Perspectives on Racism, Disparities, and Health Equity

Advancing Solutions

Friday, November 18th, 2022

Virtual Conference

HEALTH EQUITY
race
gender
difference
quality
care
age
equity
healthcare
health
education
injury
society
disease
treatment
mortality
discrimination
ethnicity
opportunities
insurance
mental health
location
policy
practice
disparity
testing
system
disability

	Friday, November 18, 2022
8:30am–8:40am	Welcome and Introduction Jay Schechtman, MD, MBA *Chief Clinical Officer, Healthfirst* Susan J. Beane, MD, FACP *Executive Medical Director, Healthfirst*
	Keynote
8:40am–9:05am	Debbie Salas-Lopez, MD, MPH *Senior Vice President of Community and Population Health, Northwell Health Professor of Medicine, Hofstra-Northwell Zucker School of Medicine* **A Community Health Equity Journey**
9:05am–9:15am	Question and Answer Session
	Panel 1
9:15am–10:15am	Wendy Wilcox, MD, MPH, MBA, FACOG *Chief Women's Health Service (WHS) Officer, NYC Health + Hospitals* **Addressing Birth Equity and Beyond in New York City Health + Hospitals** Elizabeth Brondolo, PhD *Professor, Director, Collaborative Health Integration Research Program (CHIRP), Department of Psychology St. John's University* **Aging in Place: A Managed Care Plan, Hospital, and University Collaboration to Identify Risk and Resilience Factors** Ayrenne Adams, MD, MPH *Clinical Lead, Medical Eracism, NYC Health + Hospitals* **Medical Eracism Initiative**

Time	Session
10:15am–10:45am	Question and Answer Session
10:45am—10:55am	Break
Panel 2	
10:55am–11:35am	Christopher Joseph, MSW/MPH *Executive Director, EngageWell IPA* Sam Rivera *Executive Director, OnPoint NYC* **Harm Reduction is Health Equity** Deborah A. Levine, LCSW, ACSW *Director, Harlem Health Initiative at the City University of New York School of Public Health* Andrea Isabel López, MPH *Project Manager, Center for Innovation in Mental Health, City University of New York School of Public Health and Health Policy* **Harlem Strong Mental Health and Economic Empowerment Coalition: A Multisector Community Collaborative for System Transformation**
11:35am–11:55am	Question and Answer Session
11:55am–12:00pm	Final Remarks and Adjournment
Dismiss Session	

Jay Schechtman, MD, MBA

Chief Clinical Officer, Healthfirst

Jay Schechtman, MD, MBA, has been with Healthfirst since 1999 and is responsible for all aspects of members' care and quality, encompassing medical and care management, clinical performance outcomes, and pharmacy.

Dr. Schechtman is an industry expert in population health, accountable care, high-risk populations, and integrated products. Dr. Schechtman also serves as the Assistant Clinical Professor in Community and Preventive Medicine at the Icahn School of Medicine at Mount Sinai.

Prior to working at Healthfirst, Dr. Schechtman was a National Medical Director for Magellan Specialty Health and a full-time academic physician at the Mount Sinai Medical Center in New York. He obtained a medical degree from Mount Sinai School of Medicine and an MBA from the combined healthcare management program of Mount Sinai and Baruch College. Dr. Schechtman is board-certified in rehabilitation medicine and was chief resident at Mount Sinai.

Susan J. Beane, MD, FACP

Executive Medical Director, Healthfirst

Susan J. Beane, MD, FACP, joined Healthfirst in 2009, bringing with her extensive professional experience in managed care. As Executive Medical Director at Healthfirst, Dr. Beane focuses on transforming the delivery of care and optimization of medical outcomes through provider and community partnerships. Her interest and passion is collaboration across the healthcare delivery system to design and implement programs that improve access and equity for Healthfirst members and their communities.

Dr. Beane is a graduate of Princeton University and Columbia University Vagelos College of Physicians and Surgeons.

Debbie Salas-Lopez, MD, MPH

Senior Vice President of Community and Population Health, Northwell Health Professor of Medicine, Hofstra-Northwell Zucker School of Medicine

As Senior Vice President of Community and Population Health, Debbie Salas-Lopez, MD, MPH, oversees Northwell Health's community and public health strategy, including community health investment, community relations, strategic community partnerships, as well as the smoking cessation, human trafficking, and Food as Health programs. Dr. Salas-Lopez's leadership was critical during the COVID-19 pandemic. She and her team have partnered with various community and faith-based leaders to identify their mostpressing needs, which became the catalyst for Northwell's faith-based testing initiative—a program where Northwell partners with community-and faith-based centers to offer free diagnostic and serology (antibody) testing. Dr. Salas-Lopez is also leading the Long Island Regional Health Equity Task Force, which has been tasked with providing equitable and safe COVID-19 vaccine distribution and education to lower-income communities.

Dr. Salas-Lopez joined Northwell in 2019 as Senior Vice President of Transformation, responsible for system value-based initiatives that improve health and care delivery. She assumed her leadership role after serving as the chief transformation officer at Lehigh Valley Health Network, where she led strategy and oversaw a unique and broad portfolio, including community-based and population health initiatives, telehealth, connected care, andinnovation, strategic partnerships, and operational redesigning of the clinical delivery system.

At Lehigh Valley, Dr. Salas-Lopez held various academic and clinical leadership positions. In 2009, she was appointed as the Leonard Parker Pool Chair of Medicine, a role she served in until 2015, when she became an associate chief medical officer. In 2017, she was appointed chief transformation officer for Lehigh Valley Health Network. Academically, she was a professor of medicine at the University of South Florida, Morsani College of Medicine, and the College of Public Health. She is a fellow of the American College of Physicians.

She has collaborated with many community-based organizations on issues related to prevention, screening, and healthcare access and has partnered with other healthcare institutions to address community needs. She has led initiatives to improve quality of care and the health of the community, reduce costs, and provide better care coordination. Dr. Salas-Lopez is a nationally recognized speaker and educator in women leaders in medicine, healthcare disparities and equity in care, cultural awareness and language-appropriate services, and the impact of social and economic factors on health. In 2021, Modern Healthcare named her to its annual Top 25 Women Leaders as a "Woman to Watch." She also received the 2021 Tribute to Excellence in Health Care award from the United Hospital Fund.

Elizabeth Brondolo, PhD

Professor, Director, Collaborative Health Integration Research Program (CHIRP), Department of Psychology, St. John's University Director of Clinical Research, Department of Family Medicine, Jamaica Hospital Medical Center Affiliate Faculty, NewYorkPresbyterian-Queens

Dr. Brondolo is a professor at St. John's University in Queens, New York, and Director of the Collaborative Health Integration Research Program (CHIRP). Dr. Brondolo and her students conduct programmatic, mechanistic research aimed at understanding the effects of stress on health. Their projects include studies of the effects of stress associated with work, racism, poverty, and end-of-life.

The research conducted by CHIRP employs a variety of methodologies, including ambulatory monitoring and ecological momentary assessment, to bring the "lab to the field." Dr. Brondolo's research has been funded by the National Institutes of Mental Health; National Heart Lung; and Blood Institute; National Institute of Occupational Safety and Health; the American Heart Association; and other organizations.

She has been a permanent member of several study sections, including Mechanisms of Emotions Stress and Health and the Clinical Trials review for NHLBI. She is currently serving on the Steering Committee on Health Disparities for the APA and is chair of the Working Group on Stress and Health Disparities. Among other awards, she has received the Patricia Barchas Award from the American Psychosomatic Society for her work in sociophysiology.

Dr. Brondolo has published widely (80+ papers) in behavioral medicine and health. One of her primary commitments is developing the pipeline of scholars from diverse backgrounds who will generate the knowledge and methods to reduce racial disparities in health. Dr. Brondolo is also a working clinician, specializing in the treatment of post-traumatic stress and bipolar disorder, and the author of Break the Bipolar Cycle: A Day-to-Day Guide to Living with Bipolar Disorder (McGraw Hill).

Ayrenne Adams, MD, MPH

Clinical Lead, Medical Eracism, NYC Health + Hospitals

Dr. Ayrenne Adams is a primary care physician who is passionate about designing, implementing, and evaluating health system structures, programs, and policies to achieve equitable care and outcomes for all patients. She is an Assistant Clinical Professor in the Department of Medicine at NYU Grossman School of Medicine and is the Clinical Lead of the Medical Eracism initiative at NYC Health + Hospitals, tasked with removing race-based algorithms in clinical care within the enterprise. She also serves as a Clinical Director on the Social Determinants of Health team within the Office of Ambulatory Care and Population Health at NYC Health + Hospitals, developing and expanding social needs screening and referrals programs throughout the enterprise. She also practices adult primary care at Tremont Community Health Center, a federally qualified health center in the South Bronx.

She graduated with distinction from Duke University with a major in History and minor in Chemistry. Prior to medical school, she participated in Teach for America and taught third grade homeroom to students residing in the west side of Chicago. She graduated cum laude from Emory University School of Medicine with Alpha Omega Alpha honors and received her Master of Public Health in Behavioral Science and Health Education at the Rollins School of Public Health. She completed her Internal Medicine/Primary Care residency training at Brigham and Women's Hospital, a Harvard Medical School affiliate. She has been named a 2022 40 Under 40 Leader in Health by the National Minority Quality Forum and is a recipient of the Darryl Powell Social Justice Award as well as the Martin P. Solomon Primary Care Scholarship.

Wendy Wilcox, MD, MPH, MBA, FACOG

Chief Women's Health Officer, NYC Health + Hospitals

Dr. Wendy Wilcox is the Chief Women's Health Officer for New York City Health + Hospitals. Dr. Wilcox is responsible for the strategic development, enhancement of quality and safety, and growth of the women's health service line in NYC Health + Hospitals. An experienced board-certified obstetrician gynecologist, Dr. Wilcox chairs the Women's Health Council and has continued to lead the Maternal Mortality Reduction Initiative, which launched in 2018 and encompasses the Maternal Home and obstetric safety simulation programs.

As Co-Chair of the New York State Task Force on Maternal Mortality and Disparate Racial Outcomes (2018–2019), Dr. Wilcox led a group of NYS leaders in Women's Health and other policy makers to examine the root causes of maternal mortality and its disproportionate effect on Black women and other women of color. Through her work in the Brooklyn Maternal Mortality Task Force (2021–present), New York State Maternal Mortality Review Board, ACOG D2 Safe Motherhood Initiative and others, Dr. Wilcox continues to lead efforts focused on improving maternal health and improving equity for black birthing people.

Christopher Joseph, MSW/MPH

Executive Director, EngageWell IPA

For nearly 15 years, Chris Joseph (he/him) has been dedicated to addressing socioeconomic and racial health disparities among marginalized NYC communities. Chris joined the EngageWell IPA in January 2019, overseeing program innovation, clinical integration, and quality management initiatives and assumed the Executive Director role in July 2021. Prior to EngageWell, Chris oversaw NYC's largest HIV Care Coordination Program at Mount Sinai's Institute for Advanced Medicine and managed an SDOH intervention at Woodhull Medical Center where undergraduate Health Advocates connected low-income, pediatric families living in Brooklyn to community resources and public benefits. Since 2011, Chris has participated in NYC's Ryan White HIV Planning Council & Integration of Care Committee helping to improve NYC's safety-net system for people with, or at risk, for HIV.

Chris was also an Adjunct Instructor for four years at LaGuardia Community College where he taught Population Health for the Community Health Worker Certificate Program.

In 2015, Chris's health equity work earned him an Emerging Social Work Leadership Award from the National Association of Social Workers NYC Chapter. Chris grew up in East Detroit, Michigan, earning Master of Public Health and Master of Social Work degrees from the University of Michigan - Ann Arbor (Go Blue!).

Sam Rivera

Executive Director, OnPoint NYC

Sam has more than 29 years of progressive experience in social services. His primary focus of expertise lies in Criminal Justice and Reentry, HIV/AIDS, Harm Reduction, Addiction/Recovery, and Mental Health. He currently serves as the Executive Director of OnPoint NYC, a harm reduction organization that provides services to active drug users and sex workers in Northern Manhattan and the South Bronx, many of whom are low-income or homeless as well as of color and LGBTQ. He brings to this role his several decades of cutting-edge service provision experience and a commitment to social justice. He has dedicated his professional career to ameliorating the harms associated with the War on Drug Users, those impacted by the criminal justice system, racism/sexism, structural inequality, and mass incarceration and will continue to work to end systematic barriers to populations that are most vulnerable.

Deborah A. Levine, LCSW, ACSW

Director, Harlem Health Initiative at The City University of New York School of Public Health

Deborah Levine is the Director of The City University of New York School of Public Health's Harlem Health Initiative, a role in which she addresses neighborhood service priorities and aims to reduce health disparities throughout Harlem.

Levine began her training at Fairleigh Dickinson University, where she earned a bachelor's degree in social work followed by a master's degree in clinical social work with a minor in family therapy at New York University. She later honed her abilities in Hunter College's post-graduate program in social work supervision and training, Columbia University Graduate School's Institute for Not-for-Profit Middle Management program, and its leadership and executive management program.

Throughout her career, she has worked to apply capacity building and technical assistance to community-based organizations, national non-profits, and houses of worship by implementing strategies that increase access to and utilization of health promotion, disease prevention, and risk-and-reduction avoidance services for racial/ethnic minority individuals.

Levine is a founding board member and national secretary of the National Black Women's HIV/AIDS Network, Inc. She also serves on the board of the Coalition on Positive Health Empowerment (COPE), an organization dedicated to the eradication of viral hepatitis. She is the community co-chair for New York Knows and chair of the New York City Department of Health and Mental Hygiene's Women's Advisory Board. Levine was recently appointed to the NYC Health + Hospitals Community Advisory Board, where she will sit on the mental health subcommittee.

Andrea Isabel López, MPH

Project Manager, Center for Innovation in Mental Health, City University of New York School of Public Health and Health Policy

Andrea Isabel López is a Project Manager at the Center for Innovation in Mental Health at the City University of New York (CUNY)School of Public Health and Health Policy. She received a Bachelor of Arts in International Relations and Latin American Studies from Syracuse University. She also received her MPH in Community Health from the CUNY Graduate School of Public Health and Health Policy. Prior to joining the Center for Innovation in Mental Health, Andrea completed the Margaret E. Mahoney Fellowship with the New York Academy of Medicine, where she explored barriers to care in the Latino community and the role of community health workers. Andrea has also worked as a Research Project Coordinator and Associate Researcher for multiple NIH-funded projects at the Icahn School of Medicine at Mount Sinai and the Albert Einstein College of Medicine. Andrea was born and raised in San Juan, Puerto Rico, and is committed to advancing health equity for the Latino community and improving representation in the research field.

PRESENTATIONS

Devastating Toll of COVID-19 on the U.S. by Race/Ethnicity

COVID-19 Cases, Hospitalizations, and Deaths, by Race/Ethnicity

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases[1]	1.8x	0.6x	1.4x	1.7x
Hospitalization[2]	4.0x	1.2x	3.7x	4.1x
Death[3]	2.6x	1.1x	2.8x	2.8x

Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., among frontline, essential, and critical infrastructure workers.

How to Slow the Spread of COVID-19

Wear a mask

Stay 6 feet apart

Wash your hands

CDC

References on back

cdc.gov/coronavirus

The COVID-19 Experience

700,000 + Vaccines

Total number is understated due to limited testing in the early stages of the crisis

Going into Vulnerable Communities – High Need, High Risk……

- *Northwell received requests from churches, government agencies, Chambers of Commerce, employers, skilled nursing facilities, police and fire departments, and others for testing and education…..*

"Northwell nurses and staff were efficient and compassionate."
– Rev. Adolphus Lacey, Bethany Baptist Church, Brooklyn

COVID-19 Community Testing Partnerships

Northwell Health has provided COVID-19 diagnostic and antibody testing at over 100 sites in traditionally underserved areas across New York State

Over	Over
100,000K	**875+**
COVID Tests Administered	Locations

Driving Down COVID-19 Rates in LI's Minority Communities

A Public Health victory experts describe as the most successful turnaround in the US

"I think it's unique and it's important. I want to know what Long Island did right so that we can try and replicate that in other areas that are diverse."

- Dr. Eliseo J. Pérez-Stable, Director of the National Institute on Minority Health and Health Disparities

COVID-19 Vaccine

On December 14th, 2020, Northwell Health received its first batches of the vaccine and began vaccinating our team members. Sandra Lindsay, a critical care nurse at Long Island Jewish Medical Center, was the first person not participating in a trial to be vaccinated in the U.S.

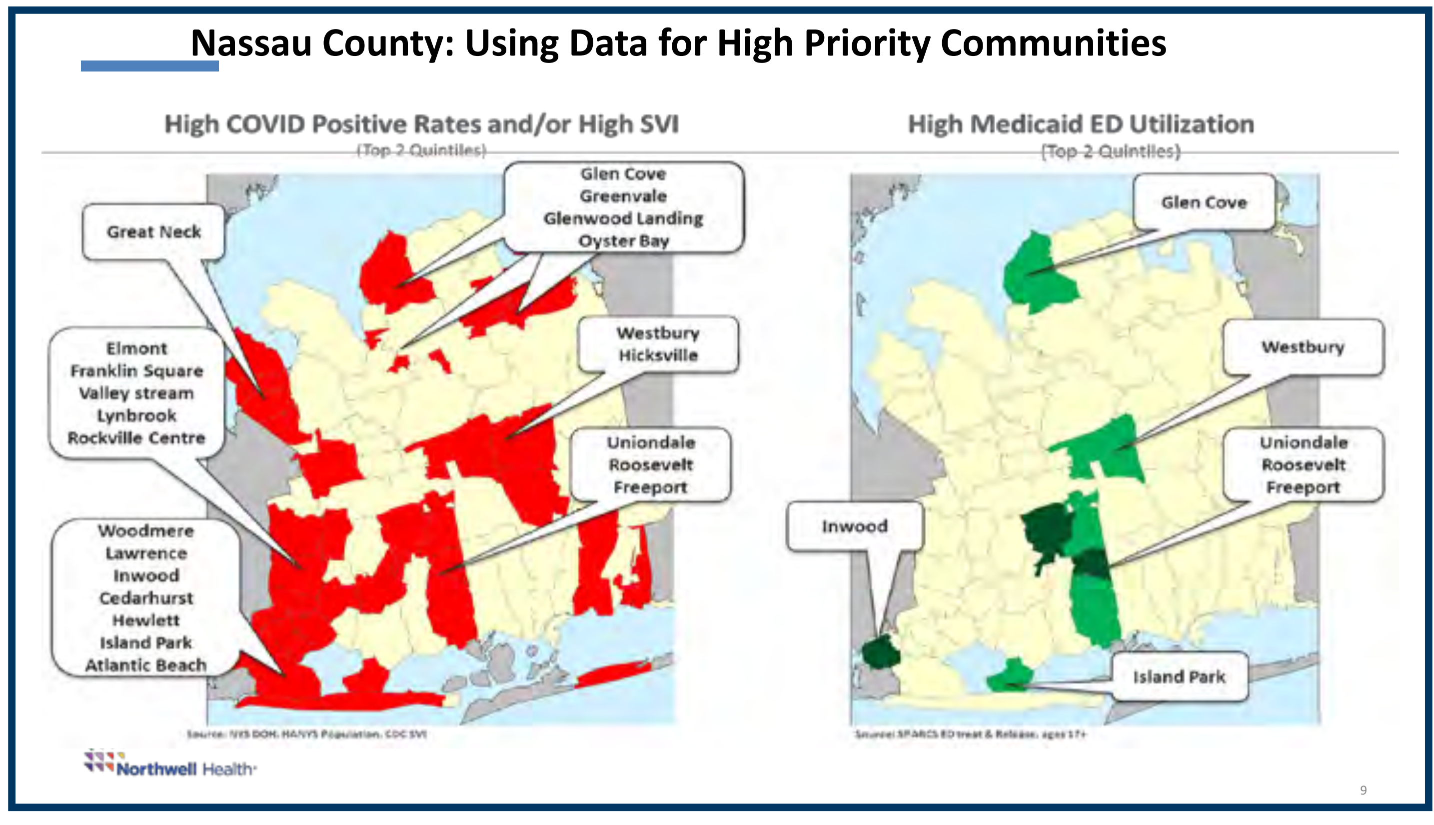
Vaccine Distribution: A Data Driven Approach

- Used to identify zip codes that have the highest need for COVID-19 vaccination.
- This prioritization will be instrumental in the development of regional HUBs for vaccine distribution.

