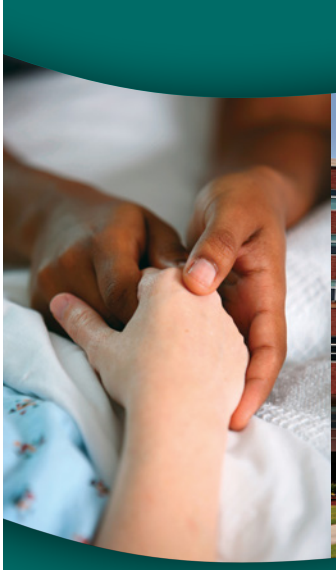
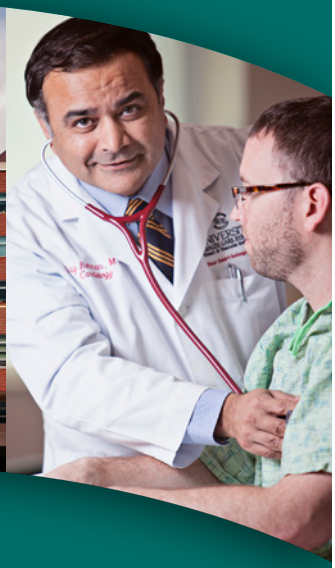
2016

COMMUNITY HEALTH NEEDS ASSESSMENT
IMPLEMENTATION STRATEGY





UNIVERSITY
HEALTH CARE SYSTEM

IMPLEMENTATION STRATEGY GUIDE 2016

UNIVERSITY HEALTH CARE SYSTEM

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Introduction

Executive summary

University Hospital's 2016 Implementation Strategy Guide (ISG) accompanies its 2016 Community Health Needs Assessment (CHNA). The CHNA identifies Richmond County (GA), Aiken County (SC), and Columbia County (GA) as the community University Hospital serves. The CHNA lists 10 health needs as priorities in that community: heart disease and stroke; cancer; arthritis, osteoporosis and chronic back conditions; diabetes; respiratory diseases; chronic kidney diseases; nutrition and weight status; access to health services; mental health and mental disorders; and health literacy. This ISG describes which of those University Hospital intends to adopt as priorities and which it does not. The ISG provides a rationale for this choice. For the health needs we will address, the ISG describes the actions the hospital intends to take to address the health needs and the anticipated impact of these actions. It also identifies the resources the hospital plans to commit to address the health needs and describes any planned collaboration between the hospital and other organizations in addressing those needs.

University Health Care System's mission, vision and values

The *mission* of University Health Care System is to improve the health of those we serve.

The *vision* of University Health Care System is patients will insist on University, employees will be proud to be part of University, and physicians will prefer University because we set the standard for high-quality, safe care and exceptional service.

The *values* of University Health Care System are Quality, Safety, Service, People, Growth and Affordability.

Rationale for not creating implementation strategies for all health needs

We selected 10 needs based on our assessment of the prevalence and severity of the needs. Although we recognize chronic kidney diseases, respiratory diseases and mental health as prevalent and severe, we chose not to adopt them as priorities.

Chronic kidney diseases

University Hospital continues to treat patients with end-stage renal disease and chronic kidney disease, but does not have an organ transplant service. We have determined that the best role we can play in the community with regard to these diseases is to address diabetes and obesity in the community. Nutrition and Weight Status and Diabetes are health needs we have adopted instead. There are many organizations treating kidney disease in our community. These include dialysis service providers and physician groups (e.g., Nephrology Associates, Augusta Dialysis Center, NCA-Augusta). Also, Augusta University provides the only kidney transplant service in Georgia outside of Atlanta.

Respiratory diseases

As we do for patients with chronic kidney diseases, University Hospital treats patients with respiratory diseases, helping them stabilize from asthma attacks or COPD exacerbations. We admit many of these patients and are working to prevent their readmission by improving our ability to educate patients on managing their illness and by improving our success rate in getting them short term follow up appointments in an outpatient setting. We are also growing our ability to see these patients in a pulmonary disease management setting. As far as community outreach and impact outside of the hospital setting or post-discharge follow-up, we have chosen to focus on other health needs due to resource constraints. Kohl's Cares, which is an asthma awareness and education program for children and families, provides important resources and support to children and families in the Central Savannah River Area. Our organization also has smoking cessation programs and pulmonary rehab for patients who suffer from COPD, emphysema, and other pulmonary issues. Children's Hospital of Georgia also provides pediatric asthma services.

