Community Service Plan Update
Rome Memorial Hospital, Rome, NY
Submitted: 9-15-2012

This third update of the 2009-2012 Community Service Plan reflects Rome Memorial Hospital’s efforts to achieve New York State’s Prevention Agenda goals through collaboration with community partners including the Health Departments of Oneida and Herkimer counties, Oneida County Health Coalition, Herkimer County HealthNet, local hospitals (St. Elizabeth Medical Center and Faxton St. Luke’s Healthcare), and many other community agencies.

It is not the intent of the 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.

RMH, along with other area hospitals, participated in the community health assessment process led by the Oneida County Health Department, as a member of the county’s MAPP (Mobilizing for Action through Planning and Partnerships) Advisory Team (MAT) and the Oneida County Health Coalition Steering and Sub-Committees.

Though the MAT’s role ended with the completion of the assessment, the community partners involved in the Oneida County Health Coalition (OCHC) continue to meet to develop and implement strategies to address the community health priorities.

As a hospital, RMH is uniquely positioned to provide insight to barriers observed in the daily delivery of care, support educational initiatives for patients and providers, assist in the recruitment of providers to improve access to care, and facilitate enrollment in free and low-cost health insurance programs. RMH uses the data gathered through the community health assessment
process to address the community’s needs by adapting its own resources and/or joining partners with common goals.

Mission, Vision & Values Statements

- Mission: We provide quality healthcare with compassion.
- Vision: Exceptional people delivering exceptional care for a healthier community.
- Values: We commit to accountability, respect, integrity, innovation and excellence always.

Rome Memorial Hospital’s mission, vision and values statements were last revised as part of the development of its 2011-2013 strategic plan.

Hospital Service Area

RMH is located in Oneida County. The hospital’s primary service area includes Rome and the surrounding rural communities of Camden, Taberg, Lee Center, Blossvale, Boonville, Verona, Ava, Holland Patent, Westernville, West Leyden, Vernon, Cleveland, Durhamville, Forestport, Constableville, Oriskany, Port Leyden, Westmoreland, Stittsville, Barneveld, Westdale, Lyons Falls, and Williamstown. The population of the primary market is approximately 100,000 people.

For selected specialties, such as senior behavioral health care, RMH’s service area extends into the surrounding counties of Madison, Herkimer, Lewis and Onondaga counties.

No changes to the primary service area were made since the submission of the last Community Service Plan update in September 2011.

Identification of Public Health Priorities

Based upon the Community Health Assessment process, five areas from the state’s Prevention Agenda were identified as the top health priorities in Oneida, as well as nearby Herkimer county. They are:

- Physical Activity and Nutrition
- Access to Quality Health Care
- Healthy Mothers, Healthy Babies, Healthy Children
• **Chronic Disease**

• **Mental Health and Substance Abuse**

Although the hospitals (Rome Memorial Hospital, St. Elizabeth Medical Center and Faxton St. Luke’s Healthcare) initially agreed to focus their collaborative efforts with the health department and key stakeholders in three areas (Healthy Mothers, Healthy Babies, Healthy Children; Mental Health and Substance Abuse; and Chronic Disease), hospital representatives participated in all five sub-committees.

**Prevention Agenda Updates**

The Oneida County Health Coalition Steering Committee was the primary body overseeing progress of the work groups tasked with advancing the public health priorities identified in the 2010-2013 Oneida County Community Health Assessment. Representatives included the Oneida County Health Department, the county’s three hospitals, the federally qualified health center in Utica, Kids Oneida, Medical Societies of Herkimer and Oneida Counties, Mohawk Valley Resource Center for Refugees, and Herkimer County Integrated Planning. Although the committee’s meetings are less frequent and some of the workgroups are now dormant, the hospitals in Oneida County continue to work with their community partners in support of the identified state prevention agenda priorities.

An update on the progress of the work groups is discussed below, along with RMH’s specific initiatives that support the state’s prevention agenda.

**Physical Activity & Nutrition**

**Goal:**
To promote regular physical activity and healthy eating to reduce the poor health outcomes and large healthcare costs associated with obesity.

**Measures:**
Four measures were identified in the Oneida County 2010-2013 Community Health Assessment to assess the success of strategies implemented through community partnerships
and efforts of individual organizations that share the same goal to promote regular physical activity and healthy eating.

The four measures include:

- Decrease the percentage of obese pre-school children (2–4 year olds) enrolled in WIC from 14.7% to 11.6% or less by 2013.
- Decrease the percentage of adults who are obese (BMI>30) from 23.7% to 15% or less by 2013.
- Increase the percentage of adults eating five or more fruits or vegetables per day from 28.6% to 33% by 2013.
- Increase percentage of adults engaged in some type of leisure-time, physical activity from 76.6% to 80% or higher by 2013.

These long-range measures will be updated in the county’s 2014-2017 Community Health Assessment. Short-term measures include the completion of deliverables, such as the development of the Get Moving! handbook and pilot wellness program.

**Update:**

After completing its Get Moving! initiative, The Regional Health Council of Herkimer and Oneida Counties has been dormant. With representation from public health, hospitals and community agencies, the Regional Health Council of Herkimer and Oneida Counties developed and disseminated an evidence-based practice guide for physical activity and nutritional interventions that have the potential to reduce the morbidity and mortality associated with obesity. With a focus on a la carte interventions, the handbook was distributed in September 2010 to regional partners as a resource for schools, communities and workplaces. Each of the interventions includes references to model programs and implementation tips for success.

Authored by a master of public health graduate student, the guide was funded by the Healthy Communities Grant from the NYS Department of Health through the Oneida County Department of Health with substantial support by Herkimer County Healthnet and the
participation of the Herkimer County Public Health and the United Way of the Valley and Greater Utica Area.


The council’s primary initiative for 2011 was the development of the *Get Moving!* Employee Wellness Pilot Program for Oneida and Herkimer county employees. Through the generosity of program sponsors, participants received a complimentary three-month gym membership, health and wellness informational materials, coaching sessions, as well as pre- and post-assessment screenings for body mass index (BMI), weight, blood pressure, waist circumference, Hemoglobin A1c Diabetes Test Information (HBA1C), cholesterol, and triglyceride levels. All testing, coaching and gym memberships were donated by the program sponsors, which included Faxton-St. Luke’s Healthcare, Herkimer County HealthNet, Rome Memorial Hospital, Oneida and Herkimer counties and their health departments, as well as Function Better Fitness centers.

A total of 73 employees from Oneida & Herkimer counties started the Get Moving Program by participating in a pre-assessment. With the exception of HBA1C and Triglycerides, the averages of all pre-assessment findings were outside of the normal (healthy) range. The intensive program achieved measurable short-term results, as demonstrated by the post-assessment measures.

In Oneida County, 77% of participants completed the program. Of the 44 participants completing the program:

- 32 or 73% reduced their BMI;
- 29 or 66% reduced their waist circumference;
- 30 or 68% lost weight; and
- 24 or 55% improved laboratory results.
In Herkimer County, 38% of participants completed the program. Of the 6 participants completing the program:

- 4 or 67% reduced their BMI;
- 4 or 67% reduced their waist circumference;
- 5 or 83% lost weight; and
- 5 or 83% improved laboratory results.

Although the program demonstrated short-term results, it was not feasible to continue or expand the pilot program to other employers due to lack of sustainable funding.

Recognizing that investing in employee wellness starts at home, RMH, FSLHC, and SEMC have achieved recognition by the American Heart Association as Fit-Friendly Worksites for going above and beyond when it comes to their employees’ health.

Some of RMH’s employee wellness activities include: Weight Watchers at work; “take the stairs” campaign; 8-week couch to 5K running program; smoking cessation support; Wednesday Walks, free flu shots, and healthy food options in the cafeteria. In addition, the RMH has entered discussions for an agreement with the local YMCA to develop a relationship to enhance wellness programs for hospital employees and patients of RMH-owned physician practices.

**Access to Quality Care**

**Goal:**
To address barriers, such as affordability and availability, that can prevent individuals from accessing quality healthcare services to achieve the best possible health outcomes.

**Measures:**
Nine measures were identified in the Oneida County 2010-2013 Community Health Assessment to assess the success of strategies implemented through community partnerships and efforts of individual organizations that share the same goal to promote access to quality care. The nine measures include:
Increase the percentage of adults with health care coverage from 84.3% to 100% by 2013.

Increase the percentage of adults with a regular health care provider from 86.8% to 96% or higher by 2013.