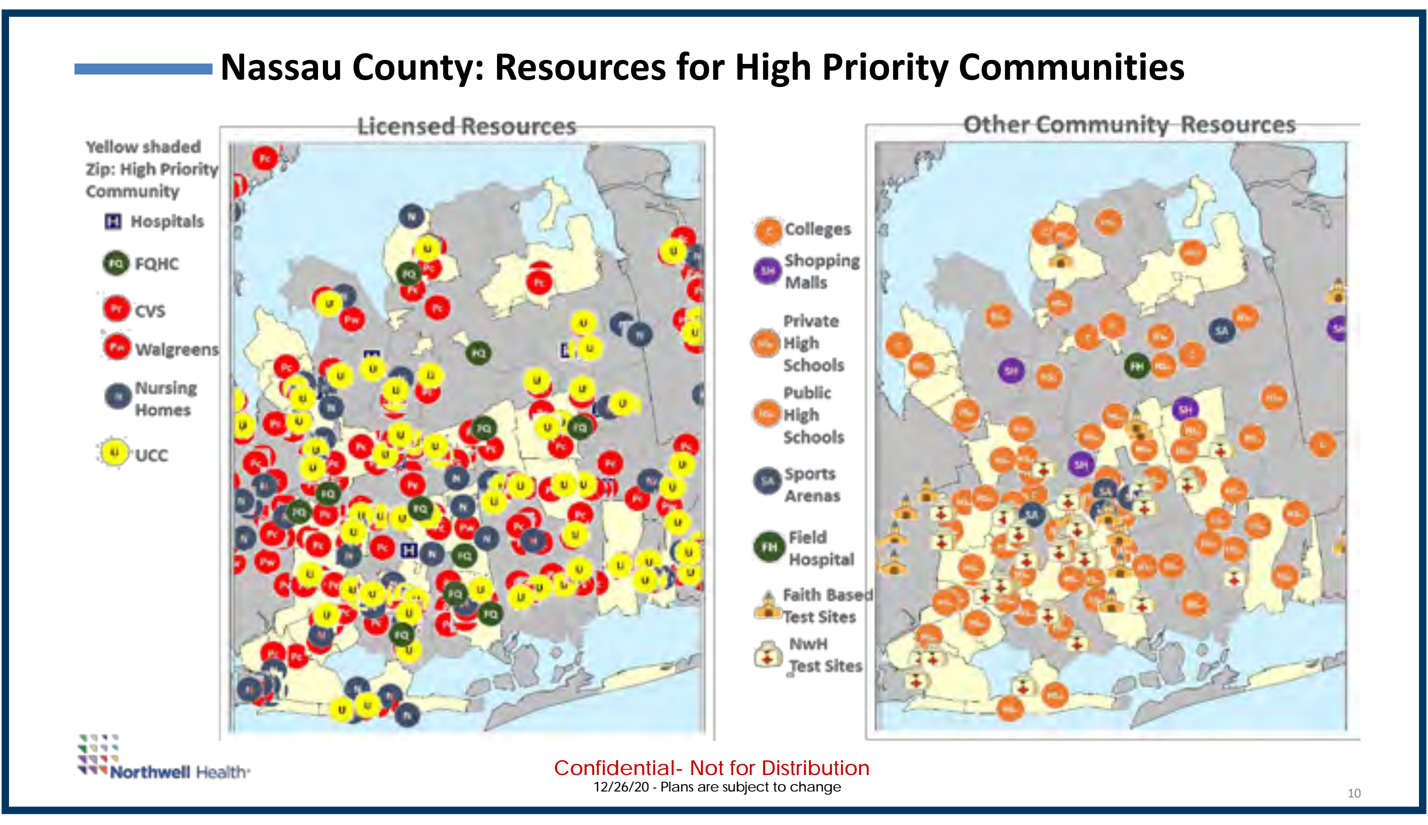
Metrics	Description and Explanation	Weight
Population 65+	Identified as members of phase 1C, the 65+ population is most susceptible to death from COVID-19 and is responsible for the largest percentage of deaths.	x1
Population Non-White	The non-white population is a proxy to measure the underserved populations. As COVID-19 has disproportionally affected the underserved communities, the NY Vaccine Equity Task Force was created to ensure equitable distribution of the vaccine.	x1
Medicaid Utilization	Another proxy for the underserved population, emergency department Medicaid utilization is used to determine areas that have less access to care.	x1
COVID Daily Positive (12/20)	Three metrics that are used to determine the hardest hit areas on 12/20, the week leading up to 12/20, and the total number of COVID-19 positive results. This provides insights into who is currently at risk and who has felt the worst of the epidemic from the beginning.	x1
COVID 7 Day Average (12/20)		x1
COVID Total Positive (12/20)		x1
SVI	The Social Vulnerability Index (SVI) is a metric defined by the CDC to identify the underserved communities on socioeconomic status, household composition & disability, minority status & language, and transportation.	x1

- Each metric was assigned a weight of 1 and was tested against one another to ensure that no two measures were highly correlated.

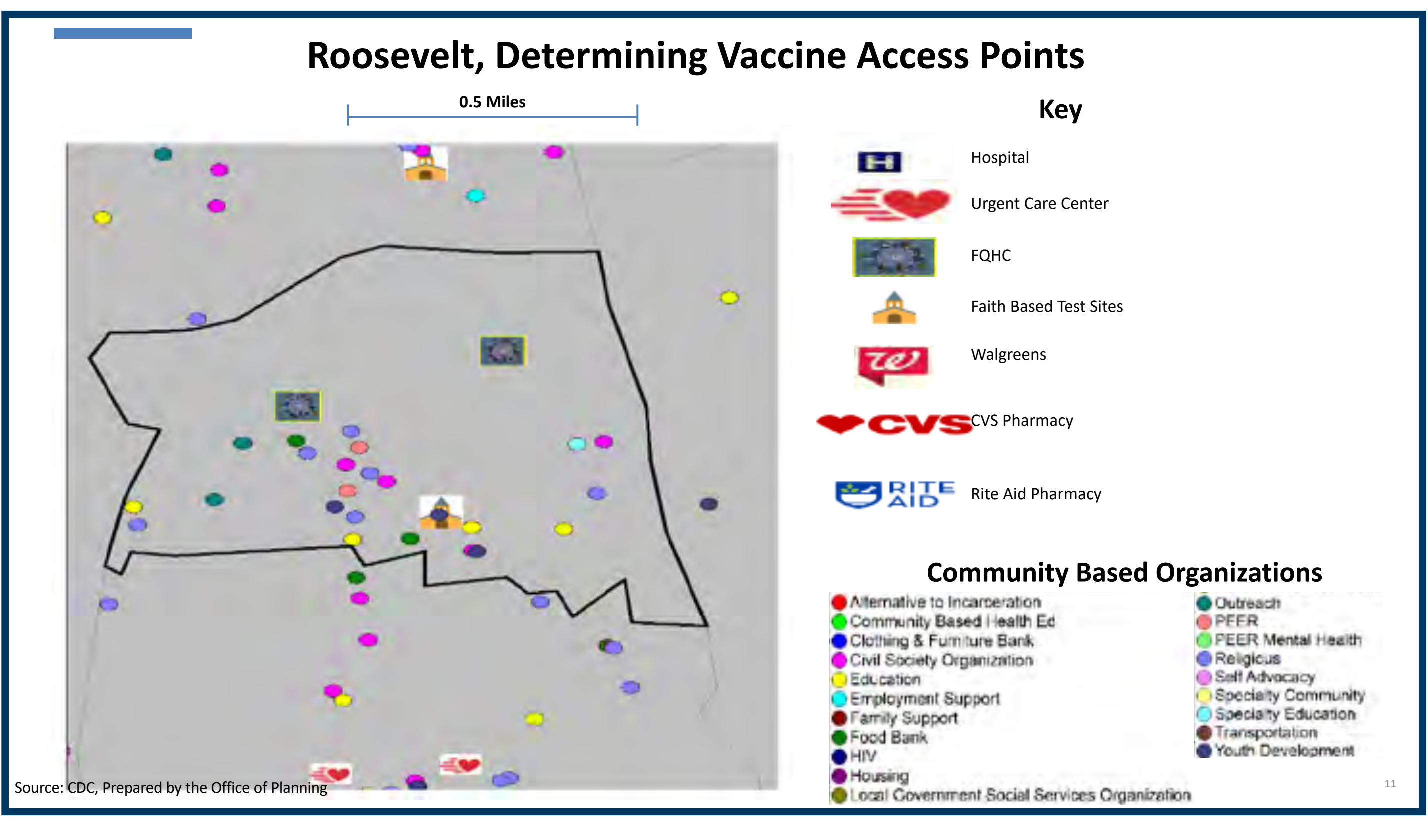
Prepared by the Office of Strategic Planning/mc



Nassau County: Using Data for High Priority Communities
High COVID Positive Rates and/or High SVI
(Top 2 Quintiles)
Great Neck
Glen Cove
Greenvale
Glenwood Landing
Oyster Bay
Elmont
Franklin Square
Valley stream
Lynbrook
Rockville Centre
Westbury
Hicksville
Uniondale
Roosevelt
Freeport
Woodmere
Lawrence
Inwood
Cedarhurst
Hewlett
Island Park
Atlantic Beach
High Medicaid ED Utilization
(Top 2 Quintiles)
Glen Cove
Westbury
Uniondale
Roosevelt
Freeport
Inwood
Island Park
Northwell Health
9



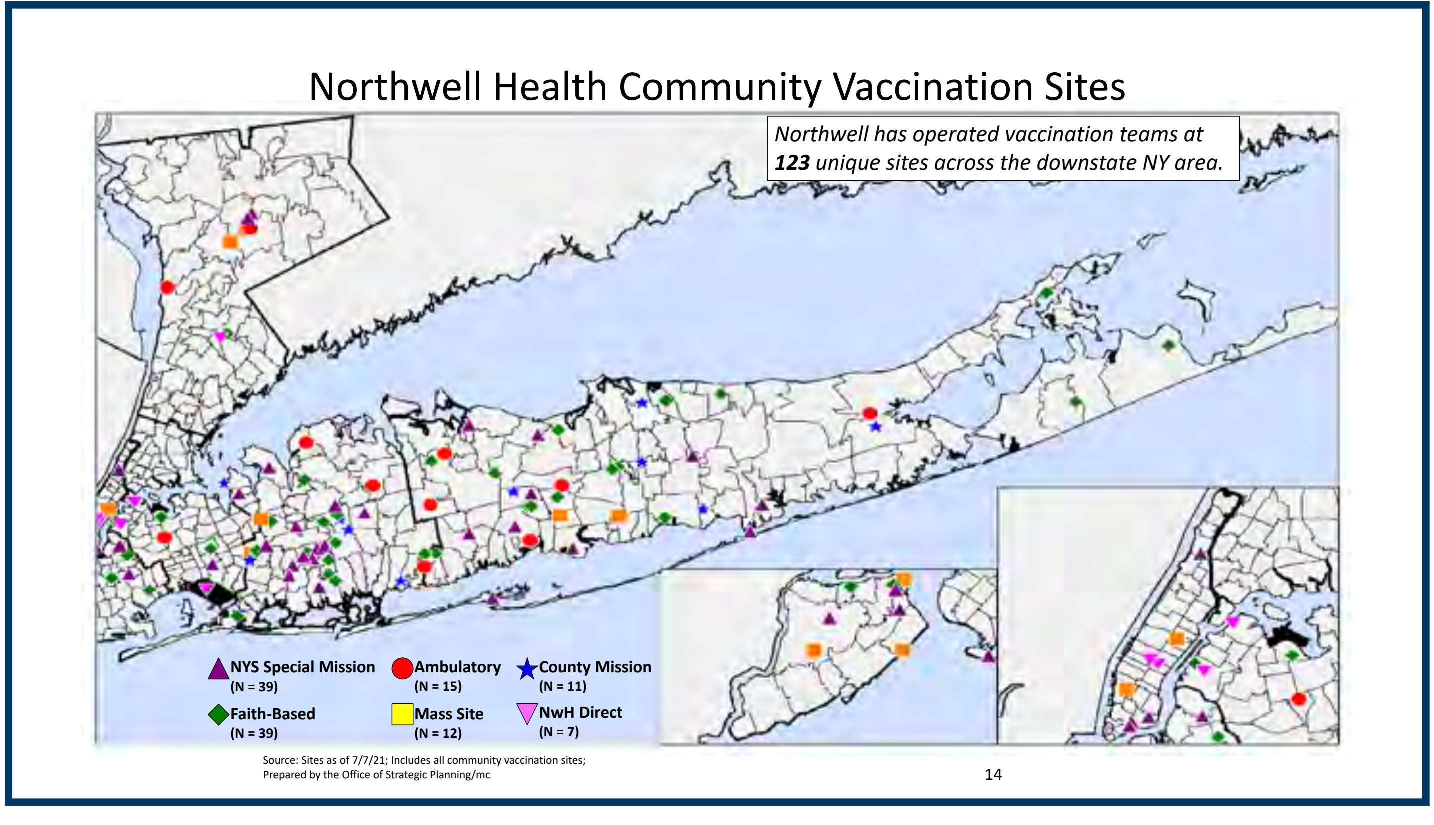
Nassau County: Resources for High Priority Communities
Licensed Resources
Other Community Resources
Yellow shaded Zip: High Priority Community
Hospitals
FQHC
CVS
Walgreens
Nursing Homes
UCC
Colleges
Shopping Malls
Private High Schools
Public High Schools
Sports Arenas
Field Hospital
Faith Based Test Sites
NwH Test Sites
Northwell Health
Confidential- Not for Distribution
12/26/20 - Plans are subject to change
10



Long Island Vaccination Hub: Tracking Vaccines in Real-Time
Eligible That Did Not Receive a Vaccine by Zip Code – Nassau County

Source: NYSIIS Data as of 4/10/21

Health Equity Taskforce
The Health Equity Taskforce (HET) established in January 2021 to ensure the safe, effective, and equitable distribution of the COVID-19 vaccine to high-risk, underserved communities on Long Island, and in particular, communities of color.
100+
Community, faith-based, tribal, and county/state representatives from Nassau and Suffolk
Education, Outreach and Community Planning Subcommittee
100,000+
Community vaccinations at over 90 faith-based and pop-up locations
Education:
Development of culturally appropriate, health literate resources focused on reducing vaccine hesitancy
Grace Cathedral International
Islamic Center of Long Island
Grace Cathedral International



Northwell Health Community Vaccination Sites
Northwell has operated vaccination teams at 123 unique sites across the downstate NY area.
NYS Special Mission (N = 39)
Ambulatory (N = 15)
County Mission (N = 11)
Faith-Based (N = 39)
Mass Site (N = 12)
NwH Direct (N = 7)
Source: Sites as of 7/7/21; Includes all community vaccination sites; Prepared by the Office of Strategic Planning/mc
14

Vaccine Equity For Underserved Communities:
Grace Cathedral International and Prayer Tabernacle COGIC

Mobile Units in Parking Lots

Holocaust Survivors Getting Vaccinated at Jewish Community Center

Newsday: Long Island's Black and Latino Communities make COVID-19 Vaccination Gains

- **Seven of the 10 Long Island zip codes** with the biggest increase in COVID-19 vaccination rates are predominantly Black and Latino.
- **The increase over about two weeks** was 4 percentage points in majority Black and Latino areas and 2.9 points in places without a Black and Hispanic majority.
- **Experts and community leaders** say **more intensive outreach** by trusted local nonprofits and residents, **greater accessibility** and the **vaccinations of family members** and friends are among the reasons.

Source: Newsday

17

COMMUNITY HEALTH EQUITY COLLABORATIONS
Foundational Components: Data, Collaborations, Research, and Education

Community Initiatives Prioritized With the Community

Initiatives and Programs

Education

- Northwell Community Scholars Program
- General Community Education
- Cohen's Children's Medical Center School Programs
- Center for Learning & Innovation Programs
- Others

Economic Vitality

- Supplier Diversity Initiatives
- Workforce Readiness Programs
- Employment Opportunities at Northwell
- Others

Neighborhood & Physical Environment

- Social Determinants of Health i.e.. Food Insecurity
- Sustainability/Climate Change
- Gun Violence Program
- Human Trafficking Program
- Tobacco Cessation Program
- NY Islanders/Rangers Partnership
- Others

Health & Healthcare Disparities

- Mental Health
- Diabetes & Obesity
- Maternal Health
- Cancer Prevention
- Access : i.e. Belmont Clinic, Fire Island
- General Outreach and Screening on chronic conditions
- Vaccinations i.e.. COVID, Flu, Event Medicine

STRATEGIC COMMUNITY PARTNERSHIPS

HEALTH EQUITY TASKFORCE

RECENT ACCOMPLISHMENTS

100,000+ COVID-19 tests administered

700,000+ Community vaccinations

100+ community, faith-based, tribal, and county/state partners collaborating on community health equity

875+ faith-based and community pop-up testing and vaccine locations

200+ participants in inaugural Mental Health Faith Leaders Forum

NORTHWELL COMMUNITY HEALTH ALLIANCE

Established the **Northwell Community Health Alliance** to expand work on other disparities across all our service areas.

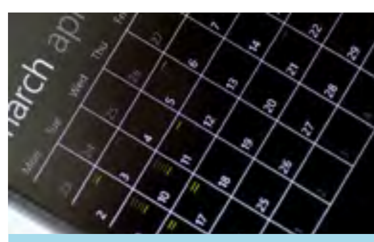
30+ MEMBERS
Community, faith-based, tribal, & county leaders representing New York, Westchester, Nassau and Suffolk County.

HEALTH EQUITY
Members from all counties work together on community health equity.

MONTHLY MEETINGS
Inaugural meeting began journey of collaboration and partnerships.

NORTHWELL CLERGY ADVISORY COUNCIL

WHO?
Select faith-based leaders representing various houses of worship throughout New York, Westchester, Nassau and Suffolk County.



WHEN?
Members from all counties will meet regularly in alignment with the larger Northwell Community Health Alliance.

WHAT?
Members will provide guidance on impact and progress of community health equity initiatives within the faith-based community.

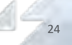
Established the **Northwell Clergy Advisory Council** to gather input from key faith leaders on health and wellness priorities in support of Northwell Health's Community Health Equity mission.

Federally Qualified Health Center Partnerships

GOAL: Cross-collaboration Federally Qualified Health Centers across our region to improve health outcomes in underserved populations. This includes partnerships with LIFQHC, Sunriver, and Charles Evans.

WORKSTREAMS:

1. Data Sharing	2. MUTUAL REFERRALS	3. INITIATIVES RELEVANT TO HEALTHCARE DISPARITIES
Sharing data on mutual patients to improve continuity and quality of care.	Patients discharged from a Northwell emergency room that fit a defined criteria are referred to a LIFQHC within close proximity to their residence.	• Develop a bi-directional communication process for all FQHC maternal patients who deliver at Northwell hospitals. • Partnership with Northwell service lines and FQHC Health team to share educational opportunities for community. • Collaboration with FQHC's Healthcare teams to share educational collateral for new Northwell initiatives.



