NYU Hospitals Center

One-Year Community Service Plan Update

Submitted: September 15, 2010

1. Mission Statement

No changes were made to NYU Hospitals Center's Philosophy Statement since its 2009 Community Service Plan was submitted. The Hospitals Center's Vision continues to be a world-class, patient-centered, integrated, academic medical center. Its Mission, in partnership with the NYU School of Medicine continues to be threefold: to serve, to teach and to discover.

NYU Hospitals Center's commitment to the community it serves continues to be illustrated by the following principles that are outlined in its Philosophy Statement:

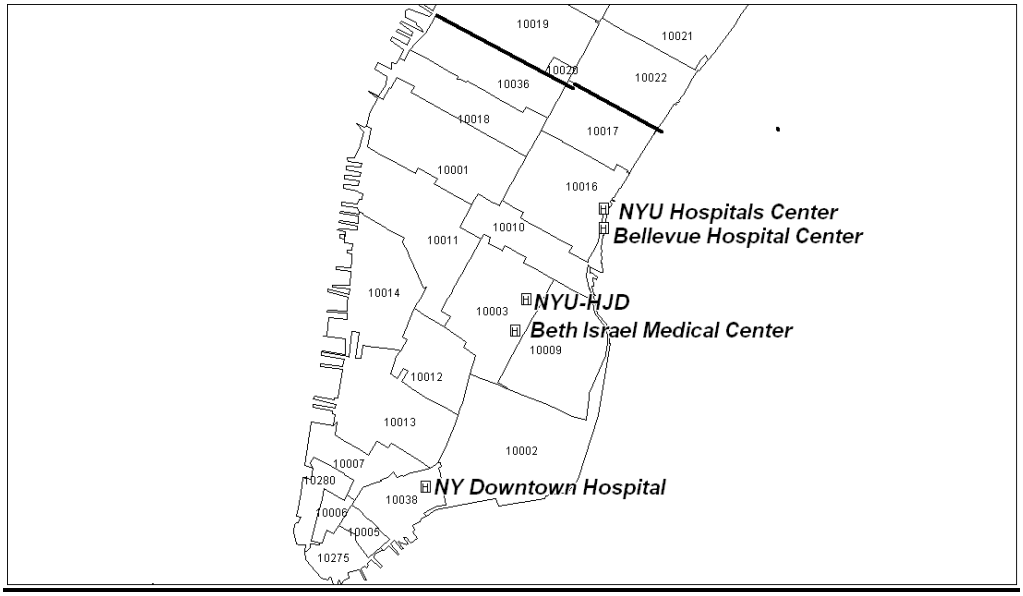
- Design and implement programs which demonstrate the Hospitals Center's commitment to serving the healthcare needs of its community;
- Partner with other community providers to address both long term and emergent public health needs;
- Align with other areas of the Medical Center to develop community outreach programs focused on wellness and the prevention of illness.

2. Hospital Service Area

In its 2009 Community Service Plan submission, NYU Hospitals Center focused its community health agenda on the population residing south of 42nd Street in Manhattan as defined by respective zip codes. Residents of this area accounted for 18% of NYU Hospitals Center's discharges and NYU Hospitals Center was the only major academic medical center located within this area.

Since our submission and with the closing of Saint Vincent's Medical Center, NYU Hospitals Center reconsidered the definition of its local community. The northern boundary of NYU Hospitals Center's community was expanded from 42nd Street to 59th Street. NYU Hospitals Center's local community now includes both the residential population and those whose place of employment are located within this area.

Hospitals Located South of 59th Street



Neighborhood	Zip Codes	2007 Estimated Population[1]	Ethnicity	% Children Aged < 18 years	% Population Aged 65+	Median Household Income
Downtown	10004-7, 38, 280, 282	35,097	25.1% Asian 11.3% Hisp.	16.3%	10.9%	$ 80,727
Lower Eastside	10002, 03, 09	214,897	30.7% Asian 20.1% Hisp.	16.4%	14.1%	$ 42,704
Greenwich Village/Soho	10012, 13, 14	92,112	24.5% Asian	14.0%	13.9%	$ 57,148
Gramercy Park/Murray Hill	10010, 16, 17	102,438	14.0% Hisp.	8.9%	7.8%	$ 70,589
Chelsea	10001, 11	68,846	12.5% Hisp. 10.2% Asian	12.9%	14.0%	$ 64,466
Clinton	10018	5,278	25.5% Asian	16.4%	7.9%	$ 48,935
Below 59th Street Total		**518,668**	**23.2% Asian 13.3% Hisp.**	**15.0%**	**13.8%**	**$ 57,441**
Manhattan		**1,631,383**	**13.2% Black 11.2% Asian 25.2% hsip.**	**17.7%**	**13.8%**	**$ 57,477**
New York City		**8,229,263**	**28.7% Black 12.0% asian 28.0% Hisp,**	**22.4%**	**12.9%**	**$ 43,991**

