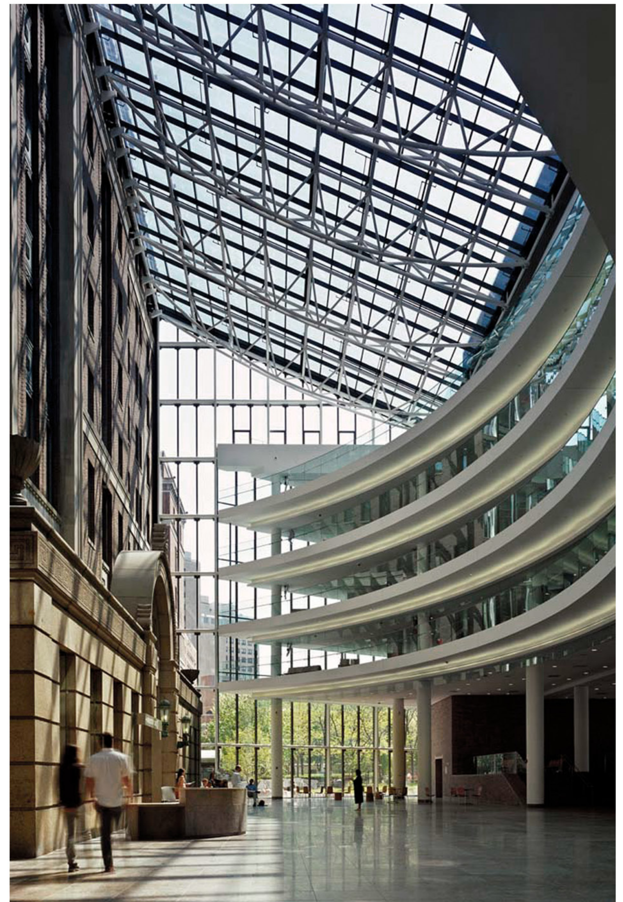
2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY

BELLEVUE HOSPITAL CENTER



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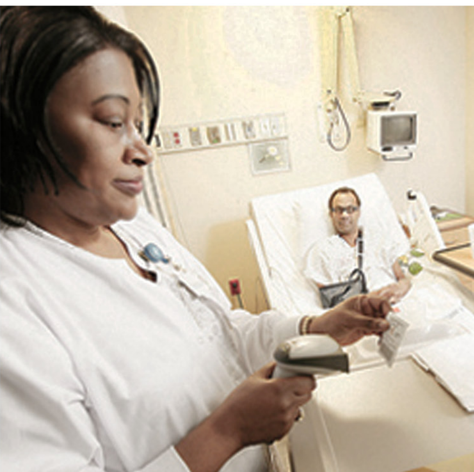

BELLEVUE HOSPITAL CENTER

462 First Avenue
New York, NY 10016
(212) 562-4141

Prepared by Marcy Pressman and Steve Bohlen. For additional information, call (212) 562-4516.

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HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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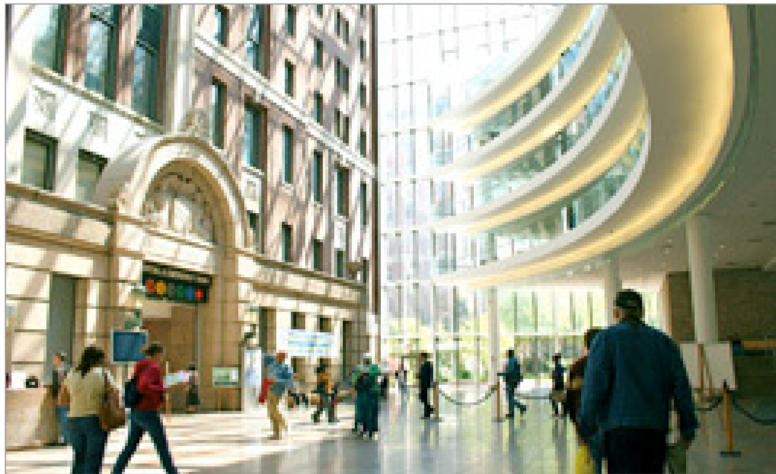
Introduction to

Bellevue Hospital Center



Bellevue Hospital Center (BHC) is America's oldest continuously operating hospital, established in 1736, and has a distinguished history of innovative contributions to public health, medical science and education. A member hospital of the New York City Health and Hospitals Corporation (HHC), the nation's largest public hospital system, BHC is affiliated with the NYU School of Medicine and offers a wide range of medical, surgical and psychiatric services in both an inpatient and outpatient setting. BHC is also a major referral center for highly complex cases city-wide and serves as a medical facility for dignitaries visiting New York City, including the President of the U.S. and diplomats from the United Nations.

BHC facilities include a 24-story patient care facility housing more than 800 inpatient beds and six Intensive Care Units; a world-renowned Emergency Service and Trauma Center; and a 4-story modern Ambulatory Care Pavilion.

The following charts provide a snapshot summary of key indicators for Fiscal Year (FY) 2012 (July 2011-June 2012):

SNAPSHOT FY 2012

Staffing	
Full-time employees	5,046
Budget	
Total operating budget	$755M
Beds	
Total certified/operating beds	912/828
Total certified/operating Psychiatry beds	339/327
Total Chemical Dependency/Detox beds	20
Key Indicators	
Discharges	31,309
Average Length of Stay – Acute care	5.2
Average Length of Stay – Psychiatry	16.4
Average Length of Stay – Rehabilitation	19.9

Clinic Visits	
Total Emergency Room	124,396
Total visits (non-Emergency Room)	524,152
Total primary care	121,264
Total psychiatric	47,121
Total physical medicine	18,174
Total methadone and chemical dependency	67,003
All other clinic visits	270,590

BHC is considered the "flagship" of HHC, a public benefit corporation whose mission has always been to provide comprehensive and high quality healthcare to all, regardless of their ability to pay, in an atmosphere of dignity and respect. HHC, the largest municipal healthcare organization in the country, is a $6.7 billion integrated healthcare delivery system that provides medical, mental health and substance abuse services through its 11 acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers and more than 70 community based clinics. HHC Health and Home Care also provide in-home services in the local communities it serves.

HHC is a crucial access point for local communities that have historically been overlooked by private physicians and voluntary hospitals seeking optimal market share in an extremely competitive healthcare environment. HHC's commitment to caring for patients regardless of their ability to pay, ultimately gives it the highest "market share" of low-income, uninsured patients across this City.

Based on 2010 New York State institutional and health center cost reports, HHC hospitals provided a far higher proportion of care to self-pay (or uninsured)

patients than any other single healthcare provider in New York City. In 2010, HHC acute care hospitals were the source of 37% of all uninsured inpatient discharges, 43% of uninsured ED visits and 67% of uninsured clinic visits among all New York City hospitals. This volume of uninsured care translates into approximately $698 million in uncompensated care annually at HHC. BHC's safety-net burden is illustrated in the following Exhibit 1.

