New York State Prevention Agenda Community Service Plan

REPORT 2019-2021

SBH Health System
BRONX

SBH Health System

New York State Prevention Agenda Community Service Plan 2019-2021

Table of Contents

NEW YORK STATE PREVENTION AGENDA

COMMUNITY SERVICE PLAN 2019- 2021

ST. BARNABAS HOSPITAL, INC. D/B/A SBH HEALTH SYSTEM

County covered in this assessment and plan: **Bronx County**

This document is submitted as the **requirement for the 2019-2021 Community Service Plan** through the New York State Department of Health and assesses the health needs of Bronx County, New York.

Participating Local Health department (s) (LHDs) and Contact information:

This report is supplemented with information provided by the New York City Department of Health and Mental Hygiene (NYC DOHMH). The regional NYC DOHMH contact for information is Jan Bedell, MD, Assistant Commissioner, Bronx Neighborhood Health Action Center. jbedell@health.nyc.gov

Participating Hospital System and Contact Information:

This report covers the entities of SBH Health System - St. Barnabas Hospital, SBH Ambulatory Care Center, SBH Behavioral Health and the affiliated primary and specialty care practices.

The **contact** for this report is Ninfa Segarra, JD, Senior Vice President, Government & Community Affairs, Chief Diversity Officer, - SBH Health System, nsegarra@sbhny.org
Phone number: 718-960-9476

Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals.
This report was not completed as part of a coalition.

EXECUTIVE SUMMARY

SBH Health System's Mission and Values Statement:

St. Barnabas Hospital, Inc. d/b/a SBH Health System (SBH) is a community- based, patient-friendly healthcare system serving individuals and families in the Bronx. Its expanding healthcare network provides high-quality inpatient, outpatient and emergency medical, mental health and dental services throughout the borough. SBH is dedicated to providing quality care in a compassionate, comprehensive and safe environment where the patient always comes first, regardless of their ability to pay. The Core Values of the SBH Health System are **Diversity, Respect, Integrity, Vision, and Excellence (DRIVE).** SBH is home to St. Barnabas Hospital, a seven-story ambulatory care facility, and a 40-station dialysis treatment center. SBH provides primary care, specialty services and behavioral healthcare at convenient community sites throughout the Bronx. To reinvest in the community, SBH served as a partner, entered into a $256 million, mixed-use development that includes affordable housing units with 314 apartments, built and managed by L&M Development. The project includes a 50,000-square foot, Bronx Health and Wellness Center managed by SBH, that will offer programs focused on prevention and healthy choices for the Bronx community.

Summary Prevention Agenda Priorities 2019-2021 – Three Priorities Initiatives

SBH is committed to furthering the goals set forth in the NYS DOH Prevention Agenda through the selection of three priority agenda initiatives consistent with the Department's goals. Selected after review of secondary and primary data, community engagement and align with NYS Prevention Agenda**.** Each area chosen keeps in mind available or prospective resources to serve the community.

1. **PREVENT CHRONIC DISEASES**

Focus Area 1: Healthy Eating and Food Security
Goal 1:3: Increase food security
Objectives: 1.2: Decrease the percentage of children with obesity among public school in New York City
Disparities: Food insecurity is a significant social determinant of health for communities of color
Interventions: 1.6 – Screen for food insecurity, facilitate & actively support referral

According to Feeding America (2017), the Bronx is the "hungriest borough" in NYC, with a 16% food insecurity rate, determined by the relationship between food insecurity and closely linked indicators of food insecurity (i.e. poverty, unemployment, etc.). Unlike other parts of the country, 100% of food insecure individuals in the Bronx are eligible for federal anti-hunger programs. By identifying food insecurity, screening for eligibility and providing guidance on the available nutrition programs, we can improve food security for Bronx residents. The clinician will screen for food insecurity. The target is screening at well child visits for patients ages 5 – 17 years old, from Medicaid eligible households. If the family screens positive for food insecurity, a referral for nutritional services is made.

2. **PROMOTE A HEALTHY AND SAFE ENVIRONMENT**

Focus Area; 1: Injuries, violence and occupational health
Goal: 1.2: Reduce violence by targeting prevention program particularly to highest risk population
Objectives: 1.2.d: Reduce the rate of ED visits due to assault from 152 to 151 per 10,000.
Disparities: The high crime rate is reflective of the socio-economic indicators of SBH service area.

While crime has significantly dropped throughout New York City, violent crime is an ongoing health risk in the Bronx, particularly among youth. In the community survey and in various forums, violent crime was cited as a major concern. The rate of felony assaults rate of murder and non-negligent homicide remains far higher in the Bronx than the rest of New York City. Assault related mortality rates are higher in the Bronx than the rest of New York City. SBH will implement Hospital Responder program, a community-based gun violence prevention designed on public health principles. It is a collaborative with Bronx Rises Against Gun Violence ("B.R.A.G."), Doctors of the World USA, the New York City Department of Health & Mental Health and NYPD. The lead agency is B.R.A.G. that works to prevent violence and assist in protecting the health of individuals and the public. B.R.A.G. deploys "trusted credible messengers" from the community with similar backgrounds to trauma victims identified as Hospital Responders (HR). HRs are responsible for delivering anti-violence messages and messages of

change at the patient's bedside in SBH emergency department to prevent retaliation and/or repeat episodes of violent injury.

3. **PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN**

Focus Area 2: Perinatal and Infant Health
Goal 2:2: Increase breastfeeding
Objective: 2.2.1.0: Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among infants
Disparities: The Bronx has the lowest rate to exclusively breastfeed in hospital in NYC.
Intervention 2.2.2: Promote & implement maternity care practices consistent with the Baby Friendly Hospital Initiative – NYS DOH Ten Steps to a Breastfeeding Friendly Practice Guide

According to the NYS DOH document, "Contributing Causes of Health Challenges", breastfeeding saves lives, improves health and reduces cost. Hospitals can have a significant impact on improving rates by supporting breastfeeding women. The report states that many factors negatively affect a women's breastfeeding experience. According to NYC Vital Statistics, the Bronx has the lowest proportion of infants exclusively breastfed in a hospital in New York City SBH will implement a holistic plan to encourage and support mothers, before/during and after delivery. SBH joined the NYC Breastfeeding Hospital Collaborative to work toward achieving Baby Friendly designation. SBH established a multidisciplinary committee comprised of individuals from nursing to IT, dietary to administration. Extensive changes will be made from prenatal to post discharge care. The changes made will incorporate skin-to-skin contact until first latch and feed for breastfeeding moms. Caesarean moms are allowed to bond with their infants during the immediate post-op recovery period. There are no pacifiers, artificial nipples or formula given to breast feeding moms. Discharge plans include breastfeeding support groups.

Data Review Process

The process for preparing the 2019-2021 Community Health Needs Assessment was an inter-organizational and community collaborative process, with the goal of developing an assessment that was reflective of the needs of the community including clinical and social determinants of health. The process involved the collection of primary and secondary data. SBH obtained data from various sources

such as NYC DOHMH Community Health Profiles, NYS DOH databases and national databases. SBH, with its partners, reviewed the extensive primary and secondary data. During 2018-2019, SBH explained the NYS Prevention Agenda, reviewed secondary data on demographics and health indicators, and discussed potential priorities and interventions. In addition, SBH consulted with numerous public health experts in New York City and New York State Health Departments. These discussions led to the selection of priorities identified in this document.

Partnerships and Community Engagement

SBH has developed deep partnerships and collaborations to address the long list of health disparities in the Bronx. SBH is involved in active collaboration with stakeholders outside of the health field – in education, housing and other areas – to develop innovative programs that affect the social determinants of health. Each of the priority area initiatives have deep partnerships with both community-based organizations and health care government agencies that secure both resources and technical oversight. Public participation in assessing community needs and setting priorities has been a continuous process over the past three years. We engaged a range of stakeholders with particular focus on economically challenged and racially diverse local residents to assess community needs; set priorities aligned with the NYS Prevention Agenda 2019-2024.

Evidence Based Interventions and Tracking Measures

Under Prevent Chronic Diseases, SBH is using evidence-based strategies regarding screening for food insecurity at well child visits using a Hunger Vital questionnaire. *Under Safe & Healthy Environment*, SBH, is using Cure the Violence, community-based gun violence prevention project designed on public health principles. *Under Healthy Women, Infants and Children*, SBH is following the Baby Friendly standards to promote and sustain breastfeeding. Each program has a mechanism to track progress. Both the Cure Violence and Baby Friendly initiatives have oversight by the NYC DOHMH. Additionally, SBH will learn from the experiences of our partners to improve the outcomes of the interventions.

INTRODUCTION

St Barnabas Hospital Inc. - SBH Health System

Organizational Background

St. Barnabas Hospital, doing business as, SBH Health System (SBH) is a community- based, patient friendly healthcare system serving individuals and families in the Bronx. Its expanding healthcare network provides high-quality inpatient, outpatient and emergency medical, mental health and dental services throughout the borough. SBH Health System's mission, vision and values serve as the guide for pursuing clinical excellence by delivering science-driven, patient-centered care and training the next generation of healthcare professionals. The Core Values of the SBH are **Diversity, Respect, Integrity, Vision, and Excellence (DRIVE**). DRIVE is set in the focused direction of embodying SBH's vision of being the hospital of choice in the Bronx, with superior service and innovative programs that meet the diverse needs of the community.

SBH is committed to improving the health and wellness of the community and is dedicated to providing the highest quality care in a compassionate, comprehensive and safe environment where the patient always comes first, regardless of their ability to pay.

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. SBH delivers a full continuum of services for people of all ages, from infancy to the end of life, through the following entities.

At the center is St. Barnabas Hospital, a 422 bed acute care and state-designated Level II Trauma Center. It contains a state-designated Stroke Center, AIDS Center, Hyperbaric Wound Center, an infusion center, Center for Sleep Medicine and hospice among its diverse services. SBH is one of three trauma centers in the Bronx.

St. Barnabas has become a NICHE-designated hospital. NICHE designation – which stands for Nurses Improving Care for Healthsystem Elders – demonstrates a hospital's commitment and continued progress in improving quality, enhancing the patient and family experience, and supporting the hospital's efforts to serve its communities. NICHE's vision is for all patients ages 65 and over to receive sensitive and exemplary care. This is imperative at every hospital, but especially at SBH where we care for many geriatric inpatients (including those admitted to our new 6-room Acute Care for Elders, or ACE, unit on the 3rd floor) and outpatients (such as in the Center for Comprehensive Care and our patient clinics) as well as a geriatric ED.

SBH Ambulatory Care Center's primary care physicians and specialists offer a full scope of healthcare services. St. Barnabas Hospital is a Level 2 Trauma Center. It is a Level III NCQA Patient Centered Medical Home (2014 standards). SBH Behavioral Health is one of the largest providers of mental health services in the Bronx, providing more than 92,000 visits annually.

At the SBH Hemodialysis Center, Bronx residents suffering from end-stage kidney disease can receive dialysis treatment in its state-of-the-art facility.

To improve patient health & safety, SBH Health System has adopted Lean Daily Management (LDM), which focuses on improving performance on a few quality metrics every day. The goals revolve around patient health and safety, reducing waste, improving the patient experience and employee satisfaction. It requires hospital executives to meet each morning to conduct short visits at 20 of the hospital's medical/surgical units. During each visit, executives check in on four metrics that each of the units has chosen to monitor, with the goal of improvement.

SBH Health System serves as a medical education site for young practitioners who are committed to serving people who live in racial/ethnic diverse, economically changed, medically underserved, urban communities. Every year, SBH trains 250 physicians and offers residency programs in a variety of disciplines including emergency medicine, internal medicine, pediatrics, family practice, general surgery and osteopathic manipulation treatment, podiatry and psychiatry. SBH operates one of the country's largest hospital based general practice dental programs (with residencies in general dentistry, pediatric dentistry, anesthesia and orthodontia). SBH Health System is the primary clinical affiliate of the CUNY School of Medicine at The City College of New York and affiliated with the New York College of Osteopathic Medicine and the Albert Einstein School of Medicine.

SBH Role in Transformation of Healthcare in the Bronx

SBH is playing a pivotal role in the transformation of health care in the Bronx. This includes acting as the lead partner in Bronx Partners for Healthy Communities (BPHC), a NYS Delivery System Reform Incentive Payment (DSRIP) project. It is a consortium of more than 200 Bronx community-based organizations that are working together to improve health care delivery and outcomes for Bronx residents. A number of BPHC initiatives are showing reduced ED visits, and unnecessary re-hospitalizations through improved care coordination and addressing social determinants of health.

Additionally, SBH has begun the implementation of Planetree's person-centered status with great success. The pilot program has seen significant increases in patient satisfaction scores and has had a very positive feedback from our staff. It is rolling out to more inpatient units. SBH's most recent HCAHPS scores reflect directly on the ongoing Planetree training. St. Barnabas Hospital has improved in eight of 10 domains. The rate of responsiveness by hospital staff has improved by 11.8%.

St. Barnabas Hospital is ranked as the #1 hospital for quality in primary care according to the latest ranking among the 41 institutions participating in the HealthFirst Quality Incentive Program. SBH has been an active participant in the HealthFirst Quality Incentive Program (HQIP) program since it began in 2012 and has demonstrated continued improvement in its performance. Receiving a 4-star ranking, St. Barnabas was ranked as the #1 hospital for HealthFirst Medicaid patients and among the top five hospitals for HealthFirst Medicare, when compared with all participating hospitals.

SBH is also a founding member of the Bronx Accountable Healthcare Network, which aligns services for Medicaid beneficiaries who are currently utilizing significant resources within the system. As a large outpatient provider of mental health, substance abuse and medical outpatient services, SBH plays an important role in this initiative.

Due to the diversity of the Bronx population, healthcare institutions must be able to provide language appropriate and culturally sensitive services. To meet the healthcare needs of persons with Limited English Proficiency, as well as those with vision, hearing and speech impairment. SBH has a Linguistic and Culturally Appropriate Assistance Program. In 2018, SBH provided more than 319,601 minutes of interpretation in over three hundred languages, including Spanish, Arabic, French, Bengali, Vietnamese, Yemen Arabic, Albanian, Mandarin, Soninke and Twi. This averages 30,000 requests for OPI interpreting every month. Additionally, at SBH we provide in-house qualified healthcare interpreting classes for our staff to provide meaningful access to care and assist providers and patients communicate more effectively.

Third Ave Building Project

As an anchor institution in the community, SBH Health System is part of an urban microorganism. SBH leadership understands that reinvesting in the community is a requirement. SBH, as partner, entered into a $256 million, mixed-use development that includes affordable housing units with 314 apartments, built and managed by L&M Development. It also includes a 50,000 square foot health and wellness space managed by SBH.

The Bronx Health and Wellness Center at SBH is designed to build a culture of lifelong wellness and self-empowerment by offering innovative services and programs focused on prevention and healthy choices for the Bronx community. The center will include a fitness center, a rooftop farm, a teaching kitchen, holistic programs like yoga and meditation an urgent care center, a breast imaging center and women's and children's health services.

SBH has entered into a partnership with Project EATS to manage the urban farm. The rooftop farm will deliver nutritious fruits and vegetables. SBH has entered into a license agreement with Goldring Center for Culinary Medicine at Tulane University. The teaching kitchen will offer cooking classes, using Tulane's curriculum, which will educate local residents, staff and community health workers. A medical fitness club will be established.

Statement of Executive Review

Community Service Plan Submission date: December 30, 2019

St. Barnabas d/b/a SBH Health System's Community Service Plan (CSP) process and secondary data was approved by the Board of Trustees on November 25, 2019.

Attached in Appendix C is the resolution passed by the Board of Trustees on November 25, 2019.

The report will be made available to the public in various formats.

Dissemination strategy is explained on page 90

COMMUNITY HEALTH ASSESSMENT PROCESS AND METHODS

Description of the community assessed

For the purposes of this Community Service Plan, Bronx County is the defined community service area for this Assessment. SBH operates a Level II Trauma center and offers high-demand programs such as a mobile mammography program that serves the county.

The Bronx population is 1.43 million (2018). The Bronx covers 42 square miles. The Bronx is one of the most densely populated counties in the nation. The Bronx is home to 17% of the New York City's population. SBH primary service areas are comprised of the following Bronx zip codes: 10451, 10453, 10454, 10455, 10457, 10458, 10459, 10460 and 10468. Thirty seven percent of SBH patients in 2018 came from 10457 and 10458. These zip codes are primarily in Bronx Community District #6, known as Belmont- East Tremont. It is within this geographic area that the SBH Health System has distributed its community based primary care and specialty ambulatory services.

All data reported in pages 29 to 69 is from the 2017 American Community Survey, unless otherwise noted. The Bronx is the nation's poorest urban county; 28% of the population lives in poverty (compared to 15.9% citywide) and the median household income is $37,397 (compared to $56,942 in Brooklyn, 64,509 in Queens, 79,201 in Staten Island and 85,071 in Manhattan). According to NYC Community Health profiles (2018), SBH primary service area, Belmont/East Tremont district, poverty rate is 31%.

About 40% of Bronx children live below poverty; the eighth 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 34, trailing only Tompkins and Jefferson counties.

Identification of the main health challenges facing this community

While the health status of the Bronx has improved in recent years, the gap between the Bronx and other boroughs remains and it has maintained. The Bronx remains a hotspot for excess mortality, diabetes, obesity, asthma, drugs/opioids, and HIV/AIDS in New York City.

The top inpatient discharges and reasons for treat-and-release ED visits at St. Barnabas Hospital, January-September 2019 are substance abuse (alcohol and opiates), respiratory illnesses (asthma and COPD), behavioral diagnoses, diabetes and hypertension (Appendix B).

The community faces multiple, complex health and social needs. According to county health rankings, the Bronx is 62 out of 62 counties in New York State regarding health outcomes and factors. According to 2018 NYC Community Health profiles, the Bronx has the highest rate of unmet medical care in New York City.

Discussion of the contributing causes of the health challenges

According to NYC DOHMH Community Health profiles (2018), in Belmont and East Tremont, access to affordable housing and employment opportunities with fair wages and benefits is also closely associated with good health. Rent burdened households pay more than 30% of their income for housing and may have difficulty affording food, clothing, transportation and health care. Sixty percent of Belmont and East Tremont residents are rent burdened, a higher rate than residents citywide. One way to consider the effect of income on health is by comparing death rates among neighborhoods.

"Avertable deaths" are those that could have been avoided if each neighborhood had the same death rate as the five wealthiest neighborhoods. Using this measure, 46% of deaths could have been averted in Belmont and East Tremont

According to the December 2018 Community Ranking – Child Well-being in NYC Community Districts, 80 percent of the districts classified as high-risk districts are in the Bronx. This analysis covers six domains identified as indicators of child well-being. For the period between childhood and adulthood, Belmont-East Tremont, primary service area, scored as the highest risk community. The top six communities that scored highest risk in domain of family and community are all in the Bronx. This covers households more likely to include adults without a high school diploma, headed by a single parent and high rates of violent crime.

According to the Bureau of Labor Statistics, the unemployment rate in the Bronx in 2018 was 5.7%, the second highest in New York State. In 2015, 71.9% of Bronx residents, ages 25 and older, have received their high school diploma or GED; this is substantially lower than citywide (83.7%) and statewide (86.4%) attainment rates. The Bronx has the fourth highest proportion of single parent headed households with children (59.5%) among US counties.

These social determinants, which describe the conditions that Bronx residents live, learn, work and age negatively affect the wide range of health and quality of life outcomes and risks. Having at least one unmet social need is associated with increased rates of depression, diabetes, and hypertension. That is evident when you examine the health indicators of Bronx residents.

The Bronx is one of the most diverse counties in the nation. 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 one county in the eastern United States has a lower proportion of Non-Hispanic whites and only one has a higher proportion of Latinos (Miami-Dade County).

The Bronx is 56.2% Hispanic/Latino of any race, 29.0% are non-Hispanic black, 9.1% are non-Hispanic white and 3.8% are non-Hispanic Asian. More than one-third (36.4%) of Bronx residents were born outside of the United States and 55.6% of births among Bronx residents were to foreign-born mothers in 2016 according to New York City Vital Statistics data. In the Bronx, more people speak a language other than English at home (60%) than speak "only English" (40.0%); 48.0% speaks Spanish at home.

Its foreign-born population comes from diverse corners of the globe (in order of frequency) the Dominican Republic, Jamaica, Mexico, Ghana, Ecuador, Bangladesh, Guyana, Honduras, Nigeria, Trinidad & Tobago and Italy; with no other country of origin accounting for more than 1% of the foreign-born population. As the population in the Bronx is exceptionally diverse, improvements in the health of the general population must necessarily address racial/ethnic and socioeconomic drivers of health disparities.

Issues related to health dipartites and high-risk populations

Mortality Rates & Causes of Death: From 1999 through 2017, the age-adjusted mortality rate in the Bronx declined 33.8% (from 956.8 to 637.4 per 100,000). Despite this improvement, the Bronx has a higher age-adjusted mortality rate that is 20.5% higher than the rest of New York City. The age-adjusted <75y mortality rate (e.g., premature mortality) is 38.7% higher in the Bronx than the rest of NYC.

The leading causes of death in the Bronx are heart disease (185.2 per 100,000), cancer (136.5), unintentional injuries (37.1), influenza/pneumonia (29.2), stroke (25.4), diabetes (22.9) and chronic lower respiratory disease (22.3). About 64.2% of unintentional injury deaths are related to drug/alcohol overdose. The most common causes of cancer death include lung cancer, colorectal cancer, blood cancer/leukemia, breast cancer and pancreatic cancer.

Compared to the rest of New York City, the Bronx has excess mortality rate (e.g., >50% higher than the rest of the city) for the following causes: viral hepatitis, anemias, HIV/AIDS, essential hypertension and hypertensive kidney disease, septicemia, influenza and pneumonia, unintentional injuries, assault/homicide and chronic liver disease and cirrhosis.

While the rate of assault –related hospitalizations has decreased in the Bronx and across NYC, it remains the highest in the Bronx compared to other boroughs. In the Bronx, the rate of assault-related hospitalizations is about two times higher among those who are non-Hispanic black compared to the Hispanic or non-Hispanic white populations.

Diabetes: According to the NYC DOHMH Community Health Survey in 2017, 17.5% of adults in the Bronx reported that they were previously diagnosed with diabetes, compared to 11.5% citywide. From 2002-2017, the prevalence of diabetes among Bronx adults increased 119%. The prevalence of diabetes is significantly higher among Latino and non-Hispanic black residents of the Bronx, as well as those with less education. According to the NYS DOH, the average (age-adjusted) rate of hospitalizations for short-term complications of diabetes per 10,000 in 2016 was 65 per 100,000 in the Bronx, significantly higher than the New York City rate of 39 and statewide rate of 40 per 100,000.

Obesity: In 2017, 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/m2); 34.9% compared to 25.1% citywide. The prevalence of obesity increased 47.3% in the Bronx since 2002. Unlike the rest of the city, the upward trend in the obesity prevalence in the Bronx has not stabilized. Similar to adult obesity, the Bronx has the highest rates of obesity among children, 17.6% vs. 13.5% in the rest of New York City; the prevalence does not appear to be declining over time. Males and those who are Hispanic or non-Hispanic black are more likely to be obese.

Asthma: According to the NYC DOHMH Community Health Survey in 2017, 17.0% of Bronx adult residents reported that they were previously diagnosed with asthma (13.4% citywide). According to the NYS DOH, in 2016, the emergency department visits per 100,000 for asthma was 243.8 per 10,000, more than twice that of NYC overall (122.9 per 10,000) and 5-times the statewide rate (42 per 100,000). Asthma ED visits are significantly elevated in all parts of the Bronx with the exception of the 10471, 10464, 10463, 10470 and 10465 zip codes. Rates are particularly high in the South Bronx (zip codes: 10454, 10451 and 10455).

Drugs & Opioids: In 1999, the age-adjusted mortality rate due to accidental drug overdoses was 10.4 per 100,000. By 2017, this increased 122% (23.1 per 100,000), making it a leading cause of death among Bronx residents. The death rate due to drug overdose is now comparable to that of diabetes or chronic lower respiratory disease. The Bronx has amongst the highest opioid burden (a measure that combines non-fatal and fatal overdose data) rates in New York State of 465.7 per 100,000 compared to 290 per 100,000 in New York City and 300.3 per 100,000 statewide.

In 2018, the NYC Department of Health and Mental Hygiene reported, 391 Bronx residents died of drug overdoses — accounting for 31% of all drug fatalities citywide.

HIV/AIDS: Based on data from the New York City Department of Health in 2017, the Bronx (31.8 per 100,000) has the highest incidence (new cases) of HIV in New York City. Despite this difference, the trends in HIV incidence in the Bronx are encouraging; they have declined approximately 68% from 2002 to 2014, from 99.7 per 100,000 to 31.8 per 100,000.

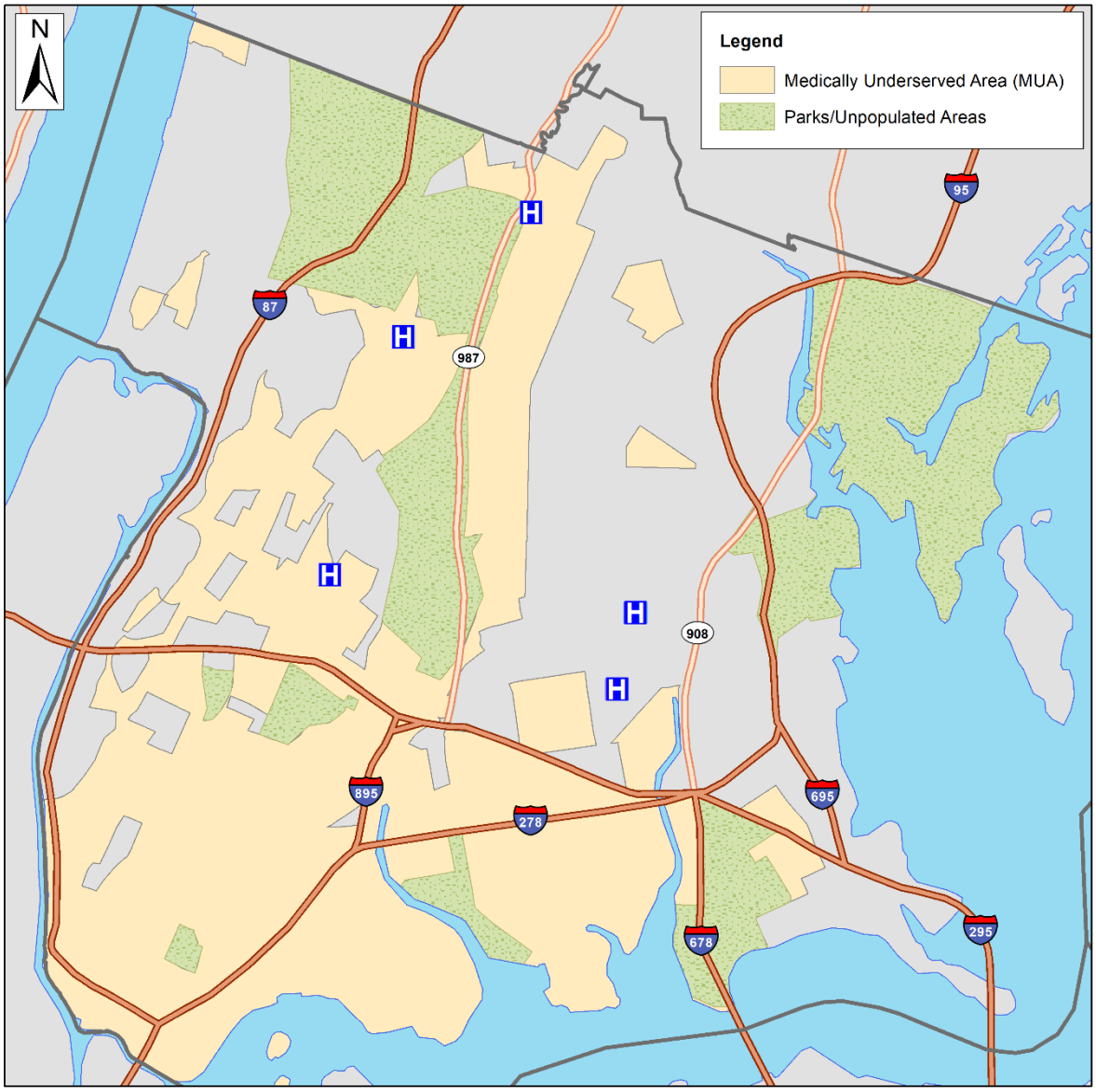
Medically Underserved Area Population

Due to various economic and social determinates, 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 applies to a neighborhood or collection of census tracts 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 Healthcare Provider Shortage Areas (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 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).

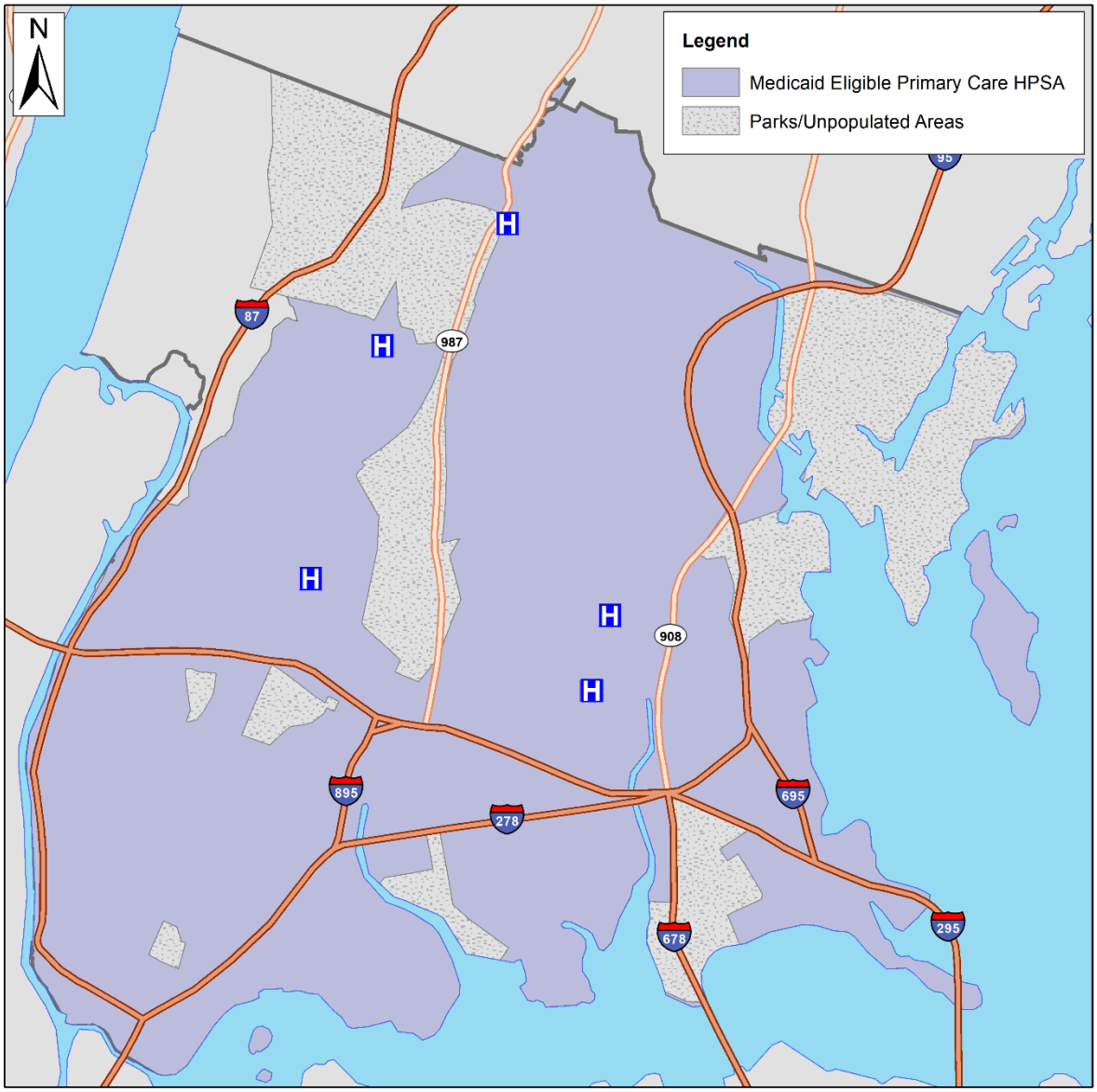
The Bronx has 18 MUA neighborhoods, with a combined population of 898,781 or 63.1% of the county population (see **Figure 1- page 16**). The Bronx has six Medicaid Primary Care Health Professional Shortages Areas (HPSA) designated neighborhoods (Pelham, Crotona, Northeast Bronx, High Bridge, Fordham, Hunts Point), which cover 93.7% of the county population (see **Figure 2- page 17**). The Bronx also has six Medicaid eligible mental health HPSAs (Pelham, Crotona, High Bridge, Fordham, Hunts Point, Riverdale), covering 84.2% of the Bronx population.

Figure 1. Map of Medically Underserved Areas (MUA) in the Bronx



Data source: Health Services Research Administration, 2019

Figure 2. Map of primary care health professional shortage areas in the Bronx



Data source: Health Services Research Administration, 2019

Summary of assets and resources that can be mobilized to address health issues identified

SBH Health System has an extensive array of services that can be accessed to advance the selected priorities. This is an up to date description of the services, interventions and the related NYS Prevention targets.

