Community Health Needs Assessment-Implementation Strategy Report and Community Service Plan 2022-2024

Montefiore Medical Center

Office of Community & Population Health
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The Community Health Needs Assessment-Implementation Strategy Report and Community Service Plan 2022-2024 contains data representing Bronx County, the northernmost county of New York City and the third most densely populated county in the United States. This document is submitted as the requirement for the 2022-2024 Community Health Needs Assessment-Implementation Strategy Report and Community Service Plan for the Schedule H Requirement of the Internal Revenue Service 990 tax form and assesses the health needs for the Bronx, County, New York.

The participating hospital is Montefiore Medical Center, a part of the Montefiore Health System, and encompasses the five Bronx campuses (Moses, Wakefield, Weiler/Einstein, Westchester Square, and the Hutchinson Campus) and the ambulatory sites in Bronx County. The contact for information that pertains to this report is:

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Executive Summary

The 2022-2024 Montefiore Medical Center Community Service Plan

Every three years, all non-profit hospitals are required to complete a Community Service Plan that aligns with the priorities included in the 2019-2024 New York State Prevention Agenda. The plan outlines actions the hospital will take to address the significant health needs identified and the disparities in health outcomes of the communities served. It is based on an assessment of community health needs and assets conducted in collaboration with internal and external stakeholders and community partners, as well as from a review of publicly available data.

Montefiore Medical Center's 2022-2024 Community Health Needs Assessment-Implementation Strategy Report and Community Service Plan was reviewed by the Montefiore Board of Trustees on December 15, 2022. The Community Health Needs Assessment-Implementation Strategy Report and Community Service Plan report was uploaded to the Montefiore website on December 30, 2022.

Who We Are

Montefiore Medical Center (MMC), in partnership with multiple Bronx hospital and healthcare providers, community stakeholders, including the New York City Department of Health and Mental Hygiene's Bronx Health Bureau (NYCDOHMH), community organizations and community residents, has conducted the 2022 Community Health Needs Assessment for the 2022-2024 Community Service Plan to identity the significant health concerns of Bronx County.

MMC, as described in this report, consists of the Montefiore Health System facilities within Bronx County and includes three hospital campuses (Moses, Weiler/Einstein and Wakefield), the Children's Hospital at Montefiore (CHAM), the off-campus hospital-based Emergency Department at Montefiore – Westchester Square, the Montefiore Hutchinson Campus, and the sites of the Montefiore Medical Group, the Montefiore School Health Program, and numerous other community-based locations. All of these services are supported by the broader resources of the nationally ranked multi-county Montefiore Health System (MHS).

MHS is the premier academic health system and the University Hospital for Albert Einstein College of Medicine, serving 3.1 million people living in the New York City region and the Hudson Valley. MHS delivers science-driven care where, when and how patients and communities need it most, combining nationally recognized clinical excellence with expertise in accountable, value-based care that focuses on its patients, their families and the community.

MMC's Executive Leadership and Board of Trustees sponsor the Community Health Assessment process through the Office of Community and Population Health (OCPH). OCPH continually develops and maintains ongoing relationships with community-based organizations interested in the health issues most impacting the populations of the regions we serve.

Who We Serve

MMC has identified the Bronx as its primary service area. The Bronx is the sixth smallest county in the nation with 42.1 square miles. The Bronx is also the third densest county in the nation with 34,242 people per square mile, making it home to more than 1.4 million people.

The Bronx is one of the most diverse counties in the nation. According to 2020 Census data, 54.8% of Bronx residents are Hispanic/Latino of any race, 28.5% are non-Hispanic black, 8.9% are non-Hispanic white and 4.6% are non-Hispanic Asian. More than one-third (33.7%) of Bronx residents were born outside of the United States. In the Bronx, more people speak a language other than English at home (57%) than speak "only English" (more than 40 languages). The Bronx was New York City's first borough to have a majority of people of color and is the only borough with a Latino majority. Its foreign-born population comes from diverse corners of the globe, including the Dominican Republic, Jamaica, Mexico, Ghana, Ecuador, Bangladesh, Guyana, Honduras, Nigeria, Trinidad & Tobago and Italy. As the population in the Bronx is exceptionally diverse, improvements in the health of the general population must necessarily address racial/ethnic and socioeconomic drivers of health disparities.

County Health Rankings and Roadmaps, a program of the University of Wisconsin Population Health Institute and funded by the Robert Wood Johnson Foundation, provides annual rankings comparing the health of counties across country. Using national and state data sources, county-level measures are used to rank the health of counties to others within the same state. Of the 62 counties in New York State, the Bronx consistently ranked 62 in measures for health factors and health outcomes According to the 2022 County Health Rankings, the relative ranking of the Bronx has improved for 2 subcategories: Length of Life and Health Behaviors. Improvements are captured through measure like access to exercise and reductions in binge drinking which speak to health behaviors. The improvements in measures related to Length of Life and Health Behaviors demonstrates that Bronx residents are more engaged in activities to manage and improve their health. This commitment by residents, organizations and institutions in the borough to make healthier choices and increase access to resources to improve health outcomes is one of the great assets of the Bronx.

Summary of Assets

In addition to the great diversity of the borough, the Bronx has many assets and resources. Bronx residents have access to public and private schools of higher education, open spaces, healthcare facilities, community gardens, community- and faith-based organizations, fitness facilities, bike lanes and much more. The full report includes descriptions that highlight many of the assets and resources in the Bronx that play an important role in supporting and providing needed health resources to residents across the borough. Many community-based organizations and institutional partners mentioned in the report support the work proposed for the 2022-2024 Community Service Plan.

Hospitals and Clinics

The Bronx has 313 healthcare facilities, including public and private hospitals, medical clinics, federally qualified health centers (FQHCs), community health centers, and independent community based primary care providers that provide services to the community. These clinical providers include New York City's public hospital system, and providers such as Montefiore Health System, BronxCare, and St. Barnabas Hospital; all provide primary and specialty care throughout the borough. MMC has partnered with hospitals and health systems in the Bronx and in New York City to share information, where appropriate, and resources to better serve our residents.

Local Health Department

New York City has a strong local health department, the NYC DOHMH, which provides population health programming and leads city-wide and initiatives to improve the health of local communities. Through NYC DOHMH's local Bureau of Bronx Neighborhood Health, Bronx community members and organizations have access to programs, services, and spaces for planning and organizing around heath. MMC continues to partner with NYC DOHMH and the Bureau of Bronx Neighborhood Health to provide residents with health promotion and educational information and programming, aimed at improving the health of our communities.

Open Spaces

The NYC Department of Parks and Recreation is responsible for maintaining the city's parks and open spaces and providing recreational opportunities for New York City residents. The Bronx is home to 6,612 acres of open space, including three of New York City's largest parks (Pelham Bay Park, Van Cortlandt Park, and Bronx Park) making the Bronx the borough with the greatest number of acres of green space. The public parks connect Bronx residents to health promoting resources and programming, such as recreation centers, playing fields, playgrounds and free community events that promote community cohesion and connect residents to their local park spaces.
The Bronx is also home to more than 140 community gardens. These community gardens serve as an important space for communities in the Bronx and across the city. The benefits of community gardens have been studied widely and include:

- Improved access to nutritious foods
- Safe space for community members to gather, share resources and organize
- Space for recreational and educational programming
- Increased consumption of fruits and vegetables

MMC recognizes the importance of community gardens and green spaces and has supported the development and maintenance of both in the Bronx, including the creation and expansion of edible gardens in partnership with local nonprofits and schools.

Public Libraries

Public libraries provide important educational and literacy services to our communities. There are thirty-three public libraries in the Bronx. In addition to educational services, our public library system provides a range of services to the community including, but not limited to, community

events and assistance with health insurance plan enrollment through the Health Insurance Marketplace. Collaborations with the local branches of our public library system has been a valuable resource for many of our community health and education programs. They provide spaces to share valuable information on health-related programming offered by our hospitals and allow us to connect with and learn from community members to better serve residents.

Public and Private Schools
The Bronx has 423 public and private schools and 8 colleges and universities. In 2020, universities and colleges in the Bronx awarded 16,886 degrees. Many offer services and resources to support both the educational and health needs of their student populations. For example, NYC Department of Education offers health and wellness programming for public schools across the city.

Many schools partner with community organizations and health systems to expand the number and types of resources offered to their students to address both clinical, and non-clinical health needs. One great example of this partnership is Montefiore's School Health Program which is the largest and most comprehensive school-based health program in the country. By working in partnership with our public school system, MMC provides coordinated primary and preventive healthcare to elementary, middle and high school students throughout the Bronx. Services include medical, mental health and dental care along with community health programming for students and families. Additionally, MMC works closely with high schools, colleges, universities, and city agencies in the Bronx to offer internships, summer youth programming, and employment opportunities for students.

Community Organizations
The Bronx is home to hundreds of community-based organizations (CBOs) and faith-based organizations (FBOs) that serve as an important resource for Bronx residents. They are a trusted source of referrals for local community services and help residents connect to culturally and linguistically targeted health education and chronic disease management programming, health insurance enrollment, treatment adherence and linkage to care. Services provided by CBOs and FBOs include, but are not limited to:

- Advocacy for social and regulatory changes that will positively impact health outcomes for residents of the Bronx;
- Referrals and resources for supportive housing, and affordable housing options;
- Social services programs such as the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Medicaid and subsidized childcare;
- Legal assistance related to immigration issues, housing issues, and domestic violence; and
- Food and nutrition resources, including food pantries, meal service, home-delivered meals, and nutrition education programming.

The Bronx also has a rich history of activism and engagement in local, national, and global issues. This history has continued forward and been extremely valuable to the Bronx as a whole. We regularly engage with community members through our Community Advisory Boards. MMC recognizes the value of the residents and community members we serve across the borough and

continue to incorporate more opportunities for community voice, feedback, and leadership in our initiatives.

Primary Data Collection Process

For the 2022 Community Health Needs Assessment Survey, MMC participated in the Community Health Needs Assessment Survey Collaborative led by the Greater New York Hospital Association (GNYHA). The Community Health Needs Assessment Survey Collaborative included multiple health systems and hospitals across New York State. Working with the GNYHA CHNA Survey Collaborative, a survey was developed and distributed to community members as the main method of primary data collection. The survey was available on paper and electronically through a survey link and QR code and was available in 10 languages.

More than 1,400 surveys were collected in the Bronx as part of the GNYHA CHNA Survey Collaborative. One of the main survey questions asked community members to rank the importance of a list of 21 health areas/conditions. The included health conditions were chosen to align with the 2019-2024 New York State (NYS) Prevention Agenda Priorities and Focus Areas. For the same menu of health areas/conditions, community members were also asked to rank their level of satisfaction with the current services in their neighborhood. Participants identified Violence (Including gun violence), Mental health/depression, Women's and maternal health care, Asthma/breathing problems or lung disease, Cancer, Stopping falls among elderly, and Obesity in children and adults as the seven top community health priorities. Please see Table 1 below:

Needs Attention	Maintain Efforts	Relatively Lower Priority
Violence (Including gun violence)	Dental care	Substance use disorder/drug addiction (including alcohol use disorder)
Mental health/depression	COVID-19	Arthritis/disease of the joints
Women's and maternal health care	Access to health/nutritious foods	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah
Asthma/breathing problems or lung disease	High blood pressure	Sexually Transmitted Infections (STIs)
Cancer	Heart disease	Infant health
Stopping falls among elderly	Diabetes/elevated sugar in the blood	HIV/AIDS (Acquired Immune Deficiency Syndrome)
Obesity in children and adults	Adolescent and child health	Hepatitis C/liver disease

Table 1. Health priorities selected by Bronx Residents from the community health survey for the CHNA.

In addition to participation in the survey collaborative, MMC worked with community stakeholders to identify priorities for the 2022-2024 CHNA cycle. Community stakeholders include the NYCDOHMH Bronx Bureau of Neighborhood Health, Bronx Community Boards, MMC's Community Advisory Boards, community organizations and community residents.

Secondary Data Collection Plan

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, diabetes, preterm births, teen pregnancy rates, poverty, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screening , HIV incidence, lung, colorectal, prostate and breast cancer incidence rates. 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. Whenever possible these measures aligned with those outlined in the New York State Prevention Agenda Dashboard.

Community Health Improvement Plan/Community Service Plan

While the health status of the Bronx has improved in recent years, the gap between the Bronx and other boroughs remains. To identify priorities and programming for the 2022-2024 CHNA cycle, MMC reviewed and assessed primary data from the 2022 Community Health Needs Assessment Survey, community feedback from stakeholders and community members, recent secondary data on health outcomes for Bronx residents, key health disparities in the Bronx, and the resources and priorities of the health system. Based on the priorities for the NYS Prevention Agenda and input from the community, priorities and focus areas for the Community Service Plan (CSP) were selected to allow us to address pressing health needs of the community while working closely with community partners with a focus on addressing key health disparities in the Bronx.

For the 2022-2024 Community Service Plan cycle, MMC has identified two priority areas in which the supportive services and programs provided by MMC and the needs of the community aligned: 1) Cancer and 2) Women's and Maternal Health Care. All initiatives are described in detail in the full report. Below is a summary of the programs selected for the CSP.

Cancer Screening

The Bronx faces a formidable cancer burden. Late-stage diagnosis of screen-detectable cancers at Montefiore Einstein Cancer Center (MECC) in 2020-21 was 22.5%, with rates exceeding 30% in several neighborhoods in the Bronx. Although poverty throughout the Bronx is high with 30% living below the federal poverty level, late-stage diagnosis does not occur exclusively in the poorest neighborhoods.

Based on NY State Dept of Health 2019 "Information for Action Reports", adherence to cancer screening in our catchment area was 71.5% colorectal (CRC), 84.0% breast, and 80.5% cervical, respectively. Of the 62 NY State counties, Bronx ranked 27th, 12th, and 42nd in terms of cancer screening and close to state medians in each case. Although these rates alone indicate room for improvement, they do not tell the whole story. MECC conducted the Bronx Catchment Area Survey in 2017- 2018, which included complete data on cancer attitudes and screening behavior from 1430 respondents reflecting the demographics of the Bronx. A subset of 608 respondents completed an in-depth module on stress experienced in the past year due to social determinants of health. We found that 62% of Bronx residents reported high stress related to at least one social determinant, including problems with money for food and other needs (38%), employment (28%), transportation (21%), housing (19%), physical limitations (23%) medical care (14%) and public services (11%). Nearly 40% identified 3 or more sources of high stress. Analysis revealed that each high-stress exposure reduced the likelihood of adherence to colorectal cancer screening by 10%, mammography by 15%, and Pap testing by 16%. In sum, although many in our catchment area can obtain timely cancer screening, these data suggest the importance of reaching segments of the Bronx community particularly affected by social determinants of health.

MECC will implement two cancer screening programs as part of the 2022-2024 CSP to address disparities in screening rates. Programs included in the 2022-2024 CSP are the "Sidewalks to Screenings" program and NYC CONNECT. The identified programs will address the following prevention agenda priority:

Prevention Agenda Priority: Prevent Chronic Diseases
Focus Area 4: Preventive Care and Management
Goal 4.1: Increase cancer screening rates

The leading indicators we will use for increasing cancer screening rates are 1) increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines; 2) increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years); and 3) increase the percentage of adults aged 50-64 who receive a colorectal cancer screening based on the most recent guidelines.

Maternal Health

The 2019 NY State Taskforce Report on Maternal Mortality and Disparate Racial Outcomes reported that the maternal mortality rate for Black women in New York is 51.6 deaths per 100,000 live births compared to 15.9 deaths per 100,000 live births for white women. Black women are approximately three times more likely to die in childbirth than white women. Given these stark disparities, it is crucial that health systems implement strategies to prioritize and improve maternal health outcomes. One important pathway for health systems in addressing disparities in order to advance health equity, is to screen for unmet social needs and connect patients who want help to both internal and external resources to address those needs.

