PETITIONER:

Heart'n Soul Hospice of the Carolinas
10106 Saffir Court, Mint Hill, NC 28227
Mecklenburg County – Health Service Area V

CONTACT:

David Turner
Chief Operating Officer
Telephone: 313-205-8040
Email: dturner@heaertnsoulhospice.com

Kevin Allison
Chief Operating Officer
Telephone: 704-777-1407
Email: kallison@heartnsoulhospice.com

Dr. Andre Lee
Chief Administration Officer
Telephone: 313-673-7098
Email: alee@heartnsoulhospice.com

PETITION:
Heart'N Soul Hospice of the Carolinas is submitting a special needs petition for an additional home care office in Mecklenburg County, NC for the 2025 SMFP.

BACKGROUND

Heart'N Soul Hospice of the Carolinas is a grassroots organization that stems from decades of hospice and acute care experience that seeks to provide the utmost in culturally competent end-of-life-care for communities of opportunity regardless of race, ethnicity or social economic status.
Heart'n Soul Hospice of the Carolinas is an expansion of Heart'n Soul Hospice that originated in Nashville, TN by David Turner, Dr. Andre Lee, and Pastor Sandy McClain. These leaders in hospice, acute care and pastoral services understands and recognizes the important role that culturally competent providers, particularly those with similar life experiences, can serve in reducing health disparities and improving quality of life for terminally ill patients and their loved ones.

Since Heart'n Soul Hospice opening in Nashville, TN, we have expanded services into two key states, Washington and Florida, impacting over 20 counties of underserved communities. Our partnerships have grown with organizations of impact in each community, including: public, private and historically black universities, health care systems, distributors and physicians. We have garnered a relationship with our community and continuing to increase a diverse utilization for all patients in our service area.

Our unique approach to hospice care, is exemplified in our Chief Operating Officer, Kevin Allison, DHA, a native of Mecklenburg County. Dr. Allison has been involved in establishing our agencies and is intimately involved in Heart'N Soul's efforts to serve his home community. The abilities of our leaders is to look beyond the obvious and advocate for the people in these communities of opportunity; which are drought of advocacy and resources.

Reducing racial and ethnic disparities is a critical priority and is essential to delivering effective and equitable healthcare in Mecklenburg County. According to the National Hospice and Palliative Care Organization (NHPCO), increasing access in a community involves a commitment to inclusion that is fostered through the establishment of relationships within the community while recognizing, respecting, and valuing differences. Cultural diversity among healthcare providers is known to improve quality of care, build trust, enhance communication, and correct misunderstandings to reduce health disparities. Heart'N Soul strives to ensure that each patient receives empathetic home-based hospice care in a manner befitting their culture, customs, and/or personal preference. Its hospice patients benefit from the culturally competent palliative care provided in the comfort of their own homes, and the quality of care and compassion that can be delivered for patients and their loved ones is unparalleled.

Heart'N Soul Hospice is submitting a special needs petition for an additional home care office in Mecklenburg County, NC for the 2025 SMFP.

2. Statement of Requested Change:

Cited Methodology: Home Care Office Methodology, Chapter 13,
In citing the Hospice Home Care Office Methodology in the proposed 2025 State Facilities Medical Plan (SMFP), step 4 presents statistical concerns for all providers.

The SMFP's methodology suggest, there is not a numeric need as its sole basis of provider consideration. Yet, the Healthcare Planning and Certificate of Need Section has approved the expansion of providers in consecutive years, while denying petitioners seeking to begin operations. The methodology is used to project a numeric need for offices or agencies for a specific county; this process is only applicable for new providers. Existing providers have a separate process that is completely avoidant of the petitioning process. Existing providers are to communicate their desire for a new county, regardless of the SMFP's detailed need for additional offices or agencies.

The secondary process allows for expansion of existing providers to any county, if no new offices or agencies are opened in the approved county. This impacts the number of reported hospice patient deaths (Table 13B, column E/F) while not impacting the number of licensed hospice offices in county (Table 13B, column L), creating a constant surplus from the credited hospice admissions (column K).

The methodology needs to represent the approved agency expansions by county to accommodate for the allowed growth, absent of the methodology numeric needs suggestion. The methodology is a measure of success, not a barrier for entry. Any surplus or deficit realized is simply a measure of performance and zero merit on unmet need.

The last update to the methodology was in 2012, over 10 years since the last adjustment.

3. Reasons for Proposed Change:

The requested change to the methodology is an attempt to align with the actual need being determined by the providers, patients and performance in Mecklenburg County.

Current providers have supported the illegitimacy of the methodology and currently circumvent the process entirely. This has been confirmed by the agency and a report on expanded providers year to year is not recorded by the agency. The need to protest the methodology is nonexistent, given the secondary process being provided by the Healthcare Planning and Certificate of Need Section. The usage of the methodology is a measure of success and will never require augmentation given the purpose is to show performance as ratio of state/county related deaths compared to county admissions.

All major hospice providers use data source, Health Pivots for national reporting an index accountability; this is Medicare based data and correlates directly with provider performance. It is understood that this data is a measure of key performance indicators that dictate hospice planning

and business development. This Health Pivots data has not been shared with the state and alludes to alarming rates of rank as a response to the current provider resource base in North Carolina.

Health Pivots Database:

- North Carolina is ranked **25th** among all states in hospice penetration rates. *South Carolina is ranked 8th overall, outperforming NC; *see table 2*
  *Compared among most populous states, NC ranks 7 out of 10 states; see table 1
- North Carolina is ranked **40th** among all states for End-Of-Life - % Died in HHA w/out Hospice in 2023 (Apr 2022 to Mar 2023); see attachment (label: HP_EOL Percent Rank).
  * this is a critical level

Adverse Effects on Providers/Consumers:

- As a hospice referral, Dr. Mark Collins, CEO of One Health, representing more than 170 Mecklenburg County stated, "(his) physicians are experiencing the existing disparity from the deficit in the area from a lack of connection and attraction of patients that stem from a defined and factual opposition to existing hospice providers based on a known gap in cultural competence and ability to reach patients by these existing providers."
- A large, underserved area of Mecklenburg County nicknamed the Crescent and Wedge is a concentration of disadvantaged communities of color covering SIX zip codes (28205, 28206, 28208, 28212, 28216, 28217) because of historical practices like redlining and other housing discrimination strategies that were harmful to communities of color. There are zero agencies in Mecklenburg County focused on this area. see attachment: Mecknc DAM_ Collection Preview
- Mecklenburg Hospice Penetration (HP) rate is 0.78 and its Death Service Ratio (DSR) is 0.57; a critical level for Medicare Enrollees, the conversion rate for 2023 is -***0.21****, patient equivalent missed 35,559.* See attached: HP_Hospice Minority Access
  - Black Enrollees: HP is 0.62 and DSR is 0.46; *-0.16 patient missed 8,280*.
  - Hispanic Enrollees: HP is 0.56 and DSR is 0.32; *-0.24 patients missed 782*.
  - Asian Enrollees: HP is 0.75 and DSR is 0.55; *-0.20, patients missed 780*.
  - White Enrollees: HP is 0.87 and DSR is 0.64; *-0.23, patients missed 23,428*.
  - Native Enrollees: *unrecorded by Health Pivots*.
- Of 50,000 deaths in 2023, only 29% were through hospice: either residential or facility. 44% of deaths were at private residence, off service. 20% were residential or nursing facilities. 7% were hospitals. This is an unrealized opportunity that we have identified.
- In 2023 Ch. 13 Patient Origin Report, there are 25 licensed operating providers, reduced down to 11 actual providers with 2 providers dominating the market with 91.4% market share; controlling 3,833 of the total 4,174 deaths in the county.

- In the Ch. 13, Table A: Inventory of Licensed Hospice Agencies; there are 9 listed licenses, yet they are only 2 agencies recorded for Mecklenburg County, VIA and Novant Health. This gives the appearance of choice for patients which is shown to be a hinderance for patient usage when perceived variety is realized.

Mecklenburg County's population and sheer growth deserves to be adequately reflected in the availability of hospice home care agencies in the county. With a population exceeding one million and being one of the fastest growing counties in the state, Mecklenburg County has experienced no change in the number of new hospice home care providers that could help address the growing need for culturally competent end-of-life care relative to the increasing number of minorities in the region.

