2014 UPDATE

Catholic Health
Kenmore Mercy Hospital

Community Health Needs Assessment & Community Service Plan

IMPLEMENTATION STRATEGY 2014 – 2016

Catholic Health
Kenmore Mercy Hospital

James Millard
President & CEO
Kenmore Mercy Hospital

November 2014

Dear Community Resident:

As one of the largest health care providers in Western New York, 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 every three years to understand the health concerns and issues faced by community residents. Our strategy for addressing needs identified in the Assessment is included here.

The assessment process is a collaborative effort between Catholic Health and other local organizations concerned about the health of our community, including Catholic Medical Partners, Erie County Department of Health, Buffalo State College, and the University at Buffalo. As part of the assessment, we solicit input from these, and other, community organizations, individuals and groups. The result is a comprehensive review that helps us evaluate the programs and services we offer to address the health and wellness needs of the people who rely on us for care.

The completed assessment provides the framework for our implementation plans which address the identified and prioritized community needs. One of the areas emphasized in our assessment and plan is the need to address health disparities in our community by improving access to care, especially for the poor and underserved. To this end, in 2012, Catholic Health provided more than $60 million in charity care and community benefit for the people of Western New York.

Catholic Health is committed to leading the transformation of health care in our community and to improving the health of its residents, enhancing the experience of patients and reducing the cost of care. Our commitment to quality is demonstrated by our achievement of the highest quality rankings in cardiac, vascular, orthopedics and women's services through government and third-party quality rating agencies. In addition, our commitment to help patients make informed healthcare decisions is evidenced by our recently launched public website, www.knowyourhealthcare.org, which contains important healthcare quality information.

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

James M. Millard

Introduction

This document outlines Catholic Health's Implementation Strategy for improving the health of the population in the community they serve by addressing the priorities identified through the Community Health Needs Assessment.

In 2013, Catholic Health (the System), including Kenmore Mercy Hospital, Mercy Hospital of Buffalo, Sisters of Charity Hospital, and Sisters of Charity Hospital - St. Joseph Campus, jointly, conducted a Community Health Needs Assessment (CHNA) to better understand the health needs of the community they serve and to fulfill the requirements of both the Internal Revenue Service (IRS) and the New York State Department of Health (DOH). To ensure the assessment is comprehensive, input from the public and several community organizations was solicited. As part of this coordinated initiative, the System developed a three-year Implementation Strategy to address the health needs identified in the assessment.

Catholic Health's assessment represents an internal collaboration across its facilities, and collaboration with external organizations in the community, to identify the health needs of the community and develop a strategy for addressing them. The systematic process used helped identify significant health needs across Catholic Health's Erie County service area including among vulnerable and under-represented populations. It also helped identify ways in which continued collaboration could improve patient care, preventive services, overall health, and quality of life.

Building the Groundwork

The 2013 health needs assessment identified a number of unmet or partially met health needs in Erie County. The purpose of this document is to describe how these needs will be addressed over a three-year period. The organizational framework of this Implementation Strategy is built around the New York State Prevention Agenda Priorities.

5 Priority Areas

1. **Improve Health Status and Reduce Disparities**
2. **Prevent Chronic Disease**
3. **Healthy Women, Infants and Children**
4. **Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections**
5. **Promote Mental Health and Prevent Substance Abuse**

Five priority areas, each with multiple focus areas, have been identified (see insert). The Catholic Health response to these focus areas will be guided by the Institute for Healthcare Improvement's Triple Aim, which suggests that improvement in healthcare can be optimized by focusing simultaneously on improving population health, reducing cost and improving the patient experience. [1] Certain themes that are foundational to addressing health needs

[1] http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx, accessed September 11,2013

are repeated throughout the Implementation Strategy. These themes include access to care, hospital readmissions, preventable hospitalization, education, screenings, and primary care.

Each priority area is addressed in conjunction with the hospital's specific programs, resources, and collaborative engagements within the community. Any health needs the hospital does not plan to address at this time are listed with a rationale at the end of this document.

The measures of progress and annual targets for improvement were informed by Healthy People 2020, New York State's Prevention Agenda 2017 Objectives, and internal measures and benchmarks where applicable.

New York State Community Service Plan

In New York State (NYS), all not-for-profit hospitals are required to develop a Community Service Plan (CSP). One of the NYS requirements is that each organization, with the local department of health and other providers in their county, collaboratively choose to work on two New York State Department of Health, Prevention Agenda priority focus areas and address disparities in at least one of them. Catholic Health, including its three hospitals, worked collaboratively with Catholic Medical Partners, Erie County Department of Health, Kaleida Health, Buffalo State College, State University of New York at Buffalo and other local organizations. The two priorities selected collaboratively are listed below. Catholic Health commits to maintaining engagement with local partners throughout the duration of the Implementation Strategy.

Priority #1: Prevent Chronic Disease

Focus Area: Increase access to high-quality chronic disease preventive care and management in both clinical and community settings

Goal: Increase screening rates for cardiovascular disease and diabetes, as well as, for breast, cervical and colorectal cancers, especially among disparate populations

Objective: Increase the percentage of adults (50-75 years) who receive a colorectal cancer screening

Disparity: Provide screening and treatment for lower income patients and those without health insurance

Priority #2: Promote Healthy Women, Infants and Children

Focus Area: Maternal and infant health

Goal: Increase proportion of NYS babies who are breastfed

Objective #1: Increase the percent of infants exclusively breastfed in the hospital

Objective #2: Improve racial, ethnic and economic disparities in breastfeeding rates

Objective #3: Increase the percent of infants ever breastfed in the hospital

Objective #4: Provide private space at each Catholic Health facility for breastfeeding

Disparity: Improve racial, ethnic and economic disparities in breastfeeding rates

Implementation Planning Model

An implementation planning model (illustrated below) was used to chart the goals, objectives and strategies for each health need to be addressed. Within the plan for each priority area, the initiatives planned or action items required are listed. Each plan also shows the measures that will be used to track progress and the annual targets. The individual plans also indicate with which other organizations Catholic Health will collaborate to meet the plan goals.

