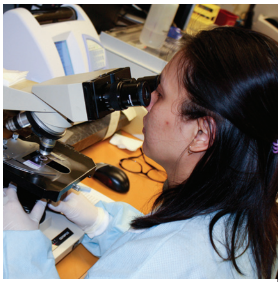

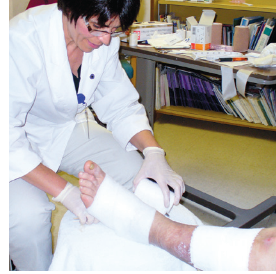

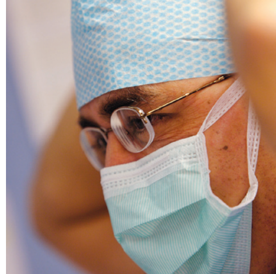

St. Elizabeth Medical Center

Community Service Plan 2010

Prepared for the New York State Department of Health

September, 2010

St. Elizabeth Medical Center

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1. Mission Statement

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

St. Elizabeth Medical Center community, inspired by St. Francis of Assisi and faithful to the teachings of the Roman Catholic Church, is committed to excellence in healthcare and education. We pledge to do this with compassion and respect for the dignity of all.
The Mission Statement has not changed.

2. Hospital Service Area

St. Elizabeth Medical Center's Primary Service Area (PSA) consists of the zip codes in which 80% of its patients live (mostly Oneida County and some within Herkimer County). Its Secondary Service Area (SSA) consists of zip codes in which the remaining 10+% of its patients live (mostly outlying regions of Oneida and Herkimer counties, plus some zip codes in Madison and Lewis counties.) Methods used to determine the service area are analysis of patient origin, based on home zip code.

This definition has changed since the Community Service Plan was submitted in 2009.

3. Participants and Hospital Role

A. Participants

Community partners involved in assessing the community health needs include: St. Elizabeth Medical Center, the Health Departments of Oneida and Herkimer counties, the Oneida County Health Coalition, Herkimer County HealthNet, Faxton St. Luke's Healthcare, Rome Memorial Hospital, Little Falls Hospital, Oneida County Dept. of Mental Health, United Way of the Valley and Greater Utica Area, American Cancer Society, Mohawk Valley Resource Center for Refugees, Multicultural Association of Medical Interpreters, Catholic Charities, American Heart Association, American Diabetes Association, Visiting Nurse Association of Utica and Oneida County, Inc.

In July, the Executive Director of the United Way of the Valley and Greater Utica Area left his position, which may change some procedures for the Physical Fitness and Nutrition priority area.

B. Hospital Role

The 2009 Community Service Plan was based upon extensive assessments of the health status in Oneida and Herkimer counties. The assessments were created by the Health Departments of Oneida and Herkimer counties, the Oneida County Health Coalition, Herkimer County HealthNet and local hospitals, with input from many other health and social service agencies, business leaders, clergy, educators and law enforcement officers. The plan identified specific community health improvement actions in relationship to the State of New York Department of Health Prevention Agenda. These are:

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

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

During the community health assessment process in 2009, St. Elizabeth Medical Center (SEMC) identified appropriate employees to sit on each of the Public Health Priority work groups, to represent the hospital and communicate plans and action items. These SEMC employees are expected to report the outcomes of meetings to the SEMC Community Design Team, which meets monthly.

Community partners continue to meet in the Health Priority work groups, at the intervals described below.

- **Healthy Mothers, Healthy Babies, Healthy Children** – monthly since May 2010
- **Mental Health and Substance Abuse** – met with Oneida County Dept. of Mental Health and its committees and subcommittees to coordinate, not separately as a work group
- **Chronic Disease** – monthly since April 2010
- **Access to Quality Healthcare** – met several times throughout the 2009-2010 year

- **Physical Fitness and Nutrition** – coordinated through the Regional Planning Team and the United Way of the Valley and Greater Utica Area, which meets approximately quarterly. Next meeting is set for September 16, 2010.

The Oneida County Health Coalition Steering Committee is the group that oversees local priorities. This committee meets monthly, and met on August 6, 2010.

