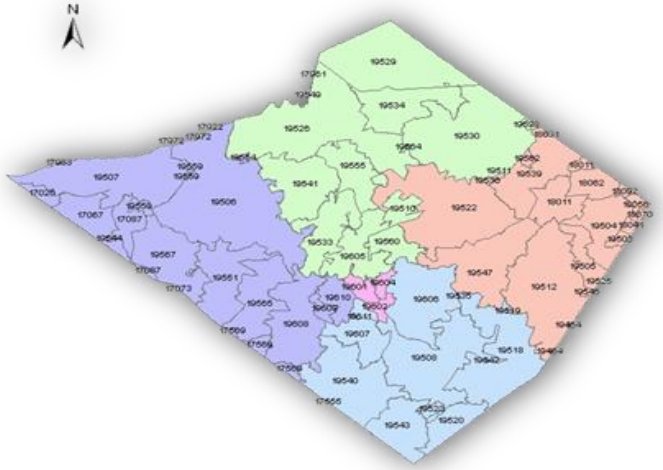
St. Joseph Regional Health Network

Reading, PA

Community Health Needs Assessment Implementation Plan

Board Approved: May 1, 2013



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Executive Summary

St. Joseph Regional Health Network (SJRHN) located in Reading, PA is pleased to provide its Community Health Needs Assessment Implementation Plan, a comprehensive look at the market's health needs and what the organization is doing (or will be doing) to address these concerns. As a faith-based, non-profit entity operating in both an underserved urban as well as rural area, addressing community health is fundamental to our existence and a core focus of our day-to-day work. With this said, creating a formal implementation plan to meet Patient Protection and Accountable Care Act requirements was straightforward; SJRHN passionately lives its mission "...as we move toward the creation of healthier communities"[1] and we appreciate the opportunity to showcase what we do best: act for those in need.

The Community Health Needs Assessment was a comprehensive study done in partnership with SJRHN's primary competing health organization: Reading Health System, as well as the Berks County Community Foundation and the United Way of Berks County. Pooling resources of these four community-minded organizations was the best opportunity to conduct a thorough analysis of the region (i.e., Berks County). The formal assessment was conducted by Public Health Management Corporation of Philadelphia, PA and concluded that the area of study reflects many national trends in health status. However, there are certain subpopulations and regions within the county that require two broad-based recommendations: (1) increase access to care and (2) enhance personal health behaviors. Noting the breath of components these recommendations could cover, a community-wide Advisory Committee, who represented the broader community in this endeavor, was tasked with assessing the findings and prioritizing areas of opportunities. The three priorities that came out of this process were: (1) preventive care, (2) prenatal care, and (3) specialty care. SJRHN responded accordingly by focusing its implementation plan on the following objectives:

Objective 1: SJRHN will provide preventive healthcare services that will reduce the prevalence of diabetes and obesity, and include routine dental care;

Objective 2: SJRHN will increase the utilization of prenatal care with a particular emphasis on the disproportionately high rate of adolescent pregnancies in the City of Reading;

Objective 3: SJRHN will improve the availability of specialty care, particularly for the uninsured and under-insured and work toward enhancing access for patients to behavioral health services.

SJRHN programs associated with each of these objectives include:

1a - Reducing Obesity: Diabetes Wellness, Children's Metabolic Clinic, and Girls on the Run;

1b - Providing Dental Care: Dental Services Program, Children's Free Dental Clinic, and Children's Sealant Program;

2 - Increasing Prenatal Care: Centering Pregnancy™ Program;

3a - Improving Specialist Availability: Specialty Clinics and Better Breast Health Program;

3b - Enhancing Access to Behavioral Health Services: Behavioral Health Clinic and Primary Care Integration with Behavioral Health.

[1]Excerpt from SJRHN Mission Statement.

These eleven initiatives were developed and vetted with key community partners who care for the underserved and are also sensitive to the cultural diversity of the region, in addition to the organization's leadership, physician champions, and front-line staff within the SJRHN family. In concert, the St. Joseph Medical Center Foundation (the charitable fundraising arm of SJRHN) approved support for some of these programs beginning in March of 2013, noting the impact these improvements could make in the health status of our market. The Foundation's priority, termed the "Creating a Healthier Community Initiative", will be a key focus of gifting and will help to supplement these community benefit projects targeted for growth and expansion.

Realizing one organization can not "do it all" for the community, SJRHN would also like to acknowledge other organizations in the community with like-minded missions who are our true collaborators in realizing change to community health. The success of these programs depend on the relationships we continue to establish with those who are also passionate about these improvements.

SJRHN is confident our part is making a difference in the health of the region. The programs contained in this document are tangible, showing actionable progress towards addressing priority health concerns. We stand behind our implementation plan and look forward to continuing our mission in caring for those in need of Berks County, PA.

This Community Health Needs Assessment Implementation Plan was approved by the St. Joseph Regional Health Network Board of Directors on May 1, 2013.

