Weill Cornell Medical Center


Lawrence Hospital

Columbia University Irving Medical Center

Westchester Division

The Allen Hospital

Lower Manhattan Hospital

Morgan Stanley Children's Hospital

# NewYork-Presbyterian Hospital

# Community Service Plan (CSP) Implementation Plan 2019-2021

October 2019

## County/Counties or service area covered in this assessment and plan:

There are 380 community ZIP codes mostly within NYC (including portions of Bronx, Kings, New York, Queens, and Richmond Counties), but also neighboring communities of NYC (including portions of Westchester, Nassau, Dutchess, Orange, Putnam and Rockland Counties).

## Participating Local Health Department(s) (LHDs) and contact Information:

The New York City Department of Health and Mental Hygiene
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Westchester County Department of Health
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## Participating Hospital/Hospital System(s) and contact information:

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## Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals:

NewYork-Presbyterian, NewYork-Presbyterian Allen Hospital, NewYork-Presbyterian/Columbia University Irving Medical Center, NewYork-Presbyterian Hospital/Weill Cornell Medical Center, NewYork-Presbyterian Morgan Stanley Children's Hospital, NewYork-Presbyterian Lawrence Hospital, NewYork-Presbyterian Lower Manhattan Hospital, and NewYork-Presbyterian Westchester Behavioral Health Center.

Also, the Westchester County Health Planning Coalition (WCHPC), inclusive of the Westchester County Department of Health (WCDOH) and the sixteen local Westchester County Hospitals are collectively working together to identify and address local health priorities associated with the New York State Prevention Agenda (NYSPA).

# Table of Contents

## *Executive Summary*

## *Introduction to Our Community Service Plan (CSP)*

NewYork-Presbyterian Hospital (NYPH) completed a Community Health Needs Assessment (CHNA) to identify the needs of the community we serve, developed a Community Service Plan (CSP) and developed an implementation plan to address the areas of highest need. The community, spanning from New York City to the counties just outside of NYC, represent a broad diversity of demographics, socioeconomics, and health service utilization needs, and require a custom approach to community service planning. The leaders of NYPH are dedicated to the community with a mission to be the premier healthcare institution serving our greater community by providing excellence in clinical care and patient safety, education, clinical research, and service. This document outlines the process, priorities, partners, and intended community-based improvement activities for 2019 – 2021. The CHNA process aligns with the 2019 – 2024 New York State Prevention Agenda. The Prevention Agenda is the state health improvement plan that develops a local action plan to improve the health and well-being of all New Yorkers and to promote health equity in all populations who experience disparities.

NYPH is part of NewYork-Presbyterian (NYP), one of the nation's most comprehensive and integrated academic healthcare delivery systems. Founded nearly 250 years ago with the fundamental belief that every person deserves access to the best care, NYP now includes NYPH with its seven campuses, the three Regional Hospitals consisting of NewYork-Presbyterian Queens, NewYork-Presbyterian Brooklyn Methodist Hospital, and NewYork-Presbyterian Hudson Valley Hospital, as well as more than 200 primary and specialty care clinics and medical groups, and an array of telemedicine services. NYPH and each of the Regional Hospitals conduct their own community health needs assessment and develop independent community service plans.

## *Partner Involvement & Commitment*

We collaborated with NYP, the New York City Department of Health and Mental Hygiene (DOHMH), the Westchester County Department of Health, Citizens' Committee for Children of New York (CCC), Columbia University Mailman School of Public Health (CUMSPH), Weill Cornell Medicine, Greater New York Hospital Association (GNYHA), local Community-Based Organizations (CBOs), and the New York Academy of Medicine (NYAM) to adopt a community focused process of collecting and analyzing measurable data (quantitative) and views voiced by the community (qualitative) from a variety of sources. The collaborative process ensured significant input from the key stakeholders and local community through questionnaires and focus groups conducted in multiple languages at multiple locations to engage the community in their setting. Our partner and communication engagement allowed us to customize an implementation plan to improve the health and wellness of the community.

## *Data Driven Priorities*

The CHNA and CSP process was data driven, utilizing publicly available and measurable data along with community input from numerous sources and were combined to analyze the health and challenges of our community. The analysis focused upon the identification of high disparity communities and utilized data related to demographics, socioeconomic status, insurance status, social determinants of health, health service utilization, and NY State Prevention Agenda priorities. Data sources include the Citizens' Committee for Children of New York (CCC) Keeping Track Online, Data City of New York, Data2Go.NYC, NYC Health Atlas; NYC Mayor Report on Poverty, the Association for Neighborhood & Housing Development, Behavioral Risk Factor Surveillance System (BRFSS), Claritas, NYC Community Health Profile, State Cancer Profiles, U.S. Department of Agriculture, Cares Engagement, Claritas, New York State Community Health Indicator Reports (CHIRS), the Robert Wood Johnson County Health Rankings, State Cancer Profiles and the United Hospital Fund. NYPH recognizes that our

community challenges are complex and healthcare outcomes are often linked to societal issues; therefore, community input from focus groups and community questionnaires were gathered and allowed for a diverse group of involvement with awareness to culture, race, language, age, gender identity and sexual orientation. The collected data was ranked to provide detailed insight into the communities with high disparities and was then prioritized to determine the highest health needs for the identified communities. The prioritized data provided insight into community health needs and challenges and allowed us to establish focus areas and goals as outlined in the New York State Prevention Agenda.

Based on the data collection, community input, and analysis processes completed, we, in partnership with local community based organizations, will target the neighborhoods of Washington Heights, Lower East Side, and Mt Vernon, which will allow the utilization of NYPH resources and new investment opportunities to concentrate improvement efforts and directly impact the community within the three-years of the service plan.

## *Priority Areas of Focus*

The analyzed and prioritized data allowed for the identification of a community of focus as well as priority areas to impact the healthcare of the most vulnerable populations. We will focus efforts related to the prevention of (1) chronic disease, (2) promotion of healthy women, and children, (3) promotion of well-being to prevent mental health and substance abuse and (4) prevention of communicable diseases. To align with the constantly changing dynamics of the community, we have revised the focus and initiatives as compared to our 2016-2018 community service plan which included the prevention of chronic disease by increasing tobacco cessation resources, mental health promotion through education and training, and the prevention of HIV, STD's, Vaccine-Preventable Diseases and Healthcare-Associated Infections.

## *Progress Improvement Tracking*

Initiatives will be tracked quarterly and data will be used to continuously improve the program based on the outcomes of the project as well as input from the community. Annual reports will be developed with our community partners in order to evaluate intervention impact (using both outcome and process measures) and submitted to meet state and federal expectations.

The Community Health Needs Assessment and Community Service Plans will guide our efforts for 2019 – 2021 as we strive to improve the health of our community. Access to this document is provided on our website at https://www.nyp.org/about-us/community-affairs/community-service-plans.

| Priority Area & Focus | Intervention / Strategy |
|---|---|
| **Prevent Chronic Disease** | |
| Goal 1.1 Increase Access to Healthy and Affordable Foods and Beverages | • Expansion of the existing NYPH Obesity Prevention Program Choosing Healthy & Active Lifestyles for Kids (CHALK). CHALK aims to address obesity using a socio ecological model as its theoretical framework. |
| **Promote Healthy Women, Infants, & Children** | |
| Goal 1.2 Reduce Maternal Mortality & Morbidity | • Implement the Healthy Steps – 2 Generation Approach Model for improving maternal-child health in primary care and community settings by providing integrated mental health services to low-income, and uninsured pregnant women and the newborn child, and establishing co-management strategies with partner community agencies. |
| **Promote Well-Being & Prevent Mental & Substance Use Disorders** | |
| Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan | • Increase the number of Mental Health First Aid (MHFA) trainings to NYPH Staff and Community and Faith Based organizations, in Washington Heights, Inwood, Lower East Side and Mt. Vernon. MHFA is an international training program proven to be an effective intervention for mental health education, prevention and addressing stigma. NYPH will partner with Gracie Square to increase our number of MHFA trainings. |
| Goal 2.4 Reduce the prevalence of major depressive disorders | • OMH licensed mental health program providing treatment in the home, community, and clinic sites in targeted communities and for targeted patients utilizing in-person and tele-mental health modalities for the geriatric population. |

| | |
|---|---|
| | • NYPH will partner with Gracie Square to expand our tele-psych visits |
| **Prevent Communicable Diseases** | |
| Goal 2.2 - Increase Viral Suppression<br>Goal 4.1 - Increase the number of persons treated for Hepatitis C Virus (HCV)<br>Goal 4.2 Reduce the number of new HCV cases among people who inject drugs | • The NYPH ETE Initiative would create a HIV and HCV elimination strategy that would a) increase HIV and HCV testing and linkage to care, b) re-engage HIV+ and HCV+ individuals to care, and c) expand effective HIV and HCV prevention services, like PrEP and Medication Assisted Treatment.<br>• Utilizing existing multi-campus dashboards the NYPH initiative would link, in real-time, all new HIV and HCV diagnoses, those (thousands) individuals out of care, and those in need of preventive services. Expanded deployment of a Health Priority Specialist in existing sites, like NYPH EDs, would be the effector arm for the intervention. In addition to a major investment in a Mobile Medical Unit (MMU). |

## Introduction

NewYork-Presbyterian Hospital (NYPH) is a world-class academic medical center committed to excellence in patient care, research, medical education, and community service. NYPH is ranked #1 in the New York metropolitan area by U.S. News and World Report and repeatedly named to the Honor Roll of "America's Best Hospitals." NYPH has approximately 2,600 beds, more than 6,500 affiliated physicians, and 20,000 employees; we have over 2 million visits annually including 310,000 emergency department visits. NYPH is comprised of, for the purposes of this CHNA, the following seven (7) campuses: five (5) in New York City: NewYork-Presbyterian/Weill Cornell Medical Center, NewYork-Presbyterian/Columbia University Irving Medical Center, NewYork-Presbyterian Morgan Stanley Children's Hospital, NewYork-Presbyterian Allen Hospital, NewYork-Presbyterian Lower Manhattan Hospital, and two (2) in Westchester County: NewYork-Presbyterian Lawrence Hospital, and NewYork-Presbyterian Westchester Behavioral Health Center.

## Purpose

NYPH is deeply committed to the community members residing in the boroughs of New York City, Westchester County, and the surrounding areas by delivering a range of innovative programs and services intended to educate and provide resources to prevent illness, maintain health, and improve the overall well-being of the community. The community health needs assessment (CHNA) process is undertaken every three years to determine the high need communities and health disparities that can be most positively impacted by focused interventions. The CHNA aligns with the New York State 2019-2024 Prevention Agenda (NYS PA) priorities to improve health equity for all New Yorkers through partnerships with community organizations to address social determinants of health (SDoH) and interventions to reduce disparities in health indicators. Through the NYS PA alignment with the health system CHNA process, the state has improved its overall national ranking from 28$^{th}$ to 10$^{th}$ healthiest state since 2008.

NYPH completed this CHNA to update its understanding of the needs of local community members and the conditions that influence their well-being, and to assemble a three-year plan to enhance community health in areas identified as high disparity neighborhoods. The CHNA and service plan data collection and action planning process utilized by NYPH was designed to achieve the following goals to ensure a comprehensive analysis of the community need:

## Definition of Health

The definition of health historically referenced only physical health, but the definition for this CSP is rooted in the knowledge that it is increasingly important to understand the broader components of health and well-being and how it can be impacted and improved. For the purpose of this document:

> *Health is a holistic combination of physical health (absence of sickness or pain), mental health, and wellness for which there is an individual and a community wide responsibility.*

## Process & Governance

NYPH engaged with NYP to create a collaborative, community focused approach to the development of the CHNA. NYP created a robust governance structure with representation from NYPH, the Regional Hospitals, community members, and community health experts. The following committees were convened for this process:

- *Data Committee* – managed the data collection and analysis process to ensure data integrity and inclusion of social determinant of health indicators and quality health indicators
- *Methods Committee* – created the processes to engage community members in the CHNA process through community health needs questionnaires and in-person focus groups
- *Steering Committee* – leadership engaged in oversight of the CHNA development and strategic decision making for the CHNA and CSP

In addition to the formal committee structure, NYP also convened Community Health Think Tank meetings across NYPH and the Regional Hospitals to engage key clinical and operational leaders in the process of initiative planning and operationalization. The Community Health Think Tanks are intended to continuously engage key stakeholders in the performance feedback and improvement process and support evaluation impact monitoring

and reporting for the CSP.

