



**Our Mission is Simple...**

**It's you.**



**Community Service Plan (CSP) 2014 Update**

**HealthAlliance Hospital**

Broadway Campus • Mary's Ave Campus

**Margaretville Hospital**

HealthAlliance of the Hudson Valley  
Mary's Avenue Campus • Broadway Campus • Margaretville Hospital

2014-2016 Community Service Plan  
**2014 Update of Public Participation/Assessment of Public Health Priorities**

For information on HealthAlliance Background, Mission, Service Area, Three Year Plan of Action, Financial Aid Program, and Changes Impacting Community Health/Provision of Charity Care/Access to Services, please refer to the 2014-2016 Community Service Plan, also available on our website, [www.hahv.org](http://www.hahv.org).

Through collaboration with county public health and community-based organizations, HealthAlliance Hospitals aligned together to address three Prevention Agenda Priorities for the years 2014-2016. These priority areas and 2014 updates include:

- 1) Chronic Disease Prevention
- 2) Healthy Mothers, Healthy Babies, Healthy Children
- 3) Mental Health Promotion and Substance Abuse Prevention

**Prevention Agenda Priority: Prevent Chronic Disease**

**Prevention Agenda Focus Area: Reduce Obesity in children and adults**

**Community Health Needs Addressed: Exclusive Breastfeeding, Obesity  
Ulster County**

***1. Goal: Expand the role of healthcare and health service providers and insurers in obesity prevention.***

a. Objective: Increase % of infants born in NYS hospital who are exclusively breastfed during the birth hospitalization by 10% from 43.7% (2010) to 48.1%

***2. Goal: Prevent childhood obesity through early child-care and schools.***

a. Objective: Increase the number of school districts that meet or exceed NYS regulations for physical education.

***3. Goal: Create community environments that promote and support healthy food and beverage choices and physical activity.***

a. Objective: Increase the % of adult's age 18+ who participates in leisure-time physical activity.

**HAHV Response**

The Breastfeeding Coalition, of which HAHV is a member, educates the community at large about breastfeeding benefits and identifies policy changes to support this option. The Family Birth Place offers prenatal classes and educates expectant mothers about the benefits of breastfeeding.

HAHV is also near the end stages of receiving 'baby-friendly' status which recognizes hospitals that successfully implement evidence-based breastfeeding initiatives.

The Community Heart Health Coalition (CHHC) creates nutrition and physical activity opportunities that result in chronic disease prevention for the community.

CHHC will work with child care centers to support changes with regard to physical activity, nutrition and reduced screen time.

CHHC is also engaged in promotion of physical activity among the adult population via free exercise classes, Kingston Walks program and nutrition workshops and will soon place a priority on the adult disability population.

#### **Update 2014**

Total births were 345 with 266 patients (77%) who breast fed at all during the admission exceeding the benchmark of 75% and 136 patients (39%) who breastfed exclusively almost reaching the benchmark 40%. Although we did not achieve our goal this year of 48% for exclusively breastfeeding, we have increased the number of those who breast feed at all during their hospital stay. To increase those numbers the following has been implemented:

- All staff at the Family Birth Place are now Certified Lactation Counselors.
- The Family Birth Place joined an initiative, a quality improvement project to increase breastfeeding rates in New York, with The National Institute for Children’s Health Quality (NICHQ) and the New York State Department of Health (DOH) who are teaming up to help hospitals improve their breastfeeding rates. A new, five-year quality improvement project will guide nearly 80 hospitals in creating environments that support breastfeeding and reduce racial, ethnic and economic disparities in New York State breastfeeding rates.
- By identifying funding for and implementing the NAPSACC program, CHHC worked with childcare centers to identify and create changes in nutrition, physical activities, and decreased screen time. Metrics- 8 centers, 218 children, 47 staff impacted
- CHHC worked with the GED classes and English as a Second Language classes in Ellenville administered by UC BOCES to include a burst of movement into their break time called ‘Let’s Move a Little Ulster County’ for 12 students. This program was developed with input from the NYSDOH
- CHHC worked with the HAHV employee wellness committee to expand their role in obesity prevention by enhancing internal communications regarding lactation support in the worksite
- CHHC maintains an active presence on the Maternal Infant Services Advisory Coalition