In 2021, MMC established the Community Health Worker Institute (CHWI) to integrate social care into the delivery of health care by adding community health workers to clinical teams. It is the aim of the CHWI to test an innovative CHW model at scale across MMC's primary care network. The CHWI will provide support to seven Obstetrics and Gynecology (OB/GYN) outpatient practices at MMC to establish social needs screening workflows and integrate referral systems to community health workers (CHWs). MMC will establish a social care coordination team in each department, which will include administrative staff, patient navigators, social workers, clinicians, and CHWs. Provider champions in each department will be recruited and trained to build and lead the care coordination team. The CHWI will address the following prevention agenda priority:

> Prevention Agenda Priority: Promote Health Women, Infants and Children
>
> Focus Area 4: Cross Cutting Healthy Women, Infants, & Children
>
> Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations

Although lead indicators were not identified in the 2019-2024 NYS Prevention Agenda for this goal, the team has identified key measures for this work. MMC seeks to 1) conduct a social needs assessment on 50 percent of active pediatric patients and mothers at participating practices; 2) provide referral support to at least 50 percent of patients who are identified as having an unmet social need(s) and request assistance; and 3) link at least 50 percent of families to appropriate social service agencies.

Resources and Appendices

The Community Health Needs Assessment and implementation report concludes with information for web-based resources, sample survey documents and supplemental maps.

The 2022-2024 Montefiore Medical Center Community Health Needs Assessment and Community Service Plan

The completion of a Community Health Needs Assessment-Implementation Strategy Report and Community Health Needs Assessment is a requirement of the Internal Revenue Service's 990 tax documentation requirements under the Patient Protection and Affordable Care Act (PPACA). The PPACA requires hospitals to assess and address the health needs of the communities they serve. This Community Health Needs Assessment meets the first component of these requirements, providing a report of the process, methods and results of a comprehensive assessment of the needs of the community served by MMC. The second component encompasses the Implementation Strategy and Community Service Plan, which further describes the significant health needs of the community, highlighting the programs and strategies to address these significant health needs, and delineating the metrics to be used to evaluate the impact of these strategies.

Introduction

Who We Are

Montefiore Medical Center (MMC) is a part of Montefiore Health System - the premier academic health system and the University Hospital for Albert Einstein College of Medicine, serving the 3.1 million people living in the New York City region and the Hudson Valley. Montefiore Health System delivers science-driven care where, when, and how patients and communities need it most, combining nationally recognized clinical excellence with expertise in accountable, value-based care that focuses on its patients, their families, and the community. MMC's Executive Leadership and Board of Trustees sponsor the Community Health Assessment process through the Office of Community and Population Health. MMC's Office of Community and Population Health developed a community integrated approach which maintains ongoing relationships with community-based organizations working to address the health issues most impacting the populations of the regions we serve.

MMC, as described in this report, consists of the Montefiore Health System facilities within Bronx County. This includes three hospital campuses (Moses, Weiler/Einstein, and Wakefield), the Children's Hospital at Montefiore (CHAM), the off-campus hospital-based Emergency Department at Montefiore – Westchester Square, the Montefiore Hutchinson Campus, and the sites of the Montefiore Medical Group and the Montefiore School Health Program. All these services are supported by the broader resources of the nationally ranked multi county Montefiore Health System.

Montefiore's Mission Statement and Strategy:

MMC's mission, vision and values serve as the guide for pursuing clinical excellence—breaking new ground in research, training the next generation of healthcare leaders, and delivering science-driven, patient-centered care. Our mission, to heal, to teach, to discover and to advance the health of the communities we serve – builds upon MMC's rich history of medical innovation and community service and is exemplified in our exceptional, compassionate care and dedication to improve the well-being of those we serve.

MMC is Bronx County's largest employer and provider of healthcare, delivering care to approximately a third of the borough's 1.4 million residents where the nation's most diverse population of immigrants lives and works. As the University Hospital for the Albert Einstein College of Medicine, MMC consists of 11 hospitals, five located in Bronx County, the largest school-based health program in the nation, an extensive home healthcare agency, and an ambulatory network of nearly 200 locations throughout the Bronx and Westchester counties.

An update of the Strategic Planning Process was completed in June 2019 which included the expanded statements of the medical center's Mission, Vision and Values.

Mission:

To heal, to teach, to discover and to advance the health of the communities we serve.

Vision:

To be a premier academic medical center that transforms health and enriches lives.

Values:

Humanity, Innovation, Teamwork, Diversity, Equity and Quality

In fulfillment of that process, the five Strategic Goals were established, which included:

1. Create the "One Montefiore Einstein Experience"

2. Grow specialty and subspecialty care

3. Elevate Einstein's standing in research and education

4. Be a national leader in wellness and optimizing health of populations

5. Be a supportive pillar of community health

To explicitly maximize the Impact of our Community Service, MMC's commitments to optimize the health of populations and be a supportive pillar of community health, OCPH and the Office of Community Affairs have been charged with the following:

- Oversee, support and coordinate MMC's diverse portfolio of community health improvement programs and activities,
- Enhance MMC's capacity to assess and measure the health needs of the communities it serves,
- Identify, assess and select a limited number of top-priority health needs in the communities MMC serves for specific focus, and
- Lead and coordinate MMC-wide efforts, and, where possible, work with community partners to measurably improve the health of the communities we serve.

MMC has made significant advancements in achieving its strategic goals and will continue focus its efforts to make a real, measurable difference in the health of populations, and communities it serves.

MMC is dedicated providing support to patients in need of financial assistance and has remained at the forefront in establishing leading-edge Financial Assistance programs for our patients. MMC's current program includes a multi-lingual information and counseling component. Information on MMC'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.

Description of Community/Population Served

Who We Serve

MMC has identified the Bronx as its primary service area. In 2020, the population of the Bronx was 1.47 million. While the Bronx is the sixth smallest county in the nation with 42.1 square miles, it is also the third densest county in the nation with more than 34,000 people per square mile.
The Bronx is one of the most diverse counties in the nation. According to 2020 Census data, 54.8% of Bronx residents are Hispanic/Latino of any race, 28.5% are non-Hispanic black, 8.9% are non-Hispanic white and 4.6% are non-Hispanic Asian. More than one-third (33.7%) of Bronx residents were born outside of the United States. In the Bronx, more people speak a language other than English at home (57%) than speak "only English" (more than 40 languages). The Bronx was New York City's first borough to have a majority of people of color and is the only borough with a Latino majority. Its foreign-born population comes from diverse corners of the globe, including the Dominican Republic, Jamaica, Mexico, Ghana, Ecuador, Bangladesh, Guyana, Honduras, Nigeria, Trinidad & Tobago and Italy.

In addition to the great diversity of the borough, the Bronx has many assets and resources. The Bronx has 6,612 acres of open space, making up nearly a quarter of its land mass. According to the 2022 County Health Rankings from the Robert Wood Johnson Foundation, all Bronx residents have access to exercise opportunities, defined as residing in a census block that is within half a mile of a park, or in an urban census block that is within one mile of a recreation facility. Additionally, the Bronx is home to 88.5 linear miles of bike lanes, and more than 140 community gardens.
Bronx households have seen a steady increase in annual income since 2013. According to the US Census, the median household annual income of Bronx households was $41,895 in 2020 compared to the median annual income of $40,088 in 2019, representing a 4.51% annual growth between 2019 - 2020. While we have seen improvement in the median annual income for Bronx households, it remains lower than the median annual household income of $64,994 across the United States.
The Bronx saw a small increase in owner occupied housing, from 19.7% in 2019 to 20.1% in 2020 according to US Census data. The Census also reported an increase in the median property value in

the Bronx, increasing to $427,900 in 2020, from $404,700 in 2019. Investments in the built environment can not only increase the value of homes in a neighborhood but can also improve health outcomes for the residents. One great example is investments in parks and other green spaces to encourage physical activity and increase access to health food.

Each year in March, the University of Wisconsin Population Health Institute, with support from the Robert Wood Johnson Foundation, releases a new version of the County Health Rankings. Within each state, all counties are ranked across 35 measures within two broad domains: health outcomes and health factors. While there is no overall ranking, each county is given a ranking within each domain. Each domain is composed of subcategories that are also given a ranking relative to the other counties in a state. The relative ranking of the Bronx has improved for 2 subcategories: Length of Life and Health Behaviors. Improvements are captured through measure like access to exercise and reductions in binge drinking which speak to health behaviors. Measures also show improvements in the clinical domain, including measures like having a primary care provider, getting vaccinated for the flu, and preventable hospitalizations. The improvements in measures related to Length of Life and Health Behaviors demonstrates that Bronx residents are more engaged in activities to manage and improve their health.

While Bronx residents have made progress in different areas such as improvements in health behaviors and increases in income, education and homeownership, communities across the Bronx continue to experience gaps in key areas impacting individual and community health and wellbeing. Between 2019-2020, there was a decline in employment for Bronx County residents at a rate of -1.71% (US Census Bureau). While annual income has increased over the last few years, the Bronx continues to see higher rates of poverty compared to the national average. In the Bronx, 27% of the population is living below the poverty line, compared to the national average of 12.8%. Further, while 36.5% of children in the Bronx are living below the poverty level, this is a 7.5% decrease from 2014.

Among the 62 counties in New York State ranked as part of the County Health Rankings, the Bronx has consistently ranked #62 for both the health outcomes and health factors domains. A closer look into the categories factored into each domain shows that the Bronx has consistently received low rankings related to the following 4 categories: Quality of Life, Social and Economic Factors, Clinical Care, and Physical Environment. The low rankings in these categories point to a need for

continued and increased investments upstream in areas like government and healthcare to impact systems which goes beyond individual health choices. This stresses the importance of MMC's continued investment in partnerships, programming, and advocacy to better addresses the social determinants of health. As the population in the Bronx is exceptionally diverse, improvements in the health of the general population must necessarily address racial/ethnic and socioeconomic drivers of health disparities.

Community Assets and Resources

In addition to the great diversity of the borough, the Bronx has many assets and resources. Bronx residents have access public and private schools of higher education, open spaces, healthcare facilities, community gardens, community- and faith-based organizations, fitness facilities, bike lanes and much more. The full report includes descriptions that highlight many of the assets and resources in the Bronx that play an important role in supporting and providing needed health resources to residents across the borough. Many community-based organizations and institutional partners mentioned in the report support the work proposed for the 2022-2024 Community Service Plan.

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The NYC Department of Parks and Recreation is responsible for maintaining the city's parks and open spaces and providing recreational opportunities for New York City residents. The Bronx is home to 6,612 acres of open space, including three of New York City's largest parks (Pelham Bay Park, Van Cortlandt Park, and Bronx Park) making the Bronx the borough with the greatest number of acres of green space. The public parks connect Bronx residents to health promoting resources

and programming, such as recreation centers, playing fields, playgrounds and free community events that promote community cohesion and connect residents to their local park spaces.
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MMC recognizes the importance of community gardens and green spaces and has supported the development and maintenance of both in the Bronx, including the creation and expansion of edible gardens in partnership with local nonprofits and schools.

Public Libraries
Public libraries provide important educational and literacy services to our communities. There are thirty-three public libraries in the Bronx. In addition to educational services, our public library system provides a range of services to the community including, but not limited to, community events and assistance with health insurance plan enrollment through the Health Insurance Marketplace. Collaborations with the local branches of our public library system has been a valuable resource for many of our community health and education programs. They provide spaces to share valuable information on health-related programming offered by our hospitals and allow us to connect with and learn from community members to better serve residents.

Public and Private Schools
The Bronx has 423 public and private schools and 8 colleges and universities. In 2020, universities and colleges in the Bronx awarded 16,886 degrees. Many offer services and resources to support both the educational and health needs of their student populations. For example, NYC Department of Education offers health and wellness programming for public schools across the city.

Many schools partner with community organizations and health systems to expand the number and types of resources offered to their students to address both clinical, and non-clinical health needs. One great example of this partnership is Montefiore's School Health Program which is the largest and most comprehensive school-based health program in the country. By working in partnership with our public school system, MMC provides coordinated primary and preventive healthcare to elementary, middle and high school students throughout the Bronx. Services include medical, mental health and dental care along with community health programming for students and families. Additionally, MMC works closely with high schools, colleges, universities, and city agencies in the Bronx to offer internships, summer youth programming, and student employment opportunities for students.

Community Organizations
The Bronx is home to hundreds of community-based organizations (CBOs) and faith-based organizations (FBOs) that serve as an important resource for Bronx residents. They are a trusted source of referrals for local community services and help residents connect to culturally and

linguistically targeted health education and chronic disease management programming, health insurance enrollment, treatment adherence and linkage to care. Services provided by CBOs and FBOs include, but are not limited to:

- Advocacy for social and regulatory changes that will positively impact health outcomes for residents of the Bronx;
- Referrals and resources for supportive housing, and affordable housing options;
- Social services programs such as the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Medicaid and subsidized childcare;
- Legal assistance related to immigration issues, housing issues, and domestic violence; and
- Food and nutrition resources, including food pantries, meal service, home-delivered meals, and nutrition education programming.

The Bronx also has a rich history of activism and engagement in local, national, and global issues. This history has continued forward and been extremely valuable to the Bronx as a whole. We regularly engage with community members through our Community Advisory Boards. MMC recognizes the value of the residents and community members we serve across the borough and continue to incorporate more opportunities for community voice, feedback, and leadership in our initiatives.

The assets described above were assessed in 2022 through examination of resources known to MMC and verified through municipal sources including the New York City government webpage, www.nyc.gov which provides information on land use, municipal sites, parks, schools and other relevant community located assets, and the New York Public Library website www.nypl.org. Additionally, MMC has gained knowledge of local community resources through supportive databases for patient referrals through sites like www.nowpow.com and www.hitesite.org.

Community Health Needs Assessment Process

Description of Community Health Status

While the health status of the Bronx has improved in recent years, the gap between the Bronx and other boroughs remains and has maintained. The Bronx remains a hotspot for excess mortality, diabetes, obesity, asthma, and other health conditions in New York City. Additionally, certain groups, such as some historically racial/ethnic minorities or those with less education, experience poorer health outcomes. Secondary data was used to capture a snapshot of health conditions,

health outcomes and health practices across the county to better understand the health needs of the populations served by MMC. The following section presents this data and summarizes some key health disparities in the Bronx.

The rate of premature deaths (defined as death before the age of 65) in the Bronx is 33.4% which is higher than the premature death rate for New York City (25.9%) and higher than the NYS Prevention Agenda target (22.8%). Unfortunately, a closer look at these numbers reveals disparities in the percentage of premature deaths by race/ethnicity. Specifically, there is a difference of 22.3% between non-Hispanic black and non-Hispanic white population in the Bronx. Disparities also exist between non-Hispanic white and Hispanic populations with a difference of 18.3%. According to the New York State Prevention Agenda, there has been no significant change in the difference in premature death rates compared to 2018.

The Bronx has an age-adjusted preventable hospitalization rate of 225.2 which is higher than the rate for all of New York City (134.3), New York State (125.9), and the Prevention Agenda 2024 Target (115.0). This measure improved significantly from the rate of 232.5 in 2018. Unfortunately, the difference in rates between Black non-Hispanics and White non-Hispanics, and Hispanics and White non-Hispanics has worsened. The difference in rates of preventable hospitalizations between Black non-Hispanics and White non-Hispanic in 2019 (123.8) is higher than the difference in rates from 2018 (109.5). The difference in rates of preventable hospitalizations between Hispanic and White non-Hispanic populations in 2019 (90.4) is also higher than the measure from 2018 (78.9). These differences are higher than the New York State Prevention Agenda targets of 94.0 and 23.9 for each group, respectively.

There are a multitude of reasons certain populations and geographic areas have poorer health outcomes; these reasons include, but are not limited to, differences in access to health care, quality of care, physical environments, and economic and educational opportunities. For example, 26.4% of residents live in poverty in the Bronx compared to 13.9% across the state. In New York State overall, those who are black (14%) and Hispanic (15.1%) are more likely to be living in poverty than those who are white (5.6%). This is also the case in the Bronx where Hispanic (29.3%) and

black (24.8%) populations in the borough are more likely to be living in poverty than those who are white (19.6%).

The Prevention Agenda 2024 target for health insurance coverage among adults aged 18-64 is 97%, and in the Bronx 89% of adults are covered, compared to 92.5 across the state. There was no significant change in these measures from 2018. There was also no significant change in percentage of adults that have a regular health care provider. In the Bronx, 73.2% of adults have a regular health care provider compared to 75.4 % New York City and 79.1% in New York State (79.1%). These measures are below the NYS Prevention Agenda target of 86.7%.

