2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY

METROPOLITAN HOSPITAL CENTER

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

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METROPOLITAN HOSPITAL CENTER

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An Introduction to
Metropolitan Hospital Center

Metropolitan Hospital Center (MHC) is a full-service community hospital located on First Avenue in the East Harlem neighborhood of New York City. MHC provides state-of-the-art care and leading-edge technology to patients from all five New York City boroughs and surrounding areas, regardless of ability to pay.

Since its founding in 1875, MHC has been affiliated with New York Medical College (NYMC), representing the oldest partnership between a hospital and a private medical school in the United States. MHC takes pride in training physicians and other clinical staff, many of whom continue their work in community health long after completing their studies.

MHC is a Level II Trauma and 911 receiving hospital, providing emergent, urgent care to adult, pediatric, and psychiatric patients. It offers a continuum of comprehensive preventive, primary, secondary, and tertiary healthcare services. Patients have access to over 90 primary care and specialty services, a state-of-the-art Intensive Care Unit, a comprehensive surgery department, Physical Medicine and Rehabilitation services, and a Behavioral Health Pavilion with inpatient and outpatient mental health and substance abuse programs.

MHC has 356 certified beds of which 319 are operating, and 122 psychiatry beds. Hospital utilization data for Fiscal Year 2012 (July 2011-June 2012) indicate 415,497 outpatient and primary care visits, 56,926 emergency department visits, 11,372 dental visits, 1,235 babies delivered, 14,723 discharges, and a 71% occupancy rate.

MHC is fully accredited by The Joint Commission. In addition, MHC's pediatrics, adult primary care, and HIV primary care have been recognized by the National Committee for Quality Assurance Physician Practice Connections ® - Patient Centered Medical Home ™ Program. Patient Centered Medical Home (PCMH) standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication and patient involvement.

A Safety Net Facility

MHC is a safety net hospital, a facility of the New York City Health and Hospitals Corporation (HHC), a public benefit corporation whose mission has always been to provide comprehensive and high quality healthcare to all, regardless of their ability to pay, in an atmosphere of dignity and respect. As the table that follows indicates, MHC's safety net burden is 76% of services provided, higher than either the average of all voluntary nonprofit hospitals in the city or hospitals that are part of MHC's parent corporation.

HHC, the largest municipal healthcare organization in the country, is a $6.7 billion integrated healthcare delivery system that provides medical, mental health and substance abuse services through its 11 acute care hospitals that include MHC, four skilled nursing facilities, six large diagnostic and treatment centers and more than 70 community based clinics. HHC Health and Home Care also provide in-home services in the local communities it serves.

HHC is a crucial access point for local communities that have historically been overlooked by private physicians and voluntary hospitals seeking optimal market share in an extremely competitive healthcare environment. HHC's commitment to caring for patients regardless of their ability to pay, ultimately gives it the highest "market share" of low-income, uninsured patients across this City.

SAFETY NET BURDEN

Utilization by Payer Mix as a Percent of Total

	NYC Voluntary Nonprofit Hospitals Average*	All HHC Hospitals	Metropolitan
Discharges			
Uninsured	3%	4%	5%
Medicaid	33%	38%	70%
Total Safety Net	**36%**	**42%**	**75%**
ED Visits			
Uninsured	16%	20%	31%
Medicaid	39%	41%	47%
Total Safety Net	**55%**	**61%**	**78%**
Clinic Visits			
Uninsured	11%	19%	24%
Medicaid	55%	52%	51%
Total Safety Net	**66%**	**71%**	**75%**

* Excludes HHC hospitals.

Source: 2010 Hospital Institutional Cost Report, and 2010 Health Center Cost Report.

Includes all NYC acute, general care hospitals and any wholly owned or controlled community health centers, including HHC.

Discharges exclude normal newborns. ED visits include treat and release, and visits that result in admission. Clinic visits include comprehensive care and primary care visits only.

HHC's uncompensated care costs are $698 million.

