NewYork-Presbyterian
The University Hospital of Columbia and Cornell

NEW YORK-PRESBYTERIAN HOSPITAL
2013 COMMUNITY SERVICE PLAN
YEAR 1 UPDATE SUMMARY

December 2014

EXECUTIVE SUMMARY

The New York and Presbyterian Hospital (New York-Presbyterian Hospital or NYP) plays a dual role in healthcare, as both a world class academic medical center and as a leading community and safety-net Hospital in our service area. New York-Presbyterian is committed to providing one standard of care to all patients through a range of programs and services to local, regional, national and international communities. New York-Presbyterian is achieving this by enhancing access to its Emergency Departments and Ambulatory Care Network, promoting health education and prevention, offering culturally competent language access services, and providing charity care to qualified individuals among the uninsured and underinsured.

New York-Presbyterian's Vision is to maintain our position among the top academic medical centers in the nation in clinical and service excellence, patient safety, research and education.

STRATEGIC INITIATIVES

New York-Presbyterian's Strategic Initiatives were updated in 2013 to support the ultimate goal: "We Put Patients First *Always*." This means that New York-Presbyterian must make patients the first priority and strive to provide them with the highest quality, safest, and most compassionate care and service *Always*.

New York-Presbyterian's six Strategic Initiatives are:

1. Culture- Our culture is defined by our core beliefs, which guide everything we do, both in our interactions with patients, and with each other. Our culture of respect, teamwork, excellence, empathy, innovation and responsibility help us continue to deliver the best care possible while meeting the challenges ahead.

2. Access- Improve and Expand Access: We will continue to work to improve and expand access to the Hospital and the Physician Organizations. Patients should be able to receive care promptly and not have long waits to schedule appointments. We will also work with our Healthcare System members to broaden our geographic reach and expand care delivery to the communities we serve.);

3. Engagement- Engage Staff and Patients: Engaged staff are actively involved in the work they do and the care they provide to patients and their families. Engaged staff will help us deliver the highest quality, most compassionate care and service, and ultimately the best patient experience. At the same time, engaged patients actively participate in their own health and recovery. We will provide patients with tools and educational materials to help manage their own care, as well as enhance cultural competence among our staff

4. Health & Wellbeing- Enhance Health and Wellbeing: The Hospital is committed to fostering health and wellbeing as part of our patient care and community service mission, and, as an integral part of our culture. In 2013, we successfully launched NYPBeHealthy as a new, comprehensive wellness and prevention initiative designed specifically for our staff. The program offers employees enhanced access to new and existing Hospital programs, healthier choices in our cafeterias, and targeted information to help our staff meet their individual health goals.

5. Value- Deliver and Demonstrate Value: We must deliver the highest quality care as efficiently and effectively as possible, as this is important for both our financial health and for our patients who contribute to the costs of their care. Our Making Care Better Initiative will help us reduce unnecessary clinical variability, promote quality and safety, and achieve efficiency. We will also continue to seek opportunities to streamline processes and reduce unnecessary costs through HERCULES and Operational Excellence initiatives.

6. High Reliability- Provide Highly Reliable, Innovative Care: We want to provide the highest quality and safest care to every single patient with every single interaction. To achieve this goal, we will focus on developing highly-reliable processes, enhancing our culture of safety, and reducing variability in care.

These Strategic Initiatives support the ultimate goal: "We Put Patients First *Always*."

HOSPITAL'S MISSION STATEMENT

NYP Hospital's Mission Statement has not changed since the 2013 Comprehensive Community Service Plan Update.

SERVICE AREA

NYP Hospital's service area has not changed since the 2013 Comprehensive Community Service Plan Update, and is defined as the counties of New York, Queens, Kings, Bronx and Westchester.

PUBLIC PARTICIPATION

New York-Presbyterian is committed to serving the vast array of neighborhoods comprising its service area and recognizes the importance of preserving a local community focus to effectively meet community need. New York-Presbyterian adheres to a single standard for assessing and meeting community need, while retaining a geographically focused approach for soliciting community participation and involvement, and providing community outreach. NYP fosters continued community participation and outreach activities through linkages with the New York-Presbyterian Community Health Advisory Council, the New York-Presbyterian/Weill Cornell Community Advisory Board, the New York-Presbyterian/Allen Hospital Advisory Committee, the New York-

Presbyterian/Westchester Division Community Advisory Board, the New York-Presbyterian/Lower Manhattan Hospital Community Advisory Board, and Community Districts 1, 2, 3, 8 and 12. New York-Presbyterian has also assessed community need in consultation with a large group of community physicians that share parts of the same service area.

