MONROE COUNTY

JOINT COMMUNITY

SERVICE PLAN

Lakeside Health System
Rochester General Health System
Unity Health System
University of Rochester Medical Center

- *Highland Hospital*
- *Strong Memorial Hospital*

2011

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Introduction

Monroe County
Joint Community Service Plan
Introduction

This is the twelfth year that the hospitals of Monroe County have jointly submitted a community service plan to the New York State Department of Health. This unique effort, done in collaboration with the Monroe County Department of Public Health, has allowed the hospitals in Monroe County to go well beyond the basic requirements of submitting individual community service plans. A review of previous joint submissions will show a variety of community initiatives that have benefited our patients and the residents of Monroe County; benefits that would not have been otherwise realized.

This year, 2011, is no exception and has the added benefit of a close alliance between the hospitals and the local health department as Monroe County has developed its Community Health Assessment. The hospitals have been pleased to be able to participate in this process with the Monroe County Department of Public Health in support of Commissioner Daines's Prevention Agenda.

Further, a goal of the Monroe County hospitals in this plan is participation in the Finger Lakes Health Systems Agency's 2020 Performance Commission process. A specific objective of this process is the reduction of avoidable admissions (PQI admissions) again, a major initiative of NYSDOH.

The Monroe County hospitals are pleased and proud to submit this Joint Community Service Plan.

Mission Statements

Lakeside Health System

Vision Statement

Lakeside Health System seeks to be a national model for community healthcare through its delivery of high quality, personal trusted care.

Mission Statement

Lakeside Health System is to be the center of our healthcare community and to provide the highest level of quality, compassionate, cost-effective care. The services we provide to our customers are rooted in an integrated delivery system.

Rochester General Health System

Mission Statement

To improve the health of the people served by providing high quality care, a comprehensive range of services, convenient and timely access, delivered with exceptional service and compassion.

Unity Health System

Vision Statement

Unity will be viewed as the leading provider in the markets we serve, known for the excellent quality and service that we deliver to our customers.

Mission Statement

The mission of Unity Health System is to make a positive difference in the health and well-being of those we serve.

Strong Memorial Hospital

Mission Statement

We improve the well-being of patients and communities by delivering the highest quality health care in a safe, compassionate environment enriched by education, science, and technology.

HIGHLAND HOSPITAL

An Affiliate of the UNIVERSITY of ROCHESTER MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

Highland Hospital

Mission Statement

Commitment to service excellence in health care, with patients and their families at the heart of all we do.

Service Area

Monroe County
Joint Community
Service Plan

Service Area

Because this plan is a joint submission of the hospitals in Monroe County and has been prepared in collaboration with the Monroe County Department of Public Health, and within the context of its Community Health Assessment, the plan's service area is Monroe County.

Public Participation, Assessment of Public Health Priorities, and Dissemination of the Report to the Public

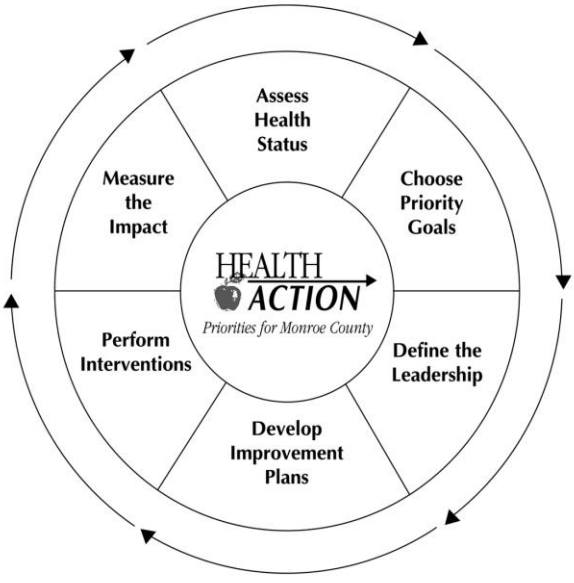
Public Participation, Assessment of Public Health Priorities, and Dissemination of the Report to the Public

The needs assessment that has guided our joint effort over the past several years is a robust community-wide process involving all four health systems, the county health department, and other key community stakeholders. We believe it is unique in New York State and that it has resulted in a more comprehensive needs assessment than any system could perform individually. It has also allowed the health systems to be involved in planning efforts and service provision that goes beyond clinical care and enter the domains of prevention and public health. The process, known as **HEALTH *ACTION***, is described below.

The four health systems represented in our community service plan are key participants in **HEALTH *ACTION***, which is a community-wide health improvement initiative coordinated by the Monroe County Department of Public Health. The vision for **HEALTH *ACTION*** is continuous, measurable improvement in health status in Monroe County. This is implemented by selecting priorities for action from health goals identified in community health report cards in each of the following focus areas:

- Maternal and Child Health
- Adolescent Health
- Adult/Older Adult Health
- Environmental Health

The process used by **HEALTH *ACTION*** for each focus area is shown in this graphic.



To accomplish a community engaged health status assessment, the Steering Committee of **HEALTH *ACTION*** established five subcommittees to develop the initial community health report cards: Maternal/Child Health, Adolescent Health, Adult Health, Older Adult Health and Environmental Health. These committees were charged with compiling and analyzing data to identify measures of health status for each of the report cards, identifying five to ten goal areas, preparing report cards for publication, and making recommendations about priorities for action. As report cards are updated, these committees are re-convened to provide consultation.

Below are lists of community agencies/organizations represented on the Board of Health report card committees for each of the life stage areas.

Maternal/Child Health Report Card Committee
Child Health Studies Unit, University of Rochester
Children's Institute
Healthy Start Rochester
Monroe County Department of Public Health
Monroe Plan for Medical Care
Perinatal Network of Monroe County
Social Work Department, Golisano Children's Hospital

Adolescent Health Report Committee
HUTHER-DOYLE Addiction Prevention and Treatment Services
Metro Council for Teen Potential
Monroe County Department of Public Health
Monroe County Office of Mental Health
Monroe County Youth Bureau
Threshold Center for Alternative Youth Services
University of Rochester Departments of Community and Preventive Medicine, Medicine and Pediatrics

Adult /Older Adult Health Report Card Committee
Center for Community Health, University of Rochester
Department of Geriatrics, Rochester General Health System
Department of Medicine, Highland Hospital
Department of Psychiatry, University of Rochester Medical Center
Evercare
Excellus
Finger Lakes Health System Agency
Lifespan of Greater Rochester
Monroe County Office for the Aging
MVP Health
Nursing Program, the College at Brockport
Olsan Medical Group
Rochester Area Community Foundation

Publication dates of the most recent report cards are as follows:

- Maternal Child Health Report Card -2003
- Adolescent Health Report Card – 2006
- Adult/Older Adult Health Report Card - 2008.

After the publication of each report card, the respective report card committee hosts a series of community forums with health professionals, community organizations and Monroe County residents in order to obtain input on which health goals should be priorities for action. During the forums there is a brief presentation of the goals and measures contained in the report card. Forum participants are then asked to rank the goals based on the following criteria: importance; sensitivity to intervention; control; and timeliness. In addition, participants are asked which goal they think should be a priority for action.

Information about the most recent forums held in Monroe County can be found below.

In 2004, the Maternal/Child Health Report Card Committee conducted 15 health forums with 142 people. Below is a list of groups that hosted the forums.

Maternal Child Health Forums	
African American Health Task Force	Rochester Early Enhancement Project
Association of Agency Directors	Rochester City Elementary School Nurses
Community Pediatricians	Peter Castle Family Resource Center Parents Group
Early Childhood Development Initiative	Head Start Parents
Head Start Staff	Healthy Start Clients
Hispanic Health Coalition	Skip Generation
Monroe County Board of Health	Webster "Mom's Group"
Quality Assurance Representatives from Health Insurers	

Based on feedback from the forums, the following goals were selected as priorities for action:

- Increase Physical Activity and Improve Nutrition
- Improve Social and Emotional Well Being and Reduce Child Abuse/Neglect and Violence Against Children.

In 2006, the Adolescent Health Report Card Committee conducted 22 forums with 284 participants including youth, parents, and professionals that work with youth. Below is a list of groups that hosted the forums.

Adolescent Health Forums	
African American Health Care Group	Parents of Families Affected by HIV/AIDS
Asset Partner Network	Penfield Health Class
Brockport School Wellness Committee	Penfield School Wellness Committee
Children's Detention Center Home & Careers Class	RCSD Secondary Health Teachers
City Recreation Staff	BOCES Secondary School Nursing Supervisors –RCSD
Drug Free Coalition at North Street Rec Center	University of Rochester Department Pediatrics
Edison Tech Health Class	Via Health School Health Professionals

Franklin Health Class	Wheatland Chili Health Class
Henrietta Parents of Children Involved in Asset Prg.	Wilson Health Class
Metro Council for Teen Potential	Youth Services Quality Council
Monroe County Board of Health	Youth Voice One Vision

Based on the feedback received during the forums, the Board of Health, in 2007, selected the following goals as priorities for action:

- Increase Physical Activity and Improve Nutrition
- Build Youth Assets

In 2008, the Adult/Older Adult Health Report Card Committee conducted 29 health forums and obtained feedback about health priorities from 450 adults, older adults, professionals, and representatives from community-based organizations that work with this population. Below is a list of groups that hosted the forums.

Adult Health Forums	**Older Adult Health Forums**
African American Health Coalition, FLHS	Elaine Hubbard Center for Nursing Research on Aging, UR
African American Leadership Development Program, United Way	Geriatric Grand Rounds, FL Geriatric Education Center of Upstate NY & Geriatric/Aging Division of UR
Beta Chi Chi Chapter of Chi Eta Phi Sorority, Inc.	Geriatric Nurse Resource Group at ViaHealth
Community Counts Group, Office of Mental Health Promotion, UR Department of Psychiatry	Home Care of Rochester (HCR), Program Managers and Executive Staff
Grace United Methodist Church Deacon's Table	Lifespan Congregate Meal Program Participants
Greater Rochester Health Foundation Staff	Lifespan staff
Health Associations Collaborative (HAC), FLHSA	Lifespan volunteers
Judicial Process Commission	Northwest Congregate Meal Program Participants
Latino Health Coalition, FLHSA	Northwest YMCA older adult volunteers
Mental Health Promotion Task Force, FLHSA	Senior Center Coordinators
Monroe County Board of Health	Valley Manor Resident Group

Public Health Committee, Monroe County Medical Society	
Preferred Care Medical Advisory Team	
Public Health Grand Rounds Faculty, staff and students, UR	
Rochester Business Alliance, Health Planning Group	
ROC City Coalition	

Based on the feedback obtained during the forums, the Board of Health, in 2009, selected the following goals as priorities for action for adult and older adult health:

- Increase Physical Activity and Improve Nutrition
- Improve Prevention and Management of Chronic Disease
- Improve Mental Health (reduce violence among adults and elder abuse among older adults).

Prevention Agenda Priorities

The process for developing the 2009 Joint Community Service Plan, in which we developed our Three Year Plan of Action, involved representatives from the four health systems and the Monroe County Department of Public Health meeting together throughout the past year to determine which Prevention Agenda priorities we should pursue together. These discussions were informed by the process noted above. We decided that our community service plan will focus on two items:

- Increase Physical Activity and Improve Nutrition
- Improve Prevention and Management of Chronic Disease.

Specific goals related to these Prevention Agenda priorities were presented in the 2009 plan. Progress towards these goals will be discussed in the section Update on the Plan of Action.

Dissemination of the Report to the Public

All of the health systems in Monroe County are fortunate to be governed by boards made up of community representatives who volunteer their time and expertise. This Joint Community Services Plan is shared with our board members and they are encouraging of this cooperative effort. In addition, we will be posting this plan on our websites and submitting copies to the Healthcare Association of New York State.

