NYC HEALTH+ HOSPITALS | Bellevue

2016

IMPLEMENTATION STRATEGY

Implementation Strategy, 2016 Update

Purpose of the Community Health Needs Assessment and Implementation Strategy

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

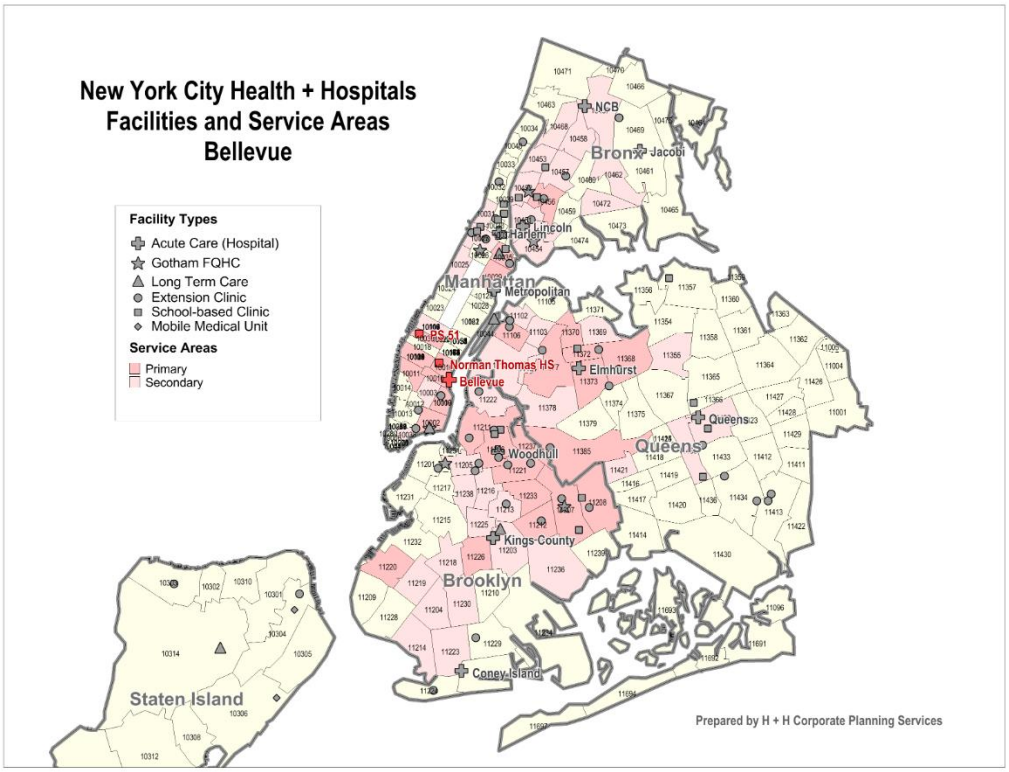
Community Served

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

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

Located on an 11-acre campus based on First Avenue and 27th Street in the Gramercy Park-Murray Hill neighborhood in Manhattan, NYC Health + Hospitals / Bellevue serves a diverse patient population from communities throughout the New York metropolitan area service area which includes the neighborhoods of Bedford Stuyvesant /Crown Heights, Chelsea/Clinton, East Harlem, East New York, Flatbush/E. Flatbush, Gramercy Park/Murray Hill, Greenpoint, Highbridge/Morrisania, Long Island City/Astoria, Ridgewood/Forest Hills, Sunset Park, Union Sq./Lower East Side, West Queens, and

Williamsburg/Bushwick.1 The map below shows the primary service area in red. Bellevue is labeled in red and other NYC Health + Hospitals sites are in gray. The NYC Health + Hospitals / Bellevue service area encompasses many neighborhoods that the federal Health Resources and Services Administration (HRSA) has identified as being medically underserved and/or or having a shortage of health providers (HPSA) and also has a facility-specific mental health HPSA designation for high average daily census and workload.2



Required Components of the CHNA

1) Definition of community served
2) A prioritized description of the significant health needs of the community

[1] Primary service area is defined as the Zip codes that comprise the residence of 50% of its ambulatory patients. Primary and Secondary service area combined comprise 75% of patients and includes the Zip codes: 10001, 10002, 10009, 10010, 10011, 10016, 10029, 10035, 10036, 10456, 11106, 11206, 11207, 11208, 11211, 11212, 11220, 11221, 11226, 11233, 11237, 11368, 11370, 11372, 11373, 11377, and 11385.
[2] A Medically Underserved Area /Population (MUA/P) designation applies to a neighborhood or collection of census tracts based on four factors: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. A Healthcare Provider Shortage Area (HPSA) is a collection of census tracts that has been designated as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals).

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

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

Requirements of the Implementation Strategy

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

Process and Methods for Conducting the CHNA

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

- Heart disease, high cholesterol, stroke
- Cancer
- Diabetes
- Asthma and other breathing issues
- Hypertension/ high blood pressure
- Violence

- Mental illness and psychiatric disorders
- Dementia including Alzheimer's
- Obesity
- Premature births, low birth weight
- HIV, Hepatitis, STDs
- Alcohol and/or drug use
- Smoking

Community and Facility Input

Community Advisory Board ("CAB")

The process used to conduct the 2016 CHNA was presented to each CAB individually. A survey was administered anonymously and confidentially to each CAB member asking them to indicate the relative importance of each of the 13 identified community health needs in their community. In an open discussion, CAB members were also asked about community health needs not included in the survey question. These responses were coded for inclusion in the prioritization matrix (see detailed explanation below).

