United Hospital Fund

Shaping New York's Health Care: Information, Philanthropy, Policy

SPRING 2010

Blueprint

In This Issue

A WORD WITH JIM TALLON
The health reform law means urgent business. Far from being lulled by future targets, planning for change must begin now.
PAGE 3

GRANTMAKING
A new study asks immigrants themselves about barriers to obtaining needed health care.
PAGE 4

RECENT GRANTS
The Fund awards $463,000 for seven projects.
INSERT

QUALITY IMPROVEMENT
The first class of clinical quality fellows shows that leadership is the key to change.
PAGE 5

SERVICE HONORED
Outstanding hospital trustees are saluted at the Fund's annual tribute.
PAGE 6

HOSPITAL FINANCES
Academic medical centers lead the city's hospitals financially, but still trail their national counterparts.
PAGE 7

NEW BOARD MEMBERS
Two New York leaders join the Fund's board.
PAGE 7

ON THE CALENDAR
OFF THE PRESS
ON THE WEB
PAGE 8

New Quality Improvement Collaborative Focuses on Family Caregivers

With health care for seriously or chronically ill patients often involving transitions from one facility or care setting to another, patients, health care professionals, and family members too frequently find themselves unsure of what to expect and how to prepare for the next setting. These transitions—from hospital to rehabilitation in a nursing home, or from either of those to home, often with home care agency services—put patients at high risk of rehospitalization and dangerous medication errors—in part because of a lack of coordination and shared knowledge between health care facilities, and between health care professionals and family caregivers, the unseen bedrock of chronic care services.

That's why creating two types of partnerships—among health care providers and between providers and family caregivers—is the goal of the United Hospital Fund's latest initiative, Transitions in Care–Quality Improvement Collaborative, or TC-QuIC. The new initiative focuses on helping providers redesign four key transition steps: identifying and assessing family caregivers' needs and abilities, to closely involve them in crafting a realistic plan of care; preparing and supporting them to carry out the complex tasks required of them; improving the processes that take place on the often hectic day of transition; and creating a feedback loop among providers and family caregivers to measure performance and impact.

TC-QuIC's strategy is built on the principle that improved provider processes can be greatly strengthened by deliberately and thoughtfully involving family caregivers. To that end, participating hospitals, nursing home rehab centers, and home care agencies and hospices will use the informational materials developed by the Fund for its Next Step in Care campaign.

Are you a caregiver?
Do you know someone else who is?
www.nextstepincare.org can help.

"STRUCTURED ENGAGEMENT"

These teams will use the provider-tested materials —guides and checklists for caregivers in English, Spanish, Chinese, and Russian, and assessment tools for providers—available on the Next Step in Care website (www.nextstepincare.org) for "a structured, uniform, thoughtful engagement of family caregivers," explains Carol Levine, director of the Fund's Families and Health Care Project. And as they structure practice changes to work better within each facility, they will also be focusing on coordinating efforts with all the partners in these transitions, she adds. "Change in general isn't easy, and changing health care practice is tougher still,

continued on page 2

New Quality Collaborative

continued from page 1

but that's what this collaborative is committed to doing, given this increasingly critical challenge."

Nowhere is the need for real change more evident than in the issue of medication safety. "The average senior with chronic health conditions is taking nine medications, many with serious side effects and different physiologic responses than in younger patients," notes David Cohen, MD, senior vice president for clinical integration and affiliations at Maimonides Medical Center, and co-chair of the initiative, along with Audrey Weiner, DSW, president and CEO of Jewish Home Lifecare, and Ms. Levine. Medication errors harm some 1.5 million people in the U.S. annually, and are responsible for thousands of deaths. They also are closely related to the rapid rehospitalization of many patients.

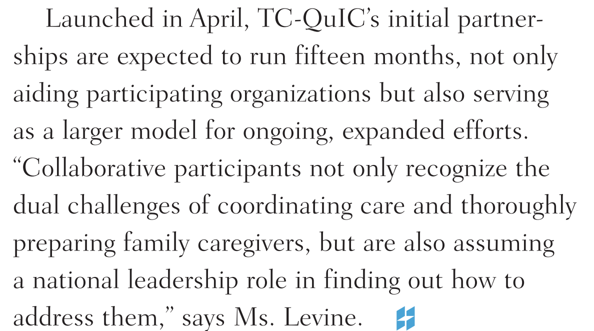
Better medication management often depends on the family caregiver, who on a daily basis manages complex medication regimens, frequently with inadequate preparation. TC-QuIC will test and implement standardized new ways to ensure that information on medications the patient has been using, including non-prescription ones, is passed on accurately to all the partners in transitions, and will provide training and supporting tools to help family caregivers manage new regimens once patients return home.

