Catholic Medical Center

Community Health Implementation Plan

October 2013

Introduction

The Affordable Care Act of 2010 requires all not-for-profit hospitals to conduct a Community Health Needs Assessment every three years. To better serve their communities as well as meet the requirements, Catholic Medical Center (CMC) and Elliot Health System (the Elliot) partnered to conduct the assessment. The hospitals are now using that information to create Community Health Implementation Plans (CHIP) to address the needs identified through this process.

This CHIP covers the Manchester Health Service Area (HSA) which is defined by the New Hampshire Department of Health and Human Services and includes the towns of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, New Boston, and the City of Manchester. The residents of these towns receive most of their health care from Catholic Medical Center and Elliot Hospital.

The population of the Manchester HSA is growing in size and is increasingly multicultural, with residents reflecting a variety of nationalities and languages. Although predominantly Caucasian, there has been an influx of refugees in the City of Manchester in the last several years as part of the New Hampshire Refugee Resettlement Program. Refugees have come to New Hampshire from more than 30 nations and represent a diverse group of ethnic minorities.

Another factor of the HSA is that the population is aging. The number of adults age 65 and older is expected to increase 18% through the year 2018, with many of the towns within this HSA experiencing over 30% growth in this age group. The Demographics section of this report includes more detail of this significant statistic.

Catholic Medical Center

Catholic Medical Center is a licensed acute care hospital and healthcare organization offering a wide variety of healthcare services in a highly technical and mission-oriented environment. Our history is rich with religious connection and commitment to the well-being of the human race, and we work hard to evolve to meet and exceed patient expectations.

Mission:
"The heart of Catholic Medical Center is to provide health, healing and hope in a manner that offers innovative high quality services, compassion, and respect for the human dignity of every individual who seeks or needs our care as part of Christ's healing ministry through the Catholic Church."

Along with the usual in-patient services, Catholic Medical Center also offers many other services including: Behavioral Health Services, Breast Care Center, Cancer Care, Cholesterol Management Center, Community Health Services, Diabetes Resources Institute, Diagnostic Imaging, Emergency Department, Laboratory, The Mom's Place, New England Heart Institute, New England Sleep, Center, Obesity Treatment Center, Primary Care Physicians and Locations,

Rehabilitation Services, Respiratory Services, Surgical Care Group, Urgent Care at Bedford, The Wellness Center, Wound Care Center.

Community Information

The 2013 Community Health Needs Assessment focused on the Health Service Area (HSA) of Greater Manchester, a market which is primarily served by Catholic Medical Center and Elliot Hospital. The Manchester HSA is home to approximately 180,000 residents and is comprised of the towns of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, New Boston as well as the City of Manchester. These towns are located in three different counties (Hillsborough, Rockingham and Merrimack) within the State of New Hampshire with 60% of the residents of the HSA living within the City of Manchester.

The population of the Manchester HSA is changing; not only is it aging, it is becoming increasingly multicultural with residents reflecting a variety of nationalities, languages, ethnic traditions, religious beliefs and ideologies.

The 65+ population within the HSA is projected to realize an 18% growth through 2018 and many other towns within the HSA will experience over 30% growth in the 65+ age group. This is significant given a 2012 report from the University of New Hampshire Carsey Institute which notes that the aging population will increase the cost of providing state and local services.

The majority of racial and ethnic diversity within the Manchester HSA is within the City of Manchester, as the city has nearly 84% of the minority population in the Manchester HSA residing within its city boundaries. Of the 18,943 Hispanics within the Manchester HSA, just over 88% reside within the City of Manchester.

The changing diversity of the City of Manchester is partly the result of the city being a site for refugee resettlement. Over the past five years Manchester received over 2,100 refugees, this is more than any other city or town within the state.

One resulting effect of the increase in refugees is that over 70 languages are now spoken in the Manchester School System. Over the past five years, an average of about 1,000 students in the Manchester School System are considered to have Limited English Proficiency (LEP). A person with LEP may have difficulty speaking or reading English and thus have difficulty communicating effectively in school.