PROGRAM NAME	DESCRIPTION	INTERVENTION MEASURES	NYS PREVENTION AGENDA
SBH Baby Friendly Hospital - Increase Breastfeeding	The three basic tenets of the program are: 1. Human milk fed through direct breastfeeding is the optimal way for infants to be nurtured and nourished; 2. The first days in the birth facility should be a time of bonding and support between mother and baby; and 3. Every mother should be informed about the importance of breastfeeding and respected to make her own decisions.	Intervention 2.2.2: Promote & implement maternity care practices consistent with the Baby Friendly Hospital Initiative – ten steps to successful breast feeding.	PROMOTE A HEALTHY WOMEN, INFANTS AND CHILDREN Focus area 2: Perinatal & Infant Health Goal 2.2: Increase breastfeeding – increase percentage of infants who are exclusively breastfed in the hospital
SBH Centering Pregnancy Program	Group based prenatal care model; expecting mothers have the opportunity to receive routine prenatal care and extensive group education & make lifelong connections with other women.	The program results in a decrease in the rate of pre-term and low weight babies, increased rates of breastfeeding and improved immunization rates.	PROMOTE A HEALTHY WOMEN, INFANTS AND CHILDREN Focus area 2: Perinatal & Infant Health Goal 2.2: Increase breastfeeding – increase percentage of infants who are exclusively breastfed in the hospital
SBH Women, Infants and Children (WIC) Program	The WIC Program provides nutrition, health, fitness, and breastfeeding information and monthly nutritional tailored food packages for eligible participants. They conducts Mommy and Me Yoga, CPR certification classes, & Milk line (breastfeeding peer counselors) .	Participants receive information and classes on nutrition, wellness, fitness, breastfeeding, and farmer's market checks and how to access other services our WIC program provides.	
"Dentist in the Community" SBH Department of Dentistry & Oral Surgery	SBH Dental has extensive outreach efforts. SBH goes to schools for screenings to provide preventive fluoride and sealants in some schools. SBH attends health fairs, pre-schools, foster care organizations, day camps to provide education and screenings.	Reach underserved children and adults in the community to educate them about oral health and what they need to improve/maintain a healthy and functional dentition.	PROMOTE A HEALTHY WOMEN, INFANTS AND CHILDREN Focus area 3: Child & Adolescent Health Goal 3.3: Reduce dental caries among children
SBH: Medication-Assisted Outpatient Alcohol Use Disorder	Addiction Medicine department treats patients with alcohol use disorder. Medication can help re-balance your brain and decrease your cravings for alcohol.	Medications in combination with individual & group counseling to manage cravings and daily triggers that can led to drinking.	PROMOTE WELL-BEING AND PREVENT MENTAL & SUBSTANCE USE DISORDERS Goal 2.1: Prevent underage drinking & excessive alcohol consumption by adults
SBH: Opioids Overdose Prevention Program System (OOPP)	SBH distributes naloxone kits and teaching to patients, friends and family members. It is currently hospital-wide.	Increase availability of/access to overdose reversals (Naloxone) training	PROMOTE WELL-BEING AND PREVENT MENTAL & SUBSTANCE USE DISORDERS Goal 2.2: Prevent opioid & other substance misuse & deaths
SBH: Relay Program	Wellness advocate, with first-hand experience with substance use/trained as a peer advocate, encounter the patient within an hour of called in by the	Reduce the opioid overdose epidemic	PROMOTE WELL-BEING AND PREVENT MENTAL & SUBSTANCE USE DISORDERS Goal 2.2: Prevent opioid & other substance misuse & deaths

	department after a non-fatal patient overdose. The advocate offers overdose risk reduction counseling and opioid overdose rescue training, connects them with appropriate services, and stays in contact with the individual for up to 90 days.		
SBH Hand Hygiene Protocol	Proper hand hygiene is a key metric monitored on daily basis through observances. Through the efforts of Infection Control Department (IC), other hand hygiene efforts have been implemented to help decrease the risk of Hospital Acquired Infections. Monthly audits of hand hygiene from a cross section of the hospital system are collected.	Proper hand hygiene is one of metrics gathered by a member of the senior management team conducting daily observances for several months now. Results from IC led audits are shared with hospital leadership through various forums.	PREVENT COMMUNICABLE DISEASES Goal 5.1: Improve infection control in healthcare facilities
SBH: Stop C. diff at the door	New protocols, in addition to the use of an ATP wand were implemented. Employing a stronger disinfectant to clean patient rooms and ORs. Initiated molecular testing for patients suspected of the disease once they enter the ER. Replaced the system of sending out stool specimens, to having it done in-house, which can be completed within an hour.	C. Diff committee includes representatives: infectious diseases, nursing education, the emergency department, the NICU, ESD, IT and administration. They developed processes and systems to better define and differentiate community-acquired onset from hospital-acquired cases of C. diff.	PREVENT COMMUNICABLE DISEASES Goal 5.2 Reduce infections caused by multidrug resistant organisms and C. difficile
SBH Pediatrics: Screening for food insecurity (establish 2019)	SBH Pediatric clinic will build into EMR question to screen for food insecurity. It will link food insecure patients to community based services.	Increase screening rates Increase access to nutrition related services	PREVENT CHRONIC DISEASES Focus area 1: Healthy Eating & Food Security Goal 1.1: Increase access to healthy and affordable foods & beverages
SBH Health & Wellness Center Urban Farm (establish 2019)	Project EATS is Partner to SBH with its urban farm & farm stand. Project EATS is in the process of operating a rooftop farm in new SBH building.	Goal is to increase the consumption of affordable, local, organic, farm-fresh produce by increasing access and by providing support for healthy eating habits.	PREVENT CHRONIC DISEASES Focus area 1: Healthy Eating & Food Security Goal 1.1: Increase access to healthy and affordable foods & beverages
SBH Farmacy – Food as Medicine	Objective is to encourage healthy eating for SBH maternity and pediatric patients and clients of SBH WIC (Women, Infants, Children). This an innovative project that focuses on the importance of eating fresh produce sold at SBH Farm stand.	Those participating in the Farmacy Program receive an Rx card that provides them with a 50 percent discount on all produce sold at farm stand, workshops on healthy eating and recipes and food preparation tips.	PREVENT CHRONIC DISEASES Focus area 1: Healthy Eating & Food Security Goal 1.1: Increase access to healthy and affordable foods & beverages
SBH Mammography Mobile Unit	Provides safe breast screening and health education. The mobile van reaches out to women in the Bronx community. It is equipped with state-of-the-art digital technology – 3D - that provides safe, accurate images. Also provides women with breast education. The unit is scheduled to visit local organizations.	Criteria: Women over 40, who have not had a mammogram in the past year, are eligible and there is no charge for women with no health insurance coverage.	PREVENT CHRONIC DISEASES Focus Area 4: Preventive Care and Management Goal 4.1: Increases cancer screening rates for breast, cervical and colorectal cancer Mobile van Increase the percentage of women with annual household income less than $25,000

SBH Center for Comprehensive Care – Certified Medical Home	Outpatient chronic disease management. The CCC's separate centers for Geriatrics, Asthma, Allergy, Diabetes, and Sleep Disorders are co-located, fostering ease of access to comprehensive care.	Assist patients in managing their chronic conditions to avoid re-hospitalization and emergency department visits, and live healthier lives.	PREVENT CHRONIC DISEASES Focus Area 4: Preventive Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
SBH Senior Health Center Center for Comprehensive Care	It addresses the special healthcare needs of older adults. A team performs physical, ambulation, memory, nutritional, hearing and visual screenings. Treated are those medical conditions common to seniors.	Changes in patients' function are monitored that can affect their well-being and independence, including falls and balance issues, osteoporosis, urinary incontinence, memory loss, dementia and depression.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
SBH Healthy Aging Initiative	Four part program to management chronic health conditions thru nutrition education, medication education and diabetes management geared toward seniors	Goal is to increase the consumption of affordable, local, organic, farm-fresh produce by increasing access and by providing support for healthy eating habits.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
SBH Diabetes Center/Center for Comprehensive Care	Provides patients with education that can help them modify behavior & better manage their disease and related conditions. Directed by a board certified endocrinologist & a nurse practitioner, the team collaborates with a dietitian, primary care physician, medical assistant, clinical pharmacist and others. Aim is to achieve optimal health status, better quality of life, & reduce the need for hospitalizations and emergency room visits.	Aim is accomplished through diabetes self-management training that focuses on patients eating healthy, being active, monitoring their blood sugar, taking medication, and reducing risks.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
SBH Sleep Center/ Centre for Comprehensive Care	The Sleep Center, directed by a physician board certified in sleep medicine, does in-hospital and at-home sleep studies, and treats both adults and children with a variety of sleep disorders. For obstructive sleep apnea common treatments include the use of the CPAP (Continuous Positive Airway Pressure) device. Center also treats patients with insomnia, parasomnias, narcolepsy, restless leg syndrome & other sleep disorders.	About 5 % of adults and children suffer from obstructive sleep apnea (OSA). For those with type 2 diabetes the disorder is closer to 80%.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
SBH Asthma Biologic Therapy	Treatment of intramuscular injections, Omalizumab (Xolair), Nucala or Fadenra, offers adults and children with persistent and severe asthma with conditions that are not controlled by inhaled corticosteroids alone or in combination with long acting bronchodilators or leukotriene pathway inhibitors.	Decrease the number of asthma attacks in patients with severe and difficult to treat asthma.	

SBH LDCT (Low Dose Computed Tomography) Lung Cancer Screening Program	A clinically structured collaboration between pulmonologists, thoracic radiologists, oncologists and patient navigators, is for individuals at risk for developing lung cancer.	Early detection of lung cancer.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases
SBH Bronx Health Talk	Original free service that allows internet users to pull audio files from a podcasting website. SBH medical experts discuss relevant health care topics in a conversational, easy to understand manner.	Podcast targeted to general public in the Bronx.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
SBH FollowMyHealth (FMH)	A free online patient portal that provides access to the patient's personal health records and empowers patients to manage their care. It assists patients to monitor their weight, blood pressure and/or manage a chronic condition. Patients are encouraged to fulfill their prescriptions through the portal and email their providers, through secured messaging.	The intervention measures include making patients more comfortable with utilizing the portal to reduce clinic visits and patients being more proactive with their health. There has been significant growth of patient membership since its implementation.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote evidence based care to prevent and mange chronic diseases in clinical setting Promote the use of health information technology

SBH Community Physician Referral Office (CPRO)	CPRO is a point of contact for all of patient scheduling needs. CPRO schedules specialty appointments and radiology requests. CPRO provides expedited access to appointments at SBH Health System. CPRO informs the physician's office & the patient regarding appointment and provides the patient's medical results to the physician's practice.	Provide private practice patients quality care in a timely and sensitive manner.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote evidence based care to prevent and mange chronic diseases in clinical setting Promote the use of health information technology
SBH Matter of Balance	Eight week structured group that emphasizes practical strategies to reduce the fear of falling and increase activity levels. SBH conducts sessions of this program both at its facilities and in community settings.	To reduce injuries by providing injury prevention programs for children, adults and senior citizens.	PROMOTE A HEALTHY & SAFE ENVIRONMENT Focus area 1: Injuries, violence & occupational health Goal 1.1.: Reduce falls among vulnerable populations Stop the annual increase in rate of death due to falls among residents ages 65 and over
SBH Stop the Bleed	Individuals (bystanders) are trained to help in a bleeding emergency before professional help arrives. The goal is to stabilize the patient with open would until First Responders arrive. It is an American College of Surgeons program.	Train both community members and SBH staff.	

DATA COLLECTION PROCESS

Primary Data Collection

Three primary data collection strategies were used in conjunction with secondary data to triangulate the identification of community health priorities in the Bronx. The primary method of primary data collection was a survey of Bronx residents implemented in the Spring and early Summer of 2019. To ensure an efficient gathering of primary and secondary data, SBH worked closely with Montefiore Office of Community & Population Health. The Montefiore Office of Community & Population Health created a two-page instrument that could be completed on paper or online with stakeholder input. The survey was available in both English and Spanish. Half-page handouts were made in both English and Spanish to hand out at community events with a QR code that automatically linked participants to the online survey.

The survey was designed to be completed in less than 5 minutes and was based on a survey we previously used in 2016 to assess community health needs. The survey included questions on what community members perceived to be the priority health concerns in the community where they lived. We also asked participants to identify what intervention strategies would provide the most benefit to their community. Participants were also asked to identify their individual health priorities. Based on our prior work in this area we often see a discontinuity between responses to the "community" and "individual" questions. For each of these questions, a menu of more than 20 areas/topics was included. These included categories chosen to align with the 2019-2024 New York State Prevention Agenda Focus Areas. Beyond questions specifically related to community health concerns, participant demographic and health status data were collected. Copies of the English and Spanish versions of the paper survey are provided in Appendix A

Survey participants were sought using various approaches:

- E-mails were sent to relevant list-serves with links to the survey
- Health fairs and other events staffed by Montefiore Office of Community & Population Health and SBH Health System personnel.
- Surveys were disseminated at community board meetings throughout the Bronx
- Strategically disseminated by key partners including the NYC Department of Health & Mental Hygiene and SBH Health System

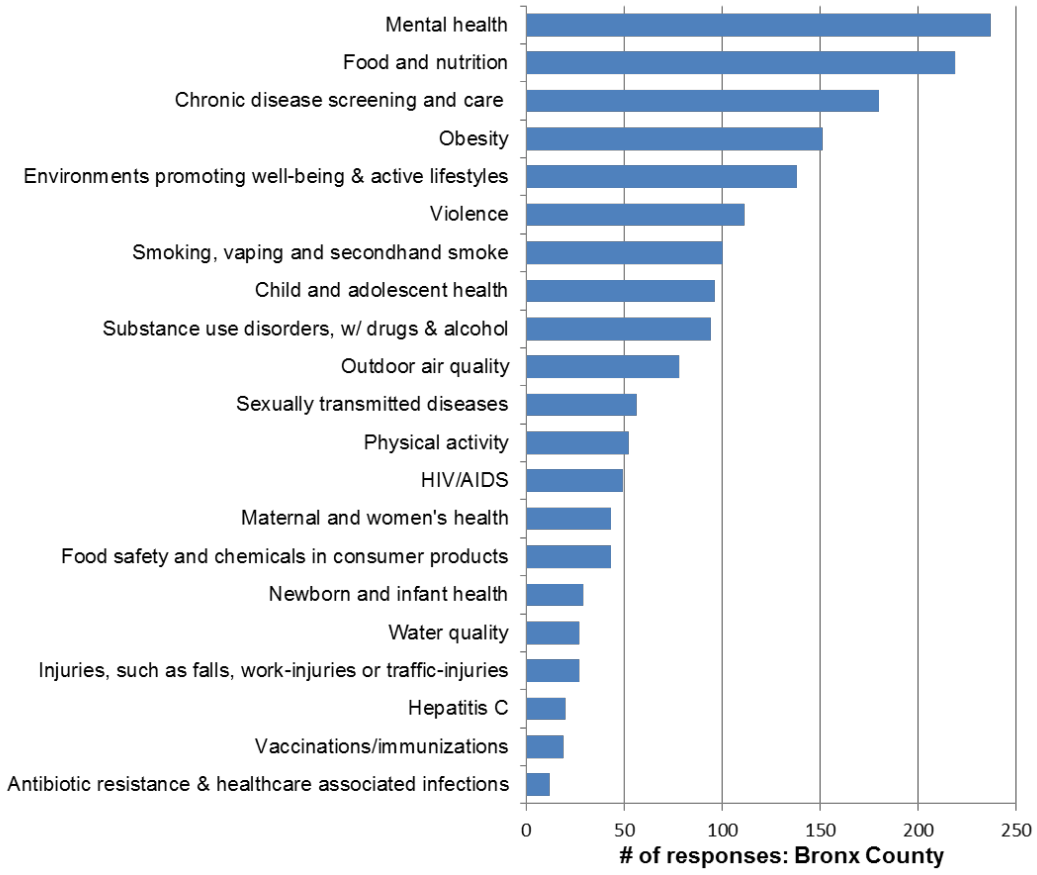
Paper copies were manually entered into the online survey tool and the Montefiore's Office of Community & Population Health analyzed the data. In the following pages, the results of the survey are shown in several tables plus a summary of the outcomes.

Note: The survey captured a reasonable age distribution of Bronx residents, though adults age 25-34y are slightly over-represented in the survey. Typical of surveys like this, women are over-represented. This is because women are more likely to participate in community events and activities are more likely to complete surveys. The survey captured an increased proportion of more highly educated residents than the Bronx overall, but the race/ethnicity distribution is comparable. The survey as disproportionately completed by individuals who indicated that they spoke English, as opposed to Spanish at-home.

Table 1. Socio-demographic comparison of Bronx Community Health Survey and Bronx Population from the American Community Survey, 2017		
	Percent (%)	
	Bronx Community Health Survey (n=538)	**American Community Survey, 2017**
Age		
18-24	8.0	10.4
25-34	29.0	16.1
35-44	17.8	12.6
45-54	13.0	12.8
55-64	14.7	10.9
65-74	12.9	7.0
75+	4.7	5.4
Sex		
Female	71.4	54.1
Male	28.6	45.9
Education		
Less than HS	4.9	27.1
HS	17.8	27.6
Some College	25.5	27.2
College or More	51.9	18.2
Race/Ethnicity		
Hispanic	43.5	54.3
Non-Hispanic Black	39.1	29.4
Non-Hispanic White	8.6	10.3
Other	8.6	6.0
Primary Language Spoken At Home		
English	73.5	39.1
Spanish	16.9	48.6
Other	9.6	12.4

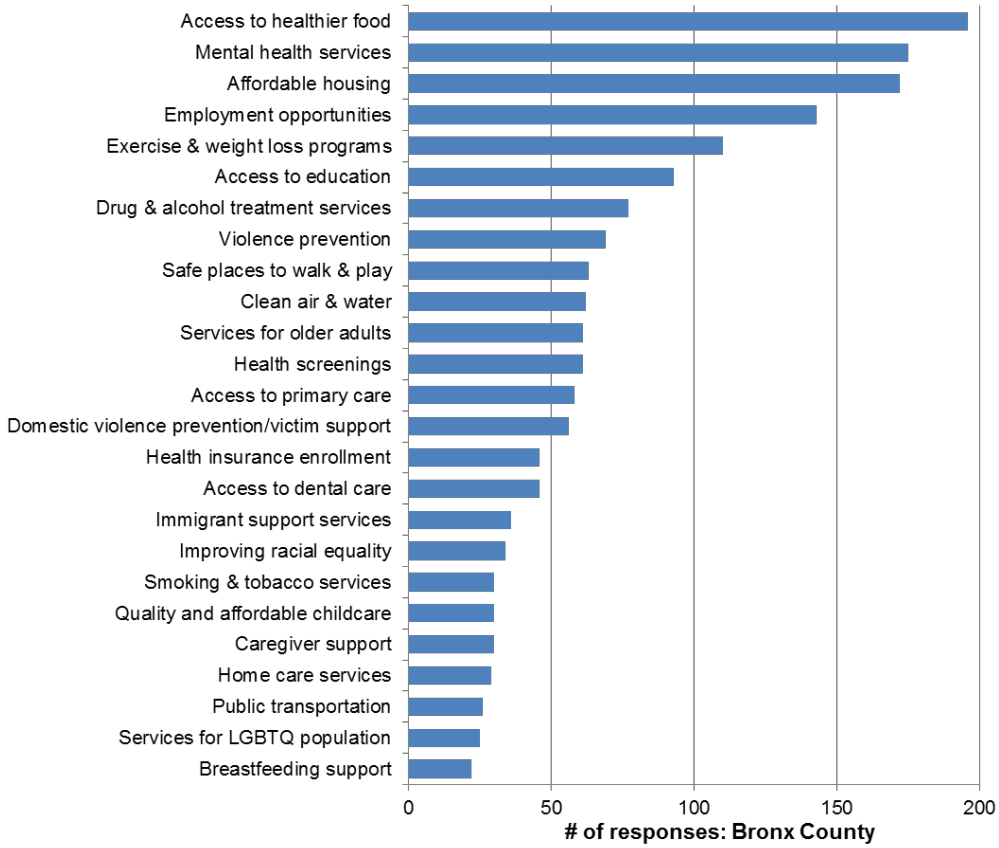
Data Source: American Community Survey 2017 and American Community Survey, 2017 Microdata for Race/Ethnicity; For Bronx CHS, n=538 except for race/ethnicity where n=430 (blank responses were excluded)

Table 2. Community priorities in the Bronx Community Health Survey, 2019



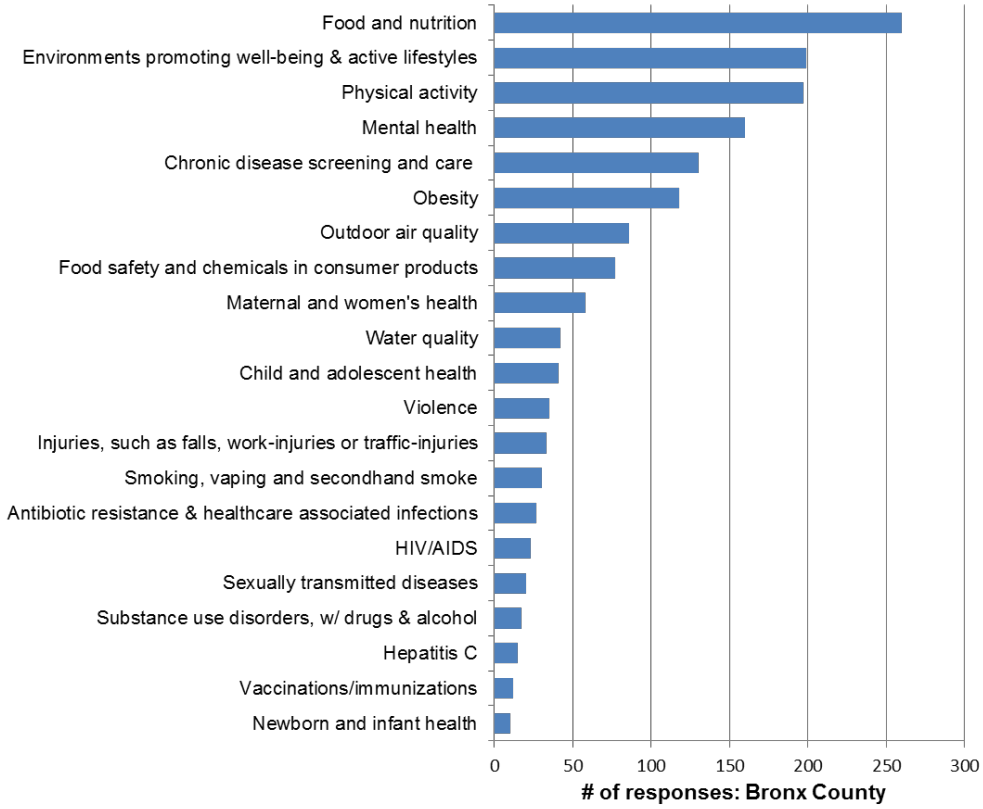
Participants were asked to identify the top 3 community health priorities out of a list of more than 20 options. This data is of critical importance to the hospitals as it tells us what community members think are the priority areas. In this survey, mental health, food and nutrition, chronic disease screening and care, and obesity were the top identified priorities. Additional responses receiving a large number of responses included environments promoting well-being and active lifestyles, violence, and smoking (including vaping and secondhand smoke).

Table 3. Most helpful actions for the community in the Bronx Community Health Survey, 2019



Participants were also asked to identify what actions or activities would be most helpful for their community. The leading responses to this question were access to healthier food, mental health services, affordable housing, employment opportunities and exercise and weight loss programs.

Table 4. Individual priorities from the Bronx Community Health Survey, 2019



In addition to asking survey participants to think about community issues we also asked them to report on the priority health issues for themselves. The responses to this question differed slightly from the community concerns. Food and nutrition, environments that promote well-being and active lifestyles, physical activity, and mental health were the top priorities.

In summary, mental/behavioral health and obesity-related health issues were identified by participants as priority areas.

Table 5. Survey Summary

	Priority Area for Community	Action Area for Community	Personal Priority Area
Ranking	**Bronx County**	**Bronx County**	**Bronx County**
1	Mental Health	Access To Healthier Food	Food And Nutrition
2	Food And Nutrition	Mental Health Services	Environments That Promote Well-being & Active Lifestyles
3	Chronic Disease Screening and Care	Affordable Housing	Physical Activity
4	Obesity	Employment Opportunities	Mental Health
5	Environments That Promote Well-being & Active Lifestyles	Exercise And Weight Loss Programs	Chronic Disease Screening And Care
6	Violence	Access to Education	Obesity

Note: Bronx County includes n=538 respondents

Secondary Data Collection

The Bronx has been an epicenter of the asthma, HIV/AIDS, and drug epidemics and excess mortality rates from heart disease, stroke, and diabetes compared to city-wide and national averages. Multiple data sources were used to support the identification and selection of the priority items identified, which were then selected, and reviewed with partners. To ensure an efficient gathering of primary and secondary data, SBH worked closely with Montefiore Office of Community & Population Health.

In addition to the review of primary data, 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, disparities by race/ethnicity and socioeconomic status, and sub-county differences, when available, for more than 20 measures, including: poverty, having a primary care provider, having health insurance coverage, obesity (adults and children), diabetes, teen births, preterm births, breastfeeding, flu vaccination, receipt of colonoscopy, colorectal cancer incidence, breast cancer incidence, new HIV diagnoses, chlamydia diagnoses, preventable hospitalizations, asthma hospitalizations, fall-related hospitalizations, assault hospitalizations, smoking, opioid-related mortality, depression, and suicide. The metrics were selected as they represent the continuum of risk factors and health outcomes of interest and are publicly available.

These data were obtained from multiple population-based datasets including the Global Burden of Disease Project, American Community Survey, New York City Community Health Profiles, New York City Community Health Survey, New York City Youth Risk Behavior Survey, New York State Statewide Planning and Research Cooperative Systems (SPARCS), National Vital Statistics Surveillance System, New York State Vital Statistics, New York City Vital Statistics, New York City Sexually Transmitted Diseases Surveillance Data, New York City HIV/AIDS Epidemiology Reports, and the New York State Cancer Registry.

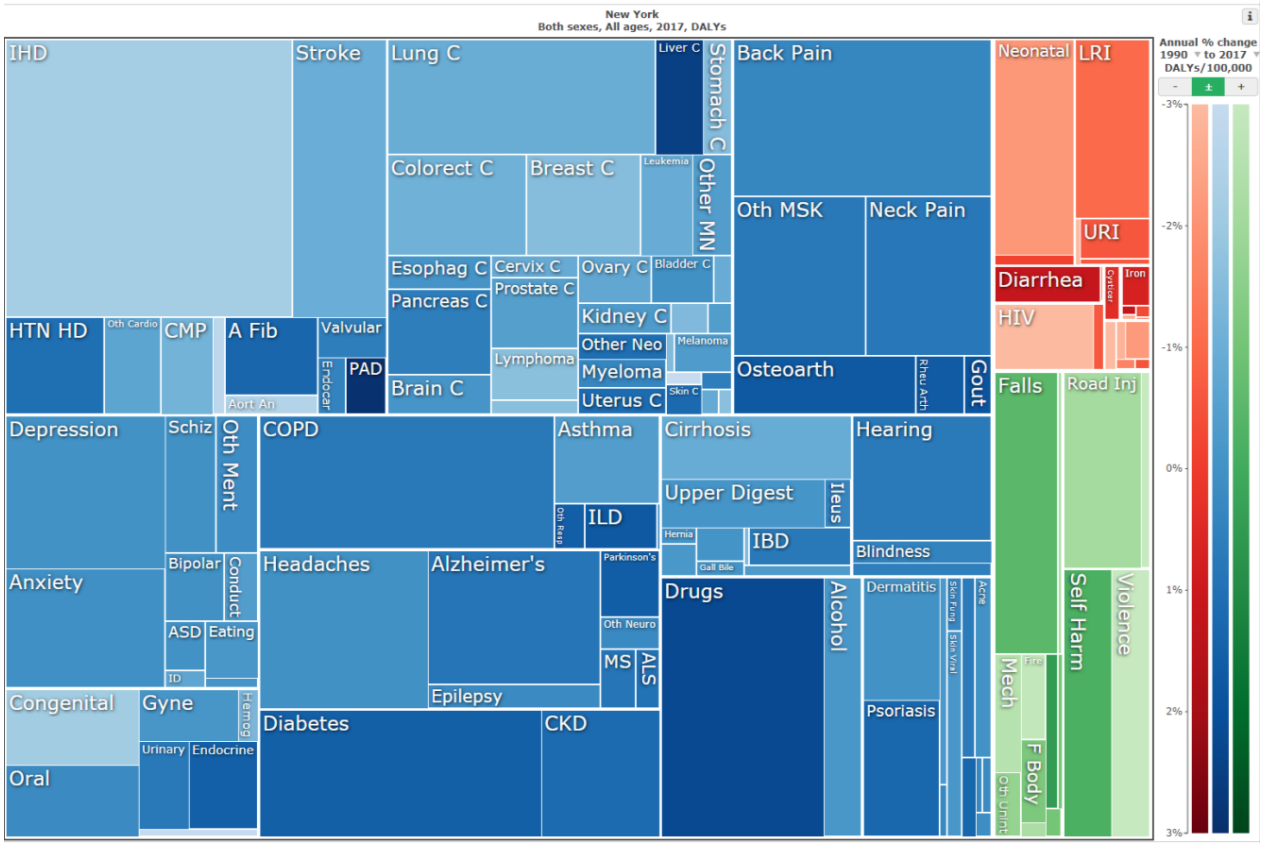
Additional data was obtained from the New York City Community Health Profiles and the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard.

The secondary data is shown in the following pages 29 to 69.

The data sources used are summarized in **Appendix F**

Presentation of Secondary Data

Figure 1. Leading causes of disability adjusted life years in New York State, 2017

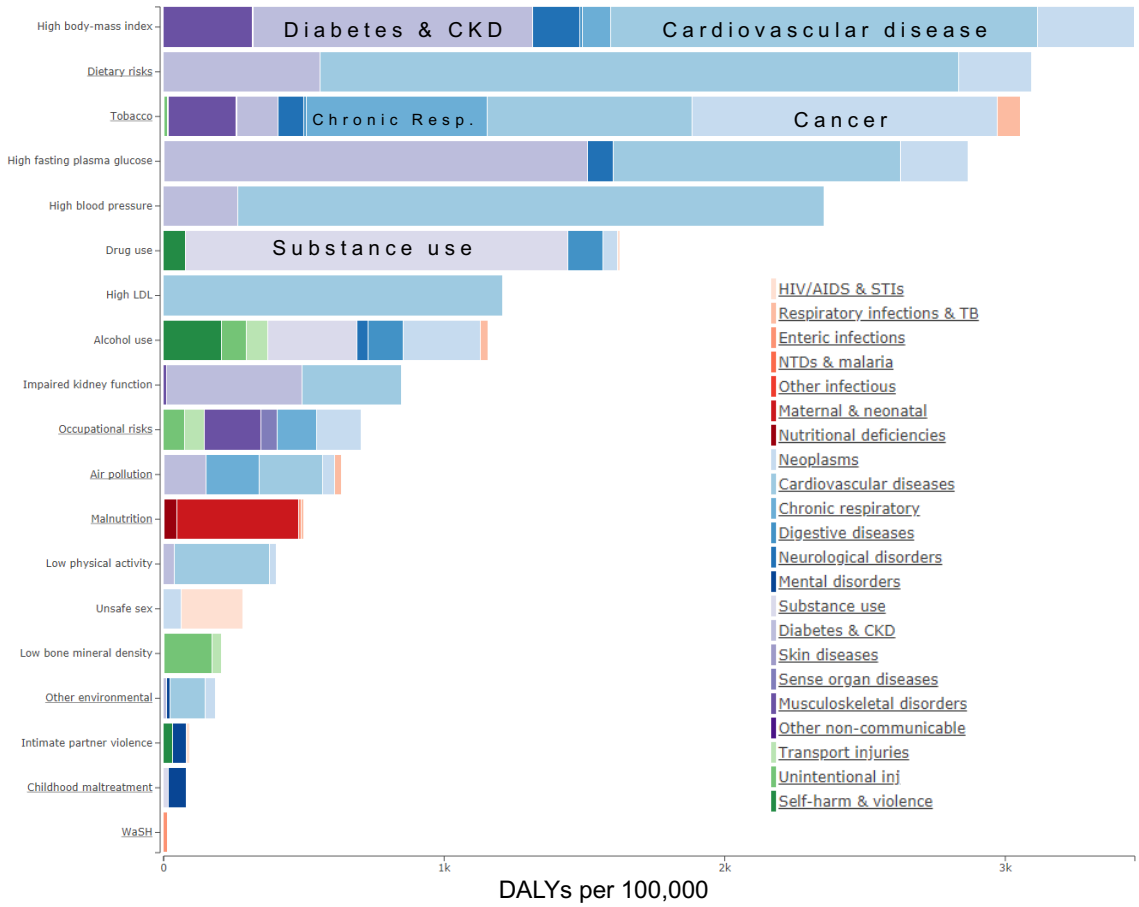


Data source: 2017 Global Burden of Disease Project.

The leading causes of ill health in New York State as measured by disability adjusted life years are ischemic heart disease (8.8%), drug use disorders (4.7%), low back pain (4.5%), chronic obstructive pulmonary disease (4.4%) and diabetes mellitus.

The saturation of the graph shows the proportionate change in DALYs from 1990 to 2017. Among leading causes of disability, the largest increases were observed for liver cancer (+2.5%), drug use disorders (+2.2%) and osteoarthritis (+1.8%). Major declines were observed for HIV/AIDS (-7.4%) and tuberculosis (-5.9%).

Figure 2. Distribution of disability adjusted life years by risk factor in New York State, 2017.



Data source: 2017 Global Burden of Disease Project.

In New York State, the finest level of geographic data from the Global Burden of Disease project, elevated body mass index (BMI) is responsible for the highest proportion of disability adjusted life years (a summary measure combining fatal and non-fatal health status). Elevated BMI is responsible for excess ill health via its association with cardiovascular disease, diabetes, and some cancers.

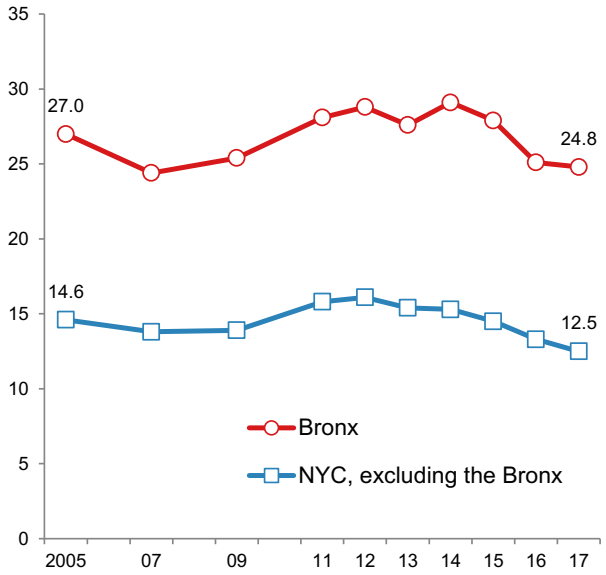
Dietary risks are the second leading contributor to ill health, due to associations with cardiovascular disease, diabetes and some cancers. Within dietary risks (data not shown), low whole grains, high sodium, low nuts and seeds and low fruit are the leading causes of ill health.

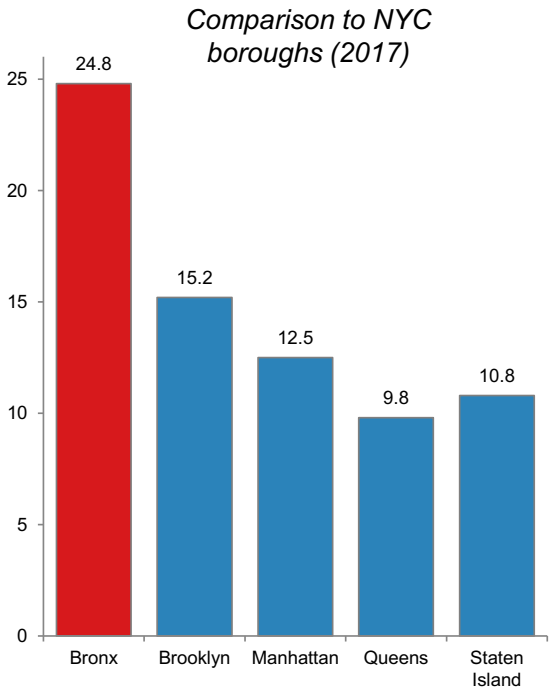
Tobacco is the third leading causes of ill health, with strong associations with many cancers, cardiovascular disease and chronic respiratory disease.

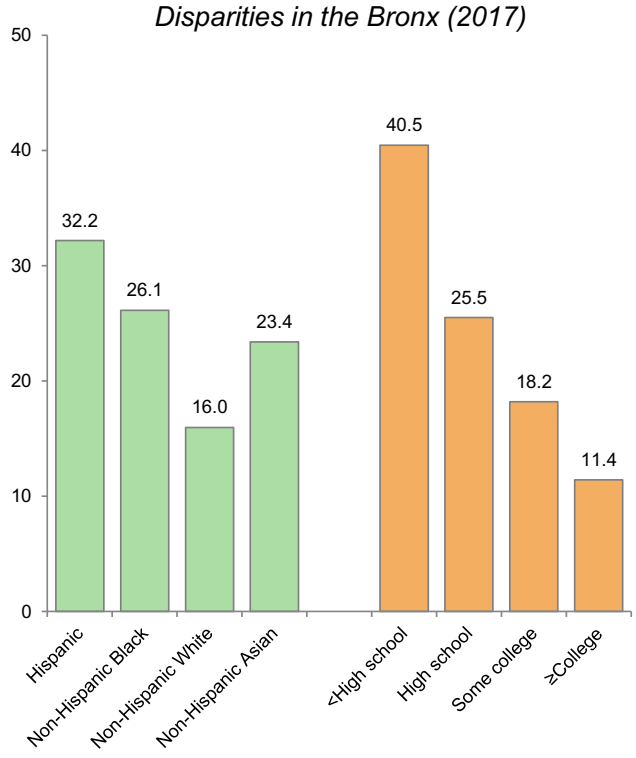
High fasting plasma glucose and high blood pressure are also leading causes of ill health.

In New York State, in 2017, drug use is the sixth leading cause of disability.

