The New York Hospital Medical Center of Queens

Community Service Plan 2009

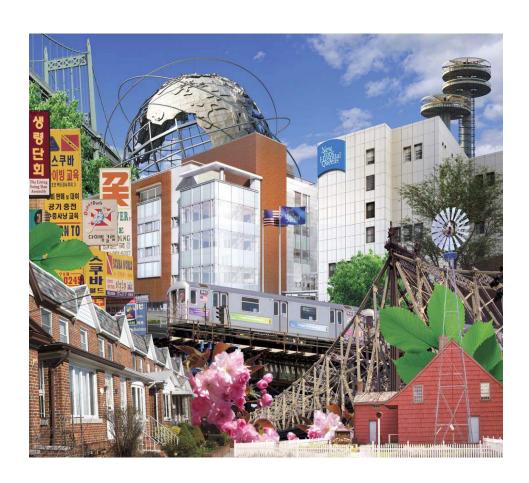


Table of Contents

I.	Mission Statement	Page 3
II.	Service Area	Page 3
III.	Public Participation	Page 7
IV.	Assessment of Public Heath Priorities	Page 12
v.	Three Year Plan of Action	Page 22
VI.	Financial Aid Program	Page 38
VII.	Changes Impacting Community Health/ Provision of Charity Care/Access to Services	Page 39
VIII.	Dissemination of the Report to the Public	Page 39

I. The Mission Statement for New York Hospital Queens

To provide our greater community with excellence in clinical care, patient safety, education, clinical research and service.

IA. Changes to the Mission Statement

There have been no changes to the mission statement since the last Community Service Plan submission.

II. Service Area

IIA. Hospital Service Area

The New York Hospital Queens uses Queens County for community/local health planning for the purposes of the Community Service Plan. The Hospital serves residents from every Take Care New York (TCNY) defined neighborhood in the borough. The neighborhoods are based on UHF definitions that are specified by zip code.

New York Hospital Queens Volume and Market Share Inpatient Discharges by Queens Neighborhood¹ 2008

Neighborhood	Inpt Discharges	Market Share		
Central Queens	3,307	32.8%		
Jamaica	3,035	7.8%		
Northeast Queens	1,118	11.9%		
North Queens	9,561	32.7%		
Rockaways	122	0.6%		
Northwest Queens	847	4.0%		
Southeast Queens	896	3.8%		
Southwest Queens	1,467	5.5%		
West Central Queens	2,488	9.0%		
West Queens	4,965	10.4%		

Source: HANYS Market Expert Discharges 2008. Excludes normal newborns

¹ NYC Department of Health and Mental Hygiene, Community Health Profiles, 2006; Neighborhood Definitions

New York Hospital Queens Volume and Market Share Ambulatory Care Visits by Queens Neighborhood 2008

Neighborhood	Total Visits	Market Share
Central Queens	10,539	10.2%
Jamaica	13,976	13.6%
Northeast Queens	3,924	3.8%
North Queens	25,147	24.4%
Rockaways	1,017	1.0%
Northwest Queens	3,520	3.4%
Southeast Queens	6,932	6.7%
Southwest Queens	7,485	7.3%
West Central Queens	3,490	3.4%
West Queens	26,865	26.1%

Source: NYHQ Eagle Information Systems Reports, 2008.

IIB. Description of Service Area.

Service Area Demographics

Queens County is the largest of the five boroughs of New York City, with a population of approximately 2.32 million living in an area of 112 square miles. The county has experienced a 3% growth since the last census in 2000.²

DEMOGRAPHIC CHARACTERISTICS		
	Queens County	USA
2000 Total Population	2,229,379	281,421,906
2008 Total Population	2,258,067	304,141,549
2013 Total Population	2,269,389	319,161,431
% Change 2008 - 2013	0.5%	4.9%

Minority populations comprise approximately sixty-four percent of the total population. White non-Hispanics represent 29.5% of the total population. Black non-Hispanics represent 18.1 %, Asian and Pacific Islanders 20.1% and Hispanics 26.8%.³

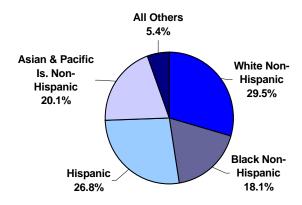
Queens County residents represent 100 countries and speak more than 120 dialects. Since the liberalization of immigration laws in the 1960s, Queens County has become a harbor of cultures with 46% of its total population foreign born. Queens ranks second highest for share of total foreign-born residents (48.4%) among the nation's counties. ⁴

³ Claritas, Inc. 2008, Thomson Healthcare

² US Census Bureau, 2008 estimates.

⁴ Terrazas, A., Batalova, J. "US in Focus", MPI Migration Information Source, December 2008.

Queens Population Distribution by Race/Ethnicity



Socioeconomic Status⁵

Median household income of the Queens population is approximately \$53,000, and is below the median household income for New York City and New York State.³ In 2007, 12.2% of Queens' residents were living below the poverty level, comparing favorably to New York State at 13.8%. Approximately 16% of the patients served by New York Hospital Queens are enrolled in Medicaid.

QUEENS COUNTY HOUSEHOLD INCOME DISTRIBUTION

2008 Household Income	HH Count	% of Total
<\$15K	109,353	14.1%
\$15-25K	74,955	9.7%
\$25-50K	192,489	24.8%
\$50-75K	150,105	19.3%
\$75-100K	98,618	12.7%
Over \$100K	151,196	19.5%

There are more than 34,500 businesses located in Queens, from small retail stores to large manufacturers. No single company or industry is dominant, although health services, air transportation, and services are major sectors. The largest share of the Queens workforce (32%) is employed in the service sector, followed by wholesale and retail trades (21.3%) transportation and public utilities (14.9%) and manufacturing (11.3%). Government accounts for 7.6% of the workforce and financial, insurance and real estate (FIRE) employs 5.9%.

Queens has a diverse educated workforce. More than 70 percent of residents over age 25 have a high school diploma, and more than 20% have a college degree. 6

5

⁵ US Census Bureau, FedStats, 2007; NYHQ Financial Planning Reports 2009

⁶ Claritas, Inc. 2008, Thomson Healthcare

Queens County EDUCATION LEVEL

EDUCATION ELVEL						
Education Level Distribution						
2008 Adult Education Level	Pop Age 25+	% of Total				
Less than High School	174,419.0	11.2%				
Some High School	223,182.0	14.4%				
High School Degree	431,888.0	27.8%				
Some College/Assoc. Degree	347,105.0	22.3%				
Bachelor's Degree or Greater	378,335.0	24.3%				
_Total	1,554,929.0	100.0%				

III. Public Participation

IIIA. Participants

New York Hospital Queens collaborates with many organizations and community groups in ongoing discussion and analysis of community health need and resource availability to establish service and program priorities.

A representative list of participants in the development of the 2009 Community Service Plan submission follows:

American Association of Chinese American Physicians (ACAP)

Korean American Physicians' Organization (KAPO)

New York Hospital Queens Health Outreach® Membership

New York City Department of Health and Mental Hygiene

New York City Office of Emergency Management

Greater New York Healthcare Association

New York Hospital Queens Board of Trustees and Clinical Leadership

New York State Department of Health Office of Health Systems Management

Queens Borough President's Hospital Task Force

General Community Focus Group

Chinese and Korean Patient Focus Group

Interboro Regional Health Information Organization

General Public Comment

IIIB. Outcomes

<u>Association of Chinese American Physicians (ACAP) and Korean American Physicians Organization</u> (KAPO)

The hospital has a longstanding partnership with the Association of Chinese American Physicians and the Korean American Physicians Organization. The Hospital's Physician Relations Office coordinates meetings and discussions with ACAP and KAPO leadership. Meetings have been held in both the hospital and in community settings to continue our established dialogue regarding health needs of the Chinese and Korean communities and opportunities for the hospital and ACAP/KAPO to work together to refine and address priorities. Meetings were held on November 17, 2008, February 4, and April 28, 2009.

Both organizations identified need for initiatives in DOH prevention priorities. A broad range of established and proposed initiatives to address wellness, prevention, early diagnosis and treatment of relevant health priorities have been identified and/or implemented through this collaborative effort, including recruitment of Chinese and Korean speaking physician and nurses, a multi-cultural Hospitalist program, co-sponsored breast cancer research, and relocation and expansion of a community based Family Health Center.

Health Outreach® Membership

NYHQ's Health Outreach® program for senior citizens conducts ongoing membership surveys of its 3000 registered members to elicit their input into the development of annual education programs that address wellness and prevention priorities. Results from 436 surveys returned in 2008 identified access to education and screening programs for established NYSDOH public health priorities including Chronic Disease, Physical Activity and Nutrition as priorities for the Health Outreach® program.

