St James Mercy Hospital

ST. JAMES MERCY HOSPITAL

Community Service Plan 2013

Executive Summary

Hospitals in New York State are required by the Department of Health to create and publicly distribute an annual "Community Service Plan," which identifies and describes progress toward collaboratively meeting health priorities in their service areas. The progress of these activities must be reported annually for three years through updates of the Community Service Plan to the Department of Health and publicly. 2013 marks the first year of the three-year cycle.

In 2012, St. James Mercy Hospital (SJMH) collaborated with community health agencies in an eighteen-month Community Health Assessment to identify and prioritize health care needs in Steuben County (comprising a significant portion of SJMH's primary service area) for the next three years. This comprehensive process, based on the NYS 2013 – 2017 "Prevention Agenda" initiative, was coordinated by Steuben County Public Health and included the three county hospitals (St. James Mercy Hospital, Corning Hospital, Ira Davenport Memorial Hospital), area health organizations, and local residents.

The process of collecting data, soliciting opinions, facilitating a process, and guiding a discussion helped determine not only what the most pressing problems facing county residents are, but also what can be effectively and efficiently addressed. In the end, SJMH, Steuben County Public Health and the partner agencies identified two challenging areas under the New York State Department of Health priority of the prevention of chronic disease:

1. **Reduce obesity in children and adults**
2. **Reduce heart disease and hypertension**

The disparity the partners chose to address was:

Promote tobacco cessation, especially among low SES (socioeconomic status) populations and those with mental health illness

Chronic diseases are among the leading causes of death, disability and rising health care costs in New York State (NYS). Specifically, they account for approximately 70% of all deaths in NYS, and affect the quality of life for millions of other residents, causing major limitations in daily living for about 10% of the population. Costs associated with chronic disease and their major risk factors account for more than 75% of our nation's health care spending[1]. Obesity is a major contributor to chronic disease.

Obesity Prevalence

- The percentage of NYS adults who are overweight or obese increased from 42% in 1997 to 60% in 2008.
- The percentage of obese adults in New York State more than doubled from 10% in 1997 to 25% in 2008.
- Obesity among children and adolescents has tripled over the past three decades. Currently, a third of New York's children are obese or overweight.
- Healthcare to treat obesity-related illnesses and conditions cost the United States an estimated $150 billion and NYS more than $7.6 billion every year.[2]

In Steuben County the age adjusted percentage of adults who are obese (BMI 30 or higher) is 27.6% compared to the New York State rate of 23.1%.[3] Public health officials across the state and the nation must take steps to address this rising epidemic. Without strong action to reverse the obesity epidemic, children may be facing a shorter lifespan than their parents.

Heart Disease Prevalence

Cardiovascular Disease (CVD) is the leading cause of death in the United States and in NYS. In New York State, CVD killed almost 59,000 residents in 2007. For every person who dies from a heart attack, 18 people survive. For every person who dies from a stroke, seven people survive. Many of these survivors are disabled and cannot lead

[1] CDC Chronic diseases: The Power to Prevent, the Call to Control http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm
[2] New York State Dept. of Health Obesity Prevention http://www.health.ny.gov/prevention/obesity/
[3] New York State Dept. of Health New York State Community Health Indicator Reports - Obesity and Related Indicators http://www.health.ny.gov/statistics/chac/indicators/obs.htm

productive lives. Stroke is a leading cause of premature, permanent disability among working-age adults in the United States. Stroke alone accounts for the disability of more than a million Americans. The economic impact of CVD and stroke on the health system will grow as the population ages.[4]

Hypertension and tobacco use are two major contributing factors to cardiovascular diseases. The age-adjusted cardiovascular disease mortality rate in Steuben County is 249.5 compared to the upstate New York rate of 244.7.[5] The age-adjusted percentage of adults who smoke cigarettes in Steuben County is 22.1% compared to the upstate NY rate of 18.9%. Failing to effectively address obesity and heart disease will mean premature death and disability for an increasingly large segment of Steuben County residents.

SJMH and Steuben County Public Health along with their partners have developed a Community Health Assessment and Improvement Plan (specific to Public Health) and Community Service Plan (specific to SJMH) to address these issues.

SJMH's three-year plan of action (aka Community Service Plan) to address the priorities includes the following programs, in addition to supporting community health initiatives and activities led by Steuben County Health Priorities Team:

Reduce Adult Obesity

a. **Breastfeeding Education**
   SJMH participates in the Healthy People 2020 maternal/infant health initiative to promote breastfeeding as the most complete form of nutrition for most infants and a healthy approach to maternal weight control. SJMH staff will promote national "Baby Friendly Hospital" standards, focused on educating parents in the importance of breastfeeding and decreasing the use of pacifiers and formula. This initiative is in collaboration with local health organizations including WIC (Women, Infants and Children), Public Health Nursing, Lamaze educators, and the MOMS (Medicaid, Obstetrical and Maternal Services) program.

