NYC HEALTH+ HOSPITALS | Harlem

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 also required subsequently to list and describe the clinical services and programs available to meet the health needs identified in the CHNA.

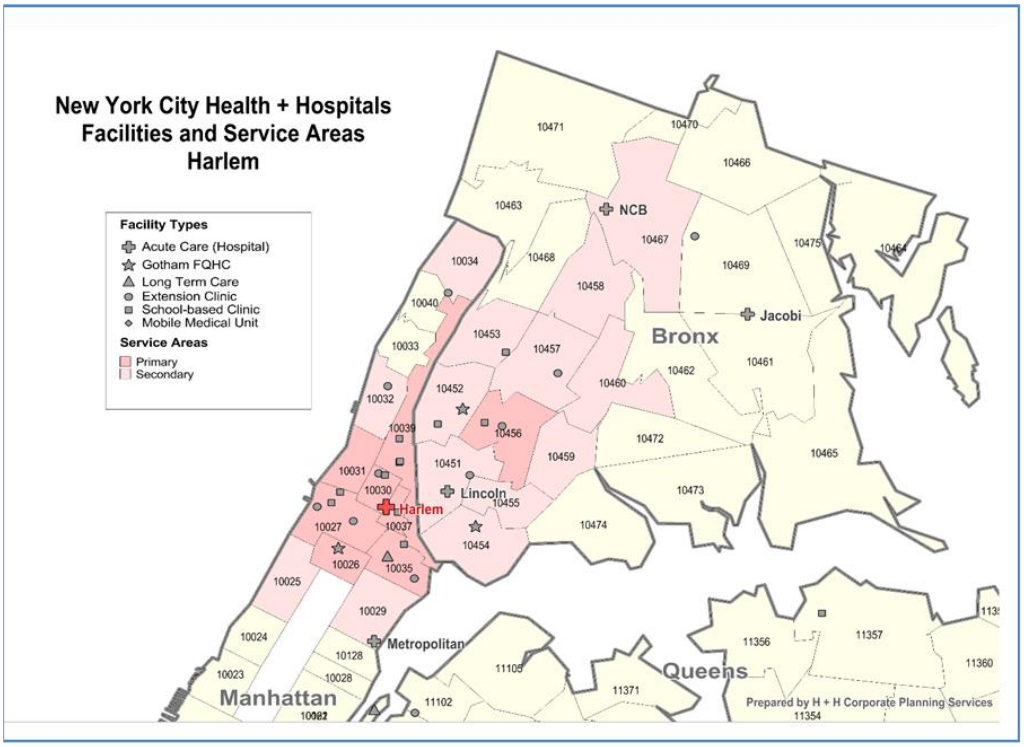
Community Served

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.

NYC Health + Hospitals / Harlem and its extension sites provide the full spectrum of preventive, ambulatory, and inpatient care for children and adults. NYC Health + Hospitals / Harlem 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 / Harlem is a healthcare facility in Central Harlem, providing healthcare services to the residents of Harlem, Upper Manhattan and the South Bronx. Located in Central Harlem at 506 Lenox Avenue in the Zip code 10037, Harlem Hospital provides healthcare for an ethnically and economically diverse service area which includes the neighborhoods Central Harlem/Morningside Heights, Crotona/Tremont (Bronx), East Harlem, Fordham/Bronx Park (Bronx), Highbridge/Morrisania (Bronx),

Hunts Point/Mott Haven (Bronx), Upper West Side, and Washington Heights/Inwood.[1] The map below shows the primary service area in red and the secondary service area in light red. Other NYC Health + Hospitals sites are identified in gray. The NYC Health + Hospitals / Harlem 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).[2] NYC Health + Hospitals / Harlem is specifically located in special population (Medicaid) Dental, Mental Health, Primary Care HPSAs and the West-Central Harlem medically underserved population.



NYC Health + Hospitals / Harlem provides a disproportionate share of services for the borough's low income and uninsured population. In 2014, 22% of its ambulatory visits, and 25% of its ED visits were uninsured compared with 5% and 13%, respectively, at Voluntary Manhattan hospitals. In addition, 69% of its inpatient discharges were either uninsured or enrolled in Medicaid, compared to 26% at Manhattan's Voluntary hospitals.