[1]Source: 2007 Population estimates, ethnicity, age, Median Household Income - Geolytics

3. Participants and Hospital Role

NYU Hospitals Center is in the process of establishing an Office of Community Health (OCH) which would create a direct and coordinated linkage with its community related to its health. The OCH will be primarily concerned with the long term mission of improving the health of the local community by connecting it to the strengths of NYU Langone Medical Center's clinical, educational and research activities.

Each of the NYU Hospitals Center Community Initiatives identified in the 2009 Community Service Plan submission has established relationships with community partners and incorporates community input in the implementation of their various efforts.

For example, the Enhancing Self Care Advocacy Program Education in Heart Failure (ESCAPE HF) works closely with Senior Centers in the community; the Hypertension Screening and Control Program works closely with the New York City Department for the Aging (DFTA), the United Hospital Fund, and the staff at the Naturally Occurring Retirement Communities (NORCS) located south of 42nd Street; the banishing Obesity and Diabetes in Youth (BODY) Project works closely with the NYC Board of Education and the School-Based Health Center at the Norman Thomas High School; and the *ParentCorps* Program works closely with Mr. Recy Dunn, Executive Director of the New York City Department of Education's Office of Early Childhood Education and his staff on all aspects of design and initiation of the dissemination model.

4. Identification of Public Health Priorities

The Public Health Priorities that were identified in the 2009 Community Service Plan submission included the following:

Chronic Disease

Heart Failure - Enhancing Self Care Advocacy Program Education in Heart Failure (ESCAPE HF). Heart failure prevalence increases with increasing age and affects about 1 in 6 people over the age of 80 years. This program is designed to implement community based educational programs in order to inform senior citizens on the most common symptoms of heart failure and the steps they can take to reduce the risk of developing heart failure, or if heart failure is already present, steps they can take to improve quality of life. The educational sessions of the program are conducted in Senior Centers below

42nd Street in Manhattan under the supervision of Stuart Katz, MD, Director of Heart Failure Programs at NYULMC. The education intervention program is being administered in the community by Laura Sara R'bibo, our heart failure community health care worker, in conjunction with nursing school faculty Victoria Dickson and Debbie Chyun, and with the assistance of our heart failure staff nurse practitioners Judith Schipper and Grace Domingo and other NYULMC staff with relevant expertise. The goals of the program are to increase knowledge about heart failure and cardiovascular wellness in the community, improve quality of life, and reduce long-term risk of hospitalization in Seniors living in NYC south of 42nd Street.

Physical Activity and Nutrition

Hypertension - The aim of this project is to train teams of older adults living in Naturally Occurring Retirement Communities (NORCs) and their affiliated nurses to take blood pressure and deliver lifestyle counseling to NORC residents with uncontrolled hypertension. This study focuses on providing sustainable skills so the trained NORC residents and nurses can continue to provide this service to NORC residents after this project is complete. The project evaluates the effect of BP screening and lifestyle counseling delivered by trained teams of NORC residents and nurses in improving BP, weight, diet and physical activity habits. Three NORC communities below 42nd Street in Manhattan are participating. The program is offered in Spanish or English depending on the demographic makeup of the participating NORC. Results from this project will help determine the feasibility and effectiveness of training teams of NORC residents and nurses to measure BP and deliver lifestyle counseling in reducing BP and improving lifestyle behaviors in NORC residents with uncontrolled hypertension. If this program shows promising results, the next step will be to expand this model within the NORC setting to provide a greater impact on the larger community.

Childhood Obesity – The aim of this initiative is to target both ends of the childhood age spectrum. The first effort targets children enrolled in New York City's Universal Pre-Kindergarten programs and the second initiative targets adolescents identified as being at high-risk for obesity-related illness.

