Humility of Mary Health Partners

2013 Community Health Needs Assessment Implementation Strategy

St. Joseph Health Center

Final
10/5/13

Identifying Information

Hospital Name: St. Joseph Health Center (SJHC)

Primary Address: 667 Eastland Avenue Warren, Ohio 44484

Tax Identification Number: 34-0505560

Regional Chief Executive Officer: Robert Shroder

Hospital President: Kathy Cook

Date Report Prepared: 6/20/2013

Governance Committee Reviewing Report: Strategic Planning Committee	Date: 8/8/2013
Date Report Approved by Regional Governing Board:	Date: 9/3/2013
Due Date for Form 990 filing that will include implementation strategy:	Date: 11/14/2013
Hospital Tax Year to which implementation strategy applies	Year 2013

Implementation Strategy

In order to address needs identified in the Community Health Needs Assessment (CHNA), SJHC will engage key community partners in implementing new strategies across the service area. The Implementation Strategy will explain how SJHC will address health needs identified in the CHNA by continuing/expanding existing programs and services, and by implementing new strategies. It will also explain why the hospital is not yet positioned to address all the needs identified in the CHNA, and if applicable, how SJHC will collaborate with other community organizations in doing so.

Prioritized Health Needs

Diabetes

The Diabetes 5 or D5 is an all-or-none bundle of recommended clinical quality measures for persons living with diabetes. It represents five goals diabetics need to achieve to reduce risk of complications such as heart attack, stroke and problems with the kidneys, eyes and nervous system. SJHC has set a goal of increasing diabetic patients established at the employed primary care practices that meet D5 goals to 31 percent by 2015. In 2012, the four employed primary care practices in the Trumbull County community have a combined average of 13.4 percent. To reach primary care physicians not employed by our system, the HMHP Care Network, our Clinically Integrated Organization, will integrate these same goals for community physicians enrolled in the program.

In 2013, Humility of Mary Health Partners (HMHP) focus at the Canfield Fair was diabetes education. The Canfield Fair is one of the largest state fairs in the US and attracts over 2,500 people from the tri-county area each year to the health building. Also, our active collaboration in the Diabetes Partnership of the Mahoning Valley will further assist those in the community with education, information, resources and support to minimize the effect diabetes has on their life and the lives of those who care for them.

Currently, HMHP Diabetes Education Program sponsors the annual Diabetes Expo. Some highlights of the educational program include: featured speakers (physicians and others), educational and resource exhibits, pharmaceutical and glucose meter exhibits, ask the pharmacist, dietitian, and physician, lunch, and a Chinese auction. This event typically attracts approximately 300 individuals from the surrounding area. Also, HMHP is an active participant in Community Health Care Initiatives/ Diabetes Workgroup whose objective is to enhance the quality of healthcare, expand healthcare education and promote a culture of best practices. This coalition of community stakeholders, launched in 1999 by the United Auto Workers (UAW), General Motors (GM), the International Union of Electrical Workers(IUE-CWA), and Delphi. Participating organizations include: American Diabetes Association (ADA), Anthem BC & BS, Blue Cross and Blue Shield of Michigan, Employers' Health Care Coalition of Ohio, Humility of Mary Health Partners, Lake to River Health Care Coalition, Primary Healthcare Associates, Trumbull County Health Dept., UAW/GM, Valley Care, and the Youngstown Community Health Center. SJHC will continue to explore community partnerships to develop innovative ideas to address this community need.

Baseline Data for Employed Primary Care Practices

The practices listed below are the HMHP employed primary care practices located in the SJHC community. This chart displays the percentage of patients that met the D5 criteria in 2012.

