

Humility of Mary Health Partners

# 2013 Community Health Needs Assessment Implementation Strategy: SEBHC

**St. Elizabeth Boardman Health Center**

# Identifying Information

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**Hospital Name:** St. Elizabeth Boardman Health Center (SEBHC)

**Primary Address:** 8401 Market Street, Boardman Ohio 44512

**Tax Identification Number:** 34-0505560

**Regional Chief Executive Officer:** Robert Shroder

**Hospital President:** Genie Aubel

**Date Report Prepared:** 5/15/2013

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), SEBHC will engage key community partners in implementing new strategies across the service area. The Implementation Strategy will explain how SEBHC will address health needs identified in the CHNA report 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 report, and if applicable, how SEBHC will collaborate with other community organizations in doing so.

## Prioritized Health Needs

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### Prenatal Issues

Humility of Mary Health Partners will be moving Labor and Delivery services to SEBHC in spring 2014. The development of this service line will enhance care and access in southern Mahoning and Columbiana Counties. Focusing specifically on low birth weight (LBW), SEBHC has set a goal of decreasing the percentage of low birth weight deliveries to 10 percent (a 2 percent decrease). In 2012, at St. Elizabeth Health Center (the current location of Labor and Delivery), 213 patients that delivered greater than 23 weeks had babies that were less than 2,500 grams at birth (12 percent of deliveries).

The Mahoning Youngstown (M/Y) Birth Outcome Equity Initiative is a part of a national initiative designed to strengthen the scientific focus and evidence base for realizing equity in birth outcomes in urban U.S. cities. Through the combination of strategies shown to improve birth outcome disparities and data-driven decisions specific to the target populations in participating communities, teams will engage in a local equity project aimed at reducing the disparity in birth outcomes. SEBHC will be an active participant at the local level.

HMHP Resource Mothers Program provides services to low-income, high-risk pregnant and parenting women and their babies to help them access the services and health information needed to have a healthy pregnancy, birth and lifestyle. The Resource Mothers serve as mentors, teachers, and advocates to give support to pregnant and parenting women in the community. The Resource Mothers visit participants on a monthly basis during their pregnancy and for one year after the birth of the child. We achieve our goals by helping women connect to health care and needed social services within the community as well as providing education about pregnancy and parenting. The Resource Mothers provides bilingual (Spanish/English) services, therefore are able to meet and identify the needs of the Spanish-speaking community. The program offers classes on Safe Sleep, CPR, Healthy Relationship, Home Safety and Newborn Care, transportation to our participants for doctors and social service appointments and referrals are also made to appropriate community agencies when necessary and guidance to participants enrolling into local colleges, GED programs, and finding employment by assisting with resumes and filling out applications and grant forms.

### 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. SEBHC 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 17.9 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 partnership 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. SEBHC will continue to explore community partnerships to develop innovative ideas to address this community need.

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. SEBHC 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 SEBHC 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)
Mill Creek FHC	Noel Stickle	11.7%	31%
Mill Creek IM	Noel Stickle	18.3%	31%
Boardman Complete FHC	Noel Stickle	23.9%	31%
<b>Combined Average</b>		17.9%	

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

# Health Need #1: Prenatal Issues

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Goal: Decrease percentage of low birth weight babies delivered at SEBHC\* from 12% to ≤10% by 2015

Outcome Measure: % of LBW delivered at SEBHC (*Baseline: 12% of deliveries resulted in LBW babies at SEHC in 2012*)

## 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>
Actively participate in M/Y Birth Outcome Equity Initiative (Anna Klejka, Sr. Marie Ruegg, Ellen Ford, Marsha Baumgartner, Dee Traylor)	Positively impact community collaboration to develop programs and initiatives around prenatal issues	Improve birth outcome in vulnerable populations and evidence based need to eliminate disparities in birth outcomes	Ohio Equity Institute, City Match, Ohio Department of Health,	Akron Children's Hosp. YCHD, YSU, MCDBOH, Drs. Nalluri & Hill, Youngstown Office on Minority Health
Design and implement local equity project ( Anna Klejka , Sr. Marie Ruegg, Ellen Ford, Marsha Baumgartner, Dee Traylor and Kay Leonhart)	Reduce disparities in birth outcomes	TBD based on equity project	Labor and Delivery Services, physician enterprise, mission and community outreach	M/Y Birth Outcome Equity Initiative
Develop HMHP Care Network quality initiatives and expand offering to community physicians (Toni Stefan)	Community physicians involvement and alignment with quality initiatives	Improved birth outcomes in community	HMHP Care Network, Business Development	Community Physicians
Explore the feasibility of offering Prenatal classes- 1 <sup>st</sup> and 2 <sup>nd</sup> trimester (Childbirth Education & Community Outreach)	Develop curriculum, with emphasis on prenatal care, smoking cessation and other contributing factors	Implement evaluation tool to assess the impact of new curriculum	Childbirth education, explore grant funding, and assess prenatal education programs in Catholic Health Partners (CHP) and other regional hospital settings	M/Y Birth Outcome Equity Initiative

\*Effective April 2014, Labor and Delivery services will be moving from SEHC to SEBHC.

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# Health Need #2: Diabetes

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Goal: Increase percent of 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 (Baseline: 17.9% combined average in 2012 for the 3 Boardman practices)

## 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)	Increase referrals of diabetic patients to pharmacy assistance, diabetes education, smoking cessation and other appropriate services	Decrease active smokers and improve D5 compliance	Staff education on the D5	Diabetes Partnership of the Mahoning Valley
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 diabetes and the D5. (Dr. Nicholas Kretsoulas)	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, hours reported in CBISA, referral tracking)	Focus on Diabetes for the 3 year period, Grant writing	TBD

# Needs not being addressed in Implementation Plan

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## Obesity

Because of the direct correlation between obesity and diabetes, the strategies and activities aimed at reducing diabetes will also reduce obesity. In the tri-county area, there are resources allocated to address this need such as our multiple health and wellness programs offer at St. Joe's at the Mall, Slim Down program, aimed at weight reduction, the Silver Sneakers program, through United Healthcare which provides older members access to wellness services and Akron Children's offering childhood obesity programming. Additionally, this facility is located on the same campus as YMCA, which offers a wonderful facility and several wellness programs to the community. Obesity will continue to be a community health focus.

## 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. SEBHC 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 SEBHC 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. HMHP is also in the process of developing Patient Center Medical Homes. 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. In the future, SEBHC hopes to develop a family medicine residency, whose clinics would be housed on the SEBHC campus and provide greater access and preventive care to the community.