NYC HEALTH+ HOSPITALS | North Central Bronx

2016

IMPLEMENTATION STRATEGY

Purpose of the Community Health Needs Assessment and Implementation Strategy

The Affordable Care Act ("ACA") requires that any tax-exempt, Internal Revenue Service-designated 501(c) (3) hospital complete or update a publicly-available, comprehensive Community Health Needs Assessment ("CHNA") every three years to document its understanding of the unique characteristics and needs of the local communities it serves. In a companion document known as the "Implementation Strategy," each facility is also required subsequently to list and describe the clinical services and programs available to meet the health needs identified in the CHNA.

Community Served

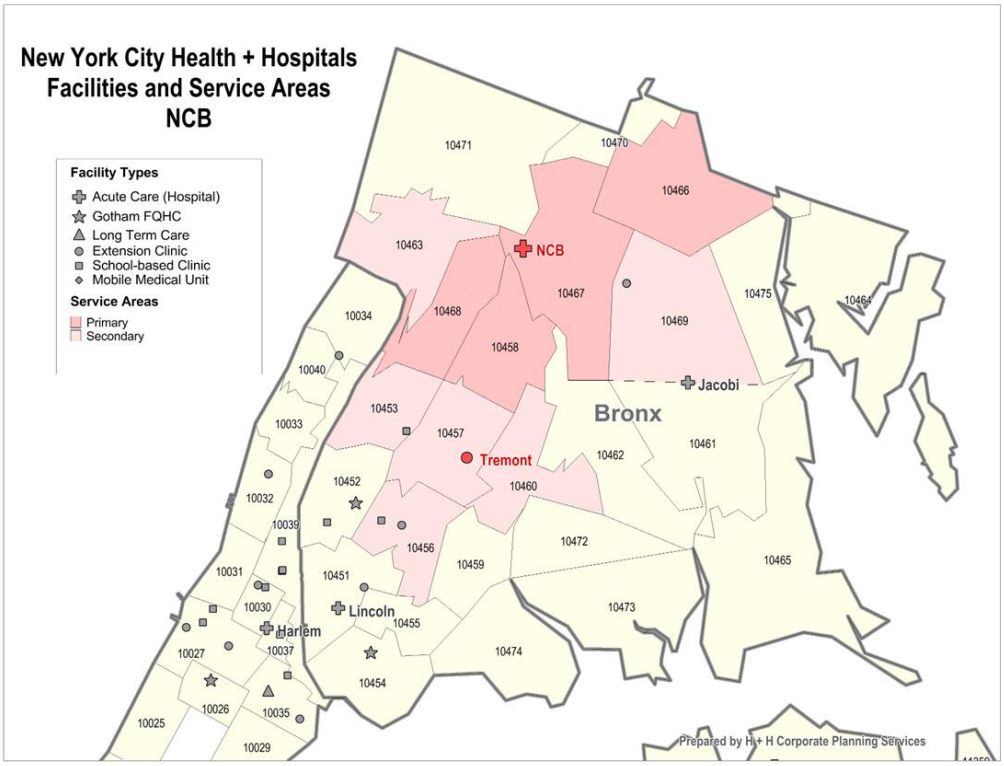
NYC Health + Hospitals serve all New Yorkers in every neighborhood in New York City regardless of their ability to pay. Addressing disparity throughout New York City, NYC Health + Hospitals is the safety-net for the uninsured and underserved in New York City.

The NYC Health + Hospitals/ North Central Bronx and its extension sites provide the full spectrum of preventive, ambulatory, and inpatient care for children and adults. NYC Health + Hospitals/ North Central Bronx is a member of NYC Health + Hospitals, the largest municipal health care organization in the country and New York City's public safety net health care system. NYC Health + Hospitals is an integrated health care delivery system of 11 acute care hospitals, one long term acute care hospital, five nursing homes, and 74 community health centers (including school-based and mobile health sites). NYC Health + Hospitals also provides home care services and operates MetroPlus Health Plan, a wholly owned subsidiary that offers low- or no-cost health care insurance to the nearly 500,000 New Yorkers enrolled in its Medicaid, Medicare, and New York State Health Plan Marketplace managed care plans.

