2013

Community Service Plan 2014-2016

SAMARITAN MEDICAL CENTER

IN COLLABORATION WITH THE FORT DRUM REGIONAL HEALTH PLANNING ORGANIZATION

SAMARITAN MEDICAL CENTER | 830 Washington Street, Watertown, NY 13601

Notice

This plan fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA) requiring that non-profit hospitals develop a three-year action plan to address community health needs as identified in a current Community Health Assessment **(see addendum: Community Health Assessment 2013: Tri-County Region)**. The plan, which was developed with project management and consultation by Fort Drum Regional Health Planning Organization, included extensive input from the patient-centered leadership team at Samaritan Medical Center.

Patient-Centered Leadership Team

The Patient-Centered Leadership Team is comprised of:

- **Thomas H. Carman –** President and Chief Executive Officer
- **Beth Fipps –** Vice President of Foundation & Community Services
- **Paul A. Kraeger** – Senior Vice President of Finance & Administrative Services
- **Brian O'Hearn, RN –** Vice President of Patient Care Services & Chief Nursing Officer
- **Tony Joseph –** Vice President of Long-Term Care
- **M. Andrew Short –** Vice President of Information Services & Chief Information Officer
- **Randy Fipps –** Assistant Vice President of Operations & Behavioral Health Services
- **Mario Victoria, MD –** Vice President of Medical Affairs
- **Barbara Morrow –** Assistant Vice President of Compliance/Chief Compliance Officer
- **Chris Bastien –** Assistant Vice President of Support Services
- **Sean Mills –** Assistant Vice President of Finance & Chief Financial Officer

Acknowledgements

Additional support for the development of this document was provided by:

- **Jenna Moore* –** Grants Manager
- **Theresa Quintin* –** Director of Healthcare Resource Management

* North Country Health Compass Partners

Table of Contents

Background

In April 2013, the Fort Drum Regional Health Planning Organization (FDRHPO) was awarded a New York State Rural Health Network Development Grant. One of the grant's key objectives is to facilitate a regional Community Health Assessment (CHA), and facility-specific Community Service Plans (CSPs) for partner hospitals. The community was defined as all residents of the rural counties of Jefferson, Lewis and St. Lawrence Counties in New York. FDRHPO therefore established a steering committee (North Country Health Compass Partners) as a collaborative group with representation from public health agencies, hospitals, and community-based organizations within the tri-county region. Samaritan Medical Center has representation in the North Country Health Compass Partners. The hospital was also actively engaged in the development of the regional Community Health Assessment.

This Community Service Plan was designed to be responsive to the identified community health needs, while incorporating data on available population health indicators. The plan's strategies are grounded in evidence and were designed to maximize regional collaborative efforts.

North Country Health Compass Partners

Participating Organizations

Public Health

- Jefferson County Public Health Service
- Lewis County Public Health Agency
- St. Lawrence County Public Health

Hospitals

- Canton-Potsdam Hospital
- Carthage Area Hospital
- Claxton-Hepburn Medical Center
- Clifton-Fine Hospital
- E.J. Noble Hospital
- Lewis County General Hospital
- Massena Memorial Hospital
- River Hospital
- Samaritan Medical Center
- Fort Drum MEDDAC (CLINIC)

Community-Based Organizations

- Excellus BlueCross BlueShield
- Fort Drum Regional Health Planning Organization
- Jefferson County Community Services
- Lewis County Community Recovery Center
- Lewis County Community Services
- North Country Family Health Center[1]
- North Country Prenatal/Perinatal Council
- St. Lawrence County Community Services
- St. Lawrence County Health Initiative

[1] Federally Qualified Health Center

Guidance

The New York State Department of Health (NYSDOH) released information[2] in 2012 to guide hospitals during the development of their Community Service Plans. The document outlined that Community Service Plans should include:

1. The hospital Mission Statement
2. A definition and brief description of the community served
3. Information outlining stakeholder participation
    a. Identifying participants involved in assessing community health needs
    b. Description of the outcomes of the stakeholder input process
    c. Description of how stakeholder notification of these sessions was accomplished
4. An assessment and selection of public health priorities
5. A three-year action plan to address community health needs
6. A description of how the plan will be made available to the public
7. A brief description of the process that will be used to maintain engagement

The state's guidance informed the development of the action plan and the outline of this Community Service Plan.

[2] Local Health Department Community Health Assessment and Improvement Plan and Hospital Community Service Plan Guidance, 2013: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf

The Hospital

Samaritan Medical Center (Watertown, NY) is a 294-bed not-for-profit community medical center serving Jefferson, Lewis, and St. Lawrence Counties. The hospital offers a full spectrum of inpatient and outpatient healthcare services. From primary and emergency care to highly specialized medical and surgical services, such as cancer treatment, neonatal intensive care, behavioral health and addiction services, and imaging services, Samaritan Medical Center and its team of healthcare professionals proudly serves the medical needs of our civilian and military community.

Mission Statement

Samaritan shall provide high quality, comprehensive, safe, and compassionate healthcare services to meet the needs of our civilian and military community.

