Community Service Plan 2016 - 2018

The Mission of Oswego Hospital is to provide accessible, quality care and improve the health of residents in our community.

Oswego Hospital An Affiliate of Oswego Health www.oswegohealth.org

1. Define the Service Area

Oswego Health, which includes Oswego Hospital, is the healthcare leader in Oswego County, providing care to the majority of its 120,000 residents. Within the boundaries of Oswego County are the cities of Fulton and Oswego, as well as several towns and villages, including Central Square, Mexico, Parish and Phoenix. The specific zip codes in Oswego Health's Primary Service Area include: 13069, Fulton; 13074, Hannibal; 13093, Lycoming; 13107, Maple View; 13111, Martville; 13114, Mexico; 13115, Minetto; 13121, New Haven;13126, Oswego; and 13142, Pulaski. Secondary Service Area: 13036, Central Square; 13064, Fair Haven; 13076, Hastings; 13131, Parish; 13132, Pennellville; 13135, Phoenix; and 13156, Sterling.

2. Participating Local Health Departments and their contact information

To develop this report, Oswego Health collaborated with the Oswego County Health Department. Specifically, Oswego County Director of Public Health Jiancheng Huang, JHuang@oswegocounty.com and Diane Oldenburg, Senior Public Health Educator, Diane@ oswegocounty.com.

3. Participating Hospital/Hospital System and contact information

Oswego Health staff working on this report included Oswego Health Chief Medical Officer Renato Mandanas, MD, rmandanas@oswegohealth.org; Chief Strategy Officer Jeff Coakley, jcoakley@oswegohealth.org; Director of Patient Quality and Patient Safety Kathryn Pagliaroli, kpagliaroli@oswegohealth.org; Oswego Health Director of Community Health Services Brenda LaMay, NP, blamay@oswegohealth.org; Oswego Health Certified Diabetes Educator Susan Callaway, scallaway@ oswegohealth.org; and Director of Public Relations Marion Ciciarelli, mciciarelli@oswegohealth.org.

4. Name of Coalition/entity

Documents for this CSP were developed and written by Oswego Health and the Oswego County Health Department.

Executive Summary

1. Selected Prevention Agenda Priorities

Prevent Chronic Disease

Promote Mental Health and Prevent Substance Abuse

Disparity: Reduce smoking among pregnant women

2. Changes

Oswego Health and Oswego County Health Department (OCHD) continue to support the priorities in the 2013 reports as data shows they continue to be among the area's most pressing health improvement needs.

For this report, however, Oswego Health and OCHD have decided to also implement additional activities that address obesity in the county. This decision was based upon the NYS Prevention Agenda Dashboard, that revealed Oswego County's percentage of adults who are obese was 32.2 percent compared to the NYS rate of 24.9 and the Prevention Agenda objective of 23.2 percent. In addition, obesity among children and adolescents remains high at 23.1 percent. Obesity rates among this population are 17.3 percent for NYS excluding NYC, and the prevention agenda goal for 2018 is 16.7 percent.

The health system will also continue to work with OCHD officials to reduce the number of pregnant women, particularity low income pregnant women who smoke in our county, which is a disparity.

3. Data Used

The data used to determine the selected priorities included Oswego Health's own patient data and its patient readmissions rates, as well as the Oswego County data provided by the New York State Prevention Agenda Dashboard.

Oswego Health also used the services of Research and Marking Strategies (RMS) which conducted research for the health system's 2015 Community Health Needs Assessment. The firm utilized primary and secondary sources to gather information about the healthcare resources available within the Oswego Health service area.

4. What Partners Are You Working With and What are their Roles in the Assessment and

Implementation Process?

In developing and implementing its CSP objectives, Oswego Hospital worked alongside its many healthcare partners who include: Oswego County Health Department, Oswego County Opportunities, Oswego Hospital Medical Staff, Cornell Cooperative Extension, Tobacco Free Network, Fulton and Oswego YMCAs, Oswego County Mental Hygiene, Farnham Family Services and the Rural Health Network of Oswego County, which includes 35 health and human services agencies, as well as payor representatives, that provide services in Oswego County.