Unfortunately, disparities exist for other health outcomes in the Bronx. The following sections highlight a few key health conditions where disparities exits for populations in the Bronx with a specific focus on populations served by MMC. Many of the conditions included below were also identified as priorities by community members through the GNYHA Community Health Needs Assessment survey for the Bronx.

Maternal and Child Health

Data from the NYS Prevention Agenda Dashboard shows that the maternal mortality rates and percentage of preterm births worsened in the Bronx from 2016-2019. The maternal mortality rate per 100,000 live births from 2017-2019 (22.0) was higher than the rate from 2016-2018 (18.1). The percentage of preterm births also increased, increasing to 10.3% in 2019 versus 9.7% in 2018. There was no significant change found in the infant mortality rate per 1,000 births, although the rate for the Bronx (5.4) continues to be higher than that of New York City (4.0), New York State (4.3), and the NYS Prevention Agenda target (4.0).

Sadly, Black women are approximately three times more likely to die in childbirth than white women. The 2019 New York State Taskforce Report on Maternal Mortality and Disparate Racial Outcomes reported the maternal mortality rate for Black women in New York is 51.6 deaths per 100,000 live births compared to 15.9 deaths per 100,000 live births for white women. The Report specifically addresses the impact of racism on maternal outcomes. They note that overtime, both

individual and structural racism can compromise health, leading to more adverse birth outcomes for Black women.

Cancer

In the Bronx, the age-adjusted death rate for cancer per 100,000 population was 130.6 compared to the overall rate for NYC of 135.9, according to the NYS Department of Health. We know that early detection and diagnosis of cancer can save lives and helps us better connect people to needed care and support for better outcomes. Unfortunately, the Bronx faces a daunting cancer burden. According to data from Montefiore-Einstein Cancer Center, late-stage diagnosis of screen-detectable cancers in 2020-21 was 22.5%. In several neighborhoods in the Bronx, rates of late-stage diagnosis exceeded 30%. This represents a 15% increase between 2015-2019 and is 47% higher than the CDC's 2015-2019 U.S. estimates. Factors including immigration, language and cultural barriers, multiple chronic medical and psychiatric conditions, insufficient access to care, environmental exposures and other social determinants of health contribute to this inordinately high rate of late-stage cancer.

Asthma

Since the last report, the Bronx has seen improvements in the rate of asthma related ED visits for people aged 0-17 years. In 2019, the Bronx had a rate of 280.7 compared to 368.7 in 2018. This rate is still higher than the rate for New York City (156.8), New York State (99.9) and the Prevention Agenda target (131.1).

In 2017, the prevalence of people in the Bronx who had ever been told they have asthma was 17%, higher than any other borough in the city, and higher than the overall prevalence for NYC (13.4%). The overall prevalence in NYC for those reporting that they currently have asthma was 4.8% compared to 6.8% in the Bronx.

Diabetes

Preventative screenings are an important line of defense in the identification and treatment of chronic conditions like diabetes. The 2024 New York State Prevention Agenda objective for the percentage of adults 45 years and older that have been tested for high blood sugar is 71.7%. In the

Bronx, 67.3% of adults aged 45 years and older have tested for high blood sugar in the past 3 years compared to 68.3% in New York City and 60.4% in New York State. Unfortunately, while this measure has increased, there hasn't been a significant change compared to the last measure of 64.4% in 2016. Diabetes also disproportionally affects Black and Hispanic populations in the Bronx. Data from the NYS Department of Health in 2017-2019 show that the age-adjusted rate of diabetes mortality per 100,000 population was higher for Black (30.8 and Hispanic (24.4) groups, compared to White (18.3) and Asian populations (15.6).

Obesity

Data from the NYS Prevention Agenda shows little to no improvement in measures for obesity and physical activity for youth and adults in the Bronx. Data from 2017-2018 shows that the percentage of children and adolescents with obesity was 24.8% compared to 23.9% from 2016-2017. Unfortunately, the percentage of children with obesity, among children aged 2-4 years participating in the WIC program slightly worsened, increasing from 14.5% in 2016 to 14.8% in 2017. Both measures are higher than the NYS Prevention Agenda target of 13%, and the measures for New York City (13.1%) and New York State (13.9%). Measures of obesity in adults are similar, with 30.5% of Bronx adults 2018, compared to 31.7% in 2016. This measure was also higher compared to New York City (25.6%) and New York State (27.6%).

Medically Underserved Communities

The Bronx has a long history as a medically designated underserved area or having a shortage of healthcare providers. The Medically Underserved Area /Population (MUA) and Healthcare Provider Shortage Area (HPSA) designations originate from the Health Resources and Services Administration (HRSA).

The MUA designation applied to a neighborhood or collection of census tracts is based on four factors: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The HPSA designation is for a collection of census tracts that has been designated as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals),

and mental health (shortage of mental health professionals). HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care (HRSA). The Bronx has 18 MUA neighborhoods, compared to 7 in Queens, 15 in Brooklyn, and 8 in Manhattan. The Bronx also has six Medicaid Primary Care HPSA designated neighborhoods and six Medicaid eligible mental health HPSAs.

Primary Data Collection Process

For the 2022 Community Health Needs Assessment Survey, MMC participated in the Community Health Needs Assessment Survey Collaborative led by the Greater New York Hospital Association (GNYHA). The Community Health Needs Assessment (CHNA) Survey Collaborative included multiple health systems and hospitals across New York State. In addition to participation in the survey collaborative, MMC worked with community stakeholders like the New York City Department of Health and Mental Hygiene's Bronx Bureau of Neighborhood Health, Bronx Community Boards, MMC's Community Advisory Boards, community organizations and community residents to gather input about the health needs of the communities we serve.

The 2022-2024 Community Health Needs Assessment (CHNA) was an inter-organizational and community collaborative process, initiated with the goal of providing greater insight into the health and social needs of community members residing in the Bronx. Data presented in the 2022-2024 CHNA includes both primary data collection as well as complementary secondary data from a wide range of sources. The method of primary data collection involved a survey of Bronx residents that took place during the Spring and early Summer of 2022. The primary data collection strategy was used to identify community health priorities in the Bronx, in addition to secondary data.

Photo of Montefiore's flyer to promote the GNYHA CHNA Collaborative Survey

Working with the Greater New York Hospital Association's CHNA Survey Collaborative, a survey was developed and distributed to community members as the main method of primary data collection. A nine-page survey that could be completed on paper or online was created in collaboration with the Greater New York Hospital Association's CHNA Survey Collaborative. Online survey options were accessible through a survey link and QR code. The survey was available in 10 languages, with participants completing surveys in English, Spanish, and Arabic.

The survey asked community members to rank the importance of a list of 21 health conditions. These conditions included categories were chosen to align with the 2019-2024 New York State Prevention Agenda Priorities and Focus Areas. For the same menu of health areas/topics, community members were also asked to rank their level of satisfaction with the current services in their neighborhood. Survey participants were also asked about the overall health of the people who live in their community and their individual health status. Based on our prior work in this area we often see a difference between responses to the "community" and "individual" questions. Beyond questions specifically related to community health concerns, participant demographic and health status data were collected. Additionally, this assessment included novel questions related to respondents' COVID-19 needs and challenges, including access to in-person and virtual medical care, and access to resources to prevent and treat COVID-19. A complete copy of the paper survey can be found in the Appendix.

Survey Distribution Strategy

Flyers were made in both English and Spanish to hand out at community events and were shared widely via email listservs, social media posts and in the local newspaper with a QR code that automatically linked participants to the online survey.

The primary method of reaching participants was at in-person community events. Community outreach and contact was first established with local organizations including colleges, food pantries, and local institutions such as the Bronx Zoo and New York Botanical Garden. Engagement and collaboration with departments across MMC contributed to successful survey outreach through tabling at community outreach, health screening, and community education events. To encourage community members to fill out surveys in person, tables were set up at community events throughout the Bronx. For example, survey outreach was conducted at Bronx Health Week, the Office of Community and Population Health's Community Education Workshops, the Bronx Zoo's Run for the Wild, and Montefiore School Health Program's food distribution events. Additionally, MMC's Office of Community and Population Health (OCPH) conducted targeted outreach to reach marginalized populations and communities in the Bronx. Surveys were distributed during events for Pride Month, and collaborations with R.A.I.N. Total Care Inc. and members of our Community Advisory Boards helped us reach our older adult population, LGBTQ+ population, individuals who are unhoused, and immigrant populations in the Bronx via community fairs and festivals during the summer.

Photo of staff from OCPH explaining GNYHA CHNA Collaborative Survey to community member at 'Run for the Wild' at the Bronx Zoo

Some community partners elected to bring the survey to community events and locations in the Bronx to help us reach more people. Surveys were also promoted and distributed by community organization contacts via social media, newsletters, board meetings, and flyers. Surveys were distributed between April 11th and June 30th of 2022. In total, 1,413 surveys were collected. Paper surveys were entered online manually, and all data were later analyzed by

Photo of staff from OCPH explaining GNYHA CHNA Collaborative Survey to community member at Bronx Week event on Mosholu Parkway in the Bronx

the Greater New York Hospital Association (GNYHA). Below is a full list of events and partners that supported survey distribution in the Bronx.

Partners that Supported Outreach through Survey Promotion and/or Providing Space(s) for Survey Outreach
▪ Bronx Borough President's Office ▪ Bronx Community Health Network ▪ Bronx Health REACH ▪ Bronx Zoo ▪ City University of New York (Lehman College, Hostos Community College, CUNY Graduate Center) ▪ Engage NYC ▪ HealthFirst ▪ Jewish Association Serving the Aging (JASA) ▪ R.A.I.N. Total Care, Inc. ▪ Montefiore Community Advisory Boards ▪ Montefiore-Mosholu Community Center ▪ Montefiore's Project BRAVO Food Pantry ▪ Montefiore School Health Program ▪ Mosholu Preservation Corporation ▪ Neighborhood Association for Inter-Cultural Affairs (NAICA) Transitional Housing Program ▪ Northeast Bronx YMCA ▪ New York Botanical Garden ▪ St. Anthony of Padua Roman Catholic Church

Input Representing the Broad Interests of the Community

To better understand community health needs, MMC used multiple methods to gather input from community members and key community and government stakeholders. In addition to the Community Health Needs Survey and review of secondary data measures, MMC used additional methods to gather input from community members and key community and government stakeholders. From February through April, representatives from MMC's Office of Community and Population Health and the Office of Community Relations met key stakeholders to begin early outreach for the GNYHA CHNA Collaborative Survey. Presentations were made to the health

committees of Community Boards 4,7,11, and 12. Presentations were also made to MMC's Community Advisory Boards (CABs). During these preliminary meetings, board members were asked to participate in a brief survey to identify the health needs of their community and what actions they felt would best address the identified needs.

The Montefiore Community Advisory Boards, which serve the MMC Acute Care campuses in the Bronx consist of membership serving the twelve Bronx Community Boards and represent key constituencies in those communities including local police precinct councils, large faith-based organizations, and major social service providers. Between Winter 2021 through Summer 2022, staff of MMC's Office of Community and Population Health, the Office of Community Relations and the Office of Government Relations also engage with the Bronx Borough President's duly appointed representatives of the official twelve Bronx Community Boards. In preparation for the 2022-2024 Community Health Needs Assessment process, staff from the Office of Community and Population Health met with and presented at meetings for our Community Advisory Boards, local Bronx Community Boards, and coalition meetings for Community-based organization partners. In addition to receiving input from these regional boards and their community membership, the staff also solicits information from elected leaders through health focused events which allow the sharing of secondary data with the local elected officials to receive confirmation or alternate opinion on the impacts felt by the communities they represent.

MMC also participates with several coalitions, most notably the #Not 62 Coalition – The Campaign for a Healthy Bronx. In 2014, MMC lead a multi-stakeholder application to the Robert Wood Johnson Foundation's Culture of Health Prize which was awarded to the Bronx in 2015 in recognition of the significant collaborative achievements the county has made in health. However, despite these gains, the Bronx continues to have the lowest ranking in New York State, ranking 62 out of 62 in the 2022 County Health Rankings from the Robert Wood Johnson Foundation. As a founding member and ongoing participant of the #Not 62 Steering Committee Stakeholder Group, we, along with the over 90 partner organizations in the coalition to work collaboratively to address agreed on significant health issues impacting the community through continued its partnerships. The identification of priority areas selected has been enhanced through the input from the New York City Department of Health and Mental Hygiene's Bronx Bureau of Neighborhood Health. In addition to the county-wide coalition, MMC collaborates with the New York City Department of

Health and Mental Hygiene (NYCDOHMH) and works closely with its communities to ensure that community participation occurs by working with a variety of community advisory boards (CABs). MMC participates in a variety of organized partnerships and collaboratives, working with other providers in the Bronx, and have worked extensively with representatives of the affected communities through these CABs to identify health care needs and determine the appropriate configuration of services.

As the CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) review, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. MMC will continue to work with its partners on existing program initiatives.

Stakeholder, Partner, and Community Feedback

MMC presented findings and selected interventions from the 2019-2021 CHNA cycle to key community stakeholders including our Community Advisory Boards, Community Boards in the Bronx where our hospitals are located, and community-based organizations in the borough. Some community members shared concerns about asthma rates in the Bronx and requested data from MMC on asthma rates in the Bronx from the 2019-2021 CHNA and CSP reports. A link to the full reports and supporting data on asthma rates were shared with the group. MMC did not receive any written feedback on the previous community health assessments.

Secondary Data Collection Process

The communities of the Bronx are not homogeneous. While the Bronx is New York City's youngest borough, it also has the distinction as the borough with the second largest number of languages spoken at home, as well as having New York City's smallest non-Hispanic White population. Age, ethnic and cultural diversity elements have necessitated the evaluation of disparities and inequities facing the populations we serve.

Secondary data presented throughout this report was used to better understand the needs identified by community members who participated in the GNYHA Community Heath Needs Assessment Survey. Additionally, secondary data was used to support development of the Community Service Plan by providing a greater understanding of community needs, resources and health challenges faced by populations across different neighborhoods in the Bronx.

Description of Statistical Tests or Processes

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 21 measures, including: diabetes, asthma, cancer, dental care, access to healthy/nutritious food, COVID-19, health disease, high blood pressure, mental health/depression, women's and maternal health, infant health, adolescent and child health, obesity, substance use disorder/drug addiction, cigarette smoking/tobacco use, sexually transmitted infections, and HIV/AIDS. These data were obtained from multiple population-based datasets including, but not limited to, the American Community Survey (formerly referred to simply as the Census), New York State Statewide Planning and Research Cooperative Systems (SPARCS), New York State Vital Statistics, New York City HIV/AIDS Annual Surveillance Statistics, 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. A listing of the data sources used to complete the secondary data analysis and identify the issues of concern beyond experience and direct observation are listed below.

Bronx Secondary Data Sources

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 identify community characteristics and evaluate the percent of families living in poverty and the percentage of adults with health insurance. For more information on ACS please visit http://www.census.gov/programs-surveys/acs/about.html.

National Vital Statistics Surveillance System: The National Center for Health Statistics collects and disseminates national vital statistics, including births and deaths from state/local jurisdictions (e.g.,

state departments of health). This data source was used to estimate the teen birth rate, the proportion of births that are preterm, the opioid-related mortality rate and the suicide-mortality rate. For more information on NVSSS please visit https://www.cdc.gov/nchs/nvss/index.htm.

New York City Community Health Survey: The New York City Community Health Survey (CHS) is an annual telephone survey of approximately 10,000 NYC adults, of which about 15-20% live in the Bronx. The complex survey is conducted in English, Spanish, Russian and Chinese (Mandarin and Cantonese) and provides a representative sample of NYC adult 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 Department of Health & Mental Hygiene, the Department of Education, and the National Centers for Disease Control and Prevention conduct the New York City Youth Behavior Risk Survey (YRBS) every two years. The self-administered 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 proportion of infants exclusively breastfed in the hospital and the opioid burden 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 preventable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, asthma ED visits, and the opioid burden rate . For more information about SPARCS please visit: http://www.health.ny.gov/statistics/sparcs/.

