Guided by Faith, Committed to Excellence

Community Service Plan 2009

Prepared for the New York State Department of Health
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St. Elizabeth Medical Center

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I. Mission Statement

A. Mission Statement for St. Elizabeth Medical Center (SEMC)

St. Elizabeth Medical Center community, inspired by St. Francis of Assisi and faithful to the teachings of the Roman Catholic Church, is committed to excellence in healthcare and education. We pledge to do this with compassion and respect for the dignity of all.

B. Changes to the Mission Statement

None

II. Service Area

A. Hospital Service Area

St. Elizabeth Medical Center's primary service area includes all communities in Oneida and Herkimer counties. The population of this service area is approximately 293,790 people.

The secondary service area for the Medical Center includes the above primary service area plus Madison, Lewis and Otsego counties. The population of the secondary service area is approximately 451,694 people.

B. Description of Service Area

Methods used to determine the service area are analysis of patient origin, based on home zip code.

III. Public Participation

A. Participants

This 2009 Community Service Plan is based upon extensive assessments of the health status in Oneida and Herkimer counties. The assessments were created by the Health Departments of Oneida and Herkimer counties, the Oneida County Health Coalition, Herkimer County HealthNet and local

hospitals, with input from many other health and social service agencies, business leaders, clergy, educators and law enforcement officers. This plan identifies specific community health improvement actions in relationship to the State of New York Department of Health Prevention Agenda.

St. Elizabeth Medical Center (SEMC) was an active participant in both the Oneida County and Herkimer County community health assessments. At the request of organizations serving both counties, a Regional Health Summit was held in April 2009 to combine the findings of each county's health assessment and identify regional priorities. The following is a description of the public participation process in each county and the regional summit.

B. Outcomes

Oneida County Process

The Medical Center, along with other area hospitals, participated in the assessment process led by the Oneida County Health Department that used the MAPP (Mobilizing for Action through Planning and Partnerships) framework to conduct the majority of our Community Health Assessment (CHA) activities.

A community health assessment planning team of approximately 25-30 individuals was convened in January 2008 that consisted of the Steering Committee members of an existing community health partnership, the Oneida County Health Coalition, and additional key community stakeholders. This group is the MAPP Advisory Team (MAT). Several sub-committees were created to accomplish the assessment.

Visioning:

May & June 2008

- We asked the community, "What does a healthy Oneida County mean to you?" Visioning was also used to promote and kick off the overall CHA process. The community was invited to participate through news media, including television and print newspapers, at numerous forums.

Data Collection:

June – December 2008

- A comprehensive data and chart book was compiled.

Community Themes Assessment:

June – December 2008

- Focus Groups, HANYS Healthy Conversations, Community Survey. These meetings were publicized through press releases sent to all regional news media and held at sites including senior citizen centers and business leaders' meetings. Community surveys were available online and were distributed (and collected) at public events and in primary care office waiting rooms.

Forces of Change Assessment:

September 2008

- Over 140 diverse representatives from Herkimer, Madison, and Oneida counties attended this event to identify significant trends, factors and events that impact, or will impact, the region's health and public health system.

Oneida County Health Priorities:

January 2009 – April 2009

- On April 6, 2009, over 40 individuals participated in the priority-setting process for Oneida County by reviewing the data and collectively identifying the most significant issues for the county.

Herkimer County Process

In Herkimer County, the assessment was led by Herkimer County HealthNet, a rural network, which obtained a grant to support the County Health Department in completing the assessment. A method similar to the MAPP process was used. A Steering Committee was created to assure the significant input from a wide spectrum of health and non-health organizations. The Steering Committee began its work in September and by May 2009, more than 60 organizations had participated in a series of large and small group meetings.

A community kick-off/visioning meeting in November was followed by a series of outreach focus groups targeting seniors, providers and the public – with a special effort to reach out to the most distant community in the county, the Town of Webb. In March, a second community-wide meeting was held to review the data collected and opinions expressed at the focus groups. Participants used the framework of the NYSDOH Prevention Agenda to identify the health priorities for Herkimer County:

Regional Health Priorities:

April 2009

Since both Oneida and Herkimer counties have similar health issues addressed by organizations that serve both counties and because the United Way had undertaken an initiative to identify health investment areas for the Oneida-Herkimer Region, on April 24, 2009, both counties coordinated their priority-setting efforts. The purpose was to identify health priorities for the Region from the NYSDOH Prevention Agenda. Over 130 individuals participated in this event. This collaborative Regional Health Summit was sponsored and coordinated by representatives from the region's hospitals, LHDs, CHA Planning Teams and the United Way. This included the following organizations:

- St. Elizabeth Medical Center
- Herkimer County Health Department
- Herkimer County HealthNet
- Oneida County Health Coalition & MAPP Advisory Team
- Oneida County Health Department
- Faxton-St. Luke's Healthcare
- Rome Memorial Hospital
- United Way of the Valley and Greater Utica Area

At the conclusion of the meeting, actions and volunteers interested in each priority area were identified, collected and organized by the sponsors (Regional Planning Team).

