

Community Service Plan

E.J. Noble Hospital

Prepared by:

Charles P. Conole, FACHE

Chief Executive Officer

September 10th, 2009

I. Mission Statement

A. Mission Statement for E.J. Noble Hospital

The core values of the mission statement are based on the principle of meeting the community's primary healthcare needs and the appropriate development of establishing clinical referrals when deemed necessary.

- The clinical programs and services offered by the hospital and related primary care clinics will be driven by and defined by community needs that are determined by the payors of healthcare within the community and other forums such as Business/Industry and Social/Community Service Clubs. This determination will be matched to the hospital resources by the Board of Trustees.
- The hospital will develop relationships through which the community can access healthcare services not available locally.
- The hospital will continuously strive for financial viability while maintaining a commitment for providing charity services within all clinical components of our system of healthcare.
- The hospital will provide a good working environment for its team of employees, physicians and volunteers. This will include a smoke free campus and provisions of health and wellness programs such as smoking cessation and weight watchers programs.

B. Changes to the Mission Statement

The mission statement has been reviewed by the Administrative team, the Medical Staff and the Board of Trustees and no needed changes were identified within the past year. The mission statement remains viable and reflects our current status.

II. Service Area

A. Hospital Service Area:

E.J. Noble Hospital services an encatchment area of approximately 29,000 citizens for southern St. Lawrence, western Lewis, and northern Jefferson counties. The towns served include: Antwerp, Russell, Claire, DeKalb, Depeyster, Hammond, Fine, Fowler, Gouverneur, Hermon, Macomb, Edwards, Oswegatchie, Pitcairn, Clifton, Rossie, and Harrisville.

B. Description of Service area

Our service area is defined by utilizing zip codes from patient's seeking service and matching these zip codes to the most current US census data. We also conduct a geographical analysis for outreach and currently this is defined as approximately a 25 mile radius from the hospital. This large geographical sparsely populated area is primarily a farming community with mining industries, paper industry and steel plants.

III. Public Participation

- A. The participants involved in assessing community health needs included workgroup meetings with: St. Lawrence County Public Health Department, St. Lawrence County Health Initiative, St. Lawrence County Community Services (Mental Health & Drug, Alcohol), and other Hospitals located in the same county, including; Clifton Fine Hospital, Massena Memorial Hospital, Claxton-Hepburn Medical Center and Canton-Potsdam Hospital. This workgroup met on the following dates to review and discuss community needs. May, 21st, July 8th and August 17th, 2009.
- B. On July 27th 2009, Healthcare Providers across the county were invited to discuss the issues that they see as relevant. Invitees included: Rescue Squads, Respiratory Therapists, Nurses, Physicians and Discharge Planners.
- C. In 2008, a county wide health needs assessment survey was completed by the SLC Health Initiative, a nonprofit agency of which E.J. Noble Hospital works closely, including serving on the Board of Trustees. 1,199 residents were queried about their health care needs, including: Access to Care, Ambulance / ER services, Vision Health, Dental Health, Immunizations, High Risk Health, Sun Exposure, Weight Control, Exercise, Milk

E.J. Noble Hospital
Community Service
Comprehensive 3 Year Plan

consumption, Fruits and Vegetables, Vitamins, Tobacco use, Alcohol Consumption, Diabetes, Cardiovascular Health, Stroke, Blood Pressure, Cholesterol, Colorectal Cancer

Screening, Joint, Women's health, Men's health, Sexual activity, Disability, Falls, Lyme Disease/ insect bites, Lead exposure, Rabies and Disaster Preparedness.

- D. We reviewed the Statewide Planning and Research Cooperative data (SPARCS) data for our facility. Our overall business plan was also reviewed.
- E. The Prevention Agenda items were presented to our Community Rotary Club on August 13th 2009. Review of our tentative priority items was conducted and input was received.
- F. An open public forum was held on September 1nd, 2009 to review the Prevention Agenda and receive input from interested citizens. This public forum was advertised in the local community paper, the Tribune Press on August 28th and was posted in local stores and on local electronic bulletin boards. Invitations were sent to local active civic community groups as well.
- G. The Prevention Agenda selection items were also reviewed with the Medical Staff members at our facility on September 9th.