5. How are you engaging the broad community in these efforts?

As part of the development of its 2015 Community Health Needs Assessment, RMS conducted 405 phone surveys for Oswego Health, as well as interviewed key community stakeholders to learn the community's health concerns.

In addition, Oswego Health along with other healthcare leaders in the county has formed the Oswego County Integrated Delivery Network. This collaboration includes the Rural Health Network, Oswego County Opportunities, Northern Oswego County Health Services Inc., along with the Health and Social Services Departments of Oswego County. This coalition has been awarded a Rural Health Network Development Planning Grant that is being utilized to develop a strategic plan. This plan will result in a new county entity that addresses, but not duplicates, the management and care coordination for those needing health and social services in the county.

6. What specific evidence-based interventions/ strategies/activities are being implemented to address the specific priorities and the health disparity and how were they selected?

Prevent Chronic Disease

To reduce obesity in the county, the health system will continue to support breastfeeding programs such as the Breastfeeding Quality Improvement Hospital Initiative and will work with the sole OB/GYN practice in the county to implement breastfeeding programs, such as *NYS's Breastfeeding Friendly Practices*. In addition partners with continue to participate in the Oswego County Breast Feeding Coalition, to work to increase referral to certified lactation consults within the County, and work to make Oswego County a breast feeding friendly community. In addition, OCHD will continue to work to expand the number of elementary schools that utilize the Healthy Highway curriculum.

To address the smoking disparity among low income

pregnant women, Oswego Health will support and work with the Oswego County Health Department on initiatives, such as *Smoke Free for My Baby and Me* to reduce the smoking rate among pregnant mothers.

In its efforts to reduce the incidents of diabetes, heart failure and chronic obstructive pulmonary disease (COPD), Oswego Health continues to partner with the OCHD and ARISE partner to offer the Chronic Disease Self-Management (CDSM) curriculums developed by Stanford University and the Prevent T2 curriculum developed by the CDC as part of the National Diabetes Prevention Program.

These classes were selected once it was determined they would be effective, impactful and an appropriate fit for community members. To that end, class participants routinely tell instructors how the program has improved their health status.

Promote Mental Health and Prevent Substance Abuse

To reduce suicide rates, Oswego Health and Oswego County will share data on suicide, suicide attempts and the prevention efforts. They will also offer gatekeeper training and screen for suicide risk in primary care or substance abuse programs. The healthcare providers will reach out to groups that have a higher risk for suicide or suicide attempts than the general population

Oswego Health and OCHD will join with other community partners to support the Suicide Prevention Task Force.

7. How are progress and improvement being tracked to evaluate impact? What process measures are being used?

Prevent Chronic Disease

PROCESS MEASURES

Obesity Prevention:

- Monitor the number of breastfeeding mothers at discharge.
- Implement program, New York State Breastfeeding Friendly Practices, and monitor number of participating practices.
- Continue to participate in the Oswego County Breastfeeding Coalition.
- Establish a Breastfeeding Friendly care continuum in Oswego County through participation in the Creating Breastfeeding Friendly Communities grant

- Number of Elementary Schools participating in the Healthy Highways Curriculum
- Monitor behavior change as demonstrated by students in Healthy Highways schools

Reduce Premature Birth, a Disparity, Will Monitor:

- Number of women participating in Smoke Free For Baby and Me.
- Number of pregnant women smoking that seek care at Oswego County OB/GYN

Chronic Disease, Will Monitor:

- Data from Quality Technical Assistance Center (QTAC)
- Number of Participants
- Number of Programs Offered

Promote Mental Health and Prevent Substance Abuse

Will Monitor:

- Number of primary care, urgent care and emergency department providers receiving monthly suicide data.
- Number of primary care and substance abuse professional trained.
- Number of groups at high risk for suicide.

