STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

NOVEMBER 12, 2014
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

I. CALL TO ORDER — **JOSEPHINE BOLUS, RN**

II. ADOPTION OF OCTOBER 7, 2014 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

III. SENIOR VICE PRESIDENT'S REPORT — **LARAY BROWN**

IV. INFORMATION ITEMS

i. **DSRIP COMMUNITY NEEDS ASSESSMENT REVIEW AND PRELIMINARY FINDINGS**
DONA GREEN, SENIOR ASSISTANT VICE PRESIDENT, CORPORATE PLANNING/HIV SERVICES

ii. **IMPROVING ACCESS TO CARE FOR LGBT PATIENTS**
MARK WINIARSKI, ASSISTANT DIRECTOR OF PLANNING, CORPORATE PLANNING SERVICES

STEPHEN DAVIS, DIRECTOR OF NURSING EXCELLENCE AND UTILIZATION MANAGEMENT
METROPOLITAN HOSPITAL CENTER

DR. NADIA DUVILAIRE, MEDICAL DIRECTOR
COMPREHENSIVE LGBT HEALTH CENTER, METROPOLITAN HOSPITAL CENTER

EVELYN BORGES, ASSOCIATE DIRECTOR, OFFICE OF PATIENT EXPERIENCE/
FOUNDER, THE LGBT PATIENT AND FAMILY ADVISORY COUNCIL, BELLEVUE HOSPITAL CENTER

VANESSA AUSTIN, PUBLIC HEALTH EDUCATOR II, HARLEM HOSPITAL CENTER

V. OLD BUSINESS

VI. NEW BUSINESS

VII. ADJOURNMENT **JOSEPHINE BOLUS, RN**

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

OCTOBER 7, 2014

The meeting of the Strategic Planning Committee of the Board of Directors was held on October 7, 2014 in HHC's Board Room located at 125 Worth Street with Josephine Bolus presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, NP-BC, Chairperson of the Committee
Ram Raju, M.D.
Anna Kril
Robert F. Nolan
Bernard Rosen
Patricia Yang, representing Deputy Mayor Lilliam Barrios-Paoli

OTHER ATTENDEES

J. DeGeorge, Analyst, New York State Comptroller
M. Dolan, Senior Assistant Director, DC 37
C. Fiorentini, Analyst, New York City Independent Budget Office
S. Newmark, Mayor's Office
K. Raffaele, Analyst, Office of Management and Budget
D. Woodrooffe, Analyst, Office of Management and Budget

HHC STAFF

P. Albertson, Senior Assistant Vice President, Operations
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
C. Barrow, Assistant Director, Lincoln Medical and Mental Health Center
D. Benjamin, Senior Corporate Health Project Advisor, Restructuring
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations

T. Carlisle, Associate Executive Director, Corporate Planning Services
E. Casey, Assistant Director, Corporate Planning and HIV Services
D. Cates, Chief of Staff, Office of the Chairman
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
L. Hansley, Director, Organizational Innovation and Effectiveness
L. Isaac, Assistant Director, Corporate Planning and HIV Services
J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
S. Kleinbart, Director of Planning, Coney Island Hospital
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman
K. Madej, Director of Marketing, Communications and Marketing
R. Mark, Chief of Staff, President's Office
H. Mason, Deputy Executive Director, Kings County Hospital Center
I. Michaels, Director, Media Relations, Communications and Marketing
T. Miles, Executive Director, World Trade Center Environmental Health Center
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
C. Patterson, Breakthrough Deployment Officer, Kings County Hospital Center
C. Pean, Associate Director, Harlem Hospital Center
S. Penn, Senior Director, World Trade Center Environmental Health Center
N. Peterson, Senior Associate Director, Woodhull Medical and Mental Health Center
M. Romney, M.D., Associate Medical Director, Kings County Hospital Center
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs
L. Sainbert, Assistant Director, Chairperson's Office
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
J. Wale, Senior Assistant Vice President, Behavioral Health
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

The meeting of the Strategic Planning Committee was called to order at 10:20 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, NP-BC. The minutes of the September 9, 2014 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Federal Update

Lame Duck

Ms. Brown began her report by stating that there was no clear answer on what would be accomplished in the lame duck session. Notwithstanding, work on the following list of items have been mentioned including Permanent SGR "doc fix" with or without pay-fors; reauthorization of the James L. Zadroga 9/11 Health and Compensation Act; amendment to Affordable Care Act (ACA) to allow socioeconomic adjustments, readmission penalties, reductions in Medicare reimbursement for various hospital outpatient procedures; and adoption of Short Stay Hospital Reimbursement Policy referred to as the Two Midnight Rule.

James L. Zadroga 9/11 Health and Compensation Act

Ms. Brown reported that, before Congress departed to focus on re-election campaigns, bills were introduced in the Senate (S. 2844) and House (H.R. 5503) to reauthorize the World Trade Center Health Program and the September 11th Victim Compensation Fund through 2041. Ms. Brown added that it was unclear if any action would be taken concerning the reauthorization of this Act during the lame duck session.

Ms. Brown announced that the victims compensation component of the same Act had a quickly approaching deadline of October 12, 2014, for the registration of anyone diagnosed with 9/11 related cancers. A press conference to reinforce the deadline will be held on Tuesday, October 7, 2014 at 2 PM by Senator Gillibrand along with Congressmembers Nadler, Maloney and King. Ms. Brown informed the Committee that it was anticipated that reauthorization of Zadroga would also be a key component of the message delivered.

FEMA and Hurricane Resiliency

Ms. Brown reported that, on October 3, 2014 FEMA had arranged for staff from the US Senate Appropriations Committee to tour Bellevue Hospital Center with a focus on the need for funding of resiliency efforts to ensure continued operations if there were to be to be another storm of Hurricane Sandy's magnitude. Ms. Brown reported that Dr. Raju led HHC's delegation and that the visit went smoothly.

State Update

Medicaid Global Spending Cap Update

Ms. Brown reported that the New York State Department of Health had released the latest Medicaid Global Spending Cap report at the end of September. She added that the total State Medicaid expenditures that were covered under the cap for FY 2015 were $10 million, or .2%, under projection through July 2014. In addition, through July, spending under the cap was $5.83 billion with statewide Medicaid program enrollment of 5,828,876 persons.

Labor and Delivery Services at North Central Bronx Hospital (NCB)

Ms. Brown reported that following a pre-reopening survey that would be conducted by the New York State Department of Health (SDOH) this week, it was anticipated that there would be a ribbon cutting ceremony. This ribbon cutting ceremony will acknowledge the many months of hard work of various stakeholders including community and union members, and Bronx elected officials. Additionally, it will provide these stakeholders with a tour of the new refurbished space at NCB. Ms. Brown announced that it was anticipated that NCB's Labor and Delivery Services would reopen for business sometime next week.

Ms. Brown explained that the SDOH survey was scheduled this week and that HHC was very optimistic that there would be very little or no findings. Ms. Brown stated that there were some cosmetic renovations made to the unit. She also shared with the Committee that Mr. Nolan had asked about the status of the women who were now in their second trimester. Ms. Brown stated that those women whose prenatal care was in progress now have another option in addition to Jacobi Hospital. They will be excited to return to NCB and deliver their babies there. Ms. Brown reported that the hospital and the community had been engaged in outreach efforts to the community to promote the upcoming return of the stork. Following the reopening, HHC will launch an extensive outreach campaign to make sure that all NCB community residents are informed of the return of these important services.

Mr. Nolan thanked Ms. Brown for the update on the reopening of the Labor and Delivery Unit at NCB. He acknowledged Dr. Raju, Ms. Brown, NCB's former Chief Operating Officer (COO), Sheldon McCleod, as well as the newly appointed COO, Anthony Rajkumar, for their hard work. Mr. Nolan commented that, taking into consideration that Montefiore Hospital's OB/GYN patients are served by Albert Einstein Medical Center, the community was thrilled about the reopening of the Labor and Delivery Unit at NCB as it is the only one in the West Bronx.

INFORMATION ITEM

Kings County Hospital Center's (KCHC) Emergency Department Transformational Journey

Ms. Marie-Laure Romney, MD, Assistant Medical Director, Department of Emergency Medicine

Ms. Joanna Omi, Senior Vice President, Organizational Innovation and Effectiveness, introduced Ms. Marie-Laure Romney, MD, Assistant Medical Director of KCHC's Department of Emergency Medicine and Ms. Claire Patterson, Breakthrough Deployment Officer of the Central Brooklyn Health Network. Ms. Omi informed the Committee that Dr. Romney's presentation would highlight the Breakthrough accomplishments of a very difficult, challenging and longstanding problem.

Ms. Omi informed the Committee that, it is well known that flow time and the amount of time it takes to get through the Emergency Department (ED) in hospitals across the nation, in New York State and at HHC hospitals, are known to be longer than it needs to be for both patients and staff. In addition, Ms. Omi stated

that these long wait times and long flow times have financial, access and patient satisfaction implications. Ms. Omi explained that, as work is continuing to align Breakthrough more closely with some of the Corporation's clinical initiatives, it was timely to provide the Committee with an example of how Breakthrough had been applied, over an extended period of time, to a very challenging problem with incrementally positive results. Ms. Omi informed the Committee that the Breakthrough team at KCHC was fantastic. She explained that Dr. Romney was an embedded facilitator. With the support of Ms. Claire Patterson, Dr. Romney had gone through several layers of Breakthrough training. Ms. Omi stated that, as the Process Owner for the work that is happening in the ED Department at KCHC, Dr. Romney would be presenting KCHC's ED transformation journey.

Dr. Romney began her presentation by providing an overview of KCHC's Emergency Department. Dr. Romney reported that KCHC provided more than 140,000 ED visits each year. Kings County Hospital Center is a Level 1 Trauma Center with 1,400 trauma admissions (one third being penetrating traumas). KCHC has a 12% admission rate (15-20% of admissions to a critical care setting). It is a designated Stroke, Hypothermia and SART Center. Furthermore, KCHC is a teaching hospital with a large EM residency and pediatric fellowship programs, and an active research program.

