In partnership with our community...

SBH
Health System
BRONX

Community Health Needs Assessment and Community Service Plan

December 2016

SBH Health System

Community Health Needs Assessment and CSP Implementation Strategy 2016

EXECUTIVE SUMMARY

1. The Community Health Needs Assessment and Community Service Plan

The Affordable Care Act requires hospitals to assess and address the health needs of the communities they serve. This Community Health Needs Assessment meets the first component of these requirements, providing a report of the process, methods and results of a comprehensive assessment of the needs of the community served by SBH Health System. The second component encompasses the implementation strategy and Community Service Plan, as required by New York State Public Health Law, which will further discuss the significant health needs of the community, describe the programs and strategies to address these significant health needs, and delineate the metrics to be used to evaluate the impact of these strategies.

SBH Health System's combined Community Health Needs Assessment (CHNA) and Community Service Plan (CSP) was approved by the Board of Trustees on December 14, 2016. The Community Health Needs Assessment (CHNA) and Community Service report was uploaded to the SBH Health System website December 30, 2016.

SBH Health System's Community Commitment

Throughout our 150 year history, SBH has benefited the community by developing health care services that respond to the evolving healthcare needs of the diverse community it serves. As a result, SBH has grown from a small hospital focused on treating chronic diseases into a community-based healthcare network that provides comprehensive inpatient, outpatient and emergency medical, mental health and dental services.

To address the broad and acute health needs of the Bronx communities it serves, SBH delivers a full continuum of services for people of all ages, from infancy to the end of life, through the following entities such as the SBH Ambulatory Care Center, St. Barnabas Hospital, SBH Behavioral Health (formerly Fordham-Tremont Community Mental Health Center), Southern Medical Group, and the SBH Hemodialysis Center as well as a New York Hospice site. The St. Barnabas campus is also home to the 199-bed Bronx Gardens Nursing Home.

SBH Health System also serves as a medical education site for young practitioners who are committed to serving people who live in low-income, medically underserved, urban communities. Every year, SBH trains 280 physicians and offers residency programs in a variety of disciplines, including emergency medicine, internal medicine, pediatrics, family practice, general surgery and (beginning in the fall of 2016) psychiatry. SBH also operates one of the largest hospital-based general practice dental residency programs in the United States. SBH Health System is the primary clinical affiliate of the CUNY School of Medicine at The City College

of New York and is affiliated with the New York College of Osteopathic Medicine and the Albert Einstein School of Medicine.

The population SBH Health System serves is one of the most diverse in the nation. SBH Health System has been an incubator for programs that improve patients' access to culturally appropriate services, and its progressive financial aid policy and robust entitlement enrollment program support access to care for those in need.

SBH Health System's Mission, Vision and Values Statement

SBH Health System's mission, vision and values serve as the guide for pursuing clinical excellence delivering science-driven, patient-centered care and training the next generation of healthcare leaders.

In 2011 the organizational mission, vision and values statement was modified to represent the changing times in the healthcare environment and the institution's unwavering pledge to our community for excellence in healthcare and service. Our mission statement now reads "St. Barnabas Hospital is committed to improving the health of our community and is dedicated to providing compassionate, comprehensive and innovative healthcare in a safe environment where the patient always comes first. All individuals will be provided complete, open and timely access to the highest quality of care, regardless of their ability to pay."

The Core Values of the St. Barnabas Health System are Diversity, Respect, Integrity, Vision, and Excellence (DRIVE). Our DRIVE is set in the focused direction of embodying our **Vision** of being "the hospital of choice in the Bronx, with superior service and innovative programs that meet the diverse needs of our community."

SBH Health System has made significant advancements in achieving its strategic goals and will continue focus its efforts to make a real, measurable difference in the health of populations, and communities it serves.

COMMUNITY HEALTH NEEDS ASSESSMENT

2. Definition and Description of the Community

SBH Health System has identified the Bronx as its primary service area and it is within this geographic area that SBH Health System has distributed its community-based primary care and specialty ambulatory services. SBH's primary service area is comprised of the following Bronx zip codes: 10451, 10453, 10454, 10455, 10457, 10458, 10459, 10460, and 10468. However, given that SBH operates a Level 2 Trauma center and offers high-demand programs such as a Mobile Mammography program, it serves the entire Bronx.

Bronx County is New York City's first borough to have a majority of people of color and it is the only borough with a Latino majority. The Bronx is amongst the youngest counties in New York State with a median age of 33.6 and 25.3% of the population being under the age of 18y. The Bronx has the highest proportion of single-parent headed households in the US (19.2%). Furthermore, with the Bronx has qualified as a Whole County Health Professions Shortage Area (HPSA) by HRSA, since 2008, as almost half (45%) of our population is currently living in a HPSA designated geographic area.

2a. The Population of the Bronx

SBH Health System has identified the Bronx as its primary service area. In 2015, the population of the Bronx was 1.46 million. The Bronx is the nation's poorest urban county; in 2015, according to the American Community Survey, 27.9% of families live in poverty (compared to 16.8% citywide) and the median household income is $35,176 (compared to $51,141 in Brooklyn, $60,422 in Queens, $71,622 in Staten Island and $75,575 in Manhattan). Forty-three percent of Bronx children live below poverty; the ninth highest proportion for any county in the United States, and the highest for any urban county. The Bronx is amongst the youngest counties in New York State, with a median age of 33.6, trailing only Tompkins County and Jefferson County; 25.3% of the population is <18y. The Bronx has the highest proportion of single-parent headed households (19.2%) among counties in the US. In 2015, SBH Health System served approximately 500,000 Bronx residents, or roughly 36% of the total Bronx population.

There are 7.4% of Bronx households on public assistance, twice the percentages in New York City (4.2%) and New York State (3.4%), and 29% of residents receive Supplemental Nutrition Assistance Program and nearly one-half (49.2%) of Bronx residents receive public assistance [includes TANF, Medicaid and SSI benefits]. Over eighty percent of Bronx students are eligible for free/reduced-price meal programs. According to the Bureau of Labor Statistics, the unemployment rate in the Bronx in 2015 was 7.7%, the highest in New York State. In 2015, 71.2% of Bronx residents ages 25 and older have received their high school diploma or GED, though this is substantially lower than citywide (81%) and statewide (86%) attainment rates.

The Bronx is one of the most diverse counties in the nation according to the 2015 American Community Survey, 10.0% was non-Hispanic White, 29.3% non-Hispanic Black, and 55.1% were Hispanic/Latino of any race. More than one-third (35.3%) of Bronx residents in 2015 were born outside of the United States and 51.9% of births among Bronx residents were to foreign-born

mothers in 2014 according to New York City Vital Statistics data. In the Bronx, more people speak a foreign language at home (predominantly Spanish [48.2%]) than speak "only English" (39.9%). The Bronx was New York City's first borough to have a majority of people of color and is the only borough with a Latino majority. Only three counties in the eastern United States have a lower portion of Non-Hispanic whites and only one has a higher proportion of Latinos (Miami-Dade County). Its new immigrants come from diverse corners of the globe (in order of frequency): the Dominican Republic, Jamaica, Mexico, Ecuador, Guyana, Ghana, Honduras, Italy, Trinidad & Tobago, and Bangladesh. Approximately one in five (19%) Bronx residents are not US citizens. As the population in the Bronx is exceptionally diverse, improvements in the health of the general population must necessarily address low-income, ethno/cultural/race based disparities.

2b. Medically Underserved Communities

The Bronx has a long history as a medically designated underserved area or having a shortage of providers. These designations, Medically Underserved Area /Population (MUA) and Healthcare Provider Shortage Area (HPSA) originate from the Health Resources and Services Administration (HRSA).

The MUA designation applied to a neighborhood or collection of census tracts is based on four factors: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The HPSA designation is for a collection of census tracts that has been designated as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care (HRSA).

The Bronx has 18 MUA neighborhoods, with a combined population of 815,000. Most of these neighborhoods are located south of Interstate 95 (I-95), which is where most of the primary care HPSA designations are located. An additional six Bronx neighborhoods may also qualify for MUA designation. The Bronx has 8 Primary Care HPSA designated neighborhoods (Morris Heights, Highbridge, Soundview/West Farms, Morrisania, Tremont, Parkchester/Throgs Neck, Fordham/Norwood, and Hunts Point/Mott Haven), 6 Mental Health HPSAs (West Central Bronx, Hunts Point/Mott Haven, Soundview, Parkchester/Throgs Neck, Kingsbridge/Riverdale, and

Fordham/Norwood), and 3 Dental HPSAs (Central Bronx, Southwest Bronx, and Morris Heights/Fordham).

2c. A Snapshot of Health Disparities in the Bronx

The Bronx has been an epicenter of the asthma, HIV, and drug epidemics and also has excess mortality rates from heart disease, stroke, and diabetes compared to city-wide and national averages. As the Bronx mortality rates remain significantly high, the number of physicians practicing in the Bronx continues to dwindle, earning the county a federal Health Professional Shortage Area (HPSA) designation.

While the Bronx has continued to improve, along with New York City, in the overall reduction of negative health outcomes, the gap between the Bronx and the other boroughs remains and it has maintained its status as the epicenter of the asthma, HIV, and drug epidemics in New York City. The County also continues to demonstrate excess mortality rates from heart disease, stroke, and diabetes compared to citywide and national averages.

Mortality Rates

In 2014, based on data from the New York City Department of Health and Mental Hygiene (NYC DOHMH), the Bronx had the highest age-adjusted all-cause mortality rates (640 per 100,000) in New York City (580 per 100,000 for all of NYC). According to the 2015 County Health Rankings from the Robert Wood Johnson Foundation, the Bronx has the 58th out of 62 highest rates of premature death, losing 7,050 years before 75 per 100,000 compared to 5,457 per 100,000 compared to New York State. The leading causes of death among Bronx residents in 2014 were coronary heart disease (194 per 100,000), cancer (152 per 100,000), influenza & pneumonia (27.3 per 100,000), chronic lower respiratory disease (23.3 per 100,000), and diabetes mellitus (22.8 per 100,000); for each of these causes of death, rates were higher in the Bronx as compared to NYC overall.

Asthma

According to the NYCDOHMH Community Health Survey in 2014, 14.2% of Bronx adult residents reported that they had been previously diagnosed with asthma. The percentage of Bronx adults with asthma was higher than the New York City percentage of 11.3%. According to the NYSDOH, in 2014, the emergency department visits per 100,000 for asthma was 274 per 100,000, more than twice that of NYC overall (134 per 100,000) and 5-times the statewide rate (85 per 100,000). The age-adjusted death rate due to chronic lower respiratory diseases among Bronx residents was 23.3 per 100,000 in 2014; higher than the New York City rate of 20.0.

Diabetes

According to the NYC DOHMH CHS in 2014, 14.0% of adults in the Bronx reported that they had previously been diagnosed with diabetes, compared to 10.7% citywide. From 2002-2014, the prevalence of diabetes among Bronx adults remained higher than the citywide prevalence. According to the NYSDOH, the average (age-adjusted) rate of hospitalizations for short-term complications of diabetes per 10,000 from 2012-2014 was 117 per 100,000 in the Bronx, significantly higher than the New York City rate of 71 and statewide rate of 65 per 100,000. The age-adjusted death rate due to diabetes was 23 per 100,000 Bronx residents in 2014; higher than the New York City rate of 19.9 per 100,000. In both the Bronx and NYC overall, the mortality rate due to diabetes declined.

Obesity

In 2014, based on data from the NYC DOHMH Community Healthy Survey, the Bronx had the highest prevalence of adult obesity (defined as body mass index≥30 kg/m^2); 30.3% compared to 24.7% citywide. The prevalence of obesity increased in the Bronx through 2012, peaking at 31.9%, stabilizing thereafter. Similar to adult obesity, the Bronx has the highest rates of obesity among children, 13.4% vs. 11.8% in the rest of New York City, though like adult obesity, the prevalence appears to be declining (down from 15.3% in 2003).

HIV/AIDS

Based on data from the New York State Department of Health in 2014, the Bronx (36.2 per 100,000) has the second highest incidence (new cases) of HIV, trailing only Manhattan (40.8 per 100,000). Despite this difference, the trends in HIV incidence in the Bronx are encouraging; they have declined approximately 59% from 2002 to 2014, from 87.4 per 100,000 to 36.2 per 100,000.

3. Assessment of Community Health Needs

The process to identify the needs of the community involved the collection of secondary and primary data. Multiple conversations and meetings were convened internally and with external partners, and a thorough review of the data was conducted, all of which will frame the development of the Implementation Strategy. In this Community Health Needs Assessment, these collaborations and partnerships are described.

Multiple data sources were used to support the identification and selection of the priority items which were identified, selected, and reviewed with the partners. A listing and brief summary of the data sources used to complete the secondary data analysis that were used to identify the issues of concern beyond experience and direct observation are included in this report.

The collection of primary data from a representative sample of the Bronx residents was an important element of the development of the Community Health Needs Assessment. The Bronx is an ethnically diverse borough with a population of 1.4 million that despite economic and environmental improvements since the 1970's continues to include numerous groups with difficulties such as low health literacy, limited income, English proficiency, and lack of insurance or insurance knowledge. To capture the voices of various sectors of Bronx community residents and workers from various perspectives, a mixed-methods approach to data collection consisting of coordinated focus groups and participation in conjunction with the New York City Department of Health and Mental Hygiene's Community Consultations process as well as multi-lingual electronic surveying directed through partnering Bronx organizations was used.

As the community residents, the clinical provider community and the community based/faith based/ and non-governmental organization communities had been engaged in a non-typically large number of near simultaneous data collection processes for regional grants, awards and reporting requirements, SBH Health System agreed to co-engage with both the New York City Department of Health and Mental Hygiene's Community Conversation process, as well as the Westchester County Department of Health's online Community Resident and Provider Health Surveys to facilitate the implementation of the primary data collection process for the Community Health Needs Assessment for Bronx County and to assist in the facilitation of these community level connections thereby alleviating additional surveying overload.

Using data collected through these sources, the impact on the community's health by the interventions implemented can be measured and analyzed. As the borough with the smallest non-Hispanic White population in New York City, focusing on disparities is inherent in everything that SBH Health System accomplishes. The priority areas selected and each of the planned interventions focus on specific priority populations and address the ethnic and cultural disparity defined in the indicators for the population served by SBH Health System.

3a. Collaborations/Partnerships/Public Participation

In 2014, SBH Health System was a key participant in the multi-stakeholder application, led by Montefiore, to the Robert Wood Johnson Foundation's Culture of Health Prize which was awarded to the Bronx in 2015 in recognition of the significant collaborative achievements the county has made in health. . However, despite these gains, the Bronx continues to have the lowest ranking in New York State, ranking 62 out of 62 in the 2016 County Health Rankings from the Robert Wood Johnson Foundation. The Culture of Health stakeholder group continues to work collaboratively to address agreed on significant health issues impacting the community, specifically diet and exercise, alcohol and drug use, sexual health, access/quality of care and air and water quality, and has formed a County wide coalition, the #Not 62 Coalition – The

Campaign for a Healthy Bronx. The significant areas are among the identified areas for which both the data and SBH Health System have determined a community need.

SBH Health System also collaborated with the New York City Department of Health and Mental Hygiene's (NYCDOHMH) Community Consultations to prepare this CHNA. We reviewed the Take Care New York 2020 Priorities and identified points of alignment between the New York State priorities, the New York City Goals and the needs identified through the CHNA data review process. In 2016, the data collection process was expanded to include factors related to the social determinants of health, which have been acknowledged to have broad reaching impact on addressing community health outcomes. The identified priorities in the Bronx (not in ranked order) were (1) Obesity, (2) High School Graduation, (3) Smoking, (4) Air Quality and (5) Child Care as the top 5 priorities identified from 8 community meetings. Obesity received, by far, the highest average score, earning an average ranking of 17.5 out of 23, compared to high school graduation (15.1 out of 23), which was second. Obesity was the only priority identified as a top 5 concern in each of the 8 community meetings. SBH Health System attended and participated in 7 Bronx community meetings as follows: East Tremont on 1/5/16; Pelham Parkway on 1/16/16 Hunts Point on 3/5/16; Mott Haven on 3/11/16; and High Bridge on 3/12/16.

SBH Health System has developed additional approaches to the assessment of community needs and health priorities and to the establishment of partnerships with community organizations including working with a variety of community boards (CBs). SBH Health System participates in a variety of organized partnerships and collaboratives, working with other providers in the Bronx, and works extensively with representatives of the affected communities to identify health care needs and determine the appropriate configuration of services.

3b. Description of Process and Methods

The process for preparing the 2016-2018 Community Health Needs Assessment/CSP was an inter-organizational and community collaborative process, initiated with the goal of developing an assessment and strategic plan that was reflective of the needs of the community including the clinical and social determinants of health. The CHNA process was conducted jointly with the Montefiore Medical Center, as the organizations have an overlapping service area in Bronx County. Moreover, as the clinical service provides and social service organizations had been over sampled due to the near simultaneous compilation of reports and state/federal proposals during the period, novel collaborations with other health care institutions and the local departments of health were engaged for the collection of primary data, while secondary data

sources are noted. As such, the assessment, results, and prioritization sections for the two CHNA reports CHNA/CSP are similar.

3b.i Primary Data Collection Process and Methods

The New York State Department of Health required that the Community Health Assessments (CHA) to be conducted through the local Departments of Health were to be carried out in 2016 as opposed to 2017 when they were previously scheduled. In previous years, results from the CHA had been used as an important secondary data element.

Three primary data collection strategies were used to triangulate the identification of community health priorities in the Bronx, including: 1) the 2014 Community Needs Assessment (CNA) conducted by the New York Academy of Medicine (NYAM), 2) the New York City Community Consultations, implemented by the New York City Department of Health and Mental Hygiene, and 3) a survey of Bronx residents implemented in collaboration with the Westchester County Department of Health to support the CSPs/CHNAs for hospitals in Westchester County. The methods and key results of each of these primary data collection activities are summarized below. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

3c. 2014 Community Needs Assessment

SBH Health System participated in the 2014 Bronx-wide Community Needs Assessment (CNA) process as the Bronx County DSRIP, BPHC Lead Organization, conducted by the New York Academy of Medicine on behalf of several Bronx Delivery System Reform Incentive Payment (DSRIP) Participating Provider Systems (PPS). The NYAM CNA included both primary and secondary data collection, with both a review of public datasets as well as community focus groups and surveys.

3d. New York City Community Consultations

Overview & Methods

SBH Health Systems leveraged data collected by the New York City Department of Health & Mental Hygiene (NYC DOHMH) from the Take Care New York 2020 (TCNY 2020) Community Consultations[1]. The Community Consultations were spearheaded by NYC DOHMH to support hospitals in preparing their CHNAs and CSPs.

The Community Consultations were held across New York City, with 8 events held in the Bronx, corresponding roughly to Community Districts with high rates of poor health outcomes. Participants were asked to rank 23 health priorities (e.g., obesity, violence, asthma or smoking) in order of importance to their community.

In order to make the Community Consultations accessible to as many New Yorkers as possible, DOHMH staff with expertise in policy, communications, community engagement and intergovernmental affairs collaboratively selected Consultation sites based on the following criteria:

- Location within, or proximity to, neighborhoods with high rates of poor health outcomes
- Accessibility by subway or, in the case of outer neighborhoods, by other common modes of transportation
- Availability of a free or inexpensive venue meeting the following requirements
- Neutral and welcoming space
- Open during evening and/or weekend hours
- Layout accommodating to small group discussions
- AV equipment

The Community Consultation results aim to inform the development of strategies to improve population health outcomes through a focus on closing health equity gaps. This is why DOHMH prioritized outreach efforts to lay community members living in neighborhoods with high rates of poor health outcomes. DOHMH did this by using internal communication channels and leveraging outreach support from sister agencies, healthcare organizations, nonprofit organizations, city officials (elected and non-elected), and faith-based leaders. DOHMH provided grants to 11 community organizations to support our joint outreach efforts.

Press announcements and print media

- At the launch of the Community Consultations, DOHMH targeted press outreach at large-circulation newspapers in order to raise overall awareness of the process

[1] More details on the TCNY 2020 Community Consultations can be found here: https://www1.nyc.gov/site/doh/health/neighborhood-health/tcny-community-consultations-results.page

- Once the Consultations were ongoing, DOHMH targeted additional press outreach at local outlets, community calendars and blogs serving the neighborhoods where Consultations were being held
- DOHMH did an additional press release at the launch of Online Voting

Social media

- DOHMH promoted each Consultation and Online Voting on our website, and partners promoted select Consultations on their own websites
- DOHMH created a Facebook event page for each Consultation, with some pages created in more than one language
- DOHMH and partners additionally promoted each Consultation and Online Voting through twitter and Facebook posts
- DOHMH paid for sponsored social media promotion targeting social media users based on their location

Dissemination of print materials (flyers, posters, postcards)

- Print materials in multiple languages were hung and disseminated in the venues hosting the Consultations and nearby public spaces
- Print materials were directly handed out to community members by staff and partners who canvassed the neighborhoods near the Consultations

Word-of-mouth

- DOHMH staff and partners spoke directly with local organizations (churches, businesses, schools, housing developments, arts organizations) and residents through street outreach conducted in the days before each Consultation
- DOHMH and partners promoted the Consultations by making announcements at local events, such as church services, school meetings, etc.
- DOHMH and partners sent out emails about the Consultations and Online Voting to lists of additional partners and lay community members

Community consultation outreach targeted participation of lay community members, with special emphasis on those who live in impoverished neighborhoods and are at high risk of poor health. We used a combined model of in-person consultations and online consultation. We received input from 1033 New Yorkers and 207 Bronx residents (20%).
Residents were asked to select their community district of residence (in the paper ballot at Community Consultations, or in the online survey) and rank a list of indicators provided by

DOHMH in order of importance (where 1 = most important). DOHMH analyzed the results using a simple point system, in which each ranking was assigned a point value from 1-23 (with the indicator ranked 1 receiving 23 points, and the indicator ranked 23 receiving 1 point). The indicators that received the most points from all participants' rankings were identified as top priorities.

Preliminary data published earlier in 2016 identified the top priorities of a given Consultation, by collectively analyzing all of the ballots completed and collected at that in-person Consultation. The final results by community district and borough presented above combine the prioritization done at the in-person consultations and the online survey. In order to identify the top priorities of a given borough, DOHMH collectively analyzed all ballots (in-person and online) on which participants had noted a community district of residence located within that borough.

3e. Community Survey

Methods

The survey was disseminated by the Bronx Partners for Healthy Communities to community based organizations and other Bronx partners such as the Community Affairs Office of the Bronx Borough President, and data were evaluated for those working/residing in the Bronx. The survey was administered from August 2016 through October 2016 using Survey Monkey. Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health.

4. Identification and Prioritization of Community Health Needs

Data Sources and Analytic Notes

Multiple data sources were used to support the identification and selection of the priority items, which were identified, selected, and reviewed with partners.

Secondary Data Collection Process and Methods

A listing and brief summary of the data sources used to complete the secondary data analysis that were used to identify the issues of concern beyond experience and direct observation are listed below.

4a. Listing of Data Sources

i. American Community Survey
ii. New York City Community Health Survey
iii. New York City Youth Behavior Risk Survey
iv. New York State Vital Records Data
v. New York State Statewide Planning and Research Cooperative Systems (SPARCS)
vi. New York State Bureau of HIV/AIDS
vii. New York State Cancer Registry
viii. New York City Community Health Profiles
ix. New York State Prevention Agenda Dashboard

4b. Description of Data Sources

American Community Survey: The American Community Survey (ACS) replaced the Decennial Census as an ongoing survey of the United States population that is available at different geographic scales (e.g., national, state, county, census tract or census block group). ACS is a continuous survey that addresses issues related to demographics, employment, housing, socioeconomic status, and health insurance. In the current report, data from ACS was used to evaluate the percent of families living in poverty, the percent of households that are limited English speaking and the percentage of adults or children with health insurance. For more information on ACS please visit http://www.census.gov/programs-surveys/acs/about.html.

New York City Community Health Survey: The New York City Community Health Survey (CHS) is an annual random digit dial telephone survey of the NYC adult population. CHS is a complex survey that provides a representative sample of NYC residents. Addressing a wide range of topics, in the current report CHS data were used to estimate the percent of adults with a primary care provider, the percent of adults who are obese, the percent of adults who are current smokers, the percent of adults who received a colorectal cancer screening, and the percent of adults getting a flu immunization. For more information about CHS please visit http://www1.nyc.gov/site/doh/data/data-sets/community-health-survey.page.