St. Joseph Regional Health Network Overview

St. Joseph Regional Health Network (SJRHN) is a not-for-profit healthcare provider located about an hour drive northwest of Philadelphia in the City of Reading, Pennsylvania. Founded in 1873 by the Sisters of St. Francis, SJRHN -- doing business as St. Joseph Medical Center -- provides a full-range of outpatient and inpatient diagnostic, medical, surgical, and therapeutic services through a two-campus system in Berks County, with satellite locations throughout the area to serve the county's nearly 412,000 residents and beyond. Its current hospital was constructed in 2006 and is currently licensed for 204 beds. In addition, its comprehensive network of ambulatory facilities include 14 centers distributed throughout its market as well as a comprehensive multi-disciplinary healthcare campus in Downtown Reading (explained below). Hospital admissions exceeded 8,100 in FY2012 and more than 45,000 visits are made to the medical center's emergency department annually. Uncompensated care and other community benefits grew in real dollars from $8.5 million to $10.4 million between FY2011 and FY2012. In addition to St. Joseph Medical Center, SJRHN also includes 100 employed providers (73 physicians and 27 mid-levels), an outpatient pharmacy, medical equipment company, and the St. Joseph Medical Center Foundation. It is the 8th largest employer in Berks County and is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

SJRHN is part of Catholic Health Initiatives (CHI), a national not-for-profit system headquartered in Englewood, Colorado. The faith-based system operates in 18 states and includes over 80 hospitals; 40 long-term care, assisted- and residential-living facilities; two community health-services organizations; two accredited nursing colleges; and home health agencies. In fiscal year 2012, CHI provided more than $715 million in charity care and community benefit, including services for the poor, free clinics, education and research. With total annual revenues of more than $10.7 billion and approximately 86,000 employees, CHI ranks as one of the largest faith-based health systems in the United States.

Our mission, vision, and core values define who we are and serve as "touchstones for our employees".

Our Mission is to nurture the healing ministry of the Church by bringing it new life, energy and viability in the 21st century. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities;

Our Vision is to live up to our name as one CHI:

Catholic: Living our Mission and Core Values;
Health: Improving the health of the people and communities we serve;
Initiatives: Pioneering models and systems of care to enhance care delivery; and

Our Core Values that guide SJRHN are**:**

Reverence: A profound spirit of respect for all;
Integrity: Moral wholeness and honesty;
Compassion: Being one with others in their sorrow and dignity;
Excellence: Continually surpassing standards to achieve and improve quality.

To further elaborate on SJRHN's Downtown Campus, it is the largest ambulatory facility in the City of Reading and is a hub for comprehensive patient-centered care, delivered with cultural, linguistical, and educational sensitivity. Because the City of Reading is home to a young, impoverished, and ethnically diverse population, the major focus of the Downtown Campus is on connecting patients with healthcare providers in an outpatient setting. It is an active "one-stop" facility with more than 20 departments, support services, and community partner tenants. Adult and pediatric primary care, dental services, immunizations, prevention and wellness, diabetic care, obstetric/gynecological care, as well as many diagnostic and theraputic services can all be found within this facility. In addition, the Downtown Campus also houses SJRHN's family practice accredited osteopathic residency program as well as an American Dental Association-accredited dental residency program. In St. Joseph Family and Women's Care (a primary care practice which functions as the medical home to many city residents), 79 percent of the patients seen were from the following funding sources: Medical Assistance, Self Pay, Charity Care, Migrant Farm Workers, and Immigration (FY 2012). Noting the unlimited healthcare needs of the City of Reading and despite the limited resources within healthcare, SJRHN continues to look for new and innovative ways to maximize access and provide community benefit at our Downtown Campus that hold the organization's standard of high quality outcomes, in a consistent and cost effective manner.

Comprehensively, SJRHN has been committed to taking a leadership position in maintaining and improving community health. It serves as an advocate on important health care issues that will enable the people of Berks County to become more vibrant and healthful. Likewise, SJRHN continues its focus on community health initiatives and is mindful of the needs of those we serve.

Community Health Needs Assessment Overview*

The community health needs assessment, on which this implementation plan is based, was finalized in January 2013 and jointly sponsored by St. Joseph Regional Health Network, Berks County Community Foundation, Reading Health System, and the United Way of Berks County. It was conducted by Public Health Management Corporation, a private non-profit public health institute out of Philadelphia, PA and was overseen by a county-wide advisory council that represented the broader community. Its area of focus was Berks County, PA, the general service area of St. Joseph Regional Health Network.

The complete 129 page community health needs assessment is accessible at: www.thefutureofhealthcare.org. Overall, the health status of Berks County's population compares favorably to Pennsylvanians and *Healthy People 2020* goals. Nonetheless, a number of disparities do exist among the subareas and subpopulations studied. Although these disparities are not isolated in any one geographic region compared to Berks County as a whole, they are most likely to be statistically significant for the City of Reading, the county's largest urban area, where the highest concentrations of poor, uninsured, racial minorities, and individuals who identify their ethnicity as Hispanic or Latino reside.

