Ulster County HealthAlliance Hospitals CSP

2018 Update

Completed by: Laurie Mozian
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Priority	Focus Area	Goal	Objectives	Disparities	Interventions/ Strategies/Activities	Family of Measures	2018 Progress to Date	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s)	Strengths	Challenges? How will they be addressed?
Prevent Chronic Diseases	Increase access to high quality chronic disease preventive care in both clinical and community settings.	3.3: Promote culturally relevant chronic disease self-management education.	Develop a sustainable infrastructure for widely accessible, readily available, self-management interventions that link community and clinical settings and make use of lifestyle intervention professionals such as registered dietitians, exercise physiologists and social workers. Implement weight reduction if population is overweight. Increase the consumption of whole grains and plant-based foods. Increase the number of days and the duration of physical exercise, as well as knowledge.	Yes. This targets the population with an income of less than $25k per year. Low income populations will be targeted at health fairs and at the People's Place.	Develop a sustainable infrastructure for widely accessible, readily available, self-management interventions that link community and clinical settings and make use of lifestyle intervention professionals such as registered dietitians, exercise physiologists and social workers. HealthAlliance will offer a six-session Wellness and Weight Management Series that is open to the entire community, monthly plant-based diet cooking classes and weekly exercise classes including yoga and Smart Bells.	Conduct pre- and post-tests to determine if participants: -Increase their consumption of fruits, vegetables and whole grains -Increase their frequency and the duration of moderate to vigorous physical exercise -Increase their knowledge of healthy lifestyles -Weight loss if overweight	As reported in the 2017, this program has been discontinued due to attendance challenges and the need to identify a more evidence based approach.				
	Increase access to high quality chronic disease preventive care in both clinical and community settings.	Goal 3.1: Increase screening rates for cardiovascular disease, diabetes, and breast, cervical and colorectal cancers, especially among disparate populations.	Objective 3.1.1: By December 31, 2018, increase the percentage of women aged 50-74 years with an income of < $25,000 who receive breast cancer screening, based on the most recent clinical guidelines (mammography within the past two years), by 5% from 76.7 (2010) to 80.5%. Increase access to breast cancer screening for uninsured and underinsured women. Increase the number of women who enroll in the Cancer Services Program.	Yes. Outreach efforts will take place at People's Place, the Migrant Education Center and at other health fairs that target people who may be uninsured or underinsured and do not have access to cancer screenings.	Breast Cancer Screening: Women who are uninsured and underinsured will be identified through community outreach efforts and enrolled in the Cancer Services Program. The Fern Feldman Anolick Center for Breast Health will open for a special period of time when women enrolled in the Cancer Services Program will be offered free breast cancer screenings. A Spanish translator will be available to provide support to Spanish-speaking women. Child care will be provided.	Women with positive findings on the breast cancer screening will be tracked by the Breast Patient Navigator.	Yearly the screening focus changes. This year the focus was on skin cancer. Breast Cancer was the 2016 focus.				
		Goal 3.1: Increase screening rates for cardiovascular disease, diabetes, and breast, cervical and colorectal cancers, especially among disparate populations. Increase education about the importance of colon cancer screening and improve access to cancer screenings among the uninsured and underinsured.	Objective 3.1.3: By December 31, 2018, increase the percentage of adults (50-75 years) who receive a colorectal cancer screening based on the most recent guidelines (blood stool test in the past year or a sigmoidoscopy in the past five years and a blood stool test in the past three years or a colonoscopy in the past 10 years) by 5% from 68.0% (2010) to 71.4%. Increase colon cancer screening among adults age 50 to 75.	Yes. The population with an income less than $25k will be targeted through outreach at sites that serve a lower income population such as People's Place and the Migrant Education Center.	Colon Cancer Screening: Women and men between the ages of 50 and 75 will be educated about the importance and methods of colon cancer screening through hospital-wide marketing and events. Outreach efforts will be made to connect the uninsured and underinsured with free colon cancer screenings offered by the Cancer Services Program.	Men and women who are screened through the Cancer Services Program will be identified and guided to ensure access to care.	Yearly the screening focus changes. Colon Cancer was the 2017 focus. This year the focus was on skin cancer.				
	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings	Goal #3.2: Promote use of evidence-based care to manage chronic diseases	By December 31, 2018 to increase the number of adults in community who have been screened for skin cancer	Yes. The per capita income in Kingston, NY, in 2013 was $23,353 per City-Data.com. The disparity we are targeting is the population with income of less than $25k.Outreach was done with an advertisement in the newspaper – Ulster Publishing and The Kingston Freeman, announcing the event. We put it in our newsletter which reaches approximately 2,000 people. We created a flyer (attached) which was sent to BAT (Bringing All Agencies Together). various churches, Hudson Valley Mental Health, Resource Center for Accessible Living, Office for the Aging, and Family. These organizations reach underserved populations	This was an activity of our cancer committee. Yearly the screening focus changes. This year the focus was on skin cancer.	The Skin Cancer Screening followed the guidelines of the American Academy of Dermatology. A full body skin cancer assessment was performed by a Board Certified Dermatologist.	Screening took place at Dermatologists' office 9 to 1 pm.....the office of Dr. Kircher. (Arlene Cohen, RN and Ellen Marshall were present) 22 patients were screened by Dermatologist. Of those 22 patients screened, 11 were found to have findings that needed to be followed by a dermatologist. Of the 22 patients, there were 3 biopsies recommended to rule out	Other (please describe partner and role(s) in column D)	The medical doctor offered his services and office for screening intervention.	Strengths of the Program: The Screening utilized the skilled staff and facility of a Licensed Dermatologist and was free to the patient and of no cost to the Hospital. Since there were no copays or fees collected, the screening was a service to low income and/or underinsured populations Patients were given the names of all the local Dermatologists in the community and all suspicious findings were followed in a timely manner.	Challenges of the Program : Identifying underserved members of the community in need of skin cancer screening and marketing the skin cancer screening program to these populations.

