EXECUTIVE SUMMARY

2016

COMMUNITY SERVICE PLAN

BRONX-LEBANON HOSPITAL CENTER
HEALTH CARE SYSTEM
Bronx-Lebanon is committed to furthering the goals set forth in the New York State Department of Health Prevention Agenda, through the selection of two priority agenda initiatives, consistent with the Department’s goals. The priority areas selected are Ambulatory/Chronic Care and Mental Health/Substance Abuse. Bronx-Lebanon, in building on these two priorities, is collaborating with its DSRIP and community partners in developing a plan of action consistent with its mission of Promoting and Achieving Health Care Excellence.

**Priority 1: Prevention of Chronic Disease—Increase Access to High Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings.**

This initiative addresses the serious health problems impacting the Bronx community, including the high incidence of asthma, diabetes, and obesity, among other key areas. It expands on the efforts of Bronx-Lebanon’s Health and Wellness Center (completed in 2014), which is now accommodating 125,000 outpatient visits, annually. An important emphasis will be directed to expanding outpatient services and enhancing access, with the overall goal of keeping patients and the community healthy and well and out of the hospital.

**Priority 2: Mental Health/Substance Abuse—Prevent Substance Abuse and Other Mental, Emotional, Behavioral Disorders.** This initiative enhances access to integrated mental health and primary care services. It includes the development of community based programs that enhance/expand on the efforts of Bronx-Lebanon’s Life Recovery Center for Chemical Dependency patients (completed in 2014), as well as its comprehensive mental health programs, which account for more than 200,000 visits annually.

Since its previous Community Service Plan submission, Bronx Lebanon was designated as a Performing Provider System (PPS) lead in the New York State Department of Health
EXECUTIVE SUMMARY

Delivery System Reform Incentive Payment (DSRIP) program. As a result, Bronx Lebanon is collaborating with its community partners on several major initiatives which are responsive to its two Community Service Plan Priority Areas.

While Bronx-Lebanon has many ongoing programs related to the two priority agendas, its DSRIP initiatives will address the disparities created by poverty, racial, ethnic and linguistic barriers to care, and lack of access to health care, in addition to promoting disease prevention.

The first DSRIP focus area is evidence based practices for diabetes management. Its goal is to improve outcomes, through the use of care coordination, patient education, and self management. Intervention strategies include the implementation of best practices, development of care coordination teams, training interdisciplinary staff, and utilizing Electronic Health Records to track patient outcomes. Counseling/education will also be provided to diabetes patients, and mobile medical teams will be deployed to ensure access. Process measures include engaging a minimum 80 percent of primary care providers within the PPS in evidence based diabetes management, and reducing avoidable hospitalizations, among other areas.

Care coordination teams will include primary care physicians, specialists, social workers, community health workers, pharmacists, and nurse coordinators. Partnerships with community organizations and other providers will ensure that patients have support services, including meals on wheels, transportation, dental, podiatry, optometry, and behavioral health care. Bronx Lebanon will also partner with Medicaid Managed Care Organizations, as well as the New York City Departments of Health and Mental Health.

The second DSRIP focus area strengthens the mental health and substance abuse infrastructure across systems. This initiative addresses chronic disease prevention, treatment and recovery for individuals with mental health and chemical dependency disorders. The
infrastructure for provision of mental health/substance abuse care is enhanced and poverty services will be integrated into primary and behavioral health care programs. Intervention strategies will include collaboration among stakeholders, co-location of psychiatric services at outpatient practices, provision of cultural and linguistic training to staff, and utilization of the collaborative SBIRT model, an evidence based approach for prevention of substance abuse. In addition, access to peer support services will be expanded through work with integrated teams. Poverty reduction interventions will also be implemented that directly impact behavioral health. The key milestones for assessing this project will include convening a cross-PPS joint planning committee, establishing a workplan and timeline, and collaborating on shared resources and data platforms.

Bronx-Lebanon will partner with participating PPS primary care practices and community-based agencies, such as food pantries, financial assistance programs, employment support, visiting nurses, and housing advocacy groups. The role of these groups will be to develop poverty reduction interventions and to identify and recruit the target patient population. Examples of partners providing key social and medical services are: VIP Services, Communilife, and St. Christopher's Inn.

The following Outcome Measures will be used to track progress in the two priority focus areas: Chronic Disease (Priority One):

- Cardiac disease: blood pressure and cholesterol levels
- Diabetes: increase the proportion of adults with diabetes whose A1C level is below 8 and increase the percentage receiving all four screening tests (A1C test, lipid profile, eye exam, and nephropathy monitoring)
- Obesity: Body Mass Index
EXECUTIVE SUMMARY

• Asthma: Number of hospital admissions via the ER.

Priority Two (Mental Health/Substance Abuse)

• Psychiatric ER usage
• Readmissions for acute mental health/substance abuse conditions
• Utilization/attendance of outpatient substance abuse programs (detox, rehabilitation)

In addition to these two focus areas, Bronx-Lebanon has initiated/enhanced/expanded key programs since submission of its last Community Service Plan. These programs will support and promote the New York State Department of Health's Prevention Agendas related to Prevention of Chronic Disease and Mental Health/Substance Abuse. Described more fully in the Plan, these initiatives include population health efforts in low income housing, cardiovascular disease risk reduction, and health literacy/training of workers to reduce hospital readmissions.

Bronx Lebanon has also submitted 12 Certificate of Need Applications (December, 2016) to Expand and Enhance Outpatient Primary, Mental Health, and Pediatric Services. These projects are consistent with the DSRIP goals of keeping patients and the community healthy and out of the hospital through disease management at the inpatient and outpatient levels.