Monitoring the Implementation Strategy

A dashboard showing implementation plan measures will be used to gauge progress throughout the three-year duration. Catholic Health will maintain engagement with its community partners by establishing work plans for collaborative efforts to achieve annual targets. The Catholic Health Internal Steering Committee will continue to meet to discuss and track progress of the implementation plans and collaborative efforts with community partners. On an annual basis, the objectives and initiatives will be reviewed, appropriate adjustments applied and rolled forward.

2014 Implementation Update

Catholic Health worked with its community partners throughout 2014 on implementation. The Catholic Health Internal Steering Committee met regularly to track the progress of implementation and the collaborative efforts with community partners. Project owners reviewed the implementation plans and provided progress updates. Progress to target for each project is reported beginning on page 7 and following the descriptions of the project. Any adjustments to objectives and initiatives are reflected in this document.

List of Catholic Health Priority Topics and Implementation Plans

A. Improve Health Status and Reduce Health Disparities

1. Physician Recruitment
2. Charity Care / Medicaid
3. Community Health Workers
4. Faith Community Nursing
5. Access to Care in Medically Underserved Areas
6. Community Outreach
7. Preventable Hospitalizations

B. Prevent Chronic Disease

8. Cardiovascular Health – Congestive Heart Failure
9. Stroke – Cerebrovascular Disease
10. Diabetes Mellitus
11. Peripheral Arterial Disease
12. Colorectal Cancer

C. Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections

13. Seasonal Influenza Vaccination
14. House-Wide Central Line-Associated Bloodstream Infections
15. HIV

D. Promote Healthy Women, Infants and Children

16. Breastfed Babies

E. Promote Mental Health and Prevent Substance Abuse

17. Collaborate with Community Mental Health Providers
18. Health Home
19. Integrate Mental Health and Physical Health

Health Needs Priority: Physician Recruitment		
Prevention Agenda Linkage: Improve Health Status and Reduce Health Disparities		
Identified Need: Erie County has a community need for primary care physicians and for many specialty care physicians to adequately service the medical needs of the residents of Erie County. With the implementation of health insurance exchanges in January 2014, there will be an even greater demand for primary care physicians and the subsequent specialty care needed to follow.		
Goals	**Objectives**	**Strategies**
• Increase access to medical care in the community	• Recruit new primary care physicians to Erie County from outside the region • Recruit new specialty care physicians to Erie County from outside the region • Increase mid-level providers system-wide as a complement within our CMP physician practices	• Income Guarantees • Loan Forgiveness • Stipends
Collaboration		
• Catholic Health private practice physicians • Catholic Medical Partner physicians • Other hospital providers in the region to share in the recruitment of unique and/or highly specialized physicians • Catholic Health leadership, hospital and ministry; Catholic Medical Partners leadership		
Initiatives		
• Secure Ministry Leadership support to recruit each year • Source for viable candidates (utilizing internal recruitment staff and external recruitment firms) • Attend physician career fairs and professional meetings to identify viable candidates • Recruit from local residency and fellowship programs • Consider recruitment of Foreign Medical Graduates (FMG) requiring visa support • Consider recruitment incentive packages to recruit physicians to known physician specialties that are underrepresented in WNY		

Measurement	Target 2014	Target 2015	Target 2016
Number of new PCPs to Erie County from outside the region.	1	2	2
Number of new Specialty Care physicians to Erie from outside region.	1	2	2
Number of mid-level providers added to CMP practices.	.5	3	1

TARGET RESULTS KEY: Met or Surpassed 100% | 85% or greater | Less than 85%

Health Needs Priority: Charity Care / Medicaid

Prevention Agenda Linkage: Improve Health Status and Reduce Health Disparities

Identified Need: Assistance for individuals and families in the Catholic Health service area in need of health care services that are without or have limited health insurance coverage.

Goals	Objectives	Strategies
• To provide benefit and access to care to the poor and vulnerable and the broader community within the Catholic Health served community	• Reduction in uninsured patient population with a corresponding increase in patient enrollment in exchange programs and NYS Medicaid	1. Educate staff, volunteers, and members of the community about enrolling uninsured 2. Partner with community groups to help uninsured individuals understand and access their coverage options 3. Inform and educate patients about their eligibility for Healthcare Assistance Program (charity care) 4. Offer Medicaid enrollment assistance 5. Provide clinic services for Medicaid patients 6. Provide health professions education 7. Provide Cash and In-Kind Services to the community served by Catholic Health

Collaboration

- Catholic Medical Partners
- Medicaid via the Department of Social Services
- Catholic Charities, City Mission, Friends of the Night People, Habitat for Humanity, Health Science Charter School, Food Bank and other community groups as needed
- Area educational schools offering licensed clinical programs, including but not limited to the State University of New York at Buffalo, Daemen College, Trocaire, and Niagara University