IV. Assessment of Public Health Priorities

A. Criteria of Public Health Priorities

Criteria utilized to identify these as the highest priority items included: the percentage of the population directly affected by the issue; severity of the issue; and consequences of the issue. Since the community assessment process in both counties reached the same health priorities, the Regional Health Summit concentrated on identifying specific actions to address the priorities. People who attended the summit identified several strategies related to the priorities. They also indicated which priority/strategy they would be willing to work on with others in workgroups.

B. Selected Prevention Agenda Priorities

The Community Assessment processes in both Herkimer and Oneida counties identified the same items from the Prevention Agenda as the health priorities for their respective counties. They are:

- **Healthy Mothers, Healthy Babies, Healthy Children**
- **Mental Health and Substance Abuse**
- **Chronic Disease**
- **Access to Quality Healthcare**
- **Physical Fitness and Nutrition**

In a follow-up meeting, the hospitals (St. Elizabeth Medical Center, Faxton-St. Luke's Healthcare and Rome Memorial Hospital), the Oneida County Health Department and the Herkimer County Health Department agreed to focus their efforts and work with others regarding:

- **Mental Health and Substance Abuse – Specific action area: The lack of acute, emergency, especially community mental health services for adolescents.**

- **Healthy Mothers, Healthy Babies, Healthy Children – Specific action area: Complete the merger of the PCAP clinics operated by St. Elizabeth and Faxton-St. Luke's and enhance those services with the potential offering of community services, such as Medicaid Enrollment and WIC enrollment at the new site. This tactic would also include actions for increasing the Health Departments' role in prenatal and post-natal education.**

- **Chronic Disease – Specific Action: Since tobacco use is the basic cause of many chronic diseases, the hospitals and health departments agreed to expand on the smoking cessation efforts of Tri-County Quits.**

C. Status of Priorities

These action areas are the focus of the three-year action plans required by the NYSDOH for collaborative health improvement initiatives by the health departments and the hospitals. The first

priority above is one that requires a new community initiative. The other two priorities represent existing programs that will be supplemented with support from community partners.

The Health Summit Steering Committee will convene meetings to provide others the opportunity to work with the health departments and hospitals or to form additional groups to work on other issues and strategies identified at the Summit.

D. Non-Prevention Priorities Considered in Assessment Process

St. Elizabeth Medical Center employees help to meet the needs of the community in many ways, in and outside of the hospital. "Community Benefits" are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. St. Elizabeth Medical Center provides many outreach and community-based services to people in our community. Our Catholic tradition and Medical Center mission teach us to put the needs of the poor and vulnerable first. Therefore, the Medical Center has developed a Community Benefit Program to track and quantify these actions. Community benefit activities include charity care for people unable to afford services; health education, risk assessment and illness prevention; mentoring; and efforts to advance communities. Such actions are often developed in collaboration with community members and other organizations to improve health and quality of life.

In support of the Medical Center's mission, staff members at all levels of the organization donate time and services to communities across the region. While this has been ongoing since St. Elizabeth's founding in 1866, only during the past three years has the information been compiled. Records are still incomplete. However, we can report with certainty that in 2008, at least 179 Medical Center employees donated **1,552 hours**, interacting with **6,445 community attendees**. These hours translate into a value of **more than $58,784.**

V. Three-Year Plan of Action

A. Strategies for Selected Priorities

The five Public Health Priorities identified in Section 4 are existing issues that are taking on renewed focus. On June 24, 2009, representatives from Oneida County hospitals, the United Way of the Valley and Greater Utica Area, Oneida County Health Department, Herkimer County Health Department and

Herkimer County HealthNet met to discuss coordination of Health Summit workgroups and formation of a "Regional Health Coordinating Council" to meet on a quarterly basis.

Actions taken include a meeting on August 25, 2009 with representatives of the above organizations plus Catholic Charities, Oneida County Health Coalition, Kids Oneida, Medical Societies of Herkimer and Oneida Counties, Mohawk Valley Resource Center for Refugees, and Herkimer County Integrated Planning, members of the Oneida County Health Coalition Steering Committee/MAPP Team and Herkimer Community Health Assessment Steering Committee to form the Regional Health Coordinating Council. The Council's proposed purpose to date is to improve communication; coordinate Health Summit workgroups; problem-solve, communicate and report on successes and challenges. Currently, this focus is evolving.

Discussions will continue regarding these groups' future roles and the proposed integration of these organizations' representatives into one collaborative "Regional Health Coordinating Council" to organize and guide the priority area workgroups identified at the Regional Health Summit and to continue to enhance the way that we oversee and monitor the health status of our communities. The Council will reconvene in October 2009 to launch workgroups and release Community Health Assessments.

The top three selected priorities are discussed below and defined in terms of five points, numbered 1 to 5.

Priority 1 – Mental Health and Substance Abuse

1. As mentioned above, this priority is preexisting, but action is urgently needed for acute and community mental health services for adults, adolescents and children. The Oneida County Department of Mental Health (OCDMH) has created an Emergency Psychiatric Services System (EPSS) committee, which meets quarterly and includes representatives from all three Oneida County hospitals (St. Elizabeth, Faxton-St. Luke's and Rome Memorial), and the Mobile Crisis Assessment Team of the Neighborhood Center. Also included were representatives of local law enforcement and community mental health providers.

