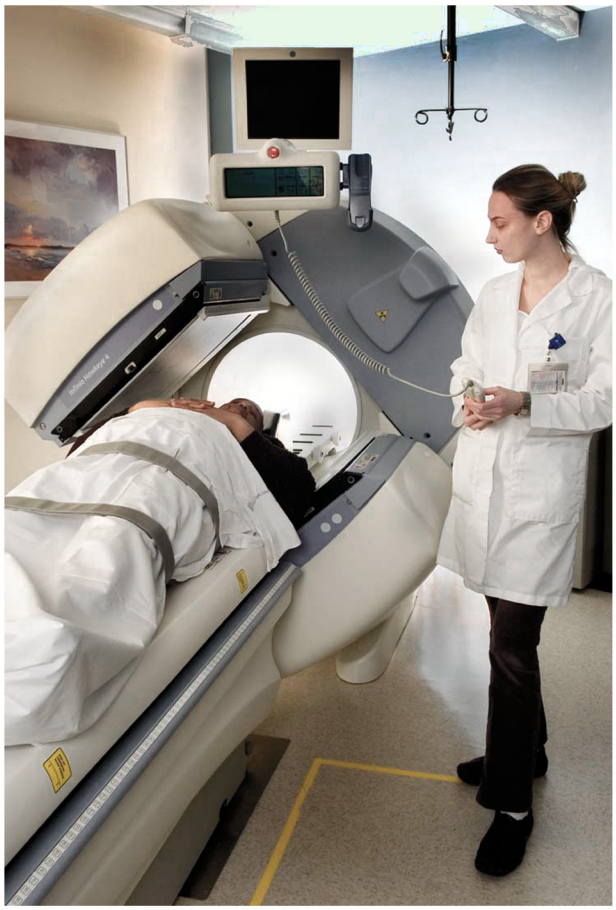
2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY

Woodhull North Brooklyn Health Network MEDICAL CENTER

WOODHULL MEDICAL CENTER



HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

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I. Description of Community Served by Woodhull Medical Center

For over 25 years, Woodhull Medical & Mental Health Center (WMC) has been the largest safety net hospital provider in northern Brooklyn. As illustrated in Exhibit 1, WMC far exceeds the NYC hospital average in terms of self-pay (which frequently means very little or no payment is received) for inpatient discharges, Emergency Department and outpatient clinic visits.

EXHIBIT 1: SAFETY NET BURDEN
WMC Compared to Non-HHC NYC Hospitals

Service Type	NYC Hospitals Average*	WMC
Discharges		
Self Pay	3%	9%
Medicaid	33%	66%
Total Safety Net	36%	75%
ED Visits		
Self Pay	16%	33%
Medicaid	39%	51%
Total Safety Net	55%	84%
Clinic Visits		
Self Pay	11%	35%
Medicaid	55%	48%
Total Safety Net	66%	83%

* Excludes HHC hospitals.
Source: 2010 Hospital Institutional Cost Report, and 2010 Health Center Cost Report.

WMC is a member of the NYC Health and Hospitals Corporation, the largest public hospital system in the country and is affiliated with NYU School of Medicine. In fiscal year 2012, WMC:

- Discharged over 16,000 patients
- Had over 118,000 visits to its Emergency Department
- Generated approximately 528,000 non-emergency primary and specialty care visits through its comprehensive multi-site ambulatory network
- Delivered over 2,000 newborns
- Performed 8,000 ambulatory surgeries, and
- Brought health screenings and prevention-focused education to over 5,000 community residents through its Division of Community Partnerships.

WMC is located, quite literally, at the intersection of three Brooklyn neighborhoods – Williamsburg, Bushwick and Bedford-Stuyvesant. It is also located in a federally designated primary care Health Professional Shortage Area (HPSA), which begins to illustrate the level of community need in its proximity. WMC's service area is defined as 13 zip codes that account for 75% of its unique outpatients served from July 1, 2011 through June 30, 2012, excluding individuals who only had 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: WMC SERVICE AREA DEFINITION/ZIP CODES

	Zip Code	Unique Out-Patients	% of Total	CUM. %
Primary	11206	13,422	17.3%	17.3%
Service Area	11221	10,008	12.9%	30.1%
(PSA)	11237	6,355	8.2%	38.3%
	11385	5,103	6.6%	44.8%
	11207	4,416	5.7%	50.5%
subtotal		*39,304*		
Secondary	11211	4,048	5.2%	55.7%
Service Area	11208	3,182	4.1%	59.8%
(SSA)	11233	3,007	3.9%	63.7%
	11222	2,329	3.0%	66.7%
	11212	2,077	2.7%	69.3%
	11216	1,735	2.2%	71.6%
	11205	1,456	1.9%	73.4%
	11213	1,391	1.8%	75.2%
subtotal		*19,225*		
TOTAL PSA & SSA		**58,529**		

Source: Siemens Data Warehouse, Run date 10/15/12

A map of the service area shows that WMC's patient base resides in Northern Brooklyn and the westernmost Queens zip code, 11385 (Exhibit 3).

As shown in Exhibit 4, there were 403,135 residents in the primary service area in 2010. This area experienced a 6.4% population increase from 2000 and an additional 7.8% increase is projected from 2010 to 2018.

In 2010 there were 500,061 residents in the secondary service area and this area experienced a 1.7% increase from 2000. An additional 7.3% increase is predicted by 2018. Service area growth is partially attributable to more people moving into Brooklyn and specifically the neighborhoods of Bedford-Stuyvesant and Williamsburg.

