NYC HEALTH+ HOSPITALS | Kings County

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

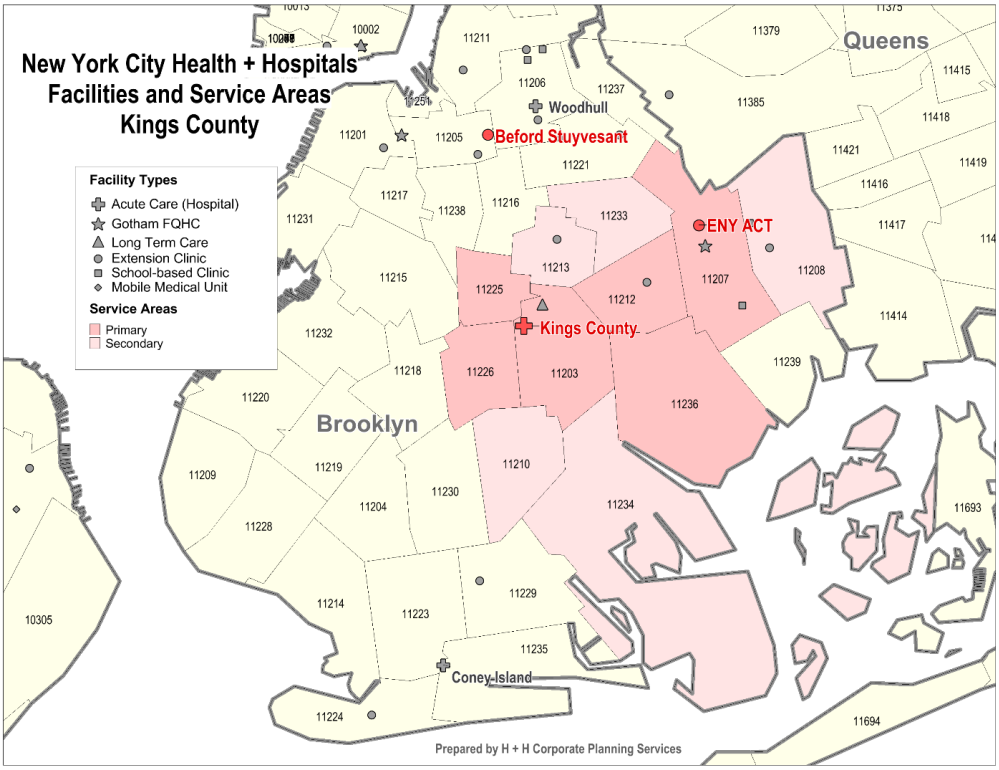
NYC Health + Hospitals serve all New Yorkers in every neighborhood in New York City regardless of their ability to pay. Addressing disparity throughout New York City, NYC Health + Hospitals is *the* safety-net for the uninsured and underserved in New York City.

The NYC Health + Hospitals/Kings County and its extension sites provide the full spectrum of preventive, ambulatory, and inpatient care for children and adults. NYC Health + Hospitals/Kings County 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.

Located in the heart of Central Brooklyn in the neighborhood of East Flatbush-Flatbush at 451 Clarkson Avenue in Zip code 11203, NYC Health + Hospitals / Kings County's primary service area includes the zip codes: 11203, 11207, 11212, 11213, 11226 and 11236 and secondary service area of zip codes 11208, 11210, 11225 and 11233. These 10 zip codes comprise much of the neighborhoods of Bedford Stuyvesant, Crown Heights, Canarsie/Flatlands, East New York and Flatbush/East Flatbush.[1] The map below shows the primary service area in red and the secondary service area in light red.

[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.

Kings sites are labeled in red and other NYC Health + Hospitals sites are in gray. The NYC Health + Hospitals / Kings County 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 providers.[2] NYC Health + Hospitals / Kings is specifically located in a federally designated primary care HPSA, a mental health HPSA, a dental HPSA, and the Crown Heights medically underserved area. NYC Health + Hospitals / Kings also has a facility-specific mental health provider shortage designation for high average daily census and workload.



[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).

NYC Health + Hospitals / Kings County provides a disproportionate share of the borough's low income and uninsured population. In 2014, 33% of their ambulatory visits, and 31% of their ED visits were uninsured compared to 7% and 11% at Voluntary and State hospitals in Brooklyn. In addition, 67% of its inpatient discharges were either uninsured or enrolled in Medicaid, compared to 42% at Brooklyn Voluntary and state hospitals.

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 / Kings County 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, Cholesterol Stroke	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
	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
	Treat-To-Target Hypertension Program	Reduce hypertension target levels to 140/90 in patients enrolled in *Treat-To-Target Hypertension Program* at Kings County Hospital.	Adult patients with uncontrolled hypertension seeking primary care services.	Continue to identify adult patients with uncontrolled hypertension and enroll them in an intensive care management that includes a home blood pressure monitor, medication adherence counseling, and follow-up with an RN to ensure the patient reaches target blood pressure levels.	Achieve a reduction in a population-level blood pressure target of 140/90.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Wellness Center Hypertension Exercise Program	Promote greater compliance of patients diagnosed with hypertension and other cardiovascular risk factors by engaging them on maintaining a personal exercise routine.	Patients with hypertension (and other cardiovascular risk factors) needing assistance on initiating and maintaining physical activity.	Identify adult patients with hypertension and other related cardiovascular disease and enroll them in a regularly scheduled basic aerobic exercise program supervised by staff within the Wellness Center and primary care management staff.	Achieve a level of continued participation of patients enrolled in a regular aerobic exercise routine.
	"Fit Kids" Weight and Healthy Heart Initiative	Promote healthy heart activities and sustained regular physical activities in overweight/ obese pediatric patients.	Overweight/obese pediatric patients with age-specific BMI levels above the 85th percentile.	Identify and enroll pediatric patients with an age-specific BMI above the 85th percentile in an ongoing and personalized health behavior action plan under the supervision of a primary care physician.	Patients screened in primary care, patients enrolled, program attendance levels, and record of physical activities from logbook
	Anticoagulation Program for Patients with or at High Risk of Stroke With Atrial Fibrillation	Promote better anti-coagulation medication compliance in adult patients at high risk for stroke with atrial fibrillation.	Adult patients at high risk of stroke with atrial fibrillation.	Identify and enroll adult patients with or at high risk of stroke with atrial fibrillation in a program on maintaining compliance with their anti-coagulation medication regime using in-person and telephone-based encounters.	Patients identified in primary care, patients enrolled, patients contacted, monthly medication renewals

