BronxCare Health System

Community Health Needs Assessment and Community Service Plan

2019 – 2021

Copies of this document can be downloaded from the BronxCare Health System website at BronxCare.org.

This Community Health Needs Assessment and Community Service Plan covers select neighborhoods in Bronx County.

We welcome your questions and comments. Please contact Errol Schneer, Vice President of Planning, Marketing, and Public Relations at 718-FAMILY-1 (718-326-4591).

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Executive Summary

Prevention Agenda Priorities and Disparities

BronxCare is committed to furthering the goals set forth in the New York State Prevention Agenda (2019-2024), through the selection of two Priorities. The Priorities selected are Prevent Chronic Diseases and Promote Well-Being and Prevent Mental and Substance Use Disorders. BronxCare, in building on these two Priorities, is collaborating with its Delivery System Reform Incentive Payment (DSRIP) Program and community partners in developing a plan of action consistent with its mission of Promoting and Achieving Health Care Excellence in Caring for the Bronx.

I. Priority Area: Prevent Chronic Diseases
Focus Area: Preventive Care and Management

This initiative addresses the serious health problems impacting the Bronx community, including the high incidence of asthma and lung diseases, diabetes, cardiovascular disease, cancer, and other chronic diseases. An important emphasis will be directed to expanding outpatient services and enhancing access to disease prevention and management services, with the goal of keeping the community healthy and out of the hospital.

Prevent Chronic Diseases was selected as a Priority based on findings that conditions such as asthma and diabetes are linked to health and socioeconomic disparities in the Bronx community.

II. Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders
Focus Area: Prevent Mental and Substance Abuse Disorders

There is a major need for metal health and chemical dependence services in the Bronx Community. This initiative enhances access to integrated mental health and primary care services. It includes community-based programs that enhance and expand on the efforts of BronxCare's comprehensive mental health programs, including mental health and chemical dependence services.

Data Sources

Data was collected from a wide range of sources to develop a demographic and health profile of the Bronx and, specifically, BronxCare's primary service area. The service area is defined by zip code to encompass the United Hospital Fund neighborhoods of Crotona-Tremont, Highbridge-Morrisania, Hunt's Point-Mott Haven and Fordham-Bronx Park. For data sources not available by zip code, a close approximation to the service area was utilized. Map 1 shows the primary service area and its 12 zip codes. Sources include but are not limited to:

- Robert Wood Johnson County Health Rankings, 2019
- US Census Bureau's American Community Survey and American Fact Finder, 2013-2017
- United Hospital Fund of New York Various Publications, 2019
- Claritas, Inc. Population Facts, 2016-2021
- New York City Department of Health Community Health Profiles, 2018
- New York City Department of Health EpiQuery Data, 2015-2017

- New York City Department of Health and Mental Hygiene Vital Statistics Survey, 2018
- New York State Department of Health Prevention Agenda(s), 2013-2018 and 2019-2024
- New York State Department of Health Statistics, 2015-2018
- New York City HIV/AIDS Annual Surveillance Statistics, 2016 and 2018

Partners

BronxCare continues to move forward as a Performing Provider System (PPS) lead in New York State's DSRIP Program. The DSRIP program (entitled Bronx Health Access) is providing BronxCare and its community partners with the opportunity to adapt to a value-based payment system, with an emphasis on keeping patients and the community healthy.

BronxCare's senior management team continually monitors the progress of process measures identified in the Community Health Needs Assessment and Community Service Plan and maintains open channels of communication to ensure that community partnerships are reinforced and expanded.

Evidence-Based Interventions, Strategies, and Activities

Interventions, Strategies, and Activities related to Priority Area I, Prevent Chronic Diseases utilize a number of evidence-based practices, including: implementing patient-centered communication styles that incorporate patient preferences and address cultural barriers to care, employing timely and evidence-based treatment decisions that are tailored to individual patient conditions and employing team-based care models.

Interventions, Strategies, and Activities related to Priority Area II, Promote Well-Being and Prevent Mental and Substance Use Disorders, enhance psychiatric services at inpatient and outpatient levels, provision of cultural and linguistic training to staff, and utilization of the collaborative Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based approach for prevention of substance abuse.

Tracking Progress and Improvement

BronxCare's senior management, administrative staff, physicians, nurses, and Board of Trustees will review progress in addressing the two priorities. The following measures will be used to track progress in meeting community and chronic health needs:

Priority Area: Prevent Chronic Diseases

Focus Area: Preventive Care and Management

Asthma and Lung Diseases

- Continue asthma education efforts, with aim of reducing the high incidence of adult asthma hospitalizations and emergency room asthma visits for children, and improve access to services through public relations/promotional campaigns, as well as through health fairs and community forums.

- Reach 1,000 participants through the Asthma Home-Based Self-Management Program by 2021.
- Develop partnerships with Medicaid managed care plans serving the community in order to help expand the Asthma Home-Based Self-Management Program.
- Continue to work with DSRIP and other community partners to expand outreach and education efforts.

Pre-Diabetes and Diabetes

- In 2020 and 2021, increase number of HbA1c tests performed by 10 percent from the current level of 7,000 HbA1c tests for 2019.
- In 2020 and 2021, increase number of urine microalbumin tests performed by 10 percent from the current level 7,000 urine microalbumin tests for 2019.
- In 2020 and 2021, increase number of retina scans performed by 10 percent from the current level of 1,175 retina scans for 2019.
- In 2020, reach 250 participants through the Owning Diabetes program from the current level of 165 in 2019.
- In 2020 expand the diabetes telehealth program.

Cardiovascular Disease

- Continue to provide high quality services to manage coronary heart disease and treat heart attacks, heart failure, and abnormal heart rhythms.
- Continue to deliver high level diagnostic and treatment series in coordination with patients and their primary care providers.
- Continue to implement quality improvement measures for heart attack patients.
- Continue to receive recognition from the American Heart Association for the high-quality care provided.

Cancer

- Build awareness of cancer services offered at the BronxCare Mount Sinai Cancer Care facility. Relocate cancer services into a state-of-the-art Cancer Care Center in conjunction with a projected 30,00 patient visit goal in 2021.
- Initiate community outreach educational events and public forums.
- Initiate meetings with community physicians and DSRIP partners to solidify base of referrals and increase awareness of services offered.

Other Chronic Conditions

- Increase engagement with individuals and families in the Bronx Community through the Community Health Workers and other initiatives in 2020 and expand the program.
- Continue efforts to expand the Community Health Workers.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area: Prevent Mental and Substance Abuse Disorders

Goal 1: Address opioid crisis with the aim of reducing overdoses.

- In 2020, screen 1,000 individuals for Opioid Use Disorders, building on the 2019 goal of screening 500 individuals.
- In 2020, provide more than 130,000 visits through the Opioid Treatment Program, building on the 2019 goal of 115,000 visits.
- In 2020, provide on-site integrated mental health services at BronxCare's outpatient network.
- In 2020, add Buprenorphine as third Medication Assisted Treatment option through the Opioid Treatment Program.
- In 2020, provide 17,000 visits through the Chemical Dependence Outpatient Treatment Program, building on the 2019 goal of 15,000 visits.
- In 2020, reach 6,000 patients through the Pain Management Practice, building on the 2019 goal of 4,500 patients.

Goal 2: Address high incidence of suicide and continue Zero Suicide grant program to reduce this most serious problem.

- In 2020, provide services through the Zero Suicide program to 10,000 individuals, building on the 2019 goal of services to 5,000 individuals.
- In 2020, expand the Zero Suicide prevention efforts to BronxCare's outpatient practices.

Goal 3: Continue to address the serious mental health issues and achieve emotional wellness in the Bronx Community.

- In 2020, provide Consultation Liaison services to 6,000 individuals, building on the 2019 goal of services to 4,400 individuals.
- In 2020, reinforce and expand Collaborative Care services.

In addition to the two selected priority areas, BronxCare continues to move forward in providing a comprehensive range of services at the inpatient and outpatient levels, as well as through its numerous community initiatives.

Mission

BronxCare Health System's mission is to deliver the highest quality accessible care in responding to the needs of the community, while assuring an environment where patient safety and satisfaction are most important. This mission is directed to embracing a safety culture that is reporting, learning, fair, and just, as well as building a health care network that is continuously striving for excellence by opening its arms to heal, to teach, and to care.

At BronxCare, we anticipate and respond to changes in order to reinforce our essential leadership role in the provision of quality and comprehensive care.

Vision

BronxCare Health System's Vision is to continually reinforce our leadership role in Promoting and Achieving Health Care Excellence. We are and will continue to be an economic anchor, innovator, and engine for positive change. In looking to the future, BronxCare will fulfill its community service mission and vision of Caring for the Bronx by maintaining strong partnerships with community organizations, labor unions, governmental agencies, and health care providers, among numerous other groups. Ongoing participation and input from BronxCare's Board of Trustees, leadership team, medical and nursing staff, employees, and community boards are also most important in achieving successful outcomes in a safe environment.

Values

BronxCare Health System's values involve providing high quality, comprehensive, accessible, and compassionate care, as well as achieving optimal patient safety and satisfaction levels. The continuing emphasis is on learning and improving the quality of care we deliver. Our values are enhanced by systematically designing, measuring, analyzing, and refining BronxCare Health System's operations to keep pace with medical and technological advances, as well as the needs of the community.

Overview

BronxCare is the largest voluntary, not-for-profit health and teaching hospital system serving the South and Central Bronx, with 859 beds and more than 4,500 employees. Its two main hospital divisions, comprehensive psychiatric and chemical dependency programs, long-term care facility, and extensive outpatient network are delivering high quality and accessible services to the community. BronxCare is now among the largest providers of outpatient services in New York City, with close to one million visits annually. Its emergency room is also responding to 141,000 visits, one of the busiest in New York.

In 2017, BronxCare Health System received full accreditation from the Joint Commission, the leading accrediting authority for hospitals in the nation. Its medical school affiliation with the Icahn School of Medicine at Mount Sinai and Clinical Collaboration with the Mount Sinai Health System, as well as 16 accredited residency and fellowship programs, are strong indicators of excellence. BronxCare's outpatient practices are also certified as a Level Three Patient-Centered Medical Home (the highest designation) by the National Center for Quality Assurance.

As an engine for positive change, BronxCare has infused more than $300 million into the Bronx economy, including a 60,000 square foot BronxCare Health and Wellness Center for outpatient care, completed in 2014, 56,000 square foot BronxCare Life Recovery Center for chemical dependency services, also completed in 2014, and numerous other capital projects, including a soon-to-be-completed 10,000 square foot state-of-the-art Cancer Center, Linear Accelerator, and Interventional Radiology Suite.