New York City HIV/AIDS Annual Surveillance Statistics: The HIV Epidemiology and Field Services Program (HEFSP), within the New York City Department of Health and Mental Hygiene, collects and manages all data on HIV infection and AIDS diagnoses in the NYC. This data source was used to estimate HIV diagnoses rates: https://nyc.gov/site/doh/data/data-sets/hiv-aids-annual-surveillance-statistics.page

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 Sexually Transmitted Disease Surveillance Data: New York City Sexually Transmitted Disease Surveillance Data are provided in EpiQuery by the Bureau of Sexually Transmitted Disease Control, within the NYC Department of Health and Mental Hygiene. The bureau receives and manages reports of cases of seven types of STDs, which are provided by health providers and clinical laboratories within NYC. This data was used to provide an estimate of chlamydia rates for this report. For more information, please visit: https://www.health.ny.gov/statistics/diseases/communicable/std/

Data Tools and Reports

Global Burden of Disease: The Global Burden of Disease (GBD) project from the Institute of Health Metrics and Evaluation at the University of Washington uses a comprehensive risk-assessment framework to summarize the collective impact of risk factors and health outcomes on adverse health. Specifically, GBD combines many datasets to estimate disability adjusted life years (DALYs) associated numerous outcomes and risk factors. DALYs are a summary measure of population health that combines information on fatal health events and non-fatal health states. This is an important advantage over vital statistics which do not capture the important health impact of non-fatal health states (e.g., back pain, moderate depression, or alcohol use). GBD also allows for the estimation of DALYs attributed to specific risk factors, including body mass index, smoking, dietary risks, occupational risks, air pollution, etc. Data from the GBD is available at the global, national and state-level; local-estimates are not available. Despite this limitation this information can be used to

understand the most important areas of intervention to improve population health. Data are available at: https://vizhub.healthdata.org/gbd-compare/

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 aggregates 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/

Summary of Key Findings

GNYHA CHNA Collaborative Survey Results

In total, 1,413 individuals completed the GNYHA CHNA Collaborative Survey. Of the survey participants that provided a zip code, all 25 zip codes in the borough were represented, with most responses coming from three zip codes: 10467 (13%), 10456 (10%), and 10458 (8%). English and Spanish were the most common languages spoken at home. Other languages represented include Bengali, Arabic, and Russian. It is important to note that survey participants were allowed to skip questions throughout the survey, and some participants left questions blank, which may impact the data.

The anonymous survey asked respondents their age, gender, and education level. These demographic data are presented in Table 1. Data shows that the most represented age range of the GNYHA CHNA Collaborative Survey respondents were 45-74 years old, making up 44% of total respondents. A majority of respondents identified as female (79%) followed by 20% identifying as male. For education level, 41% of the respondents completed college or more, while 24% completed some college, 19% completed High School, and the remaining 16% completed less than High School.

Table 1: Socio-demographic information of GNYHA CHNA Collaborative Survey Respondents in the Bronx, 2022
Percent (%)

	GNYHA CHNA Collaborative Survey (n = 1,413)
Age	
18 – 24	4%
25 – 29	5%
30 – 44	22%
45 – 64	44%
65 – 74	16%
75+	8%
Gender	
Female	79%
Male	20%
Nonbinary, another gender	0%
Prefer not to say	1%

Education	
Less than HS	16%
HS	19%
Some College	24%
College or more	41%

Table 2 provides more sociodemographic data of survey respondents, highlighting employment status, annual household income, and health insurance. Most survey respondents were employed full-time for wages or salary (35%) or retired (23%). Over a third of respondents reported an annual household income of $20,000 or less at 36%. The next most common household income bracket was between $30,000 to $49,999 at 14%. When asked about health insurance, most respondents had “a plan purchased through an employer or union” (34%), Medicare (27%), and Medicaid or another state program (23%).

Table 2: Socio-demographic information of GNYHA CHNA Collaborative Survey Respondents in the Bronx, 2022 Percent (%)

	GNYHA CHNA Collaborative Survey (n = 1,413)
Employment Status	
Employed full-time for wages or salary	35%
Retired	23%
Unable to work	11%
Employed part-time for wages or salary	10%
A homemaker	7%
Unemployed for 1 year or more	6%
Self-employed	3%
A student	3%
Unemployed for less than 1 year	2%

Annual Household Income	
Less than $20,000	36%
$20,000 to $29,999	12%
$30,000 to $49,999	14%
$50,000 to $59,999	8%
$60,000 to $74,999	10%
$75,000 to $99,999	9%
$100,000 or more	11%
Health Insurance	
A plan purchased through an employer or union	34%
Medicare	27%
Medicaid or other state program	23%
A plan that you or another family member buys on your own	3%
TRICARE (formerly CHAMPUS), VA, or Military	0%
Alaska Native, Indian Health Service, Tribal Health Services	0%
Some other source	5%
I do not have any kind of health insurance coverage	7%

Table 3 presents the racial and ethnic data collected from survey respondents. Majority of respondents identified as Hispanic (58%), followed by Black, non-Hispanic at 26%, White, non-Hispanic at 10%, and Asian/Pacific Islander, non-Hispanic at 3%. Of those of Hispanic/Latinx origin or ancestry, Puerto Rican, and Dominican were the most represented respondents at 40% and 37%, respectively. For those of Black Heritage or Ancestry, 38% identified as African American while 36% identified as Caribbean or West Indian. Among respondents who identified as of Asian Heritage or Ancestry, 44% identified as Asian Indian, 21% identified as Chinese, and 16% identified as Filipino.

Table 3: Racial and Ethnic information of GNYHA CHNA Collaborative Survey Respondents in the Bronx, 2022 Percent (%)

	GNYHA CHNA Collaborative Survey (n = 1,413)
Race/Ethnicity	
Hispanic	58%
Black, non-Hispanic	26%
White, non-Hispanic	10%
Asian/Pacific Islander,non-Hispanic	3%
North African/Middle Eastern, non-Hispanic	0%
Other,non-Hispanic	3%
Hispanic/Latinx Origin or Ancestry	
Puerto Rican	40%
Dominican	37%
Mexican	9%
Other Central American	4%
Ecuadorian	3%
Other South American	2%
Cuban	0%
Colombian	0%
Other	4%
Black Heritage or Ancestry	
African American	38%
Caribbean or West Indian	36%
A recent immigrant or the child of recent immigrants from Africa	9%

Asian Heritage or Ancestry	
Asian Indian	44%
Chinese	21%
Filipino	16%
Korean	2%
Vietnamese	2%
Other	14%

Health Question Results

Beginning in early 2020, COVID infections spread rapidly across the United States, with the WHO declaring the disease a pandemic in March of 2020. The rise of COVID infection rates heightened social isolation measures to mitigate the spread of the disease. The 2022 Community Health survey included questions about the COVID-19 pandemic and its impact on the health needs of respondents and their communities (Table 4). Questions included in the survey asked respondents about their COVID-19 related needs, changes in access to both in-person and virtual medical appointments, and new daily life stressors they may be experiencing. Responses indicated that at-home COVID-19 test, personal protective equipment, and in-person COVID-19 testing were some of the top needs of respondents, at 45%, 34% and 29%, respectively. Within the last 12 months, respondents also noted feelings of anxiety or depression (38%) and increased household expenses (32%).

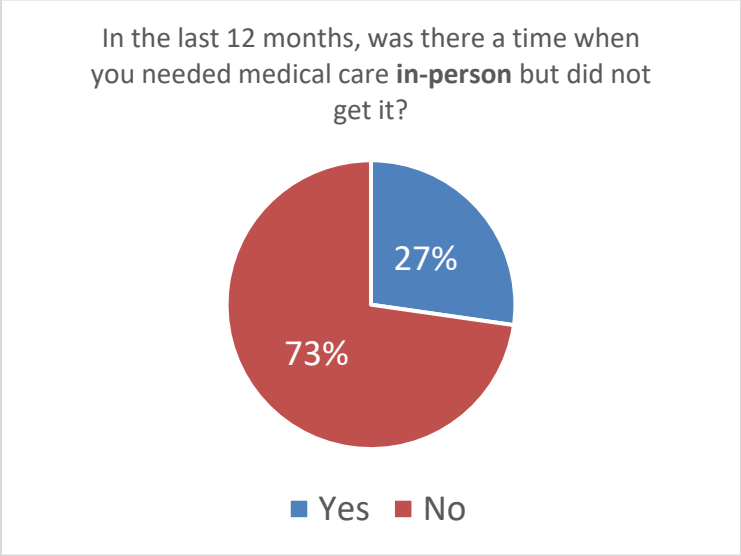
Table 4: COVID-related information of GNYHA CHNA Collaborative Survey Respondents in the Bronx, 2022 Percent (%)

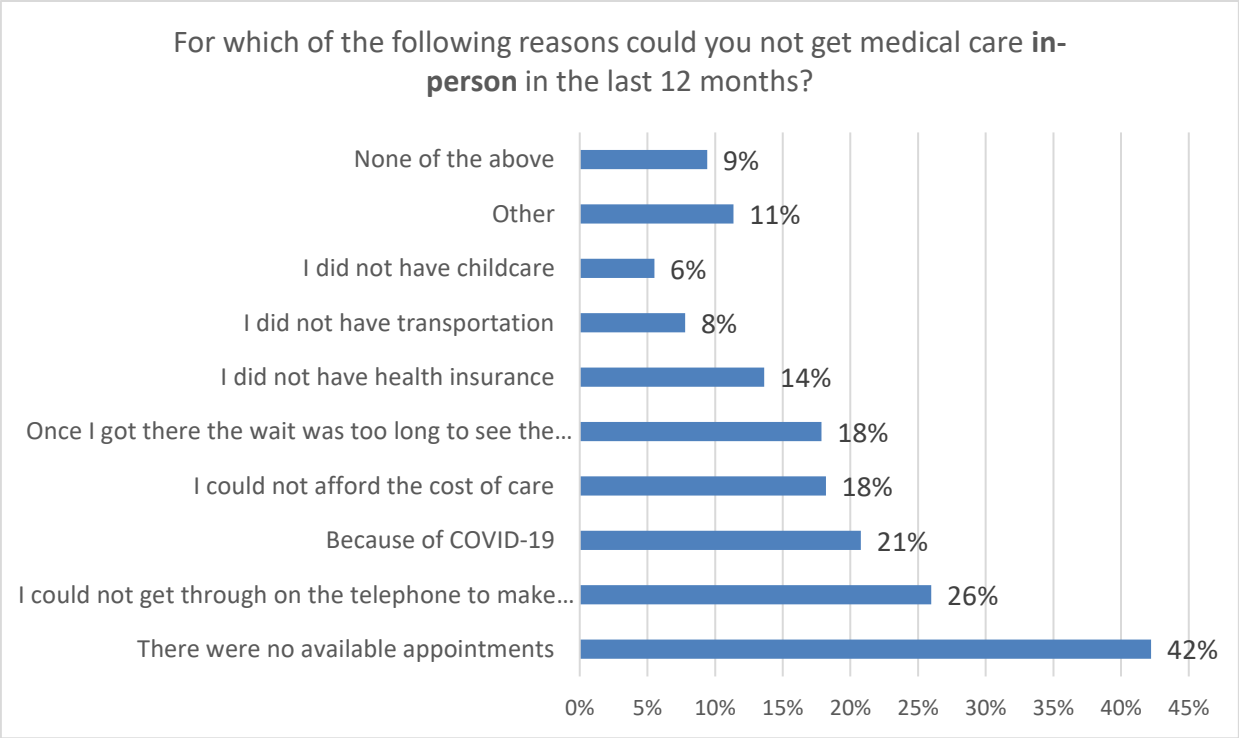
	GNYHA CHNA Collaborative Survey (n = 1,413)
COVID Needs	

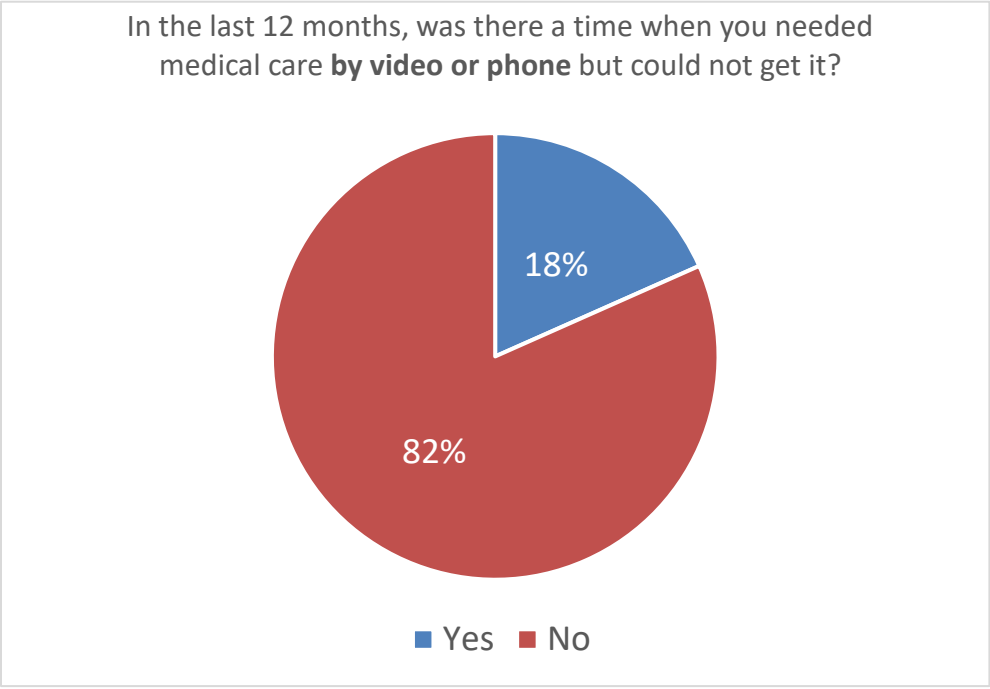
At-home COVID-19 tests	45%
Personal protective equipment (e.g., masks, hand sanitizer, face shields, gloves)	34%
In-person testing for COVID-19 (e.g., doctor's office, pharmacy, mobile van)	29%
Reliable source(s) of information on COVID-19	28%
Boosters for COVID-19	27%
COVID-19 vaccination	23%
Treatment for COVID-19	21%
In the last 12 months, have you experienced any of the following?	
Anxiety or depression	38%
Increased household expenses	32%
Difficulty paying utilities or other monthly bills	17%
Difficulty paying your rent/mortgage	16%
Increased medical expenses	14%
Hunger or skipped meals because you did not have enough money to buy food	9%
None of the above	26%

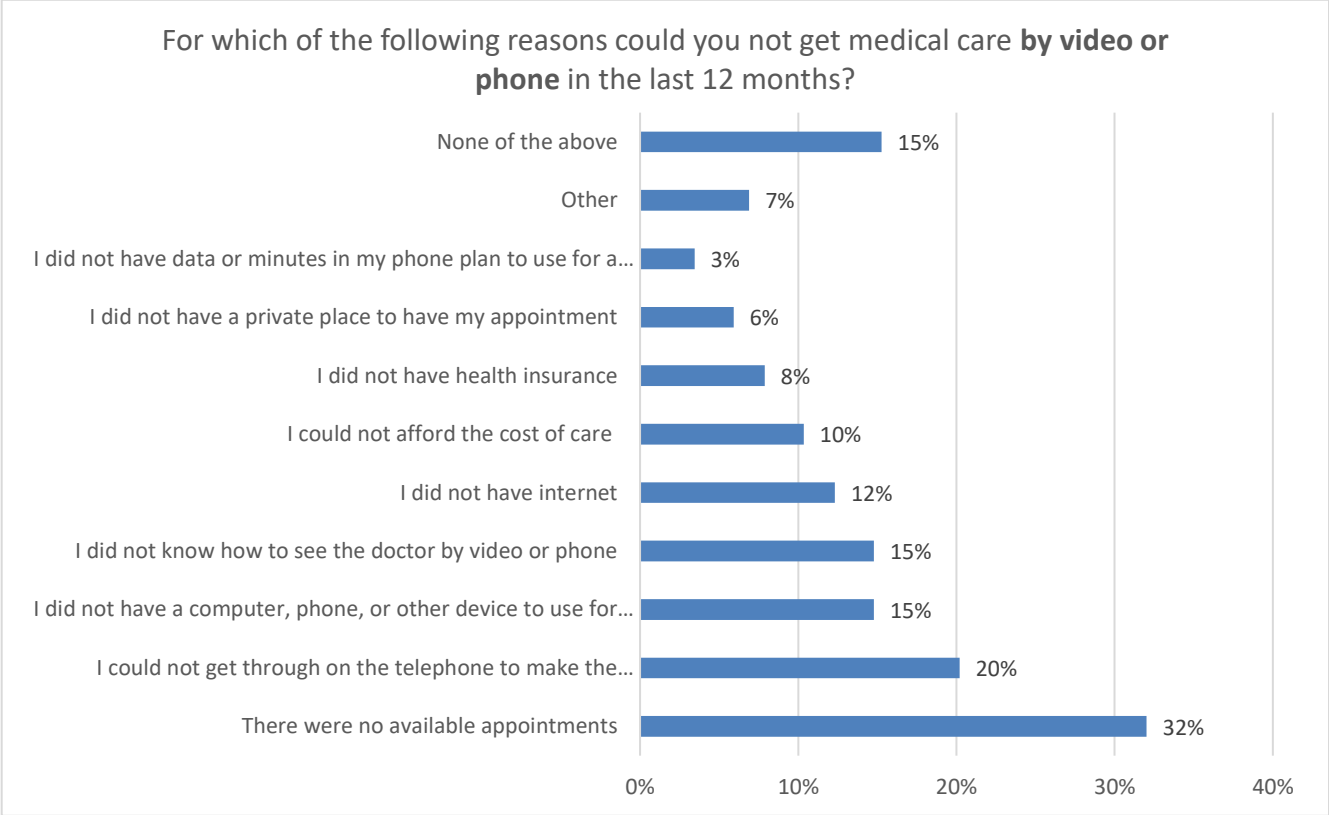
To further understand the effect of COVID on healthcare accessibility, respondents were asked if there was a time in the last 12 months where they were unable to received medical care either in-person by virtually (by phone or video). The survey data showed that access to both in-person and virtual medical care were not affected for most people who responded to this question. Most respondents noted increased difficulty in accessing in-person appointments (27%), while 18% noted increased difficulty in accessing virtual appointments over phone or video. For those who

were affected, the most common reason listed was the lack of available in-person appointments at 42% and 32% for virtual appointments.