ASSESSMENT OF PUBLIC HEALTH PRIORITIES

The assessment of Public Health Priorities through the quantitative and qualitative findings on the community's health, as well as the input collected during Public Participation through interviews and formal group meetings serve as the foundation for NYP's community health planning. It is our goal to link our services more directly to specific health risks or disease conditions that can lead to overall community health improvement. This effort coincides with NYSDOH's Prevention Agenda Toward the Healthiest State that asks hospitals to select prevention agenda priorities based on community health need and collaborate with the State and other providers to show measurable improvement over time. Our community health initiatives also align with the efforts of the New York City's Department of Health and Mental Health's Take Care New York programs.

Selection of Two (2) Prevention Agenda Priorities

New York-Presbyterian selected two Health Prevention Agenda Priorities on the basis of NYSDOH and NYCDOHMH data, input and feedback from the public, as well as formal quantitative and qualitative studies. Data compiled by the NYCDOHMH indicates that there are significant numbers of people without primary care providers in sectors of the New York-Presbyterian service area. The quantitative studies also indicated that a number of chronic diseases are highly prevalent in the New York-Presbyterian service area. These include diabetes, heart disease, asthma and cancer. Studies also suggest that mental health-depression is a major concern.

In consideration of the above cited quantitative and qualitative data, New York-Presbyterian has chosen the following priority areas:

1. Prevent Chronic Disease
2. Promote Mental Health & Prevent Substance Abuse

THREE (3) YEAR PLAN OF ACTION

In order to accomplish its two Prevention Agenda Priorities New York-Presbyterian and its collaborators have adopted the following strategic objectives:

- Develop the Patient Centered Medical Home (PCMH) – The Medical Home model has been adopted as an efficient and effective means to improve access and improve health by building high quality primary care while better managing the patient flow in the NYP Emergency Department and its specialty clinics.

- Expand Disease Prevention and Management – Care Management of chronic diseases has been chosen as an important tool to combat chronic diseases, particularly diabetes, heart disease, depression and pulmonary diseases.

- Develop the Health Home (HH)– The NYSDOH Medicaid Health Home model has been adopted as an efficient and effective means of providing care management in a community collaborative manner in order to target and support patients suffering from multiple chronic co-morbidities including behavioral conditions, alcohol and other substance abuse.

- Build Cultural Competency – Skills-based training in cross-cultural communication, language access, and health literacy strategies as well as the integration of a diverse workforce including Patient Navigators and Community Health Workers will be deployed in the ambulatory clinics and emergency departments.

- Information Technology- IT solutions will be explored in order to facilitate both access improvement and chronic disease management.

These five strategic objectives are reflected in the programs and initiatives that have been formulated as part of the Three Year Action Plan which is summarized below:

<u>Prevent Chronic Disease</u>

- 2014
  - Obtain NCQA Level 3 Patient Centered Medical Home (PCMH) Certification (2011) for all Ambulatory Care Network (A.C.N.) practices.
  - Plan a PCMH empanelment strategy using Sorian scheduling system and the Electronic Health Record to facilitate access and continuity.
  - Pilot Interdisciplinary Plan of Care (IPOC) patient print outs that are culturally competent and promote health literacy.
  - Plan PCMH-Emergency Department (ED) Transition of Care (TOC) program.
  - Pilot Cultural Competency training for all staff and clinical personnel.
  - Develop Children with Special Health Care Needs (CSHCN) Registry
  - Establish collaboration with key Community Based Organizations to conduct Cancer screenings in the community.
  - Hold Cancer screening community health fair.

<u>Promote Mental Health & Prevention Substance Abuse</u>

- 2014
  - Educate and train all NYP/Columbia and NYP/Weill Cornell campus PCMH teams on Integrated Clinical and Behavioral Care.

