NYC HEALTH+ HOSPITALS | ONECITY HEALTH

# COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY PLAN 2019

## 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.

The following hospitals, organized by county, serve the communities addressed in this Implementation Strategy Plan:

### Bronx

- NYC Health + Hospitals/Jacobi
- NYC Health + Hospitals/Lincoln
- NYC Health + Hospitals/North Central Bronx

### Brooklyn

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

### Manhattan

- NYC Health + Hospitals/Bellevue
- NYC Health + Hospitals/Harlem
- NYC Health + Hospitals/Henry J. Carter Long-Term Acute Care
- NYC Health + Hospitals/Metropolitan

### Queens

- NYC Health + Hospitals/Elmhurst
- NYC Health + Hospitals/Queens

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

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# About NYC Health + Hospitals

As the largest public health care system in the U.S., NYC Health + Hospitals' mission is to deliver high-quality health care services to all New Yorkers with compassion, dignity and respect, without exception. The system is an anchor institution for the ever-changing communities it serves, providing hospital and trauma care, neighborhood health centers, skilled nursing facilities and community care, including care coordination and home care. NYC Health + Hospitals serves as a preeminent teaching facility and as a designated treatment center for the U.S. President.

Over **1.1 million** New Yorkers served annually

**11** hospitals

**5** level I trauma centers

**1** level II trauma center

**1** level II pediatric trauma center

**+70** community centers

**1** long-term acute care hospital

**5** skilled nursing facilities

**+40K** employees

correctional health services

## OneCity Health

OneCity Health is the largest Performing Provider System (PPS) in New York State, formed under the auspices of the Delivery System Reform Incentive Payment (DSRIP) program, comprising hundreds of health care providers, community-based organizations and health systems.

**+750k** Medicaid lives

**+200** partners

## MetroPlus

The NYC Health + Hospitals health plan, MetroPlus, provides low to no-cost health insurance to eligible New Yorkers across the five boroughs. Earning 5 out of 5 stars, MetroPlus is a top health plan in New York State.

**+500k** lives

## HHC ACO

The HHC Accountable Care Organization (ACO) is a collaborative venture including physician affiliate organizations, NYC Health + Hospitals acute care, outpatient and skilled nursing facilities, as well as teaching administration, quality assurance and supervisory services.

**+10k** Medicare lives

**8** partners

# INTRODUCTION

As the largest public health care system in the United States and an anchor institution in communities throughout New York City, NYC Health + Hospitals delivers high-quality health services with compassion, dignity and respect to all, without exception. Many of the people served by NYC Health + Hospitals experience an outsized chronic and behavioral disease burden, as reflected in previous community health needs assessments (CHNAs). These health outcomes are partly driven by long standing structural inequities such as entrenched racism and sexism, neighborhood income, access to quality, affordable housing, access to healthy, affordable food, safe places for physical activity and social support.[1-6]

As a leading health care provider and employer, NYC Health + Hospitals directly responds to these issues through investments in services to unite and elevate communities. As a result of strategic investments through the system's transformation plan and New York State's Delivery System Reform Incentive Payment (DSRIP) program, health trajectories of the communities served by NYC Health + Hospitals have improved. These investments have strengthened primary and preventive care, boosted health coverage for New Yorkers, modernized health care delivery system-wide and enabled crucial innovative partnerships with community-based providers and organizations. However, challenges persist.

NYC Health + Hospitals, the largest public health care system in the United States, serves over 1 million people annually and offers comprehensive, accessible and affordable health care to all, without exception. The system's 11 acute care hospitals and long term acute care hospital provide top-ranked trauma care, offer dozens of inpatient specialties and mental health services and keep communities healthy through a robust network of primary and specialty care for children and adults. NYC Health + Hospitals facilities have earned numerous special designations for quality and culturally responsive care and have received top ranks by U.S. News and World Report.

In 2019, NYC Health + Hospitals completed a CHNA to identify, better understand and prioritize the health needs of the communities served. The CHNA process was conducted by OneCity Health, the NYC Health + Hospitals Performing Provider System (PPS). OneCity Health utilized a multi-stakeholder approach to identify system-wide population health needs as well as the local needs of the diverse neighborhoods served. Findings from the CHNA were driven by a combination of quantitative and qualitative data from over 450 community surveys, 16 inclusive community forums held at NYC Health + Hospitals facilities and more than 60 expert interviews with system leadership and community stakeholders.

## COMMUNITY DEFINITION

NYC Health + Hospitals serves over 1.1 million New Yorkers every year across the city's five boroughs and empowers them to live their healthiest life. The community is defined by vibrant and diverse neighborhoods.

NYC Health + Hospitals has historically served as the health care safety net for New Yorkers and cares for all without exception. In fact, 70% of NYC Health + Hospitals' patients are insured by Medicaid or have no insurance (compared to 40% for voluntary hospitals throughout New York City).

The system offers 60% of behavioral health services city-wide while voluntary hospitals have closed or reduced services in recent years.

Two priority health needs were identified in the 2019 CHNA:

1. Reducing the burden of life cycle-driven illness and health equity challenges
2. Redesigning health care for communities:
    a) Rethinking health care systems
    b) An infrastructure for scaling

The CHNA was approved and adopted by the NYC Health + Hospitals Board of Directors in June 2019.

This Implementation Strategy Plan (ISP) describes the transformative initiatives and programs NYC Health + Hospitals and its community partners have or will implement to address the priority health needs identified in the 2019 CHNA. Continuous evaluation and monitoring of these initiatives and programs and NYC Health + Hospitals' overall strategic focus will be developed to ensure they are improving health equity in communities served. This report can also be used as a starting point for individuals to understand the breadth of resources available to the community.

# IMPLEMENTATION STRATEGY

The ISP outlines how NYC Health + Hospitals will address the priority health needs identified in the 2019 CHNA at both a system and local level. The report inventories transformative initiatives and programs underway, as well as solutions the system will consider moving forward to address the priority health needs.