Input regarding the program is also obtained from Health Outreach® community partners who sponsor Health Fairs and wellness/prevention public education and screening activities:

- DeVry Institute
- The Rock Church
- Visiting Nurse Service of NY
- YWCA Queens
- Bowne Street Community Church
- Our Lady of Grace RC Church
- YMCA Beacon Center
- Queens College
- SelfHelp
- Senator Frank Padavan
- Korean Community Services
- Young Israel of Hillcrest
- Tiffany and Company
- Grace Church
- York College
- St. Mark AME Church
- NYPD 109th Precinct
- Charles B. Wang Community Health Center

- Shin Kwang Church
- Galilee Gospel Chapel
- B'nai Brith House
- Sterling NY METS, LP
- St. Alban's Congregational Church
- Korean Church of Queens
- NYS Dept. of Transportation
- Con Edison
- Variety Boys & Girls Clubs of Queens
- Assembly Woman, Nettie Mayersohn
- Greater Allen Cathedral Senior Residence
- KHYM Foundation
- Diocese of Brooklyn Clergy
- Church of Jesus Christ of Latter Day Saints
- Queens Centers for Progress
- Queensborough Community College

New York City Department of Health and Mental Hygiene (NYCDOHMH)

The information from meetings and communications from GNYHA In November of 2008 and February 2009 were used in the analysis and findings of the 2009 plan. The Hospital also communicated with the NYCDOHMH (telephone conversation, Spring 2009) to obtain additional information regarding established priorities to be considered in the development of the 2009 plan. NYCDOMH advised the Hospital that the Greater New York Healthcare Association was acting on their behalf to disseminate Community Service Plan information.

The hospital also participated with the NYCDOHMH, multiple metropolitan area hospitals and other public safety organizations such as the Office of Emergency Management in a series of meetings in 2008 to discuss emergency preparedness and surge capacity issues and priorities and the development and implementation of plans to meet community need. The Office of Emergency Management disseminates meeting notifications.

1/16/08-GNYHA Emergency Preparedness Coordinating Council (EPCC)-EM activities for hospitals

1/24/08-NYP System Office EM meeting-system hospital EM activities/planning

3/13/08-NYC Department of Health Emergency Preparedness Coordinators Meeting

3/28/08-GNYHA EPCC meeting-EM hospital activities

5/8/08-NYP System EM meeting system hospital EM activities/planning

5/21/08-NYS DOH Operation Empire Express Planning Meeting (exercise)

7/10/08-NYC DOH meeting-ventilator surge project for hospitals

9/9/08-NYC DOH hospital shelter in place meeting

10/23/08-NYCMED Communications Exercise

12/5/08-hazardous materials decontamination team planning/training meeting

New York Hospital Queens Board of Trustees and Clinical Leadership

A strategic planning meeting was held on February 27, 2009 including the Chairman of the Board, Trustees, Chairmen of all hospital clinical departments, and senior administrative executives to identify priorities for current and future hospital activities.

The New York Hospital Queens Board is comprised of medical staff and administrative leadership as well as regional and local business and community leaders whose members actively participate in planning activities of the Hospital. The leadership group identified priorities that relate to prevention agenda indicators access to quality health care services for the hospital's constituents, management of chronic disease and injury, and community (emergency) preparedness.

Key strategies discussed include:

- Expansion of primary care capacity
- Increased availability of relevant specialty care in community based and hospital settings
- Enhance ability to meet increasing demand for emergency/trauma and inpatient adult medical surgical and intensive care.

As a follow up to the meeting, specific prevention initiatives identified for exploration included a Home Visit (House Calls) program, increased participation with community boards, expansion of smoking cessation activities, and an upgrade of the Hospital's website to enhance community access to health education and Hospital services.

New York State Department of Health Office of Health Systems Management

Hospital leadership engaged New York State Department of Health OHSM representatives at multiple meetings and conference calls in 2007 and 2008, and most recently in Albany on March 27, 2009, and has participated in the Queens Borough President's Hospital Task Force in a special meeting held on March 19, 2009 and in subsequent teleconferences to address capacity problems associated with closure of four Queens hospitals over the past few years. As a result of those discussions, NYHQ asked for, and was granted, emergency certification for 50 additional adult medical surgical beds, and has since submitted a Certificate of Need application to expand its Emergency Department. The Hospital is preparing a grant application to submit to HEALNY Queens to fund the project.

General Community Focus Group

Over 35 members of the Queens community including community leaders, police officers, business owners, non-profit representatives and hospital volunteers attended a meeting to discuss a prevention agenda on July 23, 2009. Participants were asked to identify priority needs for healthcare programs and services. New York Hospital Queens' Department of Public Affairs and Marketing hosted the meeting.

Key issues raised by attendees included:

- Declining numbers of physicians who participate in insurance plans
- Need for more education of youth regarding healthy lifestyles and disease prevention

- Increased potential for terror related and/or other disasters in Queens due to presence of two
 major airports and internationally known sports venues. Decreased capacity to manage
 disaster due to hospital closings.
- Infectious Disease concerns. Lack of adequate surveillance/enforcement of immunization for resurgence of diseases such as tuberculosis. Potentially insufficient availability/process to vaccinate for return of H1N1.
- Need to focus on parental role in education regarding dangers of smoking and poor nutrition
- Need for increased education and enforcement of laws governing jaywalking, use of cell phones in automobiles, etc., that contribute to accident and injury.

Chinese and Korean Patient Interviews

The Hospital contracted with a private Asian specialist market research company to conduct one-on-one interviews with 70 Chinese and 70 Korean former patients to ascertain their perceptions with regard to services provided by the hospital compared to patient priorities. The survey was conducted in May 2008.

Barriers to care identified included language and cultural differences that negatively impacted patients' experiences.

Results of the survey identified opportunities for enhancement of communication, in particular, availability of physicians, nurses and other staff who speak the patient's language, as well as more attention to cultural amenities

Interboro Regional Health Information Organization (RHIO)

In September of 2007, New York State established HEAL NY Phase 5 Health Information Technology grant opportunities as a key element of New York's health care reform agenda. The grants were intended to transform health care delivery from today's largely paper-based system to an electronic, interconnected system – "leading to improvements in health care quality, affordability and outcomes."

Interboro RHIO submitted and was awarded a HEAL 5 Grant in November of 2007. New York Hospital Queens is one of the RHIO's four acute care hospitals, partnered with Elmhurst and Queens Hospital Centers and Woodhull Medical and Medical Health Center to develop and implement a regional interoperable electronic health record across 53 zip codes in Queens and Brooklyn. Membership also includes health insurance plans, long term and home care organizations, community health centers, and private physician practices.

2008 planning meetings took place on April 30, May 28, September 15, and October 30th.

The value proposition of the Interboro RHIO is to create opportunities to improve health care quality and safety, including prevention agenda priorities such as access to care and improved management and outcomes of chronic conditions.

The RHIO promotes and supports community physician adoption of electronic medical records, which include prevention measure reporting. Clinicians can use these electronically generated prevention measure reports to facilitate public health reporting and to transform the healthcare practices from a focus on disease management to one focused on prevention. The electronic exchange of information among

providers should also streamline monitoring and recording, and potentially reduce costs.

General Public Comment

The hospital also placed notices in the lobby of the hospital, on the hospital's website at www.nyhq.org, and in local newspapers inviting public comment and input on health priorities from the entire Queens community for the development of the Community Service Plan. Notices were posted in July and comments accepted through beginning of September. This initiative was found to be the least effective, method of identifying community health issues. Participating responders identified increased access to support groups for elderly immigrants and chronic conditions as a health priority.

IV. Assessment of Public Health Priorities

IVA. Criteria of Public Health Priorities

Two major criteria drive the hospital's determination of prevention agenda priorities for continued and future focus - demonstration of need and the ability to positively impact outcomes.

The hospital combines information and opinion elicited from key participants described here with established indicators for health status for Queens County. Sources include:

- NYSDOH County Health Indicator Profiles
- NYSDOH Prevention Agenda Towards the Healthiest State 2008
- NYCDOHMH Community Health Profiles
- NYSDOH Prevention Quality Indicators (PQI)
- New York State whitepaper "Queens Health Profile"

Mapping of Take Care New York key health issues by Queens' neighborhoods to corresponding NYSDOH Prevention Agenda Priority Indicators provides a template for identifying prevention initiative focus.

New York State Department of Health Prevention Agenda Public Health Priorities Key Health Issues By Queens County Neighborhood

	North	Central	North East	South East	Jamaica	West Central	North West	West	South West	Rockaway
(A) Access to Care	X	X	X			X	X	X	X	X
(B) Healthy Mothers and Babies	X			X	X				X	X
(C)Activity/Nutrition				X	X					X
(D)Unintentional Injury			X	X		X				X
(E)Chronic Disease	X	X			X	X	X	X		X
(F)Tobacco Use	X						X			X
(G)Infectious Disease					X		X	X		X

Source: Take Care New York, Community Health Profiles, 2nd ed.; New York City Department of Health and Mental Hygiene, 2006; NYSDOH Prevention Agenda, August, 2008.

When TCNY Key Health Issues for Queens County neighborhoods are cross-matched to Prevention Agenda Indicators, Access to Care and Chronic disease issues are most broadly distributed, followed by Health for Mothers and Babies, and Infectious Disease, and finally Activity and Nutrition and Tobacco Use.

