# Table of Contents

Expanding Our Reach to Help More Neighbors ........................................ 1
Community and Population Health Leadership ................................ .... 2
About NewYork-Presbyterian ............................................................. 3
Division of Community and Population Health: Our Mission .............. 4
Clinical Services: Ambulatory Care Network ..................................... 6
  Ambulatory Care Network Nursing ............................................... 11
  Telehealth .................................................................................. 13
Community Health Programs ........................................................... 14
  ANCHOR (Addressing the Needs of the Community Through Holistic, Organizational Relationships) .......................... 15
  Behavioral Health Clinical Services (Outpatient) ............................. 16
  Building Bridges, Knowledge and Health Coalition .......................... 18
  Center for Community Health and Education .................................. 19
  CCHE: Family Planning Program and Young Men’s Clinic ................. 20
  CCHE: School-Based Health Center Program ................................. 21
  CCHE: Uptown Hub ...................................................................... 22
  Center for Community Health Navigation ...................................... 24
  Centering Pregnancy Program and The Carnegie Hall Lullaby Project 26
  Collaborator Network Workforce Development and Training .......... 27
  Choosing Healthy & Active Lifestyles for Kids™ (CHALK) ................. 28
  Compass ..................................................................................... 30
  Community-Based Sexual Health .................................................. 31
  Cultural Competency and Health Literacy Workgroup ....................... 35
Health & Housing ........................................................................ 36
Health for Life ............................................................................. 37
Health Home ............................................................................... 38
Healthy City Kids ......................................................................... 39
Lang Youth Medical Program ......................................................... 40
Manhattan Cancer Services Program ............................................... 41
NewYork-Presbyterian Performing Provider System Impact Grants ...... 42
Outreach Program ........................................................................ 43
Reach Out and Read Program ........................................................ 44
The Family PEACE (Preventing Early Adverse Childhood Experiences) Trauma Treatment Center .......................... 45
Turn 2 Us (T2U), ............................................................................ 46
Waiting Room As a Literacy & Learning Environment (WALLE) .......... 47
Women, Infants, and Children Program (WIC) ................................. 48
Workforce Development and Training: Payment Reform Resources and Support ........................................... 49
Education and Training ................................................................ 50
Health Reform ............................................................................ 53
Healthcare Networks .................................................................... 54
Expanding Our Reach to Help More Neighbors

The year 2018 was one of growth and expansion for the Division of Community and Population Health, enabling us and our collaborators to provide healthcare services, education, and linkage to care to more people than ever before — including those who live near other hospitals within the NewYork-Presbyterian regional network. Efforts such as these link residents of our communities with high-quality health care, as well as encourage them to advocate for their own health and that of their family members.

NewYork-Presbyterian has a long history of caring for our community. In addition to providing care to residents of Washington Heights and Inwood, the Upper East Side, East Harlem, and northwest Queens, we can now meet the needs of other residents through initiatives such as:

• The Center for Community Health Navigation, which expanded their work to NewYork-Presbyterian Brooklyn Methodist Hospital and NewYork-Presbyterian Queens.

• The Uptown Hub, a Youth Opportunity Hub that empowers members to advocate for themselves and reach their personal, academic, and career aspirations.

• Health for Life — a comprehensive weight management program for children, teens, and their families — was expanded to the Ambulatory Care Network Broadway Practice.

• Choosing Healthy & Active Lifestyles for Kids (CHALK) expanded to the George Washington High School Campus and now provides services for adolescents.

• We are investing in telehealth to increase access to our services and have achieved favorable results in this year’s pilot programs in neurology, dermatology, pharmacy, and behavioral health.

• We are reaching more individuals than ever before through our targeted outreach efforts, with more than 4,000 people served in 2018 through a variety of public health initiatives.

Our teams are increasingly identifying and addressing social determinants of health outcomes, such as the presence of trauma in the home. At the Second Annual Clergy Summit, members of the Building Bridges, Knowledge and Health Coalition engaged 100 faith-based members who heard a minister, a local politician, and doctors from the Family PEACE program and NewYork-Presbyterian psychiatric practices address this year’s theme: Trauma — Compassionate Care and Communities of Faith. ANCHOR (Addressing the Needs of the Community through Holistic Organizational Relationships) staff members conducted a survey to better understand health practices and social determinants of outcomes, with the goal of connecting residents with community-based organizations.

This report also details our educational programs, including Pediatric and Adolescent, Adult Medicine, and Family Medicine residency programs, initiatives led by nurses and advanced practice nurses to educate their colleagues, and the Lang Youth Medical Program for underserved middle school and high school students. These programs bolster the future of community health by providing guidance for tomorrow’s leaders today.

In 2019, we will undergo a Community Health Needs Assessment of our ten campuses, in collaboration with community members, patients, public health experts, and local health officials. We look forward to the results of this analysis, which will help guide our public health strategy in the years to come.

Sincerely,

Paul J. Dunphy
Senior Vice President & Chief Operating Officer
NewYork-Presbyterian Allen Hospital & Ambulatory Care and Community Health Network
Community and Population Health Leadership

Paul J. Dunphey
Senior Vice President & Chief Operating Officer
NewYork-Presbyterian Allen Hospital & Ambulatory Care and Community Health Network

Nelson Mesa
Director
Ambulatory Quality Improvement

Davina V. Prabhu
Vice President
Ambulatory Care Network

Andres Nieto
Director
Community Health Outreach & Marketing

Elaine Fleck, MD
Associate Chief Medical Officer
NewYork-Presbyterian Ambulatory Care Network - Associate Clinical Professor Columbia University Irving Medical Center

Jennie Overell
Director
Ambulatory Care Network NewYork-Presbyterian/Columbia

Mark Krugman, RN
Director of Nursing
Ambulatory Care Network

Alpa Prashar
Director of Operations
NewYork-Presbyterian is one of the nation’s most comprehensive, integrated academic healthcare systems, dedicated to providing the highest quality, most compassionate care to patients in the New York area, nationally, and across the globe. In collaboration with two renowned medical schools, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons, NewYork-Presbyterian is consistently recognized as a leader in medical education, groundbreaking research, and innovative, patient-centered clinical care.

NewYork-Presbyterian has four major divisions:

- **NewYork-Presbyterian Hospital**
  NewYork-Presbyterian Hospital is ranked #1 in New York and a top five hospital in the nation in U.S. News & World Report’s “Best Hospitals” survey.

- **NewYork-Presbyterian Regional Hospital Network**
  Comprised of leading hospitals in and around New York and delivers high-quality care to patients throughout the region.

- **NewYork-Presbyterian Physician Services**
  Connects medical experts with patients in their communities to expand coordinated healthcare delivery across the region.

- **NewYork-Presbyterian Community and Population Health**
  Encompasses ambulatory care network sites and community healthcare initiatives, including NewYork Quality Care, an Accountable Care Organization.

### THE SEVEN-CAMPUS ACADEMIC MEDICAL CENTER

- **NewYork-Presbyterian/Weill Cornell Medical Center**
  525 East 68th Street
  New York, NY 10065
  212-746-5454

- **NewYork-Presbyterian/Columbia University Irving Medical Center**
  622 West 168th Street
  New York, NY 10032
  212-305-2500

- **NewYork-Presbyterian Lower Manhattan Hospital**
  170 William Street
  New York, NY 10038
  212-312-5000

### REGIONAL HOSPITAL NETWORK

- **NewYork-Presbyterian Brooklyn Methodist Hospital**
  506 6th Street
  Brooklyn, NY 11215
  718-780-3000

- **NewYork-Presbyterian Morgan Stanley Children’s Hospital**
  3959 Broadway
  New York, NY 10032
  800-245-KIDS

- **NewYork-Presbyterian Lawrence Hospital**
  55 Palmer Avenue
  Bronxville, NY 10708
  914-787-1000

- **NewYork-Presbyterian Allen Hospital**
  5141 Broadway
  New York, NY 10034
  212-932-4000

- **NewYork-Presbyterian Westchester Division**
  21 Bloomingdale Road
  White Plains, NY 10605
  914-682-9100

### 2018 FACTS AND FIGURES

#### Leadership
- **Steven J. Corwin, MD**
  President and Chief Executive Officer

- **Laura L. Forese, MD**
  Executive Vice President and Chief Operating Officer

#### Employees
- Full Time Equivalent: 47,217
- Residents and Fellows: 2,527
- Attending Physicians: 7,736
- Total Physicians: 10,263

#### Inpatient Statistics
- Total Beds: 4,067
- Inpatient Days: 1,249,949
- Discharges: 220,481
- Deliveries: 25,857

#### Outpatient Statistics
- Total Outpatient Visits: 3,428,630
- Ambulatory Surgeries: 155,399
- Emergency Department Visits (includes ED admissions): 693,454

#### Neighborhood Statistics
- Medical Group Visits: 2,326,092
- Clinic Visits: 986,070
- Telehealth Visits: 106,736

#### Payor Mix
- Medicare: 36.1%
- Medicaid: 29.5%
- Commercial: 33.0%
- Self Pay: 1.2%

For more information, visit www.nyp.org and find us on Facebook, Twitter, Instagram, YouTube and Healthmatters.nyp.org

Find a Doctor Referral Call Center
877-NYP-WELL
www.nyp.org
NewYork-Presbyterian’s Division of Community and Population Health collaborates with community, hospital, and academic organizations to improve the health and well-being of children, adolescents, and adults in the communities we serve.

The Division conducts a comprehensive community needs assessment every three years to increase our understanding of the health and social needs of the communities we reach. Based on the results, we create a community service plan outlining health priorities we will address and our approach to each one. We leverage NewYork-Presbyterian and community resources to decrease local health disparities through innovative population health initiatives, care provider training, scholarship, and research that are collaboratively developed, executed, assessed, and maintained. The combination of NewYork-Presbyterian’s skills and resources with the talents, energy, and resources of our community partners enables us to achieve our goals. Together, we aim to reduce hospital length of stay, avoidable emergency department visits, inpatient admissions, and readmissions within 30 days. These efforts also support initiatives that:

- Empower individuals and families to promote health and wellness
- Better navigate local systems of care and local resources
- Improve school readiness and academic achievement
- Ultimately improve quality of life
NewYork-Presbyterian has a history of working to enhance the health of individuals in our surrounding communities.

A Long-Term Commitment to Our Neighbors

NewYork-Presbyterian has a history of working to enhance the health of individuals in our surrounding communities. As one of the largest academic medical centers in the country, we leverage our patient care, research, and educational resources to address health inequities at the local level. In the Washington Heights and Inwood (WHI) communities, we and our community collaborators have united for more than 30 years to build the infrastructure needed to bolster and maintain vital population health initiatives.

Who We Serve

The WHI communities are highly diverse. More than 70% of residents identify as Hispanic and have encountered cultural, social, and language obstacles to care. WHI also experiences a disproportionate health burden compared to the rest of New York City. One in three residents lives below the poverty line. Diabetes, asthma, heart failure, depression, and childhood obesity are major health concerns. WHI is a federally designated “empowerment zone,” indicating that it has one of the greatest concentrations of poverty in the United States and is eligible for special grants, loans, and investments to improve residents’ lives.

Some 524,000 people live in the NewYork-Presbyterian/Weill Cornell Medical Center area, which includes communities of the Upper East Side of Manhattan, East Harlem, and northwest Queens. Twenty-five percent of the NewYork-Presbyterian/Weill Cornell region is of Hispanic descent, with an additional 11% African American and 11% Asian/Pacific Islander. Thirty-one percent of the population in this region is foreign born. While English is the most common language, 22% report Spanish as their primary language. There are more than 125,000 people on Medicaid living in the NewYork-Presbyterian/Weill Cornell area, and 13% do not have health insurance.
Clinical Services: Ambulatory Care Network
The Ambulatory Care Network touches all of our communities, making it easier for everyone to access high-quality, affordable, patient-friendly care in their own neighborhoods.

NewYork-Presbyterian’s Division of Community and Population Health provides clinical services through its Ambulatory Care Network (ACN), which includes 14 primary care sites, seven school-based health centers, 13 mental health school-based programs, and over 60 specialty practices. We serve generations of families from across New York City who represent a wide array of nationalities and ethnic and religious backgrounds.

The Ambulatory Care Network touches all of our communities, making it easier for everyone to access high-quality, affordable, patient-friendly care in their own neighborhoods. We provide a broad range of services. When specialized care or hospitalization is required, our compassionate and helpful staff coordinate patients’ needs with the extraordinary range of specialty programs and resources available at NewYork-Presbyterian.