BronxCare is continuing to move forward as a PPS lead in New York State's Delivery System Reform Incentive Payment (DSRIP) Program. The DSRIP program (entitled Bronx Health Access) is providing BronxCare and its community partners with the opportunity to adapt to a value-based payment system, with an emphasis on keeping patients and the community healthy. Bronx Health Access is now ranked first among Performing Provider Systems in the Bronx, third city-wide and eighth in New York State.

The importance of fulfilling BronxCare's essential community role is evident throughout the Bronx. Its staff regularly provides free checkups, screenings, and nutritional counseling at schools, nursing homes, senior citizen centers, churches, and other community organizations. A Diaspora Practice is also responding to the health and social service needs of the African community.

In the educational area, BronxCare's innovative Apprenticeship Program, a collaborative effort with the 1199SEIU Labor Union and other key organizations, is widely recognized for its success in recruiting and training frontline health care workers to effectively reach out to the community. BronxCare's Mobile Health Units are also bringing physicians and medical services directly into the community. The BronxCare Health System has also maintained a strong bottom line position, especially significant in the current environment.

At the BronxCare Health System, we are proud of our longstanding and successful efforts to deliver the highest quality, comprehensive, compassionate, and accessible services in Caring for the Bronx.

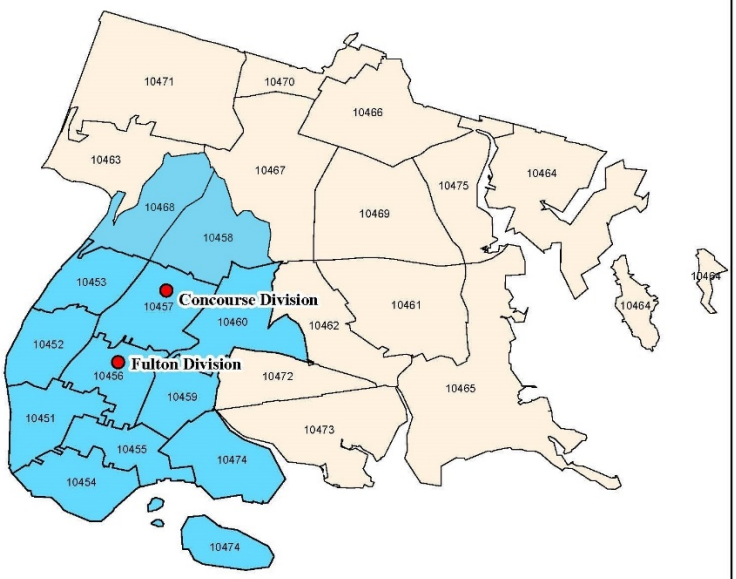
Community Health Needs Assessment

Definition, Description, and Demographics of Community Served

BronxCare's service area is among the poorest in the nation with high disease incidence rates, large minority and immigrant populations, and low socioeconomic status. The primary service area (PSA) includes the South and Central Regions of the Bronx. It consists of the following zip codes:

- Highbridge-Morrisania (Zip Codes 10451, 10452, and 10456)
- Hunts Point-Mott Haven (Zip Codes 10454, 10455, 10459, and 10474)
- Crotona-Tremont (Zip Codes 10453, 10457, and 10460)
- Parts of Fordham-Bronx Park (Zip Codes 10458 and 10468)

Map 1
BronxCare Primary Service Area



This service area contains 20 geographic units or populations that are designated by Health Resources and Service Administration, as Health Professional Shortage (HPSA) or Medically Underserved Areas (MUA) for primary care, mental health, and dental care. These areas include:

- Morrisania Primary Care HPSA
- Soundview -Medicaid-Eligible Primary Care HPSA
- Crotona-Medicaid-Eligible Primary Care HPSA
- Fordham/Norwood Medicaid-Eligible Primary Care HPSA
- Highbridge Primary Care HPSA
- Tremont Primary Care HPSA
- Hunts Point/Mott Haven Primary Care HPSA
- West Central Bronx Mental Health HPSA
- Hunts Point/Mott Haven Mental Health HPSA
- Soundview Mental Health HPSA
- Fordham /Norwood Mental Health HPSA
- Southwest Bronx Dental HPSA
- Central Bronx Medicaid-Eligible Dental HPSA
- Morris Heights/Fordham Medicaid-Eligible Dental HPSA
- Soundview Medicaid -Eligible Dental HPSA
- Highbridge Service Area MUA
- Morrisania Service Area MUA
- Hunt's Point Service Area-MUA
- Mott Haven Service Area MUA
- Bathgate Service Area MUA

BronxCare is a "safety-net" provider, serving a large number of Bronx residents who are on public insurance programs or uninsured. In 2017, based on analysis of Institutional Cost Report data (the latest available), fully 64 percent of BronxCare's 25,000 non-newborn discharges were Medicaid (58 percent) or Uninsured (6 percent).

Data Sources

Data was collected from a wide range of sources to develop a demographic and health profile of the Bronx and, specifically, BronxCare's primary service area. The service area is defined by zip code to encompass the United Hospital Fund neighborhoods of Crotona-Tremont, Highbridge-Morrisania, Hunt's Point-Mott Haven and Fordham-Bronx Park. For data sources not available by zip code, a close approximation to the service area was utilized. Map 1 shows the primary service area and its 12 zip codes. Sources include but are not limited to:

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- New York State Department of Health Statistics, 2015-2018
- New York City HIV/AIDS Annual Surveillance Statistics, 2016 and 2018

Health Rankings

According to the Robert Wood Johnson County Health Rankings, 2019, and other sources, the Bronx has the following characteristics:

- Out of 62 counties in New York State, the Bronx ranks *lowest* or near bottom for:
  - Quality of Life
  - Health Outcomes and Health Factors
  - Clinical Care
  - Social and Economic Factors
  - Physical Environment
- 27 percent of population are in poor or fair health.
- 9 percent of births are low birth weight.
- Premature mortality was significantly higher in BronxCare's service area neighborhoods-270 per 100,000 compared to 169 per 100,000 for New York City.
- 16 percent of adults are smokers.
- 30 percent of adults are obese.
- 31 percent are physically inactive.
- 16 percent report excessive drinking.
- 9 percent are uninsured.
- 68 percent have graduated high school.
- 6.2 percent were unemployed.
- 39 percent of children are living in poverty.
- 61 percent of children are in single parent households.
- Preventable hospital stays are 56 per 100,000 compared to 41 per 100,000 for New York State.
- 59 percent receive mammography compared to 62 percent in New York State (2018).

The 2018 New York City Community Health Survey, conducted annually by the New York City Department of Health, indicates high rates for the following health conditions, risk factors, and behaviors in BronxCare's service area:

- Obesity
- Diabetes
- Asthma
- Hypertension
- Elevated cholesterol
- Restricted Access to Healthy Food
- Smoking Rates
- Serious Psychological Problems

The following statistics, as reported in the 2018 NYC Community Health Profiles report, underline the pressing health needs in BronxCare's service area:

- 16 percent are smokers.
- 38 percent are obese.
- 37 percent have hypertension.
- 13 percent of adults went without needed medical care.

The South and Central Bronx is among the most impoverished areas in New York City, New York State, and the United States. Much of the South and Central Bronx is designated as a Medically Underserved Area(s) and a Health Professional Shortage Area(s). It is characterized by high rates of poverty, large minority and immigrant populations, and low socioeconomic status, as indicated by education, employment and homeless rates. Furthermore, with respect to established health indicators which reflect social determinants of health and as such impact access, this service area ranks very low. The proportion of the population receiving public assistance, such as Medicaid, is much higher than average. The prevalence of certain diseases, many of which are preventable and linked with poor socioeconomic status, is high. These diseases include diabetes, cancer, asthma, obesity, stroke, heart disease, depression/mental illness, pneumonia, glaucoma, diabetic retinopathy, and sexually transmitted diseases.

BronxCare provides health care services to a large, densely populated area comprised of a diverse population. This population faces a variety of economic barriers, social issues, and special needs. The majority of the service area population is ethnic/racial minorities and contains a young (0-19) population. Based on U.S. Census forecasts through 2021, 32 percent of South and Central Bronx residents are under 20 years of age.[1] More than one out of every three people living in the Bronx is foreign born, a factor also associated with lack of access to health insurance, (with the majority from Latin America).

The largest concentration of New York City's African immigrants, 56,000, reside in the Bronx. The neighborhoods served by BronxCare, particularly the Central Bronx, are home to a significant proportion of the borough's African immigrants, largely originating from the African nations of Nigeria, Kenya, Guinea, Senegal, Ghana, Togo and Gambia.[2]

According to American Fact Finder (2013-2017), almost 220,000 immigrants reside in Central and South Bronx constituting more than one-third of the borough's total. This section of the Bronx has one of the more diverse mixes of immigrants, with substantial representation from the non-Hispanic Caribbean (Guyana, Jamaica, and Trinidad and Tobago), Central America (Honduras, Guatemala, and El Salvador), and Africa (Ghana and Nigeria). Dominicans are the largest group in this section of the Bronx. Other Latin American countries, including Mexico and Ecuador are also represented. The South and Central Bronx is home to Asian immigrants, and a growing Bangladeshi population.

The BronxCare service area is characterized by high rates of poverty, unemployment, and homelessness, with significant unmet health needs and health disparities. Residents of these

[1] Claritas, Inc., Population Facts 2016 through 2021
[2] U.S. Census, American Fact Finder. 2013–2017

neighborhoods have significant barriers to accessing primary medical services, including economic (low-income or Medicaid eligible), cultural, and linguistic barriers. Among service area residents, most premature deaths are associated with chronic illnesses or health behaviors including: cancer, heart disease, diabetes, asthma, chronic lung disease, HIV/AIDS, drug-related conditions, renal failure, chronic liver disease, and homicide.

Population Data

Published data from Claritas, Inc.[3] provides population estimates and projections through 2021, based on census information and detailed demographic characteristics relevant to health care needs and socioeconomic levels.

Age

Within the service area are 745,000 residents (U.S. Census, American Fact Finder 2013-2017). This population is projected to grow by an additional 4 percent through 2021. The service area is characterized by the following demographic characteristics:

- Sizable younger population, with 28-29 percent under age 17, compared to 21 percent for New York City;
- Lower proportions of elderly (65+), with 9 percent over age 65, compared to 14 percent for New York City.