Key Health Issues detail for Queens County residents identified in the most recent (2006) Take Care New York (TCNY) New York City Department of Health and Mental Hygiene Neighborhood Community Health Profiles follows:⁷

North Queens

- O Women in North Queens are less likely to get regular Pap tests for cervical cancer (70%) than those in NYC overall (80%). (AE)
- o Mothers in North Queens are less likely to receive timely prenatal care than mothers in NYC overall. (B)
- o The percent of adults with diabetes increased in North Queens between 2002 and 2004, and obese adults in this community are more likely to have diabetes. (E)
- o One fifth of North Queens residents currently smoke. (F)

Central Queens

- o The primary cause of premature death in Central Queens is cancer. (AE)
- o Although cancer-screening rates in Central Queens are high in comparison with other neighborhoods, they remain below TCNY targets. (AE)
- o The leading causes of death in Central Queens are primarily long-term (chronic) illnesses, for which many preventive measures and medical management are available. (E)

Northeast Queens

- o Cancer is the primary cause of premature death in Northeast Queens. . (AE)
- Cancer screening rates among women and older adults in Northeast Queens remain below TCNY targets. (AE)
- Hospitalizations for fall-related injuries particularly hip fractures among older adults are more common in Northeast Queens than in New York City overall. (D)

Southeast Queens

- Mothers in Southeast Queens are less likely to receive early prenatal care than in NYC overall.
 (B)
- o The infant mortality rate in Southeast Queens is higher than Queens and NYC overall. (B)
- o Hospitalizations for injuries due to motor vehicle traffic accidents are more common in Southeast Queens than in NYC overall (D)
- o In Southeast Queens, adults are more likely to be obese than in Queens overall (C)

Jamaica

- o Less than half of older adults in Jamaica get their annual flu shot—well below both the NYC overall percent and the TCNY target (G)
- o In Jamaica, mothers are less likely to get timely prenatal care and babies are more likely to be born with low birth weight than in NYC overall. (B)
- The death rate due to diabetes is higher in Jamaica than in New York City overall, and the community also have higher rates of avoidable hospitalizations for diabetes-related conditions.
 (E)
- o More than 1 in 5 Jamaica residents smoke. (F)
- o In Jamaica, more than one fifth of adults are obese. (C)

⁷ Prevention Agenda Public Health Priorities are matched to TCNY Key Health Issues as indicated by letters in the parenthesis.

West Central Queens

- One in 4 adults in West Central Queens is currently uninsured or went without health insurance at some time during the previous year. (A)
- o Women in West Central Queens are less likely to get cancer screenings for breast and cervical cancer than women in New York City overall. (AE)
- o Hospitalizations for falls among older adults, as well as related hip fractures, are more common in West Central Queens than in New York City overall. (D)

Northwest Queens

- One in 5 Northwest Queens adults smokes, and smokers in this community are less likely to be trying to quit than smokers in NYC overall. (F)
- o Women in Northwest Queens are less likely to get regular Pap tests for cervical cancer than women in NYC overall. (AE)
- o Northwest Queens has the second highest proportion of uninsured adults among all NYC neighborhoods, and foreign-born residents of this community are more likely to be without health insurance than those born in the U.S. (A)
- o In Northwest Queens, the rate of HIV diagnoses and the rate of people living with HIV/AIDS is higher than the Queens rates and lower than NYC overall. (G)

West Queens

- One third of adults in West Queens do not have a primary health care provider- a higher proportion than in both Queens and NYC overall. (A)
- o Women in West Queens are less likely to get regular Pap tests than women in NYC overall (AE)
- West Queens has the highest percent of adults without health insurance among all 42 NYC neighborhoods, and foreign-born residents in this community are more likely to be uninsured than those born in the U.S. (A)
- o In West Queens, the rate of HIV diagnoses and the rate of people living with HIV/AIDS are higher than the Queens rates, but lower than the rates in NYC overall. (G)

Southwest Oueens

- O Women in Southwest Queens are less likely to get regular Pap tests for cervical cancer (72%) than women in NYC overall (80%). (AE)
- Mothers in Southwest Queens are less likely to receive timely prenatal care than moms in NYC overall, and the proportion of babies born with low birth weight is also higher in this community.
- o Southwest Queens has one of the highest percentages of uninsured adults among the 42 neighborhoods in NYC (23%), and foreign-born residents in this community are less likely to have health insurance than those born in the U.S. (A)

Rockaways

- Both hospitalizations and deaths from heart disease are more common in the Rockaways than New York City overall. (AE)
- o Mothers in the Rockaways are less likely to have had timely prenatal care than those in NYC overall, and the teen pregnancy rate in this community is also higher. (B)
- o Hospitalizations for falls among older adults, as well as hip fractures, are more common in the Rockaways than NYC overall. (D)
- In the Rockaways, adults are more likely to be obese than in Queens and New York City overall.
 (C)
- o More Rockaway residents smoke than in Queens and New York City overall. (F)
- o In the Rockaways, the rate of HIV diagnoses and the rate of people living with HIV/AIDS in the community are higher than in Queens but lower than in NYC overall. (G)

Prevention Quality Indicators

Prevention Quality Indicators are another good source of information for determining prevention priority focus. Developed by the Agency for Healthcare Research and Quality (AHRQ), Prevention Quality Indicators (PQIs) are a measure by which providers and policymakers identify potential access or quality-of-care problems related to prevention, to plan specific interventions, and to evaluate how well these interventions meet the goals of preventing illness and disability. Although these indicators are based on hospital inpatient data, they provide insight into the quality of the health care system *outside* the hospital setting.

More specifically, PQIs are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive" (ACS) conditions in adult populations. These are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the education needed for appropriate self-management; or, patients may be hospitalized for asthma if they do not have ready access to providers who can direct appropriate "rescue" therapy in order to mitigate exacerbations, thereby avoiding hospitalization. The PQIs consist of 14 ACS conditions, which are measured as rates of hospital admissions.

The geographic area used to calculate PQI rates in NYHQ's primary service area (PSA) was defined as ZIP Code 11355 (in which NYHQ is located) and its contiguous ZIP Codes (11368, 11354, 11358, 11365, 11367). This is in keeping with the methodology often used in the New York State Department of Health (NYSDOH) State Hospital Review and Planning Council (SHRPC) Staff Reports. Using the NYSDOH on-line PQI calculator, the following PQI rates were found for the PSA.

PQI Admissions and Rates Comparison NYHQ, PSA, NYS 2007

		Data from DOH website				NYHO		
		NYHQ	PSA	NYS	PSA vs.	2007 Data		NYHQ Rate
PQI	Description	Adms	Rate	Rate	NYS	Adms	Rate	Vs. PSA
1	Diabetes short-term complications	75	27	52	-48%	50	18	-33%
2	Perforated appendix	-	-	22	-	-	20	-
3	Diabetes long-term complications	405	152	155	-2%	354	102	-33%
5	COPD	371	141	178	-21%	400	146	3%
7	Hypertension	190	70	61	15%	180	65	-6%
8	CHF	818	303	443	-32%	1,083	394	30%
9	Low birth weight	-	-	-	-	-	-	-
10	Dehydration	243	89	89	0%	250	91	2%
11	Bacterial pneumonia	768	283	381	-26%	862	314	11%
12	UTI	451	165	169	-2%	551	200	21%
13	Angina w/o procedure	142	53	50	6%	165	60	13%
14	Uncontrolled diabetes	104	38	39	-3%	85	31	-19%
15	Adult asthma	309	114	174	-34%	436	159	39%
16	Lower-extremity amputation	105	40	37	8%	-	-	-

Source: NYS DOH PQI Database

PQI rates in the Hospital's (NYSDOH model) primary service area compare favorably with statewide experience:

- For nine (9) out of the 12 PQI categories for which comparison data is available, the rate of admissions in the Hospital's PSA was lower than or equal to the statewide rate, indicating that the available health care resources in the PSA (led by NYHQ itself) are doing a better job at addressing PQI conditions in primary care settings (and keeping them out of tertiary care settings such as hospitals) than providers statewide.
- NYHQ has lower PQI rates for all three (3) diabetes-related PQIs (#'s 1, 3 and 14), as well as hypertension (a risk factor for diabetes), compared to the PSA.
- Moreover, PQI rates in NYHQ's PSA are lower than the statewide rates for most of those conditions
 that have the highest number of admissions, including chronic heart failure, bacterial pneumonia,
 urinary tract infections and chronic obstructive pulmonary disease.

However, the Hospital draws patients from a much broader geographic area:

• For seven (7) of the 12 PQI categories for which comparison data is available, the total number of admissions at NYHQ alone is greater than the number of admissions in the PSA (according to the data from the DOH website) This is an indication that NYHQ's true service area extends beyond the six (6) PSA ZIP Codes used in this analysis and shows the broader regional reliance on NYHQ.