## APPROACH

To address the priority health needs identified in the 2019 CHNA, OneCity Health brought together interdisciplinary stakeholders including NYC Health + Hospitals' system leadership and front-line facility staff, city agencies and PPS partners. The ISP was developed through the following approach:

1. NYC Health + Hospitals catalogued transformative initiatives and programs underway system-wide and at each hospital that address the priority health needs of the communities served.*

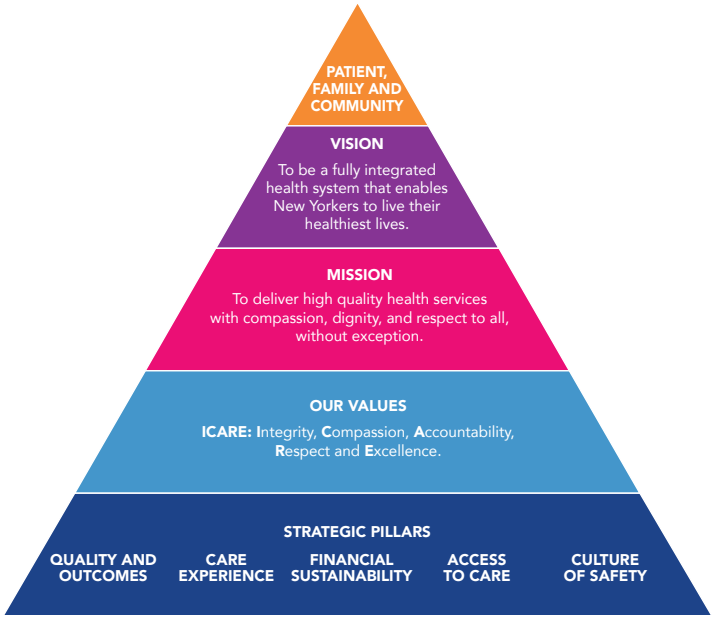
2. OneCity Health facilitated multi-stakeholder planning through three working groups with over 50 participants representing NYC Health + Hospitals, PPS partner organizations and city agencies. Working group members designed and pitched solutions to address the priority health needs based on their daily experiences serving the community. Members then prioritized solutions that will be reviewed by NYC Health + Hospitals executive leadership through the system's clinical and business strategic planning processes.**

3. Looking forward, NYC Health + Hospitals will continue to invest in programs, services and partnerships that address the priority health needs of the community. To ensure services and programs are truly designed through the lens of the patient and community, NYC Health + Hospitals will engage community members, including through its existing Community Advisory Boards (CABs) and Patient and Family Advisory Councils (PFACs), and OneCity Health's growing network of over 200 community-based partners.

## STRATEGIC FRAMEWORK

The NYC Health + Hospitals Strategic Framework demonstrates how the system's vision, mission, values and strategic framework aim to support the patient, family and community (Figure 1). The goals and tactics in this report are guided by the strategic framework, which consist of: quality and outcomes, care experience, financial sustainability, access to care and culture of safety. The framework is the foundation of the system's vision to be a fully integrated health system, which requires effective organization of its community assets and partners including MetroPlus, its health plan, OneCity Health and the HHC ACO, its Accountable Care Organization, to improve the overall health of the communities served in a financially sustainable manner.

**Figure 1: NYC Health + Hospitals Strategic Framework**




*See Appendix: Glossary of NYC Health + Hospitals Transformative Initiatives and Programs on page 18.
**See Appendix: Proposed Solutions for Consideration on page 33.

## ADDRESSING PRIORITY HEALTH NEEDS

### REDUCING THE BURDEN OF LIFE CYCLE-DRIVEN ILLNESS AND HEALTH EQUITY CHALLENGES

The environmental conditions into which someone is born, plays, lives, works and ages present social and economic risk factors that impact health and life expectancy. These factors combined with the evolution of one's health throughout their life cycle can lead to poor health outcomes including airway diseases, heart disease and diabetes. To ensure every New Yorker has the same opportunity to live a healthy life, life cycle-driven illness must be addressed and social and economic risk factors reduced.

### Goal: Reduce the burden of life cycle-driven illness and address health equity challenges

**Tactic: Manage the health of patients throughout their life cycle by engaging them in services to improve health outcomes across life stages**

NYC Health + Hospitals is poised to build long-term relationships with the community and its patients that can improve health outcomes throughout the life cycle. The system and its over 70 neighborhood health center, hospital and skilled nursing facility locations can help community members to build a strong foundation for life at birth and infancy, establish healthy behaviors at adolescence and achieve quality of life through adulthood. By designing structurally competent health care services embedded with person-centered values and delivered with cultural humility,patients are better able to engage in their health on an ongoing rather than episodic basis.[7,8] Further, providing medical staff with implicit bias training ensures that all patients receive the same level of care. This approach aims to significantly reduce the burden of life cycle-driven illness.

To do this, NYC Health + Hospitals is developing comprehensive programs, coordinated through primary care, including integration with specialty care for higher risk patients. For example, patients with behavioral health needs (e.g. mental health and substance use disorders) will be able to receive integrated primary and behavioral health care at a single site to eliminate the stigma traditionally associated with behavioral health needs and their treatments. YouthHealth and Pride Health Centers offer tailored health and social services for adolescents and patients who identify as LGBTQ to meet their unique health needs. Further, patients living with or at-risk of developing diet-related illness or airway diseases can receive a full range of services through their primary care provider, who is able to escalate specialty care needs upward through the interdisciplinary care team.

SPOTLIGHT

**DSRIP Home-Based Environmental Asthma Program**

Priority health need addressed: Reducing the burden of life cycle-driven illness and health equity challenges: Airway diseases (asthma, COPD)

Since 2017, NYC Health + Hospitals, with the support of OneCity Health, has provided an integrated home-based asthma program to pediatric patients with uncontrolled asthma. Starting in 2019, services expanded to adult patients with asthma and COPD. The program aims to reduce avoidable hospital visits and improve patient care by connecting patients to primary and specialty care, social services and home remediation. In this model, community health workers partner with patients and providers to provide a home and environmental asthma assessment, disease-management education and referrals to social services. Success is measured by a reduction in avoidable hospital inpatient and Emergency Department use, increased medication adherence and connections to primary and specialty care.