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Heart Health Behavior Program	Increase the number of obese patients with elevated BMI enrolled in a physical activity and healthy diet regime using a multi-lingual, low literacy goal setting card.	Primary care patients screened for obesity and elevated BMI levels	Identify and enroll obese patients with elevated BMI levels into a personalized health action plan encompassing specific physical activity and dietary goals using a multi-lingual, low literacy goal setting card under the supervision of a primary care professional.	Patients screened in primary care, patients enrolled, program attendance levels, record of physical activities from goal setting card, and record of dietary goal setting card
Diabetes	DSRIP– Care Transitions	To provide a 30-day supported transition period for patients who are being discharged from the hospital and are at high risk of readmission	Patients identified early in their hospital stay as having a high risk of readmission	Identify high risk patients using risk stratification algorithms and on-site assessments. Assess patient needs in the hospital and develop a care plan prior to discharge. Transition management teams will bridge the patient to resources in the community setting by leveraging the OneCity Health partner network and screen and refer patients for community-based programs.	Number of participating patients with a care transition plan developed prior to discharge; pain; depression; advanced directives.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Diabetes Education Program	Reduce A1C levels in individuals participating in program at course completion.	Diabetic patients seeking primary care services.	Continue to identify adult patients with diabetes and enroll them in an intensive six-week diabetes education course focused on how to apply healthy eating and other lifestyle concepts to real-life situations.	Achieve a reduction in population level A1C levels from baseline.
	Diabetes Care Management	Reduce the number of patients documented with uncontrolled diabetes using insulin.	Patients with uncontrolled diabetes using insulin utilizing primary care services.	Identify adult patients with uncontrolled diabetes and enroll them in an outpatient-base program that provides medication adherence through a mixture of clinic-based and telephone-based care management.	Pre- and post glucose levels, registrant and clinic/contact records and completion rates
Mental Health	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.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Behavioral Health Primary Care Clinic- Fully Integrated Patients	Maintain and improve medical and Behavioral Health (BH) outcomes for "fully integrated" patients; Maintain progress with patients at the lowest appropriate level of care, who have shown improvements with functioning in the community; and increase access to BH services for patients in need.	Patients receiving "fully integrated" behavioral health and medical care in the Behavioral Health Primary Care Clinic.	**Plan:** Continue to implement and monitor the model of the "fully integrated care" and transition behavioral health patients from Adult Outpatient Department (AOPD) to Primary Care Clinic (PCC). Continue training modules for PCC staff targeting key behavioral health disorders (i.e. depression, psychosis, and substance use) and care provision using model with access to a consulting psychiatrist.	Improved patient care outcomes evidenced by attendance at "integrated" appointments, low utilization of BH services including Comprehensive Psychiatric Emergency Program (CPEP) and inpatient, and improved medical outcomes.
	Ambulatory Detox Program	Enhance access to substance abuse treatment services by adding ambulatory detoxification to the continuum of care; Reduce unnecessary utilization of inpatient detoxification services.	Individuals seeking detox level of care for addictions treatment.	Develop ambulatory detoxification program as a new level of care to attract additional patients as an alternative to inpatient care for appropriate candidates.	Improved access to medication-assisted treatment for addictions by attracting new individuals into ongoing care while decreasing length of stay and unnecessary inpatient admissions for detox services

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Kings Early Episode Psychosis Program (KEEP)	Improve and maintain behavioral health outcomes for unstable patients while reducing unnecessary utilization of CPEP and inpatient services.	Patients with early onset psychotic disorders recently released from psychiatric inpatient or at risk for psychiatric acute care hospitalizations.	Identify and enroll patients with early onset psychotic disorders or at risk for them in an ambulatory behavioral health program for regular and ongoing high-level care management overseen by behavioral health team.	Improved patient care outcomes evidenced by program participation and low utilization of acute care BH services including CPEP and inpatient.
Cancer	No Cost Colon Cancer Screening Program	Increase the number of adults screened in primary care services to determine whether they have had a previous colonoscopy at 50+ years and/or follow up colonoscopy within 10 years per clinical standard; and refer that population for a colonoscopy as required; Improve the number of those completing a colonoscopy exam; and refer those with a positive outcome into the necessary treatment in a timely fashion.	Patients seeking care in a primary care clinic setting	Survey all patients receiving primary care services that are at age-specific risk for colon cancer to facilitate referral to initial and follow up colonoscopy screening, and treatment as appropriate.	Increased number of adult primary care patients who are screened for and obtain a colonoscopy procedure at 50+ years and follow up at 10 years. Increase the number of persons referred to treatment with a positive colonoscopy outcome.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Smoking and Tobacco Cessation Program	Identify and promote the use of nicotine replacement therapy in persons who use tobacco products.	Patients who use tobacco products	Identify primary care and hospital patients for risk factors related to tobacco use and enroll them in a tobacco cessation and counseling program under the supervision of a primary care physician.	Increase the number of patients identified with risk factors for tobacco use utilizing tobacco cessation and counseling services.