



# Fiscal Year 2020 Implementation Strategy

NMC Community Health Needs Assessment

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PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
		Resources & People		Short Term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	By June 30, 2020...
<b>Improve</b> - Wellbeing - Mental Health - Behavioral Health	<b>Reduce Barriers</b>	Generations Social Worker Avery Vogt	<b>Expand Caregiver Support (FY18)</b>	<b>FY 2018</b> Secure a consistent place to meet with easy access for elderly patients  Meeting space secured in the south conference room. Plans to hold meeting once a quarter led by Generations Social Worker	<b>FY 2019</b> Held a minimum of four Caregiver Support meetings.  Ten caregiver support group meetings held at Newton Medical Center in FY 2019. Topics for meetings included: Overcoming holidays/special occasions, Caregiver Grief, Self-Care, Dementia, and Caregiver Guilt. Attendance at the meetings has been consistent with 3-7 attendees each meeting.  Assessment of the meeting value has been completed via written evaluations and electronic evaluations. This data was qualitative in nature and will be utilized for content development.	<b>FY 2020</b> Maintain reach of care and support services through direct service, community partners and volunteers resulting in 3-5 new members each quarter and 2-3 support service referrals per support group session.	Decrease the percentage of adults reporting physical or mental health kept them from doing usual activities (self-care, work, recreation) in the past 30 days from 25.8% to 24.8% as reported by the Kansas Behavioral Risk Factor Surveillance System.
			<b>Develop survey tool for Caregivers who participate in Caregiver Support meetings to provide feedback on impact on stress related to Caregiver Role and support needs to drive meeting agendas (FY19).</b>				

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short Term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
		<b>Resources &amp; People</b>		<b>Short Term (Year 1)</b>	<b>Intermediate (Year 2)</b>	<b>Long Term (Year 3)</b>	<b>By June 30, 2020</b>
<b>Improve</b> - Wellbeing - Mental Health - Behavioral Health	<b>Enhance Skills</b>	Director of Therapy Services - Belinda Schuler	<b>Expand Better Breather's Group (FY18)</b>	<b>FY 2018</b> Investigate methods to increase participation and referrals to this program  Engaged Pulmonologist and communicating this with patients.  Developing marketing strategies and community events to increase awareness. Average number of participants for FY18 was 5.75.	<b>FY 2019</b> Increased number of participants in Better Breather's Group by 10% (goal of 6 attendees).  Participant number for Better Breathers club has met goal with 7-10 attendees  NMC Respiratory Therapists served as resource for long term care facility Schowalter Villa as they work toward initiating a COPD support group.	<b>FY 2020</b> Increase the number of Better Breathers Club attendance by 10%. (Total of 8 attendees consistently).  <b>Collaborate with Newton Home Health, Harvey County Health Ministries and NMC Case Management to become a resource to Long Term Care facilities for the development of COPD support groups.</b>  <b>The Respiratory Care team will be available for two or more presentations during the 2020 FY.</b>	<b>Define Community Wide Falls program and develop meaningful metrics and targets.</b>