CROSS-SETTING TEAMWORK

The Collaborative is not just about providers working with caregivers, however. It is also about fostering collaborations among two or more institutions that share patients—looking at the complete transition, both discharge and admission—rather than focusing only on the phase within a single institution. "As they work better within their own facilities, providers will also be able to work better beyond them. A critical change will be to develop processes that 'close the loop,'" says Dr. Weiner, because that will ensure essential communication among providers and family caregivers about what is working better and what needs further improvement.

One team, for example, will tackle the management of patients with congestive heart failure, from the perspectives of hospital, rehab unit, home care services, and even hospice care. Participants hope to simultaneously improve caregiver education, by having a clinical pharmacist discuss medications with each caregiver in the hospital, and by using the Next Step in Care medication management form and other standardized tools in each of the participating facilities.

Launched in April, TC-QuIC's initial partnerships are expected to run fifteen months, not only aiding participating organizations but also serving as a larger model for ongoing, expanded efforts. "Collaborative participants not only recognize the dual challenges of coordinating care and thoroughly preparing family caregivers, but are also assuming a national leadership role in finding out how to address them," says Ms. Levine.



PARTICIPATING PROVIDERS

HOSPITALS

Beth Israel Medical Center, Coney Island Hospital, Franklin Hospital, Lutheran Medical Center, Maimonides Medical Center, Metropolitan Hospital Center, Montefiore Medical Center, New York Community Hospital, New York Hospital Medical Center Queens, NYU Langone Medical Center, The Allen Hospital of NewYork-Presbyterian

NURSING HOMES/REHABILITATION CENTERS

Cobble Hill Health Center, Isabella Geriatric Center, Jewish Home Lifecare-Bronx Division, Jewish Home Lifecare-Manhattan Division, Lutheran-Augustana Skilled Nursing Facility, Orzac Center for Extended Care, Saints Joachim and Anne Nursing and Rehabilitation Center

HOME CARE/HOSPICE AGENCIES

Extended Home Care, First to Care, HHC Health and Home Care, North Shore-LIJ Home Care Network, North Shore-LIJ Hospice Network, Visiting Nurse Service of New York

Blueprint

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The United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York.

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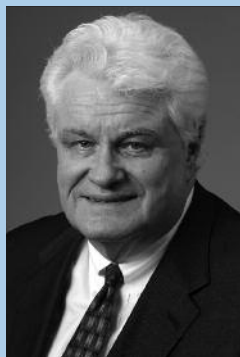
United Hospital Fund

A Word
WITH JIM TALLON

The "Wait-and-See" Majority



The health reform law is a remarkable achievement, in a typically American, incremental sort of way, keeping most of what we have and filling in the gaps. Through Medicaid expansions and subsidized private coverage, millions will gain insurance. Beginning with changes in Medicare, new approaches to payment reform and service coordination will be tested and supported. And, rhetoric aside, the resulting modest cost growth will be fully paid for.

While each day we still hear expressions of anger, detailed polls indicate support for many specific elements of the plan. With time, we hope, those whose invective is fueled by fear and confusion will give way to a "wait-and-see" majority.

Some, of course, will continue the political debate, as is their right. The Left will attack the perceived demon of private insurance. The Right will attack its own bogeyman, government. The challenge to the health care crowd is not to silence the political debate, but rather to focus on the real expectations of that wait-and-see camp.

A THREEFOLD CHALLENGE

That will clearly be hard work, beginning with the law's expansion of insurance coverage. In states with historically low public benefit levels, Medicaid expansions will represent a culture change not unlike that of the civil rights movement. Even here in New York, with higher eligibility standards, almost a million people eligible for public insurance are not enrolled. The insurance exchanges that will be crafted will have to reflect our myriad regional insurance markets and coordinate the various forms of coverage available. But at least New York understands the roadmap.

A second, uncharted dimension of health reform deals with limiting cost growth and improving quality, despite unrelenting financial, political, and institutional pressures. To the wait-and-see majority, most of whom already have coverage, the real test will be whether health reform can "bend the cost curve" while maintaining or improving the quality of services—the "value, not volume" mantra.

This is urgent business. Far from being lulled by future targets, planning for change must begin now.

