St. Joseph Health Community Benefit & Community Health Needs Assessment

What is Community Benefit?

- Nonprofit hospitals must do something to benefit the community
  - In California, what and how much are not specified
  - St. Joseph Health (SRMH & PVH) has traditionally run multiple social and health care services programs
  - Increasingly, Community Benefit is looking at how to have a broader system impact than delivering services to individuals

Why a Community Health Needs Assessment?

- Requirement to conduct a needs assessment **every 3 years**
- Define the **community served**
- Assess the community's health: identify and prioritize **needs**; identify **resources** to address needs
- **Develop CHNA report**
- Adopt an **Implementation Strategy** to address identified health needs

CHNA Priorities

- Access to Resources
- Behavioral Health (Mental Health / Substance Abuse)
- Housing Concerns and Homelessness

Primary Mission Driven Approaches and Target Populations

- Population Health Strategies aimed at addressing the needs of high risk, higher acuity individuals that are frequent utilizers of services
- Prevention and Education Strategies aimed at building a healthy and resilient community

CARE Network

- Comprehensive team approach
- Provide medical care or care coordination, social work, resources navigation
- Integrated behavioral health services
- Adapt and integrate existing programs, including Care Coordination and CB House Calls and Mobile Health Clinic

CARE Network

CARE Network Teams:

- **Transitional Care** for vulnerable discharged patients
- **Complex Care Management or Intensive Outpatient Care Management (IOPCM)** for high utilizers with complex medical, socio-economic and psychosocial needs
- **Chronic Disease Management** for patients with unmanaged chronic diseases (top 6 diagnoses)
- **Behavioral Health Case Management** for frequent users with substance abuse and/or mental health
- **Mobile Medical Care and Brief Case Management** for sheltered homeless with medical and psychosocial needs
- **Medical Care Management for Homebound Poor** serving vulnerable patients at risk for hospitalization and without resources for home care
- **Integrated Behavioral Health** providing consultation, assessment and therapeutic approaches for CARE Network clients across teams
- **Brief ED Navigation** for patients without insurance and/or a medical home, who are homeless or are frequent utilizers (Open Access to Community Care Program)

In addition, a Medical Legal Partnership (MLP) pilot project with Legal Aid of Sonoma County will provide legal counsel and assistance to CARE Network caregivers and their patients so as to reduce or remove legal barriers associated with their condition (e.g., legal residency, benefits eligibility, eviction, employment, domestic violence, custody issues, etc.)

Behavioral Health Services

Objectives:

- Expand psychiatric services and clinical supports to address behavioral health needs of vulnerable populations
  - Partner with the St. Joseph Health Medical Group to form a team of a psychiatrist and two psychiatric nurse practitioners with expertise to manage patients with complex psychiatric and substance use disorder conditions. (*This team would advise and support hospitalists and primary care providers of inpatients and outpatients, as well as directly treat outpatients, without regard to their status or insurance coverage. This team would also provide advice and support to CARE Network caregiver teams.)*
  - Assess the potential to expand capacity of the St. Joseph Health Outpatient Behavioral Health Program to serve more uninsured and underinsured patients

- Improve access to behavioral health services for high acuity individuals by addressing institutional policies, coordination, and systems countywide
  - Convene and provide staff to a Behavioral Health Working Group of the Committee for Healthcare Improvement (CHI) of Health Action to identify, develop, and implement policy and systems change efforts needed to improve the behavioral health system of care, particularly for high acuity individuals.

Homelessness/Housing

Objective:

- Expand access for homeless individuals to medical and other support services that improve quality of life and reduce ED use and hospitalizations
  - Provide financial support to ensure the provision of needed respite care for homeless patients after discharge from the hospital. (*This will include the stabilization and/or expansion of Project Nightingale and the establishment of similar services in other needed areas of the county.)*
  - Provide Mobile Medical Team services at homeless shelters and supportive housing locations.
  - Research and bring forward models for expanding full service Permanent Supportive Housing (PSH). Explore regional approach to expanding PSH services and number of units with health system and other community partners.
  - Convene and support the Health Care for the Homeless Collaborative (HCHC) to coordinate existing and develop new health care services for homeless population.