2011 Update on the Three Year Plan of Action

2011 Update on the Three Year Plan of Action

As a result of the Assessment of Public Health Priorities conducted by the Monroe County hospitals in collaboration with the Monroe County Department of Public Health, described in the previous section, the hospitals decided to develop their three year plan of action around two Prevention Agenda priorities:

- Increase Physical Activity and Improve Nutrition
- Improve Prevention and Management of Chronic Disease.

This section of the 2011 Community Service Plan will describe progress toward the goals identified in last year's plan.

Increase Physical Activity and Improve Nutrition

Increase Physical Activity and Improve Nutrition has been a **HEALTH *ACTION*** priority for several years. Previous Monroe County Hospital Community Service Plans have highlighted some of the work the hospitals have done in this area, including the Physician Prescription Exercise Program, the Survey of Pediatricians related to obesity prevention practices, the development of the Resource Directory of Nutrition and Physical Activity Programs, and work with schools on their wellness plans.

In June of 2009, the Monroe County Department of Public Health and the University of Rochester's Center for Community Health convened the Monroe County Physical Activity and Nutrition Task Force. The vision for the Task Force is "Monroe County adults will maintain healthy eating and physical activity supported by policies and environments (physical and social) that promote healthy lifestyles at home, work and in the community." The mission is to "Identify and implement sustainable policy and environmental changes that promote increased physical activity and improved nutrition among adults in Monroe County."

Agencies and organizations represented on the coalition are listed below.

Physical Activity and Nutrition Task Force	
African American Health Coalition	Monroe County Parks Department
City of Rochester, Mayor's Office	Monroe Plan for Medical Care
Excellus Blue Cross Blue Shield Rochester Region	MVP Health Care
Finger Lakes Health Sys. Agency	Paychex, Inc.
Foodlink	Local Restaurant Association
Greater Rochester Health Foundation	U of R Dept. of Community and Preventive Medicine
Ibero-American Action League, Inc.	University of Rochester Medical Center
Latino Health Coalition	University of Rochester, Center for Community Health
Monroe County Dept. of Planning and Development	Unity Health System
Monroe County Parks Dept.	Wegmans Food Markets, Inc.
Monroe County Department of Public Health	Westside Health Services
Monroe County Medical Society	YMCA of Greater Rochester

The Task Force compiled a list of 22 evidence-based, promising, or recommended policy/environmental/system strategies to improve nutrition and/or increase physical activity. The strategies were drawn from three major reports that had surveyed research on a wide variety of interventions to address these issues:

- Community Guide to Preventive Services Recommendations: What Works to Promote Health http://www.thecommunityguide.org/index.html
- Recommended Community Strategies and Measurements to Prevent Obesity in the US (Centers for Disease Control and Prevention) http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm
- Texas Obesity Policy Portfolio http://www.dshs.state.tx.us/obesity/pdf/TexasObesityPolicyPortfolio.pdf

During several meetings Task Force members studied, reviewed and ranked these interventions based on the following criteria:

- How much does the community value (care about) this change?
- How much measurable impact would this policy/environmental change have? (thinking about a 10-year horizon)
- How likely is it that this community can enact this policy/environmental change?

- How likely is it that the community can amass the resources to implement and sustain this change?
- How likely it is this policy /environmental change will reduce disparities?

Based on these discussions and rankings, the Task Force developed a list of high priority areas to address:

- Healthy work places (environmental, policy and program supports)
- Safe neighborhoods and built environment policies that support physical activity
- Medical practice interventions and community based behavior change programs for underserved populations

Monroe County hospitals will work with the Physical Activity and Nutrition Task Force to explore and implement one or two environmental or policy changes within each hospital to promote physical activity and/or healthy eating among staff and/or visitors. Possible changes may include:

- Placement of point-of-decision prompts near elevators to encourage use of stairs
- Implementation of physical activity breaks
- Implementation of food pricing strategies in hospital cafeterias that encourage buying healthy foods
- Creation of, or enhanced access to, places to be physically active, combined with informational or outreach activities. For example, hospitals may create walking trails on the hospital grounds for use by staff and visitors.

Members of the Community Service Plan Group for each hospital agreed to be responsible for assuring the implementation of at least one change within their hospitals.

Overall community measures of this goal will include the following data from the Monroe County Adult Health Survey:

- % adults who are overweight or obese
- % of adults who engage in leisure-time physical activity
- % of adults who consume 5 or more servings of fruits and vegetables per day.

Members of the Community Service Plan Group for each hospital were responsible for assuring the implementation of at least one change within their hospital. Outlines of individual hospital programs and participation have been developed in 2010 and appear in Attachment 1.

Improve Prevention and Management of Chronic Disease

The Monroe County hospitals chose three initiatives to support this Prevention Agenda priority:

- Improve asthma care of children through establishment of the Breath of Hope Asthma Program

- Improve diabetes care in primary care offices by increasing the number of primary care physicians who are NCQA-certified in diabetes care

- Reduce preventable hospitalizations (PQI admissions) by participating in the Finger Lakes Health Systems Agency 2020 Performance Commission process.

Improve Prevention and Management of Chronic Disease

The Breath of Hope Asthma Program

Since 2008, the Department of Pediatrics at the University of Rochester Medical Center has been coordinating an effort to create a program that provides a mobile asthma service in support of primary care practices and other community agencies in their efforts to care for children with asthma and their families. The effort has included Monroe County's hospitals, a local community health center, the Rochester City School district, and other community stakeholders. Recently a program director was hired and a decision was made to pilot the program in Unity Pediatrics, a pediatric practice in inner-city Rochester.

The program recognizes that managing childhood asthma is a difficult and complicated process and requires interventions beyond primary care office visits. A van will be staffed by community health nurse educators and will visit children with asthma in a variety of settings, e.g. school or home, to help provide the support for patients around the intricacies of education, self-management, etc. Children and families in need of these services will be identified through data registries that would be developed.

Breath of Hope

Background:

Asthma is one of the most common long-term conditions among children today. There are about 9 million children in the United States under the age of 18 years who have been diagnosed with asthma.

- Several studies have shown that up to 40% of children who have parents with asthma will develop asthma
- Between 50% and 80% of children with asthma developed symptoms before the age of 5 years
- In 2005, asthma was 25% more common among African Americans than among Caucasians

Monroe County is one of several NYS counties with the worst air pollution grades.

Breath of Hope Asthma *demonstration pilot* is the implementation of SMH tested clinical practices in asthma management and adaptation of these practices to community-based (i.e., community pediatricians' offices-based) settings. Implementation in the community outpatient setting best serves the overarching goal of this initiative – to keep children with asthma out of the hospital, out of the ED, in their schools, and in their communities and homes. This has the added benefit of keeping their parents at work and vastly lowering the direct and indirect costs of healthcare to the community.

Steering Committee members include:

American Lung Association
Regional Community Asthma Network of the Finger Lakes
Anthony Jordan Health center
Excellus
Rochester General Hospital
Golisano Children's Hospital at URMC
University of Rochester Medical Center
Unity Health System
Rochester City School District
Monroe Plan for Medical Care

Demonstration Pilot Development: Coordinating the exchange of information among the diverse array of care providers to assure appropriate care is difficult and time consuming and impedes the patient and family's ability to function as an activated patient. The Breath of Hope pilot positions families as a central participant in care and manages essential asthma data via a centralized, multi-user, secure information management system.

Pediatric Practice Demonstration Sites: Each of the five pediatric practices that serve predominantly the inner-city Rochester pediatric population is still active in the Breath of Hope pilot. Identification of patients facing challenges in maintaining asthma control continues in the following practices:

a. Golisano Children's Hospital General Pediatric Practice;
b. Culver Medical Group
c. Unity Health Care General Pediatric Network;
d. RGH Health General Pediatric Practice;
e. The Anthony Jordan Health Center.

Asthma Registry/Database: Data are maintained in the BoH database and also recorded directly by BoH care coordinators in the respective BoH pilot site medical records.

Care Coordination Service Model: Care Coordinators contact families bi-monthly by phone, schedule home visits to provide spirometry testing and asthma education with all identified families. BoH care coordinators also connect with families at the pediatric practices to obtain consent, provide asthma education and conduct spirometry testing.

Outcomes: Breath of Hope YTD Statistics

	RGPA	**Jordan**	**Unity**	**AC6**	**Culver**	**TOTAL**
Pt. Identified	27	23	25	21	21	117
Pt. Consented	27	23	25	21	16	112
# of contacts	276	177	358	227	200	1238
# of ACT	70	40	66	80	62	318
Avg ACT Score	19	17	19	19	20	19
# of home visits	7	4	9	2	7	29
PFT	6	4	9	5	7	31

Education and Asthma Information Dissemination:

Breath of Hope was presented at the NICHQ Rochester site visit as an exemplary program for health care quality improvement focusing on family-centered care. The Breath of Hope website can be found at www.rochesterbreathofhope.org

BoH Program Evaluation: Preliminary findings indicate that three medical outcomes were statistically different after our patient sample participated in our program.

1. The number of rescue inhaler prescriptions (e.g., albuterol) for each patient decreased on average by almost four prescriptions per year. Less frequent use of rescue inhalers suggests better asthma control.
2. The average number of PCP visits per patient increased by nearly three visits per year. Increased PCP visitation suggests improved reliance and engagement with the primary care system.
3. The average ACT score increased by about 2.5 points per patient. An ACT score of 19 or above is considered "controlled asthma", and our sample patients average a score of almost 19 after our intervention.

Two other important medical outcomes saw an average improvement, but this improvement did not rise to the level of statistical significance.

1. The average number of hospitalizations & ED visits decreased in our sample by 0.13 visits per patient per year.
2. There was decreased prescribing of prednisone after patients joined our program.

Related Outcomes: The **collective efforts** of the **various Rochester asthma initiatives** that inspired the Breath of Hope collaborative yield promising asthma statistics. These asthma initiatives demonstrate efficacy of the use of community-and hospital-based education, standardized practice across the community and hospital, and behavioral guidance in improving outcomes and decreasing ED visits and inpatient admissions and increasing consistency of community and hospital prophylactic outpatient follow-up visits for children with asthma.

Data for the 13 month comparative period ending July 2011 show:

- 64% of URMC inpatients leave with a completed Asthma Action Plan
- 17.9% decrease in ICU stays
- New Asthma Education Pathway will be launched in September on GetWellNetwork's GetWellTown site

For patients who presented at SMH there was:

- 10.2% decrease in SMH ED asthma visits
- 16.9% decrease in SMH inpatient admissions

Goals:

- Full enrollment with patients who engage in active program participation
- Spirometry evaluations for 100% of enrolled patients

- Operations evaluation and process change recommendations for each of the five BoH pilot practices
- Asthma Medical Home practices instituted in pilot practices

NCQA Diabetes Care

NCQA is the only national program that provides certification in diabetes care for primary care physicians. The program recognizes established standards for the provision of good diabetes care, provides a mechanism for measuring individual physician and practice performance against those standards – both process and outcomes measures – and provides certification to physicians who demonstrate expert adherence to these accepted standards. Measurement against standards serves as a prompt for performance improvement.

The Rochester Regional Quality Improvement Initiative (RRQII), a collaborative effort of local insurers, the American Diabetes Association, the Rochester Business Alliance, the Finger Lakes Health Systems Agency, the Monroe County Department of Public Health, and NYSDOH, developed a program in Monroe County that resulted in thirty-seven local primary care physicians becoming NCQA-certified for diabetes care. The group disbanded when the project was completed. Most of the physicians who received certification are employed by Monroe County hospitals or closely affiliated practices.

Using the experience of RRQII as a model, and as part of this three year plan, the Monroe County hospitals proposed to increase the number of primary care physicians who would receive NCQA certification in diabetes care.

As a result of these efforts, the number of primary care physicians certified by NCQA for diabetes care increased from 37 in 2009 to 148 in 2010. These physicians are located in 38 different clinic locations throughout the Rochester region.

