Ambulatory Care Network
2007 Progress Report

CARING FOR OUR COMMUNITY
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Welcome

Day in and day out, NewYork-Presbyterian Hospital is a visible partner in promoting the health and well-being of the communities it serves. Through the Hospital’s Ambulatory Care Network (ACN) — 13 primary care practice sites, 7 school-based health centers, and 65 subspecialty care clinics — our physicians, nurses and health care professionals provide care to over 250,000 New York City residents, with 776,000 visits per year. Our patients come from the neighborhoods served by NewYork-Presbyterian Hospital/Columbia University Medical Center, Morgan Stanley Children’s Hospital, The Allen Pavilion, and NewYork-Presbyterian Hospital/Weill Cornell Medical Center. They represent a wide array of nationalities, ethnic and religious backgrounds, and speak multiple languages.

Many patients span generations and have been patients in the ACN for many years. Some of the communities we serve are economically deprived, with large numbers of Medicaid and Medicare patients, and some are without any health care coverage at all.

The Ambulatory Care Network reaches into all our communities, making it easier for everyone to access high quality health care services in their own neighborhoods. When specialized care or hospitalization is required, patients find a compassionate and helpful staff who can facilitate their access to the extraordinary breadth of specialty programs and resources at NewYork-Presbyterian Hospital.

The Ambulatory Care Network is one of the most extensive of its kind, providing a comprehensive range of services from primary care and prevention programs to virtually every medical specialty. Integrated into the very fabric of community life, the ACN’s many outreach efforts include health fairs and screenings, annual flu vaccinations, education and advocacy on behalf of those in need. In addition to caring for our communities, the ACN sites also serve as the primary venue for the outpatient teaching experience for resident physicians under the supervision of attending physicians.

NewYork-Presbyterian Hospital is committed to the success of this community health care network, providing support for staff development, facilities renovations and expansion, and the latest information technology that enhances medical record keeping and facilitates the efficient and safe delivery of care.

Staff consider it a privilege to serve their communities. Our patients, in turn, routinely express their appreciation for our concern, our commitment to quality care, and presence in their neighborhoods.

Jaclyn A. Mucaria
Vice President
Ambulatory Care and Patient-Centered Care
NewYork-Presbyterian Hospital
Ambulatory Care Network

FACTS AND FIGURES

• 13 Primary Care Practice Sites
• 7 School-Based Health Centers
• 65 Subspecialty Care Clinics
• 775,847 Total Patient Care Visits in 2006

Did you also know the Ambulatory Care Network...

• is leading national efforts to work with schools and communities to prevent and reduce childhood obesity
• is one of only 4 programs funded across the country by the Merck Childhood Asthma Network to reduce the impact of asthma in communities
• has developed training curricula for residents to lead quality improvement efforts that are a model, drawing regional and national attention
• has a program of integrating mental health services in primary care practices that has been commended by the Department of Health and Human Services and has been highlighted at numerous professional society meetings
• is one of 15 sites across the country funded by the Department of Justice to support and treat children living in families affected by domestic violence
• has developed model processes for providing data to individual physicians about how their patients are doing with their diabetes care
• is a site for over 1,500 NewYork-Presbyterian Hospital residents and fellows to be trained by faculty in our two Ivy League medical schools — Columbia University College of Physicians and Surgeons and Weill Cornell Medical College — to be the future leaders of health care in this country
• is a place where over 750,000 patient visits occur each year and in which a dedicated group of physicians and staff do their best every day to provide the highest quality of care and patient service

Distribution of Visits

Payor Mix

0% 5% 10% 15% 20% 25% 30% 35% 40% 45%
Primary Care Specialty Care

0% 5% 10% 15% 20% 25% 30% 35% 40%
Medicaid Managed Care Medicaid Fee for Service Medicare Commercial Self-Pay Other

NewYork-Presbyterian/ Columbia
NewYork-Presbyterian/ Weill Cornell
Ambulatory Care Network LEADERSHIP

Cynthia Sparer
Senior Vice President and Chief Operating Officer
Women’s, Children’s and Community Health

Jaclyn Mucaria
Vice President
Ambulatory Care and Patient-Centered Care

Marci Ecker Allen
Financial and Business Administrator

Judy Aponte, RN
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NewYork-Presbyterian Hospital/ Columbia University Medical Center

Hanna Gungor
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Brian Hale
Director, Ambulatory Care Network
NewYork-Presbyterian Hospital/ Weill Cornell Medical Center

Daniel Hyman, MD, MMM
Chief Medical Officer

Andres Nieto
Director
Community Health, Outreach and Marketing

Lorraine Tiezzi
Director
Center for Community Health and Education
Extending Our Reach
Establishing and nurturing partnerships is at the core of the mission of the Ambulatory Care Network. The relationships that are formed with community organizations, faith-based programs, local schools, and city and state agencies are critical in enabling the ACN to extend the reach of NewYork-Presbyterian Hospital’s health care services.

The ACN’s tapestry of outreach efforts is a vibrant mix of programs designed to meet the physical, mental health, and social needs of patients of all ages. Staff are particularly interested in reaching people who too often do not seek out health care, with the aim of connecting them to preventive and primary care services. The ultimate goal is to improve the health of the communities served by the ACN. By bringing the Hospital’s vast health care resources out to the neighborhoods, the Ambulatory Care Network is establishing relationships and building coalitions that will ultimately benefit the entire community.

Community Health and Outreach
The ACN’s Community Outreach Program works to educate and improve the health of the community through health promotion, disease prevention and education. Programs are based on the needs of the community and developed in partnership with key community-based organizations and providers to ensure that people in the community have a reliable source of medical care. From street fairs to events with schools and churches, thousands of community residents are exposed to health information as a result of the efforts of the Ambulatory Care Network and its partners.

Each year, numerous health events are held in the community with screenings for thousands of individuals. In 2006 over 70 outreach events were held and more than 5,800 people were screened for diabetes, obesity, heart disease, hypertension and vision problems. Among these events were:

- a women’s heart disease prevention and screening sponsored by the Sister to Sister Foundation;
- four Youth Track and Field and Wellness Jamborees attended by over 5,000 children and designed to educate them and their parents about exercise, wellness and preventative health;
- a taxicab health fair in collaboration with Morgan Stanley Children’s Hospital, which reached a predominately Latino population of 400 livery cab drivers at risk for developing
health problems, as well as provided education on child car seat safety; and

• an influenza vaccine program in partnership with the Visiting Nurse Service-Partners in Care, local elected officials and community- and faith-based organizations, providing over 5,000 flu and pneumococcal vaccines.

Center for Community Health and Education

With over $4.1 million in Federal, State, and City grants, the Center for Community Health and Education is making tremendous inroads into improving the health and welfare of children, adolescents and young adults through the following programs:

• Adolescent Tobacco-Use Prevention and Cessation Program
• Child Vision Program
• Community-Based Adolescent Pregnancy Prevention Program
• School-Based Health Centers
• School-Based HIV Prevention Program
• Young Men’s Clinic
• Male Family Planning Research Project
• HIV Rapid Testing in Family Planning Clinics
• Community-Based Family Planning Center

Diabetes Management Program

One in eight New Yorkers has diabetes. Diabetes is reaching near epidemic proportions, and it is the fifth leading cause of hospitalization in the Washington Heights and Inwood areas. All ACN internal medicine, geriatric, and family medicine practices are actively engaged with the New York City Department of Health and Mental Hygiene in a project that aims to improve the care of adults with diabetes mellitus. The practices have undertaken a wide range of efforts to improve diabetes care through initiatives that include:

• patient educational seminars on diabetes self-management;
• quarterly patient newsletter;
• microalbumin testing at all sites;
• education of staff and providers to ensure that all patients receive appropriate testing and treatment, including nutritional counseling;
• provider reports that identify patients in need of more active care management;
• the creation of diabetes patient education materials in English and Spanish.

Faith-Based Community Health Nursing

The Ambulatory Care Network partners with faith-based organizations on a health initiative that is improving the lives of parishioners in its communities. This important undertaking provides a number of health care
Juana Moya
Office Assistant
Associates in Internal Medicine (AIM) Practice

We provide care that people in our neighborhood really need. Patient care is number one. My role is a combination of things...I help the doctors and my co-workers, serve as a liaison between nurses and doctors, and handle phones, data entry, and scheduling. We are here for the patients. One of our patients needed a prescription. It was very cold out so I called the pharmacy for her. It was a big help to the patient and something small that I did. You really need to like what you do. Providing empathy and respect are the most important aspects of my job.

Maria Elena Ballesteros
Breastfeeding Specialist
Women Infants and Children (WIC) Program

My job is to educate, promote and support the Women Infants and Children (WIC) Program participants, as well as medical residents, with a focus on the importance of breastfeeding as the natural nutrition system for a baby. A note I received from a patient is so special to me because she recognized my mission — why I am here, doing what I love. In part, she wrote, “I want to thank you for all the help you gave me...You have changed my life in relation to the nutrition of my little one. I will not stop breastfeeding at six months as I previously was thinking. I know you will be sharing your knowledge and good company with mothers who need it most. I wish the best to you and your loved ones.”

Julie Chipman, CSW
Social Worker
Adult Psychiatry Service, Integrated Mental Health Program

I see patients for short-term psychotherapy, and I am the evaluation coordinator responsible for screening new patients. We focus on assessing patients’ psychosocial and psychiatric needs and try to tailor the necessary treatment. In my work, I’ve also gone out with the mobile crisis team to help patients. The most important aspect of my job is to get patients the care to meet their specific needs in a timely fashion.

Milagros Rodriguez
Patient Financial Advisor
UrgiCare Center

We are the only UrgiCare site in the local community. The patient does not need an appointment to see the provider and does not have to wait for a long time, which is very important. Having providers and staff who are bilingual is also important so that we can communicate with our Hispanic population. My role is to provide all the patients with what they need in terms of assistance and information in order for them to have a pleasant experience. “We Put Patients First” means that we will provide them with a comfortable and safe environment where they know they will be well cared for.
Working closely with faith-based organizations, ACN’s parish nurses establish relationships with ministers to identify the pressing health care needs of parishioners. With the assistance of an outreach coordinator, they develop programs and sponsor events, such as health fairs and health education programs. The ACN continues to develop programs within congregations, such as the identification of an on-site patient navigator to facilitate access of parishioners to the health care environment and, if they are ill, to help link them to the Hospital’s Ambulatory Care Network and other appropriate health care services.

In Central Harlem, the ACN is a member of a coalition of both faith-based and community-based organizations called “Building Bridges, Building Knowledge, Building Health” (BBKH). The members of this interfaith, multicultural coalition have joined together to examine minority health disparity issues, including access to health care, insurance, access to medications, and chronic disease management, and then

Jessica Rodriguez
Patient Financial Advisor
Family Medicine at the Herman “Denny” Farrell, Jr. Community Health Center

As a patient financial advisor, I register patients, check them in, and make sure they are discharged with the appropriate information. When patients come in with a problem and I’m able to help them, I feel good. There is a lack of education in the community, and the fact that we’re providing health care and education makes a difference in their lives.

Kathy Olivo
Outreach Coordinator
Community Health Outreach and Marketing

One of the most important aspects of my position is connecting patients to greatly needed services such as health care, health insurance, and other referral services. Our services are important because they provide health awareness through free screenings and health education. There have been many instances when we have screened patients, found them to have abnormal results, and immediately referred them for further testing and care.
have taken steps to address some of those issues by combining networks, resources and information. In June 2006, the coalition held its second annual Day of Hope. This large community event included free health screenings, health information and counseling, and inspirational speeches by the Honorable Charles Rangel, Dr. Herbert Pardes, President and CEO of NewYork-Presbyterian Hospital, and others. The staff trained adolescents from various community organizations as health care volunteers performing outreach to their peers and encouraging them to engage in healthy living.

This past year, Metropolitan Community United Methodist Church, a partner faith-based organization, received a $10,000 General Board of Global Ministry HIV Grant to launch an HIV Education and Counseling Program. The Global Ministry, a philanthropic organization affiliated with Methodist churches, awarded a grant to expand upon the ACN’s work in diabetes through the hiring of community health workers. Four other faith-based partners in East Harlem participated in a needs assessment survey to evaluate the health care needs of their communities that will be used to target areas of need in the coming year. In partnership with Northern Manhattan Perinatal Partnership, BBKH also received a five-year grant from the New York State Department of Health Office of Minority Health to develop a program in diabetes.

Healthy Schools, Healthy Families

With support from a grant from HRSA several years ago, the ACN and the Division of Community Pediatrics of Columbia University launched the Healthy Schools, Healthy Families initiative to reach medically underserved children in Washington Heights and Inwood. The program was extended to East Harlem in partnership with the
Division of General Pediatrics at NewYork-Presbyterian/Weill Cornell, serving some 5,000 children in seven elementary schools (kindergarten through fifth grade). The program seeks to cultivate healthy lifestyle behaviors, including physical fitness, good nutrition, and regular doctor visits. In addition, the program is helping to improve the health of children by creating school-based health programs for obesity, asthma, depression and other chronic conditions, as well as facilitating access to preventive, primary and specialty care, health insurance and social services.

Healthy Schools, Healthy Families focuses on the importance of exercising regularly and eating a healthy diet. Program staff are also playing a leading role in a national CDC-funded project that involves 17 other hospital-sponsored programs to address the epidemic of overweight and obese youth.

Grant-Supported Programs

The Ambulatory Care Network has been extremely successful in obtaining new funding, with grants awarded from numerous governmental agencies and private foundations. Grant-funded programs well underway include:

**Washington Heights-Inwood Network (WIN) for Asthma**

In November 2005, the ACN in collaboration with Community Pediatrics and multiple community organizations, was awarded a $2 million grant from the Merck Childhood Asthma Network for a four-year program to develop a network of care for children with asthma in Northern Manhattan. The program, WIN for Asthma, is designed to coordinate and improve care for children with poorly controlled asthma; reduce their hospitalizations, emergency department visits, and missed school days; and ultimately help families gain control and self-confidence in managing their child’s asthma. The program helps families identify and reduce triggers for their children’s asthma, improve communication with their physicians, understand medications, and increase adherence to care and treatment.