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Prevent Chronic Disease	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Goal 3.3: Promote culturally relevant chronic disease self-management education.	Objective 3.3.1: By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease or diabetes who have taken a course or class to learn how to manage their condition.	Yes. The per capita income in Kingston, NY, in 2013 was $23,353 per City-Data.com. The disparity we are targeting is the population with income of less than $25k.	Diabetes Education: Develop a sustainable infrastructure for widely accessible, readily available, self-management interventions linked to the clinical setting. Maintain ongoing, evidence-based classes and individual appointments to help individuals with diabetes manage the various aspects of self-management.	Weight, Hgb, A1C, lipids, eye exam and patient satisfaction data are collected and reported annually to the American Diabetes Association.	798 patient visits through 9/30/18. Diabetes Self-management education (DSME) classes held 2x/week. 279 individual patients were seen in first three quarter of 2018. 88 People attended free monthly support groups. Topics included Inhaled insulin, cardiology, nutrition; access to local low cost fruits and vegetables, pharmacy issues, nephrology, nutrition labeling, Ophthalmology and a session on the stress of chronic disease led by a	Patient	Patients participate in community classes and attend counseling sessions	The American Association of Diabetic Educators provides evidence that Diabetes Education shows a statistically significant reduction in Hg A1C for people with diabetes. Our patient statistics reinforce those findings. https://professional.diabetes.org/content/recognition-requirements#custom-collapse-0-ii-what-are-the-requirements	The challenges that we have with our Diabetes Education Program include patient follow through, inconsistencies with insurance reimbursements and language barriers for some patients.
Prevent Chronic Disease	Reduce obesity in children and adults.	Expand the role of healthcare and health service providers and insurers in obesity prevention.	Per NYSDOH, by 2018, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by at least 10% to 48.1%. Increase number of mothers who ever breastfed during their hospital stay from 82% (end of June 2016) to 85% by the end of 2018. Increase the number of women who breastfed exclusively during their hospital stay from 51% (end of June 2016) to 55% by the end of 2018.	Yes. The per capita income in Kingston, NY, in 2013 was $23,353 per City-Data.com. As the safety net hospital we serve the population with income of less than $25k. For maternity services, HealthAlliance had a 26% market share, with over 75% of these patients being Medicaid enrollees.	Family Birth Place: Continue with current best practices, such as immediate skin-to-skin and rooming-in. These are practices that are required for Baby-Friendly designation, which is expected by the end of 2016. Increase percentage of full-time and part-time nurses who are Certified Lactation Counselors from 53% to 75% by end of 2018.	Monitor the rate of mothers who ever breastfed and who exclusively breastfed while at HealthAlliance.	Breastfeeding Rates • Any breastfeeding: the benchmark is 85% o 1st Quarter: 92% o 2nd Quarter: 81% o 3rd Quarter: 93% • Exclusive breastfeeding: The benchmark is 50% o 1st Quarter: 57% o 2nd Quarter: 42% o 3rd Quarter: 42% Breastfeeding policies are current. We removed the CLC training due to lack of financial means to support the training of the nurses.				
						Receive Baby-Friendly designation of the HealthAlliance Hospital: Broadway Campus from Baby-Friendly USA, Inc.	Breastfeeding Rates • Any breastfeeding: the benchmark is 85% o 1st Quarter: 92% o 2nd Quarter: 81% o 3rd Quarter: 93%	Other (please describe partner and role(s) in column D)	Baby Friendly USA is the agency to designate a Baby friendly hospital.	Starting the effort to bring the Baby Friendly USA people to HealthAlliance to screen for Baby Friendly Certification. Getting the entire hospital on board to buy in to the importance of achieving this best practice.	It has been challenging to meet the goal of 75% of staff trained as CLCs by the end of 2018. We have a limited education budget and it is an expensive class. We are