Reduce Preventable Hospitalizations and Low Acuity Emergency Room Visits

The 2020 Commission, formed in 2008 and staffed by the Finger Lakes Health Systems Agency, was a collaborative process to assess and make recommendations about the number of new hospital acute care beds needed in the community. The 2020 Commission recommended that the local hospitals in Monroe County reduce the number of new hospital beds they requested from

the NYSDOH, and at the same time develop inter-disciplinary community initiatives to reduce hospital use. The Commission recommended these goals:

- Reduce by 25% the annual number of PQI hospitalizations
- Reduce by 15% the number of low acuity emergency room visits to Rochester General Hospital, Strong Health Hospitals, and Unity Hospital
- Reduce by 20% the number of low acuity admissions of residents in outlying counties to Rochester General Hospital, Strong Health Hospitals, and Unity Hospital

The Commission further recommended that goals be set related to improvements in health system effectiveness and efficiency, and improvements in health status, with an emphasis of reducing health disparities.

The 2020 Performance Commission, staffed by the Finger Lakes Health Systems Agency (FLHSA), evolved from the 2020 Commission. Local hospitals, health care providers, the Monroe County Department of Public Health, health insurers, and the business community are represented on the Performance Commission.

In the Three Year Plan of Action in the 2009 Community Service Plan, the hospitals indicated they would work with the Commission to identify and implement changes to improve management of chronic disease with specific goals to reduce PQI admissions and low acuity emergency room visits. Cooperation with and support of this effort is a major initiative being tracked in this three year plan.

Updates 2011:

Strong Memorial Hospital (SMH) and Highland Hospital (HH) continue to focus on controlling preventable readmissions and are working on comprehensive readmission reduction strategies by enhancing our discharge planning, engaging with community partners (specifically VNS - our affiliate home care agency) on post discharge coaching for our high risk discharges (which include patients with chronic conditions). Specifically, Strong Memorial and Highland Hospitals are working on reducing readmissions for all patients with an additional focus on the Acute Myocardial Infarction 30-Day Readmission Rate, Heart Failure 30-Day Readmission Rate and Pneumonia 30-Day Readmission Rate. In the first quarter of CY 2011 the overall hospital readmission rate for SMH was 11.62% with a FY 12 target of 9.88%

representing a 15% targeted reduction in the overall readmission rate. The rates of readmissions (Medicare 30-Day Readmissions for "Any Cause" July 2007 – June 2010) were as follows: Acute Myocardial Infarction 30-Day Readmission Rate 18.4%, Heart Failure 30-Day Readmission Rate 23.7% and Pneumonia 30-Day Readmission Rate 20.9% with a targeted rate respectively as follows: 15.64%, 20.15% and 17.51%" For Highland Hospital the 30 day overall readmission rate for FY 11 was 8.04% with an FY 12 target of 7.25% representing a 10% targeted reduction in overall readmissions. The other rates of readmissions were as follows: Acute Myocardial Infarction 30 day readmission rate 17.12%, Heart Failure 16.67% , Pneumonia 14.63% and Cardio Obstructive Pulmonary Disease 20.18% with targeted rates respectively as follows: 15%, 15%,13,18%.

The hospitals are also working to have all of our primary care clinics (11 for Highland Hospital and 14 for Strong Memorial Hospital) and the practices in our primary care network certified as Medical Homes. Medical Home certification requires that primary care practices have a care manager to facilitate management of patients with chronic conditions who are at high risk for inpatient and ED utilization and data coordinators to better manage the flow of information regarding patient condition throughout the practices. At Strong Memorial Hospital our Pediatric clinic has just become certified and Medicine, OB/GYN and Medicine-in-Psychiatry have submitted applications. Also included in our Medical Home efforts is the establishment of a Medical Home for chronic mentally ill patients in our Strong Ties program and Highland Hospitals' Family Medicine.

Strong Memorial and Hospital Highland Hospital along with Rochester General Hospital Health System, Unity Hospital, and Excellus Health Plan, are participating in the "Rochester Patient Safety - Clostridium Difficile Prevention Collaborative" (CDPC) utilizing specific C. difficile infection reduction interventions to decrease the incidence of C. difficile by 30% over 3 years beginning in the 4th quarter of 2011. Requirements for achieving the targeted reduction in C. difficile infection include environmental measures (cleaning and disinfection of equipment and the environment), infection prevention measures (contact precautions such as gloves and gown and private room, dedicated equipment, hand hygiene emphasizing soap and water) and education (policy standardization and fostering culture change).

Attachment 2 is FLHSA's 2010 Report to the 2020 Performance Commission. It describes the specific actions that have taken place to support and advance the goals of the 2020 Performance Commission. It describes the work groups that have been established to accomplish the goals and activities and progress to date. The Monroe County hospitals have been active participants in these work groups, as noted in the rosters included in the report.

Financial Aid Program and Changes Impacting Community Health, Provision of Charity Care, and Access to Services

Financial Aid Program
and
Changes Impacting Community Health, Provision of Charity Care, and Access to Services

Not unlike other hospitals in New York State, the hospitals in Monroe County have experienced increased demands on their financial aid programs as the economy has deteriorated. In addition, as employers have moved to insurance plans with higher deductibles and co-pays, patients are requiring financial aid in greater numbers.

Nonetheless, Monroe County's hospitals continue to endorse and adhere to guidelines from the Healthcare Association of New York State: Financial Aid/Charity Care Policy at New York's Not-for-Profit Hospitals. The significant amounts of financial aid provided by Monroe County's hospitals appear in the individual Institutional Cost Reports submitted by the hospitals.

Specific examples of how Monroe County hospitals have enhanced their financial aid programs appear below.

- Lakeside has not seen any challenges or success yet from the provisions.
  Lakeside now works with an outside vendor (Relay Health) that has a staff member on-site that assists with informing patients of our charity care/financial aid assistance program. A staff member reviews, processes, and answers questions promptly as it relates to the charity care/financial aid program. Onsite at Lakeside a Medicaid Liaison who discusses our charity care/financial aid program with patients who would not qualify for MCD and also helps patients to complete the application and provide substantiated documentation.

- Rochester General Health System (RGHS) has made a substantial change this year in the amount of financial assistance it awards to both uninsured and underinsured patients. For example, prior to this change, RGHS awarded 100% financial assistance to uninsured patients at or below 100% of the Federal Poverty Level (FPL). Uninsured patients between 101% and 400% of the FPL were then

given incremental discounts based on Medicare rates. With our current policy, 100% assistance is now awarded for uninsured patients up to 200% of the FPL, with incremental discounts being given for patients between 201% and 400% of the FPL. Additionally, with recognition of higher deductible insurance plans and the needs from greater assistance to those with insurance, RGHS has increased the percentages of assistance it awards to those who are underinsured.

In addition, in 2011 RGHS placed two Financial Counselors in the Emergency Department who screen uninsured patients for insurance and financial assistance.

- Unity Health System continues to monitor all access points within the system to identify uninsured patients. Financial counselors, Medicaid liaisons, social workers, and facilitated enrollers are available to assist with the application process for both insurance and financial assistance coverage. In 2011, the financial assistance program was extended to ACM Laboratory. When a patient is approved for financial assistance, the discount is also applied to their ACM bill.

  The Unity Medical Group completed a Lean/Six Sigma project focused on assisting self pay patients meet their financial obligations. The program continued throughout 2011 and has resulted in additional financial assistance applications/approvals. A similar project was completed in the Walk-in Care Center and one in the Emergency Center is planned for 4th quarter, 2011.

  A electronic tracking system was established for tracking financial assistance applications throughout all of Unity Health System, including ACM. This system has streamlined the back end processing function and improved customer service.

- Strong Memorial and Highland Hospital have focused a great deal of attention over the past three years ensuring that patients understand the hospitals' financial assistance/charity care programs. This includes not only providing patients with information on the hospitals' financial assistance programs when they are seen at the hospitals, but also placing information directly on the Medical Center's and Highland Hospital's website. The hospitals also have dedicated staff to work with patients on the charity care application process. As a result of these efforts, the amount of charity care provided by the hospitals has tripled over the past four years.

facing has placed financial pressures on Monroe County's hospitals. These financial pressures resulted from reimbursement cuts, increased demand on financial aid programs, and increased pension costs. Nonetheless, the hospitals will continue to work together with the Monroe County Department of Public Health and the Finger Lakes Health Systems Agency to implement the goals of this Joint Community Service Plan.

Attachment 1

2011 Area Hospital Wellness Programs

University of Rochester – 2011 Employee Wellness

- Worksite Community Supported Agriculture program delivers locally grown produce to UR employees (onsite) who enroll between June-October for Summer and December-March for Winter
- Promotion of Neighborhood farmers markets (Southwedge and Southwest)
- A major cafeteria expansion is underway for 2010 to increase healthy eating options

Program element: Access to fitness facilities/physical activity

- Two fitness centers are located at UR
- URMC Wellness Center offers 24-hour access
- R-Club (River Campus Fitness Center) opened M-F 6:30-8:00 p.m. and Saturday mornings
- Facilities are affordably priced
- Payroll deduction option
- Personal trainers, year round programming (tai-chi, aerobics, fitness challenges etc…)
- Safe and up-to date equipment
- Other fitness initiatives at the UR:
    - Annual events (National Trails Day, Bike to Work Week, Chase Corporate Challenge)
    - Indoor walking paths through AHA Start! Walking Program
    - Telephonic physical activity program "Energize" offered through Carewise Health
    - Walking clubs and Online walking resources
    - Workplace Yoga
    - CDC stairwell signage posted

University of Rochester – 2011 Employee Wellness

- Eat Well Live Well Challenge
- Stair Challenge during National Nutrition Month
- On site Sculpting classes – HH
- Website access walking maps, BMI calculator for staff and list of current activities- HH
- On site health and wellness fairs
- Participant- Worksite Alliance of Greater Rochester

Program element: Use of health risk assessments

- Employees/spouses/domestic partners are encouraged to complete an online personal health assessment* on an annual basis

- Participants receive an individualized report, recommendations on how to improve their health, and access to tools and online wellness programs

  * To date, over 5,000 employees/spouses/domestic partners have completed a PHA in 2010

Program element: Health education and programs

- Well-U holds health education classes on various topics throughout the year including National Health Observances that promote healthy lifestyle choices (Go Red Day, National Health Care Decisions Day etc…)
- The Benefits Office offers monthly educational sessions about health benefits and financial fitness
- Employees have access to free ergonomic evaluations and work station adjustments
- Health Education mailings offered through Carewise Health
- Departments within the Medical Center offer health education programs
- EAP Health Bites Series offers monthly lunch time talks on such topics:
  - Preventing Heart Attack and Stroke
  - Navigating health websites
  - Autism Spectrum Disorder
  - Crime Prevention
  - Social Networking sites and children
  - Reducing the stress of parental breakup

Program element: Access to biometric testing

- Employees and qualified spouses/domestic partners are encouraged to get a biometric screening on an annual basis (done by the School of Nursing (SON))

University of Rochester – 2011 Employee Wellness

- No cost to the employee/qualified spouse/domestic partner
- Participants receive confidential and immediate results*, feedback and recommendations

  * The University receives an aggregate report from the SON with results and recommendations, but no individual data is shared.

Program element: Access to health screenings (mammography, colonoscopy, prostate exams, etc.)