Bronx-Lebanon's Department of Development and External Affairs continues to meet on a regular basis with community, church, civic, consumer and business groups (including local Community Planning Boards 3 and 4) to gain their input, in terms of addressing health needs and enhancing the hospital's ongoing relationship with the community. Data sources for the Community Service Plan identify the demographic characteristics of the service area and serious health needs of the population. These sources include the Robert Wood Johnson Foundation, NYC DOH Community Health Profiles, Claritas, Inc census projections and, NYS DOH PQI’s.
1. SERVICE AREA

Bronx-Lebanon’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); and Crotona-Tremont (zip codes 10453, 10457, and 10460). Table 1
BRONX-LEBANON COMMUNITY SERVICE PLAN

This service area contains 13 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
- 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
- Fordham/Norwood Mental Health HPSA
- Southwest Bronx Dental Care HPSA
- Morris Heights/Fordham Dental HPSA
- Highbridge Service Area MUA
- Morrisania Service Area MUA
- Mott Haven Service Area MUA
- Bathgate Service Area MUA

Bronx-Lebanon is a “safety-net” provider, serving a large number of Bronx residents who are on public insurance programs or uninsured. As shown on the table below, 67% of discharges were “safety net” as compared to 37% overall for New York City.

<table>
<thead>
<tr>
<th>Table 2: Inpatient Payor Mix, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bronx-Lebanon Hospital Center</strong></td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Acute Care Discharges, excluding</td>
</tr>
<tr>
<td>newborns</td>
</tr>
<tr>
<td>Uninsured</td>
</tr>
<tr>
<td>Medicaid</td>
</tr>
<tr>
<td>Total Safety Net</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Source: 2014 Hospital ICR’s*
BRONX-LEBANON COMMUNITY SERVICE PLAN

2. DEMOGRAPHIC AND HEALTH STATUS PROFILE

Data Sources

Data was collected from a wide range of sources to create a demographic and health profile of the Bronx and, specifically, Bronx-Lebanon’s primary service area. The service area is defined by zip code to encompass the United Hospital Fund (UHF) neighborhoods of Crotona-Tremont, Highbridge – Morrisania and Hunts Point-Mott Haven. For data sources not available by zip code, a close approximation to the service area was utilized. The attached map shows the primary service area and its ten zip codes. Sources include:

- Robert Wood Johnson (RWJ) County Health Rankings, 2016;
- Claritas, Inc., 2016;
- Census Bureau’s 2014 American Community Survey;
- New York City Department of Health Community Health Profiles, 2015;
- New York State Department of Health, Prevention Quality Indicators, 2012;

Health Rankings

According to the Robert Wood Johnson County Health Rankings, 2016, the Bronx has the following characteristics:

- Out of 62 counties in New York State, the Bronx ranks lowest or near bottom for:
  - Overall mortality and morbidity
  - Socioeconomic factors
  - Physical environment
- 29% of population are in poor or fair health
- 10% of births are low birth weight
- 19% of adults are smokers
- 29% of adults are obese
- 29% are physically inactive
- 14% report excessive drinking
- 16% are uninsured
- Only 56% have graduated high school
- 9.8% were unemployed
- 43% of children are living in poverty
- 63% of children are in single parent households
- Preventable hospital stays are 58/100,000 vs. 38 for New York State
- Only 70% receive diabetes monitoring vs. 90% in New York State
- Only 61% receive mammography vs. 71% in New York State
The southwest Bronx remains one of the most impoverished in New York City, New York State, and the United States. Much of the South Bronx is designated as a Medically Underserved Area, as well as a Health Professional Shortage Area. 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 levels of health and access to services, 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 low socioeconomic status, is high. These include obesity, stroke, heart disease, asthma, pneumonia, diabetes, glaucoma, diabetic retinopathy, and sexually transmitted diseases.

Bronx-Lebanon 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 very young population: One-third of South and Central Bronx residents are under 20 years of age. One out of every three people living in the Bronx is foreign born, with the majority from Latin America (55%). According to the November, 2014 Bronx Community Needs Assessment (NYAM), the Bronx has 132,000 foreign born without health insurance. The neighborhoods served by the hospital, particularly in the Central Bronx, are home to the largest concentration of African immigrants in New York City (originating from the West African nations of Mali, Guinea, Senegal, Ghana, Togo and Gambia). According to “The Newest New Yorkers,” a study of immigration published by the New York City Department of City Planning in 2013, over 140,000 immigrants reside in Central and South Bronx constituting nearly one-third of the borough total. Dominicans are the largest group in this section of the Bronx, but other Latin American countries, including Mexico and Ecuador are well represented. In Mott Haven-Port Morris, Soundview-Bruckner, and West Farms-Bronx River, Dominicans are the top foreign-born group, but only account for about one-third of the total. Mexicans accounted for over one-quarter of immigrants in Mott Haven-Port Morris and over one-fifth in Soundview-Bruckner, to the north. Central and South Bronx also have a sizable share of Asian immigrants, buoyed by a growing Bangladeshi population and a mix of smaller groups, such as Chinese, Pakistanis, and Yemenis. In fact, this section of the Bronx has one of the more diverse mixes of immigrants, with substantial representation from the nonhispanic Caribbean (Guyana, Jamaica, and Trinidad and Tobago), Central America (Honduras, Guatemala, and El Salvador), and Africa (Ghana and Nigeria).

The hospital’s service area is characterized by high rates of poverty, unemployment, and homelessness, with significant unmet health needs and health disparities. Residents of these neighborhoods have significant barriers to accessing primary medical care services, including economic factors (low-income or Medicaid eligible), cultural factors, and/or linguistic barriers. Among Medicaid recipients, almost ninety percent of deaths are associated with chronic illnesses including: congestive heart failure, chronic lung disease, cancer, coronary artery disease; renal failure, peripheral vascular disease, diabetes, chronic liver disease and dementia.

---

1 Claritas, Inc., 2016
Population Data

Published data from Claritas, Inc.\(^3\) provide population estimates for 2016 and projections through 2021, based on census data and include detailed demographic characteristics relevant to health care needs and socioeconomic levels.