The following recommendations are made based in response to issues raised by the Community Health Needs Assessment:

Target 1: Access to Essential Health Care

Increase the capacity of existing providers and add new providers to improve access to essential healthcare services for at-risk populations. These needs include:

- Primary care and specialty care;
- Mental health services, including psychiatrists;
- Early prenatal care, particularly for Black and Hispanic/Latina women; and
- Patient navigators and case managers to assist at-risk populations in circumventing barriers to accessing essential health care.

Encourage the community to work together to establish a Berks County Health Department to focus on such population health objectives as:

- Providing preventive screenings and health education to at-risk subpopulations;
- Addressing barriers at-risk populations face in accessing affordable medications, dental care and vision care; and
- Coordinating community responses to issues affecting population health.

Improve the social service agencies' and health care providers' capacity to address unique linguistic and cultural factors that affect access to care by large segments of the Hispanic/Latino population, specifically:

- Increasing the availability of bilingual, culturally appropriate services, particularly in specialists' offices;
- Better educating at-risk populations about the value and availability of preventive services;
- Improving at-risk populations' understanding of eligibility requirements and application processes for publicly-funded health insurance; and
- Addressing concerns of those at-risk populations whose legal status represents a barrier to accessing essential health services.

Target 2: Enhance Personal Health Behaviors

Increase programs and interventions which address personal health behaviors that negatively impact health. Priorities should include:

- Developing strategies to address adolescent pregnancy, particularly in the City of Reading;
- Assisting smokers in quitting with cessation programs.
- Addressing obesity, especially in children; and
- Developing a concerted effort to reduce binge drinking in the County as a whole.

The Community Advisory Committee to the Berks County Community Health Needs Assessment reviewed the report and drew conclusions that were consistent with those of PHMC, most notably that:

- The overall health status of Berks County residents is reasonably good compared to norms for Pennsylvania and *Health People 2020* goals;
- Enhancing preventive, primary, and specialty care for certain at-risk populations is the most direct approach to advancing the community's health status; and
- The greatest disparities in health status are concentrated among the poor, the Hispanic and Latino community, and in particular for those who reside in the City of Reading.

Recognizing that the issues raised by the report will require considerable time and resources to address adequately, the Community Advisory Committee suggested that efforts be focused around a set of more immediate priorities. The three priorities chosen are:

- Preventive Care:
  - Reducing the prevalence of obesity; and
  - Providing routine dental care.
- Prenatal Care:
  - Increasing the utilization of prenatal care with a particular emphasis on the disproportionately high rate of adolescent pregnancies in the City of Reading.
- Specialty Care:
  - Improving the availability of specialty care, particularly for the uninsured and under-insured; and
  - Enhancing access to behavioral health services.

St. Joseph Regional Health Network has embraced these priorities as their focus of community need efforts. Its implementation plan on addressing these needs follows.

*Excerpts and direct verbiage taken from the Berks County, Pennsylvania - Community Health Needs Assessment. For complete document, see http://www.thefutureofhealthcare.org/assets/community-health-needs-assesment.pdf

SJRHN Implementation Plan Overview

St. Joseph Regional Health Network (SJRHN) is confident in its ability to implement programs to directly address community need. As a non-profit entity founded and rooted in a 140 year history of providing care to the poor and underserved, SJRHN establishes tangible initiatives (that make a difference in the health of those we serve) through various opportunities both within the organization and with key community partners. It consistently fulfills its responsibility as a tax-empempt organization as a high quality, low cost provider and a source of community benefit.

SJRHN, as a managing partner of the Community Health Needs Assessment in Berks County, tasked a sub-committee of the Board with the oversight of the organization's involvement in this process. In addition to direction and input to the needs assessment which was completed in January 2013, the subcommittee also oversaw the strategy behind the implementation plan. Many stakeholders both within the organization and in the community were consulted to give substance to the details behind the initiatives.

The three objectives that SJRHN is pursuing support the three main priorities of the needs assessment. Actual programs within each of these objectives detail the means of accomplishing the objectives. The three priority objectives and overview of programs are shown on the next two pages. In addition, this implementation plan shows a two-page summary of each initiative with the following details explained:

1. Program Description
2. Objective to be Achieved
3. Community Partners
4. Timeframe
5. Financial Commitment (where available)
6. Measure(s) of Success (for future tracking)
7. Long-Term Sustainability
8. Executive Sponsor

While not every detail is known for these programs (some information was unavailable at time of this document completion), the infrastructure is identified and will become more comprehensive as the programs are monitored and mature over time.

SJRHN would also like to acknowledge the support of the St. Joseph Medical Center Foundation who is assisting some work within this plan as well as our community partners. The Foundation is focusing its annual funding efforts to a program titled "Creating A Healthier Community Initiative" to help address several of the key health issues identified here. These initatives are identifed with a  in this document and any identified funding details are also included in the program's financial commitment section. Our community partners are many and are the true source of success in addressing health needs. We regret if we have missed acknowledging any of them in this document.

St. Joseph Regional Health Network Priorities for Community Health Needs

Objective 1:
SJRHN will provide preventive healthcare services that will reduce the prevalence of diabetes and obesity, and include routine dental care.

Objective 2:
SJRHN will increase the utilization of prenatal care with a particular emphasis on the disportionately high rate of adolescent pregnancies in the City of Reading.