4. Identification of Public Health Priorities

B. Selected Prevention Agenda Priorities

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

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

At the Oneida/Herkimer Regional Health Summit March 26, 2010, the hospitals (St. Elizabeth Medical Center, Faxton St. Luke's Healthcare and Rome Memorial Hospital), the Oneida County Health Department, Herkimer County Health Department and other partners agreed to focus their efforts and work with others regarding these health-improvement goals:

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

- **Mental Health and Substance Abuse –** Specific action area: The lack of acute, emergency, especially community mental health services for adolescents was identified in 2009. As a result of meeting with the Oneida County Dept. of Mental Health to coordinate priorities within their planning process, action areas changed. 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.

- **Chronic Disease –** Specific action area planned was: Since tobacco use is the basic cause of many chronic diseases, the hospitals and health departments agreed to expand on the smoking cessation efforts of Tri-County Quits. The Chronic Disease Work Group is comprised of representatives from several different healthcare and community organizations and has agreed to a collaborative approach in meeting the following two data-driven objectives:

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

Although identified as health priorities for our counties and populations, Access to Quality Healthcare and Physical Fitness and Nutrition were not among the three highest priorities identified by local hospitals last year. However, St. Elizabeth Medical Center did identify staff members to sit on those work groups. Goals for these two Prevention Agenda items are:

- **Access to Quality Healthcare –** Participants identified a goal of reducing emergency room usage for primary non-emergent purposes via a public education campaign. Three objectives were identified:
  - Survey four hospital centers for emergency room usage.
  - Research and identify existing health literacy resources that have proven successful in communities nationwide.
  - Identify and contact existing community systems, services and individuals who provide some form of education or awareness training.
  - Identify and confirm alternative primary care sources to accommodate the target populations to ensure healthcare needs continue to be met.

Physical Fitness and Nutrition – The activities being promoted by the United Way of the Valley and Greater Utica Area have focused on this priority area. The "Get Moving!" campaign is the most tangible; however, there are conversations regarding farmers' markets and food pantries that need to be carried out. At the Oneida/Herkimer Regional Health Summit March 26, 2010, "Get Moving!" T-shirts were distributed, along with copies of two memorializing petitions passed by the Board of Legislators in both Oneida and Herkimer counties. The petitions represented their support of a

regional campaign and launch of a community-wide initiative to combat obesity by collaborating and promoting a healthy lifestyle for residents. Regular exercise is the key component of the "Get Moving!" campaign.

5. Update on the Plan of Action

The Oneida County Health Coalition Steering Committee meets monthly, and has become the body that oversees progress of the Public Health Priorities work groups. Representatives include not only the hospitals, but 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. The Steering Committee's purpose is to improve communication; coordinate Health Summit workgroups; problem-solve, communicate and report on successes and challenges.

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

Priority 1 – Mental Health and Substance Abuse

The three-year plan outlined in 2009 was:
2009-2010 – Work groups 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 Regional Health Coordinating Council (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.

As noted above, a result of the work group's meetings with the Oneida County Dept. of Mental Health to coordinate priorities within their planning process was that action areas changed. 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.

1. This priority is preexisting and 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 met quarterly in 2009 and includes representatives from all three Oneida County hospitals (St. Elizabeth, Faxton-St. Luke's and Rome Memorial), and the Mobile Crisis Assessment Team (MCAT) of the Neighborhood Center. Also included were representatives of local law enforcement and community mental health providers.

2. As the Oneida County Mobile Crisis Assessment Team (MCAT) ceased assessing adults in Emergency Departments as of August 1, 2009 and ceased assessing children there as of October 1, 2009, three EPSS Subcommittees worked 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 last full group meeting of the Emergency Psychiatric Services System (EPSS) committee was held January 25, 2010, at which time it was decided that quarterly meetings were no longer needed in lieu of ongoing subcommittee work. The three subcommittees, Transition, 9.41/Utilization Review and Community Development, continued to meet periodically since then on their appointed charges. (A "9.41" is an emergency admission for immediate observation, care and treatment.) Data is also being collected regarding MCAT's shift from a primary ED responder to greater mobility to the community-at-large for situations involving both children and adults.

Subcommittee results in 2010 are:

<u>Transition (Adult)</u> – This is no longer operational, as formal protocols have been developed and implemented and all related trainings have been completed; local hospitals have hired or realigned staff to replace MCAT functions in the ED. For example, nearly a year ago St. Elizabeth Medical Center hired two licensed social workers to fulfill functions formerly performed by MCAT staff. These social workers are now on call for the ED and have been trained to screen both adults and children for mental-health issues. They give recommendations for treatment to ED providers.