Age

The service area contains nearly 594,000 people as of 2016. This population grew six percent between 2010 and 2016 and is projected to grow by four percent through 2021. The service area is characterized by the following demographic characteristics:

- Relatively low median age when compared with New York City: 31.1 versus 36.4 percent;
- Sizable younger population, with 33 percent under 21, compared with 25 percent for New York City;
- Lower proportions of elderly (65+) when compared with the city: nine percent versus 13 percent

Ethnicity

The service area is 71 percent non-white as compared with 56 percent for New York City. 37 percent of the population are African-American (versus 25 percent in New York City) and 67 percent are Hispanic (any race) versus 29 percent in New York City. Over one half of the households in the Bronx speak Spanish at home versus only 25 percent statewide.

- The largest ethnic/nationality groups in the PSA are:
  
<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puerto Rican</td>
<td>146,000</td>
</tr>
<tr>
<td>Mexican</td>
<td>35,000</td>
</tr>
<tr>
<td>Sub-Saharan African</td>
<td>37,000</td>
</tr>
<tr>
<td>West Indian</td>
<td>20,000</td>
</tr>
<tr>
<td>Chinese</td>
<td>1,500</td>
</tr>
<tr>
<td>Asian Indian</td>
<td>2,400</td>
</tr>
<tr>
<td>Cuban</td>
<td>3,400</td>
</tr>
</tbody>
</table>

\(^3\) Claritas, Inc., is a database service which continually updates census data and develops projections on the zip code level for a wide variety of sociodemographic characteristics.
Socioeconomic Status

The service area is home to individuals with a disproportionate lack of education, poverty and need for public assistance.

- **Education**: While 11 percent of New York State residents completed only a ninth-grade education, this proportion is nearly 20 percent in the PSA;

- **Income/poverty**: Median household income in the service area is well under the citywide level: $24,157 versus $49,127. The proportion of households with incomes below $25,000 is high at 52 percent, compared with only 28 percent citywide. In the PSA, 38 percent of families live in poverty versus only 17 percent in New York City.

- **Public Assistance**: The service area has very high rates of dependence on public assistance, including Medicaid. In 2014, this proportion was over 50 percent: as shown below. According to the Bronx Community Needs Assessment (November 2014) the highest concentrations of Medicaid beneficiaries in the Bronx reside in Bronx-Lebanon Hospital Center’s service area. Approximately 72 percent of the community are Medicaid beneficiaries and 17 percent uninsured as per the Community Needs Assessment.

<table>
<thead>
<tr>
<th>Community</th>
<th>% of Population Receiving Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mott Haven</td>
<td>61%</td>
</tr>
<tr>
<td>Hunts Point</td>
<td>55%</td>
</tr>
<tr>
<td>Morrisania</td>
<td>61%</td>
</tr>
<tr>
<td>High Bridge</td>
<td>56%</td>
</tr>
<tr>
<td>Crontons</td>
<td>61%</td>
</tr>
<tr>
<td>Tremont</td>
<td>56%</td>
</tr>
<tr>
<td>Bronx</td>
<td>45%</td>
</tr>
<tr>
<td>NYC</td>
<td>34%</td>
</tr>
</tbody>
</table>

**Source**: New York City Department of City Planning, Community District Profiles 2014

- **Employment**: The PSA has a much higher unemployment rate when compared with New York City: Ten percent versus 6.6 percent. 43 percent are not in the labor force, compared with 37 percent in New York City.
A. Health Status of Bronx-Lebanon’s Community

Consistent with the demographics and socioeconomics of Bronx-Lebanon’s primary service area, the health status measures demonstrate greater morbidity and poor health outcomes than other areas of New York City and New York State.

Health Status and Statistics

According to the New York City Community Health Profiles (2015), Bronx-Lebanon’s primary service area has high rates of death from diabetes, heart disease, and cancer. In addition, death from complications of HIV/AIDS and incidents associated with mental and behavioral disorders were higher ranked causes of death in the South Bronx than in other parts of the Bronx and New York City.

Diabetes and Other Preventable Conditions

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

- Of the ten New York City community districts with the highest rates of diabetes-related mortality, five are located within Bronx-Lebanon’s service area.\(^5\)
- Individuals from minority groups, particularly African Americans and Latinos, are more likely to develop type 2 diabetes (insulin-resistant) than Caucasians and represent almost a quarter of all adult diabetics.\(^6\)

A high proportion of Bronx-Lebanon’s service area residents reported being in fair or poor health in the 2015 New York City Community Health Survey. Maps shown in the Appendix from the 2015 survey indicate high rates of the following health conditions, risk factors, and behaviors:

- Obesity
- Diabetes
- Asthma
- Hypertension
- Elevated cholesterol
- Smoking rates
- Serious psychological problems

In the three neighborhoods which contain or overlap Bronx-Lebanon’s service area

---

\(^4\) Data from this section, unless otherwise noted, is from the New York City Department of Health, Community Health Profiles, 2015.

\(^5\) New York City Department of Health, June, 2013; Diabetes-related mortality in New York City.

\(^6\) Healthy People, 2020.
BRONX-LEBANON COMMUNITY SERVICE PLAN

(Central Bronx, Highbridge/Morrisania and Hunts Point/Mott Haven), the following statistics underline the pressing health needs in this area:

- 20 percent are smokers
- 35 percent are obese
- 16 percent have diabetes
- 17 percent went without needed medical care

Key health issues identified in the 2015 New York City Community Health Profiles (New York City Department of Health) indicate extensive needs in the community for enhanced access to medical care and prevention. Specifically, the UHF-defined neighborhoods which constitute the service area exhibit very high rates of the following poor health outcomes when compared with New York City overall:

- Avoidable hospitalization rates for diabetes and asthma. For example, in the Tremont, Morrisania, Crotona and Mott Haven neighborhoods, this rate was triple the New York City rate: 749 to 786 per 100,000 for asthma versus only 249 for New York City. For diabetes, this rate was over twice as high: 687 to 740 in the service area versus 312 for New York City.

- Premature mortality was significantly higher in service area neighborhoods—305 to 346 per 100,000 versus 198 for the city.

- Behavioral (psychiatric, alcohol and drug) hospitalizations per 100,000 were two to three times higher in the service area than in New York City.