Third, there is an emerging vision of "high-performance health care," encompassing strengthened primary care; improved coordination of services; a shift from payments for individual services to bundled, even capitated, payments; linkage of all encounters through electronic records; and better engagement of patients in maintaining their health and understanding their care—in a nutshell, changing how we deliver care and changing how we pay for it.

WHERE DO WE GO FROM HERE?

Three themes also frame any strategy for the future. First, this is urgent business. Cost pressures are real and unrelenting. When temporary federal Medicaid support ends in 2011, state budget crises will intensify. Businesses face annual premium growth, still in a soft economy. Public support for reform remains uncertain. Far from being lulled by stated reform opportunities and future targets, planning for change needs to begin now.

Second, while high performance can be achieved in individual parts of the system, the components have to connect in new and different ways, and performance must be defined across them. Primary care can be improved but it needs seamless connection, when necessary, to specialty care. Inappropriate emergency room care can be deflected but not when hospitals view the ER as a portal for admissions. Reducing readmissions requires coordination between hospitals and nursing homes or home care, and the involvement of patients and their families. Financial transactions have to support intended outcomes.

Third, we need to define a new locus of activity, somewhere between statewide planning and local neighborhood concerns. Payers, providers, patient representatives, and government officials must work out new arrangements at a regional level, whether that's defined, variously, as one county or several, New York City, or even an individual borough.

The tasks are daunting, but there's real opportunity. Literally dozens of strategic conversations are taking place among providers. State and federal financial support for health information technology expansion has created new capacity for coordination, and doctors and hospitals are in the discussion as well.

A senior business executive once said to me, "Stop telling me about the problem. Show me some solutions." For the wait-and-see majority change will not come easily. But health reform provides an opportunity for a fundamental shift in how we provide and pay for care—a strong start on the road to solutions.

GRANTMAKING

Focusing on Immigrants' Insurance Needs

When Evgenia's gynecologist told her that she had several abnormal test results and would need additional tests, she was naturally upset. A Russian immigrant, Evgenia (not her real name) lacked insurance, although she was eligible for public insurance from New York State. So she sought a second opinion—from a man who happened to be repainting her apartment, and who used to be a gynecologist in Russia. He told her the results were normal, given her age.

Evgenia's story—and its implications for thousands of New Yorkers—is far from unique, as shown by a new study on the barriers to immigrants' obtaining health insurance and necessary care, conducted by the New York Immigration Coalition (NYIC), with grant support from the Fund.

While noncitizens make up 12 percent of the state's population, they comprise 29 percent of all uninsured New Yorkers under 65—and some 140,000 of the estimated 800,000 New Yorkers who are uninsured although eligible for a public health insurance program.

WIDESPREAD MISPERCEPTIONS

To better understand the reasons for this troubling lack of coverage, and how to overcome them, the authors of the report went right to the source: immigrants themselves, from the city's Korean, Russian-speaking, and Mexican immigrant communities.

Many of the immigrants interviewed believed that a person must be a citizen to be eligible for any public health insurance. While that's not always the case, that widespread assumption leads to addressing health care needs in less-than-optimal ways—delaying necessary care, or filling prescriptions overseas, or relying on advice from fellow immigrants, former doctors not licensed to practice here.

"Many immigrants avoid seeking care in the U.S. because of cost," says lead author Maysoun Freij, formerly with NYIC and now senior evaluator and researcher at the New York Academy of Medicine. "They are not aware of benefits such as financial assistance or public insurance. And their reliance on informal care here, or on care in other countries, puts them at risk for medical complications."

THE FEAR FACTOR

Why do so many immigrants eligible for public insurance lack it? The study points to numerous administrative, linguistic, and cultural barriers, including fears of creating liability for their immigration sponsors, being denied lawful permanent residency, or being deported. Although many of these concerns have no basis in law, they are pervasive. Even professional health advocates sometimes hesitate to affirm that government offices will honor official policies. As one advocate put it, "I let them know that, technically, it's not going to happen, but... I just wonder."

Many immigrants eligible for public insurance lack coverage and delay necessary care or rely, instead, on informal care.

The study notes several possible steps to increase immigrants' willingness and ability to enroll in public coverage (see box), especially important in the context of health care reform. While the recently enacted legislation provides limited new coverage options for noncitizens, the new law may increase confusion about eligibility, and further increase immigrants' reluctance to enroll. Locally, the New York Immigration Coalition is working to effect change in several ways: at a grass-roots level with community-based organizations that provide services to immigrants, and with city and state policymakers.