<u>Transition (Children and Youth)</u> – The Transition Subcommittee's goal was to convert MCAT's ED coverage to hospital staff by training in screening and assessment for adults and children. This was to enable hospitals to develop resources and internal proficiencies to help meet these needs. The goal was that it would also address systems obstacles, particularly the procuring of appropriate referrals to inpatient and outpatient resources. The subcommittee developed a survey and distributed it to various

stakeholders (including NYS Office of Mental Health, hospital EDs, and the MVPC Pinefield Unit) to examine perceptions and possible reasons for the lengthy ED stays for children.

The Transition Subcommittee outcome measure was defined: To reduce the length of stay for children who remain in the ED, once medically cleared via:

a. Data Collection and Performance Measurement
b. Continued review and refinement of existing protocols
c. Training for all providers related to the three protocols
d. Finalization of the MCAT follow-up protocol, so EDs can utilize MCAT as part of a viable discharge plan.

St. Elizabeth Medical Center held training for Nursing, Case Management and Social Work staff in January 2010 on basic admission criteria and the paperwork process involved at Mohawk Valley Psychiatric Center's Pinefield Children and Youth Unit. This was followed by a panel of representatives from United Cerebral Palsy, the Neighborhood Center/Kids Oneida, House of the Good Shepherd and Oneida County Probation Department to review their services. Addressed were: ways in which those organizations' services and staff members might assist EDs in supporting the need for admission, and rationale for discharge.

Oneida County Department of Mental Health has also trained the following providers in the use of information-sharing protocol and/or the Children & Youth ED Protocol: Neighborhood Center in Utica and Rome; UCP/CHBS, Insight House, House of the Good Shepherd, Milestones and the Utica Rescue Mission's Addiction Crisis Center.

Transition Subcommittee members also met with representatives of Oneida County Department of Social Services (OCDSS), to discuss registration requirements to admit children and youth to DSS custody at MVPC Pinefield. The need for a Case Review Process for high users of EDs and inpatient psychiatric services has also been discussed. A meeting was held on July 16, 2010. The subcommittee continues to meet monthly in an effort to address ongoing communication issues between providers, EDs and MVPC's Pinefield.

<u>9.41/Utilization Review</u> – The Utilization Review Subcommittee's goals were to 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 was also to address individual and collective system obstacles and arrange case conferences. It last met on July 20,

2010 with ongoing monthly meetings scheduled. A Memorandum of Understanding between Oneida County Department of Mental Health, Oneida County Law Enforcement, Oneida County Hospitals, Emergency Medical Services and local community supports (known collectively as the Emergency Psychiatric Services System) is nearly finalized, awaiting only a couple of signatures; cases are reviewed for appropriateness and are tracked by transport method and presenting problem(s).

In addition, progress includes finalization of a Request For Examination form for law enforcement officials, a Case Review Form, and a statistical reporting process that monitors outcomes.

Performance outcome measures are:

1. MCAT face-to-face community screenings will achieve the same numbers as prior to MCAT leaving the EDs.
2. MCAT will demonstrate increased law enforcement interactions on the 4-12 p.m. shift.
3. Total 9.41s (emergency admissions for immediate observation, care and treatment) will decrease in number.

Community Development – This subcommittee no longer meets. Its goal was 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.

MCAT has provided numerous trainings throughout the community regarding its changed role and how to effectively negotiate the restructured Emergency Psychiatric Service System. Data collected over time reflects a gradual decrease in law enforcement pick-up orders, with a corresponding increase in MCAT community screenings. Performance Measurement indicators have been implemented for MCAT. No peer staff members have been hired to date.

The Oneida County Department of Mental Health continues to gather relevant data electronically from the EDs at St. Elizabeth Medical Center, Faxton St. Luke's Healthcare and Rome Memorial Hospital, and adult inpatient psychiatric units (including Mohawk Valley Psychiatric Center) to help identify a group of high-risk, high-use individuals of services and Medicaid, in hopes that a more strategic, cost-effective focus can then be applied to these cases.

It is anticipated that the next full group Emergency Psychiatric Services System (EPSS) meeting will be held in January 2011.

One of the overall goals of the strategies was 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. This goal has not been met. However, on May 24, 2010, Oneida County Department of Mental Health (OCDMH) hosted a meeting with OMH NYCAT, SUNY Upstate, Neighborhood Center, CHBS, Kids Oneida and HGS to promote the Children's Tele-psychiatry initiative that is free to OMH Licensed clinics. In June 2010, OCDMH promoted the TEACH initiative – a mini-fellowship program through SUNY to provide pediatric telephone psychiatric services to Oneida County pediatricians and primary care physicians. Information about the programs was shared with the Oneida County Health Coalition and physicians through Slocum Dickson Medical Group, Rome Medical Group and the Medical Societies of the Counties of Chenango, Oneida, Oswego, Herkimer, Madison and Cayuga. As of September 2, 2010, one MD has completed the program.