Alternatives to Purposed Change:

The State Medical Facilities Plan requires an additional section to publish the approved agencies that were approved to expand into counties different then their originally approved counties. This requested data is vital to align the projected need versus the approved needs of the state and health related services. The delineator can be added to the existing Chapter 13 table section to continue its transparency into certificate of need.

The consolidation of new and existing hospice providers process to requests to operate in any counties is detrimental to the integrity of the Certificate of Need process and the ability of the Governor appointed committee that has responsibility to moderate health resources in North Carolina effectively.

Having these dual processes will indefinitely present "zero needs" for any county in North Carolina, with the ability for existing providers to request additional counties after the SMFP's submission each year. There is a need to reduce the listed organizations that are segmented by license number and not by ownership presents an over representation of service providers (col. L). The term "office" is reflective of a physical location and does not reflect the various providers and agencies. The need for agencies to be grouped by actual agents is necessary to delineate service providers.

4. Evidence of Proposed Change would not Result in Unnecessary Duplication:

In North Carolina, there has not been a new provider for at least 10 years. Given the process for existing providers there continues to be an expansion of existing practices with zero controls that require a provider to expand competence until Policy GEN 5, as a result of Heart'n Soul Hospice efforts last petition cycle.

In analyzing the hospice data presented by the state, for Mecklenburg County there are only 2 originating organizations that are licensed in the county, VIA and Novant. VIA has **85%** of the county licensed market share and Novant has 15% of the county. There are a total of 25 licensed providers operating in Mecklenburg County and yet when utilizing the hospice data reported by Medicaid to Health Pivots, Mecklenburg County continues to struggle with hospice penetration rates.

Reviewing the hospice data report, there is a limited offering of services and providers based on the originating providers for Mecklenburg County.

TITLE: License Providers for Mecklenburg County			
SOURCE: Hospice Database, 2023 Hospice Data, Table 2 Ent_Sec A			
strFacCnty	Mecklenburg		
strLicensee	**strPrimaryDBA**	**strLicenseNum**	**Sum of lngHospiceID**
Hospice & Palliative Care Charlotte Region	**Via Health Partners**	HOS1702	103
Hospice & Palliative Care Charlotte Region	**Via Health Partners**	HOS3132	166
Hospice & Palliative Care Charlotte Region	**Via Health Partners**	HOS4436	248
Hospice & Palliative Care Charlotte Region	**Via Health Partners Levine & Dickson Hospice House at Aldersgate**	HOS4933	277
Hospice & Palliative Care Charlotte Region	**Via Health Partners Levine & Dickson Hospice House at Huntersville**	HOS3727	226
Hospice & Palliative Care Charlotte Region	**Via Health Partners Levine & Dickson Hospice House at Southminster**	HOS4588	251
The Presbyterian Hospital	**Novant Health Hospice**	HOS1445	262

As mentioned by Mark Collins, CEO of One Health, the largest primary care group in Mecklenburg County, there is a significant unmet need for historically underserved and communities of opportunity. As Dr. Collin's stated, he continues to represent over 170 providers and experience daily hardships in hospice and palliative care; citing "there simply is a large gap in the ability to reach communities of opportunity with current providers and connection to the most vulnerable communities in Mecklenburg County".

As confirmed by committee Member Tim Rogers of the Association of Home and Hospice Care of NC, the methodology has not been modified or adapted in over 10 years. We agree in this creates significant concerns for a progressive approach to hospice deliver and recognition of services new providers offer to our community.

5. Evidence that Change is Consistent w/ 3 Basic Principles:

Safety and Quality

Cultural competence has become an essential component of healthcare, given the recent impact of bias and negative outcomes experienced by all races and ethnicities. Heart'n Soul Hospice focuses on providing care to those who are marginalized and unaffected by general marketing efforts. Our focus is on people who require the extra mile to reach and are limited in either education, abilities, or other limiting factors that would impact quality of life. In Mecklenburg County, we are diverse and simply cannot allow for attempts in service to count for service.

Quality health in Mecklenburg County can be attributed to the hospice penetration rate that is marginal as compared to similar counties and states. The ability to gauge quality, is predicted with patient usage; if there is little to no usage, this can be inferred to suggest the quality is simply not an attractor for patient choice. As healthcare leaders, we know that patient quality is a requirement to establish a trusting environment that nurtures patient vulnerability. The vulnerability for patients in this market has been displaced as having an alternative to hospice care; which is no care, as displayed in the death percent for NC that 44% of deaths were in a private residence, off service.

Access

In North Carolina, Medicaid Expansion was successful, acknowledging an attempt to reach vulnerable communities in raising the requirements for coverage granting access to more than 500,000 North Carolinians. With Mecklenburg County, being amongst the most desired areas to live and work, we have not realized the unmet need that is due because of this major influx of patients.

In the report from the 2023 Hospice Database, Section D, we are reminded of the opportunity that exist across North Carolina for death. As reported below, only 29% of all deaths in North Carolina were through hospice care. There is significant opportunity to improve hospice deaths in Residential Care Facility, Nursing Facility and Private Residence; in utilizing early detect methods and cultural competence we can predict a 5% impact for hospice involved deaths in preceding years.

A vital measure of success for Hospice is "hospice penetration rate", in aligning North Carolina among the most populous states, we are held to 7th and our neighboring state also ranks higher on this list. The state's current practices continue to limit the hospice services of vulnerable patients and this number will continue to reduce given the influx of migrants to the Charlotte-Mecklenburg Market. The projected population for Charlotte-Mecklenburg is expected to grow to beyond its current 1.1M by 2% annually, for the next 4 years (Source: https://datausa.io/profile/geo/mecklenburg-county-nc#demographics).

Value

In 2023 Ch. 13 Patient Origin report, states there are 25 licensed operating providers in Mecklenburg County, in aligning duplicate providers the number of providers is reduced to 11 actual providers with 2 providers dominating the market with 91.4% market share: controlling 3,833 of the total 4,174 deaths in the county.

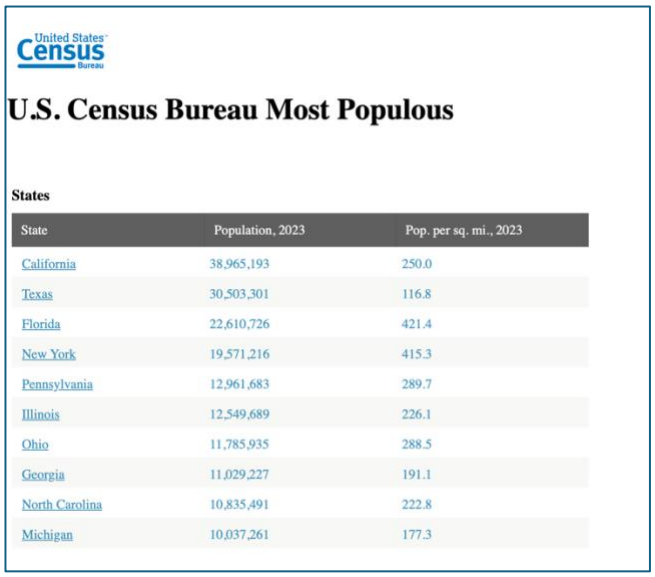
The resources that are reduced when there are little provider variety has shown to limit patient choice of services and present a consistent method of marketing and patient delivery. This is what healthcare leaders identify as "best practices"; this is a hinderance for patient attraction and engagement with untapped markets in the service area.

We are reminded that value comes from competition and if we remove new vendors from providing new ideology and practices, we will continue to see the subpar utilization by marginalized communities. These practices result in the spread of monopolistic tactics that stem from a central, larger partner in the market.

The current providers are members of a central hospice association that has defined what providers should govern and practices a reduced belief in hospice practices. The largest donor to the organization is one of the largest hospice providers in the county and state. If we are to understand how services and perspectives have been limited, we trace the source of concern to this central point.

The value Heart'n Soul Hospice shares is that which aligns with the Healthy People 2030 objective "Increase the proportion of territorial public health agencies that are accredited - PHI-D07". We are a prime example how a maintain status quo has hindered growth in our service area.