Figure 3. Percent of Families Living in Poverty





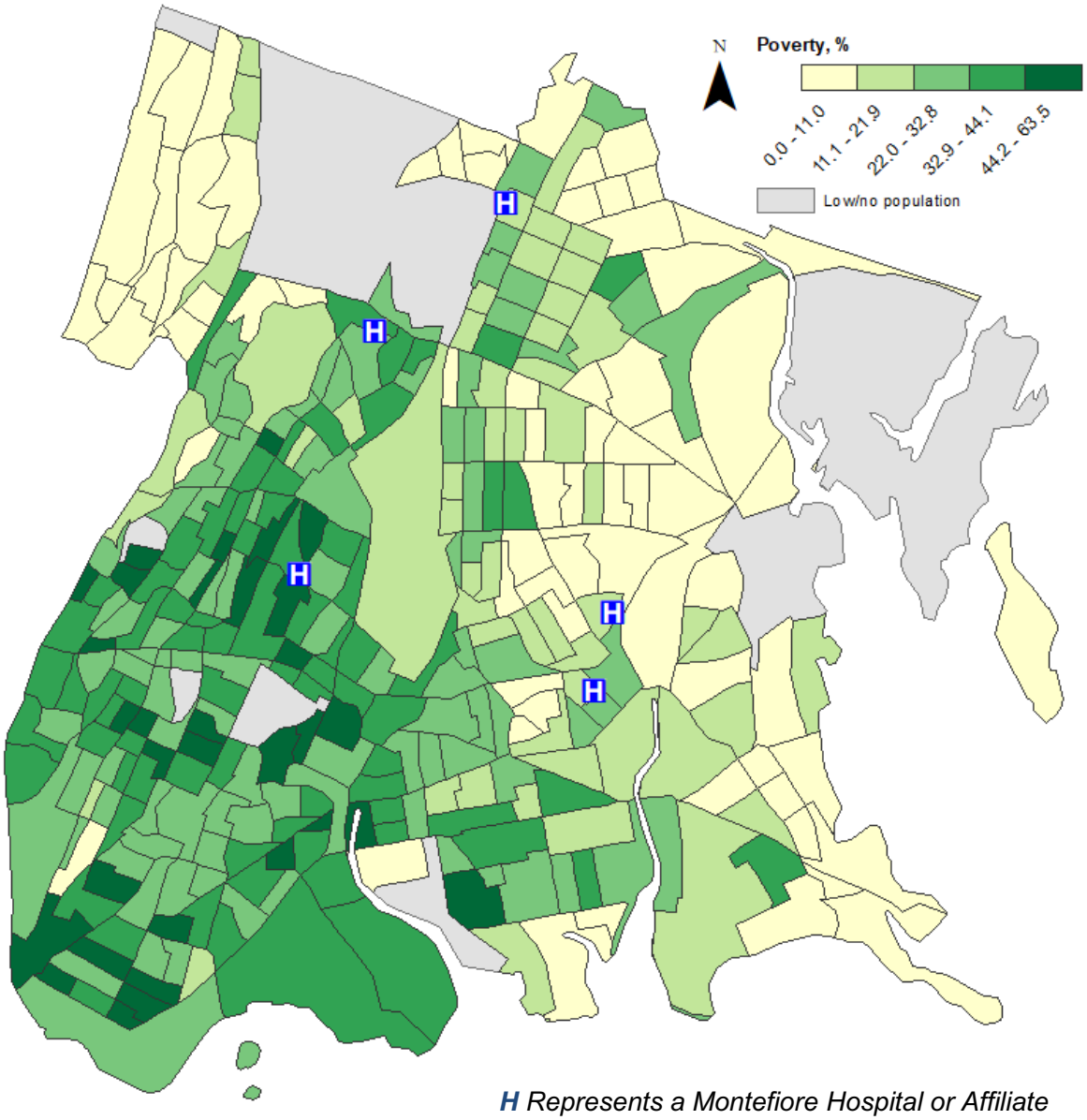


Data source: American Community Survey.
Disparities data from Public Use Microdata.

In 2017, about ¼ of families in the Bronx were living in poverty, which is nearly twice the percentage of families in the rest of NYC. In the Bronx, the percentage of families living in poverty is highest among the Hispanic and non-Hispanic black populations, and in the South Bronx.

Figure 4. Percent of Families Living in Poverty in the Bronx

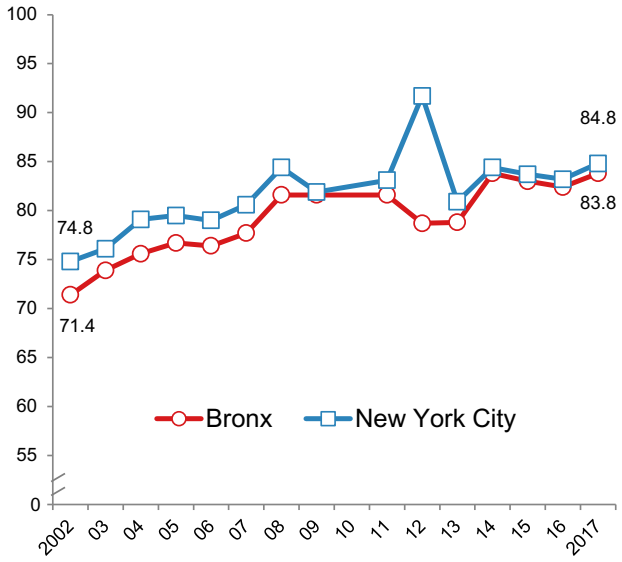
Differences by Census Tract



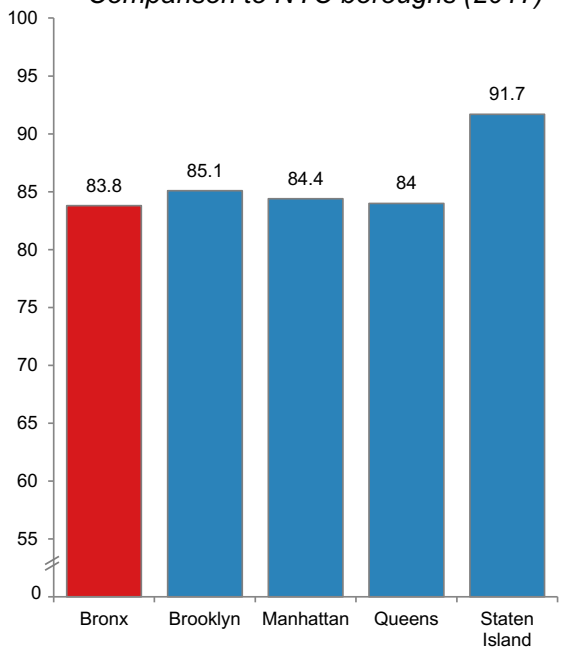
H *Represents a Montefiore Hospital or Affiliate*

Data source: American Community Survey (2013-2017)

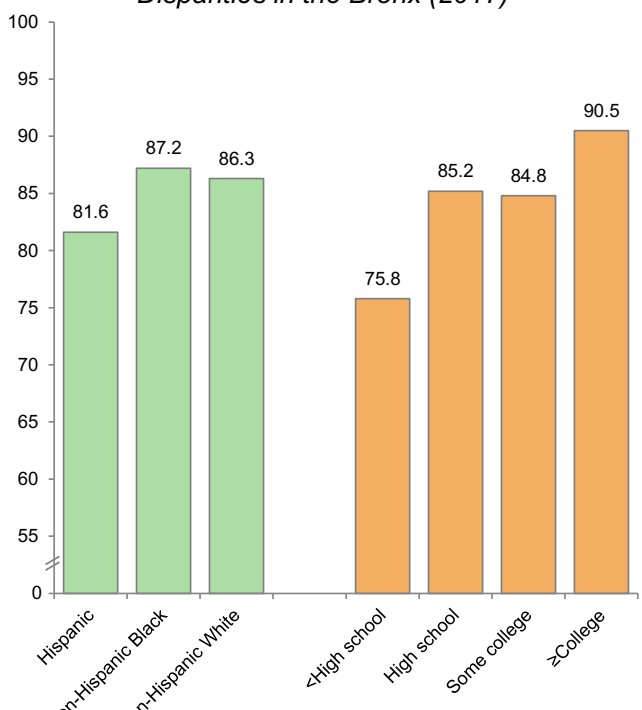
Figure 5. Percent of Adults who Report Having a Primary Care Provider



Comparison to NYC boroughs (2017)



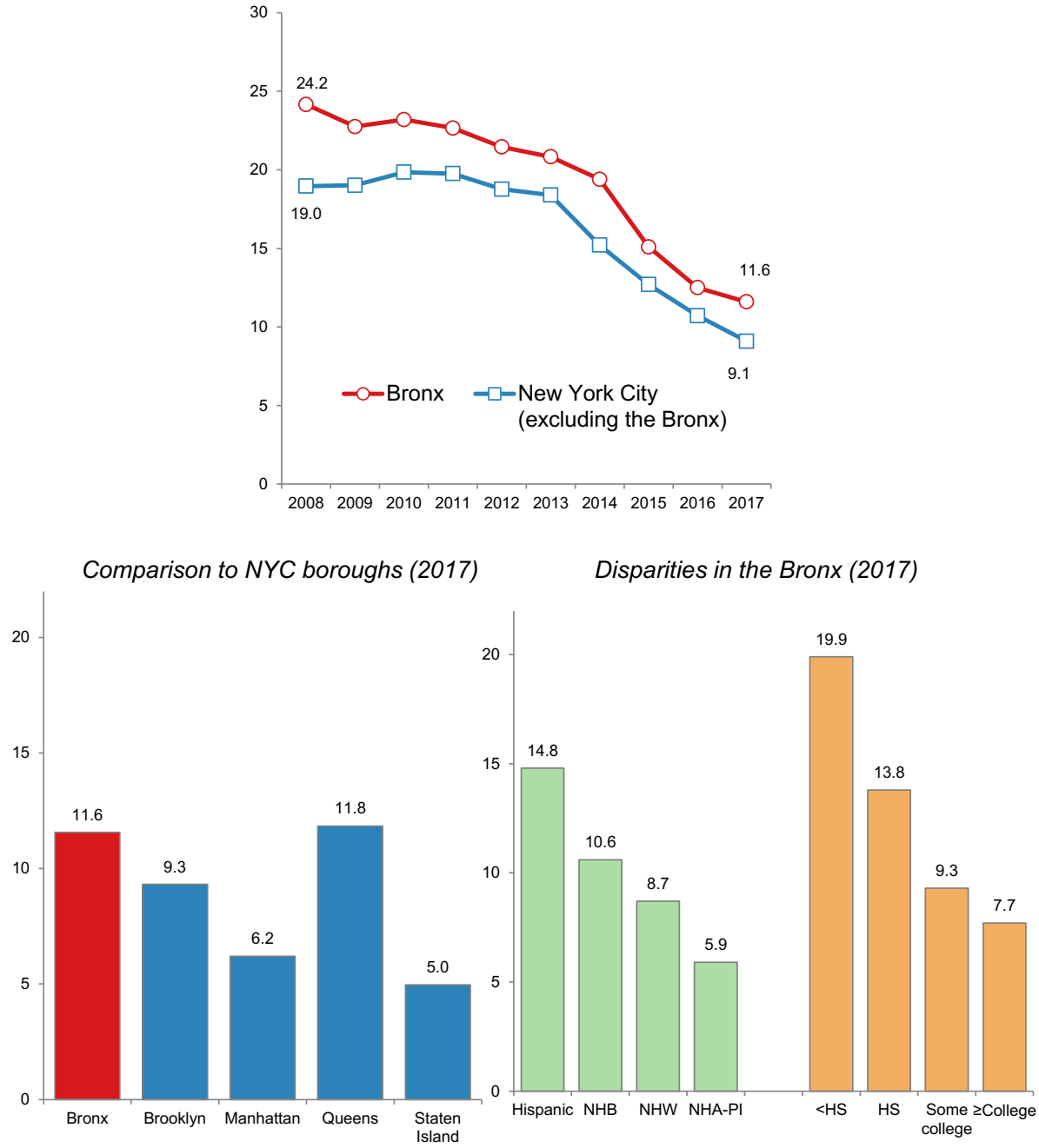
Disparities in the Bronx (2017)



Data source: NYC Community Health Survey.
Data are age-adjusted. Trend data not available in 2010.

For nearly the last two decades, the percent of adults with a primary care provider has increased across NYC. The percent of adults with a PCP increases as level of education increases.

Figure 6. Percent of Adults (18-64y) who Lack Health Insurance

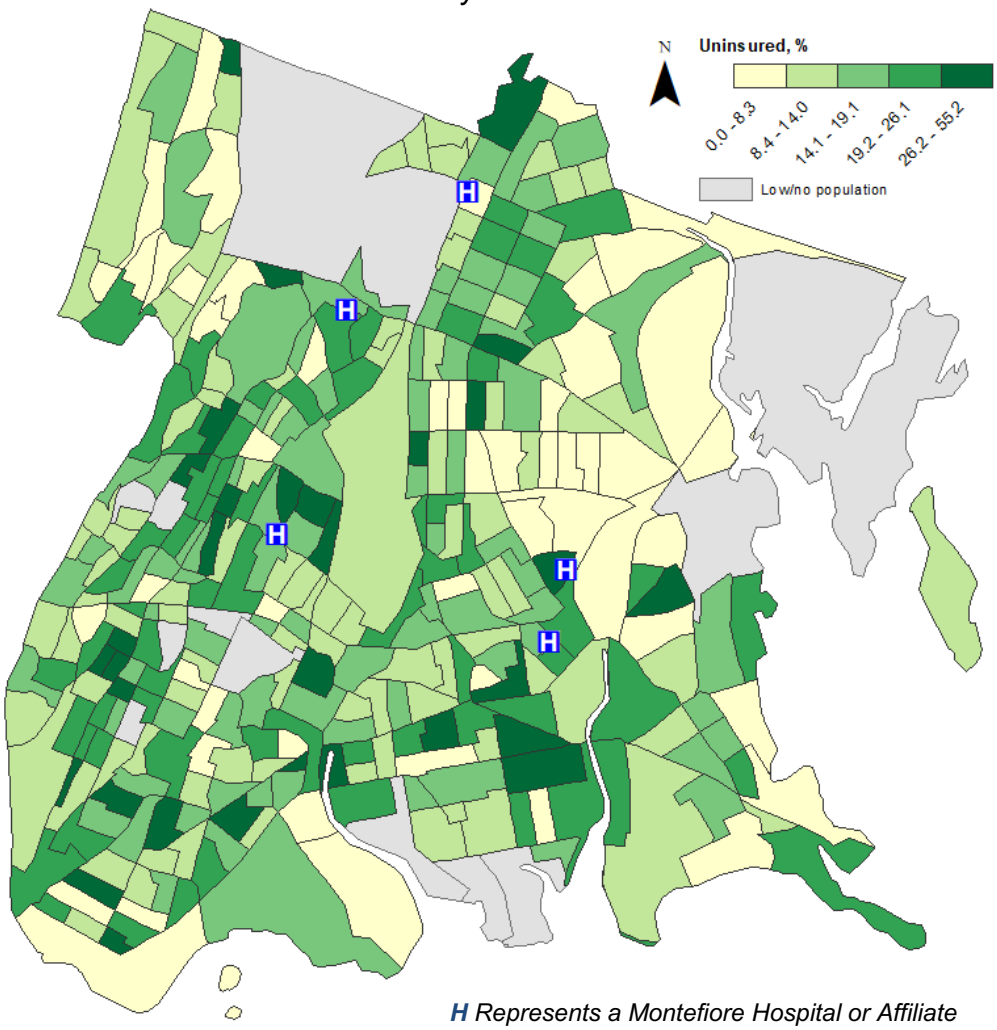


Data source: American Community Survey. Disparities data from Public Use Microdata.

While the percent of adults who lack health insurance has been decreasing in NYC over the last decade, the Bronx still maintains a higher percent compared to the rest of NYC. In the Bronx, those with lower education and those who are Hispanic are less likely to have insurance.

Figure 7. Percent of Adults (18-64y) who Lack Health Insurance in the Bronx

Differences by Census Tract



H *Represents a Montefiore Hospital or Affiliate*

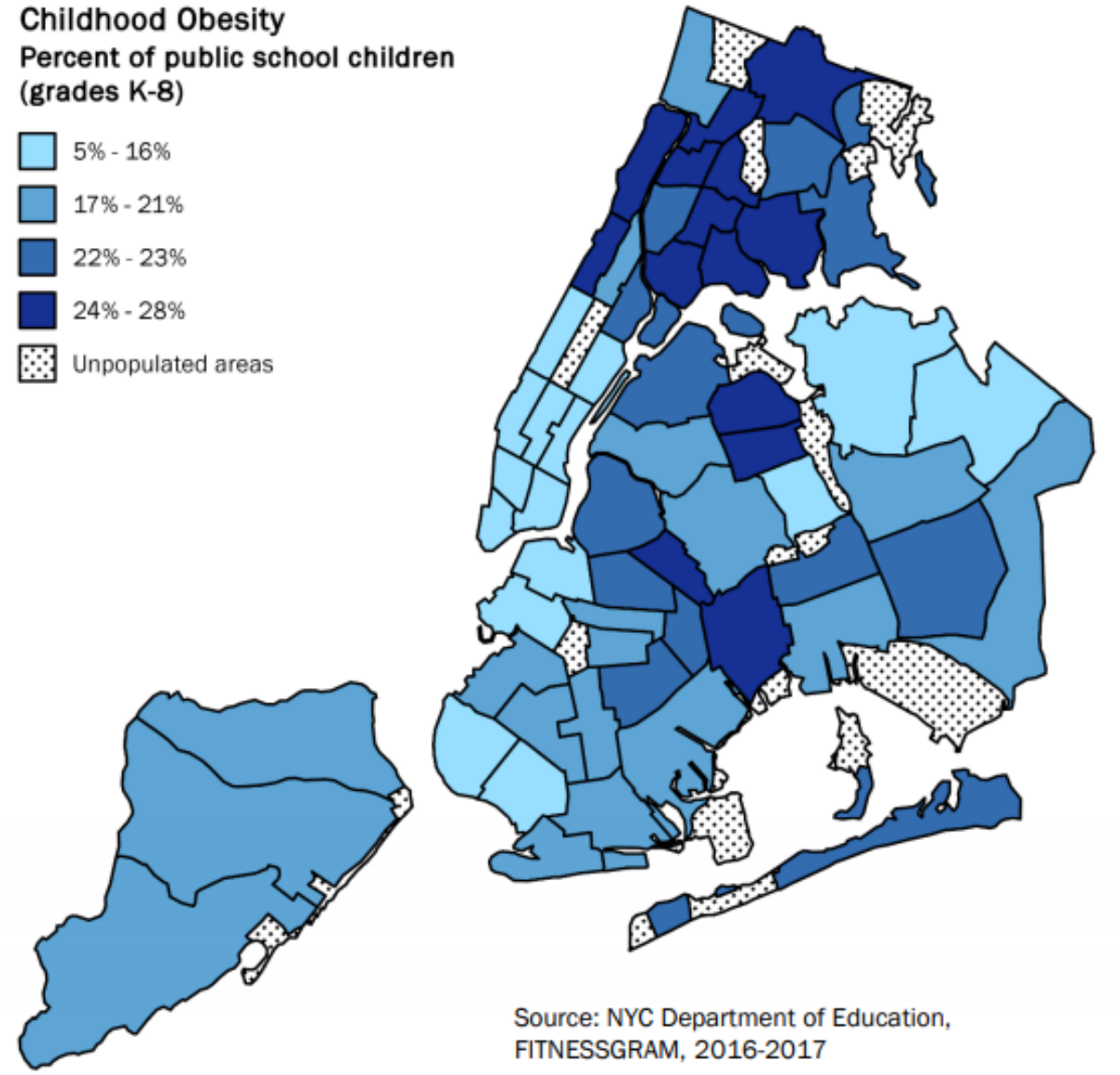
Data source: American Community Survey (2013-2017)

Figure 8. Percent of Students who are Obese

Data source: NYC Youth Risk Behavior Survey. Trend data not available at borough-level before 2003.
Map data from NYC Department of Education FITNESSGRAM, 2016-2017.

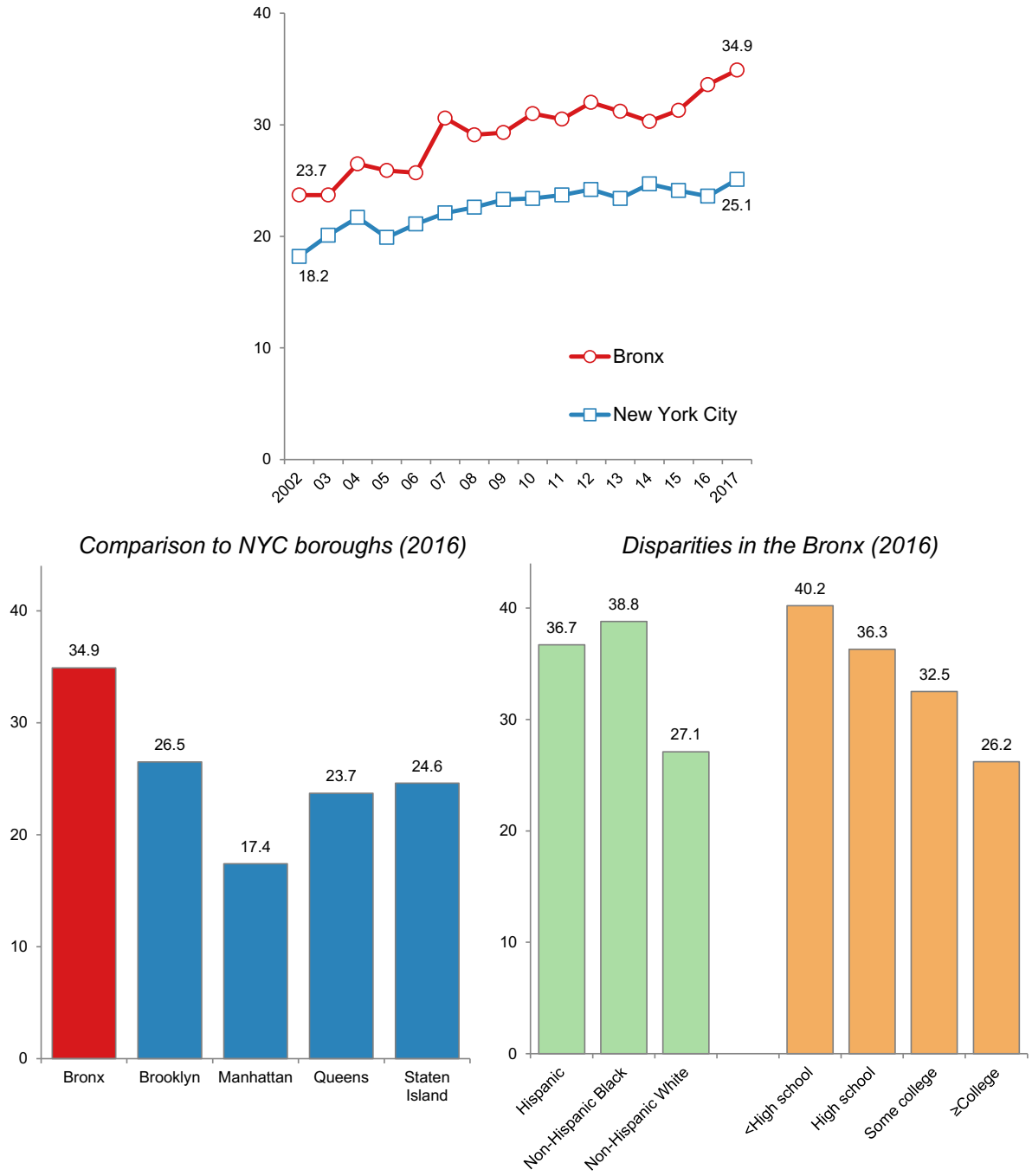
Overall, the percent of obese students has increased across NYC since 1999, with the Bronx having a higher percent than the rest of NYC. Males and those who are Hispanic or non-Hispanic black are more likely to be obese.

Figure 9. Percent of Students who are Obese



Map from New York City Community Health Profiles, 2018

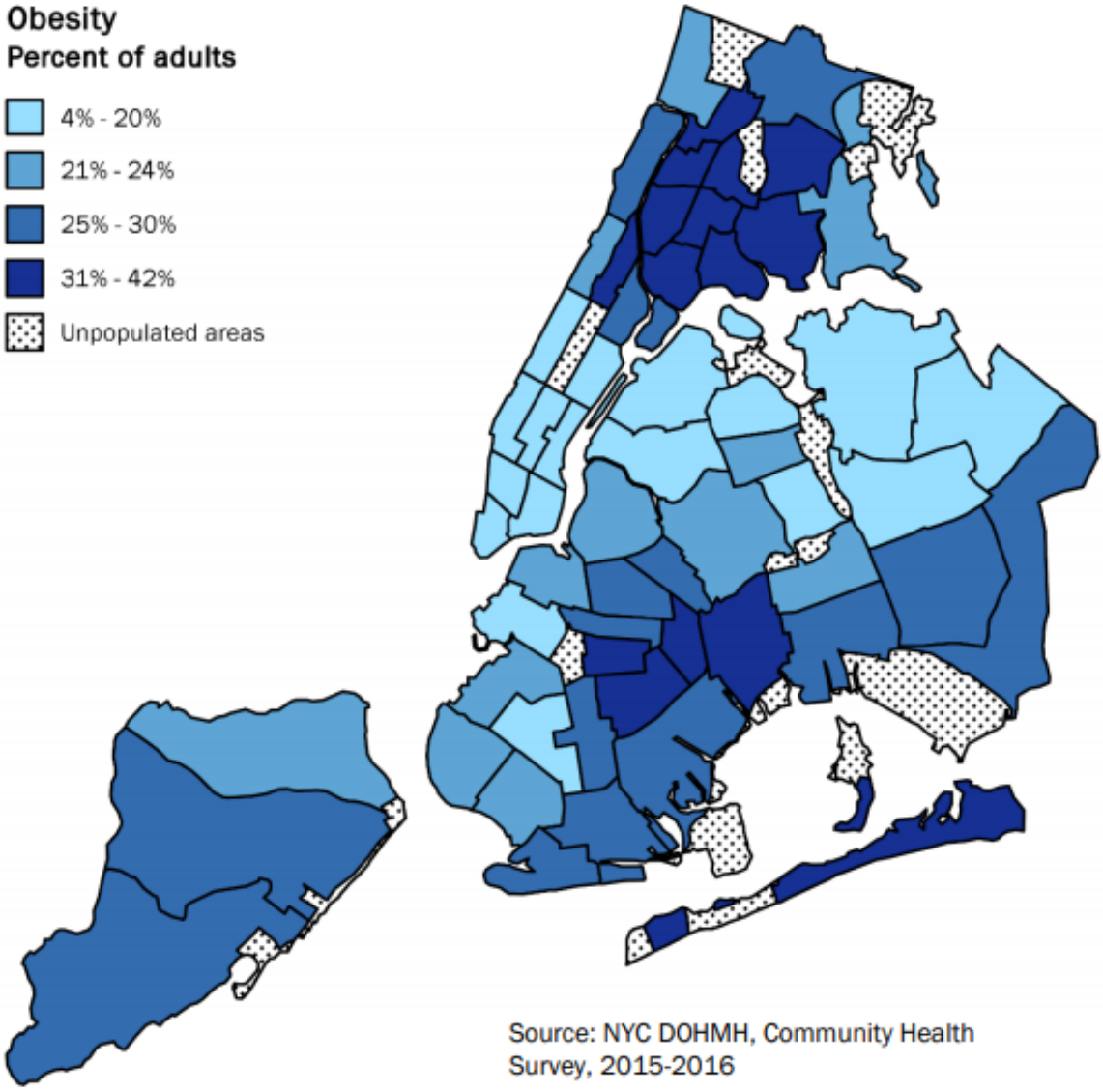
Figure 10. Percent of Adults who are Obese (BMI ≥ 30kg/m^2)



Data source: NYC Community Health Survey. Data are age-adjusted.

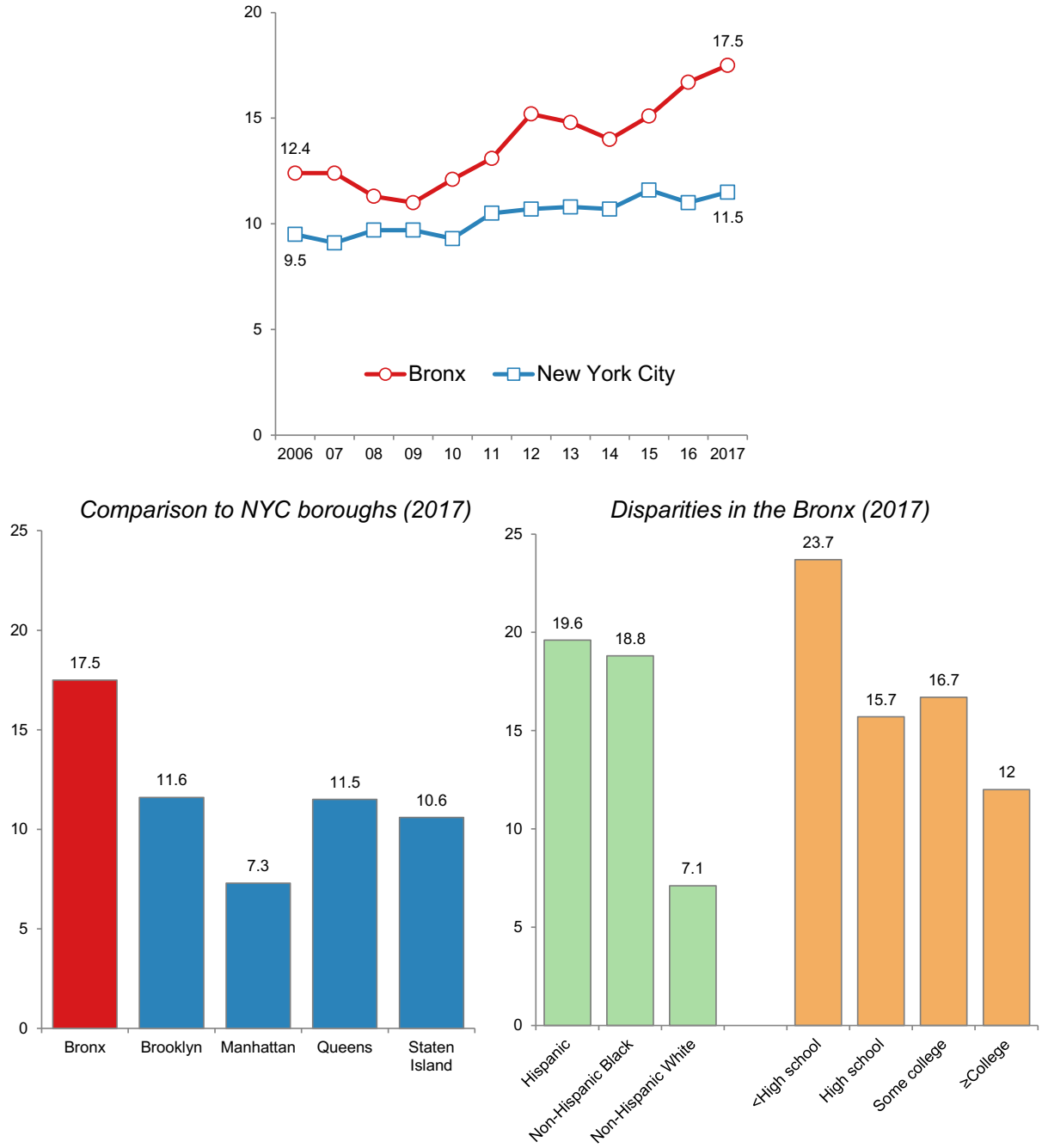
In the last 15 years, there has been an increase in the proportion of adults who are obese across NYC, with the Bronx having a higher proportion compared to other boroughs. In the Bronx, the proportion of adults who are obese is higher among those who have lower education or are among the Hispanic and non-Hispanic black populations.

Figure 11. Percent of Adults who are Obese (BMI ≥30kg/m^2)



Map from New York City Community Health Profiles, 2018

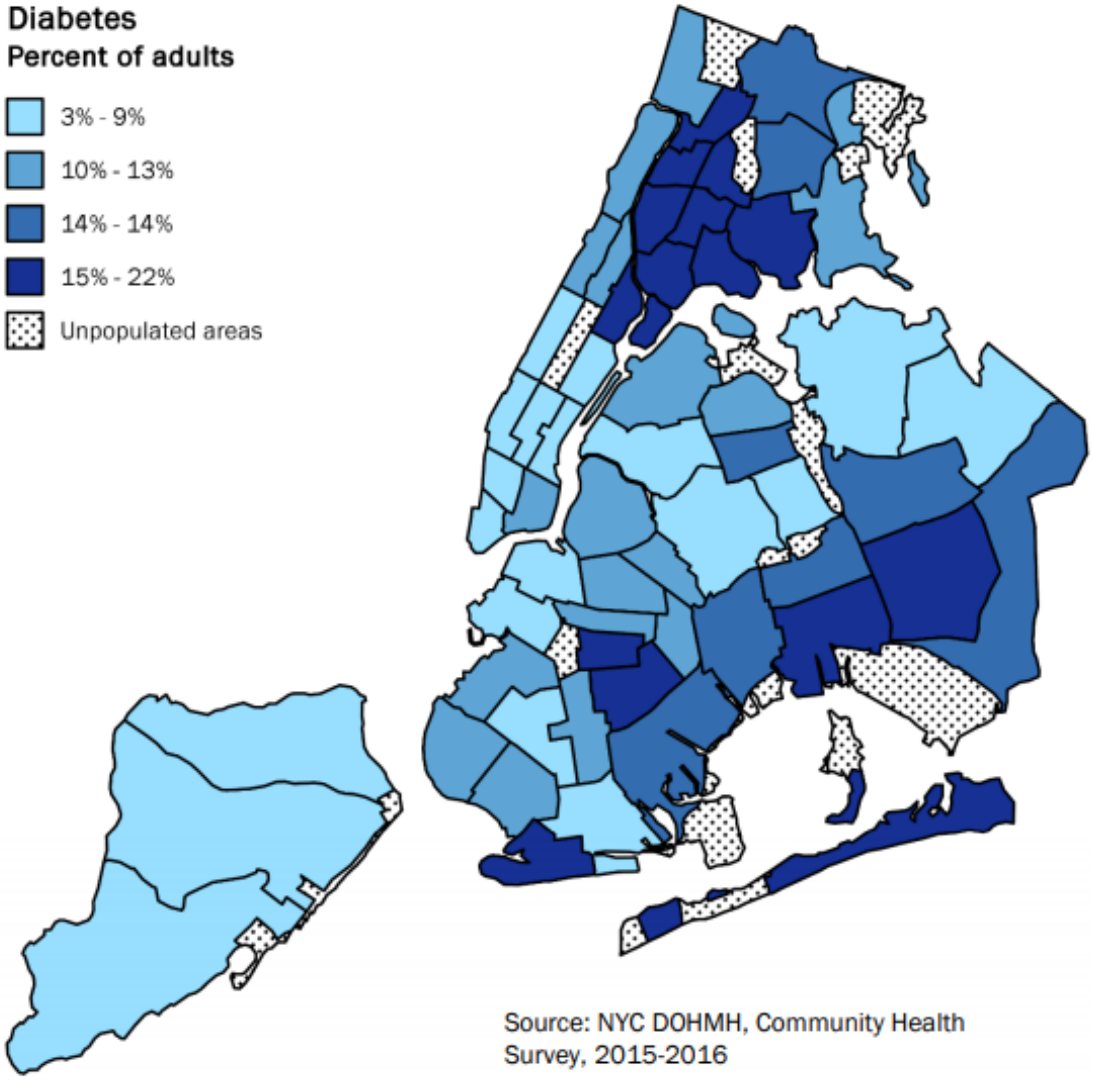
Figure 12. Percent of Adults who Have Been Told They Have Diabetes



Data source: NYC Community Health Survey. Data are age-adjusted.