Another goal was to install computer programs and gain access for community partners to share information and input data on patients. Although computer programs have not been installed, the two social workers hired by St. Elizabeth Medical Center (SEMC) have been in communication with social workers at other local hospitals. They have shared lists of community resources among themselves and with other community partners. It has been a substantial operational improvement to SEMC to have the social workers focus upon these responsibilities. This system is more efficient for staff and patients, and results in better communication between providers, patients and family members. The social workers share information with partners on the most effective actions and strategies. The results are that healthcare providers are no longer bogged down by contacting community partners on mental-health issues. Nurses can spend more time on patient health needs. As Rome Memorial Hospital does not have an inpatient psychiatric unit, its staff sends patients either to SEMC or Faxton St. Luke's Healthcare, depending upon bed availability.

A third goal was for OCDMH to research grant funding for an Electronic Medical Record (EMR) for the purpose of sharing patient information. In terms of the EMR, Oneida County Department of Mental Health continues to share and support grant opportunities with the Oneida County Office of Mental Health (OMH) providers. Regular meetings related to OMH clinic restructuring are hosted by the Department of Mental Health and record-keeping as it relates to the new OMH clinic regulations are an important part of that meeting.

Another goal in 2009 was to research NYS guidelines to learn if medications may be adjusted for patients with developmental disabilities or mental health problems. Through the Oneida County Emergency Psychiatric Services System and, specifically, the UR/9.41 subcommittee, data continues to be analyzed on a monthly basis to determine if MCAT/Provider Community Crisis Intervention is impacting the numbers of ED presentations for mental health assessments. Closer analysis of MCAT data, hospital ED data and law enforcement data is indicated and OCDMH is taking steps to reconcile these sources of information for a more accurate analysis.

In addition, Oneida County Department of Mental Health has facilitated a collaboration between the Addiction Crisis Center (ACC), Department of Social Services and Conifer Park's Detox. Program (primarily for opiates). An arrangement has been made for patients without insurance who present (at local Emergency Departments or ACC) with active/acute withdrawal to be triaged from Oneida County to Conifer Park with Emergency (expedited) Medicaid. Conifer Park provides transportation to its facility. Discussion regarding expanding this service to include other substance use is ongoing.

Oneida County Department of Mental Health is now gathering data on the numbers of individuals who are brought to Oneida County Emergency Departments under MHLS 22.09 (public intoxication). Education/training with law enforcement on the use of this custody transport (22.09) is ongoing. Once this data is accurately tracked, OCDMH can better plan for substance-abuse treatment, including the need for a "medically supervised" detoxification facility for Oneida County. Currently, ACC is considered a "medically monitored" detoxification facility.

4. Goals will continue to be measured for effectiveness by:

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

Priority 2 – Healthy Mothers, Healthy Babies, Healthy Children

The initiatives identified by the teams in Oneida and Herkimer counties include better access to care and coordination of care. The under-served are identified as a high priority.

- **<u>Better access to care includes consolidation of OB Care Services at one provider location.</u>**

Background:

St. Elizabeth Medical Center and Faxton St. Luke's Healthcare 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 began collaboration to centralize the services at one site and provide a comprehensive, community-based program. The project involved renovations to the existing 1,810-square-foot OB Care Center located at the St. Luke's Campus of Faxton St. Luke's Healthcare and a new addition of 3,860 square feet. The new center, initially projected to be complete in 2010, would 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. The initial plan called 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. 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.

Status update of overall goals for the initiative

- Coordinate and centralize OB care services for uninsured/underserved, high-risk women and streamline OB/GYN services in one community-based care center.

The organizations (Faxton St. Luke's Healthcare and St. Elizabeth Medical Center) are currently working with the New York State Department of Health to address and secure a successful reimbursement model for the new, combined program. The development and implementation of the model has delayed the progress of the program. An extension of the $1.6 million HEAL NY Phase 7 award is being applied for in anticipation of a successful resolution of the reimbursement barrier.