Reduce Heart Disease

a. **Chronic Heart Failure (CHF) Reduction Program**
   SJMH is expanding its patient education resources to 1) reduce cardiac readmissions, complications and emergency room visits, and 2) improve overall rehabilitative outcomes through the establishment of post-discharge monitoring of CHF patients, development of an in-house patient education center, and enhanced outpatient referral services to help patients better manage their cardiac disease and prevent unnecessary admissions.
b. **Heart Disease Support Group**
   SJMH will create a community-based Heart Disease Support Group to supplement ongoing education and behavior modification efforts initiated during hospitalization, ultimately to achieve long-term maintenance of changed behavior and better health.

Reduce Tobacco Use With Low Income/Mental Health Populations

a. **Tobacco Use Assessment with Adolescent Outpatients**
   SJMH is initiating a program to address adolescent tobacco use with low-income patients as part of a new outpatient behavioral health outreach initiative, integrating evidence-based tobacco use screening, cessation assistance, referral to services, and tracking of patients' success to reduce or eliminate tobacco use among adolescents.

The specific three-year plans with measurements for these four programs are detailed in full in the body of the Community Service Plan, and will be updated annually and communicated publicly. In addition, the Steuben County Health Priorities Team 2013 – 2015 Work Plan is attached (appendix A). SJMH and its partners will continue to meet regularly and work collaboratively to address the identified healthcare priorities.

[4] New York State Dept. of Health Cardiovascular Disease https://www.health.ny.gov/diseases/cardiovascular/heart_disease/
[5] New York State Dept. of Health New York State Community Health Indicator Reports http://www.health.ny.gov/statistics/chac/indicators/

St. James Mercy Hospital Community Service Plan

Mission Statement

Faithful to our sponsor, the Sisters of Mercy, St. James Mercy Hospital, a member of CHE (Catholic Health East) Trinity Health, is a community of persons committed to being a transforming, healing presence within the rural communities we serve, particularly addressing the needs of the poor, underserved and disadvantaged.

Definition of the Community Served

Located in the rural Southern Tier of New York State in Steuben County, SJMH is the sole community provider within its service area. The primary service area for SJMH is the 15-mile radius extending from Hornell (zip code 14843), and includes the towns of Wayland to the northeast and Troupsburg to the southeast (just outside of the 15-mile radius). The secondary service area is the 30-mile radius extending from Hornell.

The population for Steuben County remains relatively flat, increasing 0.3% from 2000 to 2010 to 98,990 and is projected to remain flat through 2014 (*2010 Census*). The population aged 65 and over comprises 16% of the county compared to 13% for New York State population (*2010 Census*). Steuben is one of the most economically challenged counties in NYS with unemployment of 8.2% (*August 2013, NYS Dept. of Labor*).

Public Participation Process

Led by the S²AY Rural Health Network, SJMH and Steuben County Public Health Department along with local community partners utilized the Mobilizing for Action through Planning and Partnership (MAPP) process to determine two priorities and a disparity from the 2013 – 2017 Prevention Agenda. The MAPP process is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs, and forming effective partnerships for strategic action. The MAPP tool was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC).

In early 2012, key Steuben County partners were brought together to become familiar with the MAPP process and determine pertinent local questions. Steuben County Public Health Department invited participants from a wide range of the organizations – aka "Steuben County Health Priorities Team", comprised of entities that are committed to improving the health of county residents:

- Steuben County Public Health Department
- St. James Mercy Hospital
- Arnot Health
- Guthrie Health
- Steuben Rural Health Network
- Health Ministry of the Southern Tier
- S²AY Rural Health Network
- Cancer Services Program of Steuben County

During the process this group met on a bi-monthly basis to collaboratively critique and assist in promoting and executing the community health needs assessment, which led to the development of the Steuben Health Priorities Team Work Plan. The Team continued to meet bi-monthly through 2013 to ensure that the initiatives outlined in the Work Plan are able to be implemented, monitored and evaluated.

