



2008 Community Service Plan

Submitted September 15, 2009 by: Faxton-St. Luke's Healthcare



Faxton-St. Luke's Healthcare

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1656 Champlin Avenue, Utica, NY 13502 • (315)624-6000 • www.faxtonstlukes.com



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**Community Service Plan
Faxton-St. Luke's Healthcare
Utica, New York**

Submitted: September 15, 2009

Introduction:

Faxton-St. Luke's Healthcare (FSLH) is pleased to present its 2008 Community Service Plan based on 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.

It is not the intent of this Community Service Plan to duplicate the data, community input, and detailed description of the processes that are contained in both the Oneida County and Herkimer County Community Health Assessments. That information is available on the county web sites or by contacting the county health departments.

SECTION 1: FAXTON-ST. LUKE'S HEALTHCARE MISSION STATEMENT

To provide the highest quality health care in our region.

SECTION 2: FSLH GEOGRAPHIC SERVICE AREA:

FSLH's primary and secondary service areas, as based on a zip code analysis of patient origin, includes all communities, except the most distant western towns, in Oneida County and all but the most south eastern towns, in Herkimer County. The population of this service area is approximately 287,371 people.

For selected specialties, such as dialysis and cancer care, FSLH is recognized as a tertiary center serving parts of Madison, Lewis, Fulton, Hamilton, and Montgomery counties. The population of the tertiary market is approximately 365,000 people.

SECTION 3: PUBLIC PARTICIPATION

FSLH 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.

Oneida County Process

FSLH, along with other area hospitals, participated in the assessment process led by the Oneida County Health Department which 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 consists 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.

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

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 are or will impact the region's health and public health system.

Oneida County Health Priorities:

January 2009 – April 2009

- On April 6, 2009 more than 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 Processes

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, which included FSLH, was created to provide 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 '08 was followed by a series of out reach 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

- Due to the fact that Oneida and Herkimer counties have similar health issues addressed by organizations which serve both counties and because the United Way had recently undertaken an initiative to identify health investment areas for the Oneida-Herkimer Region, on April 24, 2009 both counties coordinated their priority setting efforts to identify the health priorities for the Region from the NYSDOH Prevention Agenda. More than 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 agencies:
 - Faxton-St. Luke's Healthcare
 - Herkimer County Health Department
 - Herkimer County HealthNet
 - Oneida County Health Coalition & MAPP Advisory Team
 - Oneida County Health Department
 - St. Elizabeth Medical Center
 - Rome Memorial Hospital
 - United Way of the Valley and Greater Utica Area
 - Mohawk Valley Perinatal Network
- At the conclusion of the meeting actions plans were developed and volunteers interested in each priority area were identified, collected and organized by the sponsors (Regional Planning Team).

SECTION 4: COMMUNITY HEALTH PRIORTIES

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**
- **Access to Quality Healthcare**
- **Chronic Disease**
- **Physical Fitness and Nutrition**

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. The people who attended the summit identified several tactics related to the priorities. They also indicated which priority/tactic they would be willing to work on with others. (See attachment: 1. Health Summit Priorities Action Items)

Action areas for the hospital community service plans.

In a follow-up meeting, the hospitals (FSLH, St. Elizabeth Medical Center, 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 consolidation of the PCAP clinics operated by FSLH and St. Elizabeth 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 area – Tobacco use is a significant factor/contributor to many chronic diseases. The hospitals and health departments collaborate with the smoking cessation efforts of Tri-County Smoking Cessation Center.**

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

The Health Summit Steering Committee will convene a meeting(s) to provide others the opportunity to work with the health departments and hospitals or to form additional groups to work on other issues and tactics identified at the Summit. The next Summit will take place in October 2009 and be coordinated by the Departments of Health for Oneida and Herkimer.

SECTION 5: 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, 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 the formation of a "Regional Health Coordinating Council" that could meet on a quarterly basis.

Actions taken include a meeting 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 on August 25, 2009 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 future roles of the groups 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 and 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.

Each selected priority will be discussed below.

Mental Health and Substance Abuse – 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), the Mobile Crisis Assessment Team of the Neighborhood Center. Also included were representatives of local law enforcement and community mental health providers.

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 proficiency to help meet these needs. It will also address systems obstacles particularly 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.

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
- ◆ Hospital representatives meeting with Upstate Cerebral Palsy (UCP), Oneida County and OCDMH in 1 to 3 years, for UCP and other sites for mentally challenged people who live in community residences
- ◆ 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.

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.

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.

Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center 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.

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.

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 which incorporates best practices to decrease low birth weight infants, decrease risk factors associated with the population service, all within an economical model.

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, and 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:

<i>Indicator</i>	<i>Oneida County</i>	<i>Herkimer County</i>	<i>NY State</i>	<i>HP2010 Goal*</i>	<i>Significance</i>
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 2003-2003)

*: HP2010 – Healthy People 2010

** : Fewer than 20 events in the numerator; therefore the rate is unstable

Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center 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.

Chronic Disease Management - includes the Smoking/Tobacco Cessation Program administered by the Tri-County Tobacco Cessation Center located at the Regional Cancer Center of Faxton-St. Luke's Healthcare.

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 Faxton-St. Luke's Healthcare, St. Elizabeth Medical Center, Mohawk Valley Heart Institute, Oneida Healthcare, Rome Memorial Hospital, Little Falls Hospital, Community Memorial Hospital, Slocum Dickson Medical Group, PLLC and BRiDGES.

