CHRISTUS SPOHN Health System


# 2015-16 Community Health Implementation Plan

## Our Mission

*To extend the healing ministry of Jesus Christ*

## Our Vision

*CHRISTUS HEALTH, a Catholic health ministry, will be a leader, a partner and an advocate in the creation of innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God's healing presence and love.*

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## MISSION FOR IMPLEMENTATION

CHRISTUS Spohn Health System is part of CHRISTUS Health, formed in 1999 to strengthen the 147-yearold, faith-based health care ministries of the Congregations of the Sisters of Charity of the Incarnate Word of Houston and San Antonio. Founded on the **Mission "to extend the healing ministry of Jesus Christ**," CHRISTUS Health reaches out to, and beyond, the more than 60 communities we serve to help those in need.

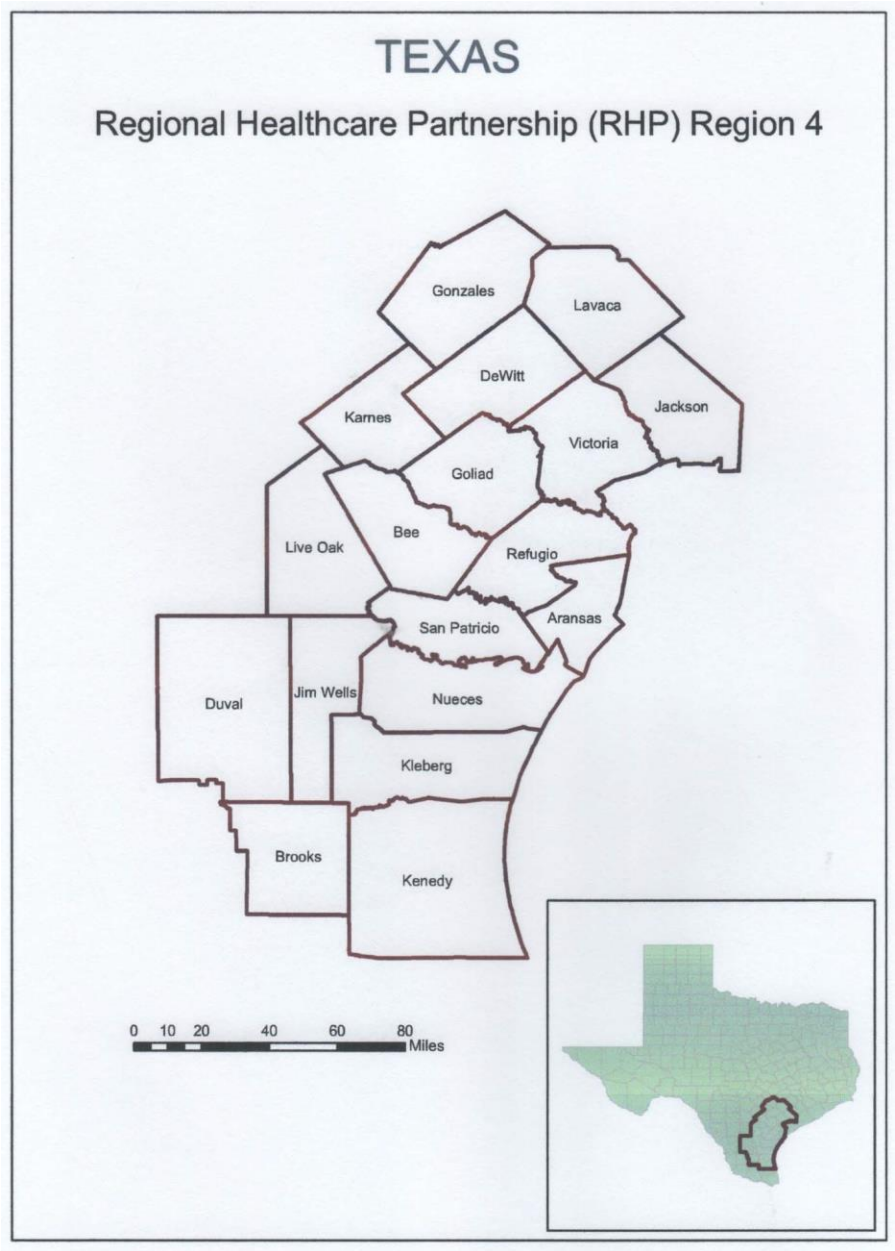
The **Vision of *CHRISTUS HEALTH***, *a Catholic health ministry, is to "be a leader, a partner and an advocate in the creation of innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God's healing presence and love."* CHRISTUS Spohn Health System responds to the health care needs through services provided at CHRISTUS Spohn Hospital Corpus Christi with three campuses -- the 557-bed Shoreline campus, the 341 bed Memorial campus, and the 158-bed South campus. Additionally, we serve our communities through CHRISTUS Spohn Hospital Kleberg with 100 beds in Kingsville, CHRISTUS Spohn Hospital Alice with 135 beds in Alice, and CHRISTUS Spohn Hospital Beeville in Beeville with 69 beds. Each of the facilities of CHRISTUS Spohn Health System shares one objective - to lead the way to a healthier community.
The CHRISTUS Spohn Health System is located along the lower Texas coastal area (often called the Coastal Bend); its service area includes a 18-county area with a population of approximately 600,000 individuals. In our fiscal year 2016, we were privileged to serve hundreds of thousands of individuals in various ways including over 190,658 visits to our emergency departments; over 9,559 inpatient surgery procedures; over 9,954 outpatient surgery procedures; over 37,000 patients who were discharged from our hospitals, and over 423,000 patients who received outpatient care at our facilities. Touching the lives of the people around us is what makes CHRISTUS Spohn Health System stand apart. Allowing others to touch us gives us a vision for the medically needy in each of the communities we serve. Whether it is the life of a child expecting a future filled with miracles, the life of a man in need of a critical heart surgery, or the life of a woman about to give birth to her first child, CHRISTUS Spohn Health System's health care services work to provide the highest quality care regardless of an individual's ability to pay. The CHRISTUS Spohn region offers comprehensive health care ranging from its primary care family health clinics, to its six acute care hospitals, the only Level II Trauma Center in the region, and the only inpatient behavioral medicine program that accepts the uninsured. In addition, a comprehensive Cancer Center, Palliative Care program and collaboration with CHRISTUS Home Health and CHRISTUS Hospice provides care for patients and their families at the end of life.