NYC Health + Hospitals / North Central Bronx, a fixture in the Bronx Norwood community, is located in the Fordham-Bronx Park area (Zip code 10467), with a service area that encompasses Crotona/Tremont, Fordham/Bronx Park, Highbridge/Morrisania, Kingsbridge/Riverdale, and Northeast Bronx.[1] The map below shows the primary service area in red and the secondary service area in light red. The hospital's sites are labeled in red and other NYC Health + Hospitals' inpatient and outpatient sites are in labeled in gray. The NYC Health + Hospitals / North Central Bronx service area encompasses many neighborhoods that the federal Health Resources and Services Administration (HRSA) has identified as being medically underserved and/or or having a

[1] Primary and Secondary Service area is defined as the Zip codes that comprise the residence of 50% and 75% of its ambulatory patients, respectively. NCB's primary and secondary service area includes Zip codes: 10453, 10456, 10457, 10458, 10460, 10463, 10466, 10467, 10468, and 10469.

shortage of health providers (HPSA).[2] NYC Health + Hospitals / North Central Bronx is specifically located in special population (Medicaid) Dental, Mental Health, Primary Care HPSAs and the Bedford Park medically underserved area.



NYC Health + Hospitals / North Central Bronx provides a disproportionate share of services for the borough's low income and uninsured population. In 2014, 18% of its ambulatory visits, and 27% of its ED visits were uninsured compared to 12% and 16% at Voluntary hospitals in Bronx. In addition, 67% of its inpatient discharges were either uninsured or enrolled in Medicaid, compared to 51% at Voluntary hospitals in Bronx.

Required Components of the CHNA

1) Definition of community served
2) A prioritized description of the significant health needs of the community
3) Transparency in the process and methods used to conduct the CHNA, including how it took into account input from the community served and prioritized community health needs

[2] A Medically Underserved Area /Population (MUA/P) designation applies to a neighborhood or collection of census tracts based on four factors: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. A Healthcare Provider Shortage Area (HPSA) is a collection of census tracts that has been designated as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals).

4) A description of the resources potentially available to address the identified significant prioritized community health needs
5) An evaluation of the impact of actions taken to address the significant health needs identified in the previous CHNA report (June 2013).

The 2016 CHNA reports were adopted by the New York City Health + Hospitals Board of Directors in June 2016.

Requirements of the Implementation Strategy

The U.S. Department of the Treasury and the IRS requires a hospital organization to specifically address each of the community health needs identified in the CHNA, and describe the strategies that will be used to address these priority needs. This may entail providing a list of programs and/or clinical services (new or continuing) available to address each need. If the hospital facility does not intend to meet the needs identified in the CHNA, it is required to explain explicitly why it does not intend to meet such health need.

Process and Methods for Conducting the CHNA

A work group composed of representatives from the planning offices from all hospitals in the NYC Health + Hospitals system and Central Office was formed to coordinate and conduct the CHNA. To identify community health needs, the work group reviewed documentation from City, State and Federal public health resources, including but not limited to Take Care New York 2020, New York State Prevention Agenda 2013-2018 and Healthy People 2020, as well as previous need assessments conducted for the hospital system. From this review, an initial list of over 40 potential community health needs were identified. To refine the list, the work group solicited input from other facility representatives, resulting in the 13 community health needs below (note: this is not in priority order):

- Heart disease, high cholesterol, stroke
- Cancer
- Diabetes
- Asthma and other breathing issues
- Hypertension/ high blood pressure
- Violence
- Mental illness and psychiatric disorders
- Dementia including Alzheimer's
- Obesity
- Premature births, low birth weight

- HIV, Hepatitis, STDs
- Alcohol and/or drug use
- Smoking

Community and Facility Input

Community Advisory Board ("CAB")

The process used to conduct the 2016 CHNA was presented to each CAB individually. A survey was administered anonymously and confidentially to each CAB member asking them to indicate the relative importance of each of the 13 identified community health needs in their community. In an open discussion, CAB members were also asked about community health needs not included in the survey question. These responses were coded for inclusion in the prioritization matrix (see detailed explanation below).