SPOTLIGHT

**Comprehensive Maternal Care and Pregnancy Prevention Program**

Priority health need addressed: Reducing the burden of life cycle-driven illness and health equity challenges: Pregnancy and birth outcomes

NYC Health + Hospitals, in partnership with the Mayor's Office, is implementing a comprehensive maternal care program with the focus of identifying and responding to pregnancy-related morbidity and mortality for women of color.

In the Maternal Medical Home, Maternal Care Coordinators and social workers enhance care by assisting patients who are at higher risk of developing health problems during their pregnancy. They help patients to navigate their appointments and receive supportive services.

#safemomsnyc is a simulation-based program that trains doctors, nurses and others on the delivery team to respond to the highest risk emergency situations in the Labor and Birthing suites.

The Interval Pregnancy Optimization program helps to improve maternal health by training providers to ask patients specifically about pregnancy intention. In this way, the health of the woman may be optimized before she becomes pregnant.

The Mother-Baby Coordinated Visit program aims to increase adherence to the postpartum visit by having the patient scheduled with the baby's visit.

Further, NYC Health + Hospitals is adopting implicit bias and anti-racism training and is focusing on a culture that emphasizes safe and respectful care. Success will be measured by a reduction in maternal morbidity and mortality outcome disparities and improved prenatal and postpartum care.

**Populations facing unique health equity challenges[9]**

- Adolescent and young adult
- Survivors of domestic violence
- Individuals with food insecurity
- Homeless or individuals with housing instability
- Immigrant
- Incarcerated or previously incarcerated
- LGBTQ
- Pregnant women of color

**Tactic: Partner with the community to offer programs and services that reduce health equity challenges**

High-quality clinical care is critical to improving health outcomes, but this alone cannot close the health equity gaps often faced by communities served by NYC Health + Hospitals. Partnerships that enable connections between the health care and other systems (e.g. criminal justice, foster care, public housing, shelter, food etc.) are essential to address poor health outcomes. These services are made available to patients through the co-location and optimization of referrals. To identify patients who could benefit from these services, NYC Health + Hospitals offers benefits screening and enrollment for health insurance, food and social services and support for housing services, legal assistance and income tax filing.

In partnership with real estate developers, the system has repurposed unused space to offer over 1,300 units of supportive and affordable housing. In addition, NYC Health + Hospitals provides clinical care at one-stop NYC Family Justice Centers, which offers comprehensive care for survivors of domestic violence. Through DSRIP funding, OneCity Health is investing in partnerships and programs to address health equity challenges including food and housing insecurity and health literacy.

## SPOTLIGHT

### Woodhull Residence | Comunilife

Priority health need addressed: Reducing the burden of life cycle-driven illness and health equity challenges: Populations facing unique health equity challenges

NYC Health + Hospitals, in partnership with Comunilife, a not-for-profit community-based organization specializing in supportive housing development, launched the Woodhull Residence in 2019. The brand new 89-unit supportive and affordable housing residence was converted from a parking lot located on the NYC Health + Hospitals/Woodhull campus. The residence provides 54 studio apartments for formerly homeless adults living with special needs and 35 studio apartments for low income community residents. Comunilife aims to combat the outsized chronic and behavioral disease burden among individuals living with housing instability. Success will be measured through health outcomes and patient satisfaction.

## SPOTLIGHT

### Correctional Health Services

Priority health need addressed: Reducing the burden of life cycle-driven illness and health equity challenges: Populations facing unique health equity challenges

NYC Health + Hospitals/Correctional Health Services (CHS) operates one of the nation's largest correctional health care systems and provides patients with medical and mental health care, substance use treatment, dental care and social work services. Since joining the NYC Health + Hospitals system in 2016, CHS has expanded access to care through telehealth services, decentralized care services to local detention centers and enhanced community reentry support services.

## REDESIGNING HEALTH CARE FOR COMMUNITIES: RETHINKING HEALTH CARE SYSTEMS

By redesigning the health care system around communities and patients, providers can more easily treat patients holistically, rather than treat diseases alone. An empowered patient experience is one where the patient and provider can build a long-term relationship and jointly establish clear goals, resulting in a more approachable, meaningful and personalized health care encounter.

### Goal: Improve ease of access to and navigation through the health system

**Tactic: Design services around the end user, the patient – this includes services that are easy and convenient to access, structurally competent and delivered with cultural humility**

By designing services that respond directly to patient and provider needs, health care systems can deliver services that make it easier for patients to engage in care and achieve better health outcomes. NYC Health + Hospitals has and continues to expand high-quality preventive and primary health care to more convenient locations, including plans for three comprehensive health centers to be opened by the end of 2020. In addition, over 70 health centers offer after-hours options and new ExpressCare centers provide walk-in and after-hours urgent care.

The individuals served by NYC Health + Hospitals come from the different cultures that comprise New York City. The system continues to be an industry leader in providing structurally competent health care delivered with cultural humility – including providing language appropriate services in patients' preferred modality. To prevent the chilling effect of Public Charge, NYC Health + Hospitals continues to assure immigrant communities that the system remains steadfast in its mission to deliver health care to all New Yorkers without exception and regardless of income, immigration or insurance status.

SPOTLIGHT

**Expanding access to community-based care and the Caring Neighborhoods Initiative**

Priority health need addressed: Rethinking health care systems: Ease of access and navigation

Through initial support from the Mayor's Caring Neighborhoods Initiative, NYC Health + Hospitals has expanded access to primary and specialty care in underserved communities at eight new or renovated sites across New York City. NYC Health + Hospitals plans to open three new full-service ambulatory care sites by the end of 2021, which will offer comprehensive, one-stop ambulatory care and wellness support services. This expansion will allow the system to serve over 50,000 more New Yorkers. Success will be measured by patient satisfaction and the number of patients served.