GETTING MORE IMMIGRANTS INSURED: STEPS TO CONSIDER

- **OUTREACH:** Increase resources for community-based health advocates who help immigrants navigate the health care system;
- **EDUCATION:** Promote linguistically and culturally appropriate communication about coverage options, and address concerns about enrolling in public health insurance;
- **PUBLIC POLICY:** Simplify and reduce required documentation for public coverage, create an affordable buy-in option, and allow individuals to purchase full-premium private health insurance regardless of immigration status.

—adapted from the report *Mutual Responsibility*, http://www.uhfnyc.org/publications/880646

Quality Fellows Lead Way in Improving Care

For sixteen early- to mid-career physicians, the past fifteen months have been an immersion in quality improvement and leadership techniques taught by recognized leaders across the metropolitan area—followed by "capstone" projects applying that learning in their own hospitals. The greatest lesson learned? Changing hospital practices to improve the quality of care can be accomplished—without significant investment of funds—through leadership, communication, and scrupulous attention to systematic, team-driven care.

The "students" are members of the first class of the joint United Hospital Fund/Greater New York Hospital Association Clinical Quality Fellowship Program, designed to equip them with the skills to become champions for quality improvement in their institutions. The program focuses on measurably stepping up the quality of patient care by standardizing procedures for specific situations, sustaining those initiatives, and creating a broader culture of care throughout each institution. Training recently began for a second class of fellows.

Each quality fellow worked with an interdisciplinary team to design and implement a capstone project. For example, Suhas Nafday, MD, director of Newborn Services for the Children's Hospital at Montefiore–Weiler Hospital, addressed problems related to very-low-birthweight infants admitted to the neonatal intensive care unit with low body temperatures, by leading the development of a checklist and protocols, improving communication, and coordinating efforts by an interdisciplinary team. His project reduced the percentage of low-temperature babies by about a third; concurrent improvements were shown in related complications, including fewer cases of brain hemorrhage and retinal disease, and even lower mortality.

Speaking of plans to ensure the initiative's sustainability, Dr. Nafday notes that the "back and forth" among staff in developing the checklist "created a sense of ownership." But continuing to hold meetings to ensure that the checklist and protocols become a part of each clinician's daily routine, and "monitoring our numbers…until I can be certain that these efforts are sustainable," are also important, he notes. Having positive results can itself contribute to sustainability.

Formalizing protocols for very-low-birthweight babies was the focus of one quality project.

"All the projects showed measurable outcomes and, clearly, all the fellows really learned how to effectively incorporate team dynamics to bring about change," says Hillary Jalon, project director for the Fund's Quality Strategies Initiative. "While their projects were highly impressive, the real benefit will be their ability to spread the culture of quality throughout their organizations."

Lower Premiums, But Less Value For Ill Insured

The nuances and logistics of health plans can be bewildering, for both employers and beneficiaries. But a growing trend in the way group insurance is structured is making one thing clear: the most common method of keeping premiums from skyrocketing for all is raising the stakes—and costs—for those for whom insurance is most essential.

"Cost sharing—deductibles, copayments, and coinsurance—has for decades been an important tool in the insurance market as a deterrent to overutilization," says Peter Newell, co-director of the Fund's Health Insurance Project, and co-author, with Gorman Actuarial, of *Cost Sharing in New York's Health Insurance Market*. "But increasingly it's being used to help offset annual premium increases. And that's degrading the value of group insurance as a risk-spreading device; those with greater health care needs are bearing the brunt."

The report shows how enrollees' out-of-pocket costs would vary depending on their health care needs and their plans' specifics. Among the report's findings:

- Deductibles affect premiums more than other cost-sharing devices do;
- High deductibles or combinations of cost-sharing devices can reliably produce premium reductions of 50 percent or more;
- Federal health reform could magnify the importance of cost sharing in New York.

Support for the report was provided by the New York State Health Foundation and the New York Community Trust.

TRUSTEE TRIBUTE

Fund Celebrates Hospital Trustees

Saluting the exemplary dedication and service of this year's 38 honorees, more than 700 health care and community leaders, family members, and friends gathered at the Waldorf-Astoria on May 14 for the Fund's 20th annual Tribute to Hospital Trustees. Recipients of the Distinguished Trustee Awards represented the Fund's beneficiary not-for-profit hospitals, New York's municipal hospital system, and seven metro-area hospitals participating in the Fund/Greater New York Hospital Association quality improvement collaboratives.