Vision Statement

Samaritan will be recognized, foremost, as the preferred provider of Inpatient, Outpatient, Emergency, and Long-Term Care services in Jefferson County. Additionally, our health system will enhance selected specialty services to meet the needs of the North Country.

Hospital Values

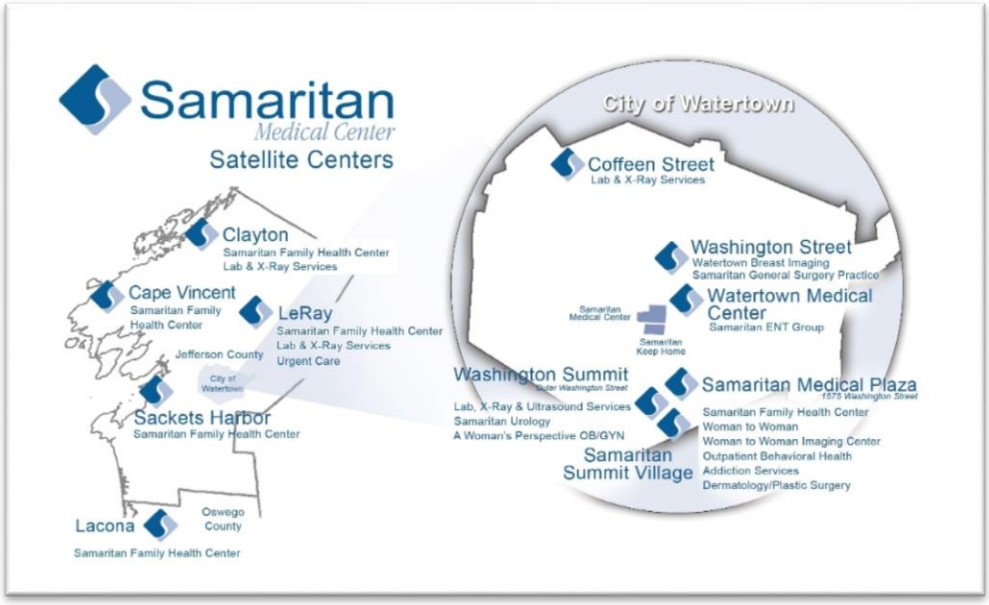
In order to succeed as a team, in meeting the healthcare needs of those we serve, Samaritan is committed to:

Honesty
Empathy
Accountability
Respect
Trust

Service Area

Samaritan Medical Center and its affiliates provide many healthcare related services throughout northern New York and the Fort Drum region. The main facility in Watertown features an emergency department, inpatient and outpatient services, surgical care center and administration functions. The hospital also operates satellite health centers in Cape Vincent, Clayton, Lacona, LeRay, Sackets Harbor and Watertown.

Map of Satellite Centers



Definition

For the purposes of community health planning and development of the Community Service Plan, the hospital's service are is defined by the zip codes from which approximately 75% of inpatient admissions originate. While this definition facilitated analysis of the hospitalization data, it excluded the lower quartile which referred to zip codes in Lewis and St. Lawrence Counties.

Service Area, by Zip Code[3]

Zip Code	Town
13601	Watertown
13603	Watertown
13637	Evans Mills
13605	Adams
13602	Fort Drum
13624	Clayton
13619	Carthage
13634	Dexter
13612	Black River
13616	Calcium
13656	LaFargeville
13606	Adams Center

[3] Source: 2011 Inpatient Data from the New York State Department of Health (NYSDOH) Statewide Planning and Research Cooperative System (SPARCS)

Description

The hospital services all residents of Jefferson, Lewis and St. Lawrence Counties in New York. This three-county region is sparsely populated with over 255,000 people spread over 5,000 square miles of land mass. Population density of the region is approximately 49.7 persons per square mile, while the estimate for the entire state is 411.2 persons per square mile. The entire region has been designated a Health Professional Shortage Area (HPSA). In each county, the number of primary care physicians, obstetricians/gynecologists, general surgeons, psychiatrists and dentists are significantly below state averages.

The area is extremely unique because the region's community healthcare system supports Fort Drum, the only US Army installation with a division of soldiers and families without its own hospital. Most specialty care and all inpatient care for the 40,000 TRICARE beneficiaries in the region are provided by the community hospitals and healthcare providers.

From the Regional Community Health Assessment (CHA)

Vital statistics, community perception and population health data all highlight the burden of chronic diseases within the three county region. The chronic diseases of major concern are obesity, diabetes, cardiovascular disease, chronic lower respiratory disease[4], and colorectal cancer. During a recent community health needs survey, residents emphasized the burden of mental illness, and inadequate access to behavioral health treatment, within the region. The population data for binge drinking and suicides underscore the critical importance of improving mental, emotional and behavioral health outcomes in the region.

Across the region, there are relatively low immunization and screening rates, and a relatively high incidence of preventable outcomes (specifically flu hospitalization and colorectal cancer). Children within the region receive insufficient well-child care and have poor oral health outcomes. Residents in each county expressed concern regarding access to care, especially in relation to mental health treatment. The rural environment also presented transportation challenges for individuals attempting to make medical appointments.