Infectious Disease

Hepatitis B – The aim of this initiative was to work closely with St. Vincent's Medical Center to develop, evaluate, and disseminate evidence-based practices to be applied to the predominantly Chinese population that utilized St. Vincent's Chinatown Health Services, a health care clinic located at 25 Elizabeth Street in Lower Manhattan.

5. Update on the Plan of Action

Since NYU Hospitals Center's Community Service Plan was submitted in 2009, much progress has been made on each of the initiatives included in the plan. The following summarizes the activities to date:

Chronic Disease

Heart Failure - Enhancing Self Care Advocacy Program Education in Heart Failure (ESCAPE HF). A core working group of individuals with interest in heart failure and community health was created and has met every 2-4 week since January 2010. This group includes Stuart Katz, MD, director of heart failure programs at NYULMC, heart failure nurse practitioners Judith Schipper and Grace Domingo, Victoria Dickson, Ph.D and Debbie Chyun, Ph.D. at the NYU Nursing School, and staff members from the Rusk Institute whom have expertise in exercise and nutrition. A heart failure community worker, Laura Sara R'Bibo, MPH was hired in May 2010 and has joined the working group. The meetings develop the structure of the program and the educational curriculum for implementation in the Senior Centers. Monthly meetings have also been conducted with Dr. Mariano Rey in order to coordinate our community efforts in heart failure with other cardiovascular health community worker programs affiliated with NYULMC. We have successfully implemented the first major phase of our plan in May 2010. We planned and completed delivery of three weekly education centers at the Caring Community Senior Center located on Washington Square North. The education objectives during these 3 sessions included heart failure awareness, the role of exercise in cardiovascular wellness, and the importance of dietary salt reduction in cardiovascular wellness. These sessions were well attended and rated highly by participants. Due to budget cuts, the Caring Community is currently consolidating its operation in a reduced number of centers, but we have an ongoing dialog with the leadership and will plan to return for additional sessions at the Washington Square North site and other Caring

Community sites in the fall. Since most of the members of the Caring Community have internet access either at home or in the Center, we have also initiated an effort to create an electronic platform for ongoing communication with members of the Caring Community in the form of a health blog. Informatics specialists at the Nursing School are assisting in this endeavor. We are implementing another educational effort at the Sirovic Senior Center on East 12th Street in the East Village starting in fall 2010. In this program we will be providing more specific information on recognition of heart failure symptoms and specific instruction on heart failure self-management over a period of 12 weeks (how to take medicines and reduce dietary sodium, how to recognize worsening symptoms and when to call for help). We will also be formally assessing the acquisition of new knowledge with validated questionnaires before and after the program and will track the impact of the program on the health care status of the population.

Future plans are to identify other Senior Centers south of 59th Street in order to further expand community outreach. Our goal is to identify 5-10 such centers with sequential formal 12-week teaching programs repeated on a quarterly basis and interim daily to weekly contact with center members via electronic links or on-site visits with other existing community health workers. These efforts will be based in part on a geographical analysis of zip codes of patients admitted to Tisch Hospital for primary diagnosis of heart failure over the past 24 months. We will identify centers in regions with high-density admissions and examine demographics in low-density regions to determine whether the low rate of admissions is due to absence of elderly populations or related to other socio-economic and/or cultural factors that might be altered by educational interventions.

Most of the barriers to program development that were initially encountered have been resolved over time, including assembly of our working team, identification of appropriate centers for the program implementation and identification, hiring and training of our heart failure health community worker. All of the critical program elements are now in place and we do not anticipate significant barriers in further implementation of the program.

Physical Activity and Nutrition

Hypertension - Over the past year, we have reached out to key stakeholders in the community to gain interest and solidify our project plan as well as obtain administrative and Institutional Review Board (IRB) approval for the project. Because the goal of the project is to train seniors to take blood pressure (BP) measurements and deliver brief lifestyle counseling our natural first step was to reach out to the New York City

Department for the Aging (DFTA) to explore options for piggybacking our program with their existing Voluntary BP Program (VBPM) that runs in area senior centers. Our group would contribute to this program by adding a lifestyle counseling piece whereby we would train seniors to deliver lifestyle counseling for BP reduction either in a group session format or as individual sessions when seniors are having their BP taking by the senior volunteers running the program. In these preliminary conversations, DFTA suggested we consider translating our materials into Spanish and doing some of the trainings with Spanish-speaking seniors as they are disproportionately affected by hypertension. After discussing the proposal internally, DFTA decided not to participate in the program as they felt uncomfortable with having senior volunteers act as lifestyle counselors imparting information.