- Develop screening protocols, risk stratification and tracking systems for patients with diabetes, asthma, heart failure and depression at all NYP/Columbia
- Develop screening protocols, risk stratification and tracking systems for patients with hypertension, obesity and depression at all NYP/Weill Cornell campus PCMHs.
- Integrate clinical and behavioral care protocols for depression in patients with diabetes, asthma, heart failure and depression at all NYP/Columbia and diabetes, hypertension, obesity and depression at the NYP/Weill Cornell campus PCMHs.
- Develop Depression registry
- Establish formal Health Home collaborations with culturally competent behavior and substance abuse service-providing Community Based Organizations in Lower Manhattan.

The 2014 Action Plan grid that follows reflects our progress on these initiatives.

New York-Presbyterian – Columbia Campus (Milstein, MSCHONY, Allen)

Prevention Agenda Priorities	2014 Plan	2014 Update
Prevent Chronic Disease **Focus Area:** Increase access to high-quality chronic disease preventive care and management in both clinical and community settings **Goals** - Increase screening rates for cardiovascular disease, diabetes, and breast/cervical, colorectal cancers, especially among disparate populations - Promote use of evidence-based care to manage chronic diseases. - Promote culturally relevant chronic disease self-management education.	- Obtain NCQA Level 3 PCMH Certification (2011) for all 7 ACN Clinics. Focus and provide panel management, and self-management support on diabetes, asthma and CHF. - Develop electronic COPD/Asthma Registry in Amalga. - Implement COPD/Asthma and CHF Transitions of Care (TOC) protocols. - Plan PCMH empanelment strategy using Sorian system and EMR to facilitate access and continuity. - Pilot Interdisciplinary Plan of Care (IPOC) print outs for patients that is culturally competent and health literacy accessible.	- 6 ACN Clinics obtained NCQA Level 3 PCMH Certification (2011). Additional required information to meet full Level 3 for the remaining site will be submitted to NCQA before December 30, 2014. - COPD/Asthma registries were developed using the Amalga tool. - COPD/Asthma and CHF Transitions of Care (TOC) protocols were developed and implemented across all PCMH sites. In addition, a half day campus wide symposium was held to train the PCMH sites. - Developed a working group that met throughout the year. The team worked with the IT-EMR and Sorian scheduling system to develop tools in the EMR that would facilitate empanelment and physician panel management. - Interdisciplinary Plan of Care (IPOC) print outs were developed, and piloted in the pediatric population. Plans are underway to expand the pilot to include adult sites. These print out have been initially developed in English and Spanish, and are culturally competent and health literacy accessible.

	- Plan PCMH -ED TOC program.	- Plans for a PCMH -ED TOC program are under development and being considered as part of our NYS DSRIP application submission.
	- Pilot Culturally Competency training for PCMH personnel.	- A Cultural Competency training curriculum was developed for PCMH personnel and has been rolled out throughout the organization. To date approximately 518 staff and providers have been trained.
	- Plan adult Obesity full spectrum program: preventive-medical-surgical	- A Plan has been developed to expand the pediatric obesity prevention program (Choosing Healthy and Active Lifestyles for Kids-CHALK) into the family and adult population, and also enhance linkage of the PCMHs with adult endocrine obesity medical treatment as well as bariatric surgical services at NYP.
	- Develop Children with Special Health Care Needs (CSHCN) electronic Registry.	- An electronic registry was developed for Children with Special Health Care Needs (CSHCN).
	- Plan, recruit and hire staff for CSHCN program.	- Plans for a CSHCN program are under development and being considered as part of our NYS DSRIP application submission.
	- Develop Regional Health Collaborative (RHC) collective impact methodology.	- A Regional Health Collaborative (RHC) collective impact methodology was developed and local community based organizations were recruited to collaborate on projects. This collaborative is also being expanded as part of our NYS DSRIP application submission.

	- Select new RHC targeted areas of focus.	- The RHC has been evaluating other potential areas of focus such as ESRD/Renal Failure, HIV/AIDS, and Palliative Care. Several of these are being considered as part of our NYS DSRIP application submission.

New York-Presbyterian – Columbia Campus (Milstein, MSCHONY, Allen)

Prevention Agenda Priorities	**2014**	**2014 Update**

<u>Promote Mental Health & Prevent Substance Abuse</u>
 	
Focus Area: Strengthen infrastructure across systems
 	
Goals
 	
- Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment, and recovery.
 	
