ST. JAMES MERCY HOSPITAL

COMMUNITY SERVICE REPORT 2012

St. James Mercy Hospital
2012 Community Service Plan Update
Executive Summary

Hospitals in New York State (NYS) are required by the Department of Health to create and publicly distribute an annual "Community Service Plan," which identifies and describes progress toward meeting health priorities in their service areas.

In 2009, St. James Mercy Hospital (SJMH) participated in a Community Health Assessment to identify and prioritize health care needs in Steuben County (SJMH's primary service area) for the next three years. This assessment process, based on the NYS "Prevention Agenda" initiative, was coordinated by Steuben County Public Health and included the three county hospitals (St. James Mercy Hospital, Corning Hospital, Ira Davenport Memorial Hospital) and area health organizations.

As a result of the community assessment, two priorities were identified for Steuben County: **Access to Quality Health Care** and **Chronic Disease**. SJMH is collaborating with area health organizations on an ongoing basis to address these needs and report the progress in its annual Community Service Plan. In 2012, SJMH is participating in the next three-year cycle of the Community Health Assessment, and will revise activities and outreach regarding health priorities, as appropriate, for the 2013 Community Service Plan.

In 2012, SJMH has continued to make progress in four key projects related to **Access to Quality Health Care**:

- **Partnership with Guthrie Healthcare:** In June 2011, SJMH announced an affiliation agreement with Guthrie Healthcare System (GHS), culminating a process that began in March 2010 when both parties agreed to explore a relationship that would secure access to services for the community and address the need to enhance physician recruitment efforts, and to assist in the creation of an electronic health record. The focus of the affiliation in 2012 has been physician alignment and recruitment, specifically for cardiology and primary care. To enhance access to local cardiology services, a cardiologist from GHS began coming on-site to SJMH two days per month in February 2012, and will continue to increase his time at SJMH as demand and referrals increase. GHS staff currently are working on-site with SJMH clinic physicians and managers to develop alignment strategies. Additional recruitments are underway for needed specialty services.

- **Behavioral Health Renovation**: To improve care delivery and access to safe and modern facilities, SJMH allocated significant capital toward relocation and renovation of the adult inpatient psychiatric care unit. With the appropriate NYS Department of Health and NYS Office of Mental Health approvals, construction began in July 2011 and was completed in April 2012. On-site inspections by Department of Health and Office of Mental Health officials were conducted in June 2012, with approval to occupy pending completion of additional construction requirements. The requirements were met and patients were transferred to the newly-completed unit in August 2012. The project is officially completed.

- **Uninsured Children Outreach Project**: This pilot program, in collaboration with the Hornell City School District, is designed to address the issue of students without health insurance. In 2010, education of parents of pre-K through grade 6 students specific to Medicaid and Child Health Plus (CHP) insurance was completed and Medicaid information was distributed to parents of 1,250 students. An on-site facilitated-enroller process has been replaced with an online application process. A review of public insurance program

enrollment indicates that in calendar year 2011, 26 children applied for insurance and 25 were approved. As of July 2012, 29 new children applied for insurance and 29 were approved.

- **Cancer Screening Outreach Program:** As the lead organization for the Cancer Services Program of Steuben County, SJMH is partnering with Corning Hospital to increase access to cancer screening services for uninsured women who utilize local food pantries. As a result of the outreach effort, 398 men and women enrolled in the Cancer Services Program in 2011, which was 113% of the intended goal. The 2012 goal was to increase enrollment by 5% (20 additional enrollments or 418 total), including increased emphasis in reaching male clients for colorectal cancer screenings. As of July 2012, 277 women and men had enrolled in the Cancer Services Program, which is 66% of the 2012 goal.

Relative to the **Chronic Disease** priority, SJMH has identified two key projects:

- **Certified Diabetes Education Program:** In 2010, SJMH initiated development of a certified diabetes education program to assist primary care providers in decreasing the rates of diabetic complications. In 2011, the community education target of 1000 hours was completed. The patient educator achieved certification in July 2011 and program certification (accreditation) was achieved in October 2011. Program goals, performance improvement activities, and metrics were established for 2012 and included increased collaboration with local agencies, documented clinical indicators for outcomes reporting, and a goal of 100 new enrollees in 2012. As of June 2012, 41 new individuals had been enrolled in the Diabetes Education Program. Below is a change report documenting clinical outcome measurements that evaluate the effectiveness of educational interventions.

