Community Health Needs Assessment and Implementation Strategy Report 2019-2021

Montefiore New Rochelle/

Montefiore Mount Vernon

Office of Community & Population Health

12/30/2019

Montefiore Medical Center

Community Health Needs Assessment and Implementation Strategy Report 2019-2021

Table of Contents

Item	Page Number
Executive Summary	5
The 2019-2021 CHNA	11
Introduction • Organizational Background • Statement of Executive Review • Date report is made available to the public	11
CHNA Process and Methods • Description of the process and methods used to conduct the assessment • Involved Personnel • Description of Planned Approach o analytical methods used to identify the community health needs o description of statistical tests or processes	13
Input Representing the Broad Interests of the Community • Stakeholders and partners that participated in the prioritization process • Methodology for selection including group consensus processes • Comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy	15
Definition/Description of the Community Service Area • Description of the population/community served by the hospital facility • Unique community characteristics/resources	16
Secondary Data Collection Plan • Data and information sources for secondary data o agency or organization o retrieval date o year of data available and used o Web address o rationale for use of these data sources	23
Primary Data Collection Plan • Data and information sources for primary data collection • Description of type of methodology (interviews, survey, focus group) • Rationale for methodology selection	26

• Setting(s) of primary data collection
  ○ Specific target populations response rate by setting and population (number interviewed, numerator and denominator of surveys sent and returned — include percentage and actual numbers)
  ○ Description and list of successful approaches and identification
  ○ Description and list of barriers, challenges and unsuccessful approaches	

Presentation of Data • Overview (Maps)	29
Review of Key Findings • Summary List of Specified Community Needs	62
Special Considerations • Gaps in information that limited the ability to assess the community served • Description and list of specific gaps	64
Implementation Strategy Report	66
Significant Needs to Be Addressed • Anticipated impact of those actions • Description of resources available to address the health need • Planned collaborations with other facilities or organizations	66
Significant Needs Not Addressed • Explanation of rationale • Anticipated impact of those actions • Description of alternate resources available to address the health need • Web based Resources Dissemination Strategy	70 133 135
Appendix	136

Montefiore New Rochelle/ Montefiore Mount Vernon

Community Health Needs Assessment and Implementation Strategy Report 2019-2021

Cover Page

This New York State 2019-2021 Community Health Assessment and Improvement Plan and Community Service Plan are covering Westchester County, one of the centrally located counties within the New York City metropolitan area situated in the Hudson Valley with a population of about one million people. This document is submitted as the requirement for the 2019-2021 Community Health Needs Assessment and Implementation Strategy Report for the Schedule H Requirement of the Internal Revenue Service 990 tax form and assesses the health needs for Westchester County, New York.

The participating hospitals in the health system are Montefiore New Rochelle Hospital and Montefiore Mount Vernon Hospital, a part of the Montefiore Health System, and encompasses the municipalities of the City of New Rochelle, the City of Mount Vernon and the county of Westchester. The contact for information that pertains to this report is:

Montefiore Health System
Office of Community and Population Health
3514 DeKalb Avenue
Bronx, NY 10467

Nicole Harris-Hollingsworth, EdD, MCHES
Assistant Vice President, Community & Population Health
nholling@montefiore.org

Executive Summary

The Community Health Needs Assessment Requirement

The Affordable Care Act 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 Montefiore New Rochelle and Montefiore Mount Vernon. The second component encompasses the Implementation Strategy, which will further discuss the significant health needs of the community, describe the programs and strategies to address these significant health needs, and delineate the metrics to be used to evaluate the impact of these strategies.

Montefiore New Rochelle and Montefiore Mount Vernon's Community Health Needs Assessment (CHNA) process and secondary data was approved by the Community Services Committee of the Board of Trustees on December 19, 2019. The Community Health Needs Assessment (CHNA) report was uploaded to the Montefiore website December 30, 2019.

Introduction

This report covers the two hospital campuses of the Montefiore Health System located in Lower Westchester County: Montefiore New Rochelle and Montefiore Mount Vernon. The information for each section is presented in a staggered format, with appropriate titles indicating the specifics of each hospital. As the communities are closely geographically located and share a countywide service area, have high migration between their facilities and have staff that operate between the facilities, the reporting of data, while representing their demographic distinctions, is unified.

Montefiore Mount Vernon (MMV), located at 12 North Seventh Avenue, Mount Vernon NY, 10550, is a licensed 121-bed hospital. As a community-based teaching hospital, MMV has been serving the medical needs of the community and region since its founding in 1891. MMV provides emergency, inpatient, critical care and ambulatory services. Montefiore Mount Vernon is a New York State designated Stroke Center, an HIV/AIDS Center, and site of the Beale Chronic Wound Treatment and Hyperbaric Center. The Montefiore School of Nursing is located adjacent to Montefiore Mount Vernon's Campus.

Montefiore New Rochelle (MNR) is a 242-bed, community-based teaching hospital offering primary, acute and emergency care to the residents of southern Westchester County. Since its founding in 1892, Montefiore New Rochelle facility has provided for the diverse medical needs of the community and region it serves and continues to provide inpatient, critical care and ambulatory services.

Both facilities are part of the 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. Montefiore's Executive Leadership and Board of Trustees sponsor the Community Health Assessment process through the Office of Community and Population Health. Montefiore's Office of Community and Population Health developed a community integrated approach which maintains ongoing relationships with community based organizations interested in the health issues most impacting the populations of the regions we serve.

Community Service Plan Process and Methods

The process to identify the needs of the community involved the collection of both secondary and primary data. Multiple conversations and meetings were convened internally and with external partners, and a thorough review of the data was conducted, all of which will frame the development of the Implementation Strategy.

Montefiore New Rochelle and Montefiore Mount Vernon engaged with the Westchester County Department of Health's online Community Resident Survey to facilitate the implementation of the primary data collection process for the Community Health Needs Assessment for Westchester County and to assist in the facilitation of these community level connections thereby alleviating additional surveying overload. While the exact priorities identified through each of these approaches varied somewhat, there was a consistent placement of healthy eating and food security, and its related environmental factors (e.g., access to healthier food) and health consequences (e.g., chronic disease care and screening), as the top community health priorities looking forward.

Primary Data Collection Process

In collaboration with the Westchester County Department of Health, a community needs survey was conducted in the Winter and Spring of 2019. The community survey could be completed via a web-based tool (SurveyMonkey) or on paper; with paper surveys were available in English and Spanish, with the capacity for supplemental translation to other languages by request. The primary distribution of the survey was conducted through the Westchester County Department of Health's Office of the Administrator and was made available through its website at the direction of the Commissioner of Health and the County Executive, which then directed it for distribution to the County's elected officials. The Montefiore Hudson Valley Collaborative also distributed the survey to its membership of over 900 hospitals, community based organizations,

faith-based organizations and other social service providers. As the survey was co-compiled through a coalition of hospitals represented by the three nonprofit hospital systems in Westchester County, there was not any institutional bias toward any individual hospital in the survey. Due to its electronic format, dissemination as widespread, however limited quantities of paper surveys were available on request. The survey was disseminated through multiple distribution points including to hospitals, other health care providers, community-based organizations and others.

Secondary Data Collection Process

In addition to the review of primary data, to capture an up-to-date high-level view of the health status of Westchester County residents, we evaluated temporal trends, differences between Westchester and peer counties and sub-county differences, when available, for more than 20 measures, including: obesity, preterm births, teen pregnancy rates, poverty, linguistic isolation, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screening, HIV incidence, lung, colorectal, prostate and breast cancer incidence rates, and hospitalizations for asthma, diabetes, assaults, heart attacks and falls. These data were obtained from multiple population-based datasets including the American Community Survey (formerly referred to simply as the Census), New York State Expanded Behavioral Risk Factor Surveillance System (BRFSS), New York State Statewide Planning and Research Cooperative Systems (SPARCS), New York State Vital Statistics, New York State HIV/AIDS Epidemiology Reports, and the New York State Cancer Registry. Additional data was obtained from the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard.

Presentation of Data

The collection and interpretation of the primary and secondary data for the Community Health Assessment has produced a series of comprehensive maps, charts and graphs detailing the clinical and social health factors present in the community. Measured across over twenty domains and correlated to provide outcomes for Westchester County as compared to peer counties across New York State, analysis related to disparities, hot spot maps detailing intensity by geographic UHF determinations, correlated to topical issues of the NYS Prevention Agenda, a ranking of individual priorities, community priorities, and suggested interventions is provided in summary in the three attached tables.

Review of Key Findings

While Westchester County remains among the healthiest counties in New York State, several of its individual municipalities continue to have significant health gaps. Portions of lower Westchester, specifically Mount Vernon, Yonkers, New Rochelle and White Plains are “hot

spots" for various health outcomes, such as asthma and preterm births in the County. Additionally, certain groups, such as some racial/ethnic minorities or those with less education, experience poorer health outcomes.

Some Westchester populations have excess mortality rates. For example, the age-adjusted mortality rate per 100,000 for the non-Hispanic black (695.1 per 100,000) and non-Hispanic white (657.0 per 100,000) populations are significantly higher than for the Hispanic population (493.2 per 100,000). Additional data and descriptions are provided in the report to expand on additional health challenges and disparities present in the populations served by both hospitals.

Summary of Assets

The assets presented for the cities of New Rochelle and Mount Vernon are presented representative to their individual geography. The information provided also includes County assets as each city has assets within that are the County-wide center for that asset.

The City of New Rochelle is the anchor city for the Long Island Sound Region of Westchester County. While three times the size of Mount Vernon, the city has only a slightly larger population (79,877 vs. 68,671). Mount Vernon is the 3rd most populous city in Westchester County (n=68,671). The city is 4.4 square miles and is the 2nd most densely populated city in New York State, trailing only New York City. According to the 2017 American Community Survey, Mount Vernon has 68,671 residents and has experienced 0.4% population growth from 2000 to 2017.

Both of these cities are located in Westchester County, the 3rd healthiest county in New York State, according to the County Health Rankings, produced by the University of Wisconsin. Residents of Westchester County have access to a number of community resources including public and private schools, open spaces, healthcare facilities, community gardens, bike lanes and much more.

Implementation Strategy Report

Significant Needs to Be Addressed

The Priority Areas that were selected in 2016 have been expanded upon to have greater alignment with the initiatives of the Delivery System Reform Incentive Payment Program (DSRIP). Montefiore New Rochelle and Montefiore Mount Vernon will continue its work on Maternal and Child Health with an emphasis on breastfeeding. Furthermore, Montefiore New Rochelle and Montefiore Mount Vernon will continue their participation with the Westchester County Department of Health's CSP Collaborative to coordinate their alignment with the County's other healthcare providers.

While the exact priorities identified through each of these approaches varied somewhat, there was a consistent placement of food and nutrition, and its related environmental factors (e.g., access to healthy food) and health consequences (e.g., diabetes, cardiovascular disease), as the top community health priority looking forward. In addition, more than 20 pieces of secondary data from numerous publicly-available population-based datasets were reviewed to collect an up-to-date view of the health status of the communities. Triangulating between priorities for the Prevention Agenda, DSRIP and the community, focus areas were selected that would allow us to work with a broad area of community partners in a wide range of activities.

In the Comprehensive Community Services plan developed for 2016-2018, the priority areas selected are Prevent Chronic Disease and Promote Healthy Women Infants and Children. Through the projects and activities initiated during that plan, Montefiore New Rochelle and Montefiore Mount Vernon were able to contribute to the overall trend improvements in those areas for New York State. However, although Westchester County has continued to be among the top five and has shown improvements along with the rest of New York State, the rates for conditions identified in the communities of Mount Vernon and New Rochelle remains higher in most cases than the countywide and statewide averages.

Montefiore has elected to retain these two priority areas Prevent Chronic Disease and Promote Healthy Women Infants and Children for the 2019-2021 plan. As described within the Community Description and Service Area section of this proposal, Westchester County, while gradually increasing in ethnic diversity has hotspots where populations, up to 90%, identify as a cultural/racial/ or ethnic minority. As the racial and ethnic populations have shown disparate rates of impact, in consultation and collaboration with community partners, within Prevent Chronic Diseases the focus area and goal that was selected is: Focus Area 4: Chronic Disease Preventive Care and Management, Goal 4.2 Increase early detection of cardiovascular disease, diabetes, pre-diabetes and obesity, under Objective 4.2.1: Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%. Montefiore New Rochelle and Montefiore Mount Vernon have also added a new priority area for this cycle: Prevent Communicable Diseases, with a focus on vaccine preventable diseases, specifically HPV.

Montefiore New Rochelle and Montefiore Mount Vernon have identified three Prevention Agenda Priority Areas:

1. **Preventing Chronic Disease** with a specific focus on Preventive Care and Management.

Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

2. **Promote Healthy Women Infants and Children**, Focus Area: Perinatal and Infant Health, Goal 2.2: Increase breastfeeding, Objective 2.2.1.0: Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among all infants.

3. **Prevent Communicable Diseases, Focus Area** : Vaccine Preventable Diseases

Goal 1.1: Improve vaccination rates, Objective 1.1.2: Increase the percentage of NYS 13-year-old adolescents with a complete HPV vaccine series by 10% to 37.4%

Significant Needs Not addressed

In addition to the multiple resources that have been developed at Montefiore independently and through partnership with other organizations, there continues to be a need for community-based programs and resources that can augment Montefiore's programs and services.

There is an extensive set of resources that are available to meet the needs of Westchester residents which cannot be met entirely by Montefiore program and services, or that choose to utilize external organizations. Since the previous version of this report in 2016, Montefiore has begun using the internet database platform www.nowpow.com, to connect patients to needed resources, which has been a challenge for the health care sector. Many Montefiore sites have been introduced to this new online resource and work is underway to more seamlessly integrate this kind of solution into the various workflows across the ambulatory, ED and inpatient settings. As Montefiore is an organization that works with complex health needs and whose community faces multi-factorial crises that impact upon overall health, providing information, accessibility and review of such external resources and links provides additional information on available resources to address community needs for our community partners.

The use of an internet database will allow Montefiore 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.

The 2019 Community Health Needs Assessment

The completion of a Community Health Needs Assessment and Implementation Strategy Report 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 Montefiore New Rochelle – Montefiore Mount Vernon. The second component encompasses the Implementation Strategy, which further discusses the significant health needs of the community, describe the programs and strategies to address these significant health needs, and delineate the metrics to be used to evaluate the impact of these strategies.

The Montefiore New Rochelle – Montefiore Mount Vernon Community Health Needs Assessment (CHNA) process and secondary data was approved by Montefiore Board of Trustees on December 19, 2019. The Community Health Needs Assessment (CHNA) report was uploaded to the Montefiore website December 30, 2019.

Introduction

This report covers the two hospital campuses of the Montefiore Health System located in Lower Westchester County: Montefiore New Rochelle and Montefiore Mount Vernon. The information for each section is presented in a staggered format, with appropriate titles indicating the specifics of each hospital. As the communities are closely geographically located and share a countywide service area, have high migration between their facilities and have staff that operate between the facilities, the reporting of data, while representing their demographic distinctions, is unified.

About Montefiore New Rochelle Hospital and Montefiore Mount Vernon Hospital

Montefiore Mount Vernon (MMV), located at 12 North Seventh Avenue, Mount Vernon NY, 10550, is a licensed 121-bed hospital. As a community-based teaching hospital, MMV has been serving the medical needs of the community and region since its founding in 1891. MMV provides emergency, inpatient, critical care and ambulatory services. Montefiore Mount Vernon is a New York State designated Stroke Center, an HIV/AIDS Center, and site of the Beale Chronic Wound Treatment and Hyperbaric Center. The Montefiore School of Nursing is located adjacent to Montefiore Mount Vernon's Campus.