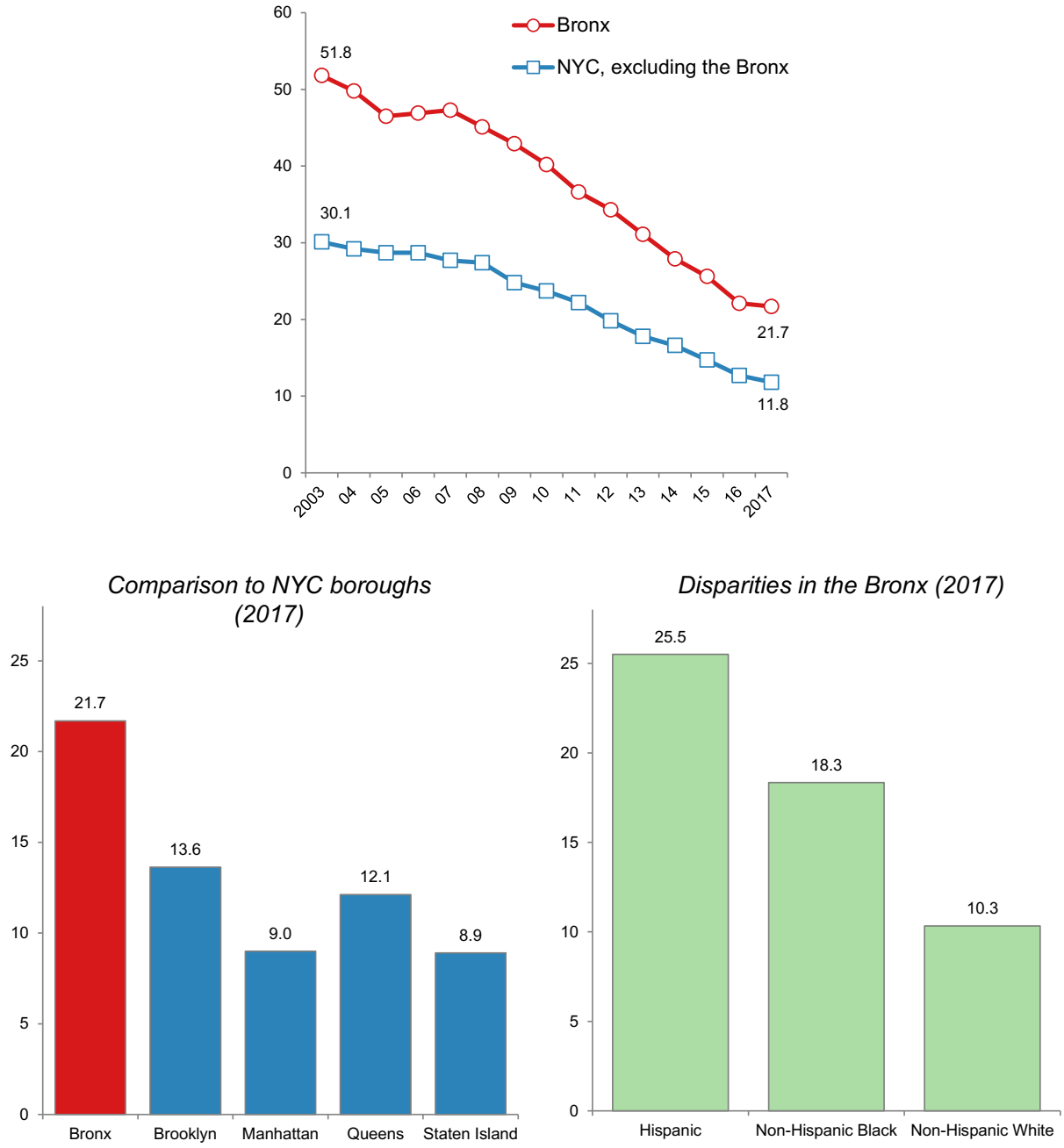
For over the last decade, there has been an increase in the percent of adults who have diabetes across NYC, with the Bronx having a higher percent compared to other boroughs. In the Bronx, the percent of adults who have diabetes is higher among those who have less than a high school education or are Hispanic or non-Hispanic black.

Figure 13. Percent of Adults who Have Been Told That They Have Diabetes



Map from New York City Community Health Profiles, 2018

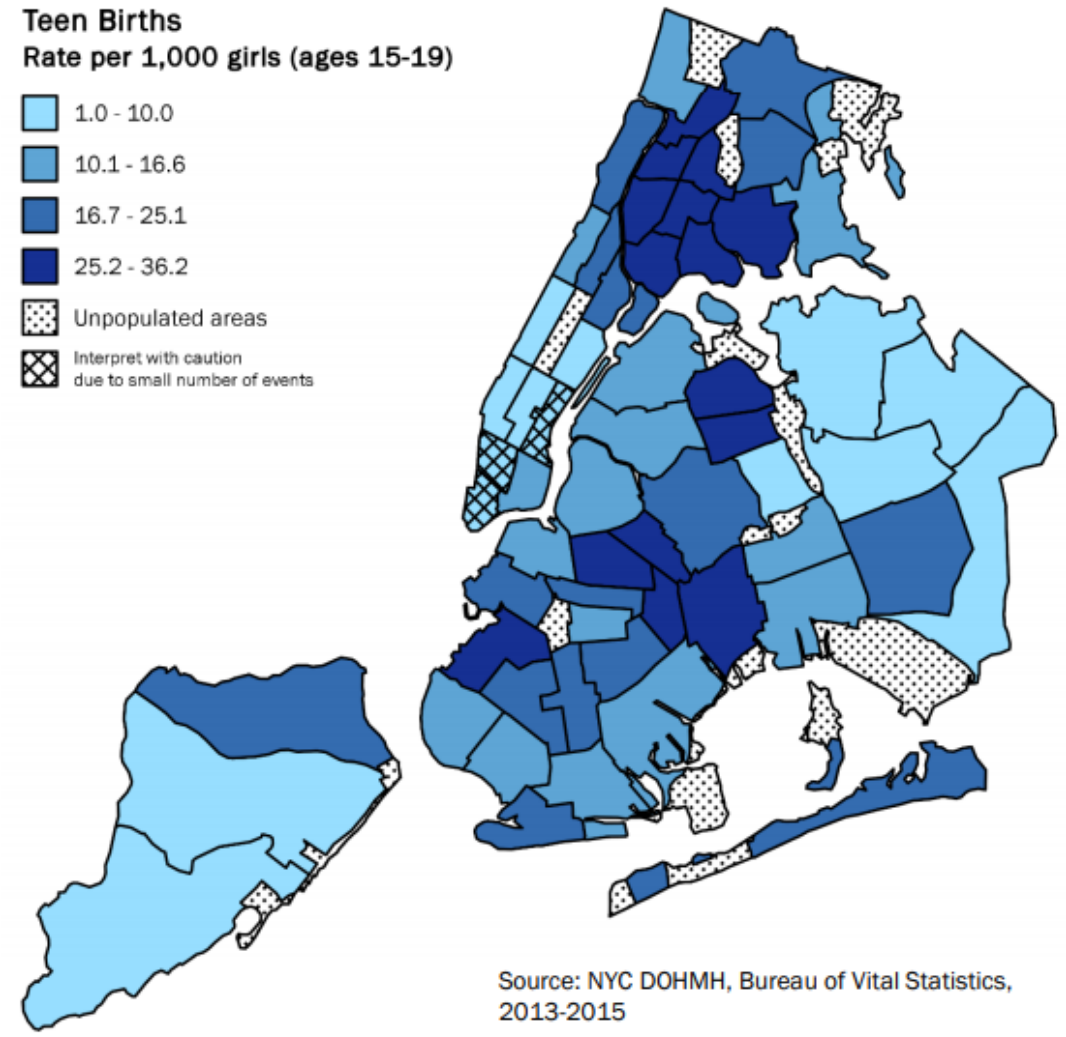
Figure 14. Teen Birth Rate (15-19y) per 10,000



Data source: National Vital Statistics Surveillance System and National Center for Health Statistics Population Estimates.

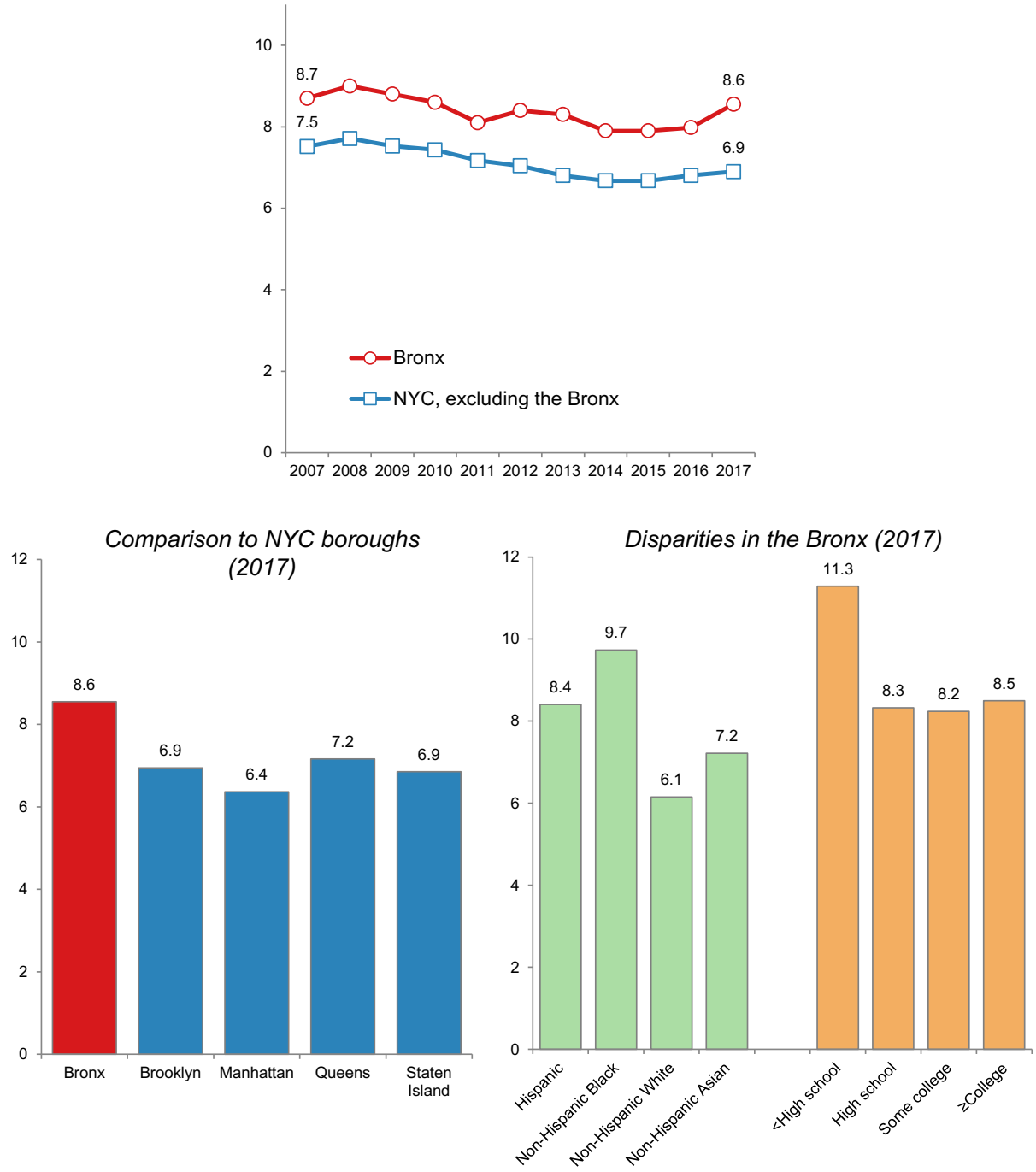
Overall, the teen birth rate in NYC has been decreasing in recent years, but the Bronx still has a higher rate than other boroughs. In the Bronx, the non-Hispanic white population has lower teen birth rates.

Figure 15. Teen Birth Rate (15-19y) per 1,000



Map from New York City Community Health Profiles, 2018

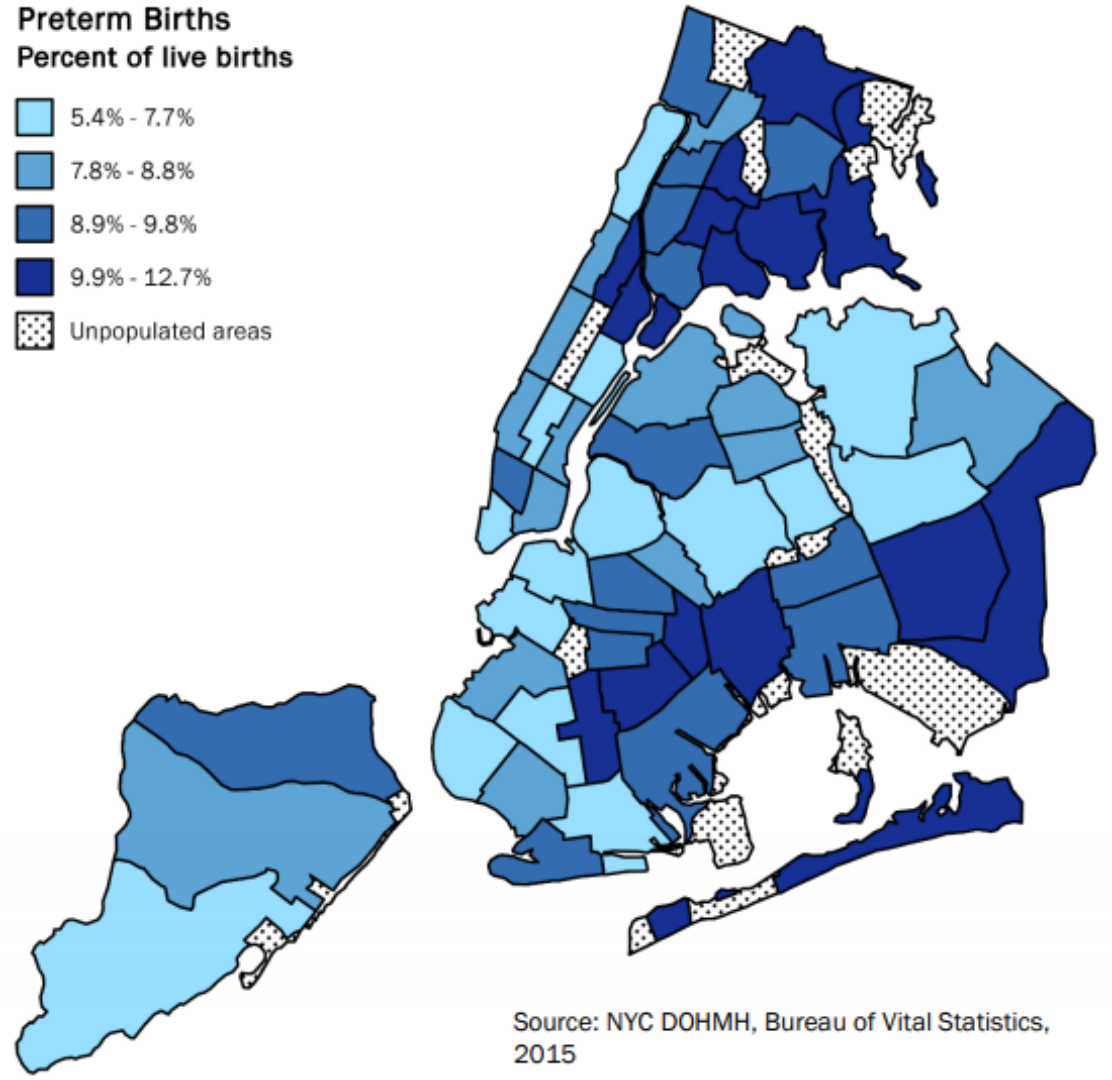
Figure 16. Proportion of Births that are Preterm (<37 weeks)



Data source: National Vital Statistics Surveillance System. Data are limited to single-births.

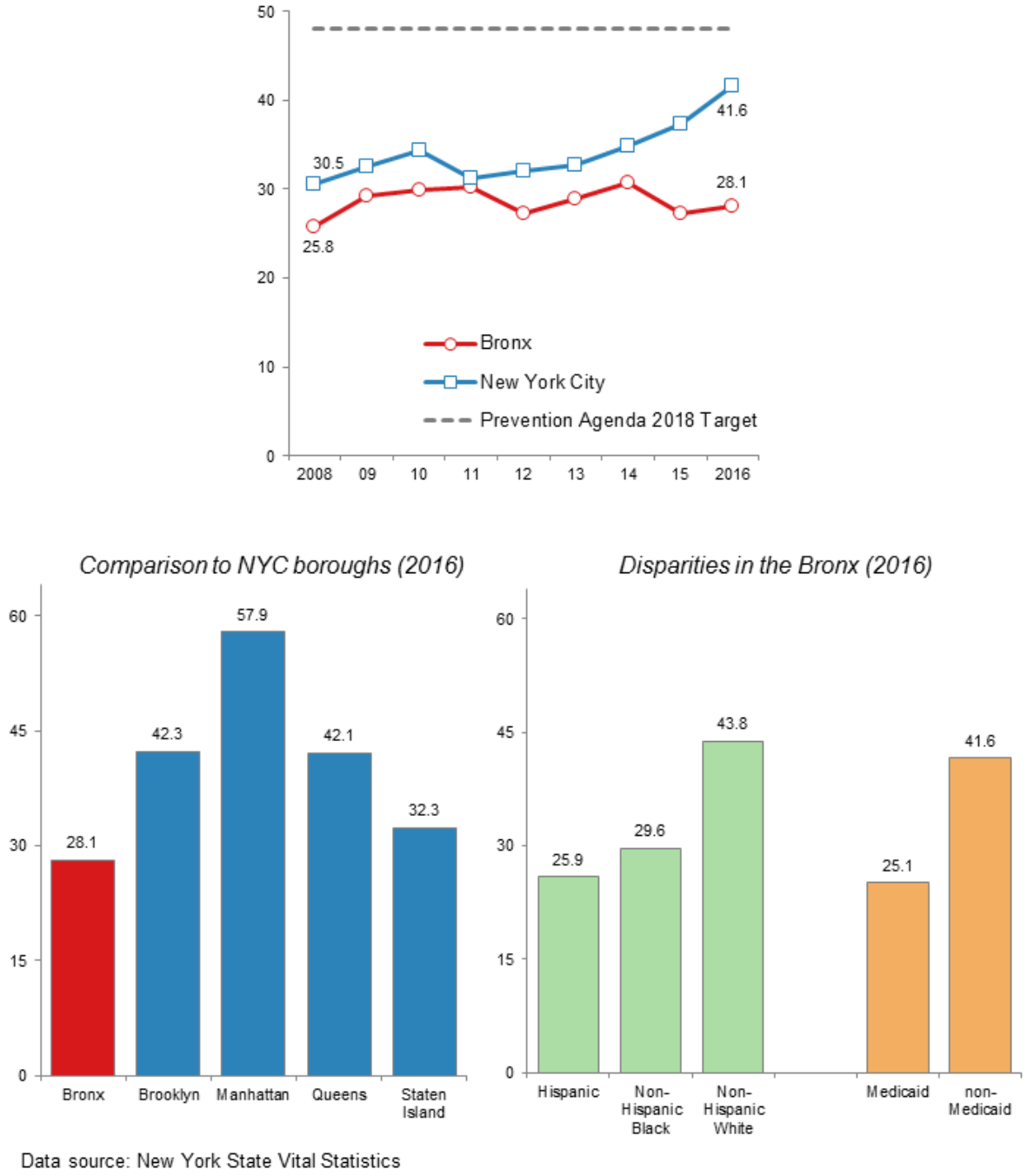
The proportion of births that are preterm in the Bronx has remained relatively unchanged from 2007 to 2017, although it remains higher than in any other borough. In the Bronx, the proportion of preterm births is highest among those with less than a high school education and the non-Hispanic black population.

Figure 17. Percent of Births that are Preterm (<37weeks) Map



Map from New York City Community Health Profiles, 2018. Analysis not limited to single births.

Figure 18. Proportion of Infants Exclusively Breastfed in the Hospital

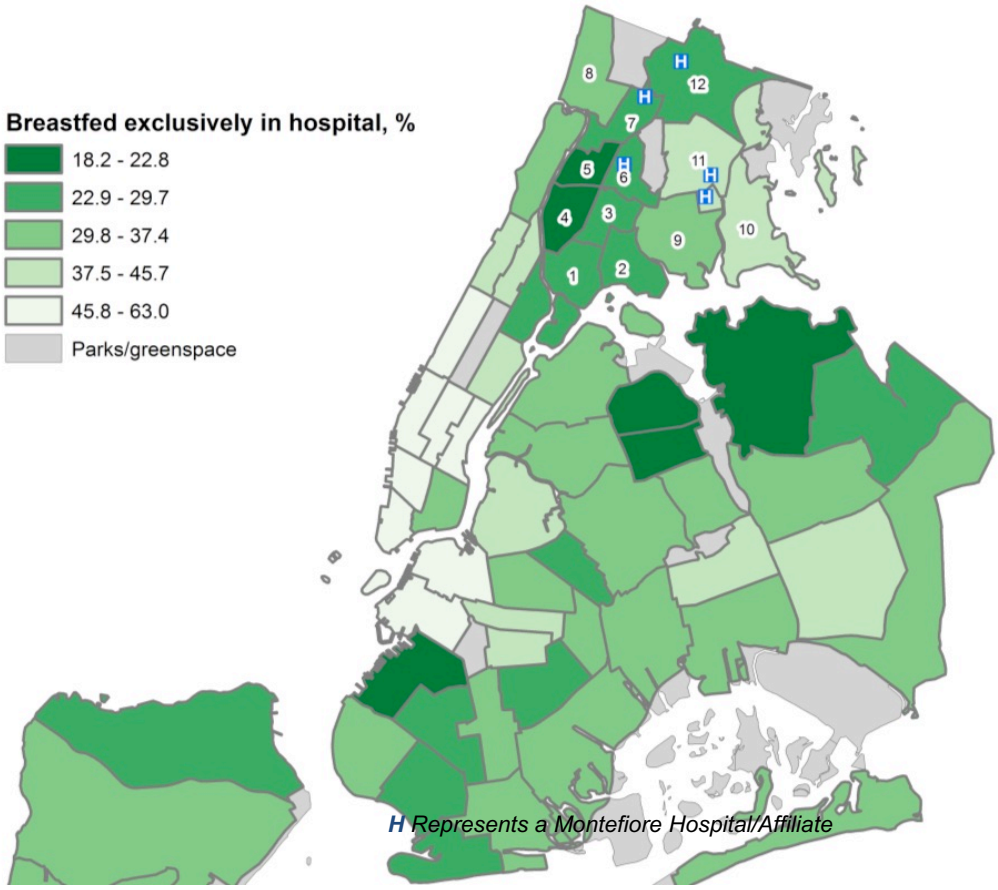


Data source: New York State Vital Statistics

While the proportion of infants exclusively breastfed in the hospital has been increasing in NYC, the proportion breastfed in the Bronx remains lower. The proportion of infants exclusively breastfed in the hospital has been increasing in NYC from 2008 to 2016, but it still falls below the NYS Prevention Agenda 2018 goal. In the Bronx, the proportion of infants exclusively breastfed in the hospital is lowest among those who are Hispanic, non-Hispanic black or have Medicaid.

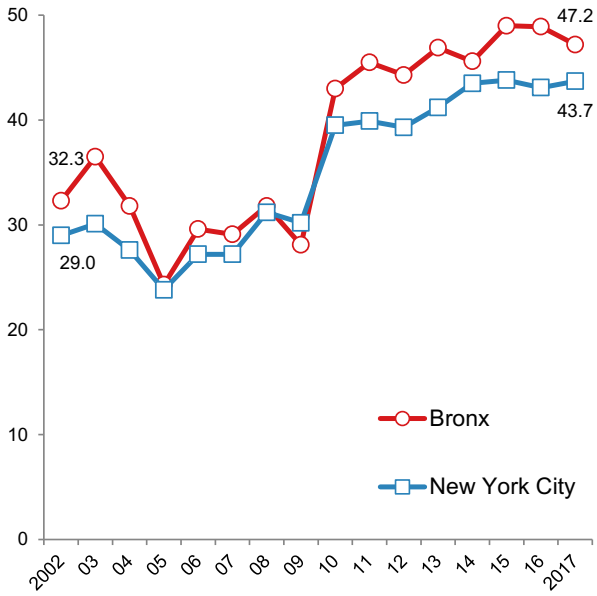
Figure 19. Percent of Infants Exclusively Breastfed in the Hospital Map

Differences by Community District (2013-2016)

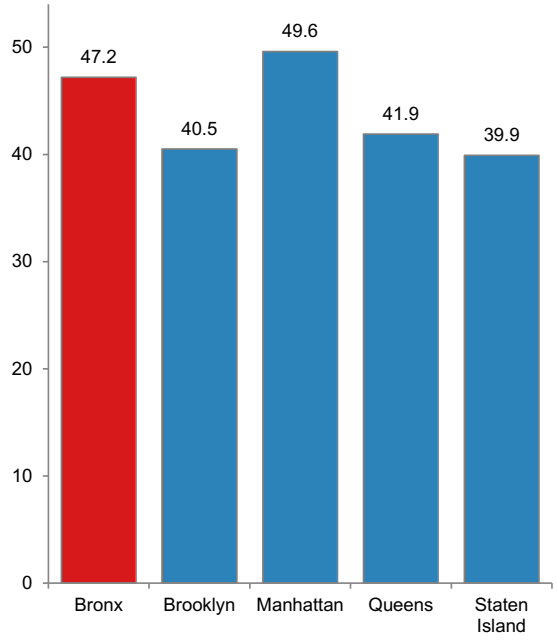


Data source: New York State Vital Statistics (2013-2016)

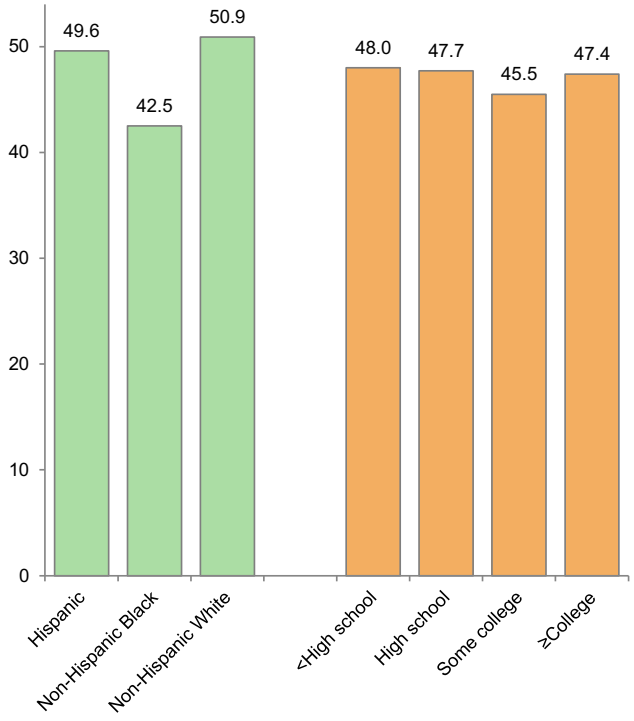
Figure 20. Proportion of Adults Receiving a Flu Vaccination in the Past Year



Comparison to NYC boroughs (2016)



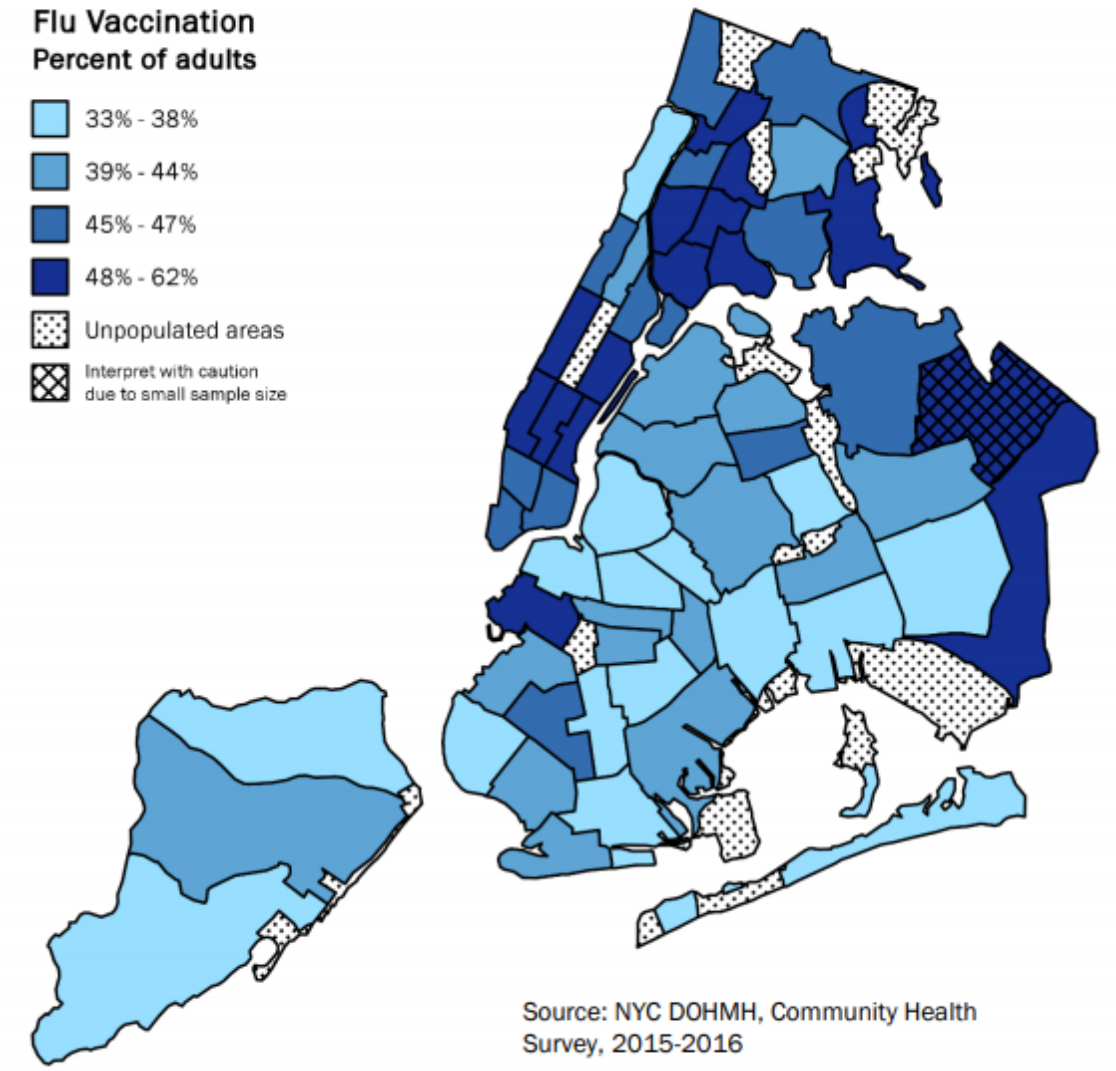
Disparities in the Bronx (2016)



Data source: NYC Community Health Survey.
Data are age-adjusted.

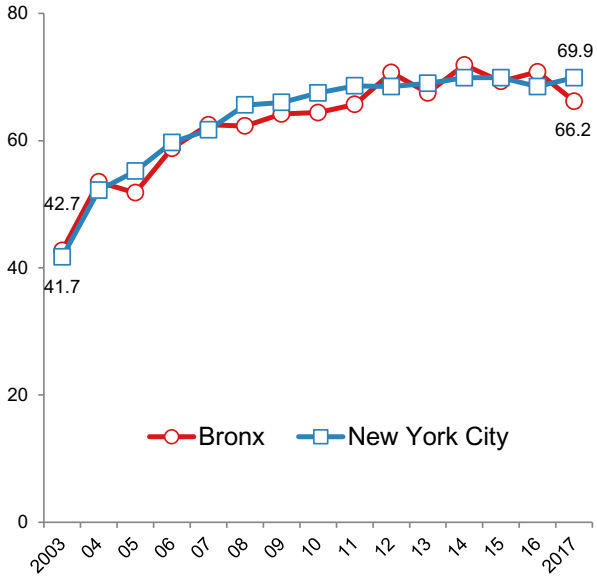
There was a decrease in the proportion of adults who received the flu vaccination from 2003 to 2005, but the trend has been increasing over all, with the proportion in the Bronx being second highest after Manhattan. The proportion of adults receiving the flu vaccine in the Bronx is lowest among the non-Hispanic black population, with little to no difference based on education.

Figure 21. Percent of Adults Receiving a Flu Vaccination in the Past Year

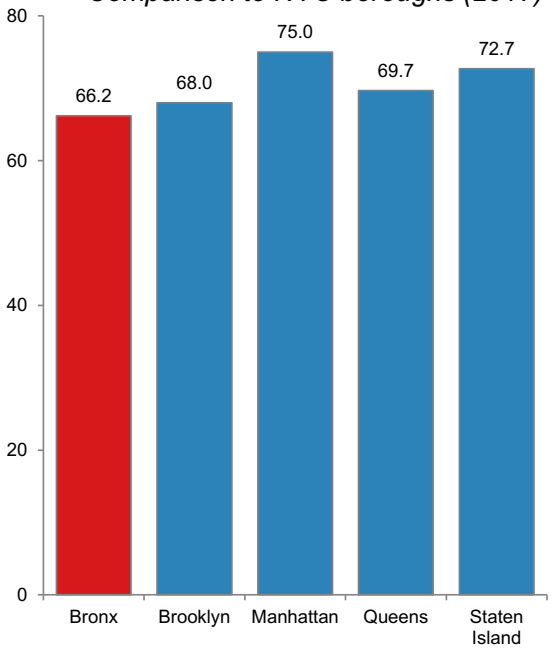


Map from New York City Community Health Profiles, 2018

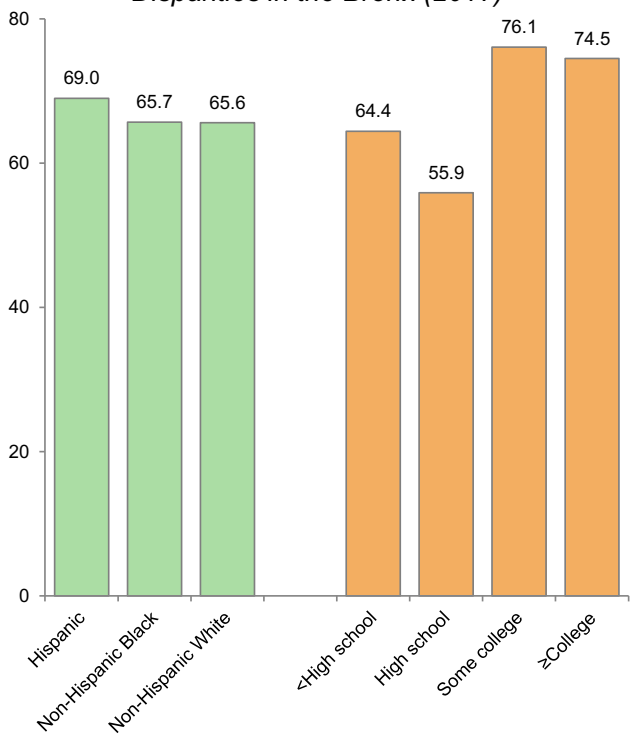
Figure 22. Percent of Adults Who Have Had a Colonoscopy in the Last 10 years



Comparison to NYC boroughs (2017)



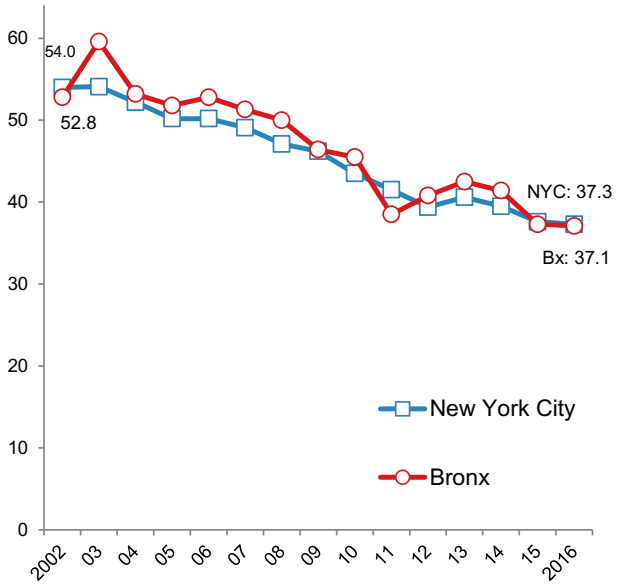
Disparities in the Bronx (2017)

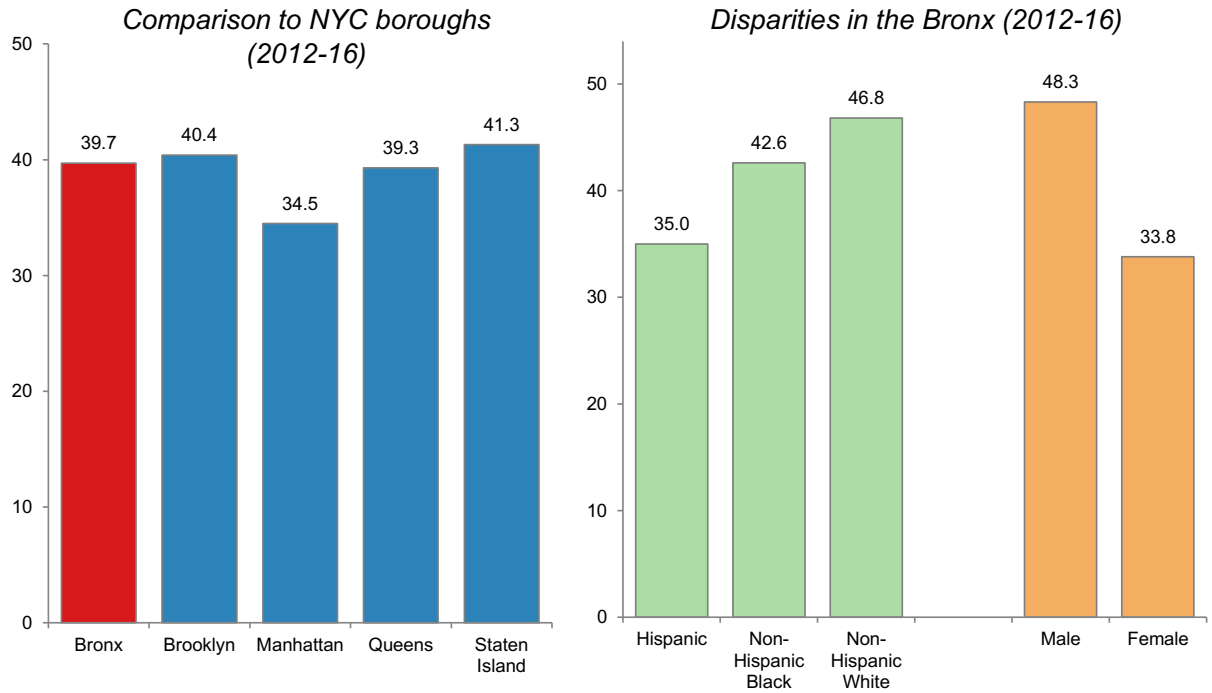


Data source: NYC Community Health Survey.
Data are age-adjusted.

