

MEMO

To: Public Stakeholders
From: Bronx Lebanon Health Center Performing Provider System (BLHC PPS)
Re: BLHC PPS Community Needs Assessment

In order to improve the health care system, it is critical to first understand the services needed by the community. To that end, the New York State Department of Health (NY DOH) requires that a Community Needs Assessment (CNA) be conducted as part of designing the Delivery System Reform Improvement Program (DSRIP). To fulfill this requirement, the Bronx Lebanon Health Center Performing Provider System (BLHC PPS) conducted multiple studies: a qualitative analysis, a quantitative report, and a physician survey. This memo has been developed in order to provide an overview of the CNA conducted for the BLHC PPS, and to tie the findings of the CNA back to the needs of the Bronx community and to DSRIP project selection. The three CNA surveys conducted include:

- The New York Academy of Medicine (NYAM) conducted the quantitative portion of the CNA entitled “New York City Health Provider Partnership: Bronx Community Needs Assessment” which looked at the needs of the entire Bronx County.
- Researchers Resource LLC conducted the qualitative portion of the CNA entitled “A Qualitative Community Needs Assessment for the Bronx Lebanon Hospital Center Delivery System Reform Incentive Payment Program” which examined the needs of patients living in the BLHC PPS.
- Harbage Consulting LLC conducted a survey of physicians and other providers practicing in the BLHC PPS in order to solicit additional opinions on the most pressing health care issues facing the community.

An extensive process was undertaken in the development of the CNA and in the identification of community needs. Approximately 600 surveys were completed by Bronx residents, ages 18 and older. Survey respondents were identified and recruited by local organizations, including community

based organizations, senior centers, social service and health providers, and through NYAM initiated street outreach—at street fairs, subway stops, and other places where people congregate. The surveys were translated into 10 languages: Arabic, Bangla, Chinese (simplified and traditional), Haitian Creole, French, Hindi, Korean, Polish, Russian and Spanish. For the quantitative CNA, NYAM conducted 24 key informant interviews (involving 30 individuals) with community members and other stakeholders. The key informants were identified with input from the PPS. All key informants were asked about perceptions of health issues in the community, barriers and facilitators to good health, health care and other service needs, and recommendations for services and activities that may benefit the local population. For the qualitative CNA, 11 in-depth individual interviews were conducted including patients, clinicians, and organizational leadership. Participants were drawn from a variety of community based organizations and providers.

The CNA findings were utilized in not only determining which projects to pursue but to also determine which projects not to pursue on behalf of the community based on prioritizing the more significant needs and gaps.

The data that was utilized by NYAM to conduct the quantitative portion of the CNA was also utilized to develop the full picture of the BLHC PPS. The analyses of approximately 70 publicly available data sets, including reports prepared by the participating providers such as hospital and community needs assessments and reports, the NYS Department of Health, US Census, NYC Departments of Health and City Planning, academic institutions, and others, was what was largely used, in conjunction with the CNA, to arrive at identification of the most pressing health needs of the BLHC PPS. Additionally, Salient Dashboards and Salient Workbooks data was utilized as well to obtain an accurate picture of the PPS and the patients served.

As a result of this analysis, which is based on the qualitative, quantitative, and physician survey, the BLHC PPS is pursuing 10 DRSIP projects to address health care needs and gaps that cross a spectrum of chronic conditions and diseases. Together with the attachments, this document constitutes the BLHC PPS CNA.

A SNAPSHOT OF THE BLHC PPS:

Approximately 59% of the entire Bronx population resides in the BLHC PPS, which is comprised of 14 zip codes in the Bronx. Riker’s Island is also part of the BLHC PPS. The map below provides a

pictorial of the BLHC PPS. This area was selected because it reflects the population that is served by the Bronx Lebanon Hospital Center (BLHC) and it is contiguous of BLHC's primary and secondary catchment areas.



The majority of the residents living in the PPS depend on government health insurance. On average, approximately 72% of the BLHC PPS are Medicaid beneficiaries, 17% uninsured, 7% dually eligible for Medicare and Medicaid, and 1% Medicare only.

The PPS is diverse in its demography. Only 16% of the total population is white. More than 66% of the population identifies as being Hispanic or Latino and 33% as African American. Approximately 21% of BLHC PPS residents are not U.S. citizens, compared to 18.6% overall for the Bronx. For a quarter of the BLHCPSS on average, they speak English “not very well.” Spanish is primarily identified as the most common non-English language spoken in the home, although the Bronx is home to immigrants from a variety of other non-Spanish speaking countries. For the Bronx overall, approximately 14,000 residents (1% of the total population) migrated from abroad less than a year ago. Also, approximately 18% of all Bronx residents are not U.S. citizens.

The Bronx is an economically depressed area. On average, more than 38% of households in the BLHC PPS live below the federal poverty level. In some neighborhoods of the BLHC PPS, it is as high as 47% of households live below the federal poverty level. The unemployment rate in the BLHC PPS is 15.8% compared to 14.2% for Bronx overall. The BLHC PPS's residents are poorer in comparison to the rest of the Bronx (28.8%) and have a higher rate of unemployment.

In general, the BLHC PPS has a population of residents who have obtained a lower level of education in comparison to the Bronx overall. The percent of the BLHC PPS that has graduated from High School is 61%, compared to 69% for the Bronx overall. Additionally, only 11.5% of the BLHC PPS has a bachelor's degree compared to 18% for the Bronx overall.

There are nine jails on Riker's Island, including one female facility and one adolescent facility. The BLHC PPS also includes Riker's Island because the BLHC does extensive work with the Department of Health and Mental Hygiene, Bureau of Correctional Health Services to improve the health of people transitioning out of incarceration and back into the community. There are over 53,000 releases from the prison system annually. Over 70% of people released to the community after incarceration return to the areas of greatest socioeconomic and health disparities, including Bronx County. In 2012, the BLHC PPS was home to an average of 1,628 per 100,000 of the population who had been incarcerated compared to 1,180 for Bronx overall. This difference is likely attributed in part to returning prisoners wanting to have access to the BLHC prisoner transition program so they are returning to the immediate community. One of the challenges in treating this population is that when they are in the corrections system, all health care is provided in-house so those individuals lose their Medicaid eligibility. Once these individuals are released from the corrections system, they return to the community and usually become Medicaid beneficiaries again looking to connect with providers in the Bronx community. This population suffers from a myriad of health conditions: 3.9% are self-report HIV infected; 5% have diabetes; 12% have hypertension; 23.7% have asthma; 23.4% have a mental health condition or needs; 46.8% report drug use; and 58.3% use tobacco.

Using data from the New York Department of Health, Vital Statistics Data (as of March 2014), the leading causes of premature death (Death before age 75) in Bronx County is as follows: 1) Cancer; 2) Heart Disease; 3) Unintentional Injury; 4) AIDS; and, 5) Diabetes. These top five causes accounted for 63% of the 13,806 premature deaths recorded for the most recent three year period.

OVERVIEW OF CNA FINDINGS: MOST PRESSING HEALTH CARE NEEDS

The CNA identified a myriad of chronic health care conditions that plague the community and cause distress for its residents. From the perspective of the community, the main health issues include: Diabetes, asthma, hypertension, chronic pain and arthritis, Hepatitis C, obesity, HIV/AIDS, mental health (anxiety and depression), and substance abuse. Additional issues that impact a patients' ability to access care in a timely manner and, therefore, function as barriers to care that were identified by patients and providers often include: safe and affordable housing, transportation, safety concerns with neighborhoods, violence, racism, inability to pay bills (challenges finding employment), family demands as a caretaker, and ability to communicate with the provider (both due to language barriers and also providers' availability).

BLHC PPS PROJECTS: JUSTIFICATION

The BLHC PPS examined the CNA and used it to help guide project selection for the 10 DSRIP areas to be addressed by the PPS. Below is an overview of the projects selected with a description of how the CNA justifies the selection of the project.

1. ***Create Integrated Delivery Systems focused on Evidence-Based***

Medicine/Population Health Management. The overarching goal of the NY DSRIP is to create systems of care to reduce avoidable inpatient admissions and readmissions. Thus, a goal of DSRIP is to reduce these types of hospitalizations by 25% over five years for the Medicaid and uninsured population. The BLHC PPS data demonstrates that this PPS is home to a significant number of Medicaid Potentially Preventable Emergency Visits (PPV) (253,636 cases) in comparison to the total number of cases (346,837) in the Bronx. This means that 73% of all PPV cases in the Bronx occur in the BLHC PPS.

Data from the New York State Department of Health (2012) demonstrates that significant improvements could be made in the BLHC PPS to reduce Medicaid hospitalizations for patients with both acute and chronic health episodes.

- For the Adult Overall Conditions Composite Prevention Quality Indicators (PQI), the number of PQI 90 Medicaid hospitalizations in the Bronx is 13,447. Approximately 70% (9,535) are attributed to the BLHC PPS.
- For the Acute Conditions Composite (PQI 91), the number of PQI Medicaid hospitalizations in the Bronx is 3,384, with 2,333 (68%) attributed to the BLPPS.
- For the Adult Chronic Conditions Composite (PQI 92), the number of PQI Medicaid hospitalizations in the Bronx is 10,063 compared to 7,202 (71%) in the BLHC PPS.

This project looks to improve the delivery system as the current system does not meet the needs of medically and behaviorally complex patients. Therefore, the primary strategy of the PPS is to increase the use of evidence based practice, decrease care delivered in silos, and increase communication among providers in the PPS through development of an integrated network of providers and clinical system interoperability. CNA findings demonstrate that patients experience long wait times for primary care, medical specialty and behavioral health appointments and that these appointments are scheduled on multiple dates and locations causing patients to miss work and/or experience financial hardship in regard to transportation costs. If services are not efficiently and conveniently provided, patients will continue to over utilize the ER for ambulatory sensitive conditions.

2. **Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services:** The distribution of preventive and primary healthcare resources in the Bronx varies across the county. The CNA discussed the variety of factors that prohibit access to timely preventative primary care. For example, being seen by multiple providers makes it difficult to forge a continuous relationship with one PCP or care team. A lack of care coordination across care settings also makes it challenging to access patients' medical information in order to determine a course of treatment or even to determine a patient's status after discharge. Finally, patient challenges with wait time for appointments, distance to travel for appointment, and limited after hours or weekend services also contribute to the challenges. The BLHC PPS has two large home health organizations in the community who will participate in this project, thus, the identified

project also matches well with available community resources.

Driving costs at emergency rooms and hospital stays is the reality because many patients do not feel that they have other options to get care when they really need it. Expanding the health home at risk intervention program to populations with chronic conditions that are driving costs will not only help individuals get better care when they need it, it will also help drive down costs. For this project, conditions were chosen by reviewing the list of chronic conditions that make an individual eligible for Health Home services in New York State, then determining which of these conditions drive the most claims in the BLHC PPS, and then examining the most common co-morbidities that typically accompany the development of these conditions. This project will target individuals most at risk for developing a second chronic condition that would qualify them for Health Home services as well as those driving the most Medicaid claims for services in hopes of cutting costs.

3. **Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic**

Health Conditions: The Observed/Expected ratios of Potentially Preventable Readmissions (PPRs) for Bronx hospitals ranges from 1.03 to 1.26. The BLHC PPS is 1.14 when looking at the data with an approximate 15,869 at risk readmissions. There are several reasons that 30-day readmissions occur. Many such reasons were identified in the CNA, including difficulties community members have adhering to medical recommendations in under-resourced and stressful home environments and issues related to the discharge process. In fact, the single most significant reason is operational and is related to communications at discharge. Patient needs are not always identified prior to discharge and the careful handoff that should take place to address those needs does not effectively take place across the BLHC PPS. This project refines protocols based on the known existing workflow problems and systematically address those issues in the form of a checklist and focuses on direct communication across systems.

4. **Ambulatory Care ICU:** Staggering rates of hospital admissions persists throughout the BLHC PPS. The CNA reveals that there are 86,156 hospital admissions projected to be followed by a readmission. Furthermore, 21.2% of Potentially Preventable Readmissions (PPR) were attributed to the BLHC PPS with 15,869 at risk admissions. Reasons

readmissions occurred were due to patients' difficulty in adhering to medical recommendations; living in under-sourced and stressful home environments; operational challenges related to unclear communications at discharge; patients' not understanding what they needed prior to discharge; and, mismanaged handoff of patients. These challenges are shown to be taking place across the BLHC PPS.

Furthermore, according to provider interviews, coordinated care for behavioral health and physical health is poor due to system fragmentation and limited integration. According to PQI measures of preventable hospitalizations specific to behavioral health, data from New York State Office of Mental Health (OMH) suggest over half (54.5% or 9,215/16,942) of Bronx Clients with mental health conditions also have one or more physical chronic health conditions. On top of these conditions, substance abuse rates of 8.5% were reported among Medicaid beneficiaries in the BLHC PPS.

This project will address these gaps by utilizing evidence-based care involving the entire multi-provider team working together simultaneously grounded on the NukaModel of care where at the core is patient wellness. Patients will be tiered based on risk and a team of providers, care coordinators, behavioral health specialists, nurse managers, and housing specialists work closely together at their highest level to serve the highest risk, multi-morbid patients, giving them care tailored to their needs. The team will address the entire gamete of patients' physical, mental, and social state. This project will have true integration of all specialists including shared locations and staff.

5. ***Integration of Primary Care Services and Behavioral Health:*** According to providers interviewed for the CNA, the integration between behavioral health and physical health services is poor and the system is fragmented. The CNA also identifies mental health and substance abuse services as being in high demand with low access to such services in comparison to primary care services. Approximately 53% of CNA survey respondents reported that mental health services were "available" or "very available" in the Bronx, compared – for example – to 77.6% who reported primary care services were "available" or "very available." The integration of behavioral health specialists into primary care clinics could help address this access issue if it entails a net increase of behavioral health resources.

Further, since a large number of survey respondents noted that they have a primary care doctor/usual source of care, co-location could have a high-impact on the population. It may also address low behavioral health services utilization among some beneficiaries because of the inconvenience of seeking care at multiple locations and the stigma associated with seeking treatment at a behavioral health location.

Approximately 22% of the total Medicaid population in BLHC PPS has a mental health condition, with approximately 8% suffering from serious psychological distress. Developing programs to help control Medicaid costs for this population is critical. This population accounts for 7% (45,850) of condition-related inpatient admissions for the BLHC PPS. The prevalence of substance abuse amongst Medicaid beneficiaries in the BLHC PPS is 8.5%. The CNA found that approximately half of survey respondents identified substance abuse services as being “not very available” or “not available at all..”

Access to mental health providers and services was cited as a major problem in the qualitative and quantitative CNA. The qualitative CNA concluded that: “All of the patients who commented said that the list [of projects] was reasonable but were most enthusiastic about programs to address HIV/AIDS and mental health.” The BLHC PPS physician and provider survey results further support this finding. The majority of the physicians who participated in the survey identified access to mental health services as being the most critical to the community. In addition to the need for substance abuse treatment identified in the CNA, members of this community have high rates of traumatic life events and PTSD, which are known to be associated with medical and psychological morbidity.

Developing and expanding programs that tie primary care services with mental health and substance abuse services will increase access to the full spectrum of health care services offered by the BLHC PPS. Additionally, developing a multidisciplinary, team-based approach is essential for successful integration of primary care and behavioral health. It expands the depth of understanding that patients are individuals with unique biological, psychological, social, cultural and economic experiences. With this knowledge, providers are equipped to consider the whole person and provide individualized, person-centered care.

6. ***Evidence based strategies for disease management in Diabetes:*** Diabetes is a major cause of morbidity and mortality in the Bronx. Community members identify diabetes as one of their greatest health concerns. The diabetes composite PQI (SOI) for the Bronx (1.24) is higher than for New York City and New York State. Rates of avoidable hospitalizations in the Bronx for short term diabetes complications are greater than those for New York City and New York State. Potentially preventable Medicaid hospitalizations for uncontrolled diabetes appears highest in East Tremont. This project proposes to address the needs of diabetics in East Tremont and surrounding areas in the south Bronx by establishing a Center of Excellence in diabetes.

Approximately 10% of the total Medicaid population in the BLHC PPS has diabetes, with 3% of this population experiencing condition-related utilization and hospital admissions. Approximately 69% of the Diabetes Composite PQI S01 hospitalizations are attributed to the BLHC PPS. In 2012, there were 792 potentially avoidable hospitalizations for short term diabetes complications (PQI 01) among Bronx Medicaid beneficiaries, of which the BLHC PPS accounts for 550 (69%). There were 1,585 potentially avoidable hospitalizations for long term diabetes complications (PQI 03) among Bronx Medicaid beneficiaries, of which the BLHC PPS accounts for 1,091 (68%). Additionally, there were 327 cases of uncontrolled diabetes (PQI 14) in Bronx, of which 255 (77%) were attributed to the BLHC PPS. Lastly, of the 136 lower-extremity amputation among patients with diabetes (PQI 16), 71 (52%) were patients in the BLHC PPS. The NYAM portion of the CNA concluded that, “Many community members see diabetes as their greatest health concern.”

7. ***Expansion of Asthma Home-Based Self-Management Program:*** Approximately 9% of the total Medicaid population in the BLHC PPS has a condition-related utilization for asthma. Of the total 733 Asthma in Young Adults Prevention Quality Indicators (PQI) hospitalizations, 566 were attributed to BLHC PPS (77%). Approximately 52.6% of asthma preventable PDI hospitalizations in 2012 were among very young children ages 2-5 according to the CNA. The CNA highlights the impact that indoor and outdoor housing conditions and environmental factors have on triggering respiratory conditions such as asthma. The NYAM portion of the CNA concluded that “.....a strong foundation is needed to implement the DSRIP clinical improvement projects around medication

adherence and home-based self-management, which includes a focus on reducing home environmental triggers.” The CNA findings strongly supports the focus of this asthma home-based self-management program for both children and adults.

8. ***8. Increase Support Programs for Maternal & Child Health.*** The BLHC PPS has a higher percentage of births between ages of 15-19 and 15-50 in comparison to the Bronx overall. Additionally 82% of the births are Medicaid or self-pay compared to 75% for the Bronx overall. Approximately 10.5% of the BLHC PPS births get late or no prenatal care and about 9.7% of births are low-birth weight. Racial disparities in the Bronx reflect that there are 1.4 times the number of preterm births for blacks and 1.2 times for Hispanics as compared to non-Hispanic whites. Pregnancies in the Bronx, and the South Bronx in particular, are often complicated by one or more of social, economic, and environmental factors as well. The goal of this project is to develop new resources to improve maternal and child health outcomes; reduce preterm births, the number of low birth weight babies born, and the rate of infant and maternal mortality; increase well-baby visits; increase the rate of moms receiving prenatal care; and reduce the rates of hospitalizations and emergency room utilization by developing an interdisciplinary team of physicians, psychiatrists, psychologists, nurses, health educators, community health workers and social workers, and partnering with community-based organizations.
9. ***9. Increased Early Access to HIV Care.*** This project is being pursued by multiple PPSs – it is a city wide DRSIP project – as early access to HIV care has been identified as a priority area by multiple CNAs. The fourth leading cause of premature deaths in Bronx County is AIDS. Three of the four hardest hit neighborhoods in the Bronx are in the BLHC PPS: High Bridge-Morrisania (2,353/100,000), Hunts Point-Mott Haven (2,290/100,000), and Crotona- Tremont (2,207/100,000). Neighborhoods with the highest incidence of HIV also have higher rates of concurrent HIV/AIDS diagnoses, and are the same neighborhoods with the highest prevalence: Morrisania/High Bridge, and Mott Haven/ Hunts Point. The qualitative report in the CNA concluded that: “All of the patients who commented said that the list [of DSRIP projects] was reasonable but were most enthusiastic about programs to address HIV/AIDS and mental health.” Among Medicaid Managed Care Beneficiaries in the Bronx who are HIV positive, or who have been diagnosed with AIDS, 91% are engaged

in care, 69% received appropriate viral load monitoring, and 70% of those 19 or older received syphilis screening. Approximately 2% of the total Medicaid population in BLHC PPS is HIV positive.

While treatment for HIV/AIDS is fairly accessible in the Bronx, halting the spread of HIV in order to curb the number of new cases is critical. This project will focus on education and prevention by creating a peer driven health navigation services model to support early access to, and retention in, HIV care.

10. **Strengthen Mental Health & Substance Abuse Infrastructure Across Systems:** The CNA documents that on average, more than 38% of households in the BLHC PPS live below the federal poverty level. In some neighborhoods of the BLHC PPS, it is as high as 47% of households live below the federal poverty level. The unemployment rate in the BLHC PPS is 15.8% compared to 14.2% for Bronx overall. The median household income in the Bronx is \$34,300 compared to \$51,865 in NYC. The BLHC PPS's residents are poorer in comparison to the rest of the Bronx (28.8%) and have a higher rate of unemployment. The literature supports the fact that poverty impacts mental illness both directly and indirectly. As such this project component will focus on integrating poverty services into primary care and behavioral health. Specifically, the project will focus on building infrastructure and collaboration between the many community based agencies whose interventions directly reduce poverty.

The CNA also documents domestic violence as a significant community concern that has received inadequate attention. 31% of respondents indicated that health education programs on domestic violence are needed in their communities, and a key informant indicated that 100% of children in an early childhood program had witnessed domestic violence. Further, a key informant stated “when you come from communities who have been just so devastated by war and trauma, that what was happening to the fathers and their uncles is that a lot of times they didn’t get treatment. They were totally traumatized, and they were taking it out on the mothers...” In response to the pervasive problem of domestic violence in the Bronx community, this project proposes to develop and expand home-visiting programs – to prevent disorders among youth and strengthen families. We

will also develop trauma informed care capacity throughout the PPS to reduce the impact of traumatic experiences. Strengthening trauma-informed prevention, early intervention and collaborative treatment strategies offers opportunities to reduce the impact of traumatic experiences

Injuries caused by trauma are numerous and complex. Trauma is a risk factor for mental, emotional and behavioral disorders and has far-reaching consequences throughout the lifespan. The Adverse Childhood Experiences (ACE) study examined the long-term effects of adverse childhood experiences. More than 17,000 adults participated in the retrospective study and provided information about childhood and family circumstances, social and health status and behavioral characteristics. Study findings provide conclusive evidence that childhood adverse experiences impair physical health, mental health, and overall well-being. More specifically, adverse childhood experiences have a marked impact on adolescent health, teen pregnancy, smoking, alcohol and drug abuse, sexual behavior, mental health and work performance. Study investigators found a striking relationship between the number of adverse childhood experiences associated with adult morbidity and mortality, such as smoking, obesity, physical inactivity, depression, suicide attempts, alcoholism and drug abuse. The grave and enduring consequences of childhood trauma demonstrate the importance of early intervention and continuous care.

SUMMARY

The BLHC PPS is committed to improving the health care of its residents through the development of programs that address the top health care challenges facing the community. The ten projects outlined above are supported by the Community Needs Assessment findings and process, and represent the best thinking of the more than 100 providers and community partners who are committed to this process and have been engaged in project development. Together, we can ensure that the almost 600,000 residents living in the BLHC PPS who are Medicaid beneficiaries get access to the most appropriate care at the appropriate time, while making use of our community's limited resources in the best manner possible.

**New York City Health Provider Partnership
Bronx Community Needs Assessment
Final Report October 3, 2014**



NYAM

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OVERVIEW

The goal of the Delivery System Reform Incentive Payment (DSRIP) program is to promote community-level collaborations and focus on system reform in order to reduce avoidable inpatient admissions and emergency room visits by 25% over 5 years for the Medicaid and uninsured populations in New York State. To inform the health system transformation that is required under the DSRIP program, several emerging Performing Provider Systems (PPSs) contracted The New York Academy of Medicine (NYAM) to complete a Bronx-wide Community Needs Assessment (CNA). The CNA was governed and monitored by a Steering Committee consisting of representatives from each of the following emerging PPSs: **A W Medical; The New York City Health and Hospitals Corporation (HHC) including representatives from their central office, Jacobi Medical Center (HHC), and Lincoln Medical Center (HHC); and St. Barnabas Hospital (dba SBH Health System).**

The specific aims of the CNA process are to:

- Describe health care and community resources,
- Describe communities served by the PPSs,
- Identify the main health and health service challenges facing the community, and
- Summarize the assets, resources, and needs for the DSRIP projects.

Methods

NYAM utilized both primary and secondary data collection and analyses to inform this CNA. To ensure the perspective of community members and stakeholders was incorporated into the reported findings and to respond to specific questions that could not be sufficiently addressed through secondary source data alone, NYAM collected and analyzed primary data, including 24 key informant interviews (involving 30 individuals), 21 focus groups with community members and other stakeholders, and approximately 600 community surveys.

NYAM developed the primary data protocol in collaboration with the PPSs using standard research methods consistent with DSRIP CNA guidance. Key Informant interview, focus group, and survey questions focused on community conditions conducive to health promotion, primary health concerns, available programming and services, disparities in access and use, and recommendations regarding strategies to promote improved health. NYAM collected this data, after IRB approval, in partnership with numerous community organizations, which were identified in collaboration with PPS representatives and represented a range of populations, e.g., older adults, immigrant populations, and people with disabilities, and neighborhoods. NYAM also used street outreach for survey administration, focusing on neighborhoods identified as having large numbers of Medicaid and/or uninsured populations. The data collection materials were translated into ten languages. Socio-demographic characteristics of survey respondents included: 48% Black/African American, 38% Latino, 10% Asian,

43% foreign born, 12% limited English proficient, 78% living below the poverty line, 52% on Medicaid and 12% uninsured. The mean age of respondents was 46, with a range of 18 to 95.

The NYAM team analyzed the data using standard qualitative and quantitative methods; we have reported common themes, as appropriate, throughout the report. NYAM also conducted a review of secondary source data, including an analysis of more than 70 data sets, and a review of the literature, including existing hospital community health needs assessments and community reports. (See Section F. of this report and the attached Bibliography for a detailed list.)

Summary of Findings

The population in the Bronx is burdened by a myriad of health challenges and socioeconomic circumstances that foster poor health outcomes. It is the least healthy county in New York State, and has high rates of chronic disease such as diabetes, cardiovascular disease, and respiratory disease including asthma/COPD, cancer and high rates of obesity.¹ The Bronx leads New York State in the percentage of premature deaths in people aged less than 65 years;² the leading causes of these deaths in the county are cancer, heart disease, unintentional injury, AIDS and diabetes.³ The Bronx also outpaces NYC overall in household poverty and low educational attainment, and is approximately on par with city rates of unemployment and health insurance.⁴ More than half of the Bronx population speaks a language other than English in the home, and many are immigrants, presenting possible additional cultural and regulatory challenges to health care access.⁵ Among the Medicaid population, the Bronx ranks highest among all boroughs in NYC in the rate of potentially preventable inpatient hospitalizations, including for chronic conditions overall, and for certain chronic conditions such as circulatory conditions, respiratory conditions and diabetes.⁶ It also ranks second among the NYC boroughs in the rate of preventable emergency room visits (PPV).⁷

From the perspective of the community, the main health issues include diabetes, obesity, cancer, cardiovascular disease, asthma, violence and behavioral health issues, including anxiety, depression and substance use.⁸ Community members clearly connect these common health conditions to conditions of

¹ RWJ County Health Rankings 2014, available at http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2014_NY_v2.pdf, accessed September 8, 2014.

² The Bronx figure is 33.9% compared to the NYS figure of 23.9%. Source: “Percentage of premature deaths (before age 65 years), 2012” New York State Prevention Agenda Dashboard, using Vital Statistics Data.

³ NYC DOHMH Epiquery System, Vital Statistics data, accessed August 2014.

⁴ US Census American Community Survey 5-year, 2008-2012.

⁵ According to US Census data, approximately one in five Bronx residents are not US Citizens (US Census American Community Survey, 5 year table, 2008-2012). It is possible that this number may be underreported due to undocumented individuals

⁶ 2011-2012 Medicaid Prevention Quality Indicators, New York State Department of Health, Office of Quality and Patient Safety, 2014, as reported by the Office of Health Systems Management.

⁷ Ibid.

⁸ NYAM primary data findings, September 2014.

poverty, including—but not limited to—insecurity with respect to housing and other basic needs, unsafe environments, and poor access to healthy foods. The community members associate health problems with depression, and likewise depression with poverty. People reported concerns about jobs, housing, access to government benefits programs, and the safety of their streets. A dramatic indicator of poverty, with obvious health implications, is food insecurity (hunger), which was described as a challenge by multiple respondents.

The costs incurred—in both time and money—for medical care remain problematic and act as a barrier to effective use of prevention and disease management services from the perspective of community members. The income criteria for Medicaid are described as unrealistic, given the cost of living in New York City, and the working poor who do not qualify for Medicaid have trouble affording even the subsidized premiums of insurance (or are not eligible for subsidies) offered through the Health Exchange. Community members (and providers) consistently describe long wait times for visits and at the time of a visit. Furthermore, the possible need for multiple visits (e.g., for tests or specialist services), discourages timely use of services and for many makes the emergency department a rational choice for “one stop shopping”.

Furthermore, the policy environment reportedly presents a number of challenges to residents and providers. For example, funding and regulatory agencies have differing requirements that 1) limit continuity of care for patients with multiple healthcare needs and 2) put high demands on provider organizations that work with multiple systems. Funding for high-demand services, such as care coordination, is limited and consequently salaries for the positions are relatively low. Low salaries make hiring difficult and may necessitate selection of candidates that are under-qualified, particularly considering the expectations of the job. Lack of trust or engagement (or possibly time) in care coordination on the part of medical providers is also considered to limit the potential effectiveness of care coordination models. Finally, a consistent electronic health record was described as a challenge for agencies offering care coordination services, as they had to utilize multiple systems.

Key informants participating in the CNA, representing a cross-section of professions and fields, described distinct populations with particular health care – and health – challenges. For example, individuals with severe alcohol or substance abuse disorders, who often have high rates of mental and physical illness and homelessness, are frequent users of emergency department services. However, emergency departments mostly lack the resources to address the psychosocial needs that might increase stability within this population, and decrease their use of health care services. Undocumented residents are described as hesitant to use health care services due to cost considerations and fear of deportation. When they do access medical services, it is late and sporadic.

Impact on Project Selection

Domain 2 Projects

The high number of potentially preventable inpatient admissions, emergency visits, and potentially preventable readmissions in this area suggests that systems transformation is needed. Thus, for the county as a whole, the needs assessment suggests that any of the DSRIP domain 2 projects could be appropriate. For an individual Performing Provider System, a specific project may be more appropriate dependent on ongoing initiatives, current infrastructure, payor mix, partners, and service area.

In addition to the DSRIP Domain 2 projects focused on creating integrated delivery systems (Domain 2A), implementation of care coordination and transitional care programs (Domain 2B), and connecting settings (Domain 2C), the New York State Department of Health has announced it is adding a new project (Domain 2D) focused specifically on the uninsured.⁹ In the Bronx, approximately 217,000 people are uninsured, accounting for approximately 10% of all the uninsured individuals in New York State.¹⁰ Adults between the age of 18 and 65 account for the largest proportion of uninsured in the Bronx, with a rate of 20% versus approximately 2% among those aged 65 and older, and approximately 5% among children aged 0-17. (See Appendix B, Table 22.) Within the borough, the highest number of uninsured are clustered in parts of Fordham-Bronx Park south through to Hunts Point-Mott Haven. (See Appendix A, Map 3.)

A significant portion of the uninsured the Bronx may be undocumented.¹¹ The 2008-2012 5-year American Community Survey estimated that 131,665 (or 60.7%) of the total number of 217,009 uninsured Bronx residents were foreign born.¹² Of these 131,665 foreign-born uninsured residents, the largest number were born in Latin American countries (86,572, 65.8%), followed by those born in non-Hispanic Caribbean countries (16,070, 12.2%), African countries (13,699, 10.4%), Balkan and Eastern European countries (3,349, 2.5%), and South Asian countries (2,766, 2.1%).¹³ Within the borough, uninsured foreign born Latinos live primarily in the south Bronx and west of the Grand Concourse, with approximately 11,000-13,000 people living in each of the following Community Districts (CD): CD 1&2, Hunts Point, Longwood, and Melrose; CD 9, Castle Hill, Clason Point, and Parkchester; CD 4, Concourse, Highbridge, and Mount Eden; CD 5, Morris Heights, Fordham South, and Mount Hope; and CD 7, Bedford Park, Fordham North, and Norwood. Those who are uninsured and were born in non-Hispanic Caribbean countries reside primarily in CD 12, Wakefield, Williamsbridge, and Woodlawn. African-born uninsured residents reside primarily on either side of the Grand Concourse, in CDs 3 and 6, Belmont, Crotona Park East, and East Tremont; CD 4, Concourse, Highbridge, and Mount Eden; and CD 5, Morris Heights, Fordham South, and Norwood. Uninsured residents born in Balkan and eastern European

⁹ This project will also focus on low- and non-utilizing Medicaid beneficiaries.

¹⁰ US Census, American Community Survey, 5 year data, 2008-2012.

¹¹ NYAM Primary Data Collection, preliminary findings, August, 2014

¹² US Census, American Community Survey, 5 year data, 2008-2012.

¹³ Ibid.

countries live primarily in CD 11, Pelham Parkway, Morris Park, and Laconia; and uninsured residents born in South Asian countries live primarily in CD 9, Castle Hill, Clason Point, and Parkchester.¹⁴

Despite health reform, data suggest that insurance coverage remains problematic (or is increasingly problematic) even for those eligible.¹⁵ Community members and key informants describe income restrictions for Medicaid as unrealistically low, and self-purchased coverage, even when subsidized, as too expensive for low-income populations (or some are not eligible for subsidies), given the difficulties of paying for basic necessities like food and housing. Lack of health insurance is reported to result in reduced use of preventive and community based care and increased emergency department use.¹⁶

Domain 3 Projects

As noted above, Bronx ranks highest among all New York City boroughs in the rate of potentially avoidable inpatient hospitalizations, and ranks second among the NYC boroughs in the rate of preventable emergency room visits (PPV).¹⁷ The greatest proportion of potentially preventable admissions (PQI) in the Bronx are for chronic conditions including respiratory conditions such as asthma/COPD, cardiovascular conditions such as heart failure and hypertension, and diabetes.¹⁸ Thus, these also represent the areas of opportunity for reducing preventable inpatient stays. The Medicaid beneficiaries who account for the largest proportion of these preventable admissions are concentrated in the areas of the Bronx in a wide corridor from Fordham-Bronx Park in the north, south alongside the Grand Concourse to the South Bronx.¹⁹ These areas also account for the highest proportion of potentially preventable emergency room visits.²⁰

Behavioral Health

Among the Bronx population as a whole, the age-adjusted percentage of adults with poor mental health for 14 or more days of 9.1%, as well as the age-adjusted suicide rate of 5.4%, are lower than the state rates and roughly on par with citywide rates.²¹ However, in the Bronx, 7.1% of all people report experiencing serious psychological distress, compared to 5.5% in NYC overall.²² The Pelham-Throgs Neck

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ 2011-2012 Medicaid Prevention Quality Indicators, New York State Department of Health, Office of Quality and Patient Safety, 2014, as reported by the Office of Health Systems Management.

¹⁹ NYS DOH 2012.

²⁰ NYS DOH 2012.

²¹ The “poor mental health” measure is from 2008-2009 BRFSS and Expanded BRFSS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. The suicide rate is for the years 2010-2012 from Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

²² Serious psychological distress is a composite measure of 6 questions in the Community Health Survey regarding symptoms of anxiety, depression and other emotional problems. New York City Department of Health and Mental

area and the South Bronx, in particular, appear to be disproportionately impacted by psychological distress with approximately 8%-9% of residents reporting it. (See Appendix B, Table 31.) Those in Hunts Point-Mott Haven, High Bridge-Morrisania and Crotona-Tremont also report high rates of psychological distress, with approximately 5%-8% of those surveyed reporting it. The myriad of stresses on lower income residents were considered overwhelming to some and contributed to high levels of depression.²³ Low-income immigrant populations may have additional stressors of assimilation, as well as poorer access to care, due to insurance and language issues.²⁴

Community members also marked that substance use and alcohol abuse are pressing issues. Indeed, in 2012, the last year for which data is available, an estimated 639.2 per 100,000 emergency room visits in NYC were due to non-alcohol, illicit drugs.²⁵ In the Bronx, the age-adjusted percentage of adult binge drinking among the total population “during the past month” for the borough was nearly one-in-five (18.5%) in 2012, similar to the overall NYC rate (19.6%) for the same time period. (See Appendix B, Table 33.) Also, key informants described behavioral health issues as one factor in delaying or precluding appropriate preventive and primary health care. According to the director of Bronx CBO serving a number of residents with mental health and substance abuse issues, *“Survival is the most important thing, so not health, not seeing a doctor... but that’s just – literally hustling to survive each day is the number one goal.”*

There are no PQI measures of preventable hospitalizations related specifically to behavioral health. However, New York State Office of Mental Health (OMH) data suggest that over half (54.4% or 9,215/16,942) of Bronx clients served by OMH-licensed and OMH-funded programs have one or more physical chronic health conditions, indicating a need for coordinated behavioral and physical health care. (See Appendix B, Table 32.)

The geographic distribution of behavioral health resources (see Appendix A, Map 88) appears to match the widespread distribution of behavioral health-related service utilization in the Bronx;²⁶ however, questions as to the adequacy of these resources in terms of capacity were raised in focus groups and key informant interviews. In addition, there were concerns about concentration of particular services, such as methadone programs in particular neighborhoods, resulting in perceived declines in safety and quality of life for community members. Per DSRIP behavioral health clinical improvement projects, the

Hygiene, Community Health Survey 2012 data, as reported on Epiquery <http://nyc.gov/health/epiquery>, accessed August 2014.

²³ NYAM Primary Data findings, September, 2014.

²⁴ Ibid.

²⁵ Drug Abuse Warning Network, 2011: New York City – 5 Boros: Drug-Related Emergency Department Visits, 2004-2011 - Illicits (excluding alcohol) Rockville, MD: Center for Behavioral Health Statistics and Quality, SAMHSA, 2013

²⁶ These numbers and rates reflect possible duplicated counts of beneficiaries if a beneficiary's calendar year utilization was found by NYS DOH to occur across multiple Episode Disease Categories within a single Major Diagnostic Category. Therefore, the numbers reflect the Weighted Number of Beneficiaries with Condition-Related Utilization, and the rates reflect the Weighted Condition Prevalence Among Beneficiaries, by multiple counting beneficiaries for utilization across multiple co-morbidity Episode Disease Categories within a Major Diagnostic Category.

integration of behavioral health specialists into primary care clinics could help address this issue if it entails a net increase of behavioral health resources, as well as a smoother and quicker referral process between primary care and behavioral health. Further, it may also address low behavioral health services utilization among some beneficiaries resulting from the inconvenience and the stigma associated with seeking treatment at a behavioral health provider location. Conversely, the integration of primary care services into existing behavioral health services settings could help address the high rates of co-morbidity between behavioral health and chronic physical health conditions for those currently utilizing behavioral health services.

According to providers themselves, the system is fragmented, with possibly poorer integration within behavioral health services themselves than between physical and behavioral health. Behavioral health services are reported to be highly regulated by multiple agencies: Office for People with Developmental Disabilities (OPWDD), Office for Alcoholism and Substance Abuse Services (OASAS), and Office of Mental Health (OMH) with patient care being restricted according to the funding and regulatory agency—despite the frequency of co-occurring disorders. Thus, a mental health provider might be limited in the severity of illness that can be treated, the age of the patient, and other factors.²⁷

Cardiovascular Disease

Heart disease is the top cause of mortality among the white, black, and Hispanic populations of the Bronx²⁸ and is recognized by community members as a major health problem. It is also second leading cause of premature death in the borough.²⁹ The age adjusted cardiovascular disease hospitalization rate in the Bronx is 210.8 per 10,000, higher than either NYC (173.6) or NYS (159.9).³⁰ Similarly the age adjusted mortality rate for diseases of the heart was 225.8 in the Bronx, 212.2 in NYC, and 198.6 in NYS.³¹ Within the broad category of heart health, the Bronx fares worse than NYC and NYS on all age-adjusted indicators.³²

In 2012, the number of potentially preventable hospitalizations among Medicaid beneficiaries for circulatory conditions (PQI S02 Circulatory Composite) in the Bronx was 3,173, accounting for about one in five (20.1 %) of all such admissions in the State. (See Appendix B, Table 44.) The ratio of observed/expected (O/E) admissions in the Bronx (1.34) was higher than the ratio for NYC (1.06) for the same time period. (See Appendix B, Table 44.) At the zip code level within the borough, the highest number of preventable hospitalizations and the highest observed / expected PQI ratios for the

²⁷ Ibid.

²⁸ New York City Vital Statistics, “Top Ten Leading Causes of Mortality 2012,” accessed via the EpiQuery interactive tool, August, 2014

²⁹ Premature deaths (< age 75) for the three years 2010-2012. Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics

³⁰ 2009-2011 data reported on the NYS Dept of Health Website County Health Assessment Indicators, https://www.health.ny.gov/statistics/chac/chai/docs/chr_58.htm, accessed September, 2014.

³¹ Ibid.

³² Ibid.

Circulatory Composite measure are found along the Grand Concourse from High Bridge – Morrisania to Fordham – Bronx Park. (See Appendix A, Map 40.)

Approximately 185.02 out of 100,000 Medicaid beneficiaries in the Bronx were hospitalized for conditions related to hypertension, compared to 124.02 in NYC and 105.5 in NYS. In 2012, there were 969 potentially preventable hospitalizations among Medicaid beneficiaries for hypertension (PQI 07) in the borough. (See Appendix B, Table 44.) The variation in hospitalization rates for conditions related to hypertension between neighborhoods in the Bronx is wide. For example, the rate in Kingsbridge-Riverdale is 115.66 per 100,000, compared to a rate of 261.85 in the Northeast Bronx. (See Appendix A, Map 45.)

There were 2,013 potentially preventable hospitalizations among Medicaid beneficiaries for heart failure (PQI 08) in the Bronx. (See Appendix B, Table 44.) The range for observed/expected admissions heart failure was 0.7 to 2.87. The lowest rates in Kingsbridge-Riverdale and highest in Pelham Bay-Throgs neck area. (See Appendix A, Map 46.)

In 2012, adult angina without procedure (PQI 13) accounted for 191 potentially preventable hospitalizations in the Bronx. (See Appendix B, Table 44.) The range for observed/expected admissions for adult angina without procedure is 0.0 to 2.1, with the lowest rates in the Throgs Neck- Pelham Bay and Kingsbridge-Riverdale areas and the highest in Highbridge, Bedford Park, Mott haven, Port Morris, Baychester, Wetchester Heights, and Parkchester. (See Appendix A, Map 50.)

The highest rates of cardiovascular-related service utilization (including pharmacy) among Medicaid beneficiaries were found in Kingsbridge – Riverside and Northeast Bronx; however, the highest numbers were found along either side of the Grand Concourse from High Bridge–Morrisania to Fordham–Bronx Park.³³ (See Appendix A, Map 26.) In regard to disease information and support services, these areas of the Bronx with high rates of condition-related utilization and high numbers of circulatory composite PQI hospitalizations appear to have those services available, with the exception of the Fordham – Bronx Park area. Specialty cardiology services similarly appear to be located in or near the areas of greatest need, with the exception of the Fordham – Bronx Park area (See Appendix A, Map 71.)

Diabetes

The diabetes composite PQI (S01) for the Bronx (1.24) is higher than for New York City (1.01) and New York State (1.00).³⁴ (See Appendix B, Table 44.) Many community members see diabetes as their

³³ These numbers and rates reflect possible duplicated counts of beneficiaries if a beneficiary's calendar year utilization was found by NYS DOH to occur across multiple Episode Disease Categories (e.g., hypertension and congestive heart failure) within a single Major Diagnostic Category (e.g., Diseases and Disorders of the Cardiovascular System). Therefore, the numbers reflect the Weighted Number of Beneficiaries with Condition-Related Utilization, and the rates reflect the Weighted Condition Prevalence Among Beneficiaries, by multiple counting beneficiaries for utilization across multiple co-morbidity Episode Disease Categories within a Major Diagnostic Category.

³⁴ NYS Dept of Health 2012 data, accessed August, 2014.

greatest health concern.³⁵ Within the Bronx, the range for PQI S01 observed/expected ratios is 0.8 to 2.26. (See Appendix A, Map 39.) Across New York State, only 51% of Medicaid Managed Care beneficiaries with diabetes received all recommended tests in the last year, and 33% of Medicaid Managed Care beneficiaries in NYS with diabetes have poorly controlled HbA1c (>9%).³⁶

In 2012, there were 792 potentially avoidable hospitalizations for short term diabetes complications (PQI 01) among Bronx Medicaid beneficiaries, with a borough-wide Observed/Expected (O/E) ratio of 1.13.³⁷ (See Appendix B, Table 44.) Within the borough, twelve zip code areas with an O/E ratio greater than 1.00 account for 493 or 62% of these hospitalizations.³⁸ (See Appendix A, Map 42.) These 493 hospitalizations are found in three clusters: from High Bridge-Morrisania to Crotona-Tremont east of the Grand Concourse; in northeast Bronx from north of Bronx Park to Pelham Bay Park; and in southeast Bronx from Soundview to Throgs Neck (See Appendix A, Map 42.) Potentially avoidable long-term complications from diabetes hospitalization (PQI 03) rates among Medicaid beneficiaries in the Bronx vary by neighborhood. Rates of such hospitalizations are highest in Kingsbridge, Mott Haven, and Pelham Bay Park neighborhoods. (See Appendix A, Map 43.) Potentially preventable Medicaid hospitalizations for uncontrolled diabetes (PQI 14) appears highest in East Tremont. (See Appendix A, Map 51.) Potentially avoidable hospitalizations for lower extremity amputation (PQI 16) for Medicaid Beneficiaries with diabetes appear to be largely concentrated in the north east Bronx. The highest rates are found in Eastchester, Baychester, Co-op City, Pelham Gardens, and Mott Haven. (See Appendix A, Map 53.)

The geographic concentration of Diabetes PQI hospitalizations makes the potential return on investment in practice reforms high in terms of reduced PQI admissions. The Diabetes Resources map (See Appendix A, Map 72) appears to show current geographic alignment of diabetes care management resources and need (shown in terms of Diabetes Composite PQI S01 hospitalizations) in or near the High Bridge-Morrisania, Crotona-Tremont, and Bronx Park areas; but apparently less alignment of resources with need in the northeast and southeast clusters where resources are lacking, although the areas between these two clusters do have specialty diabetes clinical resources.

Asthma

CNA participants reported that asthma was among the most significant health concerns, with causation commonly attributed to indoor (e.g., mold, cockroaches, rodents) and outdoor (e.g., exhaust) environmental conditions.³⁹ While the observed rate of PQI respiratory admissions has declined in the Bronx since 2009, it remains far above the expected rate, with an Observed/Expected ratio of 1.42 for the Respiratory Composite PQI. (See Appendix B, Table 44 and Chart 50.) There were 4,116 Respiratory Composite (PQI S03) PQI hospitalizations in the Bronx in 2012. (See Appendix B, Table 44.) This includes

³⁵ NYAM Primary data findings, September, 2014.

³⁶ QARR, 2011

³⁷ NYS Dept of Health 2012 data, accessed August, 2014.

³⁸ Ibid.

³⁹ NYAM Primary Data Collection, preliminary findings, August 2014.

3,383 COPD or Asthma in Older Adults (PQI 05) PQI hospitalizations and 733 Asthma in Younger Adult (PQI 15) PQI hospitalizations. (See Appendix B, Table 44.) The areas of the Bronx with the highest PQI respiratory composite hospitalizations are located in a corridor that runs from parts of Fordham-Bronx Park south along both sides of the Grand Concourse to Hunts Point – Mott Haven. (See Appendix A, Map 41.)

When looking at the location of asthma health care resources in relation to Respiratory Composite PQI hospitalizations (See Appendix A Map 73), there appears to be fairly good alignment of health care resources to need; however, the relationship of these resources to the prevention of PQI hospitalizations is uncertain, especially when considering additional socio-demographic variables that may be influencing the PQI hospitalization outcomes, such as language barriers, constraints on time, and lack of insurance. Whatever the current efficacy of these resources in preventing asthma-related hospitalizations, a strong foundation is needed to implement the DSRIP clinical improvement projects around medication adherence and home-based self-management, which includes a focus on reducing home environmental triggers. Regarding home environmental triggers, limited data is available. However, data on the rate of serious housing violations by Community District, i.e., housing code violations that are considered “immediately hazardous or serious,” show prevalence in many of the same neighborhoods with high numbers of preventable respiratory PQI hospitalizations (See Appendix A, Map 15.)

The highest total Medicaid PQI hospitalizations for asthma among young adults occurs along the same corridor as does the PQI respiratory composite. (See Appendix A, Map 52.) Among children in the Bronx who are Medicaid beneficiaries, the asthma rate of 701.47 per 100,000 is startlingly higher than the NYC overall rate of 426.91 per 100,000 and the NYS overall rate of 210.39 per 100,000.⁴⁰ Childhood asthma rates in the borough range from 418.8 per 100,000 in Kingsbridge-Riverdale to 987.9 per 100,000 in Hunts Point. Additionally, DOH data suggests that the majority, 981 or 52.6%, of the 1,865 pediatric asthma preventable PDI hospitalizations in 2012 were among very young children, aged 2-5.⁴¹ Among older adults in the Bronx, the COPD/Asthma PQI O/E ratio is 1.38, significantly higher than the city ratio of 1.01. (See Appendix B, Table 44.) Consistent with other asthma indicators, the highest number of Medicaid PQI hospitalizations for COPD and asthma in older adults are clustered in the corridor from Fordham-Bronx Park south to the South Bronx. (See Appendix A, Map 44.)

⁴⁰ Medicaid Prevention Quality Indicators, 2012.

⁴¹ The asthma PDI is reported for children aged 2-17, but the PDI chronic composite (which includes asthma and diabetes) is reported only for those aged 6-17. Thus the difference (decrease) in numbers between those two measures is a result of the loss of the asthma admissions for children aged 2-5 in the chronic composite. Thus, it is the young children aged 2-5 that represent the bulk of the asthma PDI numbers. As explained in an email transmission from the NYS DOH dated August 25, 2014: “Each PDI has a different age criteria, asthma is 2-17 years, diabetes is 6-17 years, gastroenteritis and uti are both 3 months to 17 years. These 4 PDI make up the overall composite PDI, however, that age criteria is 6-17 years. This results in the loss of patients age 3 months up to 6 years, hence the decrease in numbers. The same situation occurs in the acute and chronic composites. The composite age group is 6-17, however, that doesn’t reflect the actual age groups in the individual measures.”

HIV

The fourth leading cause of premature deaths in the Bronx is AIDS, accounting for approximately 30% of all such deaths in NYC.⁴² The HIV/AIDS prevalence rate for the Bronx (approximately 1,660 per 100,000 population) is higher than the NYC rate (1,370 per 100,000), and variation exists within the borough.⁴³ Four UHF neighborhoods in the borough have a higher HIV/AIDS prevalence rate than the city as a whole: High Bridge-Morrisania (2,353/100,000), Hunts Point-Mott Haven (2,290/100,000), Crotona-Tremont (2,207/100,000), and Fordham-Bronx Park (1,696/100,000).⁴⁴ In terms of numbers of People Living with HIV/AIDS (PLWHA), these neighborhoods account for a total of 16,996 PLWHA or 73.7% of all PLWHA in the Bronx.⁴⁵ (See Appendix B, Table 35.) The age adjusted mortality rate for AIDS in the Bronx (20 per 100,000) is more than twice the rate of NYC (9.4 per 100,000) and four times the rate for NYS (4.7 per 100,000).⁴⁶ Neighborhoods with the highest incidence of HIV also have higher rates of concurrent HIV/AIDS diagnoses, and are the same neighborhoods with the highest prevalence: Morrisania/High Bridge, and Mott Haven/ Hunts Point.⁴⁷ (See Appendix B, Chart 38.)

Bronx residents who are HIV positive, or have been diagnosed with AIDS, have rates of viral load suppression (60.19%) slightly lower than New York City (61.2%) and New York State (62.2%).⁴⁸ Among Medicaid Managed Care Beneficiaries in the Bronx who are HIV positive, or who have been diagnosed with AIDS, 91% are engaged in care, 69% received appropriate viral load monitoring, and 70% of those 19 or older received syphilis screening.⁴⁹ Viral load suppression is a key factor in reducing transmission of HIV and maintaining good health.

Within the borough, there are wide racial disparities in HIV incidence. In 2011, the latest year for which data is available, the rate of new HIV diagnoses among African Americans living in the Bronx was nearly 4 times higher than the new HIV diagnosis rate among Whites living in the Bronx (76.7 compared to 19.1 cases per 100,000 people). The rate of new HIV diagnoses among Latinos living in the Bronx was more than 2 times higher than the new HIV diagnosis rate among Whites living in the Bronx (41.8 compared to 19.1 cases per 100,000 people). (See Appendix B, Chart 37).

⁴² “County Number of 3-Years Premature [< age 75] Deaths” Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics.

⁴³ NYC DOHMH 2011

⁴⁴ Ibid.

⁴⁵ 2011 data, the latest year for which information is available, from the New York City Department of Health and Mental Hygiene.

⁴⁶ NYS Dept of Health County Health Assessment Indicators, 2009-2011,

https://www.health.ny.gov/statistics/chac/chai/docs/sti_58.htm, accessed September, 2014.

⁴⁷ Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

⁴⁸ HIV Ambulatory Care Performance, 2011

⁴⁹ QARR, 2012

According to key informants in the field, transmission among injecting drug users (IDUs) in the Bronx has dropped dramatically, likely due to access to clean syringes from syringe exchange programs—although hepatitis C remains a concern, since it is more easily transmitted.

The HIV/AIDS Resources map (See Appendix A, Map 75.) suggests a geographic alignment between Medicaid Beneficiaries with an HIV/AIDS service utilization and the location of HIV/AIDS resources, which is also consistent with the prevalence PLWHA by UHF neighborhood. The existing health care and ancillary services structure appears to provide a strong foundation for implementing the related DSRIP projects. However, key informants providing services to HIV-infected individuals describe significant changes in funding priorities, with increasing resources going toward medical management, and less funding available for supportive services, including housing for people with HIV. Given the aging of the HIV-infected population, and the potential medical complications of HIV medication, a large number of people with HIV/AIDS also have more common chronic conditions, including diabetes and heart disease. Integration of medical services is therefore essential.

Perinatal Care

Over the period 2010-2012, there were 21,867 live births per year on average in the Bronx, representing nearly one in five (18.5%) births in New York City and nearly one in ten (9.1%) in the State over the same time period.⁵⁰ The percentage of all births in the Bronx that were Medicaid or self-pay was 75.4%, compared to 59.7% in NYC and 50.1% in the State; the percentage of Medicaid or self-pay births across Bronx zip codes ranged from 23.6% to 87.5%. (See Appendix A, Map 8.) Fertility rates are also higher in the Bronx (59 births in the past year per 1,000 women age 15-50) than in NYC (52 per 1,000) and NYS (50 per 1,000).⁵¹ For young women, the difference is even greater, with a rate of 34 births in the past year per 1,000 women age 15-19, compared to 21 per 1,000 in NYC and 17 per 1,000 in NYS.⁵² The highest fertility rates are found along the western side of the Grand Concourse from High Bridge to Fordham – Bronx Park, and in the south in Mott Haven, Hunts Point, and Soundview. (See Appendix A, Maps 6-8.) The teen pregnancy rate is also higher in the Bronx than NYC and NYS, at 60.8 per 1,000 compared to 44.2 per 1,000 in NYC and 35.7 per 1,000 in NYS.⁵³ (See Appendix A, Map 7.)

In 2012, the latest year for which data is available, the percentage of preterm births in the Bronx (12.2%) was higher than in NYC (10.8%) or NYS (10.8%).⁵⁴ Preterm birth is associated with low birth weight and poor health outcomes. The overall low birth weight (LBW) rate for the Bronx over the time period 2010-2012 was 9.5%, compared to 8.5% for NYC and 8.1% for the state.⁵⁵ Within the Bronx, the LBW rates ranged from 1.9% to 12.8%, with the highest rates found in two clusters of zip codes – one in the south central part of the borough from Mott Haven, Morrisania, to Claremont Village; and the other in the

⁵⁰ NYS Vital Statistics, 2010-2012, <http://www.health.ny.gov/statistics/chac/perinatal/>, accessed September 2014.

⁵¹ Ibid.

⁵² Ibid.

⁵³ NYS Vital Statistics, 2012

⁵⁴ NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

⁵⁵ Ibid.

northeast part of the borough in Wakefield, Eastchester, and Co-Op City. These neighborhoods also experience the highest rates of infant mortality. (See Appendix A. Map 6.)

Racial disparities also persist in the borough in the number of preterm births, with 1.4 times the number of preterm births among the black population than among the non-Hispanic white population for the time period 2010-2012 and 1.2 times the number of Hispanic preterm births than non-Hispanic white preterm births in the same time period.⁵⁶ (See Appendix B, Table 68). Though, these racial and ethnic disparities were narrower in the Bronx than in NYC and NYS in the same time period.⁵⁷

In the Bronx, the percentage of mothers receiving prenatal care starting in the first trimester was lower than the NYS and NYC rates (71.8% and 70.4%, respectively) by over 10%, and more than one-third (37.0%) of mothers in the Bronx received prenatal care beginning in the third trimester (months 7-9), compared to 23.9% for NYS and 28.7% in NYC.⁵⁸ (See Appendix B, Table 61). Additionally, the Bronx neonatal death rate was slightly higher than NYC and NYS at 3.5 per 1,000, compared to 2.9 per 1,000 in NYC and 3.3 per 1,000 in NYS.⁵⁹

Domain 4 Projects

Domain 4 projects are intended promote population health and reduce health risks. Specifically, these projects are to: (1) promote mental health and prevent substance abuse, (2) prevent chronic disease, including promoting tobacco use cessation and improving preventive care and disease management for chronic diseases not covered in Domain 3b, (3) prevent HIV and STDs, and (4) promote healthy women, infants and children. As noted above, the Bronx-wide population is burdened by chronic disease, including cancer. They also have high rates of teenage pregnancy, and high incidence and prevalence of HIV and other STDs. As many as one in five adults in some neighborhoods of the Bronx report being a current smoker.

(1) Promote Mental Health and Prevent Substance Abuse

As noted in the section on Domain 3 projects above, among the Bronx population as a whole, the age-adjusted percentage of adults with poor mental health for 14 or more days of 9.1%, as well as the age-adjusted suicide rate of 5.4%, are lower than the state rates and roughly on par with citywide rates.⁶⁰ However, in the Bronx, 7.1% of all people report experiencing serious psychological distress, compared

⁵⁶ Ibid.

⁵⁷ The ratio of black to white preterm births in NYC was 1.8 and in NYS was 1.62 for the period 2010-2012. The ratio of Hispanic to white preterm births in NYC was 1.39 and in NYS was 1.25 for this time period. Source: NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard, accessed August 2014.

⁵⁸ NY State Vital Statistics, 2012

⁵⁹ Ibid.

⁶⁰ The “poor mental health” measure is from 2008-2009 BRFSS and Expanded BRFSS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. The suicide rate is for the years 2010-2012 from Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

to 5.5% in NYC overall.⁶¹ The Pelham-Throgs Neck area, in particular, appears to be disproportionately impacted by psychological distress with approximately 8% of residents reporting it. (See Appendix B, Table 31.) Those in Hunts Point-Mott Haven, High Bridge-Morrisania and Crotona-Tremont also report high rates of psychological distress, with approximately 5%-8% of those surveyed reporting it. The myriad of stresses on lower income residents were considered overwhelming to some and contributed to high levels of depression.⁶² Low-income immigrant populations may have additional stressors of assimilation, as well as poorer access to care, due to insurance and language issues.⁶³

Community members also marked that substance use and alcohol abuse are pressing issues. Indeed, in 2012, the last year for which data is available, an estimated 639.2 per 100,000 emergency room visits in NYC were due to non-alcohol, illicit drugs.⁶⁴ In the Bronx, the age-adjusted percentage of adult binge drinking among the total population “during the past month” for the borough was nearly one-in-five (18%) in 2012, similar to the overall NYC rate (19.6%) for the same time period. (See Appendix B, Table 33.) Also, key informants described behavioral health issues as one factor in delaying or precluding appropriate preventive and primary health care. According to the director of Bronx CBO serving a number of residents with mental health and substance abuse issues, *“Survival is the most important thing, so not health, not seeing a doctor... but that’s just – literally hustling to survive each day is the number one goal.”*

Access to mental health services is reported to be limited, some mental health providers report that community organizations and residents are not aware of available services or how to access them.⁶⁵ In addition, behavioral health issues generally carry greater stigma than other health concerns, which tends to limit use of services. There were also concerns about concentration of particular services, such as methadone programs in particular neighborhoods, resulting in perceived declines in safety and quality of life for community members. Key informants and focus group participants both reported that many affected individuals and families try to address problems internally.

According to providers themselves, the system is fragmented, with possibly poorer integration within behavioral health services themselves than between physical and behavioral health. Behavioral health services are reported to be highly regulated by multiple agencies: Office for People with Developmental Disabilities (OPWDD), Office for Alcoholism and Substance Abuse Services (OASAS), and Office of Mental Health (OMH) with patient care being restricted according to the funding and regulatory agency—

⁶¹ Serious psychological distress is a composite measure of 6 questions in the Community Health Survey regarding symptoms of anxiety, depression and other emotional problems. New York City Department of Health and Mental Hygiene, Community Health Survey 2012 data, as reported on Epiquery <http://nyc.gov/health/epiquery>, accessed August 2014.

⁶² NYAM Primary Data findings, September, 2014.

⁶³ Ibid.

⁶⁴ Drug Abuse Warning Network, 2011: New York City – 5 Boros: Drug-Related Emergency Department Visits, 2004-2011 - Illicits (excluding alcohol) Rockville, MD: Center for Behavioral Health Statistics and Quality, SAMHSA, 2013

⁶⁵ NYAM primary data findings, September, 2014.

despite the frequency of co-occurring disorders. Thus, a mental health provider might be limited in the severity of illness that can be treated, the age of the patient, and other factors.⁶⁶

(2) Prevent Chronic Disease

a. Promoting tobacco use cessation

The domain 4 project on this topic is intended to “promote tobacco use cessation, especially among low SES populations and those with poor mental health.”⁶⁷ The percentage of cigarette smoking among adults in the Bronx is roughly on par with NYC and NYS rates (15.8% in the Bronx versus 15.5% in NYC and 16.2% in NYS in 2012), but rates vary by neighborhood. Approximately one in five of adults in Pelham-Throgs Neck (21.2%) and the South Bronx (18.2%) report being a current smoker compared to less than one in ten in Kingsbridge-Riverdale (7.3%) and Fordham-Bronx Park (7.5%).⁶⁸ (See Appendix B, Table 34.)

b. Preventive care and disease management for chronic diseases not covered in Domain 3b

The leading cause of premature death in the borough is cancer.⁶⁹ (See Appendix B, Table 27.) Rates for some preventive screening measures in the Bronx are on par with NYC and NYS, e.g., approximately half (53%) of adults Medicaid beneficiaries aged 50-75 years received appropriate colorectal cancer screening in the borough, compared to 52% in NYC and 49% in NYS in 2012, the latest year for which data is available.⁷⁰ (See Appendix B, Table 66.) However, the borough lags in other related risk factors, such as obesity.

The prevalence of obesity in the Bronx is higher than in NYC or NYS, with nearly one in three (32%) of all adults in the Bronx obese, versus 24.2% in NYC and 23.6% in the state.⁷¹ (See Appendix B, Table 31.)

⁶⁶ Ibid.

⁶⁷ New York’s MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan, Attachment J.”NY DSRIP Strategies Menu and Metrics,” 2014.

⁶⁸ These neighborhood estimates should be interpreted with caution. The estimate's Relative Standard Error (a measure of estimate precision) is greater than 30% or the sample size is less than 50, or the 95% Confidence Interval half width is greater than ten, making the estimate potentially unreliable. Source: NYC DOHMH Community Health Survey, 2012

⁶⁹ Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics.

⁷⁰ State data obtained from the 2012 BRFSS and reports the “Percentage of adults who received colorectal cancer screening according to most recent guidelines.” Those complying with recent guidelines included individuals who used a blood stool test at home in the past year; and/or, sigmoidoscopy in the past 5 years and blood stool test in the past 3 years; and/or, had a colonoscopy in the past 10 years. However, the 2012 NYC Community Health Survey only reports the percentage of respondents who received a “colon cancer screening in last 10 years.”

⁷¹ This is 2012 data for Bronx and NYC from the Community Health Survey, 2012. It is 2008-2009 data for New York State from the NYS Department of Health, County Health Assessment Indicators, 2010 –2012.

The obesity rate varies widely within the borough with the highest rates in a corridor from parts of Fordham-Bronx Park down to the South Bronx. There are also very high rates in parts of Pelham-Throgs Neck.⁷² (See Appendix A, Maps 17-18.) Among women and children participating in the United States Department of Agriculture Food and Nutrition Service Women Infant and Children (WIC) program, approximately 29% of pregnant women were overweight, and 27% of pregnant women were obese in the Bronx in the time period 2010-2012. These Bronx rates are higher than the corresponding rates in NYS (approximately 27% overweight, 24% obese) and NYC (approximately 27% overweight, 22% obese).⁷³

Focus group participants attributed obesity to a number of causes, including the limited access and relatively high cost of healthy food.⁷⁴ In the Bronx, a mere 6% of adults report eating five or more fruits or vegetables per day, compared to approximately 9% in NYC and 27% in NYS.⁷⁵ Focus group participants also described the challenges of changing dietary behavior in general—and of losing weight, in particular—despite obvious negative health consequences. Cultural preferences for fried and certain high caloric foods were acknowledged. Although obesity was in part attributed to individual motivation and community conditions, more comprehensive and consistent educational messaging from providers, as well as improved access to affordable healthy food, were also recommended by community members.⁷⁶ Promising programs described by key informants including cooking demonstrations; linkages between providers and food stores, so that the former can provide support regarding promotion of healthy choices; and farmers market participation in food subsidy programs like SNAP and Health Bucks.⁷⁷

(3) Prevent HIV and Sexually Transmitted Diseases (STDs)

As noted above in the section on Domain 3 projects, the fourth leading cause of premature deaths in the Bronx is AIDS, accounting for approximately 30% of all such deaths in NYC.⁷⁸ The HIV/AIDS prevalence rate for the Bronx (approximately 1,660 per 100,000 population) is higher than the NYC rate (1,370 per 100,000), and variation exists within the borough.⁷⁹ Four UHF neighborhoods in the borough have a higher HIV/AIDS prevalence rate than the city as a whole: High Bridge-Morrisania (2,353/100,000), Hunts Point-Mott Haven (2,290/100,000), Crotona-Tremont (2,207/100,000), and Fordham-Bronx Park

⁷² It should be noted these rates are by UHF neighborhood, as rates are not available at the zip code level, so there could be variation within these UHF neighborhoods that is not captured here.

⁷³ Source: Bronx County: County Health Assessment Indicators, 2010 – 2012 data
http://www.health.ny.gov/statistics/chac/chai/chai_58.htm#bronx, accessed August 2014.

⁷⁴ NYAM Primary data findings, September 2014.

⁷⁵ 2008-2009 data found at Bronx County: County Health Assessment Indicators, 2010 – 2012 data
http://www.health.ny.gov/statistics/chac/chai/chai_58.htm#bronx, accessed August 2014.

⁷⁶ NYAM Primary data findings, September 2014

⁷⁷ Health Bucks, worth \$2 each, are developed and distributed by the NYC Health Department and can be used to purchase fresh fruits and vegetables at all farmers' markets in NYC.

⁷⁸ "County Number of 3-Years Premature [< age 75] Deaths" Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics.

⁷⁹ NYC DOHMH 2011

(1,696/100,000).⁸⁰ In terms of numbers of People Living with HIV/AIDS (PLWHA), these neighborhoods account for a total of 16,996 PLWHA or 73.7% of all PLWHA in the Bronx.⁸¹ (See Appendix B, Table 35.) The age adjusted mortality rate for AIDS in the Bronx (20 per 100,000) is more than twice the rate of NYC (9.4 per 100,000) and four times the rate for NYS (4.7 per 100,000).⁸² Neighborhoods with the highest incidence of HIV also have higher rates of concurrent HIV/AIDS diagnoses, and are the same neighborhoods with the highest prevalence: Morrisania/High Bridge, and Mott Haven/ Hunts Point.⁸³ (See Appendix B, Chart 38.)

Bronx residents who are HIV positive, or have been diagnosed with AIDS, have rates of viral load suppression (60.19%) slightly lower than New York City (61.2%) and New York State (62.2%).⁸⁴ Among Medicaid Managed Care Beneficiaries in the Bronx who are HIV positive, or who have been diagnosed with AIDS, 91% are engaged in care, 69% received appropriate viral load monitoring, and 70% of those 19 or older received syphilis screening.⁸⁵ Viral load suppression is a key factor in reducing transmission of HIV and maintaining good health.

Within the borough, there are wide racial disparities in HIV incidence. In 2011, the latest year for which data is available, the rate of new HIV diagnoses among African Americans living in the Bronx was nearly 4 times higher than the new HIV diagnosis rate among Whites living in the Bronx (76.7 compared to 19.1 cases per 100,000 people). The rate of new HIV diagnoses among Latinos living in the Bronx was more than 2 times higher than the new HIV diagnosis rate among Whites living in the Bronx (41.8 compared to 19.1 cases per 100,000 people). (See Appendix B, Chart 37).

According to key informants in the field, transmission among injecting drug users (IDUs) in the Bronx has dropped dramatically, likely due to access to clean syringes from syringe exchange programs—although hepatitis C remains a concern, since it is more easily transmitted.

The HIV/AIDS Resources map (See Appendix A, Map 75.) suggests a geographic alignment between Medicaid Beneficiaries with an HIV/AIDS service utilization and the location of HIV/AIDS resources, which is also consistent with the prevalence PLWHA by UHF neighborhood. The existing health care and ancillary services structure appears to provide a strong foundation for implementing the related DSRIP projects. However, key informants providing services to HIV-infected individuals describe significant changes in funding priorities, with increasing resources going toward medical management, and less funding available for supportive services, including housing for people with HIV. Given the aging of the

⁸⁰ Ibid.

⁸¹ 2011 data, the latest year for which information is available, from the New York City Department of Health and Mental Hygiene.

⁸² NYS Dept of Health County Health Assessment Indicators, 2009-2011, https://www.health.ny.gov/statistics/chac/chai/docs/sti_58.htm, accessed September, 2014.

⁸³ Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

⁸⁴ HIV Ambulatory Care Performance, 2011

⁸⁵ QARR, 2012

HIV-infected population, and the potential medical complications of HIV medication, a large number of people with HIV/AIDS also have more common chronic conditions, including diabetes and heart disease. Integration of medical services is therefore essential.

(4) Promote Healthy Women, Infants and Children

The domain 4 project on this topic is specifically focused on reducing premature, or preterm, births.⁸⁶ As noted above, in 2012, the latest year for which data is available, the percentage of preterm births in the Bronx (12.2%) was higher than in NYC (10.8%) or NYS (10.8%).⁸⁷ Also, as noted above, preterm birth is associated with low birth weight and poor health outcomes. The overall low birth weight (LBW) rate for the Bronx over the time period 2010-2012 was 9.5%, compared to 8.5% for NYC and 8.1% for the state.⁸⁸ Within the Bronx, the LBW rates ranged from 1.9% to 12.8%, with the highest rates found in two clusters of zip codes – one in the south central part of the borough from Mott Haven, Morrisania, to Claremont Village; and the other in the northeast part of the borough in Wakefield, Eastchester, and Co-Op City. (See Appendix A. Map 6.) These neighborhoods also experience the highest rates of infant mortality.⁸⁹ Racial disparities also persist in the borough in the number of preterm births, with 1.4 times the number of preterm births among the black population than among the non-Hispanic white population for the time period 2010-2012 and 1.2 times the number of Hispanic preterm births than non-Hispanic white preterm births in the same time period. (See Appendix B, Table 68.) Though, these racial and ethnic disparities were narrower in the Bronx than in NYC and NYS in the same time period.⁹⁰

In the Bronx, the percentage of mothers receiving prenatal care starting in the first trimester was lower than the NYS and NYC rates (71.8% and 70.4%, respectively) by over 10%, and more than one-third (37.0%) of mothers in the Bronx received prenatal care beginning in the third trimester (months 7-9), compared to 23.9% for NYS and 28.7% in NYC.⁹¹ (See Appendix B, Table 61). Additionally, the Bronx neonatal death rate was slightly higher than NYC and NYS at 3.5 per 1,000, compared to 2.9 per 1,000 in NYC and 3.3 per 1,000 in NYS.⁹²

An important component of promotion of healthy women, infants and children is the reduction in teenage pregnancy. Key informants working in the field described a number of evidence based and promising practices related to teen pregnancy, including better linkages to health centers that provide

⁸⁶ New York's MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan, Attachment J."NY DSRIP Strategies Menu and Metrics," 2014

⁸⁷ NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

⁸⁸ Ibid.

⁸⁹ Ibid.

⁹⁰ The ratio of black to white preterm births in NYC was 1.8 and in NYS was 1.62 for the period 2010-2012. The ratio of Hispanic to white preterm births in NYC was 1.39 and in NYS was 1.25 for this time period. Source: NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard, accessed August 2014.

⁹¹ NY State Vital Statistics, 2012

⁹² Ibid.

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October 3, 2014

family planning services, improved access to long-acting and emergency contraception, and adolescent medical visits with the parent out of the exam room—for at least part of the time.⁹³

⁹³ NYAM primary data findings, September 2014.

INTRODUCTION

Background

In April, 2014, New York State finalized a waiver amendment from the Centers for Medicaid and Medicare Services that allows for reinvestment of approximately \$8 billion in projected savings resulting from the State's Medicaid Redesign Team reforms. These funds will be used to support transformation of the health care system in NYS to promote clinical and population health. The majority of the funds will be distributed through a Delivery System Reform Incentive Payment (DSRIP) program. A central part of the DSRIP program is the formation of Performing Provider Systems (PPS) - collaborative partnerships between hospitals, community-based organizations, and other health care providers across the full spectrum of care. The goal of DSRIP is to advance innovative projects designed to transform the safety net health care delivery system, improve population health, and reduce avoidable hospital use.

To inform the DSRIP project planning process, PPSs are required to complete a Community Needs Assessment (CNA). The New York Academy of Medicine (NYAM) was contracted to complete a borough-wide CNA in the Bronx. The CNA was governed and monitored by a Steering Committee consisting of representatives from each of the following emerging PPSs: **A W Medical, Jacobi Medical Center (HHC), Lincoln Medical Center (HHC), St. Barnabas Hospital (dba SBH Health System)**, as well as representatives from the New York City Health and Hospitals Corporation (HHC) central office .

The specific aims of the CNA process are to:

- Describe health care and community resources,
- Describe communities served by the PPSs,
- Identify the main health and health service challenges facing the community, and
- Summarize the assets, resources, and needs for the DSRIP projects.

This report follows the New York State Department of Health (DOH) CNA Guidance dated June 6, 2014, and the section headers A-F, therein. Also attached here are a glossary of key terms, a bibliography, and appendices including Appendix A. Maps of The Bronx, Appendix B. Tables, Charts and Graphs, and Appendix C. Primary Data Collection Instruments. Forthcoming is an Appendix D with Primary Data Collection Findings. In addition to these appendices, NYAM will provide an electronic version of the tables with zip code (or UHF neighborhood, or Community District) level data, as available.

SECTION A. DESCRIPTION OF HEALTH CARE RESOURCES AND COMMUNITY RESOURCES

Sections i and ii

Health Care Resources

In the Bronx, a large proportion of community members that were surveyed appear to be engaged regularly in primary and preventive care. (See Appendix B., Primary Data tables.) Approximately eighty percent of survey respondents reported having a “primary care provider or personal doctor;” 85% reported that there’s a place they “usually for health care, when it is not an emergency.” Just over half of respondents (53%) went to a primary care doctor’s office, 16% went to a hospital outpatient clinic, 13% went to a community/family health center, and 7% went to a specialist doctor’s office. Eighty-four percent reported that the place they usually go is in the Bronx; 12% reported that it is Manhattan. Eighty percent of respondents reported that their last routine check-up was within the last year. Over 90% reported having a routine check-up in the last two years. Over half (58%) had seen a dentist.⁹⁴

However, there also seemed to be high use of the emergency room and episodes where respondents went without care. Over 40% of survey respondents had been to the ER in the last year. Over one quarter reported that there was a time in the last 12 months when they needed “health care or health services but did not get it.” The most common reasons were lack of insurance (37%), cost of co-pays (26%), “couldn’t get an appointment soon or at the right time” (12%) and concerns about the quality of care (9%).⁹⁵

Independent of the actual number of health care resources described in the sections below, a strong theme that emerged from the primary data collection (key informant interviews and focus groups) was the perception that there was an insufficient access to the high quality providers on a timely basis. A key informant working in the South Bronx explained:

Because it’s the Bronx. You know how hard it is to get [organizations] to come up here to do anything? And generally they don’t get providers... The services in a lot of the outer boroughs are not at the level of quality that they should be. I’m saying that as a Bronx-based provider... You’re going to vote with your feet, you’re going to go to where you think you’re going to receive good services. And in the cases of a lot of our folks that are marginalized and do experience being stigmatized... for people to feel that they’re receiving a great service, that they’re being respected, they’re going [out of the Bronx] to go to that service. (key informant, community based organization)

⁹⁴ NYAM Primary data findings, September, 2014.

⁹⁵ Ibid.

- **Hospitals**

There are 7 major hospital systems in the Bronx with 10 locations: Bronx Lebanon Hospital Center (Concourse Division and Fulton Division); Calvary Hospital; Jacobi Medical Center (HHC); Lincoln Medical and Mental Health Center (HHC); Montefiore Medical Center (Weiler Hospital, Henry and Lucy Moses Division, and Wakefield Hospital); North Central Bronx Hospital (HHC); and St. Barnabas Hospital. These hospitals have a total of 3,794 (approximately 2.74 per 1,000 population) certified hospital beds, with bed capacity ranging from 164 to 767 per hospital, for an average of 379 beds per hospital. Several hospitals are clustered in southeast Bronx, with the rest scattered in a corridor extending from northeast Bronx to Hunts Point–Mott Haven. (See Appendix A, Map 79.) Of these hospitals, the HHC system hospitals (Jacobi Medical Center, Lincoln Hospital Center and North Central Bronx Hospital) treat the largest proportions of Medicaid and uninsured populations. The Veterans Administration also operates one hospital in the Borough, the James J. Peters VA Medical Center.⁹⁶ Focus group and key informant interviews expressed frustration with long wait times at local hospitals.

- **Ambulatory surgical centers**

There are approximately 14 ambulatory surgery centers and 22 office-based surgical practices in the Bronx with one cluster in the higher SES neighborhoods in the east and the others spread across the borough. These surgical centers and practices seem to be missing from several neighborhoods with high Medicaid and uninsured populations like High Bridge – Morrisania. (See Appendix A, Map 63.)

- **Urgent care centers**

Because there is no standardized definition or regulation of urgent care centers in NYS, it is difficult to comprehensively catalog them (there also appears to be more recent rapid proliferation). According to the HITE SITE, the American Academy of Urgent Care database, and a web-based search, there are 10 urgent care centers in the Bronx. Because they target insured patients, urgent care centers also tend to be concentrated in higher income communities: four in Pelham-Throgs Neck, one in Riverdale-Kingsbridge River, two in Northeast Bronx, and one each in Crotona-Tremont, Hunts Point- Mott Haven, and Fordham. (See Appendix B, Table 3 for full list.)

- **Health Homes**

There are five NYS Department of Health designated ‘health homes’ in the Bronx providing care management and service integration to Medicaid beneficiaries with complex chronic medical and behavioral health conditions. They are: Bronx Lebanon Hospital Center, Bronx Accountable Healthcare Network Health Home, Community Care Management Partners (CCMP), LLC, Community Health Care Network, and New York City Health and Hospitals Corporation.

⁹⁶ US Department of Veterans Affairs, 2013,

- **Community Health Centers, including Federally Qualified Health Centers (FQHCs)**

There are approximately 255 diagnostic and treatment centers (D&TC) in the Bronx, which include outpatient care for primary care visits and specialty clinics such as for dental, Ob/Gyn. Of these, 39 are FQHCs which appear to be predominantly located in Crotona–Tremont and seem to be absent from other high need areas of central and northern Bronx like Fordham–Bronx Park, as well as sections of the Southeast Bronx. One hundred fifty-one (151), or 59% of D&TCs, serve Medicaid and uninsured populations and are also similarly clustered in Crotona–Tremont and less densely spread across other areas with high Medicaid and uninsured populations listed above.⁹⁷ (See Appendix A, Maps 55-58.) We have hours of operation information for approximately 101 out of the 151 clinics that service Medicaid and Uninsured patients. Of those, approximately 41.6% list some weekend operating hours, approximately 50.5% list some evening hours.

Among survey respondents, about 13% reported that they go to a community/family health center for non-emergency healthcare services. In addition, approximately 16% of respondents said they access these services at a hospital-based clinic and about 6% at a private clinic.⁹⁸

- **Physicians including private, clinics, hospital based including residency programs**

According to the Center for Health Workforce Studies Physician Re-Registration data published online by the NYS Department of Health, there were 4,325 physicians in the Bronx in 2013, or approximately 312 per 100,000 population, lower than the rate for NYC (428 per 100,000) overall.⁹⁹ Of these 4,325 physicians, 457 are listed as Pediatric, 219 are Pediatric Sub-specialty, 213 are Ob/Gyn, 1,100 are “Other Primary Care,” 554 are “Other Sub-specialty,” 243 are Surgery, 394 are “Mental Health,” and 1,144 are “Other or Missing.”¹⁰⁰

In the Bronx, the number of primary care and “mental health” physicians range considerably across zip codes: Pediatricians range from 0 – 74 by zip code; Ob/Gyn physicians range from 0-76 across zip codes; and other primary care physicians, including family practice, general practice and non-specialty internal medicine range from 1-180 by zip code. “Mental health” physicians range from 0 - 112 across zip codes in the Bronx; the zip code with the largest number of mental health physicians (112) is 10461, where Calvary Hospital, Jacobi Medical Center, and two Montefiore Hospital divisions are located.

¹⁰¹While data does not appear to exist regarding the appropriateness or capacity of these physician rates by Bronx neighborhood, the literature suggests that areas with a higher penetration of primary care

⁹⁷ This includes the New York State DOH “Safety Net Clinics” list, as of August 26, 2014, and clinics listed on HITE SITE that accept Medicaid or have a sliding-fee-scale or provide services to patients free of charge.

⁹⁸ NYAM Primary Data Collection, preliminary findings, August, 2014.

⁹⁹ Center for Health Workforce Studies, 2013 data, published by NYS DOH online at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_workforce_information.htm, accessed September 17, 2014.

¹⁰⁰ Ibid.

¹⁰¹ Center for Health Workforce Studies, Analysis of Physician Re-registration Data, 2014. Received from HHC.

physicians have overall higher health levels and lower costs.¹⁰² Also, mental health services were described by CNA participants as lacking, with a particularly serious gap in mental health services for children and adolescents.

Safety Net Physicians

The number of safety net physicians – defined as non-hospital based providers with at least 35% of all patient volume in their primary lines of business associated with Medicaid, dual-eligible or uninsured patients - ranges considerably among zip codes in the Bronx from 0 to 345, with an average of 46.5 per zip code.¹⁰³ Several clusters of safety net physicians appear to be located in neighborhoods with high Medicaid and uninsured like Crotona – Tremont and Fordham – Bronx Park but are noticeably less densely located in sections of the Southeast Bronx and the southernmost portion of Crotona – Tremont. Additionally, there is a large cluster of safety net physicians in the section of the Southeast Bronx where Jacobi Medical Center, Calvary Hospital and two Montefiore divisions are located. (See Appendix A, Maps 83-84.)

Physicians Assistants and Nurse Practitioners

In the Bronx, there are approximately 337 nurse practitioners (24.2 per 100,000 population, compared to 47 per 100,000 in NYC¹⁰⁴ and 76¹⁰⁵ NYS), and 244 physician assistants (17.5 per 100,000 population compared to 36 per 100,000 in NYC and 61 in NYS).¹⁰⁶ Approximately 135 nurse practitioners and physician’s assistants in the Bronx are safety net providers.¹⁰⁷ These non-physician safety net providers vary considerably by zip code, from 0 to 41 in the Bronx, with an average of 5.4 per zip code.¹⁰⁸ (See Appendix A, Maps 83-84.)

Physicians Serving Self-Pay Patients

According to Center for Health Workforce Data, there are approximately 196 physicians in the Bronx whose self-pay patients comprise more than 30% of their panels.¹⁰⁹ Of these, 42 are primary care physicians, 6 are OB/GYNs, 11 are pediatricians (excluding pediatrics sub-specialties), and 40 are “mental health” physicians. The number of these physicians ranges from 0-55 by zip code, with an average of 8.2 per zip code. These physicians are dispersed rather sparsely throughout the borough,

¹⁰² Starfield, Barbara et al., “Contribution of Primary Care to Health Systems and Health,” *Milbank Quarterly* 83(3): 457-502.

¹⁰³ New York State Department of Health “Eligible Safety Net Physicians” list, as of August 26, 2014. Accessed at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_safety_net_definition.htm.

¹⁰⁴ Includes midwives

¹⁰⁵ Includes midwives

¹⁰⁶ Martiniano R, Siwach G, Krohl D, and Smith L. *New York State Health Workforce Planning Data Guide 2013*. Rensselaer, NY: Center for Health Workforce Studies, September 2013.

Report: [nys_health_workforce_planning_data_guide_2013.pdf](#) (5.9 MB)

¹⁰⁷ New York State Department of Health “Eligible Safety Net Physicians”, as of August 26, 2014

¹⁰⁸ Ibid.

¹⁰⁹ Center for Health Workforce Studies, Analysis of Physician Re-registration Data. 2008-2013 Blended.

with several neighborhoods that have little to no primary-care, OB/GYN, or “mental health” physicians serving over 30% self-pay, including portions of the Southeast Bronx and Crotona – Tremont that have high numbers of uninsured. (See Appendix A, Map 89.)

Access and Adequacy of Care, Providing Culturally Appropriate Care and Creating Linkages with Hospitals, Health Plans and Community Organizations

Of those surveyed, over half of Bronx respondents said that they access non-emergency healthcare services at a primary care doctor’s office and over three quarters reported that primary care medicine was “very available” or “available.” Nearly one third of respondents reported that pediatric and adolescent services were “not very available” or “not available at all.”¹¹⁰

Physicians in the Bronx, including hundreds represented by IPAs, have worked toward creating better linkages with hospitals, health plans and community providers. For example, the Corinthian Medical IPA, which has over 1,200 physician members, approximately 30% of which are based in the Bronx, has a mission to create a “network of medically accomplished and culturally sensitive physicians” and works with major health plans and government partners to ensure “complete and efficient care” for its patients.¹¹¹ They have formed an Accountable Care Organizations and have Medicaid contracts with seven major health plans in NYC. Despite these efforts, key informants and focus group participants report that gaps remain in culturally and linguistically competent providers, particularly for immigrant populations that are relatively new to the Bronx, such as Africans and South East Asians.¹¹²

I don’t care where you come from, but it has to be people seeing people who look like them, that are like them, who speak like them and who feel like this people are – have my interests on my –their mind. ... Seriously, you need to have a program where you have people who look like me, who will be there to pass along information to the people is critical. (immigrant focus group participant)

- **Specialty medical providers including private, clinics, hospital based including residency programs**

In addition to primary care physicians, there are approximately 2,535 specialty physicians, or 182.2 per 100,000 population compared to 271 per 100,000 in NYC. These Bronx specialists include 579 Internal Medicine subspecialists (41.6 per 100,000 population), 92 general surgeons (6.6 per 100,000 population), 289 surgery subspecialists (20.8 per 100,000), 391 general psychiatrists (28.1 per 100,000 population) and 1,184 physicians other specialties (85.1 per 100,000 population).¹¹³ About 38% of Bronx

¹¹⁰ NYAM Primary Data Collection, preliminary findings, August, 2014.

¹¹¹ “Corinthian Fact Sheet” provided by AW Medical Offices, September 2014

¹¹² Ibid.

¹¹³ Martiniano R, Siwach G, Krohl D, and Smith L. *New York State Health Workforce Planning Data Guide 2013*. Rensselaer, NY: Center for Health Workforce Studies, September 2013.

survey respondents reported that medical specialists were “not very available” or “not available at all.”¹¹⁴

- **Palliative Care**

There are approximately seven facilities serving Medicaid and the Uninsured in the Bronx providing specialty pain management services. These include nursing homes, health centers and a hospice. Additionally, there are 30 facilities with hospice services (these include nursing homes, hospices and general hospitals) located in the borough.¹¹⁵ There may be additional organizations providing pain management services in the borough, but no exhaustive directory of such services could be identified.

- **Dental providers including public and private**

There are approximately 348 dentists, or 25 per 100,000 population compared to 74 per 100,000 population in NYC. In the Bronx, there are approximately 184 dental hygienists (13.2 per 100,000 population).¹¹⁶ One hundred and twelve dentists are designated safety net dentists by NYS DOH.¹¹⁷ The number of safety net dentists ranges from 0 to 23 across Bronx zip codes, with an average of 4.5 per zip code. There are also approximately 44 dental clinics in the Bronx, located primarily in south/central Bronx.¹¹⁸ (See Appendix A, Maps 77-78.)

Approximately 70% of survey respondents report that dental services are available or very available in their community and 60% report having been to the dentist in the prior 12 months. Many focus group respondents expressed concerns regarding out-of-pocket costs for particular dental services.

- **Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based**

Based on a review of GNYHA HITE data, there are approximately 73 programs and services specializing in physical therapy, occupational therapy and/or speech therapy.¹¹⁹ There are a few clusters of these programs in Kingsbridge – Riverdale and Fordham – Bronx Park, with many dispersed throughout the borough. However, it appears that the Southern-most section of the Bronx has relatively few rehabilitative services of this kind. (See Appendix A, Map 64.) Please note that there may be more

¹¹⁴ NYAM Primary Data Collection, preliminary findings, August, 2014.

¹¹⁵ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August 2014.

New York State Department of Health “Home Health and Hospice Profile,” as of July, 2014.

¹¹⁶ Ibid.

¹¹⁷ New York State Department of Health “Eligible Safety Net Physicians”, as of August 26, 2014

¹¹⁸ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August 2014.

¹¹⁹ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August 2014.

organizations providing these types of therapy, but no exhaustive directory of such services could be identified.

- **Behavioral health resources**

- **Mental Health**

There are 391 general psychiatrists in the Bronx, which is a rate of 28.1 per 100,000, much lower than the NYC rate of 49 per 100,000.¹²⁰ There are 1,883 social workers in the Bronx, or 135.3 per 100,000 compared to 231 per 100,000 in NYC.¹²¹

Behavioral Health resources, including outpatient, inpatient, support and emergency programs as well as youth programs, appear to be clustered in sections of Kingsbridge – Riverdale, Crotona – Tremont, High Bridge – Morrisania and Pelham – Throgs Neck. Conversely, there appear to be very few resources in the southern-most section of the Bronx in Hunts Point – Mott Haven and in the Southeast Bronx. Some zip codes with relatively high percentages of beneficiaries with behavioral health-related utilization, like 10471 in Kingsbridge – Riverdale (which has the highest rates) and 10461 in Pelham - Throgs Neck, have clusters of these programs, while others seem to have a dearth of these resources even though a relatively high percentage of beneficiaries in those zip codes had behavioral health-related utilization in the calendar year. These zip codes include: 10463 in Kingsbridge – Riverdale, 10475 in Pelham – Throgs Neck, 10454 in Hunts Point – Mott Haven and 10473 in Southeast Bronx. (See Appendix A, Map 88, and section below.)

Key informants also note the shortage of mental and behavioral health services, as well as the barriers to increased capacity:

For mental health, substance abuse—the way reimbursement is being structured—it’s straining programs and there are many programs right now that are trying to survive within the new payment structure. So there is a concern that they could do more, but because of budget constrictions they’re limited in the number of visits and services that they’re able to provide, even on extended hours. And then when you look at who can truly benefit from mental health services, you also have a working population, and if you’re not open later in the evening or on the weekends, then that excludes another group. By the same token, I’ve been involved with another mental health clinic and the staff expressed grave concerns regarding extended hours during the winter because it gets dark so early and safety... So just crime in certain neighborhoods and high-risk areas—because of that fear and of safety—not opening as late as they could to serve the population. (Key informant, community based organization)

¹²⁰ Martiniano R, Siwach G, Krohl D, and Smith L. *New York State Health Workforce Planning Data Guide 2013*. Center for Health Workforce Studies.

¹²¹ Ibid.

Additionally, about 53% of survey respondents reported that mental health services were “available” or “very available” in the Bronx, compared – for example – to 77.6% who reported primary care was available.¹²²

Per DSRIP behavioral health clinical improvement projects, the integration of behavioral health specialists into primary care clinics could help address this issue if it entails a net increase of behavioral health resources. Further, since a large number of survey respondents noted they have a primary care doctor/usual source of care, co-location could have a high-impact on the population. It may also address low behavioral health services utilization among some beneficiaries because of the inconvenience of seeking care at multiple locations and the stigma associated with seeking treatment at a behavioral health location. Conversely, the integration of primary care services into existing behavioral health services settings addresses the high rates of co-morbidity between behavioral health and chronic health conditions for those currently utilizing behavioral health services.

Inpatient and Residential

There is one State-run adult psychiatric hospital in the Bronx, The Bronx Psychiatric Center, with 181 beds.¹²³ At Bronx general hospitals, there are 393 psychiatric inpatient beds, which is 37.9 beds per 100,000 compared to 41.0 in NYC. In addition, there are a number of residential treatment and assertive community treatment facilities. (See Appendix B, Table 6.)

There are 155 mental health residential programs in the Bronx, including apartment/treatment, children and youth community residences, congregate support, congregate treatment, single room occupancy (SRO) community residence, supported housing community service, and supported/SRO.¹²⁴ There is also a New York City Department of Health and Mental Hygiene administered Single Point of Access (SPOA) and a SPOA Housing Project staffed by the Center for Urban Community Services, which has been operating in the Bronx since August 2003.¹²⁵ In addition, there are 9 emergency programs: 2 CPEP crisis intervention programs, 5 crisis intervention programs, 1 crisis program with respite beds, and 1 home-based crisis intervention program (See Appendix A, Map 88).

Outpatient and Support

There are 63 outpatient programs in the Bronx, including 9 ACT programs, 41 clinic treatment programs, 4 comprehensive PROS with clinical treatment programs, 2 continuing day treatment (CDT) program, 6 day treatment programs, and 1 partial hospitalization program. Additionally, there are 51 mental health support programs in the Bronx, including but not limited to family support services, supportive case

¹²² NYAM Primary Data Collection, preliminary findings, August, 2014.

¹²³ New York State Office of Mental Health “County Capacity and Utilization Data Book, Calendar Years 2012-2013,” prepared April, 2014.

¹²⁴ New York State Office of Mental Health, “Local Mental Health Programs in New York State” Directory, as of August, 2014.

¹²⁵ New York State Office of Mental Health web site and the Center for Urban Community Services at <http://www.cucs.org>.

management, vocational services, adult home supportive case management (SCM), HCBS waiver services, and Psychosocial Clubs (Club Houses). There are 15 targeted case management (TCM) programs serving 1,760 patients as of August, 2011 (the most recent available date).¹²⁶ (See Appendix A, Map 88.)

South Bronx residents participating in the CNA expressed a concern that there is an overabundance of supportive services programs in their community, affecting quality of life and perceptions of safety in particular neighborhoods. Similarly, a mental health advocate and focus group participant in a northern Bronx community complained that services were not available there, because of community level prejudice.

Youth

Of the 288 mental health programs in the Bronx, 71 mental health programs serve youth: 7 emergency programs, 3 inpatient programs including one residential treatment facility (RTF), 3 other residential programs, 32 outpatient programs including 6 day treatment programs and 24 support programs including one HCBS waiver program.¹²⁷ (See Appendix A, Map 88.)

- **Alcohol/Drug Use Resources**

Based on GNYHA and NYC Dept. of City Planning data, there are approximately 107 alcohol/drug use programs and services in the Bronx.¹²⁸ Many of these programs are clustered in south/central Bronx and very few programs are located in Pelham-Throgs Neck, Northeast Bronx and Fordham-Bronx Park. (See Appendix A, Map 61.) The availability of outpatient substance use resources appear to align fairly well geographically with need, providing a foundation for the implementation of community-based detoxification and withdrawal management services as outlined in the DSRIP Project Toolkit. However, some communities report that an overabundance of such services affects quality of life and perceptions of safety. Approximately half of survey respondents identified substance abuse services as being “not very available” or “not available at all.”¹²⁹

Inpatient

There are 33 inpatient alcohol/drug use programs in the Bronx: 4 medically managed detoxification programs with a total capacity of 110 beds, one medically supervised withdrawal program with 30 beds, 2 inpatient rehabilitation programs with a total capacity of 68 beds, 10 intensive residential programs

¹²⁶ New York State Office of Mental Health, “Targeted Case Management Programs Location with Program Capacity,” August 2011.

¹²⁷ New York State Office of Mental Health, “Local Mental Health Programs in New York State” Directory, as of August, 2014, and the New York State Office of Mental Health web site.

¹²⁸ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August 2014 and New York City Department of City Planning “Selected Facilities and Program Sites,” as of June, 2014.

¹²⁹ NYAM Primary Data Collection, preliminary findings, August, 2014.

with a total capacity of 987 beds, one residential rehabilitation service for youth with 28 beds, one methadone to abstinence residential service with 110 beds, 5 community residence programs with a total capacity of 136 beds, and one additional community residence program with an unreported bed capacity.¹³⁰ (See Appendix A, Map 62.)

Outpatient

There are 74 outpatient alcohol/drug use programs in the Bronx: three syringe exchange programs, one medically supervised withdrawal program with a capacity of 15 patients, 13 methadone maintenance/treatment programs with a total capacity of approximately 8,995 patients, one outpatient rehabilitation program, three vocational rehabilitation programs and 34 other outpatient medically supervised programs.¹³¹ (See Appendix A, Map 62.)

Additionally, there are approximately 107 doctors certified to prescribe buprenorphine in the Bronx.¹³²

- **Skilled nursing homes, assisted living facilities**

There are 46 nursing homes with a total bed capacity of 11,732 scattered throughout the borough.¹³³ There appear to be more nursing homes located in the northern neighborhoods of the Bronx including Northeast Bronx, Fordham – Bronx Park and Kingsbridge – Riverdale. (See Appendix A, Maps 65-66.)