Mental Health and Substance Abuse

According to the New York City Community Health Survey 2015, residents of the South Bronx experience high rates of mental illness and alcohol and drug abuse.

- The service area had a high rate of psychiatric hospitalization, ranging from 809 to 1220 per 100,000 versus 684 for New York City.

- Drug-related hospitalizations per 100,000 are over three times higher in the PSA (2027 to 3130) versus New York City overall (900).

- Alcohol related hospital use rates were also twice the New York City rate: 1,800 to 2,367 per 100,000 versus 1,020 in New York City. The Morrisania neighborhood has the highest rate in the city.
Infant Mortality/Low Birth Weight/Teen Pregnancy

Infants are the most vulnerable population and residents of the Primary Service Area have disproportionate mortality, low birth weight, and teen pregnancy compared to New York City as a whole.

- The neighborhoods which include Bronx-Lebanon’s service area had high infant mortality rates in 2015, ranging from 5.5 per 1,000 in Highbridge to 7.7 in Morrisania. These exceed the New York City rate of 4.7.

- Late/no prenatal care rates were high in the PSA: 13.6 to 15.6% versus 7.4% for New York City.

- The teen birth rate in the service area was 43 to 45 per 1,000, nearly twice the New York City rate of 23.6.

With the closing of maternity and NICU services at North Central Bronx Hospital in August 2013, fewer providers and fewer beds are available to provide high-risk maternity and infant care in the Bronx.

HIV/AIDS

Incidence and prevalence of HIV and AIDS are higher in the Primary Service Area than in New York City as a whole.7

- New diagnoses of HIV range from 38.8 to 52.6 per 100,000 in the service area versus 30.4 in New York City.

- The number of people living with HIV/AIDS as of 12/31/2013 in the PSA was 14,488.

Hospital Admissions/Avoidable Hospitalizations (see Table 4)

The latest data from the New York State Department of Health Prevention Quality Indicators (2012) demonstrates that the Bronx overall has significantly higher hospital admission rates for major chronic illness when compared to other boroughs and, therefore a greater potential for reduction of utilization through expanded primary care. In addition, for each condition, African-Americans experienced higher admission rates than other racial/ethnic groups.

7 New York City Department of Health Annual AIDS Surveillance Statistics, 2013.
### Table 4: Potentially Avoidable Inpatient Discharges (Composite PQI), 2012

<table>
<thead>
<tr>
<th></th>
<th>Rate Per 100,000</th>
<th>Bronx</th>
<th>Brooklyn</th>
<th>Manhattan</th>
<th>Queens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td>2,482</td>
<td>1,731</td>
<td>1,360</td>
<td>1,318</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Rate Per 100,000</td>
<td>495</td>
<td>347</td>
<td>230</td>
<td>225</td>
</tr>
<tr>
<td>Respiratory Conditions</td>
<td>Rate Per 100,000</td>
<td>701</td>
<td>393</td>
<td>304</td>
<td>269</td>
</tr>
<tr>
<td>Circulatory Conditions</td>
<td>Rate Per 100,000</td>
<td>653</td>
<td>503</td>
<td>350</td>
<td>386</td>
</tr>
</tbody>
</table>

3. ASSESSMENT AND SELECTION OF PREVENTION AGENDA PRIORITIES

Among the five broad priority areas in the New York State Prevention Agenda, Bronx-Lebanon has selected two priority areas for which there continues to be a major need.

A. Priority 1: Prevention of Chronic Disease—Increase access to high quality chronic disease preventive care and management in clinical and community settings.

This project will:

- Build on the successful completion of Bronx-Lebanon's Health and Wellness Center (completed in 2014), which is now accommodating 125,000 outpatient visits.
- Increase ambulatory care services and programs in response to the needs of the community.
- Address the health care needs of the growing West African population.
- Expand initiatives related to heart disease, cancer, asthma, and diabetes, as well as reducing obesity, among other key areas.
- Improve access to state-of-the-art primary and specialty care services.
- Continued education to increase health awareness throughout the community.

The rationale for selection of this priority is the ability of the initiative to be consistent with Bronx-Lebanon's ongoing efforts to Promote and Achieve Health Care Excellence. With Bronx-Lebanon's extensive ambulatory and community network of practices (BronxCare) and its dedication to enhancing access to care for its underserved communities, this role will be enhanced and expanded through this first priority agenda and its component initiatives. In addition, criteria that will be used include:

- Ability of planned services to reduce high and unnecessary use of costly acute and emergency room services
- Ability of service to reduce health disparities to the medically underserved

As a DSRIP Lead Entity, Bronx-Lebanon is working with a wide range of partners to identify key health problems in the community and to develop and expand initiatives to address these issues. In addition, Bronx-Lebanon seeks to improve its interventions in the area of chronic disease, based on empirical information and input from its partners regarding pressing health needs. Bronx-Lebanon also continues to meet with its partners to refine and improve the implementation of its Prevention of Chronic Disease Community Service Plan Initiative.
Bronx-Lebanon is actively collaborating with its DSRIP partners in pursuing eight projects to address chronic disease access and prevention. These projects are summarized below:

2.a.i.: Build an integrated delivery system to end service fragmentation focusing on evidence based medicine and population health management

2.a.iii.: Expand access to community based primary care services through integrated care teams for high risk patients who do not meet Health Home eligibility

2.b.iv.: Provide 30 day care transitions post discharge to minimize re-hospitalizations for key chronic diseases

2.b.i.: Create ambulatory care ICUs for patients with multiple comorbidities including use of non-physician interventions for chronic care needs

3.c.i.: Develop evidence based best practices for disease management, focusing on diabetes, smoking and vaccination compliance

3.d.ii., 3.f.i., and 4.c.ii.: These projects address asthma self management; maternal and child health prevention of high risk pregnancy outcomes; and access to HIV care.

Bronx-Lebanon has also submitted Certificate of Need Applications (December, 2016) to implement its DSRIP Goals and Objectives, including those in the Prevention of Chronic Disease (Community Service Plan – Priority 1) Area. When implemented, the projects proposed in these applications will have a significant impact in keeping patients and the community healthy and well (and out of the hospital), through Disease Management and related Population Health Initiatives.

