St James Mercy
HEALTH SYSTEM

ST. JAMES MERCY HOSPITAL

COMMUNITY SERVICE REPORT 2009

St. James Mercy Hospital
2009 Community Service Plan

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.
Reviewed, revised and approved by Board of Directors – March 2007

2. Service area

The primary service area (PSA) for St. James Mercy Hospital (SJMH) is the 15-mile radius extending from Hornell, 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 (SSA) is the 30-mile radius extending from Hornell.

The PSA population of 43,843 (2008) will experience little growth and is projected to be 43,853 in 2013. Although the cohort comprising the pediatric population (age 0 – 17) is significantly smaller than the US population cohort (20.9% vs. 24.4%, respectively) the reverse is true in the 18 - 24 year cohort (16.7% vs. 9.8%, respectively). The senior population (age 65 and over) comprises a slightly larger proportion of the PSA population than is observed in the general US population.

3. Public Participation

The MAPP (Mobilizing for Action through Planning and Partnership) process was used in 2009 to conduct a comparable four-part Community Health Assessment in six of seven counties (Seneca, Schuyler, Steuben, Ontario, Wayne and Yates), and to compare data between Network Counties and develop common objectives.

Several assessments were conducted. The first examined the Community Health Status Indicators. The second assessment evaluated the effectiveness of the Public Health System and the role of the Public Health Department within that system. The third was the Community Themes and Strengths Assessment, conducted through Focus Group meetings throughout the county. The fourth assessment was conducted through Focus Group meetings and evaluated the "Forces of Change" that are at work locally, statewide and nationally, and what types of threats and/or opportunities are created by these changes.

4. Assessment of Public Health Priorities

Once the four-part Community Health Assessment results were tallied, a finalized list of the top issues from all components of the process was compiled, and the data were presented at a meeting of community health care representatives, including SJMH. The group was charged with ranking the priorities based on knowledge of health needs and available services, along with the data presented and to select two to three priorities:

- Access to Quality Health Care
- Chronic Disease

Additional data were considered from a 2008 needs assessment conducted by Marketing students from Alfred University. The methodology and results follow:

- A hard copy survey was mailed to 6,867 people randomly within the 30-mile SSA
- 1,012 people responded, for a response rate of 14.74%
- 65% were female; 35% male, with a median age of 54 (age of respondents ranged from 13 – 92 years old)
- 521 responses were from Hornell, Bath and Wellsville, or 51.5% of respondents

Respondents to the AU study identified their top ten needs. Seven of the needs are already addressed in the PSA and/or at SJMH (including chiropractic, ultrasound, heart monitoring, carotid Doppler measuring, diagnostic imaging, and rehabilitation services). Because these services do exist locally, it is imperative that they be marketed more effectively to patients. Three service needs identified by respondents are clearly under-represented in the PSA (sports medicine, wellness & health promotion, and pain management), and indicate potential growth areas. One identified need (cardiac angiography) does not exist and is not appropriate for SJMH.

As a sole community provider, SJMH intends to develop and enhance services that are appropriate to the needs of the service area, in particular those addressing chronic disease, wellness, and access to quality health care. The following provides an overview of the community health status of the SJMH service area.

SJMH Primary Service Area Demographics (15-mile radius of Hornell including Wayland and Troupsburg)

- Service area population of 43,843 (2008) will experience little growth and is projected to be 43,853 in 2013.
- As indicated below, the PSA has a significant aged population that utilizes health care services at a level much higher than other groups.
- In addition, the PSA contains a significant number of residents living in rural areas, with 69.7 persons per square mile as compared to 401.9 per square mile for NYS. This segment of the population has historically been underserved for health care services, further strengthening the case for the new Ambulatory Care Center (ACC).
- Although the cohort comprising the pediatric age group (0 - 17) is significantly smaller than the US population cohort (20.9% vs. 24.4%, respectively) the reverse is true in the 18 - 24 cohort (16.7% vs. 9.8%, respectively). The senior population (age

65+) comprises a slightly larger proportion of the service area population than is observed in the general US population (see below):

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	**2008**	**% of Total**	**2013**	**% of Total**	**USA 2008 % of Total**
0-14	7,181	16.4%	6,783	15.5%	20.1%
15-17	1,962	4.5%	1,665	3.8%	4.3%
18-24	7,309	16.7%	7,458	17.0%	9.8%
25-34	5,601	12.8%	5,919	13.5%	13.4%
35-54	10,945	25.0%	10,190	23.2%	28.6%
55-64	4,874	11.1%	5,377	12.3%	11.0%
65+	5,971	13.6%	6,461	14.7%	12.7%
Total	**43,843**	**100.0%**	**43,853**	**100.0%**	**100.0%**