## TARGET AREA/ POPULATION

The CHRISTUS Spohn Health System Corporation is located along the lower Texas coastal area (often called the Coastal Bend), and its service area includes an 18-county area with a population of approximately 600,000 individuals.

The 2015 - 2016 Coastal Bend Community Health Needs Assessment surveyed the following counties, in the area demarcated as Regional Health Partnership (RHP) 4:

CHRISTUS SPOHN Health System




| | | |
|---|---|---|
| **Aransas** | **Gonzalez** | **Lavaca** |
| **Bee** | **Jackson** | **Live Oak** |
| **Brooks** | **Jim Wells** | **Nueces** |
| **DeWitt** | **Karnes** | **Refugio** |
| **Duvall** | **Kenedy** | **San Patricio** |
| **Goliad** | **Kleberg** | **Victoria** |

**PRIORITY HEALTH NEEDS**

The CHRISTSUS Spohn Community Benefit Task Force and the CHRISTUS Spohn Executive Team met to review the 2016 Community Health Needs Assessment. The 2016 Coastal Bend 18 County Health Needs Assessment report is based on information garnered from a community survey (convenience sample), an on-line survey of health care and social service providers, and targeted interviews with health care and social service providers. In addition, "First Look" discussions with health care and social service providers and local health systems' leaders were held In Nueces and Victoria counties to review the data and begin to prioritize the top health needs of the region.

Based on the data in the Community Health Needs Assessment produced June 2016 (see separate document) and feedback provided by CHRISTUS Spohn Health System, CHNA Advisory Board, CHRISTUS Health leadership, and the many community partners and organizations who participated in the CHNA process, the priority health needs for the communities served by CHRISTUS Spohn Health System are:

1. Access to Health Care, and Use of the Emergency Room for Primary Care
2. Preventable Hospitalizations
3. Prevalence of Chronic Conditions (including pneumonia)
4. Lack of Health Literacy
5. Women's Health Issues

**SELECTED IMPLEMENTATION STRATEGY**

The following implementation strategies outline actions CHRISTUS Spohn will take over the next three years to address the priority health needs listed above.