New York City Youth Behavior Risk Survey: The New York City Youth Behavior Risk Survey (YRBS) is an ongoing collaboration of the New York City Department of Health & Mental Hygiene, the Department of Education and the National Centers for Disease Control and Prevention. Conducted every two years, on odd years, the survey asks a representative sample of New York City high school students (grades 9-12) about their health status and health behaviors. The current report uses data on childhood obesity obtained from NYC YRBS. For more information about YRBS please visit: https://www1.nyc.gov/site/doh/data/data-sets/nyc-youth-risk-behavior-survey.page

New York State Vital Records Data: The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report vital records data were used to examine the percentage of life births that are preterm and the teen pregnancy rate. For more information on the New York State Vital Records please visit: https://www.health.ny.gov/statistics/vital_statistics/

New York State Statewide Planning and Research Cooperative Systems (SPARCS): SPARCS is the primary source of data on ED visits and inpatient hospitalizations at New York State hospitals. All inpatient admissions and ED visits at NYS hospitals are sent to SPARCS and compiled into a master database. SPARCS data was used to estimate the rates of avoidable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, asthma ED visits, hospitalizations for short-term diabetes complications, and hospitalizations for heart attacks. For more information about SPARCS please visit: http://www.health.ny.gov/statistics/sparcs/.

New York State Bureau of HIV/AIDS: Data on HIV incidence (new cases) were obtained from the NYS Bureau of HIV/AIDS, which receives reports of all new HIV diagnoses to NYS residents meeting an established case definition. For more information please visit: https://www.health.ny.gov/diseases/aids/general/statistics/.

New York State Cancer Registry: The New York State Cancer Registry was used to summarize data on new cases of breast cancer, prostate cancer, lung cancer and colorectal cancer. The Cancer Registry receives notice of all cancer diagnoses to NYS residents and classifies the cancers using established definitions. For more information on the New York State Cancer Registry please visit: https://www.health.ny.gov/statistics/cancer/registry/.

New York City Community Health Profiles: The Community Health Profiles are produced by the New York City Department of Health & Mental Hygiene, and summarize a number of contextual, behavioral and health indicators by Community District. The Community Health Profiles are not a database, but rather a collection of data from diverse databases, including the American Community Survey, the NYC Community Health Survey, and SPARCS. For more information please visit: https://www1.nyc.gov/site/doh/data/data-publications/profiles.page

New York State Prevention Agenda Dashboard: An additional resource for data was the New York State Prevention Agenda Dashboard, which was produced by the New York State Department of Health and systematically collects data for the entire state and for each county for dozens of health indicators that align with the New York State Prevention Agenda. Like the Community Health Profiles, the Prevention Agenda Dashboard is not a single database, but rather a compilation of diverse databases. For more information please see: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

5. Measures and Identified Resources to Meet Identified Needs

Internal Resources and Measures

SBH Health System is a leader in community health and has a long history of developing innovative approaches to care and tailoring programs to best serve the changing needs of its community. These include, but are not limited to the following: Community Service Plan, Community Services Strategy, Accountable Care Organization, Patient-Centered Medical Home, Disease Management Programs, and Community Outreach. The integration of these innovative approaches serves SBH Health System well in its services to its community.

SBH Health System has a vast portfolio of programs and services that address a majority of the significant community health needs identified in the Community Health Needs Assessment. The breadth and depth of the programs and services vary, but each address a need identified in the community.

Across the identified significant priority areas, numerous indicators with associated metrics are described which will be utilized to demonstrate improvements needed to provide evidence of the impact of SBH Health System's efforts in addressing the health needs of its community.

6. External Resources and Linkages

In addition to the multiple resources that have been developed at SBH Health System independently and through partnership with other organizations, there is an extensive set of resources that are available to meet the needs of Bronx residents which cannot be met entirely by SBH Health System programs and services, or that choose to utilize external organizations. Foremost amongst those are the ambulatory care services offered by Union Community Health Center, a local Federally Qualified Health Center. A description follows in the Implementation Plan section of this report.

7. INTRODUCTION TO SBH HEALTH SYSTEM

St. Barnabas Hospital d/b/a SBH Health System (SBH) has served the Bronx since 1866. Throughout its 150 year history, SBH has benefited the community by developing health care services that responded to the evolving healthcare needs of the diverse community it serves. As a result, SBH has grown from a small hospital focused on treating chronic diseases into a community-based healthcare network that provides comprehensive inpatient, outpatient and emergency medical, mental health and dental services.

To address the broad and acute health needs of the Bronx communities it serves, SBH delivers a full continuum of services for people of all ages, from infancy to the end of life, through the following entities with a listing of comprehensive services found in the latter portion of this report:

- St. Barnabas Hospital: A 422 bed acute care hospital and State-designated Level II Trauma Center that is qualified to treat the most critically ill and severely injured patients. Its State-designated Stroke Center and AIDS Center provide much-needed services to Bronx residents. Additional services include medical/surgical, maternity, pediatric, geriatric, behavioral health and emergent care. To better serve its community, St. Barnabas recently completed major improvement projects, adding a Hyperbaric Wound Center, a full-service ambulatory surgery center, a state-of-the-art operating suite, an infusion center, a Center for Sleep Medicine and a Hospice. It is also home to a federally designated Community Center of Excellence in Women's Health. The Hospital operates a Mobile Mammography program that delivers breast cancer screening to communities across the Bronx.

- SBH Ambulatory Care Center: SBH is a major provider of ambulatory care services, with more than 400,000 outpatient visits annually. Its primary care physicians, specialists and subspecialists offer a full scope of healthcare services to meet our patients' changing healthcare needs. The Center has achieved designation as a Level III NCQA Patient-Centered Medical Home (2014 standards), which means that our patients benefit from the newest and most effective models of care available.

- SBH Behavioral Health (formerly Fordham-Tremont Community Mental Health Center): One of the largest providers of mental health services in the Bronx, SBH Behavioral Health provides vital services through various programs designed to support and meet the mental health needs of adults, teenagers and children in the borough. SBH's highly trained staff handles more than 92,000 visits annually.

- Southern Medical Group: A satellite of SBH Health System, Southern Medical Group offers adults and children living in the South Bronx community known as The Hub easy access to quality primary and specialty healthcare. The facility offers co-located mental health services provided by SBH Behavioral Health. This arrangement makes a full range of mental health diagnostic and treatment modalities and support services immediately accessible to community residents.

- SBH Hemodialysis Center: Bronx residents suffering from end-stage kidney disease can receive dialysis treatment at SBH's Hemodialysis Center, a state-of-the-art facility that delivers the highest quality treatment available. Dialysis patients benefit from the coordinated teamwork of a highly trained bilingual staff that includes an on-site medical director, kidney specialists (nephrologists), nutritionists, social workers, dialysis techs, and nurses with special certification in nephrology.

Medical Education: SBH Health System also serves as a medical education site for young practitioners who are committed to serving people who live in low-income, medically underserved, urban communities. Every year, SBH trains 280 physicians and offers residency programs in a variety of disciplines, including emergency medicine, internal medicine, pediatrics, family practice, general surgery and (beginning in the fall of 2016) psychiatry. SBH also operates one of the largest hospital-based general practice dental residency programs in the United States. SBH Health System is the primary clinical affiliate of the CUNY School of Medicine at The City College of New York and is affiliated with the New York College of Osteopathic Medicine and the Albert Einstein School of Medicine. It is accredited by the Joint Commission.

Population Health: SBH Health System strives to be creative in its approach to care in order to benefit the Bronx communities it serves. Presently, it is transforming how it delivers care by shifting away from the traditional inpatient setting to ambulatory settings that have been found to better serve patients at a lower cost. This transformation includes improved ED case management, an increased focus on care transitions and shifting resources to a more appropriate level of care. As a result it inpatient discharges have decreased profoundly during the past several years. SBH has also assumed a leadership role in New York's Delivery System Reform Incentive Payment (DSRIP) program, a five-year project that seeks to fundamentally restructure the delivery of health care across the state. SBH is the lead partner in the Bronx Partners for Healthy Communities, a coalition of more than 200 Bronx-based providers (with 35,000 employees) and organizations that are working together to implement new approaches

to care delivery, which are designed to increase patient access and improve health outcomes for Bronx residents.

St. Barnabas Hospital's long-standing commitment to the community covers 150 years since the hospital first opened its doors as the Home for the Incurables. This commitment has expanded and evolved through considerable thought and care in considering our communities' most pressing health needs. We examine these needs through periodic reviews and for this year have engaged in a Community Health Needs Assessment (CHNA) as well as an implementation strategy within the CSP. This recent assessment was completed by teams comprised of SBH staff, community leaders and other local stakeholders. It includes quantitative and qualitative data that guide both our community benefit and strategic planning.

NEW YORK STATE HEALTH IMPROVEMENT PLAN – IMPLEMENTATION CSP

8. Collaborations/ Partnerships/Public Participation

This report provides information on the individuals, groups and organizations that are participating in the focused Implementation Plan activities that evolve out of the CHNA process. As the CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) review, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. SBH Health System will continue to work with its partners on existing program initiatives.

As previously reported, SBH Health System was a key participant in the multi-stakeholder application to the Robert Wood Johnson Foundation's Culture of Health Prize which was awarded to the Bronx in 2015 in recognition of the significant collaborative achievements the county has made in health. The Culture of Health stakeholder group continues to work collaboratively to address agreed on significant health issues impacting the community, and have formed a County wide coalition, the #Not 62 Coalition – The Campaign for a Healthy Bronx. The significant areas are among the identified areas for which both the data and SBH Health System have determined a community need.

In addition to the county-wide coalition, SBH Health System collaborated with the New York City Department of Health and Mental Hygiene's (NYCDOHMH) Community Consultations to prepare this CHNA. A review of the Take Care New York 2020 Priorities and identified points of alignment between the New York State priorities, the New York City Goals and the needs identified through the CHNA data review process was conducted. In 2016, the data collection process was expanded to include factors related to the Social Determinants of Health, which have been acknowledged to have broad reaching impact on addressing community health outcomes. The identified priorities in the Bronx (not in ranked order) were (1) Obesity, (2) High

School Graduation, (3) Smoking, (4) Air Quality and (5) Child Care were the top 5 priorities identified from 8 community meetings. Obesity received, by far, the highest average score, earning an average ranking of 17.5 out of 23, compared to high school graduation (15.1 out of 23), which was second. Obesity was the only priority identified as a top 5 concern in each of the 8 Bronx community meetings.

In addition to this collaborative input from NYCDOH/MH, SBH Health System worked closely with its communities and ensured that community participation occurred by working with many of the local community boards (CBs). SBH Health System participates in a variety of organized partnerships and collaboratives, working with other providers in the Bronx, and we worked extensively with representatives of the affected communities through these CBs to identify health care needs and determine the appropriate configuration of services. Beyond the formal structure that SBH Health System established to gain input from the communities it serves, the health system participates in a variety of organized partnerships and collaboratives, working with other providers in the Bronx, the NYCDOHMH, community-based organizations in the Bronx and members of the community in planning and developing initiatives aimed at improving the health of the people of the Bronx. SBH Health System has developed additional approaches to the assessment of community needs and health priorities and to the establishment of partnerships with community organizations.

In addition, SBH Health System's Office of Community and Government Affairs has developed a community level approach involving relevant community based organizations interested in the particular health issues being addressed. This provides for a closer alignment between the community level goals of SBH Health System and the organizational goals of the community organizations. This approach is the Community Alliance for Healthcare Awareness [CAHA] which as a community level coalition brings together aspects of the community that may have a significant impact on community health. The CAHA group meets monthly throughout the year and is open to all members of the public whether group, organization or individual.

Lastly, within the formal structure that SBH Health System has established to engage the broad community in the CHNA and implementation strategy is the SBH Community Service Plan workgroup. The hospital leadership is very much aware that in order to effect positive change, health-care leaders continually must prioritize policy issues, develop effective collaborations, and increase diversity. There is a wide breadth of community representation in our hospital's Community Service Plan deliberations and implementation, assessment of community health needs and eventual selection of the hospital's public health priorities. In addition, the workgroup membership includes representation from the office of various local elected officials, hospital trustees and hospital senior management as well as health programs leadership and public health experts.

New members are welcomed into the group on an ongoing basis. Since the last CSP report, one of the newer members to the CSP workgroup has been the DSRIP PPS, Bronx Partners for Healthy Communities, a group that operates in concert with SBH's transformation plan that focuses on improving the consistency and coordination of care to achieve more effective population health management. The CSP workgroup facilitator is a hospital administrator responsible for community affairs and government relations and familiar with the medical service area, hospital services and community benefits. SBH Health Systems CSP workgroup meetings were held throughout 2016 – January 28th, March 24th, May 26th, September 22nd, and October 27th. This CSP and the CHNA represent the collaborative work of a multitude of dedicated people and institutions, organizations and agencies all of whom commit valuable resources to the execution of our three-year plan and serve as members of the Community Service Plan Workgroup.

A full listing of the participants and their affiliations and grouping within the CSP Workgroup is attached as Appendix A. The listing provides information on the individuals, groups and organizations that are participating in the focused implementation plan activities that evolve out of the CHNA process. The CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) report and there is strong alignment between the areas of focus in both documents thus the single document presentation. SBH Health System will continue to work with its partners on existing program initiatives.

9. Identification and Prioritization of Community Health Needs

In order to identify community health needs we conducted an assessment of secondary data, including data from population-based surveys, hospital discharges and numerous other data sources. This information was complemented by the collection of primary data via a community-member and provider-survey.

9a. Secondary Data Analysis

The secondary data evaluation consists of two distinct approaches. First, we used data from the Statewide Planning and Research Cooperative System (SPARCS) to examine the leading causes of hospitalization, avoidable hospitalizations, and ED visits for St Barnabas hospital. Second, we completed an assessment of secondary data for more than 20 core health indicators from several population-based data sources.

9b.Overview of SPARCS Data for SBH Health System

Top 20 Inpatient Diagnoses in 2015

Table 1 summarizes the top 20 inpatient discharges at St Barnabas Hospital in the Bronx, using the most recently available SPARCS data. Because of the transition from ICD-9 to ICD-10 in October 2015 data are presented in two sections, one for October-December 2015, for ICD-10 codes, and one for January-September 2015, for ICD-9 codes.

- For both time periods, single live born vaginal birth was the most common discharge code, followed by septicemia, not otherwise specified.
- Cesarean delivery was the third most common discharge, followed by chest pain and pneumonia organism.
- Other leading diagnoses were COPD with exacerbation, heart failure, syncope, urinary tract infections, kidney failure, myocardial infarction, and conditions related to sickle-cell disorders. Additional discharge codes are described in **Table 1**.

Table 1. Summary of primary discharge diagnosis codes for inpatient discharges at St. Barnabas Hospital in the Bronx in 2015 among Bronx residents.

ICD 10: October-December		*ICD 9: January-September*	
Diagnosis description	*Discharges*	*Diagnosis description*	*Discharges*
Alcohol dependence uncomplicated	200	Other and unspecified alcohol dependence, unspecified	856
Opioid dependence uncomplicated	174	Single liveborn infant delivered vaginally	465
Single liveborn infant delivered vaginally	156	Opioid type dependence, continuous	342
Sepsis organism NOS	111	Septicemia NOS	332
Single liveborn infant delivered by cesarean	71	Chest Pain NEC	226
Pneumonia Organism NOS	69	Single liveborn infant, delivered By Cesarean	218
COPD with exacerbation	65	Pneumonia Organism NOS	215
Syncope & collapse	54	Obstructive chronic bronchitis with (acute) exacerbation	176
Chest Pain NEC	53	Syncope & collapse	162
Post-term pregnancy	35	Other and unspecified alcohol dependence, unspecified	157
Maternal care for scar from previous cesarean delivery	34	Schizoaffective disorder, NOS	151
Alcohol dependence with intoxication uncomplicated	31	Alcohol Withdrawal	133
Acute on chronic systolic heart failure	30	Asthma NOS with Exacerbation	120
Schizoaffective disorder NOS	28	Acute Kidney Failure NOS	114
Paranoid schizophrenia	28	Chronic obstructive asthma with (acute) exacerbation	113
Acute Kidney Failure NOS	27	Leg Cellulitis	108
Alcohol dependence with withdrawal uncomplicated	27	Other and unspecified noninfectious gastroenteritis and colitis	102
Noninfective gastroenteritis & colitis NOS	26	Post term pregnancy, delivered	96
Alcohol dependence with withdrawal NOS	26	Cerebral artery occlusion, unspecified with cerebral infarction	91
Non-ST elevation myocardial infarction	24	Previous cesarean delivery, delivered	89
Acute on chronic diastolic heart failure	24		

Acronyms: NOS = not otherwise specified; NEC = not elsewhere classified

Top 20 Avoidable Inpatient Diagnoses in 2015 at SBH Health System

Table 2. Summary of primary discharge diagnosis codes for ambulatory care sensitive condition discharges at SBH Hospital in the Bronx in 2015 among Bronx residents.

ICD 10: October 2015-December 2015		*ICD 9: January 2015-September 2015*	
Diagnosis description	*Discharges*	*Diagnosis description*	*Discharges*
Chest Pain NEC	327	Chest Pain NEC	1018
Pneumonia Organism NOS	326	Pneumonia Organism NOS	934
COPD w exacerbation	321	Asthma NOS W Exacerbation	691
Syncope & Collapse	258	Acute & Chronic Systolic Heart Failure	663
Acute on chronic systolic heart failure	234	Syncope & Collapse	654
Urinary tract infection site NOS	226	Urinary Tract INF NOS	588
Acute on chronic diastolic heart failure	199	Chronic Obstructive Asthma with Exacerbation	560
Asthma NOS w exacerbation	143	Acute & Chronic Diastolic Heart Failure	553
Chest Pain NOS	121	OCB W Exacerbation	516
Acute bronchiolitis due to respiratory syncytial virus	106	Dehydration	469
Cellulitis left lower limb	98	Asthma W Status asthmaticus	445
Acute bronchiolitis NOS	90	Leg Cellulitis	435
Dehydration	90	Atrial Fibrillation	429
Viral intestinal infection NOS	83	Viral Enteritis NOS	355
Noninfective gastroenteritis & colitis NOS	79	Epilepsy NOS W/O Interactions	285
Asthma NOS w status asthmaticus	74	Colon Diverticulitis	252
Mild persistent asthma w status asthmaticus	73	Non-infective Gastroenteritis NEC&NOS	243
Gastro-esophageal reflux disease w/o esophagitis	72	Chest Pain NOS	240
Moderate persistent asthma w status asthmaticus	70	Diabetes Mellitus, Type 2 /NOS W Manifestations NEC NSU	232
Mild intermittent asthma w status asthmaticus	70	Other cardiac Dysrhythmias	218
Total	**7,364**	**Total**	**21,875**

Data source: SPARCS 2015. Acronyms: NOS = not otherwise specified; NEC = not elsewhere classified

Top 20 ED Diagnoses

Table 3. Summary of primary discharge diagnosis code for Emergency Department (ED) visits at St Barnabas Hospital in the Bronx in 2015 among Bronx residents.

Diagnosis/Description	Number
Viral Infection NOS	4,756
Acute Upper Respiratory Infection NOS	4,531
Headache	4,071
Abdominal Pain-Site NEC	3,815
Lumbago	3,416
Non-infective Gastroenteritis NEC&NOS	3,339
Asthma NOS W Exacerbation	3,332
Acute Pharyngitis	3,000
Chest Pain NEC	2,934
Pain in Limb	2,775
Chest Pain NOS	2,671
Other specified complications of pregnancy, antepartum condition or complication	2,665
Asthma NOS	2,448
Fever NOS	2,447
Dizziness & Giddiness	2,422
Cough	2,378
Otitis Media NOS	2,181
Urinary Tract INF NOS	2,086
Strep Sore Throat	2,006
Epigastric Abdominal Pain	1,881
Total	**177,681**

Data source: SPARCS 2015. NOS = not otherwise specified; NEC = not elsewhere classified

10. Population-Based Secondary Data Review

To capture an up-to-date high-level view of the health status of Bronx residents, we evaluated temporal trends, differences between Bronx and the rest of New York City and sub-county differences, when available, for more than 20 measures, including: obesity, preterm births, teen pregnancy rates, poverty, linguistic isolation, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screening, HIV incidence, lung, colorectal, prostate and breast cancer incidence rates, and hospitalizations for asthma, diabetes, assaults, heart attacks and falls. These data were obtained from multiple population-based datasets including the American Community Survey (formerly referred to simply as the Census), New York City Community Health Profiles, New York State Statewide Planning and Research Cooperative Systems (SPARCS), New York State Vital Statistics, New York State HIV/AIDS Epidemiology Reports, and the New York State Cancer Registry. Additional data was obtained from the New York City Community Health Profiles and the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard. The data are presented in the following pages. A review of the results from the primary and secondary data collection process illuminated major categories of health needs that were important across the populations surveyed, reflected in the data as critical, and in alignment with the New York State Prevention Agenda. The Priority Area identified with key data points highlighted is to **Prevent Chronic Disease** with the two focus areas selected as **(1) Reducing Obesity in Children and Adults**, for the targeted objective to decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day by 5% from 20.5% (2009) to 19.5% among all adults and (2) By 10% from 42.9% (2009) to 38.6% among adults with an annual household income of < $25,000. The second focus area is (2) **Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings** with the goal of Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations for the objective of increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%.

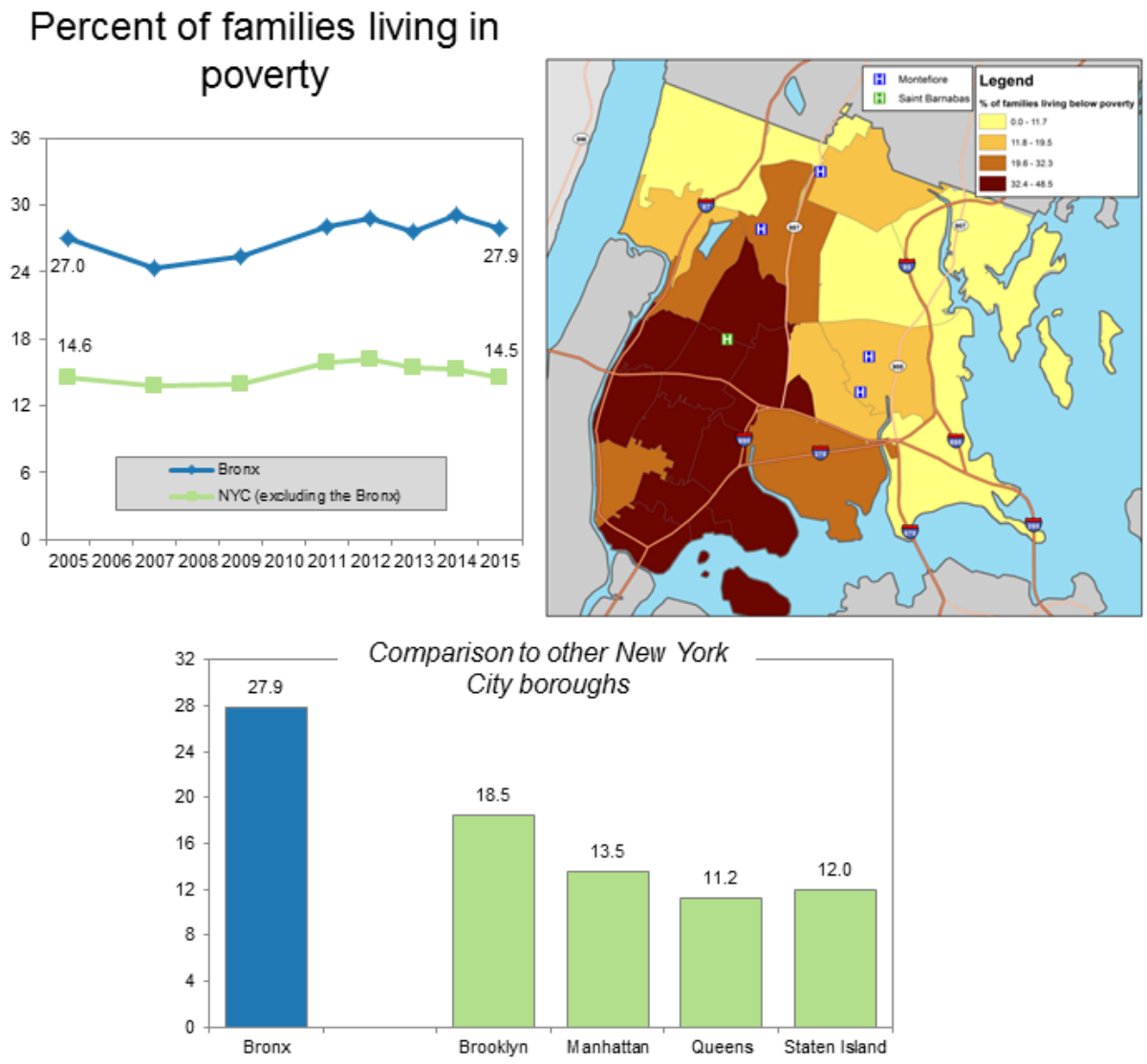
Additional measures correlated to these will be collected and include:

- % of adults 18 years and older who consume 1 or more sugary drinks per day (NYS CHS)
- % of respondents ages 18 years and older who smoke or use tobacco some days or every day (HCAPS)
- % of respondents who discussed or were recommended cessation medications (HCAPS)

- % of respondents who discussed or were provided cessation methods or strategy (HCAPS)
- % of patients with diabetes who received the following tests: A1C, cholesterol, eye exam, nephropathy (HEDIS)
- % of patients with diabetes whose most recent A1c >9% (HEDIS)
- % of patients with diabetes whose most recent LDL was <100 (HEDIS)

The **disparities** that we hope to reduce will largely be focused on **race/ethnicity**. In preparation for this we are optimizing our ability to capture this information in our electronic health record. This will enable us to assess health disparities for many of the quality measures listed above.