**Lang Youth Medical Program**

In 2003, the Eugene M. Lang Foundation and NewYork-Presbyterian Hospital created the Lang Youth Medical Program to inspire and support young people from Washington Heights to attend college and become future leaders in the sciences. Lang Scholars participate in hands-on science activities and experiments while working alongside health professionals in multiple hospital settings. Upon successful completion of the Lang Youth Medical Program, students are eligible for college tuition assistance.

Currently, 43 Lang Scholars in the seventh to tenth grades are enrolled in the program. The students serve as role models for other young people in Washington Heights, committing every Saturday and a month of their summer vacation each year to reaching their goals. Over 75 NewYork-Presbyterian and Columbia University faculty volunteer for the program, serving as lecturers, mentors and advocates. The Lang Scholars have made presentations to over 600 elementary school students and conducted healthy snack-making and exercise workshops with second through fifth graders. In addition, they created radio public service announcements that aired on New York City’s WCBS radio station.

**Family PEACE (Promoting Education, Advocacy, Collaboration, Empowerment) Program**

Though domestic violence is prevalent in all areas of New York, the Washington Heights community has a particularly high rate, and the highest rate of domestic homicide in New York City.

The ACN’s PEACE Program targets this major problem and has become nationally recognized for its innovative methods to help
families affected by domestic violence. In 2005, the program was selected as one of 15 national Safe Start Promising Approaches sites funded by the U.S. Department of Justice’s Office of Juvenile Justice and Delinquency Prevention. In addition, the program received a grant from the Joe Torre Safe at Home Foundation to create an in-depth training program for health care providers, medical assistants and patient financial advisors to help increase identification of families living with domestic violence. The program also provides mental health services for children and their caregivers who are exposed to domestic violence. This includes child/parent psychotherapy, relationship-based counseling and group counseling.

The PEACE program also collaborates with the Hospital’s DOVE (Domestic and Other Violence Emergencies) program and community agencies. In addition, a community council has been formed to assist in developing a strategic plan to reach children exposed to domestic violence, create cross-agency protocols, and refer families to an intervention program for children.

In 2006, the program trained more than 1,000 health care providers at NewYork-Presbyterian Hospital and several community-based organizations on how to identify, screen, and respond to domestic violence.

**Pharmacy Assistance Program**

Salud a Su Alcance (SASA) Pharmacy Assistance Program was launched in August 2002 with funding from the HRSA under the Community Access Program Initiative and is currently supported with grants from the New York Community Trust and United Hospital Fund. The Pharmacy Assistance Program helps patients access free medications provided by more than 200 pharmaceutical companies through their Indigent Drug Programs. The mission of SASA Pharmacy Assistance Program is to expand access to affordable medication for uninsured and underinsured patients living in New York City, particularly targeting those who are most in need — the uninsured patients with chronic medical conditions. A coordinator assists health providers in setting up systems to maximize the utilization of the program and to provide in-service training for practice staff. A community liaison processes all prescriptions, maintains the database, works with representatives of pharmaceutical companies to facilitate application approval, provides guidance and advocacy to patients who might be ineligible for the Pharmacy Assistance Program and tracks changes in eligibility criteria.

**We Put Patients First**

Providing patient-centered care is the highest priority in the ACN practices. Staff have implemented and continue to develop initiatives to enhance the quality of care and service provided to patients. Each practice has at least one Unit Care Champion — a nurse, medical assistant, social worker, nutritionist, or patient financial advisor/registrar — who guides their co-workers in the use of “best practice” solutions and tools. In 2006, each primary care site also elected a Physician
SPOTLIGHT ON…

Maura Frank, MD  
Medical Director  
Pediatrics Practice  
NewYork-Presbyterian/Weill Cornell  

“We Put Patients First” is the focus of our patient-centered care philosophy in our Hospital and in our pediatrics practice. What this means for us is that everyone in our practice must act professionally at all times. It means responding to a wide range of patient needs, not limiting ourselves to the medical needs alone. To do this, we coordinate care with our full patient-centered care team, which includes the medical team, the social worker, registration staff and the Medicaid counselor as well. We remain alert at all times for patients whose needs are not being met.

Mercedes Crespo  
Supervisor  
Irving Sherwood Wright Center on Aging  

“We Put Patients First” means that the patient is our priority, our reason for being here. Each patient is treated with respect, courtesy, and friendliness. We want to make sure that patients’ needs are always met during their visit at the Wright Center, from answering questions about their medication to helping them into a cab. We try to “wow” our patients at every encounter. It is truly a team effort.

Amanda Ascher, MD  
Medical Director  
Washington Heights Family Health Center  

“We Put Patients First” means we do everything we can to make the patient’s experience as seamless and as satisfying as possible. Each one of us — maintenance, front desk staff, medical assistants, nurses, providers, administrators — does whatever it takes, within our power, to make sure that the patient is safe, seen in a timely manner, and that their needs are addressed. We put patients before job descriptions, before lunch and breaks, going above and beyond to make sure each patient is treated the way we would like to see our loved ones treated.

Sonia Rouse-Proctor  
Practice Administrator  
Broadway Practice  

“We Put Patients First” means that no matter what we are doing, we stop to help our patients, address their concerns, and direct them to where they need to go or who they need to see. We want them to know that they matter and are very important to us. We want them to recall their visit to our practice with the knowledge that we cared enough to stop, pause, listen and help. They are important to us, and we are important to them.
In 2005 and 2006, several grants were awarded to ACN programs and sites by NewYork-Presbyterian and its Volunteer Services to help improve patient care and services:

- **Audubon Practice** To provide parent education programs to improve health care for children
- **Charles B. Rangel Community Health Center** To purchase teaching tools, patient educational materials and patient incentives to promote a healthy lifestyle in adults and children with obesity
- **Washington Heights Family Health Center** To provide an interactive education program in the reception area

Patient satisfaction is measured by key data collected through the Press Ganey Survey. The top three 2006 priorities were:

1. Sensitivity to Patients’ Needs
2. Response to Concerns/Complaints During Visit
3. Nurses’ Instructions/Explanations and Cheerfulness of Practice

Care Champion. Currently, the ACN has nearly 40 initiatives underway, including:

- electronic appointment reminder letters
- enhancing reception areas
- calls to patients following visit
- informing patients about delays and use of beepers for patients
- enhanced visibility and role of nurses in patient care and education
- implementation of service recovery at all sites

The ACN is committed to improving access to care for people living in the communities surrounding NewYork-Presbyterian. The ACN has begun to redesign the patients’ visit with the assistance of the Primary Care Development Corporation, which provides training and coaching. As a result, eight ACN staff teams have identified new strategies for working together to better register, triage, treat and discharge patients. New processes primarily involve creating teams that work with the physician to handle all aspects of the patient visit, making the patient experience much more efficient and pleasant.

Patient satisfaction is measured by key data collected through the Press Ganey Survey. The top three 2006 priorities were:

1. Sensitivity to Patients’ Needs
2. Response to Concerns/Complaints During Visit
3. Nurses’ Instructions/Explanations and Cheerfulness of Practice

In addition, individuals and teams were recognized for their outstanding efforts in delivering patient-centered care:

### 2005 Patient-Centered Care Awards

#### Individuals
- Charles Bowen/Community Health and Education
- Rosa Rivera/Family Medicine at Farrell

#### Teams
- Audubon Practice
- Community Health and Education
- Washington Heights Family Health Center
- Wright Center

### 2006 Patient-Centered Care Awards

#### Press Ganey Awards

#### Highest Rated
- Fort Washington Practice
- Wright Center

#### Most Improved
- Cornell Internal Medicine Associates
- Broadway Practice

#### Sustained Excellence
- Allen Medical Practice (3FE)

#### Awards Based on Nominations

#### Team Awards
- Family Medicine at Farrell
- Process Redesign Team/NewYork-Presbyterian/Columbia
- Process Redesign Team/NewYork-Presbyterian/Weill Cornell
- Allen Medical Practice (3FE)

#### Leadership
- Sonia Rouse-Proctor, Administrator
  Broadway Practice
Christine Chestnut, RN  
Clinical Nurse 1  
Perinatal Center

My role in the high-risk perinatal clinic includes educating and reinforcing patients’ instructions regarding such things as gestational diabetes, nutrition and self-care during a high-risk pregnancy, as well as closely observing patients who might show signs of pre-term labor or who are having multiple births. The most important aspect of my job is to ensure that each patient receives the best care that I can give. One must be an advocate for the patient, and the best way to do that is to put one’s self in the patient’s place, and always treat each individual with respect and courtesy. Having empathy towards all patients helps to ease their anxieties.

Estella Padron, RN  
Clinical Nurse 1  
Audubon Practice

Our practice is important to the local community because there are a lot of children who need care to maintain their health. As a clinical nurse, I triage and administer any care that is needed for the pediatric population. I implement new programs and feel the most important aspect of my job is addressing the patient’s strongest issue. There are many little things that I do that can make a difference in a patient’s life. Many parents are comfortable with me and they call me. I’m on a first-name basis with many of them. It’s kind of nice.

Alicia Rosario  
Coordinator, Registration  
Pediatric Psychiatry Service

I do a little bit of everything — generate statistics, handle insurance authorizations, train staff, and solve computer and printer problems. I also assist with insurance complications, dealing with both the patient and the clinician. “We Put Patients First” means taking that little extra step that makes a difference. Patients coming here are looking for help. When I bring them to my office, I try to ease their anxieties.

Iraida Torres  
Patient Financial Advisor  
Broadway Practice

I’m the first person patients see when they come in the door. I treat patients with courtesy and respect and help to make them feel comfortable while they’re here. Patients feel comfortable talking to me. I’m a people person. And, I like what I do. There is a real need for health services in this community. Being here makes a difference in my patients’ lives.
In an effort to appropriately direct patients to outpatient care rather than the emergency department, a number of innovative approaches have been implemented. These include an UrgiCare Center that is available for walk-in appointments so that patients can be seen for episodic issues and then be redirected to their primary care provider. Patients who come into the urgent care practice and do not have a primary care provider are assisted in setting up an appointment with someone who will coordinate their care. The UrgiCare Center is staffed with physicians from Emergency Medicine who can address medical or surgical problems.

The ACN Access Unit performs insurance verification and obtains authorizations. To facilitate patient access to care, ACN sites follow the Hospital charity care policy for uninsured patients who do not qualify for Medicaid or Medicaid managed care. Referrals are made to affiliated managed care plans, Child Health Plus, or Family Health Plus for those who may be eligible. The ACN’s goal is to enroll as many people into health plans as possible in order to expand and improve access to health care services.

The Ambulatory Care Network Call Center facilitates appointment scheduling for seven ACN sites, approximately 40 community-based physicians and some 50 community agencies. Calls are received through a toll-free number, 1-866-4-MD-APPT, or forwarded from ACN practices. In 2006, the Call Center received 260,000 calls, with the majority of them coming from NewYork-Presbyterian Hospital’s catchment area. The number of requests for specialty appointments from community physicians exceeded 9,600 for the year. In addition to scheduling appointments for primary and specialty services, the Call Center also assists patients and providers in identifying appropriate resources to meet the patients’ needs, including scheduling appointments for diagnostic services.

Efforts to form relationships with community-based organizations have been very successful, helping to link patients to ACN providers.
As a pediatric registered nurse, my role entails a lot of multitasking — collaborating with the doctors, practicing preventive medicine and patient teaching. There is a lot of familiarity with our patients — we are almost like an extended family. We also act as mediators for patients to access higher levels of care or other support services. When patients come here, they should feel that they are important enough to receive the best care. The Rangel team members communicate well with each other as we focus on providing the best care possible.

Our practice makes it convenient for elderly patients to access care. We provide many specialties for this growing population, including gynecological services and dental care. As a Patient Financial Advisor, I greet patients; assist them in their every need; register them and direct them to the nurse; arrange transportation; and schedule follow-up appointments. The most important part of my job is making sure that our patients are comfortable, letting them know that we are here to help them, and making them feel that they want to come back.

The education and care we provide to women in our community is vital. They are “us,” and we take care of them immediately and treat them with respect. When women walk into the clinic, they’re nervous. We understand them and tell them what they will experience during their visit. As clinic supervisor, I do everything. Wherever there is a void, I make sure it’s filled.

I am responsible for helping to prepare patients for their examinations, getting them settled in the exam room, and directing them to the next stage of their visit. I’m lucky — I chose a job in a field that I enjoy. I treat patients the way I would hope I and my family members would be treated. Our clinic provides so many diverse services for the Hispanic community, and everyone on staff is bilingual. We can give our patients all the care they need in one place.
Quality Care: Our Number One Priority

The ACN Quality Management Program focuses on improving the safety and effectiveness of the care provided to patients, with both physicians and nurses spearheading quality and performance improvement initiatives.

A Clinical Quality, Safety, and Compliance Committee of physicians, nurses, social workers, nutritionists, practice administrators, and quality/performance improvement staff, collaborates to address disease-specific topics and patient safety issues. Among them are hypertension, asthma, diabetes, and childhood immunizations.

Improving Health Care Delivery Through Innovation

The Ambulatory Care Network continues to keep pace with changes in information technology and innovative approaches to managing clinical data and to enhance operational processes. As part of the Hospital-wide effort to facilitate patient care, ACN sites are implementing electronic medical record systems.

In 2006, a Hand Holder appointment reminder initiative was piloted to decrease patient no-show rates and to increase patient satisfaction. Confirmation letters mailed to patients’ homes, eight days prior to appointments, included time and location of the appointment, what to bring, important phone numbers, a map of the clinic site, and information on parking and public transportation. The program produced positive results, including a decrease in no-show rates, as well as an increase in patient volume and revenue at Cornell Internal Medicine Associates and Associates in Internal Medicine. Recently, the program was also implemented at the Pediatrics and Women’s Health practices at NewYork-Presbyterian/Weill Cornell and the Washington Heights Family Health Center, and it will continue to be expanded to other primary care practices and specialty clinics.

Promoting Academic Excellence

The Ambulatory Care Network is the primary venue for the training of housestaff in outpatient care. More than 1,500 residents and fellows provide care to patients in the ACN under the supervision of faculty from Columbia University College of Physicians and Surgeons and Weill Cornell Medical College.

The Ambulatory Care Network also pursues an active research program in collaboration with a number of medical school departments.