The median household income for the City of Manchester is $53,278. This is significantly lower than all others towns within the Manchester HSA and is also lower than the median household income for the state, which is $64,664.

Similar to the median household income statistics, the City of Manchester has a significantly higher percent of individuals and families living below poverty, 10.2% and 13.8%, respectively. Since poverty is highly associated with increased health risk behaviors, low educational

attainment, poor health status, unemployment, and a lower self-reported quality of life, it is a significant trend.

A measurement of the continued increase in youth poverty is the number of students enrolled in Free/Reduced Meal Plans in schools. A student who is eligible for free meal enrollment must come from a household where the total annual income per family falls below 130% of the federal poverty guidelines (i.e. for a family of four, this would equate to $29,965 or less annually). For a student to be eligible for reduced meal enrollment, the total annual household income per family must fall below 185% of the federal poverty guidelines (i.e. for a family of four, this would equate to $42,643 or less). Over 50% of Manchester students are enrolled in the Free and Reduced Meal programs and of those, 90% are receiving free meals while only 10% are receiving reduced cost meals. This means that over 7,100 students and their families are living at or below 130% of the poverty level in the Manchester School District. This impoverished population is larger than the entire population in some towns within the Manchester HSA and state.

During the 2011-2012 school year, the Manchester School District identified 1,115 students who were homeless, representing more than 7% of the total student population. Although it is challenging to estimate the adult homeless population in the City of Manchester due to a number of factors, in the survey conducted with community members within the Manchester HSA, homelessness ranked in the top ten of community concerns. Many survey respondents noted the increasing presence of homeless people and saw this as an emerging issue and trend.

Needs Assessment Summary

The Manchester HSA Community Health Needs Assessment conducted by Catholic Medical Center and the Elliot Health System, with the assistance of the Manchester Health Department, was completed in June 2013. The assessment began with a review of the 2009 Community Health Needs Assessment, *Believe in a Healthy Community*.

A variety of different secondary data sources were accessed. They included the Centers for Disease Control and Prevention (CDC), New Hampshire Department of Health and Human Services, NH HealthWRQS and the City of Manchester Department of Health. A detailed list of data sources can be found in Appendix A of the Greater Manchester Community Health Needs Assessment 2013.

Healthy People 2020 (HP 2020) is a CDC initiative to track health behaviors and trends across the country. Part of this program is the creation of health related targets and goals that communities and states strive to meet. This report utilized as many of those targets as were available and applicable.

During March, April and May of 2013, the hospitals also conducted seven focus groups which included clergy, first responders, pregnant women, school nurses, Bhutanese refugees as well as two seniors groups. Due to concerns on the part of many participants, anonymity was

guaranteed and hence, they will not be listed by name in the appendix. A group discussion was conducted on March 25, 2013 with members of the Manchester Sustainable Access Project which included the Public Health and Deputy Public Health Directors, Manchester Health Department; the President, Mental Health Center of Greater Manchester; the Chief Medical Officer, Catholic Medical Center, Executive Director, Community Health Services, Catholic Medical Center; Vice President of Planning and Business Development, Elliot Health System and the Medical Director, Dartmouth-Hitchcock Manchester Clinic. (See Appendix B of the Greater Manchester Community Needs Assessment for the detailed list). The focus and discussion group attendees will often be referred to as 'community members' in this report.

During this same period of time, a survey was distributed to seniors at the Manchester Senior Center, the Rotary and the clients, patients, and staff at The Mental Health Center of Greater Manchester, with 50 responses being returned.