Increase the percentage of births with early prenatal care from the 3rd quartile to the 4th quartile (Q4) or better by 2013.

Increase the percentage of early stage diagnosis of breast cancer from 68% to 80.0% or higher by 2013.

Increase the percentage of early stage diagnosis of colorectal cancer from 42% to 50.0% or higher by 2013.

Increase the percentage of adults who have seen a dentist in the past year from 70.3% to 83% or higher by 2013.

Decrease the percentage of all 3rd grade children with untreated caries (cavities) from 38.2% to 21.0% or lower by 2013.

Increase the percentage of all 3rd grade children with at least one dental visit in the last year from 75.2% to 83.0% or higher by 2013.

Increase the percentage of all 3rd grade children with dental insurance from 77.5% to 100.0% by 2013.

These long-range measures will be updated in the county’s 2014-2017 Community Health Assessment. The priority for the county’s three hospitals is recruiting physicians to improve access to care. Unless this basic need is addressed, eliminating other access barriers can’t be fully effective. As Rome Memorial Hospital doesn’t have a dental program, its initiatives are limited to addressing the first five measures.

Update:
While not identified as a core component of Oneida County’s hospitals’ 2009 action plans, the Access to Quality Care initiative had a collaborative team of area agencies working to reduce emergency room usage for primary non-emergent purposes via a public education campaign. The committee conducted a survey of urgent care centers to determine hours of operation and investigated existing public education materials.
Although the access committee established by the Oneida County Health Coalition was dormant in 2011, the Medical Societies of Monroe, Herkimer and Oneida counties, the Finger Lakes Health Systems Agency (FLHSA), and Excellus BlueCross BlueShield launched an educational campaign urging people to call their physician first for non-urgent issues to reduce avoidable visits to the emergency room. The campaign urged patients to use an urgent care site when a medical issue doesn't require an emergency room visit, or if they can't get in to see their regular physician. There are three urgent care facilities in the Utica/New Hartford area and one in Rome.

Expansion of urgent care services is one of the top priorities identified by Rome area residents during a recent gap analysis of healthcare services. Although RMH’s application for a HEAL-NY grant was not approved to construct an addition to house an urgent care on site, the hospital is continuing to investigate other options to fund the project. The urgent care facility would provide a less costly alternative for patients who don’t have a physician or who are unable to get an appointment with their own physician.

**Physician Recruitment**

In the Mohawk Valley, one of the major barriers of reducing non-emergent emergency room visits and improving the overall health of the community is the shortage of primary care providers. The healthcare delivery system in New York is undergoing rapid transformation, driven in part by the state’s Medicaid Redesign Plan, the anticipated implementation of federal health reform initiatives, and the aging of the physician population. As more people have access to health insurance, demand for primary care and specialty services is expected to increase dramatically. An analysis by the Association of American Medical Colleges is projecting that the gap between supply and demand will grow to 62,900 physicians by 2015, more than doubling to 130,600 by 2025.

According to a study by the Center for Health Workforce Studies School of Public Health, University at Albany (CHWS), the ratio of primary care physicians to the population was lowest in the Mohawk Valley region, with 71 full-time equivalent physicians per 100,000 population, compared to the state average of 94. In addition, the Mohawk Valley experienced the least amount of growth in PCPs between 2005 and 2009, only 4% compared to the state
average of 7%. With similar statistics for specialty physicians, the region has the lowest ratio of total physicians in the state, with 175 FTE physicians per 100,000 population, compared to the state average of 307.

The Mohawk Valley region’s shortage of physicians will be exacerbated by the aging of the physician population. According to CHWS, 16% of the region’s physicians across all specialties are older than 65. Another 31% are age 55 to 64, compared to the state average of 25% for this age cohort. Replacing the physicians who will be retiring over the next several years will take a significant investment of time and resources to ensure our community’s access to even the most fundamental medical care.

Recruiting physicians to the Mohawk Valley is complicated by the national physician shortage. It’s challenging to compete against communities that promise warmer weather, a better call schedule, higher reimbursements and lower malpractice insurance. In a larger community, doctors have more time to spend with their family if they share night and weekend call responsibilities with a group of 20 doctors instead of only three or four. In addition, the region has a large population of residents who depend upon Medicaid, which pays physicians poorly for their services. Physicians are attracted to communities with a higher percentage of privately insured residents where they have greater earning potential.

According to a Merritt Hawkins survey of final-year residents, only six percent of respondents are interested in practicing in a community with a population less than 50,000 people (the size of Rome) with only another 10% willing to consider a city the size of Utica (less than 100,000 people). The vast majority, 84%, want to locate in communities with more than 100,000 people.

Strategies that the hospitals have used with some success to recruit physicians to the Mohawk Valley include:

- Employing physicians. Sixty-three percent of Merritt Hawkins’ search assignments in 2011/12 featured hospital employment of the physician, up from 56 percent the previous year and only 11 percent eight years ago. The hospitals bear all the risks and the costs of
establishing the practice, which typically operates at a loss. Hospitals further bear the on-
going risks posed by the threat of declining reimbursement to physicians as NYS and the Federal government deal with the growth of Medicaid and Medicare spending on healthcare services. Although the cost of living is lower in the Mohawk Valley, physicians expect to earn the same compensation that they would receive anywhere else in the country.

In Rome, RMH has recruited two family practitioners, a pediatrician, neurologist, general surgeon, and an orthopedic surgeon to serve the community through employment agreements since 2011. In addition, a group of urologists was brought to the community through a contractual service agreement.

- Joint recruitment efforts. St. Elizabeth Medical Center (SEMC) and Faxton St. Luke’s Healthcare (FSLH) examine and assess the number of physicians in the community, including specialists, and identify community need together. The Utica hospitals are exploring options for establishing a closer affiliation, which is expected to enhance physician recruitment efforts.

- Expanding the use of retained search firms. In late 2011, RMH entered into an exclusive recruitment contract with Merritt Hawkins to assist in its recruitment of primary care physicians for its Article 28 clinic and its affiliated primary care practice.

- Leveraging local residency programs. In 2010, the St. Elizabeth Family Medicine Residency program was awarded a $1.92 million grant from the United States Department of Health and Human Services Health Resources and Services Administration (HRSA) to train an additional 10 family medicine residents over the five-year grant period. About 50% of graduates remain in the local community to practice medicine.

**Facilitated Enrollment**

Participating in facilitated enrollment efforts is another way the county’s hospitals are trying to address access barriers. With patient consent, the hospitals refer patients to facilitated enrollers to help them assemble the documents that they need to apply for low-cost or free health insurance. RMH has shared its referral form with its primary care and specialty
physician practices to increase the number of patients enrolled in affordable insurance options and promoted these options at its annual health fair.

**Free Screenings**
The county’s hospitals continue to provide free screenings to promote early detection of disease. Some of these programs include:

- RMH’s partnership with several agencies to provide screenings and health information at its annual health fair. The health fair featured blood tests for total cholesterol and glucose, as well as screenings for children’s speech development, posture, colorectal cancer, blood pressure, sleep apnea, depression, dementia, and vision, lead testing for children and pneumonia immunizations for adults. More than 200 people attended the health fair held in May 2011. The 2012 health fair is scheduled in the month of September. RMH also offers free colorectal cancer screenings in March and prostate specific antigen tests in September. In 2012, the hospital screened 485 people in Rome, Boonville and Camden for colorectal cancer. In 2011, 150 free PSAs were provided.

- FSLHC’s Give Kids A Smile, a one-day event where dentists, dental staff and community volunteers donate their time to provide free dental care to children who do not have a dentist. The event provided participating children with preventative treatment such as exams, cleanings, sealants and fluoride varnish.

- SEMC’s participation in the First Annual Central Oneida County Volunteer Ambulance Corps (COCVAC) Community Health & Safety Expo, held at North Star Orchards in Westmoreland. COCVAC hosted the Expo in partnership with North Star Orchards on September 17, 2011. St. Elizabeth Medical Center provided two educational booths on outpatient services and Mohawk Valley Heart Institute (MVHI). Three registered nurses from St. Elizabeth Medical Group in Clinton also answered questions and provided free blood pressure screenings.
Looking Ahead

Recruiting primary care physicians and key specialists to the Mohawk Valley and retaining them will continue to be the major priority to improve access to healthcare services. In addition to traditional recruitment and development strategies, the hospitals will continue to explore telemedicine and physician extender opportunities to address shortage areas that are difficult to fill.

