Catholic Health

Community Health Needs Assessment &
Community Service Plan

# Implementation Strategy 2016-18

Catholic Health
Mount St. Mary's Hospital

**5300 Military Road Lewiston, NY 14092**
**(716) 298-2146**

December 2016

Dear Community Resident:

As one of the leading health care providers in Niagara County, we continually look for ways to improve the health of those who reside in our community. To support this effort, we conduct a Community Health Needs Assessment (CHNA) every three years to understand the health concerns and issues faced by community residents. Based on the CHNA conducted in 2016, a Community Health Improvement Plan (CHIP) for 2016 through 2018 was developed to address those needs that are deemed substantive and that Mount St. Mary's Hospital is most able to affect.

The assessment process was a collaborative effort between Mount St. Mary's Hospital and other local organizations concerned about the health of our community, including the Niagara County Department of Health, several community organizations, and other hospitals in Niagara County. In addition to a comprehensive countywide survey that generated more than 2,000 responses, we solicited input from other community organizations, individuals and groups in the form of surveys and community meetings. This input helped us develop focused programs and services that best address the health and wellness needs of the people who rely on us for care.

Mount St. Mary's, as part of Catholic Health, is committed to leading the transformation of health care in our community and to improving the health outcomes for all patient populations. To that end, in 2015, Catholic Health provided more than $99 million in charity care and community benefit for the people of Western New York.

We look forward to working together with you and our community partners to improve the health and quality of life for the residents of Niagara County. We welcome you to learn more about Catholic Health and Mount St. Mary's by visiting www.chsbuffalo.org, or calling HealthConnection at 716-447-6205.

President & CEO
Mount St. Mary's Hospital

Bernadette Franjoine
Vice President, Mission Integration
Mount St. Mary's Hospital

## Introduction

The 2016 Niagara County Community Health Needs Assessment began by bringing together the participants from the 2013 process. This included the Niagara County Department of Health, and representatives of the four hospitals in Niagara County: Mount St. Mary's, Niagara Falls Memorial, DeGraff Memorial, and Eastern Niagara. The process was coordinated by the $P^2$ Collaborative of Western New York.

Initial meetings focused on evaluating activities from the 2013 CHNA's and the County Health Department's Community Service Plan priorities. Subsequent sessions were devoted to developing a countywide questionnaire to survey residents and initiatives to gather as much relevant data as possible from surveys, interviews, and focus groups.

The countywide questionnaire resulted in more than 2,000 responses from residents of Niagara County, including more than 1,000 who were residents of the Primary Service Area of Mount St. Mary's Hospital.

As part of this coordinated initiative, Mount St. Mary's worked to develop an updated three-year (2016-2018) Community Health Improvement Plan/Implementation Strategy (CHIP/IS) to continue the collaboration in our community to improve patient care, preventive services, overall health, and quality of life. Our input process covered many segments of the community including individual surveys, community organizations, local health officials and others of varying socioeconomic backgrounds.

## Significant Community Health Needs Themes

The 2016 community outreach and research revealed the following themes with regard to significant health care needs and disparities in Erie County, many of which will be targeted by Catholic Health as part of its Community Health Improvement Plan.

1) *Reduce Healthcare Disparities in Vulnerable Population Through "Trauma-Informed" Care Practices*
2) *Address Diabetes Management and Prevention*
3) *Stroke Prevention & Support*
4) *Increase Percentage of Adolescents with HPV Immunization*
5) *Increase Proportion of Infants who are Fed Breast Milk*
6) *Helping High Risk Moms to Prevent Prematurity and Address Opioid Dependence*
7) *Reduce Percentage of Pre-Term Births*
8) *Provide Pediatric Care Coordination*
9) *Provide Mental Health First Aid Training*

## Overview of Process Leading to 2016-2018 CHIP

Mount St. Mary's followed the process described below in completing its Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP).

**1. Establish the Assessment Infrastructure**
An Internal Steering Committee (ISC) was established with representation from throughout the hospital and our off-site clinics including acute care operations, clinical service lines, Mission Integration, Nursing, and Education. The ISC reviewed IRS & DOH requirements and established the project timeline and work plan.

**2. Defining the Purpose and Scope**
Not-for-profit hospitals in New York State are required to develop a CHIP with requirements that are similar to those of the IRS. NYS requires that each organization, in cooperation with the local department of health and other providers in their county, collaboratively choose to work on two Prevention Agenda priority focus areas and address disparities in at least one of them.

**3. Collect and Analyze Data**
Mount St. Mary's, working with the $P^2$ Collaborative, Niagara County Department of Health and other hospitals, conducted focus groups at various locations attended by residents of the community, a specific focus group at our Neighborhood Health Center, one for hospital associates and volunteers, and one targeting medical providers. Input also received from focus groups conducted throughout Niagara County by the Niagara County Department of Health. We also provided a written survey to area community organizations, block clubs, and gathered input from participants and leadership in other community health initiatives such as Healthy Communities Niagara.

**4. Identify Resources/Community Collaboration**
The ISC reached out to Mount St. Mary's Hospital associates and various health care and social service leaders in the community to identify resources and potential ways of collaborating to meet project objectives. Additionally, those in our organization involved in other community organizations provided input.

**5. System Prioritization of Community Needs**
Mount St. Mary's 2016-2018 CHIP first considered the New York State Prevention Agenda (NYSPA) framework and the need for a continuation of programming identified in the 2013 CHIP. The 2016-2018 CHIP projects link to the NYSPA as outlined in the project plans provided in this report. Final selection of the 2016-2018 projects was aided by the application of criteria developed by the ISC. Clinical and administrative representatives from Catholic Health participated in the evaluation process utilizing the following six criteria:

- Existing leadership structure can support effort
- Current data collection effort confirms need and its significance in the community
- Meaningful opportunity exists to collaborate with external partners and make a meaningful impact
- Related initiative aligns with and will not compromise the Ministry's Mission and goals
- Other resources required are realistic and within the organizations capacity/budget
- The likelihood that substantial or meaningful impact can be made in our stated service area

**6. Development of Community Health Improvement Plan and Monitoring of Progress**

The ISC developed implementation plans for the 11 significant health needs that were highlighted in the most recent CHNA outreach and are tied to the NYS Prevention Agenda. Two of these projects are designated community collaboration priorities. Each project plan specifies the goals, and objectives for addressing the prioritized significant community health needs. Additionally, each plan specifies the actions to be taken, collaborations that will be instituted, the resources required and the measures of success. To facilitate the accomplishment of these goals Catholic Health made an intentional decision of allocating one percent of its net income from previous year, for projects related to community needs. The ISC will utilize a dashboard with implementation plan measures will be used to gauge progress throughout the three-year duration. The ISC will meet on a quarterly basis to assess activities and make adjustments as required.