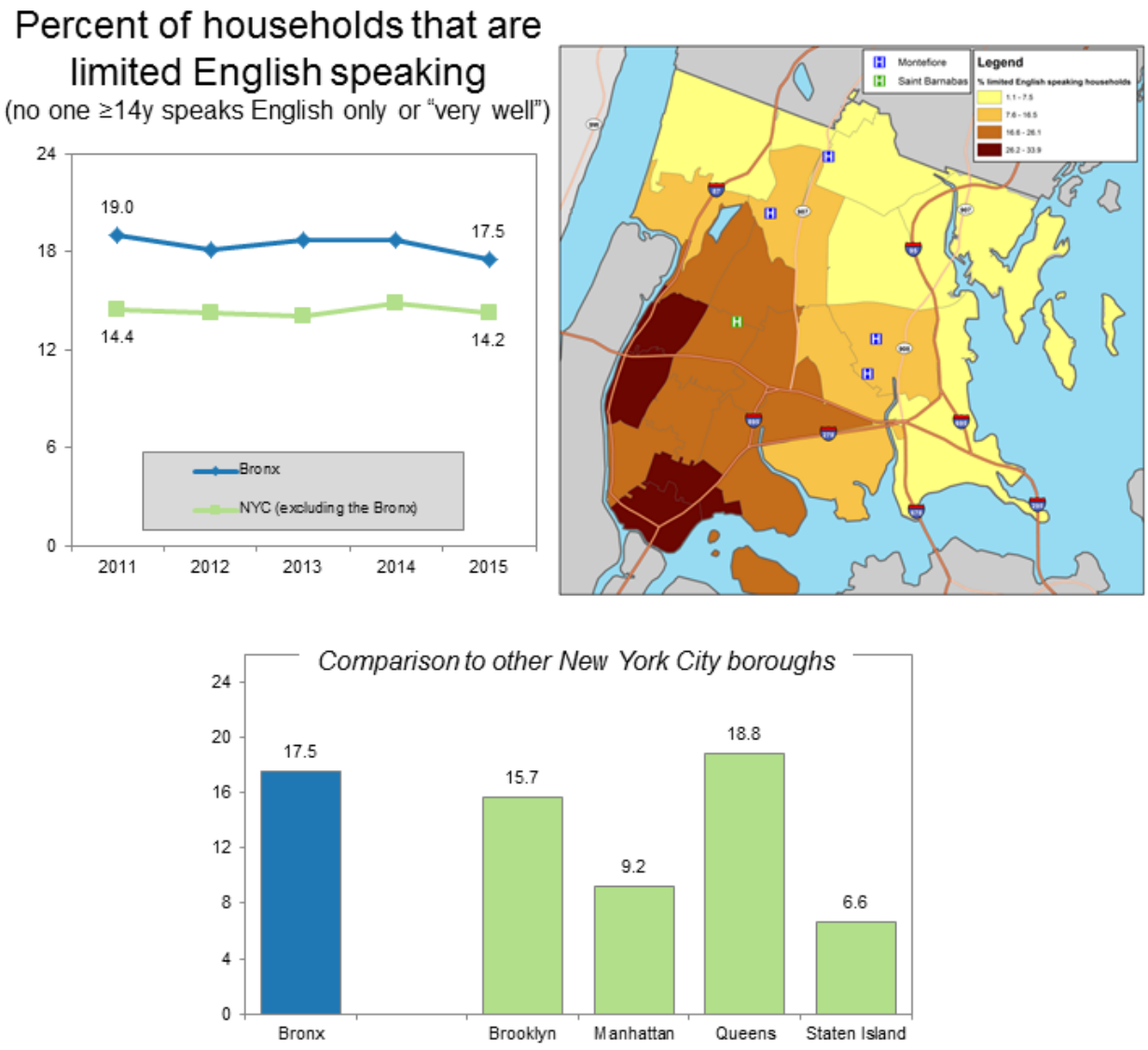
Figure 1. Percent of families living in poverty.



Data source: American Community Survey

- The Bronx has the highest poverty rate of the 5 boroughs, and is about twice as high as the rest of New York City.
- The percent of families living in poverty in the Bronx has remained relatively stable over the past 5-years, after increasing slightly from 2007-2011.
- The poverty rate in the Bronx is highest in the South Bronx.

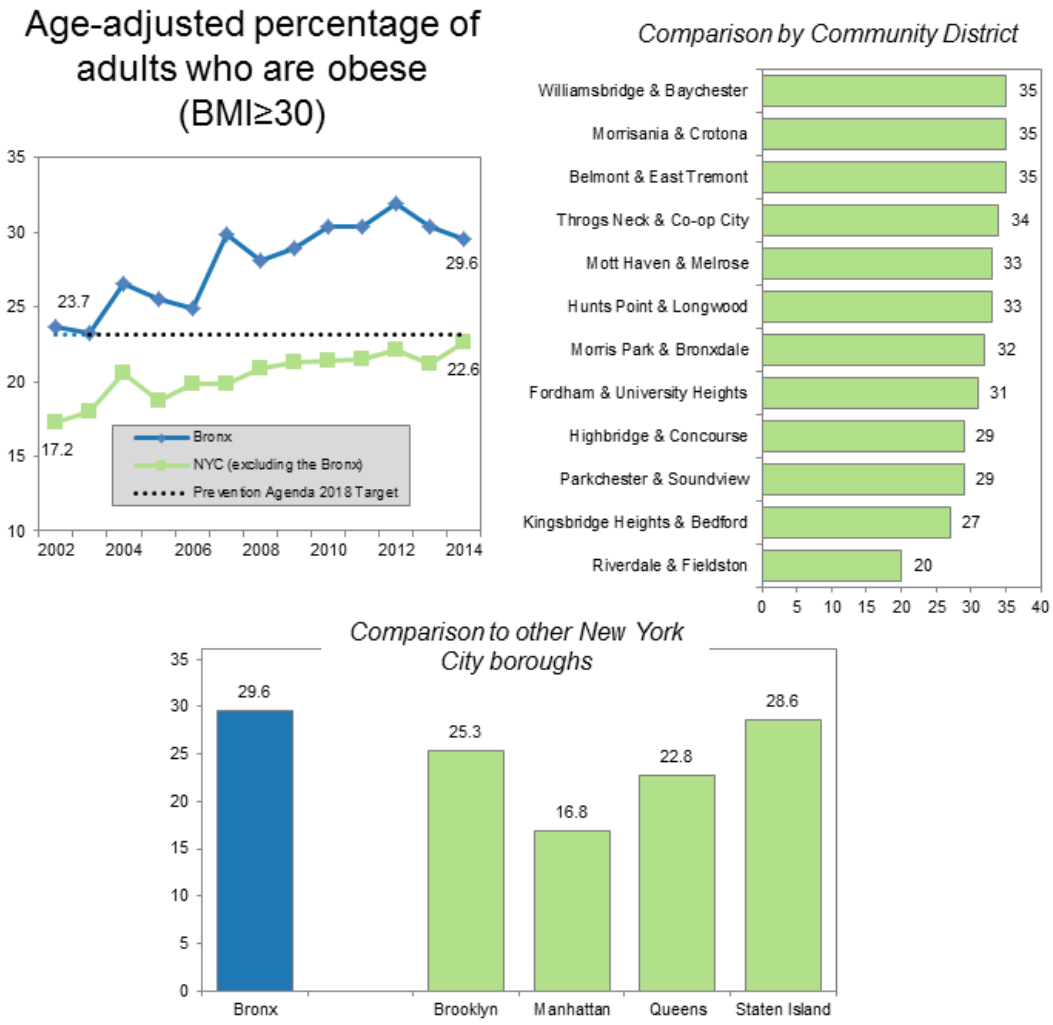
Figure 2. Percent of households that are limited English speaking



Data source: American Community Survey

- More households in the Bronx are considered limited English speaking than the rest of New York City, and percent of households that are limited English speaking is second highest of the 5 boroughs (following Queens).
- The percent of households that are linguistically isolated has decreased slightly from 19% in 2011 to 17.5% in 2015; across the rest of the city, the percentage has been relatively stable.
- Pockets of linguistic isolation are observed in the Mott Haven/Port Morris neighborhood and Highbridge/Morris Heights, but remain elevated in much of the South Bronx and parts the Central Bronx.

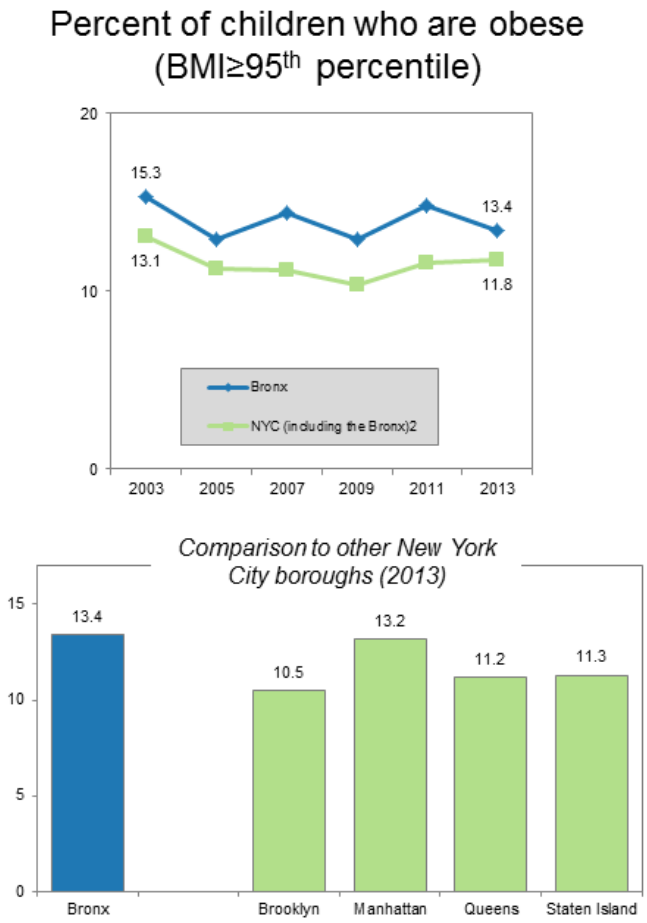
Figure 3. Age-adjusted percentage of adults are who are obese



Data source: New York City Community Health Survey

- The percentage of Bronx adults who are considered obese has increased over the past 12 years from 23.7% to 29.6%, however, since 2012, this number has decreased.
- Despite stabilizing in recent years, the prevalence of obesity among Bronx adults remains 30% higher than the rest of New York City.
- The burden of obesity in the Bronx is not equally distributed; Williamsbridge & Baychester, Morrisania & Crotona, and Belmont & East Tremont have the greatest burden, while Riverdale & Fieldston and Kingsbridge Heights & Bedford have the lowest.

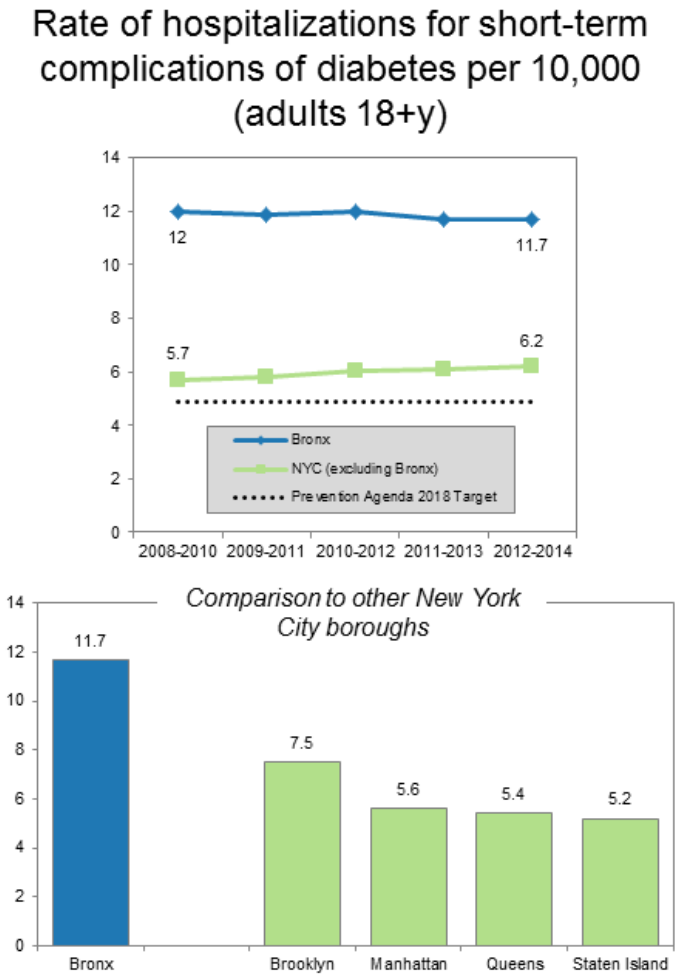
Figure 4. Percent of children who are obese



Data source: New York City Youth Behavior Risk Survey

- There is some evidence that childhood obesity, among 9th-12th graders attending public schools has declined in the Bronx and the rest of New York City.
- Despite this improvement, children in the Bronx are 13% more likely to be obese than residents of the rest of New York City.

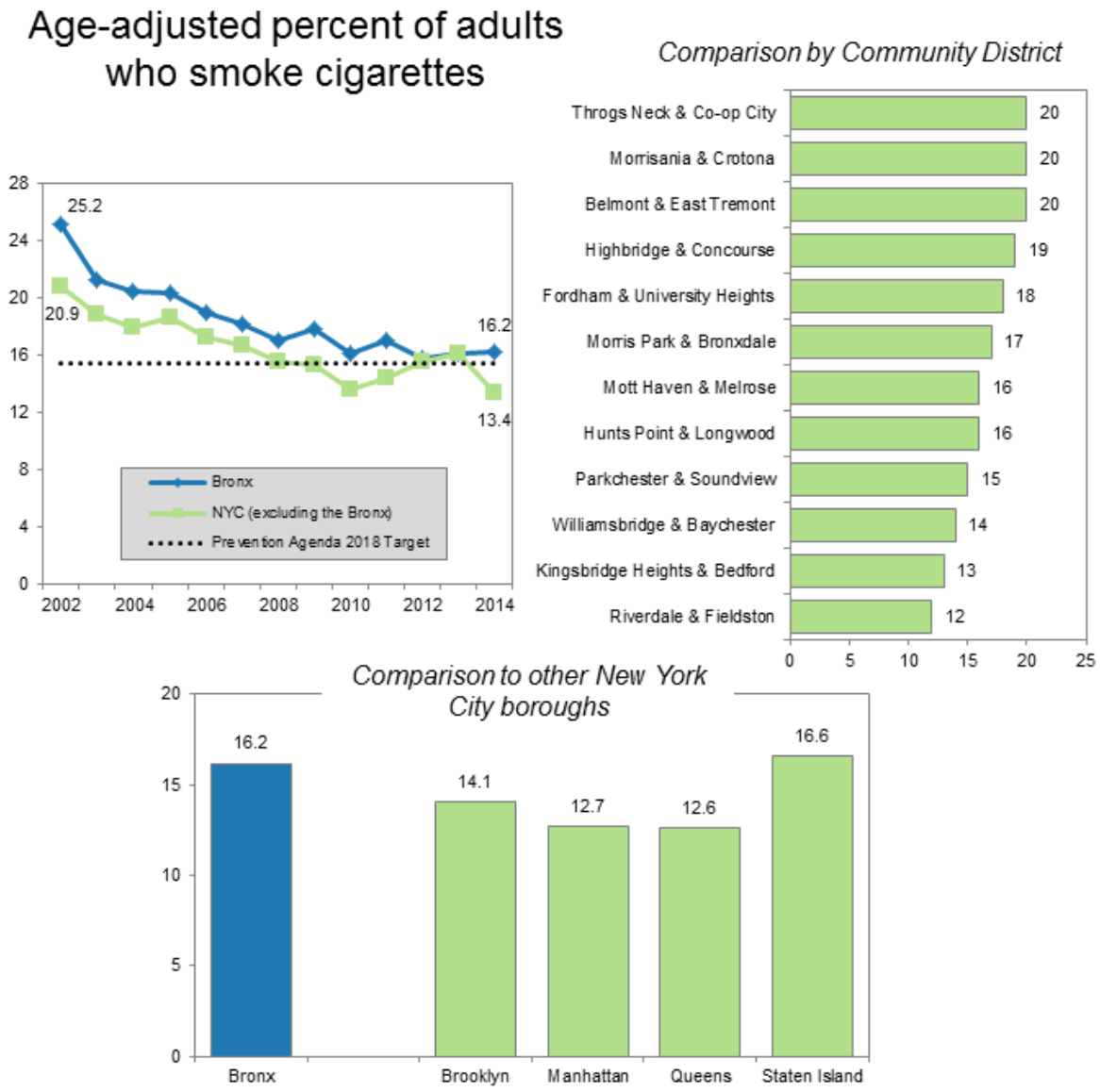
Figure 5. Rate of hospitalizations for short-term complications of diabetes per 10,000



Data source: SPARCS

- Rats of hospitalization for short-term complications of diabetes are nearly 90% higher in the Bronx as compared to the rest of New York City despite increases in the rest of New York City.

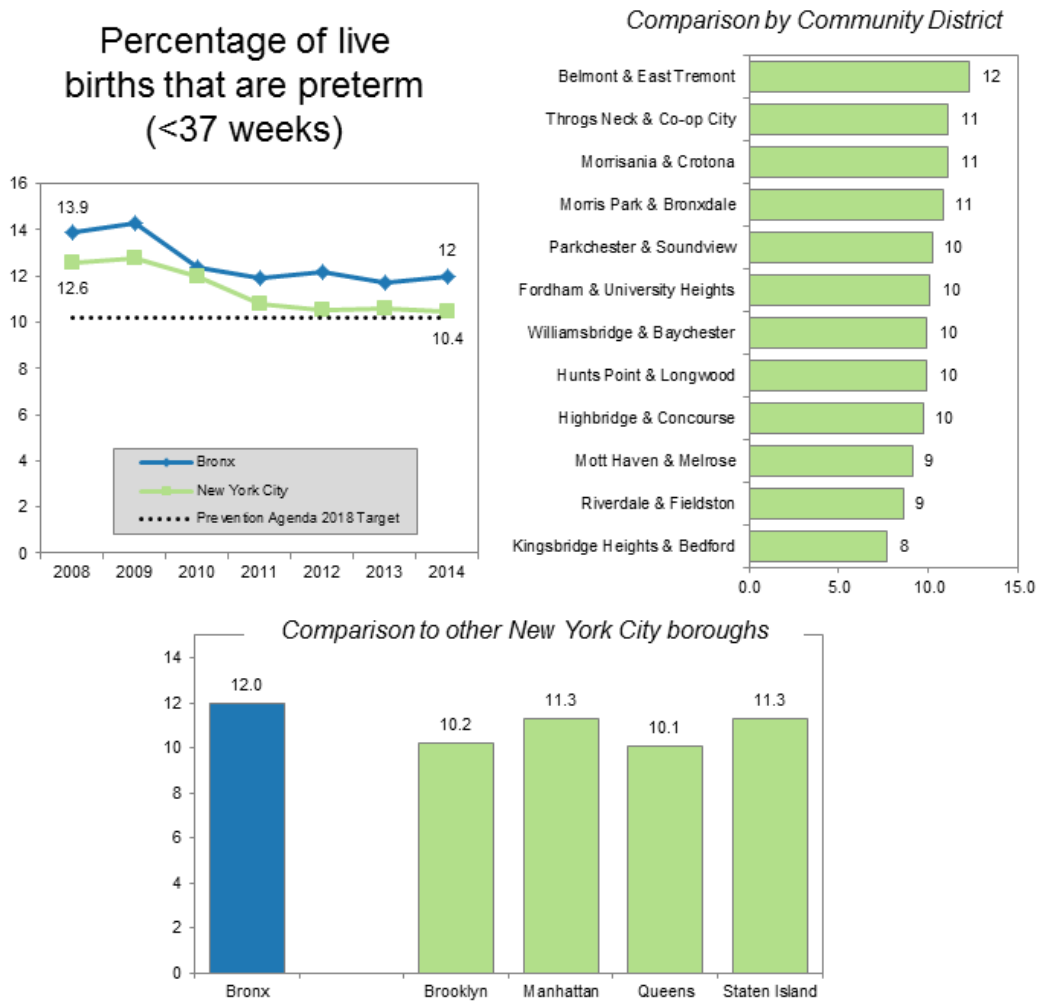
Figure 6. Age-adjusted percent of adults who currently smoke cigarettes



Data source: New York City Community Health Survey

- In both the Bronx and the rest of New York City, cigarette smoking among adults has declined, but Bronx residents continue to be more likely smoke than New York City residents overall.
- Current cigarette smoking is lowest in Riverdale & Fieldston and Kingsbridge & Bedford Park and highest in Throggs Neck & Co-Op City, Morrisania & Crotona and Belmont & East Tremont.

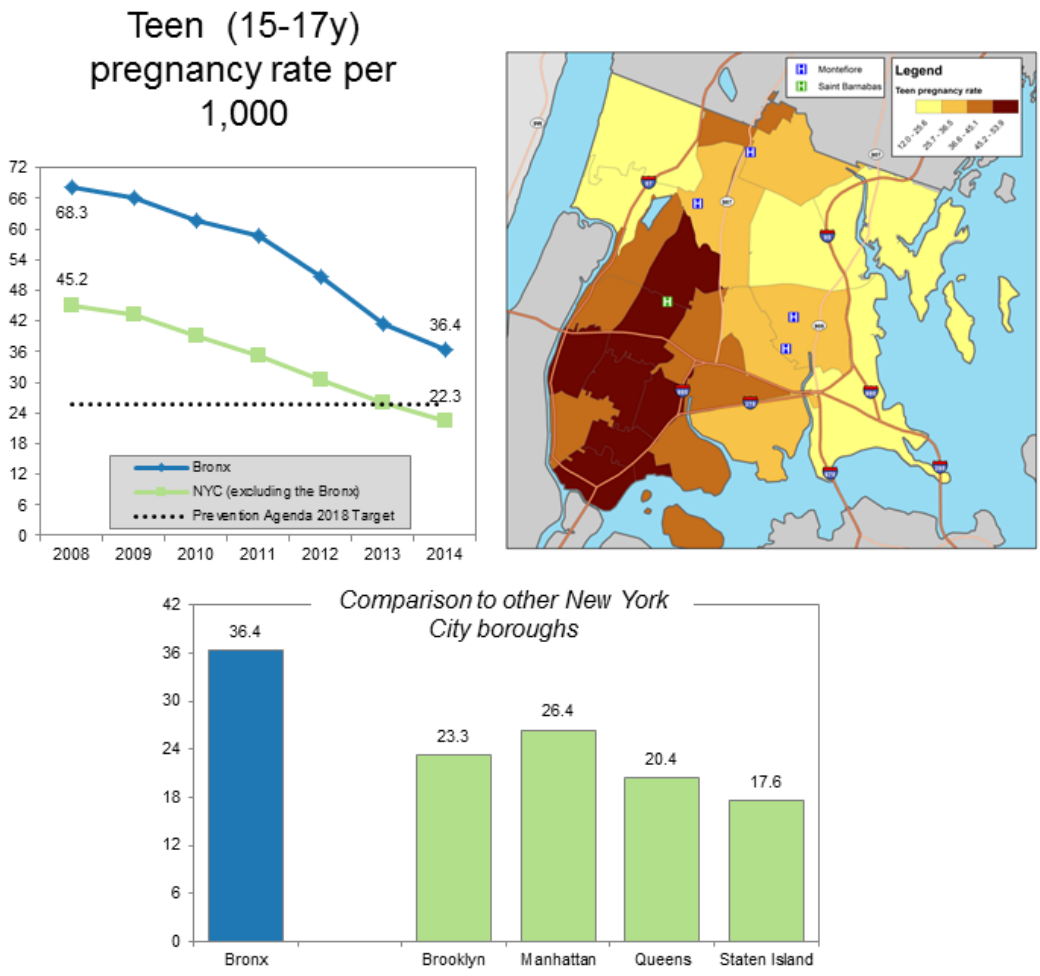
Figure 7. Percentage of live births that is preterm



Data source: New York State Vital Statistics

- In both the Bronx and the rest of New York City, preterm births have declined, but Bronx residents continue to be more likely to experience preterm birth than New York City residents overall.