Healthy Mother, Health Babies, Healthy Children

Goal:

To promote positive health outcomes early in pregnancy and early in a newborn’s life to improve the quality of life throughout the course of life.

Measures:

Ten measures were identified in the Oneida County 2010-2013 Community Health Assessment to assess the success of strategies implemented through community partnerships and efforts of individual organizations that share the same goal to improve maternal and child health outcomes. The 10 measures include:

- Reduce the pregnancy rate for 10-14 year olds from the 4th quartile (Q4) to the 3rd quartile (Q3) or lower by 2013. Q4: 1.4 per 1,000; Q3: 0.8 - 1.4.
- Decrease the percent of low birth weight births (<2.5 kg) from the 4th quartile (Q4) to the 3rd quartile (Q3) or lower by 2013. Q4: 8.7%; Q3: 7.5% - < 8.2%.
- Increase the percent of births with early prenatal care from the 4th quartile (Q4) to the 3rd Quartile (Q3) or lower by 2013. Q4: 70.4%; Q3: 76.65% - < 80.6%
- Decrease the infant mortality (< 1 year) rate from the 4th quartile (Q4) to the 3rd Quartile (Q3) or lower by 2013. Q4: 7.0 per 1,000; Q3: 5.5 - 6.9.
- Increase the percent of WIC mothers still breastfeeding at 6 months from 19% to 50.0% or higher by 2013.
- Decrease the rate of gonorrhea from 58.2 per 100,000 to 19.0 per 100,000 by 2013.
- Decrease the percent of indicated reports of child abuse and from 36.0% to 27.0% or lower by 2013.
Decrease the incidence rate among children <72 months of age with a confirmed blood lead levels>=10μg/dl from 4.9 per 100 to 0 per 100 by 2013.

- Decrease the prevalence of tooth decay in 3rd grade children to 42.0% or lower from 59.0% to 42.0% by 2013.
- Decrease the percent of annual high school drop outs (students enrolled in grades 9-12) from 2.4% (2007-2008) to 2.0% by 2013.

These long-range measures will be assessed in the next update of the county’s Community Health Assessment. Rome Memorial Hospital has participated in initiatives supporting the first five measures. Short-term measures include the completion of deliverables, such as the development of the Teenage Pregnancy Prevention Network and workshop, and tracking specific indicators at the hospital/clinic level for breastfeeding and smoking cessation.

**Update:**
The two primary initiatives for the Healthy Mother, Healthy Babies, Healthy Children priority area included:

1. Reducing teenage pregnancy and
2. Increasing numbers of pregnant women seeking care during 1st trimester.

**Reducing Teenage Pregnancy**
The Mohawk Valley Perinatal Network (MVPN) and Planned Parenthood established a Teenage Pregnancy Prevention Network that includes community partners Faxton St. Luke’s Healthcare (FSLH), St. Elizabeth Medical Center (SEMC), Rome Memorial Hospital (RMH), CareNet and Herkimer/Oneida County Planning.

In March 2011, the group hosted a teen pregnancy workshop for school nurses, teachers and community agencies on the topic of teen health, including teenage pregnancy and sexuality. The workshop was presented to 94 participants.
Sixty-seven evaluations were completed by school personnel and agencies. The information was assessed. Broader-reaching communication vehicles for students on the topic of teen pregnancy and prevention are in development. New programs include a Teen Support Group offered through Planned Parenthood and MVPN (active in September 2011) and a Facebook page www.facebook.com/ImInTheKnow. Information has also been made available for a variety of publications that teens access and the Teen Pregnancy Workshop has been made an annual program.

**Increasing Numbers of Pregnant Women Seeking Care During First Trimester**

Led by the Mohawk Valley Perinatal Network (MVPN), the Maternal-Child Health workgroup addresses priority areas of low birth weight, preterm birth, and early entry to prenatal care, which are common problems in our community.

In April 2011, the MVPN Consortium participated in the review of an assessment of Maternal Child Health Care Needs in the Mohawk Valley. Kara Williams presented on behalf of the Community Health Foundation of Western and Central New York, which commissioned the assessment.

The assessment identified limited postpartum services and the lack of a standardized assessment of needs as significant gaps in care. Barriers in transportation, cultural variations and a limited supply of qualified professionals were also contributing factors.

Of those interviewed as part of the assessment, 80 percent had received care during their first trimester, indicating progress in the goal to start prenatal services early. However, unemployment, varying levels of family support and unaddressed mental health issues following birth signal that postpartum services need to be simultaneously addressed for continued prenatal success.

In 2012, MVPN in partnership with Oneida and Herkimer County Health Departments, Bassett Healthcare, FSLH, RMH and SEMC, began promoting a telephone hotline number and outreach program of prenatal services for pregnant women who are Medicaid recipients. The outreach program team provides resources at each site to help enroll pregnant women
for insurance, WIC benefits, link them to a provider for prenatal care and follow up care for up to one year after the baby’s birth. The program is part of the New York State Growing Up Healthy initiative.

RMH has been a safety net for prenatal and obstetric services since 1986, when the state authorized the hospital to open its Prenatal Care Services (PCS) program because of the lack of providers accepting Medicaid patients and the uninsured. Although the program operates with an annual loss of approximately $200,000, it is essential to the residents of Rome and the surrounding rural communities. In 2011, more than 40% of the 638 babies delivered at RMH were born to mothers who were PCS patients. Incremental progress has been made in ensuring that women receive early prenatal care. In 2011, only 57% of PCS patients started prenatal care in the first trimester, compared to 65% through the first half of 2012.

Because pregnant women who smoke cigarettes are nearly twice as likely to have a low-birth-weight baby as women who do not smoke, providing ongoing smoking cessation support is a key initiative of the PCS. The providers proactively address smoking during routine prenatal visits, linking women who smoke with available cessation support. All patients are assessed for tobacco use and 100 percent of identified smokers receive cessation counseling.

At the PCS, approximately 1 out of 5 pregnancies is considered high or very high risk, with the balance classified as moderate risk. The risk is compounded when patients don’t keep their scheduled prenatal appointments or go for needed diagnostic testing. Based upon a review of 2008 to 2010 data, visit compliance for prenatal care appointments was approximately 80%. Incremental progress was made in 2011 with a visit compliance of 83%.

In 2013, RMH plans to implement the Centering Healthcare Institute’s CenteringPregnancy program at its PCS to further improve visit compliance and enhance birth outcomes. Funded by a $50,000 grant from the Health Foundation for Western and Central New York, the CenteringPregnancy model brings women out of the exam room into a group setting where they receive basic prenatal checkups, build community with other women, and gain
knowledge and skills in pregnancy, childbirth and parenting. Healthcare providers facilitate
groups of 8-12 women of similar gestational ages. Instead of short visits alone with a
provider, CenteringPregnancy features ten 120-minute sessions.

Because of the positive impact that breastfeeding has on the health of the mother and her
newborn, RMH has lactation counselors on staff to provide breastfeeding education at the
PCS and postpartum support in the Maternity Department. RMH’s existing outreach and
educational programs also support the state’s initiative. Specifically, these programs
include:

• The Maternity Department’s Weigh Station to provide mothers who are breastfeeding
  added support and ensure that babies are gaining weight at a healthy level.
• Babycare Basics and Breastfeeding Education programs for new parents to help them
  acquire the necessary skills for taking care of a newborn.
• In 2012, RMH supported the Mohawk Valley Breastfeeding Network’s new
  “Breastfeeding Café” in Rome to provide pregnant and breastfeeding moms a place to
  support one another, socialize and get breastfeeding clinical support if needed. The
  group meets twice a month at the Trinity Church, 215 W. Court St. in Rome.

The number of mothers who choose to breastfeed their children has been increasing
incrementally from 66.2 percent in 2010 to 68.2 percent in 2011. As of July 2012, the
number had climbed to 69.5%.

In 2011, FSLH received funding from the United Way of the Valley and Greater Utica Area
to develop a Patient Navigation program in its OB Care Center (OBCC). The program,
which began in September, is funded at $70,000 a year for two years. Estimated expense of
the program is $92,000 annually. FSLH funds the difference between the grant and the
actual cost.