All of our Ambulatory Care Network primary care practices are Patient-Centered Medical Homes, where patients receive care from a team of dedicated healthcare providers, led by their primary doctors. With patient participation, the medical team coordinates and manages treatment plans so patients and their families receive the best care. With the support of State funding and generous donors, we have continued to enhance our clinical care by implementing innovative programs targeting specific health needs in the communities we serve. We have embedded these programs seamlessly into our practice operations, and they function in collaboration with our clinical staff to ensure our patients receive the care they need. The following is a description of some of our clinical offerings.

**Ambulatory Care Network Primary Care Improvement**

Through DSRIP, there have been a number of targeted efforts to improve the quality of care and health outcomes for high-risk and high-cost adult and pediatric populations with complex care needs in the Ambulatory Care Network’s primary care practices. Culturally competent and family-centered nurse care managers, social workers, psychiatric nurse practitioners, and community health workers (CHWs) have been augmented and embedded in practices to coordinate care. Collaboration has increased among providers and community-based organizations to meet the needs of the population. Palliative care screening, risk assessment, and dedicated staffing have been integrated within practices to address unmet palliative care needs. More than 16,000 adults and 10,000 patients have been reached, and over 1,600 have received palliative care.

The NewYork-Presbyterian Performing Provider System has numerous programs across the Hospital and collaborator network to connect patients and families with the care they need.
**Behavioral Health (BH) Crisis Program**

Heather Straccia MD, CTI, *Clinical Lead*
hs2736@cumc.columbia.edu

Warren Y.K. Ng, MD, MPH, *Medical Director*
Outpatient Behavioral Health
ywn9001@nyp.org

Supported by DSRIP initiatives, the BH Community Crisis Stabilization Program transformed our outpatient psychiatric services by developing two new key interventions: a Critical Time Intervention Team (CTI) and BH Crisis HUB. The BH Crisis HUB and Treat-Link-Connect Brief Crisis Treatment Program were integrated into Adult Outpatient Behavioral Health Services. These programs target patients with comorbid behavioral health, substance use, and social determinants of health needs by providing rapid triage, assessment, and linkage to comprehensive services, utilizing a multidisciplinary team in partnership with community-based organizations and providers.

- The CTI team assists patients in potentially destabilizing periods of transition as well as intensive behavioral health services in the community for three to nine months. Most patients have co-occurring substance use issues, chronic medical conditions, unstable housing, and psychosocial stressors. Since the program began in 2017, the CTI team has cared for 124 patients, and the 30-day hospital readmission rate has declined from 50% to 19%. Patients with chronic medical conditions, including those that had not been effectively treated, have received extensive health management and linkage to appropriate medical care.

- The BH Crisis HUB has served over 900 patients and provides effective linkage to outpatient medical and psychiatric/substance use treatment.

**Tobacco Cessation Services**

David Albert, DDS, MPH, *Clinical Lead*
daal@cumc.columbia.edu

Julie Chipman, *Program Manager*
chipmaj@nyp.org

Tobacco Treatment Services (TTS) facilitates adoption of tobacco treatment by Ambulatory Care Network and Hospital clinicians. The team — patient navigators and nurse practitioners who are dedicated to TTS or are content experts who integrate TTS into their primary care roles — has engaged nearly 3,700 ACN patients in tobacco treatment. In 2018, the team trained providers and medical assistants on tobacco treatment and engagement across the ACN and continued outreach activities in the practices. TTS staff organized a texting campaign with ACN adult patients and tabling events across the clinics in November to raise awareness about The Great American Smokeout. The program expanded into areas with a high concentration of tobacco users, including the Pulmonology Clinic and Adult Psychiatry Clinic; developed new educational materials on hookah and other tobacco products; and introduced the use of carbon monoxide monitors (an important diagnostic tool in tobacco treatment and prevention education) into the ACN. The TTS team participated in community activities, including tobacco treatment educational workshops, health fairs, and sponsorship of an annual Tobacco Treatment Specialist training for hospital and community-based organizations in the tri-state area.
Health Information Exchange Expansion

Patricia Hernandez, LCSW, Manager
pah9051@nyp.org

The Division of Community and Population Health uses the Health Information Exchange to support team-based care across the Hospital and the network of community-based collaborators. The Division employs Healthix — a New York State-sponsored information exchange platform — to enhance access to patient records across health providers; improve receipt of clinical event notifications (targeted messages on patients’ use of emergency departments, inpatient facilities, and so forth); and improve community provider access to a patient’s health data from across New York State. To date, the Division has granted access to 14 community-based collaborators, with three more organizations scheduled to go live in 2019. In addition to working on granting access to more collaborators, the Division is focusing on adoption and usability across the network of collaborators.

Transitions of Care Program

Leslie Chiu, Manager
ima9008@nyp.org

Claudia Beck, Clinical Lead
cbb9003@nyp.org

The Transitions of Care (ToC) program strengthens continuity of care between NewYork-Presbyterian inpatient units and subsequent settings to reduce the risk of avoidable 30-day readmissions to the hospital and/or emergency department. The ToC model operates at NewYork-Presbyterian Allen Hospital, Columbia University Irving Medical Center, Weill Cornell Medical Center, and Lower Manhattan Hospital. The goals of the program are to identify and engage Medicaid patients at increased risk for readmission and to provide education for these patients and their caregivers on disease and self-management; facilitate timely follow-up with primary care provider(s); and coordinate medical and social service needs to overcome barriers to safe transitions. Among 30-day care transitions in 2018, 594 patient discharges were reached, and there were 833 high-utilizer discharges through the MAX Series at NewYork-Presbyterian/Columbia — a New York State-sponsored initiative to improve care pathways for high utilizers of inpatient care. There was a 4% reduction in the 30-day readmission rate from 2016-17 (40%) to 2018 (36%). The NewYork-Presbyterian/Columbia team expanded on previous MAX Series efforts at NewYork-Presbyterian/Weill Cornell, implementing new assessments by Emergency Department care coordinators and social workers to identify drivers of utilization and establish daily huddles to link patients with various community teams. The ToC team also expanded in October 2018 to include an embedded care coordinator and part-time outreach specialist employed by ACMH, Inc., an agency focused on patients with behavioral health needs.

SPECIALTY PRACTICES

Same Day Access Center
21 Audubon Avenue
at West 166th Street, 1st Floor
New York, NY 10032
212-342-4700

NewYork-Presbyterian/Weill Cornell Medical Center
525 East 68th Street
New York, NY 10065

Cardiology 646-962-5558
Dentistry (adult) 212-746-5190
Dentistry (pediatric) 212-746-5119
Endocrinology 212-746-6285
Neurology 212-746-2323
Orthopedics 212-746-4500

NewYork-Presbyterian/Columbia University Irving Medical Center
622 West 168th Street
New York, NY 10032
866-463-2778

Allergy, Audiology, Dermatology, ENT (adult and pediatric), Neurology (adult and pediatric), Nutrition, Ophthalmology, Orthopedics (adult and pediatric), Urology (adult and pediatric), Pulmonary Medicine, Rehabilitation Medicine, Speech Pathology

Grants Received
Total Grant Awards in 2018: $14,358,486
Includes both government and foundation grant support
# Ambulatory Care Network Community Practices

## COLUMBIA UNIVERSITY VOLUME BY PRACTICE – 2018 VISITS

<table>
<thead>
<tr>
<th>PRIMARY CARE</th>
<th>VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM Group</td>
<td>68,455</td>
</tr>
<tr>
<td>Audubon</td>
<td>34,330</td>
</tr>
<tr>
<td>Broadway</td>
<td>40,437</td>
</tr>
<tr>
<td>Farrell</td>
<td>23,834</td>
</tr>
<tr>
<td>Rangel</td>
<td>19,853</td>
</tr>
<tr>
<td>Urgicare Center</td>
<td>10,470</td>
</tr>
<tr>
<td>Washington Heights</td>
<td>34,948</td>
</tr>
</tbody>
</table>

### SUBTOTAL PRIMARY CARE 232,327

<table>
<thead>
<tr>
<th>SPECIALTY CARE</th>
<th>VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>1,166</td>
</tr>
<tr>
<td>Child Advocacy</td>
<td>320</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>855</td>
</tr>
<tr>
<td>Comprehensive Health</td>
<td>19,169</td>
</tr>
<tr>
<td>Dermatology</td>
<td>9,574</td>
</tr>
<tr>
<td>Family Planning</td>
<td>23,288</td>
</tr>
<tr>
<td>Ft. Washington</td>
<td>2,990</td>
</tr>
<tr>
<td>Movement Disorder</td>
<td>613</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>19,399</td>
</tr>
<tr>
<td>PEACE Program</td>
<td>2,165</td>
</tr>
<tr>
<td>School Based</td>
<td>22,354</td>
</tr>
<tr>
<td>Thyroid</td>
<td>575</td>
</tr>
</tbody>
</table>

### SUBTOTAL SPECIALTY CARE 102,468

## VC3 CLINICS VISITS

<table>
<thead>
<tr>
<th>VC3 CLINICS</th>
<th>VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>VC3 - Allergy</td>
<td>866</td>
</tr>
<tr>
<td>VC3 - Ortho</td>
<td>7,110</td>
</tr>
<tr>
<td>VC3 - Pediatric Neuro</td>
<td>1,409</td>
</tr>
<tr>
<td>VC3 - Pediatric Ortho</td>
<td>1,363</td>
</tr>
<tr>
<td>VC3 - Psychiatry</td>
<td>1,447</td>
</tr>
</tbody>
</table>

### SUBTOTAL VC3 12,195

## VC10 CLINICS VISITS

<table>
<thead>
<tr>
<th>VC10 CLINICS</th>
<th>VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>VC10 - Chest</td>
<td>2,182</td>
</tr>
<tr>
<td>VC10 - Neurology</td>
<td>3,791</td>
</tr>
<tr>
<td>VC10 - Neurosurgery</td>
<td>562</td>
</tr>
<tr>
<td>VC10 - Newborn</td>
<td>1,854</td>
</tr>
<tr>
<td>VC10 - Newborn Nutrition</td>
<td>1,048</td>
</tr>
<tr>
<td>VC10 - Nutrition</td>
<td>1,092</td>
</tr>
<tr>
<td>VC10 - Otolaryngology</td>
<td>4,565</td>
</tr>
<tr>
<td>VC10 - Special Gyn</td>
<td>1,117</td>
</tr>
</tbody>
</table>

### SUBTOTAL VC10 16,211

## PSYCH CLINICS VISITS

<table>
<thead>
<tr>
<th>PSYCH CLINICS</th>
<th>VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Psych</td>
<td>23,191</td>
</tr>
<tr>
<td>Pediatric Psych</td>
<td>29,220</td>
</tr>
</tbody>
</table>

### SUBTOTAL PSYCH 52,411

## TOTAL SPECIALTY CARE 183,285

## TOTAL COLUMBIA UNIVERSITY ACN 415,612

## WEILL CORNELL VOLUME BY PRACTICE 2018 VISITS

<table>
<thead>
<tr>
<th>PRIMARY CARE</th>
<th>VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>17,886</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>16,508</td>
</tr>
<tr>
<td>WCIMA</td>
<td>50,934</td>
</tr>
<tr>
<td>WCIMA at Wright</td>
<td>6,486</td>
</tr>
<tr>
<td>Wright Center on Aging</td>
<td>9,803</td>
</tr>
</tbody>
</table>

### SUBTOTAL PRIMARY CARE 101,617

## SPECIALTY CARE VISITS

<table>
<thead>
<tr>
<th>SPECIALTY CARE</th>
<th>VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Dental</td>
<td>8,147</td>
</tr>
<tr>
<td>Baker CSS</td>
<td>12,775</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2,295</td>
</tr>
<tr>
<td>Chelsea CSS</td>
<td>14,196</td>
</tr>
<tr>
<td>CSS Dental</td>
<td>1,574</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>782</td>
</tr>
<tr>
<td>Fracture</td>
<td>431</td>
</tr>
<tr>
<td>Hand Surgery</td>
<td>189</td>
</tr>
<tr>
<td>Neurology</td>
<td>2,636</td>
</tr>
<tr>
<td>Pediatric Dental</td>
<td>3,069</td>
</tr>
<tr>
<td>PFT Lab</td>
<td>881</td>
</tr>
</tbody>
</table>

### SUBTOTAL SPECIALTY CARE 46,975

## TOTAL WEILL CORNELL ACN 148,592

## METHADONE VISITS

<table>
<thead>
<tr>
<th>METHADONE</th>
<th>VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult HIV SVC</td>
<td>1,314</td>
</tr>
<tr>
<td>Adult</td>
<td>27,755</td>
</tr>
</tbody>
</table>

### TOTAL METHADONE 29,069

## TOTAL NUTRITION 1,396

## ACN-Payor Mix 2018 Sum of Cases

<table>
<thead>
<tr>
<th>Payor Type</th>
<th>Sum of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Managed</td>
<td>49%</td>
</tr>
<tr>
<td>Medicare Managed</td>
<td>14%</td>
</tr>
<tr>
<td>Medicare FFS</td>
<td>11%</td>
</tr>
<tr>
<td>Commercial</td>
<td>11%</td>
</tr>
<tr>
<td>Medicaid FFS</td>
<td>10%</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>
AMBULATORY CARE NETWORK NURSING

Nurses in NewYork-Presbyterian’s Ambulatory Care Network are committed to ensuring patients receive the best care possible. Working to the highest level of their licenses, they follow the Professional Practice Model, which is characterized by:

• **Advocacy.** Empowering patients, families, communities, and colleagues to ensure culturally competent and compassionate care.