EXHIBIT 1: BHC'S SAFETY NET BURDEN

Utilization by Payer Mix as a Percent of Total

	NYC Voluntary Nonprofit Hospitals Average*	All HHC Hospitals	Bellevue
Discharges			
Uninsured	3%	4%	8%
Medicaid	33%	38%	57%
Total Safety Net	**36%**	**42%**	**65%**
ED Visits			
Uninsured	16%	20%	38%
Medicaid	39%	41%	36%
Total Safety Net	**55%**	**61%**	**74%**
Clinic Visits			
Uninsured	11%	19%	31%
Medicaid	55%	52%	45%
Total Safety Net	**66%**	**71%**	**76%**

* Excludes HHC hospitals.
Source: 2010 Hospital Institutional Cost Report, and 2010 Health Center Cost Report.
Includes all NYC acute, general care hospitals and any wholly owned or controlled community health centers, including HHC.
Discharges exclude normal newborns. ED visits include treat and release, and visits that result in admission.
Clinic visits include comprehensive care and primary care visits only. HHC's uncompensated care costs are $698 million.

I. Description of the Community Served by BHC

Although BHC is located in the Kips Bay neighborhood on the east side of Manhattan, its primary service area is defined as 27 zip codes that account for 50% of its unique outpatients served from July 1, 2011 through June 30, 2012, excluding individuals who had only an emergency room visit. The primary service area accounts for 50% of unique patients and the secondary service area accounts for an additional 25% (Exhibit 2).

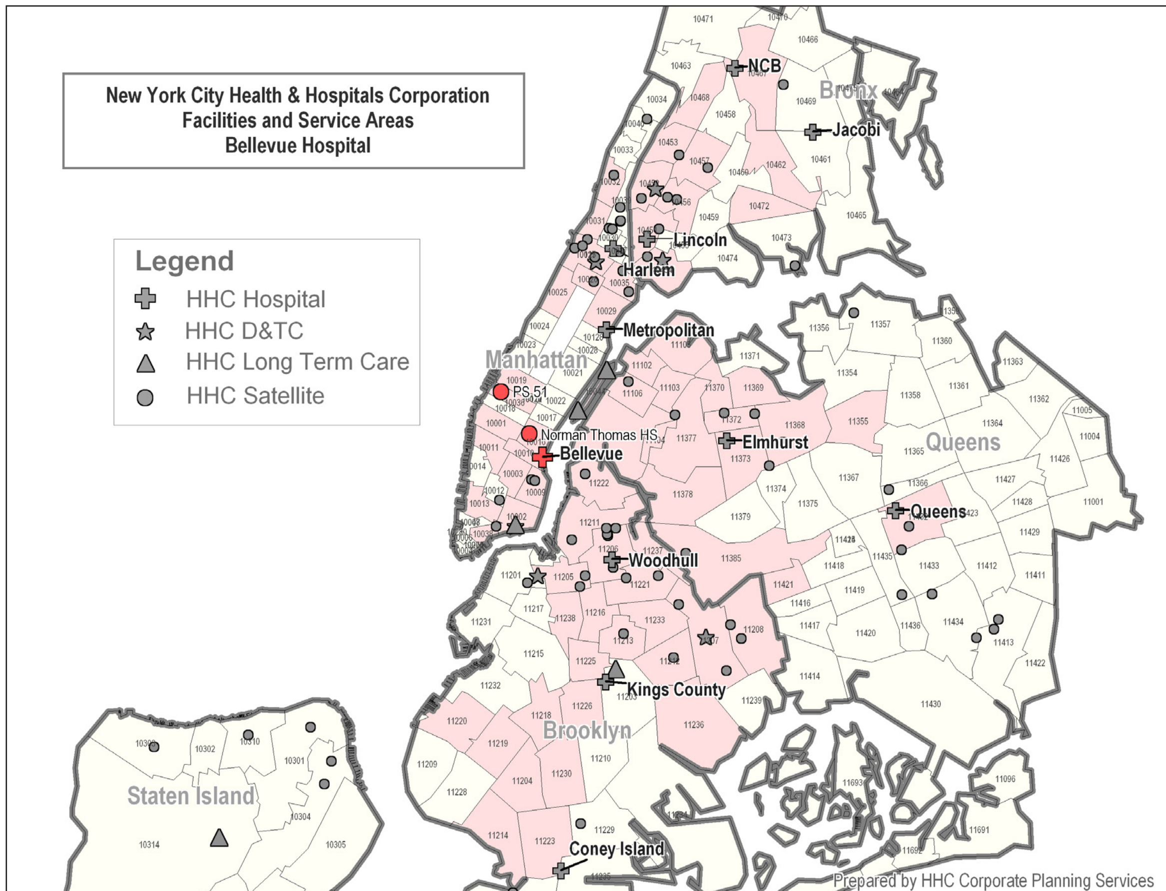
EXHIBIT 2: BHC PRIMARY SERVICE AREA BY ZIP CODE

Priority	ZIP CODE	Unique Outpatients	% Of Total	Cumulative %
1	10002	5,055	5.57%	5.57%
2	10009	3,521	3.88%	9.45%
3	10016	2,914	3.21%	12.67%
4	11237	2,380	2.62%	15.29%
5	11368	2,365	2.61%	17.90%
6	11385	2,308	2.54%	20.44%
7	11377	2,181	2.40%	22.85%
8	11206	2,134	2.35%	25.20%
9	11373	2,077	2.29%	27.49%
10	11211	2,035	2.24%	29.73%
11	11221	1,727	1.90%	31.64%
12	11208	1,364	1.50%	33.14%
13	11372	1,339	1.48%	34.62%
14	10029	1,313	1.45%	36.06%
15	11207	1,235	1.36%	37.42%
16	11370	1,233	1.36%	38.78%
17	11220	1,208	1.33%	40.11%
18	10001	1,092	1.20%	41.32%
19	11226	1,072	1.18%	42.50%
20	10011	964	1.06%	43.56%
21	10003	901	0.99%	44.56%
22	10035	882	0.97%	45.53%
23	10036	871	0.96%	46.49%
24	10010	864	0.95%	47.44%
25	11106	862	0.95%	48.39%
26	11222	820	0.90%	49.30%
27	10456	816	0.90%	50.20%

Source:Unique outpatients served between July 1, 2011 through June 30, 2012. Excludes individuals who only had an emergency room visit. Siemens Data Warehouse, Run date 10/15/13

A map of the Primary Service Area shows that BHC's patient base resides mostly in Southern Manhattan, Northern Brooklyn and Western Queens, with additional patients from Northeast Manhattan and Southern and Central Brooklyn. (Exhibit 3).

EXHIBIT 3: BHC PRIMARY SERVICE AREA MAP



As shown in Exhibit 4, there were 1,811,222 residents in the primary service area in 2010. The area experienced a 3.8% population increase from 2000 and an additional 5.8% increase is projected from 2010 to 2018.

