

St. Joseph Health System

Implementation Strategy Narrative

Overview

St. Joseph Health System, a member of Ascension Health, is a 47-bed acute care facility providing medical care to the communities of Iosco County and the sunrise side since 1953. Our Catholic philosophy directs us to care for those most in need, permeates our ministry, and strengthens our commitment to provide Healthcare That Works, Healthcare That is Safe, and Healthcare That Leaves No One Behind.

From September 2015 to April 2016, a comprehensive Community Health Needs Assessment (CHNA) was conducted by St. Joseph Health System (SJHS) in collaboration with District Health Department #2, AuSable Valley Community Mental Health, and a network of community stakeholders. The Community Health Needs Assessment is a valuable tool used to identify and prioritize Iosco County's significant health issues and to develop and implement action plans, and pursue funding opportunities. This assessment process is an extension of the previous CHNA that was published in 2013.

The 2016 Community Health Needs Assessment includes collection and review of the most recent secondary data from local, state and federal sources as well as input from community members, stakeholders and partners. Health specific data, as well as data that outline the social determinants of health were also included.

An external collaborative group was formed to promote community collaboration, collect, share and interpret data, identify health disparities and determine resources to address those needs. This group represents a broad section of the population including: business, health care, education, social service agencies, and community leaders. Primary data was also gathered in the form of a community-wide survey in order to determine the health challenges of those we serve including the most vulnerable. Once preliminary data was collected, it was strategically shared with the external steering committee and network of collaborative partners. Subsequent meetings were held to produce a list of current community programs and resources available, as well as, finalize a prioritized needs list. Data was also reviewed by District Health Department #2 Health Officer, Denise Bryan.

Prioritized Needs

Through a comprehensive process of data collection and analysis, and gathering input from community members, the 2016 Community Health Needs Assessment has identified the following health challenges and issues as the highest priority needs for Iosco County:

I. Chronic Disease Management

Overall, Iosco County ranks among the poorest in the state for health outcomes (81 of 83 counties) and the worst for Length of Life (83 of 83). Community members list obesity and overweight issues, high blood pressure and diabetes as the most prevalent health care challenges they face. It is also well documented that almost ½ of those trying to manage a chronic illness have multiple conditions. Centers for Disease Control and Prevention reveal that nearly 45% of Iosco County residents are obese, nearly 60% of adults aged 18 and older self-report that they have been told by a doctor, nurse or other health professional that they had high cholesterol, 52% of the Medicare population reports hypertension (high blood pressure) and 9.9% of Iosco County has been diagnosed with Diabetes.

II. Health and Lifestyle Education

Overall, Iosco County ranks among the poorest in the state for health behaviors (81 of 83 counties) and the worst for Length of Life (83 of 83). Iosco County also ranks 42nd of 83 for health behaviors including challenges in adult smoking (25%), inadequate fruit and vegetable consumption (83%) and physical inactivity (22%). Particularly alarming is the percentage of mothers who smoked while pregnant at nearly (38%). This is a leading health factor contributing to poor delivery outcomes. In a community-wide survey, community members (55%) list improving nutrition as a high priority in improving the health of their community. As part of the nutrition spectrum, fruit and vegetable consumption is a relevant indicator of healthy eating practices. Current behaviors are determinants of future health and the low consumption of healthy foods can lead to significant health issues. Our health is directly linked to what we eat or don't eat. Michigan Profile for Healthy Youth Survey (MiPHY) data reports 15% of middle school students as obese (at or above the 95th percentile for BMI by age and sex) and 21% as overweight (at or above the 85th percentile and below the 95th percentile for BMI by age and sex). High school students in the 11th grade are reported as 17% obese and 14% overweight. It is interesting to note that 51.9% of middle school and 47.7% of high school students report trying to lose weight.

III. Behavioral Health

Mental health is a major concern in the community. In a community-wide survey, residents (41%) list improving mental health services in regards to suicide and depression as a high priority, ranking it one of the top two needs in improving the health of the community. Suicide rates in Iosco County are more than double that of the state and national average. Centers for Medicare and Medicaid Services report that 17% of the Medicare population struggles with depression. Substance use and abuse is very real and reaching epidemic proportions. The number of Michigan deaths from drug overdose has tripled since 1999 with the majority of these deaths attributed to prescription drugs. Community members (32%) have also identified Substance Abuse Rehabilitation Services as a high priority in improving the health of the community. Internal data from the St. Joseph Health System Obstetrics Department shares distressing data in reference to drug use by expectant mothers. Of 174 deliveries since July 2015, 67 have resulted in Child Protective Services referrals due to positive drug screens and four newborn transfers for drug withdrawal.