From Hospital Inpatient and Emergency Department Data

Demographics[5]

Indicators	**Service Area***	**NY State**
Economy		
Per capita income	**$22,106**	$31,796
Children living below poverty level (percent of population)	**20.8%**	20.3%
Families living below poverty level (percent of population)	**12.4%**	11.0%
Elderly living below poverty level (ages 65+, percent of population)	10.0%	11.5%
Education		
Individuals with a high school degree or higher (ages 25+, percent of population)	88.4%	84.6%
Individuals with a Bachelor's degree or higher (ages 25+, percent of population)	**20.7%**	32.5%
Social Environment		
Single-parent households (percent of population)	**35.0%**	19.5%
Elderly living alone (ages 65+, percent of population)	**28.3%**	10.4%
Transportation		
Households without a vehicle (percent of population)	**9.8%**	5.7%

* Rates in **bold** do not meet the NY State benchmark.

[4] Chronic lower respiratory disease (CLRD) comprises three major diseases: chronic bronchitis, emphysema, and asthma, that are all characterized by shortness of breath caused by airway obstruction.

[5] Source: 2007-2011 US Census

Health[6]

Indicators	Service Area*	NY State
Diabetes		
ED rate due to diabetes (ages 18+, per 10,000 population)	**19.1**	18.6
ED rate due to uncontrolled diabetes (ages 18+, per 10,000 population)	**2.9**	1.5
Hospitalization rate due to diabetes (ages 18+, per 10,000 population)	13.8	17.2
Hospitalization rate due to uncontrolled diabetes (ages 18+, per 10,000 population)	1.7	1.7
Heart Disease & Stroke		
ED rate due to heart failure (ages 18+, per 10,000 population)	**7.5**	4.4
Hospitalization rate due to heart failure (ages 18+, per 10,000 population)	27.4	31.5
Immunizations and Infectious Diseases		
ED rate due to bacterial pneumonia (ages 18+, per 10,000 population)	**30.9**	18.4
ED rate due to hepatitis (ages 18+, per 10,000 population)	**1.3**	0.5
ED rate due to vaccine-preventable pneumonia and influenza (per 10,000 population)	**14.9**	7.9
Hospitalization rate due to bacterial pneumonia (ages 18+, per 10,000 population)	30.8	31.3
Hospitalization rate due to hepatitis (ages 18+, per 10,000 population)	0.9	1.6
Hospitalization rate due to vaccine-preventable pneumonia and influenza (per 10,000 population)	0.6	1.4
Other Conditions		
ED rate due to dehydration (ages 18+, per 10,000 population)	**16.7**	13.1
ED rate due to urinary tract infections (ages 18+, per 10,000 population)	**156.5**	69.4
Respiratory Diseases		
*ED rate due to COPD** (per 10,000 population)*	**41.7**	19.1
ED rate due to pediatric asthma (per 10,000 population)	59.5	63.1
*Hospitalization rate due to COPD** (per 10,000 population)*	**37.3**	27.6
Hospitalization rate due to pediatric asthma (per 10,000 population)	**14.0**	11.9
Substance Abuse		
ED rate due to alcohol abuse (ages 18+, per 10,000 population)	26.6	31.0
Hospitalization rate due to alcohol abuse (ages 18+, per 10,000 population)	11.6	18.1

* Rates in **bold** do not meet the NY State benchmark.

** COPD = Chronic obstructive pulmonary disease.

Summary

The regional CHA and available hospitalization data confirm the significant burden of chronic disease affecting the hospital's patient population. The diseases of particular concern are diabetes, cardiovascular disease and respiratory diseases (specifically chronic lower respiratory diseases which include COPD).

While the population data cited in the regional CHA indicate a high burden of substance abuse, rates of alcohol abuse identified in the emergency department (ED) and inpatient setting are lower than the state average. This observation may be due to individuals avoiding care for substance abuse outcomes.

On average, ED rates exceed state averages for diabetes, heart failure, bacterial pneumonia, hepatitis, vaccine-preventable infectious diseases, dehydration, and urinary tract infections. For the same conditions, hospitalization rates are lower than the state average. The data suggest that for those conditions, care in the emergency department is sufficient and patients do not require additional interventions, or a higher category of care (i.e. hospitalization). These rates may underscore community feedback regarding low access to care, and attempts to seek care through the emergency department for the uninsured, underinsured and Medicaid populations.