In 2005, at NewYork-Presbyterian/Columbia, ACN practices worked with the Maternal-Fetal Medicine group of the Department of OB/Gyn to offer clinical trials on new therapies to prevent pre-term labor or other complications of pregnancy for women receiving antenatal care; the Neurology Department, which offers clinical trials related to seizure disorders and depression for patients in the adult neurology specialty clinic on Vanderbilt 10; and the Department of Psychiatry, which is developing a research partnership with primary care pediatricians to evaluate the effectiveness of a co-located, integrated model of care for children with attention deficit hyperactivity disorder.

At NewYork-Presbyterian/Weill Cornell, the Department of Public...
I am one of the staff who is responsible for administering chemotherapy and blood products to patients. It is so important to make patients feel comfortable. “We Put Patients First” to me means guaranteeing excellent care to patients and their families. I believe that outpatient therapy is more advantageous than inpatient therapy, as patients can have a life. Part of our job is to boost our patients’ morale. We have great teamwork. All the staff like working here, and the patients notice that.

Lydia Henry
Staff Assistant
Cornell Internal Medicine Associates

I assist doctors with scheduling appointments and special tests, arrange transportation for patients, and perform pre-certifications and pre-authorizations for insurance. We always try and put the needs of our patients first. To me, it is a principle I always follow: to make sure that patients get what they need, that they’re comfortable, and that we give them the best care. For one particular patient, I solved her problem within five minutes by speaking to a doctor and printing a new prescription for her. She had been upset, and I made her happy.

Katherine Alexander
Registrar
Long Island City Community Practice

I play a lot of roles — registrar, friend, confidant — and sometimes all three at once! I am always trying to build a rapport with patients. As the patients get to know you, they tell you more about what is going on with them. I also try to be a liaison between the patient and the doctor. Our doctors go above and beyond just medical care in serving patients.

Margaret Murphy, RN
Staff Nurse
Hematology/Oncology Treatment Center (Infusion Center)

It would be hard for patients if we weren’t here. We have many patients with co-morbidities and they are able to access other services through us. I’m responsible for the daily running of the clinic, which includes screening, assessment and intake of new patients. We ensure that our patients’ rights are protected, and that they are always treated with the dignity and respect that they deserve. It’s rewarding to see mothers who were once at risk for losing their children come in years later, off drugs, and with their family.

Kim Alexander, MSW, CASAC
Clinical Supervisor
ADP and Adult Services Clinic (Methadone Maintenance Treatment Program)
Health has collaborated with the ACN on a number of efforts, and they are currently engaged in a study evaluating attitudes and expectations of ACN providers related to the implementation of the new electronic medical record system.

Residents in pediatrics on both campuses are engaged in Quality Improvement efforts that are both improving the care of patients, as well as fulfilling residency education requirements. In 2006, the ACN received a grant from United Hospital Fund to extend and evaluate this program in other New York City training programs.

**Planning for the Future**

The Ambulatory Care Network embarked on a nine-month strategic planning process that involved the evaluation of current business and clinical care delivery models. Strategies to improve performance were identified in the financial, operational and clinical care delivery arenas. Since the plan’s development in April 2005, a combination of budget adjustments, improved efficiencies, increased focus on revenue and patient visit redesign has resulted in a significant financial improvement. In 2006, the following strategic measures were implemented:

- The Broadway Practice expansion and total renovation was completed, increasing its square footage by 60% to 15,000 square feet and doubling the number of exam rooms to accommodate an increase of 17,000 visits per year.
- The Nagle Avenue site closed and Family Medicine was relocated to the Farrell site.
- Renovations took place at the Cornell Internal Medicine Associates Practice and the adult dental clinic at NewYork-Presbyterian/Weill Cornell.
- Practices are piloting strategies to enable patients to more easily receive same-day or same-week appointments and reduce the wait time to see primary care providers. Operating hours of several clinics were also extended to further improve patient access.
- The newly renovated dental suite at the Fort Washington Practice opened to serve geriatric patients, complementing the already existing geriatric practice.

Going forward, the Ambulatory Care Network seeks to improve access at all practices, increase the number of managed care and commercial plans accepted, develop revenue enhancement initiatives, and pursue programs and services that ensure the highest quality of care for patients. This will be accomplished by continuing to partner with the people who live in the Hospital’s communities to help them be as healthy as possible. That is the mission and that is the commitment of the Ambulatory Care Network.
**Ebony Rodriguez**
Registrar
Irving Sherwood Wright Medical Center on Aging

Registrars are the first staff members patients see, especially during their first visit. Therefore, I feel the most important part of my job is greeting patients. Because we cater to an older population, we can focus on the special needs of a geriatric patient. For my patients, I go beyond my specified duties. I am bilingual so if I have a Spanish-speaking patient, I help make arrangements for him or her. I get popcorn for a patient who loves it. To me, “We Put Patients First” means providing our patients with the best service we can, in all aspects.

**Joyce Klimoski, RN**
Staff Nurse
Surgical Associates Clinic
NewYork-Presbyterian/Weill Cornell

I am the charge nurse for a combined practice of three clinics and 10 surgical practices for adults and senior adults. As nurses, we do a lot of explaining, reassuring, hand-holding, and teaching of patients. We’re not just giving the best clinical care, but also treating the whole patient. One patient diagnosed with cancer also had some memory problems. I helped with setting up pre-surgical and post-op appointments and was available for any questions or clarifications the patient needed regarding care. It was very rewarding to me to have been able to help.

**Sharon Harris**
Medical/Surgical Technician
Pediatrics Practice
Helmsley Tower 5

As a medical/surgical technician, I greet patients, weigh them, draw blood, test for hearing and vision, as well as order supplies. Making sure that the children are vaccinated and that they’re healthy and safe is important. I have helped a patient who was incarcerated to go straight when he got out, and now he is working towards his GED. Another patient calls me his “second mother.” Working with children, I try to make them as happy as they can be, and ensure that all our patients are satisfied to the best of our abilities.

**Yoaitza Rodriguez**
Registrar
Women’s Health Practice
Helmsley Tower 5

I handle the telephone and help patients who have questions. I also greet them and schedule appointments. I do whatever I can do to make patients happy. The most satisfying part of my job is knowing that my patients are happy.
The ACN Practices at NewYork-Presbyterian/Columbia

- Adult Psychiatry Service
- Allen Medical Practice
- Ambulatory Nutrition Services and Women Infants and Children (WIC) Program
- Associates in Internal Medicine (AIM) Practice
- Audubon Practice
- Broadway Practice
- Center for Community Health and Education
- Family Medicine at Herman “Denny” Farrell, Jr. Community Health Center
- Fort Washington Geriatric Practice
- Pediatric Psychiatry Service
- Perinatal Center (High-Risk Obstetrics)
- Charles B. Rangel Community Health Center
- Specialty Clinics
- UrgiCare Center
- Washington Heights Family Health Center
The Adult Psychiatry Service serves patients in the Washington Heights, Inwood and Harlem communities, as well as those patients who receive primary care at NewYork-Presbyterian/ Columbia. The Integrated Mental Health Program provides consultative mental health care in most of the neighborhood-based ACN sites.

**Adult Psychiatry Clinic**

- **English Community Service Clinic** — group treatment along with psychopharmacology treatment and short-term individual psychotherapy;
- **Acute Treatment Team** — short courses of treatment and crisis interventions;
- **Rafael Tavares Community Service Clinic** — individual, group, family and psychopharmacology services for Hispanic patients;
- **Mentally Ill Chemical Abusing Program** — group therapy and psychopharmacology treatment for patients who are mentally ill with a substance abuse problem;
- **The Family Clinic** — couples, family and multi-family group services to primarily Spanish-speaking patients;
- **Adult Psychiatry Service** — individual evaluations and psychotherapy with psychopharmacology treatment available as needed;
- **The Lucy A. Wicks Clinic for HIV Mental Health** — services for patients (individuals and group) affected by HIV. Psychopharmacology treatment also is available as needed.

**Integrated Mental Health Program**

- The adult practice of the Integrated Mental Health Program includes psychologists and psychiatrists working in five of the ACN primary care practices, providing consultation, brief treatments and referrals for ongoing care.

**Serving Our Patients**

Psychiatrists, psychologists, social workers and other health care professionals provided a full range of mental health services in 2006 totaling 25,927 patient consultations. Volume in the Integrated Mental Health Program for both pediatric and adult patients totaled 5,421 consultations. The majority of care was provided to patients between the ages of 18 to 65 (90%), with 10% of patients over the age of 65.

In the clinics, adult psychiatry services were provided for patients with Medicaid managed care (32%), as well as Medicaid fee-for-service (30%), Medicare fee-for-service (30%), commercial insurance, and self-pay. In the adult Integrated Mental Health Program, the majority of care was provided to patients with Medicaid managed care (60%), along with Medicaid fee-for-service (25%), Medicare fee-for-service (10%), commercial insurance and self-pay.

**Providing Patient-Centered Care**

The Adult Psychiatry Service has implemented a number of measures to better serve its patients, including expansion of a centralized evaluation service, availability of psychopharmacology services, and enhancing the psychology externship program for bilingual clinicians, thereby increasing the number of clinicians available to patients.

Discharge planning efforts are geared toward encouraging patients to return to their highest level of functioning in the community, once they are stable. The service has also tripled the size of the monthly socialization meeting for long-term patients who require only psychopharmacology or social support.

The service has initiated a joint program with NewYork-Presbyterian/Columbia to provide on-site HIV testing and began development of a new program focused on preventive services and treatment of the family as a whole. It has also continued its focus on assessing smoking-cessation needs and referrals for treatment.

In addition, the Department of Psychiatry conducts a homeless outreach program and a mobile crisis service.

**Homeless Outreach Program**

The Homeless Outreach Program provides assessment and referral services for mentally ill individuals who are homeless in the communities of Washington Heights and Inwood. A dedicated team links clients to needed services, including psychiatric outpatient clinics, NewYork-Presbyterian/Columbia’s psychiatric emergency room, dual diagnosis and substance abuse programs, private and public shelters, psychosocial clubs, food pantries and soup kitchens. The team psychiatrist performs psychiatric evaluations of clients who are not already connected to psychiatric treatment, and team case workers provide supportive counseling.
In 2005, 1,345 homeless clients were served for a total of 3,291 interactions. The majority of patients were in the 35 to 64 age range and three-quarters of clients were male. In addition to providing case management services, the team placed a renewed emphasis on field touring, reinforcing its commitment to find and assist the homeless mentally ill. A new engagement tool, the Hygiene Pack, was developed to help team members form alliances with individuals encountered during the tours. The result of these efforts was a 16% increase in the number of persons served compared to 2004.

The team continues to work closely with the psychiatric emergency room and the Hospital’s psychiatric inpatient units to help ensure consistent and “gap-free” care.

MOBILE CRISIS SERVICE

The Mobile Crisis Service provides psychiatric crisis outreach to patients living in the communities of Washington Heights, Inwood and Marble Hill in the Bronx. Staff members perform urgent in-home evaluations of patients who are experiencing acute psychiatric symptoms, but cannot access traditional services such as outpatient clinics or psychiatric emergency rooms. Workers either facilitate admission to the Hospital’s psychiatric emergency room or carry out short-term counseling, medication management, psychoeducation, and referral to longer-term psychiatric follow-up, as indicated. Patients are typically followed by the team for two to four weeks.

The service continued to focus on adapting treatment plans to better serve the severely and persistently mentally ill and began referring recidivistic and non-adherent patients for Assertive Community Treatment (ACT), with an ACT team in Harlem and Washington Heights.

Patients who are uninsured are referred to agencies, such as the Neighborhood Care Team of the Association of Progressive Dominicans, which can assist them in obtaining benefits.

Since 2003, the Mobile Crisis Service has been tracking the number and nature of successful referrals made by the team to longer-term mental health providers. (A successful referral is defined as a referral for which the patient is seen at least once by the receiving agency.) In 2004 and 2005 the team increased its emphasis on reviewing patients’ treatment plans during routine home visits. Coincident with these efforts, successful referrals increased 22%.

ACCOMPLISHMENTS

The Adult Psychiatry Service has consolidated leadership for both clinic sites, as well as the Integrated Mental Health Program, facilitating a comprehensive and streamlined approach for assessing and meeting the mental health needs of the community.

Staff have continued to provide the highest quality mental health care for inner-city patients, and at the same time, offer a robust training experience for mental health trainees.

New outstanding clinicians dedicated to meeting the service’s goals and mission are helping to insure compliance with organizational readiness, including staff training and environment of care issues.

The service automated treatment updates and implemented a new review system for behavioral health. Training of all clinicians in developing behavioral and measurable treatment goals resulted in 50% improvement in timeliness of updates. In addition, accessibility to services has been greatly enhanced. All referrals are screened and triaged within two days, and patients in crisis are seen immediately.

Performance improvement projects included implementation of a program to provide patients with transportation reimbursement on-site; a process to collect cash co-pays; and assessing patient tobacco use and referring them to a smoking-cession treatment.

The Mobile Crisis Service experienced a 22% increase in the number of patients successfully referred to mental health providers between 2003 and 2005. For the past year, it has functioned as the mobile team for the Child Community Psychiatric Emergency Program of Morgan Stanley Children’s Hospital.

LOOKING AHEAD

The Adult Psychiatry Service is focusing on an array of programs and initiatives that will decrease the length of stay in order to accommodate new patients. Plans include:

• providing more targeted short-term treatments;
• developing and tracking additional quality indicators in the clinics and in the Integrated Mental Health Program;
• pursuing grants to enhance and expand clinical services for HIV patients;
• reducing the wait time for appointments with Spanish-speaking clinicians;
• developing and implementing an electronic medical record;
• improving revenue collection;
• developing and implementing systems for monitoring visit authorizations for patients with Medicaid managed care; and
• refining and improving medical record review processes.

In addition, the Homeless Outreach Program will be collaborating with researchers from the Center for Homelessness Prevention Studies to develop neighborhood “networks of care” for mentally ill homeless patients. The Hospital’s program has been selected as one of the key service providers in the network that will be formed in Upper Manhattan.

