New York State Department of Health

Health Equity Impact Assessment Template

Refer to the Instructions for Health Equity Impact Assessment Template for detailed instructions on each section.

SECTION A. SUMMARY

1. Title of project	Rehabilitation SNF Swing and ICU (Step-Up) Beds
2. Name of Applicant	St. James Hospital
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	MP Care Solutions **Kim Hess**, COO khess@monroeplan.com **Howard Brill**, SVP Population Health Management and Quality hbrill@monroeplan.com **Colleen Boyle**, Product Manager cboyle@monroeplan.com **Todd Glanton**, SVP Technology and Analytics, IT tglanton@monroeplan.com **Sylvia Yang**, Health Systems Analyst syang@monroeplan.com
4. Description of the Independent Entity's qualifications	The Monroe Plan was founded in 1970 to provide innovative means to providing healthcare for the underserved in Upstate New York. We have over fifty years of experience partnering with providers, managed care organizations and community-based organizations to reduce disparities, bringing a deep understanding of all facets of healthcare and its constituencies. We are a data-driven organization experience delivering actionable data and designing data-informed and financially-sustainable programs. We have long-term relationships with stakeholders and community organizations and a large team providing direct face-to-face care and outreach to vulnerable persons throughout the Upstate Region.
5. Date the Health Equity Impact Assessment (HEIA) started	10/09/2023
6. Date the HEIA concluded	1/8/2024

7. Executive summary of project (250 words max)

St. James Hospital is a newly constructed facility with fifteen licensed beds. The project involves designating two skilled nursing swing beds for rehabilitation services and converting two beds for "step-up" or ICU services that support mechanical ventilation.

8. Executive summary of HEIA findings (500 words max)

The St. James Hospital service area includes portions of Allegany and Steuben Counties. Allegany County is one of the poorest counties in New York State. The service area has historically experienced a decline in the availability of medical and dental services, especially specialty services. As a result, accessing healthcare services may require long-distance travel to the major urban areas of Buffalo and Rochester. Long-distance travel creates a barrier for low-income, aging and disabled persons through the cost and time involved in travel, limitations in vehicle ownership, and inability to travel independently. A large percentage of service area residents, 45.6%, are on public health insurance coverage. In addition, Allegany and Steuben Counties include an Amish community for whom the impact of long-distance travel to urban areas is compounded.

The service area is predominantly white, with 93.1% of the population white, 2.2% Black, and 3.0% Latino, with a total population of 30,465. The overall poverty rate for the service area is 9.4%, calculated as a weighted average from the ACS zip code estimates. However, there was wide variation in poverty rates across the service area, with two ZCTAs having poverty rates above 25% (with a high margin of error). Transportation is a critical barrier for persons who lack vehicles in rural areas. For the service area, 10.2% of the households had no vehicles available.

The Independent Assessor was able to engage multiple community stakeholders for input on the project, including, Allegany and Steuben County Departments of Health, the Say2 Network /Pivital public health network, the Finger Lakes Community Health Center, the Oak Orchard Community Health Center, St. James Hospital employees, Casa Trinity, ProAction community advocates, and the Ardent Solutions network and coalition.

All of the interviewed community stakeholders strongly supported the project. The project is expected to improve availability and access to SNF rehabilitation and ICU services, with positive health equity impacts for the identified underserved groups. Both services will also improve the quality of life, allowing family and friends who otherwise may have to travel two hours to visit loved ones. Increasing the number of ICU beds may reduce disparities in mortality rates for rural communities.

Community stakeholders noted that local transportation is a significant barrier within the service area. The underserved groups also experience problems with food and housing insecurity. Home care is problematic in the area, and adequate post-discharge care is a concern. A lack of communication about service availability within the provider community may limit the impact of new services. The area also suffers severe healthcare worker shortages.

To address these concerns, the Assessor recommends that St. James provide care coordination that includes support for utilizing transportation services and consider supporting transportation alternatives. Home visitation post-discharge by community health workers to support social needs may help reduce post-discharge risks, as well as create entry-level positions for the healthcare workforce. Telehealth and in-home monitoring are also viable means to increase post-discharge support, and school-based health centers in the area can be used for this purpose. Communicating the availability of services in Allegany County to non-system providers may help ensure that the new services are fully accessed by those needing the services.

SECTION B: ASSESSMENT

For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.

STEP 1 – SCOPING

1. Demographics of service area: Complete the "Scoping Table Sheets 1 and 2" in the document "HEIA Data Tables". Refer to the Instructions for more guidance about what each Scoping Table Sheet requires.

   The assessment service area was defined using the Hospital's service area in the Certificate of Need. It includes portions of Steuben and Allegany Counties, with the Hospital located in Hornell, New York in Steuben County. On the northwest and southeast sides, the service area borders but does not include HRSA-designated medically underserved areas. Scoping Sheets 1 and 2 were completed using the U.S. Census Bureau 2022 5-year estimates for the ZCTAs. Racial and ethnic distributions by ZCTA are displayed visually in Figure 1. Allegany County ranked seventh highest in New York State poverty in 2020, and Steuben 26th highest (NYS Office of State Comptroller 2023).

