NYC HEALTH+ HOSPITALS | Woodhull

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

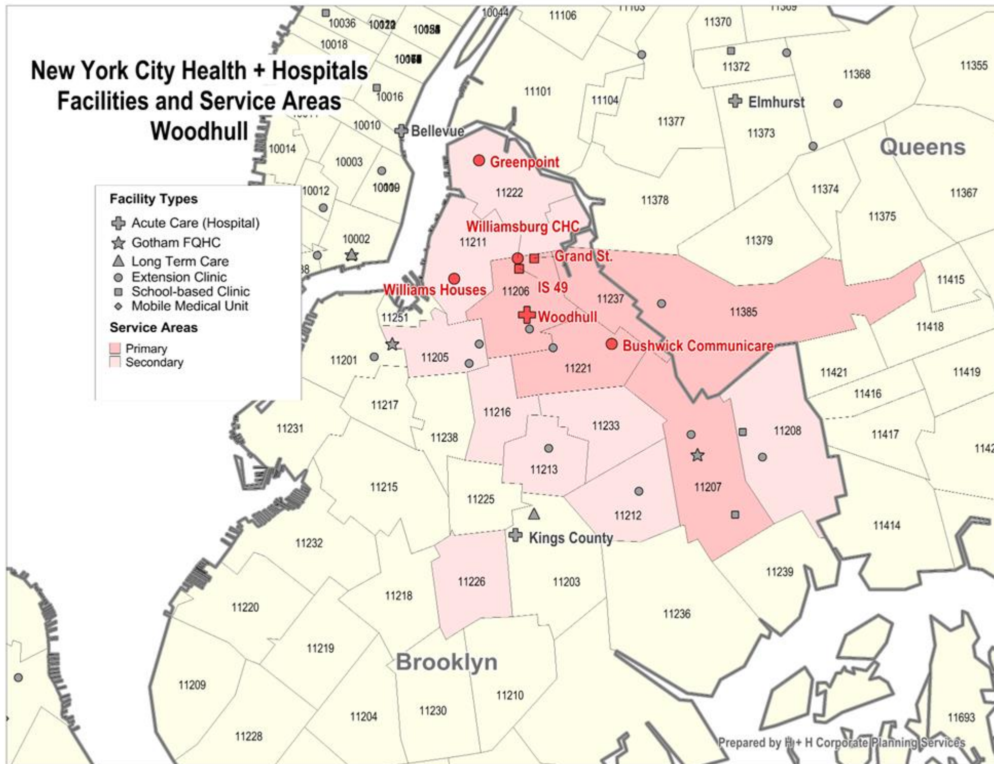
NYC Health + Hospitals serve all New Yorkers in every neighborhood in New York City regardless of their ability to pay. Addressing disparity throughout New York City, NYC Health + Hospitals is the safety-net for the uninsured and underserved in New York City.

The NYC Health + Hospitals/Woodhull and its extension sites provide the full spectrum of preventive, ambulatory, and inpatient care for children and adults. NYC Health + Hospitals/Woodhull 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 at the intersection of three northern Brooklyn neighborhoods – Williamsburg, Bushwick, and Bedford-Stuyvesant in Zip code 11206, Woodhull's service area includes the neighborhoods of Bedford Stuyvesant/Crown Heights, Downtown/Heights/Slope, East New York, Flatbush/E. Flatbush, Greenpoint, Ridgewood/Forest Hills, and Williamsburg/Bushwick.[1] The map below shows the primary service area in red and the secondary service area in light red. Woodhull sites are labeled in red and other NYC Health + Hospitals sites are in gray.

[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. Woodhull's primary and secondary service areas includes Zip codes: 11205, 11206, 11207, 11208, 11211, 11212, 11213, 11216, 11221, 11222, 11226, 11233, 11237, and 11385.

The NYC Health + Hospitals / Woodhull 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] Woodhull is specifically located in a federally designated primary care HPSA, a mental health HPSA, and a dental HPSA and also has a facility-specific mental health provider shortage designation for high average daily census and workload.



NYC Health + Hospitals / Woodhull provides a disproportionate share of services for the borough's low income and uninsured population. In 2014, 32% of its ambulatory visits, and 32% of its ED visits were uninsured compared to 7% and 11% at Voluntary and State hospitals in Brooklyn. In addition, 73% of its inpatient discharges were either uninsured or enrolled in Medicaid, compared to 42% at voluntary and State hospitals in Brooklyn.

Required Components of the CHNA

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

[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 NYC Health + Hospitals / Woodhull'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.

Health Need	Action/Project	Objective	Target Population	Implementation Strategy	Anticipated Outcome
Hypertension	DSRIP – Cardiovascular Health	Improved primary care as related to cardiovascular health, including aspirin use, blood pressure control, cholesterol management, and smoking cessation.	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	Decrease in number of admissions with a principal diagnosis of hypertension, number of people whose blood pressure was adequately controlled.