New York State Department of Health "Queens Health Profile"

The most recent information on the health status of Queens County was published in August, 2009, by the Department of Health. The DOH issued a whitepaper called the "Queens Health Profile" that identified the following challenges to healthcare in Queens County:

- Population is expected to increase between 4% and 8% by 2015.
- Preventable hospitalizations are less likely in Queens, but opportunities exist for better management of diabetes and hypertension.
- The aging population may mean 2% to 13% more Queens Prevention Quality Indicators.
- If Department of Health recommended efficiencies, i.e., avoidance of preventable hospitalizations, better chronic disease management, and reduced length of stay, are achieved the borough will still require between 50 and 350 additional inpatient beds by 2015.
- ED visits grew by 6% and ED admissions grew by 8% in the two years from 2006 to 2008.
 - o Overcrowding will continue in several Queens EDs despite planned additional capacity
 - o As much as 50% of ED visits may be inappropriate or avoidable.
 - O Diverting ½ to ½ of inappropriate/avoidable visits to clinics would require up to 5% additional clinic capacity, but may effect a net cost reduction
- Queens has approximately half as many full time physicians as New York City.
 - o Having the number of Queens' residents without a primary care provider would require approximately 20-24% increase in primary care resources borough-wide by 2015
 - To bring the FTE physician ratio to state-wide value of 90 MDs per 100,000 population will require up to 30% more primary care MDs in Queens by 2015.

IV B/C. Selected Prevention Agenda Priorities and Status of Initiatives

The following three Prevention Agenda Priorities have been selected for focus during the three-year period between 2009 and 2012:

#1. Prevention Priority Indicator: Access to Quality Care: % of Adults with Regular Health Provider

NYHQ Initiative: Expansion of the Primary Care Base

Status: Existing program

The Hospital's Physician Relations Office, working with the clinical leadership from each of the major clinical disciplines, Medical Staff Society leadership and relevant culturally aligned physician organizations, such as the Association of Chinese American Physicians, the Korean American Physician Association, and others, are collaborating to improve the percentage of adults in Queens County with regular health providers through the identification, recruitment and credentialing of high quality primary care physicians from the multiple ethnic backgrounds represented by the Hospital's patient population.

#2. Prevention Priority Indicator: Access to Quality Care: Early Stage Cancer Diagnosis - Colorectal

NYHQ Initiative: Colonoscopy Patient Navigator Program

Status: New program

Beginning in October, 2009 the Hospital will contract with the New York City Department of Health and Mental Hygiene to initiate a Colonoscopy Patient Navigator Program. The contract provides funding for two full time navigators for one year with an option to renew for a second year if funding is available. The program is designed to increase screening colonoscopies in Chinese and Hispanic adults, who are less likely to participate in screening activities than the general population⁸.

#3. <u>Prevention Priority Indicator: Chronic Disease – Diabetes short-term complication</u> hospitalization rate.

NYHQ Initiative: The Diabetes Education Program

Status: New program

New York Hospital Queens' Cardiac Health Center has entered into partnership with The Diabetes Care and Information Center of New York, offering a community-based American Diabetes Association recognized educational program for diabetic patients and families. Program content is derived from evidence-based studies and in compliance with standards for Diabetes Self-Management Education.

17

⁸ NYCDOHMH Cancer Prevention and Control Program, November, 2006.

IV B/C. Continued: Other Prevention Agenda Priorities and Status of Initiatives

<u>Prevention Priority Indicator: Access to Quality Care: % of adults with regular health care provider</u>

NYHQ Initiative: Interoperable electronic medical record initiative

Status: Existing program

New York Hospital Queens is a partner in the Interboro Regional Health Information Organization (RHIO) a clinical data exchange serving Queens, northern Brooklyn, and the surrounding metropolitan NY area, which facilitates the sharing of patient information between authorized health care providers at the point of care.

When linked to the Interboro RHIO, providers become part of an interconnected community that, through clinical data sharing, can achieve dramatic improvements in both the quality and cost of healthcare.

By incorporating a significant portion of the community physicians and health care providers in our service area, we can create real opportunities to improve healthcare in terms of safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.

<u>Prevention Priority Indicator: Access to Quality Care: Early Stage Cancer Diagnosis - Breast</u>

NYHQ Initiative: Breast Cancer Awareness Public Education Campaign

Status: Existing program

The New York Hospital Queens' Breast Center physicians and staff participate annually, in collaboration with the American Cancer Society, to promote breast cancer awareness and early detection in the community. The Hospital has been designated a flagship hospital for Making Strides Against Breast Cancer due to the level of participation in breast cancer related initiatives. Throughout the year, and in particular during October, Breast Cancer Awareness month, The Breast Center Team engages hospital employees and the public in numerous activities designed to positively influence women's perceptions about the benefits of breast cancer screening.

NYHQ Initiative: Breast Cancer Clinical Research Projects Status: Existing program

The New York Hospital Queens Breast Center, The Theresa and Eugene M. Lang Center for Research and Education, NYHQ clinical departments of Surgery and Pathology, and the Cancer Center, in partnership with the Association of Chinese American Physicians and American Cancer Society Asian Initiatives representatives have joined in a genetic research project. The collaborative project is exploring changes in the DNA codes and genes unique in Asian women. Another collaborative research project including NYHQ and the University of Medicine and Dentistry of New Jersey physicians and research staff is in progress that may help in the non-invasive diagnosis of breast cancer.

<u>Prevention Priority Indicator: Tobacco Use - % cigarette smoking in adolescents and adults</u>

NYHQ Initiative: Health Outreach® Smoking Cessation Program

Status: Existing program

New York Hospital Queens Health Outreach®, has established partnerships with the American Lung Association, American Heart Association, and New York State Department of Health "Queens Quits" program to enhance opportunities to reduce smoking among Queens residents.

<u>Prevention Priority Indicator: Healthy Mothers/Healthy Babies/Healthy Children – Increase</u> % of 2-year old children who receive recommended vaccines.

NYHQ Initiative: Vaccines for Children (VFC)

Status: Existing program

Between 1989 and 1991, a measles epidemic in the United States resulted in tens of thousands of cases of measles and hundreds of deaths. Upon investigation, Centers for Disease Control (CDC) found that more than half of the children who had measles had not been immunized, even though many of them had seen a healthcare provider. In partial response to that epidemic, Congress passed the Omnibus Budget Reconciliation Act creating the Vaccines for Children (VFC) Program in 1994. New York Hospital Queens contracts with the VFC to provide free vaccines to eligible children.

<u>Prevention Priority Indicator: Healthy Mothers/Healthy Babies/Healthy Children – % of early prenatal care (1st Trimester).</u>

NYHQ Initiative: Prenatal Care Assistance Program (PCAP)

Status: Existing program

New York Hospital Queens participates in the New York State Medicaid Program preferred provider model for obstetrical care, PCAP, to deliver quality, comprehensive perinatal care services to eligible low-income uninsured and underinsured women to improve perinatal outcomes.

<u>Prevention Priority Indicator: Physical Activity and Nutrition -% of obese children grades K through 10.</u>

NYHQ Initiative: Fit Kids Program Status: Existing program

The division of Gastroenterology in the Department of Pediatrics offers a community based Fit Kids program designed to teach and promote healthy lifestyles. The program includes exercise sessions and also nutrition and exercise education classes that give basic health, nutrition and exercise information to the children and parents.

<u>Prevention Priority Indicator: Physical Activity and Nutrition -% of obese children grades K through 10.</u>

NYHQ Initiative: Fit Kids Advocacy Status: New program

The Department of Pediatrics is actively involved in a collaborative effort led by NYC Council Member Tony Avella in support of a United States Congress action to pass the FIT Kids Act, legislation that would amend the Elementary and Secondary Education Act of 1965 to improve standards for physical education. If passed, the amendment will require state and local educational agencies to provide annual reports on school health and physical education programs. It also calls for the promotion of healthy active lifestyles and improvement in professional development programs for educators by including training for physical and health education teachers.

Prevention Priority Indicator: Healthy Environment – Asthma Related Hospitalizations

NYHQ Initiative: New York Hospital Queens Pediatric Asthma Center

Status: Existing program

The New York Hospital Queens offers the longest-running community based program in Queens County dedicated to the care of children with Asthma. The Center's objective is to minimize the impact of Asthma related symptoms and illness on both the patient and family and to reduce acute exacerbations requiring hospitalization.

Under the direction of a full-time Pediatric Pulmonologist, patients undergo complete initial medical and environmental assessment and then participate in ongoing treatment and maintenance. Routine follow-up care and progress is closely monitored. Disease management education is provided at all visits and personal counseling is provided when needed to assist patients and families in handling the emotional stress related to asthma.

NYHQ Initiative: New York Hospital Queens Pediatric Asthma Center

Status: New program - Asthma Self-Management Toolkit

New York Hospital Queens will participate in an advisory workgroup including the NYSDOH, IPRO, the New York City Asthma Initiative, APNY and others in an 18 month project to develop an asthma self-management toolkit for New Yorkers with asthma and their families was recommended by the New York State Consensus Asthma Guideline Expert Panel to compliment the Asthma Guideline Toolkit that was recently published.