NORTHWELL COMMUNITY SCHOLARS PROGRAM

NORTHWELL COMMUNITY SCHOLARS

RECENT ACCOMPLISHMENTS

- Received **$250,000 in philanthropic support** from Bank of America and **$50,000** from National Grid
- **Executed partnership agreements** with high schools, NCC and SCCC, and Long Island Community Foundation
- **Reached approx. 7,500 high school students through Medical Career Day**
- **Completed application process for inaugural cohort of students** from Bayshore, Brentwood, Hempstead, and Freeport High Schools.
  - ✓ Freshman – 53 applications received; 40 accepted
  - ✓ Seniors – 98 applications received; 95 accepted
- Held **award ceremonies to recognize freshmen and seniors' acceptance to the program.**
- **Hired Program Manager for Student Success** to partner closely with students, high schools and colleges to ensure students are supported throughout the program
- **Developed mentor application process, through which 164 Northwell employees volunteered to serve as mentors**
  - Mentor orientation to be held in October 2022 in collaboration with MentorNY
  - Pilot implementation of mentorship platform, Qooper, to facilitate matching and communications is underway
- **Developed agreement to collaborate on health disparities** (i.e. diabetes, obesity, mental health, etc.) with high schools
  - ✓ Brentwood executed agreement

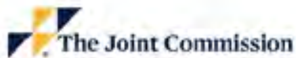
SDOH SCREENING

Social Determinants of Health Screening

SOCIAL NEEDS SCREENING – THE REGULATORY AND BUSINESS CASE

Centers for Medicare & Medicaid Services (CMS): Fiscal year (FY) 2023 inpatient prospective payment system (IPPS)

- Inpatient Quality Reporting System, screening for social drivers, voluntary reporting 2023, mandatory reporting 2024



Joint Commission: Hospital Accreditation Program

- Reducing Health Care Disparities, Six elements of performance, one address social needs

National Committee for Quality Assurance (NCQA): PCMH recognition program

- Address SDoH as a fundamental component of the medical home transformation process/designation

NORTHWELL SDOH SCREENING HIGHLIGHTS

Continued screening in **13** hospitals and outpatient practices

Updated **Pediatric SDOH Screener**

Medicine: Enhanced faculty and staff SDOH **education**

OCIO: Enhancement of **system-wide dashboard**

One standard screener – AHC HRSNS

- 10 questions
- 5 Domains: Housing instability, Food Insecurity, Transportation problems, Utility help, Interpersonal safety

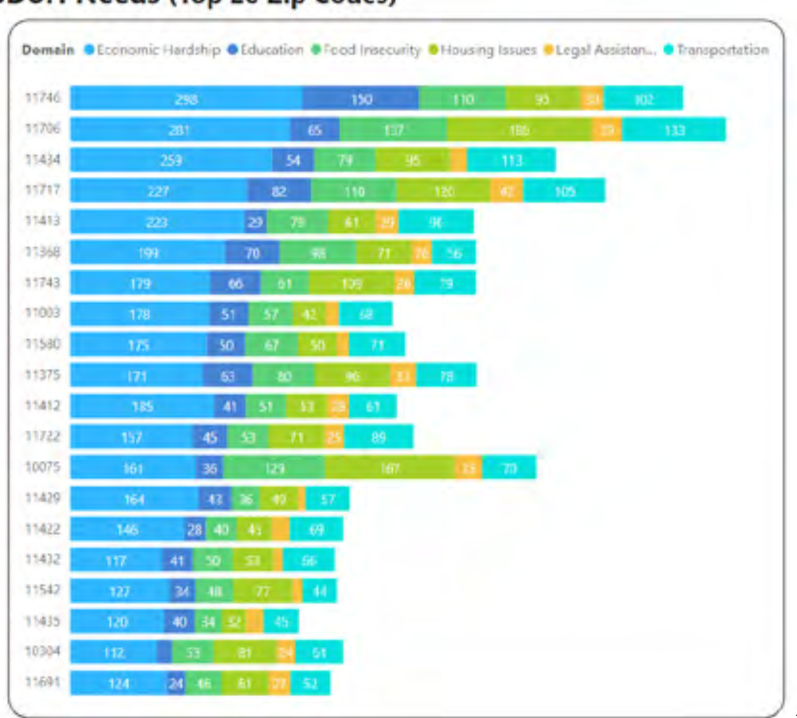
Followed **National Landscape**

Met with **external stakeholders** (GNYHA, HANYS)

SDOH DASHBOARD

Positive SDoH Needs (Top 20 Zip Codes)

Zip Code	City (Patient Home)	County	# Positive Screeners
11746	HUNTINGTON STATION	Suffolk	454
11706	BAY SHORE	Suffolk	432
11434	JAMAICA	Queens	381
11717	BRENTWOOD	Suffolk	349
11413	SPRINGFIELD GARDENS	Queens	302
11368	CORONA	Queens	285
11743	HUNTINGTON	Suffolk	283
11003	ELMONT	Nassau	264
11580	VALLEY STREAM	Nassau	262
11375	FOREST HILLS	Queens	257
11412	SAINT ALBANS	Queens	256
11722	CENTRAL ISLIP	Suffolk	248
10075	NEW YORK	New York	227
11429	QUEENS VILLAGE	Queens	226
11422	ROSEDALE	Queens	210
11432	JAMAICA	Queens	192
11542	GLEN COVE	Nassau	189
11435	JAMAICA	Queens	185
10304	STATEN ISLAND	Richmond	184
11691	FAR ROCKAWAY	Queens	177



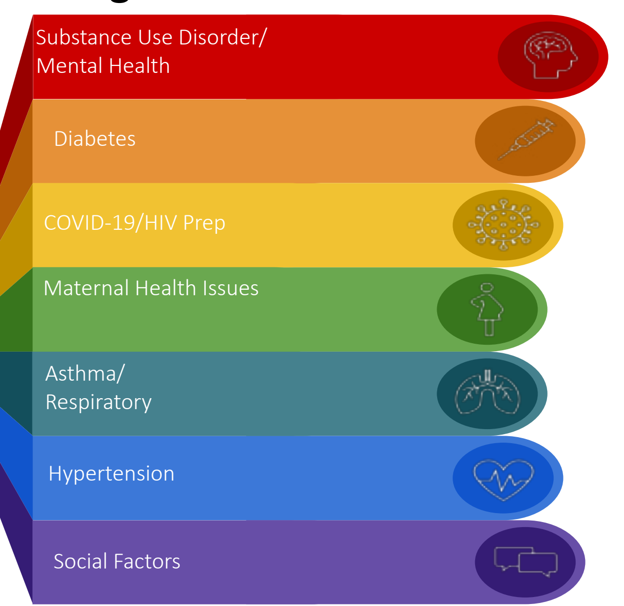
31

Staten Island PPS & Healthfirst Initiatives

Northwell Health

Healthfirst -Staten Island PPS Navigation Initiatives

- HF & PPS have developed a Navigation Process to engage individuals with or at-risk of chronic disease.
- Process includes assessment, emphasis on PCP relationship and referral for resources to meet client needs
- A full SDOH screening is accomplished with referrals to supports, health coaching, training, employment
- CBOs', Faith Based and social care providers are in the network to make and receive referrals
- Certain CBOs' have been selected to provide navigation to their clients, utilizing the same technology platform in alignment with the PPS and HF goals



Impacting Communities Through Population Health Partnerships

Northwell Health

Social Determinants of Health
10 community-based organizations serving over 45,000 clients by assessing SDOH needs and making automatic referrals through SI PPS platform

Healthfirst Partnerships
Partner with community-based and clinical partners to improve health outcomes and facilitate navigation at the community level

Workforce Development
NYS and US DOL certified apprentice sponsor
Set to train nearly 1,000 CHWs, CRPAs, CNAs and HHAs over the next 4 years

Community Health Initiatives

Health Equity
Partner with BIPOC and LGBTQI+ led organizations to help inform population health strategy
Recruit trainees from underserved backgrounds

Behavioral Health
Innovative programs designed to identify individuals at risk of overdose and connect to care and services

Integrated Technology
IT platform allows for seamless navigation at community level, SDOH, and RHIO connectivity enabling multidirectional information between the network partners

FOOD AS HEALTH: Meeting the Need, Impacting Chronic Illnesses

35

36

FOOD INSECURITY INITIATIVES

PROGRAMS SPANNING ALL AGES

CENTRAL REGION

Cohen Children's Medical Center
- Wellness on Wheels
- Creating Breastfeeding Friendly Communities
- Healthy Corner Stores

Glen Cove Hospital
- Food as Medicine
- North Shore Sheltering Program

LIJ Medical Center
- WIC Program

LIJ Valley Stream
- Food as Health Program

Zucker School of Medicine
- Social Health Alliance to Promote Equity (S.H.A.P.E.)

PARTNERS:
- Baldor
- Greater Springfield Community Church
- The Interfaith Nutrition Network
- Island Harvest
- Long Island Cares

EASTERN REGION

Huntington Hospital
- Nutrition Pathways Program
- WIC RISE

South Shore University Hospital
- Food as Health Program
- Jammin' for the Community

PARTNERS:
- Island Harvest
- Long Island Cares
- The Interfaith Nutrition Network
- US Foods
- Baldor

WESTERN REGION

Phelps Hospital
- Senior Vitality Program

Northern Westchester Hospital
- Community Education and Outreach Program (CHEOP)

Staten Island University Hospital
- Clementine Collective/Healthy Bodega Program

PARTNERS:
- US Foods
- City Harvest
- Clementine Collective-HEALTH for Youth
- Feeding Westchester
- TASH Farmers Market
- Gulotta House
- Mt. Kisko Interfaith Food Pantry

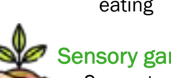
LOOKING FORWARD:
NORTHWELL'S COMMITMENT TO SUSTAINABLE COMMUNITIES

In October 2022, Northwell and Queens County Farm Museum announced a 5-year collaborative to promote community health and wellness through farming and agriculture.

Proposed four key pillars of this strategic alliance include:

Access to agriculture through education

- Co-brand programming
- Strengthen public's connection to healthy food and healthy eating



Sensory garden programs

- Support social-emotional and independent living skill needs of children with autism and other disabilities through seeing, smelling, feeling, tasting and working at the Queens Farm

Farm-to-Table

- Procure farm fresh food for Northwell patients and team members
- Develop with innovative patient and employee offerings, such as recipes, cooking demos, and tastings

Volunteer and apprenticeship-based opportunities

- Provide Northwell Community Scholars Program participants access to the farm to learn about agriculture and related careers
- Create a Student Ambassador program to provide agriculture/environmental community service opportunities

NUTRITION PATHWAYS PROGRAM

In partnership with the Dolan Family Health Center in Huntington, Island Harvest provides patients who screen positive for food insecurity with **12 personalized nutrition counseling sessions, access to nutritious foods from their on-site healthy food pantry, referrals to community resources, and assistance with SNAP, as well as a weekly community food distribution** to area residents in need.

As of August 31, 2022 – After 1 Year of Operation

PROGRAM DETAILS

- 162 individuals enrolled
- 1,139 counseling sessions conducted
- 250 individuals participate in the weekly food box distribution
- 15,024 meals provided to participating patients through weekly one-on-one sessions
- 25,650 meals provided through the weekly on-site community food box distribution

OUTCOMES

- 44% improvement in Body Mass Index
- 42% reduction in blood pressure
- 51% reduction in A1C
- 55% increased consumption of healthy foods
- 58% reduced consumption of unhealthy foods
- 25% reduction in number of meals eaten away from home
- 45% increased physical activity

WELLNESS ON WHEELS (WOW)

- A mobile van-based school/community program for elementary school children (Pre-K-4) and their families.

Students participate in hands-on learning activities related to:

- The importance of healthy fresh food and a balanced diet.
- The need for daily physical activity and physical fitness.
- Growing fruit and vegetable plants.

Families who screen positive for food insecurity are:

- Assisted with applying for SNAP benefits.
- Connected to community-based resources to address other social needs.
- Eligible to participate in a 30-week weekend healthy food backpack program (school-based program) or an 8-week box of produce distribution program (community-based program).

5,000+

Children in underserved communities reached in 2021

10,000

Children to participate in the program in 2022

In 2022, thanks to funding of $465,000 from Rite Aid and Mother Cabrini, the program will be expanded.

BELMONT PARK COMMUNITY GARDEN

Backstretch Employee Service Team, New York Racing Association, and Belmont Park staff, Northwell Health Community Outreach and Community Relations **transformed two 36 ft. x 7 ft. plots of dirt into a community garden in the residential section of the grounds of Belmont Park.**

RECENT ACCOMPLISHMENTS

Collaboratively, the group raked the dirt and dug nearly 100 holes to plant more than:

- **40** pepper plants (25 hot, 11 medium, 4 green Bell),
- **32** tomatoes (large and Cherry),
- **10** eggplant,
- **6** cucumber,
- **6** zucchini and a few dozen green bean seeds.
- A variety of herbs including **4** parsley plants, **4** cilantro, and **2** mint.

Providing fresh vegetables will supply important disease-fighting phytonutrients to the diets of the workers who live at the track, many of whom are **immigrants at higher risk for developing diabetes and other chronic health conditions.**

FOOD DISTRIBUTION EVENTS

FOOD INSECURITY PARTNERSHIPS IN PRIORITY ZIPCODES

Who?

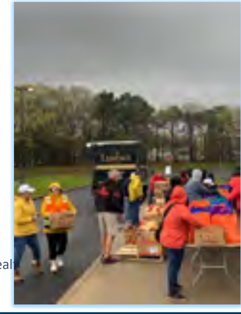
- Northwell Community & Population Health
- Local Northwell Hospital (SSUH, South Oaks, Mather, etc.)
- **Community Partners:** Suffolk County Women's Alliance To End Food Insecurity (SCWATEFI), Lessing's Hospitality Group & DiCarlo Food's

What & When?

- Food Distribution events started in November 2021
  - Three drive-thru events to date distributing fresh produce & vegetables to over 500 families per event.
  - Northwell leverages our local facilities and Community partner spaces for these events.
  - Additional resources are provided (ex: food pantry locations and health education.)
  - Upcoming event on 11/19 will target 1000 Families.

COMBATING FOOD INSECURITY ONE DRIVE-THRU AT A TIME...

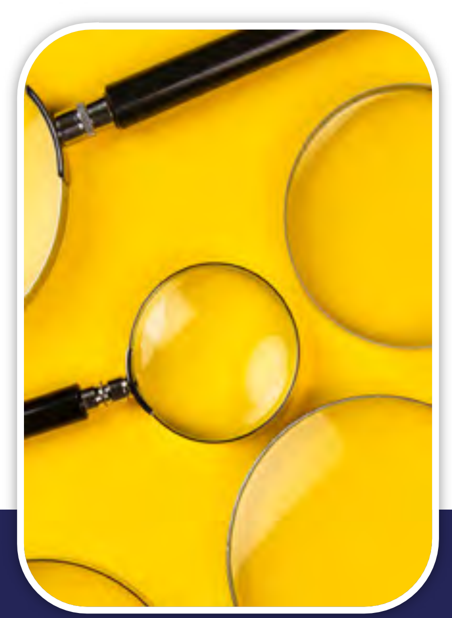
Over 43,000 pounds of assorted food distributed to date. Partnership will continue in 2023. We incorporate SNAP Benefit enrollment for ongoing support



Reducing the risk for chronic disease starts at the supermarket…

Northwell registered dieticians engaging community members in Spanish on 10/21 in Freeport:

Food Insecurity Resource Cards



HEALTHCARE DISPARITIES FOCUS AREAS:

MENTAL HEALTH
DIABETES/OBESITY
CANCER PREVENTION
MATERNAL HEALTH

FAITH LEADER'S MENTAL HEALTH FORUM PART I

Addressing the Mental Health Crisis Post COVID-19

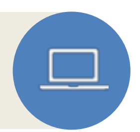
In March 2022, Northwell Health convened faith leaders to join an interfaith dialogue to discuss the mental health crisis and identify the top needs/gaps in our communities.

Over 40 clergy representing diverse religious faiths and cultures attended in person with others joining us virtually from across New York City, Long Island, and Westchester.

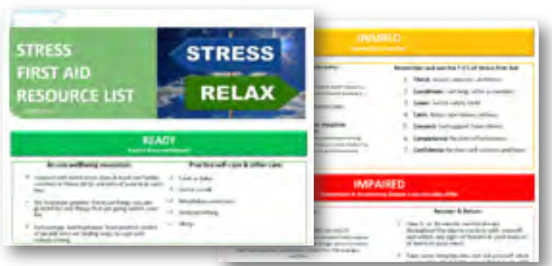
FAITH LEADER'S MENTAL HEALTH FORUM PART II: WE TOOK ACTION

VIRTUAL STRESS FIRST AID WORKSHOP FOR FAITH LEADERS

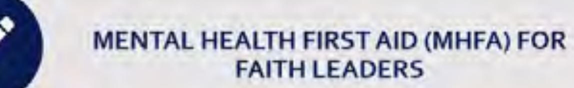
LED BY DR. MAYER BELLEHSEN



In June, Northwell held a **Stress First Aid workshop for Faith Leaders** to support the self-care needs of over 55 faith clergy.



We also began hiring Community Health Ambassadors to embed in houses of worship and community-based organizations.



Northwell partnered with the Mental Health Association of Nassau County to offer MHFA in-person on **September 28th.**

Northwell partnered with the Association for Mental Health and Wellness to offer MHFA virtually on **October 19th.**

26 clergy have been trained as of **November 4th.**

FAITH LEADER'S MENTAL HEALTH FORUM PART II:

SOLUTIONS & NEXT STEPS

On November 1st 2022, Northwell reconvened faith leaders to continue the interfaith dialogue.

More than 65 clergy representing diverse religious faiths and cultures attended from across New York City, Long Island, and Westchester, and **over 20 were trained in Stress First Aid.**

MENTAL HEALTH

GOAL: Enhance access to services and resources to address the mental health crisis in our communities.

FOCUS AREAS AND ACTIVITIES:

- Provide education to increase awareness of mental health issues in the community and reduce associated stigma.
- Partner with trusted community and faith-based leaders to develop holistic and equitable community-based solutions to mental health needs such as the Nassau and Suffolk County Mental Health Resource List in English and Spanish.
- Establish innovative models to bring mental health services/resources into the community to "meet people where they are" and bridge the gap.

RECENT ACCOMPLISHMENTS – Mental Health Faith Leader's Forum

- **3/29, 11/1:** Held an interfaith dialogue on the mental health crisis in our communities and potential ideas for how to collaborate to address those needs. Over 100 faith leaders of diverse religious faiths and cultures attended from across New York City, Long Island, and Westchester.
- **6/29, 9/28:** Held a Stress 1st Aid, Mental Health Certification workshop to support the self care needs of over 55 faith leaders from across New York City, Long Island, and Westchester.

DIABETES & OBESITY

GOAL: Limit risk factors for developing diabetes through screenings, education and intervention.

FOCUS AREAS AND ACTIVITIES:

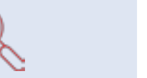
1. SCREENINGS	2. REFERRALS	3. DIABETES PREVENTION PROGRAM	4. SCHOOL INTERVENTION
• Community spaces • Mobile access • Awareness, education & referral	• Identifying additional needs of populations & provide referrals to resources	• Assist w/ development & rollout – Feinstein • Community member education / enrollment	• WOW Program • Northwell Community Scholars • School Stakeholders

CANCER

GOAL: Reduce the incidence of cancer and cancer-related illness, disability, and death.

FOCUS AREAS AND ACTIVITIES:

1. SCREENINGS



- Develop partnerships with CBO's, FBO's, and Community leaders
- Health fairs & screenings

2. RESEARCH

- Leverage catchment area analysis to determine interventions
- Partner with community leaders on research education and outreach within communities

3. CLINICAL TRIALS

- Partner with community leaders to understand community beliefs and barriers
- Increase access to clinical trials for minority communities

4. EDUCATION & OUTREACH

- Dissemination of patient-facing literature
- Have a presence at community events, health fairs, etc.

MATERNAL HEALTH

GOAL: Improve birth outcomes and health outcomes for birthing women through education, outreach and accessibility.