## *Partner Engagement*

In conducting the 2019 CHNA, NYPH collaborated with the New York City Department of Health and Mental Hygiene (NYC DOHMH), Westchester County Department of Health (WCDOH), Westchester County Health Planning Coalition, Westchester County Community Health Summit, Citizens' Committee for Children of New York (CCC), Columbia University Mailman School of Public Health (CUMSPH), Weill Cornell Medicine, New York Academy of Medicine (NYAM), and Greater New York Hospital Association (GNYHA). These partnerships ensure that all aspects of the CHNA process, from the data collection and analytics to the collection of community input and health need prioritization, were community centric in its approach. Each collaborator added to the ongoing work by providing insight on the publicly available data for the various regions specific to the NYPH high disparity communities, while providing guidance on collecting stakeholder and community feedback and incorporating best practices for the CHNA.

NYPH validated and refined the quantitative data results through the use of (1) primary data and community input from facilitation of focus groups and administration of community health need questionnaires to area residents as well as (2) leveraging other community assessments such as the Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment and the CCC's series of Community Needs Reports (in Northern Manhattan, Staten Island, Brownsville Community District in Brooklyn and Elmhurst-Corona in Queens).

NYPH engaged NYAM to gather qualitative information through an extensive process of community health needs questionnaires (CHNQs) and focus groups. The CHNQs gathered input from respondents across the five boroughs, Westchester County, and Putnam County on their perceptions of personal and community health, ways to improve the health of the community, and how they access both health systems generally and NYP specifically. NYAM also facilitated focus groups of community

members to obtain local perspectives on the health and needs of the community at large. NYPH partnered with several community-based organizations to host these twenty-two focus groups:

- Asian Americans for Equality
- Battery Park Seniors
- Brooklyn Pride Center
- Bronxville Senior Citizens, Inc.
- Caribbean Women's Health Association
- Carter Burden Network
- Caring for the Homeless and Hungry of Peekskill
- CAMBA
- Church of the Epiphany
- Columbia University Irving Medical Center
- Community League of the Heights
- Dominican Women's Development Center
- Downtown Health Association
- Eastchester Community Action Partnership
- Elmcor
- Field Library
- Hamilton-Madison House
- Harlem Pride
- Henry Street Settlement
- HOPE Community Services
- Hudson Valley Gateway Chamber of Commerce
- HRH Care Community Health
- Make the Road New York
- Marble Hill Resident Council
- Northern Manhattan Coalition for Immigrant Rights
- NYP Community Leadership Council
- NYP Lower Manhattan Community Advisory Board (CAB)

- Uptown Community Physicians
- NYP Weill Cornell Community Advisory Board (CAB)
- NYP Westchester Behavioral Health Center Community Advisory Board (CAB)
- People's Theatre Project
- Public Health Solutions
- Shorefront Y
- Stanley M. Isaacs Neighborhood Center
- Town of Yorktown New York
- The Korean Community Services of Metropolitan New York Inc.
- The Yorktown Chamber of Commerce
- Upper Manhattan Interfaith Leaders Coalition
- Weill-Cornell Medicine
- Yonkers Police Athletic League

## Data Mining & Analytics

NYPH engaged in a dynamic data collection and analytic process to ensure that the community and its needs were well represented throughout the CHNA development process. NYPH utilized both quantitative and qualitative data to create a picture of the health needs of the defined communities. The quantitative data focused on publicly available measurable indicators at the Neighborhood Tabulation Area (NTA) for the New York City community and county level indicators for geographies outside of NYC, while the qualitative data focused on the primary perspectives and input from community members obtained through questionnaires and focus groups. Additionally, NYPH leveraged community assessments to provide additional perspectives of the community including the Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment and the CCC's series of Community Needs Reports (in Northern Manhattan, Staten Island, Brownsville Community District in Brooklyn and Elmhurst-Corona in Queens).

### Quantitative Data

NYPH utilized data sets from multiple sources to analyze community health need and health risks to the specific neighborhood level in NYC. The analysis utilized the Neighborhood Tabulation Area (NTA) geography of 29 indicators across five domains: demographics, income, insurance, access to care and New York State Prevention Agenda (NYS PA). Additional indicators, among categories of demographics, socioeconomic status, insurance status, social determinants of health (SDoH), health status, and health service utilization were collected to assess community health needs, to identify disparities, to utilize in prioritizing the implementation strategies and to support health intervention planning (See data sources in Appendix A).

The NYPH defined community also included geographies outside of NYC. An analysis of community health need and risk of high resource utilization was undertaken by ZIP code using the Community Need Index (CNI) score which is an average of five different barrier scores that measure various socio-economic indicators of each community. The

resulting information provided an illustration of where there is more or less need comparatively between communities by ZIP code. Although the CNI score was obtainable at the ZIP code level, indicators for the non-New York City communities were publicly available at the county level. Indicators similar to those collected by NTA were evaluated for Dutchess, Nassau, Orange, Rockland and Westchester Counties.

### *Qualitative Data*

NYPH underwent an extensive process to obtain community input through numerous forums. The qualitative data was obtained through community questionnaires and surveys, focus groups, and extensive community asset research reports. The community input ensured a comprehensive representation of our community inclusive of multiple languages, socio-economic statuses, culture, race, age, and gender identity. Summaries of each qualitative input source are included below, and additional details can be found in the Community Health Needs Assessment at https://www.nyp.org/about-us/community-affairs/community-service-plans.

**Focus Groups & Questionnaires**

The New York Academy of Medicine was engaged to complete a community needs questionnaire (CHNQ) and focus groups of the NYPH community. The CHNQs were conducted in person at community events, focus groups, and at campus NYP Community Advisory Board (CAB) meetings. NYPH received 1,074 responses, of which 49.1% were received in-person, 43.9% online, and 7.0% NYP CAB meetings.

Twenty-two (22) focus groups were conducted across NYC and Westchester County in partnership with community-based organization and the NYP CABs. Focus groups were completed in multiple languages and events were held to ensure diversity and engagement that truly represents the community.

### Westchester County Department of Health (WCDOH) Community Health Survey

The Westchester County Department of Health completed a survey of Westchester County residents to gain insight into their perspectives on personal health, community health needs, and mechanisms for improving community health. NYAM completed an analysis of a subset of the responses WCDOH received for the residents within the NewYork-Presbyterian Lawrence Hospital community in southern Westchester County; 2,047 of the 3,524 total responses WCDOH received.

### Westchester County Community Health Summit

The Westchester County Health Planning Coalition collaboratively hosted a Community Health Summit to elicit feedback from the local community, government, and health and social service providers related to their perspective on the health and social needs of their clients with the goal of advancing the NYS PA priority areas. Over 70 attendees across health and community-based organizations participated in the facilitated sessions and a gallery walk intended to promote conversation focused upon four of the NYS PA priority areas:

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants, and Children
4. Promote Well-Being and Prevent Mental and Substance Use Disorder

Attendees identified strengths and resources in the community, barriers and gaps to improvement, action items that would benefit and align with the NYS PA priority areas, and SDoH that are essential to any developing strategies.

**Herbert Irving Comprehensive Cancer Center of Columbia University Community Health Needs Assessment**

In 2018, the Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University conducted a community health needs assessment for the five New York City boroughs, Westchester, and Rockland Counties in New York, and Bergen County in New Jersey. The assessment, developed with 15 other National Cancer Institute (NCI) funded sites across the country, was further refined with NYC-specific questions through collaboration with Albert Einstein and Mount Sinai Cancer Centers. The survey includes questions related to healthcare access and barriers, screening behaviors, social determinants of health, demographics, HPV and hepatitis screening and vaccination, tobacco use, medication use, alcohol use, physical activity, environmental exposures, cancer family history, survivorship, and views and attitudes toward genetic testing and clinical trials.

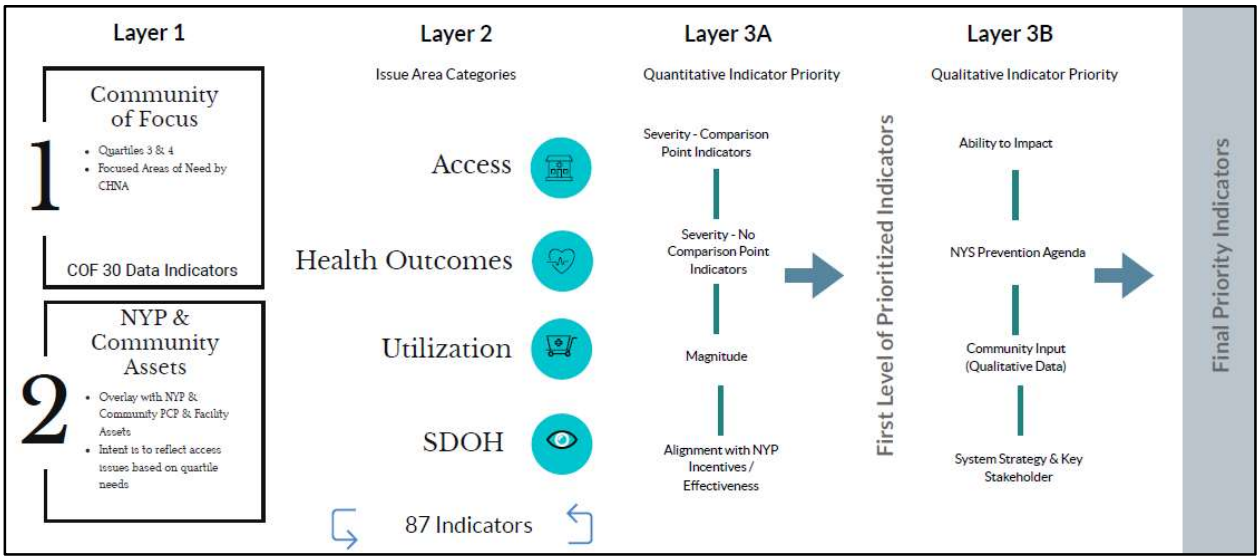
**Citizens' Committee for Children of New York (CCC)**

The Citizens' Committee for Children of New York (CCC) gathered quantitative and qualitative data to identify assets or resources in several NYC neighborhoods. The resulting publications are 1) From Strengths to Solutions: An Asset-Based Approach to Meeting Community Needs in Brownsville – A Citizens' Committee for Children of New York Report , 2) Celebrating Strengths, Addressing Needs: Community Driven Solutions to Improve Well-Being in Northern Manhattan, 3) The North Shore of Staten Island: Community Driven Solutions to Improve Child and Family Well-Being, and 4) Elmhurst/Corona, Queens: Community Driven Solutions to Improve Child and Family Well-being detail these communities, their biggest issues, numerous assets and specific recommendations for health. For the full reports on the CCC New York website refer to https://www.cccnewyork.org/data-reports/.

## *Data Prioritization Process*

A prioritization process was created to analyze the quantitative and qualitative data inputs collected through the CHNA process. The process had several layers in which the data was input and prioritized to arrive at the final priority indicators.