Community-Based Prevention

Objectives:

- Sustain and improve access to resources to promote health
- Improve the health of the community through upstream efforts

Strategies:

- Provide essential preventive services for children, isolated or vulnerable residents, and pregnant women.
- Promote and deliver community-based programs that promote health and resiliency.

Access to Resources

- Continuation of existing Dental Programs providing services to children 0-16.
- Mobile Health Clinic will continue providing primary care to Sonoma Valley and Windsor residents without access to primary care.
- Growing Together Perinatal Program will continue to provide resources for pregnant and parenting families.

Community-Based Behavioral Health

Programs/Initiatives:

- Examine and evaluate existing school-based programs currently offered by SJH Community Benefit (Healthy for Life and Circle of Sisters) to see how they could be redesigned, transformed, or transferred

- Objective is to create new and/or expand existing school-based behavioral health trauma-informed prevention-focused programs

- What advise or referrals to existing programs or coalitions can members of the MCAH Advisory Board offer?

Community-Based Behavioral Health

Programs/Initiatives:

- Participate with community-based organizations, government agencies, and existing coalitions to identify, develop, and potentially support upstream community-based prevention strategies and interventions that are trauma informed. (e.g., *La Plaza* project of On The Verge, the Sonoma County Wellness Arts Collaborative, the Early Childhood Development capacity-building project of First 5 and the Community Foundation, CAP Sonoma's Community Building Initiative, the Nurse-Family Partnership and other home visiting programs, ACES Connection, Restorative Justice Collaborative, Daily Acts' Resilient Hubs Network, Sonoma County Mental Health Collaborative, and the Sonoma County Mental Health & Spirituality Initiative)
- What potential do you see for this strategy?
- Recommendations for existing initiatives, programs or coalitions?
- Do you see a need for this enhancement and alignment of these efforts?

Community-Based Behavioral Health

Intersections Initiative:

- An initiative of the St. Joseph Health Community Partnership Fund in partnership with the Prevention Institute
- Multi-sectoral coalition to advance health equity by creating policies, strengthening systems, and transforming organizational practices
- Explicitly focused on upstream approaches to address community determinants of health, i.e., no funding for services and programs
- 3-year project beginning now with a 4-month strategic planning period followed by 2.5 years of implementation
- Administered locally by SJH Community Benefit staff
- Utilizes the Prevention Institute's Spectrum of Prevention, Adverse Community Experiences and Resilience (ACE/R), and Tool for Health and Resilience in Vulnerable Environments (THRIVE) frameworks
- Early planning has identified housing equity that will lead to improved conditions for community mental health and wellbeing as the primary focus of the Sonoma County Intersections Coalition

Community Benefit Framework

ST. JOSEPH HOSPITAL SANTA ROSA COMMUNITY BENEFIT PLAN FRAMEWORK FY18-FY20					
	POPULATION HEALTH			COMMUNITY HEALTH/ENVIRONMENT	
HEALTH PRIORITY	**ACCESS TO RESOURCES:**	**BEHAVIORAL HEALTH**	**HOMELESSNESS/ HOUSING**	**ACCESS TO RESOURCES:**	**BEHAVIORAL HEALTH**
TARGET POPULATION	**High acuity, high risk individuals, uninsured or underinsured frequent users of services**		**Persistently homeless and precariously housed**	**Perinatal, Children, Community members & Families**	**Community, children, youth, families**
INITIATIVES	**CARE Network:** • Transitional Care • Complex Intensive Case Management • Chronic disease case management • Medical case management for homebound poor	CARE Network Behavioral Health Integration	• CARE Network • Mobile Health Services for Homeless • Homeless Care Coordination (SRCH)	Children's Dental Services	Community-Based Trauma-Informed Mental Health Initiatives and Programs (preferably school-based)
		Expand Psychiatric Services (Grant)	Homeless Respite Care (e.g., Project Nightingale, COTS, etc.)	Mobile Health Services for Sonoma Valley	Sonoma County Intersections Initiative Coalition
		Outpatient Behavioral Health Program	Supportive Housing Planning & Support (HCHC, CoC, etc.)	Growing Together Perinatal Program	CHI Behavioral Health Working Group