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short Term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
		<b>Resources &amp; People</b>		<b>Short Term (Year 1)</b>	<b>Intermediate (Year 2)</b>	<b>Long Term (Year 3)</b>	<b>By June 30, 2020</b>
<b>Improve</b> - Wellbeing - Mental Health - Behavioral Health	<b>Provide Support and Enhance Skills</b>	Chief Medical Officer	<p><b>Reduce the number of bone fractures through Own the Bone Program</b></p> <p><b>Utilize screening reports for patients that present to the Emergency Room with diagnosis of fall to identify patients who may benefit from participation in Community Fall Prevention Program (FY19).</b></p> <p><b>Implement follow-up process related to screening through the orthopedic clinic &amp; expand to Outpatient Clinics (FY19).</b></p> <p><b>Expand community and provider education about the Own the Bone Program</b></p>	<p><b>FY 2018</b>                      Expand participants enrolled by identifying potential participants through the ED</p> <p>Approximately 50 Own the Bone participants for FY18.</p> <p>Screening and reporting modalities developed for patients that present to the Emergency Room with diagnosis of falls. Developing follow up process related to screening through the orthopedic clinic</p>	<p><b>FY 2019</b>                      Increased participants in Own the Bone Program by 5% (to 55 participants).</p> <p>In September of 2018 Rex Wittman and Tiana Gaines began as key providers for the “Own the Bone” program. Current enrollment is approximately 80 persons. Patients are being identified for this program out of the Newton Orthopaedic and Sports Medicine Clinic rather than the ER exclusively. This change in referral pattern has increased the number of enrollees. Dr. Craig and Jeff Couchman, RPT, are developing education for Fall Prevention for this program.</p> <p>During the month of May, which is National Osteoporosis Month, Newton Medical Center posted content on their Facebook site regarding the “Own the Bone” Program.</p>	<p><b>FY 2020</b>                      Own the Bone program will increase enrollment by 10% (to 88 participants)</p> <p><b>Goal-Marketing campaign to increase community awareness related to Fall Prevention</b></p>	<p><b>Define Community Wide Falls program and develop meaningful metrics and targets.</b></p>

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
<b>Improve</b> - Wellbeing - Mental Health - Behavioral Health	<b>Provide Support and Enhance Skills</b>	Population Management APRN and Chief Clinical Officer	<b>Incorporate a Palliative Care program at our hospital</b>	<b>FY 2018</b> Investigate models for Palliative Care and develop a plan.  Palliative Care Consult developed and implemented in the acute care setting. To date four palliative care consults completed by Dr. Spurlock or Karen Lehman ARNP. Case Management provided 813 patients with Advance Care Planning information and 21% of these patients have completed their Advanced Care Plan or named a Durable Power of Attorney.  Advance Care Planning visits developed and implemented in home health setting during FY18. Baseline rate 0% due to lack of process in place to address this need for Home Health patients.  Finalizing documentation and reporting modalities.	<b>FY 2019</b> - 50% of patients participating in Right-On-Track and Home Health, identified as not having a Durable Power of Attorney appointed, will appoint a Durable Power of Attorney through the Advanced Care Planning Program. - Palliative Care screens and consults were submitted based on patient need. - Implemented documentation for Advance Care Planning visits offered to Home Health patients. - Host Decision Day 2019 for community  - The ROTP continues to encourage participants to complete their ACP. Karen Lehman, APRN continues to facilitate completion of ACP for the ROTP and Newton Home Health. - 428 inpatients without Advanced Directives were given Advanced Care Planning (ACP) information, of that 428, 52 (12%) patients signed Advanced Directive documents. - Dr. Loeffler and Karen Lehman APRN spoke on Advanced Care Planning at the Bethel College Lifetime Learning program where over 200 people were in attendance. - Jennifer Speer RN, Case Manager, who is part of the NMC Ethics Committee, conducted "advanced directives" speaking engagements in the community including St. Matthews Episcopal Church, Kiwanis and the Newton Chamber of Commerce breakfast in March 2019 reaching an additional 50 people. - Case Management has completed education with ER staff on obtaining Advanced Directives and confirms that all necessary forms are located in NMC's document management system  <b>Home Health</b> - FY 2019, 97.7% of Home Health new admissions have been assessed for advanced care planning.	<b>FY 2020</b> Advanced Care Planning will continue to be provided by Karen Lehman for inpatients referred from Case Management  Increase Palliative Care screens and consults for inpatients by 5% for FY 2020.  Decision Day will be offered at multiple locations a minimum of two times in FY 2020  >75% of the Home Health new admissions will have Advanced Directives completed	By June 30, 2020
			<b>Host Decision Day 2019 for community (FY19).</b>  <b>Implement documentation and reporting for Advance Care Planning visits now being done in Home Health patient population (FY19).</b>				

