A PATH TO WELLNESS

Community Health Needs Assessment

Community Health Improvement Plan/Community Service Plan

2025–2027

SBH Health System BRONX

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.
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- **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.
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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/

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

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.

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.