The Mobile Crisis Service will begin a new initiative to create a stronger connection to patients being referred to the team from the psychiatric emergency room. A clinician from the Mobile Crisis Service will meet with these patients before their discharge from the emergency room in order to introduce the team’s services, review discharge plans and schedule a time for a home visit. A major goal is to increase the ability to contact and engage patients following discharge from the ER.
OVERVIEW

The Allen Medical Practice provides specialty health care in the following services:

• **Geriatrics**, focusing on the patient’s physical, psychological and social needs while providing continuity of care between inpatient hospitalization and outpatient visits, as well as cardiology services geared for the elderly
• **Urology**, offering a full range of urologic services, including diagnostic testing
• **Vascular services**, including non-invasive diagnostic testing, wound care and nutrition screening
• **General surgery**, providing postoperative and hospital discharge follow-up
• **Orthopedic services**, including general orthopedics and sports rehabilitation
• **Neurology**
• **Wound Service**, providing care for non-healing wounds for the disabled, geriatric and diabetic patient population

SERVING OUR PATIENTS
In 2006, the Allen Medical Practice accommodated 10,480 patient visits, serving patients from 18 years to over 80. With the expansion of the Wound Healing Program, the number of surgical visits increased from 1,776 to 3,483.

PROVIDING PATIENT-CENTERED CARE
The Allen Medical Practice serves a large geriatric population. As one example of how care is designed to meet the needs of the community, the practice has initiated a Wound Healing Program to care for elderly, disabled and diabetic patients. Nurses are assigned to each patient, following established protocols for wound care of diabetic foot ulcers, pressure ulcers and venous ulcers. The Wound Healing Program complements and works closely with services such as vascular, podiatry, plastic surgery, nutrition, social work, physical therapy, and occupational therapy to provide optimal care for all wound patients. The program includes a treatment room for minor debridement and skin grafting.

ACCOMPLISHMENTS
The Allen Medical Practice continues to collect ongoing quality indicator data through a number of initiatives, including GYN cytology tracking, patient telephone surveys, and a patient identification quality assurance program.

Four Patient Financial Advisors were assigned to a central registration area in order to foster and promote an atmosphere of teamwork and professionalism.

In 2006, for five consecutive months the Allen Medical Practice surpassed its patient satisfaction targets for overall quality of care and two indicators. For this achievement they received the Sustained Excellence Award.

LOOKING AHEAD
Ongoing goals include the improvement of staff accountability; the further development of the Wound Healing Program; and a continued emphasis on enhancing patient care and satisfaction.
AMBULATORY NUTRITION SERVICES AND WOMEN INFANTS AND CHILDREN (WIC) PROGRAM

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Amy Friedman, MS, RD, CDN
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Women Infants and Children (WIC) Program
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New York, NY 10032
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Valrose Lounds
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Ambulatory Nutrition Services

OVERVIEW
Ambulatory Nutrition Services offer a number of nutritional programs for residents of the Washington Heights and Inwood communities of Northern Manhattan, the Upper East Side and Queens.

SERVING OUR PATIENTS
This program offers medical nutrition therapy and education for men, women and children of all ages. Care is delivered by nutritionists at 12 ACN sites in Washington Heights and Inwood, two in the Upper East Side and one in Queens.

ACCOMPLISHMENTS
Ambulatory Nutrition Services added an additional site at the Charles B. Rangel Community Health Center.

In collaboration with Ambulatory Nutrition Services, the Women Infants and Children (WIC) Program held an annual Nutrition Conference and Breastfeeding Conference.

LOOKING AHEAD
In 2007, the Ambulatory Care Network will partner with the Department of Food and Nutrition in order to develop a more robust and integrated program for Ambulatory Nutrition Services. Provision of nutrition services throughout the sites will be enhanced. For example, ambulatory nutrition services will be available to oncology patients receiving radiation and infusion therapy.

Expansion and collaboration also includes the addition of the Nutrition Wellness Center to Ambulatory Nutrition Services. The Nutrition Wellness Center offers individual nutrition counseling and group classes. It is hoped that the Nutrition Wellness Center will be further expanded to the NewYork-Presbyterian/Columbia campus.

Further collaboration with the Department of Food and Nutrition includes participation of ACN nutritionists in the training of dietetic interns and nutrition fellows.

Ambulatory Nutrition Services will continue to seek additional funding to support and increase existing services and programs. Plans for the establishment of a billing process for Ambulatory Nutrition Services are underway.

Women Infants and Children (WIC) Program

OVERVIEW
The Women Infants and Children (WIC) Program offers a number of nutrition services for residents of the Washington Heights and Inwood communities of Northern Manhattan. This Federal- and State-funded nutrition education and supplemental food program serves prenatal, breastfeeding and postpartum women, infants and children up to the age of five.

WIC-eligible participants receive group nutrition education, individual high-risk nutrition counseling, food vouchers, as well as breastfeeding education and support. There are three WIC sites in Washington Heights and one in the Inwood area.

In addition, an Enhanced Peer Counselor Breastfeeding Program provides peer counselors who offer guidance and support to prenatal and breastfeeding women enrolled in the WIC program.

SERVING OUR PATIENTS
The WIC Program sees approximately 56,320 patient visits per year and the Enhanced Peer Counselor Breastfeeding Program accounts for approximately 226 consultations each year.

WIC and breastfeeding program patients are primarily covered under Medicaid (80%).

ACCOMPLISHMENTS
Among patient-centered care initiatives and quality and performance programs are the ongoing collection and analysis of data from patient satisfaction surveys. A survey of WIC patients has shown 85% of patients are satisfied with services and hours of the program.

Staff are also seeking ways to improve access and reduce wait time for new and follow-up appointments.

The Women Infants and Children Program held an annual Nutrition Conference and Breastfeeding Conference in collaboration with Ambulatory Nutrition Services.

LOOKING AHEAD
Staff will continue working on initiatives to increase the number of patient visits in the WIC Program.
ASSOCIATES IN INTERNAL MEDICINE (AIM) PRACTICE

Associates in Internal Medicine (AIM) Practice
NewYork-Presbyterian Hospital/Columbia University Medical Center
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OVERVIEW
The Associates in Internal Medicine (AIM) practice offers general medical care to residents of the Washington Heights, Inwood, and Harlem communities of Upper and Northern Manhattan. The practice also coordinates referrals for on-site specialty consultations in cardiology, endocrinology, gastroenterology, geriatrics and geriatric psychiatry, nephrology, and podiatry. The AIM physicians have particular expertise in the treatment of thyroid disease, arthritis, liver disease, and memory disorders.

The practice's comprehensive array of health care services and health education services includes:
- anti-coagulation management programs
- asthma management
- cytology
- diabetes management
- diabetic retinopathy screenings
- flu vaccinations
- HIV testing
- nutrition counseling
- preventive care
- routine medical examinations
- social work services

The AIM practice is the primary postgraduate ambulatory teaching site for 143 residents and 47 fellows in the Department of Medicine at Columbia University Medical Center. Through training at AIM, they acquire outstanding knowledge, experience and skills in the delivery of primary and specialty care.

SERVING OUR PATIENTS
Between 2002 and 2006, patient volume increased from 71,700 visits to 79,982, with patients ranging in age from 18-44 (30%), 45-64 (40%), and 65 and older (30%). Internal medicine accounted for the largest number of patient visits (54,586), followed by anticoagulation management (6,079) and cardiovascular care (4,056).

The AIM practice cares for patients with Medicaid managed care (40%), Medicare (37%), Medicaid fee-for-service (15%), commercial insurance and self-pay.

ACCOMPLISHMENTS
Patient satisfaction scores rose in a number of areas, including overall quality, which increased from 73.2 to 74.4; registration process, 69.2 to 71.1; physician/nurse practitioner courtesy and caring, 80.8 to 82.8; and nurses courtesy and caring, 78.6 to 87.8.

AIM nursing staff have developed and implemented comprehensive educational seminars in specific diseases, including asthma, hypertension, and osteoporosis, that historically have had a high prevalence among the practice’s patients. The practice also plans to implement a medication management class.

AIM staff implemented several key patient-centered care projects focusing on telephone etiquette, with 100% compliance using a new telephone script. Other projects included improvements in making positive first impressions and, most noteworthy, employee helpfulness achieved through the “mystery caller” initiative. An ongoing initiative emphasizes the importance of maintaining eye contact with patients, smiling, and asking to be of assistance.

LOOKING AHEAD
Going forward, the AIM practice will continue to stress improvements in patient-centered care; better access to services, especially the subspecialties; implementation of an electronic medical record system; and an improved telephone scheduling system. In addition, staff will focus on enhancing processes for following up on laboratory and radiology reports.

The anti-coagulation program will soon begin point of care testing that will enhance patient satisfaction by reducing waiting time for results.
OVERVIEW
The Audubon Practice is a primary care facility that provides pediatric, gynecological and obstetrical services on an outpatient basis to residents of the Washington Heights and Inwood communities of Northern Manhattan.

Staff are committed to providing quality care to patients and their families. Patients are served by a caring staff that respects patient rights, cultural diversities, and individual needs.

The pediatrics practice cares for children from birth to 20 years. Services include well baby care, preventive care and treatment for both acute and chronic conditions, such as urinary tract infections and asthma. Also offered are programs in pediatric allergy, neurology, and psychiatry, as well as nutrition services, social services and HIV counseling. Patients have 24-hour telephone access to practice staff. Physicians from the Audubon Practice provide inpatient coverage thereby providing continuity of care. Subspecialty care is provided through referral.

The OB/Gyn practice also offers comprehensive obstetrics and gynecology services, including ante-partum and postpartum care, routine exams, sonography and laboratory services.

Residents provide care under the supervision of attending physicians.

SERVING OUR PATIENTS
In 2006, the Audubon Practice accommodated 37,898 patient visits (34.68%, OB/Gyn, and 65.32%, pediatrics).

The majority of patients are covered under Medicaid managed care plans (67%), followed by Medicaid fee-for-service (21%), as well as Medicare, commercial insurance and self-pay.

General clinical services provided include:
- **Pediatrics** — general care, neurology, psychiatry/psychology, nutrition, HIV counseling and social services;
- **OB/Gyn** — gynecology, obstetrics, endocrinology/reproductive, surgery, HIV counseling, nutrition and social services.

PROVIDING PATIENT-CENTERED CARE
The Audubon Practice’s pediatrics service continues to expand programs and initiatives geared to adolescents, including a comprehensive reproductive health care program. A pediatric nutritionist is available for consultations and follow-up on obesity. The practice also has an extensive asthma program that emphasizes education and improved asthma management.

A domestic violence program, incorporating staff from social services, pediatrics, medicine, OB/Gyn, as well as community-based organizations, is improving the identification and support of victims of domestic violence.

New programs initiated in OB/Gyn include a Pelvic Pain Clinic for patients with endometriosis and adhesive disease, began in conjunction with the Hospital’s pain management service. Urodynamic studies are now provided to our patients suffering from incontinence.

ACCOMPLISHMENTS
The Audubon Practice initiated its own “is there anything else that I can do for you, I have time” campaign to improve overall patient satisfaction scores, achieving a 51% staff compliance (up from 38%). Staff are continuing to monitor “positive first impressions” when greeting patients, as well as adherence to dress code and ID visibility.

LOOKING AHEAD
The Audubon Practice will extend its hours to allow for approximately 7,000 additional patient visits. Streamlining system operations and focusing on efficiencies are high priorities.

The practice has implemented a redesign initiative to drastically decrease patient cycle time and improve patient satisfaction. Staff will address areas of opportunity identified for improvement on patient satisfaction surveys.

Other goals include efforts to move toward electronic medical record implementation; improve no-show rates and patient/session rates; and further improve asthma care by developing a reminder system for asthma patients to receive influenza vaccines.
**OVERVIEW**

The Broadway Practice provides primary health care for residents of the Washington Heights and Inwood neighborhoods of Northern Manhattan. In 2006, staff provided care to 35,516 patient visits in pediatrics, internal medicine, obstetrics, gynecology, psychiatry and psychology (adults and children). In addition, the practice offers social work assistance, as well as services in HIV counseling, nutrition, genetics and podiatry.

The pediatrics practice offers well child care and acute care. The practice also participates in the Reach Out and Read Program and is involved in community pediatric activities in conjunction with the pediatric residency program. The internal medicine program provides general and acute care; the OB/Gyn service offers patients prenatal, postpartum and general gynecology care.

**SERVING OUR PATIENTS**

In 2006, the Broadway Practice saw an increase of 1,748 visits from 2005, largely due to the addition of psychology and psychiatry services and the renovation and expansion of the practice.

The majority of patients are covered under Medicare, Medicaid, and Medicaid managed care plans. More than 90% of the pediatric visits are Medicaid, Medicaid managed care, or Child Health Plus. Obstetrics patients are covered by PCAP, Medicaid and Medicaid managed care plans.

**PROVIDING PATIENT-CENTERED CARE**

The practice’s pediatrics service is pursuing several initiatives including the Reach Out and Read Program to promote literacy; Project DOCC (Delivery of Chronic Care), aimed at increasing medical residents’ awareness of the complex medical and social issues facing families of children with special health needs; and a residency quality improvement project focusing on the identification and treatment of children with hypertension.

As part of an ACN system-wide effort, a diabetes initiative and support group program is promoting diabetes management education to improve health outcomes. In addition, the practice has implemented the Columbia University Manhattan Smoking Cessation Program as part of routine screening.

**ACCOMPLISHMENTS**

The Broadway Practice underwent a number of renovations during 2006, with expansion in pediatrics, internal medicine and obstetrics and gynecology in order to meet a volume goal of 50,000 visits annually.

In 2006, the Broadway Practice was the first ACN practice to surpass their patient satisfaction targets for overall quality of care and two indicators. They achieved this five times in 2006. That same year, Sonia Rouse-Proctor received a Leadership Award.

**LOOKING AHEAD**

Future plans include continuing site renovations; integrating additional faculty and support staff; and implementing an electronic medical record system. Support services will be expanded to accommodate increased volume, along with additional anticipated patient visits in pediatric psychology, HIV counseling, and nutrition.

Staff will continue to focus on patient satisfaction by decreasing the cycle time and improving the telephone triage process.
For 29 years, the Center for Community Health and Education (CCHE) at the Mailman School of Public Health has collaborated with NewYork-Presbyterian Hospital/Columbia University Medical Center to provide comprehensive reproductive health care and primary care services to the communities of Northern Manhattan and the South Bronx. The center operates two distinct service programs: the Family Planning Center and the School-Based Health Center.