Identified Needs

- Behavioral Health Issues: mental health services and access, substance abuse – specifically illicit drug use and tobacco use
- Obesity: diabetes, poor eating habits, lack of physical activity
- Aging Issues: stroke, Alzheimer's, pneumonia, transportation, medication coordination, caregiver support, inadequate out of home care
- Chronic disease: heart disease, cancer, COPD, asthma
- Ambulatory Care Sensitive Conditions – marker for lack of adequate preventive care: need care coordination
- Barriers to access of health care services related to poverty: lack of insurance, cost, transportation, lack of information on how to access care and what services are available if uninsured, language, lack of a medical home
- Teen Pregnancy
- STD's: specifically chlamydia
- Dental services/access: specifically for adults
- Violence & Crime: neglect and abuse, safe neighborhoods, suicide, youth crime

Needs to be Addressed by Catholic Medical Center

At CMC, the primary care practices are evolving to the Patient Centered Medical Home Model or PCMH. The Medical Home is an approach to providing comprehensive primary care for children, adolescents, and adults. The PCMH is team-based and focused on maximizing the quality of care patients receive. It also seeks to improve the coordination of care and to foster a relationship of trust between patients and their providers.

CMC is taking a proactive approach to preventative medicine by introducing Care Coordinators to the Primary Care practices. Clinical resource specialists will work with the practices most high risk patients to assure they understand their medications and follow-up care. They will develop relationships with the patients by having ongoing conversations with them, answering their questions, discussing their concerns and helping to prevent unnecessary emergency room visits that can end up costing these patients a lot of money. The patient centered model encourages active participation and partnering with patients to help manage and to improve the quality of their lives.

The benefits of the medical home is that patient care will become proactive, comprehensive and committed to keeping patients educated and engaged in their personal care plans. It will promote early prevention, and build a trusted partnership between the patient, their doctor and the patient's care team.

The implementation of the Medical Home Model within CMC's practices is an important step in addressing at least three of the needs identified in the 2013 Greater Manchester Community Needs Assessment: Chronic disease, Ambulatory Care Sensitive Conditions, Barriers to access of health care services related to poverty and will potentially impact some of the Obesity issues as well. This is documented in the following implementation plan.

Need #1 –

A) **Behavioral Health: Mental health access and services; Substance abuse-specifically illicit drug use and tobacco use**
B) **Violence and crime: Neglect and abuse, safe neighborhoods, suicide, youth crime**

Because mental illness is often intrinsically entwined with violence and crime, Catholic Medical Center has decided to combine these two identified needs.

Strategies:

The West Side Neighborhood Health Center at CMC will expand mental health services to patients of the Pregnancy Care Center.

Patients at the Pregnancy Care Center who choose a primary care provider at the West Side Neighborhood Health Center will have access to the Behavioral Health Services provided by the APRN on site.

Psychiatric illness in the mother may cause significant morbidity for both the mother and her child. Depression and anxiety during pregnancy have been associated with a variety of adverse pregnancy outcomes. Women who suffer from psychiatric illness during pregnancy are less likely to receive adequate prenatal care and are more likely to use alcohol, tobacco, and other substances known to adversely affect pregnancy outcomes. Other adverse affects in children born to depressed mothers include low birth weight, fetal growth retardation and preterm delivery. During the postpartum period, about

85% of women experience some type of mood disturbance of which 10 to 15% develop more significant symptoms of depression or anxiety.

A thorough risk/benefit analysis of pregnant women with psychiatric illness, including evaluating the impact of untreated illness on the baby and the mother, as well as the risks of using medication during pregnancy is extremely important. Providing mental health services to mothers will have a positive impact on both the mother and child.

Anticipated Impact: Increased identification and treatment of women who suffer from psychiatric illness during and after pregnancy, resulting in more adequate prenatal and postpartum care, a reduction in the use of alcohol, tobacco, and other substances by the mother, and a reduction in the adverse affects to the child.

Plan to Evaluate Impact: Monitor the number of patients from the Pregnancy Care Center who are referred and treated for behavioral health conditions at WSNHC.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Mental Health Center of Greater Manchester, Pregnancy Care Center.

CMC's Health Care for the Homeless program will provide mental health services and substance abuse counseling for the homeless in Manchester.