**7. Board Approval and Public Availability of the CHNA/CHIP Plan**

The Mission Committee of the Hospital's Board was engaged throughout the CHNA process by reviewing progress, providing feedback and endorsing the resulting work product. The final CHNA was approved by both the Mission Committee and the Hospital's Board. The CH Hospital Boards of Directors reviewed and approved the CHIP plans for each of its hospitals on October 14, 2016. Reports have been published electronically on the Catholic Health website with hard copies available upon request at each hospital.

## Summary of Community Health Improvement Plan

Mount St. Mary's Hospital is committed to addressing the significant health needs of its community which is reflected in the hospital's updated three-year (2016-2018) Community Health Improvement Plan (CHIP). The plan began with the prioritization of the significant health needs identified in the CHNA. Mount St. Mary's considered the importance placed on those needs by both New York State as outlined in the Prevention Agenda and by a local assessment conducted by the Niagara County Department of Health and an assessment conducted as a county to support the projects chosen as part of the statewide DSRIP initiative to improve care to the Medicaid and underinsured population. Mount St. Mary's assessed its capabilities and resources with the potential to partner with others in the community to select projects that had the greatest opportunity to reduce the health disparities and meet the needs of the western Niagara County community.

### Mount St. Mary's Hospital Implementation Plans and Partners

1) Reduce Healthcare Disparities in Vulnerable Population Through "Trauma-Informed" Care
2) Address Diabetes Management and Prevention
3) Stroke Prevention & Support
4) Increase Percentage of Adolescents with HPV immunization
5) Increase Proportion of Infants who are Fed Breast Milk
6) Helping High Risk Moms to Prevent Prematurity and Address Opioid Dependence
7) Reduce Percentage of Pre-Term Births
8) Provide Pediatric Care Coordination
9) Provide Mental Health First Aid Training
10) Prevent Chronic Disease/Disparity: Mental Hygiene – **Niagara County Community Collaboration Priority**
11) Promote Mental Health & Prevent Substance Abuse – **Niagara County Community Collaboration Priority**

**Mount St. Mary's Hospital Project 1: Reduce Healthcare Disparities in Vulnerable Population Through "Trauma-Informed" Care Practices**

**Designated Mount St. Mary's Project Leaders:** Bernadette Franjoine, VP Mission Integration, Mount St. Mary's
**Catholic Health Leadership Sponsor/Support:** Bart Rodrigues, SVP & Chief Mission Officer, Catholic Health

**NYS Prevention Agenda:** Improve Health Status and Reduce Health Disparities; supports DSRIP cultural and structural competency initiatives and community response with regard to Access to Affordable Care.

**Goal(s) addressing community need:**

Our focus group conversations with various local health and human service agencies as well as community members highlighted the importance of improving access to care and care outcomes for the poor and disadvantaged to improve population health. These populations are more likely to have higher levels of chronic diseases, are less likely to utilize wellness visits, and have poorer health outcomes than the general population. Some organizations in area have instituted trauma-informed care practices to provide better support and engagement with vulnerable communities. In Erie County most recent health indicators indicate that premature death rate (<75 years) for general population is 37.9%, but for blacks is 60.4%, Asian/Pacific Islanders 58.6%, Hispanics 67%. In Niagara County the premature death rate (<75 years) for general population is 40.6% for the general population, 61.4% for blacks, 70.6% for Asian/Pacific Islanders, and 57.1% for Hispanics.

**Project's Target Population:**

Members of Erie and Niagara County vulnerable communities including, but not limited to: those who suffer from behavioral health or substance abuse problems, are part of racial or religious minorities, are part of the Medicaid population, are immigrants, identify as Lesbian, Gay, Bisexual or Transgender or are HIV positive.

**Outcome Objectives:** Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

PA 2.1 - Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics


PA 2.2 - Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics


Track hospital specific preventable hospitalization and work to reduce preventable hospitalization from 2016-2018.

**Project Process Measures:**

**Year 1 (2016):** creation of advisory group; (2) inventory existing cultural and structural competency initiatives.

**Year 2 (2017): ):** (1) continue ad hoc advisory group meetings (2) continue inventory of existing cultural and structural competency initiatives; (3) conduct a gap assessment (4) develop implementation plan based on gap assessment results.

**Year 3 (2018):** (1) implement the plan.

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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):**<br>(1) Develop an advisory group that includes community partners (such as UB School of Social Work's Institute of Trauma and Trauma Informed Care, P2, Evergreen, Catholic Charities, Niagara County health and human service agencies).<br>(2) Conduct organizational assessment to identify gaps<br>(3) begin organizational trainings on principles trauma and trauma-informed care<br>4) coordinate efforts with Erie County | **Year 2 (2017**(1) continue participation in ad hoc advisory groups (2) continue inventory of existing cultural and structural competency initiatives; (3) participate in a gap assessment (4) support implementation plan based on gap assessment results. | **Year 3 (2018):** (1) support and act on implementation plan. |
| **MSMH Resources Necessary:** | **Year 1 (2016):** Seek funding through CH Community Benefit Grant up to $20,000 per year. Collaborate with Erie County to utilize funds for UB Institute of Trauma and Trauma Informed Care to conduct organizational assessment, trainings for staff and develop champion program which includes follow up workshops with champions from 2016-2018 | **Year 2 (2017):** Seek funding through CH Community Benefit Grant up to $20,000 per year. | **Year 3 (2018):** Seek funding through CH Community Benefit Grant up to $20,000 per year. |
| **Collaboration: Who and how each partner will interact to affect the project goal** | **Year 1 (2016):** Participation in ad hoc advisory group with the following: University of Buffalo School of Social Work's Institute of Trauma and Trauma Informed Care, Catholic Charities, Evergreen and others. Work with existing initiatives helping to support cultural competency and care such as the DSRIP Structural Competency Initiative and Home Care's Medicaid trauma-informed care training programs. | **Year 2 (2017):** Continue work with existing partners to identify opportunities for implementing action plan. | **Year 3 (2018):** Continue to work with existing partners and identify new partners. |

**Mount St. Mary's Hospital Project 2: Diabetes Management and Prevention**

**Designated Mount St. Mary's Project Leaders:** Megan Kosmoski, Diabetes Educator, Mount St. Mary's Hospital

**NYS Prevention Agenda Link:**
Community response with regard to Diabetes and Overweight/Obesity
Promote Healthy Women, Infants and Children
Improve Health Status and Reduce Disparities
Increase Access to Care with Focus on Poor and Vulnerable communities
Increase Access to High Quality Chronic Disease Preventative Care and Management
Prevent Chronic Disease

**Goal(s) addressing community need:**

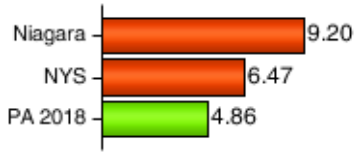
Diabetes is a national health epidemic with almost 30 million Americans diagnosed and another 89 million Americans having pre-diabetes. According to the CDC (Centers for Disease Control), as of 2013, 9.5% of Niagara County residents have been diagnosed with diabetes. Glucose management and reaching/maintaining a healthy weight is paramount to preventing diabetes, diabetes related complications and mortality. Education is the key to helping patients prevent and manage chronic condition. Patients must have a clear understanding of the disease process, medications used for treatment, prevention of complications, monitoring blood glucose and problem solving. With this knowledge, patients can live longer, more healthful lives and utilize fewer healthcare dollars in emergency room visits, cardiac care, dialysis, etc.

