NYC HEALTH + HOSPITALS | ONECITY HEALTH

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY PLAN

Companion Document
2019

Brooklyn and Staten Island

ABOUT THE IMPLEMENTATION STRATEGY PLAN

This Implementation Strategy Plan for NYC Health + Hospitals has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a Community Health Needs Assessment (CHNA) at least once every three years and adopt an Implementation Strategy Plan to meet the community health needs identified in the CHNA. This Implementation Strategy Plan is intended to satisfy each of the applicable requirements set forth in proposed regulations.

This companion document to the Implementation Strategy Plan addresses the following hospitals:

Brooklyn

- NYC Health + Hospitals/Coney Island
- NYC Health + Hospitals/Kings County
- NYC Health + Hospitals/Woodhull

A digital copy of the Community Health Needs Asessment is available: https://www.nychealthandhospitals.org/publications-reports/2019-community-health-needs-assessment

A digital copy of this Implementation Strategy Plan is available: https://www.nychealthandhospitals.org/publications-reports/2019-implementation-strategy-plan

Community input is encouraged. Please address CHNA ISP feedback to chna@nychhc.org

For additional information on available services visit http://www.nychealthandhospitals.org

For information on insurance coverage visit: http://www.nychealthandhospitals.org/insurance

INTRODUCTION

This companion document to the 2019 CHNA Implementation Strategy Plan outlines the transformative initiatives and programs NYC Health + Hospitals' Brooklyn hospitals and its community partners have or will implement to address the priority health needs identified in the 2019 CHNA. This document can be used as a starting point for individuals living in Brooklyn, Staten Island and across New York City to understand the breadth of resources available to the community.

BUILDING HEALTHY COMMUNITIES

The priority health needs identified in the 2019 CHNA are structural and complex. Addressing them requires continued collaboration between NYC Health + Hospitals, city agencies, community partners and, crucially, patients. To ensure continued alignment with community members, NYC Health + Hospitals' Queens hospitals will co-design initiatives and programs with its Community Advisory Boards (CABs) and Patient and Family Advisory Councils (PFACs). The following strategic elements inform the transformative initiatives and programs NYC Health + Hospitals' Queens hospitals will implement to strengthen the health system for all New Yorkers.

- Tailor clinical services for populations facing health equity challenges to reduce health disparities
- Repurpose unused space for preventive care services to address life cycle-driven illness and health equity challenges
- Implement new care models to expand patient access to convenient and appropriate health care including expanding virtual care and enhancing care coordination within the NYC Health + Hospitals unified call center
- Leverage real-time data and analytics, digital health tools and Epic H2O to engage patients, families and interdisciplinary care teams for a streamlined health care experience – these data could support community-wide health promotion, quality improvement and evaluation efforts
- Connect patients, interdisciplinary care teams and social service providers through health information exchange networks to foster patient access to community resources and promote shared decision making, to support community health promotion and quality and evaluation efforts
- Increase awareness of tools to identify needed clinical services and increase understanding around health care costs and billing for both patients and providers
- Test high-value care models at NYC Health + Hospitals and scale sustainable solutions

RESOURCE COMMITMENT

NYC Health + Hospitals will commit both financial and in-kind resources during FY 2019–2021 to implement transformative initiatives and programs. Resources include clinical and nonclinical services, partnerships and innovative solutions prototyping through OneCity Health PPS Partners and NYC Health + Hospitals, including its ACO, as well as staff time devoted to advance collective work, charitable contributions and employee volunteerism.

BROOKLYN

17 county health ranking[1]
out of 62 counties in New York

80.1 years life expectancy[1]
compared to New York City average of 81.2 years

What is the community's perception?