Health Care for the Homeless Manchester, also known as the Mobile Community Health Team at Catholic Medical Center, has been addressing the multi-faceted health needs of homeless men, women, children, teens and families in Manchester, since 1988. The estimated 1700 homeless in Manchester struggle daily with abject poverty, unemployment and lack of affordable housing. As patients, they suffer common health problems, exacerbated by years of medical neglect, lack of access to care, malnutrition, and exposure to communicable disease. They often harbor a tri-morbidity of co-occurring medical, mental health and addiction disorders. Comprehensive medical, nursing, and behavioral health care as well as addiction counseling, is offered daily at shelters in Manchester by the Health Care for the Homeless case management team. This program will continue with the same level of support and commitment.

Anticipated Impact: Increase in the number of homeless patients being screened for mental illness and addiction and referred for treatment.

Plan to Evaluate Impact: Monitor to assure 90% of patients receiving care through the Health Care for Homeless Program are screened for mental illness and addiction, and referred to appropriate services.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Serenity Place, Farnum Center, Keystone Hall, Phoenix House, (addiction treatment programs), Mental Health Center of Greater Manchester, V.A. Medical Center, Manchester Health Department.

Explore expanding the mental health assessment section of the patient risk questionnaire used in our primary care practices to improve early identification and treatment of mental illness.

For people of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience mental health problems.

CMC will research mental health screening tools being used in primary care settings around the nation to determine if the current screening tool used in CMC primary care practices can be enhanced.

Anticipated Impact: Impact will be determined once screening tool is decided upon.

Plan to Evaluate Impact: Evaluation will be established when the screening tool is implemented.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Need #2 –

Obesity: Diabetes, poor eating habits, lack of physical activity

Strategies:

CMC will participate in the Manchester Collaborative for Healthy Living, a collaborative effort between the Manchester Health Department and various agencies in the city of Manchester.

This committee will focus on the development of a community-based, organizational campaign to reduce sugar sweetened beverage promotion.

Anticipated Impact: Reduction in the promotion and consumption of sweetened beverages at participating organizations.

Plan to Evaluate Impact: Monitor promotion and sales of sweetened beverages to determine impact of program.

Resources the Hospital Plans to commit: Staff time.

Collaborations: Manchester Health Department, Minority Health Coalition, Anthem, American Heart Association, American Cancer Society, Breathe NH.

Explore the development and implementation of a fruit and vegetable prescription program with our Primary Care Practices

Providers will "prescribe" a determined number of servings of fruit and vegetables each day. CMC will explore collaboration with the Manchester Health Department and local farmers markets for discounted purchases of fruits and vegetables when a patient shows a prescription.

The program will foster collaboration between CMC, the Manchester Health Department and local farmers, to promote increased consumption of fruits and vegetables, and improved health among community members.

Anticipated Impact: Impact will be determined once program feasibility is ascertained and subsequent development and implementation is completed.

Plan to Evaluate Impact: Evaluation will be established when the program is implemented.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Manchester Health Dept., local farmers markets.

Need #3 –

Aging Issues: Stroke, Alzheimer's, pneumonia, transportation, medication coordination, caregiver support, inadequate home care

Strategies:

CMC's Parish Nurse Program will provide nursing consultations and screenings at parishes throughout the Greater Manchester Area.

Members of a number of churches in the Manchester area have access to a registered nurse for health and wellness consultations, through CMC's Parish Nurse Program. Parish nurses promote wellness by addressing the physical, emotional and spiritual needs of members.

This program offers a range of health education programs and screenings. Parish nurses may refer members to appropriate resources for additional care, which can result in earlier intervention and improved access to health care.

The parish nurse develops or secures support services for parish members and advocates for the needs of the underserved members of the community. Congregation members also utilize their talents in health-related programs that promote wellness as a vital part of the church's healing ministry.

Anticipated Impact: Community members have access to parish nurses at locations throughout the community for consultation to address physical, emotional and spiritual needs.

Plan to Evaluate Impact: A methodology of tracking the number of referrals and follow-through is being developed in order to capture the effectiveness of this program.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: 17 Community Parishes.

