Community Service Plan 2016

St. Lawrence County, NY

St. Lawrence County Public Health Department
80 State Hwy 310, Suite 2
Canton, NY 13617
Contact: James Rich, MPH, Director

Gouverneur Hospital
77 West Barney Street
Gouveneur, NY 13642
Contact: Jennie Flanagan, Chief Quality/Compliance Officer
jflanagan@gvnrhospital.org
315-535-9229

Coalition Completing Assessment on Behalf of Gouverneur Hospital:

St. Lawrence Health Initiative
6439 State Hwy 56
PO Box 5069
Potsdam, NY 13676
Contact: Anne Marie Snell, Executive Director
anne@gethealthyslc.org

Adirondack Health Institute
101 Ridge Street
Glens Falls, NY 12801
Contact: Margaret Vosburgh, CEO
mvosburgh@ahihealth.org

St. Lawrence Health System's Community Health Needs Assessment available at:
www.stlawrencehealthsystem.org

Executive Summary

Gouverneur Hospital (GH), under its parent, St. Lawrence Health System, Inc., (SLHS) conducted a formal Community Health Needs Assessment in 2014, which encompassed SLHS's extensive research on needs conducted for the North Country Health Systems Redesign Commission and its own strategic planning process. Based on the needs of the North Country, SLHS has developed a comprehensive plan designed to increase specialist and primary care physician and mid-level provider recruitment and retention; expand and enhance access to outpatient services; and improve quality of healthcare services for the people of the St. Lawrence County.

In alignment with New York State's Prevention Agenda, two priorities and one disparity guide our work and this Community Service Plan (CSP) over the next three years. The two priorities selected are: 1) Increasing access to high-quality chronic disease preventive care and management in clinical and community settings; and 2) Promoting mental health and preventing substance abuse. The disparity that will be addressed is geographic isolation, specifically transportation needs.

In 2013 our local area health coalition chose to focus its efforts on chronic disease with an emphasis on heart disease. While we continue to address this condition, in the next three years our focus will be on preventing obesity and reducing tobacco use. The 2013 CSP focus on mental health and substance abuse disorders remains unchanged. In 2013, a major disparity identified was the availability of cancer screenings. We continue to emphasize access to cancer screenings while shifting our focus to the broader disparity affecting access to care: geographic isolation.

Data reviewed are detailed in the St. Lawrence Health System Community Health Needs Assessment document. In summary, we relied on federal Census data, New York State Department of Health Data, and data available through the Robert Wood Johnson Foundation's County Health Rankings.

Gouverneur Hospital's (GH) two major partners in assessing and planning for the community's health needs are St. Lawrence Health Initiative (SLHI) and Adirondack Health Institute (AHI). SLHI is a coalition of hospitals, healthcare organizations, and the local Public Health Department. AHI is the Performing Provider System (PPS) network under which GH pursues Delivery System Reform Incentive Payment (DSRIP) program goals. These goals have arisen from our Community Health Assessment and shape this Community Service Report.

Community engagement in assessing and planning for community health needs is sought in a variety of ways, including meetings with community leaders, service groups, and civic organizations; a survey carried out by St. Lawrence Health Initiative; representation on the hospital's and System's board of directors from leaders representing all sectors of the community; representation on a Patient Advisory Council by members from across the spectrum; and one-on-one meetings with community and government leaders.

Specific evidence-based interventions and strategies being implemented to address specific priorities and the health disparity are to dedicate staff members to specific roles; adopt hospital policies on food and beverages served to patients and employees and develop a program for improving the health status of employees; develop and enhance partnerships with community groups; and establish school-based programs. Supplementing these programs and assisting to increase awareness of the issues they address is a robust series of community engagement strategies. These include an education series conducted in conjunction with SOAR North Country, a member-directed lifelong learning organization; community luncheon-lectures held at the hospital and in community centers; health fairs in conjunction with community partners; a Women's Wellness Day open to all community members; and outreach to food bank clients via the St. Lawrence County Community Development Program.

