SCOTTSDALE HEALTHCARE®

Scottsdale Healthcare
Update to the
2013 Community Health Needs Assessment
Implementation Plan
Osborn Medical Center

Modified September 2014

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Scottsdale Healthcare
Community Health Needs Assessment Implementation Plan 2013-2016
Executive Summary

In 2013, Scottsdale Healthcare completed a Community Health Needs Assessment in accordance with the proposed IRS rules mandated through the Affordable Care Act (2010). Through this assessment, five health needs were identified: Cardiovascular Disease, Heart Failure, Diabetes, Obesity, and five Cancers (Lung, Breast, Prostate, Colon, and Melanoma). After approval from the Board of Directors, a Community Health Needs Assessment Implementation Plan was developed to address the identified health needs. Both the Community Health Needs Assessment and the original a Community Health Needs Assessment Implementation Plan can be found on the Scottsdale Healthcare website. These reports include a more detailed explanation of the needs, the data used to identify them, and the methodology behind the action plan

In the second quarter of 2013, Scottsdale Healthcare reached an agreement to affiliate with John C. Lincoln Health Network, a neighboring non-profit hospital network operating two hospitals in Phoenix, Arizona. The affiliation was formalized in October 2013, and the Scottsdale Lincoln Health Network was created. Both legacy organizations have a strong history of community benefit activity that seeks to meet the needs of the populations they serve. Over the next few years, many changes will occur in both organizations as the two systems become fully integrated.

One of the objectives with the integration process is to identify industry best practices within healthcare. This has resulted in the strategic realignment of some of the identified programs from the original Community Health Needs Assessment Implementation Plan. Some of the programs have already been integrated into existing departments, while others will be temporarily suspended until appropriate internal resources are identified.

One of the key goals of the affiliation is to better meet the health needs of the community as the healthcare industry evolves. Although this modified, Community Health Needs Assessment Implementation Plan will identify the suspension of several programs, ultimately the affiliation with John C. Lincoln Health Network will allow both organizations to more effectively meet community needs.

Overview of Community Health Needs Assessment Implementation Plan

The Scottsdale Healthcare Community Health Needs Assessment Steering Committee developed a Continuum of Care framework for the original Community Health Needs Assessment Implementation Plan in late 2013. The Continuum of Care contains six areas where education or healthcare can be provided to an individual. Each program or service was evaluated to determine where it aligns within the Continuum of Care.

The Steering Committee also reviewed the programs for priority populations and determined if the programming available through Scottsdale Healthcare was at a capacity to achieve an impact on the target populations. The measurements include: sufficient, gap, scale, communication, or not applicable. The Steering Committee used the following definitions when determining capacity.

1. Sufficient: We believe that the programs/services have enough scale based on the estimated population segment size to make a significant impact on the health of our community over a three year time horizon.
2. Gap: There are currently no relevant and accessible programs/services in place to meet the needs of the identified population segment.
3. Scale: Programs/services currently exist for this population segment, however there is likely currently not enough scale (capacity) to make a significant impact.
4. Communication: There are relevant and accessible programs/services but they are not currently being targeted to the population segment.
5. N/A: Programs/services are not applicable to this key population segment.

Impact of Integration

Some of the free and low-cost services that focused on prevention and health screening were provided by the Community Health Services department at Scottsdale Healthcare, working with other departments. After the completion of the 2012 Community Health Needs Assessment, the programs were realigned to focus specifically on the five priority needs.

The integration process of the Scottsdale Healthcare and John C. Lincoln Health Network required the identification and inclusion of best practices from hospitals across the United States. As such, the combined organization made the decision to embed the community benefit activities into the various service lines. An example of the revised structure is the tobacco cessation programs which will now be offered through the Virginia G. Piper Cancer Center (VGPCC).

This change is strategic since tobacco cessation hopes to prevent lung cancer and the VGPCC's mission focuses on cancer prevention, identification, and treatment.

As Scottsdale Healthcare and John C. Lincoln become fully integrated and the 2015 Community Health Needs Assessment is complete, areas where the combined organization can provide leadership and expertise will be identified and programs will be redesigned and integrated to meet the needs. We will continue to partner with the different organizations and agencies that work within Scottsdale.

There are many programs and services that Scottsdale Healthcare implements to improve the outcomes related to the five priority needs. Scottsdale Healthcare offers fitness opportunities to community members through Cardiac Rehab, the Virginia G. Piper Cancer Center, and Women's Health Services. Health screenings are available through Corporate Health, NOAH, and the Virginia G. Piper Cancer Center. The following tables show each of the programs and services that continue to be offered by Scottsdale Healthcare.