Based on 2010 New York State institutional and health center cost reports, HHC hospitals provided a far higher proportion of care to self-pay (or uninsured) patients than any other single healthcare provider in New York City. In 2010, HHC acute care hospitals were the source of 37% of all uninsured inpatient discharges, 43% of uninsured ED visits and 67% of uninsured clinic visits among all New York City hospitals. This volume of uninsured care translates into approximately $698 million in uncompensated care annually at HHC. ◆

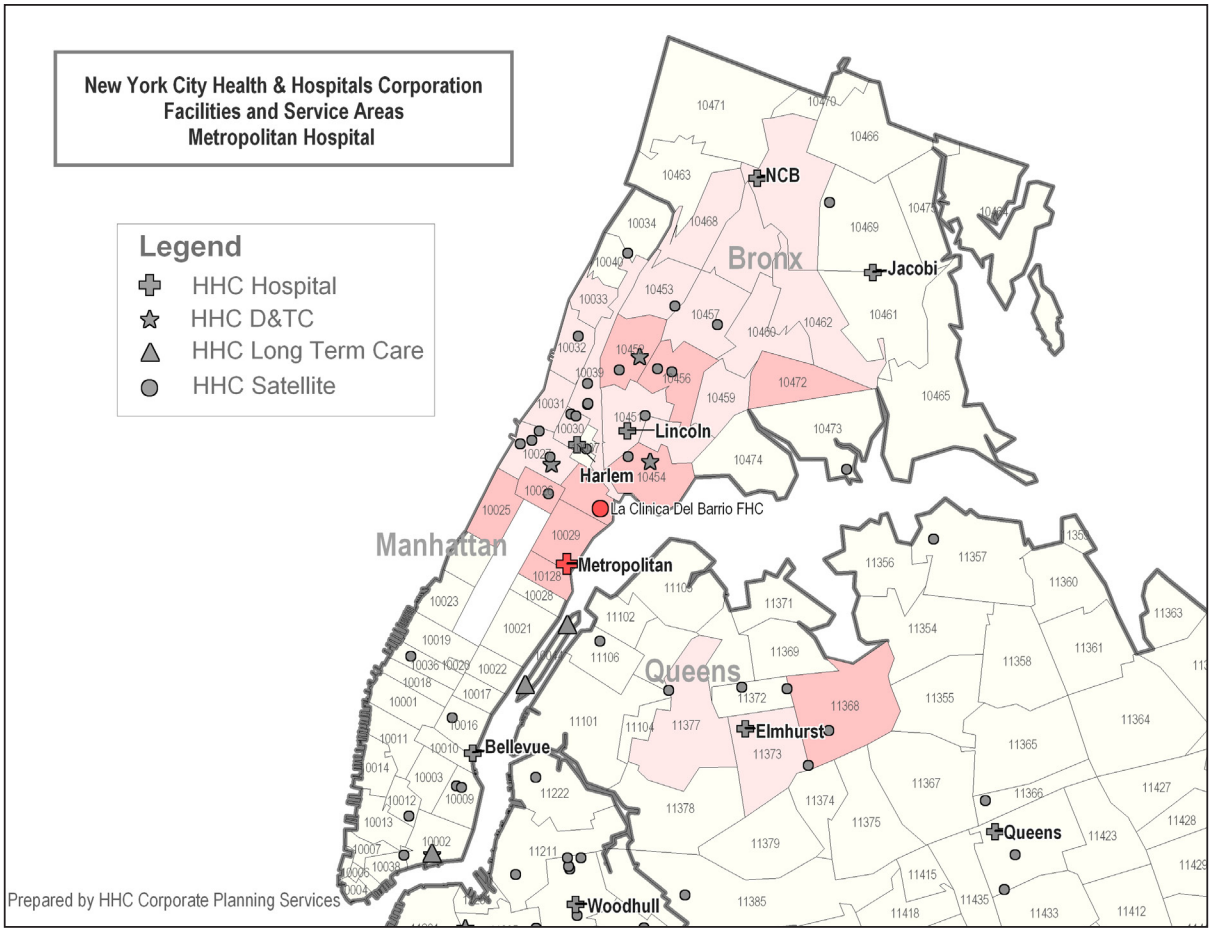
I. Description of Community Served by MHC

U.S. Census 2012 data, reanalyzed by Claritas, confirm there are 674,401 residents in MHC's primary service areas, which are zip codes: 10029, 10035, 10128, 10025, and 10026 in Manhattan; 10454, 10472, 10452, and 10456 in the Bronx; and 11368 in Queens. Residents of these areas make up over 50% of MHC's patients. These zip codes represent the neighborhoods of East Harlem, Yorkville, Harlem, Morningside Heights and the Upper West Side in Manhattan; Hunts Point and Mott Haven in the Bronx; and Elmhurst and West Queens in Queens. This area experienced a 4.4% increase from 645,775 in 2000 to 674,401 in 2012. An additional 4% increase is predicted in the next five years.