Montefiore New Rochelle (MNR) is a 242-bed, community-based teaching hospital offering primary, acute and emergency care to the residents of southern Westchester County. Since its founding in 1892, Montefiore New Rochelle facility has provided for the diverse medical needs

of the community and region it serves and continues to provide inpatient, critical care and ambulatory services.

Montefiore New Rochelle has a number of leading-edge services and programs that have earned distinction by state and national organizations for achieving and maintaining the highest quality of care within the specialty, including: Designated as a Center of Excellence by the American Society of Metabolic and Bariatric Surgery New York State-designated Stroke Center New York State-designated Area Trauma Center—the only one in southern Westchester. Montefiore New Rochelle is a New York State-designated perinatal hospital with a Level 3 Neonatal Intensive Care Unit that provides state-of-the-art care for fragile newborns Gold Seal of Approval from The Joint Commission as a certified Center of Excellence in both hip and knee joint replacement for the Montefiore Mount Vernon campus as well.

Both facilities are part of the 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. Montefiore's Executive Leadership and Board of Trustees sponsor the Community Health Assessment process through the Office of Community and Population Health. Montefiore's Office of Community and Population Health developed a community integrated approach which maintains ongoing relationships with community based organizations interested in the health issues most impacting the populations of the regions we serve.

Information on additional programs and services can be found at www.montefiore.org and www.doingmoremontefiore.org. Additional information about community specific initiatives can be found at www.montefiore.org/community.

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

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

Montefiore Medical Center's Community Service Plan was approved by the Community Services Committee of the Board of Trustees on December 19, 2019. The Community Service Plan was uploaded to the Montefiore website December 30, 2019.

Community Health Needs Assessment Process and Methods

The process for preparing the 2019-2021 Community Health Needs Assessment was an inter-organizational and community collaborative process, initiated with the goal of developing an assessment that was reflective of the needs of the community including the clinical and social determinants of health. The 2019-2021 Community Health Needs Assessment involved a primary data collection strategy in conjunction with secondary data. The method of primary data collection involved a survey of Westchester County residents that took place during the Spring and early Summer of 2019. The primary data collection strategy was used to identify community health priorities in Westchester County, in addition to secondary data.

Involved Personnel

A two-page instrument that could be completed on paper or online was created by the Montefiore Office of Community & Population Health with stakeholder input. The survey was available in both English and Spanish. Half-page handouts were made in both English and Spanish to hand out at community events with a QR code that automatically linked participants to the online survey.

Description of Planned Approach

In order to identify community health needs we conducted an assessment of secondary data, including data from population-based surveys, hospital discharges and numerous other data sources. This information was complemented by the collection of primary data via a community-member and provider-survey.

The survey included questions on what community members perceived to be the priority health concerns in the community where they lived. Participants were asked to identify what intervention strategies would provide the most benefit to their community. Participants were also asked to identify their individual health priorities. Based on our prior work in this area we often see a discontinuity between responses to the "community" and "individual" questions. For each of these questions, a menu of more than 20 areas/topics is included. These included categories chosen to align with the 2019-2024 New York State Prevention Agenda Focus Areas. Beyond questions specifically related to community health concerns, participant demographic and health status data were collected.

The secondary data used to identify community health needs is described in **Section 6**. The secondary data evaluation consists of two distinct approaches. First, we used data from the Statewide Planning and Research Cooperative System (SPARCS) to examine the leading causes

of hospitalization, avoidable hospitalizations, and ED visits for Montefiore New Rochelle and Montefiore Mount Vernon. Second, we completed an assessment of secondary data for more than 20 core health indicators from several population-based data sources. An overview of the SPARCS Data for Montefiore New Rochelle and Montefiore Mount Vernon, specifically the top 20 inpatient diagnoses and top 20 reasons for treat-and-release emergency department (ED) visits are included in Appendix B and Appendix C.

Description of Statistical Tests or Processes

To capture an up-to-date high-level view of the health status of Westchester County residents, we evaluated temporal trends, differences between Westchester County and the rest of New York State and sub-county differences, when available, for more than 20 measures, including: obesity, preterm births, teen pregnancy rates, poverty, linguistic isolation, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screening, HIV incidence, lung, colorectal, prostate and breast cancer incidence rates, and hospitalizations for asthma, diabetes, assaults, heart attacks and falls. These data were obtained from multiple population-based datasets including, but not limited to, the American Community Survey (formerly referred to simply as the Census), US Census Bureau Small Area Health Insurance Estimates, New York State Statewide Planning and Research Cooperative Systems (SPARCS), NYS Expanded Behavioral Risk Factor Surveillance System, New York State Vital Records, New York State Sexually Transmitted Disease Surveillance Data, and the New York State Cancer Registry. Additional data was obtained from the City Health Dashboard 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 that was used to identify the issues of concern beyond experience and direct observation are listed below.

<u>Listing of Data Sources</u>

i. American Community Survey
ii. US Census Bureau Small Area Health Insurance Estimates
iii. NYS Expanded Behavioral Risk Factor Surveillance System New York State Vital Records
iv. New York State Statewide Planning and Research Cooperative Systems (SPARCS)
v. Student Weight Status Category Reporting System (SWSCRS)
vi. New York State Cancer Registry

vii. New York State Immunization Information System

viii. Global Burden of Disease

ix. NYS HIV Surveillance System

x. New York State Sexually Transmitted Disease Surveillance Data

xi. New York State Vital Records Data

xii. New York State Prevention Agenda Dashboard

xiii. National Vital Statistics Surveillance System

Input Representing the Broad Interests of the Community

Montefiore New Rochelle and Montefiore Mount Vernon meets regularly with the local Department of Health, and continues to participate in a MHVC DSRIP aligned Collaborative with membership from St. Joseph's Medical Center (including St. Vincent's Hospital – Westchester), St. John's Riverside Hospital, White Plains Hospital, and Burke Rehabilitation Hospital working to ensure that the CSP and DSRIP goals retain their alignment. 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. Montefiore will continue to work with its partners on existing program initiatives.

In addition to this collaborative input from the local Department of Health and clinical partners, Montefiore worked closely with its communities including the Mount Vernon Community Advisory Board (MVCAB). In addition, (1) work with a variety of organized partnerships and collaboratives, (2) working with other providers in lower Westchester as well as (3) extensive work with representatives of the affected communities has helped Montefiore to identify health care needs and determine the appropriate configuration of services.

Beyond the formal structures that Montefiore established to gain input from the communities it serves, Montefiore's Office of Community and Population Health participates in a variety of informal organized partnerships and collaboratives, working with other providers in the Westchester, the Westchester County Department of Health, community-based organizations and others, using a community level approach that involves relevant community based organizations interested in planning and developing initiatives aimed at improving the health of the residents of Westchester County.

Definition/ Description of the Community Service Area

Definition and Description of the Community/Service Area: Population of Westchester County

Montefiore New Rochelle and Montefiore Mount Vernon have identified Westchester County as their primary service area. Westchester County has a population of 975,321 and is approximately 430.5 square land miles. It is the 7th most populous county in New York State. The county seat of Westchester is White Plains (56,404) and other major cities include Yonkers (200,999), New Rochelle (79,877) and Mount Vernon (68,671). In 2017, the median household income for Westchester was $89,968, 4th highest in New York State, after Nassau, Putnam and Suffolk Counties.

Westchester County is the 3rd healthiest county in New York State, according to the County Health Rankings, produced by the University of Wisconsin. Despite its overall high ranking, there is considerable room to improve population health in Westchester County, while also reducing health disparities, as each of these cities is a hotspot for both high-need populations and poorer health outcomes.

Mount Vernon

Mount Vernon is the 3rd most populous city in Westchester County (n=68,671). The city is 4.4 square miles and is the 2nd most densely populated city in New York State, trailing only New York City. According to the 2017 American Community Survey, Mount Vernon has 68,671 residents and has experienced 0.4% population growth from 2000 to 2017.The city has the highest proportion of non-Hispanic black residents in Westchester County at 64% (compared to 13.5% countywide). One-third of all residents are foreign born. Additionally, it is the seat of Westchester County's homeless services and senior services programs, housing a

disproportionate number of lower-income residents. Mount Vernon is located just north of the Bronx and bordered by Pelham, Bronxville, Eastchester, and Yonkers.

There are about 25,000 households in Mount Vernon, of which one-quarter (25.3%) are families with children. Of the family households with children, over half (53.7%) are singled-headed households. Mount Vernon has a slightly younger than Westchester County, with a median age of 38.5 years versus 40.6 years. The population is also slightly more female (54.5% versus 51.6% in Westchester County).

Mount Vernon is among the most ethnically diverse communities in Westchester County. Its population is 64.3% non-Hispanic black, 16.1% non-Hispanic white, 15.4% Hispanic, 2.0% non-Hispanic Asian and 1.9% non-Hispanic other. One-third (33%) of its residents are foreign-born. Among the foreign-born population, more people (55%) speak only English at home than Spanish (19%) and other languages (26%). The city's foreign-born population comes from diverse corners of the globe (in order of frequency): Jamaica (42% of foreign-born residents), Dominican Republic (8%), Brazil (6%), Haiti (4%), Guyana (4%), Mexico (3%), Italy (3%), Trinidad & Tobago (3%), the United Kingdom (2%), and Portugal (2%).

The city has the second highest percentages of residents living below poverty in Westchester County. About 15% (14.8%) of the population lives below the poverty level (9.4% countywide) and the median household income is $54,573 (compared to $89,968 countywide). Twenty-percent of Mount Vernon children live below poverty; nearly twice the countywide proportion (11.7%).

A larger proportion of the population is publicly insured (40% versus 30% in the county) and uninsured (9.8% versus 7.8% in the county). A larger proportion of Mount Vernon households (4.3%) are on cash public assistance than in the county overall (2.0%) and New York State (3.4%). Over three-quarters (79.7%) of students in Mount Vernon public schools were eligible for reduced or free lunch during the 2016-2017 school year. The Mount Vernon unemployment

rate of 8.7% is the highest unemployment rate in Westchester County. Over one-quarter (28.4%) of Mount Vernon residents ages 25 and older have received a bachelor's degree or higher; lower than countywide (47.7%) and statewide (35.3%) attainment rates.

New Rochelle

The City of New Rochelle is the anchor city for the Long Island Sound Region of Westchester County. While three times the size of Mount Vernon, the city has only a slightly larger population (79,877 vs. 68,671). Since 2000, the population of New Rochelle has grown by 10.7%, compared to Mount Vernon (0.4%), Westchester County (5.6%) and New York State overall (4.3%).

There are approximately 28,000 households in New Rochelle, of which, 29.5% are families with children. Of the family households with children, one -quarter (24.9%) are single-headed households. The city has a slightly younger population (median age 39.4) than Westchester County overall (40.6y), although higher than in New York State (38.4y).

New Rochelle is ethnically diverse. Its population is 45.0% non-Hispanic white, 29.4% Hispanic, 18.5% non-Hispanic black, 4.5% non-Hispanic Asian, and 2.5% other race/ethnicities. Almost one-third (29.6%) of its residents are foreign-born, compared to 25.4% countywide. Among the foreign-born population, more people speak Spanish (48%) at home than English (21%) and other languages (31%). The city's foreign-born population comes from diverse corners of the globe (in order of frequency): Mexico (22% of foreign-born residents), Jamaica (8%), Guatemala (7%), Peru (6%), Italy (5%), India (5%), Colombia (4%), Dominican Republic (4%), Haiti (3%) and Brazil (3%).

A marginally higher proportion of the population is publicly insured (32.7% versus 30% in the county) and uninsured (10.4% versus 7.8% in the county). About 2 percent (2.3%) of New Rochelle households are on cash public assistance; slightly higher than in Westchester County (2.0%). Over one-tenth (11.2%) of New Rochelle's population lives below the poverty line

(compared to 9.4% countywide) and the median income is $77,320 (compared to $89,968 countywide). A larger proportion of children live below the poverty line in New Rochelle (14.2%) than in the county overall (11.7%) and over half (52.2%) of students in public schools qualifies for free or reduced lunch during the 2016-2017 school year. unemployment rate is 7.3%, higher than the countywide (6.5%) and statewide (6.8%) rates. Finally, the proportion of the population ages 25 and older with at least a bachelor's degree (44.0%) in New Rochelle is similar to the county overall (47.7%) and higher than in New York State (35.3%).

Regional Health Disparities

While Westchester County remains among the healthiest counties in New York State, several of its individual municipalities continue to have significant health gaps. Portions of lower Westchester, specifically Mount Vernon, Yonkers, New Rochelle and White Plains are "hot spots" for various health outcomes, such as asthma and preterm births in the County. Additionally, certain groups, such as some racial/ethnic minorities or those with less education, experience poorer health outcomes.

Some Westchester populations have excess mortality rates. For example, the age-adjusted mortality rate per 100,000 for the non-Hispanic black (695.1 per 100,000) and non-Hispanic white (657.0 per 100,000) populations are significantly higher than for the Hispanic population (493.2 per 100,000).

While Westchester County has an age-adjusted preventable hospitalization rate below the rate for all of New York State and the Prevention Agenda 2018 Target, there are areas and sub-populations that have excess preventable hospitalization rates. For example, the rate is 142.1 in ZIP Code 10801 in New Rochelle and 235.0 per 10,000 ZIP Code 10550 in Mount Vernon. Rates are generally elevated in the southern portion of the county, including Yonkers, Mount Vernon, the southern section of New Rochelle, and in the northern portion of the county, namely Peekskill. Further, the rate of preventable hospitalizations for the non-Hispanic black

population (193.5 per 10,000) is 2.9 times higher than the rate for the non-Hispanic white population (67.4 per 10,000). The rate for the Hispanic population (56.0 per 100,000) is slightly lower than the non-Hispanic white population.

There are a multitude of reasons certain populations and geographic areas have poorer health outcomes; these reasons include, for example, differences in access to health care, quality of care, physical environments, and economic and educational opportunities, to name a few. For example, while a smaller proportion of individuals live in poverty in Westchester County than in New York State overall, those who are black (16.6%) and Hispanic (19.4%) are more likely to be living in poverty than those who are white (5.9%).

While the Prevention Agenda 2018 target for health insurance coverage among adults age 18-64 is 100%, 90% of adults are covered in Westchester County. In certain areas, such as Port Chester, a much smaller proportion of the population has health insurance (69.8%), and in other areas such as Scarsdale, almost all residents have health insurance (99.9%). Additional areas with lower health insurance coverage include White Plains, Yonkers, Mount Vernon and southern portions of New Rochelle. There are also disparities by race/ethnicity; 92.4% of the white and 88.5% of the black populations have health insurance, only 72.9% of the Hispanic population does.

Disparities are also present for other health outcomes. There is tremendous geographic variation in the rate of asthma ED visits in Westchester County. While Westchester County has a rate of 62.5 per 10,000, below the rate for New York State overall (86.2) and the Prevention Agenda 2017 Target (75.1), certain areas have much elevated rates. Specifically, the asthma ED visit rate ranges from 241.8 per 10,000 population in ZIP Code 10550 in Mount Vernon, to 5.9 per 10,000 in parts of Rye. Rates are generally elevated in Mount Vernon, southern portions of New Rochelle, Yonkers, White Plains, Ossining, and Peekskill. Education and socioeconomic status are also important determinants of health status and outcomes. In Westchester County,

adults with no college education are more likely to have diabetes than adults with at least some college education (13.9 vs. 7.0% respectively).