Ethnicity

The service area is 80 percent non-white compared to 57 percent for New York City. 33 percent of the population are African-American compared to 25 percent in New York City and 68 percent are Hispanic (any race) compared to 29 percent in New York City. Over 32 percent of the population in the service area are not proficient in English, compared to 23 percent in New York City.

Socioeconomic Status

The service area is home to many individuals facing high unemployment, low income/high poverty levels and low educational attainment, all of which contribute to health disparities.

- *Education*
  - While only 19 percent of New York City residents have less than a high school education, the BronxCare service area averages 38 percent, but is as high as 41 percent in some sections.
- *Income/Poverty*
  - Median household income in the BronxCare service area, is below $25,000, well under the Citywide level of almost $58,000.
  - The proportion of households with incomes below $25,000 is 52 percent, compared to 28 percent citywide.
  - In the BronxCare service area, between 31 and 34 percent of families live in poverty compared to 20 percent in New York City.

3. Claritas, Inc., Population Facts 2016 through 2021

- *Public Assistance/Lack of Health Insurance*
  - The service area has high rates of dependence on public assistance, including Medicaid.
  - According to the U.S. Census American Fact Finder, more than 65 percent of service area residents are characterized as low income (below 200 percent of the Federal Poverty Level) and 40 percent are below 100 percent of the Federal Poverty Level compared to 20 percent for New York City.
  - 55 percent of BronxCare service area residents are public insurance beneficiaries. 14 percent of BronxCare's service area adults are without health insurance, compared to the New York City average of 12 percent.
- *Employment*
  - BronxCare's service area has high unemployment rates compared to the New York City rate of 9 percent, with unemployment at 16 percent in BronxCare's service area.
- *Crime*
  - BronxCare's service area has a significantly higher rate of non-fatal (violent) assault hospitalizations- 150 per 100,000 compared to 59 per 100,000 for New York City.

Other Comparative Statistics[4]

In BronxCare's service area one in three adults consider themselves to be in fair or poor health. Social determinants of health, economic factors affecting health status and physical environment also place the service area among the most challenging in New York City. As a result, BronxCare's service area's health status measures demonstrate greater mortality, morbidity and poor health outcomes than most areas within New York City and New York State.

[4] Data from this section, unless otherwise noted, is from the New York City Department of Health, "Community Health Profiles", 2018 and U.S. Census American Fact Finder,2013- 2017. Data also drawn from United Hospital Fund of New York. "Healthier Homes, Healthier Childhoods: How Medicaid Can Address the Housing Conditions Contributing to Pediatric Asthma". 2019

Significant Health Needs/Main Health Challenges

According to the New York City Community Health Profiles (2018), BronxCare's primary service area has high rates of premature death from diabetes, heart disease, and cancer. In addition, premature deaths from complications of HIV/AIDS and incidents associated with mental and behavioral disorders, and substance abuse were higher ranked causes of death in the South and Central Bronx than in other parts of the Bronx and New York City.

Asthma

Asthma is a leading cause of hospitalization among children and adults. As recently reported by the United Hospital Fund of New York, asthma is a key health indicator and social determinant of health, as issues including substandard housing, poor indoor and outdoor air quality and presence of cockroaches among other factors are all asthma triggers. These conditions are identified as particularly prevalent in BronxCare's service area. The South and Central Bronx now has the highest incidence rates in New York City.

- The emergency room visit rate for asthma in children (5-17) is approximately 430 per 10,000 in the service area, compared to 223 per 10,000 for New York City. But the rate of 647 per 10,000 in Mott Haven/Melrose, is virtually three times the Citywide rate and the highest of all New York City neighborhoods.
- The adult asthma emergency room visit rate (18 and older) in the service area is 250 per 10,000, compared to 99 per 10,000 for New York City.
- Adult asthma hospitalizations range from 28 to 51 per 10,000 in the service area, compared to 11 per 10,000 in New York City.
- The percentage of service area homes with three or more environmental triggers was more than 31 percent, compared to 13.5 percent in New York City.

Diabetes

Disparities in diabetes prevalence rates, related to racial/ethnic background and socioeconomic status are seen nationally and in New York State as well as in the South and Central Bronx.

- More than 700,000 adult New Yorkers are diagnosed with diabetes. An additional 164,000 are estimated to have diabetes but are not yet aware of it. As many as 22 percent of BronxCare service area adults has a diabetes diagnosis compared to 11 percent in New York City. The four New York City neighborhoods with the highest rates of diabetes are in BronxCare's service area.
- The childhood obesity rate is 24 percent in the Bronx compared to 20 percent in New York City. More than 32 percent of BronxCare's service area residents have one or more sugary drinks daily, compared to 23 percent in New York City.
- 77 percent of Bronx residents receive diabetes monitoring compared to 86 percent in New York State.
- The Bronx hospitalization rate for diabetes as a primary diagnosis is 36.7 per 10,000, significantly higher than the New York City rate of 22.8 per 10,000.
- The Bronx diabetes mortality rate of 25.6 per 10,000 is higher than the rate of 20.3 per 10,000 for New York City.
- Individuals from minority groups, particularly African Americans and Latinos, are more likely to develop Type 2 diabetes (insulin-resistant) than Caucasians. This group represents almost a

quarter of all adult diabetics in the nation.[5]

Heart Disease

Heart disease is the number one or two causes of premature death in the BronxCare service area, depending upon the specific neighborhood. The New York State Prevention Agenda (2019-2024) identifies as a Focus Area, Chronic Disease Preventive Care and Management. Specific associated goals and interventions include the increase in the early detection of cardiovascular disease, promotion of strategies that improve the detection on undiagnosed hypertension, increase in the percentage of adults whose blood pressure is adequately controlled.

- Heart disease was leading cause of death in Bronx county, at 201 per 100,000, compared to 184 per 100,000 in New York City and 177 per 100,000 in New York State (NYS Vital Statistics, 2018).
- In the BronxCare service area, premature death from heart disease were as high as 59.6 per 100,000, compared to 32,9 per 100,000 in New York City.
- 37 to 42 percent of adults in the BronxCare service area have been diagnosed with hypertension, compared to 28 percent in New York City.

Cancer

Depending upon the specific neighborhood, cancer is either the number one or two cause of premature death throughout the BronxCare service area.

- The overall cancer mortality rate under age 65 in BronxCare's service area is 59.6 per 100,000 compared to 46.2 per 100,000 in New York City, but is as high as 66.3 per 100,000 in Mott Haven.
- In the BronxCare service area, lung, liver, colorectal and breast cancer are the leading causes of cancer-related premature death. 59 percent of Bronx residents receive a mammography compared to 62 percent in New York State and 16 percent are smokers.
- The breast cancer mortality rate in Bronx County (2012-2016) is 23 per 100,000 females, compared to 19 per 100,000 in New York City and State.

Birth Related Indicators/Infant Mortality

Infants are among the most vulnerable population and residents of BronxCare's service area are experiencing disproportionate mortality, low birth weight, and teen pregnancy.[6]

- The infant mortality rate was 4.3 per 1,000 births in BronxCare's service area compared to 4 per 1,000 in New York City.
- Late/no prenatal care rates were 11.6 percent compared to 6.7 percent in New York City.
- The teen birth rate of 28.7 per 1,000 is significantly higher than the New York City rate of 16 per 1,000.

[5] Healthy People, 2020. Office of Disease Prevention and Health Promotion.
[6] New York State Department of Health. "Bronx County/Zip Code Perinatal Data, 2014-2016". June 2018.

HIV/AIDS

The incidence and prevalence of HIV and AIDS are higher in the service area than in New York City. [7]

- As of 12/31/18, more than 22,500 individuals in the service area were living with HIV/AIDS.
- New diagnoses of HIV/AIDS are 39 per 100,000 in the BronxCare service area compared to 25 per 100,000 in New York City.
- As in other parts of the City, HIV diagnosis data indicates a significant decrease in new diagnoses for Bronx County, from 1317 in 2001 to 440 new diagnoses by 12/31/18.[8]

Mental Health/Substance Abuse

The New York State Prevention Agenda (2019-2024) identifies as a Priority Area the prevention of mental and substance abuse disorders. Specific associated focus areas include but are not limited to the prevention of opioid and other substance misuse and deaths, reduction in the prevalence of major depressive disorders, and prevention of suicide. According to the New York City Community Health Profiles (2018) and the New York State Opioid Annual Report, 2018, BronxCare's service area residents are at high risk for mental illness, suicide risk, and substance/opioid use.

- The service area had a high rate of psychiatric hospitalizations, 1,435 per 100,000 in Morrisania, compared to 676 per 100,000 in New York City.
- Drug-related deaths, of 22.3 per 100,000 is significantly higher in BronxCare's service area than the New York City rate of 9.4 per 100,000. Additionally, substance abuse ranks among the top five causes of premature death in the service area.
- Bronx County opioid related hospitalizations of 25.3 per 100,000 are well above the New York City rate of 13.6 per 100,000. Similarly, emergency room visit rates for opioid overdoses for Bronx County are 31 per 100,000 compared to 20.8 per 100,000 for New York City.
- Bronx County opioid deaths of 18.6 per 100,000 exceed the New York City rate of 11.5 per 100,000.

[7] New York City Department of Health Annual AIDS Surveillance Registry as of 2016 and 2018.
[8] NYC Department of Health. "HIV Surveillance Annual Report, 2018

Community Service Plan

Priorities, Focus Areas, and Data Sources

An analysis of the data described in the previous section translates into an extremely medically underserved area characterized by low socioeconomic status and other factors that place the community at risk for many serious health conditions. Of these, BronxCare has identified two Priorities from the New York State Prevention Agenda (2019-2024) for which there continues to be a significant need in the Bronx community, as well as a Focus Area for each of the priorities.

I. Priority Area: Prevent Chronic Diseases
   Focus Area: Preventive Care and Management

   Prevent Chronic Diseases and Preventive Care and Management were selected as a Priority and Focus Area based on findings from BronxCare's Community Health Needs Assessment that chronic conditions, such as asthma, diabetes, cardiovascular disease, cancer, and other chronic diseases are linked to health and socioeconomic disparities in the community.

II. Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders
   Focus Area: Prevent Mental and Substance Abuse Disorders

The two selected Priorities and Focus Areas were based on an analysis of local community health and socioeconomic data from a variety of sources, including:

1. Data sources including but not limited to:
   - Robert Wood Johnson County Health Rankings, 2019
   - US Census Bureau's American Community Survey and American Fact Finder, 2013-2017
   - United Hospital Fund of New York Various Publications, 2019
   - Claritas, Inc. Population Facts, 2016-2021
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   - New York State Department of Health Statistics, 2015-2018
   - New York City HIV/AIDS Annual Surveillance Statistics, 2016 and 2018

2. Feedback from community partners.
   Ongoing and regularly scheduled meetings with community partners are an essential part of the Community Health Needs Assessment and Community Service Plan development process. These meetings are attended by BronxCare's administrative, medical, nursing, and DSRIP leadership. In addition, BronxCare's Division of Development and External Affairs, continually strengthens and reinforces relationships with community organizations.

3. Feedback from DSRIP stakeholders.
   Now in its fifth year as a Performing Provider System lead in New York State's DSRIP Program, BronxCare solicits input from DSRIP stakeholders on an ongoing basis. A strong committee mechanism is proving to be most effective in identifying and addressing health care needs and outcomes (with an emphasis on the two Priorities selected from the New York State Prevention Agenda 2019-2024). Among the many committees in place are:
   - Steering Committee: This committee is responsible for creating a structure to integrate Performing Provider System partners and is directly involved in the decision-making process.
   - Finance and Payment Reform Committee: This committee is responsible for activities including budgeting, fund distribution, and monitoring the financial operation of the Performing Provider System. It makes recommendations to the Steering Committee about the budgeting, management, and distribution of funds, and advises the Steering Committee on capital grant applications.
   - Clinical and Quality Committee: This committee takes on a vital role in ensuring the implementation of evidence-based best practices, monitoring quality of care and performance, and developing strategies for project improvement.
   - IT Committee: This committee is responsible for addressing the technological framework that allows for integrated health care delivery. It enables the Performing Provider System to meet DSRIP project clinical and reporting requirements.
   - Workforce Committee: This committee reviews and implements various training modules available to Performing Provider System partners.
   - Stakeholder Engagement Workgroup: This committee is responsible for reaching out to Performing Provider System partners, patients and their families, and other key stakeholders. It provides health education and is actively involved in fulfilling the goals and objectives of participating partners.

4. Town Hall Meetings
   The Performing Provider System schedules Town Hall meetings to maximize input and feedback. These meetings serve as a central platform to update partners on the status of DSRIP projects, in addition to engaging stakeholders.

5. Outreach
   BronxCare maintains continued outreach with its DSRIP and other partners, including:
   - **BrightPoint**, a leading provider of integrated Health Care and Social Support Services, is providing valuable input in the primary and chronic care areas. Collaborative efforts are being directed to the diabetes area and, in particular, reduction in readmission rates for the high incidence of uncontrolled diabetes. BrightPoint is also a referral source to the BronxCare Health System for specialty services and diagnostic support.
   - **BronxWorks**, a multi-service agency specializing in housing and supportive care, is involved in a collaborative effort to address the high incidence of asthma in the community. It is also an important referral source.
   - **Claremont Healthy Village**: This initiative involves more than 45 community partners and is aimed at addressing the high incidence of asthma in the Bronx.

- **CommuniLife**, an organization that provides permanent and transitional housing, is collaborating with BronxCare and taking an active role in providing medical respite beds. Plans are moving forward to expand medical and related programs for the homeless population, thereby providing a continuum of care and improved access for them.
- **Garden of Eden/Garden of Life**: A collaborative effort with this organization has provided important opportunities for improved education and nutritional counseling for individuals with diabetes.
- **Morris Heights Health Center** is an important partner in addressing the high incidence of asthma and diabetes in the community. A recent initiative includes pharmacists assigned to provide follow-up telephone calls and onsite consultation regarding prescription compliance. BronxCare is also providing integrated specialty services in orthopedic, vascular, and other medical areas on site at the Morris Heights Health Center.
- **Mount Sinai Health System** continues to provide valuable input and serves as a back-up facility for highly specialized tertiary care. In addition, BronxCare also has a Medical School affiliation with the Icahn School of Medicine at Mount Sinai. BronxCare and Mount Sinai are collaborating in implementing a comprehensive Cancer Care Program which will be completed in the Spring of 2020.
- The **New York City Departments of Health and Mental Hygiene** are important data resources. The staffs of these departments have provided BronxCare with valuable input in evaluating health care trends.
- The **New York State Department of Health** is an important resource for BronxCare. It has also taken on an essential role in reviewing BronxCare's Certificate of Need projects related to the health care needs of the community. These projects encompass the priorities and goals set forth in BronxCare's Community Health Needs Assessment and Community Service Plan.
- The **New York State Office of Alcohol and Substance Abuse Services (OASAS)** continues to provide essential guidance in the planning and implementation of BronxCare's chemical dependence programs. The OASAS staff was also instrumental in the development of BronxCare's Life Recovery Center for chemical dependence care.
- The **New York State Office of Mental Health (OMH)** continues to provide BronxCare's Department of Psychiatry with important assistance in the development and implementation of psychiatric inpatient and outpatient programs. OMH has also taken on a key role in grant collaboration, including BronxCare's recent "Zero Suicide" grant and ALACRITY Critical Time Intervention initiative.
- **Urban Health** a network of federally qualified health centers, is working with BronxCare in addressing diabetes, asthma, and women's health area, among many other areas.
- **1199SEIU Training and Employment Fund**: 1199SEIU United HealthCare Workers East, New York City Department of Small Business Services, La Guardia Community College, and other key organizations have collaborated with BronxCare in initiating an Apprenticeship Program. It is recognized as a unique and innovative program that is training front line health care workers to effectively reach out to the community.
- **Other Partner Organizations**: BronxCare collaborates with numerous organizations throughout the Bronx community, including Destination Tomorrow and Marsha's House (for the LGBT population), Sienna House (in the women's health area), and Bronx Defenders and Bronx End the Epidemic (in the community health access areas). BronxCare's Community Advisory Boards, as well as Community Planning Board 3 and

Community Planning Board 4 are actively involved in the planning process, providing valuable input on the health care needs of the community.

6. Feedback from physician and physician group partners.
   BronxCare solicits ongoing feedback from its physician and physician group partners, including:
   - Advanced Preventive Medicine
   - AMTH Medical PC
   - AW Medical Office
   - Boston Road Medical
   - Brightpoint Health
   - Bronx Metro Health
   - Concourse Rehabilitation and Nursing Center
   - Concourse Village Primary
   - Corinthian Medical IPA
   - Damian Family Care Center
   - Dr. Baldevbhai V. Patel
   - Dr. Chaula Patel
   - Dr. Cruz Herrera
   - Dr. Guillen Rafael
   - Dr. Patel Rasik
   - Dr. Madan Paul
   - Dr. Stephen Perez
   - Essen Medical Associates
   - Grand Concourse Medical Practice
   - Jerome Medical
   - JLDH Medical Services
   - La Casa De Salud Medical Center
   - Med Alliance
   - MedCare Plus
   - Morris Heights Health Center
   - Morris Park Medical
   - Mt. Hope Family Practice
   - Soundhealth Medical Practice
   - The Institute for Family Health
   - Urban Health
   - Vanguard Health Center
   - Numerous Other Groups

7. Surveys
   BronxCare's Division of Development and External Affairs solicited input from a broad spectrum of the community, including leaders of community-based organizations, community board members, and local business owners/managers. During a three-month period (August 2019 to October 2019), a survey was conducted. Survey respondents rated the overall health

and quality of life in BronxCare's service area, as well as BronxCare's effectiveness in addressing health care needs.

Survey Results

- The overall health and quality of life in the South and Central Bronx was rated as below average.
- BronxCare's effectiveness in addressing the health care needs of its community was rated as very good to excellent.
- Respondents identified critical health needs as:
    - Obesity and Nutrition
    - Asthma and Air Quality
    - Diabetes
    - Substance Abuse Disorders
    - Mental/Behavioral Disorders
- Senior citizens and communities of color were identified as most at risk for health and quality of life issues.
- Barriers preventing the provision of health care services were identified as:
    - Access to Services
    - Access to Insurance
    - Need for Additional Community Resources

Goals and Objectives

For each of the Priorities and Focus Areas, BronxCare identified Goals and Interventions, as well as Planning and Implementation Strategies.

I. Priority Area: Prevent Chronic Diseases

Focus Area: Preventive Care and Management

Goal 1: Improve self-management skills for individuals with asthma, prediabetes and diabetes, cardiovascular disease, cancer, and other chronic diseases.

Goal 2: Increase early detection of asthma, prediabetes and diabetes, cardiovascular disease, cancer, and other chronic diseases.

Goal 3: Increase screenings for individuals with asthma, prediabetes and diabetes, cardiovascular disease, cancer, and other chronic diseases.

II. Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area: Prevent Mental and Substance Abuse Disorders

Goal 1: Address opioid crisis with the aim of reducing overdoses.

Goal 2: Address high incidence of suicide and expand Zero Suicide grant program to reduce this most serious problem.

Goal 3: Continue to address the serious mental health issues and achieve emotional wellness in the Bronx Community.

I. Priority Area:
Prevent Chronic Diseases

I. Priority Area: Prevent Chronic Diseases
Focus Area: Preventive Care and Management

Asthma and Lung Diseases

Goal: Improve self-management skills for individuals with asthma.

- Interventions, Strategies, and Activities
  - BronxCare's Pediatric Asthma Center maintains an Asthma Home-Based Self-Management Program, which includes environmental trigger reduction, self-monitoring, medication use, and medical follow-up, as well as, reducing avoidable emergency room visits and inpatient hospitalizations. The Center's pulmonologists, allergists, pediatricians, clinical pharmacists, and outreach staff help patients and their families gain control over the disease. These efforts are enhanced by an outreach team of nurses and certified asthma educators that provide home visits and environmental assessments. Patients are screened for participation in the program in BronxCare emergency room, inpatient units, and outpatient settings.
  - BronxCare's Division of Pulmonary/Critical Care Medicine provides comprehensive pulmonary treatment, including primary and preventive care, as well as education in self-management to adult patients with lung diseases, including asthma, pneumonia, chronic obstructive pulmonary diseases, and lung cancer, among other serious problems. State-of-the-art bronchoscopy equipment, including endobronchial ultrasound for examination and sampling of the lung is also utilized. This type of testing enables early recognition and treatment of lung conditions, such as cancer, and infectious diseases, among other problems.
- Process Measures and Time-Framed Targets
  - Continue asthma education efforts, with aim of reducing the high incidence of adult asthma hospitalizations and emergency room asthma visits for children, and improve access to services through public relations/promotional campaigns, as well as through health fairs and community forums.
  - Reach 1,000 participants through the Asthma Home-Based Self-Management Program by 2021.
  - Develop partnerships with Medicaid managed care plans serving the community in order to help expand the Asthma Home-Based Self-Management Program.
  - Continue to work with DSRIP and other community partners to expand outreach and education efforts.