EXHIBIT 3: WMC SERVICE AREA MAP

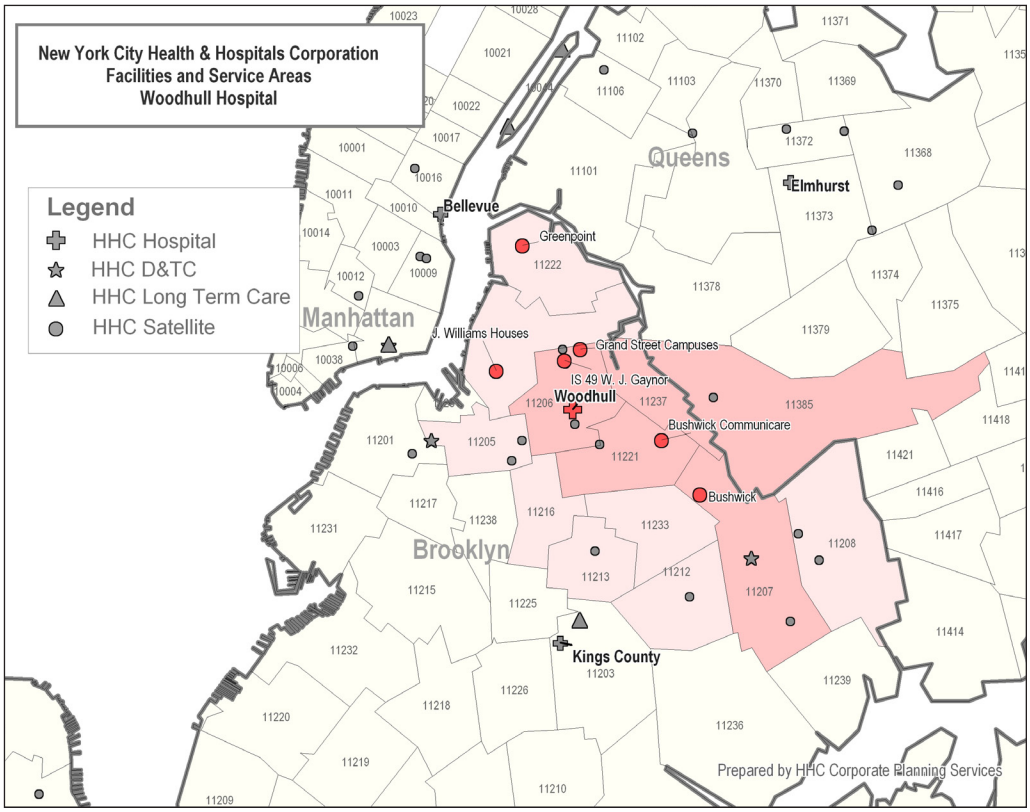

EXHIBIT 4: WMC PRIMARY & SECONDARY SERVICE AREA POPULATION

	Population			Change 2000 - 2010		Change 2010 – 2018	
	2000	2010	2018	No.	Per.	No.	Per.
PSA	378,910	403,135	434,746	24,225	6.4%	31,611	7.8%
SSA	491,560	500,061	536,747	8,501	1.7%	36,686	7.3%
TOTAL	**870,470**	**903,196**	**971,493**	**32,726**	**3.8%**	**68,297**	**7.6%**

Source: Claritas 2013

The service area population is slightly younger than Brooklyn and NYC as a whole. Exhibit 5 shows a larger percentage of residents are in the younger age groups and conversely, smaller percentages of service area residents in the upper age groups.

The WMC service area's racial/ethnic 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 both the primary and secondary service areas has increased, reflecting a trend that has occurred across Brooklyn as a whole. The Black population is projected to continue to decline through 2018. The percent of Asians living in the service area has increased but lags far behind Brooklyn and NYC.

EXHIBIT 5: 2010 AGE DISTRIBUTION, WMC SERVICE AREA COMPARED TO BROOKLYN & NYC

Age Group	WMC Service Area	% of Total	Brooklyn	% of Total	NYC Total	% of Total
0-14	189,552	21.0%	493,116	19.7%	1,457,981	17.8%
15 - 17	40,773	4.5%	101,210	4.0%	308,787	3.8%
18-24	109,392	12.1%	265,225	10.6%	868,736	10.6%
25 - 44	287,008	31.8%	767,195	30.6%	2,545,461	31.2%
45-64	194,684	21.6%	590,156	23.6%	1,995,295	24.4%
65 - 84	72,817	8.1%	246,670	9.8%	850,683	10.4%
85+	8,970	1.0%	40,951	1.6%	141,056	1.7%
TOTAL	**903,196**	**100.0%**	**2,504,523**	**100.0%**	**8,167,999**	**100.0%**

Source: Claritas 2013

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

	PSA	SSA	Brooklyn	NYC
White	35.3%	27.0%	42.8%	44.6%
Black	34.5%	55.7%	34.3%	26.6%
Asian	4.2%	3.5%	10.5%	9.8%
Other	26.0%	13.8%	12.4%	18.9%
Hispanic	44.2%	21.7%	19.8%	27.0%

Source: Claritas 2013

EXHIBIT 7: TRENDS IN RACE/ETHNIC DISTRIBUTION - WMC, BROOKLYN & NYC

	WMC PSA		WMC SSA		Brooklyn		NYC	
	2000	2018 Proj.	2000	2018 Proj.	2000	2018 Proj.	2000	2018
White	28.8%	39.1%	21.3%	31.0%	41.2%	44.2%	44.6%	43.9%
Black	36.2%	32.5%	59.1%	52.2%	36.4%	32.3%	26.6%	24.3%
Asian	3.5%	4.9%	2.1%	4.6%	7.5%	12.1%	9.8%	14.4%
Other	31.5%	23.5%	17.5%	12.2%	14.8%	11.3%	18.9%	17.4%
Hispanic	44.7%	43.5%	22.7%	20.9%	19.8%	19.3%	27.0%	29.0%

Source: Claritas 2013

While the borough of Brooklyn has enjoyed highly publicized growth in new businesses and residential development in the last decade, a significant portion of households surrounding WMC continue to suffer from poverty, low levels of education and poor health status.

Exhibit 8 illustrates the high rates of poverty in WMC's service area. Poverty rates for all families, and for those families with children, are significantly higher in the service area than in Brooklyn and in NYC. Over 26% of all families and over 35% of families with children live below Federal poverty guidelines.

In 2009 the Brooklyn Healthcare Improvement Project (B-HIP) was formed to examine healthcare availability, access, and utilization in Northern and Central Brooklyn. The B-HIP was led by the State University of New York Downstate Medical Center and it focused on a 15 zip code geography that overlaps all but one zip code of WMC's primary service area and almost 2/3 of the secondary service area. Exhibit 9 provides additional evidence that the service area suffers disproportionately from poverty.

The extent of poverty within the service area is also reflected in the insurance status of Woodhull's patients (see Exhibit 1 on page 1). Two-thirds of WMC inpatient discharges, 51% of the total Emergency Department visits and 48% of outpatient primary visits are Medicaid. In addition, 33% of Emergency Department and 35% of primary care visits are uninsured/self-pay. In comparison, only 16% of Emergency Department and 11% of outpatient primary care visits in New York City hospitals, excluding HHC facilities, are self-pay.

EXHIBIT 8: POVERTY RATES IN WMC SERVICE AREA COMPARED TO BROOKLYN & NYC

	Total Families		Families w/ Children	
Area	Above Poverty	Below Poverty	Above Poverty	Below Poverty
Service Area	73.6%	26.4%	64.7%	35.3%
Brooklyn	80.8%	19.2%	72.8%	27.2%
NYC	83.3%	16.7%	75.6%	24.4%

Source: Claritas 2013

EXHIBIT 9: FOOD STAMP UTILIZATION, B-HIP STUDY AREA COMPARED TO BROOKLYN AND NYC

Indicator	B-HIP Study Area	Brooklyn	NYC
Food stamp/SNAP benefits in past 12 months	22%	20%	17%
Per capita money income in past 12 months	$20,181	$23,605	$30,498

Source: B-HIP, Final Report: Making the Connection to Care in Northern and Central Brooklyn, 8/8/2012

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.

Many WMC service area adults have not attained high levels of education. As shown in Exhibit 10, almost 33% of primary service area adults and 24% of secondary service area residents have not completed high school, compared to 15% nationally. Studies have shown that higher education levels are associated with lower morbidity rates from the most common acute and chronic diseases, independent of demographic and labor market factors. Individuals who have attained higher levels of education are less likely to self-report a past diagnosis of an acute or chronic disease, less likely to die from the most common acute and chronic diseases, and are less likely to report anxiety or depression. ("Education & Health," National Poverty Center, University of Michigan, Gerald R. Ford School of Public Policy, Policy Brief #9, March 2007).