[6] Source: 2009-2011 Hospitalization and Emergency Department Data from the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP)

Assessment and Selection of Public Health Priorities

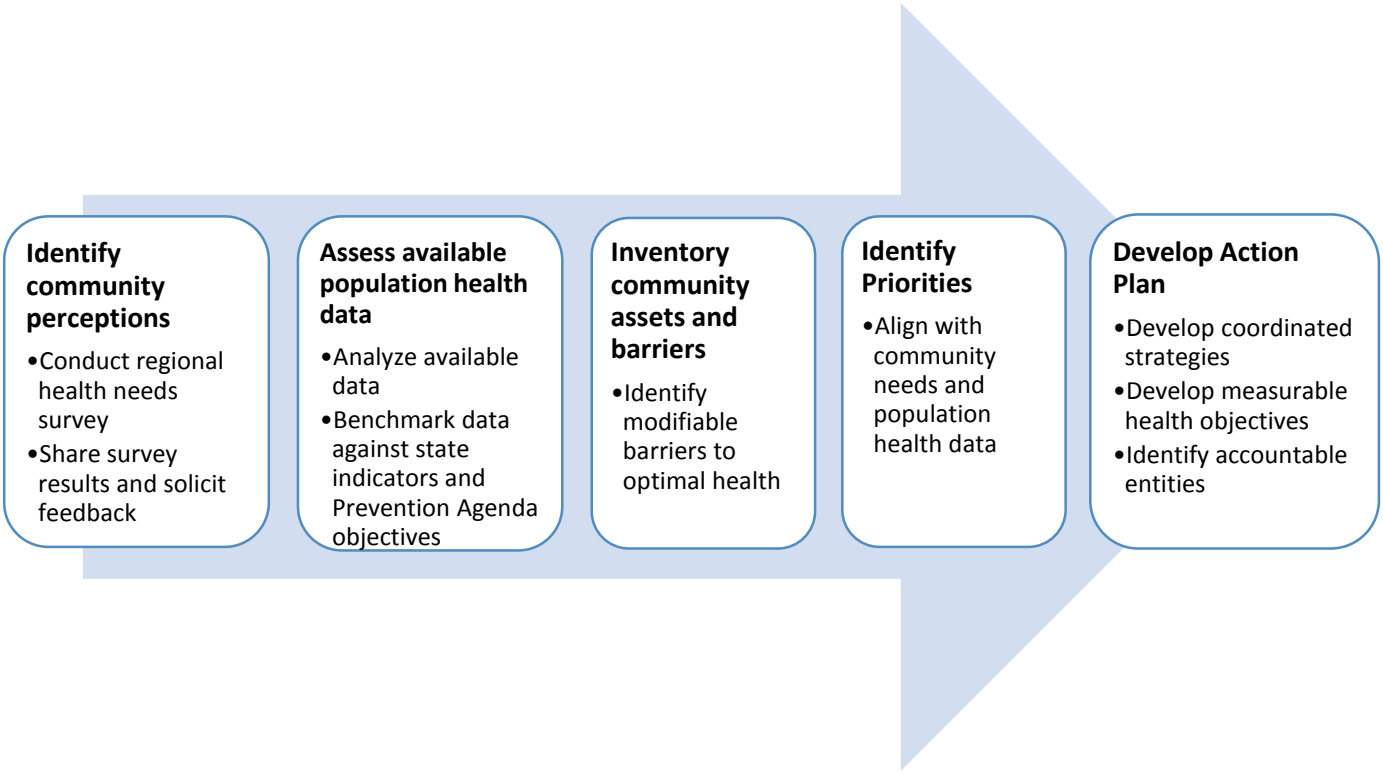
The 3-Year Action Plan (*see page 12*) contains initiatives and objectives that are tailored specifically to the hospital's service area, while remaining aligned with the most current version of the New York State health improvement plan (The Prevention Agenda 2013-2017[7]). The Prevention Agenda maintains a vision of "New York as the healthiest state in the nation," and our Action Plan is designed to assist the state in achieving that vision.

The Prevention Agenda serves as a catalyst for action as well as a blueprint for improving health outcomes and reducing health disparities. For the 2013-2017 period the state has identified five Priority Areas for intervention and monitoring:

- Prevent Chronic Diseases
- Promote Healthy and Safe Environments
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV, STDs, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Selection Process

To achieve meaningful, sustainable impact the New York State Department of Health (NYSDOH) recommends that communities "identify at least two priorities" from the Prevention Agenda 2013-2017[8]. The North Country Health Compass Partners employed a systematic approach to identify priorities and develop the regional Action Plan, and hospital Community Service Plans, as outlined in the flowchart below:



[7] Additional information on the New York State Prevention Agenda 2013-2017 can be found online at: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

[8] Local Health Department Community Health Assessment and Improvement Plan and Hospital Community Service Plan Guidance, 2013: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf

The regional priorities were selected after carefully evaluating community health needs, population health data, regional assets, and regional barriers. The process of identifying the regional priorities involved input from 28 stakeholders including hospital CEOs, hospital administrators, public health employees (directors, health planners, nurses and educators), and representatives from community-based organizations across the three counties. Stakeholders ranked Prevention Agenda priorities and goals using an online survey tool which displayed health indicators related to each priority.