As conversations with DFTA dissolved, we switched focus from senior centers to Naturally Occurring Retirement Communities (NORCs). We were approached by the United Hospital Fund (UHF), an organization that is currently implementing chronic disease management programs in NORCs. UHF is very interested in working with us and based on conversations with them, we created and submitted an IRB protocol for review. IRB approval for this program is necessary because we plan to collect data from NORC residents that will allow us to evaluate the program and determine program feasibility, efficacy and long-term sustainability. IRB approval was received in July 2010. Through UHF we connected with the Phipps Houses NORC on E 29th Street between Park and Madison Avenue. We secured a letter of support from the Director of Senior Services at Phipps and are currently holding meetings at the NORC with plans to implement the program there in October 2010. We plan to roll out the program with two other NORC sites in early 2011.

Childhood Obesity - During the past year, the *ParentCorps* project distributed best practices and child-friendly posters for healthy development to 872 Community-Based Organizations across NYC reaching over 50,000 Pre-K students. In addition, 2 full-day training sessions were conducted with all 85 NYC DOE Pre-K Social Workers on best practices related to mental health, activity and nutrition for young children. We also conducted professional training session for NYC DOE early childhood borough directors and associate directors on best practices related to mental health, activity and nutrition for young children. We translated materials into Spanish and carried out assessments of children's health with parents and childcare providers of Asian children residing on the Lower East Side of Manhattan and initiated discussions with service providers (e.g., Chinatown ChildCare, YWCA) serving young children within the NYU

Hospitals Center catchment area (below 59th St in Manhattan). All activities have been carried out as planned and have been extremely well received. We elected to first conduct an assessment of Asian American families within the catchment area prior to translating materials. We are in the processes of evaluating these data that will inform next steps with Non-English Speaking Asian Families in the catchment area. Adaptation of materials and translation will take place this fall.

During the past year, the BODY Project has been extremely successful in implementing its plan with fantastic buy in from the community. Other than the significant bureaucratic barriers (obtain IRB approval from NYULMC, NYC Department of Education, NYC Department of Health and Mental Health, as well as sign-off from each of the principals of the schools we are in), there have been no significant barriers to implementation.

In the fall of 2009, height, weight and waist circumference measurements were collected on 2,913 high school students to calculate Body Mass Index (BMI). This alone was a great deal of work, since it must be performed individually in a sensitive manner, while ensuring privacy. This information was used to approach all the overweight and obese students (see definitions below) as well as 200 lean adolescents for participation in the voluntary medical screen. After the BMI evaluations, students were approached individually, had the project explained to them, and solicited and obtained their assent for participation in the free medical screen.

In the spring of 2010, of the eligible 1,177 students, 1,022 students agreed to participate and we obtained 613 parental consents, and successfully completed medical screens and surveys on 500 students. We are continuing to collect data during the current summer school session and at the time of this summary we have obtained consent from an additional 212 students, obtained an additional 165 parental consents and completed an additional 164 medical screens, for a total of 664 medical screens completed year to date.

Blood samples obtained during the medical screen are taken directly to the NYULMC outpatient laboratories for processing and the results are faxed to Dr. Convit the very next day where they are immediately reviewed by him. This process has uncovered three students with undiagnosed type 2 diabetes, which allowed Dr. Convit to contact parents and connect these students with the pediatric diabetes clinic at Bellevue for emergent evaluation.

The rates of insulin resistance (pre-diabetes) short of type 2 diabetes as well as the rates of cholesterol problems reported in the table below reflect the data from the 500 medical screens obtained this past spring during the regular school year, which were entered into a data base and available for analysis. The ongoing evaluations done during the summer school session, although all individually checked by Dr. Convit, are not yet available for statistical analysis. The following are the rates of insulin resistance and dyslipidemia for the first 500 students split by BMI group as lean (BMI $\leq$ 25 kg/m^2), overweight (BMI > 25 kg/m^{2}but < 30 kg/m^2), and obese (BMI $\geq$ 30 kg/m^2) student groups, respectively:

	Insulin Resistance	**Dyslipidemia**
Lean	1.2%	7%
Overweight	6.3%	20.3%
Obese	32.4%	25%

The data from the medical screens being conducted during summer school (which we anticipate will be about 200 children) has not yet been entered and analyzed as it is still being collected as at the date of this report. We expect the rates of abnormalities in insulin function and cholesterol profiles to be similar in this subset.