Facility Users

NYC Health + Hospitals engaged approximately 150 adult facility users from each hospital throughout the main facilities and within community-based clinic sites to complete an anonymous and confidential survey. Survey questions included demographics, health insurance status, language preferences, health concerns, primary and preventive health care utilization, barriers in obtaining ambulatory care and reasons for use of emergency care. Respondents were asked to indicate the relative importance of each of the 13 identified community health needs in their community. These responses were coded for inclusion in the prioritization matrix.

Facility Leadership

Hospital leadership were engaged to indicate the relative importance of each of the 13 identified community health needs in their service area; and their responses were included in the prioritization matrix. Leadership was also invited to comment on the final ranking of health needs, and assisted in the identification of facility programs to address these concerns.

Secondary Data

To measure the prevalence of chronic conditions and health concerns, data were extracted from several publically available datasets, including the New York City's Department of Health and Mental Hygiene's Take Care New York 2020, New York State Department of Health's Prevention Agenda 2013-2018, federal agencies, Centers for Disease Control and Prevention and Healthy People 2020. (For a full list of sources, please see the 2016 CHNA.)

Prioritization of Community Health Needs

For the 2016 CHNA, hospitals were required to identify community health needs and to rank them in order of priority. Hospitals developed their facility-specific community health needs prioritization by ranking the community needs as determined by CAB members, facility users, hospital leaders, and the prevalence of the conditions within their respective communities – independently - to create an overall blended rank score of each community health need.

Facility users, CAB members, and hospital leaders completed a survey which asked them to rate each of the 13 community health needs using the criteria: “Very Serious” = 3; “Somewhat Serious” = 2; “Not Serious” = 1. The option, “Don’t Know/Not Applicable” was also provided to respondents, but excluded for the scoring.

Condition prevalence within the hospital service area was considered in prioritizing the community health needs. A ‘z’ score, which represents the distance/variance between the raw score (service area average) and the population mean (citywide average) in units of the standard deviation, was calculated for each condition prevalence. A positive number suggests that the service area experiences a higher prevalence of the condition than the rest of the city, while a negative number suggest a lower prevalence in the area relative to other NYC neighborhoods.

Each of the community health needs were assigned a rank from 1 to 13 by each of the three groups –CAB members, facility users, and hospital leaders – based on their survey results. Community health needs were also assigned a rank from 1 to 13 based on their prevalence, using ‘z’ scores. Finally, scores from each of the four categories were added together and health issues were ranked based on their overall score.

Community health needs that were considered significant were ranked among the top five of identified needs. The final list, including the identified significant community health needs, were reviewed by hospital leadership.

NYC Health + Hospitals Comprehensive Response to Community Health Needs

NYC Health + Hospitals has developed numerous initiatives to address community health needs and to support and improve patient and population health, with additional programs to be launched soon. Programs include local, or facility-specific, innovations as well as system-wide projects undertaken as part of the New York City Delivery System Reform Incentive Payment Program (DSRIP).

DSRIP is a five-year program to foster and reward comprehensive Medicaid reform efforts. It provides incentives to create a collaboration among Medicaid providers and community groups that successfully improves patient and population health. In DSRIP, the collaboration with other partners is referred to as a Performing Provider System (PPS). It demonstrates its success and earns revenue by completing a set of state-guided health improvement projects and meeting specific outcome milestones.

