases of blindness, kidney failure, and non-traumatic lower limb amputations among adults. Diabetes is also a major cause of heart disease and stroke. Diabetes was the seventh leading cause of death in the United States in 2011- overall, the mortality risk among people with diabetes is about twice that of people without diabetes of the similar age.

Diabetes affects 25.8 million Americans, or 8.3% of the United States population. The prevalence rate of diabetes in the hospital community is especially high in the Mid and North Counties (11% and 12%, respectively) compared to other areas of St. Louis, and the two sub-county areas have higher rates of obesity and sedentary lifestyles, both risk factors of diabetes. The diabetes mortality rate is also highest in North County and 14% of North St. Louis County residents are uninsured which impact their access to care and education about their disease.

Effective therapy can prevent or delay diabetes complications. However, seven million Americans with diabetes are undiagnosed, and another 79 million Americans have pre-diabetes which greatly increases their risk of developing diabetes in the next several years. Few people receive effective preventative care, which makes diabetes an immense and complex public health challenge. If the awareness of pre-diabetes and diabetes increases in North County, it will positively impact the health of the community, therefore the hospital will offer free community screenings and education programs. The screenings will help increase awareness about pre-

diabetes and diabetes and ideally lead to earlier interventions by the patient's provider. Referrals will be made to the hospital's education program as appropriate. The formal education program will be available at the hospital to help patients and their families learn how to prevent or delay diabetes complications. The outcomes of the education program are positive: an average of one percent decrease in HgbA1c and 4 lbs. of weight lost by the end of the program. (A one percent decline in HgbA1c decreases the risk of micro-vascular complications by 35%, diabetes related deaths by 25%, and heart attacks by 18 %.)

Program Goals:

I. Increase the awareness of pre-diabetes and diabetes in the primary services area of Christian hospital.

II. Increase the number adolescents and adults with pre-diabetes/diabetes who receive formal education in our community. (Healthy People 2020 –Objective D-14)

Program Objectives:

Goal I Objectives:

Increase the awareness of pre-diabetes and diabetes in the primary services area of Christian hospital.

a. Maintain the number of glucose and HgbA1c screenings as prior year.
b. Increase the number of screening locations by 5% over prior year.
c. To seek that 30% of abnormal screenings seeks further medical evaluation and intervention during each screening.

Program Action Plan: Pre-diabetes and Diabetes Screenings

The Diabetes Screening Team (DST) provides free screenings at various locations four times per week from 9:30 AM – 12:30 PM. The screening locations are promoted through postcards mailed to 30,000 households quarterly, the hospital website, the Diabetes Institute, 314-747-WELL (9355) calls, posters within the hospital, and various hospital health fairs.

Any patient with an abnormal screening result will be recommended to follow-up with their physician for further testing and a copy of the result will be faxed to provider's office with the patient's consent. If the patient does not have a physician, they are given the BJC referral line, 314-747-WELL (9355); any uninsured patients will be referred to a clinic. The Christian Hospital Diabetes Institute staff will follow-up with all abnormal screening with a phone call a week or two after the screening to see if the patient has seen a physician or at least has plans to do so. If the patient is not able to be reached by phone, a letter is mailed with additional education information. Patients are also encouraged to attend the formal education classes for diabetes prevention or diabetes management at the outpatient center.

Program Outcome: Early diagnosis of diabetes

Program Outcomes Evaluation:

The number of screenings will be tracked daily and the locations will be tracked annually. Abnormal glucose and HgbA1c screenings will also be tracked in addition to the number of follow-up calls or mailing related to abnormal findings. We will also track the number of individuals who stated that they received a medical care or intervention after they were screened.

Program Goal II Objectives:

Increase the number of adolescents and adults with pre-diabetes/diabetes who receive formal education in our community.(Healthy People 2020-objective D-14)

a. Increase the number of patients educated by 5% over prior year
b. Increase the number of uninsured patients educated by 5% over prior year.
c. Maintain a one percent decrease in HgbA1c from baseline to completion of the program.
d. Increase patient's goal achievement of a (4) or (5) rating from 50% to 55%.