SJMH Patient Profile

- The hospital serves individuals of all ages. In 2007, of 3,368 inpatient admissions 16% were under the age 18, 33% were age 65+, and 9% were 85 or older.
- Five service lines accounted for 74% of admissions in 2007: Psychiatry (26.8%), General Medicine (17.4%), Pulmonary (12.5%), Obstetrics (9.2%), and Cardiovascular Diseases (8.1%).
- The proportion of "indigent" care at SJMH (Medicaid, Self Pay, Charity Care) as a percent of total care is as follows:

SJMH 2008 "Indigent Care" Statistics

	Medicaid	Self Pay	Charity Care
Inpatients	50.9%	8.2%	1.1%
Outpatients	7.5%	3.6%	0.5%
Office Visits	22.4%	3.2%	1.9%

Work Plan for Health Priorities

The following is SJMH's work plan defining timeframes and activities to accomplish the objectives in the county-wide Community Health Improvement Plan, specific to the two identified health priorities:

1. Access to Quality Health Care

SJMH views the Access priority as encompassing a number of diverse yet related issues:

- Gap between long-term care and staying at home (i.e. lack of assisted living or other continuum of care services)
- Shortage of specialists locally, requiring patients to travel long distances for specialized care

- Growing number of under- and uninsured patients due to the weak economy and job losses, resulting in delay or avoidance of treatment. 2005 Census data indicate that 13.3% of Steuben County residents under the age of 65 are uninsured.
- Rural nature of the primary service area and lack of mass transit and adequate transportation services
- Growing number of primary care providers who cannot or will not take new patients, including those who are uninsured
- Configuration of SJM's aging facility and distance between services within and outside of the primary campus, creating challenging access for some patients (such as transportation and parking)

2. Chronic Disease

SJMH views the Chronic Disease health priority as follows:

- There is a higher incidence of chronic conditions in the PSA than in the rest of the state.
- Steuben County's death rate/100,000 (977.2) is significantly higher than the state rate (764.6).
- The county experiences significantly greater rates of death due to lung cancer, cerebrovascular disease, and breast cancer than the state, overall.
- The proportion of adults reporting that they smoke (30.8%) is significantly higher in Steuben County than in the state, overall (18.2%).
- A greater proportion of Steuben County residents are obese (24.9%) than in the state, overall (22.9%).
- A greater proportion of PSA residents assess their own health as "poor" compared to county, state and national benchmarks. The 30-mile radius population compares more closely to the PSA self-reported health status than to the other benchmark areas (see below):

Local Market Households by Health Status Ranking
Selected Age Type: All Ages
Selected Health Status Type: Total

Self-Reported Health Status	% Reporting				
	PSA	Steuben Co.	30 mi Radius	NY	USA
1-Excellent	0.0%	3.7%	1.4%	22.6%	19.1%
2-Very Good	3.3%	9.9%	5.9%	20.8%	19.3%
3-Good	37.9%	29.7%	34.9%	18.2%	20.4%
4-Fair	20.6%	29.7%	22.8%	13.5%	19.3%
5-Poor	38.2%	27.0%	35.0%	24.8%	22.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Market Expert Community Health Assessment 1.0
Thomson's PULSE Healthcare Survey
BRFSS

SJMH is focused on the treatment and management of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Chronic Renal Disease. The following outlines local chronic disease issues:

Diabetes: Hornell and Steuben County as a whole, compared with upstate New York (variance columns), have the following rates of diabetes per 10,000 population:

Description	Hornell Rate/10,000	Steuben Co. Rate/10,000	Hornell - Variance	Steuben Co. - Variance
Diabetes - short term complication	5.0	6.6	3.6%	37.4%
Diabetes - long term complication	17.9	11.5	61.7%	3.7%
Uncontrolled diabetes	1.0	1.7	-38.8%	5.6%
Lower extremity amputation	7	2.4	155.2%	-12.9%

Chronic Obstructive Pulmonary Disease (COPD): The Hornell rate of COPD is 52.7 per 10,000 compared to the upstate New York rate of 21.6, a variance of 144.2%. The Steuben County rate is much lower at 29.7, but considerably higher than upstate.

Congestive Heart Failure (CHF): The Hornell rate of hospitalizations for CHF is 54.7 per 10,000 compared to the upstate rate of 46.0, a variance of 19%. The rate for Steuben County as a whole is lower than Hornell at 50.4, but still higher than upstate.