SPOTLIGHT

**ExpressCare**

Priority health need addressed: Rethinking health care systems: Ease of access and navigation

ExpressCare provides the community with a new and convenient way to access health care through walk-in urgent care centers. Through ExpressCare, patients are promptly seen by a provider, connected to primary care and other services and enrolled in insurance when applicable. The clinical model, designed in partnership with OneCity Health, supports the goal of the DSRIP program to reduce avoidable hospital usage, including unnecessary Emergency Department visits, by 25 percent by 2020. Success is measured through several metrics including wait times in ExpressCare and number of linkages to primary care. ExpressCare centers are open at NYC Health + Hospitals/Lincoln and Elmhurst with plans to expand centers to other NYC Health + Hospitals sites in the next three years.

SPOTLIGHT

**NYC Care**

Priority health need addressed: Rethinking health care systems: Ease of access and navigation

NYC Care ensures that all New Yorkers have access to care through low and no-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. The program launched in August 2019 in the Bronx with plans to expand to all boroughs.

In the first two months alone, over 5,000 patients were enrolled. Success is measured by the number of patients enrolled in and seeking care through the program.

## Goal: Optimize the patient-provider relationship

**Tactic: Improve patient continuity of care with primary care providers**

When patients and providers are able to develop long-term relationships and achieve continuity of care, patients experience higher quality care and achieve better health outcomes. Historically, patients have entered NYC Health + Hospitals through the Emergency Department, but investments in primary care providers, stronger linkages to primary care for patients and enrolling patients in insurance and NYC Care means that patients can more easily access primary care services and build relationships with their interdisciplinary care team.

NYC Health + Hospitals is making scheduling easier for patients by implementing a patient-centered scheduling system, providing patient continuity with their interdisciplinary care team and "open access" scheduling options for same-day appointments. This model accounts for the unpredictable and busy schedules of individuals served by NYC Health + Hospitals. Through Epic and eConsult,* the system is enhancing communication and optimizing access between primary care providers and specialists and their patients.

## Goal: Increase transparency of health care costs for patients and providers

**Tactic: Enable shared decision making between patients and providers guided by clinical need and value-based care options rather than financial constraints**

Through the system-wide implementation of Epic H2O, NYC Health + Hospitals providers will have access to decision support tools so they can help patients make decisions informed by clinical effectiveness and costs. Simultaneously, through Epic MyChart, patients are able to understand how much a procedure or medication costs and can access easy-to-read medical bills.

All patients, including those with health care through NYC Care, can connect to a 24/7 customer service line to understand how and where to access their dedicated interdisciplinary care team as well as the cost of care. Access to this level of service is unprecedented among historically uninsured communities.

### SPOTLIGHT

**ICARE and person-centered care**

Priority health need addressed: Rethinking health care systems: Patient-provider relationships

ICARE is a system-wide employee value system that aims to integrate Integrity, Compassion, Accountability, Respect and Excellence into service delivery, rounding and leadership development. Through ICARE trainings, this initiative is increasing staff awareness and engagement in the mission and vision of NYC Health + Hospitals, with the ultimate goal of enhancing the patient experience. Success is measured by the percentage of staff trained in ICARE.

New person-centered care initiatives aim to involve patients, the interdisciplinary care team and other stakeholders in actively co-designing solutions specific to local and individual needs.

### SPOTLIGHT

**Epic**

Priority health need addressed: Information sharing

Epic H20, the NYC Health + Hospitals electronic health record, serves as a unifying platform for communication and collaboration across NYC Health + Hospitals' more than 70 locations and partner sites enabling coordinated care as a single integrated system. Further, Epic H2O improves patient care through clinicians' timely access to patients' complete health records. Simultaneously, Epic MyChart enables patients access to their health records allowing them to actively participate in health care decision-making with their interdisciplinary care team. Success will be measured by patient satisfaction and quality of care.

*See page 12.

## REDESIGNING HEALTH CARE FOR COMMUNITIES: AN INFRASTRUCTURE FOR SCALING

NYC Health + Hospitals must take advantage of its scale and reach while tailoring services to the diverse needs of the communities served. Health care systems should be designed around the individual patient journey and information should flow seamlessly between a patient and their interdisciplinary care team, especially when transitioning between care settings. To realize the benefits of being a system, NYC Health + Hospitals should continue to build an engaged workforce, enable information sharing and provide services in a financially sustainable way. If systems operate as a system in name-only, clinical staff have to spend more time navigating separate entities rather than focusing on patient care and patients have to navigate fragmented services.

### Goal: Build and optimize workforce capacity

**Tactic: Increase recruitment and retention of a talented workforce**

With the goal of increasing the preventive and primary care-focused workforce, NYC Health + Hospitals launched two clinical recruitment campaigns to identify, recruit and retain clinicians: Docs4NYC and Nurse4NYC.

NYC Health + Hospitals offers a range of professional development opportunities to staff including leadership development and research opportunities to ensure continued career development. NYC Health + Hospitals also launched Health Care Administration Scholars and Clinical Leadership Fellowship programs to develop the next generation of clinical leaders in the areas of administration, population health and quality. Through the New York State Care Restructuring Enhancement Pilot program, administrative and clinical hospital staff are being trained to serve patients in community-based settings.

**Tactic: Ensure the workforce can work to their highest level of experience, skills and licensure**

NYC Health + Hospitals is maximizing roles within the interdisciplinary care team to ensure clinicians and support staff can practice at the top of their licenses to maximize time spent in direct patient care, population health management and system-wide quality improvement efforts. The system has also expanded the use of community health care workers and peers to support patient navigation and act as extensions of the interdisciplinary care team by offering communication and health coaching support in communities. These new care team members help to build trust, promote information sharing and optimize time at each clinical visit.

**Tactic: Support providers in managing their emotional health**

Through the Arts in Medicine and Helping Healers Heal programs, NYC Health + Hospitals is responding to compassion fatigue and physician burnout, common in health care providers and jobs with high emotional stress. These programs help clinicians continue to connect with patients and offer high-quality, compassionate care.