The OBCC refers high-risk women to the Patient Navigation program based on a risk
screening tool completed for each patient. Two part-time staff members (a nurse and a
health educator) fill the role of patient navigator. The nurse is a FSLH employee and the
health educator is employed by MVPN.
The annual goal of the program is to each year enroll up to 40 high risk women who are identified through the OBCC. In the past eleven months, 28 women have been referred to and participate in the Patient Navigator program. Each patient visit may vary from every two weeks to once a month, depending on the risk of the pregnancy and the baby’s gestational age.

Both staff members meet with women at the OBCC to make meetings more convenient for patients. The nurse may also accompany patients to ancillary visits while helping them to advocate for themselves.

The nurse encourages the women to ask their provider questions to increase communication between providers and their patients. This relationship building helps to improve patient compliance, therefore improving birth outcome. While the program has been piloted in the Syracuse area, no other Patient Navigation program currently exists in the Mohawk Valley.

FSLH is the birth center for the Utica area with 2,110 births in 2011. Of those births, approximately 50 percent were born to mothers who are patients of the OBCC. In that same year, the OBCC had 722 patients with 7,413 patient encounters. All new patients to the OBCC or those referred through MVPN are screened for the program. Particularly high-risk women are those with previous pre-term or low birth weight infants, teens, those with co-morbidities such as high blood pressure and chronic stress (domestic violence, homelessness, substance abuse, no or poor emotional or financial support).

The program helps to raise awareness and knowledge of preconception/interconception health among high-risk women, reduce stress levels among high-risk, pregnant women and reduce rates of very preterm birth (before 32 weeks).

**Laborist Model Implemented at FSLH for OB Care Center Patients**

Beginning in 2011, FSLH launched its OB/GYN Hospitalist program, frequently referred to as a “Laborist” program. The program provides care to women followed in the FSLH OBCC and assists private practice OB/GYN physicians whenever needed.
Three full-time and three part-time, board-certified OB/GYN physicians and one certified nurse midwife/nurse practitioner staff the program. The annualized cost of providing the program is $1.67 million, with expected revenue of only $500,000. The Laborists provide 24-7 coverage of the Labor and Delivery Unit.

**Area of Concern Regarding County Support of High Risk Mother and Babies**

The Maternal/Child Nursing program (MCH) of Oneida County plays a vital role in the health and wellness of our most underserved and vulnerable community, mothers and newborns. FSLH and RMH work collaboratively with the MCH team, which includes the Community Health Workers (CHW). This partnership supports improved health for mothers and newborns. FSLH and RMH work with the MCH team through the OBCC, PCS and through referrals identified by the teams in Labor and Delivery, Nursery and Post Partum.

The MCH is at risk of no longer being funded by Oneida County. Oneida County continues to operate the program while looking for a community agency to take over the current MCH responsibilities. To date, no agency has stepped forward to take over the current service.

To eliminate the program or reduce funding would have a devastating impact on the community health and place an additional burden of care on FSLH and RMH. Listed are some of the benefits that the MCH program currently brings to the community and to our Maternity/OBCC/PCS patients:

**Oneida County Community Health Workers (CHW):**

- See high-risk maternity patients, many of which are teenagers, whose medical conditions include gestational diabetes, heart disease. Many of these patients are economically disadvantaged individuals with socioeconomic, emotional and/or psychiatric issues.

- Provide for diabetic patients, teaching them about the disease, encouraging them to do blood glucose monitoring and insulin administration. CHWs coordinate with clinics such as the OBCC/PCS, MCH nurses and physicians if blood sugars are not controlled.
The MCH/CHW team supports women with pregnancy-induced hypertension, encouraging continued MCH nursing to monitor blood pressure checks, teach about the disease and help with diet and exercise. They also make early assessments of anything that is abnormal and alert providers. These patients are considered high risk and if something goes wrong or they are not monitored, they can progress very quickly to having seizures, which could result in complications and possible loss of the baby.

• CHWs support and help typically noncompliant patients (patients who don’t show up regularly for appointments or adhere to their medical plans of care). They can help provide transportation, refer patients to social workers and other resources to help patients get needed supplies and medications.

• If patients are unable to keep their appointments with the OBCC/PCS, nurses who are part of the MCH/CHW team can perform assessments including vital signs and fetal heart rate checks.

• In premature infants, the ability to provide consistent evaluations and direct patients to needed services such as speech, hearing and early intervention play a role in the overall health of the newborn and prevents further complications.

• They follow up with high-risk patients after the babies are delivered and discharged home.

• Much of the social information used to support the patients at the OBCC/PCS comes from the maternal/child nurses in our community. They are valuable and trusted resources who know the people and the community.

• MCH/CHW team provides ante partum and postpartum teaching.

• They work closely with refugees and immigrants to ensure they begin prenatal care and continue with care throughout gestation and after delivery.
• Provide continuation of correct and accurate information from OB providers to home via patient and family members.

• CHW are in patients’ homes, so they are able to recognize environmental and social issues and provide support and resources based on what they observe.

• They can make referrals for housing safety issues to make sure apartments/homes are in compliance with safety standards such as lead compliance, heat, screens in windows, etc.

• CHWs provide referrals to Head Start and Early Intervention.

The health and wellbeing of the women and newborns in our community should continue to be supported by funding the Maternal/Child Nursing program, a program that works in partnership with the hospitals’ prenatal and maternity services.

**Chronic Disease**

**Goal:**
To develop strategies for the prevention, early detection and management of chronic disease, such as cancer, heart disease, stroke and diabetes, to reduce the morbidity and mortality associated with these diseases.

**Measures:**
Eleven measures were identified in the Oneida County 2010-2013 Community Health Assessment to assess the success of strategies implemented through community partnerships and efforts of individual organizations that share the same goal to improve the prevention, early detection and management of chronic disease. The 11 measures include:

- Decrease diabetes prevalence in adults from 8.0% to 5.7% or less by 2013.
- Decrease diabetes short-term complication hospitalization rate for adults from 5.33 per 10,000 to 3.9 per 10,000 or less by 2013.
- Decrease the coronary heart disease hospitalizations rate from 65.9 per 10,000 to 48.0 per 10,000 by 2013.
- Decrease the congestive heart failure hospitalization rate (ages 18+ years) from 36.3 per 10,000 to 33.0 per 10,000 or less by 2013.

- Decrease the cerebrovascular (stroke) disease mortality rate from 31.8 per 100,000 to 24.0 per 100,000 or less by 2013.

- Decrease the colorectal cancer mortality rate from 17.4 per 100,000 to 13.7 per 100,000 or less by 2013.

- Increase the % of adults age 50 and older that have had a sigmoidoscopy or colonoscopy within the past 10 years from 62.9% to 80%.

- Increase the % of women age 40 and older that have had a mammogram within the past 2 years from 81.9% to 90%.

- Decrease the percentage of overweight (27.8%) and obese adults (23.7%) to 15% or lower by 2013.

- Increase the number of healthcare organizations and providers that effectively implement the public health service clinical practice guideline for treating tobacco use and dependence.

- Increase the number of public and private health insurance plans that provide comprehensive, lifetime coverage of tobacco dependence treatment.

These long-range measures will be assessed in the next update of the county’s Community Health Assessment. Rome Memorial Hospital has participated in initiatives supporting the first 10 measures. Short-term measures include the completion of deliverables, such as disseminating screening guides from the Preventative Health Partnership to provider sites, and tracking hospital specific data regarding participation in education and screening events.

**Update:**

The Oneida and Herkimer County Chronic Disease Work Group was formed in response to the identification that our communities have a higher incidence than state and national averages of chronic diseases. The most recent county health assessment data (Oneida County 2010-2013) confirmed that the high incidences of chronic diseases such as diabetes and hypertension were likely contributing to higher-than-average rates of heart disease and
stroke, plus higher mortality rates. The work group’s charter spearheads an expanded regional effort that develops and implements strategies that enhance the health and wellness of community members in Oneida and Herkimer counties.

Since its inception in 2010, the group has identified common threads among the target diseases groups:

- Need for increased healthcare provider understanding of best practices for prevention;
- Lack of appropriate community health screenings; and
- Lack of an information “clearinghouse” in each county to disseminate information on existing services related to prevention and treatment.

Two strategies were implemented in 2010:

- Use of evidence-based practice guides by healthcare providers to review with their patients, as well as encouraging patient self-advocacy.
- Establish a means through which businesses, agencies and providers might gain access to screening, prevention and treatment resources. Establish a method to keep information current and up-to-date.

Use of evidence-based practice guides by healthcare providers to review with their patients, as well as encouraging patient self-advocacy.