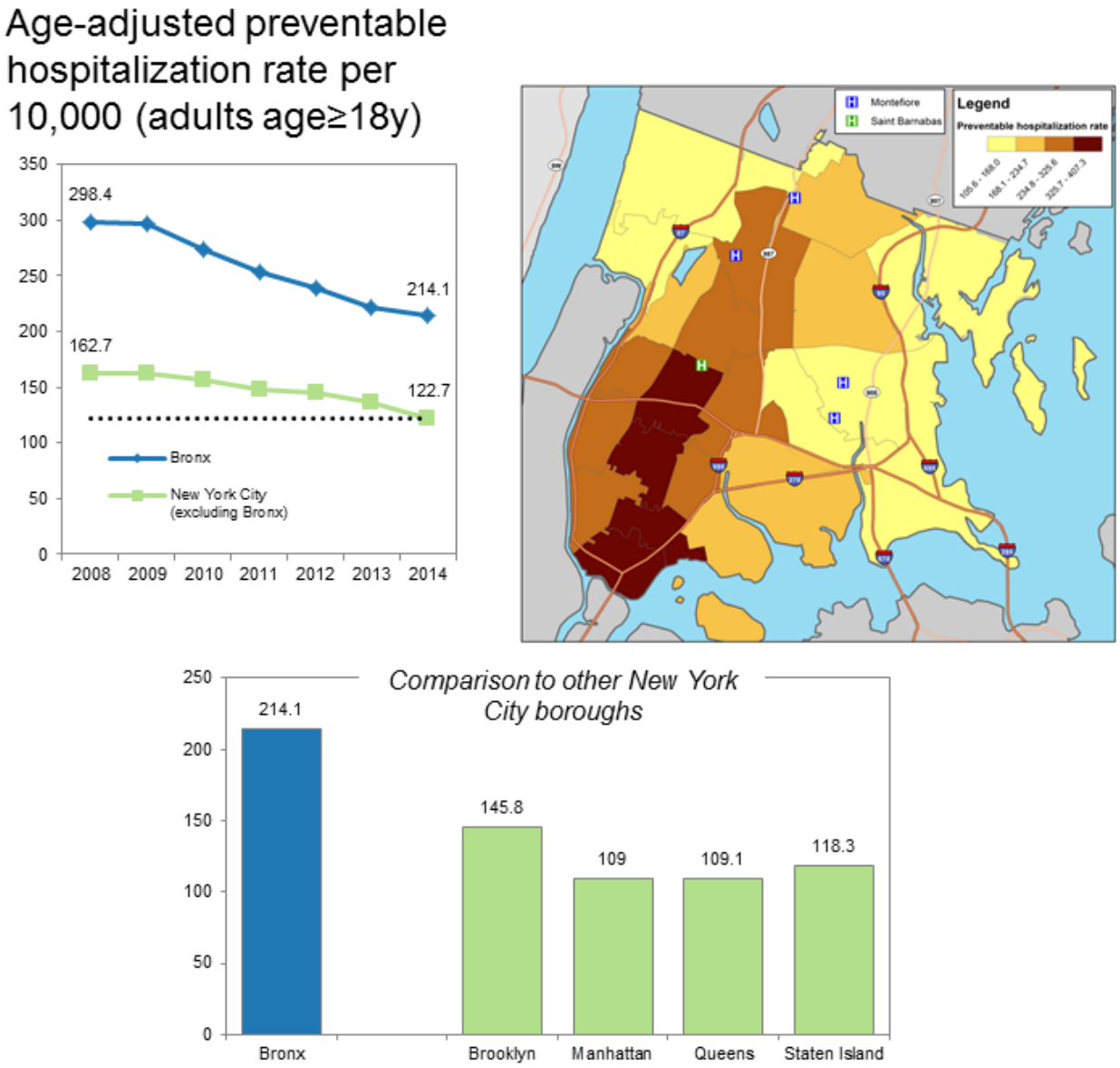
Figure 8. Teen pregnancy rate



Data source: New York State Vital Statistics

- Coinciding with the decline in preterm births, the teen pregnancy rate (and teen birth rate) has declined in both the Bronx and the rest of New York City
- Teen pregnancies remain 63% higher in the Bronx as compared to the rest of New York City.
- Teen pregnancies are most common in the South Bronx.

Figure 9. Age-adjusted preventable hospitalizations[2] per 10,000

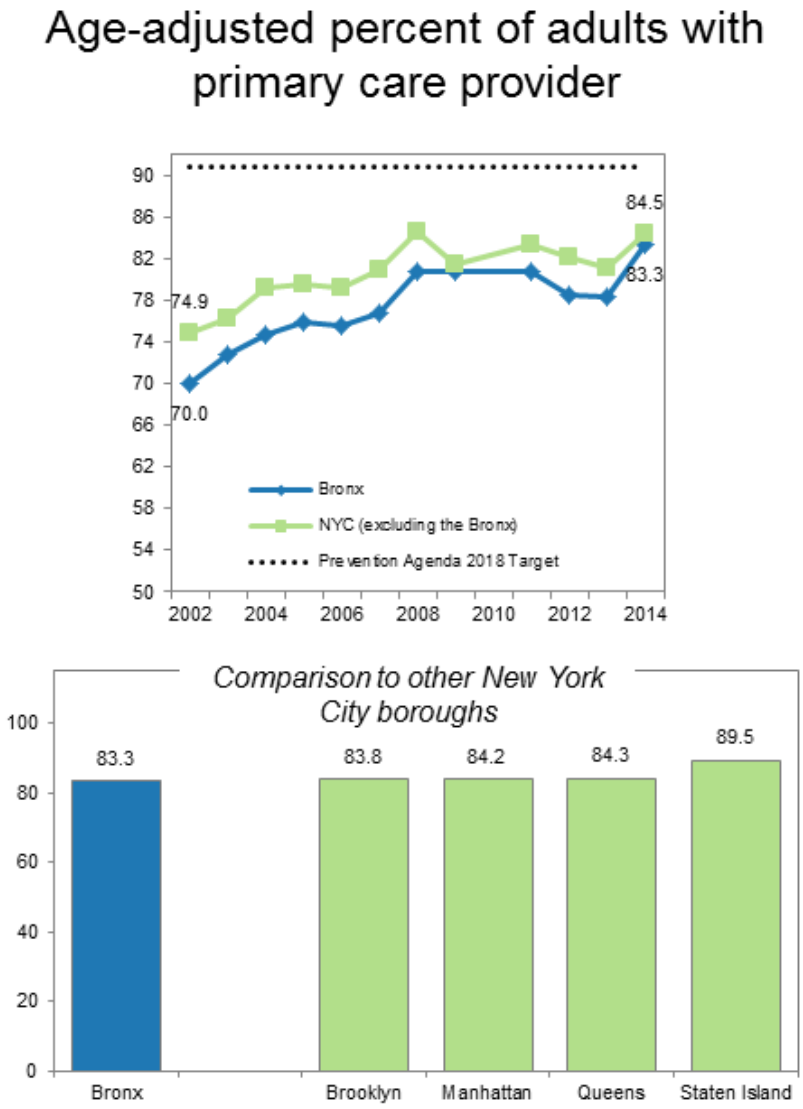


Data source: SPARCS

- The age-adjusted rate of preventable hospitalizations declined in both the Bronx and the rest of New York City, but the rate of decline appears to be greater in the Bronx (-28% compared to -25% in the rest of New York City).
- Preventable hospitalizations were most common in the South Bronx.

[2] Defined as hospitalizations for the following: (1)Short-term complication of diabetes (2)Long-term complication of diabetes (3)Uncontrolled diabetes (4)Lower-extremity amputation among patients with diabetes (5)Hypertension (6)Congestive heart failure (7)Angina (8)Chronic obstructive pulmonary disease (9)Asthma (10)Dehydration (11)Bacterial pneumonia (12)Urinary tract infection.

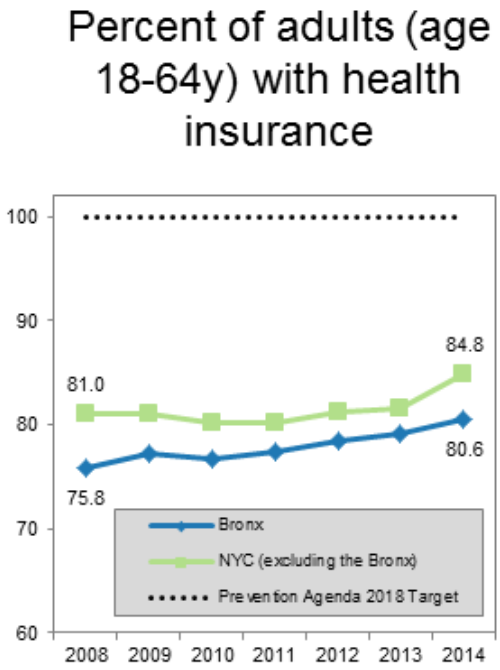
Figure 10. Age-adjusted percent of adults with a primary care provider

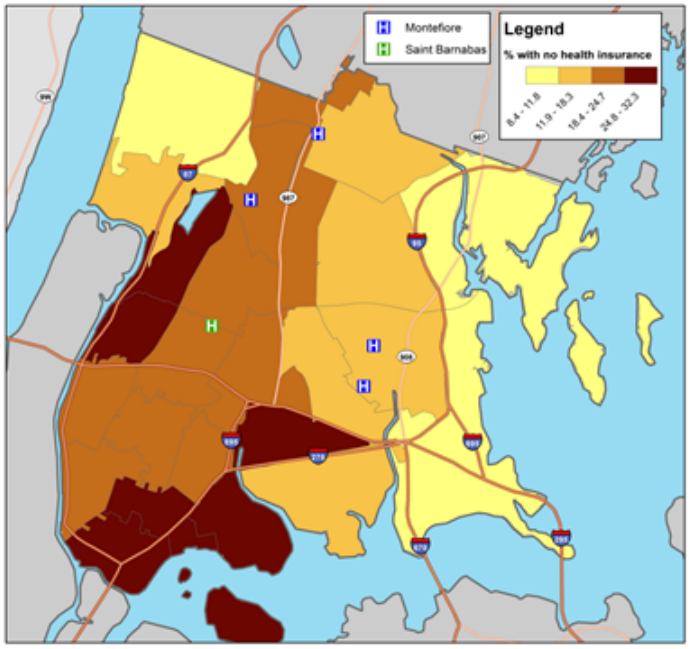


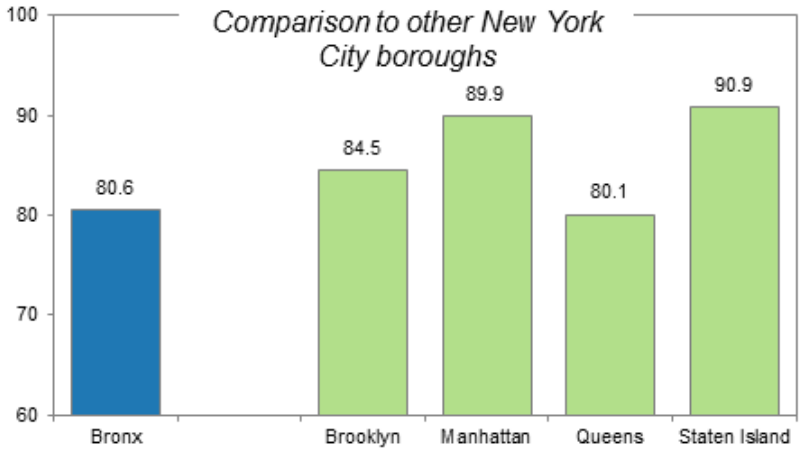
Data source: New York City Community Health Survey

- In both the Bronx and the rest of New York City, the percentage of adults with a primary care provider has increased.
- In the early 2000s residents of the rest of New York City were 7% more likely to have a primary care provider than Bronx residents; this disparity decreased to less than 2% by 2014.
- Despite these gains, compared to the other boroughs Bronx residents are least likely to have a primary care provider.

Figure 11. Percent of adults (age 18-64y) with health insurance



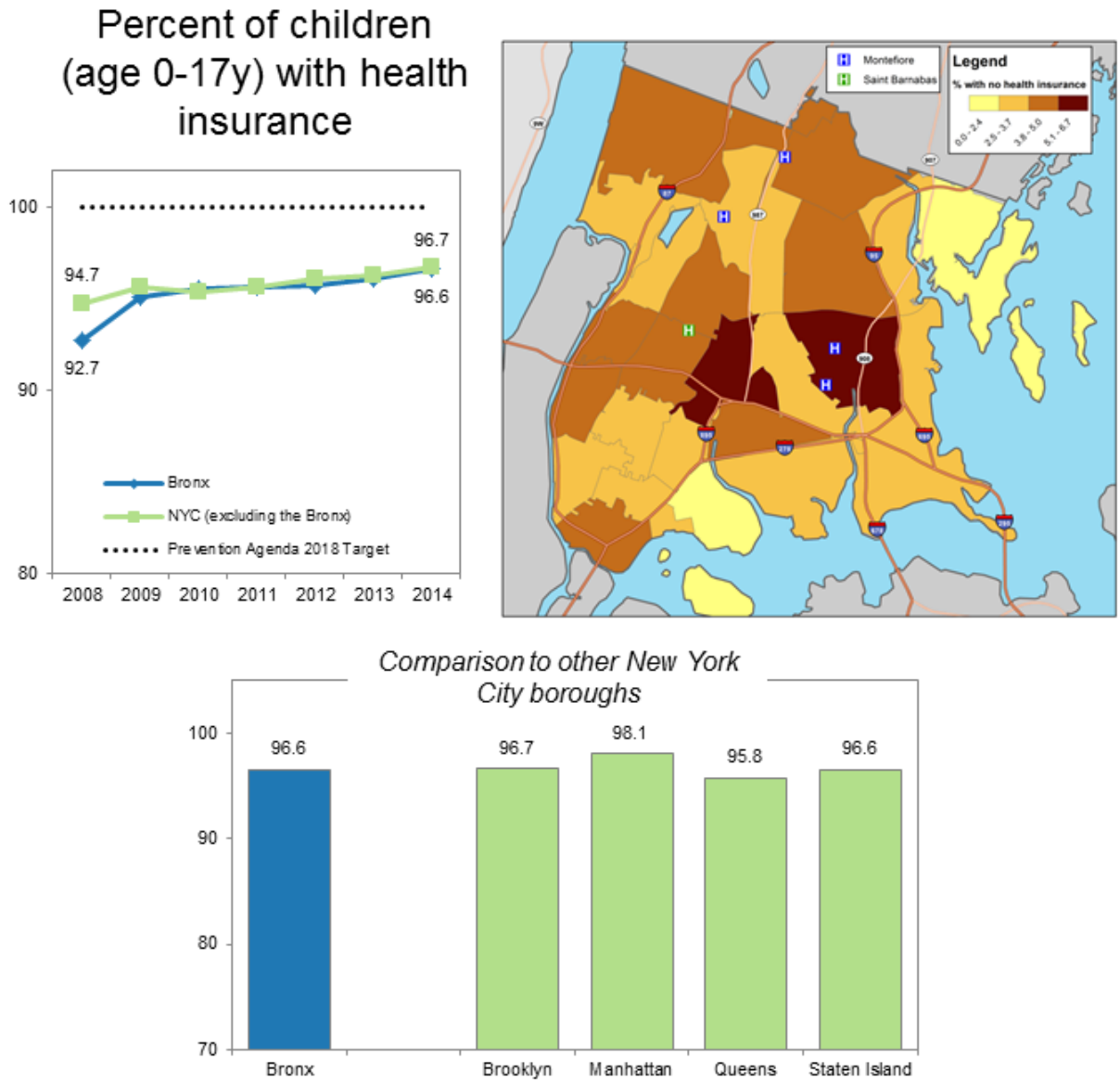




Data source: American Community Survey

- The percent of non-elderly adults (age 18-64y) who have health insurance increased in both the Bronx and the rest of New York City. This increase was driven in large part by Medicaid expansion and the implementation of the Affordable Care Act.
- After Queens, the Bronx has the second lowest percentage of non-elderly adults with health insurance.
- Clusters of not having insurance were observed through the middle-section of the Bronx, with hotspots observed in Mott Haven/Port Morris, Soundview and Morris Heights/University Heights.

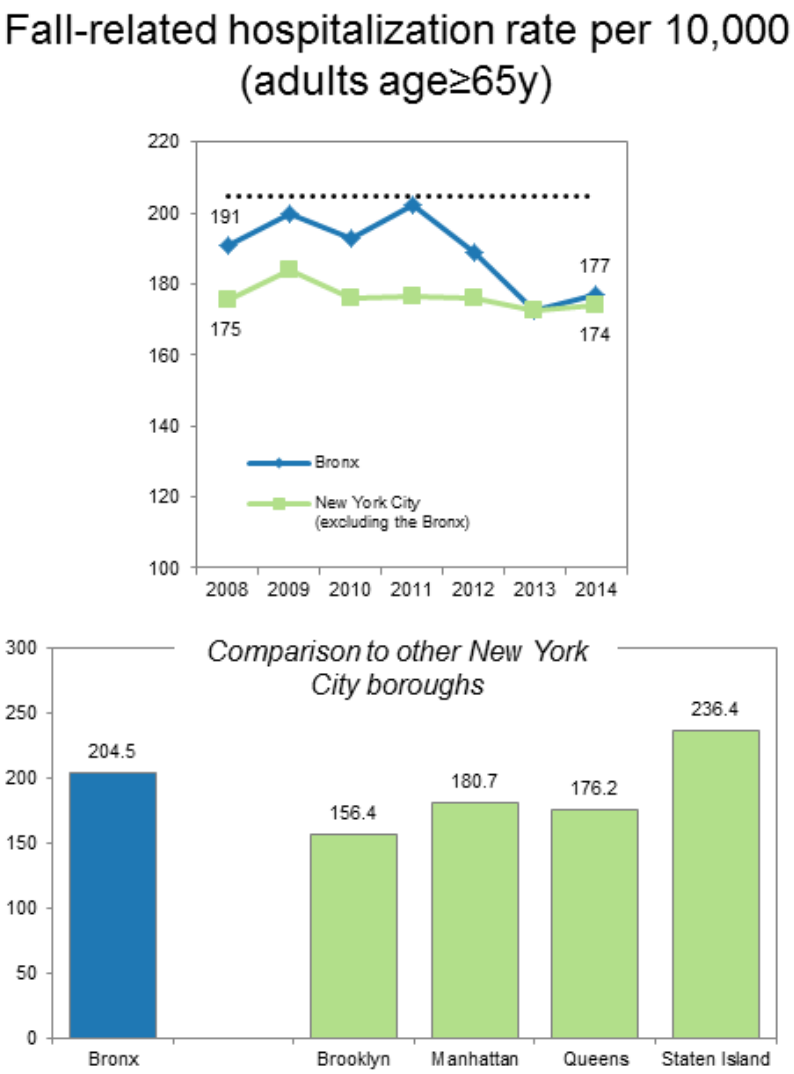
Figure 12. Percent of children (age 0-17y) with health insurance



Data source: American Community Survey

- The percent of children (age 0-17y) who have health insurance increased in both the Bronx and the rest of New York City. This increase was driven in large part by Medicaid expansion and the implementation of the Affordable Care Act.
- In 2008, residents of the rest of New York City were somewhat more likely to not have insurance as compared to Bronx residents, but this disparity completely disappeared by 2014.
- Clusters of not having insurance among children were observed in West Farms/Belmont and Morris Park/East Bronx.

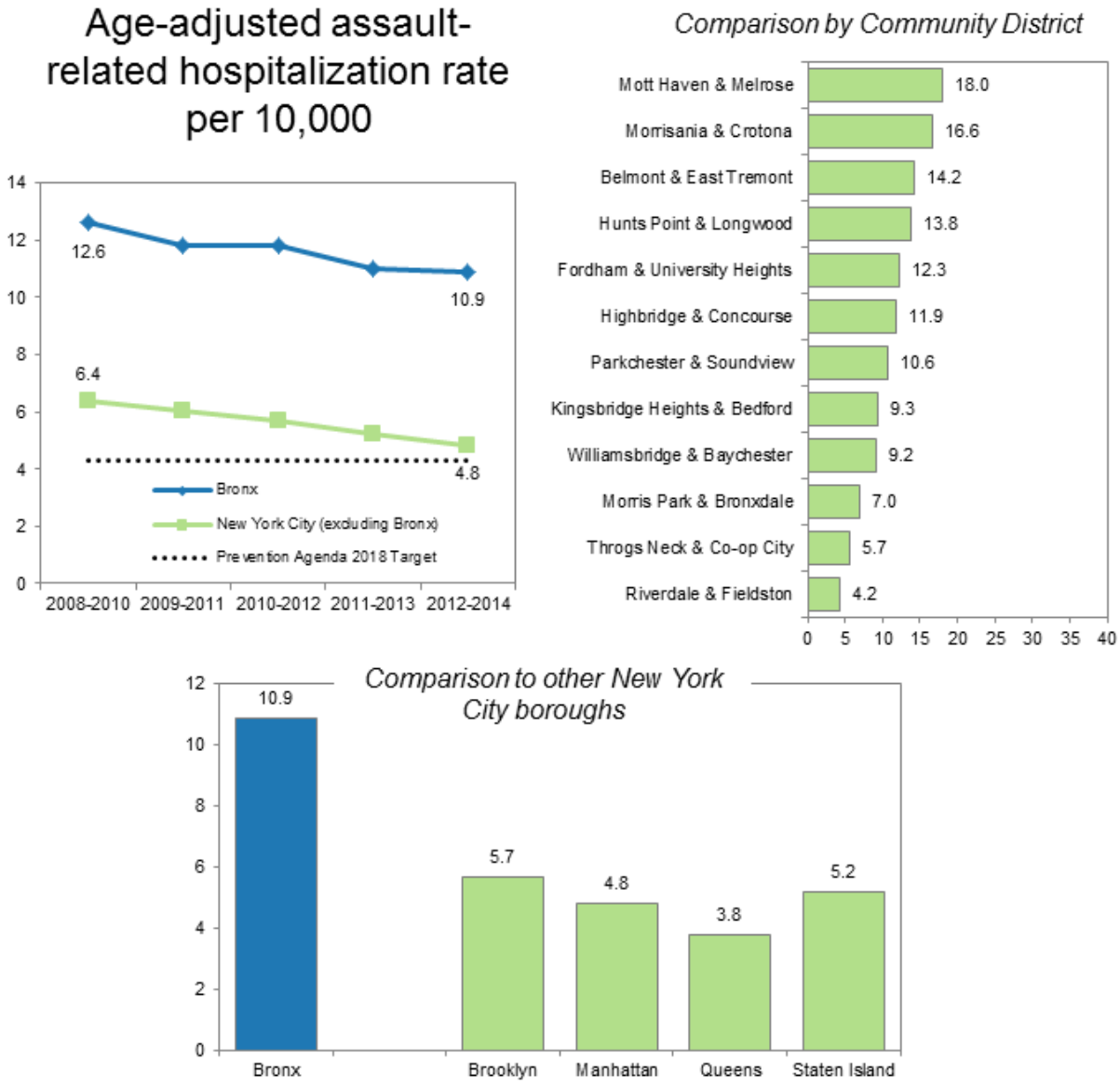
Figure 13. Fall-related hospitalization rate per 10,000



Data source: SPARCS

- Fall-related hospitalizations among older adults declined in the Bronx, while remaining relatively stable in the rest of New York City. As of 2014, there was little difference in rates comparing the Bronx to the rest of New York City.

