Community Service Plan 2016-2018

Montefiore Medical Center

Office of Community and Population Health

12/6/2016

This document is submitted as the requirement for the 2016-2018 Community Service Plan through the New York State Department of Health

Montefiore Medical Center

Community Service Plan 2016-2018

Table of Contents

New York State 2016 Community Health Assessment and Improvement Plan and

Community Service Plan

Cover Page

1. *Identify County/Counties or service area covered in this assessment and plan*

This New York State 2016 Community Health Assessment and Improvement Plan and Community Service Plan are covering Bronx County, the northernmost county of New York City and the third most densely populated county in the United States.

2. *Participating Local Health Department(s) (LHDs) and contact Information*

The New York City Department of Health and Mental Hygiene is the participating Local Health Department for the region. Within Bronx County, there is a local Bronx Neighborhood Health Action Center focused on promoting health equity and reducing health disparities in the Bronx's high needs neighborhoods. For this report, the contact is:

Bronx Neighborhood Health Action Center
1826 Arthur Avenue
Bronx, NY 10457
Attention: Assistant Commissioner Jane Bedell, MD

3. *Participating Hospital/Hospital System(s) and contact information*

The participating health system is Montefiore Health System, which encompasses five Bronx campuses (Moses, Wakefield, Einstein and Westchester Square, and the Hutch Metro Center). The contact for information that pertains to this report is:

Montefiore Health System
Office of Community and Population Health
3514 DeKalb Avenue
Bronx, NY 10467
Attention: Nicole Harris-Hollingsworth, EdD

4. *Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals.*

This is not applicable for this submission.

Executive Summary – (Four Doubles Spaced Pages Maximum)

As the University Hospital for Albert Einstein College of Medicine, Montefiore Medical Center (MMC) is a premier academic medical center nationally renowned for its clinical excellence, scientific discovery and commitment to its community. MMC is part of Montefiore Health System, which is one of New York's premier academic health systems and a recognized leader in providing exceptional quality and personalized, accountable care to approximately three million people in communities across the Bronx, Westchester and the Hudson Valley. Recognized among the top hospitals nationally and regionally by U.S. News & World Report, Montefiore provides compassionate, patient- and family-centered care and educates the healthcare professionals of tomorrow. The Children's Hospital at Montefiore is consistently named in U.S. News' "America's Best Children's Hospitals," and is second among those in the New York metro area. With four hospitals, 1,536 beds and over 87,000 annual admissions, MMC is an integrated health system seamlessly linked by advanced technology. State-of-the-art primary and specialty care is provided through a network of more than 180 locations across the region, including the largest school health program in the nation and a home health program. Montefiore's partnership with Einstein advances clinical and translational research to accelerate the pace at which new discoveries become the treatments and therapies that benefit patients. The medical center derives its inspiration for excellence from its patients and community, and continues to be on the frontlines of developing innovative approaches to care.

MMC has identified two Prevention Agenda Priority Areas:

1) Preventing Chronic Disease with a specific focus on reducing obesity in children and adults.

Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.

2) Promoting Healthy Women, Infants and Children with a specific focus on Maternal and Infant Health.

Goal #1: Reduce premature births in NYS.

The two Priority Areas selected in 2013 have been re-selected in 2016, though one of the focus areas changed from increasing breastfeeding to reducing premature births as a way to create better alignment with the initiatives of the Delivery System Reform Incentive Payment Program (DSRIP). DSRIP has a very strong focus on both the prevention and management of chronic diseases and behavioral health issues (including substance abuse), and given these are significant risk factors for premature births, we believe that by continuing our chronic disease prevention work in our clinics and extending our reach into the community, we can significantly reduce preterm births.

As part of our prior work and to support the CHNA and CSP process, Montefiore, with its partners, has gathered extensive primary data on community health priorities using various methods and approaches. We participated in the 2014 Bronx-wide Community Needs Assessment conducted by the New York Academy of Medicine on behalf of several Bronx DSRIP Participating Provider Systems (PPS). In addition, we have obtained data from the New York City Department of Health & Mental Hygiene Community Consultations related to the Take Care New York 2020 (TCNY 2020) goal-setting process and conducted a web-based survey assessing the community health concerns of the community. While the exact priorities identified through each of these approaches varied somewhat, there was a consistent placement of obesity, and its related environmental factors (e.g., access to healthy food) and health consequences (e.g., diabetes), as the top community health priority looking forward. In addition, more than 20 pieces of secondary data from numerous publicly-available population-based datasets were reviewed to collect an up-to-date view of the health status of the communities. Triangulating between priorities for the Prevention Agenda, DSRIP and the community, focus areas were selected that would allow us to work with a broad area of community partners in a wide range of activities.

The obesity prevention work in the community involves a wide array of partners, including the NYC DOHMH, other health care providers, CBOs like City Harvest, Community Trust and the Bodega Owner's Association, industry players like PespiCo and Jetro, and the Bronx Healthy Food Retail Networking Group. These community partners meet regularly to discuss progress and align efforts, and to report out on bodegas and supermarkets they are engaged with. Partners like the NYC WIC Vendor Program are assisting us in getting access to bodega owners to introduce various initiatives like the Montefiore Healthy Store Initiative which is currently working with 14 bodegas across the Bronx.

Our premature birth prevention includes several prongs. The first is the Montefiore Nurse Family partnership which targets first time Medicaid eligible Bronx Mothers and provides home-based visits pre and post pregnancy to improve the health and wellness of the mother and baby. Community partners like Catholic Guardian Services and Healthy Start help refer mothers to the program. In 2016, Montefiore received a $125,000 grant from the Lopez Foundation to augment this work. The second prong of our strategy is to enhance the number of schools with school-based health centers who can provide a wide array of services to children and adolescents in Bronx schools, including long-acting contraceptive options to young girls (helping to reduce disparities in teen pregnancy) and screening for other premature birth risk factors like smoking, diabetes, alcohol and drug use. The third prong of our strategy includes enhancing our screening and treatment of chronic diseases across our clinical settings by embedding evidence-based best practices, using population health management strategies to identify patients with gaps in care, and referring patients for additional intensive coaching, either one-on-one with health educators, certified diabetes educators and dieticians, or for classes conducted by certified coaches (e.g. Diabetes Prevention Program). Our data suggests that women are more likely than their male counterparts to engage in these educational options making it a good strategy to engage pregnant women or women of child bearing age.

Montefiore has a long history of broad community engagement that ranges from each hospital having its own Community Advisory Board (CAB) which meets monthly from September to June, the community outreach teams from Community Relations and the Community and Population Health, as well as the myriad of community collaborations we participate in. Montefiore has a leadership role in a variety of critical community and public health efforts : the executive board of the #Not62 Campaign, the Health Department's Advisory Committee, the South Bronx Rising Together Executive Committee, and the Bronx Health and Housing Coalition, to name a few. The committees give Montefiore trust-based access to the communities we serve, which we continue to foster by participating in (and presenting at) community sponsored events, Community Board meetings and local conferences.

The leading indicator we will use for preterm births is the % of births that are premature (as defined by the NYSDOH Vital Statistics data). The leading indicators we will use for obesity are the percentages of adults and children who are obese (NYC CHS, NYC Fitnessgram, NYC YRBS). Recognizing that a key part of our approach to reducing premature births will be focused on the management of risk factors like smoking, cardiovascular health and diabetes, additional process indicators will also be collected including:

- % of adults 18 years and older who consume 1 or more sugary drinks per day (NYS CHS)
- % of respondents ages 18 years and older who smoke or use tobacco some days or every day (HCAPS)
- % of respondents who discussed or were recommended cessation medications (HCAPS)
- % of respondents who discussed or were provided cessation methods or strategy (HCAPS)
- % of patients with diabetes who received the following tests: A1C, cholesterol, eye exam, nephropathy (HEDIS)
- % of patients with diabetes whose most recent A1c >9% (HEDIS)
- % of patients with diabetes whose most recent LDL was <100 (HEDIS)

Report

1. Community Description and Service Area

Montefiore has identified the Bronx as its primary service area. With 1.4 million residents, the Bronx is the nation's poorest urban county; 27.9% of families live in poverty (compared to 16.8% citywide) and the median household income is $34,284 (compared to $53,482 city-wide). Forty-three percent of Bronx children live below poverty; the ninth highest proportion for any county in the United States, and the highest for any urban county. In 2015, Montefiore served approximately 500,000 Bronx residents, or roughly 36% of the total Bronx population.

There are 7.4% of Bronx households on public assistance, twice the percentages in New York City (4.2%) and New York State (3.4%), and 29% of residents receive Supplemental Nutrition Assistance Program. %). Over eighty percent of Bronx students are eligible for free/reduced-price meal programs. The unemployment rate in the Bronx is 7.8, the highest in New York State. Despite the high poverty and unemployment rates, 70% of Bronx residents ages 25 and older have received their high school diploma or GED, though this is lower than citywide (80%) and statewide (85%) attainment rates.

More than 87% of Montefiore's hospitals' discharges are residents of the Bronx, and it is within this geographic area that Montefiore has distributed the vast majority of its community-based primary care. The Bronx is one of the most diverse counties in the nation according to the 2013 US Census with a population at was estimated to be 10.5% non-Hispanic White, 43.3% Black, and 54.6% Hispanic/Latino of any race. As the population in this region has exceptionally high rates of ethnic diversity, due to the high proportions of ethnic minorities, improvements in the health of the general population will address ethno/cultural/race based disparities.

The Bronx is ethnically diverse. The population of Bronx County is 54.3% Hispanic, 33.2% African-American, 10.6% White, 3.7% Asian, and 3.3% Other. Almost one-third (34.7%) of its residents are

foreign-born and 40.7% of the births are to foreign-born mothers. Among these immigrants, more people speak a foreign language at home (predominantly Spanish) than speak "only English." Its new immigrants come from diverse corners of the globe (in order of their numbers): Dominican Republic, Jamaica, Mexico, Ecuador, Guyana, Ghana, Honduras, Italy, Trinidad & Tobago, and Bangladesh. As over 80% of individuals served by the Health System are represented in the above demographics, the ethnic, gender and socio-economic health disparities that are challenging the Bronx population will be encountered, acknowledged, recorded and addressed.

2. Data Collection Process

The Bronx has been an epicenter of the asthma, HIV/AIDS, and drug epidemics and also has excess mortality rates from heart disease, stroke, and diabetes compared to city-wide and national averages. Multiple data sources were used to support the identification and selection of the priority items identified, which were then selected, and reviewed with partners.

Primary Data Collection

Three primary data collection strategies were used to triangulate the identification of community health priorities in the Bronx, including: 1) the 2014 CHNA conducted by the New York Academy of Medicine (NYAM), 2) the New York City Community Conversations, implemented by the New York City Department of Health and Mental Hygiene, and 3) a survey of Bronx residents implemented in tandem with the Westchester County Department of Health to support the CSPs for hospitals in Westchester County. The methods and key results of each of these primary data collection activities are summarized below. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

Montefiore participated in the 2014 Bronx-wide Community Needs Assessment (CNA) process conducted by the New York Academy of Medicine on behalf of several Bronx Delivery System Reform Incentive Payment (DSRIP) Participating Provider Systems (PPS). The NYAM CNA included both primary and secondary data collection, with both a review of public datasets as well as community focus groups and surveys[1]. Feedback from the community members was that they were primarily concerned with diabetes, obesity, cancer, cardiovascular disease, asthma, violence and behavioral health issues. Community members connected these issues most closely with housing insecurity, unsafe environments and poor access to healthy foods.

In addition, we leveraged data collected by the New York City Department of Health & Mental Hygiene (NYC DOHMH) from the Take Care New York 2020 (TCNY 2020) Community Consultations[2]. The Community Conversations were spearheaded by NYC DOHMH to support hospitals in preparing their CHNAs and CSPs. The Community Consultations were held across New York City, with 8 events held in the Bronx, corresponding roughly to Community Districts with high rates of poor health outcomes. Participants were asked to rank 23 health priorities (e.g., obesity, violence, asthma or smoking) in order of importance to their community. For the Bronx, obesity, high school graduation, smoking, air quality and child care were the top 5 priorities identified from 8 community meetings. Obesity received, by far, the highest average score, earning an average ranking of 17.5 out of 23, compared to high school graduation (15.1 out of 23), which was second. Obesity was the only priority identified as a top 5 concern in each of the 8 community meetings.

Lastly, in collaboration with the Westchester County Department of Health, with whom we were collaborating on data collection for Westchester County, we fielded a web-based survey assessing

[1] More details on the NYAM CNA can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/st_barnabas_hosp_dba_sbh_health_system/3.4_st_barnabas_cna.pdf

[2] More details on the TCNY 2020 Community Consultations can be found here: https://www1.nyc.gov/site/doh/health/neighborhood-health/tcny-community-consultations-results.page

community health concerns. The survey was disseminated to community based organizations and other partners in the Bronx, and data were evaluated for those working/residing in the Bronx. The survey was administered from August 2016 through October 2016 using SurveyMonkey. Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health. Among 127 participants, obesity, diabetes, drug abuse, nutrition and mental health as the 5 most important community health priorities in the Bronx. The five priorities with the greatest potential to improve population health were exercise/weight loss programs, access to healthy foods, affordable housing, community education and clean air & water.

Despite each of these different methods and approaches to primary data collection in gathering community input, there was a consistent focus on obesity and related behaviors and outcomes as the main community health concerns.

Secondary Data Collection

In addition to the review of primary data, to capture an up-to-date high-level view of the health status of Bronx residents, we evaluated temporal trends, differences between Bronx and the rest of New York City and sub-county differences, when available, for more than 20 measures, including: obesity, preterm births, teen pregnancy rates, poverty, linguistic isolation, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screening, HIV incidence, lung, colorectal, prostate and breast cancer incidence rates, and hospitalizations for asthma, diabetes, assaults, heart attacks and falls. These data were obtained from multiple population-based datasets including the American Community Survey (formerly referred to simply as the Census), New York City Community Health Profiles, New York State Statewide Planning and Research Cooperative Systems (SPARCS), New

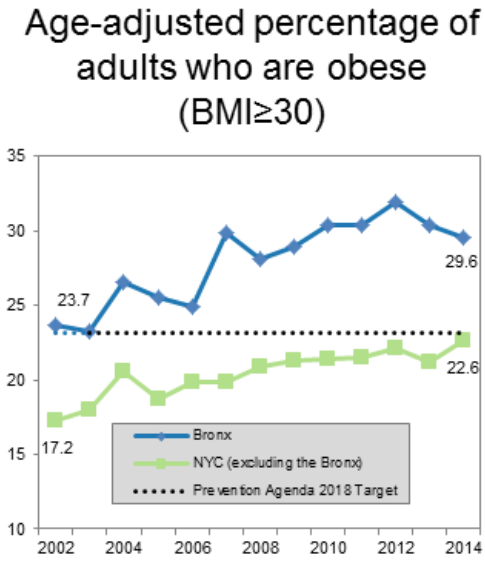
York State Vital Statistics, New York State HIV/AIDS Epidemiology Reports, and the New York State Cancer Registry. Additional data was obtained from the New York City Community Health Profiles and the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard. The data sources used are summarized in Appendix A and the data themselves are presented in Appendix B.