EXHIBIT 10: WMC SERVICE AREA RESIDENT'S ADULT EDUCATION LEVEL DISTRIBUTION COMPARED TO U.S

Adult Education Level	PSA	SSA	USA
< than High School	16.6%	9.5%	6.3%
Some High School	16.0%	14.3%	8.6%
High School Degree	31.0%	31.4%	28.7%
Some College/Assoc. Degree	20.1%	21.6%	28.5%
Bachelor's Degree or >	16.2%	23.2%	27.8%

Source: © 2012 The Nielsen Company, © 2013 Truven Health Analytics Inc.

The service area population scores poorly on many health indicators. According to New York City Department of Health (NYCDOH) Community Health Survey data, service area residents have higher rates of diabetes, obesity, hypertension, asthma and tobacco use than NYC as a whole (Exhibit 11). The variation on key health indicators by neighborhood illustrates the differing needs of certain populations and neighborhoods in North Central Brooklyn.

Findings presented in the B-HIP final report further illustrate the disparity between communities served by WMC and the borough and city (Exhibit 12).

EXHIBIT 11: WMC SERVICE AREA RESIDENT'S PERFORMANCE ON KEY HEALTH INDICATORS COMPARED TO NYC

PSA	Diabetes	Obesity	High Choleterol	Hypertension	Asthma	Adult Tobacco Smoker	Binge Drinking*
Williamsburg/Bushwick	14.2%	33.6%	33.6%	37.7%	9.1%	11.9%	10.8%
Bed-Stuy/Crown Heights	14.3%	36.6%	25.4%	33.5%	20.8%	17.1%	13.8%
East New York	16.4%	30.7%	30.1%	37.2%	15.2%	18.3%	12.8%
SSA							
Greenpoint	7.3%	24.8%	32.4%	21.9%	9.6%	15.2%	19.1%
Ridgewood/Forest Hills	7.0%	18.3%	28.1%	26.2%	15.5%	13.7%	19.2%
Flatbush/E. Flatbush	9.0%	25.2%	22.9%	32.8%	4.4%	15.4%	14.2%
PSA & SSA Combined	**11.1%**	**28.6%**	**27.7%**	**31.8%**	**12.6%**	**15.3%**	**14.8%**
NYC	**10.5%**	**23.7%**	**30.6%**	**28.9%**	**11.9%**	**14.8%**	**17.9%**

Source: 2011 NYCDOH Community Health Survey Epiquery databases.

* Binge drinking episode within the past 30 days

EXHIBIT 12: HOSPITAL UTILIZATION AND MORTALITY STATISTICS, B-HIP STUDY AREA
Compared to Brooklyn and NYC

Indicator	B-HIP Study Area	Brooklyn	NYC
Psych discharges per 1,000 residents	8.7	6.3	6.9
Drug/Alcohol discharges per 1,000 residents	8.8	5.7	7.2
Premature mortality per 1,000 residents	5.4	3.6	3.7

Source: B-HIP, Final Report: Making the Connection to Care in Northern and Central Brooklyn, 8/8/2012

For large numbers of WMC 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 communicate effectively regarding the importance of filling prescriptions, diet, exercise, etc.

Exhibit 13 shows that almost 40% of residents in WMC's primary service area speak Spanish in their homes. In FY2012 WMC provided interpretation services over 50,000 times to its patients and their families.

In conclusion, WMC is the largest safety net provider in Northern Brooklyn. The need for access to healthcare services in WMC's communities is high. While Brooklyn has recently enjoyed highly publicized growth and development, there are large disparities within the borough.

The communities served by WMC are largely Hispanic and Black. 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 WMC are impoverished. Over 26% of all families and over 35% 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 less healthy than other New Yorkers. They have higher rates of diabetes, obesity, hypertension and asthma than the residents of Brooklyn and NYC. ◆

EXHIBIT 13: ORIGIN OF LANGUAGE SPOKEN AT HOME WMC SERVICE AREA COMPARED TO BROOKLYN & NYC

Area	English	Spanish	Asian	European	All Other
PSA	48.0%	39.5%	3.1%	8.3%	1.1%
SSA	67.2%	18.9%	1.4%	10.7%	1.8%
Brooklyn	54.2%	17.0%	8.2%	17.8%	2.7%
NYC Total	51.4%	24.6%	8.6%	13.1%	2.4%

Source: Claritas 2013

II. Process and Methodology

The information contained in this Community Health Needs Assessment was derived from two types of information:

- Primary source focus groups
- Supplemental/secondary information

Primary Source: Focus Groups: WMC conducted three focus groups in March 2013, each with a different group of participants:

- WMC patients,
- Community stakeholders, including local residents and representatives of community-based organizations,
- A group comprised of health care providers/staff including representatives from Emergency Medicine, and Psychiatry that included community health experts, some of whom live in the service area.

The focus group questions were designed to produce the necessary content of a Community Health Needs Assessment, and the groups' facilitators followed a plan that allowed 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 their names would not be associated with specific responses. Following are the questions that were posed to each group (Exhibit 14).

EXHIBIT 14: FOCUS GROUP QUESTIONS, WMC COMMUNITY HEALTH NEEDS ASSESSMENT

The patient focus group was asked:

- 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?
- On a scale from 1-5 (1 being the lowest), how does this hospital respond to each health need listed?
- Tell us about the greatest problems you and your family members face getting healthcare at WMC? [If there aren't many responses, probe with: "Have you had a bad experience? Tell us about it?"]
- What changes can this hospital make so it can better respond to the needs and problems you've just mentioned?
- What do you think are the greatest strengths of WMC?

The community stakeholder focus group was asked:

- What do you think are the greatest strengths of healthcare in your community served by WMC?
- What are the greatest weaknesses of healthcare in your community served by WMC?
- 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?
- On a scale from 1-5 (1 being the lowest), how does WMC respond to each health need listed?
- How can the facility better respond to each specific health need?

The healthcare providers/staff were asked:

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

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

Supplemental, or secondary, information: To assist with reporting community health needs in depth, the focus group results were supplemented 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

As described in the previous section, each focus group was asked to respond to a series of questions that elicited information related to strengths and weaknesses of the nearby health care practices and delivery systems, unmet needs, and common illnesses/healthcare issues facing the community.

Reponses related to unmet need and common health problems were collapsed and a single list was created (Exhibit 15). The list includes some issues that fit within the broad context of public health, such as crime and violence in the community. ◆

EXHIBIT 15: HEALTH NEEDS/PREVAILING ILLNESSES

- Access issues for adult ambulatory care/urgent care (long waits to get an appointment and long waits when here for an appointment).
- Asthma
- Behavioral health services for pediatric and adolescents – inpatient and crisis residence
- Cancer
- Care management / robust Primary Care Medical Home model to address complex needs of our community – diseases such as diabetes, CHF, asthma – and issues such as medication education
- CHF/Heart Disease
- Crime/Violence
- Diabetes
- High blood pressure/hypertension
- HIV
- HIV (adolescent)
- Home services
- Language problems
- Mental health
- Obesity – nutrition & exercise promotion
- Parenting skills
- Stroke

IV. Community Assets Identified

WMC and its off-site centers provide health services to large numbers of service area residents. A partial inventory of other community assets is included in the following exhibits.

