A PATH TO WELLNESS

Community Health Needs Assessment

Community Health Improvement Plan/Community Service Plan

2025–2027

SBH Health System BRONX

A. COVER PAGE

ST. BARNABAS HOSPITAL, INC.
D/B/A SBH HEALTH SYSTEM
COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)
COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)
COMMUNITY SERVICE PLAN (CSP)
2025–2027

NEW YORK STATE PREVENTION AGENDA
2025–2030

1. County covered in this Assessment and Plan: Bronx County

This document is submitted as the **requirement for 2025–2027 CHNA/CSP Plans** through the New York State Department of Health and assesses the health needs of the Bronx, New York.

2. Individual Plan:

This report was not completed as part of a coalition.

3. Organizations and contact information:

- **The participating Local Health Department (LHD):** This report is informed by HealthyNYC 2030 Agenda - New York City Department of Health and Mental Hygiene.
  - LHD CHA/CHIP liaisons:
    - Ramon Cabrera (RCabrera@health.nyc.gov)
    - Laura Gonzalez (LGonzalez4@health.nyc.gov)
- **Participating Hospital System**

  This report covers the entities of SBH Health System: St. Barnabas Hospital, SBH Ambulatory Care Center, SBH Behavioral, SBH Health & Wellness Center and the affiliated primary and specialty care practices.
- **SBH Health System CSP Liaison:**
  - Name: Ms. Ninfa Segarra, JD, Senior Vice President
  - Email: nsegarra@sbhny.org
  - Phone: 1-718-960-9476
- **Contributions:**
  - King Kodua, Researcher
  - Amanda Martinez, Health Equity Associate
  - Darien Morales, Graphic Designer

OUR MISSION

SBH Health System is committed to improving the health and wellness of our 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.

OUR VISION

To be the healthcare partner of choice in the Bronx, providing superior service and transformative programs that meet the diverse needs of our community.

OUR VALUES

Diversity - Respect - Integrity - Vision - Excellence

SBH
Health System
BRONX

SBH Health System embodies the DRIVE to Person-Centered Excellence

B. A MESSAGE FROM THE PRESIDENT & CEO

President & Chief Executive Officer, David A. Perlstein, MD

Over the past 10 years, we have increasingly recognized our role as an *Anchor Institution* and have accelerated our commitment to improving the health and wellness of the community, building a compelling reputation as an essential collaborative healthcare provider, consistently offering high-quality services, positive patient and physician experience, and strong social drivers of health supports.

SBH Health System performed this annual community health needs assessment to help drive our programmatic priorities and unsurprisingly some of the greatest needs include those associated with extreme poverty. Our focus this year is not significantly different from previous years and includes addressing the community's concerns about housing affordability, food insecurity and public safety, however more specific needs were also identified including the need to address obesity and dental care as well as behavioral health issues and gun violence. We were surprised that educational needs and job opportunities were not listed as the most significant needs for the community. We also learned that addiction services were not highly ranked, but that may be due to the relative saturation of addiction services available in the community.

At SBH Health System we believe in meaningful collaboration and have long committed to changing how we deliver care. In our Health and Wellness Center, we spend more on prevention then on treatment; our community health approach which incorporates a teaching kitchen, fitness center and rooftop farm, are all leading to improvements in the health and wellness of our patients. We are fully engaged in a battle to address the social influencers of health and believe that our continued success will be dependent on changing how our community views our role in their health.

We want to decrease the need for emergency and inpatient care by maximizing the health and wellness of our patients, building for a better future. Doing this in the current payment model is financially difficult; however, it is the right thing to do if we believe that healthcare delivery should be patient centered. This is not a solo endeavor and will require significant partnerships across the entire continuum including state and local government, as well as meaningful collaboration amongst community providers, hospitals, patients, and payers. We have built our strategic plan around our desire to be an anchor partner to the community, and we have built a shared vision focused on four puzzle pieces: *Achieving Financial Stability, Expanding Community Engagement, Advancing Population Health and Transforming the Physical Environment*. These pieces are all connected and driven by the desires of our patients who remain central to everything we do.

Some examples of our accomplishments over the past few years include:

1. We have reported three successive years with positive margin:
   - Partnered with New York City safety net hospitals to advocate for payment reforms and capital reforms resulting in expansion of the Medicaid Directed Payment program and New York State Safety Net Transformation Grant Programs.
   - Awarded:
     - Significant capital funding to replace and modernize our under-sized aged Emergency Department and add a CPEP unit to accommodate our community's growing behavioral health needs.
     - Funding to support partnership with Cityblock, a private healthcare company, focused on maximizing effectiveness of managing highly complex behavioral health patients to prevent treatment lapses and readmissions.
     - Funding from Medicaid Managed Care Organizations to build and deliver care in a new Medical Psychiatric Unit, meant to minimize the disruption of behavioral health delivery during medical crises.
     - Funding to build a third inpatient behavioral health unit and modernize Ambulatory Care building.
   - Successfully installed EPIC and Oracle over a nine-month period to replace our previous medical records and financial software.
   - Continue to build on our almost 20-year full risk relationship with Healthfirst, the largest not-for-profit managed care organization in New York State. We currently take full risk on over 30,000 individual members, allowing us to have the freedom to invest in alternative ways of caring for our patients, focusing on prevention over admission.
   - We actively built a relationship with the new CUNY School of Medicine and serve as their primary clinical partner, educating hundreds of students annually.
   - We are in active discussion with New York City Health and Hospitals System (the largest municipal system in the US) to collaborate on improving healthcare delivery across the entire continuum, discussing opportunities for regionalization to improve access and outcomes for our shared patients.
2. We have grown community engagement programs through synergies with our Health and Wellness Center.
   - Multiple Diabetes and Obesity prevention programs with community groups which include clinical services and education while offering membership to our fitness center, exercise/movement classes, and healthy cooking classes in our teaching kitchen.
   - Co-manage violence interrupter and prevention programs with our partner Bronx Rises Against Gun Violence, including Boxing instruction and other wellness opportunities for at risk youths who have been exposed to gun violence.
   - Offer our Health and Wellness Center to host community-based meetings and conferences.

All of these strategies fit into our desire for becoming the *Healthcare Partner of choice in the Bronx*, adopting the vision to build and expand a comprehensive anchor collaborative aimed at empowering community members by fostering health and wellness that can lead to more opportunities for our Bronx patients to live happier, hopeful and healthier lives.

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D. EXECUTIVE SUMMARY

SBH Health System Mission Statement

St. Barnabas Hospital, d/b/a SBH Health System (SBH), is a community-based, patient-centered healthcare system serving individuals and families in the Bronx. SBH Health System is committed to improving the community's health and wellness by providing the highest quality care in a compassionate, comprehensive, and safe environment; where the patient always comes first, regardless of their ability to pay, race/ethnicity, immigration status, or sexual orientation.

SBH Health System's mission, vision, and values guide the pursuit of clinical excellence by providing evidence-based, patient-centered care and training for the next generation of healthcare professionals. SBH Health System's core values are Diversity, Respect, Integrity, Vision, and Excellence. SBH Health System's vision is to become a comprehensive integrated delivery network for the Bronx community, with a compelling reputation as an essential healthcare provider consistently offering high-quality services, positive patient and physician experience, and strong social drivers of health supports.

SBH Health System is a significant employer of 2,800 people, of which 82% are nonwhite, and 65% are female. Most full-time employees live in the Bronx. The average tenure of the currently employed is nine years. These factors represent the diversity of and commitment to the community SBH Health System serves.

Description of the Community

For this 2025 Community Health Needs Assessment, Bronx County is the defined community service area. In 2023, the Bronx had 1,356,476 residents according to Census data, down from the 1,461,151 number recorded in 2020. The Bronx is a historically working-class borough characterized by high ethnic diversity, socio-economic challenges, and vibrant community activism. Its' residents have, and continue to, face tremendous healthcare, economic and environmental challenges. The Bronx is the only New York City borough with a Latino majority and largest proportion of nonwhite population. Minority residents make up 90% of the Bronx population, higher than any other county.

The Bronx is considered the poorest urban county in the U.S. Approximately 31% of the population lives below the poverty line, which is significantly higher than the New York City average of about 20.4%. Similarly, residents of the Bronx experience much higher rates of material hardship than residents across other boroughs at 34%. The Robin Hood Poverty Tracker (2025) cited the Bronx with the highest overall disadvantage at 58%, Brooklyn at 47%, Manhattan at 49%, and Queens at 49%.

According to the U.S. Census, the Bronx, having a median age of 36.7 is among the youngest counties in New York State, compared to the state median of 40.1. County Health Ranking reports that 23.9% of Bronx residents are under 18 years of age, higher than the statewide rate of 20.22%. In Community District #6, 28% are under 18 years old. Meanwhile, 15.3% of Bronx residents are 65 or older. The Bronx child poverty rate stands at 39%, the highest in the nation. According to the 2024 American Community Survey, 23.2% of families in the Bronx live below the poverty threshold. Within this group, 14.5% of two-parent households fall below the poverty line, while the prevalence is substantially higher among single-parent households at 32.8%.

One-third (36.27%) of Bronx residents were foreign born according to the 2023 U.S. Census Bureau. This marks steady growth in the foreign-born population. As of 2023, approximately 33.7% of Bronx County residents, about 478,000 people were born outside the United States, surpassing the national average of 13.8%.

As of the latest U.S. Census data, 26% of Bronx residents speak only English at home and 74% speak a language other than English at home. Over 50% of the population speak Spanish. The rest speak a wide range of languages including Bengali, Arabic, French, Chinese and various African and Caribbean languages.

Serious crime rates plague the lives of residents of the Bronx. There is extensive discussion of the extent and impact of such a destructive environment.

Prevention Agenda Priorities

SBH Health System positioned the community, clinical staff and partners to effectively select priorities and projects that align with the community survey results, New York State Department of Health Prevention Agenda 2025–2030, and HealthyNYC 2030 goals. The selected priorities and interventions will have a positive impact on the health and well-being of the Bronx.

Domain 3: Neighborhood & Built Environment

Domain Goal	All people in New York have equitable access to a healthy and safe environment
Priority	Injuries and Violence
Goal	Prevent intentional and unintentional injuries
CHNA Survey	Ranked #1 for importance; #26 below average satisfaction; #1 for improvement in services
Intervention	Hospital-Based Violence Intervention Programs (HVIP)
Intervention	Youth Engagement Violence Preventions/Risk Reduction

Domain 4: Health Care Access & Quality

Domain Goal	All people in New York have access to timely, affordable and high-quality health care services
Priority	Prevention Services for Chronic Disease Prevention and Control
Goal	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases
CHNA Survey	Ranked #2 in importance; #7 in average satisfaction of services; #7 in areas of improvement
Intervention	Expand screening for social care needs among all adults with chronic diseases, with a focus on colorectal cancer screening

Domain 1: Economic Stability

Domain Goal	All people in New York have the financial security and support needed to thrive
Priority	Poverty
Goal	Identity, promote and implement progress that addresses poverty
CHNA Survey	Ranked # 12 in importance; #18 below average satisfaction; #5 in areas of improvement
Intervention	Conduct screening of inpatients, with specific exclusions, of five Center for Medicaid Services Health-Related Social Needs (HRSN)

Data Review

An extensive review of the 2022 projects was conducted. This review ensured lessons learned were considered, recognized new community partnerships, and changes in hospital operations, such as the implementation of EPIC, and factors that served as a foundation for proposed 2025–2027 priority projects. This process included deciding whether 2022 Community Service Plan projects should be incorporated into the 2025 Community Health Needs Assessment Plan (CHNA).

There were three primary sources of data: the 2025 Community Health Survey, the Collection of SBH Health System's Patients Race, Ethnicity, and Language Data, and SBH Patient data from Electronic Medical Records. Collecting race, ethnicity, and language (REaL) and patient medical information as primary data in the CHNA process was essential for a comprehensive understanding of community health needs.

SBH understands that there are barriers to accurate patient self-reported data such as REaL data. SBH explains the purpose and importance of this data collection to both patients and staff; clearly communicate how the data will be used and assure patients of confidentiality. There is extensive training for registrars that collect this data on how to respond to questions and concerns from patients.

REaL data is monitored monthly to determine completeness, accuracy, and trends. The 2025 community survey results on race, ethnicity, and language correspond to patient responses recorded in EPIC. Key indicators are reviewed at monthly Executive Quality Assurances and Performance Improvement (QAPI) meetings.

With the implementation of EPIC electronic medical records, patient medical information is available for real-time analysis. For this Community Health Needs Assessment, primary data included SBH patients' lab tests, follow-up visits, and patient monitoring. This included recovery rates, readmission rates, patient-reported outcomes, patient satisfaction, infection rates, etc.

Using up to date secondary data, SBH Health System captured the most current view of the health status of Bronx residents, evaluated temporal trends, differences between the Bronx, New York City, and New York State, disparities by race/ethnicity, socioeconomic status, and neighborhood differences, for more than 15 measures.

The measures included: poverty, health insurance coverage, obesity (adults and children), access to a primary care provider, preventable hospitalizations, fall related hospitalizations, breast cancer incidence, colorectal cancer incidence, COVID vaccines, diabetes, preterm births, breastfeeding, assault-related hospitalizations, violent crimes, oral health care, opioid-related mortality, depression, and suicide.

The 2025 survey results were a crucial part of the analysis of the Community Health Needs Assessment (CHNA) process. Below are the responses provided by Bronx residents, both within the SBH service area and beyond. The responses from residents in the SBH service area and the Bronx show comparable rankings in terms of the community's priorities. The health challenges named in this assessment are prevalent throughout the county.

SBH & Bronx Community Health Survey Summary:

This table summarizes health concerns respondents ranked above or below average.

	SBH Primary Service Areas (n=1,683)	Bronx County Service Areas (n=3,337)
Needs Attention	1. Violence (including gun violence) 2. Affordable housing and homelessness prevention 3. Dental care 4. Mental health disorders (such as depression) 5. Assistance with basic needs like food, shelter, and clothing 6. Obesity in children and adults	1. Violence (including gun violence) 2. Dental care 3. Affordable housing and homelessness prevention 4. Access to healthy/nutritious foods 5. Mental health disorders (such as depression) 6. Asthma, breathing issues, and lung disease 7. Assistance with basic needs like food, shelter, and clothing
Maintain Efforts	7. Cancer 8. Access to healthy/nutritious foods 9. Stopping falls among elderly 10. Heart disease 11. Diabetes and high blood sugar 12. High blood pressure 13. Asthma, breathing issues, and lung disease 14. Women's and maternal health care 15. Adolescent and child health	8. Cancer 9. Heart disease 10. Stopping falls among elderly 11. Diabetes and high blood sugar 12. High blood pressure 13. Women's and maternal health care 14. Infant health
Relatively Lower Priority	16. Job placement and employment support 17. Access to continuing education and job training programs 18. Substance use disorder/addiction (including alcohol use disorder) 19. Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah 20. Infectious diseases (COVID-19, flu, hepatitis) 21. Infant health 22. Arthritis/disease of the joints 23. School health and wellness programs 24. Sexually Transmitted Infections (STIs) 25. HIV/AIDS (Acquired Immune Deficiency Syndrome) 26. Hepatitis C/liver disease	15. Obesity in children and adults 16. Access to continuing education and job training programs 17. Job placement and employment support 18. Substance use disorder/addiction (including alcohol use disorder) 19. Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah 20. Adolescent and child health 21. Infectious diseases (COVID-19, flu, hepatitis) 22. Arthritis/disease of the joints 23. School health and wellness programs 24. Sexually Transmitted Infections (STIs) 25. HIV/AIDS (Acquired Immune Deficiency Syndrome) 26. Hepatitis C/liver disease

Based on data collection and discussions with community and other partners, SBH Health System selected the following priorities:

- Injuries & Violence Prevention
  - Ranked #1 for importance
  - Ranked #26 in below average satisfaction of services
  - Ranked #1 for improvement in services
- Colorectal cancer screening
  - Ranked #5 in importance
  - Ranked #7 in average satisfaction of services
  - Ranked #5 in areas of improvement
- Conduct screening for five Center of Medicaid Services domains
  - Ranked #12 in importance
  - Ranked #18 in below average satisfaction of services
  - Ranked #5 in areas of improvement

Partners & Roles

There are several community and government partners involved in the proposed projects:

1. Hospital-Based Violence Intervention Project (HVIP) and Youth Engagement Activities:

Community Based Organization Partner: Bronx Rises Against Gun Violence (B.R.A.G.) Hospital Responders, credible messengers, provide near-time bedside services to patients, friends and family injured by violence. They deliver wrap-around services to agreeable participants and their families; additionally, they provide services during hospitalization and after discharge.

New York City Government Agencies: The New York City Department of Youth and Community Development (DYCD): the grantor of the contract, to operate the SBH HVIP and youth engagement activities. DYCD supports training and technical assistance, performance monitoring, oversight of the budget, and continuous quality improvement to track outcomes and enhance service delivery.

The New York City Department of Health and Mental Hygiene (DOHMH), Violence Prevention Initiative: supports hospitals by providing training such as hospital responder training and utilizes a trauma-informed approach with Cure Violence-based practices for effective HVIP service delivery. DOHMH closely monitors data reporting and offers technical support.

The New York City Police Department (NYPD) 46th and 48th Precincts: cover the primary service area of SBH Health System. Through this collaboration, SBH and the NYPD exchange mutual violence intervention strategies and community outreach resources, thereby forming an alliance that fortifies community bonds and enhances public safety for Bronx residents and individuals at high-risk of violence.

2. Pathways for Better Health Outcomes:

Lead: SBH Health System

As lead, SBH is responsible for the overall management of the project. Medicaid high risk patients involved have been identified jointly by SBH Population Health and Healthfirst to be included.

Service Delivery Partner: Cityblock Health

Cityblock Health operates on a value-based care model which meets patients where they are. They adjust services to complement the care they're getting from SBH Health System and Healthfirst. This project aims to reach out to a population of SBH and Healthfirst high-risk patients and provide them with services. These services are voluntary; patients can choose to participate and sign consent.

Insurance Partner: Healthfirst

Healthfirst is a not-for-profit health insurer offering affordable plans. SBH has a risk contract with Healthfirst, covering 31,000 patients, including 13,000 primary care patients. The subgroup of SBH patients identified to participate is the focus of this project. The target population for this project is 2,700 SBH Healthfirst Medicaid high-need patients.

A key focus of the partnership is Transitions of Care, where Cityblock nurses and care managers provide follow-up and education after hospital discharge. Cityblock Care Pathways further enhances clinical outcomes, offering structured condition management for prevalent diseases such as diabetes, hypertension, COPD, and heart failure. These pathways combine clinical and social interventions, emphasizing education, monitoring, and preventative care to empower patients in managing their health.

3. Screening for Health-Related Social Needs of Inpatients:

This screening is primarily conducted by the Department of Nursing. It has been incorporated into the admission process.

EPIC facilitates both the collection of screenings and the ability to track rates of compliance. There is extensive involvement by several departments to ensure quality improvement by tracking the data.

Achieving compliance is monitored in various ways. Reports on the progress of screenings are given to the Executive Quality Improvement and Improvement Committee consistently to determine if corrections are required to improve the screening rates.

Community Engagement: SBH Health System has significant partnerships with community organizations, churches, local businesses, labor unions, and other healthcare organizations. To promote health equity, SBH practices meaningful community engagement.

Meaningful community engagement requires working with and listening to community members to address the issues that affect their well-being. They are best equipped to identify their own strengths and challenges.

The SBH Wellness Alliance gatherings are a year-round initiative that promotes community engagement. The attendees are from all sectors of the community, along with SBH clinicians to implement community health improvements.

At SBH Wellness Alliance monthly meetings, SBH public health experts, community-based organization representatives, local businesses, relevant health insurance companies, educational institutions, elected officials and health related government agencies participated in the discussion of primary and secondary data, including 2025 community health survey.

Once the community survey data was received, the results were presented to the community, SBH clinical staff, and leadership. Additionally, SBH presented results at the two local community boards monthly meetings. SBH staff and community members reviewed the new 2025–2030 New York State Prevention Agenda to familiarize themselves with the 24 key priorities that address health conditions, behaviors, and systemic issues.

The priorities chosen in this plan are aligned with the New York City Department of Health population health initiative, HealthyNYC 2030, the New York State Prevention Agenda 2025–2030, and the health needs identified through the SBH 2025 Community Health Needs Assessment.

Interventions & Strategies

1. Interventions - Gun Violence Prevention:

Gun violence is a public health crisis threatening New York City. Violence affects the community SBH Health System serves, devastating families. A public health approach focuses on prevention, treatment for at-risk individuals, and changing social expectations; recognizing gun violence as a critical, preventable public health issue. The community health survey identified violence as the number one concern for Bronx residents. SBH is committed to addressing this pressing concern through these two violence prevention interventions.

Hospital Based Violence Intervention (HVIP): Implement multi-sector violence prevention programs guided by the Cure Violence framework through a hospital-based intervention in a high-risk community affected by gangs and violent crime. This SBH project provides services to support victims and community members affected by violence.

As a trauma center, SBH leads efforts to address the local violence epidemic. The SBH Emergency Medicine Department (ED) is the clinical lead, with staff trained in the HVIP model. Clinical teams assess, stabilize, and treat patients with injuries from violent trauma and identify potentially eligible participants using established criteria.

SBH staff notify Bronx Rises Against Gun Violence (B.R.A.G.) Hospital Responders via text about a potential eligible patient. After verbal consent from the patient, B.R.A.G. Hospital Responders discuss their services. Due to its parent organization's resources, B.R.A.G. offers a wide range of services. Following patient engagement, they provide a brief assessment to SBH staff and continue communications with the patient after discharge.

Youth Engagement Violence Preventions/Risk Reduction: Increase educational, recreational and employment opportunities for at-risk youth through summer work experience, boxing/fitness and mentoring opportunities. In 2022, the New York City Department of Youth & Community Development awarded SBH Health System a contract to expand youth services. These activities enhanced SBH ability to connect and provide guidance to at-risk youth.

The SBH Youth Boxing & Fitness Program offers structured training in boxing, self-defense, and physical fitness to Bronx youth at the SBH Health & Wellness Center. Under the Director of the SBH Teaching Kitchen, they engage in hands-on culinary cooking classes to promote healthy eating habits.

There are two mentoring programs. Emergency Medicine Science, Technology & Medicine Pipeline Program (S.T.A.M.P.) and Summer Enrichment & Mentorship Program (S.E.M.P.) which aim to increase the number of underrepresented minorities in medicine and healthcare-related careers.

2. Intervention - Pathways to Better Health Outcomes:

This project aims to increase screenings for colorectal cancer and provide wrap-around services to achieve both New York State and New York City chronic disease prevention goals; and provide referrals to appropriate community resources and support services.

The Cityblock partnership with SBH will transform care delivery, reduce provider burden, ensure continuity, improve care coordination, and manage high-risk patients through a trusted partner. This Cityblock project aims to reach SBH Healthfirst high-risk patients and provide voluntary services; patients can choose to participate and sign consent.

Within the SBH Health System Healthfirst population, there's a rolling cohort of 2,700 patients with high and rising risks. If a patient declines or drops out, the next eligible patient is approached. Eligibility is determined through claims and includes patients with high medical expenses and 2+ chronic conditions, or 1 chronic condition and 1 behavioral health diagnosis. Patients are excluded if they have hemophilia, liquid cancers, transplants, or catastrophic claims.

A key focus of the partnership is Transitions of Care, where Cityblock nurses and care managers provide follow-up and education after hospital discharge. Cityblock Care Pathways further enhances clinical outcomes, offering structured condition management for prevalent diseases such as diabetes, hypertension, COPD, and heart failure. These pathways combine clinical and social interventions, emphasizing education, monitoring, and preventative care to empower patients in managing their health.

The Cityblock care model re-engages patients, reduces total care costs, and improves health outcomes through a multidisciplinary approach that includes primary care, behavioral health, and social services. Their care team, comprising of community-based nurses, social workers, pharmacists, behavioral health specialists, and others, is available 24/7/365 to meet patients at home, in the clinic, or virtually.

3. Intervention - Screening for Health-Related Social Needs:

Conduct screening of inpatients (age 18 & over, with specific exclusions) for the Center for Medicaid Services (CMS) five Health-Related Social Needs (HRSN) domains. These factors are part of the framework for addressing social drivers of health (SDOH).

In this intervention, we are screening for five CMS HRSN:

1. **Food Insecurity:** A limited or uncertain access to adequate quality and quantity of food at the household level.
2. **Housing Instability:** This encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded spaces, and actual lack of sheltered housing.
3. **Transportation Needs:** Limitations that impede transport to destinations required for daily living.
4. **Utility Difficulties:** Inconsistent availability of electricity, water, oil, or gas.
5. **Partner Violence:** Screening for exposure to intimate partner violence, child abuse, and elder abuse.

Patient Screening eligibility:

- 18+ years or older
- If 18+ or older and have legal caretaker and/or guardian, they need to be present
- Inpatient: the first 12 hours of admission to every unit
- Exclusions: Those that are “declined” and are “unable”

Progress & Evaluations

Measures: Each intervention has specific indicators, population focus, baseline, and target number.

Domain 3: Neighborhood & Built Environment:

Intervention - Hospital Based Intervention Program:

SMART(IE) Objective: Decrease the ratio of assault-related emergency department visits of Hispanic compared to White, Non-Hispanic persons from 5.7 to 5.5. (SPARCS)

Desired Outcome: Increase Emergency Department dispatch rate of referrals for assault related injuries to Bronx Rises Against Gun Violence (B.R.A.G.)

Indicator: Percentage of dispatched referrals for high-risk individuals assaulted with a sustained injury of gun shot or stab wound to B.R.A.G., community-based organization.

Data: EPIC reports

Population Focus: At-risk youth ages 14–24 and their families impacted by violence in SBH service area zip codes.

Baseline: 50% (2024)

Target: 60% (2027)

Intermediate measures: 61% (2026)

Intervention - Youth Engagement:

SMART(IE) Objective: Decrease the ratio of assault-related emergency department visits of Hispanic compared to White, Non-Hispanic persons from 5.7 to 5.5.

Desired Outcome: Increase youth engagement in each activity. Specifics in **Appendix G**.

Indicator: Numbers of youth engaged and number of classes in proposed activities. Specifics in **Appendix G**.

Data: EPIC reports

Population Focus: At-risk youth ages 14–24 and their families impacted by violence in SBH service area zip codes.

Baseline: Attendance number of youth and classes conducted (2024). Specifics in **Appendix G**..

Target: Increase attendance or number of classes. Specifics in **Appendix G**.

Domain 4: Health Care Access & Quality:

Intervention - Pathways to Better Health Outcomes:

SMART(IE) Objective: Pathways to Better Health Outcomes: Increase the percentage of Medicaid high-need adults who are up to date on their colorectal cancer screening based on the most recent HEDIS guidelines from 74% to 82%.

Desired Outcome: A greater percentage of adults aged 45–75 is compliant with the HEDIS Colorectal Cancer Screening (COL) metric.

Indicator: Cancer Screening, percentage of adults who are compliant with the HEDIS Colorectal Cancer Screening (COL) metric.

Data Source: Epic and insurance claims

Subpopulation of Focus: Adults aged 45–54 years

Baseline: 74% (2025)

Target: 82% (2027)

Domain 1: Economic Stability:

Intervention - Screening of Health-Related Social Needs:

SAMART(IE) Objective: Screen for five Center for Medicaid Services Health-Related Health Need.

Desired Outcome: Conduct screening of inpatients eligible, with specific exclusions, for the five Center for Medicaid Services Health-Related Social Needs.

Indicator: Screening rate percentage and HRSN positivity percentage

Data Source: EPIC dashboards

SBH is tracking the screenings using EPIC dashboards:

- Year to date screening rate percentage
- Number of screened patients/Number of patients eligible
- Patients included in the numerator if screened for all five HRSN during their admission

Baseline: 74% screening rate of the eligible inpatients

Target: 80% screening rate of the eligible inpatients

Evaluations

Effective measurement requires robust data collection. SBH Health System collects demographic data on race, ethnicity, and language (REaL) and patient specific information. In analyzing such data, we can uncover progress, trends, and disparities.

Progress to achieve objectives involves everyone in your organization. Engaging stakeholders, from leadership to front-line staff, to ensure buy-in and accountability. There are several vehicles to achieve this engagement, such as the Executive Quality Assurance and Performance Improvement Committee. SBH Departments will report on implementation of the projects. They will examine the desired outcomes and targets to determine compliance and if any corrections must be made. It will include both successes and areas for growth and outline the steps we will take to address challenges.

SBH Health System has significant partnerships with community organizations, churches, local businesses, labor unions, and other healthcare organizations. To promote health equity, SBH practices meaningful community engagement. Meaningful community engagement requires working with and listening to community members to address the issues that affect their well-being.

Meaningful community engagement uses the expertise of our community, who are best equipped to identify their own strengths and challenges. The SBH Wellness Alliance serves as a crucial tool in building and maintaining trust with our community and ensuring the long-term success of our community-based programs.

The SBH Wellness Alliance meets monthly. In the United Hospital Fund 2025 Bronx Region report, the Wellness Alliance is recognized as an opportunity for integration. Monthly reports on the projects will be on the agenda.

We will use the data and feedback collected to refine our measurement strategies.

E. ORGANIZATIONAL BACKGROUND

St. Barnabas Hospital, d/b/a SBH Health System (SBH), is a community-based, patient-centered healthcare system serving individuals and families in the Bronx. SBH Health System is committed to improving the health and wellness of the community, providing the highest quality care in a compassionate, comprehensive, and safe environment where the patient always comes first, regardless of their ability to pay, race/ethnicity, immigration status, or sexual orientation.

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In 2024, SBH payor mix consists of government payors:

Medicaid:
- **88.2%** of inpatient discharges
- **56.8%** of outpatient visits

Dual Eligible Accounted for:
- **27.6%** of inpatient discharges
- **19.2%** of outpatient visits

Commercially Insured Patients:
- **6.55%** of inpatient discharges
- **10.5%** of outpatient visits

SBH Health System has the following entities:

St. Barnabas Hospital is a private, not-for-profit, safety net community hospital with 422 acute care beds. In 2024, SBH averaged 67,776 adult patients, 13,781 pediatric patients, 75,909 emergency visits, 58,594 specialty clinic visits, 759 methadone-maintenance program visits, 63,106 treat and release visits, and 1,760 ambulatory surgeries. The hospital had 14,866 inpatient discharges in 2024 and 450,839 outpatient visits in 2024. The hospital is designated Level II Trauma Center and Stroke Center.

The **Ambulatory Care Center**, in 2024, provided 450,839 outpatient visits. It offers a full range of adult, adolescent, pediatric primary care and specialty care services, including surgical, cardiac, cancer, and high-risk prenatal care. Behavioral Health, nutrition, social work, and care management services are provided.

The **Emergency Department** is the front door to our system for many Bronx residents. It is one of the busiest in the Bronx with over 75,000 visits per year on average, more than the capacity built of 55,000. SBH Health System has been awarded funding to modernize and expand the emergency department to complete the establishment of a continuum of behavioral health and emergency services resources for Bronx residents.

The **Department of Behavioral Health** provides 75 inpatient adult mental health beds. SBH offers comprehensive outpatient mental health services. Programming includes adult inpatient, consultation-liaison, outpatient behavioral health, community recovery service, psychotherapy and psychopharmacological services to all ages, with 1,285 visits in 2024. SBH has instituted an inpatient Medical Psychiatric Unit (MPU), a hospital ward that coordinates acute medical conditions and mental health challenges, with 1,078 patients served in 2024.

The **Addiction Medicine Department** offers comprehensive services and individualized inpatient and outpatient programs, including inpatient detoxification, behavioral counseling, outpatient Methadone maintenance, and Suboxone treatment. The substitute therapy program supported 1,621 visits during 2024.

Hemodialysis and other related services to address kidney diseases are offered. In 2024, the outpatient dialysis program, among the largest in the Bronx, handled 21,988 visits with 40 stations.

F. COMMUNITY HEALTH ASSESSMENT (CHA)

1. Community Description:

a. Service Area

For 2025 SBH Community Health Needs Assessment, Bronx County is the defined community service area. In 2023, the Bronx had 1,356,476 residents according to Census data; down from 1,461,151 recorded in 2020. It is 17% of New York City's and 7% of New York State's population. The Bronx covers 42 square miles and is one of the most densely populated counties in the United States.

SBH Health System's primary service areas are in the following Bronx zip codes (highest to lowest number of patients): 10457, 10458, 10460, 10456, 10453, 10468, 10462, 10467, 10459, 10472, and 10452. In 2024, 38% of SBH patients came from 10457 and 10458 zip codes. The zip codes with the largest number of patients are primarily in Bronx Community District #6, which includes the communities of Belmont, Bathgate, Tremont, and West Farms.

b. Demographics

The Bronx is a historically working-class borough characterized by high ethnic diversity, socio-economic challenges, and vibrant community activism. Its' residents have, and continue to, face tremendous healthcare, economic and environmental challenges. The Bronx is the only New York City borough with a Latino majority and largest proportion of nonwhite population. 90% of Bronx residents are people of color, higher than any other county. In 2023, the Bronx demographic breakdown was:

Hispanic: 55%

Black: 30%

White: 9%

Asian: 5%

American Indian or Alaskan Native: 3.1%

Native Hawaiian or Other Pacific Islander: 0.4%

The percentage of Latinos in the Bronx continues to be significant. However, the country of origin has changed. Historically, the majority of Latinos were from Puerto Rico, are now from the Dominican Republic. This meaningful change in national origin required a review of cultural competence training and support services.

As of the latest U.S. Census data, languages spoken in the Bronx:

- English only: 26% of Bronx residents speak only English at home.
- Language other than English: 74% speak a language other than English at home.
- The vast majority speak Spanish (over 50% of the total population).
- The rest speak wide range of languages including Bengali, Arabic, French, Chinese, and various African and Caribbean languages.

As of 2023, approximately 33.7% of Bronx County residents, about 478,000 people, were born outside the United States, surpassing the national average of 13.8%. This marks a slight increase from 33.4% in 2022, showing steady growth in the foreign-born population. The majority of the Bronx's foreign-born residents hail from Latin America, accounting for 74.3% of this demographic. Other regions of origin include Africa (12.2%), Asia (8.4%), and Europe (4.8%). Among the unauthorized immigrant population in the Bronx, estimated at 115,000 individuals, the top countries of origin are:

Dominican Republic: 35,000 (30%)

Mexico: 32,000 (28%)

Honduras: 8,000 (7%)

Ecuador: 7,000 (6%)

Ghana: 4,000 (3%)

In 2022, in New York City, more than 200,000 children live in linguistically isolated households. These are homes in which no one over the age of 13 speaks English "very well", which raises concerns about access to resources due to language barriers. The highest percentage is in the Bronx at 16%, followed by Brooklyn & Queens at 15%. The percentage of homes that are "not proficient in English" in New York State is 7%.

SBH Health System meets its' legal obligation to provide language access by securing PROPIO to provide interpreter services including American Sign Language. In 2024, PROPIO provided language services in 63 languages, 39,960 audio interpretations, and 30,882 video interpretations.

The Bronx is considered the poorest urban county in the U.S. Approximately 31% of the population lives below the poverty line, which is significantly higher than the New York City average of about 20.4%. Similarly, residents of the Bronx experience much higher rates of material hardship than residents across the other boroughs at 34%. The Robin Hood Poverty Tracker (2025) cited the Bronx with the highest overall disadvantage at 58%, Brooklyn at 47%, Manhattan at 49% and Queens at 49%. The median household income in the Bronx is around $40,888, which is substantially lower than other New York City boroughs:

Bronx: $40,888

Brooklyn: $60,231

Queens: $68,666

Staten Island: $82,783

Manhattan: $86,553

According to NYU Furman Center, Belmont/East Tremont (primary service area), median household income in 2023 was $32,020, about 60% less than citywide median household income ($78,480). The poverty rate was 41.4% in 2023 compared to 18.2% citywide.

The Bronx child poverty rate stands at 32.4%, the highest in the nation. According to the 2024 American Community Survey, 23.2% of families in the Bronx live below the poverty threshold. Within this group, 14.5% of two-parent households fall below the poverty line, while the prevalence is substantially higher among single-parent households at 32.8%.