Employees who enroll in a University Health Care Plan (approximately 19,000 members) have access to in-network preventive care at no cost

- Since 2008, when the University began to offer preventable health services at no cost to health care plan enrollees, the number of adult, child, and well-baby visits per 1,000 members increased by over 10% across the board

Program element: End-of-life planning

- Well-U collaborates with Aetna and Excellus to offer an annual National Health-Care Decisions Day
  - Review of Excellus compassionate care website and materials
  - Promotion of Health-Care Proxy and Living Will
  - Promotion of website doyourproxy.org

Program element: Incentives to embrace healthful behaviors

- Cash incentives are offered to qualified employees who complete a Personal Health Assessment.
- Cash incentives are offered for the completion of a telephonic Disease Management Program
- Cash incentives are offered for the completion of a Wellness coaching program (telephonic coaching through Carewise Health or telephonic/in-person at the Healthy Living Center)
- NRT provided at no cost for qualified employees who enroll in a tobacco dependence or smoking cessation program
- Prescription drug discount for qualified DM participants (conditions include asthma, congestive heart failure, coronary artery disease, diabetes, hypertension)

Program element: Rewards/recognition for success

- Employees who complete a Weight Watchers program with perfect attendance may be reimbursed 50% of the upfront cost
- Plans are underway to institute a formal wellness recognition program

University of Rochester – 2011 Employee Wellness

Program element: Return to Work:

- Program is designed to help an employee to reach full recovery following illness or injury by allowing timely and appropriate treatment while he or she continues in meaningful work. The goal is to return the employee to regular duty within 90 days or as soon as his or her medical condition permits.

Program element: Safe Patient Handling Initiative

- Safe Patient Handling Task Force formed to monitor and evaluate safety
- Hoyer Lift available on every unit
- Sarah 300 Lift to Stands
- Hover Mats

Program element: Dedicated Employee Health Services Department

- Annual health reviews for all employees include PPD plant, blood pressure read, review of medication and latex allergy, and individual counseling as needed
- Behavioral health and medical referrals provided
- Fit testing for protection against tuberculosis
- A hearing conservation program is provided
- Free flu clinics are located at employee work sites
- Workers' Compensation and disability case management by onsite physician and team of clinicians

Program element: Annual Health Fairs

- Health and wellness fairs are provided at numerous locations to allow participation where employees work
- Biometric screening
- Stress reduction tips
- Nutritional samples and information
- Flu vaccines
- Blood pressure reads
- Pharmacy discount information provided
- Health and wellness vendors

University of Rochester – 2011 Employee Wellness

Additional Health and Wellness Initiatives:

- Onsite flu shots
- Pre-natal breast-feeding classes available through Strong
- Nutrition Counseling (available through Healthy Living Center, or University Food and Nutrition Department)
- Weight Watchers at Work
- Carewise Health Offerings:
    - 24/7 Health Advocacy Line
    - Telephonic Health Coaching:
        - Nutrition Management
        - Obesity
        - Physical Activity
        - Pre-Diabetes
        - Pre-Hyperlipidemia
        - Pre-Hypertension
        - Stress Management
        - Tobacco Cessation
        - Weight Management
    - Telephonic Disease Management for:
        - Asthma
        - Atrial Fibrillation
        - COPD
        - CHF
        - Diabetes
        - CAD
        - Hypertension
        - Hyperlipidemia
        - Low Back Pain
        - Stroke/TIA
    - High Risk Maternity Management (Telephonic)
    - Web-based Lifestyle Management:
        - Nutrition
        - Stress Management
        - Tobacco Cessation
        - Weight Management
- Healthy Living Center Services:
    - Tobacco Dependence
    - Pre-Diabetes
    - Hyperlipidemia
    - Mindfulness Stress Reduction
    - Weight Management

University of Rochester – 2011 Employee Wellness

Program Evaluation:

- The University implemented a data aggregator to store and analyze medical, pharmacy, lifestyle management/disease management, and short-term and long-term disability data. This will assist in future program planning.

ROCHESTER GENERAL HEALTH SYSTEM

Rochester General Health System
Employee Health/Fitness/Nutrition Initiatives - 2011

Fitness / Wellness Programs

- Fitness center membership discounts available
- RGHS on site fitness center under construction at Riedman Campus to open 2012
- RGH campus has 1.5 mile walking / fitness trail
- Indoor walking path guides for up to 1.0 mile
- On-site Weight Watchers Program

Food / Nutrition Enhancements

- Whole grain salad items offered in fresh salad bar
- Minimum one Healthy Choice meal added to cafeteria menus
- Nutrition information posted to aid customers in making healthy meal choices
- Heart Healthy recipes available to staff on line
- Employee events with refreshments now include fruit and fresh vegetable healthy choices
- Behavioral Health offering healthy recipes in InTouch newsletters

Health Education

- Annual Healthy Heart fair open to staff and public
- Annual Colo-rectal Cancer Awareness Fair
- Spring Allergy / Asthma Alert
- Department of Medicine offers regular seminars on disease management and healthy behaviors
- GRIPA provides case management & health education for team members enrolled in the health plan
- GRIPA Jeopardy Challenge health education initiative
- Provided blood pressure screening at Juneteenth Celebration
- Participate in Alesi Family health & fitness fair at the DomeArena
- Participate in Sen Robach Women's Health Fair at Greece Ridge mall

Rochester General Health System
Employee Health/Fitness/Nutrition Initiatives - 2011

- Participate in Sen Morelli's Health Fair at Temple B'rith Kodesh
- Rochester Jazz Fest on site blood pressure screening and first aid

Sport & Recreation

- More than 120 employees participated in the Annual Tour de Cure Cycling Fundraiser
- Chase Corporate Challenge had 85 participants this year
- Over 500 employees participated in the Annual American Heart Association Heart Walk
- 300 employees participated in ACS Making Strides Against Breast Cancer, with planning this year to participate at same level

Health Screenings

- Employee health department conducts annual health assessment for each employee
- Free flu shots to all employees
- Blood pressure and cholesterol screens available at several events during the year

Mental Health Support

- EAP available for employees and families
- Crisis response team available to provide support to employees following any serious incident
- Healing Garden at Rochester General Hospital for the benefit of patients, their families and employees
- 'Reawakening the Heart – Caring and Renewal in Nursing Practice. During Nurses week, sent several nursing staff to this retreat at St. John Fisher College

Health & Safety

- RGHS maintains a smoke free environment at all of its affiliates
- Smoking cessation aids available at employee discounted prices
- Hiring of a full time Injury Prevention Specialist for the RGHS in July 2009
- Safe patient handling initiatives to prevent injury to patients and staff, including
    - New Safe Patient Handling (SPH) Policy, available online
    - Significant investment in SPH Equipment
    - New 2011 Safe Patient Handling Mandatory Education for all patient care personnel

    - Established protocol for proactive response and follow up with team member injuries
    - Readily available problem solving and physical assistance as needed with patient mobility needs
- Individual Team Member and Departmental Ergonomic Assessments available
- Back Safety and Ergonomic In-services readily available to all department
- Violence in the Workplace Initiative; Internal team developing resources and protocols to promote staff, patient and visitor safety
- Transitional return to work program available for all employees who have incurred a work related injury
- As a Baby Friendly hospital, services are provided to support breast feeding, available to employees as well as patients, including a 24x7 link line and access to lactation consultant to answer questions about breast feeding
- Provided birthing center and security team with car seat installation seminars conducted by the Monroe County Office of Traffic Safety. Additionally, sent several employees to Child Passenger Safety Certification training, certifying them to teach parents how to safely install car seats.
- At the annual bike helmet fitting and distribution event at Rochester General Hospital in the spring, 1200 bike helmets were fit and distributed to children.

Unity Health System – 2011 Employee Wellness

Program element: Maintaining smoke-free buildings and grounds

- Unity has smoke-free buildings; limited smoking huts are stationed 50 feet away from entrances.
- There are plans to move to a completely smoke-free environment in the near future
- NYS Smokers Quit Line available to employees

Program element: Behavioral health resources

- Free EAP for employees and family members
- Medication review and referrals offered during annual health reviews
- Mental health resources available through Excellus
- Behavioral health, chemical dependency and Adolescent & Women's Community residences onsite

Program element: Healthy food selections (onsite cafeteria and vending machines)

- Half-portion selections available along with low-fat foods
- Café offerings will be coded for nutritional value: green, yellow and red in the fall 2011
- Extensive fruit and salad bars
- Nutritional information posted in cafeteria
- Healthy food samples offered during Eat Well Live Well Challenge
- Special activities during National Nutrition Month (prizes, free healthy food samples, quizzes)
- Seasonal onsite farmers markets
- Unity Hospital Café expansion and renovation will be completed in 2012 and will offer healthier options

Program element: Access to fitness activities

- Discount to "Total Sports Experience" for employees and family members
- "Walk About" maps created for several sites to encourage walking
- "Take the Stairs" campaign with signage at elevators and in stairwells
- Reimbursement monies for gym memberships are available through Excellus plans

Unity Health System – 2011 Employee Wellness

- Annual fitness events: Chase Corporate Challenge & Flower City Challenge

- Eat Well Live Well Challenge includes free pedometers and numerous prizes for continued participation throughout the eight-week period
- Community 5k and 10k sponsored by Unity – Pound the Ground for Vets, East Avenue Grocery Run, Tour de Cure, Breast Cancer Walk, Walk to End Alzheimer's, and Yoga
- No Boundaries: learn to run program offered at Unity at Ridgeway/ Fleet Feet Sports

Program element: Health education and programs

- Unity's Employee Wellness Promotion Committee routinely posts health and wellness information on our website and publishes articles in the Unity Connection newspaper
- Employees have access to free ergonomic evaluations and work station adjustments
- A Wellness Calendar is given to all employees by their manager
- Preventative health mailings are provided through Excellus along with Health Coaching
- Unity's Department of Medicine offers regular seminars on disease management and healthy behaviors
- "Let's Talk Health" – ongoing free seminars and health screenings
- Onsite traveling health fairs
- National observances: Go Red Day, World No Tobacco Day, Diabetes Alert Day, Great American Smokeout
- Free family health and activities workshops

Program element: Access to biometric testing

- Employees are encouraged to participate in biometric screenings annually through the Employee Health Services Department
- Free onsite blood tests for glucose and cholesterol check

Program element: Access to health screenings (colonoscopy, prostate exams, etc.)

- Employees, and family members, have co-pays waived or reduced for preventive screenings when provided by a Unity facility

Program element: End-of-life planning

- Promotion of Health-Care Proxy and Living Wills through our physician practice offices
- Information available through Excellus' compassionate care website

Unity Health System – 2011 Employee Wellness

Program element: Rewards/recognition for success

- Employees who have "success stories" (weight loss, disease management) are featured in our Unity Connection newsletter and the internet
- Plans are underway to research financial incentives to reward employees who achieve healthy goals

Program element: Data utilization

- Unity compiles aggregate data from health, disability and Workers' Compensation claims utilization to analyze needs and create future wellness programs

Program element: Return to work

- Unity's short-term disability and Workers' Compensation plans allow for employees to return to work in light duty areas to more easily transition into their jobs has resulted in a 7% decrease in lost time for Worker's Compensation claims
- Our disability data consistently shows shorter periods of disability for our employees compared to benchmark

Program element: Safe Patient Handling (SPH) Program

- There is a dedicated full-time licensed physical therapist who manages this program to prevent employee and patient injuries experiences a 9% decrease in patient handling related employee injuries
- All employees involved in patient care participate in 3 hours of training along with a competency evaluation
- Annual competencies are currently being developed
- Unity purchased $175,000 in lift-related equipment in 2010 with more capital spend expected in 2011
- It is anticipated that future educational SPH training will extend to residents, patients and families

Program element: Dedicated Employee Health Services Department

- Annual health reviews for all employees include PPD plant, blood pressure read, review of medication and latex allergy, and individual counseling as needed
- Behavioral health and medical referrals provided
- Fit testing for protection against tuberculosis
- A hearing conservation program is provided
- Free flu clinics are located at employee work sites
- Workers' Compensation and disability case management by onsite physician and team of clinicians

Program element: Annual Health Fairs

- Health and wellness fairs are provided at numerous locations to allow participation where employees work
    - Biometric screening: body mass index and body fat percentage
    - Back safety and stretching
    - Smoking cessation counseling
    - Stress reduction tips
    - Nutritional samples and information
    - Flu vaccines
    - Blood pressure reads
    - Pharmacy discount information provided
    - Promotion of Total Sports Experience membership and Rochester Athletic Club
    - Pulmonary peak flow testing
    - Sleep disorders
    - Care management and referrals