CMC will review our current patient transportation services to determine if there is additional demand for services by our patient population to improve access to care.

CMC's Patient Transport Service provides transportation for patients to and from CMC providers. In FY13, transportation was provided for patients on 5,405 occasions. In addition, CMC provided 602 Taxi vouchers to CMC patients. CMC will examine the current demand for services to determine if there is additional need.

Anticipated Impact: Impact will be determined once it is ascertained whether there is additional demand for services.

Plan to Evaluate Impact: Evaluation will be established when the review is completed.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Need #4 –

Chronic disease: Heart disease, cancer, COPD, asthma

Strategies:

CMC to expand the Medical Home Model to all PCP practices within the next 2 years.

See pages 5 & 6 for the description of the Medical Home Model that will be implemented to help address this need.

Anticipated Impact: Patient care will become proactive, comprehensive and committed to keeping patients educated and engaged in their personal care plans and chronic disease management. It will promote early prevention, and build a trusted partnership between the patient, their doctor and the patient's care team.

Plan to Evaluate Impact: Monitor CMC practices to assure 100% adopt Medical Home Model within the next two years. Monitor quality indicators as established by third party payers, National Quality Foundation, Health Care Effectiveness Data and Information Set (HEDIS), etc. to evaluate the quality of health of the patient population.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

CMC Primary Care Practices will set up the Electronic Medical Record (EMR) to prompt providers to provide Smoking Quit Kits to all patients who are smokers.

This model was successfully implemented for inpatients and will be expanded to include CMC's primary care practices. This will provide the patient with resources for tobacco cessation, as well as education on the risks of smoking and the benefits of quitting.

Anticipated Impact: Increase in smoking cessation resulting in fewer smokers.

Plan to Evaluate Impact: Monitor the number of kits distributed. A review of the linkage between patients identified to receive kits and whether they self report having quit smoking as a result.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Breathe New Hampshire.

CMC will provide free Chronic Disease Self Management classes throughout the year to community members.

Chronic Disease Self Management classes provide patients with the skills needed to better manage a chronic condition. These educational programs will provide information on adopting healthy lifestyle behaviors, communicating with the healthcare team, problem solving, and goal setting.

Anticipated Impact: Community members will develop the skills needed to better manage a chronic condition.

Plan to Evaluate Impact: Participant program evaluations.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

CMC will provide various health screenings on an ongoing basis for free or a small fee.

CMC's Community Health Services department has a long history of providing free or low cost screenings for the community. Community screenings provide access to services, and early detection of disease for the underserved population, resulting in improved patient outcomes. Screenings provided by CMC include Cholesterol Screenings, Osteoporosis Screenings, Breast and Cervical Cancer Screenings, Colorectal Cancer Screenings, Skin Cancer Screenings, COPD Screenings and Blood Pressure Screenings.

Anticipated Impact: Increased access to services, and early detection of disease for the underserved population, resulting in improved patient outcomes.

Plan to Evaluate Impact: Track the number of patients identified as at risk and referred for follow-up.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Dartmouth Hitchcock, Elliot Health System, Breathe NH, Anna Ryan, MD, Dermatologist.

Need #5 –

Ambulatory care sensitive conditions: marker for lack of adequate preventative care, need for care coordination

Strategies:

CMC to expand the Medical Home Model to all PCP practices within the next 2 years.

See pages 5 & 6 for the description of the Medical Home Model that will be implemented to help address this need.

Anticipated Impact: Increased access to comprehensive medical care, early detection and disease prevention before a condition escalates requiring acute or emergency care.

Plan to Evaluate Impact: Will monitor quality indicators as established by third party payors, National Quality Foundation, Health Care Effectiveness Data and Information Set (HEDIS), etc. to evaluate the quality of health of the patient population.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

CMC will staff Community Health Workers in the emergency department to identify and provide primary care access for the homeless.

An increasing concern of people who are homeless and who have no health insurance is a lack of access to primary medical care. Often times, instead of visiting a primary care provider for a health concern, they delay care until the health concern becomes serious and/or requires emergency care.