### SPOTLIGHT

**Clinical recruitment campaigns including Docs4NYC and Nurse4NYC**

Priority health need addressed: An infrastructure for scaling: State of the workforce

To expand access to care, NYC Health + Hospitals launched two targeted recruitment campaigns for doctors and nurses: Docs4NYC and Nurse4NYC. The Nurse4NYC campaign focuses on four high need specialty areas where nurses are needed the most: ambulatory department; behavioral health; correctional health services; Emergency Department/Trauma; home care. These campaigns are supported by social media advertising on Google, LinkedIn, Facebook and Instagram. Since 2018, through Docs4NYC, Nurse4NYC and other recruitment efforts, 37 primary care physicians, 426 registered nurses, 229 nursing support staff and revenue staff were hired. Success will be measured by the number of patients served.

### Goal: Improve communication and information sharing across patients and providers

**Tactic: Ensure more effective communication between providers and with patients through technology-enabled platforms**

With the system-wide implementation of Epic H2O, patients and providers will have transparency into the full picture of a patient's health and can participate jointly in making health care decisions. Through Epic MyChart, patients can review their medical history, book appointments, request prescription refills and communicate with their interdisciplinary care team. NYC Health + Hospitals also offers health care maintenance and appointment reminders via their preferred language and modality. With eConsult, primary care providers can connect with specialists and advise patients on a timely basis. Community providers can also connect to Epic H2O, which fosters patient access and care coordination beyond the four walls of the hospital.

## Goal: Provide services in a way that are financially sustainable

**Tactic: Enhance revenue opportunities and reduce administrative expenses**

NYC Health + Hospitals is implementing a five-year financial plan consisting of significant revenue generating and cost-saving initiatives that aim to bolster the system's financial position while expanding health care services. To date, NYC Health + Hospitals has closed almost two-thirds of its $1.8 billion projected budget gap.

**Tactic: Prepare the system for a value-based payment environment**

Investments in transformation efforts and the DSRIP program, which aims to improve access and quality and promote community-based care, are preparing the system for the shift to a value-based payment environment. This means increased and easier access to high-quality holistic care designed to improve health outcomes at a lower cost and with a better patient experience.

**Tactic: Boost health care and insurance coverage to all New Yorkers**

New York City and NYC Health + Hospitals are guaranteeing health care for all New Yorkers through NYC Care and efforts to expand enrollment in MetroPlus. More New Yorkers have access to primary care providers, integrated clinical services, coordinated care, prescription drugs and 24/7 customer service than ever before. This is possible through expanded access to financial counselors and to GetCoveredNYC and MetroPlus health plan enrollers based in facilities and in the community.

### SPOTLIGHT

**HHC ACO**

Priority health needs addressed: An infrastructure for scaling: Financial sustainability

NYC Health + Hospitals' Accountable Care Organization (ACO) – a group of doctors and other providers who coordinate care for patients under the Medicare Shared Savings Program (MSSP) – is the only MSSP ACO based in New York State to earn shared savings for six consecutive years and one of only 18 ACOs around the country to have earned that distinction. The ACO's performance demonstrates NYC Health + Hospitals' ability to provide quality patient care at a lower cost. The ACO performed highest in the Preventive Health area, which includes screening for patients with depression, helping patients quit smoking and proper use of aspirin for patients with heart disease. Success is measured by shared savings earned.

### SPOTLIGHT

**OneCity Health**

Priority health needs addressed: An infrastructure for scaling: Financial sustainability

OneCity Health, the largest PPS in New York state, is prototyping innovative solutions through new collaborations across hospital, community and managed care organization partners that meet the goals of DSRIP and will be sustained through new value-based payment arrangements. Investments aim to provide streamlined, person-centered care to address upstream social risk factors for poor health and to reduce avoidable hospital utilization by redesigning care models supported by robust data analytics capabilities.

Through OneCity Health's $5 million DSRIP Innovation Fund, the largest statewide, partners prototyped new food and wellness delivery models, community based organization-led peer outreach, health education programs and developed the "Ask Me, AsthMe!" asthma health literacy app. OneCity Health has achieved significant reductions in avoidable hospital use and financial savings and is awaiting final performance results. Success is measured by DSRIP performance, earned value-based payment incentives and a reduction in avoidable utilization rates.

## Goal: Optimize the integration of assets across the system

**Tactic: Promote coordination and integration of clinical, financial and social services to deliver a seamless and streamlined patient experience**

As the largest public health care system in the United States, NYC Health + Hospitals operates a robust network of acute-care hospitals, a long-term care hospital, neighborhood-based primary care centers, nursing homes and post-acute centers, a home care agency and a health plan, MetroPlus. To support this network, the system is dedicated to building an infrastructure that optimizes efficiency, reliability and integration with the ultimate goal of increasing access to primary care as well as tailored delivery of high-quality, clinical services. This includes enhancing data sharing, standardized high-quality clinical services and seamless communication across the network. Further, OneCity Health has provided technical assistance for capacity building and other supportive services to prepare its growing PPS partner network for successful partnerships with NYC Health + Hospitals and health plans, including MetroPlus.

# LOOKING FORWARD

## 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 will continue to engage community members, including through its existing CABs and PFACs. The following strategic elements inform the transformative initiatives and programs NYC Health + 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.

## EVALUATION

NYC Health + Hospitals will continue to disseminate findings from the CHNA to system staff and community members alike. Additionally, NYC Health + Hospitals will promote and raise awareness of transformative initiatives and programs identified in this report. Evaluation plans will be established or continued. Further, OneCity Health has invested in the Institute for People, Place and Possibility (IP3) Assess, a data analytics platform that helps to identify health needs and areas of opportunity to inform place-based investments. NYC Health + Hospitals will use the platform to support continuous monitoring and evaluation of NYC Health + Hospitals and community-level impact in making progress towards the system's overall strategic focus and in closing health equity gaps.

# NOTES AND REFERENCES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7. Structural competency can be defined as the trained ability to discern how a host of issues defined clinically as symptoms, attitudes or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization or even about the very definitions of illness and health. See also www.ncbi.nlm.nih.gov/pmc/articles/PMC4269606.

8. Practicing cultural humility goes beyond being respectful and responsive to health beliefs and practices and cultural and linguistic needs of individuals – it requires acknowledgment and celebration of an individual's identity and agency over their own experience. See also www.rwjf.org/en/blog/2018/06/practicing-cultural-humility-to-transform-healthcare.html.