   The service area is predominantly white, with 93.1% of the population white, 2.2% Black, and 3.0% Latino, with a total population of 30,465. The zip code with the highest proportion of racial and ethnic minorities is 14802, which is the location of Alfred College, which has a population of 4431. For this college location, the percentage of Blacks is 12.0% and Latinos 8.6%. with a White

population of 79.6%. The poverty rate in this zip code is strikingly low, at only 0.7% (with a 3% margin of error). Hornell's zip code, 14843, is the most populous in the service area, with 12,569 persons or 41% of the service area, is composed of 94.3% Whites, 0.9% Blacks, and 1.0% Asians, and 2.5% Latinos. The poverty rate in this zip code is 11.3%. All other zip codes in the service area are 95% White.

The overall poverty rate for the service area is 9.4%, calculated as a weighted average from the ACS zip code estimates. The Hornell zip code (14843) has a poverty rate of 11.3%. Hornell's food stamp benefit rate is 18.4%. However, the median income is $53,247, suggesting significant income inequality. There are other zip codes in the area with higher poverty rates, although with the small population size, the margin of error indicates that these estimates have weak credibility. The highest is zip code 14819, with a 28.9% poverty rate, 14803, with a 25.5% rate, 14855, with a 16.8% rate and 14884, with a 13.4% rate. The 14819 zip code also had a Food Stamp benefit rate of 20.1%. The 14819 zip code has a population size of 740 persons.

A large percentage of the service area's population, 45.6% are on public insurance coverage. In the 14803, 14823, 14843 zip codes over half the residents receive public health benefits.

Transportation is a critical barrier for persons who lack vehicles in rural areas. For the service area 10.2% of the households had no vehicles available. The 14802, 14819, 14823, 14843, 14855, and 14855 zip codes had at least 9% of households without vehicles. The Hornell zip code had 13.5% of households without vehicles. Stakeholders described transportation as a significant barrier for underserved persons in the area.

The disabled population, according to ACS survey data, was 15.9% of the total population for the service area.

Sources:

NYS Office of State Comptroller 2023. New Yorkers in Need: A Look at Poverty Trends in New York State for the Last Decade | Office of the New York State Comptroller (ny.gov) Accessed 12/11/2023

2. Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:
   - ❑ X Low-income people
   - ❑ Racial and ethnic minorities
   - ❑ Immigrants
   - ❑ Women
   - ❑ Lesbian, gay, bisexual, transgender, or other-than-cisgender people

- ❑ X People with disabilities
- ❑ X Older adults
- ❑ Persons living with a prevalent infectious disease or condition
- ❑ X Persons living in rural areas
- ❑ X People who are eligible for or receive public health benefits
- ❑ People who do not have third-party health coverage or have inadequate third-party health coverage
- ❑ Other people who are unable to obtain health care
- ❑ X Not listed (specify):

  Amish community

3. For each medically underserved group (identified above), what source of information was used to determine the group would be impacted? What information or data was difficult to access or compile for the completion of the Health Equity Impact Assessment?

   The service area is in two rural counties and the ACS data shows that several of the zip codes have high poverty rates. For these reasons, the low-income and rural underserved categories were selected. In sum, the area is characterized by rural poverty. The area also has high utilization of public health insurance coverage.

   The program change includes the addition of rehabilitation beds. Persons with disabilities and older persons are expected to be higher utilizers of rehabilitation services. In addition, community stakeholders identified both groups as concerns.

   Community stakeholders and the Allegany and Steuben County Departments of Health discussed the Amish community as an underserved group. A recent estimate of Amish population in the counties of the service area is 2,965.

   Sources:

   ACS, 2022 Five-Year Estimates

   Burdge, Edsel. 2023. "Amish Population in the United States by State and County, 2020." Retrieved December 22, 2023 (https://groups.etown.edu/amishstudies/files/2020/10/Amish_Pop_by_state_and_county_2020.pdf).

   Allegany County Department of Health

   Steuben County Department of Health

   Community Stakeholders

4. How does the project impact the unique health needs or quality of life of each medically underserved group (identified above)?

   Low-income, Persons living in rural areas, Persons receiving public health benefits

   Low-income persons in rural areas are less likely to have vehicles, which impacts health equity in multiple ways (Braveman et al. 2022). Even with vehicle access the long distances and travel times create barriers to access. Community stakeholders indicated that consumers are sometimes reluctant to seek medical services that require travel to Rochester or Buffalo. Local ICU and rehabilitation services allow persons to stay closer to home avoiding transfer to distant locations. Having inpatient rehabilitation services locally provides better access and makes it a better modality for rehabilitation services when needed.

   Also, travel time for family, and other visitors is reduced by providing these services in the service area. Having social support improves the quality of life for patients and has been shown to improve patient safety (AACN 2016, Dragoi, Munshi, and Herridge 2022).

   In the United States, there are significant disparities in the availability of ICU beds between wealthier urban communities and lower-income rural communities (Kanter, Segal, and Groeneveld 2020). These disparities impact mortality rates, particularly for Covid-19.