The Family Planning Center

SERVING OUR PATIENTS

The Family Planning Center (FPC), located at 21 Audubon Avenue in Washington Heights, provided comprehensive reproductive health care services to 12,787 patients (11,135 women and 1,652 young men), who made 40,208 visits in 2005-2006. Patients are primarily Latino (91%), and live in the Washington Heights and Inwood communities, the South Bronx and Manhattan below 154th Street.

The FPC provides comprehensive reproductive health care that includes physical exams; screening and treatment of sexually transmitted infections; breast and cervical cancer screening; all FDA-approved methods of hormonal and barrier contraceptives; pregnancy testing and counseling; HIV testing and counseling; health education; and mental health counseling.

In addition, the FPC also offers a Young Men’s Clinic (YMC), providing family planning services, including contraception and sexually transmitted infection screening and treatment for young men between the ages of 12 and 30, and Project S.T.A.Y. (Services to Assist Youth), a weekly clinic for 42 HIV-positive adolescents who receive comprehensive primary care, as well as family planning and supportive counseling services.

In 2006, the FPC provided care for patients with Medicaid (55%), as well as those without health coverage (33%), and those on a sliding scale (12%).

PROVIDING PATIENT-CENTERED CARE

The clinical areas of the Family Planning Center focus on the reproductive health needs of adolescent and adult females, and adolescent and young adult males. A full range of clinical services and programs include:

- Colposcopy Clinic, which provides cervical cancer screening;
- PCAP Enrollment Unit, which facilitates the application process, enabling patients to have earlier access to prenatal care services;
- Entitlement Screening for patients who do not have insurance;
- Community Education Initiatives Program, which provides an Adult Parent Education Program (APEP), a 10-week course on family life offering parents information about sexuality, communicating effectively with adolescents about sexuality, substance use, HIV/STIs, pregnancy prevention, and promoting positive family relationships. (Since its launch in 1991, APEP has graduated nearly 2,000 participants);
- Enhanced HIV Services, including Rapid HIV Testing, which was made possible by a three-year grant from the Federal Office of Population Affairs, one of only three awarded in New York State;
- Young Men’s Health Initiative to promote family planning services for males.

ACCOMPLISHMENTS

In 2005-2006 the Family Planning Center/Young Men’s Clinic participated in a patient-centered care initiative aimed at increasing the number of patients who receive HIV pre-test counseling. The FPC achieved this goal by adding a waiting room group HIV education module to its existing individual HIV testing and counseling activities. As a result of these efforts, a higher percentage of patients receive HIV pre-test counseling, and a higher percentage of patients receiving counseling choose to be tested.

In 2005, the FPC implemented an open access appointment scheduling system to accommodate patient needs.

The FPC also provided group health education sessions for 9,169 patients and conducted a community outreach program, consisting of 13 educational sessions at community-based organizations and 27 sessions in schools (other than the School-Based Health Centers) and community colleges.

LOOKING AHEAD

The FPC will continue to improve data collection and evaluation using the revised Client Visit Form, and will complete a full year of integration of HIV rapid testing into the FPC/YMC practice.
The FPC will be implementing a patient-centered care initiative to offer beepers to patients so they may leave the practice rather than wait. This will reduce the congestion in the reception area and improve the patient experience.

**School-Based Health Centers**

**SERVING OUR PATIENTS**

The School-Based Health Center (SBHC) programs began in 1986 in partnership with local community school districts (CSD) in order to provide primary care services to students in Washington Heights. As the program developed, clinics opened in CSD 5 and CSD 3. During the school year 2005-2006, the center operated six School-Based Health Centers at George Washington High School, Intermediate Schools 52, 143, 164 and 136, and the Promise Academy. In 2006-2007, the center opened its seventh School-Based Health Center at the Thurgood Marshall Academy located in Central Harlem. Together, these schools have an enrollment of more than 8,000 students who made more than 38,192 patient visits in 2005.

The School-Based Health Centers offer primary medical care, as well as mental health and health education services. This includes physical examinations, immunizations, management of chronic conditions (e.g., diabetes, asthma), and reproductive health services for sexually active middle and high school students. Students served are covered by Medicaid fee-for-service (56.7%), private insurance (4.2%), Child Health Plus (2.4%), and 36% of students have no health insurance.

**PROVIDING PATIENT-CENTERED CARE**

SBHC programs and services include comprehensive health assessment (physical/mental), diagnosis and treatment of minor and acute pain, routine management of chronic conditions, prescriptions for acute problems and conditions, laboratory testing, reproductive health care, health education, mental health and crisis intervention, social services, psychological services, psychiatric evaluations, dental care with some treatment, specialty care, and vision screening with provision of free eyeglasses. In addition, the SBHCs provide health education programs focusing on pregnancy prevention, HIV prevention, and smoking cessation and prevention.

The majority of SBHC medical visits are for well adolescent care, reproductive health-related diagnoses, immunizations, and minor accidents and injuries. The most common mental health diagnoses include parent/child relationship problems and adjustment disorder, and depression. Health education visits are primarily for reproductive health concerns such as puberty and abstinence skills reinforcement.

**ACCOMPLISHMENTS**

In 2006, CCHE received funding from New York City’s Department of Mental Health to provide training and technical assistance through the Emergency Contraception Awareness and Access Program. This program will help develop and implement a training program for SBHC providers and other school staff working with adolescents in NYC public schools. The training will provide these professionals with knowledge and skills, administrative tools and protocols, technical assistance, and a forum to discuss their concerns about providing emergency contraception.

Increased support for the Community-Based Adolescent Pregnancy Prevention Program has enabled the center to expand pregnancy prevention and male involvement services at IS 52.

The SBHC program continues to collect patient satisfaction data and solicit patient input through a variety of mechanisms, including focus groups, Peer Education Program, Community Health Initiatives Education Program and patient satisfaction surveys.

In 2005, JCAHO auditors spent three days visiting all SBHC sites, which were commended as a “national model” for the provision of school-based health care.

In 2005-2006 the SBHC participated in a successful patient care improvement initiative to increase the percentage of students returning signed parental consent forms for SBHC enrollment and increase the percentage of uninsured student patients referred for health benefits assistance.

In 2005-2006, the Community Health Initiatives program provided a total of 83 health education presentations for community groups, youth organizations, and groups of parents with a total of 1,455 participants.

In an ongoing effort to promote parent involvement, Parent Nights were held at SBHCs in 2005-2006. Parents received information on clinic services, dental services, insurance enrollment, consent forms and also toured the clinic facility.

**LOOKING AHEAD**

SBHC is implementing the new training and technical assistance program in emergency contraception for SBHCs throughout New York City.

SBHC will continue to build on patient-centered care initiatives to improve patient satisfaction by promoting team-building activities and reinforcement of positive behaviors. Center staff will also closely monitor quality assurance activities to ensure compliance.
Family Medicine at the Herman “Denny” Farrell, Jr. Community Health Center is a primary care facility serving community residents in the Washington Heights area of Northern Manhattan. Established in 1994, the Farrell Center cares for a low-income patient population of predominantly Hispanic, African-American and Asian residents who have emigrated from the Dominican Republic, Honduras, Mexico, Guatemala, Jamaica, Haiti, Senegal, West Africa, and Ethiopia.

Family Medicine at Farrell provides comprehensive care for the entire family. It is the medical specialty that integrates biological, clinical, and behavioral sciences. The scope of family practice is all ages, both sexes, each organ and disease entity. The practice also provides podiatry, mental health services, skin procedures, musculoskeletal and women’s health services, including colposcopy, early termination of pregnancy, and family planning services.

SERVING OUR PATIENTS

In 2005 the Family Medicine program saw a total of 25,500 patient visits. A decrease was noted in 2006 largely due to the move from its original site at Nagle Avenue to its current location at 158th street.

The Farrell Center cares for patients with commercial, Medicare and Medicaid plans.

PROVIDING PATIENT-CENTERED CARE

The family medicine staff uses a collaborative approach to care. Residents, attending physicians, and social workers make home visits, which include clinical as well as risk assessment in the patient’s home.

The practice participated in the New York City Depression and Diabetes Collaborative to promote best care models for diabetic care. The program targeted all diabetic patients who had been seen in the last two years at the practice.

Community care is innate to family medicine. The community does not end in the Washington Heights area of Manhattan. Residents and attending physicians make an annual trip to the Dominican Republic to offer primary care to more remote communities, and to build strong alliances with the medical community abroad.

The Farrell Center is the primary training site for 18 family medicine residents. The practice also hosts medical students and student nurses to enhance their skills and medical/nursing experiences.

ACCOMPLISHMENTS

In addition to partnering with the Call Center to schedule specialty appointments, the practice updated its electronic medical record in May of 2006 by switching to Eclipsys.

Family Medicine at Farrell also successfully completed the PCAP survey.

Patient-centered care, quality and performance improvement initiatives were supported with the implementation of a patient satisfaction survey and regular reporting of clinical quality indicator data in such areas as medical peer reviews, JCAH0 monitoring, and pain management.

Staff instituted a number of procedures and further streamlined processes to improve patient care. These included a patient-centered care redesign. In July 2006 the practice switched from a traditional scheduling system to an open access system. Wait times for appointments decreased from two weeks to one day. The no-show rate also decreased from 33% to 18%.

In the summer of 2006, the Nagle Family Medicine Practice was relocated from 64 Nagle Avenue to the Herman “Denny” Farrell, Jr. Community Health Center, located at West 158th Street and Morgan Place.

LOOKING AHEAD

The practice will continue to build on its campaign to improve internal and external customer satisfaction by promoting team-building activities and reinforcing positive behaviors. Center staff will also monitor quality assurance activities to ensure compliance.
FORT WASHINGTON GERIATRIC PRACTICE

Overview
The Fort Washington Geriatric Practice cares for older adults who reside in the Washington Heights and Inwood sections of Northern Manhattan, Queens, and portions of the Bronx. The practice provides services in geriatric medicine, dentistry, psychiatry, podiatry, gynecology, social services, nutrition, as well as nursing intervention services.

Serving Our Patients
Patients range in age from 60 to over 90 years, many of whom are self-referred or referred to the practice from the Emergency Department of NewYork-Presbyterian Hospital and the UrgiCare Center. In 2006, the Fort Washington Geriatric Practice provided care to over 9,000 patient visits, caring for patients with dual Medicare and Medicaid eligibility (74%), with the remaining covered by Medicaid (14%), Medicare (6%), private insurance (3%) and self-pay (3%). Of the total number of patient visits, 70% were for geriatric medicine, followed by social services (12%), podiatry (10%), psychiatry (5%), and gynecology (3%).

Providing Patient-Centered Care
As a specialized geriatric practice, the physicians and staff take a holistic approach to care, focusing not only on the physical well-being of patients, but also their mental health and social services needs as well. The practice is proud of its patient-centered philosophy of “We Put Patients First,” engendering a loyal patient population, as evidenced by a low rate of missed appointments.

Accomplishments
The Fort Washington Geriatric Practice, which recently added adult/geriatric dental care to services offered, is also taking part in the New York City Depression and Diabetes Collaborative to promote best care models for patients with these conditions.

In 2006, based on the Press Ganey Patient Satisfaction Survey, the practice reached the highest overall mean score among the NewYork-Presbyterian/Columbia ACN practices, and was recognized by the Hospital for being the Highest Rated Site. It also received the Star Award three times in 2005 for achieving excellent scores in patient satisfaction.

Looking Ahead
Future initiatives are geared toward increasing patient satisfaction and becoming a Center of Excellence in geriatric care. The practice is evaluating an opportunity to incorporate a broader level of services and programs that are in high demand for the geriatric population, including on-site ophthalmology, cardiology, cardiology testing, densitometry and gastrointestinal testing.
PEDiatric psychiatry service

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Morgan Stanley Children’s Hospital of NewYork-Presbyterian  Margaret McCarthy
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OVERVIEW

The Pediatric Psychiatry Service is one of the major providers of child and adolescent mental health services in Upper Manhattan. Affiliated with Columbia University College of Physicians and Surgeons and the New York State Psychiatric Institute (NYSPI), the Pediatric Psychiatry Service offers diagnostic and therapeutic services to several thousand children and their families annually. In 2006, the service accommodated 33,000 outpatient visits and 1,800 inpatient consultations. Annually, it provides mental health evaluation and treatment to some 3,250 children and adolescents. An extensive range of Hospital and community-based treatment to children with attention deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder; and six specialty clinics:

- **Children’s Anxiety and Depression Clinic** providing psychopharmacological and psychotherapeutic treatments for a broad range of mood and anxiety disorders;
- **Pediatric Consultation and Liaison Clinic**;
- **Disruptive Behaviors Disorders Clinic** providing parent training, and psychopharmacological and psychotherapeutic treatments to children with attention deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder;
- **Neuropsychiatry Clinic** for children with pervasive developmental, psychotic, and seizure disorders;
- **Special Needs Clinic** for children and families affected by HIV and substance abuse; and
- **Infant/Family Service** for young children and their parents.

The Pediatric Psychiatry Service provides mental health services in five local elementary schools. The Mobile Outreach, Referral and Education program offers on-site evaluation, brief stabilization and facilitates referral to mental health services in eight elementary schools and one middle/high school.

SERVING OUR PATIENTS

Patients come to outpatient clinics through a Diagnostic Intake Service that provides psychiatric and psycho-educational evaluation and treatment planning to 400 children and adolescents annually, and the Comprehensive Emergency Service, which provides assessment, stabilization and referral for services to over 1,200 urgent or emergent cases per year.

The Integrated Mental Health Primary Care Program (IMP) provides behavioral health teams to ACN sites to increase community access to behavioral health interventions. In 2006, the IMP was recognized by the U.S. Department of Health and Human Services’ Expert Work Group on Pediatric Subspecialty Capacity and the Maternal and Child Health Bureau as “a superb model of how to build collaborative systems of care.” The IMP program serves as the foundation for a multi-year collaborative research grant received by the Child Psychiatry Department at Columbia University, the Ambulatory Care Network, along with the Departments of Pediatrics and Psychiatry at Morgan Stanley Children’s Hospital. The program expects to see a total of 5,600 patient visits in 2007.