Hospitals – Exhibit 16 lists hospitals within WMC's service area and also includes The Brooklyn Hospital Center, which is located at the service area border. All of these hospitals have suffered/are suffering serious financial hardships. Wyckoff Heights, Brookdale and Interfaith were identified as the three 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. The Brooklyn Hospital Center emerged from bankruptcy several years ago.

If any of these hospitals closed services or closed completely, WMC would be impacted by increased visits to its Emergency Department, and increased demand for outpatient and inpatient services. Demand for WMC services has been impacted in the recent past by hospital and hospital-service closings in its market. For example, from 2005 to 2007 the Emergency Department experienced an increase of over 4,000 visits from patients residing in zip codes of hospital service closures and consolidations. WMC's obstetric volume and market share increased when St. Mary's Hospital closed and Interfaith Medical Center discontinued its obstetric service.

EXHIBIT 16: HOSPITALS IN/NEAR WMC SERVICE AREA

Hospital Name	Address	Zip Code	Distance from WWC
Wyckoff Heights Medical Center	374 Stockholm St	11237	1.5
Interfaith Medical Center	1545 Atlantic Av	11213	2.0
The Brooklyn Hospital Center	121 DeKalb Avenue	11201	2.6
Brookdale Hospital	2853 Linden Blvd	11212	5.8

Source: New York State Department of Health website

Ambulatory Care Sites - Exhibit 17 lists Federally Qualified Health Center sites in the WMC service area.

EXHIBIT 17: FEDERALLY QUALIFIED HEALTH CENTER SITES, WMC SERVICE AREA

Name	Address	Zip Code
CARE FOR THE HOMELESS	75 LEWIS AVE	11206
COMMUNITY HEALTHCARE NETWORK, INC.	94-98 MANHATTAN AVE	11206
BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC., THE	1238 BROADWAY	11221
BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC., THE	794 MONROE ST	11221
CARE FOR THE HOMELESS	89-111 PORTER AVE	11237
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	116 WILLIAMS AVE	11207
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	360 SNEDIKER AVE	11207
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	400 PENNSYLVANIA AVE	11207
CARE FOR THE HOMELESS	1675 BROADWAY	11207
FLOATING HOSPITAL INCORPORATED (THE)	515 BLAKE AVE	11207
ODA PRIMARY HEALTH CARE CENTER, INC.	420 BROADWAY	11211
SUNSET PARK HEALTH COUNCIL, INC.	300 SKILLMAN AVE	11211
COMMUNITY HEALTHCARE NETWORK, INC.	999 BLAKE AVE	11208
HOUSING WORKS, INC.	2640 PITKIN AVE	11208
CARE FOR THE HOMELESS	357 SARATOGA AVE	11233
FLOATING HOSPITAL INCORPORATED (THE)	599 RALPH AVE	11233
SUNSET PARK HEALTH COUNCIL, INC.	1424 HERKIMER ST	11233
SUNSET PARK HEALTH COUNCIL, INC.	2402 ATLANTIC AVE	11233
SUNSET PARK HEALTH COUNCIL, INC.	424 LEONARD ST	11222
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	259 BRISTOL ST	11212
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	408 ROCKAWAY AVE	11212
BROWNSVILLE COMMUNITY DEVELOPMENT CORPORATION	592 ROCKAWAY AVE	11212
BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC., THE	114 KOSCIUSZKO ST	11216
BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC., THE	1456 FULTON ST	11216
BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC., THE	195 SANDFORD ST	11205

EXHIBIT 17: FEDERALLY QUALIFIED HEALTH CENTER SITES, WMC SERVICE AREA continued

BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC., THE	300 WILLOUGHBY AVE	11205
BROOKLYN PLAZA MEDICAL CENTER	297 MYRTLE AVE	11205
BROOKLYN PLAZA MEDICAL CENTER	77 CLINTON AVE	11205
FLOATING HOSPITAL INCORPORATED (THE)	39 AUBURN PL	11205
ODA PRIMARY HEALTH CARE CENTER, INC.	517 PARK AVE	11205

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 (NYSDOH) licensed facilities that provide services including primary and specialty physician services and ambulatory surgery (Exhibit 18).

EXHIBIT 18: NYSDOH ARTICLE 28 DIAGNOSTIC & TREATMENT CENTERS IN WMC SERVICE AREA

Name	Address	Zip Code
COMPREHENSIVE HEALTH CARE AND REHABILITATION SERVICES LTD	148 WILSON AVENUE	11237
QUEENS SURGI-CENTER	83-40 WOODHAVEN BOULEVARD	11385
BEDFORD MEDICAL FAMILY HEALTH CENTER INC	100 ROSS STREET	11211
ODA PRIMARY HEALTH CARE CENTER INC	14-16 HEYWARD STREET	11211
BROOKDALE FAMILY CARE CENTER INC	2554 LINDEN BOULEVARD	11208
URBAN STRATEGIES / BROOKDALE FAMILY CARE CENTER	1873 EASTERN PARKWAY	11233
AMUMC / AMERICAN MEDICAL CENTERS	434 ROCKAWAY AVENUE	11212
BROWNSVILLE MULTI-SERVICE FAMILY HEALTH CENTER	592 ROCKAWAY AVENUE	11212
BEDFORD STUYVESANT FAMILY HEALTH CENTER INC	1456 FULTON ST	11216
MEDCARE LLC	468 LAFAYETTE AVENUE	11205

Source: NYS DOH Website, comprehensive clinics as of 2/1/13

Senior Centers - There are six senior citizen centers and two senior housing sites in the service area that WMC partners with on a variety of geriatric outreach efforts (Exhibit 19).

EXHIBIT 19: SENIOR CENTERS/SENIOR HOUSING PARTNERS, WMC SERVICE AREA

ATLANTIC AVENUE SENIOR CENTER
70 PENNSYLVANIA AVENUE, BROOKLYN, NY 11208

BORINQUEN PLAZA SENIOR CENTER
80 SEIGEL STREET, BROOKLYN, NY 11206

BUSHWICK HYLAN SENIOR CENTER
50 HUMBOLDT STREET, BROOKLYN, NY 11206

COOPER PARK SENIOR CENTER
288 FROST STREET, BROOKLYN, NY 11222

DIANA JONES SENIOR CENTER
9 NOLL STREET, BROOKLYN, NY 11206

DUNCON GENNS SENIOR HOUSING
725 EVERGREEN AVENUE, BROOKLYN, NY 11207

DUPONT STREET SENIOR HOUSING
80 DUPONT STREET, BROOKLYN, NY 11222

FENIMORE SENIOR CENTER
276 FENIMORE STREET, BROOKLYN, NY 11225

Primary Care Physicians - Obtaining an accurate physician count is extremely difficult. The B-HIP project conducted extensive canvassing and data collection to inventory primary care resources. It found 699 FTE primary care providers for its 15 zip code study area, which overlaps significantly with WMC's service area. As was stated previously in this CHNA, WMC is located in a federally designated primary care shortage area, so although there appears to be a large number of primary care providers, their numbers do not support the community population's need for primary care services.