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# APPENDIX: GLOSSARY OF NYC HEALTH + HOSPITALS TRANSFORMATIVE INITIATIVES AND PROGRAMS

As of October 2019, the following initiatives and programs throughout NYC Health + Hospitals 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 family planning services | Programming and services focused on family planning including, but not limited to: family planning counseling, long acting reversible contraception (LARC) expansion, termination of pregnancy up to 24 weeks gestational age and medication abortion. |
| 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, on-site 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. |
| RELIAS | RELIAS is a web-based, self-paced learning program with modules focused on fetal heart rate interpretation, shoulder dystocia, obstetric hemorrhage and other obstetric emergencies. |
| 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. |
| Asthma-Free Bronx | This City Hall initiative, run by the NYC Department of Health and Mental Hygiene, NYC Health + Hospitals and the NYC Department of Education, provides a suite of personalized interventions aimed at reducing Emergency Department visits and inpatient admissions of asthmatic pediatric patients in the South Bronx. As a part of this program, community health workers also provide asthma education including self-management education, environmental assessments and pest-remediation services. |

| Airway diseases (asthma, COPD), continued | |
|---|---|
| **Initiative** | **Description** |
| DSRIP Home-Based Environmental Asthma Program | This program assigns a community health worker to support patients with frequent or severe asthma attacks. Community health workers conduct home assessments and provide services including self-management education and pest-remediation services. This program was launched in 2017 for children and is expanding to include adult patient populations. |
| Remote medication management | The remote medication management program ensures asthmatic patients are in compliance with medications prescribed by physicians. |
| 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. |
| Community Advisory Board (CAB) community forums on opioids | NYC Health + Hospitals CABs continue to hold open community forums on the impact of opioids in the community, including hosting opioid overdose prevention trainings (Naloxone) for community members. |
| 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.<br><br>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. |
| 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. |

| Behavioral health (mental health, substance use disorder), continued | |
|---|---|
| **Initiative** | **Description** |
| 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. |
| School program for behavioral health adolescent inpatients | Public School 35 is a hospital-based public school providing educational and behavioral services for children aged 5-19 years with mental health disorders. |
| 3-2-1 IMPACT! | 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. |

| Diet-related diseases (diabetes, hypertension) | |
|---|---|
| **Initiative** | **Description** |
| BlueStar app | Through this app, patients receive individualized coaching, reminders, education and support to help manage their Type 2 diabetes. |
| 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. |
| 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. |
| Plant-Based Lifestyle Medicine Program | This pilot program began at Bellevue in 2018 with the goal to help patients access a healthy lifestyle that includes a whole-foods, plant-based diet to improve, and in some cases reverse, diet-related chronic illness. |
| Primary care-centered diabetes management initiative | Programming includes: clinical pharmacists, teleretinal screening, digital peer mentoring and digital coaching. |

| Diet-related diseases (diabetes, hypertension), continued | |
|---|---|
| **Initiative** | **Description** |
| 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** |
| Acute Care for the Elderly (ACE) Unit | The ACE Unit is comprised of an interdisciplinary care team that supports older adults in maintaining their independence and preventing physical and mental decline during treatment for acute illness. The ultimate goal is to return patients to their everyday routines and living situations. |
| Community Services, Inc. partnership | This partnership between NYC Health + Hospitals/Queens and CBO Sunnyside Community Services, Inc. addresses caregiver support for patients suffering from Alzheimer's disease and dementia. |
| 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. |
| Palliative care | Palliative care provides inpatient and outpatient services to help relieve pain and discomfort in patients with chronic or advanced illnesses. |
| Senior community engagement efforts | Ongoing efforts throughout several NYC Health + Hospitals facilities that include activities such as Harlem's Annual Senior Health Festival, where community partners engage with attendees and provide outreach to local senior centers. |

| 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. |

| Homeless or individuals with housing instability, continued | |
|---|---|
| **Initiative** | **Description** |
| 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. |
| Program for Survivors of Torture | This program offers medical, mental health and social/legal services to survivors of torture and persecution overseas. |

| 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. |
| Union Settlement Youth Opportunity Hub | In partnership with the District Attorney's Office, Youth Opportunity Hubs knit together community-based providers to provide coordinated services in new or updated physical spaces for young people in target neighborhoods. The Hubs provide attractive social spaces and link neighborhood service providers to provide one-stop, comprehensive support for at-risk children, teens and young adults in order to prevent them from becoming involved in the criminal justice system. |
| 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** |
| East Harlem Community Alliance | NYC Health + Hospitals/Metropolitan is a leader in this consortium of over 185 nonprofits, businesses, religious organizations and government agencies working together to enhance the vitality and well-being of the East Harlem community. |
| 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. |
| The Global Health Institute | The Global Health Institute at NYC Health + Hospitals/Elmhurst supports and advances groundbreaking research, grows existing relationships with community and global partners, hosts educational events for the community and helps to improve clinical and patient experiences. |

| Other, continued | |
|---|---|
| **Initiative** | **Description** |
| 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.<br><br>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. |
| ExpressCare | ExpressCare provides the community with a new and convenient way to access health care through urgent care walk-in centers. Through ExpressCare, patients are promptly seen by a provider, connected to primary care and other services and enrolled in insurance when applicable. |
| 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. |
| 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 a 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 to provide sustainable mechanisms for high-value care. |