The Bronx has the highest proportion of single-parent-headed households with children (59.2%) in 2023. It is significantly higher compared to other New York counties, Brooklyn (35.2%), Manhattan (34.6%), Queens (29.4%), and Staten Island (26.3%).

According to the U.S. Census, the Bronx is among the youngest counties in New York State, with median age of 36.7 compared to the state median of 40.1. County Health Ranking reports that 23.9% of Bronx residents are under 18 years of age, higher than the statewide rate of 20.22%. In the Bronx Community District #6, 28% are under 18 years old. Meanwhile. 15.3% of Bronx residents are 65 or older, compared to 18.6% statewide. In the Bronx Community District #6, 11% are aged 65 or older.

Bronx Community District #6 elementary school absenteeism rate is 38%, the Bronx rate is 32% and both are higher than the NYC overall rate at 22%.

The Bronx has consistently had the highest unemployment rates in New York State. According to the Bureau of Labor Statistics, the unemployment rate in the Bronx was approximately 16.9% in 2020. These rates are the highest among all New York State counties and significantly above the statewide average.

According to 2025 Bronx Community District Needs #6 (primary service area), leads in unemployment rates, and only 56% of residents take part in the labor market. In 2023, in the Bronx, 23.9% ages 25+ lacked a high school diploma. In Bronx Community District #6, 29.2% of ages 25+ lacked a high school diploma. Both are higher rates than New York City.

Incarceration takes a toll on individuals, families and communities. Jail incarceration rate (ages 16 and older) is 196 per 100,000 in New York City, 303 per 100,000 in the Bronx and 458 per 100,000 in Bronx Community District #6. Lastly, serious crime rates plague the lives of residents of the Bronx. Later in this document, there will be an extensive discussion of the extent and impact of such a destructive environment.

While progress has been made, LGBTQIA+ individuals in the Bronx continue to face unique challenges and disparities, particularly at the intersection of race and socioeconomic status. The LGBTQIA+ population in the Bronx is growing and becoming more vocal about their needs for services and amenities. The Bronx still faces a lack of explicitly LGBTQIA+ friendly community gathering spots compared to other boroughs like Brooklyn or Manhattan.

Stigma, discrimination, and a lack of culturally competent healthcare providers create barriers for LGBTQIA+ individuals in the Bronx to access quality care. LGBTQIA+ adults are less likely to have a regular healthcare provider and may face insurance coverage disparities.

SBH Health System, joined other healthcare and community-based organizations, to support efforts to combat discrimination, ensure equal access to healthcare and support services, and foster a truly inclusive and welcoming environment for all LGBTQIA+ individuals in the Bronx.

2. Health Status Description:
a. Data Sources
i. Primary Data Sources

There were three primary sources of data: 2025 SBH Community Health Survey, the Collection of SBH Health System Patients Race, Ethnicity, and Language Data, and other SBH Patient medical information.

GNYHA Survey Collaborative

In 2025, Greater New York Hospital Association (GNYHA) offered member hospitals and health systems the opportunity to participate in the Community Health Needs Assessment (CHNA) Survey Collaborative during the planning year of the New York State 2025–2030 *Prevention Agenda*. GNYHA developed the health needs assessment survey, while member hospitals recruited participants from their communities to respond to the survey.

Member hospitals participating in the 2025 CHNA Survey Collaborative received the following resources and support before, during, and after the initiative:

- Promotional materials and marketing templates to share the survey.
- Support and strategies to reach populations of focus.
- Web-based survey available in 19 languages.
- Bi-weekly geographic and demographic reports by zip code or county to increase response rates.
- GNYHA staff data management, cleaning, analysis, and reporting.
- Comprehensive Excel codebook with health issues rankings, cleaned survey data, and raw data.
- Multiple forums and office hours throughout the year and one-on-one technical assistance.

GNYHA Survey Design

Members provided input in multiple stages through a collaborative and iterative process to design the 2025 CHNA collaborative survey. GNYHA employed best practice approaches in survey design and needs assessment when developing the survey. The survey used validated questions from existing surveys such as the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System and the New York City Department of Health and Mental Hygiene's Community Health Survey. GNYHA minimized the respondent burden by keeping the survey length to a minimum.

The 2025 survey used a non-probability convenience sample. A web-based survey tool and a paper-based tool were used to collect survey data. Community members completed the survey online in a format compatible with mobile devices, and paper surveys were made available in the top 19 languages spoken in New York State. Before the collaboration began, SBH provided GNYHA with a list of our service area's zip codes. Hospitals recruited members of their community to participate in the survey and entered data from paper surveys online.

Community members that qualified for the survey were aged 18 and above and lived within the SBH Health System service area. During the survey fielding period, GNYHA held member forums in which members shared best practices and challenges in recruiting community respondents for the survey. GNYHA produced biweekly geographic and demographic reports (age, gender, employment status, race, etc.) summarizing the responses in our service area, which allowed SBH to adjust our dissemination strategy.

For the implementation of the community survey, SBH Health System made it available in English and Spanish. Flyer handouts with QR code automatically linked respondents to the online survey, and flyers were made in English and Spanish. The survey included questions on what Bronx residents perceived as the priority health concerns in their community. Participants were asked to identify what intervention strategies would benefit their community most and to identify their health priorities. Importance and satisfaction ratings for the health conditions were derived by taking an average of the responses for each health condition. Therefore, a menu of over 20 health concerns was included. These categories were chosen to align with the New York State 2025–2030 *Prevention Agenda* focus areas.

Beyond questions specifically related to community health concerns, participant demographic and health status data were collected. SBH requested a comparison of its' responses to the overall Bronx responses. This analysis showed extensive alignment. It was clear that the residents in the SBH service area and Bronx County shared similar priorities.

Survey participants were recruited using various approaches:

- Health fairs and other events staffed by SBH Health System personnel.
- Critical community partners strategically disseminated surveys.
- Discussed at monthly SBH Wellness Alliance meetings.
- Summer Youth employees conducted the survey in different departments within the hospital.
- Conducted outreach through social media platforms and employee engagement platforms.

Paper copies were manually entered into the online link survey tool for GNYHA to analyze the data. The following pages will show the survey results in several tables.

Following the survey's close, GNYHA provided SBH with a report summarizing survey responses, respondent demographics, and a spreadsheet with the processed respondent-level data for their service area, allowing for participating hospitals to conduct deeper analyses. GNYHA provided technical assistance to each hospital to interpret their results and identify areas of need and create custom reports as requested by members. Copies of the English and Spanish versions of the flyer and paper survey are provided in **Appendix A**.

Collection of SBH Patients Race, Ethnicity, Language Data, & SBH Patient Data from Medical Records

Collecting and using race, ethnicity, and language (REaL) data as primary data in the CHNA process was essential for a comprehensive understanding of community health needs. Both the collection of REaL data and patient conditions/outcomes data were included in the community health needs assessment process. Such data allows SBH to identify health disparities and service gaps to promote health equity for all patients. This data also facilitates pinpointing specific areas for targeted evidence-based interventions.

With the implementation of EPIC electronic medical records, patient data is available for analysis. For this CHNA, primary data included SBH patients' lab tests, follow-up visits, and patient monitoring. This included recovery rates, readmission rates, patient-reported outcomes, patient satisfaction, infection rates, etc.

SBH understands that there are barriers to accurate patient self-report data. SBH explains the purpose and importance of this data to both patients and staff; clearly communicates how the data will be used and assures patients of confidentiality. There is extensive training of registrars that collect data on how to respond to questions and concerns from patients.

REaL data is monitored monthly to determine completeness, accuracy, and trends. The survey results on race, ethnicity and language correspond to patient responses recorded in EPIC. This information is shared with pertinent senior staff to incorporate into directing organizational priorities. Key indicators are reviewed at monthly Quality Assessment and Performance Improvement (QAPI) meetings.

ii. Secondary Data Sources

Compared to citywide and national averages, the Bronx has been an epicenter for many health indicators including asthma, obesity, drug epidemics, and excess mortality rates from heart disease, cancer, and diabetes. To collect pertinent secondary data, we determined what type of information was needed (numbers, trends, case studies, background information). We updated prior data and selected geographic areas relevant to the project.

Secondary data came from:

- Published sources: books, academic journals, magazines, newspapers.
- Government & public agencies: census data, health statistics, economic reports, labor statistics.
- Institutional reports: not for profit publications, think tank studies.
- Relevant online databases.
- Media & internet: websites, blogs, news archives.

Collected the Data Systematically:

- Searched academic databases or libraries.
- Downloaded reports, datasets, or archives from reliable sources.
- Used search strategies (keywords, filters, date ranges).

These measures analyzed aligned with those used by the New York State Prevention Agenda Dashboard 2030 and the New York City Healthy People 2030 Agenda.

b. Data Collection Methods

i. Primary Data Collection Methods

GNYHA Survey Results

The number of participants in the survey were: 3,337 Bronx residents, of which 1,683 responses were from the SBH Health System service area. The comparison shows similar views between the SBH service area and the total Bronx residents.

Participants from 10467 and 10458 were overrepresented in this survey due to living in the SBH service area. The survey captured a reasonable age distribution of Bronx residents, though adults ages 55–74 years are slightly overrepresented. Typical of surveys like this, women are overrepresented. Women are more likely to take part in community events and more likely to complete surveys. The survey captured an increased proportion of more highly educated residents in the Bronx, but the race/ethnicity distribution is comparable. One interesting note is an increase from the 2022 survey of individuals that speak Spanish at home. In the 2022 survey, it was 36%; in the 2025 survey, it is 54% Spanish at home.

The following charts list the results of the 2025 survey responses of individuals within the SBH service area.

Importance and Satisfaction Rankings:

This chart summarizes issues that respondents ranked above or below average in importance and satisfaction for SBH Health System's service areas.

Needs Attention: Above average importance and below average satisfaction	• Violence (including gun violence) • Affordable housing and homelessness prevention • Dental care • Mental health disorders (such as depression) • Assistance with basic needs like food, shelter, and clothing • Obesity (in children and adults)
Maintain Efforts: Both importance and satisfaction are above average	• Cancer • Access to healthy/nutritious foods • Preventing falls among elderly • Heart disease • Diabetes and high blood sugar • High blood pressure • Asthma, breathing issues, and lung disease • Women's and maternal health care • Adolescent and child health
Relatively Lower Priority: Both importance and satisfaction are below average	• Job placement and employment support • Access to continuing education and job training programs • Substance use disorder/addiction (including alcohol use disorder) • Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah • Infectious diseases (COVID-19, flu, hepatitis) • Infant health • Arthritis/disease of the joints • School health and wellness programs • Sexually Transmitted Infections (STIs) • HIV/AIDS (Acquired Immune Deficiency Syndrome) • Hepatitis C/liver disease

These issues are important to our service area, but they are generally unsatisfied with related services: they may indicate need for new or improved community health efforts.

These issues are important to our service area, and they are generally satisfied with services: they may indicate opportunities to sustain investment in ongoing community health efforts.

These issues are not as important to our service area, and they are generally unsatisfied with services: they may indicate need for new community health efforts or additional resources.

Importance Rankings:

This chart summarizes issues that respondents ranked above or below average in importance for SBH Health System's service areas.

Rank #1–6: Highest average importance	1. Violence (including gun violence) 2. Cancer 3. Affordable housing and homelessness prevention 4. Dental care 5. Access to healthy/nutritious foods 6. Preventing falls among elderly
Rank #7–15: Above average importance	7. Heart disease 8. Mental health disorders (such as depression) 9. Diabetes and high blood sugar 10. High blood pressure 11. Asthma, breathing issues, and lung disease 12. Assistance with basic needs like food, shelter, and clothing 13. Women's and maternal health care 14. Adolescent and child health 15. Obesity (in children and adults)
Rank #16–26: Below average importance	16. Infectious diseases (COVID-19, flu, hepatitis) 17. Infant health 18. Arthritis/disease of the joints 19. School health and wellness programs 20. Job placement and employment support 21. Access to continuing education and job training programs 22. Sexually Transmitted Infections (STIs) 23. Substance use disorder/addiction (including alcohol use disorder) 24. HIV/AIDS (Acquired Immune Deficiency Syndrome) 25. Hepatitis C/liver disease 26. Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah

These issues are important to our service area and may indicate to continue efforts for issues.

These issues are important to our service area and may indicate performance improvement opportunities.

These issues are not as important to our service area and may indicate opportunities for continued health education or community health investment.

Satisfaction Rankings:

This chart summarizes issues that respondents ranked above or below average in satisfaction for SBH Health System's service areas.

Rank #16–26: Below average satisfaction	26. Violence (including gun violence) 25. Affordable housing and homelessness prevention 24. Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah 23. Substance use disorder/addiction (including alcohol use disorder) 22. Job placement and employment support 21. Mental health disorders (such as depression) 20. Obesity (in children and adults) 19. Access to continuing education and job training programs 18. Assistance with basic needs like food, shelter, and clothing 17. Dental care 16. Preventing falls among elderly
Rank #7–15: Above average satisfaction	15. Access to healthy/nutritious foods 14. Sexually Transmitted Infections (STIs) 13. Hepatitis C/liver disease 12. School health and wellness programs 11. HIV/AIDS (Acquired Immune Deficiency Syndrome) 10. Arthritis/disease of the joints 9. Asthma, breathing issues, and lung disease 8. Women's and maternal health care 7. Cancer
Rank #1–6: Highest average satisfaction	6. Diabetes and high blood sugar 5. Adolescent and child health 4. Heart disease 3. Infectious diseases (COVID-19, flu, hepatitis) 2. High blood pressure 1. Infant Health

Our service area is generally unsatisfied with services, and these issues may indicate opportunities for continued health education or community health investment.

Our service area is generally satisfied with services, and these issues may indicate performance improvement opportunities in community health initiatives.

Our service area is very satisfied with related services, and these issues may indicate programs to continue community health efforts in.

Socio-Demographic Comparison:

The table below represents socio-demographic data from survey respondents:

	Percent (%)	
	SBH Community Health Survey (n=1,683)	Bronx Community Health Survey (n=3,337)
Age		
18 – 24	6%	5%
25 – 34	12%	10%
35 – 44	16%	14%
45 – 54	17%	17%
55 – 64	25%	25%
65 – 74	19%	21%
75+	4%	7%
Gender Identity		
Cisgender Man	20%	22%
Cisgender Woman	77%	76%
Gender Minority	3%	2%
Education		
Grades 8 (Elementary) or less	5%	4%
Grades 9 through 11 (Some High School)	10%	9%
Grade 12 or GED (High School Graduate)	27%	24%
College 1 year to 3 years (Some college or technical school)	30%	30%
College 4 years or more (College graduate)	28%	33%
Race and Ethnicity (do not add to 100%)		
American Indian or Alaska Native alone or in combination	3%	3%
Asian alone or in combination	3%	3%
Black or African American alone or in combination	33%	37%
Hispanic or Latino alone or in combination	61%	53%
Middle Eastern or North African alone or in combination	1%	1%
Native Hawaiian or Pacific Islander alone or in combination	0%	0%
White alone or in combination	7%	11%
Language Spoken at Home		
English-only speaker	36%	44%
Spanish	54%	46%
Arabic	1%	1%
Bengali	1%	1%
Burmese	0%	0%

Chinese	0%	0%
French	2%	1%
Haitian Creole	1%	1%
Hindi	0%	0%
Italian	1%	1%
Japanese	0%	0%
Korean	0%	0%
Nepali	0%	0%
Polish	0%	0%
Russian	0%	0%
Urdu	0%	0%
Yiddish	0%	0%
Other	6%	6%

Data Source: SBH and Bronx Community Health Survey, 2025. Note: A qualified respondent is 18+ and living within the service area. Percentages may not add to 100% because respondents could choose more than one option.

Individual Priorities:

This table documents the views of the respondents on the overall health of the community, their individual physical health and mental health.

	Percent (%)	
	SBH Community Health Survey (n=1,683)	Bronx Community Health Survey (n=3,337)
In general, how is the overall health of the people of your neighborhood?		
Excellent	3%	3%
Very Good	6%	7%
Good	32%	36%
Fair	43%	41%
Poor	15%	13%
In general, how is your physical health?		
Excellent	7%	6%
Very Good	14%	14%
Good	37%	39%
Fair	35%	33%
Poor	8%	7%
In general, how is your mental health?		
Excellent	15%	16%
Very Good	20%	20%
Good	30%	35%
Fair	24%	23%
Poor	8%	6%

Data Source: SBH and Bronx Community Health Survey, 2025

ii. Secondary Data Collection Methods

Using up to date secondary data, SBH Health System captured the most current view of the health status of Bronx residents, evaluated temporal trends, differences between the Bronx, New York City, New York State and the nation, disparities by race/ethnicity, socioeconomic status, and neighborhood differences, for more than 15 measures.

The measures included: poverty, access to a primary care provider, health insurance coverage, obesity (adults and children), diabetes, preterm births, maternal health, breastfeeding, breast cancer incidence, preventable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, oral health care, opioid-related mortality, violent crimes, depression, and suicide.

Methodology:

- Evaluated the quality of data based on who collected it, whether it is reliable, up-to-date, and unbiased.
- Evaluated quality & relevance on who produced the data (author/source credibility), when was it published (Check date for relevance) and why it was collected (Check for bias).
- Organized the data by creating a spreadsheet to log sources (author, title, date, link, notes). Keep detailed notes and citations.
- Analyzed to compare various sources and use the data to note trends or provide background.

c. Community Engagement

Aligning with New York State Prevention Agenda 2030, New York City Healthy People 2030, and using both primary and secondary data, SBH Health System conducted the 2025 Community Health Needs Assessment. The findings informed the 2025 Community Service Plan which identified priorities health needs and selected evidence-based interventions.

Public Health experts at SBH, community-based organizations, local businesses, relevant health insurance companies, educational institutions, elected officials and government agencies participated in the discussions of primary and secondary data, including the community health survey, and subsequent prioritization of projects. A list of stakeholders and partners involved in the planning and prioritization process is provided in **Appendix H**.

In 2025, SBH Wellness Alliance held meetings with SBH staff and community members. They evaluated the 2022–2024 plan, and conducted the 2025 Community Health Needs Assessment process. These discussions reviewed primary and secondary data, addressed health disparities and their root causes, and explored proposals to improve health outcomes.

Sampling of the SBH Wellness Alliance meeting topics:

2022

- SBH Injury Prevention Project
- Mental Health Market Place
- Food Insecurity
- Colon Cancer Screenings
- Stop the Bleed (at several meetings)
- ACES: Assertive Community Engagement & Success
- Overdose Mortality Fact Sheets by Race/Ethnicity 2022
- HealthPlex, Teaching Kitchen & other services at SBH (at several meetings)
- Social Determinants of Health Food Security Solutions (at several meetings)
- Community Health Needs Assessment update
- SBH Community Service Plan (CSP) updates (at several meetings)

2023

- CPR Training
- Stroke Awareness
- Efforts to End Gun Violence
- SBH Emergency Dept. Renovation
- Coach Training for Alliance Partners
- Medicaid changes (at several meetings)
- Healthy Eating Habits throughout the holidays

2024

- Mental Wellness Month
- Birth Defects Prevention Month
- Cervical Health Awareness Month
- HealthPlex, Teaching Kitchen & other services at SBH (at several meetings)
- Heart Awareness
- Stroke Awareness
- SBH Violence Prevention Initiatives (at several meetings)
- Back to school-immunizations
- National Childhood Obesity Awareness
- SBH School Based Dental Screenings
- Bronx RHIO COVID Survey
- NYCDOHMH Diabetes and Prenatal Diabetes Workshops
- Safety Holiday Eating
- Importance of Mammogram

d. Relevant Health Indicators

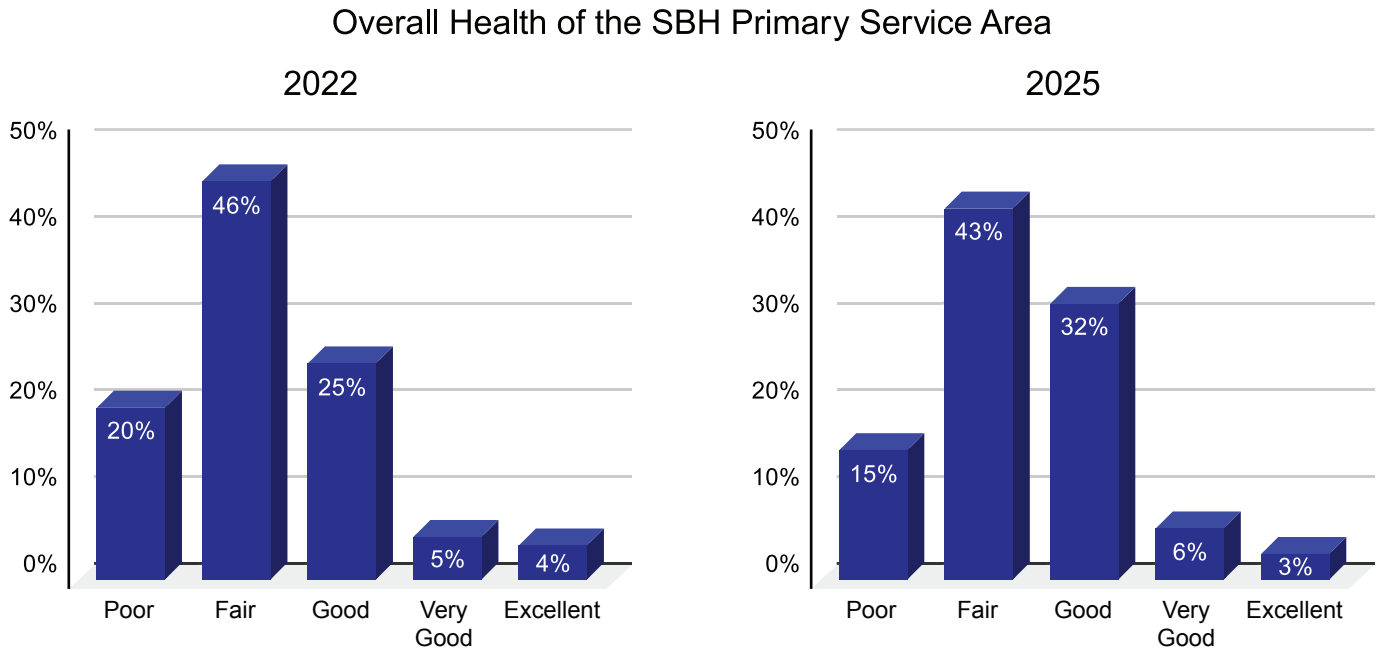
According to 2025 County Health Rankings and Roadmaps, the Bronx ranks 62 of 62 counties in New York State in terms of health outcomes and factors. It has been number 62 since 2011. Bronx residents have a higher percentage of the population that self-report health as poor or fair. New York City overall rate is 16%; the Bronx is 28%. In County Health Rankings, Bronx residents said they had 5.1 poor physical health days; New York City is 3.9.

Health problems are more prevalent in the Bronx than in other boroughs. More than a quarter of Bronx residents (28%) report having health problems, compared with 20% in Queens, 22% in Brooklyn, and 23% in Manhattan. Citywide 53% of residents reported adequate access to health care services compared with only 17.9% of Bronx residents. According to Statewide Planning and Research Cooperative System (SPARCS) (2022), Bronx residents experience higher than average rates of preventable hospitalizations among adults. The Bronx rate is 108.9 per 10,000; the overall New York City rate is 105.4 per 10,000.

As of 2021, the Bronx had some of the highest rates of public health insurance enrollment in New York State, largely due to Medicaid expansion during the pandemic. Despite these gains, the borough continues to face significant health disparities, with many residents lacking resources and information needed to enroll or re-enroll in health coverage.

Overall Health of the SBH Primary Service Area

Below are Community Health Survey responses comparing how participants viewed the overall health of the service area in 2022 and 2025. The "Poor" category went down 5 points, that corresponds to 7 points increase in the "Good" category.



Data Source: Community Health Survey 2022, Community Health Survey, 2025

Mortality Rates and Causes of Death: From 2019 to 2022, the age-adjusted morality rate in the Bronx increased by 10.62% (654.2 to 723.7 per 100,000). The Bronx has a higher age-adjusted rate of 23.42%, which is higher than the rest of New York City. The age-adjusted ^75y mortality rate (e.g., premature mortality) is 56.30% in the Bronx and 45.40% in New York City.

The leading causes of death in 2022 in the Bronx were heart disease (186.5 per 100,000), cancer (111.6 per 100,000), unintentional injuries (79.5 per 100,000), COVID-19 (48.1 per 100,000), Cerebrovascular Disease (25.8 per 100,000), diabetes (23.9 per 100,000), and pneumonia/influenza (20.2 per 100,000). Drug overdoses account for 69.67% of unintentional deaths. Heart disease had a higher number of deaths in males than females while females had a higher number in cerebrovascular disease than males. The most common causes of cancer death include breast, prostate, lung, and colorectal cancer.

The Bronx has excess neighborhood mortality rates, with East Tremont coming in second for highest neighborhood mortality rates at 888.8 per 100,000, compared to the rest of New York City in 2022. According to the New York State Department of Health, heart disease, cancer, cerebrovascular disease, diabetes, unintentional injuries, homicides/assaults, chronic lower respiratory, influenza and pneumonia has been the highest causes of death among Bronx residents from 2013 to 2022.

Diabetes: In 2022, 15.3% of adults in SBH Health System's Congressional District reported being diagnosed with diabetes, compared to 13.4% for the entire Bronx, and 11.4% citywide. The mortality rate (age-adjusted) for diabetes in the Bronx for 2022 was 23.8 per 100,000 while it was 17.2 per 100,000 citywide. In addition, the prevalence of diabetes is significantly higher among Latino and Non-Hispanic Black populations. According to the New York State Department of Health, the average (age-adjusted) rate of hospitalizations due to complications of diabetes in the Bronx was 36.2 per 10,000 in 2022, which is significantly higher than the New York City rate of 20.5 per 10,000 and the statewide rate of 17.7 per 10,000. From 2019 to 2022, the rate of hospitalizations for diabetes decreased by 14.82%.

Maternal Mortality in the Bronx: The Bronx has the highest maternal mortality rate among all New York City boroughs. The rate in the Bronx stands at 29.4 per 100,000, in contrast to New York City's rate of 20.4 per 100,000. Notably, maternal mortality rates experienced an 11.3% increase between 2018 and 2022.

Breastfeeding: According to the New York State Department of Health (2022), the Bronx has the second lowest proportion of infants exclusively breastfed. The New York City rate is 40.7%, and the Bronx rate is 29.6%. Among Latino/Hispanic infants in the Bronx, 26.2% were exclusively breastfed, while 31.9% of Black infants were breastfed. Infants in the Bronx that were fed with formula among breastfed infants are higher than New York City, 67.6% in the Bronx, 55.2% in New York City.

Prenatal Birth and Care: In 2023, in the Bronx, there were 16,347 live births. In SBH's congressional district, 65.9% of births had prenatal care begin in the first trimester in 2022. In the Bronx in 2023, 64% of live births received early prenatal care, 23.7% received care in the second trimester, and 12.3% received late to no prenatal care according to the March of Dimes. 24.8% of live births were to women who received inadequate prenatal care. According to March of Dimes data, the percentage of live births receiving late prenatal (after first and second trimesters) or no prenatal care is the highest in the Bronx at 12.3%; New York City's overall rate is 8.2%.

Preterm Births: In 2023, 1 in 9 babies (11%) in the Bronx were born preterm according to March of Dimes. The rate of preterm birth in the Bronx is higher than the citywide rate (9.3%). Black infants have the highest percent of pre-term births at 13.7% compared to Hispanic infants at 10.4%, Asian at 10.0%, and White at 8.6%. The Bronx remains the highest preterm births at 11%, while Brooklyn (8.4%), Manhattan (8.7%), Queens (9.6%), and Staten Island (9.0%).

Obesity: In 2022, based on data from the New York State Department of Health, the Bronx had the highest prevalence of adult obesity (defined as body mass index≥30 kg/m2) than in any other borough of New York City; 34.7% compared to 25.6% citywide. The prevalence of obesity has increased by 4.7% in the Bronx since 2019. Similar to adult obesity, the Bronx has the highest rates of obesity among children and adolescents, 25.8% vs. 20.9% in the rest of New York City.

Asthma: According to the New York City Department of Health, in 2022 6.4% of Bronx adult residents reported being diagnosed with asthma (4.3% citywide). The rate of emergency department visits for asthma in the Bronx was 156.2 per 10,000 in 2022; that was 21,253 visits. The Bronx rate is more than the rate for New York City overall (54.9 per 10,000). Rates are exceptionally high in zip codes: 10453, 10457, 10460. In addition, asthma ED visits have increased for most of the Bronx except for the 10471, 10464, and 10465 zip codes.

Breast Cancer: The breast cancer incidence rate among females in the Bronx is 113.7 per 100,000. In 2022 according to the New York State Cancer Registry, breast cancer is highest among White females (149.0 per 100,000), then Black females (120.7 per 100,000), Asian females (102.7 per 100,000), and Hispanic females (101.0 per 100,000). Citywide, the breast cancer incidence rate is 127.5 per 100,000, Brooklyn 125.8 per 100,000, Manhattan 137.1 per 100,000, Queens 126.4 per 100,000, and Staten Island 143.6 per 100,000. Breast Cancer mortality in the Bronx is 17.1 per 100,000, and highest among Black females (21.7 per 100,000). Citywide breast cancer mortality rate is 16.2 per 100,000.

Drugs & Opioids: In 2023, the age-adjusted mortality rate of accidental drug overdoses was 78.0 per 100,000. From 2020, the rate increased by 36.2%, making it a leading cause of death among Bronx residents. Bronx neighborhoods with the highest rates of overdose in 2023 were, Crotona-Tremont (115.7 deaths per 100,00), Hunts Point-Mott Haven (138.9 deaths per 100,00), Highbridge-Morrisania (106.4 deaths per 100,000), and Fordham-Bronx Park (78.3 deaths per 100,000). In 2023, the New York City Department of Health & Mental Hygiene reported that 858 Bronx residents died of drug overdoses, accounting for 27.98% of all drug fatalities citywide.

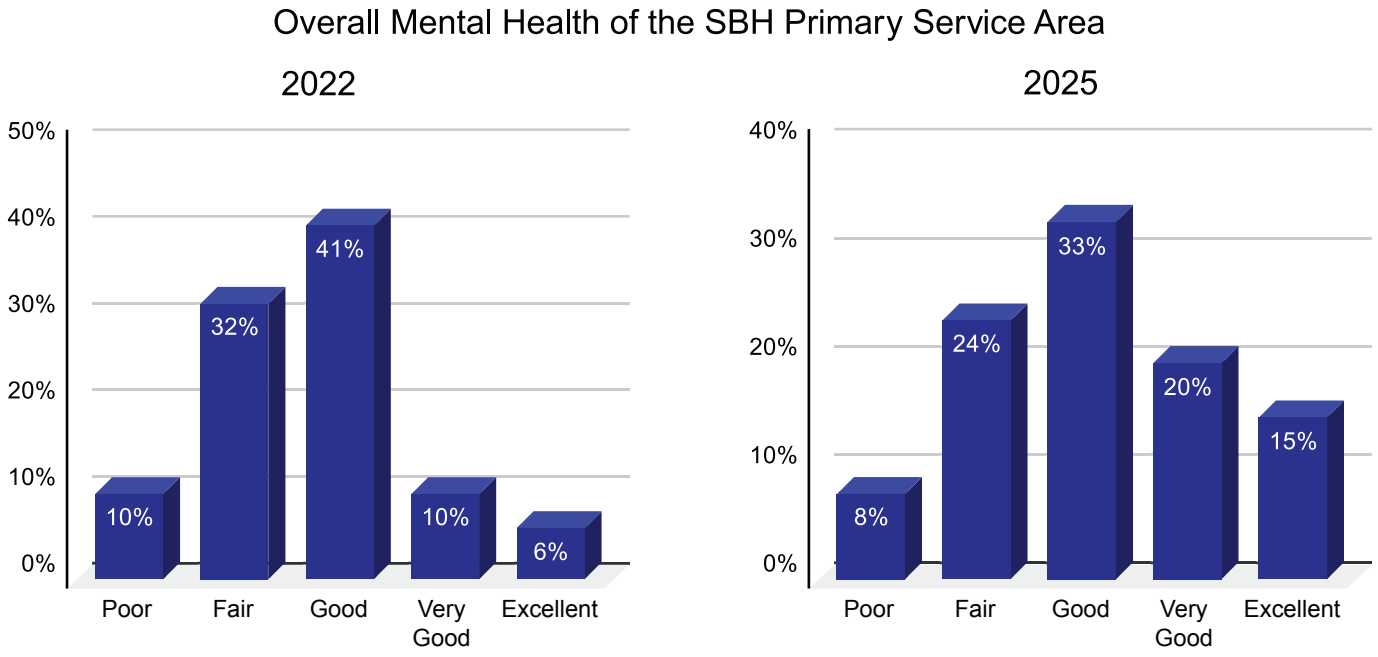
In addition, the Bronx has the highest opioid burden death rates in New York City of 78.0 per 100,000 compared to Manhattan (36.0 per 100,000), Brooklyn (32.9 per 100,000, Queens (24.5 per 100,000), Staten Island (40.1 per 100,000).

Oral Health: According to the New York City Department of Health, the number of adults who had a dentist visit within the past year is lower in the Bronx than in any other borough. In 2019, the age-adjusted percentage of adults who had a dentist visit within the past year was 61.5%. According to New York State Medicaid and Child Health Plus, the Bronx also had the lowest percentage of children with at least a single dental visit. In 2022, the rate of children (ages 2–20 years) with at least one dental visit in government sponsored insurance programs was 43.6%. The Bronx rate for age-adjusted oral cavity and pharynx cancer mortality is 2.3 per 100,000 (New York State Cancer Registry 2021).

Mental Health & Depression in the Bronx: According to the Mayor's Office of Community Mental Health, one in five New Yorkers experiences mental illness each year. In the Bronx, the burden is disproportionately higher, with some residents facing even greater challenges in accessing mental health care. A 2023 study by the New York Health Foundation, the Bronx has the highest percentage of current depression among all New York City boroughs is 12%, compared to Manhattan (7%), Brooklyn (8%), Queens (7%), and Staten Island (6%).

