Lutheran HealthCare (LHC) is an academic, faith-based, community health care and social support organization committed to excellence. We are the principal provider of health care for the residents of southwest and central Brooklyn. This uniquely integrated health care system includes Lutheran Medical Center (LMC), Lutheran Family Health Centers (LFHC), Lutheran Augustana Center for Extended Care and Rehabilitation (LAC), Senior Housing and Community Care Organization.

Lutheran HealthCare 2012 Community Service Plan UPDATE

I. Mission Statement for Lutheran HealthCare

Indicate and describe any changes made to the mission statement, if applicable. If no changes were made, please so indicate.

This mission statement was formally adopted by the Lutheran Medical Center Board of Trustees at their regular meeting on October 24, 1990, and has been reaffirmed annually since. It remains unchanged.

II. Hospital Service Area

Please describe the hospital service area. Indicate any changes to the primary service area in the community service planning. Indicate whether or not any changes have occurred since the 2011 submission.

Lutheran HealthCare (LHC) which includes Lutheran Medical Center (LMC), Lutheran Family Health Centers (LFHC), Lutheran Augustana Center for Extended Care and Rehabilitation (LAC), Senior Housing and Community Care Organization is primarily located throughout southwest and central Brooklyn serving one of the most culturally, ethnically and linguistically diverse communities in the world. We have recently expanded to include locations in Manhattan, Queens and Staten Island. LHC considers its current service area to be:

Zip Codes fully contained:

11203, 11204, 11209, 11210, 11214, 11215, 11217, 11218, 11219, 11220, 11223, 11224, 11225, 11226, 11228, 11230, 11231, 11232

Zip codes partially contained:

10011, 10001, 10003, 10010, 10011, 10012, 10016, 10018, 10027, 10035, 10036, 10301, 10455, 11201, 11207, 11212, 11213, 11216, 11217, 11121, 11213, 11229, 11233, 11234, 11235, 11236, 11238, 11239, 11433

Community Demographics*:

37 percent Latino/Hispanic
27 percent Chinese
10 percent Orthodox Jewish
7 percent Arabic
7 percent Russian
28 percent live below 100 percent Federal Poverty Level
16 percent are over the age of 60

*2000 Census data

III. Participants and hospital role

Identify the community partners involved in assessing the community health needs (e.g. community groups, local health departments, etc). Please explain the role (s) of the hospital in the process to identify community health needs in selecting prevention agenda priorities. If applicable, identify any changes to the participants and the public process occurring after your last submission.

Lutheran's participatory process is directed by and in cooperation with senior leadership, community partners, patients, and staff representatives from clinical, research, administrative, and community outreach divisions.

LHC uses demographic and diagnostic data from hospital admissions; ambulatory care visits, utilization rates and community-level data sets and reports. These include but are not limited to: the federal Decennial Census and American Community Survey (issued by the NYS Department of City Planning); "Statistics and Data" provided by the New York State Department of Health (http://www.health.state.ny.us/statistics/) including PQI, QARR, BRFSS, and NYS Cancer Registry; Prevention Quality Indicator data; "Community Health Profiles," and numerous other reference materials compiled by the New York City Department of Health and Mental Hygiene.

Lutheran includes as its community partners, the New York City Department of Health and Mental Hygiene, ACUS- Asian Community United Society, Arab American Association of N.Y., Arab American Family Support Center, BCA- Brooklyn Chinese American Association, Brooklyn NORC Coalition, Brooklyn Pride Center, Caribbean Women's Health Association, Center for Family Life, CPC-Brooklyn Branch- Chinese American Planning Council, Federation of Italian American Organizations, Good Neighbors NNORC, Guild for Exceptional Children, Heartshare, Homecrest Community Services, Housing Works, Jewish Community House of Bensonhurst (Bensonhurst NORC), MAS Youth Center, Metropolitan Jewish Health System, Mixteca, Muslim Federation, Opportunities for a Better Tomorrow, Project Reach Youth, Salam Lutheran Church-Maha, Shore Ridge Cares, Southwest Brooklyn Coalition for Health, The Guild for Exceptional Children, United Senior Center of Sunset Park , Visiting Nurse, and We are All Brooklyn. We meet with community partners bi-annually as outlined in the 2009 CSP.