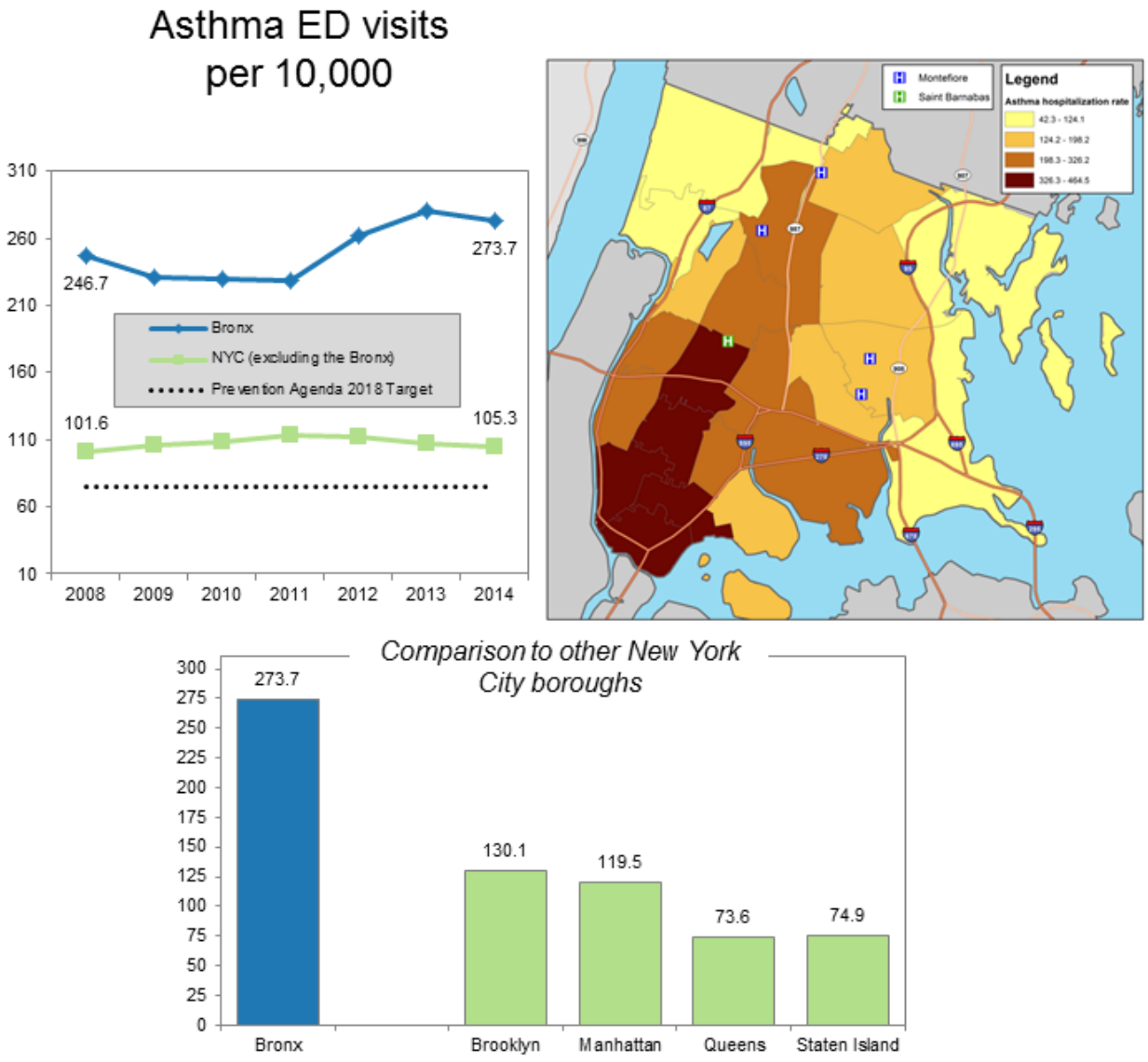
Figure 14. Age-adjusted assault-hospitalization rate per 10,000



Data source: SPARCS

- Age-adjusted assault-related hospitalizations in both the Bronx and the rest of New York City declined, but a substantial disparity remained.
- Bronx residents had more than 2.5-fold higher rates of assault-related hospitalizations than the rest of New York City and more than the Prevention Agenda 2018 Target.
- Disparities within the Bronx were also apparent; rates were highest in Mott Haven & Melrose, Morrisania & Crotona, and Belmont & East Tremont; rates were lowest in Riverdale & Fieldston and Throggs Neck & Co-Op City.

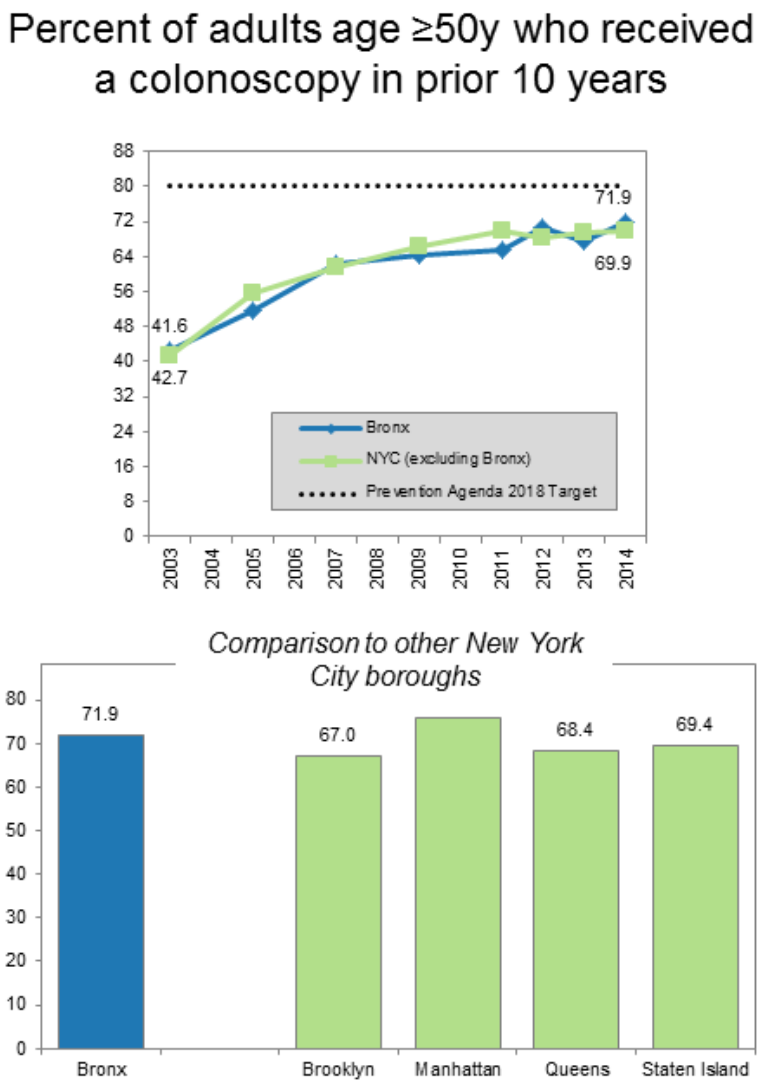
Figure 15. Asthma emergency department visits per 10,000



Data source: SPARCS

- Asthma ED visits in the Bronx were stable from 2008-2011, but increased thereafter. They remained more than 2.5-fold higher than the rest of New York City and nearly 4-fold higher than the Prevention Agenda target.
- Disparities within the Bronx were also apparent; rates were substantially higher in the South Bronx and lower in Riverdale & Fieldston and Co-Op City & Throgs Neck.

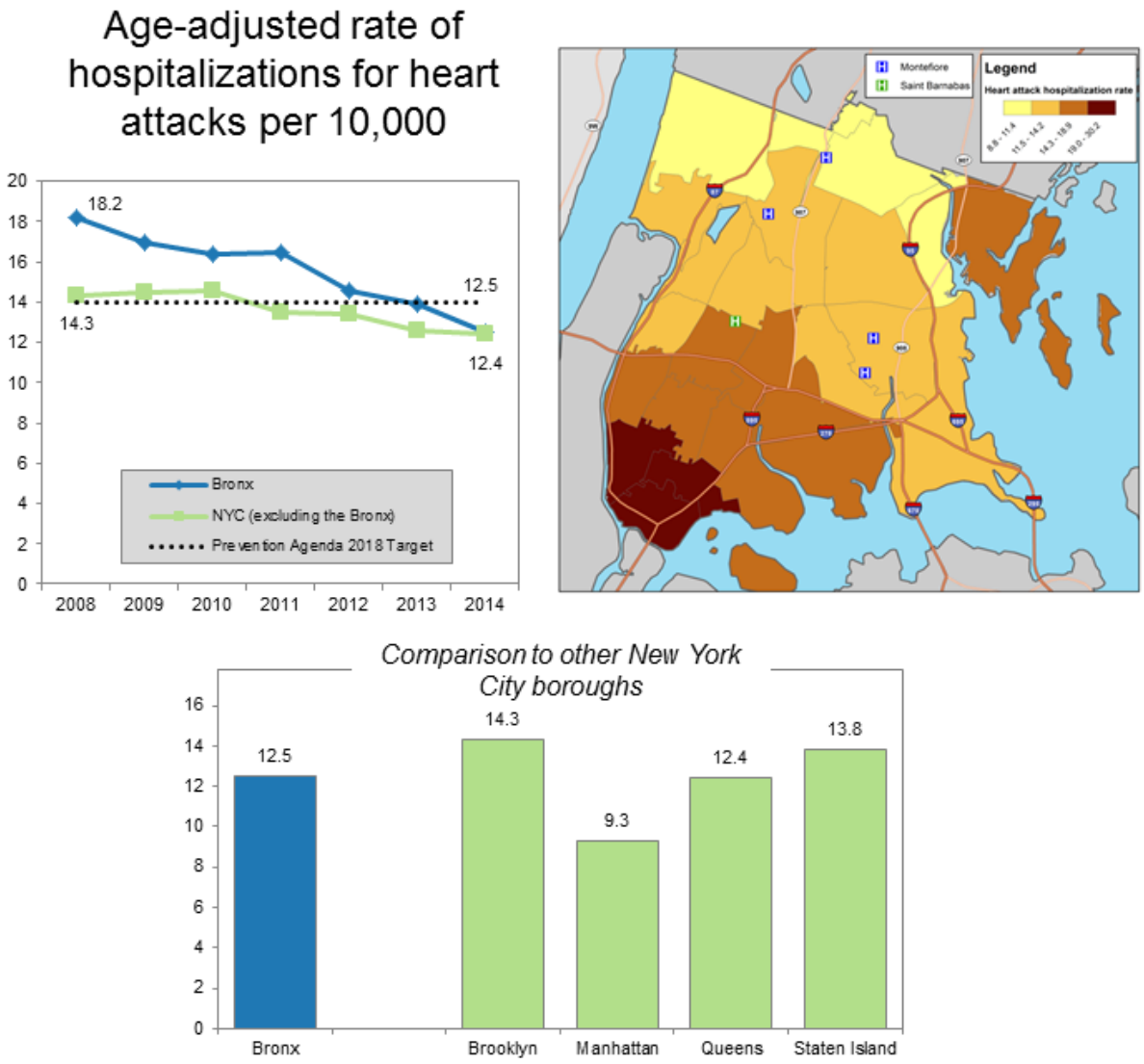
Figure 16. Percent of adults age≥50 who received a colonoscopy in the prior 10 years



Data source: New York City Community Health Survey

- In both New York City and the Bronx, rates of receiving a colonoscopy among adults age ≥50y increased, but remained below the Prevention Agenda target.
- The rate of increase has been comparable in the Bronx compared to the rest of New York City.

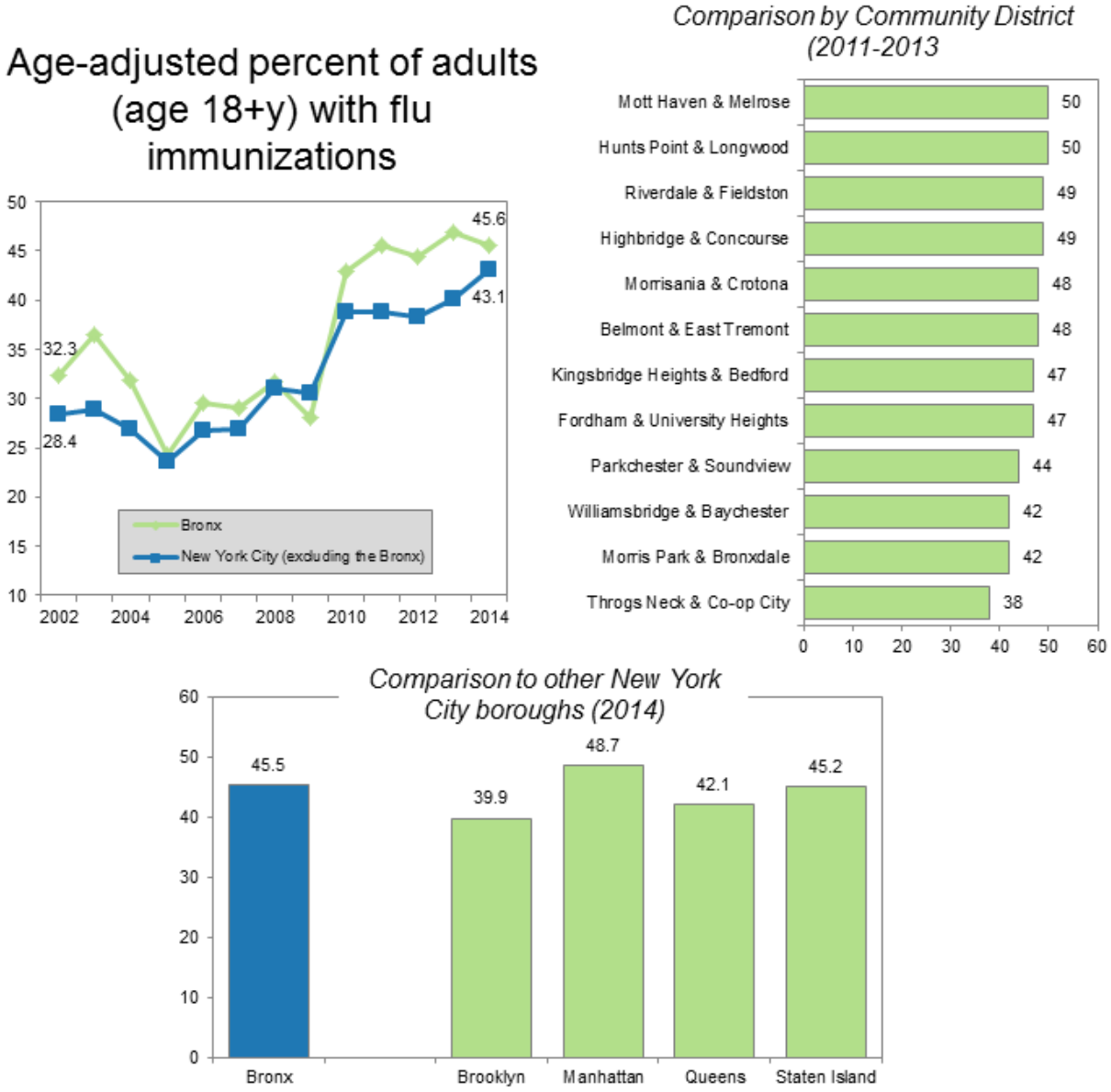
Figure 17. Age-adjusted rate of hospitalizations for heart attacks per 10,000



Data source: SPARCS

- Age-adjusted hospitalizations for heart attacks (myocardial infarction) declined substantially in the Bronx and are now comparable to rates in the rest of New York City.
- A distinct north-south gradient in heart attack hospitalizations was observed in the Bronx, with the highest rates in the South Bronx and lower rates in the North Bronx, including Riverdale, Wakefield and the Co-Op City areas.

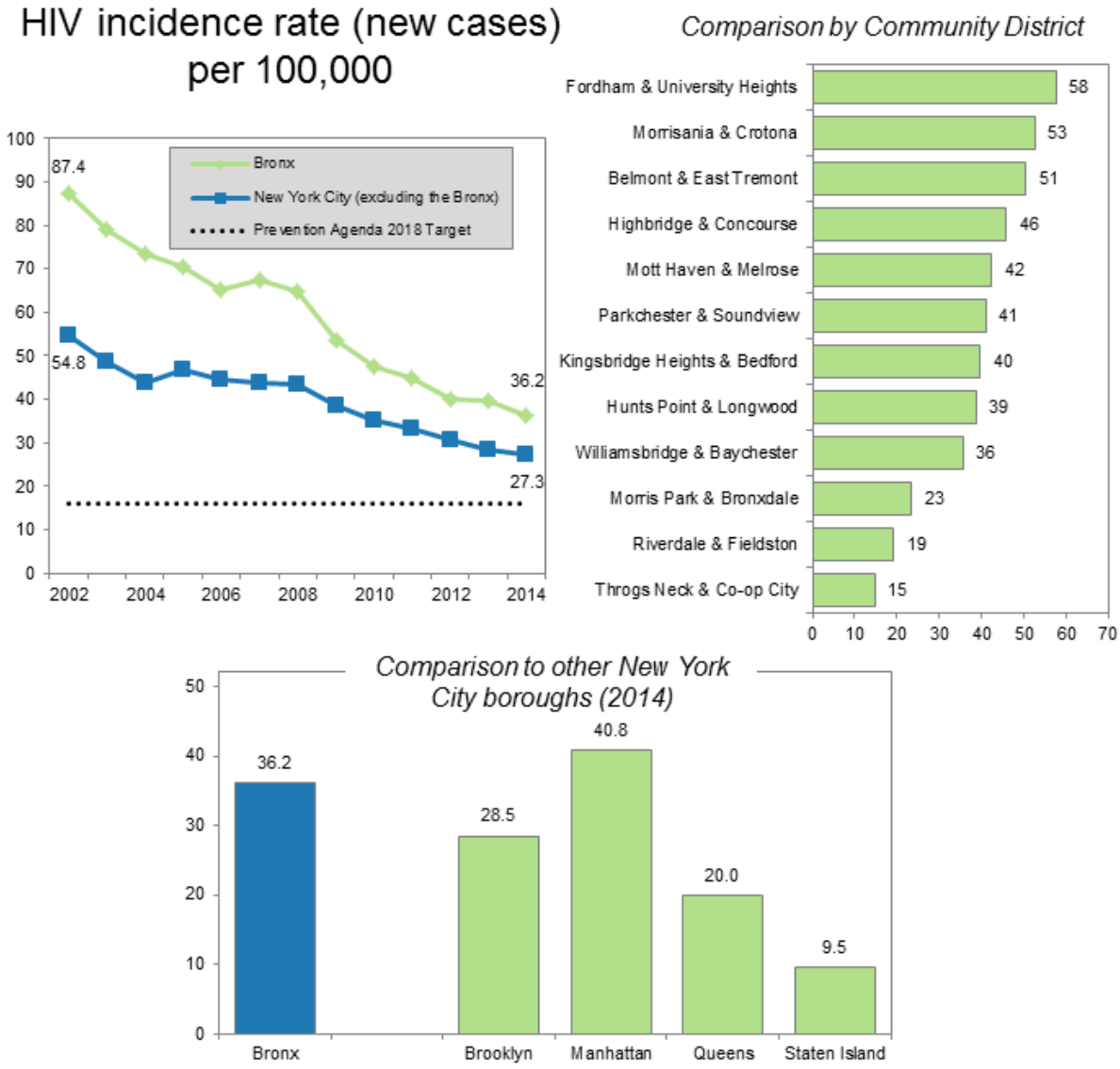
Figure 18. Age-adjusted percent of adults getting immunized for the flu



Data source: New York City Community Health Survey

- Receipt of flu immunizations among adults was relatively stable from 2002-2010 in both the Bronx and the rest of New York City, increasing thereafter.
- Bronx adults were marginally more likely to receive a flu immunization than residents of the rest of New York City.
- Uptake of flu immunizations were highest in the Mott Haven & Melrose, Hunts Point & Longwood, Riverdale & Fieldston, Highbridge & Concourse, and lowest in Throgs Neck & Co-Op City.

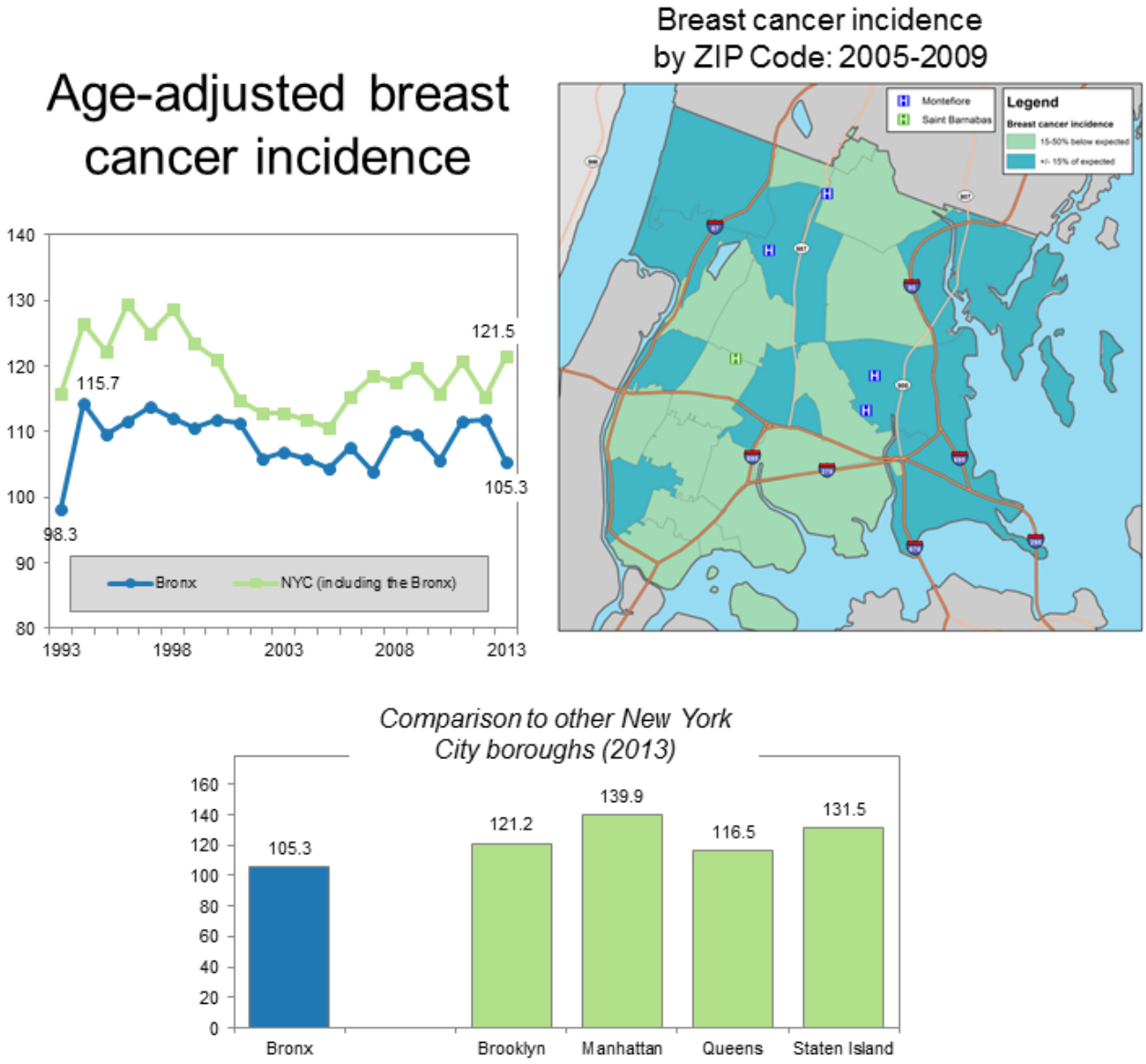
Figure 19. HIV incidence rate per 100,000



Data source: New York State HIV/AIDS Epidemiology Reports

- Incidence rates of HIV in the Bronx have declined more than 59% compared to 50% in the rest of New York City.
- The Bronx has the second highest incidence rate of HIV compared to the other New York City boroughs, trailing only Manhattan.
- Rates of HIV varied 3.9-fold within the Bronx by Community District; rates were highest in Fordham & University Heights and lowest in Throgs Neck & Co-Op City.