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Heart Failure Initiatives/Program

Care Continuum

Organizational	Prevention	Screening/Diagnosis	Disease State Management	Acute Treatment	Post-Acute	Palliative
NOAH	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Promotora	1. Access to care 2. Patient Centered Medical Home (in progress) 3. CVD and Stroke Screening	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease Management (in progress) 4. Behavioral Health Education 5. Nutrition Education and	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Care Coordination Community Case Management	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Family Education
Corporate Health	1. WellPath Program (Salt River Pima Rsv)	1. Cholesterol/Glucose Screenings 2. Silverstone Retirement Center	N/A	N/A	1. Occupational Health Clinic	N/A
Service Line	1. SHC Website Education-all areas 2. Heart and Vascular Community Lectures 3. Chest Pain Recognition-Activating 911 4. Body, Mind and Spirit exercise class (Shea, Osborn Yoga only) 5. Essential Touch Workout Center (Shea) 6. The Heart of a Woman Forum (Shea) 7. Tobacco Cessation-Adults	1. Heart Rhythm Center (Shea & Osborn) 2. Heart Health Screening (Shea) 3. SHC Mobile Health Unit 4. Women's Wellness Program (Shea)	1. Cardiac Rehab Center (Shea) 2. Body, Mind and Spirit exercise class (Shea, Osborn Yoga only) 3. The Heart of a Woman Forum (Shea) 4. Cardiac Rehab Support Group (Shea) 5. TeleHealth Case Management Monitoring 6. Cardiac Rehab Heart Healthy Education Classes (Shea)	1. Heart Rhythm Center (Shea & Osborn) 2. Structural Heart Program (Shea & Osborn) 3. SHC Inpatient Case Management Team 4. ADHS SHARE program for treatment of Cardiac Arrest 5. ICA Echo Accreditation 6. Chest Pain Accredited Center	1. Clinical Trial Research 2. Area Agency for Aging Region 1 3. ED 2 Home 5. Cardiac Rehab Fitness Center (Shea)	
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease	1. Access to Care 2. Patient Centered Medical Home
Employee Wellness	1. Purewellness online tracking	1. Wellness screenings	1. Disease Management			
Community Outreach/Sponsorships/ Marketing						
Sponsorships - Community Benefit						
Community Partnerships/Alliances	1. Foothills Caring Corp 3. Foothills Community Foundation 4. School Districts 5. Senior Centers (COS) 6. Stonegate Community Center	1. Fountain Hills Screening Center 2. Senior Centers (COS) 3. School Districts 4. Stonegate Community Center	1. Nuture	1. Partnership Mayo Clinic Transplant/LVAD Support	1. Skilled Nursing Agencies 2. Rehab Agencies 3. Group Homes 4. Hospice	1. Hospice Coordination

Heart Failure Modifications:

- Continue cardiovascular and stroke screenings
- Continue tobacco cessation programs
- Increase community participation with Cardiac Rehab Center
- Continue recruitment of physician partners
- Adopt EPIC electronic medical records to improve coordination of care

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Cardiovascular Disease Initiatives/Program

Care Continuum

Organizational Area/Dept.	Prevention	Screening/Diagnosis	Disease State Management	Acute Treatment	Post-Acute Treatment	Palliative Care
NOAH	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Promotora 4. CVD and Stroke Screening	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease management (In progress) 4. Behavioral Health Education 5. Nutrition Education and Management	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Care Coordination Community Case Management
Corporate Health	1. Corporate Challenges 2. Lunch and Learn	1. WellPath Program (Salt River Pima RSV) 2. Cholesterol/Glucose Screenings 3. Silverstone Retirement Center	N/A	N/A	1. Occupational Health Clinic	N/A
Service Line	1. SHC Website Education 2. Heart and Vascular Community Lectures 4. Body, Mind and Spirit exercise class 5. Essential Touch Workout Center (Shea) 6. The Heart of a Woman Forum (Shea) 7.Tobacco Cessation-Adults	1. Heart Health Screening (Shea) 2. Body Composition Screening (Shea) 3. Heart Health Bus Unit 4. Women's Wellness Program (Shea)	1. Heart of a Woman Forum (Shea) 2. Stroke Survivor and Caregiver Education and Support Group (Osborn) 3. Cardiac Rehab Center (Shea) 4. Body, Mind and Spirit Exercise Class (Shea except yoga is offered at Osborn) 5. TeleHealth Case Management Monitoring 6. Cardiac Rehab Heart Healthy	1. Chest pain Accredited Center 2. ADHS Share program for treatment of Cardiac Arrest 3. Structural Heart program (Osborn and Shea) 4. SHC Inpatient Case Management Team 5. ICA Echo Accreditation	1. Clinical Trial Research 2. Area Agency for Aging Region 1 3. ED 2 Home 4. Care coordination Community Case Management 5. Cardiac Rehab Fitness Center (Shea)	N/A
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home
Employee Wellness	1. Purewellness online tracking	1. Wellness screenings	1. Disease Management			
Community Outreach/Sponsorships/Marketing	1.AHA "Go Red for Women"" 2.H&V Civic/Municipality Participation and Education					
Sponsorships - Community Benefit			1.American Heart Association			
Community Partnerships/Alliances	1. Foothills Caring Corp 2. Foothills Community Foundation 4. School Districts 4. Senior Centers (COS) 5. Stonegate Community Center	1. Fountain Hills Screening Center 2. Senior Centers (COS) 3. School Districts 4. Stonegate Community Center	1. Nuture	1. Partnership Mayo Clinic Transplant/LVAD Support 2. Heart Health Bus Unit	1. Skilled Nursing Agencies 2. Rehab Agencies 3. Group Homes 4. Hospice	1. Hospice Coordination