NYHQ Initiative: New York Hospital Queens Pediatric Asthma Center

Status: New program – Asthma Advocacy

He is also a member of NY Senator Kirsten Gillibrand's Health Children Advisory Group. The group includes hospitals such as NYU, Mount Sinai, as well as community organizations. The asthma related goal of this effort is to effect legislation that will make inhalers available to low-income children, have schools create management plans for asthma cases, increase availability of certified asthma educators and to enhance asthma research.

<u>Prevention Priority Indicator: Chronic Disease – Coronary heart disease and Congestive Heart Failure hospitalization rates.</u>

NYHQ Initiative: The Cardiac Health Center

Status: Existing program

New York Hospital Queens' Cardiac Health Center was the first community-based cardiac disease prevention and rehabilitation facility in Queens County. The Center is under the supervision of a Medical Director who is a Board Certified Cardiologist and who is assisted by a staff of physicians, nurses, nutritionists, and exercise therapists. The program focuses on education, early detection and treatment as the most important way to prevent and manage cardiovascular disease. The Center's education programs in nutrition and exercise help many individuals make the lifestyle changes they need for a heart healthy future.

<u>Prevention Priority Indicator: Chronic Disease – Coronary heart disease, Congestive Heart Failure, Diabetes and Stroke Hospitalization Rates</u>

NYHQ Initiative: Health Outreach® Public Education and Community Health Fair and Screening Program.

Status: Existing program

New York Hospital Queens Health Outreach® program is a long standing community outreach initiative to support the health and well being of the community's senior population. The program operates from a storefront facility where seniors can access health information and assistance to navigate health care related issues. The program conducts an active education and early detection program that concentrates on the population's identified health priorities, especially cardiovascular health and diabetes risk and detection.

<u>Prevention Priority Indicator: Community Preparedness - % of population living in jurisdiction</u> with state-approved emergency preparedness plans.

NYHQ Initiative: Disaster Preparedness

Status: Existing program

New York Hospital Queens is an active participant in various emergency management related community forums, including the GNYHA Emergency Management Steering Committee that helps to set priorities for the GNYHA Emergency Preparedness Council. Collaborative goals established include ensuring hospital preparedness through a partnership with other emergency providers (police, fire, EMS) vis-à-vis, implementation of incident command through NIMS and HICS training and response matrices, discussion of risks and hazards that can affect the entire area (coastal storms, surge capacity, mass fatality planning, evacuation and pandemic planning).

V. Three-Year Plan of Action

IV A. Strategies for Selected Priorities

I. Selected Prevention Priority Indicator: Access to Quality Care: % of Adults with Regular Health Provider

NYHO Initiative: Increased availability of Primary Care Physicians

1: Status: Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

The priority will be addressed by increasing availability of bi-lingual primary care physicians via:

Continued dialogue with multi-cultural physician groups currently involved in the initiative Expansion of the initiative to include additional relevant physician groups Coordination of recruitment and credentialing activities
Utilization of multi-cultural Hospitalist program to provide inpatient care when needed Effective communication to relevant publics regarding physician availability

Chairmen and administrative leadership from primary care related Clinical Departments, working with Medical Staff Society leadership, the Vice President for Physician Relations, and relevant culturally aligned physician organizations, such as the Association of Chinese American Physicians, the Korean American Physician Organization, the Excelsior IPA, representing the Hispanic community and others, will assist with ongoing needs evaluation and the identification of high quality primary care physicians from the multiple ethnic backgrounds represented by the Hospital's patient population.

Regular meetings are held by the Chairman of Medicine, VP for Physician Relations and administrative staff to review recruitment and credentialing process. Newly credentialed physicians are given one-on-one orientation to ensure a fundamental knowledge base of services available to address multi-cultural issues.

The strategy also includes a multi-cultural hospitalist program. Four full-time physicians each of whom speaks English and either Chinese, Korean, Spanish or Russian provide hospital-based care for patients of those attending physicians based in the community who prefer to spend more time managing patients' health in their practice. Each hospital-based physician provides coordinated inpatient care, in the patient's preferred language, working with the patient's primary care provider to achieve improved outcomes of the acute care episode and a continuum for overall better health.

The Vice President of Physician Relations communicates progress on recruitment efforts to the relevant physician groups so that they can in turn communicate availability to their constituents. All physicians are also entered into the Hospital's physician referral service which can be accessed on the Hospital's website and via a toll free number - (800) 282-6684.

3: The Overall Goals of the Strategies

The goal of the collaborative effort is to ensure adequate availability of culturally relevant physicians in the community.

The objective of the initiative is to increase the numbers of non-English speaking patients who regularly see a primary care provider.

The program is designed to provide patients with the security of having sufficient numbers of physicians who speaks their language and can manage their health in the community in a culturally sensitive manner, and who can access to culturally sensitive hospital- based diagnostic and treatment services when required.

4: How the Goals will be measured for effectiveness.

The internal success of the initiative will be measured by results of the Hospital's physician recruitment efforts. The external success will be demonstrated by an increased % of adults in Queens County with a regular provider over the three-year period of the plan.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

Discussion with Russian physician representatives will begin in the Fall of 2009. Additional physician groups will be added to discussions when evolving demographics require. The Hospital is also exploring the potential for a Home Visit program through a partnership with the Visiting Nurse Service of New York.

II. Selected Prevention Priority Indicator: Early Stage Cancer Diagnosis - Colorectal

NYHO Initiative: Colonoscopy Patient Navigator Program

1: *Status:* New program

2: How will the priority be addressed by the hospital and community partners and by whom?

The priority will be addressed by creation of a navigation initiative that will:

Expand outreach by targeting key clinics and other potential services within the hospital Provide community education and outreach to community institutions, providers and organizations.

Arrange screenings and supporting patients through the entire process, assisting with access issues, and developing relationships with providers.

Beginning in October 2009 the Hospital will contract with the New York City Department of Health and Mental Hygiene to initiate a Colonoscopy Patient Navigator Program. The Cancer Prevention and Control Program at the New York City Department of Health and Mental Hygiene launched the Colonoscopy Patient Navigator Program in 2003. The goal of the program is to improve the low rates of colorectal cancer screening in New York City.

Two navigators will be recruited to New York Hospital Queens who will be responsible for coordinating educational programs, arranging and supporting colorectal cancer screening appointments and supporting the patient through the entire screening process. The navigators' patient-related function is guiding colonoscopy patients through the health care system by assisting with access issues, developing relationships with service providers, providing education and support through the procedure prep process, and tracking interventions and outcomes. They will also be responsible for tracking program data and reporting on a quarterly basis to the NYC DOHMH Cancer Prevention and Control Program

3: The Overall Goals of the Strategies

The overall goal of the strategy is to enhance access to screening colonoscopy for Asian and Hispanic residents in Queens County.

4: How the Goals will be measured for effectiveness.

Effectiveness will be measured by tracking program outcomes through the NYCDOHMH navigator database including:

- Number of appointments made through the Navigator Provider Program
- Show rate of patients registered through the Navigator Provider Program
- Incremental colonoscopies completed as a result of the Navigator Provider Program.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

Strategies may be modified through feedback obtained by participation in the New York City Navigator Program Network (NPNnyc) and from providers and community organizations who participate in the program.

III. Selected Prevention Priority Indicator: Chronic Disease – Diabetes short-term complication hospitalization rate.

NYHQ Initiative: The Diabetes Education Program

1. *Status:* Existing program supplemented by community partner.

2: How will the priority be addressed by the hospital and community partners and by whom?

New York Hospital Queens has a longstanding program of diabetes education and screening that is offered to individual patients through its Ambulatory Care Centers and to the general community through the Health Outreach® public education lectures and screening programs. More than 2,400 Queens residents were screened for diabetes in 2008.

To enhance the existing program, the Hospital's Cardiac Health Center, working in partnership with The Diabetes Care and Information Center of New York, launched an ongoing Diabetes Education Program in January of 2009 that is conducted by certified clinical diabetes educators—a nurse and a registered dietician, who are specially trained to teach people how to control and manage diabetes.

Program content is derived from evidence-based studies and meets national standards for Diabetes Self-Management Education.

The curriculum includes the right foods to eat, how to make good meal choices when dining out and during the holidays, ways to best manage and control blood sugar levels throughout the day, times to accurately test glucose levels, signs to look for when diabetes goes out of control, and areas of the body that can be affected by out-of-control diabetes, like the eyes, feet and heart.

Learning sessions are given as a group and on a one-to-one basis. The classes are broken up into two, 4-hour blocks.

3: The Overall Goals of the Strategies

The goal of the program is to increase patients and families' capacity to manage behaviors that are under their control such as diet, exercise and consistent self-care to manage diabetes.

4: How the Goals will be measured for effectiveness.

The effectiveness of the program will be measured internally by pre and post course evaluations of participants, and externally by reduced hospitalization rates for short-term diabetes complications over the three-year period of the plan.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

This new educational format in partnership with the Diabetes Care and Information Center of New York will offer opportunity for feedback from community physicians and participants. Feedback from these groups will provide input into program design.