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	By June 30, 2020
<p><b>Improve</b></p> <ul style="list-style-type: none"> <li>- Wellbeing</li> <li>- Mental Health</li> <li>- Behavioral Health</li> </ul>	<p><b>Provide Education</b></p>	<p>Population Management APRN</p>	<p><b>Incorporate an education program on falls in our community (FY18).</b></p> <hr/> <p><b>Continue to identify patients and/or community members who would benefit from participation in “Stepping On” program to meet minimum participant requirement (8).</b></p> <p><b>Develop and implement “Stepping On” referral process for patients receiving care in the ED and therapy department related to a fall (FY19).</b></p> <p><b>Investigate resource funds to assist participants with startup costs of the program (FY19).</b></p>	<p><b>FY 2018</b>  <b>Develop and implement a community falls education program</b></p>	<p><b>FY 2019</b>  <b>Hold at least one (1) “Stepping On” program in FY19</b></p> <p>This program has been scheduled three different times this fiscal year with no enrollees. (enter specific dates with 0 enrollees)</p> <p>In April, a grant was received for \$750 from KDHE directed toward payment of enrollment fees for this program.</p> <p>Case Management and Para-medicine Program targeted persons known to have a history of falls for participation in this inaugural program offering.</p> <p>The program will be hosted by Trinity United Methodist Church beginning July 19, 2019. NMC will continue to serve as a resource. The referral period remains open at this time.</p>	<p><b>FY 2020</b>  <b>NMC Case Management, Outpatient therapy, and Home Health will utilize fall risk criteria screening tools to increase referrals to Community “Stepping On” Program at Trinity Heights United Methodist Church.</b></p>	<p><b>Define Community Wide Falls program and develop meaningful metrics and targets.</b></p>

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	By June 30, 2020
<p><b>Improve</b></p> <ul style="list-style-type: none"> <li>- Wellbeing</li> <li>- Mental Health</li> <li>- Behavioral Health</li> </ul>	<p><b>Provide Information</b></p>	<p>Quality and Analytics</p>	<p><b>Make Education on the safety and benefit of influenza and pneumococcal immunizations available to our NMC inpatients (FY18)</b></p> <p><b>NMC Family Practice Clinics (FY19)</b></p> <p><b>Identify percent of inpatients who have not received the seasonal influenza vaccination upon assessment that were then provided the flu vaccination during their acute inpatient admission</b></p> <p><b>Identify patients who have visits in the Family Practice clinics, who upon intake interview, have not had the seasonal Influenza vaccination and were provided the flu vaccine at that visit.</b></p>	<p><b>FY 2018</b></p> <p><b>Find and adopt a current resource for distribution to our patients</b></p> <p>Vaccine Information Sheets for Influenza and Pneumococcal vaccinations are provided to all inpatients at the time of vaccination. Newton Medical Center assessed influenza vaccination status on 97.7% of inpatients during 2017-2018 Influenza vaccination and provided influenza vaccinations to patients who wanted to receive the vaccination.</p>	<p><b>FY 2019</b></p> <p><b>Newton Medical Center assessed 98% of all inpatients for influenza vaccination during the flu season from October 1, 2018 to March 31, 2019</b></p> <p><b>Newton Medical Center clinics documented flu vaccinations at each visit either by administering the vaccine to those patients who chose to receive it or by documentation in the patients immunization history (if administered elsewhere) during the 2018-2019 flu season</b></p> <p>During the 2018-2019 flu season, NMC assessed an average of 98% Inpatients. January through April, 2019 (flu season extended due to increased local episodes) statistics demonstrated a 99.9% assessment rate following an intervention, initiated by the Quality Department, in nursing documentation.</p>		