- Alleviate current obstetrician shortage at Faxton St. Luke's Healthcare by sharing physician services and increase efficacy of treatment by using family practice residents to assist in providing treatment.

The organizations have explored a "Laborist" model for provider coverage. There are currently 12 "Laborist" models across the country managed by an organization known as Delphi Healthcare Partners, Inc. This possible model would be compatible with the Family Practice Residency program of St. Elizabeth Medical Center.

- Remove perceived barriers to accessing prenatal care services.

Much of 2010 was spent identifying what resources were currently available, areas of overlap, as well as unmet needs. Work groups are addressing access to prenatal care, access to care and teen pregnancy prevention.

Team members include Catholic Charities, Planned Parenthood, YWCA Mohawk Valley, Mohawk Valley Perinatal Network, St. Elizabeth Medical Center, Faxton St. Luke's Healthcare, Oneida County Health Department, Cornell Cooperative Extension, Care Net Pregnancy Center of CNY, Utica Safe Schools and Herkimer County Health Net.

The Maternal-Child Health work group is addressing priority areas of low birth weight, preterm birth, and early entry to prenatal care. Led by Diana Haldenwang of the Mohawk Valley Perinatal Network, the team is exploring a concept known as **Centering Pregnancy**, a model of group healthcare delivery coordinated through local prenatal care centers and private obstetrical offices. A community-wide presentation will be held in September 2010. Following the program, the team will develop specific action plans and timelines for implementation, should the model be adopted.

Notes about the model:

Centering Pregnancy has three components – health assessment, education, and support – provided in a group facilitated by a credentialed health provider and a co-facilitator who is a nurse or other appropriate staff member. This evidence-based redesign of healthcare delivery helps promote safety, efficiency, effectiveness, timeliness, culturally appropriate patient-centered care, and more equitable care. Group participants meet regularly with their care provider and other group participants for much longer (up to two hours) than a usual check-up visit.

Evidence suggests that outcomes for people receiving care in groups are uniformly better than for those in traditional care. The model has shown to help reduce preterm birth for women in Centering groups, increase patient satisfaction, increase breast-feeding rates, and improve knowledge and readiness for birth and parenting.

It has been proven that Centering pregnancy can be cost neutral, with the reduction in preterm births saving significant dollars within the health system. Other considerations of cost effectiveness also include long-term measures such as: incidence and effective treatment of depression, maternal and childhood obesity, school readiness, and effective contraception.

- Communication and outreach, access to care

In 2010, informational posters/brochures have been developed and distributed by Faxton St. Luke's Healthcare and Mohawk Valley Perinatal Network to promote an awareness of resources available for newly pregnant mothers, all to support and encourage the importance of good prenatal care.

- Teen Pregnancy Prevention

Teen Pregnancy Prevention Network is led by Rachael Poczatek and Emmie Comstock, Mohawk Valley Perinatal Network. The objective of the team is to decrease the percentage of adolescent teen pregnancies of 15-19 year-olds in Oneida, Herkimer and Madison counties by 5-10% over the course of five years (2011 to 2016) as measured by the NYS Dept. of Health Vital Records Data.

Strategies include:

- A half-day training and awareness program for Health and Physical Education teachers, school nurses, family educators, and any other interested school personnel on various sex-education topics.

Target dates for a program will tie to available days with school personnel, such as a scheduled day off (Superintendents Day) in the spring 2011 and summer 2011.

Partners include:

- BOCES Oneida, Herkimer, Madison
- BOCES Madison, Oneida
- Local schools
- Agencies within our network - Utica Safe Schools, YWCA, Faxton St. Luke's, Planned Parenthood, MVPN, AIDS Community Resources, Catholic Charities, etc.

- Collaborate with Compeer and local colleges to recruit volunteers to be mentors for local mentoring programs (Compeer, Hamilton College, For the Good, etc.) Target date to be determined.

Partners include:

- Compeer
- Hamilton College - For the Good
- Other local colleges

A free community program offered in September 2010, "Understanding and Engaging Teens" by the Mohawk Valley Perinatal Network, is part of educational services to help agencies and care providers better understand what motivates youth and provide information on how to engage them in their own health decisions.

Barriers to Care

Barriers to care continue to be the scheduling and access for convenient appointment times, providing shorter wait times for care, 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.