Assessment and Selection of Public Health Priorities

Four assessments inform the entire MAPP process using both qualitative and quantitative methods. The first assessment examined the Community Health Status Indicators through two methods: collecting relevant statistical data using the New York State Department of Health (NYSDOH) Community Health Indicator Reports and a variety of other secondary sources (completed by S²AY Rural Health Network staff), and collecting primary data by conducting a comprehensive survey among a random sample of community residents to determine their opinions, health-related behaviors and health needs. A total of 747 completed surveys were returned in Steuben County. Surveys were

conducted electronically through a Survey Monkey link, along with paper copies which were distributed to the public through employers, health, educational and human services agencies and through other community groups. The survey encompassed questions in the five Prevention Agenda areas that the NYSDOH has identified as high priority issues on a statewide basis.

The second assessment evaluated the effectiveness of the Public Health System and the role of Steuben County Public Health Department within that system. This was done using a modification of the Local Public Health System Assessment tool developed by the CDC (Centers for Disease Control) and NACCHO (National Association of County and City Health Officials). This was also conducted via an electronic survey on Survey Monkey. A diverse group of key informants were chosen to complete the survey, including community leaders who are familiar in some way with the local public health system.

The third assessment was the Community Themes and Strengths Assessment that was conducted through focus groups held throughout the County, and looked at the issues that affect the quality of life among community residents and the assets Steuben County has available to address health needs. The focus groups included students of a GED classes in Corning and Hornell, members of the Greenwood Fire Dept. and students of an English-as-a-second-language class. These groups helped augment the responses of the public health system assessment and findings of the survey of community residents.

Once results were tallied, a finalized list of the top issues from all components of the assessment process was compiled. A series of meetings was held with the Steuben Health Priorities Team to present the data and select priorities. The Team was charged with ranking the priorities based on their knowledge of health needs and available services, along with the data presented, to select two priorities and one disparity. This was accomplished using the Hanlon Method, which focuses most heavily on how effective any interventions might be, utilizing the following formula to rank priorities: (A & 2B) X C where A = the size of the problem, B = the severity of the problem and C = the effectiveness of the solution.

Emphasis is placed on effectiveness of the solution, with the hope of making wise use of limited resources by targeting solutions that are known to be effective. Participants also consider the weight of the propriety, economic feasibility, acceptability, resources and legality (PEARL) of issues in this ranking system. Numerical values were determined by each Team participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores. While the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since Team respondents ranked each component (size, seriousness and effectiveness of the solution) individually using a paper ranking form, the rankings were not heavily influenced by group dynamics. Based upon the ranking through the Hanlon Method, Steuben County's scores on the top health related issues in the county were:

Issue	Hanlon	Pearl
Obesity	180.86	6.07
Smoking/Tobacco	152.07	6.64
Cancer	151.57	4.86
Heart Disease	139.21	5.50
Depression/other mental illness	130.50	4.79
Cerebrovascular Disease	122.00	4.43
Substance Abuse	108.57	4.64
Diabetes	108.07	6.29
Births to teens	103.21	5.14
CLRD/COPD	102.38	5.54
Problems with Teeth or Gums	84.57	5.29
Unintentional Injuries	79.86	5.43
Behavioral Problems in Children	79.14	4.07

Community partners discussed all these health concerns, but concentrated on the top ranked issues. After reviewing, discussing and considering county assessments, data, and previous initiatives the Team decided to focus on the top two priorities of:

1. **Reduce obesity in children and adults**
2. **Reduce heart disease and hypertension**

And the following disparity:

Promote tobacco cessation, especially among low SES populations and those with mental health illness

Prevalence of the Problems in Steuben County

- The percentage of New York State adults who are overweight or obese increased from 42% in 1997 to 60% in 2008.
- The percentage of obese adults in New York State more than doubled from 10% in 1997 to 25% in 2008.
- Obesity among children and adolescents has tripled over the past three decades. Currently, a third of New York's children are obese or overweight.
- Healthcare to treat obesity-related illnesses and conditions costs the United States an estimated $150 billion and NYS more than $7.6 billion every year.[6]

In Steuben County the age adjusted percentage of adults who are obese (BMI 30 or higher) is 27.6% compared to the New York State rate of 23.1%.[7] Public health officials agree this is a rising epidemic.

Cardiovascular Disease (CVD) is the leading cause of death in the United States and in the state. In NYS, CVD killed almost 59,000 residents in 2007. For every person who dies from a heart attack, 18 people survive. For every person who dies from a stroke, seven survive. Many survivors are disabled and cannot lead productive lives. Stroke is a leading cause of premature, permanent disability among working-age adults in the United States. Stroke alone accounts for the disability of more than a million Americans. The economic impact of CVD and stroke on the health system will grow as the population ages.[8] Hypertension and tobacco use are two major contributing factors to cardiovascular diseases. The age-adjusted cardiovascular disease mortality rate in Steuben County is 249.5 compared to the upstate New York rate of 244.7.[9] The age-adjusted percentage of adults who smoke cigarettes in Steuben County is 22.1% compared to the upstate NY rate of 18.9%. Failing to effectively address obesity and heart disease will mean premature death and disability for an increasingly large segment of Steuben County residents.