#### **Prevention Agenda Priority: Prevent Chronic Disease cont'd**

**Prevention Agenda Focus Area: Increase access to high quality chronic disease preventive care and management in both clinical and community settings**

**Community Health Needs Addressed: Cancer, Diabetes, Heart Disease**

*1. Goal: Increase screening rates for cardiovascular disease, diabetes and breast/cervical/colorectal cancers, especially among disparate populations.*

a. Objective (Reduce Disparity): Increase the % of women age 50-74 years with an income of < \$25,000 who receives breast cancer screening by 5% from 76.7% to 80.5%.

b. Objective: Increase the % of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%

**2. Goal: Promote use of evidence-based care to manage chronic diseases**

a. Objective: Increase the % of adult health plan members with diabetes whose blood glucose is in good control (hemoglobin A1C less than 8%) by 7% from 58% (2011) to 62% for residents enrolled in Medicaid Managed Care; and by 10% from 55% (2011) to 60.5% for residents enrolled in commercial managed care insurance.

b. Objective (Reduce Disparity): Increase the % of adult health plan members with diabetes whose blood glucose is in good control by 10% from 56% (2011) to 62% for black adults enrolled in Medicaid Managed Care.

c. Objective: Reduce the rate of hospitalizations for short-term complications of diabetes by 10% from 3.4 per 10,000 (2007-09) to 3.06 per 10,000 for residents' age 6-17 years and from 5.4 per 10,000 to 4.86 per 10,000 for adults 18+.

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

a. Objective: Increase by at least 5%, the % of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.

**HAHV Response**

HAHV's Breast Education and Breast Outreach Program (BEBOP) is a service to educate the community of free cancer screenings and support services available to the uninsured and underinsured. HAHV is also in partnership with the CSP of the Hudson valley to promote breast, cervical and colorectal cancer screenings to the uninsured.

HAHV's will seek to address the prevalence of heart disease through community health education and public screenings as well as the Diabetes Education Center. The Diabetes education center is committed to providing individuals with the skills and knowledge to manage diabetes and serves as a community resource center where training and educational programs are offered for our community. Individuals who are proficient at managing their diabetes are less likely to develop complications such as heart disease thereby reducing the potential for hospitalizations.

The CHHC hosts nutrition workshops to help people make informed choices about their health.

**2014 UPDATE**

- Referrals to the Oncology Support Program at the Reuner Cancer Support House increased by 70% from 2013 (153) to 2014 (258); participants in support groups, classes, and special events stayed exactly the same at 3,754; and oncology support visits increased 35% from 747 to 1007.
- The Oncology Support Program selectively targeted the Latino community. Efforts by Bilingual Staff include:
  - Cancer Services Program and BEBOP Informational brochures and fliers about free screenings distributed at post offices, businesses that mainly employ part-

- time and have no benefits, medical provider offices, libraries, churches, and multicultural festivals and health fairs
- Presented at The Washbourne House for Domestic Violence in Woodstock.
- The Diabetes Education Center desires to implement the New York State Diabetes Prevention Program (DPP). This is an evidence-based, lifestyle modification program designed for people with pre-diabetes or who are at risk for developing diabetes. The approach of reaching pre-diabetic patients is not a service currently offered by the Center nor is it offered elsewhere in the community. The purpose of the NYS DPP is to assist participants in setting and achieving personal lifestyle goals to prevent the onset of diabetes and the many chronic complications associated with the disease. The program aligns with the NYS Prevention Agenda, as well as HealthAlliance’s desired goal for better population health to reduce manageable chronic in-patient admissions.
- The Diabetes Education Center offers education and training to adults and teens with Type 1, Type 2 or gestational diabetes.
- Although their attendance in classes has decreased a bit, most likely due to providers offering services in their offices, they continue to offer pump trainings, continuous glucose studies, monthly support groups and have added a quarterly cooking/recipe modification class.
- In late 2013, CHHC worked with Kingston to draft and pass a healthy vending resolution.
- Offers direction as an advisory board member of the YMCA Farm Project to promote the availability of high quality, accessible and affordable vegetables in the inner city.
- Provides leadership and support for Live Well Kingston Coalition & chairs Eat Well Kingston focus group.
- ❖ Live Well Kingston (LWK), city-endorsed health coalition facilitated by Cornell Cooperative Extension of Ulster County and for which HealthAlliance is a founding partner and contributes financially to and as a working partner.
  - Four people from the healthcare industry officially joined and participated in the LWK Leadership team in 2014.
  - Four Focus Teams (workgroups) were established: Travel Well, Play Well, Eat Well, and Age Well. A chair of these focus teams was identified.
  - The Age Well Focus Team focused on defining what it means to age well and on developing a needs assessment incorporating input from Kingston’s senior citizens of what they feel would be needed to lead healthier and more active lifestyle.
  - Eat Well participants shared their work on healthier eating in Kingston, brainstormed their vision of what a healthy food environment would look like, and discussed the role of the Eat Well Focus Team in advancing this vision.
  - Travel Well Focus Team formed, which consists of three groups in Kingston working on walking and bicycling advocacy – the Complete Streets Advisory Council (CSAC), Bike-Friendly Kingston (BFK), and the Kingston Land Trust Rail Trail Committee (KLT RTC).

