CAROLINAS SPECIALTY HOSPITAL

Community Health Needs Assessment 2013 - 2015

CAROLINAS
SPECIALTY HOSPITAL

Dear Community Resident:

It is indeed our pleasure to share with you the **2013-2015 Carolinas Specialty Hospital (CSH) Community Health Needs Assessment**. On behalf of the CSH Board of Directors, our Medical Staff and the more than 160 employees, we hope you will find this information educational and useful as we participate in the overall planning of the health care needs of our community.

As you look through this report, much of the information was gathered through the resources provided by the Mecklenburg County Health Department. The information provided by the Health Department was vitally important to us as we reviewed the information and designed our Community Health Needs Assessment. And quite frankly, we couldn't have done it without their information. There are other key players in the development of the information we used to design our Assessment: Novant Health and Carolinas Healthcare System also provided various forms of information and data to allow us to design our Assessment.

We may be a small provider in the hospital and healthcare landscape but our role is a very important one. Every hospital in our service area has consulted, referred and transferred at least one (and many have sent hundreds) to CSH. We take our role in the Post-Acute Care environment extremely seriously and continue to evaluate how we can better serve our community.

Please continue to support our efforts by participating in our focus groups, community seminars and other educational offerings. We believe our patients and our community are a vitally important part of who we are and what we are trying to accomplish. With your continued support we will continue to improve and grow.

Daniel C. Dunmyer, BA, MHA
CEO Carolinas Specialty Hospital

Curtis Copenhaver
Chairman, Governing Board of Directors

I. Introduction

Carolinas Specialty Hospital, a nonprofit 501 (C) (3) has conducted a community health needs assessment in 2013 to identify the most pressing needs in our community. The assessment is designed to identify the health needs of the Carolinas Specialty Hospital service area and specifically for patients, who, in the past, have required our specialized services.

a. Organization Overview

Carolinas Specialty Hospital (CSH) was first formed in 2002 and received our license and Medicare certification in January, 2003. We are licensed as a Long Term Acute Care Hospital (LTAC) and serve a specialized population. Our population is generally those patients who are on a ventilator, considered medically complex, have significant wounds or have intravenous needs for particular antibiotics (often times it is a combination of these stated conditions). These patients will generally be admitted from a Short Term Acute Care Hospital (STAC) after having had a significant length of stay and requiring more intense care than can be received in other post-acute care settings. Although we serve hospitals and patients from many states, the primary service area for our patients is in Mecklenburg and surrounding counties.

CSH employs more than 160 talented staff and has a medical staff consisting of well over 100 primary and specialty physicians and mid-level practitioners. We work together every day to achieve our Mission, Vision and Values:

Mission:

Carolinas Specialty Hospital was founded as a nonprofit hospital to provide exceptional healthcare with dedication and compassion to medically complex, extended stay patients.

Vision:

Carolinas Specialty Hospital's vision is to be the premier provider of Long Term Acute Care in our region with measurable outcomes in a cost effective manner.

Values:

- An atmosphere for patients that fosters dignity
- A healthcare culture that promotes discussion and sharing ideas working toward best practices
- An employee environment that nurtures achievement, growth, and personal satisfaction.

We are a 40 bed hospital which started on the 7th floor of CMC Mercy and on September 11, 2013 moved to our new location in South Charlotte at 10648 Park Road, Charlotte, North Carolina, 28210. The new hospital is a joint venture between Carolinas Specialty Hospital and Carolinas Healthcare System. It houses forty private rooms for Carolinas Specialty Hospital as well as 29 private, inpatient rooms for Pineville Inpatient Rehabilitation Hospital. The two independently owned and operated hospitals have joined together to forge the future of Post-Acute Care (PAC) services. The two hospitals share the radiology, pharmacy, environmental services, plant operations and nutritional services, thus improving the efficiencies throughout the hospital.

The new Carolinas Specialty Hospital allows for improved privacy for our patients, larger rooms to accommodate today's technology and a comfortable setting with outstanding panoramic views of the surrounding community.

b. Our Community

We are a nonprofit 501 (C) (3) hospital committed to health and well-being of our community. Our patients are primarily made up of the 65 years of age and above age cohort. Although we serve many patients between the ages of 30 and 64, the majority of our patients (and thus our focus) is primarily on the Medicare age group. We offer a tremendous variety of services to this and all of the age groups we serve. Many of these services have evolved through constant assessment of our performance from our patients and their families.