The New York City Community Health Survey (2022) further confirmed that the Bronx continues to have higher depression rates than any other borough. Four out of the top five NYC neighborhoods with the highest prevalence of depression are in the Bronx:

- Crotona–Tremont: 18.3%
- Hunts Point–Mott Haven: 18.1%
- Pelham–Throggs Neck: 17.6%
- Fordham–Bronx Park: 17.5%



Data Source: Community Health Survey 2022, Community Health Survey, 2025

Suicide Mortality: Fordham-Bronx Park area has the highest suicide mortality in the Bronx, rating at 7.5 per 100,000 while the entire Bronx is at 6.5 per 100,000. The suicide mortality rate has gone up in the Bronx from 2019 to 2022 by 2.4%. Citywide, the suicide mortality rate is 6.8 per 100,000; the highest being in Manhattan 6.9 per 100,000, the Bronx 6.5 per 100,000, Staten Island 6.2 per 100,000, Brooklyn 5.6 per 100,000, and then Queens 5.4 per 100,000.

e. Secondary Data Charts

Figure 1: Poverty Rates

Access to Healthcare:

Figure 2: Percentage of Adults who lack Health Insurance

Figure 3: Percentage of Adults with Health Insurance

Figure 4: Percentage of Adults who report having a Primary Care Provider

Rates of Hospitalizations:

Figure 5: Rate of Preventable Hospitalizations

Figure 6: Rate of Hospitalizations due to Falls 65+

Figure 7: Breast Cancer Incidence

Obesity:

Figure 8: Percentage of Students who are Obese

Figure 9: Percentage of Adults who are Obese

Figure 10: Percentage of Adults who have been told they have Diabetes

Oral Health:

Figure 11: Oral Cavity and Pharynx Cancer

Figure 12: Percentage of Children (aged 2–20) with at least one Dental Visit

Mental Health:

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Figure 14: Suicide Mortality Rate

Figure 15: Opioid Related Mortality

Figure 16: Rate of Assault Related Hospitalizations

Figure 17: Rate of Adults with New HIV Diagnosis

Figure 18: Percentage of COVID Vaccines All Ages

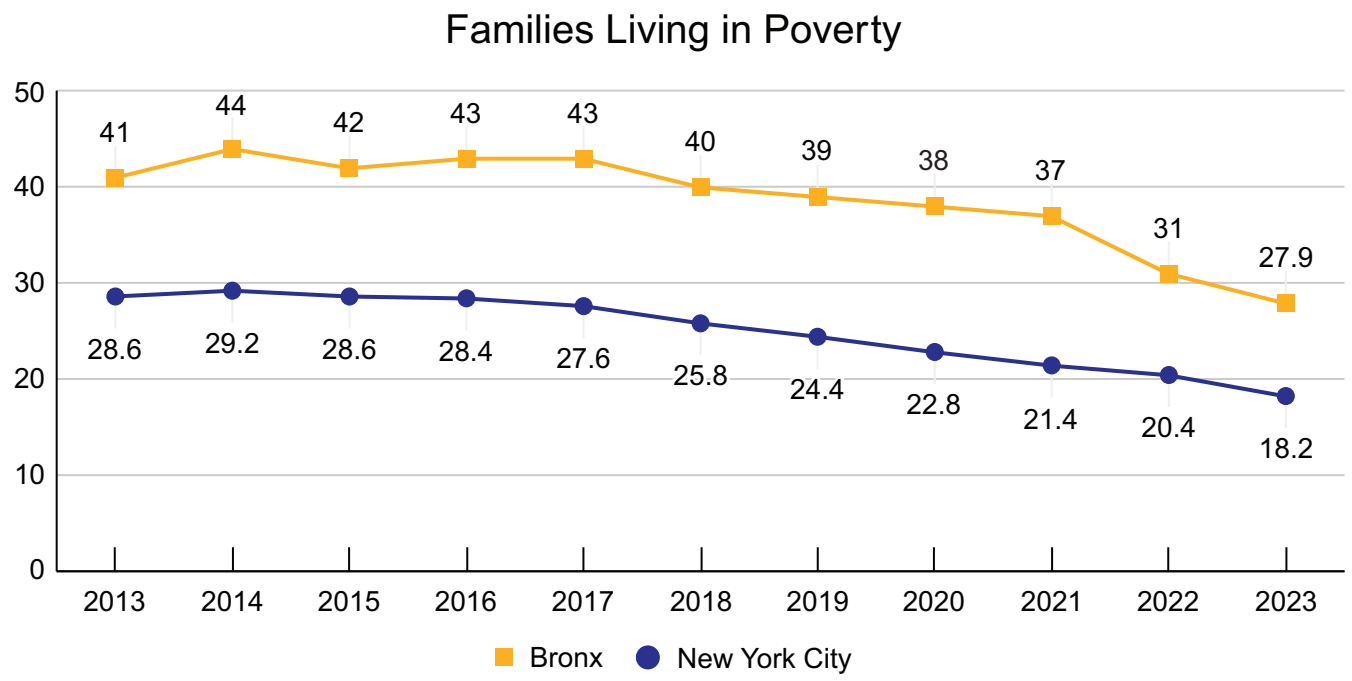
Figure 19: Rate of Asthma Hospitalizations

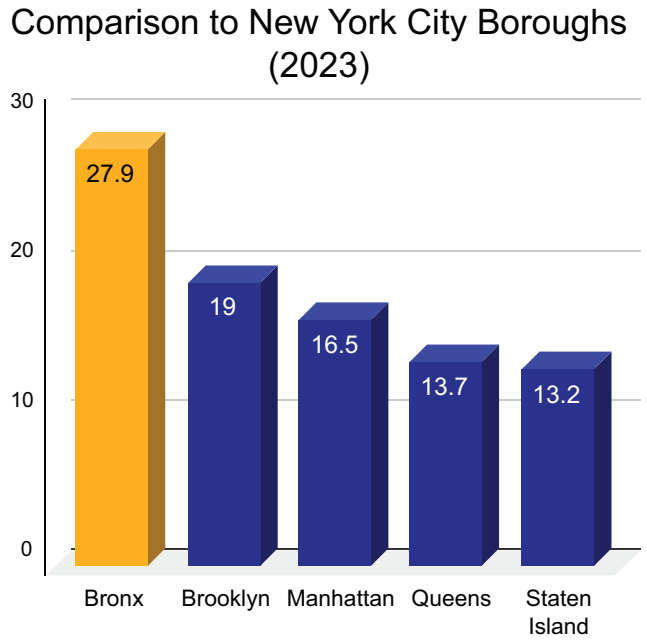
Figure 20: Same Sex Couple Breakdown

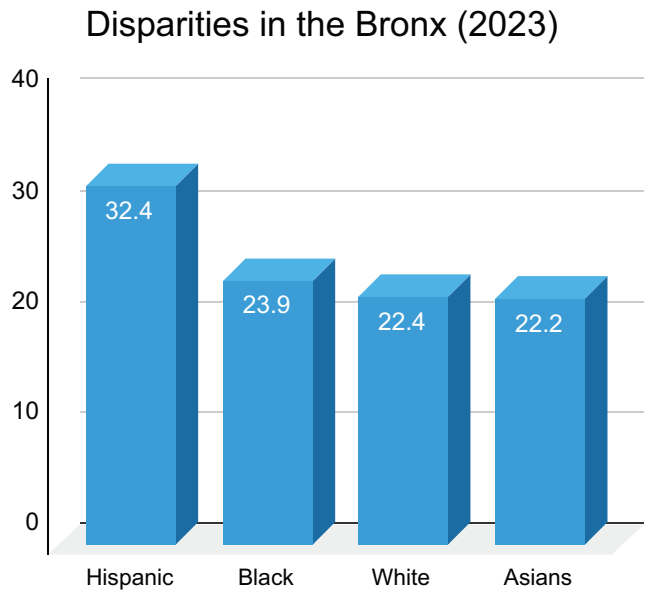
Colorectal Cancer:

Figure 21: Screening Rate, Incidence Rate, and Mortality

Figure 1



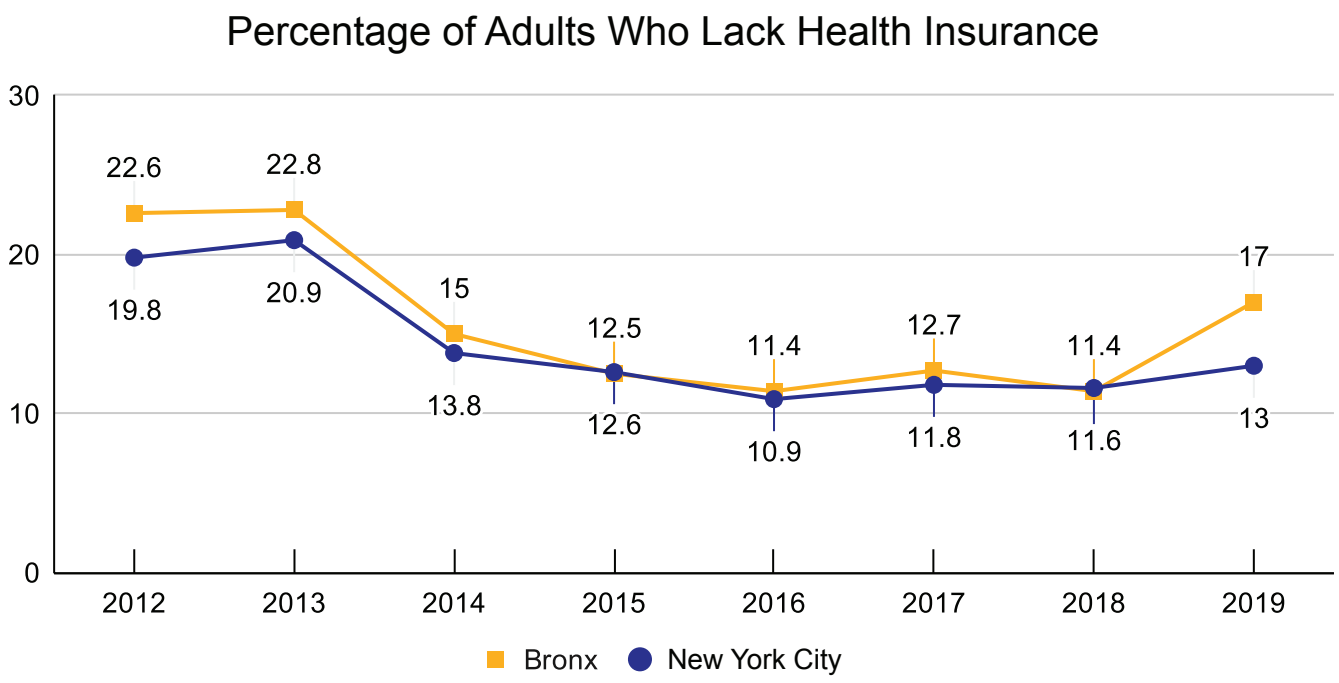


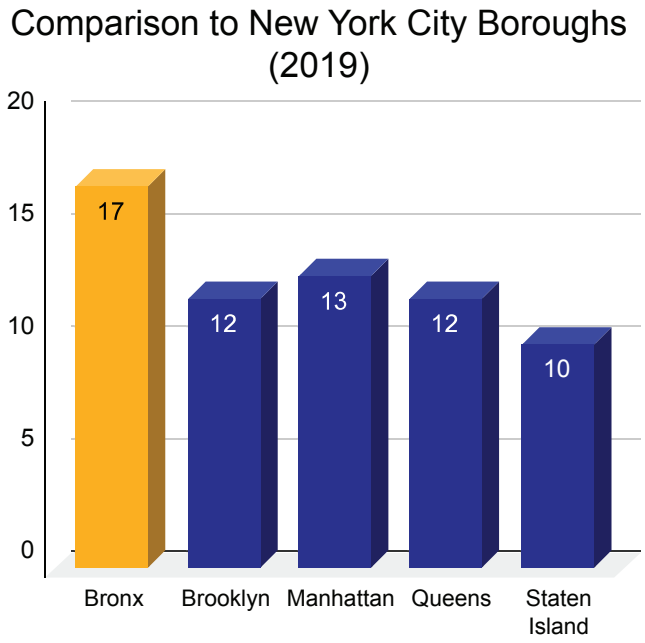


Data Source: United States Census Bureau, 2023. American Community Survey, 2023

In 2023, the Bronx was the highest of all New York City boroughs for families living in poverty, with the percentage being double that of Staten Island.

Figure 2

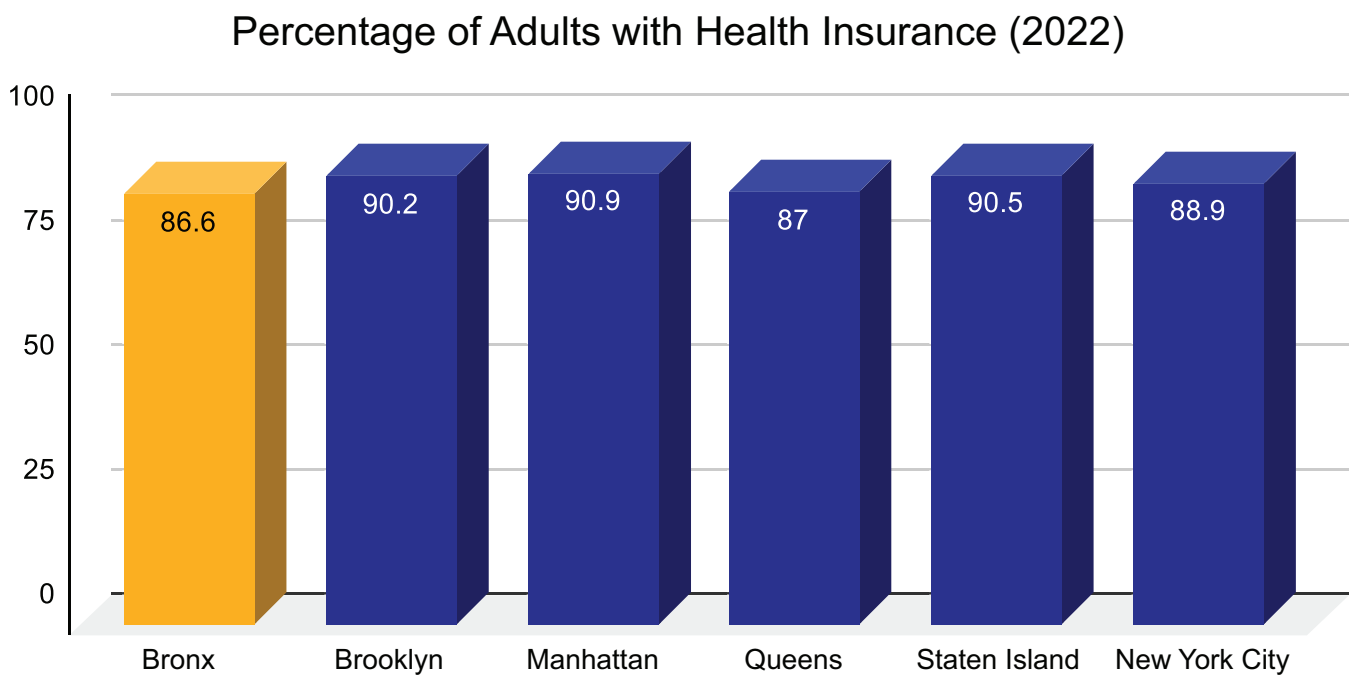


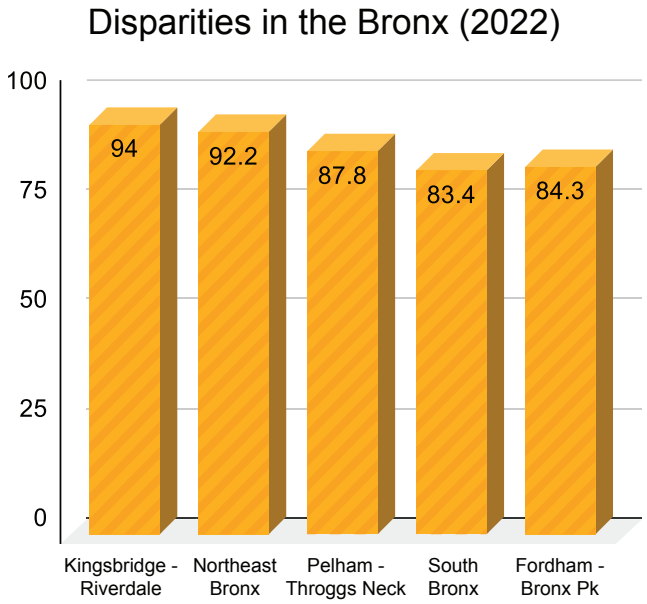


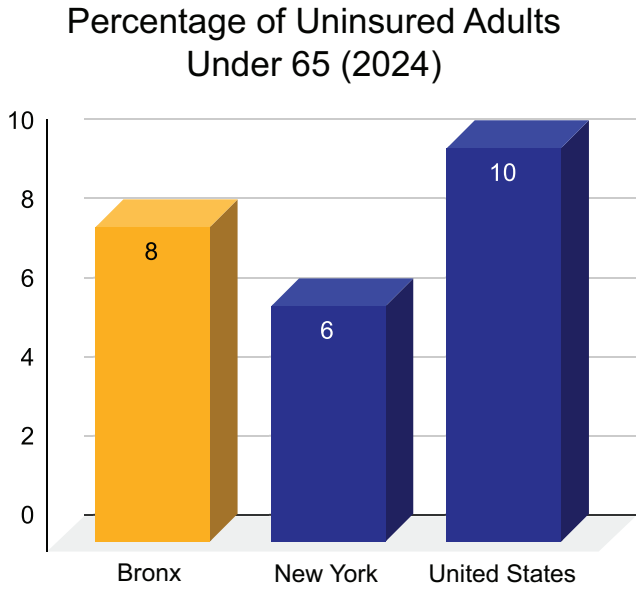
Data Source: New York City Department of Health and Mental Hygiene. EpiQuery – *Health Care Access and Use*, 2019

While the percentage of adults who lack health insurance has decreased in New York City over the last decade, the Bronx still maintains a higher rate than the rest of New York City.

Figure 3



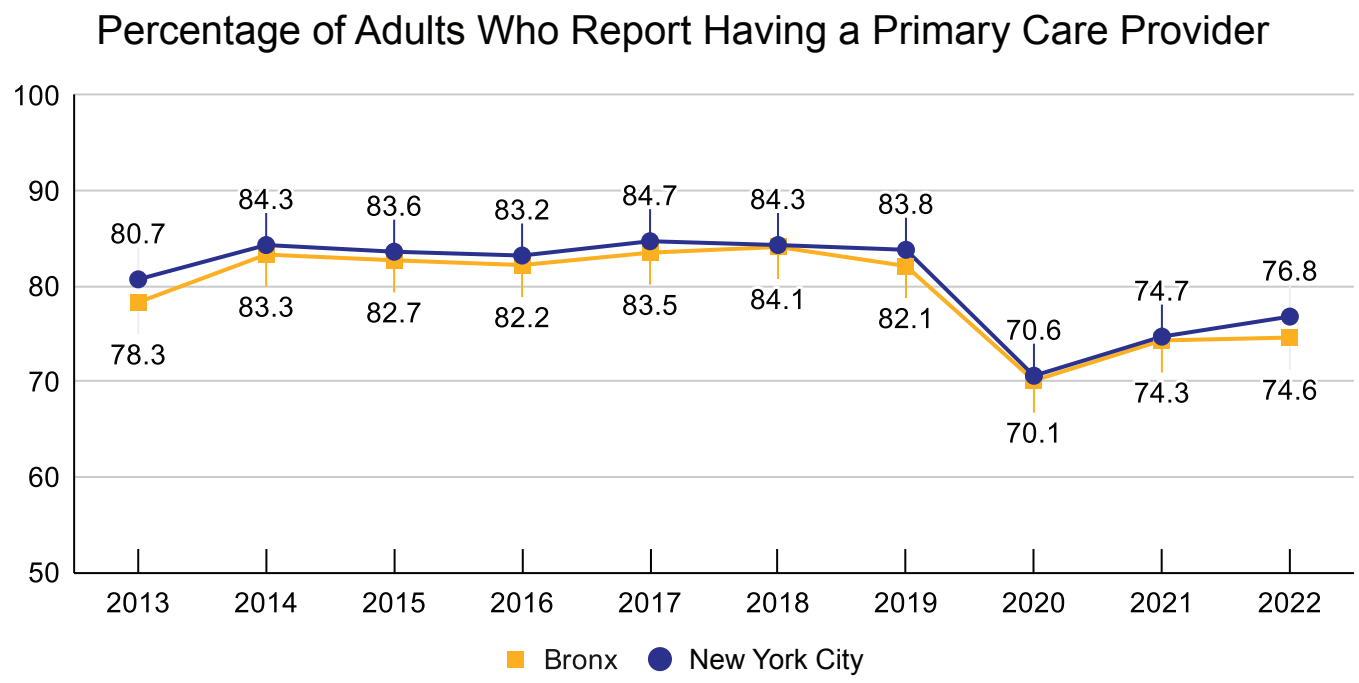


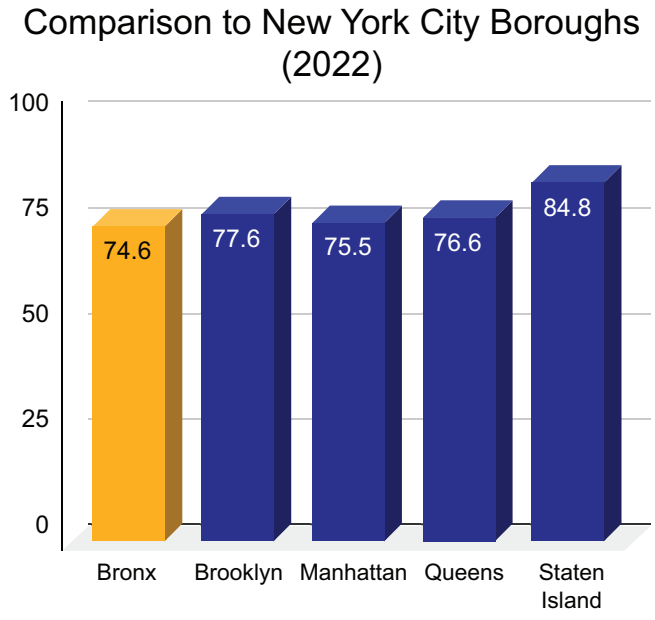


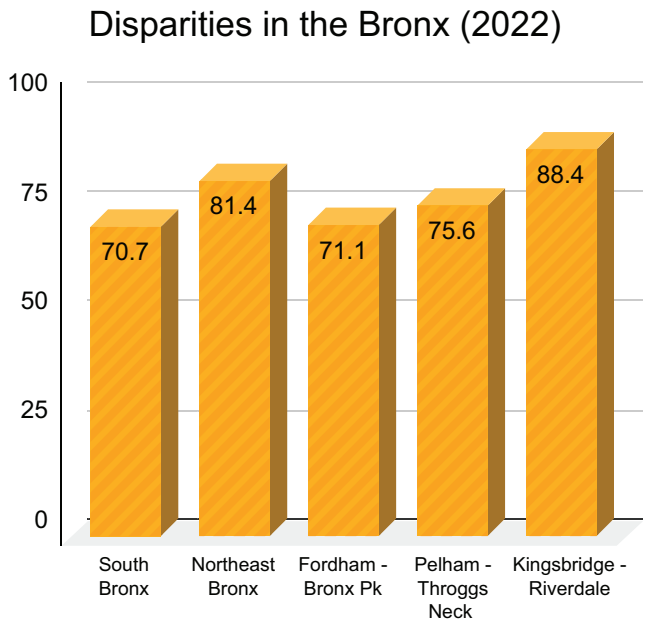
Data Source: New York City Department of Health and Mental Hygiene. Environment and Health Data Portal, 2022, County Health Rankings & Roadmaps Health Infrastructure Study, 2024

The Bronx ranks last compared to all New York City boroughs for adults with health insurance coverage. Bronx adults with health insurance are higher in the Kingsbridge-Riverdale and Northeast neighborhoods.

Figure 4



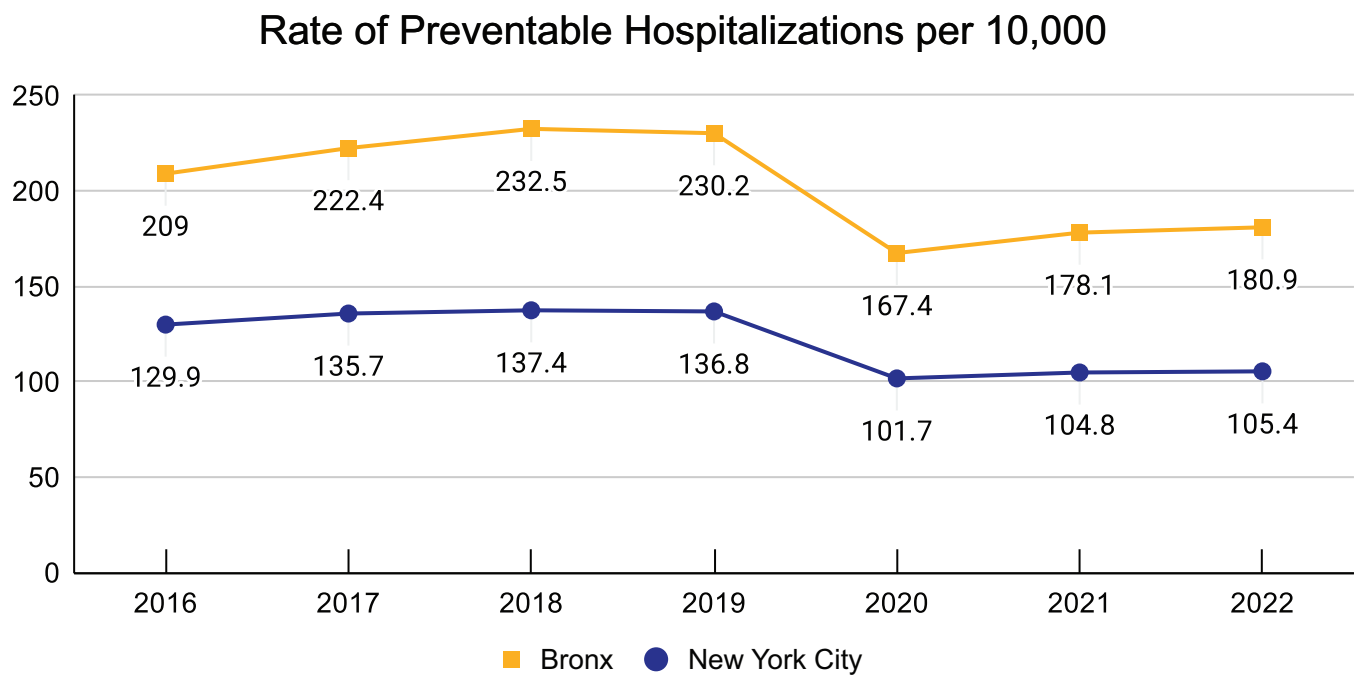


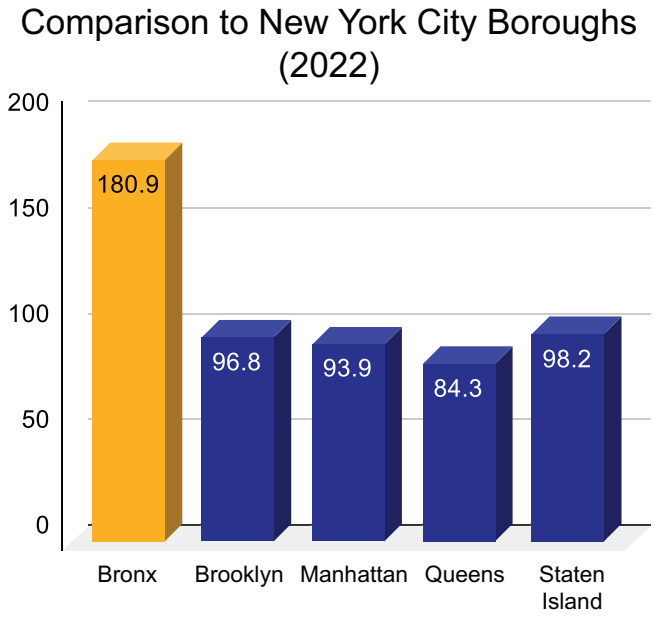


Data Source: New York City Department of Health and Mental Hygiene. Environment & Health Data Portal, 2022

The percentage of adults with a primary care provider has decreased across New York City. The Bronx has the lowest percentage compared to other boroughs, with the South Bronx being the lowest of Bronx areas.

Figure 5

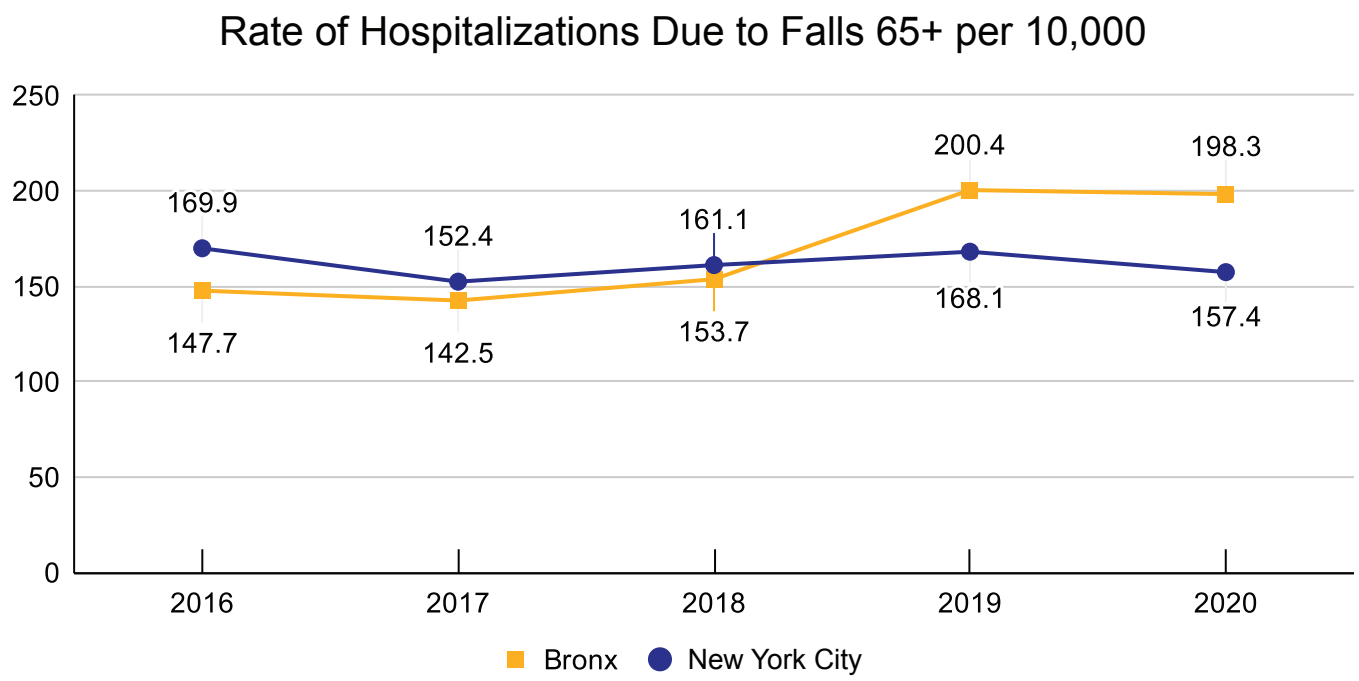


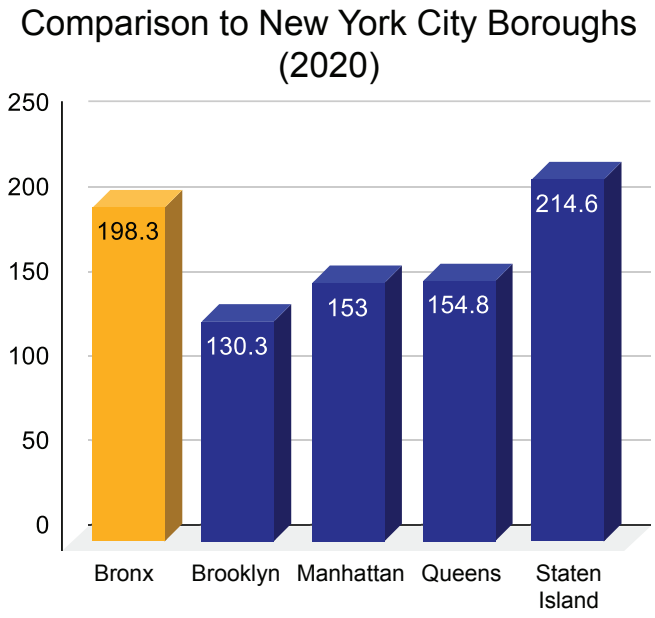


Data Source: [New York State Department of Health Prevention Agenda Dashboard, 2022]

The rate of preventable hospitalizations among adults has overall decreased before 2020. From 2020–2022 preventable hospitalizations increased and the Bronx has remained the highest across New York City.

Figure 6

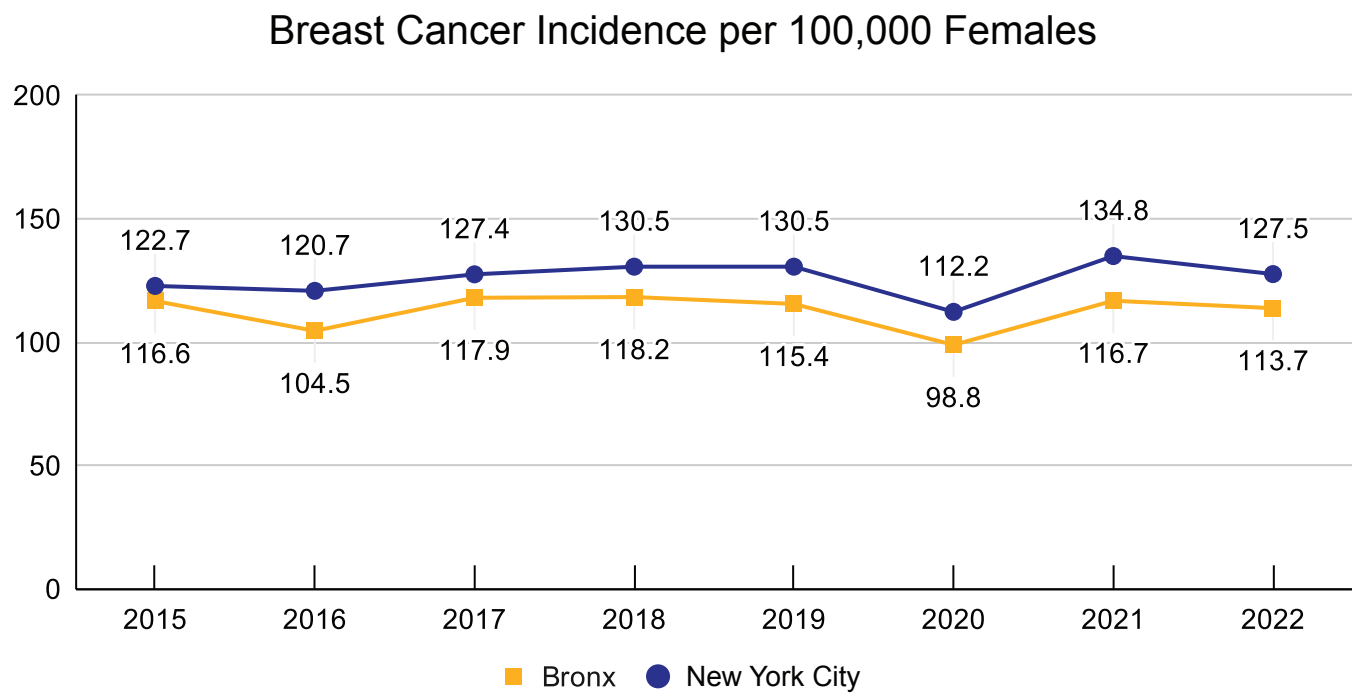


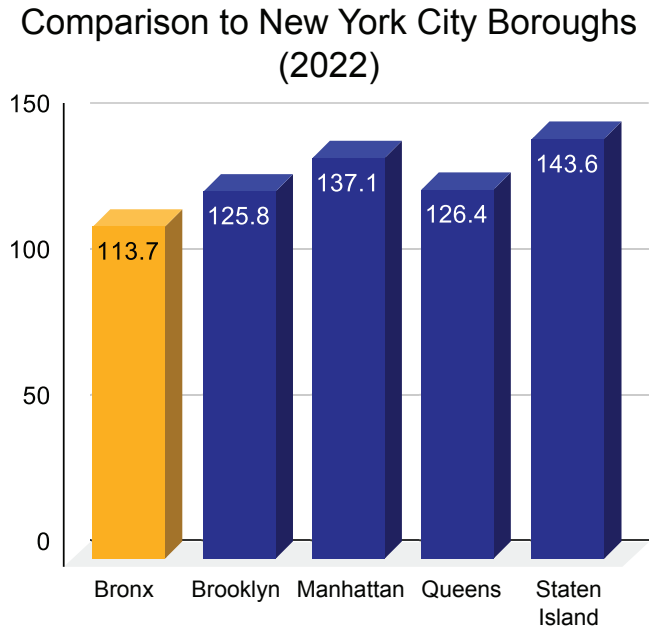


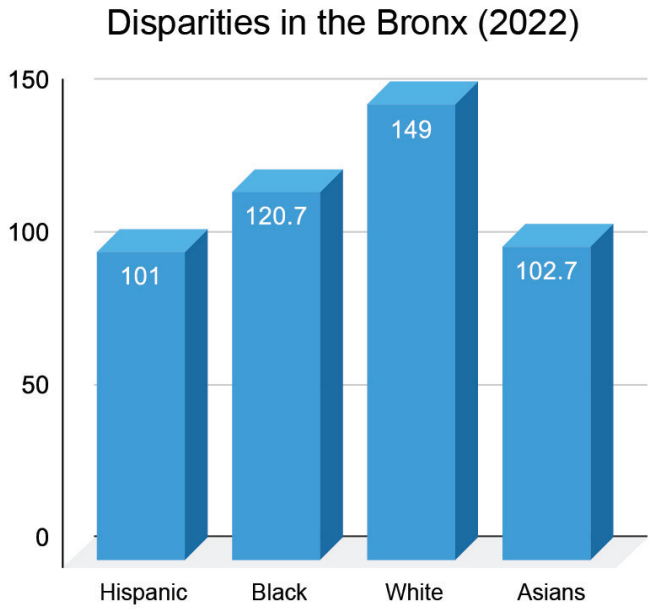
Data Source: New York State Department of Health Prevention Agenda Dashboard, 2020

The rates of hospitalizations due to falls have decreased from previous years but still remain relatively unchanged. In 2020, the Bronx came in second for the highest rates, behind Staten Island.