Initiatives

- Utilize posters, brochures, website and patient bills to provide information about the Healthcare Assistance program (charity care)
- Contracting with Medicaid qualification specialists, working directly with the patients, families and Medicaid via the Department of Social Services to assist in Medicaid enrollment
- Supervision of clinical students at Catholic Health hospitals, clinics, nursing homes, etc.
- Expand enrollment assistance program, with particular focus on obtaining primary care physician services for Medicaid and former uninsured patients
- Automatic enrollment for uninsured patients presenting at Catholic Health hospitals, presumptive eligibility, and unlimited time to appeal for greater benefits and benefits for underinsured patients
- Provide primary care and other services in Catholic Health clinics located in underserved areas
- Transition the current uninsured patient population to insured status through access to exchange plans created by the Affordable Care Act or NYS Medicaid program with an expanded enrollment assistance program replacing the current Medicaid enrollment assistance program
    - As this transition occurs, increase the amount of benefit to the community by increasing other

benefits such as Health Professions Education and Cash and In-Kind Services to provide additional access to care to the Catholic Health served community

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Increase number of Uninsured enrolled in new insurance programs	2,969	Planning Year, Baseline	Increase 2% over 2014	Increase 2% over 2015
Number of uninsured who qualified for charity Care who received Charity Care		New Measure Added for 2015	100%	100%

Health Needs Priority: Community Health Workers (CHW)		
Prevention Agenda Linkage: Improve Health Status and Reduce Health Disparities / Prevent Chronic Diseases		
Identified Need: Access to health care for specific high-risk populations.		
Goals	**Objectives**	**Strategies**
• Increase access to medical services for high-risk population • Provide additional component to care management team as it relates to population management	• Establish objectives as part of development of program	• Plan and implement a Community Health Worker program consistent with population health management • Align the Community Health Worker as part of Care Management team of the designated practice • Work with community organizations on development of certificate program for CHW
Collaboration		
• Working with community sponsors of Community Health Worker training programs		
Initiatives		
• Design Community Health Worker program • Identify at risk population for program pilot • implement Community Health Worker program pilot		

Measurement	Baseline	Target 2014	Target 2015 *	Target 2016
Establish measurement through planning and implementation processes	TBD	Planning	Implemen-tation	

** Implementation will begin in 2015 as part of DSRIP program.*

Health Needs Priority: Faith Community Nursing		
Prevention Agenda Linkage: Improve Health Status and Reduce Health Disparities / Prevent Chronic Diseases		
Identified Need: To identify "at risk" populations and broaden the available services to the parishioners of faith based institutions.		
Goals	**Objectives**	**Strategies**
• Remove barriers to health care • To ensure holistic health and prevention or minimization of illness	• Increase the number of contacts to receive health education, screening and referrals	• Identify and address health concerns of collaborating faith institution contacts • Promote/communicate currently available health care and resources
Collaboration		
• Catholic Medical Partners • Community faith institutions		
Initiatives		
• Maintain formal program, policies and procedures, and implement database for program coordination and tracking • Apply pre- and post-survey of contact health concerns for each new institution • In collaboration with Catholic Health Community Outreach, provide screenings • Offer educational and group support sessions for identified concerns • Provide referral information • make available accurate health information through brochures and other take-a-ways		

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Establish Faith Community Nursing at additional faith institutions	1	Add 1 New Parish	Add 2 New Parishes	Add 2 New Parishes
Increase number of contacts		Establish Baseline	100	100

TARGET RESULTS KEY: Met or Surpassed 100% | 85% or greater | Less than 85%

Health Needs Priority: Access to Care in Medically Underserved Areas		
Prevention Agenda Linkage: Improve Health Status and Reduce Health Disparities		
Identified Need: Urban areas of buffalo have higher incidence of many chronic diseases as well as higher utilization of emergency services for urgent and primary care.		
Goals	**Objectives**	**Strategies**
• Increase access of community to primary care services- primary prevention and secondary prevention • Promote access to evidence-based care to manage chronic disease • Reduce disparity	• Pilot implementation plan in Sisters of Charity Hospital underserved area. Expansion to Kenmore Mercy Hospital underserved area dependent upon success of pilot.	
Collaboration		
Initiatives		

Health Needs Priority: Community Outreach

Prevention Agenda Linkage: Improve Health Status and Reduce Health Disparities / Prevent Chronic Diseases

Identified Need: Access to preventive care, primarily for those who are underserved.

Goals	Objectives	Strategies
• Identify chronic disease and disease states in community members, particularly the underserved through outreach • Provide access in the comfort-zones of our underserved neighbors: churches, community centers, senior groups, shops, neighborhood events	• Increase biometric health screenings in targeted underserved areas • Connect community participants with education and health services in order to manage identified and non-identified health conditions	• Biometric screenings at no cost to the community • Build relationships and partnerships in identified underserved areas • Promote educational opportunities for people with and/or at risk for chronic disease and disease states

Collaboration

- **Collaborate with internal and external service providers and community contacts to offer screenings:**
  - Catholic Medical Partners
  - Erie County Health Department
  - Parish Nurse Association of WNY / Faith Community Nursing
  - American Diabetes Association
  - American Heart Association / American Stroke Association
  - American Cancer Association
  - Partners in Prevention
  - P2 Collaborative
  - Buffalo Prenatal / Perinatal
  - Project Homeless Connect
  - All denominations of faith-based church communities Community groups, senior centers, neighborhood events, various employers and service providers