Area healthcare organizations and providers are encouraged to use existing screening materials from the American Cancer Society (ACS), American Heart Association (AHA), and American Diabetes Association (ADA). Screening guides from the Preventative Health Partnership, a national collaborative of the ACS, AHA and ADA, were selected as the method to affordably disseminate evidence-based standards to healthcare providers and their patients.

The Tri-County Tobacco Cessation initiative is a collaborative effort of Faxton St. Luke’s Healthcare (FSLH), St. Elizabeth Medical Center (SEMC), Rome Memorial Hospital (RMH), Mohawk Valley Heart Institute, Little Falls Hospital, Community Memorial
Each month, tobacco cessation classes are offered in Oneida and Herkimer counties and hosted by the participating organizations at no charge to the community. The Tri-County team works in cooperation with the New York State Smoker’s Quit Line and provides resources for smokers who seek help in changing their behavior.

The schedule for the classes is distributed to all participating facilities and local provider offices. Class availability is regularly announced through local media outlets.

The same teams work to promote and support smoking cessation within their own facilities, with the majority of the facilities being smoke free.

**Establish a means through which businesses, agencies and providers might gain access to screening, prevention and treatment resources. Establish a method to keep information current and up-to-date.**

Online resources were geared for the general community and healthcare providers were determined to be the best method for overall access. Appropriate online linkages are available through the websites of the County Health Departments. The online resources include:

- Cancer Services Program
- Children with Special Healthcare Needs
- Community Wellness
- Emergency Preparedness
- Health Education and Information
- Maternal Child Health
- Physically Handicapped Program
- Education and Transportation of Handicapped Children Program
- WIC (Women, Infants and Children Nutritional Supplement Program)
The Chronic Disease Work Group, comprised of representatives from different healthcare and community organizations, has established two, data-driven objectives for 2011-2012:

- Increase healthcare provider interventions related to prevention and early detection of chronic diseases (cancer, heart disease, stroke and diabetes).
- Reduce the morbidity and mortality associated with cancer, heart disease, stroke and diabetes.

The Chronic Disease Work Group is focusing its efforts on disease management of diabetes.

Serving Rome and the northern part of Oneida County, RMH provides free Type 2 diabetes education classes every month for diabetics and their families. The nurse educator covers exercise, diet, and medication management to help newly diagnosed diabetics understand how to manage controllable risk factors and prevent future complications. The nurse educator also speaks at local organizations and employer-sponsored wellness events to emphasize the importance of early detection and management of diabetes.

The Central New York Diabetes Education Program (a cooperative program of SEMC and FSLH) collaborates with the Oneida and Herkimer County Departments of Health and other agencies in the discussions of how best to increase the use of evidence-based standards and practices in the management and education of diabetes. Funded by FSLH, the Central New York Diabetes Program operated at a loss of nearly $17,000 in 2011 due in part to the lack of reimbursement from insurers, as well as the cost of services provided for patients who have limited or no insurance.

Key components of this initiative are provider and community education. The hospitals work with primary care providers on identifying diabetic patients within their practices, setting up protocols for education, and following up on patient management and outcomes. The program works with a diverse population and has educational materials available in Russian, Spanish and Bosnian. The team provides to the community at no charge grocery store tours up to five times annually. The program helps educate individuals and families about healthy choices/healthy lifestyles.
The Mohawk Valley Heart Institute (MVHI), a cooperative program of St. Elizabeth Medical Center and Faxton St. Luke’s Healthcare, hosted two community forums/events in 2011 providing educational and screening opportunities to health care providers and the community.

MVHI offered a community risk assessment screening at the American Heart Association’s Heart Run/Walk Health & Fitness Expo on Friday, March 4, 2011. Volunteers from both hospitals staffed the screening program throughout the day and provided the following screenings at no charge: cholesterol, heart attack risk assessment, stroke, diabetes, blood pressure and pulse as well as tobacco cessation counseling. The event screened 481 community members and followed up with those participants who had results out of range and needed additional follow up for care. The Health & Fitness Expo was held again on March 2, 2012 at which time MVHI screened 506 community members at no charge.

On May 21, 2011 MVHI hosted a teaching day for health care providers and the community about heart disease including diagnosis and treatment. The event held at Masonic Medical Research Laboratory had 138 registrants, 70 of which were providers. The presentations were videotaped and made available for the community on the MVHI web site. MVHI hosted a second annual teaching day for healthcare providers and the community about heart disease on March 24, 2012, also at the Masonic Medical Research Laboratory. There were 88 registrants.

In addition to serving on the work group, Rome Memorial Hospital has maintained a long-standing commitment to prevention and early detection through an active Education Department. Through its Education Department, RMH sponsors monthly lectures at the hospital and provides speakers, displays and screenings for local organizations and businesses to promote early detection, treatment and management of chronic disease.

Some of the largest outreach efforts included participation in health fairs at the Defense Finance and Accounting Service and Oneida Indian Nation in November 2011, reaching more than 1,300 people. Following is a summary of RMH’s activities through July 2012.
**Anti-smoking Programs:** As cigarette smoking remains the leading cause of preventable death in the United States and produces substantial health-related costs to society, RMH continues to invest in tobacco cessation programs.

- In conjunction with Tri-County Quits, RMH hosted quarterly smoking cessation classes for the community (16 served).
- In collaboration with the Rome Area Chamber of Commerce Education Committee & Center for Family Life and Recovery, RMH provided tobacco and drug prevention education to area fifth graders. This educational program uses interaction and tangible consequences that the students can identify with now, not decades down the road. (400 served).

**Blood Pressure Screening:** Untreated high blood pressure can lead to serious diseases, including stroke, heart disease, kidney failure and eye problems. Since people with high blood pressure generally have no symptoms, about 20% of people with high blood pressure don’t know they’re at risk. RMH offers free screenings at area pharmacies and senior centers to provide ongoing monitoring for patients that suffer from high blood pressure and early detection for those who are at risk. RMH also provided free blood pressure screening at the American Heart Association Indoor Walk in Rome, along with information on smoking cessation and sleep apnea. (893 people served at 38 clinics).

**Choose to Move:** For the last 10 years, RMH has partnered with the American Heart Association, Rome City School District and several medical and exercise professionals to offer a free 10-week exercise and education program to help people reduce their risks of heart disease and stroke. (58 served in 2011)

**Community Diabetes Class:** Diabetes can increase the risks of other health problems, such as heart disease, kidney problems, blindness and circulatory problems. To help diabetics take charge of their disease, RMH offers a free Type 2 diabetes class each month that stresses the importance of keeping their diabetes in check through healthy eating, exercise, and medication. Each month, approximately four diabetics attend the program.
Health Lectures: RMH hosts numerous health lectures throughout the year to promote health and wellness. In addition to its Health Night and Senior Live & Learn lecture series, the hospital serves as a resource for many organizations throughout the community when they need experts to speak about health-related topics.

- Health Night topics, including number served: sleep apnea (41), type II diabetes (58), breast cancer navigator program (11), osteoporosis (27), living with heart failure (34), healthy eating for life (14), carpal tunnel syndrome (32), free and low-cost health insurance (66), and hernia repair (26).
- Senior Live & Learn topics, including number served: flu prevention (6), breast health (2), healthy eating on a budget (11), and medication management (13).
- Speakers’ Bureau topics, including number served: poison prevention (36), first aid (36), stress management x2 (83), sleep (30), staying active in winter (3), living with arthritis (23), hypertension (24), managing difficult behaviors x3 (85), type II diabetes (75), fall prevention (19), family therapy (27), drug and alcohol prevention for middle school students x2 (103), substance abuse in the elderly (72), de-escalating behaviors (20), sun safety (20).
- Special programs: synthetic drug awareness for community x2 (103), dangers of clandestine meth labs for professionals (60), synthetic drug awareness for agencies x2 (70), drugs of abuse for law enforcement (150).

Health Fairs: For many years, RMH has sponsored a community health fair with free screenings and information to promote health and wellness. In 2011, the hospital partnered with the Rome City School District to reach a broader audience, especially families with children to help them make lifestyle changes and modify their risk factors earlier in life to prevent chronic disease. Attracting more than 200 people, the event featured 52 booths, activities and free screenings, including cholesterol, glucose, blood pressure and depression screening. The 2012 community health fair is scheduled to be held in September.