# APPENDIX: NYC HEALTH + HOSPITALS TRANSFORMATIVE INITIATIVES AND PROGRAMS BY BOROUGH

As of October 2019, the following initiatives and programs throughout NYC Health + Hospitals and organized by borough 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 | Bronx | Brooklyn, Staten Island | Manhattan | Queens |
|---|---|---|---|---|
| **Pregnancy and birth outcomes** | | | | |
| Comprehensive family planning services | | | Bellevue, Metropolitan | |
| Comprehensive maternal health programming | | System-wide | | |
| Maternal homeless support program | | Kings County | | |
| Maternal Medical Home | | Kings County | | |
| QINCA program | | Kings County | | |
| RELIAS | | | Bellevue | |
| Simulation training | | System-wide | | |
| Stork's Nest | | Kings County | | |
| **Airway diseases (asthma, COPD)** | | | | |
| "Ask Me, AsthMe!" program | | Kings County | | |
| Asthma-Free Bronx | Lincoln | | | |
| DSRIP Home-Based Environmental Asthma Program | Jacobi, Lincoln, North Central Bronx | Kings County, Woodhull | Bellevue, Harlem, Metropolitan | Elmhurst, Queens |
| Remote medication management | | | | Elmhurst |
| Smoking Cessation | Jacobi, Lincoln, North Central Bronx | Woodhull | Harlem | Elmhurst, Queens |
| **Behavioral health (mental health, substance use disorder)** | | | | |
| Assertive Community Treatment (ACT) | Jacobi, North Central Bronx | Coney Island, Woodhull | Bellevue, Metropolitan | Elmhurst, Queens |
| Behavioral health critical time interventions | Lincoln | Coney Island | Harlem, Metropolitan | |
| Community Advisory Board (CAB) community forums on opioids | | | Metropolitan | |
| Comprehensive Psychiatry Emergency Program (CPEP) | Jacobi, Lincoln, North Central Bronx | Kings County, Woodhull | Bellevue, Harlem | Elmhurst, Queens |

| Initiative | Bronx | Brooklyn, Staten Island | Manhattan | Queens |
|---|---|---|---|---|
| **Behavioral health (mental health, substance use disorder), continued** | | | | |
| Emergency Department Addiction Leads | | System-wide | | |
| Healthy Steps | | Coney Island | | |
| Inpatient Consult for Addiction Treatment and Care in Hospitals (CATCH) | Lincoln | Coney Island, Woodhull | Bellevue, Metropolitan | Elmhurst |
| Integrated care centers and collaborative care model | | System-wide | | |
| Medication Assisted Therapy (MAT) expansion | | System-wide | | |
| Partial Hospitalization (PHP) | North Central Bronx | Kings County | Bellevue | Elmhurst, Queens |
| School program for behavioral health adolescent inpatients | | | Metropolitan | |
| 3-2-1 IMPACT! | | | Bellevue | Queens |
| **Diet-related diseases (diabetes, hypertension)** | | | | |
| BlueStar app | | | Metropolitan | |
| Diabetes cooking classes | | Kings County | Metropolitan | |
| Diabetes Prevention Program | | System-wide | | |
| Digital Peer Mentoring Program | | Kings County | | |
| Food and nutrition resources | | System-wide | | |
| Plant-Based Lifestyle Medicine Program | | | Bellevue | |
| Primary Care-Centered diabetes management initiative | | System-wide | | |
| Shape Up NYC classes | Jacobi, Lincoln | Kings County | Harlem, Metropolitan | Elmhurst |
| 30-day care transitions | | System-wide | | |
| Treat-to-Target (T2T) Hypertension Program | | System-wide | | |
| **Aging and frailty** | | | | |
| Acute Care for the Elderly (ACE) Unit | | Woodhull | | |
| Community Services, Inc. partnership | | | | Queens |
| COMPACT Model | | Woodhull | | |
| Geriatrics practice | | Woodhull | | |
| NICHE certification | | System-wide | | |
| Palliative care | Jacobi, Lincoln | | Bellevue, Harlem, Henry J. Carter, Metropolitan | Elmhurst, Queens |
| Senior community engagement efforts | | | Metropolitan | |

| Initiative | Bronx | Brooklyn, Staten Island | Manhattan | Queens |
|---|---|---|---|---|
| **Homeless or individuals with housing instability** | | | | |
| Housing assistance | North Central Bronx | Kings County, Woodhull | Bellevue, Harlem, Metropolitan | Elmhurst |
| Hospital-housing developer partnerships | | Kings County, Woodhull | Metropolitan | Queens |
| Respite and transitional housing | Jacobi, Lincoln | Kings County, Woodhull | Bellevue | Elmhurst, Queens |
| **Incarcerated or previously incarcerated** | | | | |
| Point of reentry/transition clinic for correctional health | | Kings County | Bellevue | |
| **Immigrants** | | | | |
| Interpreter services, any modality | | System-wide | | |
| NYLAG Clinics | | System-wide | | |
| Program for Survivors of Torture | | | Bellevue | Elmhurst |
| **LGBTQ** | | | | |
| Leader in LGBTQ Healthcare Equality designation | | System-wide | | |
| The Pride Health Centers | | | Bellevue, Metropolitan | |
| **Adolescents and young adults** | | | | |
| 100 Schools Project | | System-wide | | |
| KIDs Ride Program | | Woodhull | | |
| Union Settlement Youth Opportunity Hub | | | Metropolitan | |
| YouthHealth centers | | System-wide | | |
| **Survivors of domestic violence** | | | | |
| Family Justice Centers | | System-wide | | |
| SAFE program | | System-wide | | |
| **Individuals with food insecurity** | | | | |
| Access to food and nutrition resources, including farmers markets, food coordinators, local food partnerships and medically-tailored meals | | System-wide | | |
| **Other** | | | | |
| East Harlem Community Alliance | | | Metropolitan | |
| Expand health care, insurance and benefits enrollment | | System-wide | | |
| The Global Health Institute | | | | Elmhurst |
| Tax preparation services | | Kings County | | Elmhurst |
| Violence prevention programs (e.g. Guns Down Life Up (GDLU), Kings Against Gun Violence (KAVI)) | Jacobi, Lincoln, North Central Bronx | Coney Island, Kings County, Woodhull | Bellevue, Harlem | Queens |