African Americans compose 28% of this population; Hispanics, 31%; Asian and Pacific Islanders, 4.5%; and other, 2.9%. The hospital's service area includes some of the neighborhoods with the highest poverty rates in the city. Families living in poverty account for 28.1% of the families in the primary service area overall, with rates reaching as high as 47% in zip code 10454; the citywide percentage is 19.3%.

2013 Claritas data indicate that 58% of residents in the hospital's primary service area speak a language other than English, with nearly 46% speaking Spanish—higher percentages than citywide data, which shows 49% of New Yorkers speaking a language other than English, and 25% speaking Spanish in particular. The hospital uses language interpreters and CyraCom phones to provide linguistically appropriate services to patients who speak a language other than English, with 29,791 interpretations provided last year.

Over 25% of HHC patients are classified as Limited English Proficient (LEP). In order to assist its facilities with challenges inherent in meeting the LEP patient population's language access needs, HHC established the Center for Culturally and Linguistically Appropriate Services (CLAS) to provide central resources and guidelines to expand the application of best practices and monitor language access and cultural competency across HHC. The CLAS offers a comprehensive framework of support, best practices and training models to support HHC facilities that includes: increasing staff awareness of the impact of culture on healthcare management and importance of building cultural competency skills and training to improve health outcomes, patient safety and satisfaction; implementing cross-cultural strategies to promote patient safety and quality healthcare for HHC's diverse patient population; providing culturally competent care that is sensitive, safe, beneficial and meaningful to people from different cultures.



Community Health Status

New York State Department of Health data describe some of the significant health disparities in the community served by MHC. The following chart compares data for the hospital's borough compared to averages for New York City. ◆

Health issue	Manhattan	NYC average
Preventable admissions (adult) – respiratory per 100,000 population	680	413
Preventable admissions (adult) for diabetes per 100,000 population	488	307
Preventable admissions (adult) total per 100,000 population	2,455	1,720
Drug hospitalizations per 10,000 population	45.9	35.4
HIV new cases rate (2008-2010) per 100,000 population	63.8	42.9

Source: New York State Department of Health at www.healthy.ny.gov/statistics

II. Process and Methodology

MHC is committed to being responsive to patients, community members and other stakeholders to ensure that the hospital effectively meets the needs of the community it serves. The hospital works to engage the community throughout the year in a variety of ways, with the involvement of the hospital's Community Advisory Board, hospital leadership and staff including the community outreach unit. The Community Health Needs Assessment (CHNA) provides an additional opportunity to collect the opinions of community members in order to review service priorities and inform the hospital's strategic planning process.

The CHNA team began with a review of the most recent statistics from city, county, state sources. New data sources were identified and incorporated. Additional data from discharge and interviews with medical, social service and emergency department staff were also collected. The initial review included analysis of trends and

comparisons within the community and with other like sized communities. Based on this analysis, survey questions were developed for groups that included MHC's staff, external stakeholders, and patients.

The target population for the survey was broadly defined as stakeholders and members of the MHC community, including community residents, patients, and providers. Between June 21 and October 5, 2012, the community outreach team administered nearly 684 questionnaires, with 556 completed by patients and community members, and 128 completed by providers. Community surveys were distributed in both English and Spanish, with bilingual staff available to assist in the completion of surveys as needed. The provider group consisted of hospital staff from a variety of clinical and non-clinical areas. Although the surveys were anonymous, providers were asked to broadly identify their area of primary work at the hospital.

The questionnaire was designed to gather information in three sections:

1. **Background Information:** included questions regarding the demographic information of survey respondents;
2. **Your Experience:** a number of questions regarding community members' recent interactions with the healthcare system and healthcare providers' perceptions of the experiences of patients;
3. **Community Needs:** asked respondents to identify and prioritize social and medical issues facing them individually as well as their communities, with additional questions about the state of available healthcare options.