• **Autonomy.** Fostering self-directed practice through critical thinking and accountability.

• **Collaboration.** Promoting interprofessional communication and coordination of patient- and family-centered care.

• **Evidence-based practice.** Integrating clinical expertise, scientific findings, and patient preferences to improve outcomes.

• **Professional development.** Committing to personal, clinical, and scholarly growth to optimize the patient experience. RNs are certified in their specialties and use the clinical ladder to advance their professional growth, as well as teach nursing staff about various topics to enhance their development and competencies. Advanced practice nurses have their PhDs, DNPs, and Certificates in Mental Health in primary care and other specialties.

Committee Leadership and Participation

Nurses and advanced practice nurses chair, co-chair, and participate in various committees, such as the monthly Practice Committee, Quality & Patient Safety, Magnet Committee, and the Advanced Practice Nurses Committee. They are involved in decision-making at the practice and department levels, collaborate with various disciplines to enhance care, and contribute their input regarding practice and policy changes, evidenced-based projects, and standardization of care.

Expediting Primary Care

Through the Centralized Clinical Telephone Center, nurses take calls from primary care sites to assist patients with prescription refills, triage care, and speeding the ability to meet patient care needs, with the goal of decreasing Emergency Department and walk-in visits. This support enables staff at practice sites to deliver care to patients with fewer interruptions.

Supporting School-Based Health Centers

Self-directed advanced nurse practitioners provide comprehensive care, vaccinations, and other services to nearly 6,000 enrolled children and adolescents at seven school-based health centers in the community. Nurses collaborate with medical directors, nursing and operational management teams, school administrators, and other professionals to provide high-quality care to students each day.
**AMBULATORY CARE NETWORK NURSING continued**

**Interdisciplinary Collaboration**

Nurses collaborate with other disciplines throughout the network on various initiatives, such as:

- The Baby-Friendly Designation, by interviewing patients to evaluate their baseline knowledge, encouraging mothers to breast feed and providing education on its importance and health benefits for infants, and providing a baby-friendly environment at practice sites.
- Taking active roles in telemedicine at practices where nurses triage patients and assist them through the telehealth process and follow-up.
- Support groups for siblings of children with chronic conditions, a joint venture between nurses and child life specialists. These siblings often experience high anxiety and sadness. A six-week curriculum was developed to address family dynamics, worries, coping skills, and self-esteem building.
- Serving as facilitators and educators for Centering Pregnancy, which provides new mothers with education and support during pregnancy and the early period after childbirth. This program has resulted in a decrease in low birthweight babies, preterm deliveries, and sexually transmitted diseases and an increase in breastfeeding rates. (For more information, page 26.)

**Magnet Designation and Journeys**

In 2019, NewYork-Presbyterian/Weill Cornell achieved the prestigious Magnet® recognition from the American Nurses Credentialing Center. The work to get to this point began years before 2019, with nurses examining data and methods to improve patient outcomes, enhancing communication among nurses, and encouraging nursing engagement through collaborative work, peer review, and ensuring they have a voice to enhance patient care and safety through committees, policy changes, and onsite activities. NewYork-Presbyterian Allen Hospital has begun its Magnet journey to seek this designation.

**Sharing Research and Expertise**

Advanced practice nurses are involved in scholarly activities, presenting and publishing their work regionally and nationally on programs such as:

- Eating Healthy Living health project
- Expedited partner treatment for *Chlamydia* in female adolescents (poster presentations and peer-reviewed journal articles)
- Providing intrauterine devices to adolescents in nontraditional settings (book chapter)
- Use of acupressure to treat dysmenorrhea in female adolescents (manuscript in preparation)
Mission and Goals

In 2018, the Division of Community and Population Health began piloting telehealth services across primary care, specialty care, and behavioral health settings. Building on NYP OnDemand, NewYork-Presbyterian’s comprehensive digital health service platform, the Division is using telehealth technology to support its mission of improving health and well-being in the communities we serve by:

- Increasing access to high-quality primary care, specialty care, and behavioral health services.
- Improving outcomes in people with chronic conditions (such as chronic obstructive pulmonary disease, diabetes, and high blood pressure) and reducing the length of inpatient hospital stays due to these conditions.
- Reducing avoidable trips to the emergency department.

By shifting the model of care delivery, the Division is looking to increase incremental access and meet our patients where they are — in our practice sites, in their homes, and in the community.

Number of People Reached
April-December 2018: 432 visits

Access Improvement Highlights

<table>
<thead>
<tr>
<th>Program</th>
<th>In-Person Lag</th>
<th>Telehealth Lag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>9 weeks</td>
<td>24 hours</td>
</tr>
<tr>
<td>Dermatology</td>
<td>5 weeks</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Med Management</td>
<td>7 days</td>
<td>24 hours</td>
</tr>
<tr>
<td>Behavioral Health Management</td>
<td>3 months</td>
<td>3 weeks</td>
</tr>
</tbody>
</table>
Community Health Programs
Mission and Goals

In 2017, the Division of Community and Population Health received funding from the Center for Medicare and Medicaid Innovation (CMMI) Accountable Health Communities (AHC) program to systematically address patients’ health-related social needs through universal screening and referrals to community service providers. The Division leveraged the grant’s resources to standardize and expand existing Ambulatory Care Network pre-visit screening efforts, transitioning from paper- to tablet-based screening across the following domains: depression, substance use, asthma, housing, food insecurity, transportation, utilities, and domestic violence. In 2018 (the second year of the AHC grant), 3,970 patients in three ambulatory care sites and three emergency departments received tablet-based clinical and/or social needs screening. By screening for health-related social needs and clinical risk factors, the Hospital seeks to identify the most vulnerable patients and improve their access to preventive services through social and clinical interventions in the community.

By screening for health-related social needs and clinical risk factors, the Hospital seeks to identify the most vulnerable patients and improve their access to preventive services through social and clinical interventions in the community.

Number of People Reached

3,970 Number of patients screened
190 Number of high-risk patients accepting navigation services and referred to community-based organizations
55 Number of patients whose identified psychosocial needs have been resolved
The Division of Community and Population Health at Columbia University Irving Medical Center has developed comprehensive Behavioral Health Outpatient Clinical Services for children, adolescents, and adults to better meet the needs of our community. Many services are provided in partnership with community-based programs and/or within community primary care clinics or schools. Behavioral Health Clinical Services are comprised of two comprehensive clinical components: Child/Adolescent and Adult clinical services.

CHILD/ADOLESCENT BEHAVIORAL HEALTH SERVICES

Community and Acute Child and Adolescent Outpatient Services

Liora Hoffman, PhD
Program Clinical Director
Denise Leung, MD
Program Medical Director

Special Needs Clinic and School-Based Mental Health Program

Alexandra Canetti, MD
Program Medical Director
Jennifer Cruz, PhD
Program Clinical Director

Mission and Goals

Child/Adolescent Psychiatric Services provides the highest quality community-based mental health care to our youth and their families. Mental health needs influence medical, social, educational, and occupational outcomes for families in our community; our care promotes health and wellness. Direct clinical care serves over 2,000 families annually, with prevention interventions having a wide-reaching impact. Comprehensive clinical services create a spectrum of mental health care reaching from homes and schools in the community to primary care and hospital-based clinic programs. A tiered approach to care equips our partners, reduces stigma, and provides intensive care for those most in need.

Number of People Reached

2,100+ Children and adolescents receiving mental health care
33,000+ Child and adolescent mental health visits
2,000+ Youth impacted by intensive school-based prevention interventions

Key Accomplishments

Child/adolescent behavioral health services are integrated into the community to meet families where they are and provide services across diverse settings. The Child and Adolescent Community Clinic at NewYork-Presbyterian Morgan Stanley Children's Hospital provides premier care for families using innovative, evidence-based treatments for children and adolescents from birth through age 21 in their homes, in schools, and in primary care settings.

- The Home-Based Crisis Intervention Program features a fully bilingual English/Spanish team that uses evidence-based approaches adapted for the community to provide the highest quality of care to those with the highest need.

- The School-Based Mental Health Program provides psychological evaluation, treatment, consultation, and workshops to children (ages 4-13, grades pre-K through 8), families, and school staff—coordinating with our Home-Based Crisis Intervention Teams to ensure care is integrated from home to school for children with the highest need.

- The innovative Integrated Mental Health Program (IMP), embedded within four community pediatric primary care ACN clinics, provides psychiatric and psychological services.

Specialty programs meet specific care needs for youth and families and include:

- The Special Needs Clinic for families with children who have a chronic illness and are struggling with mental health and medical needs. Family members can receive care alongside their children to improve outcomes and increase access.

- The Promise Project at Columbia (for Learning Disorders) offers comprehensive neuropsychological evaluations and advocacy for underserved children with learning disorders and serves over 300 youth per year.
• The NewYork-Presbyterian Youth Anxiety Center serves emerging adults in need of targeted mental health care. The programs support and empower young adults in collaboration with community-based organizations and aim to reduce disparities in access to care.

We also provide training sessions and workshops for community providers, teachers, and parents to equip them to provide the highest quality, community-based mental health care.

ADULT OUTPATIENT BEHAVIORAL HEALTH SERVICES

Carisa Kymissis, MD
Program Medical Director

Diana Punales, PhD
Supervising Psychologist

Mission and Goals

The Adult Outpatient Psychiatry Clinic provides culturally and linguistically responsive mental health care, ensuring that every patient is treated with the utmost respect and empathy and offering the highest quality training to the next generation of clinicians. Individual and group psychotherapy, family and couples counseling, psychopharmacology, psychological testing, and social work consultations are available. Clinicians also address issues associated with the stigma and discrimination that patients with mental illness and their families may experience. Through a centralized intake system, we process referrals to facilitate admission to our clinic and enhance each patient’s psychiatric treatment experience.

Number of People Reached

1,400+ Adults who received mental health care
26,000+ Adult mental health visits

Key Accomplishments

Specialty programming offered in our clinic includes:

• Dialectical Behavior Treatment (DBT) program, offering all five modes of DBT (individual therapy, skills group, phone coaching, consultation team, and case management) in Spanish and English, delivered by psychologists, psychiatrists, social workers, and substance abuse counselors.

• Clinic-based crisis intervention services from social work and psychiatric providers to identify patients requiring more intensive coordination of care due to the complexity of their care needs. The team also provides real-time linkage to long-term mental health care.

• Specialty treatment services for individuals and family members affected by HIV, LGBTQ individuals, people with co-existing mental health and substance abuse disorders (MICA services), monolingual Spanish-speaking patients, and pregnant and post-partum women.

• Training across disciplines, including clinical psychology interns and externs, medical residents, and medical students.

In addition, the Adult Integrated Mental Health-Primary Care Program (IMP) provides integrated mental health services to patients in NewYork-Presbyterian ambulatory primary care practices, including consultations and short-term treatment. The IMP program is committed to universal screening for depression and has incorporated the Collaborative Care model, with psychiatrists supervising behavioral care managers to ensure patients achieve meaningful improvement of their mental health symptoms.
Building Bridges, Knowledge and Health

Mission and Goals

Building Bridges, Knowledge and Health (BBKH) is a coalition of faith and community-based organizations that collaborate to decrease racial/ethnic health disparities and enhance the health and well-being of residents of Northern Manhattan, Harlem, and the Bronx. Church members are a valuable resource for the BBKH coalition. They work as conduits of good health to respond to community health needs and implement interventions that achieve meaningful and lasting results.

NewYork-Presbyterian Outreach has collaborated with BBKH member churches — including the Narrow Door Church, Christ Church, and Grace Tabernacle in the Bronx, where we provided free vision and blood pressure screenings and instruction in Hands-Only CPR training. In partnership with NewYork-Presbyterian Breast Surgeon Lisa Wiechmann, MD, we also presented free cancer workshops for three community churches. Finally, last fall, the first Spanish 12-week heart health education course was offered at one of our member churches.