   Community stakeholders commented that some providers in the service area do not take Medicaid insurance and persons receiving Medicaid coverage have difficulties arranging appointments. St. James Hospital accepts Medicaid insurance. There is no documented information that public coverage would affect use of short-term SNF or ICU services in other facilities.

People with Disabilities, Older Adults

The quality of life issues discussed for low-income persons living in rural areas are applicable and magnified for people with disabilities and older adults. Persons with disabilities and older adults are also likely to have a greater need for rehabilitation services and are exposed to increased risks that lead to ICU stays.

Amish Community

Transportation as a barrier to access is also applicable for the Amish community. Having shorter travel times to services has a positive impact for this group. In general, Amish people are likely to prefer and use healthcare closer to their own community and support networks compared to distant large urban areas.

Sources:

AACN. 2016. "Family Visitation in the Adult Intensive Care Unit." Critical Care Nurse 36(1):e15–18. doi: 10.4037/ccn2016677.

Braveman, Paula, Julia Acker, Elaine Arkin, Katrina Badger, and Nicole Holm. 2022. "Advancing Health Equity in Rural America."

Dragoi, Laura, Laveena Munshi, and Margaret Herridge. 2022. "Visitation Policies in the ICU and the Importance of Family Presence at the Bedside." Intensive Care Medicine 48(12):1790–92. doi: 10.1007/s00134-022-06848-1.

Kanter, Genevieve P., Andrea G. Segal, and Peter W. Groeneveld. 2020. "Income Disparities In Access To Critical Care Services." Health Affairs 39(8):1362–67. doi: 10.1377/hlthaff.2020.00581.

Community Stakeholders

5. To what extent do the medically underserved groups (identified above) currently use the service(s) or care impacted by or as a result of the project? To what extent are the medically underserved groups (identified above) expected to use the service(s) or care impacted by or as a result of the project?

   Using available data it is difficult to determine the number of low-income persons who currently or are expected to use rehabilitation or ICU services. The available data also makes it difficult to determine disability status. There is no data on service use by the Amish community.

   Swing beds for rehabilitation provide short-term care as an alternative to transfer to skilled nursing facilities. There were 276 persons in the service area during

2022 who had been discharged to skilled nursing facilities. It is not possible to distinguish between persons needing SNF for short-term care and those requiring long-term SNF care. The average age was 76.2, and 83.7% were over the age of 65. The SPARCs data indicates that 49.3% were receiving Medicare, which seems low for the age distribution, and 22.1% had a Medicaid payor. Of the persons age 65 and over, 51.1% indicated Medicare reimbursement and 19.5% received Medicaid benefits.

During 2022, there were less than 10 persons in the service area who used inpatient facility rehabilitation services in any facility.

No persons in the service area had been utilizers of swing beds, based on a type of bill code of 18X.

For ICU services during 2022, there were 366 users in the service area. The average age was 58.1 years, and 47.0% were age 65 or over. Among the ICU users, 22.4% were on Medicaid and 32.2% were receiving Medicare.

6. What is the availability of similar services or care at other facilities in or near the Applicant's service area?

   St. James is the only hospital in the service area offering these services (see Figure 1). Near the service area, Nicholas H. Noyes, Jones Memorial, and Ira Davenport (Arnot Health) Hospitals are within 20 miles of St. James Hospital. Corning Hospital is approximately 30 miles from St. James Hospital. (Because rural road networks can be limited, drive time can be longer than direct distances may imply. Prolonged travel times can be especially true during winter driving conditions.) As the discharge analysis shows in Question 7, service area residents travel to further hospitals for these services.

   Skilled nursing facilities (SNF) in Steuben and Allegany counties, which may provide rehabilitation services, are listed in Table 1. In the service area, the SNFs are Maple City and Elderwood.

Table 1 Skilled Nursing Facilities with Rehabilitation Services in Steuben and Allegany Counties

Facility	Miles
Maple City Rehabilitation and Nursing Center	0.1
Elderwood at Hornell	2.3
Steuben Center for Rehabilitation and Healthcare	19.0
Ira Davenport Memorial Hospital SNF/HRF	20.0
Wellsville Manor Care Center	20.3
Highland Park Rehabilitation and Nursing Center	20.3
Houghton Rehabilitation & Nursing Center	27.0
Absolut Center for Nursing and Rehabilitation at Three Rivers, LLC	30.1
Cuba Memorial Hospital Inc SNF	33.0
Corning Center for Rehabilitation and Healthcare	33.7

Source (Skilled Nursing Facilities): NYS Department of Health 2023. "NYS Health Profiles." https://profiles.health.ny.gov/nursing_home Accessed on 12/17/2021.

7. What are the historical and projected market shares of providers offering similar services or care in the Applicant's service area?

   The individual facility cell sizes for acute care inpatient rehabilitation services fall below reportable thresholds for SPARCs data. Long-term care facilities do not report to SPARCs; consequently, utilization at those facilities is unavailable.

   The SPARCs data did not identify any swing bed utilization from users living in the service area.

   ICU market share is shown in Table 2. Over fifty percent of the utilization is at Strong Memorial Hospital in Rochester, New York.

