

Humility of Mary Health Partners

# 2013 Community Health Needs Assessment Implementation Strategy

**St. Elizabeth Health Center**

Final  
10/5/13

# Identifying Information

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Hospital Name: St. Elizabeth Health Center (SEHC)

Primary Address: 1044 Belmont Ave, Youngstown, OH 44501, Mahoning County

Satellite Unit: St. Elizabeth Emergency and Diagnostic Center

Satellite Address: 6252 Mahoning Avenue, Youngstown, Ohio 44515, Mahoning County

Tax Identification Number: 34-0505560

Regional Chief Executive Officer: Robert Shroder

Hospital President: Donald Koenig

Date Report Prepared: 6/4/2013

Governance Committee Reviewing Report: Strategic Planning Committee

Date: 8/8/2013

Date Report Approved by Regional Governing Board:

Date: 9/3/2013

Due Date for Form 990 filing that will include implementation strategy:

Date: 11/14/2013

Hospital Tax Year to which implementation strategy applies

Year 2013

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# Implementation Strategy

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In order to address needs identified in the Community Health Needs Assessment (CHNA), SEHC will engage key community partners in implementing new strategies across the service area. The Implementation Strategy will explain how SEHC will address health needs identified in the CHNA by continuing/expanding existing programs and services, and by implementing new strategies. It will also explain why the hospital is not yet positioned to address all the needs identified in the CHNA, and if applicable, how SEHC will collaborate with other community organizations in doing so.

## Prioritized Health Needs

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### Diabetes

The Diabetes 5 or D5 is an all-or-none bundle of recommended clinical quality measures for persons living with diabetes. It represents five goals diabetics need to achieve to reduce risk of complications such as heart attack, stroke and problems with the kidneys, eyes and nervous system. SEHC has set a goal of increasing diabetic patients established at the employed primary care practices that meet D5 goals to 31 percent by 2015. In 2012, the three employed primary care practices in the Mahoning County community have a combined average of 14.1 percent. To reach primary care physicians not employed by our system, the HMHP Care Network, our Clinically Integrated Organization, will integrate these same goals for community physicians enrolled in the program.

In 2013, Humility of Mary Health Partners (HMHP) focus at the Canfield Fair was diabetes education. The Canfield Fair is one of the largest state fairs in the US and attracts over 2,500 people from the tri-county area each year to the health building. Also, our active collaboration in the Diabetes Partnership of the Mahoning Valley will further assist those in the community with education, information, resources and support to minimize the effect diabetes has on their life and the lives of those who care for them.

Currently, HMHP Diabetes Education Program sponsors the annual Diabetes Expo. Some highlights of the educational program include: featured speakers (physicians and others), educational and resource exhibits, pharmaceutical and glucose meter exhibits, ask the pharmacist, dietitian, and physician, lunch, and a Chinese auction. This event typically attracts approximately 300 individuals from the surrounding area. Also, HMHP is an active participant in Community Health Care Initiatives/ Diabetes Workgroup whose objective is to enhance the quality of healthcare, expand healthcare education and promote a culture of best practices. This coalition of community stakeholders, launched in 1999 by the United Auto Workers (UAW), General Motors (GM), the International Union of Electrical Workers(IUE-CWA), and Delphi. Participating organizations include: American Diabetes Association (ADA), Anthem BC & BS, Blue Cross and Blue Shield of Michigan, Employers' Health Care Coalition of Ohio, Humility of Mary Health Partners, Lake to River Health Care Coalition, Primary Healthcare Associates, Trumbull County Health Dept., UAW/GM, Valley Care, and the Youngstown Community Health Center. SEHC will continue to explore community partnerships to develop innovative ideas to address this community need.

## Baseline Data for Employed Primary Care Practices

The practices listed below are the HMHP employed primary care practices located in the SEHC community. This chart displays the percentage of patients that meet the D5 criteria for 2012 for the primary care practices.