Selection Criteria

The selection of priorities and goals for regional health improvement was based on expressed community health needs and population health data indicating the health issues that were of greatest concern. To be selected for steering committee consideration, a priority should address:

- health outcomes that did not meet state benchmarks
- health outcomes that were regional (not county-specific) priorities
- at least one health disparity

Stakeholders were also encouraged to consider the following when making an informed decision about which priorities should be selected:

- impact on other health outcomes
- resources available
- impact on the physical and social environment
- ease of implementing solutions
- leadership support available
- importance to the public health system

Identification of Priorities

The survey results (*see Appendix 1*) indicated that the leading regional goals (ranked 1-10) were clustered into three Prevention Agenda priorities. These three priorities were:

- Prevent Chronic Diseases
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse

Stakeholder Participation

The North Country Health Compass Partners have held monthly meetings since April 2013. These meetings will continue and involve strategic planning sessions aimed at developing, implementing and evaluating regional efforts to improve population health. Information regarding meetings and the results of meetings is primary shared electronically, unless otherwise noted. Additional efforts to engage stakeholders included:

- The online survey tool to engage stakeholders in the selection of Prevention Agenda priorities and goals was open from July 29, 2013 to August 15, 2013.
- The "Promote Mental Health and Prevent Substance Abuse" ad hoc work group session which was held on September 9, 2013.
- The "Prevent Chronic Diseases" ad hoc work group session which was held on September 9, 2013.
- Meeting with the sole regional pediatric dentist (Dr. Andrew Beuttenmuller) to brainstorm strategies to address oral health issues affecting children on September 13, 2013.
- The "Promote Healthy Women, Infants and Children" ad hoc work group session which was held on September 16, 2013.

Meeting with the FDRHPO Provider Executive Committee (PEC), comprised of physicians within the region, on September 25, 2013.

While developing an inventory of regional assets, regional barriers, protective factors, contributing factors and gaps related specifically to the identified regional priorities (*see Appendix 2*), the North Country Health Compass Partners developed ad hoc work groups. These groups had representation from the North Country Health Compass Partners with additional organizations (listed below) being engaged in this process.

Prevent Chronic Diseases

- Cornell Cooperative Extension of Jefferson County
- Office for the Aging (Jefferson County)
- YMCA (Jefferson County)

Promote Healthy Women, Infants and Children

- A Woman's Perspective
- Benchmark Family Services
- Care Net
- Cornell Cooperative Extension of Jefferson County
- Department of Social Services (Jefferson County)
- Jefferson-Lewis Childcare Project
- Medical Examiner (Jefferson County)
- North Country Family Health Center – WIC
- Planned Parenthood of NCNY
- Victims Assistance Center of Jefferson County
- Women's Way to Wellness (Carthage Area Hospital)

Promote Mental Health and Prevent Substance Abuse

- ACR Health (formerly AIDS Community Resources)
- Behavioral Health Clinic (Carthage Hospital)
- Children's Home of Jefferson County
- CREDO Community Center
- Family Counseling Service of Northern NY
- Jefferson County Alcohol and Substance Abuse Council
- Mental Health Association
- North Country Behavioral Healthcare Network
- Suicide Prevention Coalition (Jefferson County)
- Transitional Living Services of Northern NY
- Watertown Veteran's Center

Three-Year Action Plan

The Action Plan outlines goals, objectives, improvement strategies and performance measures with time-framed targets for the 2014-2016 period. These activities all relate to the selected NYS Prevention Agenda priorities and goals as follows:

- **Prevent Chronic Diseases**
  - **Increase access to preventive care**
- **Promote Healthy Women, Infants and Children**
  - **Improve child health**
- **Promote Mental Health and Prevent Substance Abuse**
  - **Strengthen infrastructure**

PRIORITY AREA: Prevent Chronic Diseases
GOAL #1: Increase access to preventive care among disparate populations within Jefferson, Lewis and St. Lawrence Counties, NY.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Indicators	**Source**	**Frequency**
By December 2015, increase the number of patients that actively use the patient portal to 10% of the population accessing care at the Watertown Family Health Center (2013 baseline data: 8%)	*FDRHPO*	*Annually*
By December 2016, increase the number of patients that actively use the patient portal to 11% of the population accessing care at the Watertown Family Health Center. (2013 baseline data: 8%)	*FDRHPO*	*Annually*

OBJECTIVE #1: By December 2015, increase the number of patients that actively use the patient portal to 10% of the population accessing care at the Watertown Family Health Center (2013 baseline data: 8%).

BACKGROUND ON STRATEGY
Description: Patient portal utilization is associated with improved patient care and streamlined provider workflow.
Source: The Office of the National Coordinator for Health Information Technology: http://www.healthit.gov/
Case Studies: *"Patient Portal Benefits Patient Care and Provider Workflow": http://www.healthit.gov/providers-professionals/patient-portal-benefits-patient-care-and-provider-workflow*
Policy Change (Y/N): N

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Provide technical assistance to Family Health Centers providers to encourage utilization of patient portals	December 2015	Staff time, travel	FDRHPO North Country Health Information Partnership	Increased utilization of patient reminder systems	
Send reminders to patients for preventive and follow-up care via patient portals	December 2015	Provider guidance, Staff time	Family Health Center staff	Sustained reminder system	

PRIORITY AREA: Prevent Chronic Diseases
GOAL #2: Adopt medical home or team-based care models.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Indicators	**Source**	**Frequency**
By June 2014, achieve Level 3 Patient-Centered Medical Home (PCMH) designation (2011 standards) for the Graduate Medical Education (GME) Clinic. (current: PCMH Level 3 status achieved for Family Health Centers)	*NCQA*	*Once*
By December 2016, demonstrate ability to maintain Level 3 status for the Family Health Centers and GME Clinic.	*NCQA*	*Ongoing*

OBJECTIVE #1: By June 2014, achieve Level 3 Patient Centered Medical Home (PCMH) designation (2011 standards) for the Graduate Medical Education (GME) Clinic.