Needs That Will Not Be Addressed

St. Joseph Health System will not directly address the transportation health need identified within the 2016 CHNA. Additionally, while access is not specifically called out as a strategy, it is embedded in each Implementation Strategy. While critically important to overall community health, the transportation priority did not meet internally determined criteria that prioritized addressing needs by either continuing or expanding current programs, services and initiatives to steward resources and achieve the greatest community impact. For the area not chosen, there are other service providers in the community better resourced to address this priority. St. Joseph Health System will work collaboratively with these organizations as appropriate to ensure optimal service coordination and utilization.

Summary of Implementation Strategy

An action plan follows for each prioritized need, including the resources, proposed actions, planned collaboration, and anticipated impact of each strategy. See attached action plans for each priority area.

Prioritized Need #1: Chronic Disease Management

GOAL: To support health care transformation and population health, SJHS will leverage the strengths of Ascension Mid-Michigan’s current chronic disease management programs and services throughout the region to develop the capacity to offer services and specialized disease specific education and programming including Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Congestive Heart Failure (CHF)

Action Plan: Disease Specific Education and Programming

STRATEGY 1: Provide Diabetes/Nutrition education accredited programming via St Joseph Health system in the Tawas community

BACKGROUND INFORMATION:

- **Target population:** Patients with Type 1 & 2 Diabetes Mellitus (DM), Chronic Kidney Disease (CKD), and adults/children who are at risk due to overweight/obesity
- **How the strategy addresses social determinants of health, health disparities and challenges of the underserved:** Iosco County ranks 81st of 83 counties for overall health outcomes. 9.9% of Iosco County residents have been diagnosed with Diabetes, 44% of the county’s population is obese, 59% have high cholesterol, and 30% have high blood pressure.
- **Strategy source:** DSME is evidence-based programming with specific program parameters and accreditation to achieve desired patient health outcomes. <http://dpacmi.org>
www.diabetes.org; www.cdc.org

RESOURCES: *(List resources that will be committed to implement strategy)*

- Regional Director for Diabetes and Wound Care, Certified Diabetes Educators, Community Health Workers, Registered Nurses (RN)/Registered Dietitians (RD)

COLLABORATION: *(List partner organizations and/or community groups that will collaborate on strategy)*

- PHO physician group, Ascension Medical Group (AMG), Ascension Michigan Population Health Affinity Team

ACTIONS: *(List main actions needed to implement strategy and achieve the SMART objectives above)*

1. Establish a multi-disciplinary task force to oversee the project and development of plan
2. Determine resource needs, allocation strategy and place/hours of operation.
3. Research accreditation requirement as it relates to Diabetes Education (American Association of Diabetes Educators-AADE; American Diabetes Association-ADA; State of Michigan)
4. Select and apply for Accreditation
5. Establish cost center and the structure and process to support charges/billing etc.
6. Establish education on and operationalize data base and clinical forms to enable patient scheduling and collection of all necessary elements required for Accreditation and annual reporting
7. Utilize newly developed communication tools/messaging (from Health & Lifestyle Education Strategy) to inform Physician groups, PHO organizations, and community of referral avenues for

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patients with Diabetes or Nutritional needs

- 8. Conduct DSMET program in Tawas community

ANTICIPATED IMPACT: *(List SMART objectives; ensure specific and measurable outcomes, i.e., change(s) in learning, actions and/or conditions):*

PROCESS OUTCOMES

Short Term – Diabetes Chronic Disease Management Program will be developed at St. Joseph Health System

Medium Term – Patients will be enrolled in Diabetes Self-Management Program (DSMET)

Long Term – For patient’s enrolled in DSMET group classes, will show increased healthy behaviors as demonstrated by any of the following: eating habits, weight loss, increased physical activity, improved lab/clinical results

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

OBJECTIVE:	STATE PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
Insert #	Identify relevant community objective(s)	Identify relevant state objective(s)	Identify relevant national objective(s)
Decrease the mortality and morbidity of diseases such as DM, CKD, CHF, complications, through education and nutritional management program	Community Health Needs: Chronic Disease Management Health & Lifestyle Education	Reduced Readmissions Standardized Diabetes Model of Care	<p><u>Healthy People 2020</u> Educational and Community based programs: Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life. Nutrition and Weight Status: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. DM: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.</p>

CKD: CKD and end-stage renal disease (ESRD) are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors.

