NYC HEALTH+ HOSPITALS | Carter

2016

IMPLEMENTATION STRATEGY

IMPLEMENTATION STRATEGY, 2016 UPDATE

Purpose of the Community Health Needs Assessment and Implementation Strategy

The Affordable Care Act ("ACA") requires that any tax-exempt, Internal Revenue Service-designated 501(c) (3) hospital complete or update a publicly-available, comprehensive Community Health Needs Assessment ("CHNA") every three years to document its understanding of the unique characteristics and needs of the local communities it serves. In a companion document known as the "Implementation Strategy," each facility is also required subsequently to list and describe the clinical services and programs available to meet the health needs identified in the CHNA.

Community Served

NYC Health + Hospitals serve all New Yorkers in every neighborhood in New York City regardless of their ability to pay. Addressing disparity throughout New York City, NYC Health + Hospitals is *the* safety-net for the uninsured and underserved in New York City.

The NYC Health + Hospitals / Henry J. Carter County and its extension sites provide the full spectrum of preventive, ambulatory, and inpatient care for children and adults. The NYC Health + Hospitals / Henry J. Carter is a member of NYC Health + Hospitals, the largest municipal health care organization in the country and New York City's public safety net health care system. NYC Health + Hospitals is an integrated health care delivery system of 11 acute care hospitals, one long term acute care hospital, five nursing homes, and 74 community health centers (including school-based and mobile health sites). NYC Health + Hospitals also provides home care services and operates MetroPlus Health Plan, a wholly owned subsidiary that offers low- or no-cost health care insurance to the nearly 500,000 New Yorkers enrolled in its Medicaid, Medicare, and New York State Health Plan Marketplace managed care plans.

As a share of its total volume, NYC Health + Hospitals provides three times greater share of ambulatory care to the uninsured than other New York City hospitals (27% and 8%, respectively) and twice as many ED visits (29% and 13%, respectively). Medicaid and uninsured patients together account for nearly twice as many hospital stays compared to other New York City hospitals (66% and 37%, respectively).

The NYC Health + Hospitals / Henry J. Carter is a Joint Commission-accredited 201 bed long term acute care hospital (LTACH) with an adjoining 164 bed nursing home.[1]

[1] A "long term acute care hospital" (LTACH) is a federal designation for facilities that anticipate the length of a patient hospitalization to last more than 25 days due to the complexity of care required. These facilities provide specialized acute care for these patients, offering a level of staffing, specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour/7-day-

Serving the Greater New York metropolitan area, Carter is designed, equipped and staffed to provide specialized clinical support for high acuity, medically fragile patients on a 24-hour basis.

NYC Health + Hospitals / Henry J. Carter LTACH offers high quality care to patients with complex medical needs. Our areas of excellence include ventilator care, post-surgical and wound care, and the management of complications from common chronic illnesses. Our patients receive comprehensive assessments and treatment planning from an interdisciplinary team including Medicine, Nursing, Rehabilitation Medicine, Pulmonary Services, Respiratory Therapy, Pharmacy, Diagnostic Radiology, Pathology/Laboratory, Psychiatry, Dentistry, Clinical Dieticians, Social Work and sub-specialty consultative services staff. The hospital also maintains specialty units for the care of ventilator-dependent patients with monitored beds used for ventilator-weaning purposes and other medical needs.

NYC Health + Hospitals / Henry J. Carter is affiliated with the New York University School of Medicine, which provides primary and consultative sub-specialty clinical services to Carter patients. In addition, the Facility maintains nursing education programs and allied health profession training programs through this affiliation.

Required Components of the CHNA

1) Definition of community served
2) A prioritized description of the significant health needs of the community
3) Transparency in the process and methods used to conduct the CHNA, including how it took into account input from the community served and prioritized community health needs
4) A description of the resources potentially available to address the identified significant prioritized community health needs
5) An evaluation of the impact of actions taken to address the significant health needs identified in the previous CHNA report (June 2013).

The 2016 CHNA reports were adopted by the New York City Health + Hospitals Board of Directors in June 2016.

Requirements of the Implementation Strategy

a-week basis. LTACHs care for patients with serious respiratory conditions, including those who are ventilator-dependent, and this level of care is not generally available or appropriate in short term acute care settings. Many LTACH patients are admitted directly from acute care hospitals' Intensive Care Units.

Admission to a LTACH is required when there is a documented history of past treatment failures and exacerbation of acute symptoms in other settings, and a pattern of readmissions to a short term, acute care hospital.