Figure 7



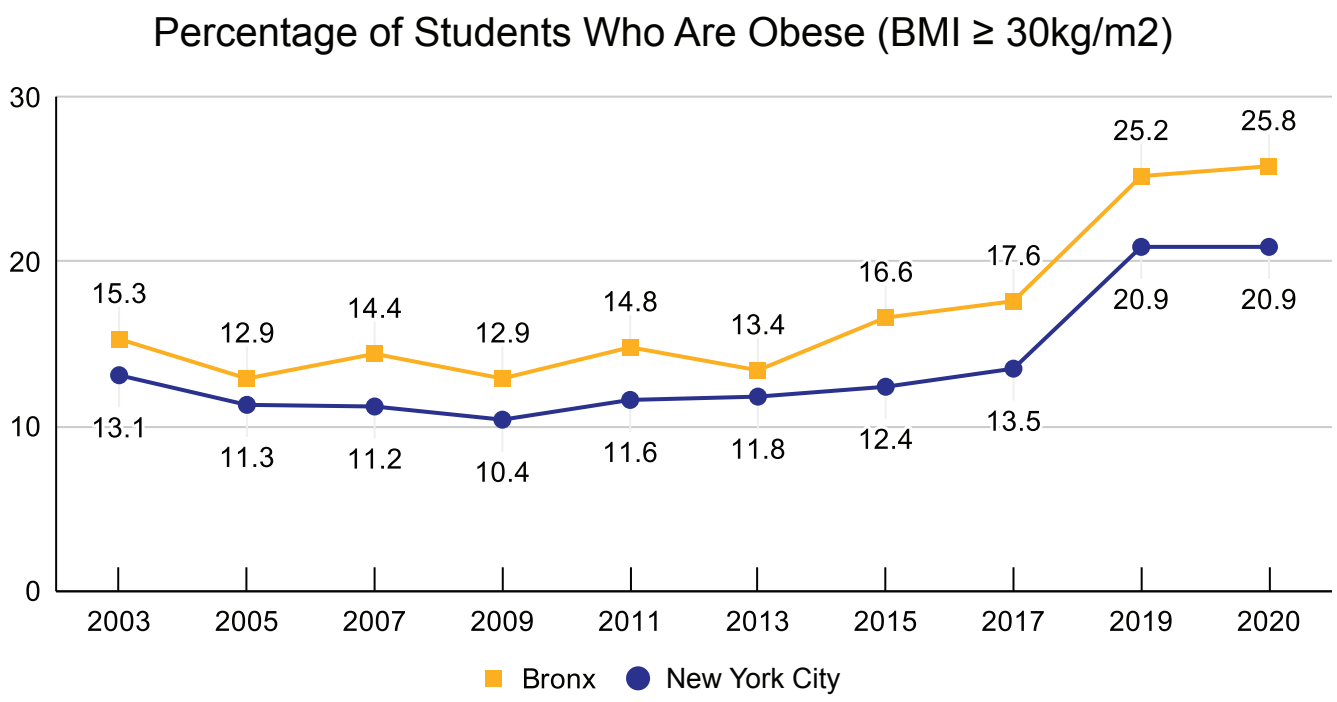


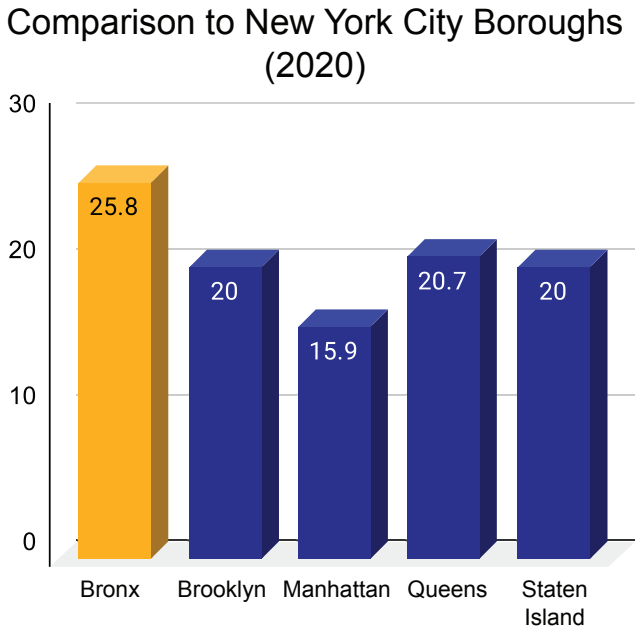


Data Source: New York State Department of Health Cancer Statistics Dashboard

Over the last decade, the incidence of breast cancer has remained relatively unchanged in the Bronx and New York City, 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 8

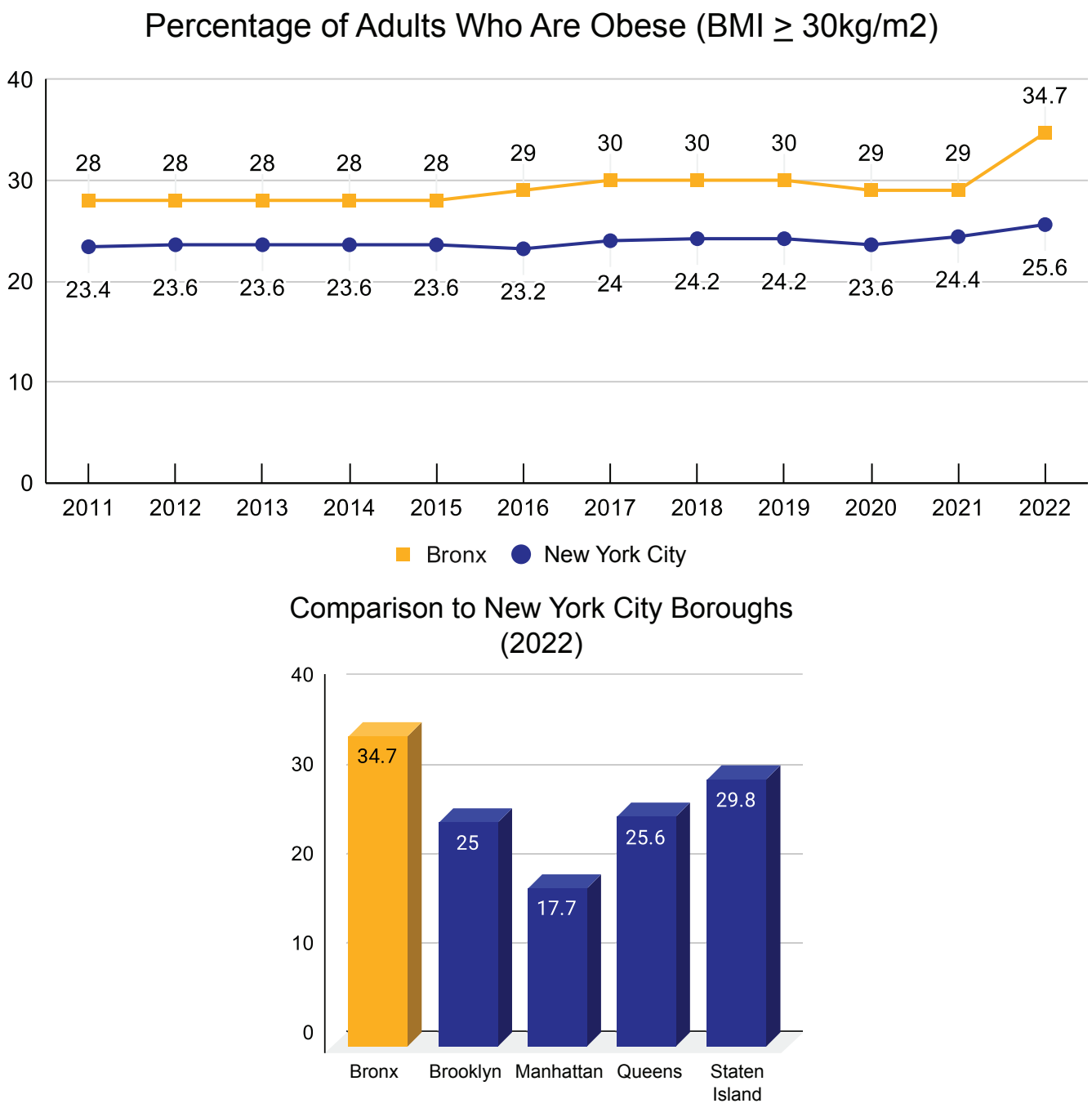




Data Source: New York State Prevention Agenda Tracking Dashboard, 2020

Overall, the percentage of obese students has increased across New York City since 2003. Compared to the other New York City broughs, the Bronx is the highest for student obesity and is higher than the New York City average percentage.

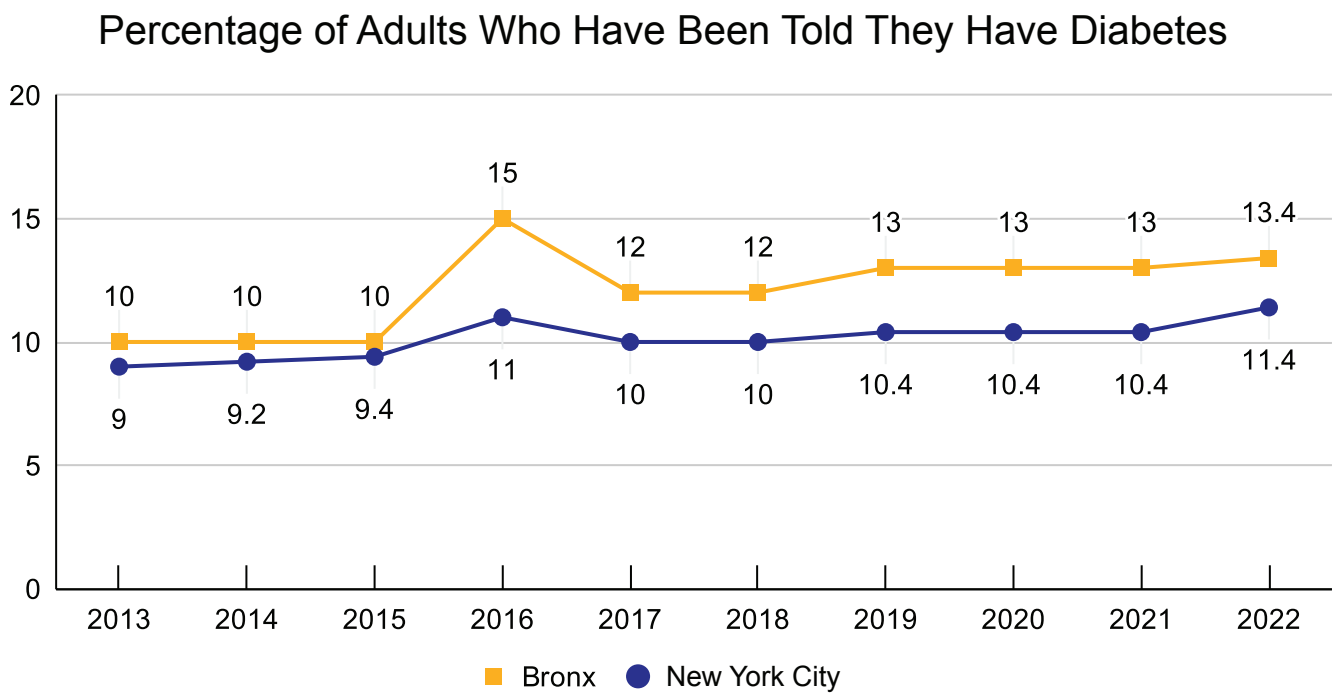
Figure 9

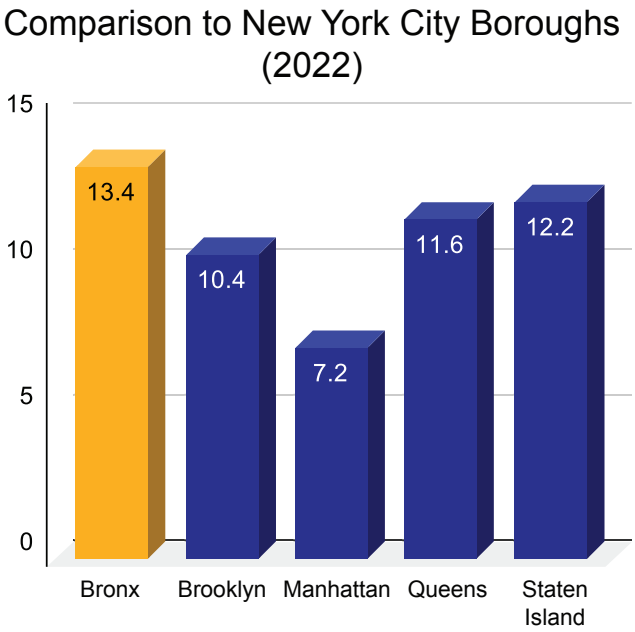


Data Source: New York State Community Health Indicator Dashboard, 2022

Over the last decade there has been an increase in the proportion of adults who are obese in the Bronx; it continues to remain the highest across New York City. For the Bronx, in just a year, from 2021–2022 adulthood obesity increased by 5.7%.

Figure 10

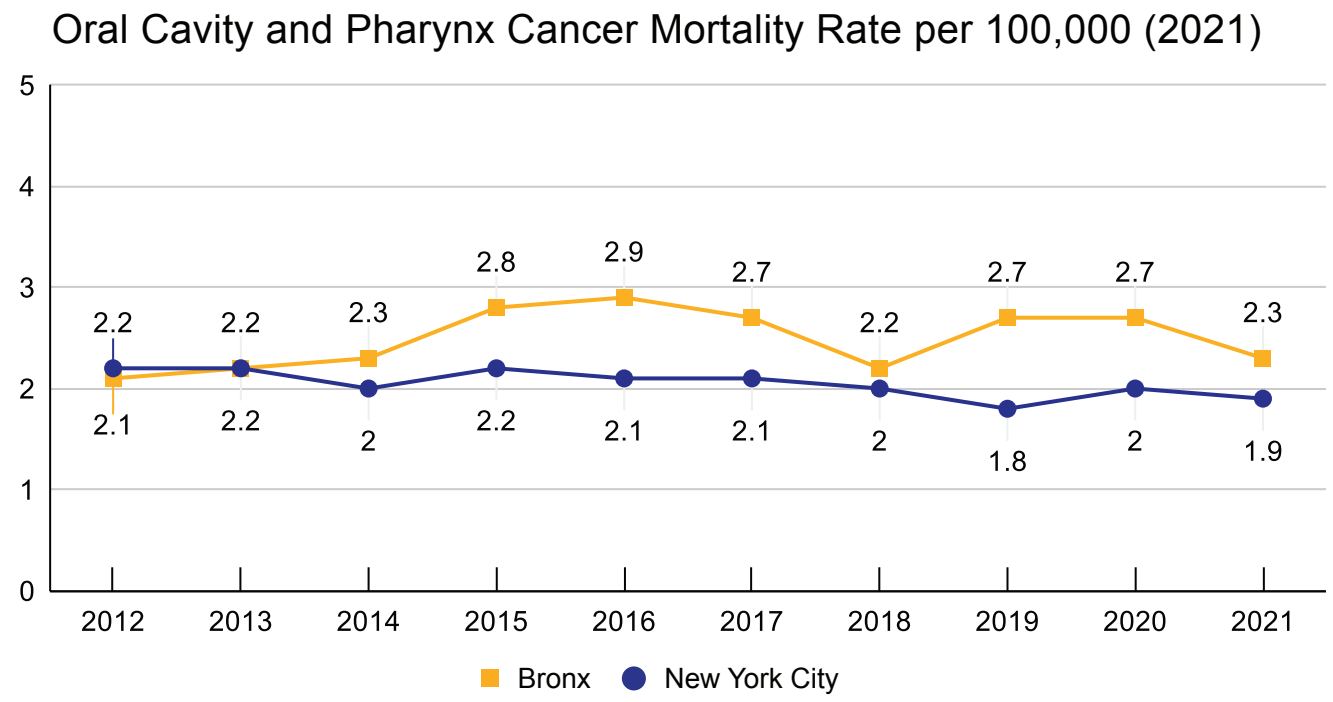


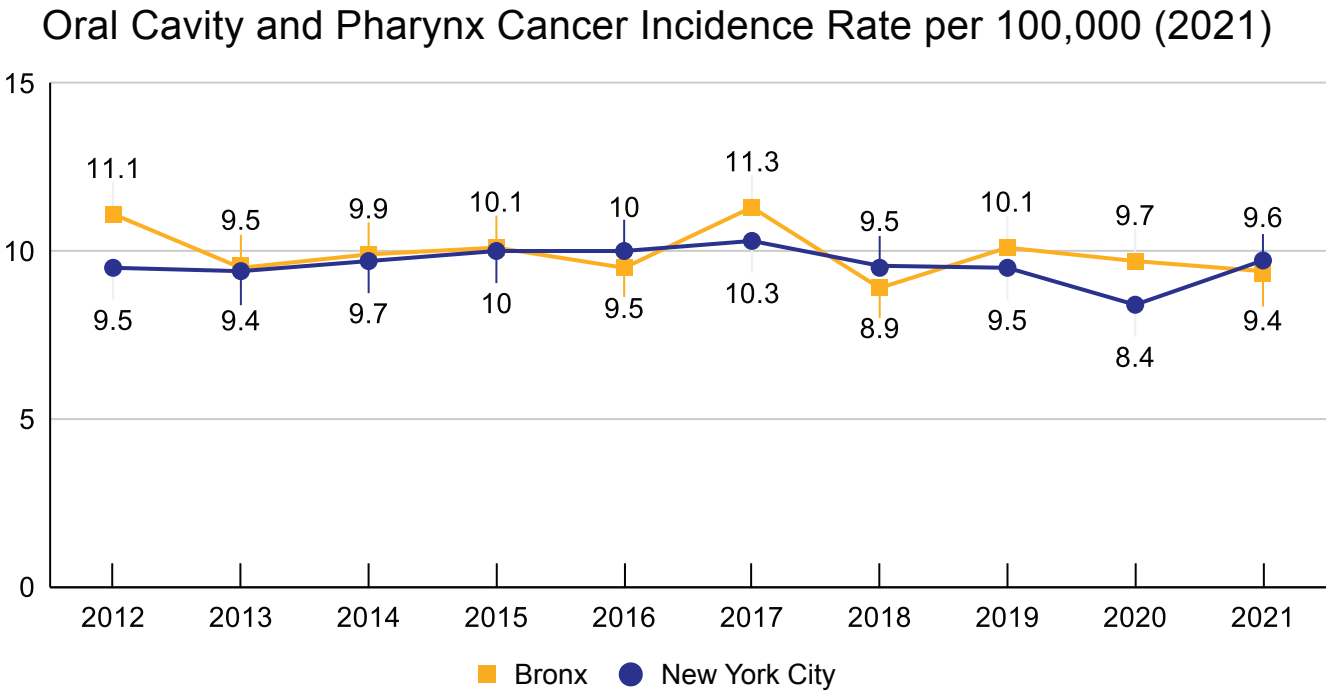


Data Source: New York State Community Health Indicator Reports Dashboard, 2022

Prevalence of diabetes in adults has continued to increase across New York City. While other boroughs like Manhattan and Brooklyn are lower than the New York City average, the Bronx is higher and remains the highest than another borough.

Figure 11

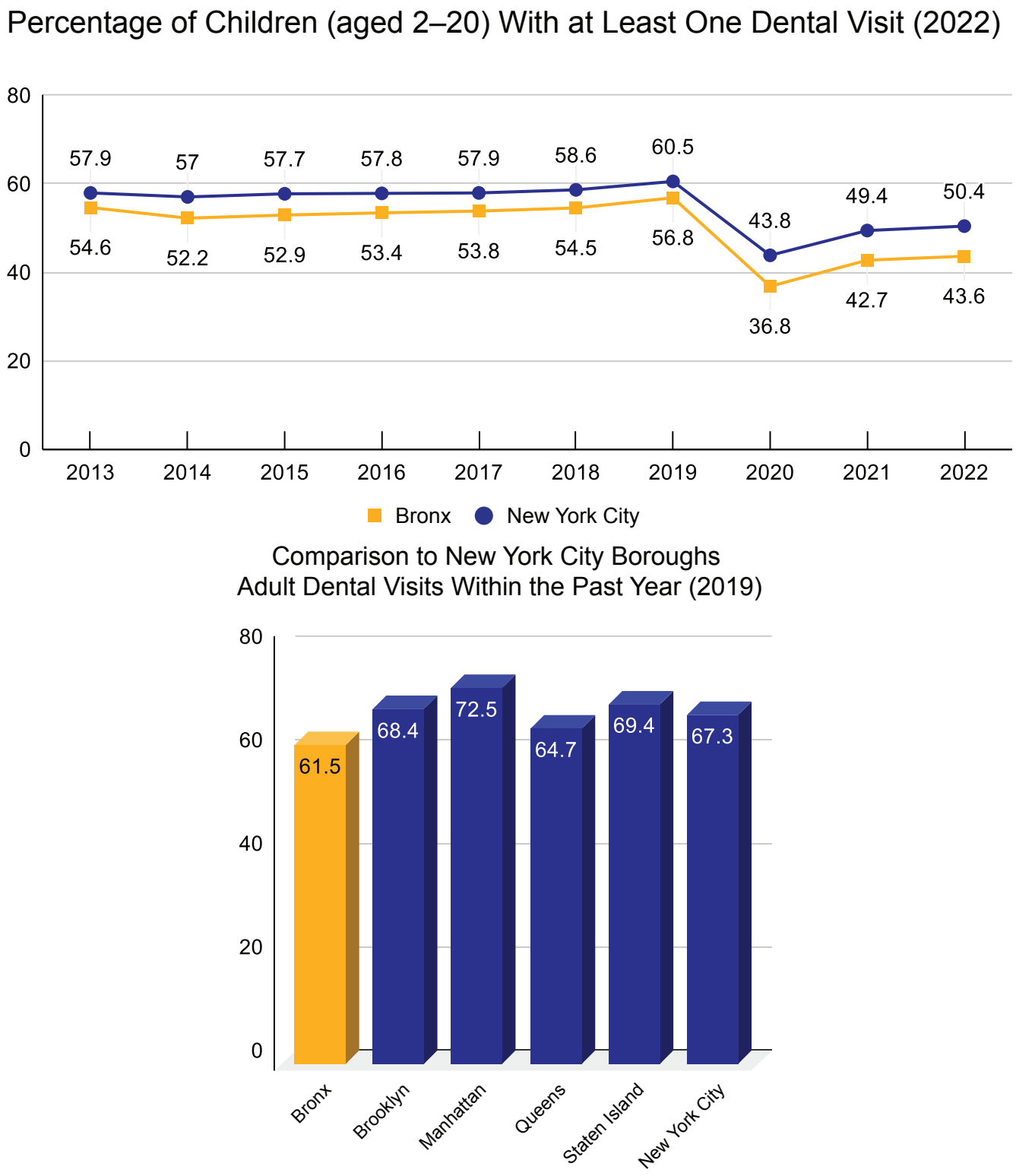




Data Source: New York State Community Health Indicator Reports

The Bronx is lower than the New York City average oral cancer mortality rate, and lower than the New York City average oral cancer incidence rate. Overall, the oral cancer mortality rate and oral cancer incidence rate have decreased.

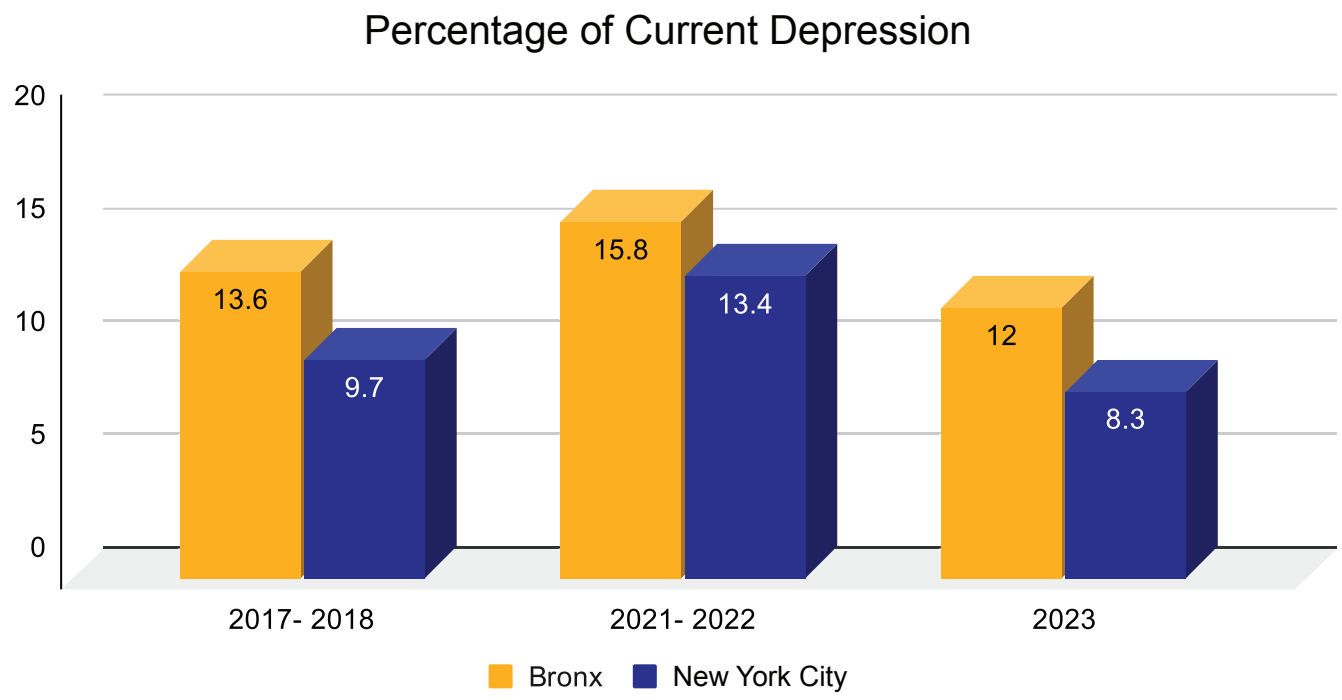
Figure 12

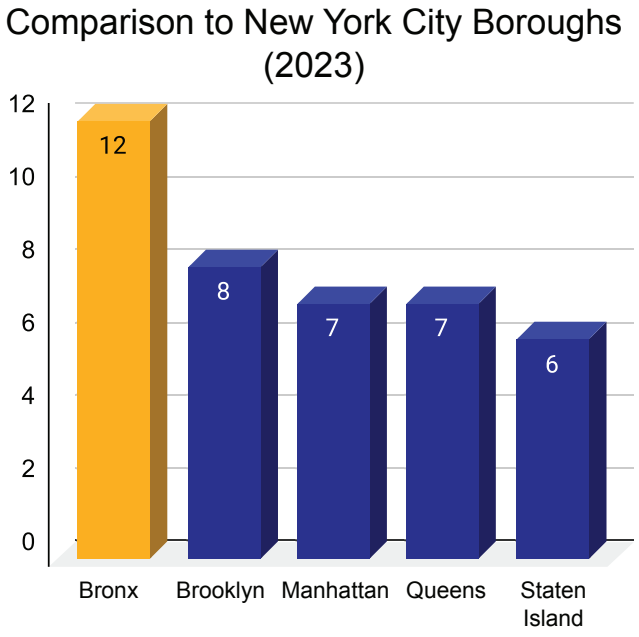


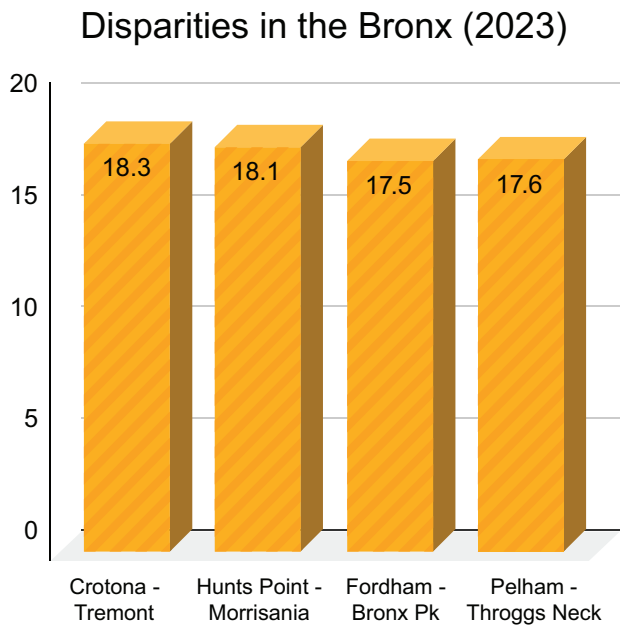
Data Source: New York State Community Health Indicator Reports

The percentage of adults who had a dentist visit within the past year is lowest in the Bronx than in any other borough, and lower than the New York City average for children who have had a dental visit in the past year.

Figure 13



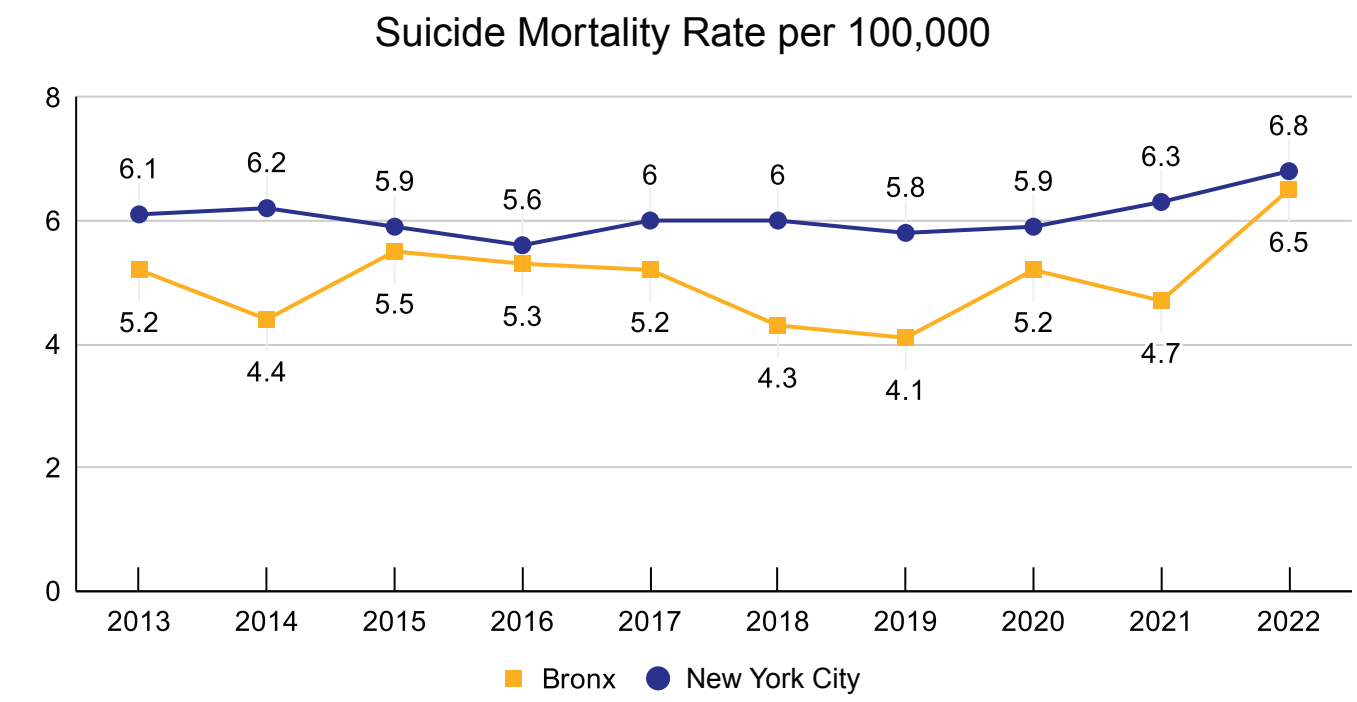


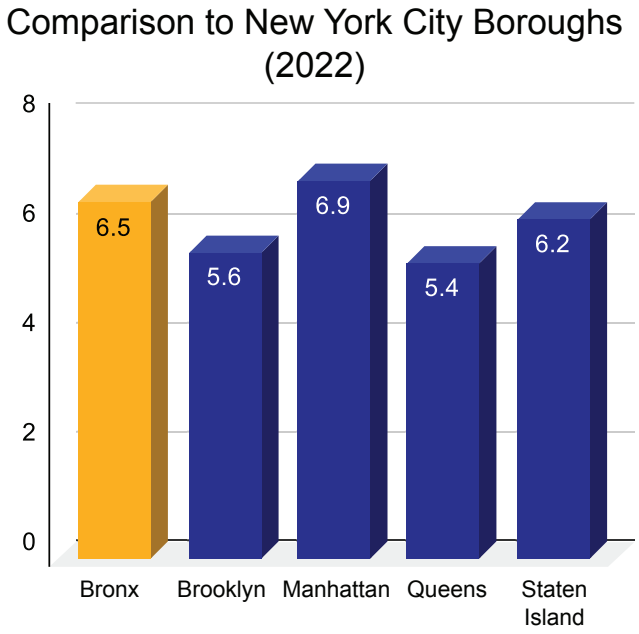


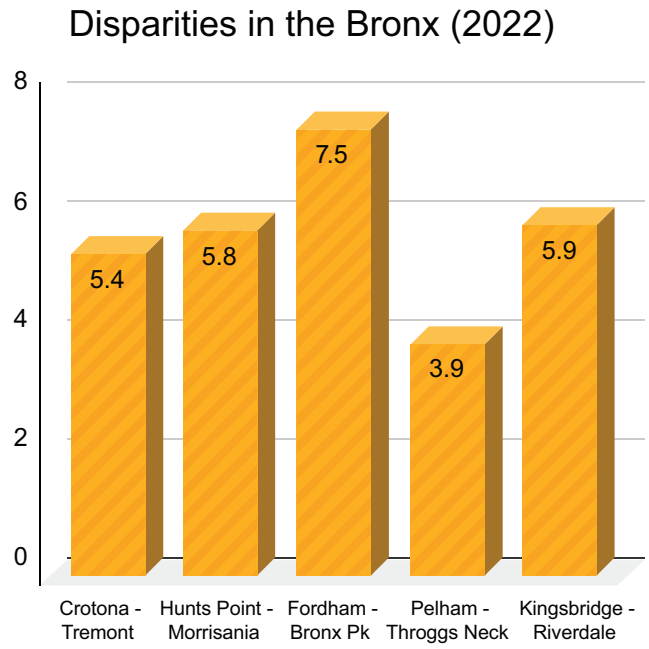
Data Sources: New York City Department of Health and Mental Hygiene. Environment and Health Data Portal, 2023
Depression in NYC People, 2024

From 2017–2023, the rate of adults with depression has decreased but the Bronx still is the highest in comparison to other New York City boroughs. While other boroughs are below the New York City average, the Bronx is above it with the SBH Health System service area having the highest prevalence.