Percentage of Patients that meet D5 Criteria by Practice			
Practice	Practice Manager	2012	Goal (by 2015)
Austintown FHC	Nancy L.	20.0%	31%
Belmont FHC	Nancy L.	12.1%	31%
Internal Medicine Clinic	Jeanie Colyar	10.4%	31%
<b>Combined Average</b>		14.1%	

## Obesity

According to the Behavioral Risk Factor Surveillance System 2010 (BRFSS), thirty-five percent of the population in the Youngstown area is obese (BMI greater than 30). Since HMHP is the largest employer in the tri-county area, SEHC chose its employees as the target population. The goal is to decrease the percentage of employees that are obese based on the annual Health Risk Assessment (HRA). With a focus on nutrition and physical activity, the actions developed will help improve the health of the employees. Below are some programs that help support this goal.

### Stepping Out Program

Through our Stepping Out Program, we collaborate with United Methodist Community Center, Greater Millcreek Community Center and Associated Neighborhood Centers/McGuffey Center to provide fitness activities such as line dancing, Salsa, Zumba, aerobics and chair aerobics and healthy eating and cooking demonstrations as well as assessments for blood pressure, body fat, BMI, weight, and waist measurement assessments at locations in underserved neighborhoods in Youngstown.

### Neighborhood Health Watch

Through our Neighborhood Health Watch (NHW) program, a registered nurse provides screenings for diabetes and heart disease with referral to primary care and also health education for prevention and healthy lifestyle. We collaborate with numerous community agencies in underserved areas of the Mahoning Valley in order to provide services at their locations. NHW sites include Norton Manor, Rockford Village, Greater Mill Creek Community Center, Gutknecht Tower, Warren Family Mission, Tod's Crossing, Amedia Plaza, United Methodist Community Center, local barber and beauty shops and SCOPE Senior Centers in Niles, Howland, Lordstown, Cortland, Champion and Warren.

### Know Your Numbers

Through our Know Your Numbers program, blood sugar, blood pressure, total cholesterol, HDL, LDL & triglycerides screenings are provided. Participants then attend a presentation to learn what their numbers mean and how to improve them, including healthy eating and exercise. Presentation also provides education about hypertension, cholesterol, heart disease and diabetes.

## **One Step at a Time Walk Fitness Program**

In our One Step at a Time Walk Fitness program, participants receive a walk log, pedometer and in-home walk DVD to encourage an increase in activity during 6-8 weeks of the program. Participants log minutes of activity per week and receive weight, waist measurement, body fat and BMI screenings pre and post to assess improvement.

## **Sisters in Red**

300 Sisters in Red is a yearly program planned and implemented in collaboration with The Youngstown Chapter of the Links, Inc., Delta Sigma Theta Sorority, Anthem, Youngstown State University, and the American Heart Association with the goal of increasing the number of minority women who have been screened for diabetes, hypertension, cholesterol, obesity, and osteoporosis and increasing their knowledge action about health issues.

## **Farmers' Markets and Fruit and Vegetable Prescription Program**

HMHP collaborates with Lake to River Food Cooperative to provide Farmers' Markets at St. Elizabeth Health Center Campus and at the courthouse square in downtown Warren. Markets were held monthly May through November with the goal of providing fresh fruits and vegetables from local farmers to designated food deserts within the Mahoning Valley. In 2013, we added a Fruit and Vegetable Prescription component whereby physicians in our St. Elizabeth Ambulatory Care Center, St. Elizabeth Family Health Center, Austintown Patient Centered Medical Home and St. Joseph Community Care Center write a "prescription" whereby a patient can receive a voucher to buy produce at the Farmer's Markets.

## **Hispanic, Latino, and Immigrant Health Program (HLIHP)**

Our Hispanic, Latino, and Immigrant Health Program (HLIHP) seeks to improve the health of our Hispanic, Latino and Immigrant communities. We collaborate with the Diocese of Youngstown, Organización Cívica y Cultural Hispana Americana (Hispanic community center), St. Paul's Catholic Church and Community Legal Aid to plan and implement the program.