There are also ten Adult Care Facilities in the Bronx, with a total capacity of 1,445 beds. Seven of these facilities have Assisted Living Programs (ALP), with a total capacity of 578 beds. In addition, one program has Assisted Living Residence (ALR) bed capacity of 195, enhanced ALR bed capacity of 35 and special needs ALR bed capacity of 20. These adult care facilities appear to be concentrated in the northern part of the borough in Northeast Bronx, Fordham – Bronx Park and Kingsbridge – Riverdale. There appears to be only one adult care facility in southern Bronx located in Hunts Point – Mott Haven. (See Appendix A, Map 65-66.)

- **Home care services**

There are 11 certified home health agencies (CHHA), 16 long term home health care agencies (LTHHC), and 6 home care hospice agencies that service Bronx residents. Of these agencies, 2 CHHAs, 9 LTHHCs,

¹³⁰ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August 2014 and New York City Department of City Planning “Selected Facilities and Program Sites,” as of June, 2014.

¹³¹ Outpatient capacity information was only available for Methadone Maintenance/Treatment Programs. Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August 2014 and New York City Department of City Planning “Selected Facilities and Program Sites,” as of June, 2014.

¹³² Substance Abuse and Mental Health Services Administration “Physicians Certified for Buprenorphine Treatment,” accessed July, 2014.

¹³³ New York State Department of Health “New York State Nursing Home Profile,” as of July, 2014.

and 2 home care hospice, are located in the Bronx.¹³⁴ Approximately 36% of survey respondents reported that home care was “not very available” or “not available at all.”¹³⁵

- **Laboratory and radiology services including home care and community access**

There are 3 D&TC-based clinical laboratories and 21 hospital-based clinical laboratories in the Bronx.¹³⁶ In addition, there are approximately 14 health centers with radiology services that provide care to those with Medicaid and the uninsured.¹³⁷

- **Specialty developmental disability services**

There are approximately 316 developmental disability programs in the Bronx and the majority (82%) of them are residential, with a total bed capacity of 1,649 beds. These include supervised community residences, individualized residential alternative programs, and intermediate care facilities. There are also 58 non-residential programs including day training programs, clinic treatment programs, day habilitation programs, counseling and crisis intervention programs, supported work/employment training programs and recreation programs.¹³⁸ Developmental Disability resources are located throughout all parts of the borough, but some neighborhoods, such as portions of Pelham – Throgs Neck, Hunts Point – Mott Haven and Kingsbridge – Riverdale, have relatively fewer resources than others. (See Appendix A, Map 67.)

Specialty services providers such as vision care and DME

There are 55 optometrists in the Bronx (4.0 per 100,000 population)¹³⁹ and approximately five health centers serving Medicaid beneficiaries and the uninsured population provide eye care services.¹⁴⁰ Among survey respondents, about 34% reported that vision services were “not very available” or “not available at all.”¹⁴¹

¹³⁴ New York State Department of Health “Home Health and Hospice Profile,” as of July, 2014.

¹³⁵ NYAM Primary Data Collection, preliminary findings, August, 2014.

¹³⁶ New York State Department of Health “HCRA Provider List,” as of July, 2014.

¹³⁷ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August 2014. New York City Department of City Planning “Selected Facilities and Program Sites,” as of June, 2014. New York State Department of Health, 2014. Health Resources Services Administration “Health Care Service Delivery and Look-Alike Sites,” accessed August, 2014. New York State Department of Health “Safety Net Clinics,” as of June, 2014.

¹³⁸ New York City Department of City Planning “Selected Facilities and Program Sites,” as of June, 2014.

¹³⁹ Center for Health Workforce Studies.

¹⁴⁰ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August 2014. New York City Department of City Planning “Selected Facilities and Program Sites,” as of June, 2014. New York State Department of Health, 2014. Health Resources Services Administration “Health Care Service Delivery and Look-Alike Sites,” accessed August, 2014. New York State Department of Health “Safety Net Clinics,” as of June, 2014.

¹⁴¹ NYAM Primary Data Collection, preliminary findings, August, 2014.

- **Pharmacies**

There are 73 NYS DOH designated safety net pharmacies located in the Bronx. Of their total prescriptions, 33 pharmacies have between 35% and 49% Medicaid prescriptions, 35 have between 50% and 74% Medicaid prescriptions and 5 have 75% or more Medicaid prescriptions. The total number of Medicaid prescriptions for these pharmacies ranges from 1,647 to 204,969 with an average of 28,799 per pharmacy. Key informants noted that there appears to be no 24 hour pharmacies in the neighborhoods south of the Cross Bronx Expressway. (See Appendix B, Table 7 for a full list of safety net pharmacies in the Bronx.)

- **Local Health Departments**

The New York City Department of Health and Mental Hygiene is the local health department for New York City, including the Bronx. DOHMH has a District Public Health Office located in Tremont designed to serve high-need areas of the borough. In addition to the population health projects of DOHMH in the borough, the Bronx DPHO focuses on two major population health initiatives: teenage pregnancy and promoting physical activity and good nutrition. In addition, the DeBlasio administration has recently established a new Center for Health Equity within the DOHMH that will reportedly oversee the Bronx DPHO (as well as the DPHOs in East Harlem and Brooklyn) and implement new efforts to address health disparities. For DSRIP projects, DOHMH has offered to serve a technical assistance role to PPS in the borough, particularly regarding population health projects.

- **Managed care organizations**

There are 9 Medicaid Managed Care (MMC) plans and 3 HIV Special Needs Plans (SNPs) serving the Bronx.¹⁴² Many of these plans also serve members in other counties. While plan enrollment data is not available at the county level, the 9 MMC plans serving the Bronx had a total NYC enrollment of 2,256,087 million members as of 2012.¹⁴³ (See Appendix B, Table 4.)

- **Area Health Education Centers (AHECs)**

The Bronx Westchester Area Health Education Center is located in Bedford Park and hosts the following programs: Community Health Experience, a summer program for medical school students interested in gaining exposure to community and public health experiences through placement in a community organization and specialized lecture series; the Medical Academy of Science and Health (MASH), a camp promoting health professions to students in grades 6 to 9; the Summer Health Internship Program, a summer internship placement program for high school and college students; the Health Career Bridge Program, a program offered during the school year for juniors in high school interested in exploring

¹⁴² New York State Department of Health Division of Managed Care and Program Evaluation “County Directory of Managed Care Plans,” as of July, 2014.

¹⁴³ United Hospital Fund, “Medicaid Managed Care Enrollment by Region,” 2012.

health careers; and the Health Careers Internship Program, a program for college students aspiring towards careers in health care settings.

Community Based Resources

The Bronx has a large number of community based resources. However, CNA participants expressed concerns about capacity (small staff and budgets), quality, and health care linkages to those services that might benefit their patients.

I think it's less about [health care] access and more about all of the other things that are hindering access: poverty, chaotic drug use, unstable housing, hunger. So that's why we spent so much time attacking those issues so they can get stabilized so then they can think about medical care. So I think what's lacking is more commitment of resources to really addressing homelessness and hunger and those things that once they're stabilized, access becomes much, much easier. (key informant, community based organization)

Because physicians like us, we have absolutely zero knowledge of community resources, and there are plenty of community resources (key informant, health provider)

- **Food pantries, community gardens, farmer's markets**¹⁴⁴

There are 154 food banks in the Bronx, including 120 food pantries and 30 soup kitchens.¹⁴⁵ In addition, there are 32 community gardens and 45 farmers markets.¹⁴⁶ Although CNA respondents noted an increase in farmers markets and more nutritious food available through food pantries, as well as nutrition and exercise programs, these assets are noticeably absent from Pelham-Throgs Neck and Northeast Bronx, where the obesity rate is the highest in the borough (See Appendix A. Map 70.) In addition, 42.4% of survey respondents reported that healthy food was “not very available” or “not available at all” in their neighborhood.¹⁴⁷

- **Financial assistance and support including clothing and furniture banks**

Approximately 89 organizations throughout the Bronx provide some type of financial assistance to their participants. Some of these organizations serve special populations including but not limited to: people with developmental disabilities, low-income homeowners, people with mental illness, older adults, pregnant women, mothers and children, immigrants, families at risk of eviction and older adults. Four

¹⁴⁴ If an organization provides multiple services, they are included under each header for which they provide services.

¹⁴⁵ Food Bank for New York City “Food Bank Locator,” Accessed July 2014.

¹⁴⁶ New York State Department of Agriculture & Markets “New York State Farmers’ Markets,” accessed July 2014. New York City Department of Health and Mental Hygiene “New York City Farmers Markets,” accessed July 2014.

¹⁴⁷ NYAM primary data findings, September, 2014.

Financial Empowerment Centers that offer free individual, professional financial counseling, are located in the Bronx: two in High Bridge-Morissania, one in Central Bronx and another in Southeast Bronx. There are also 23 WIC programs throughout the Bronx.¹⁴⁸

Additionally, based on GNYHA data, at least 13 community-based organizations in the Bronx provide “material goods” services, free clothing and/or furniture and about four community-based organizations provide utility assistance. There are also 3 clothing banks located in the Bronx.¹⁴⁹

- **Individual Employment Support Services**

About 66 organizations in the Bronx provide employment/vocational support services to varying populations including but not limited to: people with developmental disabilities, people who are homeless or formerly homeless, people who are homebound, minorities, immigrants, high-risk adolescents, unemployed women, people with mental illness and Native Americans.¹⁵⁰ However, a majority of survey respondents, 64.3%, reported that job training was “not very available” or “not available at all” in their community.¹⁵¹

- **Housing services, including advocacy groups and housing providers, including those for the homeless population**

There are approximately 78 non-profit or public agencies and community based organizations that provide housing services of varying types located in the Bronx. These include intake and community centers; housing programs including emergency shelters, transitional housing programs, temporary housing, community residences, SROs and supportive housing programs; case management agencies; public and non-profit clinics; and advocacy, empowerment and counseling/support organizations. Many of these agencies provide housing services to special populations, including but not limited to: pregnant teens; people with mental illness, disabilities, and/or substance use; people living with HIV/AIDS (PLWHA), homeless mothers with children; homeless veterans; older adults; immigrants; adolescents aging out of foster care.¹⁵² There are approximately 97 New York City Housing Authority (NYCHA) Developments and 124 NYCHA Community Facilities located in the Bronx.¹⁵³ Housing and homeless

¹⁴⁸ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

¹⁴⁹ Seedco, Earn Benefits Online “Clothing Resources Spreadsheet,” accessed August, 2014.

¹⁵⁰ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

¹⁵¹ NYAM primary data findings, September, 2014.

¹⁵² Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

¹⁵³ This compares to 103 NYCHA developments and 146 community facilities in another large NYC borough, Brooklyn, and 352 NYCHA developments and 536 community facilities in NYC overall. New York City Housing

resources, including Homebase¹⁵⁴ locations, housing and rent assistance programs, NYCHA community facilities and shelters, appear to be located predominantly in the southern Bronx neighborhoods of Crotona – Tremont, High Bridge – Morrisania and Hunts Point – Mott Haven (though the eastern portion of Hunts Point – Mott Haven appears to have very few of these resources). The concentration of poverty in neighborhoods with a large number of NYCHA developments presents distinct challenges to health and service providers.

Concentrated poverty, you've got a neighborhood [that] has a poverty rate of about 46%. The Bronx in general is about 26% which is still ridiculous, but that area has that concentrated poverty because of all the NYCHA housing projects. And so when you get that kind of concentrated poverty and then the violence, sexual violence, domestic violence, street violence, gang violence, drug violence, it's a perfect storm for breeding ground for spreading illness, disease, lots of psychiatric issues and lots of drugs. (key informant, community based organization)

Comparatively, Northeast Bronx, Kingsbridge – Morrisania and Pelham – Throgs Neck seem to have few housing resources. (See Appendix A, Maps 90-91.)

Similar to other parts of NYC, CNA participants described a lack of affordable housing, inadequate housing resources, and poor conditions for low-income populations, including rodents, cockroaches, and poor maintenance. Additionally, among survey participants, close to half identified affordable housing as “not very available” or “not available at all.”¹⁵⁵

The Bronx—particularly the South Bronx—has a well-known history of housing degradation and loss to arson. According to some key informants, in the rebuilding of the Bronx, the needs of long-time residents have been ignored, in favor of higher income populations. However, the legacy of housing activism, can be described as a strength of community:

And the South Bronx has a pretty vibrant history of having pushed back against the bad mortgage practices and done a lot of community organizing around unfair practices and pushing for affordable housing. And I don't think the affordable housing situation is solved, but it's a lot better than it was, and there's a lot more attention put into affordable housing. So that's like a rich recent history that I think a lot of community-based organizations were forged during that time period, and then they came to take on health because that's sort of, you know, housing,

Authority (NYCHA) “NYCHA Development Data Book,” as of 2014. New York City Housing Authority “Directory of NYCHA Community Facilities,” as of 2013.

¹⁵⁴ NYC Department of Homeless Services “Homebase” homeless prevention locations offer individualized services to low-income families at risk of becoming homeless through a community-based network of providers. These services include: emergency rental assistance, landlord mediation, job training, among others.

¹⁵⁵ NYAM primary data findings, September, 2014.

health education, as far as kind of primitive needs that we all want... So the strength of the earlier community struggles around housing, I think, has helped us in terms of the, the pertinent things around health.

- **Not for profit health and welfare agencies**

There are approximately 441 non-profit social service agency sites scattered throughout the Bronx.¹⁵⁶ Over one third of survey respondents reported that social services were “not very available” or “not available at all.”¹⁵⁷

- **Local governmental social service programs**

There are 43 local governmental agencies located in the Bronx such as food stamp programs, a Medicaid office, job centers, a home care program and a drop-in center. They are predominantly located in central and southwest Bronx. (See Appendix A. Maps 81-82.)¹⁵⁸

- **Community Outreach Agencies**

There are approximately 21 organizations in the Bronx including community service organizations, care management agencies and treatment and prevention programs, including syringe exchange/harm reduction programs, among others, that conduct outreach activities ranging from mobile outreach and syringe exchange to outreach and crisis intervention. They attempt to meet the needs of many different populations that are considered to be among the most vulnerable and difficult to engage, including but not limited to: homeless populations, veterans, victims of domestic violence, PLWHA, and people who inject drugs (PWID)/active drug users.¹⁵⁹

We define ourselves by the problems and the issues that we’re facing and confronting in the Bronx through, you know, driven by poverty, lack of access to medical care, and some of the other issues like food and nutrition and HIV and Hepatitis and drug overdoses that are really disproportionate in the Bronx. ... what separates us from a Lincoln Hospital or a Montefiore Medical Center, a lot of things, but primarily is that our primary target population community that we’re trying to reach are those who are most marginalized, most stigmatized. That’s very intentional in our work. And I would say that hospitals, healthcare organizations, managed care plans, federally qualified health centers, for the most part, have – their primary intent is to open up access to medical care for everybody. And while they may see people who are very

¹⁵⁶ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

¹⁵⁷ NYAM primary data findings, September, 2014.

¹⁵⁸ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

¹⁵⁹ Ibid.

marginalized and stigmatized, it's not their primary purpose and their vision and mission. (key informant, community based organization)

- **Transportation Services**

Based on analysis of GNYHA HITE data, there are approximately 21 organizations in the Bronx that provide varying types of transportation services. Four of these provide transportation for seniors and one provides transportation services for the disabled.¹⁶⁰ While there may be other organizations that provide transportation services to their participants, no directory or inventory of these services seems to exist. Access-a-Ride is the Metropolitan Transit Authority's (MTA) para-transit service, available to those certified as eligible due to mobility restrictions. However, CNA participants reported that the services are structured in such a way, with long and unpredictable wait times, that makes it difficult for those targeted to use it to access scheduled appointments. Access-a-Ride also seems to have limitations within the Bronx and regarding drop-off at accessible bus stops that are impractical for those with mobility issues.

I have access-a-ride. Access-a-ride doesn't take me anywhere in the Bronx. It goes to Queens, Brooklyn and Staten Island. But I cannot use it here in the Bronx. Now the last time I called them for them to take me to [Manhattan], I went over to 5th Avenue to the hospital. She told me "you can take this bus, and it will take you to Manhattan, and that bus will drop you off." And then I said, "so what do I do now? I have difficulty walking." And where they were gonna drop me off would have been at least two blocks and that hospital I was going to I know for a fact, two blocks is like four. I'm gonna have to walk. And I couldn't walk so I said "I have to walk there. What do you suggest I do?" "Uh well uh ma'am." I said "You can't help me. Thank you very much." (focus group participant)

Transit services are particularly important in the Bronx as large portions of the borough are not accessible by subway and there are no trains that travel east-west, meaning that many trips outside a particular neighborhood require both bus and subway travel and may require payment of two fares:

When you go [to the health center], you always got to get a referral for this, for that, and the third. So you are going to end up in a two fare zone. To get to that referral, because they never conduct it on site. They could say, 'Okay you have a problem with your left eye. Here is a referral to go 40 blocks away, and that's where you have to go, and you come back here for your results. But then I might give you a referral to go to the GYN that is 50 blocks away,' and so forth and so

¹⁶⁰ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

on. So either way you look at it, you are getting on the train, while they are right around the corner. (focus group participant)

Still, about 90% of survey respondents identified transportation as “available” or “very available.”¹⁶¹

- **Religious service organizations**

There are many faith based institutions and religious service organizations offering a range of services in the Bronx. We have included these institutions and organizations throughout our inventory of community based resources listed and accounted for here. Faith organizations provide a number of valuable services, including health education, health fairs, food pantries, visiting the homebound, and social support, as well as specific programing that promotes weight loss, physical activity, and proper nutrition.¹⁶² However, it is important to note that many people travel to faith institutions, and they may serve a broader—rather than their local—community.

- **Specialty community-based and clinical services for individuals with cognitive or developmental disabilities**

Both the community based and clinical resources for individuals with intellectual and developmental disabilities are included in the health care resources section above. Serving individuals with developmental disabilities is considered to be challenging in the changing healthcare environment, as they may also have multiple co-morbidities, providers are not trained to recognize or address behaviors associated with developmental disabilities, and accommodations may be required (e.g., to visit length) due to issues around comprehension.¹⁶³

- **Peer, Family Support, Training and Self- Advocacy Organizations**

Based on a review of GNYHA HITE data, there appear to be approximately 26 organizations in the Bronx that offer peer, family support and self-advocacy programs and services to populations with psychosocial issues including individuals with mental illness, disabilities, alcohol/drug use, involvement in the criminal justice system and their families, among others.¹⁶⁴ There may be additional organizations providing these services as part of their broader menu of services, but a complete directory with that information does not appear to exist.

¹⁶¹ NYAM primary data findings, September, 2014.

¹⁶² Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

¹⁶³ Ibid.

¹⁶⁴ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

- **NAMI**

The National Alliance on Mental Illness (NAMI) Bronx Families & Advocates, is located in Southeast Bronx and serves all of Bronx County. NAMI offers family, peer, teacher and provider education, training and support through support and recovery groups and other programs.¹⁶⁵

- **Youth development programs**

There are 336 Department of Youth and Community Development (DYCD)-funded programs located in the Bronx of the following types: 239 after-school programs; 25 family support programs including housing programs and fatherhood initiatives; 30 employment and/or internship programs; 60 summer programs and 3 runaway and homeless youth programs, among others. There are also 53 Mayor’s Office Programs offering education, employment, health and justice programming.¹⁶⁶ Both DYCD-funded and Mayor’s Office programs seem to be clustered in Southern Bronx in the Hunts Point – Mott Haven, High Bridge – Morrisania and Crotona – Tremont, and less densely spread throughout Pelham – Throgs Neck, Northeast Bronx and Kingsbridge – Riverdale. (See Appendix A, Maps 92-93.) In addition, there are approximately 65 organizations including public libraries, shelters, housing facilities, community centers, recreation centers, and other types of community-based organizations, that offer after-school and/or youth group services in the Bronx. 38 organizations in the Bronx have summer youth programs and 30 organizations offer tutoring.¹⁶⁷

- **Foster Children Agencies**

There are 49 Administration for Children’s Services (ACS) Community Partners providing preventive and family treatment and rehabilitation services throughout the borough, and three ACS Child Protective Borough Offices located in Southeast Bronx, Bronx Park-Fordham and High Bridge-Morrisania.¹⁶⁸

- **Education: schools, community-based education programs including programs for health professions/students, libraries**

There are approximately 541 schools in the Bronx, including 158 public elementary schools, 69 public middle schools, 20 public junior/senior high schools, 109 public high schools, 44 public charter schools, and 101 private/parochial schools. Particularly in the South Bronx, school quality is reported to be poor and dropout rates are high, impacting future opportunities for individuals as well as the strength of the community.

¹⁶⁵ National Alliance on Mental Illness (NAMI) Website.

¹⁶⁶ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of Augusts, 2014.

¹⁶⁷ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

¹⁶⁸ Administration for Children’s Services (ACS) “ACS Community Partners”

The poverty is there and the low education levels, which I think are worth noting. There are areas of the South Bronx where seven percent of the adults have a college degree. That means 93 percent of adults do not have a college degree. That is like a staggering educational segregation. You know, I don't remember off the top of my head what Manhattan is like, but it's like 40 or 50 percent of adults have a college degree. So, the young people who are growing up in these areas, the odds that they meet a grown-up from their neighborhood who has a college degree is exceedingly low. And that reverberates through the health impact as well. So people often think about the poverty piece, which is huge, but one of the ways that gets reflected is in the education level, so also that area, also has low rates of four-year high school graduation. I don't know exactly what it is, but for the city it's only 63 percent or something, so if you're talking about young men in the South Bronx, I don't have the data exactly current—but it's gotta be less than 50 percent. So that means the high schools are mostly creating dropouts and not successful high school graduates, and that has a huge health impact and the long-term employment impact and all of those things...You know, the school system can try as hard as it can, but it's very ill-equipped to deal with and under-resourced to deal with all the myriad of issues that, that young people present in high school. (Key informant, government)

There are four public colleges located in the Bronx: Hostos Community College (CUNY) in High Bridge-Morrisania, Herbert H Lehman College (CUNY) in Bronx Park-Fordham, Bronx Community College (CUNY) in Central Bronx and Maritime College at Fort Schuyler (SUNY) in Southeast Bronx.¹⁶⁹

There are also 135 community-based organizations in the Bronx providing education services such as GED/High School Equivalency (HSE) preparation, ESL, citizenship classes, SAT prep classes, job readiness training, financial literacy and vocational skills programs. Some of these organizations offer education services to special populations including out-of-school youth and adults, children with developmental disabilities, formerly incarcerated and immigrants.¹⁷⁰ There are approximately three Associates' Degree Nursing programs and two Health Worker programs located in the Bronx.¹⁷¹ There are 40 public library branches in the Bronx scattered somewhat evenly throughout the borough, though some zip codes such as 10474 in Hunts Point – Mott Haven and 10465 in Pelham – Throgs Neck, have no libraries. (See Appendix A, Maps 94-95.)

¹⁶⁹ New York City Department of City Planning "Selected Facilities and Program Sites," as of June, 2014.

¹⁷⁰ Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

¹⁷¹ New York State Education Department Office of the Professions "New York State Nursing Programs" and New York State Department of Health "Community Health Worker Programs," Accessed July, 2014.

- **Reentry Organizations and Alternatives to Incarceration**

There are approximately ten organizations that offer criminal justice offender services located in the Bronx. These services include: civic engagement, linkage to employment and educational services, transitional and supportive housing, recreational events, mental health care, HIV/AIDS services, peer education, peer support, case management and substance use treatment.¹⁷² Given the high need within this population, services seemingly are inadequate:

People are also chronically - in the same way that folks are chronically homeless, they're chronically involved in our jail system. And those folks are the same folks that you would expect to see in the shelters or that are the folks that came out of prison and come back [to Rikers]. Folks come out of prison, they don't really necessarily have the tools that they need to be successful on the outside, and that includes folks that come out with, you know, very serious health conditions. (Key informant, government)

Section iii Domain 2 Metrics

See Appendix B, Tables 8 and 9.

¹⁷² Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE) data, as of August, 2014.

SECTION B. DESCRIPTION OF THE COMMUNITY TO BE SERVED

Section i: Demographics of the Bronx Population

Population Size, Age, Sex, and Race/Ethnicity

The Bronx's large population of 1.4 million is approximately 17% of the total NYC population, and approximately 7% of the statewide population. Almost two thirds of the Bronx's population are working age adults (aged 18-64); over one quarter are children (aged 0-17) and about ten percent are older adults (aged 65+). The age of the Bronx's population is slightly younger than the NYS and NYC populations, with about 5% more children and slightly lower proportions of older and working age adults. A little over half of the Bronx population is female, roughly analogous to the populations of NYC and NYS. (See Appendix B, Table 11.)

The Bronx's population is racially and ethnically diverse. Approximately one in three (34.7%) people in the Bronx identify as Black or African American, a much larger proportion than NYC as a whole (25.1%) or NYS (15.9%).¹⁷³ In fact, the Black/African American population in the Bronx accounts for approximately 16% of the total Black/African American population in New York State.¹⁷⁴ The Black/African American population includes US born and immigrant populations, including significant numbers from Caribbean nations, and increasing numbers from Africa.¹⁷⁵ Over half (54%) of the Bronx population identifies as Hispanic/Latino of any race, accounting for approximately 22% of this population statewide.¹⁷⁶ Historically, Latinos in the Bronx were from Puerto Rico. There are now reportedly more immigrants from the Dominican Republic and Central America. About 4% of people in the Bronx identify as Asian. According to key informants, the population of the Bronx is increasingly diverse with increasing numbers of South Asian (primarily Bangladeshi and Pakistani) and Southeast Asian immigrants. (See Appendix B, Table 12.)

Citizenship Status and Language Spoken at Home

According to available data, approximately one in five (19%) people in the Bronx are not US citizens, comparable to NYC (18%) but higher than the State rate of approximately one in ten people (11%).¹⁷⁷ Approximately 468,927 people, or approximately one-third of the Bronx population, were born outside

¹⁷³ US Census American Community Survey, 5 year table, 2008-2012.

¹⁷⁴ Ibid.

¹⁷⁵ NYAM primary data findings, September, 2014.

¹⁷⁶ US Census American Community Survey, 5 year, 2008-2012.

¹⁷⁷ Ibid.

of the United States.¹⁷⁸ High proportions of non-citizens are found throughout the Bronx and especially high rates are on the western edges of Crotona-Tremont and Fordham-Bronx Park. These areas, along with Hunts Point-Mott Haven, also have high rates of residents who speak English less than “very well.”¹⁷⁹ (See Appendix A. Maps 9-10.) These numbers likely underestimate the undocumented population, which is reported to be substantial in the Bronx. The concerns of other immigrant populations are magnified among the undocumented. Access to most services is limited, and the fear of deportation results in lower utilization of services that are available, including health services. Providers report that people who are undocumented want to avoid providing information about themselves, and avoid “the system” to the greatest extent possible.¹⁸⁰ Those who are not US citizens and who speak English less than “very well” may experience additional regulatory or cultural barriers to health care access. Although bilingual providers and interpretation may be available for the largest language groups, smaller populations feel the burden of translation and interpretation falls on them. In addition, residents complain about the quality and reliability of language services offered, whether in person or by phone.

So we have heard of folks that are living up in the Bronx, perhaps because that’s where they got placed in NYCHA housing¹⁸¹, but all of their services are in Brooklyn. So they go to the grocery in Brooklyn. Their friends are there. Their doctors are there. So that’s a tremendous amount of time to be able to travel to get culturally-competent, language-accessible programs and services. So then that’s a real big challenge that we’re seeing across a lot of communities, in the Asian-American community (Key informant CBO)

Over half (57%) of Bronx residents report speaking a language other than English at home.¹⁸² Approximately half (46.4%) speak Spanish or Spanish Creole; approximately 3% speak African languages, and approximately 1% each speak French (including Patois and Cajun), Italian, Indic or Indo-European languages. (See Appendix B, Table 18.)

¹⁷⁸ Ibid.

¹⁷⁹ Ibid. This is self-reported data in response to the American Community Survey questions: a) Does this person speak a language other than English at home? If YES, b) What is the language?, and c) How well does this person speak English? Very well; Well; Not well; Not at all.

¹⁸⁰ NYAM primary data findings, September, 2014.

¹⁸¹ There are approximately 97 NYCHA Developments and 124 NYCHA Community Facilities located in the Bronx. , NYCHA community facilities and shelters appear to be located predominantly in the southern Bronx neighborhoods of Crotona – Tremont, High Bridge – Morrisania and Hunts Point – Mott haven (though the eastern portion of Hunts Point – Mott Haven appears to have very few of these resources). Comparatively, Northeast Bronx, Kingsbridge – Morrisania and Pelham – Throgs Neck seem to have few housing resources. (See Appendix A, Maps 88-89.)

¹⁸² US Census, American Community Survey, 5 year data, 2008-2012

Foreign Born and Uninsured

The 2008-2012 5-year American Community Survey estimated that 131,665 (or 60.7%) of the total number of 217,009 uninsured Bronx residents were foreign born.¹⁸³ Of these 131,665 foreign-born uninsured residents, the largest number were born in Latin American countries (86,572, 65.8%), followed by those born in non-Hispanic Caribbean countries (16,070, 12.2%), African countries (13,699, 10.4%), Balkan and Eastern European countries (3,349, 2.5%), and South Asian countries (2,766, 2.1%).¹⁸⁴ (See Appendix B, Table 22b.)

Uninsured foreign born Latinos live primarily in the South Bronx and west of the Grand Concourse, with approximately 11,000-13,000 living in each of the following Community Districts (CD): CD 1&2, Hunts Point, Longwood, and Melrose; CD 9, Castle Hill, Clason Point, and Parkchester; CD 4, Concourse, Highbridge, and Mount Eden; CD 5, Morris Heights, Fordham South, and Mount Hope; and CD 7, Bedford Park, Fordham North, and Norwood. Those uninsured born in non-Hispanic Caribbean countries reside primarily in CD 12, Wakefield, Williamsbridge, and Woodlawn. African-born uninsured residents reside mostly on either side of the Grand Concourse, in CD 3&6, Belmont, Crotona Park East, and East Tremont; CD 4, Concourse, Highbridge, and Mount Eden; and CD 5, Morris Heights, Fordham South, and Norwood. Uninsured residents born in Balkan and eastern European countries live primarily in CD 11, Pelham Parkway, Morris Park, and Laconia; and uninsured residents born in South Asian countries live primarily in CD 9, Castle Hill, Clason Point, and Parkchester.

Uninsured

In the Bronx, approximately 217,000 people are uninsured, accounting for approximately 10% of all the uninsured individuals in New York State.¹⁸⁵ Adults between the age of 18 and 65 account for the largest proportion of uninsured in the Bronx, with a rate of 20% versus approximately 2% among those aged 65 and older, and approximately 5% among children aged 0-17. (See Appendix B, Table 22.) Within the borough, the highest number of uninsured are clustered in parts of Fordham-Bronx Park south through to Hunts Point-Mott Haven. (See Appendix A, Map 3.)

A significant portion of the uninsured the Bronx may be undocumented.¹⁸⁶ Despite health reform, data suggest insurance coverage remains problematic (or is increasingly problematic) even for those eligible.¹⁸⁷ Income restrictions for Medicaid are considered unrealistically low, and self-purchased coverage is repeatedly described as too expensive, given the difficulties of paying for basic necessities including food and housing.

¹⁸³ Ibid.

¹⁸⁴ Ibid.

¹⁸⁵ US Census, American Community Survey, 5 year data, 2008-2012.

¹⁸⁶ NYAM primary data findings, September, 2014.

¹⁸⁷ Ibid.

I would say that poverty is the main concern because people are finding it - number one, they're unemployed or they're underemployed or they're working places where they cannot get health insurance and now with the new law, they must have health insurance. So they - like I said, if - when people have to decide between having health insurance and having food in their stomach, they'd rather eat (Key informant, community based organization)

Lack of health insurance was reported to result in reduced use of preventive and community based care and increased emergency department use.¹⁸⁸

Income, Education and Unemployment

The median household income in the Bronx is approximately \$34,300 per year, significantly lower than NYC (\$51,000) and NYS (\$57,000). Over one-quarter (29%) of households in the Bronx lives below the federal poverty level, compared to just under one-fifth (19%) in NYC and approximately 14% in NYS. Furthermore, these figures are not adjusted for the higher cost of living in New York City compared to other parts of the State. There are relatively high rates of poverty throughout the Bronx, with the highest rates of poverty in Hunts Point-Mott Haven, where nearly half of households have incomes below the federal poverty level (FPL).¹⁸⁹ There are also high rates of poverty in High Bridge-Morrisania, Crotona-Tremont and Fordham-Bronx Park where approximately 25%-40% of households have incomes below the FPL.¹⁹⁰ These are also the areas of the county with the highest rates of unemployment. As described by key informants, poverty has implications for communities and families. (See Appendix A. Maps 4-5.)

Living in poor community, you have poor quality schools. You have lack of safety in your streets. The air quality is bad. (Key informant, provider)

It's cheaper to eat rice and chicken. So finances have a lot to say also with food choices, because if you have a large family and you want, you know, the food to go longer or further with the number of people in the household, what is it you're buying? Is it more expensive to buy oranges, grapes, strawberries and watermelon than it is to have other items that may not be as nutritious? (Key informant, community based organization)

Approximately 7 out of ten (69%) Bronx residents aged 25 or higher has a high school degree or equivalent, lower than NYC (79%) and NYS (85%). Those aged 25 or higher who have earned a bachelor degree is lower at 18%, compared to 34% in NYC and 33% statewide.¹⁹¹ (See Appendix B, Table 14.)

¹⁸⁸ Ibid.

¹⁸⁹ US Census, American Community Survey, 5 year data, 2008-2012

¹⁹⁰ Ibid.

¹⁹¹ Ibid.

Medicaid

Medicaid beneficiaries in the Bronx represent 14.1% of the Medicaid beneficiaries in New York State (821,339 of 5,835,794), while comprising 7.1% of the overall State population. The percentage of the total population who are Medicaid Beneficiaries varies across zip codes from 17.5% to 84.2%, with an overall percentage for the borough of 59.2%. (See Appendix A, Map 1.) The highest proportion of the population who are Medicaid Beneficiaries are in a single large cluster that reaches from the Fordham – Bronx Park area between the Botanical Garden and the Harlem River in the north, and continues southward along both sides of the Grand Concourse through Morris Heights, Mouth Hope, High Bridge – Morrisania, to Mott Haven.

Older Adults/ Dual Eligible Beneficiaries

Older adults covered by Medicare alone are not a focus for the DSRIP program which is primarily focused on Medicaid and uninsured populations, however there are a number of low-income adults who are dually-eligible for Medicaid and Medicare the Bronx. Approximately 60% of the Bronx older adult population of 147 thousand is dually eligible for Medicaid and Medicare.¹⁹² Bronx “duals” account for approximately 20% of all dually eligible individuals in NYC, and approximately 10% in NYS.¹⁹³ Dual eligible individuals live in many parts of the borough with the highest numbers in parts of Fordham-Bronx Park, Crotona-Tremont, and High Bridge-Morrisania. (See Appendix A, Map 2 and Appendix B, Table 23.)

Ambulatory Difficulties and Disability

Among Bronx households, 29.1% have a disabled household member (someone with a hearing, vision, cognitive, ambulatory, self-care, or independent living difficulty). The comparable percentage for NYC is 21.2% and for New York State is 22.5%.

Approximately 44.2% (64,949) of Bronx residents aged 65 and older have an ambulatory difficulty, comparable to NYC (42.5%) and NYS (39.8%).¹⁹⁴ Among Bronx residents aged 18-64, approximately 7% (60,771) have an ambulatory difficulty, higher than the rate in NYC (4.3%) overall and NYS (4.4%).¹⁹⁵ Within the Bronx, ambulatory difficulty among the age 65+ population is concentrated in Mott Haven and Hunts Point, extending to the northeast through Soundview, Parkchester and Pelham Parkway. For those aged 18-64, the rates are much lower but ambulatory difficulty still affects a sizable number of

¹⁹² New York State Department of Health, 2012 data. Note, it is possible to be dually eligible for Medicare and Medicaid if you have a low-income and are long term disabled, without being over the age of 65.

¹⁹³ Ibid.

¹⁹⁴ Ambulatory difficulty is self-reported data in response to the American Community Survey question “Does this person have serious difficulty walking or climbing stairs?” Source: US Census American Community Survey 5-year, 2008-2012.

¹⁹⁵ Ibid.

people, with a similar concentration in Mott Haven and Hunts Point but extending more directly north rather than northeast. (See Appendix A, Maps 11-12 and Appendix B, Table 25.)

Individuals with disabilities and ambulatory difficulties may have multiple barriers to access to care, including inadequate transportation services, providers that lack appropriate accommodation for individuals with disabilities or are insensitive to these individuals, and practice rules (e.g., visit lengths that are inconsistent with appropriate care).¹⁹⁶ Examples of access barriers—and their implications—were described by a key informant working in the field. Unfortunately, the barriers are considered even more significant in community provider settings as compared to hospital settings.¹⁹⁷

- *A requirement, for example, that you come to an appointment timely, or if you miss an appointment three times, you can be dis-enrolled from a program or a provider. If you use Access-a-Ride for example, it is almost impossible to know when you will arrive at a location on a consistent basis. The service is simply of such poor quality that if you cannot use the subways where you need to go, or the buses, and you need door-to-door transportation, you need flexibility in appointment scheduling.*
- *In the health setting, practitioners are often listed – clinics are often listed as being wheelchair accessible in managed care program directories. But in fact, according to a survey by the Community Service Society, it was found that these practitioners have steps at their front entrance. The providers don't even know what accessibility means. And so they list themselves as accessible, but when you go to their site or you call them on the phone, they'll say, "Oh yes, we have a few [steps] at our entrance, but that's no big deal."*
- *We have people who avoid health practitioners because they are routinely stigmatized and humiliated. The No. 1 problem people with disabilities have cited to us in studies is that they're dealing with practitioners who do not understand their disability, and who do not treat them with respect. People will go to the health practitioner, and if there's an aide with them, the health practitioners will address themselves entirely to the aide. As if the person sitting with a disability in front of them is not the person to whom they should be directing their comment, is not in charge of themselves, is not able to communicate, is not a thinking person. People with disabilities that are physical often complain that people treat them as if they have a low IQ.*

¹⁹⁶ NYAM primary data findings, September 2014.

¹⁹⁷ Ibid.

Housing: Types and Environment

Approximately 30% of Bronx households are headed by a female with no spouse, accounting for approximately 14% of all such households in NYS.¹⁹⁸ Approximately 30% of all households in the Bronx are comprised of a single person living alone.¹⁹⁹ (See Appendix B, Table 19.) A number of focus group participants expressed concerns about single parent households, feeling that they are in need of supports:

Like counseling for a lot of people in this community because we have a lot of broken families, which is single mothers, and single fathers, too. And that's why a lot of our youth have the tendency to don't continue in school, and get into drugs. And also men, you know, and women are getting into drugs. So I think that we should have more services – programs, services that they could allot for counseling regarding help about how to deal with divorce, how to deal with a parent leaving, things like that. (focus group participant)

Serious Housing Violations²⁰⁰ and Housing Environment

Many lower income populations live in apartments with poor maintenance, but given the restricted options, they have little leverage when advocating for repairs. Higher rates of serious housing violations per 1,000 units are found along either side of the Grand Concourse from High Bridge to Fordham – Bronx Park.²⁰¹ (See Appendix A, Map 15.) Concerns about housing, including high rents and poor conditions, are a significant source of stress for lower income residents.²⁰²

Housing big, big need. You have individuals that are complaining that landlords are converting their buildings into shelter-like settings and offering tenants that have been there for several years \$5,000, \$6,000 to move out so that they can convert that building and secure city funding and reimbursement for that type of client profile or tenant profile (key informant, community based organization)

As noted above, there are approximately 97 NYCHA Developments and 124 NYCHA Community Facilities located in the Bronx.²⁰³ NYCHA community facilities and shelters appear to be located predominantly in the southern Bronx neighborhoods of Crotona – Tremont, High Bridge–Morrisania and Hunts Point – Mott haven (though the eastern portion of Hunts Point – Mott Haven appears to have

¹⁹⁸ US Census American Community Survey, 5 year data table, 2008-2012.

¹⁹⁹ Ibid.

²⁰⁰ “Serious housing violations” are Class C (immediately hazardous) housing code violations issued by the NYC Department of Housing Preservation and Development.

²⁰¹ *State of New York City's Housing and Neighborhoods in 2013: The Bronx*. NY: NYU Furman Center; 2013:22.

²⁰² Ibid.

²⁰³ This compares to 103 NYCHA developments and 146 community facilities in another large NYC borough, Brooklyn, and 352 NYCHA developments and 536 community facilities in NYC overall. New York City Housing Authority (NYCHA) “NYCHA Development Data Book,” as of 2014. New York City Housing Authority “Directory of NYCHA Community Facilities,” as of 2013.

very few of these resources). Comparatively, Northeast Bronx, Kingsbridge – Morrisania and Pelham – Throgs Neck seem to have few housing resources. (See Appendix A, Maps 90-91.)

Homeless Population

The NYC Department of Homeless Services houses approximately 55,000 people per night through its shelter system; there are an estimated 3,000 people living on the street in NYC. The homeless population includes single adults and families with and without children. Although many are people that have come into the system due to particular interpersonal or economic difficulties, others have behavioral health issues that make it difficult to remain housed, and which may be, in turn, further exacerbated by homelessness. According to a key informant that works with the homeless:

A lot of clients have very significant mental illness; very significant substance use – largely, alcohol, but ... a lot of opioids. ... Our clients are not different than the highest poverty clients.

I think on the Families with Children side, there is a very significant proportion of our families coming in because they are domestic violence [DV] victims. And, they may not qualify for a DV shelter. That's something that's determined at our intake center. Or, they may decline going to a DV shelter – even though they qualify for it. Of course, the psychological and sometimes physical ramifications of having been a DV victim – for both the Head of Household – the responsible parent – and for the kids is very, very significant.

Homeless New Yorkers tend to be disconnected from primary care and a medical home and are reportedly frequent users of emergency departments. According to the key informant cited above:

Our clients use EMS all the time for things that – if one were confident that they had a medical home – they would be calling. A child has a 102 degree fever – this is not a newborn. We would call our pediatrician and ask what to do. But, they are not calling pediatricians.... I think, often feel disconnected. Maybe they've been placed in a borough that is not their home borough, and they're not connected to the doctor who was across the street.

She attributes a portion of this lack of coordination to hospital and provider practice:

If I'm hospitalized at Hospital X, and I have an outpatient service – the expectation ... is that: You've had them on your inpatient service for two weeks. Have this institutional transference and pop them into your outpatient service – whether it be psych or medical. It's not happening. They're being sent to walk-in clinics. If it's a voluntary hospital, we're not seeing them take ownership. Sometimes they're sent to an HHC hospital.... The hospitals – and I say this not only about our psychiatrically ill populations but even about our Family shelters: They have no clue, for the most part, as to where these homeless people are landing, what services are in the shelters, what connection they have to medical services, what they're able and not able to

do. You can't give a single adult or a street homeless person an appointment for a colonoscopy three weeks from now. You can't. If you think that somebody needs a colonoscopy – you have to do it while you have them inpatient.

Recommendations for improved coordination of care, more efficient use of services, and improved health focus on targeted outreach and care coordination involving multiple hospital staff persons, including social workers in the emergency department and on the inpatient service. In addition, key informants in multiple fields emphasized the importance of supportive housing for high need homeless populations.

Crime and Jail Admissions

While crime has been declining overall in NYC for the past 15 years, the issue persists in parts of the Bronx.²⁰⁴ Data suggests that the highest rates of serious crime in the borough are in the South Bronx. (See Appendix A, Map 14.) Residents describe a proliferation of guns, particularly among young people, and fear of “who’s crazier than you out there.” Despite reported declines, violence and safety were significant concerns in certain Bronx communities, limiting engagement in physical activity for children and adults.²⁰⁵

Along with a declining crime rate and Rockefeller drug law reforms in 2009, the number of new NYC Jail and NYS Prison admissions has been steadily declining over the past 15 years.²⁰⁶ Despite the reductions in crime and incarceration, concerns around aggressive policing practices remain a concern to key informants that work with affected populations, who emphasized the diminished life chances resulting from involvement in the criminal justice system and the need to place a greater emphasis on alternative to incarceration and disincentives for inappropriate guilty pleas, particularly for crimes, like sex work, that may be motivated primarily by the need to survive rather than by criminal intention.²⁰⁷

I mean we’re big supporters of not having young, black and Latino men get criminal records that early in their lives. Then what happens to them when they’re at Rikers and in the prison system? And then what happens when they come back and are there jobs for them, and what are they going to wind up doing, and what kind of diseases are they exposing themselves to? (Key informant, community based organization)

Domestic Violence

Domestic violence is a topic that resonated with several interviewees and focus group participants as a significant community concern that has received inadequate attention. Of Bronx survey respondents,

²⁰⁴ Brennan Center “How NYC Reduced Mass Incarceration”. Accessed August , 2014 at

http://www.brennancenter.org/sites/default/files/publications/How_NYC_Reduced_Mass_Incarceration.pdf

²⁰⁵ NYAM primary data findings, September, 2014.

²⁰⁶ Brennan Center for Justice at New York University School of Law “How NYC Reduced Mass Incarceration”.

²⁰⁷ Ibid.

31% reported that health education or programs on domestic violence are needed in their community. Although not necessarily more prevalent, domestic violence issues were particularly relevant in immigrant communities, due to possibly different standards in their home country as compared to the US, stigma, lack of linguistically and culturally appropriate resources, and fear of deportation—particularly in mixed immigration status families. Immigrant groups coming from war-torn countries may also perpetuate the violence they experienced. Examples of comments from key informants and focus group participants include:

There are these young men in his community that the image that they have always seen when they were growing up was the way that their fathers would treat their mothers, right? And then they realized later on when they were kind of able to unpack it and get treatment was really, when you come from communities who have been just so devastated by war and by trauma, that what was happening to the fathers and their uncles is that a lot of times they didn't get treatment. They were totally traumatized, and they were taking it out on the mothers. So that's how – so these young men were growing up thinking, well, that's how you treat women. (key informant, immigrant focused organization)

A provider, working for many years with low-income children, described the perceived pervasiveness of domestic violence:

Our psychologist in our early childhood program I asked him what percentage of kids in our early childhood program he thought has [observed] domestic violence and he said 100 percent (key informant, provider)

Section ii: Health Status

According to Bronx residents completing the CNA survey, the greatest health concerns in their community are diabetes (55%), drug and alcohol use (47%), hypertension (41%), asthma (39%), obesity (35%), and cancer (34%). The most common self-reported health problems were hypertension (26%), asthma (20%), chronic pain (20%), high cholesterol (19%), and depression or anxiety (19%).

Approximately 34% of respondents were overweight and 31% were obese; 25% described their health as fair or poor. Community residents participating in focus groups echoed these concerns and also added behavioral health issues such as depression and anxiety. Violence was also commonly cited as a significant problem in the Bronx. These overall findings correlated to information provided by key informants and focus group participants, for example:

I'm looking at obesity, I'm looking at smoking, I'm looking at and hearing as well as diabetes, hypertension. You know, we have a senior population that's also in poverty mode (key informant, community based organization)

Leading Causes of Death and Premature Death

'Diseases of the heart' is the leading cause of death among White, Black and Hispanic populations in the Bronx.²⁰⁸ The top ten causes in order are: diseases of the heart, cancer, influenza and pneumonia, diabetes, chronic lower respiratory disease, cerebrovascular disease (stroke), accidents except drug poisoning, essential hypertension and renal diseases, mental and behavioral disorders due to accidental poisoning and other psychoactive substance use, and Alzheimer's disease. The leading causes of death in the borough are closely aligned to those in NYC and NYS. (See Appendix B, Table 26.)

The top five causes of premature death in the Bronx are cancer, heart disease, unintentional injury, AIDS, and diabetes.²⁰⁹ This closely aligns with the top five causes of premature death in NYC, and matches the top three causes of death in NYS, for the same time period.²¹⁰ (See Appendix B, Table 27.)

Potentially Preventable Hospitalizations (PQI), Emergency Visits (PPV), and Readmissions (PPR)

In the Bronx in 2012, there were a total of 151,653 inpatient hospitalizations, approximately 9% (13,447) of which were considered potentially preventable.²¹¹ The Bronx has higher than expected rates of potentially preventable inpatient (PQI) hospitalizations, with the highest ratio for of Observed /

²⁰⁸ New York City Vital Statistics, "Top Ten Leading Causes of Mortality 2012," accessed via the EpiQuery interactive tool, August, 2014.

²⁰⁹ Premature deaths (< age 75) for the three years 2010-2012. Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics.

²¹⁰ The number 4 cause of premature death in NYS for the same time period is Lower Respiratory Disease, and the 5th cause is Diabetes.

²¹¹ In the same time period, in NYC, 7.6% (45,026/593,363), and in NYS, 7.2% (68,948/954,889) of hospitalizations were considered potentially preventable. Source: NYS DOH 2012.

Expected (O/E) hospitalizations for diabetes in the Bronx.²¹² (See Appendix B, Table 44.) Within the borough, the highest overall O/E PQI ratios are consistently found in a single narrow cluster that reaches from the Williamsbridge and Fordham–Bronx Park area in the north, and continues southward along the east side of the Grand Concourse through Belmont, East Tremont, Claremont Village, and Morrisania, to Mott Haven. (See Appendix A, Map 35.) Turning to absolute numbers of PQI admissions, the geographic areas of concern extend to the areas west of this corridor, to the communities between the Grand Concourse and the Harlem River. (See Appendix A, Map 35.)

Region	PQI S01 Diabetes composite		PQI S02 Circulatory Composite		PQI S03 Respiratory Composite	
	PQI admissions	O/E ratio	PQI admissions	O/E ratio	PQI admissions	O/E ratio
Bronx	2,775	1.24	3,173	1.34	4,116	1.42
NYC	9,289	1.01	11,116	1.06	12,216	1.02
NYS	14,121	1.00	15,795	1.00	18,654	1.00

This general pattern of clustering holds true when looking at the disease-specific composite measures, with the notable concentration of young adult asthma and respiratory composite PQI hospitalizations in the southern part of the borough, extending across both sides of the Grand Concourse. (See Appendix A, Maps 41, 52). The 2009-2012 trend data for the whole of the Bronx across the Chronic Composite PQI and the major diagnostic category composite PQIs are presented in Appendix B, showing a slight general downward pre-DSRIP trend. (See Appendix B, Charts 45-51.)

²¹² The Observed/Expected ratio is a measure of how well each geographic region is doing, taking into account basic demographic differences. A ratio less than 1.00 denotes performance that is better than expected; a ratio greater than 1.00 denotes performance that is worse than expected.

All PQI Indicators

PQI Indicator	# of Medicaid PQI Hospitalizations, Bronx	# of Medicaid PQI Hospitalizations, NYC	# of Medicaid PQI Hospitalizations, NYS	PQI Observed / Expected ratio		
				Bronx	NYC	NYS
Adult Overall Conditions Composite (PQI 90)	13,447	44,943	69,084	1.31	1.02	1.00
Adult Chronic Conditions Composite (PQI 92)	10,063	32,619	48,568	1.34	1.03	1.00
Adult All Diabetes Composite (PQI S01)	2,775	9,289	14,121	1.24	1.01	1.00
Adult Diabetes Short-term Complications (PQI 01)	792	2,533	4,506	1.13	0.91	1.00
Adult Diabetes Long Term Complications (PQI 03)	1,585	5,357	7,572	1.31	1.07	1.00
Adult Uncontrolled Diabetes (PQI 14)	327	1,178	1,679	1.16	1.04	1.00
Lower Extremity Amputation among Adults with Diabetes (PQI 16)	136	432	699	1.38	0.97	1.00
Adult All Circulatory Conditions Composite (PQI S02)	3,173	11,116	15,795	1.34	1.06	1.00
Adult Hypertension (PQI 07)	969	2,991	3,938	1.51	1.10	1.00

PQI Indicator	# of Medicaid PQI Hospitalizations, Bronx	# of Medicaid PQI Hospitalizations, NYC	# of Medicaid PQI Hospitalizations, NYS	PQI Observed / Expected ratio		
				Bronx	NYC	NYS
Adult Heart Failure (PQI 08)	2,013	7,426	10,902	1.28	1.04	1.00
Adult Angina Without Procedure (PQI 13)	191	699	955	1.26	1.09	1.00
All Adult Respiratory Conditions Composite (PQI S03)	4,116	12,216	18,653	1.42	1.02	1.00
COPD and Asthma in Older Adults (PQI 05)	3,383	10,486	16,244	1.38	1.01	1.00
Asthma in Younger Adults (PQI 15)	733	1,730	2,410	1.61	1.11	1.00
Adult Acute Conditions Composite (PQI 91)	3,384	12,328	20,521	1.24	0.99	1.00
Adult Dehydration (PQI 10)	691	2,403	3,958	1.26	0.98	1.00
Adult Bacterial Pneumonia (PQI 11)	1,424	5,353	9,347	1.20	0.96	1.00
Adult Urinary Tract Infection (PQI 12)	1,269	4,572	7,216	1.27	1.04	1.00
Pediatric Overall Conditions Composite (PDI 90): ages 6-17 years	1,151	2,909	3,774	1.58	1.19	1.00

PQI Indicator	# of Medicaid PQI Hospitalizations, Bronx	# of Medicaid PQI Hospitalizations, NYC	# of Medicaid PQI Hospitalizations, NYS	PQI Observed / Expected ratio		
				Bronx	NYC	NYS
Pediatric Chronic Conditions Composite (PDI 92): ages 6-17 years	958	2,255	2,903	1.69	1.19	1.00
Pediatric Asthma (PDI 14): ages 2-17 years	1,865	4,282	5,384	1.80	1.73	1.00
Pediatric Diabetes Short-term Complications (PDI 15): ages 6-17 years	74	234	380	1.16	1.04	1.00
Pediatric Acute Conditions Composite (PDI 91): 6 - 17 years	193	654	871	1.17	1.16	1.00
Pediatric Gastroenteritis (PDI 16): ages 3 months - 17 years	558	1,758	2,333	1.31	1.18	1.00
Pediatric UTI (PDI 18): ages 3 months - 17 years	134	602	929	0.80	1.04	1.00

Data Source: New York State Dept of Health, 2012

Potentially Preventable ER Visits (PPV)

There were 346,837 Potentially Preventable Emergency Visits (PPV events) in the Bronx in 2012. The overall Observed/Expected (O/E) PPV ratio for the Bronx is 1.06, but the range of PPV/100 Beneficiaries across zip code areas was wide, 23.7 – 49.4 with a corresponding O/E ratio range of 0.80 – 1.27, indicating opportunities for reducing PPV. (See Appendix A, Map 54.) Primary data findings from focus groups and key informant interviews point to rational bases for beneficiaries’ choice of utilizing ED for primary care and specialty care services available in one stop. Establishing co-located primary care services—and/or a more effective case management and referral system— in Emergency Departments, with services structured in a patient-centered manner informed by these findings, may divert inappropriate and costly primary care delivery from Emergency Departments in areas of the Bronx with high numbers of PPV events, which are found along either side of the Grand Concourse from High Bridge – Morrisania to the northern border of the borough (See Appendix A, Map 54.)

Factors that contribute to high emergency department visits include long wait times for medical appointments. Among survey respondents using emergency rooms in the past year, 12% reported that “*didn’t have insurance,*” was the reason for using the ER.

I know of this one person who was afraid that she had cancer of some type, and she had an appointment that was three months away. She said after a week she was going bonkers, went to the ER, says, “Let them test me here, let them run the x-rays and all that,” and that’s what she did. And she got information before the three month period. She said, “I could be dead by then.” (Key informant, community based organization).

Our neighborhood there in Mott Haven sees a lot of overdose, sees a lot of violence, is disproportionately impacted by a lot of things that would send you to the emergency room, but it’s not managed in an outpatient setting or a primary care setting like diabetes and heart disease, which we see a lot of, asthma. It’s interesting, in our pharmacy, we get aggregate data on the top medications and prescriptions that are delivered to our folks, and number one by far are psychiatric medications, which is something that can easily send you to the emergency room if it’s not managed. (Key informant, community based organization)

Potentially Preventable ER Visits (PPV)	NYS	NYC	Bronx
Medicaid PPV Events	2,111,519	1,191,549	346,837
Medicaid Zip Code Population	5,852,350	3,593,035	822,108

Potentially Preventable Readmissions (PPR)

The Observed / Expected ratios of Potentially Preventable Readmissions (PPRs) for Bronx hospitals range from 1.03 to 1.26 (excluding one small sample size outlier), with an overall ratio of 1.13.

Facility Name	At Risk Admissions	Observed PPR Chains	Observed / Expected PPR	Observed PPR Rate	Expected PPR Rate	Expected PPR Chains
BRONX LEB HSP CTR CONCOURSE DIV*	15,869	1,443	1.14	9.09	7.95	1,262
CALVARY HOSPITAL	61	7	2.54	11.48	4.52	3
JACOBI MEDICAL CENTER	10,172	694	1.03	6.82	6.65	676
LINCOLN MEDICAL/MENTAL HLTH	13,130	855	1.07	6.51	6.1	801
MONTEFIORE MEDICAL CENTER	32,086	2,381	1.11	7.42	6.67	2,140
NORTH CENTRAL BRONX HOSPITAL	4,551	311	1.10	6.83	6.19	282
ST BARNABAS HOSPITAL	10,287	1,134	1.26	11.02	8.76	901
BRONX HOSPITALS TOTAL	86,156	6,825	1.13	n/a	n/a	6,065

Source: New York State Department of Health, 2012

*PPR is not available from DOH for Bronx Lebanon Fulton Division, which offers behavioral health related services.

Post-discharge issues focused primarily on the difficulties community members have adhering to medical recommendations in under-resourced and stressful home environments.

Patients that are going hungry and they don't even ask the question – is there enough food in the home or do you need a referral to a food pantry or Meals on Wheels program? And then, you know, if they're going through their treatment and there are all these other medications and you don't have food, it upsets everything and it contributes to another visit to the hospital (key informant, community based organization)

They will not have the ability to go back home and continue the behavior, because the support systems are not adequate. So we try to give them home care, sometimes we advise them on mid-level specialties, things like that. We are talking about really sick patients here. You know, so I see that everybody's working, everybody has issues, they have their own problems, health problems, so you can see the lack of support (key informant, provider)

BEHAVIORAL HEALTH

Mental Health

Among the Bronx population as a whole, the age-adjusted percentage of adults with poor mental health for 14 or more days of 9.1%, as well as the age-adjusted suicide rate of 5.4%, are lower than the state rates and roughly on par with citywide rates.²¹³ However, in the Bronx, 7.1% of all people report experiencing serious psychological distress, compared to 5.5% in NYC overall.²¹⁴ (See Appendix B, Table 31.) The Pelham-Throgs Neck area, in particular, appears to be disproportionately impacted by psychological distress with approximately 9% of residents reporting it. Those in Hunts Point-Mott Haven, High Bridge-Morrisania and Crotona-Tremont also report high rates of psychological distress, with approximately 5%-8% of those surveyed reporting it. The myriad of stresses on lower income residents were considered overwhelming to some and contributed to high levels of depression.²¹⁵ Low-income immigrant populations may have additional stressors, as well as poorer access to care, due to insurance and language issues.²¹⁶

Alcohol/Drug Use

Community members also marked that substance use and alcohol abuse are pressing issues. Indeed, in 2012, the last year for which data is available, an estimated 639.2 per 100,000 emergency room visits in NYC were due to non-alcohol, illicit drugs.²¹⁷ In the Bronx, the age-adjusted percentage of adult binge drinking among the total population “during the past month” for the borough was nearly one-in-five (18%) in 2012, similar to the overall NYC rate (19.6%) for the same time period. (See Appendix B, Table 33.) Also, key informants described behavioral health issues as one factor in delaying or precluding appropriate preventive and primary health care. According to the director of Bronx CBO serving a number of residents with mental health and substance abuse issues, “*Survival is the most important*

²¹³ The “poor mental health” measure is from 2008-2009 BRFSS and Expanded BRFSS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. The suicide rate is for the years 2010-2012 from Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

²¹⁴ Serious psychological distress is a composite measure of 6 questions in the Community Health Survey regarding symptoms of anxiety, depression and other emotional problems. New York City Department of Health and Mental Hygiene, Community Health Survey 2012 data, as reported on Epiquery <http://nyc.gov/health/epiquery>, accessed August 2014.

²¹⁵ NYAM primary data findings, September, 2014.

²¹⁶ Ibid.

²¹⁷ Drug Abuse Warning Network, 2011: New York City – 5 Boros: Drug-Related Emergency Department Visits, 2004-2011 - Illicits (excluding alcohol)Rockville, MD: Center for Behavioral Health Statistics and Quality, SAMHSA, 2013

thing, so not health, not seeing a doctor... but that's just – literally hustling to survive each day is the number one goal."

Mental health is an issue because of the complex environment they live in, the poor support. So we see a lot of depression, a lot of anxiety and that leads to an impact on their own health: adherence to medications, adherence to follow-up. Family getting separated because of that. There's a social impact because of their mental health and drug abuse. That's a problem it goes across all demographics (key informant, provider)

Comorbidities with physical health

There are no PQI measures of preventable hospitalizations related specifically to behavioral health. However, from New York State Office of Mental Health (OMH) data, we know that over half of the clients served by OMH-licensed and OMH-funded programs have one or more physical chronic health conditions, indicating a need for coordinated behavioral and physical health care. Approximately 54.4% (9,215/16,942) of Bronx clients served had at least one chronic medical condition. (See Appendix B, Table 32.) In 2012, 188,401 Bronx Medicaid beneficiaries had behavioral health-related service utilization (including pharmacy). Of these beneficiaries, 62,092 had an inpatient admission during the year, for any reason, i.e., the admission was not necessarily related to behavioral health. These 62,092 beneficiaries represent 7.6% of all Bronx Medicaid beneficiaries, and they accounted for a total of 151,167 inpatient admissions in 2012. They were concentrated in neighborhoods located on either side of the Grand Concourse from Fordham–Bronx Park to High Bridge–Morrisania. (See Appendix A., Map 31.)

The geographic distribution of behavioral health resources (see Appendix A, Map 88) appears to match the widespread distribution of behavioral health-related service utilization in the Bronx;²¹⁸ however, questions as to the adequacy of these resources in terms of capacity were raised in focus groups and key informant interviews. Per DSRIP behavioral health clinical improvement projects, the integration of behavioral health specialists into primary care clinics could help address this issue if it entails a net increase of behavioral health resources. Further, it may also address low behavioral health services utilization among some beneficiaries resulting from the stigma associated with having a behavioral health condition and seeking treatment at a behavioral health services provider location. Conversely, the integration of primary care services into existing behavioral health services settings could help address the high rates of co-morbidity between behavioral health and chronic physical health conditions for those currently utilizing behavioral health services.

²¹⁸ These numbers and rates reflect possible duplicated counts of Medicaid Beneficiaries if a beneficiary's calendar year utilization was found by the NYS Department of Health to occur across multiple Episode Disease Categories (e.g., hypertension and congestive heart failure) within a single Major Diagnostic Category (e.g., Diseases and Disorders of the Cardiovascular System). Therefore, the numbers reflect Weighted Condition-Related Utilization, and the rates reflect Weighted Condition Prevalence Among Beneficiaries, by multiple counting beneficiaries for utilization across multiple co-morbidity Episode Disease Categories within a Major Diagnostic Category.

Care Coordination and Disease Management

According to providers themselves, the system is fragmented, with possibly poorer integration within behavioral health services themselves than between physical and behavioral health. Behavioral health services are reported to be highly regulated by multiple agencies: Office for People with Developmental Disabilities (OPWDD), Office for Alcoholism and Substance Abuse Services (OASAS), and Office of Mental Health (OMH) with patient care being restricted according to the funding and regulatory agency— despite the frequency of co-occurring disorders. Thus, a mental health provider might be limited in the severity of illness that can be treated, the age of the patient, and other factors.²¹⁹

Historically, your systems like OMH and OASAS, up until very recently, they really worked in silos. So if you came into a mental health clinic and in your intake appointment, you said, “You know, I smoke pot a couple times a week,” a red flag would go up. You talk to your supervisor and they say, “They have to go to substance abuse.” So until those doors really become integrated, I mean really become integrated in treatment and acceptance and a model of care, we’re going to continue to run into these types of challenges because it’s very fragmented. (key informant, multiservice organization)

Disease management is also a challenge. In the Bronx, 46% of Medicaid recipients who were prescribed antidepressant medications continued to use the medication for the entirety of the 12-week acute treatment phase, which is similar to NYC (47%) and slightly lower than NYS (50%).²²⁰ In the Bronx, 64% of children enrolled in Medicaid who were prescribed medication for ADHD completed a follow-up visit with a practitioner within 30 days of starting the medication (the initiation phase), which is on par with NYC (64%) and above the percent in NYS (56%).²²¹ Also, approximately 56% of adults enrolled in Medicaid in the Bronx who were hospitalized for a mental illness received a follow up within 7 days of discharge, which is just above the rate for all Medicaid beneficiaries in NYC and on par with the rate for Medicaid beneficiaries in NYS.²²² (See Appendix B Table 53.)

ASTHMA/RESPIRATORY CONDITIONS

CNA participants reported that asthma was among the most significant health concerns, with causation commonly attributed to indoor and outdoor environmental conditions, some of which are difficult to affect.²²³

If you start looking at the statistics, it's very mind-boggling the statistics on asthma in the Bronx. It's mainly related to the built environment. I mean there is a genetic predisposition, no doubt. ... But we call it the asthma alley because ...you have I87 Highway, you have the Cross Bronx

²¹⁹ Ibid.

²²⁰ QARR 2012

²²¹ QARR 2012

²²² Ibid.

²²³ NYAM primary data findings, September, 2014.

[Expressway], then you have I95. So, there's a triangle in the South Bronx, and the number of trucks—the traffic, 24/7 is jam-packed. And the inner roads all [have] pollution, particulate matter. All those things contribute a lot. And, of course, with the environment of the housing units, you have the mold and the cockroaches, and rodents. People live in conditions which are regularly ... We give care to people who come in walking through the door, we don't even do a history of them first, we just treat them in the asthma room. And then we discharge them. So they get the treat right away, but, but, ah, you know, they go back home and they have the same triggers and they get worse. (Key informant, provider)

While the observed rate of PQI respiratory admissions has declined in the Bronx since 2009, it remains far above the expected rate, with an Observed/Expected ratio of 1.42 for the Respiratory Composite PQI. (See Appendix B, Table 44 and Chart 50.) There were 4,116 Respiratory Composite (PQI S03) PQI hospitalizations in the Bronx in 2012. (See Appendix B, Table 44.) This includes 3,383 COPD or Asthma in Older Adults (PQI 05) PQI hospitalizations and 733 Asthma in Younger Adult (PQI 15) PQI hospitalizations. (See Appendix B, Table 44.) The areas of the Bronx with the highest PQI respiratory composite hospitalizations are located in a corridor that runs from parts of Fordham-Bronx Park south along both sides of the Grand Concourse to Hunts Point – Mott Haven. (See Appendix A. Map 41.)

When looking at the location of asthma health care resources in relation to Respiratory Composite PQI hospitalizations (See Appendix A Map 73), there appears to be fairly good alignment of health care resources to need; however, the relationship of these resources to the prevention of PQI hospitalizations is uncertain, especially when considering additional socio-demographic variables that may be influencing the PQI hospitalization outcome. Limited data is available regarding home environmental triggers. However, data on the rate of serious housing violations by Community District, i.e., housing code violations that are considered “immediately hazardous or serious,” show prevalence in many of the same neighborhoods with high numbers of preventable respiratory PQI hospitalizations (See Appendix A, Map 15).

Asthma in younger adults and children

The highest total Medicaid PQI hospitalizations for asthma among young adults occurs along the same corridor as does the PQI respiratory composite. (See Appendix A, Map 52.) Among children in the Bronx who are Medicaid beneficiaries, the asthma rate of 701.47 per 100,000 is higher than the NYC overall rate of 426.91 per 100,000 and the NYS overall rate of 210.39 per 100,000.²²⁴ Childhood asthma rates in the borough range from 418.8 per 100,000 in Kingsbridge-Riverdale to 987.9 per 100,000 in Hunts Point. Additionally, DOH data suggests that the majority, 981 or 52.6%, of the 1,865 pediatric asthma preventable PDI hospitalizations in 2012 were among very young children, aged 2-5.²²⁵

²²⁴ Medicaid Prevention Quality Indicators, 2012.

²²⁵ The asthma PDI is reported for children aged 2-17, but the PDI chronic composite (which includes asthma and diabetes) is reported only for those aged 6-17. Thus the difference (decrease) in numbers between those two measures is a result of the loss of the asthma admissions for children aged 2-5 in the chronic composite. Thus, it is

Asthma in Older Adults

Among older adults in the Bronx, the COPD/Asthma PQI O/E ratio is 1.38, significantly higher than the city ratio of 1.01. (See Appendix B, Table 44.) Consistent with other asthma indicators, the highest number of Medicaid PQI hospitalizations for COPD and asthma in older adults are clustered in the corridor from Fordham-Bronx Park south to the South Bronx. (See Appendix A, Map 44.)

CARDIOVASCULAR DISEASE

Heart disease is the top cause of mortality among the white, black, and Hispanic populations of the Bronx.²²⁶ It is also second leading cause of premature death in the borough.²²⁷ The age adjusted cardiovascular disease hospitalization rate in the Bronx is 210.8 per 10,000, higher than either NYC (173.6) or NYS (159.9).²²⁸ Similarly the age adjusted mortality rate for diseases of the heart was 225.8 in the Bronx, 212.2 in NYC, and 198.6 in NYS.²²⁹ Within the broad category of heart health – cardiovascular disease – and stroke, the Bronx fares worse than NYC and NYS on all age-adjusted indicators.²³⁰

In 2012, the number of potentially preventable hospitalizations among Medicaid beneficiaries for circulatory conditions (PQI S02 Circulatory Composite) in the Bronx was 3,173, accounting for about one in five (20.1 %) of all such admissions in the State. (See Appendix B, Table 44.) The ratio of observed/expected (O/E) admissions in the Bronx (1.34) was higher than the ratio for NYC (1.06) for the same time period. (See Appendix B, Table 44.) At the zip code level within the borough, the highest number of preventable hospitalizations and the highest observed / expected PQI ratios for the Circulatory Composite measure are found along the Grand Concourse from High Bridge – Morrisania to Fordham – Bronx Park. (See Appendix A, Map 40 .)

Approximately 185.02 out of 100,000 Medicaid beneficiaries in the Bronx were hospitalized for conditions related to hypertension, compared to 124.02 in NYC and 105.5 in NYS. In 2012, there were 969 potentially preventable hospitalizations among Medicaid beneficiaries for hypertension (PQI 07) in the borough. (See Appendix B, Table 44.) The variation in hospitalization rates for conditions related to hypertension between neighborhoods in the Bronx is wide. For example, the rate in Kingsbridge-

the young children aged 2-5 that represent the bulk of the asthma PDI numbers. As explained in an email transmission from the NYS DOH dated August 25, 2014: “Each PDI has a different age criteria, asthma is 2-17 years, diabetes is 6-17 years, gastroenteritis and uti are both 3 months to 17 years. These 4 PDI make up the overall composite PDI, however, that age criteria is 6-17 years. This results in the loss of patients age 3 months up to 6 years, hence the decrease in numbers. The same situation occurs in the acute and chronic composites. The composite age group is 6-17, however, that doesn’t reflect the actual age groups in the individual measures.”

²²⁶ New York City Vital Statistics, “Top Ten Leading Causes of Mortality 2012,” accessed via the EpiQuery interactive tool, August, 2014

²²⁷ Premature deaths (< age 75) for the three years 2010-2012. Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics

²²⁸ 2009-2011 data reported on the NYS Dept of Health Website County Health Assessment Indicators, https://www.health.ny.gov/statistics/chac/chai/docs/chr_58.htm, accessed September, 2014.

²²⁹ Ibid.

²³⁰ Ibid.

Riverdale is 115.66 per 100,000, compared to a rate of 261.85 in the Northeast Bronx. (See Appendix A, Map 45.)

There were 2,013 potentially preventable hospitalizations among Medicaid beneficiaries for heart failure (PQI 08) in the Bronx. (See Appendix B, Table 44.) The range for observed/expected admissions heart failure was 0.7 to 2.87. The lowest rates in Kingsbridge-Riverdale and highest in Pelham Bay-Throgs neck area. (See Appendix A, Map 46.)

In 2012, adult angina without procedure (PQI 13) accounted for 191 potentially preventable hospitalizations in the Bronx. (See Appendix B, Table 44.) The range for observed/expected admissions for adult angina without procedure is 0.0 to 2.1, with the lowest rates in the Throgs Neck- Pelham Bay and Kingsbridge-Riverdale areas and the highest in Highbridge, Bedford Park, Mott haven, Port Morris, Baychester, Wetchester Heights, and Parkchester. (See Appendix A, Map 50.)

The highest rates of cardiovascular-related service utilization (including pharmacy) among Medicaid beneficiaries were found in Kingsbridge – Riverside and Northeast Bronx; however, the highest numbers were found along either side of the Grand Concourse from High Bridge – Morrisania to Fordham – Bronx Park.²³¹ (See Appendix A, Map 26.) In regard to disease information and support services, these areas of the Bronx with high rates of condition-related utilization and high numbers of circulatory composite PQI hospitalizations appear to have those services available, with the exception of the Fordham – Bronx Park area. Specialty cardiology services similarly appear to be located in or near the areas of greatest need, with the exception of the Fordham – Bronx Park area (See Appendix A, Map 71.)

DIABETES

The diabetes composite PQI (S01) for the Bronx (1.24) is higher than for New York City (1.01) and New York State (1.00).²³² (See Appendix B, Table 44.) Many community members see diabetes as their greatest health concern.²³³ Within the Bronx, the range for PQI S01 observed/expected ratios is 0.8 to 2.26. (See Appendix A, Map 39.) Across New York State, only 51% of Medicaid Managed Care beneficiaries with diabetes received all recommended tests in the last year, and 33% of Medicaid Managed Care beneficiaries in NYS with diabetes have poorly controlled HbA1c (>9%).²³⁴

²³¹ These numbers and rates reflect possible duplicated counts of beneficiaries if a beneficiary's calendar year utilization was found by NYS DOH to occur across multiple Episode Disease Categories (e.g., hypertension and congestive heart failure) within a single Major Diagnostic Category (e.g., Diseases and Disorders of the Cardiovascular System). Therefore, the numbers reflect the Weighted Number of Beneficiaries with Condition-Related Utilization, and the rates reflect the Weighted Condition Prevalence Among Beneficiaries, by multiple counting beneficiaries for utilization across multiple co-morbidity Episode Disease Categories within a Major Diagnostic Category.

²³² NYS Dept of Health 2012 data, accessed August, 2014.

²³³ NYAM Primary data findings, September, 2014.

²³⁴ QARR, 2011

Hospitalizations

Rates of Medicaid avoidable hospitalizations in the Bronx for short-term diabetes complications are greater than those for New York City and New York State.²³⁵ The rate of hospitalizations for short-term diabetes complications (PQI 01) among Medicaid beneficiaries is higher in the Bronx (151.22 per 100,000) than in the city overall (105.03 per 100,000), and higher than the state overall (110.31 per 100,000).²³⁶ In terms of numbers of avoidable hospitalizations due to short-term diabetes complications, the Bronx overall had 792 PQI 01 hospitalizations with a borough-wide Observed/Expected (O/E) ratio of 1.13.²³⁷ (See Appendix B, Table 44.) Within the borough, twelve zip code areas with an O/E ratio greater than 1.00 account for 493 or 62% of these hospitalizations.²³⁸ (See Appendix A, Map 42.) These 493 hospitalizations are found in three clusters: from High Bridge-Morrisania to Crotona-Tremont east of the Grand Concourse; in northeast Bronx from north of Bronx Park to Pelham Bay Park; and in southeast Bronx from Soundview to Throgs Neck (See Appendix A, Map 42.)

Long-term complications from diabetes hospitalization rates among Medicaid beneficiaries in the Bronx vary by neighborhood. Rates of such hospitalizations are highest in Kingsbridge, Mott Haven, and Pelham Bay Park neighborhoods. (See Appendix A Map 43.) Potentially preventable Medicaid hospitalizations for uncontrolled diabetes appears highest in East Tremont. (See Appendix A. Map 51.) Lower extremity amputation rates for Medicaid Beneficiaries with diabetes are largely concentrated in the north east Bronx. The highest rates are found in Eastchester, Baychester, Co-op City, Pelham Gardens, and Mott Haven. (See Appendix A, Map 53.)

The geographic concentration of Diabetes PQI hospitalizations makes the potential return on investment in practice reforms high in terms of reduced PQI admissions. The Diabetes Resources map (See Appendix A, Map 72) appears to show current geographic alignment of diabetes care management resources and need (shown in terms of Diabetes Composite PQI S01 hospitalizations) in or near the High Bridge-Morrisania, Crotona-Tremont, and Bronx Park areas; but apparently less alignment of resources with need in the northeast and southeast clusters where resources are lacking, although the areas between these two clusters do have specialty diabetes clinical resources.

HIV/AIDS and STDs

The fourth leading cause of premature deaths in the Bronx is AIDS, accounting for approximately 30% of all such deaths in NYC.²³⁹ The HIV/AIDS prevalence rate for the Bronx (approximately 1,660 per 100,000

²³⁵ NYS Dept of Health 2012 data, accessed August, 2014.

²³⁶ Ibid.

²³⁷ NYS Dept of Health 2012 data, accessed August, 2014.

²³⁸ Ibid.

²³⁹ “County Number of 3-Years Premature [< age 75] Deaths” Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics.

population) is higher than the NYC rate (1,370 per 100,000), and variation exists within the borough.²⁴⁰ Four UHF neighborhoods in the borough have a higher HIV/AIDS prevalence rate than the city as a whole: High Bridge-Morrisania (2,353/100,000), Hunts Point-Mott Haven (2,290/100,000), Crotona-Tremont (2,207/100,000), and Fordham-Bronx Park (1,696/100,000).²⁴¹ In terms of numbers of People Living with HIV/AIDS (PLWHA), these neighborhoods account for a total of 16,996 PLWHA or 73.7% of all PLWHA in the Bronx.²⁴² (See Appendix B, Table 35.) The age adjusted mortality rate for AIDS in the Bronx (20 per 100,000) is more than twice the rate of NYC (9.4 per 100,000) and four times the rate for NYS (4.7 per 100,000).²⁴³ Neighborhoods with the highest incidence of HIV also have higher rates of concurrent HIV/AIDS diagnoses, and are the same neighborhoods with the highest prevalence: Morrisania/High Bridge, and Mott Haven/ Hunts Point.²⁴⁴ (See Appendix B, Chart 38.)

Bronx residents who are HIV positive, or have been diagnosed with AIDS, have rates of viral load suppression (60.19%) slightly lower than New York City (61.2%) and New York State (62.2%).²⁴⁵ Among Medicaid Managed Care Beneficiaries in the Bronx who are HIV positive, or who have been diagnosed with AIDS, 91% are engaged in care, 69% received appropriate viral load monitoring, and 70% of those 19 or older received syphilis screening.²⁴⁶ Viral load suppression is a key factor in reducing transmission of HIV and maintaining good health.

Within the borough, there are wide racial disparities in HIV incidence. In 2011, the latest year for which data is available, the rate of new HIV diagnoses among African Americans living in the Bronx was nearly 4 times higher than the new HIV diagnosis rate among Whites living in the Bronx (76.7 compared to 19.1 cases per 100,000 people). The rate of new HIV diagnoses among Latinos living in the Bronx was more than 2 times higher than the new HIV diagnosis rate among Whites living in the Bronx (41.8 compared to 19.1 cases per 100,000 people). (See Appendix B, Chart 37).

According to key informants in the field, transmission among injecting drug users (IDUs) in the Bronx has dropped dramatically, likely due to access to clean syringes from syringe exchange programs—although hepatitis C remains a concern, since it is more easily transmitted.

In '95 ... the new infection rate among injection drug users was 54%, so literally one out of every two people had HIV or AIDS. Now it's under 4%. We've got very few new infections. We have a

²⁴⁰ NYC DOHMH 2011

²⁴¹ Ibid.

²⁴² 2011 data, the latest year for which information is available, from the New York City Department of Health and Mental Hygiene.

²⁴³ NYS Dept of Health County Health Assessment Indicators, 2009-2011, https://www.health.ny.gov/statistics/chac/chai/docs/sti_58.htm, accessed September, 2014.

²⁴⁴ Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

²⁴⁵ HIV Ambulatory Care Performance, 2011

²⁴⁶ QARR, 2012

lot – we see a prevalence around Hepatitis C, because it's so much more communicable, with the cotton and other stuff.

The HIV/AIDS Resources map (See Appendix A, Map 75.) suggests a geographic alignment between Medicaid Beneficiaries with an HIV/AIDS service utilization and the location of HIV/AIDS resources, which is also consistent with the prevalence PLWHS by UHF neighborhood. The existing health care and ancillary services structure appears to provide a strong foundation for implementing the related DSRIP projects. However, key informants providing services to HIV-infected individuals describe significant changes in funding priorities, with increasing resources going toward medical management, and less funding available for supportive services, including housing for people with HIV.

We still have the state ADAP program²⁴⁷ that covers immigrants, the undocumented and uninsured. So the system of care for HIV is well-built. What's peeling away are some of the supportive services that keep people in care or bring them to care in the first place. I think substance use treatment services and mental health services have blossomed finally.... Community-based programs that used to provide supportive services for HIV ... have been pared down, and there's more of a funder focus on medical [unclear] HIV care, putting more funding in the hospital setting for case management, HIV case management. (key informant, CBO)

Given the aging of the HIV/AIDS population, as well as the potential medical complications of HIV medications, they are also at high risk of more common chronic conditions, including diabetes and heart disease. Integration of medical and supportive services is therefore essential.

They're giving away a syringe while people's toes are falling off from diabetes and not asking about the diabetes. You're irrelevant if you start doing that.... That was the light bulb for me.... doing syringe exchange and ...[not] worrying about people's diabetes or psychiatric conditions, and that's what they were dying from. It's immoral, it's wrong to just focus on one thing because that's what you're funded to do. (key informant, community based organization)

Other STDs

The case rates for gonorrhea and chlamydia in the Bronx greatly exceed those of NYC and NYS. While some variation between neighborhoods exists, Kingsbridge/ Riverdale is the only neighborhood that has low STD rates. Crotona, Morrisania, and Mott Haven are the neighborhoods that have the highest rates of STDs. The all ages case rate for gonorrhea in the Bronx is (240.8 per 100,000) and in NYC (151.8 per 100,000) and NYS (95.8 per 100,000). All ages chlamydia case rates in the Bronx for both men and women (823.7 males and 1689.4 females per 100,000) are also dramatically higher than in NYC (508.7 males and 973.9 females per 100,000) and NYS (323 males and 674 females per 100,000). Similarly, the

²⁴⁷ The AIDS Drug Assistance Program (ADAP) provides free medications for the treatment of HIV/AIDS and opportunistic infections.

pelvic inflammatory disease hospitalization rate for females aged 15-44 years of age is 9.8 per 10,000 in the Bronx, but only 4.8 per 10,000 in NYC and 3.5 per 10,000 in NYS.

MATERNAL/CHILD HEALTH

Over the period 2010-2012, there were 21,867 live births per year on average in the Bronx, representing nearly one in five (18.5%) births in New York City and nearly one in ten (9.1%) in the State over the same time period.²⁴⁸ The percentage of all births in the Bronx that were Medicaid or self-pay was 75.4%, compared to 59.7% in NYC and 50.1% in the State; the percentage of Medicaid or self-pay births across Bronx zip codes ranged from 23.6% to 87.5%. (See Appendix A, Map 8.) Fertility rates are also higher in the Bronx (59 births in the past year per 1,000 women age 15-50) than in NYC (52 per 1,000) and NYS (50 per 1,000).²⁴⁹ For young women, the difference is even greater, with a rate of 34 births in the past year per 1,000 women age 15-19, compared to 21 per 1,000 in NYC and 17 per 1,000 in NYS.²⁵⁰ The highest fertility rates are found along the western side of the Grand Concourse from High Bridge to Fordham – Bronx Park, and in the south in Mott Haven, Hunts Point, and Soundview. (See Appendix A, Maps 6-8.) The teen pregnancy rate is also higher in the Bronx than NYC and NYS, at 60.8 per 1,000 compared to 44.2 per 1,000 in NYC and 35.7 per 1,000 in NYS.²⁵¹ (See Appendix A, Map 7.)

In 2012, the latest year for which data is available, the percentage of preterm births in the Bronx (12.2%) was higher than in NYC (10.8%) or NYS (10.8%).²⁵² Preterm birth is associated with low birth weight and poor health outcomes. The overall low birth weight (LBW) rate for the Bronx over the time period 2010-2012 was 9.5%, compared to 8.5% for NYC and 8.1% for the state.²⁵³ Within the Bronx, the LBW rates ranged from 1.9% to 12.8%, with the highest rates found in two clusters of zip codes – one in the south central part of the borough from Mott Haven, Morrisania, to Claremont Village; and the other in the northeast part of the borough in Wakefield, Eastchester, and Co-Op City. These neighborhoods also experience the highest rates of infant mortality. (See Appendix A. Map 6.)

Racial disparities also persist in the borough in the number of preterm births, with 1.4 times the number of preterm births among the black population than among the non-Hispanic white population for the time period 2010-2012 and 1.2 times the number of Hispanic preterm births than non-Hispanic white preterm births in the same time period.²⁵⁴ (See Appendix B, Table 68). Though, these racial and ethnic disparities were narrower in the Bronx than in NYC and NYS in the same time period.²⁵⁵

²⁴⁸ NYS Vital Statistics, 2010-2012, <http://www.health.ny.gov/statistics/chac/perinatal/>, accessed September 2014.

²⁴⁹ Ibid.

²⁵⁰ Ibid.

²⁵¹ NYS Vital Statistics, 2012

²⁵² NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

²⁵³ Ibid.

²⁵⁴ Ibid.

²⁵⁵ The ratio of black to white preterm births in NYC was 1.8 and in NYS was 1.62 for the period 2010-2012. The ratio of Hispanic to white preterm births in NYC was 1.39 and in NYS was 1.25 for this time period. Source: NYS

In the Bronx, the percentage of mothers receiving prenatal care starting in the first trimester was lower than the NYS and NYC rates (71.8% and 70.4%, respectively) by over 10%, and more than one-third (37.0%) of mothers in the Bronx received prenatal care beginning in the third trimester (months 7-9), compared to 23.9% for NYS and 28.7% in NYC.²⁵⁶ (See Appendix B, Table 61). Additionally, the Bronx neonatal death rate was slightly higher than NYC and NYS at 3.5 per 1,000, compared to 2.9 per 1,000 in NYC and 3.3 per 1,000 in NYS.²⁵⁷

OBESITY

The prevalence of obesity in the Bronx is the highest of the city boroughs, with nearly one in three (32%) of all adults obese, versus approximately one in four (24.2%) in NYC and the State (23.6%).²⁵⁸ (See Appendix B, Table 66.) The obesity rate varies widely within the borough with the highest rates in a corridor from parts of Fordham-Bronx Park down to the South Bronx. There are also very high rates in parts of Pelham-Throgs Neck.²⁵⁹ (See Appendix A. Maps 17-18.) Among women and children participating in the United States Department of Agriculture Food and Nutrition Service Women Infant and Children (WIC) program, approximately 29% of pregnant women were overweight, and 27% of pregnant women were obese in the Bronx in the time period 2010-2012. The Bronx rates are higher than the corresponding rates in NYS (approximately 27% overweight, 24% obese) and NYC (approximately 27% overweight, 22% obese).²⁶⁰

In the Bronx, a mere 6% of adults report eating five or more fruits or vegetables per day, compared to approximately 9% in NYC and 27% in NYS.²⁶¹ Roughly 70% of adults reported participating in a leisure time physical activity in the last 30 days, slightly lower than NYC (72%) and NYS (76%) rates. Focus group participants attributed obesity to a number of causes, including the limited access and relatively high cost of healthy food. They also described the challenges of changing dietary behavior in general—and of losing weight, in particular—despite obvious negative health consequences. Cultural preferences for fried and certain high caloric foods were acknowledged.

The South Bronx: number one, it's a healthy food desert. I think it's getting better because of concerted efforts by a lot of people, businesses and funders and City Harvest and Food Bank have done remarkable work on that. But I think for the most part, if you walked into a bodega you

Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard, accessed August 2014.

²⁵⁶ NY State Vital Statistics, 2012

²⁵⁷ Ibid.

²⁵⁸ This is 2012 data for Bronx and NYC from the Community Health Survey, 2012. It is 2008-2009 data for New York State from the NYS Department of Health, County Health Assessment Indicators, 2010 –2012.

²⁵⁹ It should be noted these rates are by UHF neighborhood, as rates are not available at the zip code level, so there could be variation within these UHF neighborhoods that is not captured here.

²⁶⁰ Source: Bronx County: County Health Assessment Indicators, 2010 – 2012 data

http://www.health.ny.gov/statistics/chac/chai/chai_58.htm#bronx, accessed August 2014.

²⁶¹ 2008-2009 data found at Bronx County: County Health Assessment Indicators, 2010 – 2012 data
http://www.health.ny.gov/statistics/chac/chai/chai_58.htm#bronx, accessed August 2014.

wouldn't find a piece of fruit or a vegetable, and if you did, it would be like a plantain. Everything is canned. We've got people who are obese who are starving because they're eating empty calories. Chips and fried chicken and fried this and fried that. And so I think that's diet and a sedentary lifestyle and lack of access to fresh foods is a huge driver of the poor health of the Bronx, and the South Bronx in particular (key informant, community based organization)

Although obesity was commonly attributed to individual motivation and community conditions, more comprehensive and consistent messaging from providers was also recommended:

Talking about obesity would also be really helpful, because ... that's not something that doctors are really talking about or feel – they may feel uncomfortable raising or ill-equipped to talk to, talk about to people. ...Community members have reported back that doctors and health care professionals, in general, talk about certain illnesses, like diabetes, hypertension, heart – a lot of these things are inevitable, right? Or kind of like, "Okay, you have hypertension, here's your medication," as opposed to actually there are things that you can do, lifestyle changes that you can make. (key informant, health advocacy)

TOBACCO USE/CESSATION

The domain 4 project on this topic is intended to “promote tobacco use cessation, especially among low SES populations and those with poor mental health.”²⁶² The percentage of cigarette smoking among adults in the Bronx is roughly on par with NYC and NYS rates (15.8% in the Bronx versus 15.5% in NYC and 16.2% in NYS in 2012), but rates vary by neighborhood. Approximately one in five of adults in Pelham-Throgs Neck (21.2%) and the South Bronx (18.2%) report being a current smoker compared to less than one in ten in Kingsbridge-Riverdale (7.3%) and Fordham-Bronx Park (7.5%).²⁶³ (See Appendix B, Table 34.)

²⁶² New York's MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan, Attachment J."NY DSRIP Strategies Menu and Metrics," 2014.

²⁶³ These neighborhood estimates should be interpreted with caution. The estimate's Relative Standard Error (a measure of estimate precision) is greater than 30% or the sample size is less than 50, or the 95% Confidence Interval half width is greater than ten, making the estimate potentially unreliable. Source: NYC DOHMH Community Health Survey, 2012

Section iii: Domain 3 and 4 Metrics

Domain 3 Metrics: Clinical Improvement

See attached Appendix B.

Domain 4 Metrics: Improve Health Status and Reduce Health Disparities

See attached Appendix B.

SECTION C: IDENTIFICATION OF THE MAIN HEALTH AND HEALTH SERVICES CHALLENGES

The population in the Bronx is burdened by a myriad of health challenges and socioeconomic circumstances that foster poor health outcomes. It is the least healthy county in New York State, and has high rates of chronic disease such as diabetes, cardiovascular disease, and respiratory disease including asthma/COPD, cancer and high rates of obesity.²⁶⁴ The Bronx leads New York State in the percentage of premature deaths in people aged less than 65 years;²⁶⁵ the leading causes of these deaths in the county are cancer, heart disease, unintentional injury, AIDS and diabetes.²⁶⁶ The Bronx also outpaces NYC overall in household poverty and low educational attainment, and is approximately on par with city rates of unemployment and health insurance.²⁶⁷ More than half of the Bronx population speaks a language other than English in the home, and many are immigrants, presenting possible additional cultural and regulatory challenges to health care access.²⁶⁸ Among the Medicaid population, the Bronx ranks highest among all boroughs in NYC in the rate of potentially preventable inpatient admissions, including for chronic conditions overall, and for certain chronic conditions such as circulatory conditions, respiratory conditions and diabetes.²⁶⁹ It also ranks second among the NYC boroughs in the rate of preventable emergency room visits (PPV).²⁷⁰

From the perspective of the community, main health issues include diabetes, obesity, cancer, cardiovascular disease, asthma, violence and behavioral health issues, including anxiety, depression and

²⁶⁴ RWJ County Health Rankings, 2014, available at http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2014_NY_v2.pdf, accessed September 2014.

²⁶⁵ The Bronx figure is 33.9% compared to the NYS figure of 23.9%. Source: “Percentage of premature deaths (before age 65 years), 2012” New York State Prevention Agenda Dashboard, using Vital Statistics Data.

²⁶⁶ NYC DOHMH Epiquery System, Vital Statistics data, accessed August 2014.

²⁶⁷ US Census American Community Survey, 5-year table, 2008-2012.

²⁶⁸ According to US Census data, approximately one in five Bronx residents are not US Citizens (US Census American Community Survey, 5 year table, 2008-2012). It is possible that this number may be underreported due to undocumented individuals.

²⁶⁹ 2011-2012 Medicaid Prevention Quality Indicators, New York State Department of Health, Office of Quality and Patient Safety, 2014, as reported by the Office of Health Systems Management.

²⁷⁰ Ibid.

substance use.²⁷¹ Community members clearly connect these common health conditions to conditions of poverty, including—but not limited to—insecurity with respect to housing and other basic needs, unsafe environments, and poor access to healthy foods. Health problems were also connected with depression. However, the link between depression and poverty was also particularly obvious, as people worried about jobs, housing, entitlements, and the safety of their streets. The linkage to poverty makes the search for solutions more challenging.

You have to fight poverty. It doesn't necessarily always mean getting everybody a job but you can get people at least the entitlements, SNAP entitlements, the things that we fight for, get them into the shelter system or housed. I think those – that's why we spend so much time doing that work. It becomes easier to knock down the barriers to access to medical care and behavioral health... the Bronx, the Bronx Health County rankings came out again a week or two ago and that's what I brought up is we were 62 out of 62 again. So what you guys have been doing, hospitals, it ain't working. You can talk about – you can shift the conversation to population health and managing population health. It's not working, guys, and what I'm doing is not working. (key informant, community based organization)

A dramatic indicator of poverty, with obvious health implications, is food insecurity, which was described by multiple respondents.

It's just stunning to me the amount of hunger. We call our congregate food program an emergency food program, but the fact is even with food stamps, we've still got a lot of people coming to the program because food stamps aren't enough. (key informant, community based organization)

Patients that are going hungry and they don't even ask the question – is there enough food in the home or do you need a referral to a food pantry or Meals on Wheels program? And then, you know, if they're going through their treatment and there are all these other medications and you don't have food, it upsets everything and it contributes to another visit to the hospital (key informant, community based organization)

The costs incurred—in both time and money—for medical care remains very problematic and acts as a barrier to effective use of prevention and disease management services from the perspective of community members. The income criteria for Medicaid are described as unrealistic, given the cost of living in New York City, and the working poor who do not qualify for Medicaid cannot afford the premiums of insurance offered through the NYS Health Insurance Exchange.

Most people are leery as to whether they're going to be charged, what they can charge for and not be charged for. It basically boils down to money. You know, you make a choice. 'Do I go to the grocer or see the doctor? Do I pay my rent?' It's a money issue. (focus group participant)

²⁷¹ NYAM primary data findings, September, 2014

²⁷¹

And sometimes simply can't afford them, because not everybody's eligible for Medicaid, you know. And then there is this group of individuals that fall in between Medicaid and private health insurance. Unfortunately, that group is much larger than any of us would like to see (key informant, community based organization)

Community members (and providers) consistently describe long wait times for visits and long wait times at the time of a visit. Furthermore, the possible need for multiple visits (e.g., for tests or specialist services), discourages timely use of care and makes the emergency department a rational choice for “one stop shopping”.²⁷²

Furthermore, the policy environment reportedly presents a number of challenges to residents and providers. For example, funding and regulatory agencies have differing requirements, which 1) limits continuity of care for patients with multiple healthcare needs and 2) puts excessive demands on provider organizations that work with multiple systems. Funding for high-demand services, such as care coordination, are limited and consequently salaries for the positions are relatively low. Low salaries make hiring difficult and may necessitate selection of candidates that are under-qualified, particularly considering the expectations of the job.

We have to find people that are from the managed care world, that are from the hospital world. We have to find professionals that understand those worlds and they also have to be database professionals, they have to be able to navigate Navitar, they have to be able to navigate Dashboard, they have to be able to input information into these databases, and into our own database, and to be able to do it many times offsite. You're stuck between a rock and hard place, because people with enough skills and training to work with such a high acuity, in most cases, group of clients. But then also they'll have, like the background is more like data entry... You want them to come in with some of the skills, 50% of the skills, I mean, maybe we have to teach them the other 50%. Maybe they come in with substance abuse skills but they don't know mental health and they don't diabetes and primary healthcare concerns, or maybe it's the other way around. It feels like [it's too much to ask of a person], but you have to make it work. (Key informant multiservice agency).

Lack of trust or engagement (or possibly time) in care coordination on the part of medical providers also was considered to limit the potential effectiveness of care coordination models.

What's missing is ... saying to individual providers that this is important, and you need to be responsive, and you need to talk to people, and you need to interact with care coordinators. One of the biggest problems and flaws in the system is that in all of our contracts... we're required to go to providers, individual PCP's and psychiatrists, and get information from them both about their care that they're providing to our client or their patient or the lab work that's been done, tests, reports, anything that they're doing with our patient. We need to get access to that

information so that we can help to provide better care and to guide that person along in the care that they're getting. So if they get prescribed a specific medication, we can say, "Are you taking that medication? Where are you at with it? Have you filled the prescription?" Those kind of things. The problem is, on the provider's side, they don't get paid. No one's telling them – no one's saying to them from the funder level ... "You must communicate with these people." ... so the providers ignore us. (key informant, multiservice organization)

Finally, a consistent electronic health record was described as a challenge for agencies offering care coordination services, as they had to utilize multiple systems.