OneCity Health is the NYC Health + Hospitals /led PPS which includes the NYC Health + Hospitals system's integrated network of 11 hospitals, 5 nursing homes, dozens of community based health centers, NYC Health + Hospitals/Home Care, NYC Health + Hospitals' health insurance plan, MetroPlus, and more than 400 community partners across the region. Focused on identifying and engaging patients in care before they become sick, OneCity Health is undertaking 11 initiatives, or projects, to become an integrated delivery system of health and social service providers that closes critical gaps in the continuum of care and reduces avoidable hospital use by 25 percent by 2020.

The Implementation Strategy below includes NYC Health + Hospitals /North Central Bronx's DSRIP projects as well as facility-specific initiatives that will address the "significant," or top 5, community health needs identified through the CHNA process.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
Cardio-vascular disease; Hypertension	DSRIP - improve cardiovascular disease management	Support primary care excellence in cardiovascular health (e.g., aspirin use, blood pressure control, cholesterol management, smoking cessation); support patient self-management of cardiovascular health; reduce preventable hospitalizations and emergency room visits	High-risk and affected populations	Follow standardized treatment protocols for hypertension and cholesterol management; adopt strategies from the Million Hearts Campaign (national initiative led by the CDC and CMS); providers to support tobacco control; employ patient self-management plans; coordinate with community based organizations to support education and cultural competencies; health Homes to coordinate care management to existing disease management activities	Potentially avoidable admissions, readmissions, and ER visits, aspirin use; adequately controlled blood pressure; admissions with a principal diagnosis of hypertension; smoking advice and cessation medications health literacy, self-management goals.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Project RED (Re-Engineered Discharge)	Through reducing fragmented care during transitions, we hope to improve patient engagement and education, reduce readmissions and ensure patients attend their follow-up appointments.	Patients with Congestive Heart Failure and those recovering from acute myocardial infarction	Patients are matched with a primary care team. Patient education and interventions occurs during and post hospital stay. Patients are contacted within 72 hours of discharge and connected with an appointment within seven days.	Heart disease related re-admissions.
	Cardiovascular Risk Registry	Identify, manage, and target patients with hypertension in order to ensure population chronic disease management, adherence to medications and other treatment plans	Al patients in the primary care panel with cardiovascular disease	Using data to identify high risk patients, patients in the cardiovascular risk registry are monitored closely by the care team, with frequent patient contact. This includes outreach such as mailing, calls andnurse visits for pressure checks. For patients not at blood pressure goal, additional outreach measures are taken to improve control	Percentage of total population with hypertension whose blood pressure is well controlled

Asthma and other Respiratory	DSRIP - Home Environmental Asthma Management Program	Reduce avoidable ED use and hospitalizations related to asthma by changing the patient's indoor environment to reduce exposure to asthma triggers.	Patients with poor asthma control.	Form active partnerships with primary care (including school-based clinics), inpatient, and ER. Engage community health workers trained with understanding of local communities who will provide home visits. Establish home remediation services to remove sources of allergens from the home such as mold and vermin. Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Number of participating patients based on home assessment log, patient registry, or other IT platform. Admissions with principal diagnosis of asthma; persistent asthma who received at least one controller medication who filled controller prescription; Asthma medication with persistent asthma.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
Diabetes	Diabetes Registry	Identify, manage, and target patients with Diabetes in order to ensure population chronic disease management, adherence to medications and other treatment plans	All Diabetic patients in the primary care panel	Using data to identify and track Diabetes patients in order to ensure adherence with appropriate treatment plans. Patients out of compliance outreach mailing, calls and regular nurse visits for A1C level checks, nutrition education, and group visits.	Rates of Diabetes patients with controlled blood sugar, blood pressure, and appropriate screening.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	DSRIP– Care Transitions	To provide a 30-day supported transition period for patients who are being discharged from the hospital and are at high risk of readmission	Patients identified early in their hospital stay as having a high risk of readmission	Identify high risk patients using risk stratification algorithms and on-site assessments. Assess patient needs in the hospital and develop a care plan prior to discharge. Transition management teams will bridge the patient to resources in the community setting by leveraging the OneCity Health partner network and screen and refer patients for community-based programs.	Number of participating patients with a care transition plan developed prior to discharge; pain; depression; advanced directives.
Obesity	Farmers Markets	Provide Bronx residents with a low-cost, local source to buy fresh and nutritious fruits and vegetables	Total service area population	Host farmers market between mid-June to late November while also providing health education and outreach events.	