Measurement of progress and improvement is tracked in several ways: through DSRIP reporting on health improvement; through survey data; through COMPASS (QTAC-NY) data; and through hospital readmission and ER visit data. Staff members involved in implementation and measurement include providers, nutritionists, social workers, nurse managers, care managers, along with the Chief Quality/Compliance Officer. See Work Plan below for specific process measures.

Report

1. Central, Eastern, and Southern St. Lawrence County are the communities being served by Gouverneur Hospital (GH) and this Plan. The service area has been defined by patient zip codes from our primary service area, which encompasses the Towns of Canton, Hermon, Richville, Dekalb Jct., Gouverneur and Antwerp; and a secondary service area defined by the Towns of Edwards, Harrisville and Indian River.

   This area of St. Lawrence County is largely rural. Its population of approximately 111,900 is served by two sole community provider hospitals (CPH and Claxton-Hepburn Medical Center), one municipal hospital in Massena (Massena Memorial), and two Critical Access hospitals, (Gouverneur as the sister hospital to CPH, and one in Clifton-Fine). These hospitals lie at least 30 miles from one another. No roadway wider than two lanes serves the County. The communities these hospitals serve are remote from one another and difficult to reach in winter weather conditions, which can prevail for more than six months of the year. There is sporadic public transportation.

   St. Lawrence County's population is classified by the US Census as overwhelmingly "white, non-Hispanic." A portion of the population is "transient," in that it is composed of college students and seasonal residents. One of the fastest growing segments of the population is the Amish community. The population is poor and suffers from higher rates of obesity, tobacco use, deaths from alcohol abuse, and chronic conditions than other parts of the state. Mental health services and substance abuse prevention and treatment services are few and far between. Of 62 counties in New York, St. Lawrence ranks 51st for overall health as measured by the Robert Wood Johnson Foundation County Rankings. Median household income is $32,356, compared to

$59,269 for households in all of New York State. The unemployment rate is 7.7% compared to 6.3% for all of New York. This rural, remote environment is less conducive to physical exercise and healthy eating than in other areas of New York or the nation. St. Lawrence County includes two federal EPA Superfund Clean-up sites located in Massena and Lisbon.

2. Data used for this Plan come from several sources and are detailed in the St. Lawrence Health System's Community Health Needs Assessment. Data sources include the Prevention Agenda Dashboard, County Health Rankings, US Census Bureau, Behavioral Risk Factor Surveillance System, SPARCS, and our Performing Provider System network partner, Adirondack Health Institute (AHI). In addition, data were sourced from Health Data New York and from a survey conducted in 2016 under the auspices of the St. Lawrence Health Initiative.

3. This Plan provides objectives, tactics, and a time-frame for addressing two Prevention Agenda Priorities and one Disparity. The two Priorities are to 1) Prevent Chronic Disease; and 2) Promote Mental Health and Prevent Substance Abuse. The Disparity chosen is isolation, specifically lack of transportation. GH joined with its Local Health Department (LHD) and other hospitals and healthcare organizations under St. Lawrence Health Initiative, which sponsored a Community Health Needs Assessment for a tri-County area including St. Lawrence County. These data and conclusions of that CHNA confirmed earlier conclusions for our service area reached through our own strategic planning, through the North Country Healthcare Redesign Commission process, and through the Delivery System Reform Incentive Payment (DSRIP) program. Through our participation in the AHI PPS, a CHNA was performed and is congruent with our LHD effort.

The Work Plan involves several already-established programs: the Health Coaches program refers to pre-health college students who undergo a rigorous healthcare immersion experience, followed by being matched with a patient who has a chronic disease. Health Coaches act as liaisons between the patient in his or her home and the healthcare system. The program has expanded to include all four area colleges. It has also begun to include a Health Buddy component, in which students are matched with appropriate children and their families for coaching on proper nutrition, exercise, and sleep habits that have been proven to combat obesity.

Living Healthy Workshops are modeled on an evidence-based program developed by Stanford University. Over a six-week period, participants learn to set goals relating to their chronic disease(s), develop strategies and tactics to achieve their health goals, and learn techniques for managing their disease(s) out of the hospital setting.