There are disparities in other health outcomes, such as maternal and child health. There is considerable geographic variation in the proportion of births that are preterm, with 14.7% of births being preterm in Mount Vernon compared to 8.4% in North Castle, the municipality with the lowest rate. Non-Hispanic black women are more likely to have preterm births (15.7%), as compared to the non-Hispanic white (11.5%) and Hispanic women (12.0%).

There are also disparities in the proportion of infants exclusively breastfed in the hospital. Less than half of infants are exclusively breastfed in the hospital in Westchester County, which is below the proportion in New York State overall and the Prevention Agenda Target of 48.1%. There are also within-county geographic disparities. Specifically, proportions range from 20.5% and 28.4% in Rye and Yonkers, respectively, to 83.2% in Peekskill. Overall, the proportion of infants breastfed exclusively in the hospital is lower in the southern portion of the county: just over one-third are exclusively breastfed in Mount Vernon (36%) and New Rochelle (35.8%). Additionally, non-Hispanic white women are most likely to breastfeed exclusively in the hospital (58.6%), followed by Hispanic women (42%) and non-Hispanic black women (35.4%). There are further disparities by insurance status: 40.7% of infants whose primary payer is Medicaid were exclusively breastfed in the hospital, compared to 46.2% of infants whose primary payer is not Medicaid.

Additional secondary health data is presented in Section 7.

Medically Underserved/HPSA Designation Status

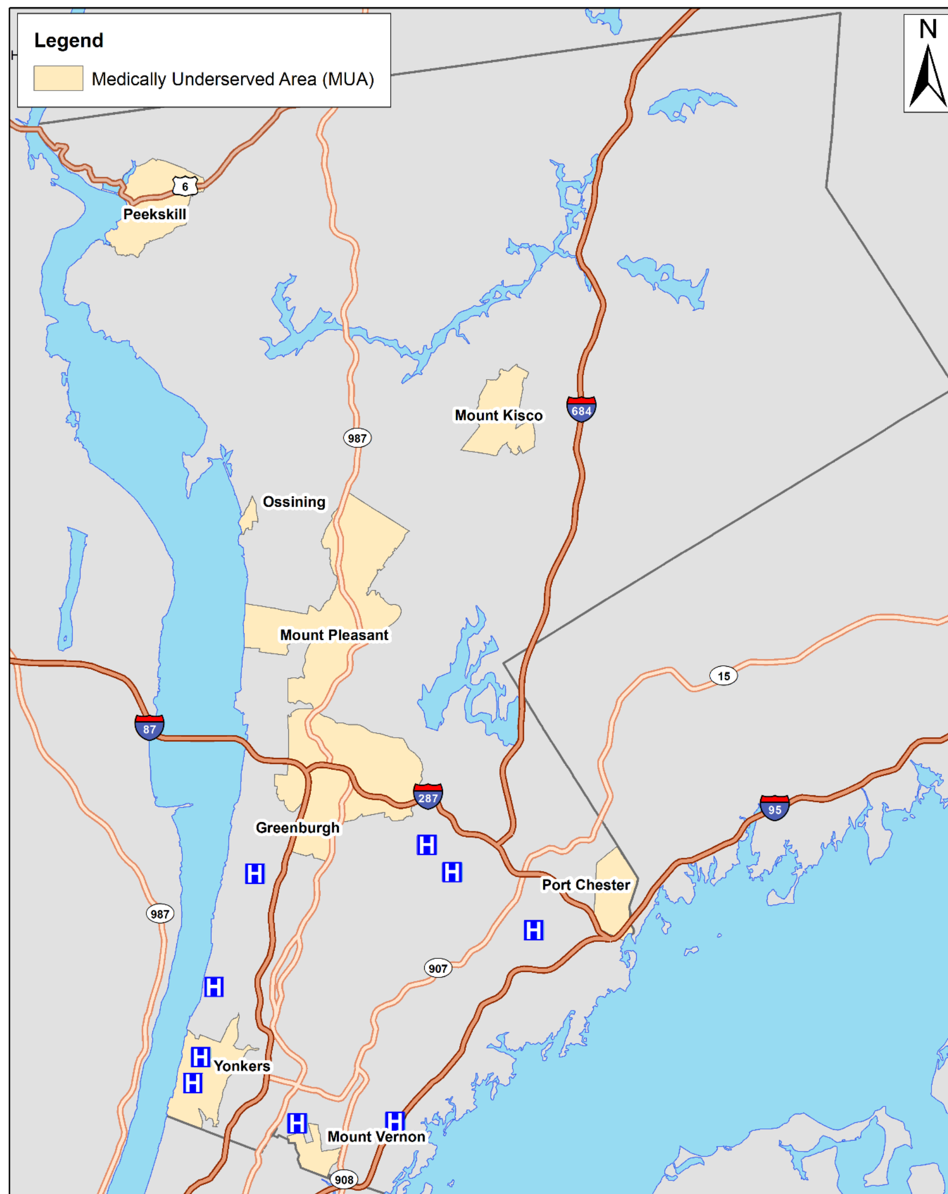
The City of Mount Vernon has been deemed to have a geography that meets the criteria as a medically underserved area, with respect to its access to primary care services. This categorization is based on an index value that includes the infant mortality rate, the poverty rate, the percentage of elderly population and the primary care physician to population ratio.

Physician shortage:

While the city of Mount Vernon was previously identified as a Primary Care Health Professional Shortage Area, the designation was withdrawn in 2019.

Despite some challenges, the City of New Rochelle is not considered an underserved community by MUA/HPSA standards.

Figure 1: Medically Underserved Areas in Westchester County, NY



Secondary Data Collection Plan

Westchester County 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 for mapping the percentage of adults with health insurance. For more information on ACS please visit http://www.census.gov/programs-surveys/acs/about.html.

US Census Bureau Small Area Health Insurance Estimates: The U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) program provides modeled, single-year estimates of insurance coverage at the county-level and by various demographic, economic and geographic characteristics. Data from this program was used to estimate insurance coverage for adults. For more information please visit https://www.census.gov/programs-surveys/sahie/about.html

New York State Cancer Registry: The New York State Cancer Registry was used to summarize data on new cases of breast 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/.

NYS Expanded Behavioral Risk Factor Surveillance System (NYS Expanded BRFSS): The NYS Expanded Behavioral Risk Factor Surveillance System (NYS Expanded BRFSS) supplements the CDC BRFSS. Specifically, it provides county-level estimates of various health behaviors and outcomes. Data from the NYS Expanded BRFSS was used to estimate multiple indicators in this report, related to access to a primary care provider, poor mental health, cigarette smoking, obesity, colorectal cancer screening, flu immunization and binge drinking. https://www.health.ny.gov/statistics/brfss/expanded/

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, hospitalizations for short-term complications of diabetes, and the opioid burden rate. For more information about SPARCS please visit: http://www.health.ny.gov/statistics/sparcs/.

Student Weight Status Category Reporting System (SWSCRS) data: The Student Weight Status Category Reporting System provides weight status data for children and adolescents at public schools in New York State, excluding NYC at the school district, county, and region-levels and by grade groups. This data was used to estimate child/adolescent obesity. For more information please visit
https://www.health.ny.gov/prevention/obesity/statistics_and_impact/student_weight_status_data.htm

New York State Immunization Information System: The New York State Immunization Information System (NYSIIS) provides data on immunizations for all residents <19y at the county-level in the state, excluding NYC. Healthcare providers are required by law to report all immunizations for this population to NYSIIS. This data was used to estimate the immunization status of children between 19-35 months. For more information please visit
https://www.health.ny.gov/prevention/immunization/information_system/

NYS HIV Surveillance System: The NYS HIV Surveillance System, run by the AIDS Institute Bureau of HIV/AIDS Epidemiology in the New York State Department of Health, provides data on new HIV/AIDS diagnoses and other factors relating to HIV/AIDS, such as linkage to care. This report uses data on HIV incidence from this source. For more information please visit:
https://www.health.ny.gov/diseases/aids/general/about/surveillance.htm.

New York State Sexually Transmitted Disease Surveillance Data: NYS Sexually Transmitted Disease Surveillance Data are provided by the Bureau of STD Prevention and Epidemiology within the NYS Department of Health (DOH). Cases are reported by the 57 local health departments in NYC to the NYS DOH. This report uses this data to estimate rate of chlamydia in each county. For more information, please visit:
https://www.health.ny.gov/diseases/aids/general/about/surveillance.htm

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 preterm births, proportion of infants exclusively breastfed in the hospital, the adolescent pregnancy rate, the suicide rate, 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/

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 opioid-related mortality rate. For more information on NVSSS please visit
https://www.cdc.gov/nchs/nvss/index.htm

Data Tools

City Health Dashboard: The City Health Dashboard is produced by the Department of Population Health at NYU Langone and the Robert F. Wagner School of Public Service at NYU, in partnership with the National Resource Network. It is funded through the Robert Wood Johnson Foundation. The dashboard aggregates data from multiple sources for the 500 largest cities in the United States, including Yonkers, Mount Vernon and New Rochelle. For more information please see: https://www.cityhealthdashboard.com/

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 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/

Primary Data Collection Plan

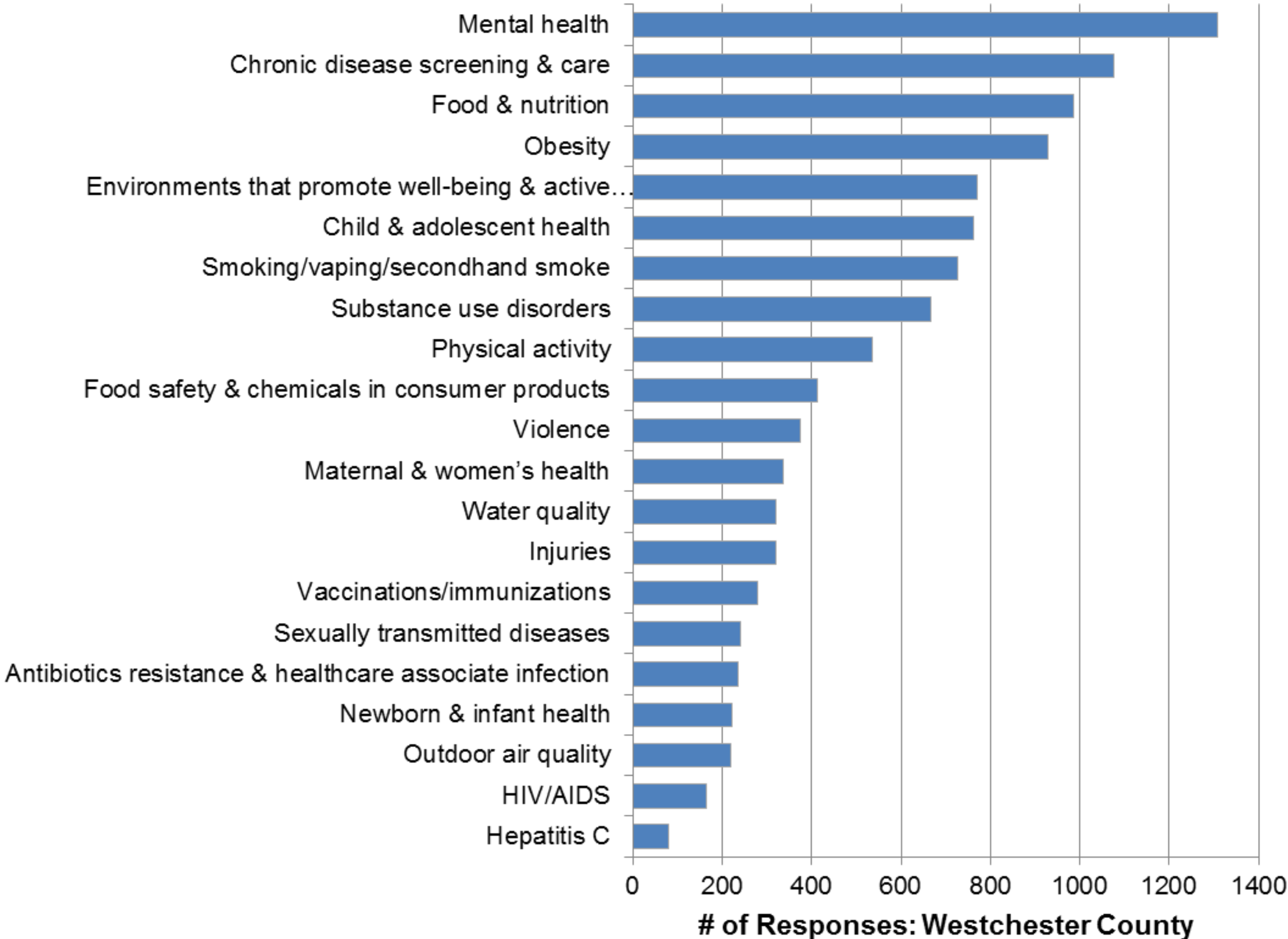
Primary data collection for the Westchester County Community Health Needs Assessment was done collaboratively between partner institutions and the Westchester County Department of Health. Community input on health priorities in Westchester County was gathered through a community survey and an in-person summit with stakeholders. The methods are summarized in below. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

Community Survey

For the community survey, a total of 3524 surveys were completed among individuals working-in or residing-in Westchester County. Seventy-three percent of respondents were women, 26% were men and 1.0% as a different identity including non-binary, trans female/trans woman, trans male/trans man. The survey was completed by a wide-range of ages: 7.9% were 18-24y, 18.1% were 25-34y, 17.5% were 35-44y, 17.4% were 45-54y, 18.3% were 55-64y and 20.9% were ≥65y. Thirty-three percent of respondents identified as Hispanic and 43.4% identified as non-Hispanic white and 15.1% as non-Hispanic black. Respondents resided throughout the county, with 13% living in a White Plains ZIP Code (10601, 10603, 10604, 10605, 10606, 10607, 10608).