FOCUS AREAS AND ACTIVITIES:

1. PREECLAMPSIA

Dispense low dose aspirin and disseminate low dose aspirin education to at risk maternal patients

2. HEALTH

Provide education flyers and outreach focused on negative risk factors affecting pregnancy

3. SEXUAL HEALTH

Provide education and outreach on STDs, birth control options, and empowerment on respecting one's body

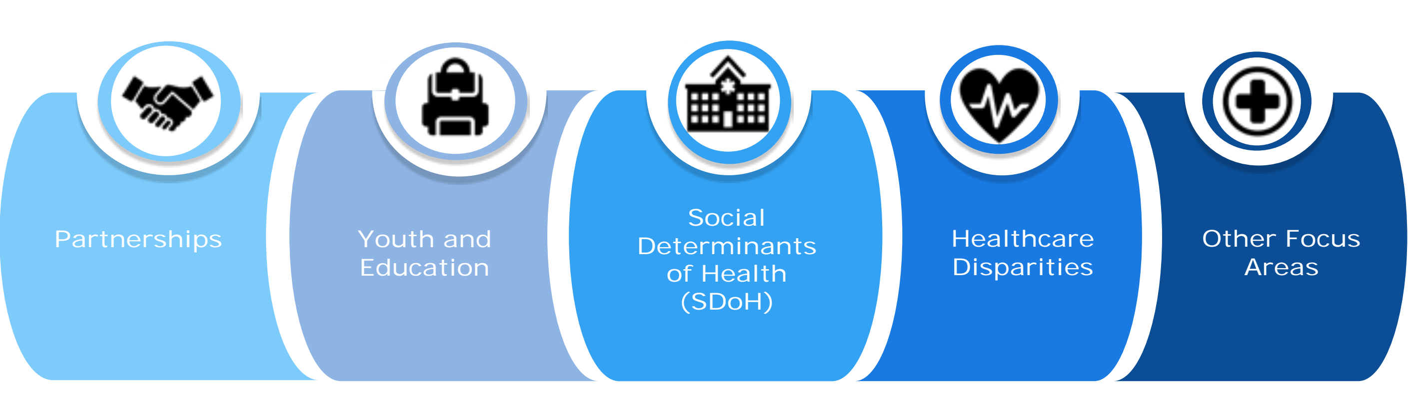
4. FAMILY PLANNING

Provide outreach and education on different methods of birth control and effective family planning

5. MENTAL HEALTH

Provide education on potential psychological distress that may impact positive birth outcomes

2023 AREAS OF FOCUS

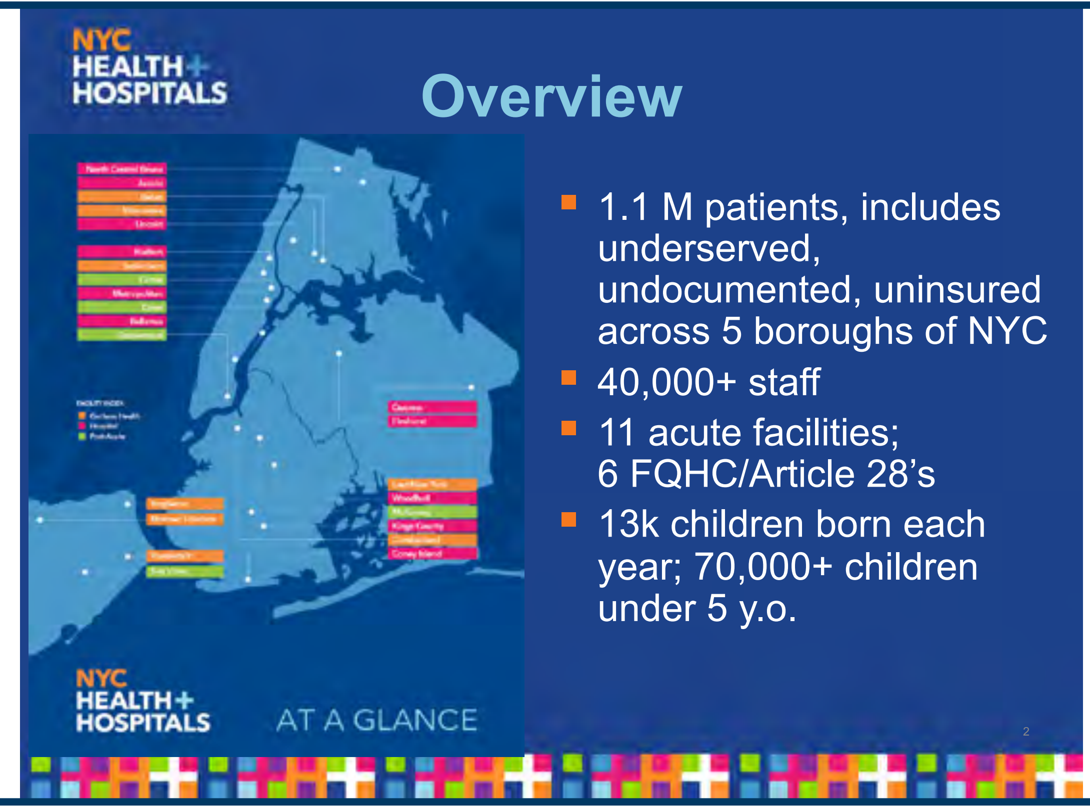


53

Addressing Birth Equity and Beyond in New York City Health + Hospitals

Wendy Wilcox, MD, MPH, MBA, FACOG
Chief Women's Health Officer, NYC H+H
November 18, 2022

Perspectives on Racism, Disparities, and Health Equity: Advancing Solutions by Healthfirst



Overview

- 1.1 M patients, includes underserved, undocumented, uninsured across 5 boroughs of NYC
- 40,000+ staff
- 11 acute facilities; 6 FQHC/Article 28's
- 13k children born each year; 70,000+ children under 5 y.o.

NYC HEALTH+ HOSPITALS

Overview

- 5 Long-Term Care Centers
- Correctional Health
- Community Care (a.k.a. Home care)
- NYC Care- a health care access program that guarantees low cost and no-cost services to New Yorkers to do not quality for or cannot afford health insurance
- Express Care—Urgent Care/Walk-in centers
- MetroPlus– health insurance coverage to eligible people living in New York City

Critical Partnerships

Healthfirst is an MCO that has partnership and risk-sharing with NYC Health + Hospitals

NYC HEALTH+ HOSPITALS

NYC Health + Hospitals

Our Mission

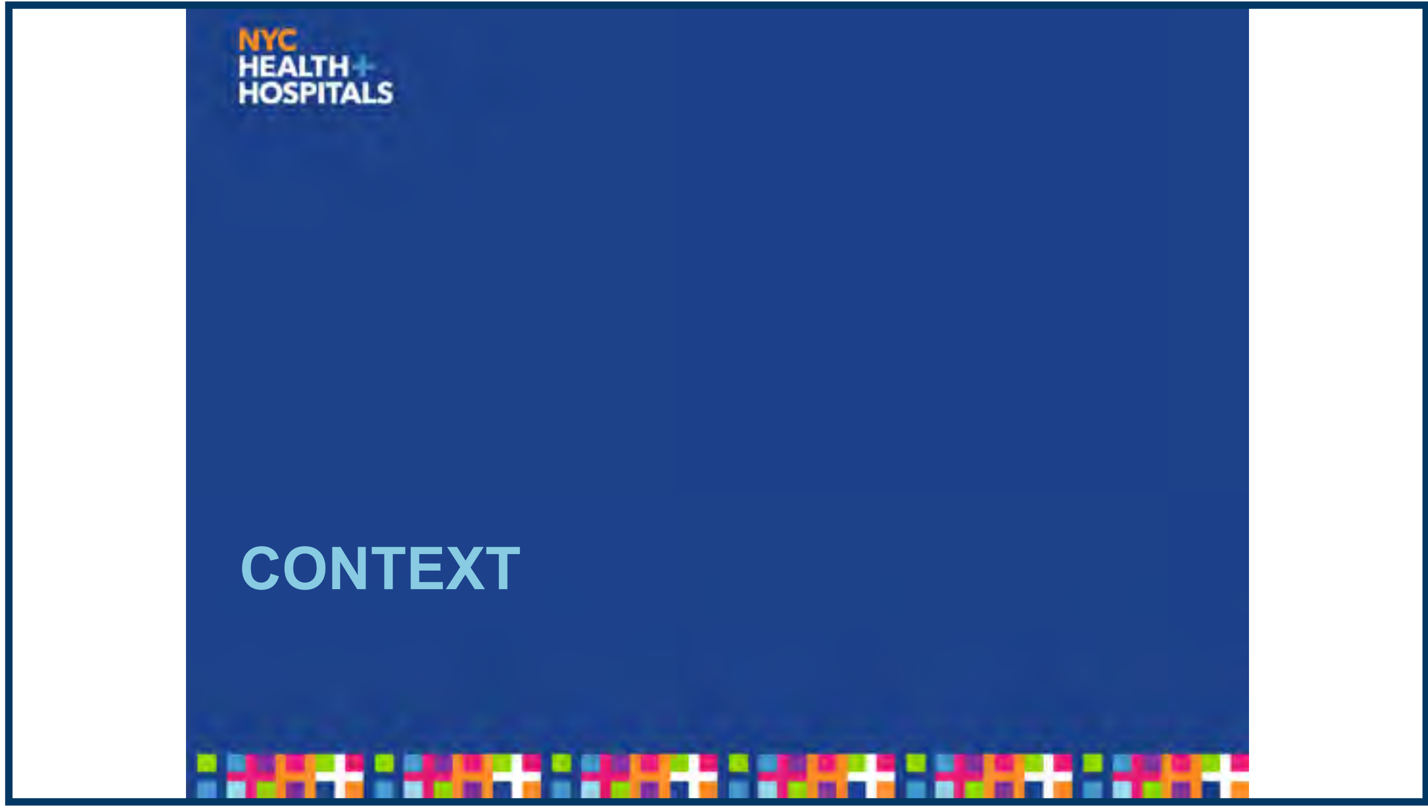
Our mission is to extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services of the highest quality in an atmosphere of humane care, dignity and respect.

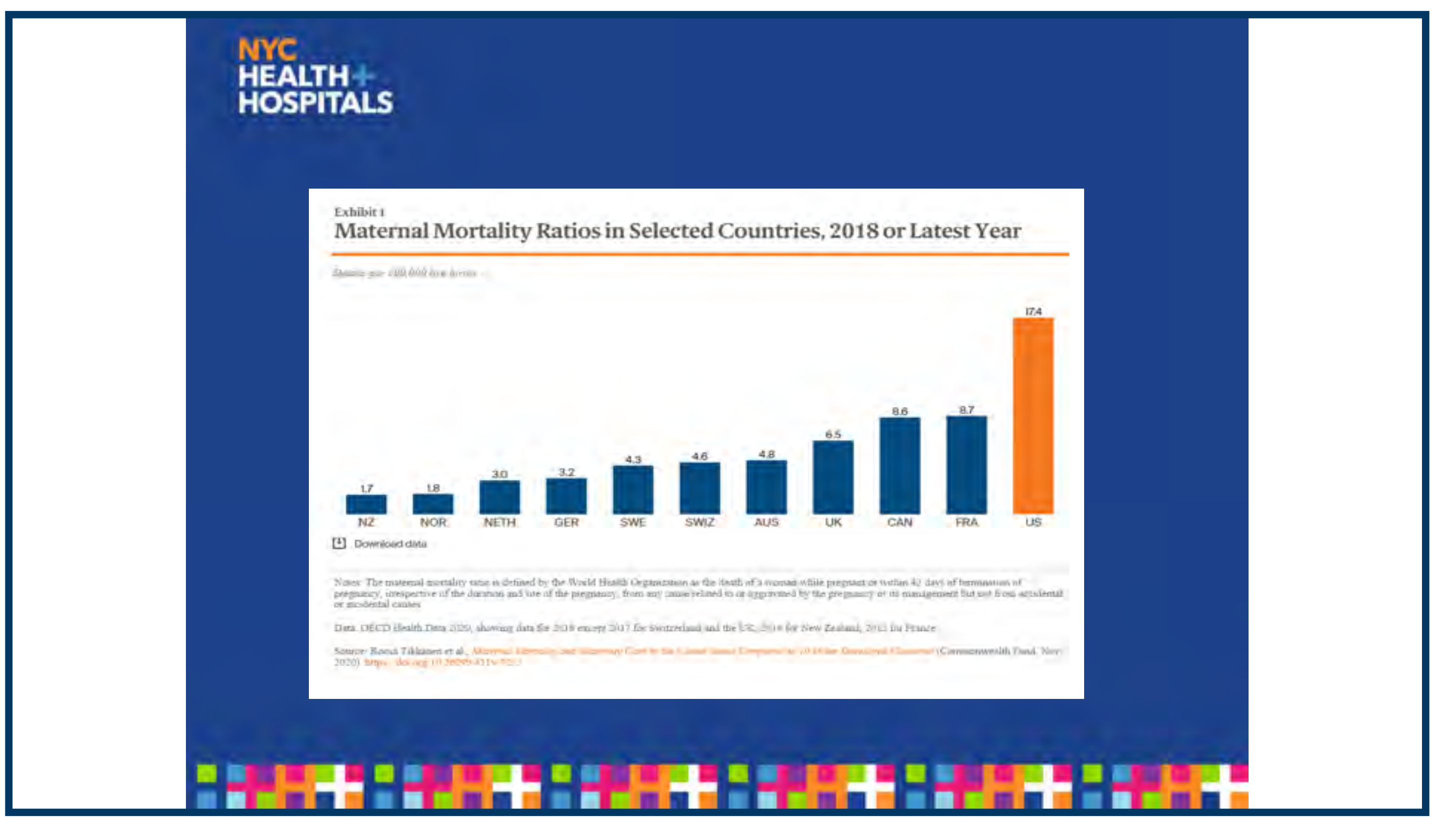
Our Brand Promise

Empower every New Yorker – without exception – to live the healthiest life possible by providing equitable, high-quality, culturally responsive, and affordable health care in every community.

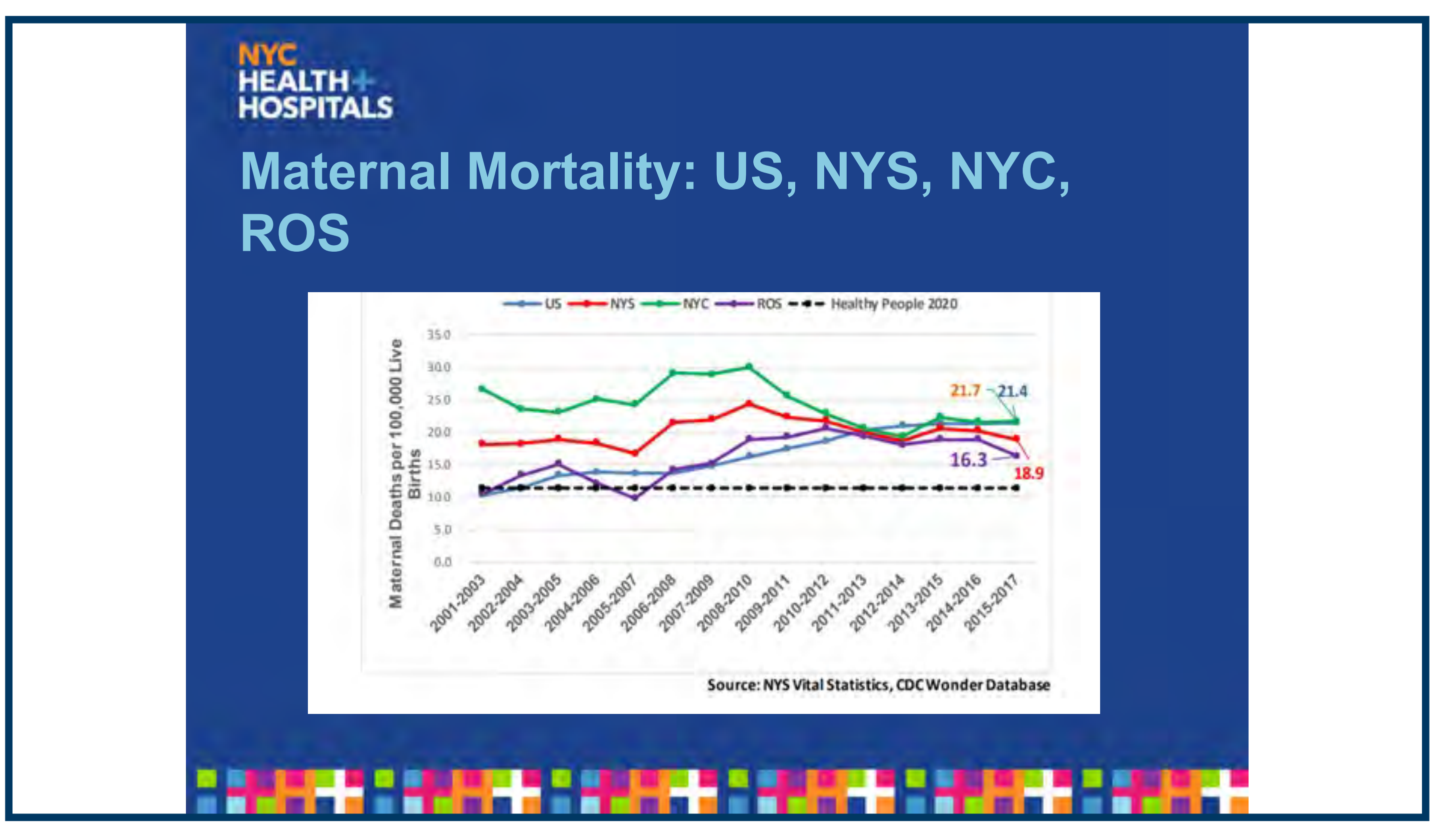
NYC HEALTH + HOSPITALS

How do we improve birth equity for birthing people who receive care at NYC Health + Hospitals?

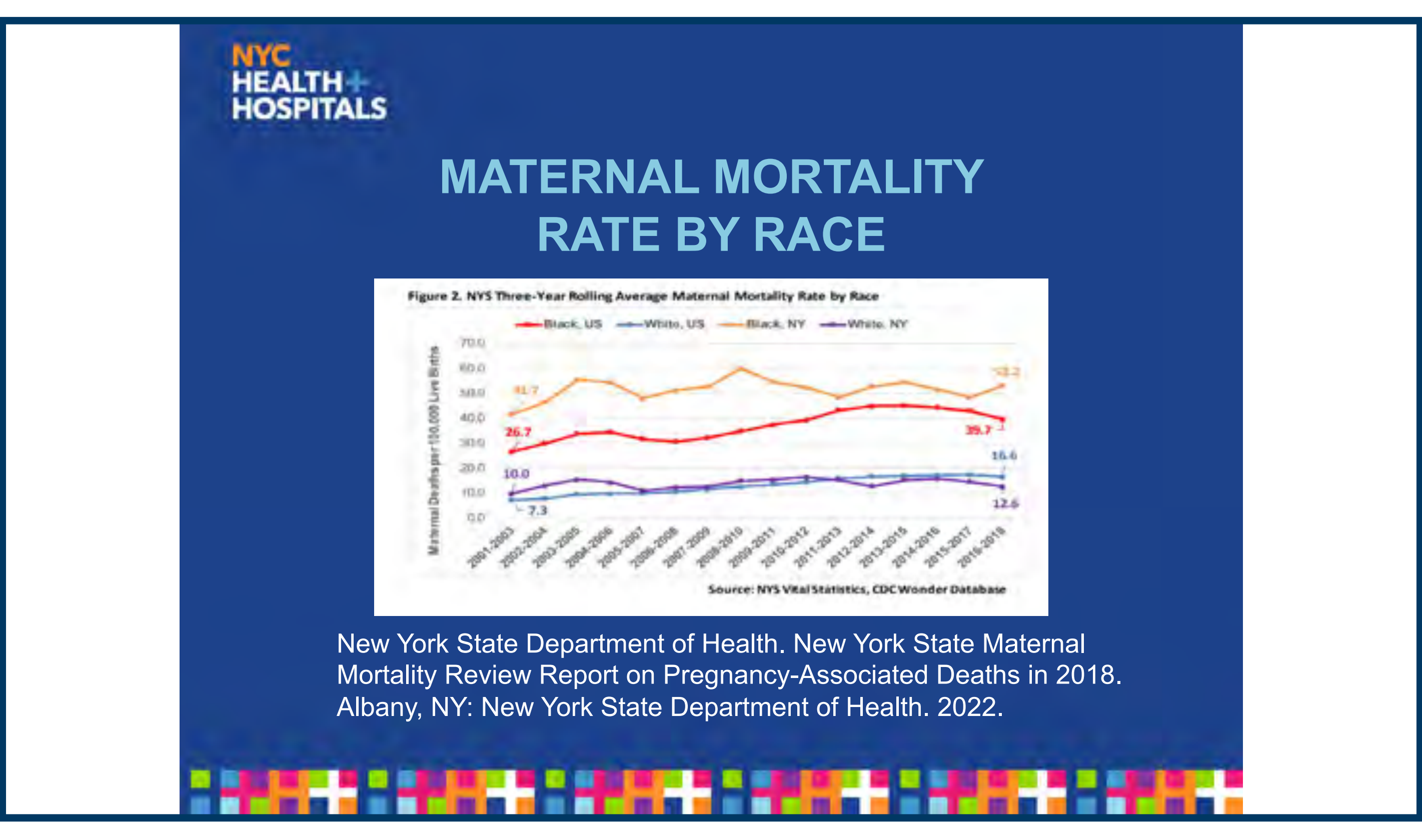




NYC
HEALTH+
HOSPITALS
Exhibit 1
Maternal Mortality Ratios in Selected Countries, 2018 or Latest Year
1.7
1.8
3.0
3.2
4.3
4.6
4.8
6.5
8.6
8.7
17.4
NZ
NOR
NETH
GER
SWE
SWIZ
AUS
UK
CAN
FRA
US
Download data



NYC
HEALTH+
HOSPITALS
Maternal Mortality: US, NYS, NYC, ROS
US
NYS
NYC
ROS
Healthy People 2020
Maternal Deaths per 100,000 Live Births
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
2001-2003
2002-2004
2003-2005
2004-2006
2005-2007
2006-2008
2007-2009
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
2013-2015
2014-2016
2015-2017
21.7
21.4
16.3
18.9
Source: NYS Vital Statistics, CDC Wonder Database


NYC HEALTH+ HOSPITALS
MATERNAL MORTALITY RATE BY RACE
Figure 2. NYS Three-Year Rolling Average Maternal Mortality Rate by Race
Black, US
White, US
Black, NY
White, NY
Maternal Deaths per 100,000 Live Births
26.7
10.0
7.3
35.7
16.6
12.6
Source: NYS Vital Statistics, CDC Wonder Database
New York State Department of Health. New York State Maternal Mortality Review Report on Pregnancy-Associated Deaths in 2018. Albany, NY: New York State Department of Health. 2022.