**Project's Target Population:**

All patients, additional focus for education and resources at the Neighborhood Health Center to assist those who may have transportation and access difficulties.

**Outcome Objectives:** Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

PA 22 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years




Track rate of hospitalizations to reduce preventable hospitalization from 2016-2018.

**Project Process Measures:**

**Year 1 (2016):** Identify baseline, establish process to communicate/raise awareness among associates and community stakeholders. Create advisory board, provide certification training for Diabetes Educator, educate the medical community on Diabetes Prevention Program (including National Health Institute trials that proved weight loss and exercise reduce risk by up to 58%), create a "call to action" to enroll patients into program.

**Year 2 (2017):** Host DPP at NHC utilizing external resource, partner with local farms to provide healthy options in primary care setting, expand number of providers offering DPP, support efforts for providers to track improved A1C numbers for enrollees. Review program for opportunities to increase participation/access to services, evaluate other social service programs that could support, consider additional community partners, and rebuild gestational diabetes classes.

**Year 3 (2018):** Host DPP at MSM Hospital and NHC utilizing internal and external resources, pilot support group for ongoing healthy weight management and behaviors, increase enrollment into DPP. Review program for opportunities to increase participation/access to services, evaluate other social service programs that could support, consider additional community partners, track monthly metrics, and collaborate with community outreach wellness events.

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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):** Develop advisory board that includes internal and external stakeholders, provide training for Diabetes Educator, engage providers and additional community members, develop multi-year plan for program and data tracking, provide inpatient and outpatient education programs. Collaborate to develop communication mechanism / process to raise awareness with special attention to our associates who could qualify and address medical needs | **Year 2 (2017):** Host program at NHC to include education and healthy meal at each session, address transportation for participants, identify additional provider and community members (Faith Community Nursing and Creating a Healthier Niagara Falls coalition, engage local growers to provide produce to areas without access, host food preparation demonstrations). Collaborate with associates to review program outcomes, identify opportunities to increase participation (especially preventative health care and OB patients), and host information table. | **Year 3 (2018):** Host two programs (MSM Hospital and NHC) to include healthy meal at each session, address transportation for participants, identify additional provider and community members (Niagara Falls School System), host food preparation demonstrations, pilot support group. Collaborate with associates to review program outcomes, identify opportunities to increase participation (especially preventative health care and OB patients), host information table/ screening, and evaluate community educational opportunity. |
| **MSMH Resources Necessary:** | **Year 1 (2016):** $3,500: $2,500 to cover certification course, $1,000 for marketing and printed materials, and Catholic Health Diabetes Educator. | **Year 2 (2017):** $6,000: $5,000 to cover cost of meals at each session, $1,000 for marketing and printed materials, and Catholic Health Diabetes Educator. | **Year 3 (2018):** $9,000: $8,000 to cover cost of meals at each session, $1,000 for marketing and printed materials, and Catholic Health Diabetes Educator |
| **Collaboration: Who and how each partner will interact to affect the project goal** | **Year 1 (2016):** American Diabetes Association, Niagara County Department of Health, CH Diabetes Educator, Associates, community stakeholders, medical staff. | **Year 2 (2017):** Creating a Healthier Niagara Falls, YMCA, YWCA, senior and community centers, housing authority and churches, Associates, community stakeholders, medical staff (primary care, OB), case management, faith community nursing. | **Year 3 (2018):** Niagara Falls School System, Associates, community stakeholders, medical staff (primary care, OB), case management, faith community nursing. |

**Mount St. Mary's Hospital Project 3: Stroke Prevention and Support**

**Designated Mount St. Mary's Project Leader:** Rosanne Schiavi, Stoke Program Coordinator, Mount St. Mary's Hospital
**Catholic Health Leadership Sponsor/Support:** Bernadette Franjoine, [1]VP, Mission Integration, Mount St. Mary's Hospital

**NYS Prevention Agenda Link:**
Community response with regard to Access to Affordable Care and Heart-Related Issues
Improve Health Status and Reduce Disparities
Increase Access to Care with Focus on Poor and Vulnerable communities
Increase Access to High Quality Chronic Disease Preventative Care and Management
Prevent Chronic Disease

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| **Goal(s) addressing community need:** | Raise awareness of stroke signs and symptoms. Reduce the number of strokes in WNY with special attention to those at high risk and/or underserved populations of the community. Provide post stroke support through community group workshops and educational events. Education, particularly to the underserved, in stroke prevention through health assessments, healthy eating habits and active life style. | | |
| **Project's Target Population:** | Adults (18+), special attention to underserved communities in Niagara County. Support for patients and/or families who have suffered a stroke. | | |
| **Outcome Objectives:** | Provide information to the community enhance awareness of stroke risk factors and improve response rate/effectiveness of treatment at Mount St. Mary's | | |
| **Project Process Measures:** | **Year 1 (2016):** Identify baseline, establish process to communicate/raise awareness among associates and community stakeholders, create multi-year plan for screening/education sessions, to include stroke support group. | **Year 2 (2017):** Review hospital programs for opportunities to increase participation/access to services, establish stroke support group, evaluate other social service programs that could support, consider additional community partners, track monthly metrics, host 4 screening/education/support group sessions. | **Year 3 (2018):** Review hospital program for opportunities to increase participation/access to services, evaluate other social service programs that could support, consider additional community partners, track monthly metrics, host 5 screening/education/support group sessions, collaborate with community outreach wellness events. |
| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):** Collaborate to develop metrics to track monthly, develop communication mechanism / process to raise awareness with special attention to our associates who could qualify and address medical needs, include strategy for underserved population. | **Year 2 (2017):** Collaborate with associates to review program outcomes, identify opportunities to increase participation (especially preventative health care, Neighborhood Health Center patients), host information table and screening/ education events, evaluate inclusion of additional community partners (faith | **Year 3 (2018):** Collaborate with associates to review program outcomes, identify opportunities to increase participation (especially preventative health care, Neighborhood Health Center patients), host information table and screening/ education events, evaluate inclusion of additional community partners (faith |