Community Service Plan Report

1. Description of Community Being Served

The service area for this Community Service Plan and Community Health Assessment encompasses Oswego County, a rural upstate area.

The total population of Oswego County is 120,628 with 49.9% male and 50.1% female. This total population figure has remained relatively flat over the past 5 years (decreasing slightly by 1.2%) and is projected to experience a very slight increase from 2015 to 2020 (<.5%).

Oswego County's stable population base is helpful in determining the resources required to serve the population over the next several years.

While the overall population is relatively stable, the population of individuals aged 65 or greater is expected to increase from 13.9% in 2015 to 16.3% in 2020. This represents a significant change and validates that

the growth in the older population segment will undoubtedly mean a greater demand for services.

The population in Oswego County is predominantly white, with less than 5% of the population identified as any other race.

Although representing a small percentage of the overall population, Oswego County is experiencing growth in all other races other than white (including those persons of two or more races) and in persons of Hispanic ethnicity. In addition, the County has a small population of Amish families. These segments need to be monitored with regard to access to services and cultural and language barriers.

Approximately 18.5% of Oswego County's population lives below the poverty level, which is significantly higher than the 10.4% reported in 2010. This represents a negative trend, indicating that economic hardship is growing within the County. Among those households living in poverty, 27.5% of children under the age of 18 are living in poverty.

The most likely family unit to be living in poverty are single-mothers with children under the age of 5, where a majority (69%) of those families live in poverty.

2. Data Reviewed for This Report

The data used to determine the selected priorities included Oswego Health's own patient data and its patient readmissions rates, as well as the Oswego County data provided by the New York State Prevention Agenda Dashboard.

Oswego Health also used the services of Research and Marking Strategies (RMS) which conducted research for the health system's 2015 Community Health Needs Assessment.

Among the key health findings reported by the County Prevention Agenda Dashboard and RMS:

- A significant portion of Oswego County residents are found to engage in risky behaviors that impact the overall health of the County.
- Three out of every four Oswego County adults are considered overweight or obese.
- The percentage of children and adolescents in Oswego County are considered overweight or obese is 23.1%, compared to the New York State (excluding NYC) figure is 17.3%
- One out of every four adults smokes cigarettes (28%).

Oswego County's suicide rate,14.4% per 100,000, is nearly twice as high as NYS as a whole, which is 7.9%. While the rate has improved since 2013 CSP, it is still a concern.

• The incidence rate for Oswego County regarding substance abuse/injury/mental health is consistently higher than rates of the larger NYS regions with unintentional injuries, motor vehicle and non-motor vehicle mortality rates all being in the (bottom) 4th quartile. Chlamydia case rates among woman aged 15-44 had significantly worsened, going from 1078 per 100,000 in 2013 to 1,419 per 100,000 in 2014.

3. Identify Prevention Agenda Priorities:

- Prevent Chronic Disease
 - o Reduce Obesity in Children and Adults
 - o Reduce Illness Disability and Death related to tobacco use and second hand smoke
 - o Increase access to high quality chronic disease preventive care and management both in the clinical and community setting
- Promote Mental Health Well-Being & Prevent Substance Abuse
 - o Prevent Suicides Amon Youth and Adults

Along with using available data to select these priorities, as a part of the development of Oswego Health's 2015 Community Health Needs Assessment, RMS interviewed key community stakeholders regarding their opinions of the county's health status. The key stakeholder surveys supported the RMS data in regard to the county's top health concerns.

4. Priority Area: Prevent Chronic Disease

FOCUS AREA 1: Reduce Obesity in Children and Adults

Goals for Oswego Hospital and Oswego County Health Department —

To promote Healthy Women and Children, Oswego Hospital and the Oswego County Health Department will encourage and recruit pediatricians, obstetricians and gynecologists, and other primary care provider practices and clinical offices to become New York State Breastfeeding Friendly Practices. Oswego Hospital will continue to participate in the NYS Breastfeeding Quality Improvement Hospital Initiative.