Dr. Romney reported that KCHC's Rapid Improvement Event (RIE) was held in September 2013. She highlighted that, 90 days following the RIE, there had been tremendous improvement in the triage to physician assignment in the Adult Main ED (ESI 3). She explained that the target of 66 minutes for about 4,219 demands was not only reached, but was also sustained for a year following the RIE, in spite of an increase in ED volume. Dr. Romney noted that, while this process had been successful, it was consistently being revisited to ensure adherence to that standard of work.

Dr. Romney reported on the work that was being done to improve the time from physician assignment to disposition in the main ED (ESI 3). She stated that the target of 200 minutes (3hr: 20 min) had not yet been reached but there had been an impressive decline. Additional RIEs have been scheduled in the coming months to help bring those minutes below the established target.

Dr. Romney reported on the results of the Rapid Improvement Event that was held on August 19-23, 2013 to address the ED treatment flow. The event team members included the following participants:

<u>Team Members</u>:
1. Steve Malcome, RN, ED
2. Alfonso Stewart, PCA ED,
3. Cassandra Bradby, MD
4. Nagela Sainte-Thomas, MD Peds ED
5. Sanjean Philoxy, Asst. Dir. Pt. Relations

<u>Subject Matter Experts:</u>
Dr. Peacock, Medical Informatics
Christopher Russo, Pharmacy
Team Leader: 6. Sonja Miller RN, ED
Process Owner: Marie Romney, MD
Executive Sponsor: Eric Legome, MD
Facilitator: Maritza Cales, Abra Havens
Coach: Claire Patterson, Breakthrough Deployment Officer (DBO)

Dr. Romney described the Reason for Action. She stated that patient flow within the Adult ED was fragmented, starting with delayed check-in, nursing assignment and postponements in the initiation of treatment. This produces decreased quality of care, increased length of stay and inconsistent information exchange between clinicians, nurses and patients.

Dr. Romney described what the Gemba Walk revealed about the Current State of the Adult Main ED. She explained that there were delays in physician's awareness of patient's assignment to a bed in the Adult Main ED; recorded patient bed assignment did not always correspond to patient's actual location; delays in the initiation of care following patient evaluation; and plan of care not consistently communicated to all treatment providers. As such, the goal or the Target State was to have the nurses check the bed assignments and placements in a timely manner; and most importantly, to foster a team approach to patient care by including the charge and head nurse in the doctor's rounds so that they are provided with an overview of what is going on in the department, which would ensure that team members do not drift away from the standard work.

Dr. Romney reported that a Gap Analysis was conducted to identify the root causes of those issues. It was identified that there were some communication and policy and procedure issues. Dr. Romney reported that the major gaps that were identified included ineffective patient tracking, some gaps in the knowledge of how to use the ED Whiteboard and varied skill level of staff. Dr. Romney reported that, following the RIE, some experiments were conducted to identify which changes were worth implementing as presented in the Solution Approach and Rapid Experiment charts below:

Box 5: Solution Approach

Potential Root cause:	If We:	Then We:	Metric
Lack of clarity about who is responsible to complete specific tasks	Create standard role & responsibilities for key players	Know who is accountable to complete each task	Median Triage to Assignment
Staff lack of knowledge regarding use of white-board	Re-inservice staff on white-board tools	Will have a clear understand-ing on how to use the whiteboard to manage flow	Median Assignment to Disposition
Incorrect bed/location assignment	Assign one person to be in charge of patient check-in	Decrease time spent search-ing for patients and delays in check-in and assignment	Median Triage to Assignment
Poor hand-off	Create a system that allows for RN-RN hand-off for all new assignments	Will improve communication to decrease delays in treatment	Median Assignment to Disposition
MDs see patients in batches	Eliminate batching and create 1 by 1 flow	Decrease the amount of time that patients wait before they see their doctor and receive treatment	Median Assignment to Disposition
Varied skill levels	Standardize the skillset required to work in the ED	Enhance the level of care for our patients	Median Triage to Assignment

Box 6: Rapid Experiments

Experiment	Expected Outcome	Actual Outcome	Follow up
Charge nurse simultaneous RN and bed assignment based on acuity	Decrease time from charge nurse assessment to placement	12 patients placed in an average of 2 minutes	Implement
Clerk responsible for consent and chart	Zero charts lost	0/12 charts lost	Implement
Charge/Head/Quad nurse included in ED resident rounds	Faster implementation of treatment plan	2 quads with bidirectional communication between MD's and RN's	Implement
Resident 1:1 flow with standard WIP	Faster implementation of treatment plan	Fewer delays in presentation to attending	Implement
Division of nursing responsibilities between ED patients and medication administration for admitted patients	Faster nursing assessments and execution of orders for ED patients	2 implementations 1 during day shift, 1 during evening shift. Data to be gathered and reported	Implement

Dr. Romney stated that, at the conclusion of the RIE, it was identified that there were other issues that needed to be addressed to complete KCHC's ED transformational journey, which are described in the Completion Plan chart provided below:

Box 7: Completion Plan

RIE	Project	JDI	What	Who	When
X			Develop A3 to determine and quantify benefit of RN assignment to medication administration for admitted patients	Josepha Miranda, RN	9/6/13 RIE scheduled for Jan2014
		X	Explore feasibility of modifying whiteboard to track completion of Quad RN nursing assessment	Josepha Miranda, RN	9/6/13
		X	In-service all staff on standard work (MD's, nursing, clerical)	Marie-Laure Romney, MD Josepha Miranda, RN Otis Freeman	9/13/13
		X	De-activate hard stop in Quadramed for triage note completion with regard to check-in assignment	Eddie Antoine	9/16/13
		X	In-service staff on use of whiteboard	Marie-Laure Romney, MD Josepha Miranda, RN	9/13/13

Dr. Romney reported on the Confirmed State of KCHC's ED transformation journey as of September 1, 2014. Dr. Romney stated that all targets were met within 30 days of the RIE, with exceptions being timeliness and delivery, and triage to assignment. Dr. Romney stated that as these issues were being addressed concerning these metrics, the 82 minutes was reduced to below the 71 minutes target and this performance level has been sustained. Dr. Romney commented that the Breakthrough team reviewed these metrics from time to time to ensure that the work to improve patient experience did not compromise the quality of care being delivered to patients.

Dr. Romney described some of the insights from the Breakthrough team who worked on KCHC's ED transformational journey as the following:

What Went Well

- A better understanding of ED process
- Hearing the opinions of people from different roles
- Everyone added something
- Gemba walk
- We all agreed on the plan that was executed

What Could Improve

- Hit on a lot of things that were out of scope

What Helped

- Cleaned up some misconceptions of the ED flow
- Seeing the staff/patients in action
- Identified multiple gaps in patient flow
- Running experiment helped confirm Target state
- Having Nursing Leadership around

What Did We Learn

- If simple direction is given, staff will have clear understanding of their responsibilities
- The difference in duties PCA/PCT & Head Nurse vs. Charge Nurse
- How batching effects efficiency
- There is no evidence of standard skill set requirements to work in the ED

What Hindered

- Digressions
- Re-assessment of scope
- Many problems to be addressed globally
- Talking over each other

Dr. Romney concluded her presentation by describing, as outlined below, some of the improvements that were generated from the ED transformational journey and the impact that those changes have had on staff, patients and their families:

- Less time spent looking for charts
- Less wait time before nursing assessments
- Faster response to changes in medical condition
- Fewer delays in medication administration

- Smoother-running process with fewer bottlenecks
- Greater emphasis on the usage of the whiteboard
- Improved tracking of patient flow through treatment
- Happier patients and staff

Mr. Rosen, Committee Member, commented that Dr. Romney appeared to be very pleased with the results of the work that was conducted in the ED. He added that, regardless of the diagnosis of the individual going through the ED, the patient's experience would be tremendously improved when all these steps are in place.

Ms. Anna Kril, Board Member, commented that Dr. Romney's enthusiasm was a testament to the success of the Breakthrough work being done at KCHC's ED. She thanked Dr. Romney for doing a terrific job. Ms. Brown added that improvements could only happen when new strategies are constantly being tried and monitored. She added that RIEs involved a lot of hard work.

Ms. Patterson informed the Committee that Dr. Romney had achieved both Green and Blue level certifications (Process Owner). Her personal development plan is to achieve Bronze level certification. Ms. Patterson affirmed that Dr. Romney embodied the concept of transformation, which further validated the need for training. Ms. Patterson thanked Dr. Raju for supporting the ongoing work to develop Breakthrough leaders.

Mrs. Bolus asked Dr. Romney to describe KCHC's ED staffing issues. Dr. Romney responded that, while having more staff would always be helpful, the goal was to maximize available resources and to staff to meet demand as best as possible. However, Dr. Romney noted that it was a slow moving process.

Mrs. Bolus asked Dr. Romney to explain the improvements that had been made in the KCHC's ED Fast Track Area. Dr. Romney responded that an RIE was recently conducted in the Fast Track Area. Dr. Romney stated that the 6-bed Fast Track Area, at a service level of 140,000 visits per year, could be faster. She highlighted that there was a boarding issue in the Main ER, which indirectly impacted the Fast Track flow. Dr. Romney explained that, once the Main ED is completely full, the next sick patient would be transferred to the Fast Track Area, which only holds six beds.

Mr. Nolan, Committee Member, extended his congratulations to both Dr. Romney and Ms. Patterson on their successful transformational journey at KCHC. Mr. Nolan asked if Dr. Romney would have been able to tackle these issues faster 10 years earlier. Dr. Romney answered that the issues in the ED were very complex. She noted that Breakthrough provided a systematic way of addressing the issues, which ultimately made KCHC's ED's transformation successful. Dr. Romney reminded the Committee that Breakthrough teaches staff to identify the root causes of problems. She noted that the goal was not to put a band aid on the problem, but to step back and work to identify the root cause. Mr. Nolan asked Dr. Romney if she would have been able to identify the root causes and find the solutions 10 years earlier. Dr. Romney responded affirmatively. However, she stressed that Breakthrough provided an organized way of doing so, especially by following the metrics.