The hospital also participated in other health fairs sponsored by employers or other agencies. Those events, including number served, are listed below:

- NYSNA Booth at New York State Fair (100)
- Vernon Verona Sherrill Community Day (200)
Senior Services Expo at Ava Dorfman Center (175)
United Cerebral Palsy (75)
Oneida Indian Nation (800)
Defense Finance and Accounting Service (500)
Rome Heart Walk Expo (125)
YMCA Healthy Kids Day (300)
Staley Upper Elementary (145)

Colorectal Cancer Screening – It is estimated that as many as 60% of colorectal cancer deaths could be prevented if all men and women aged 50 years or older were tested. RMH has taken several steps to improve the screening rate in our community. These included

- Increasing educational outreach regarding the importance of colonoscopies through displays at health fairs, lectures, stories in newspapers and in the hospital’s quarterly senior publication. The hospital also placed paid advertising to reach adults turning 50 to encourage them to schedule their colonoscopy. In addition, the hospital’s CEO agreed to be interviewed for a feature story after his colonoscopy to help others overcome any fears that they may have about the procedure
- Expanding the use of the EZ Detect screening tool as an alternative to the traditional fecal occult blood test slides to address people’s negative attitudes toward collecting a stool sample for analysis and expanded the program. With the fecal occult blood test slides, even monetary incentives weren’t enough to increase the free screening numbers above 80. Now, approximately 500 people participate in the EZ Detect screening, which is offered annually in March at Mohawk Valley Radiation Medicine, as well as Camden Family Care and Boonville Family Care. These same three facilities also offer free PSA tests for early detection of prostate cancer every September.

Cancer Services Program – RMH participates with the Cancer Services Program to provide free mammography screening for the uninsured and underinsured to promote early detection. The nurse navigator from the hospital’s Breast Center works closely with the CSP to help secure additional resources for underserved women diagnosed with breast cancer.
Flu Vaccination Clinic – To protect residents from the flu and prevent unnecessary hospitalizations, RMH sponsors flu clinics in the fall and winter (205 immunized).

Senior Behavioral Health Conference – RMH sponsors an educational conference for professionals involved in the care of patients with mental health disorders (200 participants).

Several of RMH’s strategic initiatives also support the goal to reduce the morbidity and mortality associated with chronic disease.

Reducing Readmissions - In September 2011, RMH launched a new discharge liaison program to reduce hospital readmissions and improve patient outcomes in high-risk patients, who are hospitalized for congestive heart failure, pneumonia, and chronic obstructive pulmonary disease. In addition to assisting in the development and implementation of the discharge plan, the coordinator makes post-discharge calls to reinforce the patients understanding of their discharge plan and the importance of following through on scheduled appointments.

Stroke Telemedicine – In early 2012, RMH became a partner in the Upstate University Hospital Telemedicine Stroke Program to improve access to neurology services. The telemedicine program allows neurologists to remotely examine patients in RMH’s Emergency Department and make recommendations regarding treatment.

Wound Care: RMH received state approval to provide wound care and hyperbaric services to serve the high-risk diabetic and long-term care population in Rome and northern Oneida County. Advanced wound care services results in earlier recovery, less hospitalization, prevention of prolonged disability, and cost savings for the health care system. The new service is expected to open in early 2013.

Looking ahead, the adoption of electronic medical records in primary care offices will provide a powerful tool to better manage chronic conditions and improve compliance with routine screenings. For example, in 2012, RMH’s largest primary care practice adopted
Medent, which has a disease management module that organizes preventative health measures into color-coded areas so providers can easily see what screenings are due.

**Mental Health/Substance Abuse Priority Area**

**Goal:**
To implement strategies to address mental health issues and improve access to mental health services.

**Measures:**
Three measures were identified in the Oneida County 2010-2013 Community Health Assessment to assess the success of strategies implemented through community partnerships and efforts of individual organizations that share the same goal to improve mental health outcomes in the community. The three measures include:

- Decrease the suicide mortality rate from 8.9 to 4.8 per 10,000 or lower by 2013.
- Decrease the percent of adults reporting 14 or more days with poor mental health in the last month from 11% to 7.8% or less by 2013.
- Decrease the percentage of binge drinking past 30 days in adults from 21.1% to 13.4% or less by 2013.

Although each of the New York State Office of Mental Health licensed programs establish Performance Measurements and Outcome Measurements on a quarterly basis to Oneida County Office of Mental Health, those are not routinely shared with the public.

Due to extensive 2012 budget cuts, much of the Oneida County Mental Health Department focus has been on:
- Maintaining the current continuum of services and
- Improving and enhancing communication and collaboration among systems and providers.

Accomplishments and setbacks are identified in the update.
Update:

The specific need was identified as: The lack of acute, emergency, especially community, mental-health services for adolescents. This was identified in 2009, and as a result of meeting with the Oneida County Department of Mental Health (OCDMH) to coordinate priorities within its planning process, action areas changed in 2010. Access to mental healthcare, cross-systems collaboration and suicide rates have been areas that the county health department’s Mental Health Subcommittee has identified that integrate with the findings of the County’s Community Health Assessment.

A. This priority is preexisting and action is still urgently needed for acute and community mental health services for adults, adolescents and children. The OCDMH has created an Emergency Psychiatric Services System (EPSS) committee, which includes representatives from all three Oneida County hospitals (St. Elizabeth Medical Center, Faxton St. Luke’s Healthcare, and Rome Memorial Hospital), and the Mobile Crisis Assessment Team (MCAT) of the Neighborhood Center. Also included were representatives of local law enforcement and community mental health providers.

B. As the Oneida County Mobile Crisis Assessment Team (MCAT) ceased assessing adults in Emergency Departments as of August 1, 2009 and ceased assessing children there as of October 1, 2009, EPSS formed three Subcommittees to work on plans to improve mental health/substance abuse services to patients. Each collaborative committee is comprised of representatives of the above organizations. The committees were established as a Utilization Review Subcommittee, a Transition Subcommittee and a Community Development Subcommittee. The Utilization Review Subcommittee includes 9.41s (9.41s are emergency admissions for immediate observation, care and treatment). The Transition Subcommittee has been renamed the Children and Youth Communication Workgroup.

Providers continue to collaborate on mental health and substance abuse issues. The OCDMH holds meetings of its Adult Single Point of Access and Accountability (ASPOA/A) twice monthly, which are attended by nearly 30 mental health and substance abuse providers, including the three hospitals. The ASPOA/A processes over 1,000 referrals for mental health
case management and housing per year. OCDMH also hosts subcommittees related to Mental Health, Substance Abuse and Developmental Disabilities.

The EPSS for Children and Youth Communication Workgroup meets quarterly and has made a great deal of progress in addressing system barriers related to children and youth who utilize inpatient, outpatient and Emergency Department (ED) mental health services.

Successes in the mental health arena in the 2011-2012 year included:

- Successful reduction in the length of time that children are “parked” in the Emergency Departments after a disposition has been reached. This is a result of improved communication at all levels of care and the use of an Admission Protocol for Pinefield Child and Adolescent Program.
- Each of Oneida County’s three hospitals, St. Elizabeth Medical Center (SEMC), Faxton St. Luke’s Health (FSLH) and Rome Memorial Hospital (RMH), have hired two full-time social workers, to serve the needs of ED patients. The hospitals have combined efforts to create a consistent assessment tool for patients, improving care and communication between the facilities. SEMC staff continues to hold case conferences with OCDMH to better serve frequent ED visitors; staff examines patient obstacles to care in an effort to minimize impact on hospital resources. A Memorandum of Understanding is due to be rewritten this coming fall about sharing information to enhance the continuum of care.
- SEMC hired an additional per diem social worker to assist the other two on weekend call for the ED and is currently recruiting a full-time social worker with trauma experience. SEMC is also expanding services to provide one-to-one daily counseling throughout the hospital’s medical and psychiatric floors and units.
- FSLH instituted a weekend social worker model of care in the Emergency Department during the summer of 2012 to support patient-and-family needs and help with discharges.
- RMH created a video titled “What to Expect: Child Mental Health Crisis in the Emergency Room” and showed it to the Children and Youth Communication Workgroup (C&YCWG) and the 9.41 Utilization Review Subcommittee at their May
meetings. It received favorable comments and additional copies of the video were
distributed to treatment providers. The video is also available online at YouTube.

- The C&YCWG reviewed an informational Parents Brochure explaining Mohawk Valley
Psychiatric Center’s Pinefield Children and Youth Unit in March and sent it to staff at
hospital EDs for input. The brochure was developed by Oneida County’s Parent
Advocates in conjunction with Pinefield. The brochure was later approved for
distribution.