The role of the Community Health Worker is to connect patients who are homeless with primary care services available at the CMC's Health Care for the Homeless Program.

Anticipated Impact: Connecting patients who are homeless with primary care services will provide access to comprehensive medical care, early detection and disease prevention before a condition escalates requiring acute or emergency care.

Plan to Evaluate Impact: Monitor the number of homeless patients seen in the E.D. who establish primary care with the Health Care for the Homeless Program.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Serenity Place, Farnum Center, Keystone Hall, Phoenix House,(addiction treatment programs), Mental Health Center of Greater Manchester, V.A. Medical Center, Manchester Health Department.

CMC will implement a Primary Care Access Line that will allow patients to establish themselves with a primary care provider with a single phone call.

The Primary Care Access Line will assist patients in establishing a primary care provider with a single phone call. The patient's needs and preferences will be reviewed and an appointment will be set up for the patient during the call, making the process easier and preventing a delay in services or a lack of follow through.

Anticipated Impact: Helping patients establish a primary care provider will provide access to comprehensive medical care, early detection and disease prevention before a condition escalates requiring acute or emergency care.

Plan to Evaluate Impact: Monitor the number of patients who are established with a primary care provider.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

CMC will explore the development of a prescription delivery program with Rite Aid Pharmacy to assist patients in filling their prescribed discharge medication at the time of discharge from the hospital.

Anticipated Impact: Impact will be determined once a plan is developed.

Plan to Evaluate Impact: Evaluation will be established once the program is implemented.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Rite Aid Pharmacy.

Need # 6 –

Barriers to access to health care services related to poverty: lack of insurance, cost, transportation, lack of information on how to access care, and what services are available if uninsured; language, lack of medical home

Strategies:

CMC to expand the Medical Home Model to all PCP practices within the next 2 years.

See pages 5 & 6 for the description of the Medical Home Model that will be implemented to help address this need.

Anticipated Impact: The Medical Home Model will improve the coordination of care and foster a relationship of trust between patients and their providers. It will help the patient access comprehensive, preventative care to reduce unnecessary emergency room visits that can end up costing the patients a lot of money.

Plan to Evaluate Impact: Will monitor quality indicators as established by third party payers, National Quality Foundation, Health Care Effectiveness Data and Information Set (HEDIS), etc. to evaluate the quality of health of the patient population.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

CMC's Health Care for the Homeless program will provide comprehensive care to the homeless population in Manchester.

Health Care for the Homeless (HCH) Manchester, also known as the Mobile Community Health Team at Catholic Medical Center, has been addressing the multi-faceted health

needs of homeless men, women, children, teens and families in Manchester, since 1988. The estimated 1700 homeless in Manchester struggle daily with abject poverty, unemployment and lack of affordable housing. As patients, they suffer common health problems, exacerbated by years of medical neglect, lack of access to care, malnutrition, and exposure to communicable disease. They often harbor a tri-morbidity of co-occurring medical, mental health and addiction disorders. Comprehensive medical, nursing, and behavioral health care as well as addiction counseling, is offered daily at shelters in Manchester by the Health Care for the Homeless case management team.

Anticipated Impact: The homeless population in Manchester will have access to comprehensive medical care, behavioral health services, and addiction counseling and treatment.

Plan to Evaluate Impact: Monitor the number of homeless patients served by the HCH team.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Serenity Place, Farnum Center, Keystone Hall, Phoenix House,(addiction treatment programs), Mental Health Center of Greater Manchester, V.A. Medical Center, Manchester Health Department.

CMC's West Side Neighborhood Health Center will provide comprehensive care to Manchester's underserved and refugee population.

Under and uninsured residents can access primary care at the West Side Neighborhood Health Center (WSNHC), which specializes in caring for refugees, from newborns to the elderly. The WSNHC provides supportive well-child care, ill child care, adolescent care to the age of 18 and general internal medicine and behavioral health services for those over 18. WSNHC serves as a medical home for the refugee population.