The OCHD is also partnering with REACH CNY, Inc., on the Creating Breastfeeding Friendly Communities grant.

This work seeks to promote a breastfeeding friendly continuum of care from pregnancy through the infancy period, promoting evidence based breastfeeding education/management, increase breastfeeding initiation, exclusivity and duration in Oswego County.

The OCHD is also partnering with Oswego City School District and the Fulton school district to implement a Healthy Highways curriculum that emphasizes health choices in the areas of nutrition and physical activity. As part of this initiative, a professor from SUNY Oswego is assisting with evaluating the success of this program via knowledge and behavior change surveys.

PROCESS MEASURES

- Monitor the number of breastfeeding mothers at discharge
- Implement program, New York State Breastfeeding Friendly Practices, and monitor number of participating practices.
- Continue to participate in the Oswego County Breastfeeding Coalition.
- Establish a Breastfeeding Friendly care continuum in Oswego County through participation in the Creating Breastfeeding Friendly Communities grant
- Number of Elementary Schools participating in the Healthy Highways Curriculum
- Monitor behavior change as demonstrated by students in Healthy Highways schools

FOCUS AREA 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke

The Oswego County health and human service community is concerned about the smoking disparity among low income pregnant women. The county healthcare leaders recommend that all women are counseled on and screened for tobacco use during prenatal visits.

The OCHD will continue to coordinate the *Smoke Free* for *Baby and Me* initiative with the single OB provider practice in Oswego County. All pregnant woman are screened for tobacco use and those that smoke are offered an opportunity to enroll in the *Smoke Free for Baby and Me* program, a program that offers smoking cessation counseling coordinated with regularly scheduled OB appointments and diapers as an incentive for women that quit smoking. This program has been expanded to women that have not quit during pregnancy but are looking to quit prior to the baby turning two years old. Oswego Health continues to be a valuable partner in this initiative, sending staff from the maternity floor to advisory meetings for this project. OCHD and OH with continue to work with our health and human services partners to address this disparity.

PROCESS MEASURES:

- Number of women participating in Smoke Free For Baby and Me.
- Number of pregnant women smoking that seek care at Oswego County OB/GYN

FOCUS AREA 3: Increase Access to High Quality Chronic Disease Prevention Care

Oswego Health and County of Oswego Health Department Goals:

In its efforts to reduce the incidents of diabetes, heart failure, COPD, obesity and smoking. Oswego Hospital and the OCHD will continue to offer the evidencebased *Healthy Living* Chronic Disease Self-Management Program (CDSMP) classes. Oswego Health Registered and Licensed Practical Nurses, who serve as Community Educators, will assist in leading these classes. OCHD Public Health Education staff will also provide classes in the community.

In addition, a new diabetes initiative, Prevent T2 has been implemented by Oswego Health and Oswego County. This year-long evidence-based program has been approved by the Centers for Disease Control (CDC). Participants learn how to eat healthy, add physical activity to their routine, manage stress, stay motivated, and solve problems that can get in the way of healthy changes.

The health partners will offer several sessions of these classes each year throughout the three-year cycle of this report. Data will be shared on the progress made by participants.

To complement the CDSMP classes, Oswego Health's Certified Diabetes Educator provides outpatient services and leads two community diabetes support groups. ARISE will also partner with Oswego Health and Oswego County Health Department to provide CDSMP and Diabetes Self-Management Program classes in the community. In addition, Oswego Health and Oswego County will add a new focus area this year to address obesity in children and adults. To reduce obesity in the county, the health system will continue to support breastfeeding programs such as the Breastfeeding Quality Improvement Hospital Initiative and will work with the sole OB/GYN practice in the county to implement breastfeeding programs, such as *NYS's Breastfeeding Friendly Practices*.