The percent of adults who have had a colonoscopy in the last 10 years has increased in NYC but the Bronx has the lowest percent compared to other boroughs. In the Bronx, those with at least some college education are more likely to have had a colonoscopy in the last 10 years.

Figure 23. Colorectal Cancer Incidence per 100,000



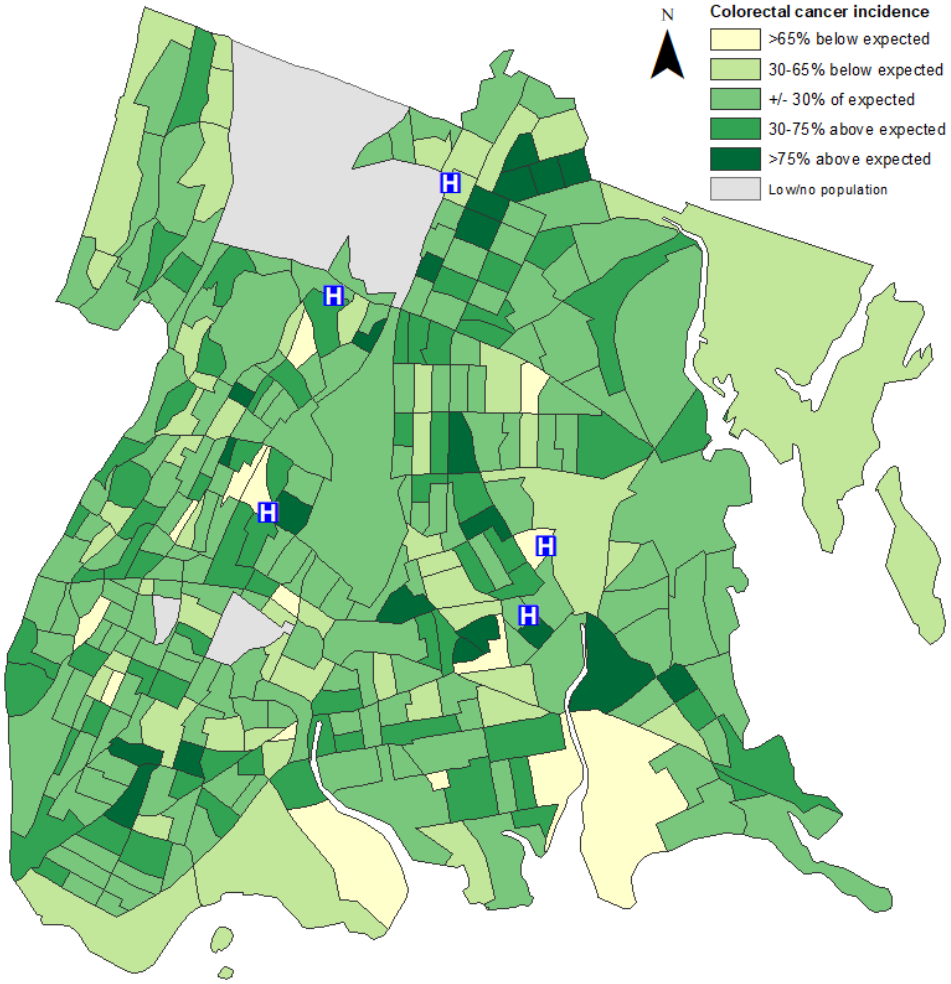


Data source: New York State Cancer Registry.
Data are age-adjusted.

The incidence of colorectal cancer has decreased across NYC as a whole in the last two decades. The incidence of colorectal cancer is higher among men and the non-Hispanic white population.

Figure 24. Colorectal Cancer Incidence in the Bronx

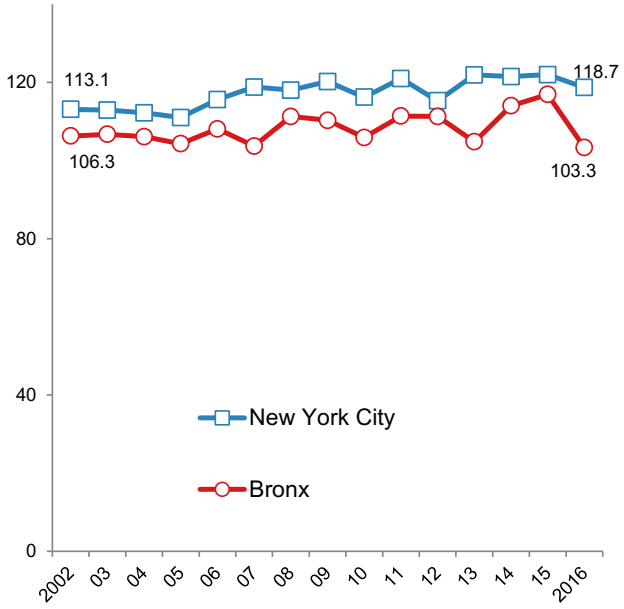
Differences by Census Tract



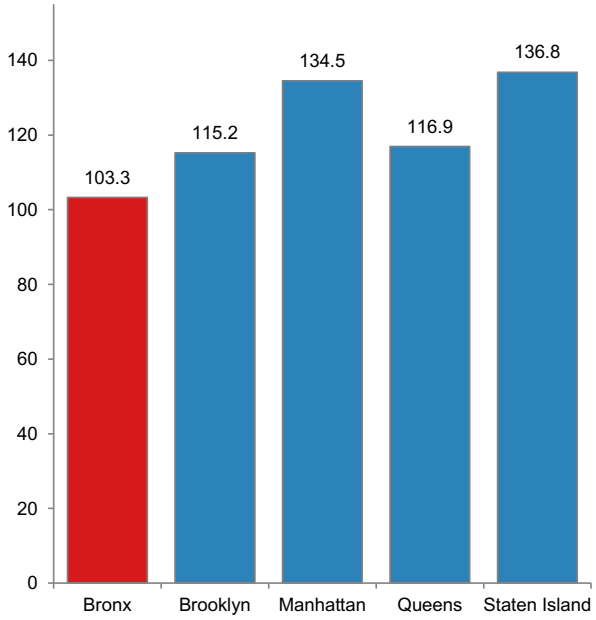
***H** Represents a Montefiore Hospital/Affiliate*

Data source: New York State Cancer Registry, 2010-2014. Data are age- and sex-adjusted.

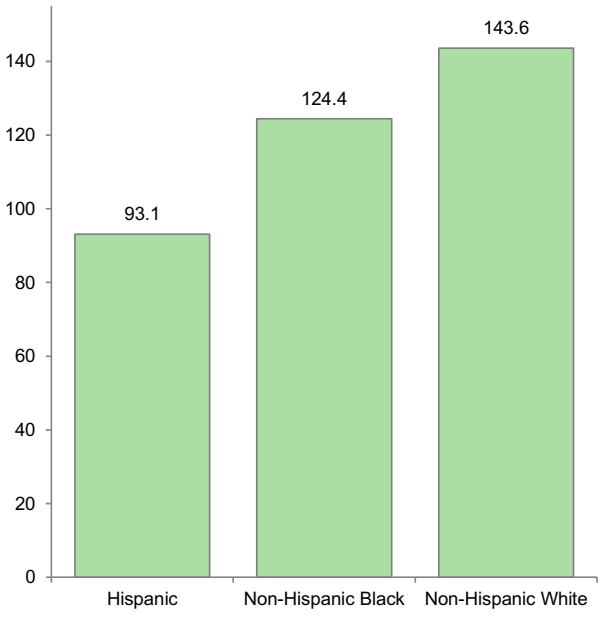
Figure 25. Breast Cancer Incidence per 100,000 Female



Comparison to NYC boroughs



Disparities in the Bronx (2012-16)

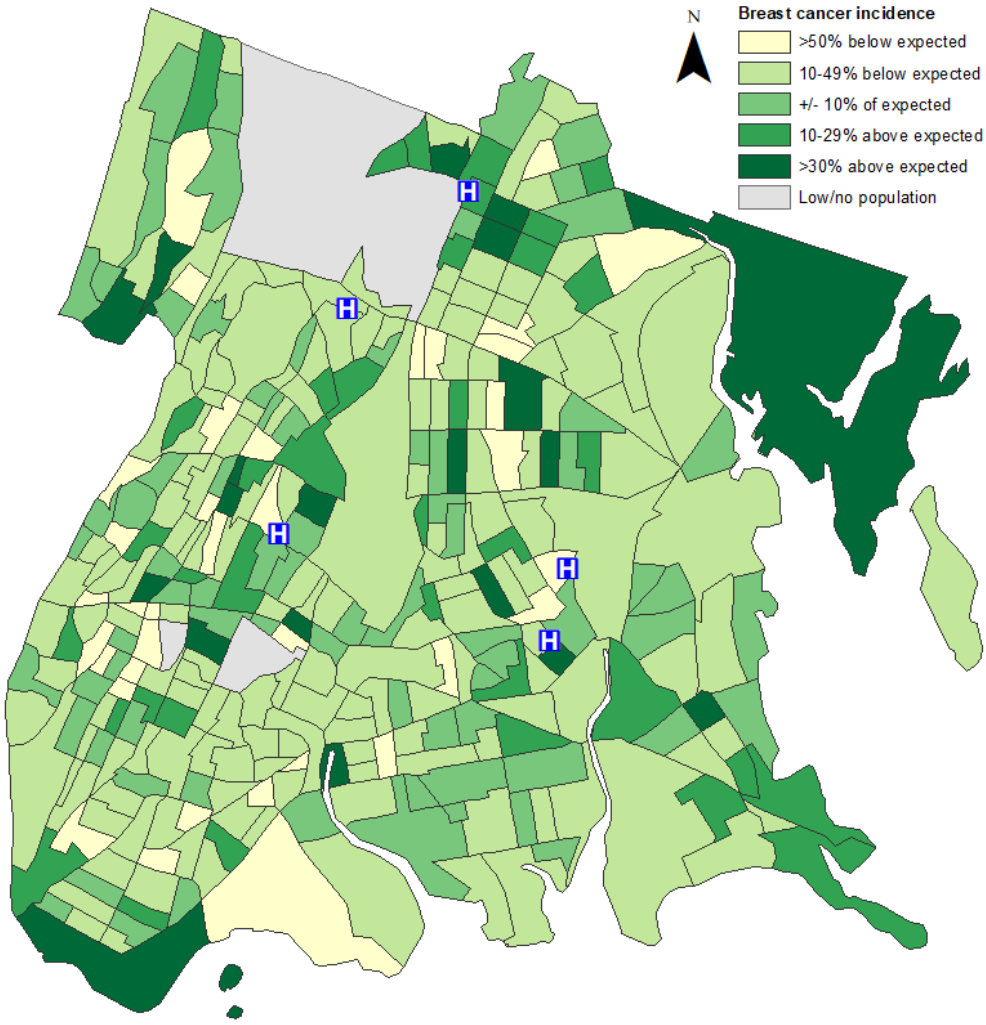


Data source: New York State Cancer Registry.
Data are age-adjusted.

For over the last decade, the incidence of breast cancer has remained relatively unchanged in the Bronx and NYC, with the incidence in the Bronx being lower than in any other borough. In the Bronx, the incidence of breast cancer is lowest among the Hispanic population.

Figure 26. Breast Cancer Incidence in the Bronx

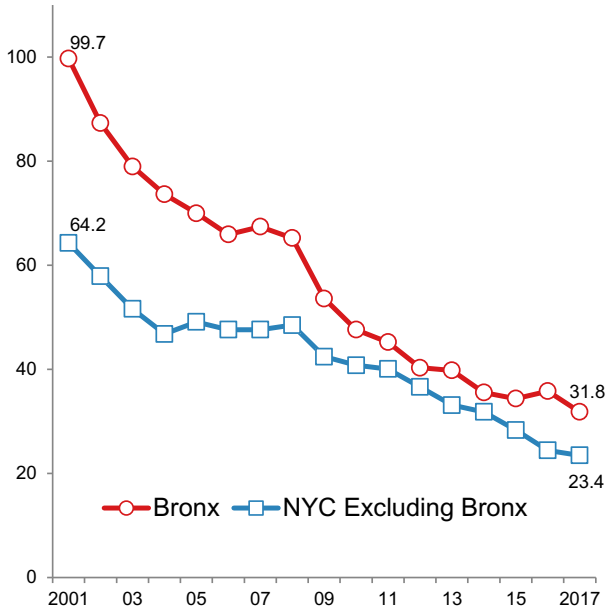
Differences by Census Tract

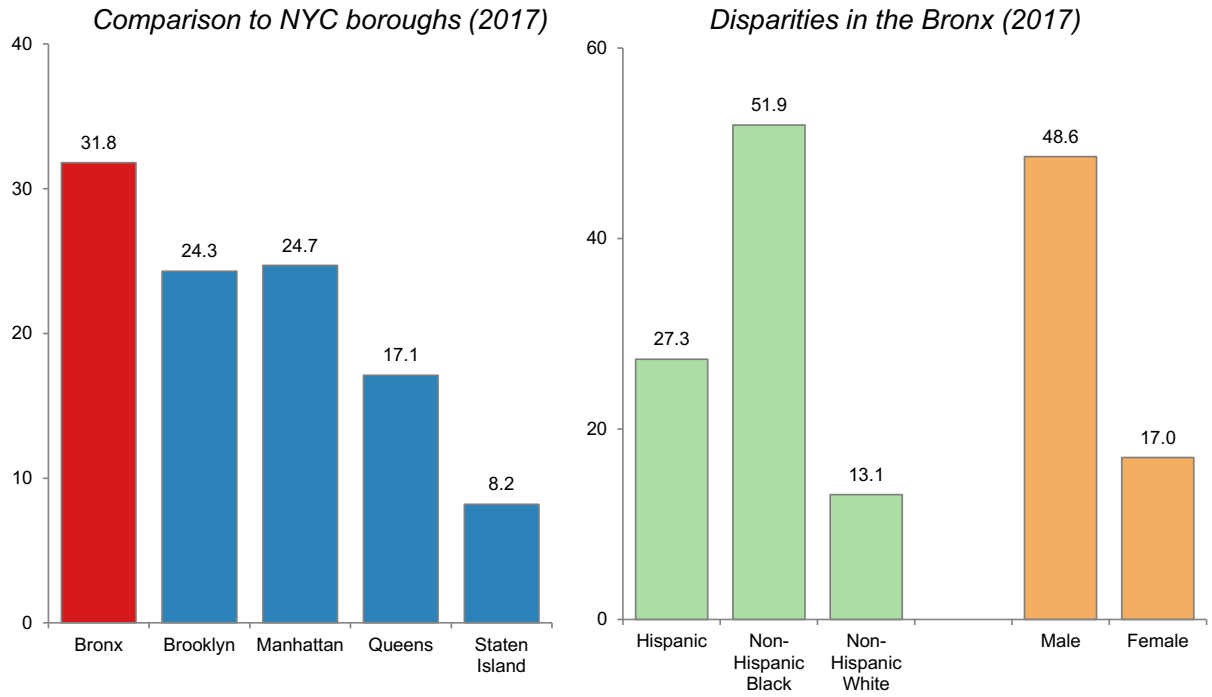


H *Represents a Montefiore Hospital/Affiliate*

Data source: New York State Cancer Registry, 2010-2014. Data are age-adjusted.

Figure 27. Rate of HIV Diagnoses per 100,000

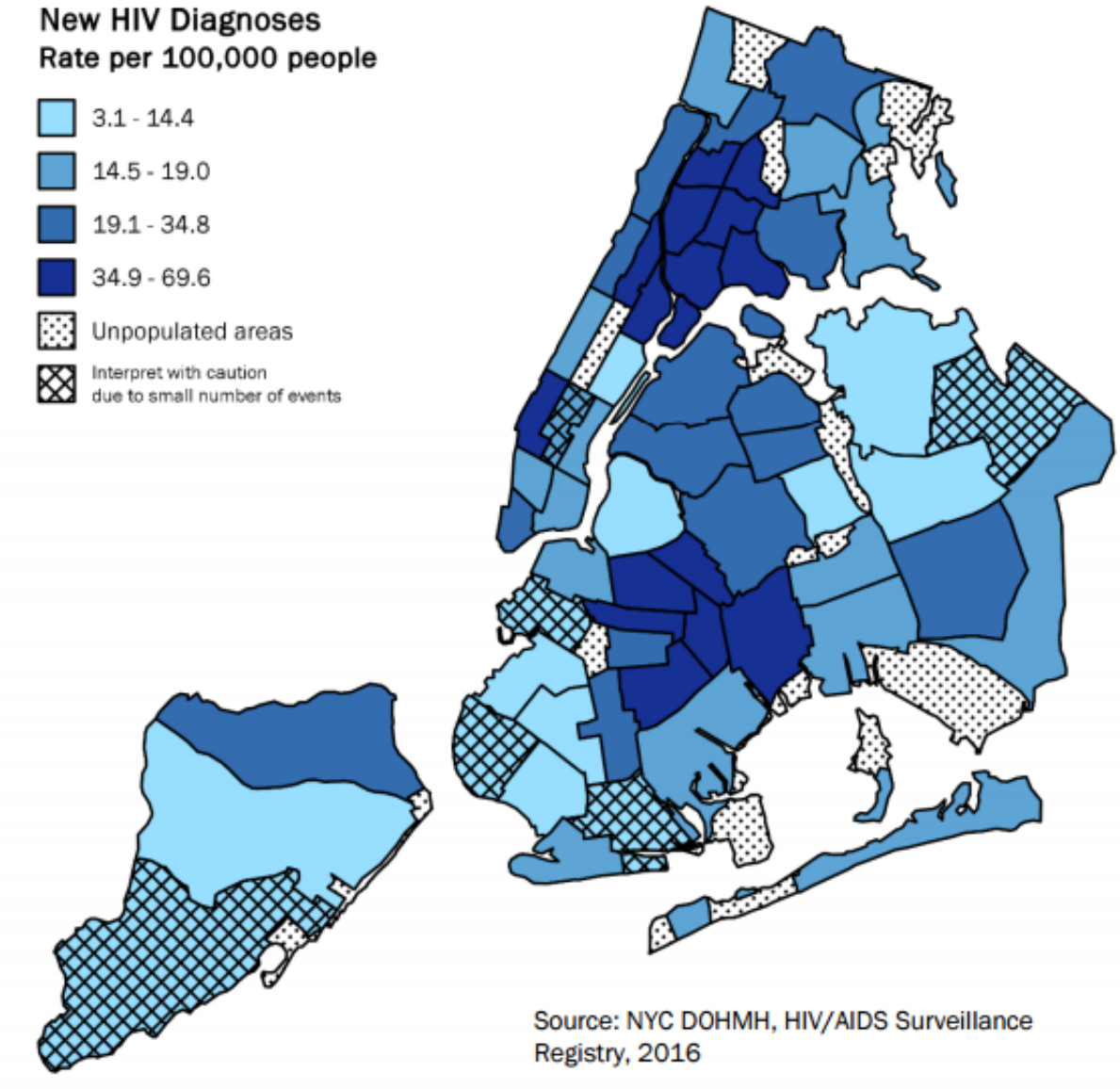




Data source: NYC HIV/AIDS Annual Surveillance Statistics, 2017.

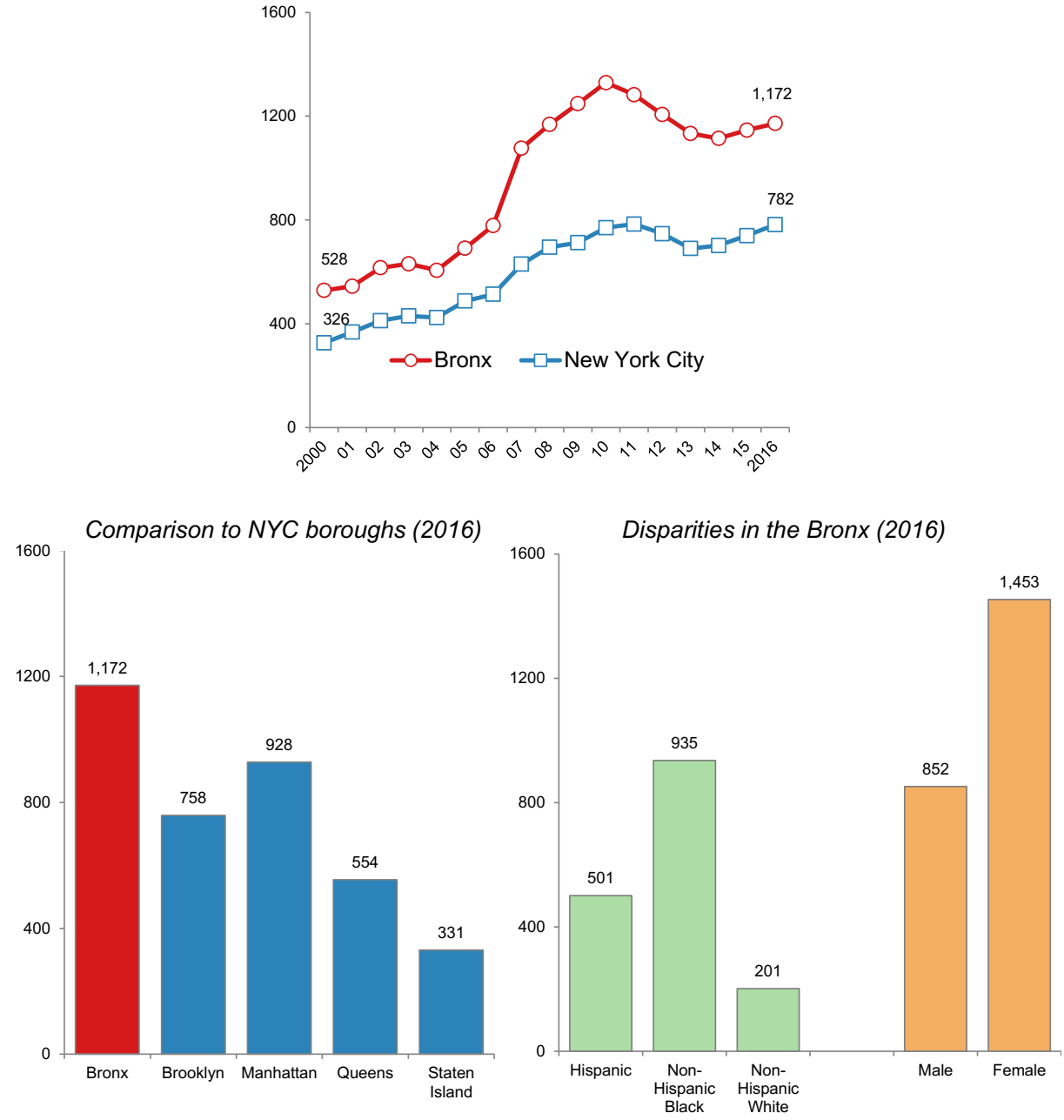
The rate of HIV diagnoses has decreased for the Bronx by 68.1% from 2001 to 2017, but it's still higher compared to the other NYC boroughs. In the Bronx, the rate of HIV diagnoses is much higher among males and those who are non-Hispanic black.

Figure 28. Rate of HIV Diagnoses per 100,000



Map from New York City Community Health Profiles, 2018

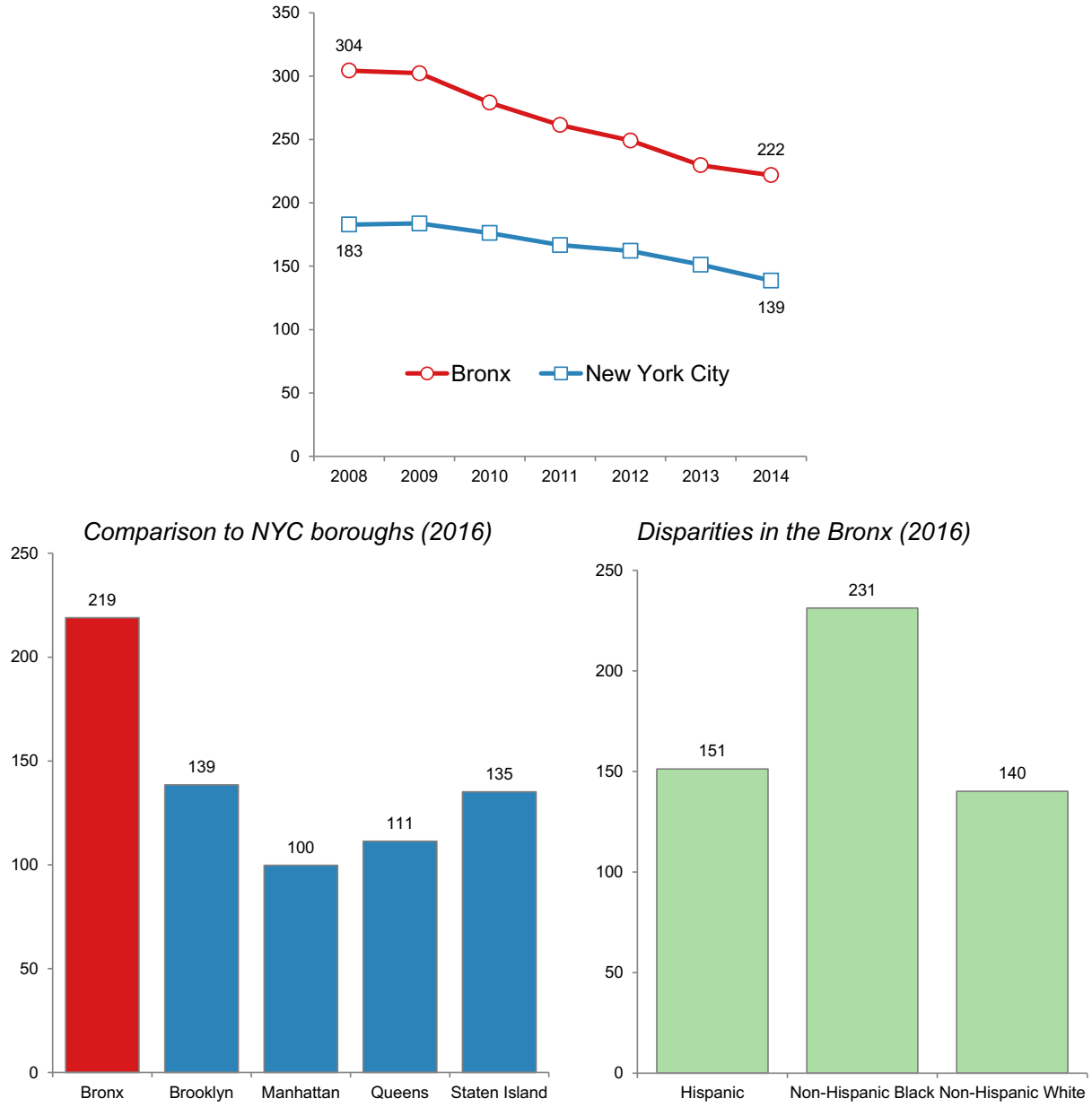
Figure 29. Rate of Chlamydia per 100,000



Data source: NYC Sexually Transmitted Diseases Surveillance Data.

From 2000 to 2016, the rate of chlamydia has been increasing in NYC, with the rate in the Bronx remaining higher compared to other NYC boroughs. In the Bronx, the rate of chlamydia is higher among females and those who are non-Hispanic black.

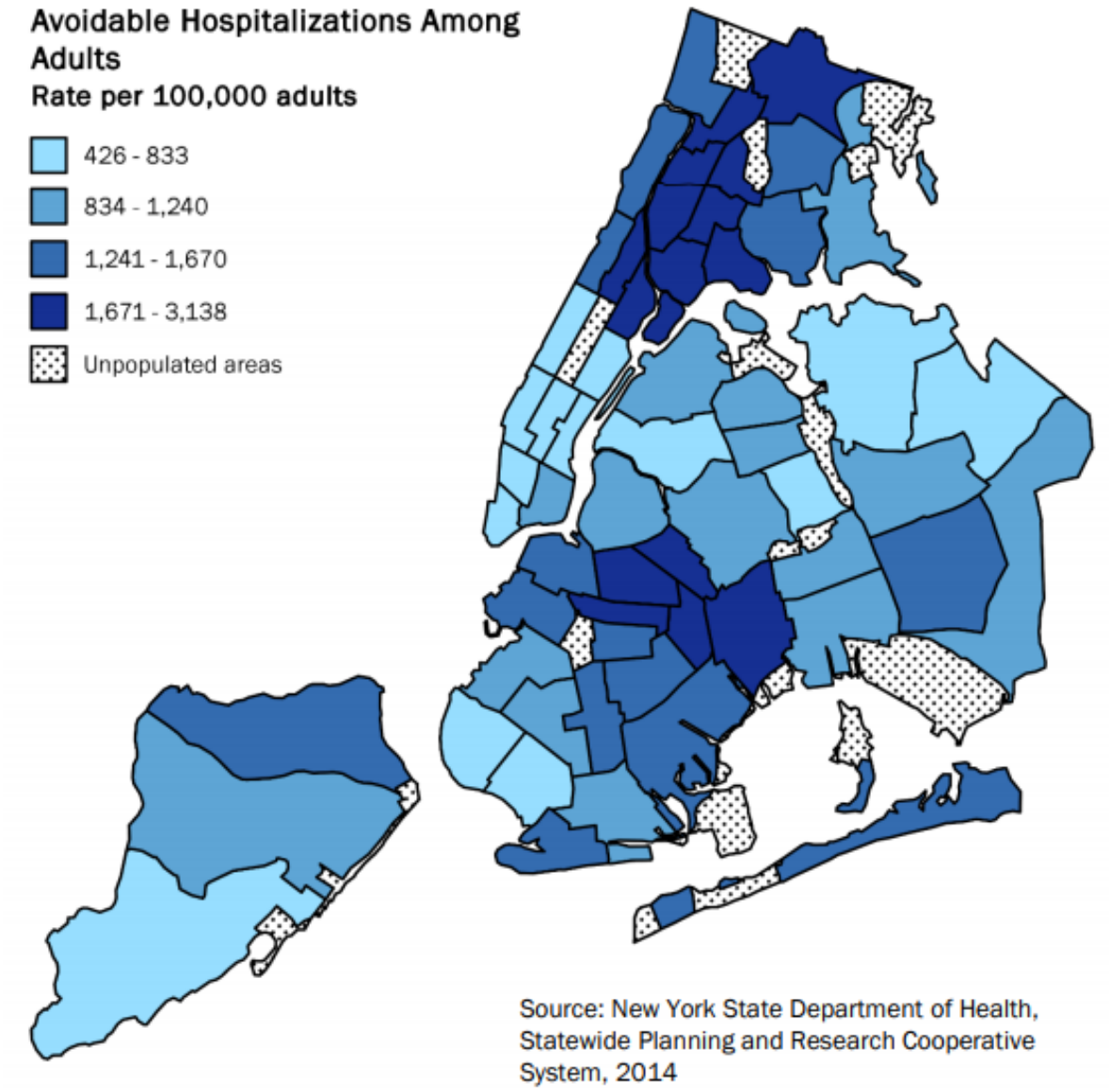
Figure 30. Preventable Hospitalizations Rate per 100,000 Adults



Data source: Statewide Planning and Research Cooperative System (SPARCS). Trend data not available past 2014 due to switch to ICD-10 in 2015. Data are age-adjusted.

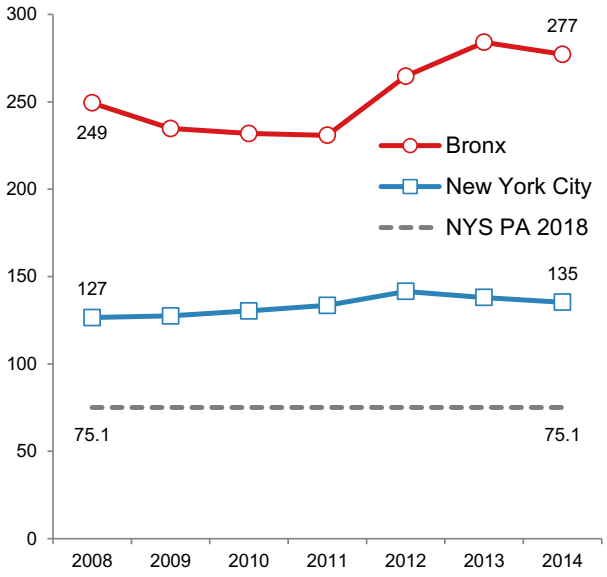
The rate of preventable hospitalizations among adults has decreased in NYC in the last decade, with the rate in the Bronx remaining higher than other NYC boroughs. In the Bronx, the rate of preventable hospitalizations in adults is highest among the non-Hispanic black population.

Figure 31. Preventable Hospitalizations Rate per 100,000 Adults

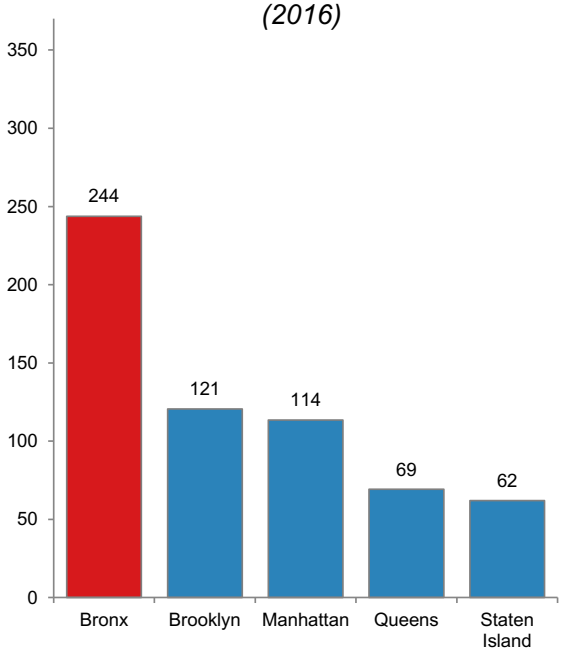


Map from New York City Community Health Profiles, 2018

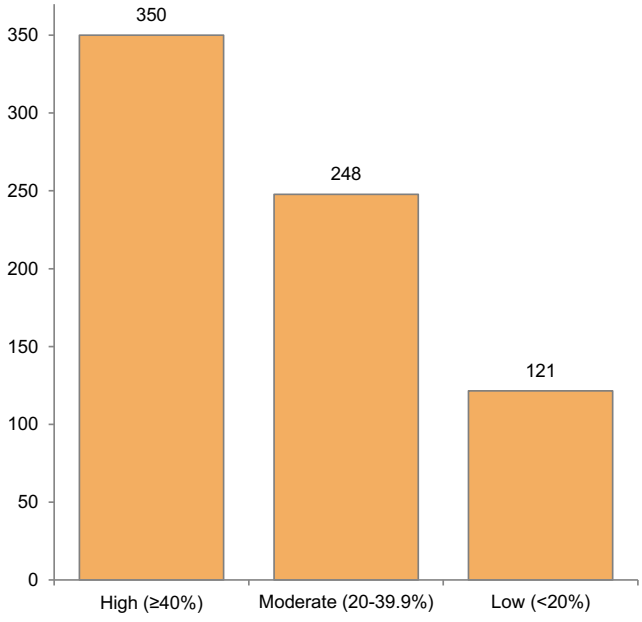
Figure 32. Asthma Hospitalizations per 10,000



Comparison to NYC boroughs (2016)



Disparities in the Bronx (2010-2014)

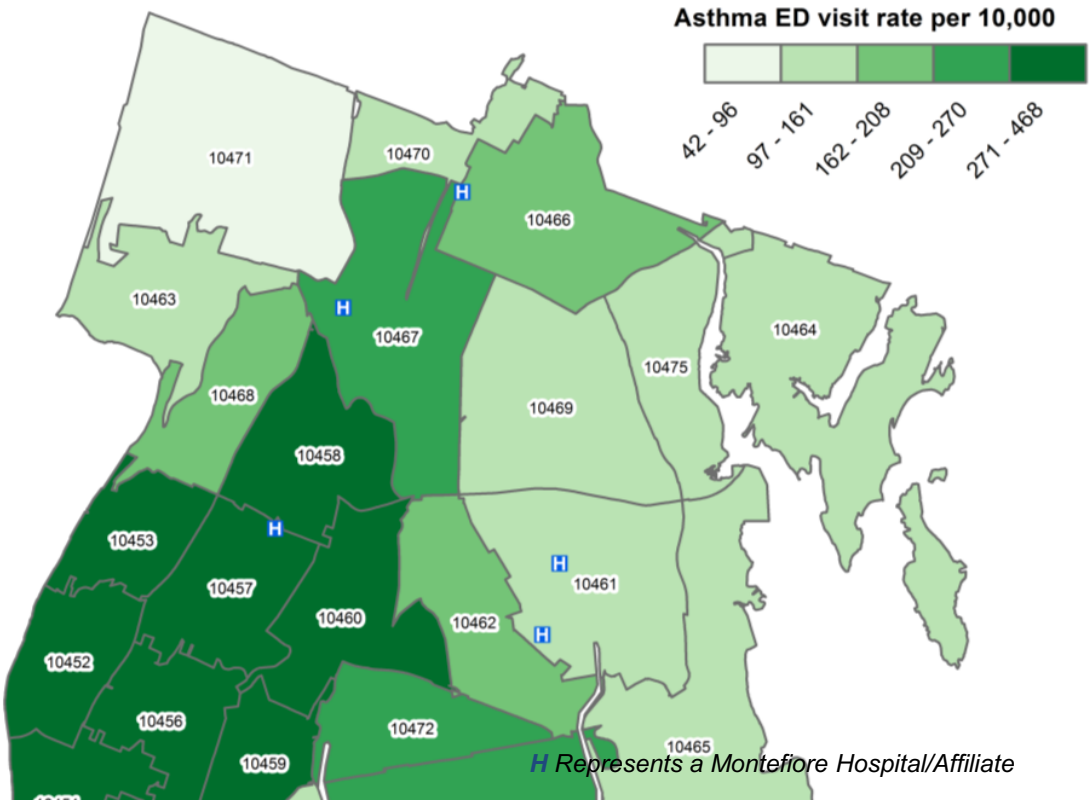


Data source: New York State Statewide Planning and Research Cooperative System. Trend data not available past 2014 due to switch to ICD-10 in 2015. Data not age-adjusted.