Ms. Omi added that the Corporation was slowly but surely cutting down on the expenses associated with external help for Breakthrough training. She noted that Dr. Romney's embeddedness was one of the ways that this was being done. Having not just staff within the Breakthrough office but also engaging operational staff to become Breakthrough leaders to lead this work without external support.

Ms. Omi informed the Committee that, because she has being working for the Corporation for more than a decade, she was able to speak about how these types of problems have been handled over time. Ms. Omi explained that, even ten years ago, root cause analysis was considered to be an important factor in addressing problems. However, what was missing was a structured infrastructure built around that analysis to ensure that once the root cause was identified that there would be structured ways to identify and test solutions. Ms. Omi explained that root cause analysis included testing solutions immediately. For those solutions that did not work, it was comforting to know that the staff would not be blamed if it failed. As for the successful experiments, these solutions could be incorporated in a structured way and supported by a monitored management system. These solutions are then used to create standard work. Staff are then trained on that standard work, which is made visual as part of a management process to ensure sustainment over time.

Ms. Omi noted that this event in particular was important to look at because, as Dr. Romney mentioned at the beginning of her presentation, there had been an extended period of time that even during the increase in volume, they were able to continue to see a decrease in the wait time. Ms. Omi highlighted that the wait time would have been reduced even more significantly if there was not an increase in the number of ED patients. Ms. Omi referred to Dr. Romney's comment and restated that there is tremendous fluctuation in ED volume over time. Therefore, the concern is that there could be an increase of thousands more patients over a period of a year with the same level of staffing. Their standard work was deployed and adjusted to meet those changes in demand. Ms. Omi agreed that ten years ago, staff would have been able to figure out the right solution; however, once the environment changed, the solution no longer applied.

Ms. Omi informed the Committee that HHC's next challenge with Breakthrough, as Dr. Romney had mentioned earlier, was the ability to staff to meet demand. Ms. Omi explained that being able to staff to meet demand involved learning how to create standard work that could be adjusted to meet changes. In addition, Ms. Omi stated that organizations that have been applying Lean/Breakthrough for a longer period of time were able to adjust staffing with demand because they have learned how to incorporate those changes in different sets of standard work. Ms. Omi noted that this was the next advanced level to be achieved at KCHC's ED.

Mrs. Bolus thanked Dr. Romney for her fantastic job at KCHC.

ADJOURNMENT

There being no further business, the meeting was adjourned at 10:48 AM.

DSRIP Community Needs Assessment Review and Preliminary Findings

HHC Board of Directors
Strategic Planning Committee

Corporate Planning Services
November 12, 2014

Outline

- Purpose of Community Needs Assessment (CNA)
- Methodology and Data Sources
- DSRIP Guidelines and Valuation
- Key Findings in Select Queens Neighborhoods
  a) Demographics
  b) Population Health
  c) Additional Health Challenges
  d) Gaps Between Resources and Needs

Purpose of the DSRIP CNA

- The DSRIP CNA builds on the recently completed health assessments tied to the New York State Prevention Agenda
- To choose the most effective projects, the Performing Provider Systems (PPSs) must understand the broad health status and health care system in the geographic region in which they are functioning
- The CNA forms the basis and justification for system transformation, clinical improvement and population health improvement

Source: NYSDOH Webinar June 2014

What the CNA Tells Us?

Who aren't we reaching?

What is the scale of concern with special populations?

What are the big problems we have missed in the past?

What aren't we doing that patients want/need?

Where are the service gaps?

Where are we over-resourced?

CNA Data Collection, Analysis, and Interpretation

- Project 1
- Project 2
- Project 3
- Project 4
- Project 5
- Project 6
- Project 7
- Project 8
- Project 9
- Project 10
- Project 11

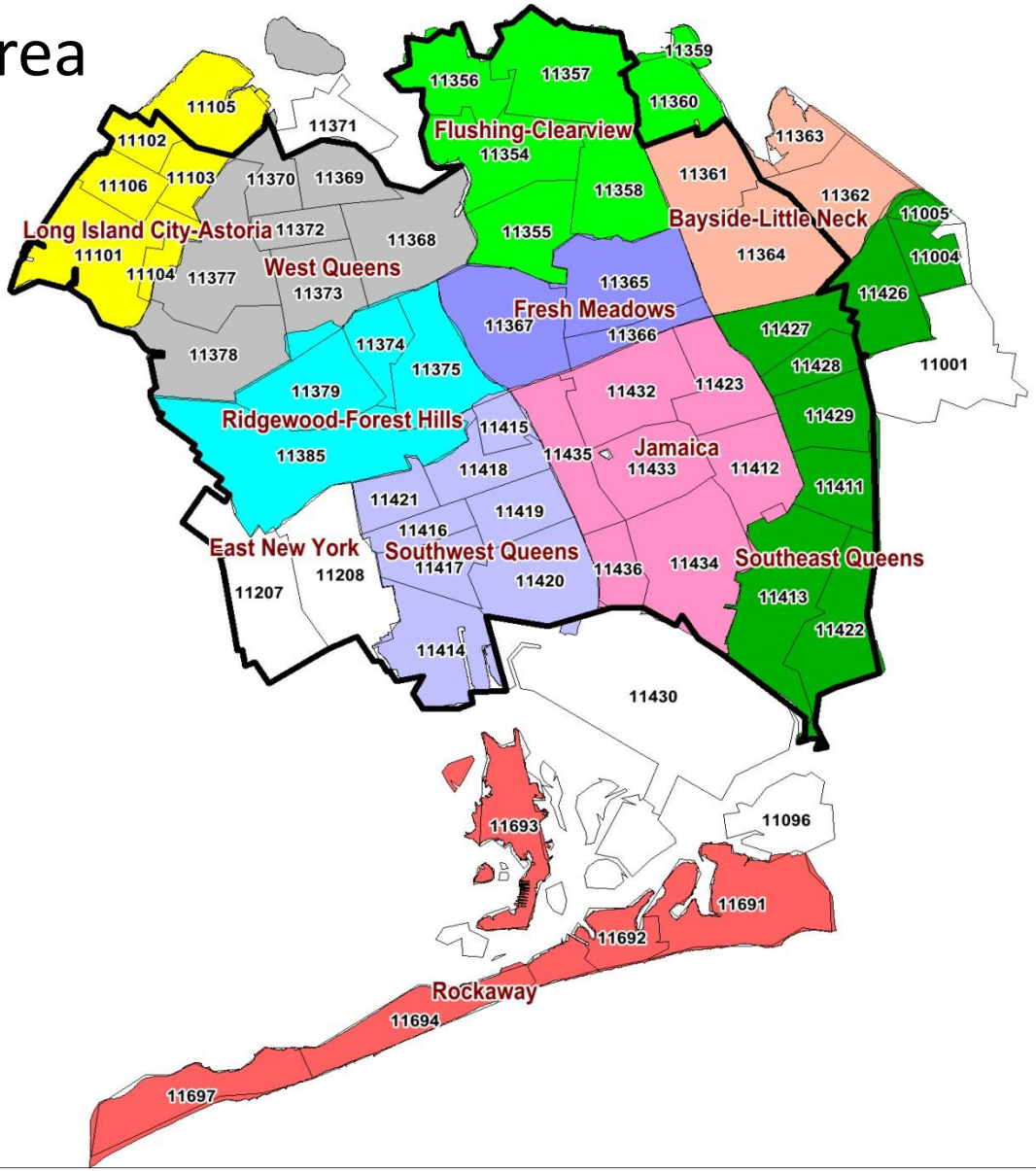
Service Area

- The HHC PPS will prioritize its efforts in neighborhoods that have a high Medicaid and /or Uninsured population, and where the PPS will have a sufficient range of services and resources to improve population health
  - Queens: All neighborhoods excluding the Rockaways and Eastern Queens, and including East New York in Brooklyn
  - Manhattan: North of 90th St, extending into the South Bronx (due to the fluidity of patients between the two boroughs); and south of West 58th St. and East 40th St.
  - Bronx: All neighborhoods
  - Brooklyn: All neighborhoods