On the horizon:

2010-2011 Anticipated completion of the OB Care Center at the St. Luke's Campus of Faxton St. Luke's Healthcare and full consolidation of services, including greater access to care for the under-served. Members of the Healthy Mothers, Babies and Children work group will continue to support the development of a community-wide model that provides comprehensive care, decreases pre-term births, improves patient satisfaction and increases breast-feeding rates and readiness for birth and parenting. The team will continue outreach and implementation of teen pregnancy-prevention strategies.

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

Priority 3 – Chronic Disease Management

In 2009, the 3-year plan focused upon Tobacco Cessation, which was 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. There are currently 123 participating partner healthcare provider organizations, including St. Elizabeth Medical Center, Faxton St. Luke's Healthcare, Mohawk Valley Heart Institute, Oneida Healthcare, Rome Memorial Hospital, Little Falls Hospital, Community Memorial Hospital, Slocum-Dickson Medical Group, PLLC and BRiDGES.

The Tri-County Tobacco Cessation Center received an additional 3-year grant from the NYSDOH in 2009. The grant is funded and reviewed annually. Members from the Tri-County team participate in the Chronic Disease Work Group.

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

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

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

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

Local Cessation Services/Effectiveness of Program

Success of the program is measured through the success of individual facilities and community education and compliance. Department of Health Tobacco Control Program deliverables, growth required/measured annually include:

- Number of healthcare provider organizations that participate in provider education and sustainable documentation systems change
- Number of healthcare provider organizations that move to a "maintenance" phase; demonstrating sustained changes in standard of care for the treatment of tobacco dependence (criteria exist)
- Number of trainings and technical assistance visits provided by Cessation Center staff to local healthcare provider organizations
- Number of Medicaid claims for pharmacotherapy for smoking cessation
- Number of Medicaid claims for smoking cessation counseling (pregnant women)
- Number of healthcare provider referrals to the New York State Smokers' Quitline.

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 Health Care Provider Organizations (HCPOs) and Primary Care Providers (PCP), collect and analyze outcomes data, and administer stipends to organizations that host the classes.

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

The Tobacco Cessation Center also supports cessation among local employers and college campuses. Started in 2004, the Cessation Center had 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 combined counseling, pharmacotherapy and support for employees and students at participating organizations. As the DOH funding for the provision of Nicotine Replacement Therapy has significantly diminished, the Cessation Center has worked with local employers to enhance their cessation benefits available through their own health insurance, making the program sustainable.

In addition to working through the Tri-County Tobacco Cessation Center, the Oneida and Herkimer Counties Chronic Disease Work Group is dedicated to an expanded regional effort to develop and implement strategies that will enhance the health and wellness of the community members in Oneida and Herkimer counties. The group is comprised of representatives from different healthcare and community organizations and has agreed to a collaborative approach to meet the following two data-driven objectives:

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

As of July 17, 2010, the work group has met four times (April 22, May 27, June 24 and July 17) and has a standing meeting set for the fourth Thursday of each month at 8 a.m. At the initial meeting, informal sub-groups were formed and completed a root-cause analysis of the data-driven objectives related to cancer, heart disease, stroke and diabetes. Common areas between the diseases were identified:

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

Strategies to address the common areas were conceived. At subsequent meetings, subject-matter experts were invited to join the group; the strategies were refined and a permanent subgroup was formed to research and make recommendations related to best practices. Much discussion has ensued over the use of screenings as a method to meet our objectives. The group has come to consensus in agreeing that screenings should be viewed in two ways: engaging patients who have health insurance to participate in

covered health screenings and the provision of community screenings to target populations (uninsured, those who live in rural areas, and target populations identified in the data).

Recommended strategies and operational methodologies:

I. Develop and distribute evidence-based practices guides to local healthcare providers for review with their patients, as well as encouraging patient self-advocacy.

A. Utilize existing screening recommendation materials from the American Cancer Society (ACS), American Heart Association (AHA), and American Diabetes Association (ADA). Screening guides are a product of the Preventative Health Partnership, a national collaborative of the ACS, AHA and ADA. They include the most up-to-date screening recommendations and have been field-tested by the Preventative Health Partnership.

B. Utilize current work group member activities, i.e. County Fairs, Canal Days, etc. to distribute the screening guidelines.