The U.S. Department of the Treasury and the IRS requires a hospital organization to specifically address each of the community health needs identified in the CHNA, and describe the strategies that will be used to address these priority needs. This may entail providing a list of programs and/or clinical services (new or continuing) available to address each need. If the hospital facility does not intend to meet the needs identified in the CHNA, it is required to explain explicitly why it does not intend to meet such health need.

Process and Methods for Conducting the CHNA

A work group composed of representatives from the planning offices from all hospitals in the NYC Health + Hospitals system and Central Office was formed to coordinate and conduct the CHNA. To identify community health needs, the work group reviewed documentation from City, State and Federal public health resources, including but not limited to Take Care New York 2020, New York State Prevention Agenda 2013-2018 and Healthy People 2020, as well as previous need assessments conducted for the hospital system. From this review, an initial list of over 40 potential community health needs were identified. To refine the list, the work group solicited input from other facility representatives, resulting in the 13 community health needs below (note: this is not in priority order):

- Heart disease, high cholesterol, stroke
- Cancer
- Diabetes
- Asthma and other breathing issues
- Hypertension/ high blood pressure
- Violence
- Mental illness and psychiatric disorders
- Dementia including Alzheimer's
- Obesity
- Premature births, low birth weight
- HIV, Hepatitis, STDs
- Alcohol and/or drug use
- Smoking

Community and Facility Input

Community Advisory Board ("CAB")

The process used to conduct the 2016 CHNA was presented to each CAB individually. A survey was administered anonymously and confidentially to each CAB member

asking them to indicate the relative importance of each of the 13 identified community health needs in their community. In an open discussion, CAB members were also asked about community health needs not included in the survey question. These responses were coded for inclusion in the prioritization matrix (see detailed explanation below).

Facility Users

NYC Health + Hospitals engaged approximately 150 adult facility users from each hospital throughout the main facilities and within community-based clinic sites to complete an anonymous and confidential survey. Survey questions included demographics, health insurance status, language preferences, health concerns, primary and preventive health care utilization, barriers in obtaining ambulatory care and reasons for use of emergency care. Respondents were asked to indicate the relative importance of each of the 13 identified community health needs in their community. These responses were coded for inclusion in the prioritization matrix.

Facility Leadership

Hospital leadership were engaged to indicate the relative importance of each of the 13 identified community health needs in their service area; and their responses were included in the prioritization matrix. Leadership was also invited to comment on the final ranking of health needs, and assisted in the identification of facility programs to address these concerns.

Secondary Data

To measure the prevalence of chronic conditions and health concerns, data were extracted from several publically available datasets, including the New York City's Department of Health and Mental Hygiene's Take Care New York 2020, New York State Department of Health's Prevention Agenda 2013-2018, federal agencies, Centers for Disease Control and Prevention and Healthy People 2020. (For a full list of sources, please see the 2016 CHNA.)

Prioritization of Community Health Needs

For the 2016 CHNA, hospitals were required to identify community health needs and to rank them in order of priority. Hospitals developed their facility-specific community health needs prioritization by ranking the community needs as determined by CAB members, facility users, hospital leaders, and the prevalence of the conditions within their respective communities – independently - to create an overall blended rank score of each community health need.

Facility users, CAB members, and hospital leaders completed a survey which asked them to rate each of the 13 community health needs using the criteria: “Very Serious” = 3; “Somewhat Serious” = 2; “Not Serious” = 1. The option, “Don’t Know/Not Applicable” was also provided to respondents, but excluded for the scoring.

Condition prevalence within the hospital service area was considered in prioritizing the community health needs. A ‘z’ score, which represents the distance/variance between the raw score (service area average) and the population mean (citywide average) in units of the standard deviation, was calculated for each condition prevalence. A positive number suggests that the service area experiences a higher prevalence of the condition than the rest of the city, while a negative number suggest a lower prevalence in the area relative to other NYC neighborhoods.

Each of the community health needs were assigned a rank from 1 to 13 by each of the three groups –CAB members, facility users, and hospital leaders – based on their survey results. Community health needs were also assigned a rank from 1 to 13 based on their prevalence, using ‘z’ scores. Finally, scores from each of the four categories were added together and health issues were ranked based on their overall score.

Community health needs that were considered significant were ranked among the top five of identified needs. The final list, including the identified significant community health needs, were reviewed by hospital leadership.