Top 5 contributors to poor health and death in Brooklyn[2]

Risk factors	Causes
Poverty and low-income status	Diabetes
Housing access affordability and quality	Heart disease and high blood pressure
Obesity and high BMI	Mental health disorders, including depression
Aging and frailty	Stroke
Stress and emotional well-being	Drug use, including opioids

Leading causes of premature deaths in Brooklyn[3]

Cancer	Heart Disease	Unintentional Injury	Diabetes	Stroke	CLRD
2,108 deaths	**1,748** deaths	**478** deaths	**305** deaths	**192** deaths	**191** deaths
79.1 per **100,000**	**65.4** per **100,000**	**18.7** per **100,000**	**11.4** per **100,000**	**7.3** per **100,000**	**7.1** per **100,000**

Health status in Brooklyn[4]

40% have one or more chronic conditions

1 County Health Rankings & Roadmaps Program (2019).2019 County Health Rankings Report. Retrieved from www.countyhealthrankings.org/reports/2019-county-health-rankings-key-findings-report

2 2019 Community Health Needs Assessment Survey Findings (2019). Tabulated by OneCity Health.

3 New York State Department of Health (2018). Vital Statistics of New York State. Retrieved from www.health.ny.gov/statistics/vital_statistics/vs_reports_tables_list.htm

4 Salient Interactive Miner (2017). Based on Medicaid attributed lives and tabulated by OneCity Health.

STATEN ISLAND

28 county health ranking[1]
out of 62 counties in New York

79.8 years life expectancy[1]
compared to New York City average of 81.2 years

What is the community's perception?

Top 5 contributors to poor health and death in Staten Island[2]

Risk factors	Causes
Chronic pain and arthritis	Diabetes
Obesity and high BMI	Heart disease and high blood pressure
Access to mental and behavioral health care	Asthma
Exercise and physical activity	Drug use, including opioids
Disability and access to care for people with disabilities	Mental health disorders, including depression

Leading causes of premature deaths in Staten Island[3]

Heart Disease	Cancer	Unintentional Injury	Pneumonia and Influenza	CLRD	Diabetes
1,368 deaths	**881** deaths	**164** deaths	**145** deaths	**138** deaths	**126** deaths
245.7 per **100,000**	**156** per **100,000**	**33.1** per **100,000**	**26.2** per **100,000**	**25.6** per **100,000**	**22.7** per **100,000**

Health status in Staten Island[4]

45% have one or more chronic conditions

1 County Health Rankings & Roadmaps Program (2019).2019 County Health Rankings Report. Retrieved from www.countyhealthrankings.org/reports/2019-county-health-rankings-key-findings-report

2 2019 Community Health Needs Assessment Survey Findings (2019). Tabulated by OneCity Health.

3 New York State Department of Health (2018). Vital Statistics of New York State. Retrieved from www.health.ny.gov/statistics/vital_statistics/vs_reports_tables_list.htm

4 Salient Interactive Miner (2017). Based on Medicaid attributed lives and tabulated by OneCity Health.

APPENDIX: NYC HEALTH + HOSPITALS TRANSFORMATIVE INITIATIVES AND PROGRAMS BY BOROUGH: BROOKLYN AND STATEN ISLAND

As of October 2019, the following initiatives and programs at NYC Health + Hospitals facilities in Brooklyn and Staten Island most clearly address the priority health needs identified in the 2019 CHNA. Please note: this list is not exhaustive. For a description of each initiative and program, refer to Appendix: Glossary of NYC Health + Hospitals Transformative Initiatives and Programs.

For a current list of services, visit NYC Health + Hospitals' website and connect with NYC Health + Hospitals and OneCity Health on social media.

PRIORITY HEALTH NEED: REDUCING THE BURDEN OF LIFE CYCLE-DRIVEN ILLNESS AND HEALTH EQUITY CHALLENGES

Initiative	Facility
Pregnancy and birth outcomes	
Comprehensive maternal health programming	Coney Island, Kings County, Woodhull
Maternal homeless support program	Kings County
Maternal Medical Home	Kings County
QINCA program	Kings County
Simulation training	Coney Island, Kings County, Woodhull
Stork's Nest	Kings County
Airway Diseases (asthma, COPD)	
"Ask Me, AsthMe!" program	Kings County
DSRIP Home-Based Environmental Asthma Program	Kings County, Woodhull
Smoking Cessation	Woodhull
Behavioral health (mental health, substance use disorder)	
Assertive Community Treatment (ACT)	Woodhull
Behavioral health critical time interventions	Coney Island
Comprehensive Psychiatry Emergency Program (CPEP)	Kings County, Woodhull
Emergency Department Addiction Leads	Coney Island, Kings County, Woodhull
Inpatient Consult for Addiction Treatment and Care in Hospitals (CATCH)	Coney Island, Woodhull
Integrated care centers and collaborative care model	Coney Island, Kings County, Woodhull
Medication Assisted Therapy (MAT) expansion	Coney Island, Kings County, Woodhull
Partial Hospitalization (PHP)	Kings County
Diet-related diseases (diabetes, hypertension)	
Diabetes cooking classes	Kings County
Diabetes Prevention Program	Coney Island, Kings County, Woodhull
Food and nutrition resources	Coney Island, Kings County, Woodhull
Primary care-centered diabetes management initiative	Coney Island, Kings County, Woodhull
Shape Up NYC classes	Kings County