National Kidney Disease Education Program (NKDEP): Improving the understanding, detection, and management of kidney disease.

Ascension Population Health/Fee-for-value focused on optimal patient outcomes, enhance patient and provider experience, and lower cost (quadruple aim)

Prioritized Need #2: Health & Lifestyle Education

GOAL: Leveraging the strengths of Ascension Mid-Michigan's current population health programs and services throughout the region, we will develop the capacity (meet people where they are) to offer services and educational programming to increase patient knowledge, and self-management/adoption of healthy behaviors to improve nutrition (access to and consumption of healthy food), weight (optimal weight for youth and adults), and physical activity

Action Plan: Community Messaging and Education

STRATEGY 1: Develop and implement a marketing strategy/consistent messaging to inform school-based and community audiences about adoption of healthy behavior to delay or mitigate the progression of poor health/disease

BACKGROUND INFORMATION:

- **Target population:** school-aged children, parents, seniors, business community, and health providers
- Iosco County ranks 81st of 83 counties for overall health outcomes, 83rd out of 83 for length of life; 42nd out of 83 for health behaviors with challenges in adult obesity (45%) and physical activity (26%)
- **Strategy source:** Partner with families and community members in the development and implementation of healthy eating and physical activity policies, practices, and programs (CDC.gov). Partnerships among schools, families, and community members can enhance student learning, promote consistent messaging about health behaviors, increase resources, and engage, guide, and motivate students to eat healthily and be active via: Encouraging communication among schools, families, and community members to promote adoption of healthy eating and physical activity behaviors among students; Involving families and community members on the school health council; Developing and implementing strategies for motivating families to participate in school-based programs and activities that promote healthy eating and physical activity; Accessing community resources to help provide healthy eating and physical activity opportunities for students; and Demonstrating cultural awareness in healthy eating and physical activity practices throughout the school. <http://www.cdc.gov/healthyschools/npao/strategies.htm>

RESOURCES: *(List resources that will be committed to implement strategy)*

- SJHS clinical staff; Registered Nurses/Registered Dietitians/Community Health Workers, Health Foundation representatives, Physicians, Marketing representatives.

COLLABORATION: *(List partner organizations and/or community groups that will collaborate on strategy)*

- Community Leaders/Businesses; Local Farmers/Farmers Market; Children's/ Community Garden; Religious organizations; Athletic businesses; grocery stores; IRESA, (Alternative Ed);

ACTIONS: *(List main actions needed to implement strategy and achieve the SMART objectives above)*

9. Establish a Community Advisory Group comprised of key health system and community stakeholders to oversee the project and development of plan
10. Develop and implement a consistent messaging campaign strategy for school-based activities to inform the students/staff/parents/providers about the adoption of healthy behaviors
11. Connect with Chronic Disease Management strategy to create information that will be utilized for school-aged students – with focus on Diabetes
12. Hire a Community Health Worker to facilitate outreach/education programs
13. Increase scope and reach of current school-based programming to promote wellness for 5th grade students and families In the Tawas school district through: backpack program; Friday Folder program; Fit Kids program; Healthy Kids Rock program

STRATEGY 1: Develop and implement a marketing strategy/consistent messaging to inform school-based and community audiences about adoption of healthy behavior to delay or mitigate the progression of poor health/disease

ANTICIPATED IMPACT: *(List SMART objectives; ensure specific and measurable outcomes, i.e., change(s) in learning, actions and/or conditions):*

PROCESS OUTCOMES

Short Term – Health and Lifestyle Education Community Advisory Group will be formed and a program targeted at 5th grade students in the Tawas Area Schools will be developed

Medium Term – Community Health Worker will begin outreach and education programming in the schools

Long Term – Students and families will demonstrate improved self-reported knowledge, and increase consumption of fresh fruits and vegetables, regular physical activity and reduced screen time

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

OBJECTIVE:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
Insert #	Identify relevant community objective(s)	Identify relevant state objective(s)
Decrease the mortality and morbidity of diseases such as DM, CKD, CHF, complications, through education and nutritional management program	Community Health Needs: Chronic Disease Management Health & Lifestyle Education	<p>Identify relevant national objective(s)</p> <p><u>Healthy People 2020</u> Educational and Community based programs: Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life. Nutrition and Weight Status: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. DM: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM. CKD: CKD and end-stage renal disease (ESRD) are significant public health problems in the</p>

United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors.