Identified Goals and Strategies

During this stage, research and evidence-based best practices were considered by the Steuben Health Priorities Team from many different sources including the state's Prevention Agenda 2013 – 2017 and national guidance, such as the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020. The Health Impact Pyramid developed by Thomas R. Frieden, MD was utilized. This approach describes the impact of different types of public health interventions and provides a framework to improve health.

For each focus area under the selected Prevention Agenda Prevent Chronic Disease priority, objectives and goals were identified that included improvement strategies and performance measures with measurable and time-framed targets over the next three years. Strategies proposed are evidence-based or promising practices. They include activities currently underway by partners and new strategies to be implemented collaboratively. Members of the Steuben Health Priorities Team have agreed to meet on a regular bi-monthly basis to ensure that the initiatives are implemented, monitored and evaluated. Progress will also be reported annually to NYSDOH and SJMH Board of Directors, with modifications made as needed to address barriers and duplicate successes.

[6] New York State Dept. of Health Obesity Prevention http://www.health.ny.gov/prevention/obesity/
[7] New York State Dept. of Health New York State Community Health Indicator Reports - Obesity and Related Indicators http://www.health.ny.gov/statistics/chac/indicators/obs.htm
[8] New York State Dept. of Health Cardiovascular Disease https://www.health.ny.gov/diseases/cardiovascular/heart_disease/
[9] New York State Dept. of Health New York State Community Health Indicator Reports http://www.health.ny.gov/statistics/chac/indicators/

St. James Mercy Hospital's Three-Year Plan

As a result of the collaborative community health needs assessment coordinated by Public Health, SJMH will implement the following three-year action plan. Also attached for reference is the Steuben Health Priorities Team Work Plan that Public Health is submitting, to further illustrate the collaborative efforts to work towards goals and track progress.

Note: SJMH currently does not have an electronic medical record (EMR) system in place for expedient and accurate data collection and tracking. Through an affiliation with a larger health system, SJMH can add this capability in the future and/or utilize the data mining capabilities of its collaborative partners for data tracking. Therefore, most of SJMH's program tracking (i.e. health outcomes) will be tracked manually and on a smaller scale.

Reduce Obesity in Children and Adults

St. James Mercy Hospital currently participates in various efforts to address obesity. For example, SJMH staff coordinate an annual pediatrics health fair in collaboration with the Kiwanis Club "Kids' 1/4 Miler". This event promotes childhood fitness and nutrition, and attracts 300 attendees and 15 community groups. Several local organizations are developing childhood fitness and obesity reduction programs, and SJMH is evaluating if and how it can provide support and/or referrals to these programs. SJMH is also exploring sponsorship of a national non-profit initiative to introduce lifetime fitness education to underserved county school districts. The funding of this initiative may involve collaboration with other community organizations.

In regards to adult obesity, SJMH is spearheading the following collaborative program:

b. Breastfeeding Education

SJMH actively participates in Healthy People 2020, an initiative from the Department of Health & Human Services utilizing science-based, 10-year objectives to improve the health of all Americans. Specifically, SJMH participates in the maternal/infant health objective through promotion of breastfeeding as the most complete form of nutrition for most infants and a healthy approach to maternal weight control. Healthy People 2020 is targeting a breastfeeding rate of 80% at post-delivery.

Even as a small rural facility, SJMH has been a strong proponent of breastfeeding for the last fifteen years and is currently at 70% post-delivery. Staff will promote national "Baby Friendly hospital" standards, focused on educating parents in the importance of breastfeeding and decreasing the use of pacifiers and formula. SJMH is strengthening its position as a Baby Friendly Hospital by collaborating with local organizations:

- **WIC** (Women, Infants and Children) clinic through ProAction of Steuben and Yates counties, which promotes the health of women, infants and children through the provision of nutritious foods, nutrition education, healthcare referrals and other services: SJMH fills out the WIC qualification forms for new mothers, and assists in addressing concerns relative to WIC services.
- **Public Health Nursing**: SJMH assists in assessing breastfeeding, and provides support and education to supplement Public Health's program.
- **Lamaze**: SJMH is providing resources to instruct pregnant women on breastfeeding during childbirth classes.
- **MOMS** (Medicaid, Obstetrical and Maternal Services) program: Located at SJMH, the MOMS program provides comprehensive prenatal education and resources, including instruction with an on-site International Board Certified Lactation Consultant/IBCLC.