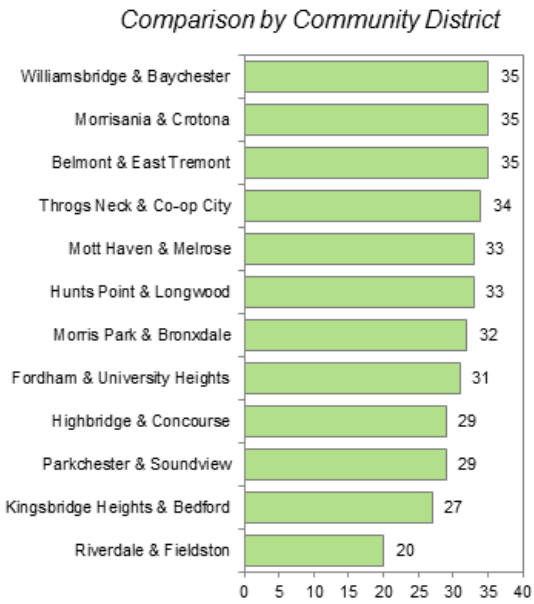
In addition to the secondary data previously described, we evaluated the distribution of different primary discharge diagnoses at Bronx-based Montefiore hospitals in 2015 using data from SPARCS. This data is presented in Appendix C.

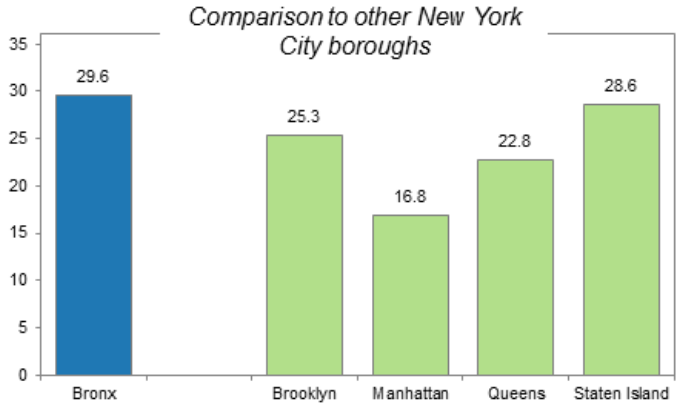
Secondary Data Related to Selected Priority Areas

Obesity and Diabetes

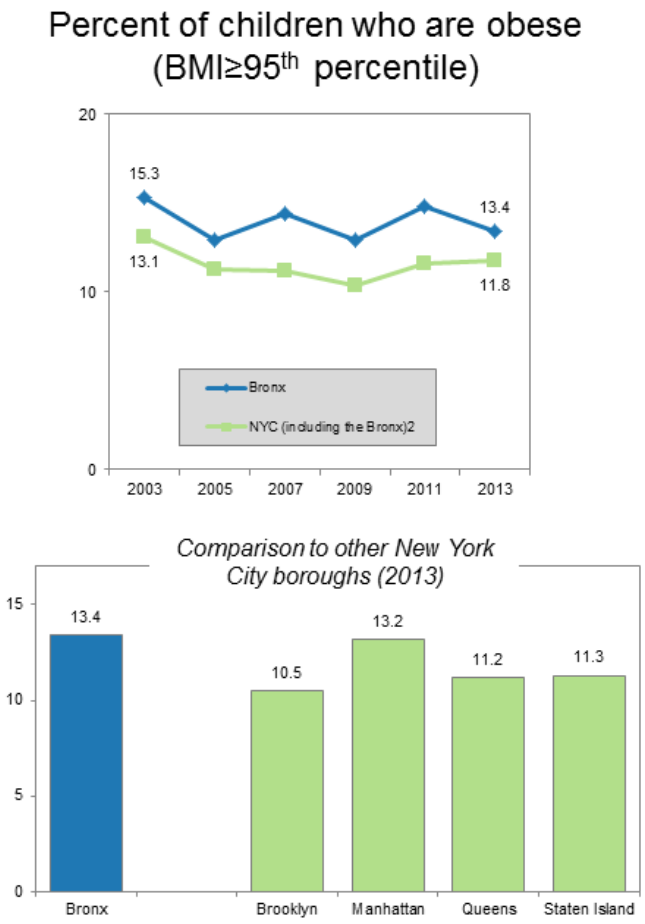
Specifically related to the priorities chosen, the data indicates that the percentage of Bronx adults who are obese continues to be much higher than the rest of New York City, though there is some evidence that obesity may be plateauing in the Bronx. The prevalence of childhood obesity has remained stable in the Bronx, but continues to be higher than the rest of New York City.



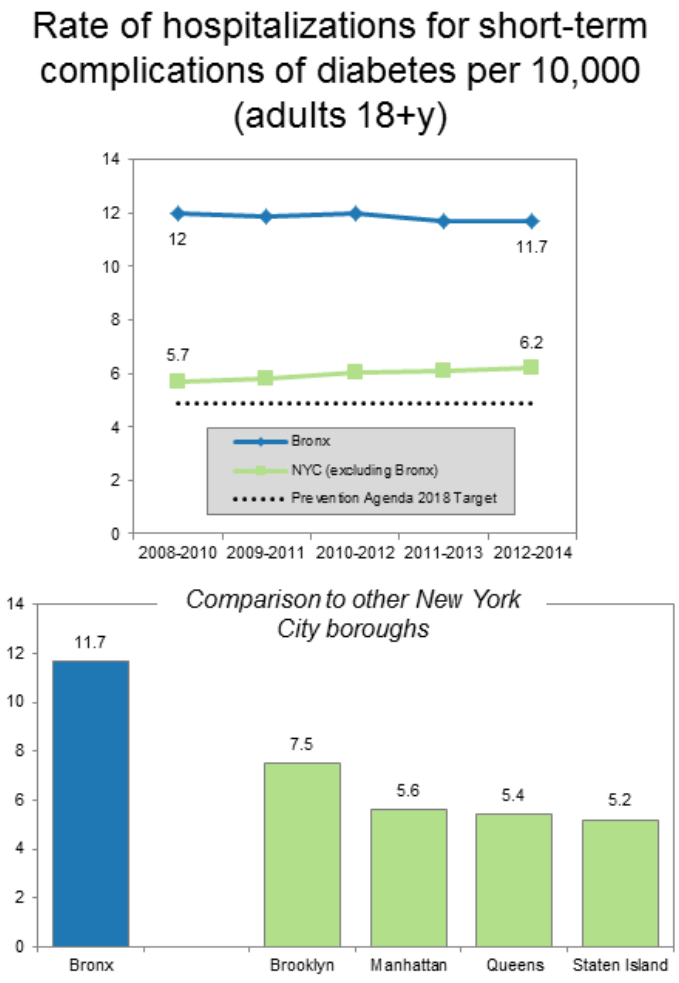




Data source: New York City Community Health Survey



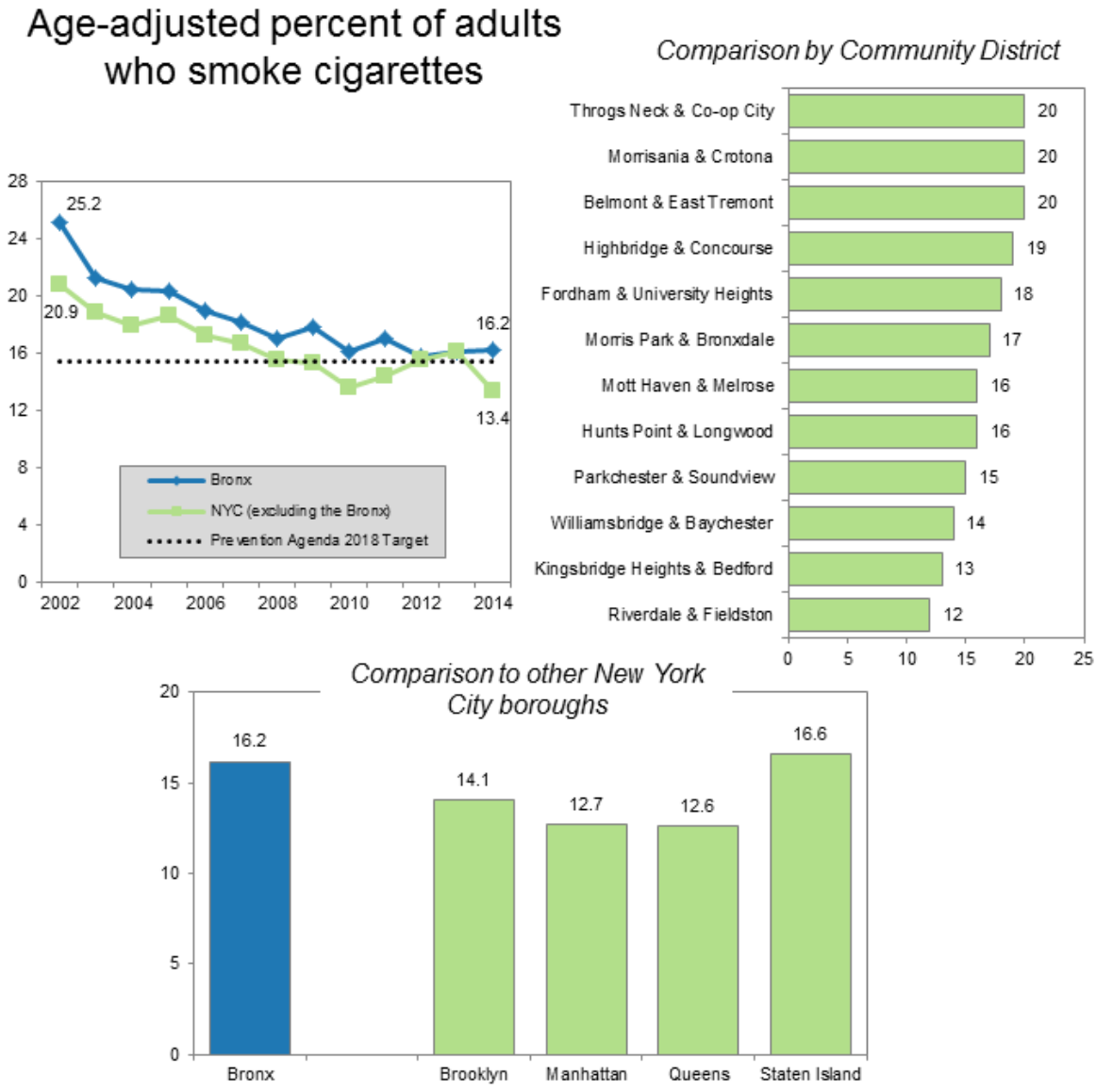
Data source: New York City Youth Behavior Risk Survey



Data source: SPARCS

Tobacco Use

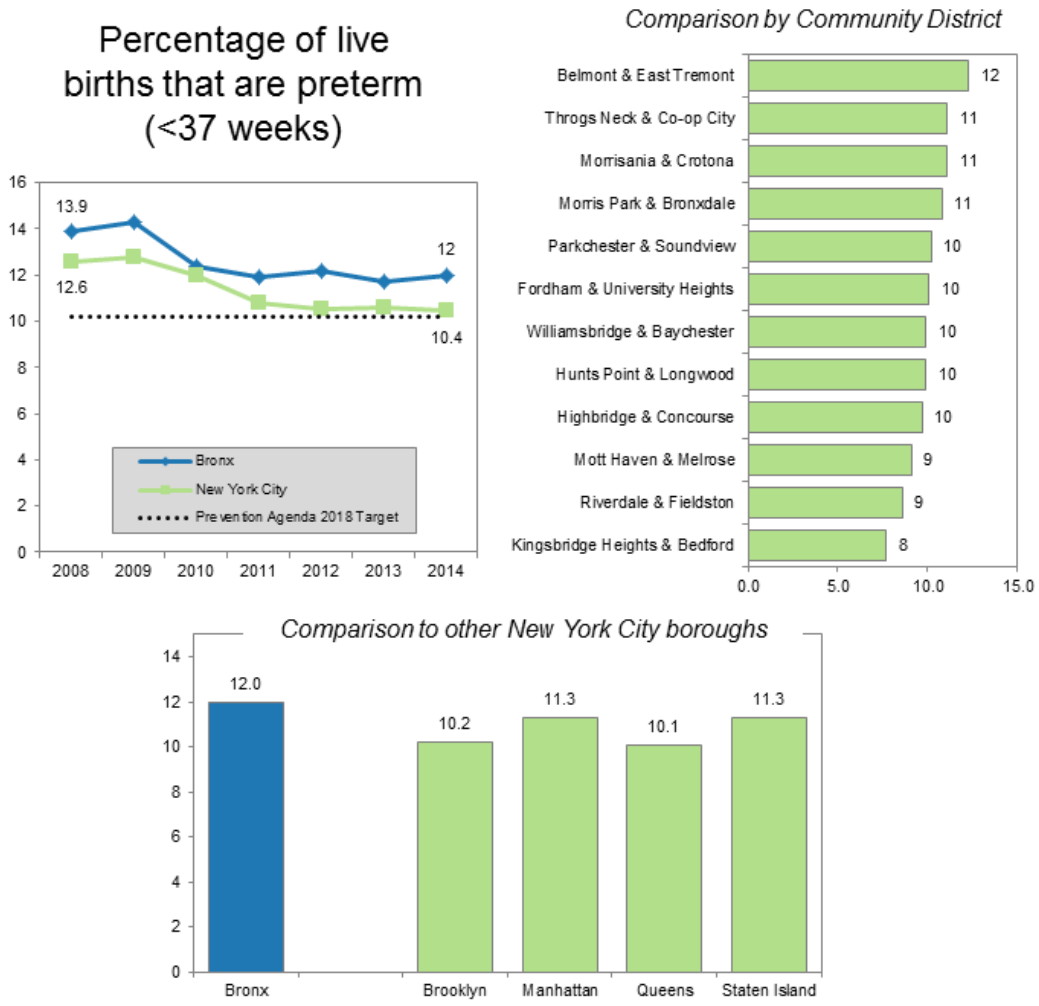
In both the Bronx and the rest of New York City, cigarette smoking among adults has declined, but Bronx residents continue to be more likely smoke than New York City residents overall.