Table 2 ICU Market Share for Service Area

Facility	Discharges	Percent of Total	Cumulative Percent
STRONG MEMORIAL HOSPITAL	205	56.0%	56.0%
NICHOLAS H. NOYES MEMORIAL HOSPITAL	55	15.0%	71.0%
ARNOT OGDEN MEDICAL CENTER	36	9.8%	80.9%
JONES MEMORIAL HOSP	17	4.6%	85.5%
F.F. THOMPSON HOSPITAL	13	3.6%	89.1%
CORNING HOSPITAL	11	3.0%	92.1%
HIGHLAND HOSPITAL	8	2.2%	94.3%
All others	21	5.7%	100.0%

Source: SPARCS 2022

8. Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance. Will these obligations be affected by implementation of the project? If yes, please describe.

   The Hospital provided the ICR Exhibit 50 for 2022. The Hospital met its obligations, receiving $940,173 in reimbursement from the Indigent Care Pool (Exhibit 50, Line 051). The audit for the ICR is still in progress. The Assessor also reviewed the Community Service Society (CSS) literature, which defined performance measures as the percentage of financial aid application approvals, financial aid applications per certified bed, and liens per certified bed. There were no red flags reported in 2012. However, the statistics from 2012 are not comparable to 2022 for this hospital.

   This project may increase the indigent care pool obligations.

   Sources:

   Benjamin, Elisabeth R., Arianne Slagle, and Carrie Tracy. 2012. "Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program." New York: CSS.

   ICR St. James Hospital 2022, "Exhibit 50".

9. Are there any physician and professional staffing issues related to the project or any anticipated staffing issues that might result from implementation of project? If yes, please describe.

   One RN per shift for ICU, 12 hour shifts (total 2)

10. Are there any civil rights access complaints against the Applicant? If yes, please describe.

    None.

11. Has the Applicant undertaken similar projects/work in the last five years? If yes, describe the outcomes and how medically underserved group(s) were impacted as a result of the project. Explain why the applicant requires another investment in a similar project after recent investments in the past.

    Medical Office Building, December 2018

    Hospital, March 17, 2020

    Note that the preceding projects were pre-Covid pandemic, and the pandemic stalled development.

    After years of declining availability of services, these projects reflect a reinvestment in healthcare services in the area. For the identified underserved groups, locally available services are highly beneficial since they avoid long-distance travel. Particularly in specialty services, the service area is underserved and will require many projects like this one to fill existing needs. Severe workforce shortages in healthcare capped the speed at which new investments can be implemented.

STEP 2 – POTENTIAL IMPACTS

1. For each medically underserved group identified in Step 1 Question 2, describe how the project will:
    a. Improve access to services and health care
    b. Improve health equity
    c. Reduce health disparities

    As described in Step1, response to Question 4 and summarized in Table 3, for all of the identified groups there is limited local availability of short-term rehabilitation and ICU services, requiring long-distance transportation which limits access. By providing locally available services, the project improves access and availability. Since long-distance transportation requires vehicles and results in lost income due to travel time (for supporting persons), local services reduce inequity among low-income families. The ability to see loved ones in the hospital improves the quality of life both for families and patients. Improved local availability and access to ICU beds may reduce disparities in mortality rates for low-income persons living in rural areas and is likely to have a similar impact on the mortality rates for the other impacted underserved groups.

    The challenges of long-distance travel to urban areas are compounded for the Amish community due to culture.

Table 3 Impact of Project on Identified Underserved Groups

Underserved Group	Impact		
	Access & Availability	Health Equity	Health Disparities
Low-income	Improves local availability and reduces access barriers due to long-distance transportation	Reduces transportation and monetary barriers	ICU bed availability may reduce disparities in mortality rates.
Persons receiving public health benefits	Improves local availability and reduces access barriers due to long-distance transportation	Reduces transportation and monetary barriers	ICU bed availability may reduce disparities in mortality rates.
People with Disabilities	Improves local availability and reduces access barriers due to long-distance transportation	Reduces transportation and monetary barriers	ICU bed availability may reduce disparities in mortality rates.
Older Adults	Improves local availability and reduces access barriers due to long-distance transportation	Reduces transportation and monetary barriers	ICU bed availability may reduce disparities in mortality rates.
Persons living in rural areas	Improves local availability and reduces access barriers due to long-distance transportation	Reduces transportation and monetary barriers	ICU bed availability may reduce disparities in mortality rates.
Amish community	Improves local availability and reduces access barriers due to long-distance transportation	Reduces transportation, monetary, and cultural barriers	ICU bed availability may reduce disparities in mortality rates.

2. For each medically underserved group identified in Step 1 Question 2, describe any unintended positive and/or negative impacts to health equity that might occur as a result of the project.

   No unintended positive or negative impacts can be inferred for the identified groups.

   A possible unintended positive impact is that the creation of ICU beds creates a career path for nursing staff at the hospital, which may help with workforce retention. The area suffers from severe healthcare workforce shortages.

3. How will the amount of indigent care, both free and below cost, change (if at all) if the project is implemented? Include the current amount of indigent care, both free and below cost, provided by the Applicant.