Figure 14



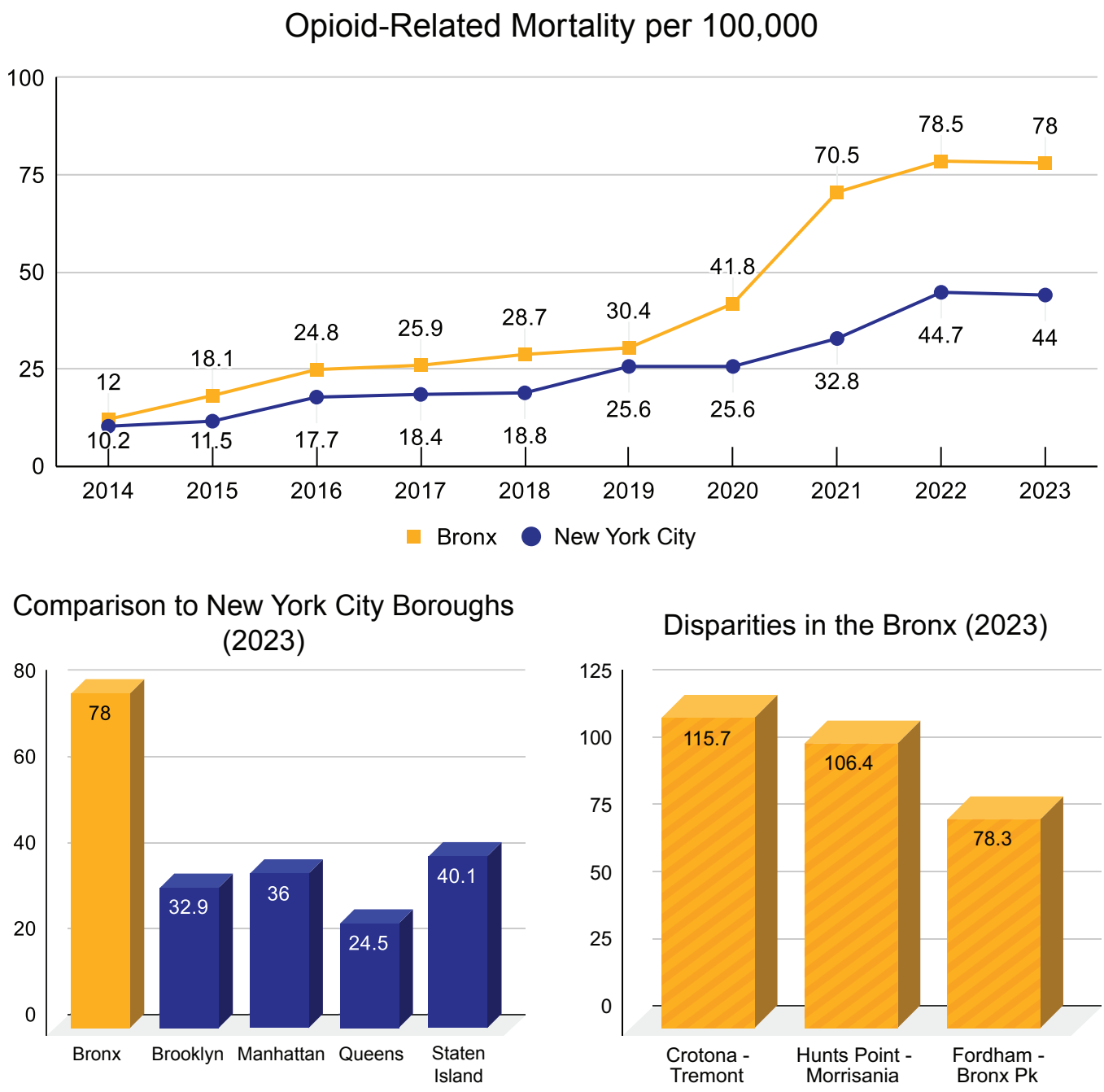




Data Source: New York City EpiBrief

The suicide mortality rate has increased in the Bronx in just a year from 2021–2022 but is still lower than the New York City average and places second highest across New York City following Manhattan. In the Bronx, the neighborhood with the highest percentage of suicide mortality is the Fordham-Bronx Pk area.

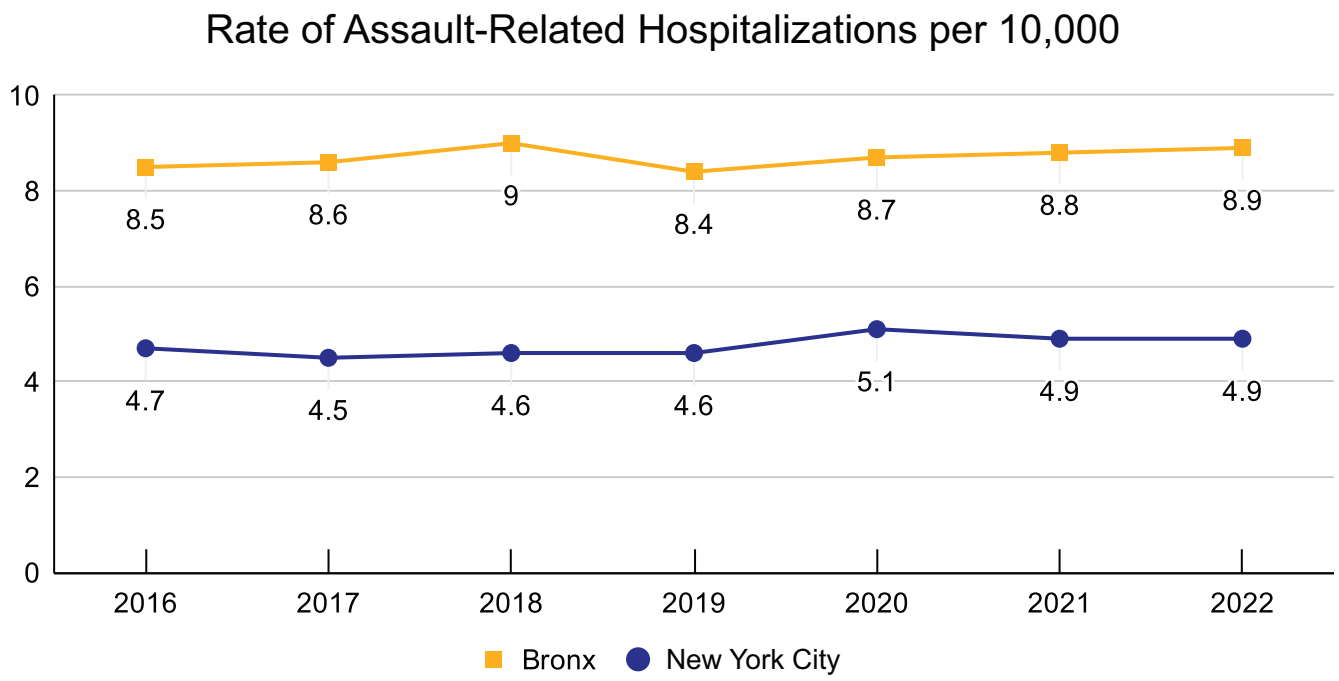
Figure 15

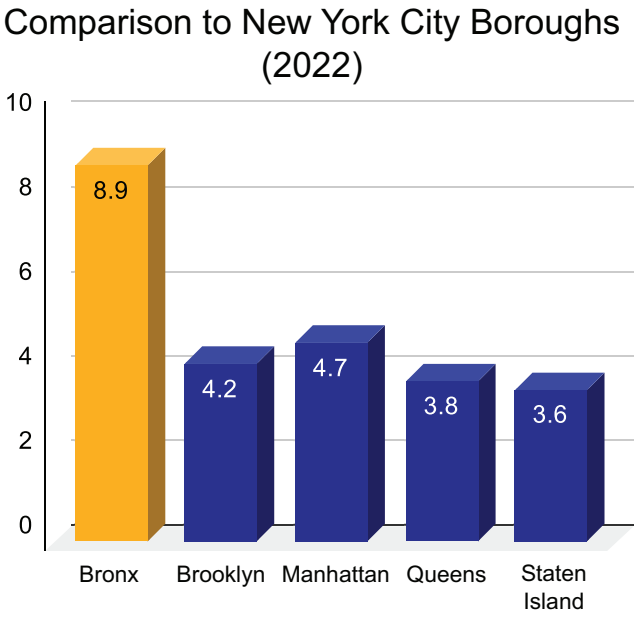


Data Source: New York City Department of Health, Epi Data Brief, 2023

Over the past decade, opioid-related mortality rates have increased in New York City, especially in the Bronx, which holds the highest rates than any other borough. Within the Bronx, the Crotona-Tremont area has the highest opioid mortality, with Hunts Point-Morrisania, and Fordham-Bronx Pk trailing behind.

Figure 16

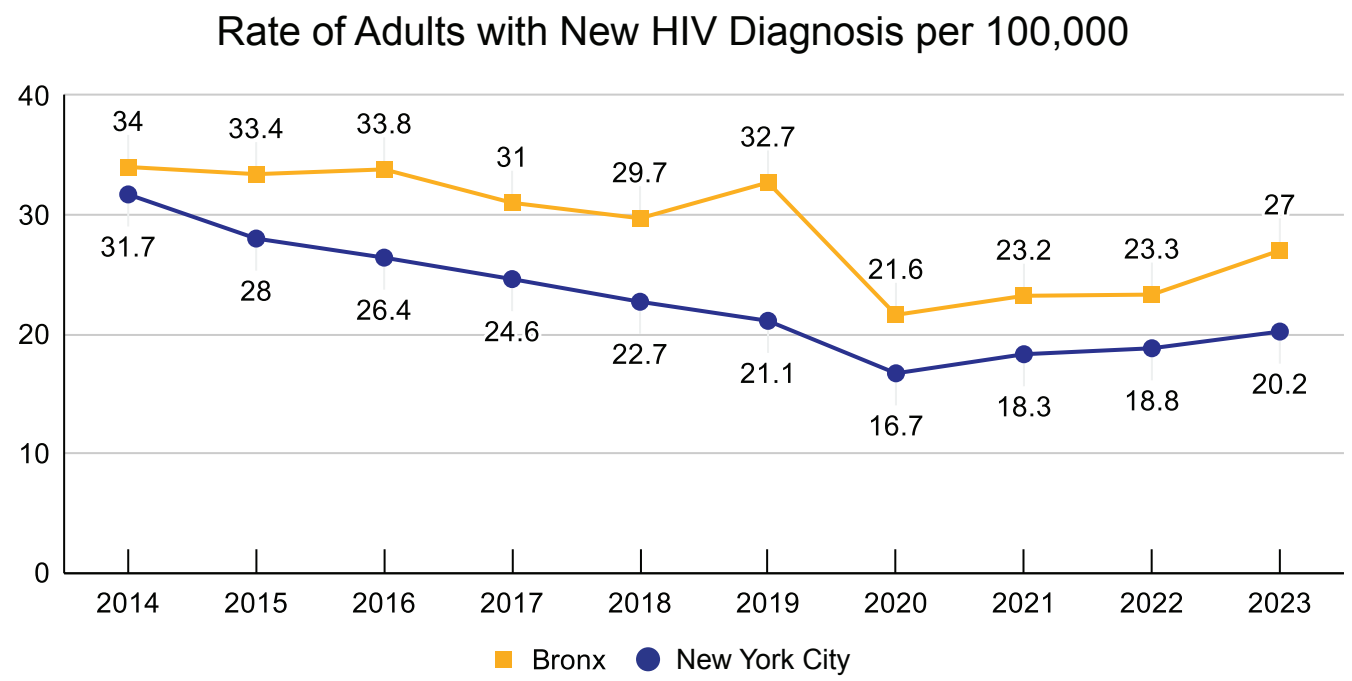


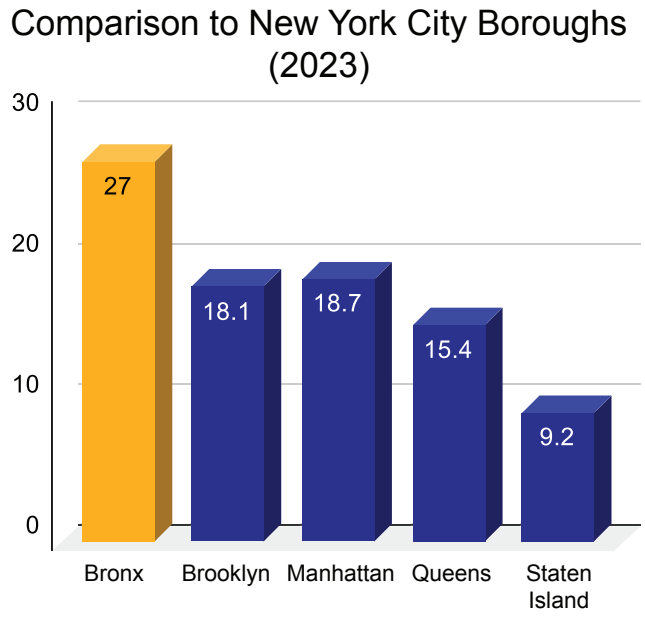


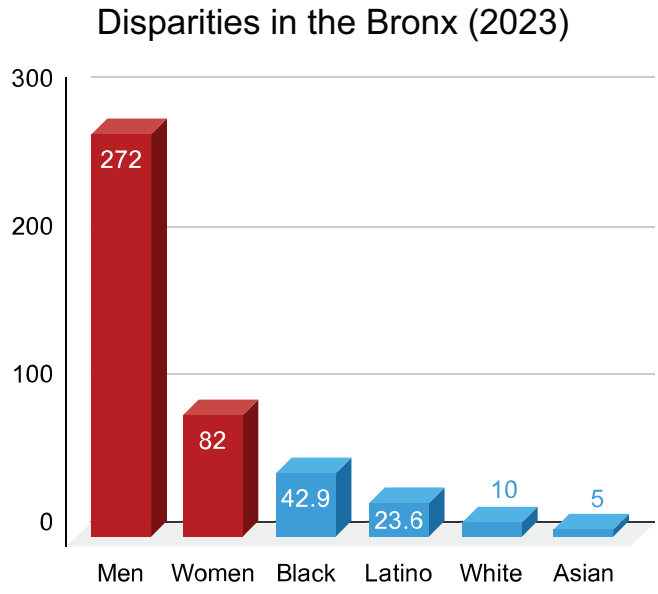
Data Source: New York State Department of Health Prevention Agenda Dashboard, 2020

The rate of assault-related hospitalizations has increased in the Bronx and New York City. The Bronx remains the highest compared to other boroughs; the rate is about two times higher among those who are Black compared to other populations.

Figure 17



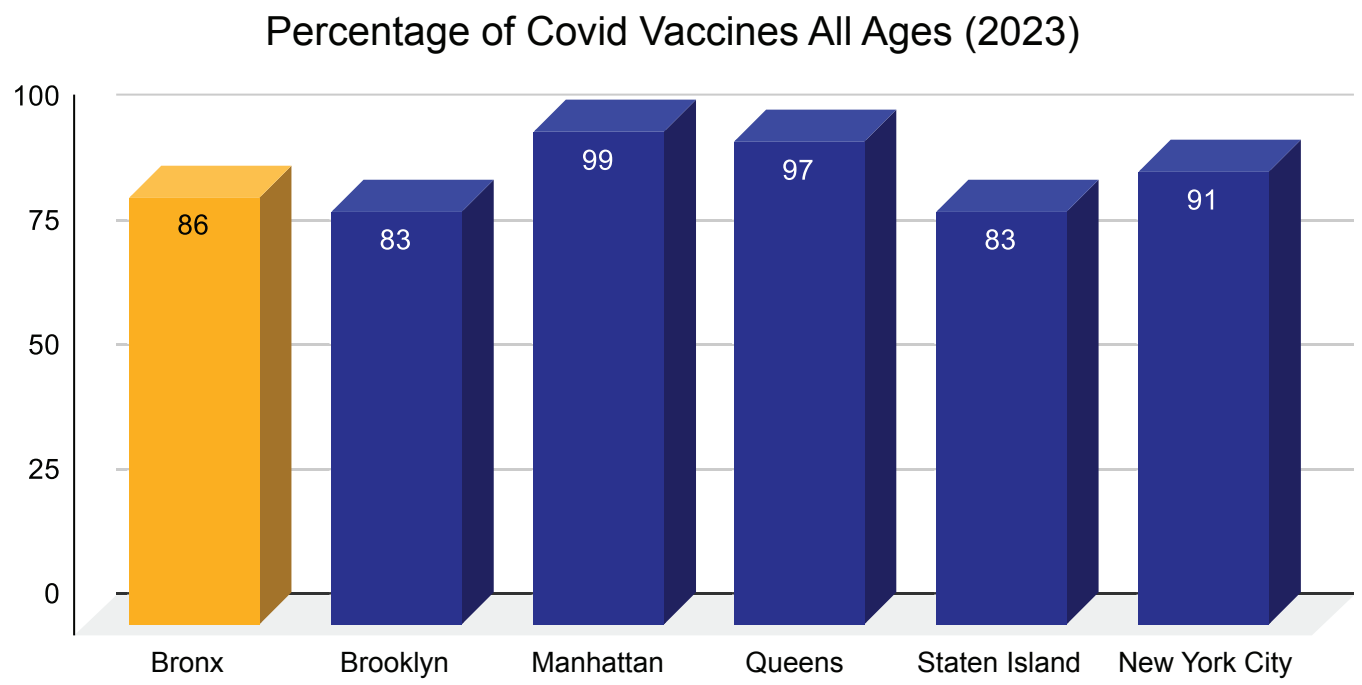


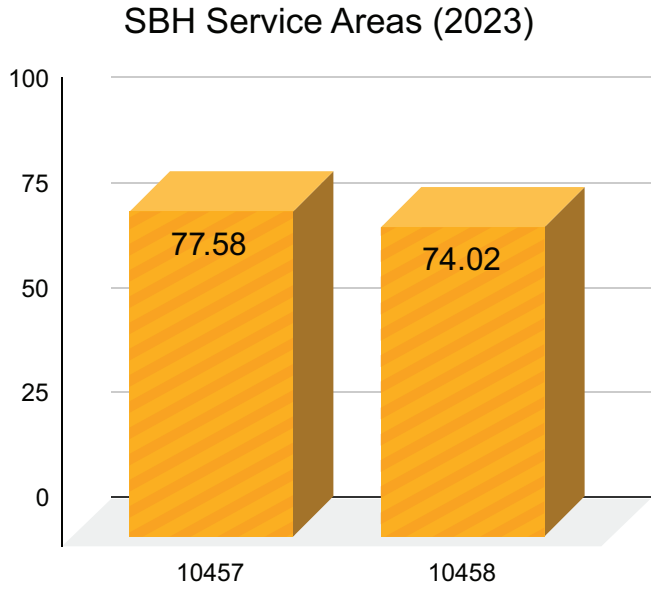


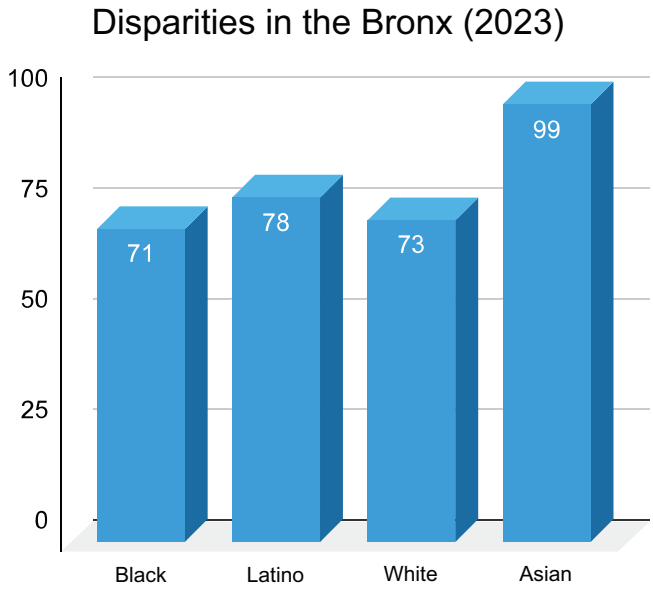
Data Source: New York City Department of Health and Mental Hygiene HIV Surveillance Annual Report, 2023

Diagnosis of HIV among adults has increased since 2019. The Bronx rate is higher than the New York City average, and rates higher than other boroughs. A higher number of men are diagnosed than women, and it is more common among the Black population, with the Latino following behind.

Figure 18



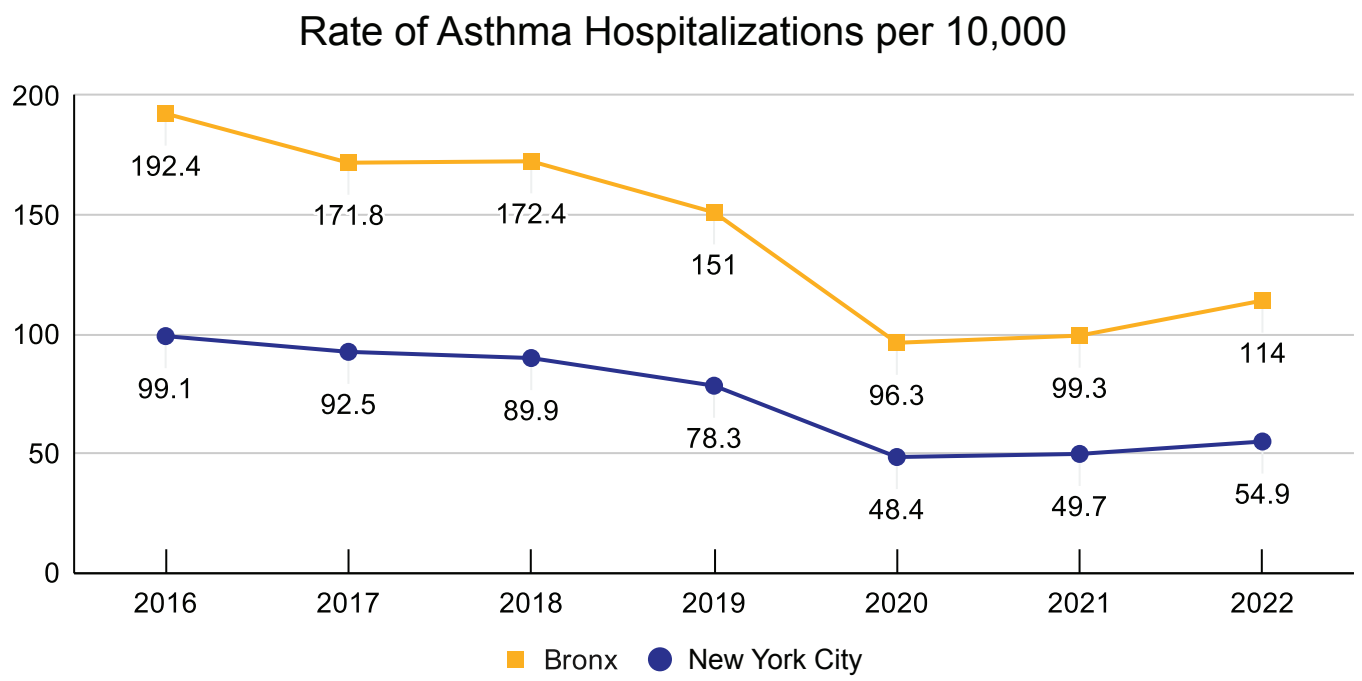


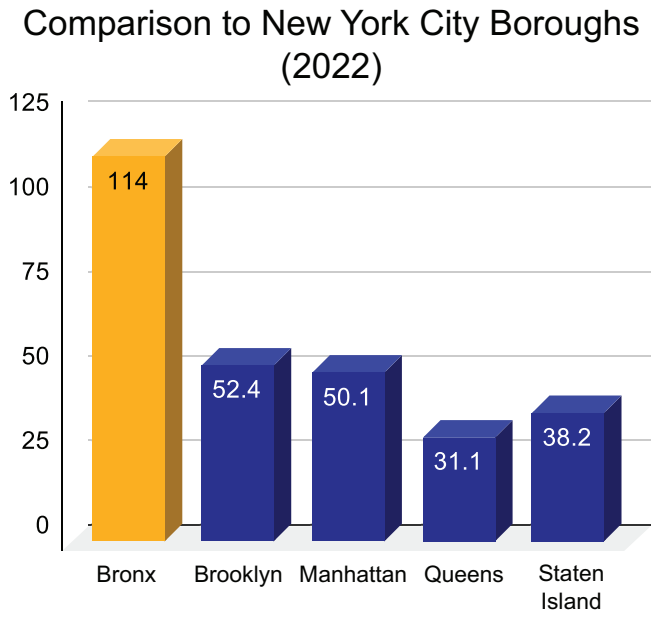


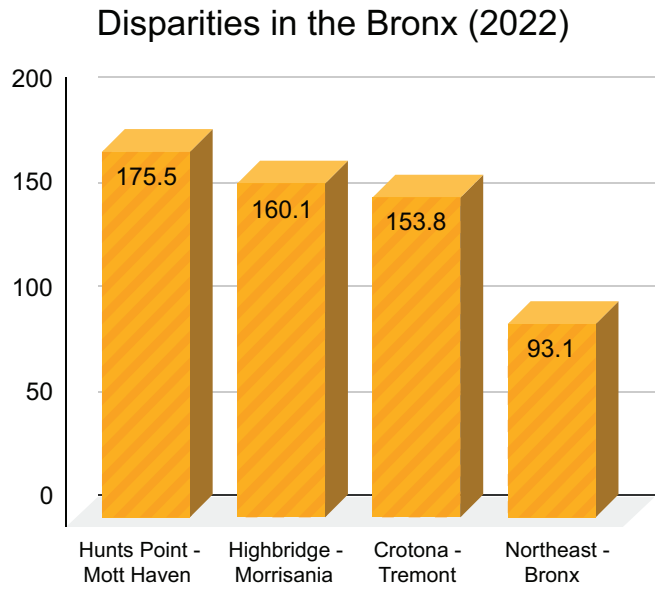
Data Source: New York City Department of Health and Mental Hygiene. COVID:19 Data

New York City rates 91% for residents with the Covid-19 vaccinations while the Bronx is at 86%. Covid-19 vaccinations are more common among the Asian population.

Figure 19



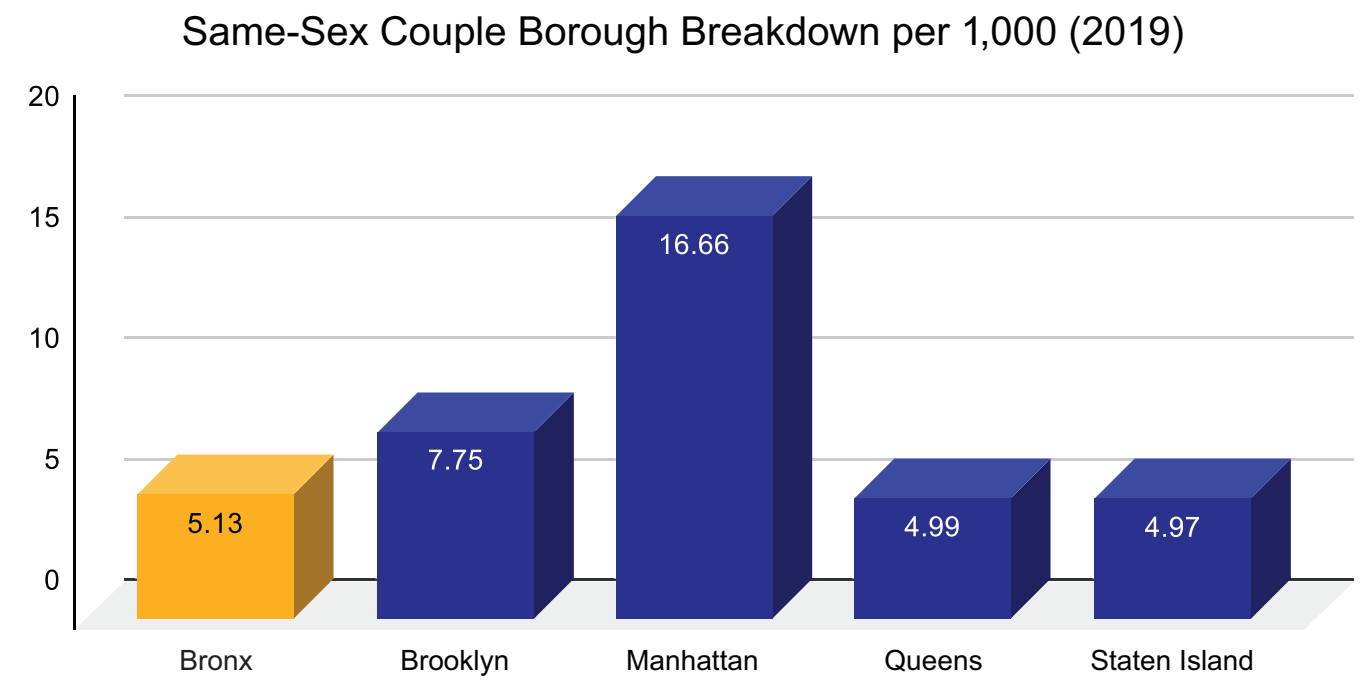


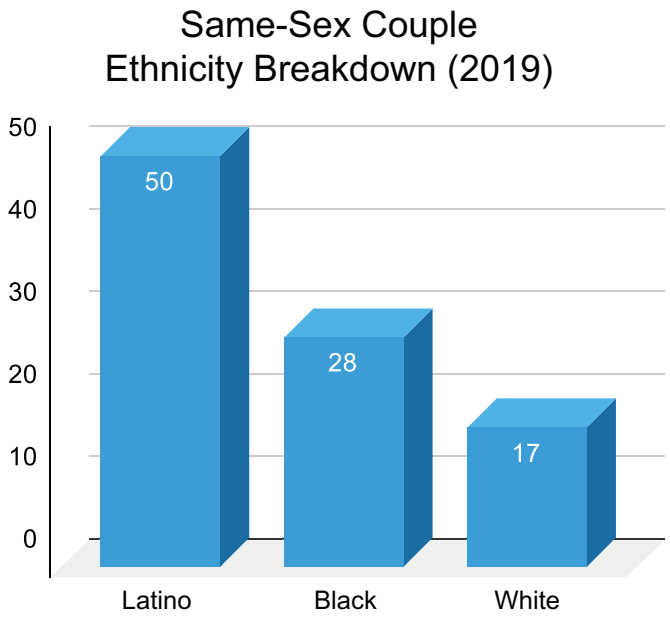


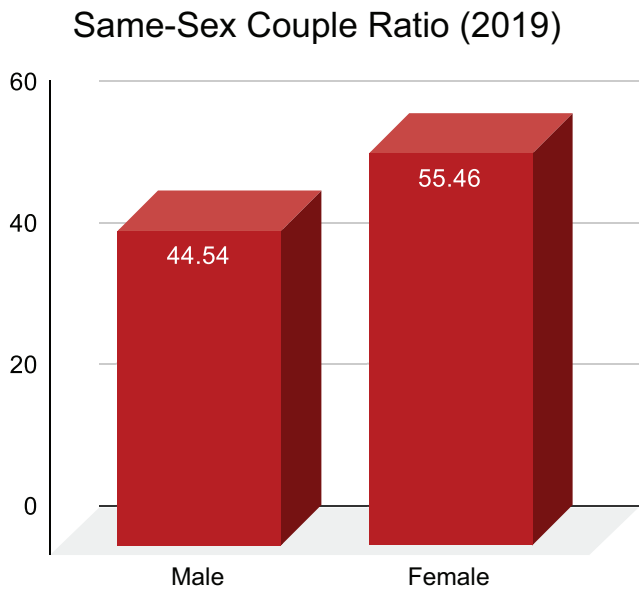
Data Source: New York City Department of Health and Mental Hygiene. Environment and Health Data Portal, 2022

The rate of asthma hospitalizations has increased since 2020, with the Bronx in the lead for the highest rate compared to the New York City average and other boroughs. In the Bronx, the Hunts Point-Mott Haven neighborhoods have the most asthma hospitalizations among adults.

Figure 20



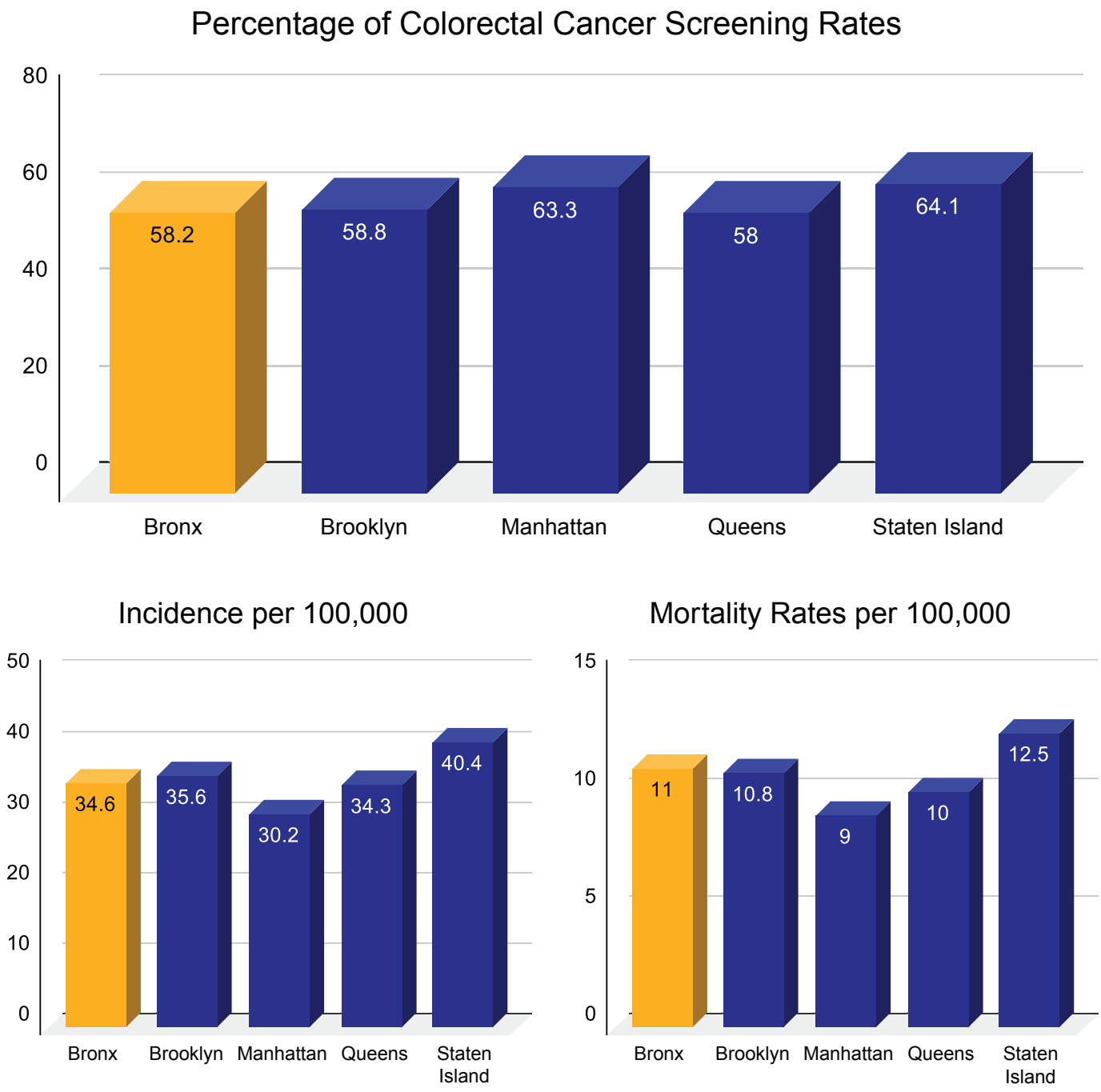




Data Source: UCLA School of Law, Williams Institute, 2019

The Bronx ranks third for the rate of same-sex couples compared to other New York City boroughs. Among this population, Latinos and Females in the Bronx are more common in same-sex couples.

Figure 21



Data Source: American Cancer Society, National Colorectal Cancer Roundtable Data Dashboard, 2024

This chart presents colorectal cancer screening rates in the Bronx in comparison to the entire New York City metropolitan area. It underscores the advancements in preventive care and emphasizes the imperative to broaden access and raise awareness to enhance early detection and mitigate disparities in cancer outcomes.

G. HEALTH CHALLENGES AND ASSOCIATED RISK FACTORS

1. National Indicators:

Medically Underserved Area and Healthcare Provider Shortage Area

Due to various economic and social drivers of health, the Bronx has a long history as a medically designated underserved area or 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 geographic area, a group of neighboring counties, or a group of urban 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 with a shortage of health professionals.