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Prevent Chronic Disease	Reduce Obesity in Children and Adults.	Create community environments that promote and support healthy food and beverage choices and physical activity.	By December 2018, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and is fully accessible to people with disabilities.	Yes. Connects with Ulster County adults with an income under $25k.	Employee Wellness: Implement evidence-based wellness programs for all public and private employees, retirees and their dependents through collaborations with unions, health plans and community partnerships that include, but are not limited to, increased opportunities for physical activity; access to and promotion of healthful foods and beverages; and health benefit coverage and/or incentives for obesity prevention and treatment, including breastfeeding support. As a role model, HealthAlliance will implement a program that incentivizes employee participation in a personal health assessment, a yearly physical and the adoption of at least one healthy behavior. The program will make health insurance rates favorable for those that participate in wellness activities. This will serve as a template for other community organizations that are interested in creating worksite wellness programs. HealthAlliance promotes healthy eating to employees by offering group nutrition classes and private nutrition/weight loss	Collect a baseline number of employees that participate in a personal health assessment and healthy behavior programs.	Due to the complexities of a transition from a full-insured to a new self-insured health insurance program in 2018, we were unable to proceed with a wellness program for our employees. HealthAlliance will resume an employee wellness initiative in 2019.				

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Promote Mental Health and Prevent Substance Abuse.	Promote mental, emotional and behavioral well-being in communities.	To promote mental, emotional and behavioral (MEB) well-being in communities.	NYSDOH Objective 1.1.1: Increase the use of evidence informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.	Yes. All Partial Hospitalization Program participants will have access to the nutritional interventions, strategies and activities provided regardless of their biopsychosocial, economic and cultural considerations.	Identify and implement evidence-based practices and environmental strategies that promote MEB health.	Pre- and post- patient surveys to indicate changes in patients' emotional, behavioral and mental health as a result of program interventions. The survey results will be processed by staff to obtain data reflecting the overall improvement in mental health for all program participants.	The total number of admissions to the adolescent partial program through 9/30/18 was 65 and total admissions for the adult partial program was 127 The measures of success used to determine the effectiveness of the program are a Patient Satisfaction Survey and the collection of statistical data each month to monitor recidivism rates. The Satisfaction Survey results for the third quarter of 2018 are as follows: Adolescent PHP satisfaction survey: 75% of patients rated the program 8-10 on a scale of 1-10. 100% of patients said that they used the DBT skills regularly. 88% of patients said that they would recommend the program to others. Adult PHP satisfaction survey: 93% of Patients rated the program 10 on a scale of 1-10. 94% of patients said that they used the DBT skills regularly. 96% of patients said that they would recommend the program to others. APHP/PHP recidivism rates: 0% of patients were readmitted within 15 days. 0% of patients were readmitted within 30 days.	Participant	The role of the participant is to engage in treatment, come to the program as scheduled and take part in treatment planning.	The strength of the program lies in its ability to provide a service not provided locally. It is unique. In addition, HAHV staff coordinate the teaching of dialectical behavioral therapy skills and supervise mental health professionals at The Kingston City School District High School . The Partial Programs are now providing Tele-psychiatry services to patients in order to improve treatment accessibility and consistency.	The main challenge for APHP/PHP during the third quarter was the medication reconciliation process. This process is the focus of our Performance Improvement Plan for 2018.
		To promote the emotional, behavioral and mental health of Partial Hospitalization Program participants.	To provide mental health services to approximately 200 people each year and facilitate improvement in the ability of the Partial Hospitalization Program participants to regulate emotions, manage behaviors and reduce symptoms of mental illness.		Provide daily dialectical behavioral therapy, education and activity groups that teach and reinforce coping skills to program participants. Provide medication management at least twice a week to program participants. Provide individual therapy at least twice a week to program participants.						
Promote Mental Health and Prevent Substance Abuse	Promote mental, emotional and behavioral well being in communities	To promote mental, emotional and behavioral (MEB) well being in communities	NYS DOH Objective 1.1.1.Increase the use of evidence informed policies and evidence based programs that are grounded	Yes. All Partial Hospitalization Program participants will have access to the nutritional interventions, strategies and activities provided regardless of	Provide family therapy as needed to program participants and their families. Coordinate services with community providers to develop a comprehensive treatment and aftercare plan.						