- Strengthen infrastructure for mental, emotional, and behavioral health promotion and mental, emotional, and behavioral disorder prevention.
	- Educate and train PCMH team on Integrated Clinical and Behavioral Care.
	
	- Develop Screening protocols, risk stratification and tracking systems.
	
	- Integrate clinical and behavioral care protocols for depression screening in patient with PCMH Chronic conditions:
	  - Diabetes.
	  - CHF
	  - COPD/Asthma
	
	- Develop Depression registry
		- Education and training were rolled out to all PCMH teams on Integrated Clinical and Behavioral Care via a half day campus wide symposium.
		
		- Screening protocols, risk stratification and tracking systems were developed with input from clinical, IT, and operational leadership.
		
		- Clinical and behavioral care protocols for depression screening in patient with PCMH chronic conditions were integrated into the continuity visit using the PHQ2 and PHQ9 depression screening tool.
		
		- Depression registry was developed and rolled out using Microsoft Amalga tool.

New York-Presbyterian – Weill Cornell Campus

Prevention Agenda Priorities	2014	2014 Update
Prevent Chronic Disease **Focus Area:** Increase access to high-quality chronic disease preventive care and management in both clinical and community settings **Goals**	- Obtain NCQA Level 3 PCMH Certification (2011) for all 7 ACN Clinics. - Implement HTN, DM, Asthma, and Obesity registries.	- Three of our ACN Clinics obtained NCQA Level 3 PCMH Certification (2011). Additional required information to meet full Level 3 for the remaining four sites will be submitted to NCQA before December 30, 2014. - The Amalga registries were expanded and specific registries around HTN, DM, Asthma, and Obesity were developed for this campus.
- Increase screening rates for cardiovascular disease, diabetes, and breast/cervical, colorectal cancers, especially among disparate populations	- Plan Contact Center to enhance access for seven PCMHs. - Implement population health tool linked to EPIC/EMR.	- Plans are under development to further enhance access at all seven PCMHs using both telephonic and online resources. - Working with the EPIC/EMR team we have developed and implemented dashboards for clinicians to facilitate population management for the chosen PCMH diseases.
- Promote use of evidence-based care to manage chronic diseases. - Promote culturally relevant chronic disease self-management education.	- Pilot Targeted Care Intervention (TCI) Program. - Implement Team Centered Care and pre-visit planning models in seven PCMHs	- A Targeted Care Intervention (TCI) staff has been piloted for the Weill Cornell Campus. - The Team Centered Care and pre-visit planning have been introduced at all seven PCMHs sites.

	- Plan empanelment strategies.	- Developed a working group that met throughout the year. The team worked with the IT-EMR and Sorian scheduling system to develop tools in the EMR that would facilitate empanelment and physician panel management.
	- Pilot Cultural Competency training.	- A Cultural Competency training curriculum was developed for PCMH personnel and has been rolled out throughout the organization. To date approximately 82 staff and providers have been trained.
	- Plan PCMH-ED Transitions of Care (TOC) Program.	- Plans for a PCMH -ED TOC program are under development and being considered as part of our NYS DSRIP application submission.
	- Implement CHW program.	- A CHW program was developed on this campus through partnerships with local community organization in Central and East Harlem.
	- Reestablish Building Bridges (BBKH) Community coalition.	- The Building Bridges (BBKH) Community coalition has been reestablished with location community based organization and faith based organizations.
	- Develop Children with Special Health Care Needs (CSHCN) Registry.	- An electronic registry was developed for Children with Special Health Care Needs (CSHCN).
	- Plan, recruit and hire staff for CSHCN program.	- Plans for a CSHCN program are under development and being considered as part of our NYS DSRIP application submission.

New York-Presbyterian – Weill Cornell Campus

Prevention Agenda Priorities	2014	2014 Update
Promote Mental Health & Prevent Substance Abuse **Focus Area:** Strengthen infrastructure across systems **Goals**		
- Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment, and recovery.	- Educate and train PCMH team on Integrated Clinical and Behavioral Care.	- Education was rolled out to all PCMH leadership teams on Integrated Clinical and Behavioral Care.
	- Develop Stepping protocols, risk stratification and tracking systems.	- Screening protocols, risk stratification and tracking systems were developed with input from clinical, IT, and operational leadership.
- Strengthen infrastructure for mental, emotional, and behavioral health promotion and mental, emotional, and behavioral disorder prevention.	- Integrate clinical and behavioral care protocols for depression screening in patient with Diabetes.	- Clinical and behavioral care protocols for depression screening in patient with PCMH Chronic conditions were integrated into the continuity visit using the PHQ2 and PHQ9 depression screening tool.
	- Develop Depression registry.	- Depression registries were developed using Microsoft Amalga tool.