- Play Well Focus Team, led by Steve Noble of the Kingston Parks and Recreation Department, had many accomplishments in 2014 that improve the attractiveness and accessibility of Kingston's parks.

**Prevention Agenda Priority: Promote Mental Health/Prevent Substance Abuse**

**Prevention Agenda Focus Area: Promote Mental, Emotional and Behavioral (MEB) Well-Being in Communities**

**Prevention Agenda Focus Area: Prevent Substance Abuse and other MEB disorders**

**1. Goal: Promote MEB well-being**

a. Objective: Increase the use of evidence-based policies and programs that are grounded on healthy development of children, youth and adults by December 2017.

**2. Goal: Prevent and reduce occurrence of MEB disorders among youth and adults.**

a. Objective: Reduce the number of youth grades 9-12 who felt sad or hopeless by 10% to no more than 22.4% by December 2017.

**3. Goal: Prevent suicides among youth and adults.**

a. Objective: Reduce suicide attempts by adolescents (grade 9-12) who attempted suicide one or more times in the past year by 10% to no more than 6.4%.

**HAHV Response**

The goals and objectives for both focus areas are similar, thus the response is the same. Originating from the Adolescent Partial Hospitalization Program is a service called: 'Practical Tips for Promoting and Maintaining Behavioral Wellness in Youth'. Staff will train and educate parents and local childhood educator's basic concepts of dialectical behavior therapy at home or in the classroom to reduce and prevent harmful or lethal behaviors in youth. Key topics include depression and/or anxiety management and suicide prevention.

**2014 Update**

The following data has been compiled for the Psychiatric Emergency Department (PED) in 2014:

- The number total number of PED visits was 2548
- The number of child/adolescent visits to the PED was 462; 162 of these visits were made by individuals age 13 and under
- The PED arranged 112 child/adolescent transfers to hospitals with inpatient mental health units for those age 17 and under; 21 of these transfers was to the State psychiatric hospital for NYS: Rockland Children's Psychiatric Center
- 800 patients who visited the PED transferred to the Mary's Avenue Campus Inpatient Mental Health Unit
- The average PED visit lasted 7.3 hours
- The PED served 256 patients presenting under the context of substance abuse/intoxication
- Quality Improvements
  - Psychiatric assessment remains composed of original material used to evaluate suicidal and homicidal risk but now includes an OMH recommended tool. This

particular tool adds new depth to the original assessment making it more reliable.