The State's not equipped to be able to mandate [a consistent electronic health record]. So everybody is left on their own to be able to design their own or to pick and choose an on-the-shelf or off-the-shelf package. And that's been what's causing the mess. So then not only do you have that, but you also don't have the communication between Health Homes to talk about a client, where a client is... being able to get some kind of a text message or an email saying a client is in an emergency room or a hospital. ...that should be really enhanced where we have much more access to the client's status, where that client is, when the client is in crisis, so that we can intervene and help the client. (key informant, Multiservice agency)

Key informants participating in the CNA, representing a cross-section of professions and fields, described multiple distinct populations with particular health care – and health – challenges. For example, individuals with severe alcohol or substance abuse disorders, who often have high rates of mental illness, physical illness and homelessness, are frequent users of emergency department services. However, emergency departments lack the resources to address the psychosocial needs that might increase stability within this population, and decrease their use of health care services.

Drug abuse is still a big problem. Alcoholism is a huge problem. And, we see a lot of admissions, a lot of patients with some sort of drug abuse or alcohol misuse. (key informant, provider)

Undocumented residents are described as hesitant to use health care services due to cost considerations and fear of deportation. When they do access medical services, it is late and sporadic.

When you have a borough that has so many immigrants, undocumented immigrants and no matter how much you try to convince them that, "Look, if you come in for healthcare, it has nothing to do with immigration, nobody's gonna report you, you don't have to be concerned," people still stay away (key informant, community based organization)

SECTION D: SUMMARY OF THE ASSETS AND RESOURCES THAT CAN BE MOBILIZED

Impact for Project Selection

Domain 2 Projects

The high number of potentially preventable inpatient admissions, emergency visits, and potentially preventable readmissions in this area, suggests that systems transformation is needed to reduce these. Thus, for the county as a whole, the needs assessment suggests that any of the DSRIP domain 2 projects could be appropriate. For an individual Performing Provider System, a specific project may be more appropriate dependent on ongoing initiatives, current infrastructure, payor mix, partners, and service area.

While each PPS will be different, there are a number of resources in the borough that primary data analysis suggests could be galvanized or mobilized to improve care:

- Expanded access to reduce wait times and increase compatibility with work and child care schedules

But something good that some clinics are doing is that in several places, they're open until late until after six and also on Saturdays. That's good because you can go there instead of the Emergency Room where you'd be waiting until 1am and not be seen. It's a great thing. (focus group participant)

- Care coordination and linkages outside the hospital walls

The other thing that I've seen that works really well is the social work department building relationships outside the walls of the hospital. So it's not just giving a referral to the shelter. But it's actually getting to know the supportive housing provider where a lot of the clients come from. And then, when Kathy shows up, the social worker [in the hospital] can call the supportive housing provider and say, "Hey, Kathy is here again. What happened?" "Yes. She really needs to be there." "Well, I think she is going to have to be here for two to three weeks. The way it looks she's going to need surgery." "Okay, we'll hold her bed." ... So really expanding your team, your relationships. If they're going to refer to detox or treatment, you let the housing provider know. (key informant, housing)

- Comprehensive and accessible supportive housing that provides services on site for those that are high users of multiple systems, which might include health care, criminal justice system, shelter system, substance abuse services, and/or foster care.

The [supportive housing] staff is there for relapse. So, "You stop taking your meds," it's that staff that's going to know. Maybe it might be a neighbor who notices first, and it's reported to the case manager who comes up and has a relationship, and it's like, "Is everything okay? Do we need to

put you in the hospital for a week?” But making sure that the main goal is housing stability, right? So doing everything they can so the person doesn’t lose their apartment. Which would happen, or probably did happen in their past life, particularly with mental illness or substance abuse. You decompensate and there’s nobody there to help you before you lose your apartment. So you end up in the shelter, the jail, the psych unit, before you can get back (Key informant, housing)

So what we’ve been advocating for... is creating a [supportive housing] system where eligibility looks at high users of multiple systems and vulnerability. Does it matter your diagnosis? You have a need. But the particular diagnosis doesn’t exclude you or only include you in particular housing availability... So that domestic violence, criminal justice, people who don’t meet chronic homeless because they’re been in psych hospital, in jail, and bouncing around, should still be able to qualify if they’re vulnerable (key informant, housing)

In addition to the DSRIP Domain 2 projects focused on creating integrated delivery systems (Domain 2A), implementation of care coordination and transitional care programs (Domain 2B), and connecting settings (Domain 2C), the New York State Department of Health has announced it is adding a new project (Domain 2D) focused specifically on the uninsured.²⁷³ In the Bronx, approximately 217,000 people are uninsured, accounting for approximately 10% of all the uninsured individuals in New York State.²⁷⁴ Adults between the age of 18 and 65 account for the largest proportion of uninsured in the Bronx, with a rate of 20% versus approximately 2% among those aged 65 and older, and approximately 5% among children aged 0-17. (See Appendix B, Table 22.) Within the borough, the highest number of uninsured are clustered in parts of Fordham-Bronx Park south through to Hunts Point-Mott Haven. (See Appendix A, Map 3.)

A significant portion of the uninsured the Bronx may be undocumented.²⁷⁵ The 2008-2012 5-year American Community Survey estimated that 131,665 (or 60.7%) of the total number of 217,009 uninsured Bronx residents were foreign born.²⁷⁶ Of these 131,665 foreign-born uninsured residents, the largest number were born in Latin American countries (86,572, 65.8%), followed by those born in non-Hispanic Caribbean countries (16,070, 12.2%), African countries (13,699, 10.4%), Balkan and Eastern European countries (3,349, 2.5%), and South Asian countries (2,766, 2.1%).²⁷⁷ Within the borough, uninsured foreign born Latinos live primarily in the South Bronx and west of the Grand Concourse, with approximately 11,000-13,000 people living in each of the following Community Districts (CD): CD 1&2, Hunts Point, Longwood, and Melrose; CD 9, Castle Hill, Clason Point, and Parkchester; CD 4, Concourse, Highbridge, and Mount Eden; CD 5, Morris Heights, Fordham South, and Mount Hope; and CD 7, Bedford Park, Fordham North, and Norwood. Those who are uninsured and were born in non-Hispanic Caribbean countries reside primarily in CD 12, Wakefield, Williamsbridge, and Woodlawn. African-born

²⁷³ This project will also focus on low- and non-utilizing Medicaid beneficiaries.

²⁷⁴ US Census, American Community Survey, 5 year data, 2008-2012.

²⁷⁵ NYAM primary data findings, September, 2014.

²⁷⁶ US Census, American Community Survey, 5 year data, 2008-2012.

²⁷⁷ Ibid.

uninsured residents reside primarily on either side of the Grand Concourse, in CDs 3 and 6, Belmont, Crotona Park East, and East Tremont; CD 4, Concourse, Highbridge, and Mount Eden; and CD 5, Morris Heights, Fordham South, and Norwood. Uninsured residents born in Balkan and eastern European countries live primarily in CD 11, Pelham Parkway, Morris Park, and Laconia; and uninsured residents born in South Asian countries live primarily in CD 9, Castle Hill, Clason Point, and Parkchester.²⁷⁸

Despite health reform, data suggest that insurance coverage remains problematic (or is increasingly problematic) even for those eligible.²⁷⁹ Community members and key informants describe income restrictions for Medicaid as unrealistically low, and self-purchased coverage as too expensive for low-income populations, given the difficulties of paying for basic necessities like food and housing. Lack of health insurance is reported to result in reduced use of preventive and community based care and increased emergency department use.²⁸⁰

Domain 3 Projects

As noted above, Bronx ranks highest among all New York City boroughs in the rate of potentially avoidable inpatient hospitalizations, and ranks second among the NYC boroughs in the rate of preventable emergency room visits (PPV).²⁸¹ The greatest proportion of potentially preventable admissions (PQI) in the Bronx are for chronic conditions including respiratory conditions such as asthma/COPD, cardiovascular conditions such as heart failure and hypertension, and diabetes.²⁸² Thus, these also represent the areas of opportunity for reducing preventable inpatient stays. The Medicaid beneficiaries who account for the largest proportion of these preventable admissions are concentrated in the areas of the Bronx in a wide corridor from Fordham-Bronx Park in the north, south alongside the Grand Concourse to the South Bronx.²⁸³ These areas also account for the highest proportion of potentially preventable emergency room visits.²⁸⁴

Behavioral Health

Among the Bronx population as a whole, the age-adjusted percentage of adults with poor mental health for 14 or more days of 9.1%, as well as the age-adjusted suicide rate of 5.4%, are lower than the state rates and roughly on par with citywide rates.²⁸⁵ However, in the Bronx, 7.1% of all people report

²⁷⁸ Ibid.

²⁷⁹ Ibid.

²⁸⁰ Ibid.

²⁸¹ Ibid.

²⁸² 2011-2012 Medicaid Prevention Quality Indicators, New York State Department of Health, Office of Quality and Patient Safety, 2014, as reported by the Office of Health Systems Management.

²⁸³ NYS DOH 2012.

²⁸⁴ NYS DOH 2012.

²⁸⁵ The “poor mental health” measure is from 2008-2009 BRFSS and Expanded BRFSS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. The suicide rate is for the years 2010-2012 from Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

experiencing serious psychological distress, compared to 5.5% in NYC overall.²⁸⁶ The Pelham-Throgs Neck area, in particular, appears to be disproportionately impacted by psychological distress with approximately 8% of residents reporting it. (See Appendix B, Table 31.) Those in Hunts Point-Mott Haven, High Bridge-Morrisania and Crotona-Tremont also report high rates of psychological distress, with approximately 5%-8% of those surveyed reporting it. The myriad of stresses on lower income residents were considered overwhelming to some and contributed to high levels of depression.²⁸⁷ Low-income immigrant populations may have additional stressors of assimilation, as well as poorer access to care, due to insurance and language issues.²⁸⁸

Community members also marked that substance use and alcohol abuse are pressing issues. Indeed, in 2012, the last year for which data is available, an estimated 639.2 per 100,000 emergency room visits in NYC were due to non-alcohol, illicit drugs.²⁸⁹ In the Bronx, the age-adjusted percentage of adult binge drinking among the total population “during the past month” for the borough was nearly one-in-five (18%) in 2012, similar to the overall NYC rate (19.6%) for the same time period. (See Appendix B, Table 33.) Also, key informants described behavioral health issues as one factor in delaying or precluding appropriate preventive and primary health care. According to the director of Bronx CBO serving a number of residents with mental health and substance abuse issues, *“Survival is the most important thing, so not health, not seeing a doctor... but that’s just – literally hustling to survive each day is the number one goal.”*

There are no PQI measures of preventable hospitalizations related specifically to behavioral health. However, New York State Office of Mental Health (OMH) data suggest that over half (54.4% or 9,215/16,942) of Bronx clients served by OMH-licensed and OMH-funded programs have one or more physical chronic health conditions, indicating a need for coordinated behavioral and physical health care. (See Appendix B, Table 32.)

The geographic distribution of behavioral health resources (see Appendix A, Map 88) appears to match the widespread distribution of behavioral health-related service utilization in the Bronx,²⁹⁰ however, questions as to the adequacy of these resources in terms of capacity were raised in focus groups and key

²⁸⁶ Serious psychological distress is a composite measure of 6 questions in the Community Health Survey regarding symptoms of anxiety, depression and other emotional problems. New York City Department of Health and Mental Hygiene, Community Health Survey 2012 data, as reported on Epiquery <http://nyc.gov/health/epiquery>, accessed August 2014.

²⁸⁷ NYAM Primary Data findings, September, 2014.

²⁸⁸ Ibid.

²⁸⁹ Drug Abuse Warning Network, 2011: New York City – 5 Boros: Drug-Related Emergency Department Visits, 2004-2011 - Illicits (excluding alcohol) Rockville, MD: Center for Behavioral Health Statistics and Quality, SAMHSA, 2013

²⁹⁰ These numbers and rates reflect possible duplicated counts of beneficiaries if a beneficiary's calendar year utilization was found by NYS DOH to occur across multiple Episode Disease Categories within a single Major Diagnostic Category. Therefore, the numbers reflect the Weighted Number of Beneficiaries with Condition-Related Utilization, and the rates reflect the Weighted Condition Prevalence Among Beneficiaries, by multiple counting beneficiaries for utilization across multiple co-morbidity Episode Disease Categories within a Major Diagnostic Category.

informant interviews. In addition, there were concerns about concentration of particular services, such as methadone programs in particular neighborhoods, resulting in perceived declines in safety and quality of life for community members. Per DSRIP behavioral health clinical improvement projects, the integration of behavioral health specialists into primary care clinics could help address this issue if it entails a net increase of behavioral health resources, as well as a smoother and quicker referral process between primary care and behavioral health. Further, it may also address low behavioral health services utilization among some beneficiaries resulting from the inconvenience and the stigma associated with seeking treatment at a behavioral health provider location. Conversely, the integration of primary care services into existing behavioral health services settings could help address the high rates of co-morbidity between behavioral health and chronic physical health conditions for those currently utilizing behavioral health services.

According to providers themselves, the system is fragmented, with possibly poorer integration within behavioral health services themselves than between physical and behavioral health. Behavioral health services are reported to be highly regulated by multiple agencies: Office for People with Developmental Disabilities (OPWDD), Office for Alcoholism and Substance Abuse Services (OASAS), and Office of Mental Health (OMH) with patient care being restricted according to the funding and regulatory agency—despite the frequency of co-occurring disorders. Thus, a mental health provider might be limited in the severity of illness that can be treated, the age of the patient, and other factors.²⁹¹

Cardiovascular Disease

Heart disease is the top cause of mortality among the white, black, and Hispanic populations of the Bronx²⁹² and is recognized by community members as a major health problem. It is also second leading cause of premature death in the borough.²⁹³ The age adjusted cardiovascular disease hospitalization rate in the Bronx is 210.8 per 10,000, higher than either NYC (173.6) or NYS (159.9).²⁹⁴ Similarly the age adjusted mortality rate for diseases of the heart was 225.8 in the Bronx, 212.2 in NYC, and 198.6 in NYS.²⁹⁵ Within the broad category of heart health, the Bronx fares worse than NYC and NYS on all age-adjusted indicators.²⁹⁶

In 2012, the number of potentially preventable hospitalizations among Medicaid beneficiaries for circulatory conditions (PQI S02 Circulatory Composite) in the Bronx was 3,173, accounting for about one in five (20.1 %) of all such admissions in the State. (See Appendix B, Table 44.) The ratio of

²⁹¹ Ibid.

²⁹² New York City Vital Statistics, “Top Ten Leading Causes of Mortality 2012,” accessed via the EpiQuery interactive tool, August, 2014

²⁹³ Premature deaths (< age 75) for the three years 2010-2012. Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics

²⁹⁴ 2009-2011 data reported on the NYS Dept of Health Website County Health Assessment Indicators, https://www.health.ny.gov/statistics/chac/cha/docs/chr_58.htm, accessed September, 2014.

²⁹⁵ Ibid.

²⁹⁶ Ibid.

observed/expected (O/E) admissions in the Bronx (1.34) was higher than the ratio for NYC (1.06) for the same time period. (See Appendix B, Table 44.) At the zip code level within the borough, the highest number of preventable hospitalizations and the highest observed / expected PQI ratios for the Circulatory Composite measure are found along the Grand Concourse from High Bridge – Morrisania to Fordham – Bronx Park. (See Appendix A, Map 40.)

Approximately 185.02 out of 100,000 Medicaid beneficiaries in the Bronx were hospitalized for conditions related to hypertension, compared to 124.02 in NYC and 105.5 in NYS. In 2012, there were 969 potentially preventable hospitalizations among Medicaid beneficiaries for hypertension (PQI 07) in the borough. (See Appendix B, Table 44.) The variation in hospitalization rates for conditions related to hypertension between neighborhoods in the Bronx is wide. For example, the rate in Kingsbridge-Riverdale is 115.66 per 100,000, compared to a rate of 261.85 in the Northeast Bronx. (See Appendix A, Map 45.)

There were 2,013 potentially preventable hospitalizations among Medicaid beneficiaries for heart failure (PQI 08) in the Bronx. (See Appendix B, Table 44.) The range for observed/expected admissions heart failure was 0.7 to 2.87. The lowest rates in Kingsbridge-Riverdale and highest in Pelham Bay-Throgs neck area. (See Appendix A, Map 46.)

In 2012, adult angina without procedure (PQI 13) accounted for 191 potentially preventable hospitalizations in the Bronx. (See Appendix B, Table 44.) The range for observed/expected admissions for adult angina without procedure is 0.0 to 2.1, with the lowest rates in the Throgs Neck- Pelham Bay and Kingsbridge-Riverdale areas and the highest in Highbridge, Bedford Park, Mott haven, Port Morris, Baychester, Wetchester Heights, and Parkchester. (See Appendix A, Map 50.)

The highest rates of cardiovascular-related service utilization (including pharmacy) among Medicaid beneficiaries were found in Kingsbridge – Riverside and Northeast Bronx; however, the highest numbers were found along either side of the Grand Concourse from High Bridge–Morrisania to Fordham–Bronx Park.²⁹⁷ (See Appendix A, Map 26.) In regard to disease information and support services, these areas of the Bronx with high rates of condition-related utilization and high numbers of circulatory composite PQI hospitalizations appear to have those services available, with the exception of the Fordham – Bronx Park area. Specialty cardiology services similarly appear to be located in or near the areas of greatest need, with the exception of the Fordham – Bronx Park area (See Appendix A, Map 71.)

²⁹⁷ These numbers and rates reflect possible duplicated counts of beneficiaries if a beneficiary's calendar year utilization was found by NYS DOH to occur across multiple Episode Disease Categories (e.g., hypertension and congestive heart failure) within a single Major Diagnostic Category (e.g., Diseases and Disorders of the Cardiovascular System). Therefore, the numbers reflect the Weighted Number of Beneficiaries with Condition-Related Utilization, and the rates reflect the Weighted Condition Prevalence Among Beneficiaries, by multiple counting beneficiaries for utilization across multiple co-morbidity Episode Disease Categories within a Major Diagnostic Category.

Diabetes

The diabetes composite PQI (S01) for the Bronx (1.24) is higher than for New York City (1.01) and New York State (1.00).²⁹⁸ (See Appendix B, Table 44.) Many community members see diabetes as their greatest health concern.²⁹⁹ Within the Bronx, the range for PQI S01 observed/expected ratios is 0.8 to 2.26. (See Appendix A, Map 39.) Across New York State, only 51% of Medicaid Managed Care beneficiaries with diabetes received all recommended tests in the last year, and 33% of Medicaid Managed Care beneficiaries in NYS with diabetes have poorly controlled HbA1c (>9%).³⁰⁰

In 2012, there were 792 potentially avoidable hospitalizations for short term diabetes complications (PQI 01) among Bronx Medicaid beneficiaries, with a borough-wide Observed/Expected (O/E) ratio of 1.13.³⁰¹ (See Appendix B, Table 44.) Within the borough, twelve zip code areas with an O/E ratio greater than 1.00 account for 493 or 62% of these hospitalizations.³⁰² (See Appendix A, Map 42.) These 493 hospitalizations are found in three clusters: from High Bridge-Morrisania to Crotona-Tremont east of the Grand Concourse; in northeast Bronx from north of Bronx Park to Pelham Bay Park; and in southeast Bronx from Soundview to Throgs Neck (See Appendix A, Map 42.) Potentially avoidable long-term complications from diabetes hospitalization (PQI 03) rates among Medicaid beneficiaries in the Bronx vary by neighborhood. Rates of such hospitalizations are highest in Kingsbridge, Mott Haven, and Pelham Bay Park neighborhoods. (See Appendix A, Map 43.) Potentially preventable Medicaid hospitalizations for uncontrolled diabetes (PQI 14) appears highest in East Tremont. (See Appendix A, Map 51.) Potentially avoidable hospitalizations for lower extremity amputation (PQI 16) for Medicaid Beneficiaries with diabetes appear to be largely concentrated in the north east Bronx. The highest rates are found in Eastchester, Baychester, Co-op City, Pelham Gardens, and Mott Haven. (See Appendix A, Map 53.)

The geographic concentration of Diabetes PQI hospitalizations makes the potential return on investment in practice reforms high in terms of reduced PQI admissions. The Diabetes Resources map (See Appendix A, Map 72) appears to show current geographic alignment of diabetes care management resources and need (shown in terms of Diabetes Composite PQI S01 hospitalizations) in or near the High Bridge-Morrisania, Crotona-Tremont, and Bronx Park areas; but apparently less alignment of resources with need in the northeast and southeast clusters where resources are lacking, although the areas between these two clusters do have specialty diabetes clinical resources.

Asthma

CNA participants reported that asthma was among the most significant health concerns, with causation commonly attributed to indoor (e.g., mold, cockroaches, rodents) and outdoor (e.g., exhaust)

²⁹⁸ NYS Dept of Health 2012 data, accessed August, 2014.

²⁹⁹ NYAM primary data findings, September, 2014.

³⁰⁰ QARR, 2011

³⁰¹ NYS Dept of Health 2012 data, accessed August, 2014.

³⁰² Ibid.

environmental conditions.³⁰³ While the observed rate of PQI respiratory admissions has declined in the Bronx since 2009, it remains far above the expected rate, with an Observed/Expected ratio of 1.42 for the Respiratory Composite PQI. (See Appendix B, Table 44 and Chart 50.) There were 4,116 Respiratory Composite (PQI S03) PQI hospitalizations in the Bronx in 2012. (See Appendix B, Table 44.) This includes 3,383 COPD or Asthma in Older Adults (PQI 05) PQI hospitalizations and 733 Asthma in Younger Adult (PQI 15) PQI hospitalizations. (See Appendix B, Table 44.) The areas of the Bronx with the highest PQI respiratory composite hospitalizations are located in a corridor that runs from parts of Fordham-Bronx Park south along both sides of the Grand Concourse to Hunts Point – Mott Haven. (See Appendix A. Map 41.)

When looking at the location of asthma health care resources in relation to Respiratory Composite PQI hospitalizations (See Appendix A Map 73), there appears to be fairly good alignment of health care resources to need; however, the relationship of these resources to the prevention of PQI hospitalizations is uncertain, especially when considering additional socio-demographic variables that may be influencing the PQI hospitalization outcomes, such as language barriers, constraints on time, and lack of insurance. Whatever the current efficacy of these resources in preventing asthma-related hospitalizations, a strong foundation is needed to implement the DSRIP clinical improvement projects around medication adherence and home-based self-management, which includes a focus on reducing home environmental triggers. Regarding home environmental triggers, limited data is available. However, data on the rate of serious housing violations by Community District, i.e., housing code violations that are considered “immediately hazardous or serious,” show prevalence in many of the same neighborhoods with high numbers of preventable respiratory PQI hospitalizations (See Appendix A, Map 15.)

The highest total Medicaid PQI hospitalizations for asthma among young adults occurs along the same corridor as does the PQI respiratory composite. (See Appendix A, Map 52.) Among children in the Bronx who are Medicaid beneficiaries, the asthma rate of 701.47 per 100,000 is startlingly higher than the NYC overall rate of 426.91 per 100,000 and the NYS overall rate of 210.39 per 100,000.³⁰⁴ Childhood asthma rates in the borough range from 418.8 per 100,000 in Kingsbridge-Riverdale to 987.9 per 100,000 in Hunts Point. Additionally, DOH data suggests that the majority, 981 or 52.6%, of the 1,865 pediatric asthma preventable PDI hospitalizations in 2012 were among very young children, aged 2-5.³⁰⁵ Among older adults in the Bronx, the COPD/Asthma PQI O/E ratio is 1.38, significantly higher than the city ratio

³⁰³ NYAM primary data findings, September, 2014.

³⁰⁴ Medicaid Prevention Quality Indicators, 2012.

³⁰⁵ The asthma PDI is reported for children aged 2-17, but the PDI chronic composite (which includes asthma and diabetes) is reported only for those aged 6-17. Thus the difference (decrease) in numbers between those two measures is a result of the loss of the asthma admissions for children aged 2-5 in the chronic composite. Thus, it is the young children aged 2-5 that represent the bulk of the asthma PDI numbers. As explained in an email transmission from the NYS DOH dated August 25, 2014: “Each PDI has a different age criteria, asthma is 2-17 years, diabetes is 6-17 years, gastroenteritis and uti are both 3 months to 17 years. These 4 PDI make up the overall composite PDI, however, that age criteria is 6-17 years. This results in the loss of patients age 3 months up to 6 years, hence the decrease in numbers. The same situation occurs in the acute and chronic composites. The composite age group is 6-17, however, that doesn’t reflect the actual age groups in the individual measures.”

of 1.01. (See Appendix B, Table 44.) Consistent with other asthma indicators, the highest number of Medicaid PQI hospitalizations for COPD and asthma in older adults are clustered in the corridor from Fordham-Bronx Park south to the South Bronx. (See Appendix A, Map 44.)

HIV

The fourth leading cause of premature deaths in the Bronx is AIDS, accounting for approximately 30% of all such deaths in NYC.³⁰⁶ The HIV/AIDS prevalence rate for the Bronx (approximately 1,660 per 100,000 population) is higher than the NYC rate (1,370 per 100,000), and variation exists within the borough.³⁰⁷ Four UHF neighborhoods in the borough have a higher HIV/AIDS prevalence rate than the city as a whole: High Bridge-Morrisania (2,353/100,000), Hunts Point-Mott Haven (2,290/100,000), Crotona-Tremont (2,207/100,000), and Fordham-Bronx Park (1,696/100,000).³⁰⁸ In terms of numbers of People Living with HIV/AIDS (PLWHA), these neighborhoods account for a total of 16,996 PLWHA or 73.7% of all PLWHA in the Bronx.³⁰⁹ (See Appendix B, Table 35.) The age adjusted mortality rate for AIDS in the Bronx (20 per 100,000) is more than twice the rate of NYC (9.4 per 100,000) and four times the rate for NYS (4.7 per 100,000).³¹⁰ Neighborhoods with the highest incidence of HIV also have higher rates of concurrent HIV/AIDS diagnoses, and are the same neighborhoods with the highest prevalence: Morrisania/High Bridge, and Mott Haven/ Hunts Point.³¹¹ (See Appendix B, Chart 38.)

Bronx residents who are HIV positive, or have been diagnosed with AIDS, have rates of viral load suppression (60.19%) slightly lower than New York City (61.2%) and New York State (62.2%).³¹² Among Medicaid Managed Care Beneficiaries in the Bronx who are HIV positive, or who have been diagnosed with AIDS, 91% are engaged in care, 69% received appropriate viral load monitoring, and 70% of those 19 or older received syphilis screening.³¹³ Viral load suppression is a key factor in reducing transmission of HIV and maintaining good health.

Within the borough, there are wide racial disparities in HIV incidence. In 2011, the latest year for which data is available, the rate of new HIV diagnoses among African Americans living in the Bronx was nearly 4 times higher than the new HIV diagnosis rate among Whites living in the Bronx (76.7 compared to 19.1 cases per 100,000 people). The rate of new HIV diagnoses among Latinos living in the Bronx was more than 2 times higher than the new HIV diagnosis rate among Whites living in the Bronx (41.8 compared to 19.1 cases per 100,000 people). (See Appendix B, Chart 37).

³⁰⁶ “County Number of 3-Years Premature [< age 75] Deaths” Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics.

³⁰⁷ NYC DOHMH 2011

³⁰⁸ Ibid.

³⁰⁹ 2011 data, the latest year for which information is available, from the New York City Department of Health and Mental Hygiene.

³¹⁰ NYS Dept of Health County Health Assessment Indicators, 2009-2011, https://www.health.ny.gov/statistics/chac/chai/docs/sti_58.htm, accessed September, 2014.

³¹¹ Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

³¹² HIV Ambulatory Care Performance, 2011

³¹³ QARR, 2012

According to key informants in the field, transmission among injecting drug users (IDUs) in the Bronx has dropped dramatically, likely due to access to clean syringes from syringe exchange programs—although hepatitis C remains a concern, since it is more easily transmitted.

The HIV/AIDS Resources map (See Appendix A, Map 75.) suggests a geographic alignment between Medicaid Beneficiaries with an HIV/AIDS service utilization and the location of HIV/AIDS resources, which is also consistent with the prevalence PLWHS by UHF neighborhood. The existing health care and ancillary services structure appears to provide a strong foundation for implementing the related DSRIP projects. However, key informants providing services to HIV-infected individuals describe significant changes in funding priorities, with increasing resources going toward medical management, and less funding available for supportive services, including housing for people with HIV. Given the aging of the HIV-infected population, and the potential medical complications of HIV medication, a large number of people with HIV/AIDS also have more common chronic conditions, including diabetes and heart disease. Integration of medical services is therefore essential.

Perinatal Care

Over the period 2010-2012, there were 21,867 live births per year on average in the Bronx, representing nearly one in five (18.5%) births in New York City and nearly one in ten (9.1%) in the State over the same time period.³¹⁴ The percentage of all births in the Bronx that were Medicaid or self-pay was 75.4%, compared to 59.7% in NYC and 50.1% in the State; the percentage of Medicaid or self-pay births across Bronx zip codes ranged from 23.6% to 87.5%. Fertility rates are also higher in the Bronx (59 births in the past year per 1,000 women age 15-50) than in NYC (52 per 1,000) and NYS (50 per 1,000). For young women, the difference is even greater, with a rate of 34 births in the past year per 1,000 women age 15-19, compared to 21 per 1,000 in NYC and 17 per 1,000 in NYS. (See Appendix B, Table 65.) The highest fertility rates are found along the western side of the Grand Concourse from High Bridge to Fordham – Bronx Park, and in the south in Mott Haven, Hunts Point, and Soundview. (See Appendix A, Maps 6-8.) The teen pregnancy rate is also higher in the Bronx than NYC and NYS, at 60.8 per 1,000 compared to 44.2 per 1,000 in NYC and 35.7 per 1,000 in NYS.³¹⁵

In 2012, the latest year for which data is available, the percentage of preterm births in the Bronx (12.2%) was higher than in NYC (10.8%) or NYS (10.8%).³¹⁶ Preterm birth is associated with low birth weight and poor health outcomes. The overall low birth weight (LBW) rate for the Bronx over the time period 2010-2012 was 9.5%, compared to 8.5% for NYC and 8.1% for the state.³¹⁷ Within the Bronx, the LBW rates ranged from 1.9% to 12.8%, with the highest rates found in two clusters of zip codes – one in the south central part of the borough from Mott Haven, Morrisania, to Claremont Village; and the other in the

³¹⁴ NYS Vital Statistics, 2010-2012 3 year data, <http://www.health.ny.gov/statistics/chac/perinatal/>, accessed September 2014.

³¹⁵ NYS Vital Statistics, 2012

³¹⁶ NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

³¹⁷ Ibid.

northeast part of the borough in Wakefield, Eastchester, and Co-Op City. These neighborhoods also experience the highest rates of infant mortality. (See Appendix A. Map 6.)

Racial disparities also persist in the borough in the number of preterm births, with 1.4 times the number of preterm births among the black population than among the non-Hispanic white population for the time period 2010-2012 and 1.2 times the number of Hispanic preterm births than non-Hispanic white preterm births in the same time period. (See Appendix B, Table 72). Though, these racial and ethnic disparities were narrower in the Bronx than in NYC and NYS in the same time period.³¹⁸

In the Bronx, the percentage of mothers receiving prenatal care starting in the first trimester was lower than the NYS and NYC rates (71.8% and 70.4%, respectively) by over 10%, and more than one-third (37.0%) of mothers in the Bronx received prenatal care beginning in the third trimester (months 7-9), compared to 23.9% for NYS and 28.7% in NYC. (See Appendix B, Table 61). Additionally, the Bronx neonatal death rate was slightly higher than NYC and NYS at 3.5 per 1,000, compared to 2.9 per 1,000 in NYC and 3.3 per 1,000 in NYS.

Domain 4 Projects

Domain 4 projects are intended promote population health and reduce health risks. Specifically, these projects are to: (1) promote mental health and prevent substance abuse, (2) prevent chronic disease, including promoting tobacco use cessation and improving preventive care and disease management for chronic diseases not covered in Domain 3b, such as cancer, (3) prevent HIV and STDs, and (4) promote healthy women, infants and children. As noted above, the Bronx-wide population is burdened by chronic disease, including cancer. They also have high rates of teenage pregnancy, incidence and prevalence of HIV and other STDs. Among the population, as many as one in five adults in some neighborhoods of the Bronx report being a current smoker.

(1) Promote Mental Health and Prevent Substance Abuse

Among the Bronx population as a whole, the age-adjusted percentage of adults with poor mental health for 14 or more days of 9.1%, as well as the age-adjusted suicide rate of 5.4%, are lower than the state rates and roughly on par with citywide rates.³¹⁹ However, in the Bronx, 7.1% of all people report experiencing serious psychological distress, compared to 5.5% in NYC overall.³²⁰ The Pelham-Throgs

³¹⁸ The ratio of black to white preterm births in NYC was 1.8 and in NYS was 1.62 for the period 2010-2012. The ratio of Hispanic to white preterm births in NYC was 1.39 and in NYS was 1.25 for this time period. Source: NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard, accessed August 2014.

³¹⁹ The “poor mental health” measure is from 2008-2009 BRFSS and Expanded BRFSS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. The suicide rate is for the years 2010-2012 from Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

³²⁰ Serious psychological distress is a composite measure of 6 questions in the Community Health Survey regarding symptoms of anxiety, depression and other emotional problems. New York City Department of Health and Mental

Neck area, in particular, appears to be disproportionately impacted by psychological distress with approximately 8% of residents reporting it. (See Appendix B, Table 31.) Those in Hunts Point-Mott Haven, High Bridge-Morrisania and Crotona-Tremont also report high rates of psychological distress, with approximately 5%-8% of those surveyed reporting it. The myriad of stresses on lower income residents were considered overwhelming to some and contributed to high levels of depression.³²¹ Low-income immigrant populations may have additional stressors of assimilation, as well as poorer access to care, due to insurance and language issues.³²²

You've got to be somebody, somebody who [was] a doctor or military for years. You come into this country and become a cashier. If you are not mentally prepared for this, this is not really a culture shock. But this is a big shock ...But sometime people don't want to talk about it. People are keeping this to themselves, but at some point you'll see they'll start talking by themselves, and start doing some things (immigrant focus group participant)

Access to mental health services is reported to be limited, some mental health providers report that community organizations and residents are not aware of available services or how to access them.³²³ In addition, behavioral health issues generally carry greater stigma than other health concerns, which tends to limit use of services.

When you grew up without this and you're a certain age, it's hard to accept getting the help. So I think that's part of the problem also. So even if it's open to you, if you weren't brought up to believe that you can go to someone else for help or therapy, it was never a part of our culture (focus group participant)

There were also concerns about concentration of particular services, such as methadone programs in particular neighborhoods, resulting in perceived declines in safety and quality of life for community members. Key informants and focus group participants both reported that many affected families try to address problems internally.³²⁴

According to providers themselves, the system is fragmented, with possibly poorer integration within behavioral health services themselves than between physical and behavioral health. Behavioral health services are reported to be highly regulated by multiple agencies: Office for People with Developmental Disabilities (OPWDD), Office for Alcoholism and Substance Abuse Services (OASAS), and Office of Mental Health (OMH) with patient care being restricted according to the funding and regulatory agency—

Hygiene, Community Health Survey 2012 data, as reported on Epiquery <http://nyc.gov/health/epiquery>, accessed August 2014.

³²¹ NYAM primary data findings, September, 2014.

³²² Ibid.

³²³ NYAM primary data findings, September, 2014.

³²⁴ Ibid.

despite the frequency of co-occurring disorders. Thus, a mental health provider might be limited in the severity of illness that can be treated, the age of the patient, and other factors.³²⁵

(2) Prevent Chronic Disease

a. Promoting tobacco use cessation

The domain 4 project on this topic is intended to “promote tobacco use cessation, especially among low SES populations and those with poor mental health.”³²⁶ The percentage of cigarette smoking among adults in the Bronx is roughly on par with NYC and NYS rates (15.8% in the Bronx versus 15.5% in NYC and 16.2% in NYS in 2012), but rates vary by neighborhood. Approximately one in five of adults in Pelham-Throgs Neck (21.2%) and the South Bronx (18.2%) report being a current smoker compared to less than one in ten in Kingsbridge-Riverdale (7.3%) and Fordham-Bronx Park (7.5%).³²⁷ (See Appendix B, Table 34.)

b. Preventive care and disease management for chronic diseases not covered in Domain 3b

The leading cause of premature death in the borough is cancer.³²⁸ (See Appendix B, Table 27.) Rates for some preventive screening measures in the Bronx are on par with NYC and NYS, e.g., approximately half (53%) of adults Medicaid beneficiaries aged 50-75 years received appropriate colorectal cancer screening in the borough, compared to 52% in NYC and 49% in NYS in 2012, the latest year for which data is available.³²⁹ (See Appendix B, Table 66.) However, the borough lags in other related risk factors, such as obesity.

The prevalence of obesity in the Bronx is higher than in NYC or NYS, with nearly one in three (32%) of all adults in the Bronx obese, versus 24.2% in NYC and 23.6% in the state.³³⁰ (See Appendix B, Table 31.) The obesity rate varies widely within the borough with the highest rates in a corridor from parts of Fordham-Bronx Park down to the South Bronx. There are also very high rates in parts of Pelham-Throgs

³²⁵ Ibid.

³²⁶ New York’s MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan, Attachment J.”NY DSRIP Strategies Menu and Metrics,” 2014.

³²⁷ These neighborhood estimates should be interpreted with caution. The estimate's Relative Standard Error (a measure of estimate precision) is greater than 30% or the sample size is less than 50, or the 95% Confidence Interval half width is greater than ten, making the estimate potentially unreliable. Source: NYC DOHMH Community Health Survey, 2012

³²⁸ Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics.

³²⁹ State data obtained from the 2012 BRFSS and reports the “Percentage of adults who received colorectal cancer screening according to most recent guidelines.” Those complying with recent guidelines included individuals who used a blood stool test at home in the past year; and/or, sigmoidoscopy in the past 5 years and blood stool test in the past 3 years; and/or, had a colonoscopy in the past 10 years. However, the 2012 NYC Community Health Survey only reports the percentage of respondents who received a “colon cancer screening in last 10 years.”

³³⁰ Community Health Survey, 2012. New York State Department of Health, 2012.

Neck.³³¹ (See Appendix A, Maps 17-18.) Among women and children participating in the United States Department of Agriculture Food and Nutrition Service Women Infant and Children (WIC) program, approximately 29% of pregnant women were overweight, and 27% of pregnant women were obese in the Bronx in the time period 2010-2012. These Bronx rates are higher than the corresponding rates in NYS (approximately 27% overweight, 24% obese) and NYC (approximately 27% overweight, 22% obese).³³²

Focus group participants attributed obesity to a number of causes, including the limited access and relatively high cost of healthy food.³³³ Long work hours and lack of home cooked meals were also mentioned.

You're selling stuff on the street there from seven o'clock to seven o'clock at night. You can't take a two hour break because you're gonna lose a client. Right? So then all that time you don't seem to eat anything, because you don't want to miss a dollar. You've got a bill to pay. You have to work six days in a week to get maybe less than \$300.00. If you don't come to work, you don't get paid that day So then when you finish at night not only are you exhausted physically and mentally, but you need to eat. And guess what we do. We walk into the restaurant and get a whole plate of food (focus group participant)

In the Bronx, a mere 6% of adults report eating five or more fruits or vegetables per day, compared to approximately 9% in NYC and 27% in NYS.³³⁴ Focus group participants also described the challenges of changing dietary behavior in general—and of losing weight, in particular—despite obvious negative health consequences. Cultural preferences for fried and certain high caloric foods were acknowledged. Although obesity was in part attributed to individual motivation and community conditions, more comprehensive and consistent messaging from providers, as well as improved access to healthy food, was also recommended. Promising programs described by key informants including cooking demonstrations; linkages between providers and food stores, so that the former can provide support regarding promotion of healthy choices; and farmers market participation in food subsidy programs like SNAP and Health Bucks.³³⁵

³³¹ It should be noted these rates are by UHF neighborhood, as rates are not available at the zip code level, so there could be variation within these UHF neighborhoods that is not captured here.

³³² Source: Bronx County: County Health Assessment Indicators, 2010 – 2012 data
http://www.health.ny.gov/statistics/chac/chai/chai_58.htm#bronx, accessed August 2014.

³³³ NYAM Primary data findings, September 2014.

³³⁴ 2008-2009 data found at Bronx County: County Health Assessment Indicators, 2010 – 2012 data
http://www.health.ny.gov/statistics/chac/chai/chai_58.htm#bronx, accessed August 2014.

³³⁵ Health Bucks, worth \$2 each, are developed and distributed by the NYC Health Department and can be used to purchase fresh fruits and vegetables at all farmers' markets in NYC.

(3) Prevent HIV and Sexually Transmitted Diseases (STDs)

As noted above, the fourth leading cause of premature deaths in the Bronx is AIDS, accounting for approximately 30% of all such deaths in NYC.³³⁶ The HIV/AIDS prevalence rate for the Bronx (approximately 1,660 per 100,000 population) is higher than the NYC rate (1,370 per 100,000), and variation exists within the borough.³³⁷ Four UHF neighborhoods in the borough have a higher HIV/AIDS prevalence rate than the city as a whole: High Bridge-Morrisania (2,353/100,000), Hunts Point-Mott Haven (2,290/100,000), Crotona-Tremont (2,207/100,000), and Fordham-Bronx Park (1,696/100,000).³³⁸ In terms of numbers of People Living with HIV/AIDS (PLWHA), these neighborhoods account for a total of 16,996 PLWHA or 73.7% of all PLWHA in the Bronx.³³⁹ (See Appendix B, Table 35.) The age adjusted mortality rate for AIDS in the Bronx (20 per 100,000) is more than twice the rate of NYC (9.4 per 100,000) and four times the rate for NYS (4.7 per 100,000).³⁴⁰ Neighborhoods with the highest incidence of HIV also have higher rates of concurrent HIV/AIDS diagnoses, and are the same neighborhoods with the highest prevalence: Morrisania/High Bridge, and Mott Haven/ Hunts Point.³⁴¹ (See Appendix B, Chart 38.)

Bronx residents who are HIV positive, or have been diagnosed with AIDS, have rates of viral load suppression (60.19%) slightly lower than New York City (61.2%) and New York State (62.2%).³⁴² Among Medicaid Managed Care Beneficiaries in the Bronx who are HIV positive, or who have been diagnosed with AIDS, 91% are engaged in care, 69% received appropriate viral load monitoring, and 70% of those 19 or older received syphilis screening.³⁴³ Viral load suppression is a key factor in reducing transmission of HIV and maintaining good health.

Within the borough, there are wide racial disparities in HIV incidence. In 2011, the latest year for which data is available, the rate of new HIV diagnoses among African Americans living in the Bronx was nearly 4 times higher than the new HIV diagnosis rate among Whites living in the Bronx (76.7 compared to 19.1 cases per 100,000 people). The rate of new HIV diagnoses among Latinos living in the Bronx was more than 2 times higher than the new HIV diagnosis rate among Whites living in the Bronx (41.8 compared to 19.1 cases per 100,000 people). (See Appendix B, Chart 37).

³³⁶ “County Number of 3-Years Premature [< age 75] Deaths” Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics.

³³⁷ NYC DOHMH 2011

³³⁸ Ibid.

³³⁹ 2011 data, the latest year for which information is available, from the New York City Department of Health and Mental Hygiene.

³⁴⁰ NYS Dept of Health County Health Assessment Indicators, 2009-2011, https://www.health.ny.gov/statistics/chac/chai/docs/sti_58.htm, accessed September, 2014.

³⁴¹ Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

³⁴² HIV Ambulatory Care Performance, 2011

³⁴³ QARR, 2012

According to key informants in the field, transmission among injecting drug users (IDUs) in the Bronx has dropped dramatically, likely due to access to clean syringes from syringe exchange programs—although hepatitis C remains a concern, since it is more easily transmitted.

In '95, the new infection rate among injection drug users was 54%, so literally one out of every two people had HIV or AIDS. Now it's under 4%. We've got very few new infections. We have a lot – we see a prevalence around Hepatitis C because it's so much more communicable, with the cotton and other stuff. ... We have to come up with better technology than we're using because they're still getting Hep C from each other (key informant, community based organization)

The HIV/AIDS Resources map (See Appendix A, Map 75.) suggests a geographic alignment between Medicaid Beneficiaries with an HIV/AIDS service utilization and the location of HIV/AIDS resources, which is also consistent with the prevalence PLWHA by UHF neighborhood. The existing health care and ancillary services structure appears to provide a strong foundation for implementing the related DSRIP projects. However, key informants providing services to HIV-infected individuals describe significant changes in funding priorities, with increasing resources going toward medical management, and less funding available for supportive services, including housing for people with HIV. Given the aging of the HIV-infected population, and the potential medical complications of HIV medication, a large number of people with HIV/AIDS also have more common chronic conditions, including diabetes and heart disease. Integration of medical services is therefore essential.

(4) Promote Healthy Women, Infants and Children

The domain 4 project on this topic is specifically focused on reducing premature, or preterm, births.³⁴⁴ As noted above, in 2012, the latest year for which data is available, the percentage of preterm births in the Bronx (12.2%) was higher than in NYC (10.8%) or NYS (10.8%).³⁴⁵ Also, as noted above, preterm birth is associated with low birth weight and poor health outcomes. The overall low birth weight (LBW) rate for the Bronx over the time period 2010-2012 was 9.5%, compared to 8.5% for NYC and 8.1% for the state.³⁴⁶ Within the Bronx, the LBW rates ranged from 1.9% to 12.8%, with the highest rates found in two clusters of zip codes – one in the south central part of the borough from Mott Haven, Morrisania, to Claremont Village; and the other in the northeast part of the borough in Wakefield, Eastchester, and Co-Op City. (See Appendix A. Map 6.) These neighborhoods also experience the highest rates of infant mortality.³⁴⁷ Racial disparities also persist in the borough in the number of preterm births, with 1.4 times the number of preterm births among the black population than among the non-Hispanic white population for the time period 2010-2012 and 1.2 times the number of Hispanic preterm births than

³⁴⁴ New York's MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan, Attachment J."NY DSRIP Strategies Menu and Metrics," 2014

³⁴⁵ NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

³⁴⁶ Ibid.

³⁴⁷ Ibid.

non-Hispanic white preterm births in the same time period. (See Appendix B, Table 68.) Though, these racial and ethnic disparities were narrower in the Bronx than in NYC and NYS in the same time period.³⁴⁸

In the Bronx, the percentage of mothers receiving prenatal care starting in the first trimester was lower than the NYS and NYC rates (71.8% and 70.4%, respectively) by over 10%, and more than one-third (37.0%) of mothers in the Bronx received prenatal care beginning in the third trimester (months 7-9), compared to 23.9% for NYS and 28.7% in NYC.³⁴⁹ (See Appendix B, Table 61). Additionally, the Bronx neonatal death rate was slightly higher than NYC and NYS at 3.5 per 1,000, compared to 2.9 per 1,000 in NYC and 3.3 per 1,000 in NYS.³⁵⁰

An important component of promotion of healthy women, infants and children is the reduction in teenage pregnancy. Key informants working in the field described a number of evidence based and promising practices related to teen pregnancy, including better linkages to health centers that provide family planning services, improved access to long-acting and emergency contraception, and adolescent medical visits with the parent out of the exam room—for at least part of the time.³⁵¹

Synergies with the Local Department of Health

As noted above, a possible source for alignment of resources and efforts to address both health care access and the determinants of poor health may be the new NYC DOHMH Center for Health Equity. DOHMH will launch the Center in 2015 “to address health disparities that result in an excess burden of ill health and premature mortality in New York City’s communities of color. The Center will focus on three key areas: leveraging policy changes to better integrate primary care and public health to serve the health needs of communities, building interagency collaboration to address the root causes of health disparities, and increasing access to care by making services more accessible in neighborhoods with the worst health outcomes.”

SECTION E: SUMMARY CHART OF THE PROJECTS TO BE IMPLEMENTED (NOT APPLICABLE)

Guided by the findings of this borough-wide CNA report, and the additional analysis that is available in the detailed data tables in Appendix B., each PPS will be selecting their own projects based on their service area within the borough, their particular patient demography, and the existing infrastructure of the PPS partners. See Appendix B for a summary chart of the currently available DSRIP Measure Preliminary Baseline Findings.”

³⁴⁸ The ratio of black to white preterm births in NYC was 1.8 and in NYS was 1.62 for the period 2010-2012. The ratio of Hispanic to white preterm births in NYC was 1.39 and in NYS was 1.25 for this time period. Source: NYS Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard, accessed August 2014.

³⁴⁹ NY State Vital Statistics, 2012

³⁵⁰ Ibid.

³⁵¹ NYAM primary data findings, September 2014.

Methods: Primary Source Data

In support of the overall aims of the CNAs, primary data were collected and analyzed to ensure the perspective of community members and stakeholders was incorporated into the reported findings and to respond to specific questions that could not be sufficiently addressed through secondary source data alone. In addressing these questions, we were particularly interested in the perspectives of Medicaid and other low-income populations, as well as the uninsured.

- To what extent are community and environmental conditions conducive to health promotion and disease prevention?
- What are the primary health concerns and health needs of residents, overall and according to neighborhood and socio-demographic characteristics?
- What are the health related programming and services available to community residents, what organizations are providing the services, and what are the service gaps?
- Are there differences in access, use and perceptions of health related programming and services according to neighborhood and according to ethnic, racial, and language groups?
- In what ways can health promotion and health care needs be better addressed, overall and for distinct populations?

The protocol for primary data collection, including the instruments and outreach, was developed by the NYAM Center for Evaluation and Applied Research (CEAR) in collaboration with the PPS's at the start of the CNA process.

Instruments and Data Collection

Data were collected through key informant interviews, focus groups, and surveys as described below.

- Resident Surveys: Approximately 600 surveys were completed by Bronx residents, ages 18 and older. Survey questions focused on basic demographics, health concerns (individual and community-wide), health care utilization, barriers to care, and use of community and other services (see appendix for Resident Survey). Survey respondents were identified and recruited by local organizations, including community based organizations, senior centers, social service and health providers, and through NYAM initiated street outreach—at street fairs, subway stops, and other places where people congregate—in targeted neighborhoods where CBO recruitment was seemingly insufficient, including East Tremont, Fordham, High Bridge, Hunts Point, Longwood, Melrose, Morrisania, Mott Haven, Parkchester and West Farms. Although the sample cannot be considered representative of the borough in a statistical sense, and gaps are unavoidable, the combination of street and organizational outreach facilitated engagement of a

targeted yet diverse population, including both individuals connected and unconnected to services. Survey respondents came from all Bronx neighborhoods; socio-demographic characteristics included: 48% Black/African American, 38% Latino, 10% Asian, 43% foreign born, 12% limited English proficient, 78% living below the poverty line, 52% on Medicaid and 12% uninsured. The mean age of respondents was 46, with a range of 18 to 95. Surveys were self-administered or administered by NYAM staff or staff or volunteers at community organizations (see Partnering with Community-based Organizations section below), who were trained and supported in survey administration by NYAM staff. The surveys were translated into 10 languages: Arabic, Bangla, Chinese (simplified and traditional), Haitian Creole, French, Hindi, Korean, Polish, Russian and Spanish. Participants received a Metrocard valued at \$10 for completing the survey.

- *Key Informant Interviews:* Twenty-four key informant interviews were conducted, including 30 individuals. Key informants were selected with input from the PPS's. A portion had population specific expertise, including particular immigrant groups, older adults, children and adolescents. Others had expertise in specific issues, including, substance abuse, supportive housing, care coordination, corrections, and homelessness. All key informant interviews were conducted by NYAM staff using an interview guide (see attached Key Informant Interview Guide). All key informants were asked about perceptions of health issues in the community, barriers and facilitators to good health, health care and other service needs, and recommendations for services and activities that may benefit the local population. Follow-up questions, asked on ad hoc basis, probed more deeply into the specific areas of expertise of key informants. The interview guide was designed for a discussion lasting 60 minutes; in fact, interviews ranged from 45 to 120+ minutes. All key informant interviews were audiotaped and professionally transcribed to ensure an accurate record and to allow for verbatim quotations. (See Appendix C for the list of Key Informants by name, position, and organization.)

Focus Groups: Twenty-one focus groups were conducted for the Bronx Community Needs Assessment. Most of the focus groups were with community members, including residents from low-income neighborhoods and residents identified as having unique health and service needs, including individuals with behavioral health issues, older adults, LGBTQ, and immigrants and/or other limited English proficient (LEP) individuals. Focus group participants were recruited by local organizations, community based organizations, senior centers, social service providers, tenant associations, and health providers. Community member interest in the focus groups was high, with some groups including up to 30 individuals. In addition to the resident groups, we conducted a small number of focus groups with community leaders, as well as providers, including behavioral health providers, care coordinators, and physicians. These groups were coordinated by collaborating PPS's, so as to ensure that the perspective of key stakeholders was incorporated into the findings.

Focus groups lasted approximately 90 minutes and were conducted using a semi-structured guide (see attached Focus Group Guide), with questions that included, but were not limited to: perceptions of health issues in the community, access to resources that might promote health (e.g., fresh fruit and vegetables, gyms), use of health services, access to medical and behavioral health care, domestic violence, and recommendations for change (see Appendix C. for focus group guide). Follow-up questions were asked on ad hoc basis, based on responses heard. Focus groups were conducted by CEAR staff members and consultants retained by CEAR, experienced in qualitative data collection and focus group facilitation. Many of the resident focus groups were co-facilitated by representatives of community based organizations that were trained by CEAR on focus group facilitation and the specific focus group protocol. Focus groups in languages other than English, Spanish and French were conducted solely by trained community partners (see Partnering with Community-based Organizations section below). Participants received a \$25 honorarium, in appreciation of their time and insights. All focus groups were audio recorded, so that transcriptions and/or detailed reports could be developed for each, and to allow for verbatim quotations.

Data Management and Analysis

Surveys: Survey data were entered using Qualtrics, a web-based survey platform. They were analyzed according to standard statistical methods, using SAS. Means and proportions were generated. As appropriate, bivariate analyses was conducted to better understand the association between health indicators and geographic, demographic, and socioeconomic characteristics.

Interviews and Focus Groups: Transcripts and focus group reports were maintained and analyzed in NVivo, a software package for qualitative research. Data were coded according to pre-identified themes relevant to health, community needs, and DSRIP, as well as themes emerging from the data themselves (see Appendix C. for code list). Analysts utilized standard qualitative techniques, involving repeated reviews of the data and consultation between multiple members of the research team. Analyses focused on 1) common perceptions regarding issues, populations, recommendations, etc., 2) the unique knowledge and expertise of particular individuals or groups and 3) explanatory information that facilitated interpretation of primary and secondary source data.

Partnering with Community-based Organizations

Consistent with DSRIP CNA guidance, NYAM conducted primary data collection in collaboration with numerous community organizations. Community organizations were identified in collaboration with PPS representatives, and represented a range of populations (e.g., older adults, immigrant populations) and neighborhoods.

As described above, community organizations assisted in recruitment for and administration of focus groups and surveys. All organizations assisting with survey administration or focus group facilitation

were provided with written guidelines including information on data collection and the general research protocol, the voluntary nature of research, and confidentiality. Organizations also participated in an in-person or phone training on data collection conducted by NYAM staff. Community organizations partnering in the research received an agency honorarium consistent with their level of responsibility

Methods: Secondary Source Data

The secondary data analyses followed the recommendations and guidelines set forth in the *Guidance for Conducting Community Needs Assessment* provided by the New York State Department of Health: (http://www.health.ny.gov/health_care/medicaid/redesign/docs/community_needs_assessment_guidance.pdf). Overall, the analyses started with publicly available, de-identified data to assess health care and community resources, disease prevalence, demographic characteristics, and social determinants of health. The aim of this component of study was to assess preventable emergency room visits and hospitalizations, as well as to develop a set of descriptive analyses on the rates of chronic conditions of the population at county and zip code levels, where available.

Our analyses of publicly available data was supplemented with review of the available literature, including reports prepared by the participating providers, the NYS Department of Health, NYC Departments of Health and City Planning, academic institutions, and others. NYAM aggregated, analyzed, and interpreted these data. Quantitative data was summarized first with descriptive statistics. More advanced techniques, including regression analysis, was used to explore relationships between relevant variables. Where possible, data was presented in graphical (charts, line graphs, and maps) format to facilitate ease of communication and comprehension. Below we list and provide brief descriptions of the data sets used:

- **NYS Community Health Indicator Reports**

These data are used to compare rates of chronic disease-specific morbidity, mortality, hospitalization and other indicators of poor health and associated health care utilization in particular communities to the corresponding rates of NYC and NYS.

<http://www.health.ny.gov/statistics/chac/indicators/>

- **Behavioral Risk Factor Surveillance System (BRFSS)**

These data are used to describe the population of New York State, New York City and counties/boroughs in terms of health status (e.g., percentage of the population uninsured, percentage with diabetes or obese, etc.). The BRFSS is a telephone survey and the de-identified, individual level data are publicly available for download from the Centers for Disease Control and Prevention. Individual-level metrics on regular source of care, mental health and chronic conditions will be obtained from BRFSS.

<http://www.cdc.gov/brfss/>

- **Statewide Planning and Research Cooperative (SPARCS)**

Aggregate and individual-level (de-identified) metrics on preventable hospitalizations, emergency department visit rates and hospitalization rates for chronic conditions will be obtained through the publicly available SPARCS data.

<https://health.data.ny.gov/Health/Hospital-Inpatient-Discharges-SPARCS-De-Identified/u4ud-w55t>

- **Prevention Quality Indicators (PQI)**

These data include preventable hospital admission rates, with observed and expected rate per 100,000 by PQI Name, allowing identification of zip code areas with elevated rates and comparison to NYC and NYS.

<https://health.data.ny.gov/Health/Hospital-Inpatient-Prevention-Quality-Indicators-P/igp6-vdi4>

<https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/izyt-3msa?>

- **Pediatric Quality Indicators (PDI)**

These data include preventable hospital admission rates, with observed and expected rate per 100,000 by PQI Name, by county, allowing comparison to NYC and NYS.

<https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/64yg-akce>

- **Potentially Preventable Emergency Visits (PPV)**

These data include potentially preventable hospital emergency department visits, with observed and expected rate per 100,000, allowing identification of zip code areas with elevated rates and comparison to NYC and NYS.

<https://health.data.ny.gov/Health/Medicaid-Potentially-Preventable-Emergency-Visits-/khkm-zkp2>

- **Hospital-specific profiles of quality of care for selected conditions**

<http://hospitals.nyhealth.gov/index.php?PHPSESSID=8884724aa17728cabe8a127921762546>

- **Medicaid Chronic conditions, Inpatient Admissions, and Emergency Room Visits**

These data are de-identified and publicly available by county and zip code for: Diabetes Mellitus, Diseases and Disorders of the Cardiovascular System, Diseases and Disorders of the Respiratory System, HIV Infection, Mental Diseases and Disorders, Newborn and Neonates, and Substance Abuse. Counts of Medicaid beneficiaries and number of ER visits and inpatient admissions by condition are also available by zip code.

<https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/wyby-m39t>

- **Medicaid hospital inpatient Potentially Preventable Readmission (PPR) Rates**

Listing of the number of at risk admissions, number of observed PPR chains, observed PPR rate, and expected PPR rate to help characterize hospital performance on this metric.

<https://health.data.ny.gov/Health/Medicaid-Potentially-Preventable-Emergency-Visit-P/cr7a-34ka>

- **NYS Prevention Agenda 2013-2017 tracking indicators**

These provide data for counties for a variety of health outcomes including rates of preterm birth, unintended pregnancy, maternal mortality, new HIV cases, new STI cases, immunization rates, obesity, and smoking.

<https://health.data.ny.gov/Health/Prevention-Agenda-2013-2017-Tracking-Indicators-Co/47s5-ehya>

- **American Community Survey 2012 5-year estimates**

These data are used to estimate demographic information by Zip Code Tabulation Area and Community District.

<http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>

- **Vital Statistics**

Aggregate metrics on premature deaths, suicide rates, and Low Birth Weight and preterm births are obtained from the NYSDOH Vital Statistics.

http://www.health.ny.gov/statistics/vital_statistics/

<https://www.health.ny.gov/statistics/chac/perinatal/index.htm>

- **NYS HIV Surveillance System and NYS STD Surveillance System**

We used the latest reports available (2012) to obtain aggregate information on the rates of HIV and STDs for the state, city and boroughs.

http://www.health.ny.gov/diseases/aids/general/statistics/annual/2010/2010-12_annual_surveillance_report.pdf

- **NYC DOHMH HIV Surveillance System**

Data on the number and rates per 100,000 population of People Living with HIV/AIDS by UHF were obtained from NYC DOHMH

<http://www.nyc.gov/html/doh/html/data/hiv-eq.shtml>

- **NYC DOHMH Community Health Survey**

Data on Obesity, Psychological Distress, Self-Reported Health Status, Binge Drinking and Smoking were obtained from the NYC DOHMH Community Health Survey

<http://www.nyc.gov/html/doh/html/data/survey.shtml>

- **Mental Health Services Utilization and Co-morbidities**

Aggregate data on utilization by service type and co-morbidities are obtained from the NYS Office of Mental Health

<http://bi.omh.ny.gov/cmhp/dashboard>

- **Rat sightings by location**

Geo-coded information on rat sightings called into 311 was obtained from NYC DOHMH

<https://nycopendata.socrata.com/Social-Services/Rat-Sightings/3q43-55fe>

- **Serious Crime rate per 1,000 residents and Serious Housing Violations per 1,000 rental units**

Rates by Community District and borough obtained from the NYU Furman Center

<http://furmancenter.org/research/sonychan>

- **NYC Department of Corrections Jail admissions**

New jail admissions data were obtained from the NYC Department of Corrections (DOC) at the zip code level through an article in The Gothamist, and at the NYC level from DOC

http://gothamist.com/2013/05/01/these_interactive_charts_show_you_w.php

<https://data.cityofnewyork.us/City-Government/DOC-Annual-Statistics/wkaa-8g8b>

- **NYS Prison admissions**

New NYS prison admissions data were obtained from the Justice Atlas of Sentencing and Corrections at the borough, NYC, and State level

<http://www.justiceatlas.org/>

- **Health Care Resources and Community Based Resources**

In addition to the data sets listed above, the following publicly available data-sets were inventoried and analyzed to assess the capacity, service area, populations served, areas of expertise and gaps in service for healthcare and community resources in the Bronx:

Health Care Resources

- New York State Department of Health Safety Net Lists
- New York State Department of Health Dental Providers that Accept Medicare/Medicaid
- New York State Department of Health AIDS Institute. "AIDS Drug Assistance Program Plus Dental Providers"

- New York State Department of Health AIDS Institute. “Ryan White Dental Clinics for People Living with HIV/AIDS
- New York State Department of Health Profiles: Hospitals, Nursing Homes, Hospices, Adult Care Facilities and other health care facilities
- New York State Department of Health Division of Managed Care and Program Evaluation Managed Care Plan Directory
- New York State Department of Health Office Based Surgery Practices in New York State
- Health Resources and Services Administration (HRSA) Health Care Service Delivery and Look-Alike Sites
- Health Resources and Services Administration Health Care Facilities (CMS)
- New York City Department of City Planning. Selected Facilities and Program Sites
- Greater New York Hospital Association Health Information Tool for Empowerment (HITE) data
- NYC Department of Education (DOE) Office of School Health School Based Health Centers
- American Academy of Urgent Care Medicine (AAUCM) website
- City MD website
- NYS Office of Mental Health (NYS OMH) Local Mental Health Programs in New York State
- NYS OMH Residential Program Indicators (RPI) Report Tool
- NYS OMH OMH TCM Programs – Location with Program Capacity
- NYS Office of Mental Health (NYS OMH), Office of Performance Measurement and Evaluation. County Capacity and Utilization Data Book, CY 2012 or 2013. April, 2014
- Bronx Westchester Area Health Education Center website
- New York State Department of Health HCRA Provider List July 2014.
- Center for Health Workforce Studies. 2008-2010 Blended Physician Data: Analysis of Physician Re-registration Data.
- New York State of Health Navigator Agency Site Locations
- Substance Abuse & Mental Health Services Administration Services Administration (SAMHSA) Physicians Certified for Buprenorphine Treatment

Community Based Resources

- NYC Department of Information Technology and Telecommunications (DoITT) Agency Service Centers
- Administration for Children’s Services (ACS) Community Partners
- NYS Education Department, Office of the Professions New York State Nursing Programs
- NYS Department of Health Community Health Worker Programs
- NYC Department of Health & Mental Hygiene (DOHMH). “Directory of Child Care and Day Care Information Offices
- GROWN NYC Community Gardens

- NYC Department of Transportation (DOT) Daytime Warming Shelters
- NYC Department for the Aging (DFTA) DFTA Contracts
- NYC Department of Probation (DOP) Directory of DOP Office Locations
- Department of Youth and Community Development (DYCD) After-School Programs
- New York State Department of Health AIDS Institute Expanded Syringe Access Programs – Healthcare Facilities
- New York City Department of Health and Mental Hygiene New York City Farmers Markets
- New York State Department of Agriculture & Markets New York State Farmers’ Markets
- New York City Housing Authority (NYCHA) Development Data Book
- NYC Department of Consumer Affairs (DCA) Financial Empowerment Centers
- NYC Department of Education (DOE) GED Plus Locations
- HRSA Ryan White Programs
- NYC DOHMH / Public Health Solutions HIV Care Services Sites
- NYC Department of Homeless Services Homebase Locations
- NYC Mayor’s Office Programs
- National Alliance for Mental Illness (NAMI) Website
- NYC DOE Public High School Programs
- NYC Women’s Resource Network Directory
- NYCHA Summer Meal Locations
- NYC DoITT Office of Adults and Continuing Education (OACE) Sites
- NYC Taxi and Limousine Commission (TLC) Paratransit Bases
- Department of Health Prevention Agenda Contractors
- NYCDOHMH Syringe Access Programs
- Department of Small Business Services Workforce 1 Career Center Locations
- NYC DOE Young Adult Borough Centers

- **Community Health Needs Assessments, Community Service Plans and Community Reports**

We also conducted a systematic review of existing Community Health Needs Assessments and Community Service Plans of the major hospitals in the Bronx and various community groups. See bibliography for titles of those reports.

LIST OF APPENDICES

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- Appendix C. Primary Data Collection Instruments and Information
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 - List of Collaborating Organizations (Focus Groups and Community Surveys)
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- Appendix D. Primary Data Findings (forthcoming)

GLOSSARY OF KEY TERMS

Avoidable Hospital Use: “This term is used to designate all avoidable hospital service use including avoidable emergency department use, avoidable hospital admissions and avoidable hospital readmissions within 30 days. This can be achieved through better aligned primary care and community based services, application of evidence based guidelines for primary and chronic disease care, and more efficient transitions of care through all care settings.” (New York State Department of Health, “NYS DSRIP Glossary”)

Clinical Improvement Milestones: “Noted under Domain 3, these milestones focus on a specific disease or service category, e.g., diabetes, palliative care, that is identified as a significant cause of avoidable hospital use by Medicaid beneficiaries. Milestones can either relate to process measures or outcome measures and can be valued either on reporting or progress to goal, depending on the metric. Every Performing Provider System must include one strategy from behavioral health. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement over baseline, using a valid, standardized method.” (New York State Department of Health, “NYS DSRIP Glossary”)

Community District (CD): New York City has 59 community districts: 12 in Brooklyn, 12 in the Bronx, 12 in Manhattan, 14 in Queens and three in Staten Island. Each community district appoints a community

board, an advisory group that is comprised of 50 volunteers to assist neighborhood residents and to advise on local and city planning, as well as other issues.

Community Needs Assessment (CNA): As defined in the NYS DOH CNA guidance, “this process includes a description of the population to be served, an assessment of its health status and clinical care needs, and an assessment of the health care and community wide systems available to address those needs.” (New York State Department of Health, “Guidance for Conducting Community Needs Assessment Required for DSRIP Planning Grant and Final Project Plan Applications,” as of June, 2014).

The specific aims of the CNA process are to:

- Describe health care and community resources,
- Describe communities served by the PPSs,
- Identify the main health and health service challenges facing the community, and
- Summarize the assets, resources, and needs for the DSRIP projects.

Delivery System Reform Incentive Payment (DSRIP): As defined by NYS DOH, “DSRIP is the main mechanism by which New York State will implement the Medicaid Redesign Team (MRT) Waiver Amendment. DSRIP’s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to \$ 6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health.” (New York State Department of Health, “DSRIP FAQs”)

District Public Health Office: Three DPHOs were established by NYC DOHMH in 2002 to reduce health disparities in the highest need neighborhoods of the city. They are located in the following neighborhoods:

- East/Central Harlem
- North/Central Brooklyn
- The South Bronx

Domain: “Overarching areas in which DSRIP strategies are categorized. Performing Provider Systems must employ strategies from the domains two through four in support of meeting project plan goals and milestones. Domain one encompasses project process measures and does not contain any strategies. The Domains are:

- Domain 1: Overall Project Progress
- Domain 2: System Transformation
- Domain 3: Clinical Improvement
- Domain 4: Population-wide Strategy Implementation”

(New York State Department of Health, “NYS DSRIP Glossary”)

DSRIP Project Toolkit: “A state developed guide that will provide additional information on the core components of each DSRIP strategy, how they are distinct from one another, and the rationale for selecting each strategy (i.e. evidence base for the strategy and its relation to community needs for the Medicaid and uninsured population). In addition, the strategy descriptions provided in the toolkit will be used as part of the DSRIP Plan Checklist and can serve as a supplement to assist providers in valuing projects.” (New York State Department of Health, “NYS DSRIP Glossary”)

MRT Waiver Amendment: “An amendment allowing New York to reinvest \$8 billion in Medicaid Redesign Team generated federal savings back into NY’s health care delivery system over five years. The Waiver amendment contains three parts: Managed Care, State Plan Amendment and DSRIP. The amendment is essential to implement the MRT action plan as well as prepare for ACA implementation.” (New York State Department of Health, “NYS DSRIP Glossary”)

New York City Department of Health and Mental Hygiene (NYC DOHMH): New York City’s local health department responsible for: disease control, mental hygiene, environmental health, epidemiology, health care access and improvement, health promotion, planning and program analysis and disease prevention and emergency preparedness and response.

Performing Provider Systems (PPS): “Entities that are responsible for performing a DSRIP project. DSRIP eligible providers, which include both major public general hospitals and safety net providers, collaborating together, with a designated lead provider for the group.” (New York State Department of Health, “NYS DSRIP Glossary”)

Population-wide Project Implementation Milestones: “Also known as Domain 4, DSRIP performing provider systems responsible for reporting progress on measures from the New York State Prevention Agenda. These metrics will be measured for a geographical area denominator of all New York State residents, already developed as part of the Prevention Agenda:
http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm”
(New York State Department of Health, “NYS DSRIP Glossary”)

Potentially Preventable Emergency Room Visits (PPVs): “Part of the nationally recognized measures for avoidable hospital use. The measures identify emergency room visits that could have been avoided with adequate ambulatory care.” (New York State Department of Health, “NYS DSRIP Glossary”)

Potentially Preventable Readmissions (PPRs): “Part of the nationally recognized measures for avoidable hospital use. PPRs measure readmissions to a hospital following a prior discharge from a hospital and that is clinically-related to the prior hospital admission.” (New York State Department of Health, “NYS DSRIP Glossary”)

Prevention Agenda: “As Part of Domain 4, Population-wide Strategy Implementation Milestones, the Prevention Agenda refers to the “blueprint for state and local action to improve the health of New

Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups who experience them”, as part of New York State’s Health Improvement Plan .

Further information: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm”

(New York State Department of Health, “NYS DSRIP Glossary”)

Prevention Quality Indicators – Adults (PQIs): “Part of the nationally recognized measures for avoidable hospital use PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for “ambulatory care sensitive conditions.” These are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The PQIs are population-based and can be adjusted for covariates for comparison purposes. Additionally there are similar potentially preventable hospitalization measures for the pediatric population referred to as PDIs.” (New York State Department of Health, “NYS DSRIP Glossary”)

Prevention Quality Indicators – Pediatric (PDIs): “Part of the nationally recognized measures for avoidable hospital use that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PDIs screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at the system or provider level. Similarly the PDIs are population based and can be also be adjusted for covariates for evaluation.” (New York State Department of Health, “NYS DSRIP Glossary”)

Project Progress Milestones: “Also known as Domain 1, measures the investments in technology, tools, and human resources that strengthen the ability of the performing provider systems (PPS) to serve target populations and pursue DSRIP project goals. The Project Progress milestones include monitoring of the project spending and post-DSRIP sustainability. In addition, submission of quarterly reports on project progress specific to the PPS DSRIP project and it’s Medicaid and low-income uninsured patient population.” (New York State Department of Health, “NYS DSRIP Glossary”)

Safety Net Provider (SNP): “Entities that provide care to underserved and vulnerable populations. The term ‘safety net’ is used because for many low-income and vulnerable populations, safety net providers are the ‘invisible net of protection’ for individuals whose lack of health coverage or other social and economic vulnerabilities limits their ability to access mainstream medical care.

Below is the DSRIP specific definition of safety-net provider:

The definition of safety net provider for hospitals will be based on the environment in which the performing provider system operates. Below is the safety net definition:

- A **hospital** must meet one of the three following criteria to participate in a performing provider system:
 1. Must be either a public hospital, Critical Access Hospital or Sole Community Hospital, or
 2. Must pass two conditions:

- A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.
 - B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals; or
3. Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community. The state will use Medicaid claims and encounter data as well as other sources to verify this claim. The state reserves the right to increase this percentage on a case by case basis so as to ensure that the needs of each community’s Medicaid members are met.”
- **Non-hospital based providers**, not participating as part of a state-designated health home, must have at least 35 percent of all patient volume in their primary lines of business associated with Medicaid, uninsured and Dual Eligible individuals.
 - **Vital Access Provider Exception:** The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. Three allowed reasons for granting an exception are:
 - A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.
 - Any hospital is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or clear track record of success in reducing avoidable hospital use.
 - Any state-designated health home or group of health homes.
 - **Non-qualifying providers** can participate in Performing Providers Systems. However, non-qualifying providers are eligible to receive DSRIP payments totaling no more than 5 percent of a project’s total valuation. CMS can approve payments above this amount if it is deemed in the best interest of Medicaid members attributed to the Performing Provider System. (New York State Department of Health, “NYS DSRIP Glossary”)

System Transformation Milestones: “Also known as Domain 2, these are outcomes based on a community needs assessment, which reflect measures of inpatient/outpatient balance, increased primary care/community-based services utilization, rates of global capitation, partial capitation, and bundled payment of providers by Medicaid managed care plans and measures for patient engagement.” (New York State Department of Health, “NYS DSRIP Glossary”)

United Hospital Fund (UHF) Neighborhood: There are 42 UHF neighborhoods in NYC, 11 of which are in Brooklyn, and each is comprised of adjoining zip codes to approximate community planning districts. (34 neighborhoods are sometimes used to increase the statistical power of the sample size).

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APPENDIX A. MAPS OF THE BRONX

October 3, 2014

The New York Academy of Medicine

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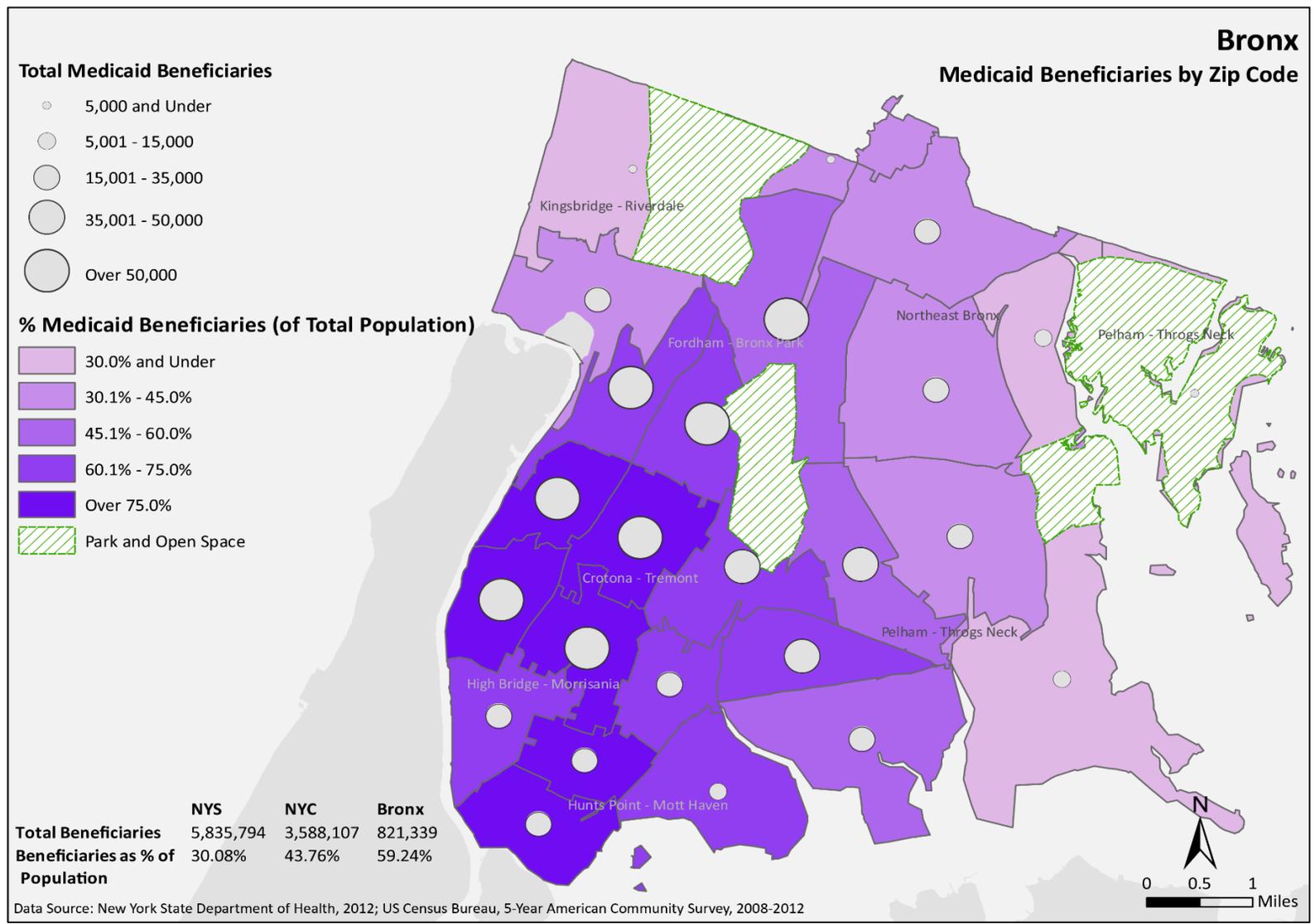
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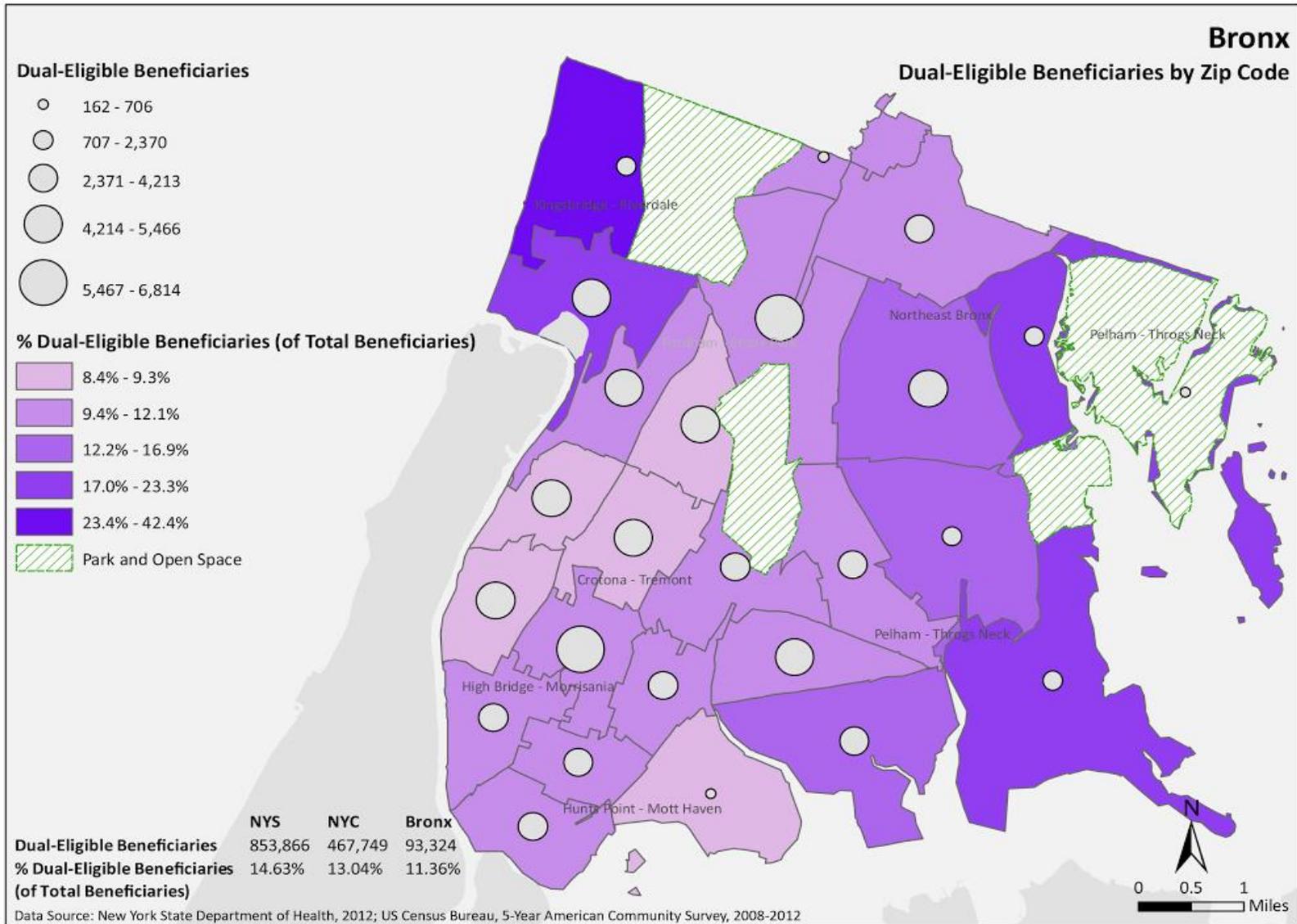
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APPENDIX A: MAPS OF THE BRONX

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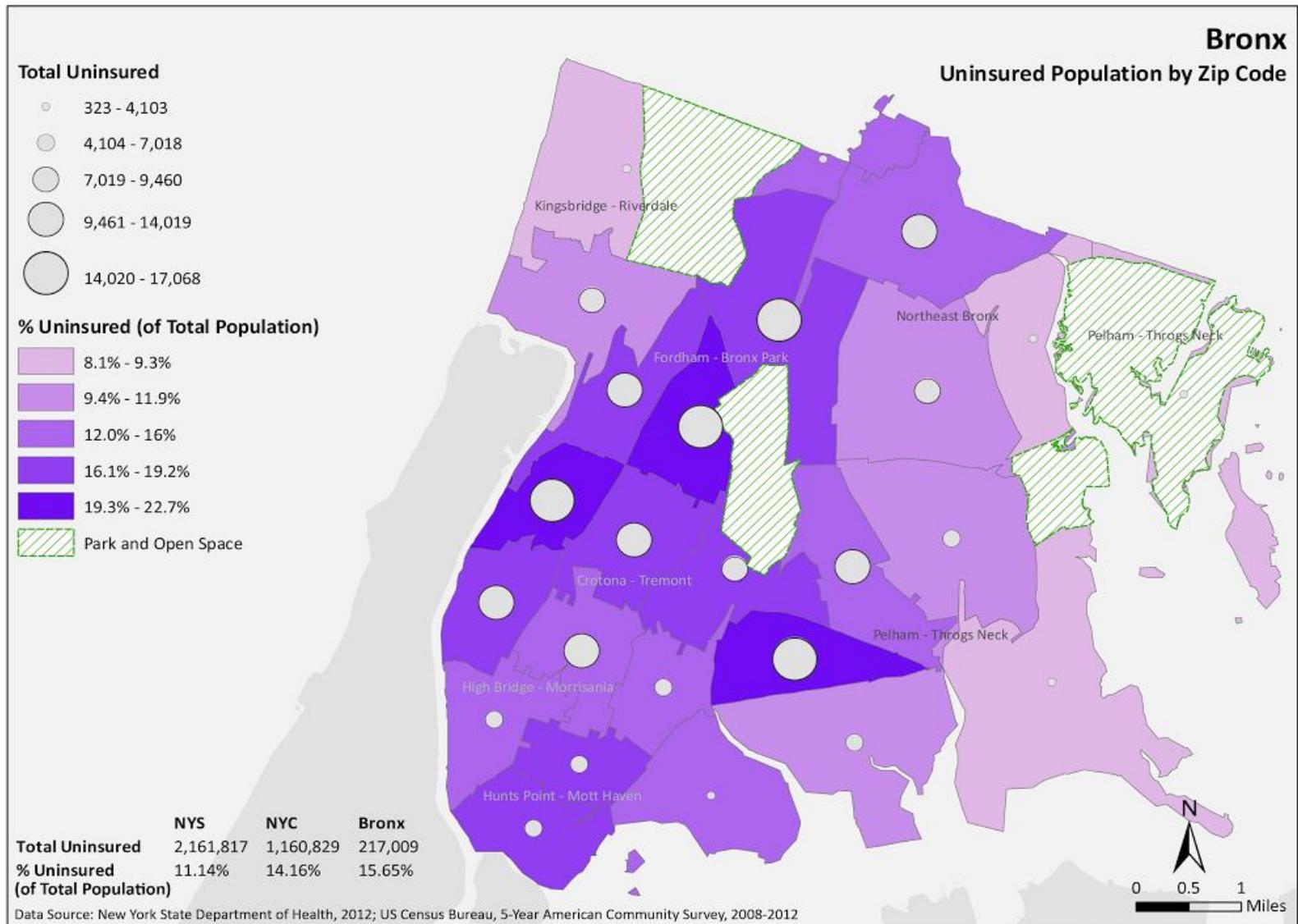


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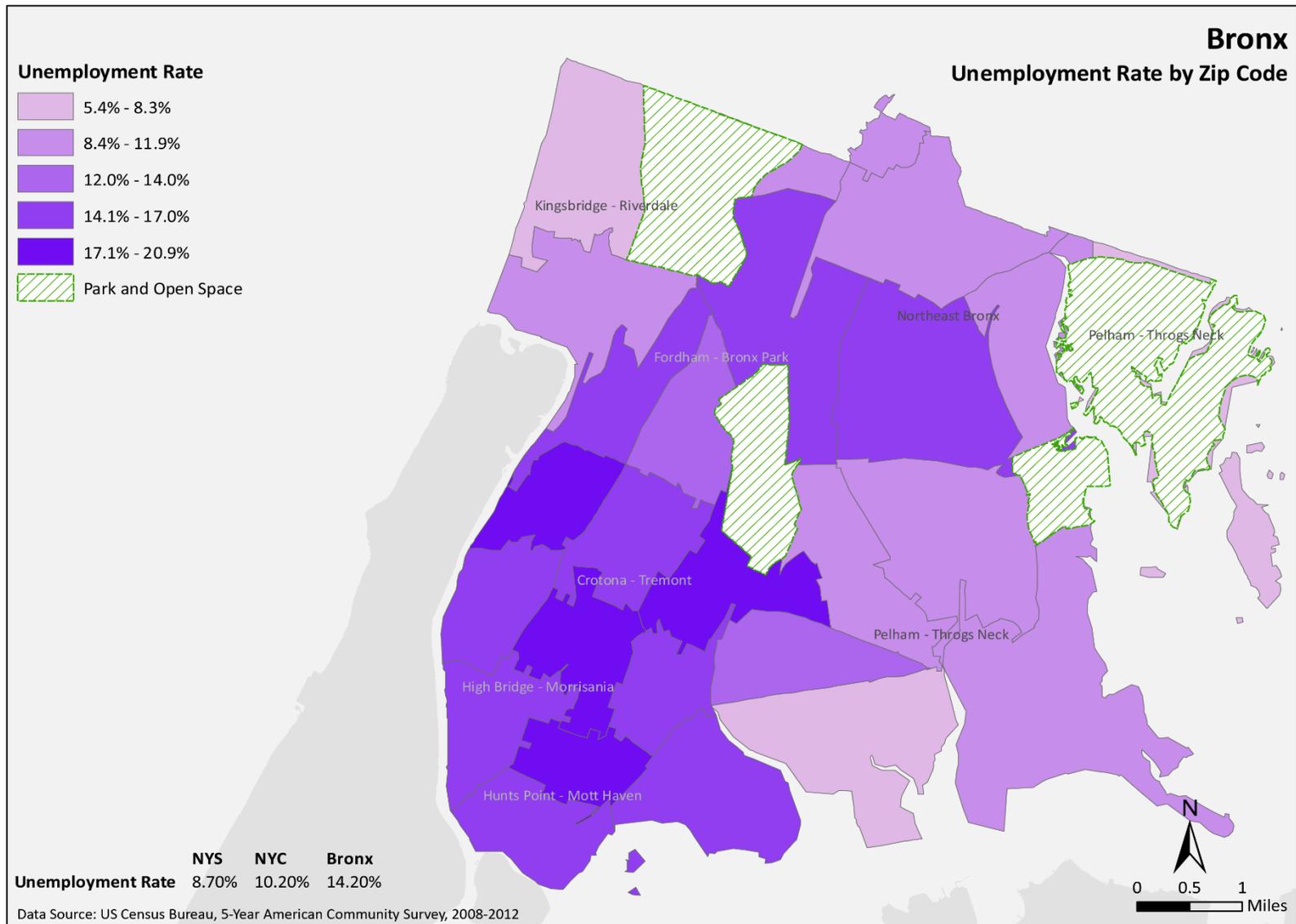
Prepared by The New York Academy of Medicine

3. Uninsured Population by Zip Code



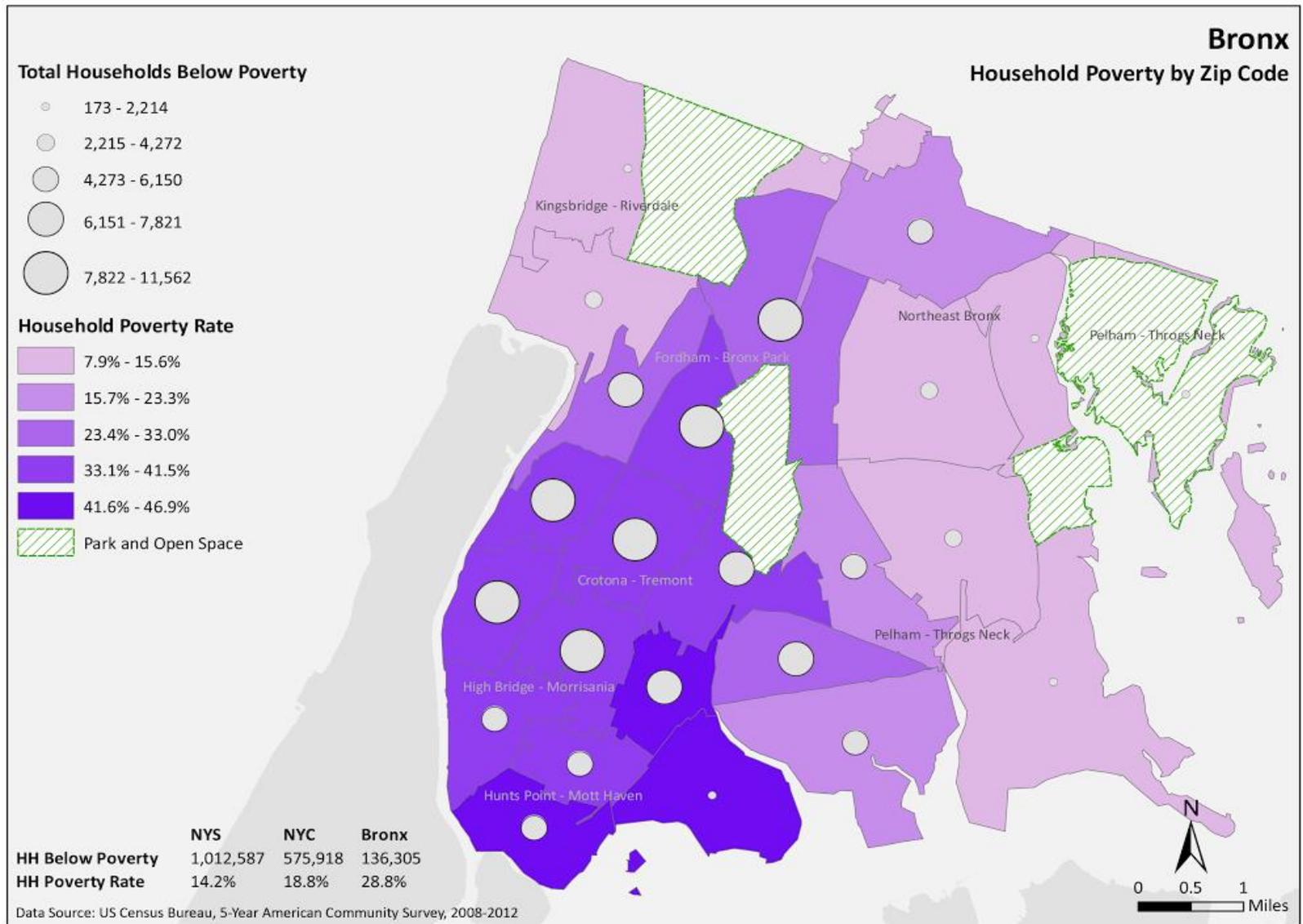
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4. Unemployment Rate by Zip Code

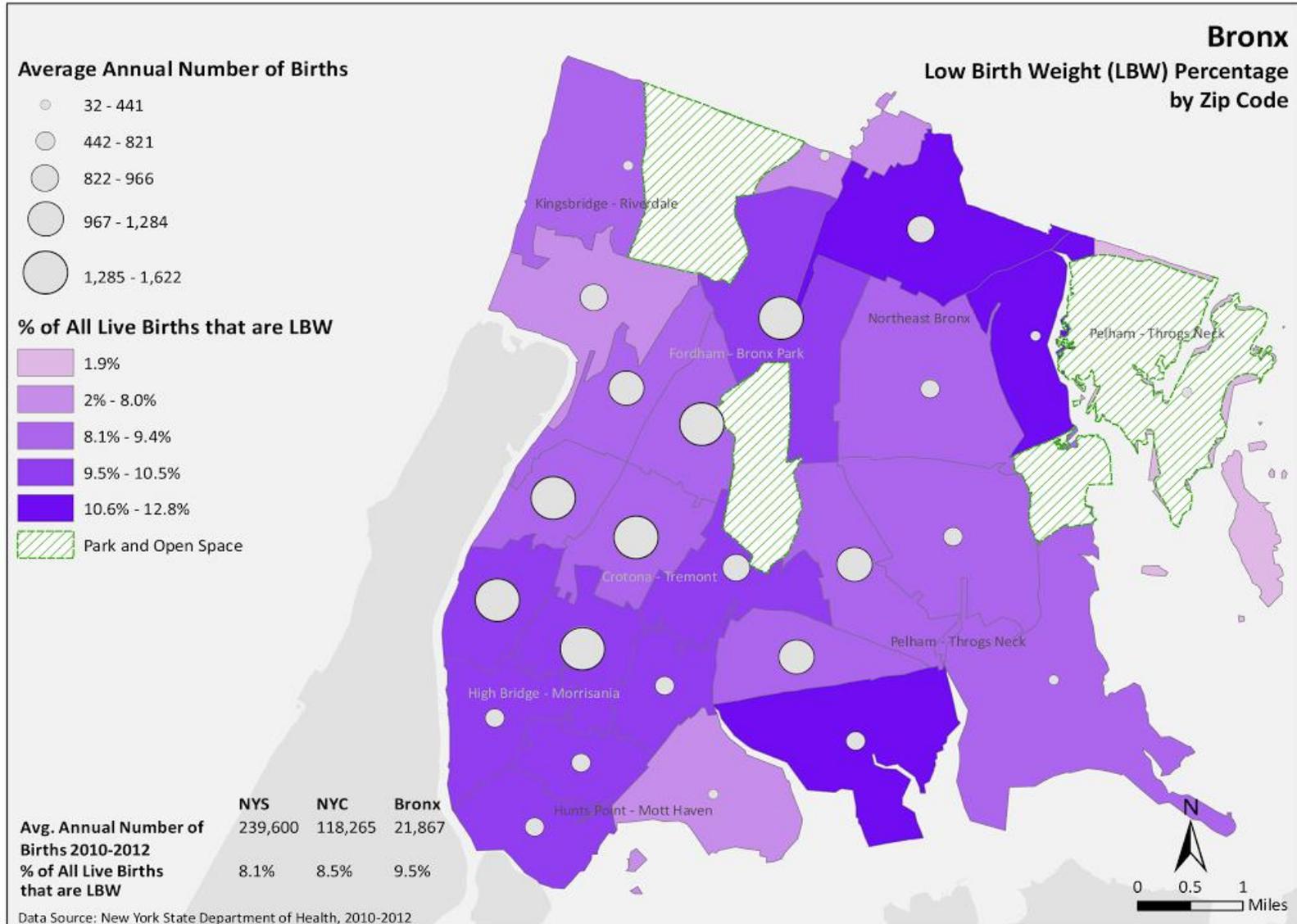


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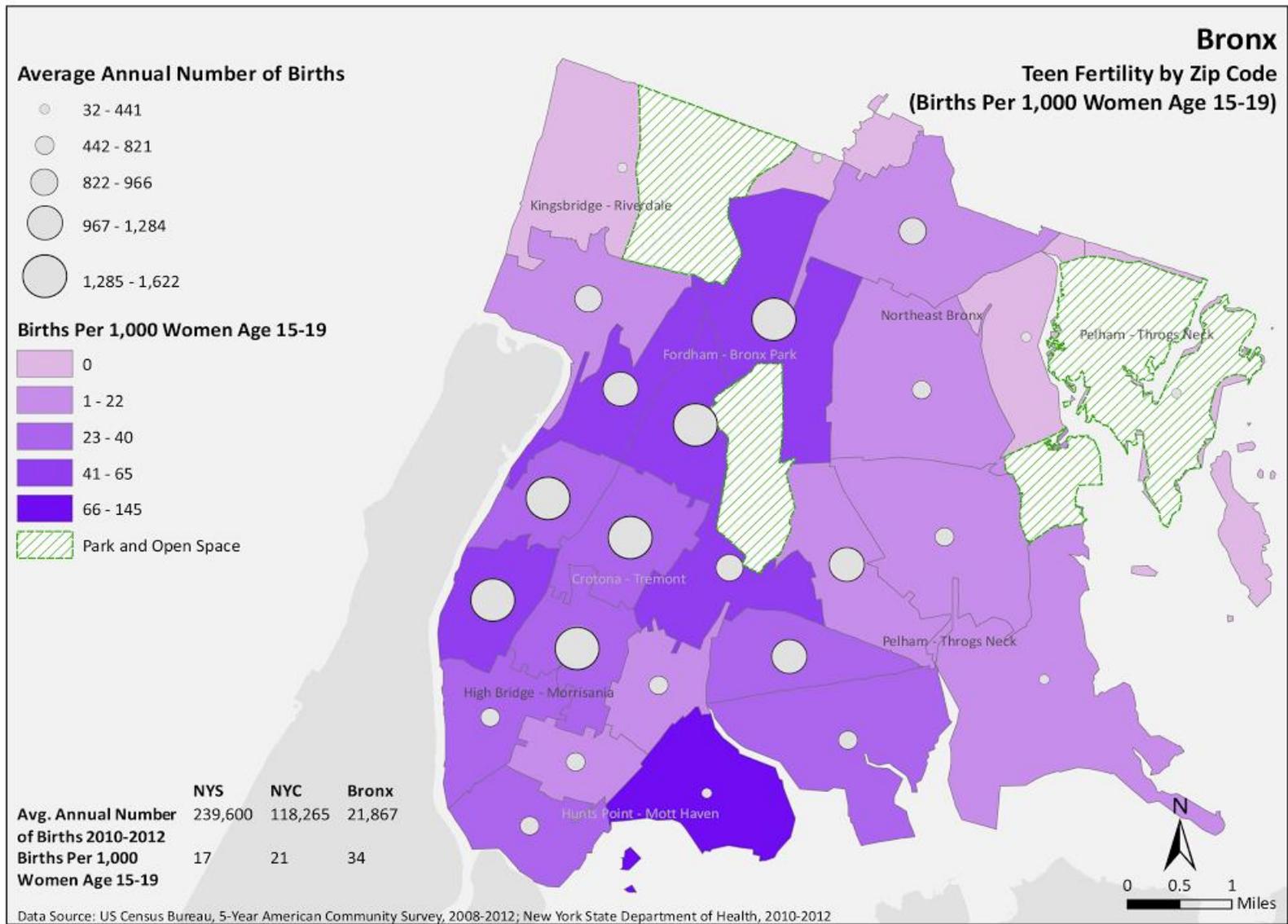
5. Household Poverty by Zip Code



