Alice Hyde Medical Center

Implementation Strategy 2013

New York State Prevention Agenda

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Our Mission: Building a Healthier Community Together

Our Vision: Alice Hyde Medical Center will distinguish itself as a trusted and respected health care leader and provider of choice, exceeding expectations through service excellence.

Introduction: Alice Hyde Medical Center (AHMC) is located in Malone, New York, ten miles from the Canadian border. Being a rural hospital in northern New York State, we are faced with unique challenges. Foremost is our need to attract and retain high-quality health care providers and offer state of the art services. We are designated as a Low Income Health Professional Shortage Area and face constant challenges in attracting and retaining physicians and specialists. While we are an affiliate of Fletcher Allen Health in Burlington, Vermont, we are 80 miles from them with a minimum travel time of 2 hours and 15 minutes. They constitute the nearest tertiary medical center and are separated from Alice Hyde Medical Center by Lake Champlain.

In 2013, we have been fortunate in recruiting a number of providers that are critical in helping AHMC meet our community's health care needs. The following specialists have been recruited: OB/GYN, Orthopedic Surgeon, Pediatrician, Urologist, Internal Medicine (2 starting in 2014), Physician Assistants (1 primary care and 1 Orthopedic), and a Family Nurse Practitioner. AHMC has also collaborated with neighboring hospitals and physician groups to bring additional services to our community. This includes: Pulmonology, Vascular Surgery, Cardiology, Medical Oncology, Radiation Oncology, and Nephrology.

Alice Hyde Medical Center Service Area and Facilities – Please see Appendix I (p. 12)

Description of prioritization process – Please see Appendix II (p. 13)

AHMC Implementation and Sustainability Plan: AHMC has created "Implementation Teams" that will be responsible for each Focus Area's Action Plan. We have collaborated with all of the agencies listed as partners in this Implementation Strategy and we are all committed to dedicating resources to the selected activities. Our relationships are established, our partnerships strong, and we share a common vision: to improve the health of our communities, through the New York State Prevention Agenda.

AHMC's Implementation Strategy will be developed under the auspices of the Community Wellness Program. Established in 2003, the Community Wellness Program serves as the focal point for community wellness outreach activities, and ensures the sustainability of AHMC's Prevention Agenda Action Plan. Through the prioritization process (Appendix II**)**, the AHMC

Prevention Agenda Implementation Team selected *Preventing Chronic Disease* as the top priority. The two focus areas that scored the highest, based on need, feasibility, and impact are:

Focus Area 1: *Reduce obesity in children and adults.*
Our interventions will be targeting childhood obesity.

Focus Area 2: *Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings.*
Our interventions will be addressing diabetes prevention and management.

Focus Area 3: *Address Health Disparities*
The greatest disparity in our county is socio-economic (SES):
20.7% of the population lived at or below the poverty level in 2011
www.health.ny.gov/statistics/chac/general

29% of children are living in poverty, according to the 2013 County Health Rankings (www.countyhealthrankings.org)

Our interventions will target or include underserved populations, in collaboration with the community agencies that serve them.

Given that AHMC's Action Plan consists of new activities, during the first year we will focus on program development and implementation, identifying baselines for future evaluation, and comparison to current benchmarks. Subsequently (2014-2015) we will establish quantifiable measures to work toward.

Partnerships:
Adirondack Medical Home/Pediatric Obesity Initiative
Adirondack Rural Healthcare Network
Adirondack Tobacco Free Network
Breastfeeding Council of Malone
Cancer Services Program
Eastern Adirondack Health Care Network
Malone Complete Streets Partnership
North Country Healthcare Providers
North Country Healthy Heart Network

Focus Area 1: Reduce Obesity in Children

Objective: By December 31, 2017, reduce the percentage of children who are obese.

AHMC will be implementing the following activities to address childhood obesity:

1. The pediatric *How's Your Health* Health Risk Assessment - supporting pediatricians in their patient and family interactions during Wellness visits

2. A community-wide *Let's Go! 5210* campaign: (per Maine's *Let's Go! 5210*)

3. *Great Beginnings New York: The Future Starts with Breastfeeding* – a New York State Department of Health initiative

Partners: Alice Hyde Medical Center and satellite Health Centers (5)
Adirondack Medical Home/Community Resource Advocates
Breastfeeding Council of Malone
Franklin County Cornell Cooperative Extension/Eat Smart New York
Franklin County Public Health/Maternal Child Health Program
North Country Children's Clinic/WIC
Pediatric Practice (2)
Wead Library
Treo Solutions

Goal 1.3: Expand the role of health care and health service providers in obesity prevention.