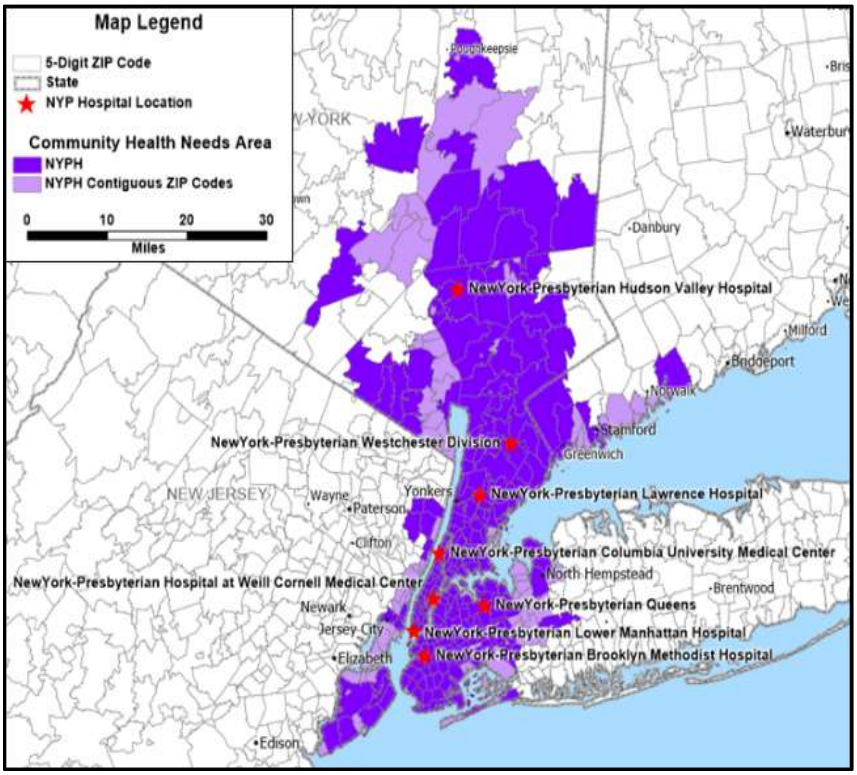
- **Layer 1** – the data from the community of focus for the 3rd and 4th quartiles (high risk areas) was utilized for the prioritization process.
- **Layer 2** – The data indicators was categorized into four categories (1) Access, (2) Health Outcomes, (3) Utilization, and (4) Social Determinants of Health (SDoH).
- **Layer 3A** – the quantitative data was ranked based on three criteria (1) severity – with a comparison to NYC or without a comparison, (2) magnitude of the population impacted, and (3) alignment with current NYPH initiatives.
- **Layer 3B** – the 3rd and 4th quartile (highest risk) data from layer 3A was utilized for layer 3B of the model; the qualitative data for this section was ranked based on four indicators of (1) ability to impact the indicator, (2) alignment with the NYS PA, (3) Community Input, and (4) NYP system stakeholder input.



## COMMUNITY HEALTH ASSESSMENT

### *Our Community At Large*

The community definition for NewYork-Presbyterian Hospital was derived using 80% of ZIP codes from which NYPH's patients originate and adding ZIP codes not among the original patient origin to create continuity in geographical boundaries, resulting in a total of 380 community ZIP codes across New York City (NYC) and several counties outside of NYC.



**NYPH Defined Community Highlights**

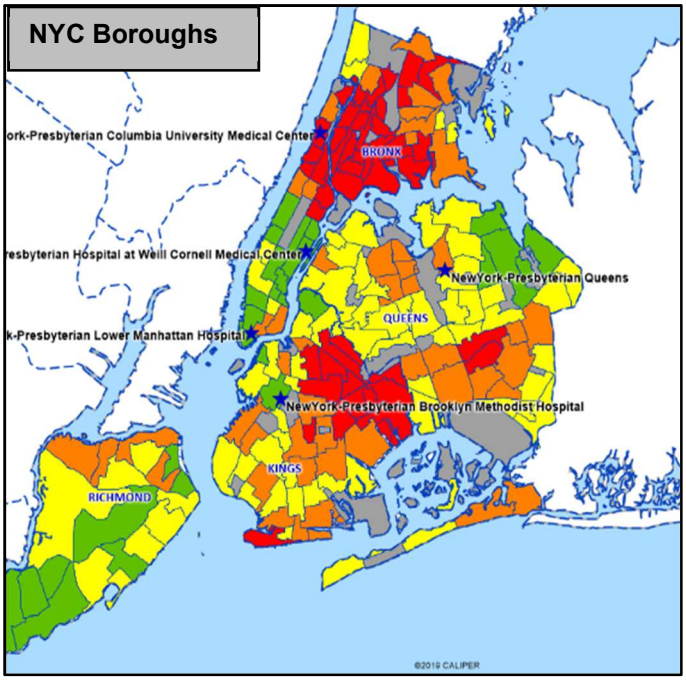
| | | |
|---|---|---|
| **11.7M PEOPLE**  <br>The defined community covers a geography of approximately 11.7M people | **2.6% GROWTH POPULATION**  <br>Forecasted to grow faster, 2.6%, than NYS 1.5%, between 2019-2024 | **14.7% 65+ POPULATION**  <br>Is slightly younger with only 14.7% of the population aged 65+ compared to 16.3% |
| **$109,086 HOUSEHOLD INCOME**  <br>The average household income, $109,086, is higher than the average of New York State, $101,507 | **6.9% UNEMPLOYMENT RATE**  <br>The unemployment rate, 6.9%, is 9% higher than the state benchmark; 1% higher percentage of white-collar workers than the state avg. | **Higher Minority Population**  <br>Higher non-White population, 63.8%, than the state 45.6%, driven by Hispanics, 28.7% and African Americans, 18.6% |

## *Our Communities of High Disparity*

To ensure that we are implementing initiatives that will impact the communities with the highest disparities with this community service plan, NYPH undertook additional analysis of community health need and risk of high resource utilization at the Neighborhood Tabulation Area (NTA) geography based upon a composite of 29 different indicators. Indicators were carefully selected across five domains: demographics, income, insurance, access to care, and New York State Department of Health Prevention Agenda Priorities. This analysis was done in parallel for both the NYPH communities located within the NYC boroughs and the communities within the surrounding counties outside of NYC.

## New York City Boroughs – Communities of High Disparity

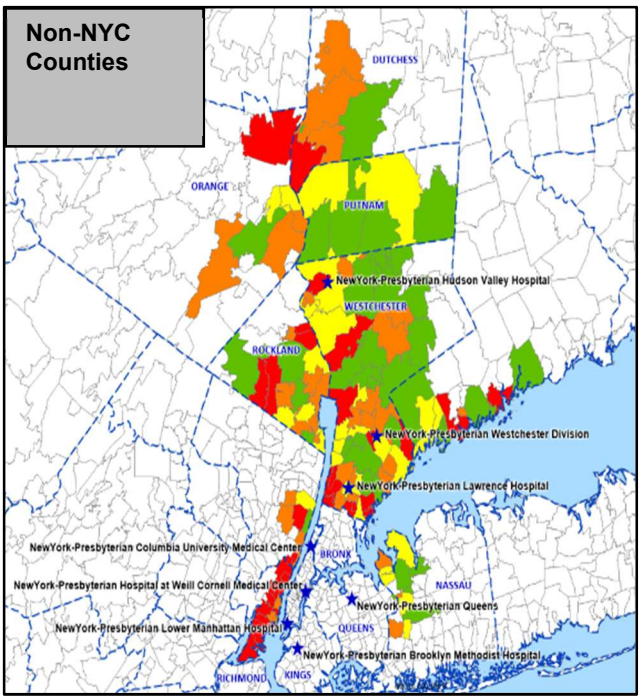
The objective was to identify the specific NYC NTAs where there is a higher health need and/or a higher expectation of required resources. The defined community's NYC ZIP codes were cross walked to 195 NTAs and then categorized into four quartiles based on identified disparities. Additional analysis was undertaken for the 97 NTAs of higher disparity in quartiles 3 and 4.




### NYPH High Disparity NYC Community Highlights

| | | |
|---|---|---|
| **4.8M PEOPLE**<br>The high disparity NYC community covers a geography of approximately 4.8M people | **52.8% FEMALE**<br>It is 52.8% female and slightly younger, 11.2% of the population is 65+, compared to NYC, 12.5% | **26.8% DID NOT COMPLETE HIGH SCHOOL**<br>There are more than NYC average percentages of residents foreign born, non-English speaking, not graduated from high school, unemployed, disabled, and single parents |
| **26.4% LIVING IN POVERTY**<br>There are more living in poverty, all ages 26.4%, than the NYC average, 20.6% and are without health insurance, 15.9%, than the NYC average, 13.5% | **43.7% MEDICAID ENROLLMENT**<br>Numerous neighborhoods also have a higher than average Medicaid enrollment, overall 43.7%, NYC 37.0% | **85.5% MINORITY POPULATION**<br>Has a much higher minority population at 85.5% (especially Black and Hispanic/Latino) than does the NYC average 67% |

## Counties Outside of New York City – Communities of High Disparity




The NYPH defined community includes areas outside of and just outside of NYC. An analysis of community health need and risk of high resource utilization was undertaken by ZIP code using the Community Need Index (CNI) score which is an average of five different barrier scores that measure various socio-economic indicators of each community. The resulting information provided an illustration of where there is more or less need comparatively between communities by ZIP code. Although the CNI score was obtainable at the ZIP code level, indicators for the non-New York City communities were publicly available at the county level. Indicators similar to those collected by NTA were evaluated for 1) Dutchess, 2) Nassau, 3) Orange, 4) Rockland and 5) Westchester Counties.

**NYPH Non-NYC Counties Highlights**

| | | |
|---|---|---|
| **3.4M PEOPLE**  <br><br>The five counties cover a geography of approximately 3.4M people | **52.8% FEMALE**  <br><br>Is 51.1% female and slightly older, 17.1% of the population is 65+, compared to NYC, 12.5% and NYS 16.3% | **10.7% DID NOT COMPLETE HIGH SCHOOL**  <br><br>There are more than NYS average percentages of residents that speak only English at home and that graduated from high school, but less unemployed, disabled and single parents |
| **6.2% FAMILIES LIVING IN POVERTY**  <br><br>There are less families living in poverty, 6.2%, than the NYS average 11.3%, but more have health insurance 89.5%, than the NYS average 87.6% | **26.8% MEDICAID ENROLLMENT**  <br><br>There are fewer enrolled in Medicaid 26.8% than the NYS average 38.1% | **41.4% MINORITY POPULATION**  <br><br>Has a lower minority population at 41.4% than does the NYC average 67%, or the NYS average 45.6% |

### *NYPH Data Highlights – High Disparity Community & Priority Areas*

Acknowledging there was variation across the NTAs and counties among specific measurable indicators for demographics, socioeconomics, Social Determinants of Health (SDoH), health status, and utilization as each require a custom approach to community service planning, there were specific communities that frequently showed more need than the others. With such a large community, covering all five boroughs of New York City and five of the counties surrounding the city, there are many neighborhoods that fell into the high disparity (3rd and 4th quartiles) communities based on the analysis and prioritization or the quantitative and qualitative data collected for the CHNA.

The NYPH community is diverse in its geography with the NYC NTAs having a younger, more minority, and economically challenged population. The SDoH concerns are concentrated upon language, safety, food insecurity, high cost of housing, and public transportation. Behavioral risk factors such as smoking, drinking, and consuming fruits and vegetables vary among the NTAs but are problematic for those in high-disparity neighborhoods.

At the same time NYPH must also serve a county population that is older, has less minorities, and is less economically challenged. The population is more likely to speak only English but still has similar SDoH concerns such as food insecurity and high cost of living. There is variance among counties for behavioral risk factors and health status that range from favorable to unfavorable. Complicating access to health care in the five counties can be the fewer number of physical health care locations than are currently available in NYC.

NYPH recognizes that community health requires a diverse approach and multiple interventions to what may seem to be the same problem for a population as complex as our defined community.