PROVIDING PATIENT-CENTERED CARE

The Pediatric Psychiatry Service provides the highest quality mental health care to children and their families. As one example, Home-Based Crisis Intervention offers immediate clinical services to children and adolescents in order to avoid inpatient hospitalization. The Consultation/Liaison Service provides psychiatric evaluation and treatment to 40 children and adolescents per month admitted as inpatients. In the school-based program, clinicians and case managers work with school personnel to identify children in need of mental health services, providing on-site urgent assessment, referral to community-based services, classroom intervention, and group and individual therapy.

ACCOMPLISHMENTS

The Parent Partners program continues running parent support groups. In 2005, a formal Parent Advisory Board was instituted to provide feedback on quality improvement to clinic leadership. In order to meet the need for expanded access to clinical services and the development of appropriate services for children and adolescents with urgent and emergent mental health problems, the Pediatric Psychiatry Service began providing mental health services in the primary care sites; expanded school-based mental health services; and established the Child and Adolescent Comprehensive Psychiatry Emergency Program. In 2005, the service began an outcome indicators project, working with the NYSPI to select a set of standardized symptom measures for integration into ongoing clinical treatment. In 2006, these outcome indicators went into routine use in the specialty clinics and have been integrated into the electronic medical record to allow for ongoing monitoring of treatment effectiveness.
PERINATAL CENTER (HIGH-RISK OBSTETRICS)

Overview

The Perinatal Center provides comprehensive care to high-risk obstetrics patients, serving a predominantly low-income population. The majority of the women are Hispanic and African-American. Patients are referred from Ambulatory Care Network practices, the Center for Prenatal Pediatrics at NewYork-Presbyterian/Columbia, St. Barnabas Hospital, Maternity Infant Care (MIC), Morris Heights Health Center in the Bronx, as well as other hospitals and community-based health clinics.

Serving Our Patients

In 2006, the Perinatal Center provided 5,490 patient consultations. The center offers high-risk obstetrics services, as well as nutrition programs, diabetes education and counseling, HIV testing and counseling, mental health services, and social services. Consultations in cardiology and anesthesiology are also available.

The center also provides the following diagnostic tests and procedures:
• EKG
• blood glucose monitoring
• peak flow measurements
• O2 saturation in the blood
• urinary catheterization specimens
• phlebotomy services
• dressing changes
• bilateral tubal ligation
• medication administration

Ultrasound and non-stress testing are also available through the Ultrasound Department. Patients are referred to subspecialty clinics, as necessary.

Providing Patient-Centered Care

Physicians at the Perinatal Center have expertise in Maternal-Fetal Medicine, and provide highly specialized care in the following areas:
• Multiple Gestations — care includes aneuploidy screening for abnormal number of chromosomes, ultrasounds to document growth and cervical length, and close monitoring of potential complications;
• Genetics/Fetal Anomalies — all patients with anomalies detected by ultrasound are referred to the Perinatal Center for subsequent prenatal care;
• Diabetes — care for pregnant women with gestational and pre-gestational diabetes that includes fetal echocardiograms, fetal ultrasounds for anomalies, management of maternal diabetes and any complications that arise, as well as group teaching by nursing staff. A registered dietitian prepares dietary recommendations and individualized meal plans for patients, who are closely monitored throughout their pregnancy;
• Preterm Birth/Poor Pregnancy Outcome — physicians provide a special clinic session for patients who have had a history of poor pregnancy outcomes to help prevent reoccurrence;
• Sloane Medical Clinic — for pregnant women with co-existing medical problems other than diabetes. In addition to a Maternal-Fetal Medicine specialist, a cardiologist, anesthesiologist, and psychiatrist are available for consultations.

In addition to offering a comprehensive clinical program, the Perinatal Center participates in a robust research program to further improve care and outcomes for high-risk obstetrics patients.

Accomplishments

The Perinatal Center has developed a number of quality and performance improvement initiatives. Indicators centered on informing patients of delays and sensitivity to their needs are targeted for improvement. As part of efforts to promote patient-centered care, the center has created clinic orientation materials and a brochure; conducts patient orientation sessions upon initial visit; and provides a hospitality cart with refreshments in the clinic waiting area.

The Perinatal Center has successfully completed the JCAHO and PCAP surveys. In addition, staff are working to streamline the consultation process from outlying clinics.

Looking Ahead

The Perinatal Center will continue building on patient-centered care initiatives to improve patient satisfaction by promoting team-building activities and reinforcing positive behaviors. Center staff will also closely monitor quality assurance activities to ensure compliance.
OVERVIEW
The Charles B. Rangel Community Health Center provides primary care to a largely Hispanic and African-American community in the Upper West Side of Manhattan, as well as to residents from the South and West Bronx. The practice offers services in internal medicine, pediatrics, psychiatry, nutrition and social work.

The Rangel Center’s care model is patterned after a private physician’s practice. An attending physician is assigned to each patient, who provides care, coordinates any medical, psychiatric and social services, and conducts follow-up in both outpatient and inpatient settings. Specialty services are provided through referral. Patients seen by pediatric residents are also assigned to an attending physician. The center participates in the New York City Department of Health diabetes initiative.

SERVING OUR PATIENTS
From 2000 to 2005, patient volume at the Rangel Center increased from 10,971 visits to 13,349, and in 2006, the center realized 696 new patients. Care is delivered to patients with Medicaid (75%), as well as those with Medicare, self-pay and commercial insurance.

PROVIDING PATIENT-CENTERED CARE
The Rangel Center launched a number of patient care improvement initiatives in the treatment of diabetes. These include the creation of a registry of patients, the development of health educational materials and classes, and outreach to the 135th Street Senior Center and the Riverbank State Park facility.

The Rangel Center continues to place a strong emphasis on medical resident education to further enhance care given to pediatric patients. In internal medicine, the center has initiated a registry of obese adults as the beginning of a treatment and study program in obesity. The center has also begun a domestic violence counseling program for women and children, made possible by a grant from the Department of Justice.

ACCOMPLISHMENTS
The Rangel Center has seen continued growth in patient visits, as well as community reputation, while maintaining existing staff levels and facility size. For the sixth straight year, the center has marked a steady increase in patient volume and achieved a milestone of 1,300 patient visits per month.

Patient satisfaction measured by the Press Ganey Survey demonstrates an overall quality of care score of 80.8. Patient focus groups reinforced the center’s high rankings, giving uniformly high marks to medical, nursing and support staff in delivery of patient care.

LOOKING AHEAD
Ongoing initiatives include improvement of the registration system and structure of patient visits, with assistance from the Primary Care Development Corporation, and other process redesign efforts. The center will also implement the Televox reminder service and begin to use the ACN Call Center for appointment scheduling.

Plans call for expansion of the first floor to accommodate a Federally funded domestic violence counseling program, as well as all non-medical services, creating additional exam room capacity on the second floor. The center will also expand clinic operating hours in order to better meet patient needs and help to reach the goal of 1,800 patient visits per month.

Clinical enhancements will include the development of group sessions and educational opportunities in the areas of diabetes, asthma, obesity, hypertension, nutrition, family and adolescent counseling, and self-defense. In addition, the center will launch a quarterly patient newsletter.
SPECIALTY CLINICS

Specialty Clinics
NewYork-Presbyterian Hospital/
Columbia University Medical Center

Vanderbilt Clinic, 3rd floor
622 West 168th Street
New York, NY 10032
(212) 305-9280 / (212) 305-8275 (fax)

Eye Clinic/Eye Institute
710 West 168th Street
New York, NY 10032
(212) 342-1190 / (212) 305-4863 (fax)

Dermatology/Herbert Irving Pavilion
161 Fort Washington Avenue, 12th floor
New York, NY 10032
(212) 305-5293 / (212) 795-1859 (fax)

OVERVIEW

NewYork-Presbyterian Hospital/Columbia University Medical Center Specialty Clinics serve an ethnically diverse patient population encompassing the communities of Northern Manhattan, including Washington Heights, Inwood and Harlem, as well as Riverdale. Patients also come from Queens, Brooklyn and New Jersey. A staff of skilled and experienced physicians and health care professionals — many of whom are bilingual — provide specialty care in the following areas: allergy, dermatology, eye diagnostic services, neurology, neurosurgery, ophthalmology, orthopedic surgery, otolaryngology, pulmonary medicine, rehabilitation medicine, surgery and urology. Between 150 and 200 physicians supervise upwards of 200 housestaff.

SERVING OUR PATIENTS

Patient volume trends fluctuate among clinical services; however, in total the Specialty Clinics provided care to 64,525 patient visits in 2006, representing 60.7% Hispanic, 15.9% African-American, as well as Asian, Black-Hispanic, and Caucasian patients. The Eye Clinic experienced a significant increase in visits with 3,000 additional consults over the previous year.

In 2006, the Specialty Clinics provided care for patients with Medicaid managed care (50%), Medicare (30%), Medicaid fee-for-service (10%), self-pay (7%), and commercial insurance (3%). Specialty and subspecialty services are provided in the following NewYork-Presbyterian/Columbia locations:

- Vanderbilt, 3rd floor — adult allergy; orthopedic surgery (hand, lower extremity, orthopedic trauma, shoulder/sports medicine, spine); rehabilitation medicine (adult general, amputee, brace, pediatric general, spinal injury, wheelchair); pediatric neurology;
- Vanderbilt, 10th floor — adult surgery (breast, general surgery, colorectal, upper gastrointestinal, vascular); adult neurology (headache, epilepsy, neurosurgery); adult pulmonary medicine; adult otolaryngology (head and neck); pediatric otolaryngology; pediatric urology; adult urology;
- Eye Institute — ophthalmology; contact lens/low vision; cornea and external disease; eye muscle; general adult; glaucoma; neuro-ophthalmology; orbital and plastic; pediatrics; retina; uveitis; diagnostic services (visual field testing);

- Neurological Institute — movement disorders;
- Herbert Irving Pavilion, 12th floor — dermatology (adult and pediatrics);
- Morgan Stanley Children’s Hospital — pediatric orthopedics (8th floor); pediatric cardiology (2nd floor).

PROVIDING PATIENT-CENTERED CARE

The Specialty Clinics strive to develop innovative strategies and programs to improve patient satisfaction and delivery of care. In one effort to streamline care processes, surgical specialties are segmented by subspecialties to enhance quality of care and to assure that patients are seen by the appropriate specialist. Staff have also partnered with radiology services to find ways to reduce delays between a patient getting X-rays and evaluation by an orthopedist. Improving the ambience of the reception rooms on Vanderbilt 10 and the renovations of the reception areas in rehabilitation and orthopedics have also added to a more comfortable and pleasant care environment. Other enhancements include the addition of recreation volunteers who offer an afternoon therapeutic playtime on Vanderbilt 3 for children seen in pediatric neurology.

ACCOMPLISHMENTS

The Specialty Clinics have made improvements in telephone response time. Staff also make telephone appointment reminders, helping to reduce the no-show rate.

Patient-centered care and improvement projects of note in 2005/2006 included: a focus on data collection for the Six Sigma project that examined patient flow and factors affecting the time it takes for a patient to be seen in the Eye Clinic; a chart request and availability project initiated on Vanderbilt 10 and on the ophthalmology service; ongoing efforts to improve communication with patients and their families, including installation of an updated telephone system in all specialty areas; and installation of new televisions in reception rooms.

Renovations of the Vanderbilt 10 and reception rooms on the 3rd floor were completed. In addition, computers and new phones have been installed in all exam rooms.

LOOKING AHEAD

The Specialty Clinics will continue to use data collected from the Six Sigma project to enhance patient care, focus on improving staff satisfaction, and increase volume of patient visits.
URGICARE CENTER

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OVERVIEW

The UrgiCare Center provides non-emergent care for walk-in patients from the Washington Heights and Inwood communities of Northern Manhattan, as well as portions of the Bronx, and serves as the gateway to NewYork-Presbyterian Hospital/Columbia University Medical Center primary care sites. The center also treats patients who are referred from other Ambulatory Care Network practices and local physicians’ offices. A dedicated minivan service transports patients between the NewYork-Presbyterian/Columbia Emergency Department, Milstein Pavilion, Presbyterian Hospital building and Vanderbilt Clinic and the UrgiCare Center.

Minor surgical procedures are performed at the UrgiCare Center. Unstable or critically ill patients are transferred immediately to the Emergency Department of NewYork-Presbyterian Hospital/Columbia University Medical Center.

SERVING OUR PATIENTS

In 2006, the UrgiCare Center provided care to 12,744 patient visits. The UrgiCare Center cares for patients with Medicaid managed care (38%), as well as Medicaid fee-for-service (16%), Medicare (10%), commercial insurance (17%), and self-pay (19%). Often, patients who come to the UrgiCare Center learn for the first time of the opportunity to enroll in a managed care plan.

PROVIDING PATIENT-CENTERED CARE

UrgiCare Center staff are committed to providing the highest quality care to patients and their families. Additional services include HIV testing and counseling. Free flu vaccinations are also provided.

The center is equipped with the most advanced technologies, including a PACS digital radiology system. A high-resolution monitor allows immediate access to imaging from the UrgiCare Center, as well as from NewYork-Presbyterian Hospital.

ACCOMPLISHMENTS

In 2005-2006, the full implementation of the PACS digital imaging system was completed. The on-site laboratory was inspected and upgraded to full level point of care status. Nursing staff instituted an improved fail-safe mechanism for lab data callbacks and X-ray follow-up.

Utilizing a fast track model, staff developed triage protocols, encouraged providers to delegate secretarial tasks, employed an online system for making appointments, and modified the registration system. These measures all contributed to a steady reduction in average length of stay (LOS) of 1.8 hours in 2006 (from 2.0 hours in 2003). Walkout rates (patients who leave before being seen by a provider) also decreased from 1.7% of patients in 2004 to 0.7% in 2006.

UrgiCare staff continues to focus on topic-based chart review and provider productivity chart reviews, conducted monthly. Improvement projects emphasizing improved customer satisfaction produced impressive results in telephone etiquette, with 94% employee compliance in 2006.

LOOKING AHEAD

Working with the Director of Community Outreach, center staff will develop and implement a comprehensive marketing plan to increase referrals.