2. As the Oneida County Mobile Crisis Assessment Team (MCAT) ceased assessing adults in Emergency Departments as of August 1, 2009 and will no longer assess children there as of October 1, 2009, three EPSS Subcommittees are working on plans to improve mental health/substance abuse services to patients. Each collaborative committee is comprised of representatives of the above organizations. The committees

are a Utilization Review Subcommittee, a Transition Subcommittee and a Community Development Subcommittee.

The Utilization Review Subcommittee will identify and review all individuals who presented with a psychiatric disability at local EDs and determine, case-by-case, if the patient was appropriate for the ED, for MCAT involvement or for another response. It will also address individual and collective system obstacles and arrange case conferences. The Transition Subcommittee will convert MCAT's ED coverage to hospital staff by training in screening and assessment for adults and children. This will enable hospitals to develop resources and internal proficiencies to help meet these needs. It will also address systems obstacles, particularly the procuring of appropriate referrals to inpatient and outpatient resources. The Community Development Subcommittee will work to expand MCAT's expertise by adding peer advocates, agreeing upon new tasks and approaches, and enhancing partnerships with other community providers such as law enforcement and DSS protective services in order to achieve the most effective EPSS response for Oneida County residents.

In addition, there are two subcommittees specifically addressing children's needs: one for children without coexisting medical needs such as mental retardation or developmental disabilities, and one for dealing with the complex needs for children and their families. The hospitals and other partners are working with United Cerebral Palsy on a 1-3 year plan, as the team projects more needs for youth who have both mental health and medical conditions. An example is youth who are diagnosed with autism, which is an area projected to see large increases. More long-term planning is required to address needs of youth with multiple issues. Plans include addressing needs for respite beds, inpatient beds that can accommodate youth in both mental health and medical categories, and medication management on a timely basis.

Through a partnership between OCDMH, the City of Utica and Social Science Associates, a $1.2 million grant has been received to increase housing capacity and address the homelessness of people with mental illness and substance abuse issues.

3. The overall goals of the strategies are to recruit a pediatric psychiatrist to the area or develop a contract with a pediatric psychiatrist via telemedicine, so children and adolescents will receive timely, effective treatment. Another goal is to install computer programs and gain access for community partners to share information and input data on patients. OCDMH is researching grant funding for an Electronic Medical Record for this purpose. Another goal is to research NYS guidelines to learn if medications may be adjusted for patients with developmental disabilities or mental health problems.

4. Goals will be measured for effectiveness by:

- ♦ Increased numbers of community screenings, so patients do not go to the ED for inappropriate mental-health concerns
- ♦ Decreased numbers of ED visits and involuntary transfers of such patients
- ♦ Development of a medically managed detoxification program in the area. There are not many services in the region that provide services for heavy substance abusers.

5. Through the new Regional Health Coordinating Council (RHCC), the current three-year plan is:

2009-2010 – Workgroups in each of the identified priority areas will identify strong leaders, examine data and determine specific community needs and measurement tools.

2010-2011 – Members of the RHCC will allocate resources, both staff and financial, to address the priority issues and take action.

2011-2012 – Members of the RHCC will measure the actions for positive outcomes and determine next steps.

Priority 2 – Healthy Mothers, Healthy Babies, Healthy Children is an existing priority for both Oneida and Herkimer counties. Better access and coordination of care, especially for the under-served, is a high priority.

1. St. Elizabeth Medical Center and Faxton-St. Luke's Healthcare currently provide GYN and/or OB Care services through their individual hospitals. The coverage area faces several challenges including high rates for teen pregnancy, infant mortality, infant low birth weight and low percentage of births with prenatal care (as compared to the New York State average). There are more than 57,000 women of childbearing age within Oneida and Herkimer counties.

2. In April 2008, the hospitals collaborated to centralize the services at one site and provide a comprehensive, community-based program. The project involves renovations to the existing 1,810 square-foot OB Care Center located at the St. Luke's Campus of Faxton-St. Luke's Healthcare as well as adding a new addition of 3,860 square feet. The new center, projected to be complete in 2010, will have 10 exam rooms, 2 procedure rooms, 2 stress rooms and additional space to accommodate the services of the St. Elizabeth Family Practice Residency Program, which will help support the staffing needs of the center. Estimated project cost (2008) is $1.6 million. The organizations applied for and received a $1.6 million grant from the HEAL NY Phase 7 awards in September 2008. Plans are being finalized now for

renovation and construction, with the first phase beginning in late 2009 and completion anticipated by summer 2010.

Annually, the two OB services see approximately 13,000 OB visits that are Medicaid insured patients as well as 1,300 GYN services. Deliveries for the community are at The Birthplace of Faxton-St. Luke's Healthcare, which sees about 2,200 deliveries on an annual basis, 825 of which are patients from the OB Care Centers.

3. The overall goals for the initiative include:

- Coordinate and centralize OB care services for uninsured/underserved high-risk women
- Streamline OB/GYN services in one community-based care center
- Alleviate current obstetrician shortage at Faxton-St. Luke's Healthcare by sharing physician services
- Increase efficacy of treatment by using Family Practice residents to assist in providing treatment
- Remove perceived barriers to accessing prenatal care services
- Research future program growth to include projects such as "Right Start." This project is an intense, case-management model that incorporates best practices to decrease low birth weight infants and decrease risk factors associated with the population serviced, all within an economical model.