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	Community Garden	Provide an educational opportunity about healthy diet and nutrition, and grow fresh produce.	Community residents, patients and staff	The garden is open to patients and the community residents. Currently, 140 individuals tend to 40 garden bends, each 32 square feet.	Number of garden beds, and program participants.
	Develop and Maintain a Bariatric Center of Excellence Program.	Provide surgical, nutritional and psychological care.	Obese patient population.	Provide comprehensive care for Bariatric patients including pre-surgical medical weight management interventions leading up to surgery. Patients undergo multi-disciplinary evaluation to ensure that the surgical procedure will be successful. Psychological, nutritional, and after care education are provided prior to and after the surgery.	Number of surgeries, and outreach sessions

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
Mental illness	DSRIP -- Integration of primary care and behavioral health services	Ensure optimal care coordination by providing coordinated, accessible behavioral health and primary care to patients with behavioral health issues; and reduce hospital admissions and ED visits for patients with behavioral health issues	Patients with undiagnosed conditions including depression, alcohol abuse; patients with mild / moderate / complex behavioral health problems; behavioral health patients with difficulty navigating routine primary care services	Will employ evidence-based standards of care including medication management and care engagement process; preventive care screenings, including behavioral health screenings (e.g. PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs; shared EHR/ clinical records.	Patients in primary care setting receiving appropriate preventive care mental health/SA screenings; patients receiving primary care services at a participating mental health or substance abuse site; patients screened using the PHQ-2 or 9/ SBIRT..

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	DSRIP - Mental health and substance abuse infrastructure	Promote evidence-based practices in MHSA care; break down silos in care to enable health professionals to collaborate and address the population's full range of MHSA needs; and target adolescents with MHSA education and outreach.	Patients ages 12 and above with MEB health diagnoses or substance use disorders (SUDs), as well as those at high-risk for developing SUDs, other MEB health diagnoses, and other health and social consequences linked to risky substance use and MEB needs. We will also engage the criminal justice reentry population	Identify and promote evidence-based programs that extend the reach of education, screening, and early intervention into existing health service footprints. Adapt or develop culturally-sensitive educational materials that inform adolescents about the nature of and risk factors for MHSA diseases All activities and programs will consider cultural and linguistic factors, including: differences in views regarding mental health and use of addictive substances; intra-cultural issues; and circumstances linked to MEB health such as trauma/violence; and, language access-related issues	Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources.

Significant Community Health Need	Action / Project	Objective	Target population	Implementation strategy	Anticipated outcome / key metrics
	DSRIP - integrate mental health and substance abuse services	Promote evidence-based practices in MHSA care; break down silos in care to enable health professionals to collaborate and address the population's full range of MHSA needs; and target adolescents with MHSA education and outreach.	Patients ages 12 and above with MEB health diagnoses or substance use disorders (SUDs), as well as those at high-risk for developing SUDs, other MEB health diagnoses, and other health and social consequences linked to risky substance use and MEB needs. We will also engage the criminal justice reentry population	Identify and promote evidence-based programs that extend the reach of education, screening, and early intervention into existing health service footprints. Adapt or develop culturally-sensitive educational materials that inform adolescents about the nature of and risk factors for MHSA diseases. All activities and programs will consider cultural and linguistic factors, including: differences in views regarding mental health and use of addictive substances; intra-cultural issues; and circumstances linked to MEB health such as trauma/violence; and, language access-related issues	Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources.

The Implementation Strategy for the 2016 Community Health Needs Assessment was adopted by the Board of Directors of NYC Health + Hospitals on September 22, 2016.

Written comments may be submitted via email to: chna@nychhc.org