EXHIBIT 4: BELLEVUE PRIMARY SERVICE AREA POPULATION

	Population			Change 2000 - 2010		Change 2010 – 2018	
	2000	2010	2018	No.	Per.	No.	Per.
PSA	1,744,544	1,811,222	1,916,960	66,678	3.8%	105,738	5.8%

Source: Claritas 2013

The primary service area population is slightly younger than New York City as a whole. Exhibit 5 shows a larger percentage of residents under the age of 65 and, conversely, lower percentages of primary service area residents in the upper age groups.

EXHIBIT 5: 2010 AGE DISTRIBUTION, BELLEVUE PRIMARY SERVICE AREA COMPARED TO NYC

Age Group	Bellevue PSA	% of Total	NYC Total	% of Total
0-14	314,000	17.3%	1,457,981	17.8%
15 - 17	64,926	3.5%	308,787	3.8%
18-24	219,202	12.1%	868,736	10.6%
25 - 44	620,383	34.2%	2,545,461	31.2%
45-64	407,856	22.5%	1,995,295	24.4%
65 - 84	161,662	8.9%	850,683	10.4%
85+	23,193	1.3%	141,056	1.7%
Total	**1,811,222**	**100.0%**	**8,167,999**	**100.0%**

Source: Claritas 2013

BHC's primary service area's racial composition is presented in Exhibit 6. The primary service area has a large Hispanic population; however it has been trending downward since 2000 and is projected to continue to do so through 2018 (Exhibit 7). At the same time, the percentage of the White population in the primary service area has increased, a trend that continues through 2018. The Black population is projected to continue to decline through 2018. The percent of Asians living in the service area has increased and will continue to do so, higher than the rate for New York City as a whole both currently and as projected through 2018.

EXHIBIT 6: 2010 - BELLEVUE SERVICE AREA RACE/ETHNIC DISTRIBUTION

	PSA	NYC
WHITE	40.0%	44.6%
BLACK	21.9%	26.6%
ASIAN	15.4%	9.8%
OTHER	22.5%	18.9%
HISPANIC	38.1%	27.0%

Source: Claritas 2013 Source: Claritas 2013. 'Hispanic' includes anyone who self-identifies as Hispanic regardless of race.

EXHIBIT 7: TRENDS IN RACE/ETHNIC DISTRIBUTION – BELLEVUE PSA & NYC

	Bellevue PSA		NYC	
	2000	2018 Proj.	2000	2018
White	38.6%	41.1%	44.6%	43.9%
Black	23.1%	20.6%	26.6%	24.3%
Asian	12.9%	16.9%	9.8%	14.4%
Other	25.4%	21.4%	18.9%	17.4%
Hispanic	38.4%	37.0%	27.0%	29.0%

Source: Claritas 2013

Exhibit 8 illustrates the high rates of poverty in BHC's primary service area. Poverty rates for all families, and for those families with children, are significantly higher in the service area than in NYC. Over 22% of all families and over 31% of families with children live below federal poverty guidelines.

EXHIBIT 8: POVERTY RATES IN BELLEVUE PSA COMPARED TO BROOKLYN & NYC

	Total Families		Families w/ Children	
Area	Above Poverty	Below Poverty	Above Poverty	Below Poverty
NYC	83.3%	16.7%	75.6%	24.4%

Source: Claritas 2013

The extent of poverty within the service area is also reflected in the insurance status of BHC's patients (Exhibit 8). Medicaid coverage accounts for 57% of Bellevue's inpatient discharges, 36% of total Emergency Department visits and 45% of outpatient clinic visits. In addition, 38% of Emergency Department and 31% of clinic visits are uninsured/self-pay. In comparison, only 16% of Emergency Department and 11% of outpatient clinic visits in New York City hospitals, excluding HHC facilities, are self-pay.

The extent of poverty among service area residents compounds the need for social services and related services including housing. This can add to the complexity of providing healthcare and in managing population health.

The primary service area population, in the aggregate, scores better on most health indicators than NYC as a whole. However, according to NYC Department of Health Community Health Survey data, service area residents in some neighborhoods have higher rates of diabetes, obesity, high cholesterol, hypertension, asthma and tobacco use than NYC as a whole (Exhibit 9). Of the eight primary service area neighborhoods served, four show higher rates of diabetes; five neighborhoods have higher rates of high cholesterol; three neighborhoods have higher rates of obesity and hypertension; and two neighborhoods have higher rates of asthma and tobacco use.

EXHIBIT 9: BHC PRIMARY SERVICE AREA RESIDENTS' PERFORMANCE ON KEY HEALTH INDICATORS COMPARED TO NYC

	Diabetes	Obese	High Choleterol	Hyper-tension	Asthma	Tobacco Current Smoker (>=18 years)	Colono -scopy (past 10 years)	Flu Shot (past 12 mos. elderly)	Mammo. (past 2 years) [Note 2]	Pap Smear [Note 2]	Binge Drinking Episode (past 30 days)
NYC rate (%)	**10.5%**	**23.7%**	**30.6%**	**28.9%**	**11.9%**	**14.8%**	**68.6%**	**57.0%**	**76.7%**	**78.4%**	**17.9%**
Primary Service Area											
West Queens	12.0%	21.8%	31.0%	25.2%	9.8%	9.7%	67.0%	58.0%	68.1%	77.5%	19.7%
Union Sq./Lower Eastside	8.8%	11.5%	31.5%	25.1%	9.7%	9.9%	80.6%	60.9%	72.2%	70.1%	24.2%
Williamsburg/Bushwick	14.2%	33.6%	33.6%	37.7%	9.1%	11.9%	72.6%	57.3%	77.4%	77.6%	10.8%
Gramercy Park/Murray Hill	4.2%	11.2%	34.8%	20.3%	10.6%	12.1%	75.1%	62.9%	74.5%	80.5%	29.8%
Chelsea/Greenwich Village	3.8%	10.1%	27.9%	14.0%	8.9%	13.3%	60.2%	64.6%	81.0%	74.3%	35.3%
Long Island City/Astoria	13.6%	32.5%	36.4%	30.3%	5.1%	23.1%	62.6%	50.6%	83.3%	79.0%	20.4%
Ridgewood/Forest Hills	7.0%	18.3%	28.1%	26.2%	15.5%	13.7%	55.2%	53.5%	71.8%	68.1%	19.2%
Bedford/Stuy/Crown Heights	14.3%	36.6%	25.4%	33.5%	20.8%	17.1%	73.4%	45.0%	81.7%	83.7%	13.8%
Aggregated Total and % of Health Indicator in Primary Service Area	9.2%	21.1%	31.0%	25.7%	11.4%	13.3%	68.7%	57.0%	75.2%	77.0%	21.9%

Notes: (1): Unless noted otherwise, all data are from the 2011 NYCDOH Community Health Survey Epiquery database. (2): Data are from the 2010 NYCDOH Community Health Survey Epiquery database.