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| | | community nursing), consider alternative patient contact method/material. | community nursing), collaborate with community outreach events. |
| **MSMH/DDCH Resources Necessary:** | **Year 1 (2016):** Mission on the Move, patient care services, case management, rehab and CMP care coordinator associates. | **Year 2 (2017):** Mission on the Move, patient care services, case management, rehab and CMP care coordinator associates. | **Year 3 (2018):** Mission on the Move, patient care services, case management, rehab and CMP care coordinator associates |
| **Collaboration: Who and how each partner will interact to affect the project goal** | **Year 1 (2016):** Associates, community stakeholders, medical staff, American Heart/Stroke Association. | **Year 2 (2017):** Associates, community stakeholders, medical staff, faith community nurses, American Heart/Stroke Association. | **Year 3 (2018):** Associates, community stakeholders, medical staff, faith community nurses, American Heart/Stroke Association. |

**Mount St. Mary's Hospital Project 4: Percentage of Adolescents with HPV Immunization**

**Designated Mount St. Mary's Project Leaders:** Patricia Villani, Neighborhood Health Center; Bernadette Franjoine, VP, Mission Integration

**NYS Prevention Agenda Link:**
Community response with regard to Access to Affordable Care, with special mention of Cancer services
Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated infections
Promote Health Women, Infants and Children
Improve Health Status and Reduce Disparities

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| **Goal(s) addressing community need:** | The NYS Immunization Information System (NYSIIS) indicated that 11,291 Niagara County adolescents 10-19 years of age (39.3%) have initiated the HPV vaccine series since 2006. Of those who have initiated the series, only 6,498 individuals (22.6%) have completed it. The current completion rate for vaccines initiated by Niagara County providers is 57.6%. This means, fewer than 4 out of 10 Niagara County adolescents have received one dose of HPV vaccine and approximately half of those who start the series go on to complete it and become fully immunized. If we consider just the completion rate, the disparity becomes clear: only 22.6% of Niagara County adolescents are protected against HPV infection. |
| **Project's Target Population** | Males and Females Ages 11-17. |
| **Outcome Objectives:** | By December 2018, achieve 50% initiation rate for HPV Immunization |

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| **Project Process Measures:** | **Year 1 (2016):**<br>Creation of advisory group, establish process to review HPV vaccination rates | **Year 2 (2017):**<br>Nursing/clinical staff CME that address HPV vaccination, include community organizations that are connected to target population, goal 40% initiation rate | **Year 3 (2018):**<br>Continue program, integrate additional community members, goal 50% initiation rate, evaluate strategy to address completion rate |
| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):**<br>schedule consult with Niagara County Department of Health (immunization program nurses), establish/ distribute parent survey/education in waiting room for nurse review with patient, formulate plan with advisory group (to include pediatricians, pediatric care coordinator, medical director). | **Year 2 (2017):**<br>Nursing/clinical staff CME that address HPV vaccination, include community organizations that are connected to target population (including those who serve vulnerable youth, provide supportive housing), continue education/ surveying/material distribution, host "back to school vaccine clinic" event. | **Year 3 (2018):**<br>Continue program, integrate additional community members (include broader City of Niagara Falls population, schools), host screening of "Someone You Love" video, incorporate viewing into educational session/ community health event. |

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| **MSMH Resources Necessary:** | **Year 1 (2016):** $4,000 to cover gift card incentive for patient education, printed material, marketing | **Year 2 (2017):** $8,000 to cover gift card incentive for patient participation, printed material, marketing (to include community vaccine clinic event). | **Year 3 (2018):** $8,000 to cover gift card incentive for patient participation, printed material, marketing (to include community vaccine clinic event and video program/education). |
| **Collaboration: Who and how each partner will interact to affect the project goal.** | **Year 1 (2016):** Niagara County Department of Health, HPV Vaccine Coalition of Niagara County, American Cancer Society, Roswell Park, Human Service agencies, Niagara Falls Schools | **Year 2 (2017):** Niagara County Department of Health, HPV Vaccine Coalition of Niagara County, American Cancer Society, Roswell Park, Human Service agencies, Niagara Falls Schools. Identify additional partners who serve vulnerable target population. | **Year 3 (2018):** Niagara County Department of Health, HPV Vaccine Coalition of Niagara County, American Cancer Society, Roswell Park, Human Service agencies, Niagara Falls Schools. Identify additional partners who serve target population on regular basis (school system and parent associations). |

**Mount St. Mary's Hospital Project 5: Donor Breast Milk for Newborns who Fail to Thrive and are in the ICU**

**Designated Mount St. Mary's Project Leaders:** Maryann Cogdill, Director of Maternity Services, Mount St. Mary's Hospital
**Catholic Health Leadership Sponsor/Support:** Aimee Gomlak, VP Women's Services

**NYS Prevention Agenda Link:** Improve Health Status and Reduce Health Disparities

**Goal(s) addressing community need:**

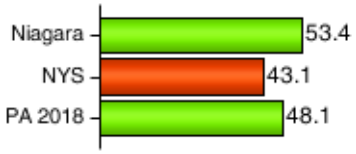
Mount St. Mary's and CH's maternity hospitals will become licensed depots for donor human milk. Breastfeeding mothers who have an excess supply of breast milk can donate milk to one of the three hospitals after a free blood test and a thorough screening interview by the New York State (NYS) Milk Bank. Donor milk is then frozen on site and shipped to the Milk Bank for processing, pasteurization, and distribution to newborns in need. Increase proportion of infants who are fed any breast milk in Erie County. CH's rates of exclusively breastfeed in the maternity hospitals as of September 2016 (SOCH 40.4%; MHB 43.3%; MSM 39.0%) lag behind the data..

**Project's Target Population**

*Mothers in Erie County, New York, who are breastfeeding and for those who are producing excess breast milk, connect them to the NY Milk Bank.
*Mothers who cannot produce breast milk or who are not able to breast feed.
*Newborns who fail to thrive, are in the NICU, or have other needs.

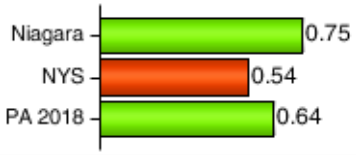
**Outcome Objectives:** Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

PA 33 - Percentage of infants exclusively breastfed in the hospital




PA 33.1 - Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanic


PA 33.2 - Exclusively breastfed: Ratio of Hispanics to White non-Hispanics




Track hospital specific exclusively breastfeed babies and work to increase breastfeeding rate (most currently available).

**Project Process Measures:**

**Year 1 (2016):**
Get Milk Depot program up and running.

**Year 2 (2017):**
Maintain program at MSMH and other 2 sites in CH, assess engagement from Neighborhood Health Center community.

**Year 3 (2018):**
Consider feasibility and desirability of expanding the depot program to the primary care sites that have pediatrics: Ken-Ton and MCCC. Determine Go/No Go. Also consider becoming a distribution site for milk as well.