- The patient care technicians and/or RN's check on each patient every 15 minutes and document their mental status and activity
- An electronic communication policy and practice to enhance information sharing between the social worker and the psychiatrist on call about patients' mental status and treatment needs was added which helps ensure the safest and most appropriate disposition possible
- Staffing and growth
  - The PED staff includes 2 FTE social workers, 4 FTE registered nurses, and 2 FTE patient care technicians.
  - One of the social workers is certified as a Spanish language interpreter.
  - Two of the PED are PMCS (Preventing and Managing Crisis Situations) trainers.
  - Three of the PED staff joined the hospital's Critical Incident Stress Management (CISM) team, one is the coordinator of the team, to respond to traumatic events at the work place and in the community.
  - People, Inc. provides a peer advocate 3 afternoons per week.
- Adolescent Partial Hospitalization Program participation and outcomes:
  - The number of recipient days (billable visits) was 1775.
  - The total number of admissions was 101 patients.
  - The total number of referrals was 186.
  - The average annual daily census was 8.
  - The average annual monthly census rate was 86%.
  - 20% of patients were referred by the Psychiatric ER.
  - 30% of patients were referred by in-patient facilities.
  - 50% of patients were referred by out-patient providers (MH clinics, schools, PCP, private clinicians).
  - The average LOS was 18 days.
  - Chart audits showed a 99% compliance rate for treatment planning and utilization review.
  - 100% of patients who graduated from APHP developed a Wellness Recovery Action Plan (WRAP) while attending the program.
  - 14% of patients were referred to in patient facilities.
  - 5% of patients were readmitted to the APHP within 15 days.\*
  - 4% of patients were readmitted to APHP within 30 days.\*

\*NOTE: All patients who were readmitted to APHP had been discharged to a higher level of care and returned to APHP as a step down when returning to the community.
- Growth:
  - The APHP has been operating since 2006. Referrals to the program have grown steadily over time. For example, there were 107 referrals received in 2013 and 186 referral received in 2014.
  - In 2007 the APHP average annual census rate was 52% as compared to an 86% census rate in 2014.

- Since October 2014 the APHP has had an ongoing list of patients waiting for admission. Plans are being considered for program expansion.
- Community networking and outreach:
  - The APHP has a general YMCA membership for all patients to be able to use the YMCA facilities during program hours while admitted to the program. The YMCA membership is funded by the Benedictine Health Foundation.
  - The Hudson Valley Foundation for Youth Health and The Benedictine Health Foundation have granted the APHP funds for a “Cozy Space” project on the unit. This project will provide patients with sensory equipment, comfortable furniture, art and music supplies, etc. which will enhance the therapeutic environment.
  - The APHP staff serves on the following committees in the community: SPOA, Children Services Planning Committee, Suicide Prevention Task Force, UC System of Care Committee, and the New Paltz Community Leadership Round Table, Eating Disorder Coalition, and the MHA in Ulster County.
  - The APHP staff attended in-services or conferences on the following: LGBTQ, PMCS, Suicide Prevention, DBT, EMDR, Somatic Experiencing, Eating Disorders, and Substance Abuse Treatment.
  - In collaboration with MHA in Ulster County, the APHP Clinical Coordinator provided multiple community trainings on mental health topics to local schools/agencies and co-created a webinar on reducing parent child conflict.
  - The APHP LCAT provided training on trauma informed therapy to the community.
  - The APHP team participated in the Mental Health Expo at HAHV as well as other community based Health Fairs.
  - The APHP provided education for several nursing students and 3 Nurse Practitioner students, and also provided internships for 2 Social Work interns, 1 Creative Arts Therapy intern and 2 music therapy interns.
- Staffing
  - The APHP staff now includes 3 FTE positions and 1 PT position.
  - The Nurse Practitioner/MD provides psychiatric services to APHP patients and families 5 days a week.
  - Education Inc. provides a tutor with no additional cost to the program.
  - Each year the APHP Clinical Coordinator supervises MSW/MHC interns, Music Therapy Interns, and Creative Art Therapy Interns.
- The HAHV Adult Partial Hospitalization Program (PHP) participation and outcomes:
  - The number of recipient days (billable visits) was 2673.
  - The total number of admissions was 187 patients.
  - The total number of referrals was 301.
  - The average annual daily census was 12.
  - The average annual monthly census rate was 83%.
  - 11% of patients were referred by the Psychiatric ER.
  - 43% of patients were referred by in-patient facilities.
  - 46% of patients were referred by out-patient providers (Outpatient providers).
  - The average LOS was 18 days.