Community-Based Organizations - A partial list of community-based organizations in the service area is included in Exhibit 20. Many of these organizations regularly partner with WMC on a variety of activities including outreach, health screenings and health education.

EXHIBIT 20: COMMUNITY-BASED ORGANIZATION PARTNERS

Name	Address	Services Provided	Days/Hours Open	Cost
Salvation Army	1151 Bushwick Ave	Family Services	Mon-Fri 9AM- 5PM	Varies
New York City Housing Authority	55 Saratoga Ave	Family Services	Mon-Fri 9AM- 5PM	Varies
City Harvest	Myrtle Ave, Tompkins & Throop	Food		Free
El Puente	311 Central Ave	Food Stamp Assistance	Call for an Appointment	Free
Round Table Day Care Center	1175 Gates Avenue	Family Service Assistance	Mon-Fri 8AM-6PM	ACS Funded
Family Dynamics	1420 Bushwick Ave	Family Counseling	Mon 12PM-8PM Tues-Fri 9AM-5PM	Free
Ridgewood Adult Center	5914 70th Avenue	Food Pantry/HRA	Tues, Weds Thur 9AM – 11PM	Free
OBT	25 Thorton St	GED,	M-F 9AM-5PM	Free
St John's Bread and Life	795 Lexington Ave	Food Pantry, Housing, Child Welfare, clothing	Vary	Free
Fountain Christian Center	11 Marcus Gar Ave	Clothing	Vary	Free
Bethel SDA Food Pantry	457 Grand Avenue	Emergency Food Pantry	Wed 3PM – 5PM	Free
Brown Memorial Baptist Church	52 Gates Avenue	Emergency Food Pantry	Tues 10AM -12PM 3rd Thurs 9AM -12PM	Free
Child Develop. Support Corp.	352-358 Classon Ave	Emergency Food Pantry	Thurs 10AM -12PM	Free
Christian Fellowship Life Center	132 Carlton Ave	Emergency Food Pantry	Thurs 1PM – 5PM	Free
Hanson Place SDA	150 S Portland Ave	Emergency Food Pantry	Thurs 3PM - 5PM	Free
Teen Challenge, Inc	444 Clinton Ave	Emergency Food Pantry	1st and 2nd Sat 10AM – 1PM	Free
Masabia of Williamsburg	65 Lee Avenue	Food Pantry	Sunday-Thursday 4pm-8:30pm	Referral from social worker preferred, first meal is free.
Jacquelyn Hernandez Adult Day Care Center		822 Lexington Ave	Adult Day Care Monday-Saturday Hours: N/A	Medicaid and private pay
Divinity Amour	499 Quincy Street	Adult Day Care, Assisted Living, Social Services	N/A	N/A
Cathedral of Joy (Church of God)	43 George Street	Food Pantry	Tuesday, Thursday: 9am-11:30am	Call for more information
St.John's Bread & Life	795 Lexington Avenue	Food Pantry	Monday-Thursday: 9am-10:30am	Call for more information
All People's Church Apostolic Faith	182 Tompkins Avenue	Food Pantry	Saturday: 10am-11:30am	Call for more information
Saint Stephen Outreach, Inc.	874 Myrtle Avenue	Food Pantry	Wednesday, Friday: 9am-10:30am	Call for more information
Solid Rock Baptist	120 Tompkins Avenue	Food Pantry	Monday, Thursday: 9:30am-12:00pm	Call for more information
Trinity Human Service Corp	153 Johnson Avenue	Food Pantry	Tuesday-Friday: 9am-12pm, 1pm-4pm	Call for more information
Bethany House & Saint Christopher	164 Suydam Street	Food Pantry	Thursday: 11am-1pm	Call for more Information
Bethesda Memorial Baptist Church	1170 Bushwick Avenue	Food Pantry	Thursday: 12pm-2pm	Call for more information
Bridgestreet Missionary	277 Stuyvesant Avenue	Food Pantry	Wednesday: 11am-2pm	Call for more information
Cornerstone Baptist Food Pantry	562-74 Madison Street	Food Pantry	Tuesday: 11am-1pm	Call for more information

V. Priorities

The priority needs developed by WMC are based on the focus group findings, analyses 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 WMC patients and families. Criteria used in selecting the priorities included:

- The burden, severity and scope related to the particular health need. For example, the community health needs assessment presents quantitative data illustrating the disproportionate burden of chronic diseases including obesity and diabetes in the WMC service area.
- The importance the community places on addressing the need. For example, our priority areas are aligned with the findings from our patient and community stakeholder focus groups.
- The feasibility of possible interventions. For example, WMC leadership acknowledged that certain issues raised by the focus groups, i.e., violence in the community, are critically important, but we are not equipped to take a lead role in addressing them at this time. We will continue to partner with other public agencies, community-based organizations and others to impact these issues, but they have not been placed on our current priority list.

The five priorities that have been identified are:

- Improving access for adult ambulatory care – specific focus on improving the time to get an appointment and the time waiting to be seen for a scheduled appointment
- Better care management to address complex needs of our community – diseases such as diabetes and asthma – and issues such as medication education
- Obesity – including nutrition services/education and exercise promotion
- Mental Health
- Diabetes

The strategies and resources to address these priority areas are presented in WMC's Implementation Plan. ◆

VI. Implementation Plan for Needs Identified in the Community Health Needs Assessment For Woodhull Medical Center, 2013-2015

Woodhull Medical Center's (WMC) community health needs assessment was conducted in collaboration with the hospital's clinical and administrative leadership, representative staff from patient programs and clinical services, community stakeholders, WMC patients, and the Health and Hospital's Corporate Planning Department. The purpose of the assessment was to identify existing and emerging healthcare needs of the local community so that WMC can develop and support meaningful and effective health and support services for its patients.

1. Priority - Improving Access for Adult Ambulatory Care

Although WMC provides approximately 550,000 outpatient visits annually, demand for ambulatory care has increased steadily, and is driven by a variety of factors including advances in technology, hospital closures in nearby neighborhoods, better management of patients with chronic diseases, and better management of patients with ambulatory care sensitive conditions resulting in fewer one-day stays and hospital readmissions.

Access to ambulatory care is a challenge. Patients may encounter lengthy wait times to get an appointment and lengthy wait times once they have arrived for an appointment. Delays in patients being seen in the ambulatory setting can result in inappropriate Emergency Department (ED) utilization, worsening health conditions, and increased preventable hospital admissions and readmissions.