In the last 12 months, was there a time when you needed medical care **by video or phone** but could not get it?
18%
82%
Yes
No

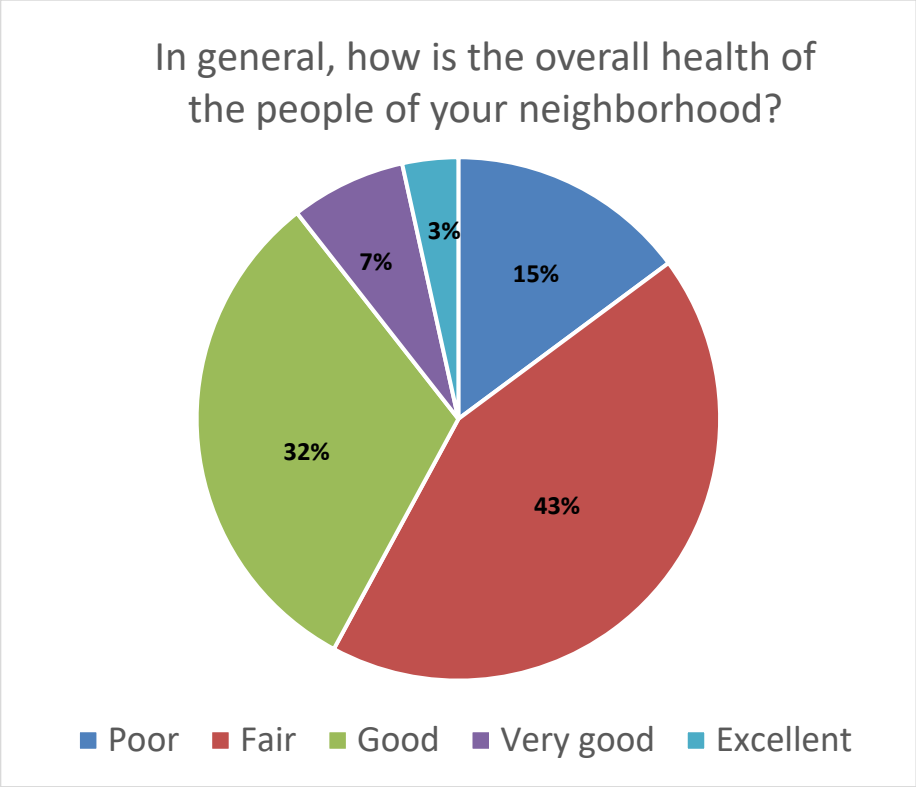


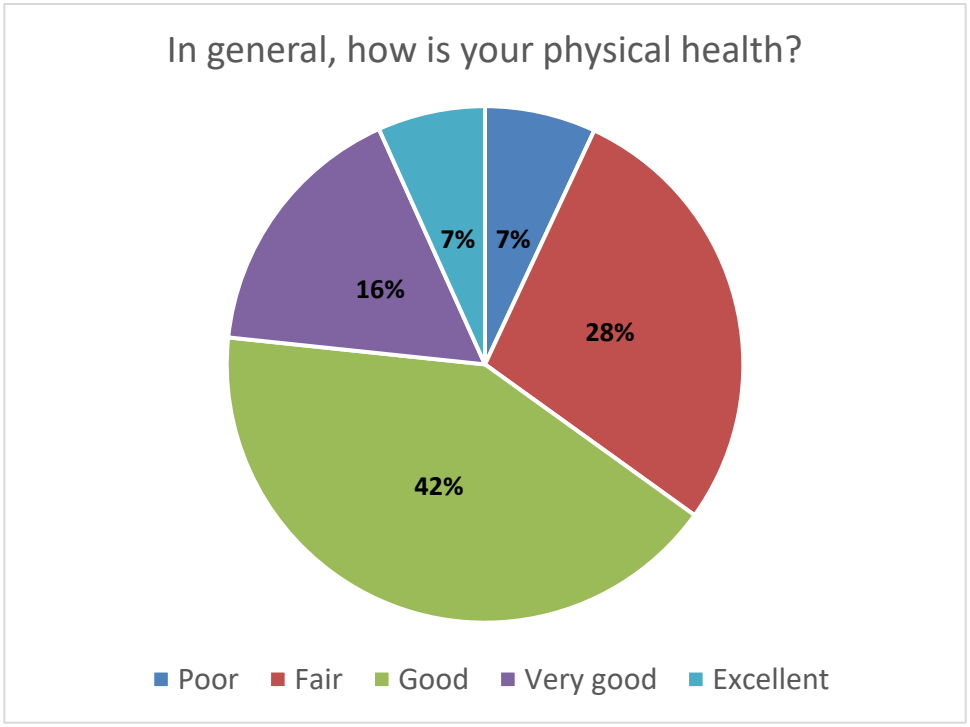
Participants were asked about their experiences with mental health and needs related to the social determinants of health (i.e. food, housing, and other expenses). They were asked whether, in the last 12 months, they experienced any of the following:

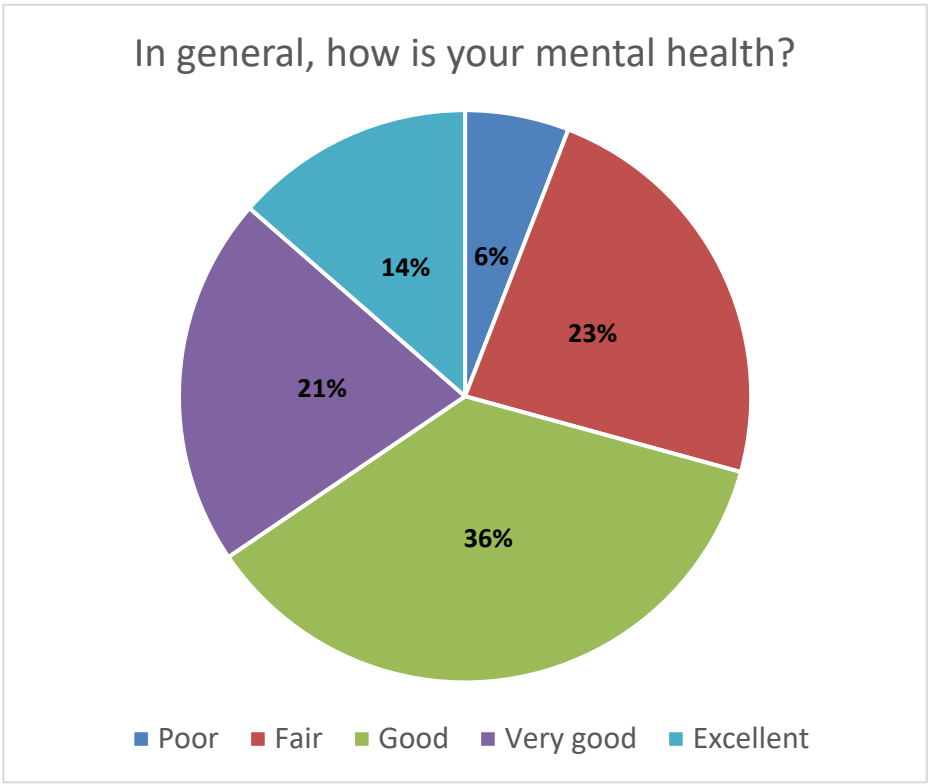
- Anxiety or depression
- Increased household expenses
- Difficulty paying utilities of other monthly bills
- Difficulty paying rent/mortgage, increased medical expenses
- Hunger or skipped meals because of lack of money
- None of the above

Experiencing anxiety or depression was the most common response at 38%, followed by increased household expenses (32%), and none of the above (26%).

Participants were also asked to assess their own physical and mental health as well as the health of their community. When rating the overall health of the people in their neighborhood, 43% of respondents indicated their neighborhood overall health was “fair”, 32% said “good”, and 15% said “poor”. When asked to rate their own general physical and mental health most respondents rated their health as good or fair. For physical health, the most common response at 42% was “good”, followed by “fair” at 28%, and “very good” at 17%. When asked about their mental health, the response distribution was similar with the most common response also being “good” at 36%, followed by “fair” at 23%, and “very good” at 21%.




In general, how is your physical health?
7%
7%
16%
28%
42%
Poor
Fair
Good
Very good
Excellent


In general, how is your mental health?
6%
14%
23%
21%
36%
Poor
Fair
Good
Very good
Excellent

Identification of Priorities

One of the key questions in the survey included a list of 21 health conditions selected based on the New York State Prevention Agenda. For this question (question #9), participants were asked to rank each of the 21 health conditions based on level of importance and level of satisfaction with existing services in their community address those health needs. Participant rankings were used to identify community priorities. Factoring in the scores for both importance and satisfaction ratings, each health condition was placed in one of three categories: needs attention, maintain efforts, and relatively lower priority (see Table 5 below). The seven health conditions listed in the "Needs Attention" category have relatively high ratings of importance and low ratings of satisfaction. Those in the "Maintain Efforts" category had high importance ratings paired with higher satisfaction ratings. The remaining category of "Relatively Lower Priority" contained health conditions that respondents categorized as lower in importance with a mix of low to high satisfaction scores.

Participant scores identified the top three health conditions needing attention as: violence (including gun violence), mental health/depression, women's and maternal health care. Additional health conditions that need attention include asthma/breathing problems or lung disease, cancer, stopping falls among elderly, and obesity in children and adults. By dividing the health condition ranking into three categories, we were able to identify areas that need more attention based on community input and feedback from the survey.

Needs Attention	Maintain Efforts	Relatively Lower Priority
Violence (Including gun violence)	Dental care	Substance use disorder/drug addiction (including alcohol use disorder)
Mental health/depression	COVID-19	Arthritis/disease of the joints
Women's and maternal health care	Access to health/nutritious foods	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah
Asthma/breathing problems or lung disease	High blood pressure	Sexually Transmitted Infections (STIs)
Cancer	Heart disease	Infant health
Stopping falls among elderly	Diabetes/elevated sugar in the blood	HIV/AIDS (Acquired Immune Deficiency Syndrome)
Obesity in children and adults	Adolescent and child health	Hepatitis C/liver disease

Table 1. Health priorities selected by Bronx Residents from the community health survey for the CHNA.

Further breakdown of the data showed the most important health conditions included dental care, violence (including gun violence), and mental health/depression. These three health conditions align with information from other health surveys led by community partners which identified the impact of COVID-19 on people's willingness and ability to seek routine care for medical needs like dental care. It also highlights the increase in awareness and incidence of community violence across the city and the need for mental health services. Survey participants also identified health conditions considered to be least important - hepatitis C/liver disease, HIV/AIDS, and Sexually Transmitted Infections.

Respondents ranked high satisfaction with services in their communities to address COVID-19, high blood pressure, and dental care. The three conditions with services that received low satisfaction rankings were violence (including gun violence), cigarette smoking/tobacco use/vaping/e-cigarettes/hookah, and substance use disorder/drug addiction.

Target Population

The target population of the 2022 GNYHA CHNA Survey included adults aged 18 and older who live in the Bronx which has been identified as the service area for MMC.

Sampling

The 2022 GNYHA CHNA Survey used a non-probability convenience sample. A web-based survey tool and a paper-based tool were used to collect the survey data. Participants who completed the survey online could use any Internet-enabled device. Surveys were available in a variety of languages. The GNYHA CHNA questionnaire was translated from English into Spanish, Chinese, Russian, Yiddish, Bengali, Korean, Haitian Creole, Italian, Arabic, and Polish. All data collected were self-reported.

Data Analysis

To determine a respondent's county, ZIP codes were allocated to counties based on ZIP Crosswalk Files (4th Quarter 2021) from the U.S. Department of Housing and Urban Development[i]. When a ZIP was split by county, it was allocated to the county where it has the highest ratio of residential

addresses. Respondents who provided a county, but no ZIP code, were not assigned to a ZIP code. Individuals who provided a ZIP code or county but did not answer any of the other survey questions were removed from the dataset.

Importance and Satisfaction ratings for the health conditions were derived by taking an average of the responses for each health condition. "Don't know" responses were set to missing. Overall Importance and Satisfaction was derived by subtracting the Importance or Satisfaction rating for each health condition from an overall average of the ratings.

Limitations

Since a person's probability of being sampled is unknown, there is no simple way to calculate and report the margin of sampling error. Respondents may be fundamentally different from the general population in some characteristics.

Implementation Strategy Report

Description of Health Needs to be Address

Through the process of completing and reviewing data obtained through the primary and secondary sources, engaging with community stakeholders and key partners, and a review of resources available within the Medical Center and through its partnerships, an Implementation Strategy was developed to address the significant needs identified. This section of the report describes the strategies to be implemented by MMC to address the identified needs of the population.

As stated in the "Primary Data Collection Process" section of this report, MMC used a key question in the GNYHA CHNA Collaborative Survey to help identify priorities for the Community Service Plan. Community members identified seven health conditions that need attention:

- Violence (Including gun violence),

- Mental health/depression,
- Women's and maternal health care,
- Asthma/breathing problems or lung disease,
- Cancer,
- Stopping falls among elderly, and
- Obesity in children and adults.

Using responses from survey participants, MMC reviewed and chose priorities from the above list of seven health conditions categorized as "Needs Attention." For the 2022-2024 Community Health Needs Assessment Process, MMC has chosen to focus on two priorities areas from the New York State Prevention Agenda: 1) Prevent Chronic Diseases, and 2) Promote Healthy Women, Infants and Children. The programs selected for each of these priority areas will address cancer prevention and care, and women's and maternal health care with a focus on addressing health disparities and the social determinants of health.

Given the range of supportive services and programs provided across Montefiore Health System and input from multiple sources as previously described, the needs selected for identification were done to ensure alignment with the New York State Prevention Agenda.

Montefiore-Einstein Cancer Center Initiatives to Address Disparities in Cancer Screening

Background

Cancer is a genetic disease, causing cells of one part of the body to divide uncontrollably. The result can be the production of a cancerous tumor that may grow and spread to other areas of the body. Without proper and timely treatment, cancer is often deadly. Robust cancer screening and prevention measures can help mitigate the harm the disease causes in a community.