Strategies, Catchment Areas and Effectiveness

Tobacco dependence 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 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 provision 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 are 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 health care 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:	158,650	43,455	43,762
-less than 9 th grade	8,816	2,354	1,781
-9 th – 12 th grade, no diploma	15,606	6,605	5,510
-HS graduate	54,293	15,391	14,519
-Some college, no degree	28,623	7,614	7,780
-College graduate: minimum 2 yr.	51,312	11,491	14,172
Citizenship:			
Native born	220,319	63,130	67,883
Foreign born	13,635	1,297	1,558
US non-citizen	7,446	359	678
Language spoken at home:			
-English	89% over age 5	95 % over age 5	95% over age 5
-Other than English	11% over age 5	5% over age 5	5% over age 5
Income			
-Median Household Income	40,466	32,924	40,184
-% of individuals below poverty level	14.8%	12.5%	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 Areas

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).

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 health care 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.

Examples of Previous Experience in Changing Systems and Quality Improvement Initiatives

Oneida Healthcare Center is a hospital, located in Oneida, New York, part of Madison County. Madison County experiences significant barriers in tobacco control, related to the casino, gas stations and convenience stores that operate under a sovereign territory agreement; proving ready access to county residents to low price cigarettes, not subject to state taxes. The hospital admitted approximately 3900 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. They are currently assessing their policy, with the intent of revising their policy 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 pages of this document summarize more specific actions identified at the Regional Health Summit on 4/24/09. Expansion and assignment of the additional priorities will be evaluated at the October 2009 Healthcare Summit. The other selected priorities include **Access to Quality Healthcare and Physical Fitness and Nutrition.**

SECTION 6: FINANCIAL AID PROGRAM

During the past year we have noticed an increasing trend of our aging population on Medicare without a supplemental plan, who cannot afford to pay the deductible/co-insurance balances. In most cases, they do not qualify for Charity Care or Medicaid. We are now offering a twelve-month interest free payment plan on balances greater than \$500 and a six-month plan for balances under \$500.

We currently have a Medicaid advocate, who meets with the self pay inpatients, while they are in house or makes an appointment to meet with them at their home to assist them in the application, attachments, and meeting with the County to seek assistance.

Due to the increasing self pay population, we have increased the number of up front financial counselors. We have purchased a software tool called Rev Runner, which will assist the counselors in determining propensity to pay. This will assist the patients in making the right choice for their financial needs whether it is affordable insurance, bank loan, interest free loan, or charity care write-off.

Through HANYS and our Relationship-Based Care initiative, we have changed our statements to a more patient friendly statement.

Our Public Relations Department has created a pamphlet for our patients that describes all of our payment options including contact numbers. This pamphlet is located in all of our waiting rooms and physician's offices and is available on the hospital website.

SECTION 7: CHANGES IMPACTING COMMUNITY HEALTH/PROVISION OF CHARITY CARE/ACCESS TO SERVICES

With a growing number of uninsured and under-insured patients the organization monitors the trends in bad debt and charity care.

2007	Charity Care	\$1,758,000	
	Bad Debt	\$7,132,309	
2008	Charity Care	\$1,724,000	
	Bad Debt	\$9,026,867	
2009	(YTD through July 2009)		Projected
	Charity Care	\$ 865,032	Annualized: \$1,482,912

Bad Debt

\$5,402,866

\$ 9,262,056

The increase in bad debt has a negative impact in the overall health of the organization and is a trend most hospitals in the country are watching and adjusting for.

FSLH is always reviewing opportunities for collaboration and consolidation. The planned consolidation of the OB Care Services (combining the PCAP services of Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center) at one location will help provide better access to care as well as support the need for additional medical staff. We received a \$1.6 million grant for the HEAL 7 initiative and anticipate construction and full consolidation to be complete in the summer of 2010.

Other collaborative efforts include the continuation of the Mohawk Valley Heart Institute. This heart surgery and rehabilitation program is a combined effort of Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center. It provides the only heart surgery program in the area ensuring access for a two county area and supports keeping our patients close to home and family.

Physician recruitment continues to be challenging for both our area and throughout New York State. Right now our organization is lacking in a number of physician specialties and that list will continue to grow in the next five years as a large number of physicians retire. New York State is less attractive than other states due to high regulation, taxes and lack of growth in the Upstate region. Physicians are looking for settings with group practices or hospital employment and for a better quality of life. They want limited or no call responsibilities, and greater access to clinical and information technology. New York State government plays a significant role in creating a better, more economical environment for physician recruitment. Continued work with our legislators is imperative for all of New York State healthcare.

SECTION 8: DISSEMINATION OF THE REPORT TO THE PUBLIC

The Community Service plan is shared with the public through our web site www.faxtonstlukes.com as well as with our community partners including the Department of Health for both Oneida and Herkimer counties, St. Elizabeth Medical Center and Rome Memorial Hospital.

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

PHYSICAL ACTIVITY AND NUTRITION

- 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 communitywide.
- 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 certification – nutritional programs

Actions:

- Community wide moving program. Target: workplaces, families (children), schools, senior centers, youth programs (boy scouts/girl scouts, etc.)
- Utilize programs already available –n 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 them" (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

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).

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

HEALTHY MOTHERS/ BABIES/CHILDREN

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

- 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)

The 2009 Community Service Plan is a publication of Faxton-St. Luke's Healthcare, Utica, New York and submitted to the New York State Department of Health by Tuesday, September 15, 2009.

Scott H. Perra, FACHE
President/CEO

Faxton-St. Luke's Healthcare
Main Campus
1656 Champlin Avenue
Utica, New York 13502

(315) 624-6000
www.faxtonstlukes.com

For additional copies of the report contact:

Debra Altdoerffer, VP
Communications and Marketing
Daltdoer@mvnhealth.com