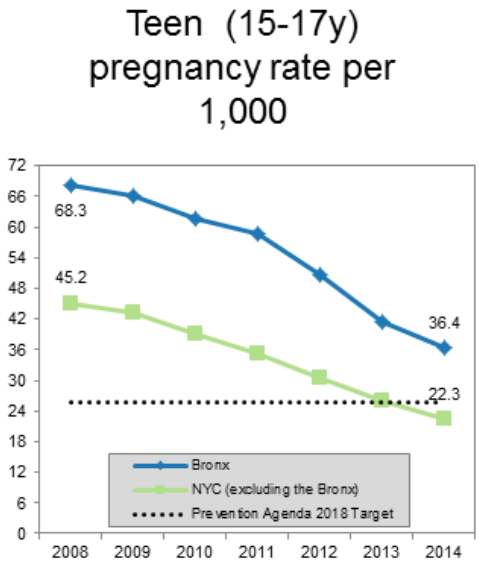
Data source: New York City Community Health Survey

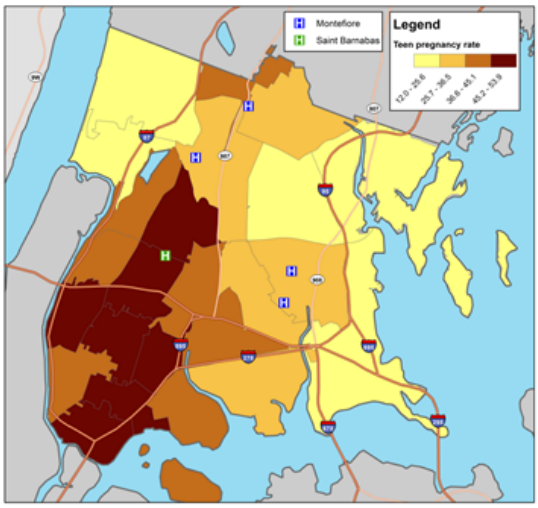
Preterm Birth

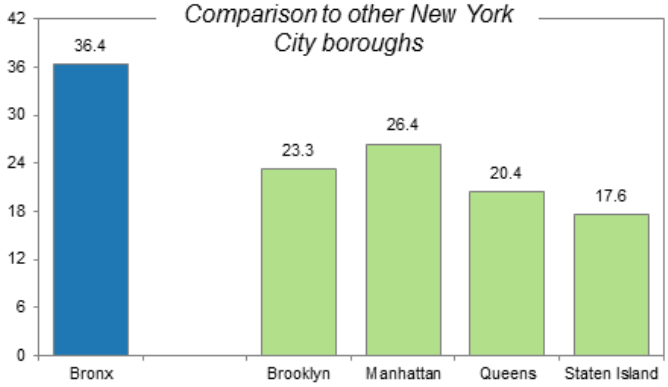
In both the Bronx and the rest of New York City, preterm births have declined, but Bronx residents continue to be more likely to experience preterm birth than New York City residents overall. Coinciding with the decline in preterm births, the teen pregnancy rate (and teen birth rate) has declined in both the Bronx and the rest of New York City.



Data source: New York State Vital Statistics







Data source: New York State Vital Statistics

Additional data points collected, including information on other chronic conditions and cancer incidence, are available in Appendix B.

3. Identified Prevention Agenda Priorities, Goals and Objectives

In the Comprehensive Community Services plan developed for 2013-2017, the priority areas selected were Prevent Chronic Disease and Promote Healthy Women Infants and Children. Through the projects and activities initiated during that plan, Montefiore Medical Center was able to contribute to the overall trend improvements in those areas for New York State. However, although Bronx County has shown improvements along with the rest of New York State, the rates for conditions identified in these areas remains higher in most cases than the Citywide and Statewide averages, therefore, Montefiore has elected to retain these two priority areas Prevent Chronic Disease and Promote Healthy Women Infants and Children for the 2016-2018 plan. As described within the Community Description and Service Area section of this proposal, the Bronx is a majority ethnic minority borough with over 54.6% of its residents identifying as Latino of any race and just under 90% identifying as a cultural/racial/ or ethnic minority. As the racial and ethnic populations have shown disparate rates of impact, in consultation and collaboration with community partners, within Preventing Chronic Disease the focus area and goal that was selected is: Focus Area 1: Reducing Obesity in Children and Adults, under Objective 1.1.1 - decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day (1) By 5% from 20.5% (2009) to 19.5% among all adults and (2) By 10% from 42.9% (2009) to 38.6% among adults with an annual household income of < $25,000.

Across Bronx County, through the efforts of the Bronx Bodega Work Group, the following groups have been working collaboratively on addressing the improvement of the retail food environment, including the reduction of consumption of sugar laden beverages. This group, consisting of health care providers, insurers, community based organizations, business owners and social service providers, meets monthly to review information, coordinate planning and implementation of

Montefiore Health System, the Institute for Family Health (Bronx REACH), Bronx Community Healthcare Network (Bronx REACH CHAMPS), Bon Secour Health System, the Department of Mental Health and

Hygiene's Bronx Neighborhood Action Center, HITN, the Bodega Owners' Association, Urban Health Plan, City Harvest, Health First, and Bronx Works.

These organizations, partnering with other New York City municipal partners such as the Department of Education, are able to have a broader reach in providing access to information and education to reduce the consumption of health foods in the populations they touch.

Priority Area: Preventing Chronic Disease
Focus Area: Reduce Obesity in Children and Adults

Goal	Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.
Outcome Objectives	Objective 1.1.1: By December 31, 2018, decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day: By 5% from 20.5% (2009) to 19.5% among all adults. By 10% from 42.9% (2009) to 38.6% among adults with an annual household income of <$25,000. (Data source: NYS BRFSS) (Health Disparities Indicator)
Interventions/Strategies/ Activities	Disseminate "Rethink Your Drink" boards across the Health System (including ambulatory care, substance abuse treatment programs, and school health sites) to serve as a tool for educating patients and the community about the amount of sugar present in commonly bought juices, sodas, and other flavored drinks. This work is supported by the Montefiore Healthy Store Initiative (MHSI) staff in partnership with youth groups at local community based organizations (CBO's) and the Montefiore School Health Program who create the boards and then use them to educate peers. They are part of the MHSI's effort to increase the demand for zero and low calorie beverages at local stores. Through MHSI, engage bodega owners in increasing supply and promotion of zero and low calorie beverages. This work with done in partnership with the Montefiore WIC vendor training program which can provide additional access to, and engagement from, bodega owners. Additional programs that will address obesity include the B'N Fit Program which addresses obesity in adolescent patients through group education and physical activity. Support from the onsite health education staff at the Montefiore Medical group sites will support this goal as well.
Process Measures	Number of boards disseminated at Montefiore sites; number of youth educated by peers on sugar content in commonly purchased sugary drinks; Number of bodegas participating in MHSI
Partner Role	CBO's and School Health sites will assist in engaging youth to make "Rethink Your Drink" boards; Bodega owners approve supply and promotion of products.

Goal	Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.
	The Healthy Beverage Zone, an effort of the #Not62 Campaign for a Healthier Bronx will assist in connecting the MHSI with local CBO's. Bronx Health REACH CHAMPS: provide funding for materials for "Rethink Your Drink" boards WIC vendor training program: will provide the MHSI team the ability to conduct presentations before or after WIC vendor trainings Additional programs that will address obesity through small group work within their programs include B'N Fit, Health Education, Montefiore Diabetes Prevention Program and collaborative work done by the #Not 62 Campaign Partners in the Bodega Initiative and the Healthy Beverage Zone.
Partner Resources	Local CBOs/Montefiore School Health Program: Access to community members/youth Healthy Beverage Zone committee: technical assistance and relationship building Bronx REACH CHAMPS: funding
By When	December 31, 2018
Will Action Address Disparity	Yes. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic.

Also within Priority Area **Preventing Chronic Disease** is the Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings. In alignment with the Community Needs Assessment that was performed in preparation of the 2014 implementation of the Delivery System Reform Incentive Payment (DSRIP) program as well as the secondary data reporting, increasing rates for the screening of diabetes, especially among disparate populations is priority in increasing the rates of screening, care, management and control of diabetes. In addition to expanding the opportunities for clinical evaluation of diabetic Bronx residents, an active engagement with the National Diabetes Prevention Program from the CDC and managed through a variety of organizations and government agencies including support for smaller faith based and community based organizations through the New York City Department of Health and Mental Hygiene, collaborating with organizations that have elected for an independent relationship with the Quality and Technical Assistance Center of NY

(QTAC-NY), and Montefiore's independent pursuit of certification through the Centers for Disease Control

(CDC) through the implementation of the Montefiore Diabetes Prevention Program,

Priority Area: Preventing Chronic Disease
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Goal	Goal #3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.				
Outcome Objectives	Objective 3.1.4: By December 31, 2018, increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%. (Data Source: NYS BRFSS)				
Interventions/Strategies/ Activities	Engagement of clinical partners in the HbA1c screening protocol as outlined in HEDIS; alignment of clinical and community based resources to address the level of patient health status (prevention, management or control)				
Process Measures	*Data source*	*HEDIS Measure #*	*Description*	*Denominator*	*Target*
Project 3.c.i Comprehensive Diabetes screening – All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor)	HEDIS 2015	0055, 0062, 0057	Number of people who received at least one of each of the following tests: HbA1c test, cholesterol screening test, diabetes eye exam, and Medicaid attention for nephropathy	Number of people ages 18 to 75 with diabetes	62.5%
Project 3.c.i Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±	HEDIS 2015	59	Number of people whose most recent HbA1c level indicated poor control (>9.0 percent), was missing or did not have a HbA1c test	Number of people ages 18 to 75 with diabetes	23.2%
Project 3.c.i Comprehensive diabetes care - LDL-c control (<100mg/dL)	HEDIS 2014	64	Number of people whose most recent level of bad cholesterol was below the recommended level (LDL-C <100 mg/dL), was missing or did not have a LDL-c test	Number of people ages 18 to 75 with diabetes	51.3%
Partner Role	Provide Access to a range of preventive, maintenance and self-management programs for individuals across the pre-diabetes and diabetes spectrum.				
Partner Resources	Partners will provide Technical Assistance, opportunities for neighborhood based cultural/linguistic specific classes, and opportunities for data sharing and collaboration				
By When	December 31, 2018				
Will Action Address Disparity	Yes. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic				

The next Priority Area that was selected is **Promote Healthy Women Infants and Children**, Focus Area: Maternal and Infant Health, Goal 1 Reduce Premature Births, Objective 1.1 - reduce the rate of preterm birth in NYS by at least 12% to 10.2%.

The election of the importance of continuing these efforts comes from the coalition of programs and organizations working in this area, which include membership from local Head Start and child care centers, family resource centers, birthing centers, hospitals and clinics, immigrants and refugee centers, and substance abuse treatment programs. Organizational support was derived through the well-established partnership networks including the Bronx Community Healthcare Network, The Bronx Health Link , which currently directs referrals through the Perinatal Information Network and collaboration and coordination with the Department of Social Services, the Department of Family Medicine and the Department of OB/GYNs, and outpatient/inpatient social workers at Montefiore, the Montefiore School Health Program and as well as mental health agencies in the county.

Priority Area: Promoting Healthy Women, Infants and Children
Focus Area: Maternal and Infant Health

Goal	Goal #1: Reduce Premature Births
Outcome Objectives	Objective 1-1 By December 31, 2018, reduce the rate of preterm birth in NYS by at least 12% to 10.2%. (This target is in alignment with the national ASTHO/March of Dimes target of 17.9% improvement by 2020 to achieve a national preterm birth rate of 9.6%)
Interventions/Strategies/ Activities	Engagement with Maternal Infant and Early Childhood Home Visiting Initiative (MIECHV)/Nurse Family Partnership ®, participation in the New York State Baby Friendly Initiative, and or Centering Pregnancy Program
Process Measures	Within the DSRIP framework in Domain 4, references to the NYS Prevention Agenda identifying measures related to the: (1) Overall Percentage of preterm births, (2) the Percentage of preterm births – Ratio of Black non-Hispanics to White non-Hispanics, (3) the percentage of preterm births – Ratio of Hispanics to White non-Hispanics and (4) Percentage of preterm births – Ratio of Medicaid births to non-Medicaid births will be collected and tracked to monitor trending over the CSP Period.
Partner Role	Engagement and referral into appropriate programs (clinical or community) to support mothers at risk for preterm delivery, including non-maternity based programs that correlate to social determinants of health that impact prematurity.
Partner Resources	Technical assistance, supportive community programming, visit assistance. Community Health Worker services
By When	December 31, 2018
Will Action Address Disparity	Yes. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic

Each of the two selected Priority Areas has received support from the New York City Department of Health and Mental Hygiene's citywide offices as well as support from the local Bronx Neighborhood Health Action Center. Montefiore, St. Barnabas, and other hospital based and community health partners participated in a series of Take Care New York #TCNY2020 Community Consultations that were led by the New York City department of Health and Mental Hygiene. Of the eight community consultations that were held in Bronx County in the neighborhoods of East Tremont (2) , Pelham Parkway, Soundview, Riverdale, Hunts Point, Mott Haven and Highbridge, every community selected Obesity as one of their top five areas of concern and through these efforts, the New York City Department of Health and Mental

Hygiene, in the re-designation of the District Public Health Offices into the Neighborhood Health Action Centers, for the Bronx, East/Central Harlem and Brooklyn, have united on three common themes (1) Nutrition and Physical Activity, (2) Teen Sexual Health and (3) Maternal Health as the focus of their borough specific operations. This exhaustive process has confirmed that there is alignment with both of the Priorities selected through the data review and primary data collection processes across multiple stakeholders.

4. Community Engagement Process

The Community Engagement process for the 2016-2016 Community Service Plan was a collaborative effort. As mentioned earlier, Montefiore Medical Center and St. Barnabas Health System along with support from the New York City Department of Health and Mental Hygiene, the Westchester County Department of Health and the New York Academy of Medicine engaged in a rigorous secondary data review as well as a primary data collection process which involved the residents of the county in focus groups, community conversations to disseminate data and an electronic surveying process, available in five languages, to understand and assess their health priorities.

To maintain that engagement, the healthcare and community institutions have embraced a borough specific coalition, the #Not62 Collaboration, which is the Robert Wood Johnson Foundation Culture of Health Prize Winner in 2014. Through this coalition, the partner hospitals, including Montefiore and St. Barnabas, along with the New York City Department of Health and Mental Hygiene's Bronx Neighborhood Action Center, the Institute for Family Health through the Bronx REACH Program, the Office of the Bronx Borough President and multiple community based organizations meet on a bi-monthly basis to discuss and to inform on how their involved coalitions are working to elevate the borough from the status of being the least health county in New York State. Additionally, presentations of the data are provided to non-health specific community organizations, such as the local Bronx Community Boards, faith based

organizations and other interested parties as requested. As of October 2016, there are 43 community based organizational partners participating in the # Not 62 campaign, more information can be found here http://bronxboropres.nyc.gov/press/releases/2016-03-17.html

Lastly, as it relates to the specifically identified goals, Under the Priority Area ***Prevent Chronic Disease*** Focus Area 1: Reducing Obesity in Children and Adults, under Objective 1.1.1 - decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day (1) By 5% from 20.5% (2009) to 19.5% among all adults and (2) By 10% from 42.9% (2009) to 38.6% among adults with an annual household income of < $25,000, Montefiore will continue to partner with local community based organizations to provide on an engagement and demand strategy to disseminate "Rethink Your Drink" boards across the Montefiore Health System (including ambulatory care, substance abuse treatment programs, and school health sites), as well as community sites including non-affiliated schools and to serve as a tool for educating patients and the community about the amount of sugar present in commonly bought juices, sodas, and other flavored drinks. Through the efforts of the #Not62 Campaign affiliated The Healthy Beverage Zone, which in 2016 won the Aetna Foundation Healthiest Cities and Counties award, as well as ongoing participation in the Bronx Bodega Workgroup – an affiliation of community groups working to increase healthy food options in local bodegas, there are broad efforts to ensure that the goal is reached.