C. Develop a protocol for utilizing the materials at select confirmed pilot healthcare providers:

Rome Medical Group
Rome Medical Group: Camden Campus
FSLH Adirondack Community Physicians' North Utica Office
FSLH Adirondack Community Physicians' Waterville Office
SEMC Clinton Medical Practice Group
SEMC Sauquoit Medical Practice Group
Little Falls Hospital Newport Primary Care Site

In addition, Mohawk Valley Heart Institute, collaboration between St. Elizabeth Medical Center and Faxton St. Luke's Healthcare, conducts an annual Cardiac Risk Assessment at the American Heart Association's Health and Fitness Expo in March. At this event, individuals are voluntarily screened for cardiac risk factors and have an opportunity to discuss their results with healthcare providers, if they choose. They are also offered printed information about cardiac health.

D. Begin pilot (provider distribution of materials and placement of patient education materials in exam and waiting rooms) September 15, 2010, ending December 15, 2010, with 30- and 90-day follow-up visits. The work group has proposed using the materials in two different ways:

- Working with a pilot study group of physician offices, patients will be exposed to a health card with information (passively) in the waiting room. Upon being escorted to an exam room, the nurse will point out a poster on the wall and give the patient a "tear-off" sheet to discuss with the provider. The provider will query the patient for questions and recommend (and hopefully, order) appropriate screens. This three-month pilot will include monthly site visits and a formal provider evaluation at the end of the trial.

- Utilizing community education opportunities, members of the chronic disease work group will distribute the "tear off" sheets at health fairs, employee fairs, etc. A formal evaluation tool has been developed to determine the effectiveness of this approach, as well.

E. Develop evaluation measures: evaluate pilot program, complete recommended process/performance improvements, with community-wide rollout (group member representation) April 2011.

F. Increase the "reach" of the information by requesting that local employers and health insurers distribute and disseminate information on health screenings.

G. Make a collective request (FSLH, Rome Memorial Hospital, SEMC, and Bassett) to local media outlets to develop and run earned media related to the screening campaign.

II. Develop a multi-organizational collaborative to provide selected community screenings to target populations (uninsured, rural community members, select target populations identified in the data).

A. Complete an assessment of what screening/education/treatment offerings are currently being offered by work group members (complete).

B. Work with Cancer Program Services (covers both Oneida and Herkimer counties) to enhance the four existing rural health fairs.

C. Supplement the current schedule with one to two additional opportunities to reach the target populations. It was the recommendation of the best practices subgroup to participate in the "Voices for Christ Crusade" in Rome on August 21. (This event drew over 2,000 participants in 2009, primarily African Americans and Hispanics from both Rome and Utica.) There was a request from organizers for healthcare participants, and a small contingent of the subgroup took part in the Crusade. (MAMI Interpreters, Rome Memorial Hospital, FSLH and CPS). The general consensus was it was valuable and if the group gets involved earlier on, it would be beneficial to participate in future years.

III. Disseminate information through an information "clearinghouse" in each county.

A. Garner an administrative commitment from the Health Department in Oneida and Herkimer counties to serve as information clearinghouses (providing resources to community/business members who are looking for local screening, prevention and treatment services within the county). This would include posting community events such as health fairs, etc. to the county DOH websites, as well as responding to requests from community members/businesses for resources to provide requested services. (Example: a local business could call the Health Department and receive information on what organizations would provide a blood pressure screening for them.) This website may be organized into direct categories: community calendar, prevention/education, treatment options, and financial resources. A subcommittee has been formed to finalize the elements of this initiative.

B. Utilizing the work group, provide the two counties with as much information as possible to utilize, develop and maintain the information clearinghouse.

C. Collectively request (FSLH, Rome Memorial Hospital, SEMC, and Bassett) that local media outlets develop and run public service announcements related to the role of the Health Departments, to provide good public relations between all of these healthcare entities and the community, and to promote collaboration among the hospitals, not competition.

Priority 4 – Access to Quality Healthcare

This identified initiative, while not a core component of the 2009 action plans, has a collaborative team of area agencies and providers working to develop an action plan for 2011 and beyond. The goal is 'better use of community health resources through health education and awareness' with a strategy to 'reduce emergency-room usage for primary, non-emergent purposes via a public education campaign.'

Four objectives have been identified:

1. Assess current emergency-room usage patterns.
2. Assess urgent and primary care providers' ability to accommodate non-emergent needs.
3. Assess current information and education campaigns designed to reduce inappropriate use of emergency rooms.
4. Develop recommendations for new strategies that will positively impact effective utilization of emergency rooms.

Implementation steps are in the development phase and the teams, and their subcommittees are gathering data through the end of 2010 with recommendations to be developed in 2011.