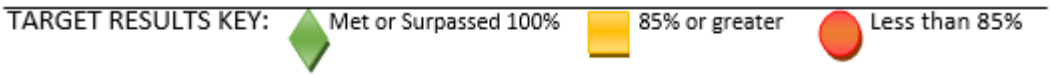
Initiatives

- **Biometric Health Screenings at No Cost to the Community**:
  - Offer blood pressure, cholesterol, BMI, and pulse oximetry screenings
  - Offer Vascular Health, Cancer, Bone Density, Physical Functional and Cardiac Health screenings
  - Individual patient consults with Community Educator RNs, overseeing physicians, clinical techs and RNs
  - Standardized identification and counseling protocols including RN administration of screenings; personalized prevention, management and follow-up recommendations; referral to convenient and available services
  - Standardized education materials used to demonstrate health impact, and are given to patients
  - Refer those with abnormal results and connect those in need of care with services of Catholic Health

- **Community Programs**:
  - Physician, RN and clinical-expert-led classes, workshops and programs
  - Offer at acute and non-acute sites
  - Design topics around service line-identified chronic disease and disease state needs
  - Participate with Project Homeless Connect to provide medical information and services to the impoverished, those that are homeless and those at risk of homelessness
- **Physician Programs:**
  - MD or DO-led classes, workshops and programs designed for PCPs, physician assistants, nurses and mid-level clinical staff
  - Bring evidence-based practice standards to WNY providers, enhance clinician and physician ability to increase access to care for patients
- **Influenza Vaccines**:
  - Vaccines/flu shots at no out-of-pocket cost
  - Offer individual patient consults with Community Educator RNs

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Annual biometric screenings	55% underserved	60% underserved	65% underserved	70% underserved
Community and physician programs: programs, classes and workshop attendance.	5,000	5,000	5,000	5,000

*Underserved: Erie County zip codes with 18%+ households earning income <$20k annually.



Health Needs Priority: Preventable Hospitalizations		
Prevention Agenda Linkage: Improve Health Status and Reduce Health Disparities / Prevent Chronic Diseases		
Identified Need: Better management of pneumonia and urinary tract infections to prevent unnecessary hospitalizations.		
Goals	**Objectives**	**Strategies**
• Reduce the need for inpatient admission for low to moderate bacterial / community acquired pneumonia and low grade urinary tract infections	• Decrease the number of admissions for pneumonia and urinary tract infections	• Adopt community acquired pneumonia guidelines for both inpatient and ambulatory settings • Adopt urinary tract treatment guidelines for both inpatient and ambulatory settings • ER care management at each hospital
Collaboration		
• Collaborate with Catholic Medical Partner physicians to facilitate screening and management • McAuley Seton Homecare to provide care, services for patients who can be managed appropriately and safely in the home environment		
Initiatives		
Practice Guidelines: • Easy access to clinical pathway for management of community acquired pneumonia and urinary tract infections in the hospital, post-acute and home environments **ER Care Management:** • Maintain expanded coverage hours to assist with triaging community acquired pneumonia and urinary tract patients to the appropriate care level **Internal Physician Advisement:** • Services available to provide peer to peer dialogue (MD to MD) relative to treatment options and level of care assignment		

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Reduce community acquired pneumonia inpatient admissions	175	Reduce 5% baseline	Reduce 5% prior year	Reduce 5% prior year
Reduce urinary tract infection inpatient admissions	70	Reduce 5% baseline	Reduce 5% prior year	Reduce 5% prior year

TARGET RESULTS KEY: Met or Surpassed 100% | 85% or greater | Less than 85%

Health Needs Priority: Cardiovascular Health – Congestive Heart Failure (CHF)

Prevention Agenda Linkage: Prevent Chronic Diseases

Identified Need: Significant opportunities continue to exist to educate, treat, and support CHF patients, especially in urban communities, where patients are less complaint with directed medical therapies, and therefore have worse outcomes in key metrics such as mortality and readmission rates.

Goals	Objectives	Strategies
• Reduce preventable hospitalizations through disease management • Provide more comprehensive support and access for urban demographics • Increase access / reduce disparity	• Reduce Readmission Rates • Improve follow up visit compliance to PCP and Cardiology • Provide more comprehensive support in the home environment	• Promote evidence-based care to manage chronic disease • Programs dedicated to patient access to primary care • More comprehensive home care support, patient navigation, and access to community resources • Better mechanisms for education

Collaboration

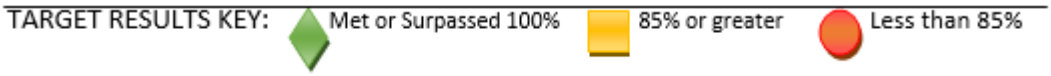
- Catholic Health's CHF team works collaboratively with Catholic Medical Partners Care Coordination programs. The focus of this work is to ensure patients are seamlessly transitioning from CHS facilities to CMP physician offices, and that high risk patients are able to receive additional support in the physician office setting.

Initiatives

- Hospital based nurse practitioner or nurse dedicated to the CHF population, responsible for rounding on all CHF patients, educating patients and bedside nurses, and coordinating patients' care throughout the continuum
- Continuing Care and Home Care specialized programs and staffing to address CHF patient needs in subacute care facilities and within their homes
- Participate in the Get With Guidelines Program with the American Heart Association. This program allows tracking of compliance with evidenced-based guidelines and also see how we compare against other organizations nationally.
  - Maintain "Target Heart Failure – Gold Status" for all hospital campuses per Get With the Guidelines Database
- Identify opportunities to improve support for CHF patients within the Sisters of Charity Hospital service area, as well as in other Urban Communities in WNY

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Reduce all cause CHF readmission rate	18.2%	Reduce 5% of baseline	Reduce 5% of prior year	Reduce 5% of prior year
Scheduled follow up visit with primary care/cardiologist prior to patient leaving hospital	85.9%	>75%	>75%	>90%
Enroll patients that are qualified in a chronic disease management program/palliative care/home MD program			Establish Baseline	*

