

Wilkes Regional Medical Center Community Needs Assessment Implementation Plan for 2016-2019

Impact Diabetes

A focus to create more awareness on the signs and symptoms of diabetes to catch it early and help those better manages if already diagnosed. Promotion will be targeted to employees, patients, visitors and the community at large.

Partner to provide blood sugar screenings with employees, industry and the community at large.

Impact Stroke

Continue awareness campaign on the signs and symptoms and immediate activation of 911. Continue to promote the FAST approach: **F** – Face drooping; **A** – Arm weakness; **S** – Speech difficulty; **T**- Time to call 911.

Continue to work on “stroke ready certification” and continued use of the tele stroke robot through the ER and expand use to inpatient care through the Medical Hospitalist.

Expand our care for stroke patients through partnering with the COMPASS project (a WFBH initiative) and collaborate with the Tele stroke program. Goals of this project are aligned with the triple aim of improving health, reducing admissions, and minimizing costs.

The COMPASS project is a post-acute stroke care model that is aimed at improving patient functional outcomes and reducing hospital readmissions. The COMPASS project will evaluate a patient centered, community-based care model to improve secondary prevention, recovery, and access to community resources for stroke survivors and caregivers. COMPASS will encourage and facilitate patient and caregiver self-management of care. WILKES Regional will be partnering with 34 other hospitals in North Carolina in the implementation of the COMPASS project .

Impact COPD

With COPD being 50% of our admissions from the ER and approximately 50% of our readmissions. Four strategies have been identified to impact the large volume of patients we care for with this diagnosis.

Develop a COPD Clinical Pathway through a multi-disciplinary committee. The clinical pathway will be triggered in the ER and will be implemented by the ER provider and the Respiratory Therapist. The pathway will be stratified based on signs and symptoms and clinical metrics of the patient. The pathway will outline the inpatient care for nursing and ancillary staff such as physical therapy, through the discharge process.

Currently Wilkes Regional does not have a Pulmonologists in the community. We would hire a Pulmonologist to be able to provide inpatient care and consults for the Medical Hospitalist, ER providers and Specialists.

Evaluate developing a pulmonary outpatient office to provide follow up care and management of acute and chronic respiratory diagnosis.

Add a Pulmonary Rehab program which would provide a structured program that will focus on nutrition and purse lip breathing education, symptom management and enhance physical endurance and strength in a clinical setting.

Hire a case manager to manage and evaluate readmissions. With 50% of their time bring dedicated to case management the other half being committed to serving as the Wilkes Regional Faith Health coordinator Partner with the new Faith Health program to assist with patients that are high risk for readmissions or non-compliance.