Initiative	Facility
Diet-related diseases (diabetes, hypertension), continued	
30-day care transitions	Coney Island, Kings County, Woodhull
Treat-to-Target (T2T) Hypertension Program	Coney Island, Kings County, Woodhull
Aging and frailty	
Geriatrics practice	Woodhull
NICHE certification	Coney Island, Kings County, Woodhull
Homeless or individuals with housing instability	
Housing assistance	Kings County, Woodhull
Hospital-housing developer partnerships	Kings County, Woodhull
Respite and transitional housing	Kings County, Woodhull
Incarcerated or previously incarcerated	
Point of reentry/transition clinic	Kings County
Immigrants	
Interpreter services, any modality	Coney Island, Kings County, Woodhull
NYLAG Clinics	Coney Island, Kings County, Woodhull
LGBTQ	
Leader in LGBTQ Healthcare Equality designation	Coney Island, Kings County, Woodhull
Adolescents and young adults	
100 Schools Project	Coney Island, Kings County, Woodhull
KIDs Ride Program	Woodhull
YouthHealth centers	Coney Island, Kings County, Woodhull
Survivors of domestic violence	
Family Justice Centers	Coney Island, Kings County, Woodhull
SAFE program	Coney Island, Kings County, Woodhull
Individuals with food insecurity	
Access to food and nutrition resources, including farmers markets, food coordinators, local food partnerships and medically-tailored meals	Coney Island, Kings County, Woodhull
Other	
Expand health care, insurance and benefits enrollment	Coney Island, Kings County, Woodhull
Tax preparation services	Kings County
Violence prevention programs (e.g. Guns Down Life Up (GDLU), Kings Against Gun Violence (KAVI))	Coney Island, Kings County, Woodhull

PRIORITY HEALTH NEED: REDESIGNING HEALTH CARE FOR COMMUNITIES: RETHINKING HEALTH CARE SYSTEMS

Initiative	Facility
Ease of access and navigation	
Expansion of primary care access in underserved and high-need neighborhoods	Coney Island, Kings County, Woodhull
Expansion of telehealth and digital coaching and monitoring expansion	Coney Island, Kings County, Woodhull
Imaging Centers of Excellence	Coney Island, Kings County, Woodhull
NYC Care	Coney Island, Kings County, Woodhull
Retail pharmacy	Coney Island, Kings County, Woodhull
Single call center	Coney Island, Kings County, Woodhull
Optimizing patient-provider relationships	
Arts in Medicine	Coney Island, Kings County, Woodhull
eConsult	Coney Island, Kings County, Woodhull
Helping Healers Heal	Coney Island, Kings County, Woodhull
ICARE	Coney Island, Kings County, Woodhull
Patient-centered scheduling and open access	Coney Island, Kings County, Woodhull
Health care cost and transparency	
Epic H2O MyChart consolidated billing and pre-payment options	Coney Island, Kings County, Woodhull
NYC Health + Hospitals' 'Find Your Insurance' tool	Coney Island, Kings County, Woodhull

PRIORITY HEALTH NEED: REDESIGNING HEALTH CARE FOR COMMUNITIES: AN INFRASTRUCTURE FOR SCALING

Initiative	Facility
State of the workforce	
CityDoctors Scholarship	Coney Island, Kings County, Woodhull
Clinical Leadership Fellowship	Coney Island, Kings County, Woodhull
Clinician recruitment programs and campaigns	Coney Island, Kings County, Woodhull
Healthcare Administration Scholars	Coney Island, Kings County, Woodhull
Nurse Residency Program	Coney Island, Kings County, Woodhull
Nursing Career Ladder	Coney Island, Kings County, Woodhull
Professional development programs for clinicians and staff	Coney Island, Kings County, Woodhull