*Increase over prior year identified using baseline data



Health Needs Priority: Stroke – Cerebrovascular Disease		
Identified Need: The incidence of acute stroke is high in Western New York, the majority of victims do not seek immediate medical attention in time for effective treatment that could reduce the burden of the disease. As a result of the well-documented increases in obesity, poor diet, and sedentary lifestyle of American youth and other stroke risk factors (e.g., diabetes and hypertension), creative intervention is critical to increasing knowledge and health-promoting behaviors. These actions may contribute to the reduction of stroke, the fourth largest killer in the United States and also the primary cause of long-term disability. Stroke survivors and their caregivers face a new set of challenges during the survivor's recovery.		
Goals	**Objectives**	**Strategies**
• Awareness and education regarding prevention strategies for vascular disease • Promote educational opportunities regarding the risk of stroke, how to recognize its symptoms and actions to take when it occurs • Encourage wellness for stroke survivors and their caregivers	• Increase awareness of the signs and symptoms of stroke in children and their parents • Educate children (and parents) about stroke warning signs/symptoms and appropriate emergency response • Increase knowledge of health promoting behaviors among participants • Connect stroke survivors and their caregivers with others in the area	• Use established FAST program: 60-minute program for fifth-grade classes, which includes handouts, a short video showing stroke symptoms, and calling 911. Include pretest for stroke knowledge (warnings signs and call 911) and post-test knowledge • Health Fair and education on making healthy choices • Form a social worker-led stroke support group
Collaboration		
Collaborate with internal and external service providers and community contacts to offer educational program: • Department of Health • Buffalo Area NYSDOH Stroke Centers • Elementary education institutions TBD		
Initiatives		
• Educate students in the signs and symptoms of stroke and what action to take when it occurs • Monthly stroke support group for stroke survivors and caregivers, providing education through expert speakers and facilitating discussion via break-out sessions to assist with decision-making, solving problems and locating resources for survivors and caregivers of those living with the effects of a stroke		

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Number of schools per year to educate	0	Planning	Implementation	3
Students, parents, grandparents, teachers, etc educated	0	Planning	Implementation	TBD
Number of stroke support groups	0	1	2	2

TARGET RESULTS KEY: Met or Surpassed 100% | 85% or greater | Less than 85%

Health Needs Priority: Chronic Disease – Diabetes Mellitus

Prevention Agenda Linkage: Prevent Chronic Diseases

Identified Need: Diabetes is a chronic disease with many high cost complications. The great need is to promote healthy lifestyles, compliance with clinical practice guidelines and improve access to health care services in order to prevent diabetes and delay its progressions once diagnosed.

Goals	Objectives	Strategies
Prevention • Increase early detection, awareness and education regarding risk factors as well as prevention strategies for diabetes Diabetes Management • Provide safe, efficacious glycemic management and self management education throughout the continuum of care Professional Education • Promote healthcare providers knowledge of evidence-based best practice diabetes management	• Increase number of patients attending outpatient and community programming • Increase number of educational offering to healthcare providers • Increase diabetes health screenings in targeted underserved areas • Increase the percent of patients with HbA1c measured in past year • Reduce the average HbA1c • Increase the percent of patients with controlled blood pressure • Increase the number of patients receiving medical nutrition therapy	• Promote educational opportunities for people with and/or at risk for diabetes • Develop educational programs aimed at prevention messages for all age groups including regular physical activity and good nutrition • Diabetes screenings at no cost to the community. • Establish Catholic Medical Partners' Diabetes care management teams in outpatient clinics (care coordinators, Registered Dietitians, Pharmacists and/or CDE's) • Develop and implement programs for healthcare providers designed to increase their awareness of diabetes standards of care and proven methods for diabetes prevention

Collaboration

- Develop collaborative practices with other community healthcare providers and healthcare training programs such as schools of nursing.
  - Catholic Medical Partners
  - Erie County Health Department
  - Parish Nurses
  - American Diabetes Association
  - Schools of Nursing, Medicine, Nutrition/Dietetics
  - Share insulin protocols with Roswell Park Cancer Institute, establishing ongoing relationship
  - Referral of patients in need of interpreter to Jericho Road practice promoting improved diabetes management
- Collaboration with P2 Collaborative to provide a diabetes care coordination initiative

Initiatives

- Standardize method of treatment of patients diagnosed with diabetes across the continuum

Inpatient:

- Diabetes education for inpatients
- Standardize education materials to be used across continuum including CMP offices
- Integrate and standardize policies across hospitals, home care, sub-acute, rehab and continuing care
- Educate healthcare professionals regarding best practice management of patients with diabetes

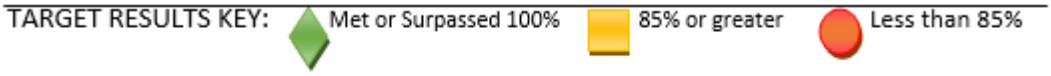
Outpatient:

- Life Skills Diabetes Management education programs
- Individual patient consults as needed with Certified Diabetes Educator (RN, RD)
- Follow-up monitoring of patients attending diabetes management programs
- Integrate Catholic Medical Partners' diabetes care management teams (care coordinators, Registered Dietitians, Pharmacists and/or CDE's) into three Catholic Health Primary Care clinics

Community:

- Community screenings and educational sessions
- Diabetes screening to include glucose, cholesterol and blood pressure assessments
- Health prevention programs for all age groups (MASH camp & health academies)