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
Prevent & Manage Chronic Disease	Reduce Barriers	Quality and Analytics, Clinical Informatics, Clinics	<p>Use new EMR platform to better communicate and capture vaccination status (FY18).</p> <p>Roll out surveillance to pilot group to identify inpatients in need of assessment &amp; vaccination (FY19).</p>	<p><b>FY 2018</b></p> <p>Share, by provider, how we do on capturing and providing the vaccination</p> <p>Health E-Filings implemented to track clinic metrics, still working on accurate reports. Surveillance ready to roll out to pilot group identifying inpatients in need of assessment &amp; vaccination.</p>	<p><b>FY 2019</b></p> <p>Newton Medical Center clinics documented flu vaccination at each visit either by administering the vaccine to those patients who choose to receive it or by documentation in the patients immunization history (if administered elsewhere) during the 2018-2019 flu season</p> <p>Data as of 3/28/2019 - 23% of patients seen during the flu season were immunized at one of our NMC owned clinics. This does not take into account those immunized at other retail locations or flu clinics.</p>	<p><b>FY 2020</b></p> <p>NMC FP Clinics will increase the number of patients assessed for flu shots by 10% for the 2019-2020 flu season</p>	<p>Increase the percentage of adults who get an annual flu vaccination from 46.9% to 48.9% as reported by the Kansas Behavioral Risk Factor Surveillance System.</p>

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
Prevent & Manage Chronic Disease	Change Consequence	Chief Medical Officer	Implement “no tobacco” policy before elective surgery (FY18)	<p><b>FY2018</b> Investigate who is currently doing this and feasibility of spread</p> <p>Orthopedic Clinic applies a no smoking policy prior to elective orthopedic surgery. All NMC Surgeons have implemented a “smoke-free” policy (intent) for elective surgeries during FY18. Newton Medical Center Surgical Department advocates for smoking cessation prior to any “planned” surgery.</p> <p>Two surgeons currently have firm no-smoking policies with accompanying testing for Cotinine.</p>	<p><b>FY 2019</b> Provide Support and Enhance Skills. NMC Surgical Department will report a 1-2 % increase in patients who are reported tobacco users and have not used tobacco within 30 days of their “planned” surgery.</p> <p>Efforts remain in place to meet this goal by gathering and distributing data to individual surgeons. In FY2019, a Meditech module was created to capture the number of patients who 1) are smokers at the time of registration for their “elective” surgery 2) have smoked in the last 30 days and 3) are exposed to 2<sup>nd</sup> hand smoke.</p> <p>Data on smoking status within 30 days of “planned” surgery supplied to CMO to use in conversations with surgeons.</p>	<p><b>FY 2020</b> Smoking status data to be analyzed for the 1-2% increase in patients who are reported tobacco users and have not used tobacco within 30 days of their “planned” surgery.</p> <p><b>CMO will provide data on smoking status within 30 days of “planned” surgery to surgeons twice in the fiscal year and will consult regarding smoking cessation goals for patients prior to “planned” surgeries.</b></p>	<p><b>Decrease the rate of smoking from 13.1% to 12.1% as reported by the Kansas Behavioral Risk Factor Surveillance System.</b></p> <p>**6/11/18 Update from Healthy Harvey Coalition Coordinator: The Tobacco work group is being led by Kaylie Regier, Prairie View Tobacco Grant Coordinator, and has established a partnership with the YMCA and Mirror to conduct tobacco cessation courses at the YMCA.</p>
			Provide KanQuit or smoking cessation materials to patients having elective surgery with history of smoking for continued cessation support. Develop reporting mechanism to assess compliance with cessation by evaluating smoking status at post-operative follow-up appointment. (FY19).				

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
Prevent & Manage Chronic Disease	Reduce Barriers	Quality and Analytics, Clinical Informatics, Clinics	Use new EMR platform to better communicate and capture smoking status and intervention (FY18).	<b>FY 2018</b> Share, by provider, how we do on capturing smoking status and using interventions Health E-Filings implemented to track clinic metrics, still working on accurate reports. Hospital patient data is being collected in new EMR reporting will need to be developed. 61% (229/378 unique patients identified as smokers) were provided smoking cessation	<b>FY 2019</b> Increased percent of patients identified as smokers who received Smoking Intervention by 10%.  Currently, 93% of the patients identified on admission as smokers have been offered smoking cessation education	<b>FY 2020</b> Increase the number of patients who are identified as smokers and offered tobacco counseling to 95%	<b>Decrease the rate of smoking from 13.1% to 12.1% as reported by the Kansas Behavioral Risk Factor Surveillance System.</b>  **6/11/18 Update from Healthy Harvey Coalition Coordinator: The Tobacco work group is being led by Kaylie Regier, Prairie View Tobacco Grant Coordinator, and has established a partnership with the YMCA and Mirror to conduct tobacco cessation courses at the YMCA.