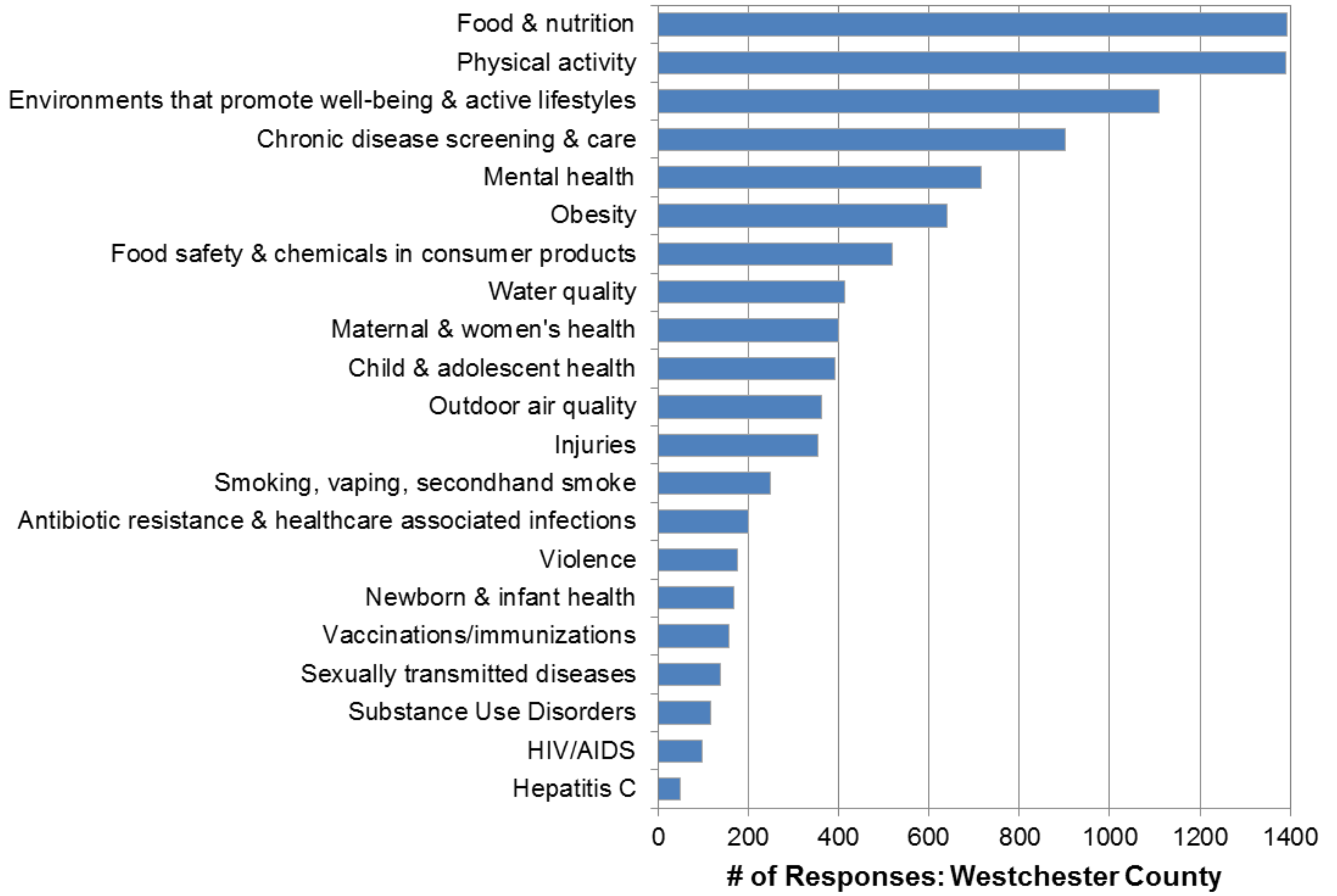
Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health. Participants were also asked to rank their own personal health priorities. The leading community health priorities identified included mental health, chronic disease screening and care, food and nutrition, obesity and environments that promote well-being and active living). The leading personal health priorities were food and nutrition, physical activity, environments that promote well-being and active living, chronic disease screening and care and mental health. The leading strategies identified included: affordable housing, mental health services, access to healthier food, exercise and weight loss programs, employment opportunities and drug and alcohol treatment services.

Community health priorities as identified by the Westchester County Community Survey, 2019



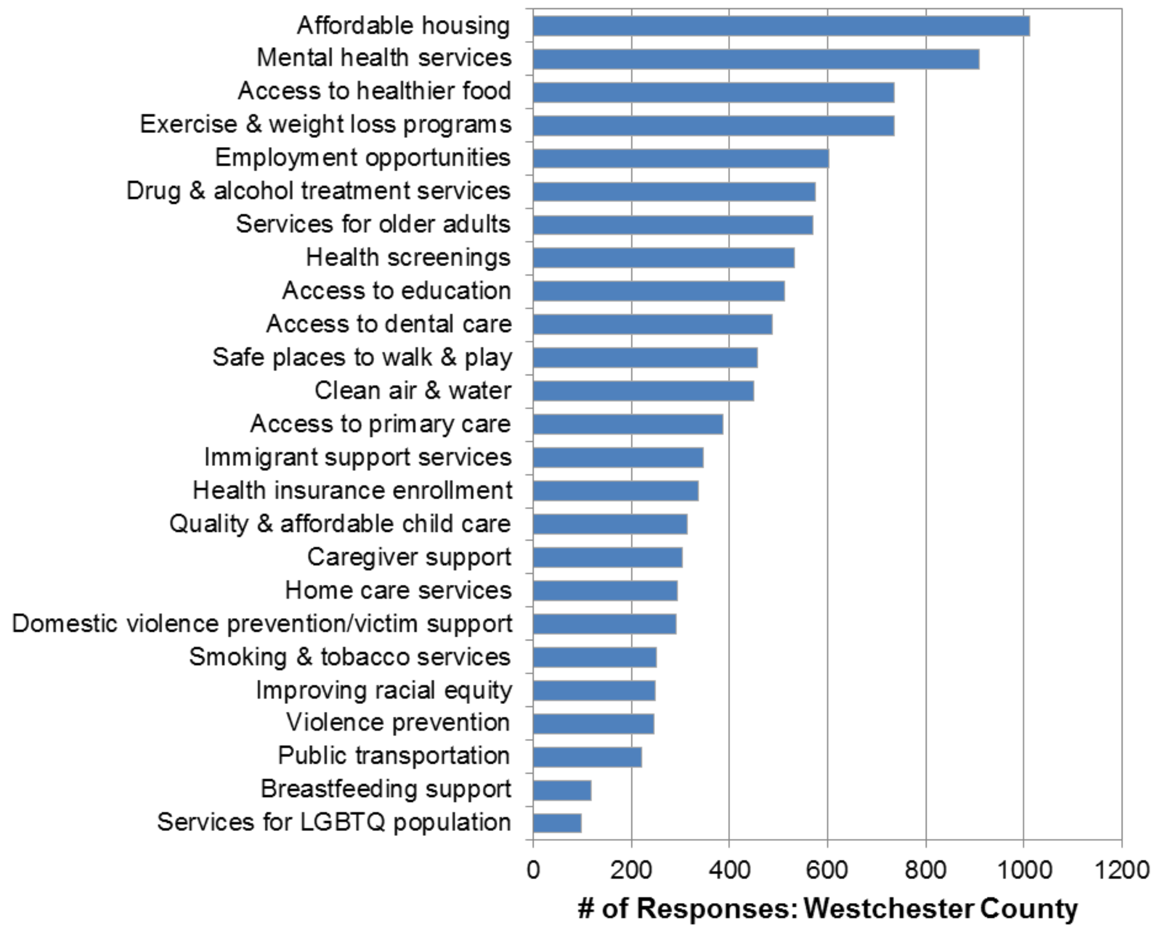
Data source: Westchester County Community Survey, 2019

Personal health priorities as identified by the Westchester County Community Survey, 2019



Data source: Westchester County Community Survey, 2019

Strategies to improve health among Westchester County residents from the Westchester County Community Survey, 2019



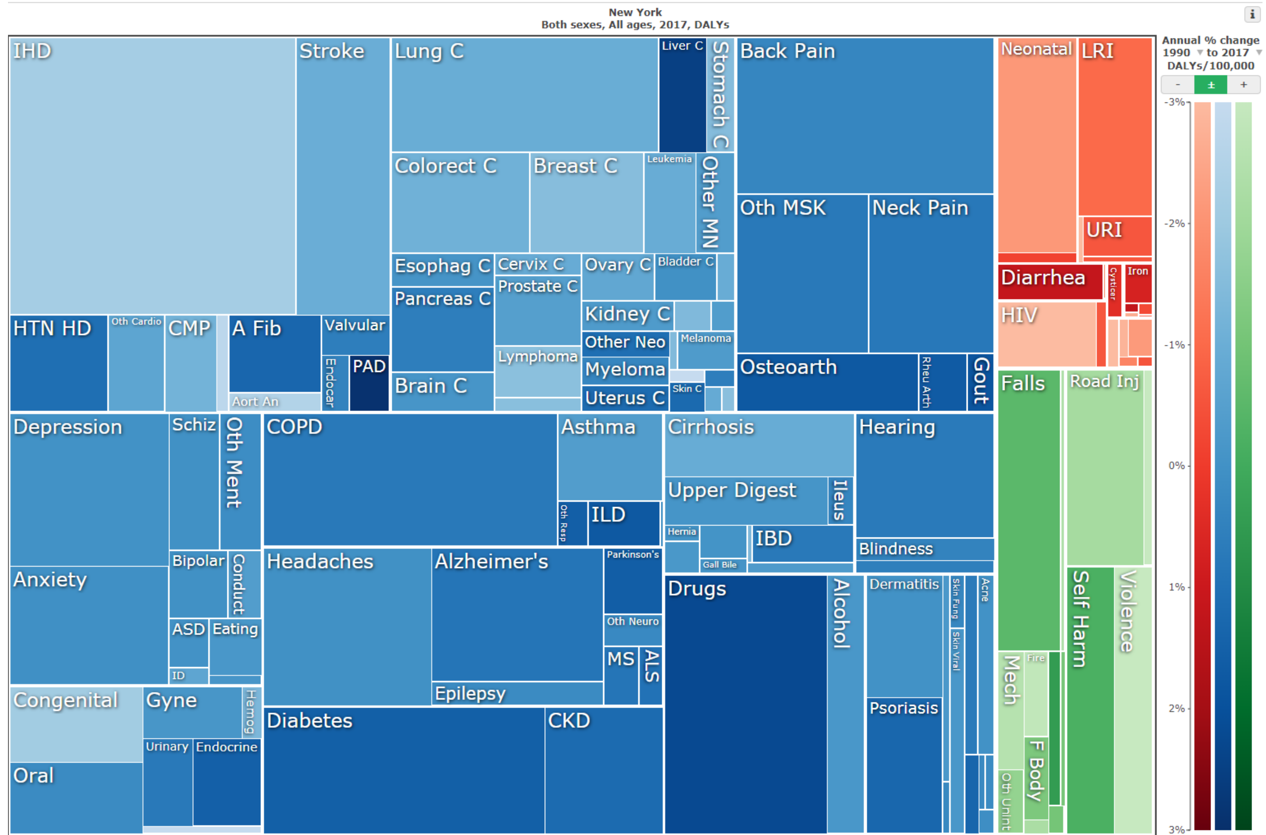
Data source: Westchester County Community Survey, 2019

Presentation of Data

This section describes the secondary data collected as part of the Montefiore Mount Vernon/ Montefiore New Rochelle Community Service Plan described in detail above.

First, data from the Global Burden of Disease project was assessed to understand the primary causes and risk factors associated with ill health in New York State. Briefly, the Global Burden of Disease project employs a unified framework to identify the leading causes of death and disability for various geographic units (e.g., the world, specific countries and sub-national units, such as states). Their approach, which combines numerous datasets accounts for data quality issues, allows us to identify the leading causes and risk factors contributing to ill health in New York State. Figure 2 shows the leading causes of ill health in New York State in 2017.

Leading causes of disability adjusted life years in New York State, 2017

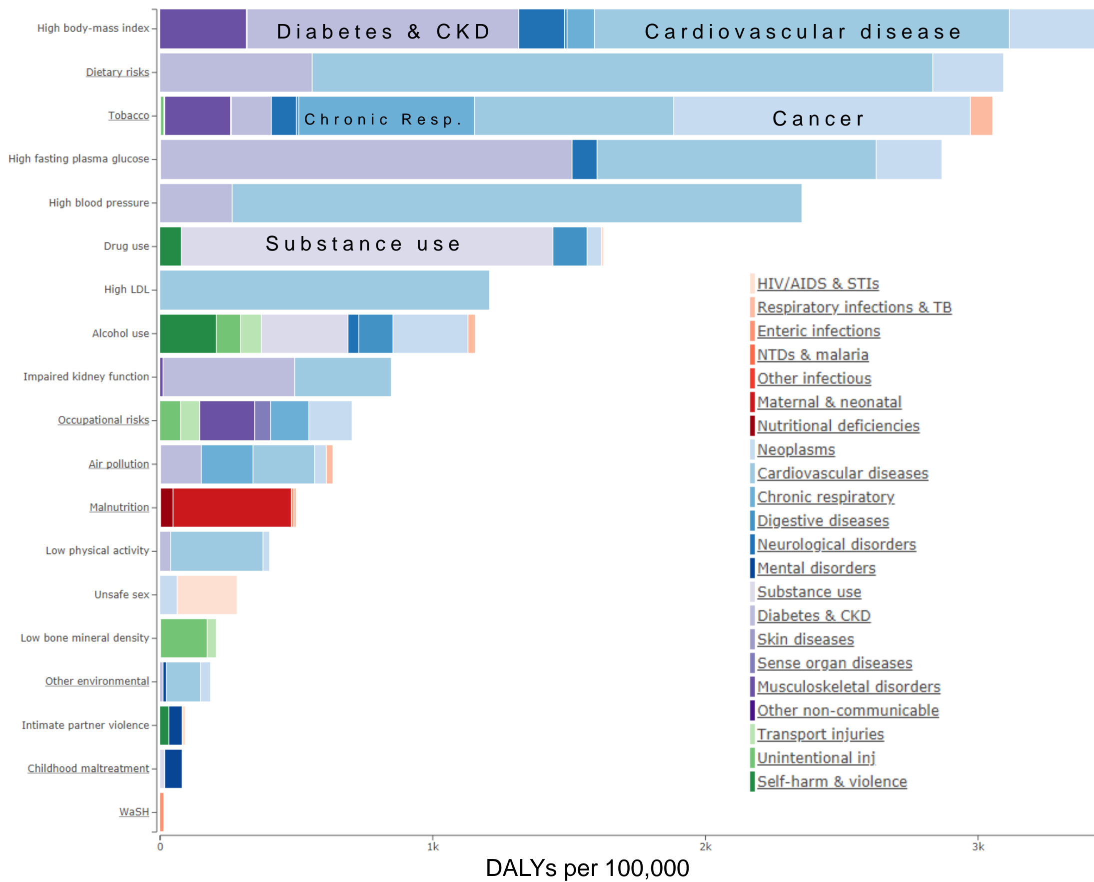


Data source: 2017 Global Burden of Disease Project.

The leading causes of ill health in New York State as measured by disability adjusted life years are ischemic heart disease (8.8%), drug use disorders (4.7%), low back pain (4.5%), chronic obstructive pulmonary disease (4.4%) and diabetes mellitus.

The saturation of the graph shows the proportionate change in DALYs from 1990 to 2017. Among leading causes of disability, the largest increases were observed for liver cancer (+2.5%), drug use disorders (+2.2%) and osteoarthritis (+1.8%). Major declines were observed for HIV/AIDS (-7.4%) and tuberculosis (-5.9%).

Distribution of disability adjusted life years by risk factor in New York State, 2017.



Data source: 2017 Global Burden of Disease Project.

In New York State, the finest level of geographic data from the Global Burden of Disease project, elevated body mass index (BMI) is responsible for the highest proportion of disability adjusted life years (a summary measure combining fatal and non-fatal health status). Elevated BMI is responsible for excess ill health via its association with cardiovascular disease, diabetes, and some cancers.

