Carthage Area Hospital, Inc.

Community Service Plan 2014-2016

1. Mission: Carthage Area Hospital provides quality comprehensive healthcare services in a community setting.

2. Service Area: Located in Northern New York**,** Carthage Area Hospital was founded as a 501(c) (3) federal tax exempt and not-for-profit organization in 1965. It is federally designated as a Sole Community Provider serving a population of approximately 85,000 residents who live in its primary and secondary tri-county service area. The facility is unique in the fact that it is located only seven miles from the Fort Drum military installation. Fort Drum is one of the only Army installations within the United States that does not have a full service hospital within its confines. The Guthrie Clinic, located on Fort Drum, provides Outpatient services only. Therefore military families are dependent upon local practitioners and facilities for their medical care such as Carthage Area Hospital's facilities, Behavioral Health Center, Dental Center and outreach clinics. Over the past 10 years the Hospital's service area has continued to expand as a result of strategic initiatives to collaborate with outlying villages, hamlets and school districts to enhance local and needed healthcare access for the medically underserved and underinsured populations. Patients accessing the majority of services are originating from the communities of Carthage, Watertown, Black River, Fort Drum, Evans Mills and Harrisville residents as determined by their zip codes. Carthage Area Hospital currently has 78 licensed beds including a 30 bed Skilled Nursing Unit. Carthage Area Hospital's service area encompasses specific geographic pockets of low income populations which are federally designated as primary care Health Professional Shortage Areas that also include dental and mental health designations.

- Per capita income is $21,310 vs. $31,796 (NYS)[1]
- 14.1% of the families are living below poverty level vs. 11.0% (NYS)[2]
- 24.2% of the children are living below poverty level vs. 20.3% [3]
- Single-parent households 35.6% vs. 19.5% (NYS)[4]
- People 65+ living alone vs.10.4% (NYS)[5]
- 79.6% of the service area residents drive to work alone vs. 54.1% (NYS)[6]
- 10.9% of households do not have a vehicle vs. 5.7% (NYS)[7]

Realizing the changing focus of healthcare to promote outpatient services as compared to inpatient services, over the past 10 years CAH has developed a network of primary and specialty care clinics including school based health centers to meet the demands of our underserved community.

[1] Census Bureau 2007-2011
[2] Census Bureau 2007-2011
[3] Census Bureau 2007-2011
[4] Census Bureau 2007-2011
[5] Census Bureau 2007-2011
[6] Census Bureau 2007-2011
[7] Census Bureau 2007-2011

The following tables[8] highlight health indicators for the tri-county area which are also benchmarked with the NYS Prevention Agenda. Carthage Area Hospital's service area comprises portions of this tri-county area thus reinforces our identified areas requiring intervention. The three Prevention Agenda priorities, which Carthage Area Hospital has addressed, take into consideration the notable poverty levels among the communities served. This ongoing disparity of poverty becomes a barrier to medical and oral health services regionally as discussed on page 10 of the attached Regional Community Health Improvement Plan 2013-2017.