The three-year plan is designed as follows:

2013: Reduce participation in commercial promotion of formula, pacifiers and related products. Screen maternity patients for ongoing breastfeeding education needs. Build a database and mechanism to track post-discharge breastfeeding outcomes.

2014: International Board Certified Lactation Consultants/IBCLC offer public presentations at community health fairs and community education days on breastfeeding and community resources. Provide educational materials to area clinicians and women's health patients and develop public service announcements around breastfeeding. Continue offering monthly breastfeeding education at childbirth classes with an ultimate goal of initiating a breast feeding support group in 2014.

2015: Modify promotion efforts as necessary and expand to additional sites as determined.

Measurement: Achieve 80% breastfeeding rate at post-delivery (prior to discharge)

Reduce Heart Disease

c. Chronic Heart Failure (CHF) Reduction Program

SJMH is committed to giving patients with a diagnosis of chronic heart failure (CHF) the tools they need to manage their health and improve quality of life. Through its Chronic Heart Failure Reduction Program, SJMH works closely with clinicians, dietitians, patients and families to monitor symptoms, activity, diet and medications. Key to success of the program is patient education that is evidenced-based, current and user-friendly. SJMH is expanding its patient education resources to reduce cardiac readmissions, complications and emergency room visits, and improve overall rehabilitative outcomes.

The three-year plan is designed as follows:

2013: Establish CHF criteria classification and staging criteria for SJMH's inpatient population. Develop a standardized post-discharge reporting tool to provide timely, enhanced communication with clinicians regarding patients' rehabilitative progress.

2014: Utilizing the new in-house education center, develop individualized education plans for outpatient cardiac rehabilitation clients around topics such as heart failure signs and symptoms, diet, medications, exercise and disease self-management. Develop telephone case management capability to help rehabilitative clients review their progress with staff and reinforce compliance with treatment. Provide inpatient education through access to the Patient Channel®, a 24-hour network that provides free, in-room education on CHF and chronic disease topics.

2015: Establish mechanism to refer cardiac patients to an outpatient heart failure clinic or telehealth resources to manage their disease and prevent unnecessary admissions.

Measurement: Create the infrastructure to reduce the incidence of stage II chronic heart failure patients advancing to stage III acute admissions. Tracking and measurement will be driven by the overall use of the education programs and heart failure referrals. When chronic heart failure criteria are established, SJMH will begin to track categories of patients presenting in the emergency department, leading to monitoring of admissions based on stage/severity. Ultimate goal is to reduce transferring/admitting stage III patients by 20%.

d. Heart Disease Support Group

Community-based heart support groups provide education, information and encouragement to cardiac patients and their families for coping with the physical and emotional stresses of cardiovascular disease. SJMH will create a community-based Heart Disease Support Group to supplement ongoing education and behavior modification efforts initiated during hospitalization, ultimately to achieve long-term maintenance of changed behavior and better health.

The three-year plan is designed as follows:

2013: Develop criteria for Hornell-based Heart Disease Support Group objectives. Identify potential participants, with focus on SJMH outpatients in their early post-discharge or long-term maintenance period.

2014: Develop a marketing strategy that targets appropriate clinicians and cardiology groups, to generate awareness and support of the program.

2015: Implement the marketing strategy to drive referrals and elicit clinicians' participation in the program (as speakers, etc.). Expand geographic outreach to establish a similar group in the Bath area.

Measurement: Reduce the rate of cardiac-related complications and hospitalizations by 50% among support group participants who have experienced a cardiac event.

Reduce Tobacco Use With Low Income/Mental Health Populations

b. Tobacco Use Assessment with Adolescent Outpatients

Child health care clinicians are in a unique and important position to address parental and adolescent smoking. SJMH is initiating a program to address adolescent tobacco use with low-income patients as part of a new outpatient behavioral health outreach initiative. The strategies will integrate evidence-based tobacco use screening, cessation assistance and referral to services. A tobacco use assessment will be included as part of the psychiatric screening in three SJMH outpatient offices. Adolescent patients who use tobacco will be offered consultation, primary treatment (i.e. medications) and family counseling.

SJMH's three-year plan is designed as follows:

2013: Develop the program goals, assessment tool, tracking tool and infrastructure with anticipated rollout in calendar year 2014.