The County Wide workgroups quickly focused on issues faced by our community that correspond to the overall prevention agenda, including the chronic diseases of: Strokes, Congestive Heart Failure, Tobacco Use and Chronic Obstructive Pulmonary Disease. Issues such as attempted suicide rates and Emergency Preparedness were also discussed as key issues to our region.

Discussions addressed issues such as:

- Lack of chronic disease support groups in our area
- Lack of a specific case management program for chronic disease.
- Failure for patients to take needed medications or inappropriately using inhalers
- Discharge planning confusions
- Shortage of patient education materials
- Noncompliance regarding smoking
- Use of the Emergency Department as primary care
- Communication difficulty between patient and physician
- Lack of standardization of patient discharge instructions between the 5 hospitals in the county

IV. Assessment of Public Health Priorities

- A. The criteria evaluated to select priorities included: reviewing New York State's Prevention Agenda toward the Healthiest State, reviewing St. Lawrence County Indicators for Tracking Public Health Priority areas, utilizing data available from the County Health Needs Assessment Study and finally, information obtained from public input. The workgroup identified which collaborative items were already in place and then identified the areas that need further planning and action. Following review of the data available to our workgroups, we identified common issues that the county could tackle as a whole.
- B. Selected Prevention Agenda Priorities: The following Prevention Agenda Priorities have been selected as key to our communities, Chronic Disease and Tobacco Use.
1. Chronic Disease: The consensus is to invest in the following Chronic Diseases: Cerebrovascular Disease (Stroke) mortality and Congestive Obstructive Pulmonary Disease (COPD).

The Prevention Agenda objective for COPD hospitalizations among adults 18 + years (per 10,000) is 31. New York States current status is 39.7. St. Lawrence County's current statistics is 76.1. In addition to this data, we also reviewed our readmission rates per our Statewide Planning and Research Cooperative System (SPARCS) data. Our 15 day readmission rates for COPD are 20% compared to NYS readmission rates of 13.3%. Our 30 day readmission rate is 30% compared to the states rate of 21.1%. Our community is primarily a farming community with significant mining industries.

The Prevention Agenda objective for Cerebrovascular disease mortality per 100,000 is 24. New York State's current status is 30.5. St. Lawrence County's current statistic is 44.3 Up until 2009; little has been done in our communities regarding Stroke education.

2. Tobacco Use:

The Prevention Agenda objective for Lung Cancer Incidence per 100,000 is 62. New York States current status is 90.8. St. Lawrence County rate is 120.1.

Tobacco use is the number one risk factor for Lung Cancer. The results of the 2008 county health assessment indicated that 37.6 percent of our population currently uses tobacco. (30.5 percent of those surveyed indicated that they currently use tobacco everyday with additional 7.1 percent indicating that they use tobacco “some days”.) 52.8 percent of those surveyed has smoked at least 100 cigarettes or 25 cigars or used chewing tobacco 5 times in their lifetime. The tobacco use issue is also closely tied to the COPD priority listed above. Despite these numbers, our County Health Department’s funding was terminated at the end of July 2009. With our county resources dwindling, it was felt to be imperative that the remaining agencies ramp up programming so we do not lose ground on this issue.

C. Status:

The Chronic Disease priority will be a new initiative for our facility. There have been county programs in the past that attempted to assist with the issue of chronic disease, but these programs ended several years ago and no further work was completed. For example, several years ago a patient education task force formed in the county to publish patient education related to Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. These booklets were initially published, with limited printing and the education materials are no longer available.