6. Reference Tables:



United States Census Bureau

U.S. Census Bureau Most Populous

States

State	Population, 2023	Pop. per sq. mi., 2023
California	38,965,193	250.0
Texas	30,503,301	116.8
Florida	22,610,726	421.4
New York	19,571,216	415.3
Pennsylvania	12,961,683	289.7
Illinois	12,549,689	226.1
Ohio	11,785,935	288.5
Georgia	11,029,227	191.1
North Carolina	10,835,491	222.8
Michigan	10,037,261	177.3

#:	State:	Most Populous:	Hospice Penetration Rate:
1	Texas	2	95.5
2	Florida	3	90.4
3	California	1	87.6
4	Georgia	8	85.3
5	Ohio	7	82.7
6	Michigan	10	77.2
7	North Carolina	9	74.6
8	Illinois	6	69
9	Pennsylvania	5	66.3
10	New York	4	36.3
	South Carolina	-	86.1

NC ranks 9th for most populous state; yet 7th among its peers and lower than South Carolina for hospice penetration rate.

TITLE: NC Death Profile**, by Death Type and Percentage**					
SOURCE: Hospice Database, 2023 Hospice Data, Section D					
Hospice	**Values**		**Legend Title**	**Table Sec D Value:**	**%:**
	Sum of lngDeaths_ResCare	3,716.00	Residential Care Facility	3,716.00	7%
*	Sum of lngDeaths_Inpatient	13,536.00	Hospice (Inpt or Residence)	13,536.00	27%
*	Sum of lngDeaths_Hospice	1,026.00	Hospice	1,026.00	2%
	Sum of lngDeaths_Home	22,466.00	Private Residence	22,466.00	44%
	Sum of lngDeaths_NurseFac	6,644.00	Nursing Facility	6,644.00	13%
	Sum of lngDeaths_Hospital	3,541.00	Hospital	3,541.00	7%
		50,929.00		50,929.00	100%

29% of all deaths were through Hospice Care. 71% were other and shows significant opportunity.

Row Labels	**Sum of Deaths:**	**%:**
Atrium Health	78	1.9%
Carolina Caring	73	1.7%
Gentiva	100	2.4%
Hospice of Davidson County	2	0.0%
Hospice of Gaston County	1	0.0%
Hospice of Iredell County	25	0.6%
Liberty Home Care	58	1.4%
Novant Health Partners	1559	37.4%
Pruitt Health Hospice	3	0.1%
Trellis	1	0.0%
Via Health Partners	2274	54.5%
Grand Total	**4174**	100.0%

Mecklenburg County Death Percentage by Provider.

91.9 % of deaths are with 2 providers.

- VIA Health Partners
- Novant Health Partners.

Home Care State Profile

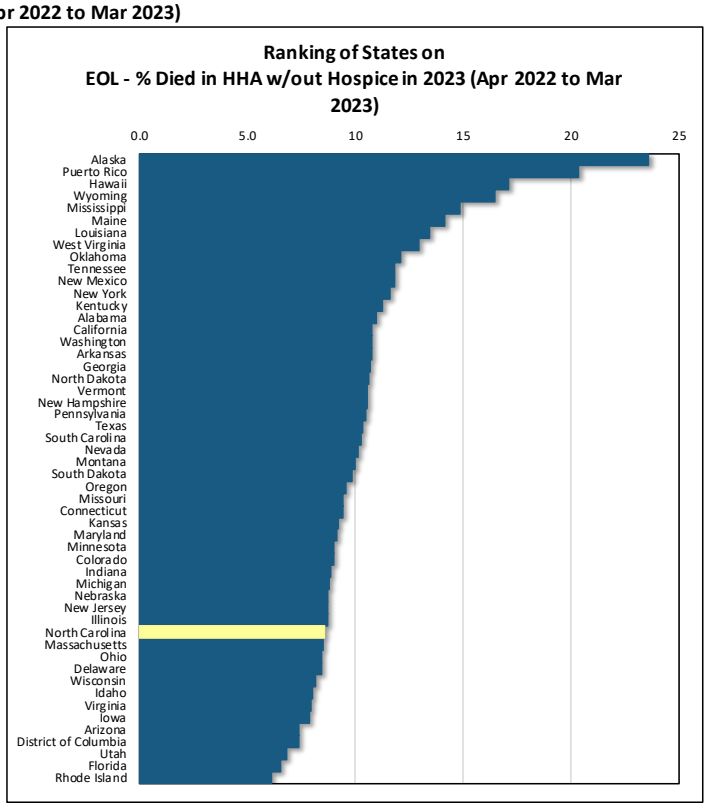
HealthPivots

Based on Medicare FFS Claims for 2023 (Through Sep 2023)

EOL - % Died in HHA w/out Hospice (2023)

Ranking of States on EOL - % Died in HHA w/out Hospice in 2023 (Apr 2022 to Mar 2023)

State	Value	Rank
Alaska	23.5	1
Puerto Rico	20.3	2
Hawaii	17.1	3
Wyoming	16.4	4
Mississippi	14.9	5
Maine	14.1	6
Louisiana	13.4	7
West Virginia	13.0	8
Oklahoma	12.1	9
Tennessee	11.8	10
New Mexico	11.8	11
New York	11.6	12
Kentucky	11.3	13
Alabama	11.0	14
California	10.8	15
Washington	10.8	16
Arkansas	10.7	17
Georgia	10.7	18
North Dakota	10.6	19
Vermont	10.5	20
New Hampshire	10.5	21
Pennsylvania	10.5	22
Texas	10.3	23
South Carolina	10.2	24
Nevada	10.2	25
Montana	10.0	26
South Dakota	9.8	27
Oregon	9.5	28
Missouri	9.4	29
Connecticut	9.4	30
Kansas	9.2	31
Maryland	9.2	32
Minnesota	9.0	33
Colorado	9.0	34
Indiana	8.8	35
Michigan	8.8	36
Nebraska	8.7	37
New Jersey	8.7	38
Illinois	8.7	39
North Carolina	8.6	40
Massachusetts	8.5	41
Ohio	8.4	42
Delaware	8.4	43
Wisconsin	8.2	44
Idaho	8.0	45
Virginia	8.0	46
Iowa	7.9	47
Arizona	7.4	48
District of Columbia	7.4	49
Utah	6.8	50
Florida	6.5	51
Rhode Island	6.1	52



Hospice Minority Access

HealthPivots

Based on Medicare Claims through Dec 2023 | Mecklenburg County, NC

Select a County List, County, or Service Area
North Carolina - Mecklenburg

HOSPICE MEDICARE UTILIZATION BY RACE/ETHNICITY

Mecklenburg County, NC

All Medicare Enrollees

Year	Medicare Enrollment	Death Service Ratio	Hospice Penetration	Days per Patient (ALOS)	% GIP Days	Payments per Patient
2014	128,333	0.51	0.72	63	3.4%	$10,506
2015	133,428	0.53	0.74	67	3.0%	$11,166
2016	138,175	0.57	0.78	62	3.0%	$10,448
2017	142,565	0.54	0.76	64	2.9%	$10,774
2018	147,848	0.57	0.78	62	2.7%	$10,731
2019	152,547	0.54	0.77	68	2.3%	$11,804
2020	156,484	0.53	0.72	66	2.0%	$11,782
2021	160,785	0.53	0.72	65	2.0%	$12,127
2022	165,454	0.54	0.75	65	2.0%	$12,273
2023	169,332	0.57	0.78	65	1.8%	$12,582

List of Included Counties
North Carolina - Mecklenburg

Black Medicare Enrollees

Year	Medicare Enrollment	Death Service Ratio	Hospice Penetration	Days per Patient (ALOS)	% GIP Days	Payments per Patient
2014	37,040	0.43	0.60	59	4.5%	$10,211
2015	39,045	0.41	0.57	62	4.8%	$10,949
2016	40,809	0.43	0.60	60	4.1%	$10,496
2017	42,478	0.43	0.62	62	4.2%	$10,968
2018	44,342	0.44	0.63	63	3.8%	$11,262
2019	46,068	0.44	0.63	61	3.7%	$11,228
2020	47,513	0.43	0.58	62	2.6%	$11,562
2021	49,140	0.42	0.57	61	2.8%	$11,827
2022	50,692	0.44	0.62	60	2.8%	$11,980
2023	51,756	0.46	0.62	58	2.8%	$12,061