4. The measurements of success include collaboration with Oneida and Herkimer counties to assess the maternal and child health status indicators beginning in 2010 and beyond, as well as creating a system that removes barriers for early entry into prenatal care.

Barriers include convenient appointment times, shorter wait times, transportation issues, a One-Stop Shopping concept for laboratory and radiology services, financial counseling, nutritional services, social work, smoking cessation and the opportunity for supporting County agencies to be available during the prenatal visits.

Health Status Indicators
The following table illustrates the maternal and child health status indicators for Oneida and Herkimer Counties, the primary service area of the current OB/GYN clinics:

Indicator	*Oneida County*	*Herkimer County*	*NY State*	*HP2010 Goal**	*Significance*
Teen (15-19) Pregnancy Rate	64.5	40.1	60.7	N/A	The Teen Pregnancy Rate is significantly higher for Oneida County.
Teen Birth Rate - % of births to teens (10-17 years)	3.2	3.4	2.3	N/A	The Teen Birth Rate for Oneida & Herkimer counties is significantly higher than the NY State Rate. Providing comprehensive pre-natal care services to this population is critical.
Infant Mortality: • Infant (<1 year) • Neonatal (<28 days)	 7.8 5.3	 8.2** 7.7**	 5.9 4.2	 4.5 2.9	The Infant Mortality Rate is higher in both Oneida and Herkimer counties in comparison to the NY State rate.
Low Birth Weight (<2.5 Kg)	8.9	6.7	8.1	5	The Low Birth Weight is higher in Oneida County than the NY State rate.
Prenatal Care: • % births with early prenatal care • % adequate prenatal care	 71.7 64.9	 73.0 64.9	 75.1 62.9	 90 90	The % of births receiving early prenatal care is lower than the NY State rate, indicating Oneida & Herkimer counties need to continue to educate women regarding the importance of prenatal care; and provide the access to adequate prenatal services.
Maternal Mortality – rate per 100,000 births	13.0**	96.5**	18.7	3.3	Unstable data due to low number of events – less than 20.
Pre-Mature Births - % <37 weeks gestation	12.9	11.1	11.9	7.6	The % of pre-mature births is higher in Oneida County than the NY State rate.
Child Mortality – Post neonatal (1 month to 1 year)	2.5**	0.5**	1.8	1.5	Unstable data due to low number of events – less than 20.

(Source: Vital Statistics 2005; NYS Family Planning/Natality Indicator 2003-2005)
**: HP2010 – Healthy People 2010*
***: Fewer than 20 events in the numerator; therefore the rate is unstable*

5. St. Elizabeth Medical Center and Faxton-St. Luke's Healthcare will be working with the DOH of Oneida and Herkimer counties to further develop the model. A community health meeting scheduled for October 2009 will begin the process. Collaborating agencies also include Catholic Charities, Mohawk Valley Perinatal Network, MV Community Action/Head Start, Planned Parenthood Mohawk/Hudson, WIC of Herkimer and Madison Counties, and the Utica School District.

2009-2010 OB Care program renovation/ is in progress with expanded work groups, in addition to the hospitals, participating in the October 2009 Health Summit.

2010-2011 Completion of the OB Care Center at the St. Luke's Campus of Faxton-St. Luke's Healthcare and full consolidation of services. Members of the Healthy Mothers, Babies and Children work group will develop priorities, assess resources and take action to develop a comprehensive approach to serving the identified population.

2011- 2012 Members of the team will continue to measure actions for positive outcomes and determine next steps.

Priority 3 – Chronic Disease Management - Smoking/Tobacco Cessation
Program: Tri-County Tobacco Cessation Center at the Regional Cancer Center

1. Tobacco Cessation is an existing priority for the region. The regional program currently in place is the Tri-County Tobacco Cessation Center at the Regional Cancer Center of Faxton-St. Luke's Healthcare. This program is funded by the New York State Department of Health Tobacco Control Program (TCP). It is a component of a comprehensive state-wide approach to "reduce morbidity and mortality and alleviate the social and economic burden caused by tobacco use in New York State" (TCP Strategic Plan).

The program is active in Oneida, Herkimer and Madison counties. Participating partners are St. Elizabeth Medical Center, Faxton-St. Luke's Healthcare, Mohawk Valley Heart Institute, Oneida Healthcare, Rome Memorial Hospital, Little Falls Hospital, Community Memorial Hospital, Slocum-Dickson Medical Group, PLLC and BRiDGES.

2. and 3. Strategies, Catchment Area and Effectiveness
Dependence on tobacco displays many features of a chronic disease and approaches to treating tobacco dependence should reflect the chronicity of tobacco dependence (Fiore et al. Treating Tobacco Use and Dependence Clinical Practice Guideline: 2008 Update).

Using evidence-based methodologies, the Cessation Center incorporates the following goals and strategies (based on the TCP Strategic Plan):

- Increase the number of healthcare organizations and providers that effectively implement the Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence.

