Posted: March, 2016

St. Joseph's Hospital Health Center
2013 Community Service Plan
Summary of 2015 Plan of Action Activity

THREE YEAR PLAN OF ACTION:

A. <u>Prevent Chronic Disease</u>: ***To increase access to high quality chronic disease preventive care and management in clinical and community settings St. Joseph's has identified three goals:***	
Promote the use of evidence-based care to manage chronic disease. **Goal 1:** To increase the percentage of adults with diabetes whose blood glucose is in good control, to reduce the rate of hospitalizations for short-term complications of diabetes and to increase the number of adults with diabetes who have learned how to manage their condition, St. Joseph's is participating in the following initiatives, along with key community partners:	
i.) Near Westside Initiative	The Near Westside Health Committee, organized with representation from multiple stakeholder groups, met monthly in 2015. Committee discussions created a platform for aligning the implementation of several collaborative projects and interventions on the Near Westside with the committee's common strategic goals.
ii.) Enhanced Diabetes Prevention Program	St. Joseph's developed a partnership with the YMCA to conduct the national evidence-based DPP program for 90 patients from St. Joseph's Primary Care Center -West over an 18 month period. This program concluded in 2014.
iii.) Nutrition Education at the Family Medicine Center	St. Joseph's provided nutritional counseling to approximately 48 patients per month for an estimated 576 patients over 2015. Staff at St. Joseph's hospital-based primary care clinics engaged patients in discussions around chronic disease management and nutrition with both physician support and the support of St. Joseph's staff dietitians.
Improve health outcomes for adults with two or more chronic conditions in Onondaga County. **Goal 2:** Together with community partners, including Catholic Charities and the Rescue Mission, St. Joseph's, through its lead health home designation, will seek to improve health outcomes and reduce the cost for Medicaid patients with two or more chronic conditions in Onondaga, Madison and Oneida counties.	

i.) Implementation and expansion of Health Home to impact health outcomes and shift utilization patterns	Patient enrollment in the health home grew over 2015 from 874 clients at year-end 2014, to 1442 clients at the end of 2015. Preliminary data demonstrates that the SJCCN team successfully made an impact on the population served within our network, with a decrease in avoidable ED visits/Medical Hospitalizations per 100 enrollees per month, and a decrease in the cost of care per member per month for dual-eligible enrollees. Specifically, engagement in the Health Home through 12/31/15 resulted in a 26% less inpatient admissions, 74% less ED visits, and 8.5% less charges than if no intervention had been performed.
Improve access to primary care and other community-based services. **Goal 3:** St. Joseph's has implemented a patient navigator program in its Emergency Department, the first of its kind in Central New York, to ensure access to primary care services and improve patient management of chronic health conditions.	
i.) Patient Navigator Program	St. Joseph's patient navigator program was in its first full year of operation in 2014. In 2015, approximately 3800 unique patients interacted with a navigator, with approximately 1237 primary care appointments scheduled for those patients who did not have an established PCP. Of all of the patients interacting with a navigator, approximately 256 referrals were made to connect uninsured patients with facilitated enrollers.

B. To <u>Reduce Obesity In Children And Adults</u> St. Joseph's Has Identified Two Goals:		
	Create community environments that promote and support healthy food and beverage choices and physical activity **Goal 1:** To increase the number of children and adults maintaining healthy weight and to reduce the age adjusted percentage of adults ages 18 years and older with annual household income less than $25,000 who are obese, St. Joseph's is participating in the following initiatives, together with community partners:	
i.)	**Near West Side Initiative - Healthy Shopper Rewards Program**	Collaborative partnership has been developed with Nojaim Brothers Supermarket, the Near Westside Initiative and the Lerner Center for Public Health promotion to integrate patient nutritional counseling with the Nuval, a nutrient value scoring system. Nojaim worked on the implementation of (Nuval) throughout 2015 and scheduled to launch the system in the store at the beginning of 2016. Concurrent with this implementation, PCC-West collaborated on an Excellus grant that will enable providers to "prescribe" healthy foods to participating patients, redeemable at Nojaim's, as a result of grant funding. The next phase in this program is to identify a shopper rewards program that will work with the partners to integrate shopper data in with the PCC-West electronic health record (for consenting PCC-West patients).
ii.)	**North Side Community Health Improvement Project**	In 2014, under the leadership of a FrancisCorps volunteer placed at St. Joseph's, a grant proposal was drafted to solicit support for the purchase and provision of fresh fruits and vegetables at the Assumption Food Pantry. Further, cooking demonstrations led by St. Joseph's nutritional services staff were organized for pantry clients, in addition to offering clients affordable and healthy menu/recipe ideas based upon products typically available through the pantry. In 2015, St. Joseph's continued to donate fresh produce to the pantry on a weekly basis, in the approximate amount of $40 dollars per week, totaling $2080 for the year.
	Create community environments that promote and support healthy food and beverage choices and physical activity. **Goal 2:** Three initiatives seek to support the creation of community environments that promote and support healthy food and beverage choices, as well as physical activity:	
i.)	**Workplace Policies**	St. Joseph's has started developing a process for evaluating all cafeteria and patient meal offerings in an effort to make the ingredients and methods of preparation as healthy as possible. At year-end 2015, just over 65% of meal offerings on average per month were determined to be "healthy," an increase of 5% over year-end 2014 (179 healthy/275 average meals per month). and just over 53% of food sales per month on average were related to "healthy" offerings.