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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):** Enlist support from staff and develop a system-wide policy/procedure for being a depot and receiving donor milk.<br>Apply to NYS DOH to add human milk to each hospital's tissue bank license.<br>Develop marketing materials to advertise each site as a depot.<br>Be approved by DOH (anticipated 4Q16) and purchase freezers/thermometers.<br>Have a staff in-service and roll out program at each site. | **Year 2 (2017):**<br>Continue staff education. Do a presentation at Clinics at MSMH on the program and how moms can donate. Share the program at OB/GYN departmental meetings and let physicians know that CHS is partnered with the NY Milk Bank and to prescribe human milk to newborns in need.<br>Present at WNY Breastfeeding Coalition meetings. | **Year 3 (2018):**<br>Meet with staff to determine feasibility and desirability. If Go, repeat roll out from 2016.<br>Determine if distribution of human milk is an option. |
| **MSMH/CH Resources Necessary:** | **Year 1 (2016):**<br>Current staff and space is sufficient to implement program. Many meetings held w NY Milk Bank, with written policy and procedure, and to develop what the program will look like at each site. NEED CHNA funds for the freezers = approximately $1,500 for 3 ($500 each). | **Year 2 (2017):**<br>Existing staff hours and physician time for in-services and dept. meetings.<br>Advertise in CHS newsletters.<br>Present at CHS Wide Management meeting to share concept and educate all staff across system. | **Year 3 (2018):**<br>If expanding to primary care sites, two additional freezers would be needed ($1,000). |
| **Collaboration: Who and how each partner will interact to affect the project goal.** | **Year 1 (2016):**<br>NY Milk Bank: do presentation on becoming a depot; submit the NYS DOH tissue bank licensing form for each hospital site to become a depot | **Year 2 (2017):**<br>Catholic Medical Partners: educate OB and Pediatric offices and encourage prescriptions for donor human milk. | **Year 3 (2018):**<br>No new partners needed. NY Milk Bank would repeat presentations and meetings, this time with primary care staff if expanding the program. |

**Mount St. Mary's Hospital Project 6: Helping High Risk Moms to Prevent Prematurity and Address Opioid Dependence**

**Designated Mount St. Mary's Project Leaders:** Maryann Cogdill, Director of Maternity Services, Mount St. Mary's Hospital
**Catholic Health Leadership Sponsor/Support:** Aimee Gomlak, VP Women's Services

**NYS Prevention Agenda Link:** Improve Health Status and Reduce Health Disparities

**Goal(s) addressing community need:**

Attempt to reduce prematurity in WNY. Increase physician's knowledge of care and treatment of dependent pregnant women and newborns. Increase access to care for dependent pregnant women as there is shortage of PMDs and OBGYNs able to prescribe buprenorphine and naloxone (Suboxone(R)). Connect pregnant women to support options. Reduce low birth weight and pre-term births as moms who usually use drugs may also be smoking, not eating well, under stress, in poor social situations, etc.

**Project's Target Population**

Health care providers, pregnant women, OBGYNs, PMDs in Niagara and County, New York, all of childbearing population in Niagara County, with special attention to those in underserved communities.

**Outcome Objectives:** Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

PA 32 - Percentage of preterm births


PA 32.1 - Premature births: Ratio of Black non-Hispanics to White non-Hispanics


PA 32.2 - Premature births: Ratio of Hispanics to White non-Hispanics


Track percentage of preterm births to reduce from 2016-2018.

**Project Process Measures:**

**Year 1 (2016):**
Support efforts to encourage OB/GYNs (in CMP) to participate in buprenorphine waiver training.
Educate OBGYN providers on triggers of prematurity.

**Year 2 (2017):**
Support efforts to Increase waiver training opportunities.
Implement policies and education to nurses, providers to, as well as programs to address prematurity.

**Year 3 (2018):**
Support efforts to Increase waiver training opportunities.
Implement policies and education to RNs, providers to, as well as programs to address prematurity.

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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):**<br>Provide education to MSMH associates about all of these issues to raise awareness. Use newsletters, etc.<br>Educate all OB providers on March of Dimes indicators for Prematurity. Encourage physician participation in waiver training.<br>Offer incentives and referrals.<br>Support application with PCSS-MAT to host another waiver training in 2017 (CME). | **Year 2 (2017):**<br>Provide education to MSMH associates about all of these issues to raise awareness. Use newsletters, etc.<br>Encourage less smoking in patients, increase use of 17P for appropriate patients.<br>Support efforts to host another waiver training. Educate physicians on other opportunities available to become certified (online and/or self-study learning). | **Year 3 (2018):**<br>Provide education to MSMH associates about all of these issues to raise awareness. Use newsletters, etc.<br>Encourage less smoking in patients, increase use of 17P for appropriate patients.<br>Continue to educate on availability of waiver training. |
| **MSMH Resources Necessary:** | **Year 1 (2016):**<br>Dr. Paul Updike<br>ARTC to host training<br>WSL/physician liaison.<br>Identify funds for new providers to become certified. | **Year 2 (2017):**<br>Dr. Paul Updike<br>CHS Legal<br>ARTC/WSL to host training | **Year 3 (2018):**<br>Dr. Paul Updike<br>CHS Legal<br>ARTC/WSL to host training |
| **Collaboration: Who and how each partner will interact to affect the project goal.** | **Year 1 (2016):**<br>Niagara County Human Service agencies – share program information to support target populations. | **Year 2 (2017):**<br>Niagara County Human Service agencies – share program information to support target populations; Catholic Medical Partners.<br>CMP - Help get the word out to physicians on training opportunities and BPPN/UL CHW program.<br>BPPN/UL - Enlist CHWs to provide outreach. | **Year 3 (2018):**<br>Niagara County Human Service agencies – share program information to support target populations; Catholic Medical Partners, - education<br>BPPN/UL - process improvement and feedback |

**Mount St. Mary's Hospital Project 7: Reduce Percentage of Pre-Term Births**

**Designated Mount St. Mary's Project Leaders:** Maryann Cogdill, Director of Maternity Services, Mount St. Mary's Hospital

**NYS Prevention Agenda Link:**
Community response with regard to Access to Affordable Care
Promote Healthy Women, Infants and Children
Improve Health Status and Reduce Disparities
Increase Access to Care with Focus on Poor and Vulnerable communities
Increase Access to High Quality Chronic Disease Preventative Care and Management

**Goal(s) addressing community need:** NYSDOH 13.5% Niagara County. Identify risk factors and community information. Standardization of care or preterm labor and labor assessment tools.

**Project's Target Population** All of the childbearing population in Niagara County, special attention to those in underserved communities.