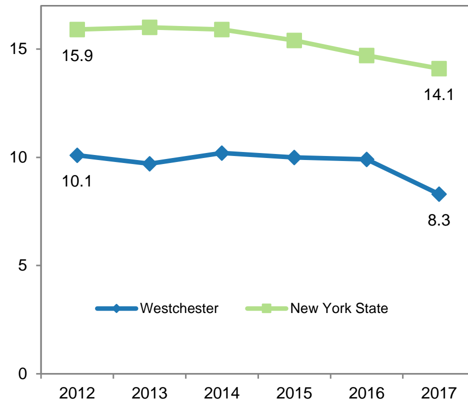
Dietary risks are the second leading contributor to ill health, due to associations with cardiovascular disease, diabetes and some cancers. Within dietary risks (data not shown), low whole grains, high sodium, low nuts and seeds and low fruit are the leading causes of ill health.

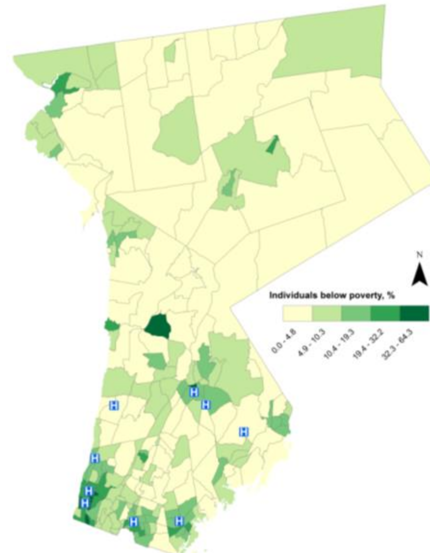
Tobacco is the third leading causes of ill health, with strong associations with many cancers, cardiovascular disease and chronic respiratory disease. High fasting plasma glucose and high blood pressure are also leading causes of ill health. In New York State, in 2017, drug use is the sixth leading cause of disability.

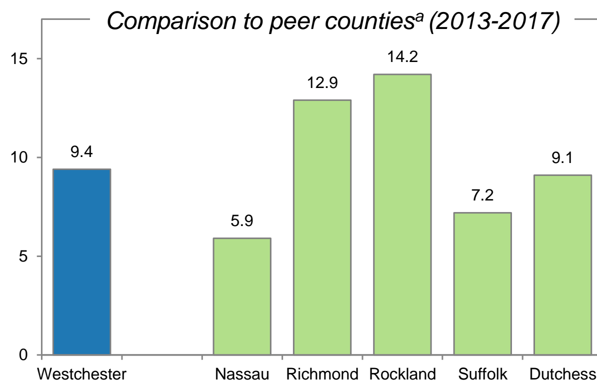
The next few dozen figures include the secondary data collected as part of this process using the data sources described above. Depending on the data available data elements may include the following: trends comparing Westchester County to New York State overall, a comparison of values to other New York State counties and data on disparities by race/ethnicity or socioeconomic status. Lastly, for some measures maps are included identifying sub-borough areas with an elevated burden of a given risk factor. Not all data elements are available for all measures based on data availability.

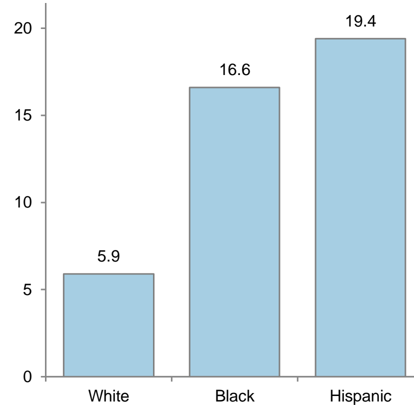
A smaller proportion of individuals live in poverty in Westchester County compared with New York State overall (8.3 vs. 14.1%, respectively). Those who are black and Hispanic are more likely to be living in poverty in Westchester County than those who are white.

Individuals Below Poverty, %







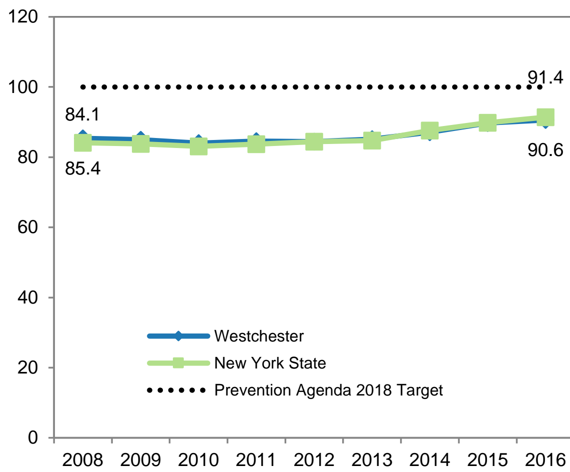


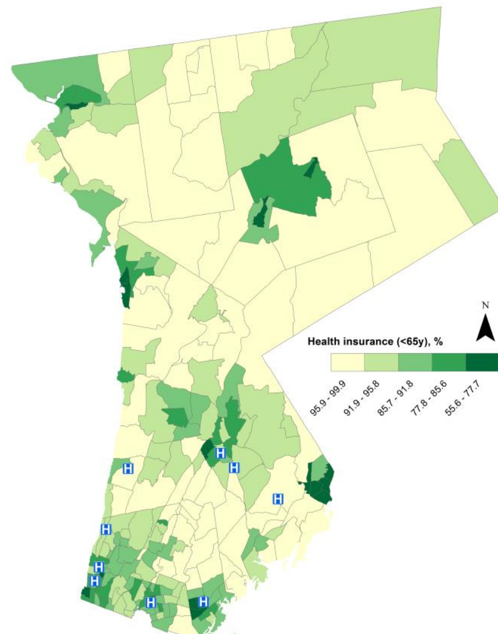
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity. [b] The white and black population includes Hispanic individuals as data is not available by race/ethnicity separately.

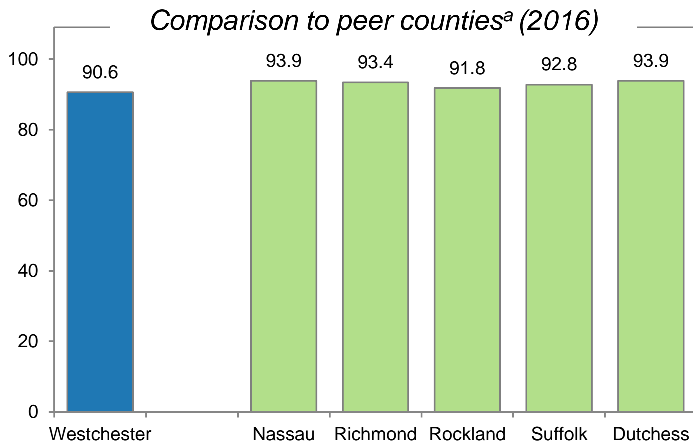
Data source: American Community Survey
Map is at the census tract level and reflect data from 2013-2017.

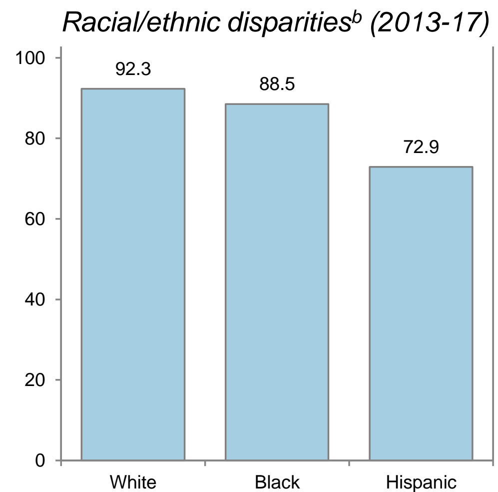
Despite an increase over the past decade, the percent of adults with health insurance in both Westchester County (90.6%) and New York State (91.4%) are below the Prevention Agenda Target of complete coverage (100%).While most white (92.9%) and black (88.5%) adults have health insurance, less than three-quarters (72.9%) of Hispanic adults do.

Individuals with health insurance (<65y), %





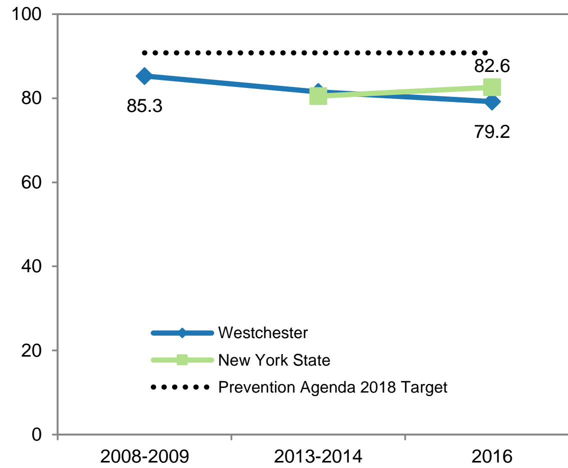


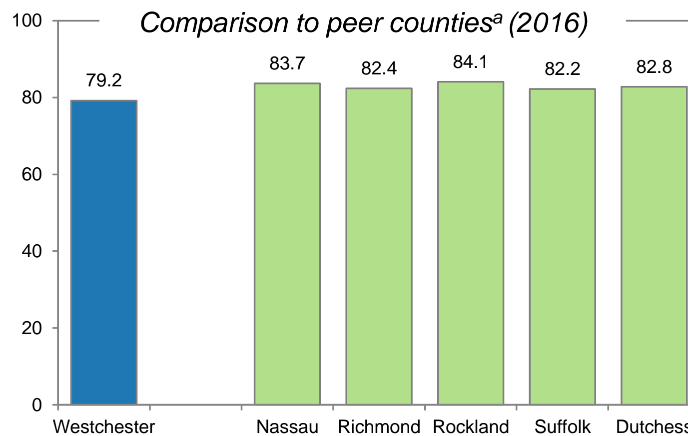


[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity. [b] The white and black population includes Hispanic individuals as data is not available by race/ethnicity separately.

Data source: New York State Prevention Agenda Dashboard
Data for map and by race/ethnicity from 2013-2017 American Community survey.
Map is at the census tract level.

Adults (ages 18-64) with health insurance, %





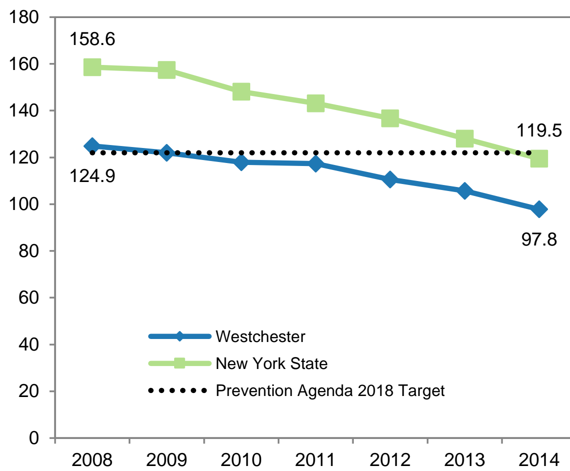
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

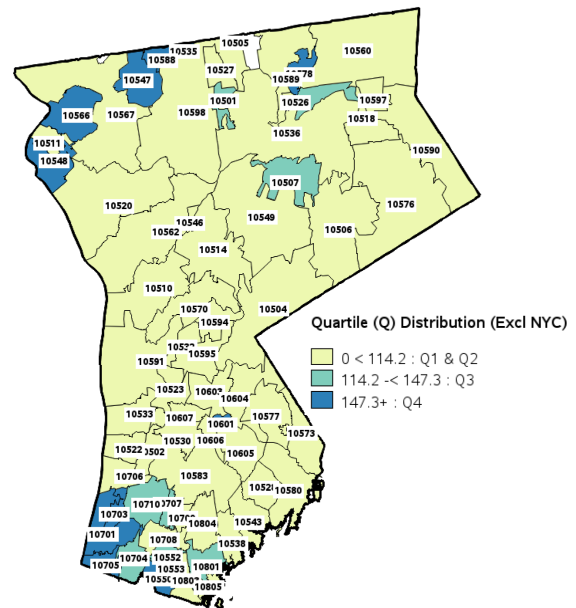
Data source: New York State Prevention Agenda Dashboard

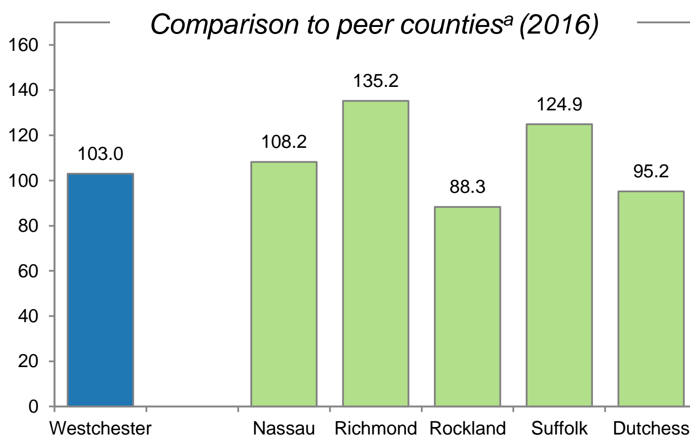
- In Westchester County, the percentage of adults with a regular healthcare provider declined from 85.3% in 2008/2009 to 79.2% in 2016.
- In comparison to its peer counties, Westchester has the lowest percentage of adults with a regular health care provider (79.2%).

The age-adjusted preventable hospitalization rate for adults has declined in both Westchester County and New York State and remains lower in Westchester County. The age-adjusted preventable hospitalization rate is much higher for non-Hispanic black adults (193.5 per 10,000) than non-Hispanic white and Hispanic adults (67.4 per 10,000 and 56.0 per 10,000, respectively).

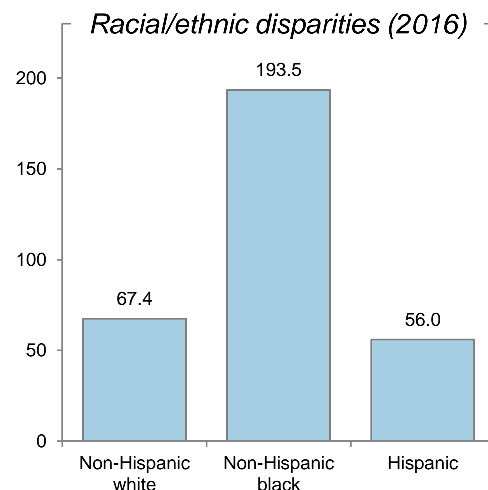
Age-adjusted preventable hospitalization rate per 10,000 (adults age≥18y)







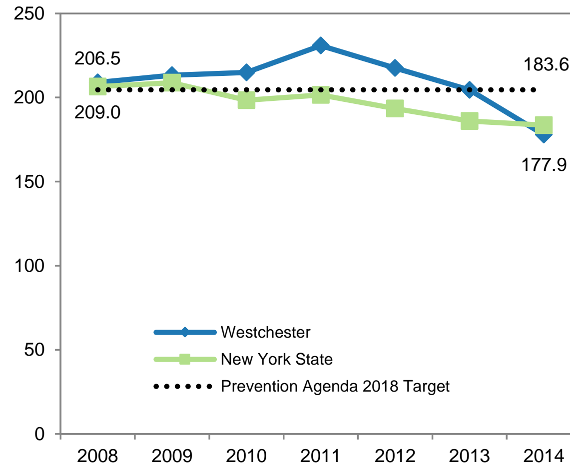
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

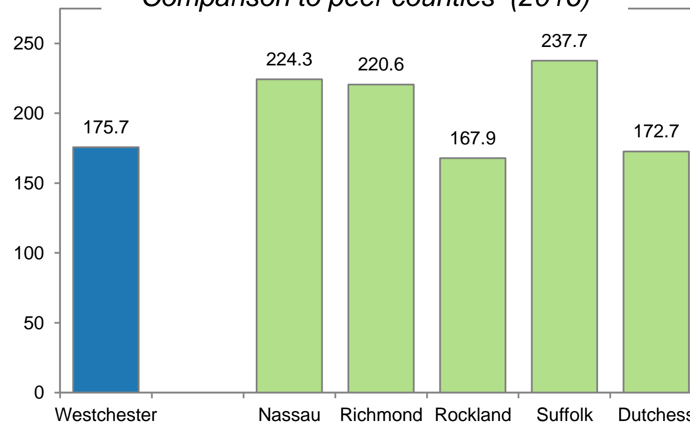


Data source: New York State Prevention Agenda Dashboard
Map is at the ZIP Code level and data are from 2010-2014.
Trend data not available past 2014 due to switch to ICD-10 in 2015.