Initiative	Facility
Information sharing	
Epic Care Link	Coney Island, Kings County, Woodhull
Epic Community Connect (OneConnect)	Coney Island, Kings County, Woodhull
Epic H2O and MyChart	Coney Island, Kings County, Woodhull
Epic Healthy Planet	Coney Island, Kings County, Woodhull
Patient appointment reminders	Coney Island, Kings County, Woodhull
Financial sustainability	
MetroPlus and GetCoveredNYC Enrollment Expansion	Coney Island, Kings County, Woodhull
Revenue and expense improvement opportunities	Coney Island, Kings County, Woodhull
NYC Health + Hospitals' Financial Transformation Plan through revenue and expense improvement opportunities	Coney Island, Kings County, Woodhull
System complexity and scale	
OneCity Health CBO capacity building	Coney Island, Kings County, Woodhull
OneCity Health primary care capacity building	Coney Island, Kings County, Woodhull

GLOSSARY OF NYC HEALTH + HOSPITALS TRANSFORMATIVE INITIATIVES AND PROGRAMS: BROOKLYN AND STATEN ISLAND

As of October 2019, the following initiatives and programs at NYC Health + Hospitals facilities in Brooklyn and Staten Island most clearly address the priority health needs identified in the 2019 CHNA. Please note: this list is not exhaustive.

For a current list of services, visit NYC Health + Hospitals' website and connect with NYC Health + Hospitals and OneCity Health on social media.

PRIORITY HEALTH NEED: REDUCING THE BURDEN OF LIFE CYCLE-DRIVEN ILLNESS AND HEALTH EQUITY CHALLENGES

Pregnancy and birth outcomes	
Initiative	**Description**
Comprehensive maternal health programming	Programming and services focused on maternal health including, but not limited to: Baby-friendly designation, Centering Pregnancy, Centering Parenting, maternal depression screening, onsite reproductive psychiatry, social work and collaborative care.
Maternal homeless support program	Partnership between NYC Health + Hospitals/Kings County and NYC Department of Homeless Services (DHS) that links patients to health care services, community based organizations and transportation.
Maternal Medical Home	This program provides care management and screening for depression, clinical conditions, trauma, social determinants of health and psychosocial conditions to individuals predisposed to or at high risk for poor or adverse pregnancy outcomes. Patients are also linked to community-based care programs and NYC Health + Hospitals.
QINCA program	This program provides education for physicians on LARC insertions and services through community providers.
Simulation training	Sometimes referred to as IMSAL, this training focuses on obstetric emergencies including: hypertensive disorders in pregnancy, maternal hemorrhage, shoulder dystocia and cardiac arrest.
Stork's Nest	Stork's Nest is a combined partnership with NYC H+H/Kings County, Zeta Phi Beta Sorority and March of Dimes. Stork's Nest aims to increase the number of women receiving early and regular prenatal care to prevent cases of low birth weight, premature births and infant deaths.

Airway diseases (asthma, COPD)	
Initiative	**Description**
"Ask Me, AsthMe!" program	This asthma smartphone application is designed for children and families with low health literacy to increase their understanding of pediatric asthma and disease self-management.
DSRIP Home-Based Environmental Asthma Program	This program assigns a community health worker to help support patients with frequent or severe asthma attacks. Community health workers conduct home assessments and provide services that include self-management education and pest-remediation services. This program was launched in 2017 for children and is expanding to include adult patient populations.
Smoking Cessation	This six-week program is designed to help individuals quit smoking. The program includes group counseling and education, telephone counseling and Nicotine-Replacement Therapy (NRP) in the adult medicine and behavioral health settings.