   Total hospital costs incurred in rendering services to uninsured patients: $584,918 (ICR 2022, Exhibit 50, ICR Line Code 001).

   It is expected that indigent care reimbursement will increase with the project changes. With the data available it is not possible to estimate the amount of the increase in hospital costs or indigent care reimbursement from adding the rehabilitation swing beds and ICU beds.

4. Describe the access by public or private transportation, including Applicant-sponsored transportation services, to the Applicant's service(s) or care if the project is implemented.

   Several public transportation systems in the service area provide interconnection across counties, navigation assistance and have mobility management services. Community stakeholders were concerned that low-literacy residents and consumers have difficulty navigating the services. They also discussed that consumers complain about the reliability of the services and worry they may be stranded or miss appointments.

   Access Allegany https://www.accessallegany.com

   Hornell Area Transit https://www.hatrides.com

   Steuben Transit https://ridesteuben.com

   NeedARide (Mobility Management) https://www.needaride.info

   Institute for Human Services (211 Helpline service)

Medicaid provides transportation through MAS. MAS 2.0 (medanswering.com)

5. Describe the extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.

   There are no major architectural changes involved.
   2018 code requirements are met for accessibility.

6. Describe how implementation of the project will impact the facility's delivery of maternal health care services and comprehensive reproductive health care services, as that term is used in Public Health Law § 2599-aa, including contraception, sterility procedures, and abortion. How will the project impact the availability and provision of reproductive and maternal health care services in the service area? How will the Applicant mitigate any potential disruptions in service availability?

   Not applicable.

   The project has no impact on maternal health care services or comprehensive reproductive health care services. It does not affect the availability or provision of of reproductive and maternal health care services in the service area.

Meaningful Engagement

7. List the local health department(s) located within the service area that will be impacted by the project.

   Steuben County Department of Health

   Allegany County Department of Health

8. Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?

   Yes

9. Meaningful engagement of stakeholders: Complete the "Meaningful Engagement" table in the document titled "HEIA Data Table". Refer to the Instructions for more guidance.

   See attached.

   In summary, the community stakeholders concurred that access and availability of medical and dental services was a significant deficiency in the service area, particularly for specialty services. As a result, transportation to Buffalo or Rochester, which may take two hours, is necessary for receiving services.

Transportation is a barrier for low-income groups, persons with disabilities, and older adults.

In the service area, mental health and substance abuse are important health problems. Social determinants of health that exacerbate health conditions include food insecurity, low literacy, and cultural resistance to preventative healthcare.

There has been a history of declining local healthcare services in the service area. These have been worsened post-Covid pandemic by severe workplace shortages. Structurally, there is a split in health care systems between Buffalo versus Rochester-based systems. One of the effects of this split is a lack of communication among providers about the availability of services.

All of the interviewed community stakeholders strongly supported the project and the additional local services that would be available. They provided many suggestions regarding enhancements and improvements related to transportation, communication, and post-discharge care.

10. Based on your findings and expertise, which stakeholders are most affected by the project? Has any group(s) representing these stakeholders expressed concern the project or offered relevant input?

    Based on the demographic data analysis and community stakeholder interviews, the groups most impacted by the project are the low-income population, persons with disabilities, and older adults. Rural poverty is a major characteristic of the service area. Persons with disabilities and older adults will be likely users of the project's services.

    Because of the lack of availability of the services in the area, long-distance transportation is necessary. Transportation is difficult for disabled persons and older adults, often requiring supportive family or friends. Because of the travel distances involved, the cost of lost wages is a major barrier to family and friends. Public transportation is limited and problematic. The community stakeholders supported locally-based rehabilitation and ICU services as a benefit that eased burdens on the identified groups.

    The community stakeholders brought up the question of post-discharge care. There is a lack of home care options in the service area. A concern is whether these persons will receive adequate follow-up care when they return home.

    One of the community stakeholder organizations brought up a lack of health insurance as a concern. This was generally not supported by the ACS data review of the service area – health insurance coverage was over 95% of the population. (Allegany and Steuben Counties, which are larger than the service area, could include low insurance coverage areas.) Other stakeholder

organizations stated that some providers did not accept Medicaid insurance. The problem may be that some local primary medical or dental providers do not accept insurance or new patients from the major managed Medicaid plans in the area. That is not an issue for St. James Hospital or the services involved in this project.

Several stakeholders brought up the Amish community as an underserved group. As a community, it is not specifically affected by the project, although persons in the community can potentially benefit from the services. The mitigation section discusses how the project could be enhanced to improve access to these and other services by the Amish community.

11. How has the Independent Entity's engagement of community members informed the Health Equity Impact Assessment about who will benefit as well as who will be burdened from the project?

    All of the stakeholder interviews were supportive of the project. The main benefit is increasing the availability of local services and reducing the barriers created by long distance transportation. Those who face transportation difficulties will have the greatest benefit, as well as those who support them who would be impacted by wage loss.

    The community engagement also identified a lack of home care services in the service area which creates vulnerabilities for aftercare.

12. Did any relevant stakeholders, especially those considered medically underserved, not participate in the meaningful engagement portion of the Health Equity Impact Assessment? If so, list.