In July, personalized reports of the 500 medical evaluations were generated and completed this past spring and mailed to the parents of participating students along with advice on how to improve the health issues reflected in the report. We will be following up shortly with phone calls to the parents to confirm that the reports were received (which we re-mail if not received), answer any questions, and when indicated connect the student and their family to health services. This approach allows us to reach far beyond the students screened, to parents, siblings and the community.

Infectious Diseases

Hepatitis B – As developed in the prior Community Service Plan, the NYU School of Medicine's Center for Immigrant Health's Center for Asian American Health in conjunction with the NYU Hospitals Center and St. Vincent's Medical Center was to develop, evaluate and disseminate evidence-based practices in providing the predominantly Chinese population utilizing St. Vincent's Chinatown Health Services with Hepatitis B screening, treatment, and a vaccination program. As conceived, this program did not occur owning to St. Vincent's Medical Center's serious financial troubles and eventual closing. Instead, the target of this program was changed to provide

care to the Latino and Haitian communities. Dr. Mariano Rey and his team worked closely with the Hispanic Nurses Association, Alianza Dominicana, El Puente Community Services, the Flatbush Haitian Center and the Beraca Baptist Church. A total of 309 Latinos were enrolled in the NYULMC Service Plan Hepatitis B Program as well as 91 Haitian Americans. The benefits of this program were that almost 400 people were screened and received education about Hepatitis B, half of those deemed susceptible (70%) were vaccinated.

6. Dissemination of the Report to the Public

The Community Service Plan was made available to the public by posting it on the NYU Hospitals Center website. It can be accessed using the following link:

http://www.med.nyu.edu/about-us/community-service-plan

Community Service Plan

The vision of NYU Langone Medical Center is to be a world-class patient-centered integrated academic medical center. In order to demonstrate activities in pursuit of this vision, NYU Hospitals Center will provide an integrated patient centered care delivery system providing primary through quaternary care. Operational and functional linkages between patient care, research, and education consistent with the direction and oversight of the Board of Trustees will provide the foundation for all activities.
In order fulfill this vision, NYU Langone Medical Center will: (1) deliver compassionate patient care that is effective and efficient; (2) provide education and guidance to the next generation of physicians; and (3) perform cutting-edge research that advances medicine and helps relieve suffering; in an environment which welcomes diversity and fosters respect for the individual.

This vision will be effectuated through an institutional commitment to maintaining a strong foundation of ethical conduct and compliance with law. In all its activities, the Hospitals Center shall promote diversity, maintain the highest standards of excellence, and promote the dignity of the individual.

7. Changes Impacting Community Health, Provision of Charity Care, and Access to Services

NYU Hospitals Center's continued strong operational and financial performance continues to facilitate its ability to contribute to community health. Since the last submission the following changes have been implemented:

- Non-New York State residents are now eligible for the Hospital's Financial Aid program for emergency services.
- The Charity Care committee is now comprised of the Senior Vice President and Vice Dean, Chief of Hospital Operations; Senior Vice President & Vice Dean for Clinical Affairs and Strategy, Chief Clinical Officer; and Senior Vice President and Vice Dean, Chief Financial Officer.
- The income eligibility levels were increased from a maximum allowable income of 400% of the Federal Poverty Level to 800% of the Federal Poverty Level.

8. Financial Aid Program

Between 2006 and 2009, there was a 125% increase in Financial Aid applications which amounted to a 56% increase in Charity Care or over $1.2 million.

		Charity Care	
Year	No. Applications	Dollars	% Change[(1)]
2006	1,162	$889,000	-
2007	1,868	$1,200,000	35.0%
2008	2,498	$1,600,000	45.0%
2009	2,607	$2,100,000	56.2%

[(1)] Percent Change since 2006

Since the new Financial Aid and Charity Care policies were put into effect in 2009, there was an increase in Charity Care applicants (109), an increase in approvals, an increase in

the percentage of applicants approved at 100%, as well as a decrease in the percentage of applications withdrawn or not completed.

Percent Applications	2006	2007	2008	2009
Approved at 100%	57%	42%	56%	68%
Approved at 75%	2%	6%	5%	3%
Approved at 50%	3%	6%	4%	4%
Approved at 25%	2%	0%	2%	2%
Approved Other Amount	2%	13%	6%	2%
Inelegible	10%	4%	8%	6%
Uncoop/Withdrawn	24%	29%	20%	14%