Additional Health and Wellness Initiatives:

- Weight Watchers at Work programs offered onsite with reimbursement upon successful completion
- Disease management health coaching provided through Excellus
- Arrangement through Excellus' health plans to provide money to Unity for employee wellness activities
- Discounts through health insurance provides benefits for children's fitness activities, LASIK surgery, hearing aids
- Medical Caring Discount program waives or reduces co-payments for employees and their families when utilizing services through Unity
- Top management support for healthy behavior as demonstrated through:
    - Creation of Employee Wellness Coordinator position
    - Employee wellness budget established
    - Employee Wellness Promotion Committee with membership representing the entire health system
- Reimbursement for No Boundaries: learn to run program, Flower City Challenge, and other Unity sponsored fitness programs/activities; upon successful completion
- Discounted gym membership for employees and their family members

Unity Health System – 2011 Employee Wellness

Program element: Maintaining smoke-free buildings and grounds

- UR Medical Center went smoke free in 2006 (inside and outside). Currently, there are two smoking outposts where smoking is permitted within the perimeters of the Medical Center.
- Employees are encouraged not to smoke and resources are available at no cost to UR employees/spouses/domestic partners:
    - Telephonic and intensive individual support through The Healthy Living Center
    - Telephonic and web-based program offered through Care Management Vendor-Carewise Health

Program element: Mental health resources

- EAP available for employees and families
- Depression screenings available annually
- Stress Management programs offered throughout the year by Well-U and EAP
- Personal Health Assessment and online "Relax" program offered through Carewise Health
- Mindfulness program offered through The Healthy Living Center
- Services offered by Aetna and Excellus

Program element: Healthy food selections (via onsite cafeteria or vending)

- Campus cafeterias expanded salad bars and increased offerings of low-fat foods

Lakeside Health System – 2011 Employee Wellness

Program Element: Outpatient Nutritional Counseling

- General Nutritional Education
  - A certified dietitian is available to the general public for nutritional education
- Diabetes Nutritional Counseling
  - A certified Diabetes Educator is on staff to provide Diabetes and pre-Diabetes nutritional counseling to the general public
- Weight Loss Program
  - The LifeSteps Weight Loss Program is a structured program available to the general public

Program Element: Outpatient Diabetes Counseling and Education

- Lakeside offers a comprehensive Diabetes and pre-Diabetes program for the general public
  - A certified Diabetes Educator is on staff for counseling
  - In addition to access to education the program offers a structured discussion and support group

Program Element: Flu Clinic

- Seasonal Influenza and H1N1 Influenza vaccination clinics are offered through Lakeside's Occupational Health Department and at each of their Urgent Care Facility locations

Program Element: Employee Assistance Program

- Employee assistance is available to all full and part time employees, their spouses and dependent children
- Confidential counseling is provided along with additional services of, among other things, alcohol and drug assessments/referrals, fitness assessments, stress management, defensive driving and smoking cessation

Program Element: Snack and Health Tips

- To augment the employee nutrition program, Lakeside includes nutrition tips it the bi-weekly employee newsletter

Lakeside Health System – 2011 Employee Wellness

Program Element: Smoke Free Environment

- Lakeside Health System has smoke free buildings and designated smoking areas for 50-100 ft away from entrance/exits to the building.
- NYS Smokers Quit line and Excellus website is available to employees

Program Element: Weight Watchers at Work

- Lakeside offers the Weight Watchers program to employees at a reduced cost, during work hours for convenience. Payroll deduction is available to make it financially accessible for all employees.

Program Element: Community Seminars

- Lakeside recognizes the needs of the communities it serves and regularly hosts presentations in a variety of venues that provide education in different areas of health concerns such as stroke and colorectal cancer.

Program Element: Access to biometric testing

- Lakeside offers an employee health fair annually and encourages employees to attend. Blood Glucose, Body fat analysis, cholesterol, weight, chair massage, blood pressure, stress reduction tips, preventive health information is all available**.**

Program Element: Safe Patient Handling Program

- A lean six group led the charge in addressing safe patient handling and the goal of decreasing injuries related to lifting.
- Multidisciplinary team meet regularly to discuss prevention of injuries related safe patient handling

Program element: Dedicated Employee Health Services Department

- Annual health reviews for all employees include PPD plant, blood pressure read, review of medication and latex allergy, and individual counseling as needed
- Behavioral health and medical referrals provided
- Fit testing for protection against tuberculosis
- A hearing conservation program is provided
- Free flu clinics are located at employee work sites

Attachment 2

FLHSA 2011 Report on 2020 Commission

The Community Health 2020 Commission on System Performance

The Community Health 2020 Commission on System Performance (the 2020 Performance Commission or the 2020 PC) was convened to develop the processes and infrastructure to support the implementation of the 2020 Commission's Investment Recommendations.

It was through the 2020 Commission that the Finger Lakes Health Systems Agency (FLHSA) evolved its health planning role as it evaluated the region's needs for additional hospital bed capacity. With collaboration from New York State DOH, FLHSA challenged the Rochester community to support a broad multi-stakeholder process to incorporate delivery redesign into the bed request process. Through this Commission and its process, that the FLHSA and community stakeholders were able to reduce the number of new inpatient hospital beds, saving millions of dollars in local capital costs and operating expenses.

Following the success of the 2020 Commission, FLHSA convened the Community Health 2020 Commission on System Performance (the 2020 Performance Commission or the 2020 PC). This follow-up Commission, a multi-stakeholder group of business, insurers, hospitals, physicians and community representatives, was charged to develop and implement the community investment recommendations set forth by the original 2020 Commission.

Following the original 2020 Commission, the hospital systems requesting bed increases were charged with assisting in reducing preventable admissions and ED visits, with the hope that fewer beds would be needed and health care delivery would be improved. The Community Health 2020 Commission on System Performance (the 2020 Performance Commission or the 2020 PC) was convened to develop the processes and infrastructure to support this charge. Along with health systems representatives, the 2020

PC's membership also includes business, labor, provider, and community leaders.

The result has been the initiation of diverse work groups facilitated by individuals experienced in engaging multi-stakeholder groups to improve quality. These work groups have developed recommendations that operationalize and guide our community's efforts to achieving the 2020 Commission's three goals by 2014:

- A 25% decrease in the number of admissions for ambulatory sensitive conditions manageable in outpatient settings;
- A 15% decrease in low-acuity visits to applicant emergency departments (EDs); and
- A 20% decrease in the number of low-acuity admissions to applicant hospitals of residents from outlying communities.[a]

The purpose of this report is to share many of the lessons already learned from current efforts. FLHSA believes that these lessons have the potential to inform other localities around the state and nation, helping to successfully translate public policy and program into improved regional health care delivery.

FLHSA also believes that these lessons have value as the NYSDOH continues the future of community health planning. Within the Rochester region, FLHSA has evolved health planning from system regulation role to system transformation. FLHSA now serves as the independent community organization – the "community table," at which all stakeholders collaborate to address the area's most pressing health needs.

Composition of the Decision Making Policy

FLHSA's new model of community health planning integrates data, analytics, and community engagement. Our decision-making approach is a proactive model that not only manages capacity on the supply side of healthcare but also works to reduce demand for services through community mobilization and education. Moreover, central to our approach, is a belief that community health planning must address health and healthcare disparities by weighing utilization volume and rates equally in the development of solutions.

It must be noted that the availability of accurate, aggregated, community-wide data lies at the heart of successful transformation in healthcare.

[a] As noted later in this section, the RWG has modified this objective.

Consequently, FLHSA's work and decision-making processes can be outlined as:

1. Identifying, through data and analytics, community health needs, gaps and disparities;
2. Convening major stakeholders to discuss health needs, gaps and disparities and establish priorities for improvement;
3. Selecting work group/coalition members who reflect the community and members provide a voice for under-represented constituencies;
4. Clearly articulating core values that frame health improvement in the construct of the "Triple Aim" – the understanding that improving the overall health of the defined population, reducing per-capita cost and improving the individual patient experience are equally important and must be equally respected and addressed;
5. Cultivating an interpersonal process that aligns improvement work with community values in a manner that addresses the concerns of all stakeholders and ensures that all participants are informed and able to be meaningfully involved; and
6. Hiring trained professionals who can act as project managers/team champions to direct the improvement projects/programs.

Mechanisms for Securing Diverse Stakeholder Input

Securing diverse stakeholder input is inherent to the work of the FLHSA. In addition to its core multi-stakeholder approach to community health improvement – the composition of which is outlined above – FLHSA's brings its unique staff infrastructure to securing diverse stakeholder input in driving change in the healthcare system. This staff infrastructure focuses on three key elements of healthcare planning: system performance, capacity management, and community health.

With regard to system performance, the agency staff capability allows it to set realistic performance targets, measures outcomes, and publicly reports results. In capacity management, FLHSA has a unique competency in it collecting and analyzing data at a community (as opposed to stakeholder) level; and then in collaborating with stakeholders to develop recommendations and strategies to meet performance targets. FLHSA has evolved and refined this competency as it fulfills its statutory duties by reviewing CON applications within the context of proactive community plans. In community health, FLHSA shares health status information with affected populations, and works with leaders of the communities at risk to set priorities, develop action plans, and educate and mobilize consumers to drive the elimination of health disparities – particularly, those disparities

related to obesity, hypertension and related diseases, and childhood lead poisoning.

Among the community's stakeholders, there continues to be a deepening appreciation for these roles. The agency's model of community health planning increasingly garners support throughout the region, with its emphases on integrating data, analytics, ensuring transparency and trust between the participating groups, carefully listening to the interests and needs of key stakeholders and creating action plans that incorporate those interests and needs into meaningful, reportable measures. This growing support is, in itself, another vehicle through which FLHSA has been able to grow its capacity to secure diverse stakeholder input as more members of the community seek to be engaged in FLHSA coalitions, commissions and task forces.

Currently, FLHSA convenes almost two dozen distinct health coalitions, commissions, networks and task forces – each with attendant subcommittees and/or workgroups. Through these community engagement vehicles, the agency works with individuals and organizations to identify unmet community health and healthcare needs and to eliminate disparities in health and healthcare services. From a community perspective, as opposed to through solely institutional efforts, community leaders are supported in developing solutions to meet these needs, eliminate disparities, and measure their results. As a result, over 1,100 people are actively working on specific FLHSA initiatives to reduce costs, improve quality and increase access to healthcare in FLHSA efforts that include:

- **The African American and Latino Health Coalitions –** FLHSA convenes these Coalitions to address local and regional health disparities by engaging leaders from disadvantaged communities. The Health Coalitions set priorities and design solutions to deal with local health disparities. The aim of these Health Coalitions is to improve the scope, quality, and availability of health services available to regional communities of color. They also seek to mobilize members of the community in health promotion, health education and the practice of positive health behaviors, as well as to improve community health status through public policy and health systems advocacy.
- **The Rochester/Finger Lakes Partnership for the Uninsured –** This collaborative partnership includes Excellus BlueCross BlueShield, MVP Healthcare, Monroe Plan for Medical Care, the City of Rochester, the County of Monroe, and the Rochester Primary Care Network. The Partnership's purpose is to monitor policy and the impact of the lack of insurance in the region, monitor initiatives from Albany, and promote universal coverage.

