

Medina Memorial Health Care System

COMMUNITY SERVICES PLAN

2009



1. Mission Statement

A. Mission Statement

“Medina Memorial Health Care System exists to improve the health of the communities we serve by creating a culture in which employees feel valued, physicians feel their patients are receiving excellent care, and patients feel the service and quality of the care they receive are extraordinary.”

B. Vision Statement

“Our goal is to be the healthcare provider of choice to the communities we serve.”

Organizational Values (relate to behavior)

1. **Accountability**: Assuming full responsibility for your thoughts, feelings, actions, and results
2. **Compassion**: Understanding others’ feelings, anticipating their needs, and responding with empathy
3. **Collaboration**: Working together by sharing knowledge, learning, and building a consensus in an effort to reach common goals
4. **Community**: We demonstrate our commitment to the community by offering quality healthcare and wellness resources, supporting local vendors, and providing rewarding employment opportunities
5. **Excellence**: Proactively pursuing the resources necessary to stay on the cutting edge of industry trends and consistently delivering exceptional service to all of our stakeholders

Pillars (relate to strategy)

1. People
2. Service
3. Quality
4. Finance
5. Growth

B. The mission statement was recently changed because MMHCS is retooling itself to be one of the top hospitals in the country. A market analysis was done with several focus groups that were both internal and external. It realized that to change the culture and to be the hospital of choice, it needed to change the mission, values and become a values driven organization. So, this was done over a period of one year. The organization is now in the process of rolling out the changes.

II. Service Area

Medina Memorial Health Care System (MMHCS) serves all of Orleans, Northern Genesee, and Eastern Niagara Counties. It is a service area that expands 370 square miles. The system also provides dialysis treatment to a larger service area that includes the above mentioned counties as well as Monroe, Wyoming, Livingston, and Allegany Counties. The two dialysis stations are located in Orleans and Genesee County.

The hospital utilized a zip code study from the a review of internal hospital patient source data, the 2006 census data, New York State demographic data and SPARCS data to determine the service area.

III. Public Participation

A. MMHCS is committed to soliciting public input in the development of the Community Service Plan. It seeks community input by staff participation in a number of community events and committees. The

Assessment of Public Health Priorities section below describes the hospital's participation with the Orleans County Health Department in conducting community focus groups to obtain further input for needed services in the county. The Board of Directors and physicians often communicate the community health needs at the various meetings. MMHCS also provides support groups for post stroke and diabetes patients, this offers an opportunity for feedback on services as well. MMHCS provides patient satisfaction surveys to all patients and these results provide MMHCS with significant feedback on the needs of the community. The system provides two community advisory boards where local agencies, providers, and past patients participate. This provides several ideas yearly that the hospital utilizes in its strategic plan and action plans.

The Community Service Plan will be publicized on the hospital website and distributed throughout the service area.

Representatives from MMHCS' Long Term Home Care Program serve on the Orleans County Certified Home Health Care Program.

MMHCS has continued to collaborate with the Office for Aging (OFA) in its efforts to provide care to the elderly. The MMHCS and OFA have participated in the "Make a Wish" initiatives and the transitioning into the community program. A variety of community agencies have participated in variety efforts to improve the well being of the community. Examples of these are:

- ❖ Orleans County Human Services Council
- ❖ MRDD
- ❖ Children with Special Needs Council
- ❖ Lake Plains Community Care Network
- ❖ Collaboration with the Orleans County Health Department by forming the "Healthy Orleans Network" discussed below.

Orleans County Health Department and the hospital formed the "Healthy Orleans Network, a collaborative that includes representatives from various local agencies that include health, social services, school, business and clergy. The goals of this multi-agency network are to:

- ❖ Improve the status of the community
- ❖ Promote access to quality health care services
- ❖ Eliminate health care disparity

C. There were three community focus group meetings that were held in the spring and summer of 2009 in conjunction with the local Health Department as well as many internal meetings with every level of care giver and a representation of the board of directors and physicians. As a result of the findings from these meetings leadership changed its management direction to incorporate what we call "Values in Action" which is a change calls for value driven activity at all levels. This resulted in the change in Mission and Values statements as outlined above. There is also a big emphasis in access to care and the management of chronic diseases like Diabetes and Chronic Heart Disease. To manage this, the hospital is recruiting primary care physicians and contemplating recruiting a pediatrician as relayed by some of the participants of the focus groups. Some of the other issues brought by the participants included:

External:

- Preventive Health Opportunities for youth to reduce obesity – exercise Gyms, walk ways
- Need for more transportation to get to physician appointments
- More doctors are needed in Medina; Medina is a health care shortage area.
- Improve communication during emergencies.
- Youth Depression needs to be addressed.