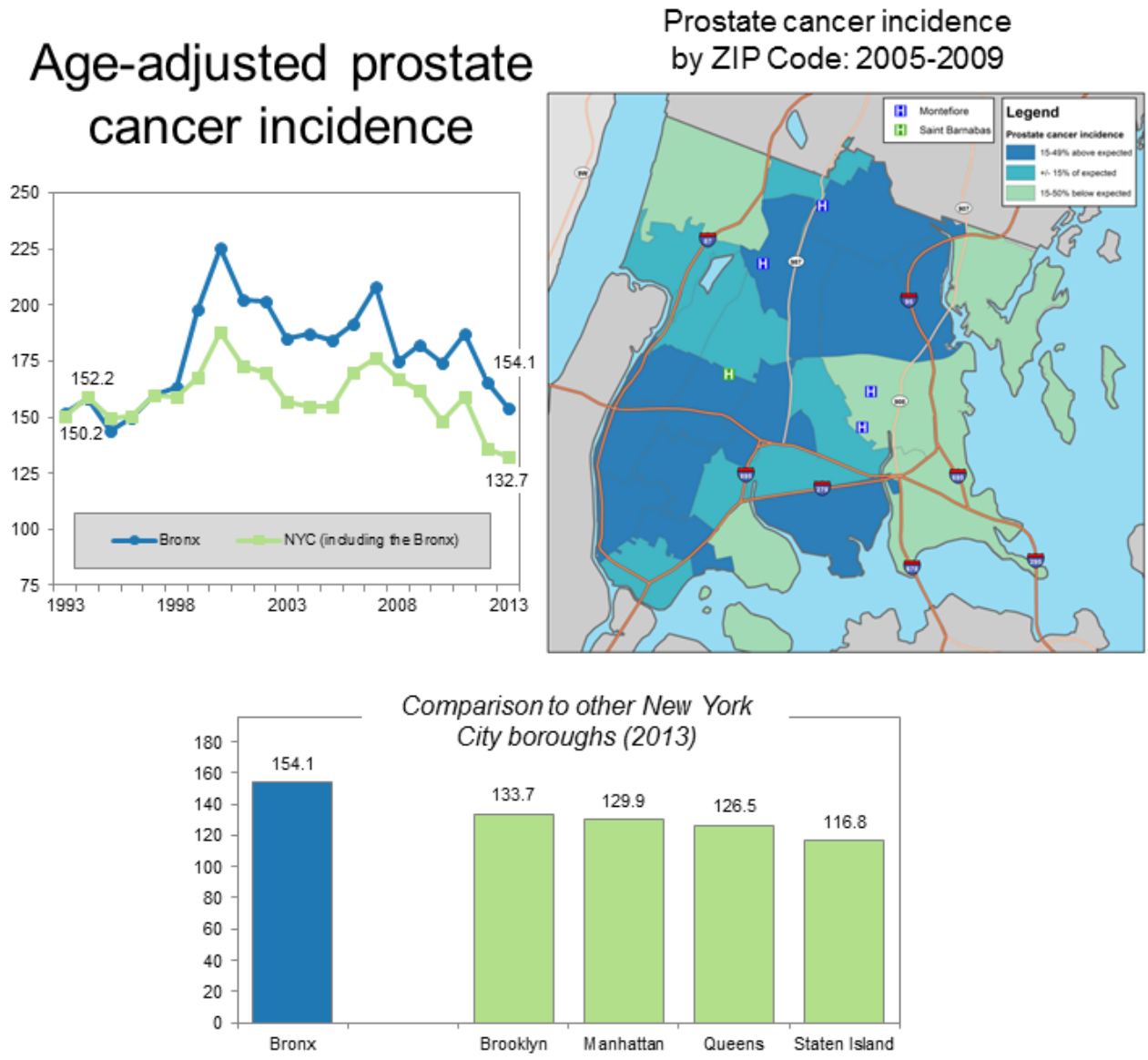
Figure 20. Age-adjusted breast cancer incidence, among women only



Data source: New York State Cancer Registry

- Breast cancer incidence declined through the 1990s, but remained stable thereafter.
- Compared to the rest of New York City, breast cancer incidence rates were lowest in the Bronx.
- There was no evidence of breast cancer incidence hotspots by ZIP Code; no ZIP Code had a higher than expected rate of breast cancer.

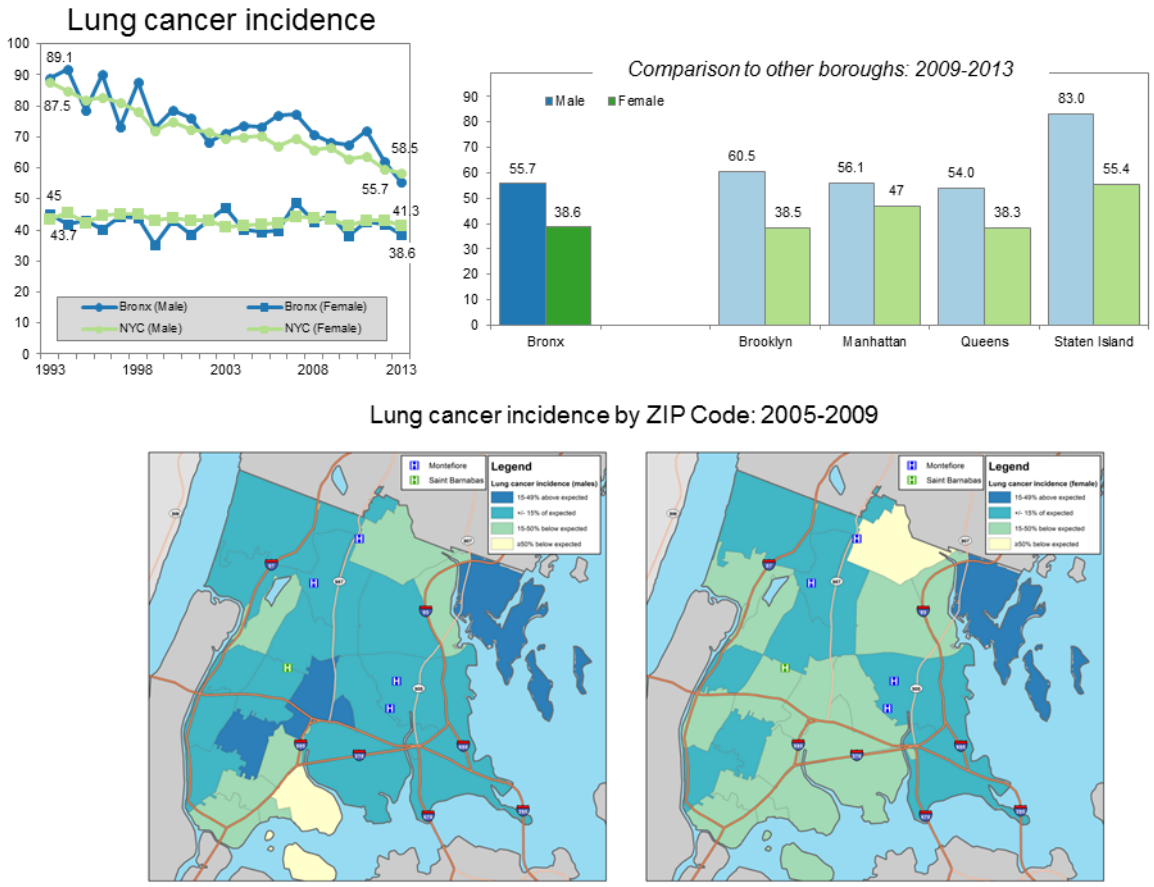
Figure 21. Age-adjusted prostate cancer incidence, among men only



Data source: New York State Cancer Registry

- Among Bronx men, rates of prostate cancer increased through the 1990s, in large part due to the widespread implementation of PSA screening, which resulted in detecting many more prostate cancers, but decreased from the early 2000s.
- Prostate cancer rates in the Bronx were higher than the rest of New York City, and 12 ZIP Codes had higher than expected prostate cancer rates.

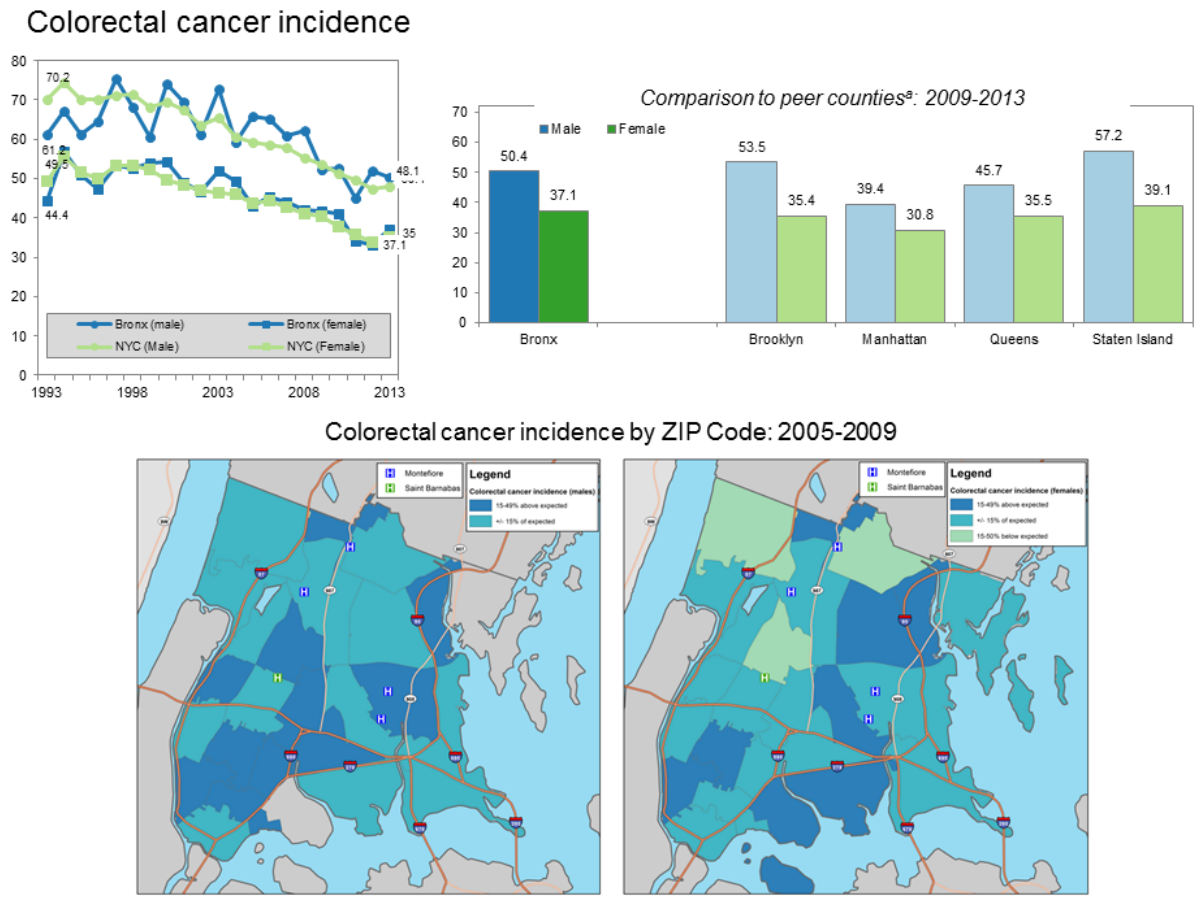
Figure 22. Age-adjusted lung cancer incidence



Data source: New York State Cancer Registry

- Among men in both the Bronx and New York City, rates of lung cancer declined, but they remained stable among women.
- Rates of lung cancer incidence were comparable in the Bronx to other New York City boroughs, with the exception of Staten Island, which has considerably elevated rates. For men, areas of elevated incidence were observed in West Farms, Morrisania and City Island. For women, only City Island had elevated rates.

Figure 23. Age-adjusted colorectal cancer incidence



Data source: New York State Cancer Registry

- Colorectal cancer incidence rates, among both men and women, have declined in the Bronx and the rest of New York City.
- Rates were generally comparable across boroughs, though Manhattan had substantially lower rates.

11. Primary Data Analysis

Three primary data collection strategies were used to triangulate the identification of community health priorities in the Bronx, including: 1) the 2014 Community Needs Assessment (CNA) conducted by the New York Academy of Medicine (NYAM), 2) the New York City Community Consultations, implemented by the New York City Department of Health and Mental Hygiene, and 3) a survey of Bronx residents implemented in collaboration with the Westchester County Department of Health to support the CSPs/CHNAs for hospitals in Westchester County. The methods and key results of each of these primary data collection activities are summarized below. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

11a. 2014 Community Needs Assessment

Results

Feedback from the community members was that they were primarily concerned with diabetes, obesity, cancer, cardiovascular disease, asthma, violence and behavioral health issues. Community members connected these issues most closely with housing insecurity, unsafe environments and poor access to healthy foods.

11b. New York City Community Consultations

Results

At eight events held in the Bronx, 43% of respondents identified as Hispanic, 32% as Black, 9% as White, 2% as Asian, 1% as American Indian or Alaskan Native, and 11% as other. Ninety-four percent (94%) identified English as their preferred language and 6% preferred Spanish. Sixty-two percent of participants were female, 27% were men, 1% identified as transgender, 1% as fluid, 1% other, and 9% declined to respond. For the Bronx overall, obesity, high school graduation, smoking, air quality and child care were the top 5 priorities identified from 8 community meetings. Obesity received, by far, the highest average score, earning an average ranking of 17.5 out of 23, compared to high school graduation (15.1 out of 23), which was second (see **Figure 24**). Obesity was the only priority identified as a top 5 concern in each of the 8 community meetings).

Figure 24. Relative rankings of top 5 priorities identified at Bronx Community Consultations

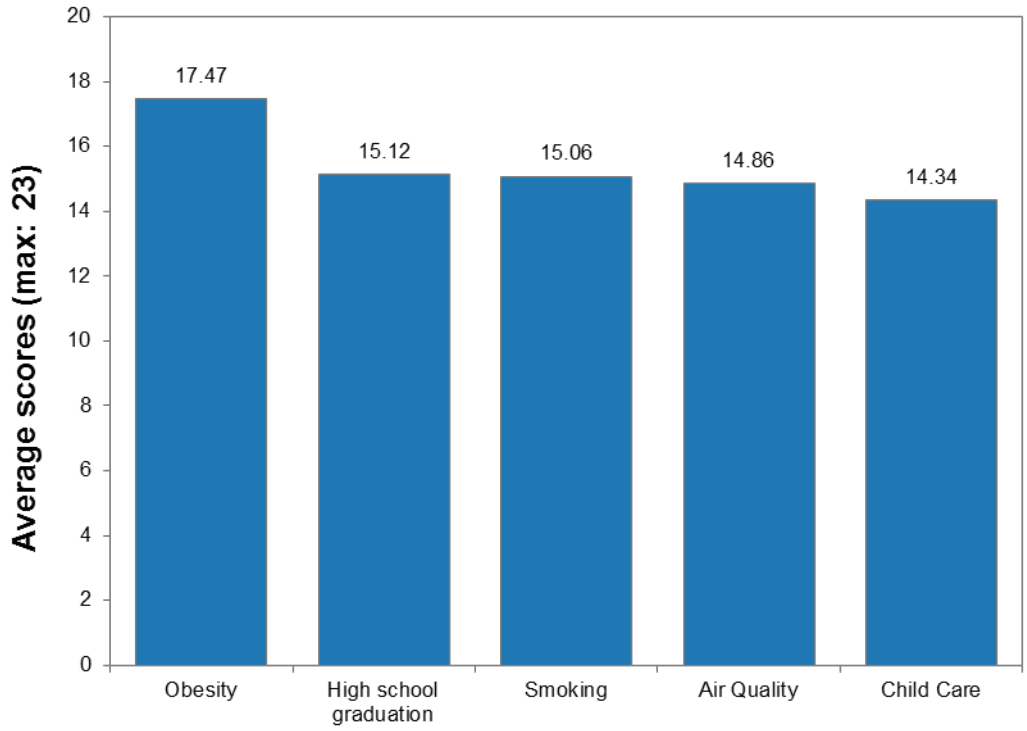


Table 4 describes the priorities identified at each Community Consultations.

Table 4. Bronx Community District Priorities

Community and Selected Priorities
Hunts Point and Longwood (CD 2)
(Including Hunts Point and Longwood)
1. Obesity*
2. High School Graduation*
3. Smoking*
4. Air Quality*
5. Child Care*
Morrisania and Crotona (CD 3)
(Including Claremont, Crotona Park East, Melrose and Morrisania)
1. High School Graduation*
2. Obesity*
3. Violence
4. Physical Activity
5. Child Care*
Highbridge and Concourse (CD 4)
(Including Concourse, Concourse Village, East Concourse, Highbridge, Mount Eden and West Concourse)
1. Obesity*
2. High School Graduation*
3. Violence
4. Air Quality*
5. Physical Activity
Fordham and University Heights (CD 5)
(Including Morris Heights, Mount Hope, South Fordham and University Heights)
1. Obesity*
2. Controlled High Blood Pressure
3. Smoking*
4. High School Graduation*
5. Physical Activity

Community and Selected Priorities

Belmont and East Tremont (CD 6)

(Including Bathgate, Belmont, Bronx Park South, East Tremont and West Farms)

1. High School Graduation*

2. Obesity*
3. Unmet Mental Health Need
4. Child Care*
5. Drug Overdose Deaths
Riverdale and Fieldston (CD 8)

(Including Fieldston, Kingsbridge, Marble Hill, Riverdale, Spuyten Duyvil and Van Cortlandt Village)

1. Obesity*

2. Physical Activity
3. Unmet Mental Health Need
4. Air Quality*
5. Controlled High Blood Pressure

* Indicates priority selected as top 5 in the Bronx.

Community Survey

Overview

Lastly, in collaboration with the Westchester County Department of Health, with whom we were collaborating on data collection for Westchester County, we fielded a web-based survey assessing community health concerns.

Methods

The survey was disseminated to community based organizations and other partners in the Bronx, and data were evaluated for those working/residing in the Bronx. The survey was administered from August 2016 through October 2016 using SurveyMonkey. Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health.

Results

The survey was completed by 127 participants. Twenty-nine percent of participants were 45-54y, 19% were 35-44y and 23% were 55-64y. Sixty-nine percent of participants were women

and 31% were men. Thirty-three percent identified themselves as being Hispanic, 36% as non-Hispanic white and 20% as non-Hispanic black.

Among 127 participants, obesity, diabetes, drug abuse, nutrition and mental health as the 5 most important community health priorities in the Bronx. The five priorities with the greatest potential to improve population health were exercise/weight loss programs, access to healthy foods, affordable housing, community education and clean air & water.

Key Findings from Analysis

Despite each of these different methods and approaches to primary data collection in gathering community input, there was a consistent focus on obesity and related behaviors and outcomes as the main community health concerns. Obesity and its related behaviors have significant impact on chronic disease, therefore, it is intended that the programs that are detailed specifically for the reduction of obesity will also impact the prevalence of diabetes, hypertension, asthma and cardiovascular disease in Bronx County

Measures and Identified Resources to Meet Identified Needs

Internal Resources and Measures

SBH Health System is a leader in community health and has a long history of developing innovative approaches to care and tailoring programs to best serve the changing needs of its community. These include, but are not limited to the following: Community Service Plan, Community Services Strategy, Accountable Care Organization, Patient-Centered Medical Home, Disease Management Programs, and Community Outreach. The integration of these innovative approaches serves SBH Health System well in its services to its community.

SBH Health System has a vast portfolio of programs and services that address a majority of the significant community health needs identified in the Community Health Needs Assessment. The breadth and depth of the programs and services vary, but each address a need identified in the community.

Across the identified significant priority areas, numerous indicators with associated metrics are described which will be utilized to demonstrate improvements needed to provide evidence of the impact of SBH Health System's efforts in addressing the health needs of its community.

The SBH System has provided a wide variety of internal resource measures to address the health needs of the Bronx community. Through its multiple care sites, services meeting the identified ranked needs of the community, including internal medicine, pediatrics, substance abuse, mental health, maternity services, and many others are provided.

Internal Resources and Measures
SBH Ambulatory Care Services by Sites

SBH Health System
Main Hospital
4422 Third Avenue
Bronx, New York 10457

- Ambulatory Surgery
- Adult Allergy
- Cardiac Catheterization
- Cardiac Stress Test
- Cardio-Pulmonary Rehabilitation
- Echocardiogram
- Endocrinology
- EEG
- EKG
- Emergency Room
    - Adult
    - Level II Trauma
    - Pediatrics
- EMG
- Geriatrics
- Holter Monitor
- Infusion Center
- Nuclear Medicine
- Pulmonary
- Pulmonary Function Tests
- Radiology
    - CT Scan
    - Fluoroscopy
    - Interventional Radiology
    - Mammography
    - Mobile Mammography
    - MRI
    - Plain Film
    - Sonograms
    - Stereotactic Breast Biopsy

SBH Health System
Center for Wound Healing and Hyperbaric Medicine
Main Hospital – 1st Floor
4422 Third Avenue
Bronx, New York 10457

- Wound Care Clinic
- Hyperbaric Services

SBH Health System
Center for Comprehensive Care
Main Hospital – 4th Floor
4422 Third Avenue
Bronx, New York 10457

- Allergy [adults and children]
- Asthma
- Breast Clinic
- Diabetes Center
- Endocrinology
- Geriatrics Senior Health
- Medication Management
- Neurosurgery
- Podiatry
- Pulmonary
- Renal
- Sleep Center

SBH Ambulatory Care Center
4487 Third Avenue
Bronx, NY 10457

- Adolescent Medicine
- Arrhythmia
- Cardiac
- Cardiac Catheterization Consult
- Coumadin Clinic
- Dermatology
- Designated AIDS Center
- Diabetic Foot Clinic
- Nutritional Services
- ENT
- Fordham-Tremont Brief Care Clinic
- Gastroenterology
- Hand Clinic

- Hemo/Oncology
- HIV Counseling and Testing
- Infectious Disease
- Interventional Radiology Consult
- Lab
- Liver/Hepatitis C
- Neurology
- OB/GYN
    - Prenatal Diabetic
    - Prenatal High Risk
- Osteopathic Manipulation Medicine
- Ophthalmology
- Optometry
- Orthopedics
- Pain Management
- Pediatrics
- Pediatric Subspecialties
    - Cardiology
    - Endocrinology
    - Gastroenterology
    - Hematology
    - IDC
    - Infectious Disease
    - Neurology
    - Renal
- PT & OT
- Plastic Surgery
- Podiatry
- Radiation Oncology
- Radiology
    - Plain Film
- Rheumatology
- Speech and Hearing
- Surgical Clinic
- Urology
- Trauma Clinic
- Vascular
- Women, Infant and Children [WIC] Program

SBH Methadone Maintenance Treatment Program
4535 Third Avenue
Bronx, NY 10457

- Methadone Maintenance with individual and group therapy
- Pre-admission for Inpatient Detox

SBH Outpatient Detox Center
4451 Third Avenue 2nd Floor
Bronx, NY 10457

- Individual and group therapy – substance use disorders

SBH Hemodialysis Center
4451 Third Avenue
Bronx, NY 10457

- Hemodialysis

Mills Building
4422 Third Avenue
Bronx, NY 10457

- Oral Surgery

Hospice of New York at St. Barnabas Hospital
4422 Third Avenue – 3rd floor
Bronx, NY 10457

- 18 beds unit

SBH Behavioral Health at Union Community Health Center
2021 Grand Concourse
Bronx, NY 10453

- Adult Outpatient Clinic
- Child, Adolescent and Family Services
- Women and Families Center
- Centralized Intake Department

SBH Behavioral Health at Union Community Health Center
260 East 188th Street
Bronx, NY 10458

- Recovery Division
- Forensic LINK
- David Casella Children's Services

SBH Behavioral Health at Southern Medical Group
326 East 149th Street
Bronx, NY 10451

- Adult Services: Individual and Group
- Children's Services: Individual and Family

Southern Medical Group
326 East 149th Street
Bronx, NY 10451

- Cardiology
- Echocardiograms/EKG
- GI
- Lab
- Medicine
- OB/GYN
- Pediatrics
- Podiatry

Arthur Avenue Comprehensive Health Physician Practice
2386 Arthur Avenue
Bronx, NY 10458

Cardiology
Dermatology
Family Practice
Internal Medicine
OB / GYN
Osteopathic Medicine
Pediatrics
Surgery

Bronx Park Medical Pavilion Physician Practice
2016 Bronxdale Avenue
Bronx, NY 10462

Cardiology
Dental

Dermatology
Endocrinology
Family Practice
Gastroenterology
Infection Control
Internal Medicine
Neurosurgery
Orthopedics
Pediatrics
Plastic Surgery
Podiatry
Primary Care
Pulmonary
Radiology
Surgery
Urology
WALK –IN URGENT CARE

SBH Health System Locations

St. Barnabas Hospital 4422 Third Avenue Bronx, NY 10457
SBH Ambulatory Care Center 4487 Third Avenue Bronx, NY 10457
SBH Behavioral Health 2021 Grand Concourse Bronx NY 10453
SBH Behavioral Health 260 East 188th Street Bronx NY 10458
SBH Hemodialysis Center 4451 Third Avenue Bronx NY 10457
The Center for Comprehensive Care 4422 Third Avenue Bronx NY 10457
SBH Methadone Maintenance Treatment Program 4535 Third Avenue Bronx NY 10457
Southern Medical Group 326 East 149th Street Bronx NY 10451
Bronx Park Medical Pavilion 2016 Bronxdale Avenue Bronx NY 10462
Arthur Avenue Comprehensive Care 2385 Arthur Avenue Bronx NY 10458

Please refer to Appendix B for the SBH Health System locations map

Community Service Activities Programs Description

In keeping with the our belief that health education and health promotion programs are essential to the mission of St. Barnabas Hospital [SBH], the staff has developed and maintains a number of community outreach activities as follows:

Speakers Bureau

St. Barnabas sponsors a Speakers Bureau that offers many resources geared to promoting wellness and educating patients, their families and residents of the communities served by the Hospital and its affiliates. Health care professionals give freely of their time to provide informational presentations and workshops to churches, schools and community based organizations on a wide range of relevant and thought-provoking topics.