Queens Service Area

Queens

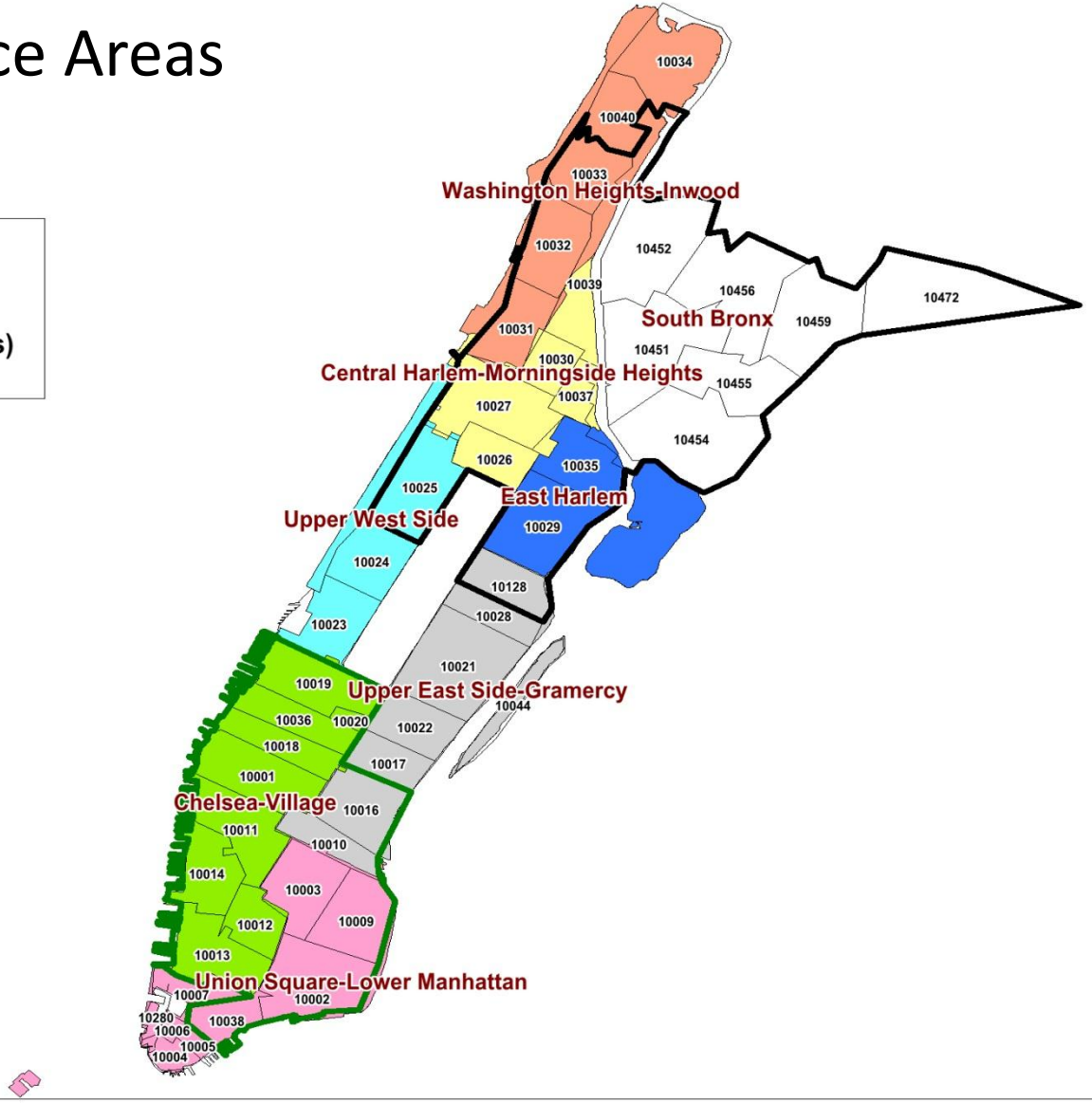
UHF Neighborhoods by Zip Code (Service Area within Bold Borders)



Manhattan Service Areas

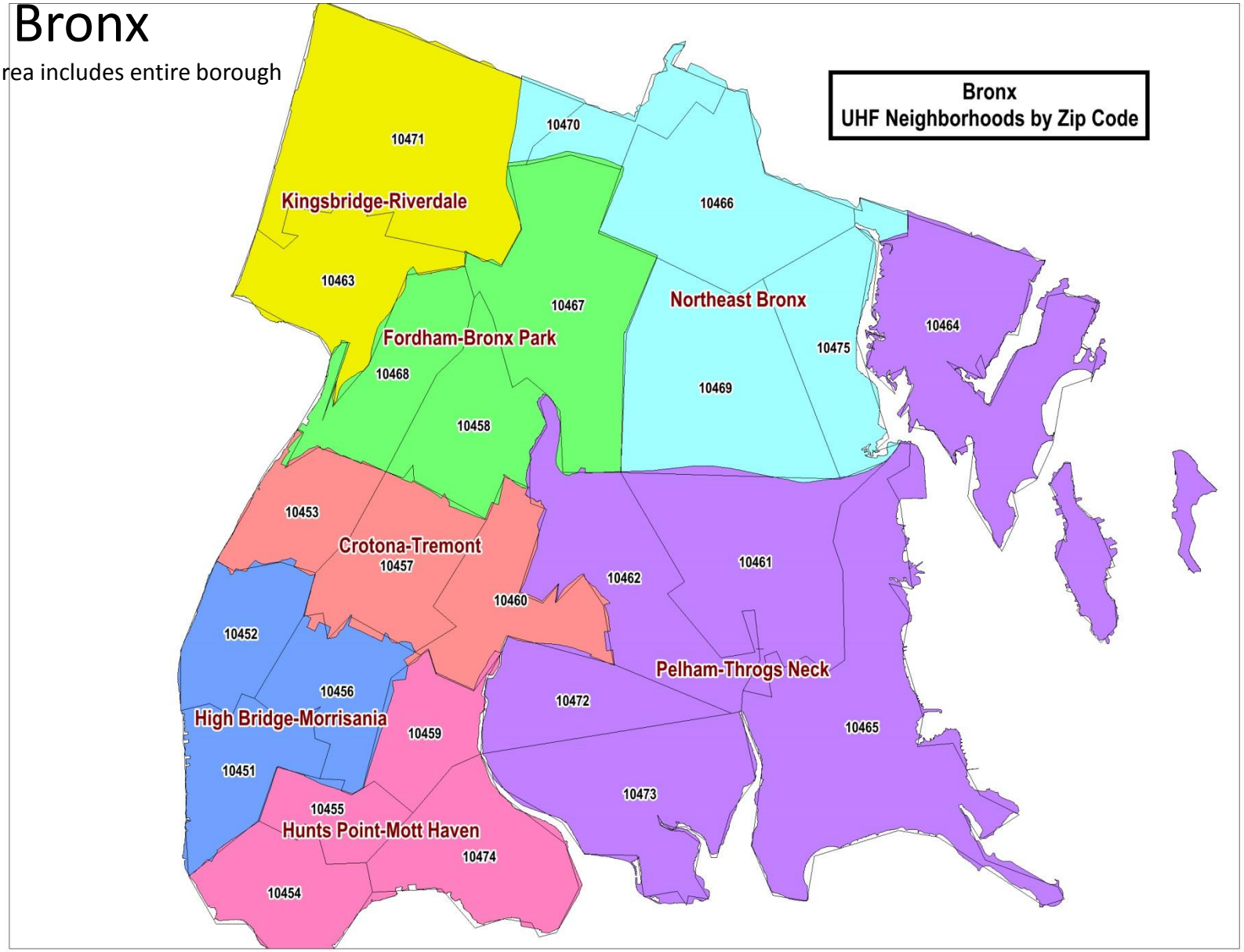
Manhattan

UHF Neighborhoods by Zip Code
(Service Areas within Bold Borders)



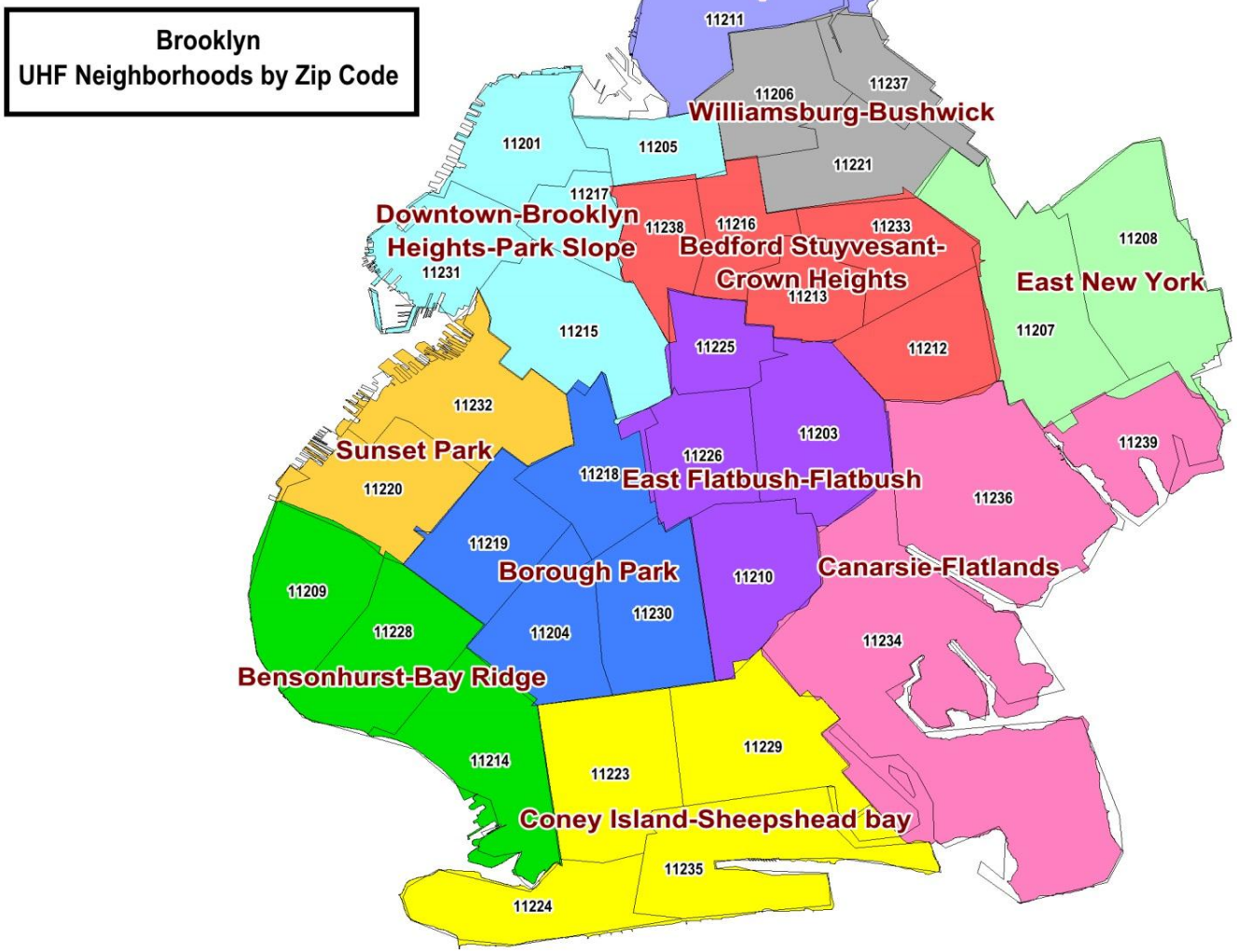
The Bronx

Service area includes entire borough



Brooklyn

Service area includes entire borough



CNA Done in Collaboration with Other PPSs

CNA Partners

- Brooklyn
  - AW Medical, Lutheran HealthCare, Maimonides Medical Center, SUNY Downstate Medical Center
- Queens
  - Medisys Health Network
- Bronx
  - AW Medical, SBH Health System/Bronx Partners for Healthy Communities