2013 Community Service Plan Year 1 Update

New York-Presbyterian – Westchester Campus

Prevention Agenda Priorities	2014	2014 Update
Prevent Chronic Disease **Focus Area:** Increase access to high-quality chronic disease preventive care and management in both clinical and community settings **Goals**		
- Increase screening rates for cardiovascular disease, diabetes, and breast/cervical, colorectal cancers, especially among disparate populations	- Establish collaboration with key Community Based Organizations to conduct Cancer screenings in the community.	- Through the work of our Redes en Accion program we develop collaborations with a variety of community based organizations such as the American Cancer Society, VNS, Gilda's Club, the local YMCA, the Leukemia & Lymphoma Society, and the Westchester Hispanic Coalition in order to work on cancer and chronic disease awareness.
- Promote use of evidence-based care to manage chronic diseases. - Promote culturally relevant chronic disease self-management education.	- Hold Cancer screening community health fair.	- We participated in a variety of community health fairs throughout the year that focused on Cancer. Many of these sites were general awareness programs; however, a number focused specifically on Breast Cancer.

Promote Mental Health & Prevent Substance Abuse **Focus Area:** Strengthen infrastructure across systems **Goals** - Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment, and recovery. - Strengthen infrastructure for mental, emotional, and behavioral health promotion and mental, emotional, and behavioral disorder prevention.	- Formalize collaborations with NYP Health Home and establish systems for networking and referrals. - Formalize linkages with NYP Health Home provider agencies.	- Formal collaborations were established with a variety of community based organization that provide Health Home services to residents in and around the Westchester and Bronx regions. These organizations included but were not limited to: AIDS Service Center, The Bridge, Isabella Geriatrics, and Village Care. - All agencies were also connected and trained on the use of the Allscript's Care Director System. This system allows for documentation of care management activity, review of utilization, and referrals to participating programs.

2013 Community Service Plan Year 1 Update

New York-Presbyterian – Lower Manhattan Campus

Prevention Agenda Priorities	**2014**	**2014 Update**
<u>Prevent Chronic Disease</u> **Focus Area:** Increase access to high-quality chronic disease preventive care and management in both clinical and community settings **Goals**		
- Increase screening rates for cardiovascular disease, diabetes, and breast/cervical, colorectal cancers, especially among disparate populations	- Establish collaboration with key Community Based Organizations, American Cancer Society, VNS and local physicians to conduct Colorectal screenings in the community.	- Through the work of our Redes en Accion program we develop collaborations with a variety of community based organizations such as the American Cancer Society, VNS, Gilda's Club, the local YMCA, Aid for Aids, the Food Bank of NYC, and Seedco in order to work on cancer and chronic disease awareness.
- Promote use of evidence-based care to manage chronic diseases. - Promote culturally relevant chronic disease self-management education.	- Hold Colorectal Cancer screening community health fair.	- We participated in a variety of community health fairs throughout the year that focused on Cancer. Many of these sites were general awareness programs; however, a number focused specifically on Colorectal Cancer, Breast Cancer, and Prostate Cancer.

Promote Mental Health & Prevent Substance Abuse **Focus Area:** Strengthen infrastructure across systems **Goals** - Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment, and recovery. - Strengthen infrastructure for mental, emotional, and behavioral health promotion and mental, emotional, and behavioral disorder prevention.	- Establish formal collaborations with culturally competent behavior and substance abuse service-providing Community Based Organizations in this community.	- Formal collaborations were established with a variety of community based organization that provide Health Home services to residents in Lower Manhattan. These organizations included but were not limited to: AIDS Service Center, ACMH, Village Care, the Bridge, and Isabella Geriatrics. - All agencies were also connected and trained on the use of the Allscript's Care Director System. This system allows for documentation of care management activity, review of utilization, and referrals to participating programs.