Facility Users

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

Facility Leadership

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

Secondary Data

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

Prioritization of Community Health Needs

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

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

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

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

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

NYC Health + Hospitals Comprehensive Response to Community Health Needs

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

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

OneCity Health is the NYC Health + Hospitals /led PPS which includes the NYC Health + Hospitals system's integrated network of 11 hospitals, 5 nursing homes, dozens of community based health centers, NYC Health + Hospitals/Home Care, NYC Health + Hospitals' health insurance plan, MetroPlus, and more than 400 community partners across the region. Focused on identifying and engaging patients in care before they become sick, OneCity Health is undertaking 11 initiatives, or projects, to become an integrated delivery system of health and social service providers that closes critical gaps in the continuum of care and reduces avoidable hospital use by 25 percent by 2020.

The Implementation Strategy below includes The NYC Health + Hospitals/Bellevue's DSRIP projects as well as facility-specific initiatives that will address the "significant," or top 5, community health needs identified through the CHNA process

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
Cardio-vascular disease; Hypertension	DSRIP - improve cardiovascular disease management	Support primary care excellence in cardiovascular health (e.g., aspirin use, blood pressure control, cholesterol management, smoking cessation); support patient self-management of cardiovascular health; reduce preventable hospitalizations and emergency room visits	High-risk and affected populations	Follow standardized treatment protocols for hypertension and cholesterol management; adopt strategies from the Million Hearts Campaign; providers to support tobacco control; employ patient self-management plans; coordinate with CBOs to support education and cultural competencies; Health Homes to coordinate care management to existing disease management activities	Potentially avoidable admissions, readmissions, and ER visits, aspirin use; adequately controlled blood pressure; admissions with a principal diagnosis of hypertension; smoking advice and cessation medications health literacy, self-management goals.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Cardiovascular Risk Registry	Identify, manage, and target patients with hypertension in order to ensure population chronic disease management, adherence to medications and other treatment plans	All patients in the primary care panel with cardiovascular disease	Using data to identify high risk patients, patients in the cardiovascular risk registry are monitored closely by the care team, with frequent patient contact. This includes outreach such as mailing, calls and nurse visits for pressure checks. For patients not at blood pressure goal, additional outreach measures are taken to improve control	Percentage of total population with hypertension whose blood pressure is well controlled
	Treat to Target	Standardized care pathway for patients with uncontrolled blood pressure utilizing multidisciplinary care team and increased patient engagement	All hypertensive patients in the primary care panel	Using goals for blood pressure levels and action plan, and standardized care pathways, hypertensive patients work closely with nurses who monitor and assist with medication adjustments, nutritional education, and lifestyle counseling.	Percentage of patients with hypertension whose blood pressure is well controlled, percentage of patients enrolled in Treat to Target who achieve successful BP control

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Cardiovascular Disease Post Discharge Clinic	To decrease readmissions and ensure adherence with treatment plans for inpatients discharged with cardiovascular disease	Inpatient discharges related to cardiovascular disease	An outpatient clinic managed by an internist that provides medication management, stabilization and short term monitoring for patients recently discharged to ensure treatment plans are executed and effective.	30 day re-admission rate for cardiovascular disease patients
Obesity	Center for Medical Weight Management	To provide non-surgical weight loss programs that enable patients to achieve their goals	Patients referred for obesity with a BMI greater than 30.0	Provide intensive medical treatment for obesity. Services include: intensive lifestyle counseling and goal-setting; individualized nutrition and physical activity recommendation and pharmaco-therapy treatments are specifically tailored to a patient's cultural background, functional capacity, and other medical conditions. Includes a Pediatric weight management program for children.	Patients successfully meeting and maintaining weight goals

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Bariatric Surgery	To provide a surgical treatment program for obesity	Patients referred for obesity with a BMI greater than 35.0	Provide comprehensive care for Bariatric Surgery patients including pre-surgical medical weight management interventions leading up to surgery. Patients undergo multi-disciplinary evaluation to ensure that the surgical procedure will be successful. Psychological, nutritional, and after care education are provided prior to and after the surgery.	Number of patients receiving bariatric surgery at Bellevue, successful weight loss
Diabetes	Diabetes Registry	Identify, manage, and target patients with Diabetes in order to ensure population chronic disease management, adherence to medications and other treatment plans	All Diabetic patients in the primary care panel	Using data to identify and track Diabetes patients in order to ensure adherence with appropriate treatment plans. Patients out of compliance outreach mailing, calls and regular nurse visits for A1C level checks, nutrition education, and group visits.	Rates of Diabetes patients with controlled blood sugar, blood pressure, and appropriate screening.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Mobile Insulin Titration Intervention (MITI) Program	To use mobile technologies to improve Diabetes management and empower patients to be an active member of their care team	Insulin-dependent Diabetic patients with poor control of blood sugar	Patients sent a daily text reminder to check their blood sugar levels and text back the results, which are reviewed by nurses. Patients and nurses communicate weekly and adjust medication dosages as needed.	Rate of enrolled patients who achieve blood pressure control
Mental Illness	DSRIP -- Integration of primary care and behavioral health services)	Ensure optimal care coordination by providing coordinated, accessible behavioral health and primary care to patients with behavioral health issues, and reduce hospital admissions and ED visits for patients with behavioral health issues	Patients with undiagnosed conditions including depression, alcohol abuse; patients with mild / moderate / complex behavioral health problems; behavioral health patients with difficulty navigating routine primary care services	Employ evidence-based standards of care including medication management and care engagement process; preventive care screenings including behavioral health screenings (e.g. PHQ-2 or 9 for those screening positive, SBIRT) shared EHR/ clinical records.	Patients in primary care setting receiving appropriate preventive care mental health/SA screenings; patients receiving primary care services at a participating mental health or substance abuse site; patients screened using the PHQ-2 or 9/ SBIRT.