In an effort to focus initiatives to make the largest impact to high disparity communities, the NYPH team analyzed all data elements and identified Washington Heights, Lower East Side, and Mount Vernon communities targeting (1) Obesity, (2) Women, Infant, and Children's Health, (3) Behavioral Health (Mental Health & Substance Abuse), and (4) HIV & Hepatitis C. Below is a summary of the analytical findings for the focused communities:

## NYPH Data Highlights for NYS PA Priority Areas

| Priority Area | NYC NTA | Counties Outside NYC | NY State Community Health Indicator Report Trends |
|---|---|---|---|
| **Prevent Chronic Disease Focus Area 1: Healthy Eating and Food Security** | **Adult Obesity**<br>Washington Heights North 26.0% ↑ than NYC<br>Washington Heights South 26.0% ↑ than NYC<br>Lower East Side 10.0%, ↓ than NYC<br>High Disparity NTAs 28.5%<br>NYC 24.0%<br><br>**Child Obesity**<br>Washington Heights North 24.0% ↑ than NYC<br>Washington Heights South 24.0% ↑ than NYC<br>Lower East Side 16.0% ↓ than NYC<br>High Disparity NTAs 22.3%<br>NYC 20.0% | **Adults Consuming 1+ Sugary Drinks per Day**<br>Westchester County 12.2%<br>NYS No Comparison<br><br>There are more adults self-reporting obesity in Dutchess, 27.0% and Orange, 29.7%, than the NYS average, 25.5%. Child obesity is highest in Orange, 19.0%. NYS, 17.3 | Trend data suggests that there may be some improvement among pre-school aged children, but continued efforts are needed among school aged children and adults. |
| **Promote Healthy, Women, Infants, and Children Focus Area 1: Maternal & Women's Health** | **The crude rate of maternal morbidity per 10,000 deliveries**<br>Washington Heights North 169.2 ↓ than NYC<br>Washington Heights South 199.0 ↓ than NYC<br>Lower East Side 162.7, ↓ than NYC<br>High Disparity NTAs 282.3<br>NYC 229.6<br><br>**Percent of preterm births among all live births**<br>Washington Heights North 9.4% ↑ than NYC<br>Washington Heights South 8.3% ↓ than NYC<br>Lower East Side 9.7%, ↑ than NYC<br>High Disparity NTAs 10%<br>NYC 9.1% | Westchester County<br>**Low Birthweight Rates**<br>Black Women 12.7%<br>Asian Women 8.8%<br>NYS 7.9%<br><br>**Premature Birth Rates**<br>Black Women 15.7%<br>Hispanic Women 11.1%<br>White Women 10.6%<br>Asian Women 10.6%<br>NYS 8.8%<br><br>Nassau, 21.4, has a higher maternal mortality rate per 100,000 live births than NYS, 18.7. | Trend data suggests there has been no significant change in the performance of maternal mortality rate per 100,000 live births. |

| Priority Area | NYC NTA | Counties Outside NYC | NY State Community Health Indicator Report Trends |
|---|---|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders**<br>**Focus Area 1: Promote Well-Being**<br>**Focus Area 2: Prevent Mental and Substance Use Disorders** | **The percent of the population self-reporting "poor mental health"**<br>Washington Heights North 9.8% ↕ to NYC<br>Washington Heights South 9.8% ↕ to NYC<br>Lower East Side 9.8%, ↓ than NYC<br>High Disparity NTAs 10.9%<br>NYC 10.3%<br><br>**Hospitalizations per 100,000 ↑ than NYC in Lower East Side**<br>Alcohol 1,150, NYC 955<br>Drug 1,241, NYC 882<br>Psychiatric 1,051, NYC 774 | Mental Disorders were the cause of 57.3% of ED visits for Westchester County<br><br>Dutchess, 13.7%, and Orange, 11.8%, have a higher percentage of the population self-reporting poor mental health than NYS average 10.7. | Trend data are not available, but the lack of available, affordable and convenient mental health services has been commented upon qualitatively. |
| **Prevent Communicable Diseases**<br>**Focus Area 2: HIV**<br>**Focus Area 4: HCV** | **New diagnoses of HIV** per 100,000 population<br>Washington Heights North 31.4 ↑ than NYC<br>Washington Heights South 31.1 ↑ than NYC<br>Lower East Side 15.2, ↓ than NYC<br>High Disparity NTAs 31.2<br>NYC 24.0<br><br>**New HCV diagnoses per 100,000 population**<br>Washington Heights North 58.8 ↓ than NYC<br>Washington Heights South 60.3 ↓ than NYC<br>Lower East Side 64.3, ↓ than NYC<br>High Disparity NTAs 65.7<br>NYC 71.8 | Overall, new diagnoses of HIV per 100,000 population are lower, 9.5, than NYS 17.9. New diagnoses of HCV were not publicly available. | The NY State Prevention Agenda is focused to a three-point plan to move closer to end the AIDS epidemic by decreasing the number of new HIV infections and to decrease the HIV prevalence in New York State. |

↕ indicates close to the NYC or NYS rate

## *Community Challenges & Contributing Factors*

NYPH completed a robust collection of community input for the CHNA process through questionnaires and focus groups. These qualitative data pieces focused on basic demographics, health concerns (individual and community-wide), health care utilization, barriers to care, and use of healthcare services. This data was collected in partnership with numerous community organizations, which were identified to represent a range of populations, e.g., older adults, immigrant, and homeless populations.

### Community Health Needs Questionnaires

NYAM conducted a Community Health Needs Questionnaires (CHNQs) process for community members and residents across the NYPH community of the five boroughs of NYC, Westchester County, and Putnam County; 1,074 CHNQs were completed in-person (49.1%), online (43.9%), and with the NYP Community Advisory Boards (NYP CABs) (7.0%). Below is a summary of the responses that were received for the most commonly reported community health issues and recommendations to improve community health:

| **Most commonly reported community health issues *** | **N=1,074** | |
|---|---|---|
| **Community health issue** | **n** | **%** |
| Alcohol & drug use | 478 | 44.5% |
| High blood pressure | 444 | 41.3% |
| Diabetes | 437 | 40.7% |
| Mental health | 411 | 38.3% |
| Cancer | 398 | 37.1% |
| Obesity | 377 | 35.1% |
| Tobacco use | 335 | 31.2% |
| * Multiple responses permitted.<br>Note: Responses selected fewer than 30% of the time are not presented. | | |

| Recommendations to improve community health* | N=1,074 | |
|---|---|---|
| **Community health recommendations** | **n** | **%** |
| Improved housing conditions | 452 | 42.1% |
| Increased # of places for older adults to live and socialize in | 449 | 41.8% |
| Reduced cigarette/vaping smoke | 430 | 40.0% |
| More local jobs | 403 | 37.5% |
| Cleaner streets | 402 | 37.4% |
| Reduced air pollution | 390 | 36.3% |
| Reduction in homelessness | 358 | 33.3% |
| More parks and recreation centers | 352 | 32.8% |
| Reduced crime | 315 | 29.3% |
| Mold removal | 272 | 25.3% |

*Multiple responses permitted
Note: Responses selected fewer than 24% of the time are not presented

## Focus Groups

In addition to the CHNQs, NYPH partnered with NYAM to conduct focus groups with community members to gain more in-depth insights from the community members. NYPH collaborated with community-based organizations to conduct the twenty-two focus groups, which were held in multiple languages. Participants shared their thoughts on the greatest community health concerns, social determinant of health issues, other problems affecting the community and healthcare, and their recommendations on how to positively impact community health.

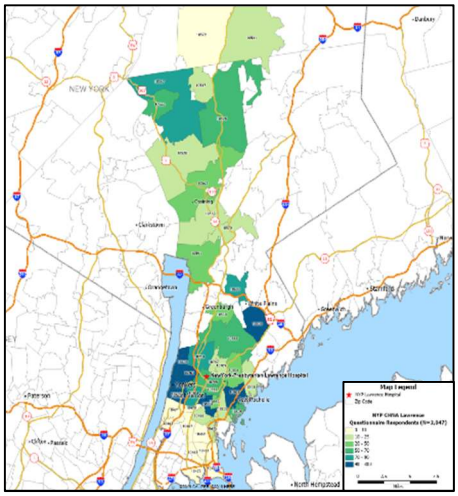
| Greatest Health Concerns | Social Determinants of Health | Other | Participant Recommendations |
|---|---|---|---|
| •Asthma<br>•Cancer<br>•Diabetes<br>•Disability & Mobility Issues<br>•Maternal – Child Health<br>•Mental Health<br>•Pain<br>•Smoking | •Income & Employment<br>•Access to Affordable Healthy Food – especially in Washington Heights and Lower Manhattan<br>•Housing<br>•Immigration & Deportation Fears<br>•Social Isolation<br>•Transportation<br>•Environmental Conditions | •Mental Health service shortages<br>•Community is used for research<br>•Mixed feelings on telehealth – older population tended to prefer in person | •Disease specific support groups<br>•Linkages to transportation<br>•Affordable Dental Services<br>•House Call Program<br>•Wellness Checks at Senior Centers<br>•Employment Programs<br>•Increased Bilingual Staff |

Diabetes, obesity, hypertension, and lack of healthy food choices are – they all go together in this neighborhood. You see nothing but Popeye's, McDonald's. When I go into BJ's, and go shopping, I see people buying nothing but salt and sugar foods.

We come from a generation where mental health – we don't talk about that. Nobody goes to counselors. Forget it. Psychiatrists – forget it. But, the truth of the matter is there's a tremendous need for it, but there's a stigma around it.

"When we cannot speak without our own – the English language, when we don't speak, we cannot tell what we feel, what we have problems, then doctors don't understand some medical issues."

## Westchester County Department of Health – Community Needs Survey



The Westchester County Department of Health conducted a community health needs survey of the residents of Westchester County. WCDOH received 3,524 responses to the survey which asked questions about personal and community health issues and how best to improve community health. NYPH had NYAM complete an analysis of a subset of the responses (2,047) from the southern Westchester County area that fell into the NewYork-Presbyterian Lawrence Hospital community definition geography. The results from this analysis showed:

| Priority Health Issues in the community where I live* | | |
|---|---|---|
| Mental health | 783 | 38.3% |
| Chronic disease screening and care | 647 | 31.6% |
| Food and nutrition | 547 | 26.7% |
| Obesity | 539 | 26.3% |
| Environments that promote well-being & active lifestyles | 445 | 21.7% |
| Child and adolescent health | 425 | 20.8% |
| Smoking, vaping, and secondhand smoke | 411 | 20.1% |
| Substance use disorders | 375 | 18.3% |
| Physical activity | 301 | 14.7% |
| Violence | 252 | 12.3% |
| Food safety and chemicals in consumer products | 242 | 11.8% |
| Injuries, such as falls, work-injuries, or traffic-injuries | 184 | 9.0% |
| Maternal and women's health | 179 | 8.7% |
| Water quality | 159 | 7.8% |
| Vaccinations/immunizations | 151 | 7.4% |
| Antibiotic resistance and healthcare associated infections | 136 | 6.6% |
| Sexually transmitted diseases | 130 | 6.4% |
| Outdoor air quality | 126 | 6.2% |
| Newborn and infant health | 124 | 6.1% |
| HIV/AIDS | 96 | 4.7% |
| Hepatitis C | 45 | 2.2% |

**Westchester County Community Health Summit**

The Westchester County Health Planning Coalition collaboratively hosted the Westchester County Community Health Summit to gain feedback on health and social needs related to the NYS PA from local community, government, health, and social service providers. From the meeting, common themes emerged across the NYS PA discussion areas:

1. There are many strengths & resources existing in the community
2. Identification of barriers and gaps is the first step to improvement
3. There are action items which could benefit all four Priority Areas.
4. Social Determinants of Health must be considered when developing strategies.

**NYS PA #1: Prevent Chronic Diseases**

- Chronic diseases were acknowledged as primarily cancer, cardiovascular disease and diabetes.
- Education begins at school to create healthy choices and habits and is critical throughout the age spectrum to promote healthy lifestyle behaviors.
- There are adequate and appropriate resources across the county, but coordination is lacking.

**NYS PA #2: Promote a Healthy and Safe Environment**

- An environment of trust and culturally safe communication must exist between the community and its residents to affect change.
- Ease of access will continue to impact choice and utilization.
- There is need to change the financial incentive structure of public assistance to pay for healthy food options.

**NYS PA #3: Promote Healthy Women, Infants, and Children**

- The health of women, infants, children and families is fundamental to overall community health.
- There is an abundance of existing resources, but there is a lack of coordination for a communal and publicly accessible platform.