"New York's health care system was built by hospital trustees. It relies on their ongoing leadership. Our honorees today continue that very important tradition," Fund President Jim Tallon told attendees. "Today's trustees face far more complex challenges than ever before, as health care inexorably changes," he added. But "what will not change is the need to continue developing innovative approaches to our hospitals' missions, as represented here both by our honorees and the quality improvement collaboratives in which many of their hospitals are involved."

Citing the important role of institutional involvement in health care, Mr. Tallon also acknowledged the generosity of the TD Charitable Foundation, which for the fifth consecutive year provided "underwriting" support for the event. The TD grant will help support the Fund's groundbreaking Next Step in Care initiative.

Joining Mr. Tallon in honoring this year's distinguished trustees were luncheon co-chairmen and members of the Fund's board of directors Patricia S. Levinson and Howard P. Milstein. A vice chairman of the Fund, Ms. Levinson is a trustee of Mount Sinai Medical Center, longtime champion of volunteerism, and recipient of the Distinguished Trustee Award in 2001. Mr. Milstein, the chairman, president, and CEO of New York Private Bank & Trust, is a trustee of Weill Cornell Medical College. Greater New York Hospital Association President Ken Raske served as luncheon vice chairman, and GNYHA Ventures President Lee Perlman chaired the luncheon journal.

Patricia Levinson, Jim Tallon, and Howard Milstein.

TD Bank's Greg Braca and Fund Board Chairman J. Barclay Collins II.

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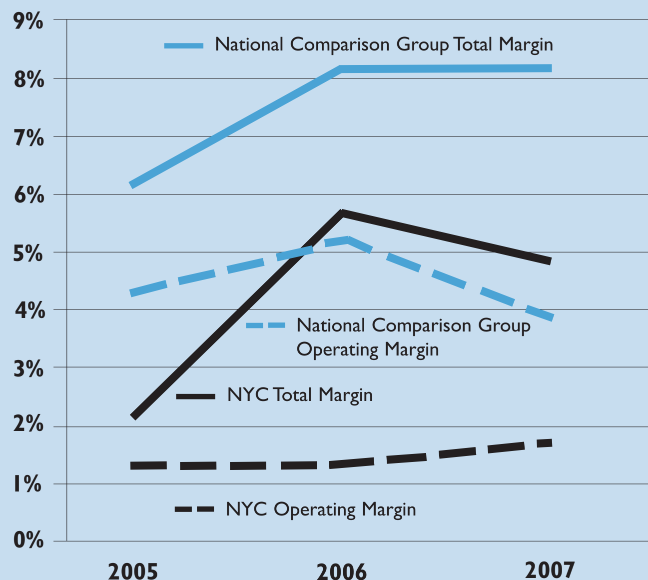
Tough Finances for Academic Medical Centers

There are more academic medical centers in New York City than anywhere else in the U.S. But while having access to so many prestigious hospitals might be a boon for New Yorkers, being in New York is tough on the hospitals themselves, according to a new Fund report.

The Financial Condition of the Leading Academic Medical Centers in New York City and the Nation, by the Fund's Steven Fass, senior financial analyst, and Sean Cavanaugh, director of health care finance, compares the financial performance of four New York City academic medical centers (AMCs) to seventeen leading AMCs elsewhere in the country, drawn from *U.S. News & World Report*'s "Honor Roll of American Hospitals." Though New York City AMCs financially outperform other New York City hospitals, their margins are much lower than those of their national peers.

The report identifies several possible factors in New York AMCs' weaker financial performance. Some, such as longer average length of stay, may be within hospitals' control. But others, more particular to New York City, are not—higher percentages of patients on public insurance, for example, which yields less reimbursement; a less profitable mix of provided services; market competition; and higher operating costs. These factors may constrain hospitals' operating margins.



Why are those important? Better operating margins may, for example, translate into more money available for upgrading medical equipment, salaries, and quality improvement initiatives.

"Financial reimbursement of hospitals is sure to change as the result of public policies at the state and federal levels and in response to commercial insurance practices," says James R. Tallon, Jr., president of the Fund. "This report shows that changes in hospital payment methods, even those affecting our best-performing hospitals, must consider the New York market's unique characteristics."

Fund Adds Two Prominent New Yorkers to Board

Chapman

Francis

Philip Chapman and Paul Francis, two business leaders with strong records of public and community service, have been elected to the Fund's Board of Directors.