For large numbers of BHC primary service area residents, navigating healthcare services is complicated by the fact that English is not their primary language. There are significant challenges coordinating care and services when language barriers exist. Establishing treatment compliance for chronic diseases such as diabetes requires patients and their providers to communicate effectively regarding the importance of filling prescriptions, diet, exercise, etc.

Exhibit 10 shows language spoken at home by BHC Primary Service Area residents (people aged 5 years and older). From July 2011 through June 2012, BHC provided interpretation services over 366,000 times to patients and their families.

EXHIBIT 10: 2013 ORIGINS OF LANGUAGE SPOKEN AT HOME BY PRIMARY SERVICE AREA (PEOPLE AGED 5 YEARS AND OLDER)

Priority	ZIP	English	Spanish	Asian	European	All Other
1	10002	25,522	15,736	32,955	3,434	757
2	10009	37,708	11,555	5,503	4,728	472
3	10016	39,224	4,067	3,807	5,712	738
4	11237	9,556	34,151	2,066	1,386	497
5	11368	14,902	72,109	8,092	7,444	1,345
6	11385	38,681	32,840	4,050	16,545	941
7	11377	19,350	30,174	17,921	16,445	1,398
8	11206	34,102	29,892	4,449	9,323	1,298
9	11373	9,684	38,497	35,511	12,907	675
10	11211	21,194	18,073	2,140	14,998	1,020
11	11221	44,504	27,813	1,070	2,072	830
12	11208	49,712	33,324	1,539	4,441	1,159
13	11372	11,697	33,958	6,738	10,631	534
14	10029	29,818	34,352	2,983	4,416	1,051
15	11207	57,963	27,671	463	2,508	599
16	11370	6,141	10,866	3,063	6,924	1,145
17	11220	18,095	34,168	34,522	5,098	2,212
18	10001	15,883	2,310	2,357	2,134	333
19	11226	60,724	12,918	1,762	17,706	2,174
20	10011	36,166	5,298	2,725	5,260	453
21	10003	41,610	3,388	4,097	4,976	637
22	10035	16,365	14,897	540	1,062	456
23	10036	16,048	4,422	2,112	2,789	265
24	10010	22,443	3,398	2,110	3,221	565
25	11106	15,170	10,172	3,356	8,309	1,154
26	11222	19,034	4,309	880	11,922	155
27	10456	32,346	41,465	441	2,553	4,124
Total		**743,642**	**591,823**	**187,252**	**188,944**	**26,987**

Source: Claritas 2013

In conclusion, BHC is a major safety net provider to large areas of NYC, which have a high need to access healthcare services.

The communities served by BHC are largely White and Hispanic, with a projected growth in the Asian population. Although the service area population is aging, children and young adults currently make up a larger percent of the population than they do in other parts of New York City.

Communities served by BHC are impoverished. Over 22% of all families and over 31% of families with children live below Federal poverty guidelines. A significant portion of borough residents households suffer from poor health status, poverty and lower than average levels of educational attainment. Service area residents, on the whole, are healthier than other New Yorkers, but some neighborhoods served have higher rates of diabetes, obesity, high cholesterol, hypertension, and binge drinking than other areas of NYC. ◆

II. Process and Methodology

The information contained in this Community Health Needs Assessment (CHNA) derives from two converging types of information. These are:

Primary Source: Focus Groups conducted by this facility in 2013

This facility conducted three focus groups in March 2013, each with a different group of participants: (a) facility patients; (b) community stakeholders, including local residents and representatives of community-based organizations, and (c) a group comprised of healthcare providers at this facility, including many who also live in our service areas. This last group included community health experts.

The patient focus group consisted of nine patients who receive services in HIV, Psychiatry, and primary care. As BHC draws its patients from across the City, so too, were the patients who participated in the focus group. They come from the following zip codes: 10460, 11219, 11230, 11225, 10035, 10010, 10011, 10304, and 10001.

The community stakeholder focus group consisted of six participants: 1) a BHC Community Advisory Board (CAB) member who resides in zip code 10010 and has expertise in customer relations; (2) a CAB member who is a certified special educator who resides in zip code 10010; (3) a CAB member with a legal background who specializes in corporate product development and resides in zip code 10016; (4) a CAB member who is a social worker with expertise in child welfare and chronic mental illness and resides in zip code 10009; (5) a social worker representing the Phipps Community Development Corporation with a background in providing service to seniors and who resides in zip code 11421; and (6) the administrative director of Children of BHC, a non-profit organization that supports hospital-based services for children.

There were 10 participants in the healthcare provider focus group representing various disciplines from a variety of services at BHC. The composition of the group is as follows: (1) a physician from the Child & Adolescent Psychiatry clinic who resides in zip code 10025; (2) a physician from the Department of OB/GYN who resides in zip code 10017; (3) a staff nurse from HIV services who has expertise in ambulatory surgery, surgery and surgical subspecialties and who resides in zip code 10039; (4) a patient care associate from the Dermatology clinic who resides in zip code 11692; (5) an administrator from the Department of Psychiatry who resides in zip code 11236; (6) a Children's counselor from the Department of Child Life & Developmental Services who resides in zip code 11218; (7) a social worker from HIV services who has expertise with pediatric and adolescent patients and who resides in zip code 11385; (8) a physician from the Outpatient Child and Adolescent Psychiatry program who resides in zip code 10003; (9) a patient care associate from the adult primary care clinic who resides in zip code 10009; and (10) an administrator from the outpatient pediatric program who resides in zip code 10039. Two of the members of this focus group indicated they are bilingual Spanish.

The focus groups' questions were designed to produce the necessary content of a CHNA, and the groups' facilitators followed a plan that would allow maximum group participation and responses over a variety of issues in about 90 minutes. Although records of participants and verbatim responses were kept, participants were assured that their names would not be associated with specific responses. Facility patients were asked the following queries:

1. What are the greatest healthcare needs in your community? Or, put another way, what health problems do you see the most among your family members and neighbors?
2. On a scale from 1-5 (1 being the lowest), how does this hospital respond to each health need listed?
3. Tell us about the greatest problems you and your family members face getting healthcare at BHC? [If there aren't many responses, probe with: "Have you had a bad experience? Tell us about it?"]

4. What changes can this hospital make so it can better respond to the needs and problems you've just mentioned?
5. What do you think are the greatest strengths of BHC?

Community members were asked the following five queries:

1. What do you think are the greatest strengths of healthcare in your community served by BHC?
2. What are the greatest weaknesses of healthcare in your community served by BHC?
3. What are the greatest healthcare needs in your community? Or, put another way, what illnesses do you see the most among your family and neighbors?
4. On a scale from 1-5 (1 being the lowest), how does BHC respond to each health need listed?
5. How can the facility better respond to each specific health need?