Priority 5 – Physical Fitness and Nutrition

While not a core priority, the Get Moving! Initiative is being developed by the *Regional Health Council* of Herkimer and Oneida Counties with the help of the community's voice through the 2010 Regional Health Summit. The project is spearheaded by a number of influential policymakers and public-health advocates from both Herkimer and Oneida counties, in addition to many local not-for-profit organizations.

Get Moving! is 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, Inc.

and the participation of the Herkimer County Public Health and the United Way of the Valley and Greater Utica Area.

Get Moving! supports the goal of improving the health/wellness of residents of Herkimer and Oneida counties. More specifically, Get Moving! aims to address the issues of physical activity and nutrition at three levels of implementation across both counties.

Three areas have been defined: **schools**, **workplaces**, and **the community.** Research suggests that successful interventions at all three levels will help to reduce the number of sedentary and overweight individuals residing in our region of NYS and subsequently reduce the poor health outcomes and large healthcare costs associated with obesity.

Strategic planning and action plans are currently under development, based upon the research conducted by master of public health candidate Kyle Miller, under the guidance of Thomas H. Dennison, Ph.D., associate director, Central New York Master of Public Health, The Maxwell School, Syracuse University.

6. Dissemination of the Report to the Public

A. Public Information

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

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

The Community Service Plan and St. Elizabeth Medical Center's Annual Report are also available at the St. Elizabeth Department of Marketing and Public Relations. St. Elizabeth welcomes public

comment and input. Contact the Department (315-798-8195; marketing@stemc.org), St. Elizabeth Medical Center, 2209 Genesee St., Utica, NY 13501.

7. Changes (Actual or Potential) Impacting Community Health, Provision of Charity Care, and Access to Services

Potential Impacts

The Medical Center's Strategic Plan is aligned with the needs of the community, particularly the need to access services. Healthcare is seeing a shift from inpatient to outpatient services. The Medical Center's goal is to continue to expand its outpatient services: urgent care, x-ray, and primary care. Total free care provided by SEMC in 2009 was more than $9.9 million.

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

1. Outpatient: expansion of services at a new building in New Hartford (2010), which include a sports medicine and rehabilitation facility and a new wound care center that contains hyperbaric chambers for optimum healing. Plans for 2011 include primary care, laboratory and imaging services and a new urgent care center.
2. Covering the uninsured: over 26,000 uninsured residents are in Oneida County. SEMC is working to ensure that all of our citizens have health coverage, especially the poor and vulnerable.

8. Financial Aid Program

Successes and Challenges

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

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

Guidelines with the high end of eligible income being 220% of the aforementioned Federal Poverty Level.

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

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

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

The final five pages of this document summarize more specific actions identified at the 4/24/09 Regional Health Summit that are planned for each Selected Priority.

MENTAL HEALTH

- Diagnosis early
- De-stigmatize
- Child and Family Clinic Plus
- Parents/Head start
- 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

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 community-wide ▪ Identify what the community has available ▪ Create an access point: where to go, what to do ▪ Incentives – employers encouraging health and wellness, insurance reductions, programs to promote in school and workplace ▪ Partners - schools, businesses, healthcare provider, service agencies, farmers, and faith community ▪ Community nutrition– community gardens/cooking classes, more access to farmer's markets (identify obstacles: weather, access, transportation, safety, time for health programs) ▪ Farmers- Developing partnerships, buy and grow locally ▪ Share purchase on local farms to get fresh produce ▪ Community Food Banks- access to fresh produce ▪ Refine public assistance in re: Nutrition and what types of foods are acceptable. Require 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 – make people aware of them (Boilermaker, Rayhill Trail, Bria Trail, Heart Run/Walks) ▪ Developing trail systems ▪ Sidewalks ▪ Winter programs ▪ Safe places ▪ Low cost ▪ Invite people into the program – means or way to encourage participation – ease of use for all people. ▪ Recruit a community of volunteers around the "community-wide theme" (tap youth/college volunteer base) ▪ Challenge community "Biggest Loser Campaign" ▪ Parks/Recreation open house in our communities ▪ Measure BMI ▪ Theme movements (Move for Life, Scavenger hunts – put clues in local newspaper- them hunts, game contests, team programs) ▪ Web sites – information ▪ Equipment exchange (bikes, balls, gloves, tennis racquets, etc.) for people who can't afford them ▪ Grants – Apply, apply, apply together as a community ▪ Take advantage of college PR programs to promote ▪ Need a "house-organization" to take ownership	**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 numbers 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

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

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

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

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