NYC HEALTH+ HOSPITALS
Medical Inequality
WAITING ROOM
FOR COLORED ONLY
BY ORDER
POLICE DEPT.
American medical system began during slavery
Up until the 1960's, racial segregation was the norm
Separate was NOT equal
Segregation took on many forms
Discrimination in nursing, medical schools, midwifery schools
Discrimination in professional societies, AMA, ANA, ACNM
Experimentation on Black people without consent

IMPACT OF STRUCTURAL RACISM

- …racism is not simply the result of private prejudices held by individuals,[8] but is also produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government, and embedded in the economic system as well as in cultural and societal norms.

Bailey, Z, Feldman, J., Bassett, M How Structural Racism Works—Racist Policies as a Root Cause of U.S. Racial Health Inequities, N Engl J Med 2021; 384:768-773
DOI: 10.1056/NEJMms2025396

NYC HEALTH + HOSPITALS

Launch of the Maternal Mortality Reduction Program

- In 2018, with City Hall support, NYC Health + Hospitals launched the MMRP
- At the time, more than 3,000 women experienced a life-threatening event during childbirth, and about 30 women died each year in New York City.
- Black, non-Hispanic women were **eight** times more likely to die in childbirth than white women in NYC.
- Black, non-Hispanic women are still three times more likely to suffer a life-threatening event in pregnancy than white women (severe maternal morbidity)

13

NYC HEALTH + HOSPITALS

MMRP

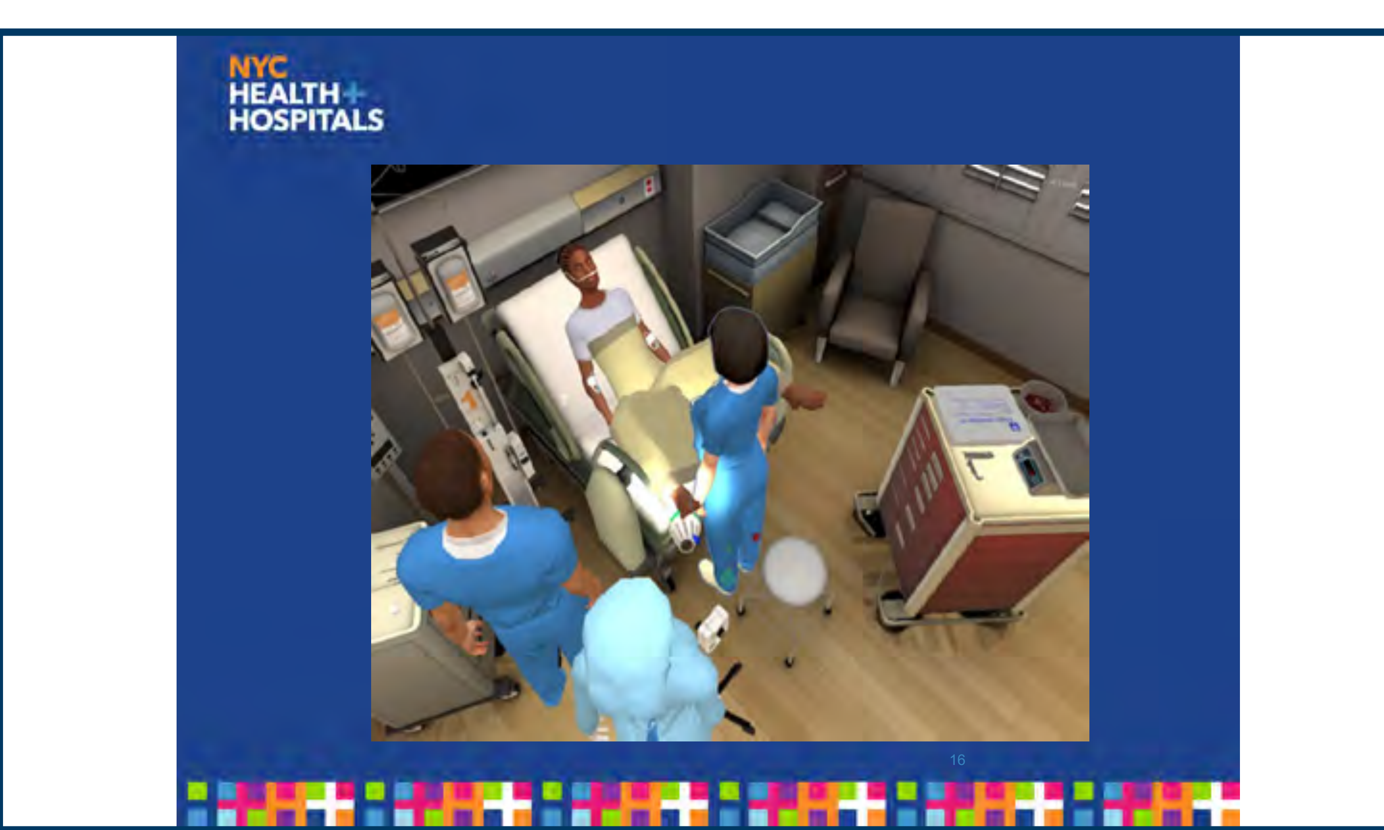
- 5 initiative program
- Included: Simulation and Maternal Home
- Soon thereafter, Implicit Bias training for H+H leadership and Board
- PDSA
- Expansive growth beyond program!

NYC HEALTH + HOSPITALS

Simulation

- NYC Health + Hospitals built 6 simulation labs in acute care facilities: Bellevue, Elmhurst, Harlem, Jacobi, Kings County and Lincoln
- All NYC H+H hospitals train maternity and postpartum staff using simulation exercises
- These simulation labs enable help OB and Anesthesia physicians, nurses, midwives, physician assistants master skills, reduce the rate of maternal mortality, and address avoidable and potentially fatal complications during childbirth.
- These simulation courses use high fidelity mannequins of color to mimic real-life emergency scenarios
- Staff were trained in OB Life Support, Obstetric Hemorrhage and Severe Hypertension in Pregnancy
- Created a Virtual Reality Simulation program

15



NYC HEALTH + HOSPITALS

Lessons Learned

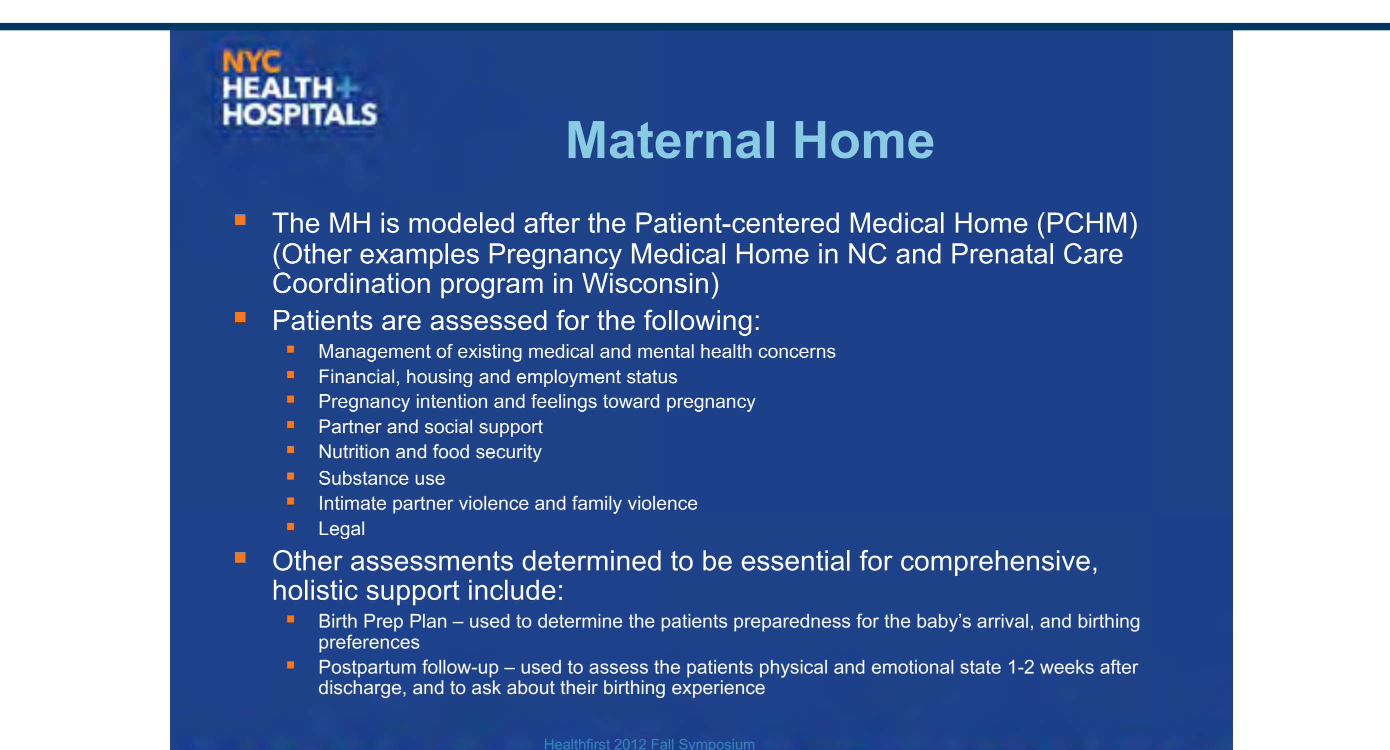
- Needed to determine cadence of re-training
- Introducing new courses
- As new technologies are developed and introduced, these need to be added to Sim courses (e.g. Jada for obstetric hemorrhage)
- Staff like Sim training
- Core leadership, resources, time

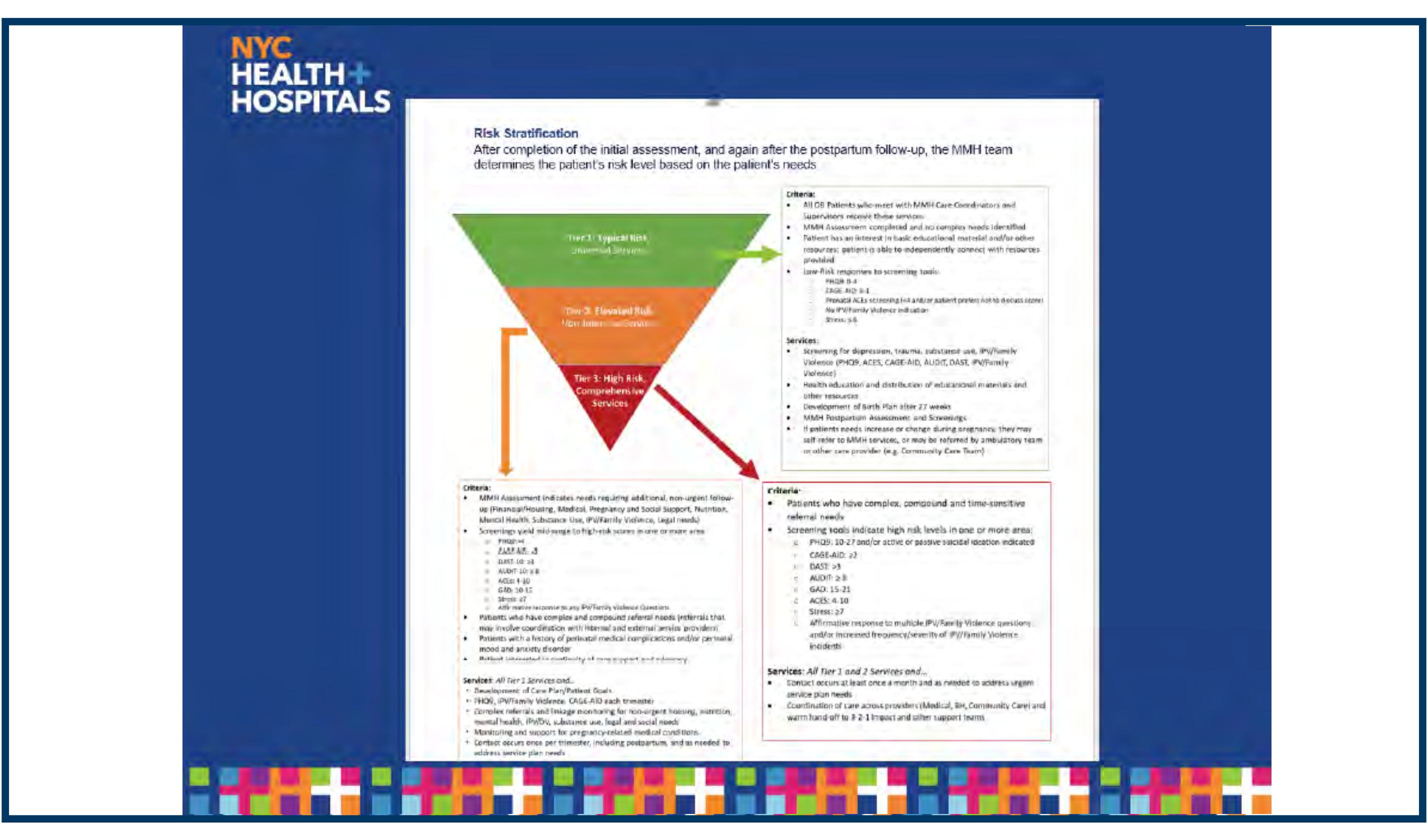
NYC HEALTH + HOSPITALS

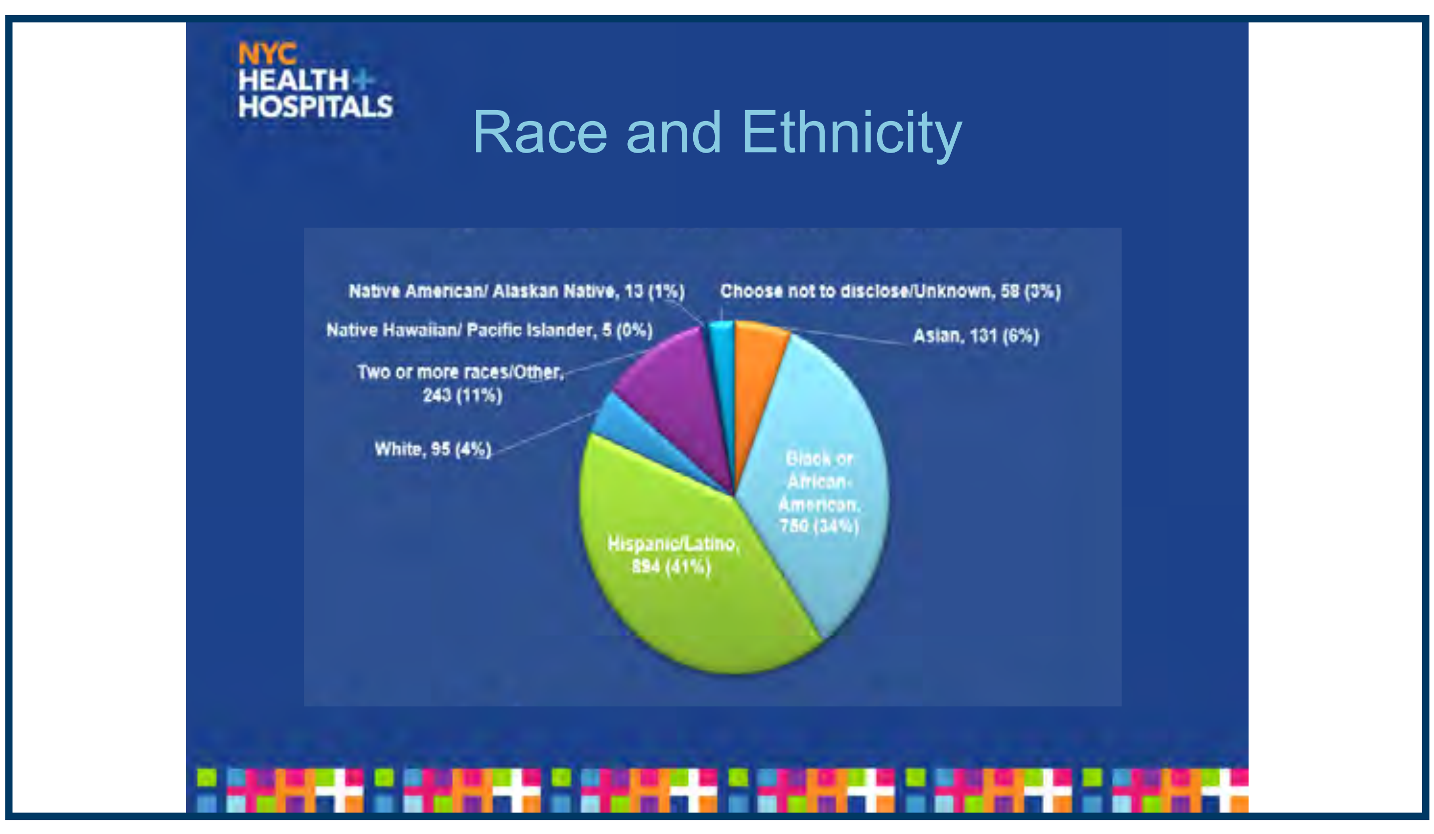
The Maternal Home

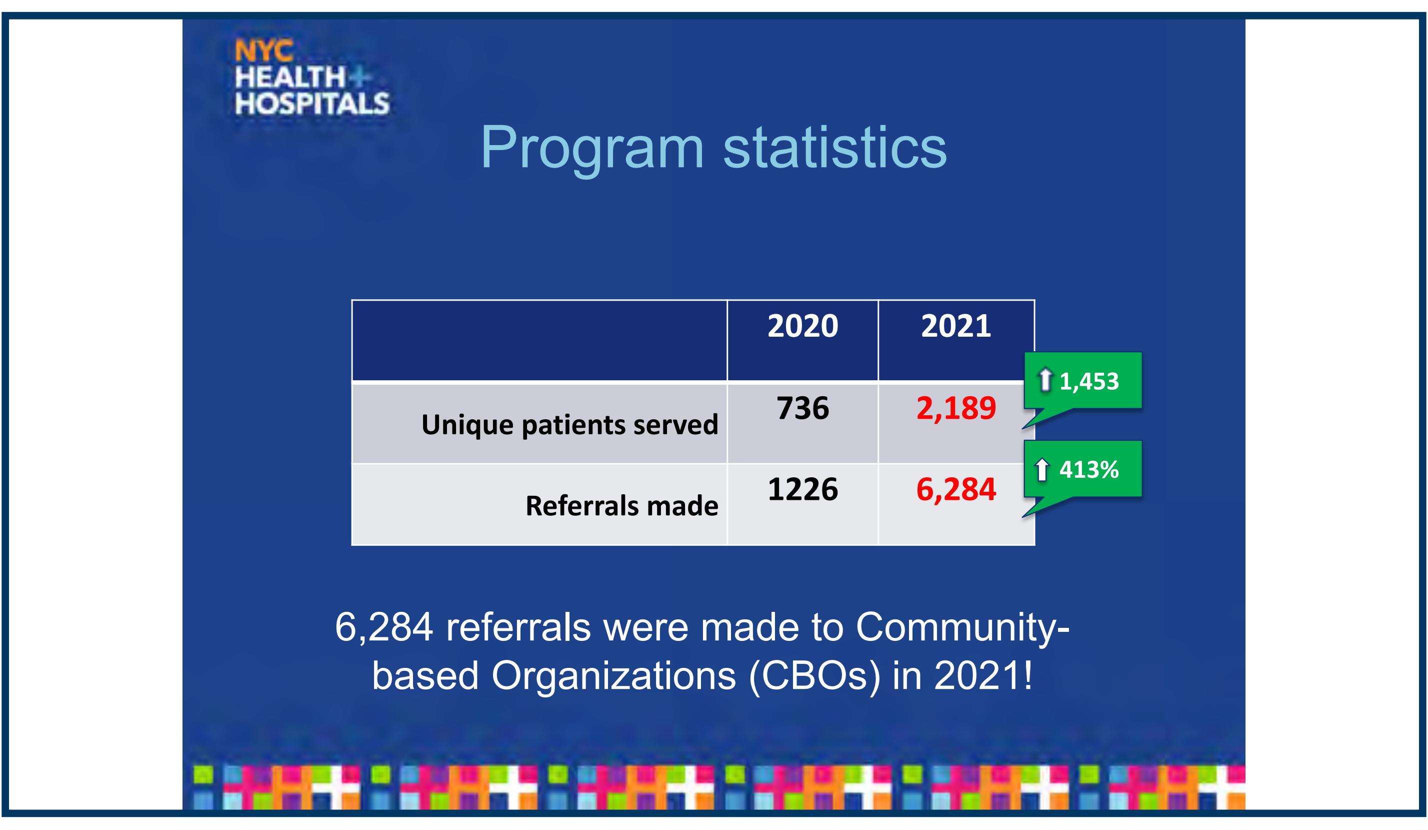
- The purpose of the Maternal Home is to provide support and comprehensive wrap-around services for pregnant persons who have need for this support due to **clinical, behavioral health or factors related to social determinants of health.**
- The Maternal Home puts patients at the center of their care and facilitates coordination to necessary support services that help provide the strongest foundation for a healthy birth and safe care for their newborn.
- The Maternal Home employs licensed social workers and maternal care coordinators