The center will continue to encourage all staff to use creative problem solving to further decrease LOS and to decrease walkouts.

Plans also call for implementation of a teambuilding workshop and the cross-training of ancillary staff within the Audubon practice.

Several goals are paramount: continue to improve patient satisfaction; maintain a pleasing and comfortable environment; expand triage responsibility; and increase the number of patient visits.

In 2006, the UrgiCare Center provided care to 12,744 patient visits. The UrgiCare Center cares for patients with Medicaid managed care (38%), as well as Medicaid fee-for-service (16%), Medicare (10%), commercial insurance (17%), and self-pay (19%). Often, patients who come to the UrgiCare Center learn for the first time of the opportunity to enroll in a managed care plan.

PROVIDING PATIENT-CENTERED CARE

UrgiCare Center staff are committed to providing the highest quality care to patients and their families. Additional services include HIV testing and counseling. Free flu vaccinations are also provided.

The center is equipped with the most advanced technologies, including a PACS digital radiology system. A high-resolution monitor allows immediate access to imaging from the UrgiCare Center, as well as from NewYork-Presbyterian Hospital.
The Washington Heights Family Health Center primarily serves residents in the Washington Heights and Inwood communities of Northern Manhattan, as well as areas of the Bronx. A multidisciplinary clinical practice, the center offers primary and preventive care in internal medicine, pediatrics, OB/Gyn, podiatry, psychiatry (adult and children), as well as child development services, social services, HIV counseling, and nutrition services.

### Serving Our Patients

Between 2003 and 2006, patient volume increased from 33,846 visits to 45,908, with the highest volume in pediatrics (16,431), followed by internal medicine (12,702) and OB/Gyn (10,904). The increased volume for internal medicine reflects additional patients who transferred from the Allen and Farrell practices after the closure of their internal medicine programs.

The center cares for patients with commercial, Medicare and Medicaid plans, with the majority of patients covered by Medicaid (70%).

### Providing Patient-Centered Care

The center provides comprehensive primary care for newborns up to adolescents 18 years of age, including healthy children and those with complex, chronic illness. In addition to diagnostic and treatment services, patients benefit from screening, health promotion, and disease prevention programs, as well as psychiatric assessment and short-term treatment on-site. The center provides 24-hour physician coverage, and coordinates all inpatient and outpatient care needed.

Patient care services include a comprehensive history and physical with follow-up; basic gynecologic care, including Pap screening and family counseling; pre-operative clearance and post-operative follow-up; diabetes education and self-management, nutrition classes, Walking for Health program, and diabetes support group; intensive asthma education; as well as screening for PPD and all adult immunizations.

### Accomplishments

The center enhanced a number of programs, including participating in the New York State Department of Health diabetes initiative; developing its child psychiatry services using a collaborative care model; expanding its Healthy Schools, Healthy Families program to include two additional elementary schools; increasing its injury prevention programs; and expanding domestic violence screening and referrals.

Community programs in pediatrics and internal medicine continued to grow and flourish, with the internal medicine service receiving a Patient-Centered Care Award for its work in promoting the diabetes initiative.

### Looking Ahead

The center is exploring ways to expand access to services, including implementing redesign efforts throughout the practices and extending daily clinic hours.

The center will continue to seek funding opportunities, including the renewal of grants for Healthy Schools, Healthy Families, the Reach Out and Read Program, the Lang Youth Medical Program, and the Community Pediatrics Program.

Plans also call for the development of a pediatric vaccine reminder program; implementation of the Eclipsys electronic medical record system, and the purchase of additional health educational materials, including DVDs for the pediatric and internal medicine reception rooms.
The ACN Practices at NewYork-Presbyterian/Weill Cornell

- Adolescent Development Services Clinic and Adult Services Clinic (Methadone Maintenance Treatment Programs)
- Cornell Internal Medicine Associates (CIMA)
- Hematology/Oncology Treatment Center (Infusion Center) and Pediatric Hematology/Oncology Clinic
- Long Island City Community Practice
- Pediatrics Practice
- Specialty Clinics
- Women’s Health Practice
- Irving Sherwood Wright Medical Center on Aging
The Adolescent Development Services Clinic and Adult Services Clinic serve patients primarily from the midtown, Upper East Side and East Harlem communities. The clinics care for opioid addicted individuals, providing comprehensive treatment services that include psychosocial services, as well as opioid agonist medications, such as methadone and buprenorphine.

During 2006, there were 21,441 visits for medication and treatment services. The majority of patient visits were covered under Medicaid (14,648), followed by Medicare (1,721), and self-pay (5,072).

The clinics provide the following services with a goal toward eliminating heroin or other illicit drug abuse and psychosocial rehabilitation:

- substance abuse counseling
- methadone and buprenorphine medication for heroin addiction
- individual, family and group therapy
- primary medical services
- HIV and hepatitis C testing, counseling and treatment
- psychiatric services
- parenting education
- health education
- referral to specialty clinics for mammography, Pap smear testing, prostate and colon cancer screening, and bone density testing
- referral for vocational and/or educational services
- social services, such as assistance with housing and entitlements

In 2005, the Adolescent Development Services Clinic and the Adult Services Clinic initiated buprenorphine treatment regimens for patients with acute heroin addiction. Treatments for hepatitis C were provided in collaboration with the GI Service.

Responding to patients’ concerns over the wait time to be seen by a physician or staff member, the clinics increased the hours of internists. The clinics also continue to focus on the following quality initiatives:

- measuring outcome indicators of successful treatment, including absence of illicit drugs, employment, educational involvement, and absence of criminality;
- assessing patients for HIV at admission and semi-annually;
- screening for HCV, bone density and prostate problems;
- improving treatment compliance for patients who are diabetic or hypertensive;
- increasing the number of patients for referrals who are unemployed and lack vocational skills; and
- smoking cessation treatment for patients.

The Adolescent Development Services Clinic and the Adult Services Clinic plan to expand research activities relating to biopsychosocial issues that affect patients, as well as expand available services including offering gynecological exams to adolescents.
OVERVIEW

Cornell Internal Medicine Associates (CIMA) is a teaching practice that follows a clinical education model in which attending physicians and residents work together to provide a single level of high quality primary care. It is the primary teaching site for the three-year Internal Medicine residency program. About 135 residents, who are supervised by attending physicians, follow their own panel of patients. CIMA provides medical care to patients from New York City and the metropolitan area, including Long Island, Connecticut and New Jersey, and is committed to serving patients from every social, demographic, and ethnic background and payor source.

CIMA attending physicians also care for their patients when they are admitted to the Hospital and staff the General Medical Consultation Service for the Hospital’s inpatients.

CIMA provides primary internal medicine care, preventive care, preoperative evaluations and general medical consultations. Patients cared for by CIMA physicians in 2006 were most commonly seen for diabetes, a particular clinical area of focus, as well as hypertension, hyperlipidemia, joint or muscle pain syndromes, depression, and for preventive health care. Referrals for consultations were provided most frequently for ophthalmology, dermatology, rehabilitation medicine, gastroenterology and gynecology.

SERVING OUR PATIENTS

Between 2001 and 2006, patient volume increased from 54,353 to 69,931. There was an 18% increase in the number of patients served between 2005 and 2006.

In 2005, CIMA physicians ordered 28,523 specialty consultations, cared for more than 2,900 inpatients (an increase from 1,850 in 2001), and ordered 23,412 diagnostic tests and 123,453 laboratory tests.

CIMA cares for patients with commercial, Medicare and Medicaid plans, with the majority of patients covered by managed care plans (41%) followed by Medicare (25%).

CIMA staff focus on patient-centered care activities such as post-visit telephone calls, visits from pet therapy dogs and sensitivity to patients’ needs.

ACCOMPLISHMENTS

In the clinical arena, CIMA continued its participation in the diabetes collaborative with great success. Psychiatric services are provided in a consult liaison model. The point-of-care testing for the anticoagulation practice, staffed by two nurse practitioners, was expanded.

A practice improvement project was implemented resulting in a near 100% success in on-time orders processing.

In 2005, CIMA also completed renovations of its reception areas and began renovation of exam rooms as part of a project that will continue over the next several years. In addition, each exam room was equipped with its own printer. This allows providers to print prescriptions and informational material while the patient is present, which is helpful for patient education and compliance.

LOOKING AHEAD

CIMA will be converting its electronic medical record from CLIMACS to EPIC, improving its telephone services, incorporating pay-for-performance monitoring of quality and process measures, and continuing with renovations of the physical space.

Over the past decade, CIMA has experienced a volume increase of nearly 180%. To accommodate additional staff and patients, CIMA has reconfigured its current physical space and transferred billing staff to an off-site location. CIMA’s strategic plan is now focused on matching its capacity to provide services with the increasing demand it is experiencing.
HEMATOLOGY/ONCOLOGY TREATMENT CENTER (INFUSION CENTER) AND PEDIATRIC HEMATOLOGY/ONCOLOGY CLINIC

Overview

The Ambulatory Care Network’s Hematology/Oncology Treatment Center cares for adult hematology/oncology patients, as well as patients who need transfusion or infusion services from other specialty areas such as rheumatology, gastroenterology, kidney transplant and others. The center is a hospital-based service with referrals from both Weill Cornell attending physicians and community practitioners.

The Pediatric Hematology/Oncology Clinic provides services to patients with oncology and hematology related illnesses. The clinic is an integrated practice that also provides infusion and transfusion services.

Serving Our Patients

The Adult Infusion Center’s current volume is approximately 14,000 treatments a year for both local and international patients. The Center collaborates with the clinical research program of the Hematology/Oncology practice to support clinical trials. As of June 2006, 54 Infusion Center patients were enrolled in clinical trials, providing treatment alternatives for colon cancer, lymphoma, myeloma, leukemia, prostate cancer, and lung cancer.

The Pediatric Hematology/Oncology Clinic also participates in clinical trials and had approximately 10,000 patient visits in 2006. The evening hemophilia clinic provides services for patients requiring regular transfusions, allowing them to maintain normal work/school schedules.

Providing Patient-Centered Care

Both areas place special emphasis on improving the patients’ experience. Patient-Centered Care Committees meet regularly to identify areas of concern and staff continually solicit feedback from patients regarding their care.

A recent Adult Infusion Center project included developing a patient education welcome packet to introduce patients to the Infusion Center and provide them with information specific to their diagnosis and treatment plan. In addition, the center has installed flat screen televisions at each of the infusion chairs and has incorporated pet therapy.

The Pediatric Hematology/Oncology Clinic has focused its patient-centered care efforts on improving patient education. The staff has collaborated with the Nutrition Department to develop patient education materials for patients and their families to improve their overall nutritional status.

Accomplishments

In 2006, a bi-campus Infusion Center Committee focused on standardizing processes and operations across practices. The goal is to improve communications and processes among the faculty practice, ancillary services, and the Infusion Center.

Looking Ahead

A highlight for the coming year is the planned groundbreaking for new adult space in 2008. The Adult Infusion Center will relocate to this larger space, enabling providers and staff to accommodate increased patient volume, more comfortably care for patients, and ensure privacy and confidentiality during care delivery. Pharmacy space will also expand by 150%. This will dramatically improve turnaround time for mixing chemotherapies. There will also be space allocated for four dedicated fast track chairs to expedite the care of those patients receiving shorter treatments.
OVERVIEW
Located across the 59th Street Bridge, the Long Island City Community Practice primarily cares for Queens residents, including families that have been loyal patients for many years and immigrants new to the neighborhood. Over the years, the practice has grown from a women and children’s health focus to a full-service medical practice that has doubled in size to include programs in adult medicine, pediatrics, obstetrics and gynecology, psychiatry, and HIV care.

SERVING OUR PATIENTS
During 2006, the practice saw 20,000 patient visits, with increases in visits to the adult medicine service. Pediatrics accounted for the largest number of visits (10,187). Residents take an active role in ongoing clinical quality improvement efforts in diabetes and asthma. The practice has begun Phase 2 of the Diabetes Collaborative with the New York City Department of Health. Childhood immunization is also a focus of a quality improvement project.

In the OB/Gyn practice, the Prenatal Care Assistance Program (PCAP) team, consisting of a nurse and nurse practitioner, social worker, dietician, medical technician, and a registrar, continues to explore ways to improve patient satisfaction. During 2005, the practice offered a psychiatrist on site, greatly benefiting patients and providers. A social worker collaborated with the psychiatrist to assist in evaluation, referral and therapy, when appropriate.

PROVIDING PATIENT-CENTERED CARE
Social work services are in high demand, particularly in obstetrics. The social worker is readily available to help patients address numerous issues, including psychiatric needs, early intervention for children who are victims of child abuse and domestic violence, assistance obtaining housing or public assistance, home care, medical transportation and funding for essential medications.

The Pharmacy Assistance Program has been a significant benefit for patients who are uninsured or do not have pharmacy coverage and cannot afford their medications.

The dietician provides nutritional counseling to patients of all ages, including pregnant women, and patients with diabetes, obesity, or hypercholesterolemia, to name a few. The dietician plays a leadership role in the Diabetes Collaborative especially in the areas of patient education and self-management.

A financial counselor assists patients with issues regarding loss of insurance, qualifying or reapplying for insurance coverage, including Child Health Plus, as well as responding to questions or concerns about medical bills.

ACCOMPLISHMENTS
During the past year, the Long Island City Community Practice began participating in Phase II of the Diabetes Collaborative and continues to utilize various tools to assist with improvement in the care of our diabetic patients. These include physician reminders in CLIMACS — the electronic health record — about necessary tests, as well as comprehensive reports on key monitoring measures for the diabetic patient.

Great strides have been made in managing immunization records for Medicaid patients through the use of EZVac and an electronic tracking of immunizations. These efforts have resulted in a significant improvement in the documentation of vaccines administered to children ages six months to three years.

An NIH-funded research study entitled “Motivational Interviewing in Hypertensive African-Americans” is underway to evaluate 190 African-American patients with poorly controlled hypertension. The study seeks to determine whether motivational interviewing is more effective than traditional care in achieving adherence to prescribed antihypertensive medications and blood pressure control.

LOOKING AHEAD
In collaboration with the ACN Quality Improvement Committee, practice staff are working on several clinical improvement projects that address asthma for adults and children, immunization status for children, and diabetic management for adults.