Under the Priority Area ***Promote Healthy Women, Infants and Children***, Focus Area: Maternal and Infant Health, Goal 1 Reduce Premature Births, Objective 1.1 - reduce the rate of preterm birth in NYS by at least 12% to 10.2%, this objective will be addressed through the implementation of several specific initiatives that address women and families in the perinatal spectrum. The 2013 Vital Statistics data has shown us that Bronx residents have some of the worse economic and health outcomes among all NYC residents. As it relates to maternal infant health, three factors of note are: a) Premature births – 11.9 %

of births less than 37 weeks were to women residing in the Bronx compared to 10.9% of women in NYC on the whole.

b) Low birth weight – a greater percentage of women living in the Bronx gave birth to low- birth weight infants than did women in the whole of NYC (7.8 versus 6.5). Highest rates were among African-American women and women younger than age 17 and older than 35.

c) Infant Mortality – The Bronx had the highest rate of infant mortality among all counties in NYC (5.7 versus 4.7). Rates for African-American women were highest.

Several programs have been identified to address this crisis. The first of these is the Maternal Infant and Early Childhood Home Visiting Imitative (MIECHV), and expansion of the nationally renowned Nurse-Family Partnership ® Program. Through MIECHV, working with first time Medicaid level income eligible mothers from prior to their 28th week of pregnancy, of the New York State Baby Friendly Hospital Initiative, evaluates its participants across six benchmark areas 1) maternal and newborn health; 2) child injuries, child abuse, neglect or maltreatment; 3) school readiness and achievement; 4) crime, including domestic violence; 5) family economic self-sufficiency; and 6) associated community resources and supports. The second program is pursuit, achievement and participation in the New York State Baby Friendly Initiative, which is process at both St. Barnabas and Montefiore. As this program coordinates with the delivery of obstetrics services and health education services for primiparous, multiparous and mothers of multiples, support for the reduction of preterm births is available across the voluntary nonprofit hospitals in the county. The last of the programs is the Centering Pregnancy Program, which has been implemented nationally since 2001 and is currently the subject of a large NIH funded evaluation project. Centering Pregnancy bases it philosophy on the concept that women need not only medical care, but also education and counseling during pregnancy, and that all those services are difficult to provide in the short visits mandated by health insurance companies. Using Centering Pregnancy, prenatal

care is offered in group sessions, with prescribed education and counseling during each session and much interaction between the women and the health care providers. Evaluation at the grant's completion, evaluation will consist of tracking pregnancy outcomes, patient satisfaction, patient knowledge of health and pregnancy topics, and other markers.

Through these clinical initiatives, which are also supported through alignment with coalitions of community based programs such as The Bronx Health Link, the New York State community perinatal services provider and Bronx County Infant Mortality Reduction Initiative partner, which allow opportunities for ongoing community engagement and course correction as appropriate.

Within Bronx County, the Bronx Partners for Healthy Communities (BPHC)is a coalition of over 200 Bronx-based organizations working together to increase patient access, care quality, and efficiency in healthcare delivery. Through ten DSRIP projects, designed to meet our community's unique health needs, BPHC is building a coordinated, community-based healthcare system focused on the wellness of every Bronx resident. Montefiore Health System and St. Barnabas Health System, through a network of relationships developed over the 130 and 150 years, respectively, that both institutions have been in the Bronx, are participating organizations within the Bronx Partners for Healthy Communities (BPHC) and will utilize the program structure within BPHC to reach participating organizations to broaden the reach of these initiatives across the Bronx.

5. Report Dissemination Process

The plan to disseminate the delivery of the Montefiore Medical Center 2016-2018 Community Service Plan report to the public will occur across a number of platforms:

The Community Service Plan will be posted to the www.montefiore.org website at the specific address http://www.montefiore.org/documents/CSP2016-2018.pdf. It can also be found through accessing the general www.montefiore.org site and clicking the Community Reports tab located in two areas of the face page, both under the Community tab or by scrolling to the bottom of the page where Community Reports is provided as hyperlinked text which can take a viewer directly to the report.

Appropriate staff will also provide community presentations to discuss the findings of the report and their relationship to particular community interests. As the New York City Department of Health and Mental Hygiene issued the 2016 Community Health Profiles and Montefiore engaged with the Community Conversations process as an additional primary data collection opportunity, this data will also be shared at community presentations to enhance the knowledge of the population on the health status of their community.

The Community Service Plan will be mailed out in hard copy to members of the Montefiore Community Advisory Boards, as well as provided to community leaders and elected officials. To facilitate this distribution, a copy of the direct link is also provided specifically to the distribution link of the Office of the Bronx Borough President, which maintains the borough's largest electronic communication list and can provide dissemination beyond the traditional healthcare partners.

A QR code for the link to the report will be made available for print materials to facilitate ease of access to the report. The QR code, accessible through most smart phone readers, for the site is provided below

Montefiore will announce through its multiple social media platforms the availability of the Community Service Plan which will be available through the following feeds:

- Facebook: https://www.facebook.com/montefioremedicalcenter
- Twitter: https://mobile.twitter.com/MontefioreNYC
- YouTube: http://www.youtube.com/user/MontefioreMedCenter

This reflects an expansion of the ways in which the Community Service Plan has been distributed as technological advances allow for broader distribution. As we move forward, additional reports, including the Community Health Needs Assessment and Implementation Plan, which will supplement the delivery of the Community Service Plan, will be found and distributed through the same pathway.

6. Supplemental Information

This Community Service Plan is reflective of a segment of the programming offered at Montefiore Medical Center. Information on additional programs and services can be found at www.montefiore.org and www.doingmoremontefiore.org . Additional information about community specific initiatives can be found at www.montefiore.org/community .

Information on Montefiore's Financial Assistance Policy can be located at http://www.montefiore.org/financial-aid-policy and is available in English and Spanish, with additional interpretations options upon request.

This document was reviewed and approved by the Montefiore Medical Center Community Services Subcommittee, as an approved committee of the Board of Trustees on November/December , 2016.

<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<>>

Appendix A: Summary of Secondary Data Sources & Analytic Notes

American Community Survey: The American Community Survey (ACS) replaced the Decennial Census as an ongoing survey of the United States population that is available at different geographic scales (e.g., national, state, county, census tract or census block group). ACS is a continuous survey that addresses issues related to demographics, employment, housing, socioeconomic status, and health insurance. In the current report, data from ACS was used to evaluate the percent of families living in poverty, the percent of households that are limited English speaking and the percentage of adults or children with health insurance. For more information on ACS please visit http://www.census.gov/programs-surveys/acs/about.html.

New York City Community Health Survey: The New York City Community Health Survey (CHS) is an annual random digit dial telephone survey of the NYC adult population. CHS is a complex survey that provides a representative sample of NYC residents. Addressing a wide range of topics, in the current report CHS data were used to estimate the percent of adults with a primary care provider, the percent of adults who are obese, the percent of adults who are current smokers, the percent of adults who received a colorectal cancer screening, and the percent of adults getting a flu immunization. For more information about CHS please visit http://www1.nyc.gov/site/doh/data/data-sets/community-health-survey.page.

New York City Youth Behavior Risk Survey: The New York City Youth Behavior Risk Survey (YRBS) is an ongoing collaboration of the New York City Department of Health & Mental Hygiene, the Department of Education and the National Centers for Disease Control and Prevention. Conducted every two years, on odd years, the survey asks a representative sample of New York City high school students (grades 9-12) about their health status and health behaviors. The current report uses data on childhood obesity obtained from NYC YRBS. For more information about YRBS please visit: https://www1.nyc.gov/site/doh/data/data-sets/nyc-youth-risk-behavior-survey.page

New York State Vital Records Data: The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report vital records data were used to examine the percentage of life births that are preterm and the teen pregnancy rate. For more information on the New York State Vital Records please visit: https://www.health.ny.gov/statistics/vital_statistics/

New York State Statewide Planning and Research Cooperative Systems (SPARCS): SPARCS is the primary source of data on ED visits and inpatient hospitalizations at New York State hospitals. All inpatient admissions and ED visits at NYS hospitals are sent to SPARCS and compiled into a master database. SPARCS data was used to estimate the rates of avoidable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, asthma ED visits, hospitalizations for short-term diabetes complications, and hospitalizations for heart attacks. For more information about SPARCS please visit: http://www.health.ny.gov/statistics/sparcs/.

New York State Bureau of HIV/AIDS: Data on HIV incidence (new cases) were obtained from the NYS Bureau of HIV/AIDS, which receives reports of all new HIV diagnoses to NYS residents meeting an established case definition. For more information please visit: https://www.health.ny.gov/diseases/aids/general/statistics/.

New York State Cancer Registry: The New York State Cancer Registry was used to summarize data on new cases of breast cancer, prostate cancer, lung cancer and colorectal cancer. The Cancer Registry receives notice of all cancer diagnoses to NYS residents and classifies the cancers using established definitions. For more information on the New York State Cancer Registry please visit: https://www.health.ny.gov/statistics/cancer/registry/.

New York City Community Health Profiles: The Community Health Profiles are produced by the New York City Department of Health & Mental Hygiene, and summarize a number of contextual, behavioral and

health indicators by Community District. The Community Health Profiles are not a database, but rather a collection of data from diverse databases, including the American Community Survey, the NYC Community Health Survey, and SPARCS. For more information please visit: https://www1.nyc.gov/site/doh/data/data-publications/profiles.page

New York State Prevention Agenda Dashboard: An additional resource for data was the New York State Prevention Agenda Dashboard, which was produced by the New York State Department of Health and systematically collects data for the entire state and for each county for dozens of health indicators that align with the New York State Prevention Agenda. Like the Community Health Profiles, the Prevention Agenda Dashboard is not a single database, but rather a compilation of diverse databases. For more information please see: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Additional Analytic Notes

Age-adjustment

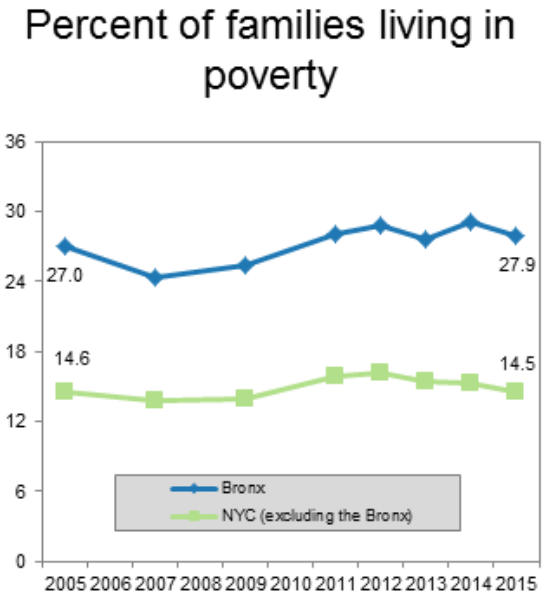
Whenever possible percentages or rates are age-adjusted in order to remove differences in the underlying age distribution of two places (or across time) from explaining differences between two places (or trends). For example, the Bronx has a lower average age than other boroughs of New York City and may therefore appear to have lower rates of specific diseases due to its younger population. By age-adjusting the data differences between rates/percentages are no longer due to differences in the age distribution of two populations.

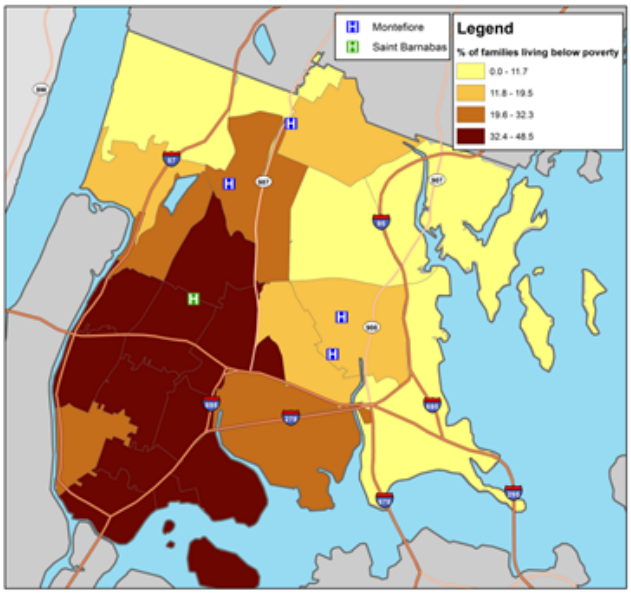
Comparison of Bronx vs. Rest of New York City

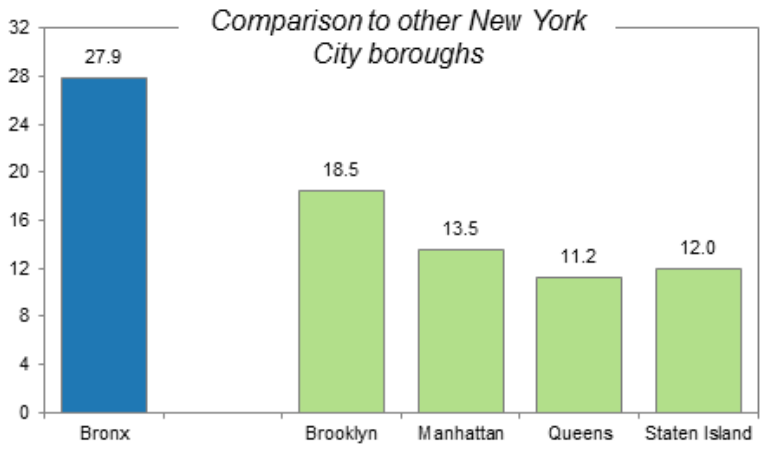
Because the Bronx represents about 17% of the New York City population when comparing the Bronx to the rest of New York City it is helpful to remove the Bronx data from the NYC calculation. Whenever possible, we calculated a New York City percentage or rate that excluded data from the Bronx. This is noted in the key to each legend by text saying “excluding the Bronx”.