IV B. Strategies for Non-Selected Priorities

Prevention Priority Indicator: Access to Quality Care: % of adults with regular health care provider.

NYHQ Initiative: Interoperable electronic health record initiative

1: **Status:** Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

New York Hospital Queens is a member of the Interboro Regional Health Information Organization (RHIO). Funded by the HEAL 1 and 5 grant programs, the RHIO supports technology that allows doctors, nurses, and other health care providers to share medical records using a computer network, instead of paper. This technology assists health care providers make information about patients available to other providers to provide better care.

Elmhurst Hospital Center was the first member to implement the data exchange as part of the HEAL 1 project at the end of second quarter of 2009 and New York Hospital Queens is targeted to implement an interface to the data exchange in early 2010.

In additional to technical infrastructure, the Interboro RHIO assists eligible community physicians with assessment, planning, system selection, license cost, purchase, and implementation of EMR software. Implementation of EMR is a significant investment, and financial assistance from the RHIO is a substantial benefit to community physicians.

Institutional members, including hospitals, nursing homes, and insurance providers are the primary conduit for educating physicians about these offers and benefits; as such, they are able to demonstrate value and partnership to their community physician networks. Additionally, as the RHIO assists physicians in implementing electronic health records as it increases the number of participants in the exchange, thereby increasing the scope and scale of the data exchange and providing a richer source of clinical data for all participants.

3: The Overall Goals of the Strategies

- To advance interoperable health information technology to improve health care quality and safety and reduce costs.
- To advance, develop and operate a health information infrastructure based on a community-driven model open to participation by all health care providers, payers and patients, which will facilitate the exchange of patient health information among disparate clinicians, other authorized entities and patients (collectively, "Health Information Users") in real time while ensuring security and privacy protections.
- To facilitate the exchange of clinical information among Health Information Users so that clinicians have access to the information necessary to guide medical decisions and care coordination.
- To promote a system where information follows the health care consumer so they are at the center of their care.

4: How the Goals will be measured for effectiveness.

The goals will be measured by the achievement of a critical mass of participants; providers, insurers, and patients who participate in the initiative.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

As the RHIO develops, patients will benefit from the shift to patient centered care and the improved communication, coordination and management of care, as well as from improved patient safety. Feedback from patients' experiences with the system will provide input into potential future modifications.

Prevention Priority Indicator: Access to Quality Care: Early Stage Cancer Diagnosis - Breast

NYHO Initiative: Breast Cancer Awareness Public Education Campaign

1: Status: Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

The New York Hospital Queens' Breast Center physicians and staff participate annually, in collaboration with the American Cancer Society, in this program to address early stage breast cancer diagnosis.

The Hospital has been designated a flagship hospital for Making Strides Against Breast Cancer due to the level of participation in breast cancer related initiatives. Throughout the year, and in particular during October, Breast Cancer Awareness month, The Breast Center Team engages hospital employees and the public in numerous activities designed to positively influence women's perceptions about the benefits of breast cancer screening.

The program includes:

- Public education in multiple languages via lectures, print articles, and television and radio interviews
- Awareness campaigns utilizing multi-disciplinary employee teams
- Participation in nationally recognized events, such as ACS Making Strides Walk
- Fundraising for Breast Cancer research.

3: The Overall Goals of the Strategies

The overall goal of the initiative is to promote breast cancer awareness and increased participation in screening for early detection.

4: How the Goals will be measured for effectiveness.

The success of the initiative is measured internally by evidence of educational programs and awareness campaigns conducted.

The 2008 program included

- Ten community based lectures given by the Medical Director of the Breast Center
- Articles in all Queens' local newspapers, including ethnic language publications. Estimated audience 2.5 million.
- A four-part weekly radio program on breast cancer awareness for a Chinese language radio station with a listening audience of over 70,000.
- Participation in the American Cancer Society's Making Strides Against Breast Cancer Walk
- Fundraising for Breast Cancer research.

The success of the initiative will be measured externally by demonstrated increased % of early stage diagnosis for breast cancer for Queens County residents over the three-year period of the plan.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

Continued dialogue with American Cancer Society representatives coupled with specific needs of relevant constituents, i.e., cultural groups, seniors, etc., will be used to identify improvements to the current program in the future.

NYHQ Initiative: Breast Cancer Clinical Research

1: **Status:** Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

The Breast Center, The Theresa and Eugene M. Lang Center for Research and Education, NYHQ clinical departments of Surgery and Pathology, and the Cancer Center, in partnership with the Association of Chinese American Physicians and American Cancer Society Asian Initiatives representatives have joined in a genetic research project. The collaborate project is exploring changes in the DNA codes and genes unique in Asian women through 3 initiatives:

- (1) Chinese Breast Cancer Genomic Project
- (2) Breast Cancer (BRCA) Mutations and Variants in Young Asian Women at High Risk
- (3) Molecular Origins of Cancer: Impact of Race on Breast Cancer

Another collaborative research project including NYHQ and the University of Medicine and Dentistry of New Jersey physicians and research staff is in progress that may help in the non-invasive diagnosis of breast cancer.

The team is working to determine if a defined set of specimens (blood, urine, sputum/saliva and breast tissue) from breast surgery patients, both benign and malignant cases, can be used to identify differences in activity and biomarker levels, and if these differences:

- 1.) can be used in a formulating a screening test for breast cancer in all women
- 2.) can distinguish cancer subtypes
- 3.) are related to the grade and/or stage of cancer (malignancy)
- 4.) reflect distinct regions of the tumor
- 5.) can distinguish early onset from late-onset (post-menopausal) cancer
- 6.) will allow for the identification of specific 'risk-factors' of different ethnic populations.
- 7.) can predict prognosis

3: The Overall Goals of the Strategies

The overall goals of the two projects are to provide valuable clinical and scientific information that may enhance the understanding of cultural factors on breast cancer and to increase early detection through use of non-invasive diagnosis.

4: How the Goals will be measured for effectiveness.

The goals will be measured by successful enrollment of study subjects.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

Study progress will be monitored by all of the partners involved in the research. initiatives Modifications to recruitment approaches to enhance enrollment will be developed and implemented.

Prevention Priority Indicator: Tobacco Use - % cigarette smoking in adolescents and adults

1: Status: Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

New York Hospital Queens Health Outreach®, has established partnerships with the American Lung Association, American Heart Association, and New York State Department of Health "Queens Quits" program to address the challenge of smoking among Queens residents.

The hospital has two American Lung Association- trained registered nurses who have historically provided traditional 7-session smoking cessation programs for the general public at the hospital. However, compliance with the program has been less than optimal, due to the multi-session commitment required of participants who would prefer to spend less time in classes and have access to more aids such as nicotine patches.

As a result of input from constituents, the program has been restructured to resemble a support group model where assistance can be provided on a per-session basis, including education on the elements of the 7-session model, but without required enrollment in a multi-week program. Participants will also have access to "Queens Quits" for smoking cessation aids. The group will meet monthly beginning in September of 2009.

Health Outreach® has also partnered with "Sabemos" a program sponsored by the Office on Smoking and Health (OSH) and the Centers for Disease Control and Prevention (CDC) to raise awareness in the Hispanic/Latino Community on the effects of second hand smoke. This education program is planned to roll out in The Theresa Lang Children's Ambulatory Center.

3: The Overall Goals of the Strategies

The goal of the redesigned Health Outreach® smoking cessation program is to increase participation. The goal of the *Sabemos* partnership is to teach parents how secondhand smoke can affect them and their children.

4: How the Goals will be measured for effectiveness.

The success of the strategies will be measured internally by increased participation in both initiatives and externally by achievement of the NYS DOH 2013 Prevention Agenda target to reduce percentage of Queens' adolescents and adults who smoke over the three year period of the plan.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

The Hospital and its partners, American Lung Association, American Heart Association, "Queens Quits" and *Sabemos* will assess impact of the changes and additions to the existing Health Outreach® Smoking Cessation Program and adjust strategies if necessary.

<u>Prevention Priority Indicator: Healthy Mothers/Healthy Babies/Healthy Children – Increase</u> % of 2-year old children who receive recommended vaccines.

NYHQ Initiative: Vaccines for Children (VFC)

1: **Status:** Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

New York Hospital Queens contracts with the Vaccines for Children (VFC) at its three Ambulatory Care Centers that provide pediatric services. Staff ensure timely immunization through effective case management, counseling parents on importance of vaccination, and conducting follow up to promote compliance.

Literature on vaccination is available and distributed at all sites. Parents can also obtain information on the subject on the Hospital's website in a specific web page designed to highlight the benefits of immunization.

3: The Overall Goals of the Strategies

The goal of the program is to assist families of children who may not otherwise have access to critical immunizations by providing free vaccines to eligible children.

4: How the Goals will be measured for effectiveness.

The Department of Ambulatory Care monitors compliance with requirements and submits results to the New York State Department of Health on a regular basis. All three Centers were in 100% compliance in 2008 for the recommended doses of 4Dtap, 3 polio, 1 MMR, 3 HIB, and 3 HepB.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

The current strategy will be modified by partnering with the HealthOutreach® to provide information on the benefits of immunization at community sites during prevention and screening programs.