Support Provided By

- The New York Academy of Medicine
  - Bronx and Brooklyn: Collected and analyzed all primary and secondary data and produced first draft of report
  - Queens: Collected and analyzed primary data
- Tripp Umbach
  - Manhattan: Conducted focus groups and performed analysis of primary data

Primary Data

- To collect primary data, NYAM and Tripp Umbach partnered with CBOs and local organizations

- Primary data collection included focus groups, key informant interviews, and a resident survey
  - 20 focus groups were conducted per borough
  - 10-15 key informant interviews were conducted per borough
  - 600 to 1,000 resident surveys were completed per borough
    - Respondents (18 and older) were identified and recruited by local organizations and through street outreach
    - Offered in multiple languages (including Spanish, French, Arabic, Bangla, Chinese, Haitian Creole, and Polish)

Organizations Participating in the CNA

FOCUS GROUPS AND RESIDENT SURVEY:

Addicts Rehabilitation Center Fund, Inc.
Adhikaar
African Diaspora and Festival Parade
ALBOR
Arab Family Support Center
Arthur Ashe Institute for Urban Health
BOOM! Health
Brookdale Healthy Families
Brooklyn Health Provider Partnership
Brownsville Multiservice Family Health Center
Caribbean Women's Health Association
Center for Independence of the Disabled in New York
Charles B. Wang Community Health Center
Chhaya Community Development Corporation
Chinese American Planning Council
Diana Jones Senior Center
East Harlem Council for Human Services
El Puente
Fortune Society
Friends of Saint Mary's Park
Gay Men's Health Crisis
Hamilton-Madison House
Harlem United
Henry Street Settlement
Highbridge Gardens Houses
Independence Care System
Jewish Association Serving the Aging (JASA)
Korean American Family Service Center
Korean Community Services
Local Initiatives Support Corporation
Make the Road NY
Mekong
Morris Heights Health Center
NADAP
New Dimensions in Care
NYCHA Johnson House
Postgraduate Center for Mental Health-Care Coordination
Queens Community House
Queens Pride House
Red Hook Initiative
Regional Aid for Interim Needs (RAIN)
Ridgewood Bushwick Senior Citizens Council
Ryan-NENA Community Health Center
Self Help Community Services
Services & Advocacy for GLBT Elders (SAGE)
Services Now for Adult Persons (SNAP)
Soundview Houses
South Asian Council for Social Services
The Door
Violence Intervention Program
William F. Ryan Community Health Center

RESIDENT SURVEY ONLY:

Callen-Lorde Community Health Center
CAMBA
Central Harlem Senior Citizens' Centers, Inc.
Iris House
The Lesbian, Gay, Bisexual & Transgender Community Center

Key Informant Interviews

African Services Committee
Kim Nichols, Co-Executive Director

AHRC
Melvin Gertner, Board member

Arab American Family Support Center
Maha Attieh, Health Program Manager
Robert Cordero, President and Chief Program Officer

Arthur Ashe Institute for Urban Health
Humberto R. Brown, Director

BOOM! Health
Robert Cordero, President and Chief Program Officer

Brooklyn District Public Health Office
Aletha Maybank, Assistant Commissioner

Brooklyn Perinatal Network
Ngozi Moses, Executive Director

Brownsville Multiservice Family Health Center
Nathalie Georges, Director

Bronx District Public Health Office
Jane Bedell, Assistant Commissioner and Medical Director

Bronx Health Link
Barbara Hart, Executive Director

Callen Lorde
Jay Laudato, Executive Director

CAMBA
Kevin Muir, VP, Health Homes/Care Management

Caribbean Women's Health Association
Cheryl Hall, Executive Director

Center for Independence of the Disabled, New York
Susan Dooha, Executive Director

Charles B. Wang Community Health Center
Nuna Kim, Medical Director

Child Center of New York
Traci Donnelly, CEO

Children's Aid Society
Lisa Handwerker, Medical Director
Maria Astudilla, Deputy Director

Coalition for Asian American Families and Children (CACF)
Noilyn Abesamis-Mendoza, Health Policy Director

Commission on the Public Health System
Anthony Feliciano, Director
Judy Wessler, Former Director

CommuniLife
Rosa Gil, President and CEO

Community Service Society
Elisabeth Benjamin, Vice President of Health Initiatives

Corporation for Supportive Housing
Kristin Miller, Director

Crown Heights Community Mediation Center
Allen James, Program Manager, S.O.S. Crown Heights

East and Central Harlem District Public Health Office
Roger Hayes, Assistant Commissioner

Haitian American United for Progress
Elsie St. Louis Accilien, Executive Director

Isabella Geriatric Center
Mark Kater, President and CEO

Jamaica Hospital Center
Jogesh Syalee, Director, School Health

Jewish American Serving the Aging (JASA)
Kathryn Haslanger, CEO
Amy Chalfy, Director of Programs

Lincoln Medical Center
Balavenkatesh Kanna, Director of Research

LISC NYC
Jessica Guilfoy, Deputy Director
Anabelle Rondon, Community Development Associate

Little Sisters of Assumption Family Health Service
Ray Lopez, Director of Environmental Health

Make the Road
Theo Oshiro, Deputy Director

NADAP
John Darin, President & CEO
Joy Demos, Assistant Director of Care Coordination

New York Immigration Coalition
Jackie Vimo, Director of Health Advocacy
Claudia Calhoon, Health Advocacy Senior Specialist

New York Lawyers for the Public Interest
Shena Elrington, Former Director of the Health Justice Program

NYC Department of Homeless Services
Dova Marder, Medical Director

NYCDOH/Rikers Island
Alison Jordan, Executive Director

NYCHA
Andrea Bachrach Mata, Senior Manager

RAIN
Anderson Torres, CEO

Ridgewood Bushwick Senior Citizens Council
James Cameron, CEO
Sandy Christian, Asst. Exec. Director - Senior & Care Management
Maria Viera, Deputy Housing Director of Social Services

Services & Advocacy for GLBT Elders (SAGE)
Catherine Thurston, Senior Director for Programs

South Asian Council for Social Services
Sudha Acharya, Executive Director

Urban Health Plan
Paloma Hernandez, Executive Director

Secondary Data

- Demographics and Population Health Status
  - Examples of data sources:
    - US Census American Community Survey
    - NYC DOHMH Community Health Survey and EPIQUERY
    - Behavioral Risk Factor Surveillance Survey
    - NYS Prevention Agenda 2013-2017 Tracking Indicators
    - NYC/NYS Vital Statistics
    - NYS Perinatal Database
    - NYU Furman Center Data on Housing

- Healthcare and Community Resources
  - Examples of data sources:
    - NYC Department of City Planning
    - Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE SITE)
    - NYS Department of Health
    - NYS Office of Mental Health
    - NYS Department of Education
    - NYS Department of Corrections (via Justiceatlas.com and Gothamist)
    - Center for Health Workforce Studies
    - National Alliance on Mental Illness (NAMI)

DSRIP CNA Scoring Process

Note that CNA accounts for 25% of overall PPS application score

DSRIP PPS ORGANIZATIONAL APPLICATION	SCORE (Sums to 100%)
Completion of CNA (e.g., quality, citations, etc.)	5%
Health Provider Infrastructure (e.g., number and types of providers, assessment of capacity, service area)	15%
Community Resources supporting the PPS (e.g., number and types of resources)	10%
Community Demographics (e.g., age, income, disability education)	15%
Community Population Health and Identified Health Challenges (e.g., health risk factors such as smoking, causes of hospitalization, and disease prevalence)	15%
Healthcare Provider and Community Resources Identified Gaps (e.g., description of the PPS' capacity compared to community needs)	15%
Stakeholder and Community Engagement (e.g., description of public engagement strategies, focus groups, and consumer interviews)	5%
Summary of CNA findings (requires completing a chart provided by the State to summarize the community needs identified that the PPS will address in its DSRIP programs and projects)	20%

DSRIP CNA Guidelines / Requirements

NYS CNA Guidelines are prescriptive concerning what should be included:

a) Exhaustive inventory of health resources and community programs available to Medicaid beneficiaries and uninsured individuals

b) Community demographics, especially as it may affect effective delivery of care

c) Current health status of the community using official criteria

d) Identification of additional health challenges, such as behavioral and environmental risk factors

e) Comparison of existing community resources and health related needs, factoring in additional health service challenges

CNA Findings in Queens

- Sample findings of three neighborhoods in Queens
  - Jamaica
  - Southwest Queens
  - West Queens
- And focusing on two DSRIP priority areas
  - Behavioral Health / Mental Health
  - Asthma

Demographics

	NYC	Queens	Jamaica	Southwest Queens	West Queens
Percent Medicaid beneficiary	44%	41%	47%	41%	51%
Percent uninsured	14%	18%	15%	16%	27%
Percent foreign born	37%	48%	44%	48%	61%
Percent below 100% Federal Poverty Level	20%	14%	15%	13%	18%
Percent of age 25+ with less than high school degree or equivalent	21%	20%	20%	22%	30%
Percent of age 65+ with ambulatory difficulty	28%	25%	28%	26%	25%
% of age 65+ with cognitive difficulty	12%	10%	11%	11%	10%

Source: US Census American Community Survey, 5 year blended, 2008-2012; Medicaid beneficiaries is NYS Dept. of Health, 2013.
Note that the uninsured data is as of 2012. Since that time, largely due to the implementation of the Health Exchange in January 2014, it is estimated that the uninsured has declined by 61% citywide, with 81% of the newly insured enrolling in Medicaid (Capital New York, October 20, 2014).