Dynamic Dialogue™ is an evidence-based tobacco cessation intervention developed by Dr. Eric Seifer, a pulmonologist on the staff of St. Lawrence Health System. Dr. Seifer has prior training in behavioral health and is also the medical director of population health for SLHS.

Peer recovery coaches and a patient navigator for substance abuse and mental health disorders are new programs that will be launched in 2017 as part of the Work Plan.

See the Work Plan below under item 4 for details of each program's objectives and timeline.

4. Work Plan:

Priority 1: Prevent Chronic Disease

Strategy Area	Objectives	Interventions/ Strategies/Activities	Process Measures	Partners	Partner Resources	Timeframe	Will Action Address Disparity?
Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings	Improve self-management of chronic disease.	SWING Bed Program realignment to increase sub-acute services with co-morbid condition analysis.	Increase volume of Swing Bed Patients by 40%	SLHS Support; Hospitalist program implementation	Swing Bed education to community and providers of services; SMC Case Management collaborative meetings and Curaspan.	End of 2nd qtr. 2016 - fully implemented.	Chronic disease management and access to care

Cont.	Reduce readmission rates and ED visits	GH Clinic and Community Health Clinic, along with Primary Care Provider offices coordination of care	Readmission rates and ED visits within 6 month timeframe	SLHS Support; Hospitalist program implementation and PCP at GH Clinic establishment for those without PCP.		Implement by Year end 2016- utilizing baseline reduce readmissions by 10%	Chronic disease management
	Provided home-based intervention for target population	GH Clinic and Community Health Clinic, along with Primary Care Provider offices coordination of care	Number of participants enrolled in the program	SLHS Support; Hospitalist program implementation; Clinic, Community Health and PCP offices		Implement PCMH by end of year 1; obtain baseline data of population served and increase by 10 % year 2; and increase by 20% year end 3.	Elderly population
	Improve self-management of chronic disease.	Living Healthy Workshops	Quality and Technical Assistance Center of New York (QTAC-NY) COMPASS survey data	SLHS Support QTAC-NY/Center for Excellence in Aging & Community Wellness	Continuing education and certification for peer leaders.	Conduct at least 4 Living Healthy Workshops per year.	Chronic Disease population

Reduce Obesity in Children and Adults	Create community environments that promote and support healthy food and beverage choices and physical activity.	Coaching Health: Implement peer coaching model for physical activity, sleep, nutrition, and overall wellness in a school based setting	BMI	Cornell Cooperative Extension	Established nutrition programs	Implement school based program in year one in one Gouveneur school. Expand to at least 2 schools by year 3	Geographic isolation and barriers that limit educational opportunities for healthy choices.
	Promote physician leadership, patient engagement and mutual accountability	Dynamic Dialogue Institute	Number of patient that quit in 1 year	SLHS Support; Hospitalist program implementation; Clinic, Community Health and PCP offices	GH Respiratory Department; Pulmonologist CPH; System Support	Implement data collection within EMR within GH, clinics and PCP offices obtaining baseline by first year end. Increase numbers subsequent years by 10%.	Transportation Access to Care and Chronic Disease Management

	Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.	Tobacco Education and Prevention:	Youth Smoking rates in St. Lawrence County	Seaway Valley Prevention Council	School aged children	All grade levels in all SLC schools will receive tobacco use prevention education by January 2018.	Geographic barriers that limit educational opportunities.
		Dr. Seifer will deliver tobacco education and prevention programming to all school aged children in St. Lawrence County		St. Lawrence County School Psychologists	Established school based, evidence based programming.		
	Reduce tobacco use among target population	Tobacco Use Youth Intervention:	Youth smoking rates in St. Lawrence County.	Seaway Valley Prevention Council	Teen Intervene Program	Tobacco Interventions will be offered on an as requested basis over the course of the next year.	Geographic barriers and transportation