Outcome Measurements		**Pre**	**Post**	**Change**
A1C Level	High	17.9	12.6	5.3
(32 records)	**Avg**	9.12	7.52	**1.6**
	Low	5.8	5.8	0
Total Cholesterol	High	252	361	-109
(27 records)	**Avg**	164.1	154.7	**9.37**
	Low	59	53	6
HDL	High	60	60	0
(27 records)	**Avg**	35	37.04	**-2.04**
	Low	14	14	0
LDL	High	180	257	-77
(24 records)	**Avg**	93.71	87.25	**6.46**
	Low	27	20	7
Triglycerides	High	563	473	90
(27 records)	**Avg**	186	165.1	**20.89**
	Low	46	43	3

- **Pulmonary Health/COPD and Smoking Cessation Program:** SJMH provides pulmonary rehabilitation services to address COPD (Chronic Obstructive Pulmonary Disease) and related conditions, with the primary objective of smoking cessation to reduce complications. The smoking cessation evaluation and stop-smoking education are now established components of inpatient and outpatient services, with direct patient teaching being provided by individual nursing staff and physicians. A review of 15 pulmonary rehabilitation patients since January 1, 2012 reveals that 1 out of 15 (or 7%) were/are smokers. Of those, 100% were counseled on smoking cessation and were provided information on treatment options. The application for American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) certification will be pursued in 2013 upon compilation of data in 2012.

Following in this document are the full results of the 2009 Community Health Assessment, including identification and selection of priorities and current updates for SJMH's programs and initiatives as of September 2012.

St. James Mercy Hospital
Community Service Plan Update
September 2012

1. Mission Statement

Faithful to our sponsor, the Sisters of Mercy, St. James Mercy Hospital, a member of Catholic Health East, is a community of persons committed to being a transforming, healing presence within the rural communities we serve, particularly addressing the needs of the poor, underserved and disadvantaged.

2. Hospital Service Area

The primary service area for St. James Mercy Hospital (SJMH) is the 15-mile radius extending from Hornell (Steuben County), New York, and includes the towns of Wayland to the northeast and Troupsburg to the southeast (just outside of the 15-mile radius). The secondary service area is the 30-mile radius extending from Hornell.

The population for the primary service area (Steuben County) remains relatively flat, increasing 0.3% from 2000 to 2010 to 98,990 and is projected to remain flat through 2014 (*2010 Census*). The population aged 65 and over comprises 16% of the primary service area compared to 13% for New York State population (*2010 Census*).

3. Service Area Health Priorities

In 2009, St. James Mercy Hospital (SJMH) participated in a collaborative, county-wide Community Health Assessment (CHA) in Steuben County to evaluate and prioritize area health care needs for the next three years, based on New York State's "Prevention Agenda" initiative. The CHA project was coordinated by Steuben County Public Health, and included studies of consumer needs and preferences through surveys and focus groups, assessment of county health resources, and meetings with the CHA group (St. James Mercy Hospital, Corning Hospital, Ira Davenport Memorial Hospital) and area health organizations to determine health care priorities.

Based on results of the county Community Health Assessment, SJMH identified two of the NYS Prevention Agenda priorities for intervention and service enhancement – **Access to Quality Health Care** and **Chronic Disease.** Collaborative efforts within the service area are required at several levels of intervention.

Access to Quality Health Care – Overview of the Problem:

- Steuben County is the state's seventh largest county and is twice as large as any of the other counties in the nine-county Finger Lakes Health System Region. Almost 30% of the county's population lives in its three urban areas – the cities of Corning and Hornell, and the village of Bath.
- The county is predominately rural with more than two-thirds of its residents living in rural areas. Nearly 80% of 2009 CHA survey respondents felt that transportation to health care and access to specialty care are issues in Steuben County.
- In Hornell, NY (location of St. James Mercy Hospital), the provider rate is 144 physicians/100,000 persons compared with the national average of 221 (*Sperling's Best Places*).
- Approximately 16% of Steuben County adults under the age of 65 do not have health insurance (*2011 County Health Rankings*).