Providers were asked these questions:

1. What do you think are the greatest strengths of healthcare in your community served by BHC?
2. What are the greatest weaknesses of healthcare in the community served by BHC?
3. What are the greatest healthcare needs in your community? Or, put another way, what illnesses do you see the most among your patients?
4. On a scale from 1-5 (1 being the lowest), how does BHC respond to each health need listed?
5. How can the facility better respond to each specific health need?

Responses for all three focus groups were recorded and were submitted to facility leadership for prioritization for the implementation plan.

Supplemental, or secondary, information

To assist with reporting community health needs in depth, we supplemented the focus group results with data that describes in additional detail the issues raised in those groups. These data came from a variety of primary and secondary sources, including: for population data, Claritas 2013, (U.S. Census data from Nielsen SiteReports, see http://www.claritas.com/sitereports/Default.jsp); New York City Health and Hospitals Corporation analyses of hospital and community health center cost reports 2010; New York City Department of Health and Mental Hygiene Community Health Surveys, (http://www.nyc.gov/html/doh/html/data/survey.shtml), several city boroughs' Statements of Community District Needs, Fiscal Year 2013, prepared by New York City's community district boards and available at http://www.nyc.gov/html/dcp/html/pub/cdnd13.shtmland, and data available from the New York State Department of Health website (http://www.health.ny.gov/statistics/). These data are presented as analyzed by the companies or agencies mentioned, or were further analyzed by HHC for purposes of this report. ◆

III. Health Needs Identified

The CHNA was conducted in early 2013 in collaboration with the hospital's clinical and administrative leadership, representative staff from patient programs and clinical services, community stakeholders, and patients who receive services. The purpose of this Assessment is to identify existing and emerging healthcare needs of the local community so BHC can develop and support meaningful and effective services for its patients that further the goals of the State and Federal health care agendas.

The patient focus group identified 17 needs including these ten:

- hepatitis C
- HIV
- obesity
- mental health
- substance abuse
- diabetes
- health education
- cancer
- hypertension
- cholesterol

The community stakeholder group identified 15 needs including these ten:

- flu
- hypertension
- diabetes
- alcoholism
- end stage renal disease
- pediatric psychiatry
- mental illness
- drug addiction
- dementia/Alzheimer's
- obesity

The provider focus group identified the following 12 priorities, including these ten:

- hypertension
- diabetes
- HIV/AIDS/STDS
- behavioral disorders
- depression and anxiety
- substance abuse
- wellness check-ups
- access to care
- coordination
- health education/literacy

From the priorities identified by each group, we identified commonalities and grouped needs accordingly. At the conclusion of that process, we identified 8 priorities which were reviewed and ranked by an interdisciplinary group of hospital leaders. An Implementation Plan was developed to address the prioritized needs. ◆

IV. Community Assets Identified

BHC provides health services to large numbers of service area residents. A partial inventory of other community assets is included in the following exhibits.

Hospitals – Exhibit 11 lists hospitals within BHC's primary service area and also includes NYU/Langone Medical Center. (BHC's medical affiliate is the NYU School of Medicine which is located adjacent to the BHC Campus.) Among the hospitals, Wyckoff Heights is experiencing or has suffered serious financial hardship and has been identified as one of the most financially troubled hospitals in Brooklyn that require immediate intervention to avert financial collapse according to the Brooklyn Medicaid Redesign Team Health Systems Redesign Work Group in 2011.

Demand for BHC services has been impacted in the recent past by the closing of a hospital in Southwest Manhattan, St. Vincent's. The closure resulted in increased visits to the BHC Emergency Department, and increased demand for outpatient and inpatient services.

EXHIBIT 11: NON-HHC HOSPITALS WITH THE BHC PRIMARY SERVICE AREA

Hospital Name	Address	Zip Code	Borough
Bronx-Lebanon Fulton	1276 Fulton Ave	10456	Bronx
Lutheran Medical Center	150 55th St	11220	Brooklyn
Wyckoff Heights Medical Center	374 Stockholm St	11237	Brooklyn
Beth Israel /Petrie Campus	10 Nathan D. Perlman Place	10003	Manhattan
Hospital for Joint Diseases	301 East 17th St	10003	Manhattan
Mt Sinai Hospital	One Gustave L. Levy Pl	10029	Manhattan
NYU Medical Center	550 First Av	10016	Manhattan

NYS DOH Website

Ambulatory Care Sites – Exhibit 12 lists Federally Qualified Health Center sites in the BHC primary service area.

EXHIBIT 12: NON-HHC HRSA GRANT FUNDED FEDERALLY QUALIFIED HEALTH CLINICS WITHIN BHC PRIMARY SERVICE AREA

Clinic Name	Address	Zip Code	Borough
BRONX LEBANON INTEGRATED SERVICE SYSTEM INC	1265 Franklin Ave	10456	Bronx
BRONX LEBANON INTEGRATED SERVICE SYSTEM INC	1276 Fulton Ave Fl 3	10456	Bronx
CARE FOR THE HOMELESS	1122 Franklin Ave	10456	Bronx
CARE FOR THE HOMELESS	1130 Grand Concourse	10456	Bronx
MORRIS HEIGHTS HEALTH CENTER INC	1116 Sheridan Ave	10456	Bronx
URBAN HEALTH PLAN, INC.	800 Home St	10456	Bronx
URBAN HEALTH PLAN, INC.	900 Tinton Ave	10456	Bronx
BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC.	1238 Broadway	11221	Brooklyn
BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC.	794 Monroe St	11221	Brooklyn
BETANCES HEALTH CENTER	280 Henry St	10002	Brooklyn
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	116 Williams Ave	11207	Brooklyn
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	360 Snediker Ave	11207	Brooklyn
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	400 Pennsylvania Ave	11207	Brooklyn
CARE FOR THE HOMELESS	89-111 Porter Ave	11237	Brooklyn
CARE FOR THE HOMELESS	75 Lewis Ave	11206	Brooklyn
CARE FOR THE HOMELESS	1675 Broadway	11207	Brooklyn
COMMUNITY HEALTHCARE NETWORK, INC.	94-98 Manhattan Ave	11206	Brooklyn
COMMUNITY HEALTHCARE NETWORK, INC.	999 Blake Ave	11208	Brooklyn
FLOATING HOSPITAL INCORPORATED (THE)	515 Blake Ave	11207	Brooklyn
HOUSING WORKS, INC.	2640 Pitkin Ave	11208	Brooklyn
ODA PRIMARY HEALTH CARE CENTER, INC.	420 Broadway	11211	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	300 Skillman Ave	11211	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	150 55th St	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	230 60th St	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	309 47th St	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	330 60th St	11220	Brooklyn