Appendix B: Additional Secondary Data

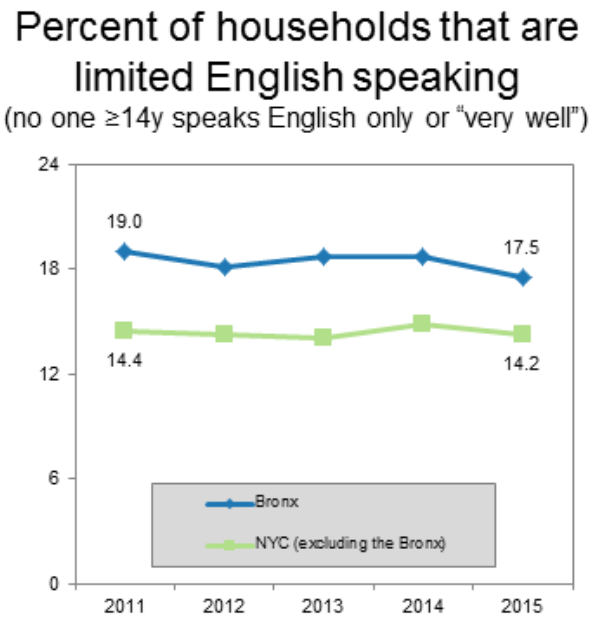
Multiple variables were reviewed and shared in the assessment of the health status of Bronx County. The following is a review of that data and the trends of Bronx County as compared to available Citywide, State and or county comparison data elements.

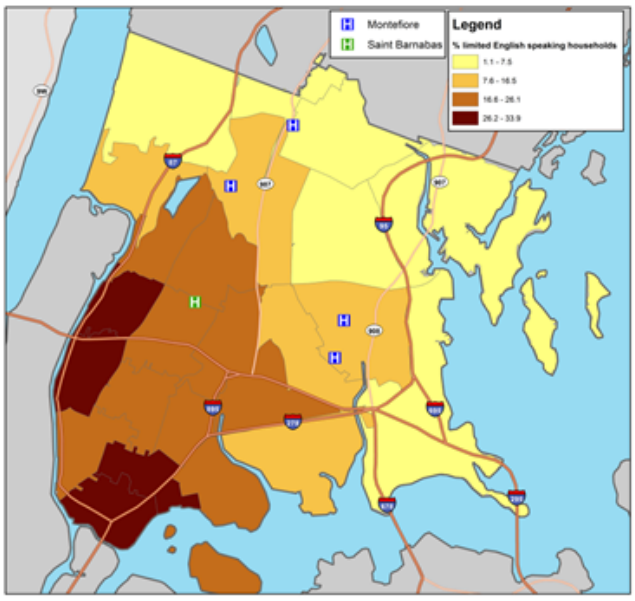


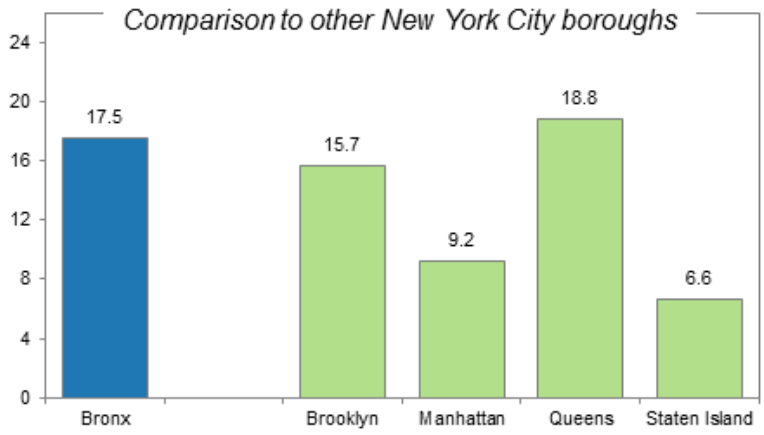




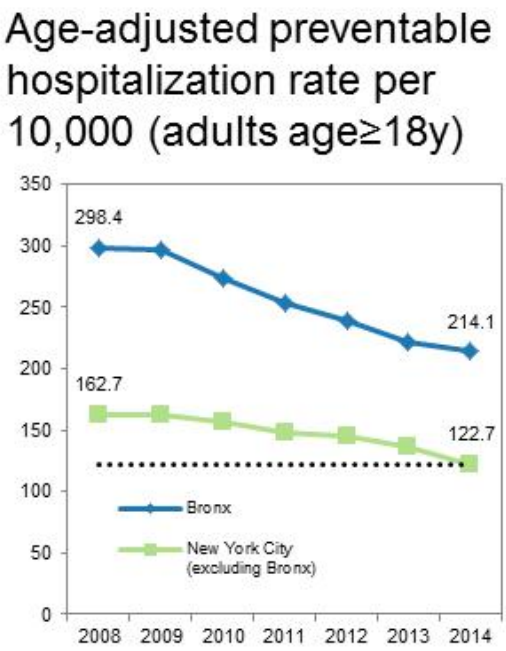
Data source: American Community Survey

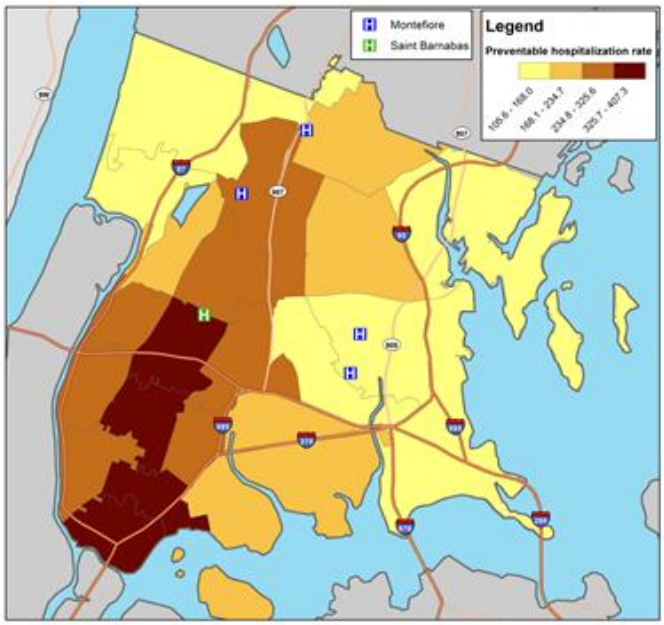


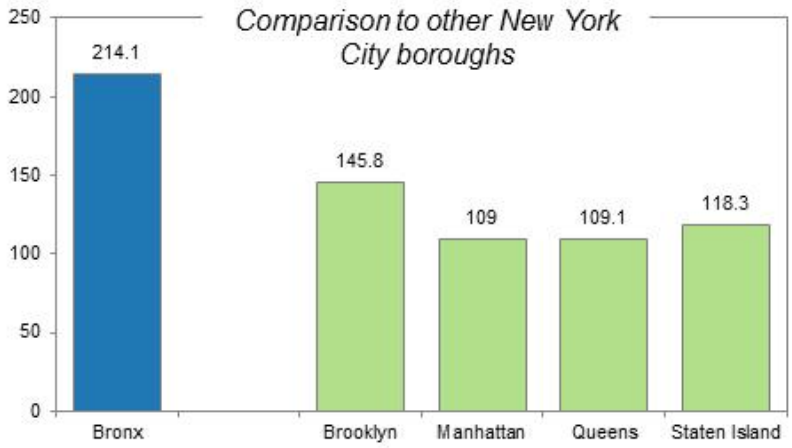




Data source: American Community Survey

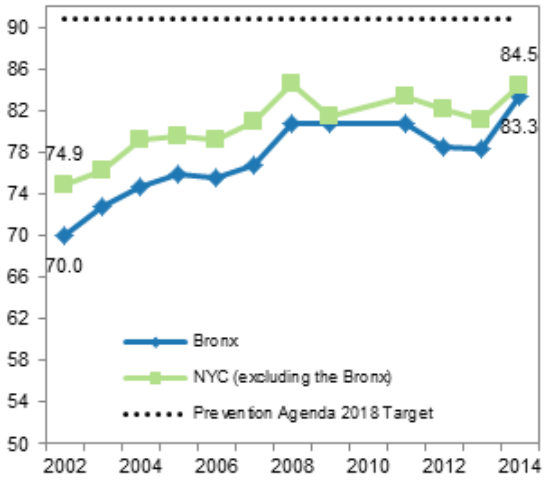


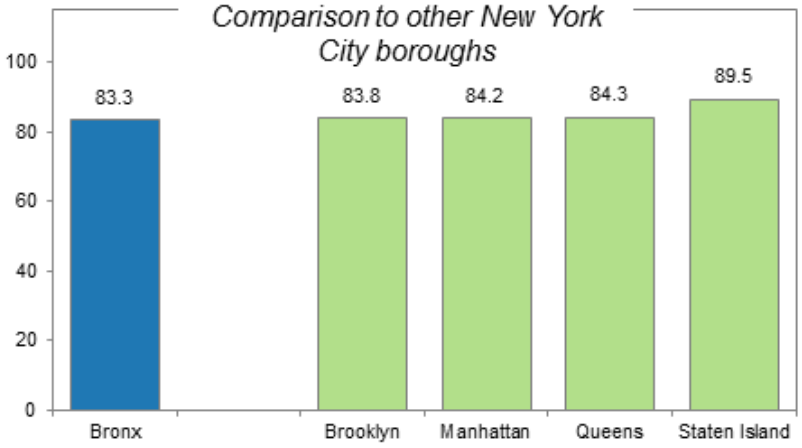




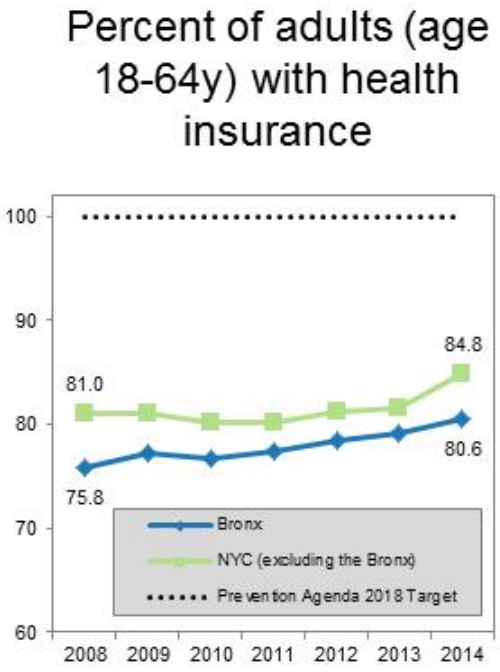
Data source: SPARCS

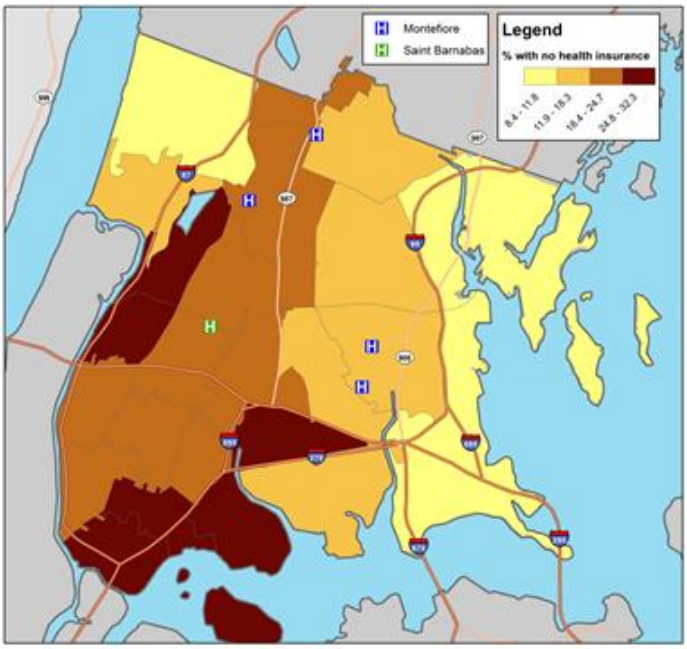
Age-adjusted percent of adults with primary care provider

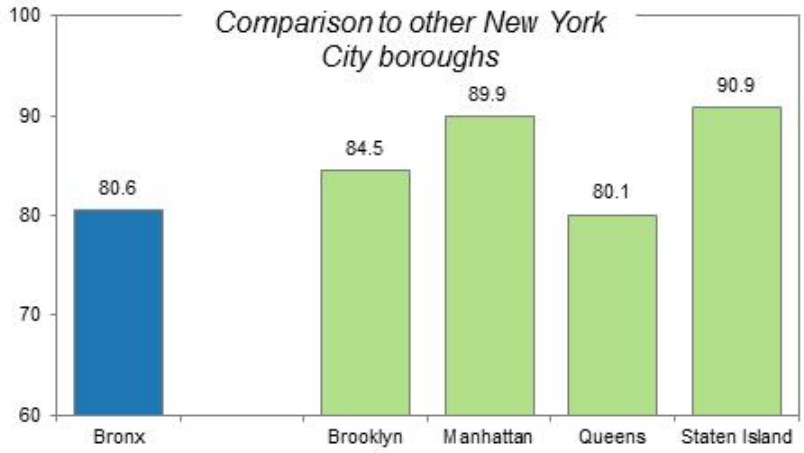




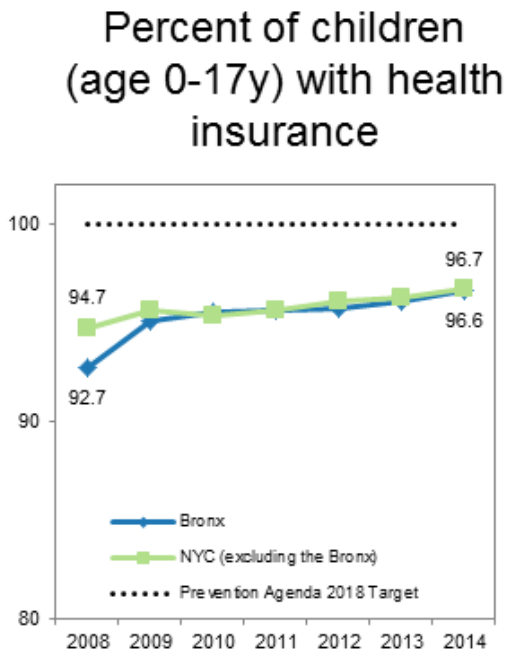
Data source: New York City Community Health Survey