**NYS PA #4: Promote Well-being & Prevent Mental and Substance Use Disorders**

- Mental health and substance use disorder was a more popular topic than promoting well-being.
- Inclusivity is needed for extending care planning to family and caregivers and promoting a multidisciplinary approach in treatment.
- There are geographical and affordability barriers to access of mental health care.

**Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment**

The Cancer CHNA performed by HICCC was administered to patients from HICCC oncology clinics and NYPH ambulatory care network (ACN) clinics and at community sites including housing shelters in the Bronx. Online surveys were conducted by voluntary participants in the summer of 2019 and is anticipated to be completed by December 2019. The results of the preliminary survey (1,021 responses of a goal of 1,250) supported:

1. Strong interest in genetic screening information across cancer patients and family members, NYPH ambulatory care network (ACN) patients and the community.
2. Even though there is a low report of current cigarette smoking, there is a high report of alternative tobacco products (hookah, vape, etc.), as high as 20% in patients from ACN clinics.
3. The cancer screening rates are high in the ACN and community respondents with exception of colorectal screening rates that are lower in the community.

After completion of the target enrollment, a full data analyses will be conducted to examine differences across sources of respondents as well as differences based on demographics including race/ethnicity, age, geographic location, and socioeconomic status.

**Citizens' Committee for Children of New York (CCC)**

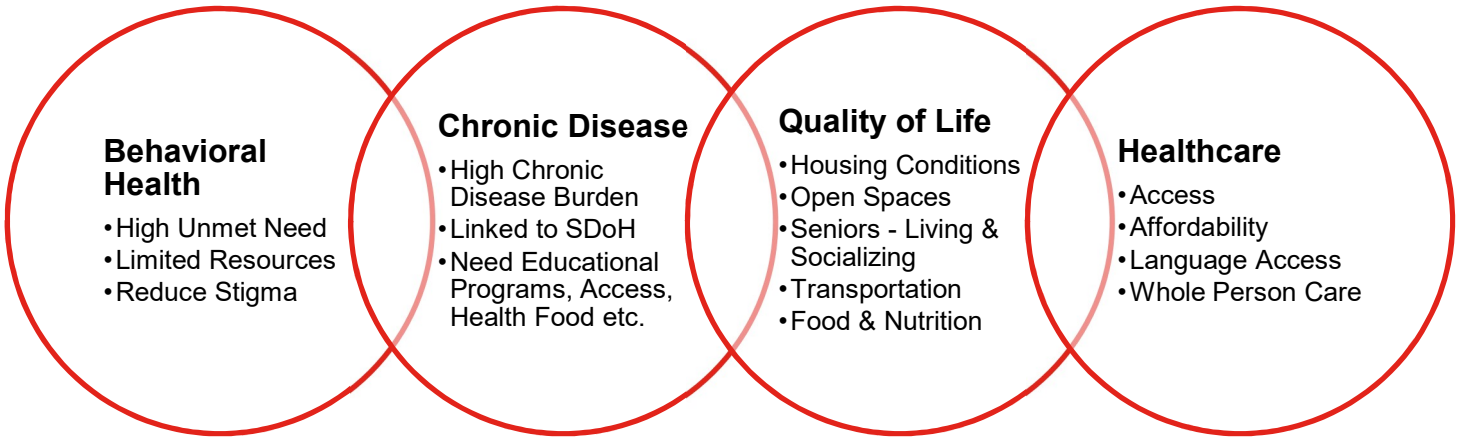
The Citizens' Committee for Children of New York (CCC) gathered quantitative and qualitative data to identify assets or resources in several NYC neighborhoods. The resulting publications, highlighted below, detail these communities, their biggest issues, numerous assets and specific recommendations for health. For the full reports on the CCC New York website refer to https://www.cccnewyork.org/data-reports/

| CCC Community | Most Common Needs | Health Recommendations |
|---|---|---|
| **From Strengths to Solutions: An Asset-Based Approach to Meeting Community Needs in Brownsville – A Citizens' Committee for Children of New York Report** | | |
| **Brownsville, Brooklyn** | • Public transportation options, banks, food retail, housing support services, and after-school and summer programs<br>• Fear of crime and violence in the community means that fewer people are using the resources—from parks to libraries to youth services<br>• Lack of affordable housing and support services designed to keep residents in their homes | • Incentivize the opening of additional food retail<br>• Improve access to healthy affordable foods; shuttle or bus service to supermarkets, and to increase awareness of the USDA pilot program for SNAP recipients to buy groceries online<br>• Outreach to ensure that residents are aware of medical and mental health services and encourage utilization of necessary services |
| **The North Shore of Staten Island: Community Driven Solutions to Improve Child and Family Well-Being** | | |
| **Staten Island** | • Lack of reliable public transportation, no subway service in and out of Staten Island<br>• Uninsured rates among children and adults on the North Shore are lower than citywide, but some caregivers interviewed shared frustrations with finding health care providers on the North Shore who accept their insurance | • Create outreach and awareness campaigns to ensure uninsured and eligible are enrolled, as well as taking advantage of nutrition programs such as WIC and SNAP<br>• Address barriers residents face finding providers within the borough who accept their health insurance coverage, especially for specialty care<br>• Offer shuttle van services for low income residents who live far from large food retail locations and promote EBT card payment for grocery deliveries.<br>• Create more green spaces and/or bring children to parks outside of their neighborhood |

| | | |
|---|---|---|
| **Celebrating Strengths, Addressing Needs: Community Driven Solutions to Improve Well-Being in Northern Manhattan** | | |
| **Northern Manhattan** | • Manhattanville in West Harlem has the lowest levels of employment among adults and lowest average household income<br>• Central Harlem has the highest rates of homelessness and most worrisome child and adult health outcomes<br>• Washington Heights faces high levels of linguistic isolation and low levels of adult educational attainment<br>• Across all neighborhoods poverty rates are higher than city average | • Promote and improve participation in WIC and other health and nutrition programs<br>• Promote a whole-family approach to physical and mental health services<br>• Establish linkages between mental health service providers and institutions outside of health and mental health clinics—to reduce barriers and stigma around accessing services<br>• Leverage schools, churches, and community-based organizations to establish and/or host peer supports for parents and young people |
| **Elmhurst/Corona, Queens: Community Driven Solutions to Improve Child and Family Well-Being** | | |
| **Corona, Queens** | • Affordable Housing to Reduce Overcrowding<br>• Opportunities for Families to Spend Time Together<br>• Multigenerational Approaches to Mental Health<br>• Supports for Immigrant Households<br>• Early Education and Afterschool Programing<br>• Safety in Public Spaces and at Home<br>• Information and Support to Access Existing Opportunities | • Multilingual outreach required<br>• Public awareness campaigns about health insurance<br>• existing health care programs and services<br>• Invest in farmer's markets and local stores to provide healthy, organic, and affordable produce<br>• Ensure families who are eligible for SNAP, WIC, and similar programs, or who need emergency food are able to access these services in spite of federal policies, such as the Public Charge Rule |

### *Qualitative Data Results Themes*

Community input was obtained for the CHNA process for NYPH through numerous sources including community questionnaires and focus groups, diseased specific surveys, and in-depth analyses of the select communities performed by CCC. Through all forums for collecting this information, we have consistently heard similar themes for the community, regardless of demographics and geography regarding their perceptions on the greatest community health challenges and ways in which to improve the communities in which they live and work.



## Health Care Policy Potential Impact

The health care policy environment can and does contribute to community-wide health improvement or conversely, to its challenges. Several policies have been identified as affecting residents of New York and the environment in which NYP operates. The NYP Government and Community Affairs team will continue to monitor and communicate changes within the health care policy environment in order to inform patient care and community-based initiatives.

Initiatives in the CSP were developed considering the following policy environment:

### Federal Change in Public Charge Rule

In August 2019, the Trump Administration announced a final rule that changes the policies used to determine whether an individual applying for admission or adjustment of status is inadmissible to the U.S. Under longstanding policy, the federal government can deny an individual entry into the U.S. or adjustment to legal permanent resident (LPR) status (i.e., a green card) if he or she is determined likely to become a “public charge.” Once the rule is enacted, officials will now consider use of certain previously excluded programs, including non-emergency Medicaid for non-pregnant adults, the Supplemental Nutrition Assistance Program (SNAP), and several housing programs, in public charge determinations. The changes will create new barriers to getting a green card or immigrating to the U.S. and likely lead to decreases in participation in Medicaid and other programs among immigrant families and their primarily U.S.-born children, beyond those directly affected by the new policy. Decreased participation in these programs would contribute to more uninsured individuals and negatively affect the health and financial stability of families and the growth and healthy development of their children.

### Affordable Care Act Challenge

A group of states presented a legal challenge to the Affordable Care Act (ACA) on the grounds that the individual mandate was unconstitutional. The case is now before a

Federal Appeals Court, which could issue a ruling at any time. If the ACA were, in fact, ruled unconstitutional, that could mean health insurers could once again refuse coverage or otherwise discriminate against patients who have preexisting conditions. Additionally, it would mean that roughly 20 million people who obtained insurance after the ACA was implemented could lose it. The ACA also made other changes to the health care system, including: expanding Medicaid eligibility for low-income adults; requiring private insurance, Medicare, and Medicaid expansion coverage of preventive services with no cost sharing; phasing out the Medicare prescription drug "donut hole" coverage gap; establishing new national initiatives to promote public health, care quality, and delivery system reforms; and authorizing a variety of tax increases to finance these changes. All of these provisions could be eliminated.

**1115 Waiver – Delivery System Reform Incentive Payment (DSRIP) Program – 2.0 Extension**

New York State has filed for an extension of its 1115 Waiver for the DSRIP initiative. If approved, the extension would further support clinical transformation efforts focused on the Medicaid population. New and ongoing funding would allow continued investments in programs focused on: improving quality outcomes, enhancing workforce development, addressing social determinants of health, and increasing community-based clinical network development.

**Elimination of religious exemptions to vaccinations for school aged children**

Amid an ongoing measles outbreak, New York State enacted a law in June 2019 to eliminate nonmedical exemptions from school vaccination requirements. The law took effect immediately. While this issue continues to be challenged in the courts, it would favorably increase the number of vaccinations among schoolchildren, decreasing unnecessary outbreaks and potential severe illnesses and deaths.

**New York State Ban on Flavored E-cigarettes**

In September 2019, New York State attempted to enact an emergency ban on the sale of flavored electronic cigarettes and nicotine e-liquids. This move was temporarily

blocked by the courts but New York State continues to pursue a ban. The proposed ban is part of a growing response to combat the increase in young people using vape products, given the appeal of flavors to the youth market. There are some who have concerns that the ban will keep people smoking regular cigarettes who may have considered switching and lead to a "black market" for vaping products with untested or unknown ingredients.

**Marijuana Decriminalization**

Legislation was passed in June of 2019 to decriminalize the use of marijuana by expunging many past marijuana possession convictions and reducing the penalty for the possession of small amounts of the drug. The bill does not fully legalize the use of marijuana. The decriminalization of small amounts of marijuana, 25 grams or less, and automatic expungement of previous convictions could encourage the use of substances which could lead to other substance abuse disorders.

**Ending the Epidemic**

New York's Ending the Epidemic initiative seeks to maximize the availability of life-saving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. The overarching goal is to achieve the first ever decrease in HIV prevalence in New York State by the end of 2020. Primary objectives are to: identify persons with HIV who remain undiagnosed and link them to health care services, and retain them in the care system to prevent further transmission and improve their health.

In New York City, the goal is to reduce the number of new infections in the City to fewer than 600 by 2020. This target aligns with the State's goal of reducing new statewide infections to fewer than 750 by 2020. In New York City, the four primary objectives are to: increase access to HIV prevention services; promote innovative, optimal treatment for HIV; enhance methods for tracing HIV transmission; and improve sexual health equity for all New Yorkers.

**Maternal Mortality Review Board**

Governor Cuomo signed legislation to create a Maternal Mortality Review Board charged to review the cause of each maternal death in New York State. New York City will also have a maternal mortality review board to review cases within the five boroughs. The Boards will make recommendations to the New York State Department of Health for clinical improvement strategies to improve overall health and outcomes of this population. They will also look at ways to reduce racial disparities in health outcomes.