E.J. Noble Hospital was the first hospital in our county to become completely, “Smoke Free”. The Tobacco use priority will incorporate existing programs that will be supplemented by refocusing attention on the systems that will work best to identifying individual tobacco use, and lead patients on the road to healthier behavior changes such as quitting or environmental issues to be put in place if they are not ready or willing to quit at this time, such as smoking outdoors one hundred percent of the time. We will renew our collaboration with the Cessation Center of Northern New York as we work on this initiative. It is uncertain at this time if the St. Lawrence County Public Health Department will offer leadership on this issue due to the loss of the Tobacco Coalition grant.

D. Priorities considered in Assessment Process:

In addition to the prevention agenda items selected as our focus, we also seriously considered Emergency Preparedness, Access to Quality Health Care and Mental Health.

Emergency Preparedness was strongly considered as a candidate from the Prevention Agenda. It was decided after reviewing the issue that Emergency Preparedness activities already occur on a regular and ongoing basis in our facility and community.

Our hospital participates in regular workgroup sessions with all St. Lawrence County Hospitals, Public Health Department and St. Lawrence County Emergency Services. We are dedicated to continuing this work. Our 2008 county survey indicated that 88.7 percent of those surveyed felt at least somewhat prepared to handle a large scale disaster or emergency, of those 52.8 felt well prepared and 35.9 felt somewhat prepared.

Access to Quality Health Care was also considered as a candidate from the Prevention Agenda. We reviewed data received from our 2008 County Health Survey and found that 90.1 percent of those surveyed indicated that they have health insurance coverage. 88.3 percent indicated that they have a regular doctor. For those without a regular doctor, only 3 percent indicated that there wasn't a doctor close to where they live. Our facility is already very cognizant of the fact that our service area is very rural and that at times traveling is difficult. To help our patients ensure that their health care needs are met, we have established primary care clinics in strategic locations in our encatchment area. We have primary care clinics established in the towns of Harrisville, Antwerp, DeKalb and Edwards, in 2009, our facility was approached by the representatives of the town of Russell NY to discuss the fact that there was no source of medical healthcare available in the town. We were requested to assist with a perceived barrier to care for the citizen of this small rural town. As a response to this need, our facility opened another primary care clinic in Russell in August 2009.

Mental Health was considered as a priority for our community plan as we have limited services available. St. Lawrence County has a hospital that specializes in Mental Health Care. St. Lawrence County also maintains a Mental Health clinic in our town. We also have a social worker on staff that assists patients in our area with access to mental health care as needed. There currently is discussion of a county project to address the suicide rates. Our facility will participate in this project. Mental Health is not a service provided by our hospital at this time due to a scarcity of mental health professionals in our region. We will continue to refer patients in need to the resources previously established in our county.

V. Three Year Plan of Action: Goal: To reduce readmission rates for patients with COPD.

A. Strategies for Chronic Disease priority (COPD):

- a. Past Strategy, reinstated: Working with the Public Health Department to review and update patient education booklets to ensure an adequate supply of current patient education material is available. Publish this education material on the Hospital's internet site.
- b. Revised Strategy: Expand system of discharged patient follow up calls to patient's discharged to home with a chronic disease diagnosis. Implement a system that provides a phone call to the patient within 48 hours after discharge.
- c. New Strategy: Work with the St. Lawrence County Health initiative to train hospital staff members to implement the "Chronic Disease Support Management Program".
- d. New Strategy: Explore the success of chronic disease programs that have been implemented elsewhere in the State or Country. Adopt those programs into our community for support of this chronic disease with ongoing education and transition care.
- e. New Strategy: Formalize our education process related to COPD. Develop a structured process that can be utilized by both inpatients and outpatients.
- f. New Strategy: Revise our QI system to include reviewing for readmission for our COPD patients at 7 days and 31 days to analyze for contributing factors that the hospital or the home care agency may be able to address going forward.
- g. The community service workgroup, consisting of the county hospitals, in addition to the St. Lawrence County Public Health Department, St. Lawrence County Health Initiative and the St. Lawrence County Mental Health Department, have agreed to continue to meet on a Quarterly basis to review progress with our community service plan, including QI data. We will review the number of COPD admissions, readmissions and the root cause

for the readmission. Strategies will be adjusted on an ongoing basis according to the feedback from these workgroup meetings.