Cardiovascular Disease Modifications

- Continue cardiovascular and stroke screenings
- Continue tobacco cessation programs
- Increase community participation with Cardiac Rehab Center
- Continue recruitment of physician partners
- Adopt EPIC electronic medical records to improve coordination of care

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Diabetes Initiatives/Programs

Care Continuum

Organizational	Prevention	Screening/Diagnosis	Disease State Management	Acute Treatment	Post-Acute	Palliative Care
NOAH	1.Diabetes Center Certification Site (in progress) 2. Promotora 3. Access to care 4. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. CVD and Stroke Screening	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease Management (in progress) 4. Behavioral Health Education 5. Nutrition Education and Management 6. Dental Services 7. Podiatric exams,	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Diabetes Group Classes 2. Dental Services 3. Access to care 4. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Family Education
Corporate Health	1. Corporate Challenges 2. Lunch and Learn	1. Cholesterol/Glucose Screenings 2. WellPath Program (Salt River Pima RSV) 3. Silverstone Retirement Center	N/A	N/A	N/A	N/A
Service Line	1. Pre-Diabetes Class (Shea) 2. Gestation Diabetes Class (Shea) 3. Essential Touch Workout Center (Shea) 4. Early Childhood Programs(Osborn) 5. Fit Club	1. Body Composition Screening (Shea) 2. Heart Health Screening (Shea) 3. SHC Mobile Health Unit	1. Comprehensive Diabetes Classes (Shea) 2. The Heart of a Woman Forum (Shea) 3. Cardiac Rehab Center 4. TeleHealth Case Management Monitoring 5. Diabetic Individual Counseling and Behavioral Management (Shea)	1. SHC Inpatient Case Management Team	1. Diabetic Individual Counseling and Behavioral Management (Shea) 2. ED 2 Home	**N/A**
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management) 4. Quality Care	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home
Employee Wellness	1. Purewellness online tracking	1. Wellness Screening	1. Disease Management			
Community Outreach/Sponsorships / Marketing						
Sponsorships - Community Benefit						
Community Partnerships/Alliances	1. Pine Towers Senior Center 2. Arizona Diabetes Coalition 3. ADA 4. JDRF 5. School Districts 6. Senior Centers	1. School Districts 2. Senior Centers	1. ADA-Type 1 & 2 2. JDRF-Focus on Type 1			

Diabetes Modifications:

- Continue promotion of SHC Diabetes Center
  - Identify partnerships with OB/GYN, NOAH, and Primary Care Providers