The Bronx faces a formidable cancer burden. Late-stage diagnosis of screen-detectable cancers at MECC in 2020-21 was 22.5%, with rates exceeding 30% in several neighborhoods (Figure 1). This

represents a 15% increase over 2015-19 and is 47% higher than the CDC's 2015-2019 U.S. estimates. Although poverty throughout the Bronx is high with 30% living below the federal poverty level, late-stage diagnosis does not occur exclusively in the poorest neighborhoods. Factors including immigration, language and cultural barriers, multiple chronic medical and psychiatric conditions, insufficient access to care, environmental exposures and other social determinants of health contribute to this inordinately high rate of late-stage cancer.

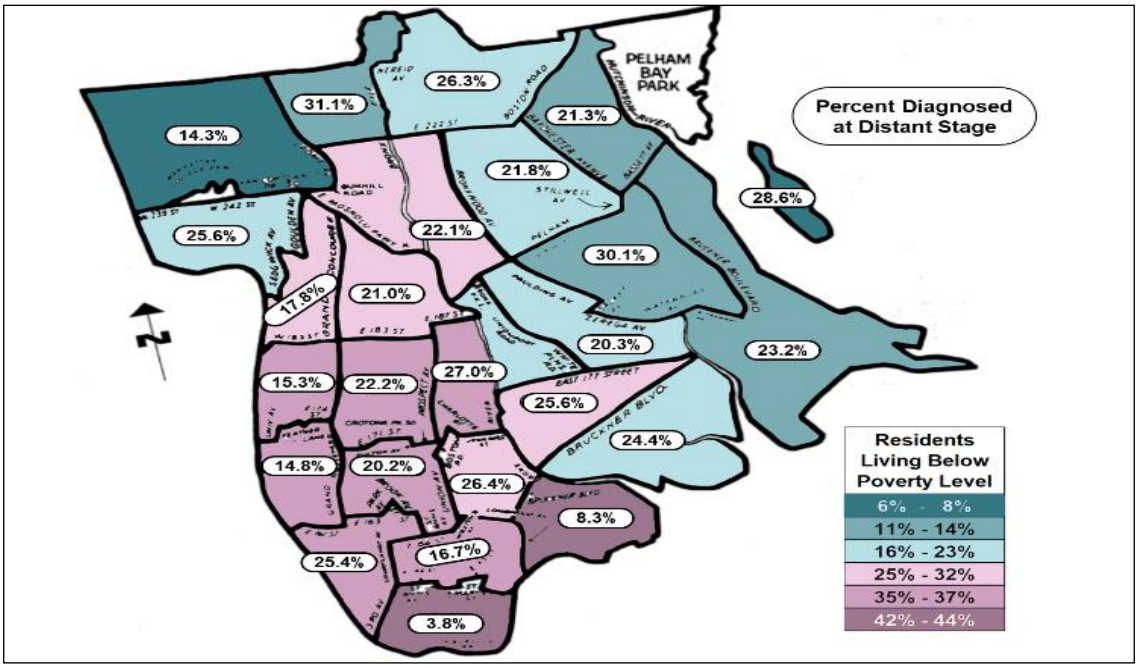


Figure 1: Late-Stage Diagnosis of Screen-Detectable Cancers at MECC (2020-21) by Neighborhood Poverty

The overarching goal of the Montefiore Einstein Cancer Center's (MECC) Community Outreach and Engagement (COE) is to promote health equity and reduce disparities in cancer-related health outcomes in our Bronx catchment area. The Bronx population is highly diverse, with neighborhoods representing multiple racial, ethnic, and linguistic enclaves. There is a tradition of community activism. Local organizations, cultural, religious and educational institutions, small businesses, and public agencies work together to improve population health. MMC is the largest employer in the Bronx and a leader in efforts to improve community health and well-being through the delivery of

high-quality care, an extensive network of safety-net clinics, established partnerships with key social services and proactive outreach.

MECC's COE efforts build upon strong relationships with community and health system partners. Activities span the entire cancer continuum, from prevention and early detection to treatment to survivorship and end-of-life care, organized around the following specific aims, to:

1. Define, assess, and monitor cancer burden in the Bronx catchment area
2. Develop, implement, and evaluate the impact of strategies to address this cancer burden
3. Foster and facilitate catchment area-relevant research by all MECC research programs (RPs)
4. Enhance underrepresented patients' access and participation in clinical trials
5. Share lessons learned through dissemination and policy to advance cancer health equity

Like MMC, MECC's catchment area is the Bronx. MMC is the main health care provider for this community, with more than 85% of MECC cancer patients residing in the Bronx. As depicted in Table 6, the Bronx has 7.3% of the state's population but only 5.6% of cancer cases, likely due to the relatively low proportion of elders and low cancer prevalence among Latinx/Hispanic residents.

Cancer cases are found disproportionately among both whites and Black/African American residents in the Bronx and in the State. Based on the 2015-2019 average, MECC provided care to 59% of all new cancer cases in the Bronx. As such, our case mix reflects the full diversity of the Bronx population.

	POPULATION (2020 US Census)				ANNUAL CANCER CASES (NYS SEER Registry 2015-2019)				MECC CANCER CASES (Cancer Registry) Jan 2021 - Dec 2021	
	New York State		Catchment Area		New York State		Catchment Area			
	n	% total	n	% total	n	% total	n	% total	n	% total
Total (% of State Rate)	**20,201,249**	**100%**	**1,472,654**	**7.3%**	**116,044.4**	**100%**	**6481.4**	**5.6%**	**4162**	**100%**
Gender										
Male	9,817,807	48.6%	695,093	47.2%	57,760.0	49.8%	3,149.0	48.6%	1,820	43.7%
Female	10,383,442	51.4%	777,561	52.8%	58,284.4	50.2%	3,332.4	51.4%	2,341	56.2%
Race										
White	12,443,969	61.6%	207,644	14.1%	90,523.6	78.0%	3,107.4	47.9%	2,152	51.7%
Black or African American	2,504,955	12.4%	487,448	33.1%	16,790.8	14.5%	2,790.8	43.1%	1,652	39.7%
American Indian or Alaska Native	222,214	1.1%	22,090	1.5%					3	0.1%
Asian	1,212,075	6.0%	69,215	4.7%	6,617.8	5.7%			144	3.5%
Native Hawaiian or other Pacific Islander	40,402	0.2%	1,473	0.1%					5	0.1%
Two or More Races	2,060,527	10.2%	191,445	13.0%						
Unknown	1,696,905	8.4%	493,339	33.5%	2,112.2	1.8%	583.2	9.0%	206	4.9%
Ethnicity										
Hispanic or Latinx	3,777,634	18.7%	807,014	54.8%	11,726.6	10.1%	2,772.6	42.8%	1,503	36.1%
Non-Hispanic or Latinx	16,423,615	81.3%	665,640	45.2%	104,317.8	89.9%	3,708.8	57.2%	2,601	62.5%
Across the Lifespan										
<18 Years	4,113,114	20.4%	349,597	23.7%	998.6	0.9%	85.8	1.3%	49	1.2%
≥ 65 Years	3,414,011	16.9%	195,863	13.3%	65,349.0	56.3%	3,200.0	49.4%	2,020	48.5%

Table 6: New York State, Bronx and MECC Demographics and Cancer Incidence

Rates of Cancer Screening and Impact of Social Determinants

Based on NY State Dept of Health 2019 "Information for Action Reports", adherence to cancer screening in our catchment area was 71.5% colorectal (CRC), 84.0% breast, and 80.5% cervical, respectively. Of the 62 NY State counties, Bronx ranked 27th, 12th, and 42nd in terms of screening and close to state medians in each case. Although these rates alone indicate room for improvement, they do not tell the whole story. As part of the NCI's Population Health Assessment Initiative, MECC conducted the Bronx Catchment Area Survey in 2017-2018, which included complete data on cancer attitudes and screening behavior from 1,430 respondents reflecting the demographics of the Bronx. A subset of 608 respondents completed an in-depth module on stress experienced in the past year due to social determinants of health. We found that 62% of Bronx residents reported high stress related to at least one social determinant, including problems with money for food and other needs (38%), employment (28%), transportation (21%), housing (19%), physical limitations (23%) medical care (14%) and public services (11%). Nearly 40% identified 3 or more sources of high stress. Analysis revealed that each high-stress exposure reduced the likelihood of adherence to colorectal cancer screening by 10%, mammography by 15%, and Pap testing by 16%. In sum, although many in our catchment area can obtain timely cancer screening,

these data suggest the importance of reaching segments of the Bronx community particularly affected by social determinants of health.

COVID Impact on Patient Engagement and Early Detection

To get greater insight into long-term trends and recent changes in access to cancer care, we examined analytic cases in the MECC cancer registry from 2010 to 2021. Figure 2 focuses on the overall volume and stage of diagnosis of cases with screen detectable cancers (breast, colorectal, lung, cervical, prostate and liver). Using 2010 as reference, this plot shows percent of change in annual volume and early-stage detection, averaged over each of three periods: 2011 to 2016 (prior to our current COE structure), 2017 to 2019 (pre-pandemic), and 2020 to 2021 (pandemic).

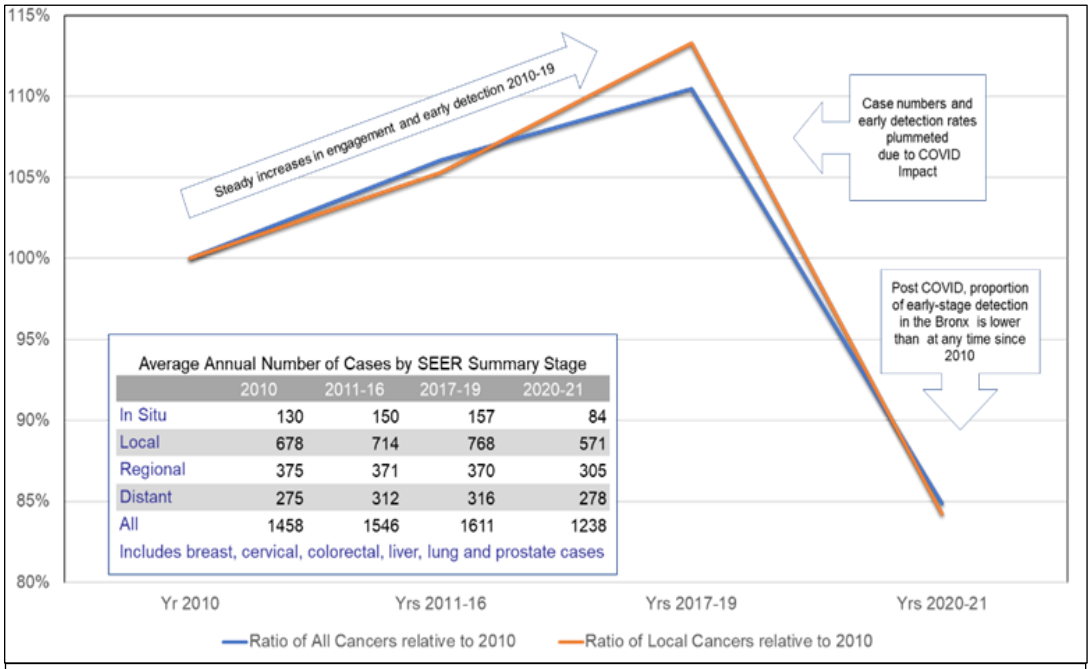


Fig.2. Changes in the Average Annual Volume and Staging of Screen-Detectable Cancers Diagnosed at MECC

This plot shows that volume of cases of screen-detectable cancers diagnosed at MECC rose steadily through 2019 (in blue), and that growth correlated with increased numbers of cancers detected at a local stage (in orange). Rates of both volume and early-stage detection dropped precipitously in 2020 to 2021 to 85% of 2010 rates, about 28% below 2017 to 2019 averages. Rates of detection at distant stage also fell from pre-pandemic rates, but less sharply (14%), indicating that decline in cancer cases at MECC was disproportionately due to drop off in early detection. Analysis of these trends, disaggregated by race, ethnicity and neighborhood, will continue to inform strategic planning with our CAB and our community and health system partners.

Cancer was selected as priority by community members who participated in the GNYHA CHNA Survey and MMC has identified cancer as a priority health condition for the 2022-2024 Community Health Needs Assessment and Community Service Plan. The narrative and data presented shows a need for services for the prevention and management of cancer with a focus on addressing the disparities in cancer care and outcomes that exist in the Bronx. MMC has selected the two programs listed below to address this health need.

Cancer Programs Selected to Address Identified Health Priority

"Sidewalks to Screenings" Program

The Montefiore Einstein Cancer Center (MECC) Community Outreach and Engagement team is charged with the goal of bringing cancer screening and education to some of the most underserved and difficult to reach communities in the Bronx. Sidewalks to Screening is a major initiative introduced by COE in 2021 to help engage or re-engage communities in cancer screening. This proactive approach was developed with input from a community advisory board to address the many social determinants of health that prevent access or deter people from preventative care, leading to high rates of late-stage diagnosis.

This initiative became especially important considering the impact of the pandemic on cancer screening and access to care. Since the program launched, the COE team has collaborated with community members and Bronx-based community organizations to host and participate in community events where team members assess barriers to cancer screening and navigate eligible individuals to breast, colorectal, prostate, cervical, lung, and liver cancer screening appointments within MMC while aiding in addressing the barriers they endorsed, like lack of insurance, fear, medical mistrust, and more. Screening and navigation services will be provided by peer navigators who speak 15+ languages and will work with each patient 1 on 1. Community members will also have access to an MECC hotline where they can access free cancer screening eligibility assessments, personalized appointment navigation in their language, and resources to overcome barriers to screening.

Photo of Montefiore provider speaking with community member at cancer screening event during Bronx Week.

MECC observed that barriers to screening often vary based on cultural identity and beliefs; therefore, the team has launched several task forces to target outreach to major cultural and social identity groups in the Bronx that are traditionally under-screened, including the South Asian, Albanian, West African, and LGBTQ+ communities. These task forces are composed of members of the community from these cultural groups and representatives from organizations that serve these populations and aim to provide culturally tailored education and navigation services to each of these communities.

Priority Area	Prevent Chronic Diseases
Focus Area	Focus Area 4: Preventive care and management
Goal	Goal 4.1: Increase cancer screening rates

Objectives	Objective 4.1.1: Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Objective 4.1.3: Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) Objective 4.1.5: Increase the percentage of adults aged 50-64 who receive a colorectal cancer screening based on the most recent guidelines
Intervention	Intervention 4.1.5: Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings.
Measures	Number of community members identified as needing cancer screening based on survey results Number/percent of community members that follow up with the BOLD team for cancer screening and other resources after completing survey Breast, cervical and colorectal cancer screening rates from provider, clinic or insurer
Partner(s)	Community-based organizations will partner with BOLD Program to offer survey and connect community members with cancer screening services Community leaders participating community advisory board will help inform planning for new events and promote existing events where community members can participate in the survey and cancer screenings
Disparities	Data from Montefiore-Einstein Cancer Center shows that although overall incidence of cancer in the Bronx is 9% lower than NYS and 4% lower than US, mortality is 10% higher than NYS and 5% higher than US. Adjusted for differences in incidence, Bronx cancer mortality is 22% higher than NYS and 9% higher than US. Program activities were

	designed to reach cultural and social identity groups in the Bronx that are traditionally under-screened.

New York City Cancer Outreach Network in Neighborhoods for Equity and Community Translation (NYC CONNECT)

The New York City Cancer Outreach Network in Neighborhoods for Equity and Community Translation (NYC CONNECT) is a community-based social determinants of health program that aims to improve access to cancer screening in four neighborhoods in Brooklyn (Sunset Park, East Flatbush) and the Bronx (Highbridge and Morrisania). NYC CONNECT is a five-year project built with the collaboration of New York University, Albert Einstein College of Medicine, Food Bank for NYC, and NYU Family Health Centers. The project aims to improve access to cancer screening and prevention in Brooklyn and the Bronx. Within the Bronx, the project focuses on two neighborhoods: Highbridge and Morrisania. Through the implementation of a community-health worker-based model of engagement and the development of racial equity strategies co-designed with community stakeholders, we aim to reduce systemic racism in the built environment, in food access and food justice, and in healthcare.