- There are inadequate sources of assisted living, senior housing and other continuum of care services in the county. Local resources cannot support the model due to the rural nature of the area.
- The configuration of St. James Mercy Hospital's aging facilities and distance between services within and outside of the primary campus impedes access to care.

Chronic Disease – Overview of the Problem:

- A significantly higher proportion of adults report that they smoke (30%) in Steuben County than in the state (15%) (*2011 County Health Rankings*).
- A greater proportion of county residents are obese (29%) than in the state (25%) (*2011 County Health Rankings*). There is a significantly higher mortality rate for COPD in Steuben Co. (49.6/100,000) than in the rest of the state (30.6/100,000) (*Behavioral Risk Factor Surveillance System/BRFSS*).
- A higher proportion of county residents assess their own health as "poor" or "fair" (14%) compared to the state (10%) (*2011 County Health Rankings)*.

The two chronic diseases of greatest focus for SJMH are Diabetes and Chronic Obstructive Pulmonary Disease (COPD):

Diabetes: Diabetes was ranked as a problem in Steuben County by 92.5% of residents (*Steuben Co. CHA*). The county rate for diagnosed diabetes is 8.2% compared to the state rate of 7.2% (*Behavioral Risk Factor Surveillance System/BRFSS*). Steuben County's mortality rate from diabetes is 24/100,000 compared to the state at 4/100,000 (*NYS Vital Statistics*). It is evident that this is a chronic disease that requires careful attention in SJMH's service area.

Chronic Obstructive Pulmonary Disease (COPD): COPD hospitalizations among adults in Steuben County are 52/10,000 versus 40 for the state (*Behavioral Risk Factor Surveillance System/BRFSS*). Death rates for chronic lower respiratory disease (per 100,000) are 54% for Steuben County compared to 33% for the state (*NYS Vital Statistics*). A major contributing factor in COPD and respiratory disease is tobacco use. The rate of cigarette smoking among adults in Steuben County is 30% versus 15% for the state (*2011 County Health Rankings*). As with diabetes, with both major causes of death and years of potential life loss above state and regional averages, COPD is a chronic disease that warrants concerted focus.

5. Update on Plan of Action

Access to Quality Health Care and Chronic Disease had previously been identified by St. James Mercy Hospital for long-term strategic focus. Following is SJMH's updated work plan defining timeframes, activities and measurements to address these priorities.

Access to Quality Health Care:

a. Partnership – Guthrie Healthcare System

In June 2011, SJMH announced an affiliation agreement with Guthrie Healthcare System (GHS). In March 2010, St. James Mercy Hospital announced it would explore a potential relationship with Guthrie Healthcare System. Based in Sayre, Pa., GHS has similar values to St. James Mercy Hospital and has proven its ability to successfully build a strong, long-term presence in a rural health care environment, as well as recruit and retain high-quality physicians.

2012 Update: The focus of the affiliation in 2012 has been physician alignment and recruitment, specifically for cardiology and primary care. To enhance access to local cardiology services, a cardiologist from GHS began coming on-site to SJMH two days per month in February 2012, and will continue to increase his time at SJMH as demand and referrals increase. GHS staff currently are working on-site with SJMH clinic physicians and managers to develop alignment strategies. Additional recruitments are underway for needed specialty services.

b. Behavioral Health Renovation: In 2010, plans to construct an ambulatory care center were put on hold due to the economic downturn and other system priorities. In response to the CHA, SJMH's long-term strategic plan, and the organization's mission, SJMH allocated capital toward the relocation and renovation of the adult inpatient psychiatric care unit to address patient safety, improve the current environment and address future care delivery for psychiatric patients.

2012 Update: Construction began in July 2011 and was completed in April 2012. On-site inspections by Department of Health and Office of Mental Health officials were conducted in June 2012, with approval to occupy pending completion of additional construction requirements. The requirements were met and patients were transferred to the newly-completed unit in August 2012. The project is officially completed.

c. Uninsured Children Outreach Project

In the fall of the 2010 school year, SJMH wellness personnel initiated a pilot program in collaboration with the Hornell City School District to address the issue of students without health insurance. This project grew out of efforts of the National Cover the Uninsured Week. According to 2010 Census data, 9.5% of Steuben County individuals under the age of 18 are uninsured. The objective of this pilot program is to educate parents of Hornell school age students about public health insurance options.