End Stage Renal Disease (ESRD): The incidence of ESRD patients (diabetic and non-diabetic) per million in NYS increased 6% from 6,835 in 2003 to 7,266 in 2006. This increase is tied to the growing incidence in diabetes. SJMH operates a 10-station Hemodialysis unit capable of treating up to 30 ESRD patients per day, and a Peritoneal unit which provides training and follow up for dialysis patients at home or in the nursing home. As the only accredited, full-service dialysis unit between Corning and Geneseo, SJMH serves on average 72 patients who are treated three times a week.

5. Three Year Plan of Action

SJMH's three-year strategic plan includes the following initiatives that address objectives included in the county-wide Community Health Improvement Plan and Access to Quality Health Care and Chronic Disease.

1. Ambulatory Care Center (**ACC**): SJMH's physical isolation makes it an essential provider of critical health care services in a large geographic area. It also has a mission-based obligation to reach out to its communities to provide needed services, especially to the disadvantaged and underserved.

To **increase access**, SJMH plans to construct an ACC on land contiguous to the long-term care facility (McAuley Manor) by the end of year 2011. When completed, this facility will bring together outpatient services currently located within the hospital and Article 28 outpatient clinics scattered among eight different buildings. This project will contribute to the overall health improvement of the community, facilitate care coordination of numerous health services, and reduce costly hospitalizations and Emergency Department visits by providing better access to primary care services.

The ACC will enhance access to quality health care and existing primary care capacity through:

- Expanding the hours of service by primary care clinics within the ACC;
- Expanding the range of primary care services offered by SJMH;
- Relocating the Express Care service (walk-in clinic) to further transition services from the Emergency Dept.;
- Reducing barriers to primary care in the PSA;
- Improving the overall quality of primary care services and care coordination;
- Implementing a central registration system, Electronic Medical Records (EMR) system; and Picture Archiving and Communications System (PACS) digital radiology system throughout the ACC, tied to the hospital to create a seamless flow of information.

Currently, outpatient services are provided in an inpatient-oriented hospital setting that is not conducive to outpatient services, a challenge for patients. Renovations or expansion is not practical given the land-locked nature of the building, as well as the extensive costs associated with renovations to meet applicable codes.

Creating the ACC offers the best option to improve access to care and to provide services in an accessible, high-quality, contemporary setting. The project also addresses the shift in care from inpatient to an outpatient setting, and will serve as a critical tool in recruiting and retaining high-quality physicians and staff to the community.

The ACC will have significant impact on admission rates in several Prevention Quality Indicators (PQIs). The relocation of Express Care (walk-in clinic) to the ACC with increased hours of operation, convenient parking, and improved access to laboratory and imaging services will be a significant improvement. Co-locating several primary care clinics within the ACC also provides opportunities to increase scheduling efficacy, decrease wait times, and facilitate care coordination of numerous health services. Patients will experience a more convenient delivery of care than the current system and will be much less likely to use the Emergency Department as a point of entry. Additionally, co-locating the Women's Center, Family Medicine/Ob, and Pediatric clinics will allow for increased rates of prenatal care and subsequent decline in low birth weight deliveries.

The ACC business plan specifically addresses the **chronic disease** priority, by facilitating outreach and education programs for at risk populations and coordinating health monitoring services. For Chronic Renal Disease, the ACC affords an opportunity to develop a center of excellence in dialysis services The addition of a

certified Diabetes educator at the ACC to assist primary care providers will also improve the rates of diabetic complications. The ACC will provide increased hours and access with better parking to enable Chronic Obstructive Pulmonary Disease (COPD) patients to make more frequent office visits. The ACC will also facilitate the coordination of a multi-disciplinary team for patients with Congestive Heart Failure (CHF), including education, management and control of symptoms, detailed drug analysis, and enhanced follow up.

2. Person-Centered Care: SJMH has recently embarked on a long-term strategy focused on addressing the "continuum of care." This philosophy embraces an integrated approach of holistic and person-centered care, to provide a continuum of services that is responsive to people's needs and choices throughout their lives – not just when they need acute care. The goal is to optimize each individual's health potential through informed decision-making, effective communication, and process facilitation – resulting in the right care, delivered in the right setting, at the right time. Integral to this concept is integration of care and planning within the entire care team – from physicians and nursing to social workers and discharge planners – to connect patients with information to make informed decisions about providers, services, and programs that support their holistic health and palliative care needs throughout their lives.

Implementing a person-centered care model will require a change in culture as well as significant investments and deployment of resources to achieve:

- Universal access to information (i.e. Electronic Medical Records/EMR)
- An information infrastructure that enables access by an individual to his or her own personal record and by professionals providing his or her care
- Integrated care management that provides each person with a multi-disciplinary care plan and the understanding needed to access community agencies
- Effective management of chronic diseases and help in coping with the aging process
- Expansion of home and community-based services in partnership with community agencies

Dovetailing with SJMH's person-centered care model is a quality of care initiative called **"Advancing Clinical Transformation,"** or ACT. The ACT initiative focuses on identifying and achieving clinical and safety breakthroughs that will benefit patients, as well as achieve financial results to strengthen and to grow our organization.