Hispanic Medicare Enrollees

Year	Medicare Enrollment	Death Service Ratio	Hospice Penetration	Days per Patient (ALOS)	% GIP Days	Payments per Patient
2014	1,631	0.41	0.66	78	3.5%	$13,549
2015	1,819	0.39	0.57	86	2.8%	$14,483
2016	1,960	0.55	0.82	75	3.1%	$12,562
2017	2,152	0.51	0.76	81	1.2%	$12,945
2018	2,333	0.49	0.67	49	4.8%	$9,028
2019	2,582	0.46	0.69	48	5.9%	$10,544
2020	2,762	0.28	0.38	63	2.8%	$12,234
2021	2,995	0.31	0.47	65	3.9%	$13,103
2022	3,256	0.42	0.69	71	0.9%	$12,752
2023	3,259	0.32	0.56	85	2.0%	$16,470

HealthPivots

Based on Medicare Claims through Dec 2023 | Mecklenburg County, NC

Select a County List, County, or Service Area
North Carolina - Mecklenburg

HOSPICE MEDICARE UTILIZATION BY RACE/ETHNICITY

Mecklenburg County, NC

Asian Medicare Enrollees

Year	Medicare Enrollment	Death Service Ratio	Hospice Penetration	Days per Patient (ALOS)	% GIP Days	Payments per Patient
2014	2,320	0.38	0.55	72	0.9%	$11,208
2015	2,466	0.46	0.59	57	2.3%	$9,401
2016	2,644	0.44	0.81	75	2.5%	$12,259
2017	2,855	0.44	0.64	68	2.2%	$10,995
2018	3,078	0.42	0.72	57	2.5%	$9,836
2019	3,286	0.41	0.61	73	1.6%	$12,066
2020	3,462	0.38	0.46	65	2.6%	$11,757
2021	3,672	0.38	0.56	75	2.3%	$13,678
2022	3,945	0.35	0.59	95	0.6%	$16,388
2023	3,900	0.55	0.75	74	1.7%	$13,941

Native Medicare Enrollees

Year	Medicare Enrollment	Death Service Ratio	Hospice Penetration	Days per Patient (ALOS)	% GIP Days	Payments per Patient
2014	105					
2015	99					
2016	103					
2017	109					
2018	112					
2019	109					
2020	118			18	6.8%	$4,444
2021	117					
2022	121					
2023	116					

White Medicare Enrollees

Year	Medicare Enrollment	Death Service Ratio	Hospice Penetration	Days per Patient (ALOS)	% GIP Days	Payments per Patient
2014	83,856	0.55	0.78	64	3.1%	$10,595
2015	86,183	0.58	0.81	68	2.6%	$11,241
2016	88,328	0.63	0.85	63	2.7%	$10,365
2017	90,193	0.60	0.82	64	2.6%	$10,716
2018	92,689	0.63	0.85	62	2.4%	$10,567
2019	94,798	0.58	0.84	71	1.8%	$12,032
2020	96,438	0.59	0.80	67	1.8%	$11,863
2021	98,313	0.59	0.81	66	1.7%	$12,185
2022	100,315	0.60	0.82	66	1.7%	$12,331
2023	101,864	0.64	0.87	67	1.5%	$12,755

Post-Acute Hospice Use

HealthPivots

Based on Medicare FFS Claims for Jul 2022 to Jun 2023 (Through December 2023)

ALL HOSPITALS LOCATED IN THE SERVICE AREA FOR ATRIUM HEALTH UNIVERSITY CITY - 340166 (HOSPITAL; 2023)

Select All Hospitals In...	Select a Hospital	Select a Year
...a Selected Hospital's Service Area	North Carolina - ATRIUM HEALTH UNIVERSITY CITY - 340166 (Mecklenburg County)	2023

2023 POST-ACUTE HOSPICE USE SUMMARY (JUL 2022 TO JUN 2023)

FOR HOSPITALS LOCATED IN THE SERVICE AREA FOR ATRIUM HEALTH UNIVERSITY CITY - 340166 (HOSPITAL)

HOSPITALS LISTED IN DESCENDING ORDER BY SIZE	2023 INITIAL HOSPITALIZATIONS			ENROLLEES WHO DIED WITHIN 6 MONTHS OF INITIAL HOSPITAL DISCHARGE							
				% OF ENROLLEES BY HOSPICE USE			DAYS PER ENROLLEE FROM INITIAL DISCHARGE TO DEATH				
HOSPITAL OF INITIAL HOSPITALIZATION	HOSPITAL COUNTY	MORTALITY RATE IN HOSPITAL (INITIAL STAY)	MORTALITY RATE WITHIN 6 MONTHS OF INITIAL DISCHARGE	DISCHARGED DIRECTLY TO HOSPICE CARE	ADMITTED TO HOSPICE LATER	NO HOSPICE	DAYS WITH HOSPICE	DAYS WITHOUT HOSPICE	TOTAL DAYS UNTIL DEATH	PERCENT DAYS WITH HOSPICE	PERCENT DAYS WITHOUT HOSPICE
NORTH CAROLINA STATE HOSPITAL AVERAGE	**North Carolina**	**3.3%**	**15.2%**	**20.5%**	**41.4%**	**38.2%**	**12**	**49**	**61**	**20%**	**80%**
CAROLINAS MEDICAL CENTER/BEHAV HEALTH - 340113	North Carolina - Mecklenburg	2.9%	11.8%	15.3%	45.0%	39.7%	11	58	68	15%	85%
ATRIUM HEALTH PINEVILLE - 340098	North Carolina - Mecklenburg	2.9%	13.3%	20.9%	45.1%	34.0%	14	45	59	24%	76%
NOVANT HEALTH PRESBYTERIAN MEDICAL CENTER - 340053	North Carolina - Mecklenburg	1.3%	13.4%	34.2%	42.6%	23.2%	12	40	52	23%	77%
NOVANT HEALTH MATTHEWS MEDICAL CENTER - 340171	North Carolina - Mecklenburg	0.7%	15.6%	27.5%	50.2%	22.3%	12	40	52	23%	77%
NOVANT HEALTH HUNTERSVILLE MEDICAL CENTER - 340183	North Carolina - Mecklenburg	0.9%	15.5%	31.3%	48.0%	20.7%	11	39	50	22%	78%
ATRIUM HEALTH UNIVERSITY CITY - 340166	North Carolina - Mecklenburg	2.7%	17.0%	12.0%	36.6%	51.4%	8	45	54	15%	85%
NOVANT HEALTH MINT HILL MEDICAL CENTER - 340190	North Carolina - Mecklenburg	0.5%	20.1%	37.1%	40.5%	22.5%	14	40	55	26%	74%

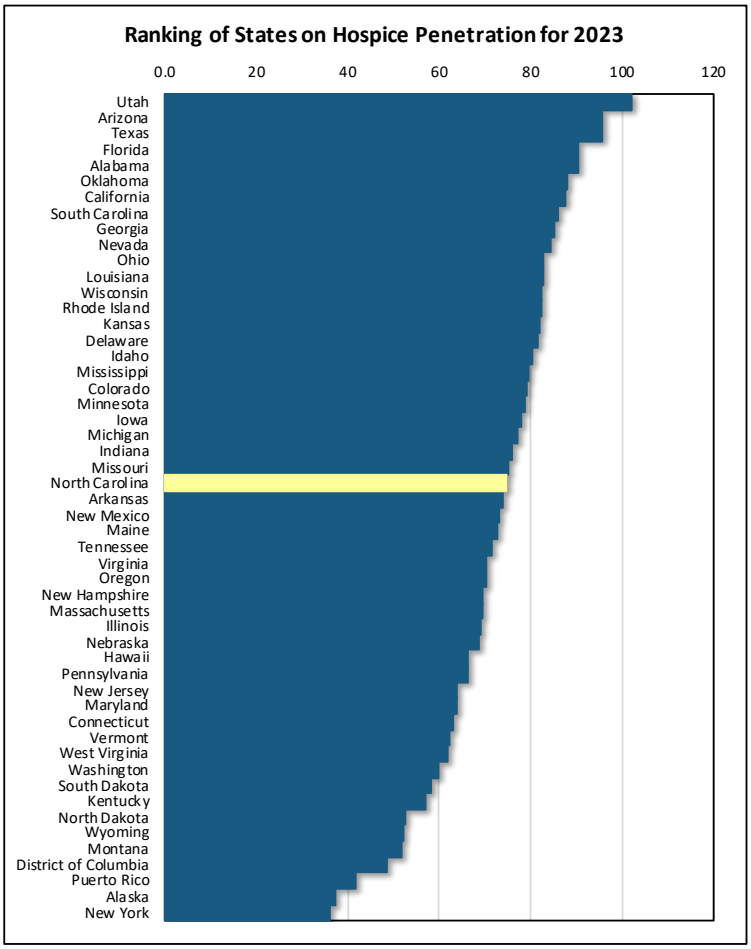
LIST OF INCLUDED COUNTIES
North Carolina - Mecklenburg