The three-year plan is designed as follows:

Steps for 2010:

- Meeting with Hornell City School District to identify issues of school age students without health insurance and discuss a plan to address need.
- Planning will continue throughout the year and will include a process to communicate information to families of all students 1st through 6th grades.
- SJMH will collaborate with county supervisor of facilitated enrollers to place an enroller in Hornell schools on specified dates as well as have the current enroller screen for the information source of parents enrolling students in insurance plans.

Steps for 2011:

- Modify processes as needed and continue program.
- Based on 2010 findings, implement process for Pre-K and Kindergarten screenings that will include information about public health insurance programs for families and children including steps for enrollment.

Steps for 2012:

- Continue to modify practices established in prior years, as needed.
- Modify processes to include 6th – 12th grades.

Measurement:

- Parents of children in Hornell City School District Elementary Schools will receive information about student health insurance resources.
- In 2009, 166 children under the age of 19 were enrolled in a health insurance program in the 14843 zip code (primary zip code for the Hornell City School District). The facilitated enrollers in the schools and at SJMH will track and monitor enrollment data related to SJMH's efforts. Note: In April 2010 the requirement to have a face-to-face meeting with a facilitated enrolled was discontinued. Because a person may go directly to county offices for enrollment, it is not possible to obtain precisely the number of students enrolled as a result of SJMH efforts from the county.
- 2010: establish SJMH enrollment program.
- 2011: increase enrollment by 5% from 2010 performance.
- 2012: increase enrollment by 5% from 2011 performance.

2012 Update: The education of parents of pre-K through grade 6 students specific to Medicaid and Child Health Plus (CHP) insurance was completed and Medicaid information was distributed to parents of 1,250 students. An on-site facilitated-enroller process has been replaced with an online application process.
A review of public insurance program enrollment indicates that in calendar year 2011, 26 children applied for insurance and 25 were approved. As of July 2012, 29 new children applied for insurance and 29 were approved.

d. Cancer Screening Outreach Program

The Cancer Services Program of Steuben County is a NYSDOH grant that provides breast, cervical and colorectal cancer screenings to uninsured and underinsured individuals in Steuben County. SJMH is the administrative lead agency on the grant and provides staff and in-kind support for all aspects of the program.

In this capacity, SJMH is partnering with Corning Hospital to increase access to cancer screening services for uninsured women who frequent local food pantries. An evidenced-based model from the Northern Appalachia Cancer Network (NACN) has been modified for development in Steuben County. The program works with local food pantries to promote access to care in a systematic and structured way. Trained volunteers make direct contact with clients at the food pantries to educate and assist them with breast, cervical, and colorectal cancer screening services, then follow up with the clients during their next visit to the food pantry.

The three-year plan was designed as follows:
<u>Steps for 2010</u>:

- Train area food pantry workers and Corning Hospital auxiliary volunteers on processes of outreach program.
- Implement program.
    - April: Flyer in food pantry bags with information and dates of project
    - May and June: Volunteer and Cancer Services Program staff hold events at food pantry. Enrollment on site will be available.
    - July: Follow up flyer in food pantry bags with contact information to enroll in Cancer Services Program.
- Evaluate program including number of clients receiving information and number enrolled in Cancer Services Program.
- Extend outreach program to other food pantries throughout Steuben County.

Steps for 2011:

- Modify program as necessary and expand to additional sites as determined.

Steps for 2012:

- Modify program as necessary and expand to additional sites as determined.

Measurement: On days that Cancer Screening Program staff is onsite, 100% of food pantry clients (women) will receive information on breast cancer prevention and access to screenings for uninsured and underinsured woman. Those who are eligible for Cancer Services Program of Steuben County will be enrolled for screening.

In 2009, 319 women received a mammography screening from the Cancer Services Program of Steuben County. In 2010, the goal was to increase this number by 5% (335 women screened, an increase of 16 individuals). It is expected that a significant amount of this increase will be from women enrolled through participation in the Cancer Screening Outreach Program.