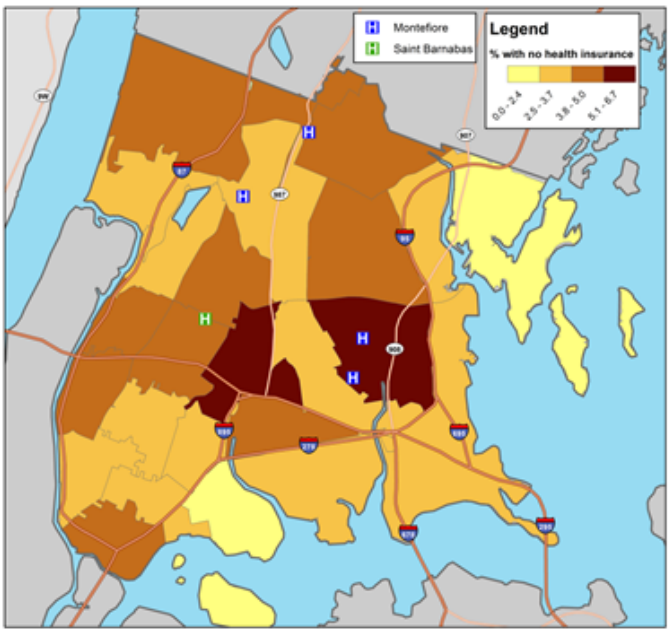


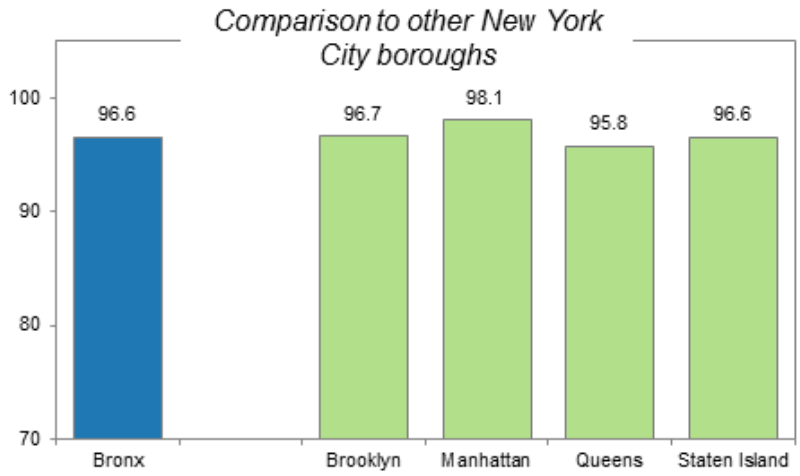




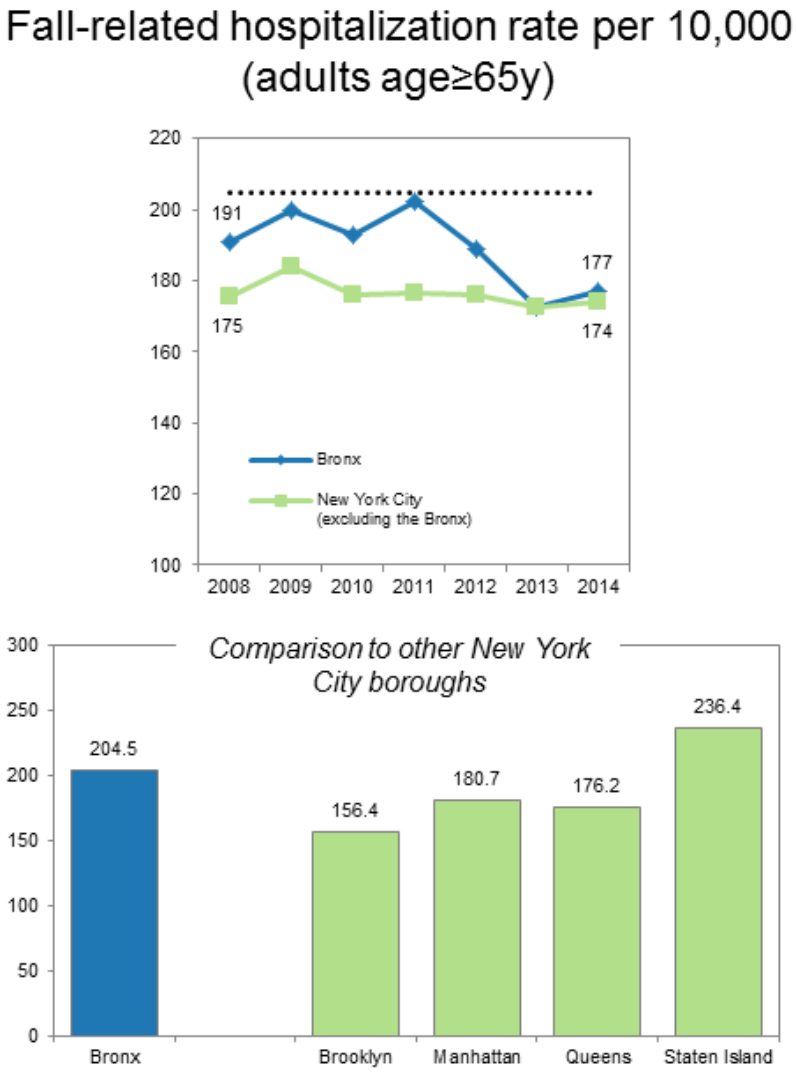
Data source: American Community Survey



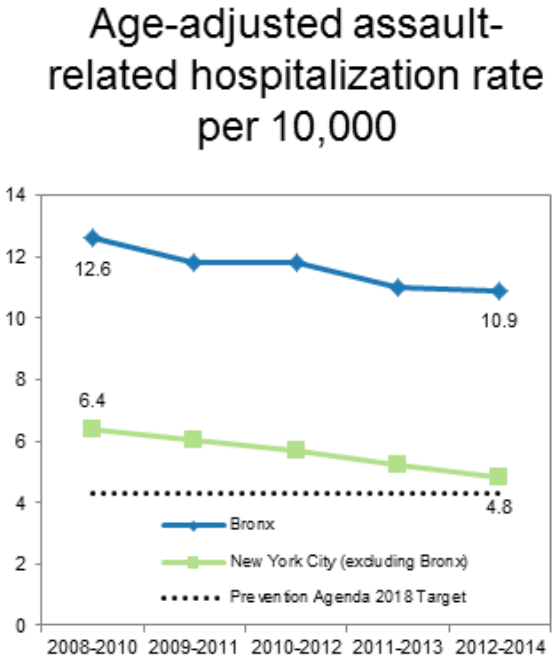


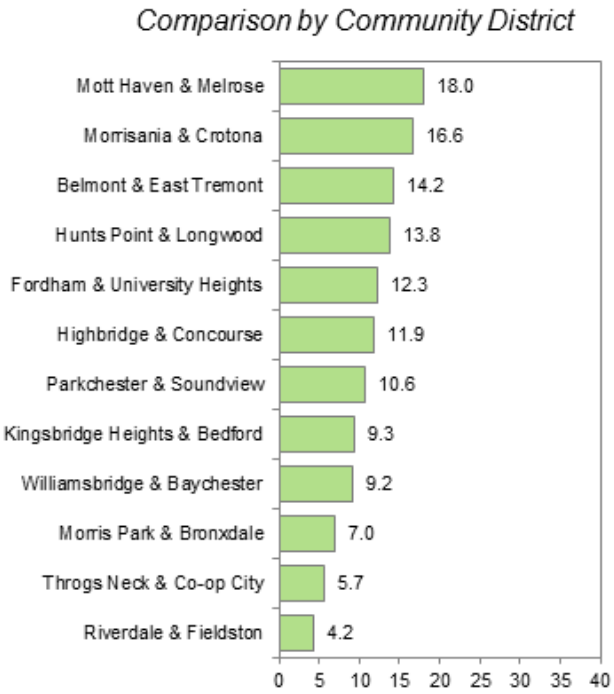


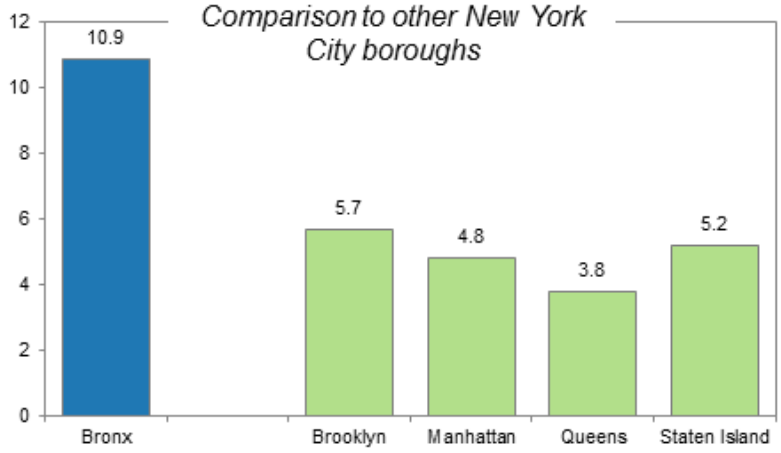
Data source: American Community Survey



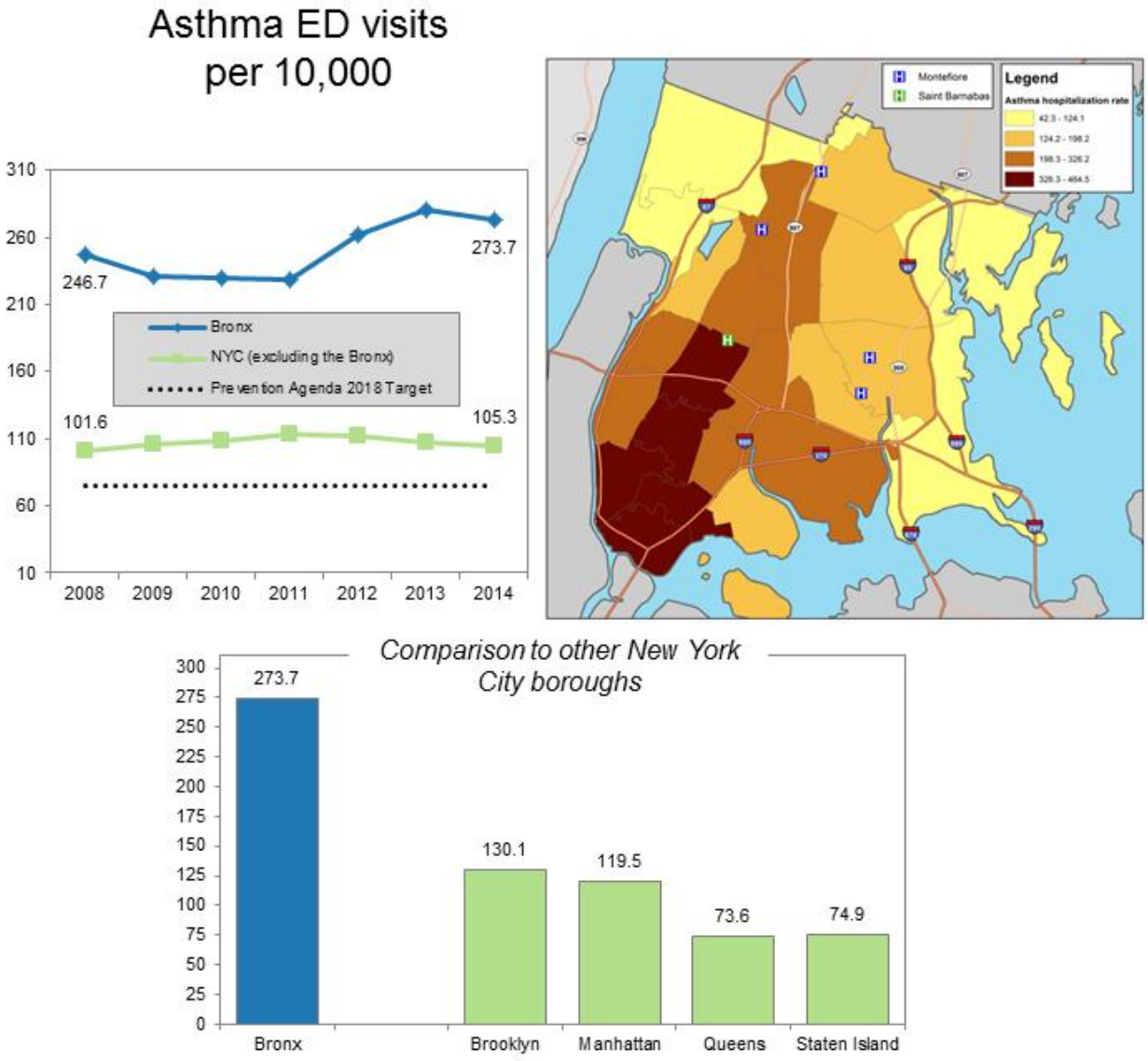
Data source: SPARCS