Primary and Secondary Service Areas

As mentioned previously, we serve primarily those patients who are from Mecklenburg and the surrounding counties or those who have family support from members living in these counties. Given our specialized services we reach out to all of the North and South Carolina communities as well as southern Virginia and Southern West Virginia. Our primary service area (Cabarrus, NC, Gaston, NC, Mecklenburg, NC, Union, NC and York, SC - 2010 Census) serves 1,731,090 residents of which, 173,584, are greater than 65 years of age. Our secondary service area

(Chester, SC, Cleveland, NC, Iredell, NC, Lancaster, SC, Lincoln, NC, Rowan, NC and Stanly, NC - 2010 Census) serves 644,585 residents of which, 91,555, are greater than 65 years of age.

Growth in both the primary and secondary markets is expected to be in the 15% range with the over 65 cohort increasing 11% in the primary market and 17% in the secondary market.

Please refer to our list of communities, as defined by the zip codes that represent our patients.

CHARLOTTE-CONCORD COMBINED STATISTICAL AREA: COUNTY POPULATION CENSUS 2000-2010, AND PROJECTED 2017

CAROLINAS SPECIALTY HOSPITAL (CSH)	2000 CENSUS			2010 CENSUS			PROJECTED 2017			SOURCE	CHANGE 2010 - 2017			
	TOTAL	65+	%65+	TOTAL	65+	%65+	TOTAL	65+	%65+		TOTAL	RATE	65+	RATE
PRIMARY SERVICE AREA														
CABARRUS NC	131,063	15,164	11.6%	178,011	20,085	11.3%	206,506	25,219	12.2%	(1)	28,495	16.0%	5,134	25.6%
GASTON NC	190,365	23,985	12.6%	206,086	27,294	13.2%	220,268	33,162	15.1%	(1)	14,182	6.9%	5,868	21.5%
MECKLENBURG NC	695,454	59,724	8.6%	919,628	81,113	8.8%	1,066,968	106,540	10.0%	(1)	147,340	16.0%	25,427	31.3%
UNION NC	123,677	11,148	9.0%	201,292	19,466	9.7%	243,738	25,940	10.6%	(1)	42,446	21.1%	6,474	33.3%
YORK SC	164,614	17,072	10.4%	226,073	25,626	11.3%	267,434	36,547	13.7%	(1)	41,361	18.3%	10,921	42.6%
SUBTOTAL	1,305,173	127,093	9.7%	1,731,090	173,584	10.0%	2,004,914	227,408	11.3%		273,824	15.8%	53,824	31.0%
PCT of CSA TOTAL	70%	63%		73%	65%		75%	67%			91%		71%	
SECONDARY SERVICE AREA														
CHESTER SC	34,068	4,317	12.7%	33,140	4,835	14.6%	33,693	5,790	17.2%	(3)	553	1.7%	955	19.8%
* CLEVELAND NC	96,287	12,965	13.5%	98,078	14,677	15.0%	96,023	17,461	18.2%	(2)	(2,055)	-2.1%	2,784	19.0%
IREDELL NC	122,660	15,150	12.4%	159,437	20,445	12.8%	172,272	26,565	15.4%	(2)	12,835	8.1%	6,120	29.9%
LANCASTER SC	61,351	7,413	12.1%	76,652	11,737	15.3%	89,070	16,077	18.0%	(3)	12,418	16.2%	4,340	37.0%
LINCOLN NC	63,780	7,350	11.5%	78,265	10,361	13.2%	81,087	13,883	17.1%	(2)	2,822	3.6%	3,522	34.0%
ROWAN NC	130,340	18,205	14.0%	138,428	19,993	14.4%	138,288	23,306	16.9%	(2)	(140)	-0.1%	3,313	16.6%
* STANLY NC	58,100	8,265	14.2%	60,585	9,507	15.7%	59,962	10,989	18.3%	(2)	(623)	-1.0%	1,482	15.6%
SUBTOTAL	566,586	73,665	13.0%	644,585	91,555	14.2%	670,395	114,071	17.0%		25,810	4.0%	22,516	24.6%
PCT of CSA TOTAL	30%	37%		27%	35%		25%	33%			9%		29%	
CHARLOTTE CSA TOTAL	**1,871,759**	**200,758**	**10.7%**	**2,375,675**	**265,139**	**11.2%**	**2,675,309**	**341,479**	**12.8%**		**299,634**	**12.6%**	**76,340**	**28.8%**

(1) Truven published age-, sex-, and zip code-specific population projections for 2017, obtained from Neilsen Demographic Data.
(2) NC Office of State Budget and Management, April 18, 2013 Update: County Total Age Groups - Standard, July, 2017
(3) SC Budget and Control Board - Office of Research & Statistics provided ESRI 2017 Population Projections by age group
* Micropolitan county

In determining which patients may end up being referred and admitted to an LTAC it is important to understand how the population numbers mentioned above are translated to patients needing LTAC services. In general approximately 2% of all Medicare admissions to short term hospitals will be mathematically qualified for an LTAC admission due to one or several clinical factors influencing their medical condition. These various medical conditions are categorized into various Diagnostic Related Groupings (DRG's – which said in another way, are a short description and categorization of a particular illness a patient may have).