18

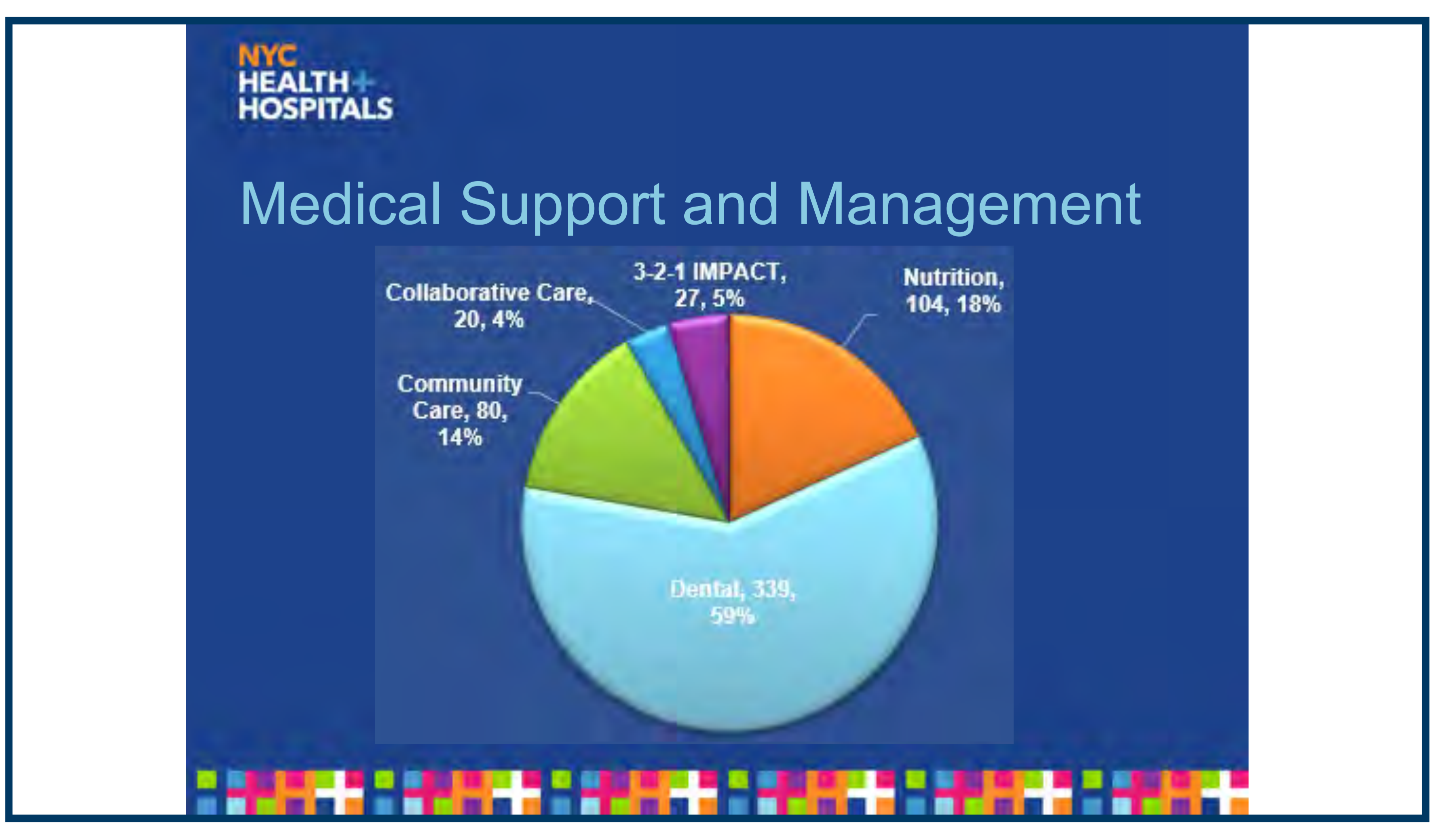

NYC HEALTH+ HOSPITALS
Maternal Home
The MH is modeled after the Patient-centered Medical Home (PCHM) (Other examples Pregnancy Medical Home in NC and Prenatal Care Coordination program in Wisconsin)
Patients are assessed for the following:
Management of existing medical and mental health concerns
Financial, housing and employment status
Pregnancy intention and feelings toward pregnancy
Partner and social support
Nutrition and food security
Substance use
Intimate partner violence and family violence
Legal
Other assessments determined to be essential for comprehensive, holistic support include:
Birth Prep Plan – used to determine the patients preparedness for the baby's arrival, and birthing preferences
Postpartum follow-up – used to assess the patients physical and emotional state 1-2 weeks after discharge, and to ask about their birthing experience
Healthfirst 2012 Fall Symposium
Effective Care for Children


NYC HEALTH+ HOSPITALS
Risk Stratification
After completion of the initial assessment, and again after the postpartum follow-up, the MMH team determines the patient's risk level based on the patient's needs
Tier 3: High Risk, Comprehensive Services
Criteria:
All OB Patients who meet with MMH Care Coordinators and Supervisors receive these services
MMH Assessment completed and no complex needs identified
Patient has an interest in basic educational material and/or other resources; patient is able to independently connect with resources provided
Low-Risk responses to screening tools:
Services:
Screening for depression, trauma, substance use, IPV/Family Violence (PHQ9, ACES, CAGE-AID, AUDIT, DAST, IPV/Family Violence)
Health education and distribution of educational materials and other resources
Development of Birth Plan after 27 weeks
MMH Postpartum Assessment and Screenings
If patients needs increase or change during pregnancy, they may self refer to MMH services, or may be referred by ambulatory team or other care provider (e.g. Community Care Team)
Criteria:
MMH Assessment indicates needs requiring additional, non-urgent follow-up (Financial/Housing, Medical, Pregnancy and Social Support, Nutrition, Mental Health, Substance Use, IPV/Family Violence, Legal needs)
Screenings yield mid-range to high-risk scores in one or more area
Patients who have complex and compound referral needs (referrals that may involve coordination with internal and external service providers)
Patients with a history of perinatal medical complications and/or perinatal mood and anxiety disorder
Services: All Tier 1 Services and...
Development of Care Plan/Patient Goals
PHQ9, IPV/Family Violence, CAGE-AID each trimester
Complex referrals and linkage monitoring for non-urgent housing, nutrition, mental health, IPV/DV, substance use, legal and social needs
Monitoring and support for pregnancy-related medical conditions
Contact occurs once per trimester, including postpartum, and as needed to address service plan needs
Criteria:
Patients who have complex, compound and time-sensitive referral needs
Screening tools indicate high risk levels in one or more area:
PHQ9: 10-27 and/or active or passive suicidal ideation indicated
CAGE-AID: ≥2
DAST: >3
AUDIT: ≥8
GAD: 15-21
ACES: 4-10
Stress: ≥7
Affirmative response to multiple IPV/Family Violence questions and/or increased frequency/severity of IPV/Family Violence incidents
Services: All Tier 1 and 2 Services and...
Contact occurs at least once a month and as needed to address urgent service plan needs
Coordination of care across providers (Medical, BH, Community Care) and warm hand-off to 3-2-1 Impact and other support teams

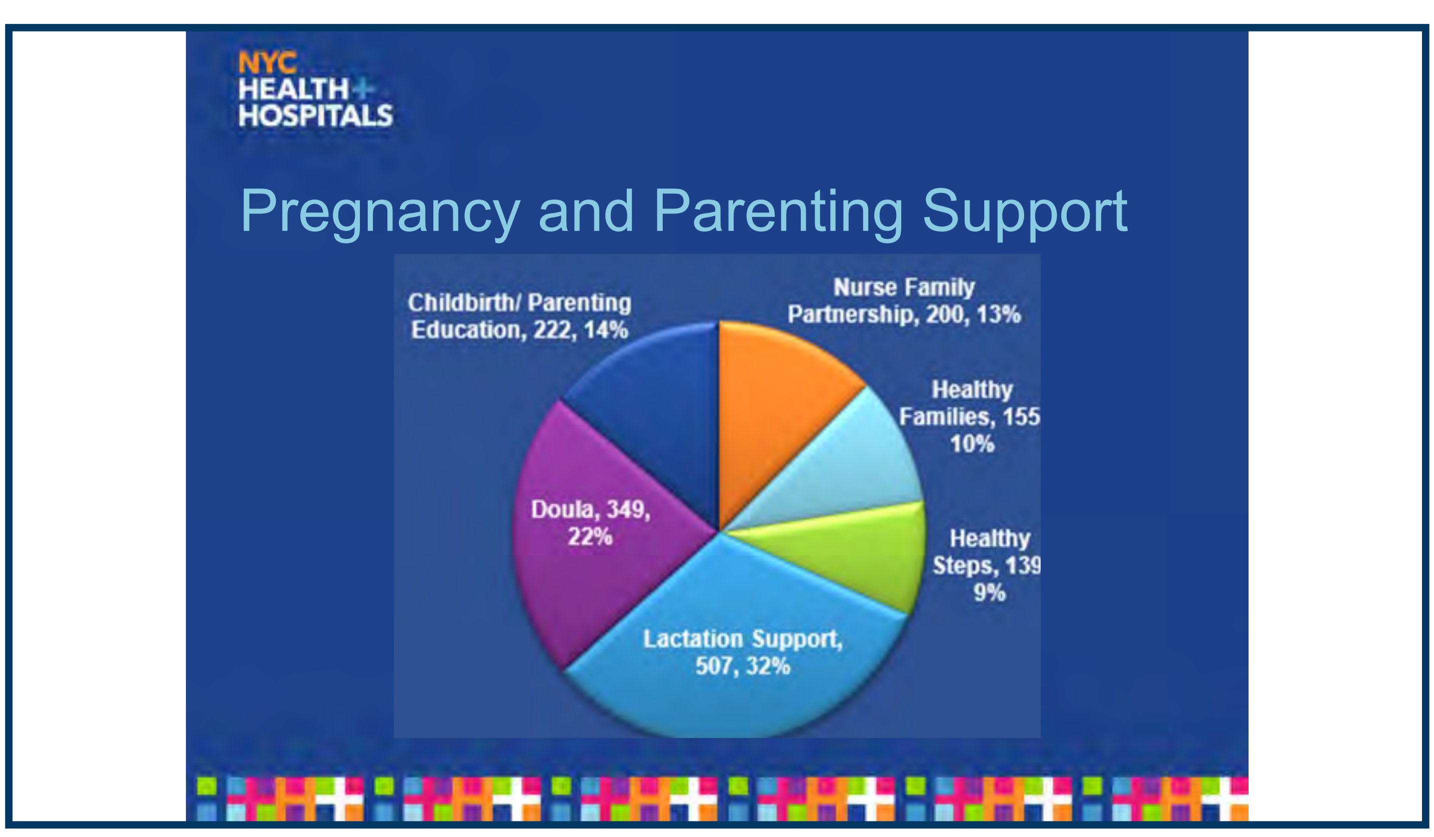




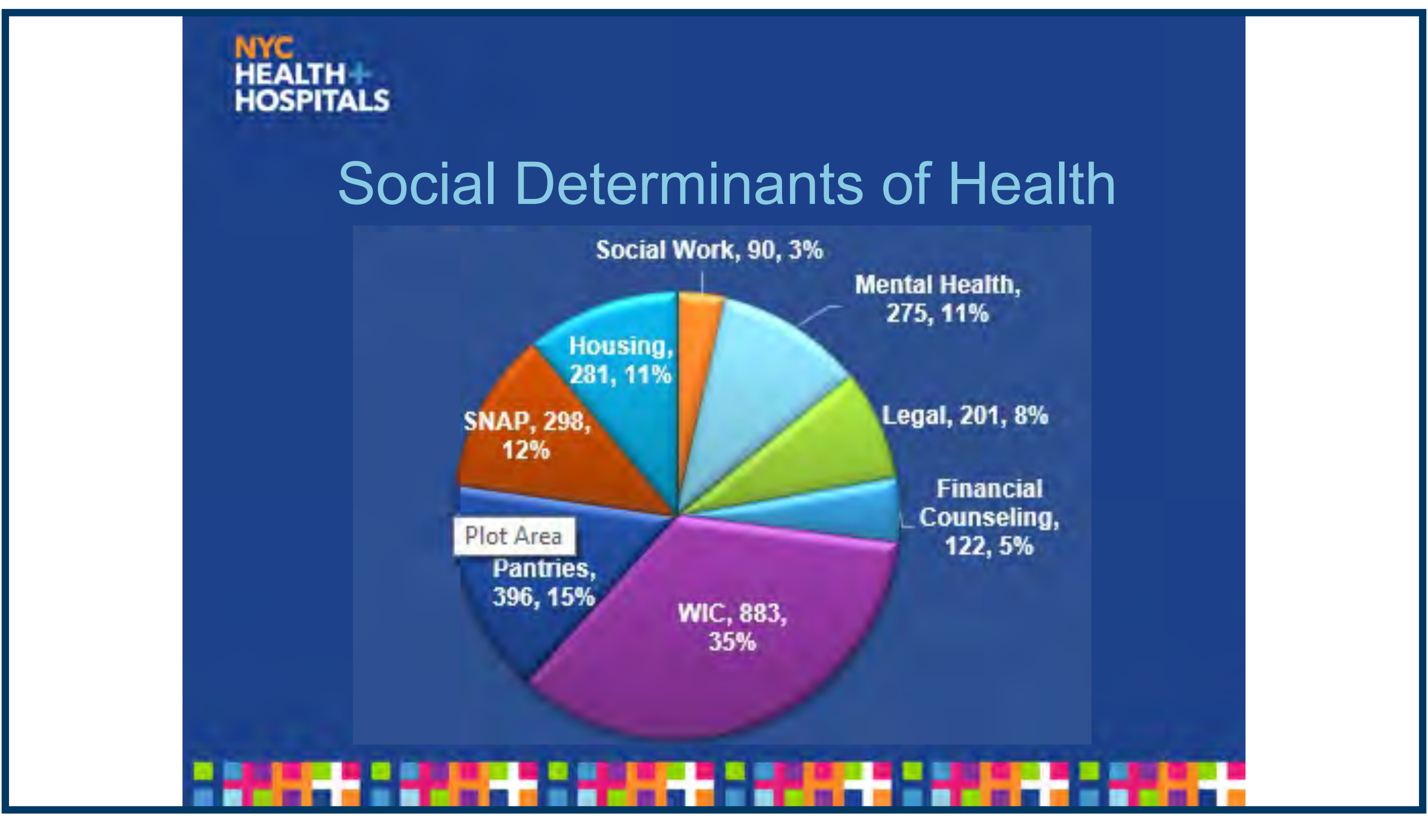
	2020	2021	
Unique patients served	736	2,189	⬆ 1,453
Referrals made	1226	6,284	⬆ 413%



NYC
HEALTH+
HOSPITALS
Medical Support and Management
3-2-1 IMPACT, 27, 5%
Collaborative Care, 20, 4%
Nutrition, 104, 18%
Community Care, 80, 14%
Dental, 339, 59%



NYC
HEALTH+
HOSPITALS
Pregnancy and Parenting Support
Childbirth/ Parenting Education, 222, 14%
Nurse Family Partnership, 200, 13%
Healthy Families, 155 10%
Healthy Steps, 139 9%
Doula, 349, 22%
Lactation Support, 507, 32%



NYC HEALTH+ HOSPITALS

Findings

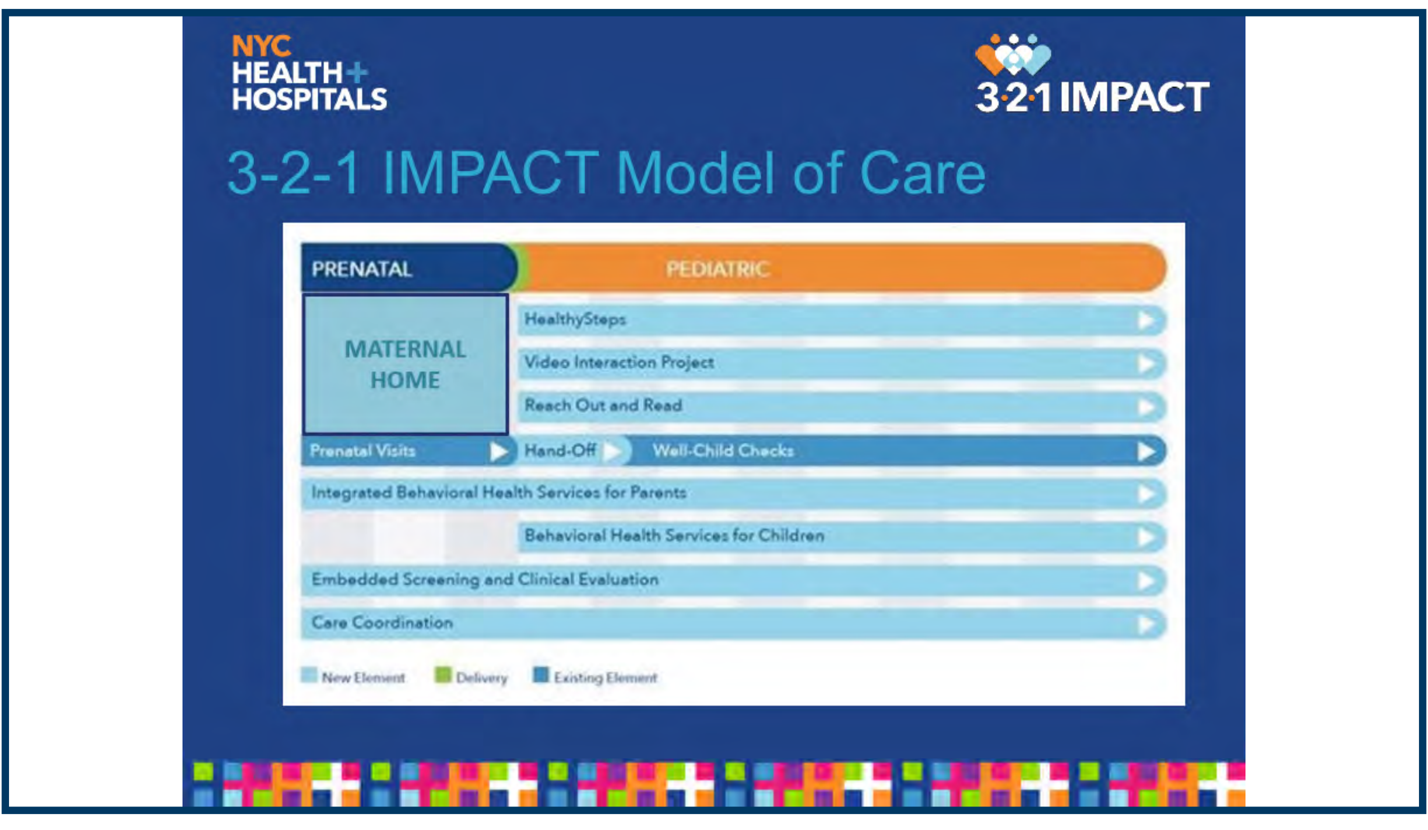
- In 2021, improvement was demonstrated in meeting initial program goals, improving:
  - Postpartum visit compliance
  - WIC/SNAP enrollment and to food pantries
  - Referrals/visits to dental care, doulas and BF support
  - Increased BH referrals and compliance with visits