Given budget and staffing constraints, the sampling process and data analysis were limited. The selection process, subject to bias, was determined by participant presence at the collection sites and willingness to participate. The data collection process involved staff from the hospital's Community Health Education and Outreach unit and a team of students from New York Medical College collecting information at scheduled outreach events and hospital clinics. Potential participants were asked if they would complete a confidential survey for MHC.

In the survey, participants were asked to identify the medical issues most affecting them individually and their community as a whole. The questionnaire listed 12 medical issues and allowed respondents to add an issue of their own choosing.

In addition to the data collected for the actual assessment of community needs, analysis of the survey was also conducted to provide feedback about the questionnaire tool. This included tracking where surveys were collected and when, what questions were answered incorrectly, and what questions patients chose not to answer. Additional feedback about the survey tool and the data collection process came from those who designed and distributed the survey.

The community needs assessment allowed for the inclusion of some qualitative data in addition to the quantitative data. To assess this, the responses to the appropriate questions were coded by looking for patterns and types of answers. Data was sorted by question number and response code. This qualitative assessment supports the quantitative results, providing more insight into the experience of the patient and provider respondents' experiences and opinions that the questionnaire raised.

Survey data was compiled and analyzed, and results were collated and presented to the hospital's senior leadership. A list of community needs was then prioritized, based on a set of criteria which included:

- Numbers of persons affected
- Seriousness of the issue
- Whether the health need particularly affected persons living in poverty or reflected health disparities
- Availability of community resources to address the need

The prioritization process identified six priority issues, which are included in this report. ◆

III. Health Needs Identified

Focus groups' responses

Community members who participated in the survey were asked to select the medical issues that they thought had the most impact (a) on their community and (b) on their individual lives. In both categories, the top issues were:

- Diabetes
- Obesity
- Asthma
- Drug/Alcohol Abuse
- High Blood Pressure
- Heart Disease

Diabetes was overwhelmingly identified as the most prevalent medical issue facing the community, selected by 60% of survey participants. Other high-ranking medical issues were obesity (36%), asthma (33%), and drug/alcohol abuse (31%). See the chart below for other responses.

Community medical issues	Percentage
Diabetes	60%
Obesity	36%
Asthma	33%
Drug/Alcohol Abuse	31%
High Blood Pressure	29%
Heart Disease	28%
Cancer	26%
AIDS/HIV	20%
Teen Pregnancy	12%
Environmental Pollution	9%
Sexually Transmitted Diseases	8%

When asked to pick the single medical issue that most affects their day-to-day lives, respondents cited diabetes (17%) and obesity (14%). High blood pressure and asthma were also identified by more than 10% of participants. Eight other conditions were identified as having impact on respondents, as this chart indicates:

Individual medical issues	Percentage
Diabetes	17%
Obesity	14%
High Blood Pressure	12%
Asthma	10%
Drug/Alcohol Abuse	9%
Heart Disease	9%
AIDS/HIV	8%
Other	6%
Cancer	5%
Environmental Pollution	4%
Teen Pregnancy	4%
Sexually Transmitted Diseases	2%

The list of identified needs and issues was presented to MHC senior leadership team, which includes the Executive Director, Medical Director, Deputy Executive Director/ Chief Nurse Executive Patient Care Services, Chief Financial Officer/Chief Operating Officer, and other administrative leaders. The team reviewed and analyzed the list, and developed a prioritized list of needs, in some cases combining and adding related issues. ◆

IV. Community Assets Identified

The assessment identified a number of strong community assets, including three hospitals and their community benefit programs, as well as a number of diagnostic and treatment centers (D&TCs) and HRSA grant-funded Federally Qualified Health Centers (FQHCs) located within MHC's primary service area. The list does not include HHC D&TCs or FQHCs in Metropolitan's primary service area.

Hospitals in Primary Service Area

Mount Sinai Hospital
Bronx Lebanon Fulton
St. Luke's-Roosevelt/St. Luke's

Diagnostic and Treatment Centers within Primary Service Area

Center for Comprehensive Health Practice
Mount Sinai Diagnostic and Treatment Center
Settlement Health
East Harlem Council for Human Services
HELP/PSI Services
Bronx Addiction Services Integrated Concepts System
Dr. Martin Luther King Jr. Health Center
William F. Ryan Community Health Center

HRSA Grant-funded FQHCs within Primary Service Area

Institute for Family Health
Settlement Health
Care for the Homeless
East Harlem Council for Human Services
Project Renewal
Sunset Park Health Council
Urban Health Plan
Morris Heights Health Center
Comprehensive Community Development Corp.
Bronx Lebanon Integrated Service System
Damian Family Care Centers
William F. Ryan Community Health Center
Community Healthcare Network

MHC maintains a variety of partnerships with many of the facilities listed, ranging from ongoing referral agreements, to collaboration on community health projects, to participation on mutual outreach programs. ◆

V. Summaries: Assessments and Priorities

Results of an extensive survey and subsequent focus groups produced a number of both community and individual health needs. Hospital leadership reviewed the priorities identified by community stakeholders.