1A. Specific needs identified in CHNA:

- WMC is also located in a federally designated primary care Health Professional Shortage Area (HPSA)
- Focus groups citing the existence of access issues for adult ambulatory care/urgent care (long waits to get an appointment and long waits when here for an appointment)

1B. Strategies to improve access to ambulatory care services

Facility/Capital Projects - In response to increased demand for primary and specialty care outpatient services, WMC reorganized ambulatory care services into comprehensive service line "Pavilions," including Women's Health, Adult Medicine and Children's Health. This reorganization has been accomplished through inpatient bed decertification and conversion of an inpatient unit to primary care. These moves and reorganization have been designed to expand capacity, decompress ED and provide coordinated medical and enabling services that are easier for patients to access. Capacity will be developed through repurposing space to outpatient primary care to expand ambulatory care capacity by 25,000 primary care visits annually.

Conversion of inpatient beds into expanded ambulatory

primary care capacity will also enable WMC to decant significant ED patient volume into the primary care space, and coordinate services to meet the increasing demand for adult medicine, women's health and pediatric primary care.

This ambulatory care redesign also supports a patient centric healthcare model that incorporates case management, multidisciplinary approach to disease management and advanced integrated electronic information systems, combined with enhanced patient visit redesign, to maximize output.

The redesign of the clinics will allow providers to utilize an increased number of examination rooms enabling greater patient access.

As a result of the capacity expansion, we anticipate accommodating 25,000 more primary care visits by men, women and children in our new Ambulatory Care Pavilions and improved clinical outcomes in chronic disease management.

Operations - WMC's Ambulatory Care Department is actively expanding access to outpatient physician practices in order to decrease the length of time until a patient is able to get an appointment and to decrease wait times when patients come for their appointments.

Expanded Hours: Adult primary care, pediatrics and HIV medical care have expanded hours:

- 8 AM – 8 PM Monday through Thursday
- 8 AM – 12:30 AM Saturday. Beginning in May 2013, Saturday hours will be expanded to 4:30 PM.
- Planning to spread expanded hours to dental, eye and gynecological services later in 2013.
- Planning for Sunday hours within the next 12-24 months.

Improved Outpatient Appointment Scheduling: A new patient scheduling system has a built in "holding deck" whereby every clinical provider has open slots built into their schedules. Clerks in the Emergency Department and on the inpatient units can access the scheduling system and book ambulatory care follow-up visits for patients.

The new system also allows clerks to see if there is a conflict with an appointment in a different hospital department, as patients may visit several departments in one day if they require diagnostic tests or specialty consults.

LEAN: LEAN is a methodology used to eliminate waste from a process and enable continuous improvement. It is HHC's organizational development and quality improvement system and LEAN is based on principles developed by the Toyota's Production System.

Ambulatory care (specifically adult primary care) has adopted a LEAN approach called Managing for Daily Improvement (MDI). MDI is designed to drive improvements in key metrics. Phase I metrics of ambulatory care's MDI work include reducing patient no-show rates for appointments and having patients in an exam room within 20 minutes of their scheduled appointment time.

Phase II, scheduled to begin in April/May 2013, will use root cause analysis methods to drill down and determine the causes related to underperformance on key metrics.

In Phase III, best practices learned in primary care will spread to other outpatient services including women's health, pediatrics and psychiatry.

2. Improved care management/coordination to address complex/chronic diseases and reduce fragmentation.

Care coordination management is one of the ways to utilize our professional relationship between the patient and provider to keep them connected with our services. It has expanded significantly from the inpatient setting and is now being integrated into primary care, the emergency room and into specialty areas including behavioral health. It is a tool used to manage chronic conditions, improve patient health, and avoid preventable hospitalizations.

2A. Specific needs identified in CHNA:

- According to NYC Department of Health Community Health Survey data, service area residents have higher rates of diabetes, obesity, hypertension, asthma and tobacco use than NYC as a whole.
- The rate of psychiatric discharges per 1,000 patients is higher in the service area than in Brooklyn and NYC.
- Focus groups identifying Care management/robust Primary Care Medical Home model are needed to address complex needs of our community – diseases such as diabetes, CHF, asthma – and issues such as medication education.

2B. Strategies to increase care management across our health service continuum to better address complex/chronic diseases in our communities

Primary Care Medical Home (PCMH) – WMC is in the process of being recertified as a Level III Patient-Centered Medical Home (PCMH) with the National Committee for Quality Assurance. PCMH is a program for improving primary care. It includes a set of standards that apply to health care settings and facilitate partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The PCMH standards are:

- Enhance Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care Support and Community Resources
- Track and Coordinate Care
- Measure and Improve Performance

Each standard has rigorous indicators that a facility must demonstrate in order to obtain PCMH certification. This model of care promotes relationships between providers and patients as a method to improve health outcomes, with a particular focus on patients with complex and/or chronic care needs.

Each PCMH team consists of two physicians, one nurse practitioner, a registered nurse, a licensed practical nurse, a patient care associate and a clerk. WMC is expanding its PCMH capacity with the addition of two physicians, four nurse practitioners and seven registered nurses.

Care Management in the Emergency Department – Two social work care managers are assigned to WMC's Emergency Department from 9:00 AM to 7:30 PM, 7 days per week. Hours will be expanded to 24/7 within the next year. They focus on several patient populations including:

- Patients with congestive heart failure
  - -Patients who have been readmitted within 30 days.
  - -Patients who have been returned to the ED within 7 days for the same reason.
- Later this year ED care management services will be expanded to include newly diagnosed diabetics and asthma patients within the next year.

Their duties include:

- Making sure patients leave with their needed medications or with access to needed medications
- Educating patients on their treatment plan
- Making sure patients have follow-up appointments with primary care or specialty physicians within 7 days
- Following-up by phone, calling patients to remind them of their primary care appointments
- Communicating with the primary care physician and inpatient care manager if the patient is admitted to the hospital

These enhanced care management services are aimed at reducing the need for acute care services and improving patient health through better management of patients with chronic conditions.

Care Management in Psychiatry – A joint pilot project between WMC's Department of Social Work and the Department of Psychiatry has been undertaken with the goals of:

- Increasing referrals for our behavioral health inpatients to our outpatient mental health practice and our Center for Integrated Health (an outpatient medicine center specifically for adult psychiatry patients) – ensuring patients who often experience difficulty navigating healthcare systems receive timely care post-discharge.
- Integration of chemical dependency and psychiatry staff to provide appropriate treatment for dual diagnosed patients.

Three social workers have been assigned to this program. When the inpatient psychiatric team identifies a patient who would benefit from care management, including patients with substance abuse histories, they notify the care managers. Care managers visit the inpatient unit at least twice prior to discharge to meet with the patient, and if possible, with their family to engage them and to build a relationship.

On the day of discharge the care managers escort the patient to the outpatient mental health practice and also introduce the patient to the clinician for an initial screening. They also provide education regarding outpatient services and will coordinate with the chemical dependency staff for a screening if the patient has a recent history of substance abuse. After the initial same day visit, the patient is introduced to the Center for Integrated Health (CIH) where they receive appointments within 10 days if needed.

Care managers exchange their telephone numbers with the patients and inform them about follow up calls by care managers two to three days before the second appointment. They also educate the patient to call the care manager if they experience any problems or a need arises while they are in the community. Patients are encouraged to walk into the clinic any time during normal business hours to talk to their therapist or care manager.