Anticipated Impact: The uninsured/underinsured population, including refuges who have resettled in Manchester, will have access to comprehensive medical care and behavioral health services.

Plan to Evaluate Impact: Monitor the number of patients who are served.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: International Institute, Manchester Health Department.

CMC's Pregnancy Care Center will provide prenatal care for women in need, regardless of their ability to pay.

The Pregnancy Care Center provides supportive prenatal care to all women and their families, regardless of their ability to pay. Our mission is to improve pregnancy

outcomes by serving those most in need and those unable to access services in a traditional prenatal setting.

The Pregnancy Care Center will expand services, adding a Centering Pregnancy Program, providing prenatal care in a supportive group environment. This program is a multifaceted model of group care that integrates the three major components of care; health assessment, education and support. Visits promote greater patient engagement, personal empowerment and community-building.

This evidence based care model has been shown to increase adherence to visits, improve birth outcomes including increased birth weights and decreased pre-term births, increase patient knowledge and readiness for labor and infant care, increase breast feeding initiation rate and increase patient satisfaction.

Anticipated Impact: Uninsured/underinsured women, including refuges who have resettled in Manchester, will have access to comprehensive prenatal care.

Plan to Evaluate Impact: Monitor the number of patients who are served.

Programs and Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Child Family Services, Carenet, Greater Manchester Mental Health Center, Habit OpCo, Manchester Metro, Our Place, Child Health Services, Families in Transition, The Way Home, Birthright.

CMC will assist patients through the Medication Assistance Program to obtain prescribed medications that they would otherwise be unable to afford.

Last year, CMC's Medication Assistance Program staff assisted over 600 individuals in the Greater Manchester Area in obtaining $2,113,650.50 in free medication from major pharmaceutical companies. Patients served by this program include the uninsured, underinsured, patients with a Medicaid spend down and patients who fall into the Medicare Part D gap.

Anticipated Impact: Patients will have access to assistance in obtaining medications they might not otherwise be able to afford.

Plan to Evaluate Impact: Monitor number of patients served and number and value of prescriptions provided to patients.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

CMC will review our current patient transportation services to determine if there is additional demand for services by our patient population to improve access to care.

CMC's Patient Transport Service provides transportation for patients to and from CMC providers. In FY13, transportation was provided for patients on 5,405 occasions. In addition, CMC provided 602 Taxi vouchers to CMC patients. CMC will examine the current demand for services to determine if there is additional need.

Anticipated Impact: Impact will be determined once it is ascertained whether there is additional demand for services.

Plan to Evaluate Impact: Evaluation will be established if additional services are implemented.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

CMC will staff Community Health Workers in the emergency department to identify and provide primary care access for the homeless.

An increasing concern of people who are homeless and who have no health insurance is a lack of access to primary medical care. Often times, instead of visiting a primary care provider for a health concern, they delay care until the health concern becomes serious and/or requires emergency care.

The role of the Community Health Worker is to connect patients who are homeless with primary care services available at the CMC's Health Care for the Homeless Program.

Anticipated Impact: Patients who are homeless will be provided with access to primary care services, behavioral health services and addiction treatment services.

Plan to Evaluate Impact: Monitor the number of homeless patients seen in the E.D. who establish primary care with the Health Care for the Homeless Program.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Serenity Place, Farnum Center, Keystone Hall, Phoenix House, (addiction treatment programs), Mental Health Center of Greater Manchester, V.A. Medical Center, Manchester Health Department.

Need #7 and #8

Teen pregnancy and STD's (specifically Chlamydia)

Strategies:

CMC's Pregnancy Care Center will provide prenatal care for teens in need, regardless of their ability to pay.

The Pregnancy Care Center provides supportive prenatal care to all women including teens, regardless of their ability to pay. The mission is to improve pregnancy outcomes by serving those most in need and those unable to access services in a traditional prenatal setting.

The Pregnancy Care Center will expand services, adding a Centering Pregnancy Program, providing prenatal care in a supportive group environment. This program is a multifaceted model of group care that integrates the three major components of care; health assessment, education and support. Visits promote greater patient engagement, personal empowerment and community-building.