- B. Strategies for Chronic Disease priority (Cerebrovascular Disease -Stroke): Goal: To provide every patient presenting with stroke related symptoms a consultation with an expert to reduce mortality / disability rates.
- a. New Strategy in April 2009: Implementation of the Telemedicine Stroke Program in conjunction with SUNY Upstate Medical Center in Syracuse. The hospital reaffirms its commitment to this collaborative effort to bring state of the art stroke care to our community. We will continue to work to perfect the implementation of this program with support from the SUNY Upstate Medical Center.
 - b. SUNY Upstate Medical Center will be consulted via the telemedicine program for every patient presenting to our ED within six hours of symptom onset. In addition, we will also consult with SUNY for any inpatient who develops stroke symptoms while an inpatient.
 - c. New Strategy: Require all Emergency Department Clinicians to maintain current certification with the National Institute of Health Stroke Scale training. Certification will be required to renew on an annual basis. Also, ongoing stroke education will be part of our general clinical education program. Our area Rescue Squad will be invited to participate in all related Stroke education programs.
 - d. New Strategy: Meet with community organizations to provide brief ongoing education programs related to importance of early stroke recognition and treatment. Hold educational meetings open to the public targeting the elderly population.
 - e. New Strategy: Partner with the St. Lawrence County Health Initiative to provide stroke education material at all health screenings conducted.
 - f. Continued strategy: regularly post information related to the "FAST" (face, arm, speech, time) initiative in public areas including waiting rooms and off site clinics.

- g. Continued Strategy: Partner with St. Lawrence County Public Health Department, St. Lawrence County Health Initiative to offer free blood pressure screening in our service area. Public Health will also distribute information on the “FAST” Program at all clinics and screening events.

- h. A Quality Improvement review will be conducted on every patient presenting with Stroke symptoms. The results will be incorporated into the QI reporting process by being reviewed in the Emergency Department meeting and also reviewed at the Medical Staff Committee meetings. This QI currently includes:
 - i. Physician / PA evaluation within 10 minutes of arrival
 - ii. Door to CT Scan initiation within 25 minutes of arrival
 - iii. Door to Reach consult within 30 minutes of arrival
 - iv. Door to CT Scan Interpretation within 45 minutes of arrival
 - v. CT Scan uploaded to Reach without difficulty
 - vi. Door to Lab results within 45 minutes of arrival
 - vii. (2) IV sites established
 - viii. Patient on cardiac monitor
 - ix. Patient started on oxygen
 - x. Suspected Stroke pre-printed orders utilized
 - xi. Inclusion / Exclusion checklist utilized
 - xii. Vital signs done per protocol
 - xiii. Transport arrangements without difficulty
 - xiv. REACH equipment works as expected?
 - xv. Copy of REACH report printed for chart?
 - xvi. If tPA indicated: Door to Drug within 60 minutes
 - xvii. If tPA indicated: consent documented
 - xviii. If tPA indicated: Vitals & Neuro’s documented according to protocol
 - xix. If tPA indicated: Foley catheter placed prior to tPA

- i. The community service workgroup, consisting of the county hospitals, in addition to the St. Lawrence County Public Health Department, St. Lawrence County Health Initiative and the St. Lawrence County Mental Health Department, have agreed to continue to meet on a Quarterly basis to review progress with our community service plan, including QI data.