- **Coalition to Prevent Lead Poisoning (CPLP)** – CPLP addresses issues that prevent the effective screening and testing of one- and two-year old children for lead poisoning and elevated blood lead levels. It also advocates for city, county and municipal policy changes that will ensure appropriate lead hazard testing, inspection and abatement in housing units that are at-risk of exposing children to lead poisonous sources. Recently, CPLP and its partners were recognized as one of five national winners of the 2009 Environmental Justice Achievement Award from the U.S. Environmental Protection Agency.
- **Healthy Eating and Active Living Through Policy Initiatives for Kids (HEALTHI Kids) Policy Team** – FLHSA's anti-childhood overweight and obesity collaborative that drives a "grassroots advocacy movement aimed at changing public policy and practice to support healthier, more active children in Rochester and Monroe County. The HEALTHI Kids "change agenda" calls for better school food, safer play areas, food standards at childhood centers, at least 45 minutes of in-school physical activity, and policies that support breastfeeding.
- **Finger Lakes HIV Care Network (FLHCN)** – FLHCN provides a forum for collaboration and promotes community awareness of HIV/AIDS, in order to reduce incidence, increase community awareness, and access to care in the nine-county Finger Lakes region for HIV/AIDS.

Through each of these coalitions, FLHSA is bringing attention to the need for improved care coordination for chronic disease management and prevention. This "demand management" component of health planning complements and responds to the inability of capacity management to – in and of itself – drive healthcare improvement; as well as to the limitations of a solely clinical approach to chronic disease management. Moreover, because of socioeconomic disadvantages, limited health literacy and poor control rates among communities of color are high. FLHSA's Community Engagement activities are a critical vehicle for ensuring that health improvement and disparities elimination activities are culturally responsive, community-generated and "owned" at the grassroots level.

Description of Data Collection and Data Analysis Activities

FLHSA is recognized as a leader in using data to build consensus around healthcare issues and solutions. FLHSA's current data files include: vital statistics, inpatient hospital discharges, ambulatory surgery discharges, emergency department discharges, cost reports for hospitals, nursing homes, and home healthcare agencies, daily patient censuses for hospitals, monthly ALC and observation patient counts for hospitals, MRI utilization

and ESRD utilization, communicable disease incidence, HIV/AIDS prevalence and incidence, behavioral risk factor surveys, and annual provider surveys of PET, MRI, and CT studies, socioeconomic characteristics, and population and demographic estimates. Additionally, FLHSA has developed algorithms for calculating some of the more commonly used measures (e.g., PQI, NYU Algorithm-identified primary care-related ED visits). These data and analytics are used to support all of FLHSA's work, from system performance, to capacity management, to community engagement.

FLHSA has made significant enhancements to its staff capabilities to enhance its ability to maintain the currency of its data bases current and to expand its capacity to monitor and analyze health and healthcare trends.

Currently, FLHSA works with NYSDOH to design de-identified files that allow its researchers to "drill down" and explore service utilization issues (e.g., inpatient readmissions). NYSDOH has access to files with individual identifiers and can link data for individuals over time and across components of the care system (e.g., hospital readmissions, frequent ED users, acute and long term care, mortality and HIV/AIDS epidemiology, inpatient and OASAS detox). As FLHSA moves forward with developing its data base it will explore with NYSDOH and county health departments the creation of de-identified files that will enable these linkages to be explored and enable the community to model flows and relationships among the various care sectors.

Discussion of Obstacles Encountered and Solutions Developed

Planning for a Regional Health System through the 2020 Performance Commission

To date, the 2020 PC's Rural Work Group (RWG) has begun its work with an in-depth review of the data that are pertinent to its goal of ensuring a sustainable regional healthcare system.

In Phase 2, it will develop a set of coherent and integrated regional strategies that will:

1. Ensure the longer term viability of community hospitals strategically located across the region;
2. Improve the adequacy and access to healthcare services for the residents of those communities; and
3. Develop system changes that will mitigate the environmental threats that would threaten the sustainability of the delivery of care in the rural communities.

Gaining Access to Outpatient Health Care Data

Other than vital statistics and disease incidence, most of FLHSA's current data are related to institutional healthcare services. However, the focus of healthcare has shifted to non-institutional ambulatory care settings and the agency currently lacks a means to track, quantify, analyze or compare such services. As the community healthcare planning agency, FLHSA requires the capacity to evaluate and inform the design of cost-effective systems of quality care.

At this time, the outpatient healthcare data needed to explore and track changes in the demand for services, evaluate community interventions, and identify unmet needs are located in individual healthcare providers' patient medical records. Consequently, the best options for beginning to assemble the diagnostic and ambulatory care data are surveys of individual patients and providers, data extraction from the regional Health Information Exchange, as well as healthcare claims records submitted to third party payers (i.e., Medicaid, Medicare, and private insurers).

FLHSA is currently working with the major private insurers in the Finger Lakes region (Excellus BlueCross BlueShield and MVP Healthcare) to develop a community healthcare claims database that would expand its analytic capabilities. Once the aggregation algorithms are developed for these insurers, the next steps will be to work with NYSDOH and local counties to include Medicaid fee-for-service claims and eventually to add Medicare claims and other private insurers' claims. Claims records generally include a diagnosis or diagnoses, a site of care, type of provider, type of visit, information about procedures or tests, drug utilization, and of course the payment mechanism. Assembling claims for individuals allows the identification of patterns of care and how the community currently uses different sectors of the region's healthcare system. Being able to track care as individuals change insurers and move from public to private insurance will also provide clues to how differences in ability to pay impact utilization patterns.

Assembling the claims data from all insurers requires a substantial investment of time and money, but it is the best option for evaluating utilization and care patterns across sectors and population cohorts and communities at this time.

Reducing Avoidable Emergency Department Visits

The 2020 PC's ED Work Group (EDWG) conducted a thorough analysis of NYS SPARCS Treated and Released (T&R) ED data. Additionally, FLHSA staff provided the Work Group with the results of a literature review on the

impact of low-acuity visits on ED overcrowding. These evaluations indicated that low-acuity visits do not significantly impact Code Red or the need for hospital beds but do indicate that the Rochester area's healthcare system is not performing as highly as the community needs.

The 2020 Performance Commission, however, still felt that reducing low-acuity ED visits was important for the community to promote the creation of a high performing healthcare system and address escalating costs. On behalf of the EDWG, the FLHSA enrolled in the Institute for Healthcare Improvement's (IHI's) Reducing Avoidable ED Visits Collaborative in August 2009. This international prototyping community was designed by the IHI to investigate novel solutions to decreasing avoidable ED utilization. The IHI conducted an extensive review of the literature and developed a framework for rapid plan-do-study-act (PDSA) cycles that each enrolled team adopted. As part of their work, each team in the collaborative identified seven "patient streams," segments of patients who flow through the ED and whose needs for alternative options and system changes may be similar. After conducting interviews with patients in each stream to identify root causes of ED utilization and develop potential strategies to address the main issues, the teams employed a PDSA cycle to test each strategy.

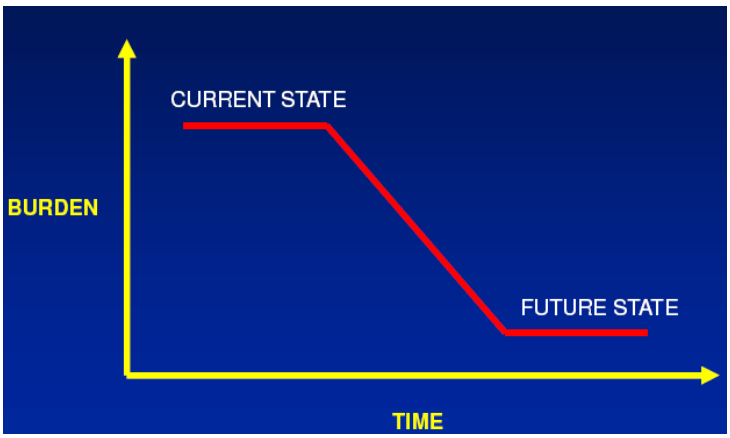
For the Finger Lakes region, three common themes emerged from the EDWG's research, which will guide the future work of this body:

1. Many patients have a weak relationship with their primary care physician (PCP) and the practice and do not perceive their PCP as the solution to resolve an acute episode;
2. Many patients lack the health knowledge/self-management skills and/or the willingness for health self-management; and
3. Patient convenience is a driver of using an ED.

In exploring these three themes, the FLHSA has built new partnerships with community efforts to address primary care and the needs of inner-city Rochester community health centers. The aim of these new partnerships has been establishing a community-wide resource center to support individual providers and practices in providing excellent care in a cost-effective and highly satisfying way to meet the needs of patients as well as providers through the construction of primary care medical homes (PCMH).

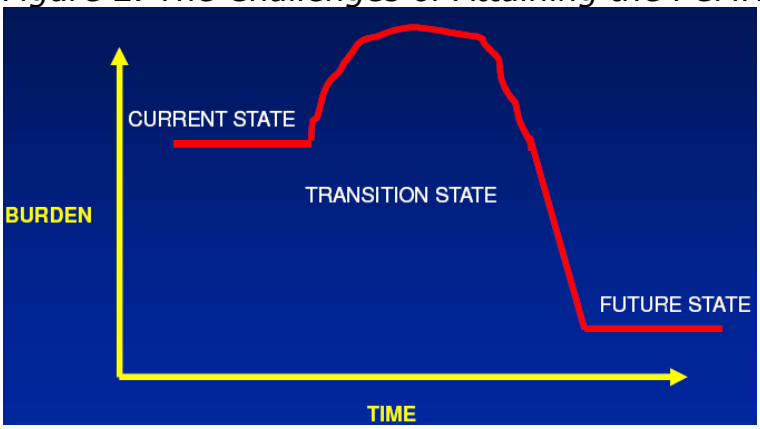
As Dr. Donald Berwick of the IHI has noted, "most [practices] can be winners" with the PCMH model.

Figure 1. The Future State of Attaining the PCMH Model Across the Community



However, the transition stage for practices to reach the PCMH criteria is extremely difficult.

Figure 2. The Challenges of Attaining the PCMH Model Across the Community



It is this painful transition stage that FLHSA seeks to ameliorate. The savings accrued by achieving the future state will only come after substantial investment and a period of increased costs.

Preliminary Recommendations

With the support of FLHSA staff, and the leadership of Chair Leonard Redon (past Vice-Chair of the 2020 Commission and Vice President of Area West Operations of Paychex) and Vice-Chair Susan Holliday (President and Publisher of the *Rochester Business Journal)*, the 2020 PC has examined local and national hospital and ED utilization trends, data, and sought insights about best practices from experts around the country. It formed two work groups to focus efforts aimed at reducing avoidable hospital admissions and reducing ED low-acuity visits. These work groups are

respectively chaired by Kathleen Parrinello, Chief Operating Officer of Strong Memorial Hospital, and Robert Thompson, Vice President of Safety Net Programs at Excellus BlueCross BlueShield (*see Appendix for the Preventable Hospitalizations and ED Work Groups rosters*).

In its June 3, 2010, meeting, the 2020 PC endorsed the recommendations of the Preventable Hospitalizations and Reducing Avoidable ED Visits Work Groups. The following section details the initiatives researched and recommended by the work groups, which will comprise a major component of FLHSA's work for the next three years.

Reducing Preventable Hospitalizations

The Preventable Hospitalizations Work Group (PHWG) agreed to first focus on reducing preventable hospital readmissions toward achieving its 25% reduction of ambulatory care sensitive admissions. The PHWG used the Federal Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs), a set of measures that can be used with hospital inpatient discharge data to identify quality of care for ambulatory care-sensitive conditions to identify potentially preventable hospitalizations in the region. Using NYS SPARCS data files, FLHSA calculated there was a 9% increase in PQI hospitalizations in the 6-FLR from 2006 to 2008. Achieving the target of reducing these admissions by 25% by 2014 would lower the volume to below 2006 actual PQI hospitalizations. The PHWG's analyses of regional and national data and relevant literature yielded the following conclusions:

1. Preventable admissions occur most in the over 50 age group; [1] [2]
2. Most preventable admissions are for treatment of coronary artery disease (CAD), heart failure (CHF), chronic obstructive pulmonary disease (COPD), pneumonia, and diabetes;
3. Preventable admissions account for 15-20% of total hospital admissions; and
4. A significant number of people admitted for preventable hospitalizations are readmitted within 30-180 days.