ii.)	**Programs for School-Based Clinics**	Discussions around the implementation of programs for school-based clinics were preliminary in 2014, with additional planning slotted for 2015. The targeted program implementation is 2016.
iii.)	**Community Gardens**	The concept for the community garden was under development in 2014, and in 2015 St. Joseph's sponsored a portion of the construction of a community garden in the Northside neighborhood surrounding the hospital campus.
	Prevent initiation of tobacco use by young adults, covering low socioeconomic populations. **Goal 3:** Through participation in a community-wide initiative to educate youth on tobacco use, St. Joseph's will decrease the prevalence of cigarette use by adults 18 to 24 years of age. Partners include the Onondaga County Health Department, Healthy Syracuse, Crouse and Upstate University Hospitals.	
i.)	**Decrease the prevalence of cigarette use by adults 18 to 24 years of age**	In alignment with the goal of decreasing cigarette use among adults 18-24 years of age, St. Joseph's trained 150 clinicians in Onondaga County in tobacco cessation strategies over 2014, and reported 2,997 Onondaga County callers to the NYS Smoker's Quitline. In the total 12-county service area covered by St. Joseph's Tobacco Cessation services, 399 total clinicians were trained in tobacco cessation strategies and the Smoker's Quitline received 11,894 total calls.

C. Promote Mental Health And Prevent Substance Abuse	
Improvement of maternal and infant health and reduction of the incidence of neonatal abstinence syndrome. **Goal 1:** St. Joseph's, in conjunction with the Onondaga County Health Department, Regional Perinatal Center, local hospitals and primary care centers, will increase education to both providers and patients regarding neonatal abstinence syndrome.	
Patient Education	In 2015, monthly open meetings for pregnant patients were continued at St. Joseph's hospital-based primary care centers. Patients had the opportunity to meet with a physician, dietician and social worker to have questions addressed and to get support for prenatal care outside of regular office visits. Community partners such as the health department attend to provide information on relevant programs and services to support the mothers.
Provider Education	In 2015, providers were educated as a group on the standard screening process to identify potential drug abuse in patients. A more comprehensive training was planned to certify providers in the screening process, but subsequent to this preliminary plan, the local DSRIP initiative selected neonatal abstinence syndrome as one of its key projects. As St. Joseph's has dedicated staff assigned to furthering each of the DSRIP projects, it is anticipated that an initiative will be implemented related to this health disparity aligned with the DSRIP process and therefore also aligned with the community partners who are involved in DSRIP.
Syracuse Healthy Start-Perinatal Substance Abuse Committee	Over 2015, St. Joseph's continued to participate in the Syracuse Healthy Start-Perinatal Substance Abuse Committee with representation from a NICU physician, a nurse practitioner and a social worker.
To promote mental, emotional and behavioral well-being, St. Joseph's will implement evidenced based practice in screening and prevention of behavioral health concerns. **Goal 2:** Through newly expanded primary care centers, which will integrate primary care and behavioral health care, St. Joseph's will seek to increase early detection of behavioral health concerns in children and adults.	
Universal Behavioral Health Screenings	Universal behavioral health screening was established at all primary care centers in 2014. Now, all patients complete a behavioral health screening tool (e.g. PHQ9) at their annual well visit, with just over 5,900 completed in 2015. As a result, just over 1,200 patients were connected with a practice social worker to follow-up with identified patients and

	connect them with needed supports and services. In addition, a Behavioral Health/Primary Care Integration steering committee was established in late 2014 to move hospital-based clinics towards the integration of behavioral health and primary care services in 2015. Behavioral Health has become a focus project under DSRIP in 2015, and St. Joseph's representatives working on that project will ensure that operations within the primary care clinics and within behavioral health align with recommended strategies.