IV. What are the goals for the selected priority area?

LHC has identified three overall goals to guide its approach to the selected Public Health Priorities:

- Expand primary care capacity to assist in lowering Emergency Room (ER) visits and wait times
- Eliminate barriers to primary care
- Enhance quality of care

These objectives provide a broad framework under which specific programmatic strategies, action steps, role assignments, etc. are organized.

The primary scope of our plan remains unchanged.

V. Please provide an update on the plan for action. Provide a summary of implementation status of your 3-year plan, including successes and barriers in the implementation process. If applicable, indicate how and why plans have been altered as a result of stated successes and barriers.

ACCESS TO QUALITY HEALTH CARE

Expand Primary Care Capacity
Sunset Park Family Health Center

Plan: LHC obtained a New York State, Department of Health, HEAL Phase 2 Grant to construct a new 25,000 square-foot primary care center annex to the Sunset Park Family Health Center, which is the existing main site within LHC's primary care network, Lutheran Family Health Centers (LFHC).

2012 Status: The Sunset Park Family Health Center for Women's Health and Pediatrics opened its doors in April 2010. Since its opening, there has been a 9.9% increase in women's health visits and a 9.1% increase in pediatric visits. The annex had approximately 70,000 visits in 2011. Together, Sunset Park Family Health Center and the Annex provide primary care services to over 38,000 patients. With 40 exam rooms and extended hours at the two sites, Sunset Park Family Health Center had over 141,000 medical visits in 2011.

Brooklyn-Chinese Family Health Center

Plan: LHC adopted a strategic plan to relocate the LFHC Brooklyn-Chinese Family Health Center site to a significantly larger facility in the same neighborhood. The new facility will increase the Brooklyn-Chinese Family Health Center's capacity by 50 percent.

2012 Status: The new Brooklyn Chinese Family Health Center opened in February 2011. Located in the heart of Brooklyn's Chinatown, this area now has the largest concentration of Chinese residents in New York City. In February of 2012, the site added service hours on Saturdays, to accommodate rapid growth of this population. Since the introduction of the new weekend hours, allowing the site to be open 7 days a week, there has been a 5.6% increase in visit volume since February 2012 as compared to last year.

Evaluation Measure (EM) 1: Number of patients using Lutheran Family Health Centers

- 2008 – 89,082
- 2009 – 99,429
- 2010 – 110,696
- 2011 – 114,779

Establish School-Based Oral Health Program

Plan: To address the growing need for school–based oral health services, LHC will establish an extensive school-based oral health program by operating dental clinics within public schools throughout New York City.

2012 Status: Lutheran works with school administrators, teachers and parents to increase the number of students that our program provides oral health services to at 16 school-based dental sites. Additionally, we provide services to approximately 4,600 students in Staten Island,

Manhattan and the Bronx. In 2011, there was a 57.4% increase in school dental patients since 2010.

EM 2: Number of Dental Patients

- 2008 – 24,609
- 2009 – 26,957
- 2010 – 31,938
- 2011 – 33,185

Eliminate Barriers to Care

Facilitate enrollment events with Health Plus

Plan: Health Plus continues to work closely with LHC's other "arms" and community partners to facilitate insurance enrollment for residents. In the coming months, with the expansion of LHC's school-based dental program, LHC and Health Plus will collaborate with participating schools to ensure that most students have health insurance.

2012 Status: In October 2011**,** Lutheran Medical Center, Health Plus and Amerigroup Corporation signed an agreement that allowed Amerigroup to purchase substantially all of the operating assets and contract rights of Health Plus, one of the largest Medicaid managed care companies in New York. Health Plus, established in 1984 by Lutheran Medical Center, currently serves approximately 320,000 members in New York State's Medicaid, Family Health Plus and Child Health Plus programs, as well as the federal Medicare program. As of May 1, 2012 the sale was completed and all Health Plus members were converted to Health Plus Amerigroup. We continue to partner with Health Plus Amerigroup on enrollment events to assist our patients in obtaining health insurance.