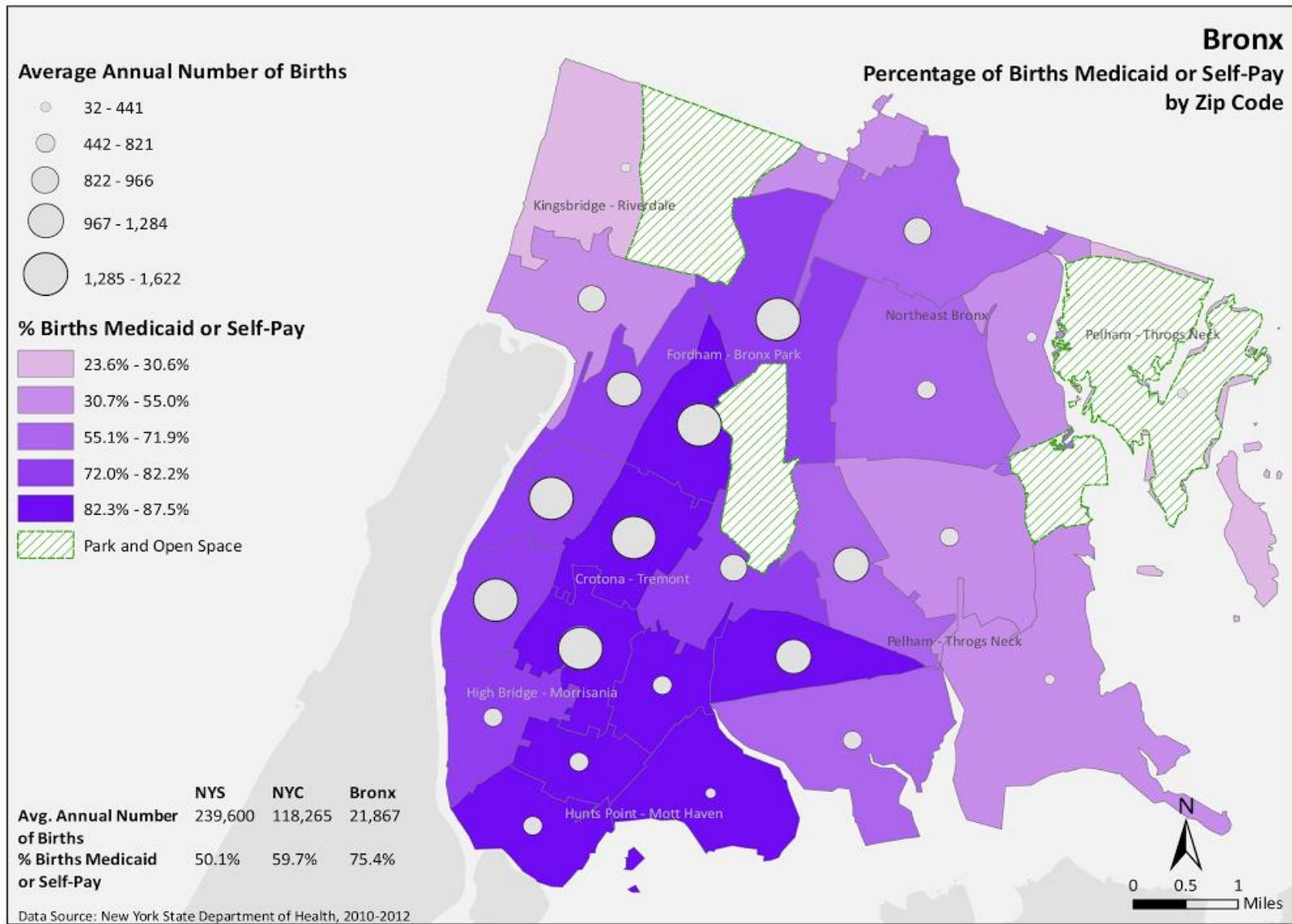
6. Low Birth Weight Percentage by Zip Code



7. Teen Fertility by Zip Code

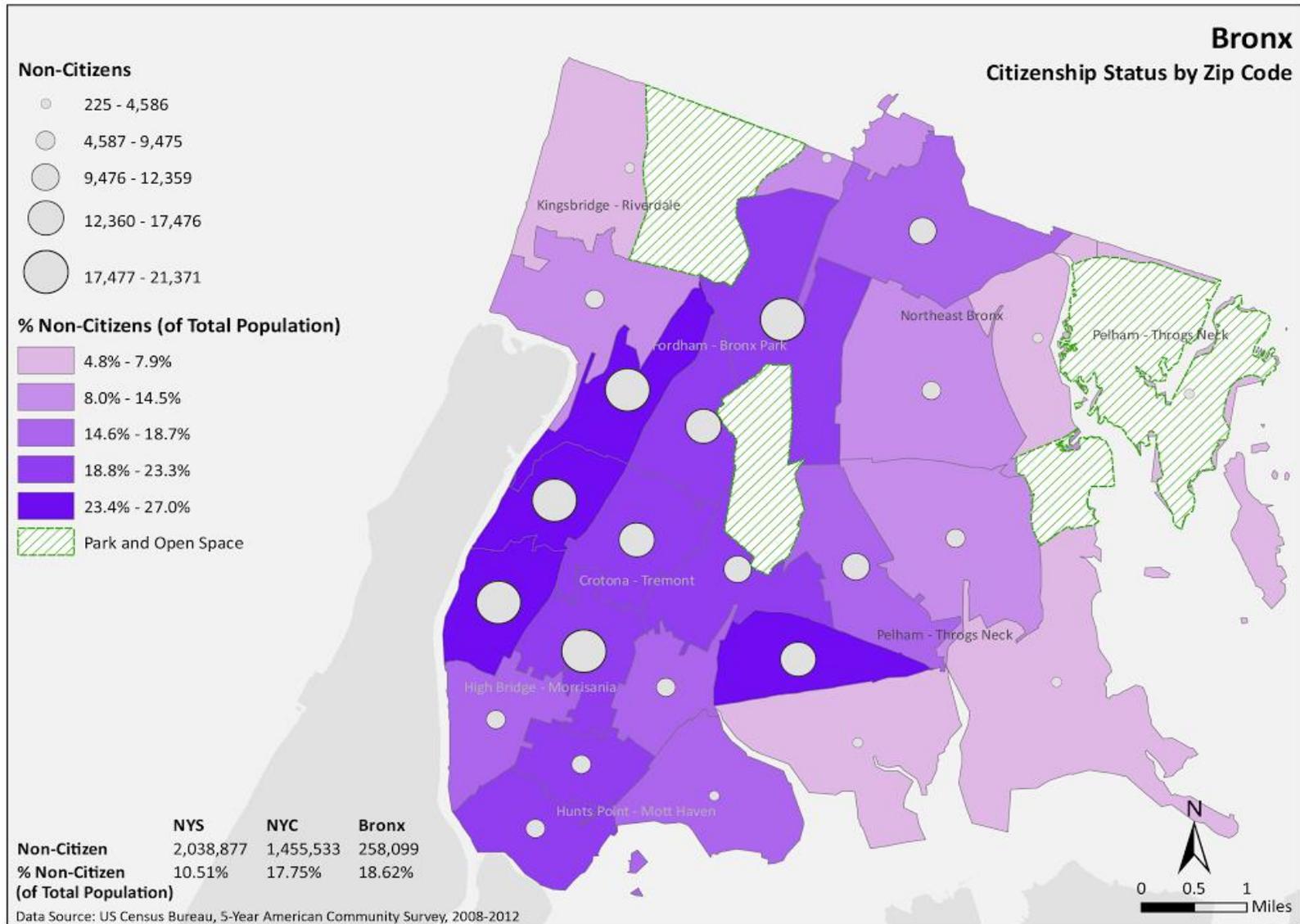


8. Percentage of Births Medicaid or Self-Pay by Zip Code



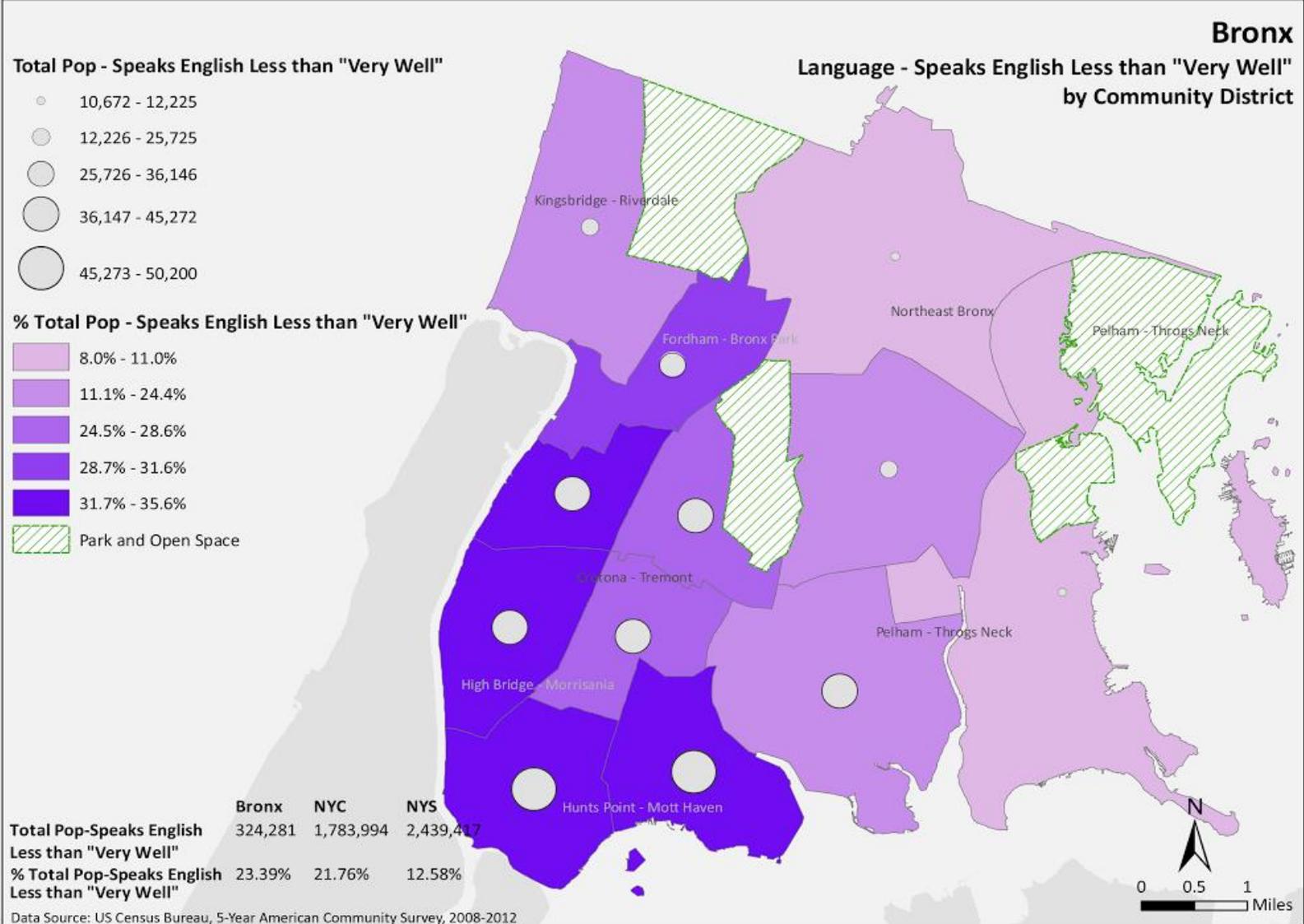
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9. Citizenship Status by Zip Code



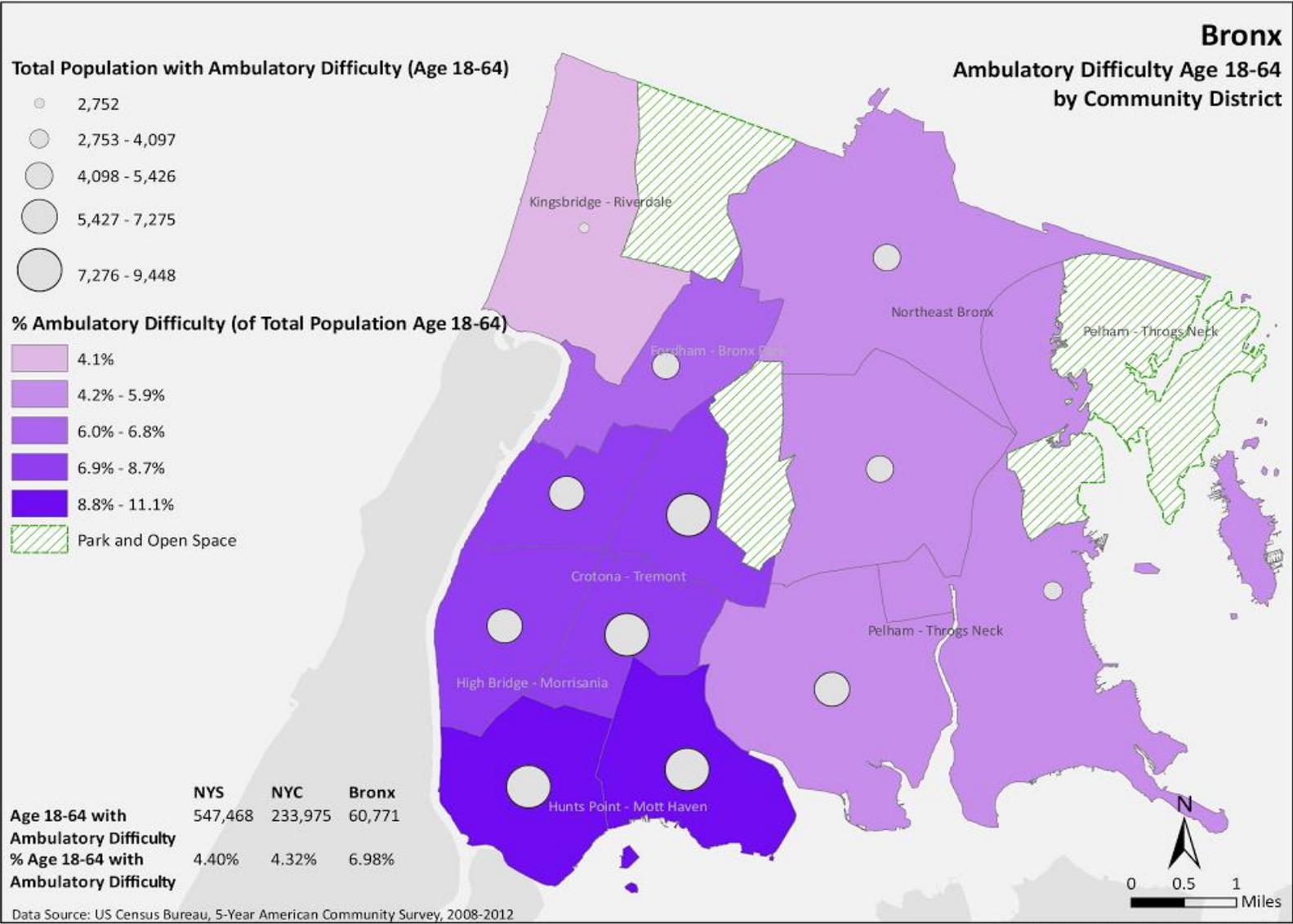
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10. Language—Speaks English Less than “Very-Well” by Community District



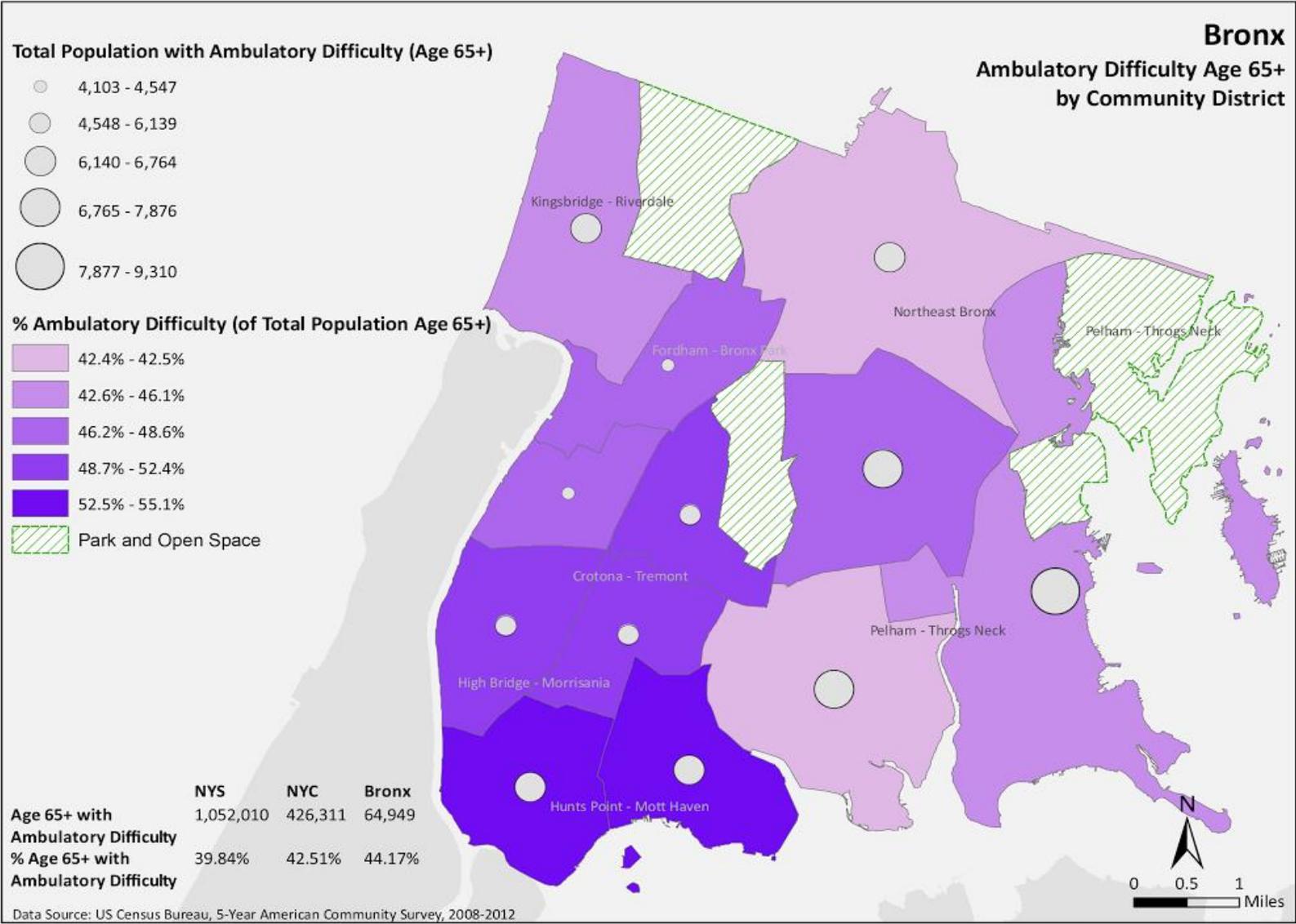
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11. Ambulatory Difficulty (Ages 18-64) by Zip Code

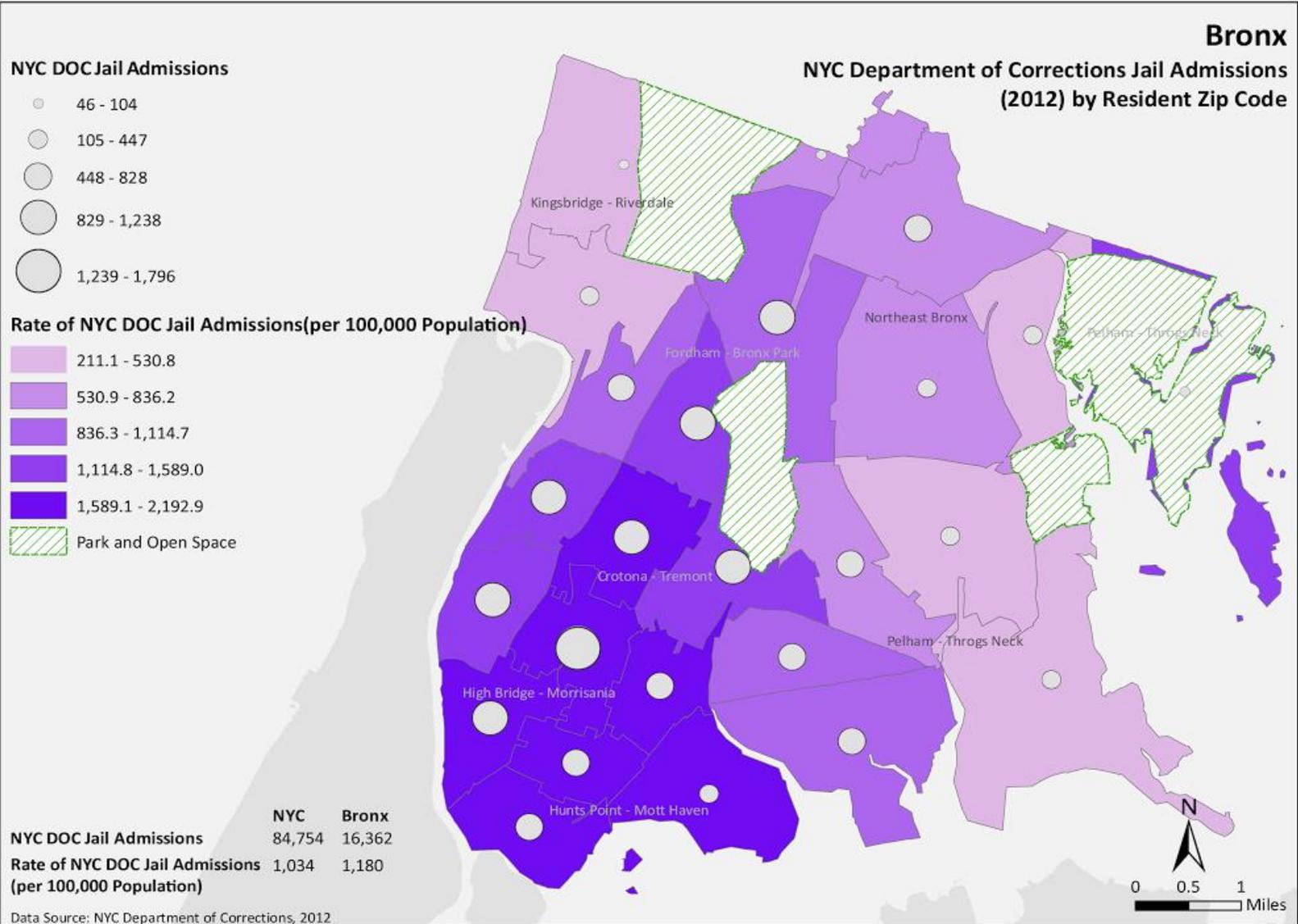


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12. Ambulatory Difficulty (Ages 65+) by Zip Code

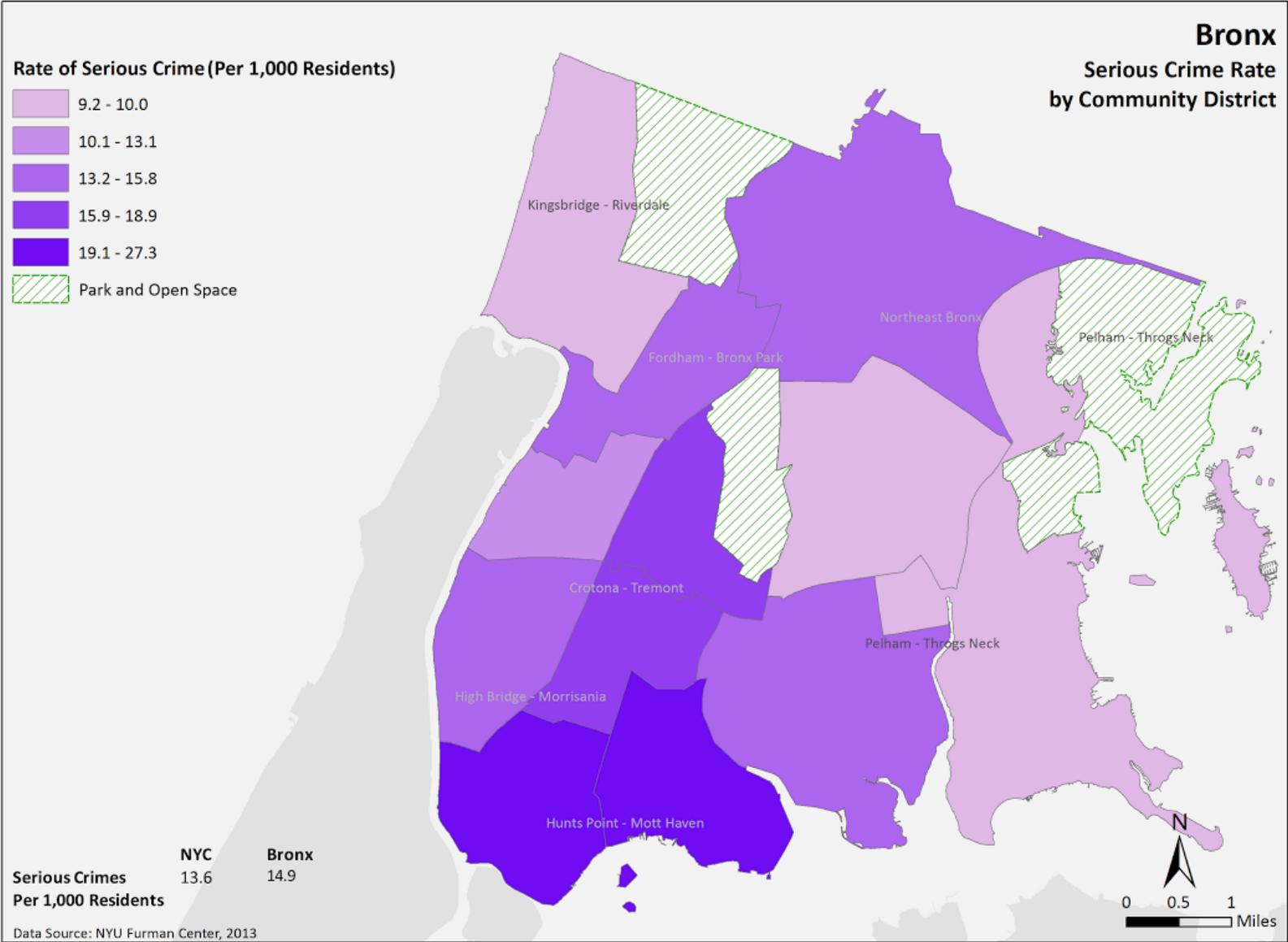


13. NYC Department of Corrections Jail Admissions by Resident Zip Code

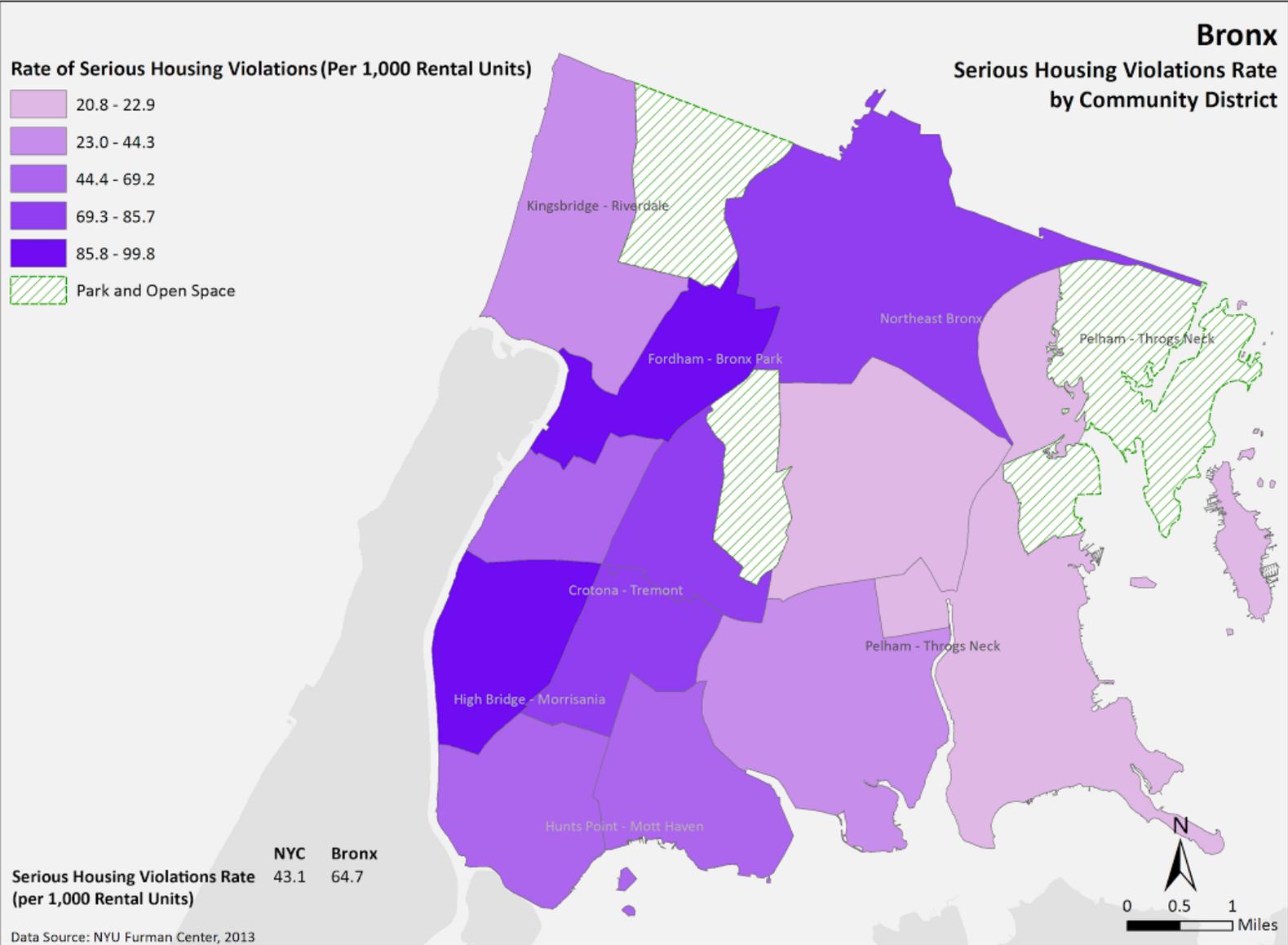


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14. Serious Crime Rate by Community District

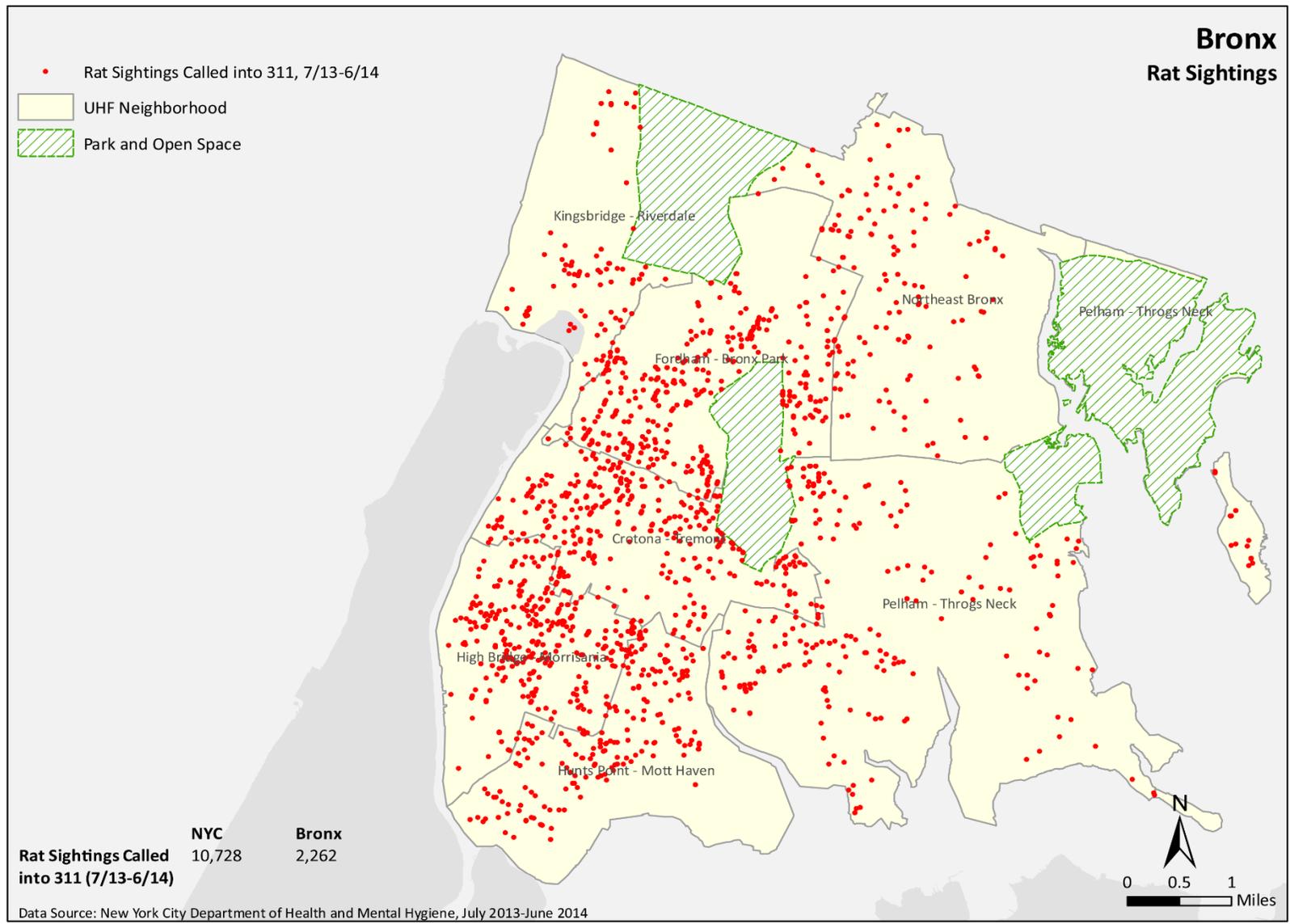


15. Serious Housing Violations by Community District

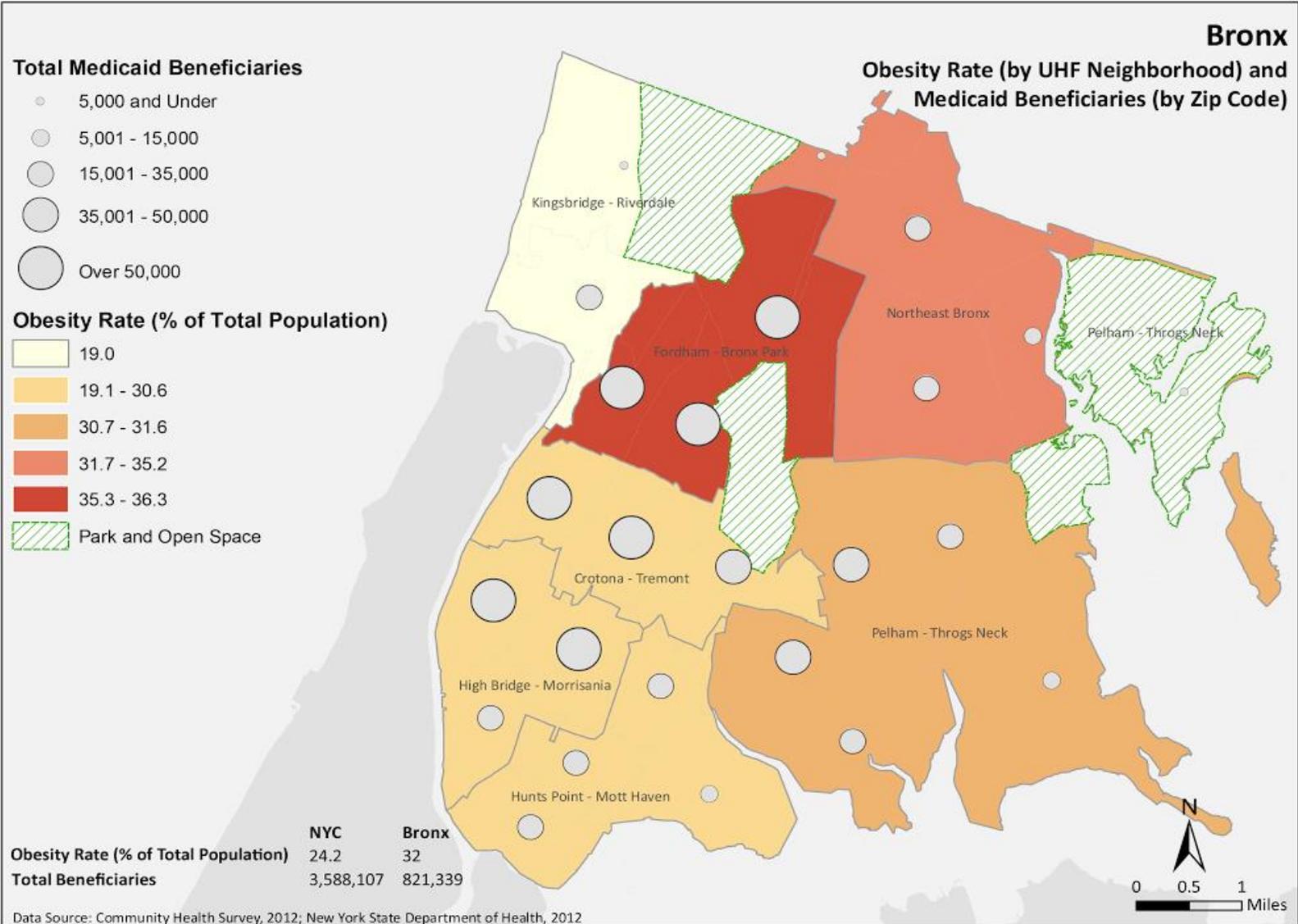


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16. Rat Sightings



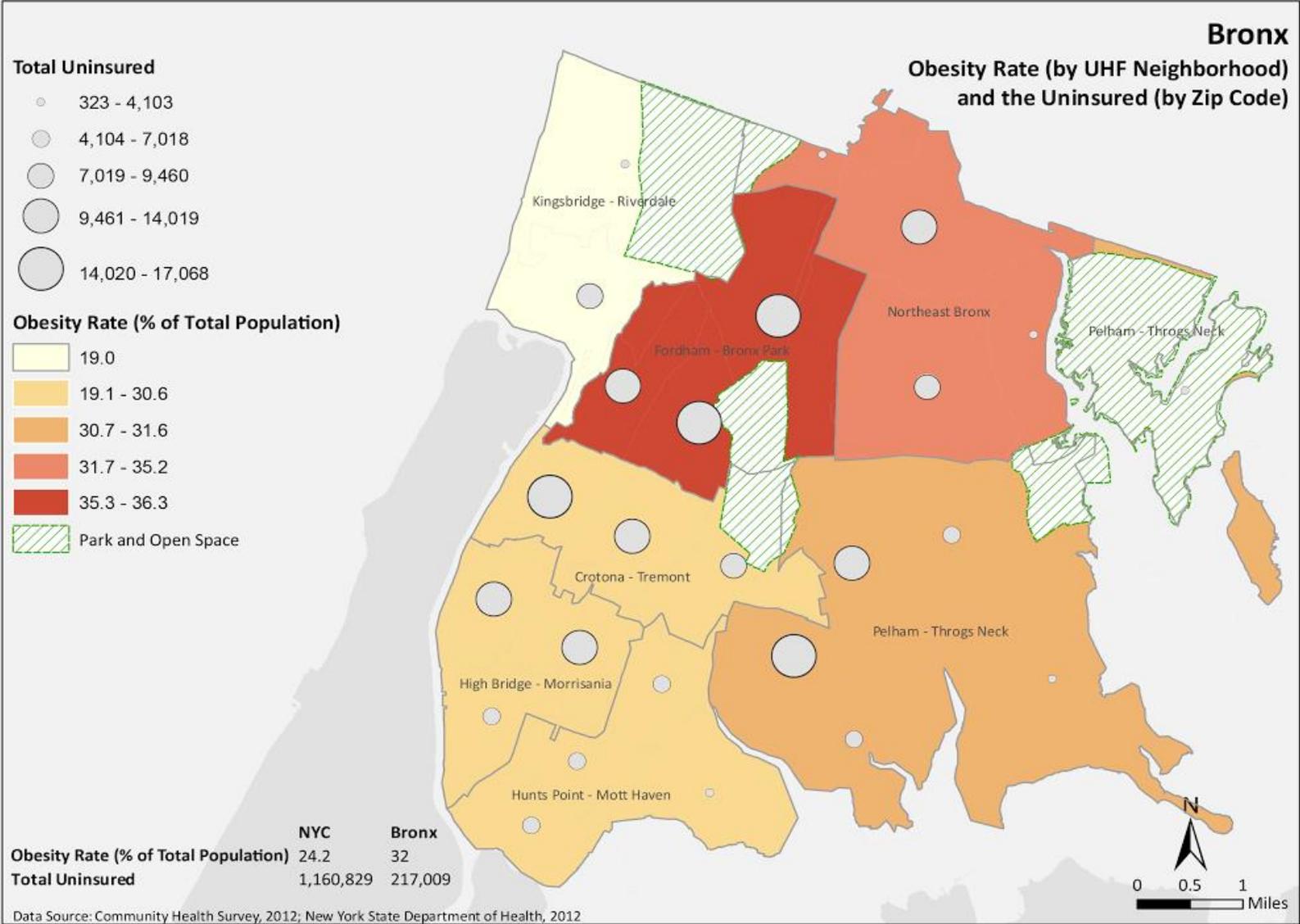
17. Obesity Rate (by UHF Neighborhood) and Medicaid Beneficiaries (by Zip Code)



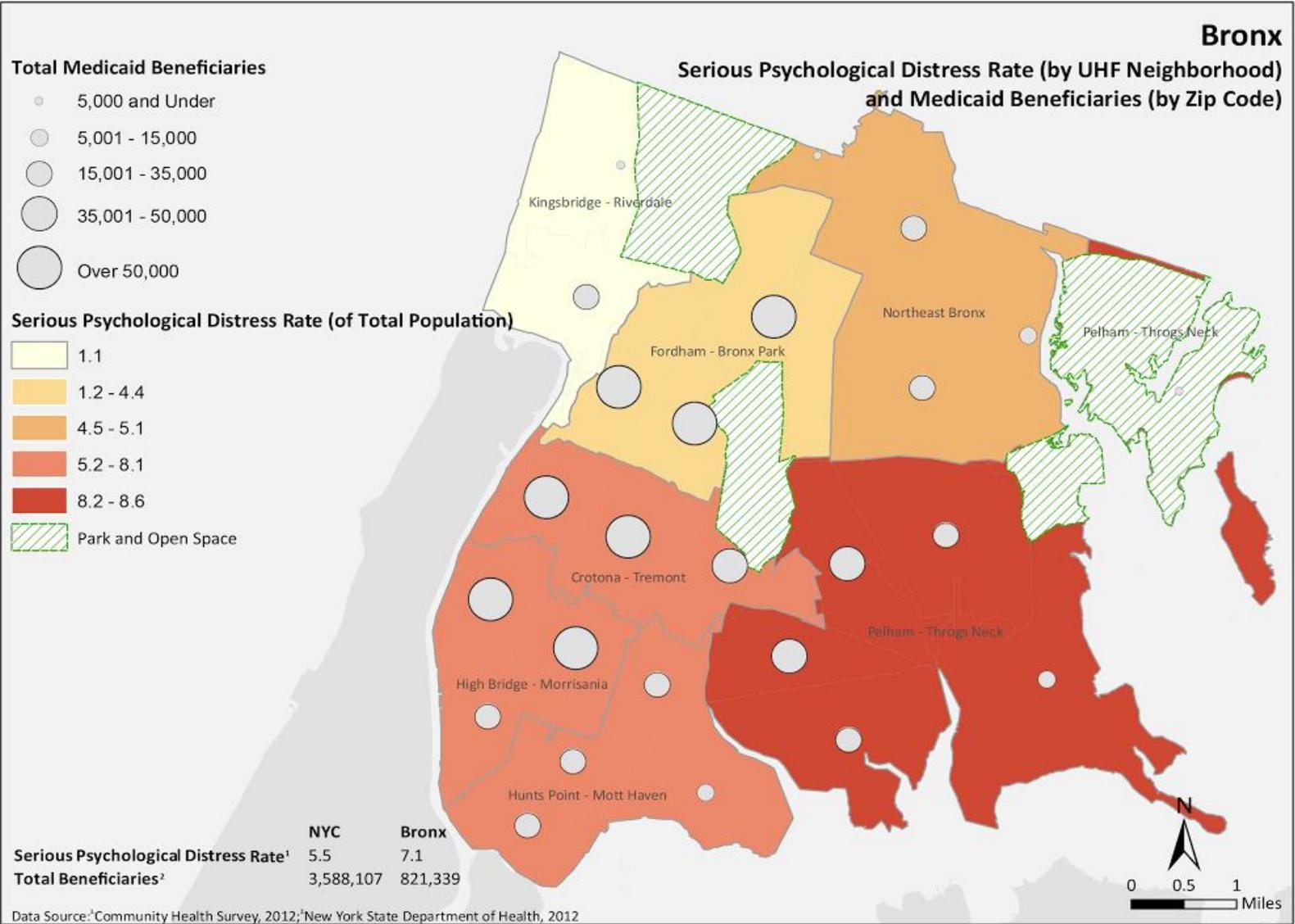
Data Source: Community Health Survey, 2012; New York State Department of Health, 2012

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18. Obesity Rate (by UHF Neighborhood) and Uninsured (by Zip Code)

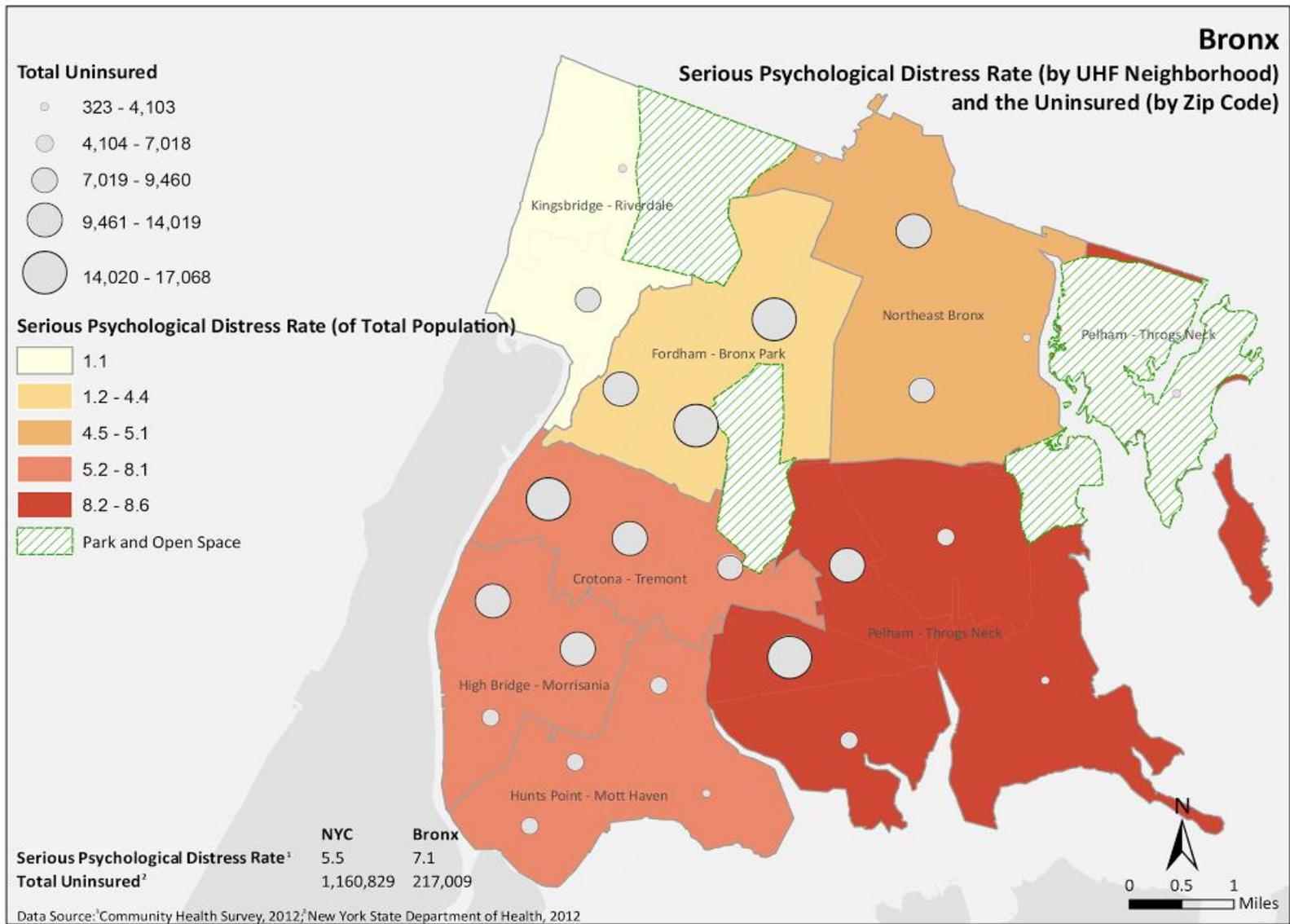


19. Serious Psychological Distress Rate (by UHF Neighborhood) and Medicaid Beneficiaries (by Zip Code)



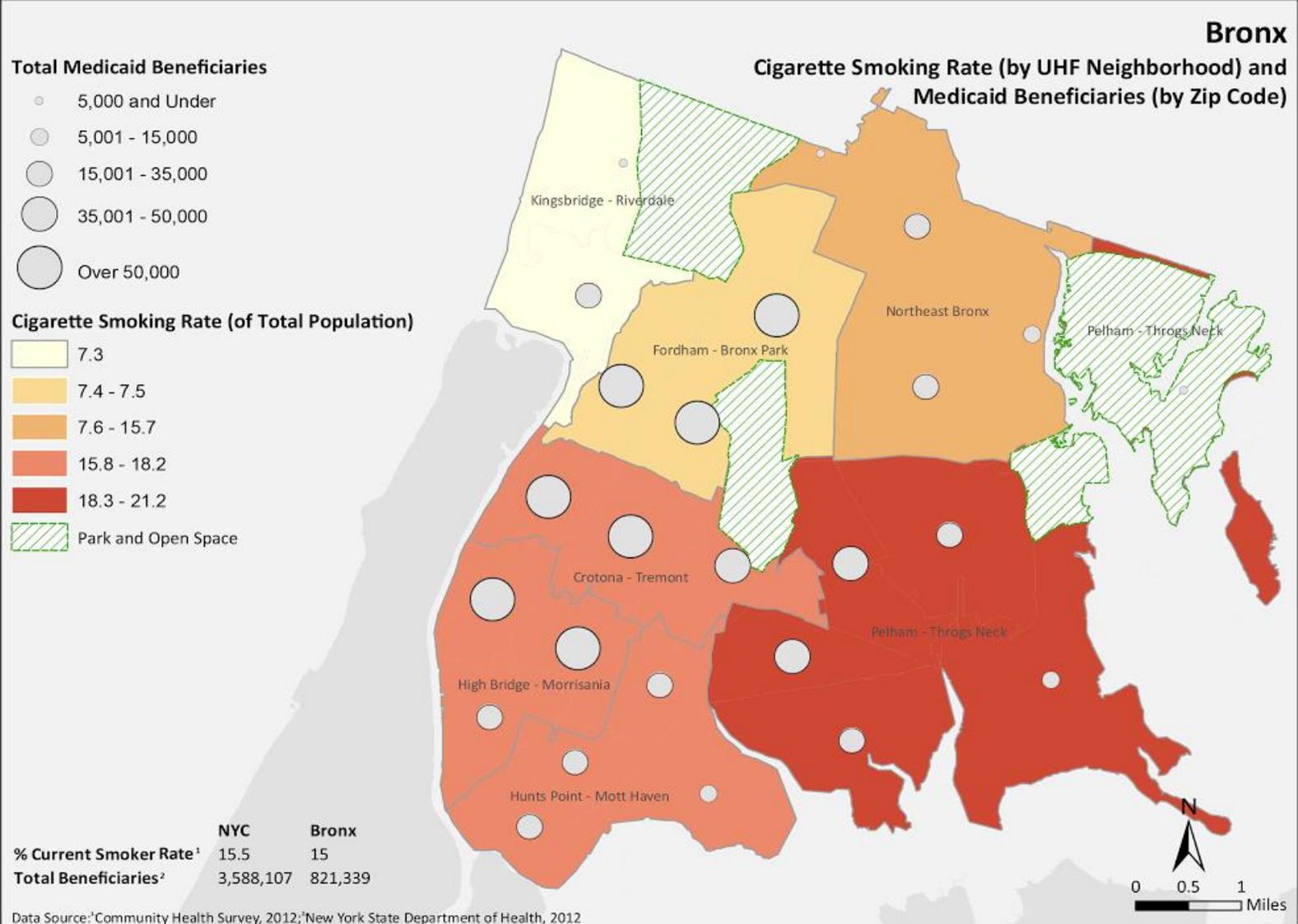
Prepared by The New York Academy of Medicine

20. Serious Psychological Distress Rate (by UHF Neighborhood) and Uninsured (by Zip Code)



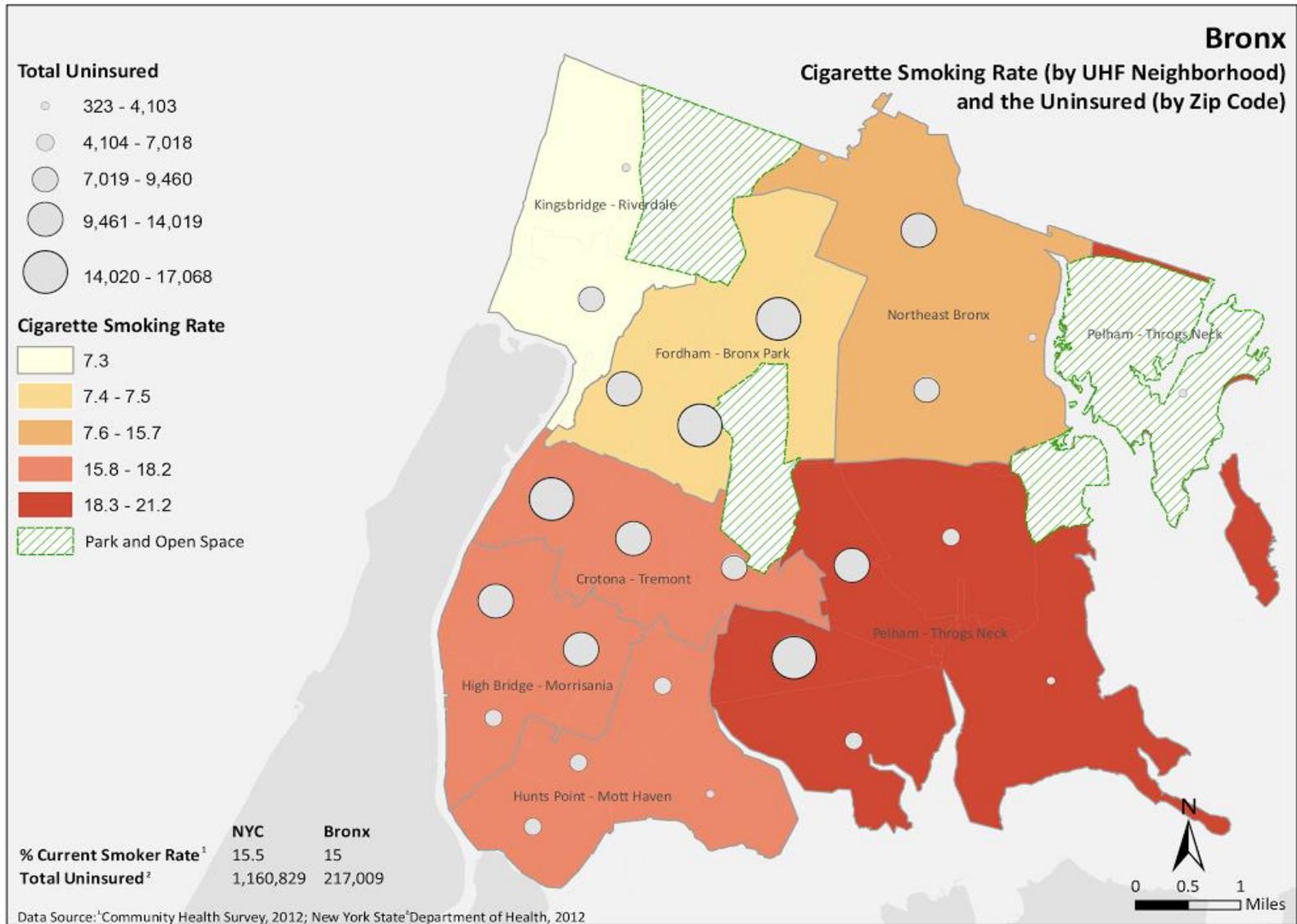
Prepared by The New York Academy of Medicine

21. Cigarette Smoking Rate (by UHF Neighborhood) and Medicaid Beneficiaries (by Zip Code)



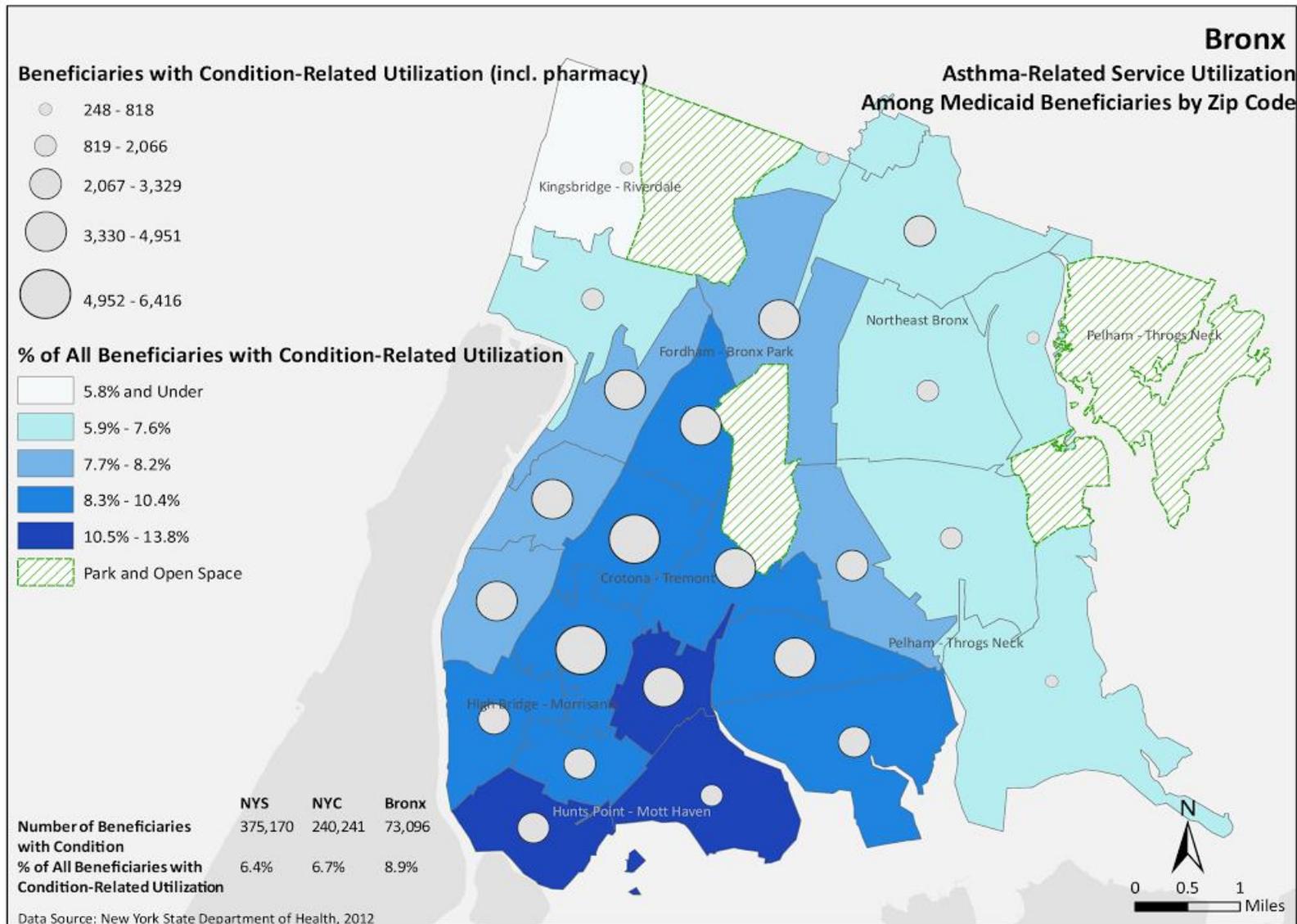
Prepared by The New York Academy of Medicine

22. Cigarette Smoking Rate (by UHF Neighborhood) and Uninsured (by Zip Code)

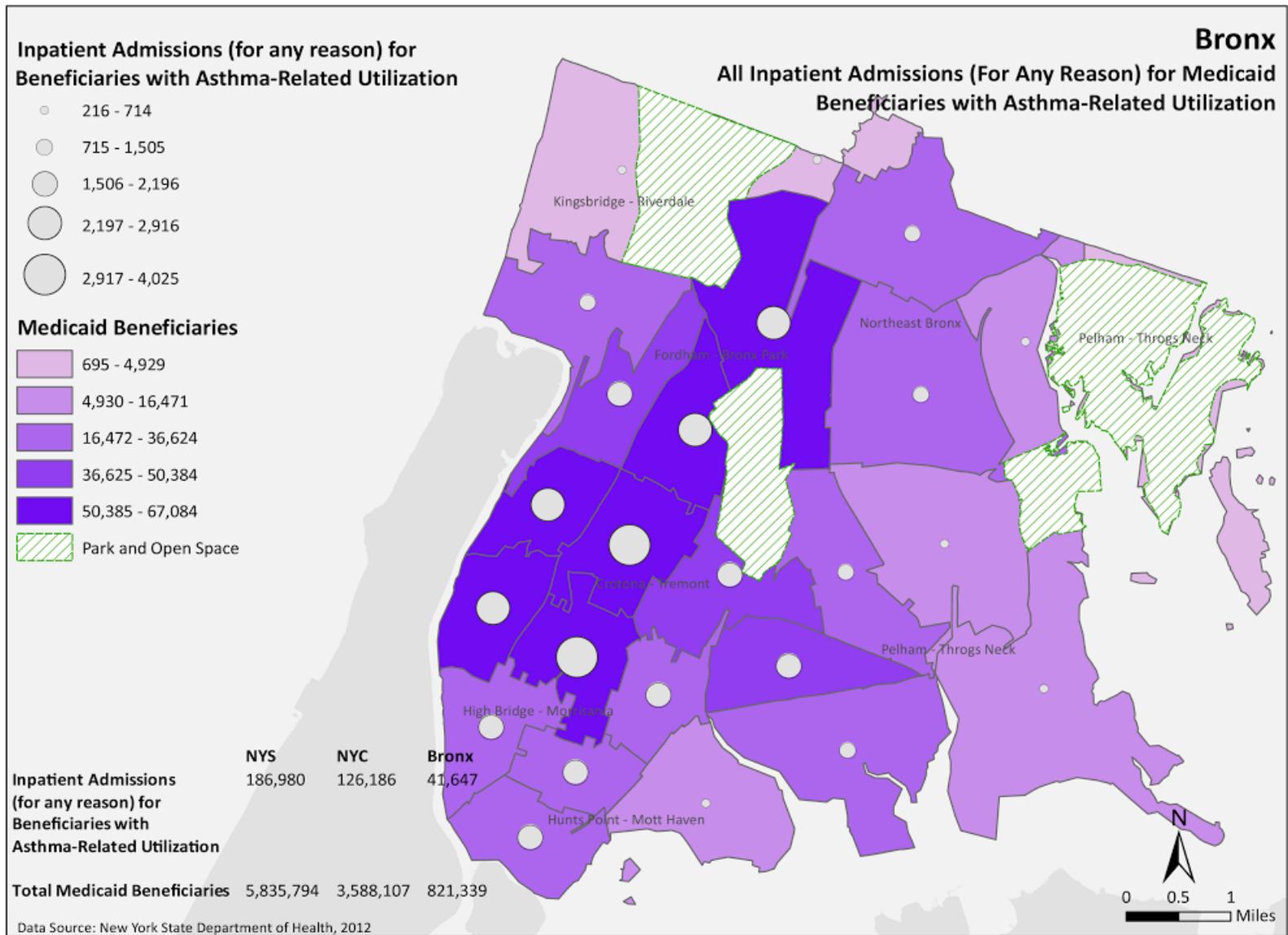


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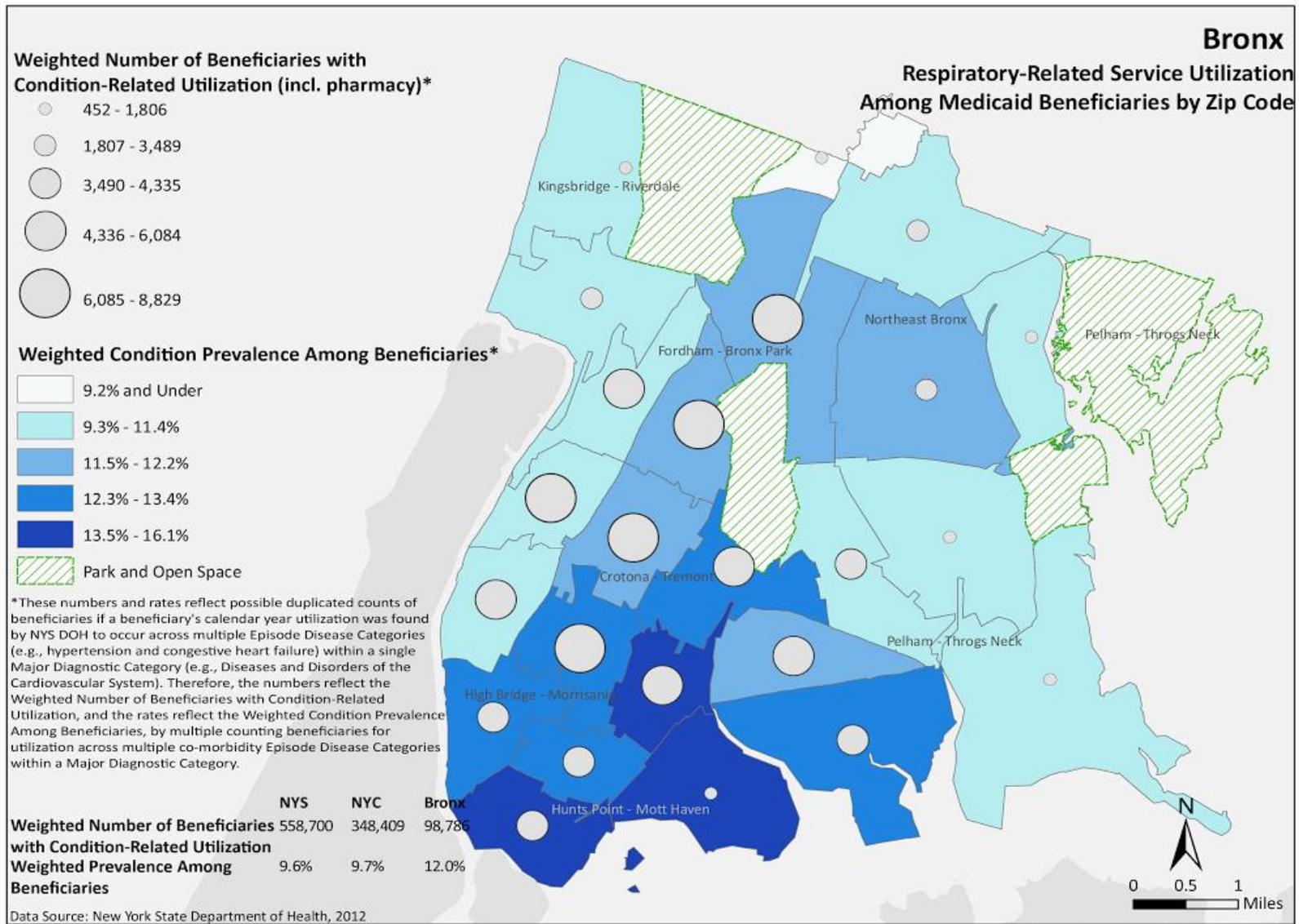
23. Asthma-Related Service Utilization Among Medicaid Beneficiaries



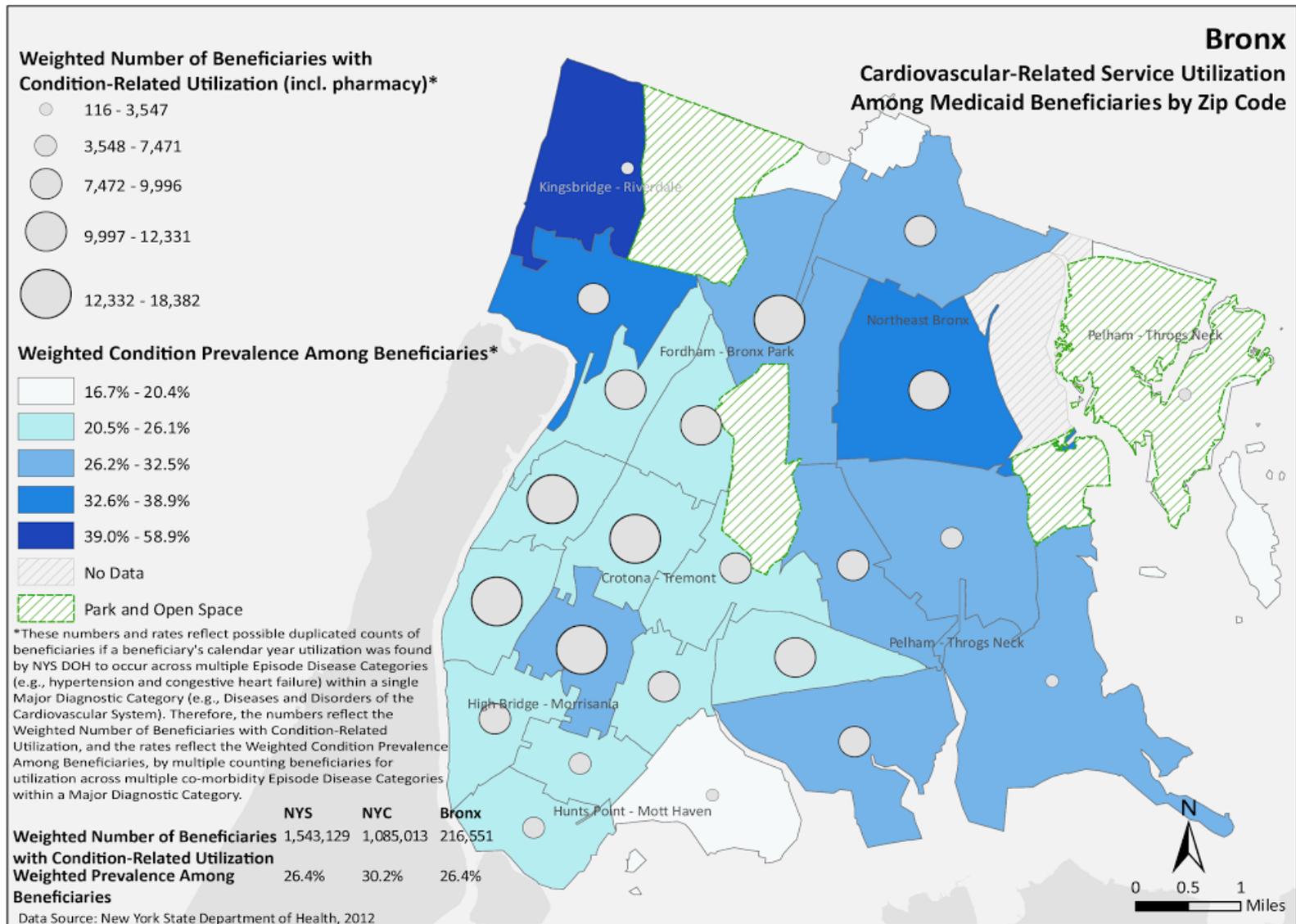
24. All Inpatient Admissions (For Any Reason) for Medicaid Beneficiaries with Asthma-Related Utilization



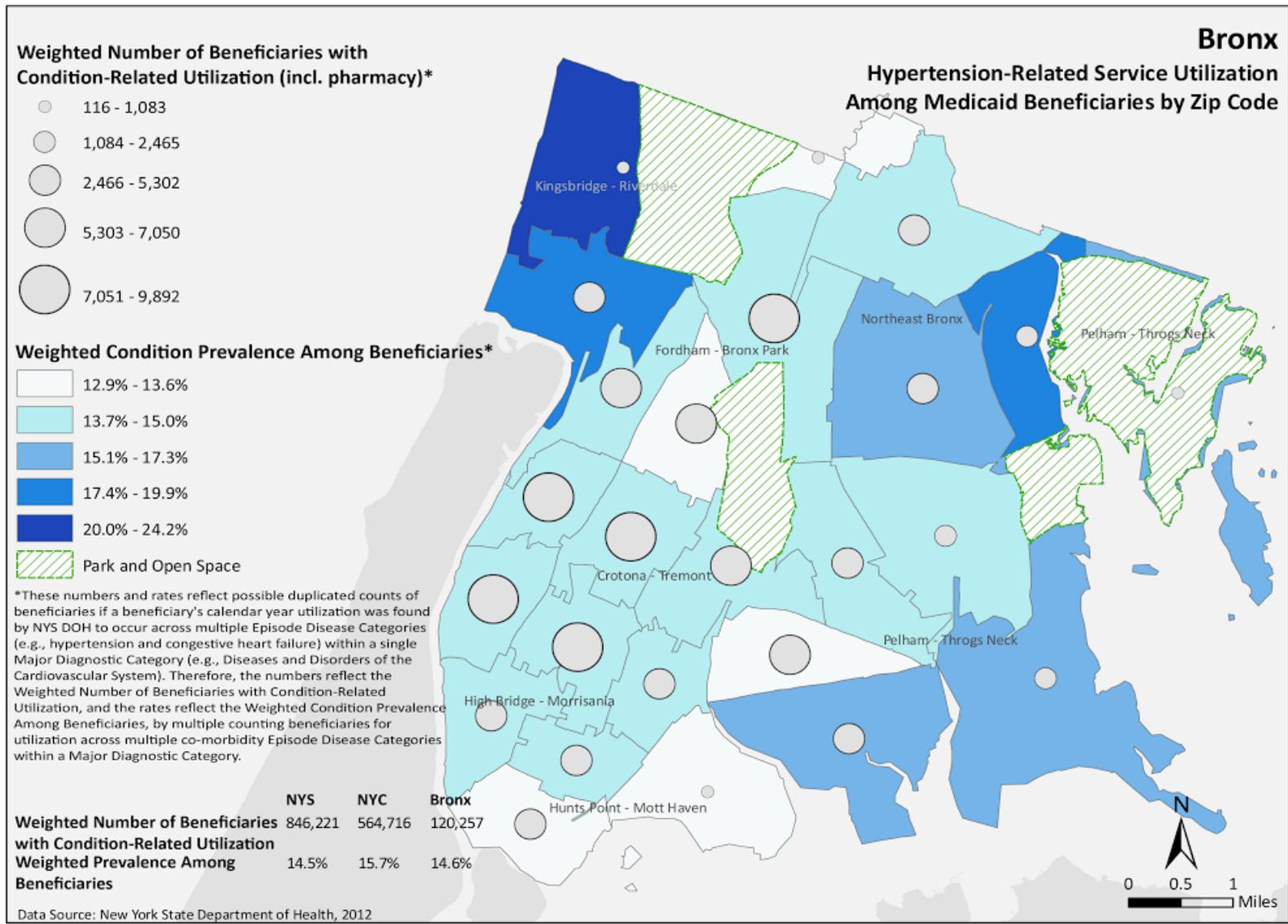
25. Respiratory-Related Service Utilization Among Medicaid Beneficiaries



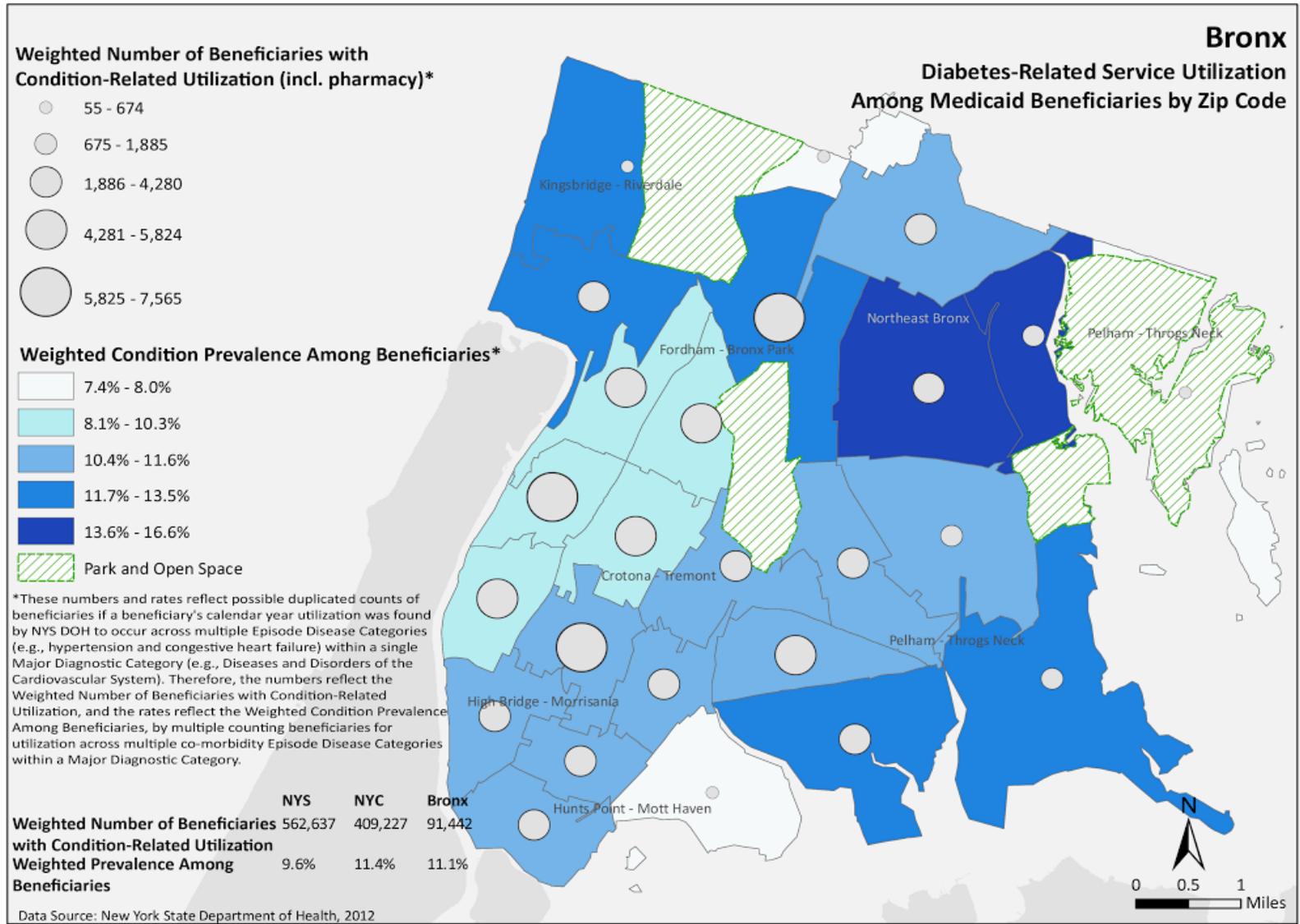
26. Cardiovascular-Related Service Utilization Among Medicaid Beneficiaries



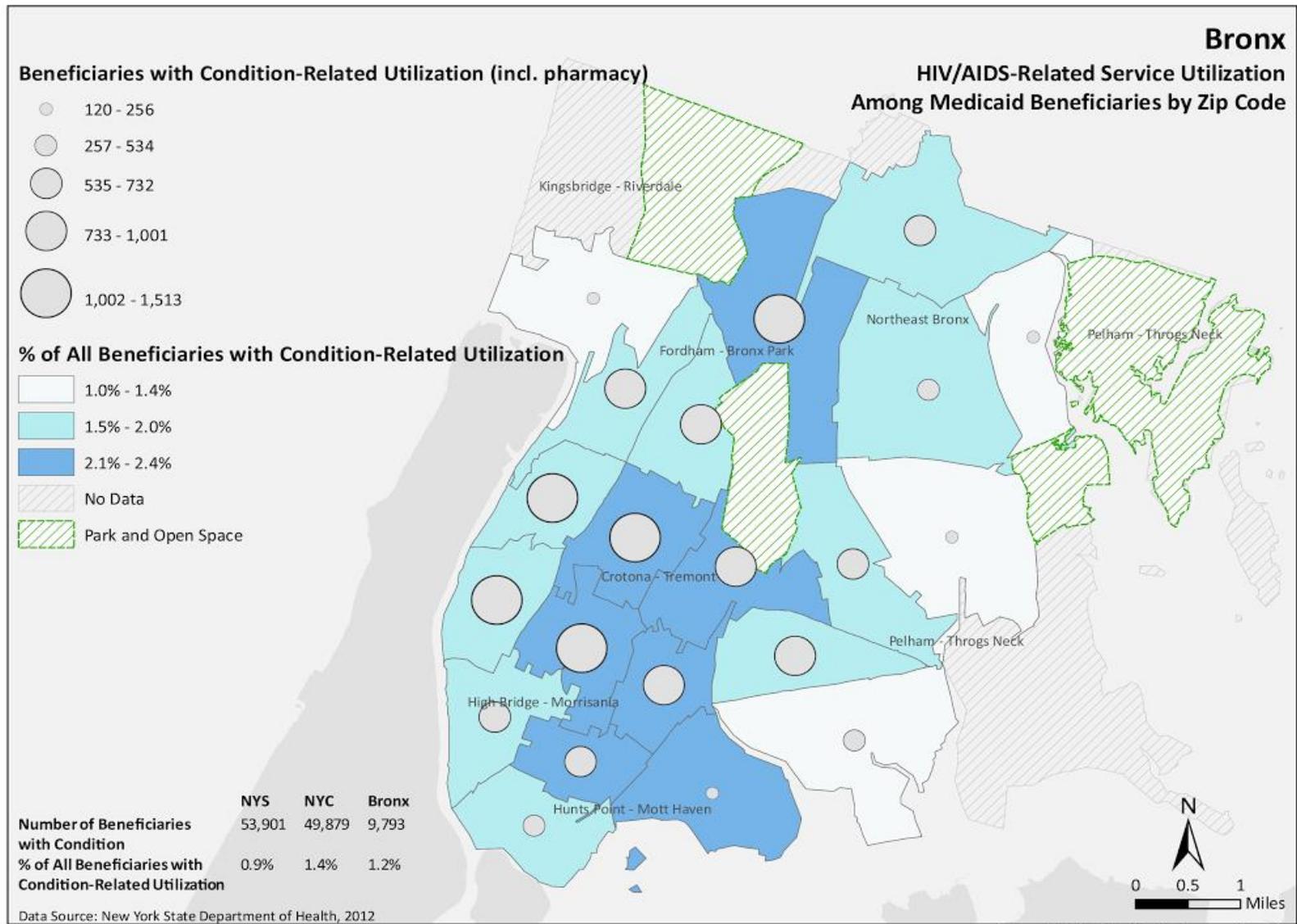
27. Hypertension-Related Service Utilization Among Medicaid Beneficiaries



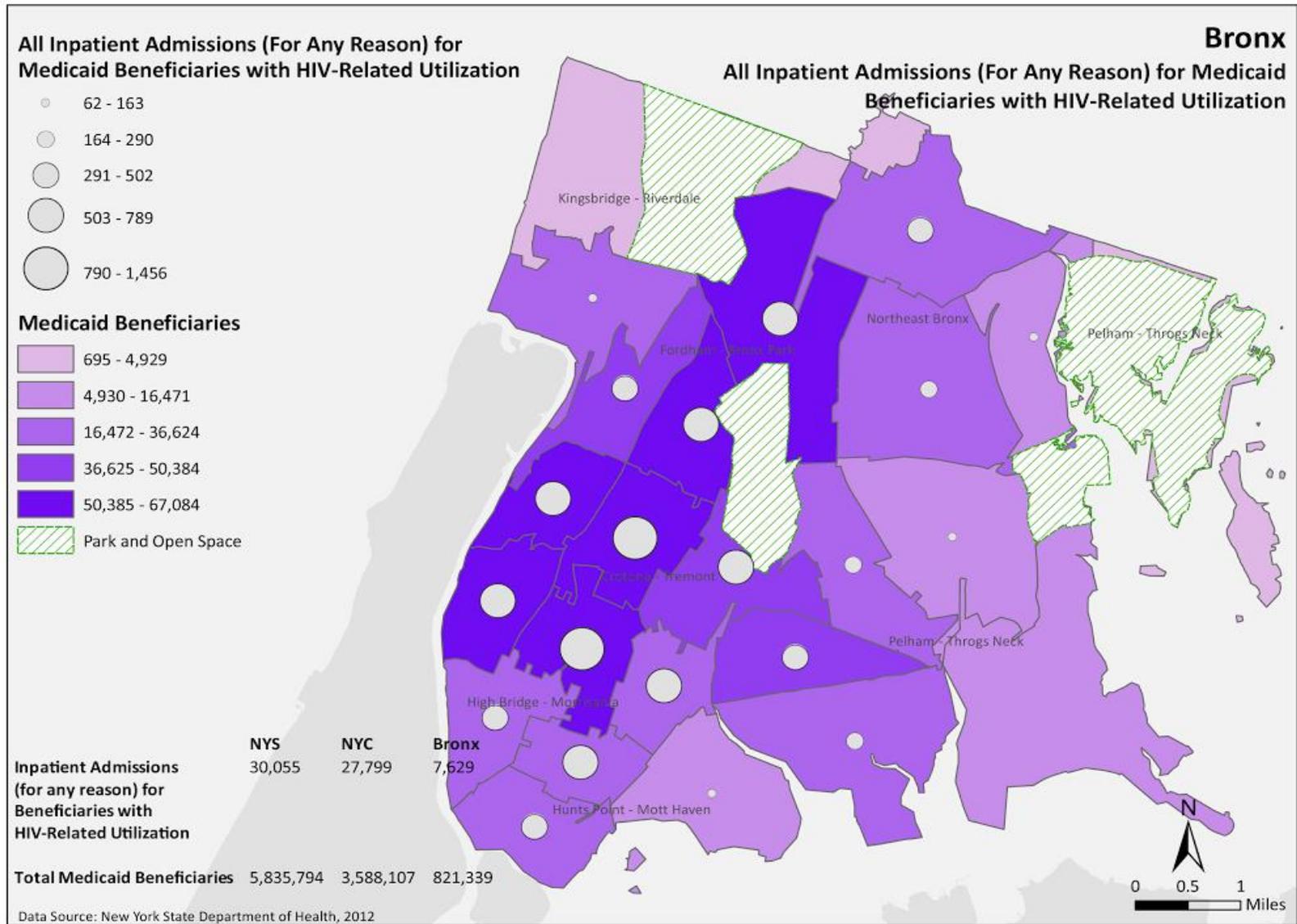
28. Diabetes-Related Service Utilization Among Medicaid Beneficiaries



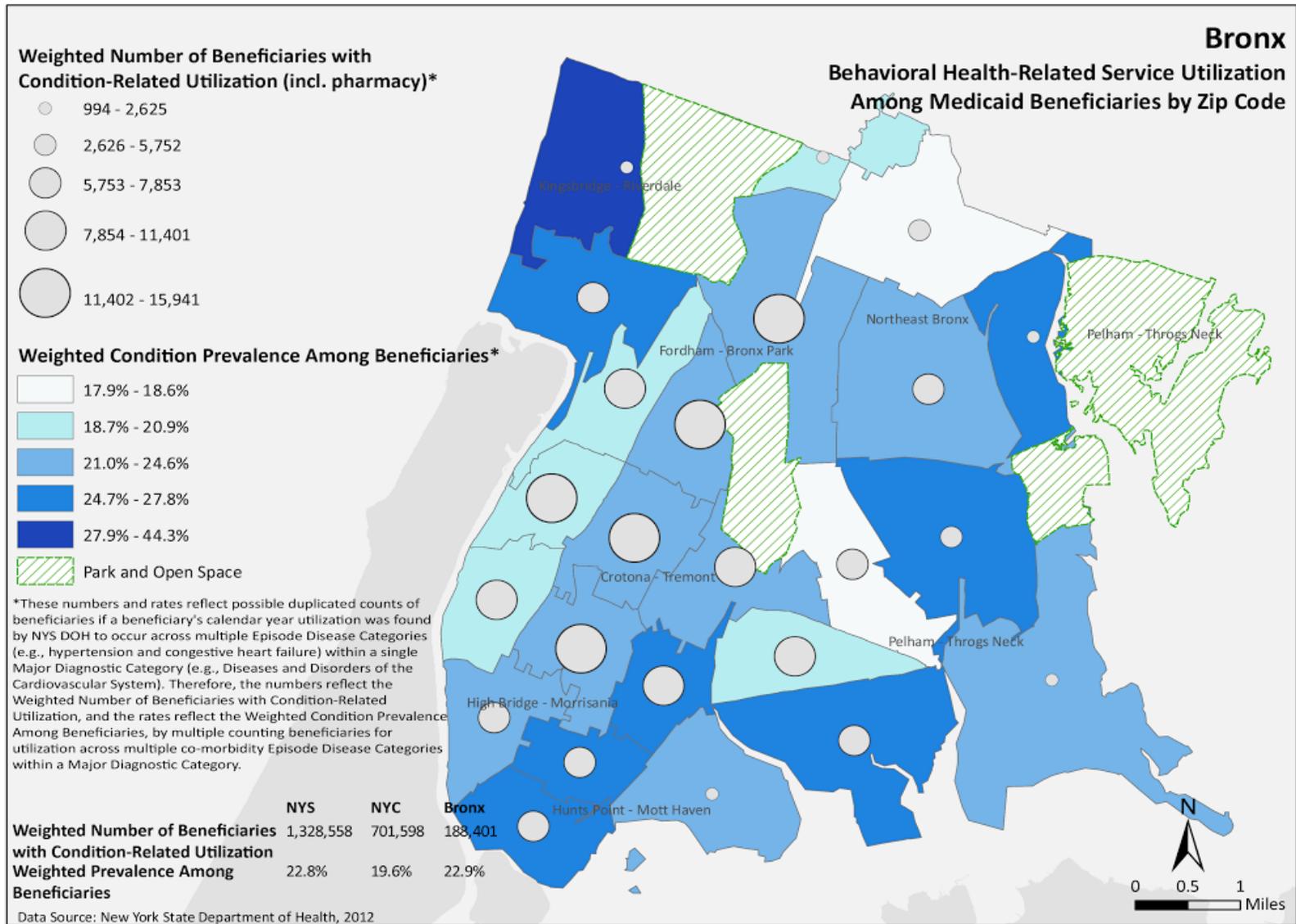
29. HIV/AIDS-Related Service Utilization Among Medicaid Beneficiaries



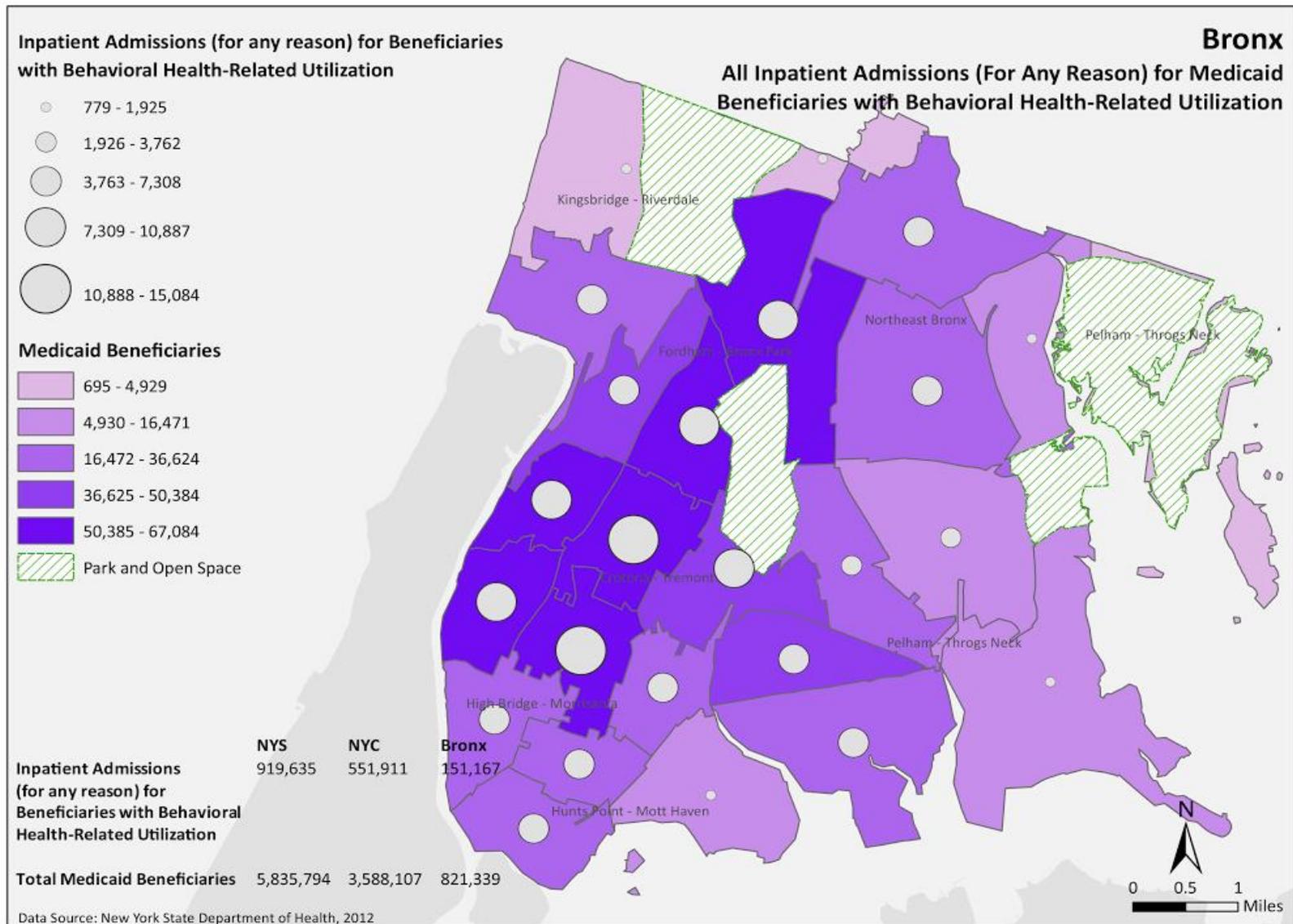
30. All Inpatient Admissions (For Any Reason) for Medicaid Beneficiaries with HIV -Related Utilization