BACKGROUND ON STRATEGY

Description: Patient-centered medical homes are associated with a wide range of positive patient outcomes.
Source: American Academy of Family Physicians: http://www.aafp.org/practice-management/pcmh/overview.html
Evidence Base*: Alexander, et al*. Does the patient-centered medical home work? A critical synthesis of research on patient-centered medical homes and patient-related outcomes. *Health Serv Manage Res. 2012; 25:51-9*
Policy Change (Y/N): Y

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Transform practice using NCQA Standards and Guidelines and apply for PCMH Level 3 designation	June 2014	Staff time (GME Clinic)	Assistant Vice President of Operations	PCMH Level 3	

PRIORITY AREA: Prevent Chronic Diseases
GOAL #3: Reduce or eliminate out-of-pocket expenses for clinical and community preventive services.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Indicators	**Source**	**Frequency**
By December 2014, establish and maintain a seasonal flu clinic.	*Samaritan Medical Center*	*Ongoing*
By December 2015, increase the number of participants in the free smoking cessation classes offered at the hospital by 5%. (baseline: unknown)	*Tobacco Cessation Center of NNY*	*Monthly*
By December 2015, increase the number of participants in the reduced-cost Early Detection Lung Cancer Screening Program by 2% (baseline: unknown)	*Samaritan Medical Center*	*Monthly*

OBJECTIVE #1: By December 2015, increase by 5% the number of participants in the tobacco cessation classes offered at the hospital by the Tobacco Cessation Center of NNY.

BACKGROUND ON STRATEGY

Description: Smoking cessation is associated with significant health benefits.

Source: Smoking and Tobacco Use: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/

Evidence Base*: Recommended by the Centers for Disease Control and Prevention: http://www.cdc.gov/Tobacco/quit_smoking/cessation/index.htm*

Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Raise awareness among health care providers and the general public about the benefits and availability of the program.	June 2014	Time, patient engagement tools	Samaritan Medical Center, Tobacco Cessation Center of NNY	Marketed intervention with sustained enrollment	

OBJECTIVE #2: By December 2015, increase by 2% the number of participants in the Early Detection Lung Cancer Screening Program.

BACKGROUND ON STRATEGY

Description: Annual lung cancer screenings using low-dose CT scans can successfully detect malignant tumors before they can spread to other parts of the body.

Source: WebMD: http://www.webmd.com/lung-cancer/news/20130904/more-evidence-backs-routine-ct-scans-for-early-lung-cancer-detection

Evidence Base*: Recommended by the American Cancer Society: http://www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer*

Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Raise awareness among health care providers and the general public about the benefits and availability of the program.	June 2014	Time, patient engagement tools	Samaritan Medical Center	Marketed intervention with sustained enrollment	

PRIORITY AREA: Promote Healthy Women, Infants and Children
GOAL #1: Improve child health.

PERFORMANCE MEASURES How We Will Know We are Making a Difference		
Indicators	**Source**	**Frequency**
By June 2014, achieve Level 3 Patient-Centered Medical Home (PCMH) designation (2011 standards) for the Graduate Medical Education (GME) Clinic. (current: PCMH Level 3 status achieved for Family Health Centers)	*NCQA*	*Once*
By December 2016, demonstrate ability to maintain Level 3 status for the Family Health Centers and GME Clinic.	*NCQA*	*Ongoing*

OBJECTIVE #1: By June 2014, achieve Level 3 Patient Centered Medical Home (PCMH) designation (2011 standards) for the Graduate Medical Education (GME) Clinic.

BACKGROUND ON STRATEGY

Description: Patient-centered medical homes are associated with a wide range of positive patient outcomes.
Source: American Academy of Family Physicians: http://www.aafp.org/practice-management/pcmh/overview.html
Evidence Base*: Alexander, et al*. Does the patient-centered medical home work? A critical synthesis of research on patient-centered medical homes and patient-related outcomes. *Health Serv Manage Res. 2012; 25:51-9*
Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Transform practice using NCQA Standards and Guidelines and apply for PCMH Level 3 designation	June 2014	Staff time (GME Clinic)	Assistant Vice President of Operations	PCMH Level 3	

In addition to the outlined strategy, Samaritan Medical Center will participate in structured, evidence-based learning collaborations to identify and address areas for improvement in clinical practice. To that end, providers within the organization will sustain engagement in the regularly scheduled meetings of community pediatricians. Samaritan Medical Center will also sustain its modified postpartum care model which promotes breastfeeding and improves maternal recovery.