Number of People Reached

In 2018, NewYork-Presbyterian — in partnership with BBKH program members — again supported New York City First Lady Chirlane McCray’s Thrive NYC initiative by offering Mental Health First Aid trainings to 200 community members. We hosted our Second Annual Clergy Summit, where nearly 100 faith-based members heard Rev. Dr. Lakeesha Walrond, Assembly member Carmen De La Rosa, and doctors from the Family PEACE program and NewYork-Presbyterian psychiatric practices address this year’s theme: Trauma — Compassionate Care and Communities of Faith. Our communities struggle with past and daily traumas, and our places of worship grapple with many of these challenges. They learned that by applying the principles of trauma-informed care, our houses of worship can bring healing and become a safe haven for those who suffer.

Key Accomplishments

Each year, BBKH partners with the NewYork-Presbyterian Outreach Program to host the Day of Hope Community Health Event in East Harlem and Hope Day in the Bronx, attracting over 1,000 city residents who access free health screenings, information, counseling, resources, medical referrals, and health insurance information. Through telephone follow-up, participants can be connected to primary care, and health counseling is reinforced. At Hope Day in the Bronx, we team up with a dozen churches that jointly help carry out this event.

Our involvement in the faith-based community also includes work that benefits the homeless population:

- Two health luncheons in the Bowery Mission Women and Men’s Residency Centers, plus their Homeless Outreach “Don’t Walk By” events (every Saturday in February) — in partnership with the Salvation Army, New York City Rescue Mission, and the Bowery Mission. We provided backpacks and medical care.
- Health education and screenings in the community in collaboration with local churches and community organizations. In 2018, we partnered with the Church of the Epiphany to provide monthly blood pressure and HIV screenings and counseling at their weekly soup kitchen which provided meals to their guests — mostly adults who were homeless or food insecure. In December, we provided free reading glasses, thermals, and coats. We also contributed thermals and coats to homeless youth who participate in the Drop-In Program at the Dominican Women’s Development Center. Screenings and coats were also provided to the Washington Heights women’s shelter, in collaboration with nurses from Milstein Hospital.
Mission and Goals

The Center for Community Health and Education (CCHE), in partnership with Columbia University Irving Medical Center, has provided comprehensive medical, mental health, and health education services to adolescents and adults in Northern Manhattan and the Bronx for over 40 years. We advance service innovations through community partnerships, research, and teaching. The CCHE is comprised of:

- The Family Planning Practice and its co-located Young Men’s Clinic
- Seven School-Based Health Centers serving 23 New York City intermediate and high schools
- The Uptown Hub, a Youth Opportunity Hub that empowers members to learn to advocate for themselves and reach their personal, academic, and career aspirations
- NYPeers, a teen peer education and leadership program
- Community and classroom-based health education and adolescent pregnancy prevention programming

Our goals are to:

- Provide comprehensive women’s and young men’s healthcare services
- Provide primary healthcare services to adolescents that include medical, mental health, and health education
- Prevent early childbearing and delay initiation of first intercourse

- Increase the use of effective contraception among sexually active men and women who are not seeking pregnancy
- Reduce the transmission of sexually transmitted infections, including HIV
- Support the healthy transition from adolescence to adulthood

CCHE collaborates with local New York City public schools; the Columbia University Irving Medical Center Departments of Population and Family Health, Pediatrics, Obstetrics and Gynecology, Family Medicine, Psychiatry, and Ophthalmology; and the Columbia University College of Dental Medicine, as well as many community-based organizations.
Community Health Programs

CCHE: Family Planning Program and Young Men’s Clinic

Mission and Goals

The Family Planning Program provides confidential and comprehensive medical, sexual health, mental health, and health education services to adolescents, women, and men to:

• Assist individuals in determining the number and spacing of their children
• Increase use of effective contraception among sexually active men and women who are not seeking pregnancy
• Prevent teen pregnancy and early childbearing
• Reduce the transmission of sexually transmitted infections and HIV
• Facilitate entry into early prenatal care for pregnant women
• Provide preventative, preconception health services, such as breast and cervical cancer screening.

The Family Planning Center (FPC) and Young Men’s Clinic have provided family planning and adolescent pregnancy prevention services to the Washington Heights/Inwood community since 1976.

Number of People Reached

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients annually</td>
<td>15,000</td>
</tr>
<tr>
<td>Adolescent patients</td>
<td>1,700</td>
</tr>
<tr>
<td>Community health education workshops</td>
<td>800</td>
</tr>
<tr>
<td>Teen health education workshops</td>
<td>2,000</td>
</tr>
<tr>
<td>Benefits and supportive services enrollment</td>
<td>2,600</td>
</tr>
</tbody>
</table>

Key Accomplishments

• **Contraceptive best practices.** The FPC has been a national leader in service-based research for women’s reproductive health, and several contraceptive best practices pioneered at the FPC have significantly improved contraceptive initiation and compliance nationally.

• **Male involvement and CDC-funded research.** Co-located at the FPC, the Young Men’s Clinic (YMC) is nationally recognized for its efforts to promote male involvement in family planning. A CDC grant supports a computer tablet-assisted intervention, designed for young males, to prevent teen pregnancy.

• **Adolescent services.** Health educators and social workers work with adolescents to develop decision-making skills, support the adoption of preventive health practices, encourage family involvement, and prevent unplanned pregnancies and sexually transmitted infections (STI).

• **Integration of HIV prevention services.** HIV prevention education and rapid testing services are fully integrated, identifying patients who are not aware of their status and linking them to care. In addition, we provide PrEP and PEP (post-exposure prophylaxis).

• **Community health education and outreach.** The FPC/YMC conducts community-based outreach and activities to impact public awareness around family planning, STI and HIV prevention, and male health.

• **Co-located benefits enrollment and access to supportive services.** We provide onsite screening and enrollment for health insurance; screening and enrollment in food stamps (SNAP); and referrals to GED and English as a Second Language (ESL) programs, job training and placement programs, and free legal assistance.

• **Recipient of NYC Council funding for services to immigrants.** The YMC has received grant funding from the New York City Council for Services to Immigrants to help focus on decreasing health disparities among foreign-born New Yorkers.

DANIEL BURNETT • Practice Administrator • burnett@nyp.org | DAVID BELL, MD • Medical Director, Young Men’s Clinic • dlb54@cumc.columbia.edu | ANA CEPIN, MD • Medical Director, Family Planning Program • ac272@cumc.columbia.edu
CCHE: School-Based Health Center Program

**Mission and Goals**

The School-Based Health Center (SBHC) Program is a network of primary care practice sites located within seven New York City Department of Education school campuses, housing 23 middle schools and high schools. SBHCs provide primary health care, immunizations, chronic illness management, sexual and reproductive health services, and care for acute illness and injury to all students on campus — facilitating access to care and preventing lost academic time. In addition, mental health care is fully integrated in the provision of care and provided onsite by psychologists, clinical social workers, and a psychiatrist. Dental services are available at select sites. Health educators provide individual counseling, conduct classroom education sessions — including evidence-based teen pregnancy prevention curricula — and train and lead peer educators who conduct educational sessions on a range of youth health promotion topics.

**Key Accomplishments**

- **Community Schools Mental Health Intervention.** Via an evidence-based framework, a broad range of school-based mental health support services promote the emotional well-being and healthy functioning of all students on the George Washington Educational High School Campus. The three tiers encompass “universal” mental health services, which provide school-wide resources to impart knowledge and promote a nurturing environment for all students; “selective” services, which support a subset of students at risk of developing mental health or substance use conditions; and “targeted” mental health services, which support students who have diagnosable mental health conditions.

- **NYPeers peer education and youth development.** Annual cohorts of youth leaders are identified to receive evidence-based training and conduct peer education on a host of health promotion topics. In addition, youth leaders spend a summer interning at the Hospital and gain professional skills and exposure to health career paths.

- **Integrative health in SBHCs.** Mindfulness, self-hypnosis, acupuncture, acupressure, aromatherapy, and yoga are integrative health modalities offered at SBHCs.

**Number of People Reached**

- **6,000** Total number of patients annually
- **2,000** Students receiving evidence-based classroom education

**LEON SMART • Practice Administrator • lds9005@nyp.org**

**MELANIE GOLD, DO, DABMA, DMQ, FAAP, FACOP • Medical Director • mag2295@columbia.edu**
By promoting positive and healthy futures, the Uptown Hub empowers youth and young adults to advocate for themselves and pursue their dreams.
Key Accomplishments

In 2018, the Uptown Hub’s pilot year, a number of key accomplishments reflected its mission to improve the well-being of youth and young adults in the community:

- Enrolling and serving 198 youth and young adults ages 14-24 who connected with programs and services and achieved goals related to job attainment and educational pursuits (including a *New York Times* College Scholarship recipient and Barnard College acceptance).

- Forming a new Uptown Hub staff comprised of two psychologists, five program coordinators, and three Hub Advocates to support program development and service delivery to Hub members (with additional staff members to be added in 2019).

- Creating new opportunities at Hub Headquarters (HQ), including the build-out of a temporary drop-in space and development of specialized programs related to employment, education, and health promotion.

- Continuing collaboration with the Division of Community and Population Health’s Center for Community Health and Education (CCHE), Project STAY, CHALK, Lang Youth Medical Program, and Behavioral Health Outpatient Services to coordinate services and establish referral pathways.

- Launching the Uptown Hub Steering Committee with community partners — Dominican Women’s Development Center, Northern Manhattan Improvement Corporation, People’s Theatre Project, Police Athletic League at the Armory, and YM & YWHA of Washington Heights and Inwood — to strategize, plan, and implement community-informed programming.

- Completing a design and feasibility study for the new physical site at the Department of Health and Mental Hygiene building on 168th Street and Broadway, with anticipated construction and site opening in 2019.

- Launching a Youth Advisory Council that gives youth voice and leadership opportunities, such as supporting NewYork-Presbyterian’s 2018 Teen Health Conference, which was planned with the Lang Youth Medical Program, CHALK, and CCHE’s Peer Educators program and was attended by approximately 250 youth across New York City.
Mission and Goals

The aim of the Center for Community Health Navigation (CCHN) at NewYork-Presbyterian is to promote the health and well-being of patients by providing culturally sensitive, peer-based support in the emergency department, inpatient, outpatient, and community settings. The overall goal is to support healthcare self-management, connect patients with care, and decrease preventable system utilization.

CCHN works to achieve its mission through five key activities:

- Improving patients’ access to care at NewYork-Presbyterian and in the community
- Deepening connections between Hospital and community resources
- Developing and sustaining innovative patient-centered initiatives
- Advancing the community health worker role and workforce
- Enhancing the community health worker knowledge base and informing best practice

Key Accomplishments

In 2018:

- **36,605** people were supported by emergency department-based patient navigators located at NewYork-Presbyterian’s Columbia, Weill Cornell, and Lower Manhattan campuses.
- **10,200** community health worker interactions took place to support adults and children in the communities surrounding the NewYork-Presbyterian/Columbia, NewYork-Presbyterian/Weill Cornell, and NewYork-Presbyterian Lower Manhattan hospitals.
- The CCHN also received a gift of **$12.5 million** from Pilar Crespi Robert and Stephen Robert to expand the CCHN to NewYork-Presbyterian Brooklyn Methodist and NewYork-Presbyterian Queens, and to expand efforts at NewYork-Presbyterian Lower Manhattan Hospital.

CCHN aims to support healthcare self-management, connect patients with care, and decrease preventable system utilization.
The overall goal is to support healthcare self-management, connect patients with care, and decrease preventable system utilization.
Centering Pregnancy Program and the Carnegie Hall Lullaby Project

Mission and Goals
Centering Pregnancy is a program offered through the NewYork-Presbyterian Ambulatory Care Network. Prenatal care is provided to a group of eight to 12 women, usually young mothers-to-be having a first or second child. Each group meets for ten two-hour sessions that span a woman’s pregnancy as well as the early period after childbirth. Our goal is to empower women to choose healthy behaviors that will benefit them as well as their babies.

In December, we received a grant from the New York Department of Health to fund the restart of the Centering Program at the Broadway Practice, which had closed in early 2016. In addition, the Department of Obstetrics and Gynecology has appointed a coordinator for the Centering program. In the next few years, we’d like to expand Centering Pregnancy to the Rangel and Audubon ACN practices.

Through the Carnegie Hall Lullaby Project, pregnant women and new mothers are matched with professional artists to write and sing personal lullabies for their infants. The project enhances maternal health, promotes child development, and enforces the parent-child bond. During the 2017-2018 year, the Lullaby Project came to five Centering Pregnancy groups.