**Outcome Objectives:** Improve 2018 Niagara County Prevention Agenda (PA) Indicators goals

PA 32 - Percentage of preterm births


PA 32.1 - Premature births: Ratio of Black non-Hispanics to White non-Hispanics


PA 32.2 - Premature births: Ratio of Hispanics to White non-Hispanics


Track percentage of preterm births to reduce from 2016-2018.

**Project Process Measures:**

**Year 1 (2016):** Identify baseline, establish process to communicate/raise awareness among associates and community stakeholders, investigate feasibility for MSM to become site for March of Dimes

**Year 2 (2017):** Review women's services program for opportunities to increase participation/access to services, plan for March of Dimes site designation (pre-term initiative), evaluate other social service programs that could support, consider additional community partners, track monthly metrics.

**Year 3 (2018):** Review program for opportunities to increase participation/access to services, complete work for March of Dimes site designation, evaluate other social service programs that could support, consider additional community partners, track monthly metrics, collaborate with community outreach wellness events.

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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):** Mandatory education for OB providers and nurses on March of Dimes PLAT Program. (PLAT = Preterm Labor Assessment and Treatment). Trinity national standard. | **Year 2 (2017):** 100% audited charts of preterm labor for 100% adherence to national standards. Community education and risk factors identified in community setting. | **Year 3 (2018):** Ongoing community education on preterm labor and identifying preterm risk factor. |
| **CH Resources Necessary:** | **Year 1 (2016):** Netlearning program for providers. | **Year 2 (2017):** Netlearning Program for providers and office practice associates | **Year 3 (2018):** Netlearning Program for providers and office practice associates |
| **Collaboration: Who and how each partner will interact to affect the project goal.** | **Year 1 (2016):** Associates, community stakeholders, medical staff, March of Dimes | **Year 2 (2017):** Associates, community stakeholders, medical staff, March of Dimes, Family & Children's Services of Niagara, Native American community. | **Year 3 (2018):** Associates, community stakeholders, medical staff, March of Dimes, Family & Children's Services of Niagara, Native American community. |

**Mount St. Mary's Hospital Project 8: Pediatric Care Coordination (Mental Health and Substance Abuse)**

**Designated Mount St. Mary's Project Leaders:** Pediatric Care Coordinator at Neighborhood Health Center
Patricia Villani

**NYS Prevention Agenda Link:**
Community response with regard to Access to Affordable Care, Alcohol and Drug Use, and Mental Health Problems
Promote mental, emotional and behavioral well-being in communities
Promote Health Women, Infants and Children
Improve Health Status and Reduce Disparities
Increase Access to Care with Focus on Poor and Vulnerable communities
Increase Access to High Quality Disease Preventative Care and Management

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| **Goal(s) addressing community need:** | Over 40% of children in Niagara Falls live in poverty and consequently are at increased risk of mental illness compared to economically stable peers. In three years, 75% of pediatric and obstetrical patients (1,750 patients) will be screened with an evidence based behavioral health tool. Those identified at low risk will receive brief intervention. Those screened at moderate-high risk will receive linkage and referral to behavioral or substance use treatment services. Patients and their families will also receive human services assessment and linkage to support and improve behavioral health outcomes. |
| **Project's Target Population** | Current Neighborhood Health Center patient base: 1,700 pediatric and 600 OB patients. |
| **Outcome Objectives:** | 75% of patients receive screening, intervention or referral.<br>75% of physicians positively assess model and care delivery.<br>20% of identified patients show improvement. |

| **Project Process Measures:** | **Year 1 (2016):** | **Year 2 (2017):** | **Year 3 (2018):** |
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| | Establish plan with following goals: 1) Integrate early behavioral health screening , intervention and referral into primary and obstetrical care to improve maternal and child health (2) positively affect the family unit and promote healthy behaviors by raising patient awareness and providing support to achieve health outcomes and self-management (3) reduce the stigma associated with seeking mental healthcare by incorporating into primary care setting, identify evidence based screening tool, train associates, EMR/reporting and referral process finalized. | 50% of target patients receive screening and intervention or referral.<br><br>50% of physicians positively assess model and care delivery. | 75% of patients receive screening, intervention or referral.<br><br>75% of physicians positively assess model and care delivery.<br><br>20% of identified patients show improvement. |

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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):**<br>Hire pediatric care coordinator, select screening tool, design screening, risk stratification and referral process, train clinical staff, prepare registry and reporting, engage external treatment providers, design communications. | **Year 2 (2017):**<br>Launch program for eligible patients, provide quarterly reporting, meet regularly with internal and external providers to review outcomes and make adjustments, address project sustainability. | **Year 3 (2018):**<br>Continue program for eligible patients, provide quarterly reporting, meet regularly with internal and external providers to review outcomes and make adjustments, address and facilitate project sustainability. |
| **MSMH Resources Necessary:** | **Year 1 (2016):**<br>Funding,<br>Care Coordinator,<br>IT and Communications resources, NHC & MSM leadership, Laptop and office supplies. | **Year 2 (2017):**<br>Funding,<br>Care Coordinator, IT and Communications resources Community Social Worker, NHC & MSM leadership, office supplies. | **Year 3 (2018):**<br>Funding,<br>Care Coordinator, IT and Communications resources, Community Social Worker, NHC & MSM leadership, office supplies. |
| **Collaboration: Who and how each partner will interact to affect the project goal.** | **Year 1 (2016):**<br>Summit Pediatrics, Dr. Thota – care providers.<br>Catholic Charities, Family Service of Niagara – referral resources. | **Year 2 (2017):**<br>Summit Pediatrics, Dr. Thota – care providers.<br>Catholic Charities, Family Service of Niagara – referral resources. | **Year 3 (2018):**<br>Summit Pediatrics, Dr. Thota – care providers.<br>Catholic Charities, Family Service of Niagara – referral resources. |

**Mount St. Mary's Hospital Project 9: Mental Health First Aid Training**

**Designated Kenmore Mercy Project Leaders:** Bernadette Franjoine and Kerry Caldwell, Mount St. Mary's Hospital
**Catholic Health Leadership Sponsor/Support:** Stephen Marks, [2]VP, Clinical Education and Professional Development; (Phyllis Dunning, DSRIP Director of Clinical Programs)

**NYS Prevention Agenda Link:**
Community response with regard to Access to Affordable Care and Mental Health Problems
Promote Mental Health and Prevent Substance Abuse
Addresses the recommendation for employers, businesses and unions to educate employees about risk factors and warning signs of MEB disorders and ways to access support services through employee health insurance. Mental Health First Aid is recognized by SAHMSA as an evidence-based practice and is on the list of recommended interventions for the NYS prevention agenda goal #2.2 Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.