Population Health: All Medicaid Beneficiaries

	NYS	NYC	Queens	Jamaica	Southwest Queens	West Queens
Potentially Avoidable ED Visits (PPV)						
Visits per 100 Beneficiaries adjusted for population *Lower is better*	36.1	33.8	30.8	33.8	31.0	33.7
Potentially Avoidable Admissions (PQI-all)						
Admits per 100,000 Beneficiaries, adjusted for population -- *Lower is better*	1,784	1,822	1,482	1,699	1,678	1,423
Potentially Avoidable Re-admissions (PPR)	NYS	NYC	All Queens Hospitals	Queens Hospital	Jamaica Hospital	Elmhurst Hospital
PPR admits as a % of total admits, adjusted for population -- *Lower is better*	6.7	7.2	6.9	7.1	7.1	6.8

Adjusted visits and admissions represent the utilization by Medicaid beneficiaries residing within the geographic area, adjusted for age, sex, race/ethnicity, population size, and case mix. Source: NYS Dept. of Health analysis of Medicaid Claims, 2012. Total admissions as it relates to PPR admits excludes very complex cases and any admissions such that a patient leaves against medical advise or is transferred to another hospital or nursing facility.

Population Health with Behavioral Health Diagnosis

	NYS	NYC	Queens	Jamaica	Southwest Queens	West Queens
Percent of Medicaid beneficiaries diagnosed with mental illness	17.1%	19.6%	14.4%	14.7%	12.2%	11.5%
Percent of adults diagnosed w/ major depression & treated w/ meds who remained on meds for >12 weeks -- *Higher is better*	50%	47%	49%	43%	51%	48%
Percent of adults w/ schizophrenia & diabetes whose diabetes was tested -- *Higher is better*	68%	70%	66%	76%	N/A- Small Sample Size	76%
	NYS	**NYC**	**All Queens Hospitals**	**Queens Hospital**	**Jamaica Hospital**	**Elmhurst Hospital**
Percent age 6+ with mental health disorder hospitalization who had outpatient visit within 30 days of discharge -- *Higher is better*	47%	43%	46%	44%	53%	43%

- Antidepressant Medication Management: Percentage of members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication and who remained on an antidepressant medication for at least 84 days (12 weeks).
- Diabetes Monitoring for People with Diabetes and Schizophrenia: Percentage of members 18 to 64 years of age with schizophrenia and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1c (HbA1c) test during the measurement year.
- Follow up after Mental Illness related hospitalization, 30 days after discharge: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a MH practitioner.

Population Health with Asthma Diagnosis

	NYS	NYC	Queens	Jamaica	Southwest Queens	West Queens
Percent of Medicaid beneficiaries diagnosed with Asthma	6.43%	6.70%	5.19%	5.78%	5.38%	4.63%
Percent of Medicaid beneficiaries diagnosed with Asthma who had at least one ED visit over 12 month period –*Lower is better*	50.3%	48.3%	43.0%	50.7%	43.9%	42.7%
Potentially Avoidable pediatric asthma admits per 100,000 Beneficiaries adjusted for population (Age 2-17, PQI 14) *Lower is better*	321	391	227	220	310	178
Potentially Avoidable asthma admits per 100,000 beneficiaries adjusted for population (Age 18 to 39, PQI 15) *Lower is better*	135	149	85	131	100	49

Adjusted visits and admissions represent the utilization by Medicaid beneficiaries residing within the geographic area, adjusted for age, sex, race/ethnicity, population size, and case mix. Source: NYS Dept. of Health analysis of Medicaid Claims, 2012.

Health Service Challenges

Reported reasons for not seeking care identified by key informants and from focus group discussions:

1. Difficulties meeting basic needs (e.g., housing, food) which leads to extended work hours and emotional stresses
2. Work, children and education tend to be prioritized over health
3. Lack of sufficient information on health and health services
4. Minimal knowledge, interest, and engagement in prevention services
5. Stigmatization of behavioral health treatment among foreign born / new immigrants
6. Fear of medical bills, medical debt, and deportation

Health Service Challenges – Patient Health Risks

	NYC	Queens	Jamaica	Southwest Queens	West Queens
Obese adults (BMI>30)	24.2%	22.3%	26.0%	38.9%	24.2%
Binge drink (5 or more drinks in one sitting in past 30 days)	19.6%	18.0%	13.7%	15.6%	22.9%
Lack of or low physical activity (within past 30 days)	22.2%	23.6%	20.6%	22.5%	24.3%
Current smoker	15.5%	14.9%	14.2%	11.5%	15.3%
Self-reported health status – reporting "fair or poor"	21.3%	20.2%	16.6%	12.6%	24.6%
Serious psychological distress	5.5%	4.1%	5.2%	5.4%	7.4%
Mammogram test within the past 2 years (women 40+)	74.6%	74.0%	74.2%	73.0%	60.0%

Source and notes: NYC Dept. of Health and Mental Hygiene. Epiquery, 2012. Behavioral risk factors are age adjusted. Serious psychological distress is a measure of six questions regarding symptoms of anxiety, depression and other emotions.

Primary Data – Behavioral Health

- 23% of survey respondents reported that mental health issues were a main concern in their community
- 17% of survey respondents report personally facing depression or anxiety
- Depression was cited as relatively common in older adults, with implications for physical health and disease self-management:

  And also one of the issues on the physical side that is connected with isolation is poor nutrition. A person oftentimes when they're alone has no incentive to cook or to eat. And we find that many of the [older adult] clients that [we see] are nutritionally compromised. (key informant, CBO)

- Emergency department staff reported that caring for patients with alcohol issues was difficult and put a strain on ED resources:

  *We see a pretty large group of patients with alcohol related issues. And so those patients are very regular here and very difficult, despite trying to get interventions for them, whether it be psychiatric interventions or substance abuse interventions. It's extremely difficult to get them connected and to get them to stay in any kind of program. Once we admit a patient with intoxication, we treat and release, they go back and drink. (*focus group)

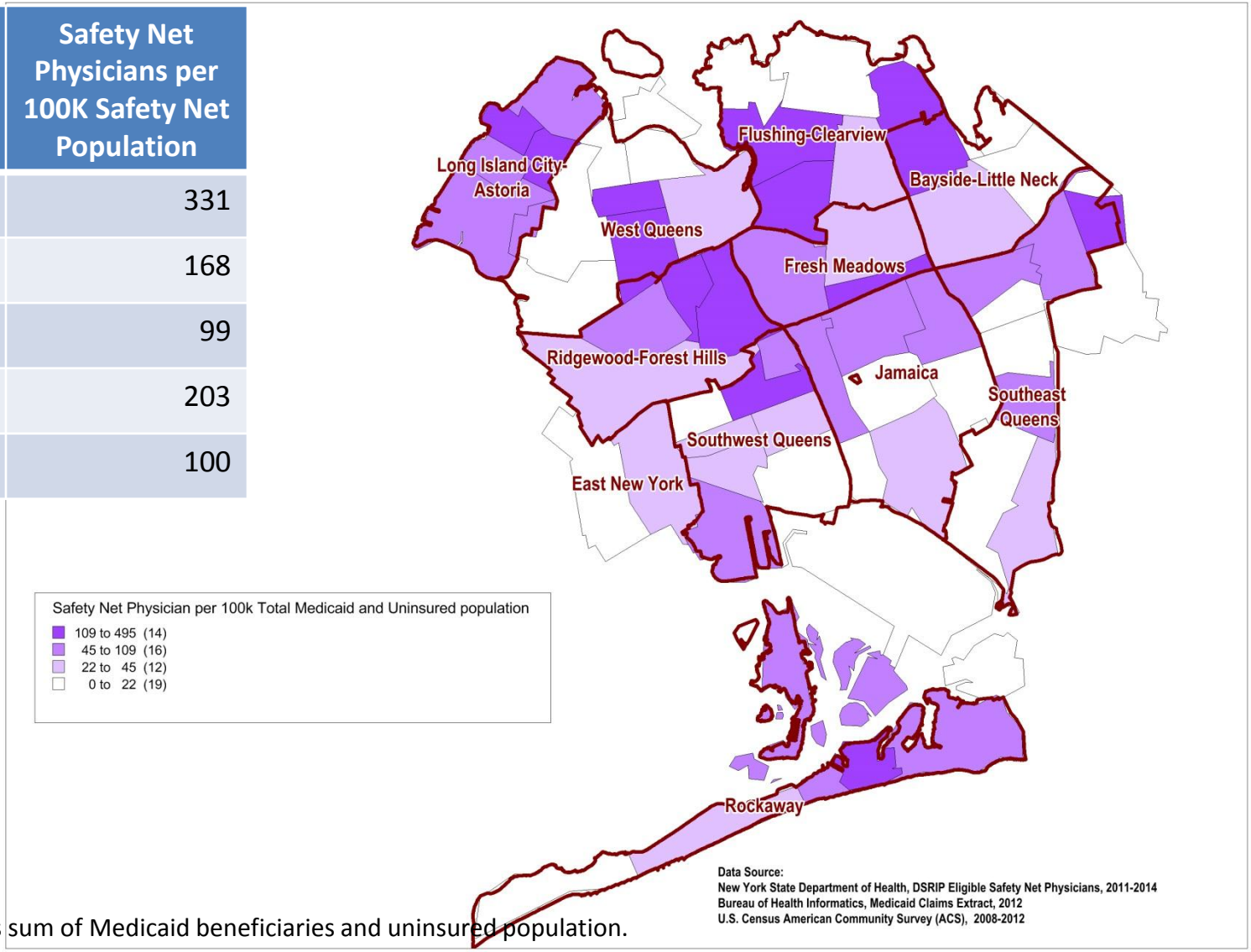
Health Service Challenges – Environmental Health Risks

	NYC	Queens	Jamaica	Southwest Queens	West Queens
Homes with cockroaches	24.0%	19.7%	20.4%	18.0%	27.9%
Adults reporting second-hand smoke at home	4.9%	5.0%	2.6%	n/a, small sample size	4.7%
Adults reporting mold in the home	9.5%	8.6%	11.6%	8.6%	10.8%
Homes with leaks	20.6%	15.2%	18.3%	12.3%	18.7%
Households rating neighborhood structures as good or excellent	75.2%	81.9%	67.4%	81.7%	78.7%

Source and notes: NYC Environmental and Health Data Portal, 2011, 2012.