Mental health

The other need we have not adopted is mental health. We recognize this as a significant need in the community but this is not a strength of University Hospital. Other organizations and resources in the community for behavioral and mental health in our community include Augusta University's Psychiatry and Health Behavior department, Serenity Behavioral Health Systems, Lighthouse Care Center of Augusta, and the Aiken-Barnwell Mental Health Center. In addition, there are over 600 providers of mental health services (including counselors) listed in Medicare's National Plan and Provider Enumeration System in our community. The other seven health needs for which we have adopted implementation strategies are listed below.

Description of the health needs for which we are adopting action plans

Heart Disease and Stroke (from Healthy People 2020)

Heart disease is the leading cause of death and stroke is the third leading cause of death in the United States. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in health care expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

Over time, these risk factors cause changes in the heart and blood vessels that can lead to heart attacks, heart failure, and strokes. It is critical to address risk factors early in life to prevent the potentially devastating complications of chronic cardiovascular disease.

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90 percent of American adults exceed their recommendation for sodium intake.

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the U.S. population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

Cancer (from Healthy People 2020)

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years, yet cancer remains a leading cause of death in the United States, second only to heart disease. The cancer objectives for Healthy People 2020 support monitoring trends in cancer incidence, mortality, and survival to better assess the progress made toward decreasing the burden of cancer in the United States. The objectives reflect the importance of promoting evidence-based screening for cervical, colorectal, and breast cancer by measuring the use of screening tests identified in the U.S. Preventive Services Task Force (USPSTF) recommendations. The objectives for 2020 also highlight the importance of monitoring the incidence of invasive cancer (cervical and colorectal) and late-stage breast cancer, which are intermediate markers of cancer screening success.

In an era of patient-centered care, effective communication between clinicians and their patients and family members fosters shared knowledge and understanding and leads to medical decisions that align with patient values. The objectives assess whether people understand and remember the information they receive about cancer screening. Research shows that a recommendation from a health care provider is the most important reason patients cite for having cancer screening tests.

Arthritis, osteoporosis, and chronic back conditions (from Healthy People 2020)

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. The Arthritis objectives for 2020 track a variety of pain, function, and intervention measures that are important for monitoring progress in addressing arthritis as a public health problem.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures. The Osteoporosis objectives for 2020 track bone mineral density as a measure of the major risk factor for fractures, and hip fractures, the major and most serious of osteoporosis-related fractures.

Chronic back pain (CBP) is common, costly, and potentially disabling. The related objective for 2020 tracks activity limitation due to chronic back conditions.

Diabetes (from Healthy People 2020)

Diabetes Mellitus (DM) affects an estimated 23.6 million people in the United States and is the seventh leading cause of death. DM:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

In addition to these human costs, the estimated total financial cost of DM in the United States in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.

The rate of DM continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with DM, and possibly earlier onset of type 2 DM, there is growing concern about:

- The possibility of substantial increases in diabetes-related complications
- The possibility that the increase in the number of persons with DM and the complexity of their care might overwhelm existing health care systems
- The need to take advantage of recent discoveries on the individual and societal benefits of improved diabetes management and prevention by bringing life-saving discoveries into wider practice

- The clear need to complement improved diabetes management strategies with efforts in primary prevention among those at risk for developing DM

Nutrition and weight status (from Healthy People 2020)

The Nutrition and Weight Status objectives for Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The objectives also emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

Access to health services (from Healthy People 2020)

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. This topic area focuses on four components of access to care: coverage, services, timeliness, and workforce.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps:

- Gaining entry into the health care system.
- Accessing a health care location where needed services are provided.
- Finding a health care provider with whom the patient can communicate and trust.

Access to health care impacts:

- Overall physical, social, and mental health status
- Prevention of disease and disability
- Detection and treatment of health conditions
- Quality of life
- Preventable death
- Life expectancy

Disparities in access to health services affect individuals and society. Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. Barriers to services include:

- Lack of availability
- High cost
- Lack of insurance coverage

These barriers to accessing health services lead to:

- Unmet health needs
- Delays in receiving appropriate care
- Inability to get preventive services
- Hospitalizations that could have been prevented

Health literacy (from health.gov)

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health literacy is dependent on individual and systemic factors:

- Communication skills of lay persons and professionals
- Lay and professional knowledge of health topics
- Culture
- Demands of the healthcare and public health systems
- Demands of the situation/context

Health literacy affects people's ability to:

- Navigate the health care system, including filling out complex forms and locating providers and services
- Share personal information, such as health history, with providers
- Engage in self-care and chronic-disease management
- Understand mathematical concepts such as probability and risk

Health literacy includes numeracy skills. For example, calculating cholesterol and blood sugar levels, measuring medications, and understanding nutrition labels all require math skills. Choosing between health plans or comparing prescription drug coverage requires calculating premiums, copays, and deductibles.