Efforts will continue on monitoring and educating patients about their asthma care. Staff will participate in local health fairs. As in the past, medical residents will lead monthly presentations at the Roosevelt Island Senior Association and will also provide blood pressure screening. A representative from the Food Stamp program will assist patients to gain access to this program. Through a partnership with In Motion Inc., Project Poder Latina, free legal counsel will also be available.
The Pediatrics Practice provides a comprehensive program of general pediatrics care for the newborn through the adolescent age of 20, as well as specialty care for this age group. The practice is an academic teaching center where patients will see the same physician for their well care, providing continuity and a comfort level benefiting both child and parent. Resident physicians are supervised by pediatric attending faculty physicians. The practice provides a multidisciplinary team approach during each child's visit with an attending physician, a resident physician, a nurse, a med surg tech and a registrar.

The practice focuses on patient education and emphasizes increased awareness in the area of healthy lifestyles, decreasing childhood obesity, increasing vaccine compliance and treating asthma. The practice is not limited to well child and sick child visits, and patients will benefit further from the 15 areas of specialty care the practice offers. Additionally, the Pediatric Center for Special Studies provides care for children infected with HIV and provides services and support for their siblings, parents and other caregivers.

SERVING OUR PATIENTS

During 2006, 15,000 patient visits were seen in the primary care practice. The practice’s Center for Special Studies provides care to patients with HIV. In 2006, they saw 1,000 patient visits. The Pediatrics Practice has an extensive specialty care program that includes allergy and pulmonary care, dermatology, endocrinology, gastroenterology, infectious diseases, neonatal care and follow-up for premature infants, neurology and renal care, as well as programs in child development, a child protection team, education and treatment of obesity and diabetes, and an early intervention program.

ACCOMPLISHMENTS

During 2005, the practice received a Patient-Centered Care Award for Teamwork and improvement in five patient satisfaction indicators. The Pediatric Center for Special Studies received a Ryan White Grant funding for three years and the Primary and Urgent Care Practice received a $1,000 grant from the Women’s Auxiliary for a Summer Fun Initiative.

The Pediatric Center for Special Studies developed and initiated two new encounter forms for HIV infected and HIV affected Clinic services. The Primary and Urgent Care Practice and Pediatric Center for Special Studies successfully converted from traditional Pap smear testing to thin prep Pap smear testing.

The Healthy Schools, Healthy Families Program expanded to two schools in East Harlem. The goal of the program is to create a climate of healthy lifestyles for these school children and their families, at school and at home. The practice successfully implemented an electronic medical record system.

Two new specialty clinics, Pediatric Endocrine and Diabetes Clinics, were opened. The Volunteers of Legal Services (VOLS) program was developed for parents and guardians of patients with legal issues. Volunteer attorneys are available in the clinic once a month to advise parents and guardians. The Summer Fun Initiative Program educates parents and children about summer activity programs with the intent to prevent and/or help treat childhood obesity.

The Big Buddies Program is ongoing and serves children aged 8 to 15, often from economically disadvantaged or single parent homes, identified through the Pediatrics Clinic. Weill Cornell Medical College students partner with these children, offering mentorship and friendship. The Hungry Red Planet project is a computer program that will be available for use by patients in the reception area. It teaches patients about healthy eating habits, exercise and healthy choices to help prevent childhood obesity. In addition, a team was organized to educate parents and guardians on the use of car seats.

In the Center for Special Studies, the Outreach Director continues to form linkage agreements and contracts with community agencies to provide HIV testing and counseling to at-risk adolescents in New York City. The center provides an Adolescent Outreach/HIV Prevention clinic one evening per week. In addition, the center began Life Skills Group workshops — a program developed to helping adolescents with such life skills as applying to colleges, applying for jobs, money management and understanding housing options.

LOOKING AHEAD

The Pediatrics Practice plans to add another session per week in the pediatric pulmonary and neurology clinics and to develop a pulmonary function lab in collaboration with NewYork-Presbyterian Hospital/Weill Cornell Medical Center.

There will be increased focus on improving the practice in regulatory readiness, patient satisfaction and service, maximizing revenue and managing expenses. The practice is looking to improve nursing standards, reorganize nursing responsibilities, and develop a new focus on educational development of all staff.
SPECIALTY CLINICS

Specialty Clinics
NewYork-Presbyterian Hospital/
Weill Cornell Medical Center
525 East 68th Street
New York, NY 10065
(212) 746-5527
(212) 746-8202 (fax)

Naomi Ramdin
Practice Administrator
nar9027@nyp.org

OVERVIEW
The Specialty Clinics serve patients of all ages from diverse cultural and socioeconomic backgrounds. Patients primarily come from Manhattan, Queens and Brooklyn.

SERVING OUR PATIENTS
Clinical areas of focus for the Specialty Clinics include:

Adult Dental/Oral Surgery
525 East 68th Street-Baker 21
New York, NY 10065
(212) 746-5190 / (212) 746-8494 (fax)

Cardiology
520 East 70th Street-Starr 4
New York, NY 10021
(212) 746-2248 / (212) 746-8451 (fax)

Endocrinology
525 East 68th Street-Baker 20
New York, NY 10065
(212) 746-6285 / (212) 746-8527 (fax)

Neurology
520 East 70th Street-Starr 6
New York, NY 10021
(212) 746-2323 / (212) 746-8742 (fax)

Ophthalmology
520 East 70th Street-Starr 8
New York, NY 10021
(212) 746-2460 / (212) 746-8870 (fax)

Orthopedics
520 East 70th Street-Starr 2
New York, NY 10021
(212) 746-4500 / (212) 746-5298 (fax)

Pediatric Dental
Helmsley Tower 1
505 East 70th Street
New York, NY 10021
(212) 746-5119 / (212) 746-8330 (fax)

Pulmonary
520 East 70th Street-Starr 5
New York, NY 10021
(212) 746-2250 / (212) 746-8808 (fax)

Surgery - General, Breast, Vascular
530 East 70th Street-M014
New York, NY 10021
(212) 746-5383 / (212) 746-5989 (fax)

Urology
520 East 70th Street-Starr 9
New York, NY 10021
(212) 746-5769 / (212) 746-8153 (fax)

In 2006, the Specialty Clinics accommodated 46,215 patient visits. This represents an increase of nearly 3,000 visits over 2005. The greatest number of visits were in ophthalmology (9,400) followed by dental and oral surgery (6,400).

ACCOMPLISHMENTS
During 2005, the Specialty Clinics received JCAHO accreditation and successfully passed the CMS survey. Initiatives focused on improving financial performance, customer service, and documentation management by optimizing registration services across specialty clinics.

New programs, including a pediatric airways service and a movement disorders program have been added to the list of specialty services offered.

The clinics continue to strive for excellence in patient service through increased efforts in the areas of phone etiquette and responsiveness to patient requests and concerns. These efforts have been supported through a formalized cross-training program for registration staff.

LOOKING AHEAD
The Specialty Clinics continue to focus on improving patient satisfaction and service, implementing policies and procedures to ensure organizational readiness, and maximizing revenue and managing expenses.
OVERVIEW

The Women’s Health Practice offers comprehensive obstetrics and gynecology services, as well as specialty care. Resident physicians, supervised by the Weill Cornell OB/Gyn faculty attending physicians, care for their own group of patients throughout their four years in the Women’s Health Practice. The Women’s Health Practice provides a multidisciplinary team approach to each patient’s care. Health care teams include a supervising attending physician, a resident or nurse practitioner, a nurse, a med surg tech and a registrar.

As a PCAP (Prenatal Care Assistance Program) Center, the practice provides free pregnancy testing to all women, comprehensive prenatal care (including free prenatal vitamins and iron), childbirth education classes, hospital and delivery care, postpartum care and health care for the baby up to one year after birth.

SERVING OUR PATIENTS

During 2006, the Women’s Health Practice saw 14,300 patients. Patients are predominately covered by Medicaid and Medicare.

In addition to general obstetrics and gynecological care, the Women’s Health Practice offers specialty care for high-risk obstetrics, gynecological oncology, urogynecology, and reproductive endocrinology. It also offers special programs such as a pelvic support service and the Teen Age Pregnancy and Parenting Program (TAPP).

An OB/Gyn social worker, TAPP social worker, nutritionist, health counselor and financial counselor are available to the Women’s Health Practice to address patients’ dietary, psychosocial and financial needs.

The OB/Gyn visits include comprehensive physical assessments and exams, ultrasound testing, lab work and referrals for other testing and consults, patient education, and follow-up by the nurses and other health care providers.

ACCOMPLISHMENTS

Prenatal intake visits have been initiated for all new OB patients. The practice now provides thin prep Pap smear testing. A Walk-in Clinic staffed by nurse practitioners is available for all patients who need urgent same day care. A Pelvic Support Clinic/Vaginal Surgery Clinic was also established and an HIV rapid testing program was implemented.

The Women’s Health Practice has successfully transitioned to the electronic health record system and all exam rooms have been equipped with computers for this purpose.

In addition, the practice launched a Women In Motion Services to provide volunteer help for women with legal problems.

LOOKING AHEAD

The practice plans to form partnerships with Inwood House and other teen pregnancy community agencies and homes to support the TAPP program. Plans are also underway to develop a lactation clinic and mothers’ room (for breastfeeding) in collaboration with the Pediatrics Practice.

There will be increased focus on improving regulatory readiness, patient satisfaction and service, maximizing revenue and managing expenses, and educational development for staff. The practice is working toward improving nursing standards.
OVERVIEW

The mission of the Irving Sherwood Wright Medical Center on Aging is to provide the highest quality primary medical care in a setting that recognizes and respects the multi-dimensional needs of an aging population. Care is delivered by an interdisciplinary health care team that includes physicians, nurses, practice assistants, a social worker, and a psychiatrist. Team members collaborate to assess patient needs and provide the appropriate services, including referrals to community-based organizations, as required.

SERVING OUR PATIENTS

The Wright Center serves patients from the Upper East Side of Manhattan, as well as the five boroughs and broader metropolitan area. Patients also come from many parts of the world, including Europe, Latin and South America, to seek out geriatric assessments from our well-known geriatricians. In addition to providing primary care and preventive services, The Wright Center has a renowned Geriatric Mental Health Program that addresses psychiatric problems commonly seen in the older adult population, including depression, sleep disorders, anxiety, personality or psychotic disorders, as well as dementia with associated behavioral problems such as wandering, shouting and aggression.

PROVIDING PATIENT-CENTERED CARE

In collaboration with Hospital for Special Surgery, the Wright Center sponsors the Greenberg Academy for Successful Aging. This program offers lectures, workshops, seminars, and other activities for older adults living in the community.

The Wright Center’s Medical House Call Program is an extremely valuable resource for the community, providing primary care for homebound older adults. These patients tend to be over 80 years old, frail, and functionally disabled. Many are homebound for either physical or psychological reasons, or a combination of both.

The Wright Center also serves an important educational function for medical students and fellows in the two-year Geriatric Medicine Fellowship Program, providing exposure to geriatric care in the outpatient setting.

ACCOMPLISHMENTS

The Division of Geriatrics and Gerontology was presented with the John A. Hartford Foundation’s Center of Excellence award to create advanced fellowship training, particularly in research, teaching and program evaluation. The Alzheimer’s Association awarded a grant for the development and testing of a Web-based educational tool for caregivers of individuals with dementia.

A collaborative project with the Department of Public Health is underway to develop electronic tools to assist hospital-based clinicians facilitate the transfer of discharge plans and patient-relevant data to community-based physicians and clinicians in home health care settings.

Another grant is enabling staff to identify medical, psychological and functional factors that are associated with self-neglect and to test the feasibility of “Cornell Scale for Self-Neglect,” a newly developed detection and severity measurement tool.

Staff continue to study the efficacy of a psychosocial screening tool to facilitate identification of psychosocial risk factors in the geriatric population that can impact their medical status.

The ACE Unit (Acute Care of the Elderly) — a model inpatient unit of 17 beds located at NewYork-Presbyterian Hospital/Weill Cornell Medical Center provides continuity of care for Wright Center patients who need hospitalization on a medical unit. Conversely, patients discharged from the ACE unit can obtain primary and follow-up care at the Wright Center from members of the same team who cared for them in the acute care setting.

The ACE Unit also serves as the site of the Yale-inspired HELP Program (Hospital Elder Life Program), which calls on the assistance of volunteers to help minimize adverse effects of hospitalization, such as delirium and functional decline.

In 2006, the Wright Center received the Highest Rated Site award for achieving the highest patient satisfaction in the ACN.

LOOKING AHEAD

The Wright Center is once again offering gynecology specialty consultations. Plans also include conversion to a new electronic medical record, increased nursing support, and a continued focus on increasing patient satisfaction.
Ambulatory Care Network
AT-A-GLANCE

1. Broadway Practice
2. IS 52 School-Based Health Center
3. Women Infants and Children (WIC) Program
4. Ambulatory Nutrition Services
5. Adult Psychiatry Service
6. Center for Community Health and Education
7. Specialty Clinics (NewYork-Presbyterian/Columbia)
8. Perinatal Center
9. Associates in Internal Medicine (AIM)
10. Pediatric Psychiatry Service
11. Fort Washington Geriatric Practice
12. Family Medicine at the Herman “Denny” Farrell, Jr. Community Health Center
13. Charles B. Rangel Community Health Center
14. Thurgood Marshall Academy School-Based Health Center
15. Allen Medical Practice
16. George Washington Educational Campus School-Based Health Center
17. IS 143 School-Based Health Center
18. Washington Heights Family Health Center
19. IS 164 School-Based Health Center
20. Audubon Practice
21. UrgiCare Center
22. IS 156 Bread & Roses High School School-Based Health Center
23. Harlem Children’s Zone Promise Academy School-Based Health Center
24. Irving Sherwood Wright Medical Center on Aging
25. Pediatrics Practice
26. Women’s Health Practice
27. Cornell Internal Medicine Associates (CIMA)
28. Adult Services Clinic
29. Adolescent Development Services Clinic
30. Specialty Clinics (NewYork-Presbyterian/Weill Cornell)
31. Hematology/Oncology Treatment Center
32. Pediatric Hematology/Oncology Clinic
33. Long Island City Community Practice