B. Priority 2: Mental Health/Substance Abuse—Prevent Substance Abuse and other Mental, Emotional, Behavioral Disorders

This project includes:

• Building on Life Recovery Facility for Chemical Dependency patients (completed in 2014).
• Continued Integration of Chemical Dependency services with Bronx-Lebanon’s comprehensive psychiatry programs.
• Expansion of community-based programs and initiatives.
• Continued collaborative efforts with government agencies and community organizations.
This priority was selected based on the following criteria:

- Ability of planned services to meet the high needs in the area for this service.
- Ability of the services to reduce use of costly inpatient levels of care
- Ability of service to reduce fragmentation of care in the mental health/ substance abuse area

As a DSRIP lead entity, Bronx-Lebanon is actively collaborating with its partners to address health disparities related to the area of mental health and substance abuse. Specifically, two of its DSRIP projects address such disparities and are described below:

3.a.i.: Integration of mental health and substance abuse with primary care to ensure coordination of services, including medication management, diabetes and cardiac screening for schizophrenics.

4.a.iii.: Strengthening of mental health and substance abuse infrastructure across systems. This intervention will support collaboration among a wide range of providers and community entities.

Bronx-Lebanon has also submitted Certificate of Need Applications (December, 2016) to implement its DSRIP Goals and Objectives, including those in the Prevention of Mental Health/Substance Abuse (Community Service Plan – Priority 2) Area. When implemented, the projects proposed in these applications will have a significant impact in keeping patients and the community healthy and well (and out of the hospital), through Disease Management and related Population Health Initiatives.

Bronx-Lebanon has a multi-pronged approach to identifying and prioritizing the health needs of its community. This includes conducting surveys with Bronx-Lebanon network patients and the community in general, analysis of health status data on a local level (county, zip code or neighborhood), and interviews and meetings with community partners.
1. Surveys

The Bronx-Lebanon health care team, through its community based programs and large ambulatory care network, surveys the health care needs of patients to identify trends related to community health needs. These trends are then addressed by management. Through surveys, Bronx-Lebanon also obtains valuable information on quality outcomes, how well needs are being met, and patient satisfaction.

Interaction with the public includes the hospital’s HeartBeat newsletter, HealthBeat television program, and website (www.bronxcare.org). HeartBeat is distributed throughout the Bronx community and prominently displayed in the hospital’s lobby areas and outpatient practice locations. The HealthBeat television program is widely viewed throughout the Bronx community. It provides a unique call-in format where viewers or consumers of health care services can have their respective questions answered regarding the medical issues of concern to them. Bronx-Lebanon’s website is continually offering consumers important information regarding hospital’s programs and services. Bronx-Lebanon has also utilized public service announcements in widely circulated newspapers to inform the public regarding its Community Service Plan. The majority of Bronx-Lebanon’s staff reside in its service area. Information regarding the hospital is easily spread through word of mouth in the community. These communication channels allow for community input regarding health issues and needs.

2. Meetings/Interviews

During interviews with community leaders, key health issues are identified, as well as the services related to address/reinforce them. Several themes emerged from previous sessions, including the need for affordable and accessible urgent care services (and the resulting reduction of ER use for primary care), and culturally and linguistically appropriate (particularly Spanish) services to help reduce health disparities in the Latino and African American communities. The need to address diabetes, and hypertension, for example, with medical preventive care and interventions, as well as via education programs, was identified and prioritized. Exposure to air pollutants was also identified as leading to cases of environmentally induced asthma, which is particularly alarming among children.

3. Input from Stakeholders (DSRIP) Community Needs Assessment

The input of stakeholders was obtained through the following methods. Approximately 600 surveys were completed by Bronx residents (age 19 and older) regarding health status and health needs. Survey respondents were identified and recruited, including community based organizations, senior centers and health care providers, and at street fairs as well. In development of the Community Needs Assessment for DSRIP projects, The New York Academy of Medicine (NYAM) conducted 24 key informant interviews with community stakeholders. In addition 11 in-depth interviews were conducted. As a result of this input from community partners, Bronx-Lebanon developed its ten DSRIP projects, including the two focus areas described in this Community Service Plan. (See Attachment I)
In addition, Bronx-Lebanon identified the following health priorities in its community:

- Access to primary care
- Mental health disorders
- Substance abuse
- Asthma
- Hypertension
- Diabetes
- Heart disease
- Cancer
- HIV
- Obesity
- Maternal/child health

4. Data Sources Utilized

Bronx-Lebanon has analyzed local community health and socioeconomic data from a wide variety of sources, including:

- Robert Wood Johnson, County Health Rankings
- New York City Department of Health, Community Health Profiles
- New York State Department of Health Bronx County Indicators
- Claritas, Inc. socioeconomic data on zip code level, based on US Census estimates and projections
- New York State Department of Health, Prevention Quality Indicators
- United Hospital Fund Community Health Atlas
- HRSA (Health Resources and Services Administration): Health Care Professional Shortage Areas and Medically Underserved Areas
- New York City HIV/AIDS Annual Surveillance Statistics
- New York City Department of Health, Annual Vital Statistics

This data translates into an extremely medically underserved area characterized by low socioeconomic status and other factors which put the community at risk for many pressing health needs. Of these, Bronx-Lebanon has identified two top priorities selected from the New York State Department of Health Prevention Agenda, namely Access to Primary Care and Chronic Disease Prevention, and the Enhancement and Coordination of Mental Health and Substance Abuse services to its community.
4. TWO HEALTH PRIORITY FOCUS AREAS

While Bronx-Lebanon has many ongoing initiatives related to the two priority agendas, its DSRIP components are reinforcing them.

A. Prevention of Chronic Disease, Focus area: Evidence based practices for diabetes management

GOAL


OUTCOME OBJECTIVES

Improve health outcomes among patients with diabetes through the use of care coordination, patient education and self management.