31. Behavioral Health-Related Service Utilization Among Medicaid Beneficiaries

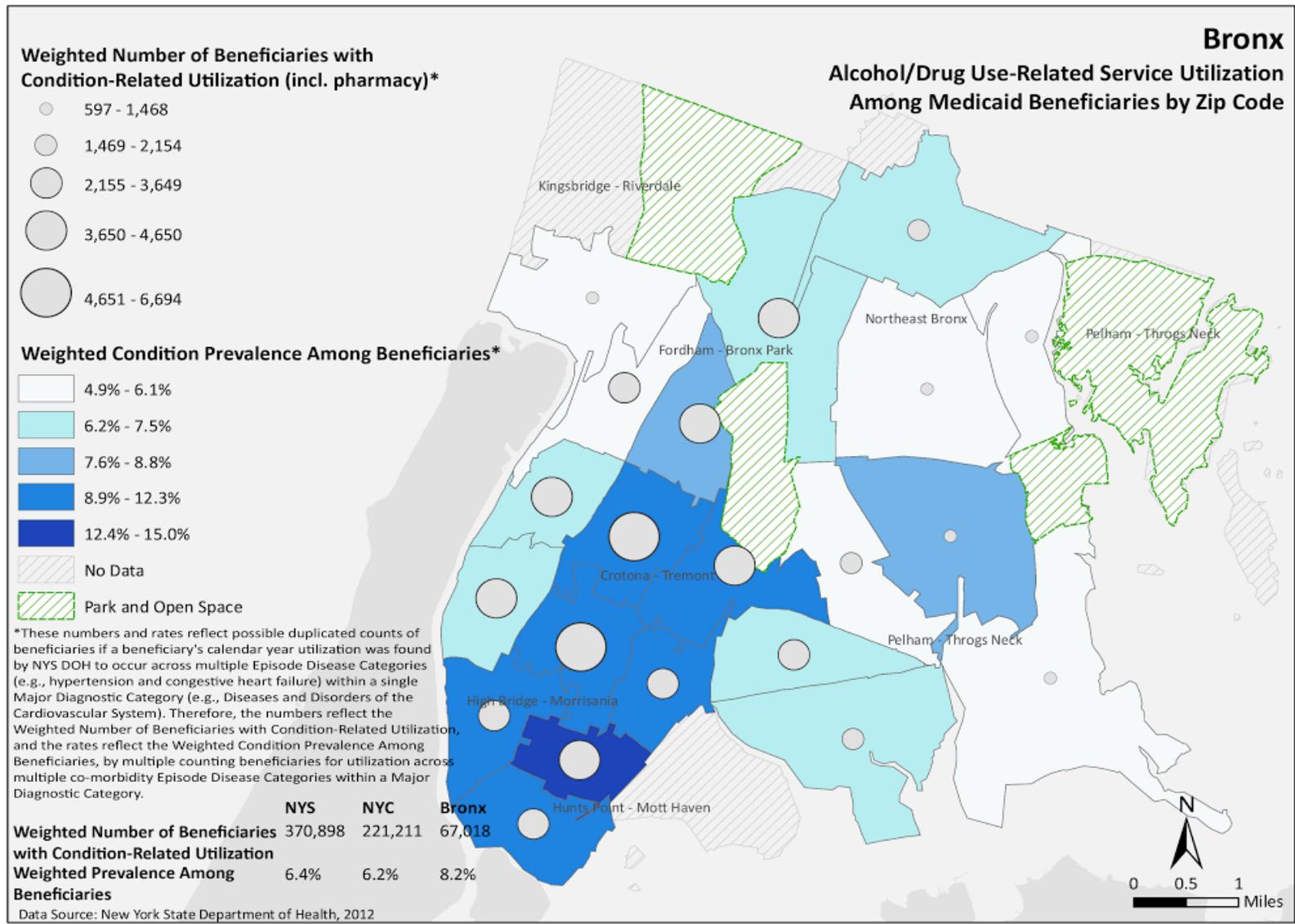


32. All Inpatient Admissions (For Any Reason) for Medicaid Beneficiaries with Behavioral Health-Related Utilization



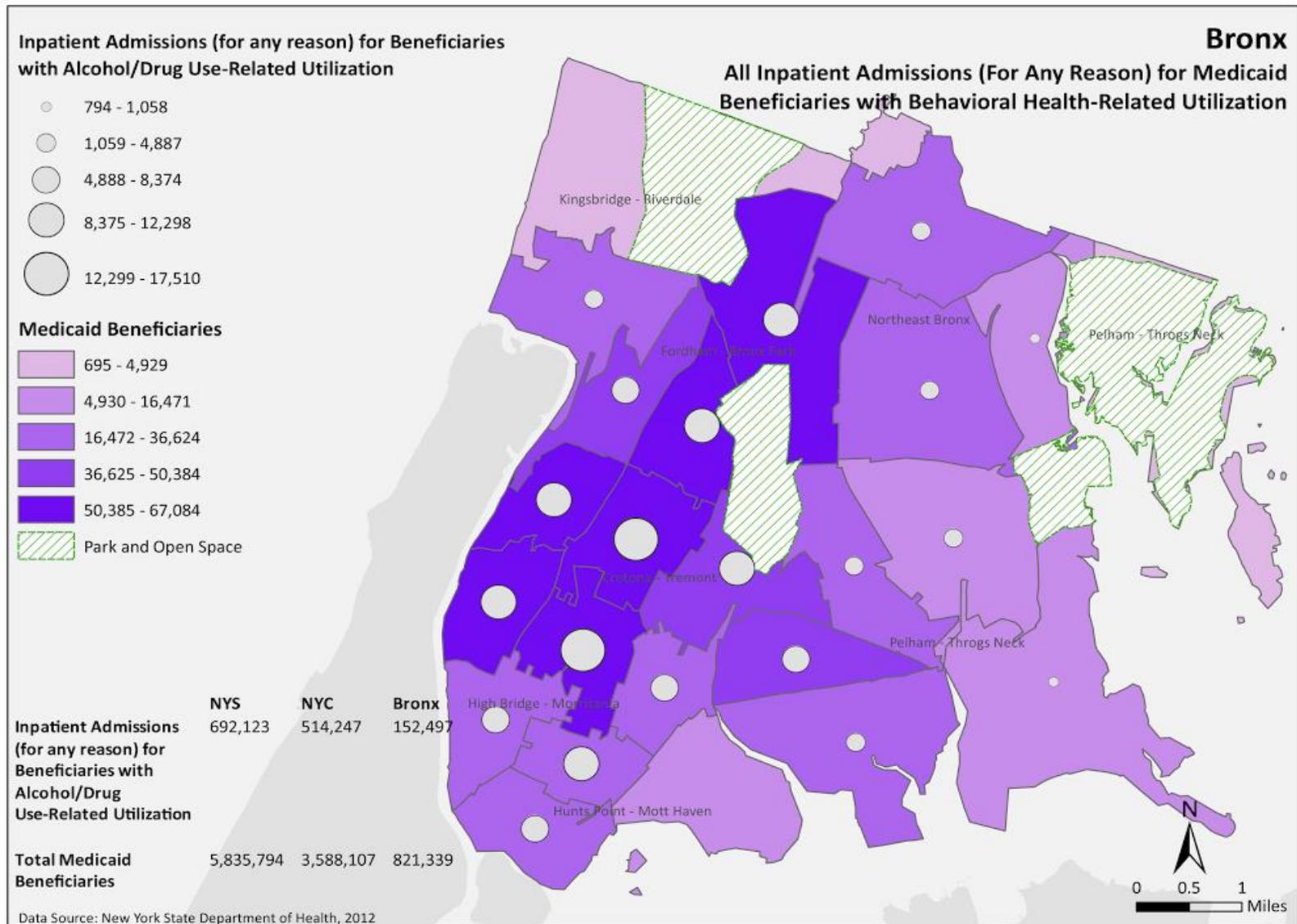
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33. Alcohol/Drug Use-Related Service Utilization among Medicaid Beneficiaries

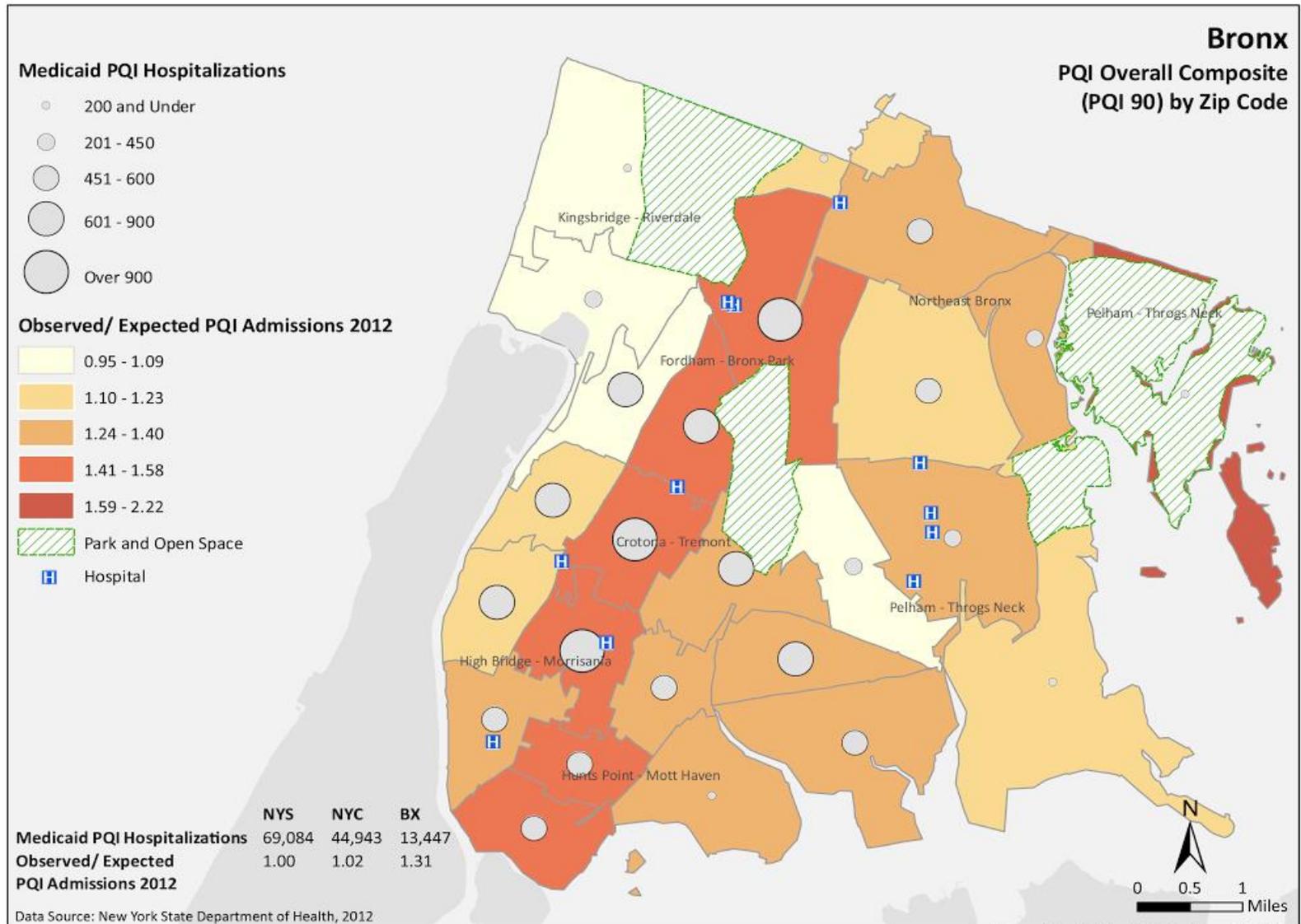


Prepared by The New York Academy of Medicine

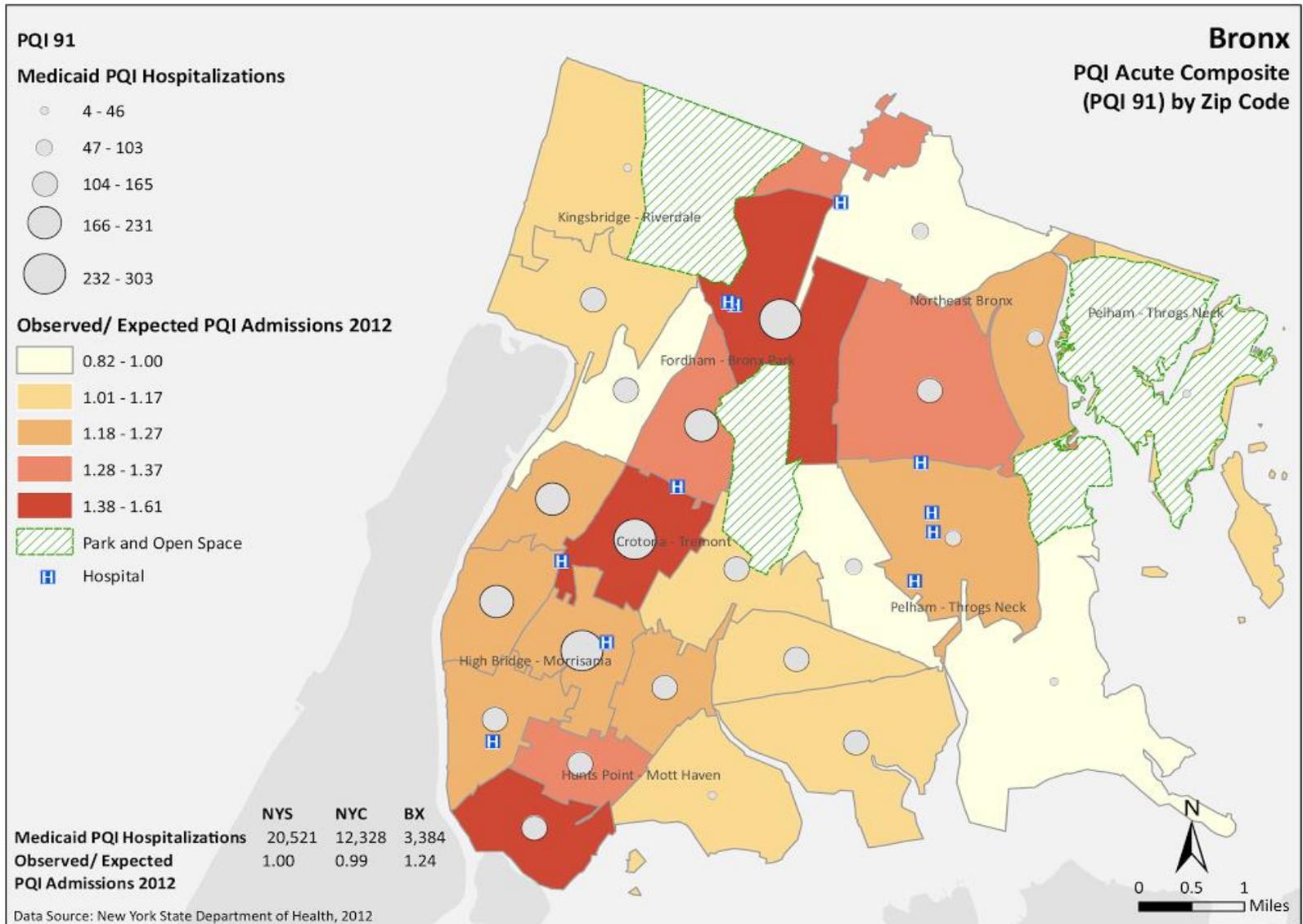
34. All Inpatient Admissions (For Any Reason) for Medicaid Beneficiaries with Alcohol/Drug Use-Related Utilization



35. PQI Overall Composite (PQI 90) by Zip Code

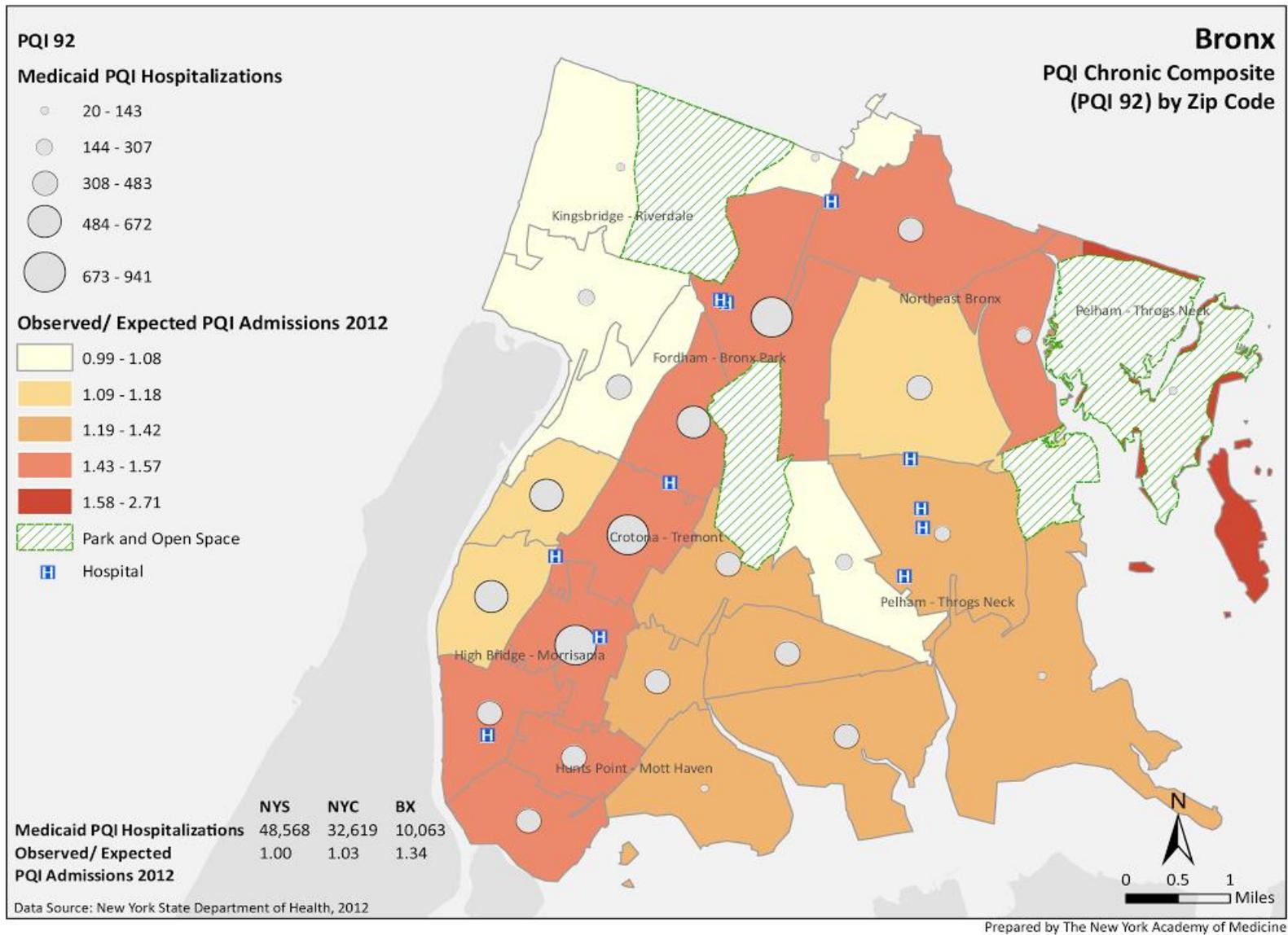


36. PQI Acute Composite (PQI 91) by Zip Code

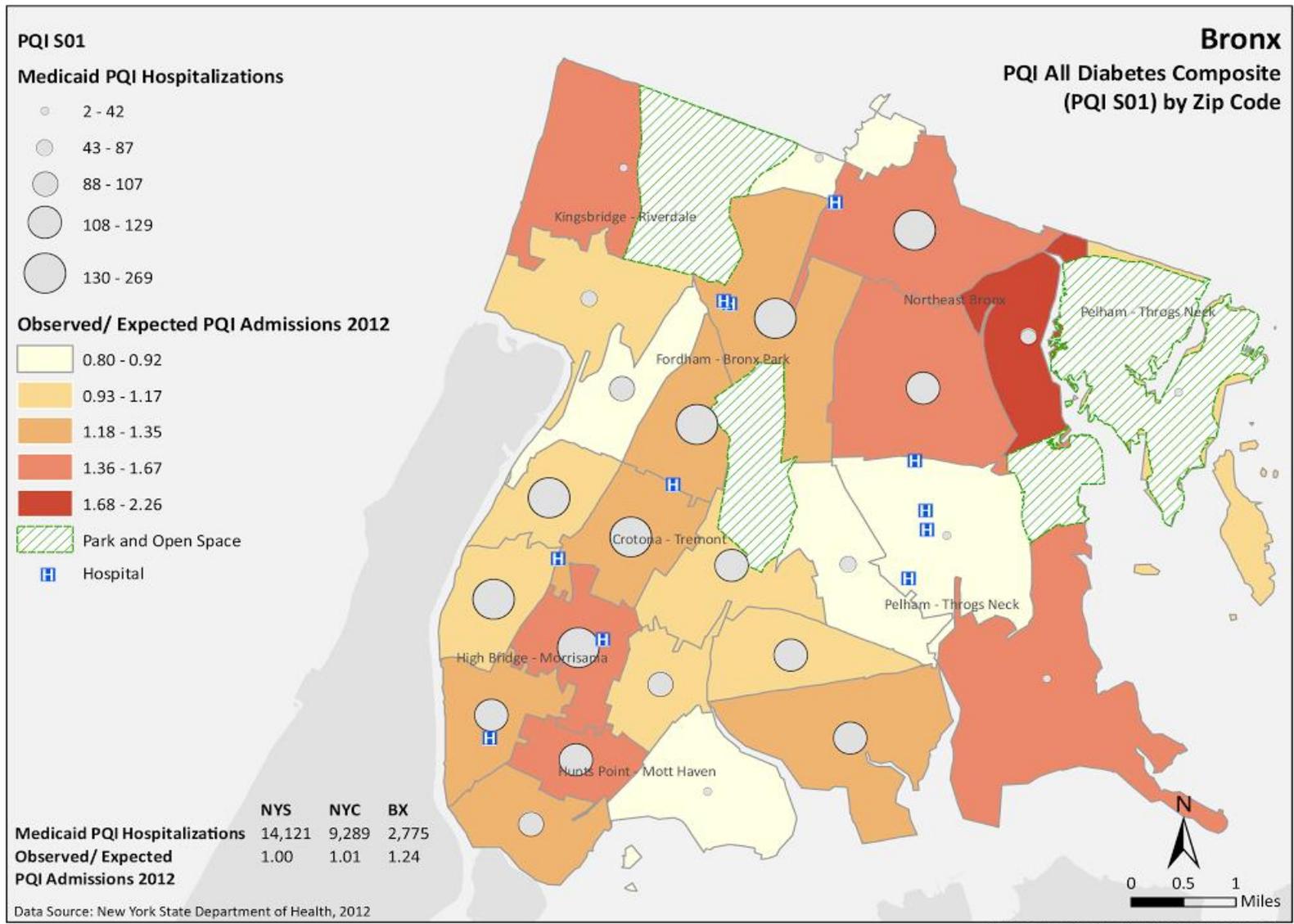


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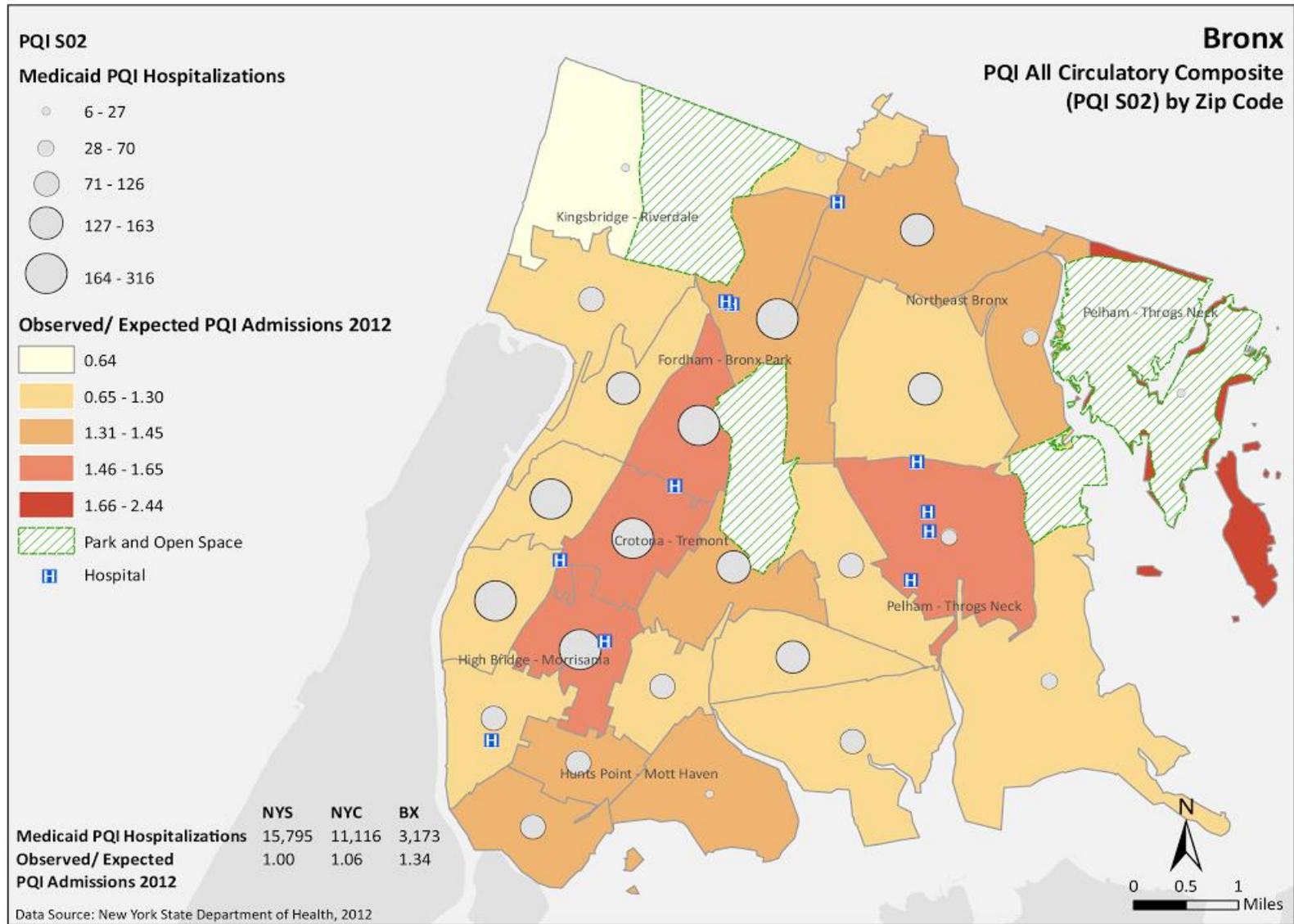
37. PQI Chronic Composite (PQI 92) by Zip Code



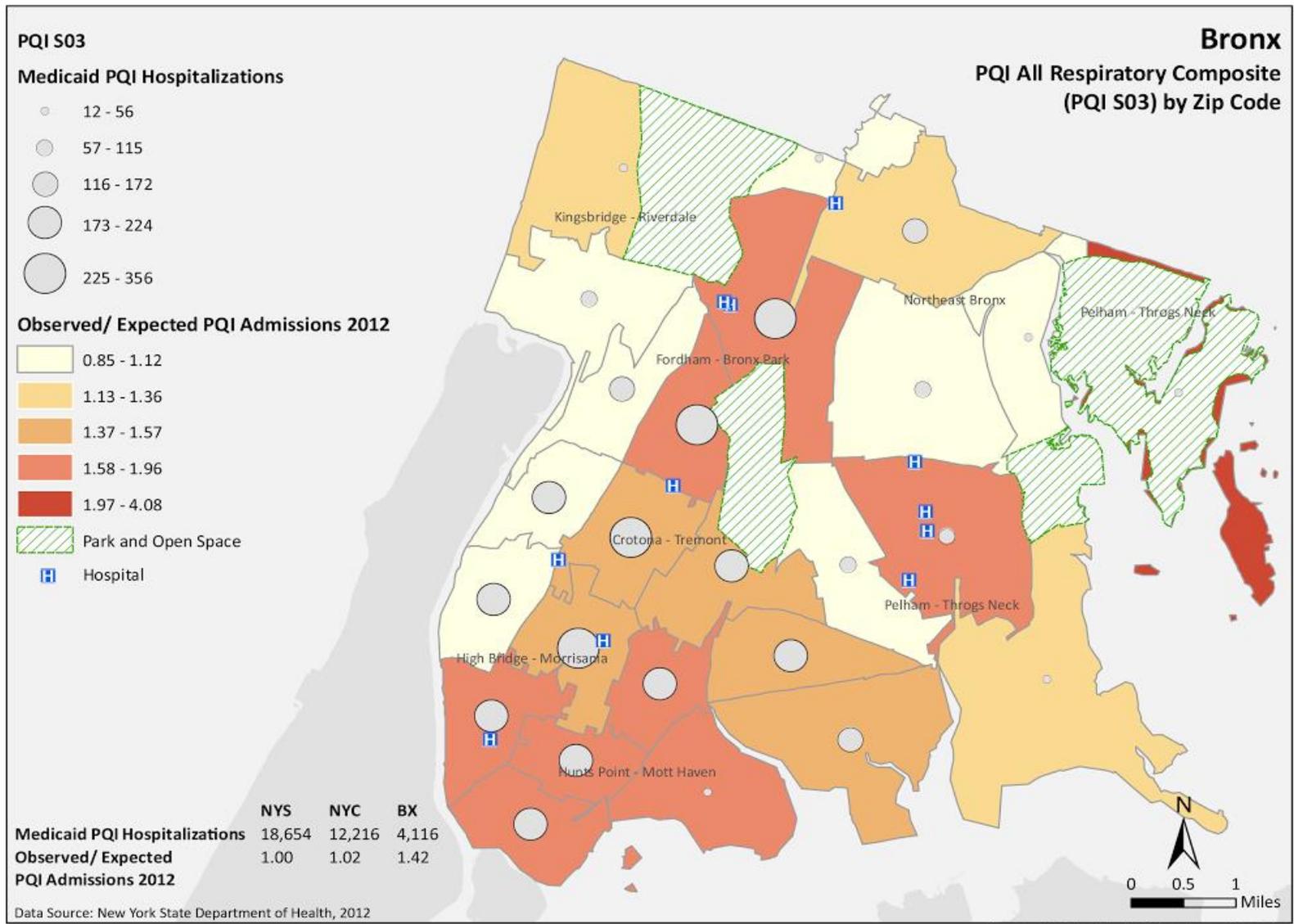
38. PQI All Diabetes Composite (PQI S01) by Zip Code



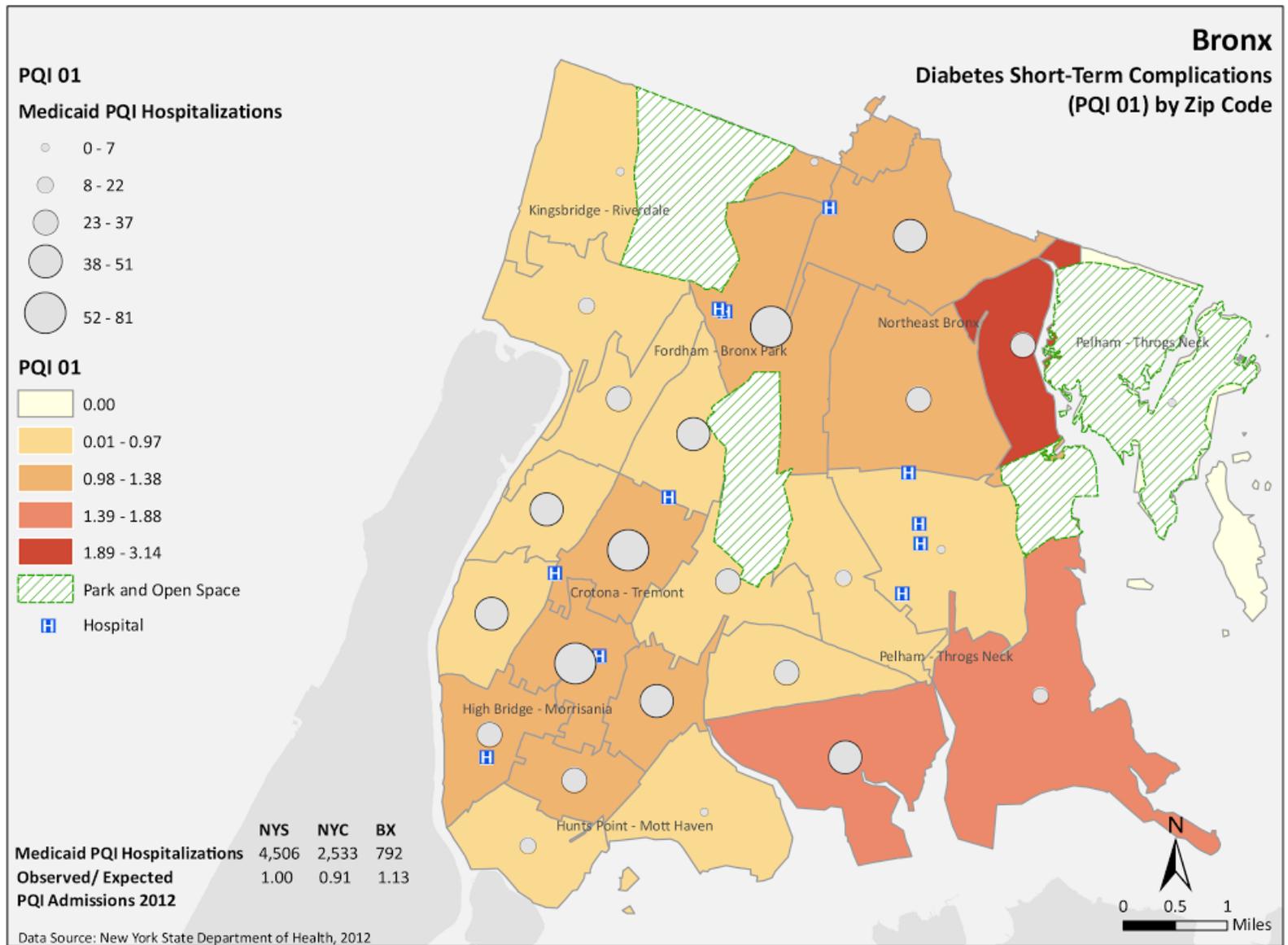
39. PQI All Circulatory Composite (PQI S02) by Zip Code



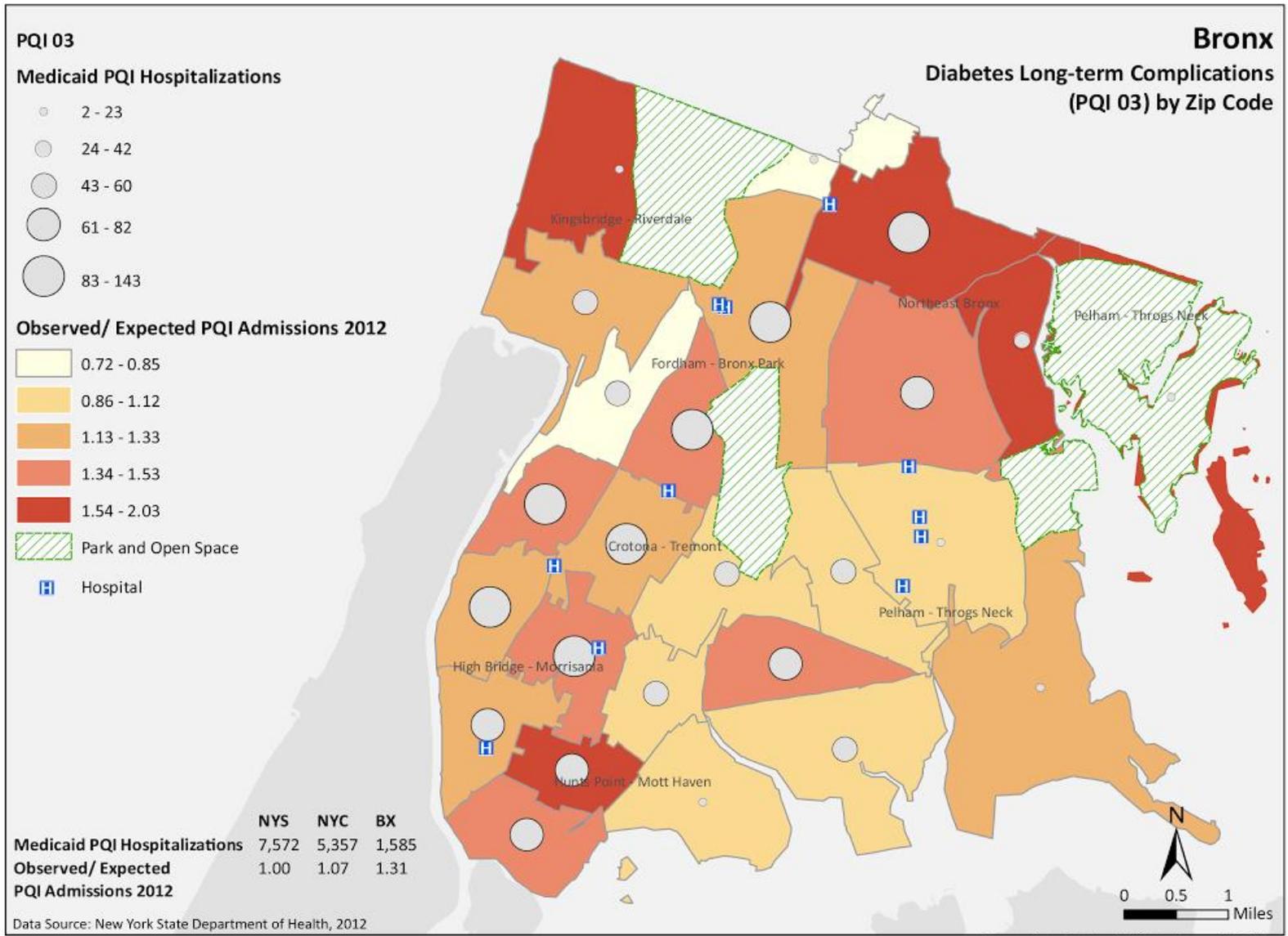
40. PQI All Respiratory Composite (PQI S03) by Zip Code



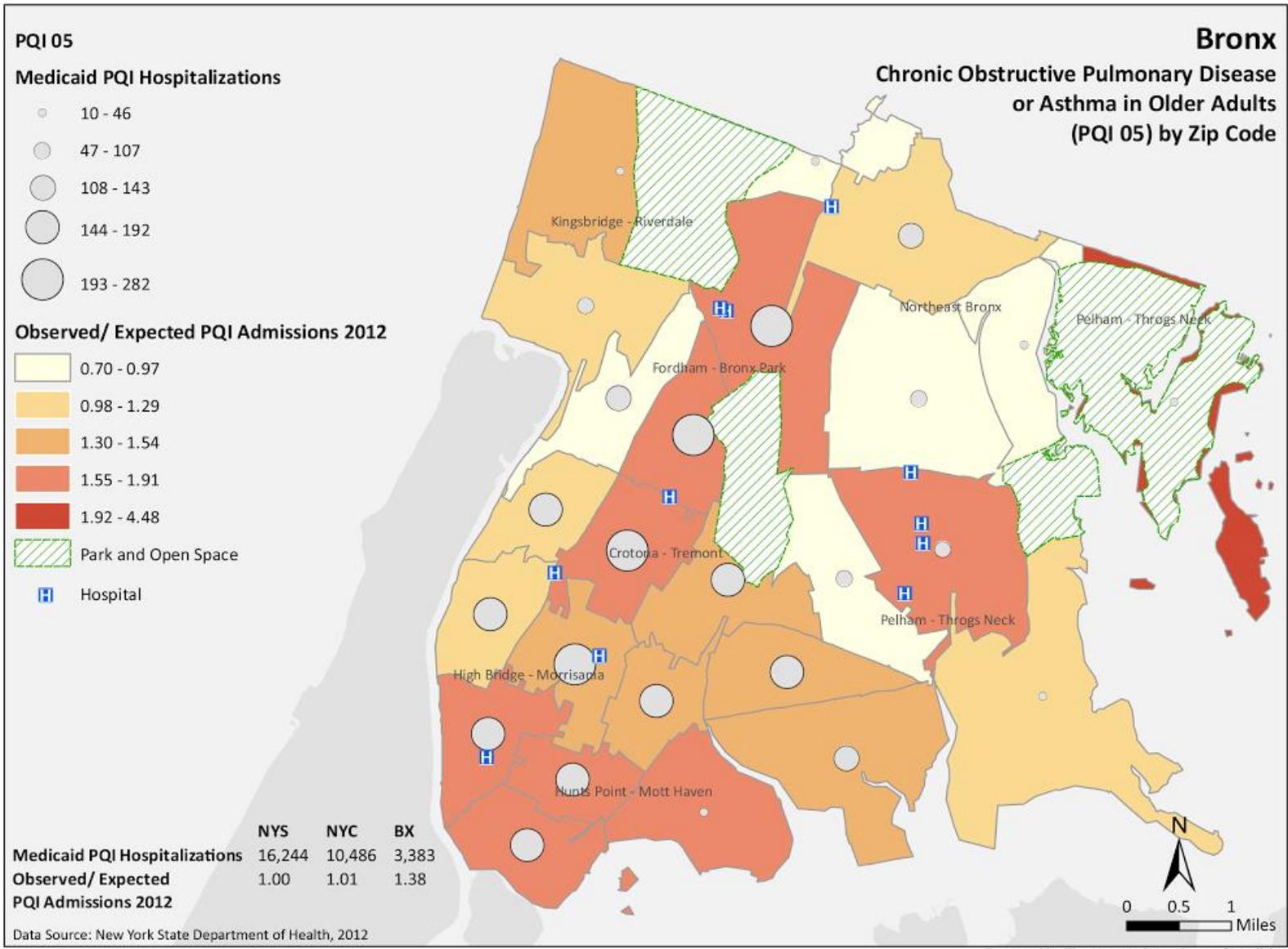
41. Diabetes Short-term Complications (PQI 01) by Zip Code



42. Diabetes Long-term Complications (PQI 03) by Zip Code

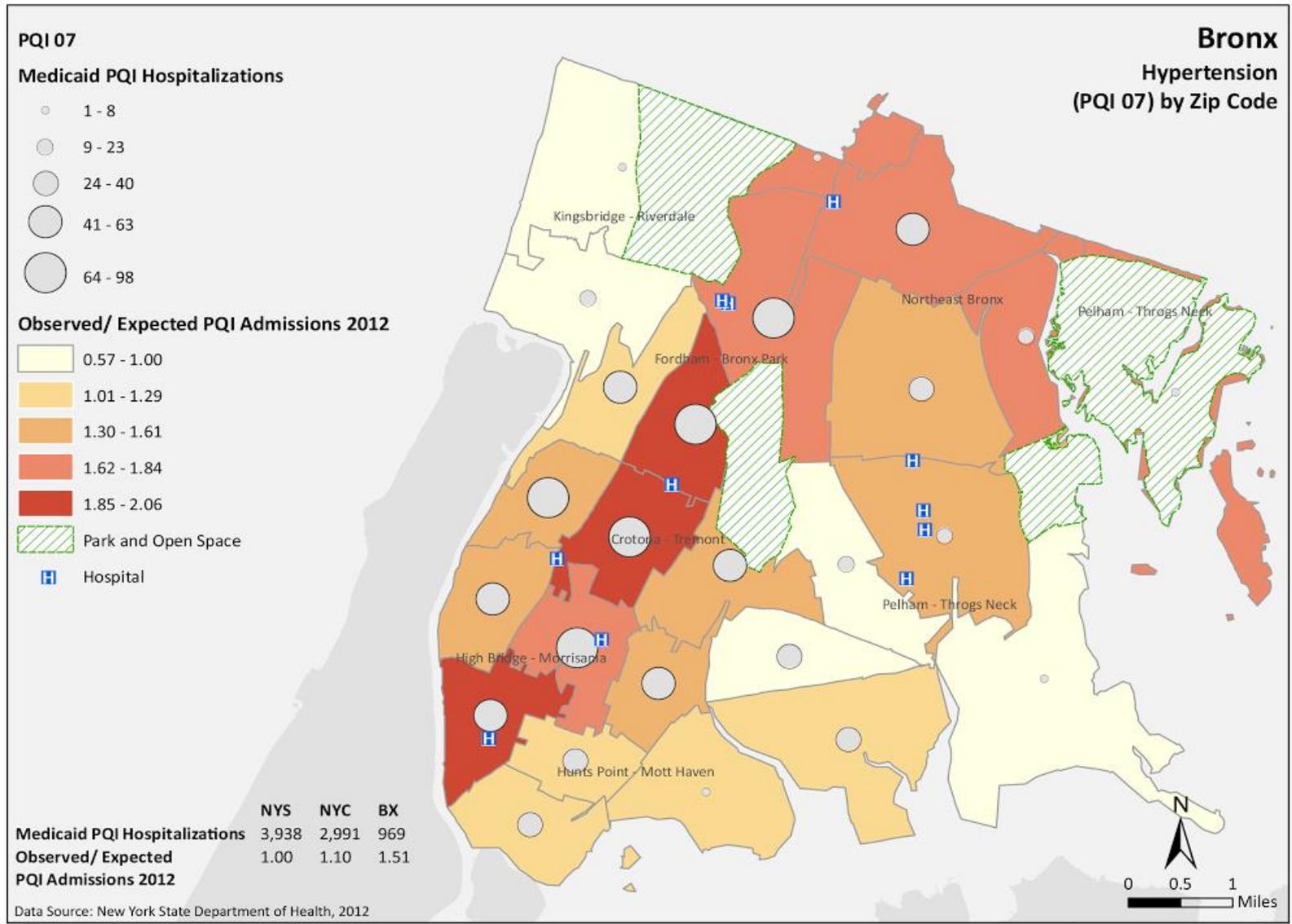


43. Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (PQI 05) by Zip Code

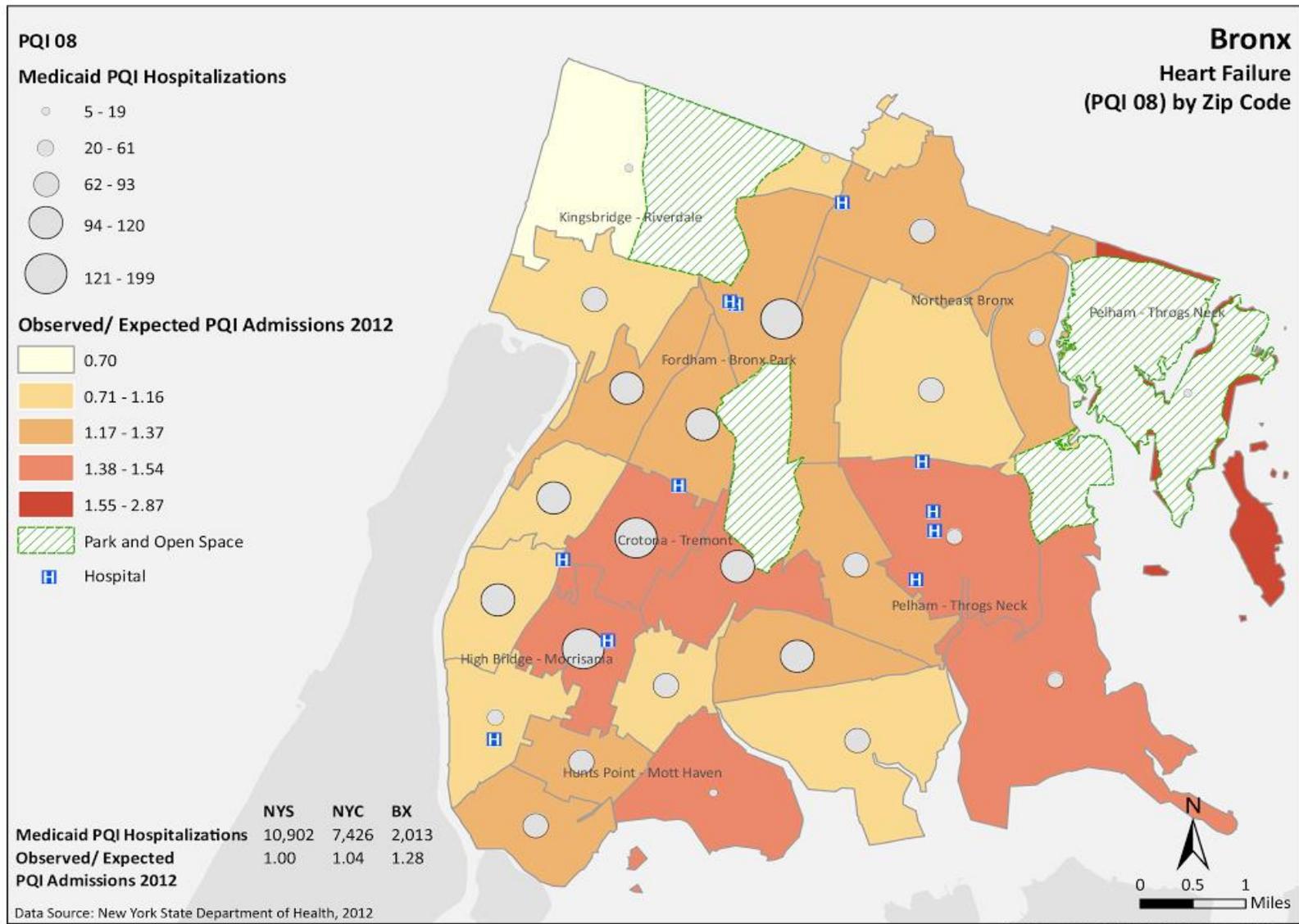


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44. Hypertension (PQI 07) by Zip Code

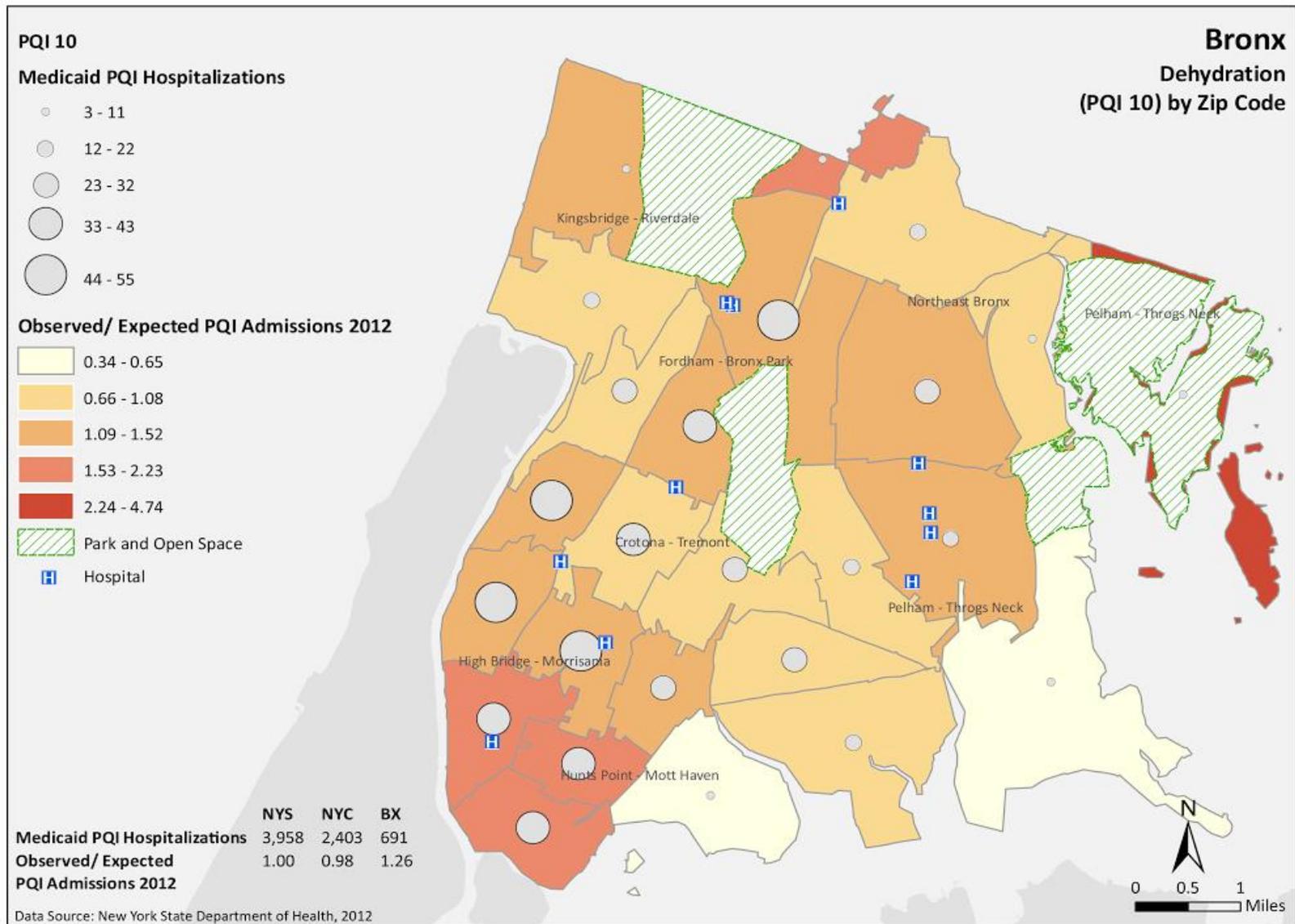


45. Heart Failure (PQI 08) by Zip Code



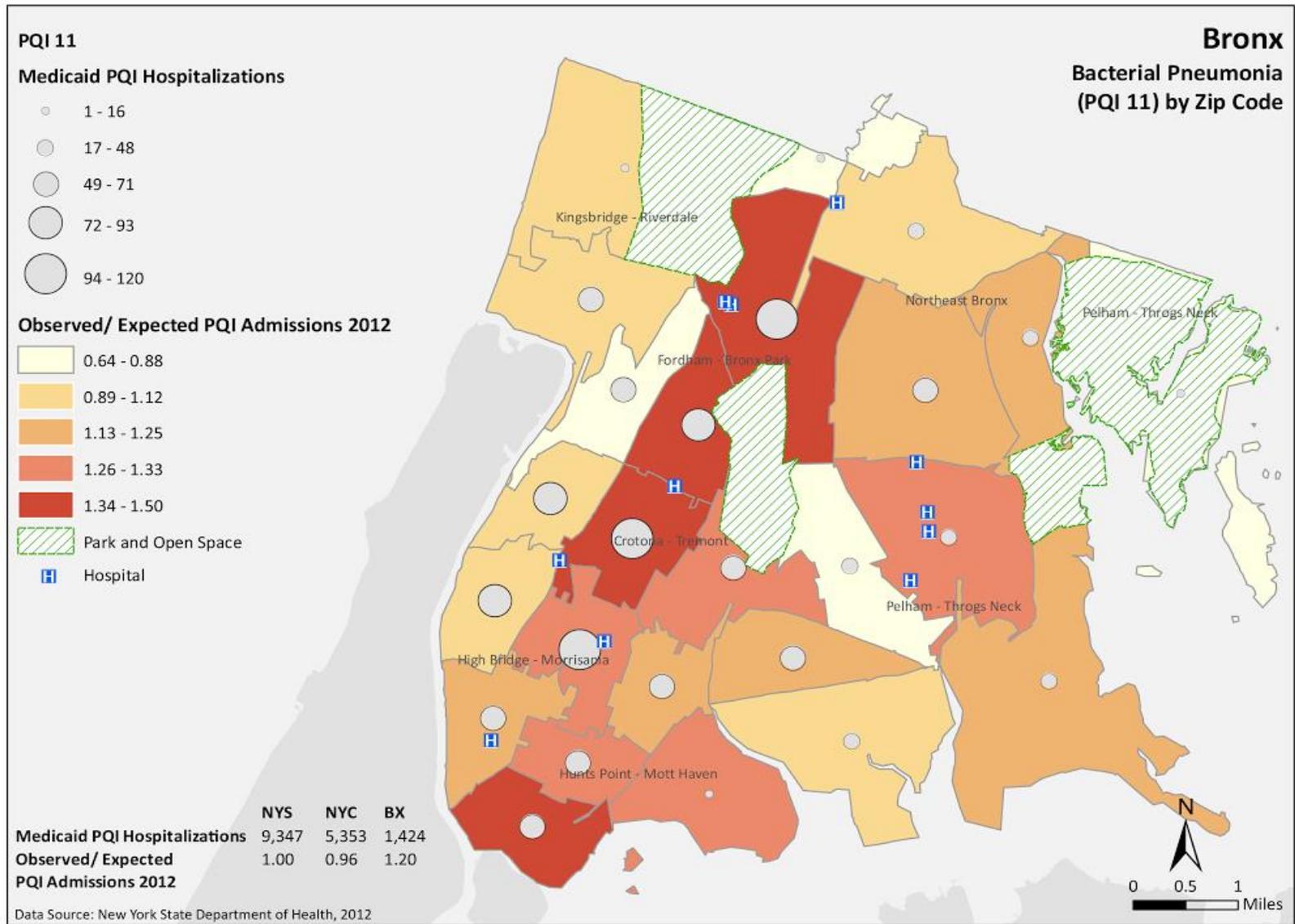
Prepared by The New York Academy of Medicine

46. Dehydration (PQI 10) by Zip Code

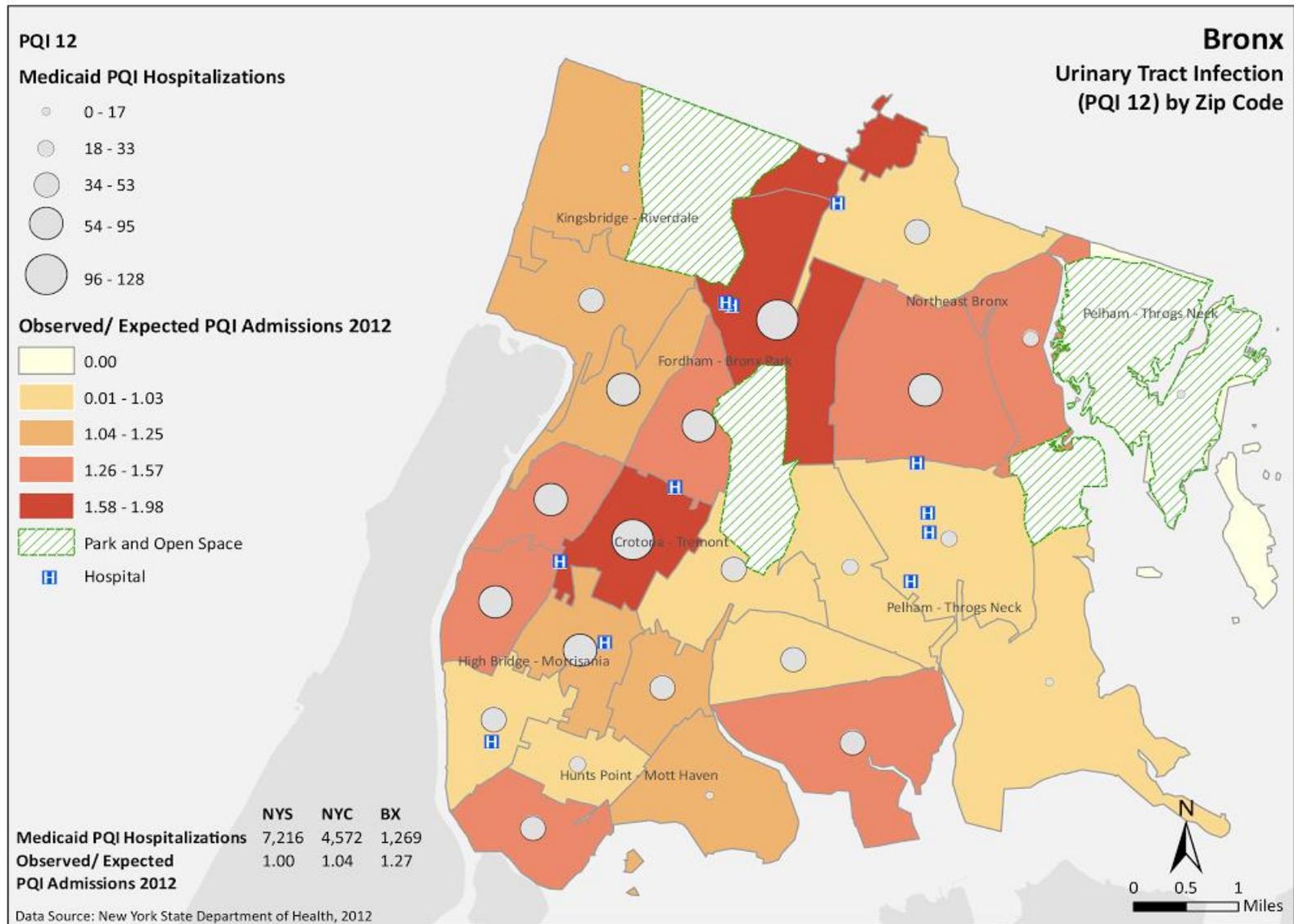


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47. Bacterial Pneumonia (PQI 11) by Zip Code

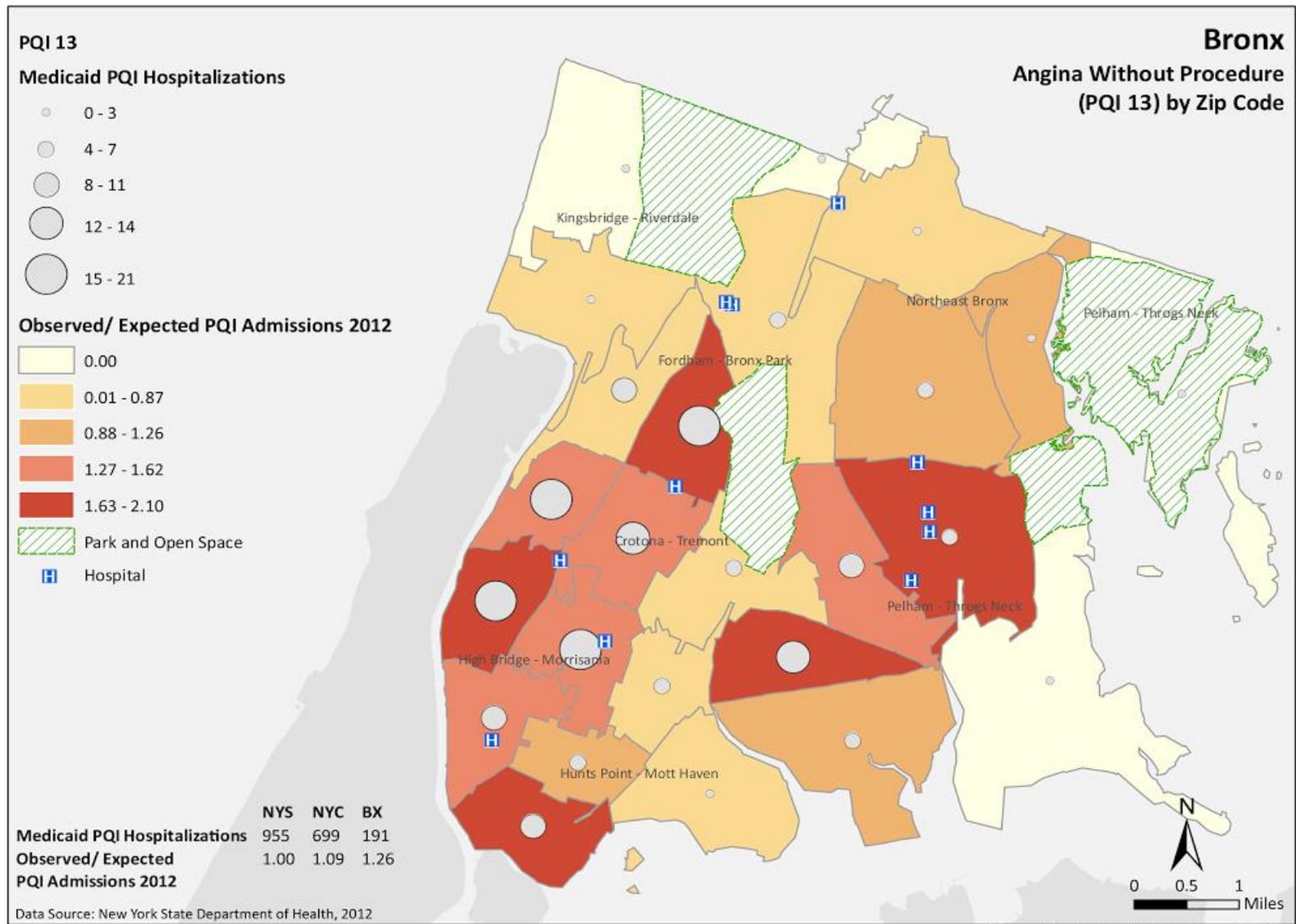


48. Urinary Tract Infection (PQI 12) by Zip Code

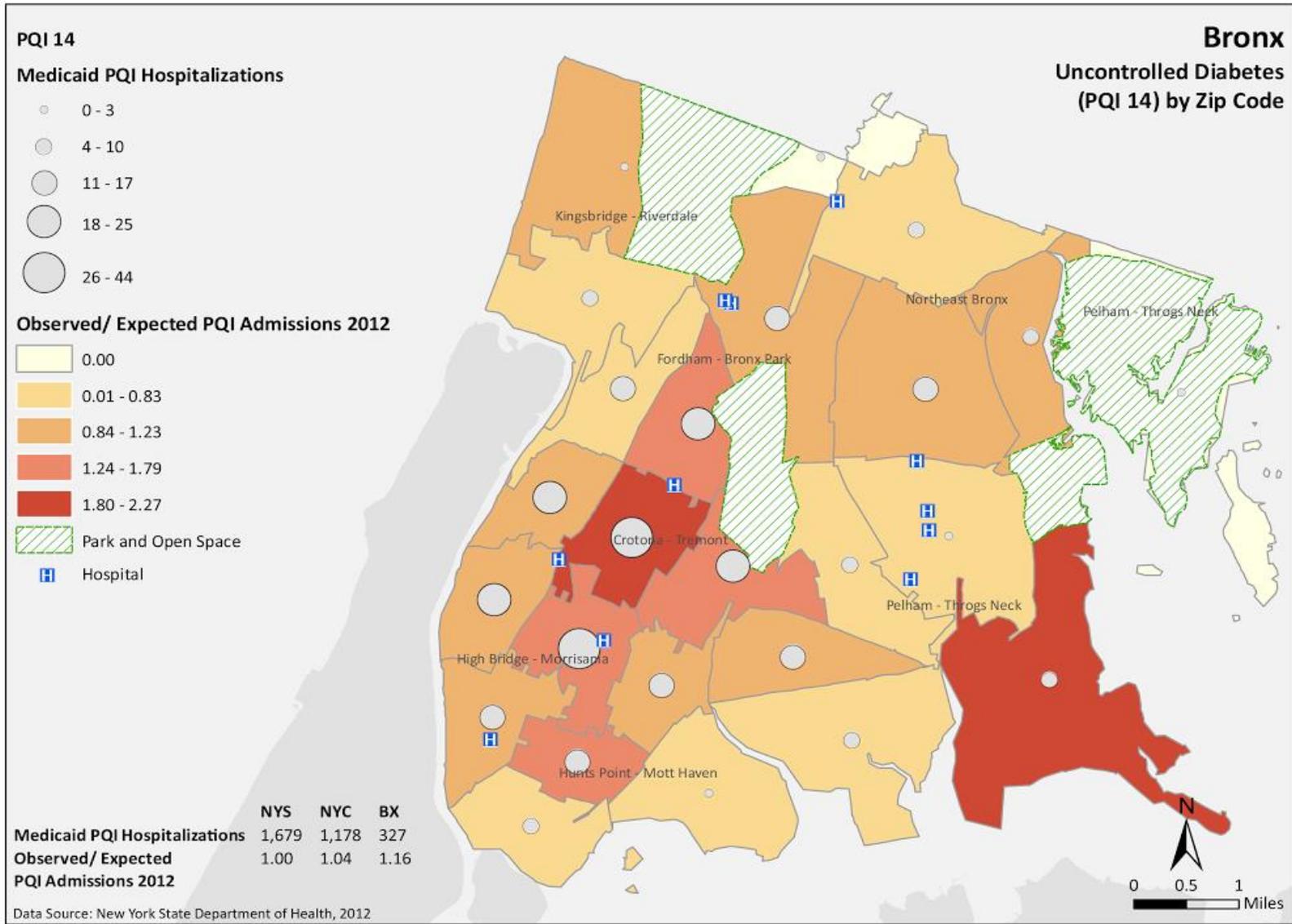


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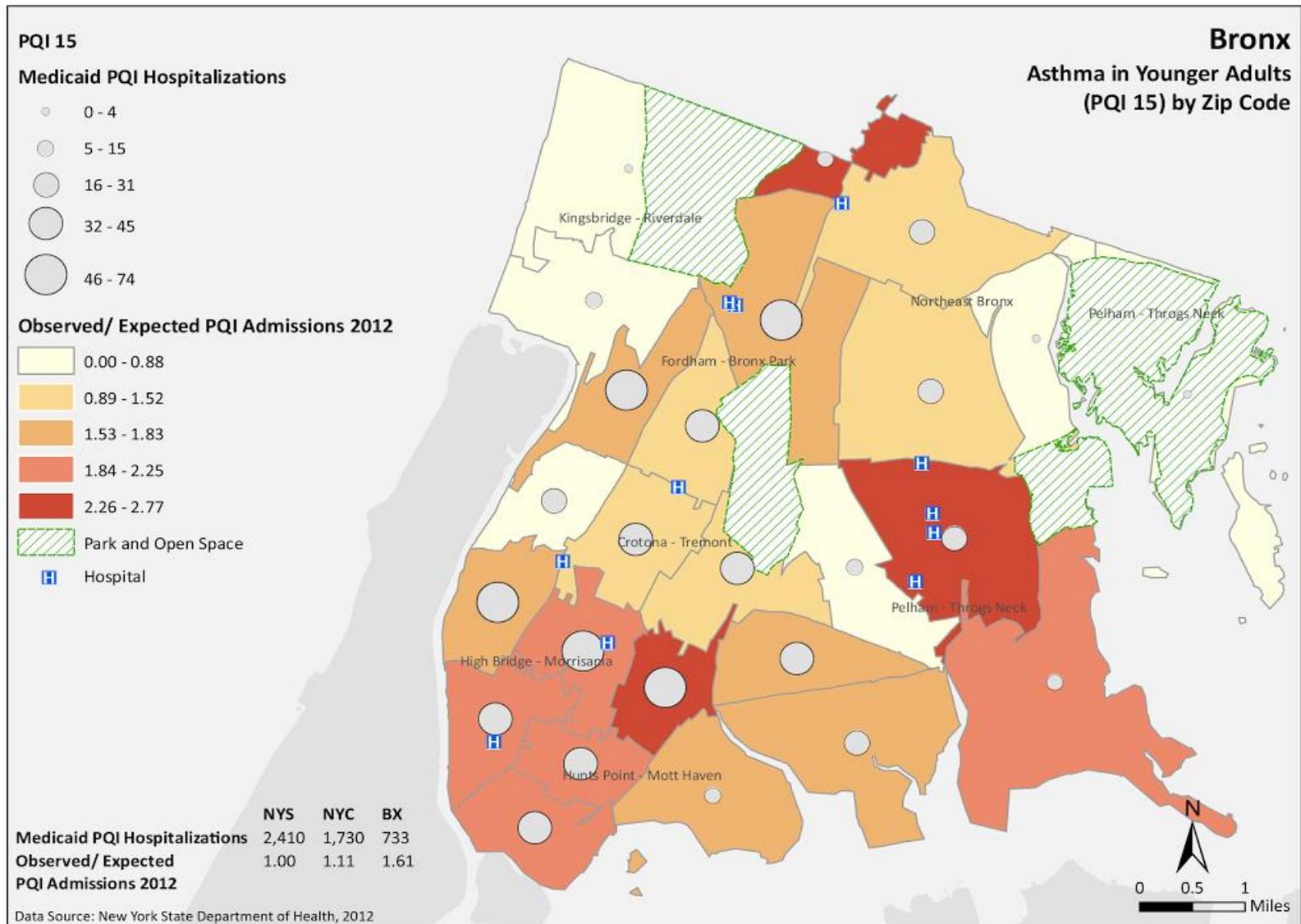
49. Angina Without Procedure (PQI 13) by Zip Code



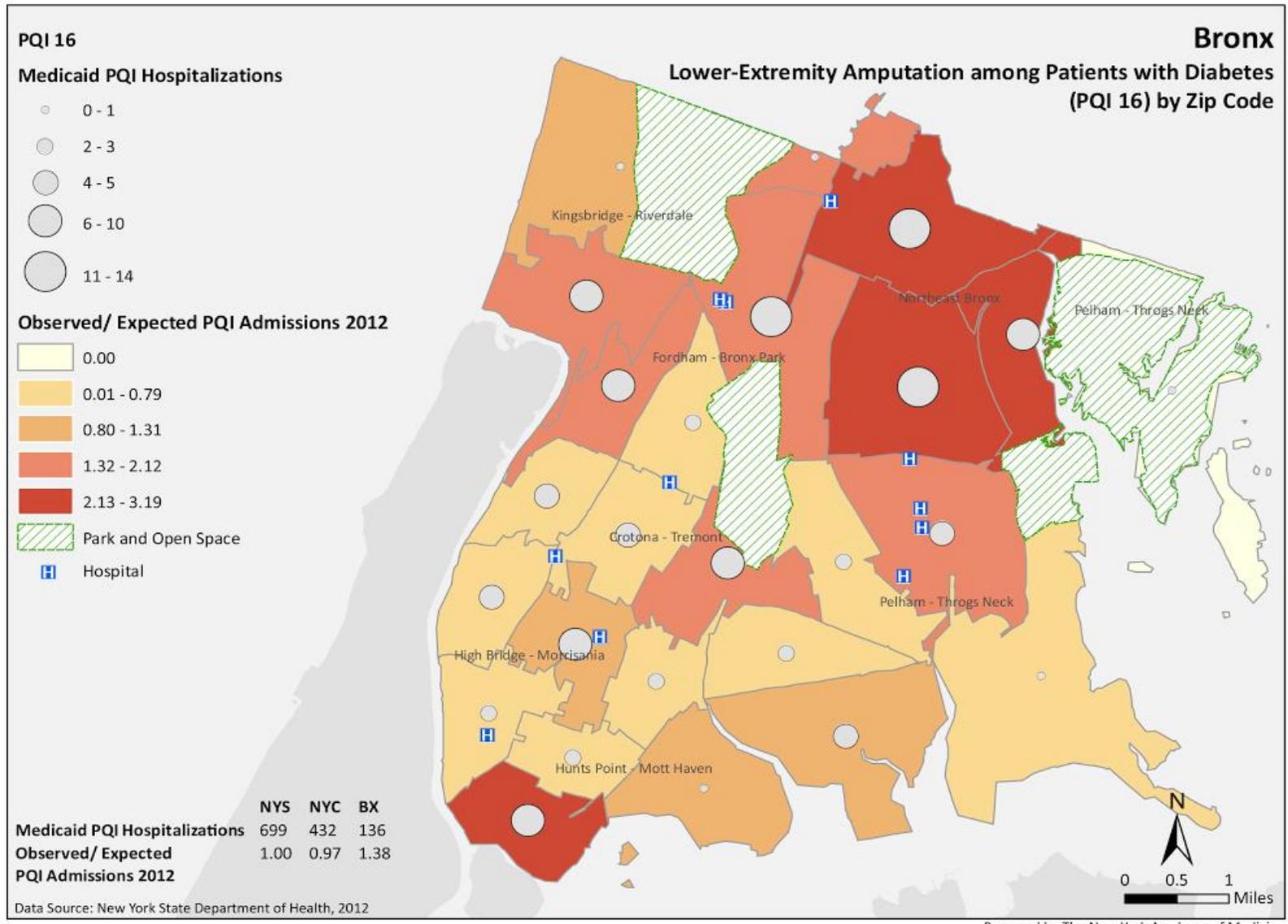
50. Uncontrolled Diabetes (PQI 14) by Zip Code



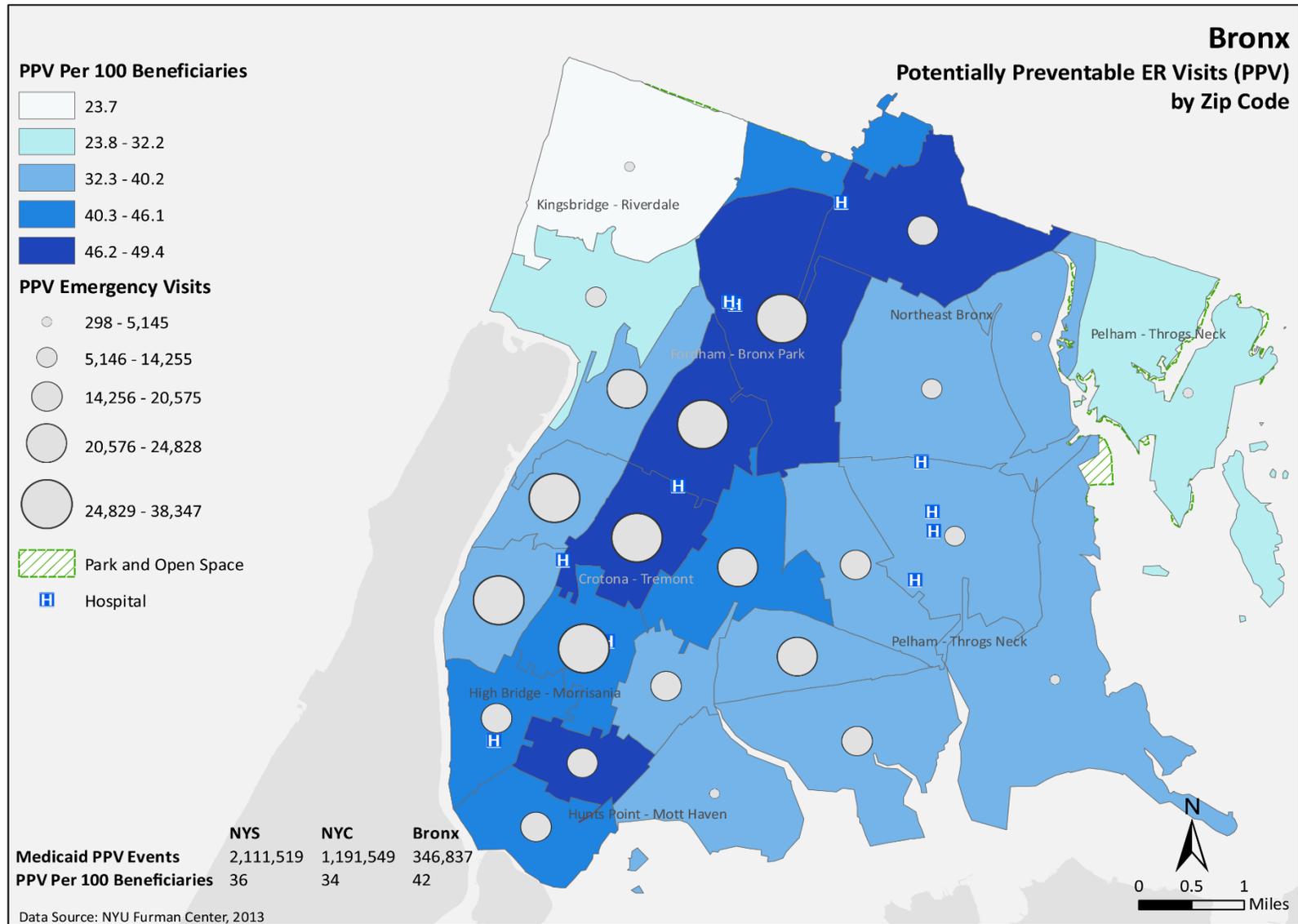
51. Asthma in Younger Adults (PQI 15) by Zip Code



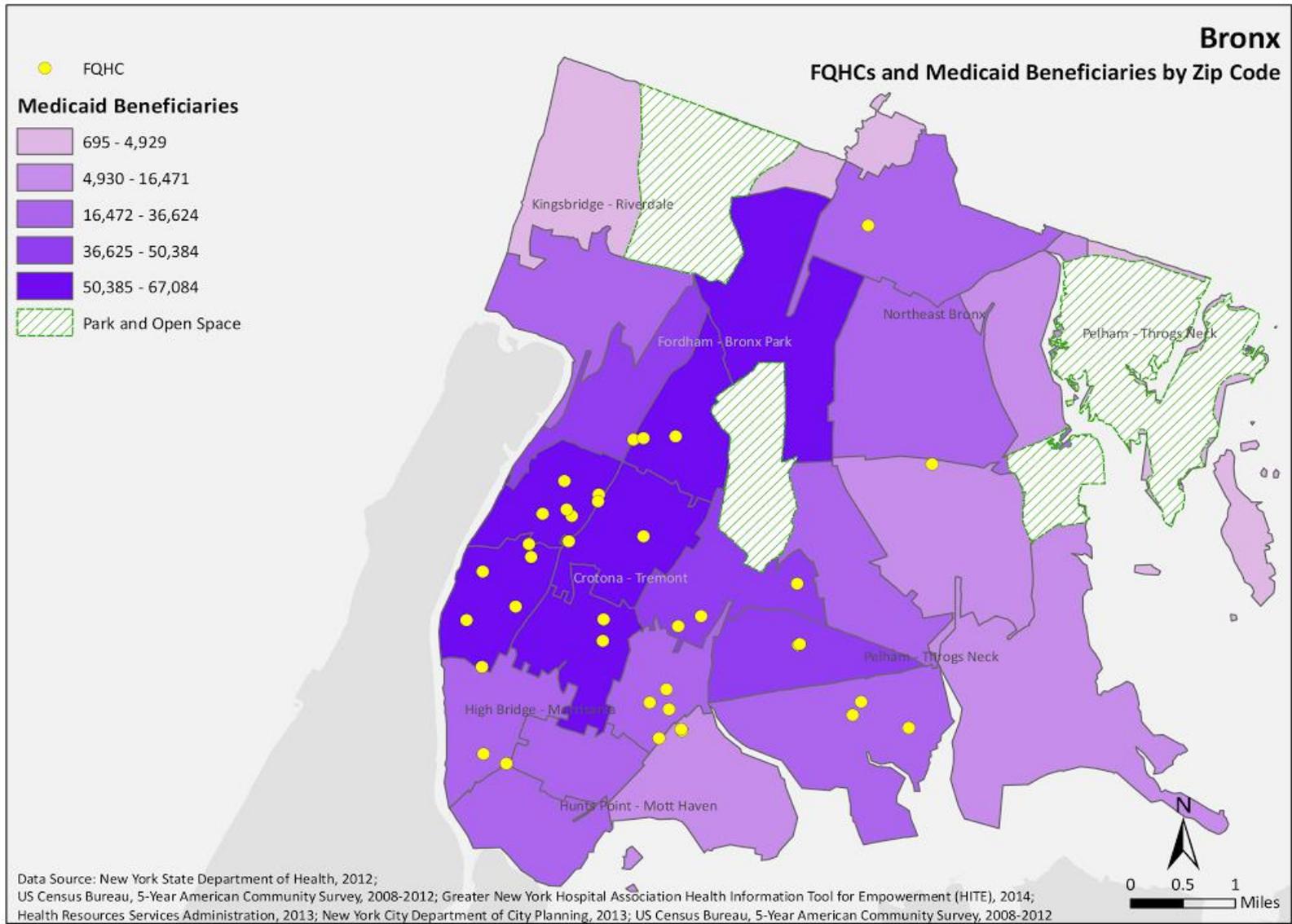
52. Lower-Extremity Amputation among Patients with Diabetes (PQI 16) by Zip Code



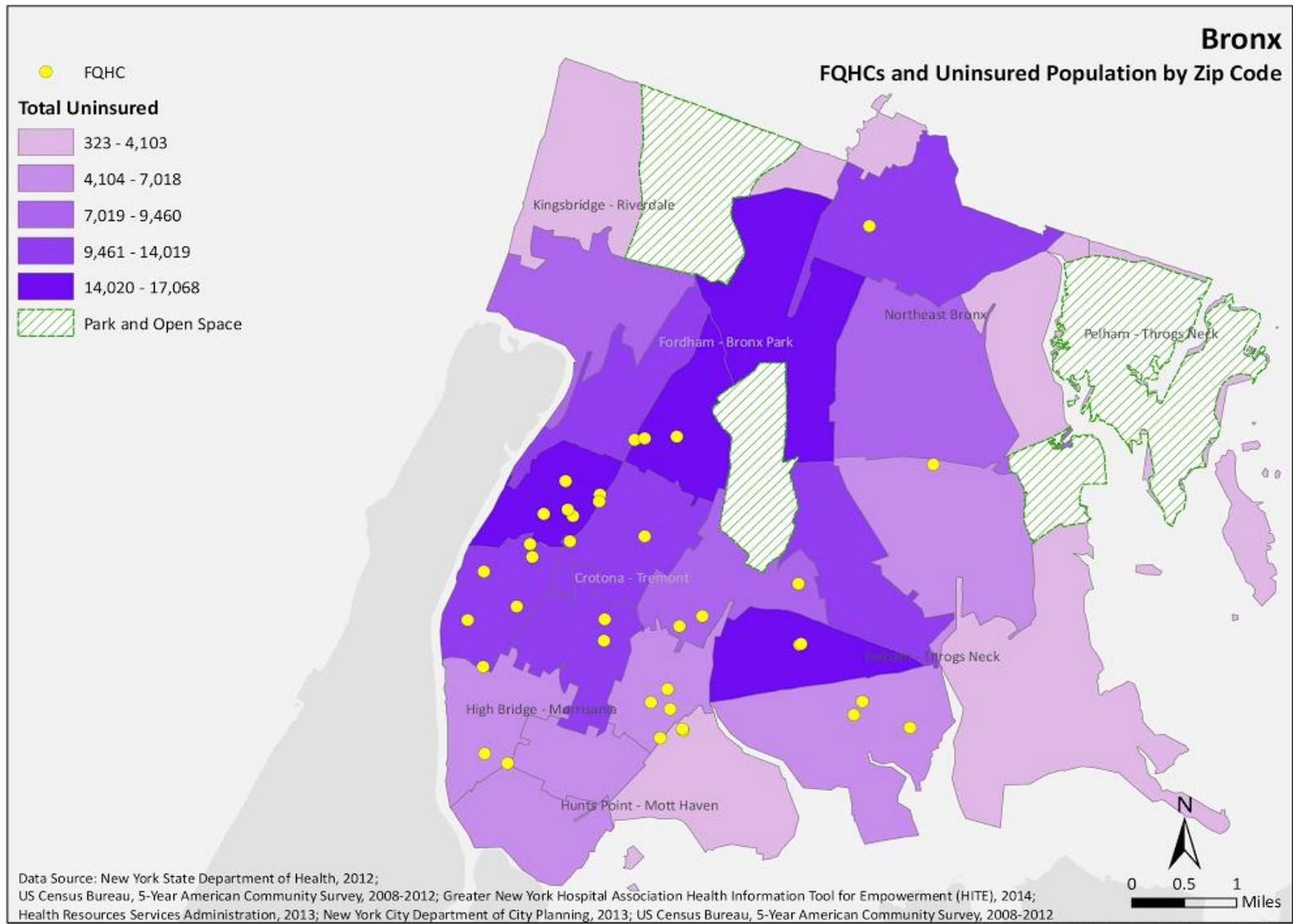
53. Potentially Preventable ER Visits (PPV) by Zip Code



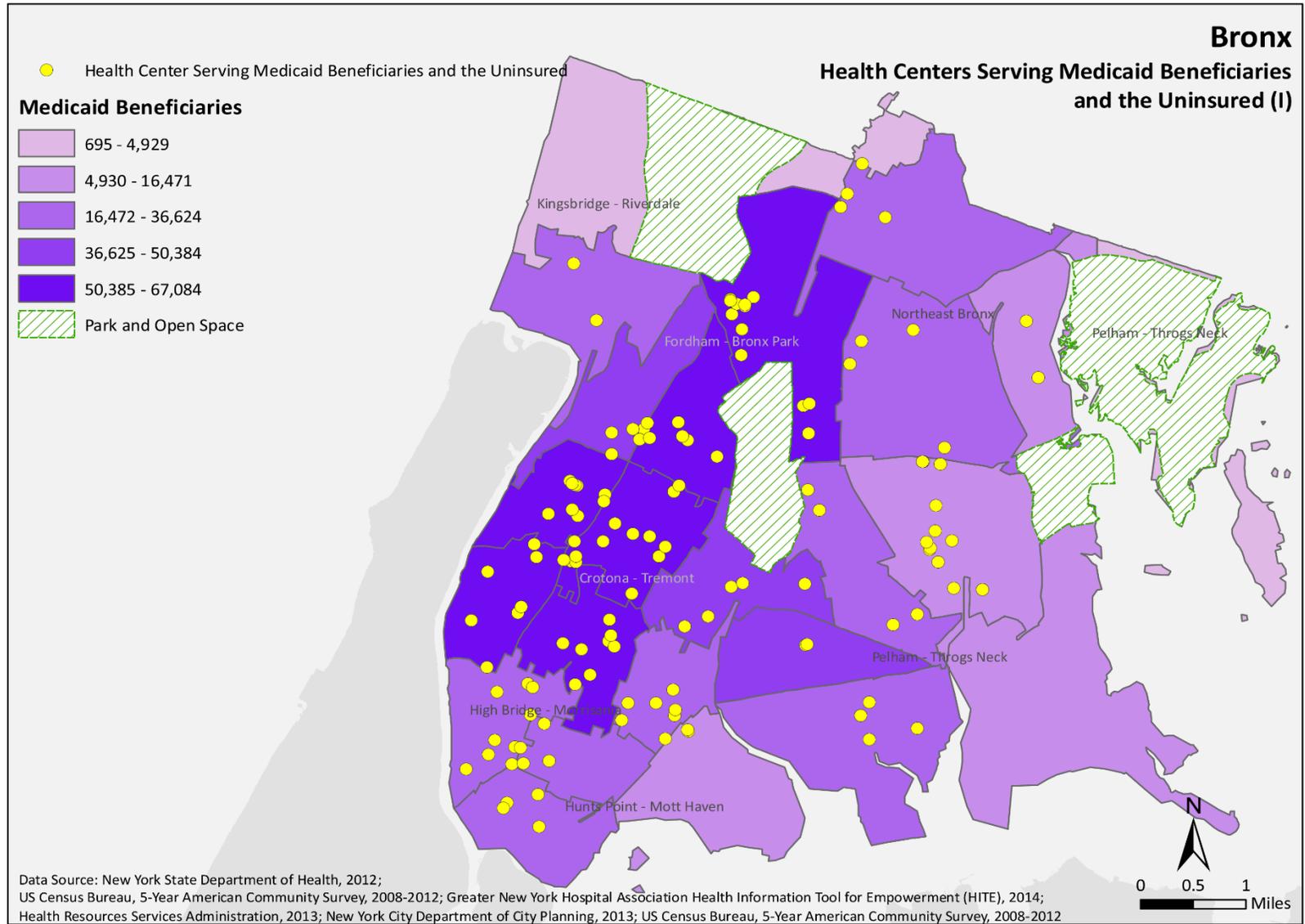
54. FQHCs and Medicaid Beneficiaries by Zip Code



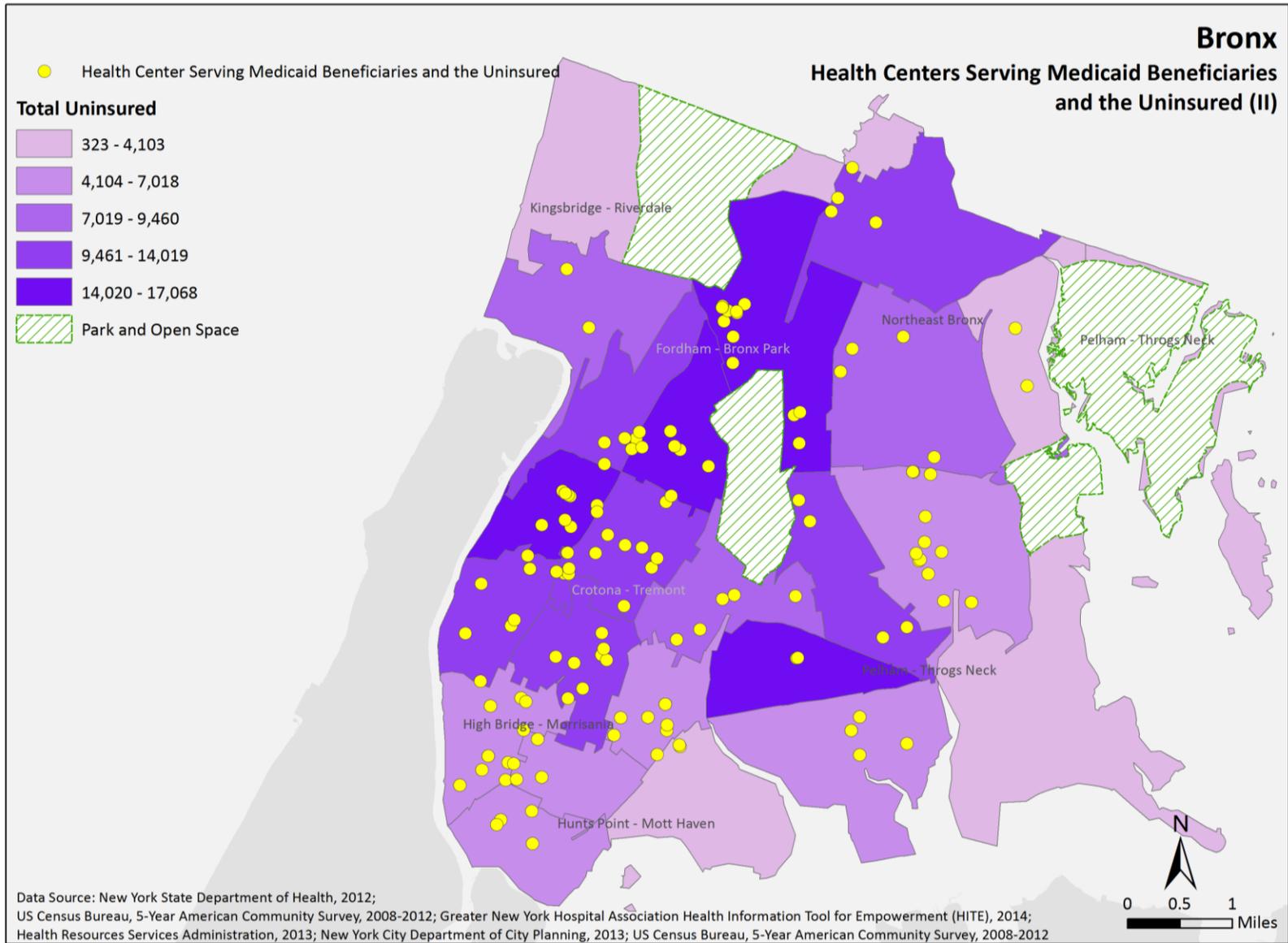
55. FQHCs and Uninsured Population by Zip Code