Internal:

- Develop a Physician Succession Plan
- Improve on Information Technology to include telemedicine

- Increase grant opportunities
- Create a strong communication system with the community due to high consumer expectations

IV. Assessment of Public Health Priorities

MMHCS and the Orleans County Health Department have chosen a collaborative approach to two Prevention Agenda priorities: Access to Care and Chronic Disease Management. These priorities were chosen based on a community health needs assessment, which included health statistics analysis and consumer focus groups and surveys conducted by both MMHCS and the Orleans County Health Department. The two highest rated concerns for the residents of Orleans County were increased access to affordable health care and cancer and other chronic disease management.

Planning meetings have been held at least monthly since February 2009. Further collaborative planning for meeting the health needs of Orleans County residents takes place through participation by MMHC and the Orleans County Health Department in the Healthy Orleans Network (HON), formed in 2008. This network is comprised of representatives from various local agencies that include health, social services, school, business and clergy. The goals of the HON are to improve the status of our community's health, promote access to quality health services and to eliminate health care disparities. Participation by MMHC and the Orleans County Health Department in this network expands the benefits of collaborative planning through shared resources that aim to:

- Improve health outcomes
- Raise community awareness
- Strengthen existing community partnerships and create new collaborations
- Create grant funding opportunities
- Share important data
- Reduce/eliminate service duplication

These benefits of additional collaboration will enhance our efforts to address the Prevention Agenda priorities of Access to Care and Chronic Disease Management. Additional collaborative planning for chronic disease management is taking place through Joint Community Planning Sessions for Orleans, Genesee and Wyoming Counties, which began in February, 2009. All three counties have chosen Chronic Disease Management as a Prevention Agenda Priority, with a focus on Congestive Heart Failure (CHF) and Diabetes Mellitus (DM). By collaborating in the three county areas, resources can be shared, avoiding duplication of program efforts, and consistency in best practice approaches can be obtained. Grant funding will also be sought, with an increased likelihood of success due to the larger population to be affected.

Our working definition of access to care is making services available to all individuals in the service area regardless of economic or ethnic background. It also implies a timely and appropriate entry into all levels of the health care system to achieve the best possible health outcomes for all. As both a designated Health Provider Shortage Area (HPSA) and a Medically Underserved / Medically Underserved Populations (MUA/MUP) area, perhaps the most significant barrier to access to care is a shortage of primary care physicians. Among the many barriers to access to care in a rural environment like Orleans County are:

- Health care is not seen as a priority, consequently; early intervention is often not utilized
- Poor health literacy, which results in poor health choices
- High poverty which results in under insurance and uninsured conditions
- Not enough primary care physicians for the population, which result in long waits for doctor appointments and over utilization of MMHCS Emergency Department for non-emergent care.
- Not enough specialty physicians
- No Dental services

- Little or no transportation - the county is rural and without much transportation. Orleans Transport Service provides some public transportation, but with limited routes
- Not enough infrastructure for community support services which results in "social admissions"
- Not having enough specialty care services for the population
- Inadequate reimbursement resulting in an inability to reinvest in resources
- Nursing shortage, especially in specialty areas (i.e. dialysis)
- A seasonal influx of migrant farm workers creates the need for additional education in Spanish

Collaboration among local organizations is an essential part of staying connected to the community and removing barriers to access to care. MMHCS, OCHD and HON are combining efforts to: Identify all current health, social service and educational resources available to our community. This provides an opportunity to determine gaps in services, and to identify where resources can be shared. For example, various community groups provide exercise and fitness programs. These programs can be jointly advertised to the community using the various agencies, and through the media to create awareness of all programs by sharing marketing/promotion of programs.

The same approach will be used to improve health literacy to enhance wellness, prevention and early intervention by providing access to information through multiple agencies throughout the community to increase awareness of available services. This system will also be used to promote health literacy for chronic disease management as part of our program to address Congestive Heart Failure and Diabetes Mellitus.

MMHCS, OCHD and HON continually seek grant opportunities to fund needed services, both as individual agencies and as collaborative effort. MMHCS recently received grant funding from the New York State Department of Health's Doctors Across New York program. This funding is being used to address the shortage of primary care services in Orleans County. An OB/GYN physician has been successfully recruited, and efforts continue to bring another Primary Care physician into the community. Grant opportunities and individual agency efforts are communicated on a regular basis in order to identify possible collaborative efforts, as well as to avoid possible duplication of effort.

Congestive Heart Failure (CHF) and Diabetes Mellitus (DM) have been selected for Chronic Care Management initiatives. Cardiovascular disease is the largest health issue in Orleans County. Cardiovascular disease and cancer account for 65% of all deaths.