The ***How's Your Health*** (HYH) Health Risk Assessment (pediatric version) is going to be incorporated into two pediatric practices. HYH is a health assessment tool that unmasks behaviorally sophisticated issues that help or impede a person's overall health and wellbeing. In addition to clinical condition support, HYH goes beyond diagnoses and conditions to address issues that impede improved outcomes; it supports coordination of care, and also connection to additional community resources and services.

Through the Pediatric Obesity Initiative (led by Adirondack Medical Home), the Obesity Prevention in Pediatric Healthcare Settings network will implement system change interventions to ensure pediatric and adolescent healthcare is delivered in concordance with the *Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity.*

Let's Go! 5210 Campaign: 5 or more servings of fruits and vegetables
2 or less hours of screen time
1 hour or more of physical activity
0 sugar-sweetened drinks

AHMC will be developing a *Let's Go! 5210* media campaign, and introducing the 5210 healthy lifestyle messages into one pediatric practice in our community. (www.letsgo.org) The *Let's Go! 5210* materials will support the pediatrician and their staff in teaching children and their families about healthy eating and physical activity.

The pediatric practice staff calculates a child's Body Mass Index (BMI) at every Wellness Visit (annual) and it is entered into the Electronic Medical Record (EMR). If a child is flagged as obese, over the 85th percentile, they are referred to a dietitian/nutrition educator or a Medical Home Community Resource Advocate.

Measurement: Introduce *Let's Go! 5210* patient resource materials in the first quarter of 2014, in one pediatric practice. As this is a new program being implemented, we will require a minimum of six months to set up the "system" for patient/family education. Once this is achieved we will establish a baseline (the number of pediatric patients categorized as obese) and an objective to achieve by December 31, 2015.

A media campaign will be developed promoting the *Let's Go! 5210* message. Objectives will be to:

- post *Let's Go! 5210* information and resources on the AHMC website by April, 2014
- develop (radio) Public Service Announcements to be aired by April, 2014
- partner with two community agencies, serving the low socio-economic population, to disseminate the *Let's Go! 5210* messaging, by May 2014

AHMC has been a registered *We Can!* (Ways to Enhance Children's Activity & Nutrition) site through the National Institutes of Health since 2009. We have engaged with hundreds of people, promoting physical activity and healthy eating, through family events, school wellness days, and health fairs. We will continue with these community outreach events.

Objective 1.3.2: Increase the percentage of infants born at AHMC who are exclusively breastfed during the birth hospitalization.

Great Beginnings NY: The Future Starts with Breastfeeding*:* AHMC is participating in the *Great Beginnings NY*: *The Future Starts with Breastfeeding* initiative; our signed letter and completed Hospital Assurance statement have been submitted to the New York State Department of Health. This will build on the work we have accomplished to date, in part due to a mini-grant awarded by the New York State Breastfeeding Council and a Community Health Award from Excellus BlueCross/Blue Shield. AHMC has joined the *Great Beginnings NY* initiative to ensure that mothers are better supported in meeting their breastfeeding goals. We will be working on these four evidence-based strategies over the next three years:

- Ensure breastfeeding infants do not receive supplementation unless medically indicated or at the request of the mother, and documented in the infant's medical chart
- Educate mothers on the impact of non-medically indicated supplementation on breastfeeding success
- Discontinue the distribution of free infant formula including discharge packs, and the provision of infant formula promotional materials in any hospital location and as part of patient education
- Provide all breastfeeding mothers with post-discharge lactation support and referrals

Measurement: Identify the number of babies who are breastfed exclusively, at discharge from the AHMC Family Maternity Center, in the first quarter of 2014. Objective will be to increase exclusive breastfeeding rates by 5% by December 31, 2014, and by 10% by December 31, 2015.

<u>Focus Area 2</u>: Increase Access to High-Quality Chronic Disease Prevention Care and Management in Both Clinical and Community Settings

Partners: Alice Hyde Medical Center
Cornell Cooperative Extension
Eastern Adirondack Health Care Network
Franklin County Public Health

Goal 3.1: Increase screening rates for diabetes, especially among disparate populations.

Objective 3.1.4: Increase the percentage of adults 18 years and older who had a test for high blood sugar of diabetes within the past three years.

Early identification and management of people with pre-diabetes and diabetes has the potential to prevent diabetes and its complications, according to the New York State Department of Health, Division of Chronic Disease Prevention (Information for Action #2013-8). The American Diabetes Association recommends that testing, to detect pre-diabetes and Type 2 diabetes, be considered for all adults who are overweight (Body Mass Index ≥ 25 kg/m^2) and who have one or more additional risk factors.