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
Prevent & Manage Chronic Disease	Provide Support	Respiratory Therapy and Quality and Analytics	Increase impact on NMC patients of intervention for tobacco users (FY18).	<b>FY 2018</b> Begin tracking follow-up with KanQuit to understand impact.	<b>FY 2019</b> Increased referrals to KanQuit for NMC patients identified as smokers by 10%. 17.7% (42/237) of patients counseled agreed to enroll in the KanQuit program	<b>FY 2020</b> Increase the number of patients identified as smokers and offered tobacco counseling to 95% with 20% agreeing to enroll in KanQuit. FY 2019-17.7% FY 2020-20% (approximately 5 patients)	Decrease the rate of smoking from 13.1% to 12.1% as reported by the Kansas Behavioral Risk Factor Surveillance System.
			Continue to track NMC patient referrals who contacted KanQuit following smoking intervention (FY19).	Initiated tracking system with KanQuit. Initiated reporting of % of smoking cessation offerings in the acute care setting;			

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
Prevent & Manage Chronic Disease	Enhance Access	Director of Therapy Services	<p><b>Utilize Pulmonologist to address chronic disease prevention and management (FY18).</b></p> <p><b>Develop marketing strategy to increase community and provider awareness of pulmonology services available at Newton Medical Center.</b></p>	<p><b>FY 2018</b></p> <p><b>Partner with pulmonology services to define/develop goals</b></p> <p>Therapies working with Pulmonology Medical Director to develop marketing strategy of pulmonology acute and chronic services. NMC had a total of 77 admissions related to primary respiratory diagnosis, and Pulmonologist exhibited 116 inpatient consults FY18 (through April 3<sup>rd</sup>, 2018).</p>	<p><b>FY 2019</b></p> <p><b>Increased post-acute care pulmonology services for inpatients at NMC by 10% by December 2019</b></p> <p>Consults FY2018-149 FY 2019 to 6/6/2019-145</p> <p>The Pulmonary Rehabilitation Program began 2/6/18</p> <p>Initial Pulmonary Rehabilitation Assessments required entering the Pulmonary Rehabilitation program. FY 2018-24 FY 2019 to 6/6/2019-39</p>	<p><b>FY 2020</b></p> <p><b>Pulmonary Rehabilitation services will host Pulmonary Education Classes for participants at least 6 times per year with presentations by the NMC Pulmonary Rehabilitation Director</b></p> <p><b>Participants in the Pulmonary Rehabilitation program will increase by 5%</b></p>	<p><b>Decrease the rate of smoking from 13.1% to 12.1% as reported by the Kansas Behavioral Risk Factor Surveillance System.</b></p>

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
Prevent & Manage Chronic Disease	Reduce Barriers	Manager of Case Management	Reduce Sepsis Readmissions (FY18).	<b>FY 2018</b> <b>Include Sepsis discharges in the Right On Track program</b>  Sepsis patients are fully integrated into the ROTP Pre-implementation Sepsis readmissions 21%. Post-implementation Sepsis readmissions 18%.	<b>FY 2019</b> <b>Reduced Sepsis Readmissions by 2%</b>  FY Q1-9% FY Q2-14% FY Q3-2%	<b>FY 2020</b> <b>Sepsis survivors will be offered enrollment in the Right On Track) program (ROTP).</b>  <b>ROTP will explore addition of social work and volunteer physician involvement for high risk acute care patients by December 2019</b>  <b>ROTP enrollees will increase by 5% as evidenced by increase in 5 patients for FY 2020</b>	Reduce Sepsis Readmissions to Newton Medical Center from 19% to 13% as reported by NMC Case Management
			Continue to reduce Sepsis Readmissions (FY19).				
	Reduce Barriers Enhance Skills and Provide Support	Manager of Case Management	Reduce Sepsis Readmissions (FY18).	<b>FY 2018</b> <b>Incorporate Sepsis focus into Transitional Care Task Force</b>  Sepsis patients are fully integrated into the Transitional Care task force Sepsis Readmission Rate: Pre-implementation 21% and Post-implementation 18%.	<b>FY 2019</b> <b>Reduced Sepsis Readmissions by 2% in FY19.</b>  FY Q1-9% FY Q2-14% FY Q3-2%	<b>FY 2020</b> <b>Optimize Sepsis Readmission reduction through Transitional Care by referring Sepsis patients to the following when appropriate: Home Health Right on Track program Wound Care Center</b>	
			Continue to reduce Sepsis Readmissions (FY19).				