Mr. Chapman, the president of the Adler & Co. management organization, has an extensive background in managing private equity and venture capital funds, and has assisted in the startup and management of numerous venture capital companies in the fields of health care and technology. Prior to joining Adler & Co. in 1993, he was a management consultant with Booz Allen & Hamilton in London. Active in community affairs, Mr. Chapman has worked with New York Cares since 2002. He is a graduate of Columbia University and the Columbia Business School.

Mr. Francis is a senior executive in the Financial Products Division of Bloomberg, LP. He joined Bloomberg in 2008, after serving as New York's director of state operations and, previously, director of the state's Division of the Budget. In 2005-2006, Mr. Francis was policy director for Eliot Spitzer's 2006 gubernatorial campaign, and subsequent transition. He spent the previous twenty-five years in the private sector, as managing partner of the Cedar Street Group and in other senior positions. He has served on the boards of numerous companies and not-for-profit organizations, including NYU and its law school. Mr. Francis is a graduate of Yale University and the NYU School of Law.

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ON THE CALENDAR

JULY 1
Next deadline for the Fund's Health Care Improvement Grant proposals.

JULY 14
"A New Era in Medicaid: Federal Reform and Fiscal Uncertainty," Fund conference. CUNY Graduate School and University Center

OCTOBER 4
United Hospital Fund Gala, honoring Kenneth E. Raske with the Health Care Leadership Award, Paula Root and Leon Root, MD, with the Distinguished Community Service Award, and the Sisters of Charity of New York with a Special Tribute. The Waldorf-Astoria

NOVEMBER 3
21st Annual Symposium on Health Care Services in New York: Research and Practice, addressing critical health care delivery issues and current research, practice, and policy advances. CUNY Graduate School and University Center.

OFF THE PRESS

The Big Picture Updated: Current Status of New York's Health Insurance Markets builds on the Fund's comprehensive 2009 report to analyze recent activity in both the private and public spheres.

Health Insurance Coverage in New York, 2006-2008 presents highlights of the most recent data on New York's uninsured, a preview of the Fund's forthcoming annual "chartbook."

New York State and the Emerging Federal Health Care Reform Blueprint examines the potential impact of key federal reform concepts on New York policymaking.

These Fund reports are available online at *www.uhfnyc.org*.

ON THE WEB

WWW.NEXTSTEPINCARE.ORG
The Next Step in Care Campaign's guides and checklists for family caregivers are now available in Chinese and Russian as well as in English and Spanish, an extension of the Campaign's resources to help family caregivers and health care providers better work together.

United Hospital Fund

Shaping New York's Health Care: Information, Philanthropy, Policy

The United Hospital Fund's philanthropy is made possible by its own fundraising and the support of foundations and other organizations.

Recent Grants

Spring 2010

ABOUT THE UNITED HOSPITAL FUND'S GRANTMAKING PROGRAM

The United Hospital Fund awards grants to not-for-profit and public hospitals, and to health care, academic, and public interest organizations, to improve health care in New York City. The Fund supports the development of model projects, sponsors research to analyze systemic problems, and fosters innovative solutions to health care issues. Grants are awarded for a period of one year unless otherwise specified. In November 2009 and February 2010, the Fund awarded seven grants, totaling $463,000.

Expanding Health Insurance Coverage

Coalition of New York State Public Health Plans / Children's Defense Fund - NY $65,000
To improve New York City's online ACCESS NYC public health insurance renewal tool through consumer and facilitated enroller testing and literacy review.

New Yorkers for Accessible Health Coverage $50,000
To analyze the policy implications of federal health reform in New York for people with serious illness and disabilities.

Improving the Quality of Care

IPRO $80,000
To design a scorecard to measure and monitor cost, quality, access, equity, and other dimensions of health system performance at a community level throughout New York State.

The New York Botanical Garden $50,000
To improve the quality of health care for underserved immigrant Latino communities by providing educational materials and training for health care practitioners concerning traditional plant-based ethnomedical practices common in these communities.

New York City Health and Hospitals Corporation $100,000
To continue the Health and Hospitals Corporation initiative to integrate effective palliative care principles and services in its hospitals, and to develop palliative care education and programs for its long-term care and home care divisions.

Continued on reverse

Redesigning Health Care Services

New York University College of Dentistry $53,000
To develop and evaluate a community-clinic referral model that aims to increase access to oral health prevention and treatment services among older adults.

Project HEALTH NY $65,000
To enhance and expand the Family Help Desk program, which helps low-income families meet housing, food, education, and other resource needs through volunteer-based services in health clinics.

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