Pre-Diabetes and Diabetes

Goal: Increase early detection of prediabetes and diabetes.

- Interventions, Strategies, and Activities
    - BronxCare is striving and succeeding in increasing the rate of screening for pre-diabetes and diabetes. This effort is providing important opportunities to reduce the time between diabetes onset and clinical diagnosis, thereby allowing for prompt multifactorial treatment. Point-of-care hemoglobin A1c (HbA1c) machines were implemented across BronxCare's outpatient practices.
    - BronxCare is working to increase the rate of screening diabetic patients for diabetic nephropathy. Diabetes remains the leading cause of end-stage renal disease (ESRD), and the detection of increased urine albumin excretion is found to be the earliest clinical evidence for this disease. Urine microalbumin tests were also been implemented BronxCare's outpatient practices.
    - BronxCare's efforts are also directed to increasing the rate of screening diabetic patients for diabetic retinopathy. Clinical studies have demonstrated that regular screening for individuals with diabetes is the most efficient and cost-effective method to detect the early stages of diabetic retinopathy. Retina scans are currently performed at outpatient practices.
- Process Measures and Time-Framed Targets
    - In 2020 and 2021, increase number of HbA1c tests performed by 10 percent from the current level of 7,000 HbA1c tests for 2019.
    - In 2020 and 2021, increase number of urine microalbumin tests performed by 10 percent from the current level 7,000 urine microalbumin tests for 2019.
    - In 2020 and 2021, increase number of retina scans performed by 10 percent from the current level of 1,175 retina scans for 2019.

Pre-Diabetes and Diabetes (Continued)

Goal: In the community setting, improve self-management skills for individuals with prediabetes and diabetes.

- Interventions, Strategies, and Activities
    - The BronxCare Diabetes Center for Excellence, which encompasses 17 clinical sites, maintains accreditation from the American Association of Diabetes Educators as a Diabetes Self-Management Education and Support program. It provides an evidence-based foundation to empower people with diabetes to navigate self-management decisions and activities. Primary care providers, specialists, certified diabetes educators, and nutritionists provide patients with a range of services that include prevention, early detection, treatment, self-management education, and referrals.
    - Based on a retrospective data analysis of patients' HbA1c and other outpatient data, BronxCare has identified individuals at the highest risk for emergency room visits and inpatient hospitalizations. Through the Owning Diabetes program, these individuals are assigned a Community Health Worker to provide coordination, education, and home visits as needed. Individuals enrolled in the Department of Family Medicine initiatives have experienced a decrease in HbA1c, emergency room visits, and inpatient hospitalizations. This Family Practice model will be replicated in future efforts.
    - A major grant from the Pershing Square Immigrant Opportunity Fund at Robin Hood, BronxCare, in partnership with Cecelia Health, is also providing personalized coaching from certified diabetes educators, via phone calls, texts, emails, and other telehealth modalities, to patients with diabetes.
- Process Measures and Time-Framed Targets
    - In 2020, reach 250 participants through the Owning Diabetes program from the current level of 165 in 2019.
    - In 2020 expand the diabetes telehealth program.

Cardiovascular Disease

Goal: Increase early detection of cardiovascular disease.

- Interventions, Strategies, and Activities
    - BronxCare's Division of Cardiology is at the forefront in the prevention and treatment of heart disease. The Division utilizes state-of-the-art technology to diagnose heart problems at an early stage and employs initiatives to decrease cardiovascular disease risk.
    - BronxCare's Mission Lifeline Quality Achievement Award from the American Heart Association is further confirmation of success in implementing quality improvement measures for heart attack patients.
- Process Measures and Time-Framed Targets
    - Continue to provide high quality services to manage coronary heart disease and treat heart attacks, heart failure, and abnormal heart rhythms.
    - Continue to deliver high level diagnostic and treatment series in coordination with patients and their primary care providers.
    - Continue to implement quality improvement measures for heart attack patients.
    - Continue to receive recognition from the American Heart Association for the high-quality care provided.

Cancer

Goal: Increase cancer screening rates.

- Interventions, Strategies, and Activities
    - BronxCare Health System and the Mount Sinai Health System have established a clinical collaboration to enhance patient care by establishing needed programs and services across multiple disciplines.
    - In addition to recognizing the need for effective screening with early detection, BronxCare is developing a Cancer Care Program in conjunction with Mount Sinai. The 10,000 square foot state-of-the-art facility will provide medical oncology, surgical oncology, and support services.
    - The BronxCare Mount Sinai Cancer Care facility includes an expanded treatment area with a dedicated chemotherapy infusion suite, as well as modern and user-friendly registration and reception areas. An onsite and specialized pharmacy is also available to patients. Board certified oncology pharmacists prepare and dispense chemotherapy, in partnership with BronxCare's medical oncologists.
    - BronxCare Breast Cancer Center is achieving successful outcomes for patients by providing advanced screening and diagnosis, as well as comprehensive, compassionate, and quality care.
- Process Measures and Time-Framed Targets
    - Build awareness of cancer services offered at the BronxCare Mount Sinai Cancer Care facility. Relocate cancer services into a state-of-the-art Cancer Care Center in conjunction with a projected 30,00 patient visit goal in 2021.
    - Initiate community outreach educational events and public forums.

- Initiate meetings with community physicians and DSRIP partners to solidify base of referrals and increase awareness of services offered.

Other Chronic Conditions

Goal: Increase early detection of other chronic diseases.

- Interventions, Strategies, and Activities
  - BronxCare offers a range of early detection services through its outpatient network. Close to one million visits are provided annually.

Goal: Improve self-management skills for individuals with chronic diseases.

- Interventions, Strategies, and Activities
  - BronxCare's Community Health Workers provide training in self-management to individuals in the community living with chronic conditions. Through an apprenticeship program developed in collaboration with 1199SEIU and other key organizations, Community Health Workers are trained to provide health education and/or encourage individuals to access a wide range of health and support services. The Community Health Workers assist individuals in developing the necessary skills and resources to improve their health status, family functioning, and self-sufficiency.
- Process Measures and Time-Framed Targets
  - Increase engagement with individuals and families in the Bronx Community through the Community Health Workers and other initiatives in 2020 and expand the program.
  - Continue efforts to expand the Community Health Workers.

II. Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

II. Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders
Focus Area: Prevent Mental and Substance Abuse Disorders

Goal 1: Address opioid crisis with the aim of reducing overdoses.

- Interventions, Strategies, and Activities
    - BronxCare's Department of Psychiatry is a leader in the provision of comprehensive mental health services and programs. Its expert team of psychiatrists, psychologists, nurses, social workers, creative art therapists, peer specialists, and Community Health Workers, among other staff members, is achieving positive patient outcomes.
    - BronxCare outpatient mental health sites are providing more than 200,000 visits annually. At these sites universal screening for Opioid Use Disorders is offered using the evidence-based Rapid Opioid Dependence Screen. Each site has psychiatrists certified to provide Medication Assisted Treatment for opioid dependence and authorized to prescribe Buprenorphine.
    - BronxCare's Department of Psychiatry offers comprehensive care for mental health and chemical dependence for adults, adolescents, and children. At the inpatient level, there are three Adult Units and one Child and Adolescent Unit. As part of the treatment process, multidisciplinary teams work on the inpatient units, as well as with BronxCare's outpatient practices to ensure safe transitions and continuity of care. The recovery process can be lengthy and requires post-discharge outpatient care.
    - BronxCare utilizes various modalities, including individual and group therapy, in addition to anti-depressants, mood stabilizers, and other medications, to achieve positive outcomes.
    - For patients with chemical dependency problems, BronxCare's Life Recovery Center is making an important difference in the recovery process. It is one of the few facilities in New York State to combine inpatient, outpatient, and residential treatment programs at one location. The Center includes 20 detoxification and 25 rehabilitation beds in addition to outpatient programs. Upon discharge, patients are referred to a community outpatient provider, including BronxCare's Opioid Treatment Program and Chemical Dependence Outpatient Treatment Program.
    - BronxCare's Opioid Treatment Program provides Medication Assisted Treatment for opioid dependence, utilizing Methadone and extended-release injectables to enhance care, as well as individual and group evidence-based psychotherapy, pre-vocational services, education groups, and other social services.
    - BronxCare's Chemical Dependence Outpatient Treatment Program assesses and treats patients with substance use disorders age 18 or older. Therapeutic modalities include individual psychotherapy, group therapy, and medication management, including Medication Assisted Treatment for opioid dependence. The program offers intensive and non-intensive outpatient addiction services, with specialized programs for individuals charged with impaired driver offenses and co-occurring mental health disorders.
    - BronxCare's Pain Management Practice provides necessary follow-up and monitoring patients with chemical dependence problems. Patients receive medical interventions, Medication Assisted Treatment for opioid dependence, therapeutic interventions, and physical therapy.

- Process Measures and Time-Framed Targets
    - In 2020, screen 1,000 individuals for Opioid Use Disorders, building on the 2019 goal of screening 500 individuals.
    - In 2020, provide more than 130,000 visits through the Opioid Treatment Program, building on the 2019 goal of 115,000 visits.
    - In 2020, provide on-site integrated mental health services at BronxCare's outpatient network.
    - In 2020, add Buprenorphine as third Medication Assisted Treatment option through the Opioid Treatment Program.
    - In 2020, provide 17,000 visits through the Chemical Dependence Outpatient Treatment Program, building on the 2019 goal of 15,000 visits.
    - In 2020, reach 6,000 patients through the Pain Management Practice, building on the 2019 goal of 4,500 patients.

Goal 2: Address high incidence of suicide and continue Zero Suicide grant program to reduce this most serious problem.

- Interventions, Strategies, and Activities
    - BronxCare's Department of Psychiatry is the only hospital in New York City and one of five in New York State to receive a Zero Suicide grant. The grant enables BronxCare to reduce suicide incidence through specialized staff training on conducting a universal suicide risk screening, comprehensive assessment, and interventions, safety planning, following up post-discharge, and ongoing monitoring. This initiative is currently in place at the inpatient and outpatient levels, as well as at the Comprehensive Psychiatric Emergency Program.
- Process Measures and Time-Framed Targets
    - In 2020, provide services through the Zero Suicide program to 10,000 individuals, building on the 2019 goal of services to 5,000 individuals.
    - In 2020, expand the Zero Suicide prevention efforts to BronxCare's outpatient practices.