- Advance tobacco-free policies and provisions of tobacco dependence treatment in all healthcare settings, including hospitals and physician practices, substance abuse treatment facilities, mental health treatment and support settings, adult care facilities and HIV care settings.
- Support employer provision and promotion of tobacco dependence treatment for employees and adoption of tobacco-free campuses.
- Increase the number of public and private health insurance plans that provide comprehensive, lifetime coverage of tobacco dependence treatment.
- Expand and sustain efforts to promote the New York State Smokers' Quitline website.

The Tobacco Cessation Center at the Regional Cancer Center of Faxton-St. Luke's Healthcare encompasses a catchment area of Oneida, Herkimer and Madison Counties. These counties represent several demographic challenges in treating tobacco use and dependence. The areas classified as cities range in population size from 3,000 to 60,000. The general population is scattered among many small towns and villages, some located as far away as 60 miles from the nearest city or hospital. Access to services, including Primary Care Providers (PCP) in some areas is limited. Gaps in care can be directly related to access issues: for example, a patient who lives in Northern Herkimer County, may have access to a PCP, but might be required to travel 50 or more miles to receive treatment for lung cancer.

Other demographics, such as attained educational levels, language and cultural diversity, and economic levels, provide additional challenges within the catchment area. For example: the City of Utica is home to the fourth largest refugee center in the United States; many of these recent refugees and their families encounter language, literacy, cultural, and economic barriers in accessing care.

The following table illustrates tobacco use in the three counties of the catchment area.

Demographic	Oneida County (2006 data)	Herkimer County (2006 data)	Madison County (2006 data)
Current use of tobacco products	26.9%	25.8%	26.7%
% of cigarette use (among all tobacco users)	22.8%	24.0%	22.7%
% using cigarettes and other tobacco (among all tobacco users)	4.1%	1.8%	4.0%
% of smokers ready to quit now or in the future	47.5%	61.7%	43.7%

% of smokers who have heard of the New York State Smokers' Quitline	50.1%	54.4%	55.7%
% of smokers advised to quit by healthcare provider	59.7%	64.4%	58.5%

The following table provides representative demographic information for Oneida, Herkimer and Madison counties that may affect tobacco use rates:

Demographic	Oneida County	Herkimer County	Madison County
Geographic area	1,213 sq. miles	1,458 sq. miles	662 sq. miles
Geographic area make-up	Cities: 3 -Utica: pop. 60,651 -Rome: pop. 34,950 -Sherrill: pop. 3,147 Towns: 26 Villages: 19	Cities: 1 -Little Falls: pop. 5,188 Towns: 19 Villages: 10	Cities: 1 -Oneida: pop. 10,987 Towns: 9 Villages: 12
Total population	233,954	64,427	69,441
Educational Attainment: (ages 25 and above) Total population age 25 and above: -less than 9th grade -9th – 12th grade, no diploma -HS graduate -Some college, no degree -College graduate: minimum 2 yr.	158,650 8,816 15,606 54,293 28,623 51,312	43,455 2,354 6,605 15,391 7,614 11,491	43,762 1,781 5,510 14,519 7,780 14,172
Citizenship: Native born Foreign born US non-citizen	220,319 13,635 7,446	63,130 1,297 359	67,883 1,558 678
Language spoken at home: -English -Other than English	89% over age 5 11% over age 5	95 % over age 5 5% over age 5	95% over age 5 5% over age 5
Income -Median Household Income -% of individuals below poverty level	40,466 14.8%	32,924 12.5%	40,184 9.8%

Medicaid eligible individuals	49,481 (21%)	14,265 (22%)	11,259 (16%)
Medicare eligible individuals (%)	15.8%	16.0%	12.9%

Current Level of Tobacco Dependence Treatment within the Catchment Area

The Tobacco Cessation Center at the Regional Cancer Center, established in 2004, has worked intensively with local Health Care Provider Organizations (HCPOs) and Primary Care Providers (PCP) during the last five years. In accordance with the New York State Department of Health Tobacco Control Program, Strategic Plan goal of "Promoting Cessation from Tobacco Use," the Cessation Center has established working relationships with 80 PCP organizations/offices and all six hospitals within the catchment area.

Sixty-eight percent of the PCP organizations and 100% of the hospitals have established a sustained systems change that incorporates treating tobacco use and dependence into their standard of care (including revision of documentation systems).

4. Local Cessation Services/Effectiveness of Program

Success of the program is measured through the success of individual facilities and community education and compliance. The Cessation Center has facilitated a well-established collaboration among local HCPOs to offer intensive intervention community smoking cessation classes at seven different locations within the tri-county region. It is the role of the Cessation Center to establish participation agreements, provide baseline training to class facilitators, facilitate the creation of the tri-annual cessation class calendar, mail calendars to local HCPOs and PCPs, collect and analyze outcomes data, and administer stipends to organizations that host the classes.

These classes have demonstrated 6-month quit rates of 20-35% and 12-month quit rates of 20-30% over time. Local healthcare providers appreciate having a local resource for cessation for their patients to enhance the services available through the Quitline. In addition, much of the hospital staff responsible for providing brief cessation interventions, as well as PCP office staff, have participated in trainings on treating tobacco use and dependence, making them available as individual, local cessation resources.