In addition to basic literacy skills, health literacy requires knowledge of health topics. People with limited health literacy often lack knowledge or have misinformation about the body as well as the nature and causes of disease. Without this knowledge, they may not understand the relationship between lifestyle factors such as diet and exercise and various health outcomes.

Health information can overwhelm even persons with advanced literacy skills. Medical science progresses rapidly. What people may have learned about health or biology during their school years often becomes outdated or forgotten, or it is incomplete. Moreover, health information provided in a stressful or unfamiliar situation is unlikely to be retained.

Action steps in response to the adopted health needs

This section includes a list of action steps we are taking to address the adopted health needs. Some action steps address several needs simultaneously.

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Expand our advanced heart failure program with operational improvements and new providers.	Better management of heart failure in the outpatient setting will prevent unnecessary hospital admissions	Number of patients seen in the advanced heart failure outpatient clinic	Two mid-level physicians and support staff		Heart disease and stroke; Access to care
Continue free Heart Attack and Stroke Prevention classes held four times per month. This class explains some of the causes of heart and vascular disease as well as early warning signs. Information is provided about how changes can be made immediately to prevent heart attack and stroke.	Increased public awareness and understanding about the process of heart attack and stroke, and how better lifestyle choices help individuals control their likelihood of heart attack or stroke.	Number of patients educated in our clinic, at health fairs and at educational talks/speaking engagements. Number of people scanned for presence of atherosclerosis at health fairs.	1.4 FTEs to manage website content, fliers and handouts		Heart disease and stroke; Health literacy

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue to serve cardiac and pulmonary rehab patients by providing prevention, rehabilitation and wellness services to cardiovascular patient population.	These patients will be rehabilitated to a better cardiac and/or pulmonary health state and will be equipped to maintain their improved condition.	Functionality as measured by pre- and post- six-minute walk. Anxiety and depression assessed by the HAD score (Hospital Anxiety and Depression scale) pre- and post-rehab. QOL (Quality Of Life) questionnaire as assessed by Dartmouth COOP pre- and post-rehab.	Nurses (RNs): 5 FTEs Respiratory therapists (RRTs): 3.6 FTEs Exercise specialists (ESs): 2.5 FTEs		Heart disease and stroke
Expand and enhance lung cancer detection and treatment with a nodule clinic and thoracic surgery program. Expand the low-dose lung cancer screening program.	Increase the number of patients diagnosed with early stage lung cancer	Number of patients enrolled in the Lung Nodule Clinic	New position created – Oncology Navigator	American College of Radiology Lung Cancer Screening Registry	Cancer

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue monthly Breast Cancer Support Group: Pink Magnolias. Free group for women who have or have had breast cancer. Information on the latest diagnostic and treatment of breast cancer as well as support from the Breast Health Center's clinical staff and fellow breast cancer survivors.	Improve access to social and emotional support	Number of individuals who attend the support group	Breast Health Center Coordinator serves as the facilitator		Cancer; Access to care
Continue monthly Breast Self-Exam Class; open to the community.	Increase opportunities for women to learn how to perform a self-exam	Number of individuals who attend the class	Breast Health Center Coordinator and Breast Health Navigator serve as the instructors		Cancer; Health literacy
Continue free monthly Breast Cancer Support Group for Young Women. A support group for women in their 20s-30s; open to the community.	Improve access to social and emotional support for young women diagnosed with breast cancer	Number of individuals who attend the class	Facilitated by Breast Health Center Program Coordinator		Cancer

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue free monthly Cancer Share Support Group.	Improve access to social and emotional support to individuals diagnosed with all types of cancer. Research has shown that individuals with such support experience better health outcomes compared to individuals who lack support.	Number of individuals who attend	Facilitated by Cancer Liaison		Cancer
Continue monthly Breast Cancer Support Group for Spouses. University's Breast Health Center facilitates and sponsors a free support group to assist spouses of breast cancer patients; open to the community.	Increase opportunities for support for people diagnosed with breast cancer and their spouses.	Number of individuals who participate in the program	Facilitated by Breast Health Center Coordinator		Cancer
Continue to offer four-week Beat the Pack Smoking Cessation Program. This free program is offered every month and is designed to help people give up all forms of tobacco.	Reduce the number of adult smokers in our service area. Provide access to tools and the support necessary to stop smoking.	Number of individuals who participate in the program	Facilitated by Cancer Registry Coordinator		Heart disease and stroke; Cancer