Objective 3:
SJRHN will improve the availability of specialty care, particularly for the uninsured and under-insured and work toward enhancing access for patients to behavioral health services.

SJRHN will provide these essential health care services with a sensitivity to the unique linguistic and cultural needs of the Hispanic and Latino at-risk populations and will consider access to care issues.

St. Joseph Regional Health Network's Priority Programs Overview

Obj. 1a - Reducing Obesity:

- Diabetes Wellness
- Children's Metabolic Clinic
- Girls on the Run

Obj. 1b - Providing Dental:

- Dental Services
- Children's Free Dental Clinic
- Children's Sealant

Obj. 2

- Centering Pregnancy™

Obj. 3a - Improving Availability:

- Specialty Clinics
- Better Breast Health

Obj. 3b - Enhancing Access to Behavioral:

- Behavioral Health Clinic
- Primary Care Integration

= SJMC Foundation-Funded Creating a Healthier Community Initiative

Priority Objective 1: Preventive Care

Priority # 1 Preventive Care: (a) Reducing the Prevalence of Diabetes and Obesity;

Diabetes Wellness Program

Program Description:

St. Joseph Family and Women's Care and the Family Practice Residency Program at the Downtown Reading Campus will apply a three part wellness program focused on diabetes (a chronic disease prevalent in individuals who are obese) to help empower patients to take care of their health. These components include:

1. Group Visits: *an evidenced-based model of care and multifaceted approach that brings both the health care team's assessment and the patient's self-assessment into a group space.* Through visits with other diabetic individuals, patients collect their weight and blood pressure data, do blood checks and have foot assessments done within the structure of the group. An individual health check with the provider also occurs with triaging of any complicated issues requiring either privacy or specialist follow-up;

2. Community Health Workers: *ethnically-sensitive and trusted members of the community who serve as liaisons between the patients, health and social services, and the community to facilitate access to care and improve the quality and cultural competence of service delivery.* These individuals will: reach out, identify, and recruit current patients from the community to join our diabetes groups and be essential in helping patients set short and long term goals; work with patients and their families to create a plan for health behavior change; develop and communicate a plan for healthcare needs between visits; gather and report results; and continually coach, motivate and communicate with patients between visits either in their homes or by telephone.

3. Diabetes Educator: *a clinically-focused individual who will work on developing a comprehensive 360 degree program to more effectively reach diabetic patients while they are in the hospital and provide enhanced education, personal follow-up, and coaching, connecting the inpatient "world" to outpatient care.* Additionally, the Diabetes Educator will work with St. Joseph Regional Health Network's employee health department to assist our own employees with diabetes-related issues. Over the next two years, the Diabetes Educator and Community Health Worker will develop diabetes support groups focused on young adults with diabetes, adults with insulin pumps and a community-based diabetes group.

Objective to be Achieved:

Ten percent reduction of Hemoglobin A1C ≥ 8 for 1,200+ registered patients at SJRHN's Downtown Campus who are diagnosed with Type 2 diabetes.

Community Partners:

As the program begins, St. Joe's will reach out to several of our community partners to explore taking this program to their clients. Most notably:
Berks Encore
Hispanic Center
Penn State Cooperative Extension
YMCA

Timeframe:

Group visits began in March 2013, with three sessions over twelve weeks, with one to three lesson(s) taught per session.
Two groups run in parallel: one in English and one in Spanish; Sessions are ongoing;
Community Health Worker program is under development, but targeted to be in place by August 1, 2013;
Diabetic educator position is posted to be filled.

Financial Commitment:	**Budget**	**Actual**
FY 2013	N/A	
FY 2014	$ 280,000	
FY 2015	$ 280,000	

SJMC Foundation-Sponsored Creating a Healthier Community

Measure(s) of Success:

Ten percent reduction of Hemoglobin A1C ≥ 8 for registered patients of St. Joseph Family and Women's Care with Type 2 diabetes

Long-Term Sustainability:

The program is funded for the first two years by the SJMC Foundation, through its Creating a Healthier Community Initiative.

Executive Sponsors/Key Contacts:

Sharon Strohecker, CNO and Katharine Navone, MD - Medical Director, SJFWC/Richard Cetkowski, CRNP
Kathy Henry, RN, and Kim Wolfe (Diabetes Education Coordinator)

Priority # 1 Preventive Care: (a) Reducing the Prevalence of Diabetes and Obesity;

Children's Metabolic Clinic

Program Description:

The Reading Elks Pediatric Clinic at the Downtown Campus in Reading offers a Metabolic Clinic Program for children ages 2-18 under the care and supervision of a pediatric provider and dietitian. This service monitors the patient's obesity in an attempt to prevent that child from developing health complications such as hypertension, high cholesterol and high lipids, sleep apnea, early heart disease, asthma, fatigue, depression, anxiety and diabetes. The child ideally needs to be seen on a monthly basis to monitor his/her weight, eating habits, perform lab work and review his/her medical needs. St. Joe's will continue to enhance these services offered.