Hospital leaders identified a number of strengths in the community served by the hospital, including the number of healthcare options available, and a number of grant-funded programs to help provide support and access to care. As an example, the close coordination between the New York City Department of Health, local hospitals, schools and community-based organizations in focusing on asthma and helping to lower the number of hospital admissions and school days missed.

A number of significant weaknesses were also noted, such as the lack of sufficient behavioral health services, the need for more affordable housing options, the increased need for services for veterans, and overall concerns about language barriers and health literacy in general.

The greatest medical needs that were prioritized by hospital leadership followed the lists created by the survey and focus group participants.

The final list matches very closely the community-identified needs:

- Diabetes
- Obesity
- Asthma
- Hypertension
- Heart disease
- Behavioral health/mental health/substance abuse ◆

VI. Implementation Strategy

The Community Health Needs Assessment (CHNA) for Metropolitan Hospital Center (MHC) was conducted in early 2013 in collaboration with the hospital's clinical and administrative leadership, representative staff from patient programs and clinical services, community stakeholders, and the HHC's Corporate Planning Department. The purpose of this assessment is to identify existing and emerging health-care needs of the local community so that MHC can develop and support meaningful and effective clinical and support services for its patients.

The existing resources and gaps in services identified through this CHNA process have been reviewed by the CHNA team, and an Implementation Plan was created to list and prioritize needs from the assessment and to articulate strategies and resources to address them.

MHC's CHNA is aligned with several of the New York State Department of Health's Prevention Agenda Priorities for 2013-2015.

Next Steps

MHC has established six service lines to address clinical needs. Each service line, headed by a senior level administrator and the chief(s) of the corresponding medical area(s), will be responsible for implementation strategies for each of the identified priorities. Working in teams with staff from community outreach, marketing, business development, and other hospital departments, each team is responsible for:

- Finding out what other community organizations are doing regarding the priority,
- Guiding the work of the team, including development of a work plan
- Establishing metrics including measurable outcomes indicators,
- Assuring work is coordinated with other service lines, and
- Communicating appropriately with the community at large.

The hospital is committed to conducting another comprehensive needs assessment in 3 years.

Addressing the priorities

MHC is addressing the six priorities identified in the following ways:

Priority: Diabetes

Diabetes Management and Education - comprehensive, one-stop care is provided by designated diabetes clinic sessions within primary care medicine, as well as in MHC's endocrinology specialty clinic. Patients are part of a team that includes a physician, a nurse, a diabetes nurse educator, a nutritionist, a home care intake specialist, a social worker, and a patient care associate. The diabetes nurse educator leads two weekly classes and facilitates a monthly diabetes support group. As part of high quality care, patients learn how to plan healthful meals with a nutritionist, have their eyes checked by a specialist in the eye clinic, and their feet examined by a foot specialist. Individual patient progress is tracked over time, with specific focus on indicators such as glucose, blood pressure, cholesterol, and depression screening. The team pays particular attention to some of the most debilitating side effects of uncontrolled diabetes, including loss of sight, lower extremity amputations and cardiovascular damage.

Eligible diabetes patients are also enrolled in HHC's House Calls Telehealth program, which facilitates direct communication with their providers. Patients receive glucometers and a telephone modem to allow self-management and monitoring from home. Nurses contact patients if their blood glucose and blood pressure readings fall outside of parameters established by the primary care physician. In addition, the nurses make weekly calls to provide diabetes self-management education, support, coaching and reminders about appointments.

Future efforts to reduce the impact of diabetes on the local community include: expanding access to qualified diabetes educators, and engaging patients in self-direction and pro-active involvement in their care by improving patient access to their health information via the electronic health record system.