Goal 3: Continue to address the serious mental health issues and achieve emotional wellness in the Bronx Community.

- Interventions, Strategies, and Activities
    - BronxCare's Department of Psychiatry provides a Consultation Liaison Service, working with physicians on BronxCare's medical units and emergency room to assess and manage patients with co-occurring behavioral illness. It arranges transfers for psychiatric services as needed and assists in post-discharge mental health follow-up care.
    - BronxCare's Collaborative Care program, an integrated behavioral health model for treating depression, is achieving improved medical and emotional outcomes for patients with asthma, diabetes, cardiovascular disease, cancer, and other chronic conditions.
- Process Measures and Time-Framed Targets
    - In 2020, provide Consultation Liaison services to 6,000 individuals, building on the 2019 goal of services to 4,400 individuals.
    - In 2020, reinforce and expand Collaborative Care services.

Workplan

Please see the workplan (Attachment I), which has been completed for each health priority that is currently addressed or will be in the next cycle.

Local Partner Engagement

BronxCare's senior management, administrative staff, physicians, nurses, and Board of Trustees will review and track progress in meeting the chronic health needs of the Bronx Community, (including the two specific Priority Areas as identified in the Community Health Needs Assessment and Community Service Plan). The following measures will be used to track progress in meeting community and chronic health needs:

Priority Area: Prevent Chronic Diseases

Focus Area: Preventive Care and Management

Asthma and Lung Diseases

- Continue asthma education efforts, with aim of reducing the high incidence of adult asthma hospitalizations and emergency room asthma visits for children, and improve access to services through public relations/promotional campaigns, as well as through health fairs and community forums.
- Reach 1,000 participants through the Asthma Home-Based Self-Management Program by 2021.
- Develop partnerships with Medicaid managed care plans serving the community in order to help expand the Asthma Home-Based Self-Management Program.
- Continue to work with DSRIP and other community partners to expand outreach and education efforts.

Pre-Diabetes and Diabetes

- In 2020 and 2021, increase number of HbA1c tests performed by 10 percent from the current level of 7,000 HbA1c tests for 2019.
- In 2020 and 2021, increase number of urine microalbumin tests performed by 10 percent from the current level 7,000 urine microalbumin tests for 2019.
- In 2020 and 2021, increase number of retina scans performed by 10 percent from the current level of 1,175 retina scans for 2019.
- In 2020, reach 250 participants through the Owning Diabetes program from the current level of 165 in 2019.
- In 2020 expand the diabetes telehealth program.

Cardiovascular Disease

- Continue to provide high quality services to manage coronary heart disease and treat heart attacks, heart failure, and abnormal heart rhythms.
- Continue to deliver high level diagnostic and treatment series in coordination with patients and their primary care providers.
- Continue to implement quality improvement measures for heart attack patients.

- Continue to receive recognition from the American Heart Association for the high-quality care provided.

Cancer

- Build awareness of cancer services offered at the BronxCare Mount Sinai Cancer Care facility. Relocate cancer services into a state-of-the-art Cancer Care Center in conjunction with a projected 30,00 patient visit goal in 2021.
- Initiate community outreach educational events and public forums.
- Initiate meetings with community physicians and DSRIP partners to solidify base of referrals and increase awareness of services offered.

Other Chronic Conditions

- Increase engagement with individuals and families in the Bronx Community through the Community Health Workers and other initiatives in 2020 and expand the program.
- Continue efforts to expand the Community Health Workers.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area: Prevent Mental and Substance Abuse Disorders

Goal 1: Address opioid crisis with the aim of reducing overdoses.

- In 2020, screen 1,000 individuals for Opioid Use Disorders, building on the 2019 goal of screening 500 individuals.
- In 2020, provide more than 130,000 visits through the Opioid Treatment Program, building on the 2019 goal of 115,000 visits.
- In 2020, provide on-site integrated mental health services at BronxCare's outpatient network.
- In 2020, add Buprenorphine as third Medication Assisted Treatment option through the Opioid Treatment Program.
- In 2020, provide 17,000 visits through the Chemical Dependence Outpatient Treatment Program, building on the 2019 goal of 15,000 visits.
- In 2020, reach 6,000 patients through the Pain Management Practice, building on the 2019 goal of 4,500 patients.

Goal 2: Address high incidence of suicide and continue Zero Suicide grant program to reduce this most serious problem.

- In 2020, provide services through the Zero Suicide program to 10,000 individuals, building on the 2019 goal of services to 5,000 individuals.
- In 2020, expand the Zero Suicide prevention efforts to BronxCare's outpatient practices.

Goal 3: Continue to address the serious mental health issues and achieve emotional wellness in the Bronx Community.

- In 2020, provide Consultation Liaison services to 6,000 individuals, building on the 2019 goal of services to 4,400 individuals.
- In 2020, reinforce and expand Collaborative Care services.

BronxCare's senior management team will monitor the progress of process measures identified in the Community Health Needs Assessment and Community Service Plan, BronxCare will maintain open channels of communication to ensure that community partnerships are encouraged and maintained.

BronxCare is committed to furthering the goals of the New York State Prevention Agenda (2019-2024) through the selection of its two priority agenda initiatives. The priorities, Prevent Chronic Diseases (Priority 1) and Promote Well-Being and Prevent Mental and Substance Use Disorders (Priority II) represent pressing health care needs in BronxCare's medically underserved and ethnically diverse community. Through collaboration with its community partners, BronxCare has developed a plan of action that addresses needed health and mental health services.

Dissemination of Community Health Needs Assessment and Community Service Plan

BronxCare's Department of Development and External Affairs continues to meet regularly with interested community, church, civic, consumer, and business groups (including local Community Boards 3 and 4) to enhance the hospital's ongoing relationships with the community. Its efforts and those of the DSRIP partners are also directed to helping individuals and groups (health organizations, churches, schools, local merchants) to improve their understanding of the goals and objections set forth in BronxCare's Community Health Needs Assessment and Community Service Plan.

BronxCare will disseminate the Community Health Needs Assessment and Community Service Plan to the public. It will be posted on the its website (BronxCare.org). The public can also request a copy by contacting BronxCare's Division of Planning, Marketing and Public Relations at 718-FAMILY-1 (718-326-4591).

Attachment I: Workplan

Name of County - Organizat BronxCare Hospital Center
2019 Workplan

Planning Report Liaison Errol Schneer
E-mail: ecsvp@erols.com

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Improve self-management skills for individuals with asthma.	• Racial/ethnic, linguistic barriers, medically indigent. • Lack of access to crucial support services which directly impact health such as nutrition, medication adherence, transportation.	oBronxCare's Pediatric Asthma Center maintains an Asthma Home-Based Self-Management Program, which includes environmental trigger reduction, self-monitoring, medication use, and medical follow-up, as well as, reducing avoidable emergency room visits and inpatient hospitalizations. The Center's pulmonologists, allergists, pediatricians, clinical pharmacists, and outreach staff help patients and their families gain control over the disease. These efforts are enhanced by an outreach team of nurses and certified asthma educators that provide home visits and environmental assessments. Patients are screened for participation in the program in BronxCare emergency room, inpatient units, and outpatient settings. oBronxCare's Division of Pulmonary/Critical Care Medicine provides comprehensive pulmonary treatment, including primary and preventive care, as well as education in self-management to adult patients with lung diseases, including asthma, pneumonia, chronic obstructive pulmonary diseases, and lung cancer, among other serious problems. State-of-the-art bronchoscopy equipment, including endobronchial ultrasound for examination and sampling of the lung is also utilized. This type of testing enables early recognition and treatment of lung conditions, such as cancer, and infectious diseases, among other problems.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of prediabetes and diabetes.		oBronxCare is striving and succeeding in increasing the rate of screening for pre-diabetes and diabetes. This effort is providing important opportunities to reduce the time between diabetes onset and clinical diagnosis, thereby allowing for prompt multifactorial treatment. Point-of-care hemoglobin A1c (HbA1c) machines were implemented across BronxCare's outpatient practices. oBronxCare is working to increase the rate of screening diabetic patients for diabetic nephropathy. Diabetes remains the leading cause of end-stage renal disease (ESRD), and the detection of increased urine albumin excretion is found to be the earliest clinical evidence for this disease. Urine microalbumin tests were also been implemented BronxCare's outpatient practices. oBronxCare's efforts are also directed to increasing the rate of screening diabetic patients for diabetic retinopathy. Clinical studies have demonstrated that regular screening for individuals with diabetes is the most efficient and cost-effective method to detect the early stages of diabetic retinopathy. Retina scans are currently performed at outpatient practices.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of cardiovascular disease.		oBronxCare's Division of Cardiology is at the forefront in the prevention and treatment of heart disease. The Division utilizes state-of-the-art technology to diagnose heart problems at an early stage and employs initiatives to decrease cardiovascular disease risk. oBronxCare's Mission Lifeline Quality Achievement Award from the American Heart Association is further confirmation of success in implementing quality improvement measures for heart attack patients.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of other chronic diseases.		oBronxCare offers a range of early detection services through its outpatient network. Close to one million visits are provided annually.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	In the community setting, improve self-management skills for individuals with prediabetes and diabetes.	• Racial/ethnic, linguistic barriers, medically indigent. • Lack of access to crucial support services which directly impact health such as nutrition, medication adherence, transportation.	oThe BronxCare Diabetes Center for Excellence, which encompasses 17 clinical sites, maintains accreditation from the American Association of Diabetes Educators as a Diabetes Self-Management Education and Support program. It provides an evidence-based foundation to empower people with diabetes to navigate self-management decisions and activities. Primary care providers, specialists, certified diabetes educators, and nutritionists provide patients with a range of services that include prevention, early detection, treatment, self-management education, and referrals. oBased on a retrospective data analysis of patients' HbA1c and other outpatient data, BronxCare has identified individuals at the highest risk for emergency room visits and inpatient hospitalizations. Through the Owning Diabetes program, these individuals are assigned a Community Health Worker to provide coordination, education, and home visits as needed. Individuals enrolled in the Department of Family Medicine initiatives have experienced a decrease in HbA1c, emergency room visits, and inpatient hospitalizations. This Family Practice model will be replicated in future efforts. oA major grant from the Pershing Square Immigrant Opportunity Fund at Robin Hood, BronxCare, in partnership with Cecelia Health, is also providing personalized coaching from certified diabetes educators, via phone calls, texts, emails, and other telehealth modalities, to patients with diabetes.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Improve self-management skills for individuals with chronic diseases.		oBronxCare's Community Health Workers provide training in self-management to individuals in the community living with chronic conditions. Through an apprenticeship program developed in collaboration with 1199SEIU and other key organizations, Community Health Workers are trained to provide health education and/or encourage individuals to access a wide range of health and support services. The Community Health Workers assist individuals in developing the necessary skills and resources to improve their health status, family functioning, and self-sufficiency.