C. Strategies for Tobacco Use:

- a. Redesign a previously successful intervention: Require all registration clerks to ask all patients if they smoke during the registration process. If the patient identifies themselves as a smoker, the registration clerk will then be required to ask them if they are interested in quitting. If the patient indicates a desire to quit, a referral to smoking cessation will be made to the Respiratory Therapy Department for follow up.
- b. Continue Current strategy: For all inpatients, the nurse taking the history asks about tobacco use. If the patient smokes, the nurse will assess for the five “A’s” (Asking every patient about tobacco use, Advising all smokers to quit, Assessing smokers' willingness to make a quit-attempt, Assisting smokers with treatment and referrals, and Arranging follow-up contacts).
- c. Utilize the “Fax to Quit” program for patients who are interested in quitting.
- d. New Strategy: Practitioners employed at hospital owned clinics will be required to inquire about smoking status at each visit and advise patients to quit. Documentation forms will be put in place that facilitates this process. We will also institute the Fax to Quit Program in all of our clinics.
- e. New Strategy for 2009: Host regular smoking cessation classes at our facility in conjunction with The Tobacco Cessation Center of Northern New York.
- f. Continue Current Strategy: Public Health will refer patients encountered at various outreach programs to the Tobacco Cessation center of Northern NY.
- g. Revised Strategy: A percentage of all inpatient and outpatient records will be reviewed on a quarterly basis to ensure that documentation of smoking status and cessation efforts are occurring.
- h. The community service workgroup, consisting of the county hospitals, in addition to the St. Lawrence County Public Health Department, St. Lawrence County Health Initiative and the St. Lawrence County Mental Health Department, have agreed to continue to meet on a Quarterly basis to review progress with our community service plan, including QI data.

E.J. Noble Hospital
Community Service
Comprehensive 3 Year Plan
VI. Financial Aid Program

E.J. Noble Hospital maintains a Financial Assistance Program which includes “Charity Care” and “Sliding Fee Discounts”. In 2007, our facility held an internal initiative to increase applications for financial assistance for our patients who would be eligible under these programs. In 2007, the facility only received 81 applications for financial assistance. Of these applications, 64 were approved. A new system was put in place that included Patient Registration clerks becoming knowledgeable about the financial services available and providing this information to all patients without health insurance at time of registration. A brochure was developed that explains the program and includes the application for assistance. In addition the process included the Patient Advocate and the Social worker following up with these individuals to help them gather the documents required to qualify. In 2008, 146 applications were filed for assistance and 79 were approved. The new process led to a 45% increase in applications received for financial assistance.

In addition to our internal financial assistance programs, we also partner with county agencies to provide services for those uninsured or underinsured patients in our service area. In particular, we partner with the St. Lawrence County Health Living (Cancer Screening Program) Program to provide mammograms, breast exams, pap smears, colonoscopy and follow up services to patients enrolled in this program. As part of this agreement, we accept reduced payments for services or write off the balance after initial insurance payment. In a similar program, we also partner with the St. Lawrence County Health Initiative to offer services at reduced rates for the uninsured or underinsured.

Our facility’s financial assistance program is currently grappling with the challenge of providing services to an increase of Amish residents. Our encatchment area’s Amish population is greatly increasing and respectively, more Amish residents are seeking care in hospital run clinics or the emergency department. Our GYN clinic reports a one-hundred percent increase in the number Amish women seeking care, estimating that they have provided services to 15-20 Amish women so far this calendar year. We have also had eleven Amish inpatients so far this year. These residents do not have health insurance, and because of their religious beliefs, will not apply for any type of government assistance. They do not have the routine documentation of proof of income required by our Charity Care and Sliding Fee programs. Currently we are dealing with each case individually, but if current trends continue, we will need to establish a financial assistance program specific to this population.

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

- A. Potential Impacts: There haven't been any significant changes to the hospital's operation or financial situation that would impact the care of the community, financial assistance and/or access to health care. One external factor that may impact the financial assistance programs available to the patients in our area is the potential for decreased State funding for the Healthy Living Partnership Program. If funding for this program is decreased, less patients would be eligible for services in our county.

VIII. Dissemination of this Report to the Public

- A. A written summary of our Community Service Plan will be released to the public via our local newspaper. The CSP will also be posted to our facility web page at www.ejnoble.org. The information will include key financial data.

- IX. Financial statement: Financial data was reported to the Department through the Institutional cost Report (ICR).