EXHIBIT 12: NON-HHC HRSA GRANT FUNDED FEDERALLY QUALIFIED HEALTH CLINICS WITHIN BHC PRIMARY SERVICE AREA continued

SUNSET PARK HEALTH COUNCIL, INC.	405 44th St	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	4520 4th Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	4812 9th Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	5008 7th Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	5010 6th Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	514 49th St	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	5421 2nd Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	5434 2nd Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	5610 2nd Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	5613 2nd Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	5616 6th Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	5800 3rd Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	6025 6th Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	6317 4th Ave	11220	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	100 Parkside Ave Fl 4	11226	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	911 Flatbush Ave	11226	Brooklyn
SUNSET PARK HEALTH COUNCIL, INC.	424 Leonard St	11222	Brooklyn
CARE FOR THE HOMELESS	197 Bowery	10002	Manhattan
CARE FOR THE HOMELESS	269 E 4th St	10009	Manhattan
CARE FOR THE HOMELESS	527 W 22nd St	10011	Manhattan
CARE FOR THE HOMELESS	1 Wards Is	10035	Manhattan
CARE FOR THE HOMELESS	12 W 21st St Fl 8	10010	Manhattan
COMMUNITY HEALTHCARE NETWORK, INC.	150 Essex St	10002	Manhattan
COMMUNITY HEALTHCARE NETWORK, INC.	79 Madison Ave	10016	Manhattan
EAST HARLEM COUNCIL FOR HUMAN SERVICES INC	160 E 120th St	10035	Manhattan
EAST HARLEM COUNCIL FOR HUMAN SERVICES INC	2253 3rd Ave	10035	Manhattan
EAST HARLEM COUNCIL FOR HUMAN SERVICES INC	319 E 117th St	10035	Manhattan
EAST HARLEM COUNCIL FOR HUMAN SERVICES INC	535 E 119th St	10035	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	269 E 4th St	10009	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	176 E 115th St	10029	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	527 W 22nd St	10011	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	113 E 13th St	10003	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	16 E 16th St	10003	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	16 E 16th St Fl 3	10003	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	40 Irving Pl	10003	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	1824 Madison Ave	10035	Manhattan
INSTITUTE FOR FAMILY HEALTH, THE	1879 Madison Ave	10035	Manhattan
PROJECT RENEWAL, INC.	8 E 3rd St	10003	Manhattan
PROJECT RENEWAL, INC.	Clarke Thomas Building 1 Wards Island	10035	Manhattan
SETTLEMENT HEALTH AND MEDICAL SERVICES, INC.	104 E 107th St	10029	Manhattan
SETTLEMENT HEALTH AND MEDICAL SERVICES, INC.	212 E 106th St	10029	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	40 Division St	10002	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	120 E 32nd St	10016	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	115 W 31st St	10001	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	127 W 25th St Fl 4	10001	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	148 8th Ave	10011	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	155 W 22nd St	10011	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	356 W 18th St	10011	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	36 7th Ave	10011	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	36 7th Ave Ste 408	10011	Manhattan

EXHIBIT 12: NON-HHC HRSA GRANT FUNDED FEDERALLY QUALIFIED HEALTH CLINICS WITHIN BHC PRIMARY SERVICE AREA continued

SUNSET PARK HEALTH COUNCIL, INC.	315 Bowery	10003	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	317 Bowery	10003	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	331 E 12th St	10003	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	36 E 1st St	10003	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	55 E 3rd St	10003	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	1 Keener Building	10035	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	216 E 120th St	10035	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	127 W 43rd St	10036	Manhattan
SUNSET PARK HEALTH COUNCIL, INC.	125 E 24th St	10010	Manhattan
UNDER 21 INC	460 W 41st St	10036	Manhattan
WILLIAM F. RYAN COMMUNITY HEALTH CENTER INC	442 E Houston St	10002	Manhattan
WILLIAM F. RYAN COMMUNITY HEALTH CENTER INC	279 E 3rd St	10009	Manhattan
WILLIAM F. RYAN COMMUNITY HEALTH CENTER INC	600 E 6th St	10009	Manhattan
WILLIAM F. RYAN COMMUNITY HEALTH CENTER INC	320 W 21st St	10011	Manhattan
WILLIAM F. RYAN COMMUNITY HEALTH CENTER INC	645 10th Ave	10036	Manhattan
URBAN HEALTH PLAN, INC.	3712 108th St	11368	Queens

Source: HRSA Data warehouse, HRSA.gov
Health Centers and Look-A-Like Sites Data Download
Healthcare Service Delivery Sites, Refresh Date 3/18/2013

The service area includes New York State Department of Health-licensed facilities that provide services including primary and specialty physician services and ambulatory surgery (Exhibit 13).

EXHIBIT 13: NON-HHC DIAGNOSTIC AND TREATMENT CENTERS WITHIN BHC PRIMARY SERVICE AREA

Centerl Name	Address	Zip Code	Borough
BRONX ADDICTION SERVICES INTEGRATED CONCEPTS SYSTEM INC AKA BASICS INC	1064 FRANKLIN AVENUE	10456	Bronx
DR MARTIN LUTHER KING JR HEALTH CENTER INC	1265 FRANKLIN AVENUE	10456	Bronx
BEDFORD MEDICAL FAMILY HEALTH CENTER INC	100 ROSS STREET	11211	Brooklyn
BROOKDALE FAMILY CARE CENTER INC	2554 LINDEN BOULEVARD	11208	Brooklyn
CALEDONIAN COMMUNITY HEALTH CENTER INC	10 ST PAUL'S PLACE	11226	Brooklyn
COMPREHENSIVE HEALTH CARE AND REHABILITATION SERVICES LTD	148 WILSON AVENUE	11237	Brooklyn
ODA PRIMARY HEALTH CARE CENTER INC	14-16 HEYWARD STREET	11211	Brooklyn
BETANCES HEALTH CENTER	280 HENRY STREET	10002	Manhattan
CENTER FOR COMPREHENSIVE HEALTH PRACTICE INC	1900 SECOND AVENUE	10029	Manhattan
COMMUNITY HEALTHCARE NETWORK	79 MADISON AVE 6TH FL	10016	Manhattan
COVENANT HOUSE	460 WEST 41ST STREET	10036	Manhattan
EAST HARLEM COUNCIL FOR HUMAN SERVICES INC	2253 THIRD AVENUE 3RD FLOOR	10035	Manhattan
HEALTH UNLIMITED	40 MONTGOMERY STREET	10002	Manhattan
INSTITUTE FOR URBAN FAMILY HEALTH, INC / SIDNEY HILLMAN CENTER	16 EAST 16TH STREET	10003	Manhattan
MICHAEL CALLEN-AUDRE LORDE COMMUNITY HEALTH CENTER	356 WEST 18TH STREET	10011	Manhattan
MOUNT SINAI DIAGNOSTIC AND TREATMENT CENTER INC	1470 MADISON AVENUE BOX 1051	10029	Manhattan
NEW ALTERNATIVES FOR CHILDREN INC	37 WEST 26TH STREET	10010	Manhattan
RYAN/CHELSEA-CLINTON COMMUNITY HEALTH CENTER INC	645 TENTH AVENUE	10036	Manhattan
SETTLEMENT HEALTH	212 EAST 106TH STREET	10029	Manhattan
UNITE HEALTH CENTER INC	275 SEVENTH AVENUE	10001	Manhattan
VILLAGECARE HEALTH CENTER	121-A WEST 20TH STREET	10011	Manhattan
WEST MIDTOWN MANAGEMENT GROUP INC	311 WEST 35TH STREET	10001	Manhattan
PRIVILEGE CARE DIAGNOSTIC AND TREATMENT CENTER	40-18 76TH STREET	11373	Queens
QUEENS SURGI-CENTER	83-40 WOODHAVEN BOULEVARD	11385	Queens