**ThriveNYC**

ThriveNYC is an initiative created by New York City to improve access to mental health services, particularly for underserved populations. The program's goals include: enhancing connections to care, increasing services to vulnerable populations, and strengthening crisis prevention and responses. ThriveNYC initiatives include: Mental Health First Aid training programs, a public awareness campaign, mental health outreach and support for veterans, mental health services in youth shelters, and drop-in centers and newborn home visiting program in shelters.

## *Prioritized Findings*

Based on the prioritization process, NYPH has 22 indicators in the 4th quartile as the highest priorities for the community. These indicators can be broadly grouped into:

- Women's Health
- Obesity and Chronic Disease
- Mental Health and Substance Use
- HIV
- Cancer

| Geography | CATEGORY | INDICATORS | Quartile |
|---|---|---|---|
| NYC & Non-NYC Counties | SDoH | Binge Drinking* | 4th |
| NYC | Health Outcomes | Cancer Incidence - Lung* | 4th |
| NYC & Non-NYC Counties | Utilization | Hospitalizations: Drug* | 4th |
| Non-NYC | Health Outcomes | Cancer Incidence - Prostate* | 4th |
| NYC & Non-NYC Counties | Health Outcomes | Diabetes | 4th |
| Non-NYC | Health Outcomes | HIV | 4th |
| NYC & Non-NYC Counties | Health Outcomes | Physical Activity | 4th |

| | | | |
|---|---|---|---|
| Non-NYC | Health Outcomes | Percentage of adults with diagnosed high blood pressure taking high blood pressure medication | 4th |
| NYC & Non-NYC Counties | Utilization | Psychiatry | 4th |
| Non-NYC | Health Outcomes | Cancer Incidence - All Sites* | 4th |
| NYC & Non-NYC Counties | Health Outcomes | Cancer Incidence - Breast* | 4th |
| Non-NYC | Health Outcomes | Cancer Incidence - Colon and Rectum* | 4th |
| NYC & Non-NYC Counties | Health Outcomes | Childhood Obesity | 4th |
| Non-NYC | Utilization | Hospitalizations: Preventable Diabetes* | 4th |
| Non-NYC | Utilization | Hospitalizations: Preventable Hypertension* | 4th |
| NYC & Non-NYC Counties | Health Outcomes | Obesity | 4th |
| Non-NYC | SDoH | Current Smokers* | 4th |
| Non-NYC | Utilization | Hospitalizations: Alcohol* | 4th |
| NYC & Non-NYC Counties | Health Outcomes | Preterm Births* | 4th |
| Non-NYC | SDoH | Sugary Drink Consumption* | 4th |
| Non-NYC | Health Outcomes | Teen Births* | 4th |
| NYC & Non-NYC Counties | Health Outcomes | Hep C | 4th |

In addition to the prioritized indicators Westchester County Health Planning Coalition (WCHPC) has collectively decided to work together to address two of the Prevention Agenda focus areas for those hospitals located within Westchester County. NewYork-Presbyterian Lawrence Hospital and NewYork-Presbyterian Westchester Behavioral Health Center, located in Westchester County, will be aligning with the WCHPC to work collaboratively on the selected priority areas:

- Prevent Chronic Diseases
- Promote Well-Being and Prevent Mental and Substance Abuse Disorder

## Community Service Plan – Focus & Interventions

### *Community of Focus*

Based on the data process of analytics and prioritization, ***NYPH will target efforts in the Washington Heights, Lower East Side, and Mount Vernon*** geographies to allow our teams to invest and concentrate efforts and directly impact a high need community within the three-years of the service plan.

### *Priority Areas of Focus*

The data outlined allowed the team to identify a community of focus as well as priority areas to impact the healthcare of the most vulnerable populations. The priority areas differ from the prior 2016-2018 Community Service Plan which included Prevent Chronic Disease; focus on diabetes, Prevent Chronic Disease; focus on childhood obesity, and Promote a Healthy and Safe Environment; reducing fall risk among most vulnerable populations. The change is based upon the data collected from outcome measures as well as input received from the community as to the priorities.

NYPH is committed to serving the community by providing a wide range of health care services and activities that are important and provide benefit to our community members. Our assessment shows that there are numerous and significant needs, and the hospital has chosen a selection of these needs in order to concentrate resources and efforts and focus evaluations on those initiatives which we believe we can most effectively execute on and which will provide the largest impact to our community. In addition, the prioritization model applied to significant community needs was rooted in the quantitative as well as the qualitative voice of the community helping to ensure that our selection was aligned with those needs ranked highly by our community members.

The selected initiatives and resulting Community Service Plan were reviewed and approved by senior leaders, hospital community advisory board members, and our

CHNA Steering Committee in the context of our organizational mission, our clinical strengths, and partnerships.

NewYork-Presbyterian Hospital has selected the focused priorities for the 2019-2021 Community Service Plan, which were reviewed as well as approved by Executive Leadership and the Board of Trustees on December 12, 2019.

***Prevent Chronic Disease*** *– Focus Area 1: Reduce Obesity & the Risk of Chronic Disease*

Goal 1.1 – Increase access to healthy and affordable foods and beverages

**Objective –** Utilize a culturally sensitive process to empower organizations to focus on nutrition and physical activity, and promote wellness through community-based partnerships, and address food insecurities

**INTERVENTION EXPLAINED:** Choosing healthy & active lifestyles for kids (*CHALK*) is *New York-Presbyterian's* obesity prevention program. CHALK aims to address obesity using a socio ecological model as its theoretical framework. The program will drive system and environmental changes that produce long lasting improvements around wellness in the targeted community of Washington Heights and Mt. Vernon, where food insecurity and obesity rates are high. CHALK's multipronged includes:

- Mobile market (client-choice style mobile food pantry serving food insecure patients by household size, up to 200 individuals per distribution; connection to community resources, cooking demonstrations, and benefits enrollment)
- Fruit and vegetable prescription program (coupons redeemable for produce at local farmers markets for patients seen at hospital community-based primary care sites ($10/month))
- Elementary schools partnership (non-prescriptive partnership model, creation of wellness councils, implementation of wellness policies, staff professional development, nutrition education, connection to community resources and partners, built environment changes that promote healthy lifestyles).

**EVIDENCE-BASE:**

1. **Mobile Market And Fruit And Vegetable Prescription Programs:**

Food insecurity is associated with poor health status (aha, 2017). Accordingly, CHALK's mobile market and fruit and vegetable prescription programs join health systems nationwide in developing best practices to address social determinants of health. Promedica, an early adopter in Toledo, Ohio, launched food pharmacy, nutrition consultation, and meal distribution programs that resulted in decreased emergency room utilization and increased primary care appointments, while reducing hospital readmissions by 53% (aha, 2017). Health-system led food pantries are an important resource for immigrant families in NYC who are less likely to access government programs (Gany et al, 2015). Obese, low income participants in fruit and vegetable prescription programs have experienced greater reductions in BMI compared to a control group (Cavanah et al, 2016). This and other food insecurity

initiatives can contribute to obesity-prevention (Chen Cheung et al, 2015). Rolling out initiatives in partnership with community leaders is recommended by the American academy of pediatrics toward reducing racial disparities in obesity (Trent et al, 2019).

American Hospital Association. (2017). *Social Determinants Of Health Series: Food Insecurity And The Role Of Hospitals.* Http://Www.Hpoe.Org/Reports-Hpoe/2017/Determinants-Health-Food-Insecurity-Role-Of-Hospitals.Pdf

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CHALK's existing elementary school partnerships in northern Manhattan have increased access to healthy lifestyles for students and their families. The CHALK model strengthens school-based wellness councils and policy implementation, increases physical activity and nutrition programing, and connects stakeholders with community partners to support sustained success post-partnership (Jarpe-Ratner et al, 2013; Rausch et al, 2015).

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**PERFORMANCE MEASURES:**

- **Mobile market:** decrease food insecurity prevalence among patients participating in the program (5% decrease over 12 months); increase access to emergency food in underserved neighborhoods (10,000- 20,000 lbs food distributed over 12 monthly distributions, reaching approximately 100-150 individuals per distribution); increase connection to external emergency food resources (30-50 households connected with local food pantries via optional site visit and maps customized by patient ZIP code)
- **Fruit and vegetable prescription program:** increase access to healthy and local produce (30-50 prescriptions redeemed by patients for fruit and vegetable coupons per season May-Nov, access to $10,000 in fruit and vegetable coupons redeemable for produce at farmers markets); increase fruit and vegetable prescription and coupon redemption (70% coupons redeemed for fresh fruits and vegetables per season)
- **Elementary schools partnerships:** increased participation in school wellness councils (25% increase over 12 month), development and adherence to wellness policy (25% increase in action items led by non-chalk members over 4 years); improve built environment (successful completion of at least one built environment improvement project per partnership); increase school capacity through connection to resources and CBO partners (3 key resource or partnership connections made each year).

**PERFORMANCE MEASURES AND TIME TARGETS 2019-2021**

- Recruit program coordinator to support expansion
- Partner with NYP CHALK team to train new staff on program strategy, partnership model, implementation and evaluation tools
- Finalize identification of community partners
- Build relationships between clinicians, school administrators, farmers markets, and community-based partners to co-design program rollout (one-on-one meetings and focus groups)
- With community input, identify programs to be tailored and implemented at each campus from pre-set menu of options: Mobile Market, Fruit and Vegetable Prescription Program, And School Partnerships.
- Ongoing program evaluation and quality improvement

Mobile Market And Fruit & Vegetable Prescription Programs:

- Establish initial sites for mobile market and fruit & vegetable prescription programs (partner with local food pantries and farmers markets)
- Onsite planning and recruitment to launch selected program(s)
- Engage key stakeholders to compile feedback on initial rollout, co-design program improvements
- Identify sites and champions to facilitate continued program expansion
- Continue to assess and improve implementation strategy in collaboration with partners

School Partnership:

- Identify potential school partners and assess organizational readiness. Launch one partnership in September 2020; complete baseline school assessment.
- Continue engagement with current school partners

**IMPLEMENTATION PARTNER(S):**

- NYPH Ambulatory Care Network
- West Side Campaign Against Hunger
- Grow NYC
- Westchester County Department of Health
- Additional Partnerships*

*CHALK is built on a responsive partnership model that couples capacity building support for grassroots community-based organizations with targeted resource connection, bridging local organizations, farmers markets, schools, NYPH clinical teams, and patients. In year 1, program staff will conduct a community assets assessment in each target community to identify potential partners, service providers, and collaborators. Partnerships with 10 to 20 of these organizations (host sites, healthy food suppliers, and resource providers) will begin in year 2.

***Promote Healthy Women, Infants, and Children*** *– Focus Area 1: Maternal & Women's Health*

Goal 1.2 – Reduce maternal mortality and morbidity

**Objective**: Implement the American Academy of Pediatrics Healthy Steps – 2 Generation Approach

**INTERVENTION EXPLAINED**: Our overarching goal is to develop a two-generation approach for improving maternal-child health in primary care and community settings by providing integrated mental health services to low-income and uninsured pregnant women and the newborn child, and establishing co-management strategies with partner community agencies. We will implement an enhanced healthy steps model using telehealth to meet mothers in their home environment and integrate community health workers to ensure that families can successfully navigate the medical and social service system. Healthy Steps is an evidence based national primary care model that aims to improve the health and well-being of mothers and their newborns. In the targeted communities of Washington Heights, we will build a network of community agencies that focus on maternal-child health in order to implement prevention strategies at a population level.

**PERFORMANCE MEASURES:**
Maternal health: decrease no show rates for postpartum checkups, increase rates of screening, treatment and follow up for maternal depression increase rate of contraception used in postpartum period, and reduce unmet caregiver health care and social service needs.

Infant health: increase rates of breastfeeding, improve adherence to child well visits, increase connection and reception of early intervention services rates of developmental screening at 9-months.