In Westchester County and New York State overall, the fall hospitalization rate for those ≥65y is declining and is below the Prevention Agenda Target. In comparison to peer counties, Westchester County has a similar rate of fall hospitalizations for those ≥65y to Rockland and Dutchess counties.

Rate of hospitalizations due to falls per 10,000 (adults≥65y)



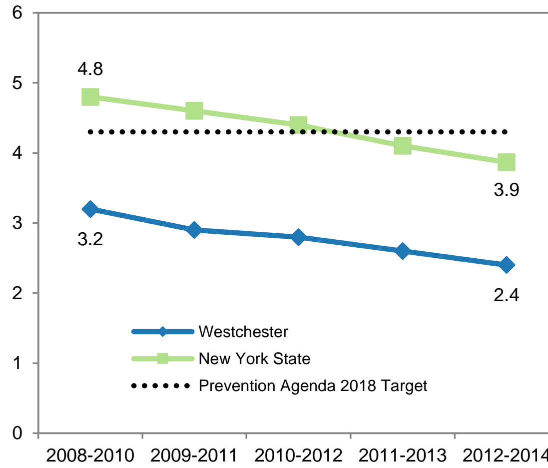


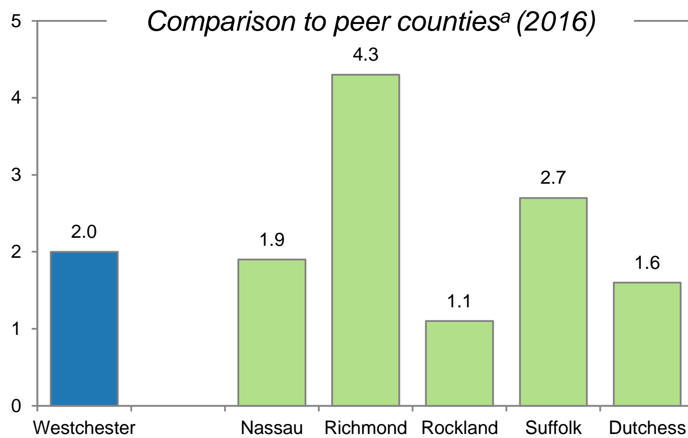
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Trend data not available past 2014 due to switch to ICD-10 in 2015.

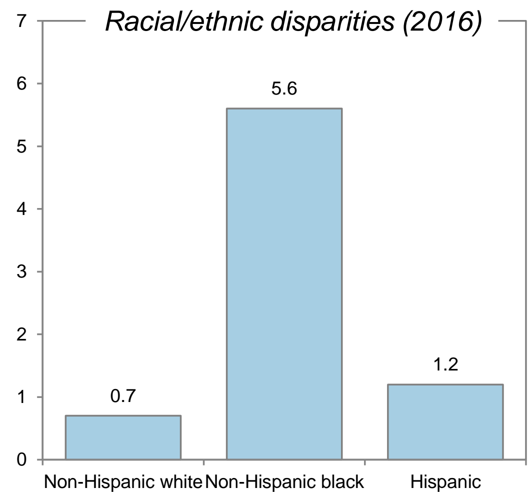
The assaulted-related hospitalization rate is over 1.5 times lower in Westchester County (2.4 per 10,000) than in New York State overall (3.9 per 10,000). The assault-related hospitalization rate is significantly higher for non-Hispanic black residents (5.6 per 10,000) than non-Hispanic white (0.7 per 10,000) and Hispanic (1.2 per 10,000) residents.

Assault-related hospitalizations per 10,000





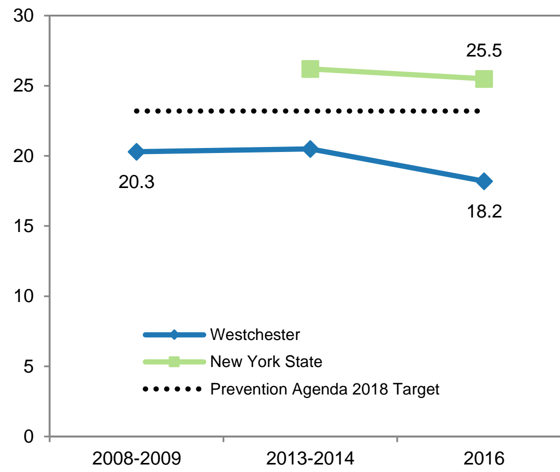
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

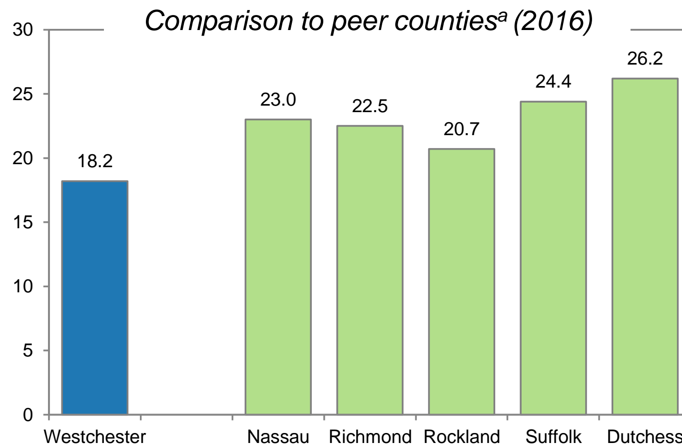


Data source: New York State Prevention Agenda Dashboard

Nearly one-fifth (18.2%) of adults in Westchester County are obese, which is below the Prevention Agenda 2018 Target and in New York State overall. Westchester County has the smallest proportion of obese adults compared to its peer counties.

Adult obesity (BMI≥30), %

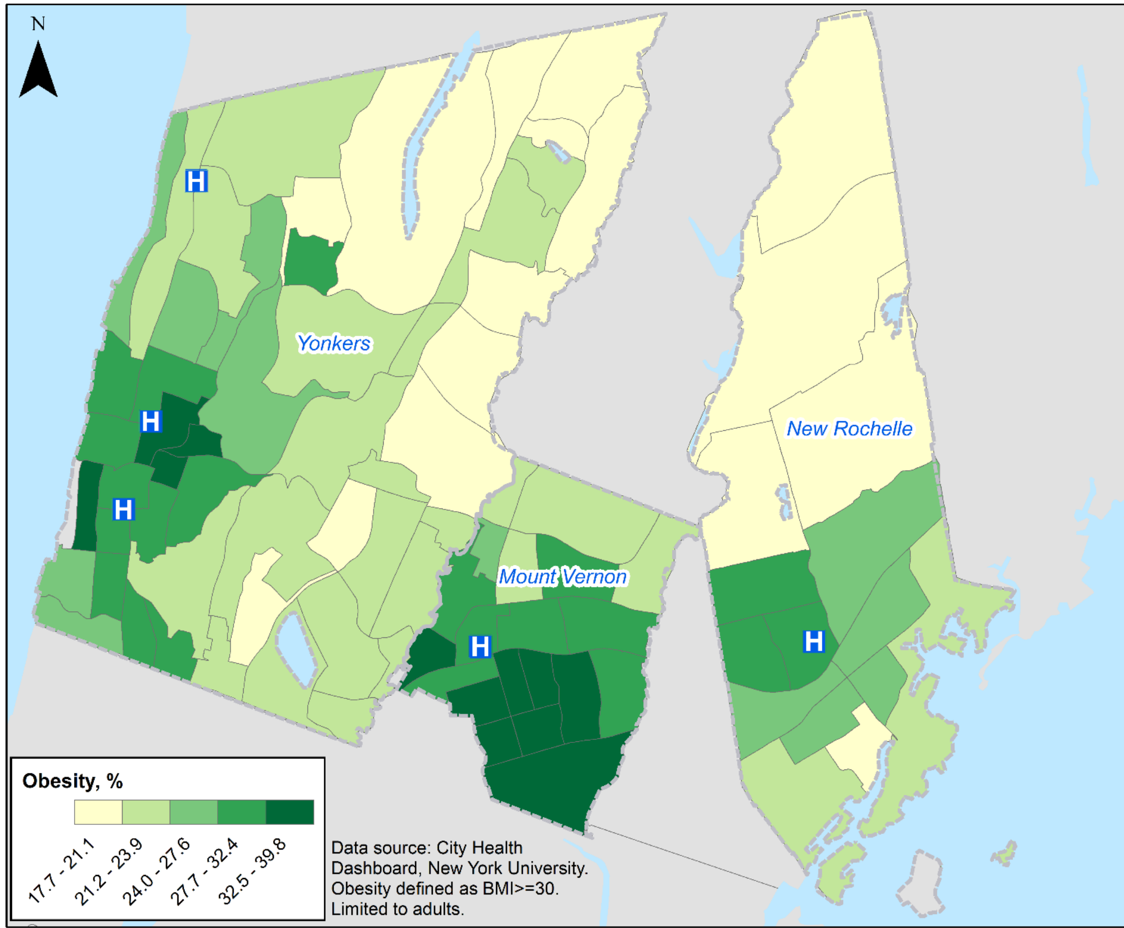




[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

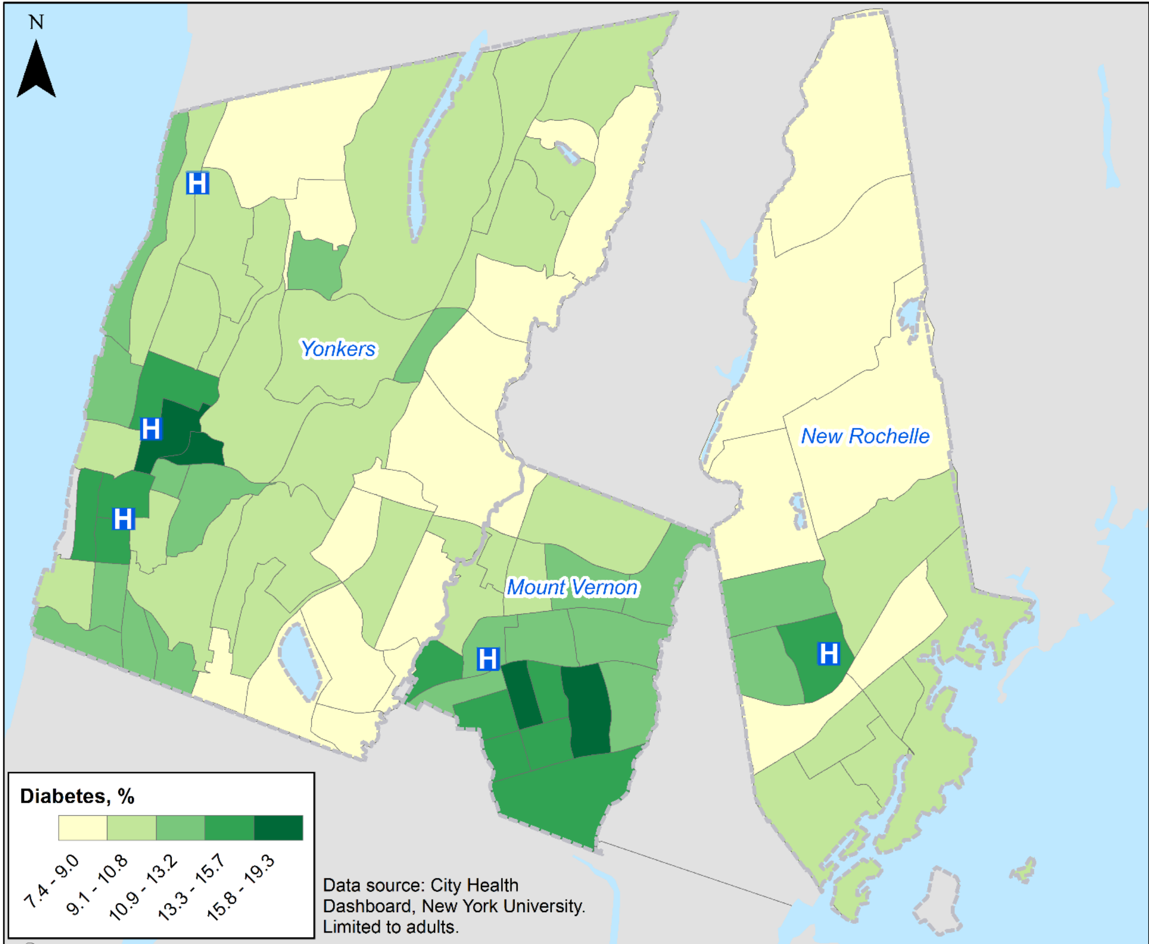
Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.

Adult obesity (BMI≥30), %



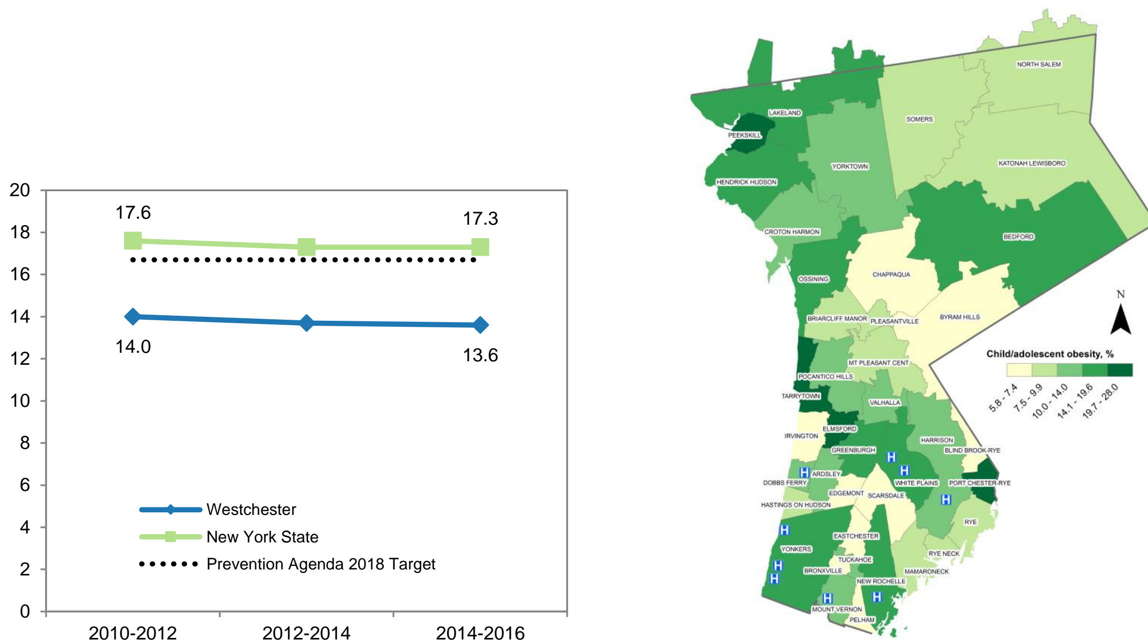
The proportion of adults with diabetes varies from 7.4% to 19.3% in the region. Overall, Mount Vernon has a higher proportion of adults with diabetes (12.9%) than New Rochelle (9.8%) and Yonkers (10.8%).