Findings

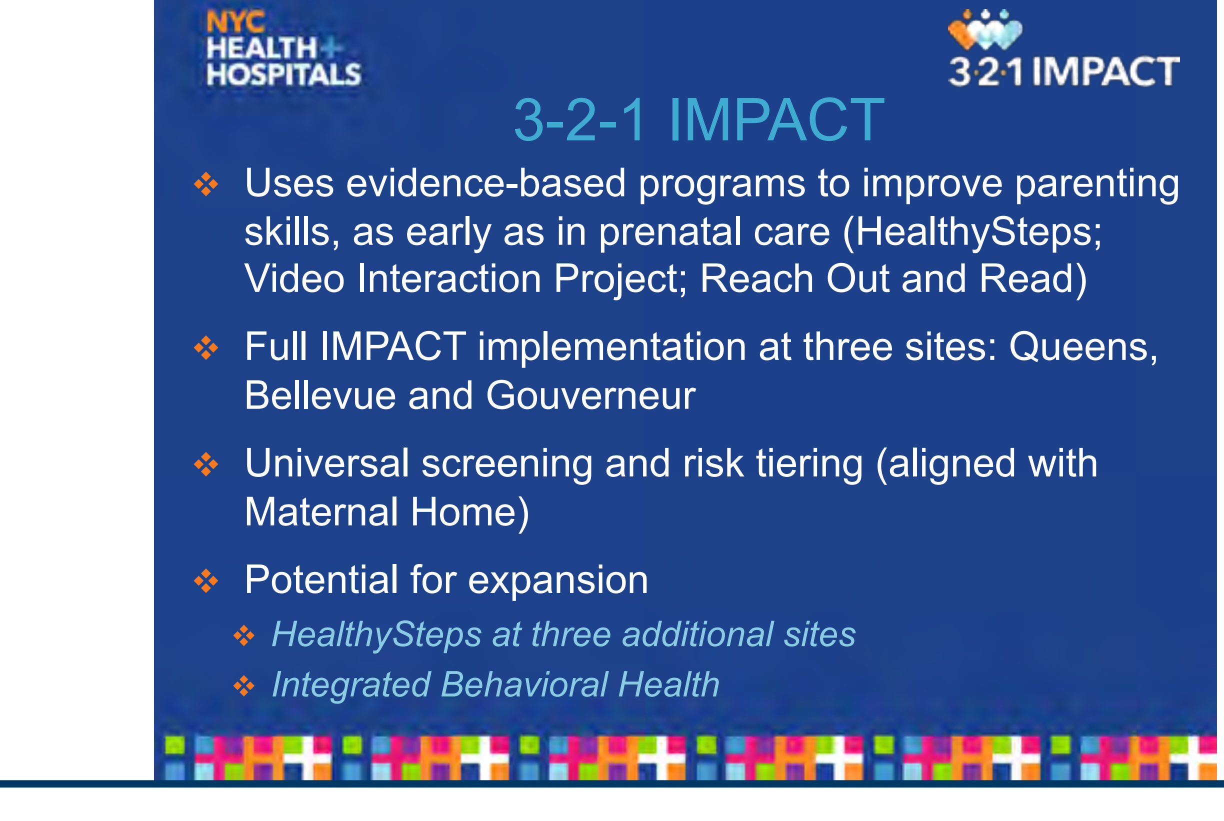
- Promising trends are being monitored and assessment of the clinical outcomes of the program is currently underway.
- Maternal Home provided critical connections during COVID
- Expansion of behavioral health supports within women's health is necessary.

3-2-1 IMPACT

- The 3-2-1 Integrated Model for Parents and Children Together (IMPACT) program supports the health and well-being of young children and their families through on-going in-clinic engagement during routine appointments.
- The program integrates three disciplines, mental health, pediatrics, and women's health, to deliver a two-generation approach that treats children and parents with one goal: to improve the long-term health trajectory for each family unit
- Supports the transition from pre-natal to post-partum care for both the mother and the baby to ensure the new parent continues to have the support they need to safely care for the infant and provide the best environment.



NYC HEALTH+ HOSPITALS
3·2·1 IMPACT
3-2-1 IMPACT Model of Care
PRENATAL
PEDIATRIC
MATERNAL HOME
HealthySteps
Video Interaction Project
Reach Out and Read
Prenatal Visits
Hand-Off
Well-Child Checks
Integrated Behavioral Health Services for Parents
Behavioral Health Services for Children
Embedded Screening and Clinical Evaluation
Care Coordination
New Element
Delivery
Existing Element



NYC HEALTH+ HOSPITALS
3·2·1 IMPACT
3-2-1 IMPACT
Uses evidence-based programs to improve parenting skills, as early as in prenatal care (HealthySteps; Video Interaction Project; Reach Out and Read)
Full IMPACT implementation at three sites: Queens, Bellevue and Gouverneur
Universal screening and risk tiering (aligned with Maternal Home)
Potential for expansion
HealthySteps at three additional sites
Integrated Behavioral Health

Long term sustainability

- Improve billing success (through advocacy) for billable providers, such as social workers and community health workers
- Additional advocacy work focused on fiscal and structures that support two generational care models (e.g. expansion of Medicaid coverage for up to one year post birth)
- Healthfirst and MetroPlus working with us to pilot test

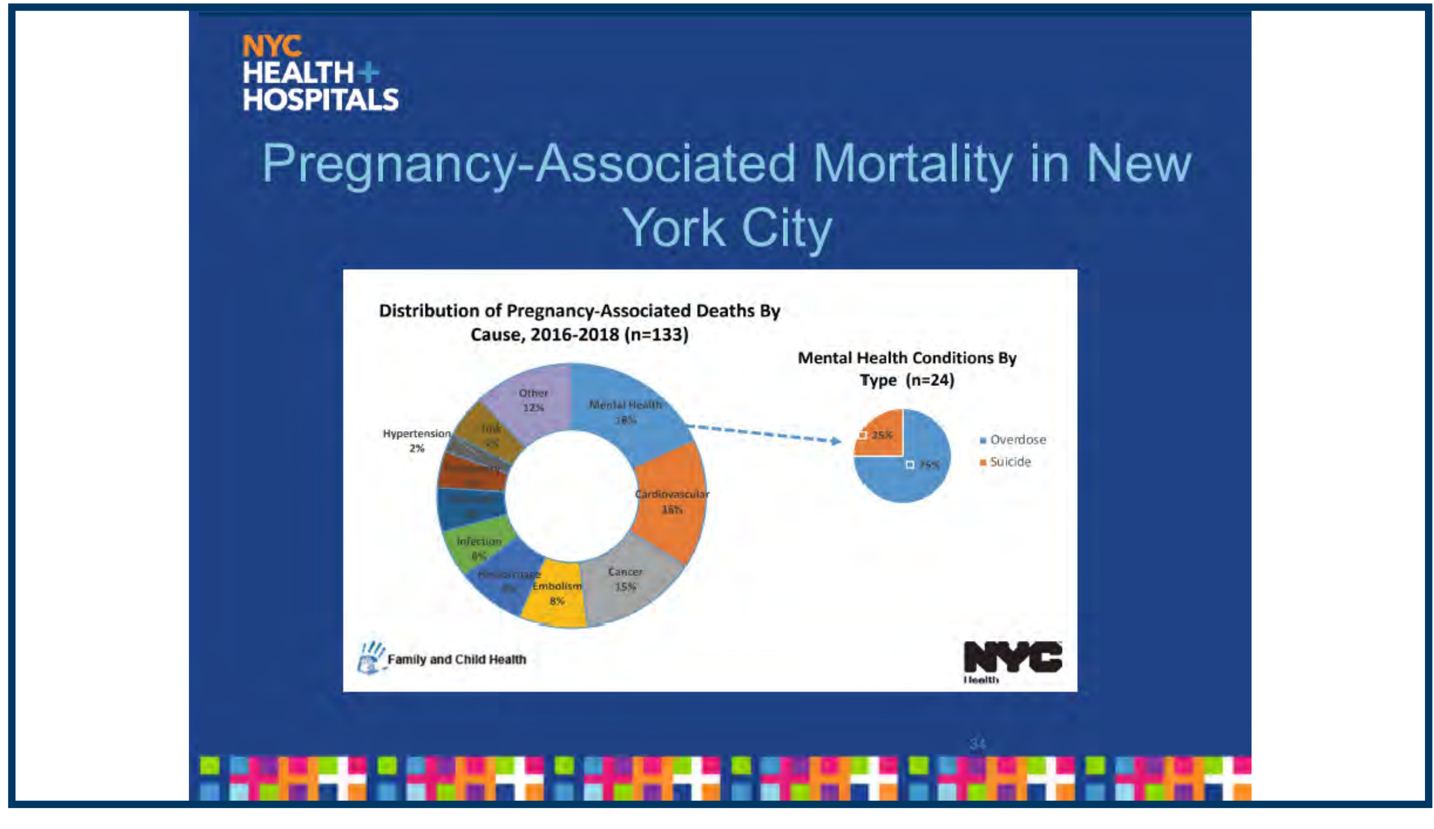
NYC
HEALTH+
HOSPITALS

LESSONS LEARNED FROM MATERNAL HOME & 3-2-1 IMPACT

- Access to mental health services needs to be increased
- Women prefer receiving mental health care in the setting of OB/GYN, Women's Health

NYC HEALTH+ HOSPITALS

An evolution…



In November 2021, the New York City Commission on Human Rights launched an investigation into practices of New York City hospitals for discrimination related to drug testing of mothers and babies.

Black children in New York City represented 23% of the city's child population but 56% of the approx. 8,000 children in the foster care system in 2018.

Focus on Substance Use

- In 2020, prior to launch of Commission on Human Rights investigation, NYC H+H changed policy on toxicology testing to require informed written consent prior to testing pregnant and postpartum women.

NYC HEALTH+ HOSPITALS

Decriminalizing substance use in pregnancy

- It is the policy and practice of NYC Health + Hospitals to treat Substance Use Disorders (SUD) as medical conditions, not moral problems
- Maternal OP on toxicology testing in pregnant patients requiring written consent (2020)
- Newborn OP on toxicology testing requiring written consent (2022)

What led to CHANGE?

1. Acknowledgement of HARM
2. Acknowledgement that this is an example of STRUCTURAL RACISM
3. Commitment by leadership that we can no longer accept the status quo

Maternal SUD Policy January 2020

- It is the policy and practice of NYC Health + Hospitals to treat Substance Use Disorders (SUD) as medical conditions, not moral problems.
- NYC Health + Hospitals providers order and perform toxicology testing on pregnant women to:
  - refer affected patients for appropriate treatment,
  - provide education on how substance use during pregnancy can affect the health of the pregnant woman and her fetus,
  - determine diagnoses and treatments when symptoms/behaviors could result from substance use or other causes.
- **NYC Health + Hospitals is replacing the previous Operating Procedure for toxicology testing in pregnant patients which only required verbal consent.**

Purposes of the Revised Operating Procedure

- Establish universal screening for substance use disorder in pregnant and women.
- Standardize criteria for toxicology testing to develop an effective plan of care for pregnant patients with substance use disorders.
- Establish a written informed consent requirement for toxicology testing in the antepartum and intrapartum periods.
- Create an equitable process for screening for substance use disorders and lead to treatment

NYC HEALTH+ HOSPITALS

Lessons Learned

- Culture eats strategy for lunch!
- Policies do NOT change behavior
- IT considerations
  - Add decision support to help providers do the right thing. Order takes providers to the information sheet and consent form
- Laboratory
  - Standardized tests across facilities, created separate panels for generalists and specialists
  - Removed cannabis from general testing
  - Removed ‘back door’ testing
  - Separated OB and Pediatric tests
- Documentation for other disciplines: SW Safe Plans of Care
- 2022 Neonatal OP was introduced

As NYC Health + Hospitals, continues to work towards birth equity for ALL birthing persons, we must look at all practices and procedures and evaluate. When necessary, changes must be made.

Highlights

- Pilot Birthing person and family Substance Use Disorder Practice (Perinatal/PP care + Pediatric+ Substance Use-Lincoln)
- Expansion of midwifery practices across four NYC Health + Hospitals (Kings, Queens, Lincoln, Harlem)
- Data (Improvement of capture and race)
- Doula pilot (Elmhurst and Queens)
- Quality review of Labor and birthing practices across NYC Health + Hospitals

Healthfirst 2012 Fall Symposium
Effective Care for Children

THANK YOU

Wendy Wilcox, MD
Chief Women's Health Officer
NYC Health + Hospitals
Wendy.Wilcox@nychhc.org

AGING IN PLACE: A Managed Care Plan, Hospital, & University Collaboration to Identify Risk and Resilience Factors

- Elizabeth Brondolo, PhD
  - St. John’s University
- Daniel Chen, MD
  - Jamaica Hospital Medical Center
- Ira Frankel, PhD, LCSW
  - Flushing Hospital Medical Center

The Challenge: Supporting Successful Aging in Place

- Aging in Place:
  - “The ability to live in one’s own home and community safely, independently, and comfortably regardless of age, income and ability level.” US CDC definition:
- Prevalence: “37% of those 65+ will require, at some point, housing in LTC institutions, an outcome that is both expensive and often not optimal.” (Longtermcare.gov)

Disparities in the quality of care

- Past 20 years – Greater increase in rates of nursing home admission for non-White (versus White) older adults (Feng, et al 2011).
- Expansion in use of Home & Community Based Services (HCBS) (Gorges et al 2019), but …
  - from 1996-2016: 16% to 57% of $
  - Black and Hispanic patients are less likely to receive high quality home care (Gorges et al 2019; Fashaw-Walters et al 2022).
  - Access to quality home-health services is related to neighborhood segregation and disadvantage. (Fashaw-Walters et al, 2022)

Improving the Quality of care

OMH: Aging in Place Project

JHMC and Flushing Hospital with their partners from the NYC Department of the Aging

Awarded a grant from the Office of Mental Health to provide community-based integrated mental health services to individuals 55+.

The goal is to promote aging-in-place and reduce institutional LTC use.

NIH's Science of Behavior Change: Public Health Implications

- Understand the mechanisms
- Understand potential moderators - group differences in needs and response

Complexity and Heterogenity

- Over 55+: A very heterogenous population.
- Multiple sociodemographic, clinical, and health care access factors contribute to institutional long term care (iLTC) LTC placement in older individuals .
  - This makes it difficult to
    - Identify variables are critical to support aging in place
    - Determine if there are systematic differences across individuals in key predictors

Use clinical and claims data to improve support for aging in place

- **Among adults age 55+, identify variables which distinguish between those who …**
- Age in place
  - with or without HBCS,
  - with or without prior short term rehabilitation services
- Required long term institutional care (iLTC)

Goals

- Are there distinct subgroups of those who age in place (or don't) with different social, clinical, and medical needs?
- Capitalize on the OMH funding to deliver what each individual needs
  - Develop a framework for personalized medicine/psychosocial treatment

Practice and Prevention Implications

- **Facilitate Intervention:**
  - **Better target interventions to the person's psychological, medical and social needs**
- **Facilitate Prevention:**
  - **Provide meaningful risk markers to help providers identify patients at risk for iLTC**

Developing a Collaborative Network

Building social and intellectual capital by adding expertise, personnel and experience

Behavioral Medicine Fellowship Program
A Collaboration of JHMC/FHMC &
St. John's University

HealthFirst – A managed care plan

Hospital/Medical Center	Community Partners
Insurance/Managed Care	University Resources

Collaborators: Administrators, Clinicians, Data Analysts and more

Organization	Personnel
Medisys: Flushing Hospital and Jamaica Hospital	Daniel Chen, Ira Frankel, Guirlande Ducenat-Payen, Ernest Baptiste, Krystal Gayle, John Dougherty
NYC Department of Aging	Meghan Shineman
HealthFirst	Susan Beane, Rashi Kumar, Sonal Upadhyay, Surabhi Hoover, Tamar Williams, Stephen Selik, Tom Wang, Sule Baptiste, Marty Masek, Ryan Delahanty, Gina DiLorenzo
St. John's University (CHIRP)	Elizabeth Brondolo, Emilia Mikrut, Andrew Miele, Luke Keating, Philip McGourty, Ivy Chen, Rebbecca Seavey

Theory: The Anderson Model

Predisposing factors- Individual and community level sociodemographic factors

Clinical Needs-

Specific risk conditions and multi-morbidity

Access Factors –

Availability and use

Using Claims and other Data to Identify Patterns of Risk and Resilience

Examining patients who were able to be served in the community vs. placed in long term institutional LTC in 2019.

Examining factors from 2017-2018 which predict their status in 2019.

Predisposing factors: From claims data and publically available databases

- **Individual level**
  - (sex, age, race, language – Claims data)
- **Neighborhood level:**
  - Threats
    - Pollution (CDC data set for census tract PM2.5 levels)
    - Crime (violent crime from COPSTAT)
  - Resources
    - Education level (ACS block group)
    - Poverty level (ACS) block groups
    - Managerial level (ACS block groups)
    - Social Cohesion (Facebook)
  - Segregation (ACS block group)
    - Index of Concentration at extremes (ACS)
    - % of each racial/ethnic group.