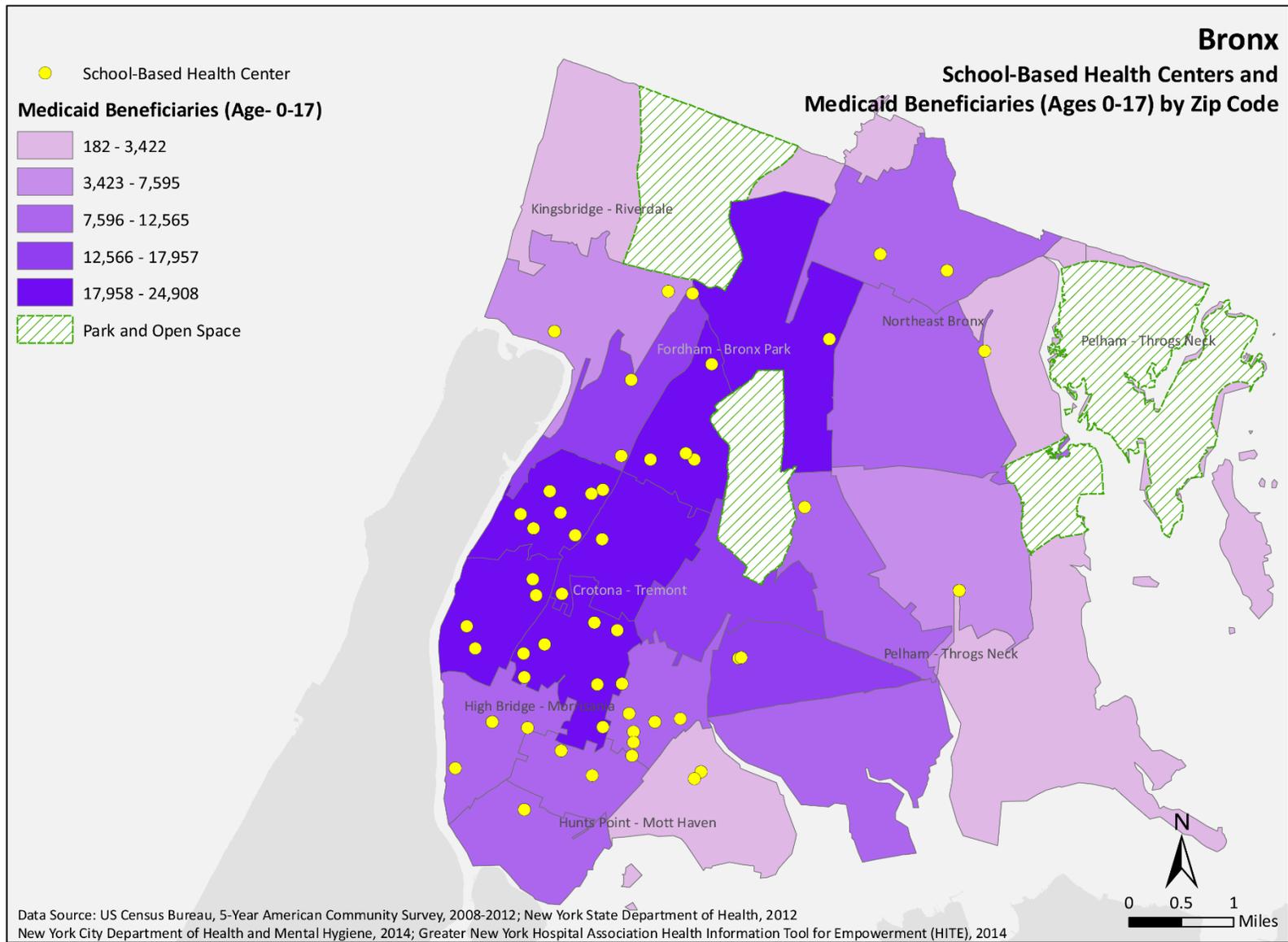
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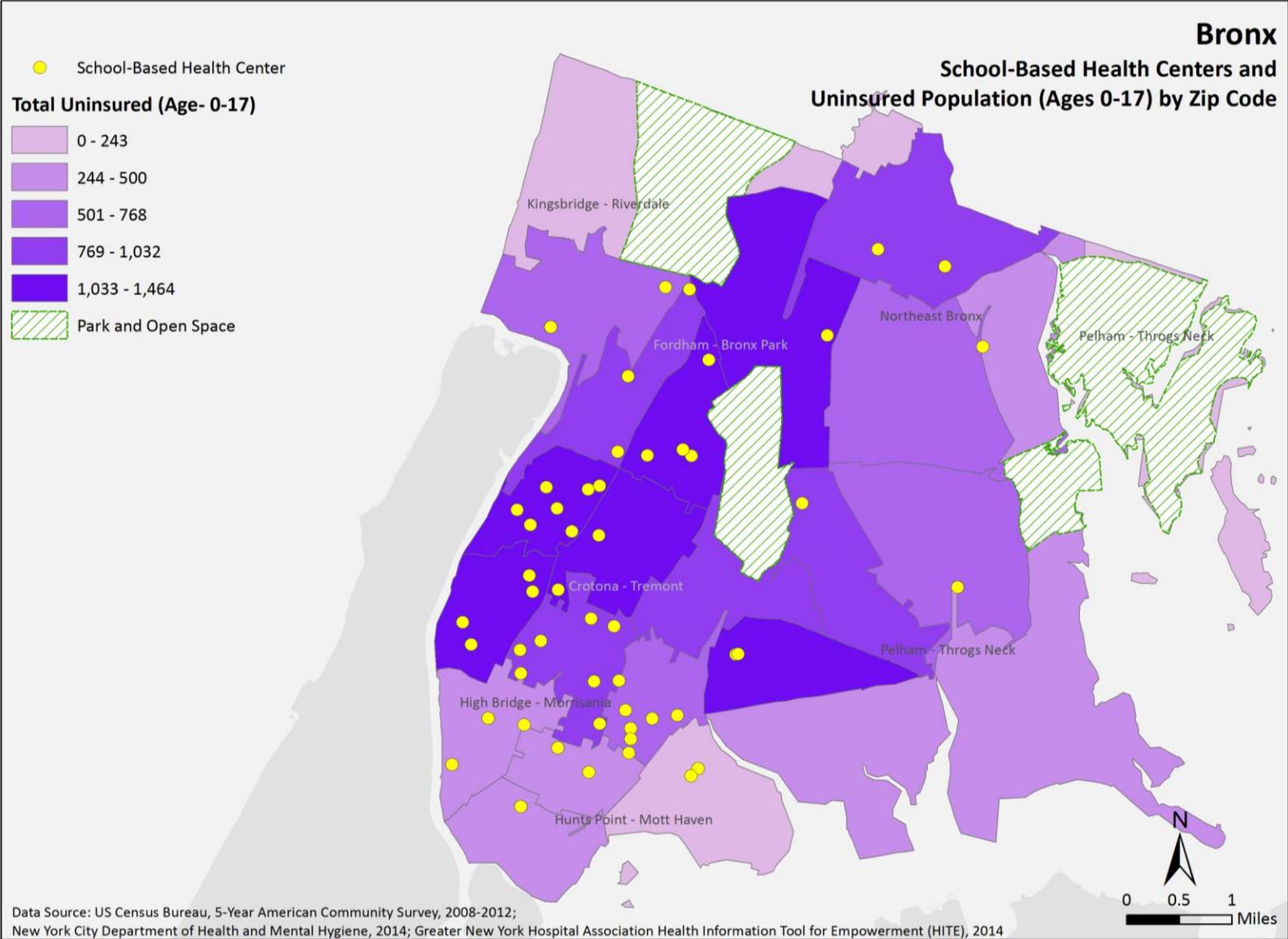
57. Health Centers Serving Medicaid Beneficiaries and the Uninsured (II)



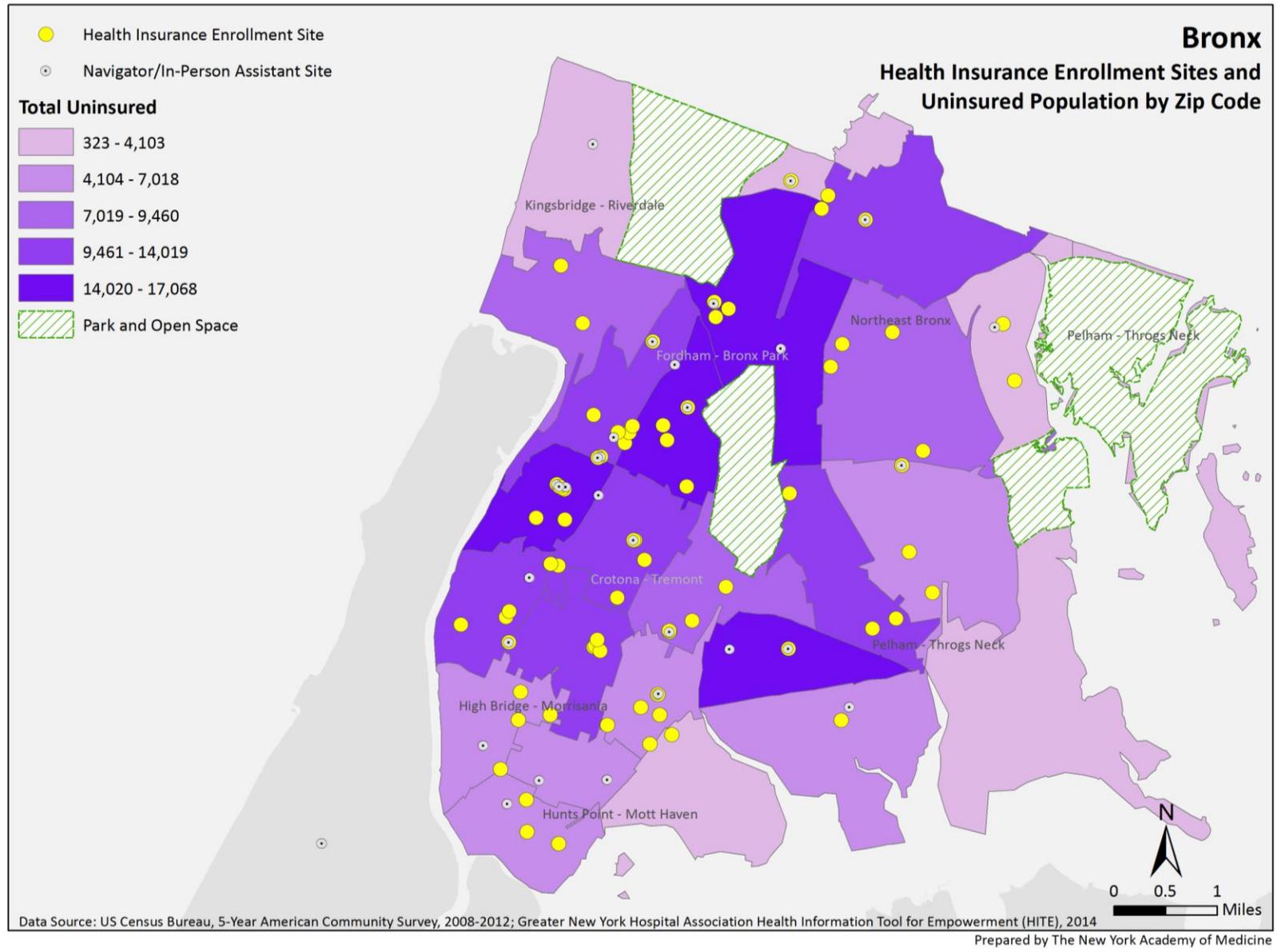
58. School-Based Health Centers and Medicaid Beneficiaries (Ages 0-17) by Zip Code



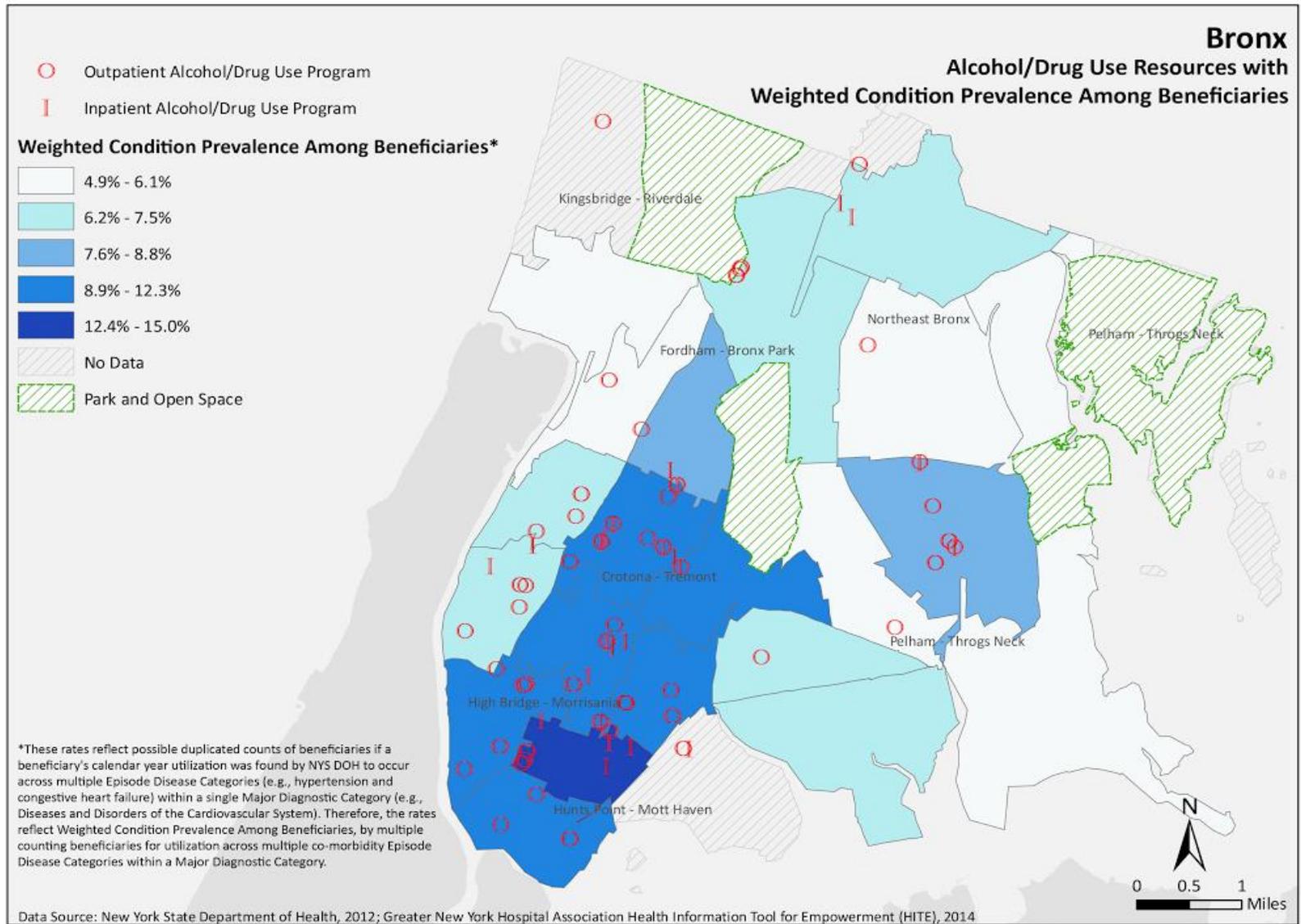
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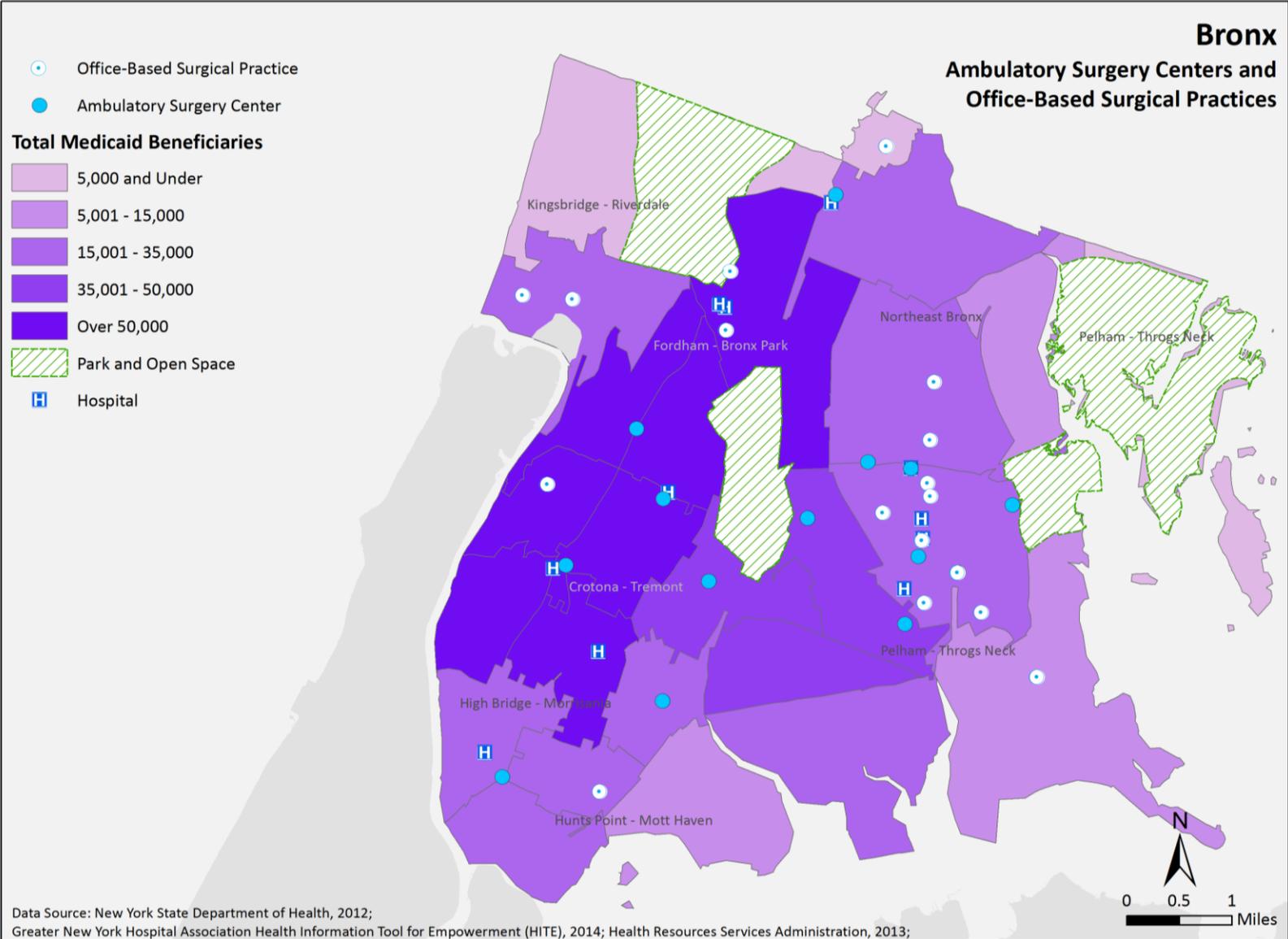
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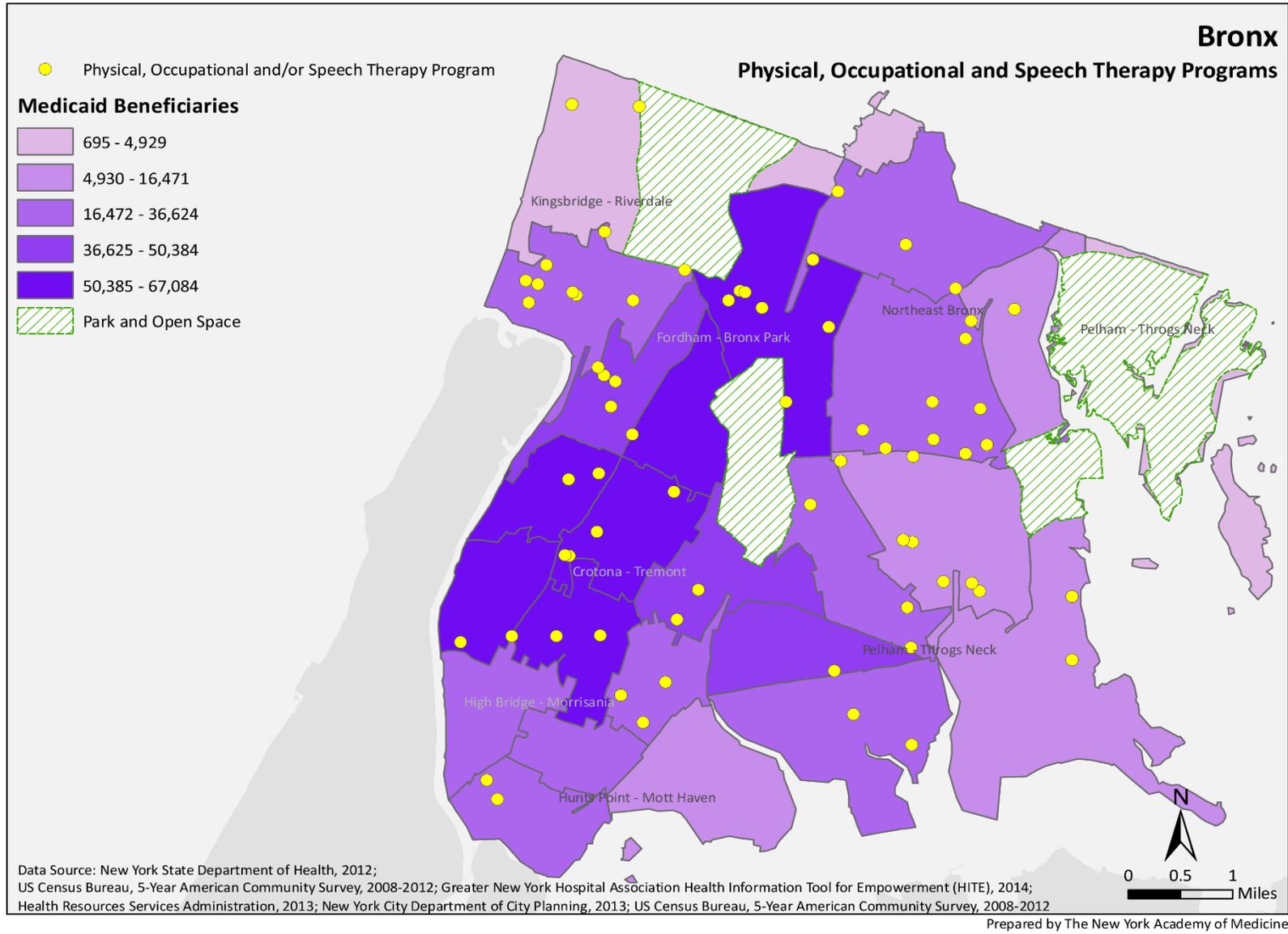


62. Ambulatory Surgery Centers and Office-Based Surgical Practices

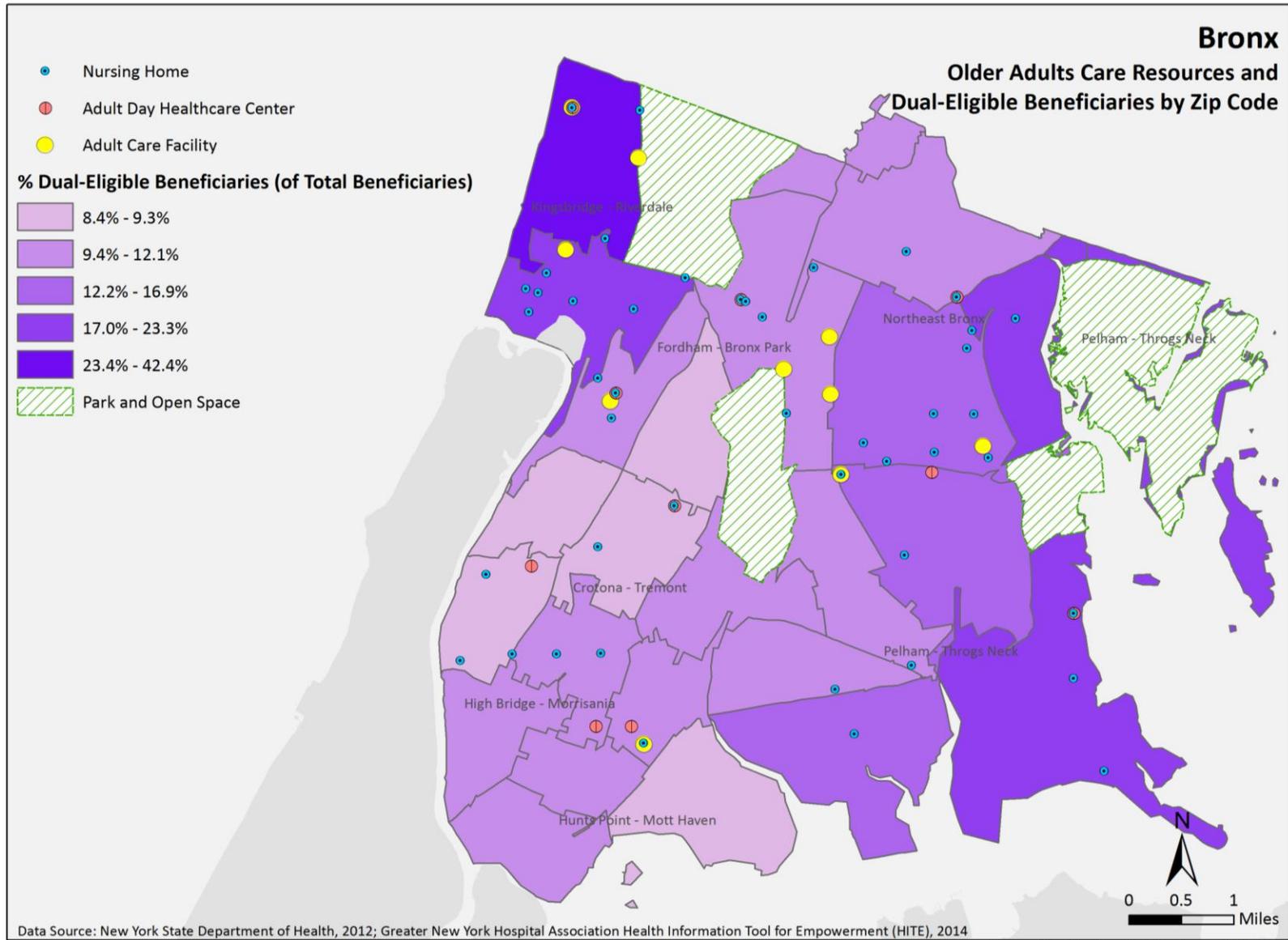


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63. Physical, Occupational and Speech Therapy Programs and Medicaid Beneficiaries by Zip Code

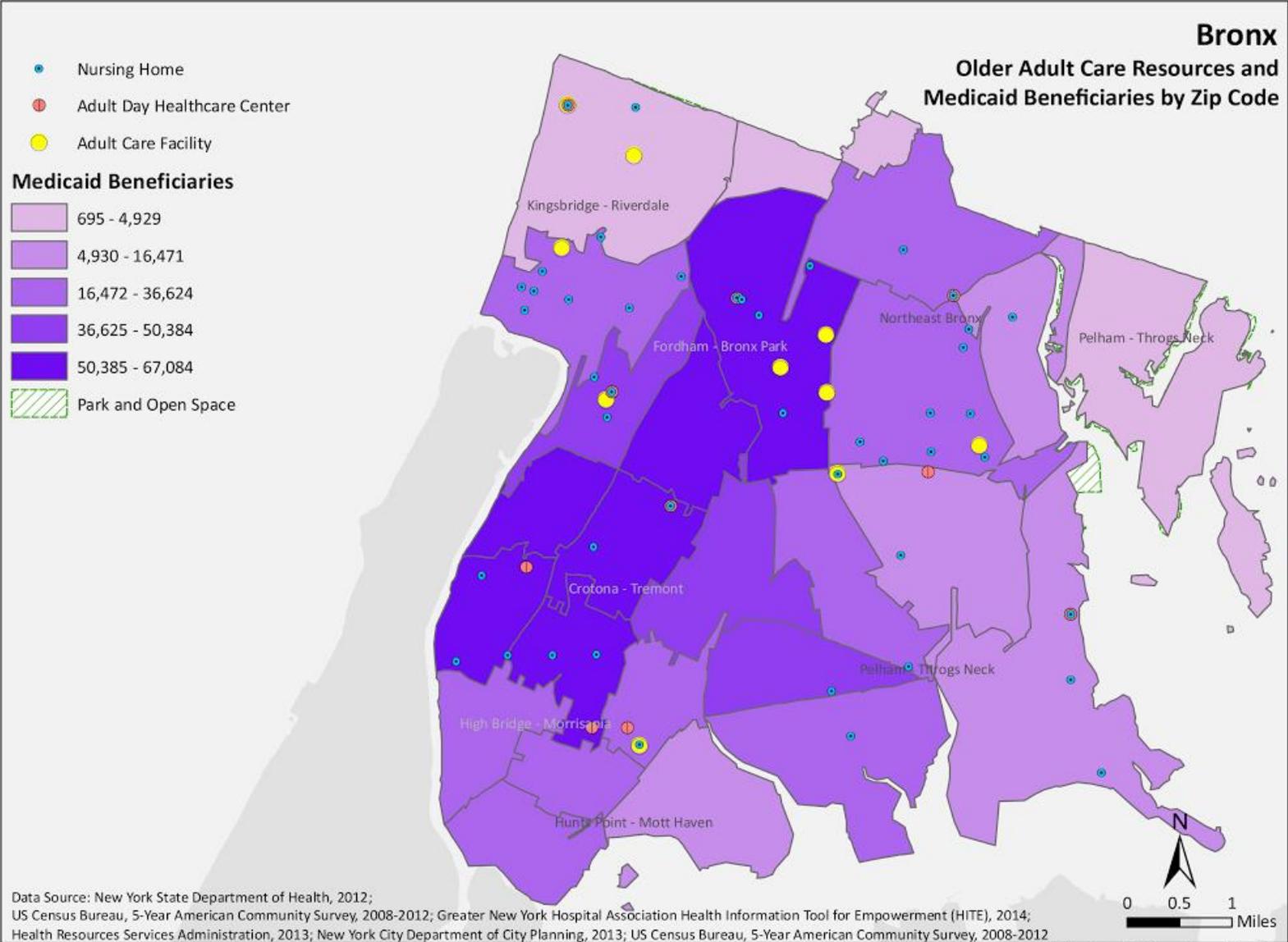


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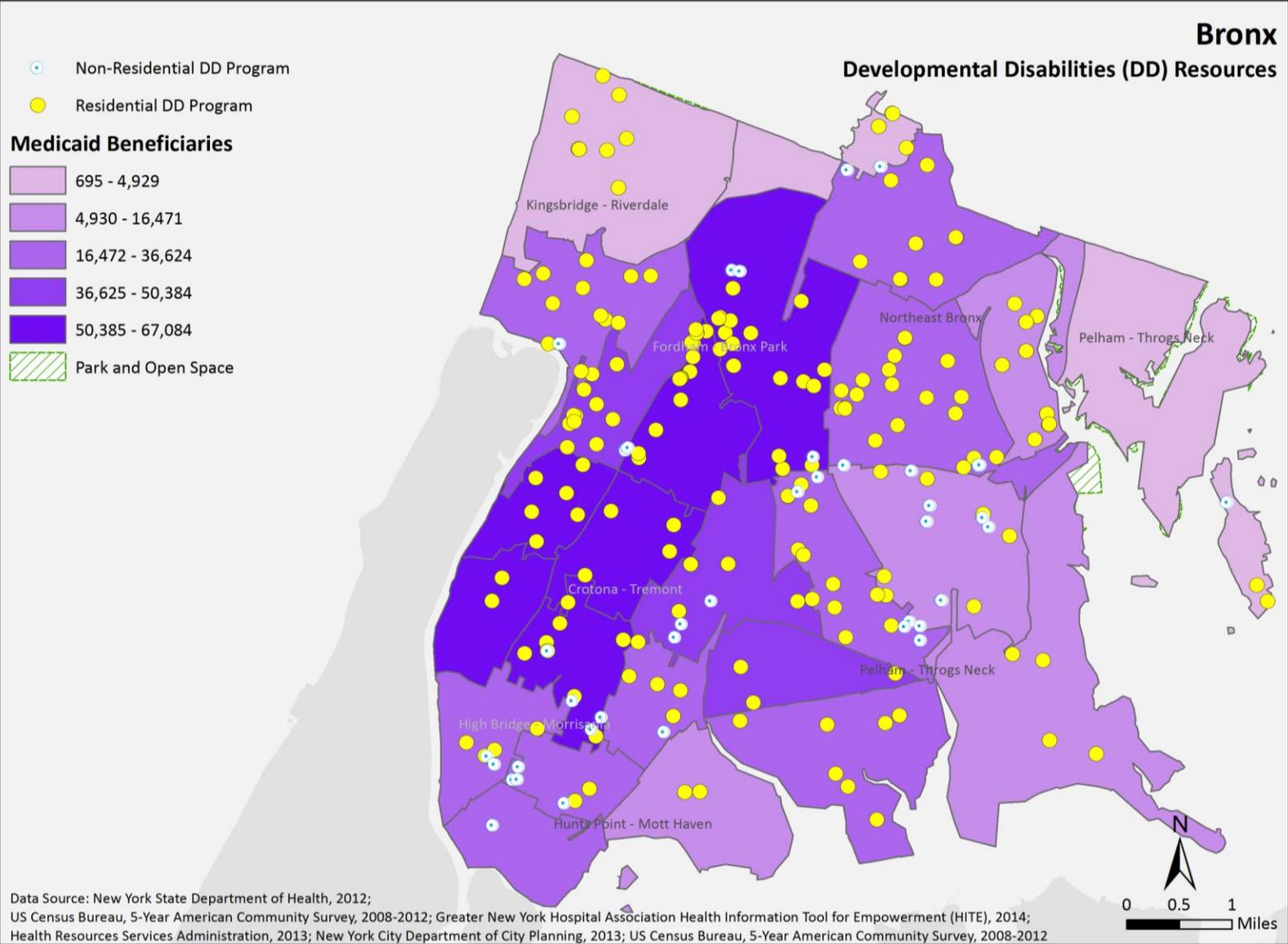


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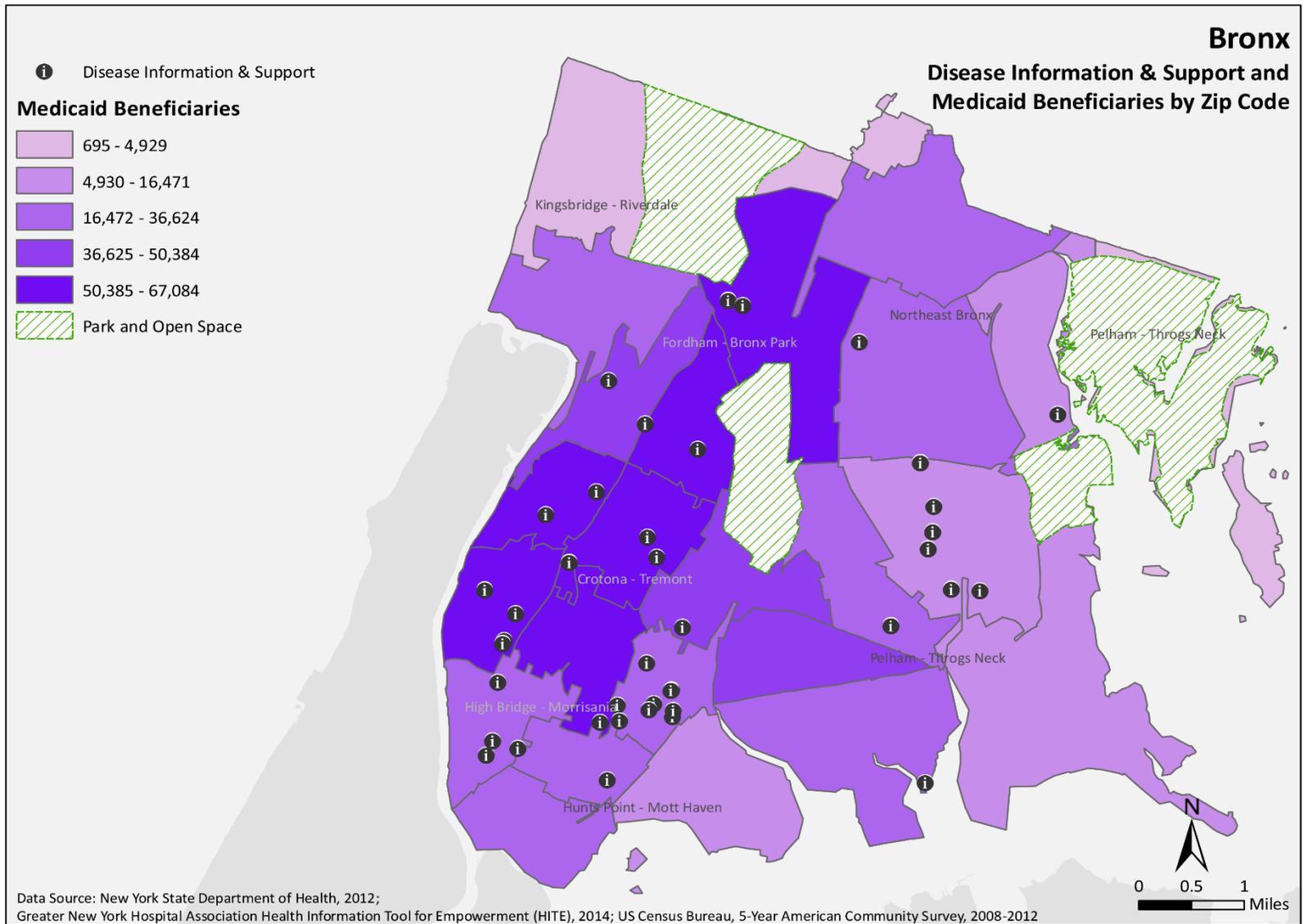
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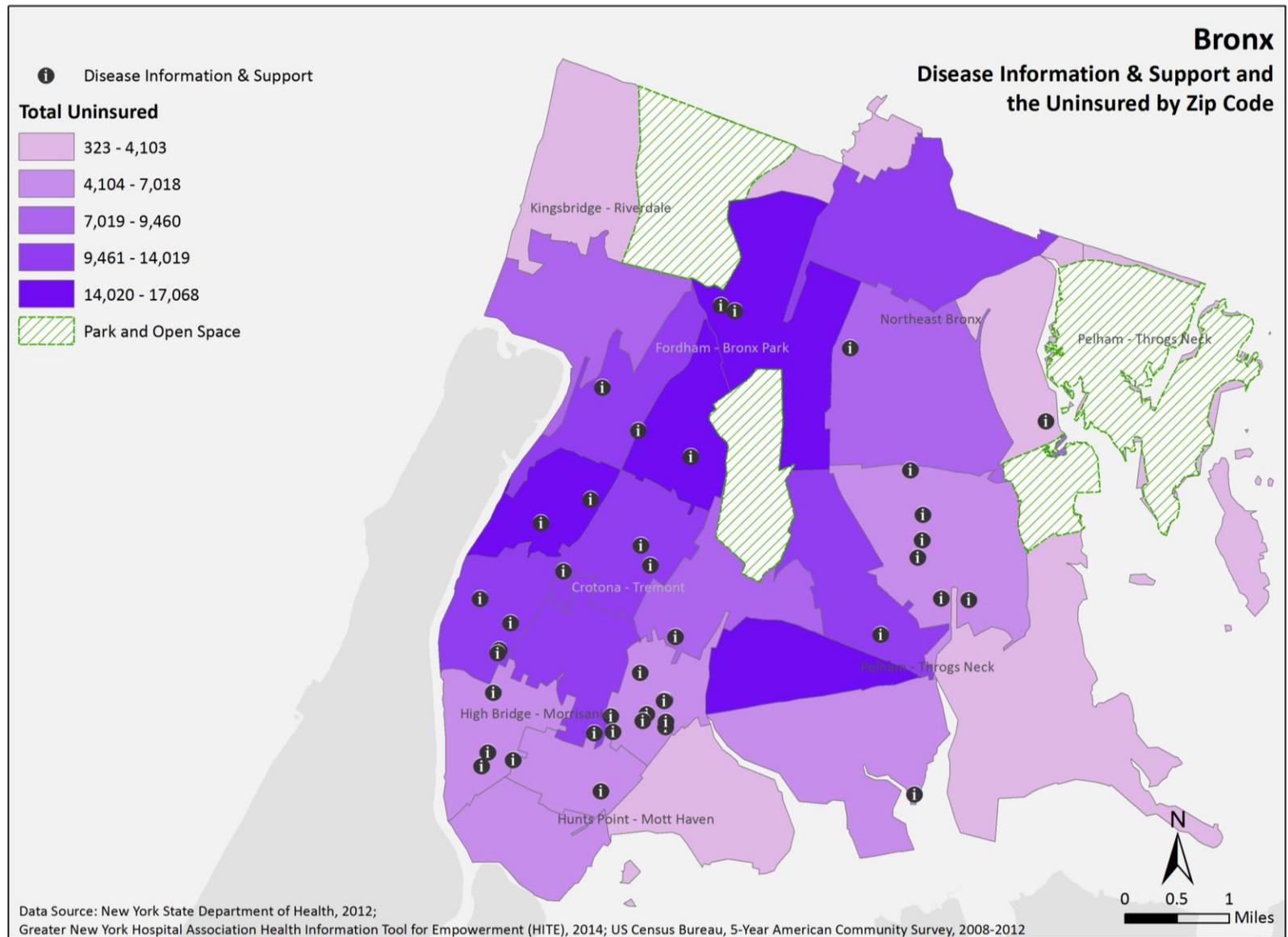
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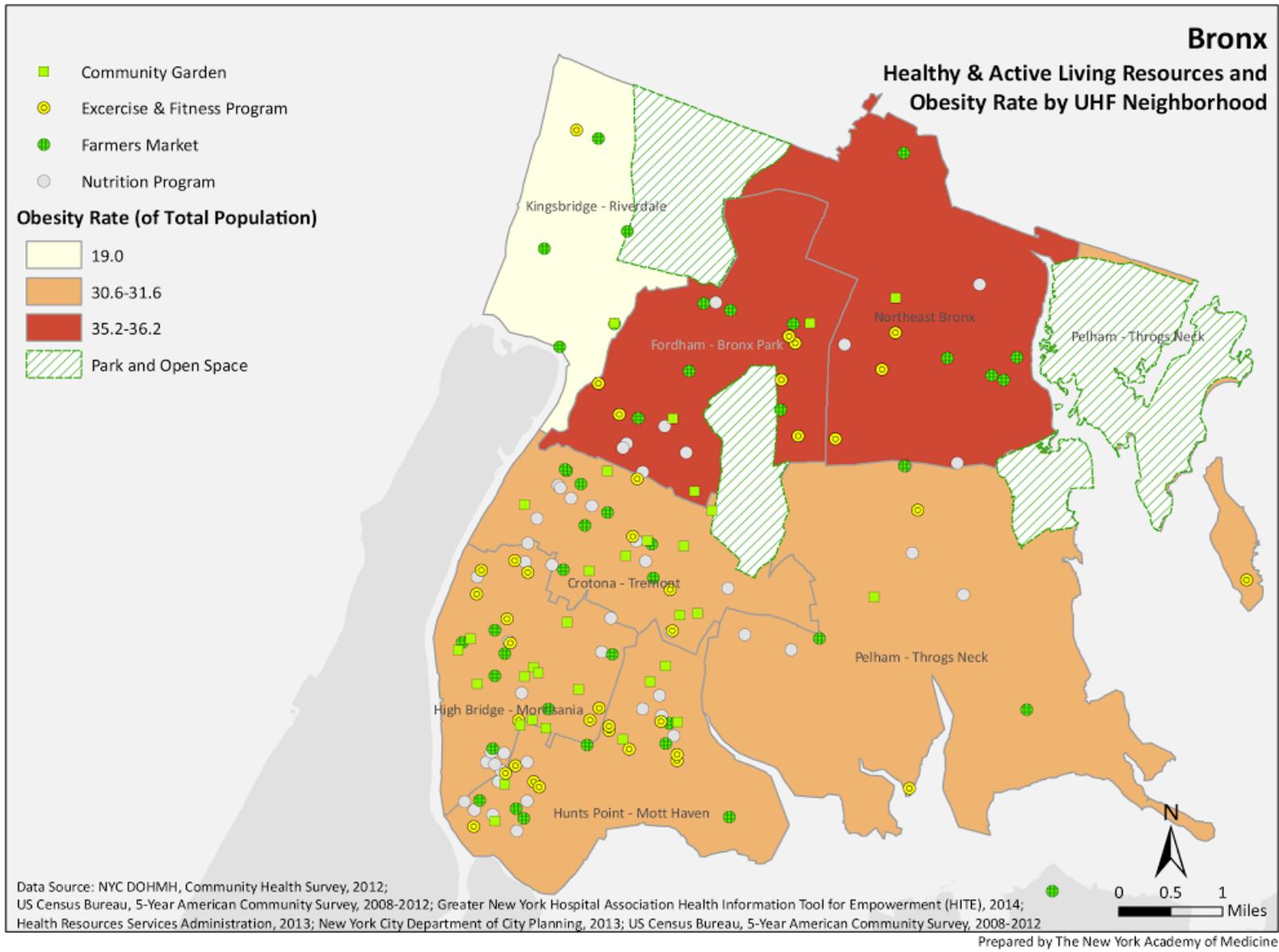
67. Disease Information and Support and Medicaid Beneficiaries by Zip Code



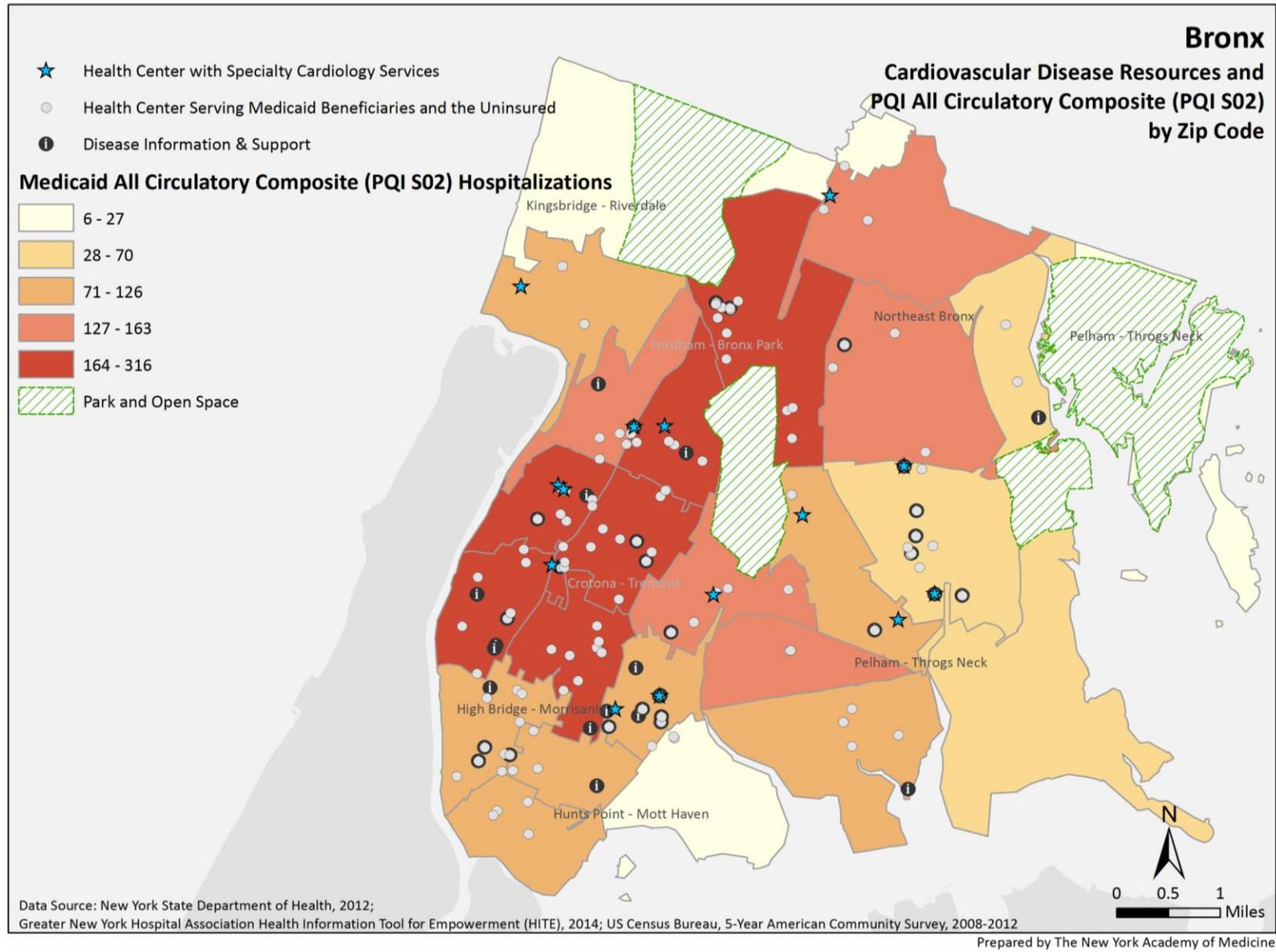
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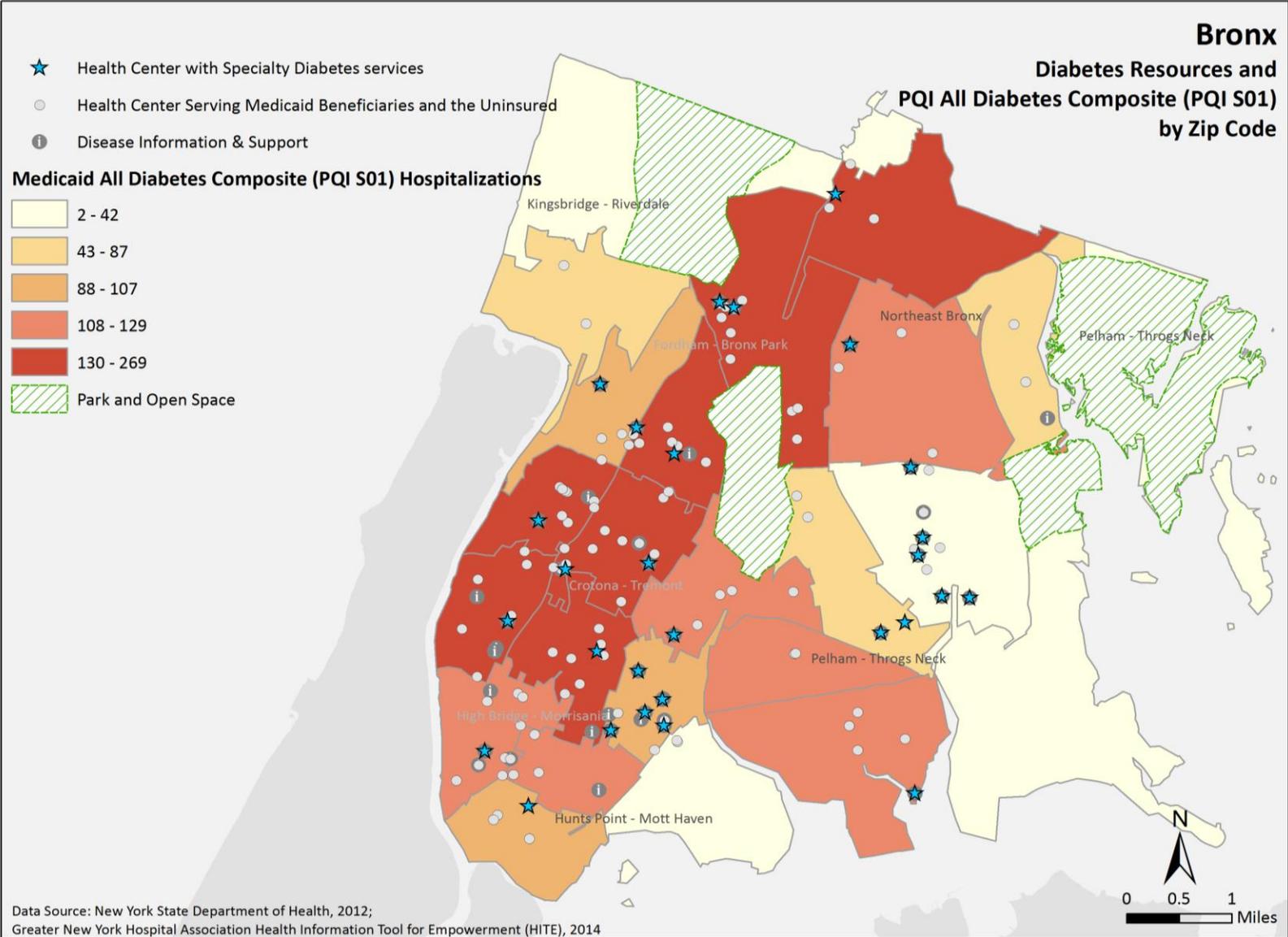
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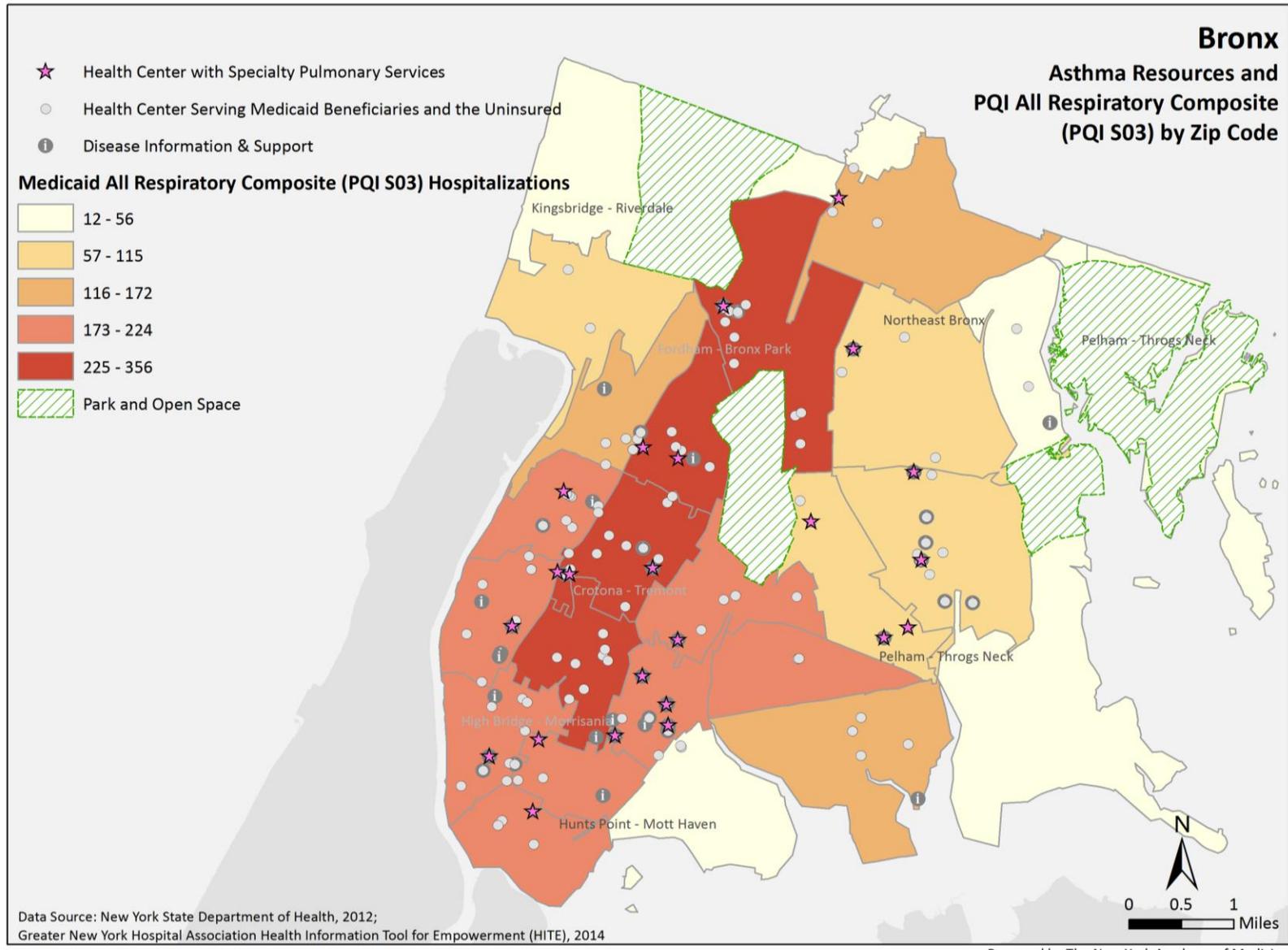
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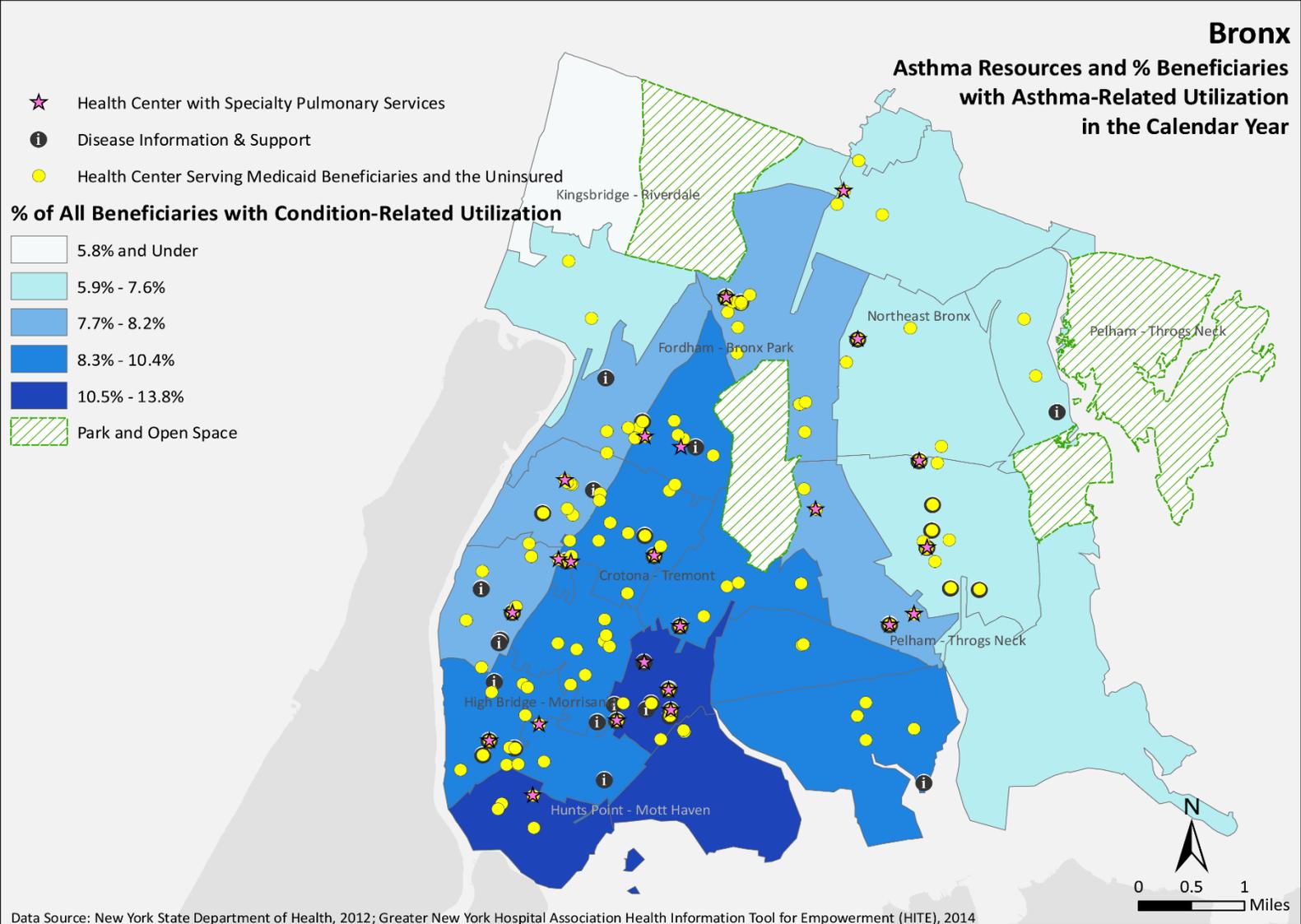
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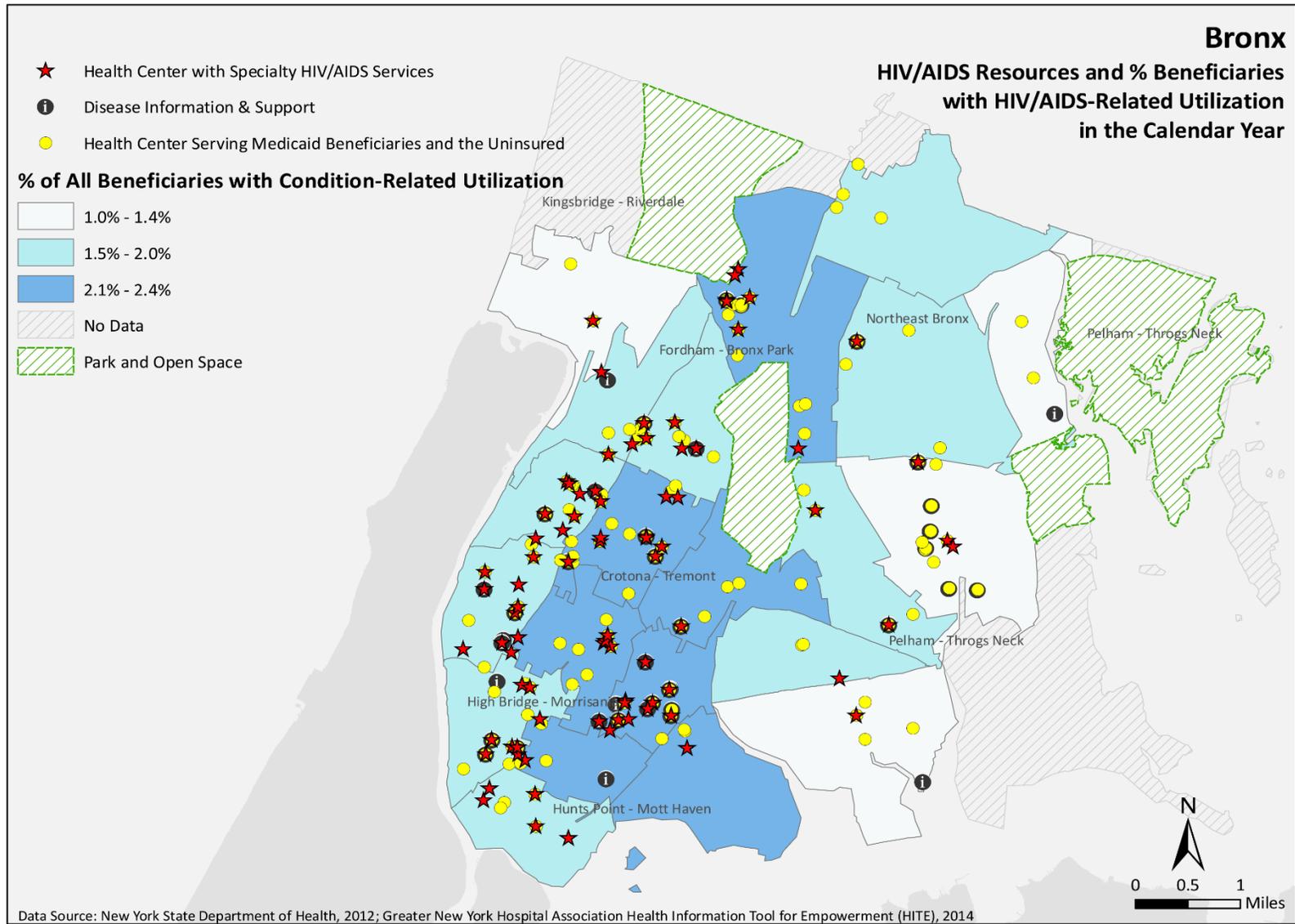


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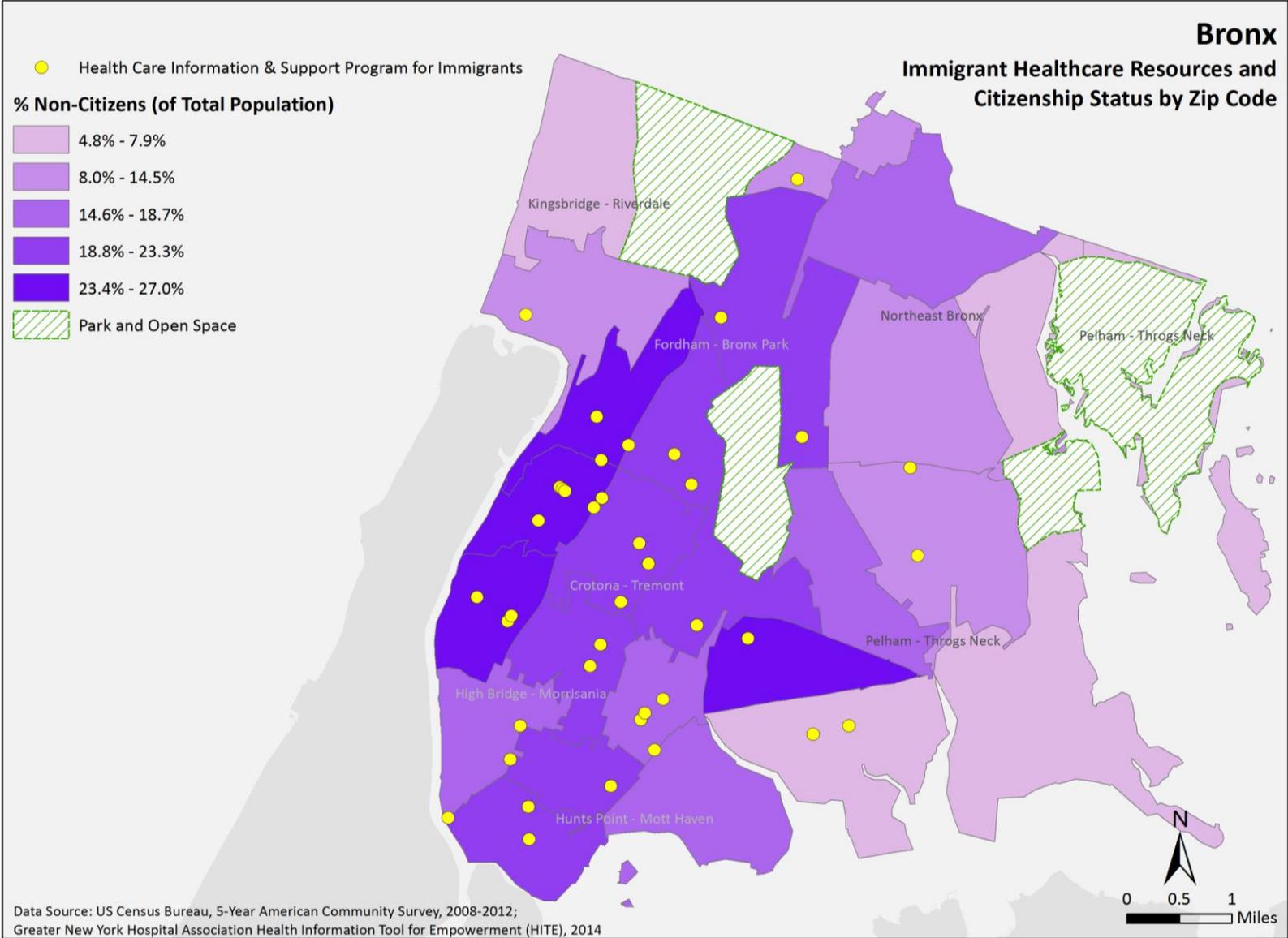


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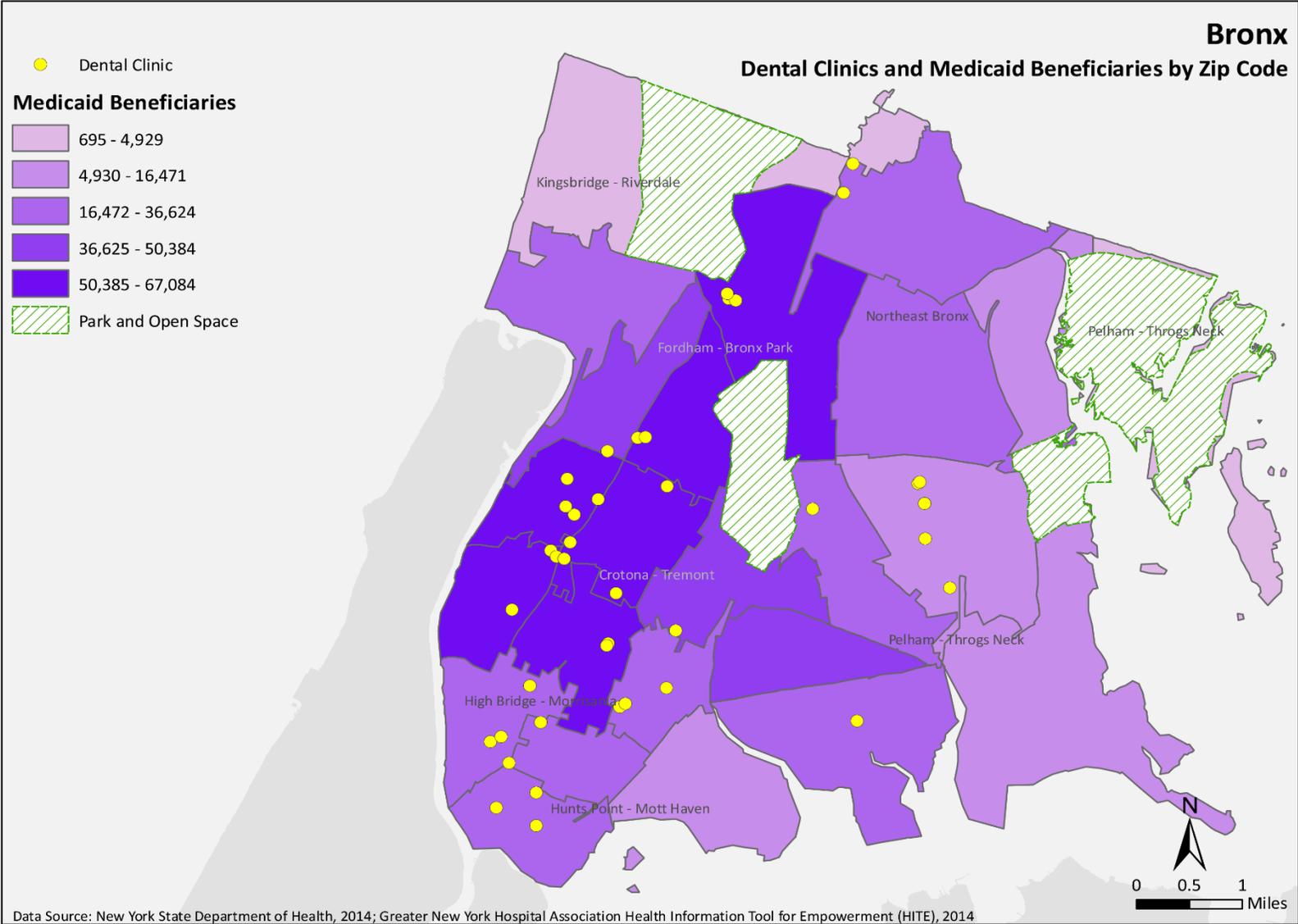
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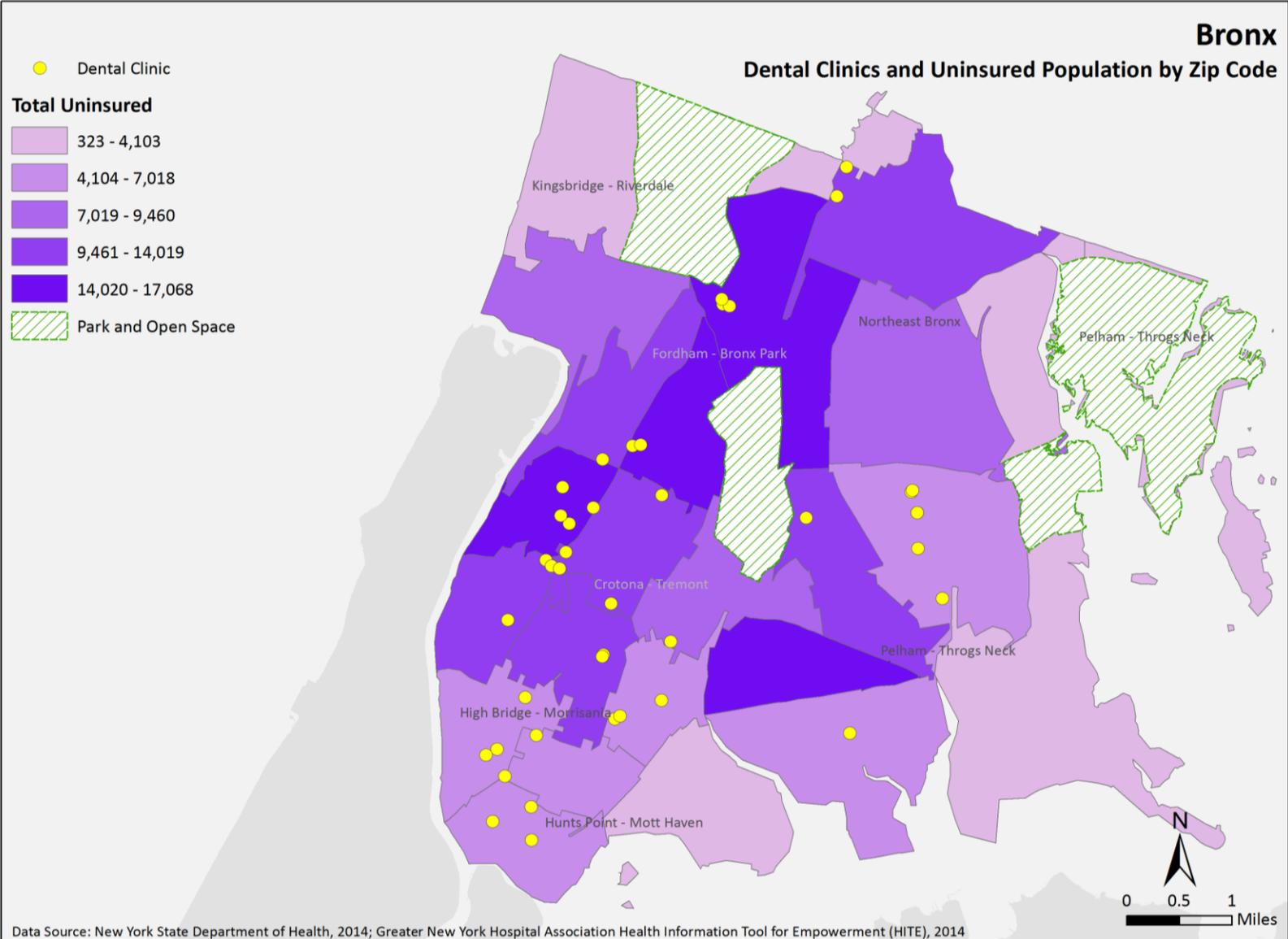


76. Dental Clinics and Medicaid Beneficiaries by Zip Code

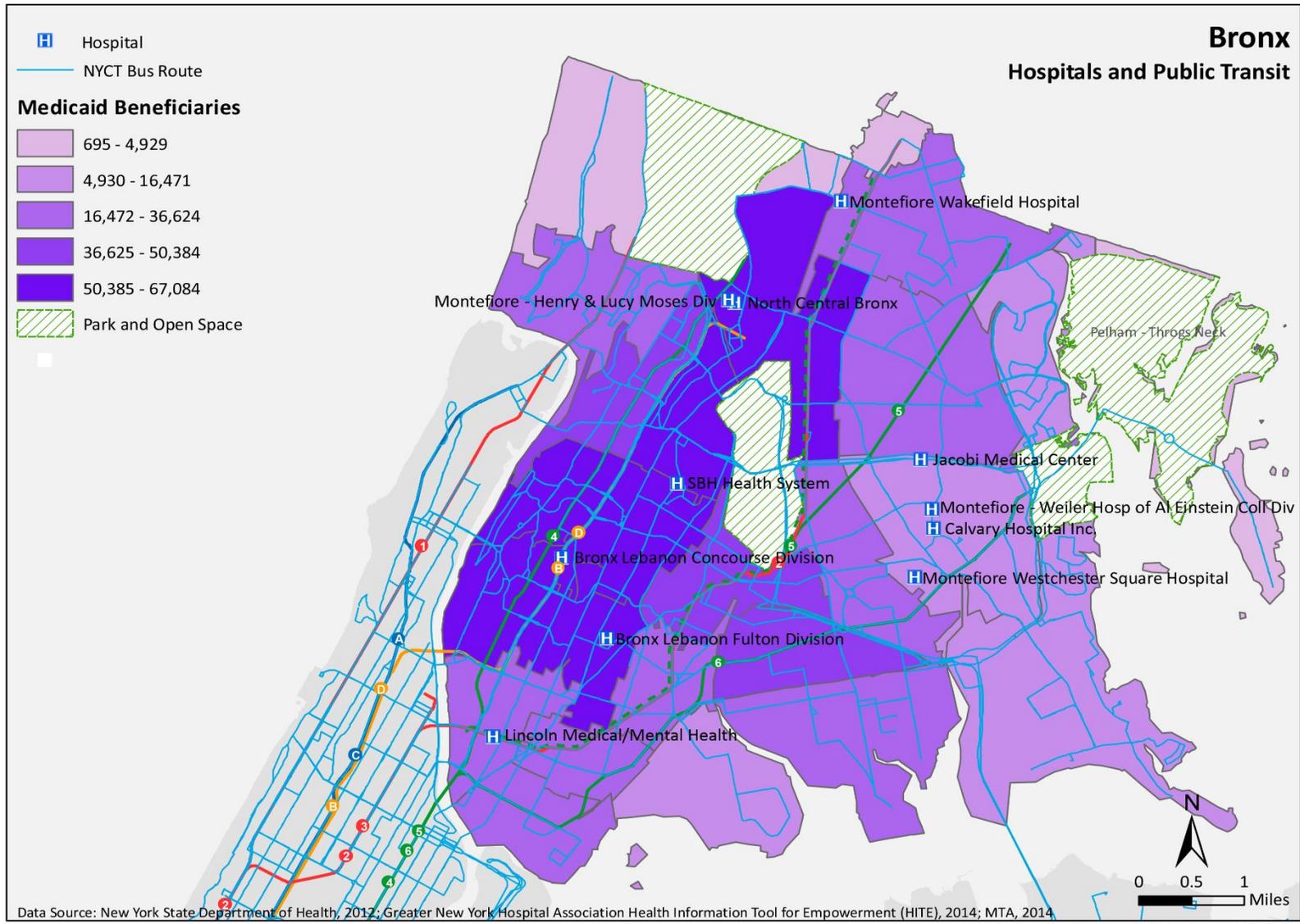


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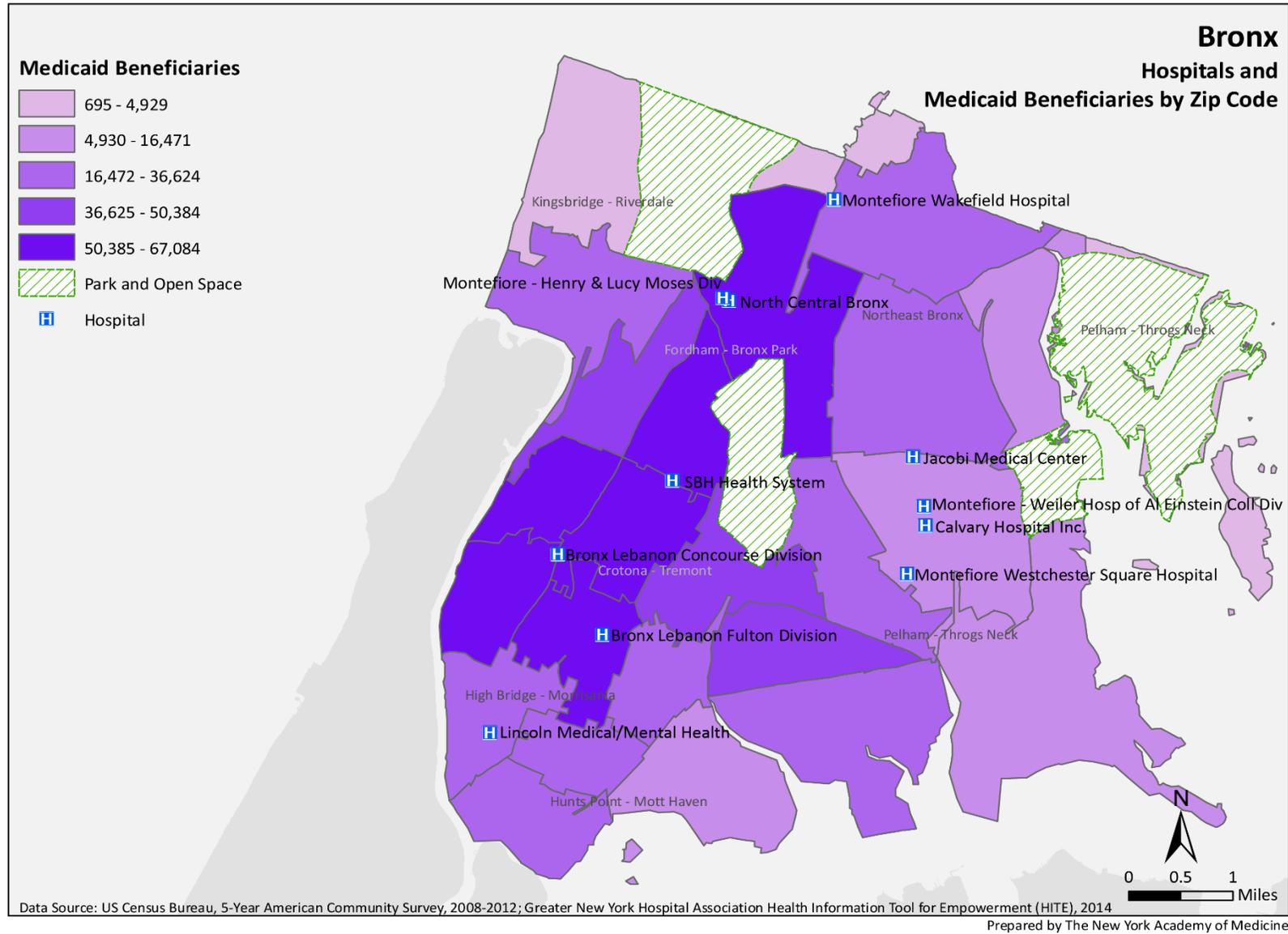


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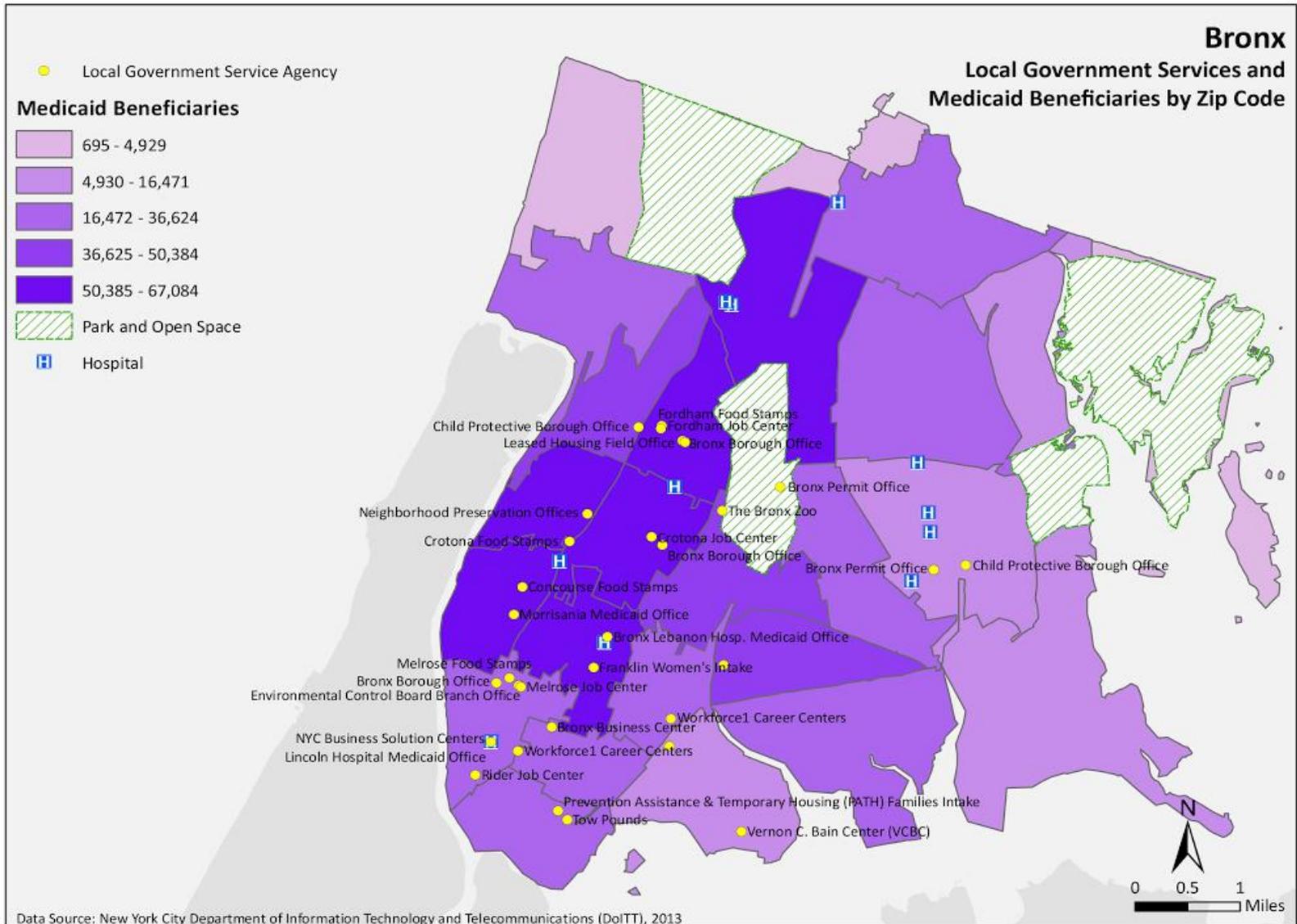


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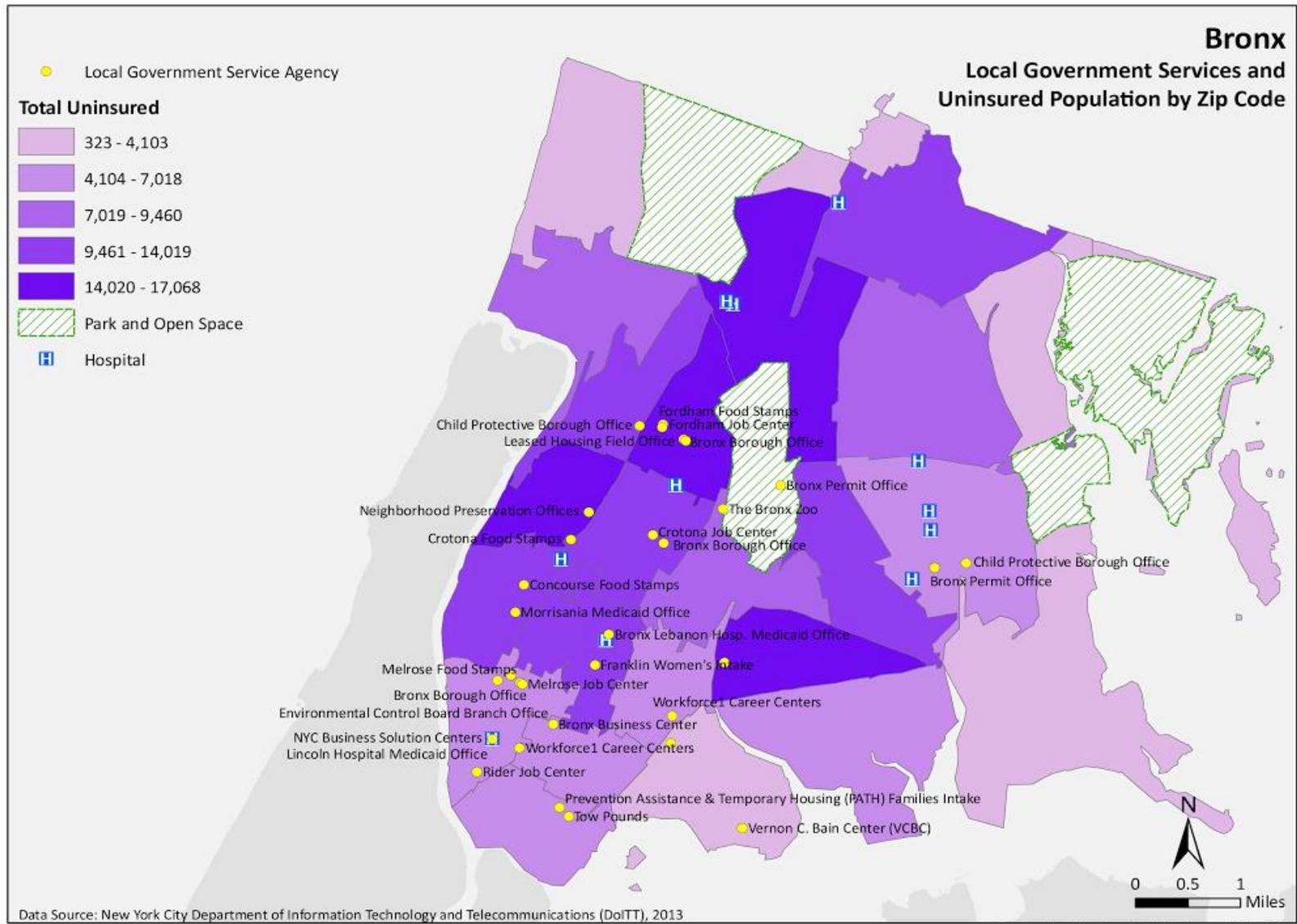
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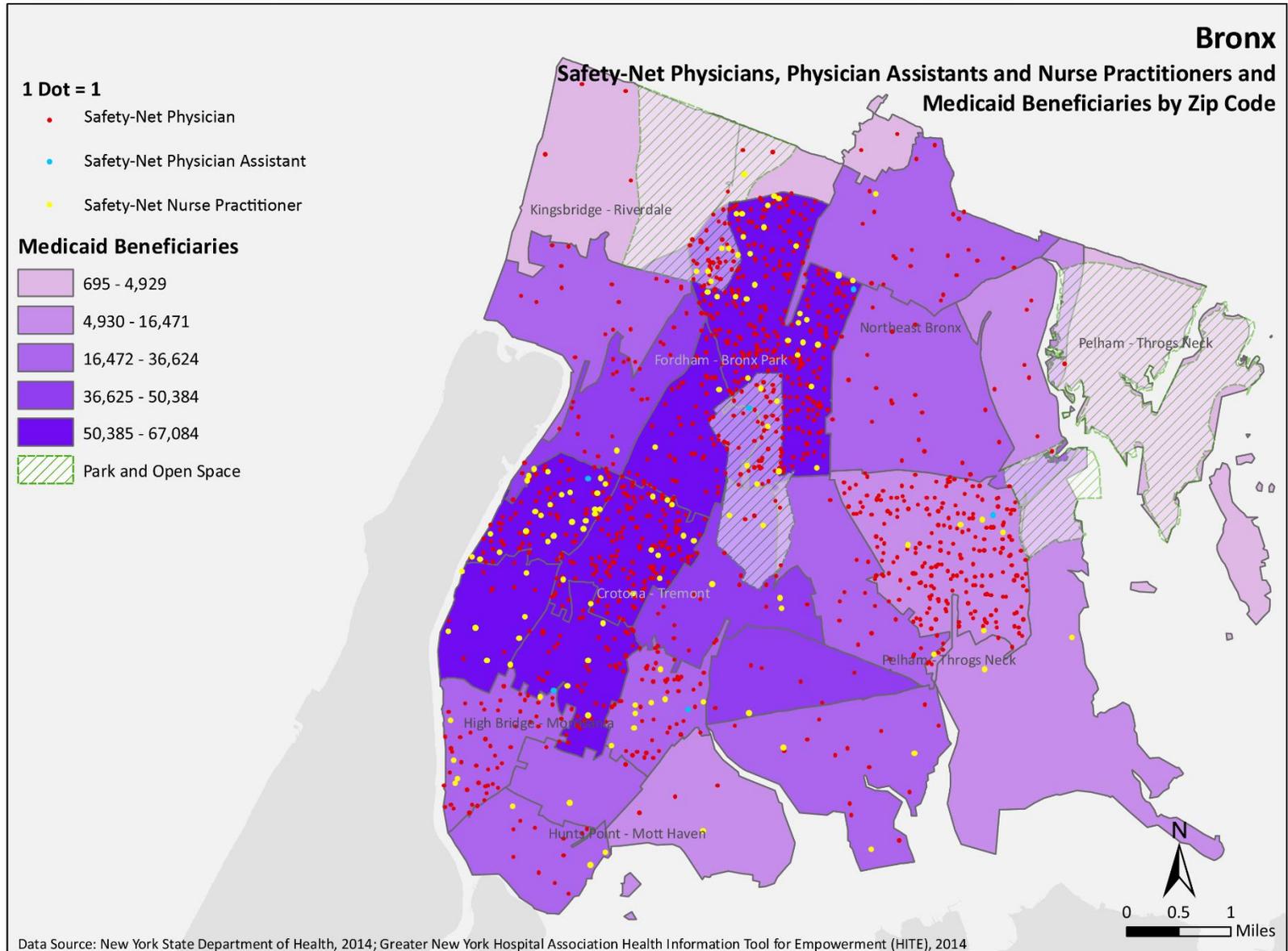
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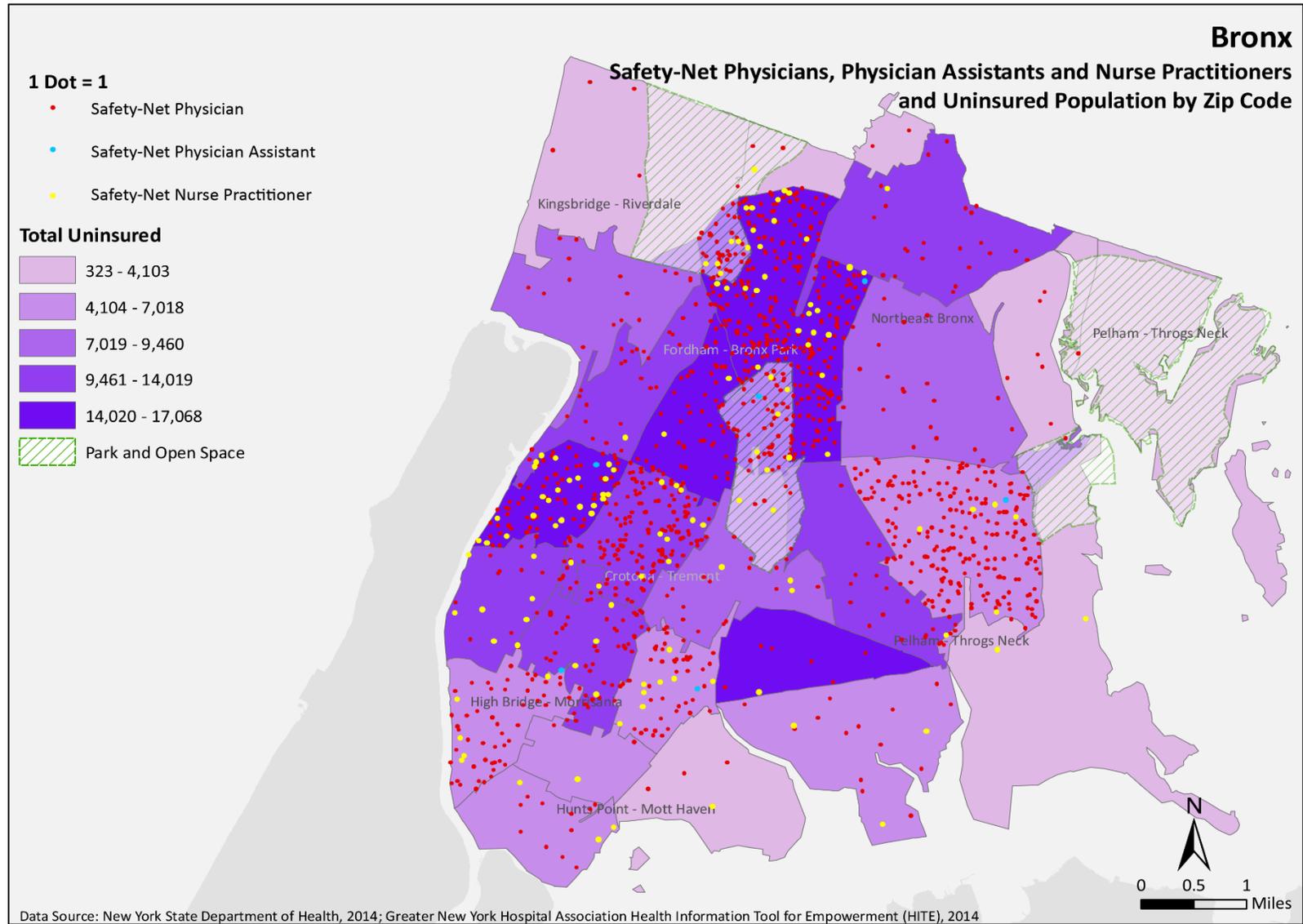