    While we interviewed other organizations that represent the disabled we were not able to engage OPWDD in Allegany and Steuben Counties.

STEP 3 – MITIGATION

1. If the project is implemented, how does the Applicant plan to foster effective communication about the resulting impact(s) to service or care availability to the following:
    a. People of limited English-speaking ability
    b. People with speech, hearing or visual impairments
    c. If the Applicant does not have plans to foster effective communication, what does the Independent Entity advise?

    The Assessor recommends the following guidelines to improve communication with persons of limited English-speaking ability:

- Use the U.S. Census Bureau American Community Survey to assess the most commonly spoken non-English language in the service area and/or, track encounters in the EPIC EMR with persons with limited English-speaking ability and provide reporting on those encounters.
- Provide written communications for 80% of the persons with limited English-speaking ability based on language use assessment.
- In written communications, include contact information for bilingual staff or contracted language lines.
- Include translated material in the public website and social media.
- Plan outreach events at locations for persons with limited English-speaking abilities.
- In the facility, provide posters or other visual aids that provide information about interpreting services in multiple languages.
- Staff training on language access resources.

We also recommend the following approaches for persons with speech, hearing, or visual impairments when appropriate.

- Outreach events with sign-language interpreters, written materials for persons with hearing impairments, and readers or large print materials for persons with visual impairments. In general, the availability of pencil and paper can assist persons with speech disabilities.
- The following specialized services may be appropriate for the hospital or scheduled video or web conferences:
  - TRS (711) service, which includes TTY and other support for relaying communication between people who have hearing or speech disabilities and use assistive technology with persons using standard telephones.
  - VRS, a video relay service, which provides relaying between people who use sign language and a person using standard video communication (smartphone) or phone communication.
  - VRI, video remote interpreting for video conferencing meetings.
- Accessible Web Sites
- General considerations
  - Visual impairment: Provide qualified readers at the hospital, information in large print, Braille, computer-screen reading kiosks, or audio recordings.
  - Hearing impairment: Provide qualified sign-language interpreters at outreach events, captioning of video presentations, or written materials.
  - Speech disabilities: For general situations, have pencil and paper available, and in some circumstances, a qualified speech-to-speech transliterator.
- Staff training on available resources.

2. What specific changes are suggested so the project better meets the needs of each medically underserved group (identified above)?

Applicable to all identified underserved groups:

Establish a Community Advisory Committee

A permanently established community advisory committee, which meets regularly, will provide the project and the Hospital with insight and support to enhance its services. Many of the enhancements and improvements recommended below are active areas of advocacy and implementation by the community stakeholders engaged for this project.

Sources:

National Academies of Sciences, Engineering, and Medicine. 2016. Systems Practices for the Care of Socially At-Risk Populations. Washington, DC: National Academies Press.

Community Stakeholders

Care coordination including transportation

In general, post-discharge care was identified as an improvement area for the project by community stakeholders. In addition to home care needs, the identified underserved groups have additional needs, such as food insecurity. Persons receiving short-term rehabilitation services and those who required ICU services are likely to have other complex medical needs that will benefit from care coordination, especially in the context of limited availability of specialty services.

Although the project reduces the long-distance transportation burden, local transportation will still be needed. Community stakeholders indicated that underserved persons will need support in navigating available local transportation resources.

Sources:

RHIHub. 2023. "Care Coordinator Model - Rural Care Coordination Toolkit." Retrieved December 14, 2023 (https://www.ruralhealthinfo.org/toolkits/care-coordination/2/care-coordinator-model).

Consider supporting transportation alternatives

Several community stakeholders discussed limitations to local public transportation. In Allegany and Steuben Counties there is a lack of trust in existing rural public transportation. Buses may not arrive when scheduled. Since walking several miles to get to a bus stop is common, becoming stranded is a fear. Medicaid-supported transportation also has a reputation for not being

reliable, resulting in missed appointments and rescheduling that can cause long delays in treatment.

Transportation alternatives would be an improvement to services. Ardent Solutions (one of the community stakeholder organizations) has a transportation program in Allegany County. Ardent Solutions is looking at building out mobility-on-demand with wheelchair vans.

There are several innovative models for transportation alternatives in rural areas. These include (RHIHub 2023, "Rural Transportation Toolkit"):

- Ride-sharing and Volunteer Models
- Taxi Vouchers
- Mobility-On-Demand
- Care Coordination and Patient Navigation for Mobility

Sources

American Hospital Association. 2017. "Transportation and the Role of Hospitals" Retrieved December 26, 2023. (https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/sdoh-transportation-role-of-hospitals.pdf).

RHIHub. 2023. "Models to Improve Access to Transportation" Retrieved December 14, 2023 (https://www.ruralhealthinfo.org/toolkits/transportation/2/models-to-improve-access).

Community Stakeholders

Utilize home visitation post-discharge by community health workers to support social needs.

In addition to the lack of conventional home care services in the service area, there are substantial social needs likely to increase post-discharge health risks. These include food insecurity, social isolation, lack of cultural support for preventative care, low literacy, and poor communication about available healthcare services.