[1] Primary and Secondary Service area is defined as the Zip codes that comprise the residence of 50% and 75% of its ambulatory patients, respectively. Harlem Hospital's primary and secondary service area includes zip codes: 10025, 10026, 10027, 10029, 10030, 10031, 10032, 10034, 10035, 10037, 10039, 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10458, 10459, 10460, and 10467.

[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).

Required Components of the CHNA

1) Definition of community served
2) A prioritized description of the significant health needs of the community
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 NYC Health + Hospitals / Harlem'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	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	Al 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

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	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 (national initiative led by the CDC and CMS); providers to support tobacco control; employ patient self-management plans; coordinate with community based organizations 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
	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, an 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	Treat to Target
	Cardiovascular disease care manager support	To reduce preventable hospitalizations and emergency room visits, to decrease the number of hospital readmissions	Patients diagnosed with congestive heart failure	Employ a continuum of early detection and diagnostic and treatment services including nutritional counseling, smoking cessation, hypertension and cholesterol screening and exercise programs to provide effective management strategies.	Potentially avoidable admissions, readmissions, and ER visits, aspirin use; adequately controlled blood pressure; admissions with a principal diagnosis of hypertension

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Collaborative Care for chronic disease management	Provide support and counseling services to patients who are identified as depressed and have a chronic disease	Patients diagnosed with depression and have an uncontrolled chronic disease	Nurses and behavioral health professionals work with patients to develop self-management goals. Guidelines are established by clinical team at NYC Health + Hospitals	Adequately controlled blood pressure, ER visits, self-management goals.
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.
	Collaborative Care for chronic disease management	Provide support and counseling services to patients who are identified as depressed and have a chronic disease	Patients diagnosed with depression and have an uncontrolled chronic disease	Nurses and behavioral health professionals work with patients to develop self-management goals. Guidelines are established by clinical team at NYC Health + Hospitals	Adequately controlled blood pressure, ER visits, self-management goals.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
Asthma	Hiring of asthma educators	To reduce the number of asthma related ED visits	Persons with asthma or at high risk of getting asthma	Engage patients before and after provider visit, educate inhaler technique and general information.	Asthma related ED visits
	Home to School to Hospital	To reduce the number of pediatric asthma hospitalizations	Children with asthma	Provide comprehensive asthma screening, treatment, case management and home interventions for children in Central Harlem. Home intervention services include: HEPA vacuum cleaner and air purifier, allergy free mattress and box spring covers, allergy free pillowcases, spacers for metered dose inhalers, peak flow meter and pest management services for severe home environmental conditions.	Asthma related ED visits
Smoking	Quit Smoking program	To educate patients who smoke and support tobacco cessation	Smokers who are referred from their primary care doctors	Counsel and educate patients on the risks of smoking. Nicotine replacement therapy and patches are provided.	Number of program enrollees; population screening an follow-up rates

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
Substance Abuse	Chemical Dependency Outpatient Clinic	Provide supportive counseling to persons with substance use disorders	Patients with substance use disorders	Provide a full range of services based on patient need and readiness to change chemicals as opiate dependence (heroin), alcohol dependence, crack cocaine or powered cocaine when coupled with either opiates or alcohol.	Behavioral health data systems, medical records, substance abuse community data
	Medically Managed Detoxification Unit	To treat patients through detoxification	Patients with substance use disorders who present to the hospital and agree to detoxification support	Medically managed unit provides care for patients treated for using alcohol, opiates and/or cocaine	Medical records, substance abuse community data.
	Substance Abuse prevention for adolescents	To provide evidence-based substance abuse prevention services	Adolescents at risk for HIV, Substance use and currently have HIV	Includes HIV and Substance Abuse prevention workshops with community based organizations, culturally sensitive social media outreach and engagement related to substance abuse and HIV prevention, training to staff at the Hospital's Adolescent medicine clinic on Substance abuse and HIV prevention.	Self-management goals, measures established by SAMHSA