During the 2011-2012 school year Lutheran and Health Plus teamed up with teachers and parents to increase the number of students participating in our school health programs. Our efforts have been well received and there has been an increase in Medicaid/Medicaid managed care enrollments amongst students in the School-based Health Program. Three of the schools (i.e. P.S 15, P.S. 24, and I.S. 88) all had increases in Medicaid enrollment greater than 20%. There was a 34% increase in Medicaid/Medicaid managed care enrollment at I.S. 88. The school now has 915 students enrolled, an increase from 603 in the 2010-2011 school year

EM 3: Number of LFHC members enrolled in Health Plus/Amerigroup

- July 2009 – 23,773
- July 2010 – 23,850
- July 2011 – 23,793
- February 2012 – 23,837 (last recorded amount before transition)
- May 2012 – 24,159 (latest number- Amerigroup)

Enhance LHC's "Cancer Outreach and Prevention Alliance" (COPA) Program

Plan: LHC is the lead agency in a coalition of community and faith-based organizations working together ***to increase access to and utilization of screening services for breast, cervical, colorectal and prostate cancer*** within its service area. LHC has established plans to expand this coalition significantly. Community partners work with LHC to increase knowledge/skill among community members for the identified cancers. Coalition activities will also include

prevention/screening, promoting community education, educating health providers, fostering partnerships and networks, improving organizational practices, and influencing policy and legislation.

2012 Status: Due to insufficient state budgets to sustain the program, the COPA program lost grant funding early in 2010 and was discontinued. Currently we have moved these goals under our Medical Home Program initiative. We have continued to work with our patients through the use of our medical and health home initiatives by utilizing best practice clinical guidelines and EMR systems.

EM 4: Percentage of women between 40 and 69 years of age who had a mammogram within the past two years

- 2008 – 35 percent
- 2009 – 46 percent
- 2010 – 60 percent
- 2011 – 59 percent

EM 5: Percentage of women between the ages of 24 – 64 who received one or more Pap tests during the measurement year or during the two years prior to the measurement year

- 2008 – 73 percent
- 2009 – 80 percent
- 2010 – 80 percent
- 2011 – 81 percent

Colonoscopy Cancer Patient Navigator Program

Plan: LHC has identified numerous barriers to colonoscopy screening for its patient population, particularly men (only 20 percent of LHC's male patients receive colonoscopy screening). Having utilized breast health patient navigators successfully over for the past several years, LHC has created a similar colorectal cancer/colonoscopy patient navigator program.

2012 Status: The Colonoscopy Patient Navigator Program ended in August 2011, successfully navigating over 1,400 patients through colonoscopy. Since the funding for this program ended, the role of the patient navigator has transitioned to the Patient-Centered Medical Home advocates provided through the American Cancer Society. The advocates help coordinate care for patients and navigate them through the health system. Through the Brooklyn Healthy Living Partnership, we are also able to provide a limited number of free colonoscopy screenings for our very low-income and uninsured patient population. These resources resulted in a significant increase in the number of colonoscopies performed in 2011.

EM 6: Number of patients successfully "navigated" through colonoscopy

- January – August 2010 (baseline data) – 651
- 2011 – 2,571

Enhance Quality of Care
Patient Centered Medical Home

Plan: LHC will implement a new model of care within the LFHC network, the Lutheran HealthCare Patient Centered Medical Home the (PCMH), which will be marked by significant improvements in organization, coordination, and integration of care – all factors that influence long-term health outcomes in the primary care setting. The PCMH model will foster more effective communication between the patient and the clinical care team and will be led by the primary care provider.

2012 Status: In 2010, LHC received recognition at eight out of the nine Family Health Center sites as a Level 3 Patient-Centered Medical Home by the National Committee for Quality Assurance (NCQA). This designation recognizes elevated standards of quality in care through emphasis on whole-person orientation and a closer patient-physician relationship designed to have a team of doctors working together to oversee all aspects of care with a proactive focus on prevention.