- Chart audits showed 94% compliance rate for treatment planning and utilization review.
- 100% of patients who graduated from PHP developed a Wellness Recovery Action Plan (WRAP) while attending the program.
- 4% of patients were referred to in patient facilities.
- 0% of patients were readmitted to the PHP within 15 days.\*
- 0% of patients were readmitted to APHP within 30 days.\*
- The PHP has been operating since 2006. Referrals to the program have remained a little over 300 for 2014/2013, up from 239 in 2012. Currently, we are advocating for higher capacity to admit those referred by outpatient provider more quickly. Referrals must come from a licensed provider who is also providing treatment to the person being referred).
- Community networking and outreach:
  - The PHP has good working relationship with community agencies; MHA staff comes to present their services to the PHP patients on a monthly basis.
  - Monty participation in the Ulster County Care Transition Coalition meeting.
  - The PHP staff attended in-services or conferences on the following: LGBTQ Committee, PMCS, Depression and CBT, EMDR
  - The PHP team participated in the Mental Health Expo at HAHV as well as other community based Health Fairs.
  - The PHP provided education for several nursing students and 1 Nurse Practitioner students, 1 Creative Arts Therapy.
- Staffing
  - 4 Full-time positions; Clinical Coordinator, RN, Social Worker/Advocate, and Office Manager.
  - 2- Part-time positions; LCSW-R/Advocate; LCAT/Advocate.
  - 3- Per-diem positions; RN, LCSW-R/Advocate, LMSW/Advocate.
  - Nurse Practitioner/MD provides psychiatric services 5 days a week.
- Mental Health Services In-patient Program data has been compiled for the 2014:
  - The total number of admissions was 923 patients.
  - The total number of discharges was 918 patients.
  - Our average annual daily census was 27.
  - Our annual occupancy rate was 68%.
  - 13% of our mental health patients were discharged to Alcohol/Drug rehab.
  - 11% of our mental health patients were over 60 years of age or older.
  - We had 8 mental health patients transferred to Rockland State Psychiatric Center.
- Growth (2011-2014):
  - All mental health patients now have Individualized Treatment Plans that include patient goal-setting, collateral input, treatment team goals for the patient, patient's strengths and liabilities, objectives that are behavioral and measurable, and discharge plans. We also have weekly reviews of patient's progress, or lack of, for each objective identified in the Treatment Plan.

- All mental health patients receive individual and/or group Dialectical Behavioral Therapy and/or Cognitive Behavioral Therapy daily.
- Upon discharge, the patient and social worker fill out a crisis safety plan which the patient takes home. It includes people and agencies to call in a crisis, warning signs to recognize what precipitates a crisis, triggers and stressors which put the patient at emotional risk, things to do that help in a crisis and coping skills.
- All mental health patients identified as high risk for suicide have a case conference before they can be discharged. All parties must agree to the discharge and the discharge plan. If not, a second psychiatrist evaluates the patient for discharge and makes the final determination. Treatment resistant patients have a case review to collaborate about changes in treatment. Treatment resistance is defined as: Readmission to mental health within 7 days, 3 restraints within 30 days, poor clinical progress and family concerns. The clinical case review is attended by the entire treatment team, Treatment Team Manager, Nurse Manager and Medical Director.
- We have added evening and weekend activity groups to include 1 or 2 evening groups each weekday and 2 to 3 groups each weekend day and 1-2 groups on holidays. We now have two groups that take place simultaneously. One is for higher functioning individuals and the other for lower cognitive functioning individuals.
- The psychiatric assessment continues to be composed of the original material used to evaluate suicidal and homicidal risk, but now includes an OMH recommended tool. This particular assessment tool adds a new depth to the original assessment making it more reliable.
- We are in the process of creating a “Comfort Room.” The use of a comfort room is considered best practice in a mental health setting. A comfort room is used to help calm anxious and agitated patients. It is a room where patients have control of their environment such as choice of music, special lighting, sound effects and objects or materials (weighted blankets or squeeze balls) that help soothe the patient.
- A Violence and Assessment Tool has been added to the nursing admission assessment. Each patient receives a numeric score that determines if patient is high, moderate or low risk of assaultive or violent behavior. Also, an Orange Dot program was initiated to visually identify patient who scores HIGH on the Violence Assessment Tool. The orange dots are placed on patient’s medical record, MAR, Kardex, Assignment Board and Close Observation Sheet.
- We now have a Fall Risk system in place for the mental health patients. Yellow dots are placed next to patient’s name on white board and close observation sheets. We also provide fall risk patients with yellow slippers. This is the best practice for fall prevention to be shared with the rest of the organization.
- Daily safety rounds are conducted on both inpatient units. A visual inspection of each unit to identify and attend to apparent safety issues such as broken,

malfunctioning or unsafe equipment, contraband, damage to walls or other property, and spills.