Indicators	Jefferson	Lewis	St. Lawrence	NY State	Objective	Data Years	Source
Prevent Chronic Diseases							
Adult obesity (BMI > 30)	31.6%	29.0%	32.0%	23.2%	**23.2%**	2008-2009	BRFSS
Pregnant women in WIC who were pre-pregnancy obese	28.0%	31.6%	27.1%	23.4%		2008-2010	NYSDOH
Child & adolescent obesity (BMI > 95th percentile)	19.2%	18.7%	24.4%	17.6%	**16.7%**	2010-2012	NHANES
Adults with diagnosed diabetes	10.7%	10.4%	10.8%	9.0%		2008-2009	eBRFSS
Pregnant women in WIC with gestational diabetes	6.5%	6.6%	6.7%	5.5%		2008-2010	NYSDOH
Adult smokers	28%	20%	27%	18%	**15%**	2011	BRFSS
Lung and bronchus cancer mortality rate (per 100,000)	53.9	45.0	66.0	42.8		2007-2009	NYSDOH
Colorectal cancer screening (adults 50-75 years)	61.1%	55.6%	64.1%	66.3%	**71.4%**	2008-2009	BRFSS
Colon and rectum cancer mortality rate (per 100,000)	19.2	18.1	19.1	15.7		2007-2009	NYSDOH
Heart attack hospitalizations (per 10,000)	21.5	17.4	18.7	15.5	**14.0**	2010	SPARCS
Indicators	**Jefferson**	**Lewis**	**St. Lawrence**	**NY State**	**Objective**	**Data Years**	**Source**
Promote Healthy Women, Infants and Children							
Federally insured children with recommended level of care	53.4%	45.8%	48.4%	69.9%	**76.9%**	2011	NYSDOH
Children ages 3-6 years	74.2%	68.5%	71.2%	82.8%	**91.3%**	2011	NYSDOH
Children ages 12-21 years	45.9%	35.8%	41.6%	61.0%	**67.1%**	2011	NYSDOH
Third-grade children with untreated tooth decay	29.5%	51.4%	39.5%	24.0%	**21.6%**	2009-2011	NYSDOH
Children (ages 19-35 months) with complete immunizations	45.5%	70.7%	61.7%	47.6%	**80.0%**	2011	NYSDOH
Elevated blood lead level rate (per 1,000 children < 6 years)	5.6	8.1	7.2	5.3		2008-2010	NYSDOH
Promote Mental Health and Prevent Substance Abuse							
Indicators	**Jefferson**	**Lewis**	**St. Lawrence**	**NY State**	**Objective**	**Data Years**	**Source**
Adult binge drinking	18.9%	22.7%	21.8%	18.1%	**18.4%**	2008-2009	BRFSS
Self-inflicted injury hospitalization rate (per 10,000)	9.0	6.0	10.6	5.1		2008-2010	SPARCS
Suicide death rate (per 10,000)	11.0	16.0	12.0	6.8	**5.9**	2008-2010	NYSDOH

[8] North Country Health Compass Partners-Regional Community Health Improvement Plan 2013-2017

3. Public Participation

Per the attached Regional Community Health Improvement Plan 2013-2017, on pages 4-6, all public participants involved with regards to assessing community health needs and their roles have been identified. Outcomes from the public participation process including any barriers or gaps were also identified.

4. Assessment /Selection of Public Priorities

Per the attached Regional Community Health Improvement Plan 2013-2017, page 10, the selection rational of particular regional priorities are discussed and support those interventions which Carthage Area Hospital has selected.

5. Three Year Plan of Action -Carthage Area Hospital's Prevention Agenda Priorities

Service Area Health Indicators and NYS Benchmarks

	CAH	NYS Benchmark	Data Period	Data Source[9]	Units
ER rate due to diabetes	21.9	18.6	2009-2011	3	Annual ER visits /100,000 pop. 18+ yrs.
Hospitalization rate due to uncontrolled diabetes	2.3	1.7	2009-2011	3	Annual hospitalizations / 10,000 pop. 18+
ER rate due to heart failure	6.7	4.4	2009-2011	3	Annual ER visits /10,000 pop. 18 + yrs.
ER rate due to bacterial pneumonia	31.0	18.4	2009-2011	3	Annual visits/10,000 pop. 18+ yrs.
ER rate due to preventable pneumonia & influenza	16.0	7.9	2009-2011	3	Annual visits/10,000 pop. 18+ yrs.
ER rate due to UTIs	174.3	69.4	2009-2011	3	Annual visits/10,000 pop. 18+ yrs.
ER rate due to COPD	47.9	19.1	2009-2011	3	Annual visits/10,000 pop. 18+ yrs.
Hospitalization rate due to COPD	43.0	27.6	209-2011	3	Annual visits/10,000 pop. 18+ yrs.
ER rate due to adult asthma	44.2	41.0	2009-2011	3	Annual visits/10,000 pop. 18+ yrs.
Hospitalization rate due to pediatric asthma	13.9	11.9	2009-2011	3	Annual visits/10,000 pop. 18 yrs. & under

[9] SPARCS

Priority # 1 Prevent Chronic Diseases

Objective: Increase access to and promote preventive care

Goals:

- Maintain Level 2 NCQA Patient Centered Medical Homes. Quality and safety are hallmarks of the medical home. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services and end of life care via ***Patient Tracking and Registry Functions.***

  Time frame: CAH will seek level 3 certifications during 2014-2016

- Implement an ER case manager position to track ER patient visits and mentor appropriate action to reduce unnecessary ER visits and readmissions. Encourage patients to become established in a Medical Home (both oral health and medical) via follow up appointments in order to increase screenings and promote chronic disease management.