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	
Prevent & Manage Chronic Disease	Enhance Skills and Provide Support	Diabetes Educator	Reduce overall Hemoglobin A1C (FY18)	<p><b>FY 2018</b>  <b>Focus Diabetes Education on reductions of hemoglobin A1C</b>            Average A1c 6.8% for 6 months post-program on patients who completed and had follow-up lab reported. Next bi-annual reporting period will be end of June, 2018.</p>	<p><b>FY 2019</b>  <b>Maintained average Hemoglobin A1C of 7.0 or below for patients participating in diabetes education program</b>            June 2018-Dec 2018-7.0%            Jan 2019-June 2019-to be available after June 30</p> <p>Diabetes- Patti Corning CDE spoke as part of the Lifetime Learning program at Bethel College on 4/10/2019. Patti and Evan Speer, NHS student) spoke to the Newton High School healthcare tract students on January 30, 2019 about Type 1 diabetes and the use of technology in the management of the disease. The Diabetes Support Group is offered on a monthly basis.</p> <p>NMC goal is to be collaborative with the YMCA on Diabetes care in Harvey County. Jennifer Speer, Case Management Director met with the YMCA pre-diabetic group to learn about potential referrals to that program for identified patients.</p>	<p><b>FY 2020</b>  <b>Maintain average Hemoglobin A1C of 7.0 or below for patients participating in diabetes education program</b></p> <p><b>Diabetic Educator will be available for at least two community presentations</b></p> <p><b>Diabetes Support Group will continue to be offered on a monthly basis</b></p>	Decrease average follow-up Hemoglobin A1C for patients who participate in our diabetes education program from 8.8% to 7.0% as reported by our Diabetes Educator
			Continue to monitor average follow-up Hemoglobin A1C levels for patients participating in NMC's Diabetes Education Program (FY19).				

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT	
		Resources & People			Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	By June 30, 2020
Prevent & Manage Chronic Disease	Increase Access	Chief Operating Officer	<p>NMC and YMCA to develop a medically-based partnership model (FY18).</p> <p>On-site and virtual tours of medically-based YMCA to understand: 1) What constitutes medically-based programming; 2) Role of a medical center and the role of the YMCA in delivering the programming; and 3) How best to execute and deliver it.</p>	<p><b>FY 2018</b> Investigate feasibility and existing models, pursue grant funding and develop a plan.</p> <p>Progress was made in understanding existing models. There are YMCA guidelines and a definition of what it means and what it takes of offer “medically-based” programming. This definition and these guidelines will form a basis for one element of a partnership model for the YMCA and NMC.</p>	<p><b>FY 2019</b> A leader from the Newton YMCA and a leader from NMC (or delegates) will conduct two site visits at medically-based YMCAs. An on-site visit to the YMCA located in Des Moines, IA to be completed by 12/31/18, and a virtual site visit via conference call with one other medically-based YMCA to be completed by 12/31/18. An analysis of findings is to be completed by 2/28/19 and a summary of findings with report of recommendations to be completed by 4/30/19.</p> <p>The new YMCA director comes from a YMCA that had partnered with a local hospital; he has first-hand knowledge and experience. Therefore, a virtual site tour will be replaced with conversations with the new Director on the topic of YMCA/Hospital collaboration. The revised action plan is as follows:</p> <ul style="list-style-type: none"> <li>• Discussion with YMCA Director completed by 6/30/19</li> <li>• Analysis of findings completed by 7/30/19</li> <li>• Summary of findings and recommendation report by 8/30/19</li> </ul>	<p><b>FY 2020</b> The Recommendations Report to be received by the end of August will achieve the goal of “How best to execute and deliver a medically-based partnership model”</p> <p><b>By June 2021 NMC will have achieved a portion of a medically-based partnership model</b></p>	<p>Increase the percentage of adults meeting the weekly physical activity recommendation from 17.1% to 19.1% as reported by the Kansas Behavioral Risk Factor Surveillance System.</p> <p>**6/11/18 Update from Healthy Harvey Coalition Coordinator: Re: Newton Bike Initiative changed to “Walk &amp; Roll Coalition” to address increasing physical activity and safety through bicycling and walking around the county. The Blue Cross Blue Shield Pathways to a Healthy Kansas grant is assisting in many areas of this health priority. A \$10,000 grant for Sand Creek Path extension at Centennial Park was received.</p> <p><b>*Decrease gaps in wellness Opportunities for those covered by our insurance from 58% to the Norm as reported by our third-party insurance administrator.</b></p>	