Percentage of Patients that meet D5 Criteria by Practice			
Practice	**Practice Manager**	**2012**	**Goal (by 2015)**
Church Hill FHC	Noel Stickle	9.4%	31%
Community Care Center	Robert Silletoe	12.4%	31%
Cortland FHC	Noel Stickle	15.9%	31%
East Market FHC	Noel Stickle	15.8%	31%
	Combined Average	13.4%	

Respiratory Disease

The Increase compliance with PQRS Group Measures for COPD (listed below):

1. Spirometry Evaluation
2. Bronchodilator Therapy
3. Influenza Immunization
4. Pneumonia Vaccination (patients 65 year or older)
5. Tobacco Use: Screening and Cessation Intervention

The PQRS National guidelines and standards for COPD is an all-or-none bundle of recommended clinical quality measures for persons living with COPD/Asthma. It represents five objectives COPD/Asthma need to achieve to reduce risk of complications such as progression of debilitation of disease process, heart attack, death as well as repeated hospitalizations and emergency room visits. It is a leading cause of death, illness, and disability in the United States. An estimated 10 million American adults were diagnosed with the condition in 2000, but data from a national health survey suggests that as many as 24 million Americans were actually affected. In 2000, COPD caused: 119,000 deaths, 726,000 hospitalizations, 1.5 million visits to hospital emergency rooms.

Comment [DT1]:

SJHC has set a goal of increasing COPD patients within the employed primary care practices and Community Care Clinic practice meet PQRS guidelines by 25 percent by 2015. In 2012, the four employed primary care practices in the Trumbull County community have a combined average of 13.4 percent. To reach primary care physicians not employed by our system, the HMHP Care Network, our Clinically Integrated Organization, will integrate these same goals for community physicians enrolled in the program. To advance the smoking cessation in the community through strong education programs for health professionals, communities and patients. Increase the compliance of medication regime through exploring the possibility of expanding the Medication Mission, Prescription Assistance to include pulmonary medications. To improve the chronic health condition of those who suffer with COPD by establishing a comprehensive Cardio/Pulmonary rehabilitation program at SJHC.

HMHP is an active participant in Community Health Care Initiatives/ Pulmonary Sleep Disorders Workgroup whose objective is to enhance the quality of healthcare, expand healthcare education and promote a culture of best practices. This coalition of community stakeholders, launched in 1999 by the United Auto Workers (UAW), General Motors (GM), the International Union of Electrical Workers(IUE-CWA), and Delphi. Participating organizations include: American Lung Association, Smoking Cessation Regional Tobacco Center, Ohio Respiratory Association, Pulmonary and Sleep Disorder Association along with the other organizations of Diabetes Association (ADA), Anthem BC & BS, Blue Cross and Blue Shield of Michigan, Employers' Health Care Coalition of Ohio, Humility of Mary Health Partners, Lake to River Health Care Coalition, Primary Healthcare Associates, Trumbull County Health Dept., UAW/GM, Valley Care, and the Youngstown Community Health Center. SJHC will continue to explore community partnerships to develop innovative ideas to address this community need.

The implementation plans (detailed on next page) for each prioritized health need will:

- Describe actions the hospital intends to take to address the need
- Describe anticipated impact of actions
- Describe plan to evaluate such impact
- Identify programs and resources the hospital plans to commit to address the need
- Describe planned collaboration in address the need

Health Need #1: Diabetes

Goal: Increase the percent of diabetic patients (employed primary care practices) that meet D5 goals (listed below):

1. Blood pressure is less than 140/90 mmHG

2. Bad cholesterol, LDL, is less than 100 mg/dl

3. Blood sugar, A1c, is less than 8%

4. Tobacco-free

5. Taking an aspirin as appropriate

Outcome Measure: 31% (combined average) by 2015

Implementation Plan

Action (Responsible Leader)	**Impact of Action**	**Plan to Evaluate Impact**	**Programs and Resources committed to addressing needs**	**Planned Collaboration**
Develop a HMHP D5 Committee (Rod Neill)	Increase compliance with D5 criteria	Quarterly report of D5	HMHP Physician Associates, Explorys software system	TBD based on preliminary results
Explore opportunities to increase referrals to supportive services (Rod Neill/Kay Leonhart)	Increase referrals of diabetic patients to prescription assistance, diabetes education, smoking cessation and other appropriate services	Decrease active smokers and improve D5 compliance	Mandatory education on D5 for RN & Case Managers	Diabetes Partnership of the Mahoning Valley/Tri-County
Develop HMHP Care Network quality initiatives and expand to community physicians (Toni Stefan)	Community physicians involvement and alignment with quality initiatives	Improved D5 outcomes in community	HMHP Care Network, Business Development	Community physicians
Primary Care Symposium to have a spotlight on Diabetes and the D5. (Dr. Nicholas Kreatsoulas)	Increase awareness and efforts to comply with D5 criteria	Assess impact via program evaluation	Medical Staff Office, HMHP Physician Associates	Community physicians