Behavioral health (mental health, substance use disorder)	
Initiative	**Description**
Assertive Community Treatment (ACT)	The ACT program functions as a "clinic without walls," providing multidisciplinary, flexible treatment and 24/7 support to individuals with severe mental illness in their homes and communities. This evidenced-based practice uses a person-centered, recovery-based approach.
Behavioral health critical time interventions	OneCity Health invested in Coordinated Behavioral Care's Pathway Home program, which provides multidisciplinary care transition services such as accompanying patients home, arranging for immediate needs such as food and filling prescriptions, ensuring transport is arranged for health care visits and providing ongoing communication and support
Comprehensive Psychiatric Emergency Program (CPEP)	CPEP is an inpatient service that facilitates children and adults with mental health disorders receiving emergency observation, evaluation and care in a supportive environment. This program has expanded to include telehealth services at select facilities and a crisis-outreach mobile intervention, which together extend the program into the community.
Emergency Department Addiction Leads and Inpatient Consult for Addiction Treatment and Care in Hospitals (CATCH)	The Emergency Department Addiction Leads program engages peer counselors to provide support to patients with substance use disorder in the emergency department. This program launched in 2019 and is currently expanding to include social workers. The CATCH Program consults patients with substance use disorder and initiates Medication Assisted Therapy (MAT) for interested patients. These consults include linkages to treatment post-discharge.
Healthy Steps	Healthy Steps – in some facilities known as 3-2-1 IMPACT! – integrates a specially trained child development professional, called a "Healthy Steps Specialist," within the primary care team. This specialist partners with families during well-child visits, coordinates screening efforts and problem-solves with parents for common and complex child-rearing and other challenges.
Integrated care centers and collaborative care model	Integrated care clinics co-locate primary care, behavioral health and care for substance use disorder in one location. In addition to allowing for coordination of care, these clinics administer a universal behavioral health screening tool and perform patient outreach to engage patients.
Medication Assisted Therapy (MAT) expansion	Services for patients with substance use disorder have now expanded to all five boroughs. These services include MAT, the distribution of naloxone kits and screening for substance use disorder.
Partial Hospitalization (PHP)	PHP is a short-term alternative to an Inpatient Psychiatric Unit stay. The step-down program provides an intensive, structured treatment environment five days a week, five hours a day for mentally-ill and mentally-ill/chemically dependent adults experiencing severe psychiatric symptoms. The program decreases the patient's length of stay.

Diet-related diseases (diabetes, hypertension)	
Initiative	**Description**
Diabetes cooking classes	Diabetes cooking classes are held at select NYC Health + Hospitals locations to provide culturally competent cooking classes tailored for patients with Type 2 diabetes.

Diet-related diseases (diabetes, hypertension), continued	
Initiative	**Description**
Diabetes Prevention Program	An evidence-based lifestyle change model based on the National Diabetes Prevention Program led by the CDC, this program is for patients who are either at-risk of diabetes or diagnosed with pre-diabetes. Programming includes coaching patients in areas including healthy eating, physical activity and stress management.
Digital peer mentoring program	This pilot program with InquisitHealth pairs patients with diabetes with a peer mentor. Peer mentors offer guidance and support to patients on how to live with and manage their diabetes.
Food and nutrition resources	A hospital-community partnership where patients are connected to a variety of on-site and community-based food and nutrition services. Food-insecure patients are enrolled in eligible food benefits, assisted with access to fresh produce or medically tailored meals and electronically referred to food pantries and group meals.
Primary care-centered diabetes management initiative	Programming includes: clinical pharmacists, teleretinal screening, digital peer mentoring and digital coaching.
Shape Up NYC classes	Led by the New York City Department of Parks & Recreation, Shape Up NYC is a free, drop-in fitness program offering classes such as aerobics, yoga, Pilates and Zumba. Class registration is not required.
30-day care transitions	OneCity Health is investing in community partners to support seamless transition for patients after a hospital discharge by assisting with access to healthy food, filling prescriptions and providing transportation to and from primary care visits.
Treat-to-Target (T2T) Hypertension Program	This program – recognized by The American Heart Association and the American Medical Association – connects patients with hypertension with chronic disease nurses to support them in controlling their blood pressure.