Medicaid Beneficiaries and Uninsured Population, and Total Safety Net Physicians

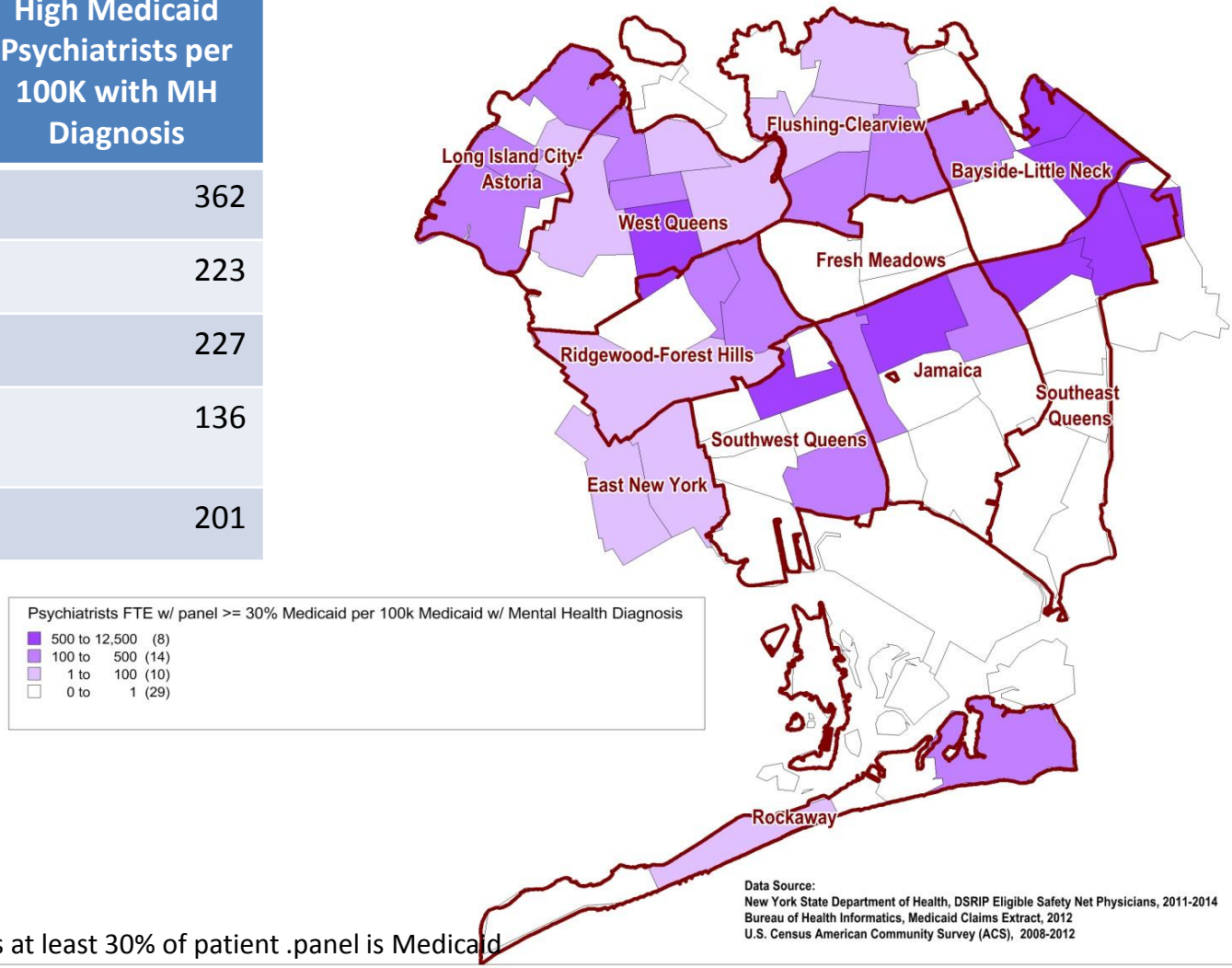
	Safety Net Physicians per 100K Safety Net Population
NYC	331
Queens	168
Jamaica	99
Southwest Queens	203
West Queens	100



Note: Safety Net defined as sum of Medicaid beneficiaries and uninsured population.

Medicaid Beneficiaries Diagnosed with Mental Illness and High Medicaid Psychiatrists

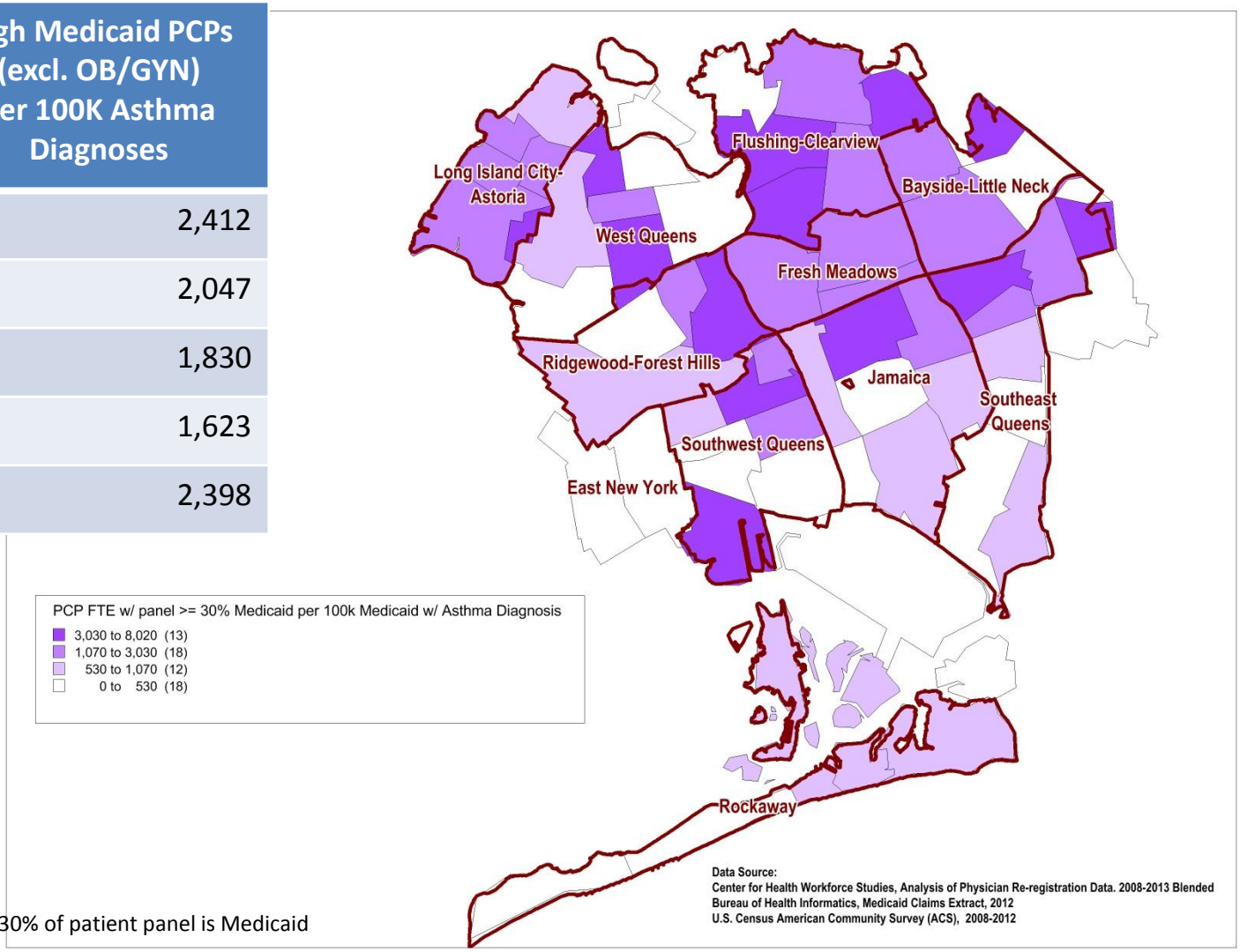
	High Medicaid Psychiatrists per 100K with MH Diagnosis
NYC	362
Queens	223
Jamaica	227
Southwest Queens	136
West Queens	201



Note: "High Medicaid" defined as at least 30% of patient .panel is Medicaid

Medicaid Beneficiaries Diagnosed with Asthma and High Medicaid Primary Care Physicians

	High Medicaid PCPs (excl. OB/GYN) per 100K Asthma Diagnoses
NYC	2,412
Queens	2,047
Jamaica	1,830
Southwest Queens	1,623
West Queens	2,398



Note: "High Medicaid" defined as at least 30% of patient panel is Medicaid

Summary

CNA findings were used to

1) Inform project selection by identifying population health concerns
2) Identify neighborhoods and zip codes citywide with greatest healthcare needs
3) Identify potential PPS Partners by showing gaps between existing provider and community resources and community need
4) Shape project design by describing target populations and align with state health priorities

CNA Supports Project Selections

System Transformation (Domain 2)	
2.a.i	Integrated delivery system
2.a.iii	Health Home at-risk intervention program
2.b.iii	ED care triage for at-risk populations
2.b.iv	Care transition intervention models to reduce 30 day readmissions
2.d.1	Project 11: Engage uninsured and Medicaid low- and non-users of care