Health Need #2: Respiratory Disease

Goal: Increase compliance with PQRS Group Measures for COPD (listed below):

6. Spirometry Evaluation
7. Bronchodilator Therapy
8. Influenza Immunization
9. Pneumonia Vaccination (patients 65 year or older)
10. Tobacco Use: Screening and Cessation Intervention

Outcome Measure: TBD based on selected guidelines

Implementation Plan

Action (Responsible Leader)	Impact of Action	Plan to Evaluate Impact	Programs and Resources Committed to Addressing Needs	Planned Collaboration
Research PQRS and other national guidelines and standards for COPD (Dr. Starr/ R. Jones)	Assess alignment and increase compliance with guidelines	Increase the Spirometer evaluations and Bronchodilator therapy usage	Flu Immunization, Pneumococcal Vaccination	American Lung Association and Smoking cessation.
Explore opportunities to increase referrals to supportive services (Steve Pavlak)	Increase referrals to prescription assistance smoking cessation and other appropriate services	Decrease active smokers	Staff education, Regional Tobacco Referral Center and Respiratory Care	Lifeline and SECH Pulmonary Rehabilitation
Assess community needs around COPD education (Steve Pavlak)	Develop comprehensive community program	Consider the number of individuals	Smoking cessation regional tobacco center, respiratory therapy, Sleep Lab and grant writing	Our regional market of Pulmonology and Community Care physicians
Feasibility of Dr. Amir speaking on the COPD Management "Gold Standard" (Dr. E. Novosel)	Increased awareness of COPD Management "Gold Standard"	March 25, 2014 Dr. Amir will present to Medical Staff the "Gold Standard" of COPD	Achieve immediate consultation of Pulmonologist for COPD patient both within the hospital and Office setting of PCP, Family Practice patients	Nursing staff, Case-manger and Respiratory therapist Dr. Amir providing a C.E.U. program along with Medical Education program
Assess feasibility of providing pulmonary rehab (B. Boccia and K. Cook)	Provide pulmonary rehab. to increase compliance with guidelines and standards for COPD	October 3, 2014, surveying for execution of moving Cardiac rehab which directly impacts employment of Cardio-Pulmonary on SJHC campus	Financial commitment to creating space for Cardio-Pulmonary program onsite. The move and collaboration will be multi-disciplinary	Cardiac Rehab., CHF, Diabetes, Nutrition, smoking cessation program, Pulmonary and Cardiac physicians,

Needs not being addressed in Implementation Plan

Behavioral Health

Currently, our system does not have the capacity to address behavioral health across the continuum of care due to the complexity of care coordination and clinical expertise required to deliver exceptional service. SJHC is seeking partnerships to address the need through various local behavioral health providers. Our corporate sponsor, Catholic Health Partners (CHP), has provided Non-Abusive Psychological & Physical Intervention (NAPPI) training for staff to gain skills necessary to deal with individuals with behavioral health issues. Additionally, behavioral health is a clinical focus that is being strategically developed by CHP and there is significant effort to recruit and retain behavioral health providers. While SJHC is not addressing the need in this plan, it is taking foundational steps to adequately address this need in the future.

Obesity

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

Access & Preventive Care

To address the need of access to care, HMHP provides significant resources at a number of locations throughout the tri-county area. In addition to St. Joseph Community Care Center, HMHP is also in the process of developing Patient Center Medical Homes. Access Health Mahoning Valley, a collaborative between HMHP and local health organizations, helps individuals gain access to care. Free clinics and Federally Qualified Health Centers (FQHC) also provide access and preventive care to the community.

Pre-Natal Issues

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