<u>Prevention Priority Indicators: Healthy Mothers/Healthy Babies/Healthy Children - % of early prenatal care (1st Trimester) and % of low birth weight.</u>

NYHQ Initiative: Prenatal Care Assistance Program (PCAP)

1: Status: Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

New York Hospital Queens participates in the New York State Medicaid Program preferred provider model for obstetrical care, PCAP, to deliver quality, comprehensive perinatal care services to eligible low-income uninsured and underinsured women. The program is offered at all New York Hospital Queens Ambulatory Care Centers providing obstetrical care.

The program includes:

- Routine pregnancy medical check-ups, lab work, and access to specialists
- Hospital care during pregnancy and delivery
- Information about pregnancy, labor and delivery
- HIV counseling and testing
- Help in applying for other programs such as WIC and low or no cost health insurance
- Full health care until at least two months after delivery
- Health care for infants for at least one year after birth

Family planning services

3: The Overall Goals of the Strategies

The goal of the program is to improve perinatal outcomes in low-income uninsured and underinsured women.

4: How the Goals will be measured for effectiveness.

The Department of Ambulatory Care monitors compliance with NYS DOH indicators and others for tracking public health priority areas. Entrance into prenatal care in first trimester was 66% between 2004 and 2006, was roughly comparable to Queens County at 66.9% with the most recent available Department of Health data for Queens County Indicators for Tracking ⁹ 2007 results for low birth weight births at 5% compared favorably with 8.3% ¹⁰ for Queens County.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

The current strategy will be modified by partnering with the HealthOutreach® to provide information on the benefits of early prenatal care at community sites during prevention and screening programs.

<u>Prevention Priority Indicator: Physical Activity and Nutrition -% of obese children grades K through 10.</u>

NYHQ Initiative: Childhood Obesity Initiative

1: Status: Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

The Department of Pediatrics and the division of Pediatric Gastroenterology have a multi-faceted strategy to combat obesity in children. The program includes participation in national advocacy initiatives coupled with a community based nutrition and exercise program modeled after the American Heart Association recommendations for diet and exercise in children.

The Department is collaborating with NYC Council Member Tony Avella in support of a United States Congress action to pass the Fitness Integrated with Teaching (FIT Kids) Act, legislation that would amend the Elementary and Secondary Education Act of 1965 to improve standards for physical education. If passed, the amendment will require state and local educational agencies to provide annual reports on school health and physical education programs. It also calls for the promotion of healthy active lifestyles and improvement in professional development programs for educators by including training for physical and health education teachers.

The exercise and nutrition program includes physical exercise sessions and also nutrition and exercise education classes that give basic health, nutrition and exercise information to the children and parents, including topics such as:

- How to read nutrition labels
- Better snacks choices

⁹ NYS Department of Health Queens County Indicators for Tracking Public Health Priority Areas, 2004-2006.

¹⁰ KIDS Count Data Center, Anne E. Casey Foundation, 2007.

- How to make better drink choices
- o How to stay active: Community activities, sports, etc.
- o Importance of Exercise and Fitness
- Various Health Topics

3: The Overall Goals of the Strategies

The goals of the program are to increase awareness of children and parents about the benefits of healthy lifestyles and to assist program participants to achieve targets and to secure legislation and potential funding for program support.

4: How the Goals will be measured for effectiveness.

The effectiveness of the program will be measured by increased participation in the program as well as participant outcomes, and successful passing of the Fit Kids Act.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

The program will be expanded in the Fall of 2009 to a 12-week program of three sessions per week in order to expand access, increase enrollment, and to obtain additional feedback from program participants and families.

Prevention Priority Indicator: Healthy Environment – Asthma Related Hospitalizations

NYHQ Initiative: New York Hospital Queens Pediatric Asthma Initiative

1: Status: Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

The New York Hospital Queens offers the longest-running program in Queens County dedicated to the care of children with Asthma. The initiative combines clinical care in the Hospital's Pediatric Asthma Center as well as active participation in American Lung Association.

The Asthma Center holds sessions in community-based facilities in Fresh Meadows and Jackson Heights and also has a mobile van that provides both educational and screening activities in local communities.

Under the direction of a full-time Pediatric Pulmonologist, patients undergo full initial medical and environmental assessment. Findings from initial evaluations are used to develop and maintain individualized treatment programs. Routine follow-up care and progress is closely monitored. Disease management education is provided at all visits and support groups and personal counseling are available when needed to assist patients and families in handling the emotional stress related to asthma.

The program offers 24-hour access to a physician by providing an after hour Asthma telephone Hot Line during evening, night, and weekend hours. The Center has approximately 3,000 active patients and 2008 annual volume exceeded 4,000 visits.

Public education and advocacy is another key element of the Asthma Center Initiative.

Asthma Center staff conducts community outreach programs, including education programs held in four local schools in 2008.

The Center 's Medical Director is a member of the Board of Directors of the New York City Chapter of the American Lung Association for the past ten years and an active member of the NYSDOH Advisory Workgroup, involved in an 18-month project that is currently developing an asthma self-management toolkit.

The development of an asthma self-management toolkit for New Yorkers with asthma and their families was recommended by the New York State Consensus Asthma Guideline Expert Panel to compliment the Asthma Guideline Toolkit that was recently published. This recommendation was further emphasized in the Guidelines Implementation Panel Report for: Expert Panel 3-Guidelines for the Diagnosis and Management of Asthma (2009). In addition, the Asthma Partnership of New York (APNY) steering committee identified this as a priority activity at their February 2009 meeting.

The Director is also a member of NY Senator Kirsten Gillibrand's Healthy Children Advisory Group. The purpose of the group is to assist the Senator to develop a legislative agenda with respect to healthy children.

3: The Overall Goals of the Strategies

The overall goal of The Pediatric Asthma Center's clinical care program is to provide comprehensive disease management based protocols for children with asthma from infancy through age 18.

The goal of the Asthma Advisory Workgroup is to assure that NYS residents with asthma will have access to accurate, culturally and linguistically appropriate asthma educational materials to assist them in controlling their asthma.

The Healthy Children Advisory Group asthma related goal is to make inhalers available to low-income children, have schools create management plans for asthma cases, increase availability of certified asthma educators and to enhance asthma research.

4: How the Goals will be measured for effectiveness.

The effectiveness of the overall goal of the Asthma Center's clinical care program is measured by continued low admission rates for hospitalization. 2008 calculated admission rate based on active patients of 2,947 and total hospital admissions of 118 provides a proxy admission rate for the Asthma Center population of 4.0.

The Asthma Advisory Group initiative will be measured by the successful production of the Self-Help toolkit.

The Healthy children Advisory Group initiative will be measured by the passing of asthma related legislation.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

Modification of strategies will be determined based on outcomes of initiatives over the three-year course of the plan, e.g., strategies will need to be developed for distribution of toolkit when published, and for collaboration with schools to implement asthma initiatives when legislation is passed.

Prevention Priority Indicator: Chronic Disease – Coronary heart disease and Congestive Heart Failure hospitalization rates.

NYHQ Initiative: The Cardiac Health Center

1: Status: Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

New York Hospital Queens Cardiac Health Center was the first community-based cardiac disease prevention and rehabilitation facility in Queens County. The Center is under the supervision of a Medical Director who is a Board Certified Cardiologist and who is assisted by a staff of physicians, nurses, nutritionists, and exercise therapists. The program focuses on early detection and treatment as the most important way to manage cardiovascular disease. The Center's education programs in nutrition and exercise help many individuals make the lifestyle changes they need for a heart healthy future.

A wide range of prevention and rehabilitation services are conducted at the site:

- . A 12-week treatment program tailored to specific needs, carefully monitored and medically supervised
- . Physical training three times per week for one hour to increase cardiac fitness (36 sessions)
- .

 Phase II/III (telemetry monitored) for individuals with known cardiac disease (covered by most insurance)
 - ☐ Phase IV (unmonitored) for individuals at high risk for cardiac disease
- . Special education programs to improve heart health by eliminating known risk factors for heart disease
- . An educational lecture series that includes topics such as anatomy and physiology, the benefits of exercise and other risk factor modifications
- Individualized nutritional counseling by registered dietitians
- . Lipid management to lower cholesterol, LDL, triglycerides and heart attack risk
- . Weight management program
- . Stress management classes and seminars
- . Smoking cessation sessions
- . Diabetes Education Program
- . Alternative Care Program incorporating Tai Chi, Yoga, Reiki, and Acupuncture as stress management techniques to lower individuals' risk of heart disease.

The Center partners with the American Heart Association, The Diabetes Care and Information Center of New York, and providers of alternative care programs to deliver comprehensive primary and secondary prevention and rehabilitation services.

3: The Overall Goals of the Strategies

The Center's goal is to promote primary and secondary prevention of cardiac disease in at risk populations and those diagnosed with existing conditions.

4: How the Goals will be measured for effectiveness.