## (1): Improve and enhance access to care for the uninsured and under-insured, and reduce use of the ED for primary care

| Major Actions | Sub-actions |
|---|---|
| **1) Continue and Expand Current Services at CHRISTUS Spohn Family Health Centers** | Anticipate continuing and expanding current CHRISTUS SPOHN family health services with the opening of the new Hector P. Garcia Family Health Center on the Memorial campus in January 2017.These services include:<br>1. Providing Walk-In Clinics with extended hours and staffed by Health care providers.<br>2. The clinic will assist patients with enrollment in Nueces County Health District plan, renewal of benefits , and access to medications that support the delivery of treatment and care. A new patient will be triaged and assessed by a Nurse Practitioner, have care plans initiated and navigated through the empanelment process as they refill prescriptions if needed, and make an initial appointment with Primary Care Physician providers. This is a crucial transitions of care process in avoiding Emergency Room visits prior to their first appointment |

| | |
|---|---|
| | 3. Centralized automatic scheduling for clinics, reducing wait time for appointments.<br>4. Access to the Specialty Clinic providing care in Different Specialties: Cardiology, Nephrology, Neurology, Gynecology, Podiatry, Urology, Surgery, Plastic Surgery, Orthopedic Trauma and Internal Medicine<br>5. The placement of a Coordinator in the Emergency Room will assist the triage process and educate patients to the appropriate level of care which may include walk-in clinic access and or same day physician appointments at the appropriate PCP location.<br>6. The new Hector P Garcia building will include an educational auditorium to provide various Patient Education classes in collaboration with other community partners to provide information on nutrition, disease management, diabetes control, heart disease, smoking cessation and other important topics. |
| | *Anticipated Outcome: Members of the community will receive appropriate care through the Family Health Clinics. CHRISTUS SPOHN will work to increase clinic visits and reduce preventable hospitalizations and inappropriate use of the ED for primary care. This will impact the following identified 2016 Community Health Needs:*<br>• *Access to Care*<br>• *Ease the Use of the Emergency Department for Primary Care Reduce Preventable Hospitalizations*<br>• *Increase Understanding and Management of Chronic Diseases*<br>• *Improve Health Literacy through Education* |
| **2) Achieve a 10% reduction in ED visits for the economically disadvantaged by improving access to appropriate care alternatives.** | 1. Use of care coordination<br>2. Collaborate with other community providers to promote alternate access points<br>3. Collaborate with community entities to explore creation of a centralized information resource.<br><br>*Anticipated Outcome:*<br>*Document the number of persons who receive appropriate care in the appropriate setting as a percentage that contributes toward the goal of a 10% reduction in the inappropriate visits to the ED by the economically disadvantaged.* |

## (2) Reduce Preventable Hospitalizations

| Major Actions | Sub-actions |
|---|---|
| **Expand access to medical care/family practice for the financially challenged.** | 1. Expand the Care Transitions program to include additional insurance plans and populations.<br>2. Continue to leverage ED Community Health Workers and track referrals to appropriate care, Primary and other Community Services.<br>3. Increase primary care visits through appropriate and timely referrals, and expanded clinic hours. |
| | *Anticipated Outcome #1: Expansion of the Care Transition Program will provide better management and understanding of Chronic Diseases, increase access to Primary Care, Reduce Inappropriate visits to the Emergency Department, and Increase Health Literacy through education and better understanding of themselves and assistance with navigating health care and other Community Resources*<br>• *Access to Health Care*<br>• *Use of Emergency Room for Primary Care*<br>• *Preventable Hospitalizations*<br>• *Prevalence of Chronic Conditions*<br>• *Lack of Health Literacy*<br><br>*Anticipated Outcome #2: CareVan Community Outreach services will continue to provide health screening for early detection of chronic illnesses such as diabetes and heart disease, flu immunizations to prevent or mitigate flu and other respiratory illness, health education, information, counseling and referral to primary care and other community resources for our vulnerable and underserved populations in the community which will impact the following 2016 Identified Community Health Needs:*<br>• *Improve management of Chronic Conditions*<br>• *Impact Respiratory and Flu issues*<br>• *Reduce Preventable Hospitalizations*<br>• *Increase Health Literacy through Education*<br>• *Continue Collaboration with HealthCare and Social Services* |