NCQA requires Lutheran to select a health indicator to improve in order to receive and maintain the NCQA accreditation as a Medical Home. Based on patient population and community need, LFHC selected the percentage of adult patients with type 2 diabetes whose most recent HbA1c is ≤ 9 percent.

EM 7: The percentage of adult patients with type 2 diabetes whose most recent HbA1c is ≤ 9 percent.

- 2008 – 68 percent
- 2009 – 68 percent
- 2010 – 70 percent
- 2011 – 70 percent

Diabetes is a major chronic health issue plaguing the population we serve. As such, we continue to intensify our efforts toward assessing and assisting patients self-manage their chronic condition. Certified Diabetes Educators, nutritionists, and Patient Centered Medical Home Advocates all work closely with the clinical staff to provide education on self-monitoring, diet and nutrition, and healthy life style tips. Through increased education, we hope to increase the number of controlled diabetics and empower patients to take charge of their diabetes and engage in lifestyle changes that will result in long-term positive health outcomes.

Also, we have recently implemented Point of Care Testing (POCT) at all LFHC sites in an effort to increase the number of controlled diabetic patients. POCT is done for all diabetic patients at the start of each appointment. Therefore, the doctor has the patient's current glucose level before seeing the patient and can more effectively discuss the patient's current status and decide to continue, revise or change the patient's current disease management plan. As a result of increased education and POCT, as of June 2012, we now have 72% of our diabetic patients with a HbA1c less than or equal to 9 percent.

Community-Based Blood Pressure Self-Monitoring

Plan: With support from community members, the New York City Department of Health and Mental Hygiene, the Fund for Public Health in New York and the Robert Wood Johnson Foundation, LHC will develop and implement a community-oriented hypertension program that utilizes the latest telemedicine technologies for blood pressure monitoring. LHC will distribute automatic blood pressure (BP) monitors with modems capable of transmitting home BP readings to a secure database for evaluation; the monitors will be distributed to 1,000 patients and community members.

2012 Status: By fall 2010, the program was able to enroll 800 participants into the study, enabling us to increase the number of diagnosed hypertensive patients and the percentage of controlled patients. In 2012, we have implemented system wide changes to help us manage the population more successfully. The most significant change was the re-configuration of the Vital Signs Reference range to highlight in red, a blood pressure value equal or greater than 130/80 mmHg in eCW, our electronic medical record. This alerts providers to follow the follow-up with the patient. Since the beginning of 2012, we now have 69% of our hypertensive patients controlled.

EM 8: The percentage of adult patients (18+ years) with hypertension whose most recent blood pressure was <140/90

2008 – 63 percent
July 2008 – June 2009 – 65 percent
July 2009 – June 2010 – 66 percent
July 2010 – June 2011 – 69 percent
July 2011 – June 2012 – 67 percent

To further enhance the quality of care among patients with diabetes, hypertension and other chronic diseases, we have implemented a Pre-Visit Planning database. This is simply a registry of patients with chronic diseases. It is updated every night and allows providers to monitor patients in “real time.” Data can be extrapolated in order to identify uncontrolled patients. Patient-Centered Medical Home advocates call these patients to make appointments and help facilitate further methods of care.

HEALTHY MOTHERS/HEALTHY BABIES/HEALTHY CHILDREN

Expand Primary Care Capacity
Expand Women’s Health and Pediatric Capacity

Plan: As described above (Access to Quality Health Care – Expand Primary Care Capacity, Strategy 1), LHC has constructed a 25,000 square-foot primary care center that will double capacity for Women’s Health and Pediatrics at LHC’s Sunset Park Family Health Center annex.