Clinical Needs 2017-2018

- From claims data
  - Medical needs (primary high-risk diagnoses)
    - E.g., neurological, cerebrovascular disease, circulatory, chronic respiratory conditions, diabetes, mental health
  - Functional impairments, recent fractures
  - Severity of comorbidity – Elixhauser, Charlson

Access in 2017-2018

- Service use from claims data
  - History of use of emergency department
  - In-patient stays, length of stays
  - Duration of days between hospitalization events
  - Readmission rates.
  - Use of HBCS (including home help, adult day care)

Access 2017-2018

- Access/coverage from healthplan
  - Plan enrollment
  - Services covered and used

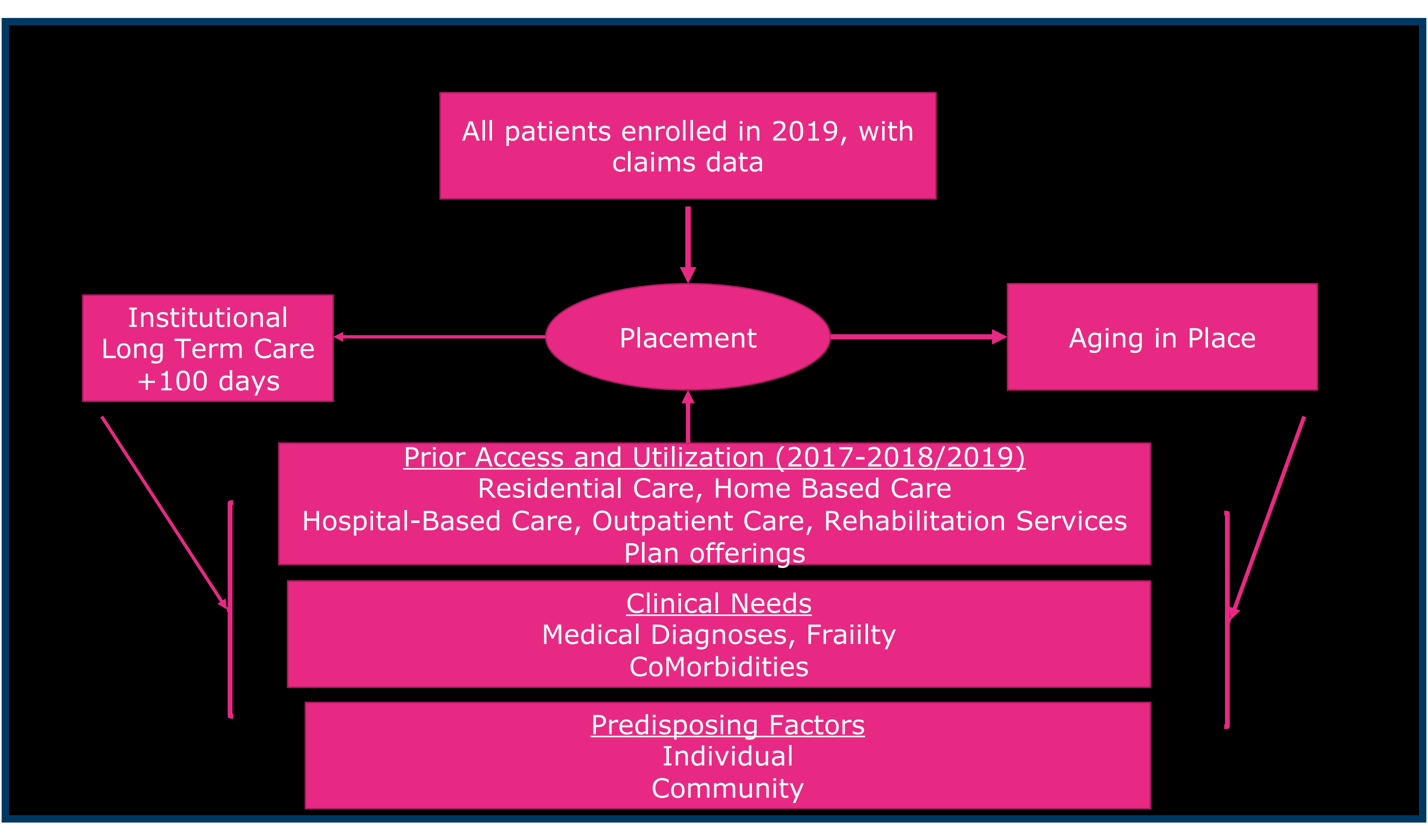
Analyses

- Distinguishing those who remained in the community vs. did not
  - Groups: Probable aging in place vs. Probable institutional LTC

    - Predicting 2019 status from 2017 and 2018 predisposing factors, clinical needs and access/utilization (Survival analyses)

Are there consistent patterns among participants?

- Identifying subgroups (Clustering Techniques)
  - Vary in predisposing, clinical and access characteristics
- Generating predictions
  - Quantify subgroup membership (cluster/class scores) predict psychosocial and clinical needs in the intervention study.



Intervention

State OMH funded service grant to improve Aging in Place

Design and Evaluation of the OMH-funded Intervention

- 72 participants 55+ each year for five years
- Recruited from multiple sites JHMC and Dept of Aging centers community referrals
- Comprehensive Assessment and Intervention
- Grant funds assessment and referral staff

Outcomes

Interventions will be tracked and outcomes evaluated using a complex battery and utilization data from JHMC/FHMC and claims databases.

Full battery at baseline, three months, and (where possible) previous two years claims data and data from census and other sources.

Long term (5-year follow-up of health care utilization)

Component	Subjective Measurement	Objective Measurement	Source(s) of Data
Medical Morbidity	Tilburg Frailty Index (physical); one-item self-rated health, QOL, and sleep quality scales; Somatic Symptom Scale; COVID-19 exposures	Charlson Comorbidity Index, polypharmacy	Patient assessment; medical/insurance records
Mental Health	PHQ-9; GAD-7; SMAST-G; DAST-10; 1-item tobacco screen; ACES-Q Trauma Inventory; Columbia Suicide Severity Rating Scale	Behavioral health ICD codes	Patient assessment; medical/insurance records
Cognitive Functioning	Subjective Cognitive Decline Questionnaire	MOCA-blind results; neuropsychiatric ICD codes	Patient assessment; medical/insurance records
Interpersonal Support	3-item brief UCLA Loneliness Scale; 7 social integration items	Marital status	Patient assessment
Economic Stability	Items from the Accountable Health Communities Health-Related Social Needs screening tool	Demographic questions regarding income and insurance	Patient assessment
Aging Services Needs	OMH Aging Services Needs Screening; person-centered screening (2 items)		Patient assessment
Acute health service utilization		Frequency and length of emergency department visits; Frequency and length of preventable acute hospitalizations (as indicated by the occurrence of any 1 of 13 AHRQ Prevention Quality Indicators: angina without procedure, asthma, bacterial pneumonia, CHF, chronic obstructive pulmonary disease (COPD), dehydration, short- or long-term complications from diabetes mellitus, uncontrolled diabetes mellitus, diabetes mellitus–related lower extremity amputation, hypertension, perforated appendix, or UTI	Medical/insurance records
Readmission Rate		Frequency of all-cause 30-day hospital readmission	Medical/insurance records
Preventative health service utilization		Frequency of outpatient medical + mental health visits	Medical/insurance records
Rehabilitation service utilization		PT and inpatient rehabilitation service use	Medical/insurance records

Drawing connections

- Use analyses from the claims data project to help understand the risk factors facing participants
- Link subgroup status with assessment outcomes
  - Which groups are most likely to have high levels of comorbidity, of substance use, of neuropsychological impairments.

These analyses can....

- Provide insight into the heterogeneity of these populations
- Provide better identification

  -Better targeting of treatment

  -Enable improve personalized, integrated care

  -Maybe provide automated guidance for health care providers

Our collaborations provide…

- Training opportunities for students
- Sharing of expertise
- Integration of clinical insight with empirical evaluation

Thank you!

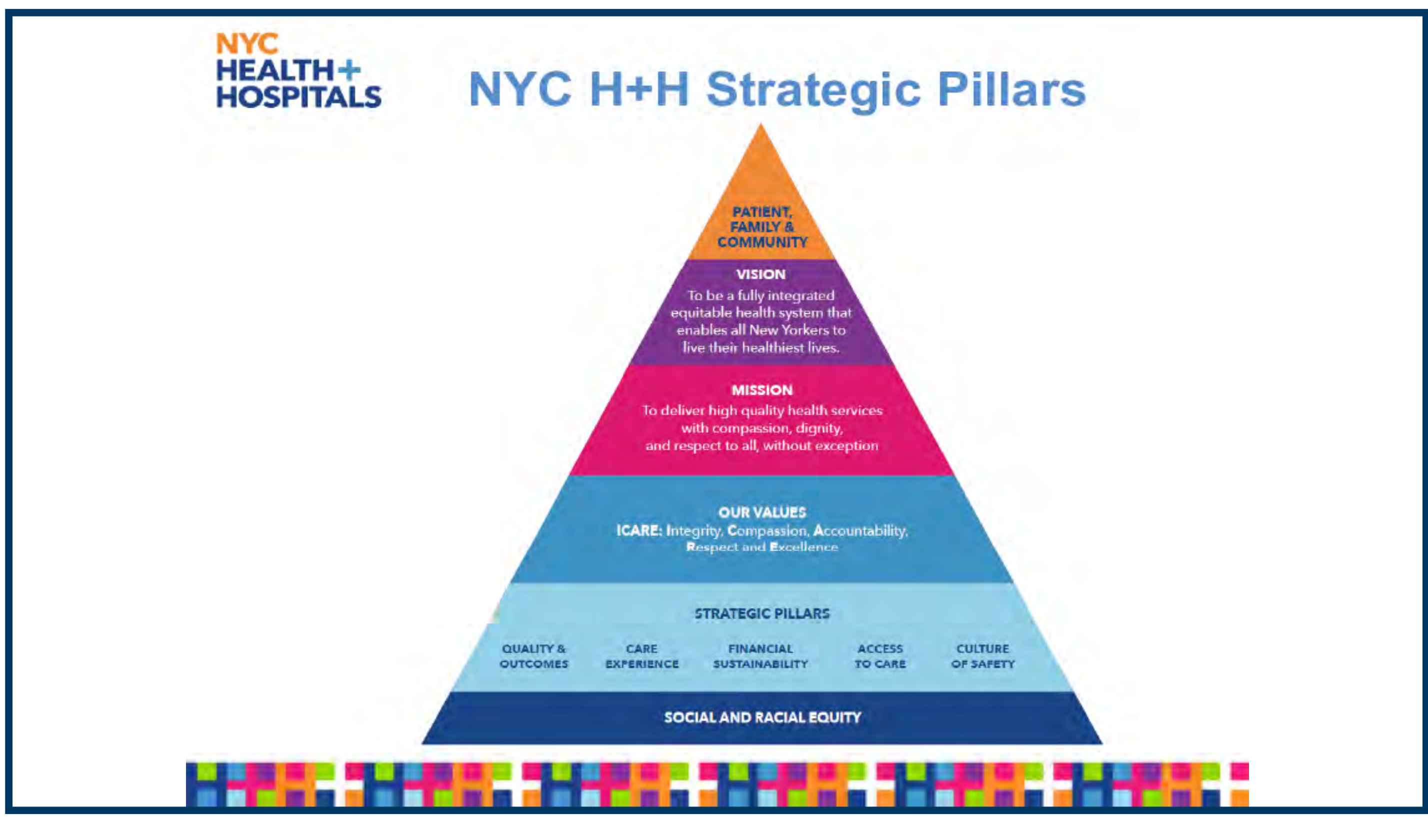
- Questions?
- brondole@stjohns.edu

Medical Eracism Initiative

Ayrenne Adams, MD MPH
Clinical Lead, Medical Eracism
NYC Health + Hospitals
November 18, 2022

NYC H+H by the numbers…

- **Nation's largest safety net healthcare system**
  - 11 acute hospitals, 70+ health centers
  - Correctional health services
- **1 Million+ New Yorkers served annually**
  - 175,000 admissions
  - 1 million emergency department visits
  - 3.5 million clinic visits (including1 million primary care visits)
  - 500,000 Metroplus members
- **Our adult patients are:**
  - 30% uninsured
  - 30% speak a language other than English
  - 5% homeless
  - Racially and ethnically diverse:
    - 34% Black/African American, 29% Hispanic/ Latinx, 7% Asian/Pacific Islander, 9% White, 16% Other



Rationale

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

Race is a social construct

14

The Apportionment of Human Diversity

R. C. LEWONTIN

Committee on Evolutionary Biology, University of Chicago, Chicago, Illinois

INTRODUCTION

It has always been obvious that organisms vary, even to those pre-Darwinian idealists who saw most individual variation as distorted shadows of an ideal. It has been equally apparent, even to those post-Darwinians for whom variation between individuals is the central fact of evolutionary dynamics, that variation is nodal, that individuals fall in clusters in the space of phenotypic description, and

FUTURE

BIOLOGY

Race Is a Social Construct, Scientists Argue

Racial categories are weak proxies for genetic diversity and need to be phased out

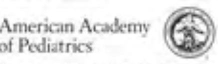
Race-Based Medicine

- *System in which race is characterized as a biological variable, translated into clinical practice and leading to inequitable care*

AMA

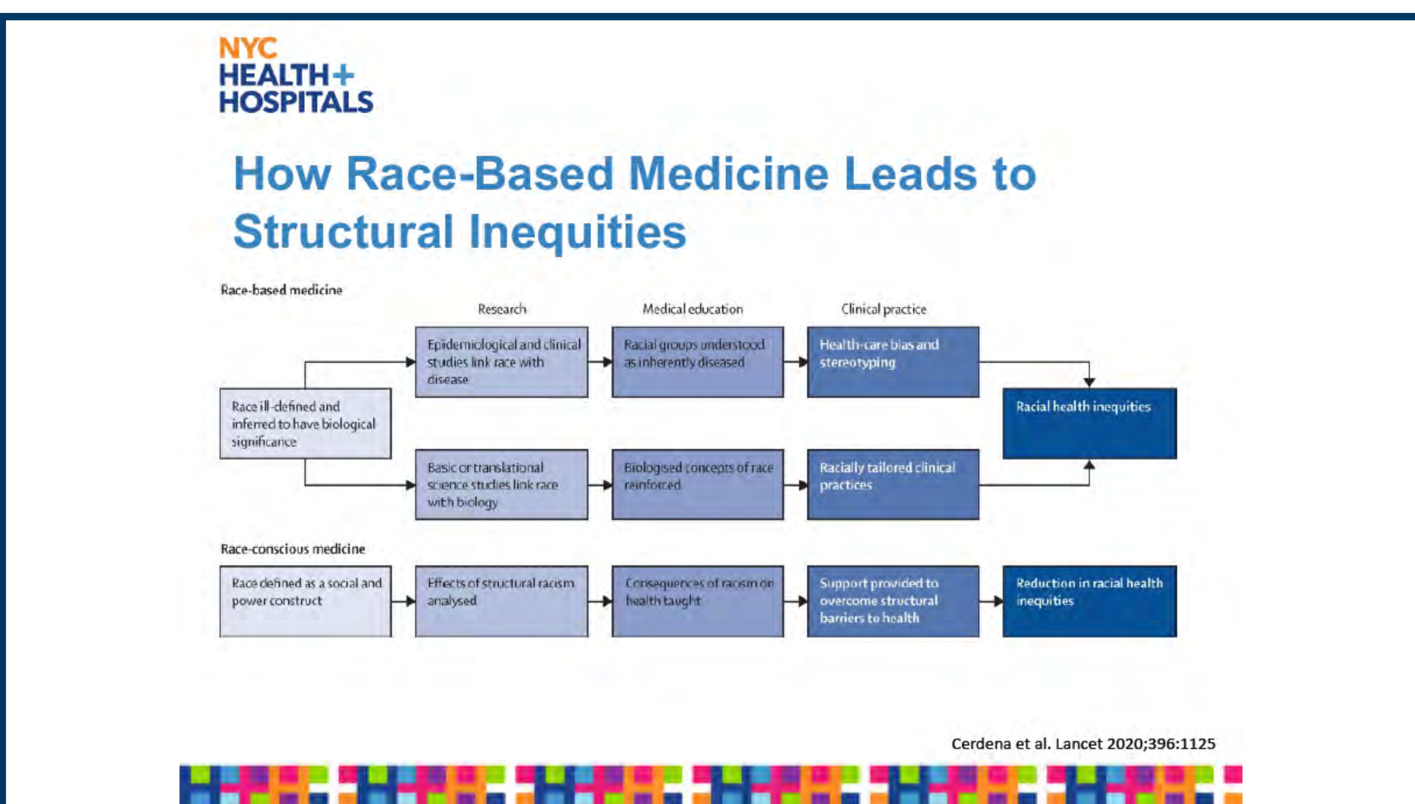
Race-based medicine is wro[n]
it?

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children



Eliminating Race-Based Medicine

The American Academy of Family Physicians (AAFP) opposes the use of race as a proxy for biology or genetics in clinical evaluation and management and in research. The AAFP encourages clinicians and researchers to investigate alternative indicators to race to stratify medical risk factors for disease states. (July 2020 BOD) (2020 COD)

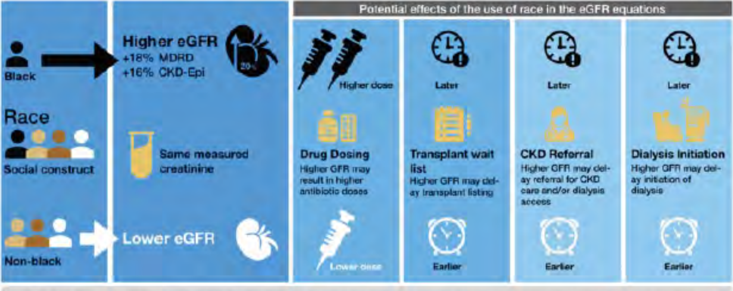


Effects of race-based eGFR on care for Black patients

Do the current eGFR equations disadvantage the black patients?

Eneanya ND, Yang W, Reese PP. Reconsidering the Consequences of Using Race to Estimate Kidney Function. *JAMA 322 Number 2, July 9, 2019.*

#NephJC



Conclusions - The use of kidney function estimating equations that include race can cause problems with transparency and may unduly restrict access to care in some cases. The marginal improvement in accuracy may not justify use of this demographic variable.

Visual Abstract by Krithika Mohan (@Krithicism), NSMC intern 2019

http://www.nephjc.com/news/raceandegfr

NYC HEALTH + HOSPITALS

How can we ensure that race-based algorithms are not informing care for NYC Health + Hospitals patients?

NYC HEALTH + HOSPITALS

"Medical Eracism" Initiative Aims to Abolish Race-Based Assessments Used for Medical Decisions

Public health care system will eliminate common diagnostic tests for kidney disease and pregnancy that are based on biased assumptions and can negatively impact quality of care for patients of color

Initiative builds on the health system's commitment to eliminate implicit bias in health care and provide equitable, quality care to all patients

Key Elements of Innovation

- Identify race-adjusted clinical algorithms being used within NYC Health + Hospitals
- Remove race-adjusted algorithms in clinical care
- Measure effects of race-adjusted algorithms on NYC H+H patients

Description of the Innovation

eGFR*	VBAC*	PFT
- Convened stakeholders - Obtained consensus - Drafted one-pager document - Engaged with Epic team and Northwell labs - Removed race from eGFR calculation	- Convened stakeholders - Confirmed that OB/Gyn department is not promoting use of VBAC calculator - Drafted one-pager document	- Reviewed literature - Signed advocacy letter encouraging ATS to review the misuse of race in spirometry
~ 6 months from start to finish		Still in process
Educating NYC H+H staff members		

*Dr. Lou Hart, Medical Director of Health Equity at Yale New Haven Health System, played a large role in implementing changes

NYC HEALTH+ HOSPITALS

Medical Eracism: Removing Race-Based eGFR

Context

- When calculating a patient's kidney function (GFR), we often use a set of calculations based on various factors to estimate their glomerular filtration rate or eGFR
- Traditionally, these risk factors include serum creatinine, age, sex and **race (Black vs. non-Black)**
- The equation reports out two values. For Black patients it increases the estimated GFR by 16-21% to account for their "increased muscle mass", though no robust scientific evidence exists to support this claim
- **The unintended consequence is to assert and propagate a biological cause for Black bodies being different from all non-Black bodies, a popular eugenicist view**

Contributing Factors

- African Americans have a **3x** and Hispanics **1.5x higher risk** of developing kidney failure than White Americans[1]
- By having higher eGFRs, Black patients might have delayed referral to specialty services, dialysis and transplantation

Key Takeaways

- The inclusion of race is fraught with bias and has lasting deleterious implications for our Black patients. **For a multitude of social and scientific reasons, the Nephrology workgroup feels strongly that the inclusion of subjective race (a social construct) as an objective (biologic) proxy for creatinine generation / clearance in the biomedical environment does not meet the scientific rigor required at NYC Health + Hospitals for our diagnostic screening tools.**

Plans for Corrective Action

- Lab Services - Standardize all eGFR calculations to use CKD-EPI eGFR(Cr) where results will be reported without race adjustment based on serum creatinine, age, sex, and is normalized to 1.73m2 body surface area
- Epic – Work to ensure raced based eGFR is no longer reported out as 2 different values to our clinicians and patients
- **Approved by Nephrology Workgroup, IM Council, ICU & OB/GYN leadership, Quality & Safety, Medical & Professional Affairs, Equity & Access Council, Clinical Lab Council, CMO Council**

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Milestones and Results To Date

- Race removed from eGFR calculation
- Gathering data to assess impact of eGFR change on patients
- Systemwide directive to not use VBAC
- Participating in citywide CERCA

NYC HEALTH+ HOSPITALS

Lessons Learned

- Engage stakeholders early
- Ground conversations in facts and evidence
- Educate team members and patients

Implication / Next Steps

- Patient engagement regarding eGFR change
- Finalizing eGFR data
- Monitoring national guidelines on PFTs

NYC HEALTH+ HOSPITALS

Summary

- Race is a social construct that can adversely affect health outcomes for Black patients when included in race-based clinical algorithms
- Healthcare systems can develop campaigns to identify and remove race-based algorithms

NYC HEALTH+ HOSPITALS

Contact Information

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