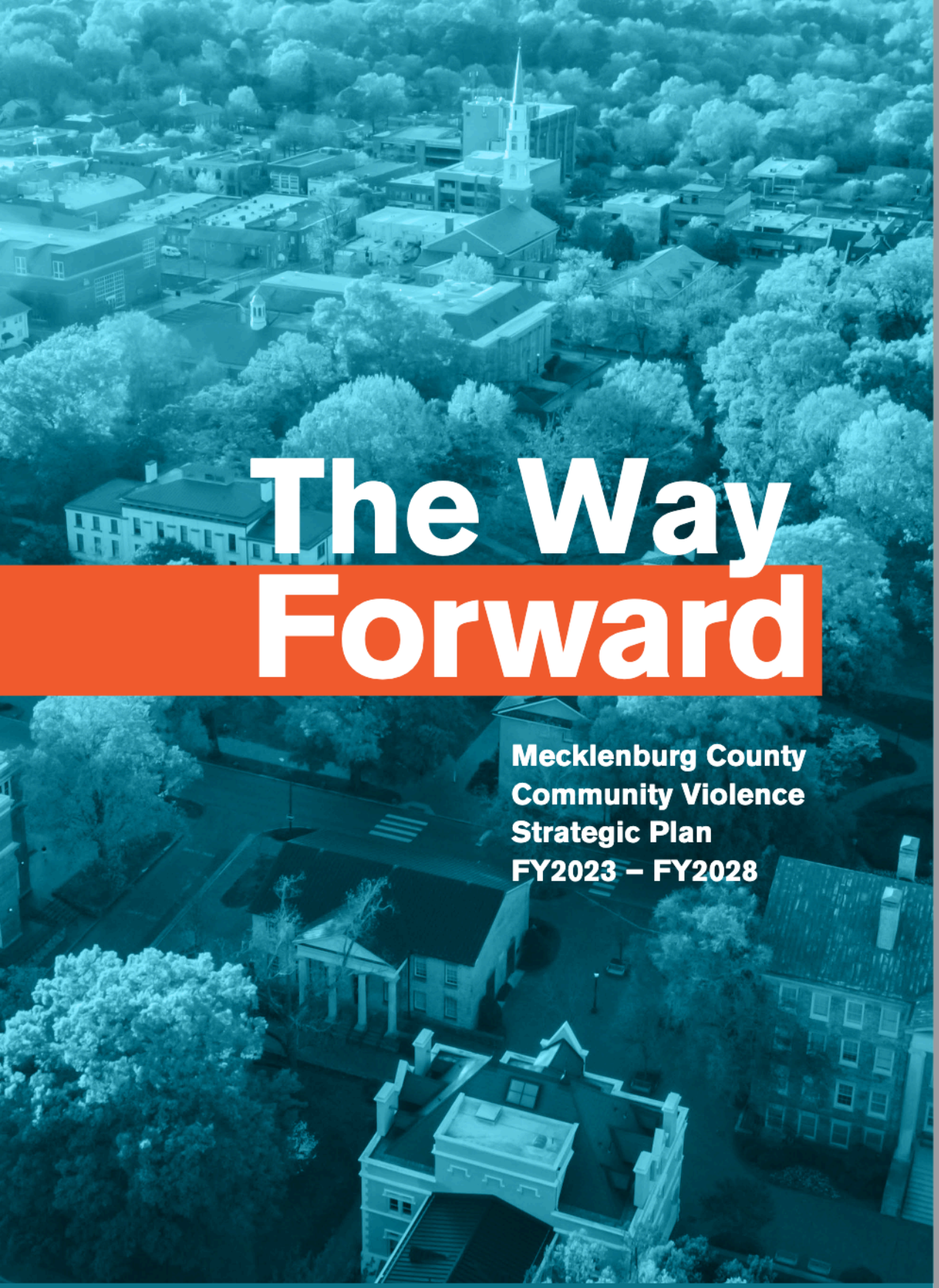
Hospice State Profile

Based on Medicare Claims for 2023 (Through Dec 2023) | Hospice Penetration (2023)

Ranking of States on Hospice Penetration for 2023

State	Value	Rank
Utah	102.1	1
Arizona	95.6	2
Texas	95.5	3
Florida	90.4	4
Alabama	90.3	5
Oklahoma	88.1	6
California	87.6	7
South Carolina	86.1	8
Georgia	85.3	9
Nevada	84.4	10
Ohio	82.7	11
Louisiana	82.6	12
Wisconsin	82.4	13
Rhode Island	82.4	14
Kansas	82.0	15
Delaware	81.5	16
Idaho	80.2	17
Mississippi	79.5	18
Colorado	79.1	19
Minnesota	78.8	20
Iowa	77.8	21
Michigan	77.2	22
Indiana	75.8	23
Missouri	75.3	24
North Carolina	74.6	25
Arkansas	73.9	26
New Mexico	73.0	27
Maine	72.7	28
Tennessee	71.4	29
Virginia	70.4	30
Oregon	70.1	31
New Hampshire	69.6	32
Massachusetts	69.3	33
Illinois	69.0	34
Nebraska	68.6	35
Hawaii	66.5	36
Pennsylvania	66.3	37
New Jersey	64.0	38
Maryland	63.8	39
Connecticut	63.3	40
Vermont	62.1	41
West Virginia	61.9	42
Washington	59.7	43
South Dakota	58.1	44
Kentucky	57.0	45
North Dakota	52.5	46
Wyoming	52.3	47
Montana	51.6	48
District of Columbia	48.8	49
Puerto Rico	41.7	50
Alaska	37.1	51
New York	36.3	52





The Way Forward

Mecklenburg County Community Violence Strategic Plan FY2023 – FY2028

MECKLENBURG COUNTY
North Carolina

Appendix

About Mecklenburg County

Of the 100 counties in North Carolina, Mecklenburg County is the second largest by population. From 2010 to 2020 the county's population grew more than 21% to more than 1.1 million residents which equates to an average yearly growth rate of approximately 2%.[1, 2, 3] Charlotte, the county's largest city, is recognized as one of the fastest-growing cities in the U.S. and was ranked the 16th largest city nationally, based on population figures from 2020.[2]

The median age of county residents in 2020 was 36.8 years. Youth ages 0-17 represented 23.3%, making Mecklenburg County second-largest in the state for total youth population. Meanwhile, the county's senior population is steadily growing, with the age group of 65 years and older representing about 12% of the population.[3]

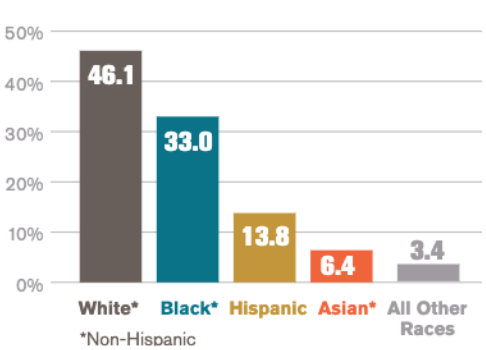
In 2019, median household income for Mecklenburg County was $66,641. In that same year, about 11% of county residents reported that they were living in poverty.[1]