Objective to be Achieved:

Enroll children with Body Mass Index (BMI) ≥ 85th percentile, and provide parents and children with education and support in controlling obesity, including prevention, education in healthy lifestyle, behavior modifications, and exercise as well as addressing comorbid conditions.

Community Partners:

Reading Elks (support in funding the initiative)
Penn State University Nutrition Links (healthy eating)
YMCA (growing relationship for exercise vouchers for pediatric patients to develop a healthy lifestyle)

Timeframe:

Patients scheduled every Thursday. New initial appointments with a Certified Registered Nurse Practitioner ('CRNP') are group visit format and include the parents. They are scheduled usually 2 or 3 Thursdays of the month, depending on need. Follow ups (individual appointments) are with the nutritionist and/or CRNP. Patients are also separated by preferred language in group sessions in order to meet the need of the patient

Financial Commitment:	**Budget**	**Actual**
FY 2013	$ 20,000	Funded through Reading Elks
FY 2014	$ 20,000	Funded through Reading Elks
FY 2015	TBD	

Children's Metabolic (Cont'd)

Measure(s) of Success:

Decrease in BMI-for-age < 85th percentile (approximately one pound per month)

Long-Term Sustainability:

The program is funded through a community partnership with the Reading Elks for two years. Noting the concern of childhood obesity nationally, new payment models or increased benefits through insurance companies,would continue to focus on prevention and wellness-type initiatives are anticipated.

Executive Sponsor/Key Contact:

Howard Davis, MD - CMO and Katharine Navone, MD, Medical Director St. Joseph Family and Women's Care/Freida Fisher, CRNP

Priority # 1 Preventive Care: (a) Reducing the Prevalence of Diabetes and Obesity;

Girls on The Run - Berks County

Program Description:

St. Joe's helped organize and is the founding sponsor of a local chapter of Girls on the Run International (national organization established in 1996). Girls on the Run (GOTR) is a character development and prevention program for girls in grades 3 through 8 which uses a fun, experience-based curriculum that creatively integrates running with life lessons in three focus areas. St. Joe's and now other growing community support sponsor the twelve week program, taught by a certified GOTR volunteer coach (who are trained and certified). The curriculum includes learning life skills through group programming, running games and workouts. The lessons include: understanding ourselves, valuing teamwork, learning about healthy relationships and understanding how we connect with and shape our community and our world. The girls choose a community service project at the end of the program. The twelve week after school program begins Fall 2013 in four Berks County schools and culminates in a non-competitive 5K event in which the girls run, walk, hop, skip or jump along with a running buddy in order to celebrate their participation in the program and all realize their full potential.

Objective to be Achieved:

Improvement of body image, eating attitudes and self-esteem; improved sense of identity; increasingly active lifestyle for program participants.

Community Partners:

Four Berks County schools to date:

Glenside Elementary
Governor Mifflin
Mifflin Park Elementary
Whitfield Elementary (Wilson District)

Timeframe:

Program begins Fall 2013, twelve week sessions, with one to three lesson(s) taught per session. Ongoing.

Girls on the Run (Cont'd)

Financial Commitment:	**Budget**		**Actual**
FY 2013	$ 5,000	toward $30,000	$5,000 to date
FY 2014	$ 5,000	toward $60,000	
FY 2015	$ 5,000		

SJMC Foundation-Sponsored Creating a Healthy Community Initiative

Measure(s) of Success:

To Be Determined closer to program inception. Considerations include:
evaluation of body image – acceptance of body size,
eating attitudes and self esteem – "What CAN I do?"
sense of identity – living free from societal stereotypes
increase in physical activity

GOAL = xx.0%

Long-Term Sustainability:

Kimberly Rivera, Executive Director (currently unpaid position) will continue to recruit and grow the Board of Directors; Kim and the Board have developed a strategic plan which outlines the need to increase the number of certified and trained coaches and volunteers; continued fund development to sustain and grow programming and activities.

Executive Sponsor:
Camille Stock, Interim Vice President, SJMC Foundation and Laura Welliver, Grants and Projects Coordinator

Priority # 1 Preventive Care: (b) Providing Routine Dental Care

Downtown Campus Dental Services

Program Description:

St. Joe's Dental Services Department, located at its Downtown Reading Campus, provides adults and children with dental exams, x-rays, cleanings, fillings, extractions, crowns, root canals, bridge work, dentures, implants, and Invisalign braces. It is currently the sole source of dental care within the City of Reading for low income individuals and functions as a dental home for many underserved individuals and families. This full-service dental department currently has more than 6,000 patient visits annually and focuses on care for those in need. The center functions as a dental residency teaching program and is fully accredited by the American Dental Association. Additionally, SJRHN Dental Services offers a free clinic to underinsured children, a free sealant program for underinsured children in Berks County schools, and an oral cancer screening program. The center has a part-time dental medical director, 4 dental residents and 5 dental preceptors.

Objective to be Achieved:

To promote quality, patient-focused dental care for those in need, especially the underserved and underinsured in a cost-effective, culturally-sensitive manner.
The department goal is to see 6,000 patient per year.