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Professional educational programs:	19	21	23	25
Expand life-skills classes, including inner-city hospital	28	30	32	34



Health Needs Priority: Peripheral Arterial Disease		
Prevention Agenda Linkage: Prevent Chronic Diseases		
Identified Need: Peripheral Arterial Disease is prevalent in Western New York, which is substantiated by the average rate of 30% abnormal ABI's at our vascular screening events.		
Goals	**Objectives**	**Strategies**
• Identify the onset of disease for individuals or population groups • Reduce the progression and complications of chronic disease • Reduce readmission rates	• Decrease readmission rates due to bypass graft failure/amputation • Decrease the number of readmissions due to advanced disease process, limb ischemia, graft failure • Increase patients enrolled in exercise program for PAD	• Awareness of and participation in prevention and control/self management • Medical management of patients • Referral to the appropriate level of care: exercise program, advanced imaging, vascular interventionalist • Develop multi-disciplinary team care approach
Collaboration		
• Collaborate with Insurance payors to support medical management and aggressive medical management of PAD and PT/Rehab services • Collaborate with PCP's, Physical Therapy, Rehab, Podiatry, Wound Care, vascular Interventionalists to create a standard of care practice		
Initiatives		
• Diabetes and hypertension management • Smoking cessation programs • Develop a multi-disciplinary team to collaborate services and referral base for patients with PAD. • Continue to work with payors to establish reimbursements for services. • Provide education to physicians including evidence based standard of care protocols and PAD program/clinic services available • Develop a PAD Rehab program similar to Cardiac Rehab Program to include exercise and patient education • Increase screening in the PCP's office to identify patients at risk for PAD and refer to the appropriate level of care • Develop referral protocol for inpatients with PAD • Evaluate amputation raters and re-intervention rates on patients enrolled in program		

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Patients enrolled in exercise program for PAD		Planning	Implementation, Baseline	100
Decrease revascularization in the patient population enrolled in program		Planning	Implementation, Baseline	
Decrease amputation rates in the patient population enrolled in program		Planning	Implementation, Baseline	
Increase quality of life for patients enrolled in program (VascuQPL tool)		Planning	Implementation, Baseline	

TARGET RESULTS KEY:  Met or Surpassed 100%  85% or greater  Less than 85%

Health Needs Priority: Colorectal Cancer		
Prevention Agenda Linkage: Prevent Chronic Diseases		
Identified Need: Colorectal Cancer is 4th in the United States in terms of new diagnosis (Prostate, Breast, Lung). It is also one of the most preventable, and when caught in early stages, most "curable".		
Goals	**Objectives**	**Strategies**
• Ensure access to home testing though FIT (Fecal Immunochemical Test) kit or Fecal Occult Blood Test (FOBT) kits at multiple sites of service- Pharmacies, PCC, PCP, Lab centers • Ensure follow up for results- PCP providers, etc.	• Pilot implementation plan in Sisters of Charity Hospital underserved area	
Collaboration		
Initiatives		

Health Needs Priority: Season Influenza Vaccination

Prevention Agenda Linkage: Prevent Vaccine Preventable Diseases

Identified Need: In compliance with the New York State Department of Health (DOH) new regulation requiring personnel in regulated settings, including but not limited to: hospitals, nursing homes, diagnostic and treatment centers, home care agencies and hospices, who have not received a flu vaccination to wear a surgical or procedure mask in areas where patients may be present.
Recognizing that health care worker vaccination rates are typically below recommended levels, requiring masks for unvaccinated workers will provide an important layer of protection against influenza transmission.

Goals	Objectives	Strategies
• Reduce preventable Healthcare - acquired flu transmissions amongst health care workers and patients at CHS	• Increase % flu vaccines given to Health care workers at CHS pursuant to DOH regulation and CH policy	• Promote health care workers to receive flu vaccine • Mandatory Mask usage by all associates who perform patient care and work in patient care areas who do not receive flu vaccine

Collaboration:

- New York State Department of Health
- Center for Disease Control

Initiatives

- Annual flu shot clinics for CHS workers
- ID Badge indicator for non-immunized workers
- Mandatory mask usage by all non-immunized workers performing patient care or while in patient care areas
  - The regulatory requirement that health care workers wear masks will be in effect during the time when influenza is categorized as prevalent in New York State as determined by the State Health Commissioner

Measurement	Baseline	Target 2013-2014 Flu Season	Target 2014-2015	Target 2015-2016	Reference
Increase percentage of employees vaccinated for seasonal flu	49.0%	Increase 25% baseline	Increase 15% 2013-14 season	Increase 10% 2014-15 season	NYSDOH

TARGET RESULTS KEY: Met or Surpassed 100% | 85% or greater | Less than 85%

Health Needs Priority: House-wide central line-associated bloodstream infections (CLABSIs)		
Prevention Agenda Linkage: Prevent Healthcare-Associated Infections		
Identified Need: Central line-associated bloodstream infections (CLABSIs) result in thousands of deaths each year and billions of dollars in added costs to the U.S. healthcare system, yet these infections are preventable.		
Goals	**Objectives**	**Strategies**
• Prevent HA Central Line blood stream infections system wide	• Reduce hospital acquired central line blood stream infections system wide	• Use CDC-recommended infection control steps every time a central line is put in and used • Remove central lines as soon as they are no longer needed • Recognize staff members or units that work hard to prevent central line infections
Collaboration		
• National Health Safety Network • CDC • Partnership For Patients • NYSDOH		
Initiatives		
Follow recommended central line insertion practices to prevent infection when the central line is placed, including: • Perform hand hygiene • Apply appropriate skin antiseptic • Ensure that the skin prep agent has completely dried before inserting the central line • Use all five maximal sterile barrier precautions: 1. Sterile gloves 2. Sterile gown 3. Cap 4. Mask 5. Large sterile drape Once the central line is in place: • Follow recommended central line maintenance practices • Wash their hands with soap and water or an alcohol-based hand rub before and after touching the line • Remove a central line as soon as it is no longer needed. The sooner a catheter is removed, the less likely the chance of infection		