<u>Top Eleven DRG's</u>

Carolinas Specialty Hospital has the 27th highest Case Mix Index (CMI) of all 427 LTAC's across the country (2011 MedPac). Over the past three fiscal years (2011-2013) our four highest volume DRG's and 5 of the top 11 of the total number of our admissions are respiratory related.

These five DRG's equate to 61% of our admissions. We routinely have patients who have significant and life threatening illnesses and fall into these five and other DRG's

	Top 11 DRGS FY 2011 -2013		
DRG Description	DRG	Discharges FY 2011 - 2013	Percent of Total
Pulmonary system diagnosis w ventilator support > 96+ hours	207	308	25%
Pulmonary edema & respiratory failure	189	272	22%
Pulmonary system diagnosis w ventilator support < 96 hours	208	94	8%
Other resp system O.R. procedures w MCC	166	60	5%
Septicemia w/o MV > 96+ hours w MCC	871	44	4%
Extensive O.R. procedure unrelated to principal diagnosis w MCC	981	32	3%
Postoperative & post-traumatic infections w MCC	862	24	2%
Skin ulcers w MCC	592	19	2%
Major gastrointestinal disorders & peritoneal infections w MCC	371	16	1%
Septicemia w MV > 96+ hours	870	16	1%
Complications of treatment w MCC	919	16	1%
	Others	342	27%
	Total	1243	100%

Respiratory	61%

II. Assessment Data

We utilized data from US Census Bureau Population Data (2010)
Mecklenburg County Health Department Community Health Needs Assessment Data (2010)
Charlotte Mecklenburg Schools Data (2010)

III. Prioritized Health Needs

(As defined by the Mecklenburg County Health Department)

The prioritized health needs of the community are as follows:

- Chronic Disease & Disability Prevention
- Access to Care
- Healthy Environment
- Substance Abuse Prevention
- Violence Prevention
- Injury Prevention
- Mental Health
- Responsible Sexual Behavior
- Maternal and Infant Health

IV. Community Health Assets

Health care facilities and other resources throughout our area are responding to the health needs of Mecklenburg County and all the surrounding counties as well. You will find below, (**not all inclusive**) a list of those services which support a healthy community:

Two short term acute care hospital systems: Novant Health and Carolinas HealthCare System

One long term acute care hospital: Carolinas Specialty Hospital

Safety Net System of Care:

One Federally Qualified Community Health Center: CW Williams

Seven Free Clinics:

- Charlotte Community Health Clinic
- Charlotte Volunteers in Medicine Clinic
- Care Ring
- Free Clinics of Our Town (Davidson)
- Matthews Volunteers in Medicine Clinic
- Lake Norman Free Clinic
- Shelter Services
- Bethesda Health Center

Carolinas Medical Center Ambulatory/Community Care Clinics

Volunteer physician care for the low-income uninsured programs

- Physicians Reach Out

Med Assist (A community pharmacy)

Mecklenburg County Health Department

Many Other Community Collaborations

V. Community Benefit Action Plan – Established for Carolinas Specialty Hospital

CSH recognizes the various strengths of our partners in providing outstanding healthcare services. Being a small, specialized hospital, we have limited resources to address the many significant needs of our community. While we may be a smaller hospital in size, our expertise has become well known throughout the Western portion of North Carolina as well as the Northern part of South Carolina…we treat and have tremendous success in the provision of care for the respiratory compromised as well as medically complex patients.

Health Issues

Smoking, obesity and other factors are very prominent in the population (over 65) whom we serve every day. Our top four patient cohorts in terms of volume are all respiratory related: ventilator support (greater than 96 hours and less than 96 hours), COPD (Chronic Obstructive Pulmonary Disease) and respiratory distress. While three other patient cohorts involving medically complex and cardiac issues are also in the top ten highest volume DRG's. Our patients will often have multiple co morbid conditions such as diabetes, ESRD, obesity and other factors which all influence the patient's ability to function. Health issues ties back to several of the Prioritized Health Needs identified in Section III, most notably ***Chronic Disease Prevention & Disability Program***

- Action Plan
  - We will implement a number of educational and screening efforts to help educate the over 65 population in our community. Residents will learn more about their health status and how to address changes to reduce the need for inpatient hospitalization.
    - Respiratory - Programs can and will include smoking cessation, exercise and other wellness approaches. There are a myriad of efforts throughout the community, therefore we envision partnering with local churches, fitness/wellness centers and other community based entities to jointly communicate our message.
    - Medically Complex – Programs and screening efforts can and will include lipid profiles, educational seminars, nutritional teachings and other efforts. We envision working with local churches, restaurants and our medical staff to provide information and services to help educate our community