There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). HPSAs are designated using several criteria, including population-to-clinician ratios, percent of population below 100% of the federal poverty level, and travel time to nearest source of care outside a HPSA area. 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 population of more than 900,000 or more than 60% of the county population (See Figure 1). In addition, the Bronx has seven Medicaid Primary Care Health Professional Shortages Areas (HPSA) designated neighborhoods (Pelham, Crotona, Northeast Bronx, High Bridge, Fordham, Hunts Point, Riverdale), which cover 93.7% of the county population (See Figure 2). 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.

The Bronx Community District #6 (Belmont/East Tremont) is designated as a medically underserved area and a Health Professional Shortage Area by the Health Resources and Services Administration (HRSA). This designation indicates a shortage of primary care providers relative to the population's needs. Belmont/East Tremont has a lower ratio of primary care physicians to residents compared to citywide averages, limiting prompt access to care.

2. Contributing Causes of Health Challenges:

Top 10 Vulnerable Counties (SVI composite score)

The Center for Disease Control (CDC) Social Vulnerability Index (SVI) is a tool designed to assess and measure the social vulnerability of communities. SVI considers a variety of socioeconomic and demographic factors that can influence a community's ability to prepare for, respond to, and recover from a disaster. Factors include poverty rates, income, employment status, levels of education, housing quality, access to transportation, minority status and English proficiency, age, individuals with disabilities, access to healthcare, and overall community resilience. The CDC lists the 10 most socially vulnerable counties using the SVI score. The Bronx scored the highest at-risk county in New York State. As of 2024, the Bronx is 16.3% of the New York City population and 7% of New York State population. Yet, it scored number one at risk county in New York State.

National indicators highlight contributing factors that undermine the health and well-being of Bronx residents. The Bronx experiences some of the most persistent health challenges in New York City, driven by a combination of long-standing systemic issues and current conditions.

The Bronx has the lowest levels of socioeconomic status, health, and education in New York City, along with diminished access to healthy and nutritious foods, thus standing for the poorest economic determinants of health. Safety net hospitals, like SBH Health System, are at the forefront of efforts to end health disparities and improve health outcomes.

Contributing factors to health challenges for Bronx residents, documented in the secondary data are:

Socioeconomic Inequities:

- Extreme poverty rates → Limited access to healthy food, safe housing, and preventive health care.
- Lower income and employment opportunities → Increased stress, reduced ability to afford medical care, and higher exposure to hazardous jobs.

Housing & Environmental Conditions:

- Old, poorly maintained housing stock → Higher rates of asthma from mold, pests, and poor ventilation.
- Lack of affordable housing → High percentage of unhoused individuals and families, severely rent burdened
- Proximity to highways and industrial sites → High air pollution, linked to respiratory and cardiovascular disease.
- Crowded living conditions → Easier spread of infectious diseases.

Food Insecurity & Nutrition Gaps:

- Limited healthy food outlets ("food deserts" and "food swamps" with many fast-food and convenience stores).
- Prohibitive cost of fresh produce → Diets high in processed, calorie-dense foods, increasing obesity and diabetes risk.

Chronic Stress & Safety Concerns:

- Community violence and crime exposure → Chronic stress, PTSD, and injury risk.
- Economic instability → Mental health strain, which can worsen physical health.

Education & Health Literacy:

- Lower educational attainment → Less access to high-paying jobs and fewer resources for healthy living.
- Limited health literacy → Difficulty navigating complex health systems.

Behavioral Risks:

- Substance use challenges including opioids and alcohol → Opioid related mortality per 100,000 Bronx is 87, New York City is 44
- Depression → Bronx is 12%, New York City is 8.3%

In the 2023 New York City Resident Survey, Bronx residents consistently scored quality-of-life issues below the overall rate compared to other boroughs. While 50% of New Yorkers viewed their neighborhood positively as a place to love, only 36.2% of Bronx residents shared this view. Similarly, the citywide rate for reporting a positive quality of life was 61.8%, while the Bronx reported only 45%.

Improving the patient's experience is critically important in healthcare because it directly influences health outcomes, trust in the system, and overall care quality. Patients who feel respected, heard and informed are more likely to follow medical advice, take medications correctly, and attend follow-up visits. This results in fewer complications, hospital readmissions, and emergency visits.

At SBH Health System, the Patient Experience Officer coordinates efforts to incorporate patient feedback into services to drive continuous organizational improvements. The SBH Executive Quality Assurance and Performance Improvement Committee (QAPI) reviews and evaluates the appropriateness and quality of clinical care with a focus on reducing disparities in access, quality and treatment outcomes.

The information gathered through patient feedback has been integrated into the health needs assessment process. This firsthand commentary offered added mechanisms to ensure both patients' perspectives are considered when evaluating the quality of current services and in shaping proposed changes in the 2025 community service plan.

3. Health Disparities:

Health disparities are differences in health outcomes and access to health care among groups of people, often linked to social, economic, and environmental disadvantages. These inequities are unfair, preventable and rooted in systemic factors rather than just individual choices.

In the prior sections, data highlighted measurable health disparities, such as higher rates of asthma in some neighborhoods compared to others. On average, Bronx residents have a life expectancy 7–10 years shorter than people living in wealthier parts of New York City. These disparities reflect patterns of inequality tied to race/ethnicity, income, education level, gender, geography, or disability status.

Health disparities in the Bronx are largely driven by social drivers of health (SDoH). Residents are disproportionately affected by factors such as limited financial resources, inadequate access to healthy foods, unsafe unaffordable housing, utility instability, and transportation barriers. These conditions contribute to significant differences in outcomes, including disease severity, life expectancy and infant mortality. Individuals facing poor social and economic circumstances often experience worse health from birth and throughout their lives, and these challenges remain widespread across the Bronx population.

SBH has been screening several social drivers of health (SDoH) for several years. For each SDoH selected for screening, SBH ensures the availability of an appropriate referral or resource to address the identified need. In 2024, SBH implemented the Centers for Medicare & Medicaid Services (CMS) screening requirements into practice for five CMS domains: food insecurity, housing stability, transportation needs, utility difficulties, and interpersonal safety. SBH has begun screenings required by the CMS Medicaid Section 1115 waiver, using the Accountable Health Communities Health-Related Social Needs Screening Tool.

In 2024, the percentage of screened eligible patients was 19.68%. Positive rates were:

Housing Stability: 26.25%
Interpersonal Safety: 18.9%
Food Insecurity: 18.5%
Transportaion Needs: 11.5%
Utility Difficulties: 8.5%

Housing Stability

Bronx Community District #6, the primary service area for SBH Health System, is characterized by a housing stock that includes a considerable number of rent-stabilized and project-based Section 8 housing. According to data from the NYU Furman Center, the district has elevated levels of Section 8 enrollment, substantial SNAP benefit usage, and a large rent-burdened population.

The Bronx has the largest share of renters in any county in New York State; more than 80% of Bronx households rent their apartments. Nearly 12% of all renters in New York State are in the Bronx, despite the county having fewer than 7% of the state's households. As of 2022, in the Belmont/East Tremont, the change in median household income outpaced the change in median gross rent by 6.7 percentage points. In 2022, 36.7% of renter households in Belmont/East Tremont were severely rent burdened (spent more than 50% of household income on rent). 90.7% of the rental units were affordable at 80% Area Median Income, 5 percentage points higher than the share in 2010.

The Bronx, historically New York City's most affordable borough, has faced mounting housing pressures. Between 2006 and 2022, median gross rent in Belmont/East Tremont rose 14.6%, and by 2024, borough-wide rent had surged 49%. Housing quality is also a concern. 39% of Bronx occupied units reported one or two problems and 26% reported three or more problems, the highest rates in the city. Overall, 39% of residents experience severe housing problems, compared to 23% citywide, underscoring the Bronx's disproportionate housing challenges.

According to the 2025 report "Breakdown by Buyer Type, Financing and Ownership", 40% of the Bronx homebuyers paid cash, compared to 44% citywide. The Bronx also had the lowest share of mortgage financed purchased in New York City. In the Bronx, homes purchased with a mortgage sold for a median price of $377,000, while cash purchases had a lower median price of $277,000.

In the Bronx, eight neighborhoods passed the 50% cash mark, mostly in areas with median prices below $300,000 suggesting a mix of investor buyers, distressed sales, and limited mortgage access. In certain areas of the Bronx, Limited Liability Corporation (LLC) are being used for bulk buying, flips or distressed acquisitions capitalizing on low entry process as the neighborhood shifts into gentrification.

In 2022, the homeownership rate in Belmont/East Tremont was 5.1%, which is lower than the citywide share of 32.7%. The homeownership rate in the neighborhood has decreased by 2.3 percentage points since 2010. In Bronx Community District #6, 32% of renter-occupied homes are adequately kept, in contrast to 52% rate for New York City.

Interpersonal Violence

The Bronx leads New York City in interpersonal violence, especially domestic violence, and non-domestic assaults. A disproportionate share of domestic violence complaints and homicides originate in the Bronx. Women in the Bronx face rising felony assault rates from both known and unknown aggressors.

In 2021, the Bronx logged over 9,500 domestic violence incidents, the highest among all the boroughs. NYPD data shows a 59% surge in domestic violence offenders from 2021–2022; seven of the top ten precincts for domestic violence complaints were in the Bronx. From 2021–2022, domestic violence homicides rose 57% in the borough.

Both mental-health and law-enforcement strategies are being mobilized, from community outreach to crisis intervention, but the scale is still significant. SBH Health System has partnered with government officials. The Bronx Borough President has declared domestic violence a public health crisis, launching awareness campaigns and urges organizations to prioritize prevention and support. In 2024, the Bronx District Attorney's office currently handled ~1,600 domestic violence cases and regularly hosts awareness events.

Food Insecurity

In 2024, the New York City Council report listed Bronx County with the highest rates of food insecurity, 20.6% of residents live in food-insecure homes; that is 320,380 residents of the population. In addition, 114,940 Bronx children (33.2%) live in food insecure households.

The Bronx faces a food insecurity crisis, with around 40% of adults stressed about food access and nearly one-quarter of households struggling. Sharp food inflation, reduced federal benefits, and limited store access worsen the gap. Five of the seven communities in New York City listed as severe food insecure are in the Bronx: West Farms (34%), Highbridge (32%), Claremont (31%), and Mott Haven (31%). SBH primary service area, Belmont/East Tremont, rated at 33.9%.

In the Bronx, 40% of households received Supplemental Nutrition Assistance Program (SNAP, formerly referred to as food stamps) benefits, compared to 18% in New York State overall and 20% in the rest of NYC in 2024. University Heights/Fordham had 35% of the population on SNAP benefits, while Belmont/East Tremont had 46% receiving benefits.

Drivers of Food Insecurity:

- Rapidly rising food costs: Food prices in New York City rose ~25% since 2019—with grocery inflation up 56% over the past decade.
- Nearly 86% of New York families say food prices are climbing faster than wages.
- Supplemental Nutrition Assistance Program (SNAP) and other pandemic-era benefits were reduced; Bronx SNAP enrollment is high (~39.4% in 2023), but any cuts hit Bronx residents particularly hard
- The Bronx has fewer supermarkets per capita; many areas are "food deserts," forcing reliance on bodegas with limited fresh produce.
- Poor nutrition correlates with high rates of obesity (~30%), diabetes, heart disease, and premature death.

Transportation Needs

With 60% of Bronx households without cars and most reliant on transit, connections (especially off-peak and cross-borough) remain inadequate, affecting commute times and job access. Local advocates call for improved intra-borough transit options (more buses, new routes), accessibility features, and inclusion in major transit projects.

Four new Metro-North stations (Hunts Point, Parkchester/Van Nest, Morris Park, Co-op City) are under construction with planned completion by 2027. These aim to reduce commute times and catalyze affordable transit-oriented development (7,000 housing units). Only 27% of Bronx subway stations are ADA-accessible (19 of 70), highlighting a pressing need for elevators, ramps, and other accommodations.

The Bronx, as compared to the other broughs, does not yet have sufficient bikes for a reliable New York City's rental bike program (Citi Bike). According to NYC Comptroller report in 2023, nearly 90% of Bronx bike stations are often empty or broken; low bike maintenance and reduced rebalancing efforts dropped by 80%. Through community engagement, improvements are expected.

Utility Difficulties

The negative economic standard of Bronx families does affect all factors of life and wellbeing. For example, water main breaks in the Bronx often lead to prolonged disruptions in water, gas, and electricity. One major break caused hundreds to go without power for 48 hours. Another incident left residents in some buildings without gas or electricity for over a week.

Roughly 34% of Bronx households spend more than 6% of their income on utility bills (electricity, gas, heating), well above the affordability threshold. Aging building infrastructure and inefficient heating systems worsen costs; some households forgo cooling despite free AC units due to high electricity prices.

In increasingly tech-enabled and tech-powered economy in New York, in an economy in which 41% of all the net new jobs in New York City since the pandemic have been in tech, where tech skills, a broadband connection, and devices are essential for accessing key services. This new scenario includes the transition to full-time remote learning and work, the demand for affordable, high-speed internet access at home rose sharply across New York City.

Conversely, the digital divide has become a major driver of inequality in New York. It is separating New Yorkers into those who not only have access to computers and broadband but with those things, access to a full world of opportunity, from education to job training, to opportunities to connect with programs and services that could change the trajectory of their lives.

In New York City, the greatest digital divide exists in the borough of the Bronx. The third-most densely populated county in the US; the Bronx is home to 1.4 million people. The Bronx has the lowest rate of broadband adoption in New York City, with 22.4% of households lacking broadband, compared to 18% in Queens and 12.5% in Manhattan.

Monthly internet bills in New York City range from $30 to $100, and laptops can tack on another $300 to $500 or more, expenses that can be out of reach for Bronx residents struggling to pay rising rent, food and childcare costs. The affordability crisis further fuels the digital divide in the Bronx, where 1 in nearly 4 homes lack broadband internet and 1 in 3 do not have computers, according to a Center for an Urban Future, July 2025: Understanding and Overcoming the Bronx Digital Divide.

Overall, the report finds, 19% of Bronx households rely on only smartphones for home internet access. The Bronx had the highest share of households without fixed broadband access in the city. Since 2023, 63.3% of Bronx households had broadband access, 20.3% relied solely on cellular data plans, and 7.1% had no internet access of any kind. In the Belmont/East Tremont area, 62.4% of households had a broadband internet subscription, and 57.0% had a computer at home.

Even though more than 30% of Bronx households lack computers at home, the borough has among the lowest number of public computer labs. One response to the digital divide is to scale up programs that are already working in the Bronx, such as laptop lending initiatives and broadband internet locations.

4. Community Assets and Resources:

Description of Community Resources

Although the Bronx has a wealth of community assets and resources, its residents continue to face significant health inequities. To ensure access to reliable and up-to-date information on community assets, SBH Health System conducts research using multiple sources. These include the New York City Department of Health and Mental Hygiene, Policy, Planning, and Strategic Data databases, along with added New York State and New York City government resources. Through these efforts, SBH can identify and engage community and government partners throughout Bronx County.

Participation in the New York 1115 Medicaid Waiver - Social Care Network, managed by SOMOS Community Care, and the development of a SBH resource list are significant sources that staff can easily access. The process of identifying and documenting resources is ongoing to ensure information remains current. SBH maintains formal partnership agreements with more than sixty community-based organizations and public schools. These agreements support targeted projects designed to address health disparities within the community.

One-quarter of the Bronx's land area consists of natural forest and open space, earning it the name "The Borough of Parks". These parks provide recreational and exercise opportunities for residents of all ages. The Bronx is also home to a wealth of cultural institutions including the New York Botanical Garden, Bronx Zoo, Bronx Children's Museum, Bronx Museum of the Arts, Bronx River Art Center, Bronx Historical Society, Bronx Opera Company, Pregones Theater, among many others. Collectively, these institutions enrich the community by promoting education, cultural engagement, and overall well-being across all age groups.

There are significant organizations committed to improving educational opportunities for residents, empowering them to achieve their goals. It is also known as the "Borough of Universities," with more than 15 institutions of higher learning. SBH has internship agreements with many of the colleges and universities. The nearby shopping district in the service area is Fordham Road. Retail stores, banks, and restaurants are available for residents. Belmont-Arthur Avenue, known as Little Italy of the Bronx, is right behind the SBH campus.

SBH Health System Resources:

SBH Health & Wellness Center ("The Wellness Center")

SBH Health System extends its value-based approach to care through a mixed-use development that integrates health services, education programming, community engagement, and affordable housing. The organization provides a continuum of services for individuals across the lifespan from infancy through end-of-life within a community-based healthcare network. Beyond clinical care, SBH also develops extensive community programs and offers resources that complement and enhance its clinical services.

The SBH Health and Wellness Center ("The Wellness Center") is part of that development project, a centerpiece of SBH Health System commitment to keep the community healthy. The Wellness Center offers a wide range of services and resources to support community health and well-being. Facilities include exercise spaces, a teaching kitchen for nutritional education, and access to organically grown food, as well as a food pantry and beehive. Clinical care services are also available, including women's health, mammography, pediatrics, and urgent care. In addition, the Wellness Center host a Supplemental Nutrition Program for Women, Infants, and Children (WIC).

During the five years (2020–2024), the SBH Health & Wellness Center provided:

170,000 Visits
1000 Teaching Kitchen Classes
1000 Pounds of Distributed Honey

Food Pantry Served:
21,000 Families
18,000 Children
48,000 Adults
11,000 Seniors

SBH Volunteer/Internships Programs

SBH operates volunteer and internship programs year-round that provide pathways to employment. The internship programs are designed for high school and college students interested in healthcare careers, offering exposure to a wide range of opportunities within the field. In addition, SBH offers onsite visits and seminars led by clinicians for elementary and high school, fostering early interest in healthcare professions.

Healthcare Partners

SBH consults with many public health experts and avails of technical assistance provided by the Center for Medicaid Services (CMS) and The Joint Commission. They provide alerts about emerging issues and disease outbreaks, bulletins with practical guidance on current, and task forces on specific issues.

The New York City Department of Health & Mental Hygiene (NYC DOHMH) supports community-centered public health solutions, to eliminate health inequities and increase the life expectancy of all city residents. SBH planning is aligned with HealthyNYC 2030 population health agenda. SBH is a partner with NYC DOHMH on several initiatives.

SBH has a robust existing partnership with Union Community Health Center (UCHC), a Federally Qualified Health Center, providing health care services from six locations throughout the Bronx since 1909. A significant number of UCHC patients are referred to SBH for inpatient or complex care.

SBH runs a Referral Services Office to build and maintain relationships with community providers and provides expedited access to appointments at SBH. In 2024, the office received 21,1469 referrals from 233 unique sites (e.g., private practices, FQHCs, behavioral health agencies, and other community-based organizations).

SBH Health System is a member of several healthcare professional organizations. Such organizations share regulatory updates, analysis, and relevant research.

- HANYS (Healthcare Association of New York State) supports solving complex healthcare issues and improving the health of New York communities.
- GNYHA (Greater New York Hospital Association) core mission is to help hospitals deliver the finest patient care in the most cost-effective way.
- America's Essential Hospitals is a member organization advocates for high quality care for people who face social and financial health care access.

H. COMMUNITY HEALTH IMPROVEMENT PLAN (CSP) 2022–2024 - REVIEW

A brief review of the two 2022–2024 priority projects:

Focus Area 1: Healthy Eating and Food Security

Goal: 1.3 Increase Food Security

Objective: Decrease the percentage of pediatric and adult primary care patients with perceived food insecurity by 10% over 24 months.

Interventions: 1.0.6 Screen for food insecurity, facilitate and actively support referral

All adult patients, both inpatients and outpatients, underwent screenings to assess food insecurity. These screenings were integrated into the broader social drivers of health approach, as previously explained. SBH Health System provided patients and community members with various forms of food aid, including food pantry, curated food bags provided upon discharge, annual holiday food distribution, and healthy cooking classes.

Despite these efforts, along with those of the government and community, the percentage of adults facing food insecurity is still a significant issue. According to the New York State Department of Health report for 2024, approximately one in four adults (24.9%) in New York State experience food insecurity. Within the state, the percentage of adults reporting food insecurity varies by county, ranging from 11.2% to 39%. Notably, the Bronx has the highest percentage of adults experiencing food insecurity at 39%, while Staten Island has the lowest at 22.1%. Furthermore, in 2024, 32.2% of children in the Bronx are food insecure.

Focus Area 1: Injuries, Violence, and Occupational Health

Goal: 1.2 Reduce violence by targeting prevention program particularly to highest risk population. 1.2.1 Implement muti-sector violence prevention designed on Cure Violence model in high-risk community where gangs are prevalent.

Intervention: Hospital-based Violence Intervention Program (HVIP)

SBH Health System's Hospital-Based Violence Intervention Program (HVIP) began full operations during this tenure. Noteworthy progress was made in developing a patient-centered approach for individuals admitted to SBH with violent injuries. In 2024, the HVIP expanded its eligibility criteria, implemented real-time screening, engaged high responders, and achieved success in follow-ups. Notably, approximately 33% of patients admitted to SBH were related to gunshot incidents, while a substantial 67% were related to stabbing or slashing incidents.

In July 2024, SBH enhanced its real-time and near real-time dispatch and screening processes. This improvement aimed to hasten rapid response to alerts about eligible patients admitted to the hospital. Hospital Responders received notifications via a de-identified text message group, enabling them to act more swiftly and efficiently.

Focus Area 1: Injuries, Violence, and Occupational Health

Goal: 1.2 Reduce violence by targeting prevention programs particularly to the highest risk population. 1.2.5 Increase educational, recreational and employment opportunities for potentially at-risk youth through summer work experience programs and internship initiatives.

Interventions: Mentoring, Employment, and Specialized Training

The following sections itemize the successful programs which were operated under the New York City grant to provide youth with educational, recreational and employment opportunities.

Youth Engagement Beyond the Emergency Room 2022–2024

Youth Non-Contact Boxing Program - 2022–2024

- 2022–2023: Bronx youths between the ages 14–22 achieved goals of improved consistency, movement, and breathing skills, training with a professional two times a week for twelve weeks. Community referrals from high-risk areas, live in SBH Health System service areas.
- 2024: Extended eligibility to 13–24 year-olds. Granted access to the fitness center to promote overall health and fitness outside of the scheduled time. Pre and post program surveys completed revealed strong satisfaction and a sense of belonging. Participants were 58% male and 41% female; 58% were Latino and 41% Black.

SBH Emergency Department Youth Mentorship - 2022–2024:

S.T.A.M.P. - Emergency Medicine Science, Technology, and Medicine Pipeline Program

- S.T.A.M.P. supported early exposure to careers within the health sciences and medical professions. Interactive outreach-based initiative by the SBH Emergency Medicine Department provided workshops at local grade schools.
- 2022–2024: SBH Emergency Medicine Physician Program Coordinator and four first year residents led lessons in 4 local grade schools with a curriculum consisting of 13 lessons.

S.E.M.P. Summer Enrichment and Mentorship Program - 2022–2024

- S.E.M.P. pipeline program participants have completed their first year in medical school interested in pursuing emergency medicine careers.
- 2022–2024: Emergency Medicine Program Director and Senior Resident hosted a six-week curriculum for medical students selected from New York City schools. Students received clinical skills workshops including Stop the Bleed, Phlebotomy, Ultrasound, Airway, and Suturing.

Youth Employment:

Summer Youth Employment - 2022–2024

- Bronx youth were immersed in healthcare professions for 6 weeks. Activities included: Meet and Greet with a Physician, shadow a clinician, confirm appointment for patients. Attended education seminars and Stop the Bleed training. Evaluations were conducted.

Youth Peer - 2022–2024

- Part-time, after-school high school student, living in the Bronx supporting programming for 8 months.

Specialized Training:

Stop the Bleed - 2022–2024

- SBH Health System conducted training sessions to broaden community readiness for traumatic bleeding emergencies, including non-clinical and clinical staff, and community members.
- 2022–2024: Training course 45 minutes long. All learners received Combat Application Tourniquet (CAT). Training successfully reached over 250 learners, increasing community preparedness.

I. COMMUNITY HEALTH IMPROVEMENT PLAN/COMMUNITY SERVICE PLAN 2025–2027

1. Major Community Health Needs:

Below are the responses provided by Bronx residents, both within the SBH Health System service area and beyond. The responses about priorities from residents in the SBH service area and the Bronx show comparable rankings in terms of the community's attention to issues. The health challenges named in this assessment are prevalent throughout the county.

SBH & Bronx Community Health Survey Summary:

This table summarizes issues of respondents ranked above or below average in SBH's Service Areas and the entire Bronx Community.

	SBH Primary Service Areas (n=1,683)	Bronx County Service Areas (n=3,337)
Needs Attention	1. Violence (including gun violence) 2. Affordable housing and homelessness prevention 3. Dental care 4. Mental health disorders (such as depression) 5. Assistance with basic needs like food, shelter, and clothing 6. Obesity in children and adults	1. Violence (including gun violence) 2. Dental care 3. Affordable housing and homelessness prevention 4. Access to healthy/nutritious foods 5. Mental health disorders (such as depression) 6. Asthma, breathing issues, and lung disease 7. Assistance with basic needs like food, shelter, and clothing
Maintain Efforts	7. Cancer 8. Access to healthy/nutritious foods 9. Stopping falls among elderly 10. Heart disease 11. Diabetes and high blood sugar 12. High blood pressure 13. Asthma, breathing issues, and lung disease 14. Women's and maternal health care 15. Adolescent and child health	8. Cancer 9. Heart disease 10. Stopping falls among elderly 11. Diabetes and high blood sugar 12. High blood pressure 13. Women's and maternal health care 14. Infant health
Relatively Lower Priority	16. Job placement and employment support 17. Access to continuing education and job training programs 18. Substance use disorder/addiction (including alcohol use disorder) 19. Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah 20. Infectious diseases (COVID-19, flu, hepatitis)	15. Obesity in children and adults 16. Access to continuing education and job training programs 17. Job placement and employment support 18. Substance use disorder/addiction (including alcohol use disorder) 19. Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah 20. Adolescent and child health

	SBH Primary Service Areas (n=1,683)	Bronx County Service Areas (n=3,337)
Relatively Lower Priority	21. Infant health 22. Arthritis/disease of the joints 23. School health and wellness programs 24. Sexually Transmitted Infections (STIs) 25. HIV/AIDS (Acquired Immune Deficiency Syndrome) 26. Hepatitis C/liver disease	21. Infectious diseases (COVID-19, flu, hepatitis) 22. Arthritis/disease of the joints 23. School health and wellness programs 24. Sexually Transmitted Infections (STIs) 25. HIV/AIDS (Acquired Immune Deficiency Syndrome) 26. Hepatitis C/liver disease

The United Hospital Fund released a 2025 report titled "Bronx Region, Regional Needs Assessment Summary." This report is based on health findings derived from the Community Health Needs Assessment (CHNA), Community Health Improvement Plan (CHIP), and Community Screening Program (CSP) reports conducted by healthcare systems in the Bronx, including SBH Health System (SBH), public health departments, and community health initiatives. The report names SBH hospital-based violence intervention projects, such as the Cure Violence Model, Youth Employment & Mentoring, and Boxing Program, as recommended interventions. Additionally, the report highlights the SBH cancer screening outreach program, which uses a mobile van to provide cancer screenings to the community.

The UHF report listed health needs across assessment:

- Physical & Behavioral Health
- Chronic Diseases
- Mental Health
- Substance Use Disorders
- Maternal & Child Health
- Suicide Risk
- Violence and Injury (gun violence, assault-related hospitalizations)
- Falls Among Older Adults

The UHF report listed health-related social needs (HRSN) across assessment:

- Poverty & Economic Stability
- Housing Instability
- Food Insecurity
- Education & Health Literacy

The UHF report listed social care and access concern:

- Access to Care

The HealthyNYC 2030 agenda named seven drivers contributing to the reduction in life expectancy: drug overdose, suicide, cardiovascular diseases, screenable cancers, COVID-19, violence, and maternal mortality. The findings of the various reports align with those named in the 2025 SBH Community Health Needs Assessment.

2. Prioritization Methods:

a. Description of Prioritization Process

By diligently implementing several steps, SBH Health System positioned the community to effectively select projects that align with the community survey results, New York State's Department of Health Prevention Agenda, and HealthyNYC 2030 goals. These selected priorities will have a positive impact on the health and well-being of the Bronx.

First, an extensive review of the 2022 projects was conducted. This review ensured that lessons learned, new community partnerships secured, and changes in hospital operations, such as the implementation of EPIC, would serve as a foundation for proposed 2025–2027 priority projects. This process involved deciding whether 2022 Community Service Projects (CSPs) should be incorporated into the 2025 community health needs assessment plan.

Prioritization involved analyzing the primary and secondary data gathered with the community. The survey results are a crucial part of the analysis of community health needs. The Community Health Needs Assessment included various encounters held within the community and presentations to SBH clinical staff and leadership to discuss the analysis of the primary and secondary data, including the SBH patient data.

In addition, the HealthyNYC 2030 goals and the United Hospital Fund 2025 Bronx Region Needs Assessment were reviewed to compare results. The reports aligned with the results and proposals found in the SBH community health needs assessment.

b. Community Engagement

SBH Health System has significant partnerships with community organizations, churches, local businesses, labor unions, and other healthcare organizations. To promote health equity, SBH practices meaningful community engagement. Meaningful community engagement requires working with and listening to community members to address the issues that affect their well-being.

Meaningful community engagement uses the expertise of our community. They are best equipped to identify their own strengths and challenges. The SBH Wellness Alliance serves as a crucial tool in building and maintaining trust with our community, ensuring the long-term success of our community-based programs.

The SBH Wellness Alliance meets monthly. In the United Hospital Fund 2025 Bronx Region report, the Wellness Alliance is recognized as an opportunity for integration. During June to September 2025, a comprehensive review of the 2022–2024 Community Service Plan projects was conducted, followed by an explanation of the 2025 community survey implementation and analysis process.

Once the community survey responses data was received, the results were presented to the community, SBH clinical staff, and leadership. SBH actively participates in and presents at the two local community boards' monthly meetings.

This entire process has led to the identification of the most pressing community needs that the community desires to address. Several potential projects have been considered, aligning with the survey's priority issues and available resources. We ensure that the chosen projects are consistent with the domains and priorities of the New York State Prevention Agenda 2025–2030, HealthyNYC 2030, and SBH Health System's focus.

c. Justification for Unaddressed Health Needs

As mentioned, the Bronx consistently ranks 62 out of 62 counties in New York State in terms of health outcomes and factors. This reflects the significant health needs that the Bronx faces, requiring urgent action from multiple partners and substantial resources.

Social and environmental factors that influence health, such as financial resources, access to nutritious food, and safe and affordable housing, are not distributed equally. Leading to significant disparities in health outcomes like disease severity, life expectancy, gun violence impact and infant mortality. These disparities are rooted in longstanding systems and structures. SBH Health System acknowledges that social needs, including long-term housing, immigration legal services, and access to specialized care, significantly impact the well-being of our community.

Addressing the immense health and social needs of Bronx communities goes beyond the direct capabilities of a single hospital system or institution. However, SBH actively identified these needs, refers patients to trusted community partners, and advocates for broader systematic changes to address these critical gaps.

Collaborative cross-sector cooperative action are as a means to meet community needs. By fostering trust and communication, a collective desire can effectively address health inequities. SBH strives to align local community health improvement planning efforts with New York State and New York City population health initiatives, which emphasize employing an equity lens.

In addition to community alliances, forming partnerships with government agencies is crucial. These projects can expand services to patents through structured alliances with specific agencies, particularly local agencies. Such partnerships enhance the ability to address unaddressed community needs. The HealthyNYC 2030 agenda provides a roadmap for forming these collaborative efforts.

3. Objectives, Interventions, and Action Plans:

a. Alignment with New York State Prevention and HealthyNYC Agendas

SBH adheres to the agendas focus on reducing health disparities and advancing health equity by addressing the root causes of illness and injury. Achieving health equity has been embedded in the SBH Health System's mission to address health disparities. All the SBH projects chosen are viewed from a health equity lens. As explained throughout this document, our service area residents face multifaceted challenges that result in negative health outcomes. The challenges faced by SBH service area residents were years in the making and have deep roots. It is years of neglect by all sectors of society. The barriers the community must overcome are many. Safety net hospitals, like SBH, are at the forefront of a war against injustice and inequity.

The staff and community members of SBH reviewed and incorporated the new 2025–2030 New York State Prevention Agenda to familiarize them with the 24 key priorities that address health conditions, behaviors, and systemic issues. SBH intentionally reviewed and incorporated the priorities of the New York City Health Department's population health initiative, HealthyNYC. Throughout this document, specific references, strategies, and goals reflect a unified approach to addressing shared priorities across both city and state frameworks, guided by SBH Health System principles.

The priorities chosen in this plan are aligned with the New York City Department of Health population health initiative, HealthyNYC 2030, the New York State Prevention Agenda 2025–2030, and the health needs named through the SBH 2025 Community Health Needs Assessment.

b. Priorities and Interventions Chosen

SBH Health System, in consultation with the community served, has selected three priorities and interventions from the New York State Prevention Agenda 2025–2030 and HealthyNYC 2030 agenda:

Domain 3: Neighborhood & Built Environment

Domain Goal	All people in New York have equitable access to a healthy and safe environment
Priority	Injuries and Violence
Goal	Prevent intentional and unintentional injuries
CHNA Survey	Ranked #1 for importance; #26 below average satisfaction; #1 for improvement in services
Intervention	Hospital-Based Violence Intervention Programs (HVIP)
Intervention	Youth Engagement Violence Preventions/Risk Reduction

Domain 4: Health Care Access & Quality

Domain Goal	All people in New York have access to timely, affordable and high-quality health care services
Priority	Prevention Services for Chronic Disease Prevention and Control
Goal	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases
CHNA Survey	Ranked #2 in importance; #7 in average satisfaction of services; #7 in areas of improvement
Intervention	Expand screening for social care needs among all adults with chronic diseases, with a focus on colorectal cancer screening

Domain 1: Economic Stability

Domain Goal	All people in New York have the financial security and support needed to thrive
Priority	Poverty
Goal	Identity, promote and implement progress that addresses poverty
CHNA Survey	Ranked # 12 in importance; #18 below average satisfaction; #5 in areas of improvement
Intervention	Conduct screening of inpatients, with specific exclusions, of five Center for Medicaid Services Health-Related Social Needs (HRSN)

c. Geographic Focus

The selected projects will be conducted in SBH's primary service areas in zip codes 10452, 10453, 10456, 10457, and 10458.

d. Resource Commitment for the Projects Selected

SBH Health System has a strong commitment to finding resources to provide community benefits to achieve health equity through projects. SBH's Department of Community Affairs, in conjunction with clinical departments, conducts health fairs, health education sessions, screening events, cultural celebrations, and more to meet the needs of the community.

SBH seeks government and private sector support to fund priority projects. Due to relationships with government officials, SBH has received awards both for expense and capital projects.

In addition to government grants, SBH provides these in-kind resources for the designated projects:

- Dedicated personnel supporting the operations and service delivery of community efforts.
- Develop infrastructure tailored to such program needs.
- Credentialing and training partnerships personnel (non-SBH employees) aligned with hospital regulations and projects standards to operate projects.
- Developed specific tracking dashboards using EPIC to track project results.

4. Action Plan - Interventions

a. Domain 3: Neighborhood & Built Environment

Domain Goal	All people in New York have equitable access to a healthy and safe environment
Priority	Injuries and Violence
Goal	Prevent intentional and unintentional injuries
CHNA Survey	Ranked #1 for importance; #26 below average satisfaction; #1 for improvement in services
Intervention	Hospital-Based Violence Intervention Programs (HVIP)
Intervention	Youth Engagement Violence Preventions/Risk Reduction

i. Statement of Need

Safety is crucial for daily life, impacting health, well-being, and development in communities, homes, schools, and workplaces. Exposure to violence, crime, or unsafe conditions causes chronic stress, anxiety, and depression. Historically, accidents were the leading cause of death among children and adolescents, but the rise in firearm-related deaths, especially among teens, has shifted the landscape, particularly in the high-risk Bronx.