Community Partners:

Berks Community Health Center
Berks County Dental Society
Berks County school districts
Berks-Schuylkill Dental Hygienist Society
Berks Technical Institute (BTI)
Hawthorne House (Frackville and Reading locations)
Keystone Farm Workers
PA Department of Health
Reading Health System
Supportive Concepts
Threshold

Timeframe:

The Dental clinic operates Monday through Friday from 7:30 am to 4:30 pm for scheduled or walk-in care.

Financial Commitment:	**Budget**	**Actual**
FY 2013		
FY 2014		
FY 2015		

Measure(s) of Success:

GOAL = xx.0%

Budget v. actual volume

Long-Term Sustainability:

Since dental services is expected to remain a strong community need, expenses associated with this clinic will continue to be funded through general operations, grants, and other community benefit resources.

Executive Sponsor/Key Contact:

Howard Davis, MD - CMO & Chris Kosenske, DMD - Medical Director, Dental Services/Kim Musko - Practice Manager, Primary Care

Priority # 1 Preventive Care: (b) Providing Routine Dental Care

Children's Free Dental Clinic

Program Description:

St. Joe's Dental Services Department and the Keystone Farmworker Health Outreach Program coordinate a free dental clinic for uninsured and underinsured children at St. Joe's Downtown Reading Campus. The Children's Free Dental Clinic is offered six times a year primarily to children from ages 2 to 18 and include: initial visits, x-rays, root canals, fluoride treatments, restorations, and others. Dental professionals, including dentists, oral surgeons, hygienists and assistants, volunteer services are available each session. Other volunteers provide project administration, transportation, interpretation, patient recruitment, on-site coordination and other services during clinics.

Objective to be Achieved: To annually treat and complete dental care needs to 60-100 uninsured and underinsured Berks County children with serious dental disease and barriers to care (20-30 children treated per session) and educate children on proper dental care.

Community Partners:

Keystone Farmworker Program
Berks-Schuylkill Dental Hygienists Association
Berks County Dental Society
Berks County School Nurses Association
Berks Oral Surgery
Berks Technical Institute (BTI)

Timeframe:

Program is offered one Saturday a month for the first six months of the year.

Financial Commitment:	**Budget**	**Actual**
FY 2013		
FY 2014		
FY 2015		

Measure(s) of Success:

GOAL = xx.0%

Number of visits and procedures

Long-Term Sustainability:

The program has received funding through grants and donations since its inception and will continue to do so.

Executive Sponsor/Key Contact:

Howard Davis, MD - CMO & Chris Kosenske, DMD - Medical Director, Dental Services/Kim Musko - Practice Manager, Primary Care

Priority # 1 Preventive Care: (b) Providing Routine Dental Care

Children's Dental Sealant Program

Program Description:

St. Joe's in partnership with the Keystone Farmworker Health Outreach program and the Berks-Schuylkill Dental Hygienists' Association coordinate an annual dental sealant project. This project targets 5-17 year old children of low income, including farmworker children. The Berks-Schuylkill Dental Hygienists' Association coordinates teams of dentists and hygienists to examine B19and place sealants as appropriate on all posterior teeth of project participants. The Director of the St. Joseph Dental Residency Program serves as the Project Director, with the Regional Manager of the farmworker program serving as Project Coordinator. Dental evaluations are provided by SJRHN dental residents or volunteer community-based private practice dentists. Sealants applied by volunteer community-based hygienists.

Objective to be Achieved:

To annually provide free dental sealants to 50 Berks County children with barriers to routine dental care.

Community Partners:

Police Athletic League (PAL)
Children's Home of Reading
Children and Youth Protective Services
Berks County School Districts
Migrant Head Start Program
Pathstone
Migrant Education Program
Area churches

Timeframe:

Once per year, on a Saturday in February

Financial Commitment:	**Budget**	**Actual**
FY 2013	overhead, dentists time	
FY 2014		
FY 2015		

Children's Sealant (Cont'd)

Measure(s) of Success:

GOAL =100.0%

Annual measure: provide free dental sealants to 50 Berks County children with barriers to routine dental care.

Long-Term Sustainability:

Grant funding, community partnership

Executive Sponsor/Key Contact:

Howard Davis, MD - CMO & Chris Kosenske, DMD - Medical Director, Dental Services/Kim Musko - Practice Manager, Primary Care

Priority Objective 2: Prenatal Care

Priority # 2 Prenatal Care

Centering Pregnancy™ Program

Program Description:

Centering Pregnancy™ is a multifaceted group model of care that integrates the three major components of care – health assessment, education, and support – into a unified program within a group setting. Eight to twelve women with similar gestational ages meet together, learn care skills, participate in a facilitated discussion and develop a support network with other group members. Within the group space, the medical practitioner and care team complete standard physical health assessments for the women. Through this unique model of care, women are empowered to choose health-promoting behaviors. Instead of short visits alone with a provider, Centering Pregnancy™ group participants receive approximately 20 hours of prenatal care across pregnancy, compared to about 2 total hours – all at no additional cost. Centering Pregnancy™ is prenatal care that serves the general needs of all pregnant women and meets the special needs of racial and ethnic groups. This prenatal care model transcends barriers to bring women together to share what they have in common: the desire to have a healthy baby and a safe, satisfying labor and delivery experience. Hearing other women share concerns which mirror their own helps the participants B10to normalize the whole experience of pregnancy. Centering Pregnancy™ groups provide a dynamic atmosphere for learning and sharing that is impossible to create in a one-to-one encounter.