AHMC is developing a diabetes screening community outreach plan to target at-risk individuals. The plan includes:

- Engaging individuals in a variety of settings, including the community college, worksites, adult centers, and social services agencies
- Creating a new duplicate form for the diabetes screening results
- Establishing a system to contact at-risk individuals to ensure follow-up with a healthcare provider

- Connecting people to community resources as needed (ie: primary care providers, facilitated enrollers/insurance marketplace navigators)

Measurement: Organize a minimum of five community-wide diabetes screening events. Objective will be to provide diabetes screening (finger stick blood glucose) to 300 at-risk individuals by December 31, 2014.

Goal 3.3: Promote culturally relevant chronic disease self-management education.

Objective 3.3.1: Increase the percentage of adults with pre-diabetes or diabetes, who have taken a course or class to learn how to manage their condition.

Diabetes Prevention Recognition Program: Alice Hyde Medical Center is currently registered as a Diabetes Prevention Recognition Program with the Centers for Disease Control and Prevention (effective June 2013); our initial two-year commitment to the CDC is being funded by Eastern Adirondack Health Care Network. We implemented the pilot program in the North Country, in October 2013, with twelve participants recruited from the Malone Central School District staff. This collaboration includes technical support from the Center for Aging and Community Wellness/Quality and Technical Assistance Center, University at Albany School of Social Welfare. The project includes rigorous data collection, which will be submitted to the CDC every six months.

The Diabetes Prevention Program is an evidence-based year-long program for people with pre-diabetes, a history of gestational diabetes, and/or at-risk for developing diabetes. It consists of 16 weekly one-hour sessions, followed by 6 to 8 monthly session, addressing healthy lifestyle changes – specifically healthy eating and being physically active. The goal is to prevent diabetes through weight loss (5-7% of starting body weight) and increasing physical activity to 150 minutes per week.

Measurement: Our goal is to conduct two Diabetes Prevention Programs per year in the greater Malone community.

<u>Focus Area 3</u>: Address Health Disparities - Improve Health Status and Remove Health Disparities

Partners: Alice Hyde Medical Center
Adirondack Health Institute
Adirondack Medical Home
Literacy Volunteers
Treo Solutions/North Country Healthcare Providers

Wead Library

The following activities and initiatives are either in place or are being developed to address the health disparities in our service area, by:

- increasing access to care
- improving communication
- removing barriers
- working with new partners

A family nurse practitioner and a physician assistant have been hired to expand the staff of the Alice Hyde Primary Care Practice. Two internal medicine physicians have also been recruited to further expand the capacity of the Alice Hyde Primary Care Practice. This has significantly expanded our ability and capacity to care for more patients in need of primary care. This is a growing need in the community and the ability to meet this growing demand is critical to the health of our community.

Alice Hyde Medical Center will be launching the *How's Your Health* (HYH) initiative in the pediatricians' practices. This program is an on-line, health-assessment tool that provides our health care providers with health, wellness, and lifestyle insight and information about their patients, thus improving communication between the patients and the health care providers; there is research and evidence that shows that engaged patients have healthier outcomes. HYH offers helpful tools for patients to improve self-care and problem solving. Furthermore, it identifies unmet needs so that healthcare providers can arrange for access to additional community resources, as needed.

Community outreach events are being planned to provide assistance in enrolling for health insurance via the *New York State of Health*, the official Health Plan Marketplace. We are partnering with enrollment specialists to identify how – and where – to best reach members of our communities.

A Discharge Communication Program has been developed to provide follow-up care for our in-patients. Patients with Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and community acquired pneumonia will be called to meet any additional needs with the goal of preventing readmission within 30-days.

An educational campaign is being developed via the North Country Healthcare Providers collaboration, to assist individuals in the decision-making process of whether they should go to an Urgent Care Clinic versus the Emergency Room.

We will be partnering with the Wead Library and Literacy Volunteers to establish new community outreach/health communications projects.

Ecological Models for Community Health Improvement:

In developing and implementing the New York State Prevention Agenda strategies, Alice Hyde Medical Center will be considering the components of three models to ensure the greatest scope for success and sustainability:

- the Health Impact Pyramid
- the sectors identified in the New York State Prevention Agenda
- the Spectrum of Prevention

Health Impact Pyramid
Socioeconomic Factors
Changing the Context to Make Individuals' Default Decisions Healthy
Long-Lasting Protective Interventions
Clinical Interventions
Counseling and Education

New York State Prevention Agenda - Sectors
Healthcare Delivery System
Employers, Businesses, and Unions
Media
Academia
Community-based Health and Human Service Agencies
Other government agencies
Governmental and Non-governmental Public Health
Policymakers and Elected Officials
Communities
Philanthropy

Spectrum of Prevention
Influencing Policy and Legislation
Changing Organizational Practices
Fostering Coalitions & Networks
Educating Providers
Promoting Community Education
Strengthening Individual Knowledge and Skills

Plan for communicating AHMC's activities to our community:

The Community Service Plan, the Community Health Needs Assessment, and the Implementation Strategy documents will be posted on the AHMC website at www.alicehyde.com. The public will be able to access these documents via the website or by request.