Aging and frailty	
Initiative	**Description**
Geriatrics practice	Provides care to adults over the age of 65 by working with a specialized team to understand the unique needs of patients. These practices coordinate throughout the spectrum of care through a single provider, who helps manage screenings, assessments and social services.
NICHE certification	NICHE (Nurses Improving Care for Healthsystem Elders) is the leading nurse-driven program designed to help hospitals and health care organizations improve care for older adults through the provision of sensitive and exemplary care.

Homeless or individuals with housing instability	
Initiative	**Description**
Housing assistance	Assistance includes, but is not limited to: referrals to Homebase housing, Breaking Ground partnerships, Roomfinders and outreach.
Hospital-housing developer partnerships	Selected NYC Health + Hospitals facilities convert clinical space for on-site housing through community initiatives and programs with partners including CAMBA, SKA Marin and Comunilife.
Respite and transitional housing	Investments in transitional supportive housing with respite providers to provide three different respite programs to patients with medical needs, mental health needs and intellectual and development disabilities who cannot be discharged to a home.

Incarcerated or previously incarcerated	
Initiative	**Description**
Point of reentry/transition clinic for correctional health	Includes the Port Clinic, which was recently established to provide primary care services to previously incarcerated patients from Rikers Island and other New York City detention centers.

Immigrants	
Initiative	**Description**
Interpreter services, any modality	Interpreter services might include language lines, remote interpretation devices, rovers for American Sign Language (ASL), live interpreters, etc.
NYLAG clinics	New York Legal Assistance Group (NYLAG) clinics are available to patients to help address health-harming legal needs.

LGBTQ	
Initiative	**Description**
Leader in LGBTQ Healthcare Equality designation	The Leader in LGBTQ Healthcare Equality designation is awarded to hospitals who exemplify LGBTQ-inclusive policies of delivering equitable care to LGBTQ communities, creating an inclusive and supportive environment for employees and demonstrating public support for the community.
The Pride Health Centers	Community health centers that offers services for women's health, men's health, gender transition, hormone therapy, HIV and STI prevention, screening and treatment services, adolescent care, social work and behavioral health services and general primary care.

Adolescents and young adults	
Initiative	**Description**
KIDs Ride	A program that introduces youth to cycling as a safe and effective means of transportation and as recreation, encouraging them to incorporate regular physical activity into their lives.

Adolescents and young adults, continued	
Initiative	**Description**
100 Schools Project	A city-wide health-system and community partnership launched to meet the needs of students with emotional, behavioral and addiction challenges in middle and high schools and city colleges. This program trains school staff to identify early signs of mental illness and substance misuse and to promote wellness and prevention.
YouthHealth centers	Centers that offer primary care, Plan B, STI testing, birth control, PrEP and comprehensive physical examinations in a compassionate, confidential and safe environment.

Survivors of domestic violence	
Initiative	**Description**
Family Justice Centers	The New York City Family Justice Center (FJC) provide free, confidential assistance for survivors of domestic and gender-based violence. NYC Health + Hospitals provides on-site mental health services, including direct care, mental health support, skill-building opportunities and mentoring to Family Justice Center staff.
SAFE program	State-designated hospital program that provides specialized care to survivors of sexual assault and/or torture.

Individuals with food insecurity	
Initiative	**Description**
Access to food and nutrition resources, including farmers markets, food coordinators, local food partnerships and medically-tailored meals	Programs established across NYC Health + Hospitals that help combat food insecurity by providing patients with increased access to food through farmers markets and local food partnerships. Food coordinators assist patients with enrolling in food benefits and connecting patients to additional community resources.

Other	
Initiative	**Description**
Expand health care, health insurance and benefits enrollment	Initiative to support patients in insurance, NYC Care and other benefits enrollment. Includes support through food coordinators and tax filing counselors.
Tax preparation services	As part of NYC Free Tax Prep, led by the NYC Department of Consumer Affairs, NYC Health + Hospitals offers free tax preparation services at many of its sites for New Yorkers earning $66,000 or less last tax year.
Violence prevention programs (e.g. Guns Down Life Up (GDLU), Kings Against Gun Violence (KAVI))	GDLU prevents violence by offering after school and summer hospital-based youth development programs, underpinned by mentoring and scholastic support. The purpose of the hospital-based youth development program is to involve at-risk young people in positive activities before they become involved with violence. KAVI, a non-profit organization started by an Emergency Medicine physician, provides a holistic approach to violence intervention to communities of color in Central Brooklyn. In hospitals, KAVI connects with youth who are both perpetrators and victims of violence to help them cope with trauma, deescalate violence and serve as active leaders in their community.