**PERFORMANCE MEASURES AND TIME TARGETS 2019-2021:**

- Create a continuum of care between pediatrics, women's health, and behavioral health by identifying a champion in each area and creating system-level links among all disciplines, including but not limited to OB, pediatrics, behavioral health across NYPH.
- Create a risk stratification approach and associated bundles of care that include biomedical and psychosocial criteria.
- Implement the enhanced Healthy Steps Model with telehealth and community health workers.
- Identify partner community social service agencies and implement a co-management strategy for individuals with highest needs. Establish model to be replicated at other campuses throughout NewYork-Presbyterian Hospital.
- Train and equip additional sites regarding two-generation approach for Healthy Steps Model with telehealth.
- Tailor risk stratification and established model to needs of each site. Identify staffing gaps to support expansion.
- Identify and build connection with local community partners capitalizing on telehealth technology so that there is service equity and access regardless of location.
- Streamlined referral network between NYPH and community partners.
- Training and equipping community partners on the Healthy Steps Model positive parenting, parenting stress, parental support, birth readiness, breastfeeding and nutrition.
- Providing comprehensive tiered levels of care across NYP and community partners from prevention to high levels of treatment.

**IMPLEMENTATION PARTNER(S):**

- NYPH Ambulatory Care Network
- Columbia  Doctors
- Weil Cornell Doctors
- NewYork-Presbyterian Medical Group
- Northern Manhattan Perinatal Partnership

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***Promote Well-Being & Prevent Mental & Substance Use Disorders*** *– Focus Area 1: Promote Well Being*

Goal 1.1 – Strengthen opportunities to build well-being and resilience across the lifespan

**Objective**: Implement a Geriatric Psychiatric Tele-Health Program

Based on the expertise that Gracie Square Hospital (GSH) can bring to the behavioral health priority area, we will partner to invest and concentrate efforts to directly impact the NYPH targeted communities with a special focus by GSH in Washington Heights and Lower East Side neighborhoods.

**INTERVENTION EXPLAINED:**

- OMH licensed mental health program providing treatment in the home, community, and clinic sites in targeted communities and for targeted patients utilizing in-person and tele-mental health modalities
- Provide targeted substance use, mental health and suicide screening and interventions (diagnostic evaluations, psychotherapy- individual, group, psychiatric medication management)
- Coordinate care with primary care and medical providers and health home and social service providers
- Home based and tele-mental health treatment for homebound elderly
- Community based workshops in seniors centers and naturally occurring retirement communities (NORC) related to mental health and wellbeing
- Community partnerships reducing mental health stigma through engaging and collaborative community prevention programs
- Services accessible and embedded in home, community and seniors centers
- Evidence based/ state of the art interventions incorporating screening and assessment tools, suicide prevention, and models of care (e.g., Improving mood-promoting access to collaborative treatment)
- Linkage to community based mental health, primary care and social service programs
- Responsive and dependable framework of prevention, screening, engagement, diagnosis, and treatment from community to high risk

**PERFORMANCE MEASURES:**

- Clinical symptoms:
  - Depression- (PHQ-9)
  - Anxiety (GAD-7)
  - Trauma and PTSD (trauma measure)
  - Dementia (Folstein Minimental Status Exam)
  - Substance and alcohol use (Drug Screen Abuse Test (DAST) and audit)
- Number of individuals receiving preventive and intervention services
- Linkage of individuals to ongoing mental health, social service, and medical care
- Reduction in avoidable emergency department visits

**PERFORMANCE MEASURES AND TIME TARGETS 2019-2021:**

- Start providing targeted substance use, mental health, and suicide screening and interventions (diagnostic evaluations, psychotherapy- individual, group, psychiatric medication management)
- Coordinate care with primary care and medical providers and health home and social service providers
- Community based workshops in seniors centers related to mental health and wellbeing
- Community partnerships reducing mental health stigma through engaging and collaborative community prevention programs
- Services accessible and embedded in home, community and seniors centers
- Evidence based/ state of the art interventions and programs
- Linkage to community based mental health, primary care and social service programs.
- Continue providing targeted substance use, mental health, and suicide screening and interventions (diagnostic evaluations, psychotherapy- individual, group, psychiatric medication management)
- Start home based and tele-mental health treatment for homebound elderly
- Services coordinated between home, community and seniors centers
- Home based and tele-mental health treatment for homebound elderly
- Responsive and dependable framework of prevention, screening, engagement, diagnosis, and treatment from community to high risk

**IMPLEMENTATION PARTNER(S):**

- Identify CBO outpatient health, mental health and community service providers including (Service Program for Older People (SPOP), Center of Excellence for Alzheimer's Disease (CEAD), Memory Disorders Clinic, New York-Presbyterian Hospital Ambulatory Care Clinic
- Coordinate with mobile crisis team and emergency department/ Comprehensive Psychiatry Emergency Program (CPEP)
- Partner with seniors centers and community programs
- Coordinate with nursing homes and homebound residents
- Coordinate with NAMI and consumer organizations

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***Promote Well-Being & Prevent Mental & Substance Use Disorders*** *–Focus Area: 1*
*Strengthen opportunities to build well-being and resilience across the lifespan*

Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan

**Objective**: Expand mental health first aid trainings to expand mental health education, increase prevention and address stigma

Based on the expertise that Gracie Square Hospital (GSH) can bring to the behavioral health priority area, we will partner to invest and concentrate efforts to directly impact the NYPH targeted communities with a special focus by GSH in Washington Heights and Lower East Side neighborhoods.

**INTERVENTION EXPLAINED:**

Mental health first aid (MHFA) is an international training program proven to be an effective intervention for mental health education, prevention and addressing stigma. Peer-reviewed studies show that individuals trained in the program achieve the following outcomes:

- Grow their knowledge of signs, symptoms, and risk factors of mental illnesses and addictions.
- Can identify multiple types of professional and self-help resources for individuals with a mental illness or addiction.
- Increase their confidence in and likelihood to help an individual in distress.
- Show increase mental wellness themselves.

NYP has been providing this training since 2015 through its building bridges, knowledge, and health coalition and in partnership with THRIVE NYC and has trained over 800 individuals. Mental Health First Aid USA is listed in the substance abuse and mental health services administration's national registry of evidence-based programs and practices.

**PERFORMANCE MEASURES:**

- Conduct assessment of staff across NYPH to ascertain training need
- Conduct assessment of Community Based Organizations (CBO) and Faith Based Organizations (FBO) collaborators to ascertain training need
- Identify 5-10 CBO's and FBO'**S** annually per each of the following NYPH campuses: Lawrence, Lower Manhattan, Cornell, and Columbia and provide MHFA training
- Number of trainings and participants
- Number of referrals to services

**PERFORMANCE MEASURES AND TIME TARGETS 2019-2021:**

- Recruit one clinical coordinator and two outreach coordinators (*new FTE's*)
- Credential NYPH staff to lead MHFA trainings
- Begin outreach to community organizations – identify two organizations for the following NYPH campuses: Lawrence, Lower Manhattan, Cornell, and Columbia to discuss strategy for MHFA training implementation
- Conduct 20-30 MHFA trainings a year

**IMPLEMENTATION PARTNER(S):**

- Westchester County Department Of Health
- Montefiore Health System (Mt. Vernon)
- NYPH Pastoral Care To Identify Faith-Based Organizations
- Hamilton-Madison House
- Gracie Square Hospital

***Prevent Communicable Diseases*** *– Focus Area 2: Human Immunodeficiency Virus (HIV) and Focus Area 4: Hepatitis C (HCV)*

Focus Area 2: Goal 2.2 - Increase Viral Suppression

Focus Area 4: Goal 4.1 - Increase the number of persons treated for Hepatitis C Virus (HCV)

Goal 4.2 Reduce the number of new HCV cases among people who inject drugs

**INTERVENTION EXPLAINED:**
Ending the HIV and HCV epidemics in NYS is now a legitimate possibility and NYPH is playing a leading role in this effort[iii]. The **NYPH ETE Initiative** would create a multi-campus HIV and HCV elimination strategy that would a) increase HIV and HCV testing and linkage to care, b) re-engage HIV+ and HCV+ individuals to care, and c) expand effective HIV and HCV prevention services, like PrEP and MAT. Utilizing *existing* multi-campus dashboards, an NYPH 'Pilot' would link, in real-time, all new HIV and HCV diagnoses, those (thousands) individuals out of care, and those in need of preventive services[iii]. Expanded deployment of a Health Priority Specialist in existing sites, like NYPH EDs, would be the effector arm for the intervention. A major investment in a Mobile Medical Unit (MMU) would also help bring these needed services to communities surrounding our medical centers. Collectively this multimodal, evidence based intervention could help NYPH end the HIV and HCV epidemics in our targeted communities[ivv].

**PERFORMANCE MEASURES:**
Performance indicators will be aligned with the HIV and HCV ETE measures promulgated by NYS and NYC, as well as project specific measure. These will include:

1. Number of monthly NYPH-wide HIV and HCV tests performed, # of positives, % linked to care, viral suppression and cured (HCV).
2. Number of monthly PrEP evaluations, starts, and maintenance in care at 6 months.
3. Number of monthly care re-engagement opportunities, successful re-engagement, and viral load suppression at 3 months and 1 year.
4. Number of monthly MMU encounters and breakdown by visit type; Testing, Re-engagement, Sexual Health (STI, PrEP, PEP), and MAT.
5. Number of monthly NYPH ED visits and hospitalizations for people living with HIV or HCV.

**PERFORMANCE MEASURES AND TIME TARGETS 2019-2021:**

- Hire project staff (Administrator, NP, Care Coordinators, Driver/Technician, and IT). These positions would be phased in during Y1
- Purchase Mobile Medical Unit
- Implement HIV and HCV Outreach Dashboards at NYP/Weill Cornell and NYPH
- Implement HIV/HCV/STI Nudge Reports at NYP/Cornell and NYPH
- Develop detailed QIP work-plan, data collection methods, and analytic reports
- Conduct detailed environmental survey of referral options for new diagnoses, re-engagement clients, PrEP/PEP clients, and OUD services
- Establish MMU schedule targeting high-risk neighborhoods and communities surrounding NYPH east and west campuses
- Provide sexual health services (PEP/PrEP), HIV and HCV testing and linkage to care, and direct HIV and HCV services via MMU
- Continue HIV and HCV Outreach Dashboard use at NYP/Cornell and NYPH via multi-institutional 'pilot' care coordinator
- Establish MMU schedule at NYPH targeting high-risk neighborhoods and communities surrounding the medical center
- Provide PEP/PrEP and HIV and HCV linkage and re-linkage services at NYPH via the MMU
- Provide sexual health services (STI screening and treatment) at NYPH via the MMU
- Integrate telemedicine visits into MMU clinical activities to scale clinical capacity
- Expand MMU schedule at NYPH targeting high-risk neighborhoods and communities surrounding the medical center
- Continue and expand MMU services at neighborhoods and high-risk communities surrounding NYPH east and west campuses, including the provision of sexual health services (STI screening and treatment), HIV PEP/PrEP, direct HIV and HCV clinical services, and re-HIV engagement services
- Expand MMU telemedicine visits to scale outreach and engagement clinical capacity

**IMPLEMENTATION PARTNER(S):**

- Alliance For Positive Change
- Argus Community
- Housing Works
- NYP Medical Group
- Weil Cornell Medical College
- Columbia University Irving Medical Center

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## *Initiative Progress Tracking*

Progress tracking will be maintained quarterly by the NYPH leadership team. Quarterly findings will be used as a quality performance improvement process to refine processes and program developmental efforts to ensure needs of the population are met. The quarterly updates will then to be used to compile an annual report to meet both the state and federal expectations of reporting.