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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	Increase cancer screening rates.	• Racial/ethnic, linguistic barriers, medically indigent. • Lack of access to crucial support services which directly impact health such as nutrition, medication adherence, transportation.	oBronxCare Health System and the Mount Sinai Health System have established a clinical collaboration to enhance patient care by establishing needed programs and services across multiple disciplines. oIn addition to recognizing the need for effective screening with early detection, BronxCare is developing a Cancer Care Program in conjunction with Mount Sinai. The 10,000 square foot state-of-the-art facility will provide medical oncology, surgical oncology, and support services. oThe BronxCare Mount Sinai Cancer Care facility includes an expanded treatment area with a dedicated chemotherapy infusion suite, as well as modern and user-friendly registration and reception areas. An onsite and specialized pharmacy is also available to patients. Board certified oncology pharmacists prepare and dispense chemotherapy, in partnership with BronxCare's medical oncologists. oBronxCare Breast Cancer Center is achieving successful outcomes for patients by providing advanced screening and diagnosis, as well as comprehensive, compassionate, and quality care.

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Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Improve self-management skills for individuals with asthma.	oContinue asthma education efforts, with aim of reducing the high incidence of adult asthma hospitalizations and emergency room asthma visits for children, and improve access to services through public relations/promotional campaigns, as well as through health fairs and community forums. oReach 1,000 participants through the Asthma Home-Based Self-Management Program by 2021. oDevelop partnerships with Medicaid managed care plans serving the community in order to help expand the Asthma Home-Based Self-Management Program. oContinue to work with DSRIP and other community partners to expand outreach and education efforts.	oContinue asthma education efforts, with aim of reducing the high incidence of adult asthma hospitalizations and emergency room asthma visits for children, and improve access to services through public relations/promotional campaigns, as well as through health fairs and community forums. oDevelop partnerships with Medicaid managed care plans serving the community in order to help expand the Asthma Home-Based Self-Management Program. oContinue to work with DSRIP and other community partners to expand outreach and education efforts.	oContinue asthma education efforts, with aim of reducing the high incidence of adult asthma hospitalizations and emergency room asthma visits for children, and improve access to services through public relations/promotional campaigns, as well as through health fairs and community forums. oDevelop partnerships with Medicaid managed care plans serving the community in order to help expand the Asthma Home-Based Self-Management Program. oContinue to work with DSRIP and other community partners to expand outreach and education efforts.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of prediabetes and diabetes.	oIn 2020 and 2021, increase number of HbA1c tests performed by 10 percent from the current level of 7,000 HbA1c tests for 2019. oIn 2020 and 2021, increase number of urine microalbumin tests performed by 10 percent from the current level 7,000 urine microalbumin tests for 2019. oIn 2020 and 2021, increase number of retina scans performed by 10 percent from the current level of 1,175 retina scans for 2019.	o7,000 HbA1c tests for 2019. o7,000 urine microalbumin tests for 2019. o1,175 retina scans for 2019.	oIn 2020, increase number of HbA1c tests performed by 10 percent from the current level of 7,000 HbA1c tests for 2019. oIn 2020, increase number of urine microalbumin tests performed by 10 percent from the current level 7,000 urine microalbumin tests for 2019. oIn 2020, increase number of retina scans performed by 10 percent from the current level of 1,175 retina scans for 2019.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of cardiovascular disease.	oContinue to provide high quality services to manage coronary heart disease and treat heart attacks, heart failure, and abnormal heart rhythms. oContinue to deliver high level diagnostic and treatment series in coordination with patients and their primary care providers. oContinue to implement quality improvement measures for heart attack patients. oContinue to receive recognition from the American Heart Association for the high-quality care provided.	oContinue to provide high quality services to manage coronary heart disease and treat heart attacks, heart failure, and abnormal heart rhythms. oContinue to deliver high level diagnostic and treatment series in coordination with patients and their primary care providers. oContinue to implement quality improvement measures for heart attack patients. oContinue to receive recognition from the American Heart Association for the high-quality care provided.	oContinue to provide high quality services to manage coronary heart disease and treat heart attacks, heart failure, and abnormal heart rhythms. oContinue to deliver high level diagnostic and treatment series in coordination with patients and their primary care providers. oContinue to implement quality improvement measures for heart attack patients. oContinue to receive recognition from the American Heart Association for the high-quality care provided.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of other chronic diseases.			
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	In the community setting, improve self-management skills for individuals with prediabetes and diabetes.	oIn 2020, reach 250 participants through the Owning Diabetes program from the current level of 165 in 2019. oIn 2020 expand the diabetes telehealth program.	o165 participants in Owning Diabetes program in 2019.	oIn 2020, reach 250 participants through the Owning Diabetes program from the current level of 165 in 2019. oIn 2020 expand the diabetes telehealth program.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Improve self-management skills for individuals with chronic diseases.	oIncrease engagement with individuals and families in the Bronx Community through the Community Health Workers and other initiatives in 2020 and expand the program. oContinue efforts to expand the Community Health Workers.	oIncrease engagement with individuals and families in the Bronx Community through the Community Health Workers and other initiatives in 2020 and expand the program. oContinue efforts to expand the Community Health Workers.	oIncrease engagement with individuals and families in the Bronx Community through the Community Health Workers and other initiatives in 2020 and expand the program. oContinue efforts to expand the Community Health Workers.

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Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	Increase cancer screening rates.	oBuild awareness of cancer services offered at the BronxCare Mount Sinai Cancer Care facility. Relocate cancer services into a state-of-the-art Cancer Care Center in conjunction with a projected 30,00 patient visit goal in 2021. oInitiate community outreach educational events and public forums. oInitiate meetings with community physicians and DSRIP partners to solidify base of referrals and increase awareness of services offered.	oBuild awareness of cancer services offered at the BronxCare Mount Sinai Cancer Care facility. oInitiate community outreach educational events and public forums. oInitiate meetings with community physicians and DSRIP partners to solidify base of referrals and increase awareness of services offered.	oBuild awareness of cancer services offered at the BronxCare Mount Sinai Cancer Care facility. oInitiate community outreach educational events and public forums. oInitiate meetings with community physicians and DSRIP partners to solidify base of referrals and increase awareness of services offered.

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Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Improve self-management skills for individuals with asthma.	oContinue asthma education efforts, with aim of reducing the high incidence of adult asthma hospitalizations and emergency room asthma visits for children, and improve access to services through public relations/promotional campaigns, as well as through health fairs and community forums. oReach 1,000 participants through the Asthma Home-Based Self-Management Program by 2021. oDevelop partnerships with Medicaid managed care plans serving the community in order to help expand the Asthma Home-Based Self-Management Program. oContinue to work with DSRIP and other community partners to expand outreach and education efforts.	Other (please describe partner and role(s) in column D)	•BrightPoint, a leading provider of integrated Health Care and Social Support Services, is providing valuable input in the primary and chronic care areas. Collaborative efforts are being directed to the diabetes area and, in particular, reduction in readmission rates for the high incidence of uncontrolled diabetes. BrightPoint is also a referral source to the BronxCare Health System for specialty services and diagnostic support. •BronxWorks, a multi-service agency specializing in housing and supportive care, is involved in a collaborative effort to address the high incidence of asthma in the community. It is also an important referral source. •Claremont Healthy Village: This initiative involves more than 45 community partners and is aimed at addressing the high incidence of asthma in the Bronx. •CommuniLife, an organization that provides permanent and transitional housing, is collaborating with BronxCare and taking an active role in providing medical respite beds. Plans are moving forward to expand medical and related programs for the homeless population, thereby providing a continuum of care and improved access for them. •Garden of Eden/Garden of Life: A collaborative effort with this organization has provided important opportunities for improved education and nutritional counseling for individuals with diabetes. •Morris Heights Health Center is an important partner in addressing the high incidence of asthma and diabetes in the community. A recent initiative includes pharmacists assigned to provide follow-up telephone calls and onsite consultation regarding prescription compliance. BronxCare is also providing integrated specialty services in orthopedic, vascular, and other medical areas on site at the Morris Heights Health Center. •Mount Sinai Health System continues to provide valuable input and serves as a back-up facility for highly specialized tertiary care. In addition, BronxCare also has a Medical School affiliation with the Icahn School of Medicine at Mount Sinai. BronxCare and Mount Sinai are collaborating in implementing a comprehensive Cancer Care Program which will be completed in the Spring of 2020. •The New York City Departments of Health and Mental Hygiene are important data resources. The staffs of these departments have provided BronxCare with valuable input in evaluating health care trends. •The New York State Department of Health is an important resource for BronxCare. It has also taken on an essential role in reviewing BronxCare's Certificate of Need projects related to the health care needs of the community. These projects encompass the priorities and goals set forth in BronxCare's Community Health Needs Assessment and Community Service Plan. •Urban Health a network of federally qualified health centers, is working with BronxCare in addressing diabetes, asthma, and women's health area, among many other areas. •1199SEIU Training and Employment Fund: 1199SEIU United HealthCare Workers East, New York City Department of Small Business Services, La Guardia Community College, and other key organizations have collaborated with BronxCare in initiating an Apprenticeship Program. It is recognized as a unique and innovative program that is training front line health care workers to effectively reach out to the community. •Other Partner Organizations: BronxCare collaborates with numerous organizations throughout the Bronx community, including Destination Tomorrow and Marsha's House (for the LGBT population), Sienna House (in the women's health area), and Bronx Defenders and Bronx End the Epidemic (in the community health access areas). BronxCare's Community Advisory Boards, as well as Community Planning Board 3 and Community Planning Board 4 are actively involved in the planning process, providing valuable input on the health care needs of the community.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of prediabetes and diabetes.	oIn 2021, increase number of HbA1c tests performed by 10 percent from the current level of 7,000 HbA1c tests for 2019. oIn 2021, increase number of urine microalbumin tests performed by 10 percent from the current level 7,000 urine microalbumin tests for 2019. oIn 2021, increase number of retina scans performed by 10 percent from the current level of 1,175 retina scans for 2019.	Other (please describe partner and role(s) in column D)	
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of cardiovascular disease.	oContinue to provide high quality services to manage coronary heart disease and treat heart attacks, heart failure, and abnormal heart rhythms. oContinue to deliver high level diagnostic and treatment series in coordination with patients and their primary care providers. oContinue to implement quality improvement measures for heart attack patients. oContinue to receive recognition from the American Heart Association for the high-quality care provided.	Other (please describe partner and role(s) in column D)	
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase early detection of other chronic diseases.		Other (please describe partner and role(s) in column D)	
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	In the community setting, improve self-management skills for individuals with prediabetes and diabetes.		Other (please describe partner and role(s) in column D)	
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Improve self-management skills for individuals with chronic diseases.	oIncrease engagement with individuals and families in the Bronx Community through the Community Health Workers and other initiatives in 2020 and expand the program. oContinue efforts to expand the Community Health Workers.	Other (please describe partner and role(s) in column D)	