82. Safety-Net Physicians, Physician Assistants, Nurse Practitioners and Medicaid Beneficiaries by Zip Code

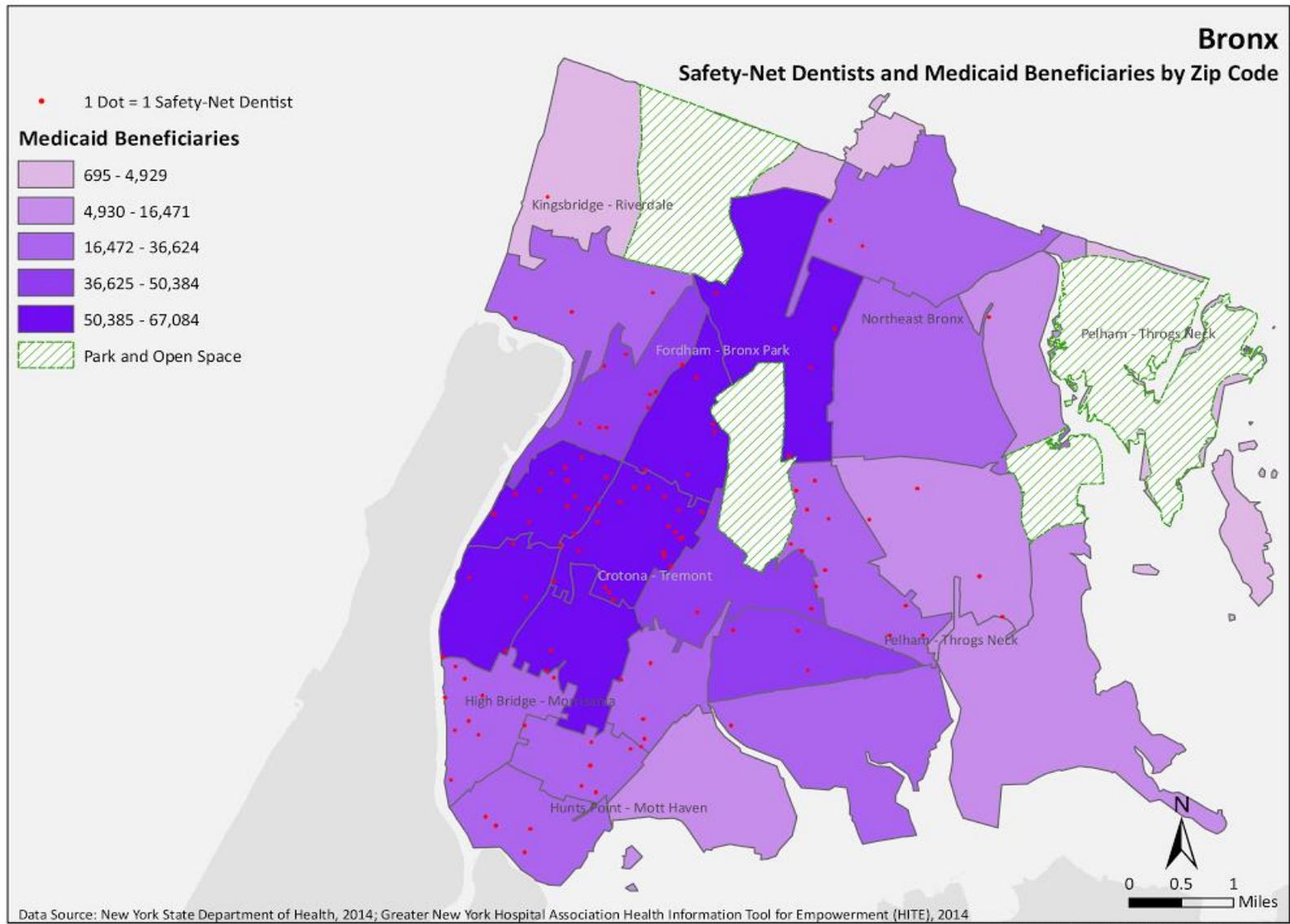


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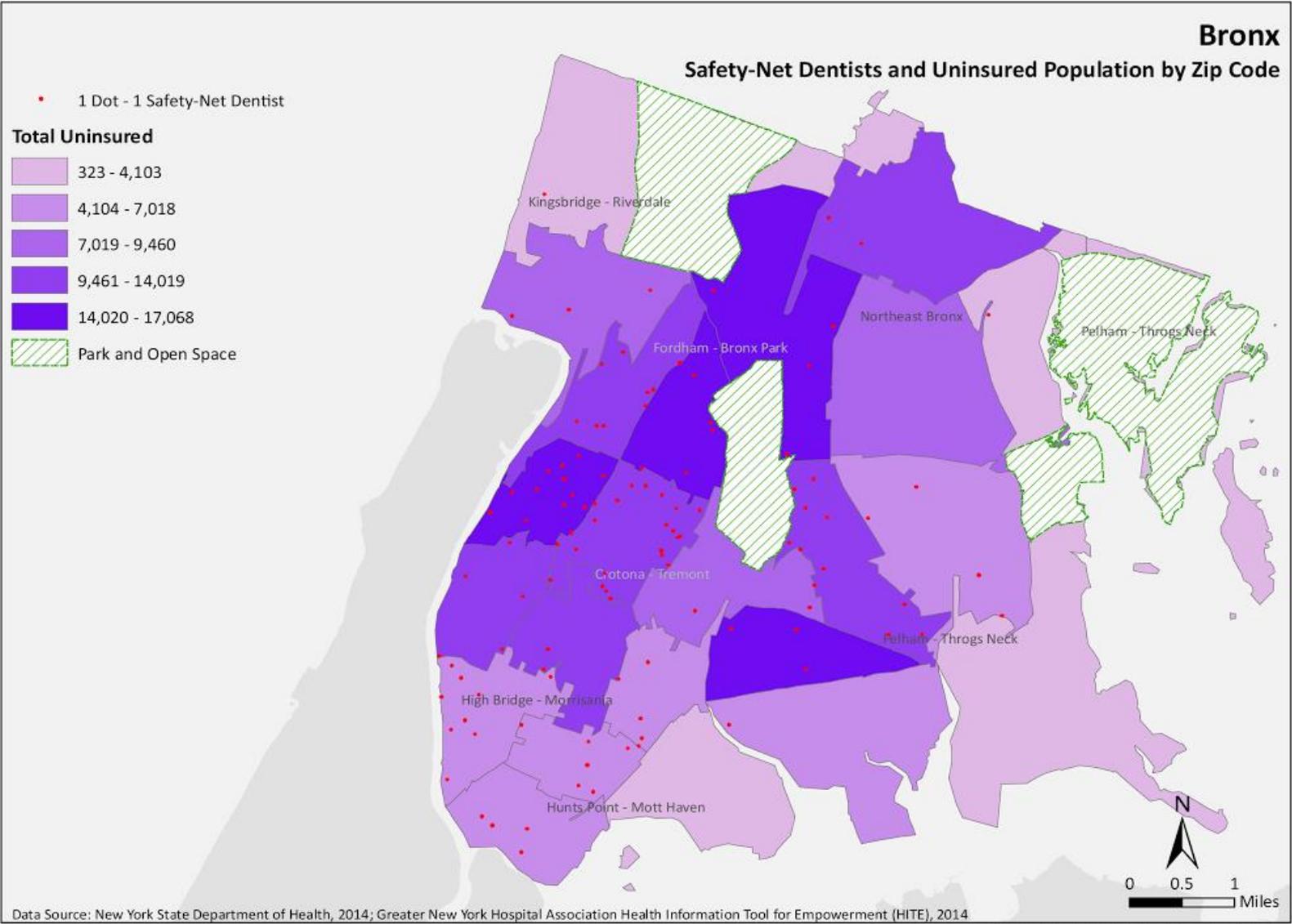
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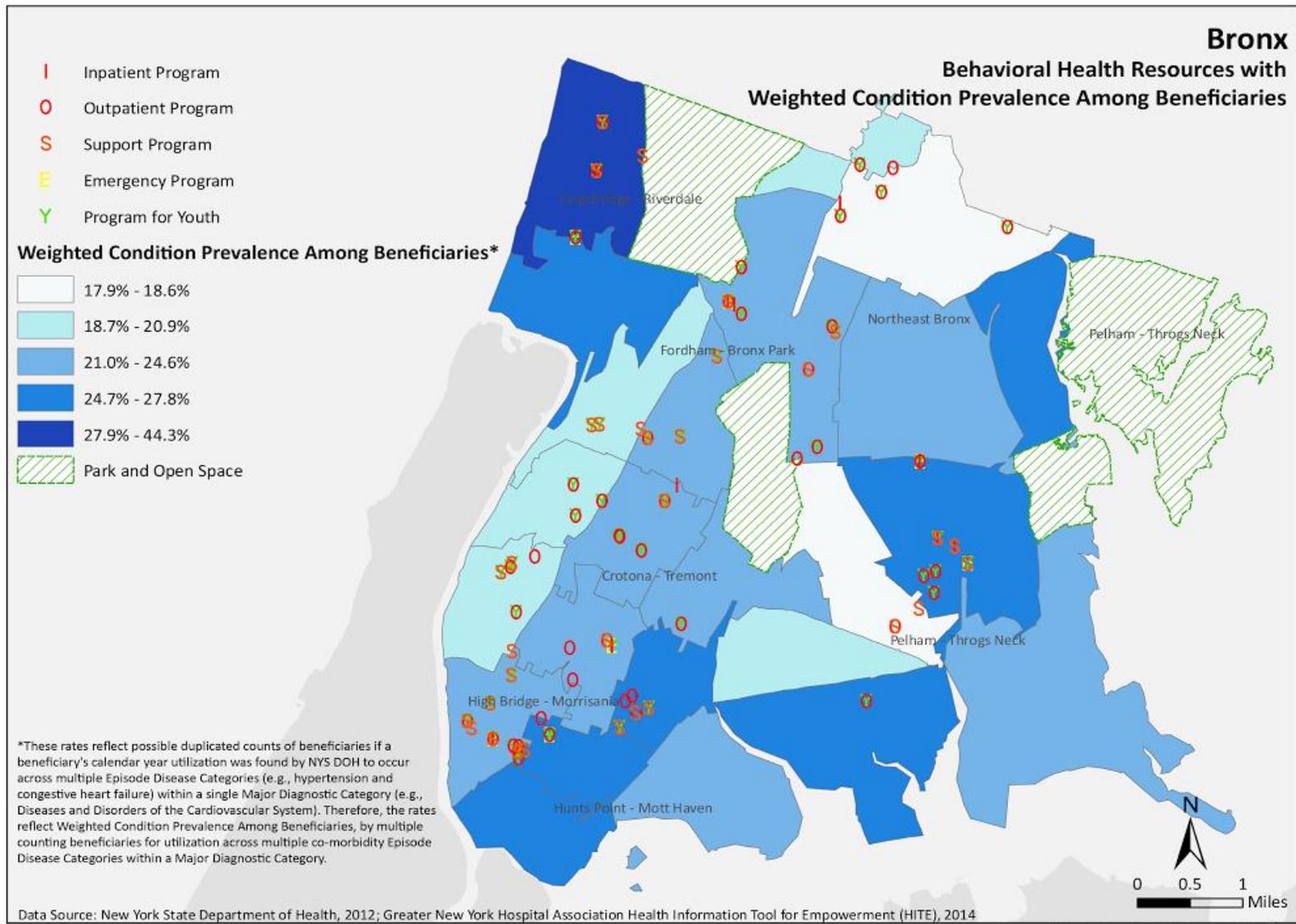
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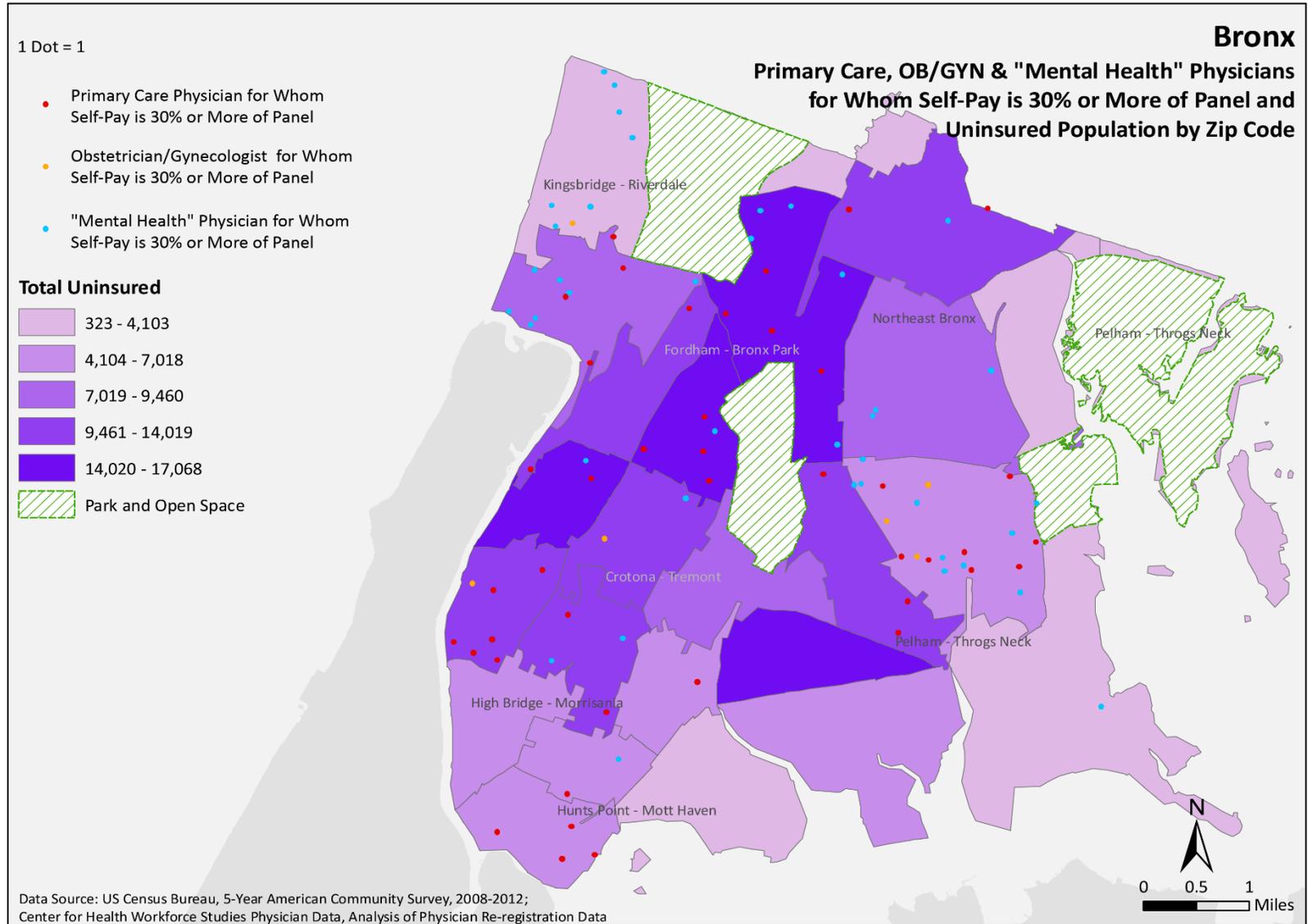
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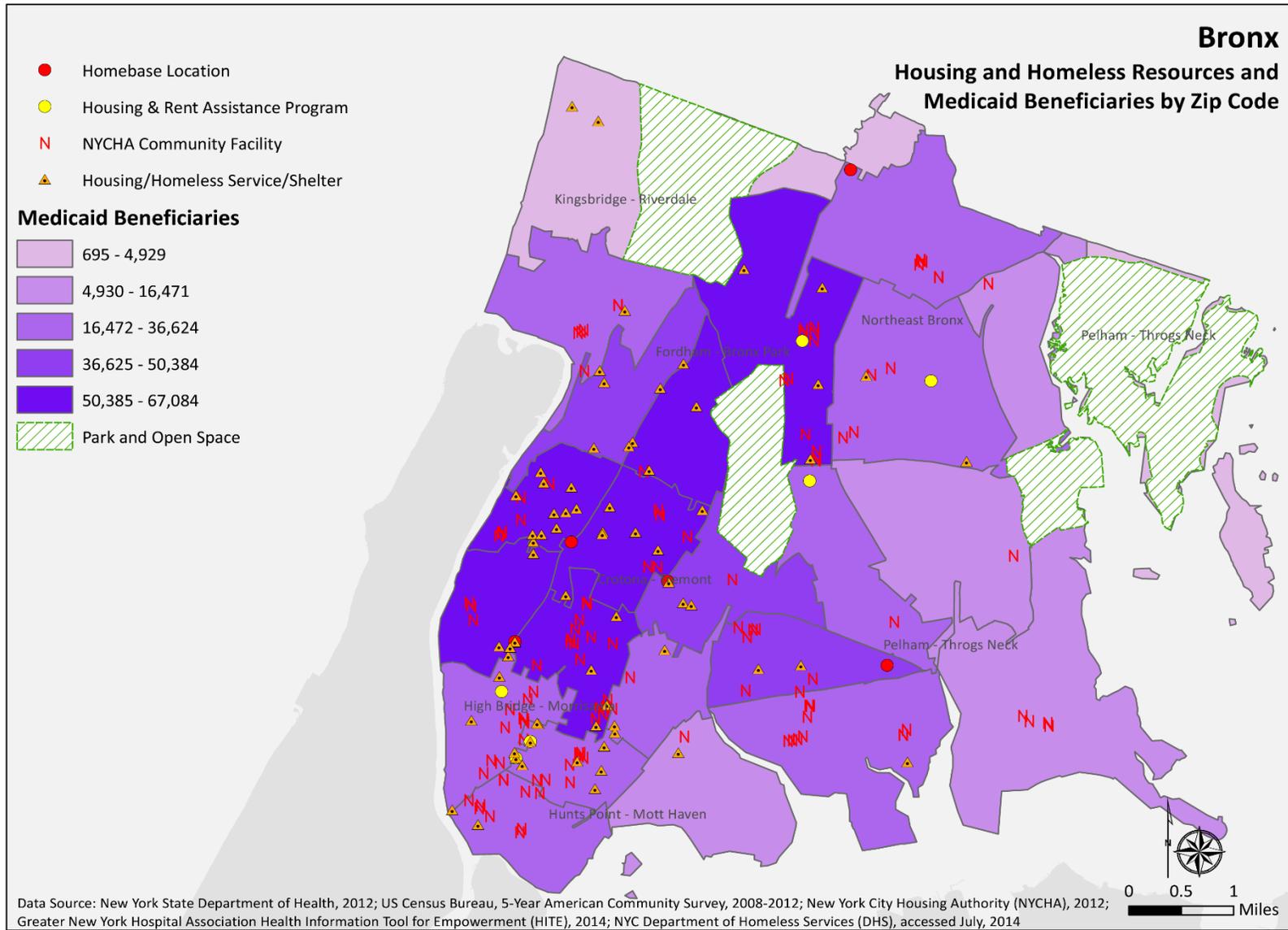


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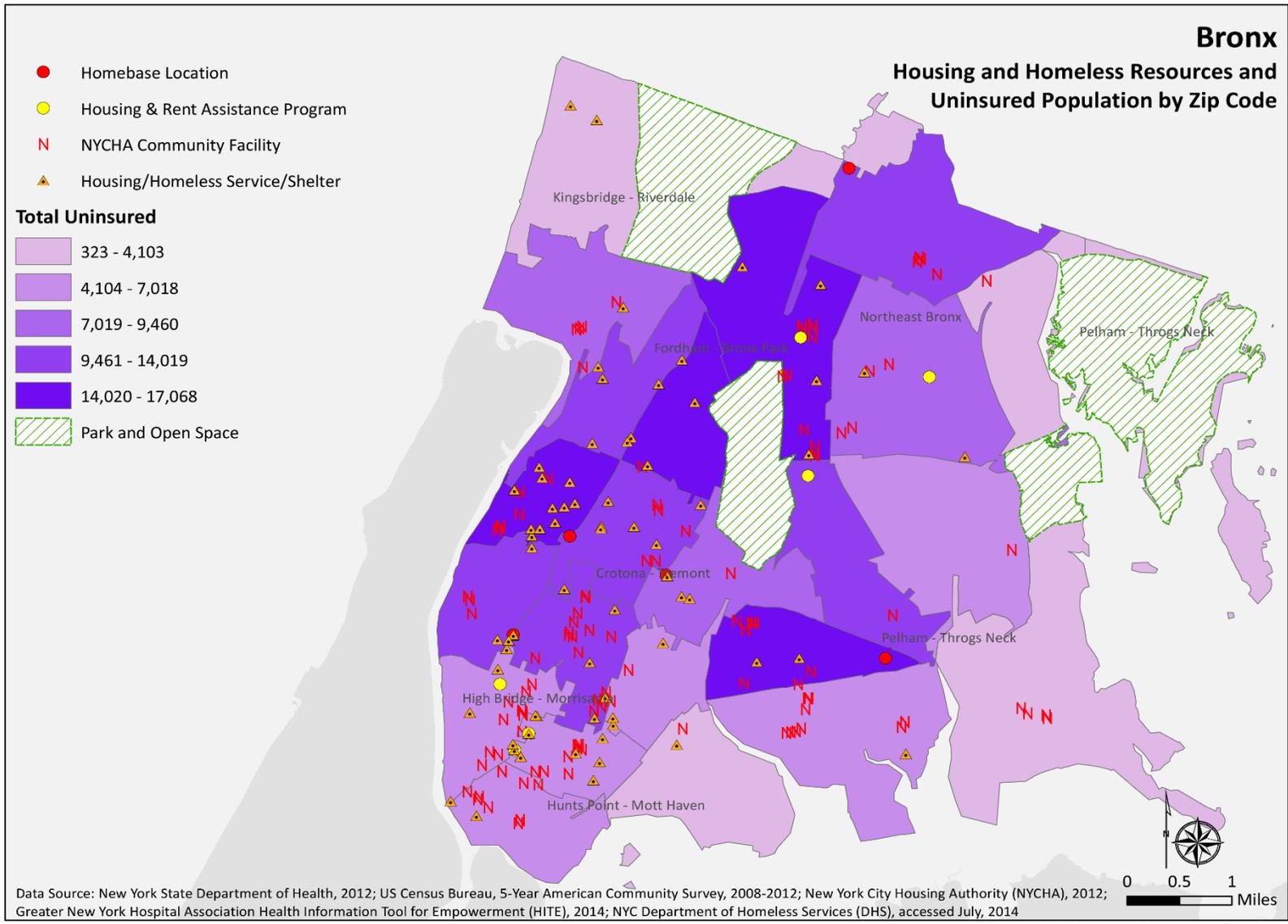


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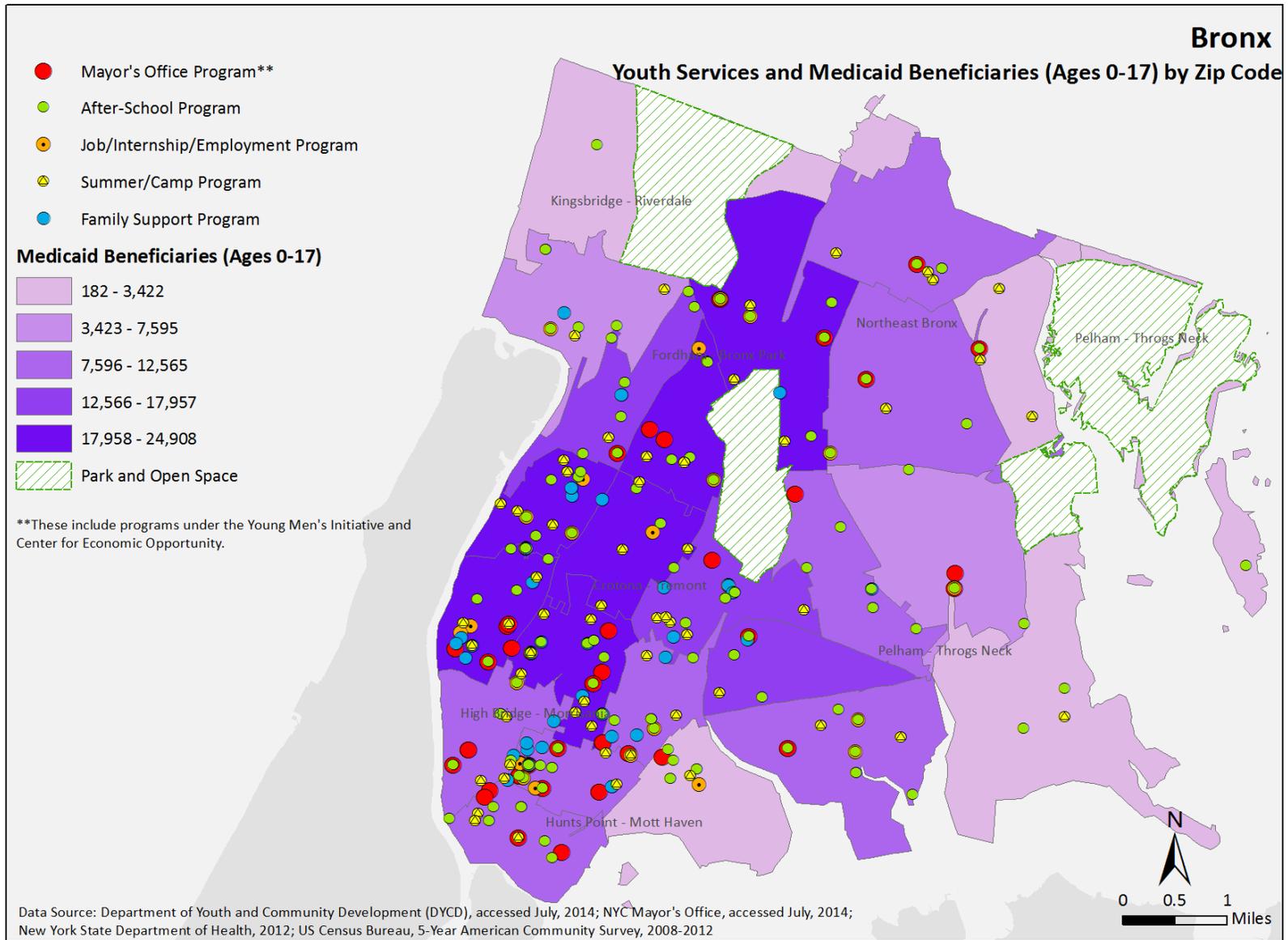
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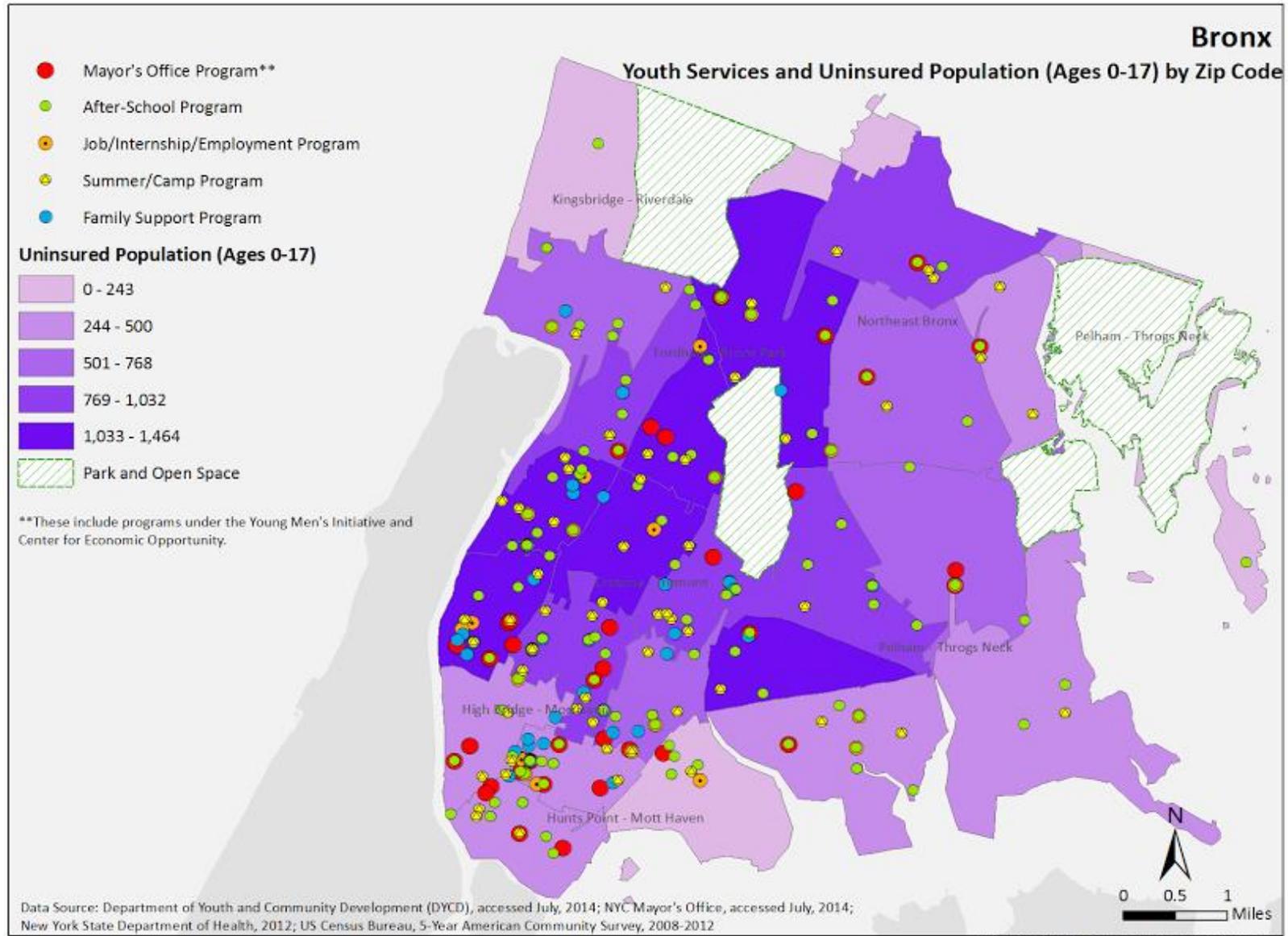
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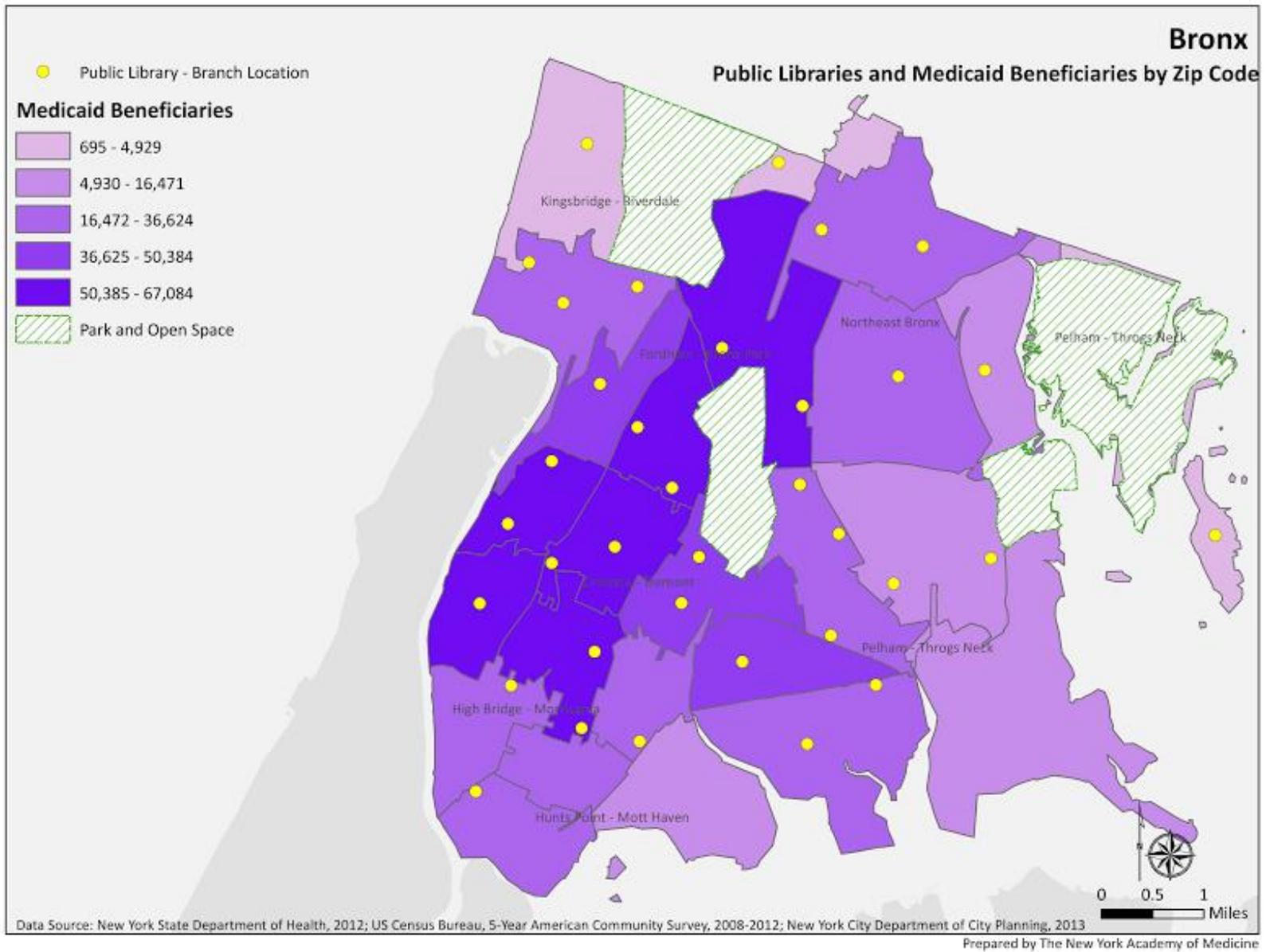
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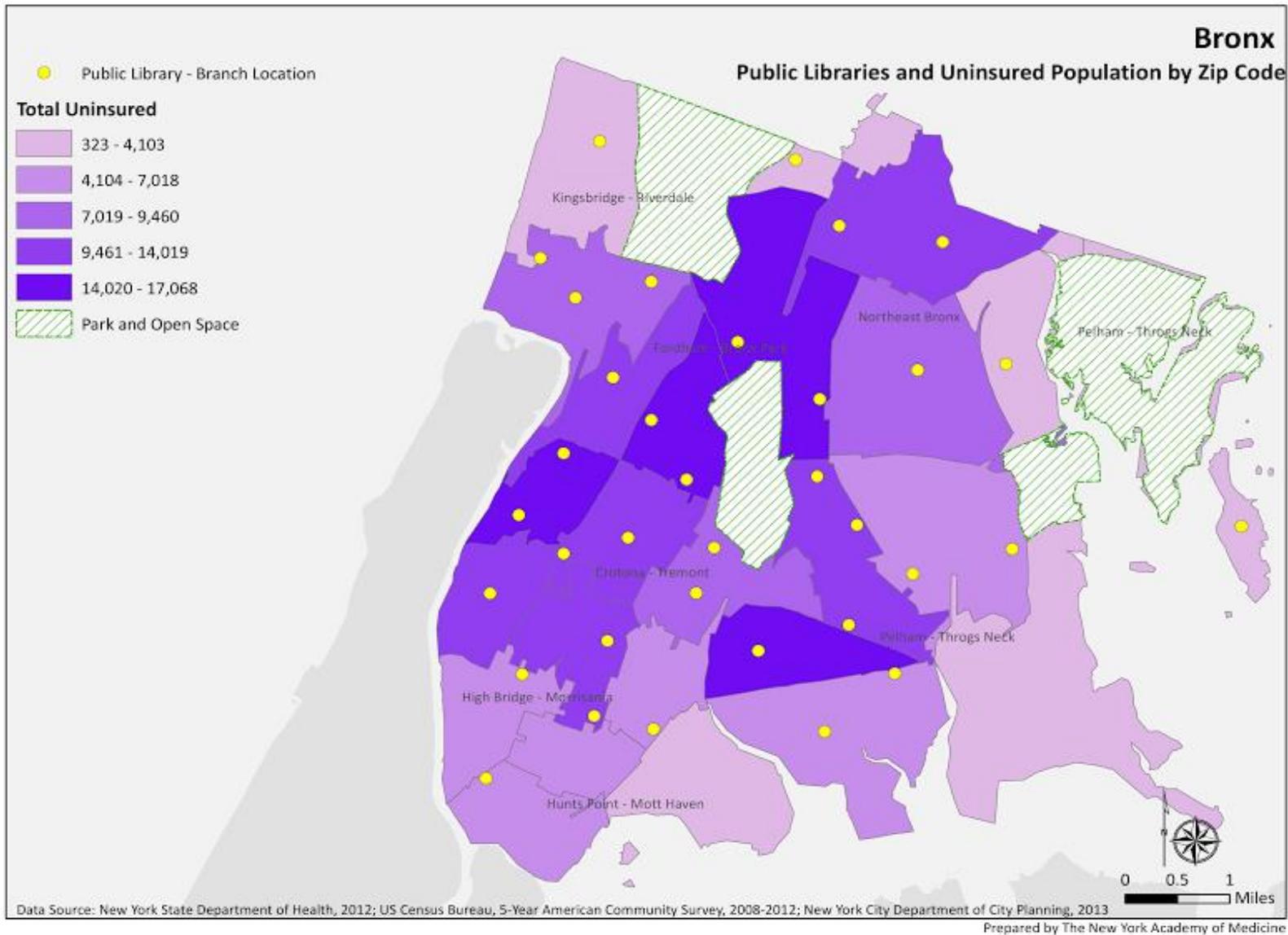
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93. Public Libraries and Uninsured Population by Zip Code



**New York City Health Provider Partnership
Bronx Community Needs Assessment
Appendix B. Tables and Charts**



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Provider Name	Address	Zip Code
Bronx Lebanon Hospital Center		
Bronx Lebanon Concourse Division	1650 Grand Concourse	10457
Bronx Lebanon Fulton Division	1276 Fulton Avenue	10456
Calvary Hospital Inc.	1740-70 Eastchester Road	10461
Jacobi Medical Center	1400 Pelham Parkway	10461
Lincoln Medical and Mental Health Center	234 East 149th Street	10451
Montefiore Medical Center		
Montefiore - Weiler Hospital	1825 Eastchester Rd	10461

TABLE 1. HOSPITALS IN THE BRONX

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Montefiore - Henry and Lucy Moses Div.	111 East 210th Street	10467
Montefiore - Wakefield Hospital	600 East 233rd Street	10466
North Central Bronx Hospital	3424 Kossuth Avenue & 210th Street	10467
St. Barnabas Hospital	4422 Third Avenue	10457

TABLE 2. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) IN THE BRONX

Facility Name	Address	Zip Code
Access Community Health Center	1500 Pelham Pkwy S	10461
Bella Vista Community Health Center	882-886 Hunts Point Ave	10474
Bronxcare - Fulton Family Practice Center	1276 Fulton Avenue	10456
Bronxcare - Mid Bronx Desperados Family Practice Center	1690 Bryant Avenue	10460
Bronxcare - Ogden Family Medical & Dental Center	1067 Ogden Avenue	10451
Bronxcare - Poe Medical And Dental Center	2432 Grand Concourse	10458
Bronxcare - Tiffany Medical & Pediatric Practice	853 Tiffany Street	10459
Bronxcare At Third Avenue	2739-45 Third Avenue	10451
Bronxcare Dental	1770 Grand Concourse	10453
Burnside Medical Center	165 E Burnside Ave	10453
Community Healthcare Network - Bronx Health Center	975 Westchester Avenue	10459
Community Healthcare Network (CHN) - Tremont Health Center	4215 Third Avenue	10457
Comprehensive Community Development Co	731 White Plains Rd	10473-2631
Delaney Sisters Health Center	2727-33 White Plains Rd	10467
Diallo Medical Center	1760 Westchester Ave	10472

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Facility Name	Address	Zip Code
Help/Psi Bronx Health Center	1543 Inwood Ave	10452
HELP/PSI Harm Reduction Health Center At Citiwide	226 E 144th St	10451
Highbridge Clinic	1381 Dr Martin L King Jr Blvd	10452
Institute For Family Health - Mt. Hope Family Practice	130 West Tremont Avenue	10453
Institute For Family Health - Stevenson Family Health Center	731 White Plains Road	10473
Institute For Family Health - Urban Horizons Family Health Center	50 East 168th Street	10452
Institute For Family Health - Walton Family Health Center And Center For Counseling	1894 Walton Avenue	10453
Inwood Clinic	1543 Inwood Ave	10452
Jessica Guzman Medical Center	616 Castle Hill Ave	10473
Martin Luther King Jr Health Center	3674 3rd Ave	10456
Morris Heights Health Center - Burnside	85 West Burnside Avenue	10453
Peninsula Community Health Center	1967 Turnbull Ave Ste 2	10473
River Avenue Health Center	880 River Ave Ste 4	10452
St Lawrence Community Health Center	1764-1766 Lawrence Ave	10472
Starhill Clinic	1600 Macombs Rd	10452-2016
Susan's Place (Care For The Homeless)	1921 Jerome Avenue	10453

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Facility Name	Address	Zip Code
Union Community Health Center - Grand Concourse	2021 Grand Concourse	10453
Union Community Health Center - Main Facility	260 East 188th Street	10458
Union Community Health Center, Inc	1 Fordham Plz	10458-5871
Urban Health Plan - Adolescent Health And Wellness Center/Club TIA	960 Southern Boulevard	10459
Urban Health Plan - Bella Vista Health Center	890 Hunts Point Boulevard	10474
Urban Health Plan - El Nuevo San Juan Health Center	1065 Southern Boulevard	10459
Urban Health Plan - Plaza Del Castillo Health Center	1515 Southern Boulevard	10460
Urban Health Plan - St. Lawrence Community Health Center	1764 Westchester Avenue	10472

Source: HRSA, 2014; NYC Dept. of City Planning, 2013; GNYHA HITE Data, 2014; NYS DOH, 2014.

Please note that, in some cases, only the main address for the FQHC was available via these sources, though an FQHC may have multiple sites.

TABLE 3. URGENT CARE CENTERS IN THE BRONX

Urgent Care Center Name	Address	Zip Code
Montefiore Medical Center - Wakefield Ambulatory Care Center	4234 Bronx Boulevard	10466
Montefiore Medical Group - Bronx East	2300 Westchester Avenue	10462
Montefiore Medical Group - Grand Concourse Site	2532 Grand Concourse	10458
Morris Heights Health Center - Burnside	85 West Burnside Avenue	10453
Urban Health Plan - Adolescent Health and Wellness Center/Club TIA	960 Southern Boulevard	10459
MedCare Plus	1643 Westchester Ave	10472
ProHEALTH Urgent Care	1049 Morris Park Ave	10461
Riverdale Urgent Care	5665 Riverdale Ave	10471
Throggs Neck Walk-In Medical Care	3231 East Tremont Ave	10461
Urgent Care of Eastchester Road	2304 Eastchester Rd	10469

Source: American Academy of Urgent Care Medicine (AAUCM) & City MD websites; GNYHA HITE Data, 2014.

TABLE 4. MANAGED CARE ORGANIZATIONS THAT SERVICE BRONX (AND OTHER COUNTIES)

Plan	Total New York City Enrollment, 2012	Plan Type
HealthFirst PHSP, Inc.	455,627	PHSP
MetroPlus Health Plan, Inc.	373,072	PHSP
New York State Catholic Health Plan, Inc.	338,708	(Fidelis Care) PHSP
AMERIGROUP New York, LLC	335,116	PHSP
UnitedHealthcare of New York, Inc.	198,234	HMO
Affinity Health Plan, Inc.	169,489	PHSP
Neighborhood Health Providers, Inc.	165,848	PHSP
Health Insurance Plan of Greater New York	164,798	HIP (Emblem Health) HMO
WellCare of New York, Inc.	55,195	PHSP
Total	2,256,087	

Source: United Hospital Fund, "Medicaid Managed Care Enrollment by Region," 2012

TABLE 5. NURSING HOMES IN THE BRONX

Nursing Home Name	Address	Zip Code
Bainbridge Nursing & Rehabilitation Center	3518 Bainbridge Avenue	10467
Bay Park Center for Nursing and Rehabilitation, LLC	801 Co-Op City Blvd	10475
Beth Abraham Health Services	612 Allerton Avenue	10467
Bronx Center for Rehabilitation & Health Care	1010 Underhill Ave	10472
Bronx Lebanon Special Care Center	1265 Fulton Avenue	10456
Bronx Park Rehabilitation & Nursing Center	3845 Carpenter Ave	10467
Casa Promesa	308 East 175 Street	10457
Concourse Rehabilitation and Nursing Center, Inc	1072 Grand Concourse	10456
Daughters of Jacob Nursing Home Company Inc	1160 Teller Ave	10456
East Haven Nursing & Rehabilitation Center	2323-27 Eastchester Road	10469
Eastchester Rehabilitation and Health Care Center	2700 Eastchester Road	10469
Fieldston Lodge Care Center	666 Kappock Street	10463
Gold Crest Care Center	2316 Bruner Avenue	10469
Grand Manor Nursing & Rehabilitation Center	700 White Plains Road	10473
Hebrew Home for the Aged at Riverdale	5901 Palisade Avenue	10471
Help/psi, Inc.	1401 University Avenue	10452
Highbridge-Woodycrest Center Inc	936 Woodycrest Avenue	10452
Hudson Pointe at Riverdale Center for Nursing &	3220 Henry Hudson	10463

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Nursing Home Name	Address	Zip Code
Rehabilitation	Parkway	
Jeanne Jugan Residence	2999 Schurz Avenue	10465
Jewish Home Lifecare, Harry & Jeanette Weinberg Campus, Bronx	100 West Kingsbridge Road	10468
Kings Harbor Multicare Center	2000 E Gunhill Road	10469
Kingsbridge Heights Rehabilitation and Care Center	3400 Cannon Place	10463
Laconia Nursing Home	1050 East 230th Street	10466
Manhattanville Health Care Center	311 W 231st Street	10463
Methodist Home for Nursing and Rehabilitation	4499 Manhattan College Parkway	10471
Morningside House Nursing Home Company Inc	1000 Pelham Parkway South	10461
Morris Park Nursing Home	1235 Pelham Parkway North	10469
Mosholu Parkway Nursing & Rehabilitation Center	3356 Perry Avenue	10467
Palisade Nursing Home Company Inc	5901 Palisade Avenue	10471
Park Gardens Rehabilitation & Nursing Center LLC	6585 Broadway	10471
Pelham Parkway Nursing Care and Rehabilitation Facility LLC	2401 Laconia Ave	10469
Providence Rest, Inc.	3304 Waterbury Avenue	10465
Rebekah Rehab and Extended Care Center	1072 Havemeyer Avenue	10462
Regeis Care Center	3200 Baychester Ave	10475
Riverdale Nursing Home	641 West 230th St	10463

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Nursing Home Name	Address	Zip Code
Schervier Nursing Care Center	2975 Independence Ave	10463
Split Rock Rehabilitation and Health Care Center	3525 Baychester Ave	10466
St Barnabas Rehabilitation & Continuing Care Center	2175 Quarry Rd	10457
St Patricks Home	66 Van Cortlandt Park South	10463
St Vincent Depaul Residence	900 Intervale Avenue	10459
Terrace Health Care Center	2678 Kingsbridge Terrace	10463
Throgs Neck Extended Care Facility	707 Throgs Neck Expressway	10465
University Nursing Home	2505 Grand Ave	10468
Wayne Center for Nursing & Rehabilitation	3530 Wayne Avenue	10467
Williamsbridge Manor Nursing Home	1540 Tomlinson Avenue	10461
Workmen's Circle Multicare Center	3155 Grace Avenue	10469

Source: NYS DOH Nursing Home Profiles, 2014

TABLE 6. BEHAVIORAL HEALTH RESIDENTIAL TREATMENT CAPACITY AND UTILIZATION IN THE BRONX

	Residential Treatment				Assertive Community Treatment (ACT)
	Congregate Treatment	Apartment Treatment	Support Programs	Supported Housing	
# of Beds or Slots	470	280	630	2,904	531
Beds or Slots /10,000 Adult Population	4.5	2.7	6.1	3.4	NA
% Occupancy Rate	84.8%	91.8%	95.5%	88.2%	98%
Median LOS (days)	296	448	749	1,340	NA
% LOS >2 years	23.5%	30.0%	53.2%	69.0%	NA

Source: OMH, 2011. Note that the data are for all payer categories, not only Medicaid.

TABLE 7. NYS DOH DESIGNATED SAFETY NET PHARMACIES SERVING THE BRONX

Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
030818	Family Pharmacy Solutions, Inc.	20,346	20,346	100.00%	By Appeal
29738	STAR PHARMA INC DBA STARHILL PHARMACY	60,240	60,240	100.00%	By Appeal
17330	EJEROME PHARMACY INC	56,000	60,400	92.72%	By Definition
020988	Mt. Carmel Pharmacy, Inc.	204,969	226,226	90.60%	By Appeal
24530	Stand Pharmacy, Inc.	42,173	55,000	76.68%	By Appeal
29963	LAURUS CORP	19,600	26,900	72.86%	By Definition
18453	NVR PHARMACY INC	23,229	33,185	70.00%	By Definition
30215	VSAS PROPERTIES LLC	6,997	10,025	69.80%	By Definition
29615	DDMH PHARMACY INC	35,000	52,000	67.31%	By Definition
18997	UPGRADE PHARMACY INC	25,191	37,813	66.62%	By Definition
30565	NEO PHARMACY INC	17,000	27,000	62.96%	By Definition

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Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
24771	75 BURNSIDE DRUG AND SURGICAL INC	52,529	83,504	62.91%	By Definition
24632	PROSPECT AVE PHARMACY	32,915	52,327	62.90%	By Definition
25605	WASHINGTON PHARMACY	35,847	63,775	56.21%	By Definition
24709	PARKCHESTER NATURAL HEALTH CENTER INC	6,500	11,600	56.03%	By Definition
29986	MY PHARMACY INC	2,932	5,274	55.59%	By Definition
28758	PHARMART DRUGS INC	29,500	53,075	55.58%	By Definition
25837	SEM AND SAM	34,355	61,864	55.53%	By Definition
15469	Pilgrim Pharmacy, Inc.	73,633	132,942	55.39%	By Appeal
28752	ROCKAWAY FAMILY PHARMACY CORP	46,913	84,743	55.36%	By Definition
29530	872 HPA DRUG CORP	19,460	35,220	55.25%	By Definition

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Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
28262	POLSAK CORPORATION	17,971	32,692	54.97%	By Definition
028058	Hispaniola Pharmaceutical Group, Inc.	43,021	80,919	53.17%	By Appeal
26372	JAFFRI ENTERPRISES	15,581	29,535	52.75%	By Definition
27296	904 PROSPECT PHARMACY INC	38,864	73,753	52.69%	By Definition
17811	WHITE PLAINS RD PHARMACY INC	23,682	44,978	52.65%	By Definition
24634	WORLD PHARMACY INC	1,647	3,146	52.35%	By Definition
17697	YNFK DRUG INC	8,434	16,128	52.29%	By Definition
26401	GCC PHARMACY CORP	31,185	60,120	51.87%	By Definition
26434	UNITED PHARMACY LLC	29,000	56,000	51.79%	By Definition
30123	TOTALCARE PHARMACY MANAGEMENT INC	10,139	19,644	51.61%	By Definition
16055	RB WILLIAMSON INC	60,667	118,000	51.41%	By Definition

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Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
30439	SCRIPTRX INC	29,722	57,886	51.35%	By Definition
28981	LEROYS PHARMACY CORP	19,125	37,288	51.29%	By Definition
26868	MERCEDES DRUG CORP	13,963	27,600	50.59%	By Definition
28814	SPECIALTY CARE PHARMACY INC	12,882	25,552	50.41%	By Definition
31173	RHESAK CORP	27,612	55,084	50.13%	By Definition
16178	Sedgwick Pharmacy, Inc.	44,010	87,962	50.03%	By Appeal
24699	NY DRUGS INC	104,364	208,727	50.00%	By Definition
26892	DRUG RITE II PHARMACY CORP	38,500	77,010	49.99%	By Definition
29326	BRONX CHEMISTS CORP	46,426	100,123	46.37%	By Definition
25499	BCP PHARMACY INC	39,518	85,344	46.30%	By Definition
24414	VENKATESWARA PHARMACY INC	31,300	68,330	45.81%	By Definition

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Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
17412	MELBOURNE CHEMISTS INC	42,645	93,289	45.71%	By Definition
23055	EAST TREMONT PHARMACY INC	31,823	70,064	45.42%	By Definition
26305	FRIENDLY PHARMACY INC	15,644	34,516	45.32%	By Definition
011440	Bronx Prescription Center South, Inc.	46,127	102,093	45.18%	By Appeal
25587	MANVIHAR PHARMACY INC	19,008	42,133	45.11%	By Definition
26988	MEGA PHARMACY LLC	20,400	45,511	44.82%	By Definition
28595	FAMILY DRUG STORE CORP	11,531	25,812	44.67%	By Definition
29917	BLONDELL RX CORP	7,046	15,957	44.16%	By Definition
24775	NAYOSHA PHARMACY	25,128	57,036	44.06%	By Definition
28951	MAR DRUG CORP	20,078	46,126	43.53%	By Definition
26825	BRUCKNER PLAZA PHARMACY INC	19,200	44,173	43.47%	By Definition

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Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
27162	PSK RX INC	16,805	38,782	43.33%	By Definition
18886	FIRO INC	18,904	43,678	43.28%	By Definition
26098	CAREMARK SRX INC	32,415	74,898	43.28%	By Definition
18005	K AND G PHARMACY INC	17,517	40,550	43.20%	By Definition
23572	TEJ PHARMACY INC	15,555	36,056	43.14%	By Definition
27195	DRUGS R US PHARMACY	18,512	42,982	43.07%	By Definition
25190	ARKAYEM LLC	15,226	35,369	43.05%	By Definition
26707	FELICITY PHARMACY	32,000	76,000	42.11%	By Definition
29894	TRUPTISUDHIR PHARMACY CORP	14,979	36,131	41.46%	By Definition
24368	CONCOURSE DRUGS INC	20,221	48,942	41.32%	By Definition
30382	RXMASTERS INC	3,751	9,162	40.94%	By Definition
26691	BARRETTO PHARMACY INC	6,026	14,922	40.38%	By Definition
18771	WILLEN PHARMACY INC	3,482	8,631	40.34%	By Definition

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Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
29543	AMBAR PHARMACY INC	10,433	26,887	38.80%	By Definition
26513	LOUIS PHARMACY INC	18,446	48,953	37.68%	By Definition
29593	PARKARE PHARMACY INC	5,212	14,045	37.11%	By Definition
30621	ARYA PHARMACY CORP	7,914	21,843	36.23%	By Definition
168	AMATO PHARMACY INC	16,371	45,256	36.17%	By Definition
24192	WEBSTER DRUGS INC	37,000	104,000	35.58%	By Definition

Source: NYS DOH, 2014

TABLE 8. DOMAIN 2.A METRICS

Measure Name	Data Year	NYS	NYC	Bronx	
Potentially Avoidable Emergency Room Visits: ED Visits for Ambulatory Sensitive Conditions, Potentially Preventable Visits (PPV), per 100 Recipients**	2012	36	34	38	
Potentially Avoidable Readmissions, by hospital location, 2012**	2012	40,687	24,388	6,825	
PQI Suite – Composite of All Measures: Adult, per 100,000 Recipients	2012	1,848	1,885	2,459	
Acute Conditions Composite (PQI 91)***	2012	555	547	706	
Chronic Conditions Composite (PQI 92)***	2012	1,294	1,336	1,749	
PDI Suite – Composite of All Measures: Pediatric, per 100,000 Recipients	2012	323	381	507	
Acute Conditions Composite (PDI 91)	2012	75	87	84	
Chronic Conditions Composite (PDI 92)	2012	248	294	422	
Getting Care Quickly					
Q4. Usually or always got care right away as soon as you needed ^a	2013	81.1%	76%	[No known public source]	
Q7. Usually or always got an appt. for check-up or routine care as soon as you needed ^a	2013	74.8%	68.9%		
Getting Needed Care					
Q19. Usually or always got care, tests or treatment you thought you needed ^a	2013	81.4%	76.9%		
Q39. Usually or always got an appointment to see a specialist as soon as you needed ^a	2013	75.1%	71.4%		
Usual Source of Care					
Q8. Never went to doctor’s office or clinic in last 6 months ^a	2013	23.9%	24.4%		

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Measure Name	Data Year	NYS	NYC	Bronx
Q8. Went to doctor's office or clinic 1-3 times in last 6 months ^a	2013	52.5%	53.7%	
Q26. Have a personal doctor ^a	2013	85.5%	84.1%	
Patient Loyalty				
Q35. Got care from a doctor or other health provider other than personal doctor ^a	2013	57.9%	52.7%	
Access/Availability of Care				
Adult Access to Preventive/Ambulatory Care (20-44) ^b	2012	95%	[No known public source]	[No known public source]
Adult Access to Preventive/Ambulatory Care (45-64) ^b	2012	96%	[No known public source]	
Adult Access to Preventive/Ambulatory Care (65+) ^b	2012	97%	[No known public source]	
Annual Dental Visit (Ages 19-21) ^b	2012	44%	[See source note]	
Annual Dental Visit (Ages 2-18) ^b	2012	57%	[See source note]	
Children's Access to PCPs/Ambulatory Care (12-24 months) ^b	2012	97%	[No known public source]	

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Measure Name	Data Year	NYS	NYC	Bronx
Children’s Access to PCPs/Ambulatory Care (25 mos-6 years) ^b	2012	93%	[No known public source]	
Children’s Access to PCPs/Ambulatory Care (7-11 years) ^b	2012	96%	[No known public source]	
Children’s Access to PCPs/Ambulatory Care (12-19 years) ^b	2012	93%	[No known public source]	
Use of Services				
Well-Child Visits & Preventive Care Visits in the First 15 Months of Life (5+ visits) ^b	2012	83%	[See source note]	[No known public source]
Well-Child & Preventive Care Visits in the 3 rd , 4 th , 5 th & 6 th Year ^b	2012	82%		
Adolescent Well-Care Visits ^b	2012	59%		

Sources:

*NYAM analysis of Potentially Preventable Readmissions data by hospital, New York State Department of Health

^a NYS DOH, 2014 “Medicaid Managed Care Program CAHPS 5.0 Adult Medicaid Survey, Continuous Quality Improvement Report,” available at:

http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/

^a As per NYS DOH Attachment J, CAHPS measures were requested for the following areas: getting care quickly, getting needed care, access to information after hours, wait time, usual source of care and patient loyalty. Questions 4, 7, 8, 19, 26, 35 and 39 of the CAHPS 5.0 survey seem to most closely align to these requests.

^b NYS DOH, “2013 Statewide Executive Summary of Managed Care in New York State,” available at:

http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2013/docs/executive_summary.pdf

**NYAM analysis of Potentially Preventable Readmissions data by hospital, New York State Department of Health

. Data is available for this measure by health plan at the following link:

http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2013/statewide/medicaid/

*** See Appendix B. Table 52 for all PQI and composites. For example, the Adult Acute Conditions Composite (PQI 91) is comprised of Adult Dehydration (PQI 10), Adult Bacterial Pneumonia (PQI 11), and Adult Urinary Tract Infection (PQI 12).

Data is not yet available from the New York State Department of Health for the other Domain 2 metrics relating to Provider Reimbursement, System Integration, Primary Care, and Medicaid Spending for Projects Defined Population on a PMPM Basis.

TABLE 9. DOMAIN 2.B METRICS

Measure Name	NYS	NYC	Bronx
Summary of HCAHPS Survey Results, October 2012 to September 2013 Discharges			
Patients who reported that their nurses "Always" communicated well	75%	[No known public source]	[No known public source]
Patients who reported that their doctors "Always" communicated well	77%		
Patients who reported that they "Always" received help as soon as they wanted	61%		
Patients who reported that their pain was "Always" well controlled	67%		
Patients who reported that staff "Always" explained about medicines before giving it to them	59%		
Patients who reported that their room and bathroom were "Always" clean	69%		
Patients who reported that the area around their room was "Always" quiet at night	51%		
Patients who reported that YES, they were given information about what to do during their recovery at home	83%		
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	63%		
Patients who reported YES, they would definitely recommend the hospital	65%		

Source: Hospital Consumer Assessment of healthcare Providers and Systems. Centers for Medicare & Medicaid Services. (July, 2014). Summary of HCAHPS Survey Results. Baltimore, MD.

<http://www.hcahpsonline.org>

TABLE 10. TOTAL POPULATION, BY GENDER

Total Population, by Gender	NYS	NYC	Bronx
Total Population	19,398,125	8,199,221	1,386,364
Male	9,391,875	3,897,434	650,728
Female	10,006,250	4,301,787	735,636

Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 11. TOTAL POPULATION, BY AGE

Age	NYS	NYC	Bronx
Child (0-17)	4,316,920	1,774,909	369,168
All Adults (18+)	15,081,205	6,424,312	1,017,196
Older Adults (65+)	2,640,634	1,002,872	147,030

Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 12. TOTAL POPULATION, BY RACE/ETHNICITY

Race/Ethnicity	NYS (A)	NYC (B)	Bronx (C)	% of Bronx Total Population (D)	Bronx as a % of that race or ethnicity in NYC (C/B)	Bronx as a % of that race or ethnicity in NYS (C/A)
White	12,808,268	3,646,181	312,055	22.5%	8.6%	2.4%
Black or African American	3,037,255	2,059,279	481,739	34.7%	23.4%	15.9%
American Indian and Alaska Native	69,500	30,743	7,196	0.5%	23.4%	10.4%
Asian	1,445,539	1,053,649	49,489	3.6%	4.7%	3.4%
Native Hawaiian and other Pacific Islander	6,477	3,866	308	0.0%	8.0%	4.8%
Other race	1,557,020	1,169,421	488,156	35.2%	41.7%	31.4%
2 or more races	474,066	236,082	47,421	3.4%	20.1%	10.0%
Total of Race Categories Above	19,398,125	8,199,221	1,386,364	100.0%	16.9%	7.1%
Hispanic or Latino (of any race)	3,425,845	2,343,458	741,954	53.5%	31.7%	21.7%
<i>Mexican</i>	447,323	308,952	70,786	5.1%	22.9%	15.8%
<i>Puerto Rican</i>	1,117,995	761,655	311,547	22.5%	40.9%	27.9%
<i>Cuban</i>	72,378	40,426	7,913	0.6%	19.6%	10.9%
<i>Other Hispanic or Latino</i>	1,788,149	1,232,425	351,708	25.4%	28.5%	19.7%

NYC Black/African American as % of Total NYC Population: 25.1%
 NYC Hispanic/Latino Population as % of Total NYC Population: 28.6%
 NYS Black/African American as % of Total NYS Population: 15.7%
 NYS Hispanic/Latino Population as % of Total NYS Population: 17.7%
 Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 13. INCOME

Income	NYS	NYC	Bronx
% HH Below Poverty	14%	19%	29%
Median HH income (USD)	57,683	51,865	34,300

Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 14. EDUCATIONAL ATTAINMENT

Educational Attainment	NYS	NYC	Bronx
% age 25+ High School+	85%	79%	69%
% age 25+ Bachelor's degree+	33%	34%	18%

Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 15. UNEMPLOYMENT

Unemployed	NYS	NYC	Bronx
% Unemployed	8.7%	10.2%	14.2%

Source: US Census American Community Survey, 5-year, 2008-2012.

TABLE 16. IMMIGRATION AND CITIZENSHIP STATUS

Immigration and Citizenship Status	NYS	NYC	Bronx
Migrated from abroad < 1 yr ago	148,931	93,367	14,421
Not a US citizen	2,038,877	1,455,533	258,099
% Not a US citizen	10.5%	17.8%	18.6%

Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 17. LANGUAGE

Language	NYS	NYC	Bronx
Total - Speak English less than "very well"	2,439,417	1,783,994	324,281
% Total - Speak English less than "very well"	12.6%	21.8%	23.4%
Spanish -Speak English less than "very well"	1,230,302	889,091	267,764

Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 18. LANGUAGES SPOKEN AT HOME

Language	Total Speakers	% of Total Pop.
Speak only English	553,446	43.2%
Spanish or Spanish Creole	594,250	46.4%
African languages	37,854	3.0%
French (incl. Patois, Cajun)	12,439	1.0%
Other Indic languages (i.e., other than Hindi, Urdu, Gujarati)	12,373	1.0%
Other Indo-European languages	11,250	0.9%
Italian	10,104	0.8%
Chinese	6,970	0.5%
French Creole	4,600	0.4%
Tagalog	4,329	0.3%
Arabic	4,206	0.3%
Russian	3,312	0.3%
Vietnamese	2,961	0.2%

Language	Total Speakers	% of Total Pop.
Urdu	2,446	0.2%
Korean	2,412	0.2%
Greek	2,143	0.2%
Other Asian languages	1,995	0.2%
Serbo-Croatian	1,463	0.1%
German	1,420	0.1%
Other Slavic languages	1,226	0.1%
Hindi	1,172	0.1%
Polish	1,090	0.1%
Mon-Khmer, Cambodian	1,005	0.1%
Japanese	734	0.1%

Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 19. HOUSEHOLD TYPE

Household Type	NYS	NYC	Bronx
Total Households	7,130,896	3,063,393	473,281
Family Households	4,646,324	1,843,819	310,803
Family Households - Married couple	3,224,971	1,103,512	126,677
Family Households - Male Householder no wife	351,847	170,979	35,203
Family Households - Female Householder no husband	1,069,506	569,328	148,923
Non-family Households	2,584,572	1,219,574	162,478
Non-family Households - Living alone	2,119,199	996,487	141,774
% of Total Households - Living Alone	30%	33%	30%
Non-family Households - Not living alone	465,373	223,087	20,704

Source: US Census American Community Survey, 5-year table, 2008-2012.

TABLE 20. INCARCERATION

Incarceration	NYS	NYC	Bronx
NYC DOC Jail admissions (2012)	NA	84,754	16,362
NYC DOC Jail admissions rate per 100,000 Population (2012)	NA	1,034	1,180
NYS Prison admissions (2008) ^a	21,141	9,640	2,848

^aThe most recent data available for NYS prison admissions is from 2008; it is likely that more recent figures would be significantly lower.

Source: NYC Department of Corrections, 2012, as cited in

http://gothamist.com/2013/05/01/these_interactive_charts_show_you_w.php and <http://www.justiceatlas.org/>

TABLE 21. MEDICAID BENEFICIARIES

	NYS	NYC	Bronx
Total Population	19,398,125	8,199,221	1,386,364
Total Medicaid Beneficiaries	5,835,794	3,588,107	821,339
Medicaid Beneficiaries / Total Population	30.1%	43.8%	59.2%
Bronx Medicaid pop. / NYC Medicaid pop.			22.9%
Bronx Medicaid pop. / NYS Medicaid pop.			14.1%

Source: NYS DOH, 2012

TABLE 22. UNINSURED POPULATION BY AGE

Uninsured	NYS	NYC	Bronx
Total Uninsured	2,161,817	1,160,829	217,009
Uninsured / Total Population	11.1%	14.2%	15.7%
Bronx Uninsured / NYC Uninsured			18.6%
Bronx Uninsured / NYS Uninsured			10.0%
Older Adult 65+ Uninsured	26,086	17,769	2,874
% Older Adult 65+ Uninsured	1.0%	1.8%	2.0%
Child 0-17 Uninsured	197,779	80,534	17,757
% Child 0-17 Uninsured	4.5%	4.5%	4.8%
Adult 18+ Uninsured	1,964,038	1,080,295	199,252
% Adult 18+ Uninsured	13.0%	16.8%	19.6%

Source: US Census American Community Survey, 5-year, 2008-2012.

TABLE 22B. UNINSURED AND FOREIGN BORN

Country/Region of Origin	Number Uninsured in the Bronx	Percent of the Total Foreign Born Uninsured Population in the Bronx
Latin America	86,572	65.8%
Caribbean	16,070	12.2%
Africa	13,699	10.4%
Balkans and eastern Europe	3,349	2.5%
South Asia	2,766	2.1%
Sub-Total of Above Groups	122,456	93.0%
Other Countries	9,209	7.0%
Total Foreign Born Uninsured in the Bronx	131,665	100.0%

Source: US Census American Community Survey, 5 year, 2008-2012

TABLE 23. DUAL ELIGIBLE BENEFICIARIES

	NYS	NYC	Bronx
Total Older Adult 65+ Population	2,640,634	1,002,872	147,030
Dual Eligible Beneficiaries	853,866	467,749	93,324
Dual Eligible/ Older Adult 65+ pop.	32.3%	46.6%	63.5%
Bronx Duals/ NYC Duals			20.0%
Bronx Duals/ NYS Duals			10.9%

Source: NYS DOH, 2012

TABLE 24. INSURANCE STATUS

Insurance Status	NYS	NYC	Bronx
Child 0-17 Beneficiaries	1,979,039	1,180,983	298,329
Total Child 0-17 Population	4,316,920	1,774,909	369,168
Child 0-17 Beneficiaries/Pop	45.8%	66.5%	80.8%
Adult 18+ Beneficiaries	3,856,755	2,407,124	523,010
Total Adult 18+ Population	15,081,205	6,424,312	1,017,196
Adult 18+ Beneficiaries/Pop	25.6%	37.5%	51.4%

Source: NYS DOH, 2012

TABLE 25. DISABILITY AND DIFFICULTY STATUS

Disability /Difficulty	NYS	NYC	Bronx
% Disabled HH member	22.5%	21.2%	29.1%
Impairments, by Age:			
<i>Hearing</i>			
age 0-17 with Hearing Difficulty	22,395	8,324	2,172
% age 0-17 with Hearing Difficulty	0.5%	0.5%	0.6%
age 18-64 with Hearing Difficulty	182,116	60,231	14,705
% age 18-64 with Hearing Difficulty	1.5%	1.1%	1.7%
age 65+ with Hearing Difficulty	310,580	105,560	15,164
% age 65+ with Hearing Difficulty	11.8%	10.5%	10.3%
<i>Vision</i>			
age 0-17 with Vision Difficulty	23,724	10,606	3,208
% age 0-17 with Vision Difficulty	0.5%	0.6%	0.9%
age 18-64 with Vision Difficulty	166,396	79,038	19,538

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Disability /Difficulty	NYS	NYC	Bronx
% age 18-64 with Vision Difficulty	1.3%	1.5%	2.2%
age 65+ with Vision Difficulty	168,818	82,840	14,900
% age 65+ with Vision Difficulty	6.4%	8.3%	10.1%
<i>Cognitive</i>			
age 0-17 with Cognitive Difficulty	112,555	36,208	13,236
% age 0-17 with Cognitive Difficulty	2.6%	2.0%	3.6%
age 18-64 with Cognitive Difficulty	413,409	165,152	47,532
% age 18-64 with Cognitive Difficulty	3.3%	3.0%	5.5%
age 65+ with Cognitive Difficulty	844,970	337,659	48,999
% age 65+ with Cognitive Difficulty	32.0%	33.7%	33.3%
<i>Ambulatory</i>			
age 0-17 with Ambulatory Difficulty	20,920	9,268	2,788
% age 0-17 with Ambulatory Difficulty	0.5%	0.5%	0.8%
age 18-64 with Ambulatory Difficulty	547,468	233,975	60,771
% age 18-64 with Ambulatory Difficulty	4.4%	4.3%	7.0%
age 65+ with Ambulatory Difficulty	1,052,010	426,311	64,949
% age 65+ with Ambulatory Difficulty	39.8%	42.5%	44.2%

Source: US Census American Community Survey, 5-year, 2008-2012.

TABLE 26. TOP 10 LEADING CAUSES OF DEATH, NYS, NYC AND THE BRONX

	Total Reported	Rate per 100,000 Population	Age-Adjusted Rate per 100,000 Population
Diseases of Heart (I00-I09, I11, I13, I20-I51)	16,730	200.7	188.2
Malignant Neoplasms (Cancer: C00-C97)	13,399	160.7	155.1
Influenza (Flu) and Pneumonia (J09-J18)	2,244	26.9	25.2
Diabetes Mellitus (E10-E14)	1,813	21.7	20.8
Chronic Lower Respiratory Diseases (J40-J47)	1,651	19.8	19.0
Cerebrovascular Disease (Stroke: I60-I69)	1,646	19.7	18.6
Accidents Except Drug Posioning (V01-X39, X43, X45-X59, Y85-Y86)	1,032	12.4	12.0
Essential Hypertension and Renal Diseases (I10, I12)	980	11.8	11.1
Mental and Behavioral Disorders due to Accidental Poisoning and Other Psychoactive Substance Use (F11-F16, F18-F19, X40-X42, X44)	812	9.7	9.2
Alzheimer's Disease (G30)	696	8.3	7.6
All Other Causes	11,452	137.4	131.0

Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [Death/Mortality Data 2000-2012]. [4 September 2014]. <http://nyc.gov/health/epiquery>

TABLE 27. TOP 5 LEADING CAUSES OF PREMATURE DEATH, NYS, NYC AND THE BRONX (2010-2012)

	Bronx				NYC			NYS		
	Cause	# of Deaths	% of NYC	Age-adjusted Premature Death Rate, per 100,000	Cause	# of Deaths	Age-adjusted Premature Death Rate, per 100,000	Cause	# of Deaths	Age-adjusted Premature Death Rate, per 100,000
#1 Cause	Cancer	3,687	17.4%	289	Cancer	21,129	248	Cancer	56,790	275
#2 Cause	Heart Disease	3,083	19.5%	241	Heart Disease	15,794	184	Heart Disease	37,255	180
#3 Cause	Unintentional Injury	721	20.3%	55	Unintentional Injury	3,555	45	Unintentional Injury	10,809	60
#4 Cause	AIDS	657	31.7%	47	Diabetes	2,581	30	Chronic Lower Resp. Dis.	6,888	32
#5 Cause	Diabetes	557	21.6%	43	AIDS	2,075	26	Diabetes	5,415	26
Total (All Causes)		13,806	20.2%			68,214			174,783	

Source: Vital Statistics Data as of March, 2014, New York State Department of Health - Bureau of Biometrics and Health Statistics

TABLE 28. SELF-REPORTED HEALTH STATUS BY NEIGHBORHOOD

Neighborhood	% Self-Report Fair or Poor Health Status	Absolute #
New York City	21.3	1,318,000
Bronx	24.0	231,000
Kingsbridge/Riverdale	12.0	9,000
Northeast Bronx	14.7	23,000
Fordham/Bronx Park	21.8	35,000
Pelham/Throgs Neck	25.6	53,000
The South Bronx	29.2	97,000

Source: NYC DOHMH Community Health Survey, 2012

TABLE 29. MEDICAID BENEFICIARY BEHAVIORAL HEALTH UTILIZATION OF CARE, BRONX PROVIDERS

Medicaid Beneficiary Utilization through Bronx County Providers			
Service type	Individuals	Medicaid Paid (\$)	Expenditure Rate (\$/Individual)
Inpatient	3,602	\$82,985,990	\$23,039
Outpatient Mental Health Clinic	20,225	\$34,739,429	\$1,718
Residential	547	\$11,466,603	\$20,963
Assertive Community Treatment (ACT)	643	\$6,157,004	\$9,575
Targeted Case Management	856	\$3,294,941	\$3,849
Continuing Day Treatment	772	\$3,584,256	\$4,643
Prepaid Mental Health Plan Recovery Services	461	\$5,908,821	\$12,817
Comprehensive Psychiatric Emergency Program	1,468	\$846,041	\$576
Partial Hospitalization	132	\$350,699	\$2,657
Intensive Psychiatric Rehab	0	\$0	\$0

Source: NYS OMH, 2012

TABLE 30. BRONX HOSPITAL BEHAVIORAL HEALTH READMISSIONS WITHIN 30 DAYS

	Hospital Name	Discharges	Readmitted Within 30 Days	
			# Readmissions	Percent
Adults (age 18 +)				
General Hospital	Bronx-Lebanon Hospital Center	1806	350	19.4%
General Hospital	Montefiore Medical Center	803	102	12.7%
General Hospital	NYC-HHC Jacobi Medical Center	1148	198	17.2%
General Hospital	NYC-HHC Lincoln Medical & Mental Health Ctr.	490	95	19.4%
General Hospital	NYC-HHC North Central Bronx Hospital	707	119	16.8%
General Hospital	St. Barnabas Hospital	951	246	25.9%
State Psychiatric	Bronx Psychiatric Center	336	38	11.3%
ADULT TOTAL		6241	1148	18.4%
Children (age 0 -17)				
General Hospital	Bronx-Lebanon Hospital Center	391	52	13.30%
General Hospital	NYC-HHC Lincoln Medical & Mental Health Ctr.	16	0	0%
State Psychiatric	Bronx Children's Psychiatric Center	61	2	3.30%
CHILDREN TOTAL		468	54	11.5%
ADULT AND CHILDREN TOTAL		6709	1202	17.9%

Source: NYS OMH, 2012.

TABLE 31. SERIOUS PSYCHOLOGICAL DISTRESS BY NEIGHBORHOOD

Neighborhood	Serious Psychological Distress	Absolute #
New York City	5.5	348,000
Bronx	7.1	71,000
Kingsbridge/Riverdale	1.1	<1000
Northeast Bronx	5.1	8,000
Fordham/Bronx Park	4.4	8,000
Pelham/Throgs Neck	8.6	19,000
The South Bronx	8.1	29,000

Source: NYC DOHMH Community Health Survey, 2012

TABLE 32. CHRONIC MEDICAL CONDITION CO-MORBIDITY OF BEHAVIORAL HEALTH CLIENTS, BY AGE GROUP

		Age		
Chronic Medical Condition	Total Clients	Below 18	18-64	65+
Total Clients Served	16,942	3,268	12,364	1,308
No Chronic Medical Condition	6,668	2,451	4,054	163
At Least One Chronic Medical Condition	9,215	658	7,467	1,089
Unknown if Chronic Medical Condition is Present	1,059	159	843	56
% of Clients Served with at least One Chronic Medical Condition	54.4%	20.1%	60.4%	83.3%

Source: NYS OMH, Patient Characteristic Survey (PCS), 2013.

TABLE 33. BINGE DRINKING BY NEIGHBORHOOD

Neighborhood	% Binge Drink	Absolute #
New York City	19.6	1,224,000
Bronx	18.5	189,000
Kingsbridge/Riverdale	18.8	11,000
Northeast Bronx	18.5	26,000
Fordham/Bronx Park	19.4	38,000
Pelham/Throgs Neck	17.2	30,000
The South Bronx	18.8	74,000

Source: NYC DOHMH Community Health Survey, 2012

TABLE 34. CIGARETTE SMOKING BY NEIGHBORHOOD

Neighborhood	% Current Smoker*	Absolute #
New York City	15.5	981,000
Bronx	15.8	156,000
Kingsbridge/Riverdale	7.3*	4,000
Northeast Bronx	15.7	23,000
Fordham/Bronx Park	7.5*	15,000
Pelham/Throgs Neck	21.2	46,000
The South Bronx	18.2	63,000

*Estimate should be interpreted with caution. Estimate's Relative Standard Error (a measure of estimate precision) is greater than 30% or the sample size is less than 50, or the 95% Confidence Interval half width is greater than ten, making the estimate potentially unreliable.

Source: NYC DOHMH Community Health Survey, 2012

TABLE 35. PEOPLE LIVING WITH HIV/AIDS (PLWHA) BY NEIGHBORHOOD

Neighborhood (UHF)	Total number of People Living with HIV/AIDS (PLWHA), 2011	Total number of PLWHA per 100,000 population
NYC All	113,319	1,370.3
Bronx total	23,068	1,663.9
High Bridge - Morrisania	4,929	2352.9
Crotona - Tremont	4,585	2207.3
Fordham - Bronx Park	4,319	1695.6
Pelham - Throgs Neck	3,671	1222.4
Hunts Point - Mott Haven	3,163	2290.2
Northeast Bronx	1,830	955.8
Kingsbridge - Riverdale	571	622.9

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Source: Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

TABLE 36. HIV RATE, BY NEIGHBORHOOD

Neighborhood	HIV Rate per 100,000	Absolute #
New York City	41.2	3,404
Bronx	47.4	662
Kingsbridge - Riverdale	21.8	20
Northeast Bronx	38.1	73
Fordham - Bronx Park	47.5	121
Pelham - Throgs Neck	34	102
Crotona - Tremont	49.6	103
High Bridge - Morrisania	69.2	145
Hunts Point - Mott Haven	71	98

Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

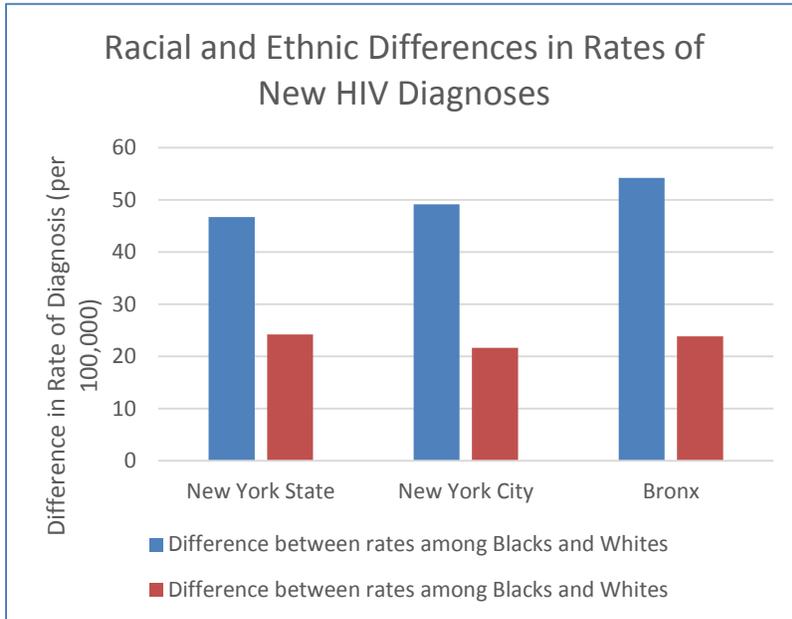
TABLE 36. CHRONIC HEPATITIS C

Location	Reported Cases	Crude Rate (per 100,000)	Age-Adjusted Rate (per 100,000)*
NYC	7,582	90.9	85.5
Bronx	1,787	126.9	not available

*adjusted to the Year 2000 Standard Population Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [Communicable Disease Surveillance Data]. [9/10/14]. <http://nyc.gov/health/epiquery>

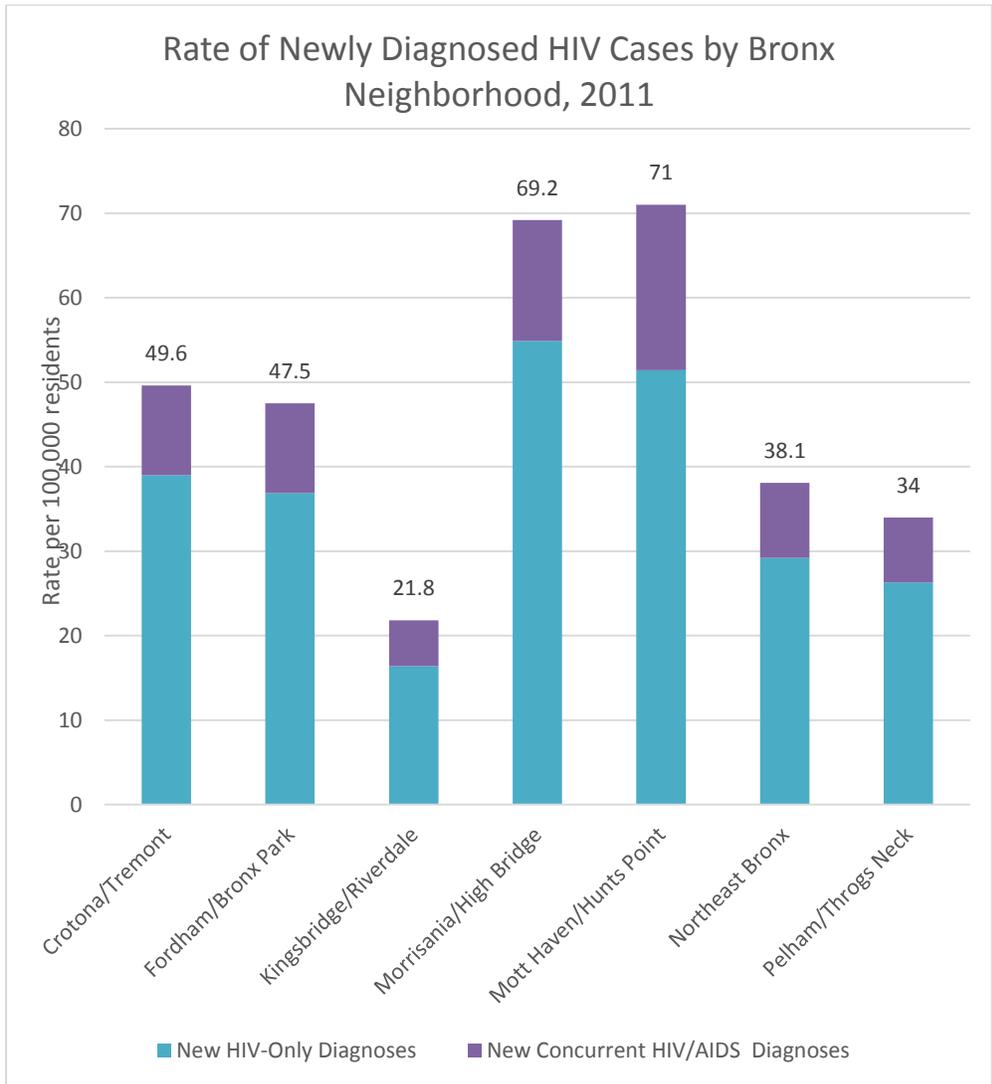
CHART 37. RACIAL AND ETHNIC DIFFERENCES IN RATES OF NEW HIV DIAGNOSES

Chart



Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

CHART 38. RATE OF NEWLY DIAGNOSED HIV CASES BY BRONX NEIGHBORHOOD, 2011



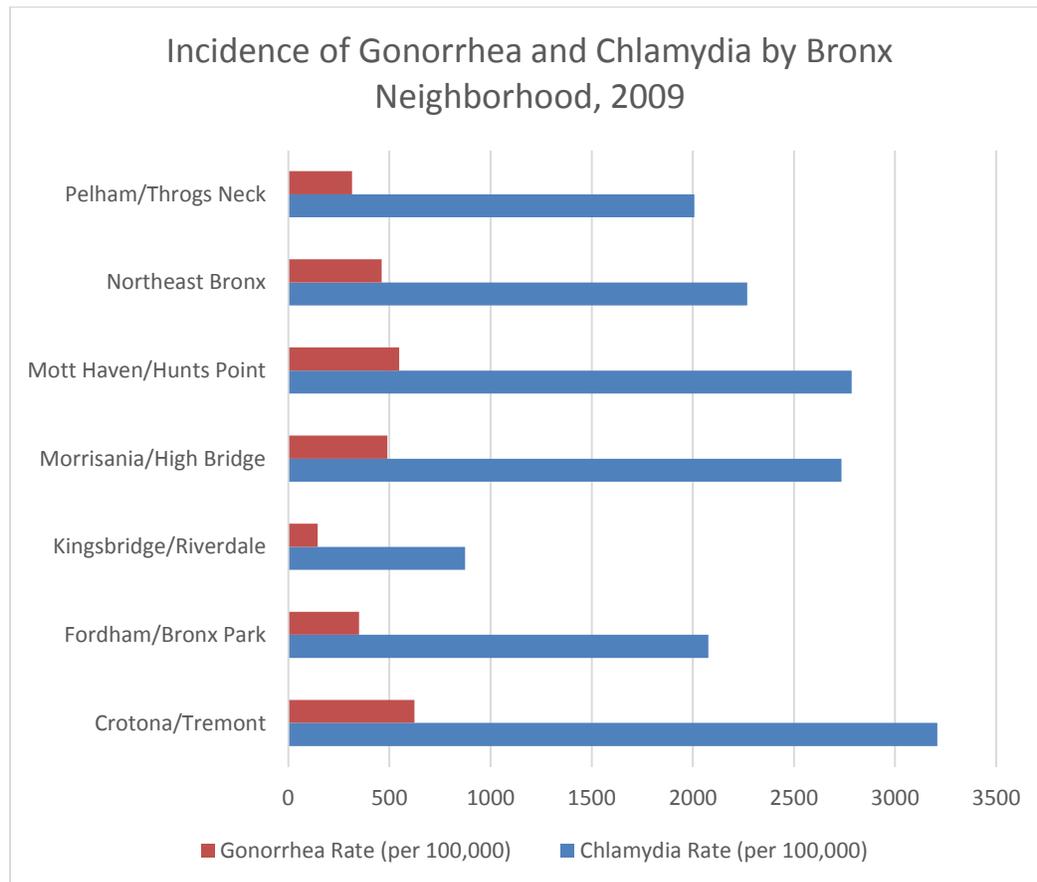
Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

TABLE 39. GONORRHEA RATE BY NEIGHBORHOOD

Neighborhood	Gonorrhea Rate per 100,000	Absolute #
New York City	130.3	10,898
Bronx	218.5	3,029
Kingsbridge	71.8	62
Northeast Bronx	230.2	434
Fordham	173.1	449
Pelham	155.2	462
Crotona	311.3	661
Morrisania	244.1	503
Mott Haven	275	375
<i>Bronx- neighborhood unknown</i>	<i>n/a</i>	<i>83</i>

Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [STD Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

CHART 40. INCIDENCE OF GONORRHEA AND CHLAMYDIA BY BRONX NEIGHBORHOOD, 2009



Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [STD Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

TABLE 41. CHLAMYDIA RATE, BY NEIGHBORHOOD

Neighborhood	Chlamydia Rate per 100,000	Absolute #
New York City	697.7	58,353
Bronx	1,238.80	17,176
Kingsbridge	453	391
Northeast Bronx	1,179.80	2,224
Fordham	1060	2,750
Pelham	1,009.10	3,003
Crotona	1,653.80	3,511
Morrisania	1,406.50	2,898
Mott Haven	1,423.60	1,941
<i>Bronx- neighborhood unknown</i>	<i>n/a</i>	458

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Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [STD Surveillance Data, 2009]. [1 August 2014]. <http://nyc.gov/health/epiquery>

TABLE 42. OBESITY RATE BY NEIGHBORHOOD

Neighborhood	% Obese*	Absolute #
New York City	24.2	1,498,000
Bronx	32	311,000
Kingsbridge/Riverdale	19	12,000
Northeast Bronx	35.2	52,000
Fordham/Bronx Park	36.3	65,000
Pelham/Throgs Neck	31.6	68,000
The South Bronx	30.6	108,000

Source: NYC DOHMH Community Health Survey, 2012.

TABLE 43. TOBACCO USE/CESSATION

Measure	NYS	NYC	Bronx
Percentage of cigarette smoking among adults ^a	16.2	15.6	15.8
Medical Assistance with Smoking Cessation ^b	[See source note]	5.8% (4.3-7.8)	5.1% (2.4-10.8)
Age-adjusted % of adults living in homes where smoking is prohibited (2008-2009) ^c	80.9	79.6	79.7

Sources:

^a State data obtained from 2012 Behavioral Risk Factor Surveillance System (BRFSS) as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. City and county data retrieved from: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [Community Health Survey 2012]. [1 August 2014].