SARAH H. KELLY, MD • Medical Director • shk1@cumc.columbia.edu

Number of People Reached

- **101** Patients in 11 Centering groups (2017-2018)
- **28** Patients who wrote lullabies (2017-2018)
- **111** Patients who have written lullabies since 2013

Key Accomplishments

Prior studies have reported favorable outcomes among women who participated in Centering programs. At NewYork-Presbyterian, our 2017-2018 outcomes compared very favorably with state and national figures:

- Preterm births (<37 weeks): 2%
- Low birthweight infants (<2,500 grams): 2%
- Very low birthweight newborns (<1,500 grams): 0%
- C-sections: 28% (19% primary and 14% repeat)
- Vaginal deliveries: 71%
- Mothers breastfeeding at hospital discharge: 98%
As part of DSRIP, the Division has continued expanding efforts to enhance the Hospital and its community collaborators’ workforce competencies and capabilities. The Hospital and collaborator organizations have continually leveraged their collective expertise to develop trainings across several platforms, including live webinars, online modules, and in-person events. Trainings in 2018 covered various topics, including:

• Quality improvement and data analytics
• Health informatics
• Value-based payment
• Chronic disease
• Cultural competency and health literacy
• Health disparities in end-of-life care
• Palliative care
• Shared decision-making and co-design
• Tobacco cessation
• Collaborative care
• Addressing housing instability
• Motivational interviewing

Throughout the year, more than 400 people attended webinar trainings and nearly 200 attended in-person trainings.
Choosing Healthy & Active Lifestyles for Kids (CHALK)

EMMA HULSE • Program Manager • emh9022@nyp.org
DODI MEYER, MD • Medical Director • ddm11@cumc.columbia.edu

Mission and Goals

NewYork-Presbyterian’s obesity prevention program, called CHALK, is a collaboration with NewYork-Presbyterian/Columbia University Irving Medical Center and the Northern Manhattan community. CHALK’s aim is to lower the prevalence of childhood and adolescent obesity in Northern Manhattan by establishing an environment where healthy lifestyles become vital components of the lives of all families.

CHALK’s programming is founded in the ten healthy habits, adapted from Healthy Directions and its Healthy Children Healthy Futures program and developed by community stakeholders to ensure that the habits are health literate, culturally sensitive, and avoid stigmatization. CHALK’s areas of focus include community organizations and programs, early childhood centers, public elementary and high schools, faith-based organizations, and NewYork-Presbyterian’s outpatient pediatric practices.

CHALK partners are connected with a full-time staff member to help them assess and create wellness goals in collaboration with the organization’s leadership and wellness champions. Organizations choose from a “menu” of options, ranging from grant writing and partnership building to promoting healthy food and active design. This approach enables an organization to create, implement, and feel ownership over their wellness goals and projects.

This non-prescriptive approach and the fluidity of CHALK make the program model easily adaptable to a variety of settings while enhancing the wellness environment specific to that organization.

Number of People Reached

CHALK partners include:

3 Early childhood centers
11 Elementary schools
3 High schools
5 Faith-based organizations
30 Community-based organizations (since 2011)
3 Farmers’ markets
ACN Primary Care Practices
CHALK received funding to expand into the high school arena. In fall 2018, the program collaborated with schools at the George Washington Campus in Washington Heights. CHALK has collaborated with three of the four schools thus far, and wellness councils have been established with the aim of transferring ownership of projects and wellness goals throughout the intervention. In addition to establishing sustainable and systemic changes that promote wellness at the campus, we are implementing NewYork-Presbyterian’s Peer Education program. Students will have the opportunity to work in a healthcare setting and learn professional, leadership, and public speaking skills to facilitate health education workshops for their peers.

The Fruit and Vegetable Prescription Program is a collaboration between the NewYork-Presbyterian Ambulatory Care Network’s Nutrition Department, GrowNYC, and CHALK, and is funded by NewYork-Presbyterian Community Relations. Registered dietitians from ACN outpatient clinics “prescribe” fruits and vegetables for their patients. These prescriptions are redeemable for $10 in fruit and vegetable coupons (“Greenmarket Bucks”) at the Grow NYC tents of the 168th Street, 175th Street, and Isham greenmarkets. In 2018, nearly 700 patients redeemed their prescriptions, with over $7,000 in fruit and vegetable coupons being distributed; 88% of the coupons were redeemed to purchase produce.

To increase access to emergency food resources, CHALK collaborates with faith-based organizations and ACN outpatient practices. Food insecurity prevalence is high in Northern Manhattan. Left unaddressed, it can contribute to obesity, heart disease, and other serious health conditions. CHALK Faith-based partnered with La Puerta Estrecha’s Food Pantry (serving clients weekly) and Holyrood Church (implementing West Side Campaign Against Hunger’s monthly Mobile Market). The Mobile Market is an innovative program that brings food pantries directly to underserved neighborhoods via food trucks. Each Mobile Market provides three days’ worth of fresh fruits, vegetables, whole grains, protein, and dairy for up to five family members — helping them meet their household food needs, connecting them to services and resources such as WIC and SNAP, and providing education about nutrition and home cooking. Together, the two faith-based sites serve about 1,000 families and distribute over 10,000 pounds of food each month. CHALK Food FARMacia brings the Mobile Market to ACN outpatient practices in Northern Manhattan. Each monthly distribution can serve 150 individuals (50 families). Patients are eligible if they have children between 0 and 5 years old and are classified as food insecure. Mobile Markets prioritize dignity and convenience, with helpful and respectful staff as well as a technologically sophisticated pre-registration system that facilitates customer-choice shopping experience, short wait times, and nutritious and culturally sensitive food options.

CHALK Youth Market Program is a partnership between CHALK and GrowNYC to offer paid summer internships to youth, enabling them to get involved with local farmers markets and provide education related to diabetes and obesity prevention. Supervised by CHALK staff, interns work at three markets in Washington Heights and Inwood, where they provide access to fresh produce and health education workshops for community members. In addition, youth interns became ambassadors of healthy living and eating among their families and neighbors, helping to improve the health and wellbeing of their community at large. NewYork-Presbyterian’s Youth Market Farm Stand operates every Wednesday in July and August outside the Broadway Practice of the Ambulatory Care Network.
The Compass Program is a new program for transgender and gender-diverse children and adolescents. Compass began in the fall of 2018 and is located in the Helmsley Tower on the Weill Cornell Medicine campus. The multidisciplinary Compass team consists of an adolescent medicine physician, pediatric endocrinologist, psychiatric nurse practitioner, and an adolescent social worker.

In a safe, welcoming, and nonjudgmental space, Compass provides:

- A comprehensive and individualized needs assessment
- Mental health counseling
- Family support
- Gender-affirming hormone treatment

In addition to patient care and family support, the team’s mission includes training pediatric providers and clinic staff to provide transgender-friendly care, advocate for transgender and gender-diverse patients within the NewYork-Presbyterian system and the outside community, and link families with trans-affirming community resources. Future goals include offering both patient and parent support groups where participants can share their experiences and concerns. Compass is currently seeing patients with Medicaid insurance up through age 19.
Community-Based Sexual Health

Mission and Goals

Sexual health programming for the community is a collaborative effort between community partners and the NewYork-Presbyterian HIV Centers of Excellence, the Comprehensive Health Program at NewYork-Presbyterian/Columbia, and the Center for Special Studies at NewYork-Presbyterian/Weill Cornell.

Medical, gynecological, psychosocial, and case management services are provided to people with HIV and those at risk for HIV, sexually transmitted infections (STIs), and hepatitis C. The patient-centered model of care features care coordinators, physicians, nurses, behavioral health clinicians, psychiatrists, and navigators. Project STAY (Services to Assist Youth), the young adults’ component, serves young people ages 13-24 onsite and in the community.

The program aims to 1. increase access to and the capacity for prophylaxis (PrEP) services, 2. increase testing and screening, and 3. link and engage patients with care.

Number of People Reached

2,096 Patients assessed for PrEP; 75% started PrEP
844 Unique clients engaged by Ready to End AIDS & Cure Hepatitis C (REACH) Collaborative, who received 2,000+ services
1,200 Clients served by Youth Access Program (YAP) services
1,400 Project STAY sexual health education workshops
1,200 Community-based STI/HIV screenings through Project STAY

MARIA V. ESPINAL • Practice Administrator • mrd9075@nyp.org | PETER GORDON, MD • Medical Director • pgg2@columbia.edu
SUZANNE SCHLEGEL • Practice Administrator • sschlege@nyp.org | SAMUEL T. MERRICK, MD • Director • stm2006@med.cornell.edu
Community-Based Sexual Health continued

Outreach, Screening, Linkage, and Prevention

These efforts are achieved through Project STAY as well as a number of new community linkages.

Project STAY

Project STAY provides services for young people between the ages of 14 and 24 who are living with or at high risk for HIV; justice-involved youth; lesbian, gay, bisexual, transgender, queer, questioning, or pansexual; and men who have sex with men. The Project STAY team includes physicians, outreach specialists, social workers, nurses and nurse practitioners, and others dedicated to making sure the young people of New York have ready access to needed healthcare services. Program members work with community leaders, academic scholars, and public health professionals to serve Harlem and other New York City communities through two major programs:

- The Specialized Care Center, providing care for young people who are HIV-positive or at risk for HIV infection.
- The Youth Access Program, which conducts community outreach, screening, and linkage to care for young people engaging in risk-taking behaviors. A youth-friendly primary care clinic provides medical and mental health services for these young people as well.

The New York City STD Prevention Training Center (PTC) is a CDC-funded program of Columbia University Mailman School of Public Health and a regional training center of the National Network of STD Clinical Prevention Training Centers. The PTC is dedicated to increasing the sexual health knowledge and skills of medical health professionals in the prevention, diagnosis, screening, and management of sexually transmitted diseases, with the goal of reducing the community burden of STIs and HIV — one of the key areas of focus for DSRIP.

New Community Linkages (for STI/HIV testing)

- The Point, a multi-service community-based agency in the Hunts Point section of the Bronx.
- Midtown Community Court, a program run by the Center for Court Innovation in Midtown Manhattan.
- Alternative high schools. Goal is to expand the network to include Harlem Renaissance High School and several schools in the Bronx.
- NYCDOHMH and LCOA (Latino Commission of AIDS). Enhanced referral of clients to NewYork-Presbyterian for PEP/PrEP

Community Navigation, Community Health Work, and Care Management

These goals are accomplished through a collaboration with the Alliance for Positive Change, the REACH Collaborative, and Care Management Services.

Community Navigation

The CHP received City Council funding to support a collaboration with the Alliance for Positive Change to leverage a Health Information Exchange to reach out to, engage, and link patients lost to care by using technology to send alerts to primary care providers or the Alliance for Positive Change when patients present at healthcare or HASA facilities. In turn, a community navigator will meet patients in real time to facilitate care coordination. This project is scalable and is well aligned with the End the Epidemic mission.

Community Health Work

With the support of DSRIP funding, the REACH Collaborative includes the Alliance for Positive Change, WHCP, Argus Community Inc., and the Dominican Women’s Development Center. Subcontracts with CBO core partners support a team of eleven Community Health Workers (CHW) and peers and have extended outreach efforts through a mobile medical van. Together, CHWs and peers form a community-based health navigation team to coordinate care and linkage to the full range of support services offered across the REACH Collaborative. The team aims to
The Comprehensive Health Program (CHP) and the Center for Special Studies (CSS) provide medical, gynecological, psychosocial, and case management services to people with HIV and those at risk for HIV, sexually transmitted infections, and hepatitis C.

Hepatitis C Program

Since 2015, the CHP has collaborated with the Washington Heights CORNER Project, a neighborhood syringe exchange program (SEP), in which CHP providers offer hepatitis C treatment onsite at the SEP. The work is funded by the NYSDOH AIDS Institute, and NewYork-Presbyterian supports a full-time linkage specialist at the SEP. NewYork-Presbyterian’s 340b pharmacy assists with medication prior authorizations, and medication can be delivered directly to CHP, where adherence support can be provided.

Since 2015, 260 people with hepatitis C have been enrolled in this program and 105 have received treatment. Nearly all of those treated have been cured. In addition, approximately 15 patients have started buprenorphine therapy for opioid use disorder through this collaboration.

Care Management

With partial support of a DSRIP-funded NewYork-Presbyterian Community Impact Grant, co-located Care Managers from the Alliance for Positive Change have been fully integrated into all three NewYork-Presbyterian HIV Centers of Excellence to provide comprehensive community-based Care Management Services.
Community-Based Sexual Health continued

Publications


Presentations

• AIDS Institute Designated AIDS Center Conference. NYP’s Comprehensive Health Program: A Designated AIDS Program looking to past, present, and future models for opportunities to advance care. February 4, 2019.