PRIORITY HEALTH NEED: REDESIGNING HEALTH CARE FOR COMMUNITIES: RETHINKING HEALTH CARE SYSTEMS

Ease of access and navigation	
Initiative	**Description**
Expansion of primary care access in underserved and high-need neighborhoods	Expanding on Mayor de Blasio's Caring Neighborhoods initiative, "One New York: Health Care for Our Neighborhoods," there are eight new or renovated health centers across New York City in Bedford Stuyvesant, Brownsville, Bushwick, Crown Heights, East Tremont, Jackson Heights, Lower East Side and North Shore Staten Island. Three additional comprehensive health centers in Bushwick, Jackson Heights and Tremont will open in 2020.
Expansion of telehealth and digital coaching and monitoring	NYC Health + Hospitals is offering a variety of digital health platforms to promote access, health engagement and chronic disease self-management. These platforms include: a multi-modal appointment reminder system, a diabetes self-management app, a telephone based peer mentorship app and an asthma self-management app.
Imaging Centers of Excellence	NYC Health + Hospitals is upgrading its medical imaging technology to provide patients with modernized, state-of-the-art technology that will produce faster and better image quality and lead to quicker diagnoses and treatment.
NYC Care	NYC Care ensures that all New Yorkers have access to care through no- and low-cost services offered by NYC Health + Hospitals. Individuals who cannot afford or are ineligible for insurance can enroll in NYC Care regardless of immigration status or ability to pay. NYC Care provides patients and families with a dedicated primary care provider, connection to a 24/7 customer service line and access to affordable medication.
Retail pharmacy	Through pharmacy expansion, all patients will have 24/7 access to comprehensive retail pharmacy services, including specialty pharmacy and central filling services.
Single call center	Through a new 24/7 customer service center (844-NYC-4NYC), patients can make appointments and gain assistance navigating services.

Optimizing patient-provider relationships	
Initiative	**Description**
Arts in Medicine	The Arts in Medicine program aims to reduce stress, support emotional health and help address compassion fatigue, historically known as physician burnout in staff.
eConsult	eConsult allows primary care providers to give their patients access to the advice of specialty care providers before the patient visits a specialty clinic, enabling primary care providers and their patients to immediately focus on a plan of action.

Optimizing patient-provider relationships, continued	
Initiative	**Description**
Helping Healers Heal	A "second victim program," Helping Healers Heal is a peer-led employee wellness program offering emotional first aid to health care providers who experience demanding circumstances in the workplace that can lead to stress, anxiety or depression.
ICARE	The ICARE values promote NYC Health + Hospitals' mission and vision and guide staff to offer the highest-quality, safest and most patient-centered care.
Patient-centered scheduling and open access	NYC Health + Hospitals is implementing patient-centered scheduling in conjunction with the system's call center to ensure patient-provider continuity. In addition, open access scheduling allows for more walk-in slots for patients with their interdisciplinary care team.

Health care cost and transparency	
Initiative	**Description**
Epic H2O MyChart consolidated billing and pre-payment options	With H2O MyChart, patients can view consolidated billing information, make payments and set up payment plans. In addition, patients can see expected drug and treatment costs.
NYC Health + Hospitals' 'Find Your Insurance' tool	NYC Health + Hospitals has made it easier for New Yorkers to understand whether their health insurance is accepted at NYC Health + Hospitals locations. The tool is accessible in many languages on NYC Health + Hospitals' website.

PRIORITY HEALTH NEED: REDESIGNING HEALTH CARE FOR COMMUNITIES: AN INFRASTRUCTURE FOR SCALING

State of the workforce	
Initiative	**Description**
CityDoctors Scholarship	CityDoctors Scholarship awardees commit to practicing primary care medicine for at least two years at one of NYC Health + Hospitals' acute care facilities. This partnership was launched in 2012 to help address the shortage of primary care physicians and to increase educational and career opportunities for local graduates.
Clinical Leadership Fellowship	This one-year fellowship is designed for post-residency graduates interested in administrative roles. Fellows are placed in one of NYC Health + Hospitals' Central Office locations to acquire hands-on, practical work experience including participation in leadership meetings and developing and leading a substantial quality improvement or population health-oriented project.
Clinician recruitment programs and campaigns	Includes DOCS4NYC and Nurse4NYC, Mental Health Service Corps, CityDoctors Scholarship, Healthcare Administration Scholars and Clinical Leadership Fellows.