$66,641

2019 Median Household Income

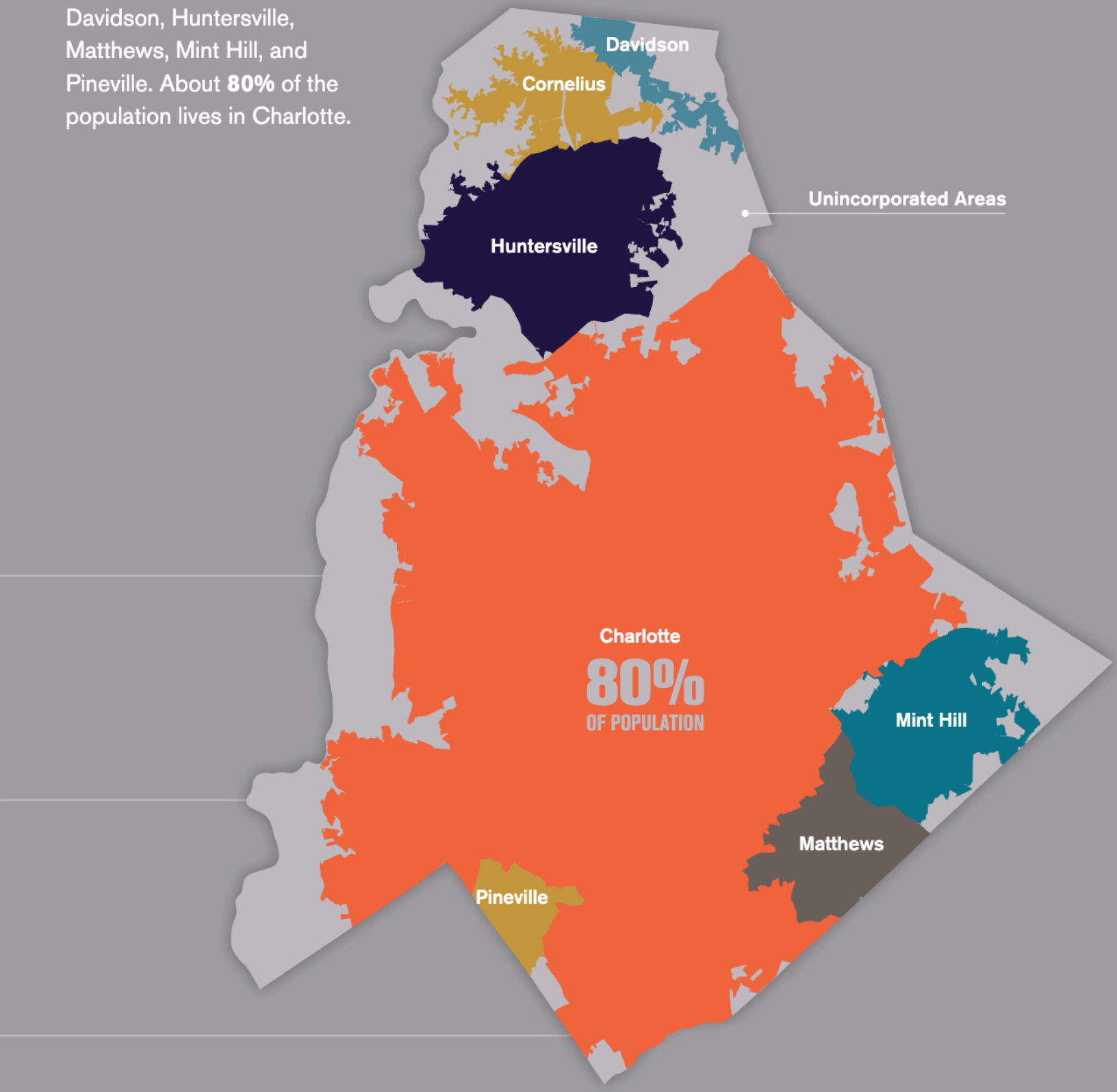
36.8 years

2020 Median Age



MECKLENBURG COUNTY

Mecklenburg County includes six other municipalities along with Charlotte: Cornelius, Davidson, Huntersville, Matthews, Mint Hill, and Pineville. About **80%** of the population lives in Charlotte.



Risk and Protective Factors of Community Violence

Violence has several different forms. There are many factors that increase or decrease the likelihood of violence. These factors are known as **risk factors** and **protective factors**, where risk factors are things that make it more likely that people will experience violence, and protective factors are things that may lessen the chances of experiencing violence.[9, 10]

It is important to understand that risk factors are not a direct cause of community violence, and that protective factors do not ensure an individual or community members will not be involved in violence.[9,10]

Another important thing to understand is that risk and protective factors can overlap in the same way that different types of violence overlap. This can happen because there is a combination of influences at the individual, family, peer, and social levels that affect the likelihood of a person being involved in community violence, either as a victim or someone committing a violent act.[10]

While there are many risk and protective factors related to community violence, the examples below are supported by research and reflect the views Mecklenburg County residents shared through community engagement activities.[9,10] The figure below provides an overview of both types of factors:

Figure 1: **Risk & Protective Factors for Community Violence**

The Burden of Community Violence

Community Violence takes its toll on communities in ways that go far beyond physical injury. In addition to the physical harm or death, victims and others exposed to violence can often experience mental and emotional trauma.[11]

Research shows us that people living in communities where violence is common have an increased risk for developmental, behavioral and health-related problems caused by the longterm stress that is associated with ongoing exposure to violence.

Some critical areas in which frequent exposure to community violence can have negative impacts on a person are:

Learning & Development

- Disrupts brain development causing lower impulse control and impaired ability to concentrate, make decisions and follow instructions.
- Reduces academic performance, which leads to lower educational attainment and can limit career ambitions or opportunities.

Mental Health and Emotional Well-being

- Increases risk of Post-traumatic stress disorder (PTSD), substance abuse, depression and suicide.
- Causes hypersensitivity to threats which can lead to prolonged chronic stress.

Behavior

- Increases likelihood of disruptive, aggressive or violent behavior.
- Increases acceptance of violence as a legitimate response, which can lead to perpetuation of cycle of violence.

Chronic (long-term) Illness

- Extreme increase in the likelihood of negative health behaviors such as smoking, poor nutritional habits, eating disorders and poor sleeping habits.
- Increases risk for obesity as a result of not feeling safe enough to engage in outside physical activity.
- Increases risk for heart disease, diabetes, cancer, and asthma.

The Financial Cost of Community Violence

The financial costs of community violence can be seen at the following levels:[12]

INDIVIDUAL LEVEL

Loss of work and inability to pay bills

Caring for a loved one who experienced a life-changing injury from community violence

COMMUNITY LEVEL

Small businesses moving away from communities where violence becomes common

Companies unwilling to move their headquarters to a city due to it's reputation for violence

BROADER SOCIETY

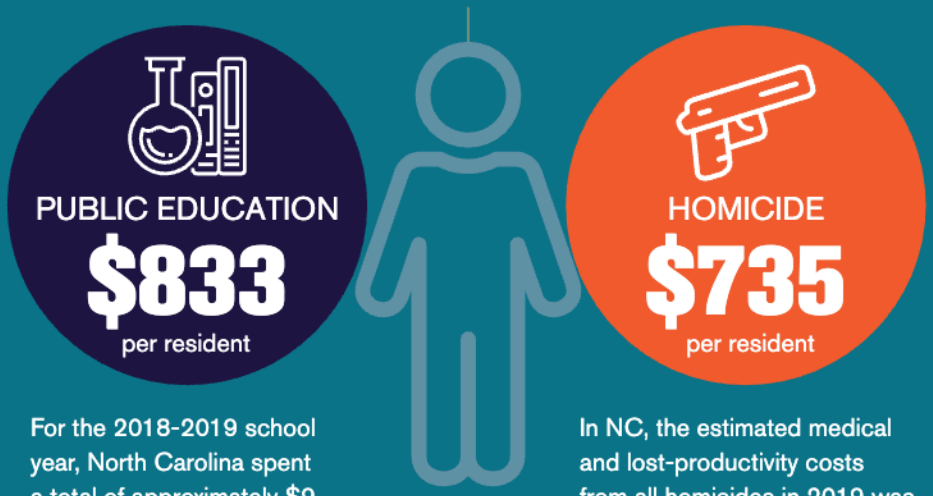
Payment of medical bills for victims who are uninsured or under-insured

Loss of tax revenue from a victim who can no longer work as a result of community violence

The Centers for Disease Control and Prevention (CDC) estimates that homicides cost the U.S. economy around $26 billion each year in medical costs and costs related to lost work and productivity.