2014: Engage SJMH adolescent psychiatrist to identify tobacco users among low-income patients (ages 11 – 17), by documenting smoking status during mental health consultations at three clinical offices. Gather data about tobacco use, assess patients' interest in quitting smoking and acceptance of cessation assistance, and provide educational materials and information on free or low-cost cessation services and products. Recommend pharmacotherapy, as appropriate, for relief of withdrawal symptoms and to aid cessation. Provide documentation in patient charts for manual tracking of the program.

2015: Track and document success of patients' smoking cessation efforts during follow up visits with primary care providers. Train pediatrics clinicians to conduct smoking assessment and counseling. Modify the program as necessary.

Measurement: SJMH will track the number of adolescent psychiatric patients in three outpatient clinics assessed positive for tobacco use; number who receive smoking cessation information and assistance information; and number who actually stop using tobacco within one year of clinical interaction. Caveat: The ability to maintain information on patients over a three-year period will be wholly dependent upon continued use of SJMH's adolescent psychiatrist or a primary provider in the Hospital system. In addition, once patients reach the age of 18 SJMH will be unable to follow them. Creating a position of smoking cessation coordinator would greatly enhance program results, but SJMH currently cannot fund this position without State or other assistance.

Dissemination of the Plan to the Public

SJMH will disseminate its Community Service Plan (CSP) and annual updates in a variety of ways including the employee intranet, public website (www.stjamesmercy.org) and e-mail. Notices of availability will be placed with the local media. Copies of the CSP will be made available to the Health Association of NYS (HANYS), appropriate CHE (Catholic Health East) Trinity Health administration, and SJMH administration and management. SJMH staff and physicians will be notified that the CSP is posted on the employee intranet. The CSP will also be made accessible to local community leaders and organizations such as the mayor of Hornell, mayor of North Hornell, Hornell Chamber of

Commerce, Hornell Partners for Growth, St. James Mercy Hospital Board of Directors, St. James Mercy Foundation Board of Directors, St. James Mercy Properties Board of Directors, Catholic Charities, Steuben Rural Health Network, and Steuben County Health Priorities Team. Portions of the plan will be used for business development activities and presentations. SJMH will track and evaluate progress of its plan of action on an annual basis, make mid-course corrections and additions as appropriate, and submit/post updates to interested parties as noted above.

Process to Maintain Engagement with Local Partners

SJMH will continue to actively participate as a member of Steuben County Health Priorities Team, comprised of key partners from a wide range of health/social service organizations throughout the county:

- Steuben County Public Health Department
- St. James Mercy Hospital
- Arnot Health
- Guthrie Health
- Steuben Rural Health Network
- Health Ministry of the Southern Tier
- S^{2}AY Rural Health Network
- Cancer Services Program of Steuben County

This group will continue to meet regularly to ensure that the initiatives outlined in the Steuben Health Priorities Team Work Plan are implemented, monitored and evaluated, and to provide support to Team members for internal initiatives. SJMH will also maintain close working relationships with the community partners outlined in its individual Community Service Plan to ensure effective utilization of resources and track progress toward addressing county health priorities.

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Appendix A

2013 – 2015 Steuben Health Priorities Team Work Plan (of which SJMH is an active member)

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in Children and Adults					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**A. Create community environments that promote and support healthy food and beverage choices and physical activity**	A1. Support and encourage programs such as 10K walk/run through Ira Davenport, Walk with the Doc through Guthrie, Pop Can Fun Run through Corning Hospital, Girls on the Run, Strong Kids Safe Kids, the Wine Glass Marathon, Hornell CSD Pace grant and the Fit and Fun Program through Hornell YMCA.	Steuben Health Priorities Team (SHPT), Public Health (PH), Local Hospitals	November 2013 – ongoing	# of participants, # of activities
		A2. To increase community physical activity, investigate and contact applicable parties to compile resources and create a central guide to promote local hiking trails and the area's natural resources. Investigate creating and annually updating an online resource guide as well as the cost of printed copies. Provide link to guide on partner websites and social media outlets.	SHPT with possible partners: Steuben County Conference and Visitors Bureau, Chemung County "River Friends", Traffic Safety Board, 2-1-1	January 2014 – ongoing	Schedule created to update guide, guide created, QR code created, online hits, # of partners posting link
		A3. Advocate for the inclusion of creating healthy environments with Regional Economic Development Council, including the Rails to Trails program.	SHPT, County Rotaries	January 2014 – ongoing	# of contacts made # of projects including healthy environments proposed
		A4. Work with local media to reach community members highlighting our initiatives. Efforts will include social media, radio shows/service announcements and striving to develop a relationship with WETM and other local television shows to explore the possibility of creating a yearly campaign.	Local TV stations (WETM), local radio stations, PH, SHPT	April 2014 – ongoing	# PSA's/messages provided to various media outlets, # appearances made/social media posts ("likes", etc.)