3.1

PRIORITY	STRATEGY	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	By June 30, 2020
Develop Viable Transportation Options for Health Needs	Change Physical Design	Provider Services Manager	Walking Path Expansion	<b>FY 2018</b> Investigate feasibility, pursue grant funding and develop a plan.  Met with city to discuss next steps ensure compliance with codes & regulations.	<b>FY 2019</b> Pursued grant funding to expand and improve the safety and appearance of Walking Paths.  Pathways grant will be coupled with a recent grant received by NMC's Dr. J. Koontz for exercise equipment along a walking path	<b>FY 2020</b> BCBS Pathways grant and an Exercise path grant received by Dr. Koontz will be combined to improve the pathways around NMC.  Implementation date set to occur before June 31, 2020 (corresponding with end of BCBS grant)	Increase the percentage of adults meeting the weekly physical activity recommendation from 17.1% to 19.1% as reported by the Kansas Behavioral Risk Factor Surveillance System.

3.2

PRIORITY	STRATEGY	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	By June 30, 2020
Develop Viable Transportation Options for Health Needs	Change Physical Design	Provider Services Manager	Improve the appearance of the walking paths to encourage use  Partner with Eagle Scouts to build nesting boxes for geese to improve path maintenance	<b>Investigate feasibility, pursue grant funding, and develop a plan</b>  Sourcing funding	<b>Pursued grant funding to expand and improve the safety and appearance of NMC walking paths.</b>  A walking path plan is in development utilizing grant funding.	<b>FY 2020</b> BCBS Pathways grant and an Exercise path grant received by Dr. Koontz will be combined to improve the pathways around NMC.	Increase the percentage of adults meeting the weekly physical activity recommendation from 17.1% to 19.1% as reported by the Kansas Behavioral Risk Factor Surveillance System.

PRIORITY	STRATEGY	INPUTS	ACTIVITIES	OUTPUTS			IMPACT
				Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	By June 30, 2020
Develop Viable Transportation Options for Health Needs	Change Physical Design	Provider Services Manager	NMC Farmland use to support patient therapies (FY18)	<p><b>Investigate feasibility, pursue grant funding, and develop a plan</b></p> <p>To be developed after walking path expansion is started.</p> <p>Provider Services Manager to sit on Food/Farm Council</p>	<p><b>Food Access</b></p> <p><b>Community Garden food plots:</b></p> <ul style="list-style-type: none"> <li>NMC food plot project delayed until 2019-2020 growing season for full implementation.</li> <li>Halstead Co-op (Bentley location-2 acres).</li> <li>Speer family has expanded their plot to 3 acres.</li> <li>Speer Family presented "Can one-acre and \$100 change the world," at "No-till of the Plains" annual meeting educating famers from all over the Midwest and Canada about how to incorporate no-till gardens into their cover crop rotations.</li> <li>Dr. Craig offered update that a fishing contest for youth is in the planning stage as the pond was stocked again Fall of 2018.</li> </ul> <p>Fishing dock and walkway must be constructed prior to planning of the fishing derby.</p>	<p><b>Goal for Food Access:</b></p> <p><b>A minimum of two plots will be planted with the purpose of donation to local food pantries</b></p> <p><b>Fishing from NMC pond delayed until 2020 due to lack of fish maturity. Fishing derby slated for <u>Spring 2020</u></b></p>	<p><b>Increase the percentage of adults meeting the weekly physical activity recommendation from 17.1% to 19.1% as reported by the Kansas Behavioral Risk Factor Surveillance System.</b></p>