Source: NYSDOH Website, Comprehensive Clinics as February 1, 2013

V. Priorities

The priority needs developed by BHC are based on the focus group findings, analysis of quantitative health and social indicators as presented in this community health needs assessment, the resources available within the communities we serve, and our experience working with BHC patients and families. BHC's CHNA is aligned with several of the New York State Department of Health's Prevention Agenda Priorities for 2013-2017.

The priorities identified by the CHNA and ratified by BHC's leadership are:

1. Mental Illness
2. Diabetes
3. Hypertension
4. Substance Abuse
5. Health Literacy
6. Cancer
7. Obesity
8. HIV/AIDS/STDs

VI. Implementation Strategy

Below is a description of the specific implementation strategies for each of the priority areas.

1. Mental Illness

BHC has embarked on a number of initiatives to identify patients with mental illness, integrate primary care and mental health services, and improve access to outpatient services for both adults and adolescents. Specifically, we will be increasing depression screening in the primary care setting for adult and pediatric patients. Among the pediatric patient population, we are looking to screen parents/caregivers to provide supportive services, if needed.

Also, our goal is to integrate more behavioral health practitioners within the primary care setting in order to ensure the integration of services and to provide a "one-stop" model of care for those in need of mental health services. For children who have psychiatric emergencies, we have the only Children's Comprehensive Psychiatric Emergency Program (CPEP) in New York City.

For outpatient psychiatric services, we have deployed the HHC Breakthrough (Lean) methodology of performance improvement to reduce delays for appointments as well as to reduce delays on the day of the appointment while waiting for a practitioner. Also, we have created patient panels to ensure continuity between patients and their primary care providers.

Currently, among our active adult primary care population of 25,805 patients in 2012, 16% have a diagnosis of depression (4,108 patients). Of these, there were 608 Emergency Department visits per 1,000 patients and 242 admissions per 1,000 patients. By deploying the strategies described above, we hope to decrease this by 5 percent for an effective rate of 578 Emergency Department (ED) visits per 1,000 patients and 230 admissions per 1,000 patients.

2. Diabetes

The Diabetes Team at BHC has been recognized by the American Diabetes Association and the National Committee for Quality Assurance for the delivery of quality diabetes care. As part of the HHC, BHC participates in the diabetes chronic disease collaborative. All patients with a diagnosis of diabetes are entered into our chronic disease registry and are tracked with regard to compliance with care algorithms and outcomes (such as HgA1c levels). Feedback from the database is provided regularly to providers.

All active diabetic patients in the adult primary care practice have been assigned to a primary care provider to ensure continuity of service. We are also looking to deploy our care management model to design specific care plans for each patient based on his/her needs. These care plans are developed in collaboration with the patient and include self-care goals. In addition, "at risk" patients are provided either care coordination or care management services (or both).

Patients "at risk" are defined as patients who have poor compliance, have more than one visit to the ED within a one-year period and/or one or more admissions during that same time period, and who have one or more socioeconomic risk factors such as homelessness. The "at risk" patients will be tied to either a specific care manager who provides the clinical care management and/or a care coordinator who ensures the patient is in compliance with his/her treatment regimen and/or follow-up care.

For obese patients with diabetes, we have developed an intensive medical weight management clinic and have expanded access to bariatric surgery clinic. Our bariatric services have been designated as a Center of Excellence by the American Cancer Society.

As of calendar year 2012, there were 1,524 patients with a diabetes diagnosis, representing 6% of our adult population who are actively engaged with a primary care provider. Of these, four of every five patients (803 patients per 1,000) made visits to the ED within the year, and 2.5 of every five patients (500 per 1,000) had an inpatient admission. By deploying the strategies above, we expect to achieve a 10% improvement for an effective rate of 723/1,000 visits to the ED and 401/1,000 admissions to the hospital. Also, we have a diabetic registry of 4,773 active patients with a diagnosis of diabetes that may or may not be receiving care from a

primary care physician at BHC. These patients have been engaged in care at least once in the last nine months. Among this population, 17% had blood glucose levels greater than or equal to 9 (normal is less than 5.7). We expect to decrease this to 12% using the strategies described above.

3. Hypertension

BHC's goal is to reduce the incidence of hypertension among its adult community. Similar to the strategies described above for the diabetic population, BHC is connecting patients to primary care providers for continuity and management of their disease. Nursing care management will be more fully developed to expand access to hypertension management services, including regular blood pressure checks, counseling on diet and exercise as well as medication management.

Regular performance reports will be provided to the primary care providers, and self-care plans will be developed in collaboration with the patients. Through the patient-centered medical home initiative, BHC is seeking additional dietician support as well to develop culturally appropriate diets for our patients. Group classes will be developed on such topics as healthy cooking and stress management.

In 2012, 41% of the patients in our adult primary care practice (10,605 of 25,805) had a diagnosis of hypertension with blood pressures at our above 140/90. Using the strategies described above, we expect 64% of our patients to have controlled blood pressures.

4. Substance Abuse

BHC is an active partner in New York State's Health Home program (HH) which seeks to enroll "high utilizers" of emergency and inpatient services. Patients with substance abuse and mental illness diagnoses are among the highest acuity patients in this program. As part of the program, we will be enrolling patients who have been identified by New York State to receive care management, care coordination, primary care, substance and mental health services as determined by the needs of the patient. Each patient will receive a care plan and be actively managed by their care team. The patients in the HH program may also include patients with a diagnosis of HIV and/or AIDs.

Currently, BHC is in the beginning of implementation of the HH program with the goal of caring for more than 300 high risk patients. The program focuses on care management in the community and works to help these patients become connected to regular care and stay connected to care. In addition to the six care coordinators who focus on the chronically ill, substance abusers and homeless patients, BHC's Virology Community Follow-up Program (COBRA) is in the process of moving into the HH model as well. The COBRA portion of the HH program has the capacity to provide care coordination to 180 patients by care managers who comprise six full-time employees. There are three populations from which we can accept patients into the program: HIV-infected patients from the Virology Clinic (using set criteria for referral) in need of intensive care management, high-risk patients from the primary care clinic, and a New York State Department of Health list of high risk patients.

Currently the six FTEs (full-time equivalent) from the COBRA program are caring for 103 patients (17 patients each on average).