The Cessation Center has established a comprehensive employee and student cessation protocol that includes the distribution on Nicotine Replacement Therapy (NRT) to individuals whose insurance does

not cover NRT. This program combines counseling, pharmacotherapy and support for employees and students at participating organizations.

5. Examples of Previous Experience in Changing Systems and Quality Improvement Initiatives

Oneida Healthcare Center is a small hospital, located in Oneida, New York, Madison County. Madison County experiences significant barriers in tobacco control related to a local casino, gas stations and convenience stores that operate under a sovereign territory agreement; providing ready access to county residents to low-priced cigarettes, not subject to state taxes. The hospital admitted approximately 3,900 patients last year. With the support and technical assistance of the Cessation Center, Oneida Healthcare Center has developed and implemented a sustainable systems change for treating tobacco use and dependence in their inpatient population that consistently meets established benchmarks. It is currently assessing its policy, with the intent of revising it to include use of the Fax-to-Quit process for follow up upon patient discharge. Additionally, Oneida Healthcare Center has established a tobacco-free facility policy, a comprehensive employee cessation program, and enhanced insurance coverage for employees for tobacco cessation benefits.

St. Elizabeth Medical Center Family Residency Program (Hobart Street Clinic) is located within the city of Utica, serving an economic and culturally diverse patient population. The clinic provides interpreter services in 33 languages to a population representative of recent refugees who are, in general, facing challenges such as language barriers, low literacy, illiteracy, transient living situations, and low socio-economic status. Implementing a multi-year plan, the clinic has fully implemented the Public Health Service Guideline, as evidenced by the following:

- Provides ongoing education to attending physician and family practice resident staff on treating tobacco use and dependence
- Institutionalized a systems change that incorporates the five A's into the medical record
- Provides language and literacy appropriate patient education materials
- Offers on-site, individual counseling for patients ready to quit
- Offers free Nicotine Replacement Therapy, with on-site distribution, to patients with barriers to access
- Collects and analyzes data for quality improvement purposes (meets established benchmarks)
- Has a documented 20% decrease in tobacco use rates over 7 quarters.

The Tri-County Tobacco Cessation Center has received an additional 3-year grant from the NYSDOH. The grant is funded and reviewed annually. Members from the Tri-County team participate in the Regional Health Care summits and will be part of the Chronic Disease Team that will meet in October 2009.

The final five pages of this document summarize more specific actions identified at the 4/24/09 Regional Health Summit that are planned for each Selected Priority, including
Priority 4 – Access to Quality Healthcare and
Priority 5 – Physical Fitness and Nutrition.

VI. Financial Aid Program

A. Successes and Challenges

The Mission of St. Elizabeth Medical Center is to care for all who request healthcare services, especially the poor.

Our Patient Information Guide includes telephone numbers for the patient to call regarding the various programs that are available to assist the patient with paying his or her account. Our Patient Statements contain a message alerting the patient of our Discount Policies. For those patients who are truly unable to pay, the Medical Center offers the Mother Bernardine Charity Care Program. Enrollment in this program is based only upon the prior year's earnings and no consideration is given for assets owned by the patient. The application is updated annually and is based on current Federal Poverty Level Guidelines with the high end of eligible income being 220% of the aforementioned Federal Poverty Level.

The Medical Center employs three In-House Patient Account Specialists, as well as a fourth Specialist who works specifically with the Women and Children's Health Center and Medical Group sites, as needed. The Patient Account Specialists focus on Inpatient and Emergency Department accounts while the patient is still in the hospital. The goal is to determine the patient's eligibility for state insurance coverage and to obtain coverage, if applicable. During the Pre-registration process, accounts that are self pay are automatically forwarded to the Patient Account Specialists, who also assist patients in applying for Unemployment Insurance, Disability Insurance and Social Security. These staff members also work closely with Discharge Planners and the area's nursing homes and outpatient rehabilitation

centers. Additionally, the Mohawk Valley Perinatal Network staff members are on site two days a week and the Medical Center staff works closely with them to obtain insurance coverage for the patient.

The increased numbers in our aged population have presented many challenges related to the collection of patient account balances. Coupled with an increase in the out-of-pocket deductible/coinsurance balances on regular commercial carrier accounts, this has caused us to develop alternative opportunities for repayment.

All self-pay Inpatient and Outpatient accounts have their balances significantly reduced at the time of billing. Extensions for repayment are commonly given for all such accounts.

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

A. Potential Impacts

The Medical Center's Strategic Plan is aligned with the needs of the community, particularly the need to access services. Healthcare is seeing a shift from inpatient to outpatient services. The Medical Center's goal is to expand its outpatient services: urgent care, outpatient rehabilitation, x-ray, primary care and wound care.