Specific to diabetes, our bilingual health educator provides health screenings for diabetes and heart disease at Mexican restaurants, the Salvation Army and Spanish churches, and teaches about healthy lifestyle. The HLIHP has served clients from Puerto Rico, Mexico, Guatemala, Dominican Republic, Colombia, Honduras, Venezuela, Nicaragua, Panama, and Peru and other Latin American countries.

## **Heart Disease**

Mahoning County has a heart disease mortality of 203.6 deaths per 100,000 compared to the Ohio rate of 191.7 deaths per 100,000 (Ohio Dept of Health, 2010). The national Healthy People 2020 goal is 100.8 deaths per 100,000. Mahoning County has a stroke rate of 49.9 deaths per 100,000 compared to Ohio rate 42.2 deaths per 100,000. The national Healthy People 2020 goal is 33.8 per 100,000. According to the County Health Rankings from University of Wisconsin, in 2012, 23% of adults were smokers in Mahoning County. Although there are hereditary factors that you cannot change one can mitigate the risk of developing heart disease by improving their diet, exercising 30 min everyday, and quitting smoking. SEHC continues its efforts to reach and maintain top quartile performance for heart failure quality measures by 2015. SEHC plans to collaborate with the Area Agency on Aging to decrease heart failure 30-day readmissions. Also, palliative care will be integrated into the congestive heart failure clinics.

Currently when patients are diagnosed with congestive heart failure (CHF) and discharged from our facilities they are provided a scale for daily weight updates, a care plan to follow and are scheduled for an appointment with their physician or follow-up in the CHF clinic. Expanding the capacity and education opportunities of the CHF clinic and services will improve the heart health of the community by increasing awareness of community resources surrounding

heart disease. In-patients who meet criteria are also given one complementary home visit through our Home Care provider to assess potential needs for community resources. We will assess the feasibility of expanding this Home Care pilot and enhancing the coordination of post-acute care.

To reach the greater community (nursing homes, VA, Area Agency on Aging), we will assess the feasibility of expanding current programs and creating an education program for community partnerships. This will provide education to organizations that admit patients to our facilities to recognize early warning signs and prevent heart failure.

The implementation plans (detailed on next page) for each prioritized health need will:

- Describe actions the hospital intends to take to address the need
  - Describe anticipated impact of actions
  - Describe plan to evaluate such impact
  - Identify programs and resources the hospital plans to commit to address the need
  - Describe planned collaboration in address the need
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# Health Need #1: Diabetes

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Goal: Increase diabetic patients (employed primary care practices) that meet D5 goals (listed below):

1. Blood pressure is less than 140/90 mmHG
2. Bad cholesterol, LDL, is less than 100 mg/dl
3. Blood sugar, A1c, is less than 8%
4. Tobacco-free
5. Taking an aspirin as appropriate

Outcome Measure: 31% (combined average) by 2015

## Implementation Plan

<b>Action (Responsible Leader)</b>	<b>Impact of Action</b>	<b>Plan to Evaluate Impact</b>	<b>Programs and Resources committed to addressing needs</b>	<b>Planned Collaboration</b>
Develop a HMHP D5 Committee (Rod Neill)	Increase compliance with D5 criteria	Quarterly report of D5	HMHP Physician Associates, Explorys software system	TBD based on preliminary results
Explore opportunities to increase referrals to supportive services (Rod Neill/Kay Leonhart)	Increase referrals of diabetic patients to prescription assistance, diabetes education, smoking cessation and other appropriate services	Decrease active smokers and improve D5 compliance	Canfield Fair, Staff education on the D5	Diabetes Partnership of the Mahoning Valley/Tri-County
Develop HMHP Care Network quality initiatives and expand to community physicians (Toni Stefan)	Community physicians involvement and alignment with quality initiatives	Improved D5 outcomes in community	HMHP Care Network, Business Development	Community physicians
Primary Care Symposium to have a spotlight on D5 criteria (Dr. Nicholas Kreatsoulas)	Increase awareness and efforts to comply with D5 criteria	Assess impact via program evaluation	Medical Staff Office, HMHP Physician Associates	Community physicians
Canfield Fair (Susan Stewart & Kay Leonhart)	Increase awareness of pre-diabetes and diabetes prevention and control in community	TBD (# of attendees, hrs reported in CBISA, referral tracking)	Focus on Diabetes for the 3 year period, Grant writing	