Copies may be requested from the Department of Community Relations at 518-481-2794.

Significant health needs not addressed in AHMC's Implementation Plan:

While we will be focusing on the top two priorities as an opportunity to develop and implement new Prevention Agenda strategies and activities, AHMC will continue to provide the following interventions:

- AHMC participates in offering the *Chronic Disease Self-Management Course*, as we have since 2007. Adirondack Medical Home and Franklin County Public Health serve as the lead agencies to coordinate CDSMP in Franklin County, in collaboration with Eastern Adirondack Health Care Network. AHMC has two trained co-facilitators and will continue in a support role for the CDSMP. Since AHMC is the lead agency for the Diabetes Prevention Program (DPP) pilot in the North Country, we are focusing on developing the DPP in our Implementation Strategy.

- AHMC is certified by the American Diabetes Association (ADA) as a provider of Diabetes Self-Management Education. Certification by the ADA assures the program provides a complete educational experience based on the needs of the patient and the recommendations of the patient's primary caregiver. Multiple Diabetes Self-Management Education courses are offered each year; the course targets individuals newly diagnosed with diabetes or who are in need of improved diabetes care and management. The course content continues to reflect current best practices for diabetes care and management.

- The Focus Area to *Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure* was identified as the third Prevention Agenda priority, in the regional and facility prioritization process. In collaboration with, and guidance from, the North Country Healthy Heart Network (HHN) Tobacco Dependence Specialist, AHMC has an established system for providers to screen for tobacco use and refer patients to the New York State Quitline. HHN is one of 19 Cessation Centers funded by the NYS Department of Health Tobacco Control Program (TCP), to serve Clinton, Essex, Franklin and Hamilton counties in upstate New York. Cessation Centers work with health-care organizations and providers to implement systems to screen patients for tobacco use, and prompt providers to offer advice and assistance to quit.

AHMC's Electronic Medical Records (EMR) system was set up in the Health Centers and primary care practices, by the Health Information System team, to meet the Medical Home standards and guidelines. Prompts were created in the computer program to:

(1) Remind providers about evidence-based counseling (the 5 A's)
(2) Document that counseling took place
(3) Ease the providers' work flow

To further streamline the referral process, the HIS team set up the EMR auto-fill feature so that, at the click of a button, the completed referral form was instantly sent to the NYS Quitline. This process also triggers a feedback mechanism to the provider, for patient progress reports. AHMC was one of the first in the state to implement this system. Prior to this system implementation (2012), there were 4 referrals from AHMC providers faxed to the NYS Quitline. From January to September, 2013 (after implementation) there were 30 referrals via the EMR system, to the NYS Quitline.

APPENDIX I

Alice Hyde Medical Center Services and Service Area

Celebrating 100 years of serving the community, Alice Hyde Medical Center (AHMC) opened on September 15, 1913. Located in Malone, New York, AHMC offers advanced medicine and exceptional health care that is provided by top-notch professionals and physicians. The Medical Center is accredited by the Joint Commission, and its Medical Imaging Department and Laboratory are accredited by the American College of Radiology and the Joint Commission, respectively. AHMC is comprised of:

- A 76-bed acute care facility
- A 75-bed long-term care facility
- Four community health centers
- A walk-in clinic
- Specialty centers: Cancer Center, Orthopedic and Rehabilitation Center, Cardiac Rehabilitation Unit, Hemodialysis Center, Sleep Lab, and Dental Center.

The Medical Center is an affiliate and health partner of Fletcher Allen Health Care, a premier academic tertiary care center in Burlington, Vermont. The Medical Center provides service to 55,000 residents in northern Franklin County, eastern St. Lawrence County, and western Clinton County.

In July 2013, the Medical Center began constructing a state-of-the-art Nursing Home and Assisted Living Facility. Upon completion, it will be the first facility of its kind to serve Franklin County. The $35 million project includes the construction of a 98,000-square-foot, three-story skilled nursing facility and a 22,500-square-foot, two-story assisted living facility. The existing Alice Hyde and Franklin County Nursing homes will consolidate into the new facility that will house 165 beds and feature private and semi-private rooms, large social areas, country kitchens for customization of special diets and preferences, large living rooms, and a centrally located atrium in the nursing home. The project is slated to be completed in the fall of 2014.