PRIORITY AREA: Promote Mental Health and Prevent Substance Abuse
GOAL #1: Strengthen mental health infrastructure across all systems.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Indicators	**Source**	**Frequency**
By December 2014, increase the number of behavioral health-related Continuing Medical Education courses that are offered for providers within the region. (baseline: unknown)	*Graduate Medical Education*	

OBJECTIVE #1: *By December 2014, increase the number of behavioral health-related Continuing Medical Education courses that are offered for providers within the region.*

BACKGROUND ON STRATEGY

Description: Collaboration enhances information sharing and increases training opportunities for providers and behavioral health professionals.

Source: http://www.afsp.org/preventing-suicide/key-research-findings

Evidence Base*: "Educating the Medical Community to Recognize and Treat Depression" recommended by The American Foundation for Suicide Prevention*

Policy Change (Y/N): N

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Develop a meeting schedule and research collaborative training opportunities.	December 2014	Time	Vice President of Medical Affairs	Meeting schedule, CME training schedule	

In addition to the outlined strategy, Samaritan Medical Center will sustain participation in New York State Screening, Brief Intervention, and Referral to Treatment (NYSBIRT) and regional Behavioral Health Committees (hosted by FDRHPO). The hospital has also embarked on the acquisition of an electronic health record (EHR) system for the Behavioral Health Clinic. The proposed system should streamline workflow and provide tools to improve care management.

Our facility has also initiated plans for clinical integration of the Behavioral Health Clinic and the primary care clinics. This modification is designed to improve behavioral health outcomes and reduce the regional burden of behavioral health conditions.

Dissemination of the Plan

This Community Service Plan will be posted on the hospital's website (http://www.samaritanhealth.com/), and on the websites of the North Country Health Compass Partners and affiliated organizations. To improve community engagement, the plan will also be posted on the North Country Health Compass website (www.ncnyhealthcompass.org) in early 2014.

Maintaining Engagement

Samaritan Medical Center has representation on The North Country Health Compass Partners. The collaborative group has been in existence for the past six months and the members are highly engaged. Meetings are held on a monthly basis to achieve the mission of developing, implementing and evaluating regional health improvement initiatives through research, data analysis, community engagement and collaboration among public health departments, hospitals and community-based organizations.

Appendix 1 - Ranking of Prevention Agenda Priorities and Goals: Survey Results

A total of 28 surveys were completed by representatives at regional hospitals, public health agencies, and community-based organizations. The results are displayed below in rank order. Note that the priorities, focus areas, and goals are adopted from the NYS Prevention Agenda 2013-2017. The top three priorities were then selected as the regional priorities for the development of the community health improvement plan. As shown, "Prevent Chronic Diseases" was ranked as the top priority.

PRIORITY	FOCUS AREA	GOALS	Rating (1-10)	RANK* (1 - 44)
Prevent Chronic Diseases	**Increase access to preventive care**	**Increase screening rates (CVD, diabetes, cancer)**	9.08	**2**
	(Cumulative rating = 8.7)	**Promote evidence-based care**	8.83	**4**
		Promote self-management education	8.20	**10**
	Reduce tobacco-related illness/death	**Prevent initiation by youth & young adults**	8.92	**3**
	(Cumulative rating = 8.3)	**Promote cessation (esp. among low SES populations)**	8.52	**6**
(Cumulative rating = 8.2)		**Eliminate secondhand smoke exposure**	7.42	**24**
	Reduce obesity in children and adults	**Create healthy community environments**	8.17	**11-T**
		Prevent childhood obesity through daycare/schools	8.12	**14-T**
	(Cumulative rating = 7.8)	**Expand the role of health care, providers, insurers**	8.08	**16**
		Expand the role of employers	6.80	**29-T**
Promote Healthy Women, Infants & Children	**Child health**	**Increase % of children receiving comprehensive care**	9.23	**1**
	(Cumulative rating = 9.0)	**Reduce prevalence of dental caries**	8.72	**5**
	Preconception and reproductive health	**Increase utilization of preventive services among women**	8.07	**17**
	(Cumulative rating = 7.9)	**Reduce rate of adolescent and unplanned pregnancies**	7.70	**22**
(Cumulative rating = 7.9)	**Maternal and infant health**	**Increase breastfeeding**	7.96	**18-T**
		Reduce premature births	7.55	**23**
	(Cumulative rating = 7.1)	**Reduce maternal deaths**	5.84	**40**
Promote Mental Health & Prevent Substance Abuse	**Strengthen infrastructure across systems**	**Support collaboration among professionals**	8.35	**8**
	(Cumulative rating = 8.3)	**Strengthen infrastructure**	8.28	**9**
	Promote Mental, Emotional, Behavioral Health	**Promote MEB well-being in communities**	7.93	**20**
	Prevent substance abuse and disorders	**Prevent underage drinking, prescription drug abuse**	8.15	**13**
(Cumulative rating = 7.9)		**Prevent occurrence of MEB disorders**	8.12	**14-T**
	(Cumulative rating = 7.7)	**Prevent suicides**	7.96	**18-T**
		Reduce tobacco use among adults with poor mental health	6.46	**35-T**