- The Community Health and Behavioral Services Program (CHBS) through Upstate
Cerebral Palsy added new staff in the spring and began providing counseling and
medication administration services at SEMC’s Sister Rose Vincent Family Medicine
Center and at the Utica Community Health Center. The CHBS waiting list decreased by
March.

- Community partners collaborated to provide data to demonstrate the need for Crisis
Respite for youth. House of Good Shepherd (HGS) explored the use of both the Milton
Abelove Children’s Shelter (MACS) and Foster Care for Respite for youth who are
experiencing a situational crisis and do not require inpatient hospitalization and are not
in Department of Social Services custody. As a result, a proposal was developed and
presented to Commissioner Linda Nelson, who will seek a small amount of funding for
next year.

- A new Addiction Recovery Systems (ARS) site was created in Rome late in 2011, where
group meetings and social activities are held as part of the program.

- OCDMH is seeking additional funding through OMH to provide additional community
support as a result of the ward closures at Mohawk Valley Psychiatric Center (MVPC).
Those supports are intended to reduce hospitalizations, unnecessary Emergency
Department presentations and reduce incarcerations.

As background, MVPC staff was notified February 7, 2012, that two wards at MVPC
would be closed and one ward (24 beds) would be relocated to Hutchings Psychiatric
Center (HPC) in Syracuse, NY. Twelve individuals were returned to the facilities they
originally were transferred from; a total of twenty-four (24) patients were relocated to
HPC. The remaining 40 or so patients were placed into community settings or nursing
homes as clinically indicated.
All outpatient services will remain intact. The Herkimer, Rome and York Clinics will continue to serve over 1,000 individuals. MVPC will maintain its Assertive Community Team, Intensive Case Management, Transitional Living Center, Family Care, Residential and Rehabilitation Services.

Two Community Support Teams will be added to each facility, which will be staffed by 13 employees. These teams are designed to assist individuals who are returning to the Utica-area community after discharge from HPC. The addition of the 13 staff members per facility will help to offset the staffing reductions at MVPC.

The teams will also be available to aid individuals in supportive apartments and assist them in keeping appointments. Workers will help these individuals engage with community providers so that their psychiatric/physical needs can be met to enable them to continue to live in the community with these supports and reduce inpatient admissions. Effective May 7, 2012 all MVPC catchment-area psychiatric admissions were sent to HPC.

- OCDMH took over leadership of EPSS for Adults and the 9.41/Utilization Review Committee in the fall of 2011. Data collection measures were revised to more accurately reflect the numbers of unnecessary Emergency Department referrals. This group continues to improve communication between the mental health system and law enforcement.

Barriers in mental health include:

- Budget cuts to OCDMH that included the loss of contracts with Legal Aid, Compeer and the Mohawk Valley Center for Refugees. Hospitals also suffered cuts to Medicare and Medicaid reimbursement rates, which result in more limited resources for patients.

- New York State government is still decreasing inpatient psychiatric beds for both adults and children. Early in 2012, NYS announced that adult inpatient wards at Mohawk Valley Psychiatric Center (MVPC) would close in 2012. MVPC closed one adult ward by May and a second on June 15. Overall, admissions to Pinefield increased dramatically
by May. In the fall, it is expected that Children and Youth inpatient services at Pinefield will move to the Wright building while maintaining its census of 30 beds. Pinefield hopes to retain the psychiatric and clinical staff.

- OCDMH no longer has its database, which contained over 10 years of historical treatment information on clients; however, it has Single Point of Access and Accountability (SPOA/A) data dating back four years. When a case review is presented, it is very important that all relevant information be gathered prior to the meeting as departments wouldn’t have all the information. There currently is no database to track client history in detail. This means that 9.41 pick-ups will be maintained manually in a file and that staff no longer has a database on clients’ admissions and discharges to inpatient units. This may impact case reviews; more research will have to be done to determine a client’s involvement with the network of providers.

- Community partners collaborated to provide data related to the need for crisis respite for youth. House of Good Shepherd (HGS) explored the use of both the Milton Abelove Children’s Shelter (MACS) and Foster Care for Respite for youth who are experiencing a situational crisis and do not require inpatient hospitalization. HGS has downsized residential services over the last few years. The organization is assessing the need and feasibility of utilizing a wing at the MACS facilities for respite for children not in Department of Social Services custody.

This voluntary program would seek to re-frame and re-label the crisis to build on family strengths to move forward and return the child/youth home. The Mobile Crisis Assessment Team (MCAT), Clinics, hospital EDs and schools all indicated that there is a need. The plan would be that families are not charged for this service. There is limited funding; however, there may be options available if agencies can define the specific need. A draft of Respite Admission Criteria was distributed to members of the C&YCWG, along with a data collection tool. A proposal is being developed.

Substance abuse is closely tied to mental health issues in the region and there has been a significant increase in substance abuse in Oneida County during the past year. Use of strong “bath salt” stimulants and synthetic marijuana has been the biggest risk to health and safety
of both patients and hospital ED staff. There is also a high incidence of suicide among bath salts users.

Hospital leaders have discussed with staff members ways for them to be safer amid dangers posed by bath salt users. These include increased alertness and awareness; de-escalation methods such as soft lights and voices; and Behavioral Management Techniques (BMT) training.

Hospital ED staff members have taken part in ongoing training sessions with law enforcement and pre-hospital providers and poison-control staff. RMH hosted a community health night on Synthetic Drug Abuse March 28, 2012 with the Rome Police Department; OCDMH sponsored a session July 24, 2012 at the Radisson Hotel-Utica Centre.

Sessions on healing, applied suicide intervention skills, SAFE talk and current drug trends were held through Oneida County during June and July of 2012. In addition, the Herkimer Police Department requested training for a 2-3 hour block to include ACC/MCAT and ED, during a Chief’s Meeting on June 21, 2012. A brochure was distributed; however, the meeting is now tentatively scheduled. The training will include an overview of the brochure, provide an understanding regarding MCAT, ACC services and hospital services that are provided once an individual is brought in under 9.41 MHL custody.

The OCDMH Office of Alcoholism and Substance Abuse Services (OASAS) holds meetings every other month to discuss area agency’s related activities and to collaborate. Partners include Catholic Charities, Shelter Plus Care, Veteran Homeless Outreach, McPike Addiction Treatment Center, the Center for Family Life and Recovery, Delta Recovery Services LLC, 820 River Street, Father Young Program, Insight House, Milestones CNY Services, Community Recovery Center of Rome, the Rescue Mission’s Addiction Crisis Center and Beacon Center. Many that house people in need who have substance abuse dependence consistently had a full census throughout the year.

OCDMH Planning highlights for 2013 include:

- Development of infrastructures and practices that address outcome management;
• Implementation of more services under one license to reduce cost, especially in outpatient settings;
• Focus upon evidence-based practices;
• Increase program oversight and accountability;
• Meet the ongoing need for a medically supervised programs;
• Meet need for increased treatment cost due to synthetic drug abuse.

Successes in controlling substance abuse in patients include:
• Social workers (SW) have expedited the process of getting patients resources, since they have established relationships with contacts. This includes SW preparing extensive referral forms.
• Wait time has been greatly reduced for getting both youth and adults to community resources. It is very rare that a child spends the night at the ED now. Patients are seen by counselors within five business days of their ED visit.
• SPOA/A is an Oneida County committee that meets to determine the best level of care for a child or adult with a high level of need.

The OCDMH 9.41 Utilization Review Subcommittee meets bimonthly to reduce system barriers and provide collaboration between providers/participants of the Memorandum of Understanding (MOU). The Mobile Crisis Assessment Team (MCAT) has moved some of its staff to the Oneida County 9-1-1 Center and to the Addictions Crisis Center. 9.41 Utilization Review Subcommittee members noted that the effects of synthetic marijuana can be delayed up to 7 days. The SEMC Psychiatric Unit (inpatient) reported in March 2012 that up to one-third of its patients have symptoms related to the use of synthetic marijuana and bath salts.

Strategies for Emergency Departments include:
• Training and education to and from community providers;
• Case reviews;
• Find a way to include inpatient MDs in this group; and
• Assure that more ED staff (Case Managers) are a part of that meeting.

Strategies for Inpatient Units are:
• Process review for difficult cases;
• Include all systems in review of cases; and
• Include crisis services in client treatment planning.

