

Implementation Strategy to Address Needs Identified in Community Health Needs Assessment for Sparrow Hospital

Fiscal years 2016-2018

Covered facilities

Sparrow Clinton Hospital
Sparrow Clinton Outpatient and Ambulatory Sites, including
Sparrow Medical Group

Community Health Needs Assessment

A Community Health Needs Assessment was conducted in coordination with the Healthy Capital Counties collaborative. It consisted of three public health departments and four area hospitals to identify the most pressing community health needs. This process included gathering input from the community regarding health indicators and reviewing results from the previous CHNA for 2013-2015. In addition, Sparrow Clinton presented the previous findings to executive leaders including the Sparrow Clinton Hospital Board, and SCH Board Quality and Patient Safety Committee.

Identification of health needs to be addressed

A large community gathering of a wide variety of stakeholders was held to review the findings of the CHNA and prioritize health needs. The following were selected:

- Access to primary healthcare providers
- Access to quality healthcare
- Chronic disease (including cardiovascular, diabetes, multiple chronic illnesses)
- Financial stability
- Mental health (including stress, depression, access to services)

Sparrow Clinton conducted additional studies about the needs specific to their service area to ensure feedback from all communities served. It was agreed that “Access to primary care providers” and “Access to quality healthcare” could be merged into a single category. Based upon results of all information gathered, the Sparrow Clinton Hospital board has approved the following health needs as the focus of the 2016-2018 cycle:

- Access to Healthcare
- Chronic Disease

Arriving at strategies and outcomes

Workgroups, consisting of physician and staff leadership, were established for each health need and charged with identifying appropriate strategies and outcomes to address the needs. Using an outcomes-based evaluation consultant, each group completed the following:

1. Described the patient, organizational, and community conditions that had potential to impact the identified health need. Examples include: barriers to access, availability of providers, specific needs of underserved patients, issues identified in Community Health Needs Assessment.
2. Articulated the specific outcomes to be addressed. Examples include: reduce delays in access to care, increase patient health literacy about diabetes, decrease number of low acuity patients seen in Emergency Department.
3. Identified existing, newly adopted, and future strategies to achieve identified outcomes. Examples include: expansion of convenience care services, strengthen community partnerships, increase number of diabetic patients with a Patient-Centered Medical Home.

The results of the logic models from each workgroup are delineated in the next section.

Access to Healthcare

Specific Needs Identified in CHNA:

- Access to Quality Health Care selected as health need during Healthy Capital Counties Community Prioritization key stakeholders meeting
- Ingham, Eaton, and Shiawassee county rank higher than state average for percentage of adults who have no primary care provider (Sparrow CHNA, p. 48)
- Access to healthcare ranked the most important factor that defines a healthy community in both community and provider survey (Sparrow CHNA, p. 118 and 123)

Strategies to address Access to Healthcare:

1. Expand capacity for primary care, medical home, obstetrics-gynecology, pediatric, and internal medicine by increasing number of providers.
2. Expand capacity for primary care, medical, obstetrics-gynecology, pediatric, and internal medicine by increasing number of providers.
3. Use of telemedicine services, defined as provision of medical care without provider physically present.
4. Expansion of drop in/walk in services.
5. Expanding hours for non-primary care, all others (related to payer; private vs hospital practices).

Measurable Outcomes:

1. Increase in patient visits.
2. Increase in the number of new patient (1st visit, “new”).
3. Decrease in the number of low acuity patients seen at EDs.
4. Increase in the number of patients seen by SMG non-primary care practices
5. Change in the number of patients by type of service indicating access to care occurring via less intensive, expensive paths.
6. Decrease readmission rates.

Chronic Disease – Diabetes

Specific Needs Identified in CHNA:

- Chronic Disease selected as health need during Healthy Capital Counties Community Prioritization key stakeholders meeting
- Clinton, Eaton, and Shiawassee county rank equal to or higher than state average for percentage of adults with two or more chronic conditions (Sparrow CHNA, p. 51)
- Eaton, Shiawassee, Montcalm, Gratiot, and Ionia county rank equal to or higher than state average for percentage of adults who are obese (Sparrow CHNA, p. 48)
- Obesity and Chronic Disease ranked second and third most important health problems in provider survey (Sparrow CHNA, p. 124)

Strategies to address Diabetes:

1. Participation by patients in Michigan’s PATH classes, or other diabetic education classes.
2. Development of referral linkages to other providers and organizations, e.g. dentists, Head Start, Public Health Department, etc.
3. Enhanced focus of discharge planning for diabetic patients
4. Increase the number of patients with diabetes who access complex care managers.
5. Targeted efforts toward “super users” of the Emergency Department who are diabetic with additional and/or new interventions.

Measurable Outcomes:

1. Increased patient health literacy about diabetes and prevention of diabetes.
2. Increase the percentage of patients defined as having diabetes, who have food control....OR
All patients who meet the HEDIS spec having a HbA1c completed if indicated, and not done in the 90-180 days prior to ED/hospitalization.
3. Decrease the number of preventable hospitalizations for diabetes.

Other needs identified in CHNA but not addressed in this strategy



Sparrow Clinton will address four of the five health needs identified in the CHNA and all necessary resources will be allocated to implement the above mentioned strategies. Sparrow will not address Financial Stability as it does not fall within the scope of the hospital's core competencies and other area organizations are better positioned to address this need.

Monitoring of Implementation Strategy and attainment of outcomes

Sparrow Clinton has identified key leadership individuals within the organization for each strategy. In addition, a workgroup has been established to identify sources of measurement for each outcome. A tracking document that includes identified strategies and outcomes has been created for each health need. The tracking document will be collected annually and results submitted to the Board Quality and Patient Safety committee. Pending results, adjustments or changes will be made to the strategies and measurable outcomes as deemed appropriate.