Integral to success of the person-centered care model and ACT initiatives is recruitment of physicians, nursing staff, and Academy of Certified Social Workers (ACSW) professionals. This challenge is ubiquitous across the service area and the state. SJMH's recent awards from the New York State Department of Health

"Doctors Across New York" program has provided funds specifically for the recruitment of a general surgeon, orthopedic surgeon, gastroenterologist, and psychiatrist. Given the severe shortage of medical professionals in the service area, SJMH is exploring collaborative staffing opportunities with other health care organizations.

Fundamental to the long-term success of the person-centered care model is the evaluation of service lines for financial viability, growth potential, and redundancy. This analysis will result in continued rationalization of services that are not relevant to the core business of health care and the objective of person-centered care.

6. Financial Aid Program

True to SJMH's mission of serving the poor, underserved, and disadvantaged in its rural area, a significant portion of patients can be classified as indigent (as noted below):

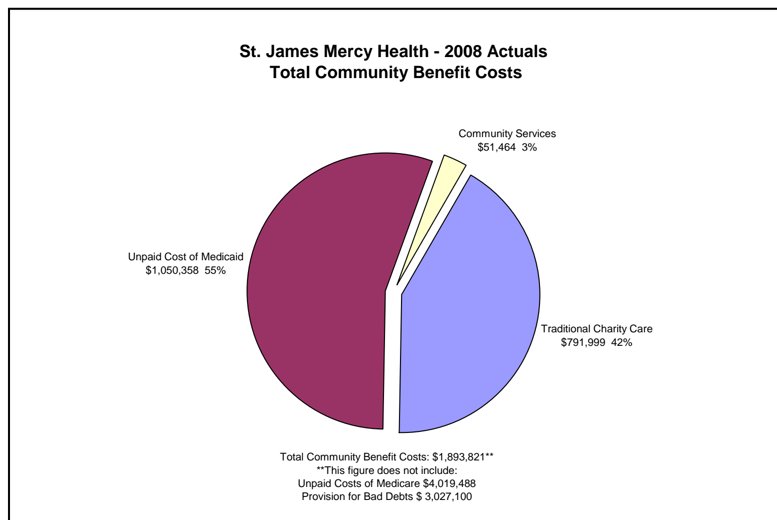
SJMH 2008 Indigent Care Statistics

	Medicaid	Self Pay	Charity Care
Inpatients	50.9%	8.2%	1.1%
Outpatients	7.5%	3.6%	0.5%
Office Visits	22.4%	3.2%	1.9%

The increased proportion of indigent patients in 2009 is attributed to the economic climate and growing unemployment rate. SJMH anticipates that indigent care will continue to grow as a percentage of total care.

A number of financial counseling services at SJMH are now available and/or in development to address the anticipated increase in indigent care:

- Interest-free payment arrangements
- Discounted rates for early payment
- Easy access to NYS medical assistance programs (i.e. NYS Medicaid)
- Outreach services to community-based resources such as food, shelter, and prescriptions, as well as senior, victim and mental health services
- Charity Care assistance for patients not approved for NYS Medicaid
- MedAssist services (new in 2008) to provide free assistance in accessing government programs and to provide assistance with medical bills for qualifying individuals and their families



7. Changes Impacting Community Health/ Provision of Charity Care/Access to Services

The recruitment and retention of professional staff are particularly challenging for a rural environment. The inability to recruit has a direct impact on access to services and limits the scope of community services. Additionally, the economic hardship across the service area has resulted in an increasing number of patients presenting to the Emergency Department for basic health care normally handled in less costly venues. Charity care, bad debt and unreimbursed costs of Medicaid and Medicare increase the financial strain of providing health care to our service area.

8. Dissemination of the Report to the Public

SJMH will disseminate its Community Service Plan in a variety of ways including the hospital's intranet, public website, and e-mail system. Notices of the plan's availability will be placed in local media. Copies of the CSP will be e-mailed to New York State Department of Health, Healthcare Association of NYS, Catholic East, and the SJMH management team. SJMH personnel and medical staff members will be notified that the CSP is posted on the hospital's intranet. A copy of the report will be made available in the public library and made accessible to local community leaders and organizations such as the Mayor of Hornell, Mayor of North Hornell, Hornell Chamber of Commerce/IDA, Hornell Partners for Growth, Catholic Charities (Bath), and the Steuben Rural Health Network.

9. Financial statement

The Institutional Cost Report (ICR) for 2008 has been submitted separately as required.

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