COMPARING COSTS

What do we spend?



For the 2018-2019 school year, North Carolina spent a total of approximately $9 billion, or about $833 per state resident.[14]

In NC, the estimated medical and lost-productivity costs from all homicides in 2019 was nearly $8 billion, or about $735 per state resident.[13]

Data from Atrium Health Carolinas Medical Center, the region's only Level-I trauma center, shows some of the financial burdens of violence using 2019 data related to patients being admitted to the hospital with gunshot wounds:[15]

GUNSHOT WOUNDS

What do they cost?

AVERAGE CHARGE:

$80,957

40% of all patients had a charge of over $50,000

AVERAGE LENGTH OF HOSPITAL STAY

5 DAYS

INSURED THROUGH MEDICAID

20%

UNINSURED OR UNDERINSURED

50+%

"Investing in violence prevention efforts in our community has great value and can save funds which may have otherwise been spent on repairing the harms of community violence only after it has occurred."

—OVP Senior Health Manager

Social Determinants of Health

While our health is largely influenced by the choices, we make for ourselves, our ability to make healthy choices greatly depends on the conditions of the places where we are born, live, learn, work, play, worship, and age. These conditions are known as the Social Determinants of Health, (SDOH) and they have a major impact on people's health, well-being, and quality of life.

The SDOH can also be used to explain how differences in health outcomes between different groups can come to exist.[16, 17]

The Crescent and the Wedge

Crime and community violence are a part of neighborhood and built environment where factors such as poverty and differences in income at the neighborhood level have also been linked to higher rates of violent crime.[17,18] In Mecklenburg County, neighborhoods which span across multiple ZIP codes (some of which include 28205, 28206, 28208, 28212, 28216, 28217) form a crescent-shaped area of high poverty levels and decreased educational attainment around the center city of Charlotte.[19]

"The Crescent," as this area is known, is also mostly made-up of communities of color.[20] The concentration of these disadvantaged Black and Brown communities was no accident. Charlotte, NC – like many American cities – is divided by income and social class.

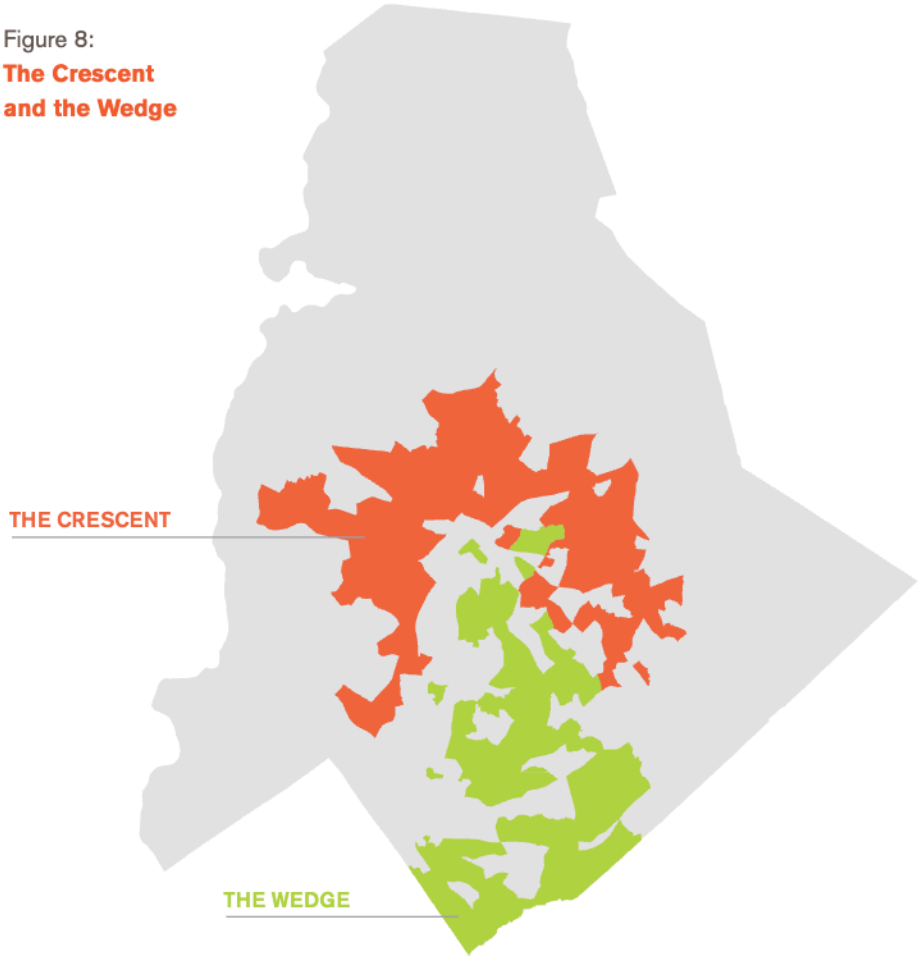
This division – also known as segregation – is the result of historical practices like redlining and other housing discrimination strategies that were harmful to communities of color.[20, 21] Segregation of these low-income neighborhoods of color was followed by years of unequal distribution of resources and a lack of money invested by local government.

Today, this can be seen through lower school performance, less access to safe areas for play or entertainment and green spaces, poor public transportation, and more exposure to pollutants. These things lead to even more damage to the community members who live, work, learn, play and age there over time.[21, 22]

"…the way Charlotte is constructed geographically, it's possible for you to drive from Myers Park into uptown or from Ballantyne, get on 77 and never have to drive through a blighted neighborhood."

—Community engagement activity participant

Figure 8:
The Crescent and the Wedge



Existing Initiatives Addressing Violence in Mecklenburg County

Violence Prevention Data Collaborative (VPDC)

The Violence Prevention Data Collaborative (VPDC) is a partnership between local government and non-government agencies in Mecklenburg County. This partnership began in August 2020 with the purpose of combining and sharing data on violent crime in Mecklenburg County. Data from the VPDC is used to make decisions about programs and policies and to measure the impact of violence prevention programs across the county. The groups involved include the following departments from the City of Charlotte, and Mecklenburg County and community organizations:

- **City of Charlotte:**
  - Innovation & Technology Department
  - Charlotte-Mecklenburg Police Department
- **Mecklenburg County:**
  - Public Health
  - Sheriff
  - Department of Social Services
  - Community Support Services
  - Criminal Justice Services
- **Community Partners:**
  - Charlotte-Mecklenburg Schools
  - Atrium Health
  - Novant Health
  - University of North Carolina Charlotte
  - Johnson C. Smith University

ATV ALTERNATIVES TO VIOLENCE Real Change

Alternative to Violence (ATV): Violence Interruption Pilot

The Alternatives to Violence (ATV) program was created in 2021 through a county and city partnership that focuses on decreasing shootings and killings within the Beatties Ford Road/LaSalle area. By using methods from Cure Violence Global, the program uses data and trusted community messengers to resolve conflict between community members and stop violence before it happens. The program also uses outreach specialists to help individuals receive services and resources to prevent future violence.

ReCAST MECKLENBURG

ReCAST

Created in 2018, the Resilience in Communities after Stress and Trauma (ReCAST) program is funded by a 5-year grant awarded to Mecklenburg County Public Health by the federal Substance Abuse and Mental Health Services Administration. This program focuses on preventing youth violence using the CDC VetoViolence model by giving grant funds to youth organizations in the community and supporting community awareness efforts like HEAL Charlotte's "Stop the Violence" campaign, which uses youth voices to spread violence prevention messages. ReCAST partners with several youth organizations and local churches to strengthen messages used in campaigns and increase street outreach. Future projects include a 15-week summer education program and a partnership with the Mecklenburg County Office of Violence Prevention to create campaigns and violence prevention programs based on youth's experience with violence.

Atrium Health Hospital-based Violence Intervention Program

The Hospital-based Violence Intervention Program (HVIP) at Atrium Health is a program that was created to increase awareness about violence as a public health issue. The program, which started in early 2022, is the first of its kind in North Carolina that provides care and support to survivors who have experienced violence. The program uses data to help identify the needs of survivors and links them to needed services within the county. Key support services include access to healthcare, mental health, legal support, housing, and any other resources that will help support healing among victims of violence.