**Goal(s) addressing community need:**

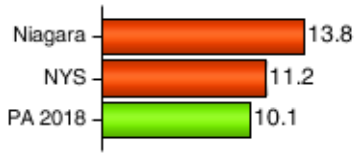
Community Health Needs Assessment Focus Groups identified need for mental health first aid training to help increase awareness and give tools to first line providers, community members, and to help make mental health first aid training as common as CPR training. This ties in strongly with the DSRIP initiatives of promoting Mental Emotional and Behavioral Health, and would align with concerns as identified by Niagara County stakeholder and resident communities.

**Project's Target Population**

Catholic Health Physicians, Nurses, and other front line staff interacting with patients, key community stakeholders (Firefighters, EMS, Catholic Charities, Community Centers, etc.), and general community

**Outcome Objectives:**

PA 42 - Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month




Reduce Niagara County percentage over a 3 year period from 2013-2014.

**Project Process Measures:**

**Year 1 (2016):** Develop Implementation Plan. Identify Mental Health First Aid (MHFA) trainers across Catholic Health.

**Year 2 (2017):** (1) Develop a steering committee (2) Conduct a gap assessment (3) Develop implementation plan.

**Year 3 (2018):** Continue implementation plan.

[2] Updated 03/31/2017

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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):** Identify associates who are certified MHFA trainers. Identify additional community partners (P2 Collaborative, Niagara County Hospitals, and Creating a Healthier Niagara Falls. | **Year 2 (2017):** (1) Participate in steering committee (2) support gap assessment (3) support development of implementation plan. | **Year 3 (2018):** Support implementation plan. |
| **CH Resources Necessary:** | **Year 1 (2016):** none | **Year 2 (2017):** Associate participation on steering committee; other resources to be determined. | **Year 3 (2018):** TBD. |
| **Collaboration: Who and how each partner will interact to affect the project goal.** | **Year 1 (2016):** Clinical Education will identify Community Partners and programs providing MHFA training. | **Year 2 (2017):** Same. | **Year 3 (2018):** Same. |

**Mount St. Mary's Hospital – Niagara County Project 10: Prevent Chronic Disease, Disparity: Mental Hygiene**

**Designated Mount St. Mary's Project Leaders:** Bernadette Franjoine, VP of Mission Integration, Mount St. Mary's Hospital

**NYS Prevention Agenda Link:**
Promote use of evidence- based care to manage chronic disease.

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| **Goal(s) addressing community need:** | Community Health Needs Assessment Focus Groups identified need for mental health first aid training to help increase awareness and give tools to first line providers, community members, and to help make mental health first aid training as common as CPR training. This ties in strongly with the DSRIP initiatives of promoting Mental Emotional and Behavioral Health, and would align with concerns as identified by Niagara County stakeholder and resident communities. |
| **Project's Target Population** | Adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. |
| **Outcome Objectives:** | By December 31, 2018 educate providers/associates and establish programming for adults with arthritis, asthma, cardiovascular disease, or diabetes in partnership with NCDOH to raise awareness regarding educational resources for referral and participation.<br><br>**Reduce Disparity**:<br><br>By December 31, 2018 include evidence-based care for chronic disease prevention and management programs to 80% of individuals with depression |

| **Project Process Measures:** | **Year 1 (2016):** Develop Implementation Plan. | **Year 2 (2017):** educate providers/associates and establish programming for adults with arthritis, asthma, cardiovascular disease, or diabetes in partnership with NCDOH to raise awareness regarding educational resources for referral and participation. | **Year 3 (2018):** educate providers/associates and establish programming for adults with arthritis, asthma, cardiovascular disease, or diabetes in partnership with NCDOH to raise awareness regarding educational resources for referral and participation.<br><br>Include evidence-based care for chronic disease prevention and management programs to 80% of individuals with depression. |
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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):** Educate providers/associates regarding recent studies and data on chronic disease. Reconvene with NCDOH and MSMH Care Management to review NCDOH evidence-based programs and opportunity to reduce re-hospitalization by 3/17. | **Year 2 (2017):** Educate providers/associates regarding recent studies and data on chronic disease.<br><br>Support new Diabetes Educator to establish diabetes education programs, to include gestational diabetic patients. Conduct 2 outreach sessions to community providers and senior centers to inform of program offerings, and to coordinate referral system into Diabetes Education by 12/31/17.<br><br>Partner with NCDOH, Niagara County hospitals and ADA to host diabetes prevention classes at the Neighborhood Health Center by 12/31/17. | **Year 3 (2018):** Educate providers/associates regarding recent studies and data on chronic disease.<br><br>Support new Diabetes Educator to establish diabetes education programs, to include gestational diabetic patients.<br><br>Partner with NCDOH, Niagara County hospitals and ADA to host diabetes prevention classes at the Neighborhood Health Center.<br><br>Continue use of depression screening tool at Article 28 primary care clinics to identify patients with depression through 12/31/18. Increase screening percentage to 80% by 12/31/17 and 90% by 12/31/18. |
| **CH Resources Necessary:** | **Year 1 (2016):** Support for Diabetes Educator | **Year 2 (2017):** Support for Diabetes Educator | **Year 3 (2018):** Support for Diabetes Educator |
| **Collaboration: Who and how each partner will interact to affect the project goal.** | **Year 1 (2016):** Niagara County Department of Health; American Diabetes Association; Neighborhood Health Center. | **Year 2 (2017):** Niagara County Department of Health; American Diabetes Association; Neighborhood Health Center. | **Year 3 (2018):** Niagara County Department of Health; American Diabetes Association; Neighborhood Health Center. |

**Mount St. Mary's Hospital – Niagara County Project 11:**
**Promote Mental Health and Prevent Substance Abuse**

**Designated Mount St. Mary's Project Leaders:** Bernadette Franjoine, VP of Mission Integration, Mount St. Mary's Hospital; Karen Hogan, Clearview Treatment Services

**NYS Prevention Agenda Link:**
Promote Mental, Emotional and Behavioral Health (MEB).
Prevent Substance Abuse
Strengthen Infrastructure

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| **Goal(s) addressing community need:** | Community Health Needs Assessment Focus Groups identified need to advance substance abuse programs and outreach to the general population. | | |
| **Project's Target Population** | General populations, especially those with mental health needs and identified substance abuse problems. | | |
| **Outcome Objectives:** | Provide trauma-informed approach education to Niagara County hospital associates and local community organizations by 12/31/17. Increase number of hospital associates trained to 30% by 12/31/18; Offer appropriate level of mental health services information to 80% of individuals who have positive depression screens by 12/31/18; Increase number of public awareness, outreach and educational efforts to change attitudes, beliefs and norms towards excessive alcohol and prescription opiate use; Support integration of MEB health within chronic disease prevention strategies. Establish MEB stakeholder involvement across Niagara County initiatives by 12/31/17 and increase by 10% by 12/31/18. | | |
| **Project Process Measures:** | **Year 1 (2016):** Develop Implementation Plan. | **Year 2 (2017):** Provide trauma-informed approach education to Niagara County hospital associates and local community organizations; Establish MEB stakeholder involvement across Niagara County. | **Year 3 (2018):** Increase number of hospital associates trained to 30%; Offer appropriate level of mental health services information to 80% of individuals who have positive depression screens; Increase number of public awareness, outreach and educational efforts to change attitudes, beliefs and norms towards excessive alcohol and prescription opiate use; Support integration of MEB health within chronic disease prevention strategies. Increase MEB stakeholder involvement across Niagara County initiatives by 10%. |