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in Children and Adults					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**A. Create community environments that promote and support healthy food and beverage choices and physical activity**	A5. Investigate and continue to develop and expand joint use agreements with county schools. Create a list of current joint use agreements and resources open to the community.	13 Steuben County School Districts, PH, SHPT	January 2014 – ongoing	# of joint use agreements, list of resources available to community members (parks, basketball courts, etc.), provide information online and track hits
		A6. Work with Corning-Painted Post Schools to attempt to expand the implementation of the PE 4 Life program including additional training of staff, equipment purchases and group advocacy with the school board.	Corning Hospital, Superintendent of schools	April 2014 – ongoing	# of staff trained, funding secured, equipment purchased
		A7. Work together to increase breastfeeding in Steuben County. Increase access to breastfeeding information and encourage continued breastfeeding after leaving the hospital. Inform and assist worksites with breastfeeding policies. Encourage healthcare professionals to heavily promote the benefits of breastfeeding, including triggers in EHR (if possible when in place), and encourage referrals to community resources. Engage and support WIC to heavily promote and support breastfeeding among their clients. Encourage breastfeeding rally sponsored by WIC and continue one-on-one support to mothers through Public Health.	Local Hospitals, WIC (Women, Infants & Children), PH	January 2014 – ongoing	EMR/EHR documentation of education in applicable facilities, % of women exclusively breastfeeding and breastfeeding at 6 months, % increase of WIC mothers breastfeeding at 6 months

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 1: Reduce Obesity in Children and Adults					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/Evaluation**
Reduce Obesity in Children and Adults	**B. Expand the knowledge base of partners in obesity prevention**	B1. Identify emerging best practices.	SHPT, Local Hospitals	April 2014 – ongoing	Best practices identified And posted online
		B2. Evaluate obesity prevention initiatives.	SHPT, Local Hospitals	September 2014 – ongoing	Initiatives evaluated, data collected and analyzed
		B3. Investigate database development to strengthen the case for resource allocation and obesity reduction programs to share with policymakers.	Local Hospitals, SHPT	January 2015 –- ongoing	All data tracked and analyzed, results shared
	C. Expand the role of public and private employers in obesity prevention	C1. Provide and promote opportunities for physical activity and links to available resources including the new hiking guide, local gyms and farmers markets to public and private employers.	SHPT, Local Hospitals, PH, Steuben RHN (Rural Health Network)	September 2014 – ongoing	Opportunities provided and promoted, online resources provided, # hits tracked
		C2. Promote, support and conduct Know Your Numbers Campaign headed by Corning Hospital and public health.	Corning Hospital, SHPT	May 2014 – ongoing	Launch of program, # of participants
	D. Increase access to high quality chronic disease preventive care and management in clinical and community settings	D1. Educate healthcare professionals to talk with their patients about their weight, nutrition, and physical activity (such as Guthrie's bariatrician). Develop a resource guide for providers regionally.	Guthrie Health, Local Hospitals, SHPT	September 2014 – ongoing	# educated, # resources disseminated

Prevention Agenda Focus Area: Prevent Chronic Disease Goal 2: Reduce Heart Disease and Hypertension					
Strategy Area	**Objective**	**Activities**	**Partners**	**Timeframe**	**Measurement/ Evaluation**
Reduce illness, disability and death related to heart disease and hyper-tension	**A. Prevention, screening, early detection, treatment, and self-management support.**	A1. Work to prevent heart disease and hypertension by assisting Office for the Aging, local hospitals and long term care facilities in reducing sodium content in all meals served including to patients, visitors, staff and the public.	Local Hospitals, Office for the Aging, ProAction, PH	October 2013 – ongoing	Establish a baseline. Reduce sodium content in meals by 30% over 3 years, by November 2016
		A2. Investigate possibility of expanding heart disease support group in Hornell. Promote support groups of all local hospitals.	Guthrie Health, St. James Mercy	September 2014 – ongoing	Creation of support group, # participating
	B. Reduce exposure to secondhand smoke	B1. Invest in efforts to create smoke-free environments throughout the community, encouraging Steuben County government to lead by example.	PH, STTAC (Southern Tier Tobacco Awareness Community Partnership)	January 2016	Steuben County government policy developed and implemented, # of smoke free policies implemented
		B2. Highlight dangers of tobacco through public service announcements and promote media campaigns with hard hitting cessation messages and the importance of tobacco free outdoors.	SHPT, Local Hospitals, Health Ministry of the Southern Tier, PH, STTAC, Tobacco Cessation Center	May 2014 – ongoing	# PSA's provided, # campaigns held