Success of the program is measured by enrollment trends and participants' achievement of targets.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

Initiatives to increase input from partners include an enhancement of the Center's website page to include direct links to the American Heart Association and other resources for health assessments and information. The Center has also initiated contact with the NYC Parks Department to develop an exercise program/walking program for employees and the community.

Prevention Priority Indicator: Chronic Disease – Coronary heart disease, Congestive Heart Failure, Diabetes and Stroke Hospitalization Rates.

NYHQ Initiative: Health Outreach® Public Education and Community Health Fair and Screening Program.

1: *Status:* Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

New York Hospital Queens Health Outreach® program is a longstanding community outreach initiative that is dedicated to the health and well-being of the community's senior population. The program includes an active education and early detection program that concentrates on the population's identified health priorities, especially cardiovascular health and diabetes risk and detection. The program operates from a store-front facility where seniors can access health information and assistance to navigate health care related issues.

In 2008, Health Outreach® staff and volunteers conducted 44 health fairs throughout Queens. More than 30 community partners hosted the Fairs in churches, synagogues, schools, and other community venues. Over 2,500 individuals benefited from the cardiovascular and diabetes screening services.

Blood Pressure – 2,512 participants

Blood Pressure Screening Exam: 2,512 participants

Glucose Screening: 2,459 participants Cholesterol Screening: 2,432 participants

Cardiovascular Risk Assessment: 1,164 participants

The program also includes screening for glaucoma, a recognized complication of diabetes that may also be related to hypertension. Health Outreach® partners with the New York Hospital Queens Eye Center and the Friends of the Congressional Glaucoma Caucus Foundation in this initiative. The program also provides free treatment at the Queens Eye Center for eligible candidates identified during screenings. More than 625 Queens residents were screened through the program in 2008 and more than 100 were referred to the Queens Eye Center for treatment.

In addition, 10 public health prevention and early detection lectures were sponsored in 2008 by Health Outreach® and held in the Hospital's Theresa and Eugene M. Lang Center for Education and Research Auditorium. The lectures are free and open to the public.

3: The Overall Goals of the Strategies

The overall goal of the initiative is to prevent hospitalization of community residents with cardiovascular disease and diabetes.

4: How the Goals will be measured for effectiveness.

The success of these and other collaborative partnership programs of Health Outreach® is continued community participation in prevention and disease management offerings and the achievement of NYS DOH 2013 Prevention Agenda targets for diabetes, cardiac disease and stroke related hospitalizations.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

The strategy will be modified by collaborating with the Cardiac Health Center and the Diabetes Care and Information Center of New York to coordinate initiatives and to explore potential for creation of a medical home model for diabetes disease management.

Prevention Priority Indicator: Community Preparedness - % of population living in jurisdiction with state-approved emergency preparedness plans.

NYHQ Initiative: Disaster Preparedness

1: *Status:* Existing program

2: How will the priority be addressed by the hospital and community partners and by whom?

New York Hospital Queens is an active participant in various emergency management related community forums, including the GNYHA Emergency Management Steering Committee that helps to set priorities for the GNYHA Emergency Preparedness Council.

The Hospital also participates in the New York-Presbyterian Health Care System emergency preparedness forum, the NYC Department of Health emergency preparedness coordinator's group, and an informal coalition of Queens' hospitals working together to develop memorandums of understanding for sharing of resources, and participation in drills and exercises.

In addition to the above greater community initiatives, NYHQ takes part in statewide desktop and community-based drills and exercises conducted by the NYS Department of Health, and citywide exercises conducted by the NYC Department of Health and/or Office of Emergency Management. Examples include our recent involvement with the H1N1 event, with both local and state DOH.

3: The Overall Goals of the Strategies

Collaborative goals established include ensuring hospital preparedness through a partnership with other emergency providers (police, fire, EMS) vis-a-vie, implementation of incident command through National Incident Management Systems (NIMS) and Hospital Incident Command Systems (HICS) training and response matrices, discussion of risks and hazards that can affect the entire area (coastal storms, surge capacity, mass fatality planning, evacuation and pandemic planning).

4: How the Goals will be measured for effectiveness.

The NYS DOH 2013 Prevention Agenda for this indicator has been achieved. However, ongoing measurement must continue to ensure that plans are evaluated for effectiveness.

New York Hospital Queens' actual state of readiness was recently tested during the H1N1 flu outbreak. The Hospital is in the epicenter of the virus' origin and experienced significant Emergency Department

volume surges during the eight-week peak course of viral activity. The Hospital's Chief Medical and Nursing Officers, along with Emergency Department and administrative leadership collaborated daily via teleconferences with the NYSDOH Metropolitan Area Regional Office, and other area hospitals to assess incidence and morbidity trends, and to share strategies regarding surge management. Collaboration during this period provided important input that formed the basis of current guidelines for a potential, and perhaps, more serious outbreak in the future.

5: How the strategies may be modified to include on-going input and support from the hospital's community partners.

The Hospital will remain closely aligned with, and work hand in hand with the Department of Health, public health experts, relevant communication specialists and other local and state agencies to modify emergency response plans, and to develop and disseminate appropriate information to the community as well as community-based organizations and resource providers based on the nature of the identified risk.

VI. Financial Aid Program

New York Hospital Queens (NYHQ) has always serviced both the underinsured and uninsured as part of its Mission. NYHQ conducts its financial aid program in full compliance with the policy and procedures set forth in the Financial Aid Law 2087.

The NYHQ application process is designed to be patient friendly. There is ample signage, which includes information regarding the Medical Center's Mission to provide quality care to all who need it, on display at all registration and intake points throughout the Medical Center as well as the various ambulatory care sites throughout the community. Financial Aid information is available in numerous languages including, but not limited to, English, Spanish, Chinese (Mandarin), Korean, Russian and Greek.

Incoming ambulatory patients are provided financial aid applications upon request. Their eligibility is determined utilizing an income scale based on federal poverty level (FPL) guidelines. Complete copies of the of the NYHQ financial aid policy and a summary of the financial aid laws, available in various languages, are also maintained at every registration point and are available upon request.

The NYHQ financial aid policy was expanded in 2008 from 300% of the federal poverty level (FPL) to 400%, enhancing the assistance provided to our patients. Enhanced computer software has been implemented to allow for presumptive eligibility for patients and families earning less than \$43,000 per year, speeding up the financial aid process.

NYHQ is in compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) and language need notifications. This is accomplished by generating quarterly preferred language reports. Current reports indicate that 15% of NYHQ patients prefer to speak Chinese (Mandarin), 9% Spanish, 5% Korean and 3% Russian. Quarterly reports are also generated by zip code to maintain and update our service area demographics.

The New York State Department of Health demographic service area, for New York Hospital Queens, is defined as the five boroughs of New York City plus the County of Nassau. NYHQ provides both emergency and elective services to patients in all of these areas. Internally generated reports indicate that 92% of those patients served are Queens County.

In 2007, NYHQ provided approximately \$10.5 million in financial assistance to both the underinsured and uninsured in our community. In 2008, that amount increased to approximately \$16.7 million in financial assistance to over 3,500 patients and families.

In 2009, in addition to increasing our financial aid to patients from 300% of the federal poverty level to 400%, services to the underinsured are being expanded as well. Coordinators have been assigned to both the Inpatient and Outpatient service lines. Full time staff are available on site to assist patients seeking financial aid.

VII. Changes Impacting Community Health Provision of Charity Care Access to Services

Potential barriers to expanded provision of charity care and expansion of access to services are largely based in financial threats associated with the following:

- Economic downturn impact resulting in unprecedented incremental financial burdens on hospitals, e.g., budget gap closure strategies like the MTA and employer taxes; increases in uninsured and underinsured resulting from rising unemployment; declining philanthropy.
- Declining reimbursement projected reductions in Medicare and Medicaid reimbursement and potential shift of funding from acute care to prevention programs before sufficient inpatient efficiencies have been achieved.
- Malpractice/defensive medicine forcing redirection of operating revenues from program support to increase reserves and fund settlements/judgments; proliferation of unnecessary testing; and most important, decreasing numbers of qualified physicians in primary care areas such as Obstetrics due to continuing increases in malpractice insurance premiums.
- Increased regulatory surveillance/tracking expansion of requirements for multiple regulatory agencies without additional funding to secure sufficient resources to mine, interpret, and report routine data and respond to inquiries.
- Continued rise in Labor costs salary and benefits demands continue to rise in the face of declining reimbursement; failing pension plans requiring increased funding.
- Lack of capital funding preventing expansion and addition of programs due to inadequate space and aging facilities.

VIII. Dissemination of the Report to the Public

A written summary of the CSP is available to the Public. Instructions for obtaining access to the Community Service Plan are posted in the Hospital's Lobby and in local newspapers.

The full <u>Community Service Plan</u> and summary are posted on the hospital website at <u>www.nyhq.org</u> The public can also make inquiries about the plan and obtain a printed copy of the summary by contacting the Department of Public Affairs and Marketing at 718-670-1065.

A copy of the summary pdf document is attached.