Using information received from enrollees, SJMH will determine if the physical presence of trained volunteers and staff in the enrollment process increases the number of enrollments.

2012 Update: As a result of the outreach effort, 398 men and women enrolled in the Cancer Services Program in 2011, which was 113% of the intended goal. The 2012 goal was to increase enrollment by 5% (20 additional enrollments or 418 total), including increased emphasis in reaching male clients for colorectal cancer screenings. As of July 2012, 277 women and men had enrolled in the Cancer Services Program, which is 66% of the 2012 goal.

Chronic Disease:

a. Certified Diabetes Education Program

In 2011 – 2012, SJMH established a certified diabetes education program. The certified diabetes educator and program assist primary care providers in improving outcomes and minimizing complications of patients with chronic diabetes.

The three-year plan was designed as follows:

Steps for 2010:

- Develop education curriculum content that includes 1,000 hours of education services provided to the community.
- Create communication tool to introduce the program to SJMH-affiliated providers.
- Initiate education for Emergency Department staff on patient survival skill training for new diabetics.
- Enroll patients into the program.
- Screen diabetic inpatients for ongoing education needs.
- Provide public presentations to educate the community on diabetes and the available community resources at SJMH.
- Build a database for patient demographics and outcome indicator management.
- Establish quarterly program reports for the diabetes education program.

Steps for 2011:

- Upon completion of the 1,000 hours community education requirement, the current patient educator can apply to take the test to be a certified diabetic educator.

- SJMH will also apply for program certification.

Steps for 2012:

- Produce outcome reports to identify the efficacy of the program (address demographics, disease type, severity of disease by A1C (average blood sugar level for 2–3 months) and A1C improvements by population sorts).
- Develop outcome improvement initiatives as needed based on collected data.

Measurement: Educator completes 1,000 hours community education and achieves successful certification as certified diabetes educator, and SJMH becomes certified as a diabetes education center. Patients enrolled in the diabetes program will receive appropriate education for self management of their disease process and be able to verbally review the principles of daily diabetes management. Each individual's comprehension will be documented and areas of deficit understanding will be addressed through ongoing education, or by alternate education services provided for the patient's significant other. The individual patient and educator will develop an individual A1C goal and there will be documented evidence of a progressive improvement in their A1C levels over a period of one year in the program. The individual patient will be counseled to obtain an annual retinal screening exam in collaboration with their primary provider.

2012 Update: The patient educator achieved certification in July 2011 and program certification (accreditation) was achieved in October 2011. Program goals, performance improvement activities, and metrics were established for 2012 and included increased collaboration with local agencies, documented clinical indicators for outcomes reporting, and a goal of 100 new enrollees in 2012. As of June 2012, 41 new individuals had been enrolled in the Diabetes Education Program. Below is a change report documenting clinical outcome measurements that evaluate the effectiveness of educational interventions.

Outcome Measurements		Pre	Post	Change
A1C Level	High	17.9	12.6	5.3
(32 records)	**Avg**	9.12	7.52	**1.6**
	Low	5.8	5.8	0
Total Cholesterol	High	252	361	-109
(27 records)	**Avg**	164.1	154.7	**9.37**
	Low	59	53	6
HDL	High	60	60	0
(27 records)	**Avg**	35	37.04	**-2.04**
	Low	14	14	0
LDL	High	180	257	-77
(24 records)	**Avg**	93.71	87.25	**6.46**
	Low	27	20	7
Triglycerides	High	563	473	90
(27 records)	**Avg**	186	165.1	**20.89**
	Low	46	43	3

b. Pulmonary Health/COPD and Smoking Cessation Program

SJMH has an established pulmonary rehabilitation service that addresses Chronic Obstructive Pulmonary Disease (COPD) and related chronic pulmonary conditions. Through a structured exercise program with clinical monitoring and medication management, pulmonary services will help to promote optimum pulmonary function for patients who have COPD or chronic pulmonary conditions. The program is directed at improving functional capacity and promoting optimum quality of life for these patients in our community.