Safety And Accountability For Everyone (SAFE) Charlotte

Safety and Accountability for Everyone (SAFE) Charlotte is an initiative adopted by Charlotte city council in October 2020. The work aims to rethink public safety while also reviewing policies and practice issues affecting the community, including unemployment, housing, transportation, and workforce development. In 2021, SAFE Charlotte provided $1 million to support grass roots organizations that work to address violence in Charlotte and plans to provide $1 million dollars more in 2022 and 2023 to continue supporting nonprofits focused on violence prevention.

Corridors of Opportunity

The Corridors of Opportunity is an economic improvement program created by the city of Charlotte focused on six areas, known as "corridors," with high job loss and poverty. The city of Charlotte plans to partner with private businesses to provide nearly $40 million dollars to create new job creations, quality services and long-term careers for corridor residents. Projects include affordable housing, community safety, buildings, transportation, workforce and business development, urban design, and financial support for programs addressing violence, including the Alternatives to Violence and Atrium Health's Hospital-Based Violence Intervention Program.

Charlotte-Mecklenburg Police Dept. Youth Programs

There are several youth programs offered by the Charlotte-Mecklenburg Police Department (CMPD) such as the Youth Diversion Program and REACH OUT. The Youth Diversion Program is designed and administered by the Charlotte-Mecklenburg Police Department in partnership with several social service agencies in Mecklenburg County. Its purpose is to offer qualified juveniles ages 6-17 the opportunity to avoid prosecution in the court system by attending an 8-hour life skills class or Teen Court. The CMPD Youth Diversion Program has nearly 800 participants per year and reports a 10% crime recidivism rate among participants.

REACH OUT (Respect, Engage, Accountability, Character, Honesty – Officers Helping Teens) is a youth program run by the Charlotte-Mecklenburg Police Department in partnership with the Mecklenburg County Sherriff's Office and the Division of Adult Correction and Juvenile Justice. This voluntary program provides first-time felony offenders between the age of 15-23 with resources, skills, and support services needed to become successful adults, and allows program participants the chance to complete court-ordered community service in an environment that provides direction and support.

The Carolina Violence Prevention Collaborative (CVPC)

The Carolina Violence Prevention Collaborative is a regional coalition that aims to break the cycle of violence in Mecklenburg County through creative education, advocacy, and collective impact strategies. The collaborative, consisting mostly of grass-roots community-based organizations and other community partners invested in reducing violence, was launched in October 2021. The Collaborative's vision is for a community with less violence and more value. The group's core values include:

- Knowledge sharing
- Collaboration
- A focus on community
- Action-driven strategies
- Innovative solutions

Glossary of Terms

Please note that the definitions below are the functional definitions that the OVP and other County partners use to define the various terms mentioned in the Strategic Plan and may differ from the definitions or descriptions from other agencies, especially for legal definitions of certain terms.

Advocacy: Publicly supporting or suggesting an idea or way of doing something.

Best Practices: Activities that show evidence of being effective in a particular setting and is can be replicated to other situations.

Centers for Disease Control and Prevention (CDC): A national government agency whose mission is to protect public health by preventing and controlling disease, injury, and disability.

Child Abuse and Neglect: Any act or failure to act on the part of a parent/caregiver that results in death, serious physical or emotional harm, sexual abuse/exploitation of a child; Any act or failure to act that presents an imminent risk of serious harm.

Chronic Disease: A disease or condition that usually lasts for 3 months or longer and may get worse over time such as cancer, heart disease, stroke, diabetes, arthritis, etc.

Community Engagement Activities: Activities such as surveys, focus groups, interviews, town halls and forums that allow community members the opportunity to express their views and provide input on community topics.

Community Partners: People, groups or organizations (both for-profit and non-profit) that work together to share information, services or provide other types of support.

Community Violence: Violence which happens between unrelated individuals, who may or may not know each other, generally taking place outside of the home.

Comprehensive Public Health Approach: A multi-step process used to address a public health problem that involves defining and measuring a problem, determining the cause/risk factors of a problem, developing and testing prevention strategies and assuring widespread adoption of effective strategies.

Domestic Violence: Physical or non-physical violence or abusive behavior occurring between people in a current or former domestic situation including current or former spouses, intimate partners, dating partners, roommates, or household members; Domestic violence can occur between people of any sex, sexual orientation, gender identity, or background.

Economic Advancement/Mobility: Opportunities for someone to gain education, training, and skills in order to find a job, increase their income, and improve their overall financial status.

Elder Abuse: A purposeful or careless act by a family member, caregiver, or other person in a trusting relationship that harms an older person; Elder abuse may include abuse that is physical, emotional or sexual as well as neglect and financial misuse.

Equity: The absence of unfair or avoidable differences among groups of people.

Evaluation: Methods used to identify what can be done to address a health problem as well as to determine the relevance, usefulness, and impact of a program, practice or policy.

Family Support Services: Community-based services that are designed to offer assistance, training or other resources related to the effective care of children by caregivers or the overall wellbeing of families; Some support services that serve families can also include temporary food, financial or housing aid.

Hospital Based Violence Prevention Programs: Programs that reach survivors of violence in the hospital and link patients to community resources aimed at addressing underlying risk factors for violence.

Infectious Disease: A disease caused by a living organism that can be spread to another, either directly or indirectly, such as through a vector (e.g. food or mosquitoes).

Intimate Partner Violence: Physical or non-physical violence or abusive behavior occurring between current or former intimate partners, dating partners, or spouses for the purpose of one partner maintaining power and control over the other. Intimate partner violence can occur between partners of any sex, sexual orientation, gender identity, or background.

Median (calculation for age, income, etc.): A number, value, or amount that is in the middle of a series of numbers, values, or amounts.

Post-Traumatic Stress Disorder (PTSD): A chronic mental health condition that is caused by either experiencing or witnessing a traumatic event.

Primary Prevention: Approaches that aim to prevent violence before it happens by decreasing the risk factors for violence and increasing the protective factors against violence.

Protective Factors: Conditions that may lessen the chances of someone experiencing violence.

Public Health: The science of protecting and improving the health of people and their communities; This work is achieved by promoting healthy lifestyles, researching disease/injury prevention, and detecting, preventing and responding to infectious diseases.

Publishing Data: Sharing plan data back with community-based organizations, hospitals, public agencies, boards of health, and the general public; This can be done through sharing on websites, uploading to data dashboards or submitting to academic journals.

Redlining: A racial discrimination practice in housing that used government maps to outline areas where Black residents lived and that characterized them as risky investment areas.

Re-entry Programs: Programs that provide services to individuals who are "re-entering" the community after being released from state or federal prison or county jail.

Restorative Justice Programs: Programs that focus on those who have been harmed and how to repair the harms they have experienced by offering opportunities to communicate and address their needs after a crime.

Risk Factors: Conditions that make it more likely that someone will experience violence.

Secondary Prevention: Approaches that focus on the more immediate responses to violence, which happen either during or immediately after it occurs.

Segregation (referring to racial residential segregation in the U.S.): Instances when African-Americans were intentionally isolated to certain neighborhoods within communities and large cities.

Sexual Violence: Forcing, attempting to force or coercing someone to take part in sex or a sex act against their will and/or without consent.

Social Determinants of Health: The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness; These circumstances are in-turn shaped by a wider set of forces: economics, social policies, and politics.

Tertiary Prevention: Approaches that focus on the longer-term impacts and consequences of violence to either prevent further harm or to prevent repeated acts of violence.

Trauma: A mental or emotional response to an event or an experience that is deeply stressful or disturbing.

Victimization: The act of making someone into a victim by harming them, either through physical violence, emotional/psychological abuse or secondary exposure to a traumatic event.

Violence Interrupter Programs: Programs that use neighborhood/community members to reach those who are affected by gun violence and build relationships to address conflict through nonviolent means, including disruption and mediation; These programs may also assist people in finding housing, education, and job opportunities.

World Health Organization (WHO): A group within the United Nations that addresses major health issues around the world by conducting educational and research programs as well as through publishing scientific papers and reports.

Youth Development Programs: A group of structured activities offered to young people (usually between the ages of 6-18) that offer either an educational, emotional, spiritual or physical benefit and often help to develop useful life skills.