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Cancer Initiatives/Programs

Care Continuum

Organizational Area/Dept.	Prevention	Screening/Diagnosis	Disease State Management	Acute	Post-Acute	Palliative Care
NOAH	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Promotora	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease Management (in progress) 4. Behavioral Health Education 5. Nutrition Education and Management	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Care Coordination Community Case Management	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Family Education
Corporate Health	1. Tobacco Cessation-Adults 2. Tobacco Prevention-Youth 3. WellPath Program (Salt River Pima Rsv)	1. Skin Screenings 3. Silverstone-Corporate Retirement Center	N/A	N/A	N/A	N/A
Service Line	1. Cooking/Nutrition Programs (Shea) 2. Body, Mind and Spirit exercise class (Shea, Osborn Yoga only) 3. Disease Specific-Community Lectures at the Cancer Center (Shea) 4. Essential Touch Workout Center (Shea) 5. Bosom Buddies Breast Cancer Support Group (TPK) 6. Tobacco Cessation-Adults 7. Tobacco Prevention-Youth	1. Cancer Screenings (Shea) 2. Body Composition Screening (Shea) 3. Cancer Genetic Screening 4. Lung screening	1. Radiation Oncology (Shea & Osborn) 2. Cancer Care Coordinator (Shea) 3. Body, Mind and Spirit exercise class (Shea, Osborn Yoga only) 4. Exercise Rehabilitation (Shea)	1.Surgical Oncology 2.Medical Oncology 3.Radiation Oncology (Shea & Osborn) 4. Bone Marrow Transplant Infusion (Shea) 5. Social Worker at Cancer Center (Shea) 6. SHC Inpatient Case Management Team	1. Cooking/Nutrition (Shea) 2. Cancer Clinical Trials (Shea) 3. Out-Patient Infusion (Shea)	1. Cancer Care Coordinator (Shea) 2. Hospice of the Valley Grief Support Group.
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management) 4. Quality Care Coordination	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management) 4. Quality Care Coordination	1. Access to Care 2. Patient Centered Medical Home
Employee Wellness	1. Purewellness online tracking	1. Wellness screenings	1. Disease Management			
Sponsorships - Marketing	1. Undy 5000 (Colon Ca) 2. Parada del Sol 3. Night for Life					
Community Outreach/ Sponsorship/Community/Benefit			Komen "Race for the Cure",			
Community Partnerships/Alliances	1. Academy of Dermatology 2. American Cancer Society 3. Ashline (Tobacco Cessation) 4. Bosom Buddies 5. Desert Cancer Foundation 6. Good Sheppard of the Hills Episcopal Church 7. Leukemia & Lymphoma Society 8. Lymphoma Research Foundation 9. Maricopa County Smokeless Tobacco Coalition 10. POP-prostate onsite project (prostate education and prevention) 11. School Districts	1. Academy of Dermatology 2. MOM-mammography 3. Colon Cancer Alliance 4. Community Dermatologist	1. Susan G. Komen			1. Hospice of The Valley

Lung Cancer Modifications:

- Continue to offer tobacco cessation

Breast Cancer Modifications:

- Support mammography screenings within the community

Skin Cancer (Melanoma) Modifications:

- Continue screenings through VGPCC and Corporate Health

Colorectal Cancer Modifications:

- Support screenings for colon cancer

Prostate Cancer Modifications:

- Continue smoking cessation

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Obesity Initiatives/Programs

Care Continuum

Organizational Area/Dept.	Prevention	Screening/Diagnosis	Disease State Management	Acute	Post-Acute	Palliative Care
NOAH	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (In progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease management (In progress) 4. Behavioral Health Education 5. Nutrition Education and Management	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Care Coordination Community Case Management
Corporate Health	1. Corporate Challenges 2. Lunch and Learn	1. WellPath Program (Salt River Pima RSV)	N/A	N/A	N/A	N/A
Service Line	1. SHC Website Education 2. Gestational Diabetes Class (Shea) 3.Pre-Diabetes Class (Shea) 4.Nutrition Programs-Cancer (Shea) 5. Essential touch Workout Center (Shea) 6. Heart and Vascular lectures 7. The Heart of a Woman Forum (Shea)	1. Bariatric Seminars 2. Body Composition Screening (Shea) 3. Heart Health Screening (Shea) 4. Women's Wellness Program (Shea) 5. PMR/Bariatric Coordinator Presentations	1. Heart of a Woman Forum (Shea) 2. Cardiac Rehab Heart Healthy Education Classes (Shea) 3. Cardiac Rehab Center (Shea) 4. Comprehensive Diabetes Classes (Shea)	1. Gastric Surgery (Shea)	1.Cardiac Rehab Fitness Center (Shea)	N/A
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1.Access to Care 2.Patient Centered Medical Home 3. Care Management (Disease Management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease Management)	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease Management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease Management) 4. Quality Care Coordination	1. Access to Care 2.Patient Centered Home
Employee Wellness	1. Purewellness online tracking	1. Wellness screenings	1. Disease Management			
Community Outreach/Sponsorships/Marketing						
Sponsorships - Community Benefit	Saguaro Track Boosters					
Community Partnerships/Alliances	1. AZ Dept of Education 2. Best Pals Preschool 3. Boys and Girls Club 4. La Petite Child Care Center 5. McCormick Ranch Preschool 6. Paiute Neighborhood Center (COS) 7. Parks and Recreation (COS) 8. City of Scottsdale 9. School Districts 10. Senior Centers	1. Foothills Community Foundation 2. Paiute Neighborhood Center (COS) 3. School Districts				

Obesity Modifications:

- Continue offering Bariatric Seminar