Additionally the care managers:

- Provide emergency call numbers for after hours and weekends and holidays
- Calls the patient two days after the discharge for follow up
- Continues to call the patient two more times before the second appointment with the MD
- Shares the patient list with the Psych ER. If any patient from the list shows up in the ER, the psych ER Physician or Social Work staff alerts the care manager and the inpatient team. The care manager and Inpatient team visit the patient in the ER to assess the reason for return to the Hospital

3. Obesity – including nutrition services/education & exercise promotion

Obesity has become a national public health crisis, and

its impact on health is well documented. It can lead to significant health problems including vascular disease, diabetes, hypertension and heart disease. Unfortunately, the causes are complex as are the treatments.

3A. Specific needs identified in CHNA:

- The rate of obesity in WMC's service area is 28.6% compared with 23.7% in NYC. Some neighborhoods in the service area had obesity rates as high as 36.6%.
- Focus groups identified obesity as a major health concern within the community.
- Obesity is a co-morbid and exacerbating condition to other chronic diseases including diabetes, heart disease, asthma and COPD, and hypertension.

3B. Strategies to lower the rates of obesity in our community:

- Woodhull does not provide bariatric surgery services on-site. Rather, we rely on our relationships with other providers to fill this gap. When morbidly obese patients are identified, or self-identify, they are seen in the ambulatory surgery practice where an abbreviated evaluation is performed to see if they are viable candidates for bariatric surgery. If they qualify and are interested, they are referred to a seminar sponsored by Bellevue's Bariatric Surgery program on bariatric surgery. This is the first step in the referral process. Once at the seminar, they are offered an intake and the process for evaluating their candidacy for bariatric surgery is begun.
- In WMC's Adult Medicine Practice, providers engage patients daily in the issues of weight management. During medical visits, patients are engaged, BMI is measured, and information is shared regarding the individual's weight and management needs. Patients are given information about and when needed, referrals for, nutritional counseling and for physical activity.
- Weight management is an integral part of chronic disease management. It is a part of the treatment plan for diabetes, hypertension, and congestive heart failure (CHF).
- In an effort to prevent and/or manage obesity in our pediatric patients, WMC has a bi-weekly Obesity Clinic that monitors children between the age of 2 to 21 who are overweight or at risk of overweight as per a body mass index (BMI) of >85%. (American Academy of Pediatrics, http://www.aap.org/obesity/about.html). Patients are referred to the clinic by their primary care provider after a complete health assessment. At the Obesity Clinic, BMI counseling is provided by an attending pediatrician and nursing staff. Nutrition referrals are made for additional follow-up. Other specialty visits (i.e. endocrine and cardiology) are made at the discretion of the attending. Patients are scheduled for follow-up visits within 8 to 12 weeks.
- WMC sponsors a summer program for overweight and obese youth. The program is managed by volunteer staff from Administration, Chronic Disease Management and Pediatrics. We also engage volunteers from the Artist's Access Program, a project that allows local artists to trade services for health care credits. Groups of 10 to 12 are seen at a time. A viable candidate is one who is:
  - between the ages of 6 and 12 years old (ideally),
  - referred by their pediatrician for weight management,
  - able to commit to long-term participation (12 weeks, both in meeting and independently),
  - able to be accompanied by a parent or guardian over age 22.

This program meets weekly and engages the participant in educational activities that encourage healthy behaviors that have been associated with achieving a healthy weight.

- WMC has been an active partner with the community to raise awareness of the need and provide culturally competent interventions for good nutrition and weight management. Toward that end Woodhull partnered with a local university and several Senior Community Centers to identify family recipes and transform them into healthier alternatives. The final product was *Cooked to Perfection: Cherished Family Recipes That Are Good for You*, a cookbook that provides the reader with healthier alternatives to family favorites. This book provides information in English and Spanish and represents the multi-cultural flavors that comprise our community.
- The Kids Ride Club (KRC) is a program designed to develop healthy lifestyles among our youth by encouraging children to incorporate regular physical activity into their daily lives. The three key elements of the program are: 1) education, 2) nutrition, and 3) physical activity. The KRC gives low-income children with little opportunity for exercise a chance to bike safely, exercise and have fun. Youth are recruited from Districts 13, 14, and 16, the school districts surrounding Woodhull. One in three of the participants is overweight or obese, and they have related health problems including asthma, which is highly prevalent in Brooklyn. In general, the youth do not typically engage in physical activity. The supervised rides are a safe way for the youngsters to have fun while exercising and interacting with peers. It teaches and encourages the children to incorporate exercise in their lives and build good lifestyle habits for adulthood. Rides are offered twice monthly in the Spring and Fall, and weekly in July and August for a total of 18 rides per year. Each ride includes an educational component that includes bike safety, and how

physical activity can keep us healthy. In addition, healthy and new food options are provided for lunch. Finally, bike riding represents the physical activity. Members are taught how to ride, brake, and signal; as well as how to use the necessary safety gear to ride safely on city streets. There is a roster of 189 active members of the KRC, including 123 children between the ages of 9 and 21 and 66 adult leaders who volunteer to chaperone the rides.

4. Mental Health

The primary mission of WMC's Department of Psychiatry is to continuously improve patient health and outcomes, and to ensure that each individual patient receives the most professional and highest quality of care possible.

The Department of Psychiatry provides an extensive array of emergency, inpatient and outpatient mental health and chemical dependency programs. The treatment services are provided by a multidisciplinary staff consisting of psychiatrists, psychologists, social workers, nurses, creative arts therapists, addiction counselors, and medical consultants.

All patients are assessed upon admission and based on their presenting problems, are treated, released, admitted or transferred to an appropriate level of care. Patients' individual needs are assessed, and individualized treatment plans are developed and implemented. Treatment goals, measurable objectives, treatment interventions, and time frames for achieving the treatment goals/objectives are established. All relevant services, within and outside the hospital are contacted in order to provide the most comprehensive and appropriate care to our patients.

Psychiatry is a major clinical service at WMC, approximately 40% of its inpatient beds are allocated for mental health. Behavioral health is a major service area on the outpatient side as well.

- Schizophrenia(s)and Schizoaffective Disorders
- Mood Disorders including Bipolar Disorder and Major Depressive Disorder Severe Anxiety Disorders
- Organic Disorder with significant psychotic symptomatology
- Severe Personality Disorders
- Impulse Control Disorder
- Attention Deficit Hyperactivity Disorder
- Conduct, Defiant, and Oppositional Disorders
- Posttraumatic Stress Disorder
- Drug and Alcohol Dependence

4A. Specific needs identified in CHNA:

- The rate of psychiatric discharges per 1,000 patients is higher in the service area than in Brooklyn and NYC
- Focus groups identifying the need for mental health services and the prevalence of mental health problems in the community

4B. Strategies to improve community mental health and to expand the scope of services available

Psychiatric Emergency Room – The psychiatric ER provides 24-hour 7-day-a week emergency care to individuals in crisis. Treatments include pharmacotherapy, crisis intervention and social service assistance.