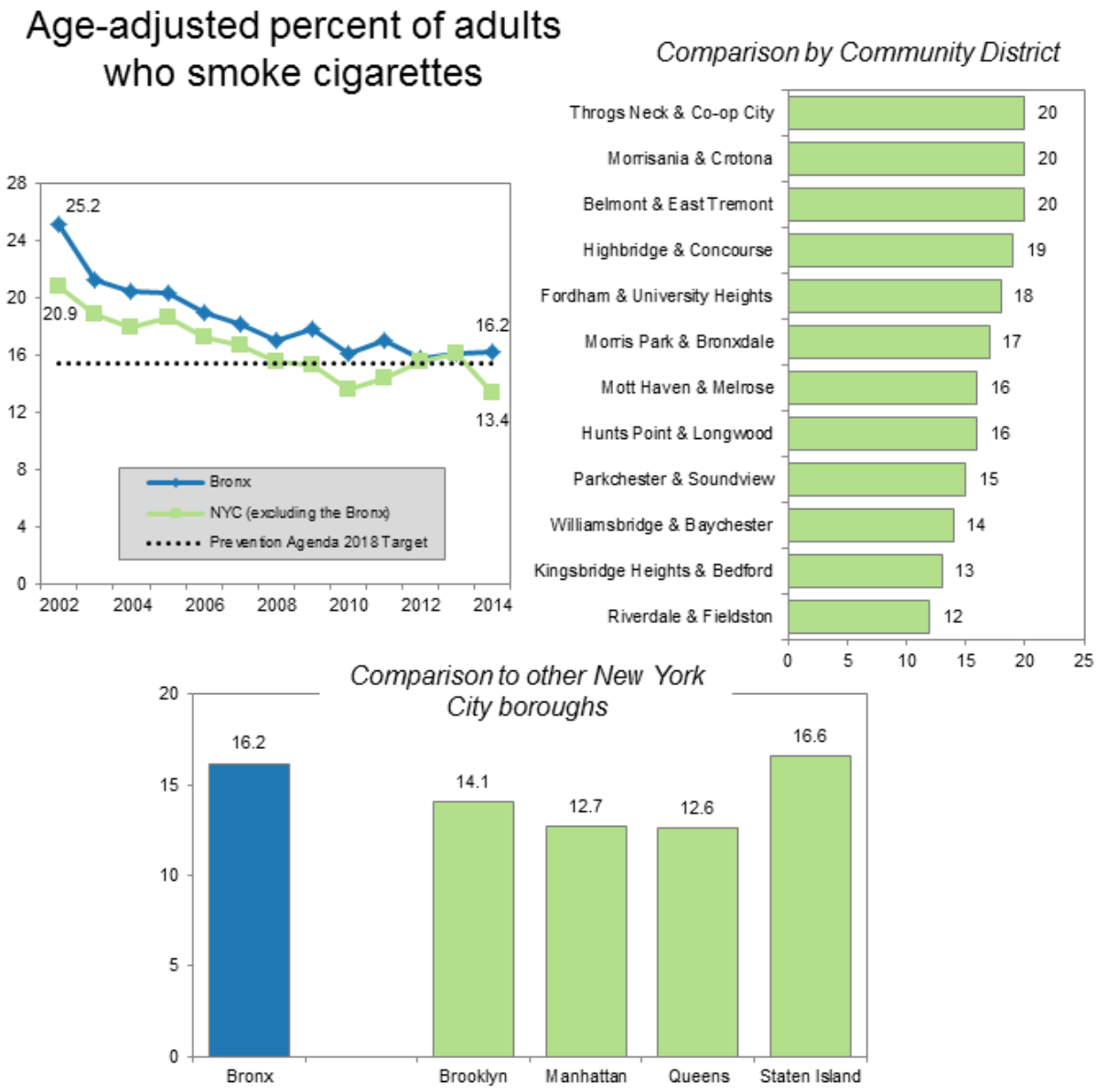




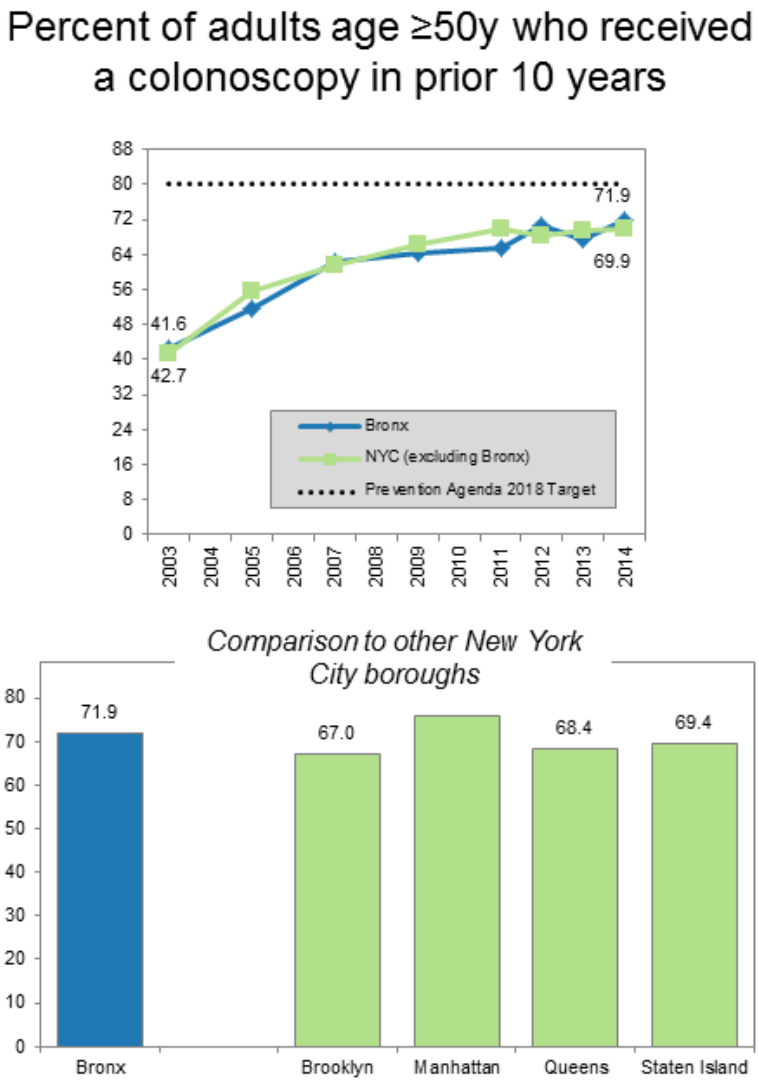
Data source: SPARCS



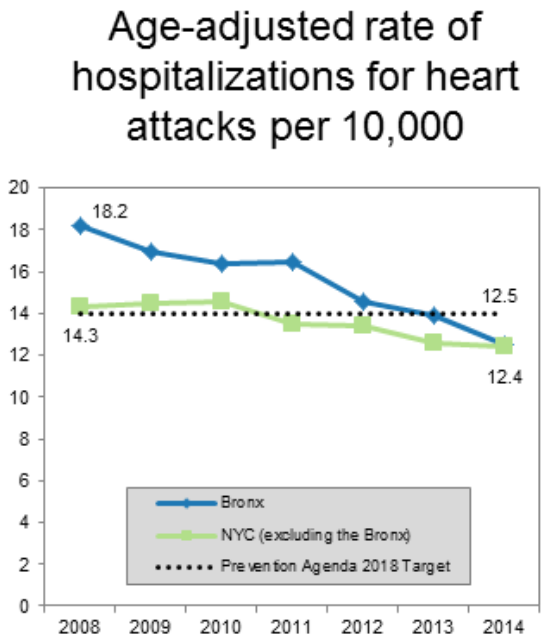
Data source: SPARCS

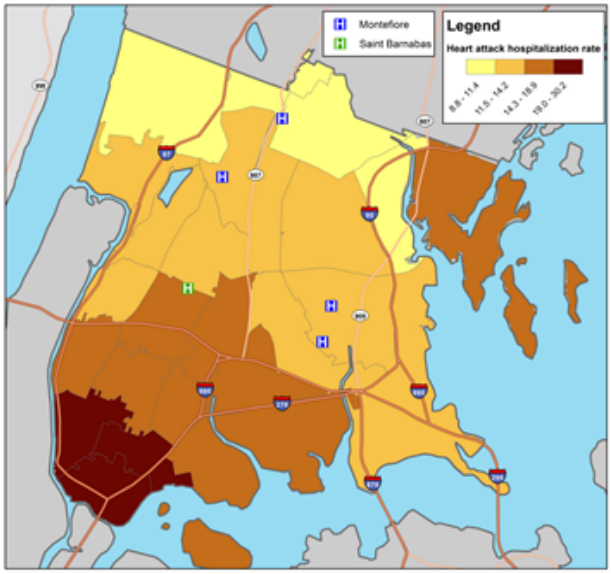


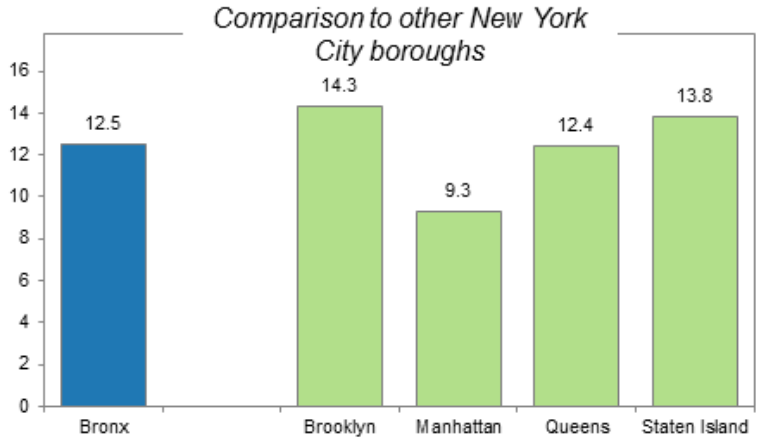
Data source: New York City Community Health Survey



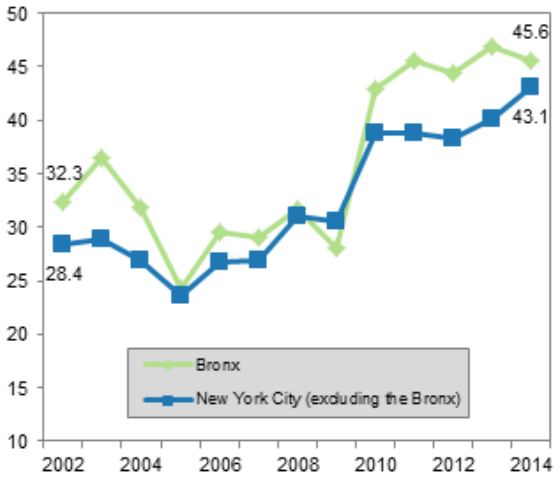
Data source: New York City Community Health Survey