The rate of asthma hospitalizations is greater in the South Bronx where the percentage of poverty is higher. The rate of asthma hospitalizations for the Bronx has increased in the last decade and remains at least two times higher than the rest of the NYC boroughs.

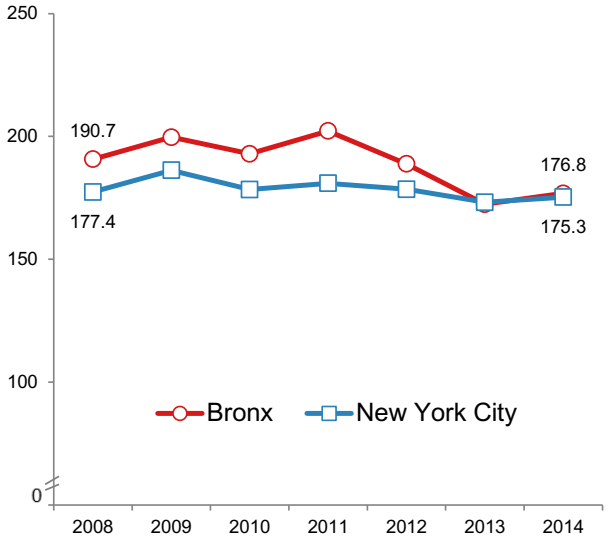
Figure 33. Asthma Hospitalizations per 10,000 in the Bronx

Differences by ZIP code

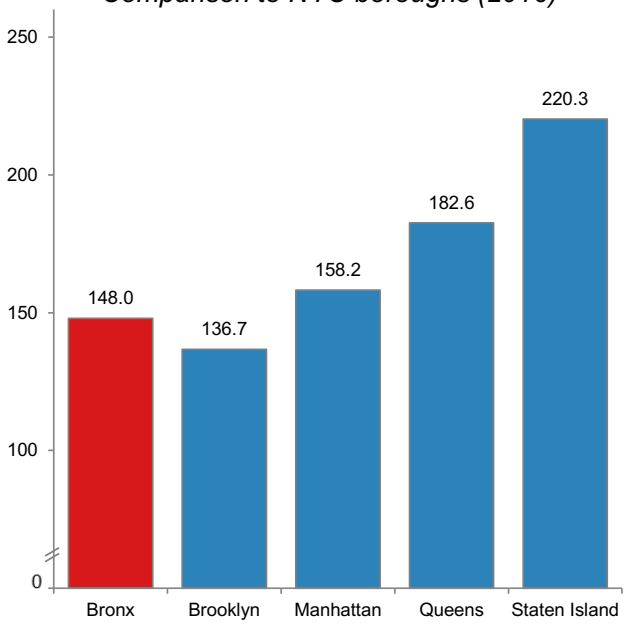


Data source: New York State Statewide Planning and Research Cooperative System, 2010-2014

Figure 34. Rate of Hospitalizations Due to Falls per 10,000 Adults Aged 65+



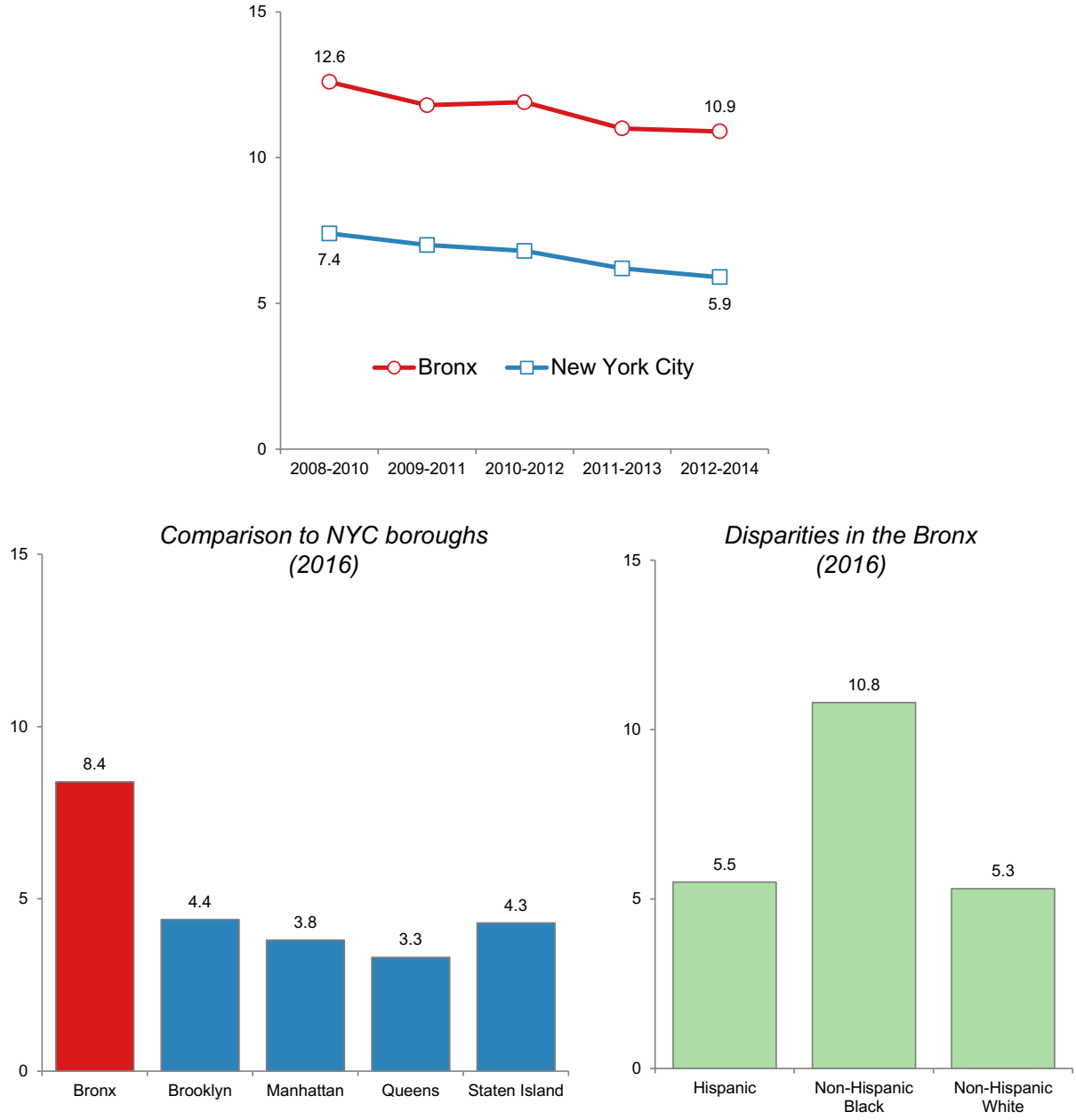
Comparison to NYC boroughs (2016)



Data source: Statewide Planning and Research Cooperative System (SPARCS). Trend data not available past 2014 due to switch to ICD-10 in 2015.

The rate of hospitalizations due to falls has been decreasing in the Bronx for the last decade while the rates have remained relatively unchanged in NYC as a whole. In 2016, the Bronx had the second lowest rate of hospitalizations due to falls.

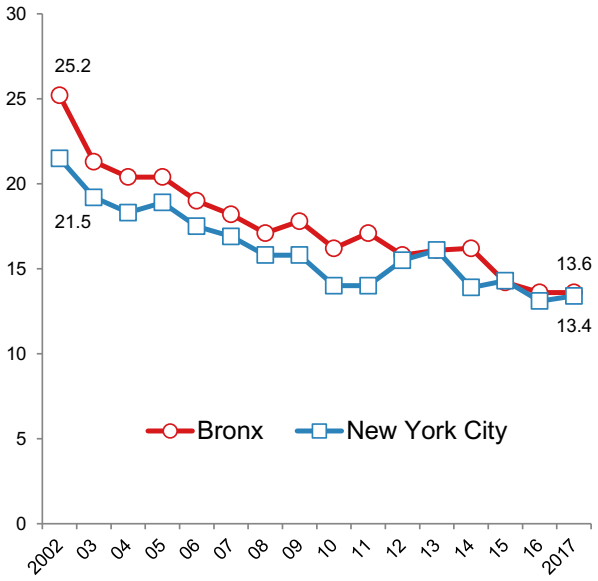
Figure 35. Assault-Related Hospitalizations Rate per 10,000



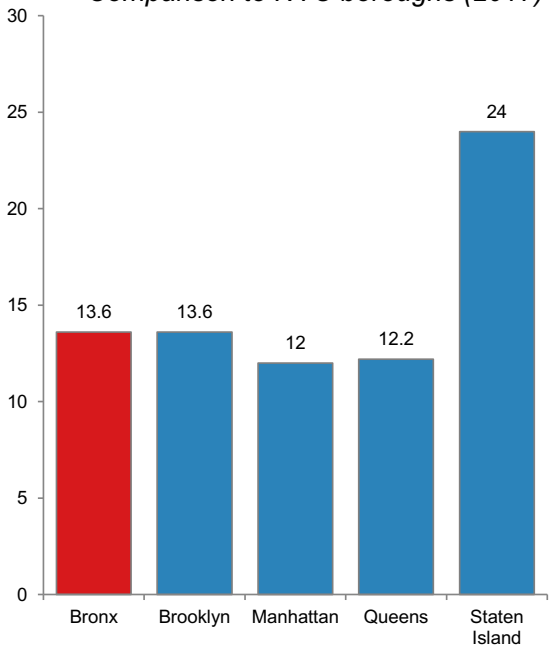
Data source: Statewide Planning and Research Cooperative System (SPARCS). Trend data not available past 2014 due to switch to ICD-10 in 2015.

While the rate of assault-related hospitalizations has decreased in the Bronx and across NYC, it remains highest in the Bronx compared to other boroughs. In the Bronx, the rate of assault-related hospitalizations is about two times higher among those who are non-Hispanic black compared to the Hispanic or non-Hispanic white populations.

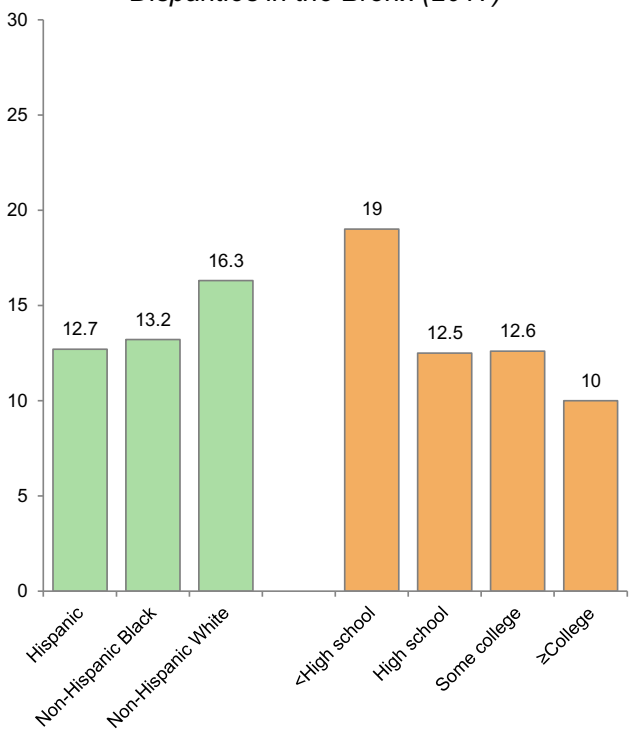
Figure 36. Percent of Adults Who Are Current Smokers



Comparison to NYC boroughs (2017)



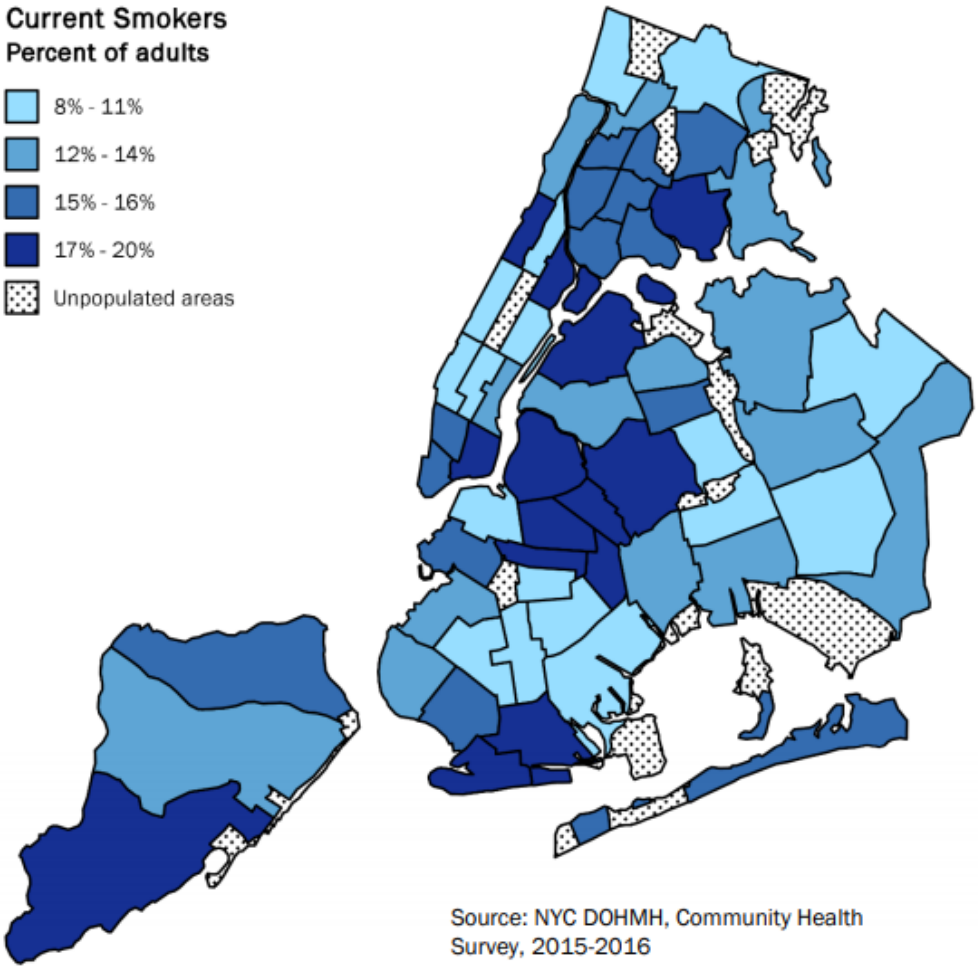
Disparities in the Bronx (2017)



Data source: NYC Community Health Survey.
Data are age-adjusted.

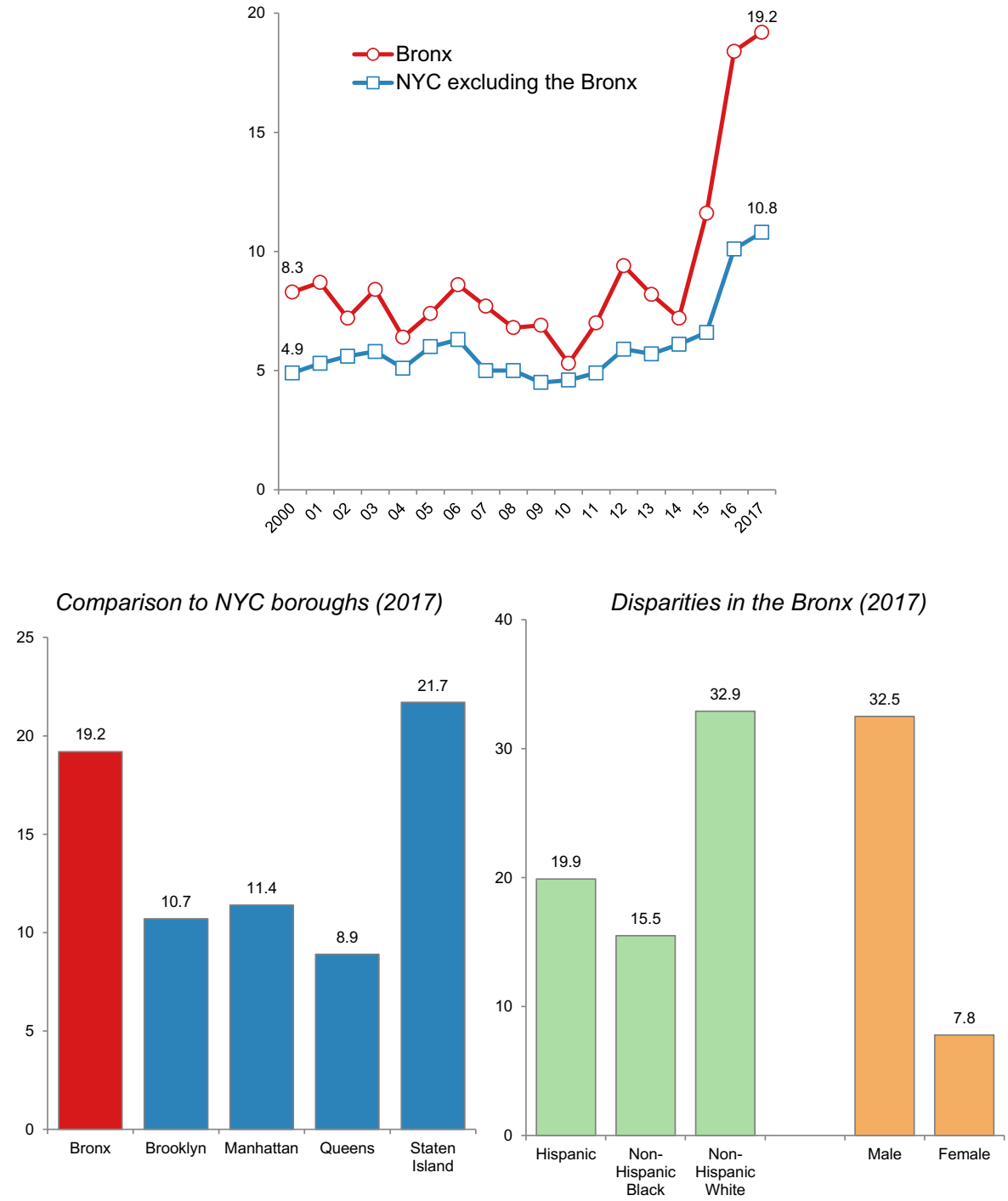
The percent of adults who are current smokers has decreased in the Bronx and NYC overall for the last two decades. In the Bronx, the percent of adults who are current smokers decreases as level of education increases.

Figure 37. Percent of Adults Who Are Current Smokers



Map from New York City Community Health Profiles, 2018

Figure 38. Opioid-Related Mortality per 100,000

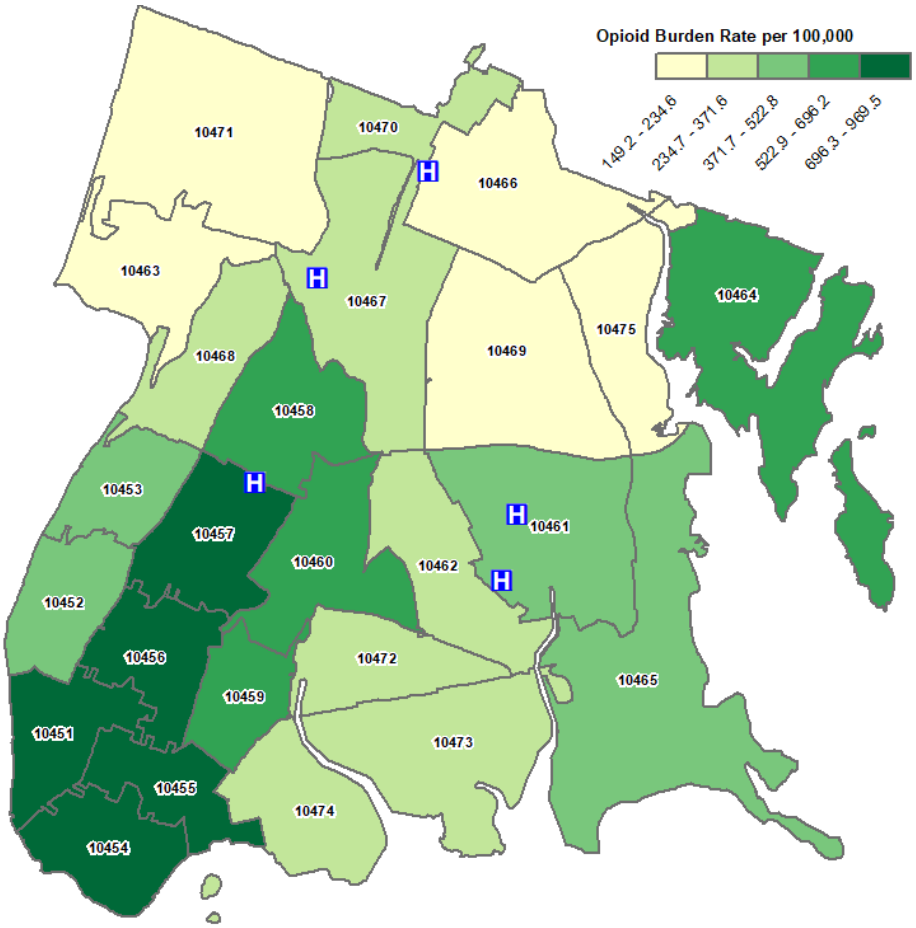


Data source: National Vital Statistics Surveillance System.

From 2000 to 2017 the rate of opioid mortality has increased in the NYC, with the rates in the Bronx being second highest after Staten Island. In the Bronx, the opioid related mortality rate is highest among males and the non-Hispanic white population.

Figure 39. Opioid Burden rate per 100,000 in the Bronx

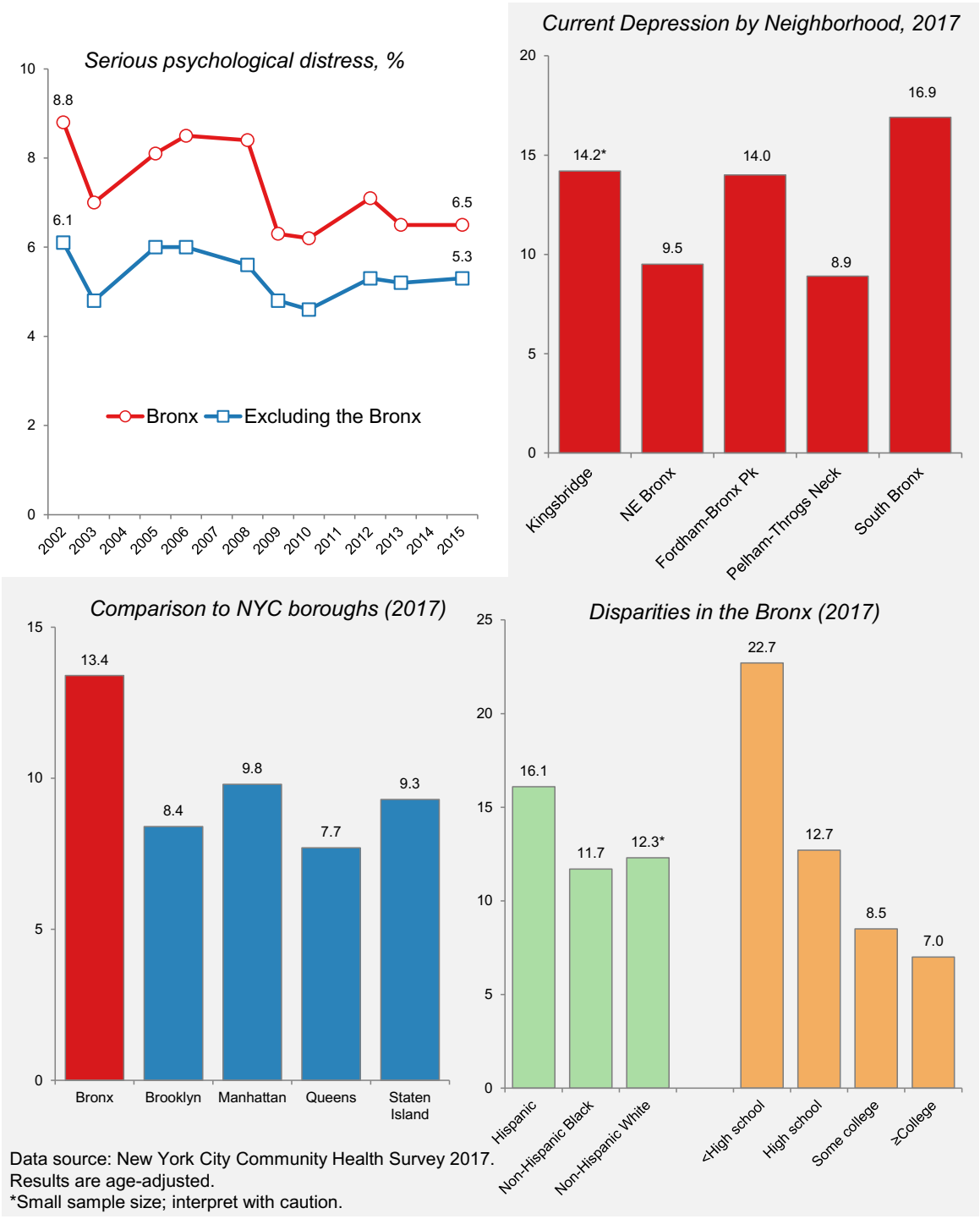
Opioid Burden Rate per 100,000, 2016



H Represents a Montefiore Hospital/Affiliate

Data source: New York State Opioid Dashboard. The opioid burden combines data from SPARCS and vital statistics.

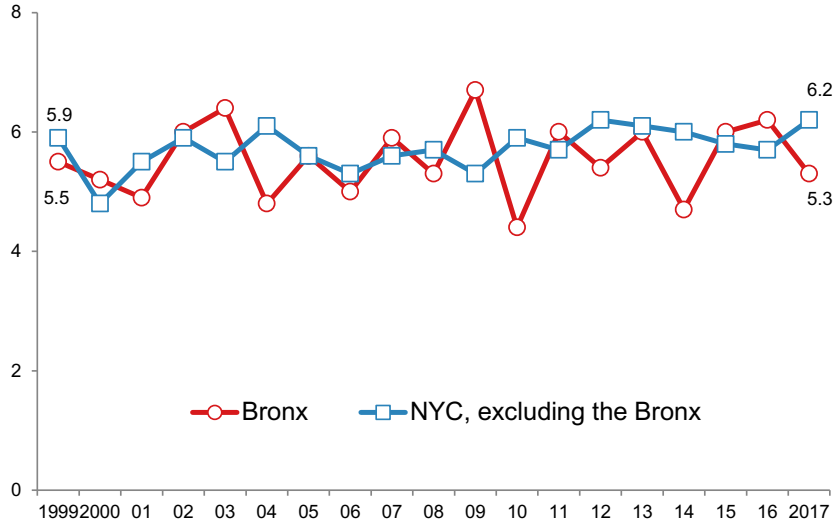
Figure 40. Percentage of Current Depression



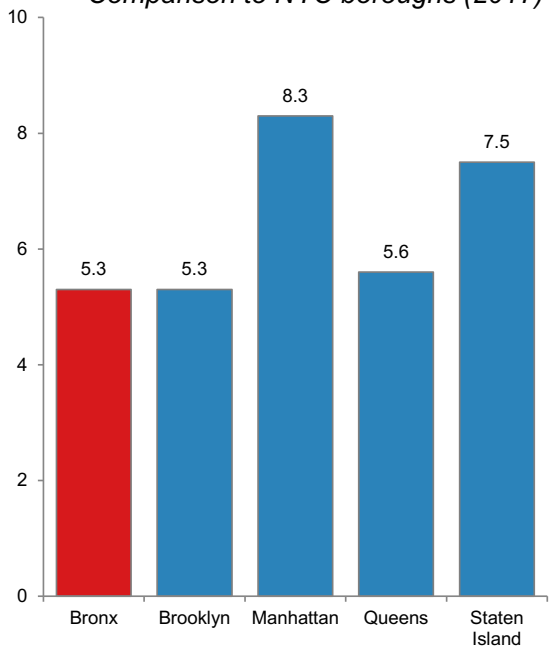
Data source: New York City Community Health Survey 2017.
Results are age-adjusted.
*Small sample size; interpret with caution.

The Bronx has a higher percent of current depression compared to other NYC boroughs, with prevalence decreasing as education level increases.

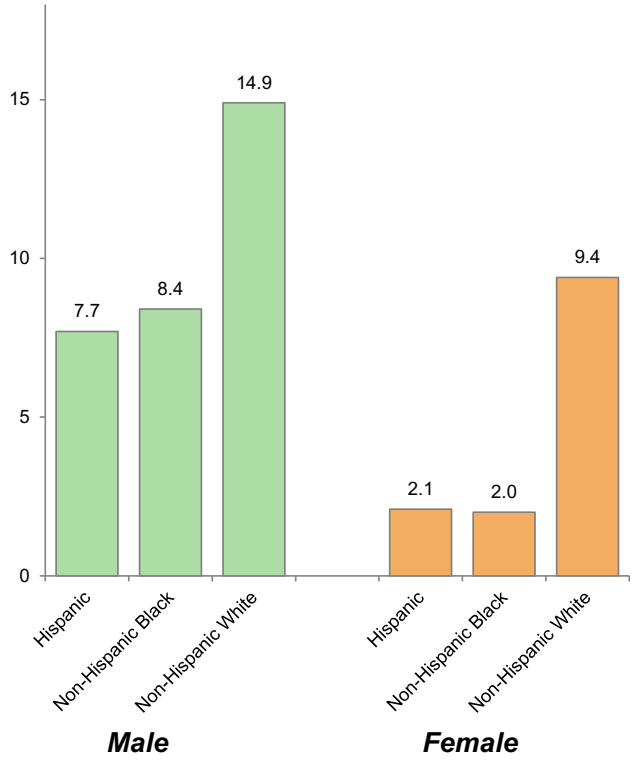
Figure 41. Suicide Mortality Rate per 100,000



Comparison to NYC boroughs (2017)



Disparities in the Bronx (2014-17)



Data source: National Vital Statistics Surveillance System. Data are age-adjusted.

The suicide mortality rate in the Bronx has remained steady from 1999 to 2017. In the Bronx, the suicide mortality rate is highest among males and the non-Hispanic white population.

IDENTIFICATION AND DISCUSSION OF HEALTH CHALLENGES

The conditions that shape health (commonly referred to as the social and environmental determinants of health) such as financial resources, access to healthy foods, and safe and affordable housing, to name a few, resulting in significant difference in health outcomes, such as disease severity, life expectancy, and infant mortality. Those who experience poor social and economic circumstances — including low income, poor education, insecure employment, food insecurity and poor housing — have worse health from the moment of birth throughout life. Such negative factors are prevalent within the Bronx population.

SBH Health System is serving this community with multiple, complex health and social needs. The Bronx has enormous health needs that require multiple partners and resources. According to county health rankings, the Bronx is 62 out of 62 counties in New York about health outcomes and factors. According to 2018 NYC Community Health profiles, the Bronx has the highest rate of unmet medical care in New York City.

The Bronx is one of the most diverse counties in the nation, 56.2% are Hispanic/Latino of any race, 29.0% are non-Hispanic black, 9.1% are non-Hispanic white and 3.8% are non-Hispanic Asian. More than one-third (36.4%) of Bronx residents were born outside of the United States in the Bronx, more people speak a language other than English at home (60%) than speak "only English" (40.0%); 48.0% speaks Spanish at-home.

Behavioral risk factors:

According to county health ranking for violent crime, Bronx County scored at 586, while overall NYC is 379. The Belmont East Tremont district is a primary source of patients. Compared with the citywide rate, Belmont/East Tremont has a higher rate of assault-related hospitalizations than the Bronx and NYC. Belmont rate is 152 per 100,000; The Bronx's rate is 113 per 100,000; NYC's rate is 113 per 100,000.

The population in the Bronx also experiences higher than average rates of preventable hospitalizations among adult. The Bronx rate is 2,091 per 100,000; the overall NYC rate is 1,033. According to NYC Community Health profiles, the Bronx has highest rate of premature deaths. The Bronx rate is 229.4 per 100,000 people; the NYC overall is 169.5 per 100,000.

The Bronx is amongst the youngest counties in New York State. The population has a median age of 34, trailing only Tompkins and Jefferson counties. About 40% of Bronx children live below poverty; the eighth highest proportion for any county in the United States, and the highest for any urban county.

According to NYC Vital Statistics, the Bronx has the lowest proportion of infants exclusively breastfed in the hospital in New York City. New York City is 41.6%; the Bronx is 28.1%. According to NYC DOHMH's Bureau of Vital Statistics, the percentage of live births receiving late prenatal (after first & second trimesters) or no prenatal care is the highest in the Bronx at 10.9%; Belmont East Tremont is 11.2%.; NYC overall rate is 6.7%.

Environmental Factors:

According to county health rankings, 39% of Bronx residents experience severe housing problems. Overall, in NYC, 24% of the population experience this.

Additionally, in the NYC Resident Survey in 2017, Bronx residents consistently scored quality of life issues below the overall rate in comparison to the other boroughs. The overall average for considering their neighborhood as a place to live in a positive light was 58.2%. Bronx residents scored 40.7%. The overall rate for a positive quality of life was 51.2%. Bronx residents scored it at 40.7%.

According to Localize (home search website), the Bronx logged the most frequent complaints about heat and hot water in New York City – a rate of 14.04 complaints per 100 households from October 2018 to May 2019.

Socioeconomic factors:

The Bronx is the poorest county in New York State with approximately 28% of residents living in poverty. In the Belmont/East Tremont district, SBH's primary service area, the poverty rate is 31%. Bronx unemployment in 2018 was 5.7%, the second highest in New York State.

According to the Bureau of Labor Statistics, the unemployment rate in the Bronx in 2018 was 5.7%, the second highest in New York State. In 2015, 71.9% of Bronx residents, ages 25 and older have received their high school diploma or GED; this is substantially lower than citywide (83.7%) and statewide (86.4%) attainment rates.