## *Assets & Resources*

NYPH recognizes that there are existing assets, resources, and partners which may be leveraged for both expertise and economies of scale to deploy initiatives collaboratively for the benefit of community health improvement. Several notable assets/resources follow.

| Asset Name | Brief Description |
|---|---|
| **Center for Community Health Navigation (CCHN)** | Supports the health and well-being of patients through the delivery of culturally competent, peer-based support in the emergency department, inpatient, outpatient, and community settings. Activities include a peer navigator program to support emergency department patients in connecting to resources, and a Community Health Worker Program based in multiple community settings. |
| **NewYork-Presbyterian Health Home** | A group of health and community agencies who collaborate to connect Medicaid members with complex medical and behavioral healthcare to services, including health promotion, individual and family support, care coordination, and community and support resources. |
| **NewYork-Presbyterian Performing Provider System (PPS)** | The PPS is a network of 90 providers and community organizations committed to improving health and addressing unnecessary hospital and emergency department utilization for Medicaid beneficiaries. |
| **REACH Collaborative (Ready to End AIDS and Cure Hep C)** | In support of the New York State End the Epidemic initiative, NYP formed an integrated prevention network with Dominican Women's Development Center, Washington Heights Corner Project, Harlem United, Argus Community, Inc., Village Care and ASCNYC. |

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| **Kress Vision Program** | Through the Kress Vision Program, NYPH and Weill Cornell Medicine provide vision services to community members who are at risk for vision impairment or blindness and face challenges regarding inadequate access to healthcare |
| **Washington Heights Youth Opportunity Hub** | In 2017, the Manhattan District Attorney's Office Criminal Justice Investment Initiative awarded NYPH a major grant to establish a Youth Opportunity Hub in Washington Heights. The new center will provide youth at risk of criminal justice involvement with access to a wide range of services and community programs, including reproductive health and HIV/STI prevention, trauma-informed mental health treatment, and substance use counseling. |
| **Ambulatory Care Network** | NewYork-Presbyterian, we have a long-standing commitment to understanding the healthcare needs of the communities we serve and adapting our programs to meet those needs. Our ultimate goal is to reduce and ultimately erase, health disparities by linking our neighbors with the world's best healthcare services. We leverage hospital and community resources to reduce health disparities through innovative population health initiatives, care provider training, scholarship, and research. These initiatives are collaboratively developed, implemented, evaluated, and sustained. |
| **CHALK (Choosing Healthy & Active Lifestyles for Kids™)** | A collaboration between NYPH, Columbia University Irving Medical Center, and the community of Northern Manhattan. |
| **Family PEACE (Preventing Early Adverse Childhood Experiences) Program** | Dedicated to improving the safety and well-being of mothers and children who have been exposed to violence in their homes. |
| **Reach Out and Read** | Pre-literacy program that links reading aloud with giving books to children aged six months to five years during their primary health care visits. NYPH's program is one of the largest of 3,000 Reach Out and Read programs nationwide. |
| **School-based Health Centers** | Serving 23 middle and high schools in Washington Heights and Inwood, the Bronx, and Harlem. In addition, behavioral health services are available in 10 school sites serving 13 elementary and middle schools in Washington Heights, Inwood, and Harlem. |
| **WIC Program** | The NYPH/Ambulatory Care Network's WIC Program is a federal and state-funded nutrition education and supplemental food program. The WIC Program provides food, nutrition, health, fitness, and breastfeeding information. |

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| **Lang Youth Medical Program** | A six-year science enrichment and medical pipeline program for talented youth who represent the diversity of the Washington Heights and Inwood communities. |
| **The T.R.U.T.H.E (Teens Remaining United Through Health Education)** | Peer Education Program at the **John F. Kennedy** and **George Washington** campuses is a one-year youth enrichment and development program that provides students with leadership skills to become peer educators in their schools and communities. |
| **Center for the Performing Artist** | A partnership between Weill Cornell Medicine, NewYork-Presbyterian Hospital, and the Hospital for Special Surgery, provides specialized, comprehensive care to professional and student artists of various disciplines. The Center is unique in its personalized approach to care. Each artist who contacts us receives a dedicated care coordinator to help him or her find the right specialist; to assist in scheduling all medical appointments, tests and procedures; and to arrange for any referrals — all free of charge. |
| **The Vincent P. Dole Institute for Treatment and Research** | Part of NewYork-Presbyterian Hospital's Ambulatory care Network, is considered one of the best methadone maintenance programs in the nation. Since its establishment in 1972 in the wake of the heroin epidemic of the 1960s, the Institute has been a source of hope and a treatment choice for individuals addicted to opiates who could not control their addiction through drug-free treatment. |
| **Vulnerable Elder Protection Team** | The first-of-its-kind, ED-based multi-disciplinary team that is available 24/7 to asses, treat, and ensure the safety of elder abuse / neglect victims while also collecting evidence when appropriate and working closely with the authorities. |
| **HIV/AIDS Care at the Center for Special Studies (CSS)** | The Center for Special Studies provides first class, HIV specialized care to people living with HIV/AIDS. CSS has offered a high standard of care in a welcoming and non-discriminatory setting since 1988. |
| **Stop The Bleed** | Stop the Bleed campaign is to make our nation more resilient by better preparing the public to save lives if people nearby are severely bleeding. This preparation is being done by raising awareness and teaching people how to learn three quick actions to control serious bleeding. |
| **Mobile Stroke Treatment Unit** | The MSTU emergency vehicle is designed to provide immediate, specialized care to people who may be having a stroke. |
| **Hands Only CPR** | In an effort to reduce the number of people who die needlessly from sudden cardiac arrest each year, NewYork-Presbyterian and the Ronald O. Perelman Heart Institute have launched the #HandsOnlyCPR campaign, a community |

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| | awareness, education and activation effort with a simple, but powerful message: Everyone Can Save a Life. |
| **Heart Smarts** | HeartSmarts, an education program developed at the Ronald O. Perelman Heart Institute at NewYork-Presbyterian/Weill Cornell Medical Center. HeartSmarts, is a faith-based community education and outreach program, it is an effective method for teaching underserved communities about heart health |
| **Chinese Community Partnership for Health (CCPH)** | In collaboration with NYP Lower Manhattan Hospitals the CCPH has served more than 200,000 people to prevent and detect chronic disease, in addition to a series of lung health initiatives and diabetes prevention workshops. |
| **Naloxone trainings** | NYP provides training to teach the public how to recognize and reverse an opioid overdose. Participants become Certified Opioid Overdose Responders and receive a free Overdose Rescue Kit with naloxone. |
| **NYC Department of Health and Mental Hygiene** | Provides a referral source and support with utilizing publically available data. |
| **Westchester County Department of Health** | Provides a referral source and support with data collection, in addition to collaboration on Prevention Agenda Priorities |
| **Service Program for Older People: SPOP** | Referral source for mental health care and related services to adults age 55 and older |
| **Community League of the Heights** | The Community League of the Heights (CLOTH) is a multi-service, community development organization dedicated to supporting and empowering the economically disadvantaged residents of Washington Heights. |
| **Alliance for Positive Change** | The Alliance for Positive Change is a community based organization that helps New Yorkers living with HIV and other chronic illnesses make lasting positive changes towards health, housing, recovery and self-sufficiency. |
| **Argus** | Argus provides innovative programs which engage and help severely disadvantaged New Yorkers and their families and loved ones free themselves from poverty and drug abuse and chemical dependency build new lives based on responsibility, work, and hope. |
| **Hamilton-Madison House** | Hamilton-Madison House is a non-profit settlement house established in 1898 to improve the quality of life for NYC. They foster the well-being of vulnerable populations including the elderly, children, the ill and handicapped, new immigrants and refugees and the unemployed. |
| **Northern Manhattan Perinatal Partnership** | NMPP delivers critical health and social services to communities throughout the Borough of Manhattan located in New York City. |
| **Washington Heights CORNER Project** | Washington Heights CORNER Project's mission is to improve the quality of life of people who use drugs or engage in sex work. |
| **Grow NYC** | Grow NYC collects collect Fruit and Vegetable prescriptions at NYC farmers markets and distributes Greenbucks and/or fruits |

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| | and vegetable coupons on behalf NYP through our CHALK program. |
| **Westside Campaign Against Hunger** | West Side Campaign Against Hunger alleviates hunger by ensuring that all New Yorkers have access with dignity to a choice of healthy food and supportive services. WSCHA worked with the CHALK program to bring food to vulnerable communities through our CHALK program. |
| **Riverstone Senior Life Services** | Provides supports and services that help older adults (60 years and older) remain healthy, active and living at home.. |
| **NYP/CUIMC Community Leadership Council, NYP/Weill Cornell Community Advisory Board, NYP Westchester Behavioral Health Center Community Advisory Board, NYP Lower Manhattan Hospital Community Advisory Board** | NYP Advisory Boards and Councils work with the Hospital to identify the needs of the community; advise how best to meet those needs; and facilitate communications between the Hospital and the community at large. |
| **Dominican Women Development Center** | An organization to empower all women and communities to advance gender equality and social justice. |
| **ARC Ft. Washington Senior Center** | |
| **YM & YWHA of Washington Heights and Inwood** | The Y is a multi-service community center that is well known for its nurturing environment and non-judgmental philosophy. |
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## *Website Availability*

The Community Health Needs Assessment and Community Service Plan can be found on the NYPH website at https://www.nyp.org/about-us/community-affairs/community-service-plans.

## *Appendix*

### Quantitative Data Sources

| Data Source | Data Period | Publicly Available Website |
|---|---|---|
| New York City | | |
| Association for Neighborhood & Housing Development | 2018 | https://anhd.org/report/how-affordable-housing-threatened-your-neighborhood-2019 |
| Behavioral Risk Factor Surveillance System (BRFSS) New York State | 2016 | https://www.cdc.gov/brfss/index.html |
| Citizen's Committee for Children Keeping Track Online | 2017 | https://www.cccnewyork.org/ |
| Claritas | 2019 | N/A |
| Data City of New York | 2018 | https://opendata.cityofnewyork.us/ |
| Data2Go.NYC | Varies by indicator 2010-2016 | https://data2go.nyc |
| Definitive Healthcare | 2019 | N/A |
| New York City Mayor Report | 2005-2017 | https://www1.nyc.gov/site/opportunity/poverty-in-nyc/data-tool.page |
| Nielsen | 2019 | N/A |
| NYC Health Atlas | Varies by indicator 2010-2015 | https://www1.nyc.gov/site/doh/health/neighborhood-health/nyc-neighborhood-health-atlas.page |
| NYC Community Health Profiles | Varies by indicator 2011-2017 | https://www1.nyc.gov/site/doh/data/data-publications/profiles.page |
| Office of the State Comptroller | 2018 | https://www.osc.state.ny.us/localgov/pubs/research/foreclosure-update.pdf#search=%20foreclosure%20 |
| State Cancer Profiles | 2018 | https://statecancerprofiles.cancer.gov/ |
| U.S. Department of Agriculture | 2015 | https://www.fns.usda.gov/data-research |
| | Additional Sources Utilized for Communities Outside New York City | |
| Behavioral Risk Factor Surveillance System (BRFSS) | 2016 | https://www.cdc.gov/brfss/index.html |
| Cares Engagement | Varies by indicator 2013-2019 | https://engagementnetwork.org |
| Claritas | 2019 | N/A |
| New York State Community Health Indicator Reports | Varies by indicator 2011-2017 | https://www.health.ny.gov/statistics/chac/indicators/ |
| Nielsen | 2019 | N/A |
| RWJ County Health Rankings | 2013-2017 | https://www.countyhealthrankings.org |
| State Cancer Profiles | 2018 | https://statecancerprofiles.cancer.gov/ |
| United Hospital Fund | 2011-2015, ACS Estimate | https://uhfnyc.org/publications/publication/new-york-counties-by-population-medicaid-enrollment-and-enrollment-rates-table |

[i] https://www.health.ny.gov/diseases/aids/ending_the_epidemic/

[ii] https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

[iii] Rana AI, Mugavero MJ. How Big Data Science Can Improve Linkage and Retention in Care. Infectious Disease Clinics of North America. 2019 Sep;33(3):807-815. doi: 10.1016/j.idc.2019.05.009

[iv] https://www.cdc.gov/hiv/risk/prep/index.html

[v] Okeke, N.L., Ostermann, J. & Thielman, N.M. Enhancing Linkage and Retention in HIV Care: a Review of Interventions for Highly Resourced and Resource-Poor Settings. Curr HIV/AIDS Rep (2014) 11: 376. https://doi.org/10.1007/s11904-014-0233-9