Selected Meeting Abstracts and Poster Presentations

• Attitudes in Assessing Patients for Pre-exposure Prophylaxis Among Pediatric and Internal Medicine Residents Training in New York City. HIV4RP. Madrid October 2018.
• An Online Survey of Hepatitis C Testing Attitudes and Practice Habits Among Residents at an Urban Medical Center. ID Week. San Francisco, CA. October 2018.
The overarching goal of the Cultural Competency and Health Literacy Workgroup is to provide guidance in cultural competence, language access, and health literacy to the Hospital and its community partners to enhance the quality of care and address healthcare inequities at the individual and population levels.

The underlying principles for this work are to adopt a person-centered, cross-cultural approach that does not stereotype individuals; to use a population health approach that applies targeted interventions to populations in need; and to promote cultural competence, linguistic access, and health literacy standards as articulated in The National Culturally and Linguistically Appropriate Services (CLAS) Standards.

The workgroup utilizes a multipronged approach to accomplish its goals. Work to date includes:

- Multiple in-person and web-based trainings. Topics of these trainings are identified through a community-wide collaborator survey.
- Creation of a framework to capture clinical data through an equity lens.
- Dissemination of best practices in health literacy.
- Participation in the NewYork-Presbyterian Diversity, Inclusion, and Belonging Committee.

The first annual Cultural Competency & Health Literacy in-person training event was held in fall 2017. Entitled "Instituting Agency Transformation for LGBTQ+ Inclusion," it was well attended by Hospital and community agency representatives. There was also a bilingual community health talk for parents of young children. Webinars and tip sheets have been co-developed with collaborators and distributed across the Hospital and community-based organizations with which the Division partners.
Health & Housing

MISSION AND GOALS

Across the country, health systems are increasingly recognizing that social determinants play a large role in an individual's overall health and well-being. Both housing instability and poor housing quality are associated with poor health and increased emergency room and inpatient utilization. The Division of Community and Population Health looks to address our patients' needs through a Housing Program, focusing on the following goals:

- Improving Hospital and community provider knowledge of housing resources and best practices
- Increasing access to patient housing opportunities by establishing a Housing Network
- Enhancing patient outcomes and the patient experience through a dedicated housing team and medical respite

In 2018, the Housing Program launched a comprehensive Housing Instability Training Series that has reached over 250 NewYork-Presbyterian staff and collaborators. The Housing Program has developed relationships with several organizations, such as the CUCS Homeless Outreach Team and Services for the UnderServed’s (SUS) eviction prevention program, Homebase. The CUCS Homeless Outreach team receives referrals from inpatient units and emergency departments for patients who report as "chronically street homeless." The Homeless Outreach Team also visits the NewYork-Presbyterian Allen Hospital and Milstein Hospital emergency departments weekly to engage patients who might be seeking shelter there.

Since early 2018, SUS’s Homebase Program has received more than 20 referrals from Ambulatory Care Network social workers for patients and families at risk of facing eviction. Several patients have been connected to Homebase resources and are now stably housed.

Finally, the Housing Program has begun developing a housing team and medical respite program to serve housing-insecure patients being discharged from our hospital, directing them to long-term housing resources.

In 2018, the Housing Program launched a comprehensive Housing Instability Training Series that has reached over 250 NewYork-Presbyterian staff and collaborators.

Since early 2018, SUS’s Homebase Program has received more than 20 referrals from Ambulatory Care Network social workers for patients and families at risk of facing eviction.
The mission of Health for Life (H4L), a comprehensive weight management program, is to provide a safe and supportive environment for 4-to-18-year-olds and their families who wish to improve their health by eating a better diet and increasing their physical activity. Through individual clinic visits and group programming, H4L empowers participants to make healthier lifestyle choices for themselves and their families.

H4L staff members work with patients who have been identified as overweight or obese by their primary care physicians, based on BMI percentile. Patients meet with doctors, dietitians, social workers, and a clinical exercise physiologist at clinic visits. Participants age 7 and older can engage in 8-week group programs, with each session consisting of one hour of nutrition education and one hour of physical activity.

- **Mission and Goals**

**Number of People Reached**

- **250**

**Key Accomplishments**

- In 2018 H4L expanded and is now a bicampus program serving NewYork-Presbyterian Ambulatory Care Network patients at the Broadway Practice and the HT-5 Pediatric Practice.

- Program participants have reported trying new foods in a group setting, eliminating sugary beverages from the house, and increasing daily walking.

- H4L staff participate in community outreach initiatives throughout the year to bring nutrition and fitness education to community partners.

**Presentations**

- Presentation of Health for Life research results to the Weil Cornell Medicine Atkins Journal Club.
Health Home

TIFFANY STURDIVANT-MORRISON, MPH • Lead • tis9034@nyp.org

Mission and Goals

The Division leads the NewYork-Presbyterian Health Home — a New York State Medicaid program that reimburses community-based organizations for the provision of high-quality care management services to at-risk Medicaid beneficiaries. In this role, the Division forms the financial, analytical, clinical, and information technology backbone for a network of agencies that collaborate to enhance the health of the Medicaid population.

As part of the Health Home, a dedicated care manager — at the Hospital or at a community-based organization — is assigned to Medicaid members who have complex medical and behavioral healthcare needs. The role of the care manager includes, but is not limited to, health promotion, provision of individual and family support, and coordination of care and referrals to community and support resources. By providing these services, the NewYork-Presbyterian Health Home hopes to reduce avoidable emergency room visits and inpatient stays and improve its members health outcomes.

Number of People Reached

The Health Home network is comprised of care management agencies who provide services to 1,982 enrolled patients:

• ACMH
• Alliance for Positive Change
• Argus Community, Inc.
• CCN General Medicine
• CREATE Inc.
• Isabella Geriatric Center
• NewYork-Presbyterian Ambulatory Care Management
• Riverstone Senior Life Services
• The Bridge
• Upper Manhattan Mental Health Center

Our care management agencies also provide outreach services to 3,985 beneficiaries. These agencies offer a broad portfolio of services, including behavioral health, housing, complex medical care, substance use treatment, and geriatric care. Services are available in Manhattan, Queens, Brooklyn, and the Bronx.

Key Accomplishments

Throughout the past year, the NewYork-Presbyterian Health Home has:

• Generated $4 million of revenue for the Health Home Network
• Expanded two new Care Management Teams: CCN General Medicine and NewYork-Presbyterian’s Comprehensive Health Program
• Developed a Health Home Quality Management Program
• Collaborated with other Health Home Networks to standardize best practices and advocate for statewide programmatic changes
• Collaborated with several Hospital initiatives to facilitate care transitions for high-risk patients
Mission and Goals

The mission of Healthy City Kids is to promote a healthy lifestyle and prevent obesity among families of preschool children. The program — which is delivered in partnership with the Lenox Hill Neighborhood House Head Start program — includes six weekly interactive sessions for parents of enrolled preschoolers and runs two to three times each year. A pediatrician and dietitian oversee the program, with each lesson taught by a pediatric resident.

Key Accomplishments

Families who have participated in Health City Kids report making numerous positive changes in their homes, such as buying healthier goods and encouraging their children to try new foods.
The Lang Youth Medical Program (Lang Youth) is a six-year health science enrichment and medical pipeline program for underserved youth who represent the diversity of the Washington Heights and Inwood (WHI) communities. Lang Youth’s mission is to inspire and motivate middle school and high school students to achieve their college and career aspirations through hands-on learning and mentorship at a world-class academic medical center. Lang Scholars meet on Saturdays during the academic year and summers during the month of July for six years from 7th-12th grades.

Lang Youth fosters an environment for academic and personal success through:

- **Health career exploration.** Hospital tours, career panels, clinical rotations, and summer internships
- **Health science education.** Hands-on curriculum interweaving human anatomy, physiology, pathology, public health, and personal wellness
- **Mentorship.** Guidance from graduate students, medical trainees, and healthcare professionals from various Hospital departments
- **College support.** College campus tours, SAT preparation, college application assistance, and academic and career development for Lang Youth alumni

Lang Youth aims to increase high school and college graduation rates, with the goal of improving health outcomes in the future. The program also helps to reduce the deficit of minority healthcare workers in the United States.

- Lang Youth inducted 15 new Lang Scholars to the program, representing 11 of our partner middle schools in WHI.

Over the past 15 years, Lang Youth has served over 200 students and their families. Since 2009, 100 students have graduated from Lang Youth, graduated from high school, and matriculated into a four-year college/university. Number of students currently enrolled in Lang Youth is 85.

The Program held its 10th annual graduation ceremony, celebrating 12 graduates. This cohort of Lang Scholars had an 86% retention rate over six years, and all are attending four-year universities — including Boston University, Syracuse University, SUNY Binghamton, and CUNY Hunter College.

NewYork-Presbyterian welcomed its fifth Lang Alumna as a full-time employee of the Hospital: Annabell Marcelino (Lang Class of 2013), who serves as Program Coordinator for the Uptown Hub.

For the first time, Lang Youth offered three summer internship placements to alumni. Sites included the Ambulatory Care Network Child Advocacy Center, Morgan Stanley Children Hospital’s Child Life Department, and Milstein Hospital’s operating rooms.

Recently, Lang Youth launched its first online new scholar application. It hopes to increase outreach to eligible 6th grade students attending public/charter middle schools in WHI.
Mission and Goals

The Manhattan Cancer Services Program (MCSP) aims to reduce disparities in cancer outcomes among underserved adults in New York State. The program serves uninsured individuals in difficult-to-reach Manhattan communities, as well as people who receive primary care through the ACN who are outside of guidance concordant cancer screening. This is accomplished by:

- Delivering community-based education, outreach, and recruitment
- Providing no-cost screening and diagnostic services
- Referring clients to treatment
- Enrolling people in the Medicaid Cancer Treatment Program
- Offering Case Management Services
- Offering support services in English and Spanish
- Offering Navigation Services to patients with government insurance who are outside of guidance concordant cancer screening, to assure adherence with screening recommendations and all diagnostic testing

Key Accomplishments

There are multiple points of entry to MCSP through nine service providers: Charles B. Wang Community Health Center, Bellevue Hospital, Callen-Lorde CHC, Ryan/Chelsea-Clinton CHC, Breast Examination Center of Harlem, Project Renewal, Multi-Diagnostic Services Inc, Mt. Sinai Mobile Mammography Program, and NewYork-Presbyterian/Columbia University Irving Medical Center. MCSP engages partners such as community-based organizations, faith-based organizations, small businesses, social service agencies, government agencies, legislators, and small media to help identify and refer uninsured individuals to these vital services.

Grants

- New York State Department of Health Integrated Cancer Services Program — Manhattan Cancer Services Program/Cancer Navigation Program (2018-2023)
- Davida T. Deutsch Breast Cancer Support Program (2016-present)
- Grace B. Lamb Trust (2017-present) — Treatment Support for Uninsured
- Komen Greater NYC (2018-2019)
- P30 Herbert Irving Comprehensive Cancer Center (2013-2019) — Community and Ambulatory Research Shared Resource

Number of People Reached

In the last 5-year funding cycle:

- 5,930 Received cancer education and were recruited through community outreach
- 15,206 Uninsured individuals were screened
- 139 People were diagnosed with cancer
- 4,157 Insured individuals were navigated to screening
- 851 Community individuals received Cancer Genetics Education

Abstracts and Presentations

Community Health Programs

NewYork-Presbyterian Performing Provider System Impact Grants

BRIAN YOUNGBLOOD • Program Manager • Behavioral Health Crisis • bjy9001@nyp.org

Mission and Goals

The Division of Community and Population Health provides an opportunity for Community-Based Organizations (CBOs) interested in expanding collaboration to develop novel interventions to support vulnerable populations. Using Delivery System Reform Incentive Payment (DSRIP) funding, the Division released a Request for Proposals (RFP) to the network of community collaborators to solicit programming ideas.

Key Accomplishments

In 2018, four CBOs received grants: God’s Love We Deliver, Metropolitan Center for Mental Health, Alliance for Positive Change, and Service Provider for Older Persons.

- **God’s Love We Deliver (God’s Love)**, a well-recognized leader in providing medically tailored meals (MTMs) for a wide-range of chronic illnesses, received a grant to develop a cross-campus MTM intervention for patients living with congestive heart failure (CHF) who frequently present in emergency department (ED) and inpatient settings. The grant supports a controlled trial study for up to 50 patients to receive 6 months of MTMs, evaluating the potential impact of this intervention on quality of life, ED/inpatient utilization, and key CHF-related metrics. This initiative is a collaboration between God’s Love, NewYork-Presbyterian/Columbia, and NewYork-Presbyterian/Weill Cornell.

- **Metropolitan Center for Mental Health (MCMH)** provides mental health and substance use disorder treatment in the Washington Heights community. A longstanding source of support to patients discharged from ED and inpatient settings, MCMH received a grant to embed intake clinicians within NewYork-Presbyterian/Columbia’s Department of Psychiatry Consultation-Liaison Service. MCMH staff meet with patients at the bedside to begin the intake process prior to discharge. They also serve as content experts for outpatient service portfolios within New York City and frequently coordinate with interdisciplinary teams. This program was launched in December 2018 and is already serving three to four patients each day who are admitted to the Milstein Hospital medical units.

