PCSI Success Stories

Strengthening Program Collaboration and Service Integration in New York City

Using Data to Target Service Integration Activities with Community Providers

In 2010, one of the nation's oldest health departments, located in the largest and one of the most diverse U.S. cities, implemented CDC's Program Collaboration and Service Integration (PCSI) initiative. The New York City Department of Health and Mental Hygiene's (DOHMH) Division of Disease Control began work to increase integration of STD, HIV, viral hepatitis, and tuberculosis services in areas of the city with the greatest burden of multiple diseases.

This effort is one of the primary goals of PCSI. Through the PCSI initiative, a service integration model was developed to assess providers' current practices around STD, HIV, viral hepatitis, and tuberculosis, and assure through technical assistance, that they have useful tools to assist them in testing and treating patients at risk for or with these diseases. PCSI staff formed a service integration workgroup to focus on implementing the service integration model. Staff includes representatives from the disease programs as well as partner programs, including DOHMH's Primary Care Information Project (PCIP).

This service integration model includes three key steps:

1. Using co-occurrence (more than one disease in a population) and co-infection (more than one disease in a single person) data to identify neighborhoods highly impacted by multiple diseases;

2. Establishing partnerships with facilities best positioned to reach impacted populations by working collaboratively across DOHMH programs and with external stakeholders; and

3. Identifying appropriate technical assistance to make it easier for providers to maximize their use of electronic health records (EHR) and adhere to current guidelines and recommendations on testing and treatment.

These steps form the foundation of DOHMH's PCSI service integration activities that are implemented through partnerships with facilities in neighborhoods with high rates of disease.

Service Integration Model

Step 1: Using data to identify neighborhoods highly impacted by STDs, HIV, viral hepatitis, and tuberculosis

Working with the disease programs, neighborhoods in NYC with high rates of disease co-occurrence are identified and illustrated through mapping using GIS software. For example, in one project, the NYC DOHMH Bureau of STD Prevention and Control expressed interest in working with Federally Qualified Health Centers (FQHCs) located in neighborhoods with high rates of chlamydia to strengthen screening. By mapping the surveillance data, several NYC neighborhoods with high rates of chlamydia, HIV, and hepatitis C were identified.

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Step 2: Partnering with facilities best positioned to reach populations impacted by STDs, HIV, viral hepatitis and tuberculosis

FQHCs are important partners for local health departments as they are usually located in areas with high morbidity and high poverty. They provide a range of services, accept Medicaid and Medicare, and are federally funded to provide services to underserved areas or populations. Many FQHCs have implemented electronic health records (EHRs), which can serve as tools to assist providers in identifying patients who need testing or treatment, can be a source of data on their patient population, and a means to evaluate services provided.

To establish partnerships with FQHCs, PCSI staff and internal health department colleagues disseminate information about the service integration project through the New York State membership association of FQHCs. This allows them to more easily identify FQHCs located in neighborhoods with high rates of disease (identified in Step 1) and approach them using already established channels.

Step 3: Identify appropriate technical assistance

The PCSI service integration workgroup works with partner FQHCs to pull baseline data from their EHRs to assess screening practices and compare them to current guidelines and recommendations. Using the EHR data to identify areas for improvement, technical assistance packages are developed to support providers in increasing screening rates, including grand rounds lectures, quick reference guides, modifications to EHRs to prompt screening and consistently capture data, and other tools. At the end of the project, EHR data will be pulled again to determine the impact of the partnership and the technical assistance provided.

FQHC Successes

Rather than DOHMH disease programs approaching FQHCs individually for partnership, the PCSI initiative brought programs together to minimize duplication of efforts and maximize interactions with clinical providers in high morbidity neighborhoods of NYC. Through this collaborative effort, DOHMH is supporting FQHCs in improving the health of their patient populations.