# Health Need #2: Obesity

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Goal: Reduce percent of employees who have a BMI greater than 30 (which defines obese)

Outcome Measure: Decrease percent of employees with BMI of obese (TBD Once 2012 baseline is known)

## Implementation Plan

<b>Action (Responsible Leader)</b>	<b>Impact of Action</b>	<b>Plan to Evaluate Impact</b>	<b>Programs and Resources Committed to Addressing Needs</b>	<b>Planned Collaboration</b>
Explore feasibility to partner with AVI Foods to provide healthy food choices in our cafeteria (Don K. & Wayne T.)	Transform cafeteria into a model for healthy eating	Develop and implement a plan to identify actions that can transform cafeteria into a model for health eating.	HMHP leadership, AVI Foods, Local farmers markets, dietitians,	AVI Foods
Partnership with Health Span to reach out to employees that have been identified as obese (Tina Fowler)	Educate and provide behavioral and clinical support for those have been identified as obese	Assess BMI of those with provided intervention or outreach	Health Span, employee health & wellness, nutrition services	TBD
Exploring innovative options/partnerships to help employees increase physical activity. (Tina Fowler)	Increase physical activity in employees	Participation in programs or partnerships	Grant writing, health & wellness	Local colleges / universities, YMCA, local wellness organizations, Greater Millcreek Community Center, United Methodist Community Center and Associated Neighborhood Centers, McGuffey Center

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# Health Need #3: Heart Disease

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Goal: Decrease CHF readmission rate

Outcome Measure: By 2015 at top quartile for heart failure to heart failure 30-day readmission rate

## Implementation Plan

<b>Action (Responsible Leader)</b>	<b>Impact of Action</b>	<b>Plan to Evaluate Impact</b>	<b>Programs and Resources Committed to Addressing Needs</b>	<b>Planned Collaboration</b>
Collaborate with Area Agency on Aging to decrease heart failure 30-day readmissions (George Semer)	Implement action items as determined by Area Agency on Aging steering committee	Evaluation of stated action items	TBD	All acute care hospitals in tri-county area and several local long term care facilities
Integrate palliative care into congestive heart failure clinic (Terry Kilbury and Mariann Pacak)	Decrease heart failure 30-day readmissions	Palliative care consults for CHF patients	Palliative care specialists	
Expand Home Health pilot (Mariann Pacak and Michael Robinson)	Decrease heart failure 30-day readmissions	Number of home health visits for congestive heart failure patients	Extension and/or enhancement of pilot	HM Home Health

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# Needs not being addressed in Implementation Plan

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## **Behavioral Health**

Currently, our system does not have the capacity to address behavioral health across the continuum of care due to the complexity of care coordination and clinical expertise required to deliver exceptional service. SEHC is seeking partnerships to address the need through various local behavioral health providers. Our corporate sponsor, Catholic Health Partners (CHP), has provided Non-Abusive Psychological & Physical Intervention (NAPPI) training for staff to gain skills necessary to deal with individuals with behavioral health issues. Additionally, behavioral health is a clinical focus that is being strategically developed by CHP and there is significant effort to recruit and retain behavioral health providers. While SEHC is not addressing the need in this plan, it is taking foundational steps to adequately address this need in the future.

## **Access & Preventive Care**

To address the need of access to care, HMHP provides significant resources at a number of locations throughout the tri-county area. In addition to St. Elizabeth Ambulatory Care Centers and Family Health Center, HMHP is also in the process of developing additional Patient Center Medical Homes similar to that center in Austintown. Access Health Mahoning Valley, a collaborative between HMHP and local health organizations, helps individuals gain access to care. Free clinics and Federally Qualified Health Centers (FQHC) also provide access and preventive care to the community.