**The "-T" designation indicates that a particular goal had a rating score that tied with another goal. A total of 44 goals were rated and ranked.*

PRIORITY	FOCUS AREA	GOALS	Rating (1-10)	RANK* (1 - 44)
Prevent HIV/STDs, Vaccine Preventable Diseases Hospital Acquired Infections *(Cumulative rating = 6.86)*	**Vaccine-preventable diseases** *(Cumulative rating = 7.36)*	**Improve childhood/adolescent immunization rates**	8.50	**7**
		Educate parents about importance of immunizations	7.81	**21**
		Decrease burden of pertussis disease	6.96	**28**
		Decrease burden of disease caused by HPV	6.80	**29-T**
		Decrease burden of influenza disease	6.71	**32**
	Sexually transmitted diseases	**Decrease STD morbidity**	7.15	**27**
	Healthcare Associated Infections *(Cumulative rating = 6.95)*	**Reduce Clostridium difficile infections**	7.36	**25**
		Reduce infections caused by multidrug organisms	7.20	**26**
		Reduce device-associated infections	6.30	**38**
	Hepatitis C Virus (HCV)	**Increase and coordinate HCV prevention and treatment**	6.54	**34**
	Human Immunodeficiency Virus (HIV) *(Cumulative rating = 5.5)*	**Increase early access to/ and retention in HIV care**	5.80	**41**
		Decrease HIV morbidity	5.20	**43**
Promote a Healthy & Safe Environment *(Cumulative rating = 6.31)*	**Injuries, violence, occupational health** *(Cumulative rating = 7.13)*	**Reduce fall risks amongst vulnerable populations**	8.17	**11-T**
		Reduce occupational injury and illness	6.77	**31**
		Reduce violence through violence prevention programs	6.46	**35-T**
	Water quality *(Cumulative rating = 6.50)*	**Reduce risks associated with drinking/recreational water**	6.59	**33**
		Increase % of residents receiving fluoridated water	6.40	**37**
	Built environment *(Cumulative rating = 5.91)*	**Improve design and maintenance of built environment**	6.28	**39**
		Improve design and maintenance of home environment	5.54	**42**
	Outdoor air quality	**Reduce exposure to outdoor air pollutants**	4.29	**44**

**The "-T" designation indicates that a particular goal had a rating score that tied with another goal. A total of 44 goals were rated and ranked.*

Appendix 2 - Summary of the Main Issues highlighted during Ad Hoc Work Group Brainstorming Sessions

Priority: Prevent Chronic Diseases

Regional Assets	Regional Barriers	Protective Factors	Contributing Factors
Interagency collaboration	Poverty	Evidence-based medicine	Genetics
School-based health initiatives	Low health literacy	Social environment supporting health	Poverty
State & Federal funding for screenings	Rural area (food deserts, long commutes)	Environmental laws [CAA, CWA, CIAA]	Unhealthy environment (policy, structure)
Rural (health-supporting) environment	Absence of family/social support	School-based health promotion	Marketing and market forces
Electronic health records	Absence of preventive care		Absence of early intervention
			Culture (unhealthy behaviors)

Priority: Promote Healthy Women, Infants & Children

Regional Assets	Regional Barriers	Protective Factors	Contributing Factors
Case management and home visit services	Culture (autonomy; unhealthy norms)	Community-based organizations	Poverty, "working poor"
North Country Prenatal/Perinatal Council	Health professional shortage (Dental, MH, SA)	Health education	Low awareness of services
School-based health initiatives	Insurance information deficit, coverage gaps	Facilitated enrollment in insurance plans	Lack of prenatal care
Interagency collaboration	Geographic isolation	Home visiting programs	Unplanned pregnancy
	Poor support for wellness, breastfeeding	Religious and service organizations	Geographic isolation
		Medicaid and supplemental programs	Family and social environment
			Nutritional status

Priority: Promote Mental Health and Prevent Substance Abuse

Regional Assets	Regional Barriers	Protective Factors	Contributing Factors
Interagency collaboration	Unfunded mandates	Early identification and intervention	Absence of early intervention
Engaged service providers	Low Medicaid reimbursements	Family and social support	Genetics and family history
Improved tri-county housing	Scant resources, high resource turnover	Community collaboration	Any form of trauma or abuse
Treatment and prevention resources	Limited access (long wait lists)	Healthy leisure activities [MH]	Substance abuse [MH]
St. Lawrence Psychiatric Center	Lack of collaborating services [MH]	Continuum of Care (CoC) housing [MH]	Social isolation [MH]
Peer-to-peer groups	Culture (unsupportive community)	Rapid response task force [SA]	Situational stressors [MH]
	Poverty	Evidence-based education in schools [SA]	Lack of self-management [MH]
		Legislation limiting access to substances [SA]	Co-occurring disease, mental illness [SA]
		Society and workforce re-integration [SA]	Ease of access and availability [SA]
		School policies and interventions [SA]	Unemployment [SA]

(Key: CAA - Clean Air Act; CBO - Community-Based Organization; CIAA - Clean Indoor Air Act; CWA - Clean Water Act; MH - Mental health; SA - Substance abuse)