2022 COMMUNITY HEALTH ASSESSMENT & COMMUNITY SERVICE PLAN

Community Health Improvement Plan

2022–2024

PREPARED FOR:

Oneida County Health Department
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Community Health Assessment

Community Needs Assessment & Implementation Plan

For the purposes of the county/hospital Community Health Improvement Plan (CHIP), we are tasked with identifying two key priority areas that the hospitals and the county health department will work on collaboratively using evidence based interventions from the New York State Prevention Agenda.

Based upon the feedback from the community and the data analysis, Rome Health, the Oneida County Health Department and Mohawk Valley Health System narrowed the priorities down to 4 areas and selected the following 2 focus areas.

Mental Health/Children Teens Social Emotional Health
Mental health was overwhelming identified as a crisis for this community and our county doesn't have a good structure in place to coordinate our efforts.

Chronic Disease Preventive Care/Screenings
While there is infrastructure in place, there are still gaps with lack of access, coordination of care, especially with vulnerable populations.
It's an area that impacts large numbers of people.

The other two areas that had emerged from the research were:
Substance Use/Opioids
Maternal Child Health

While they will not be selected as one of the two priorities in our CHIP, the health assessment will identify them as important health issues in our community that groups will continue to work on to improve outcomes. This language will be important as we seek grant support for different initiatives.

It was felt that these two areas had some infrastructure in place for collaboration and teams were already actively working on interventions within their scope of work.

Community Health Assessment

Based upon the data, Deborah Welch conducted discovery meetings with our internal stakeholders to align our objectives and interventions with the New York State Prevention Agenda and the priority areas identified by the Oneida County CHA team.

Priority Area:
Promote well-Being and Prevent Mental and Substance Use Disorders

Focus Area 2
Mental health and Substance Use Disorder Prevention

Goal 2.5
Prevent Suicide

Objectives 2.51
Reduce Suicide attempts for adolescents

Interventions 2.5.2
Strengthen access and delivery of Suicide Care –Zero Suicide: Zero Suicide is a commitment to comprehensive suicide safe care in health and behavioral health systems.

Next Steps
- Complete an inventory of existing tools used to assess suicide risk for all age groups.
- Develop an education plan for behavioral health staff, medical/surgical, ER and primary care.

Potential Measures
100% of health and behavioral health settings utilize screening tools.
X percentage of clinical staff will be trained quarterly.

Community Health Assessment

Priority Area:
Prevent Chronic Disease

Focus Area 4:
Chronic Disease Preventative Care Management

Goal 4.1
Increase cancer screening rates(specific focus breast cancer)

Objective 4.1.1:
Increase percentage of woman with annual household income less than 25,000 (FIDELIS,UHC) who receive a breast cancer screening based on recent guidelines

Intervention 4.1.1:
Work with health care providers/practices to improve screening reminder processes (eg. letters, postcards, recorded messages**,** texts, EHR alerts)

Intervention 4.1.5:
Remove structural barriers to cancer screening, such as providing flexible hours, offering cancer screening off-site*(**mobile Mammogram**),patient navigation and other administrative supports

Intervention 4.1.6:
Ensure continued access to health insurance coverage

Potential Measures
- Provider/practice screening rates
- # of patients reached through reminder system
- % of compliance with screening guidelines of those patients reached through the reminder system
- % increase of patients with health insurance coverage

Community Health Assessment

Priority Area:
Prevent Chronic Disease

Focus Area 4:
Chronic Disease Preventative Care Management

Goal 4.2
Increase early detection of cardiovascular disease, diabetes, prediabetes ,obesity

Objective 4.2.1:
Increase percentage of adults who had a test for high blood sugar or diabetes within the past 3 yrs.

Intervention:
Build consensus around clinical practice standards and monitor compliance

Potential measures:
# of patients identified with diabetes /pre-diabetes
# of patients screened by revised practice standards