Measurement	Baseline	Target 2014	Target 2015	Target 2016	Reference
Percent reduction of CLABSI	2	Maintain	Maintain	Maintain	NHSN CDC, NYSDOH 1.00

TARGET RESULTS KEY: Met or Surpassed 100% | 85% or greater | Less than 85%

Health Needs Priority: HIV

Prevention Agenda Linkage: Prevent HIV

Identified Need: In September 2010, the NYS Legislature passed the Amended HIV Testing Law and in November, 2011 the NYS Department of Health promulgated regulations to address the following key facts: Thousands of HIV-positive New Yorkers are unaware that they are living with HIV.

People living with HIV too often learn of their diagnosis late in disease progression. For example, 33% of newly diagnosed HIV cases already have or will have an AIDS diagnosis within one year. It may take ten or more years to develop AIDS.

Goals	Objectives	Strategies
• Early detection of patients with HIV	• Assure that patients consenting to HIV testing receive testing and subsequent results	• Offer HIV test to all individuals between the ages of 13 and 64 and provide results in accordance with New York State testing law

Collaboration

- Erie County Medical Center
- New York State Department of Health

Initiatives

- All individuals between the ages of 13 and 64 must be offered a HIV test in accordance with NYS guidelines for HIV testing when, a patient in the emergency room, admitted as an in-patient and seen in a primary care clinic associated with the hospital
- If test results are positive the patient will be contacted and be required to meet with a Catholic Health Associate who will explain the results and set up an appointment for follow-up treatment and community linkage
- If test results are negative the results will be mailed to the patient at the address they supplied during registration

Measurement	Baseline	Target 2014	Target 2015	Target 2016	Reference
All patients consenting to HIV test receives results	95%	100%	100%	100%	NYS

TARGET RESULTS KEY: Met or Surpassed 100% | 85% or greater | Less than 85%

Health Needs Priority: Breastfed Babies

Prevention Agenda Linkage: Promote Healthy Women, Infants, and Children

Identified Need: Increase ability for women in WNY (including patients, associates, guests, etc.) to be supported while breastfeeding. Includes actually breastfeeding baby as well as expressing breast milk as needed.

Goals	Objectives	Strategies
• Increase the proportion of NYS babies who are breastfed • Reduce disparity of breastfed babies exclusively in the hospital	• Increase % of infants exclusively breastfed in the hospital • Increase the black/Hispanic/Medicaid ratios of infants exclusively breastfed in the hospital • Increase % of infants ever breastfed in the hospital • Identified lactation room in every Catholic Health facility	• Continue drop-in access for breastfeeding moms in need of support from Certified Lactation Consultant nurses • Increase the awareness of the benefits of breastfeeding • Educate Catholic Health employees regarding the breastfeeding initiatives • Consider Baby Friendly Hospital designation –no formula • Provide private space at each Catholic Health facility for breastfeeding

Collaboration:

- Erie County Department of Health
- United Way of Buffalo and Erie County
- Neighborhood Health Centers
- Community Health Center of Buffalo
- Catholic Medical Partners providers
- Collaborate with WIC to support breastfeeding initiatives
- Peer counselors

Initiatives

- Continue Baby Café after grant funding expires
- Maintain breastfeeding in CH Mandatory educational information and orientation
- Have designated room (private, quieter, with sink – not restroom) for breastfeeding moms to use to express milk at each CH site (27+ locations) with signage at each site, all staff aware
- Identify site contact at each CHS site to learn about and share info on Breastfeeding initiatives
- Continuing Education Available for Certified Lactation and Internationally Board Certified Lactation Consultants
- Billing for Lactation work on each post partum floor/NICU
- Provide evidenced based literature and packets to physicians in CMP to become Baby Friendly

Measurement	Baseline	Target 2014	Target 2015	Target 2016	Reference
Lactation Rooms		50%	75%	100%	

TARGET RESULTS KEY: Met or Surpassed 100% | 85% or greater | Less than 85%

Health Needs Priority: Collaborate with Community Mental Health Providers		
Prevention Agenda Linkage: Promote Mental Health and Prevent Substance Abuse		
Identified Need: Concern of lack of physical health care integration with mental health care was discussed at both the Catholic Health group interviews and the Erie County Department of Health community meeting.		
Goals	**Objectives**	**Strategies**
• Support collaboration among leaders, professionals and community members working in mental, emotional and behavioral (MEB) health promotion, substance abuse and chronic disease prevention, treatment and recovery • Strengthen the infrastructure across physical and mental health systems to integrate total care for patients	• Improve MEB health diagnosis and treatment of patients who present in our ED and offer them follow-up services as quickly as possible	• Develop a crisis and ED intervention diversion program
Collaboration:		
• BryLin Hospital • Office of Mental Health • Spectrum Human Services		
Initiatives		
• OMH to approve Spectrum's mobile clinic • Spectrum providers to get credentialed • Managed Care Organizations to recognize service and agree to reimbursement rate • Establish 24/7 on-call phone number for EDE staff to call when patient presents • Set up reporting to monitor program		

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Number of calls to Spectrum Human Services for crisis intervention consult in ED	TBD		Planning	Implementation / Develop Baseline

Health Needs Priority: Health Home

Prevention Agenda Linkage: Promote Mental Health and Prevent Substance Abuse

Identified Need: Medicaid patients with complex medical, behavioral, and long-term care needs tend to be high utilizers of high cost services. Helping them appropriately access and manage these services, through improved care coordination and service integration, is essential to controlling future health care costs and improving health outcomes for this Medicaid population.