Based on these findings, the PHWG devoted special attention to the chronic diseases of congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and diabetes, as these not only comprise the majority of PQI-related hospitalizations in the 6-FLR, but for which there are also wide racial/ethnic and socioeconomic disparities. Readmission data is of particular importance because of the negative impact such readmissions have on quality of life, health status and the cost of care.

Nationally, approximately 90% of Medicare readmissions are unplanned and preventable. They have been empirically associated with a range of causes, from poor patient understanding of how to manage, arrange and organize care once home, to lack of adequate hospital preparation for patient discharge. The magnitude of the "failed transition" phenomenon in the United States has led experts across the country to investigate what can be altered in the transition management process to reduce the failure rate. Expert consultation, empirical studies and member expertise were utilized to: 1) understand the dimensions of transition failure in the Rochester region; 2) benchmark approaches to readmission reduction successfully implemented in various parts of the country; 3) articulate potential strategies for rate reduction; and 4) create, monitor and evaluate an appropriate infrastructure sufficient to decrease significantly the number of preventable admissions occurring each year in the target region.

After careful deliberations, the PHWG decided to boldly address preventable admissions and ED visits by creating a three pronged intervention designed to mature over time to address not just the causes of readmissions, but improve chronic illness care coordination sufficiently to meet the 2020 Performance Commission target of a 25% reduction in all preventable admissions by 2014.

The PHWG recommended three strategies that have shown to demonstrate a consistent decrease in PQI-related hospitalizations:

- Standardize the hospital discharge process across the 6-FLR[3];
- Embed care managers in primary care offices; and
- Implement community-based patient coaching via:
  - implementing a formal, community-wide Care Transitions Program[SM 4] demonstration; and
  - extending the concept of patient coaching across the spectrum of community-based caregiving organizations and agencies.

Discharge Planning

FLHSA convened the chairs of the discharge planning departments from each of the ten acute care hospitals in the 6-FLR, as well as a primary care physician and a hospitalist, and a representative from the Rochester Regional Health Information Organization (RHIO) (*see the Appendix for the DPSG roster*) to develop standards for discharge planning that will enhance patient safety at discharge and reduce preventable readmissions. The Discharge Planning Sub Group (DPSG) was charged with developing, coordinating and continuously improving a standardized patient discharge planning process to be employed by participating hospital systems in 6-FLR,

such that the discharge process might be made more uniform and focused more specifically on reduction of readmission for high risk patients. Throughout this process, NYS medicine and health plan discharge planning requirements and regulations will be satisfied while focusing increased attention on patient/family preparedness for hospital discharge, the prompt return to the primary care provider, and integration of appropriate community services.

The DPSG developed a set of Community Standards for Discharge Planning, along with key elements required for standards implementation:

1. **Patient/Family Centrality to the Transition Process**: each hospital will place the patient and caregiver in the center of the discharge planning process
2. **Medication Reconciliation**: hospital medical providers and health team members collaborate with patient and caregivers to optimize patient management
3. **Information Transfer**: information about the patients hospital care, condition, medications and continuing care requirements is transmitted to the PCP, Medical specialists and other care agencies
4. **Post Discharge Follow-Up**: guide continuity of care for patients returning to community-based setting

The DPSG agreed that the standards would be universally adopted and implemented by each of the ten hospitals. The standards will serve as both a developmental guideline and self-assessment tool for use as the hospitals and patients move forward with discharge process improvement and reduction of avoidable readmissions. Furthermore, the DPSG anticipated that each hospital will bring unique perspectives and resources to the task of standardizing discharge planning and reducing preventable readmissions.

In order to guide the implementation process, it was recommended that FLHSA convene an implementation sub group that would act as a regional learning collaborative for discharge planning. The learning collaborative will serve as a forum for mutual aid, in which common problems are explored and solutions shared. The learning collaborative will also create a measurement team, which will establish specifications for data collection and reporting to measure progress across the standards. Hospital performance against the standards will be uniformly evaluated across the 6-FLR to assess progress and identify areas needing improvement. The evaluation will be done within the discharge planning learning collaborative and at the onset these data will be reported in the aggregate to give members time to improve.

The estimated costs for the project over the course of two years are approximately $.5 million, with estimated net savings of $9.6 million.

Embedded Care Managers

FLHSA convened physicians, nurses, community representatives from nursing homes and patient centered medical home (PCMH) pilot practices to develop essential core elements that will successfully incorporate care managers into primary care office practices to identify and serve as the single point of contact for patients at risk of PQI admissions, readmissions and ED visits.

The Embedded Care Managers Sub Group's (ECMSG) goal is to ensure that patients will receive a seamless post-discharge hand-off that includes timely and appropriate follow-up care and community services.

- The design, development and implementation of the program is aimed to identify those at risk for hospitalization or ED visits, interface medical and social support, provide access for outreach to connect and engage patients, and focus on care transitions with patient/family education and management of chronic diseases.
- Recommended pilot practices will demonstrate readiness for change, have a sizeable Medicare Advantage population, have the ability to access external resources within the community setting and have the critical size to support a full time care manager at one or more sites.
- The care manager applicant will effectively identify both health and social needs of patients, exhibit cultural sensitivity, demonstrate knowledge of community resources, and facilitate connecting and engaging the patient with appropriate community services.

The estimated costs of the project by Year 2 are $2.6 million, with estimated net savings of $970,000.

Transitions Coaching

FLHSA convened leaders of home care agencies, community-based organizations, higher education, primary care and community health centers, insurers, and county offices on aging (*see the Appendix for the TCSG roster*) to develop the action plan for implementing the Care Transitions Program[SM], a chronic care patient coaching program that encourages patients' active participation in their care during hospitalization and post-discharge. The goal of this intervention is to decrease unnecessary dependence on hospitals and emergency departments. In the Care Transitions Program[SM], patients' goals for care are developed mutually by

the patient/family and transition coach. An expected outcome of this program is the more efficient use of available practice and community resources.

The TCSG wrote a mission statement to guide the implementation of the Care Transitions Program[SM] in the 6-FLR (*see Appendix for the TCSG Mission Statement*) and established the goal of training and placing patient coaches in the community by end of FY2010-2011. The implementation of the Coaching Transitions Program[SM] comprises four distinct components:

- Acquiring funding for the project
- Training patient coaches and forming a community-wide learning collaborative
- Staffing the organization and operations of the learning collaborative and engaging with member organizations to integrate patient coaching into their work
- Evaluation of the effects of coaching across the community

A community-wide learning collaborative comprising the agencies incorporating patient coaching into their services, the coaches themselves, and community representatives will be convened. The learning collaborative will serve as a forum for mutual aid, in which common problems are explored and solutions shared, as well as provide opportunities for continuous training. The learning collaborative will also create a measurement team, which will establish specifications for data collection and reporting to measure the impact of the coaching program on readmissions, particularly for PQI hospitalizations. Furthermore, the measurement team will evaluate the quality of the coaches and the success of the collaborative itself.

In the first year of implementation, approximately 35 transitions coaches will be trained community-wide. These coaches will come from home care agencies, as well as from care agencies from around the community. The exact numbers of community-based coaches, as well as the participating agencies, are not known at this time.

The estimated costs of implementing the Care Transitions Program[SM] by Year 2 are $4.6 million, with estimated net savings of $15.6 million.

Reducing Avoidable Emergency Department Visits

Despite the challenges it has made in its work, the 2020 PC's EDWG has made significant contributions to the community's efforts to make progress in reducing avoidable emergency department visits.

1. Supporting primary care by creating community initiatives to manage population health and nurture practices' connections to their patients
    a. Collaborating with hospitals, insurers, and the RHIO to develop a real-time ED use information system to permit consistent, rapid notification of PCPs and insurers of patients' ED visits from all of the region's EDs
        i. In conversations with ED directors and PCPs, as well as in all of the PHWG sub groups, the lack of timely notification of patients' ED visits emerged as a significant barrier to identification of a potential admission or encouraging optimal use of ED resources.
2. Collaborating with the Community Health Centers Strategy Group to create resources for primary care practices interested in transitioning toward the patient-centered medical home (PCMH) model of care.[5]
3. Promoting health self-management skills
    a. Working with the Monroe Plan for Medical Care to expand a health literacy intervention by means of giving new parents the health aid book *What to Do When Your Child Gets Sick*, which has been demonstrated to reduce the likelihood that new parents will take their child to the ED for a non-urgent episode.[6]
    b. Collaborating with the FLHSA African American and Latino Health Coalitions to identify opportunities to increase patient self-management skills
4. Addressing the need for convenient, readily accessible medical care
    a. Convening a coalition on telemedicine to expand the Health-e-Access pediatric telemedicine program at existing sites both at the practice and community levels, with the goal of expanding to two new sites. Health-e-Access was established in Rochester nine years ago and has demonstrated success in reducing low-acuity pediatric visits to the ED.[7]
        i. The EDWG analyzed low-acuity pediatric ED visits in the 6-FLR and assessed the potential of Health-e-Access to help the 2020 PC attain its target. In this process, the EDWG assessed the reports and publications that Health-e-Access has generated; interviewed several caregivers who have used Health-e-Access to have their child seen for an illness by their child's primary care practice; spoke with representatives from various organizations whose clients have been served through the program; and participated in a demonstration of the technology at one of the child care centers Health-e-Access serves.
        ii. Three potential areas of collaboration have been identified by Health-e-Access and FLHSA: 1) increasing uptake of

telemedicine among providers and the public; 2) facilitating referrals to telemedicine in Rochester City School District school sites; and 3) working with insurers to standardize payment for telemedicine encounters.

b. Investigating local urgent care center utilization and connecting with local initiatives to incentivize consumers to use urgent care centers for low-acuity episodes instead of the ED

Over the course of the next three years, the EDWG seeks to fully implement these initiatives. Of particular interest is the enhancement of primary care because this will address both the reduction of avoidable ED visits and hospitalizations. Currently, NYS has 761 recognized PCMH practices. Rochester only has nine so far. These practices received a significant amount of support to attain this status and belong to an intensive demonstration project geared toward achieving all of the criteria of a full PCMH. The EDWG seeks to promote the transition of practices community-wide to the PCMH model as is consistent with NYS's Medicaid Statewide PCMH Incentive Program.

Practice support services would be provided using three different approaches: 1) practice site services including facilitation, staff education, and patient support; 2) patient home visits as directed by the practice; 3) outreach on behalf of the practice. Service intensity would vary according to practice need and may be provided on an imbedded vs. consultative basis and on a part vs. full time basis. Practices are stratified into support categories according to assessment on three criteria: 1) practice infrastructure including EMR, organization, and other criteria; 2) culture including regular structured meetings, communication effectiveness, staff/provider turnover and satisfaction; and 3) willingness to engage in improvement efforts. Services would include:

1. Practice consultants/facilitators
2. Case Managers to provide self management support and care coordination as directed by the practice
3. Specialty support staff for patient-specific intervention and coordination between specialist providers and other providers in the healthcare system
4. Patient outreach services
5. IT consultants to assist practices with choosing, purchasing and implementing EMRs
6. Analytic support to help practices with data capture and reporting information (will coordinate services with the Regional Extension Center)

7. Licensing fees for tools such as the Patient Activation Measure, Test Tracking tools, SF-36, or other patient status assessment tools, etc.
8. Patient education material in low literacy/low numeracy/cultural competent/multiple language formats
9. Community resource tracking and coordination service
10. Provider research service, including the development of CME programs addressing local provider needs in coordination with local/regional medical education programs and available resources
11. Administrative services

The average practice is estimated to take three years to meet the PCMH requirements. The EDWG's goal is to get the practices to reduce avoidable ED visits by 15% in three years, and the long term goal is to achieve a 40% reduction. It is expected that the savings accrued from the program by the end of this time period will help fund the practices in the future.