SJMH is committed to providing ongoing pulmonary rehabilitation services for both Level II patients and Level III patients who are determined to be at a maintenance level. Level II pulmonary rehabilitation is now a covered service under Medicare. Level III includes the principles of pulmonary rehabilitation on a routine (maintenance) basis. These services are available Monday through Friday at SJMH on a private-pay basis.

In addition, pulmonary rehabilitation professionals stress that smoking cessation is a key element in healthy pulmonary function and must be promoted with smokers who have chronic pulmonary conditions. SJMH is committed to educating patients and supporting smoking cessation in our community.

In an effort to address prevention of COPD (most commonly associated with a history of smoking), SJMH and its primary care services have partnered with the New York State Coalition/Smokers Quit Site. Through this initiative, all inpatient areas, emergency services and private offices assess each patient for current smoking status. If the patient is a smoker, he/she is provided with information on quitting and access to free nicotine replacement patches.

The three-year plan was designed as follows:

Steps for 2010:

- Enhance current pulmonary rehabilitation program to include Level II and Level III services.
- Increase smoking cessation efforts with inpatients, to include widespread assessment of smoking status in inpatient, emergency department, and private offices.
- Participate in chart audits for inpatients to confirm that smoking status has been assessed.
- Provide patients with educational materials for smoking cessation and contact information for free smoking cessation products available through NYS Quit Site http://www.nysmokefree.com/.

Steps for 2011:

- Analyze and report outcome data on internal assessment compliance for the patient population.
- Identify improvement initiatives based upon outcome findings.

Steps for 2012:

- Analyze regional data on smoking status for Steuben County to identify if and how hospital and primary care initiatives are working.

Measurement: 95% of inpatients who access SJMH's primary care services assessed as smokers will receive smoking cessation information.

2012 Update: The smoking cessation evaluation and stop-smoking education are now established components of inpatient and outpatient services, with direct patient teaching being provided by individual nursing staff and physicians. A review of 15 pulmonary rehabilitation patients since January 1, 2012 reveals that 1 out of 15 (or 7%) were/are smokers. Of those, 100% were counseled on smoking cessation and were provided information on treatment options. The application for American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) certification will be pursued in 2013 upon compilation of data in 2012.

6. Dissemination of the Report to the Public

SJMH disseminates its Community Service Plan (CSP) and annual updates in a variety of ways including the employee intranet, public website (www.stjamesmercy.org) and e-mail. Notices of availability will be placed with the local media. Copies of the CSP will be made available to the Health Association of NYS (HANYS), appropriate Catholic Health East system administration, and SJMH administration and management. SJMH staff and physicians will be notified that the CSP is posted on the employee intranet. The CSP will also be made accessible to local community leaders and organizations such as the mayor of Hornell, mayor of North Hornell, Hornell Chamber of Commerce, Hornell Partners for Growth, St. James Mercy Hospital Board of Directors, St. James Mercy Foundation Board of Directors, St. James Mercy Properties Board of Directors, Catholic Charities (Bath), Steuben Rural Health Network, and Steuben County Health Priorities team.

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

As of July 2012, Steuben County had one of the highest unemployment rates (9.1%) in New York State. This rate has resulted in a growing number of uninsured individuals in the region and SJMH has experienced increased bad debt and uncompensated care. As reported through Schedule H of Form 990, SJMH estimated its 2011 bad debt expense to be $281,842. This amount is defined as expense attributable to individuals who would likely qualify for financial assistance, but for whom sufficient information was not obtained to make a determination.

8. Financial Aid Program

SJMH successfully assisted 668 families in 2011 who were underinsured or who exceeded governmental guidelines for state-funded health insurance programs. True to its mission, SJMH reaches out to all self-pay patients through its internal financial counseling process and has on-site MedAssist Eligibility Service to assist in ensuring patients are screened for governmental assistance versus financial aid. Challenges arise when patients who are screened qualify per the guidelines, but do not meet the timelines in providing required documentation. SJMH anticipates a growing need locally for financial assistance of all kinds due the weak local economy, and efforts are focused on improving internal financial assistance resources and outreach to the under/uninsured population. St. James Mercy Hospital will direct its efforts at increasing access to care for the most vulnerable – the unemployed, uninsured and/or underinsured.

For more information on this report contact:
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