## (3) Improve Understanding and Management of Chronic Disease

| Major Actions | Sub-actions |
|---|---|
| **Improve the quality of life for those suffering from chronic disease(s), and work to reduce the incidence of these or similar conditions.** | 1. Explore provision of Pneumonia vaccines to the homeless, poor and underserved via CareVan community outreach<br>2. Increase Collaboration with Skilled Nursing Facilities and Home Care<br>3. Leverage telemedicine and telehealth<br>4. Explore the addition of additional FTEs to the Care Transition program<br>5. Provide flu vaccines (free of charge) to the underserved and vulnerable members of the coastal bend. |
| | *Anticipated Outcome: Decrease the number and severity of Pneumonia and other respiratory conditions and reduce Pneumonia admissions in our hospitals* |
| | *Anticipated Outcome: Improve Access to Appropriate Care, Reduce Inappropriate Use of the Emergency Room and Decrease Preventable Hospitalizations* |

## (4) Improve Health Literacy

| Major Actions | Sub-actions |
|---|---|
| **Assist members of the community with increased understanding of health, through collaboration with other community partners, and assist individuals with navigation of healthcare system in partnership with Community Health Workers** | • Continue Care Transitions/Care Partners at CHRISTUS Spohn Memorial. Expanded to CHRISTUS Spohn Hospital-Shoreline, South, Kleberg, Alice, and Beeville.<br>• Extension of Quick Care clinic hours. Health resources guide disseminated region wide, updated every 6 months with the last update March 2016.<br>• Sharing community resources and events via CHRISTUS Spohn's Facebook/Social Media presence<br>• Implemented Tele-health capacity:<br>-Cellular based glucometer<br>-Peripheral vascular screening technologies<br>• Improved access to behavioral health services via integration of Primary Care (Spohn Robstown Family Health Center) & Behavioral Health Center-Nueces County |
| | *Anticipated Outcomes: Expansion of the Care Transition Program will provide better management and understanding of Chronic Diseases, increase access to Primary Care, Reduce Inappropriate visits to the Emergency Department, and Increase Health Literacy through education and better understanding of themselves and assistance with navigating health care and other Community Resources*<br>• *Access to Health Care*<br>• *Use of Emergency Room for Primary Care*<br>• *Preventable Hospitalizations*<br>• *Prevalence of Chronic Conditions*<br>• *Lack of Health Literacy* |

## (5) Improve Women's Health in the Community

| Major Actions | Sub-actions |
|---|---|
| **Expand women's services in the coastal bend community** | Explore the possibility of recruiting a Gynecology/Oncology specialist to the Coastal Bend |
| | *Anticipated Outcome: Improve access to women's oncological services in the Coastal Bend and return out migration of patients seeking this type of service* |
| | C***ontinue and enhance the CHRISTUS Spohn CareVan Women Services*** The CareVan mobile clinic delivers complete women's healthcare, including OB care, to the region's uninsured and underserved women. These services include: pre-natal care with referral to an OB physician for delivery, Pap Smears, laboratory and ultra-sound testing, annual exams, prescription assistance, prenatal vitamins and referrals to community partners such as WIC, Medicaid and First Friday for free mammograms. Because it is a Mobile clinic, we can respond quickly to underserved areas that require services and will continue to look at appropriate locations to provide care to our underserved |
| | *Anticipated Outcome: This comprehensive preventative and wellness care helps provide early prenatal care and education for better outcomes and healthier babies in our community and early detection of medical problems for our vulnerable women for referral to community resources and help prevent more serious health issues requiring hospitalization in the future which will impact the 2016 Identified Needs:*<br>• *Improved Women's Health*<br>• *Preventable Hospitalizations*<br>• *Access to Care*<br>• *Health Literacy*<br>• *Continued Collaboration with Health Care and Socials Services* |

**OTHER COMMUNITY NEEDS THAT CANNOT NOT BE ADDRESSED**

CHRISTUS Spohn is committed to building healthier communities and will continue to collaborate with other Hospitals and Providers in the region, whenever possible, to address those needs not specifically targeted by our system's Community Health Implementation Plan including:

- Behavioral Health
- Obesity

At this time, CHRISTUS SPOHN does not have the financial resources to further invest in services that address behavioral health and obesity in the coastal bend. Although not directly addressed in our Community Health Implementation Plan, the expansion of primary care, our efforts to improve Health Literacy, and continued Community Outreach should have a significant impact on both of these identified needs (behavioral health; obesity) in our community. We believe that through our continued Community Collaboration with a diverse group of providers and engaged community leaders we will continue to identify areas where we can work together to provide resources, health information, and access to care to improve the health and wellness of our community.