Follow Up Care

The federal government has identified a perceived "revolving door" of patients being admitted to a short term acute care hospital (STAC), being discharged to a long term acute care hospital (LTAC) or other Post-Acute Care (PAC) provider – Inpatient Rehabilitation, Skilled Nursing Facility (SNF), Home Health care only to return to the STAC (often times through the Emergency Department). Patients will often go to one two or perhaps all five of the providers mentioned above, only to go back through the process shortly after returning home or to a SNF. Educating and helping reduce this revolving door falls under the Prioritized Health Need identified in Section III, ***Access to Care***.

- Action Plan
    - Although we cannot necessarily address those patients who are involved with the other providers we will attempt to address those patients for whom we have cared for by developing a Post Discharge Follow Up (PDFP) program to monitor our patients who have been discharged home or to a SNF.
        - The PDFP will involve working with families prior to discharge as typically and already thoroughly being performed,
        - Where we will move outside the norm is to have a staff member (case manager or nurse) follow the patient during their first thirty days after discharge,
        - Phone calls,
        - laboratory values,
        - prescriptions,
        - and most importantly answers to questions will be provided to the patient and/or their family,
        - At least one home visit will be provided (for those patients in our immediate catchment area) to offer the continuity of care expected by our patients.

Dignity of Care

CSH recognizes the various strengths of our partners in providing outstanding healthcare services. Being a small, specialized hospital, we have limited resources to address the many significant needs of our community. There are two areas however, which were not directly mentioned in the various pieces of data we utilized in evaluating our community needs but fall under the Prioritized Health Needs of ***either Access to Care or Chronic Disease***. Those two areas are topics rarely addressed by those of us in the business of providing health care services but two which we find prevalent among our population, and

they are: 1) the provision of advanced directives and 2) the struggle with accepting death and dying as an outcome for a loved one. We provide high quality of care to our patients and have better outcomes than most LTAC hospitals; however, there are a percentage of our patients whose outcome (death) is inevitable and imminent, while the patient's family finds it difficult to understand. Helping loved ones to understand and accept the death of a loved one is an important part of the services of an LTAC, or any health care provider for that matter.

Although there are several studies available articulating the cost of providing healthcare in the final stages of an individual's life, our emphasis is on the ability to offer dignity in such a difficult time. We have had several patients over the past ten years whose family members either disregarded their loved ones wishes or perhaps failed to "know" the patients' wishes, thus, chose to direct their loved one's care in an aggressive manner, often times, while the patient's death was simply delayed without quality of life being added. Providing aggressive and pointed care for a patient is quite appropriate, yet when all attempts have failed to alleviate the inevitable, allowing the family to shift their focus to comfort and dignity is essential. The time to make these decisions though is not in the middle of the crisis, it is long before the crisis begins. Educating families and encouraging conversations between family members is critical to providing end of life care to the patient and support to their families.

Discussing death and dying goes on in the American healthcare system every single day. Information is gathered and discussed and decisions are made by loving and caring family members. Despite this being an everyday occurrence, death and dying discussions are believed by many (even in the health care field) as being contradictory to our mission, education and commitment to providing "health" care. It is not a topic a hospital likes to discuss, especially in open forums when it is feared that the hospital (staff and physicians) has given up hope or doesn't care about providing quality care. While these fears are genuine, it couldn't be further from the truth. Our responsibility as health care providers is to offer quality health care services as best we can and in a dignified and professional manner. Dignity, for the patient and their families is extremely important and providing a 'soap box" to better provide our patients and their families with the opportunity to thoroughly understand the medical process is part of that dignified care.

- Action Plan
    - We will meet with area experts and develop an educational approach for our community. Local churches, skilled nursing facilities, providers, palliative care experts, hospices, legal experts and others will participate in developing the most effective approach to facilitate discussions and ultimately allow patients and their families to make decisions in accordance with their wishes.
    - It is anticipated we will offer educational classes and seminars to various populations as a means to initiate conversations about "what to do" when a

loved one's prognosis is bleak or determined by their illness. These classes and seminars will be led by trained, educated and experienced health care professionals, pastors and supportive care professionals. The programs will not lead the audience to the conclusion of "withdrawal of care" or "comfort measures." It will actually lead the audience to a position where they can make the right decision for their loved one – a decision that is in the best interest of their loved one. That decision may be to pursue aggressive measures and do whatever can be done to help their family or it may be to take a direction of allowing their loved one to die with dignity. It may be to limit certain treatments while pursuing other efforts to help their loved one improve. The programs won't make the decisions for the loved ones; it will give them the ability to make the best decision for their loved one.