According to Feeding America, the Bronx and Kings counties in NYC have the highest rates of food insecurity. 31% of residents in the Bronx live in food insecure homes. 37% (over 1 in 3) Bronx children live in food insecure households. In the Bronx, 37.6% of households received Supplemental Nutrition Assistance Program (SNAP, formerly referred to as food stamps) benefits, compared to 14.9% in New York State overall and 16.5% in the rest of NYC (excluding the Bronx). Fifty-six percent of children less than 18 years lived in a household that received some form of public assistance (including Supplemental Security Income [SSI], cash assistance or SNAP/food stamps), compared to 26.9% statewide and 29.6% in the rest of NYC.

Policy environment:

As the population in the Bronx is exceptionally diverse, improvements in the health of the general population must necessarily address racial/ethnic and socioeconomic drivers of health disparities. SBH must address language barriers and cultural factors. SBH recognizes that a community's greatest challenges are complex and often linked with other societal issues that extend beyond health care services. SBH focuses on addressing unmet needs related to the social determinants of health. Evidence has shown that by addressing social needs we can help reverse damaging health effects.

SUMMARY OF ASSETS

Description of unique community characteristics/resources

A wealth of community assets and resources exist in the Bronx, yet its residents experience stark inequities in health. Through the multiple resources 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.

SBH Health system has researched various sources to have access to reliable, updated community assets. The NYC Department of Health & Mental Health, Policy, Planning & Strategic Data Use trained SBH Health System staff to access its extensive data base of community assets. This database and other NYC government sources are used by SBH to identify additional community partners throughout the county of the Bronx.

Bronx Community Connect provides a map-based platform to find, view and interact with publicly available data (open data) and Lehman College information. The goal of the site is to enable students, faculty, researchers and the public to participate in their community by facilitating inquiry, exploration, and the development of creative applications. This site brings together information about health, population, education, urban sustainability, and other Bronx-related data from New York's Open Data site.

Additionally, SBH has reviewed the community needs reports for each community board districts in the Bronx. Such reports both state their needs and the community assets available

According to Bronx Community Board 6 Community District Needs (Fiscal Year 2020), Belmont-East Tremont has a number of community assets of public schools (62), public libraries (3), hospitals and clinics (27), and parks (17). According to this report, 99% of the residents live within walking distance of a park or open space, as compared with citywide target of 85%. This district is also the home to two major cultural institutions: the New York Botanical Garden and The Bronx Zoo.

As lead partner of the PPS/ Brown Partners for Healthy Communities, SBH has access to a range of community-based organizations and health care providers conducting programs that serve our community.

The below programs operate under the umbrella of Bronx Partners for Health Communities (BPHC). Patients at SBH Health system have access to these services augmenting our ability to address the extensive list of health issue facing this community.

100 Schools Project/ Bronx Partners for Healthy Communities (BPHC)	Designed to meet the needs of students with emotional, behavioral and substance-abuse issues presents challenges for schools. Partnership of four DSRIP Performing Provider Systems the NYC Department of Education, & NYC DOHMH, the Jewish Board of Family & Children's Services.	Develop trainings for school staff & workshops for students & parents, to foster a positive impact on schools' climate & reduce the stigma of mental health. Schools learn how to connect students with local mental health providers ..	PROMOTE A HEALTHY WOMEN, INFANTS AND CHILDREN Focus area 3: Child & Adolescent Health Goal 3.1: Support and enhance children & adolescents' social –emotional development and relationships

BronxWorks ED Health and Housing Coordinator Program/ Bronx Partners for Healthy Communities (BPHC)	Housing coordinators from BronxWorks are stationed in the SBH emergency department to connect patients who are homeless to transitional and permanent housing. Residents identify patients in need and connect them to the housing coordinator.	Bridge the gap between medical conditions and social needs of patients.	PROMOTE WELL-BEING AND PREVENT MENTAL & SUBSTANCE USE DISORDERS Enable resilience for people living with chronic illness
Asthma in home visits/Bronx Partners Healthy Communities (BPHC)	Asthma in-home visits by community health workers for people with severe asthma.	Improve self-management, limit triggers and avoid hospitalizations.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
NWBCCC & Hostos Community College Asthma-Pest Management /Bronx Partners Healthy Communities (BPHC)	NWBCCC and Hostos Community College provide Integrated Pest Management Vendor Certification Program for community members to increase number of IPM vendors in the Bronx and provide workforce opportunities	Improve self-management and avoid hospitalizations	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
Northwest Bronx Community and Clergy Coalition's (NWBCCC) Healthy Buildings Program /Bronx Partners Healthy Communities (BPHC)	NWBCCC deploys teams of community organizers to private & NYCHA-owned buildings identified as asthma "hot spots" within housing and hospital admissions data. These teams provide group education, refer tenants to home visits, refer to integrated pest management.	Improve self-management, limit triggers and avoid hospitalizations.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
Asthma training/Bronx Partners Healthy Communities (BPHC)	Pharmacy delivery health workers educate patients on asthma medication use upon delivery.	Improve self-management and avoid hospitalizations.	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions
Asthma training/Bronx Partners Healthy Communities (BPHC)	Asthma education training for home care attendants across seven home care agencies; train attendants to conduct in-home warning signs test and to refer to home visits	Improve self-management and avoid hospitalizations	PREVENT CHRONIC DISEASES Focus area 4: Prevention Care and Management Goal 4.3: Promote the use of evidence based care to manage chronic diseases Improve self-management skills for individuals with chronic conditions

Resources available from various sources

SBH has developed deep partnerships and collaborations to address the long list of health disparities in the Bronx. 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. SBH is the lead partner in Bronx Partners for Healthy Communities (BPHC), a NYS Delivery System Reform Incentive Payment (DSRIP) project. BPHC is a network of 230 Bronx based organizations including two hospitals, FQHCs, long-term care and developmental disability providers, health homes, substance abuse agencies and community-based organizations. BPHC developed an online, searchable directory of health and social service organizations in the Bronx.

It provides up to date referral information used by care coordinators, patient navigators can use the tool to help patients find behavioral health and long care term providers, housing assistance, food resources, immigration services and more. SBH personnel use this and other online resources and work to integrate this kind of solution into the various workflows across the ambulatory, ED and inpatient settings.

The NYC Department of Health & Mental Health trained SBH Health System staff to access its extensive database of community assets. SBH reviewed listings of Selected Facilities and programs sites prepared by NYC Department of City Planning. This information is used to identify additional community partners throughout the county of the Bronx. Additionally, we interact with various NYC government agencies.

NYS Department of Health Assets available to meet the plan's objectives:

Perinatal and Infant Health
- Comprehensive Prenatal-Perinatal Services Networks
- Medicaid Program
- New York State Perinatal Quality Collaborative
- Regional Perinatal Centers
- The Healthy Mom-Healthy Baby Prenatal and Postpartum Home Visiting Program

Injuries, Violence and Occupational Health
- Enough is Enough Initiative
- Rape Crisis on College Campuses
- Rape and Sexual Violence Prevention Program
- Rape Prevention Education Program

Nutrition
- Hunger Prevention and Nutrition Assistance Program

There are a number of significant educational institutions in the Bronx: Fordham University, Monroe College, Metropolitan College of NY, College of Mount Saint Vincent, and City University has three campuses: Lehman College, Hostos Community College and Bronx Community College. SBH operates extensive college level internships that draw from these schools. Additionally, SBH collaborates with elementary, middle and high schools within Community Districts 5 and 6. SBH operates an extensive internship programs for high school and college students interested in healthcare professions. SBH offers onsite visits for elementary school students.
The Bronx has among the greatest number of parks in all five boroughs. The largest parks are Van Courlandt Park, Pelham Bay Park, and Wave Hill. Use of the parks for recreation and exercise are available assets for all ages. The Bronx is rich in cultural institutions: NY Botanical Garden, Bronx Zoo, Bronx Children's Museum, Bronx Museum of the Arts, Bronx River Art Center, Bronx Historical Society, Bronx Opera Company, and Pregones Theater, and many others. Such institutions enhance the wellbeing and education of all ages.

SBH maintains a relationship with the business communities through its partnerships with Belmont and Fordham Business Improvement Districts (BIDs). SBH maintains close relationships with the local BIDS and participates in outreach efforts including health fairs geared toward all ages.

Documentation of stakeholders and partners that participated in the prioritization process

SBH Board of Trustees and Executive Leadership have a strong commitment to efforts to expand and maintain working partnerships with the entire spectrum of community agencies/groups. Through the supported efforts of SBH Office of Community and Government Affairs, we have developed a community level approach involving varied community based organizations interested in health issues addressed. This provides a closer alignment between community levels goals of SBH and the organizational goals of community organizations. Additionally, there were public health experts at SBH, community based organizations, local businesses, relevant health insurance companies, elected officials and government agencies participated in various levels in the prioritization process.

Public Health Experts at SBH Health System:

Specialty	Name	Title
SBH Trauma	Nanette McEnroe Talty, RN, MSc, PGCE,	Program Manager
SBH Adolescent Medicine	Dr. Kanani Titchen, MD, FAAP,	Attending Physician/Director
SBH Community & Government Affairs	Lynette Alvarado	Director Language Culture, Governmental Affairs, State DOH designated language expert
SBH Community & Government Affairs	Caroline Davis	Director – Patient & Community Engagement
SBH OB/GYN & Pediatrics	Dr. Efosa Imafidon, DPT, MBA, NHA, PMP®, FACHE,	Administrative Director
SBH Midwifery	M. Julie Crocco CNM, MSN	Director
SBH WIC	Jose A. Tuma	Director
SBH Food & Nutrition Department	Karen Travali	Director
SBH Food & Nutrition Department	Cecilia Moy	Clinical Nutrition Manager
SBH Finance	Jerusha Bonte	Director
SBH Medicine	Dr. Manisha Kulshreshtha	MD, FACP, VP Medical Affairs
SBH Medicine	Dr. Jitendra Barmecha	SVP-CIO Information Technology & Clinical Engineering
SBH Trauma	Erik Marketan	AHA Training Center Coordinator
SBH Pediatrics	Dr. Anika Clarke	
SBH Dental	Denize Gary, RDH	Dental Hygienist
SBH Pediatrics Allergy	Dr. Alyson Smith	Division Director
SBH Dental	Dr. Dara Rosenberg	Chair/Director Dentistry Resident
SBH Pharmacy	Amanda Rampersaud	Transitions of Care Clinics Coordinator

Bronx Partners for Healthy Communities/Healthcare Experts:

Irene Kaufman	SVP Population Health/Executive Director
J. Robin Moon, DPH,MPH,MIA	Senior Director, System Integration
Shqipe Gjevukaj	Project Manager

Healthcare Experts:

Montefiore Medical Center	Dr. Nicole Hollingsworth	Vice President, Community & Population Health
NYC Department of Health & Mental Health	Clifford Larochel	Director
Greater NY Hospital Association (GNYHA)	Lloyd Bishop	Senior VP, Community Health Initiatives and Government Affairs
GNYHA, Community Health Initiatives	Amy E. Osorio	Director
NYS Department of Health Office of Public Health Practice	Priti Irani	Research Scientist
NYC DOH - Bronx Neighborhood Action Center	Ilish Neely Karla Cabrera	Family Wellness Site Coordinator, Center for Health Equity

Health Insurance companies:

HealthFirst	Juan Tavarez	Associate Director
UnitedHealth Group	Manuel Antonio Quezada	Associate Director

Local Business Groups:

Fordham Road Business Improvement District	Wilma Alonso	Director & Trustee of St. Barnabas
Belmont Business Improvement District	Phil Marino	Executive Director
CityJeans	Marko Majic	Development Director

Elected Officials:

Office of Bronx Borough President	Monica Major	Director, Education & Youth Services
NYC Council Member Richie Torres	Romina Enea	Deputy Chief of Staff
NYS Senator Gustavo Rivera	Latoya Matthews	Director of Community Affairs & Counsel
NYS Senator Gustavo Rivera	Jay Baez	Health Committee & Policy Analyst
NYS Assembly Member Victor Pichardo	Nicholas G. Peters	Communications Coordinator
NYS Senator Luis Sepulveda	Samaris Gross	Director of Interfaith/ Special Assistant

NYS Assembly Member Karine Reyes	Justin Westbrook-Lowery	Deputy Chief of Staff

Community Based Organizations & Subject Matter Experts:

Bronx Community Board #6	John Sanchez	District Manager
Bronx Rises Against Gun Violence (B.R.A.G)/Good Shepherd Services	David Caba Ildefonso Oquendo Joel Castillo	Senior Program Director
Cardinal McCloskey Head Start	Wanda Rosa	Program Director
Cooperative Home Care Association	Denise Hernandez	Director of Operations
Crotona High School	Alexandra Haridopolos	Teacher
Destination Tomorrow	Arya Melendez	Outreach Specialist
Geneva's 50/50	Chef G. Wilson	CEO & Owner
Good Shepherd Services/Monterey Cornerstone Community Center	Luis Fuentes	Program Director
La Peninsula Head Start	Nydia Serrano	
Lehman College/Health Sciences Administration	Professor Keziah Hercules	HSA Internship Coordinator
Mexican Coalition/Mexican Consulate	Karina Escamilla	Health Affairs Coordinator
Mexican Coalition	Jairo Guzman	
NYC Commission on Human Rights	Joseph U. Onwu	
NY Public Library Bronx Library Center	Elisa Garcia	Head of Teen Services
NY Psychotherapy & Counseling Center	Anthony Otten	Senior Outreach Specialist
Neighborhood S.H.O.P.P Inc.	Ruby Rosario	Program Director
NYPD Crime prevention	Lissette Henriquez	Community Affairs Officer
PHIPPS Neighborhoods	Gabriel Crespo	Case Manager
R.A.I.N One Stop	Alison Ortiz	Director
R.A.I.N Mt. Carmel Neighborhood Senior Center	Araminta Rivera	Program Director
Rising Ground	Jenny Nieves Paola Gonzalez Vargas	
Services for Underserved	Atiya Jones	Vocational Specialist
United Chaplain Faith & Hope	Jennifer Fernandez Rosario	Pastor
Union Community Health Center (UCHC)	Shannell Arroyo	Outreach & Community Relations Coordinator
Validus Preparatory Academy	Eugene Figueroa	Assistant Principal
Visiting Nurses Services NY	Mariela Gonzalez	Community Outreach
Young Audiences	Jamaal King	Program Director

Development of the Community Service Plan
Methodology for selection including group consensus processes

Public participation in assessing community needs and setting priorities has been a continuous process over the past three years. We engaged a range of stakeholders with particular focus on medically underserved and minority local residents to assess community needs; set priorities; develop design and implement programs; and share and celebrate progress and results.

The SBH Office of Community and Government Affairs serves as the primary liaison with residents, community leaders, businesses, ethnic and civic organizations in the Bronx. Through this Office, SBH employs diverse, often multi-pronged, strategies to build an extensive network of community partners to provide ongoing outreach and consultation.

SBH Office of Community and Government Affairs developed a community level approach to engage and involve all spectrums of the community. The vehicle is the **Community Alliance for Healthcare Awareness (CAHA,)** which as a community level coalition which brings together community partners to have a significant impact on community health improvements. These partners represent the ethnic and social economic profile of the community. New members are welcomed and encouraged to stay engaged. The CAHA group meets monthly throughout the year and is open to all members of the public whether a group, institution or individual. At SBH CAHA meetings, data presentations are made on the leading health concerns affecting the community. After such presentations, a discussion is held to answer any questions, or for individuals to share their experiences with the health condition in the population. During 2018-2019, SBH staff explained the NYS Prevention Agenda, reviewed secondary data on demographics and health indicators, and discussed potential priorities and interventions. These discussions led to the selection of priorities identified in this document.

In addition, over past few months, SBH consulted with numerous public health experts in New York City Department of Health and New York State Department of Health. The New York City Department of Health is an oversight partner in two of the initiatives chosen. SBH also consulted with other agencies and organizations with expertise on the needs of low-income populations and children. SBH has a strong working relationship with Bronx Community District # 6, which comprises the primary service area. SBH, on an ongoing basis, has reviewed secondary data, explained the NYS Prevention Agenda and discussed potential priorities and interventions with Community District #6.

SBH Health System has developed additional approaches to the assessment of community needs and health priorities. SBH has developed various memorandums of agreements with community organizations. SBH Health System participates in a variety of organized partnerships and collaborations, working with other providers in the Bronx, as well as elected officials' representatives of the affected communities to identify health care needs and determine the appropriate configuration of services.

COMMUNITY HEALTH IMPROVEMENT PLAN /COMMUNITY SERVICE PLAN

Introduction

SBH is committed to furthering the goals set forth in the New York State Department of Health Prevention Agenda through the selection of three priority agenda initiatives consistent with the Department's goals.

In the Community Health Improvement Plan/Community Service Plan developed for 2016-2018, the priority area selected was to Prevent Chronic Diseases and two broad focus areas to implement programs. The board focus areas were (1) Reducing Obesity in Children and Adults and (2) Increase Access to Higher Quality Chronic Preventive Care and Management in Both Clinical and Community Settings.

We reviewed the SBH Health System data for 2018 of top twenty outpatient, inpatient and emergency discharge diagnosis. The data is consistent with the primary and secondary data gathered. The top diagnoses were respiratory illnesses (asthma and COPD), substance abuse (alcohol and opiates), HIV, behavioral diagnosis, diabetes and hypertension. All these conditions are being addressed either through services provided by SBH Health System or Bronx Partners in Healthy Communities (BPHC) or other partners/referral agencies.

After a review of primary and secondary data, community participation and consultations with experts resulted in the selection of the following priority areas. Each area has been chosen keeping in mind available or prospective resources to serve the community.

In the SBH Health System submission for Community Service Plan for 2019-2021, SBH elected to adopt three priority areas:

Prevent Chronic Diseases	**A focus on reduction of obesity in children, reached through a focus on Healthy Eating and Food Security. In the community survey, food and nutrition ranked #2 for "priority health issues", access to healthier food ranked #1 in "most helpful actions for the community" and #1 as "priority health issues" for individuals. We will screen for food insecurity.**
Promote Healthy and Safe Environment	**A focus to reduce violence by targeting prevention programs particularly to highest risk populations. In the community survey and in various forums, violent crime is a major concern. SBH will implement Cure Violence with Bronx Rises Against Gun Violence (B.R.A.G.), the NYC Department of Health, Doctors of the World and NYPD.**
Promote Healthy Women, Infants and Children	**A focus to increase breastfeeding. SBH is to be designated as a Baby Friendly Hospital. The requirements to be a Baby Friendly Hospital creates the culture to teach and sustain breastfeeding practices. Under the supervision of the NYC Department of Health & Mental Health, all milestones will be reached to acquire said designation.**

Identification of Selected Priorities, Goals, Objectives and Interventions

Prevent Chronic Disease - 2016 Community Service Plan

In the 2016 Community Service Plan, SBH selected as a priority, Prevent Chronic Disease, with the focus areas to reduce obesity and promote good nutritional practices in this ethnically diverse and income challenged community. Interventions conducted in both the community and the SBH workplace were well received. The SBH Nutrition Department established the objective to educate the community, including employees, on prevention measures that will empower patients/employees to take the initiative to enhance their lifestyle and overall wellbeing. SBH did a complete overhaul of its menu, offering healthy eating options and education. SBH signed an agreement with NYC DOHMH to be a "Healthy Hospital." SBH launched a Healthy Beverage Zone (HBZ) as part of a Bronx wide movement. SBH was the first hospital to become an HBZ Champion Core Member. SBH continues to provide SSB-FREE (Sugar-Sweetened) events. SBH encourages healthy eating by regularly conducting meatless days, providing special menu items like smoothies, and uses the SBH Facebook site to educate staff on healthy eating.

As part of the 2016 CSP, SBH collaborated with Mary Mitchell Family & Youth Center, a community-based organization, to implement a Food as Medicine model. The program delivered fruits and vegetables to patients who had uncontrolled diabetes. SBH medical residents worked with a defined group of patients to change the culture of health and educate on healthy eating with the goal of improving diabetes and hypertension.

Priority Area: Prevent Chronic Disease

Focus Area 1: Healthy Eating and Food Security

Goal 1.3: Increase food security
Objective 1.2: Decrease the percentage of children with obesity among public schools students in NYC.
Disparities: Based on data for SBH primary service area, Belmont/East Tremont has a poverty rate of 31%, (which is higher than the Bronx - 25% and citywide – 20%). Additionally, eighty-seven percent of SBH patients are Medicaid and Medicaid Dual Eligible. In the Bronx, 37% of children live in food-insecure households. These indicators reflect the severe economic disparities experienced by SBH patients.
Interventions: 1.0.6:
Screening for food insecurity, facilitate, and actively support referral at well-child visits ages 5-17 identified through questions in the Electronic Medical Record (EMR). SBH Pediatric Clinic will engage in a Food Insecurity pilot to identify and address the issue by:

- Utilizing existing resources to extend the reach of providers
- Linking the community-based services to bridge the gap between clinical and social needs
- Meeting the patient/family where they are

Evidence-based: Addressing Social Determinants of Health at Well Child Visits; A Cluster RCT - Screening for social determinants of health in clinical care: moving from the margins to the mainstream Addressing Food Insecurity: a tool kit for Pediatricians (American Academy of

Pediatricians). Screening for food insecurity in clinical settings recommended as food insecurity can adversely affect a patient's health outcomes.

Family of Measures:

To increase the percentage of patients ages 5-17 screened for food insecurity at well child visit and refer to food and nutrition programs. Target population are children from Medicaid eligible households. By December 2021: Target: 70% of children from Medicaid eligible households screened at such visits. Baseline (2018): 24%. Data source: St. Barnabas patient records. Review data on monthly basis.

Projected (or implemented) Year 1(2019):

Lectures on food insecurity held during Pediatric rounds for Pediatric & Internal Medicine Rounds.
Resident rotation to community-based organizations providing nutrition-related services.
Screening tool developed to identify PEDS patients with food insecurity using Hunger Vital Sign.
Incorporate screening question in MA flow sheet (vital hunger sign).
Identify reliable referrals agencies based on criteria of availability in business hours and services, close to home and bilingual staff (when needed).
Create & distribute card for PEDS patients with resources for referrals.
Review of PEDS screening data monthly.
Monitor PEDS screening rates changes on 6-month intervals.

Projected Year 2 (2020):

Further education on food insecurity to non-clinical staff
Review the 2019 workflow for referring patients with food insecurity to the appropriate service providers to determine if changes are required
Work with IT to include referral to food and nutrition services in the discharge summary embed in well-child progress notes to determine if a referral was appropriate.
Identify appropriate services available at newly opened wellness center regarding healthy eating

Projected Year 3 (2021):

Develop referral protocols to wellness center teachings on healthy eating & other appropriate services
Evaluate the project & make corrections

Implementation Partner: Bronx Partners for Healthy Communities (BPHC) and Project EATS

Partners' Roles & Resources: BPHC- Programmatic and technical support. Project EATS operates the urban farm

Healthy Eating & Food Security
Introduction

In the 2019 community survey conducted, food and nutrition plus access to healthier food scored number one in priority health issues for individuals. Chronic disease screening and obesity scored very high as priority health issues for individuals and the community. Building on the prior CSP efforts and adhering to the community's priority health concern, SBH has chosen the priority of Prevent Chronic Diseases with Healthy Eating as a primary area.

Food plays a significant role in a patient's life. It can support the improvement of chronic disease management. It is critical for patients to understand the health implications of the food they eat. Food insecurity is associated with some of the costliest and serious health problems, including higher levels of chronic disease, a higher probability of mental health issues, higher rates of iron-deficient anemia, impaired growth of children, and more hospitalizations and longer in-patient stays.

SBH Health System is addressing the objectives to ensure food security and increase access to healthy foods through a number of initiatives. Some have been implemented (identification of resources, operating a farm stand, and PEDS screening pilot), and others are in development (rooftop farm and a teaching kitchen).

According to Feeding America (2017), the Bronx is the "hungriest borough" in NYC. It states that the Bronx has a 16% food insecurity rate, determined by the relationship between food insecurity and closely linked indicators of food insecurity (i.e., poverty, unemployment, etc.). Unlike other parts of the country, 100% of food-insecure individuals in the Bronx are eligible for federal anti-hunger programs. Thus, by identifying food insecurity, screening for eligibility, and providing guidance on the available nutrition programs, we can improve food security for Bronx residents.

A food-insecure household is forced to engage in coping strategies, often including the consumption of foods that are high in calories but low in nutritional value. This leads to poor nutrition and chronic diet-related diseases such as diabetes. In addition, Bronx households face an extremely high rent burden of 58%, whereas the citywide rate is 51%. This results in a situation of fewer resources to afford adequate food.

Families may be reluctant to seek assistance because of the stigma associated with hunger and food insecurity. SBH seeks to create an environment that provides resources and provide assistance — encouraging families to feel comfortable talking about their needs and receive help.

The physician/clinician will identify and help address the issue by screening for food insecurity. The target is screening at well-child visits for patients ages 5 – 17 years old, targeting Medicaid eligible households. A two questions survey developed with culturally sensitive and appropriate language when asked of low-income families. The questions will be included in the Electronic Health Record (EMR) under Nutritional Evaluation.

If the patient/family screens positive, the physician/clinician will make a referral to either a social worker or patient navigator. They will discuss with the patient/family the nature of the food security problem, identify the kind of resource, and identify the specific need. The Social Worker will make a referral to community-based organizations for nutritional services. A follow-up is conducted to determine if the intervention was successful.

The Bronx Partners for Healthy Communities conducted a mapping initiative to identify nutrition-related programs. They are thus providing information on community-based services to enable SBH to identify nutrition-related resources quickly. The criteria for the selection of referral agencies are: distance from the patient's home, variety of programs to ensure referral needs of the families are met, bilingual staff

(when needed), and variety of open days/hours to meet the availability of families. This creates a reliable referral pipeline for food insecurity screening.

Due to food insecurity and healthy food deserts in the Bronx, there is a renewed focus on providing families and children access to healthy food, more fruits and vegetables to decrease the number of children and families. One referral, after screening, is the SBH Farmacy Rx program. SBH, with its partner – Project EATS, operates a farm stand. The fruits and vegetables are coming from Project EATS' other farm locations. Patients are given a 50% discount on fresh produce. In 2020, SBH will be able to sell our own produce grown on our rooftop farm.

The Bronx Health and Wellness Center at SBH, which opens 2020, designed to build a culture of lifelong wellness and self-empowerment by offering innovative services and programs focused on prevention and healthy choices for the Bronx community. The center will include a rooftop farm and a teaching kitchen. The rooftop farm will deliver nutritious fruits and vegetables, and cooking classes will teach local residents, community health workers, and staff how to incorporate fresh produce into meals. SBH has entered into a partnership with Project EATS to manage the urban farm. SBH has entered into an agreement with Goldring Center for Culinary Medicine at Tulane University. Their curriculum will be used for the SBH teaching kitchen. The specific matrix for the program is in development.

Priority Area: Promote a Healthy and Safe Environment

Focus Area 1: Injuries, Violence and Occupational Health

Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations through B.R.A.G. @ SBH Hospital Responder Program
Objective: 1.2.c Reduce the rate of ED visits due to assault from 152 to 151 per 10,000. Data based on The Belmont/East Tremont community, SBH's primary service area, has the highest rate of assault related hospitalizations in NYC.
Disparities: Based on data for SBH primary service area, Belmont/East Tremont has a poverty rate of 31%, (which is higher than the Bronx - 25% and citywide – 20%). Additionally, eighty-seven percent of SBH patients are Medicaid and Medicaid Dual Eligible. These indicators reflect the severe economic disparities experienced by SBH patients.
Intervention 1.2.1: Provide referrals of eligible patients in the emergency room to B.R.A.G. violence prevention program. The eligibility criteria is a patient in trauma/ED that has a mechanism of injury:

- Gunshot wound (GSW) or involved in a shooting incident
- Penetrating Injury due to violent incident

When clinically appropriate, eligible patients will receive an SBH staff introduction to the collaboration and request for verbal consent to receive the brief confidential meeting with the Hospital Responder. The goal is for them to be 'engaged' - with a warm handoff to B.R.A.G.
Family of Measures:
The percentage of assault patients who meet the criteria for referral to B.R.A.G. Monthly reports prepared based on SBH and NYC DOHMH requirements.

Program Objectives:
By December 2021, increase by 40% the number of eligible patients, who meet the criteria approached by SBH staff and referred to B.R.A.G. for engagement
Target: 40%
Baseline: 0 %
Baseline year:
Data Source: SBH patient records
Projected (or implemented) Year 1(2019):
Finalize memo of understanding amongst the three parties.
Establish service protocols & eligibility criteria.
Dedicated hospital employee for the program.
Train ER personnel on program objectives & criteria for patient eligibility
Standardize data collection internal & external.
Add field(s) to the Trauma Registry.
Determine if a link to EMR is possible & appropriate.
Secure additional funding to cover the hospital responder position.
Projected Year 2 (2020):
Operate the program on 24/7 basis.
Ensure 24/7 coverage by SBH staff.
Review protocols and policies & make changes as appropriate
Determine if precincts chosen still appropriate
Seek opportunities for funding
Projected Year 3(2021):
Operate the program on 24/7 basis
Inventory of related hospital services and enhanced service coordination
Review protocols and policies & make changes as appropriate
Determine if precincts chosen are still appropriate
Implementation Partners (lead)
Bronx Rises Against Gun Violence (B.R.A.G)
Partners' Role(s)& Resources
B.R.A.G is lead community based agency operating the gun violence prevention program under Cure Violence principles.
NYC Department of Health & Mental Health is serving as oversight, which includes specialized training.
Doctors of the World USA is supporting the data and evaluation process.
NYPD analyses crime statistics to identify "hot zones" to target.

Promote a Safe Environment
Introduction

While crime has significantly dropped throughout New York City, violent crime is an ongoing health risk in the Bronx, particularly among youth. The violent crime rate in New York City is highest in Hunts Points in the Bronx. Most shootings occur in the southern and western portions of the Bronx, geographic area covered by SBH. The rate of felony assaults remains far higher in the Bronx than the rest of New York City. The rate of murder and non-negligent homicide is highest in the Bronx. These factors indicate a health disparity affecting the entire community. Such levels of violence negatively affects the physical

and mental health of individuals and entire communities. The high violent crime rate reflects the racial/ethnic disparities experienced by Bronx residents.

According to New York City Community Health Profiles, six of 10 community districts with the highest rates of assault hospitalizations are in the Bronx. Assault related mortality rates are higher in the Bronx than rest of New York City. Assault related mortality is highest for those ages 15-24 years old. According to Underlying Cause of Death (2013-2017), although declining, firearm assault remains the largest contributor to assault related morality rates in the Bronx.

In the community survey and in various forums, violent crime is a major concern. The Belmont East Tremont community, SBH's primary service area, has the highest rate of assault related hospitalizations in NYC. It is 152 per 100,000; The Bronx is 113 per 100,000; NYC is 59 per 100,000.

Hospital Responder:

The horrific death of Lesandro Guzman-Feliz "Junior" occurred a block away from the SBH campus. He tried to get to the hospital before passing away. This incident galvanized the community, including SBH, to address the epidemic of gun violence. Bronx Rises Against Gun Violence (B.R.A.G.) approached SBH to implement the hospital responder program in our emergency department.

This intervention implements a multi-sector violence prevention program, Cure Violence New York, in high-risk communities including those where gangs are prevalent. Cure Violence is an evidence based intervention that has shown tremendous success in lowering violent crime rates. Our initiative is addressed through the B.R.AG. @SBH Hospital Responder program. SBH is one of six hospitals in New York City that operate a hospital responder program.

SBH's program is a collaborative with the following organizations: Bronx Rises Against Gun Violence (B.R.A.G.), Doctors of the World USA (DotW), the New York City Department of Health and Mental Hygiene (DOHMH) and NYC Police Department (NYPD). Such a collaborative provides the ability to ensure data driven oversight.

The lead partner is B.R.A.G, a community-based gun violence prevention project designed on public health principles. SBH partners with B.R.A.G. to deploy trusted credible messengers from the community with similar backgrounds to trauma victims and identified as Hospital Responders (HR).

The eligibility criteria is a patient in trauma/ED that has a mechanism of injury:

- Gunshot wound (GSW) or involved in a shooting incident
- Penetrating Injury due to violent incident

There are exclusion criteria: law enforcement custody, remand, parole/probation violation, domestic violence, minor, self-inflicted (behavioral), crime victim with no risk affiliations.

When clinically appropriate by SBH staff, eligible patients will receive an introduction to the collaboration and request for verbal consent to receive the brief confidential meeting with the Hospital Responder. The goal is for them to be 'engaged' - with a warm handoff to B.R.A.G. The HR is responsible to deliver anti-violence messages and messages of change at the patient's bedside.

The contact with patients is recorded in accordance with SBH Health System and NYC Department of Health & Mental Health reporting guidelines.

The New York City Department of Health and Mental Health advises hospitals on program implementation and provides technical assistance to both SBH and B.R.A.G. NYC DOHMH conducts trainings for the hospital responders and violence intervention specialists. Jointly with Doctors of the World, NYC DOHMH will collect data from SBH and B.R.A.G. to monitor trends.

The program works on under the concept of "hot zones" which are selected by the NYC Police Department (NYPD). The following three Bronx NYPD Precincts cover the catchment areas of B.R.A.G.: 46th, 47th and 52nd based on crime statistics and intelligence.

Stop the Bleed:

SBH staff trains staff and community members on this grassroots effort that encourages bystanders to become trained, equipped, and empowered to help in a bleeding emergency before professional help arrives. This effort complements the Hospital Responder program by providing the community a tool to assist when faced with a violent incident.

Priority Area: Promote Healthy Women, Infants and Children

Focus Area 2: Perinatal & Infant Health

Goal 2.2: Increase breastfeeding
Objective 2.2.1.0: Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among all infants
Target: 51.7
Baseline: 47.0
Baseline: 2016
Data source: vital statistics
Disparities: Based on data for SBH primary service area, Belmont/East Tremont has a poverty rate of 31%, (which is higher than the Bronx - 25% and citywide – 20%). Additionally, eighty-seven percent of SBH patients are Medicaid and Medicaid Dual Eligible.
Intervention 2.2.2: Promote & implement maternity care practices consistent with the Baby Friendly Hospital Initiative – NYS DOH Ten Steps to a Breastfeeding Friendly Practice Guide
Evidence based: Baby Friendly USA (2016)
Family of measures:
The Bronx has the lowest rate of exclusively breastfeed in hospital. The Bronx rate is 28.1 %; New York City is 41.6%
By December 31, 2021, increase the percentage of infants from Medicaid eligible households, who are exclusively breastfed in the hospital by 12 %.
Target: 30%
Baseline: 18%
Baseline Year: 2018
Data source: SBH chart reviews and patient surveys

Projected (or implemented) Year 1 (2019):
Continue Safe Motherhood Initiative and Safe Sleep Initiatives.
Develop the Centering Pregnancy Program for ongoing prenatal education.
Conduct mock survey with NYC Department of Health & Mental Health.
Educate patients to use BabyScripts.
Continue hospital wide education of both clinical and non- clinical staff on Baby Friendly Breastfeeding principles.
December 31, 2019 – conduct formal survey for baby friendly designation.
Projected Year 2 (2020):
Full transition from traditional prenatal visits for low risk prenatal patients to Centering Pregnancy Model.
All prenatal patients will use setup to use BabyScripts for the Prenatal education platform.
Continue to promote Baby Friendly, Skin to Skin, rooming in to encourage breastfeeding.
Projected Year 3 (2021):
Develop Centering Parenting Program for post-partum patients to complement Centering Pregnancy Program
Expanding BabyScripts to be able to monitor prenatal patients vitals remotely
Implementation Partner: NYC Department of Health & Mental Health
Partners' Role(s)& Resources: Technical support & resources

Baby Friendly
Introduction

According to NYS DOH document, "Contributing Causes of Health Challenges", breastfeeding saves lives, improves health and reduces cost. The report states that improving breastfeeding is a shared responsibility. Hospitals can have a significant impact on improving rates by supporting breastfeeding women. The report states that many factors negatively affect a women's breastfeeding experience including social norms, lack of knowledge, lack of support, difficulties breastfeeding upon returning to work and lactation challenges. Therefore, SBH Health System has developed a holistic plan to encourage and support mothers, before/during and after delivery to address this health disparity faced by this racial/ethnically diverse, economically challenged community.

The Bronx has the lowest percentage of women saying they plan to breastfeed exclusively and the disparity with the rest of NYC has widened. The proportion of infants exclusively breastfed in the hospital has been increasing in NYC from 2008 to 2016, but it still falls below NYS DOH Prevention Agenda 2018 goal. In the Bronx the proportion of infants exclusively breastfed in the hospital is lowest among those who are Hispanic, non-Hispanic black or have Medicaid. According to NYC Vital Statistics, the Bronx has lowest proportion of infants exclusively breastfed in the hospital in New York City. As compared with New York State, which is 46.3%, it is 28.1 % in the Bronx.