INTERVENTION STRATEGIES

1. Identify and implement best practices
2. Develop care coordination teams
3. Train interdisciplinary staff
4. Utilize Electronic Health Record to track patients
5. Provide counseling and educational services to diabetes patients
6. Deploy mobile medical teams to ensure access

PROCESS MEASURES

1. Engage at least 80 percent of primary care providers within the PPS in evidence based diabetes management
2. Reduce avoidable hospitalizations
3. Reduce population A1C levels

PARTNER ROLE

Care coordination teams will include primary care physicians, specialists, social workers, community health workers, pharmacists and nurse coordinators. The following partners will ensure that patients have required support services: meals on wheels, transportation, dental, podiatry, optometry and behavioral health care. Partnerships are planned in order to share best practices with other providers, including the Health and Hospitals Corporation, St. Barnabas Hospital PPS, and Mount Sinai PPS. Bronx-Lebanon will also partner with Medicaid Managed Care Organizations, as well as the New York City Departments of Health and Mental Health.
PARTNER RESOURCES

Capital funding for Information Technology will be proposed and implemented regarding sharing renovations of program space for medical equipment; acquisitions, and renovations of community based storefront offices.

DISPARITIES ADDRESSED

- Racial/ethnic, linguistic barriers, medically indigent.
- Lack of access to crucial support services which directly impact health such as nutrition, medication adherence, transportation.

B. **Focus area: Mental Health/Substance Abuse:** 

*Strengthen Mental Health/Substance Abuse Prevention Treatment and Outcomes*

**GOAL**

Strengthen Mental Health and Substance Abuse Infrastructure across systems and settings.

**OUTCOME OBJECTIVES**

Address chronic disease prevention, treatment, and recovery for individuals with mental health and or substance abuse disorders. The infrastructure for provision of Mental Health/Substance Abuse will be strengthened. Integrate services into primary and behavioral health care. Provide education to reduce the stigma associated with mental health disorders.

**INTERVENTION STRATEGIES**

1. Support cross-disciplinary collaboration among stakeholders to address substance abuse and other mental health disorders.

2. Co-location of psychiatric services at Bronx-Lebanon’s outpatient practices: Mental health specialists will educate and train non-medical staff.

3. Provide cultural and linguistic training on mental health promotion and Chemical Dependency Prevention.

4. Utilize the collaborative care SBIRT* model, an evidence-based practice used in prevention of substance abuse.

* Screening, Brief Intervention and Referral to Treatment.
5. Expand access to peer support services, an essential component of behavioral health care which enables peers to work with integrated care teams to improve outcomes and transitions of care.

6. Develop and implement poverty reduction interventions as these directly impact mental health issues.

**PROCESS MEASURES**

Key milestones are:

1. Convene cross-PPS Joint planning committee to meet on monthly basis.

2. Establish a workplan and timeline.

3. Agree on shared resources and shared data platforms.

**PARTNER ROLE**

Bronx-Lebanon will partner with participating PPS primary care practices and community based agencies such as food pantries, financial assistance and support programs, employment support, visiting nurses, and housing advocacy groups. The role of these groups will be to develop poverty reduction interventions and to recruit and identify the target patient population who could benefit. Communilife, and St. Christopher’s Inn are representative examples of participating partners.

**PARTNER RESOURCES**

Capital funding will be required for:

1. Necessary IT in order to enhance cross-agency information sharing.

2. Renovation of space for program staff and partners.

3. Acquisitions of computers, and telephones to facilitate the interdisciplinary and interagency screening and intervention process.

4. Renovation of storefront offices in the community.

5. Construction of additional care sites, as needed.
DISPARITIES ADDRESSED

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.

C. Other Key Initiatives Supporting Bronx-Lebanon Hospital Center's Prevention Agendas

The following programs and initiatives (since the last Community Services Plan was filed) will contribute towards fulfilling the DSRIP goals, as well as the two focus areas identified and described within the Prevention Agenda. The Attachment contains highlights of recent developments at Bronx-Lebanon.

D. Recent Bronx-Lebanon Highlights

- **Capital Projects Award:** In addition to receiving designation as a DSRIP Lead, with a five-year award of $154 million, Bronx-Lebanon was awarded $12.9 million through the Capital Restructuring Financing Program for the purpose of developing and implementing capital projects which support DSRIP goals. Funding is being proposed for the following key areas:
  - Adult Primary Care Practice
  - Comprehensive Walk-in Primary Care Health Center
  - Diabetes Retinopathy Practice Relocation
  - Comprehensive Care Walk-in Behavioral Center
  - Health & Wellness Educational Center/Auditorium
  - Center for Comprehensive Care service for people with HIV/AIDS
  - Family Medicine Practice (Fulton Division)
  - BronxCare at Third Avenue Medical and Dental Practice
  - BronxCare Medical and Dental Practice at Poe
  - BronxCare Ogden Family Medical and Dental Practice
  - Pediatric Outpatient Care Center
  - Pediatric Specialty Center

- **Population Health:** This effort strives to reduce the community-wide need for hospital admissions, as well as inappropriate use of Emergency Services (ERs). For example a recent initiative is a team effort with Bronx-Lebanon Hospital Center, Health First, the American Diabetes Association, and New York City Housing Authority at Claremont Village, a low income housing development in Morrisania/Crotona. This team is initiating a wide range of efforts to improve residents' health and therefore reduce hospital admissions and readmissions. The focus is on diabetes and asthma management and prevention.
• **Cardiac Care**: Bronx-Lebanon is one of a select group of organizations participating in Center for Medicare and Medicaid Service’s (CMS) National Million Hearts Cardiovascular Disease Risk Reduction Model. This program strives to reduce the risk of cardiovascular disease.

• **Health Literacy**: Bronx-Lebanon is initiating a series of training sessions for health care workers on both cultural /linguistic competence and health literacy in order to improve communication with patients and ensure their understanding of diagnoses, treatment and preventive measures. This program will support both of the selected priority agendas—chronic care management and behavioral health. The training sessions cover a broad range of topics, including general cultural competency, health literacy, domestic violence, families with same sex parents, LGBT sensitivity training, female genital mutilation, the grieving process and approaches to Mental Health and Substance Abuse Care.