In the three SBH community surveys and the 2025 United Hospital Bronx report, Bronx residents called for gun violence prevention. Both the New York State Prevention Agenda 2025–2030 and HealthyNYC 2030 have set goals for violence prevention. The HealthyNYC 2030 agenda developed a strategy map for violence prevention.

These projects are a health approach that focuses on preventing events, providing treatment for people at the most risk, and changing social expectations. Therefore, SBH Health System will implement two linked interventions to address gun violence.

ii. Project Narrative

The proposed interventions are Hospital-Based Violence Intervention Programs (HVIP), coupled with youth engagement violence prevention/risk reduction. The interventions are documented in a FY2025 Scope of Work submitted to New York City Department of Youth & Community Development signed by SBH Health System and B.R.A.G. (Bronx Rises Against Gun Violence).

Intervention: Hospital-Based Violence Intervention Programs (HVIP)

Implement multi-sector violence prevention programs guided by the Cure Violence framework through a hospital-based intervention in a high-risk community affected by gangs and violent crime. The SBH project provides wraparound services to support victims and community members affected by violence.

As a trauma center, SBH Health System leads efforts to address the local violence epidemic. In 2021, the SBH Emergency Medicine Department (ED) was designated as the clinical lead for this initiative, with staff trained in the HVIP model. Clinical teams assess, stabilize, and treat patients with injuries from violent trauma and identify potentially eligible participants using established criteria.

Criteria for Identifying High-Risk Individuals:

- Target: 16–24 years old
- Minors require parental consent
- Eligible injury: gunshot wound or involvement in shooting incident
- Eligible injury: traumatic assault and stab/slash
- Active in violent street organization
- History of violence
- Exclusion criteria: law enforcement custody, domestic violence victims, and behavioral health patients

SBH staff notify B.R.A.G. Hospital Responders via text about a potentially eligible patient. After verbal consent, B.R.A.G. Hospital Responders discuss their services. Due to its parent organization's resources, B.R.A.G. offers a wide range of services. After patient engagement, they provide a brief assessment to SBH staff and follow up with the patient after discharge.

Ask	Pitch
SBH staff give patients an introduction to what services B.R.A.G. Hospital Responders can provide patients due to the incident.	B.R.A.G. Hospital Responders have in-depth conversation with patients about the incident, and what services are available, build trust.
If the patient consents to meeting B.R.A.G. Hospital Responders, SBH staff will inform B.R.A.G. Hospital Responders in real time to move forward with the Pitch.	If patients consent, B.R.A.G. Hospital Responders take the necessary steps to connect them to services. B.R.A.G. Hospital Responders follow-up after discharge.

The government partners are the New York City Department of Youth and Community Development (DYCD) and the New York City Department of Health & Mental Hygiene (DOHMH). Their direct involvement ensures HealthyNYC's objective of increasing HVIP program implementation capacity. The two agencies hold monthly meetings with the SBH HVIP team to monitor progress and provide specialized training. SBH's operations oversight group includes B.R.A.G. Senior Vice President, B.R.A.G. Hospital Responders, SBH Senior Vice President, SBH Injury Prevention Coordinators, and a doctor liaison from the Emergency Department. They meet monthly to review progress, identify issues, and make necessary corrections.

In addition to the HVIP, the SBH Emergency Department sponsors the Stop the Bleed program. SBH Health System trains B.R.A.G. personnel, youth and adult community members in this effort that encourages bystanders to help in a bleeding emergency before professional help arrives. This program is nationally recognized as evidence-based bystander intervention.

Intervention: Youth Engagement Violence Preventions/Risk Reduction

Increase educational, recreational and employment opportunities for at-risk youth through summer work experience, boxing/fitness and mentoring opportunities. In 2022, the New York City Department of Youth & Community Development awarded SBH Health System a contract to expand youth services. These activities enhance SBH ability to connect and provide guidance to at-risk youth.

Youth Engagement Violence Prevention/Risk Reduction programming includes: SBH Youth Boxing & Fitness Program offers structured training in boxing, self-defense, and physical fitness to Bronx youth at the SBH Health & Wellness Center. Certified boxing and exercise instructors lead sessions on non-contact boxing and strength training. Participants undergo fitness evaluations using the SECA Scale. Under the Director of the SBH Teaching Kitchen, they engage in hands-on culinary cooking classes to promote healthy eating habits.

Mentoring Program: Two mentoring programs run by the SBH Emergency Department: Emergency Medicine Science, Technology & Medicine Pipeline Program (S.T.A.M.P.) and Summer Enrichment & Mentorship Program (S.E.M.P.). Programs aim to increase the number of underrepresented minorities in medicine and healthcare related careers.

iii. Objectives

New York State Prevention Agenda 2025–2030:

SMART(IE) Objective: Decrease the ratio of assault-related emergency department visits of Hispanic compared to White, Non-Hispanic persons from 5.7 to 5.5.

Desired Outcome: Decrease assault-related injuries

Indicator: Rate of Emergency Department Visits of Assault-Related Injuries per 10,000 New York Residents

Data: Statewide Planning and Research Cooperative System (SPARCS)

Population: Everyone

Baseline: 5.7 (2022)

Target: 5.5 (2030)

Aligned with HealthyNYC 2030:

Goal: Reduce homicide deaths by 30% by 2030.

Priority Strategy: 3. Raise awareness about violence being a public health issue to facilitate the development and implementation of comprehensive policies, laws, procedures, regulations, and practices that reduce access to firearms.

Sub-Strategy: 3.1 Increase the capacity of implementers to deliver hospital-based violence programs.

Actor: Health Systems and clinical providers; community systems

Activity: Increase the capacity of implementers to deliver HVIP programs.

Aligned with HealthyNYC 2030:

Goal: Reduce homicide deaths by 30% by 2030.

Priority Strategy: 3. Raise awareness about violence being a public health issue to facilitate the development and implementation of comprehensive policies, laws, procedures, regulations, and practices that reduce access to firearms.

Sub-Strategy: 3.2 Sustain and strengthen community-based approaches to violence prevention.

Actor: Community systems

Activity: Increase access to mentorship for at-risk youth.

Intervention - Hospital Based Intervention Program:

SMART(IE) Objective: Decrease the ratio of assault-related emergency department visits of Hispanic compared to White, Non-Hispanic persons from 5.7 to 5.5. (SPARCS)

Desired Outcome: Increase Emergency Department dispatch rate of referrals for assault related injuries to Bronx Rises Against Gun Violence (B.R.A.G.)

Indicator: Percentage of dispatched referrals for high-risk individuals assaulted with a sustained injury of gun shot or stab wound to B.R.A.G., community-based organization.

Data: EPIC reports

Population Focus: At-risk youth ages 14–24 & their families impacted by violence in SBH service area zip codes.

Baseline: 50% (2024)

Target: 60% (2027)

Intermediate measures: 61% (2026)

Intervention - Youth Engagement:

SMART(IE) Objective: Decrease the ratio of assault-related emergency department visits of Hispanic compared to White, Non-Hispanic persons from 5.7 to 5.5.

Desired Outcome: Increase youth engagement in each activity. Specifics in the appendix.

Indicator: Numbers of youth engaged and number of classes in proposed activities. Specifics in **Appendix G**.

Data: EPIC reports

Population Focus: At-risk youth ages 14–24 & their families impacted by violence in SBH service area zip codes.

Baseline: Attendance number of youth or classes conducted (2024). Specifics in the review of 2022 projects.

Target: Increase attendance or number of classes. Specifics in **Appendix G**.

iv. Geographic Focus

SBH Health System's primary service areas are in the following Bronx zip codes (highest to lowest number of patients): 10457, 10458, 10460, 10456, 10453, 10468, 10462, 10467, 10459, 10472, and 10452. The zip codes with the largest number of patients are primarily in Bronx Community District #6, which includes the communities of Belmont, Bathgate, Tremont, and West Farms.

These zip codes are characterized by elevated risks of community violence, particularly assault-related injuries stemming from gunshot wounds and stabbing incidents. Strategically, SBH's geographic focus aligns with the catchment area of the B.R.A.G. and the 46th and 48th precincts of the New York City Police Department (NYPD). This alignment ensures comprehensive intervention coverage within the high-risk areas served by SBH.

v. Resource Commitment

The community prioritizes gun violence prevention, prompting SBH to allocate resources to a Hospital-Based Violence Intervention program (HVIP) and other initiatives for at-risk youth. SBH secured funding from the New York City Department of Youth and Community Development (DYCD) to deliver comprehensive interventions. DYCD, in collaboration with the NYC Department of Mental Health & Hygiene, supervises the program, providing specialized hospital response training and data system guidance. SBH expanded its activities to include fitness classes, employment opportunities, and mentoring programs for youth.

With these resources, SBH has expanded its activities, offering fitness classes, employment opportunities, and mentoring programs to youth. SBH provides institutional training for B.R.A.G. Hospital Responders, ensuring HIPAA and HealthStream compliance. SBH personnel process and clear all Hospital Responders, issuing hospital identification for secure access to deliver HVIP services.

vi. Participant Roles

Community Based Organization Partner: Bronx Rises Against Gun Violence - B.R.A.G.

In 2017, B.R.A.G. approached the leadership of SBH Health System to conduct a pilot HVIP. The pilot program has since evolved into a fully operational HVIP within the SBH Emergency Department, which has been credentialed by New York City agencies.

B.R.A.G. Hospital Responders, credible messengers, provide near-time bedside services to patients and their friends and family injured by violence. They deliver wraparound services to eligible patients and connect agreeable participants to individual and family therapy and wraparound services. B.R.A.G. provides services and support during hospitalization and after discharge. B.R.A.G. also engages youth, residents, and community organizations to promote safer streets.

By collaborating with the following City agencies and the NYC Crisis Management System (CMS), SBH advances HealthyNYC 2030 violence prevention agenda:

City Government Stakeholder: New York City Department of Youth and Community Development (DYCD)

The New York City Department of Youth and Community Development (DYCD) is the grantor of the contract to operate the HVIP and youth engagement activities. DYCD provides critical oversight of the HVIP as part of the city's Crisis.

City Government Stakeholder: New York City Department of Health and Mental Hygiene (DOHMH), Violence Prevention Initiative

The New York City Department of Health and Mental Hygiene (DOHMH) supports hospitals by providing training to designated staff. The DOHMH offers hospital responder training and utilizes a trauma-informed approach to equip SBH Health System and B.R.A.G. staff with Cure Violence-based practices for effective HVIP service delivery. DOHMH closely monitors data reporting and offers technical support.

City Government Stakeholder: New York City Police Department (NYPD) 46th and 48th Precincts

The 46th and 48th Precincts are encompassed within the primary service area of the SBH Health System. The New York City Police Department (NYPD) actively supports SBH's (HVIP) initiatives by providing real-time alert crisis notifications. SBH has formed a longstanding partnership with the NYPD's community council. Through this collaboration, SBH and the NYPD exchange mutual violence intervention strategies and community outreach resources, thereby forming an alliance that fortifies community bonds and enhances public safety for Bronx residents and individuals at high-risk of violence.

vii. Health Equity

Gun violence, a public health crisis threatening New York City, has no single cause for the systemic violence that has claimed many lives, especially young ones. Such violence affects the community SBH serves, devastating families. Recognizing gun violence as a critical, preventable public health issue, SBH is committed to addressing this pressing concern through these two violence prevention interventions.

A Center for Disease Control report (December 2024) identifies external causes (including unintentional injuries, suicide, and homicide) as the leading causes of death among youth and young adults. In 2022, unintentional injuries were the primary cause of death for individuals aged 1–44, it accounted for 30% of deaths among children aged 1–9, 40, 1% among those aged 10–24, and 37.7% for ages 25–44.

For decades, this type of violence has consistently ranked as a significant contributor to mortality among young people in New York City. A striking statistic reveals that fifty percent of shooting deaths occur in zip codes with a median household income below $50,000. However, it is important to note that only 24% of New York City's entire population lives in these zip codes.

According to the U.S. Census, the Bronx is one of the youngest counties in New York State, with a median age of 36.7 years compared to 40.1 years statewide. About 23.9% of Bronx residents are under 18, higher than the state rate of 20.2%; in SBH service area, 28% are under 18.

It is important to address root causes of violence, including structural inequities and disparities in accessing positive social drivers of health such as economic support and quality, stable housing. Social drivers of health can improve or worsen health and affect violence, while violence in turn affects determinants, such as housing, education, transportation, and economic conditions. SBH has incorporated a public health approach which focuses on prevention, treatment for at-risk individuals, and changing social expectations.

Our focus population is at risk youth in our community. Exposure to violence is a predictor of poor health outcomes, especially among children. Our partnership with B.R.A.G. (Bronx Rises Against Gun Violence) goes beyond the emergency room setting. B.R.A.G. has resources that can address the multiple social drivers of health impacting youth and their families. The ability for B.R.A.G. to intervene at this critical time in the emergency room is impactful.

In addition, the extensive array of activities, possible due to the city grant, gives SBH Health System the opportunity to build trusted relationships with at risk youth and their families. Such trust allows youth and their families to feel safe enough to express their feelings, build resilience, making them more receptive to support and intervention.

Non-fatal assault hospitalizations per 100,000 - SPARCS 2012–2014

NYC: 59	Bronx: 113	Belmont: 152

2023 Reported Violent Victimization of Youth (16–24) per 1,000 Residents

Bronx	Brooklyn	Manhattan	Queens	Staten Island
14.9	8.5	9.6	8	4.6

In 2024, the NYPD reported 15 youths under 18 killed by gunfire, up from 12 in 2023. The 48th Precinct (SBH primary service area) saw a significant rise in gun violence compared to 2023. The SBH Hospital-Based Intervention Program (HVIP) and youth engagement efforts address multiple social drivers of health. SBH screens for social drivers of health and B.R.A.G. provides resources to address factors that contribute to violence.

b. Domain 4: Health Care Access & Quality

Domain Goal	All people in New York have access to timely, affordable and high-quality health care services
Priority	Prevention Services for Chronic Disease Prevention and Control
Goal	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases
CHNA Survey	Ranked #2 in importance; #7 in average satisfaction of services; #7 in areas of improvement
Intervention	Expand screening for social care needs among all adults with chronic diseases, with a focus on colorectal cancer screening

i. Statement of Need

Many New Yorkers live with multiple chronic diseases, as stated in the New York State Prevention Agenda 2025–2030. The agenda stresses early screening, self-management, and better access to healthcare to reduce the incidence and severity of chronic diseases. The HealthyNYC 2030 plan aims to lower mortality rates from screenable cancers, including lung, breast, colon, cervical, and prostate cancers. It has a strategic map for preventing these cancers.

The chosen project aims to increase screenings for colorectal cancer and provide wrap-around services to achieve both New York State and New York City chronic disease prevention goals.

ii. Project Narrative

Pathways to Better Health Outcomes:

SBH Health System has built an innovative partnership with Cityblock Health, in collaboration with Healthfirst, focused on delivering value-based, patient-centered care to a targeted group of 2,700 high-need patients. These patients are disengaged from care, frequent users of emergency or inpatient services, and have multiple open care gaps.

This partnership is a collaborative effort to improve healthcare for a vulnerable population in the Bronx by focusing on prevention, addressing social needs, and ensuring members receive holistic, coordinated care. The partnership emphasizes seamless coordination of care between various providers, including primary care, behavioral health specialists, and social services providers. This ensures that members receive comprehensive and integrated care that addresses their complex needs.

The Cityblock partnership with SBH will transform care delivery, reduce provider burden, ensure continuity, improve care coordination, and manage high-risk patients through a trusted partner. The Cityblock project aims to reach SBH Healthfirst high-risk patients and provide voluntary services. Patients can choose to participate and sign consent.

The initial phase focuses on outreach, engagement, and obtaining patient consent. As the project progresses, SBH is developing performance metrics to measure patient retention, the number of services delivered, and the number of care gaps closed, including colon cancer screening rates.

Within the SBH Healthfirst's population, there's a rolling cohort of 2700 patients with high and rising risk. If a patient declines or drops out, the next eligible patient is approached. Eligibility is determined through claims and includes patients with high medical expenses and 2+ chronic conditions, or 1 chronic condition and 1 behavioral health diagnosis. Patients are excluded if they have hemophilia, liquid cancers, transplants, or catastrophic claims.

A key focus of the partnership is Transitions of Care, where Cityblock nurses and care managers provide follow-up and education at once after hospital discharge. Cityblock Care Pathways further enhances clinical outcomes, offering structured condition management for prevalent diseases such as diabetes, hypertension, COPD, and heart failure. These pathways combine clinical and social interventions, emphasizing education, monitoring, and preventative care to empower patients in managing their health.

The Cityblock care model re-engages patients, reduces total care costs, and improves health outcomes through a multidisciplinary approach that includes primary care, behavioral health, and social services. Their care team, comprising community-based nurses, social workers, pharmacists, behavioral health specialists, and others, is available 24/7/365 to meet patients at home, in the clinic, or virtually.

iii. Objectives

New York State Prevention Agenda 2025–2027:

SMART Objective: 33.1 Increase the percentage of adults aged 45–54 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 54.7% to 62.2%.

Desired Outcome: Increase the percentage of adults aged 45–75 who receive colorectal cancer screening based on the most recent guidelines.

Indicator: Cancer Screening (percentage of adults who receive colorectal cancer screening)

Data Source: BRFSS (Behavioral Risk Factor Surveillance System)

Subpopulation of Focus: Adults aged 45–54 years

Baseline: 54.7% (2023)

Target: 62.2% (2030)

Aligned with HealthyNYC 2030:

Goal: Reduce death due to screenable cancers, including lung, breast, colon, cervical and prostrate, by 20% by 2030.

Priority Strategy: 1. Improve access to food, housing, health care, and financial and social support.

Sub-Strategy: 1.6 Increase investments in systems and initiatives providing materials needs.

Actor: Health Systems and clinical providers; community systems

Activity: Conduct screenings and referrals for social drivers of health.

SMART(IE) Objective:

Pathways to Better Health Outcomes: Increase the percentage of Medicaid high-need adults who are up to date on their colorectal cancer screening based on the most recent HEDIS guidelines from 74% to 82%.

Desired Outcome: A greater percentage of adults aged 45–75 are compliant with the HEDIS Colorectal Cancer Screening (COL) metric

Indicator: Cancer Screening (percentage of adults who are compliant with the HEDIS Colorectal Cancer Screening (COL) metric)

Data Source: Epic and insurance claims

Subpopulation of Focus: Adults aged 45–54 years

Baseline: 74% (2025)

Target: 82% (2027)

iv. Geographic Focus

The patients in the project are from SBH's primary service areas in Bronx zip codes (highest to lowest number of patients): 10457, 10458, 10460, 10456, 10453, 10468, 10462, 10467, 10459, 10472, and 10452.

v. Resource Commitment

The New York State Department of Health awarded SBH Health System a transformative $140 million investment to address long-standing capacity issues and enhance the hospital's services for residents. The funding, which is part of the state's Healthcare Safety Net Transformation Program, will enable SBH to expand its emergency department, upgrade equipment, and enhance community health partnerships. This award includes funding for this project.

vi. Participant Roles

The Medicaid high risk patients involved have been identified jointly by SBH Population Health and Healthfirst to be included in the project.

Lead: SBH Health System

As lead, SBH is responsible for the overall management of the project.

Service Delivery Partner: Cityblock Health

The Cityblock Health operates on a value-based care model which meets patients where they are. They will adjust Cityblock services to complement the care they're getting from SBH Health System and Healthfirst. The project aims to reach out to a population of SBH Healthfirst high-risk patients and provide them with services. These services are voluntary, and patients can choose to participate and sign consent.

Insurance Partner: Healthfirst

Healthfirst is a not-for-profit health insurer offering affordable plans. SBH has a risk contract with Healthfirst, covering 31,000 patients, including 13,000 primary care patients. The subgroup of SBH patients identified to participate are the focus of this project. The target population for this project is 2700 SBH Healthfirst Medicaid high-need patients.

vii. Health Equity

Disparities in cancer screening rates and outcomes exist among different racial, ethnic, and socioeconomic groups. Increasing access to screening directly addresses these inequities. Health equity involves overcoming barriers to cancer screenings and ensuring timely, appropriate care for all populations, especially those historically disadvantaged.

Strategies to achieve health equity in cancer screening extended beyond providing tests; they involve addressing systematic barriers related to income, race, location, and insurance status that limit access to care. This collaboration embodies those principles.

Cityblock, a value-based, tech-driven healthcare organization, believes everyone deserves to be healthy, regardless of race, gender, or income. Its flexible care model extends SBH's services to high-risk patients, supporting them at home, virtually, or in Cityblock clinics. This approach enables SBH to respond effectively to community needs and patient preferences.

To advance health equity, Cityblock ensures that SBH Health System patients, particularly Medicaid members with complex needs in underserved communities, receive dignified, high-value, and evidence-based care. The integrated model combines primary care, behavioral health, and social support delivered through community clinics, at home, or virtually.

Recognizing the pivotal role of social drivers in health outcomes, the partnership extends patient access to community-based organizations and social services, providing support in areas such as food security, housing, transportation, and other essential needs. This comprehensive approach further promotes health equity.

c. Domain 1: Economic Stability

Domain Goal	All people in New York have the financial security and support needed to thrive
Priority	Poverty
Goal	Identity, promote and implement progress that addresses poverty
CHNA Survey	Ranked # 12 in importance; #18 below average satisfaction; #5 in areas of improvement
Intervention	Conduct screening of inpatients, with specific exclusions, of five Center for Medicaid Services Health-Related Social Needs (HRSN)

i. Statement of Need

Socioeconomic disparity in the Bronx, the poorest urban county in the U.S., negatively impacts physical, socioemotional, and educational health. About 31% of the Bronx population lives below the poverty line, higher than the New York City average of 20.4%. Belmont/East Tremont, our primary service area, had a median household income of $32,020 in 2023, 60% less than the citywide median of $78,480. The poverty rate in 2023 was 41.4%, compared to 18.2% citywide. These metrics indicate a substantial gap between income and the cost of living, highlighting the challenges faced by many in achieving financial security.

Community conditions impact health outcomes. There are conditions in the environments where people are born, live, learn, work, play, worship and age that affect health and quality of life outcomes and risks. They are sometimes called “social drivers of health.” (Adapted from CDC Healthy People 2030).

According to U.S. Department of Health and Human Services, Health-Related Social Needs (HRSN) are the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors.

ii. Project Narrative

Conduct screening of inpatients (age 18 & over, with specific exclusions) for the Center for Medicaid Services (CMS) five Health-Related Social Needs (HRSN) domains. The Center for Medicare & Medicaid Services (CMS) identified five Health-Related Social Needs for screening. These factors are part of the framework for addressing social drivers of health (SDOH).

In this intervention, we are screening for five CMS HRSN:

1. **Food Insecurity:** A limited or uncertain access to adequate quality and quantity of food at the household level.
2. **Housing Instability:** This encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded spaces, and actual lack of sheltered housing.
3. **Transportation Needs:** Limitations that impede transport to destinations required for daily living.
4. **Utility Difficulties:** Inconsistent availability of electricity, water, oil, or gas.
5. **Partner Violence:** Screening for exposure to intimate partner violence, child abuse, and elder abuse.

Patient Screening eligibility:

- 18+ years or older
- If 18+ or older and they have legal caretaker and/or guardian, they need to be present
- Inpatient: the first 12 hours of admission to every unit
- Exclusions: Those that are "declined" and are "unable"

iii. Objectives

New York State Prevention Agenda 2025–2027:

Smart Objectives: 1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.

Desired Outcome: Reduce the number of people living in poverty in NYS percentage of people living in poverty.

Indicator: Percentage of people living in poverty

Data Source: ACS (American Community Survey)

Population: Individuals and families living below the federal poverty threshold

Baseline: 13.6% (2018–2022)

Target: 12.5% (2030)

SMART(IE) Objective: Screen for five Center for Medicaid Services Health-Related Health Need.

Desired Outcome: Conduct screening of inpatients eligible, with specific exclusions, for the five Center for Medicaid Services Health-Related Social Needs.

Indicator: Screening rate percentage, HRSN positivity percentage

Data Source: EPIC dashboards

SBH is tracking the screenings using EPIC dashboards:

- Year to date screening rate percentage
- Number of screened patients/Number of patients eligible
- Patients included in the numerator if screened for all five HRSN during their admission

Baseline: 74% screening rate of the eligible inpatients

Target: 80% screening rate of the eligible inpatients

iv. Geographic Focus

The patients in the project are from SBH Health System's primary service areas in Bronx zip codes (highest to lowest number of patients): 10457, 10458, 10460, 10456, 10453, 10468, 10462, 10467, 10459, 10472, and 10452.

v. Resource Commitment

SBH has been screening for select Health-Related Social Needs for years. The previously selected screenings were linked to available resources. The expansion of screening and referrals for services has been made possible by two major resources.

First, the implementation of EPIC (Electronic Health Records); which facilitates recording screening information and makes it possible to develop dashboards for real-time data monitoring.

Second, SBH is one of the safety net hospitals participating in New York State Medicaid 1115 waiver. This waiver aims to help the state improve health equity; reduce health disparities; support the delivery of health-related social needs services for high-risk populations; and promote workforce development. SBH is able to refer patients for health-related social needs services and activities through the designated Social Care Network.

vi. Participant Roles

The screening for Health-Related Social Needs is primarily conducted by the Department of Nursing. It has been incorporated into the admission process. EPIC facilitates both the collection of screenings and the ability to track rates of compliance. There is extensive involvement by several departments to ensure quality improvement by tracking the data.

The following were conducted to facilitate the implementation and tracking of this data:

- Mandatory online and in-person trainings
- Monthly Nursing orientations for new nursing hires
- Departmental taskforce to monitor progress
- Clinical practice alerts
- Regularly monitor screening percentages
- Quarterly Meetings with Nursing directors
- Nursing:
  - Daily huddles and trainings for staff
  - Reminders and in-services for staff, regularly

Reports on the progress of screenings are given to the SBH Executive Quality Assurance and Performance Improvement Committee consistently to determine if corrections are required to improve the screening rates.

vii. Health Equity

SBH Health System is screening for HRSN as a moral and operational imperative. It allows SBH to see the full picture of patient health, allocate resources equitably, and partner with the community to reduce the social and structural inequities that drive poor health outcomes in the Bronx.

1. Addresses the Real-World Needs of Vulnerable Patients:

SBH Health System serves populations disproportionately affected by poverty, housing insecurity, food scarcity, and high rates of violence. By screening these Health-Related Social Needs, SBH can uncover the non-medical barriers that keep patients from following treatment plans.

SBH can connect patients to community resources such as food pantries, housing assistance, and transportation vouchers. This includes both SBH resources and referrals to the Social Care network.

Equity impact: Every patient, regardless of income or background, receives care that fits their circumstances and not just medical advice they can't realistically follow.

2. Prevents Avoidable Emergency Visits and Readmissions:

When SBH screens and supports HRSN, it can aid early intervention.

Equity impact: Reduces preventable hospitalization, freeing up resources to serve more patients while improving stability for high-risk populations.

3. Strengthens Trust and Cultural Competence:

Discussion of social needs in a respectful, culturally aware manner builds trust in the community. It encourages consistent engagement with primary care and preventive services.

Equity impact: Greater trust and communication to improve long-term health outcomes.

4. Aligns with Health Equity Mandates and Quality Goals:

Agencies like the Joint Commission, Centers for Medicare & Medicaid Services (CMS), New York State Department of Health and New York City Department of Health increasingly require such screening as part of equity and value-based care initiatives.

Equity impact: Aligns institutional goals with public health improvements.

J. PARTNER ENGAGEMENT

SBH Health System 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 strengthen the programs.

These projects are a part of the SBH Health System's overall path to health equity. SBH is, and will be, involved in efforts being conducted by government agencies, HANYS, Greater New York Hospital Association and Essential Hospitals to examine and implement means to achieve health equity.

There will be extensive monitoring efforts to judge progress, make necessary adjustments, and report to stakeholders. Discussions will be held with public health experts, from the New York City Department of Health and Mental Hygiene, New York State Department of Health, and other relevant governmental agencies to ensure we have up-to-date appraisals of the proposed interventions.

There will be ongoing discussions with SBH clinicians to determine the effectiveness of the selected programs. Regular reporting will be provided to SBH leadership to assess progress, barriers, and revisions to the implementation plan. An annual report will be provided to the Board of Trustees. Yearly updates will be provided to the New York State Department of Health.

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 community's health. There will be a robust community discussion of selected projects.

Monthly reports will be provided at SBH Wellness Alliance (SBHWA) meetings to assess progress, barriers, and necessary revisions to the implementation plan. Similar reports will be provided to Bronx Community District #5 and #6.

A significant percentage of SBH personnel are Bronx residents. On a regular basis, SBH utilizes several forums to ask for their views or concerns about the community's health needs and priorities for the Bronx. In various community settings, SBH will update the progress of the projects and ask for changes to meet goals.

K. FINDINGS WITH COMMUNITY

The SBH Health System Community Service Plan is posted on the SBH Health System website with instructions for downloading and in a format when downloaded to print in hard copy.

https://www.sbhny.org/community-engagement/

Hard copies of the plan are available without charge to anyone upon request to the SBH Department of Community and Government Affairs. **Hard copies will be available to view at the concierge desks in the hospital.**

It will be regularly distributed to community members and other interested stakeholders. Through outreach and engagement activities, SBH will continually seek to keep the community informed of our activities and get feedback and input.

The Executive Summary of the plan shares our analysis and conclusions in a more accessible format for a broader audience. **Executive Summary has been translated and made available in Spanish.**

Appropriate SBH staff will provide community presentations to discuss the findings of the report, its relationship to community interest, and request feedback.

SBH will engage the community through local media and partnering organizations.

The report will be available to employees on the SBH intranet. **A QR code was created.**

L. APPENDIX LISTING

Appendix A: 2025 SBH Community Health Needs Assessment Survey

Appendix B: Top 20 Inpatient Discharges and Treat and Release ED Visits, 2024

Appendix C: Board of Trustees Resolution

Appendix D: SBH Health System Board of Trustees, 2025

Appendix E: SBH Health System Leadership Team

Appendix F: Bronx Rises Against Gun Violence Team (B.R.A.G.)

Appendix G: Youth Engagement Beyond the Emergency Room Targets 2025

Appendix H: Stakeholders CHNA/CSP Process 2025

Appendix I: Data Sources

Appendix J: SBH Health System Financial Statement

APPENDIX A

2025 SBH BRONX COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY:

- 2025 SBH Community Health Needs Assessment Survey Outreach
- SBH Bronx Community Health Needs Assessment Survey in English & Spanish, 2025

2025 Community Health Survey

We want to improve the health services we offer to people who live in your neighborhood. The information you give us will be used to improve health services for people like yourself.

Completing the survey is voluntary. We will keep your answers private. If you are not comfortable answering a question, leave it blank.

We value your input. Thank you very much for your help.

1. Are you 18 years of age or older?

○ Yes
○ No → Thank you very much, but we are only asking this survey of people who are ages 18 and older.

2. We want people from all different neighborhoods to take part in this survey. Please tell us the zip code where you live so we can identify your neighborhood.

Zip code: _____

IF YOU PROVIDED A ZIP CODE, PLEASE GO TO QUESTION 6. YOU DO NOT NEED TO ANSWER THESE QUESTIONS.

3. Do you live in New York City?

○ Yes
○ No → Skip to question 5

4. If you live in New York City, please select the borough where you live:

○ The Bronx → Go on to page 3
○ Brooklyn → Go on to page 3
○ Manhattan → Go on to page 3
○ Queens → Go on to page 3
○ Staten Island → Go on to page 3
○ I do not live in New York City → Skip to question 5

5. If you do not live in New York City, please tell us the county where you live:

○ Albany County
○ Allegany County
○ Broome County
○ Cattaraugus County
○ Cayuga County
○ Chautauqua County
○ Chemung County
○ Chenango County
○ Clinton County
○ Columbia County
○ Cortland County
○ Madison County
○ Monroe County
○ Montgomery County
○ Nassau County
○ Niagara County
○ Oneida County
○ Onondaga County
○ Ontario County
○ Orange County
○ Orleans County
○ Oswego County
○ Tioga County
○ Tompkins County
○ Ulster County
○ Warren County
○ Washington County
○ Wayne County
○ Westchester County
○ Wyoming County
○ Yates County
○ Other_____

- ○ Delaware County
- ○ Dutchess County
- ○ Erie County
- ○ Essex County
- ○ Franklin County
- ○ Fulton County
- ○ Genesee County
- ○ Greene County
- ○ Hamilton County
- ○ Herkimer County
- ○ Jefferson County
- ○ Lewis County
- ○ Livingston County
- ○ Otsego County
- ○ Putnam County
- ○ Rensselaer County
- ○ Rockland County
- ○ Saratoga County
- ○ Schenectady County
- ○ Schoharie County
- ○ Schuyler County
- ○ Seneca County
- ○ St. Lawrence County
- ○ Steuben County
- ○ Suffolk County
- ○ Sullivan County

Health Status

6. In general, how is the overall health of the people of your neighborhood?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

7. In general, how is your physical health?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

8. In general, how is your mental health?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

9. For each of the following, please tell us: How important is each of the following to you and how satisfied are you with the current services in your neighborhood to address each issue?

	How important is this issue to you?						How satisfied are you with current services?					
	Not at all	A little	Somewhat	Very	Extremely	Don't know	Not at all	A little	Somewhat	Very	Extremely	Don't know
1. Access to continuing education and job training programs	○	○	○	○	○	○	○	○	○	○	○	○
2. Access to healthy/nutritious foods	○	○	○	○	○	○	○	○	○	○	○	○
3. Adolescent and child health	○	○	○	○	○	○	○	○	○	○	○	○
4. Affordable housing and homelessness prevention	○	○	○	○	○	○	○	○	○	○	○	○
5. Arthritis/disease of the joints	○	○	○	○	○	○	○	○	○	○	○	○
6. Assistance with basic needs like food, shelter, and clothing	○	○	○	○	○	○	○	○	○	○	○	○
7. Asthma, breathing issues, and lung disease	○	○	○	○	○	○	○	○	○	○	○	○
8. Cancer	○	○	○	○	○	○	○	○	○	○	○	○
9. Cigarette smoking/tobacco use/vaping/ e-cigarettes/ hookah	○	○	○	○	○	○	○	○	○	○	○	○
10. Infectious diseases (COVID-19, flu, hepatitis)	○	○	○	○	○	○	○	○	○	○	○	○
11. Dental care	○	○	○	○	○	○	○	○	○	○	○	○
12. Diabetes and high blood sugar	○	○	○	○	○	○	○	○	○	○	○	○
13. Heart disease	○	○	○	○	○	○	○	○	○	○	○	○
14. Hepatitis C/liver disease	○	○	○	○	○	○	○	○	○	○	○	○
15. High blood pressure	○	○	○	○	○	○	○	○	○	○	○	○
16. HIV/AIDS (Acquired Immune Deficiency Syndrome)	○	○	○	○	○	○	○	○	○	○	○	○
17. Infant health	○	○	○	○	○	○	○	○	○	○	○	○
18. Job placement and employment support	○	○	○	○	○	○	○	○	○	○	○	○
19. Mental health disorders (such as depression)	○	○	○	○	○	○	○	○	○	○	○	○
20. Obesity in children and adults	○	○	○	○	○	○	○	○	○	○	○	○
21. School health and wellness programs	○	○	○	○	○	○	○	○	○	○	○	○
22. Sexually Transmitted Infections (STIs)	○	○	○	○	○	○	○	○	○	○	○	○
23. Stopping falls among elderly	○	○	○	○	○	○	○	○	○	○	○	○
24. Substance use disorder/ addiction (including alcohol use disorder)	○	○	○	○	○	○	○	○	○	○	○	○
25. Violence (including gun violence)	○	○	○	○	○	○	○	○	○	○	○	○
26. Women's and maternal health care	○	○	○	○	○	○	○	○	○	○	○	○

Long-term COVID Effects

10. Have you ever tested positive for COVID-19 (using a rapid point-of-care test, self-test, or laboratory test) or been told by a doctor or other health care provider that you have or had COVID-19?

- ○ Yes
- ○ No → Skip to question 13

11. Do you currently have symptoms lasting 3 months or longer that you did not have prior to having coronavirus or COVID-19?

- ○ Yes
- ○ No → Skip to question 13

12. Do these long-term symptoms reduce your ability to carry out day-to-day activities compared with the time before you had COVID-19?