Medical Marketing/Promotional Activities

The staff of the Community Affairs and External Affairs Departments works in close collaboration on a host of marketing and promotional activities with regard to the extensive medical, dental and mental health service offerings of the St. Barnabas Healthcare System. Members of the staff actively participate on the Public Relations Committee, which meets weekly to discuss participation in health-related community events, advertising and marketing strategies and prepare promotional ads on a wide variety hospital services and programs for the print media.

Collaboration with Community Based Organizations and Neighborhood Service Providers

Hospital Staff serves on Bronx Community Planning Boards, boards of local organizations and local Medical Advisory Boards. In this capacity, the staffs coordinate multi-lingual presentations by all of the health disciplines of St. Barnabas at regularly scheduled board meetings, public hearings and meetings of local community organizations. This collaboration with neighborhood service networks affords the St. Barnabas staff a unique opportunity to acquaint area residents with the hospital health professionals and the constellation of health services available. The medical marketing staff enters into and maintains affiliation agreements with service providers in an effort to assure the accessibility of health care for the clients of community based providers and treatment programs. These affiliation agreements are closely monitored for efficacy and revised as needed.

Community Alliance for Healthcare Awareness [CAHA]

As part of the on-going effort to educate and inform the Bronx Community at large on the various health topics as well as to respond to community inquiries on health related topics, SBH developed the Community Alliance for Healthcare Awareness (CAHA). This group unifies local community schools (DOE and parochial), as well as Community Based Organizations, Faith Based Organizations and childcare facilities. The group meets at our Hospital facilities on the last Wednesday of every month, shares a light snack and sits to discuss various relevant topics of interest for these organizations and to share conversation on other community bulletins and civic alerts issued.

Blood and Eye Tissue and Organ Donor Drives

The Auxiliary of St. Barnabas Healthcare Facilities sponsors on site intermittent community/employee blood drives with the New York Blood Center and organ and tissue donor drives in conjunction with the Eye Bank for Sight Restoration. The Auxiliary also encourages and facilitates other sponsor sites in the community. In addition, the Auxiliary has provided financial support for pilot studies on childhood obesity/diabetes at three parochial elementary schools in the primary service area of the Hospital.

Community Health Fairs

Members of the St. Barnabas staff initiate and/or participate in health fairs in the surrounding multi-diverse and culturally rich communities. We are aware of the cultural perspectives and differences and ensure that the people receive the information in the appropriate manner. These events are held on-site at neighborhood social service centers, churches, schools and senior citizen centers, often in cooperation with the local community planning boards or merchant's associations. Health fairs are also offered on campus at or in front of hospital healthcare facilities.

"Dinner with the Doctor" conversations

St. Barnabas has developed the "Dinner with a Doctor" as an opportunity for members of the medical staff to meet with community members over an informal, nutritious meal to discuss a wide variety of health topics of interest to a broad base of health consumers and their families. Recent bilingual and trilingual presentations have included "Yes, Heart Disease can be Prevented", "Living with Diabetes", and "Prescription Medication Abuse among the Elderly". St. Barnabas Hospital and its affiliates provide health care to a culturally diverse patient population; therefore, cultural competency and cultural sensitivity are key to the success of all of the health promotion programs and educational initiatives conducted by the staff. These educational sessions provide valuable health information; familiarize community residents with the staff of St. Barnabas and the comprehensive health service offerings of the hospital; and help immeasurably to personalize the delivery of health care. The "Dinner with a Doctor" series is central to St. Barnabas Hospital's commitment to be an active member of the community.

Humanitarian Initiatives

In addition to being a vital health and human service resource to the people of the Bronx and beyond, St. Barnabas Hospital and its affiliates have a long and distinguished history of reaching out to assist victims of human tragedies both in our immediate communities, e.g., the Bronx Happy Land Social Club Fire, and in countries throughout the world. St. Barnabas has sent relief teams, medical supplies, food, clothing and monetary donations in response to floods, earthquakes, hurricanes or scud missile attacks that hit these areas.

Mobile Mammography Vehicle

St. Barnabas Hospital has the only Bronx based mobile mammography van. This vehicle is used to perform mammograms, instruct women on breast self- exam technique and for referrals to follow up health care. The services are available to both insured and uninsured women regardless of citizenship status. The vehicle also serves as a tool to distribute health related literature, to raise awareness about breast cancer and to make visitors aware of the health care services available at the hospital.

Community Center of Excellence in Women's Health [CCOE]

The hospital seeks innovative and creative ways to integrate health care delivery with other components. St. Barnabas Hospital is the only national CCOE in Federal Region II. The CCOE Health Educator orchestrates educational activities or workshops in the community on topics that have been identified as crucial by the CDC, the NY State and the NY City Departments of Health. These bi-lingual English or Spanish health workshops are guided by a class plan and utilize government approved printed materials and include class evaluation by participants

Information Display Tabling

In an ongoing effort to promote awareness of and information on a wide variety of health issues, especially those issues that constitute the main health indicators for the communities St. Barnabas serves, such as Heart Disease, COPD, Cancer, Asthma, HIV/AIDS, Diabetes and Obesity, the health educator, the Hospital's Always Caring Volunteers and health professionals representing the various health disciplines of St. Barnabas work in close collaboration on preparing posters and literature for distribution to patients, visitors and staff of the Hospital and ambulatory care sites. Health professionals remain available to address a given topic. The Health Information Display Tables, manned by the Always Caring volunteers, are strategically placed in the Hospital's main lobby and in patient waiting areas throughout the Hospital and the Ambulatory Care Network. Most of the health literature distributed is published by the federal CDC, NYS Department of Health and the NYC Department of Health-Mental Hygiene

The SBH Community Physician Education Agenda

The SBH Community Physician Education Agenda strives to improve the quality of health care in the Bronx by offering and/or hosting relevant health seminars and support programs to both community-based and hospital providers. These educational sessions are based on the needs assessment by the community and healthcare providers. Recent topics include: *The Changing Face of Immigrant Health: What the Provider Should Know; Diabetes Mellitus Chat- a global and local perspective; and Improving Health with EHR's - Meaningful Use of Electronic Health Records as well as Small Practice Listening Session.* This program is an important way to provide not only a learning opportunity but also a chance to connect and grow relationships amongst colleagues united for a similar cause.

Community Physician Referral Office

The Community Physician Referral Office is dedicated to ensure that physicians have access to all of the resources within the SBH network and that their private practice patients receive quality care in a timely and sensitive manner while receiving treatment in a large institutional setting. The office is staffed by English-Spanish bilingual, bi-cultural staff with regular work week and business hours 9 to 5.

SBH Health System provides a range of unique programs focusing on the needs of special populations/key health issues such as:

- SBH's Teen Health Center collaborates with local NYC schools and youth services organizations to advance healthy age appropriate development for teens and pre-teens in the Bronx. The Center delivers confidential reproductive health services and programs that focus on maintaining a healthy life style, improving self-esteem and academic success, and reducing risk-taking behavior
- SBH strives to achieve cultural competency to effectively reach the diverse community it serves. To meet the needs of patients with limited English proficiency [LEP] as well as those with vision, hearing and speech impairment, SBH operates a Linguistic and Culturally Appropriate Assistance Program and has recently appointed a Chief Diversity Officer who along with the Diversity Committee implement the institution's Diversity Action Plan. SBH has been recognized as "2016 Leader in LGBT Healthcare Equity" in the Human Rights Campaign's Health Equity Index, which recognizes compassionate and inclusive treatment of LGBTQ patients, visitors and employees.
- Violence ranked number 3 in priority for two Bronx neighborhoods during the 2016 NYC DOH/MH Community Consultations. SBH is a Level II Trauma Center. The SBH Trauma Unit has joined with a local program, Bronx Rises Against Guns [B.R.A.G.] to provide interventional activities at the hospital for involved individuals. In addition, the Trauma Unit along with B.R.A.G. works with the Northwest Bronx Community Clergy Association in their NYCDOH/MH TCNY funded program to address violence and at the same time develop job opportunities in our community for those involved individuals.

New York State Health Improvement Plan – Implementation Plan CSP contacts information

The participating local Health Department:

NYC DOH/MH Bronx District Public Health Office
1826 Arthur Avenue, Rm. 124, Suite 125B, Bronx, NY 10457
Contact Person: Richard Sierra, MPH, PHE
Tel: (718) 583-6568
Fax: (718) 299-3334
Email: rsierra@health.nyc.gov

For St. Barnabas Hospital [SBH Health System]

Arlene Ortiz Allende, SVP
4422 Third Avenue, Room 428, Bronx, NY 10457
Tel. 718 960-9476
Fax: (718) 960-5546
Email: aallende@sbhny.org

Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals: not applicable

14. Priority Area: Preventing Chronic Disease:
In the Comprehensive Community Services plan developed for 2013-2017, the priority area selected was Prevent **Chronic Disease** and two related focus areas. Through the projects and activities initiated during that plan, SBH Health System was able to contribute to the overall trend improvements in those areas for New York State. However, although Bronx County has shown improvements along with the rest of New York State, the rates for conditions identified in these areas remains higher in most cases than the Citywide and Statewide averages.

As a part of the submission for the New York State Health Improvement Plan for 2016-2018, required by the New York State Department of Health, SBH Health System has again elected to adopt this priority area, Prevent Chronic Disease and has selected two broad focus areas in which to implement programs. As in past years, these broad focus areas are (1) Reducing Obesity in Children and Adults, and (2) Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings. Across these focus areas, goals, with specific interventions, performance measures and time frames, were identified, and are described below.

14a. Focus Area: Reduce obesity in adults and children

As reported earlier in the Community Health Needs Assessment section, Obesity is the number one concern of the Bronx residents ascertained by the NYCDOH/MH Community Consultations. Since 2014, SBH Health System has made changes in our sugary drinks; food marketing and cafeteria healthy meals menus prompted via the CSP program interventions. The Bronx DPHO referred to SBH as one of the champions who made big changes in their organizations around sugary drinks and food marketing. We represented the County at a presentation to the then incoming Commissioner of Health and the new Associate Commission of the Center for Health Equity. This interest in addressing sugar sweetened beverages remains within the organization and continues to be addressed albeit at a slower pace. SBH recently converted all cold beverage and snack to healthy food vending machines. Our CSP partner, Union Community Health Center [UCHC], in partnership with members of the #Not62 under The Campaign for A Healthy Bronx, was selected a Healthy Community 50 finalist in the Healthiest Cities and Counties Challenge. The Challenge is a partnership between the Aetna Foundation, the American Public Health Association and the National Association of Counties. UCHC has successfully implemented a SSB [Sugar Sweetened Beverages] Free Zone. Staff signed pledges to eliminate sugar-sweetened beverages across all sites and create a role modeling environment for patients. The push against obesity is aggressive and demonstrated in our interventions for the upcoming cycle.

Priority Area: Preventing Chronic Disease
Focus Area: Reduce Obesity in Children and Adults

St. Barnabas Hospital 2016-2018					
Description of each intervention	**Details on the intervention's evidence base**	**Where intervention will take place**	**Process Measures:**	**Role of Partners in intervention**	**Partner Resources allocated toward intervention**
Action Addresses Disparity: The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic.					
GOAL: Reducing Obesity and promoting good nutritional practices in the community.					
OBJECTIVE: Offer bilingual workshops on chronic diseases prevention in the community.					
Disseminate knowledge about healthy living in community events. We will determine Body Mass Index of events' participants and advise them on their BMI status and how to keep a healthy BMI through healthy nutrition, portion control and exercises.	Knowledge is power. Studies have shown that when people are empowered they can take control over their lives.	Throughout Bronx community neighborhoods at Health fairs, Health Expos, Advisory Board meetings, PTA meetings, CBO/FBO; organized group	Quarterly review to capture # of events and # of individuals; event requires a partner commitment for minimum of 5 participants for scheduling	Partners will organize events. We will provide the expert knowledge and printed materials in English and Spanish as needed as well as promotional flyer	Partners will engage in the planning, obtaining the necessary permits from corresponding Community Board, hosting/sponsor site
Disseminate knowledge about healthy living in our schools. We will use the curriculum of the Infant Mortality Reduction Initiative (IMRI) program to provide workshops on Healthy Living in K-12 schools.	Studies have shown that when people are taught how to lead a healthy life, it affects generations thereafter.	Bronx Public and private schools elementary, Middle Schools and High Schools; After School programs	These workshops will include pre and post-tests Quarterly Review to capture # of sessions and # of participants	Partners will organize meetings and advertise the events. We will bring in educational materials and facilitate the workshops and provide printed materials as appropriate	Partners will engage in planning, obtaining clearance from supervising entities for hosting/sponsor site
Disseminate knowledge about healthy living to our Headstart centers staff. We will use the curriculum of the Infant Mortality Reduction Initiative (IMRI) program to provide workshops on Healthy Living in the Headstart centers.	Studies have shown that when people are taught how to lead a healthy life and to take care of themselves, it affects generations thereafter.	Bronx Headstart Centers (Cardinal McCloskey Little Angels, Trabajamos, Puerto-Rican Family Institute, etc.)	These workshops will include pre and post-tests. Quarterly review will capture # of Headstarts centers, # of sessions and # of participants	Partners will organize meetings and advertise events. We will bring in educational materials and facilitate the workshops.	Partners will engage in planning, advertising and programing the events; sponsor site
Disseminate knowledge about healthy living to clients of Bronx senior centers	Studies have shown that seniors much more that the general adult want to lead a healthy life.	RAIN, Morrisania Air Rights Senior Center, Harmony Senior Day Social Care, Soundview Senior Housing Center, Aquinas Housing Corporation, Belmont Apartments.	Quarterly Review for # of Centers, of sessions and of participants;	Partners are responsible for scheduling the events and inviting the center's members as well as identifying any special areas of interest	Partners will engage in planning, advertising and programming the events; sponsor site

St. Barnabas Hospital 2016-2018					
Description of each intervention	**Details on the intervention's evidence base**	**Where intervention will take place**	**Process Measures:**	**Role of Partners in intervention**	**Partner Resources allocated toward intervention**
OBJECTIVE: Use our CSP partners to organize multicultural healthy cooking demonstrations and sampling in the community.					
Make cooking an enjoyable family activity where every member can chip in. Provide healthy easy to replicate recipes, using ingredients found at our local markets and flavors that are known to all.	Studies have shown that people care more about their diet when they know what their foods are made of.	Parents Advisory Board meetings, Headstarts, schools, organized community programs	Quarterly Review; event requires a partner commitment for minimum of 5 participants for scheduling	we will bring in the necessary ingredients to prepare the meals; sites will be hosted by the partners	Partners will organize meetings and advertise events,
Using the SBH Health and Wellness Committee establish a Sugar Sweetened Beverages Free campaign for staff and for the community	Have staff sign a pledge not to drink SSB's at work site; offer the community relevant workshops	At the hospital and its ambulatory care sites; out in the community	Quarterly review of the pledges signed and collected; number of workshops and participants	Hosts workshops, post notices and flyers promoting SSB and other educational printed materials; UCHC will present on the SSB Free Zone program	Partners will allocate their time and site
Invite members of the community to join our staff walking club and walk with us in the spring, summer and fall. We will cheer up our walkers and provide water to rehydrate	30 minutes of daily exercises to maintain your weight. 1 hour of daily exercises to lose weight.	Sycamore Grove for walking and/or other physical workout activity Perimeter of SBH campus [use of our campus is subject to schedule]	Monthly review to capture number of participants and self-report of activity	Advising community participants; Partners responsible for their own transportation; cheering squads will be volunteers	Partners will allocate their time and work with the Volunteer Dept. director to schedule their workout activities.
Revamp our gardening club and invite new members to join us in this inspiring activity. Gardening will serve as a physical activity and a way to produce healthy herbs for the kitchen. We will work with the NY BG for expert advices.	People are healthier and live longer when they are connected to a network of family and friends and have special, positive interests or focus	Green spaces throughout SBH campus	Seasonal review of gardening activity; # of participants; log of activity and location	Partners will meet up on campus work on pre-approved plans	We will provide the gardening tools, partners will be responsible to do the work.
OBJECTIVE: Bring a Farmer's Market vouchers program, the Healthy Bucks, to improve the community's means to access healthy foods.					
Expand SBH Farmers' Market Healthy Bucks initiative and where feasible work with La Canasta a community food purchase club executed by CSP partner	EBT users get an additional $2 in fruits and veggies for every $5 they spend. It allows families to stretch their dollars and lead healthier lives. La Canasta is a successful neighborhood non-profit food club	Vouchers will be distributed at senior centers, schools, Headstarts and at community events.	Monthly review to follow Bronx Farmer's Market schedule	Partners will share or be responsible for voucher distribution and documentation; encourage and /or bring members to local Farmers' Markets	Partners will consult with La Canasta program where feasible &/or organize Farmers' market trips for their members or program the drop-off of the staples

St. Barnabas Hospital 2016-2018					
Description of each intervention	**Details on the intervention's evidence base**	**Where intervention will take place**	**Process Measures:**	**Role of Partners in intervention**	**Partner Resources allocated toward intervention**
OBJECTIVE: Offer breastfeeding workshops to expecting mothers and help them to exclusively breastfeed their babies for at least 6 months and successfully breastfeed for as long as it suits them.					
Certified Lactation Counselor to educate parents on the benefits of breastfeeding**.** Provide breastfeeding workshops and teach how breastfeeding protects against obesity & chronic diseases.	Studies have shown that breastfed babies are less likely to develop obesity, diabetes, allergies and more likely to achieve developmental milestones in a timely basis.	On and off SBH campus; in partnership with WIC, the hospital Baby Friendly Initiative and other community partners	Quarterly review for # of participants [mother with or without partner] at quarterly session; pre and post tests; # of referrals and types of referrals	We will facilitate the workshops and work with partners to jointly share responsibility for programming of events	Partners will work with us to program, advertise and ensure the workshops are well attended. Referrals to Storks Nest program at UCHC;

14b. Also within Priority Area **Preventing Chronic Disease** is the Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings. In alignment with the Community Needs Assessment that was performed in preparation of the 2014 implementation of the Delivery System Reform Incentive Payment (DSRIP) program as well as the secondary data reporting, increasing rates for the screening of diabetes, especially among disparate populations is priority in increasing the rates of screening, care, management and control of diabetes. In addition to expanding the opportunities for clinical evaluation of diabetic Bronx residents, an active engagement with the National Diabetes Prevention Program from the CDC and managed through a variety of organizations and government agencies including support for smaller faith based and community based organizations through the New York City Department of Health and Mental Hygiene, collaborating with organizations that have elected for an independent relationship with the Quality and Technical Assistance Center of NY (QTAC-NY), and SBH Health System's independent pursuit of certification through the Centers for Disease Control (CDC) through the implementation of the SBH Health System Diabetes Prevention Program,

Priority Area: Preventing Chronic Disease
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

St. Barnabas Hospital 2016-2018					
Description of each intervention	**Details on the intervention's evidence base**	**Where intervention will take place**	**Process Measures**	**Role of Partners in intervention**	**Partner Resources allocated toward intervention**
Action Addresses Disparity: The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic.					
GOAL: Reducing Diabetes in children and adults.					
OBJECTIVE: Offer bilingual workshops on diabetes and diabetes prevention in the community.					
Provide healthy living workshops and educate the community about portion control and foods with low glycemic index.	Studies have shown that when people know more about their food intake impact their metabolic disorders, they are more likely to achieve a better glycemic control.	Community Centers, schools, headstarts, places of worship, senior centers…	Quarterly Reviews to establish # of sessions and participants; identify # of referrals and type of referrals	Partners will organize the events. We will bring in educational materials; Partners will accept referrals	Partners will engage in the planning, advertising the events and securing the site of the meeting; will accepts referrals for service
OBJECTIVE: Use our CSP partners to organize multicultural cooking demonstrations and sampling in our community.					
Make cooking a family affair where everyone chips in.	Studies have shown that people care more about their diets when participate in the preparation of their meals.	Community centers, places of worship, schools, headstarts, senior centers.		Partners will organize the events. We will bring in the necessary materials to make the cooking possible.	Partners will engage in the planning advertising and securing the site of the event.
OBJECTIVE: Organize and promote healthy living practices such as walking clubs, running clubs, gardening clubs in our community.					
Invite members of the community to join us for our garden club and walking club	Studies have demonstrated that walking is an excellent sport suitable for all ages and gardening offers a quality leisure yet productive time.	SBH Sycamore Grove Quarter-Mile Walking pathway Optional joining of Running Club at Bronx Crotona Park		Partners will meet up for walking or gardening at agreed upon time.	Partners will allocate their time and work with the director of our Volunteer office to schedule their workout activities; NY Road Runners will provide activity
OBJECTIVE: Work with our Hispanic Diabetic patients to teach them how to shop for foods with low glycemic index.					
Hispanic Diabetic ambulatory patients will be invited to special classes of nutrition. Classes offered in Spanish will include "Shopping with an MD" component where patient accompanied to a	Studies have shown that when patients form bonds with their providers, they are more likely to comply with their treatment plans	Physicians will select the participants from their panel. Classes will be offered on SBH campus; "Shopping with an MD" will happen at local supermarkets	Participants' HbA1c will be assessed quarterly and treatment plans adjusted as appropriate by the physician	Patients will commit to attending the classes and receiving guidance as to how to improve their diet.	Dietitians visit the markets so as to discuss with owners primary findings of their commodities. Dietitians will be available to the physicians involved as well as the patients

St. Barnabas Hospital 2016-2018					
Description of each intervention	**Details on the intervention's evidence base**	**Where intervention will take place**	**Process Measures**	**Role of Partners in intervention**	**Partner Resources allocated toward intervention**
Action Addresses Disparity: The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic.					
local supermarket by a clinician who will explain and assist in food choice with low glycemic index					
OBJECTIVE: To identify and educate inpatient population with undiagnosed Diabetes or uncontrolled Diabetes					
Automatic consult for HbA1c and Capillary Blood Glucose (CBG) Capturing those patients with undiagnosed or uncontrolled DM who are not scheduled to see their physician	Values of HbA1c =>8.5 & CBG =>350 chosen as levels indicating lack of control	St. Barnabas Hospital inpatient units	Monthly numbers include # patients consulted, # patients assessed and # patients educated	Screening Assessment Education	Information Tech services; Nutrition Services

The selected Priority Areas has received support from the New York City Department of Health and Mental Hygiene's citywide offices as well as support from the local Bronx Neighborhood Health Action Center. SBH Health System, St. Barnabas, and other hospital based and community health partners participated in a series of Take Care New York #TCNY2020 Community Consultations that were led by the New York City department of Health and Mental Hygiene. Of the eight community consultations that were held in Bronx County in the neighborhoods of East Tremont (2) , Pelham Parkway, Soundview, Riverdale, Hunts Point, Mott Haven and Highbridge, every community selected Obesity as one of their top five areas of concern and through these efforts, the New York City Department of Health and Mental Hygiene, in the re-designation of the District Public Health Offices into the Neighborhood Health Action Centers, for the Bronx, East/Central Harlem and Brooklyn, have united on three common themes (1) Nutrition and Physical Activity, (2) Teen Sexual Health and (3) Maternal Health as the focus of their borough specific operations. This exhaustive process has confirmed that there is alignment with both of the Priorities selected through the data review and primary data collection processes across multiple stakeholders.