The team will work together with diverse community and clinical partners to identify and incorporate racial equity strategies to improve cancer prevention and screening outcomes among communities of color and immigrant communities. To ensure community voices and priorities are centered in the program, neighborhood action councils (NAC) made up of community partners will be convened for each neighborhood. Additionally, a community advisory board will be created as part of the program. The community advisory board will include members from the local NACs, in addition to city- and state-level partners. The CAB organizations will be involved throughout the entirety of the project from co-creation of strategies, formative research, consensus-building and prioritization, implementation, and evaluation. The role of the CAB will be to provide oversight of the project, enhance and refine community engagement, identify racial equity strategies tailored

to each neighborhood's context and environment, support implementation of the racial equity strategies, and build local endorsement for strategies.

One strategy identified for this initiative will be implemented in collaboration with the Food Bank for NYC. Working the Food Bank for NYC, MMC will identify food pantries in Highbridge and Morrisania where community members can be screened for recommended cancer screenings and social determinants of health (SDoH). Interested community members will receive referrals to cancer screenings and resources to address their SDoH needs.

Priority Area	Prevent Chronic Disease
Focus Area	Focus Area 4: Preventive care and management
Goal	Goal 4.1: Increase cancer screening rates
Objectives	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) 4.1.5 Increase the percentage of adults aged 50-64 who receive a colorectal cancer screening based on the most recent guidelines
Intervention	Intervention 4.1.1: Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts). In collaboration with the Food Bank for NYC, Montefiore-Einstein will identify food pantries in Highbridge and Morrisania where community members can be screened for recommended cancer screenings and social determinants of health (SDoH). Interested community members will receive information and referrals to cancer screenings and resources to address their SDoH needs.

Measures	Number and type of materials distributed at food pantry sites to increase awareness of and increase action to complete needed cancer screenings Number/percent of eligible community members that are referred to/ receive information for how to complete necessary cancer screenings Number/percent of eligible community members that complete necessary cancer screenings Use referral and linkage data to assess highest performing referral sources to inform program planning and develop program activities
Partner(s)	Community-based organizations will participate in community advisory board and neighborhood action councils to inform program planning, development and implementation. CBOs will also support dissemination of program information and support outreach Neighborhood leaders will participate in neighborhood action councils and will inform and support program planning and development Food pantries will provide a location and population for implementation of cancer screening and SDoH screening, and will collaborate on program implementation
Disparities	Data from Montefiore-Einstein Cancer Center shows that although overall incidence of cancer in the Bronx is 9% lower than NYS and 4% lower than US, mortality is 10% higher than NYS and 5% higher than US. Adjusted for differences in incidence, Bronx cancer mortality is 22% higher than NYS and 9% higher than US. As the largest healthcare provider in the Bronx, MMC is uniquely positioned to address disparities in cancer screening and cancer mortality rates.

Montefiore-Einstein Community Health Worker Institute Addresses Social Determinants of Health in Maternal Care

Background

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect their health and well-being. A growing body of research shows that only 20% of what influences the health of patients is related to access and quality of health care. The other 80% is found in patient's behaviors, socioeconomic conditions, and other factors that are often challenging to address in clinical visits. There is recognition throughout the health care sector that improvements in overall health metrics will depend on addressing these social determinants. The shift in the health care sector towards value-based payments has made possible expanded approaches to address health-related factors that are upstream from the clinical encounter. There is increasing interest in the role of health systems in mitigating adverse social determinants, or "social risk factors", (e.g., unstable housing, food deserts, lack of transportation) to achieve more equitable health outcomes.

Montefiore Health System is dedicated to advancing the health of the communities we serve and has adopted an overall strategy to integrate social care into healthcare. In 2016, MMC launched an initiative that introduced standardized SDOH screening within Montefiore Health System's network of ambulatory sites. The SDOH screening instrument was adapted using the Health Leads 2016 toolkit and is designed to identify SDOH needs such as housing insecurity and quality, food insecurity, legal assistance, transportation, and domestic violence.[1] A finalized version was adapted and embedded within the health system's electronic health record (Epic). Starting in 2017, MMC developed a pilot within that larger system-wide SDOH initiative at one site, called the Community Linkage to Care (CLC) program, that focuses on integration of community health workers (CHWs) to assist patients using standardized SDOH screening at primary care visits. The pilot identified six essential program components:

1) Screening workflow: Identifies who to screen, at what frequency, and by which staff members
2) Referrals: Using electronic medical record order to enable referrals from clinician and a tracking system.

[1] Health Leads' social needs screening toolkit, visit: https://healthleadsusa.org/wp-content/uploads/2016/07/Health-Leads-Screening-Toolkit-January-2017_highres.pdf.

3) CHW accompaniment: Involves active follow-up and support by CHWs to assess status of referrals and progress.
4) Provider champion(s): Clinical team member who serves as clinical contact, mentor, and/or coach to support CHW team integration and lead performance improvement initiatives.
5) Administrative liaison(s): Includes the clinical and administrative leadership to sustain program.
6) Performance improvement: Includes integrating program within ongoing, established quality improvement activities.

It also included the development of a REDCap database that served two functions: (1) an instrument for data collection, and (2) a tool for CHWs to track and follow status of patient referrals.

The CLC pilot program has evolved and as of January 2021, is now the Community Health Worker Institute. The program has expanded to 21 pediatric ambulatory sites, 5 outpatient obstetric practices, and 31 behavioral health clinics. Since 2019, over 120,000 social needs screens have been completed. Though these sites are all located within the Bronx, there are important differences between them including distinct patient demographics such as race and ethnicity, prevalence of SDOH, clinic patient volumes, and provider characteristics.

Montefiore Einstein Community Health Worker Institute

In 2021, MMC established the Community Health Worker Institute (CHWI) to integrate social care into the delivery of health care by adding community health workers to clinical teams. The institute is supported by the Robin Hood Foundation, Doris Duke Charitable Trust, the Altman Foundation, and central funds provided by Montefiore Health System. It is the aim of the Community Health Worker Institute to test an innovative CHW model at scale across MMC's primary care network.

CHWI implementation and research is supported by the Community Health Systems Lab located at Albert Einstein College of Medicine. The Community Health Systems Lab (CHSL) includes an

interdisciplinary team of researchers that support and enhance CHWI operations through technical assistance and data systems learning. The CHWI is embedded within Montefiore Medical Group where it serves as a resource for multiple clinical departments and service lines across the health system. The CHWI optimizes the recruitment, training, deployment, continuing professional development and integration of CHWs while designing a cost-effective model to sustain them. Figure 3 below shows CHWI's four primary objectives to achieve optimization of the CHW workforce at MMC:

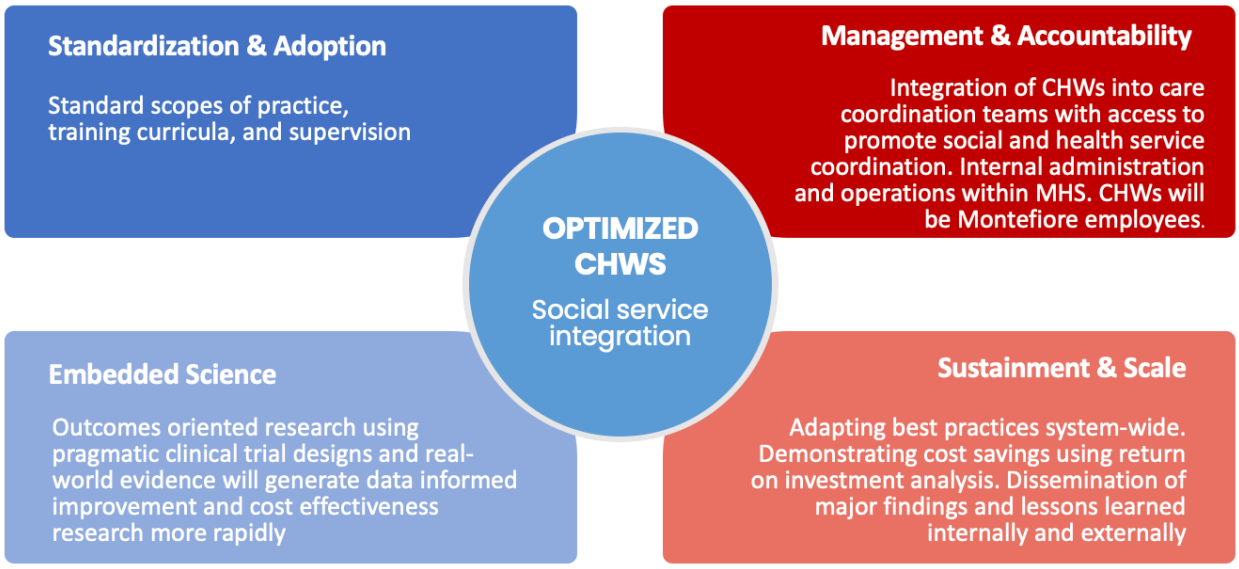


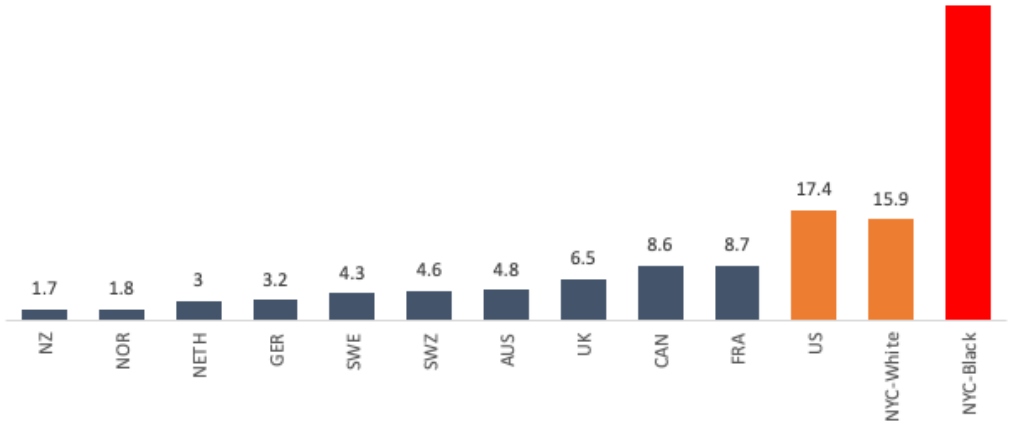
Figure 3. Montefiore-Einstein Community Health Worker Institute objectives for optimization of CHW workforce

SDoH Screening and Referrals in Obstetrics and Gynecology (OB/GYN) Practices

The 2019 New York State Taskforce Report on Maternal Mortality and Disparate Racial Outcomes reported the maternal mortality rate for Black women in New York is 51.6 deaths per 100,000 live births compared to 15.9 deaths per 100,000 live births for white women. Black women are approximately three times more likely to die in childbirth than white women. Compared to other developed countries, the US, and New York in particular, is failing to provide quality maternal health care. As the largest healthcare provider in the Bronx and the racial/ethnic makeup of the

residents of the Bronx, MMC is uniquely positioned to positively impact health disparities in maternal health outcomes.

As with children, health outcomes for mothers are largely influenced by unmet social needs that are outside the traditional healthcare setting. Racial and ethnic disparities in maternal morbidity and mortality are persistent and driven by the social conditions of mothers. Social stressors including substance abuse, intimate partner violence, and unstable or unsafe housing are common in the Bronx maternal population.



[1] NY State Taskforce Report on Maternal Mortality and Disparate Racial Outcomes, March 2019, https://www.health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf

The CHWI seeks to transform the maternal and child health practice across the health system through integration of community workers to provide comprehensive support to our most vulnerable families. The CHWI will support seven Obstetrics and Gynecology (OB/GYN) outpatient practices at MMC to establish social needs screening workflows and integrate referral systems to CHWs. MMC will establish a social care coordination team in each department, which will include administrative staff, patient navigators, social workers, clinicians, and CHWs. Two provider champions in each department will be recruited and trained to build and lead the care coordination team.

The aim of this program is to serve 3,350 families across the departments through SDOH screening, referrals to community resources, and other touchpoints with CHWs. To meet this aim, the CHWI seeks to conduct a social needs assessment, provide referral support, and link families to appropriate social service agencies. To measure success, the CHWI will track baseline and follow up data on the following outcomes:

- Social service resource received by families because of SDOH assessment and CHW engagement
- Reduction in disparities in Early Intervention rates
- Missed routine care visits
- Patient satisfaction
- Maternal morbidity and mortality
- Pre-term birth
- Infant morbidity and mortality

Dashboards have been created to track and share social need screening data. This data will be used to inform program activities and track progress on identified goals and outcomes. The CHWI has already met a key accomplishment during its collaboration with OB practices. The CHWI has seen an incredible increase in social need screens collected at the OB practices. During the ten-month period from June 2021 until March 2022, a total of 1,146 social need screens were conducted. Following intensive testing and operationalization of the new screening workflows by the CHWI team from January to March, 5,566 social needs screens were conducted in only five and a half months (April through September 15, 2022); an increase of close to 5 times in half the time.

Additionally, the CHWI has also expanded its support to other programs in Obstetrics. The CHWI are providing specialized training and supervision to a CHW hired by MMC's Fourth Trimester High Risk Clinic. The aim of this program is to provide comprehensive, multi-disciplinary postpartum care to women with high-risk pregnancy continues. The program will provide a continuum of care throughout the postpartum period and will have a patient educator/ community health worker who will provide between visit follow up and assist in making necessary care visits, including

primary care follow up, subspecialty follow up, assistance with breastfeeding and behavioral health follow up. The high-risk physician will provide counseling and education regarding the importance of lifelong primary care and information about management of subsequent pregnancies. CHWs will provide direct linkages from clinical care to community resources, and empower community members to advocate for themselves. In general, CHWs will provide coordination of care, patient education and between visit follow up.

Priority Area	Promote Healthy Women, Infants and Children
Focus Area	Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN)
Goal	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations
Objectives	n/a
Interventions	Intervention 4.1: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course. Montefiore-Einstein's Community Health Worker Institute (CHWI) seeks to (1) optimize programs that address social needs in clinical care settings, and demonstrate the value of CHWs in such interventions, and (2) measure the impact of social needs on key health disparities with a focus on maternal health outcomes. In partnership with the Department of Obstetrics and Gynecology, the CHWI aims to conduct universal social needs screening of all OB/GYN patients annually. For pregnant women, screening is performed at first OB appointment, 27 weeks gestation, and postpartum.
Measures	Number/percent of families assessed for unmet social needs Number/ percent of families referred to CHW for assistance Percent social service resource received by families because of assessment by type (e.g., housing, employment, food)

	Progress made on social need (%) reported by families as a result of CHW referral
Partner(s)	Providers will implement SDoH screening and refer patients to CHW for connection to needed resources Staff from Community-based organizations and internal MMC programs that address SDoH needs will accept referrals from CHW and help referred patients with accessing programs and resources to address SDoH need(s)
Disparities	The 2019 NY State Taskforce Report on Maternal Mortality and Disparate Racial Outcomes reported the maternal mortality rate for Black women in New York is 51.6 deaths per 100,000 live births compared to 15.9 deaths per 100,000 live births for white women. Black women are approximately three times more likely to die in childbirth than white women. As the largest healthcare provider in the Bronx and the racial/ethnic makeup of the residents of the Bronx, MMC is uniquely positioned to positively impact health disparities in maternal health outcomes.

Significant Health Needs Not Addressed

While MMC selected two out of the seven health conditions identified by community members from the GNYHA CHNA Collaborative Survey as needing attention. The other five health conditions are as follows: 1) Violence (including gun violence), 2) Mental Health/Depression, 3) Asthma/Breathing Problems or lung disease, 4) Stopping Falls Among Elderly, and 5) Obesity in children and adults. MMC provides many programs and services for the communities it serves that are not the programs featured in the Community Health Needs Assessment-Implementation Strategy Report and Community Service Plan. This includes a list of over 60 programs addressing the priorities laid out in the New York State Prevention Agenda. This section provides summary of existing and planned programs across Montefiore Health System to address the other five community-identified priorities.