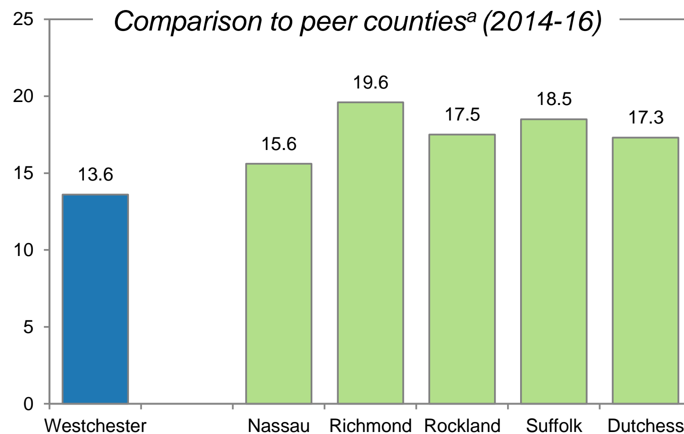
Adults with diabetes, %



A smaller proportion (13.6%) of children/adolescents are obese in Westchester county than in New York State overall (17.3%) and peer counties. Peekskill, Tarrytown, Elmsford and Port Chester-Rye school districts have the highest prevalence of child/adolescent obesity in Westchester County.

Percentage of children/adolescents who are obese



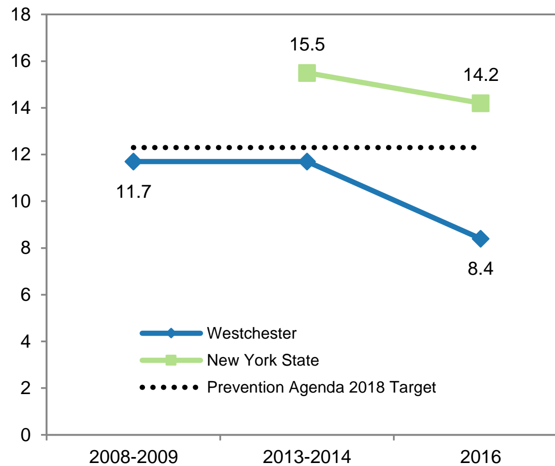


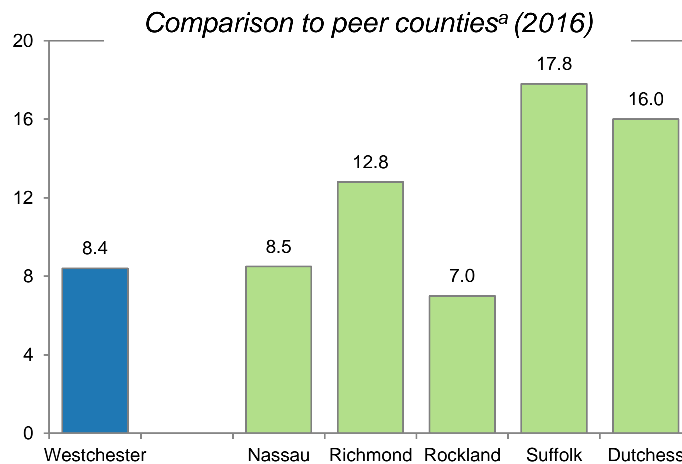
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Map is at the school district level and reflect data from 2014-2016.

Between 2013/2014 and 2016, the proportion of adults that smoke cigarettes in Westchester County declined from 11.7% to 8.4%, remaining lower than in New York State overall. The prevalence of adult cigarette smoking is second lowest in Westchester County, just after Rockland County, compared to peer counties.

Adult cigarette smoking, %

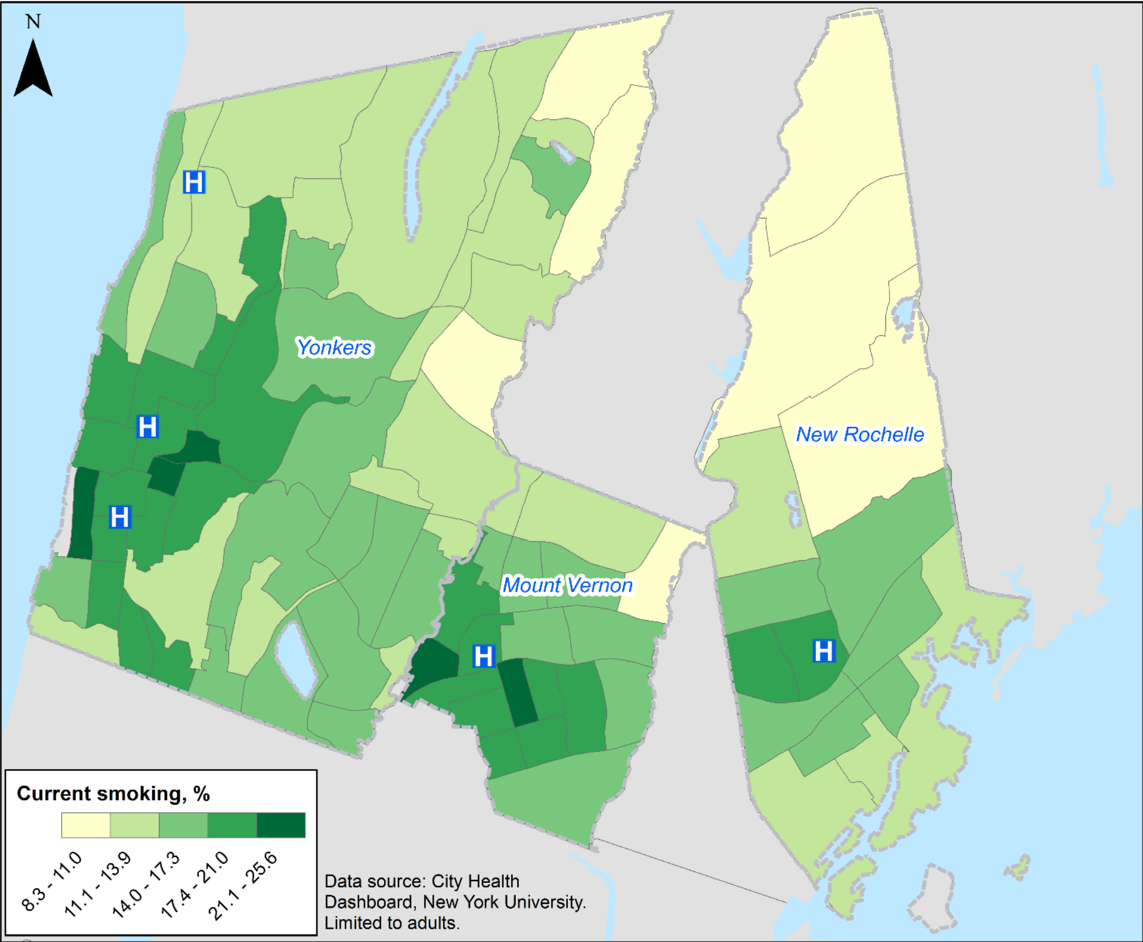




[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

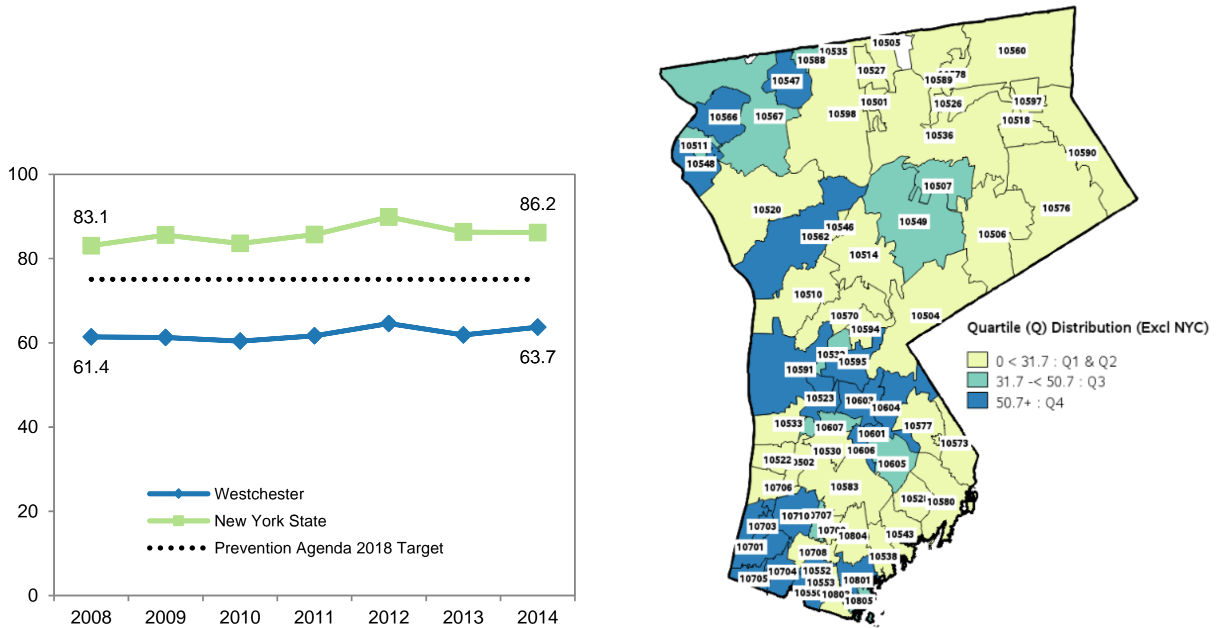
Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.

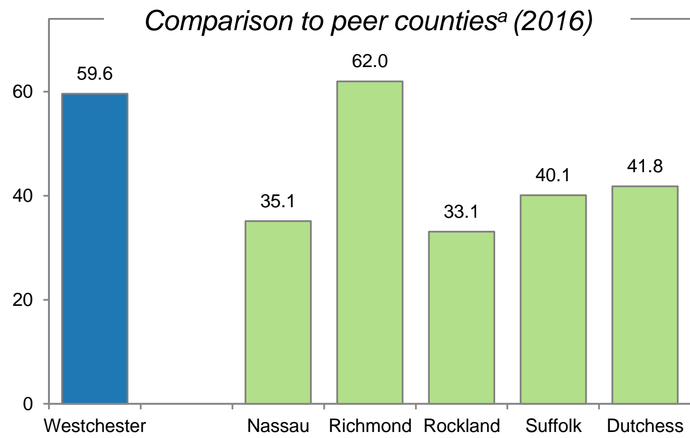
Adult cigarette smoking, %



As of 2014, the asthma ED visit rate was lower in Westchester County than in New York State overall (63.7 vs. 86.2 per 10,000) and was below the Prevention Agenda Target. However, Westchester County had the second highest Asthma ED visit rate when compared to its peer counties in 2016

Asthma ED visit rate per 10,000



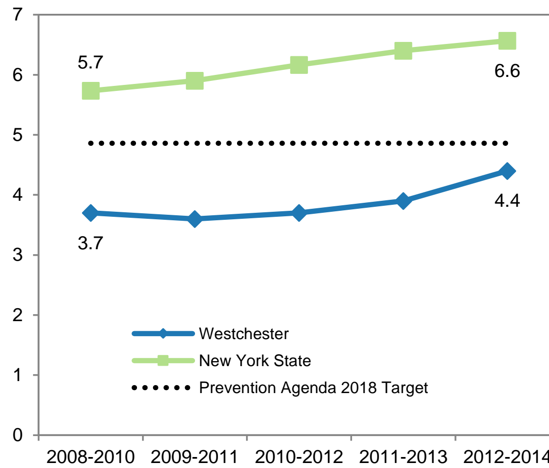


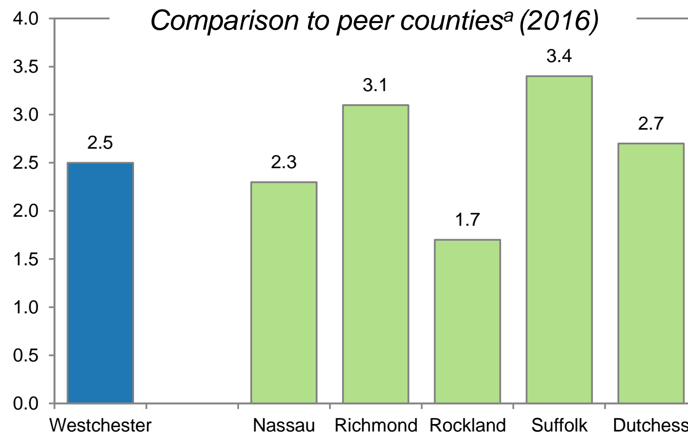
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Map is at the ZIP Code level and data are from 2010-2014.

Between 2008/2010 and 2012/2014, the adult hospitalization rate for short-term complications of diabetes increased slightly from 3.7 to 4.4 per 10,000 in Westchester County, although it remained lower than in New York State overall and the Prevention Agenda 2018 Target. In 2016, Westchester County had a similar adult hospitalization rate for short-term complications of diabetes when compared to 5 peer counties.

Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years



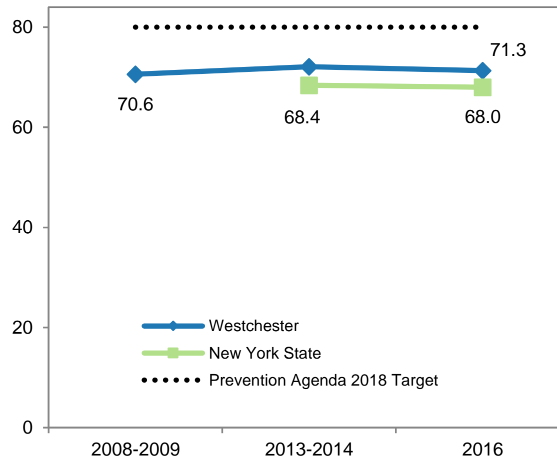


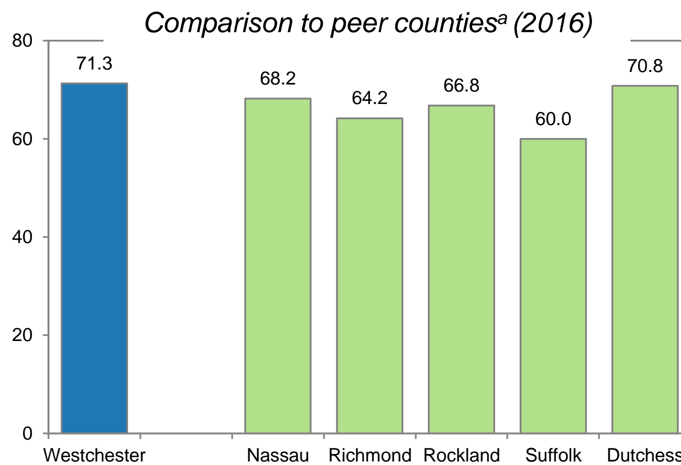
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard.
Trend data not available past 2014 due to change in ICD coding.