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue to produce at least one physician-led educational presentation annually on one of the following: Breast Cancer, Lung Cancer, Cervical Cancer, Skin Cancer, Colon Cancer, Prostate Cancer, Nutrition and Cancer.	Improved access to opportunities for cancer education.	Number of individuals who participate.	Physicians on the University Hospital medical staff; coordinated by Community Relations Specialist		Cancer; Health literacy
Continue to coordinate with local community events and businesses to arrange for community screening opportunities. The University Breast Health Center's Digital Mobile Mammography Unit reaches women unable to come to University's onsite center. With a mobile mammography unit, the center is able to take breast health care to underserved populations; to working women at business and industrial sites; and to community and church groups throughout the area.	Increase access to mammography. Improve the rate of early diagnosis of breast cancer.	Number of mammograms performed on the mobile unit	University Hospital has a dedicated staff for the Mobile Mammography Unit. The staff performs mammograms and handles patient appointments, registration and follow-up letters.	University Health Care Foundation covers expenses related to reading mammograms and vehicle maintenance.	Cancer; Access to care

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Provide education about the importance of colorectal cancer screening and how to overcome barriers to screening.	Increase the number of adults ages 50 and older who undergo regular screening for colorectal cancer. Provide information about the various, less expensive testing options.	Number of adults ages 50 and older in the University Hospital Primary Care Practices who undergo regular screening	Epic staff to revise the Health Maintenance Tab to include colorectal cancer screening and all testing options	American Cancer Society 80 percent by 2018 Initiative	Cancer; Health literacy
Increase awareness and knowledge base on Osteoporosis and Arthritis in the community by attending community health fairs and hosting at least one physician-lead education event.	Better management and outcomes of osteoporosis and arthritis, which can lead to decrease in bone fractures and increase safety practices in the community	Collect counts of individuals visiting the community health fairs Orthopedic booth. Track the number of individuals presenting at physician education events	Orthopedic MDs and Ortho/Spine Navigators; Logistical support from Community Relations		Arthritis, osteoporosis, and chronic back conditions; Health literacy
Work to prevent back injuries in youth and adolescents by providing education to adolescents and youth regarding backpack safety and safety in school sports	Decreased back injuries in youth/adolescent population	Keep track of school systems that are receiving this education, and track the number of adolescents/youth that visit our education booth at community events	Ortho/Spine Navigators		Arthritis, osteoporosis, and chronic back conditions; Health literacy

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Improve blood sugar control among patients with diabetes established with University Health Care System's employed primary care providers.	To identify all patients with elevated A1C's to refer these patients for diabetes education to provide them with the tools to have a better healthier quality of life.	The percentage of members ages 18 - 75 years of age with diabetes (Type 1 and Type 2) who had an HgA1c test during the measurement year that showed their blood sugar is under control, less than 9 percent.	Employed Primary Care Providers will adopt this as a goal. 1 FTE will manage the data collection and reporting.	University Medical Group is a part of University Health Care System, but a separate part of University Hospital	Diabetes
Continue monthly Sweet Success community education class. Sweet Success is an education program for indigent people with diabetes focusing on diet needs, health issues and caring for themselves. Provides information on managing care, treatment options and maintaining a healthy lifestyle.	To provide diabetes education to people who would not be able to afford diabetes education due to lack of insurance. These patients come away with a better understanding of their diabetes care and why it is importance to keep their blood glucose under control.	Keep a record of all attendees who attended the Sweet Success Diabetes Program in the last three years and report in three years the number of attendees who were readmitted into the hospital within three months of attending Sweet Success Diabetes Program.	1 FTE inpatient diabetes educator to facilitate, teach and be a resource to people in our community who do not have the resources to learn about diabetes and how to care for themselves.	Christ Community Center; PCP offices who have patients without insurance that need diabetes education; Inpatients without insurance.	Diabetes; Access to care; Health literacy

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue quarterly Insulin Pump Support Group.	To keep insulin pump patients up to date on the latest technology and to continually provide them with the benefits of insulin pump use.	Number of individuals who attend the Insulin Pump Support Group.	1 FTE assigned to develop lectures, facilitate and teach.	Coordinate with different insulin pump companies. Work with endocrinologists and other PCPs who have insulin pump patients. Diabetes Advisory Committee Members.	Diabetes; Health literacy
Continue to support Eating Well with Kim program. University Health Care System teams up with News 12 to produce the Eating Well with Kim segment three times a week. University Registered Dietitian and certified Diabetes Educator Kim Beavers offers healthy eating ideas along with quick, easy and healthy recipes that are provided to viewers via the University website.	Viewers will understand how nutrition choices influence their health outcomes and how to make good choices.	Facebook impressions	Part-time hourly employee in Community Relations assigned to manage the Eating Well with Kim program		Diabetes; Nutrition and weight status; Health literacy