Program Action Plan: Pre-diabetes and Diabetes Self-Management Education Program

The hospital will offer pre-diabetes and diabetes self-management classes to the hospital community to educate patients on lifestyle changes to prevent diabetes or improve their diabetes control. The program is recognized by the American Diabetes Association and is taught by a nurse and a registered dietitian who are both certified diabetes educators. Participants will attend an initial class with two follow-up visits at three months and one year. Weight and HgbA1c are tracked at each visit to monitor progress.

The program will be promoted through the screening outreach team, inpatient clinicians, social media, the hospital website, and mailers to physicians.

Program Outcomes Evaluation:

The education program will track the total number of participants as well as the number of uninsured patients that attend. Outcomes such as HgbA1C and weight at baseline and follow-up visits will be tracked as well as the patients' goal achievement at each follow-up visit.

II. CHRONIC DISEASE- OBESITY IN OUR COMMUNITY

Rationale: Overweight/obesity remains a growing concern in the county, state and country. Obesity is linked to major chronic conditions such as heart disease, diabetes, arthritis, cancer and stroke. According to the community health needs assessment, North County's obesity rate is at 36 percent, compared to the St. Louis County rate of 27 percent, showing a great need in this area for education and assistance in losing weight. If the obesity rate in North County is reduced it will positively impact the health of the community; therefore, the hospital will offer the Just Lose It weigh loss challenge two times each year. Each session will last 12 weeks. Just Lose It does demonstrate a decrease in weight among participants by approximately 4% percent per round.

Program Goals:

I. Reduce the incidence of overweight and obese individuals in North County.
II. Educate individuals on healthy lifestyle behaviors.

Program Objectives:

Program Goal I Objectives:

Reduce the incidence of overweight and obese individuals in North County.

a. Increase "Just Lose It' participation by five percent from the prior session.
b. Increase adult participation completion rate from 30 to 40 percent from the prior session.
c. Increase group weight loss at each session by one percent from the number of the previous session.

Program Action Plan: Just Lose It

Since 2009, Christian Hospital marketing and communication department has offered the weight management program, in collaboration with these partners:

- City of Bellefontaine Neighbors – weigh-in site and offers free exercise classes to participants, from power walking to water aerobics as challenges in the program
- Christian Hospital Occupational Health – weigh-in site and offers free flu shots to participants
- Curves – weigh-in site
- Emerson Family YMCA – weigh-in site and offers free workout classes for challenges in the program
- Ferguson Bicycle Shop – weigh-in site and offers free bike rides for challenges in the program.
- Christian Hospital Outpatient Rehabilitation Services – weigh-in site

- City of Florissant – Both the James Eagan Center and JFK Center – weigh-in sites
- St. Louis County Parks – weigh-in site and offers the participants a free week of walking at their track for challenges for the program.

This program fills up with 400+ participants in each session. We have increased the number of participants accepted to meet the high demand. This will allow the program to increase by 5% each session. In 2011, challenges were added to encourage people who are not in the top 10 to continue to participate. We will continue to offer challenges with incentives of a chance to win prizes at the events finale to increase the percentage of participants to stay in the program. We have also recruited a physician champion that records inspiring messages that are sent out on a weekly basis. He communicates with participants through Facebook. A Facebook page has been created for participants to share their stories and connect with other participants. It also gives us a way to share additional tips, information and motivation with participants. A weekly newsletter is given to all participants at their weigh-in sites with tips and recipes as another incentive to keep them engaged. By keeping participants engaged and motivated, a higher percent should complete the 12-week session and be successful in losing weight. To help assist participants with their weight loss goals, a weekly workout class is offered. To maintain interest, additional programs will be conducted during the 12-week sessions. Attendees will be entered into prize drawings based on the number of programs attended. The top 10 individuals with the greatest percent of weight loss will be recognized and awarded prizes at the closing celebration. Before and after photos will also be displayed.

Program Outcomes: To decrease the incidence of obesity in North County

Program Outcomes Evaluation:

Participants and the program coordinator track weights during weekly weigh-in to determine the top 10 individuals at the end of the program as well as to measure the total group weight loss during session. The total group weight loss of each session will be compared to the previous session weigh loss number to determine if there was an improvement.