2012 Status: Sunset Park Family Health Center Annex for Women’s Health and Pediatrics opened its doors in April 2010. Women's Health provides perinatal care including pregnancy testing, routine prenatal and postpartum care, care of high risk pregnancies and genetic counseling for expectant mothers 35 years and older. We offer the Prenatal Care Assistance Program (PCAP). General gynecological examinations and Pap smears, treatment of conditions such as menstrual problems, infertility and cancer screenings are provided. Family Planning services include oral contraceptives, condoms and birth control devices. Estrogen

replacement therapy for menopausal women is also available. In pediatric health, in addition to primary care, the health center provides the following pediatric specialties to handle and treat acute and chronic medical conditions in children; Cardiology, Gastroenterology, Pulmonology, Endocrinology, Neurology and Nephrology.

Eliminate Barriers to Care

Community-Based Adolescent Pregnancy Prevention Program

Plan: LHC was successful in securing funds in 2010 for the amount of $342,900 from the New York State Department of Health to establish a Community-Based Adolescent Pregnancy Prevention Program (CBAPP) to address the alarmingly high rates of adolescent pregnancy and births in Sunset Park, Brooklyn. The rates of teen pregnancy in 2006-2008 for the targeted zip codes are 108 per 1,000 in 11232 and 96 per 1,000 in 11220. Both exceed state averages, and 11232 falls in the top 90% for all NYS. The combined ASHNI score for these zip codes is 405. For our community of focus, NYC Prisms data indicates a disturbing picture of risk: out of 36 Brooklyn neighborhoods, Sunset Park has the third highest teen birth rate, second highest adolescent abortion rate. The program is being implemented through our division of Adolescent and Youth Services and is housed at the Project Reach Youth center, a multi-service community center of Lutheran Healthcare that specializes in serving adolescents. The CAPP program uses school-based group education and services at several service area schools to reduce risky behaviors and negative outcomes such as unintended pregnancy. The ultimate goal of the program is to prevent adolescent pregnancy, and function as a trusted point-of-entry to prenatal care for adolescents that do become pregnant. The program addresses the high rate of pregnancy and childbearing among Latino teens in the targeted neighborhood and, as a result, aims to narrow the gap in health disparities.

2012 Status: CAPP utilizes the "Teen Health Project," an evidence-based intervention, to provide 6-hour sexual health education workshops to in-school and out-of-school youth in Sunset Park. The "Teen Health Clinic," housed in the Park Slope Family Health Center, and the recently launched "Adolescent Clinic" in the Sunset Park Family Health Center Annex, provides services including gynecological exams, STI testing, birth control, pregnancy tests, and health education counseling. Project SAFE youth and staff collaborate with the medical staff at the Teen Health Clinic, establishing infrastructure that provides sexual health services designed to meet the unique needs of the area's adolescents. In the process of developing these clinics, Project SAFE peer educators met with clinic staff to identify and address possible barriers to obtaining sexual health services and helped to design a teen- friendly intake process and waiting area. The CAPP program also runs the MAMA prenatal support group for adolescent mothers. MAMA helps youth obtain the information and interpersonal skills they need to more effectively manage the transition to parenthood. The program uses the Love Notes curriculum.

CAPP served a total of 2,653 youth in 2011. The program enrolls a high percentage of minority adolescents with 42 percent of the youth identifying as Hispanic, 39 percent Black/African-American, and 5 percent Asian. Many of the youth participants struggle academically, and face challenges outside of school including domestic violence, loss, family disruption, and abuse. Eighty-five percent of the youth are in-school and fifteen percent are out-of-school youth. Additionally, CAPP provided risk reduction counseling to 710 youth.

Results:

- A total of 1897 adolescents were reached by adolescent teen health education and or services
- 345 adolescents received referrals to health and related social services
- 17 adolescent mothers received group and/or individual teen pregnancy education and support
- 93% of total participants indicated an increase in knowledge about community resources and how to access them and 66% of participants indicated an intent to change behavior due to the program intervention

Increase Access through the Expansion of Nurse Midwife Practice

Plan: Numerous studies have shown that nurse midwives improve access to care for expectant mothers and significantly improve birth outcomes. Driven by this and other considerations, including priorities identified through the CSP survey process and challenges in recruiting culturally congruent obstetricians, LHC has established a strategic plan to expand its outpatient nurse midwife practice.