This evidence based care model has been shown to increase adherence to visits, improve birth outcomes including increased birth weights and decreased pre-term births, increase patient knowledge and readiness for labor and infant care, increase breast feeding initiation rate and increase patient satisfaction.

Anticipated Impact: Teens will have access to prenatal care improving pregnancy outcomes by serving those most in need and those unable to access services in a traditional prenatal setting.

Plan to Evaluate Impact: Monitor number of women served.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Child Family Services, Carenet, Greater Manchester Mental Health Center, Habit OpCo, Manchester Metro, Our Place, Child Health Services, Families in Transition, The Way Home, Birthright.

CMC will provide Sexual Risk Behavior and Conflict Resolution Education for youth.

Educational programs will be offered to youth in community churches and private schools in the Greater Manchester area.

Anticipated Impact: Youth will understand the benefits of choosing sexual risk avoidance behavior.

Plan to Evaluate Impact: Monitor number of youth who receive the education. Collect participant program evaluations.

Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Various faith communities and private schools.

Need #9 –

Dental services/access: specifically for adults

Access to oral health care for adults remains a critical health need within the Greater Manchester Community. Dental caries and periodontal disease in adult patients are currently being investigated for their role in cardiovascular disease, high risk pre-term births, diabetes, and Alzheimer's disease. Dental caries and periodontal disease are both infectious diseases which, if untreated, are long term chronic infections which often lead to acute sequellae. The bacterium which is responsible for dental caries ("cavities") is transmissible, with most infections being passed from a caregiver (very often the mother) to their young child.

The CDC Data Brief from August 2012 on Oral Health Disparities analyzed data from NHANES and concluded that social determinates of race and ethnicity as well as income level/poverty status were associated with disparities in level of untreated decay, tooth retention, and edentulism.

Catholic Medical Center has a long tradition in recognizing that oral health is a key determinate in overall health and that social and economic factors result in a minority of Manchester residents suffering with the highest burden of oral disease. The Poisson Dental Facility was established at CMC in 1984 to address the oral health needs of those most at risk in our community. We provide a dental home for underserved patients of all ages who are referred by our social service agencies.

Strategies

CMC's Poisson Dental Facility will expand adult oral health services to patients at the West Side Neighborhood Health Center and the Pregnancy Care Center.

In an effort to increase access to care for adults most in need, CMC will implement two pilot projects. Our pilot programs were chosen to target the diverse socioeconomic, racial and ethnic population at the WSNHC and with the hope of removing infectious bacteria from mothers thus resulting in improved oral health for women and their children.

1. Poisson Dental Facility will provide dental treatment for patients from the West Side Community Health Center (WSNHC) with continuing care as long as patients are receiving primary care at WSNHC. The majority of patients at WSNHC are refugees who have resettled in the Manchester Community and often arrive with very poor oral health.
2. Poisson Dental Facility will provide access to exam and treatment planning for women from The Pregnancy Care Center (PCC). Our pregnant patients will then be able to receive care during their first post partum year until their treatment plans have been completed.

Anticipated Impact: Increase in number of adult patients from WSNHC and PCC who have access to dental care.

Plan to Evaluate Impact: Monitor number of adult patients from WSNHC and PCC who receive dental services at Poisson.

Programs and Resources the Hospital Plans to commit: Staff time and overhead expenses.

Collaborations: Easter Seals, Manchester Health Department, Manchester Community Health Center, Dartmouth Hitchcock Manchester.

Identified Needs Not to be Addressed

Catholic Medical Center has a long history of providing services to the community and currently has programs in place to meet every need identified in the most recent Community Health Needs Assessment. In addition to the programs we currently offer, we will expand many of our services in response to the needs of the community, which have been documented here.

Approval from the Governing Body

The Catholic Medical Center Executive Committee of the Board met on October 31, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the Implementation Strategy and provide the necessary resources and support to implement this plan.