  Time frame: CAH will utilize Vital Access Participation grant funds, as available, to implement ER case manager position beginning 2014 to reduce ER visits and readmissions by 5%.

- Maintain and expand enrollments in school based health programs to reduce ER visits for preventable and chronic diseases-no out- of- pocket expenses for clinical services & vaccines.

  Time frame: CAH will seek to increase enrollments by 5% based on continued support from NYS DOH's grant funding. 2014 ongoing.

Evidence of reducing ER visits and increasing preventative care visits will be annually evaluated utilizing SPARCS data as identified in the table on previous page. All of these goals seek to address the needs of our underserved populations while referencing the NYS Prevention Agenda Benchmarks.

Priority # 2 Promote Health Women, Infants & Children

Objective: Improve child health

Goals:

- Maintain Level 2 NCQA Patient Centered Medical Homes. Quality and safety are hallmarks of the medical home. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services and end of life care via ***Patient Tracking and Registry Functions.***

Time frame: CAH will seek Level 3 certifications during 2014-2016

- Maintain and expand enrollments in school based health programs to reduce preventable illnesses and address chronic diseases-no out- of- pocket expenses for clinical services & vaccines

  Time frame: CAH will seek to increase enrollments by 5% based on continued support from NYS DOH's grant funding. 2014-ongoing

- Maintain and promote utilization of school based dental sealant programs to reduce dental caries -no-out-of pocket expenses for dental screening and sealants.

  Time frame: CAH will seek to increase enrollments by 5% based on continued support from NYS DOH's grant funding. 2014-ongoing

- Maintain and promote utilization of school based consults with CAH registered dietitians to reduce childhood obesity rates and improve child health.

  Time frame: 2014 ongoing

- Maintain school based consults with mental health employees to address pediatric mental health issues.

  Time frame: CAH will seek to increase enrollments by 5% -2014 ongoing

- Increase behavioral health program capacity to meet the needs of the local community and those of Fort Drum.

  Time frame: CAH will seek to increase capacity -2014 ongoing

- Maintain prenatal and pediatric oral health referrals to CAH's Dental Center to reduce dental caries.

  Time frame: Increase appointments actually kept (vs. no shows) by 5% - 2014 ongoing

Evidence of improved child health and preventative care visits will be annually evaluated utilizing SPARCS and NYS DOH Oral Health data as identified in this document on page 3. All of these goals seek to address the needs of our underserved populations.

Priority # 3 Promote Mental Health and prevent Substance Abuse

Objective: Strengthen infrastructure across systems

Goals:

- Maintain school based consults with mental health employees to address pediatric mental health issues.

  Time frame: CAH will seek to increase enrollments by 5% -2014 ongoing.

- Increase behavioral health program capacity to meet the needs of the local community and those of Fort Drum.

  Time frame: CAH will seek to increase capacity by 5% -2014

- Implement CAH's Behavioral Health Center "Walk-In" services to improve response times for emergent needs.

  Time frame: 2014 ongoing

Evidence of reduced mental health and substance abuse incidents will be annually evaluated per NYS DOH data as identified in the table above. All of these goals seek to address the needs of our underserved populations.

6. Dissemination of Plan

Utilizing Carthage Area Hospital's and the North Country Health Compass Partners web sites, CAH's Community Services Plan will be made available to the general public. Stakeholder engagement of the regional partners is referenced on page 20 per the attached Regional Community Health Improvement Plan 2013-2017.

7. Description of process to maintain engagement

The attached Regional Community Health Improvement Plan 2013-2017 discusses the ongoing evaluation methods by which to maintain engagement of the North Country Health Compass Partners, track progress and redirect resources to improve impacts while maintaining quality comprehensive healthcare services to our patients here at Carthage Area Hospital.