2012 Status: The increased Women's Health capacity at the new Sunset Park Family Health Center Annex and rising birth rates have contributed to the increased demand for services and thus, the need for additional nurse midwives. In 2011, Lutheran increased midwifery service to 9 midwives from 4 in 2010, which has enabled us to see more patients earlier in their pregnancy. However, the percentage of women receiving prenatal care within their first trimester remained the same for 2011. As many of the members of our service area are undocumented, many pregnant women are fearful of seeking health care because of their legal status. Many are unaware that New York law allows them to seek care. Also, in many foreign countries, prenatal care is not the norm until their third trimester and many women are not knowledgeable of its importance. Recognizing these cultural barriers that impact the utilization of health care services, we are now using outreach workers within local churches and community based organizations to help teach women the importance of prenatal care and how to seek health care regardless of their citizenship status. As a result of these efforts, 72% of women have accessed prenatal care during their first trimester during the first six months of 2012.

EM 1: Percentage of women who enter into prenatal care during their first trimester

- 2008 – 61 percent
- 2009 – 61 percent
- 2010 – 69 percent
- 2011 – 69 percent

Enhance Quality of Care

Centering Pregnancy Project

Plan: LHC is piloting a Centering Pregnancy Project that focuses on providing group prenatal care to low – income, high – risk pregnant women. In this model, traditional one-on-one prenatal visits with the physician are replaced by in – depth, two-hour group visits involving enhanced education, social support and self-empowerment. The overall goal of the project is to improve birth outcomes and health behaviors during and after pregnancy among adolescents (aged 14 – 21) receiving prenatal care through LHC.

EM 2: Percentage of births less than 2,500 grams

- 2008 – 5.25 percent
- 2009 – 5.7 percent
- 2010 – 5.7 percent
- 2011 – 5.2 percent

2012 Status: The Centering Pregnancy pilot program ended in July 2010. Since that time Lutheran has continued to reexamine and enhance our Maternal Fetal Medicine (MFM) program. The percent of births less than 2,500 grams has improved in 2011 and our results continue to be significantly better than Brooklyn (8.4 percent) and New York City rates (8.7 percent) (last available data – 2009).

In an effort to continue to improve this outcome, Lutheran has implemented several changes and enhancements to systems and clinical protocol including:

- Developed an ongoing training program through the Electronic Health Record to capture risks in women associated with Low Birth Weight Babies and to create an appropriate treatment plan to manage risks.
- Implemented a new model of OB care, which standardizes the protocols of care for low birth weight, at risk, and high-risk pregnancy.
- Retrained staff and refined process for referring to the Network High Risk Clinic and to MFM for testing and consultation.

In November 2012, Lutheran will be piloting shared medical appointments within the health centers. Shared medical appointments involve 10-14 patients who are seen together for a 90 minute appointment. Patients will be able to learn together and learn from each other by sharing concerns and experiences within the group. Though mostly in a group, patients are still able to receive individualized medical care if necessary. We will be piloting shared medical appointments among obese, hypertensive, and/or diabetic adults, asthmatic children, and normal OB patients. The goals of implementing this service are to decrease wait time, increase appointment availability, and improve patient access to care.

Report Card Modification

Plan: LFHC uses site-specific and organization-wide report cards to track performance with respect to clinical measures and goals with the input of network-wide clinical and administrative leadership. Measures are based on community health needs, accreditation standards, and regulatory requirements. Partially in response to priorities identified during the CSP survey process, LFHC has modified its report card to include several new clinical measures and goals pertaining to maternal, perinatal and pediatric health. The CSP committee, along with community partners, will review LFHC's progress towards these goals on an ongoing basis and advise on modification of goals as necessary.

2012 Status: LHC has made modifications to the 2012 LFHC network report card under the "Quality of Care" indicators. Pharyngitis testing and follow up of negative point of care testing in children was added to the report card this year in order to enforce proper protocols in Pharyngitis testing. Our target goal for 2013 is 95%.