- HIV patients: 76 are HIV infected. Of the HIV infected patients, 78% have consented to participate in the HH Program. We are in the process of consenting all the HIV-infected patients currently on the COBRA case load and expect this to be completed over the next month.
- High risk primary care patients: We are working with the Medical Clinic PCMH teams to create criteria for referral and standard work for moving high risk patients into the HH Program. We will then receive referrals and will quickly increase our caseload through this mechanism.
- New York State Department of Health list: The most difficult patients to enroll have been from this source. Many of these patients are not receiving regular care from BHC. The staff members have each been given a set of DOH-assigned patients and are trying to find these patients through mail, phone, home visits and other community work. Finding these patients has been time consuming and we have had only limited success. The program will have an alert system soon in which we will receive an alert in real time when any of the patients are touched by any of the HHC facilities. We hope this will increase the number of patients we are able to meet with and provide much needed services to in the community.

In addition to the HH program, BHC actively refers patients to inpatient detox services located on or off the campus, depending on availability and whether the patient meets criteria as defined by the New York State Office of Alcohol and Substance Abuse Services (OASAS). BHC also partners with the New York City Department of Homeless Services and a variety of community organizations to address patients' housing needs.

5. Health Literacy

Addressing the health literacy needs of our community is a prime concern of BHC. Dr. Shonna Yin, from the Department of Pediatrics, has developed a program called HealthPix to teach parents pictorially how to administer medication to their children. Graphical displays are the

best way to communicate important information to patients with limited education and limited English proficiency. Using HealthPix as a model, we plan to expand the concept to other literature for adults, particularly as it relates to diet, exercise and medication management.

BHC is in the process of using the Breakthrough performance improvement methodology to improve the discharge processes for both the Inpatient and Emergency Services. A key component of the discharge process is patient/family education, and we will be looking at effective tools for educating patients about their diseases and follow-up care instructions.

In 2013, BHC began to survey its adult primary care population using iPADs in the clinic setting to ascertain the effectiveness of education. The specific question asked was "In the last 12 months, how often did your doctor explain things in a way that was easy to understand?" Among respondents, 88% replied "always." Our goal is to achieve a 95% response. Also, we plan to pilot similar surveys in the other primary care settings including HIV and Pediatric populations. Patient focus groups on educational materials for the most common diagnoses will be conducted to ensure any written materials given to the patient are effective as well.

6. Cancer Services

BHC's primary care providers screen patients for lifestyle habits that are known to increase risk for cancer. Education is provided as necessary to reduce the risk of developing cancer. However, as genetics plays a role and if a patient develops cancer, a wide array of services is available to meet the specialized needs of each patient.

As the tertiary care center for HHC, BHC's cancer program plays an important role in providing cancer services to all New Yorkers. BHC will expand access to cancer screening and treatment services by reducing wait times for appointments. Also, the cancer services are being aligned under a single leadership structure to ensure coordination and accountability of care. The cancer program is developing a strategic initiative based on the needs of the population we serve. One of the goals of the cancer program is to achieve designation by the American College of Surgeons (ACOS) as a Center of Excellence. Using the ACOS criteria, cancer services will improve its outreach, education, access and coordination of services.

As of September 2012, the wait for a medical oncology appointment was four weeks for a new patient and three weeks for a revisit. We plan to improve access to two weeks for both new and established patients by implementing referral and scheduling guidelines.

7. Obesity

BHC is addressing the obesity epidemic through both primary care and specialty care services using a multidisciplinary approach that includes intensive medical treatment, an evidenced-based diet program, and psychological counseling to identify psychosocial risk factors. The BHC Nutrition and Fitness Program (BENUFIT) provides comprehensive evaluation and treatment for children and youth with weight management programs. As previously noted, obese patients with diabetes are referred to an intensive medical weight management clinic and have expanded access to bariatric surgery clinic.

Key components of our strategy are to ensure continuity of care with a personalized physician and/or care team. By improving access to weight management clinic, dietary services for "at risk" patients and bariatric surgery services, BHC will be a center of excellence for obesity care throughout the City.

Our bariatric services have been designated as a Center of Excellence by the American Cancer Society. In September 2012, our waiting time for a new patient to get an appointment to the Bariatric clinic was 14 weeks and a follow-up appointment was three weeks. By adding additional capacity, we plan to reduce the wait to 2 weeks for both initial and follow-up appointments. Also, in 2012, we performed 409 bariatric surgeries and hope to achieve more than 550 annually by increasing the capacity of our program and adding additional time in the Operating Room for the bariatric surgeons.

8. HIV/AIDS/STDs

Long at the forefront of HIV care in the United States, BHC has a variety of grants to deliver "one-stop shopping" services to persons with HIV/AIDS. Goals are to maintain or increase grant support for these services. A key goal is to screen all adults presenting in the Emergency, Inpatient and Outpatient services by expanding our screening capacity. Also, the HIV/AIDS services provided will expand its care management activities and enroll existing clients in the New York State Health & Mental Hygiene (HMH) program described above.

BHC's HIV Harm Reduction Recovery Readiness and Relapse Prevention Program (HRR) is working on a project to increase patient involvement in the program, as measured by attending individual counseling sessions with the harm reduction counselor.

For patients enrolled in the program, baseline data show for three previous quarters that 40-50% of enrolled patients received an individual counseling session in the three-month period. The goal is to increase to 80% the number of clients who engage with the counselor during the quarter. This will be achieved by the harm reduction counselor checking the daily clinic appointment schedule to identify patients enrolled in HRR who have appointments for medical care but who have not had an individual counseling session in the current quarter. When they arrive to see their doctors, the counselor will engage them.

In addition to addressing HIV disease, BHC is addressing other sexually transmitted diseases.

The standard of care for HIV patients is annual STI screening (chlamydia, gonorrhea and syphilis). Bellevue data from 2011 HIVQUAL results (105 active patients reviewed) suggests that we are testing about 55% of our patients for chlamydia and gonorrhea and about 85% of our patients for syphilis. The method of chlamydia and gonorrhea testing we are currently using has been shown to miss around 50% of infections in men who have sex with men. We hypothesize that this poor accuracy has de-motivated our providers to test our patients annually.

BHC has recently participated in local validation of a rectal swab test (anal gonorrhea/chlamydia nucleic acid testing). With this local validation, the state has approved this test and BHC will begin using it soon. In addition to its accuracy, this test has been shown to be easy for patients to self-collect.

Over the coming year, we will be training our staff and providers on the use of and efficacy of this new test and will be encouraging our providers to have patients self-collect their samples. We will be monitoring our testing over time and expect to see an improvement in the percentage of patients tested for chlamydia and gonorrhea. Our goal is to increase chlamydia and gonorrhea testing to 85% of our active patients annually. ◆

VII. Approval

The Implementation Strategy has been approved by the Board of Directors of the New York City Health and Hospitals Corporation on May 30, 2013. ◆