- **Alliance for Positive Change** provides a wide range of services to patients with mental health and/or substance use disorders and is a Health Home care management agency (part of the NewYork-Presbyterian Health Home). The agency received a grant to embed a Health Home care management team, composed of a Care Manager and Peer, at the Center for Special Studies’ Chelsea Clinic.

- **Service Providers for Older Persons (SPOP)** provides behavioral health treatment to older adults living with mental health and/or substance use disorders throughout New York City. They have a long history of flexible treatment (at their main clinic, satellite sites, and in-home treatment) focused on patients age 55 and older. SPOP received grant funding to provide a dedicated therapist to work with patients referred through NewYork-Presbyterian/Columbia’s Department of Psychiatry Consultation-Liaison Service. This intervention began in November 2018 and is available to any patient admitted to Milstein Hospital.
Outreach Program

Mission and Goals

The mission of the Outreach Program is to promote health and prevent disease through education and screening, with an emphasis on early detection and interventions. Program staff seek to connect community members with reliable sources of primary medical care. The program evaluates and prioritizes the needs of underserved residents in the communities surrounding NewYork-Presbyterian’s campuses, with the goal of reducing health disparities.

Free screenings, services and counseling, health insurance information, and culturally reflective and relevant educational presentations are provided to community members. Examples include the annual Taxi Drivers’ Health Fair, Bodegueros (Grocery Shop) Health Events, and the Domestic Worker’s Health Fair.

Key Accomplishments

Observations at some of our most popular events underscore the need to continue to provide outreach to the communities surrounding NewYork-Presbyterian. For example, of 129 people screened at the Taxi Drivers’ Health Fair, 48 had abnormal results (six of whom were sent to Urgicare or the emergency department). Of 220 individuals screened at the Bodegueros Health Initiative at Jetros Cash and Carry in the South Bronx, 86 had abnormal blood pressure results (13 of whom were advised to visit the emergency department). These individuals received education and counseling and about the importance of follow-up care and accessing primary care services. Each month we returned, we met with participants who had changed their eating habits after receiving guidance at these events.

In 2018, we hosted the Domestic Worker’s Outreach event at St. Catherine’s Park on the Upper East Side, where nannies bring children to play. We were able to add another event to the year to increase the frequency of visits, screening a total of 228 nannies and connecting many of them with primary care.

Spearheaded by the Outreach Program, NewYork-Presbyterian is a major healthcare sponsor of NYC Pride and Harlem Pride events, which celebrate the LGBTQ community and promote inclusivity and equality of community members. In 2018, we increased our participation to include Family Movie Night and Youth Pride. We provided information and promoted STI testing, PrEP and PEP services, access to primary health care through our ACN clinics, adolescent sexual health services, child nutrition, and emergency preparedness. We engage some 10,000 people throughout Pride weekend each June.

The Outreach Program hosts four vaccination events each fall, in collaboration with elected officials and local senior centers. In 2018, we vaccinated 233 participants. This year, we focused on reaching the most vulnerable populations, including a homeless services location and The Washington Heights Corner Project, which serves intravenous drug users.

Number of People Reached

1,210 People screened at targeted health events
Reach Out and Read Program

EMELIN MARTINEZ • Program Manager • emm9016@nyp.org
DODI MEYER, MD • Medical Director • ddm11@cumc.columbia.edu

Mission and Goals

Reach Out and Read (ROR) is a national hospital-based pre-literacy program where children ages 6 months to 5 years can be read to and receive books during their primary healthcare visits. The ROR program of NewYork-Presbyterian/Columbia Irving Medical Center is one of the largest in New York State. Foster grandparents read to children in waiting rooms at all sites, and volunteers model reading techniques to children in the waiting room.

Number of People Reached

- More than **10,000** patients throughout **15,202** well-child visits among five Ambulatory Care Network sites
- A total of **14,115** books were disseminated by medical providers to patients during well-child visits

Foster grandparents read to children in waiting rooms at all sites, and volunteers model reading techniques to children in the waiting room.
The goal of Family PEACE (Preventing Early Adverse Childhood Experiences) Trauma Treatment Center (FPTTC) is to help very young children and their families heal after experiencing family violence, abuse, and other forms of trauma. The Center provides holistic treatment to end intergenerational cycles of violence, offering services to young children (ages birth to 5 years), their primary caregivers, and siblings (ages 6-12 years) who have also been impacted by the traumatic event. Services include:

- Dyadic treatment for young children and their caregivers
- Individual therapy
- Psychoeducational and therapeutic groups
- Art therapy, case management, crisis intervention, and psychiatry services as needed

The FPTTC provides trauma-informed and culturally responsive programming. The staff is comprised of clinical psychologists who are specialists in early childhood mental health and development, trauma, and parent-child therapy. Bilingual and bicultural staff reflect the community we service, and treatment is available in both English and Spanish.

In an effort to extend our services beyond the clinic setting and enhance access to treatment, the Center is currently embarking on integrating the NewYork-Presbyterian pediatric primary care setting and behavioral health using the Healthy Steps model. Caregivers and their children are screened for exposure to trauma and streamlined into a plan of treatment that meets their needs. FPTTC has also partnered with local community-based organizations to offer screening for trauma exposure and treatment services.

**Number of People Reached**

- 2,165 Visits with 216 unique patients
- 611 Individuals (291 adults and 320 children) screened for trauma using the Adverse Childhood Experiences (ACEs) tool
- 59 Medical residents/interns trained on how to screen for domestic violence in the primary care setting
- 17 Medical residents trained on Trauma-Informed Care (TIC)
- 290 Direct Service Providers from NewYork-Presbyterian and partner agencies trained on TIC

**Key Accomplishments**

Supported by a grant from the New York State Office of Victim Services (OVS), Family PEACE Trauma Treatment Center expanded its treatment services to victims of child abuse ages 0-5 years and their siblings. The Center recently received an additional OVS grant to provide onsite legal services to victims of crime. A full-time attorney will provide free legal consultation and representation to adults and children with issues ranging from housing to custody matters. Legal clinics will also be held at the Center and for partner agencies.

The FPTTC is a federally funded National Child Traumatic Stress Network Category III Direct Service site. The Center received a five-year SAMHSA/NCTSN grant for “Increasing Community Access to Early Childhood Evidence-Based Trauma Services,” which allows for the integration of behavioral health services into pediatric care clinics to screen for ACEs and streamline access to treatment. An onsite psychologist is available to provide families with psychoeducation and brief interventions regarding child development, parenting, child behavior, maternal depression, and interpersonal violence. The FPTTC is also very active in the community’s grassroots and advocacy efforts against domestic violence and is a member of the Washington Heights/Inwood Coalition Against Interpersonal and Domestic Violence (WHICADV) and the Upper Manhattan Collaborative.
Mission and Goals

Turn 2 Us (T2U) is a mental health promotion and prevention program serving local elementary schools in Northern Manhattan. The goals of the program are to:

- Support mental health and academic success in children at risk for a mental health disorder
- Help the entire school community (students, parents, and school staff) adopt healthy lifestyle practices that encourage wellbeing
- Improve the mental health literacy of school personnel and caretakers so they are better able to ensure that youth progress emotionally, socially, and academically
- Decrease the stigma that prevents individuals from seeking mental health-related services

Number of People Reached

Since its inception, T2U has reached over 10,000 students, caregivers, and school personnel.

Turn 2 Us promotes mental health care and prevention in local elementary schools.

Publications


Grant

- Derek Jeter’s Turn 2 Foundation (2009-present)
Waiting Room As a Literacy & Learning Environment (WALLE)

EMELIN MARTINEZ • Program Manager • emm9016@nyp.org

Mission and Goals

The Waiting Room As a Literacy & Learning Environment (WALLE) is an initiative of the New York-Presbyterian Ambulatory Care Network. WALLE aims to address the social determinants of health through a two-fold approach: enhancing health literacy by providing targeted health education, and empowering patients to seek resource referrals to support their social needs. WALLE helps medically underserved patients who are predominantly from Washington Heights, Inwood, and the Bronx, most of whom are native Spanish speakers. Bilingual volunteers are trained in the tenets of Health Literacy and the Trans-theoretical Model.

The goals of the program are to:

- Provide approaches designed to improve quality of care, patient satisfaction, and health education
- Support clinical staff by providing supplemental counseling and resources for patients
- Maximize provider-patient interactions and optimize time spent in the waiting room by engaging patients

WALLE staff aim to achieve these goals by:

- Linking patients with free/low cost community resources
- Giving patients relevant health education and improving their health literacy
- Telling medical providers about patients’ needs as identified by their caregivers
- Supporting medical providers with health education
- Assisting patients with the completion of medical forms, as needed
- A total of 64 interns were recruited and served during 2018
- WALLE interns screened over 3,000 individuals by December 28, 2018

Key Accomplishments

In 2018, the WALLE Program joined the efforts of Addressing the Needs of the Community through Holistic Organizational Relationships (ANCHOR) to screen nearly 4,000 patients who may have screened positive for issues related to food insecurity, housing, transportation, and utilities.

Sixty-four WALLE interns from various learning institutions (including Columbia University, Hunter College, City College, Berkeley College, and Lehman College) were recruited and trained to serve in the outpatient clinical settings of the Ambulatory Care Network, where services have been expanded to internal medicine and ob/gyn patients.
Women Infant and Children Program (WIC)

NALINI CHARLES • Program Manager • nac9026@nyp.org

Mission and Goals

The NewYork-Presbyterian Ambulatory Care Network’s Women, Infants, and Children (WIC) program is a federally and state-funded nutrition education and supplemental foods program. WIC clients can receive nutritional counseling, healthy lifestyle support, and breastfeeding promotion and support, as well as an individualized food packages for eligible participants.

Number of People Reached

WIC serves approximately 10,500 participants each month.

Key Accomplishments

Our Breastfeeding Help & Referral Center provides one-on-one breastfeeding support plus aids such as breast pumps, breast shells, and nipple shields to WIC participants. WIC works with mothers to increase the rates of breastfeeding initiation and duration. We continue to strive for higher breastfeeding rates through education and support provided by our nutrition and peer counseling staff.

All WIC staff have been trained and ready to take on the launch of the new electronic benefits transfer (EBT) system that is coming to NewYork-Presbyterian’s WIC program in 2019. WIC participants will be able to purchase WIC foods using the “eWIC” card. This EBT system will result in an easier, quicker, and more discreet shopping experience for WIC participants.

Our Breastfeeding Help & Referral Center provides one-on-one breastfeeding support plus aids such as breast pumps, breast shells, and nipple shields to WIC participants.
Mission and Goals

The New York State Department of Health has established the goal of 80% of Medicaid managed care payments occurring through value-based payment (VBP) arrangements. One of the most significant barriers identified by community providers and community-based organizations is the lack of familiarity with VBP contracting.

To address this need, the NewYork-Presbyterian Hospital Performing Provider System (PPS), in close collaboration with the NewYork-Presbyterian Queens PPS, co-sponsored a webinar training series for primary and specialty care providers, behavioral health providers, and community-based organizations. The two PPS worked with several experts to lead the trainings and addressed various topics, including:

- An introduction to VBP
- Overview of the New York State VBP Roadmap
- Data utilization for quality improvement
- An introduction to managed care organization VBP strategies.

Eight webinars were held in 2018, with nearly 200 people attending.
NewYork-Presbyterian’s community healthcare practices and programs offer rewarding educational opportunities for residents, fellows, and other trainees who share a passion and dedication to improving community health.

Specialized residency programs for pediatrics, adult medicine, and family medicine offer instruction, mentorship, and exposure to a wide range of healthcare issues and challenges, providing unparalleled experience for physicians early in their careers.

**Pediatric Resident Training at NewYork-Presbyterian/Columbia**

Mariellen Lane, MD: mmL2@cumc.columbia.edu  
Associate Professor of Pediatrics, CUIMC  
Assistant Program Director for Ambulatory Education, Pediatric Residency Program

At NewYork-Presbyterian/Columbia, 76 pediatric residents train in primary care at four practices: Audubon, Broadway, Washington Heights, and Rangel. Each resident maintains an active patient panel and engages in preventative care, from birth through adolescence. An additional area of resident focus is the care of the medically complex child. Residents participate in interdisciplinary team rounds and in the coordination of the complex care of their patients with social workers, a care manager, community health workers, and pediatric psychiatric nurse practitioners. Each pediatric resident also participates in a resident-driven experiential-based quality improvement (QI) curriculum embedded in his or her ambulatory practice. Residents develop and lead projects that impact patient care, emphasize inter-professional collaborative teamwork, and employ formal QI training methodology. The majority of the projects have been sustained and spread throughout the Ambulatory Care Network over an 11-year period.