Also, in accordance with our UDS performance measures, we have added BMI testing for children and adolescents. We would like to increase documentation on overweight and obese

children and want to ensure that these children have been appropriately diagnosed and receiving nutrition and physical activity counseling. Our goal for 2013 is 90%.

In 2011, "Quality of Care" indicators modified for the report cards in 2011 included; the measurement of immunizations completed by a child's second birthday, which was enhanced to include an automated-on-demand-recall database and the monitoring of children between 6 and 11 years of age who have had a dental visit in the past year.

Between 2010 and 2011 Lutheran's childhood immunization rates have increased six percent which is slightly higher than our goal of five percent. We attribute this progress to the changes in the workflow for checking childhood immunizations status in eClinicalWorks (eCW). This ongoing process review is expected to facilitate improvements that create a more seamless flow of information thus establishing enhanced capacity to track children's compliance with the immunization schedule and identify those that have not received their immunizations.

Lutheran was one of the pilot programs citywide to begin receiving information from the New York Citywide Immunization Registry (CIR). We have interfaced our electronic health records with the registry allowing us to import immunization histories into our system. We now have a real time record of immunizations, helping us to prevent missed vaccinations and avoid over-immunization of our patients regardless of where they received their vaccinations. We have also developed and implemented a pre-visit reporting system to assist providers in proactively reviewing immunization status and recalling those who need vaccines a month before a routine visit.

The percentage of children between the ages of 6 and11 years of age who have had a dental visit in the past year has increased from 55% in the first quarter of 2011 to 72% in the first quarter of 2012. Through increased tracking of this measure on report cards and working with Health Plus to enroll children and assign them with a Lutheran affiliated dentist, we have seen a 17% increase in numbers. Though the collaboration with Health Plus has ended since its conversion to Health Plus Amerigroup, providing students with dental services and enrolling children with health insurance is still a priority.

EM 3: The percentage of children by two years of age with appropriate immunizations (4 DTaP, 3 polio, 1 MMR, 3 HIB, 3 hepatitis B, 1 VZV, 4 PC7)

- 2008 – 88.6 percent (sample)
- 4th Quarter 2009 – 74 percent (sample)
- 2010 – 74 percent
- 2011 – 81 percent

EM 4: The percentage of children ages 6-11 who have had a dental visit in the past year

- 4th quarter 2009 – 43 percent
- 1st Quarter 2011 – 55 percent
- 1st Quarter 2012 – 72 percent

VI. Explain any impact or changes that have been realized to date as a result of your collaborative plan. If not applicable, explain why.

Many of the results regarding the impact of this collaborative plan are mentioned in the above report. However, the most significant impact has been from the unanticipated loss in funding for several initiatives. While we are covering these losses through the use of our medical and health home initiatives by utilizing best practice clinical guidelines and EMR systems it has become more challenging than ever to achieve the goals we set in 2009.

Additionally, we have learned that we need to restructure our efforts in community benefit planning to narrow the focus, create systems of evaluation and data collection while developing stronger systems for outcome measurement moving forward.

VII. Since completing your CSP in 2011 have you conducted any new surveys?

Yes. In late September 2010, Sunset Park, Brooklyn was one of the first 21 communities nationwide to receive a Promise Neighborhood Planning Grant from the US Department of Education. As the lead agency, Lutheran HealthCare, through the Lutheran Family Health Centers, received this $500,000 planning grant to create a Promise Neighborhood in collaboration with other community based organizations, community schools, businesses and faith based organizations. The vision of this federally funded program is that all children and youth growing up in Promise Neighborhoods have access to great schools and strong systems of family and community support to improve educational outcomes. As part of this planning process, Sunset Park Promise Neighborhood conducted an extensive community needs assessment and asset mapping. Nearly 3,000 children and adults and over 30 organizations were engaged in a process that included asset mapping activities, a comprehensive community needs survey, and a series of issue-specific focus groups.