The NYC Department of Health and Mental Health formed the NYC Breastfeeding Hospital Collaborative. The Collaborative supports maternity facilities to achieve baby-friendly designation by 2020. It provides evidence based technical support to maternity facilities, including SBH, to support breastfeeding

mothers and achieve Baby-Friendly Designation. SBH recognized that mothers who give birth at baby friendly hospitals are more likely to initiate exclusive breastfeeding and to sustain it.

SBH joined the Collaborative in June 2016 to work toward achieving Baby Friendly designation to obtain the designation in December 2019. The Baby Friendly Hospital Initiative includes four phases: discovery, development, dissemination and designation. The initiative has involved educating both patients and SBH staff who work with new moms to make the task of breastfeeding less daunting. The SBH hospital team created a multidisciplinary committee comprised of individuals from midwifery, neonatology, nursing, IT, dietary, support staff and administration. The multidisciplinary team implemented changes through the process, from prenatal to post-partum discharge care. Some of the changes included the hospital removing all bottle-feeding advertising and product advertising from literature and handouts. Baby formula are not sent home with moms on discharge from the hospital. The hospital has a committee to purchase formula at a fair market value and keep it out of view.

The changes made incorporate one hour of uninterrupted skin-to-skin contact at birth for non-breastfeeding moms and skin-to-skin contact for breastfeeding until first latch and feed for breastfeeding moms. Caesarean moms are allowed to bond with their infants during the immediate post-op recovery period. SBH will promote early skin-to-skin contact by educating women and their families of the benefits of skin-to-skin contact.

SBH will ensure that providers and staff are knowledgeable and informed on breastfeeding policies and practices. SBH clinician will continue to support skin-to-skin contact between mother and newborn immediately following birth (until the first breastfeeding is completed), and the first six hours.

All Post-Partum discharge plans include breastfeeding support groups and access to such community resources as our lactation consultants via SBH WIC. The hospital has removed all bottle-feeding advertising and product advertising from literature and handouts. Formula are not sent home with moms on discharge from the hospital. The hospital has committed to purchase formula at fair market value and keep it out of view.

In addition to education and services during/after labor, SBH Ambulatory has initiated a **Centering Pregnancy Program**. It gives expecting mothers the opportunity to receive their routine prenatal care and get extensive group education with other expectant mothers. The program consist of 10-12 women with similar due dates meeting each month until their last month of pregnancy. A midwife and a nurse who facilitate the sessions accompany each session. Program results in other locations have seen a decrease in racial disparities in rate of preterm babies and low weight, increase rates of breastfeeding and improved immunization rates.

A new feature is **Babyscripts,** an innovative application being used in the SBH prenatal and post-partum services to enhance the patient education both prenatal and postpartum women. The app is a way to improve patient-provider engagement and provide tailored communication and educational content to patients. Monthly active users have increased. As of June 2019, 300 patients have enrolled in the program and monthly users have increased showing 87% of users satisfied with the app, calling it convenient and easy access to educational content.

Maintaining Engagement and Monitoring Progress

SBH will present the implementation plan to SBH clinicians to raise awareness and seek recommendations about the interventions. There will be going discussions with clinical SBH staff to determine the effectiveness of the programs. Regular reporting will be provided to SBH leadership to determine progress, barriers and possible revisions to the implementation plan. An annual report will be provided to the Board of Trustees. Updates will be provided to NYS DOH on the website.

We will continually use data collected through various sources and learn from the experiences of our partners in providing services to shed light on the success or barriers of our proposed interventions to strength the programs.

Discussions will be held with public health experts, from NYC Department of Health and NYS Department of Health and other relevant governmental agencies, to ensure that we have up to date appraisals of the proposed interventions.

Two of the initiatives involve the New York City Department of Health & Mental Health. As mentioned, NYC DOHMH will review data and provide technical support. This provides significant monitoring to ensure quality and effective programming.

Over the duration of this implementation plan, SBH will coordinate our efforts with community organizations to continue to have a comprehensive and up-to-date understanding of community needs and resources, enabling us to maximize our collective impact to improve the communities health. There will be a robust community discussion of the community health needs assessment and the community service plan.

Monthly reports will be provided at Community Alliance for Healthcare Awareness (CAHA) meetings to determine progress, barriers and possible revisions of the selected priorities. Such meetings will include updated research or data that can provide further insights. Biannual reports of the Implementation Plan will be provided to Bronx Community District #6.

The majority of SBH personnel are Bronx residents. On a regular basis, SBH use forums to solicit their view or concerns regarding the community health needs and priorities for the Bronx. They will be engaged to monitor the implementation of the initiatives.

Dissemination Strategy

- CSP will be prominently posted on the SBH website at specific address; http://www.sbhny.org/CSP-pdf
- A print copy of this document will be available at main entrance at the concierge deck.
- Hard copies will be made available by the Office of Government and Community Affairs upon request.
- The Executive Summary will be available in Spanish.
- CSP will be sent electronically to the community leaders and elected officials.
- SBH will encourage all its organizational partners to provide an internet link to SBH online CSP.
- Appropriate staff will provide community presentations to discuss the findings of the report, its relationship to particular community interest and request comments.
- SBH will engage the community through local media including bilingual neighborhood newspapers and partnering organizations
- The report will be available to employees on the SBH intranet.
- A QR code was created.

APPENDIX

APPENDIX A – Community Health Survey was conducted in English and Spanish

Montefiore DOING MORE℠ SBH Health System BRONX

2019 BRONX COUNTY COMMUNITY HEALTH SURVEY

There are many areas where the healthcare system can make efforts to improve the community. We are interested to hear your thoughts on what issues should be a priority in your community and for your personal health. Montefiore Health SYstem and St. Barnabas Health System will use the results to help improve health programs. Please take a few minutes to fill out this survey if you are 18 years or older. Your responses are anonymous. Please return your finished responses to the ***Office of Community & Population Health, 3514 Dekalb Ave, Bronx, NY 10467. email: communityhealth@montefiore.org***

You may also take the survey online at: https://www.surveymonkey.com/r/BX_CHS_2019

Thank you for your participation!

The first few questions are about the health needs of the COMMUNITY WHERE YOU LIVE.

What THREE areas do you see as being priority health issues in the COMMUNITY WHERE YOU LIVE?

- ☐ Antibiotic resistance and healthcare associated infections
- ☐ Child and adolescent health
- ☐ Chronic disease screening and care for conditions like asthma, diabetes, cancer and heart disease
- ☐ Environments that promote well-being & active lifestyles
- ☐ Food and nutrition
- ☐ Food safety and chemicals in consumer products
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Injuries, such as falls, work-injuries, or traffic-injuries
- ☐ Maternal and women's health
- ☐ Mental health
- ☐ Newborn and infant health
- ☐ Obesity
- ☐ Outdoor air quality
- ☐ Physical activity
- ☐ Sexually transmitted diseases
- ☐ Smoking, vaping, and secondhand smoke
- ☐ Substance use disorders
- ☐ Vaccinations/immunizations
- ☐ Violence
- ☐ Water quality

What THREE actions would be most helpful to improve the health of the COMMUNITY WHERE YOU LIVE?

- ☐ Access to dental care
- ☐ Access to education
- ☐ Access to healthier food
- ☐ Access to primary care
- ☐ Affordable housing
- ☐ Breastfeeding support
- ☐ Caregiver support
- ☐ Clean air & water
- ☐ Drug & alcohol treatment services
- ☐ Domestic violence prevention/victim support
- ☐ Employment opportunities
- ☐ Exercise & weight loss programs
- ☐ Health insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Improving racial equality
- ☐ Mental health services
- ☐ Public transportation
- ☐ Quality and affordable childcare
- ☐ Safe places to walk & play
- ☐ Services for LGBTQ population
- ☐ Services for older adults
- ☐ Smoking & tobacco services
- ☐ Violence prevention
- ☐ Other _____

What population needs the greatest attention?

- ☐ Infants
- ☐ Young children
- ☐ School-age children
- ☐ Teens
- ☐ Young adults
- ☐ Middle-aged adults
- ☐ Older adults
- ☐ Other specific groups _____

The rest of the survey is about YOU and YOUR health needs

What THREE areas do you see as being priority health issues for YOURSELF?

- ☐ Antibiotic resistance and healthcare associated infections
- ☐ Child and adolescent health
- ☐ Chronic disease screening and care for conditions like asthma, diabetes, cancer and heart disease
- ☐ Environments that promote well-being & active lifestyles
- ☐ Food and nutrition
- ☐ Food safety and chemicals in consumer products
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Injuries, such as falls, work-injuries, or traffic-injuries
- ☐ Maternal and women's health
- ☐ Mental health
- ☐ Newborn and infant health
- ☐ Obesity
- ☐ Outdoor air quality
- ☐ Physical activity
- ☐ Sexually transmitted diseases
- ☐ Smoking, vaping, and secondhand smoke
- ☐ Substance use disorders
- ☐ Vaccinations/immunizations
- ☐ Violence
- ☐ Water quality

Would you say that in general your health is:

☐ Excellent ☐ Good ☐ Poor
☐ Very good ☐ Fair

Do you have somebody that you think of as your personal doctor or health care provider? ☐ Yes ☐ No

Has a doctor, nurse or other health professional told you that you had any of the following (check all that apply)?

☐ Arthritis ☐ COPD, emphysema, or chronic bronchitis ☐ Heart disease
☐ Asthma ☐ Kidney disease
☐ Cancer (excluding skin cancer) ☐ Depression/anxiety ☐ Hypertension
☐ Skin cancer ☐ Diabetes (excluding during pregnancy)

Was there a time in the past 12 months when you needed to see a doctor but could not because of the following?

Cost	☐ Yes ☐ No	**Transportion**	☐ Yes ☐ No	**Unable to get an appointment**	☐ Yes ☐ No

What type of insurance do you use to pay for your doctor or hospital bills (check all that apply)?

☐ Your employer or a family member's employer ☐ Medicare ☐ Other _____
☐ The New York State Marketplace (Exchange/Obamacare) ☐ Medicaid ☐ I don't have health insurance
☐ Military (TriCare or VA)
☐ COBRA

During the past 30 days, have you felt emotionally upset, for example, angry, sad, or frustrated, as a result of how you were treated based on any of the following…

Age	☐ Yes ☐ No	**Sexual orientation**	☐ Yes ☐ No	**Disability**	☐ Yes ☐ No
Gender identity	☐ Yes ☐ No	**Perceived immigration status**	☐ Yes ☐ No	**Other**	☐ Yes ☐ No
Race/Ethnicity	☐ Yes ☐ No	**Religion**	☐ Yes ☐ No		

The next set of questions will be used to describe who responds to the survey and will not be examined individually. Please remember that your responses are anonymous.

What is your current gender identity?

☐ Female ☐ Trans female/Trans woman ☐ Gender not listed (please state):
☐ Male ☐ Trans male/Trans man _____
☐ Non-binary person/Gender non-conforming

What is your age?

☐ 18-24 ☐ 45-54 ☐ 75+
☐ 25-34 ☐ 55-64
☐ 35-44 ☐ 65-74

What is the highest grade or year of school you completed?

☐ Less than high school ☐ Some college or technical school ☐ Advanced or professional degree
☐ High school grad/GED ☐ College graduate

What is the ZIP Code where you currently live? __ __ __ __ __

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Which one the following best describes your race?

☐ White ☐ Asian/Pacific Islander ☐ Multi-racial
☐ Black/African American ☐ American Indian/Alaskan Native ☐ Other _____

Are you currently?

☐ Employed ☐ A homemaker ☐ Unable to work
☐ Self employed ☐ Student ☐ Other _____
☐ Out of work ☐ Retired

What is the primary language spoken in your home?

☐ English ☐ Spanish
☐ Kru, Ibo, or Yoruba ☐ French ☐ Italian
☐ Bengali ☐ Albanian ☐ Mande
☐ Arabic ☐ French ☐ Other _____

Montefiore DOING MORE℠ SBH Health System BRONX

ENCUESTA COMUNITARIA DE SALUD DEL CONDADO DE BRONX 2019

Hay muchas areas donde el sistema de salud puede hacer esfuerzos para mejorar la comunidad. Estamos interesados en escuchar su opinión sobre qué asuntos deben ser una prioridad en su comunidad y para su salud personal. Montefiore Health System y St. Barnabase Health Systen usarán los resultados para ayudar a mejorar los programas de salud. Por favor tome unos pocos minutos para llenar esta encuesta si tiene 18 años o más. Sus respuestas serán confidenciales.
Si prefiere tomar esta encuesta en línea, por favor siga este enlace: **https://es.surveymonkey.com/r/BX_Salud2019**
¡Gracias por su participación!

Las primeras preguntas son sobre las necesidades de salud de la COMUNIDAD DONDE USTED VIVE.

¿Cuáles son las TRES áreas que usted considera como temas de salud prioritarios en la COMUNIDAD DONDE VIVE?

- ☐ Resistencia a antibióticos e infecciones asociadas al cuidado de la salud
- ☐ Salud de niños y adolescentes
- ☐ Exámenes de enfermedades crónicas y cuidado de condiciones como asma, diabetes, cancer y enfermedades del corazón
- ☐ Ambientes que promuevan el bienestar y estilos de vida activa
- ☐ Alimentación y nutrición
- ☐ Seguridad alimenticia y químicos en productos de consumo
- ☐ Hepatitis C
- ☐ VIH/SIDA
- ☐ Lesiones, como caídas, accidentes laborales, o accidentes de tráfico
- ☐ Salud materna y de la mujer
- ☐ Salud mental
- ☐ Salud de recién nacidos y infantes
- ☐ Obesidad
- ☐ Calidad del aire exterior
- ☐ Actividad física
- ☐ Enfermedades de transmision sexual
- ☐ Fumar, cigarros electrónicos, y humo de segunda mano
- ☐ Trastornos por uso de sustancias
- ☐ Vacunas/inmunizaciones
- ☐ Violencia
- ☐ Calidad del agua

¿Cuáles son las TRES acciones más útiles para mejorar la salud de la COMUNIDAD DONDE VIVE?

- ☐ Acceso al cuidado dental
- ☐ Acceso a la educación
- ☐ Acceso a alimentos más saludables
- ☐ Acceso al cuidado primario
- ☐ Vivienda accesible
- ☐ Apoyo a la lactancia materna
- ☐ Apoyo del cuidador
- ☐ Aire y agua limpios
- ☐ Servicio y tratamiento para alcohol y drogas
- ☐ Prevención de violencia doméstica/ apoyo para víctimas
- ☐ Oportunidades de empleo
- ☐ Programas de ejercicio y pérdida de peso
- ☐ Inscripción en seguros de salud
- ☐ Exámenes de salud
- ☐ Servicios de cuidado en el hogar
- ☐ Servicio de ayuda al inmigrante
- ☐ Mejoramiento de la igualdad racial
- ☐ Servicios de salud mental
- ☐ Transporte público
- ☐ Cuidado infantil de calidad y accesible
- ☐ Lugares seguros para caminar y jugar
- ☐ Servicios para la población LGBTQ
- ☐ Servicios para adultos mayores
- ☐ Servicios para fumadores y tabaco
- ☐ Prevención de violencia
- ☐ Otros _____

¿Qué población cree usted que necesita mayor atención?

- ☐ Infantes
- ☐ Niños jóvenes
- ☐ Niños en edad escolar
- ☐ Adolescentes
- ☐ Jóvenes adultos
- ☐ Adultos de mediana edad
- ☐ Adultos mayores
- ☐ Otro grupo específico _____

El resto de la encuesta es sobre USTED y SUS necesidades de salud

¿Cuáles son las TRES áreas que considera como temas de salud prioritarios para su salud?

- ☐ Resistencia a antibióticos e infecciones asociadas al cuidado de la salud
- ☐ Salud de niños y adolescentes
- ☐ Exámenes de enfermedades crónicas y cuidado de condiciones como asma, diabetes, cancer y enfermedades del corazón
- ☐ Ambientes que promuevan el bienestar y estilos de vida activa.
- ☐ Alimentación y nutrición
- ☐ Seguridad alimenticia y químicos en productos de consumo
- ☐ Hepatitis C
- ☐ VIH/SIDA
- ☐ Lesiones, como caídas, accidentes laborales, o accidentes de tráfico
- ☐ Salud materna y de la mujer
- ☐ Salud mental
- ☐ Salud de recién nacidos y infantes
- ☐ Obesidad
- ☐ Calidad del aire exterior
- ☐ Actividad física
- ☐ Enfermedades de transmision sexual
- ☐ Fumar, cigarros electrónicos, y humo de segunda mano
- ☐ Trastornos por uso de sustancias
- ☐ Vacunas/inmunizaciones
- ☐ Violencia
- ☐ Calidad del agua

Como considera su salud?

☐ Excelente ☐ Buena ☐ Pobre
☐ Muy Buena ☐ Normal

¿Tiene a alguien que usted considere como su medico personal? ☐ Si ☐ No

¿Algún doctor, enfermera u otro profesional de salud le ha dicho que padece de alguna de las sigvientes enfermedades? (marque todas las que apliquen)

☐ Artritis ☐ Enfermedades del corazón
☐ Asma ☐ COPD, enfisema, o bronquitis crónica ☐ Enfermedades del riñón
☐ Cancer (excluyendo el cancer de piel) ☐ Depresión/ansiedad ☐ Hipertensión
☐ Cancer de piel ☐ Diabetes (excluyendo durante el embarazo)

¿Hubo algún momento en los últimos 12 meses cuando necesitó ver a un doctor pero no pudo a causa de los siguientes?

Dinero	☐ Si ☐ No	**Transporte**	☐ Si ☐ No	**No pudo hacer una cita**	☐ Si ☐ No

¿Qué tipo de seguro usa para pagar a su doctor o las facturas del hospital (marque todas las que apliquen)?

☐ Su empleador o el empleador de un familiar ☐ Medicare ☐ Otro _____
☐ Seguro del Estado de Nueva York (Intercambio/Obamacare) ☐ Medicaid ☐ No tengo seguro de salud
☐ Militar (TriCare o VA)
☐ COBRA

Durante los últimos 30 días, se ha sentido emocionalmente molesto, por ejemplo, enojado, triste, o frustrado, como resultado de cómo fue tratado en base a los siguentes…

Edad	☐ Si ☐ No	**Orientación sexual**	☐ Si ☐ No	**Discapacidad**	☐ Si ☐ No
Identidad de género	☐ Si ☐ No	**Percepcion de estado migratorio**	☐ Si ☐ No	**Otro**	☐ Si ☐ No
Raza/Etnicidad	☐ Si ☐ No	**Religión**	☐ Si ☐ No		

Por favor recuerde que sus respuestas son confidenciales, El siguiente grupo de preguntas serán usadas para describir mejor quién responde a la encuesta y no serán examinadas individualmente.

¿Cuál es su identidad de género?

☐ Mujer ☐ Mujer transgénero ☐ Género no listado (por favor declare):
☐ Hombre ☐ Hombre transgénero _____
☐ Género no binario/Género unconforme

¿ Cuál es su edad?

☐ 18-24 ☐ 45-54 ☐ 75+
☐ 25-34 ☐ 55-64
☐ 35-44 ☐ 65-74

¿Cuál es su más alto grado de estudio o año de escuela que completó?

☐ Menos que la secundaria ☐ Algo de universidad o escuela técnica ☐ Título profesional o avanzado
☐ Graduado de secundaria/GED ☐ Graduado de universidad

¿Cuál es el Código postal donde usted vive actualmente? __ __ __ __ __

¿Usted es de origén Hispano o Latino? ☐ Si ☐ No

¿Cuál de las siguientes describe mejor su raza?

☐ Blanco ☐ Asiático/Isleño del Pacífico ☐ Multiracial
☐ Negro/Afro Americano ☐ Nativo Americano/Nativo de Alaska ☐ Otro _____

¿Está usted actualmente?

☐ Empleado ☐ Cuida del hogar ☐ No puede trabajar
☐ Auto empleado ☐ Estudiante ☐ Otro _____
☐ Sin trabajo ☐ Jubilado

¿Cuál es el lenguaje predominante que se habla en su casa?

☐ Español ☐ Inglés ☐ Kru, Ibo, o Yoruba
☐ Francés ☐ Bengalí ☐ Albanés
☐ Italiano ☐ Mande ☐ Arábica
☐ Otro _____

Montefiore DOING MORE℠ SBH Health System BRONX

Your opinion matters!

Hospitals in your community are interested in hearing about what health issues you think should be a priority. This web-based survey will only take a few minutes and should be completed by adults who live in the Bronx.

You can take the survey online by using the link below or scanning the QR code with your smartphone:

https://www.surveymonkey.com/r/BX_CHS_2019

QR code

Montefiore DOING MORE℠ SBH Health System BRONX

¡Tu opinión importa!

Los hospitales en su comunidad están interesado en escuchar acerca de sus prioridades en el ámbito de la salud y cuales deberían ser estas. Esta encuesta en línea (Página de internet) solo tomará unos minutos. Y Solo debe ser respondida por un adulto y sea residente en el Condado del Bronx.

Usted puede responder la encuesta en línea (Internet) utilizando el enlace más abajo o escaneando el código QR con su teléfono inteligente:

https://es.surveymonkey.com/r/BX_Salud2019

QR code

APPENDIX B – Top 20 inpatient discharges and treat and release ED visits

Top 20 inpatient discharges at St. Barnabas Hospital, January-September 2019

ICD-10 Code	Label	Discharges	% of total
F10	Alcohol related disorders	933	8.7%
Z38	Liveborn infants according to place of birth and type of delivery	614	5.7%
F11	Opioid related disorders	476	4.4%
A41	Other sepsis	418	3.9%
R07	Pain in throat and chest	294	2.7%
F25	Schizoaffective disorders	272	2.5%
F20	Schizophrenia	229	2.1%
E11	Type 2 diabetes mellitus	206	1.9%
F31	Bipolar disorder	177	1.7%
J96	Respiratory failure, not elsewhere classified	170	1.6%
R55	Syncope and collapse	162	1.5%
J45	Asthma	161	1.5%
J18	Pneumonia, unspecified organism	153	1.4%
N17	Acute kidney failure	151	1.4%
J44	Other chronic obstructive pulmonary disease	150	1.4%
I13	Hypertensive heart and chronic kidney disease	148	1.4%
T40	Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics	138	1.3%
L03	Cellulitis and acute lymphangitis	137	1.3%
S06	Intracranial injury	134	1.2%
I11	Hypertensive heart disease	126	1.2%
-	Other Diagnoses	5474	51.0%

Data source: Internal St. Barnabas Hospital data, January-September 2019

Top 20 reasons for treat-and-release ED visits at St. Barnabas Hospital, January-September 2019

ICD-10 Code	Label	Visits	% of total
F10	Alcohol related disorders	2485	4.9%
Z53	Persons encountering health services for specific procedures and treatment, not carried out	2008	3.9%
R10	Abdominal and pelvic pain	1999	3.9%
R07	Pain in throat and chest	1947	3.8%
M54	Dorsalgia	1671	3.3%
J45	Asthma	1664	3.3%
M25	Other joint disorder, not elsewhere classified	1514	3.0%
J06	Acute upper respiratory infections of multiple and unspecified sites	1479	2.9%
S01	Open wound of head	1446	2.8%
M79	Other and unspecified soft tissue disorders, not elsewhere classified	1223	2.4%
R51	Headache	943	1.9%
O26	Maternal care for other conditions predominantly related to pregnancy	844	1.7%
S00	Injuries to the head	843	1.7%
B34	Viral infection of unspecified site	764	1.5%
S61	Open wound of wrist, hand and fingers	695	1.4%
J02	Acute pharyngitis	669	1.3%
F19	Other psychoactive substance related disorders	603	1.2%
R42	Dizziness and giddiness	603	1.2%
N39	Other disorders of urinary system	522	1.0%
R56	Convulsions, not elsewhere classified	517	1.0%
-	Other Diagnoses	26475	52.0%

Data source: Internal St. Barnabas Hospital data, January-September 2019

APPENDIX C

Resolution Adopted by Board of Trustees of St. Barnabas Hospital on 11/25/2019

RESOLUTION TO BE ADOPTED
BY THE BOARD OF TRUSTEES OF
ST. BARNABAS HOSPITAL

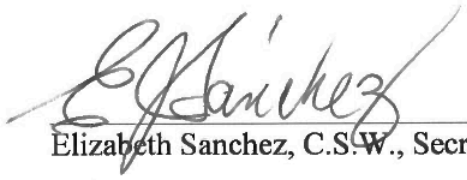
WHEREAS, the Board of Trustees (the "Board") of St. Barnabas Hospital (the "Hospital") deems it advisable and in the best interests of the Hospital to adopt an implementation strategy to meet the community health needs as identified through the 2019-2021 Community Health Needs Assessment and Community Health Improvement Plan submitted to the New York State Department of Health;

NOW, THEREFORE, it is:

RESOLVED, that the Board hereby adopts an implementation strategy to meet the community health needs as identified through the 2019-2021 Community Health Needs Assessment and Community Health Improvement Plan submitted to the New York State Department of Health in sustainably the form attached hereto as Exhibit A, subject to those changes, insertions, or omissions as may be approved by the following individuals: Chairman of the Board, Vice Chair of the Board and Treasurer; or any one of the following: President and Chief Executive Officer or Executive Vice President and Chief Operating Officer; and it is,

FURTHER RESOLVED, that this Resolution shall take effect immediately.

Dated: November 25, 2019



Elizabeth Sanchez, C.S.W., Secretary, Board of Trustees

APPENDIX D – SBH Board of Trustees

Victor R. Wright, Chairman

John Tognino, Senior Vice Chairman

David Harris, Vice Chairman

Richard G. Ketchum, Vice Chairman

Barry A. Winter, CFA

Elizabeth Juárez Sánchez, LCSW, Secretary

Mildred Allen, Ph.D.

Wilma Alonso

Afua Atta-Mensah, Esq.

Hon. John A. Barone

Nancy Busch Rossnagel, Ph.D.

Helen Foster

Artie Johnson

Charles Moerdler, Esq.

Karen Parrish

Todd Reinglass

Wendy Rodriguez

APPENDIX E – SBH Senior Leadership Team

David Perlstein, MD
President – Chief Executive Officer

Leonard Walsh
Executive Vice President – Chief Operating Officer

Eric Appelbaum, DO
Executive Vice President – Chief Medical Officer

Jitendra Barmecha, MD, MPH, FACP
Senior Vice President – Chief Information Officer

Ruth Cassidy, BS, PharmD, FACHE
Senior Vice President – Clinical Support Services
Chief Pharmacy Officer

Robert Church, RN, MS, MBA
Senior Vice President – Patient Care Services

John DiGirolomo, CHFM
Senior Vice President – Facilities Management

Mary Grochowski
Senior Vice President – Chief Financial Officer

Irene Kaufmann
Senior Vice President – Ambulatory Care and Population Health
Executive Director – Bronx Partners for Healthy Communities (DSRIP)

Ninfa Segarra, JD
Senior Vice President – Community and Government Affairs
Chief Diversity Officer

Keith Wolf, Esq.
Senior Vice President – Human Resources/General Counsel

APPENDIX F – 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. For more information on ACS please visit: http://www.census.gov/programs-surveys/acs/about.html.

National Vital Statistics Surveillance System: The National Center for Health Statistics collects and disseminates national vital statistics, including births and deaths from state/local jurisdictions (e.g., state departments of health). This data source was used to estimate the teen birth rate, the proportion of births that are preterm, the opioid-related mortality rate and the suicide-mortality rate. For more information on NVSSS please visit https://www.cdc.gov/nchs/nvss/index.htm.

City Health Dashboard National Data Base: Sponsored by NYU Langone Health and Robert Wood Johnson Foundation, City Health Dashboard is an online national database that includes community health status data for 500 of the largest US cities. Please visit: https://www.cityhealthdashboard.com/ny/new%20york/city-overview

2019 County Health Rankings and Roadmaps
The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute's 10th annual *County Health Rankings and Roadmaps* (the *Rankings*) is an online tool that provides a snapshot of a county's health status. The Rankings also allow for county-level comparisons in states across the US. Data on four health domains: health behaviors, clinical care , social and economic factors , and physical environment . More than 30 total measures are available for analysis. The *2019 Key Findings Report* focuses on the availability of secure, affordable housing and how housing impacts health.
https://www.countyhealthrankings.org/reports/2019-county-health-rankings-key-findings-report

US Centers for Disease Control and Prevention's (CDC) Interactive Atlas of Heart Disease and Stroke
The Atlas is CDC's online *mapping tool* of county-level heart disease and stroke hospitalization, health care costs, and social and economic data—all of which can be stratified by race and ethnicity, gender, and age group. Although the latest data is from 2016, the information is another source of validation to support proposed chronic disease prevention community interventions.
https://nccd.cdc.gov/DHDSPAtlas/

Opioid Misuse Community Assessment Tool
Developed by the National Opinion Research Center (NORC) at the University of Chicago, this county-level data *tool* offers insight into overdose rates and population demographics, including race and ethnicity, educational attainment, poverty rate, income, and unemployment rates. Data is available up to 2017.
https://www.norc.org/Research/Projects/Pages/national-opioid-misuse-community-assessment-tool.aspx

Map the Meal Gap
Developed by *Feeding America*, a national organization focused on domestic hunger-relief, the *Map the Meal Gap* online tool details—by state, county, and Congressional district—food insecurity trends, including the cost of food and estimated rates of eligibility for nutritional assistance programs. The map also includes food bank locations. Map the Meal Gap's Child Food Insecurity *mapping tool* provides estimates of children at risk for hunger. Food insecurity *policy reports* are also available on the site. Data is from 2017 and 2018.
https://map.feedingamerica.org/

USDA Food Environment Atlas
The United States Department of Agriculture's (USDA) *Food Environment Atlas* is an online mapping tool that reviews food environment factors by county. Issued by the USDA's Economic Research Service division, the Atlas includes more than 270 food environment indicators, encompassing:
- *Food choice*, including store proximity and number of grocery stores; food prices; and other indicators for community access to healthy, affordable food
- *Health and well-being indicators,* including food insecurity, diabetes, obesity rates, and physical activity levels
- *Community characteristics* that influence food environment—including demographic composition, income, and poverty—and access to recreation

https://www.ers.usda.gov/data-products/food-environment-atlas.aspx

New York State Vital Records 2019 County Health Rankings (the rankings) and Roadmaps
The rankings are online tool that provides a snapshot of a county's health status.
It allows for county level comparison across the United States. Please visit: https://www.countyhealthrankings.org/app/new-york/2019/rankings/bronx/county/outcomes/overall/snapshot

New York State Department of Agriculture and Markets List of Farmers' Markets
Online map available to help locate local farmers markets, farm stands and mobile markets throughout New York State. For more information Please visit: https://www.agriculture.ny.gov/AP/farmers_markets.html

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 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 City Community Health Survey: The New York City Community Health Survey (CHS) is an annual telephone survey of approximately 10,000 NYC adults, of which about 15-20% live in the Bronx. The complex survey is conducted in English, Spanish, Russian and Chinese (Mandarin and Cantonese) and provides a representative sample of NYC adult 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 Department of Health & Mental Hygiene, the Department of Education, and the National Centers for Disease Control and Prevention conduct the New York City Youth Behavior Risk Survey (YRBS) every two years. of. The self-administered 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 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 City HIV/AIDS Annual Surveillance Statistics: The HIV Epidemiology and Field Services Program (HEFSP), within the New York City Department of Health and Mental Hygiene, collects and manages all data on HIV infection and AIDS diagnoses in the NYC. This data source was used to estimate HIV diagnoses rates.

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 Sexually Transmitted Disease Surveillance Data: New York City Sexually Transmitted Disease Surveillance Data are provided in EpiQuery by the Bureau of Sexually Transmitted Disease Control, within the NYC Department of Health and Mental Hygiene. The bureau receives and manages reports of cases of seven types of STDs, which are provided by health providers and clinical laboratories within NYC. This data was used to provide an estimate of chlamydia rates for this report. For more information, please visit: https://www.health.ny.gov/statistics/diseases/communicable/std/

ImageNYC: Interactive Map of Aging

This mapping tool—developed by the New York Academy of Medicine (the Academy) and the City University of New York's (CUNY) Graduate Center's Mapping Service Center for Urban Research— contains neighborhood demographics, available resources, and health status–related data, including reasons for hospital admissions, for those 65 years and older. ImageNYC uses data provided by several New York City agencies—the Department for the Aging, DOHMH, the New York City Department of Planning, and the Department of Transportation—and can be used to determine current and projected needs of New York City's aging population. The Academy and CUNY developed the tool as part of New York City's Age-Friendly initiative, a 10-year partnership between the Academy, the New York City Mayor's Office, and the New York City Council. The initiative was also designed to be consistent with the New York State Prevention Agenda's focus on healthy aging. https://www.nyam.org/age-friendly-nyc/imagenyc/

DATA TOOLS/REPORTS

Global Burden of Disease: The Global Burden of Disease (GBD) project from the Institute of Health Metrics and Evaluation at the University of Washington uses a comprehensive risk-assessment framework to summarize the collective impact of risk factors and health outcomes on adverse health. Specifically, GBD combines many datasets to estimate disability adjusted life years (DALYs) associated numerous outcomes and risk factors. DALYs are a summary measure of population health that combines information on fatal health events and non-fatal health states. This is an important advantage over vital statistics which do not capture the important health impact of non-fatal health states (e.g., back pain, moderate depression, or alcohol use). GBD also allows for the estimation of DALYs attributed to specific risk factors, including body mass index, smoking, dietary risks, occupational risks, air pollution, etc. Data from the GBD is available at the global, national and state-level; local-estimates are not available. Despite this limitation this information can be used to understand the most important areas of intervention to improve population health. Data are available at: https://vizhub.healthdata.org/gbd-compare/

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: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm

New York City Department of Health & Mental Health Community Health Profiles 2018 – profile of Bronx Community District #6. The Community Health Profiles summarize a number of contextual, behavioral and health indicators by Community District. 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/assets/doh/downloads/pdf/data/2018chp-bx6.pdf

New York City Community Health Profiles 2018 Map Atlas: 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. 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/assets/doh/downloads/pdf/data/2018-chp-atlas.pdf

Community Risk Ranking: Measuring Child Well-Being in New York City's 59 Community Districts. The Citizen's Committee for Children (CCC) looks at 18 different indicators across six domains to determine where risks concentrate in New York City. For more information please visit: https://www.cccnewyork.org/wp-content/uploads/2018/12/CCC-Community-Risk-Ranking-December2018-1.pdf

APPENDIX G: SBH Health and Wellness Center

SBH Health System BRONX

HEALTH & WELLNESS CENTER

SCHEDULED TO OPEN IN EARLY 2020.

Find the Healthier One in You

OUR MISSION STATEMENT

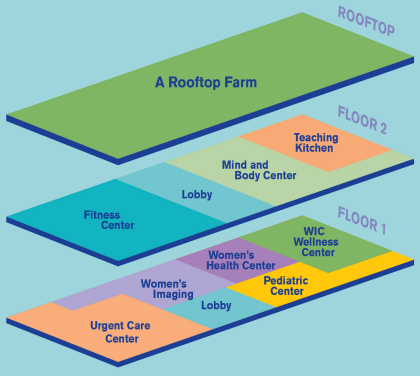
To develop an integrative health and wellness center which builds a culture of lifelong wellness and self-empowerment by offering innovative services and programs focused on prevention and healthy choices for the Bronx community.

THE PROJECT

This groundbreaking project will transform health care in the Bronx. The Health and Wellness Center at SBH will address food and housing insecurities, education, social support, and personal safety concerns – those social determinants that can ease the burden of the chronic diseases that plague our community.

The 50,000 square foot Health and Wellness Center at SBH is a part of mixed-use development that includes more than 300 units of affordable housing. The health and wellness space will feature:

- A fitness center
- A teaching kitchen that will be used as an education tool for community residents and healthcare providers



- An urgent care center
- Women's and children's health services
- A breast imaging center
- A rooftop farm

WHY IT'S SO IMPORTANT

A new paradigm is desperately needed in the Bronx. Consider the following:

- The Bronx ranks 62nd out of 62 counties in New York State in terms of health outcomes
- SBH serves a low income and ethnically diverse population with most of our patients covered by Medicaid or no insurance at all.
- The prevalence of preventable illness – obesity, asthma, diabetes and heart disease – are the highest in New York City, as is substance abuse, non-accidental trauma and behavioral health diagnoses.

HOW IT WORKS

The transformation of health care in the Bronx depends on your help.

To hear more about our story, visit
www.SBHwellnesscenter.org

BRONX PARTNERS FOR HEALTHY COMMUNITIES

Centering Pregnancy®

BABYSCRIPTS™

DOCTORS OF THE WORLD

PROJECT EATS
ART FOOD LIFE

NYC Health

BRONX RISES AGAINST GUN VIOLENCE B.R.A.G.

SBH Partners