- Monthly environmental rounds conducted with Quality, Engineering and Housekeeping departments. This is an up-close and thorough inspection.
- Several staff members have completed “Special Investigator Training.” A two day course that focused on what constitutes an OMH reportable event and how to proceed in doing the investigation of such events following OMH guidelines.
- We changed from Crisis Prevention and Intervention (CPI) to Preventing and Managing Crisis Situations (PMCS). PMCS is an OMH approved crisis prevention and intervention program. All staff is trained and attends a mandatory refresher course annually. This new training has helped to reduce our restraint use.
- We have reduced our Restraint and Seclusion episodes dramatically.
- A Mental Health Quality Specialist was hired to provide expertise regarding quality issues specific to MHS and OMH.
- We have changed our visiting policy to supervised visitation in the Activity Room. This has dramatically reduced our contraband issues.
- We now have free phone access for all patients which replaced pay phones. We are currently renovating both units.
- We had our first annual Behavioral Health Expo in May of 2014. We had over 20 exhibitors. This year’s Behavioral Health Expo will be held Saturday, 4/25/15.
- We are currently looking toward increasing the capacity of the Partial Hospitalization Programs.

### **Margaretville Hospital, Delaware County**

Professional and public focus groups were conducted in 2013 throughout Delaware County to gain insight from consumers and other stakeholders to identify the most pressing healthcare issues. The two other Critical Access Hospitals in Delaware County were consulted regarding their identified priority healthcare needs, with additional input received from the local Public Health Department, area community healthcare stakeholders, and our Acute and Emergency Department physicians and providers.

The public health priorities selected were:

- 1) Prevent Chronic Disease
- 2) Promote Mental Health and Prevent Substance Abuse

### **Prevention Agenda Priority: Prevent Chronic Disease**

### **Prevention Agenda Focus Area: Reduce Obesity in Children and Adults**

### **Community Health Needs Addressed: Obesity**

#### ***1. Goal: Create Community environments that promote and support healthy beverage choices and physical activity***

a. Objective: increase the percentage of adults ages 18 and older who participate in leisure time physical activity.

#### **Margaretville Hospital Response**

- Collaborate with the Margaretville Hospital Auxiliary Wellness Committee and area Chambers of Commerce, local government and other community organizations to develop a plan for mapping and advertising the available walking, biking, jogging and hiking routes within the hospital service area.
- Educate and engage the local physicians, mid-level health care providers, and Emergency Departments to implement the walking trail prescription program.
- Collaborate with the Margaretville Hospital Auxiliary Wellness Committee to investigate the organization of other physical activity initiatives, such as Peddlers and Paddlers, organized community activity events, and securing an indoor walking environment for the winter months to ensure leisure time activity availability year round.
- Provide leisure time physical activity event information at the hospital health fairs and at our mobile van events.
- Investigate the ability to provide diabetes educational support at the Margaretville Hospital.

#### **2014 Update**

Selection was achieved through the public discussions and analysis of patient hospital census data which identified chronic disease management issues, especially for diabetes and obesity. It was decided that a more proactive focus on disease prevention was deemed to be a root cause approach for improving personal accountability and actively choosing to live a healthier lifestyle.

- Margaretville Hospital offers a mobile van to promote community wellness on site at area workplaces, senior centers, community organizations, fairs and other public events

during warm weather months. The van helps to promote the reach and availability of educational and healthcare services and resources provided at the hospital.

- Two free health fairs are held every year in the spring and in the fall with special health activities and education focused on adults and children. The hospital and many community organizations showcase their offerings as well as services within the hospital to educate the public on what is available to them. In addition to these two events, Medical Staff provides various community educational presentations during the year. The Complete Streets Program as well as the Prescription Trails Program information are featured at the fairs.
- A DVD/Video education library for public use on health disease prevention and management has been created to also be used by staff for public education. A video education series on various healthcare topics is provided via TV in the hospital lobby during specific periods of time throughout the year.