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Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	Increase cancer screening rates.	oBuild awareness of cancer services offered at the BronxCare Mount Sinai Cancer Care facility. Relocate cancer services into a state-of-the-art Cancer Care Center in conjunction with a projected 30,00 patient visit goal in 2021. oInitiate community outreach educational events and public forums. oInitiate meetings with community physicians and DSRIP partners to solidify base of referrals and increase awareness of services offered.	Other (please describe partner and role(s) in column D)	

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Priority	Focus Area	Goal	Objectives	Disparities	Interventions
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Address opioid crisis with the aim of reducing overdoses.	This focus area will address the high proportion of Medicaid recipients with chronic disease and mental health conditions. High poverty rates in the target service area are linked to higher than average rates of Mental Health/Substance Abuse disorders.	oBronxCare's Department of Psychiatry is a leader in the provision of comprehensive mental health services and programs. Its expert team of psychiatrists, psychologists, nurses, social workers, creative art therapists, peer specialists, and Community Health Workers, among other staff members, is achieving positive patient outcomes. oBronxCare outpatient mental health sites are providing more than 200,000 visits annually. At these sites universal screening for Opioid Use Disorders is offered using the evidence-based Rapid Opioid Dependence Screen. Each site has psychiatrists certified to provide Medication Assisted Treatment for opioid dependence and authorized to prescribe Buprenorphine. oBronxCare's Department of Psychiatry offers comprehensive care for mental health and chemical dependence for adults, adolescents, and children. At the inpatient level, there are three Adult Units and one Child and Adolescent Unit. As part of the treatment process, multidisciplinary teams work on the inpatient units, as well as with BronxCare's outpatient practices to ensure safe transitions and continuity of care. The recovery process can be lengthy and requires post-discharge outpatient care. oBronxCare utilizes various modalities, including individual and group therapy, in addition to anti-depressants, mood stabilizers, and other medications, to achieve positive outcomes. oFor patients with chemical dependency problems, BronxCare's Life Recovery Center is making an important difference in the recovery process. It is one of the few facilities in New York State to combine inpatient, outpatient, and residential treatment programs at one location. The Center includes 20 detoxification and 25 rehabilitation beds in addition to outpatient programs. Upon discharge, patients are referred to a community outpatient provider, including BronxCare's Opioid Treatment Program and Chemical Dependence Outpatient Treatment Program. oBronxCare's Opioid Treatment Program provides Medication Assisted Treatment for opioid dependence, utilizing Methadone and extended-release injectables to enhance care, as well as individual and group evidence-based psychotherapy, pre-vocational services, education groups, and other social services. oBronxCare's Chemical Dependence Outpatient Treatment Program assesses and treats patients with substance use disorders age 18 or older. Therapeutic modalities include individual psychotherapy, group therapy, and medication management, including Medication Assisted Treatment for opioid dependence. The program offers intensive and non-intensive outpatient addiction services, with specialized programs for individuals charged with impaired driver offenses and co-occurring mental health disorders. oBronxCare's Pain Management Practice provides necessary follow-up and monitoring patients with chemical dependence problems. Patients receive medical interventions, Medication Assisted Treatment for opioid dependence, therapeutic
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5 Prevent suicides	Address high incidence of suicide and continue Zero Suicide grant program to reduce this most serious problem.	This focus area will address the high proportion of Medicaid recipients with chronic disease and mental health conditions. High poverty rates in the target service area are linked to higher than average rates of Mental Health/Substance Abuse disorders.	oBronxCare's Department of Psychiatry is the only hospital in New York City and one of five in New York State to receive a Zero Suicide grant. The grant enables BronxCare to reduce suicide incidence through specialized staff training on conducting a universal suicide risk screening, comprehensive assessment, and interventions, safety planning, following up post-discharge, and ongoing monitoring. This initiative is currently in place at the inpatient and outpatient levels, as well as at the Comprehensive Psychiatric Emergency Program.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	Continue to address the serious mental health issues and achieve emotional wellness in the Bronx Community.	This focus area will address the high proportion of Medicaid recipients with chronic disease and mental health conditions. High poverty rates in the target service area are linked to higher than average rates of Mental Health/Substance Abuse disorders.	oBronxCare's Department of Psychiatry provides a Consultation Liaison Service, working with physicians on BronxCare's medical units and emergency room to assess and manage patients with co-occurring behavioral illness. It arranges transfers for psychiatric services as needed and assists in post-discharge mental health follow-up care. oBronxCare's Collaborative Care program, an integrated behavioral health model for treating depression, is achieving improved medical and emotional outcomes for patients with asthma, diabetes, cardiovascular disease, cancer, and other chronic conditions.

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Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Address opioid crisis with the aim of reducing overdoses.	oIn 2020, screen 1,000 individuals for Opioid Use Disorders, building on the 2019 goal of screening 500 individuals. oIn 2020, provide more than 130,000 visits through the Opioid Treatment Program, building on the 2019 goal of 115,000 visits. oIn 2020, provide on-site integrated mental health services at BronxCare's outpatient network. oIn 2020, add Buprenorphine as third Medication Assisted Treatment option through the Opioid Treatment Program. oIn 2020, provide 17,000 visits through the Chemical Dependence Outpatient Treatment Program, building on the 2019 goal of 15,000 visits. oIn 2020, reach 6,000 patients through the Pain Management Practice, building on the 2019 goal of 4,500 patients.	oOpioid Use Disorders 2019 goal of screening 500 individuals. oOpioid Treatment Program 2019 goal of 115,000 visits. oChemical Dependence Outpatient Treatment Program 2019 goal of 15,000 visits. oPain Management Practice 2019 goal of serving 4,500 patients.	oIn 2020, screen 1,000 individuals for Opioid Use Disorders, building on the 2019 goal of screening 500 individuals. oIn 2020, provide more than 130,000 visits through the Opioid Treatment Program, building on the 2019 goal of 115,000 visits. oIn 2020, provide on-site integrated mental health services at BronxCare's outpatient network. oIn 2020, add Buprenorphine as third Medication Assisted Treatment option through the Opioid Treatment Program. oIn 2020, provide 17,000 visits through the Chemical Dependence Outpatient Treatment Program, building on the 2019 goal of 15,000 visits. oIn 2020, reach 6,000 patients through the Pain Management Practice, building on the 2019 goal of 4,500 patients.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5 Prevent suicides	Address high incidence of suicide and continue Zero Suicide grant program to reduce this most serious problem.	oIn 2020, provide services through the Zero Suicide program to 10,000 individuals, building on the 2019 goal of services to 5,000 individuals. oIn 2020, expand the Zero Suicide prevention efforts to BronxCare's outpatient practices.	oZero Suicide program 2019 goal of services to 5,000 individuals.	oIn 2020, provide services through the Zero Suicide program to 10,000 individuals, building on the 2019 goal of services to 5,000 individuals. oIn 2020, expand the Zero Suicide prevention efforts to BronxCare's outpatient practices.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	Continue to address the serious mental health issues and achieve emotional wellness in the Bronx Community.	oIn 2020, provide Consultation Liaison services to 6,000 individuals, building on the 2019 goal of services to 4,400 individuals. oIn 2020, reinforce and expand Collaborative Care services.	oConsultation Liaison services 2019 goal of services to 4,400 individuals.	oIn 2020, provide Consultation Liaison services to 6,000 individuals, building on the 2019 goal of services to 4,400 individuals. oIn 2020, reinforce and expand Collaborative Care services.

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Priority	Focus Area	Goal	Objectives	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Address opioid crisis with the aim of reducing overdoses.		Other (please describe partner and role(s) in column D)	•BrightPoint, a leading provider of integrated Health Care and Social Support Services, is providing valuable input in the primary and chronic care areas. Collaborative efforts are being directed to the diabetes area and, in particular, reduction in readmission rates for the high incidence of uncontrolled diabetes. BrightPoint is also a referral source to the BronxCare Health System for specialty services and diagnostic support. •BronxWorks, a multi-service agency specializing in housing and supportive care, is involved in a collaborative effort to address the high incidence of asthma in the community. It is also an important referral source. •CommuniLife, an organization that provides permanent and transitional housing, is collaborating with BronxCare and taking an active role in providing medical respite beds. Plans are moving forward to expand medical and related programs for the homeless population, thereby providing a continuum of care and improved access for them. •The New York City Departments of Health and Mental Hygiene are important data resources. The staffs of these departments have provided BronxCare with valuable input in evaluating health care trends. •The New York State Department of Health is an important resource for BronxCare. It has also taken on an essential role in reviewing BronxCare's Certificate of Need projects related to the health care needs of the community. These projects encompass the priorities and goals set forth in BronxCare's Community Health Needs Assessment and Community Service Plan. •The New York State Office of Alcohol and Substance Abuse Services (OASAS) continues to provide essential guidance in the planning and implementation of BronxCare's chemical dependence programs. The OASAS staff was also instrumental in the development of BronxCare's Life Recovery Center for chemical dependence care. •The New York State Office of Mental Health (OMH) continues to provide BronxCare's Department of Psychiatry with important assistance in the development and implementation of psychiatric inpatient and outpatient programs. OMH has also taken on a key role in grant collaboration, including BronxCare's recent "Zero Suicide" grant and ALACRITY Critical Time Intervention initiative.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5 Prevent suicides	Address high incidence of suicide and continue Zero Suicide grant program to reduce this most serious problem.		Other (please describe partner and role(s) in column D)	
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	Continue to address the serious mental health issues and achieve emotional wellness in the Bronx Community.		Other (please describe partner and role(s) in column D)	