Healthcare is continuously changing and St. Elizabeth Medical Center is addressing access to services in the following ways:

1. Inpatient: through a new, state-of-the-art Orthopedic Unit (2009) and Catheterization Lab (2008), meeting the community need for orthopedic and cardiac services.
2. Outpatient: expansion of services at a new building in New Hartford, which will include primary care, rehabilitation, laboratory and imaging services. Also, a new wound care center is being built, which will include hyperbaric chambers for optimum healing; and a new urgent care center.
3. Covering the uninsured: over 26,000 uninsured residents are in Oneida County. SEMC is working to ensure that all of our citizens have health coverage, especially the poor and vulnerable.

VIII. Dissemination of the Report to the Public

B. Public Information

Staff members of the St. Elizabeth Department of Marketing, Public Relations and Government Affairs (MPGA) and other Medical Center departments make the Community Service Plan (CSP) and the SEMC Annual Report available to the public upon request. Press releases about the reports and about St. Elizabeth's community services and events are provided to the news media, and posted throughout the year on the St. Elizabeth website (www.stemc.org). The MPGA also posts the Community Service Plan and the Medical Center's Annual Report there.

In addition, the CSP or the SEMC Annual Report, which includes a summary of the CSP information, are available at waiting rooms in the hospital and at offices of St. Elizabeth Medical Group; and are distributed to members of the Medical Center's Board of Trustees, the Foundation's Board of Trustees and the Mohawk Valley Heart Institute Board.

The Community Service Plan and St. Elizabeth Medical Center's Annual Report are also available at the St. Elizabeth Department of Marketing, Public Relations and Government Affairs. St. Elizabeth welcomes public comment and input. Contact the Department (315-798-8195; marketing@stemc.org), St. Elizabeth Medical Center, 2209 Genesee St., Utica, NY 13501.

REGIONAL HEALTH SUMMIT (4/24/09)
IDENTIFIED ACTIONS FOR PREVENTION AGENDA PRIORITY AREAS

ACCESS TO HEALTHCARE

- Provider shortage
- Provider recruitment

Actions:
- Tap federal and state funds (grants)
- Research Federally Qualified Health Centers
- Need to offer a work/life balance to providers
- Loan forgiveness/assistance for new providers (NPs/PAs)

Decrease, divert use of high cost consumption (i.e., ER):
- Training for first responders
- Expanding supports and follow up plan
- Recreate SAFE, supervised services of inpatient care in homes/community.

- Provider shortage
- Key indicator –healthcare workforce shortage
- Transportation
- Cost
- Lack of availability of services
- Communication to those in need (information and coordination)

Actions:
- Coordination of resources for two counties with providers
- Concentration on MDs and Dentists
- Look at expanding Telemedicine
- Increase technology and EMR for young MD recruitment
- Community education re: shortage
- Identify providers/services (i.e., mental health/substance abuse listing for public info, single point).Gathering, updating, and disseminating this information once completed.
- Need for central coordination
- ED diversion and need for other options (preventive care)

Transportation:
- Community Transportation Service (i.e., Old Forge, Herkimer Co.)– coordinate bus runs near services.(counties assist)
- O-H Transportation Committee
- Insurance acceptance of providers
- Pursue grants/funding for programs
- Volunteer coordination with current programs and expansion of those.
- Vets programs

Provider Access:
- Specialists – area-wide
- Primary care – rural
- Malpractice/litigation environment in NYS
- Collaborative Recruitment (with facilities/community)
- DANY '"restrictions"
- UNY PR Reps

Electronic Medical Records (EMR):
- Funding-Stimulus package
- Technology – connectivity with other databases (i.e., DOH, Immunizations, Offices, Hospitals)

Actions:

Transportation:
- Research/identify funding/"volunteers"
- Coordination of Herkimer County Program (Ray Schoebarlyen @ 369-3550, Fred Trimbach @ 369-2444. C.T.S. (Community Transportation Service)
- Join local groups that may currently address this
- Involve companies with bus availability in project, if willing.
- Neutral facilitator to "identify" and bring together local programs.

Provider Access:
- Review all facilities and physician groups Medical Staff Plans.
- Collaboratively include rural areas without facilities (primary and secondary service areas)
- Current providers involvement in process necessary – how?

Electronic Medical Records (EMR):
- Investigate funding (Medical Society – Kathy Dyman, Hospitals, and SUNY IT – Gary Scherzer)
- Provider interest
- Connectivity with current databases
- Local communities involved – municipalities interest