APPENDIX II

Summary of Adirondack Rural Health Network activities

Alice Hyde Medical Center, Adirondack Health and Franklin County Public Health are members of the eight-county Adirondack Rural Health Network collaboration. The Adirondack Rural Health Network (ARHN) is a program of the Adirondack Health Institute, Inc. (AHI). AHI is a 501c3 not-for-profit organization that is licensed as an Article 28 Central Service Facility. AHI is a joint venture of Adirondack Health (Adirondack Medical Center), Community Providers, Inc. (Champlain Valley Physicians Hospital Medical Center) and Hudson Headwaters Health Network. The mission of AHI is to promote, sponsor, foster and deliver programs, activities and services which support the provision of comprehensive health care services to the people residing in the Adirondack region.

Since 2002, the ARHN has been recognized as the leading sponsor of formal health planning for Essex, Fulton, Hamilton, Saratoga, Warren and Washington Counties. During 2011- 2012 the ARHN expanded its regional community health planning efforts to include Clinton and Franklin counties, and currently includes critical stakeholders from all eight counties in the regional planning process. The ARHN provides a neutral, trusted mechanism through which key stakeholders throughout the region can plan, facilitate and coordinate the activities necessary to complete their required community health planning documents, and strategize on a regional level to address common health care concerns.

Community Needs Assessment and Prioritization Process

The process of identifying the important healthcare needs of the residents of Franklin County involved both data analysis and consultation with key members of the community. The data was collected from multiple sources including publically available health indicator data, data collected from a survey conducted by the Adirondack Rural Health Network and a survey / focus group conducted by Franklin County Public Health, Adirondack Health and Alice Hyde Medical Center.

The health indicator data is collected and published by New York State and contains over 300 different health indicators. Since 2003, ARHN has been compiling this data for the region and producing reports to inform healthcare planning on a regional basis. Last year, ARHN undertook a project to systemize this data into a relational database to provide improved access and analysis. The results of this analysis provide a statistical assessment of the health status for the region and each county therein.

In December 2012 and January 2013, ARHN conducted a survey of selected stakeholders representing health care and service-providing agencies within an eight-county region. The

results of the survey are intended to provide an overview of regional needs and priorities, to inform future planning and the development of a regional health care agenda. The survey results were presented at both the county and regional levels.

In April 2013 all the stakeholders that completed the survey were invited to a community forum held on May 1st at Paul Smiths College in Franklin County. Using the results of the indicator analysis and the survey and other community assessments, 31 stakeholders met at Paul Smiths College to discuss the Health of Our Community. The group was introduced to the Prevention Agenda, the data that was collected and the prioritization process. The participants were broken in to small groups to discuss priorities in each of the priority areas. Each group then reported out to the whole group which opened it up for discussion. The group who attended the forum consisted of representatives from Adirondack Health, Alice Hyde Medical Center, Social Services, Mental Health, school districts, Public Health and several Community Based Organizations.

The next step was for key stakeholders to prioritize each of the focus areas using the prioritization matrix provided by the Center for Health Work Force Studies. Fifteen people from the 31 stakeholders that attended the May meeting were picked to do the prioritization process in either small group session or one on one. The following criteria were considered in the prioritization process, to determine need, feasibility, and impact:

- How severe is the problem?
- What is the perceived community need?
- Is there a perceived need for additional resources?
- Is funding available and sustainable?
- What is the availability of evidence-based interventions?
- What is the capacity of stakeholders to implement potential interventions?
- What is the effectiveness of current strategies?
- Are there multiple health benefits?

The results of this process were tabulated and the scores were presented to the community stakeholders. The two priority areas that scored the highest were:

- Obesity in Children and Adults
- Increase Access to High-Quality Chronic Disease Prevention Care and Management in both Clinical and Community Settings.

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APPROVAL:

At the October 23, 2013 Meeting of the Board of Directors of Alice Hyde Medical Center, the Board, which includes representatives from the community, reviewed and approved the Alice Hyde Medical Center Implementation Strategy for addressing priorities identified in the most recent Community Health Needs Assessment (CHNA) and other plans for community benefit.

Upon motion by Secretary Craig LaVigne, and duly seconded by Treasurer Brian Monette, the AHMC Strategic Implementation Plan for the CHNA/Community Service Plan developed to address the New York State Prevention Agenda was unanimously approved by the Board of Directors as presented.

Dean Johnston

Dean Johnston, Chairman

11/11/13

Date