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

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

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

| Initiative | Bronx | Brooklyn, Staten Island | Manhattan | Queens |
|---|---|---|---|---|
| **State of the workforce** | | | | |
| CityDoctors Scholarship | | System-wide | | |
| Clinical Leadership Fellowship | | System-wide | | |
| Clinician recruitment programs and campaigns | | System-wide | | |
| Healthcare Administration Scholars | | System-wide | | |
| Nursing Career Ladder | | System-wide | | |

| Initiative | Bronx | Brooklyn, Staten Island | Manhattan | Queens |
|---|---|---|---|---|
| **State of the workforce, continued** | | | | |
| Nurse Residency Program | | System-wide | | |
| Professional development programs for clinicians and staff | | System-wide | | |
| **Information sharing** | | | | |
| Epic Care Link | | System-wide | | |
| Epic Community Connect (OneConnect) | | System-wide | | |
| Epic H2O and MyChart | | System-wide | | |
| Epic Healthy Planet | | System-wide | | |
| Patient appointment reminders | | System-wide | | |
| **Financial sustainability** | | | | |
| MetroPlus and GetCoveredNYC Enrollment Expansion | | System-wide | | |
| Revenue and expense improvement opportunities | | System-wide | | |
| NYC Health + Hospitals' Financial Transformation Plan through revenue and expense improvement opportunities | | System-wide | | |
| **System complexity and scale** | | | | |
| OneCity Health CBO capacity building | | System-wide | | |
| OneCity Health primary care capacity building | | System-wide | | |

# APPENDIX: PROPOSED SOLUTIONS FOR CONSIDERATION

Below is a complete list of proposed solutions designed collaboratively during Implementation Strategy Plan working group meetings to address the needs identified in the 2019 CHNA.

Solutions voted on by Implementation Strategy Plan working group members as highest priority are indicated below with an icon.

| Priority health need: Reducing the burden of life cycle-driven illness and health equity challenges | |
|---|---|
| **Health and wellness of all populations**  | **Wellness University:** The Wellness University would be an innovative, patient-centered model integrating physician care plans, wellness and health promotion activities. Community health workers would partner with patients and their physicians at a community-based site to support populations in accessing a healthy life cycle and achieving optimal health outcomes. Recognizing the limitations of a 20 minute visit with primary care providers, community health workers and patients, working together in the Wellness University, would have sufficient opportunities in a respectful, shame-free venue to master the elements of their care plans and become empowered to take charge of their health. |
| **Pregnancy and birth outcomes**  | **E-Mom program for pregnant individuals with housing insecurity:** The E-Mom program would allow pregnant individuals with housing insecurity easy access to coordinated care visits with multi-disciplinary collaboration with the following focus areas: healthy babies, safe, stable housing, nurturing relationships and economic sustainability. |
| **Airway diseases**  | **Expansion of telehealth and health monitoring devices:** Digital health innovations integrated with inhalers can give providers access to real-time patient data to better support management of treatment plans for patients with airway diseases. |
| **Behavioral health** | **Expanded co-location and integration of primary care, behavioral health and substance use disorder services:** Patients suffering from substance use disorders must be able to seamlessly access coordinated, integrated care in one location, across NYC Health + Hospitals. Through co-location of services, the model can alleviate existing regulatory barriers around data sharing. |
| **Diet-related diseases** | **New models for on-site food markets:** Food markets (sometimes referred to as food pharmacies) provide supplemental foods to patients based on clinical and social need through a prescription from their interdisciplinary care team. Expansion would continue positive success measures experienced thus far. |
| | **SEA Change:** The Screening, Education and Access (SEA) Change program would utilize volunteer community advocates in the community including places of worship, employment, residence, refuse and recreation to screen, educate and promote access to health care in communities where individuals face high rates of diet-related diseases such as hypertension, diabetes and cardiovascular disease. |
| **Aging and frailty** | **Coordinated referral process for aging populations:** A coordinated network of services tailored to aging populations is critical to address their needs holistically. Coordinating the referral process would support in providing this essential care. |
| **Populations with health equity challenges** | **Health Advocacy Partners program:** The Department of Health and Mental Hygiene's Harlem Health Advocacy Partners (HHAP) program partners residents living in New York City Housing Authority (NYCHA) developments with community health workers, organizers and health advocates to support them to access needed services, enable healthy behavior change, support disease management and build a community. The program has demonstrated HbA1C reductions in individuals with diabetes, improved blood pressure control in persons with hypertension and reduced hospital and Emergency Department visits for persons with asthma. Expansion would further address the needs of populations with these health equity challenges. |
| **Other** | **Data integration across child welfare and health care systems:** Enhanced integration between NYC Health + Hospitals electronic health records system and the State Welfare Case Management system would allow health care providers and child protective service workers to promote bidirectional information sharing and coordinated care. |

| Priority health need: Rethinking health care systems | |
|---|---|
| **Ease of access and navigation** | **Ease of clinical and community referrals:** Enabling closed loop referrals between clinical providers and community partners through Epic would enhance care coordination through two-way communication. |
| | **Improve interpreter services:** Expanded access to interpreter services using varied communication modalities (e.g. video chat) and through the use of high-quality medical interpreters. |
| | **Augment patient call center:** A patient access care center would augment existing patient call center functions and support the patient and interdisciplinary care team around communication and information sharing, cost transparency, clinical needs and prescription refills through Epic H2O. |
| **Patient-provider relationships** | **Facilitation of discharge:** Modifications to the discharge process, especially for patients who require equipment, home care services or placement in post-acute care facilities would improve the patient experience as well as health outcomes. Many patients don't have coverage for these services and thus remain in the acute care setting, representing suboptimal care for the patients and an enormous cost to the health system. This expansion would promote patient understanding of their health action plan and ease access to coordinated follow-up care. |
| **Health care cost and transparency** | **Patient engagement and activation programs:** This type of program would aim to encourage patients, possibly through incentives, to regularly engage with their interdisciplinary care team and in other health promotion and wellness services. |
| | **Training on billing:** This training would expand provider and staff education around billing and health care costs in support of patient-centered care. |

| Priority health need: An infrastructure for scaling | |
|---|---|
| **State of the workforce** | **Career development program:** A comprehensive workforce development program would create clear career ladders through increased training opportunities towards obtainment of certificates, degrees and licenses, tuition reimbursement, mentorship programs and establishment of joint practice/teaching positions with local, public colleges and universities (e.g. CUNY). |
| **Information sharing** | **Improve information sharing and communication across provider entities and care teams:** Through Epic, collaboration and information sharing across interdisciplinary care teams, the OneCity Health PPS partner network and city agencies would continue to promote coordinated, longitudinal relationships between patients and providers. |

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