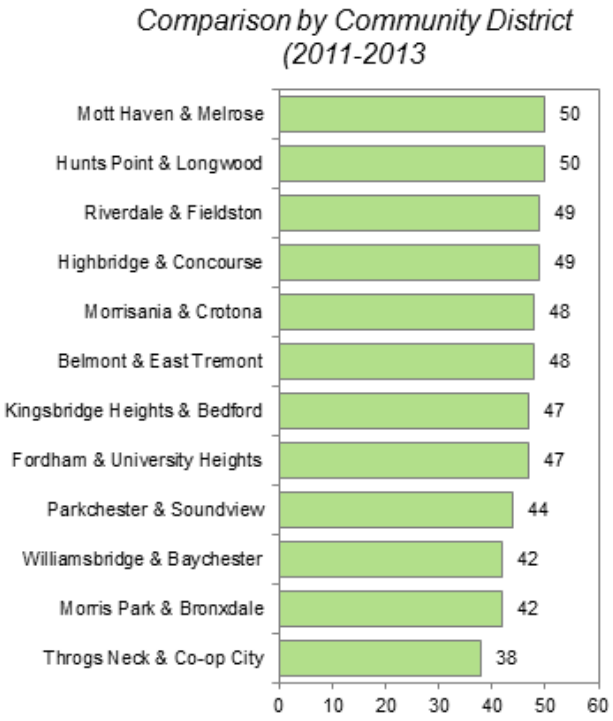


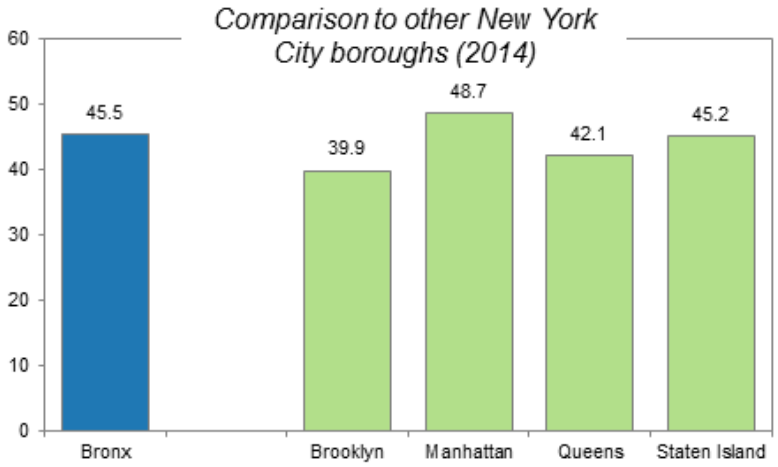




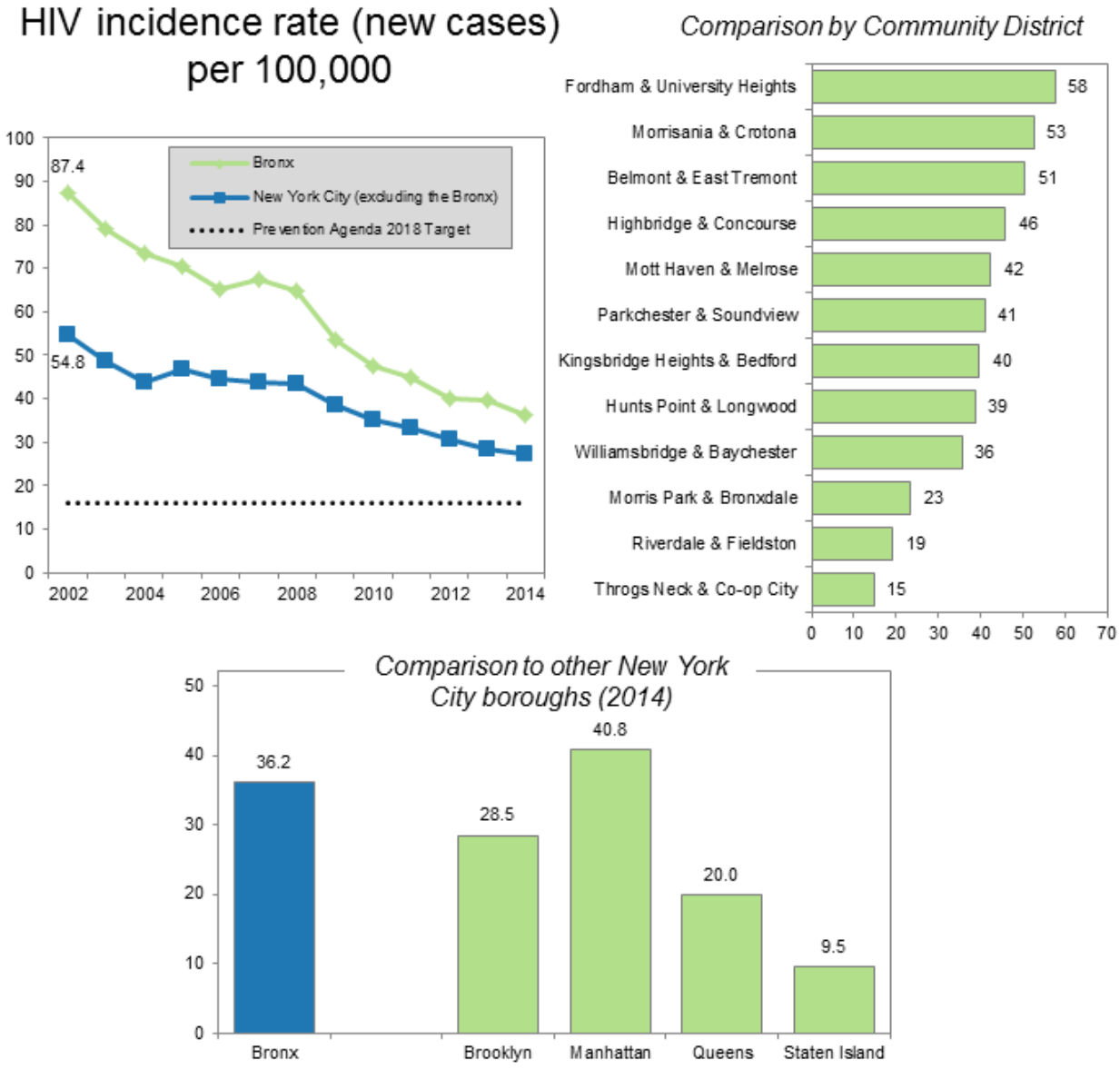
Data source: SPARCS



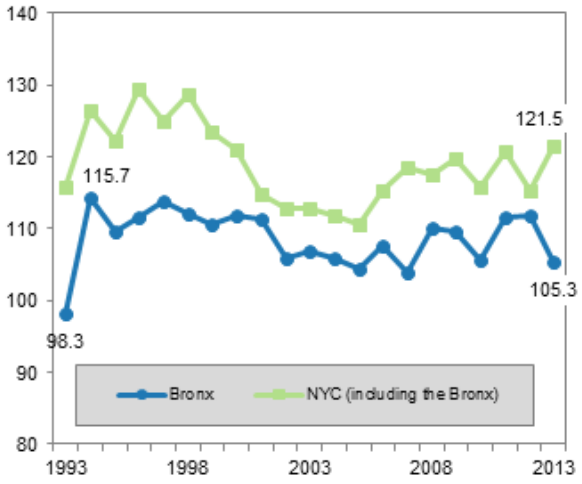


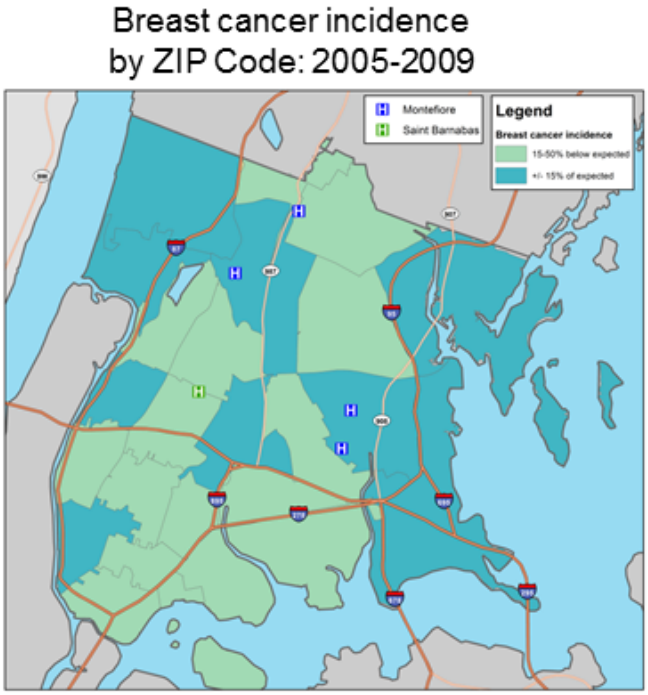


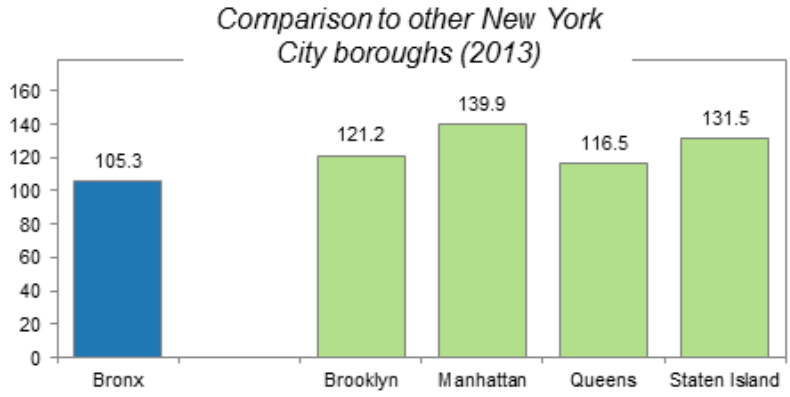
Data source: New York City Community Health Survey



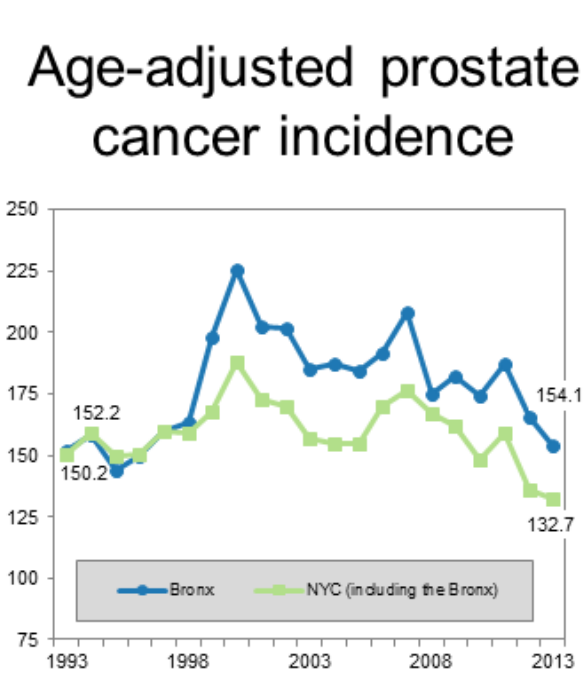
Data source: New York State HIV/AIDS Epidemiology Reports

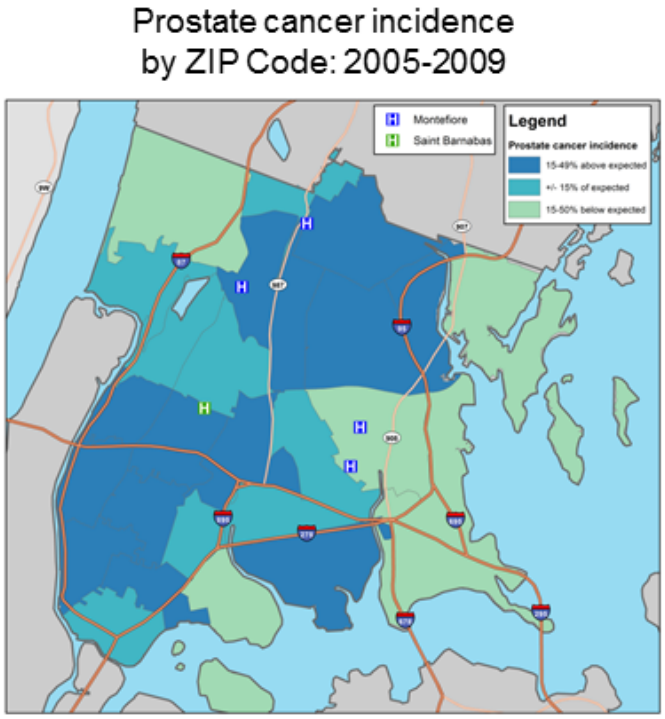


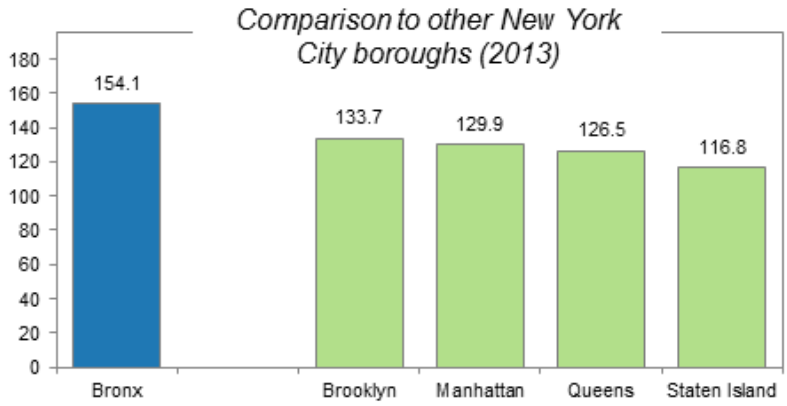




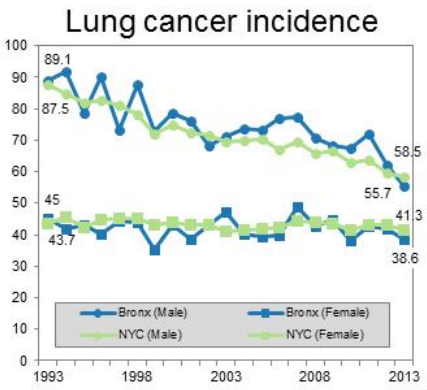
Data source: New York State Cancer Registry

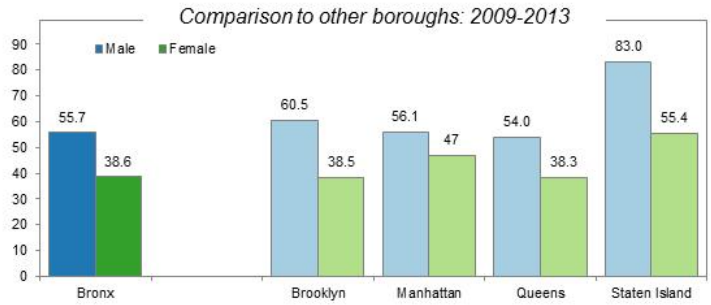




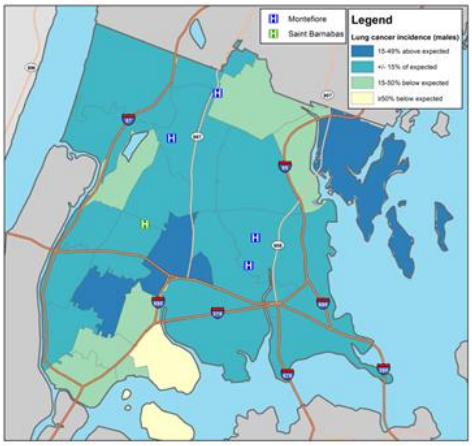


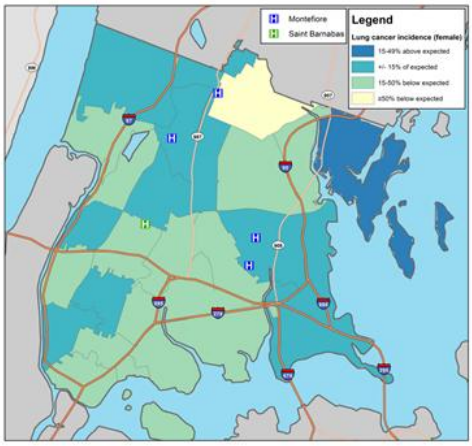
Data source: New York State Cancer Registry





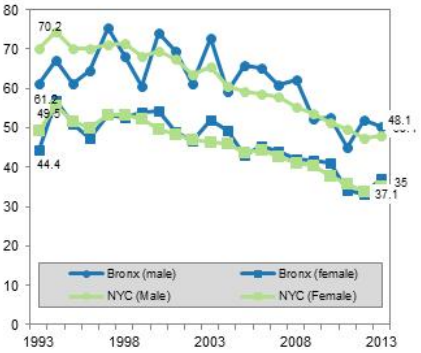
Lung cancer incidence by ZIP Code: 2005-2009

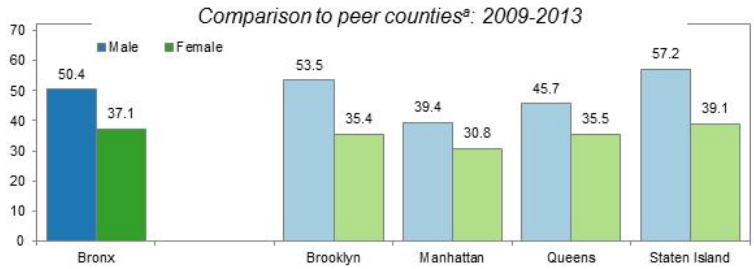




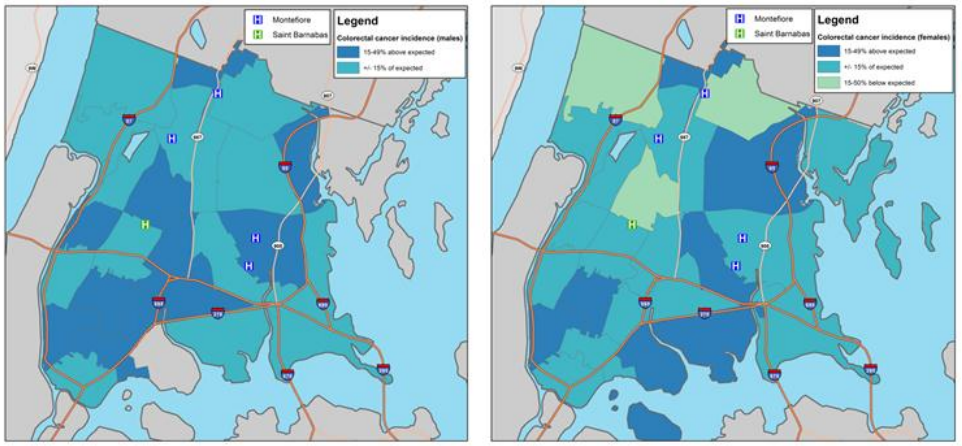
Data source: New York State Cancer Registry

Colorectal cancer incidence





Colorectal cancer incidence by ZIP Code: 2005-2009



Data source: New York State Cancer Registry

Appendix C: Summary of 2015 Inpatient Discharges

Table. Summary of primary discharge diagnosis codes for inpatient discharges at Montefiore Medical Center hospitals in the Bronx, including Montefiore Moses, Children's Hospital at Montefiore, Wakefield and Weiler

ICD 10: October-December		*ICD 9: January-September*	
Diagnosis description	*Discharges*	*Diagnosis description*	*Discharges*
Single liveborn infant delivered vaginally	945	Single liveborn infant delivered vaginally	3142
Sepsis organism NOS	621	Septicemia NOS	2114
Single liveborn infant delivered by cesarean	480	Single liveborn infant, delivered By Cesarean	1579
Pneumonia Organism NOS	383	Chest Pain NEC	1158
Chest Pain NEC	367	Pneumonia Organism NOS	1078
COPD with exacerbation	346	Coronary atherosclerosis of native coronary artery	947
Acute on chronic systolic heart failure	294	Acute on chronic systolic heart failure	868
Syncope & collapse	280	Acute Kidney Failure NOS	764
Urinary tract infection site NOS	240	Syncope & collapse	731
Acute on chronic diastolic heart failure	227	Asthma NOS with Exacerbation	717
Acute Kidney Failure NOS	217	Morbid Obesity	693
Post-term pregnancy	196	Post term pregnancy, delivered	661
ASHD native coronary artery with unstable angina	195	Hemoglobin SS Disease with Crisis	645
Maternal care for scar from previous cesarean delivery	189	Urinary Tract Infection NOS	632
Morbid obesity due to excess calories	180	Acute on chronic diastolic heart failure	623
Non-ST elevation myocardial infarction	157	Chronic obstructive asthma with (acute) exacerbation	601
Hemoglobin SS disease with crisis NOS	155	Previous cesarean delivery, delivered	586
Asthma NOS with exacerbation	151	Atrial Fibrillation	560
Chest Pain NOS	133	Obstructive chronic bronchitis with (acute) exacerbation	559
Abnormality in fetal heart rate and rhythm complicating labor and delivery	131	Dehydration	535

Acronyms: NOS = not otherwise specified; NEC = not elsewhere classified