PROCESS MEASURES:

- Data from Quality Technical Assistance Center (QTAC)
- Number of Participants
- Number of Programs Offered
- Number of schools enrolled in the Healthy Highway program
- Measure changes in knowledge and behavior of students in Healthy Highway schools

PRIORITY AREA: Promote Mental Well-Being & Prevent Substance Abuse

Oswego Hospital Behavioral Health Services Goals:

To reduce suicide rates, Oswego Health and Oswego County will share data on suicide, suicide attempts, and prevention efforts. The healthcare leaders will also offer gatekeeper training and will screen for suicide risk in primary care or substance abuse programs. In addition they will reach out to groups that have a higher risk for suicide or suicide attempts than the general population.

Oswego Hospital is furthermore collaborating with Oswego County Department of Social Services to expand the School-Based Mental Health Services. As of this year, the program is offered in ten Oswego County school districts.

The OCHD will participate in the Oswego County Suicide Prevention Coalition.

PROCESS MEASURES:

- Number of primary care, urgent care and emergency department providers receiving monthly suicide data.
- Number of primary care and substance abuse professional trained.
- Number of groups at high risk for suicide.
- Work with local EMS providers to track data on suicide/attempts.

Oswego Hospital/Health Community Service Plan Prevention Agenda Action Plan 2016 - 2018

| | | Priority Area: Prevent Chronic Disease Focus | Area 1: Reduce Obesity in | n Children and Adults | | | |
|--|---|--|--|--|--|------------------|--------------------------------------|
| Goal | Outcome Objective | Interventions/Strategies/Activates | Process Measure | Partner Role | Partner Resources | By When | Will Action Address Disparity? |
| Expand the role of loaith case, loaith services providers and insures in obsaity presention. | Increase the number of breatfielding mothers in Osarega County by 5%. | Recruit hespitals to participate in quality improvement efforts to immose basesticeting exclusivity at discharge | Number of breatlineding anthers at discharge | Ocarego Health will continue to participale in NYS BQIH | Staff including lactation consolitant, materials, seferals, data | December 2011 | Ne |
| | | | | Osango County | Staff, relieval, Coalition participation. | | |
| | | Encourage and recruit pediatricians, obstatricians and generologists, and other primary care provider partices and clinical offices to become New York State Remarkashing Friendly Practices. | Implement program and manifer number of participating practices. | Osango County Renatiending Coalition | Data, participant resonance. | | |
| | | Continued participation in the Oswego County Becastizeding Continue. | Number of relievals to factation consults at Centego Hospital and | Canell Congenative Extension | Luctation, refincals, data | | |
| | | | Comell Cooperative References | Osmeyo County OBX5YN Pontice | Data | | |
| | | Establish a Resetficeing Friendly care continuum in Generge County through participation in the Creating Resetficeing Friendly Communities grant | Number of worksins that accommodate investiveling mathems. Number of Baby Colies in County. Number of Instituture practices that achieve NYS Browstiveling. Friendly Portice designation. | REACH ONY | Centing Recetiveling Primity Communities grant constitution | | |
| | By 2018 see a reduction in childhand obesity by five percent. | Espansion of the Houldry Highwaya Program. | Number of Elementary Schools participating in the Healthy Highways | Osargo Bailti OCED | Program support Data collection and coordination | | |
| | | | Cominators Knowledge and behavior change is demonstrated by students in | Ocarego City and Fution Schwil Districts | Implement conicolum, data collection | | |
| | | | perficipating schools | SUNY Orango Wendy Cauper Program Founder | Data collection, evaluation Controlom taining | | |
| | | | | rogan rounde | LANG. | | |