National Kidney Disease Education Program (NKDEP):

Improving the understanding, detection, and management of kidney disease.

Ascension Population Health/Fee-for-value focused on optimal patient outcomes, enhance patient and provider experience, and lower cost (quadruple aim)

Prioritized Need #3: Behavioral Health

GOAL: Leveraging the strengths of Ascension Mid-Michigan's current population health programs and services throughout the region, we will develop the capacity (meet people where they are) to offer therapeutic services and educational programming to increase patient knowledge and adoption of healthy behaviors to improve mental health, and mitigate substance abuse, abuse, and violent behavior.

Action Plan: Physician and Community Prescription Education

STRATEGY 1: Enhance and/or adapt/create programming to educate about prescription drug use and mitigate abuse

BACKGROUND INFORMATION:

- Target population will be youth, parents, seniors, pregnant women, physicians, health/treatment providers including home health providers (Reverence), law enforcement, hospitals/clinics
- **How the strategy addresses social determinants of health, health disparities and challenges of the underserved:** Iosco County ranks 81st of 83 counties for overall health outcomes. The sited Medicare population in Iosco County dealing with depression is 17%. Suicide rates in Iosco County are nearly double that of the State of Michigan or the national average. 39% of newborn deliveries resulted in a Child Protection Services referral due to positive drug screens.
- **Strategy source:**
http://www.michigan.gov/lara/0,4601,7-154-72600_72603_55478-232708--,00.html
Centers for Disease Control and Prevention

RESOURCES: *(List resources that will be committed to implement strategy)*

- Anti-Stigma toolkits; NEMSAS – peer recovery counselors; support groups; volunteers, credentialed staff; CMH; Drug Courts; aligned physician team; MAPS system, community education for substance abuse; law enforcement

COLLABORATION: *(List partner organizations and/or community groups that will collaborate on strategy)*

- NEMSAS, AuSable Valley Community Mental Health, Catholic Human Services, NEMSAS, County Drug Court, SJHS physicians, law enforcement

ACTIONS: *(List main actions needed to implement strategy and achieve the SMART objectives above)*

14. Conduct a provider workshop regarding prescription drug dosage, use, and potential for abuse
15. Identify a training program and provide de-escalation training for ER staff to promote a safer environment for staff, associates, and patients
16. Obtain broad community support and participation in Michigan’s Automated Prescription System (MAPS) to protect providers and reduce prescription drug abuse
17. Collaborate with community mental health to expand and enhance limited mental health services via telemedicine utilizing existing telehealth equipment
18. Link with messaging campaign proposed as the Health & Lifestyle Education strategy to promote needed behavioral health messaging.

ANTICIPATED IMPACT: *(List SMART objectives; ensure specific and measurable outcomes, i.e., change(s) in learning, actions and/or conditions):*

STRATEGY 1: Enhance and/or adapt/create programming to educate about prescription drug use and mitigate abuse

PROCESS OUTCOMES

Short Term – Design, develop and conduct educational programs, provider workshops and trainings to target populations including prescription drug abuse, mental health sensitivity training, MAPS implementation, etc.

Medium Term – MAPS implementation, provide de-escalation training for health system staff

Long Term – Collaborate with community mental health to expand and enhance limited mental health services via telemedicine utilizing existing telehealth equipment

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

OBJECTIVE:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
Insert #	Identify relevant community objective(s)	Identify relevant national objective(s)
	Behavioral Health	<p><u>Healthy People 2020</u> Health Communication and Health Information Technology: Use health communication strategies and health information technology (IT) to improve population health outcomes and health care quality, and to achieve health equity. Substance Abuse: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children Mental Health and Mental Disorders: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Access to Health Services: Improve access to comprehensive, quality health care services.</p> <p>Ascension Population Health/Fee-</p>

for-value focused on optimal patient outcomes, enhance patient and provider experience, and lower cost (quadruple aim)