Priority: Obesity

MHC has instituted a number of standard practices in order to address obesity among the patient population and in the hospital community at large.

In order to identify and track obesity, a body mass index (BMI) is conducted for each patient at every visit. Once identified as a problem, weight loss goals are included in the patient's treatment plan, along with referral to a nutritionist, cardiovascular specialist, endocrinologist, or other specialists to address any co-existing medical conditions.

Eligible patients may be enrolled in a directed behavior modification program, focused on implementing changes in nutritional choices, eating habits, and the importance of exercise. Stress tests may be performed to determine tolerability of exercise. Patients are taught the "Plate Method" whereby the plate is divided into sections, so that they can balance their meals with healthy choices from each food groups and track their caloric intake. Booklets with calorie counts on different foods and healthy eating tips are also made available.

Counseling and raising awareness begins early for

patients in the hospital's Pediatric service. Educators and other staff promote breastfeeding among expecting and new mothers, citing health benefits including potential reduction in the risk of obesity. Parents are provided education and guidance regarding healthy/nutritious snack alternatives for their toddlers and young children. BMI screenings are provided to children starting at age 2. In addition, parents are offered nutrition counseling, activity counseling, and "screen time" counseling to determine how much time the child spends on sedentary recreational activities (such as playing with video games and electronic devices) versus active recreation. A health educator, funded by HHC Obesity Initiative, teaches sample portion size and provides nutrition counseling.

Patients on inpatient units are encouraged to walk around the unit, with distances tagged along the wall to facilitate and monitor goal-setting.

Behavioral health patients in the Psychiatry Department's Adult Day Treatment Program are offered groups on healthy living, healthy eating, and exercise. Special attention is paid to potential side effects of psychiatric medication that might lead to weight gain. Other groups examine overeating as it relates to addictive behaviors. The hospital is looking at ways to increase group therapy offering as interest in the groups continues to grow.

The Pediatrics Department has formed an interdisciplinary group to develop a standardized obesity action plan for all patients and their families. The group is focusing on standard care and targeted metabolic screenings, while considering co-morbidities such as hypertension and diabetes. Another focus is preventing or delaying smoking among pre-teens. The plan currently calls for targeted outreach to patients and their families to raise awareness of indicators for obesity, especially in families where a parent is also obese. The health educator and other staff will work closely with the hospitals outreach team to provide education at local schools, PTA meetings, churches, community-based organizations, health fairs, and other community activities.

The hospital currently offers weekly Get Fit! Classes (aerobics, yoga) open to all members of the hospital community, in partnership with instructors from Shape Up NYC. Classes will be expanded as interest grows and volunteers are available. Nutritionists and other health educators will also utilize the weekly Farmers Market sponsored by MHC in order to provide periodic classes on healthy food choices.

Priority: Asthma

Children's Asthma Program (CAP) is a comprehensive multidisciplinary program. The program and its clinic provide culturally-sensitive, bilingual education for patients and their families. Staff includes a pulmonologist and allergy/immunology specialist, health educator, and a registered nurse. The team reviews all hospital admissions and tracks all emergency visits. Follow up appointments, home visits, and intensive case management is provided as necessary.

Adult Asthma/Primary Care Program offers asthma and primary care in a single clinic setting to adults with difficult-to-manage asthma, as reflected by hospitalizations, recurrent emergency visits, or frequent requirement for oral steroids. The clinic, supervised by the hospital's Pulmonary Department, has daily sessions and has had excellent success in reducing emergency visits and hospitalizations. In addition, a traditional asthma clinic is held on Monday afternoons where patients are referred for assistance in asthma management.

MHC is also participating in the Tobacco-Free Hospitals Campaign, spearheaded by the New York City Department of Health. DOH will provide tools and resources to expand smoking cessation programs for Metropolitan's patients and staff. The hospital will monitor and track results and work with DOH to implement low-cost improvement strategies.

Priority: Hypertension

Early detection and intervention are essential to combating high blood pressure, often referred to as a "silent killer" because of its ability to go undetected long before the onset of negative symptoms. Education and intervention in the community are particularly critical for those segments of the population at highest risk, such as adult black men, who are less likely to seek primary care on a regular basis. Screenings in the community and other non-clinical settings increase the possibility of identifying individuals at highest risk.

MHC's outreach team, health educators, and clinical staff provide blood pressure screenings at community events throughout the year. In addition, they distribute information and refer community members to the hospital for follow up.