Home visitation by community health workers is a means to improve the availability and access to social needs support. In addition to the direct benefits of community health workers providing home visitation, developing community health workers provides entry into the healthcare workforce.

Sources:

Braveman, Paula, Julia Acker, Elaine Arkin, Katrina Badger, and Nicole Holm. 2022. "Advancing Health Equity in Rural America." Robert Wood Johnson Foundation.

National Academies of Sciences, Engineering, and Medicine. 2016. Systems Practices for the Care of Socially At-Risk Populations. Washington, DC: National Academies Press.

RHIHub. 2023. "Module 1: Introduction to Community Health Workers" Retrieved December 14, 2023 (https://www.ruralhealthinfo.org/toolkits/community-health-workers/1/introduction).

Community Stakeholders

Utilize Telehealth and in-home monitoring for post-discharge

Another approach to improving post-discharge care is telehealth and in-home monitoring. Some community stakeholders, while supporting the use of telehealth, are concerned that low literacy could impede in-home use. They noted that school-based health centers or libraries were effective in Steuben and Allegany Counties, and including telehealth services in those locations could enhance post-discharge care.

Sources:

RHIHub. 2023. "Rural Telehealth Toolkit - RHIhub." Retrieved December 22, 2023 (https://www.ruralhealthinfo.org/toolkits/telehealth).

Allegany County Department of Health

Steuben County Department of Health

Community Stakeholders

Communicate the availability of services in Allegany County to non-system providers

In Allegany County, there is a split between the western and eastern sides of the county with regard to Buffalo versus Rochester-based health care systems. There may be a lack of awareness of the availability of the project's new services in portions of the county. Ensuring that providers across systems are aware of the new services may help all persons in need of those services access t hem.

Sources:

Allegany County Department of Health

Support using IT Interoperability tools and Regional HIT among providers

The Allegany County Department of Health noted there is a lack of information exchange regarding testing and medical history between healthcare systems. They encouraged improved exchange of information, citing the Regional Health Information Organization (RHIO) HealtheLink as an example of a way to improve the exchange of information.

Sources:

Allegany County Department of Health

For the Amish community:

The published literature, community stakeholders and County Departments of Health all concur that the Amish community experiences cultural, transportation, and monetary barriers to access. Based on the ethnographic literature, consider the following approaches to improve access:

Provider information to local bishops about services.

The Allegany Department of Health mentioned providing communication to local school headmasters.

Include Amish representatives in a community advisory board.

Emphasize in-home visitation services, when appropriate.

Sources:

Anderson, Cory, and Lindsey Potts. 2020. "The Amish Health Culture and Culturally Sensitive Health Services: An Exhaustive Narrative Review." Social Science & Medicine 265:113466. doi: 10.1016/j.socscimed.2020.113466.

Anderson, Cory, and Lindsey Potts. 2021. "Research Trends in Amish Population Health, a Growing Literature about a Growing Rural Population." Journal of Rural Social Sciences 36(1):6.

Community Stakeholders

Allegany Department of Health

Steuben Department of Health

3. How can the Applicant engage and consult impacted stakeholders on forthcoming changes to the project?

   As recommended, a regularly meeting community advisory board would provide a means for engaging and consulting with stakeholders.

4. How does the project address systemic barriers to equitable access to services or care? If it does not, how can the project be modified?

   The service area has experienced a reduction in medical and dental services over several decades, particularly for specialty services. The project provides locally available services that otherwise require long-distance transportation. Transportation acts as a systemic barrier for low-income, older, and disabled persons. By adding local services and reducing the transportation burden, the project addresses a systemic barrier.

   As described in the preceding items, additional support for local transportation will enhance the project, as will post-discharge care.

STEP 4 – MONITORING

1. What are existing mechanisms and measures the Applicant already has in place that can be leveraged to monitor the potential impacts of the project?

   The Hospital provides standard quality of care monitoring and has the capability for collecting SDOH metrics through the EPIC EMR system. CMS is mandating the collection of SDOH metrics starting on January 1, 2024, with reportable metrics for screening and number of patients reporting positive for a screening domain.

2. What new mechanisms or measures can be created or put in place by the Applicant to ensure that the Applicant addresses the findings of the HEIA?

   Because transportation was the most significant barrier impacted by the project we recommend that the Applicant implement the following monitoring. Transportation is one of the five reportable SDOH domains required by CMS.

- Provide population-based reporting on the number of rehabilitation and ICU users who report a transportation problem.
- Collect information on the percentage of persons reporting a transportation problem who received follow-up.
- Report on those individuals who indicated a transportation problem at intake and were able to acquire reliable transportation on discharge.

STEP 5 – DISSEMINATION

The Applicant is required to publicly post the CON application and the HEIA on its website within one week of acknowledgement by the Department. The Department will also publicly post the CON application and the HEIA through NYSE-CON within one week of the filing.

OPTIONAL: Is there anything else you would like to add about the health equity impact of this project that is not found in the above answers? (250 words max)

Disclaimer:

This document was produced from raw data purchased from or provided by the New York State Department of Health (NYSDOH). However, the calculations, metrics, conclusions derived, and views expressed herein are those of the author(s) and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.