Health Need	Action/Project	Objective	Target Population	Implementation Strategy	Anticipated Outcome
	DSRIP – Care Transitions	Reduce 30-day readmissions by means of a supported transition period for patients at high risk for readmission.	Patients identified early in their hospital admission as having a high risk for readmission – risk can be from medical, social, behavioral health needs, etc.	Transition management for high risk patients includes “prescribed” care management by a multidisciplinary team considering multiple domains, coordinated by a transition manager, whose dedicated role is to work with inpatient staff and the patient/caretakers to organize, communicate, and follow-up on the patient’s care transition plan. Successful transition relies on a network of key clinical and social resources based on the patient’s risk factors.	Number of participating patients with a care transition plan, reduced 30 day readmissions

Health Need	Action/Project	Objective	Target Population	Implementation Strategy	Anticipated Outcome
	DSRIP – Health Home At Risk	Extend care management to patients who have a chronic disease and are at risk of worsening health in an effort to reduce admissions and ED visits	Patients with poor control of chronic disease despite medical intervention; social problems that impede patient's ability to self-manage; behavioral health conditions that require community support; and/or loss to follow-up.	Care management resources to enhance, not replace, PCMH team functions, by providing additional resources to address social determinants of health, including increased linkage to community-based support.	Number of patients receiving expanded care management services, reduced ED visits and inpatient admissions
	Treat to Target (T2T) Improving Self-Management of Hypertension Control	To increase blood pressure control through a treat to target model of care.	Patients with uncontrolled blood pressure and no visit in the last two months.	Using a hypertension registry, refer patients to a Clinical Pharmacist for medication review and education. Link high risk patients to primary care using direct outreach. Train nursing staff on motivational interviewing and T2T methods. Continue home BP monitoring telephonically on bi-weekly basis with patients with uncontrolled hypertension.	Adherence to PCP appointments ; patients with BP coming under control; control of total hypertensive patient population by 5%

Health Need	Action/Project	Objective	Target Population	Implementation Strategy	Anticipated Outcome
Alcohol/Drug Use	DSRIP – Care Transitions	See above			
	DSRIP – Health Home At Risk	See above			
	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.
Diabetes	DSRIP – Care Transitions	See above			
	DSRIP – Health Home At Risk	See above			

Health Need	Action/Project	Objective	Target Population	Implementation Strategy	Anticipated Outcome
	Improving Diabetes Control through Provider Coaching	Improve diabetes control as defined by A1C levels < 8; and/or seen by the provider within 6 months through a coaching program.	Patients with A1C levels of at least 8 and/or have not been seen by a primary care provider in 6 months.	Utilizing the Diabetes Registry, a Health Educator (HE) works with providers with patients in poor control. Providers are coached on strategies to bring patients back in control. Interventions include participating in weekly Team Meetings, use of a pre-planning tool, and direct outreach support.	Percent of provider panel of diabetic patients under control (A1C < 8); percent of provider panel of diabetic patients seen over a 6 month period.
	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.

Health Need	Action/Project	Objective	Target Population	Implementation Strategy	Anticipated Outcome
Obesity	Prescribe a Bike Pilot Study	Increase physical activity among patients through the use of a bike share program	Overweight and obese patients at risk for diabetes, hypertension, and cardiac disease.	Partner with NYC-DOHMH to obtain bike share memberships for patients. An interdisciplinary team will identify criteria for inclusion in the program, including BMI, co-morbidities, and familiarity with bike riding. Enrollees will be provided opportunity to learn road safety.	Program enrollees; Weight loss, relevant biologic markers, such as A1C control, blood pressure, cholesterol.

Health Need	Action/Project	Objective	Target Population	Implementation Strategy	Anticipated Outcome
Heart Disease, High Cholesterol, Stroke	American Heart Association – Silver & Gold Stroke Designation	Achieve AHA Silver (Year 1) and Gold (Year 3) Stroke Care Designation	Suspected and confirmed stroke patients	Obtain designation through improved clinical stroke metrics (patient arrival to stroke team member, turnaround times for diagnostic testing, etc.) and stroke team educational attainment. Hospitals must demonstrate at least 85 percent compliance in each of the seven Get With The Guidelines-Stroke Achievement Measures. The different levels reflect the amount of time for which the hospital demonstrates performance: Silver recognizes performance of 12 consecutive months and Gold recognizes performance of 24 consecutive months or more.	Silver and Gold level Achievement Measures.

Health Need	Action/Project	Objective	Target Population	Implementation Strategy	Anticipated Outcome
	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 andnurse 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
	DSRIP – Care Transitions	See above			
	DSRIP – Health Home At Risk	See above			