PRIORITY	STRATEGIES	INPUTS	ACTIVITIES	OUTPUTS			IMPACT	
		Resources & People			Short-term (Year 1)	Intermediate (Year 2)	Long Term (Year 3)	By June 30, 2020
<p><b>Develop Viable Transportation Options for Health Needs</b></p>	<p><b>Enhance Access &amp; Reduce Barriers (New in FY19)</b></p>	<p>Manager of Case Management</p>	<p><b>Pursue a greater understanding of community partner role(s) in providing transportation for patients if not admitted to the hospital.</b></p> <p>Work towards developing collaborative agreements, as appropriate. Affordable, secure transportation for patients needing transferred for additional mental health services has been a significant challenge.</p>	<p><b>FY 2018</b>  <b>Affordable, secure transportation for patients</b></p> <p>Newton Medical Center has established a new contract with a non-emergent, secure transportation company to provide door-to-door transportation beginning 6/18/18 for patients needing transportation to and from health care appointments or hospital departments to ensure safe, secure, reliable medical transport for this patient population.</p>	<p><b>FY2019</b>  <b>Reduced costs of non-emergent, secure transportation for Newton Medical Center patients requiring transfer to another healthcare facility or provider by 10% in Fiscal year 2019.</b></p> <p>Newton Medical Center expanded cost effective transportation options for patients by working with local non-emergent transportation provider Simply Safe. Fee for the non-emergent trip demonstrated a 58% reduction in cost for the consumer.</p> <p>The Health Harvey Transportation Committee has received a county grant. The coordinator is in the process of recruiting and training drivers. NMC will pilot the program when they are ready for passengers. Goal start date is undetermined at this time.</p> <p><b>FY2019</b>                      The Newton Fire and EMS, Newton Police Department, Newton Medical Center, Newton Home Health and Prairie View are all integrated into the Para-medicine program with criteria established for screening with direct referrals to Prairie View.</p>	<p><b>FY 2020</b>  <b>To support ongoing success of the following :</b></p> <p><b>Maintain cost per ride reduction</b></p> <p><b>Harvey County Volunteer Transportation-program up and running and serve as a “pilot” site</b></p> <p><b>Newton Private Duty staff provides and will continue to provide transportation for their clients.</b></p> <p><b>FY 2020</b>  <b>The Para-medicine program is running effectively. Goal for Year 3 is to optimize this program and enhance collaboration with the new Chief of Fire and Emergency Management Services</b></p>	<p><b>**6/11/18 Update</b> by Health Harvey Coalition Coordinator: Robert Carlton of Harvey County Dept. on Aging and Toby Harkins, Health Department Assistant Director/ Director of Nursing, have held meetings with many stakeholders and are advancing to possible solutions with NMC being a first spot to pilot transportation options.</p>	

\*By measuring our insured population, we plan to see a reflection of any community-wide efforts.

## Thank You

This document was approved by the  
Newton Medical Center Board of Directors on June 27, 2019.

Questions and concerns about Newton Medical Center's Community Health Needs  
Assessment – Strategic Plan may be directed to the Department of Quality and  
Analytics via email to [Sondra.leatherman@newtonmed.com](mailto:Sondra.leatherman@newtonmed.com).



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