State of the workforce, continued	
Initiative	**Description**
Healthcare Administration Scholars	This two-year leadership training and management program is shaping the next generation of leaders. The program requires scholars to develop quality improvement projects across the health system.
Nursing Career Ladder	NYC Health + Hospitals is offering full tuition to qualified registered nurses to earn bachelor's degree in nursing.
Nurse Residency Program	This residency program provides newly-hired, first-time nurses with on-the-job training focused on topics including ethics, decision making, clinical leadership and the incorporation of evidence-based research into practice. The program also provides new nurses with support and mentorship proven to enhance nurse satisfaction, performance and retention.
Professional development programs for clinical and non-clinical staff	NYC Health + Hospitals and OneCity Health are offering new training and development programs including: Care Restructuring Enhancement Pilot workforce development efforts, Leadership Academy, Revenue Cycle Institute, Quality Academy and educational partnerships offering scholarships and continuing education credits.

Information sharing	
Initiative	**Description**
EpicCare Link	As NYC Health + Hospitals transfers to Epic, NYC Health + Hospitals is transferring to EpicCare Link as the primary referrals platform for community providers. This web-based platform allows providers to review their patients' charts and test and lab results, receive notifications on their care and communicate with NYC Health + Hospitals' providers. NYC Health + Hospitals is offering providers a training program as a part of the transition.
Epic Community Connect	OneCity Health is offering PPS partners a sophisticated instance of Epic (OneConnect) that includes a unified patient record across NYC Health + Hospitals and the OneCity Health PPS network.
Epic H2O and MyChart	Epic H2O unifies electronic health records from over 70 locations to support clinicians in delivering high-quality, efficient care and allowing patients easy access to their records through a secure patient portal called MyChart. The new electronic health record also enables the system to better coordinate high-value care for patients.
Epic Healthy Planet	Epic Healthy Planet is a population health platform designed to identify, engage and treat high-risk and high-cost patient populations in a coordinated manner across the NYC Health + Hospitals and OneCity Health PPS networks.
Patient appointment reminders	Patient appointment reminders and other health communications are sent through an automated system based on the patient's preferred communication modality, including text, email or phone.

Financial sustainability	
Initiative	**Description**
MetroPlus and GetCoveredNYC Enrollment Expansion	With the assistance of MetroPlus Health plan and GetCoveredNYC enrollers, NYC Health + Hospitals is enrolling more New Yorkers in insurance across NYC Health + Hospitals facilities.
NYC Health + Hospitals' Financial Transformation Plan through revenue and expense improvement opportunities	NYC Health + Hospitals adopted a seven-point plan to close the $1.8 billion financial gap. The plan includes efforts to improve billing, contracting, coding and documentation; investing in patient and revenue increases; increasing health plan enrollments and reducing administrative expenses.
Value-based payment contracting	NYC Health + Hospitals and OneCity Health are designing its transformative initiatives and programs to achieve system-wide transformation to perform in value-based purchasing environments, encouraging service innovation, care model redesign and clinical quality improvements.

System complexity and scale	
Initiative	**Description**
OneCity Health CBO capacity building	OneCity Health has invested in capacity building to help community-based organization partners develop infrastructure to contract their services to hospitals and health plans based on value. As a culmination of this work, OneCity Health provided funding to community-based organizations through its Hospital-Community Partnerships initiative.
OneCity Health primary care capacity building	OneCity Health, in partnership with Primary Care Development Corporation (PCDC), offered community provider practices expert coaching with the aim of improving chronic disease prevention and management, behavioral health integration and care coordination. The aim of this work is to prepare NYC Health + Hospitals and community practices for evidence-based chronic disease management recognition to provide sustainable mechanisms for high-value care.

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