Objective to be Achieved:

The effectiveness of this model and delivery of care has been measured by health outcomes for pregnancies, specifically increased birth weight and the gestational age of the mother at delivery. Additionally, scores show increased satisfaction by both the mother and the healthcare providers.

Community Partners:

March of Dimes
Opportunity House
Community Prevention Partnership's Nurse Family Partnership Program
Centro Hispano Daniel Torres
Penn State Nutrition Links program
YMCA (Centering Parenting Class)

Timeframe:

Each group meets for at least 10 sessions throughout pregnancy and early postpartum and each session lasts approximately 90 minutes. Program first began in May 2012.

Centering Pregnancy™ (Cont'd)

Financial Commitment:	**Budget**	**Actual**
FY 2013	$97,975	$86,525 Penn National Gaming
FY 2014	$97,975	$64,475 Penn National Gaming
FY 2015	TBD	

SJMC Foundation-Sponsored Creating a Healthier Community Initiative

Measure(s) of Success:

GOAL = xx.0%

Increase the number of full-term, full-weight deliveries

Long-Term Sustainability:

Program is currently a priority funding focus from the SJMC Foundation. Currently, the organization is waiting to determine if it is a recipient of an additional grant from CHI (its parent corporation). Ongoing community outreach and partnerships are also instrumental for long-term sustainability.

Executive Sponsor/Key Contact:

Sharon Strohecker, CNO and Katharine Navone, MD - Medical Director, Kathryn Behn - OB Navigator

Priority Objective 3: Specialty Care

Priority # 3 Specialty Care: (a) Improving Availability of Specialty Care

Downtown Campus Specialty Clinics

Program Description:

A host of specialty care is offered to the underserved population through St. Joseph Family and Women's Care at our Downtown Campus. Specialties - mostly for adults - currently available include: cardiology, dermatology, podiatry, urology, and a procedure clinic (e.g., wart removal, joint injections, abscess drainage, etc). Care is provided by referral and appointment only for the patients of Saint Joseph Family and Women's Care; who have access issues to receiving the care elsewhere, because of payment concerns, transportation, or cultural needs. The specialty clinics provide care each year for more than 700 patients. These specialty clinics also provide a teaching experience for the family practice residency program which establishes continuity of care for patients with complete medical records available and primary care access+B11 for further care coordination.

Objective to be Achieved:

Provide specialty care in a culturally-sensitive manner to patients of St. Joseph Family and Women's Care who might otherwise not be able to access the required service. Continue to build number of services offered and assist patients in getting access to specialty care elsewhere in the community.

Community Partners:

Cardiology: Berks Cardiology (Dr. Gary Lattin)
Dermatology: Dr. Pam Meyers
Podiatry: Dr. Noahleen Betts, Dr. Laura Guerin, Dr. Kim Hurley, Dr. Jeff Keating, Dr. Paul Lafata, Dr. James Pace, Dr. Tim Stringer, Dr. Paul Turrisi, and Dr. John Turrisi
Urology: Dr. Gary Ginsberg, Dr. Scott Horner, and Dr. Constantine Harris

Timeframe:

Cardiology: 3-5 patients per session, clinics are held 6 times a year;
Dermatology: 25-30 patients per session, clinics are held 11 times a year;
Podiatry: 13-15 patients per session, clinics are held 36 times a year;
Urology: 7-10 patients per session, clinics are held 12 times a year;
Procedural: 7-10 patients per session, clinics are held 48 times a year

Financial Commitment:		**Budget**	**Actual**
FY 2013	$	3,000	TBD
FY 2014	$	3,000	TBD
FY 2015		TBD	TBD

Measure of Success:

GOAL = growth in number of specialty clinics offered

Long-Term Sustainability:

Specialty clinics continue to be a priority for patients served by St. Joseph Family and Women's Care, especially as the Downtown Campus moves toward becoming a patient-centered medical home and chronic disease management becomes more important. Expenses associated with the specialty clinics will continue to be funded through general operations and community benefit resources.

Executive Sponsor/Key Contact:

Howard Davis, MD - CMO and Michael Bradley, DO-Medical Director, Family Practice Residency Program/Sharon Iswalt - Specialty Clinic Coordinator

Priority # 3 Specialty Care: (a) Improving Availability of Specialty Care

Better Breast Health Initiative

Program Description:

St. Joe's Better Breast Health Initiative, which includes the Promotora Patient Navigation Project is developed to promote early detection of breast cancer in un/under insured and medically underserved women through carefully targeted community outreach and education, comprehensive screening and care coordination, and significant systems improvement efforts.

Objective to be Achieved:

To increase access to and utilization of breast health services and information by removing cultural, linguistic, financial, and other barriers to care.