- ○ Yes, a lot
- ○ Yes, a little
- ○ Not at all

Social Drivers of Health

13. During the past 12 months, have you received food stamps, also called SNAP, the Supplemental Nutrition Assistance Program on an EBT card?

- ○ Yes
- ○ No

14. During the past 12 months how often did the food that you bought not last, and you didn't have money to get more?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

15. During the last 12 months, was there a time when you were not able to pay your mortgage, rent or utility bills?

- ○ Yes
- ○ No

Health Care Access

16. What is the current source of your primary health insurance (the one you use most often)?

- ○ A plan purchased through an employer or union (including plans purchased through another person's employer)
- ○ A private nongovernmental plan that you or another family member buys on your own
- ○ Medicare
- ○ Medigap
- ○ Medicaid
- ○ Children's Health Insurance Program (CHIP)

○ Military related health care: TRICARE (CHAMPUS) /VA health care /CHAMP-VA
○ Indian Health Services
○ State sponsored health plan
○ Other government program
○ No coverage of any type

Demographic Information

17. What is your race and/or ethnicity? (Select all that apply)

□ American Indian or Alaska Native
For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

□ Asian
For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.

□ Black or African American
For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.

□ Hispanic or Latino
For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.

□ Middle Eastern or North African
For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.

□ Native Hawaiian or Pacific Islander
For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.

□ White
For example, English, German, Irish, Italian, Polish, Scottish, etc.

18. Do you speak a language other than English at home?

○ Yes
○ No → Skip to question 21

19. What is this language? (Select all that apply)

□ Spanish
□ Arabic
□ Bengali
□ Burmese
□ Chinese
□ French
□ Haitian Creole
□ Hindi
□ Italian
□ Japanese
□ Korean
□ Nepali
□ Polish
□ Russian
□ Urdu
□ Yiddish
□ Other

20. How well do you speak English?

○ Very well
○ Well
○ Not well
○ Not at all

21. Which of the following best represents how you think of yourself?

○ Gay or lesbian
○ Straight, that is not gay or lesbian
○ Bisexual
○ I use a different term

22. How do you currently describe yourself? (Select all that apply)

□ Woman
□ Man
□ Non-binary
□ I use a different term

23. Are you transgender?

○ Yes
○ No

24. What is your age?

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

25. What is the highest grade or year of school that you have completed?

○ Grades 8 (Elementary) or less
○ Grades 9 through 11 (Some High School)
○ Grade 12 or GED (High School Graduate)
○ College 1 year to 3 years (Some college or technical school)
○ College 4 years or more (College graduate)

26. Including yourself, how many people usually live or stay in your home or apartment?

_____ person(s)

27. Are you currently…?

○ Employed for wages
○ Self-employed
○ Out of work for 1 year or more
○ Out of work for less than 1 year
○ A homemaker

○ A student
○ Retired
○ Unable to work

28. What is your household's annual household income from all sources, before taxes, in the last year? By household income we mean the combined income from everyone living in the household including even roommates or those on disability income.

○ Less than $20,000
○ $20,000 to $24,999
○ $25,000 to $34,999
○ $35,000 to $49,999
○ $50,000 to $74,999
○ $75,000 to $99,999
○ $100,000 to $149,999
○ $150,000 to $199,999
○ $200,000 or more

This is the end of the survey. Thank you very much for your help.

Encuesta de Salud de la Comunidad 2025

Queremos mejorar los servicios médicos que ofrecemos a las personas que viven en su barrio. La información que nos dé se usará para mejorar los servicios médicos para personas como usted.

Completar la encuesta es voluntario. Mantendremos sus respuestas privadas. Si no se siente cómodo respondiendo una pregunta, déjela en blanco.

Valoramos su opinión. Muchas gracias por su ayuda.

1. **¿Es usted una persona mayor de 18 años?**
   - ○ Sí
   - ○ No → Muchas gracias, pero esta encuesta solo la estamos haciendo a personas mayores de 18 años.

2. **Queremos que personas de todos los barrios participen en esta encuesta. Díganos el código postal donde vive para que podamos identificar su barrio.**

   Código postal:: _____

SI DIO UN CÓDIGO POSTAL, PASE A LA PREGUNTA 6. NO ES NECESARIO QUE RESPONDA ESTAS PREGUNTAS.

3. **¿Vive en la ciudad de Nueva York?**
   - ○ Sí
   - ○ No → Pase a la pregunta 5

4. **Si vive en la ciudad de Nueva York, seleccione el distrito donde vive:**
   - ○ El Bronx → Vaya a la página 3
   - ○ Brooklyn → Vaya a la página 3
   - ○ Manhattan → Vaya a la página 3
   - ○ Queens → Vaya a la página 3
   - ○ Staten Island → Vaya a la página 3
   - ○ No vivo en la ciudad de Nueva York → Pase a la pregunta 5

5. **Si no vive en la ciudad de Nueva York, indíquenos el condado donde vive:**

○ Condado de Albany	○ Condado de Madison	○ Condado de Tioga
○ Condado de Allegany	○ Condado de Monroe	○ Condado de Tompkins
○ Condado de Broome	○ Condado de Montgomery	○ Condado de Ulster
○ Condado de Cattaraugus	○ Condado de Nassau	○ Condado de Warren
○ Condado de Cayuga	○ Condado de Niagara	○ Condado de Washington
○ Condado de Chautauqua	○ Condado de Oneida	○ Condado de Wayne
○ Condado de Chemung	○ Condado de Onondaga	○ Condado de Westchester
○ Condado de Chenango	○ Condado de Ontario	○ Condado de Wyoming
○ Condado de Clinton	○ Condado de Orange	○ Condado de Yates
○ Condado de Columbia	○ Condado de Orleans	
○ Condado de Cortland	○ Condado de Oswego	○ Otro_____

- ○ Condado de Delaware
- ○ Condado de Dutchess
- ○ Condado de Erie
- ○ Condado de Essex
- ○ Condado de Franklin
- ○ Condado de Fulton
- ○ Condado de Genesee
- ○ Condado de Greene
- ○ Condado de Hamilton
- ○ Condado de Herkimer
- ○ Condado de Jefferson
- ○ Condado de Lewis
- ○ Condado de Livingston
- ○ Condado de Otsego
- ○ Condado de Putnam
- ○ Condado de Rensselaer
- ○ Condado de Rockland
- ○ Condado de Saratoga
- ○ Condado de Schenectady
- ○ Condado de Schoharie
- ○ Condado de Schuyler
- ○ Condado de Seneca
- ○ Condado de St. Lawrence
- ○ Condado de Steuben
- ○ Condado de Suffolk
- ○ Condado de Sullivan

Estado Médico

6. En general, ¿cómo es la salud de la mayoría de las personas de su barrio?

- ○ Mala
- ○ Regular
- ○ Buena
- ○ Muy buena
- ○ Excelente

7. En general, ¿cómo es su salud física?

- ○ Mala
- ○ Regular
- ○ Buena
- ○ Muy buena
- ○ Excelente

8. En general, ¿cómo es su salud mental?

- ○ Mala
- ○ Regular
- ○ Buena
- ○ Muy buena
- ○ Excelente

9. Para cada uno de los siguientes, díganos: ¿Qué importancia tiene para usted cada uno de los siguientes puntos y qué tan satisfecho está con los servicios actuales en su barrio para tratar cada problema?

	¿Qué importancia tiene este tema para usted?						¿Qué tan satisfecho está usted con los servicios actuales?					
	Para nada	Un poco	Algo	Muy	Extremadamente	No sabe	Para nada	Un poco	Algo	Muy	Extremadamente	No sabe
1. Acceso a programas de educación continua y capacitación laboral	○	○	○	○	○	○	○	○	○	○	○	○
2. Acceso a alimentos saludables y nutritivos	○	○	○	○	○	○	○	○	○	○	○	○
3. Salud de los adolescentes y niños	○	○	○	○	○	○	○	○	○	○	○	○
4. Vivienda asequible y prevención de la falta de vivienda	○	○	○	○	○	○	○	○	○	○	○	○
5. Artritis/enfermedad de las articulaciones	○	○	○	○	○	○	○	○	○	○	○	○
6. Asistencia con necesidades básicas como comida, alojamiento y ropa	○	○	○	○	○	○	○	○	○	○	○	○
7. Asma, problemas respiratorios y enfermedades pulmonares	○	○	○	○	○	○	○	○	○	○	○	○
8. Cáncer	○	○	○	○	○	○	○	○	○	○	○	○
9. Fumar cigarrillos/consumo de tabaco/vapear/ cigarrillos electrónicos/narguile	○	○	○	○	○	○	○	○	○	○	○	○
10. Enfermedades infecciosas (COVID-19, gripe, hepatitis)	○	○	○	○	○	○	○	○	○	○	○	○
11. Atención dental	○	○	○	○	○	○	○	○	○	○	○	○
12. Diabetes y niveles altos de azúcar en la sangre	○	○	○	○	○	○	○	○	○	○	○	○
13. Enfermedades del corazón	○	○	○	○	○	○	○	○	○	○	○	○
14. Hepatitis C/enfermedad hepática	○	○	○	○	○	○	○	○	○	○	○	○
15. Presión alta	○	○	○	○	○	○	○	○	○	○	○	○
16. VIH/sida (síndrome de inmunodeficiencia adquirida)	○	○	○	○	○	○	○	○	○	○	○	○
17. Salud infantil	○	○	○	○	○	○	○	○	○	○	○	○
18. Colocación laboral y apoyo al empleo	○	○	○	○	○	○	○	○	○	○	○	○
19. Trastornos de salud mental (como la depresión)	○	○	○	○	○	○	○	○	○	○	○	○
20. Obesidad en niños y adultos	○	○	○	○	○	○	○	○	○	○	○	○
21. Programas de salud y bienestar en la escuela	○	○	○	○	○	○	○	○	○	○	○	○
22. Infecciones de transmisión sexual (STI)	○	○	○	○	○	○	○	○	○	○	○	○
23. Detener las caídas en los adultos mayores	○	○	○	○	○	○	○	○	○	○	○	○
24. Trastorno por consumo de sustancias/adicción (incluyendo el trastorno por consumo de alcohol)	○	○	○	○	○	○	○	○	○	○	○	○
25. Violencia (incluyendo la violencia armada)	○	○	○	○	○	○	○	○	○	○	○	○
26. Atención médica de la mujer y atención materna	○	○	○	○	○	○	○	○	○	○	○	○

Efectos de Largo Plazo del COVID

10. ¿Alguna vez ha dado positivo en una prueba de COVID-19 (usando una prueba rápida en el punto de atención, una prueba que se haya hecho usted mismo o una prueba de laboratorio) o un médico u otro proveedor de atención médica le dijo que tiene o tuvo COVID-19?

- ○ Sí
- ○ No → Pase a la pregunta 13

11. ¿Actualmente tiene síntomas que han durado 3 meses o más y que no tenía antes de tener coronavirus o COVID-19?

- ○ Sí
- ○ No → Pase a la pregunta 13

12. ¿Reducen esos síntomas de largo plazo su capacidad para hacer actividades cotidianas comparado con el tiempo antes de tener COVID-19?

- ○ Sí, mucho
- ○ Sí, un poco
- ○ Para nada

Determinantes Sociales de la Salud

13. Durante los últimos 12 meses, ¿ha recibido cupones de alimentos, también llamados SNAP, el Programa de Asistencia Nutricional Suplementaria (Supplemental Nutrition Assistance Program, SNAP) en una tarjeta EBT?

- ○ Sí
- ○ No

14. Durante los últimos 12 meses, ¿con qué frecuencia la comida que compró no le duró lo suficiente y no tuvo dinero para comprar más?

- ○ Siempre
- ○ Generalmente
- ○ A veces
- ○ Rara vez
- ○ Nunca

15. Durante los últimos 12 meses, ¿hubo algún momento en el que no pudo pagar su hipoteca, alquiler o facturas de servicios públicos?

- ○ Sí
- ○ No

Acceso a la Atención Médica

16. ¿Cuál es la fuente actual de su seguro médico primario (el que usa con más frecuencia)?

- ○ Un plan que compró por medio de un empleador o sindicato (incluyendo los planes que compró mediante el empleador de otra persona)
- ○ Un plan privado no gubernamental que usted u otro familiar compra por su cuenta
- ○ Medicare
- ○ Medigap

○ Medicaid
○ Programa de Seguro Médico para Niños (Children's Health Insurance Program, CHIP)
○ Atención médica relacionada con el ámbito militar: TRICARE (CHAMPUS)/Atención médica de VA/CHAMP-VA
○ Servicios de salud indígena
○ Plan médico patrocinado por el estado
○ Otro programa del gobierno
○ No tiene cobertura de ningún tipo

Información Demográfica

17. ¿Cuál es su raza u origen étnico? (Elija todas las opciones que correspondan)

□ Indio americano o nativo de Alaska
Por ejemplo, la Nación Navajo, la Tribu de los Pies Negros de la Reserva India de los Pies Negros de Montana, el Gobierno Tradicional de la Aldea Nativa de Barrow Iñupiat, la Comunidad Esquimal de Nome, los aztecas, los mayas, etc.

□ Asiático
Por ejemplo, chino, indio asiático, filipino, vietnamita, coreano, japonés, etc.

□ Negro o afroamericano
Por ejemplo, afroamericano, jamaicano, haitiano, nigeriano, etíope, somalí, etc.

□ Hispano o latino
Por ejemplo, mexicano, puertorriqueño, salvadoreño, cubano, dominicano, guatemalteco, etc.

□ Del Medio Oriente o Norte de África
Por ejemplo, libanés, iraní, egipcio, sirio, iraquí, israelí, etc.

□ Nativo de Hawái o de otra isla del Pacífico
Por ejemplo, nativo de Hawái, samoano, chamorro, tongano, fiyiano, marshalés, etc.

□ Blanco
Por ejemplo, inglés, alemán, irlandés, italiano, polaco, escocés, etc.

18. ¿Habla otro idioma en casa aparte de inglés?

○ Sí
○ No → Pase a la pregunta 21

19. ¿Cuál es ese idioma? (Elija todas las opciones que correspondan)

□ Español
□ Árabe
□ Bengalí
□ Birmano
□ Chino
□ Francés
□ Criollo haitiano
□ Hindi
□ Italiano
□ Japonés
□ Coreano
□ Nepalí
□ Polaco
□ Ruso

□ Urdu
□ Yiddish
□ Otro

20. ¿Qué tan bien habla inglés?

○ Muy bien
○ Bien
○ Mal
○ Para nada

21. ¿Cuál de las siguientes opciones representa mejor cómo piensa de usted mismo?

○ Gay o lesbiana
○ Heterosexual, es decir, no gay ni lesbiana
○ Bisexual
○ Uso un término diferente

22. ¿Cómo se describe actualmente? (Elija todas las opciones que correspondan)

□ Mujer
□ Hombre
□ No binario
□ Uso un término diferente

23. ¿Es transgénero?

○ Sí
○ No

24. ¿Cuántos años tiene?

○ 18 - 24
○ 25 - 34
○ 35 - 44
○ 45 - 54
○ 55 - 64
○ 65 - 74
○ Más de 75

25. ¿Cuál es el grado o año más alto de escuela que concluyó?

○ 8.° grado (primaria) o menos
○ 9.° a 11.° grado (algunos de secundaria)
○ 12.° grado o GED (graduado de escuela secundaria)
○ 1 año a 3 años de universidad (algunos estudios universitarios o escuelas técnicas)
○ 4 años o más de universidad (graduado de la universidad

26. Incluyéndose usted, ¿cuántas personas viven o se alojan habitualmente en su casa o apartamento?

_____ personas

27. ¿Está actualmente…?

- ○ Empleado con salario
- ○ Trabajador autónomo
- ○ Sin trabajo por más de 1 año
- ○ Sin trabajo por menos de 1 año
- ○ Ama de casa
- ○ Estudiante
- ○ Jubilado
- ○ Incapacitado para trabajar

28. ¿Cuáles fueron los ingresos anuales de todas las fuentes del grupo familiar, antes de impuestos, en el último año? Por ingresos del grupo familiar nos referimos a los ingresos combinados de todas las personas que viven en el grupo familiar, incluyendo los compañeros de habitación o aquellos que reciben ingresos por discapacidad.

- ○ Menos de $20,000
- ○ $20,000 a $24,999
- ○ $25,000 a $34,999
- ○ $35,000 a $49,999
- ○ $50,000 a $74,999
- ○ $75,000 a $99,999
- ○ $100,000 a $149,999
- ○ $150,000 a $199,999
- ○ $200,000 o mas

Este es el final de la encuesta. Muchas gracias por su ayuda.

APPENDIX B

TOP 20 INPATIENT DISCHARGES AND TREAT AND RELEASE ED VISITS

Top 20 Inpatient Discharges at St. Barnabas Hospital, 2024

ICD-10 Code	Label	Discharges
R07.9	Chest pain, unspecified	2014
Z53.21	Procedure and treatment not carried out due to patient leaving prior to being seen by health care provider	1933
W19.XXXA	Unspecified fall, initial encounter	1709
J06.9	Acute upper respiratory infection, unspecified	1532
F10.920	Alcohol use, unspecified with intoxication, uncomplicated	1175
F10.90	Alcohol use, unspecified, uncomplicated	980
R56.9	Unspecified convulsions	903
Y09	Assault by unspecified means	820
Z48.02	Encounter for removal of sutures	799
F19.90	Other psychoactive substance use, unspecified, uncomplicated	797
Z13.9	Encounter for screening, unspecified	786
R55	Syncope and collapse	754
R10.9	Unspecified abdominal pain	747
M54.50	Low back pain, unspecified	734
F10.10	Alcohol abuse, uncomplicated	718
G89.29	Other chronic pain	661
R11.2	Nausea with vomiting, unspecified	660
R42	Dizziness and giddiness	638
J18.9	Pneumonia, unspecified organism	624
J45.901	Unspecified asthma with (acute) exacerbation	606

Data Source: SBH Health System. Top 20 Inpatient Discharges and Treat and Release ED Visits. 2024.

Top 20 Reasons for Treat & Release ED Visits at St. Barnabas Hospital, 2024

ICD-10 Code	Label	Discharges
Z53.21	Procedure and treatment not carried out due to patient leaving prior to being seen by health care provider	1932
W19.XXXA	Unspecified fall, initial encounter	1612
J06.9	Acute upper respiratory infection, unspecified	1517
R07.9	Chest pain, unspecified	1479
F10.920	Alcohol use, unspecified with intoxication, uncomplicated	1158
Y09	Assault by unspecified means	807
Z48.02	Encounter for removal of sutures	799
Z13.9	Encounter for screening, unspecified	782
F19.90	Other psychoactive substance use, unspecified, uncomplicated	729
M54.50	Low back pain, unspecified	724
R56.9	Unspecified convulsions	722
G89.29	Other chronic pain	657
R10.9	Unspecified abdominal pain	647
R11.2	Nausea with vomiting, unspecified	630
F10.90	Alcohol use, unspecified, uncomplicated	583
R51.9	Headache, unspecified	577
R42	Dizziness and giddiness	542
R10.84	Generalized abdominal pain	535
K08.89	Other specified disorders of teeth and supporting structures	529
B34.9	Viral infection, unspecified	511

Data Source: SBH Health System. Top 20 Inpatient Discharges and Treat and Release ED Visits. 2024.

APPENDIX C

A RESOLUTION ADOPTED BY THE BOARD OF TRUSTEES OF ST. BARNABAS HOSPITAL

WHEREAS, the Board of Trustees 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 2025–2027 Community Health Assessment and Community Health Improvement Plan to be submitted to the New York State Department of Health.

NOW, THEREFORE, BE IT RESOLVED, by the Board of Trustees of the Hospital, that:

1. The Hospital hereby adopts an implementation strategy to meet the community health needs as identified through the 2025–2027 Community Health Assessment and Community Health Improvement Plan to be submitted to the New York State Department of Health in substantially 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 Chairman of the Board and Treasurer; or any one of the following: President & Chief Executive Officer or Senior Executive Vice President & Chief Operating Officer.

2. This Resolution shall take effect immediately.

Date: November 24, 2025

Secretary

APPENDIX D

SBH HEALTH SYSTEM BOARD OF TRUSTEES 2025

David Harris (Chair)

Wilma Alonso (Vice Chair)

Hon. John A. Barone

William T. Colona

Joshua Glassman

Amarilis Jacobo, DDS

Artie Johnson

Richard G. Ketchum (Senior Vice Chair)

Neema Kumar

David Maurrasse, Ph.D.

Charles Moerdler, Esq.

Ray Negron

Karen Parrish (Vice Chair)

Todd Reinglass (Vice Chair)

Leslie Robinson, RN, DNP

Elizabeth Sanchez, LCSW (Vice Chair & Secretary)

Edward Skloot, BA, MIA, PhD

Perry Sook, Jr.

Derek Tice-Brown, PhD., MSW

Andrew Werner

Barry A. Wintner, CFA

APPENDIX E

SBH HEALTH SYSTEM SENIOR LEADERSHIP TEAM

David A. Perlstein, MD
President & Chief Executive Officer

Eric Appelbaum, DO
Senior EVP & Chief Operating Officer

Mary Grochowski
EVP & Chief Financial Officer

Keith Wolf, Esq.
EVP & Chief Administrative Officer

Jitendra Barmecha, MD
SVP & Chief Information & Digital Strategy Officer

Robert Church, RN
SVP Nursing & Chief Nursing Officer

Bill DiBitetto
SVP Finance & Budget

Manisha Kulshreshtha, MD
SVP & Chief Clinical & Strategy Officer

Daniel Lombardi, DO
SVP & Chief Medical Officer

Ninfa Segarra, JD
SVP Communications & External, Community & Government Affairs/ Chief Diversity & Inclusion Officer

Arun Sharma
SVP Revenue Cycle & Reimbursement

Alfredo Alvarado, RN
VP Operations

Frank Conti
VP Facilities

Sam Cooks
VP Information Technology & CISO

Joan Daughajre, LCSW, MS
AVP Chief Experience Officer

Martine L. Edwards
VP Nursing Operations & Quality

Christine E. Hughes
VP & Chief Advancement Officer

Diana Almanzar
VP Chief Compliance & HIPPA Privacy Officer

Jeeny M. Job, DO
VP & Chief Medical Informatics Officer

Karen R. Johnson
VP Human Resources

Moray Joslyn
VP Ambulatory Care Quality & Population Health

Alvin C. Lin
VP Ambulatory Transformation & Innovation

Victor Pichardo
VP Community & Government Affairs

Jacqueline A. Witter, EdD
VP Chief Quality Officer

APPENDIX F

BRONX RISES AGAINST GUN VIOLENCE TEAM (B.R.A.G.)

David Caba
Senior Vice President

Jessica Caraballo
Director

Benjamin Garcia
Hospital Responder Coordinator

Guy Shoulders Jr.
Senior Administrative Manager

Joseph Smalls
Hospital Responder

Manny Nunez
Hospital Responder

APPENDIX G

YOUTH ENGAGEMENT BEYOND THE EMERGENCY ROOM TARGETS 2025

Youth Non-Contact Boxing Program 2025–2027

Non-contact Boxing Program promotes health and wellness through conditioning, skill-building, and nutrition education classes that include hands-on instruction. Equip youth with fitness skills in a supportive environment that builds confidence, resilience, and strong peer connections.

2025–2027 targets: Boxing Program will have pre and post warm up sessions and one on one mentoring with trainer. These physical fitness sessions offer participants structured 3 to 4 days of activities a week. SBH will increase enrollment amount from 15 participants to 20 participants which is the max allowed for the program. All participants have to be at risk youth and reside in the Bronx.

Each participant will practice non-contact boxing techniques twice a week, a fitness session once a week, and one nutrition session held monthly. Participants will have unlimited access to the fitness center and be provided with hands-on teaching kitchen classes throughout the program. Each participant will be evaluated through the SECA Scale pre and post. Free educational seminars will support participants in career pathways and opportunities of employment at SBH Health System.

SBH Emergency Department Mentoring Programs for Youth:

S.T.A.M.P. - Emergency Medicine Science, Technology, and Medicine Pipeline Program Summary - 2025–2027

S.T.A.M.P. aims to increase the number of underrepresented minorities in medicine through early exposure to various careers and concepts within the health sciences and medical professions. An interactive outreach-based initiative by SBH Emergency Medicine Department providing workshops at local grade schools.

2025–2027 targets: SBH Emergency Medicine Physician Program Coordinator and 4 first year residents will host age-appropriate modules and lessons in local grade schools with a curriculum consisting of 13 lessons including topics: Meet your Health Heroes, Science Fair 101, Anatomy Lab, and Professional Development. S.T.A.M.P. will provide resources to 6 local grade schools servicing zip codes 10457, 10458, 10467, 10472, with sessions of 5 classes filled with 15–20 students per classroom. Each student will be issued S.T.A.M.P. resources for their families. Emergency Medicine Residents will assist in community youth health fairs.

S.E.M.P. - Summer Enrichment and Mentorship Program Summary - 2025–2027

S.E.M.P. pipeline program for participants who have completed their first year in medical school and are interested in pursuing emergency medicine careers. Includes educational sessions, shadowing clinical staff, and enrichment activities.

2025–2027 targets: SBH will accept 8 students from medical schools for a 6-week curriculum, to familiarize them with SBH Simulation Lab, CPR, attend community events, and Stop the Bleed training. Emergency Medicine Program Director and Senior Resident will hold weekly sessions with students on Didactic Lecture Series, procedure/skills workshops, mentorship and shadowing, and a trip to the Bronx Zoo Snake Bite Center to learn about Wilderness Medicine.

Youth Employment:

Summer Youth Employment (SYEP) - 2025–2027

Bronx youth who are immersed in healthcare professions for 6 weeks. Participating in activities that include, Meet and Greet with a Physician, shadow a clinician, confirm appointment for patients. Youth attended education seminars and Stop the Bleed training. Midway & final evaluations will be conducted.

2025–2027 targets: SBH Health System will accept 50 Bronx youth with an interest in healthcare professions. Participants are placed in departments in the hospital. SBH will evaluate participants at the third week and sixth week of the program. After the 6-week program, participants will be awarded with a small ceremony with internal and external guest speakers.

All participants must attend a mandatory career-awareness seminar, community health fairs, financial literacy seminars, and resource-education seminars embedded in their schedules. Participants will be included in Simulation Lab session introduction to the use of medical equipment in a hospital setting, includes case reviews that simulate real-life scenarios in the Emergency Medicine, providing hands-on learning and practical exposure.

Youth Peer - 2025–2027

Part-time, after-school youth peer in high school, who resided in the Bronx supported programming for 8 months. 2025–2027 targets: SBH recruits a part-time, after-school youth peer, attends a local high school and resides in the Bronx. The role runs for 8 months with an opportunity to stay an extra 2 months. Youth Peer assists with operations.

Specialized Training:

Stop The Bleed - 2025–2027

Stop the Bleed is a public training initiative developed by the American College of Surgeons (ACS) for verified Trauma Centers. SBH will conduct training sessions to ensure broader community readiness for traumatic bleeding emergencies. Community members are eligible for the free training, including Middle and High School students. Clinical staff are trained with opportunities to become Instructors. Tourniquets and Bandage kits will be distributed to select groups of learners.

2025: Conduct classes to train at least 175 participants.

2026: Conduct classes to train at least 250 participants, utilizing ‘train-the-trainer’ instructors at community health hospitals.

2027: Conduct classes to train at least 300 participants, increasing community awareness and injury prevention messaging.

APPENDIX H

STAKEHOLDERS CHNA/CSP PROCESS 2025

PUBLIC HEALTH EXPERTS - SBH HEALTH SYSTEM

Agency/Department	Name	Title
SBH Administration	Ninfa Segarra, JD	Senior Vice President, Communications & Government Affairs
SBH Pediatrics	Janine Adjo, MD	Chair, Pediatrics Dept.
SBH Emergency Medicine	Edward Jarvis	Attending
SBH Emergency Medicine	Murphy Daniel, MD	Chair, Emergency Medicine
SBH Surgery-Trauma	Jinky DeCastro Singson	Trauma Program Manager
SBH Surgery-Trauma	Erik Marketan	Injury Prevention Coordinator
SBH Population Health	Moray Joslyn	Vice President-Ambulatory Care Quality & Population Health
SBH Quality Improvement	Jacqueline Witter	Vice President & Chief Quality Officer
SBH Patient Experience	Joan Dauhajre	Assistant Vice President & Chief Experience Officer
SBH Health Information Management	Yomaira Payamps	Director
SBH Dental	Dr. Christopher Lane	Chair, Dental Dept.
SBH Information Technology	Jitendra Barmecha, MD	Senior Vice President, Chief Information, & Digital Strategy Officer
SBH Administration	Daniel Lombardi, DO	Senior Vice President & Chief Medical Officer
SBH Administration	Kulshreshtha Manisha, MD	Senior Vice President, Chief Clinical & Strategy Officer
SBH Ambulatory Services	Alvin Lin	Vice President Ambulatory Transformation & Innovation
SBH Nursing	Martine Edwards	Vice President Nursing Operations & Quality
SBH Emergency Department (ED)	Colleen Leahy	ED Resident
SBH ED	Juhi Patel	Medical Resident
SBH ED	Caurice Wynter	PGY-1 Resident
SBH ED	Nia Rush	PGY-1 Resident
SBH ED	Mohoua Kane	Medical Resident
SBH ED	Trentyn Shaw	MD EM PGY-1 Resident
SBH ED	Kenneth Gordon	Medical Student
SBH ED	Kevin Narang	ED Resident
ED Nutrition Services	Danarda Adames	Registered Dietitian
ED Ophthalmology	Riti Chhibba	Optometrist
SBH Outpatient Nutrition Clinic	Angela Liu	Registered Dietitian
SBH Dental	Denize Gary	Dental Hygienist

SBH Podiatry	Dr. Emilo Goez	Director
SBH Pediatrics	Michelle Ratau	MD
SBH Supplemental Nutrition Program Women, Infants, and Children (W.I.C.)	Bernardo Gil	Director
SBH Pharmacy	Amanda Rampersaud	Chief Pharmacy Officer
SBH Teaching Kitchen	Abbie Gellman	Director
SBH Teaching Kitchen	Andrea Polvere	Culinary Instructor
SBH OBGYN	Tawana Eddings-Howard	Assistant Vice President
SBH Mammo Van/Radiology	Malissa Velez	Registrar
SBH HealthPlex	Albert Jovel	General Manager
SBH HealthPlex	Amaris Martinez	Fitness Director

HEALTHCARE EXPERTS

NYCDOH Poison Control Center	Dilem Valenzuela	Community Health Educator
Greater NY Hospital Association (GNYHA)	Lloyd Bishop	Senior Vice President & Executive Director Center on Community Health Policy & Services
Greater NY Hospital Association (GNYHA)	Benjamin Gonzalez	Senior Director, Community Health Engagement Center on Community Health Policy & Services
Greater NY Hospital Association (GNYHA)	Alejandra Diaz-Houston	Assistant Vice President, Policy Analysis Center on Community Health Policy & Services
Greater NY Hospital Association (GNYHA)	Alyssa Besser	Project Manager, Ambulatory Care and Population Health Government Affairs, Communications, & Public Policy
Greater NY Hospital Association (GNYHA)	Adrian Blader	Assistant Director Center on Community Health Policy & Services
Greater NY Hospital Association (GNYHA)	Kiley Atkins	Senior Project Associate Center on Community Health Policy & Services
Greater NY Hospital Association (GNYHA)	Sean McLaughlin	Senior Project Associate Center on Community Health Policy & Services
HealthCare Association of NYS (HANYS)	Erin Gretzinger	Director, Quality Advocacy, Research & Innovation
LiveOnNY	Iliana Almanzar	Community & Government Affairs Liaison

HEALTH INSURANCE COMPANIES

Agency/Department	Name	Title
Healthfirst	Judeson Santilil	Community Engagement Specialist
Anthem Blue Cross Blue Shield	Esteban Munoz	Community Relations Specialist
Fidelis Care	Juan Quezada	Community Relations Specialist

BUSINESS GROUPS

Agency/Department	Name	Title
Fordham Road Business Improvement District	Wilma Alonso	Executive Director & SBH Trustee
Belmont Business Improvement District	Alyssa Tucker	Executive Director

ELECTED OFFICIALS

Agency/Department	Name	Title
Bronx Borough President Vanessa Gibson	Justin Cortes	Chief of Staff
NYS Senator Gustavo Rivera	Rachel Ferrari	Chief of Staff
NYS Senator Luis Sepulveda	Henessey Reyes	Chief of Staff
NYC Council Member Oswald Feliz	Theona Rates	Chief of Staff
NYS Assemblymember George Alvarez	Taiquan Coleman	Chief of Staff
Bronx Community Board #5	Kenneth Brown	District Manager
Bronx Community Board #6	Rafael Moure-Punnett	District Manager

COMMUNITY BASED ORGANIZATIONS & EDUCATIONAL INSTIUTIONS

Agency/Department	Name	Title
Bronx Rises Against Gun Violence (B.R.A.G.)	David Caba	Senior Vice President
Bronx Rises Against Gun Violence (B.R.A.G.)	Jessical Caraballo	Hospital Responder Director
Bronx Rises Against Gun Violence (B.R.A.G.)	Guy Shoulders Jr.	Senior Administrative Manager
Bronx Rises Against Gun Violence (B.R.A.G.)	Bejamin Garcia	Senior Hospital Responder Coordinator
Bronx Rises Against Gun Violence (B.R.A.G.)	Joseph Smalls	SBH Hospital Responder

Bronx Rises Against Gun Violence (B.R.A.G.)	Manny Nunez	SBH Hospital Responder
SEBCO Residential Senior Building	Nelly Bonifaz	Coordinator
Mary Mitchell Community Center	Aleyna Rodriguez	Director
Highbridge Early Childhood Center	Minerva Cotto	Director of Community
Lehman College	Tammy Christensen	Professor HSA Internship Coordinator
Monroe College	Cathy Carbonelli	Professor HSA Internship Coordinator
Fordham University	Gilda Severiano	Professor Director of Campus Ministry Operations, Budget, & Community Engagement
SUNY Empire State University	Linda Bumcom	Program Director for the LIBIT
Mercy College	Ann B. Visconti	Senior Instructor, Health Services Management
NY Psychotherapy & Counseling Center	Anthony Otten	Senior Outreach Specialist
PHIPPS Neighborhood	Daniel Agosto	Managing Director of Workforce Development
R.A.I.N.	Dr. Anderson Torres	President & CEO
C+C Apartment Management, LLC	Nikki Wernick	Executive Vice President
Lantern Community Services	Danielle Kroll	Assistant Director of Community Health
NYC Office of Neighborhood Safety	Ivory Kennedy, BPS	Borough Manager Bronx/Harlem
NYC Department of Youth & Community Development	Sarah Whitney	Director of Employer Engagement and Partnerships
Trabajamos Community Head Start	Lisa Buchanan	Social Services Director
Cardinal McCloskey Community Services	Eileen Cummings	Social Work Director
Mt. Carmel Church	Father Jose Felix	Pastor
V.I.P. Community Health Center NYPD Precint #48 Community Council	Carmen Rivera	Chief Vocational & Community Affairs President
Eagle Academy for Young Men	Gilliam Sojourner	Parent Coordinator
NYC Public School 23	Josephine Diaz	Parent Coordinator
St. Raymond School for Boys	Pablo Aguilar	Youth Peer
Public School 721	Tina Raciti	Coordinator

APPENDIX I

DATA SOURCES

Data Sources, Data Tools, Reports & Publications

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APPENDIX J

SBH HEALTH SYSTEM FINANCIAL STATEMENT

Financial Services

SBH Health System is committed to providing financial assistance to patients who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Consistent with our mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, we strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Financial Assistance is not a substitute for personal responsibility. Patients are expected to cooperate with our procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their ability to pay. Financial needs will be determined in accordance with specific procedures that we follow.

Completed applications will be reviewed by the Credit and Patient Financial Services Department for final approval. Patients will be provided with a financial counselor who can provide assistance, in their language, or via qualified telephonic interpreters, through every phase of the charity care application process.

For more information, please visit: https://www.sbhny.org/financial-services/

SOURCES: SBH Health System Financial Assistance Policy (12/17/2024), Charity Care Policy and Financial Assistance Summary (English & Spanish).