**Community Pediatric Residents’ Training Program**

Sumeet Banker, MD MPH: sb3789@cumc.columbia.edu  
Assistant Professor of Pediatrics, CUIMC  
Associate Director Community Pediatrics

Dodi Meyer, MD: ddm11@columbia.edu  
Professor of Pediatrics, CUIMC

With one-to-one faculty mentorship, residents in the Community Pediatric Track have the opportunity to work on a project, in collaboration with a community health initiative, over three years of training that integrate three core concepts: community health, cultural competency, and advocacy. Trainees benefit from the strong community-academic partnerships between NewYork-Presbyterian, Columbia University Irving Medical Center, and the surrounding community. Future pediatricians work collaboratively to address community healthcare disparities. Residents from this program have presented their work at national meetings.

**Quality Improvement Initiatives in the Pediatric Residency Program**

Mariellen M. Lane, MD: mmL2@columbia.edu  
Assistant Professor of Pediatrics, CUIMC  
Assistant Program Director for Ambulatory Education, Pediatric Residency Program

Quality Improvement (QI) is one of the focus areas of the Clinical Learning Environment Review (CLER) program of the ACGME. Through the Pediatric Residency experiential learning QI program
at NewYork-Presbyterian Morgan Stanley Children’s Hospital, residents develop and lead projects in ambulatory practices which impact patient care, emphasize inter-professional collaborative teamwork, and use formal QI methodology. Each project is presented annually at the NewYork-Presbyterian Morgan Stanley Children’s Hospital Chief of Service. The majority of the projects have been sustained and spread, resulting in workflow changes in the ambulatory setting and support of Hospital QI priorities.

**Pediatric and Adolescent Resident Training at NewYork-Presbyterian/Weill Cornell**

Theresa Hetzler, MD: thh9024@med.cornell.edu  
*Assistant Professor of Clinical Pediatrics (Interim), Weill Cornell Medicine*

The Ambulatory Care Network Pediatric and Adolescent Practice at Weill Cornell Medicine is the major training site for pediatric resident and medical student training in primary care. Residents are trained in preventive care from the newborn period through adolescence. There is also a focus on training in the care of the medically complex child, with residents participating in a team approach bringing together social workers, a care manager, community health workers, and psychiatric practitioners. Residents also learn to care for other special populations. For example, the TAPP program trains residents and students to care for adolescent mothers and their children, while the Health for Life Program provides instruction on caring for overweight or obese children and adolescents.

**Adult Medicine Resident Training Program**

**Associates in Internal Medicine (AIM)**

Maria de Miguel, MD, MS: mh2634@cumc.columbia.edu  
*Assistant Professor of Medicine, CUIMC*  
*Director of Ambulatory Education*

Jessica Singer, MD, MPH: js3237@cumc.columbia.edu  
*Assistant Professor of Medicine, CUIMC*  
*Medical Director, AIM Practice*

**Washington Heights Family Health Center**

Elaine Fleck, MD: fleckel@nyp.org  
*Associate Professor of Medicine, CUIMC*  
*Associate Chief Medical Officer*

Lucille Torres-Deas, MD: lmt2183@cumc.columbia.edu  
*Assistant Professor of Medicine, CUIMC*  
*Director of Internal Medicine, Washington Heights Family Health Center*

Justine Phifer, MD: jep2209@cumc.columbia.edu  
*Instructor of Medicine, CUIMC*  
*Residency Site Director*

Residents in the Columbia University Internal Medicine Residency Program master the skills needed to care for a culturally diverse medically complex adult patient population at the Washington Heights Family Health Center (the training site for 15 residents) and the AIM Practice at NewYork-Presbyterian/Columbia. At the Washington Heights Family Health Center — a multidisciplinary community health center with predominantly internal medicine, pediatrics, and ob/gyn on site, as well as social work, psychiatry, podiatry, and gastroenterology — residents have a unique opportunity to learn evidence-based, ambulatory care medicine in a Level 3, patient-centered medical home.
The AIM Clinic (Associates in Internal Medicine) — the largest provider of adult primary care in Northern Manhattan, serving over 15,500 adult patients from the surrounding community and the primary referral site for those discharged from the hospital and emergency room — is the primary training site for 120 residents who interact closely with faculty in small-group didactic sessions and through one-on-one patient care teaching.

**Weill Cornell Internal Medicine Associates – Helmsley Medical Tower and Wright Center**

Judy Tung, MD: jut9005@med.cornell.edu  
Associate Professor of Clinical Medicine, Weill Cornell Medicine  
Section Chief, Adult Internal Medicine  
Chair, Department of Medicine, NewYork-Presbyterian Lower Manhattan Hospital

Fred Pelzman, MD: fpelzman@med.cornell.edu  
Associate Professor of Clinical Medicine, Weill Cornell Medicine  
Medical Director, Weill Cornell Internal Medicine Associates

Faculty and residents practice side-by-side at our fully integrated outpatient practice sites (Helmsley Medical Tower and Wright Center), providing comprehensive care to a truly diverse patient population. Both residents and faculty see a broad payer-mix, including privately insured, Medicare, and Medicaid patients in approximately equal proportions. The patient population is socioeconomically, culturally, and linguistically diverse, hailing from the entire NewYork-Presbyterian catchment area: Queens, Harlem, the Bronx, and Brooklyn, in addition to our local neighborhood. Residents serve as true primary care physicians for all aspects of a patient’s care and become proficient in the essential components of ambulatory medicine, including chronic care, urgent care, telemedicine, prevention and screening, and patient education.

- **WCIMA Helmsley Medical Tower** is the hospital-based faculty/resident practice of Weill Cornell Internal Medicine Associates, with approximately 30 attending physicians and 95 residents at this site. It is the educational hub of the resident ambulatory rotation, where didactics and morning report are hosted. Medical students rotating on their Primary Care clerkship also learn primarily at this site. Patients at this practice are characterized by complex medical illness and a high index of co-morbidities.

- **WCIMA Wright Center** is a small faculty/resident practice located just seven blocks north of the main Weill Cornell Medicine campus. There are 3 attending physicians and 16 residents at this site. The small size allows for a more intimate interdisciplinary work environment. The practice tends to have the patient diversity found at the Helmsley Tower site, but with a larger share of patients from our Upper East Side community.

**Family Medicine Residency Program**

Heather Paladine, MD: hlp11@cumc.columbia.edu  
Family Medicine Residency Program Director  
Assistant Professor of Medicine, CFCM at CUIMC

The goal of the Family Medicine Residency Program is to recruit and train tomorrow’s community healthcare leaders who wish to care for patients and their families, particularly those with problems unique to underserved urban communities. Residents learn how to develop systems to improve the health of whole communities. We encourage the education of fellow practitioners on the impact and influence of family medicine and aspire to create change. Nearly 100% of graduates go on to practice primary care, with more than half practicing in low-income communities that have a shortage of primary care doctors.
Health Reform

The United States continues to go through an unprecedented transformation in the way health care is reimbursed and delivered to Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries. Since the passage of the 2009 American Recovery and Reinvestment Act (ARRA) and the 2010 Patient Protection and Affordable Care Act (“Obamacare”), government payors have been piloting and rolling out numerous programs to encourage better care for individuals, better health for populations, and lower costs. (Source: Center for Medicare and Medicaid Services Three-Part Aim.) The Division of Community and Population Health has been the primary department responsible for participating in and responding to these policy reforms. The following are examples of delivery and reimbursement system changes in which the Division is engaged.

**Medicare Shared Savings Program/Accountable Care Organization (ACO)**

As part of the Affordable Care Act, Medicare made it possible for groups of unrelated providers to form ACOs. These new organizations will be assigned responsibility for improving the quality of care and reducing the total cost of care delivered to a specific population of Medicare beneficiaries. Beneficiaries are assigned to ACOs based on their historic relationships with primary care and other outpatient providers. ACOs that show demonstrable improvements in quality measures are eligible to partake in shared savings achieved through the program. The federal government also relieves certain noncompetitive and compensation regulations that are required for disparate providers to work together more easily.

NewYork-Presbyterian, Weill Cornell Medicine, and ColumbiaDoctors have jointly formed an ACO — NewYork Quality Care — and are responsible for approximately 35,000 Medicare beneficiaries. The ACO is focused on reducing use of inpatient and emergency department services, improving the quality of care delivered, and enhancing the use of data to drive change. As part of this program, the NewYork-Presbyterian Ambulatory Care Network is actively engaged in improving the outcomes of Medicare beneficiaries.

**New York State Delivery System Reform Incentive Payment (DSRIP) Program**

New York State is in the process of implementing a five-year, approximately $8 billion initiative to fundamentally restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over five years. Through DSRIP, organizations work together to form Performing Provider Systems (PPSs) — either coming together under a single new entity or forming a tighter collaborative — to accept responsibility for the health of a Medicaid population in their service area. These PPSs are then responsible for selecting five to ten projects based on a Community Needs Assessment, which includes feedback from community leaders, collaborators, and beneficiaries.

Through DSRIP, the NewYork-Presbyterian Performing Provider System (PPS) was developed to align the quality improvement efforts of 85 organizations to improve the health of approximately 80,000 Medicaid beneficiaries across New York City. The PPS has the potential to receive up to $97 million in funding over five years if it successfully meets its pay-for-performance goals. The Division has leveraged these resources to add frontline and community-based staff to reach the most vulnerable patients, as well as additional project management, IT, and analytics staff to build new clinical and community programs. The Division has also leveraged information technology to ensure patients have a seamless care experience across the 85 participating organizations.
NewYork-Presbyterian endeavors to provide multidisciplinary, exceptional care to our patients. We are committed to ensuring that patients who need post-acute care and outpatient behavioral health care receive the same high-quality services and experience they have come to know and trust from NewYork-Presbyterian, regardless of whether the care provider is an NewYork-Presbyterian entity. To achieve this goal, we have established a referral network of quality providers as well as seamless access, effective communications, and transitions of care among emergency department, acute, post-acute, specialty, and primary care providers. Referral networks developed by the Division of Community and Population Health include:

**Skilled Nursing Facility (SNF) and Home Health Agency (HHA) Referral Network**

Collaborating with the NewYork-Presbyterian Department of Care Coordination and care coordination leads at the Regional Hospitals, the Division performed a full assessment of facilities and home health agencies throughout the NewYork-Presbyterian and Regional Hospital Network to identify high-quality collaborators. We reviewed Center for Medicare & Medicaid Services (CMS) Nursing Home and Home Health Agency Compare star ratings, reportable CMS measures, volume and acceptance rate of referrals, specialty services offered, and locations. Through continuous communication with agencies and facilities in the NewYork-Presbyterian Referral Network, we are focusing on new opportunities for joint collaboration of program development, patient flow, and quality improvements.

**Behavioral Health and Substance Use Disorder (SUD) Referral Networks**

To improve the transition from inpatient to outpatient community providers, NewYork-Presbyterian identified high-quality providers of mental health care, SUD treatment, and care management across the NewYork-Presbyterian and Regional Hospital Network region — with the goal of ensuring that vulnerable patients requiring complex care can transition to high-quality ambulatory behavioral health care. These networks have been active and include representation from community agencies, NewYork-Presbyterian Psychiatry ambulatory care clinics, inpatient care providers, and emergency department leadership. NewYork-Presbyterian has been working with community providers to optimize programming that meets community needs, resulting in tightknit, warm handoff referral processes with local mental health and SUD providers.

The Division of Community and Population Health is working closely with NewYork-Presbyterian Care Coordination to evaluate other post-acute care settings where an enhanced relationship through referral network development may be beneficial for the patients we serve. Plans to expand the Referral Network include Pediatric Post-Acute Care, Home Health, and Hospice. These important sites of post-acute care will help to facilitate high-quality care transitions for the patients we serve every day.

The SUD network group coordinated targeted trainings for NewYork-Presbyterian and community providers, such as Medication-Assisted Treatment, the use of Narcan to treat opioid overdoses, a film series addressing bias and stigma, and collaboration with Unitas/St. Marks Institute to pilot a referral process for the Weill Cornell and Columbia University Emergency Departments to expedite “next-day appointments.” The Division also funded two collaborators to expand access to programming for patients with opioid and serious substance abuse disorders: Services for the Underserved, which serves peers in Emergency Departments, and Recovery Health Solutions, which offers a telephonic access service for expedited referrals of NewYork-Presbyterian patients in New York City’s five boroughs.
For more information about the Division of Community and Population Health and community health programs at NewYork-Presbyterian, please visit us online at nyp.org/acn.