Relevant select CNA findings

- Potentially avoidable admission rates and ER visits are high in all boroughs, but particularly in neighborhoods and zip codes with high Medicaid and uninsured populations
- Potentially avoidable admission rates for chronic diseases are 3% higher citywide than statewide
- Inadequate health services in the community contributes to inappropriate ER use (CNA interviews)
- The rate of mental health readmissions among Medicaid Beneficiaries in 23.3% in NYC compared to 20.9% statewide

Project Selection, continued

Clinical Improvement and Population-wide Projects (Domain 3 and 4)	
3.a.i	Integration of primary care and behavioral health
3.b.i	Evidence-based strategies for Cardiovascular Disease Care management
3.d.ii	Expansion of Asthma home-based self-management program
3.g.i	Integrate Palliative care into PCMH model
4.a.iii	Strengthen Mental health and substance abuse infrastructure
4.c.ii	Increase early access to and retention in HIV care
Medisys projects that do not overlap with HHC	
3.c.i	Evidence-based strategies for Diabetes Care management
4.b.i	Promote tobacco use cessation

Relevant select CNA findings

- Asthma prevalence is higher than statewide in most boroughs and parts of Queens
- Cardiovascular prevalence is 14% higher in NYC than Statewide, and the gap is much greater in hot-spot neighborhoods
- 65% of all NYC Medicaid Beneficiaries with substance use diagnosis had an admission over a one year period, a 9% greater rate than statewide
- Vast health disparities in HIV rates across the City. New HIV infection among black/African American people is 4 times than whites. Many of the same populations struggling with HIV are now challenged by increasing Hepatitis C incidence and prevalence

Improving Access to Care for LGBT Patients

Strategic Planning Committee

November 12, 2014

Background: 2008 Public Advocate Report Suggests Local Hospitals Should Do More

HHC's response:

- In-house discussions
- Explored whether La Clinica del Barrio can host an LGBT clinic
- Co-wrote grant applications with Transgender Legal Defense and Education Fund
- Mandatory training for all staff members
  - Contract with National LGBT Cancer Network to:
    - Produce a video
    - Develop curriculum
    - Conduct train-the-trainer sessions
- PeopleSoft training module available to staff
- Facilities conducted trainings and embarked on projects

2014: LGBT Advisory Committee Formed

Comprised of 25 individuals interested in LGBT-related issues and quality care for all

Issues of concern:

- Electronic health record
  - Questions regarding gender identity and sexual orientation
  - Neutral fields, e.g., “parents” instead of “mother” and “father”
- Wording in state-promulgated Patient Bill of Rights
- Translation of policies into many languages

2014: Initiative to Obtain Human Rights Campaign's Designation "Leader in LGBT Health Care"

Facility must meet "Core Four" Criteria

1. Managers and leaders must be trained
   - Two training sessions by Shane Snowdon, director of HRC's Health & Aging Program
   - Attended by approximately 400 staff members
2. "Patients' Bill of Rights" includes the terms "sexual orientation" and "gender identity"
   - Communicated to patients and employees

HHC Insider

LGBT Training Inspires and Informs Leadership

Obtaining good medical care can be challenging for many, but for members of the LGBT community (Lesbian, Gay, Bisexual, and Transgender), it can be particularly difficult.

According to figures compiled by LAMBDA Legal (a national organization working for civil rights recognition for LGBT people and those with HIV), 73% of transgender patients, 28% of LGB patients, and 36% of people living with HIV expect to be treated differently by medical personnel.

Numbers show that their concern is justified. A California-based LAMBDA Legal survey revealed that 56% of LGB and 70% of transgender patients reported at least one bias incident, such as

- Blame for their health condition
- Reluctance of staff to touch them

language or physical force

2014: Initiative for "Leader In LGBT Health Care" designation

3. Visitation policy explicitly grants equal visitation to LGBT patients and visitors
    - Communicated to patients and visitors

4. Employment policy includes the terms "sexual orientation" and "gender identity"
    - Corporate policy (0P 20-32) says:
        - "The Corporation's unequivocal policy is to provide equal opportunity to all...without regard to...gender (including 'gender identity'...)...sexual orientation...."

2014: 10 HHC Facilities Earned Designation As "Leader In LGBT Health Care Equality"

- Acute Care Facilities
  - Bellevue Hospital Center
  - Metropolitan Hospital Center
  - Harlem Hospital Center
  - Woodhull Medical & Mental Health Center
  - Jacobi Medical Center
  - North Central Bronx Hospital
  - Coney Island Hospital
  - Lincoln Medical Center
  - Elmhurst Hospital Center

- Diagnostic &Treatment Center:
  - Cumberland D&TC

Four Key Projects

Stephan Davis: Article in *Hastings Center Report*

In *LGBT Bioethics: Visibility, Disparities, and Dialogue*, special report, *Hastings Center Report, 44,* 2014

Moral Progress in the Public Safety Net:

Access for Transgender and LGB Patients

by Stephan Davis and Nancy Berlinger

As a population, people who self-identify as lesbian, gay, bisexual, or transgender face significant risks to health and difficulty in obtaining medical and behavioral health care, relative to the general public. Commonly cited risks include higher rates of homeless- ness and of suicide attempts among youth, of sexually transmitted infections and substance abuse, and of being the target of violence. Within this population, transgender people are far more likely to express concerns about how they will be treated when they seek health care. A survey conducted by Lambda Legal in 2009 found that, among nearly five thousand total respondents, "trans- gender or gender-nonconforming respondents reported experiencing the highest rates of discrimination and barriers to care." This survey also found that LGBT people of color or with low incomes were more likely to experience "discriminatory and substandard care."[3] It is therefore not surprising that transgender people of color and transgender people who are low income experience extremely high rates of discrimination in health care. Over 80 percent of low-income or uninsured transgender respondents to the Lambda Legal survey felt that they would be treated "differently" from other patients when they sought health care; this was also a significant concern of higher-income transgender people (68 percent) and of greater concern to low-income gay, lesbian, or bisexual people (39 percent) than to higher-income gay, lesbian, or bisexual people (26 percent).

"...good primary care in an inclusive environment...is an important organizational goal, and a step toward justice...."

Dr. Nadia Duvilaire: LGBT Clinic at Metropolitan Hospital

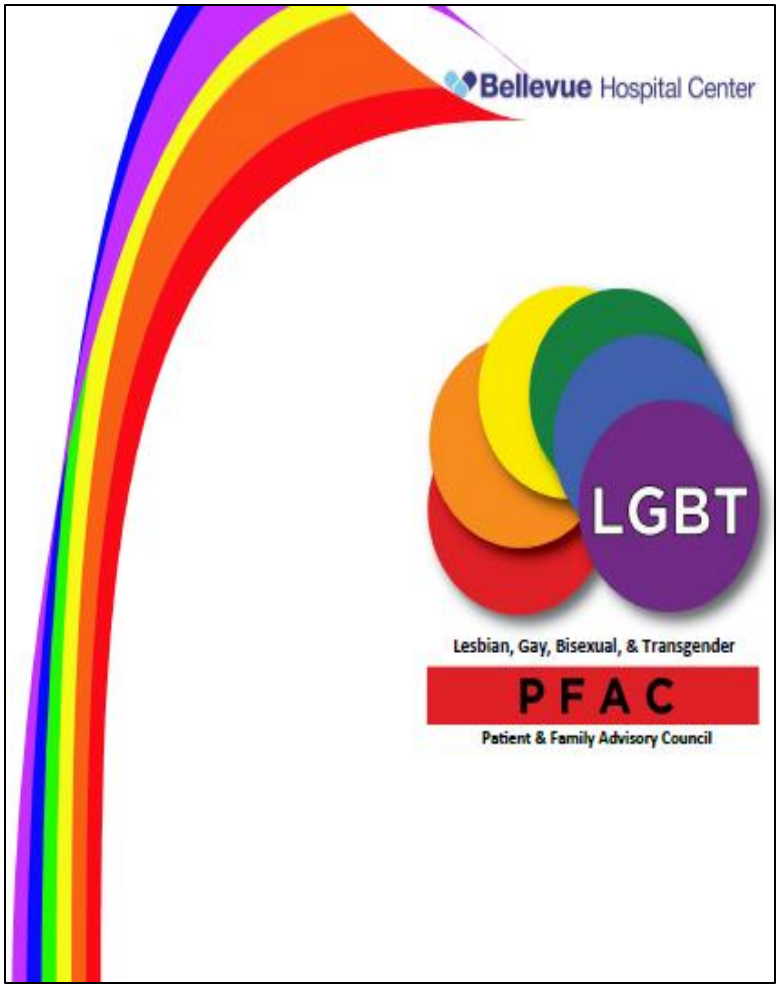
washington blade

New LGBT Health Center opens in Harlem

Pictured from left to right: Medical Director of Metropolitan Hospital Comprehensive LGBT Health Center Dr. ***Nadia Duvilaire****; patient* ***Christopher Leo Daniels****; HHC President Dr.* ***Ram Raju*** *at the launch of the hospital's Comprehensive LGBT Health Center. (Photo courtesy HHC)*

NEW YORK — New York's Health and Hospitals Corporation's Metropolitan Hospital Center in East Harlem this month opened a new LGBT Health Center that aims to better serve and remove barriers to care for LGBT New Yorkers, EDGE Boston and other media outlets report.

Evelyn Borges: LGBT Initiative at Bellevue Hospital Center



BELLEVUE HOSPITAL CENTER
OFFICE OF PATIENT EXPERIENCE
Lesbian, Gay, Bisexual, & Transgender - Patient & Family Advisory Council
(LGBT-PFAC)

CORE CONCEPTS

Dignity and Respect
Listen and honor patient, family and staff perspectives

Information Sharing
Provide and open, accurate, unbiased communication forum

Collaboration
Partnership between patients, families and caregivers

Participation
Active involvement by all members

MAINTAIN PATIENT CONFIDENTIALITY AT ALL TIMES

Vanessa Austin: LGBT Initiative at Harlem Hospital Center