NYC Health + Hospitals Comprehensive Response to Community Health Needs

NYC Health + Hospitals has developed numerous initiatives to address community health needs and to support and improve patient and population health, with additional programs to be launched soon. Programs include local, or facility-specific, innovations as well as system-wide projects undertaken as part of the New York City Delivery System Reform Incentive Payment Program (DSRIP).

DSRIP is a five-year program to foster and reward comprehensive Medicaid reform efforts. It provides incentives to create a collaboration among Medicaid providers and community groups that successfully improves patient and population health. In DSRIP, the collaboration with other partners is referred to as a Performing Provider System (PPS). It demonstrates its success and earns revenue by completing a set of state-guided health improvement projects and meeting specific outcome milestones.

OneCity Health is the NYC Health + Hospitals /led PPS which includes the NYC Health + Hospitals system's integrated network of 11 hospitals, 5 nursing homes, dozens of

community based health centers, NYC Health + Hospitals/Home Care, NYC Health + Hospitals' health insurance plan, MetroPlus, and more than 400 community partners across the region. Focused on identifying and engaging patients in care before they become sick, OneCity Health is undertaking 11 initiatives, or projects, to become an integrated delivery system of health and social service providers that closes critical gaps in the continuum of care and reduces avoidable hospital use by 25 percent by 2020.

The Implementation Strategy below highlights The NYC Health + Hospitals / Henry J. Carter's facility-specific initiatives that will address the "significant," or top 5, community health needs identified through the CHNA process.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
(1) Hypertension/ High Blood Pressure; (2) Diabetes; (3) Heart Disease, High Cholesterol, Stroke	Effectively Managing Comorbidities to Prevent Readmissions	To prevent stroke, myocardial infarction and decrease the development of complications related to diabetes during stay and post-discharge	Affected LTACH patients	(1) Monitor blood pressure, A1C and lipid levels; (2) Manage condition during hospital stay; (3) Interdisciplinary team to educate patient/family prior to discharge; (4) Social Work to schedule all medical appointments in community before patient is discharged	(1) % of non-diabetic patients with hypertension with latest BP <140/90 in past 12 months; (2) % of non-diabetic patients w/dx of ischemic vascular disease (IVD) and LDL <100 in past 12 months; (3) % of diabetic patients with latest A1c<8 in past 12; (4) % of diabetic patients with latest BP <140/90 in past 12 months; (5) % of diabetic patients w/latest LDL <100 in past 12 months; (6) Readmission to Acute within 30-days post-discharge from LTACH to lower level of care

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Navigating through levels of care: Connecting patients with appropriate care post-discharge to prevent readmissions	To identify and ensure at-risk patients are connected to coordinated services in community when discharged	At-Risk LTACH patients	(1) Ensure at-risk patients are medically stable when discharged; (2) Ensure that appropriate at-risk patients are referred to a Health Home for case management in the community; (3) Ensure home care services are secured before discharge for patients needing this service; (4) Monitor readmission to acute facilities within 30-days post-discharge	(1)% of appropriate patients that were referred to a Health Home before discharge; (2) % of appropriate patients that were referred to Home Care before discharge
Obesity	Weight reduction in non-cardiovascular or renal disease LTACH patients	Address the unhealthful physical and social environment that contributes to obesity and create supportive strategic solutions to help patients improve their health.	LTACH patients with a BMI of ≥30 not related to cardiovascular or renal disease.	(1) Dietitian will assess nutritional status of affected population; (2) Interdisciplinary team will develop a comprehensive care plan to address the problem of obesity. Interventions will include meal planning, education and counseling; (3) Patient menu will be individualized to optimize adherence to therapeutic diet; (4) Upon patient discharge to community, patients will be referred as necessary to outpatient nutrition counseling and/or community-based resources	Goal : Achieve a 5-10% weight reduction in non-cardiovascular or renal disease LTACH patients with a BMI ≥ 30 Key Metrics: (1) % of obesity patients with care plan in place; (2) % of patient adherence to care plan; (3) Patient weight loss/BMI monthly; (4) % of obesity patients appropriately referred to community-based programs or services when discharged

Note: Dementia care was identified by the community as a community health need. Henry J. Carter uses total patient community partnered care, with a strong family and community care engagement process. Henry J. Carter consists of a long term acute care hospital (LTAC) and a skilled nursing facility (SNF). Projects specific to Dementia care are managed by the SNF, which are not included in this I.S. document.