Community Health Needs Assessment

Three Year Summary 2013 – 2016

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Key needs were identified by community stakeholders which included the following:

Not all residents have access to affordable healthcare due to lack of access to health insurance, limited access to employer benefits, eligibility cutoffs for Medicaid, provider acceptance of Medicaid, Medicaid reimbursement rates, ability to afford uninsured care and residents' awareness of available services. Transportation is not user friendly for seniors, single parents, and persons with disabilities is not always available to and from medical appointments. Access to mental health and substance abuse services are limited due to a limited number of providers. Residents may be practicing unhealthy behaviors that may lead chronic conditions and poor clinical indicators. Senior care and community services related to developing an advance directive and end of life issues could improve the quality of life as resident's age.

Stakeholders discussed the following clinical health issues as the following needs:

#1 Need:

Increase education efforts related to Substance abuse / overdosing, Tobacco use prevention and Diabetes prevention

Goal:

Expand and target education program methods and offerings to reach a larger audience in at risk groups

Target Population:

Patients presenting to their Primary Care Provider

Strategies and Action Description:

A collaboration with community agencies and healthcare providers took place to heighten awareness and provide education related to substance abuse and unintentional overdosing. A screening tool was implemented for substance abuse screening in the primary care office setting. Education was provided to primary care physicians to increase awareness of early signs and symptoms of dependency and of the available community resources for their patients. The use of standardized materials is located in the physician office setting.

Resources and Partners:

A collaborative effort was made with the Kenosha County AODA Council, Kenosha Community Mental Health Providers, Primary Care Physicians, Kenosha Unified School District, United Way, The Boys and Girls Club as well as Pediatricians from the United Medical Group. The National Kidney Foundations was contacted as well regarding the diabetes prevention.

#2 Need:

Transportation for Medical Appointments

Goal:

Reduce the percentage of missed medical appointments at United Hospital System

Target Population:

Patients at risk for hospital readmissions with a diagnosis of congestive heart failure, acute myocardial infarction and pneumonia

Strategies and Action Description:

Identified potential and interested partners to participate in state and community transportation forums. Meetings were also held with individual providers to strength relationships and discuss shared concerns. A review of the scheduling process was completed for appointments. Patient interviews were conducted with missed congestive heart failure patients to determine reasons for missing medical appointments.

Resources and Partners:

Kenosha County Aging and Disability Resource Center, Wisconsin Department of Transportation, and local ambulance services.

#3 Need:

Senior Centered Services (end of life care / advance directives)

Goal:

Increase the percentage of hospitalized patients who have completed an Advance Directive at United Hospital System

Target Population:

Senior citizens and all patients that experience end of life issues

Strategies and Action Description:

A collaboration with community agencies and healthcare providers took placed to heighten awareness and provide education on advance directives and end of life care planning. Community events have been planned as well as the standardization of a screening process and educational materials in the United Medical Group Clinics.

Resources and Partners:

The Wisconsin State Medical Society, The Medical College of Wisconsin, local healthcare providers to include: nursing homes, hospice agencies, and other hospital systems

#4 Need:

Reduce the rate of hospital readmissions

Goal:

Decrease the rate of preventable readmissions for patients with congestive heart failure, myocardial infarction and pneumonia

Target Population:

Medicare patients with a diagnosis of congestive heart failure, myocardial infarction and pneumonia

Strategies and Action Description:

Post discharge appointments are scheduled for patients to follow up with their physicians to occur in seven days of the discharge. Data was analyzed to determine reasons why patients were not getting to their physician follow up appointments. A community coalition was created to assist in opening communication regarding barriers for treatment and follow up.

Resources and Partners:

Kenosha County Community Care Transitions Coalition, Quality Improvement Organization for Wisconsin (MetaStar), and United Medical Group

#5 Need:

Reduction in infant mortality in the community

Goal:

Actively participate in efforts to reduce infant mortality in the community

Target Populations:

Caregivers of infants

Strategies and Action Description:

A collaboration with community agencies and healthcare providers was initiated to heighten awareness and provide education regarding steps that can be taken to prevent infant mortality. An evaluation of educational practices was completed with pediatric and obstetrical groups and standardization of patient education took place.

Resources and Partners:

United Medical Group, Local Pediatricians, Kenosha County Division of Children and Family Services and the Public Health Department

United Hospital System is committed to being involved in the community by taking on the responsibilities of attending and participating in community committees to bring ideas forward about how to achieve the committee and community goals. Ongoing work continues with leading professionals in the community to develop programming and plans to achieve the goals.