Priority 2: Promote Mental Health and Prevent Substance Abuse

Strategy Area	Objectives	Interventions/ Strategies/Activities	Process Measures	Partners	Partner Resources	Timeframe	Will Action Address Disparity
Promote mental, emotional and behavioral (MEB) well-being in communities	Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.	Tobacco Education and Prevention: Dr. Seifer will deliver tobacco education and prevention programming to all school aged children in St. Lawrence County	Youth Smoking rates in St. Lawrence County	Seaway Valley Prevention Council St. Lawrence County School Psychologists	School aged children Established school based, evidence based programming.	All grade levels in all SLC schools will receive tobacco use prevention education by January 2018.	Geographic barriers that limit educational opportunities.
	Reduce tobacco use among target population	Tobacco Use Youth Intervention: Dr. Seifer will conduct tobacco use interventions with youth who have been identified for early tobacco use and referred to the Teen Intervene program, an evidence-based SBIRT program.	Youth smoking rates in St. Lawrence County.	Seaway Valley Prevention Council St. Lawrence County Schools	Teen Intervene Program At risk youth referrals	Tobacco Interventions will be offered on an as- requested basis over the course of the next year.	Geographic barriers and transportation

Strategy Area	Objectives	Interventions/ Strategies/Activities	Process Measures	Partners	Partner Resources	Timeframe	Will Action Address Disparity
Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.	Support efforts to integrate MEB disorder screening and treatment into primary care.	Hire on a behavioral health staff member (LCSW, nurse, or psychologist) to provide counselling services for mild to moderate mental health risk patients within the PCMH. This staff will connect higher risk patients with tertiary services in Ogdensburg through the use of telehealth for counselling within the PCMH facility.	Number of SLC residents who report poor mental health and the number of SLC residents who report having medical care for mental health issues.	Claxton Hepburn medical Center Psychiatric Ward. St. Lawrence Psychiatric Center	Tertiary Psychiatric services	The addition of a behavioral health staff will be complete by June 2017. The use of telehealth for counselling will be established by January 2018.	Geographic Barriers and Transportation

5. Gouveneur Hospital maintains engagement with local partners through a variety of means. Local organization leaders are represented on the GH Board of Directors and the board of the organization's parent, St. Lawrence Health System (SLHS). Annually, a meeting is held to gather input from the community. Throughout the year, multiple engagement opportunities occur with the partners listed in the Work Plan as well as other community groups related to them. In addition, multiple informal relationships flourish through service by the hospital's managers and senior leadership on the board of the local rescue squad, hospice organization, health education center, service on emergency medical service and fire squads and service as volunteers for local charitable organizations, including a free clinic. Through these connections, GH continually seeks input on emerging needs and how it is meeting those needs, and develops new programs. GH also has assistance from the community in supporting its medical staff recruiting: for example, college officials partner informally with GH to locate employment opportunities for spouses of potential primary and specialist recruits to the medical staff. Through sponsorship advertising, GH supports the efforts of a number of organizations. These efforts are tied to our goals under the Work Plan. For example, GH sponsors several charity events, supports three local food banks, and, through its parent SLHS, the St. Lawrence Health Initiative's Junior Iron Chef competition that involves school districts from across the region. SLHS sponsors with a local grocery chain partner, at a cost of approximately $30,000, distribution of a printed calendar to the community: the calendar contains healthy recipes, including winning recipes from the Junior Iron Chef competition. GH sponsors "Let's not meet by Accident" programs in cooperation with law enforcement and rescue personnel to impress upon high school students the impact of impaired driving; multiple

community education programs targeted at known regional health concerns including obesity, diabetes, women's health; participates in local health fairs and sponsors free health screening programs.

6. This Community Service Plan's Executive Summary will be made widely available to the public by being posted to the Gouverneur Hospital website and also on the St. Lawrence Health System website: www.gvnrhospital.org; www.stlawrencehealthsystem.org. In addition, the full report will be mailed to the 300+ members of the Friends of the St. Lawrence Health System, a group of community leaders and advocates for healthcare sustainability in the North Country.