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue free monthly "Weight Loss Surgery and You" class. This class provides information how Bariatric Surgery, in conjunction with a healthy lifestyle, can be a successful alternative approach to weight loss.	Attendees will be able to weight the pros and cons of a surgical option to help them with weight loss.	Number of participants	Tracked by Bariatric Program Coordinator		Nutrition and weight status; Health literacy
Expand prompt and primary care access points.	Increased appointment availability for patients in our community. This will also remove obstacles of distance for some patients.	Number of access points. Number of employed primary care physicians. Number of encounters completed at prompt and primary care access points.	Recruitment of physicians and staff and installation of new facilities		Access to care
Production of Healthy U Calendar for website and social media. This is a community resource for University Health Care System classes, support groups and events.	The community will have an understanding of the times and locations of education and support groups	Facebook impressions and clicks	Corporate Communications will manage		Access to care
Continue support of Public Service Announcements.	Viewers will learn about opportunities to participate in various kinds of health education programs offered by our hospital.	Estimates of viewership	Corporate Communications will manage		Access to care

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue providing free carotid artery ultrasounds at health fairs. These ultrasounds identify early signs of plaque buildup which is an indicator of heart disease. Continue to provide information on nutrition and weight management at these events.	Some members of our community will discover they are exhibiting signs of heart disease. These discoveries will enable us to provide education about ways to manage this conditions.	Number of individuals screened for heart disease at events	Heart Attack and Stroke Prevention will provide one technician and one educator for qualifying events. Event coordination is a joint effort between Heart Attack and Stroke Prevention and Community Relations.	Health fairs are collaborative efforts between local media, business and industry and faith-based organizations.	Heart disease and stroke; Diabetes; Nutrition and weight status; Access to care
November video annually to educate on lung cancer awareness and recognize The Great American Smoke out. Videos will feature physicians and/or testimonials from people who have quit smoking. Videos will be posted to YouTube and Facebook.	Increased lung cancer awareness and access to tools to help people quit smoking.	Facebook impressions and YouTube views.	Corporate Communications / Community Relations will manage.		Access to care; Health literacy

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue to provide non-hospital inpatient and outpatient services for indigent patients. This includes Project Access, which University helped develop in 2002 with the Richmond County Medical Society to care for Richmond and Columbia County indigent patients. University continues to be Augusta's largest hospital contributor of funds and services to this organization.	Improved access to medical care for indigent patients including primary and specialty care.	Amount given to these agencies	UHS has budgeted charges of $80 million in Hospital services for the Indigent & Charity care patients in fiscal year 2017. UHS will budget similar funds each year.		Access to care
Continue to support community health care clinics. These include Lamar Medical Center, Belle Terrace Health and Wellness Center, Christ Community Health Services and St. Vincent dePaul. University Hospital was instrumental in developing Lamar Medical Center and Belle Terrace Health and Wellness.	Improved access to medical care for indigent residents, including primary care; decrease in the number of Emergency Room visits.	Number of patient encounters completed by these clinics.	UHS has budgeted in fiscal year 2017 $860,944 in funds to support primary care access for Indigent & Charity Care residents in poverty areas throughout the county.		Access to care

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Continue to support uncompensated physician services for indigent and charity patients.	Improved access to specialty medical care for indigent patients.	Number of patient encounters completed by employed physicians with indigent and self-pay patients.	UHS has budgeted for 2017 $11 million dollars for Hospital required services.		Access to care
Implement “Ask Me Three” program system-wide.	Patients will understand the importance of the education they receive, and better retain the information. This will increase patient safety and engagement in their own health.	Finish training all patient care areas of the health system by April 2017.	1 full-time trainer; hundreds of super trainers. 3.5 hours per patient care staff person throughout the system.		Health literacy
Increase the number of MyChart activations.	MyChart offers patients personalized and secure on-line access to portions of their medical records. It enables them to manage and receive information about their health.	Number of new patient activations	1 full-time information systems staff person. Initiative supported by three Corporate Communications staff.		Health literacy

Action	Anticipated impact	Metric for future evaluation	Resources planning to commit	Any planned collaboration with other facilities or organizations	Health needs addressed
Diabetic eye exams among seniors	Patients will be screened for vision impairment associated with diabetes	Percentage of Medicare patients (as a proxy to patients 65 and older) who have had	Employed Primary Care Providers will adopt this as a goal. 1 FTE will manage the data collection and reporting.		Diabetes