Violence

Key staff at MMC are participating in the Gun Violence Prevention Collaborative led by Northwell Health to learn about strategies underway and resources available for gun violence prevention programming. As we explore opportunities to address this important health need, we are also learning from other local health systems, local health departments and community-based organizations about existing and planned strategies to address gun violence in the state.

Mental Health

Montefiore-Einstein Psychiatry Associates offers in-person and video therapy visits for adults and children addressing a wide range of conditions. In addition to individual, family and group mental health services, MMC also partners with community organizations to offer virtual and in-person workshops for the community covering a range of topics related to mental health led by our providers.

Asthma

MMC's Asthma Center was founded in 2011 to help asthmatic patients live active, healthy and symptom free lives. The Asthma Center provides a team approach model involving close collaboration between pulmonologists, allergists, educators, respiratory therapists, and home health care services for patients suffering from refractory, poorly controlled asthma. The Asthma Center team provides evaluation and a customized program for treatment of asthma, sinusitis, and rhinitis all at a single location. MMC also has a state-of-the-art inpatient unit at The Children's Hospital at Montefiore (CHAM) with an on-site school and a teen-friendly Child Life Program. As part of the Child Life Program, world-class subspecialists at CHAM provide consultation for hospitalized children who suffer from Asthma. Additionally, in 2021 the Children's Hospital at Montefiore (CHAM) and Einstein secured funding for a 5 year in-school community-based asthma intervention study working with community health workers to improve the health of Bronx children in about 40 schools. MMC's Division of Allergy and Immunology also supports asthmatic patients to identify and treat the underlying causes.

Stopping Falls Among Elderly

MMC partners with community organizations to provide programming and resources to address falls among older adults. This programming includes community workshops on fall prevention through partnerships with community-based organizations serving older adults. Programming and services are also offered through Burke Rehabilitation Hospital, a hospital in the Montefiore Health System network.

Obesity in Adults and Children

Addressing obesity requires a multi-pronged approach that includes addressing healthy food access, access to safe spaces to be physically active, availability of health and nutrition education programming, food insecurity, and clinical care and resources to address diet-related chronic diseases – to name a few. Programs and initiatives across Montefiore Health System provide evidence-based health services, connect patients to community resources, pilot and implement programs addressing factors related to obesity, and support policies that increase access to resources and information to support the communities we serve. Some of our work in the Bronx includes virtual and in-person community education workshops in partnership with community-based organizations, health and nutrition programming through the Montefiore School Health Program, one-on-one and group support through health educators and dietitians, distribution of fresh produce and healthy food options through our food pantry Project BRAVO, partnering with local organizations and schools to build edible gardens, providing healthy food options in our cafeterias for patients, staff and visitors, working with local business to increase access to healthy food options, and screening patients for social determinants of health (including food insecurity) and referring to community resources.

In addition to the multiple resources that have been developed at MMC independently and through partnership with other organizations, there continues to be a need for community-based programs and resources that can augment MMC's programs and services. There is an extensive set of resources that are available to meet the needs of Bronx residents which cannot be met entirely by MMC program and services, and/or are available for those that choose to use external organizations. The use of multiple free and low-cost internet databases has expanded in the public sphere such as www.auntbertha.com, www.hitesite.org, www.nowpow.com among others that have reduced the need for quickly obsolete and expensive-to-produce information and community resources referral guides.

The Community Service Plan for 2022-2024 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/communit

Since the previous version of this report in 2019, MMC has continued to expand and has a goal to scale screening and referring patients for unmet social needs. This includes the use of the electronic database platform www.nowpow.com to connect patients to needed resources, which has been a challenge for the health care sector. This online tool is a much more comprehensive and practical alternative to the home-grown referral guides that many health care providers have had to use in the past. Those were hard to keep-up-to-date and difficult to search, a problem that is largely addressed by the online version.

Many MMC sites have been introduced to this online resource and teams continue the work to integrate this kind of solution more seamlessly into the various workflows across the ambulatory, ED and inpatient settings. As MMC is an organization that works with complex health needs and whose community faces multi-factorial structural barriers that impact overall health, providing information, accessibility and review of such external resources and links, allows MMC to better address patients' social needs and build on the work of community-based organizations in serving the community.

The use of an internet database will allow MMC to connect patients to important community resources provided outside of the health system by many of our community partners to address

community needs such as housing (quality and affordability), transportation, employment, and education. MMC recognizes the importance of addressing these needs, as part of our approach to addressing the social determinants of health and are utilizing our strong community partnerships continue to provide services for Bronx residents.

Report Dissemination Plan

The plan to disseminate the delivery of the MMC's 2022-2024 Community Health Needs Assessment-Implementation Strategy Report, and Community Service Plan Report to the public will occur across several platforms. The Community Health Needs Assessment-Implementation Strategy Report and Community Service Plan Report will be posted to the www.montefiore.org website at the address: https://www.montefiore.org/community-reports.
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. Physical copies of the report will be available at the main entrances for each of the acute care facilities at the Security Desk. Appropriate staff will also provide community presentations to discuss the findings of the report and their relationship to community interests.

The report will be sent via email to members of the MMC 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. Additionally, MMC's Office of Community and Population Health will create a summary report of CHNA findings to distribute to community members and stakeholders. This brief report will highlight the community needs identified through the CHNA process and MMC's plans to address identified needs from the 2022 CHNA Survey. This summary report will be shared through similar channels as the full report.
A QR code for the link to the report will be made available for print materials to facilitate ease of access to the report.

MMC will announce through its multiple social media platforms the availability of the Community Health needs Assessment and 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

When available, the summary report will be posted online and shared through MMC' social media channels for wide distribution.

Adoption of Report by Governing Board

Statement of Executive Review and Date Report is Made Available to the Public

The MMC Community Health Needs Assessment (CHNA) and Implementation Strategy Report, and Community Service Plan was approved by Montefiore Board of Trustees on December 15, 2022. The Community Health Needs Assessment (CHNA) Report and Community Service Plan was uploaded to the Montefiore website on December 30, 2022.

Appendix

2022 Community Health Survey

We want to improve the health services we offer to people who live in your neighborhood. The information you give us will be used to improve health services for people like yourself.

Completing the survey is voluntary. We will keep your answers private. If you are not comfortable answering a question, leave it blank.

We value your input. Thank you very much for your help.

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1 Are you 18 years of age or older?

- ○ Yes
- ○ No → Thank you very much, but we are only asking this survey of people who are ages 18 and older.

2 We want people from all different neighborhoods to take part in this survey. Please tell us the zip code where you live so we can identify your neighborhood.

Zip code: _____

IF YOU PROVIDED A ZIP CODE, PLEASE GO TO PAGE 3. YOU DO NOT NEED TO ANSWER THESE QUESTIONS.

3 Do you live in New York City?

- ○ Yes
- ○ No → Skip to 5

4 If you live in New York City, please select the borough where you live:

- ○ The Bronx → Go on to page 3
- ○ Brooklyn → Go on to page 3
- ○ Manhattan → Go on to page 3
- ○ Queens → Go on to page 3
- ○ Staten Island → Go on to page 3

5 If you do not live in New York City, please tell us the county where you live:

- ○ Albany County
- ○ Allegany County
- ○ Broome County
- ○ Cattaraugus County
- ○ Cayuga County
- ○ Chautauqua County
- ○ Chemung County
- ○ Chenango County
- ○ Clinton County
- ○ Columbia County
- ○ Cortland County
- ○ Delaware County
- ○ Dutchess County
- ○ Erie County
- ○ Essex County
- ○ Franklin County
- ○ Fulton County
- ○ Genesee County
- ○ Greene County
- ○ Hamilton County
- ○ Herkimer County
- ○ Jefferson County
- ○ Lewis County
- ○ Livingston County
- ○ Madison County
- ○ Monroe County
- ○ Montgomery County
- ○ Nassau County
- ○ Niagara County
- ○ Oneida County
- ○ Onondaga County
- ○ Ontario County
- ○ Orange County
- ○ Orleans County
- ○ Oswego County
- ○ Otsego County
- ○ Putnam County
- ○ Rensselaer County
- ○ Rockland County
- ○ Saratoga County
- ○ Schenectady County
- ○ Schoharie County
- ○ Schuyler County
- ○ Seneca County
- ○ St. Lawrence County
- ○ Steuben County
- ○ Suffolk County
- ○ Sullivan County
- ○ Tioga County
- ○ Tompkins County
- ○ Ulster County
- ○ Warren County
- ○ Washington County
- ○ Wayne County
- ○ Westchester County
- ○ Wyoming County
- ○ Yates County

- ○ Other_____

6 In general, how is the overall health of the people of your neighborhood?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

7 In general, how is your physical health?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

8 In general, how is your mental health?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

9 For each of the following, please tell us: How important is each of the following to you and how satisfied are you with the current services in your neighborhood to address each health issue?

	How important is this issue to you?						How satisfied are you with current services?					
	Don't know	Not at all	A little	Somewhat	Very	Extremely	Don't know	Not at all	A little	Somewhat	Very	Extremely
1 Access to healthy/nutritious foods	O	O	O	O	O	O	O	O	O	O	O	O
2 Adolescent and child health	O	O	O	O	O	O	O	O	O	O	O	O
3 Arthritis/disease of the joints	O	O	O	O	O	O	O	O	O	O	O	O
4 Asthma/breathing problems or lung disease	O	O	O	O	O	O	O	O	O	O	O	O
5 Cancer	O	O	O	O	O	O	O	O	O	O	O	O
6 Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah	O	O	O	O	O	O	O	O	O	O	O	O
7 COVID-19	O	O	O	O	O	O	O	O	O	O	O	O
8 Dental care	O	O	O	O	O	O	O	O	O	O	O	O
9 Diabetes/elevated sugar in the blood	O	O	O	O	O	O	O	O	O	O	O	O
10 Heart disease	O	O	O	O	O	O	O	O	O	O	O	O
11 Hepatitis C/liver disease	O	O	O	O	O	O	O	O	O	O	O	O
12 High blood pressure	O	O	O	O	O	O	O	O	O	O	O	O
13 HIV/AIDS (Acquired Immune Deficiency Syndrome)	O	O	O	O	O	O	O	O	O	O	O	O
14 Infant health	O	O	O	O	O	O	O	O	O	O	O	O
15 Mental health/depression	O	O	O	O	O	O	O	O	O	O	O	O
16 Obesity in children and adults	O	O	O	O	O	O	O	O	O	O	O	O
17 Sexually Transmitted Infections (STIs)	O	O	O	O	O	O	O	O	O	O	O	O
18 Stopping falls among elderly	O	O	O	O	O	O	O	O	O	O	O	O
19 Substance use disorder/drug addiction (including alcohol use disorder)	O	O	O	O	O	O	O	O	O	O	O	O
20 Violence (including gun violence)	O	O	O	O	O	O	O	O	O	O	O	O
21 Women's and maternal health care	O	O	O	O	O	O	O	O	O	O	O	O

10 **What are your COVID-19 needs?** (Select all that apply)

- ☐ At-home COVID-19 tests
- ☐ Boosters for COVID-19
- ☐ In-person testing for COVID-19 (e.g., doctor's office, pharmacy, mobile van)
- ☐ Personal protective equipment (e.g., masks, hand sanitizer, face shields, gloves)
- ☐ Treatment for COVID-19
- ☐ Reliable source(s) of information on COVID-19
- ☐ COVID-19 vaccination

11 In the last 12 months, was there a time when you needed medical care in-person but did not get it for any reason?

- ○ Yes
- ○ No → Skip to 13

12 For which of the following reasons could you not get medical care in-person the last 12 months? (Select all that apply)

- ☐ I could not afford the cost of care (e.g., copay, deductible)
- ☐ I did not have health insurance
- ☐ There were no available appointments, or I couldn't get an appointment soon enough
- ☐ I could not get through on the telephone to make the appointment
- ☐ Once I got there the wait was too long to see the doctor
- ☐ I did not have transportation
- ☐ I did not have childcare
- ☐ Because of COVID-19
- ☐ Other
- ☐ None of the above

13 In the last 12 months, was there a time when you needed medical care by video or phone but could not get it for any reason?

- ○ Yes
- ○ No → Skip to 15

14 For which of the following reasons could you not get medical care by video or phone in the last 12 months? (Select all that apply)

- ☐ I could not afford the cost of care (e.g., copay, deductible)
- ☐ I did not have health insurance
- ☐ There were no available appointments, or I couldn't get an appointment soon enough
- ☐ I could not get through on the telephone to make the appointment
- ☐ I did not have a computer, phone, or other device to use for the visit
- ☐ I did not know how to see the doctor by video or phone
- ☐ I did not have internet
- ☐ I did not have data or minutes in my phone plan to use for a visit
- ☐ I did not have a private place to have my appointment
- ☐ Other
- ☐ None of the above

15 In the last 12 months, have you experienced any of the following? (Select all that apply)

- ○ Anxiety or depression
- ○ Difficulty paying your rent/mortgage
- ○ Difficulty paying utilities or other monthly bills
- ○ Increased household expenses
- ○ Increased medical expenses
- ○ Hunger or skipped meals because you did not have enough money to buy food
- ○ None of these

16 What type of health insurance do you use to pay for your doctor or hospital bills? Is it insurance through:

- ○ A plan purchased through an employer or union (including plans purchased through another person's employer)
- ○ A plan that you or another family member buys on your own
- ○ Medicare
- ○ Medicaid or other state program
- ○ TRICARE (formerly CHAMPUS), VA, or Military
- ○ Alaska Native, Indian Health Service, Tribal Health Services
- ○ Some other source
- ○ I do not have any kind of health insurance coverage

17 What is your age?

_____

18 Are you…

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Another gender
- ○ Prefer not to say

19 Do you describe yourself as…

- ○ Lesbian or Gay
- ○ Straight, that is not Gay
- ○ Bisexual
- ○ Other
- ○ Prefer not to say

20 Are you Hispanic or Latino/Latina/Latinx?

- ○ No
- ○ Yes → Answer 21

21 Which group best represents your Hispanic or Latino/Latina/Latinx origin or ancestry?

- ○ Puerto Rican
- ○ Dominican
- ○ Mexican
- ○ Ecuadorian
- ○ Colombian
- ○ Cuban
- ○ Other Central American
- ○ Other South American
- ○ Other

22 Which one or more of the following would you say is your race? (Select all that apply)

- ☐ White
- ☐ Black or Black American → Answer 23

23 Some people in addition to being Black, have a certain heritage or ancestry. Do you identify with any of these? (Select all that apply)

- ☐ African American
- ☐ Caribbean or West Indian
- ☐ A recent immigrant or the child of recent immigrants from Africa
- ☐ Other

- ☐ Asian → Answer 24

24 Please tell me which group best represents your Asian heritage or ancestry?

- ☐ Chinese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Japanese
- ☐ Vietnamese
- ☐ Other

- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian, Native, First Nations, Indigenous Peoples of the Americas, or Alaska Native
- ☐ Other

25 What is the highest grade or year of school that you have completed?

- ○ Grades 8 (Elementary) or less
- ○ Grades 9 through 11 (Some High School)
- ○ Grade 12 or GED (High School Graduate)
- ○ Some college or technical school
- ○ College graduate or more

26 Including yourself, how many people usually live or stay in your home or apartment?

_____person(s)

27 What is the primary language you speak at home?

- ○ English
- ○ Spanish
- ○ Mandarin
- ○ Cantonese
- ○ Russian
- ○ Yiddish
- ○ Bengali
- ○ Korean
- ○ Haitian Creole
- ○ Italian
- ○ Arabic
- ○ Other

28 What is your current employment status? Select the category that best describes you.

- ○ Employed full-time for wages or salary
- ○ Employed part-time for wages or salary
- ○ Self-employed
- ○ Out of work for 1 year or more
- ○ Out of work for less than 1 year
- ○ A homemaker
- ○ A student
- ○ Retired
- ○ Unable to work

29 What is your household's annual household income from all sources, before taxes, in the last year? By household income we mean the combined income from everyone living in the household including even roommates or those on disability income.

- ○ Less than $20,000
- ○ $20,000 to $29,999
- ○ $30,000 to $49,999
- ○ $50,000 to $59,999
- ○ $60,000 to $74,999
- ○ $75,000 to $99,999
- ○ $100,000 or more

This is the end of the survey. Thank you very much for your help