External Resources and Linkages

Earlier in this report we mentioned that a primary external resource for healthcare services is offered by Union Community Health Center, a federally qualified health center located in the Bronx. The following is a listing of those services:

Union Community Health Center
260 East 188th Street
Bronx, NY 10458

- Adolescent Medicine
- Allergy/Asthma
- Audiology
- Behavioral Health Social Work
- Cardiology
- Child Advocacy Center (Montefiore)
- Colpo
- Dentistry
    - General Dentistry
    - Orthodontics
    - Pediatric Dentistry
- EKG
- Genetics Counseling
- GI
- HIV Counseling and Testing

- Lab
- Medicine
- OB/GYN
- Optometry
- Osteopathic Manipulative Medicine
- Pediatrics
- Pediatric Subspecialties
    - Asthma
    - Developmental
    - Endocrinology
    - Neurology
- Podiatry
- PT/OT
- Radiology
    - Mammography
    - Plain Films
    - Sonograms
- Rheumatology
- Speech & Hearing
- St. Barnabas Hospital WIC Program
- Teen Pregnancy Program
- Urology
- Rapid Walk In Center

Union Community Health Center

2021 Grand Concourse
Bronx, NY 10453

- Adolescent Medicine
- Cardiology
- Dentistry
- Echocardiograms
- EKG
- GI
- Lab
- Medicine
- OB/GYN
- Optometry
- Pediatrics
- Podiatry
- St. Barnabas Hospital WIC Program
- Urology

Union Community Health Center

470 East Fordham Road
Bronx, NY 10458

- EKG
- Family Practice
- Lab
- Osteopathic Manipulation Medicine
- Optometry
- Pediatrics

Union Community Health Center at SBH Ambulatory Care Center

4487 Third Avenue
Bronx, NY 10457

- Occupational Therapy
- Physical Therapy

Union Community Health Center Dental at SBH Health System Mills Building

4422 Third Avenue
Bronx, New York 10457

- Dental
  - Adults
  - Pediatrics
  - Orthodontics

SBH Health Systems' commitment to maximizing the health and wellness of Bronx residents demands active collaboration with stakeholders outside of the health field – in education, housing and other areas – to develop innovative programs that impact the social determinants of health. We work proactively toward this end through our role as the lead DSRIP PPS, the Bronx Partners for Healthy Communities, and through a variety of smaller scale projects.
In addition to this and the multiple resources that have been developed at SBH Health System independently and through partnerships, there is an extensive need for community-based programs and resources that that can augment SBH Health System's programs and services. Knowing how to access those resources is a particular challenge for the health care sector. However, since the previous version of this report in 2013, multiple free and lost cost online search tools have been developed, such as www.auntbertha.com , www.hitesite.org , www.nowpow.com among others. These are a much more comprehensive and practical

alternative to the home-grown referral guides that many health care providers have had to use in the past. Those were hard to keep-up-to-date and difficult to search, a problem that is largely addressed by the online versions. . Many SBH Health System sites have been introduced to these new online resources and work is underway to more seamlessly integrate this kind of solution into the various workflows across the ambulatory, ED and inpatient settings. Through the resources identified on these sites, as well as the identified Bronx Partners for Healthy Communities program services provider network, health concerns that cannot be addressed within the confines of the offerings through the St. Barnabas Health System, can be managed for the population.

Maintaining Engagement with Partners

Over the next two years SBH Health System will track progress through scheduled programs reviews which for the most part are scheduled to occur quarterly. In addition, as the need arises throughout the period, conference calls and ad hoc groups will hold meetings. The reviews will be the placed on Workgroup meeting agenda and the subject of discussion at the Community Service Plan workgroup meetings. Recommendations will be considered to make any mid-course corrections and/or changes needed.

Dissemination of the Report to the Public

The plan to disseminate the delivery of the SBH 2016 Community Service Plan report to the public will occur across several platforms:

The Community Service Plan summary will be posted to the www.sbhny.org website at the specific address: http://www.sbhny.org/wp-content/uploads/2016/12/CHNA-CSP-Final-Document-For-Submission-to-NYS.pdf and placed in social media at www.facebook.com/SBHBronx and www.twitter.com/sbhbronx.

It is also made available on the hospital's intranet for employees.

The Community Service Plan will be mailed out in hard copy and sent electronically to the Community Service Plan workgroup members. The hospital encourages all its organizational partners to provide an internet link to the hospital's online Community Service Plan.

The direct link to the Community Service Plan also will be provided specifically to those individuals who are participants of the Community Alliance for Healthcare Awareness, to community leaders and elected officials including the Bronx Borough President's Office as well as to community organizations that have hosted SBH health education workshops. Hard copies will be made available upon request.

Appropriate staff will also provide community presentations to discuss the findings of the report and their relationship to particular community interests.
Copies of a summary brochure will also be made available at community health fairs, job fairs and community meetings.

The hospital also engages the community through local media including bilingual neighborhood newspapers and a quarterly magazine. These efforts are augmented by mailings of brochures, letters and flyers announcing special programs such as Access Best Care, the hospital's financial assistance program, and promulgating local health advisories.

Appendices

Appendix A: Community Service Plan Workgroup CY 2016

Appendix B: SBH Health System locations map

Appendix C: Bronx County Provider Survey and Consumer Survey

[An electronic version of the Bronx Partners for Healthy Communities Survey was provided and distributed in five languages (English, Spanish, Arabic, French Creole, and Chinese). The provider survey was designed to provide reflective comparative insight to the questions being asked of consumers of service.]

Appendix A

Community Service Plan Workgroup CY 2016

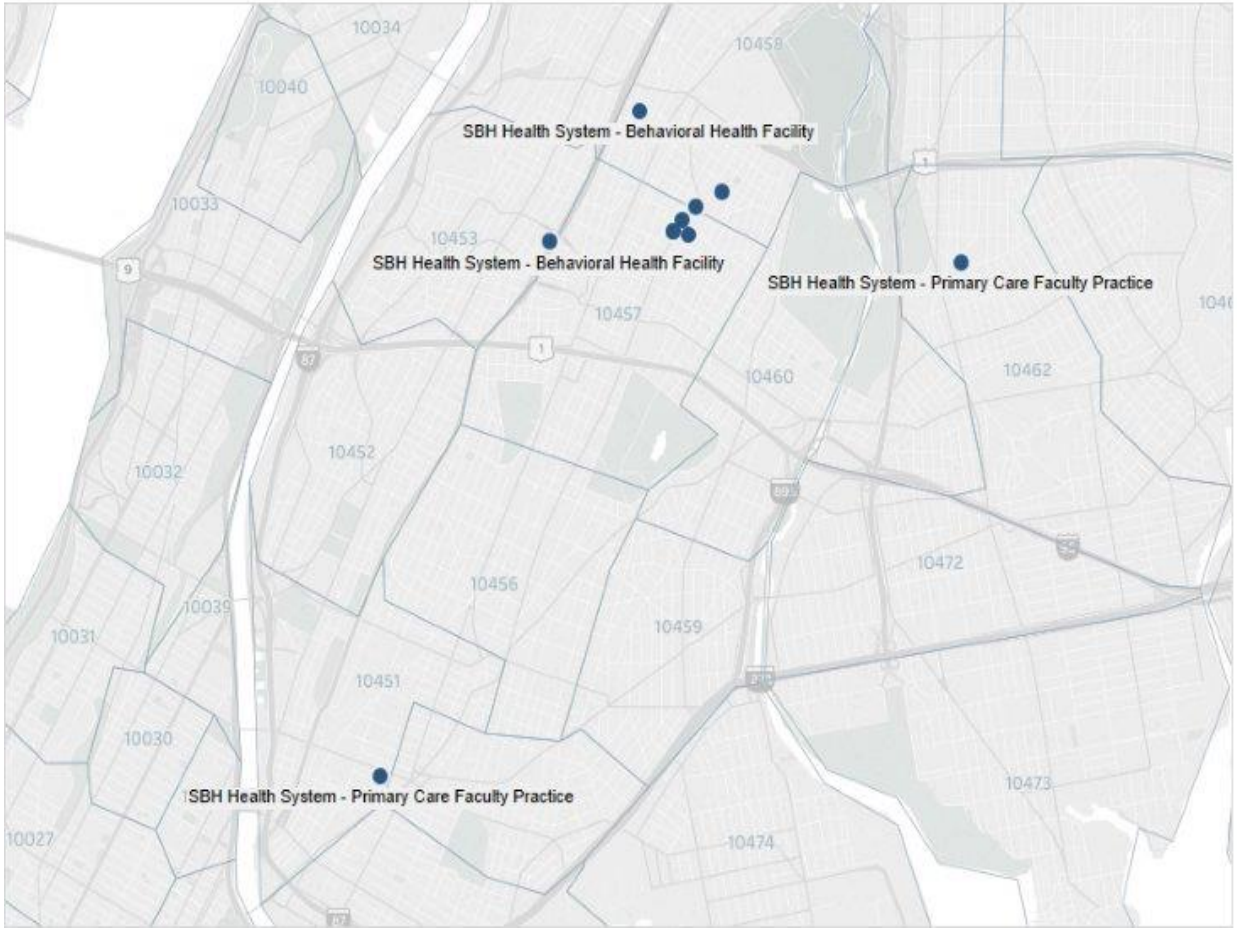
Name	Title	Organization
Alonso, Wilma	Executive Director & SBH Board of Trustee	Fordham Business Improvement District
Bonte, Jerusha	Accounting Manager	SBH Finance
Arce, Mia	Owner	Lucia Funeral Home
Aponte, Ray	Director of Community Physician Referral Office	SBH CPRO
Alvarado, Lynette	Director	SBH CCOE
Alvarez, Albert	Director DSRIP Collaboration	BPHC
Barona, Theresa	Clinical Director	SBH Ambulatory Care, Nursing
Belair, Pat	Senior Vice President	SBH Senior Leadership, Ambulatory Care
Belloise, Ralph	Director	SBH HIV/AIDS
Caba, David	Program Manager	Bronx Rises Against Guns (BRAG)
Cassidy, Ruth PharmD	SVP/Chief Pharmacy Officer	SBH Senior Leadership Clinical Support Services
Conde, Carl	Health Educator	SBH CAHA
Correa, Luz	Director of Government Relations	Union Community Health Center [UCHC] FQHC
Davis, Caroline	Director of Teen Pregnancy	SBH/UCHC Teen Center
Ditkoff, Rebecca	Registered Dietitian	SBH Nutrition Services
Dorado, Lizette	Senior Market Manager	American Cancer Society, Inc.
Dumont, Maggie	Director	SBH WIC
Eng, Nelson DO	SVP/CMO of UCHC	UCHC
Figueroa de Rivera, Elizabeth	Director Community Relations	New York Botanical Garden
Greer, Diane	Administrative Director	SBH Addiction Medicine
Granville, Dilcia PhD	Senior Public Affairs Specialist	US Food and Drug Administration
Hart, Bobbie	Exec Director	The Bronx Health Link
Hulen, Renee	Director, IT/Clinical Informatics	SBH Information Systems
Hynes, Heide	Executive Director	Mary Mitchell Family & Youth Center
Kilpatrick Foster, Yvonne	Director of Admin &Community Liaison	Sophie Davis School of Medicine/CUNY
Lesh, Amy	Clinical Nutrition Manager	SBH Nutrition
Loubriel, Diana	Administrative Assistant	SBH Administration
Macchiavello, Guido MD	Ambulatory Care Site Director	SBH Ambulatory Care Medicine

		Department
Estepan, Biarka	Senior Case Manager	PHIPPS Community Dev. Corp.
Moure-Punnett, Rafael	Director of Constituent Services	NYC City Councilmember Ritchie Torres
Murray, Tom	Director Community Affairs & President SBH Auxiliary	SBH Community Affairs and SBH Healthcare Auxiliary
Ortiz-Allende, Arlene	Sr. Vice President & Chief Diversity Officer	SBH Senior Leadership CSP Facilitator
Pafundi, Richard	Vice President	Healthfirst Managed Care
Patti, Ernest DO	Senior Attending Emergency Medicine/Distinguished Lecturer	SBH Emergency Medicine/Sophie Davis Lecturer
Perez, Jose	Chairman & CEO	Mastermind Ltd.
Robles, Yvonne	Director	SBH Volunteers
Rodriguez, Wendy	Community Board # 6 Chairperson & SBH Board of Trustee	Bronx Community District #6
Rogers, Roisin	Bronx Account Manager	Visiting Nurse Services of NY
Rondon, Miguel	Community Liaison	State Senator Gustavo Rivera
Cox-Rosado, Shirley	Regional Marketing Director	United HealthCare
Rosenberg, Dara DDS	Director	SBH Dental Services
Sierra, Richard	Public Health Educator & Community/ Health Fair Coordinator	Bronx Local District Public Health Office
Torres, Anderson PhD	President & CEO	R.A.I.N.
Torres, Elsie	Business Development Mgr.	Assist Ambulance
Velazquez, Helene	Associate Director - Latino Initiatives	American Diabetes Association
Wilson, Geneva Chef	CEO & Owner	ICCE and Geneva's 50-50

Appendix B

SBH Health System
BRONX

SBH Health System Locations



SBH Health Sytem Site Address

St. Barnabas Hospital
4422 Third Avenue Bronx, NY 10457(718) 960-9000

SBH Ambulatory Care Center4487 Third Avenue Bronx, NY 10457

SBH Behavioral Health
2021 Grand Concourse Bronx, NY 10453

SBH Behavioral Health
260 East 188th Street Bronx, NY 10458

SBH Hemodialysis Center
4451 Third Avenue, 1st Floor Bronx, NY 10457

Center for Comprehensive Care
4422 Third Avenue, 4th Floor Bronx, New York 10457

SBH Methadone Maintenance Treatment Program
4535 Third Avenue Bronx, NY 10457

Southern Medical Group
326 East 149th Street Bronx, NY 10451

Bronx Park Medical Pavilion
2016 Bronxdale Avenue Bronx, NY 10462

Arthur Avenue Comprehensive Care
2385 Arthur Avenue Bronx, NY 10458

Appendix C

BRONX PARTNERS FOR HEALTHY COMMUNITIES

BRONX COUNTY COMMUNITY HEALTH SURVEY

We want to hear your thoughts about important health issues in your community. Together, the organizations within the Bronx Partners for Healthy Communities and hospitals throughout Bronx County, NY will use the results of this short survey and other information to help improve health programs in your community. Your responses are completely anonymous. Thank you for your participation!

What are the THREE biggest ongoing health concerns for the COMMUNITY WHERE YOU LIVE?

- ☐ Access to immunizations
- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other *(please specify)* : _____

What are the THREE biggest ongoing health concerns for YOURSELF?

- ☐ Access to immunizations
- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other *(please specify)* : _____

What THREE things would be most helpful to improve YOUR health concerns?

- ☐ Access to dental care
- ☐ Access to healthier food
- ☐ Access to primary care
- ☐ Affordable housing
- ☐ Breastfeeding support
- ☐ Caregiver support
- ☐ Clean air & water
- ☐ Community education
- ☐ Dementia/Alzheimer's screening
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care services
- ☐ Exercise/weight loss programs
- ☐ Health Insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Job opportunities
- ☐ Mental health services
- ☐ Safer childcare options
- ☐ Safer places to walk/play
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other *(please specify)* : _____

How would you describe your overall health?

- ☐ Very healthy
- ☐ Healthy
- ☐ Somewhat healthy
- ☐ Unhealthy
- ☐ Very unhealthy
- ☐ Other *(please specify)* : _____

How would you describe your overall mental health?

- ☐ Very healthy
- ☐ Healthy
- ☐ Somewhat healthy
- ☐ Unhealthy
- ☐ Very unhealthy
- ☐ Other *(please specify)* : _____

Do you suffer from any chronic health conditions (*check all that apply*)

- ☐ None
- ☐ Asthma/breathing problems
- ☐ Auto-immune disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Disability
- ☐ Drug/alcohol abuse
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Memory issues
- ☐ Mental health
- ☐ Overweight/obesity
- ☐ Other *(please specify)* : _____

Do you have a health care provider for checkups and visits:		☐ Yes _____ ☐ No _____
How long has it been since you visited a health care provider for a routine physical exam or checkup?		
☐ In the past year	☐ In the past five years	☐ Never
☐ In the past two years	☐ Five or more years ago	☐ Don't know
What THREE things prevent YOU from getting medical care from a health care provider?		
☐ Nothing prevents me from getting medical care	☐ Cultural/religious beliefs	☐ Insurance does not cover service
	☐ Don't know how to find providers	☐ No transportation/too far
☐ Cannot afford	☐ Don't like going/afraid to go	☐ No childcare
☐ Cannot find a health provider who speaks my language	☐ Don't see the benefit	☐ No insurance
	☐ I have no time	☐ Other *(please specify)* : _____
☐ Co-pay/deductible too high	☐ Inconvenient office hours	
In the past 12 months, did you receive care in the emergency room?		☐ Yes _____ ☐ No _____
If yes, what is the ONE main reason for your emergency room visit?		
☐ Could not find a local health provider who speaks my language	☐ Health provider said go to emergency room	☐ Thought problem too serious for a doctor's visit
☐ Doctor's office not open	☐ No other place to go	☐ Other *(please specify)* : _____
☐ Emergency room is the closest provider	☐ Receive most of my care at emergency room	
Where do you and your family get most of your health information? (*check all that apply*)		
☐ Community-based organization	☐ Internet	☐ School/college
☐ Doctor/Health professional	☐ Library	☐ Social media (Facebook, Twitter, etc.)
☐ Family or friends	☐ Newspaper/magazine	☐ Television
☐ Health department	☐ Radio	☐ Worksite
☐ Hospital	☐ Religious organization	☐ Other *(please specify)* : _____

For statistical purposes only (your responses are anonymous), please complete the following:		
I identify as:	**What is your age:**	
☐ Male	☐ 18-24	☐ 55-64
☐ Female	☐ 25-34	☐ 65-74
☐ Other	☐ 35-44	☐ 75+
	☐ 45-54	
Zip code where I live _____	**Town/city where I live** _____	
Are you Hispanic or Latino?	☐ Yes	☐ No
What category best describes your race?		
☐ White/Caucasian	☐ American Indian/Alaskan Native	☐ Multi-racial
☐ Black/African American	☐ Asian/Pacific Islander	☐ Other
What is the primary language you speak?		
☐ English	☐ Portuguese	☐ Tagalog
☐ Spanish	☐ French	☐ Korean
☐ Italian	☐ Chinese	☐ Other *(please specify)* : _____
What is your highest level of education?		
☐ Less than high school	☐ Some college	☐ Other *(please specify)* : _____
☐ High school grad/GED	☐ College graduate	
☐ Technical school	☐ Advanced degree	
What is your current employment status		
☐ Employed	☐ Student	☐ Retired
☐ Not employed	☐ Military	☐ Other *(please specify)* : _____
Do you have any of the following types of health insurance?		
☐ Medicare	☐ Private insurance	☐ None/no insurance
☐ Medicaid	☐ Tri-Care	☐ Other *(please specify)* : _____

Please return the survey by ***September 30, 2016*** *.*

Email: bqlc@westchestergov.com Fax: 914-813-4303.

Mail: Bonnie Lam, Department of Health, 10 County Center Road, 2nd Floor, White Plains, NY 10607-1541

BRONX PARTNERS FOR HEALTHY COMMUNITIES

BRONX COUNTY PROVIDER SURVEY

We want to hear your thoughts about important health issues in the community you serve. Together the organizations within the Bronx Partners for Healthy Communities and hospitals throughout Bronx County, NY, will use the results of this short survey and other information to help improve health programs. Thank you for your participation!

Agency Name: _____
Zip code of site location: _____

Optional:
Your name _____ **Phone #** _____ **Email address** _____

How would you best describe your title/role in your agency?

- ☐ Advocate
- ☐ Alcohol/substance provider
- ☐ Allied health professional
- ☐ Behavioral health care provider
- ☐ Board member
- ☐ Dental provider
- ☐ Executive director
- ☐ Health educator
- ☐ Office manager
- ☐ Primary care provider
- ☐ Program administrator/manager
- ☐ Specialty care provider
- ☐ Other *(please specify)* : _____

Please check the categories that best describe your agency. *(Please check all that apply)*

- ☐ Alcohol/substance Abuse Agency
- ☐ Community-based Organization
- ☐ Community Health Center
- ☐ Dental Practice
- ☐ Home Care Agency
- ☐ Hospital
- ☐ Medical Practice
- ☐ Mental Health Agency
- ☐ Outpatient Clinic
- ☐ Other *(please specify)* : _____

Please check the type of services provided by your agency. *(Please check all that apply)*

- ☐ Breastfeeding support
- ☐ Case management
- ☐ Childcare
- ☐ Community education
- ☐ Dental services
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care/senior services
- ☐ Exercise/ weight loss programs
- ☐ Family planning
- ☐ Food access
- ☐ Health insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Housing
- ☐ Immigrant support services
- ☐ Immunization
- ☐ Mental health services
- ☐ Prenatal/PCAP services
- ☐ Primary care services- adults
- ☐ Primary care services- children
- ☐ Rehabilitation services
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other *(please specify)* : _____

Please check all persons served by your agency. *(Check all that apply)*

- ☐ Adults
- ☐ Children
- ☐ Disabled
- ☐ Immigrants
- ☐ Low-income
- ☐ Uninsured
- ☐ Seniors
- ☐ Other *(please specify)* : _____

What are the THREE biggest ongoing health concerns for the people/community you serve?

- ☐ Access to immunizations
- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/ suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other *(please specify)* : _____

What THREE things would be most helpful to improve the health concerns of the community you serve?

- ☐ Access to dental care
- ☐ Access to healthier food
- ☐ Access to primary care
- ☐ Affordable housing
- ☐ Breastfeeding support
- ☐ Caregiver support
- ☐ Clean air & water
- ☐ Community education
- ☐ Dementia/Alzheimer's screening
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care services
- ☐ Exercise/weight loss programs
- ☐ Health Insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Job opportunities
- ☐ Mental health services
- ☐ Safer childcare options
- ☐ Safer places to walk/play
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other *(please specify)* : _____

How would you rate the health of the people/community you serve?

- ☐ Very healthy
- ☐ Healthy
- ☐ Somewhat healthy
- ☐ Unhealthy
- ☐ Very unhealthy
- ☐ Other *(please specify)* : _____

What are the THREE most significant barriers impacting YOUR ABILITY to provide services to your patients/clients?

- ☐ Cultural competency issues
- ☐ High no-show rate
- ☐ Inadequate insurance reimbursement
- ☐ Lack of funding
- ☐ Limited bi-lingual staff
- ☐ Limited or lack of access to specialists
- ☐ Limited space and/or equipment
- ☐ Limited staffing resources
- ☐ Patient cannot afford prescription medications
- ☐ Patient non-adherence to treatment
- ☐ Staff time contrains
- ☐ Other *(please specify)* : _____

For the patients/clients you serve, what are the top THREE barriers impacting YOUR CLIENTS' ability to access your services?

- ☐ There are no issues
- ☐ Cannot afford services
- ☐ Co-pay/deductible too high
- ☐ Cultural/religious beliefs
- ☐ Don't know how to access services
- ☐ Don't like going/afraid to go
- ☐ Don't understand need to see a provider
- ☐ Inconvenient hours
- ☐ Insurance does not cover service
- ☐ Lack of time
- ☐ Lack of/or limited staff/service
- ☐ Lack of/or limited staff who speak their language
- ☐ No transportation/too far
- ☐ No childcare
- ☐ No insurance
- ☐ Unaware of services available
- ☐ Other *(please specify)* : _____

Where do community members you serve get most of their health information? *(Check all that apply)*

- ☐ Community-based organization
- ☐ Doctor/Health professional
- ☐ Family or friends
- ☐ Health department
- ☐ Hospital
- ☐ Internet
- ☐ Library
- ☐ Newspaper/magazine
- ☐ Radio
- ☐ Religious organization
- ☐ School/college
- ☐ Social media (Facebook, Twitter, etc.)
- ☐ Television
- ☐ Worksite
- ☐ Other *(please specify)* : _____

Please return the survey by ***September 30, 2016*** *.*

Email: bqlc@westchestergov.com Fax: 914-813-4303.

Mail: Bonnie Lam, Department of Health, 10 County Center Road, 2nd Floor, White Plains, NY 10607-1541

Can we contact you so you can tell us more about your ideas regarding health problems in Bronx County and what should be done about them?	☐ Yes _____ ☐ No _____