Community Partners:

American Cancer Society
Centro Hispano
Alvernia University
Breast Cancer Support Services
Community Prevention Partnership
Komen Foundation - Philadelphia Affiliate
Latina Health Task Force

Timeframe:

Both initiatives started April 1, 2013, but better coordinates cancer care between the SJRHN Downtown Campus and SJRHN Cancer Center. Current funding is through March 30, 2014.

Financial Commitment:		**Budget**		**Actual**
FY 2013				
FY 2014	April 1, 2013 - March 30, 2014	$ 116,026	Komen Philly Grant = $91,026 ACS Making Strides Grant = $25,000	
FY 2015				

Measure(s) of Success:

GOAL = 100.0%

At least 300 underserved women receive breast cancer screenings annually.

Long-Term Sustainability:

Continued Komen funding, Medicaid expansion for uninsured, Healthy Women Program funding

Executive Sponsor/Key Contact:

Sharon Strohecker, CNO & Katharine Navone, Medical Director, Karen Wagner - Director, Cancer Center, Lisa Spencer - Patient Navigator

Priority # 3 Specialty Care: (b) Enhancing Access to Behavioral Health Services

Behavioral Health Clinic

Program Description:

St. Joseph Family and Women's Center and the Family Practice Residency Program partners with a behavioral health provider (Berkshire Psychiatry) to see patients weekly in this primary care setting. Patients range in age from toddler through adults. The clinic focuses on psychological and social issues and specializes in Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). With the organization's focus on primary care teaching, Berks Psychiatry also lectures to residents weekly in concert with the clinical care available.

Objective to be Achieved:

Provide behavioral care in a culturally-sensitive manner to patients of St. Joseph Family and Women's Care who might otherwise not be able to access the required service. Continue to build services offered and assist patients in getting access to behavioral health elsewhere in the community as needed.

Community Partners:

Berkshire Psychiatry

Timeframe:

6-7 patients are scheduled weekly for a morning session

Financial Commitment:	**Budget**	**Actual**
FY 2013		
FY 2014		
FY 2015		

Measure(s) of Success:

Show rate of scheduled patients

Long-Term Sustainability:

Behavioral health clinic continues to be a priority for patients served by St. Joseph Family and Women's Care, especially as the Downtown Campus moves toward becoming a patient-centered medical home. Expenses associated with this clinic will continue to be funded through general operations and community benefit resources.

Executive Sponsor/Key Contact:

Howard Davis, MD - CMO & Michael Bradley, DO - Medical Director, FP Residency Program/Sharon Iswalt, Specialty Care Coordinator

Priority # 3 Specialty Care: (b) Enhancing Access to Behavioral Health Services

Primary Care and Behavioral Health Integration

Program Description:

St. Joe's is considering coordinating and co-locating with Berks Counseling Center ('BCC'), a state designated Community Mental Health Center, for the integration of primary and behavioral health integration in a medical home model of care. SJMC will also work closely with BCC to ensure effective outreach and recruitment, information and referral, care coordination, health promotion and prevention programming, chronic disease management and to address other emerging needs.

Objective to be Achieved:

Fully integrated primary and behavioral health care for underserved patients.

Community Partners:

Berks Counseling Center

Timeframe:

Potential October 1, 2013 start date

Financial Commitment:	**Budget**	**Actual**
FY 2013	N/A	
FY 2014	TBD	
FY 2015	TBD	

Measure(s) of Success:

GOAL = xx.0%

Tentative: Number and nature of needs addressed for shared patient population.

Long-Term Sustainability:

Pending new payment models integrating primary care and behavioral health services and billable services options for care management.

Executive Sponsor/Key Contact:

Sharon Strohecker - CNO/Mary Moyer, Director of Downtown Campus/Laura Welliver, Grants & Special Projects

Summary and Board Approval

Summary:

St. Joseph Regional Health Network (SJRHN) continues to add value and improve community health needs through its programs focusing on care for the underserved. Aligning the results from the community health needs assessment with prioritized health concerns in Berks County, SJRHN has identified key initiatives that work toward addressing these needs through this implementation plan. SJRHN continues our efforts with community partners who are also sensitive to the cultural and linguistic barriers associated with providing care to the underserved in order to pool limited resources and make an impact in the community. By identifying three objectives focusing on preventive care, prenatal care, and specialty care, SJRHN is able to execute tangible programs that will make a difference. We look forward to continued efforts of improving the health of Berks County.

Board Approval:

St. Joseph Regional Health Network's Board of Directors has been informed of the Community Health Needs Assessment process and requirements. The Board understands its commitment to this federal mandate through the Patient Protection and Affordable Care Act, as tax-exempt hospitals must perform this assessment once every three years. A publically available report must include a needs assessment, as well as an implementation strategy. The assessment and implementation plan need to be reported on the organization's IRS Form 990 (for FY13). Non-compliance may result in the organization can face a $50,000 fine per hospital per year, including a potential revocation of tax-exempt status. Both the assessment and implementation plan must by publically posted on the organization's website by the end of the FY13 fiscal year (June 30, 2013).

St. Joseph Regional Health Network Board of Directors Approval: May 1, 2013