• **Partnering for Training Community Health Workers**: A new apprenticeship program at Bronx-Lebanon will focus on preventive care and population health. Through a partnership with the 1199 Union, LaGuardia Community College, and the New York City Department of Small Business Services, community health workers will be trained to engage in follow up home visits post discharge to ensure compliance with physicians orders and to prevent readmission. Chronic health problems, particularly diabetes and asthma, will be targeted. Classroom learning will be combined with field experience to enhance career skills and earnings, while improving population health outcomes.

E. **Other Bronx-Lebanon’s Highlights (See Attachment II)**
5. ENGAGEMENT WITH PARTNERS/TRACKING PROGRAMS

Bronx-Lebanon’s management, physicians and Board will review utilization statistics on an ongoing basis. The following measures will be used to track progress in meeting community and chronic health needs:

- Number of visits by type: primary and specialty and by setting, for example:
- Average waiting times for appointments.
- Number of repeat admissions to hospital.
- Number of hospital admissions through the ER for chronic conditions.
- Number of screening tests performed by specialty.
- Patient satisfaction scores

Specifically, Bronx-Lebanon will track progress in the following chronic disease areas through these measures:

- Cardiac disease: blood pressure and cholesterol levels
- Diabetes: increase the proportion of adults with diabetes whose A1C level is below 8 and increase the percentage receiving all four screening tests (A1C test, lipid profile, eye exam, and nephropathy monitoring)
- Obesity: Body Mass Index
- Asthma: Number of hospital admissions via the ER.

Outcome measures to be utilized for tracking progress in Priority Two (Mental Health/Substance Abuse) include the following:

- Psychiatric ER usage
- Readmissions for acute mental health/substance abuse conditions
- Utilization/attendance of outpatient substance abuse programs (detox, rehabilitation, etc).

Bronx-Lebanon’s senior staff will monitor the progress of the Community Service Plan, make mid-course corrections, as required, and maintain open channels of communication to ensure that community partnerships are encouraged and maintained.

In summary, Bronx-Lebanon is committed to furthering the goals of the New York State Department of Health Prevention Agenda, through the selection of its two priority agenda initiatives, consistent with the Department’s goals. These are Ambulatory/Chronic Care and Mental Health/Substance Abuse, both of which represent pressing health care needs in the medically underserved and ethnically diverse community served by Bronx-Lebanon. Through collaboration with its community partners (private and public), Bronx-Lebanon has developed a plan of action which address gaps in health and mental health services. As a result, Bronx-Lebanon will expand its efforts to move forward in Promoting and Achieving Health Care Excellence.
6. DISTRIBUTION OF EXECUTIVE SUMMARY

Bronx-Lebanon'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 relationship with the community, including working with them to understand and providing them with Bronx-Lebanon's Community Service Plan.

Bronx-Lebanon will disseminate the Executive Summary to the public using a variety of communications methods. It will be posted on the hospital's website – www.bronxcare.org. The public can also request a copy by contacting Bronx-Lebanon’s Office of Planning, Marketing and Public Relations at 718-FAMILY-1 (718-326-4591).

Other methods for public notification include the hospital's Heartbeat newsletter and its Healthbeat television program. In the Heartbeat newsletter, there is a specific notification that the Community Service Plan is available to interested parties. A contact telephone number is also referenced. The Heartbeat television program is widely viewed throughout the Bronx community. Public service announcements regarding the Community Service Plan will also be included in the program format.
COMMUNITY MEETINGS

(Attachment I)
Town Hall Meetings (Quarterly) – These meetings serve as a platform to update all of our PPS partners on where we are with DSRIP, and any relevant information is shared. On average, there are 100 participants.

Care Coordination Project Workgroup Meetings (Weekly) – These meetings cover updates on one of our key clinical projects: Care Coordination.

Stakeholder Engagement Workgroup Meetings (Semi-monthly) – These meetings focus on various ways the PPS can engage our community partners with DSRIP. The workgroup comes up with various initiatives based on the needs of the Project Management Office and its various clinical projects.

Cultural Competency Committee Meetings (Bi-weekly) – These meetings focus on ensuring the PPS complies with cultural competency practices as it pertains to projects, communications, etc.

PCMH Workgroup Meetings (Weekly) – These meetings serve as a two way communication platform between Bronx Health Access PPS and our vendor Insight Management, who are tasked with assisting our community PCP’s obtain Level 3 2014 PCMH Status for their practices.

Clinical & Quality Meetings (Semi-monthly) – This meeting focuses on monitoring where the PPS is with outcomes and various quality measures. Also, ideas are shared as to how to improve these measures.

Workforce Committee Meetings (Monthly) – These meetings focus on reviewing and implementing various trainings that are available to our PPS partners.

Project Advisory Committee (PAC) Meetings (Quarterly) – These meetings serve as a status update for the various clinical projects of the PPS.
BRONX-LEBANON HIGHLIGHTS

(Attachment II)
BRONX-LEBANON HOSPITAL SYSTEM

HIGHLIGHTS

Our full three-year accreditation from the Joint Commission, the nation’s leading accrediting authority for hospitals, and recognition as a Top Performer on Key Quality Measures,® is a tribute to the dedicated efforts of Bronx-Lebanon’s physicians, nurses, and administrative staff, as well as Board of Trustees and employees. It is a confirmation of Bronx-Lebanon’s success in providing high quality and compassionate care, while always assuring patient safety and satisfaction.

Our selection by the New York State Department of Health as a Performing Provider System (PPS) lead in its Delivery System Reform Incentive Payment (DSRIP) program represents an opportunity for Bronx-Lebanon and its community partners to achieve progressive health care change. The $154 million award over a five-year period, and the additional $12.9 million for Capital Projects (received during its second year of operation), will result in a high performing delivery system that keeps patients and the community healthy through disease management at the inpatient and outpatient levels.