Cardiovascular Disease - Deaths and Death Rates Per 100,000 Residents

Source: 2003-2005 Vital Statistics Data as of January, 2007

Adjusted Rates Are Age Adjusted to The 2000 United States Population

Orleans County	Population 2004	Crude Rate	Adjusted Rate
	44,138	351.2	327.5

CHF is a complicated disease that often results in readmission to the hospital, not only in Orleans County but across New York State and the nation. Best practice shows that patients can be managed successfully at home with adequate support services. MMHCS is working with OCHD and the Joint Community Planning Sessions for Orleans, Genesee and Wyoming Counties to address best practice approaches to management of CHF across the three counties. The components of this collaborative approach include:

- Developing consistent patient education information and understandable, culturally appropriate educational materials and messages to increase awareness effective self-management of CHF. This will include practical recommendations that can prevent or control CHF exacerbations in individuals at risk for repeat hospitalizations.
- Standardize provider training using current clinical practice guidelines.
- Coordination of hospital discharge education with public health and home health personnel.

- Identifying resources for home follow up visits for reinforcement and education.
- Identifying program funding sources.

In addition to CHF, disease management for Diabetes is a Prevention Agenda priority. The same collaborative approach among MMHCS, OCHD and the Joint Community Planning Sessions for Orleans, Genesee and Wyoming Counties, is being used. Resources will be shared to avoid duplication of effort and to develop consistent best practice approaches for the three - county area.

Diabetes is the most rapidly growing chronic disease of our time. It has become an epidemic that affects one out of every 12 adult New Yorkers. Since 1994, the number of people in the state who have diabetes has more than doubled, and it is likely that number will double again by the year 2050. More than one million New Yorkers have been diagnosed with diabetes. It is estimated that another 450,000 people have diabetes and don't know it, because the symptoms may be overlooked or misunderstood. Diabetes is especially common in the elderly: nearly one-third of those ages 65 and older across the nation have the disease. An additional 30 percent of adults have pre-diabetes. (February 2009 issue of *Diabetes Care*). *Factors that* will increase the number of those affected by diabetes in the near future are the aging population – the well documented “baby boomers” explosion, and the epidemic of overweight and obesity that has become one of the most critical public health threats for New Yorkers and Americans. Close to sixty percent of New York State residents 18 years of age or older are overweight obese. Obesity leads to higher rates of many diseases, including diabetes, heart disease, stroke, cancer, asthma, arthritis, disability and a number of psychological conditions, including depression. Prevention Quality Indicators (PQI) for Orleans County shows possibility for improvement in Diabetes. The health risks of Diabetes are well documented:

- About 2 in 3 people with diabetes die from heart disease or stroke. The risk for heart disease and stroke is 2 to 4 times higher in people with diabetes.
- Diabetes is the leading cause of new cases of blindness among adults aged 20 to 74 years.
- Diabetes is the leading cause of kidney failure, accounting for 44 percent of new cases in 2002. In 2002, close to 154,000 people with end-stage kidney disease due to diabetes were living on chronic dialysis or with a kidney transplant in the United States and Puerto Rico.
- Diabetes causes more than 60 percent of non-traumatic lower-limb amputations each year. In 2002, about 82,000 non-traumatic lower-limb amputations were performed in people with diabetes.

The most significant opportunities for reducing both the personal and financial burdens associated with diabetes rest with increasing recognition of undiagnosed and pre-diabetes populations and providing education for management of the disease. Working within the framework the New York State Plan for the Prevention and Control of Diabetes, which emphasizes provider and public education and prevention of diabetes and diabetes related complications, MMHCS, OCHD and the Joint Community Planning Sessions for Orleans, Genesee and Wyoming Counties are sharing resources to develop strategies to:

- Increase awareness of the signs and symptoms of diabetes.
- Provide current, consistent information on diabetes risk factors, prevention and treatment.
- Develop and disseminate culturally appropriate educational materials and messages.
- Standardize provider training using current clinical practice guidelines.
- Incorporate consistent media campaigns into messages and materials.
- Develop low literacy materials.
- Provide practical recommendations about lifestyle changes that can prevent or control diabetes in individuals at risk of developing this disease or those who could experience complications of uncontrolled diabetes.
- Work with sponsors of educational workshops and training sessions to offer health care providers

- Work with physician offices to provide community-based PCPs and their office staff with training and resources to enhance the management of their patients with diabetes

The two priorities are not new initiatives for MMHCS; however, they are the most challenging. MMHCS along side the Local Health Departments and Hospitals in Genesee, Orleans and Wyoming counties have chosen this and are working together to better coordinate care which includes assessment, health education and guidance in life style changes. This coordination will also include physician offices and insurance companies. A meeting with one of the insurance companies occurred over the summer of 2009 to start the dialogue.