		▪ Local consumer interest

<table>
<tr><th colspan="3">PHYSICAL ACTIVITY AND NUTRITION</th></tr>
<tr>
<td>▪ Education
✓ Outreach with existing facility
✓ Community incentive programs
✓ Parents as exercise partners
▪ Building on existing programs
✓ Schools
✓ Rec. programs
▪ Culture
▪ Insurance incentives for physical activity
Actions:
▪ Social marketing message: “Get Moving – Get Healthy” campaign. Universal message throughout the community.
▪ Education – promote physical activities with common message community-wide.
▪ Identify what the community has available
▪ Create an access point: where to go, what to do.
▪ Incentives – employers encouraging health and wellness, insurance reductions, programs to promote in school and workplace.
▪ Partners - schools, businesses, healthcare provider, service agencies, farmers, and faith community
▪ Community nutrition– community gardens/cooking classes, more access to farmer’s markets. (identify obstacles: weather, access, transportation, safety, time for health programs)
▪ Farmers- Developing partnerships, buy and grow locally
▪ Share purchase on local farms to get fresh produce.
▪ Community Food Banks- access to fresh produce
▪ Refine public assistance in re: Nutrition and what types of foods are acceptable. Require</td>
<td>Actions:
▪ Community wide moving program. Target: workplaces, families (children), schools, senior centers, youth programs (boy scouts/girl scouts, etc.)
▪ Utilize programs already available – make people aware of them (Boilermaker, Rayhill Trail, Bria Trail, Heart Run/Walks)
▪ Developing trail systems
▪ Sidewalks
▪ Winter programs
▪ Safe places
▪ Low cost
▪ Invite people into the program – means or way to encourage participation – ease of use for all people.
▪ Recruit a community of volunteers around the “community-wide theme” (tap youth/college volunteer base)
▪ Challenge community “Biggest Loser Campaign”
▪ Parks/Recreation open house in our communities
▪ Measure BMI
▪ Theme movements (Move for Life, Scavenger hunts – put clues in local newspaper- them hunts, game contests, team programs)
▪ Web sites – information
▪ Equipment exchange (bikes, balls, gloves, tennis racquets, etc.) for people who can’t afford them.
▪ Grants – Apply, apply, apply together as a community.
▪ Take advantage of college PR programs to promote
▪ Need a “house-organization” to take ownership</td>
<td>Actions:
▪ Collaborative community initiative
▪ Partnering community programs/orgs with local schools to increase awareness and involvement in physical activity.
▪ Physical activity incentive programs
▪ Goal-oriented, measurable(UW)
▪ Mapping distances of pathways
▪ Community organizations would provide the resources so as not to burden schools
▪ Incentive to schools: recognition/PR
▪ Connecting with professionals willing to share expertise with school children (karate instructor, physical therapists, Double Dutch Team, etc.)
▪ Homework assignments related to physical activity.
▪ Increase awareness and participation in WIC.
▪ Increase number of organizations that “screen” (ask and refer to WIC).</td>
</tr>
</table>

certification – nutritional programs		

CHRONIC DISEASE

Actions

- Smoking/Tobacco, Obesity
- Education of services available
  - ✓ Public health
  - ✓ Schools/Teachers
  - ✓ Wellness policies – enforcement
  - ✓ Churches
- Develop inventory of all Services – Evidence based programs (Directory, OCHC website)
  - ✓ Promote programs
  - ✓ Measure by access to programs (attendance)
  - ✓ Collaborate/combine as needed
  - ✓ Referral system for providers – resources
- Get buy-in from primary care providers
  - ✓ Recruiting professionals – work with access portion
  - ✓ Develop links to share records (Electronic Medical Records)
- Focus to be on providers – Med school, HS. Public Health
  - ✓ Sharing of services
  - ✓ Sponsor a center of excellence to publicize education programs
- Link behaviors with outcomes – incentives
- Identify gaps in programs – consolidate

Who?

- Oneida County Health Coalition
- Health Departments
- Medical Societies
- Hospitals
- Colleges
- Civic Groups – Chamber

How?

- Survey providers
- Groups providing services
- MAPP participants
- Survey Monkey

Telemedicine – Better tech. programs

MENTAL HEALTH

- Diagnosis early
- De-stigmatize
- Child and Family Clinic Plus
- Parents/Headstart
- Substance abuse
  - ✓ Diagnosis early

Strategies:

- Head Start
- Get into home
- View agencies as resource
- Trust schools
- School-based
  - ✓ Substance abuse
  - ✓ Emotional wellness
- De-stigmatization of Mental Illness/Substance abuse
- Greater collaboration non-threatening
- Common approach
- Regional best practices
- Strengthening families
- Legislation – Clinic Plus

<table>
<tr><th colspan="2">HEALTHY MOTHERS/ BABIES/CHILDREN</th></tr>
<tr><td>
Action:
▪ Comprehensive OB Care Program
Fact:
▪ FSLH-SEMC Combining their OB Care Clinics with HEAL Grant
Concept:
▪ Consider expanding the functionality to provide as much "one-stop" shopping as possible
Functionalities:
▪ Short-term Child Care/Friendly
▪ WIC Services
▪ Nutritional Education (w/healthy meals/snacks)
▪ Facilitated enrollment for variety of services
▪ Outreach services provided by multiple agencies
▪ Identify barriers (gov't – regulatory)
▪ Focus groups with patients
</td><td>
▪ Early Prenatal Care
▪ Teen Pregnancy

▪ Increase pre-conception education (schools, parent education)
▪ Education
✓ Mentoring for both females and males,
✓ global views,
✓ parent education,
✓ realities of parenthood,
✓ life skills,
✓ self-esteem,
✓ empowerment programs
✓ colleges(providing options)
✓ state education mandate

Actions:
▪ Compile data and research-based evidence on teen pregnancy prevention programs – educate schools, government, community agencies – develop action plan
▪ Pre-conception media campaign/blitz
▪ Education

Who(?):
▪ March of Dimes
▪ Perinatal Network
▪ PCAP
▪ OCHD
▪ Healthy Families (OC & HC)
▪ Schools (K-12)
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