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| **Project Interventions / Strategic Activities by year and by site:** | **Year 1 (2016):** Begin organization and planning process | **Year 2 (2017):** Participate in an advisory board with Niagara County Hospitals and evaluate resources.<br><br>Train associates on available mental health services and facilitate patient referrals<br><br>Educate providers/associates on alcohol and substance abuse and host community outreach events<br><br>Provide mental health education materials at 100% of health fairs and events of MSMH<br><br>Add mental health on-site resources at Neighborhood Health Center | **Year 3 (2018):** continue 2017 initiatives and provide mental health education materials at 100% of activities and Neighborhood Health Center |
| **CH Resources Necessary:** | **Year 1 (2016):** Staffing and participation | **Year 2 (2017):** Staffing and participation | **Year 3 (2018):** Staffing and participation |
| **Collaboration: Who and how each partner will interact to affect the project goal.** | **Year 1 (2016):** Niagara County Department of Health; Niagara County hospitals; $P^2$ Collaborative. | **Year 2 (2017):** Niagara County Department of Health; Niagara County hospitals; $P^2$ Collaborative. | **Year 3 (2018):** Niagara County Department of Health; Niagara County hospitals; $P^2$ Collaborative. |

## 2013-16 Implementation Plans

Of those project plans initiated as part of the 2013 CHNA/CHIP process, the following have been incorporated into our normal course of operations and will continue to be supported by Mount St. Mary's Hospital:

### A. Niagara County DOH Collaborative Priorities

#### Shared Priority #1

- Prevent Chronic Disease: increase access to high-quality chronic disease preventive care and management in clinical and community settings.
- Goal: promote use of evidence based care to manage chronic disease
- Disparity: mental health, women

Results

- Eastern Niagara/Lockport Hospital: increase the percentage of adults screened for diabetes in the Hospital's Reflections Recovery Unit by 20%.
- DeGraff Memorial: increase the percentage of women screened for cardiovascular disease at their annual OB/GYN visits from zero to 60%.
- Mount St. Mary's: increase the percentage of adult patients with chronic disease who receive mental health screening at the Neighborhood Health Center from current level of approx. 10% up to 50%. Mount St. Mary's baseline of 18% in January 2014. Achieved a level of 70% in the summer of 2016.
- Niagara Falls Memorial: increase the percentage of adult health home members diagnosed with both schizophrenia and diabetes whose blood glucose is in good control.

MOVING FORWARD:
Mount St. Mary's will continue its screening for mental health on an on-going basis as part of our normal activities at our Neighborhood Health Center and other Primary Care clinics.

#### Shared Priority #2

Promote a Healthy and Safe Environment

- Goal – reduce falls among vulnerable populations

Results

- By December 31, 2017, reduce the rate of fall-related hospitalizations in the population aged 65+ by 10% to achieve a Niagara County rate of 184.1 per 10,000 residents.
- Mount St. Mary's had a baseline of 20.6% in November 2013. With efforts that included community presentations, education to patients and others, in early 2016, the rate was reduced to 19.4%. Although target not achieved, progress has been made and education is part of our on-going, regular process, including changes to our EMR in Primary Care.

MOVING FORWARD:
Mount St. Mary's will continue to make preventing falls among seniors part of our educational outreach initiatives. We have regular outreach at local senior centers and nursing homes where we provide the information on preventing falls. It is also part of our discharge planning for those patients at risk.

## B. Mount St. Mary's Hospital Identified Priorities 2013-2016

CH Assessment of 2013 Community Health Improvement Plan as of September 2016

### Priority 1: Chronic Disease (Cardio/Cancer/Stroke/Diabetes)

#### Provide education and community screenings

Mount St. Mary's will conduct a series of free community screenings throughout the year to address the identified priorities of Chronic Diseases of Cardiology, Cancer and Diabetes.

Tracking (2013 thru 2015)

- BP Screenings increase from 50% to 54%; ACE/ARB increase from 67% to 69%; Lipid Screening saw 204 participants in 2016; PSA Screening saw 159 participants in 2016
- Chest Pain Accreditation saw Door-to-Needle time reduced to 27 minutes
- Smoking Prevention: 100% of patients received smoking assessment and 100% of patients identified as smokers were provided information on NYS Quitline; Quarterly education programs provided

MOVING FORWARD:

Mount St. Mary's will continue its free community screening programs, tobacco education, and has invested in staff persons to provide nutrition and diabetes education.

### Priority 2: Healthy Mothers, Healthy Babies, Healthy Children

#### Improve Birth Outcomes and Educate the Public

Mount St. Mary's conducted a series of community programs throughout the year to address the priorities of Healthy Mothers, Healthy Babies, and Healthy Children

- Coordination of Moms Net™ is a network of agencies that provide education services and referrals to women in Niagara County
- 100% of moms screened for smoking and for Safe Environment/Domestic Violence
- Domestic Violence Training at Neighborhood Health Center
- "Feeling Safe" Domestic Violence Training for MSMH Social Workers
- 100% of patients provided vaccination information at clinic
- Total of elective deliveries <39 weeks = 0 (2014 and 2015)
- Compliance with Handling All Neonatal Deliveries Safely (HANDS) 100% (2014 and 2015)
- Extensive Outreach and Participation for Breastfeeding and Lactation Services, including establishment of a Lactation Room

MOVING FORWARD:

Mount St. Mary's will continue its screening initiatives with moms, continue to implement the HANDS program and has invested in a Lactation Coordinator.

### Priority 3: Concern Physical Activity and Nutrition (Obesity)

#### Decrease Co-Morbidities due to Obesity

Mount St. Mary's conducted a series of community programs throughout the year to address the priorities of Healthy Mothers, Healthy Babies, and Healthy Children

- Education Program Accredited by The American Association of Diabetes Educators; host of monthly Diabetes Support Group; Healthy Eating Program at Neighborhood Health Center (Cooking Demos)
- BMI assessed on 100% of patients
- Coordination of Cardio-Craze Community Wellness Walk 2015 = 180 participants
- CHEERS Program: 97 participants in 2015
- Heart Love & Soul: Care Coordination; Nutritionist; and Health Fairs

MOVING FORWARD:

Mount St. Mary's will continue to provide health information at the Heart, Love and Soul Food Pantry and at other community health fairs and events. The structured CHEERS Program is not being continued.