December 2023

Appendix: Figures

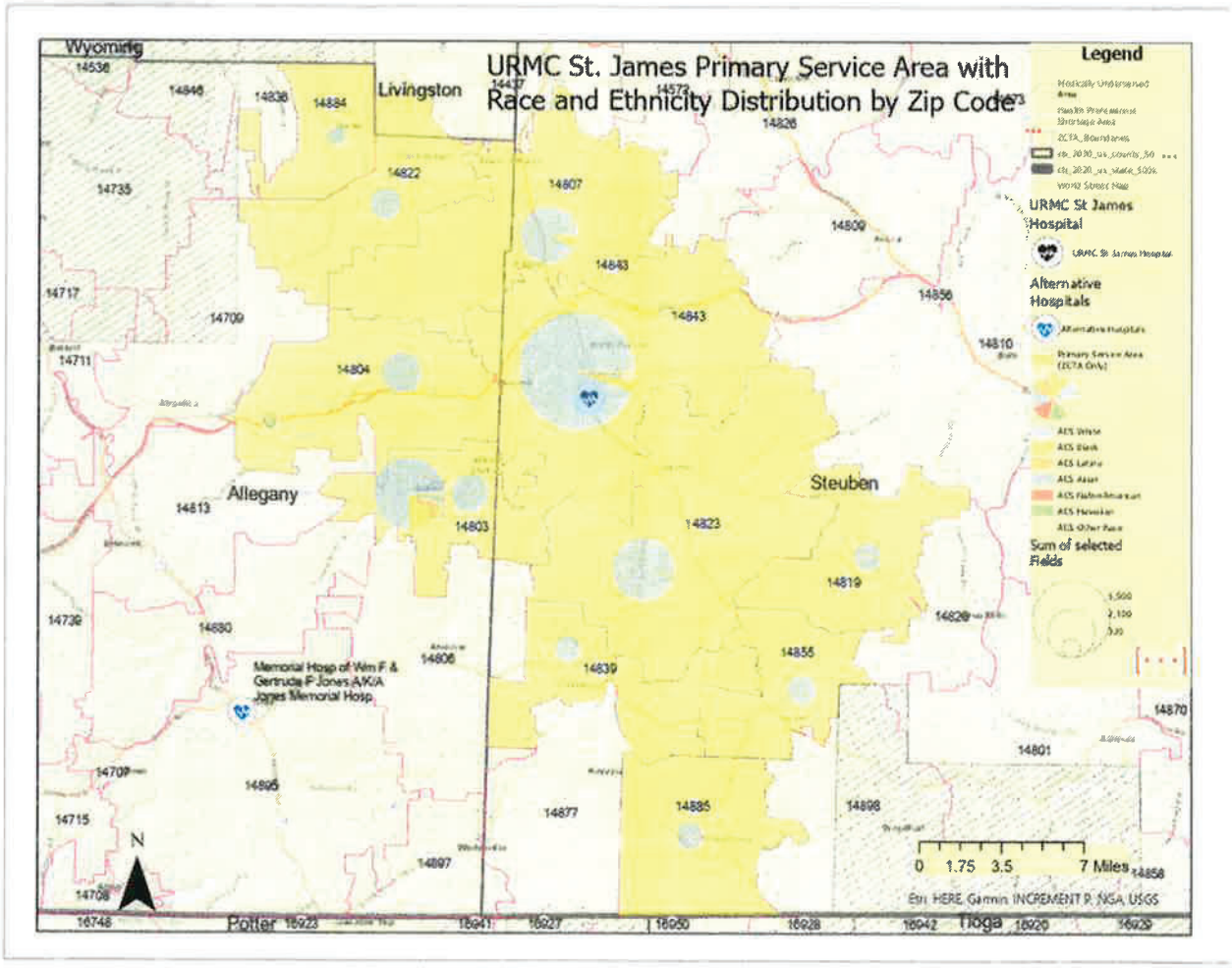

Figure 1 URMC St. James Primary Service Area with Race and Ethnicity Distribution by Zip Code

---------- SECTION BELOW TO BE COMPLETED BY THE APPLICANT ----------

SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN

Acknowledgment by the Applicant that the Health Equity Impact Assessment was reviewed by the facility leadership before submission to the Department. This section is to be completed by the Applicant, not the Independent Entity.

I. Acknowledgement

I, DENISE BECHER, attest that I have reviewed the Health Equity Impact Assessment for the "Rehabilitation SNF Swing and ICU (Step-Up) Beds" project that has been prepared by the Independent Entity, MP CARE SOLUTIONS.

Denise M Becher

Name

Executive VP

Title

Denise M Becher

Signature

1/9/24

Date

II. Mitigation Plan

If the project is approved, how has or will the Applicant mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment? (1000 words max)

As recommended, the hospital will establish a community advisory board and conduct regular meetings of the community advisory board to provide a means for engaging and consulting with stakeholders.

The hospital will advocate with other community stakeholders like local officials, county support agencies, other healthcare delivery services, and hospital internal resources to address areas of concern around transportation and post-discharge care coordination.

Please note: this narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made.