Our medical school affiliation with the Icahn School of Medicine at Mount Sinai and clinical collaboration with the Mount Sinai Health System is expanding patient care across multiple disciplines. It will link information systems to promote quality, continuity, and evaluation of care, as well as include the development of a robust population health enterprise, with shared resources as part of New York State’s DSRIP initiative.

Our Gold Plus and Target Stroke Honor Roll Award Designation from the American Heart Association/American Stroke Association’s Get With The Guidelines is a prestigious recognition of Bronx-Lebanon’s strong commitment to delivering advanced stroke treatments to patients quickly and safely.

Our Gold Plus Quality Achievement Award for Heart Failure Care from the American Heart Association’s Get With The Guidelines is an important acknowledgement of the high quality cardiology care provided by Bronx-Lebanon to patients with heart failure.

Our American Heart Association’s Mission Lifeline Quality Achievement Award is a confirmation of Bronx-Lebanon’s successful efforts to implement quality improvement measures for heart attack patients.

Our recognition by the Centers for Medicare and Medicaid Services (CMS) as one of a select group of organizations to participate in its National Million Hearts® Cardiovascular Disease Risk Reduction Model will provide an important opportunity to decrease cardiovascular risk.

Our Five Star Rating for Excellence in Maternity Care from the National “Health Grades” System, including a Labor & Delivery Excellence Award for normal deliveries and cesarean sections, is representative of the exceptional care provided by Bronx-Lebanon’s Women’s Health Center.
Our new Cardiac Catheterization Suite, including an Electrophysiology Laboratory, is addressing the growing need for cardiac services.

Our BronxCare Network volume of more than 1.2 million outpatient visits annually is reinforcing Bronx-Lebanon’s leadership role in Promoting Health Care Excellence.

Our certification as a Level Three Patient-Centered Medical Home (the highest level) by the National Center for Quality Assurance is a further indicator of Bronx-Lebanon’s outpatient excellence. The Patient-Centered Medical Home was also awarded a New York State Department of Health grant of $3 million to expand its community outreach efforts, through upgrading Information Technology.

Our New York State designated Health Home, a collaborative effort with more than 100 community-based organizations, is responding to the needs of individuals with chronic and multiple medical, mental health, and chemical dependency conditions.

Our ER is providing 139,000 visits annually, among the busiest in New York. A major ER modernization was also completed.

Our Angioplasty Program and Hypothermia Center are providing lifesaving care.

Our skilled and experienced Neurosurgeons are bringing advanced brain and spine surgery to patients.

Our Orthopaedic Team is providing trauma, hand, foot, and spine care, as well as hip and knee replacements. Its unique “Game Day Same Day” program offers athletes treatment on the same day as their injury.

Our Bariatric Surgery Program’s surgeons utilize robotic and laparoscopic procedures to benefit excessively obese patients.

Our Breast Care Center’s one-stop shopping approach for exam, imaging, and biopsy is potentially alleviating the serious problems associated with late stage breast cancer.

Our new Center for Colorectal and Gastrointestinal Health is addressing the high incidence of colorectal cancer in the community. The most advanced minimally invasive and robotic surgical techniques are utilized, when necessary.

Our new Center for Vein Care is achieving successful outcomes for patients with vein disorders.

Our Division of Urology is successful treating urinary tract, kidney, bladder, testes, and adrenal problems.

Our Women’s Health Center, Birthing Spa (offering whirlpool deliveries) and Center for Gynecologic Care are delivering the services women need in a welcoming setting. Advanced robotic surgery is also being performed, when needed, for GYN patients.

Our Level III Neonatal Intensive Care Unit’s 99 percent survival rate in saving infants, weighing as little as one to two pounds at birth, remains among the highest in the nation.
education to future primary care physicians, are confirmations of Bronx-Lebanon’s leadership in medical education and the delivery of quality patient care.

...and our $23 million in annual grants, is indeed noteworthy.
Our **Dentistry Department** is providing more than 94,000 visits annually at six convenient locations across the Bronx. It has also trained more under-represented ethnic minorities than any dental residency program in the United States.

Our **Cosmetic Dermatology Practice** is achieving outstanding results in improving physical appearance and treating skin problems.

Our **Center for Sleep Medicine** is addressing sleep disorders.

Our **South Bronx Asthma Partnership** was nationally recognized for its leadership in improving the lives of children with asthma.

Our **Multiple Sclerosis Program** is the only one in the Bronx recognized by the National Multiple Sclerosis Society.

Our **Diaspora Initiative** (through the Dr. Martin Luther King Jr. Health Center) is providing comprehensive medical and support services to the growing African population.

Our **partnership with Community Kinship Life** (CK Life), through the Department of Family Medicine, is providing compassionate medical, mental health, and support services to the Transgender Community.

Our **Special Care Center** and **Highbridge Woodycrest Center** are providing quality long-term and chronic care, with access to Bronx-Lebanon’s comprehensive inpatient, outpatient, and specialty services.

Our New York State grant funded **Community Health Navigator Initiative** is providing needed support for patients with diabetes and other chronic diseases, helping them take an active role in their health care.

Our **HealthBeat Television Program** is effectively delivering the message of health and wellness.

Our **“myBronxCare”** Portal offers patients the opportunity to have confidential access to their health information. With “myBronxCare,” patients can contact a doctor, request appointments, review lab results, and request prescription refills.

Our **Patient-Centered Care Initiative**, a collaborative effort with the 1199SEIU Union, State Nurses Association, and Committee of Interns and Residents is enhancing patient satisfaction, by empowering employees to always “put patients first.”

Our **Leadership Development Program** is providing middle management staff with an improved understanding of how to address the many issues and challenges impacting Bronx-Lebanon and other health care organizations.

Our **Mobile Health Units** are successfully reaching out to the Bronx community.

Our **15 fully accredited Residency Programs** from the Accreditation Council for Graduate Medical Education (ACGME), and American Dental Association (ADA), in addition to a federal residency training grant of $2.1 million over five years for enhanced