Comprehensive Psychiatric Emergency Program – WMC's Psychiatric Emergency Division is expanding to create a Comprehensive Psychiatric Emergency Program (CPEP). This will allow WMC to provide a full continuum of care and coordinated clinical services in our system in order to facilitate a rapid and safe return to community care commensurate with the principles of least restrictive alternative. Through enhanced services of our existing psychiatric emergency room, such as extended observation beds, the unit will be able to provide an extensive evaluation, assessment, and stabilization of the person's acute psychiatric symptoms for a period up to 72 hours, in order to prevent costly inpatient care and assure rapid return to the patient's community. This will allow us to better clinically manage the heavy users and recidivist patients that present on the unit.

The CPEP is necessary to meet the needs of the most severely debilitated individuals in our system, ultimately reducing repeated utilization inpatient admissions.

The unit will serve individuals 18 years of age and older and will operate in accordance with the provisions of section 9.40 of the Mental Hygiene Law. It will provide active treatment designed to stabilize and ameliorate acute symptoms, and to serve as an alternative to inpatient hospitalization when appropriate.

The unit will use an integrated and collaborative treatment approach with other community based providers to insure that the patients receive clinical treatment and linkages are case managed from referral through to discharge. Linkages with other providers of health, mental health, and human services, will be developed to facilitate continued participation in the rehabilitation process.

Psychiatric Consultation / Liaison Service – The service responds to requests for psychiatric evaluation and management of inpatients in Woodhull's medical/surgical services.

Adult Inpatient Service – The adult inpatient service operates 135 acute care psychiatric beds divided among six units. Acute psychiatric treatment for both voluntary and involuntary patients is provided using both psychotherapeutic and psychopharmacological interventions by multidisciplinary treatment teams.

Center for Integrated Health (CIH) – Patients who are

severely mentally ill are less likely to receive health screenings, immunizations and less likely to adhere to medication regimens. A number of factors contribute to these problems including:

- Difficulty navigating health care systems
- Poorly coordinated medical and mental healthcare
- Lack of engagement with primary care providers.

WMC Psychiatry, in tandem with the Department of Medicine, have an outpatient medicine center, CIH, for adult psychiatry clinic patients, tailored to address their unique needs, increase their engagement with primary care and improve management of their chronic medical conditions. The CIH offers a new approach, a psychiatrist and a primary care internist care for the patients together and at the same time, thereby enabling co-management of the patient and eliminating the fragmentation of care so often experienced with this patient population.

Mobile Crisis Management Teams - These teams provide urgent mental healthcare and crisis management to patients in the community. The service operates between 8 AM and 7 PM, Monday through Friday and between 8:30 AM and 4:30 PM on Saturdays.

Outpatient Adult Mental Health Practice – The practice offers a wide variety of assessment and treatment approaches to adults age 18 and over. Services include diagnosis, evaluation, individual and group therapy, crisis intervention and medication management.

Outpatient Child and Adolescent Service – This service responds to the special needs of children between the age of 5 through 18, and their families. The clinical services include diagnosis and evaluation, psychological testing, individual group play and family therapy, medication management, and parent counseling. This service also responds to consultation requests.

Single Entry Point Program - The program provides comprehensive and urgent mental healthcare to children, adolescents and their families. Along with the Child and Adolescent Service, this program provides consultation to the Pediatric Emergency Room and the Department of Pediatrics.

Pediatrics /Perinatal AIDS Liaison Service (PPALS) – PPALS responds to the special psychosocial and psychological needs of HIV+ women, their families and children with HIV illnesses.

Medically Managed Detoxification Service - This is a 38-bed inpatient service designed to deal with the effective management of withdrawal of alcohol and / or heroin.

Chemical Dependency Outpatient Clinic – Enrollment in this clinic follows the detoxification phase of the treatment continuum and incorporates individual and group therapy services, education, Alcoholics Anonymous and Narcotics Anonymous involvement and other adjunct services including acupuncture.

Tobacco Cessation Program – The program treats individuals 19 years of age and older seeking tobacco dependence treatment by medically supporting their efforts to quit smoking through intensive group counseling and craving reduction and/or nicotine replacement therapies.

Facility Improvements – To include:

- Complete renovation of all six inpatient units;
- Purchase and install new furniture in the Child Psychiatry Waiting area; and
- Enhance the child waiting area as a child-friendly activity center.

5. Diabetes

Diabetes poses a significant risk to the general health and welfare of the communities served by WMC and is at near epidemic level in the service area. From 2010 to 2011, there was a 7.7% increase in the number of diabetics receiving treatment at WMC. And in the first month of 2012, the number grew by another 1.5%.

Managing diabetes is a process that requires the coordination of many hospital resources, including nutrition, ophthalmology, and dental. The reporting of how well we are managing our diabetic population is mandated in our Patient Centered Medical Home (PCMH) model of care. For the aforementioned reasons and the fact that diabetes was listed as a major health concern in each of our focus groups, leadership identified diabetes management as a priority health concern.

5A. Specific needs identified in CHNA:

- The rate of diabetes in the WMC service area is 11.1% compared to 10.5% in NYC.
- Diabetes was identified by the community health needs assessment focus groups as a high area of need.

5B. Strategies to improve our diabetes services and our approach to treating patients with diabetes

We have implemented a multi-pronged approach to address the impact of diabetes on the health of the community as described below.

American Diabetes Association (ADA) - In January of 2013 WMC achieved ADA recognition for its diabetes program, meeting national standards for patient education and patient self-management. As a result we are now able to bill Medicare and other insurers for diabetes education services, enabling us to sustain comprehensive diabetes care.

Increased outreach - Clerical support for diabetic patient outreach was expanded. New staff is able to keep patients connected to care through follow-up calls, letters, and assistance in making appointments. We have been able to maintain patients in care, especially among the group at highest risk for falling out of care.

Diabetes registry - A web-based diabetic registry has been developed. This enables the program to help monitor the care of patients with diabetes, providing a record of how well the patient is being managed. Further, we are able to prepare reports giving feedback to providers on how they are treating within the guidelines, meeting indicators for control on diabetes, and for information sharing. There are currently more than 6,000 people with diabetes being followed in the registry.

Diabetes education - Each diabetic patient is provided a comprehensive, four-class education program. Each class covers areas specific to diabetes management, including:

- Week 1: General Overview and Basic Self-Management Skills
- Week 2: Healthy Eating and Exercise
- Week 3: Using Medication Safely and Sick Day Management
- Week 4: Foot Care and Preventing Complications

Support group - A monthly support group for patients with diabetes is offered to provide support and a venue for people to share their personal experiences with diabetes.

Access - The program provides management tools (i.e., testing supplies) at an affordable rate or for free in the event of serious financial issues.

Specialty care - Patients who are having difficulties getting their diabetes under control are referred to the Endocrine clinic, a specialty practice. Here patients are seen for consultation and evaluation. They are stabilized and returned to the PCP for management.

Care management for diabetics – As noted in Section 2B, care management is being enhanced via our PCMH designation and will be an effective model for improved management of diabetic patients in the primary care setting. Our Emergency Department is being expanded to include newly diagnosed diabetics in order to ensure they are linked to our outpatient services and receive education regarding their treatment plan and medications. ◆

VII. Approval

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