Through this comprehensive process, Lutheran has learned about the strengths and resources of the Sunset Park community. It has also learned about the needs of the community and the challenges of living in Sunset Park. Gaps in programs, services and advocacy have become clear, as have potential solutions for improving the lives of the families and children of Sunset Park.

VIII. Please list any other non- prevention agenda priorities or issues on which the hospital is working? If none, please write NA

Nonprevention Agenda Priorities include:

- Community Medicine Program
- Cultural Competence Programs
  - Arab Initiative
  - Chinese Initiative
- Electronic Medical Record
  - Bar Code Medication Administration
  - Clinical Documentation
- Health Home Initiative
- Geriatric Psychiatry
  - Electroconvulsive Therapy
- Neuroscience Department expansion
  - Epilepsy
  - Interventional Neurology
    - Bi-plane equipment installation

- Patient Centered Medical Home Program recertification
- Radiology Department expansion and modernization
  - 3-D mammography
  - MRI Machine
- Rehabilitation Program
- Vascular Surgery Department expansion

IX. Dissemination to the Public

Describe how the CSP was made available to the public. If information is posted on your hospital's website, please include the link. Include documents, newsletters or brochures created for distribution to the public with your one – year update submission, if they are not posted to the hospital's website.

LHC published this report in its entirety on our web site (www.LutheranHealthCare.org) and a summary document that includes our commitment to public health programs and financial assistance was be posted. Additionally, Lutheran currently posts on our web site information regarding financial assistance programs and will add programmatic information as it becomes available regarding prevention agenda initiatives. In addition, Lutheran provides information to the public in our patient guides, posters and financial assistance brochures; all are available throughout the health care system. Copies of the CSP update were mailed to all community partners.

X. Describe the hospital's successes and challenges regarding the provision of financial aid, in accordance with Public Health Law 2807 K, and any changes envisioned for this year. Also, include a general overview of accomplishments, process improvements and or best practices related to the hospital's financial aid program. The hospital's policy or financial data is not required.

In order to manage its responsibilities and to allow Lutheran Healthcare to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors has established a policy to assist its low-income patients in financial need so as to continue to meet its overall mission, and comply with NYS Public Law 2807 (k) (9 – a).

Some of the successes of this policy are:

- Consistency among the entire Lutheran HealthCare network
  - Eligible patients receive services without having to reapply for financial assistance at each point of care which is mutually beneficial to both the patient as well as the hospital because it reduces the patient's stress and concern while also reducing the resources needed to provide assistance.
- A prior to or within 24 business hour of admission determination of financial benefits
- Overcoming most cultural and language related issues due to our Cultural Competence programs and the diversification of our staff
  - Communication of information in multiple languages
- Early understanding of the process with Financial Assistance and/or other insurances such as Medicaid, Family Health Plus, Child Health Plus or any other available insurance coverage
- Assistance in applying for Medicaid and other insurances

- Hospital's willingness will work with patients, not eligible for any type of insurance, to the extent possible so payment of the bill is more manageable.
- Utilizing our financial assistance process to improve collections of co-insurances by advising our patients of their financial responsibilities at the time services are rendered.
- Lutheran Family Health Center treatment all patients regardless of ability to pay.
- Lutheran Family Health Center sliding fee scale based on family size and income.

Some of the challenges in implementing this policy are:

- Maximizing limited resources to assist financially distressed patients
- Helping the patients better understand and plan for meeting their financial obligations for the health care services provided by LHC.
- Maintaining an ongoing refresher education that is provided to the front-end staff, which has resulted in better, more complete Medicaid applications to Health Resources and Services Administration (HRSA.)
- Improving the Medicaid application process to reduce applications returns for additional information
- Lessening the Medicaid application denials from HRSA.
- Reducing back and forth among HRSA/Patient/Facility
- Expanding this process to 'episodic' users of health care services, such as Emergency Room treated and released patients that have traditionally been very difficult to interview and complete the financial assistance process.
- Convincing undocumented patients that providing information about themselves and their family so we can assist them in filing a Medicaid application and this information will not be used to deport them.