| | Prevent Chronic I | Disease, Focus Area 2:Reduce Illness, Disability and D | eath Related to Tobacco | Use and Secondhan | d Smoke Exposure | | |
|--|---|---|---|---|---|------------------|--------------------------------------|
| Goal | Outcome Objective | Interventions/Strategies/Activates | Process Measure | Partner Role | Partner Resources | By When | Will Action Address Disparity? |
| Reduce prenature hirth. Promote tabance use creation, especially among law SRS | By December 3016, selace the number of program warmen who smalle by 10 percent. | Ask all perguant women about tobacco use and periode augmented, perguancy-tailored nonroeling for these who scenics and offered the Sanoke Fran For Roby and Me program. | Number of women participating in Samke Pres For Haby and Me. | Osarego Henith is a Sonake Pare Casilition member. | Stoff, data. Coundination | December 2018 | Ye |
| populations and those with poor mental least Riminate expresses to second land sender. | | New mothers enrolled in the GPTIONS program will be screened for tokarno ran and offer the Southe Pres for Roby and Mc Program. | Number of pregnant waters standing that seek care at Osarego County OB/GYN | OCHD caurdinates Sanka Fran Far Baky and Me. | Screening of program women and conneling | | |
| | | | | Oswega Casaty OB/GYN | Data, practice centration | | |
| | | | | Integrated Community Planning (funding) | Tobucco Pree Network, supplies, data, funding, | | |

Continued: Prevent Chronic Disease, Focus Area 2:Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

| United Way Funding St. Joseph.'s Cessation. Hotypical Health. Cessation. (Creation) Center) | | OCO (OPTIONS) | Sciencing of pregnant, and parenting women, resultion, consisting, Contribut member, baining | |
|---|--|------------------|---|--|
| | | United Way | Funding | |
| | | Centim | Cesation h Talicing | |

| Goal | Outcome Objective | Interventions/Strategies/Activates | Process Measure | Partner Role | Partner Resources | By When | Will Action Address Disparity? |
|---|---|---|--|---|--|------------------|--------------------------------------|
| Promote Rväkene hannel care to manage chomic disease | BY December 2018 increase the puritiquian by fore percent the number of puriticipants in evidence-based chronic disease programs. | Promite and offer the following exidence-based pargram: - Claunic Disease Clownic Disease Self-Management Program. - Prevent T2 (A National dislates provention program.) - Dislates Self-Management Program. | Data from Quality Technical Assistance Center (QTAC) Number of Paticipants Number of Programs Offices | Orango Health Orango County Kealth Department ARISE Orango County Opportunities (Itoral Health Network and IMPACT Program) | Staff, muterials, multeting, meeting, space Staff, muterials, muterials, data mutagement, coordination Staff, muterials, muterials, muterials, muterials, muterials, muterials, muterials, muterials, finding | December 2011 | Ne |

| | Promote Men | tal Health and Prevent Substance Abuse, Focus J | Area 2: Prevent Substance Abuse an | d Other Mental Emo | tional Behavioral Disc | rders | |
|--|---|---|---|--|--|------------------|--------------------------------------|
| Goal | Outcome Objective | Interventions/Strategies/Activates | Process Measure | Partner Role | Partner Resources | By When | Will Action Address Disparity? |
| Prevent suicides accorg youth and adults. | By December 2018 reduce the number of solicides by five percent. | Maniter and share data an suiride, suiride allempts, and prevention efforts. | Number of primary care, argent care and energency department providers receiving muchly spicifie data. | Osarego Emilik | Soff, data, osaonas, ceditian participatian | December 2018 | Na |
| | | Offer gatekerper training to screen for suittle rick in primary care or substance above programs. | Number of primary care and, substance abuse professional trained. | OCHD | Staff, coelition participation | | |
| | | Reach out to groups that have a higher risk for suivide or suivide attempts than the general population | Number of grange at high risk for suicide. | Osarego Caunty Suicide Preventian Caulitian | Data, participant cesanakas | | |
| | | | Work with larst RMS providers, to track data an suicide/attempts. | Menter Anbolane Service | Coulition participation, data. | | |

5. Describe the Process to Maintain Engagement

Staff from Oswego Health and the Oswego County Health Department meet several times each year to assess both the community's overall health issues and the programs outlined in this report. These health partners have a strong, long history of working together to improve the health status of the community and there is no doubt that this will continue.

6. Describe Dissemination Plan for Report

Oswego Health will post its Community Service Plan on its website, oswegohealth.org and will also announce its availability in its community publications.