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Reduce illness, disability and death related to heart disease and hyper-tension	**C. Promote tobacco cessation, especially among low SES populations and those with mental health illness (disparity)**	C1. Promote cessation counseling to community residents targeting people with disabilities, mental health and substance abuse problems. Promote NYS Smokers' Quitline. Provide tobacco cessation education to clients of organizations such as home care, ARC, ProAction, Cancer Services Partnership, HMST and hospital patients. Work to promote cessation messages by sending out Quitline cards, showing cessation videos at DSS, and conducting assessments at family practice clinics in Alfred/Hornell/Wayland that include tobacco use.	2-1-1, Local Hospitals, PH, SHPT, Health Ministry, Steuben RHN, STTAC, CSP (Cancer Services Program), Tobacco Cessation Center	September 2014 – ongoing	# NYS Smokers' Quitline calls, #agencies/organizations participating in tobacco cessation education to clients
	D. Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations	D1. Participate in local and national activities and/or events that educate the public on the impact of retail tobacco marketing on youth (Point of Sale - POS) such as the Great American Smoke Out, Kick Butts Day, World No Tobacco Day, Strong Kids Safe Kids and the Adolescent Health and Wellness conference.	Local Hospitals, PH, Steuben RHN, STTAC, Tobacco Cessation Center, Local Schools	January 2014 – ongoing	# activities held and/or events attended

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Reduce illness, disability and death related to heart disease and hyper-tension	**E. Train primary care providers (PCPs) to talk with their patients about their weight and tobacco use. Provide link on EMR to community resources available for patients**	E1. Create a list of community resources specific to diagnosis and investigate the possibility of uploading into EHR's.	2-1-1, Local Hospitals, Health Ministry of the Southern Tier	September 2015 – ongoing	Inventory list of resources and availability on EHR, track usage
		E2. Provide resources and literature to educate healthcare professionals to talk with their patients about their weight (including physical activity and diet) and their tobacco use, as appropriate. Encourage discussions that include dividing goals into manageable milestones and that healthcare professionals can easily link their patients with available community resources. Investigate the use of EHR as a tool for health care providers to link patients with appropriate community resources.	Local Hospitals, Health Ministry of the Southern Tier	September 2015 – ongoing	# educated, # resources disseminated, track usage of EHR resources where applicable
		E3. When and if available, encourage the use of decision support/reminder tools of EHRs, as well as the community resource list. When and if available, continue calls by nurses to follow up with patients on follow through/ compliance. Monitor implementation.	Local Hospitals, PH, Health Ministry of the Southern Tier, SHPT	January 2015 – ongoing	Implementation of decision support and reminder tools and referrals to community resources in EHR where applicable, documentation of use and documentation of calls via EHR where applicable

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Reduce illness, disability and death related to heart disease and hyper-tension	**F. Develop infrastructure for widely accessible, readily available chronic disease self-management (CDSMP) and diabetes prevention programs**	F1. Provide CDSMP programs and continue to recruit peer trainers	Steuben RHN, PH, Southern Tier Diabetes Coalition	January 2014 – - ongoing	# of classes # trained
		F2. Offer Diabetes Prevention programs as need is expressed in the county			# participants
		F3. Sustain links to Emory University's Diabetes Training and Technical Assistance Center, and the NYS Diabetes Prevention Program and QTAC			Links sustained
	G. Promote CDSMP and Diabetes Prevention programs to health-care providers	G1. Conduct campaign that includes activities such as PSAs, articles, letters to the editor, postings on social media, mailings to healthcare providers, meetings with practice managers	Steuben RHN, PH, Southern Tier Diabetes Coalition, Local Hospitals	January 2014 – ongoing	# of articles, letters, mailings and meetings
		G2. Provide business model to hospitals/healthcare providers on the improved health outcomes with CDMSP and Diabetes Prevention programming			Business model provided
	H. Maximize organizational capacity to provide CDMSP and Diabetes Prevention Programs	H1. Explore reimbursement strategies under the new Affordable Care Act and the selected Steuben County insurance vendors for CDMSP and Diabetes Prevention programs	Steuben RHN, PH	January 2014 – ongoing	Strategies explored and findings communicated to SHPT