<http://nyc.gov/health/epiquery>

^b NYC DOHMH Community Health Survey, 2012 (Note: this source provides information only that the city and county level)

TABLE 44. ALL PQI INDICATORS, 2012

PQI Indicator	# of Medicaid PQI Hospitalizations, Bronx	# of Medicaid PQI Hospitalizations, NYC	# of Medicaid PQI Hospitalizations, NYS	PQI Observed / Expected ratio		
				Bronx	NYC	NYS
Adult Overall Conditions Composite (PQI 90)	13,447	44,943	69,084	1.31	1.02	1.00
Adult Chronic Conditions Composite (PQI 92)	10,063	32,619	48,568	1.34	1.03	1.00
Adult All Diabetes Composite (PQI S01)	2,775	9,289	14,121	1.24	1.01	1.00
Adult Diabetes Short-term Complications (PQI 01)	792	2,533	4,506	1.13	0.91	1.00
Adult Diabetes Long Term Complications (PQI 03)	1,585	5,357	7,572	1.31	1.07	1.00
Adult Uncontrolled Diabetes (PQI 14)	327	1,178	1,679	1.16	1.04	1.00
Lower Extremity Amputation among Adults with Diabetes (PQI 16)	136	432	699	1.38	0.97	1.00
Adult All Circulatory Conditions Composite (PQI S02)	3,173	11,116	15,795	1.34	1.06	1.00
Adult Hypertension (PQI 07)	969	2,991	3,938	1.51	1.10	1.00
Adult Heart Failure (PQI 08)	2,013	7,426	10,902	1.28	1.04	1.00
Adult Angina Without Procedure (PQI 13)	191	699	955	1.26	1.09	1.00

Bronx CNA Report Appendix B. Tables and Charts
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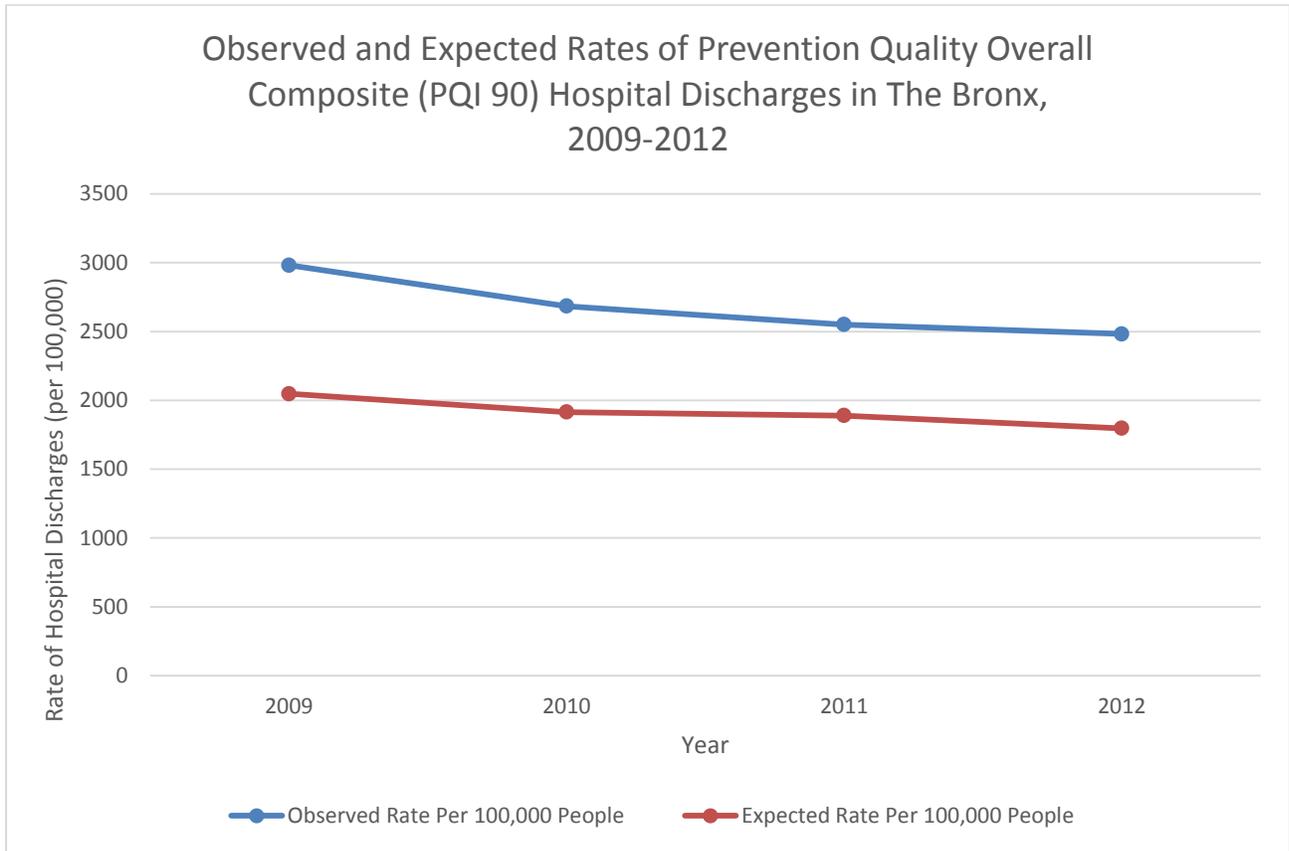
PQI Indicator	# of Medicaid PQI Hospitalizations, Bronx	# of Medicaid PQI Hospitalizations, NYC	# of Medicaid PQI Hospitalizations, NYS	PQI Observed / Expected ratio		
				Bronx	NYC	NYS
All Adult Respiratory Conditions Composite (PQI S03)	4,116	12,216	18,653	1.42	1.02	1.00
COPD and Asthma in Older Adults (PQI 05)	3,383	10,486	16,244	1.38	1.01	1.00
Asthma in Younger Adults (PQI 15)	733	1,730	2,410	1.61	1.11	1.00
Adult Acute Conditions Composite (PQI 91)	3,384	12,328	20,521	1.24	0.99	1.00
Adult Dehydration (PQI 10)	691	2,403	3,958	1.26	0.98	1.00
Adult Bacterial Pneumonia (PQI 11)	1,424	5,353	9,347	1.20	0.96	1.00
Adult Urinary Tract Infection (PQI 12)	1,269	4,572	7,216	1.27	1.04	1.00
Pediatric Overall Conditions Composite (PDI 90): ages 6-17 years	1,151	2,909	3,774	1.58	1.19	1.00
Pediatric Chronic Conditions Composite (PDI 92): ages 6-17 years	958	2,255	2,903	1.69	1.19	1.00
Pediatric Asthma (PDI 14): ages 2-17 years	1,865	4,282	5,384	1.80	1.73	1.00
Pediatric Diabetes Short-term	74			1.16	1.04	1.00

Bronx CNA Report Appendix B. Tables and Charts
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PQI Indicator	# of Medicaid PQI Hospitalizations, Bronx	# of Medicaid PQI Hospitalizations, NYC	# of Medicaid PQI Hospitalizations, NYS	PQI Observed / Expected ratio		
				Bronx	NYC	NYS
Complications (PDI 15): ages 6-17 years		234	380			
Pediatric Acute Conditions Composite (PDI 91): 6 - 17 years	193	654	871	1.17	1.16	1.00
Pediatric Gastroenteritis (PDI 16): ages 3 months - 17 years	558	1,758	2,333	1.31	1.18	1.00
Pediatric UTI (PDI 18): ages 3 months - 17 years	134	602	929	0.80	1.04	1.00

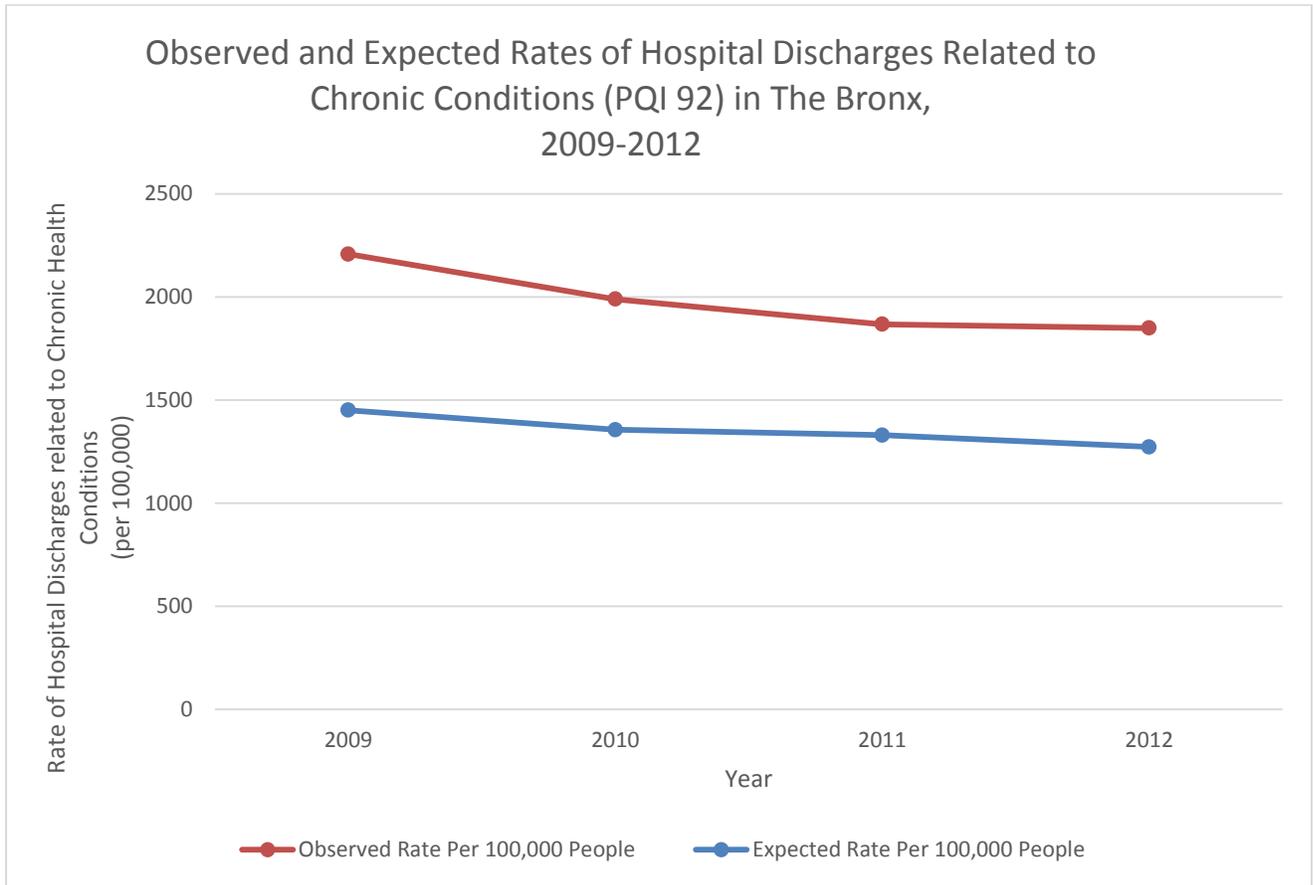
Source: 2012, New York State Department of Health

CHART 45. OVERALL OBSERVED AND EXPECTED RATES OF BRONX PQI HOSPITAL DISCHARGES, 2009-2012



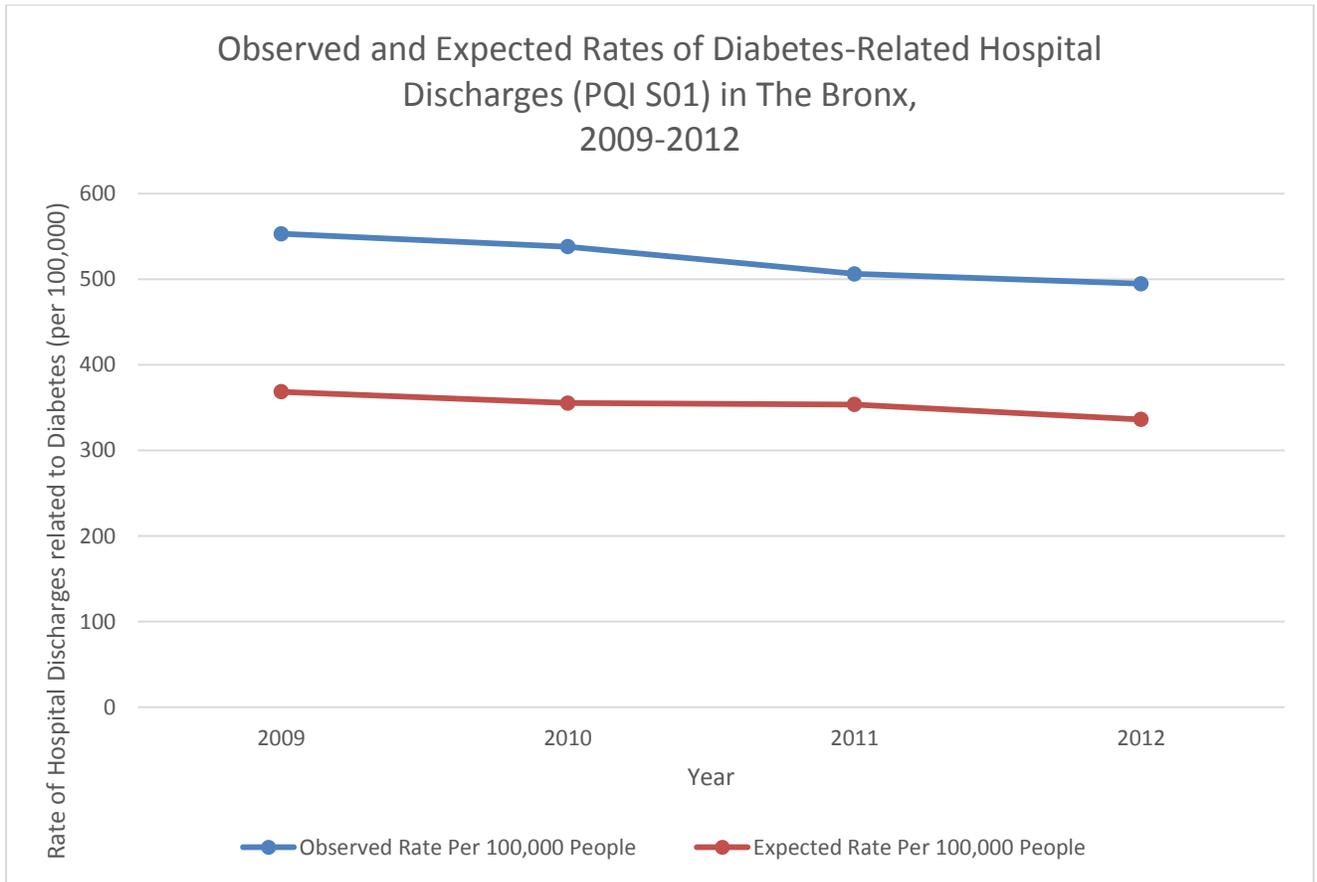
Source: NYS DOH, 2012

CHART 46. OBSERVED AND EXPECTED RATES OF HOSPITAL DISCHARGES, CHRONIC CONDITIONS, 2009-2012



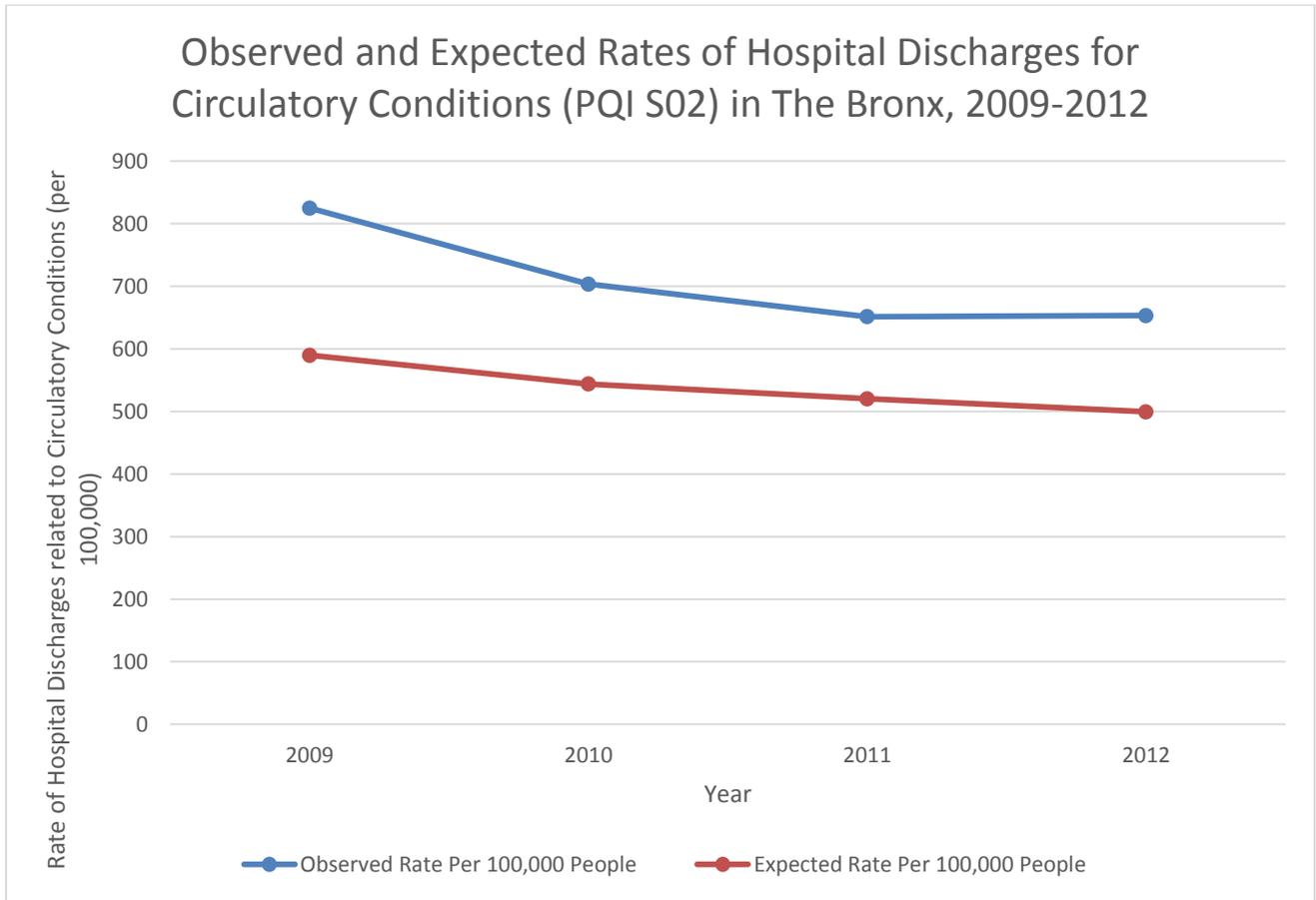
Source: NYS DOH, 2012

CHART 47. OBSERVED AND EXPECTED RATES OF HOSPITAL DISCHARGES, DIABETES, 2009-2012



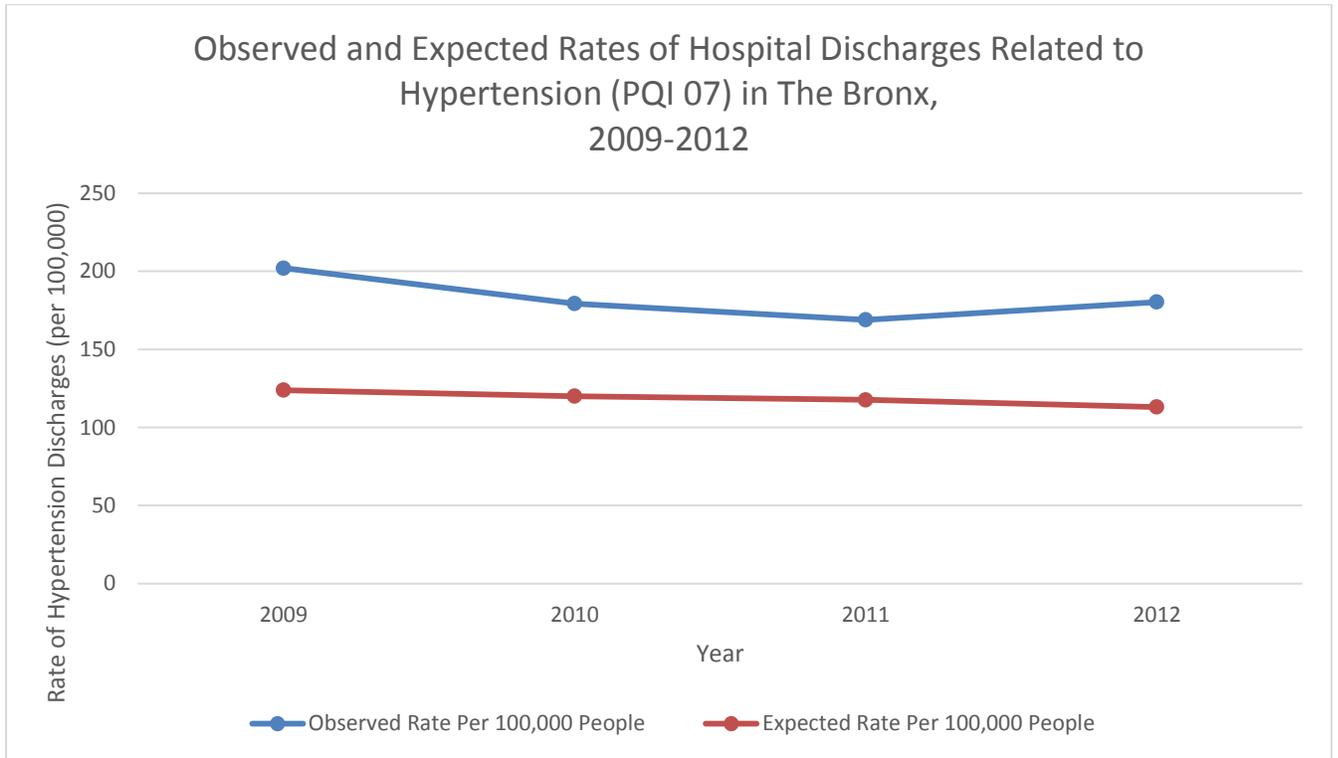
Source: NYS DOH, 2012

CHART 48. OBSERVED AND EXPECTED RATES OF HOSPITAL DISCHARGES, CIRCULATORY CONDITIONS, 2009-2012



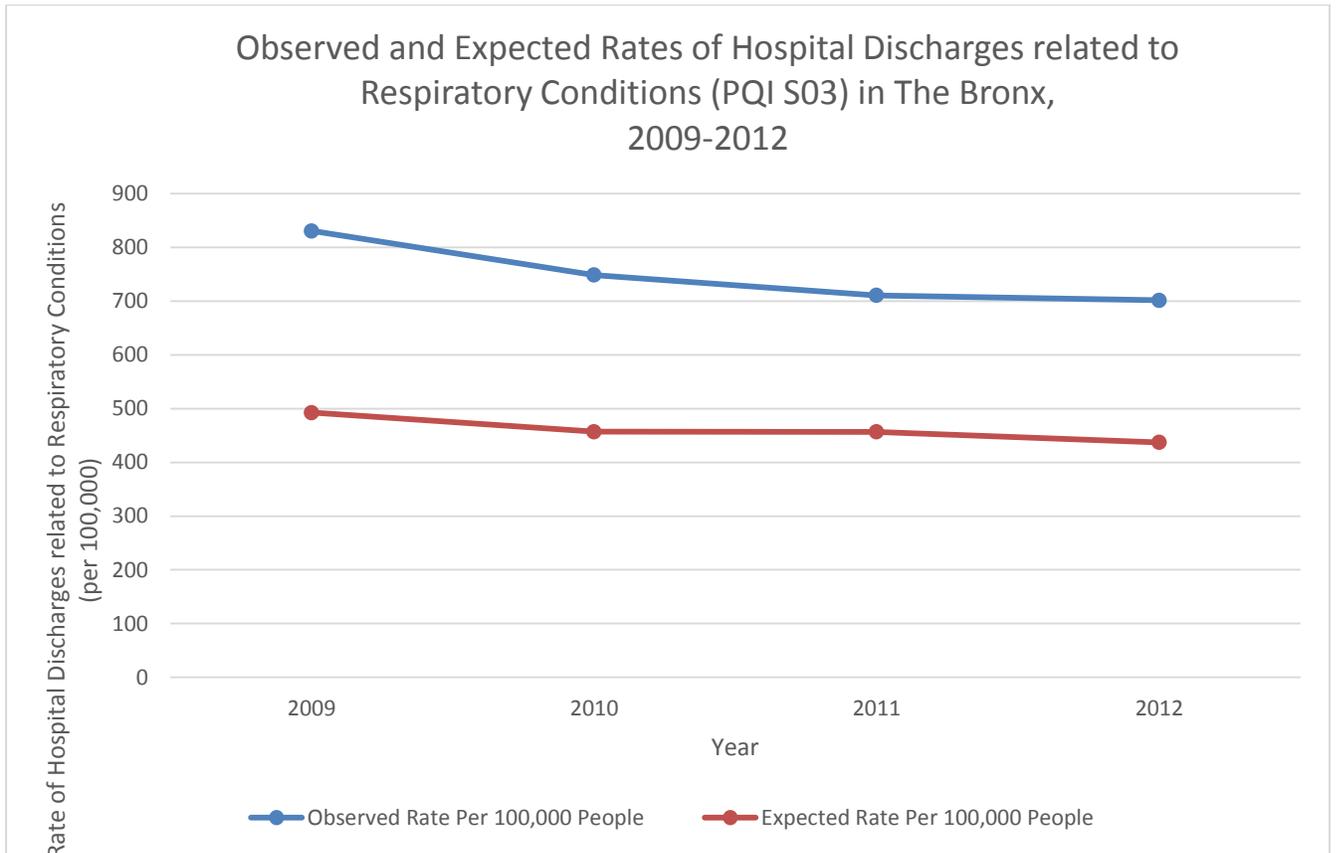
Data Source: NYS DOH, 2012

CHART 49. OBSERVED AND EXPECTED RATES OF HOSPITAL DISCHARGES, HYPERTENSION, 2009-2012



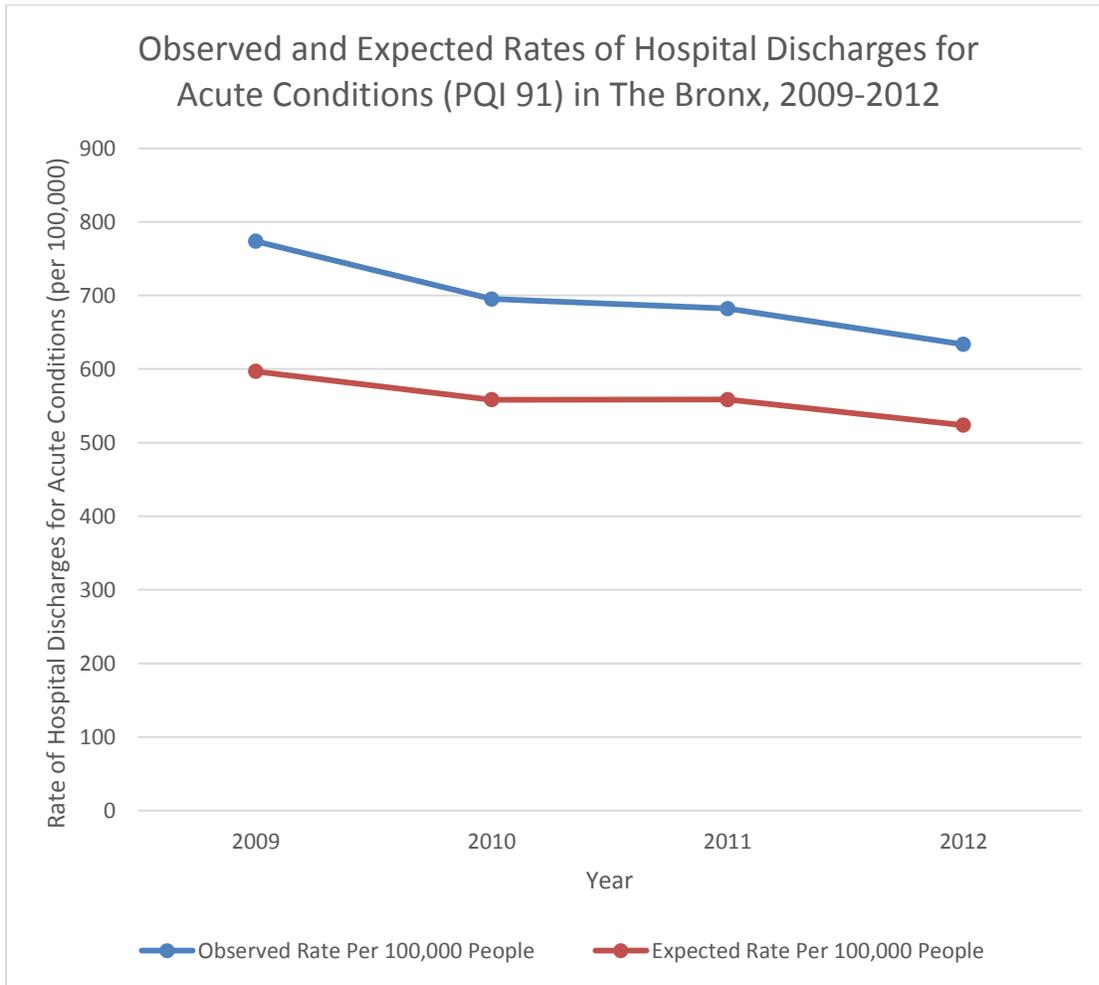
Source: NYS DOH, 2012

CHART 50. OBSERVED AND EXPECTED RATES OF HOSPITAL DISCHARGES, RESPIRATORY CONDITIONS, 2009-2012



Source: NYS DOH, 2012

CHART 51. OBSERVED AND EXPECTED RATES OF HOSPITAL DISCHARGES, ACUTE CONDITIONS, 2009-2012



Source: NYS DOH, 2012

TABLE 52. POTENTIALLY PREVENTABLE READMISSION DATA FOR BRONX HOSPITALS

Facility Name	At Risk Admissions	Observed PPR Chains	Observed / Expected PPR	Observed PPR Rate	Expected PPR Rate	Expected PPR Chains
BRONX LEB HSP CTR CNCRSE DIV*	15,869	1,443	1.14	9.09	7.95	1,262
CALVARY HOSPITAL	61	7	2.54	11.48	4.52	3
JACOBI MEDICAL CENTER	10,172	694	1.03	6.82	6.65	676
LINCOLN MEDICAL/MENTAL HLTH	13,130	855	1.07	6.51	6.1	801
MONTEFIORE MEDICAL CENTER	32,086	2,381	1.11	7.42	6.67	2,140
NORTH CENTRAL BRONX HOSPITAL	4,551	311	1.10	6.83	6.19	282
ST BARNABAS HOSPITAL	10,287	1,134	1.26	11.02	8.76	901
BRONX HOSPITALS TOTAL	86,156	6,825	1.13			6,065

Source: New York State Department of Health, 2012

*PPR is not available from DOH for Bronx Lebanon Fulton Division, which offers behavioral health related services.

TABLE 53. DOMAIN 3 METRICS, BEHAVIORAL HEALTH

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
PPV (for persons with BH diagnosis)	[No known public source]	[No known public source]	[No known public source]
Antidepressant Medication Management (Effective Acute Phase Treatment)*	50%	47%	46%
Diabetes Monitoring for People with Diabetes and Schizophrenia (aged 18-64 years)*	68%	70%	71%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (aged 18-64 years) Using Antipsychotic Medication*	79%	80%	83%
Cardiovascular Monitoring for People with CVD and Schizophrenia.	[No known public source]	[No known public source]	[No known public source]
Follow-up care for Children Prescribed ADHD Medications (Initiation Phase)*	56%	64%	64%
Follow-up after hospitalization for Mental Illness within 30 Days*	55%	51%	56%

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
Screening for Clinical Depression and follow-up			
Adherence to Antipsychotic Medications (at least 80% of treatment time) for People with Schizophrenia (aged 19-64 yrs)*	64%	63%	59%
Initiation of Alcohol and Other Drug Dependence Treatment*	78%	78%	82%
PPR for SNF patients	[No known public source]	[No known public source]	[No known public source]
Percent of Long Stay Residents who have Depressive Symptoms**	12.23%	[No known public source]	[No known public source]

Sources:

*Healthcare Effectiveness Data & Information Set (HEDIS), Medicaid Recipients, 2012, as presented by the New York State Department of Health, Office of Health Systems Management

** Nursing Home Quality Initiative 2012 (this source does not provide data at the city or county level).

TABLE 54. DOMAIN 3 METRICS, CARDIOVASCULAR DISEASE

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
PQI # 7 Hypertension, # of Discharges, 2012	3,938	2,991	969
PQI #13 Angina Without Procedure, # of Discharges, 2012	955	699	191
Cholesterol Management for Patients with CV Conditions ^a	[No known public source]	35.9% (33.3-38.7)	38.3% (30.6-46.7)
Controlling High Blood Pressure (Provider responsible for medical record reporting) ^{a,b}	63%*	67.0% (63.3-70.5)	[No known public source]
Aspirin Discussion and Use ^b Discussion of Aspirin Risks and Benefits(HMO/PPO) Aspirin Use(HMO/PPO)	49%/43% 39%/39%	[No known public source]	[No known public source]
Medical Assistance with Smoking Cessation ^a	[No known public source]	5.8% (4.3-7.8)	5.1% (2.4-10.8)
Flu Shots for Adults Ages 50 – 64 ^a	[No known public source]	51.6% (49.4 - 53.7)	56.5% (50.7 - 62.1)

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)	[No known public source]	[No known public source]	[No known public source]

Sources:

^a NYC DOHMH Community Health Survey, 2012 (Note: this source provides information only that the city and county level)

^b QARR, 2012 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

^c QARR 2011 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

TABLE 55. DOMAIN 3.B. METRICS, CARDIOVASCULAR DISEASE

Adult Hospitalizations, 2012	NYS	NYC	Bronx
Angina Without Procedure (PQI 13)	955	699	191
Hypertension (PQI 07)	3,938	2,991	969
All Circulatory Conditions (PQI 07, PQI 08)	15,795	11,116	3,173
Adult Heart Failure (PQI 08)	10,902	7,426	2,013

Source: NYS DOH, 2012 data

TABLE 56. DOMAIN 3 METRICS: DIABETES MELLITUS

Potentially Avoidable Hospitalizations, 2012	NYS	NYC	Bronx
Diabetes Long Term Complications (PQI 03)	7,572	5,357	1,585
All Diabetes Composite (PQI 01, PQI 03, PQI 16)	14,121	9,289	2,775
Adult Diabetes Short-term Complications (PQI 01)	4,506	2,533	792
Adult Uncontrolled Diabetes (PQI 14)	1,679	1,178	327
Lower Extremity Amputation among Adults with Diabetes (PQI 16)	699	432	136
Pediatric Diabetes Short-term Complications (PDI 15)	380	234	74

Source: NYS DOH, 2012 data

TABLE 57. SELECT CLINICAL IMPROVEMENT MEASURES, DIABETES

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy) ^a	51%	[See source note]	[See source note]
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing*	80%	82%	80%
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ^a	33%	[See source note]	[See source note]
Comprehensive diabetes care - LDL-c control (<100mg/dL): Lipids Controlled (<100 mg/dL) Monitoring Diabetes - Lipid Profile ^a	47% 87%	[See source note]	[See source note]
Medical Assistance with Smoking Cessation ^b	[See source note]	5.8% (4.3-7.8)	5.1% (2.4-10.8)
Flu Shots for Adults Ages 50 – 64b	[See source note]	43% (40.0-45.9)	51.5% (43.8-59.1)
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)	[No known public source]	[No known public source]	[No known public source]

Sources:

* *Healthcare Effectiveness Data & Information Set (HEDIS), Medicaid Recipients, 2012, as presented by the New York State Department of Health, Office of Health Systems Management*

^a *QARR, 2011 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)*

^b *NYC DOHMH Community Health Survey, 2012 (NYC DOHMH Community Health Survey, 2012 (Note: this source provides information only that the city and county level)*

TABLE 58. DOMAIN 3 METRICS, ASTHMA

Potentially Avoidable Hospitalizations, 2012	NYS	NYC	Bronx
All Adult Respiratory Conditions Composite (PQI 05, PQI 15)	18,653	12,216	4,116
Asthma in Younger Adults (PQI 15)	2,410	1,730	733
COPD and Asthma in Older Adults (PQI 05)	16,244	10,486	3,383
Pediatric Asthma (PDI 14)	5,384	4,282	1,865

Source: NYS DOH, 2012 data

TABLE 59. SELECT CLINICAL IMPROVEMENT MEASURES, ASTHMA

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
Asthma Medication Ratio	[See Source Note]	[See Source Note]	[See Source Note]
Medical Management for People with Asthma:			
50% Covered (Ages 5-11)	48%	[See Source Note]	[See Source Note]
50% Covered(Ages 12-18)	49%		
50% Covered(Ages 19-50)	63%		
50% Covered (Ages 51-64)	77%		
50% Covered (Ages 5-64)	57%		
75% Covered (Ages 5-11)	25%		
75% Covered(Ages 12-18)	25%		
75% Covered(Ages 19-50)	38%		
75% Covered (Ages 51-64)	53%		
75% Covered (Ages 5-64)	34%		

Source: QARR, 2012 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

TABLE 60. SELECT CLINICAL IMPROVEMENT MEASURES, HIV/AIDS

Select Clinical Improvement Measures	NYS	NYC	Bronx
HIV/AIDS Comprehensive Care : Engaged in Care [*]	89%	89%	91%
HIV/AIDS Comprehensive Care : Viral Load Monitoring [*]	66%	67%	69%
HIV/AIDS Comprehensive Care : Syphilis Screening [*]	68%	71%	70%
Cervical Cancer Screening ^a	67%	69%	67%
Chlamydia Screening, Women Ages 16-24 [*]	66%	70%	71%
Medical Assistance with Smoking Cessation	[See source note]	5.8% (4.3-7.8)	5.1% (2.4-10.8)
Viral Load Suppression ^{**}	62.2%	61.2%	60.19%

**Healthcare Effectiveness Data & Information Set (HEDIS), Medicaid Recipients, 2012, as presented by the New York State Department of Health, Office of Health Systems Management.*

*** Source: HIV Ambulatory Care Performance, 2011*

TABLE 61. SELECT CLINICAL MEASURES, PERINATAL CARE

Select Clinical Improvement Measures, 2012			
Measure	NYS	NYC	Bronx
Prenatal and Postpartum Care—Timeliness and Postpartum Visits:^{a, b}			
% mothers received postpartum checkup	90.1%	89.2%	
% mothers received prenatal care - start 1st to 3rd month	71.8%	70.4%	60.3%
% mothers received prenatal care - start 4th to 6th month	27.9%	30.5%	44.8%
% mothers received prenatal care - start 7th to 9 th month	23.9%	28.7%	37.0%
% late or no prenatal (Note: zip code level avl.)	5.4%	6.9%	10.2%
Frequency of Ongoing Prenatal Care:^c			
Frequency of Ongoing Prenatal Care 61-80%	12%	[See source note]	[See source note]
Frequency of Ongoing Prenatal Care 41-60%	6%		
Frequency of Ongoing Prenatal Care 21-40%	4%		
Frequency of Ongoing Prenatal Care <21%	8%		
Percentage of Children Who Had Five (5) or More Well Care Visits in the first 15 months*	85%	83%	83%
Childhood Immunization Status:^c			
Childhood immunization (0lmmz)	1%		
Childhood immunization-3 or more IPVs	93%		
Childhood immunization-2 or 3 rotavirus	69%		

Select Clinical Improvement Measures, 2012			
Measure	NYS	NYC	Bronx
Childhood immunization-4 or more pneumococcal	81%	[See source note]	[See source note]
Childhood immunization-2 or more HepA	37%		
Childhood Immunization-2 or more influenza	57%		
Childhood Immunization-Varicella	91%		
Childhood Immunization-MMR	93%		
Childhood Immunization-4 or more DTPs	83%		
Childhood Immunization-3 or more HepB	92%		
Childhood Immunization-3 or more Hibs	93%		
Childhood Immunization Status (Combo 3: 4-3-1-3-3-1-4)	74%		
Lead Screening in Children ^c	89%	[See source note]	[See source note]

Sources:

^a NY State Vital Statistics, 2012

^b PRAMS 2011 (postpartum metrics)

^c QARR, 2012 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

^d QARR, 2011 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

TABLE 62. SELECT CLINICAL IMPROVEMENT MEASURES, PALLIATIVE CARE

Select Clinical Improvement Measures	NYS	NYC	Bronx
Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain	[No known public source]	[No known public source]	[No known public source]
Risk-Adjusted percentage of members who had severe or more intense daily pain	[No known public source]	[No known public source]	[No known public source]
Risk-adjusted percentage of members whose pain was not controlled.	[No known public source]	[No known public source]	[No known public source]
Advanced Directives – Talked about Appointing for Health Decisions	[No known public source]	[No known public source]	[No known public source]
Depressive feelings - percentage of members who experienced some depression feeling	[No known public source]	[No known public source]	[No known public source]

Source: Not applicable

TABLE 63. SELECT CLINICAL IMPROVEMENT MEASURES, RENAL CARE

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy) ^a	51%	[See Source Note]	[See Source Note]
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ^a	33%	[See Source Note]	[See Source Note]
Comprehensive diabetes care - LDL-c control (<100mg/dL) ^a	47% 87%	[See Source Note]	[See Source Note]
Annual Monitoring for Patients on Persistent Medications – ACE/ARB ^b	92%	[See Source Note]	[See Source Note]

Sources:

^a QARR, 2011 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

^b QARR, 2012 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

TABLE 64. DOMAIN 4 METRICS: PREMATURE DEATH, PREVENTABLE HOSPITALIZATIONS, INSURANCE AND HEALTH CARE PROVIDER STATUS

Measure	Data year(s)	NYS	NYC	Bronx
Percentage of premature death (before age 65 years) ^a	2012	23.9	27.6	33.9
<i>Ratio of Black non-Hispanics to White non-Hispanics^a</i>	2010-2012	2.04	2.1	2.52
<i>Ratio of Hispanics to White non-Hispanics^a</i>	2010-2012	2.03	2.04	2.43
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years ^b	2012	135.6	158.5	238.5
<i>Ratio of Black non-Hispanics to White non-Hispanics^b</i>	2010-2012	2.06	2.27	1.76
<i>Ratio of Hispanics to White non-Hispanics^b</i>	2010-2012	1.51	1.58	1.4
Percentage of adults with health insurance - Aged 18-64 years ^c	2012	89.1	86.2	85.1
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years ^d	2012	81.5	81.7	78.7

Sources:

^a State data obtained from 2012 Behavioral Risk Factor Surveillance System (BRFSS) as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. City and county data retrieved from: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [Community Health Survey 2012]. [1 August 2014]. <http://nyc.gov/health/epiquery>

^b SPARCS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

^c US Census Bureau, American Community Survey, 2012

^d State data retrieved from the 2012 Behavioral Risk Factor Surveillance System as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard; city and county data retrieved from the 2012 NYC Community Health Survey

TABLE 65. DOMAIN 4 METRICS: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

Measure	Data Year(s)	NYS	NYC	Bronx
Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month ^a	2008-2009	10.2	9.2	9.1
Age-adjusted percentage of adult binge drinking during the past month ^b	2012	17.7	19.6	18.5
Age-adjusted suicide death rate per 100,000 ^c	2010-2012	7.8	5.7	5.4

Sources:

^a 2008-2009 BRFSS and Expanded BRFSS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

^b State data retrieved from the 2012 Behavioral Risk Factor Surveillance System as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard; city and county data retrieved from the 2012 NYC Community Health Survey.

^c Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

TABLE 66. DOMAIN 4 METRICS: PREVENT CHRONIC DISEASES

Measure	Data Year(s)	NYS	NYC	Bronx
Percentage of adults who are obese ^a	2008-2009, 2012	23.6	24.2	32
Percentage of children and adolescents (K-8 th grades) who are obese ^b	2010-2011	17.6 (excludes NYC)	21.7	23.5
Percentage of cigarette smoking among adults ^a	2012	16.2	15.6	15.8
Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years ^c	2008-2009, 2012	61.5	68.5	70.7
Asthma emergency department visit rate per 10,000 ^d	2012	88.6	139.6	260.2
Asthma emergency department visit rate per 10,000 - Aged 0-4 years ^d	2012	225.1	348.4	642.5
Age-adjusted heart attack hospitalization rate per 10,000 ^d	2012	15.1	13.5	14.6
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years ^d	2010-2012	3	3.4	5
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years ^d	2010-2012	6.1	7	12

Sources:

^a State data obtained from 2012 Behavioral Risk Factor Surveillance System (BRFSS) as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. City and county data retrieved from: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [Community Health Survey 2012]. [1 August 2014]. <http://nyc.gov/health/epiquery>

^b State data excludes NYC and was obtained from the 2010-12 Student Weight Status Category Reporting System as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard (includes children in grades K-12). City and county-level data obtained from "FitnessGram" (2010-2011) as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard (includes children in grades K-8).

^c State data obtained from the 2012 BRFSS and reports the "Percentage of adults who received colorectal cancer screening according to most recent guidelines." Those complying with recent guidelines included individuals who used a blood stool test at home in the past year; and/or, sigmoidoscopy in the past 5 years and blood stool test in the past 3 years; and/or, had a colonoscopy in the past 10 years. However, the 2012 NYC Community Health Survey only reports the percentage of respondents who received a "colon cancer screening in last 10 years."

^d SPARCS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

TABLE 67. DOMAIN 4 METRICS: PREVENT HIV/STDs

Measure	Data Year(s)	NYS	NYC	Bronx
Newly diagnosed HIV case rate per 100,000 ^a	2010-2012	18.3	33.5	43.1
<i>Difference in rates (Black and White) of new HIV diagnoses ^a</i>	2010-2012	46.7	49.1	54.2
<i>Difference in rates (Hispanic and White) of new HIV diagnoses ^a</i>	2010-2012	24.2	21.6	23.8
Gonorrhea case rate per 100,000 women - Aged 15-44 years ^b	2012	235.8	283.1	513.6
Gonorrhea case rate per 100,000 men - Aged 15-44 years ^b	2012	284.1	444.9	584.7
Chlamydia case rate per 100,000 women - Aged 15-44 years ^b	2012	1,625.1	2,047.6	3,508.2
Primary and secondary syphilis case rate per 100,000 males ^b	2012	12.4	24.3	25.8
Primary and secondary syphilis case rate per 100,000 females ^b	2012	0.5	0.7	0.9

Sources:

^a Bureau of HIV/AIDS Epidemiology data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard

^b NYS STD Surveillance System data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard

TABLE 68. DOMAIN 4 METRICS: PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

	Measure	Data Year(s)	NYS	NYC	Bronx
41	Percentage of preterm births	2012	10.8	10.8	12.2
42	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	2010-2012	1.62	1.8	1.41
43	<i>Ratio of Hispanics to White non-Hispanics</i>	2010-2012	1.25	1.39	1.21

Source: Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.

**A QUALITATIVE COMMUNITY NEEDS ASSESSMENT
FOR THE
BRONX LEBANON HOSPITAL CENTER
DELIVERY SYSTEM REFORM INCENTIVE
PAYMENT PROGRAM APPLICATION**



Presented by:
Researchers' Resource LLC
PO Box 1358
Westborough, MA 01581
researchersresource.com

October 31, 2014

A REPORT ON FOCUS GROUPS AND IN-DEPTH INTERVIEWS WITH PATIENTS, PROVIDERS AND LEADERSHIP OF COMMUNITY ORGANIZATIONS

For information or questions about this report –

Sarah A. McGraw, PhD

Researchers' Resource LLC

PO Box 1358

Westborough, MA 01581

mcgraws@researchersresource.com

Author: This report was prepared by Sarah A. McGraw, PhD of Researchers' Resource LLC.

Acknowledgements: The author thanks the Bronx-Lebanon Hospital Center for supporting this assessment and the members of the Steering Committee, Professional Advisory Committee and the CNA committee for their guidance. A special thanks to the patients, providers and organizational leaders who generously gave their time to participate in the assessment interviews and focus groups. The efforts of the staff of Urban Health and American Dental who conducted focus groups with individuals at their organizations were invaluable. Finally, thanks to the project team Beth Lorell, Corrine Warren, James Nutter, and Carol Wood-Nutter, for their hard work on this project.

BACKGROUND

The Bronx-Lebanon Hospital Center (BLHC) together with its large base of collaborating organizations and providers is applying to form a Performing Provider System (PPS) within the New York State Delivery System Reform Incentive Payment (DSRIP) program. This PPS aims to transform the current system of health care in the South and Central Bronx into an integrated delivery system based on evidence-based practices and population health management and thereby to:

- Improve the quality of clinical care through integration of medical, behavioral health, and social services
- Enhance evidence-based disease management
- Promote the health of the people living in South and Central Bronx through improved access and quality as well as through specific population-wide initiatives in the areas of mental health promotion and HIV prevention
- Diminish health care costs by reducing preventable hospitalizations among Medicaid recipients by 25% over the next five years

The PPS will pursue 10 projects under the domains of system transformation, improved health care, and population health promotion to achieve its goals.

The New York Academy of Medicine (NYAM) conducted a community needs assessment (CNA) of the entire Bronx to guide multiple PPSs that seek to serve the Bronx in the selection of their projects. Researcher's Resource was contracted by the Bronx Lebanon Hospital to conduct a qualitative assessment of the perceptions of patients, clinicians and leadership in the South Bronx to supplement the NYAM CNA.

The goal of this qualitative assessment was to hear, in their own words, how patients, providers and community leaders viewed the gaps in health care under the current system, the social determinants underlying the health care challenges faced by patients from the South Bronx community, and how patient needs can be better addressed. Also, we sought to elicit their reactions to projects being considered for the PPS, and potential challenges for the emerging PPS. These findings are intended to inform the selection of PPS projects.

METHODS

A total of 91 individuals participated in 11 focus groups and 11 in-depth individual interviews between October 8 and October 21, 2014. Participants were patients and clinicians of programs based in the South Bronx, as well as leaders of community based organizations serving this area. Table 1 shows the total number of focus groups and interview participants by respondent type.

Table 1: Organizational Affiliations and Respondent Categories of 91 Participants

	# of Focus Group Participants	# of Individual Interview Participants
Patients	34	5
Clinicians	21	2
Organizational Leadership (PAC members)	25 ¹	4

¹ Responded to questions at a PPS Professional Advisory Committee meeting on October 15, 2014.

The 39 patients were drawn from one Federally Qualified Health Center (FQHC), a dental services clinic, a home health agency, two organizations that provide substance use treatment along with transitional housing and behavioral health services. The 23 clinicians were drawn from two substance use and behavioral health services agencies, two health home agencies, and a large dental practice. The organizational leaders represented an FQHC, AIDS services, managed care and dental services.

Four individuals were involved in the conduct of the focus groups and interviews. The interview and focus group guides are provided in Appendix A. The organizations which provided access to CNA participants are listed in Appendix B.

The moderators and interviewers followed a semi-structured interview guide and each session was audio-recorded and transcribed for analysis. One focus group was conducted in Spanish by bilingual moderators and two had translators present during the session. All were translated to English for analysis.

Using content analysis, a team read the transcripts to identify key topics and themes. A trained coder used a software package to tag text corresponding to the topics or themes. Two additional analysts reviewed the codes to verify the coding and to identify additional themes within and across codes. Results of the coding were used to organize the findings reported below.

The findings are organized into two major parts. Part A provides a description of the patient challenges, their health needs and the views on the healthcare system and environmental factors affecting the community. In Part B, we discuss views on the emerging PPS.

FINDINGS - PART A: PATIENT NEEDS & THE SYSTEM OF CARE

In Part A covers: 1) the characteristics of the three types of individuals who participated in this assessment (patients, providers, and organization leaders); 2) challenges faced by patients; 3) critical health concerns of the patients; 4) problems with continuity of care; 5) communication; 6) access to care; 7) environmental factors affecting health promotion and community wellbeing; and 8) patient resources.

1) PARTICIPANTS IN THE QUALITATIVE ASSESSMENT: WHO THEY WERE

Participating Patients

Thirty-nine adult patients participated in focus groups or completed an interview. The 28 patients from whom we obtained their gender and age were between 24-93 years of age and 68% were female. A number reported caring for either young or adult children, aging parents, grandparents or grandchildren. Most lived in the Bronx but several were moved to shelters outside of the Bronx when they lost their housing. Some were born in the Bronx, others in the south and others in the Dominican Republic or Puerto Rico.

Consonant with the fact that some participants were drawn from substance use/behavioral health programs, a number reported co-morbid medical and behavioral health problems. All patients were affiliated with a clinic or other program.

The Providers and Patients They Served

The majority of the 22 providers who participated in the focus groups and interviews were care coordinators and social workers. Others were front-line providers or clinical leaders responsible for managing clinical operations.

All of the providers said their programs served individuals with high rates of health care utilization and multiple comorbid conditions. They said that their patients commonly experienced mental health and substance use disorders and homelessness. One provider described her patients:

A lot of the individuals who are high utilizers, are those who are homeless or those who are active substance abusers; those who have untreated illness.

Chronic illnesses were common among their patients, particularly HIV/AIDS. A number served patients who had physical disabilities. One organization specialized in working with the developmentally disabled. Rates of hospice care were low.

Though some providers worked with all age groups, including children, families, and foster care agencies, most served middle aged or older adults. The organizations cited English as the primary language of the patient population, although a high proportion of their clients or patients spoke Spanish as their primary language.

2) LIFE CHALLENGES FOR THE PATIENTS

Participants across the three groups (patients, providers and organizational leaders) described a number of structural and social challenges that affected patients' lives including housing, employment, and financial needs. In addition, the patients talked about transportation problems, neighborhood safety, racism, and social isolation. The overwhelming sense of facing multiple challenges was most succinctly stated by a patient who, when asked what stood out the most for him, said: "Trying to live".

Housing:

All of the participants described the lack of affordable, safe and stable housing as a concern that affected the general wellbeing and health of the patients and their families. A provider described the prominence of this concern:

Housing is number one for us, as well. And so like Maslow's Hierarchy: if basic needs are not met, everything else is secondary. So even though they come in with these crises of domestic violence, educational neglect; a lot of times housing is the issue that everyone is [asking about]: Could you help me with housing? Do you know any apartments? Do you know any brokers that take FEPS or these different programs? So interestingly, I would say – although we don't specialize in housing, they come to us with housing issues that unfortunately, we're very limited in what we can provide and refer them to, but that's definitely the number one issue.

Patients said that high rents, unemployment and lack of credit made it difficult to find good options and several reported living in shelters with their families after losing their housing. Others worried about losing housing as rents increase.

I feel the housing is the most difficult part. Because it's hard to find housing for low income people who have not so good credit, maybe no credit at all, or bad credit

Several patients reported disabilities that limited their vision or mobility; some were confined to a wheelchair or required a walker. For them, housing problems were exacerbated when buildings were not well maintained or were not handicapped-accessible. For example, one participant said:

I have use of the wheelchair, which is an electric chair, electric – motorized wheelchair...I live in an elevated building. The building is a problem because the landlord of this big complex – I've put in complaints that have not been um, properly looked at. ...Because I haven't been able to get the proper help because they don't have ramps that are able to facilitate wheelchairs. They have an old ramp in the back, an old service entrance...

The organizational leaders noted that unstable housing limited the ability to follow patients and coordinate services. One reported that when housing is a problem, clients will turn to the emergency room for shelter.

One of the major challenges that makes the care coordination difficult is homelessness. So when you can't reach the client ...all the beautiful planning that goes into it doesn't materialize when you can't get in touch with the client.

We have a tremendous amount of the population who do not have permanent housing, and when you have a transient population, the emergency room tends to become a respite shelter of sorts.

Income and Employment:

Lack of money and difficulties finding employment were concerns linked to problems with housing, safety and transportation. One patient said:

Finance is always an issue because if you ain't got no money, and you got to be places [it is difficult]

Another said:

And my finance is stressing me out...I'm broke all the time.

Several providers believed that unemployment influenced their clients' eating and exercise:

I think for some of them it would be the job and monetary portion. Um, because for most of, you know, some of the clients and their health, um, their eating habits, um, and ah, maybe, their exercise habits tend to become pretty dependent on the monetary portion. And, then with them not having a job, or things like that, and not being able to eat right."

Family Demands

Some patients cared for an adult child or their own parents, in addition to children or grandchildren. While they generally accepted their responsibilities, the demands of caring for these individuals were amplified by limited financial resources, transportation and housing. These extra demands intensified their own stress or as one man said his "trials and tribulations". A man described the difficulties his mother faced and the stress of caring for her:

...my mother's 74. I get disgusted. I get disgusted because living with what I'm living with, I have all these things, all these uh, uh, how you say? All these avenues accessible and being that she's a senior citizen, she doesn't have those accessible, those, those avenues accessible to her, you know what I'm saying? And um, it burns me up. It really burns me up because you know, I, I'm the eldest and I do, I take my part on as the eldest you know, I go over there, I do her shopping and I pay her bills for her and but now she's in a process of getting removed because she had fire in her building and so now she, she's lived with, she lived for 41 years.

Another problem related to family demands or problems cited by the providers in one focus group was elder abuse and neglect. They reported that a typical situation involved families in which an adult child depended upon a parent for financial support and housing.

The way she's spending the money on daughter, grandson and stuff and then she's often I don't have the money to eat, I don't have the money – and now daughter went out, she got to move out, she got nowhere to go. It, it's stressful.

Themes unique to the patients

Four themes emerged that were mentioned by the patients only: a) transportation; b) safety; c) racism; and d) social isolation.

Transportation:

Several patients mentioned difficulties with transportation, particularly to clinic appointments or other services. Many noted that they had to take multiple buses or trains, and those with mobility problems found it difficult to take public transportation. Several commented that clinics formerly offered transportation to visits but this service was terminated. Concerns about neighborhood safety also limited the viability of public transportation for some.

In response to lack of useful transportation, one said that she used a car service to get to her health care visits. Another reported that her concerns about security in her neighborhood did not limit her access to healthcare because she would call an ambulance in an emergency – suggesting that her preventative care visits were limited by lack of transportation and security, leaving her to seek care in an emergency and via ambulance – a costly form of transportation.

Safety:

Concerns about the safety of their homes or neighborhoods were raised in a number of the focus groups and interviews with patients. They worried about “youth in the streets”, rats in their apartments, and robbery and assaults. Several reported feeling that the police were unresponsive to problems. As one said:

So I feel like, I have five kids and I'm like wow, I got to be constantly like thinking about I have to protect my children. My husband got robbed right in the house, in our house and it was 5 p.m. broad daylight. That was two years ago and nobody did nothing. Nobody did nothing, you know, people saw it across the street. They came in bikes, they put a, a, knife to his neck and took his jewelry and his wallet and nobody know nothing, nobody did nothing you know, and even the police, when we try to catch the perpetrators, they didn't help us. They didn't, they don't help us.

Racism:

One patient focus group turned to a discussion of racism which they described as a source of distress for them. For example, a woman in this group commented that she was upset by police profiling which reflected a general racism.

I'd say for me that lately it stresses me out, there are a lot of, the prejudice going around because you can't help it but notice in the news and everything and like they're talking and a lot of people you know, that is a black or Spanish and I feel like they're creating a society of people that's paranoid, angry, and bitter because it's just like it's on the rise.

Social Isolation and Loss of Independence:

Several patient participants said that they felt isolated from their family or community, in part because their disabilities made it difficult for them to get outside and socialize. They were dependent upon aides to get out and they had limited hours for homecare.

3) CRITICAL HEALTH CONCERNS OF PATIENTS

As reported by patients and providers, asthma, diabetes, hypertension, chronic pain, problems with vision, arthritis, obesity, HIV/AIDS, Hepatitis C infection, substance use disorders, anxiety and depression were common concerns for individuals living in the South Bronx. Some patients reported that these problems worried them or limited their lives while others felt that they were coping well. For example, one man described a long list of problems but also said that he felt he was doing well, in part, because he was going to his appointments:

For me, I got a lot going on, like I said. Uh, diabetes, high blood pressure, um, GERD, acid reflux, uh, I have an enlarged prostate, ulcerative colitis, um, and I also have Hep C. So I have a lot of issues. I have a lot of issues, and I got a lot of stuff going on on any given day. Exhaustion, fatigue, um, like I said, the pains, um, just a lot going on. But I would have to say that I've been doing pretty good with all of it. .

It should be noted, that while this individual thought he was handling his health needs adequately there is evidence to suggest that many patients, particularly Medicaid patients, tend to overestimate their health status and how well they are doing with self-management.

The providers reported that their patients who experienced mental health, substance use disorders, and homelessness appeared to be more immediately focused on social, financial, and housing concerns than on their health. This is not surprising given the more immediate requirements of basic needs compared to caring for a chronic health condition. Their younger adult patients generally minimized their need for health care, as one provider explained

You know, they have a whole bunch of other things going on, and [they are] just like, "No. I can take care of it myself... I understand the benefits of it, but I think it's something I can handle"

In the view of the providers, developmentally disabled populations were similarly concerned about behavioral healthcare, housing and financial needs. The dental care providers observed that while adults sought care for their children, they tended to overlook their own dental care.

The providers felt that many of their clients faced continual challenges and crisis in their lives, and the patients were unable, for a variety of reasons, to prevent or limit these problems. This made it more difficult to focus on preventative care and health promotion.

I think so many of our clients sort of live from crisis to crisis, so sort of making an effort for the preventive – I mean – and we see that at the health level, physical level, but even somebody waits until the day they're about to be evicted and then they'll come to us. I

mean it's sort of just like you're okay – not okay, but it's just something that – you know, that's just become the norm.

4) CONTINUITY OF CARE

Poor continuity of care and the challenges providers faced to ensuring continuity of care were significant concerns voiced by patients and providers. The concerns included: a) multiple providers treating a patient; b) poor transitions across care settings and follow-up; c) structural factors that affected the quality of care coordination such as funding streams, sharing patient information, overburdened case managers and communication between providers.

Multiple providers treating a patient

Patients were frustrated by having multiple specialists and with the frequent turnover in providers.

...they change something like every six months or every year. So then I got to deal with a – a new doctor all over again.

Others were unhappy because when they went for a visit they saw a “technician” and not the doctor or had to see both, taking up extra time.

Well, when I go to see her, I need to see her and not a – and not a technician

For some, continuity in care was lost when they were required to move to another area. For example, one patient who had chronic pain said that she had difficulty getting her medication when she moved to a shelter and had to find new doctors.

...it was horrible just like I'm so far away, um, I haven't had any pain management in like three to four months, um, because of my situation – me getting – being able to get from where I am now to where my doctor was at, which caused a problem with the doctor and I because there was no communication.

Providers also raised concerns about inconsistency across the multiple primary care doctors and specialists, in addition to nurses and physicians assistants seen by their clients. This made it difficult to coordinate care plans and for the patient to get consistent instructions.

Their primary physician. We'll get one initially and then get in the home and find another one, and another – you know, like they sometimes have different doctors. But like all primary care doctors, not like a primary care, cardiologist. That's different when you've got three different doctors. But when you've got three primaries, it's a little hairy. It's a little crazy. So the nurse will do the assessment, and she'll supervise the aide. She formulates the care plan, whatever's going on. They figure out the hours with the patient or the family and the patient

Poor transitions across settings and follow-up

A number of providers viewed ineffectual transitions between care settings as a significant failing of the system.

I mean, first and foremost, I think I'd like to see, um, better coordination of services. Whether it's our outpatient, um, mental health and substance abuse services, or primary care. Our adult day health. When people are being released from the hospital, I would like to see really improved – uh, better improved care coordination among all those other services that we provide. The way things are happening now is we often find our clients are getting out of the hospital when sometimes two, three weeks, four weeks after, and we missed that opportunity to really make sure that there's um, there's after-care provided. So we would love to see that, and that's what we're hoping for.

One provider noted that the lack of “seamless” care was related to avoidable ED visits or loss of housing.

...connect with everyone in a way that is more seamless and less, um, disruptive so that we can, you know, avert emergency department visits and homeless shelter stays and hunger and, um, just a couple of little things.

Another area of concern for the providers was the ability to keep track of patients following discharge from a program.

Um, the other – I guess, maybe then, would be the challenge would be those who do become – They have graduated and are discharged from the programs. It's keeping that contact with them. So, maybe, that would be my biggest challenge, um — for a nice little chunk of those who are enrolled in our health home, is being able to keep in contact with them after they have been discharged from the program.

Structural features affecting the quality of care coordination

A number of factors affected the providers' abilities to coordinate services.

1. Funding streams and databases which differed across providers made it difficult to for providers to collaborate in the care of shared patients.

I think that's a challenge internally and externally. And I think it's – part of it is that we all sort of have – you know, separate funding streams and requirements and different databases and so it's even hard just like technology-wise to figure out a way to even know if someone in this program is receiving services – you know, with somebody in that program. So internally, I think that's a struggle but also for us to coordinate with external agencies. And I think each of us, in our own programs, have figured out other agencies that we have partnerships with that work well, but that's certainly – not across the board. And that remains a challenge.

2. A provider noted a need to create a shared system for recording patient assessments and documenting services

Take more flexibility with documentation, like sort of coordinating what it is that we're assessing for; having more of a universal tool that could be shared among providers. But I think that's one thing that really separates us, is I have to do this form and that form,

even if you're assessing the same information, it's in different ways. And if you could sort of have a more universal tool that we had more control over to develop, I think that would be helpful.

3. Some providers noted that some clients appeared to be receiving services with more than one care coordination program simultaneously. They attributed this, in part, to inter-agency competition for clients.

But also I think just sometimes our clients aren't going to tell us they're working with someone else. You know, let's say someone – they have an ACS case. A lot of times we don't know. We might accidentally find out, but it's up to – it's not always information shared so I might not even know I need to talk to Michelle except that, you know, a case manager for our program sees the client, like: wait, what are you doing here? We don't have an appointment. Like: "Oh, I'm here to see my other worker." That kind of thing. Because some of our programs are such that people might not want to share.

4. Case managers said they felt overburdened and wished for smaller caseloads so that they could offer more individualized care.

...treated [with] more individualized and find a way to deal with that because then, we can pay attention to the little things that we might miss having such big – big caseloads.

5. Providers working for programs co-located in a common building appreciated the proximity to their colleagues because it enhanced their collaboration and communication.

I think my experience with the eviction prevention program has been really good because we share the same floor. So when there are questions that we have, or families may have, I can literally go to someone – walk over and ask. And vice versa; there's been times when families are meeting – doing a screening – and they will walk to me and ask me to describe the scenario. And then I would screen to see if they are appropriate for our program and then refer accordingly. So because of the proximity of the two programs and that we share a similar space, it's very convenient for us to correspond with each other. Whereas with a program that may be in a different location, calling a point person and having them available will be very different. So we're fortunate that we're situated right next to the eviction prevention program...

5) PATIENT-PROVIDER COMMUNICATION

Many patients complained about difficulties in communicating with their providers. They described five sources factors that led to poor communication: a) providers used difficult terms or unclear explanations; b) patients were given inadequate time with a doctor during a visit and the doctors did not appear to attend to patients' individual concerns; c) translation problems; d) some staff were perceived as being disrespectful to patients; and e) limited familiarity or experience with an individual provider made patient feel uncomfortable talking to a provider and asking questions.

Understanding the provider

Providers use terminology that is difficult for patients to understand, limiting a patient's ability to comprehend his/her illness or the reasons for a prescribed treatment. While some said that they were able to continue to push the doctor for answers, others could not.

Well if it's not easy to understand, if I don't understand what they're saying, I'll ask them to explain themselves because I don't understand the terminology. Often it's the terminology or the words that they use that may be foreign to me, then that would keep me from understanding what relationship would it have to – with the problems I'm feeling or having, you know, and how does it work, and how with any medicine or treatment that I'm taking, what would it have to do with it, so I'm going to get the round about, you know, answers to it, even if it is resulting in some of the – you know, asking about some of the medicines that I'm getting, you know."

Inadequate time and attention from doctors

Feeling that the doctor was not willing to spend the time to answer questions or listen to a patient's concerns left some feeling disrespected or "disregarded" or not serving their needs.

Oh, it's another – it's another thing is like when you go to the doctor and you're being rushed because there's so much patients. And you feel like you're not getting the required time as needed, you know? You've got so much things you probably got concerns about going on your body, your health and you can't get everything out because it's like cut short: okay, give me a second, I gotta go see this person and I'll be right back with you. And by the time they get back with you, you forgot what you want to ask them, what you want to say, what's going on with you if you didn't write it down, you know, so yeah, I think that's a concern with me, as well.

In a similar vein participants complained that they felt that their providers did not always give them the services they really needed or treat them "fairly".

We're not getting the services that we need. We're not getting treated fairly and they're getting rich. That's what they're doing. We're getting you know, chump change in my opinion.

Some providers emphasized the value of tailored services that are consistent with a patient's own perceived needs or to help patients recognize their needs, and engage in the care they need is another challenge described by some providers.

You refer for a service that they find no value. So often times, like one of the things that I – I tend to pride myself on is that I ask families what they need and what they want, versus imposing what I feel will benefit them. So often times if ACS may make a recommendation for mental health services, and families feel like they don't have no issues, and they really – they'll say: "We don't have any issues." Then the mental health counseling appointment is going to get missed frequently because they find no value in it. So one of the things we have to do is kind of not impose how we feel, but find a

common ground where this may be of value to you; just try it out. So that happens quite a bit: missing appointments for mental health services is one of our biggest reasons why families might not go to appointments because they find no value in it at the time we recommend it, initially.”

One provider noted that clients were less comfortable talking with their doctor, in part because doctors appeared to be in a hurry and didn't listen carefully to what a patient had to say.

I mean, the patient and provider – maybe they aren't that comfortable. Or, either, do you know if they may be rushing them? Maybe that provider has too many patients that they just see them; they hear them, but they don't hear them... You know, they may not be real help, just here. We also serve clients, you know, they've mentioned things like that. The doctor not seeming like they have enough time, or. Um, as soon as you just, say that, you're actually finished explaining what is actually going on, they're ready – they already have an answer for you. So ...So, that leads to them not having that good relationship, then, to be able to listen to what they're actually saying.

Translation problems

Patients whose primary language was Spanish complained that many of their providers did not speak Spanish and that inhibited their communication. One worried that interpreters were not accurate in their translations.

I immediately am talking with the doctor, well if they talk like I do; if they talk English I shut down because I can't talk English, not a word.

The providers said that they made efforts to provide language services to patients who did not speak English. A number tried to assign a patient to a provider who spoke the patient's language. In other cases they used telephone translation services or found another staff person such as a receptionist or assistant to help with translation.

Disrespect

Patients expressed frustration with what they called “bad attitudes” demonstrated by reception desk staff. They felt these individuals were rude or ignored patients who had to wait while staff chatted amongst themselves. This felt disrespectful and made their visits unpleasant. A participant said:

I would send them somewhere else, and I would put someone else there that does know how to interact with people – how it should be done.

Familiarity Improves Communication

Providers noted that their clients tended to ask more questions of their case managers and social workers and fewer questions of their doctors. They observed that as patients gained familiarity with a provider through consistent contact they were able to ask more questions and better engage in their own care.

You know, it's interesting. Um, they tend to, ah, open up more, and ask more about their health on the second visit than on the first visit. The first visit is a, um, is a romance. Getting to know you a little bit; feeling it out a little bit. You go home. When the anesthesia wears off, you go, "Oh. This doesn't hurt. I'm going to go back again and ask the doctor about this, that, and the other thing. And, I don't know what the doctor said about smoking. I can't remember what the doctor said about this medication, and how to fix my gums, and my heart, and, all these things. I'm going to ask him again, because now I feel like he's my friend."

6) ACCESS TO CARE

Patients, providers and organizational leaders described three types of barriers that affected patient access to care: a) problems with scheduling a visit; b) long waits and crowded waiting rooms at scheduled visits; c) treatment models that limit missed appointments.

Problems with scheduling and reaching a doctor

Access to mental health services was a problem noted by providers and organizational leaders. This included long waiting periods to get mental healthcare or medication. Several providers saw this as a problem linked to housing instability. For example, a provider from a multiservice agency noted:

A lot of times we'll run into people who are just newly homeless because there's a psychiatric issue that a person has that clearly hasn't been diagnosed, much less gotten to the point where they've been able to get treatment. And even when you try to get somebody treatment in the community, the services are just not there. The few places that provide mental health services, they have waiting lists and that kind of thing. We do our best to provide for our clients ourselves, but even our resources are limited in that area. We even find it difficult to procure a psychiatrist on a part-time basis. So for me, that's the biggest, glaring need. Hard to even find a close second for that.

An organizational leader described delays in receiving services and medications for patients who are awaiting Medicaid approval.

Clients are often being serviced when they're Medicaid pending, but many times pharmacies don't give out medications, especially costly medications, for clients who don't have active health coverage...It can take up to 45 days for a client to turn a pending Medicaid into an active Medicaid.

Patients complained of difficulties reaching a doctor to ask questions about their care. Some found that it was difficult to talk with a doctor because the doctor would not answer questions by telephone requiring them to take time off from work for an office visit.

She won't discuss anything over the phone so like I gotta take the time off, take off from work to go in and ...

Keeping track of multiple appointments was a challenge for some patients, in particular those who had transitioned out of in-patient treatment or those for whom even basic organization is challenging:

..a friend of mine in recovery, when I came out of treatment, gave me a little appointment book, a little leather bound appointment book, so whenever I had appointments, I would write them down for each day. That way, if someone else – I had an appointment somewhere else; I wouldn't schedule it on the same day. I would just look at my appointment book. So that helped me my first three months when I came out and I was here, um, because I had become overwhelmed with appointments, and I was missing appointments, um, showing up late because I had forgotten about it and suddenly remember.

Long waits at scheduled visits and crowded waiting rooms

Patients noted that they had to wait too long to see a provider at a scheduled appointment. In the view of one woman, these long waits and crowded rooms occurred because the clinics scheduled too many patients into one time slot. In her mind this conveyed a general lack of respect of the patients' time and needs.

Don't give us all the same damn doctor's appointment the same time if you're gonna see all of us at one time. That aggravation, that as much time, people have gotten crazy. Please don't you go deaf on people.

In addition, a number complained of crowded waiting rooms.

When I go to my primary, I always try to get there first so this way I'm not waiting a long period of time because that PSI gets crowded. Other programs come there, and it gets real crowded. If you get there late, you can wait for a long time. I do not like waiting. So I get there first.

A patient in one group wished that the “mobile unit” still served her community because it was easier to see her doctor when it was available, perhaps because it was easier to get to a local van than to a more distant clinic and also because seeing the van in her neighborhood prompted her to make a visit.

And that helped, that encouraged me to go see my doctor more, you understand what I'm saying? And I feel that in that area, that, that should be addressed, bring back the mobile unit because it works.

Treatment models that limit the number of appointments a patient can miss

In the view of some providers, treatment models limited patients to a certain number of missed appointments were punitive and not helpful. These models did not account for the complex lives of these patients.

I think just more flexible services. You know, with complex populations, it seems like there's a treatment model if it's substance abuse treatment or mental health treatment. And as soon as you miss so many appointments, then you're no longer eligible, and just

sort of understanding that this is a complex population with a lot of trauma. And so then missing appointments or sort of having certain behaviors are expected. But it seems like programs can't be flexible because of all the different funding streams. And so it's rare to be able to find mental health providers, substance abuse providers, medical provider, GED, school because everyone has got all these really firm restrictions that doesn't necessarily suit a population that has most likely experienced trauma very well.

In sum, these patients repeatedly emphasized their perceptions that services were hard to reach, difficult to understand, inconsistent, and inadequate in scope to meet the various challenges they face, which go far beyond healthcare or even health itself.

7) ENVIRONMENTAL FACTORS

Patients and providers were asked about access to fresh foods and exercise among individuals living in the Central and South Bronx. Access to both was a problem for many. In addition, some patient raised concerns about exposure to second-hand smoke in their neighborhoods.

Fresh foods:

The participants were asked about eating fresh foods. Most knew that they should try to eat fresh foods and vegetables. While some said they did not find it difficult to get fresh foods, others reported that the high cost of fresh foods limited their intake.

Yeah. I know how to cook, it's just, you know, still, like I said, some things cost money. Like you go buy four peppers, and its \$5.00 sometimes, \$4.00. It's a lot of money for peppers.

Others said that they tried to do the best they could but they said they “cheated”; some reported doing this to cope with drug cravings.

I cheat a lot because I, bags of candy, ...I'm really saying bags, bags, two and three bags a day. So I cheat but I can't help it. I, they say when, when you drop a drug, you pick up another habit, but I've got my crack junk, I've been clean what, 11 years?

Like the patients, the providers were asked about access to fresh foods and exercise. Providers in one focus group discussed the possible value of offering Meals on Wheels to patients who are eligible for food stamps. One provider commented that patients don't want this service, but another countered..

Yeah but it's better to know they have something in the house than to know that they don't have nothing at all and, and some, and it was some, some of the times, the food that's in the house is junk. I'm only seeing a cup of coffee, potato chips.

In this way food insecurity is closely related to obesity and, ultimately, diabetes.

Exercise:

Like eating fresh foods, the participants were well-aware that exercise would benefit them but most reported finding it difficult to exercise for various reasons. Some said their ability to exercise was limited by pain and stiffness. Others said they would like to walk in the park but believed that the parks were unsafe. One said “*I’m scared of the parks*” (UH). Several said that they would like to join gyms but said that membership fees were too expensive.

Given the limited financial resources of the patients, a provider suggested offering free fitness classes. [Quote about how other priorities make this a real problem too]

Second hand smoke:

Patients in one focus group mentioned their concerns about cigarette smoking in public areas of apartment buildings and throughout the Bronx in general. They worried that smoking was particularly bad for their children or grandchildren with asthma. They commented: *It’s in the elevator, a lot of smoke.....In every hall...That’s in every community in the Bronx.*

8) RESOURCES AVAILABLE TO PATIENTS

The patients drew on a mixture of resources to obtain information about services or benefits. Some turned to family members.

I call a cousin because I’ve been here for a short time, I don’t know much, and so she knows how to inform me about things, and she resolves it.

Others said that when they needed information, for example about their social security or insurance benefits, they used to turn to a social service program which has since been shut down. A single place to handle a myriad of problems, including legal aid, would be most helpful:

Well, in my community, they have this place, it’s called – I want to say it’s One Step or something in that nature, where you can go to them and you can explain, you know, I had this problem. If you were getting evicted or stuff like that, that they will help you find a lawyer or someone that can say: okay, go to this place, or these people can help you. You get a referral from there. But you have to be working or you have to have some type of income to show that you’re able to pay monies back if necessary, or if you know, they’re going try to find someone to help you to deal with your whatever issue it is that you have. But that program closed down.

They now call 311 but wished there was a more comprehensive program that would provide legal referrals and social service information.

Some found it difficult to know how to find help or obtain information. A woman described difficulty figuring out how to enroll her children in school, find housing and locate healthcare.

...my mother was trying to show my brothers and my sister to the school – to the area, because it’s really far from over here. And they had to wait to next year to go...because

they don't have no [inaudible] to put the childrens over there. And the room is already full. And for houses, she don't find really a lot of house. Because we have a problem with [inaudible], that's why we moved [inaudible] so they don't have someone to help you with that. And hospitals, she hasn't found one here. And most of the stuff, they're clearly not close.

The participants used formal sources of care such as home health aides, care coordinators, meals on wheel, and social centers for support and services. Several described attending support groups or talked with their peer mentors to deal with stress or other concerns.

Those who had a case manager, care coordinator or aides expressed mixed feeling about their care. Several described instances where they felt the coordinators were unreliable or made mistakes with scheduling appointments while others were very happy and reported that the care coordinators were helpful. One man observed the following about his experiences with his current and former aides:

... he's not only very competent, he's not very or not also very positive and active, he happens to be a very friendly person. And I think that means a lot. Now, I have to admit, many aids who are a part of the organization that have not been very friendly. As a matter of fact, I have met aids where I did not want them to be in my house.

FINDINGS – PART B: THE PPS

This section describes the views of patients, providers and organizational leaders about the emerging PPS. It covers: 1) reactions to the potential PPS projects; 2) necessary improvements to the healthcare system; 3) challenges for the emerging PPS; 4) the strengths of the BLHC PPS; 5) the benefits of participating in the BLHC PPS, and 7) what member organizations believe they will bring to the PPS.

1) VIEWS ON POTENTIAL PPS PROJECTS

At the conclusion of each session, participants were asked to comment on five potential PPS projects areas:

- 1) Improving primary care and support services for patients.
- 2) Home programs to help patients with asthma manage their condition
- 3) A program to decrease HIV/AIDS in the community
- 4) A program to promote mental health in the community
- 5) A program to reduce premature births

All of the patients who commented said that the list was reasonable but were most enthusiastic about programs to address HIV/AIDS and mental health.

HIV has gotten – gotten out of control. And like the best way you can like teach people is through education, you know what I'm saying? Some type of, you know, program or whatever like that, you know.

I like that mental health one.

They suggested other areas including programs to address obesity or teenage pregnancy. A man talked about the need to teach coping skills and providing better access to legal aid.

Stress, coping skills, these things are important, stress, coping, the things that previously I was thinking about, I mean that I wanted to mention previously, you know, stress, coping skills, behavioral, how to deal with those things, you know.

But I think people just need to know, and how to have access to, yes, have access to legal aids, access to it, not just to know that they are there, but easier access to these programs to where they can tell somebody of their problems, or who they can go to to get real aid for their problems. If they have a problem with their lawyer, I mean problems with their landlord, problems with the doctor, or somebody, that they can go to. People feel lost because they can't go to – but some other [inaudible] down the street that's gonna tell them, I'd shoot that guy, you know what I mean, you know, stupid things, you know, and they get mad enough and they're hyped enough to just think of violence rather than to deal with something intelligently, and you know

The organizational leaders interviewed reacted favorably to the range of projects presented.

[the list] is very much up our alley. Our expertise is in AIDS services, behavioral health, wellness model combined with chronic disease management. So I think we are at a good starting point there...

Two recommended developing projects that focus on substance use disorders.

I think the substance abuse treatment and the recovery services are also very important because when we deal with (these) clients or patients who are the high-risk and high-need patients, they have a multitude of challenges.

2) NECESSARY CHANGES TO IMPROVE THE HEALTHCARE SYSTEM

The organizational leaders described two changes that must occur in order for the PPS to improve care.

Technology/EMR Interface:

The need to improve systems to share an individual patient's records between or among the providers serving that patient was raised by respondents multiple times throughout these interviews. One respondent noted that this will be a costly endeavor requiring adequate funds to support the work:

You have to designate sufficient resources. And a lot of it is going to be about IT, having the right EMR, the right interoperability with the other systems.

Workforce Development:

Two respondents noted a critical need for training and workforce development to support coordination and integration of care, particularly in the area of behavioral health care.

A lot of times we need a level of training and education to make sure that everyone understands the value of working on a treatment plan which incorporates both the physical and the mental health

There is definitely going to be a need for workforce development....cross training—people becoming proficient both in behavioral health diagnoses and major issues, and primary care, possibly specialty care – those referrals. So the knowledge base of the care coordinators and the professional staff will need to expand

3) CHALLENGES FOR THE EMERGING PPS

The organizational leaders described five possible areas of challenges for the PPS and partner organizations: a) ensuring adequate central resources to support the PPS; b) establishing collaborative governance; c) bringing together diverse perspectives on care while maintaining the integrity of specific practice areas; d) developing shared quality indicators; e) effective use of patient data; and f) adapting to payment reform.

Central Resources to Support the PPS:

One respondent emphasized the importance of dedicated resources within the PPS and member organizations to carry out the work of the PPS:

I think that this is going to be a lot of fulltime jobs are going to be created around the PPSs, making sure that we have the right people focused on these relationships . . .it goes back to the time commitment, the resource commitment, and the cost commitment that it's going to take to ensure that the PPSs have the right infrastructure, the right personnel focused on it day in and day out ... They have to have staff working for the PPS. And the health plan has to have dedicated resources to support the data needs of the PPSs as well.

Establishing Collaborative Governance:

Participating organizations will need to find “common ground” and mutual benefits for all members within the PPS. While governance could be a challenge as former competitors become collaborators (especially managed care plans), some suggested that the health home may provide a model for barriers and successes in governance structure. One respondent suggested that an organizing structure similar to a board of directors with various subcommittees is also a potential model.

... It can't be that one party is benefitting and the other one is losing ...It has to be an arrangement that is going to be a win-win for all. So in that sense, I think it will be less competitive and more collaborative.

One respondent worried that once the PPS is established, the hospital might fail to refer patients and share patient care with the collaborating partners, keeping most patient care for the hospital providers.

if we could figure out how we extend past the hospital, and ...all are part of the same network where we can have a level of exchange or interface between our system that allows us to track the patient, collect important data on each patient. And, more importantly, have access to the resources as it relates to specialty care ...We provide obstetric services – but we do not deliver. ...what I would love to see ...is whether or not the hospital is going to look outside of their OB folks--are they going to consider my OB folks where our patients end up delivering at Bronx Lebanon.

Bringing Together Diverse Perspectives While Maintaining the Integrity of Specific Practice Areas

One respondent noted that participants from service sectors other than primary care may bring differing perspectives to the PPS, which is desirable, but that primary health care providers will have to continue to advocate for their value.

...you'll have folks from the home care, folks from nursing homes, etc. And, while that has a lot of benefit because they need to part of the larger medical village, what ends up happening is that their ideas are so different of the ideas of the folks in primary care, and/or their recommendations, or their goal, is quite different than the goal of someone who's on the other side of the industry..

Developing Shared Quality Indicators

One respondent spoke about quality improvement and the need for common performance measures.

We have a full-quality improvement committee ...but sometimes as we define quality – it's not always as others would define quality ...what are all of the indicators? What are all of the programs that we will be participating in? And what are all the expectations—to make sure that the expectations of the hospital-based PPS are (ones) we can meet.... and specifically, that we can measure

Effective Use of Patient Care Data

One leader noted that the PPS members will have to learn how interpret and use data to guide PPS plans.

[One challenge is] going to be exchanging of data and explaining the data and putting it in a format that the PPSs can understand ...guiding the PPS to where the problem areas lie ...a lot of the PPSs probably [aren't] experienced analyzing managed care data.

Creating a system to share patient data will be complex and require extensive resources.

...going into this PPS ...there is a new interface, or exchange engine . . it could be a barrier because there's just no way that the PPS – or, I should say 'the hospital' – is going to pay for it. So, there's still going to have to be some level of configuration, customization costs, in order for my data to flow into this respective new exchanger engine...I would be concerned that some of the other folks that are (at) the table may not be able to...(have resources for) the full cost of it

Adapting to Payment Reform

One respondent anticipated that changes in payment reform will be “in constant flux,” and that will be a challenges for all organizations involved in providing care.

We are in the middle of a transformation of the healthcare system on all levels through the Affordable Care Act, coming through changes on the state level with the transition to Medicaid managed care, there are new insurance products that are going to be introduced, there are new organizations like ACOs that are being formed. So there are going be constant industry changes for the next couple of years

Keeping up with these changes will require maintaining strong relationships with payers.

Truly our challenge ...when we finally come out at the end, is making sure that we personally have a strong relationship with our managed care companies – because at the end of the day, the payers are the ones that are going to really, still, have a strong say as to what's going to happen

The upcoming changes with a PPS will require substantial infrastructure expenses on the part of the partnering organizations including costs for IT, medical health records, and billing systems. The challenge is that these expenses are occurring at a time when nonprofits are attempting to reduce

administrative overhead yet are expected to develop expertise and proficiency in these infrastructure areas. Reimbursement only for direct services, and not infrastructure costs, is a concern. One organizational leader characterized this environment as one of “competing priorities and not enough financial funding”, noting:

in the social services world, you are mostly reimbursed for direct services. But you have to have the infrastructure to provide all of that. There’s a whole layer of compliance, there’s a whole layer of IT, there’s a whole layer of interoperability that is expected with outside providers. We all have to develop basically that infrastructure, and that is at big cost.

4) STRENGTHS OF THE BLHC PPS

Some organizations participating in the BLHC PPS are also participating in other PPS’s. When asked about what they saw as the comparative advantage of the BLHC PPS to other PPS’s they focused on two specific benefits: a) a collaborative culture; b) the ability to build on the existing BLHC health home.

Collaborative Culture:

Several respondents were pleased with the collaborative nature of the BLHC PPS.

You do feel that everyone is working and aligning themselves toward these respective goals and it seems like folks in the Bronx Lebanon (PPS) are very committed to the process. So, you consistently see the same people, the same faces coming to the meetings ...we've had better discussions in the Bronx Lebanon PPS . . .and we are a lot more ahead of the game, and better prepared for the December 16th deadline (DSRIP Project Plan application due date) than the larger structures I've seen elsewhere

One leader thought collaboration was stronger in this PPS, in part, because only one hospital was involved which minimized concerns about competition among all of the collaborators.

This is one of the few PPSs that I've seen where, you know, it's a lot more collaborative. And, I think it's what the State was looking for. And, I think that's been achieved in this PPS. But I think it's being achieved right now because it's only one hospital player at the table. I'm sitting in at least one other PPS where it's a little bit tougher because it's not one hospital player—it's several hospitals ...I feel that in the meetings it's a lot more collaborative (in the BLHC PPS) because I think there's not that air of competition

Building on the existing BLHC Health Home:

The respondents were familiar with the BLHC Health Home, and saw an opportunity to expand those services through the PPS. The prospect of serving patients not currently eligible, by providing access to primary care and support services, appealed to one respondent.

the health homes, I would say that's important. Because I think the State of New York is expecting the health homes to have a major role

5) ANTICIPATED BENEFITS OF PARTICIPATING IN PPS FOR PAC MEMBERS

The organizational leaders had specific ideas about how their participation in PPS would benefit their own organizations including: a) improved focus on primary care and care coordination; b) expansion of the health home model; and c) the opportunity to implement evidence-based practices.

Focus on Primary Care and Care Coordination:

A long time provider of primary care in the community noted that:

We clearly see the value ...of primary care and its ability to reduce peoples' emergency room visits, and inpatient visits. So long as the emerging PPS focus on primary care, and care coordination, or what we call 'case management', then we could see the benefit as an institution to us, as well as to the community

Expansion of Health Home Model:

One respondent looks forward to the ability to expand the health home coordination model to conditions that are not currently included.

We would be able to expand on our Health Home Care Coordination program. It would add resources and expertise, and we would be able to contribute our expertise to it.

Opportunity to Implement Evidence-Based Practices:

Another potential benefit described by a respondent related to a PPS focus on evidence-based medicine:

We see that as an opportunity to shift how we provide service ... So, we could definitely see a benefit ...that benefit is ...a learning experience, or a reinforcement experience, wherein you realize that you've been doing a lot of evidence-based medicine, actually, for a while, and had great success. Or, you realize a new way of doing, or how to shift how you do medicine....on both ends, it could be beneficial.

I'm hoping that our affiliation with the PPS systems will enhance the quality of any outcomes that's going to be so important in terms of how the state reimburses the (health) plans going forward...making sure every member, receives the right level of service at the right time, and that hopefully will, in turn, improve our quality scores

6) WHAT PPS MEMBER ORGANIZATIONS CAN OFFER

The organizational leaders were enthusiastic about participating in the PPS and they had a clear sense of the value that their organizations would bring to the PPS and articulated their specific contributions including: a) a broad access to clients and services; and b) offering expertise in specific areas.

Broad Access to Clients and Services:

All respondents represented organizations that provide their services to other boroughs (and counties) in addition to the Bronx. A respondent described this advantage:

By us being there, we specifically bring in a slew of care coordinators that can assist with the targeted population, providing care navigation, and care services, allowing people to be navigated through all the services that they need, both in the Bronx [and] in the New York City area.

Offering Expertise

Two respondents whose organizations had extensive experience managing the full range of care required by their patients/clients noted that their involvement could help to improve the coordination of care across services.

We already have experience in the coordinating aspect – in the integration aspect. So the de-siloing of the different medical departments and behavioral health departments is very important for the PPS model. So we are already practicing that.

Two respondents said that their organizations emphasize patient-centered care through active patient outreach and tailoring services to individual patients.

We also have an expertise in reaching the clients in the community. This is also something that traditional healthcare models don't do. They have clients come to them, and we go to the clients...

We understand the idea of building services around the respective patient, and have that model be cyclical around the patient

One respondent talked about her organization's "peer coaching model"—which she described as a "non-traditional service" that is reimbursed inadequately, or not at all.

We have a very strong peer network and expertise. We also could contribute a peer training program because those services, which are sort of paraprofessional or considered paraprofessional services, are really needed in the PPS

One respondent indicated that his organization would provide:

"the data necessary to track the comings and goings of our members, so we'll bring to the table real-time data, accurate, that all the PPSs can utilize to see how they're doing."

BRIEF SUMMARY AND RECOMMENDATIONS RELATED TO PPS PROJECTS

Access to Stable and Safe Housing

The findings reflected substantial financial and social needs that were closely linked to the health and utilization patterns of the South Bronx community. The most notable of these was access to stable and safe housing. Barriers included high rents, unemployment, lack of credit, and poor handicapped accessibility.

Recommendations:

Institute programs to support patients with wrap-around services.

Improve access to legal services.

Co-locate housing programs with health care sites.

Continuity of Care

Primary care, specialty care, and social services remained, in most instances, functionally segmented or “siloes”. The lack of shared records impaired treatment planning and care coordination. Weak links between care settings caused gaps in patient transitions from in-patient care to community settings, and limited the ability of care coordinators to follow their clients after discharge.

Recommendations:

Establish clinics that offer “one-stop shopping”.

Establish shared records or interoperability.

Reduce caseloads for providers of high acuity or high risk patients.

Expand Health Home model.

Access to Care

Both patients and providers described limited access to outpatient care. Patients had difficulty making appointments and finding opportunities to ask questions of their doctor. They experienced long wait times at visits and crowded waiting rooms. Limited availability of mental health services was a specific concern for providers and patients. Patients needed more information about how to find services and other supports. Transportation to services and concerns about safety were notable barriers to care.

Recommendations

Offer clinic hours during the evening and weekend.

Increase availability of mental health services.

Provide car service to clinics, particularly during evening hours when patients may fear to travel.

Re-establish a mobile clinic.

Provide patients with information about a broad range of health and social services at the time of clinic visits.

Educate providers about available health and social services to promote appropriate referrals.

Consider systems to improve patient flow to reduce wait times and crowding.

Give patients more time with their providers during clinic visits.

Patient-Provider Communication

Patients were frustrated by what they viewed as poor communication with their providers. In particular, they felt that their doctors did not listen to them and they had difficulty understanding their doctors. This was compounded by the short amount of time doctors spent with their patients during a visit and difficulties in scheduling a visit or finding an opportunity to ask questions by telephone. These problems left them with a general sense of feeling disrespected and that they were not getting the care they needed.

Recommendations

Make clinics welcoming places where all staff members, from the front desk through to the clinician, are attuned to their patient or clients as individuals.

Institute training to improve communication with patients. This should include: using clear language; checking that patients understand what they have been told; and providing high quality translation services.

Promote patient engagement and encourage questions from patients.

Environmental Factors & Community Well-being

Patients were well aware of the importance of eating fresh food but were inhibited by the cost of available fresh foods in their neighborhoods. They also understood the importance of exercise but their opportunities were limited by concerns about the safety of parks and their neighborhoods, the high cost of a gym membership limited, and pain and stiffness. Second-hand smoking was also a concern.

Recommendations

Expand food pantries, farmers' markets, and Meals on Wheels.

Offer low cost exercise facilities with trainers.

Supporting families

Patients reported the demands of caring for adult children or older parents, and providers reported concerns about abuse and neglect. In addition, some patients mentioned feeling isolated from family and their neighborhood.

Recommendations

Establish community-based programs to support those caring for adult children or parents.

Institute culturally sensitive peer programs.

Offer ready access to social and legal services.

Provide staff training about abuse & neglect & options for intervention.

Workforce Development

Several themes emerged suggesting the need for workforce development including problems with patient provider communication, limited patient access to information about services and the expressed desire to learn and implement evidence-based practices.

Recommendations

Establish training to ensure effective patient-provider communication. This should include investing in intensive training in an evidence-based communication method (e.g., MI, IMR).

Educate providers on treatment planning.

Conduct cross-training on behavioral health to primary care, and primary care to behavioral health specialists.

Increase provider knowledge about available services and encourage patient referrals to social services and legal aid.

Disseminate evidence-based practices across collaborators.

Facilitate the sharing of practice skills across provider organizations.

Ensuring Success of the BLHC PPS

The organizational leaders who participated in this assessment mentioned several areas, which in their view were critical to successful implementation of the PPS. They included:

Recommendations

Promote a collaborative governance structure.

Shared data systems.

Determination by Leadership that an inviting, warm, and responsive culture will be the hallmark of this system in each project.

Cross agency learning opportunities with eventual sharing of staff.

Address mental health by expanding and integrating your workforce.

Limitations of this report

The short timeline required to complete this work limited the number and types of participants that could be recruited for this assessment. As a result, the information in this report does not reflect the full range of provider types. In addition, all of the patients who participated in this assessment were connected to services and their views may not reflect the views of individuals not receiving services.

APPENDIX A

PROVIDER GUIDE

PROVIDERS – Bronx Lebanon CNA interviews

Background

- 1) Would you begin by telling me a little bit about the clients/patients you serve
PROBE:
 - a. What are their most pressing concerns?
 - b. How do they rank their health needs compared to their social concerns?
 - c. How do patients evaluate their own health needs? Do they tend to minimize their need for care?

Challenges & Improvements

- 2) What are the biggest challenges you have providing care for your patient/clients?
PROBE:
Do you experience frequent cancellations/missed appointments? Do you see patterns (common reasons) for cancelled/missed appointments?
- 3) What are the most important changes that should be made to help you to improve the care you can offer?

Relationship with patient

- 4) Do you communicate with patients in their primary language? How do you communicate if you do not speak the primary language of a patient?
- 5) Do patients ask questions about their health?
- 6) Do patients usually attend appointments on their own or with family support?

Social determinants

- 7) Clearly everyone understands the fundamental importance of the social determinants of health. What do you think needs to be done to address the social factors most impacting the health and wellbeing of your clients?

Resources needed

- 8) What resources would help you to better serve your patients/clients?
PROBE: Money to do what?

Existing external resources

- 9) To which organizations or services do you refer your clients most frequently?
- 10) What services do your clients/patients need to access that are difficult to access?
FOR EACH:
 - a. What are/is the difficulty?
 - b. What would "improved access" look like?
- 11) Do you interact much with health home?
- 12) What can be done to make it easier to work with care coordinators?
- 13) What, if anything, have you heard about the PPS?
- 14) Explain the PPS. The following is a list of programs proposed for the BLHC PPS [show list].
What do you think of this list?
 - a. Are there key areas that should be added to this list that, in your view, are more critical than the areas already listed?

PATIENT GUIDE

I. PATIENTS/FAMILY MEMBERS

My name is Corinne Warren and I am calling from Researchers Resource on behalf of the Bronx-Lebanon Hospital Community Needs Assessment. We set up this interview time in advance--is this still a good time to talk?

As you probably know, we got your name from [name of organization] I would like to interview you for this community needs assessment. It is important that we hear from patients about their health care needs and learn what they think about how the health care in the South Bronx can be improved. The interview should last approximately one hour.

I will be audio-recording the interview to be sure that we reflect your views and experiences accurately. The interview recording will be transcribed, and the written transcript will be used for analysis and summary. Do you have any questions before we begin?

TURN ON THE RECORDER AND STATE THAT THE RECORDER IS ON.

Background

1. Would you begin by telling me a little bit about yourself?

PROBE: How old are you? Where do you live? Where did you grow up? Do you have any children? Please tell me about them

Daily Stressors

2. Which of these problems impact your life the most?

PROBE: Housing (how far is home from medical care), safety (do you feel safe in your neighborhood, do you feel the structure of your home/building is safe)

3. Of the problems you described which are the biggest problems you face at this point in your life?

Health

4. Tell me about your health.

PROBE: Do you have any concerns about your health at this time? What are your concerns?

5. Now I want to ask you about your diet. How easy is it for you to get fresh foods (do you shop at supermarket or corner store)?
6. How do you prepare your meals?
PROBE: Do you prepare meals or do you eat packaged meals/fast food?
7. What about exercise. How easy or difficult is it for you to get exercise? Why?
8. Do you think exercise will help you to stay healthy? Why or why not?

Relationship with provider

9. Do you feel comfortable asking your provider questions about your health?
10. How easy is it to understand what your doctor or other people caring for you tell you about your health? Why?

Sources of Help

11. When you need help with [list problems mentioned] who helps you? Where do you go for help?

PROBE IF NOT MENTIONED: Housing, food, healthcare, children, education, legal concerns

12. Who helps you to take care of your health?

PROBE: Is there anyone besides Dr. X?
What about your [mention index illness – diabetes, HIV/AIDS]

13. What are the greatest difficulties that you experience in getting help for your problem?

PROBE: What about getting health care? What problems do you have getting medical care? How do you travel to/from medical appointments? Do you feel safe walking to/from/waiting for bus/train? Does traveling with infants/children deter you from attending medical appointments? Do you have difficulty paying for public transportation?

14. Do you have a care coordinator or case manager now?

PROBE: Who is this? What does this person do for you? How often do you see this person?

15. How important are religious or spiritual beliefs in helping you to take care of your health?
15.a. How do they help you?

Improvements

16. What changes in your care would make it better?
17. Other than the services you already use [list organizations, types mentioned in questions above], what would be most helpful to you?

PROBE IF NOT MENTIONED: Housing, food, healthcare, children, education, legal concerns

Views of PPS plans

18. The BLHC PPS is thinking about several projects for the South Bronx including:

- Improving primary care and support services for patients.
- Home programs to help patients with asthma manage their condition
- A program to decrease HIV/AIDS in the community
- A program to promote mental health in the community
- A program to reduce premature births

What do you think of these projects?

Are there key areas that should be added to this list that, in your view, are more critical than the areas already listed?

If they have further questions about the PPS they can contact:

Virgilina Gonzalez, Bronx Lebanon Hospital Center:
VGONZALE@bronxleb.org

A summary report of all the assessment interviews (no individuals will be identified by name) will be made available on the Bronx Lebanon website dedicated to its initiative. It will also be presented to the Bronx-Lebanon advisory committees that are involved in this initiative.

STEERING COMMITTEE/PAC GUIDE

I. STEERING COMMITTEE/PAC

My name is Corinne Warren and I am calling from Researchers Resource on behalf of the Bronx-Lebanon Hospital Community Needs Assessment. We set up this interview time in advance--is this still a good time to talk?

As you probably know, we got your name from the list of the PPS Professional Advisory Committee (PAC) members. I would like to interview you for this community needs assessment. As you probably know, the goal of the assessment is help the planning for the PPS by gathering information about how organizations serving the community understand the current gaps in health care for individuals in the South Bronx and what resources may exist in the community that can be linked together to improve care. I will ask you questions about your views about the plans for the PPS as well as questions about who your organization serves, challenges you encounter in providing good care, the social factors that affect the health and wellbeing of your patients/clients, resources that needed to provide better care, and to which services you refer patients or clients. The interview should last approximately one hour.

It is also important for us to interview front-line staff and patients or clients for this assessment, so if you are willing, at the conclusion of the interview I would like to ask you for the names of a few providers and patients or clients in your organization.

I will be audio-recording the interview to be sure that we reflect your views and experiences accurately. The interview recording will be transcribed, and the written transcript will be used for analysis and summary. A summary report of all the assessment interviews (no individuals will be identified by name) will be made available on the Bronx Lebanon website dedicated to its initiative. It will also be presented to the Bronx-Lebanon advisory committees that are involved in this initiative.

Do you have any questions before we begin?

TURN ON THE RECORDER AND STATE THAT THE RECORDER IS ON.

Background

I want to start by asking you about your views about the emerging PPS.

Expectations about PPS

- 1) Thinking about the development of the PPS, in what way would these emerging systems benefit your organization?
- 2) In what way do you think your organization will enhance these developing systems?

Challenges for Emerging PPS

3) What are potential roadblocks for your organization's involvement in any PPS?

PROBE: Financial concerns
Workforce concerns
Labor relations

4) What specific projects would most benefit your clients and which would you like to be part of?

PROBE: For example, projects related to:
Creating an integrated delivery system
Care Coordination of Transitional Care
Clinical Improvement (e.g. behavioral health, cardiovascular health, diabetes, HIV, , etc)
Population Wide Strategies

5) New York State envisions that these PPSs develop systems with shared governance among current organizations. This means that existing organizations will have to be much more closely involved with each other than they are at present. It also means that many organizations will have to come together to form new organizations. What do you think about these changes?

- a. Do you think it is feasible
- b. What if anything worries you about this idea?

6) How would you suggest that these organizations come together? How would these organizations develop agreements with each other?

Impressions of PPS plans

7) The BLHC PPS has discussed several different projects.

- Health Home at-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Home through access to high quality primary care and support services.
- Expansion of asthma home-based self-management program
- Comprehensive strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for management of HIV/AIDS
- Promote mental, emotional and behavioral (MEB) well-being in communities
- Reduce premature births

What do you think of these projects?

Are there key areas that should be added to this list that, in your view, are more critical than the areas already listed?

DSRIP involvement

- 8) Which of the emerging DSRIP PPSs has your organization affiliated with?
- 9) Based on your knowledge, what do you see as the main differences between [name of other PPS(s) affiliated with] and [name BLHC PPS]?
 - a. What, if any, would be the advantages and disadvantages for your organization to participate with each of them?

Social determinants

Changing the topic to a more general area, I wanted to ask you about social determinants.

- 10) Clearly everyone understands the fundamental importance of the social determinants of health. What do you think needs to be done to address the social factors most affecting the health and wellbeing of your clients?

Challenges

- 11) What are the biggest challenges that you see currently for your organization?
- 12) What about going forward, what challenges do you anticipate for your organization in the future?

Resources needed

- 13) What difficulties, if any, do you experience connecting your patient/clients to services outside of your agency?

Which are the most difficult services to access?

- 14) What resources would help you to better serve your patients/clients?
 - a. PROBE: Money to do what?

Existing external resources

- 15) Are you aware of any already existing programs or organizations in the South and Central Bronx that could be enhanced to better serve your clients?
If yes, Who are they?
In your view what changes would help to enhance their services for your clients?

Providers and Patients/Clients

Can you suggest providers or patients/clients I can contact for an interview?

Get name and contact information

If they have further questions about the PPS they can contact:

Virgilina Gonzalez, Bronx Lebanon Hospital Center
VGONZALE@bronxleb.org

APPENDIX B

Organizational Sources of CNA Participants

Agency Name	Agency Function	Agency Address	Data Collection
Argus Community, Inc.	Substance abuse treatment	760 East 160 th St Bronx, NY 10456	Patient Focus Group
BronxWorks	Housing, case management, health home	1130 Grand Concourse Bronx, NY 10456	Provider Focus Group
American Dental	Large, multi-service dental practice	2535 Grand Concourse, Bronx, NY 10468	Provider interview 2 Patient Focus groups
Weston United/Bronx STAR	Transitional housing for people in recovery	3130 Villa Avenue, Bronx, NY ,10458	Patient Focus Group Providers Focus Group
Able Health Care Service	Licensed Home Care Agency	76 North Broadway, Suite 4000 Hicksville, NY 11801	Provider Focus Group
First Care of New York	Home Care Agency	2488 Grand Concourse Suite #332 Bronx, NY 10458	Provider Focus Group 5 Patient Interviews
Urban Health	Federally Qualified Health Center (FQHC)	1065 Southern Blvd, Bronx, NY 10459	Patient Focus Group
Community Healthcare Network	Federally Qualified Health Center (FQHC)	975 Westchester Avenue Bronx, NY 10459	Patient Interview
AIDS Service Center NYC	Collaborative Advocacy Organization	41 East 11th Street, 5th Floor New York, NY 10003	Patient Interview
Affinity Health Plan	Managed Care Organization	2831 3rd Avenue Bronx, NY	Patient Interview
Selfhelp Community Services	Home care, community services	520 Eighth Avenue New York, NY 10018	Provider Interview
Education & Assistance Corp	Mental health, substance abuse treatment	50 Clinton Street, Ste 107 Hempstead, NY 11550	Provider Interview
BLHC Steering Committee/PAC		Bronx Lebanon Hospital Center	2 Provider/Manager Focus Groups