Program Goal II Objectives:

Educate individuals on healthy lifestyle behaviors.

a. The staff will set a baseline of overall response rate of class participants who will incorporate healthy life style change into their life.
b. Every year, over all participant response rates of those who incorporate a healthy life style change into their life will increase by 5% from the previous year response rates.

Program Action Plan: Nutritional Education Programs

Nutritional classes along with cooking demonstrations will be conducted during the 12-week program by registered dietitians. In these classes the participants will gain knowledge about the right and wrong foods to eat, how to prepare healthy food, how to change their lifestyle and diet and different methods to use to track what they are eating, from carb counting to reading labels. Questionnaires will be distributed at end of each class asking participants if they learned something new from the class, if they plan to make a change in lifestyle based on this knowledge and rate their motivation to make this change.

Program Outcomes: To increase healthy lifestyle behavior among North County population

Program Outcomes Evaluation:

Both Just Lose It programs of North County will be evaluated by tracking data on the number of participants, completion rates, and average group weight loss.

Pre-and-Post survey will be given to participants at the beginning and the end of the sessions. The two surveys will be analyzed to determine if there is a change in the participant's response rate in order to measure the likelihood of participants to incorporate the educational aspects that they learned into their lifestyle.

III. ACCESS TO HEALTH CARE SERVICES

Rationale: Access to healthcare is an ongoing and national concern. Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It allows individuals to gain entry into the health care system, access a health care location where needed services are provided and find a health care provider with whom the patient can communicate and trust.

There are several components of access to health services, such as coverage, services, timeliness, and workforce. BJC HealthCare, as a system of hospitals, understands the importance of health insurance coverage, which helps patients get into the health care system. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Therefore, all BJC hospitals have a policy that focuses on the provision of insurance coverage as the principal means of ensuring access to health care among the underinsured and uninsured population.

Program Goal:

- *To improve access to comprehensive, quality health care services.*

Program Objective:

Every year, Christian Hospital will offer Medicaid and financial assistance enrollment to 100% of eligible patients presented for medical care.

Program Action Plan:

Christian hospital provides a Patient Account Representative who works with a Case Manager and a Social Worker to identify patients in need of assistance and meets with uninsured patients to determine their eligibility for any insurance and financial assistance. Eligible patients receive assistance with enrollment.

Program Outcome: *Increase access to health care services*

Program Outcome Measurement:

The number of individuals who receive assistance for insurance eligibility and the number of those who are enrolled in programs are tracked by the hospital.

B. NEEDS THAT WILL NOT BE ADDRESSED HOSPITAL

Christian Hospital is positioned to actively impact the top two community health needs as identified through this study. The health needs below are not currently being addressed through this study; however Christian Hospital has programs in place that allow us to influence five of the top 10 community health needs. (Listed in order of priority of needs 3-10)

Mental Health – The hospital does not currently have the financial ability to actively educate and screen the community. We offer support groups for substance abuse and other mental diagnosis through our outpatient mental health center.

Infectious Disease – The hospital does not currently have the financial ability to actively educate and screen the community for infectious disease. We do however, provide funds for free flu shots given in the community.

Reproductive Health – The hospital does not currently offer clinical support for obstetrics, thus a focus on reproductive health is minimal.

Cancer – Community benefit programs are currently funded that allow us to address cancer education and prevention such as the Men's Healthy Happy Hour where we conduct PSA screenings and the Mammo-thon, providing mammograms for underinsured women in the community. However, we do not actively coordinate a program outside of our Komen grant. The greater community is actively involved with events through the American Cancer Society.

Child Welfare – The hospital does not currently have a pediatric unit and outside of seeing children in the ED, they are transferred to a facility that can accommodate them. Our hospital and EMS trucks are considered a "safe place" and we partner with Youth In Need to ensure our youth have access to basic needs outside of medical treatment.

Socio-economic Factors – The hospital partners with organizations within the community to positively impact the growth of this area. We are a leading employer in the county and partner with various Community Development Corporations and community development organizations in an effort to improve the neighboring communities.

Senior Care – The hospital does not currently offer senior care outside of the management of Village North Retirement Home.

Dental Health – The hospital does not currently have the clinical opportunities to provide dental care to our community members.