V. Three Year Plan of Action

Following the review of the surveys and focus groups, MMHCS and Orleans Health Department chose to address access to care and chronic disease management.

Access to Care

There a variety of reasons for the lack of access to care. Lack of knowledge was noted as one reason because they often do not recognize early signs of disease so that they present in the emergency department in the late stage of the disease. The lack of transportation was another because the county is rural and without much public transportation. Though Orleans Transport Service was initiated a few years ago, there are limited routes leaving limited transportation services available. There is a seasonal need for additional education in Spanish due to the influx of migrant workers on the farms. Orleans County is a health shortage physician area so physician to patient ratios are high resulting in long waits for doctor appointments. Therefore, the patients wait for more severe symptoms that necessitate an emergency department visit. The agencies mentioned above have coordinated their care to include such areas like; the provision of transportation on off hours; exercise classes; literacy classes and health promotions for all age groups.

Chronic disease Management

The chronic diseases that were chosen include Congestive Heart Failure and Diabetes Mellitus. These were chosen because the CHF patients are often readmitted. There is a national move to reduce the readmission rates and best practice shows the patients can be at home successfully with support services.

The hospital has a community education department called Community Partners. Community Partners staff collaborate with many agencies for the sake of providing education and enhancing the health care of the community. The director of Community Partners and the education director of the Orleans County Health Department participate in the committees mentioned in #3 above and they will continue to collaborate in future educational sessions to the community. Examples of the educational programs include:

- Diabetes – 12 hour course and 1 hour support group.
- Stroke Education for signs and symptoms and the importance of early evaluation and treatment.
- Breast Self-Exam including free mammograms to uninsured through a New York State grant.
- Arthritis management with exercise.
- Safety in the summer regarding bicycle riding and safety tips.

Medina Memorial Health Care System's Community Partners Program collaborates with a number of agencies in order to seek information and impart knowledge. It has worked with the "Women's Health Initiatives" for the purpose of improving quality peri-natal care with great newborn mortality rates; "Human Services Council;" much of the education will be accomplished at special events like the Strawberry Festival, the Orleans County Fair, and many public venues such as that. Special education programs are

held throughout the year with programs advertised in the local newspapers as well as the hospital's quarterly newsletter that goes to 27,000 homes and is distributed to all agencies in the county, school fairs, local Laundromats, grocery stores, pharmacies, and doctors' offices. The teams will also go to local fire halls, schools, worksites, community agencies and senior centers to provide education. A Diabetes Risk Assessment is currently being conducted. This will result in more educational efforts to address the risk areas identified.

Many educational efforts are being addressed for Chronic Heart Failure. The Tri-County Network is working towards providing an educational program that teaches the patients the signs and symptoms of CHF, when to go to the physician, and activities to deter them from frequent hospitalizations. This will be coordinated through the Healthy Heart Orleans Network. The OFA worked with MMHCS to develop the Orleans County transition to home program. These statistics will be shared with the Health Orleans Network to monitor re-hospitalization outcomes and general well-being. This will be done through the Orleans County's New York connects committee.

VI. Financial Aid Program

Medina Memorial Health Care System is committed to providing financial aid to persons who have healthcare needs and are uninsured, under insured, ineligible for a government program, or otherwise, unable to pay for medically necessary care based on their individual financial situation. This is consistent with the Hospital's mission to deliver compassionate, high quality, affordable health care and to advocate for those who are poor and disenfranchised. MMHCS strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

The form of financial aid generally takes place as either charity care for patients that do not have the ability to pay or as a community benefit program such as wellness and educational events. Wellness includes screening programs, community outreach education, birthing classes, hypertension, and diabetes education. Medina Memorial Health Care System has a well established community outreach program.

VII. Changes Impacting Community Health/Provision of Charity Care/Access to Services

The major portion of financial aid is extended to Emergency Department services and in the hospital's Behavioral Health Unit.

Behavioral Health utilization is higher at Medina during the past year possibly due to the increased stress levels caused by the poorer economy and general challenges caused by a downsized workforce. The hospital continues to use the services of a Medicaid counselor to assist the Behavioral Health patients to complete and follow up on Medicaid and other insurance information.

VIII. Dissemination of the Report to the Public

Medina Memorial Health Care System is committed to communicating its plan to the public. The Community Partners Program is the major part of the organization that carries out the education and communication about the health system to the community. The communication to the community will include the distribution of the Community Service Plan in the following manner but not limited to:

- The many community events through the county where educational programs are held.
- Direct mailing to the community agencies.
- Distribution at the various committees throughout the counties where MMHCS' staff participate in.

- Distributed to the physician offices.
- Will be posted on the health system's website.

IX. Financial Statement

Please see Institutional Cost Report (ICR) for the System's Financial Statements.