The Suicide Prevention Coalition provides community outreach, education and training. An overview of the Professional Training Coalition, which represents various community agencies from different sectors of the field, was presented to members of the 9.41 Utilization Review Subcommittee on May 31, 2012. The Coalition's main goal is to train and educate community professionals at an affordable cost. The group discussed ways to train local law enforcement on suicide prevention through the Mental Health Association of New York, sponsored by a NYS Mental Health Suicide Prevention grant. MCAT also requested additional training on Post-vention training for staff. Training is being scheduled for MCAT staff; however, the grant is intended to increase awareness of suicide prevention through media, commercials and training. Eric Weaver will be providing training on Emotional Safety and Survival for Law Enforcement to 163 Utica Police Department officers in October. This grant’s goal is also to increase the size of the Suicide Coalition and build Connect and Post-vention response teams.

Barriers in substance abuse include:
• OCDMH budget for 2012 was cut 69 percent, to include only mandated programs.
• Insurers are requiring outpatient detoxification rather than inpatient. Providers looked at implementing this into their programs, as there is no local outpatient detox.
• Lack of housing;
• Lack of employment and vocational opportunities for individuals residing in an OASAS residential setting;
• Lack of Suboxone providers and medically supervised treatment; and
• Increase in synthetic drug use.

Impacts & Changes
The long-term measures of the community service plan will not be assessed until the next update of the county's community needs assessment. However, the most significant impacts or changes that are taking place involve strengthening relationships between partners to
improve the public health system overall and build awareness about existing services. Relationship building is essential for continued collaboration because of shrinking resources for competing priorities. Incremental changes have been observed in some measures at the hospital level, such as the number of women who are breastfeeding and receiving early prenatal care.

**New Survey Data**

In the fall of 2011, RMH invited people who had been recent patients to participate in a series of focus groups to help hospital leaders identify ways to make their hospital stay better. As a result of the patient feedback, the hospital implemented strategies to improve communication with patients and enhance their comfort. To enhance patients’ experience when they visit, the hospital also:

- Replaced beds to provide patients with a more comfortable night’s sleep;
- Installed new flat screen televisions that are compatible with headphones to promote a quieter environment and help patients pass the time;
- Implemented a welcome kit equipped with free headphones, earplugs and a sleep mask to help patients rest;
- Welcomed a new team of physicians in the Emergency Department to improve efficiency and reduce wait time; and
- Hired a discharge liaison to call high-risk patients after they go home to answer questions and identify any issues that may interfere with a speedy recovery.

In addition, RMH has begun to lay the ground work for its next comprehensive community needs assessment by conducting listening sessions with key stakeholder groups to identify access barriers, gaps in services and other health priorities for the community.

**Rome Memorial Hospital’s Strategic Plan Updates**

Although the community service plan is designed to specifically address the state’s prevention agenda, it is important to note that RMH’s strategic plan includes many additional initiatives to address our community’s needs and ensure the hospital’s continued financial viability.
Progress on a few of the major initiatives include:

**Eye Center** - A new eye center at Griffiss Business & Technology Park opened in March 2012. The joint venture between the hospital and its three ophthalmologists provides patients with a new state-of-the-art facility that specializes in ophthalmologic procedures, such as cataract, glaucoma and eyelid surgery. The project aligns with the hospital’s need to provide more available OR time for new general surgeons who have been successfully recruited to serve the greater Rome community. In addition, the designated eye center reduces the risk of delays in elective procedures that can occur in a hospital operating room due to emergency cases.

**Breast Center** - In 2010, RMH began an initiative to become a Breast Center of Excellence under the National Quality Measures for Breast Centers program to better coordinate and benchmark existing services and expand the continuum of breast cancer care for the community. The hospital implemented a breast patient navigator program to provide women and men with a possible breast cancer diagnosis with a guide to help them better understand their options and navigate the complex healthcare system.

**Health Information System** – After 18 months of assessing, building, testing, and training, RMH went live on a new health information system July 31, 2011 to better facilitate the processing and exchange of clinical, statistical and financial information. The new HIS replaces more than 30 separate financial, clinical and administrative systems – everything from patient registration, billing and payroll to patient scheduling, nursing documentation, and medication administration. The project includes several new applications that address the hospital’s goals of 1) converting from a paper-based patient medical record to a fully electronic health record and 2) providing online clinical decision support to standardize care, advance patient safety and achieve better outcomes.

As part of Phase II of the HIS project, RMH has begun the implementation of computerized physician order entry and expects to achieve Stage I Meaningful Use at the end of September 2012, by attesting that the hospital has met the targets for:
• 14 core objectives, such as using computerized provider order entry to place medication orders for a minimum of 30 percent of patients and maintaining an up-to-date problem list of active and current diagnosis for at least 80 percent of patients.
• 5 objectives from a menu set of 10, such as submitting electronic data on reportable lab results to public health agencies and implementing drug/formulary checks.
• 15 Clinical Quality Measures, such as reporting emergency department throughput, process measures for stroke patients and prevention measures for venous thromboembolism.

The elements of Stage I Meaningful Use are designed to:
• Improve quality, safety, efficiency, and reduce health disparities;
• Engage patients and families in their health care;
• Improve care coordination; and
• Improve population and public health.

**Hospitalists** – In early 2012, RMH launched a new 24-hour hospitalist program to provide coverage for patients who do not have a primary care physician when they’re admitted to the hospital. In addition, the program gives physicians on the hospital’s medical staff the option of utilizing the hospitalists to attend to their patients so they are able to focus on their office practice.

**Quality Patient Care** - RMH’s strategies for reducing the risk of health acquired infections are achieving results. By adopting evidence based practices, the hospital has eliminated central line infections in its ICU since December 2006. The hospital was one of only eight hospitals in the nation to be recognized by the U.S. Department of Health and Human Services with an “outstanding leadership award” for protecting patients from life-threatening bloodstream infections.

**Lymphedema** – In July 2012, RMH expanded its therapy services to provide lymphedema care to address the two to three month waiting list for lymphedema services in the community. Upon completion of the therapy program, patients leave with the skills necessary to manage their symptoms at home.
**Stereotactic Breast Biopsy** – In April 2012, RMH invested in stereotactic breast biopsy technology to provide women with the most minimally invasive procedure possible to diagnose breast cancer. The hospital selected the new HOLOGIC MultiCare™ Platinum prone breast biopsy table for its diagnostic precision and patient comfort. The advanced comfort package includes adjustable padding to position patients of all sizes for their comfort.

**Dissemination of the Report to the Public**

Rome Memorial Hospital’s Community Service Plan is available at [www.romehospital.org](http://www.romehospital.org).

**Successes and Challenges Regarding the Provision of Financial Aid**

With tough economic times battering the country, many people have lost their health insurance because they can’t afford the rising premiums or they’ve lost their jobs.

To help the uninsured learn more about possible options, RMH’s Patient Registration Department has developed a referral form that is faxed (with the patient’s consent) to insurers which offer free or low-cost health insurance through New York State’s Child Health Plus and Family Health Plus. The facilitated enrollers follow-up with the patients to answer questions and enroll those eligible into the appropriate programs. RMH also provides space at the hospital for program representatives to answer questions and enroll eligible patients. Signage is placed in the hospital’s lobby when the representatives are available to encourage walk-in inquiries.

In addition to helping people obtain insurance coverage, the hospital provides a financial assistance program and works with patients to set up affordable payment plans.

Financial assistance brochures are located in the hospital’s waiting areas and applications are available on the website. RMH discounts patient accounts up to 100% depending upon family income in comparison to the federal poverty level. Discounts are based upon the Blue Cross rate. RMH offers discounts to the uninsured/underinsured whose income is up to 300% of the federal poverty level.
Because lack of awareness is one of the biggest barriers, RMH provides information about available programs at health fairs and other outreach activities.

As a not-for-profit hospital, RMH is committed to being the safety net for the community’s most vulnerable populations. However, with continued cuts to the healthcare system, it will be financially impossible to sustain the growth in uncompensated care without reducing services or staff. The amount of charity care provided by the hospital increased 37% from $1.3 million in 2010 to $1.8 million in 2011. In addition, the hospital wrote off another $6.5 million in bad debt in 2011 for care that patients couldn’t afford.

In today’s healthcare environment, RMH must continually evaluate the viability of specific services and programs because of the many challenges hospitals face, including reimbursements that fail to keep pace with rising expenses, physician shortages and the continued growth in uncompensated care.