Goals	Objectives	Strategies
• Support collaboration among leaders, professionals and community members working in mental, emotional and behavioral (MEB) health promotion, substance abuse and chronic disease prevention, treatment and recovery • Reduce preventable hospitalizations and emergency department utilization • Prevent or delay the onset of disease • Improve outcomes for persons with mental illness and/or substance abuse	• Increase Health Home new patients • Decrease the number of hospital readmissions and emergency department utilization • Increase screening for clinical depression • Initiation and engagement of alcohol and other drug dependent treatment	• Implement evidence-based interventions for the prevention, detection and management of disease • Collaborate with complementary community providers to improve care coordination • Follow up after hospitalization for mental illness

Collaboration:

- Spectrum Human Services
- Evergreen Services
- 300 network providers in Erie County and 200 in Niagara County including hospitals, housing, transportation and dentists

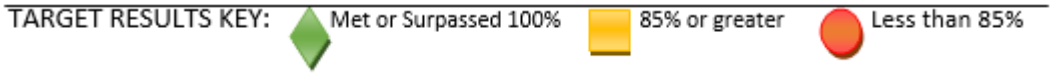
Initiatives

- Establish communication between Health Home Care Coordinators and Catholic Medical Partners office Care Coordinators to conduct case conferences regarding clients
- In 2015, fully implement GSI reporting features related to Population Manager
- In 2015, expand population served to include:
  - Dually eligible
  - Community referrals with emphasis on working with Catholic Health hospital clinics and hospital emergency departments, Catholic Medical Partners offices and Catholic Health case managers
- In 2015, Health Home will work with hospitals to create process and reports to communicate between the organizations when a Health Home patient shows in the emergency department, clinic or inpatient
- Continue to monitor screening for depression and quality regarding follow up plan
- In 2015 and 2016, develop next phase of work plan based on DSRIP projects

Measurement	Baseline	Target 2014	Target 2015	Target 2016	Reference
Increase enrollees	100	150	Increase 20% of 2014	Increase 20% of 2015	
Reduce preventable hospitalizations			Establish baseline based on CMART data results	*	Adult Core Set, HEDIS
Reduce emergency department utilization			Establish baseline based on CMART data results	*	Adult Core Set, HEDIS
Improve percentage of patients aged 18+ screened for clinical depression using standardized tool (PHQ-9) and follow up documented		95%	95%	95%	PQRS, CMS QIP, Medicare Shared Savings Program, Medicaid Adult Core Set, Meaningful Use II
Improve percentage of adolescents and adult members with a new episode of alcohol or other drug dependence who received one of the following: initiation of AOD (alcohol or other drug dependence) treatment or engagement of AOD treatment.			Establish Baseline	*	Meaningful Use I, II, Medicaid Adult Core Set, HEDIS

HH-CMART = Health Home Care Management Reporting Tool

* Increase over prior year identified using baseline data



Health Needs Priority: Integrate Mental and Physical Health

Prevention Agenda Linkage: Promote Mental Health and Prevent Substance Abuse

Identified Need: Concern of lack of physical health care integration with mental health care was discussed at both the Catholic Health group interviews and the Erie County Department of Health community meeting.

Goals	Objectives	Strategies
• Integrate mental, emotional and behavioral (MEB) disorder screening and treatment into primary care	• Identify behavioral diagnosis early to promote rapid treatment • Ensure compatibility of medical and behavioral health treatments • De-stigmatize treatment for behavioral health diagnosis	• Integration of behavioral health specialists into the primary care coordination team. • Pilot co-location of behavioral and primary care based on review of integration and patient/practice needs

Collaboration:

- Catholic Charities Monsignor Carr Institute
- Horizon Health Services
- Spectrum Human Services
- Lake Shore Behavioral Health
- Mid-Erie Counseling & Treatment Services

Initiatives

- Build mental health and substance abuse screening into patients' annual PCP visits with referral agreements between PCP and BH providers with rapid access and collaborative care plans
- Provide improved patient education, engagement and medication compliance with embedded nurse care managers
- Utilize Community Health Worker for patient follow-up
- Implement the Collaborative Care Model with integrated nurse care managers in BH settings linked to KenTon PCPs in a team approach to monitor patient outcomes and make interventions
- Based on patient/practice needs and integration model assessment, pilot co-location of behavioral and primary care

Measurement	Baseline	Target 2014	Target 2015	Target 2016
Mental health and substance abuse screening at annual PCP visit with referrals, as appropriate, to BH providers.		Measure changed to align with DSRIP initiative	450	900

Significant Needs Not Directly Addressed

Promote a Healthy and Safe Environment
Through the needs assessment, numerous areas were identified as important and clearly impact the health of the community. Catholic Health identified the "significant" needs as the New York State Department of Health Prevention Agenda priorities. Within the "priorities", Catholic Health will address numerous health needs.

There is one priority area, Promote a Healthy and Safe Environment, that through the process was prioritized lower, lack available funds factored in after consideration for the other needs that will be addressed, and potential for less impact by Catholic Health, is the one area not addressed in the implementation plan. Although, should opportunity arise, with resources available to effectively address this need, Catholic Health will reconsider for incorporation in the future.