**Prevention Agenda Priority: Prevent Chronic Disease, cont'd**

**Prevention Agenda Focus Area: Increase access to high quality chronic disease preventive care and management in both clinical and community settings**

**Community Health Needs Addressed: Diabetes**

***1. Goal: Increase screening rates for cardiovascular disease, diabetes and breast/cervical/colorectal cancers, especially among disparate populations.***

a. Objective: Increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%

**Margaretville Hospital Response**

- By December 31, 2014, complete an evaluation for the ability to establish a diabetes education program led by a certified diabetes educator on the Margaretville Hospital
- Collaborate with the HealthAlliance Diabetes Education Center in Kingston to assess the feasibility of establishing a program

**2014 Update**

In 2014, we actively began to initiate means to raise public awareness and local promotion of Diabetes Classes held locally at Margaretville Hospital with the support of the HealthAlliance of the Hudson Valley Diabetes Center in Kingston. One of our RN staff nurses completed diabetes educator training and passed her certification test to be a Diabetes Educator in December 2014. She teaches diabetes classes at the hospital every other week with approximately 35 patients having completed the program. These patients are referred by our own hospital staff as well as local providers. She also goes to senior centers, our local recreation center and plans on expanding her visits to grocery markets and public centers, such as the libraries in the area.

We are participating in a community education effort for adoption of policies to implement the Complete Streets Program in the county's villages to promote safety for roads, sidewalks, crosswalks and signage to encourage residents to get out and walk for better health. Four communities in the county have adopted complete street policies.

The Prescription Trails Program is being promoted by our Wellness Committee and local healthcare providers in the community. The providers have been given prescription pads for writing specific exercise instructions for identified patients that defines how often and how far to walk based on the individual's abilities and needs. Pamphlets and office cards have been distributed along with creation of a website: [getoutandwalk.org](http://getoutandwalk.org).

2015 plans in development include "A Diabetes Walk" to raise funds for diabetes research in May and a hospital staff group effort to get out and walk on national Get Out and Walk Day April 1<sup>st</sup>.

**Prevention Agenda Priority: Promote Mental Health/Prevent Substance Abuse**  
**Prevention Agenda Focus Area: Prevent Substance Abuse and other MEB disorders**  
**Prevention Agenda Focus Area: Strengthen Infrastructure across Systems**  
**Community Health Needs Addressed: Mental Health, Suicide**

***Goal: Prevent suicides among youth and adults.***

a. Objective: reduce the age adjusted suicide mortality by 10% to 5.9% per 100,000.

***2. Goal: Strengthen infrastructure for mental, emotional, and behavioral (MEB) health promotion and MEB disorder prevention***

a. Objective: Strengthen training and technical assistance of primary care physicians, MEB health workforce and community leaders in evidence-based training, cultural sensitivity training, approaches to MEB disorder prevention and mental health promotion.

#### **Margaretville Hospital Response**

- Collaborate with Delaware County to provide Emergency Department staff with Applied Suicide Intervention Skills Training (ASIST) and suicide first aid training for first responders.
- Collaborate with HAHV to provide education for our staff in recognition and therapeutic approaches for behavioral health issues such as the "Practical Tips for Promoting and Maintaining Behavioral Wellness in Youth" program.
- Continue to serve as a location for weekly mental health and drug addiction counseling services through the Delaware County Mental Health Department.
- Provide information, resources and referrals related to depression/suicide prevention at our hospital health fairs and during public event attendance by our mobile van
- Participate in a newly formed Delaware County Mental Health Task Force and Suicide Coalition
- Promote the utilization of Licensed Medical Social Workers in Primary Care settings.

#### **2014 Update**

Two members of our Wellness Committee have joined the county-wide Mental Health Task Force and are working with other members to assess and address the county mental health needs. One addition of services in the county is the Warm Line for support and assistance for referral. The service availability continues to be communicated to the communities through our hospital and other healthcare entities.

Our hospital has been approved for a Vital Access Provider Grant funding. The grant, written in November, will be for funding to provide adolescent mental health services by a psychiatrist specializing in that field. Referrals will come from the local schools, health care providers, and individuals needing services. Grant money from the state will be available by the end of March with federal money pending. We are currently making plans for a smooth implementation of the program. We continue to provide office space to the Delaware County Office of Mental Health for mental health and substance abuse counseling on a weekly basis.