Additional EDWG efforts will include:

1. Convening a coalition to spread successful Safety Net programs to commercial populations
2. Soon to be launched initiative to pay for differential for afterhours, work to organize practices to see if can increase afterhours capacity in the community

In all of its initiatives, the EDWG will continue to apply the PDSA model it learned in the IHI Collaborative. This will ensure rigorous measurement and careful investment of community resources into solutions. The estimated effect of the interventions it has proposed thus far is in line with achieving the targets established by the 2020 Commission. Notably, the largest effect will come from partnering with community groups working to create resources for primary care practices interested in transitioning to the PCMH model. Furthermore, it is expected that there will be considerable efficiencies gained in the PHWG's efforts to smooth patient transitions and staff primary care practices with embedded care managers.

Phase 2 of the Regional Work Group

While the original 2020 Commission was evaluating the need for hospital capacity in Monroe County, the analysis revealed that a significant number of patients hospitalized in Monroe County hospitals resided outside of the county. An exploration of the ability to care for these patients in their community of origin seemed to indicate a potential to receive their care at a local hospital and that there was unused capacity in those facilities. Consequently, the 2020 Commission recommended a community initiative to

target 20% decrease in the number of low-acuity admissions to Rochester General, Strong Memorial, and Unity hospitals of residents from outlying communities. It furthermore requested the 2020 Performance Commission review this recommendation in an effort to balance the need for services, a quality healthcare delivery system, and population health.

In December 2009, the 2020 Performance Commission launched the Regional Work Group (RWG), which focuses on the Central Finger Lakes region (Livingston, Ontario, Seneca, Wayne, and Yates counties) and the challenges of improving interaction among the Monroe County and Finger Lakes hospitals. It also seeks to ensure urban, suburban, and rural residents access to quality services. Stephen Ashley, past chair of the 2020 Commission and Chairman/CEO of The Ashley Group, chairs the RWG, and Ontario County Court Judge Craig Doran serves as its Vice-Chair (*see Appendix for the RWG Roster*).

The RWG is charged to examine in greater depth the apparent paradox of underuse of regional facilities while residents of those communities are seeking care in overloaded Monroe County facilities. It was determined that the goal of this exploration could not simply be a plan to change where people receive their care. Instead, a more detailed review was needed of what would be necessary to sustain a viable, high quality regional system of care. To that end, the group was assembled with representatives from each of the regional and Monroe County hospitals, local community representatives, and providers. The group was charged with developing recommendations supporting the delivery of regional care, without which there will be increasing demand in Monroe County and progressive decline in utilization of regional hospitals that could result in these becoming financially unsustainable and unable to provide quality services to area residents.

To date, the RWG has begun its work with an in-depth review of the data that are pertinent to its goal of ensuring a sustainable regional healthcare system and reached agreement in the following areas:

- Demographics of the Central Finger Lakes region (CFL)
  - Flat population
  - Projected demand for services driven by aging
- Definition of "outlying communities" refined based on commuter patterns and demographics
- Trends in hospitalization of residents of the CFL
  - Increasing hospitalizations in Monroe County hospitals
  - Surgery migrating to Monroe County at a faster rate than medical care

  - Physician workforce Aging physician workforce with increasing difficulty in recruitment
  - Particular issues in specialties where volume is necessary to sustain quality both at the individual physician and hospital level

The RWG currently has a subgroup that is preparing an analysis of the financial position of the regional hospitals with the focus of determining their ability to maintain sufficient volume and operating margins to sustain quality care in the future. Subsequently, the RWG plans to explore with the stakeholders models of action comprising:

- Analysis of the financial position of the regional hospitals
  - Ability to maintain sufficient volume and margin to support needed investments for future viability
- Exploration of alternative models that will support the continued viability of regional facilities and ensure access of the population to all necessary services

Based on these conclusions, the RWG has revised its original charge. In Phase 2, it will develop a set of coherent and integrated regional strategies that will:

- Ensure the longer term viability of community hospitals strategically located across the region;
- Improve the adequacy and access to healthcare services for the residents of those communities; and
  Develop system changes that will mitigate the environmental threats that would threaten the sustainability of the delivery of care in the rural communities. There are four key domains that need to be addressed:
    1. Demographic trends
    2. Workforce availability (particularly physicians, with special attention to specialists and sub-specialists)
    3. Financial resources and sustainability of the community hospitals
    4. Impact of federal healthcare reform

The second phase of the RWG will be more clearly defined as the group finalizes its report due at the end of this calendar year. However, from the current analysis and conclusions planning for Phase 2 of this work will involve:

- Developing relationships between both the regional institutions and their referral centers to:

  - Increase the proportion of rural residents who can appropriately be cared for in their local institutions receiving care there as opposed to in the Monroe County institutions
  - Assure that there is a defined system to get patients the level of care they require wherever they present for service
  - Maximize the use of local physicians while simultaneously minimizing the duplication of services
- Facilitating the institutional board and staff analysis and discussions needed to transition from their current structure and relationships to a more clinically integrated system of care for their communities

Appendix

2020 Performance Commission Roster

Leonard Redon (Chair)	Vice-President of Western Operations Paychex Corp.
Susan Holliday (Vice Chair)	President & Publisher Rochester Business Journal
Nancy J. Adams, MSM	Executive Director Monroe County Medical Society
Jean-Claude Brizard	Superintendent of Schools Rochester City School District
Stephen Cohen, MD	Vice President, Medical Affairs MVP Healthcare
Ann Costello	Director B. Thomas Golisano Foundation
Robert Dobies	ExxonMobil (retired)
Marilyn Dollinger, DNS, FNP, BC, RN	Chair, Undergraduate Nursing Program Wegmans School of Nursing St. John Fisher College Genesee Valley Nurses Association
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Norm Lindenmuth, MD	Retired Physician
John Lynch, Jr.	Senior Vice President First Niagara Benefits Consulting
Rev. George Nicholas	Senior Pastor Grace United Methodist Church
Michael Nuccitelli	President & CEO Parlec, Inc.
Louis J. Papa, MD	Primary Care Physician Partner University of Rochester Olsan Medical Group
Hilda Rosario-Escher	President and CEO Ibero-American Action League
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Robert Thompson	Vice President, Safety Net Programs Excellus BlueCross BlueShield
Gerard Wenzke	Retired CEO, First Niagara Risk Management Lakeside Health Board member

Preventable Hospitalizations Work Group Roster

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Ann Marie Cook, MPA ***Jody L. Rowe, representative***	Lifespan of Greater Rochester, Inc.; President/CEO Associate VP, Corporate Compliance Officer
Tim Czapranski	Monroe County Dept. of Public Health, Emergency Medical Services, Administrator
Elisa DeJesus, MS	Ibero-American Action League, Vice President of Family Services
Joseph A. DiPoala, Jr., MD	Ridgeview Internal Medicine Group. LLP
Pat Heffernan, LMSW	Lifetime Care, President
Travis Heider	American Diabetes Association, Rochester Chapter, Executive Director
Donna Hill, PhD, RN	Rochester City School District, District Coordinator of Student Health Services
Victoria Hines	Visiting Nurse Service, President & CEO
Gloria Hitchcock	Rochester RHIO, Project Coordinator
Bill Horner	Rochester General Hospital, Senior VP of Operations
Donna Johnston	Anthony L. Jordan Health Center, Consultant
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Clint Koenig, MD, MA, MSPH	Monroe Plan for Medical Care, Medical Director
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Rosa Lloyd, MBA	The National Kidney Foundation Serving Upstate NY, Director of Community Outreach
Michael Nazar, MD	Unity Health System, Vice President of Primary Care and Community Services
Angela Rose, RN, BSN, MHA	Lakeside Health System, Vice President Patient Care Services & CNO
Susan Saunders, LMSW	University of Rochester Medical Center, Director of Care Management
Elizabeth Zicari, RN, BSN	Home Care of Rochester, Vice President of Clinical Services

Avoidable ED Visits Work Group Roster

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Tim Czapranski	Monroe County Emergency Services, Administrator
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Kathleen C. Plum, PhD, RN	Office of Mental Health, Monroe County Dept of Human Services, Director
Jane Salamone, MD	Rochester General Medical Group, Medical Director; private practitioner
Mary Beth Schlabach, RN, BSN, MS, AE-C	Rochester Community Asthma Network of the Finger Lakes, Asthma Care Coordinator
Brian Shapley	MVP Healthcare, Vice President, Healthcare Management
Bridgette Wiefling, MD	Anthony L. Jordan Health Center, President & CEO

Discharge Planning Sub Group Roster

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Brenda Chapman, RNC, BSN	Clifton Springs Hospital & Clinic, Director of Care Coordination
Hozue Croston, LMSW	Newark-Wayne Community Hospital, Social Worker
Judy Deter, LMSW	Unity Health System, Senior Director of Care Management
Karen Fitzpatrick, BSN, RN	Geneva General Hospital, Director of Care Management
Gloria Hitchcock	Greater Rochester Regional Health Information Organization (RHIO), Project Coordinator
Paul Horsington, MSW, MPA	Lakeside Health System, Director of Social Work/Case Management
Helen Hurlburt, RN	Nicholas H. Noyes Memorial Hospital, Coordinator of Case Management
Kelly Luther, LMSW	University of Rochester Medical Center, Director of Social Work and Patient & Family Services
Dottie O'Rourke, RN, MS	Lifetime Care, Vice President, Customer Relations
William Pum, MD	Unity Health System, Chief of Ambulatory Care
Mary Savastano, LMSW	Thompson Health, Director of Case Management/Social Work
Mary Jane Stone, LMSW	Rochester General Hospital, Manager, Social Work Services
Michael Sullivan, LCSW-R, CASAC	Highland Hospital, Director, Social Work Dept

[1] Koehler, B.E., Richter, K.M., Youngblood, L., et al. (2009). Reduction of 30-day postdischarge hospital readmission or emergency department (ED) visit rates in high-risk elderly medical patients through delivery of a targeted care bundle. *Journal of Hospital Medicine, 4*(4), 211-218.

[2] Jenks, S.F., Williams, M.V., Coleman, E.A. (2009). Rehospitalizations among patients in the Medicare fee for service program. *New England Journal of Medicine, 360*(14), 1418-1428.

[3] Jack, B.W., Chetty, V.K.; Anthony, D., et al. (2009). A reengineered hospital discharge program to decrease rehospitalization: A randomized trial. *Annals of Internal Medicine, 150*(3), 178-187.

[4] Coleman, E.A., Parry, C., Chalmers, S., Min, S.J. (2006). The Care Transitions Intervention: Results of a randomized controlled trial. *Archives of Internal Medicine, 166*(17), 1822-1828.

[5] Center for Excellence in Primary Care, UCSF. (2009). The outcomes of implementing Patient-Centered Medical Home interventions: A review of the evidence on quality, access, and costs from recent prospective evaluation studies. http://familymedicine.medschool.ucsf.edu/cepc/pdf/outcomes of pcmh for White House Aug 2009.pdf.

[6] Hernan A., Young, K.D., Espitia, D., Fu, N., Farshidi, A. (2009). Impact of a health literacy intervention on pediatric emergency department use. *Pediatric Emergency Care, 25*(7), 434-438.

[7] McConnochie, K.M., Wood, N.E., Herendeen, N.H., Ng, P.K., Noyes, K., Wang, H., Roghmann, K.J. (2009). Acute illness care patterns change with use of telemedicine. *Pediatrics, 123*(6), e989-e995.

2011 Hospital Website Posting Monroe County Joint Community Service Plan

Lakeside Health:
www.lakesidehealth.org : Located on the Quality page on the right hand side.

Rochester General Hospital:
http://www.rochestergeneral.org/rochester-general-health-system/about-us/community/

Strong/ Highland:
www.**urmc**.rochester.edu/**community**-engagement/documents/JCSP-UPDATE-**URMC**-SMH-HH.pdf