Patients are screened and evaluated at every point of entry, starting at age 3. Once identified, treatment consists of behavior modification, especially regarding diet and exercise, and medication if necessary. Patients whose hypertension is difficult to control (defined as two consecutive visits without significant lowering of blood pressure) are referred to a dedicated hypertension clinic. Patients who do not respond to normal protocols may also be referred to subspecialties, especially cardiovascular and renal. Obstetricians collaborate with internists and nephrologists in cases of pregnant women with high blood pressure.

MHC will continue to provide screenings in the community and expand its community based clinical and educational services. MHC will also work closely with New York Medical College to ensure that preventive medicine remains a major curriculum element in the training of physicians and other clinical staff.

Priority: Heart Disease

Project RED (Re-Engineered Discharge) - MHC seeks to be a center of excellence for individuals with congestive heart failure (CHF) and a national leader in preventing unnecessary complications after hospitalization. The Project RED care management intervention is a patient-centered, standardized approach to discharge planning and discharge education. Project RED is designed to reduce fragmented care delivery during transitions from one level of care to another, thereby improving quality, reducing readmissions and costs and improving patient health and satisfaction. Main components of Project RED focus on: medication reconciliation; patient engagement and education; linkages to physicians and timely follow-up appointments, referrals for post-acute (home care) services; and telephone reinforcement calls post discharge. This program currently focuses on patients with congestive heart failure and patients recovering from acute myocardial infarction, and future plans involve customizing and replicating the program for patients with asthma and chronic obstructive pulmonary disease.

Priority: Behavioral health/mental health/substance abuse

MHC provides comprehensive inpatient and outpatient mental health services to individuals with emotional, psychiatric, behavioral or chemical dependency related issues in a 14-story Behavioral Health Pavilion, one of the largest mental health facilities in New York City. Treatment is available to patients who experience emotional, psychiatric, psychological, substance-related or behavioral problems.

Outpatient Services include 24-hour Emergency Psychiatric Service, walk-in evaluation, Adult Mental Health Clinic, and Child and Adolescent Clinic. The Assertive Community Treatment (ACT) program provides support services—along with blood pressure, glucose, and drug screenings—to individuals in the community with chronic mental illness and functional problems.

In addition, MHC has 122 beds for acute care psychiatric inpatient services, consisting of intensive coordinated treatment by a physician-led team of mental health professionals including psychologists, social workers, rehab and addiction counselors and 24-hour nursing care. The adolescent inpatient program also provides individual and family therapy as well as daily process groups, skill building activities and educational instruction. Certified special education teachers provide education for youth receiving acute psychiatric hospital care.

MHC provides comprehensive outpatient and inpatient services to patients who suffer from addictive behaviors. The outpatient Addiction Recovery Center integrates chemical dependency, health and mental health services, and incorporates the use of evidenced-based and emerging best practices to provide an effective continuum of education and services. A Methadone Treatment Program provides both addiction and rehabilitation counseling for adults. The inpatient Drug Detoxification Program is housed in a 19-bed unit providing detoxification for opiate addicts 18 years and older. All programs are licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

A dedicated medical staff member is embedded in the outpatient services in order to integrate medical care with mental health needs. These same patients often neglect or reject basic primary care despite experiencing high rates of co-morbidities as a result or in addition to their mental health needs. Body Mass Index screenings are conducted on all patients in behavioral health with targeted education for patients whose medications have side effects that might lead to hypertension or obesity.

Depression screenings are provided to every patient in primary care with referrals to outpatient behavioral health services as needed. In addition, behavioral health staff members offer depression screenings in the community, at health fairs, and in the hospital's lobby as well.

A smoking cessation group meets once a week in the inpatient mental health units with a doctor available to prescribe nicotine patches for patients considering quitting. A similar group, with a more preventative focus, is being formed for patients in the child/adolescent unit (ages 10-17) in order to provide support for patients before or as soon as they start smoking.

A new "Build-A-Bear" program is starting in which small groups (10 kids) decorate teddy bears and bring them back to talk about their reasons for their choices. Protocols for the group are being completed, and the groups are set to begin soon. ◆

VII. Approval

The Implementation Strategy has been approved by the Board of Directors of New York City Health and Hospitals Corporation on May 30, 2013. ◆