A larger proportion of adults (ages 50-75y) received a colorectal cancer screening in Westchester County than New York State overall in 2016 (71.3% vs. 68.0%), although both remain below the Prevention Agenda 2018 Target. Westchester County has the largest proportion of adults (ages 50-75y) receiving a colorectal cancer screening compared to its peer counties.

Adults receiving colorectal cancer screening (age 50-75y), %



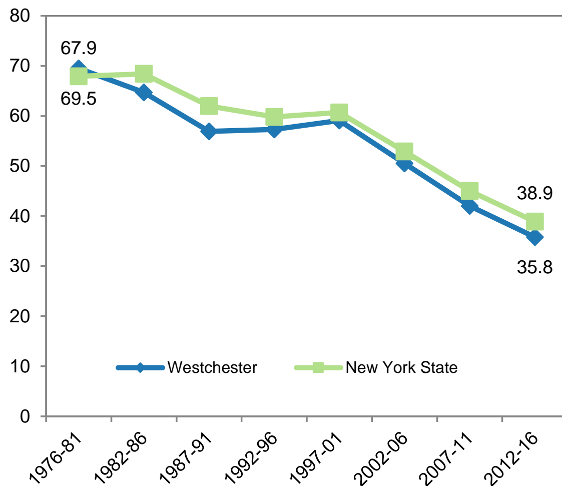


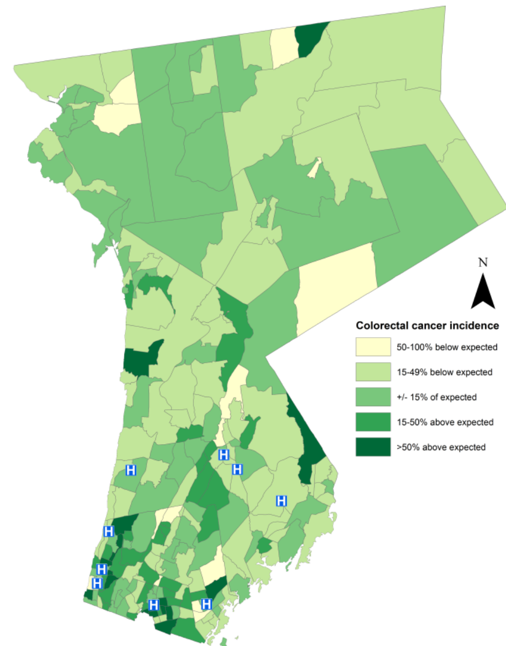
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

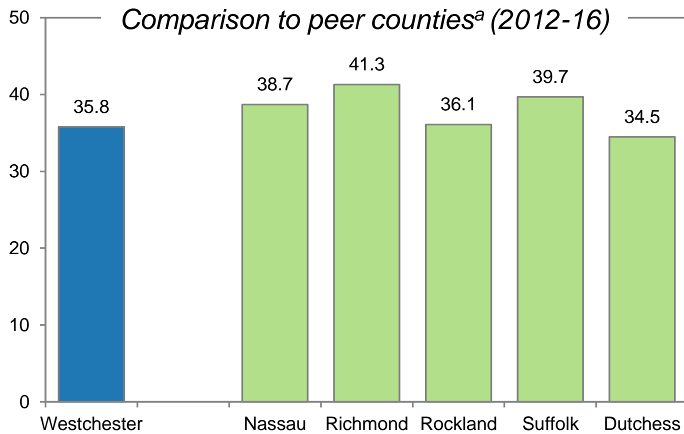
Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.

In Westchester County, the incidence of age-adjusted colorectal cancer has declined over the past few decades and remains slightly below the incidence rate for New York State overall. In Westchester County, the colorectal cancer incidence rate for Hispanic residents (30.3 per 100,000) is lower than that for non-Hispanic black residents (38.5 per 100,000) and non-Hispanic white (37.3 per 100,000) residents.

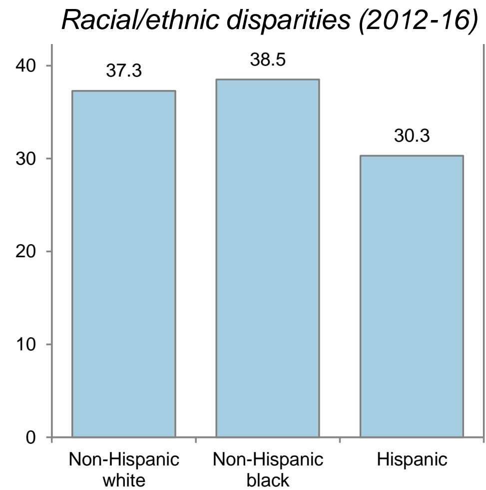
Age-adjusted colorectal cancer incidence per 100,000







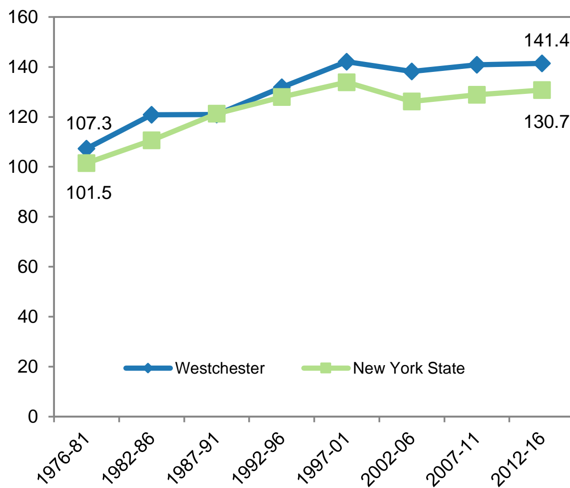
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

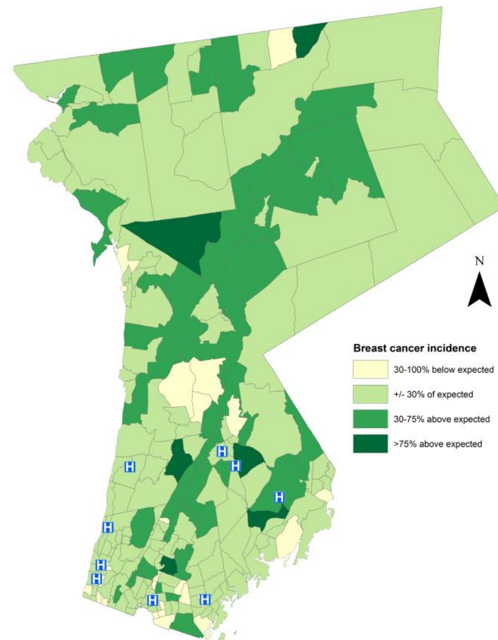


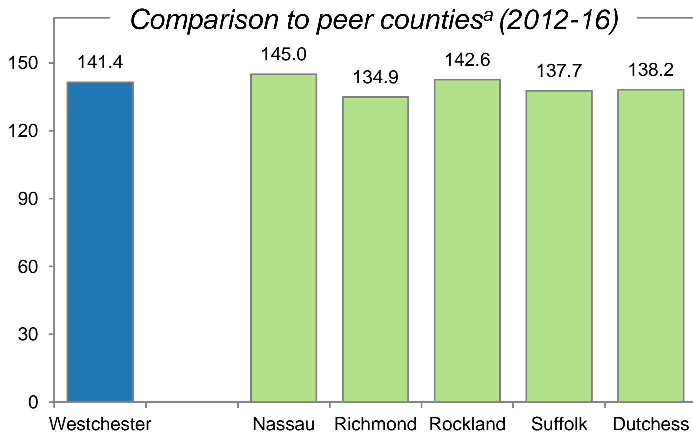
Data source: New York State Cancer Registry
Map is at the census tract level and reflects data from 2010-2014.

The age-adjusted female breast cancer incidence rate has increased in Westchester County over the past few decades and remains above the rate for New York State overall. The age-adjusted female breast cancer incidence rate is highest for non-Hispanic white residents (157.4 per 100,000 women), compared with non-Hispanic black residents (127.6 per 100,000) and Hispanic residents (101.5 per 100,000).

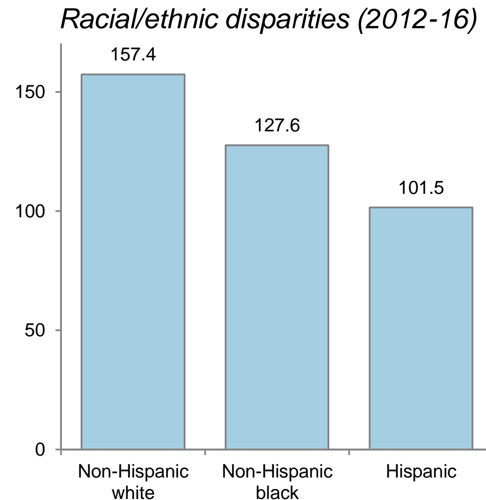
Age-adjusted breast cancer incidence per 100,000 women







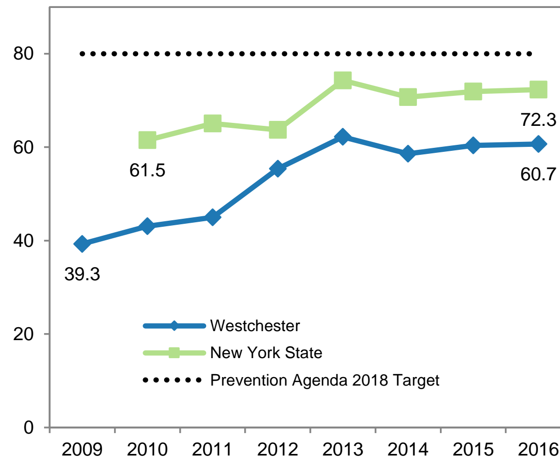
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

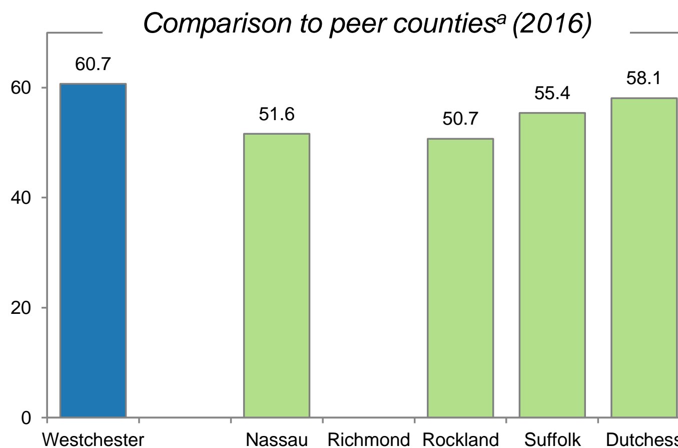


Data source: New York State Cancer Registry
Map is at the census tract level and reflects data from 2010-2014.

Despite an upward trend over the past decade, a smaller proportion of children, ages 19-35 months, have received their full immunizations in Westchester County than in New York State overall (60.7 vs. 72.3% respectively). A larger proportion of children ages 19 to 35 months receive their full immunizations in Westchester County than in peer counties.

Children (ages 19-35 mos.) with 4:3:1:3:3:1:4 immunization series, %



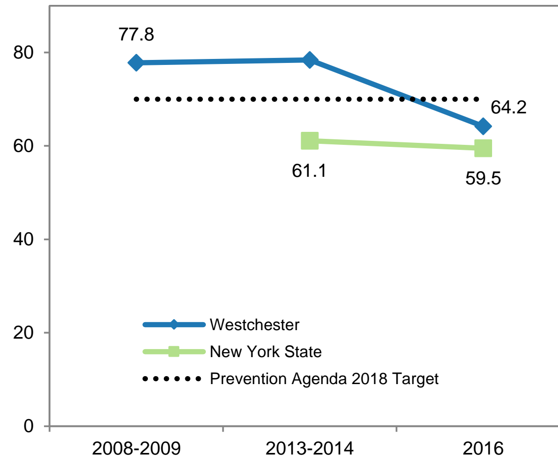


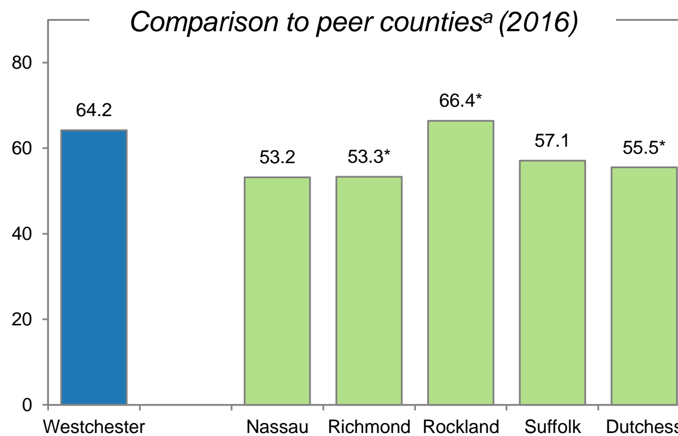
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Richmond county data not available

In Westchester County, the proportion of adults ages ≥65y who received their flu immunization declined from 77.8% in 2008/2009 to 64.2% in 2016, although it remains higher than in New York State overall (59.5%). Compared to peer counties, Westchester County tends to have a higher proportion of adults ≥65y who received their flu immunization in 2016.

Adults (≥ 65y) with flu immunization, %



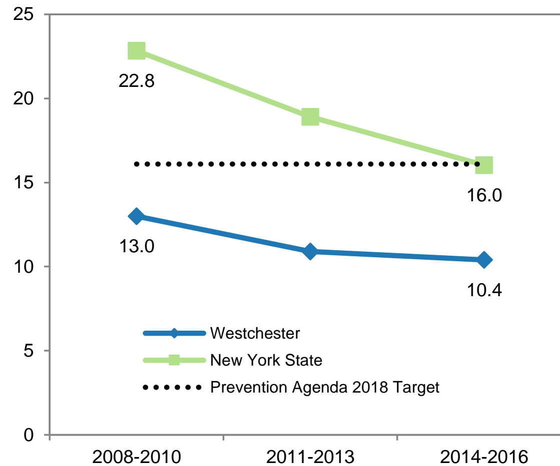


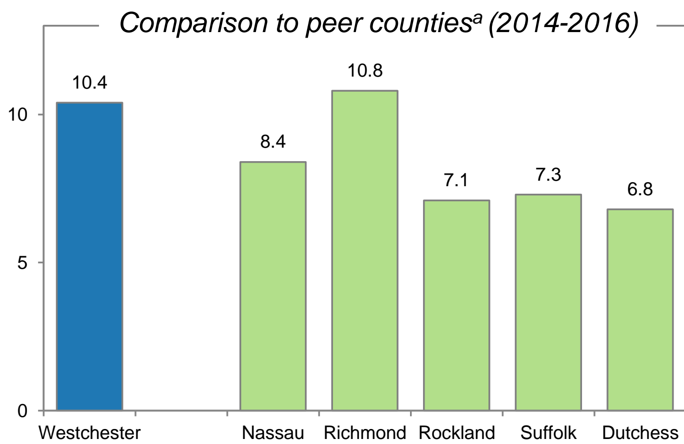
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

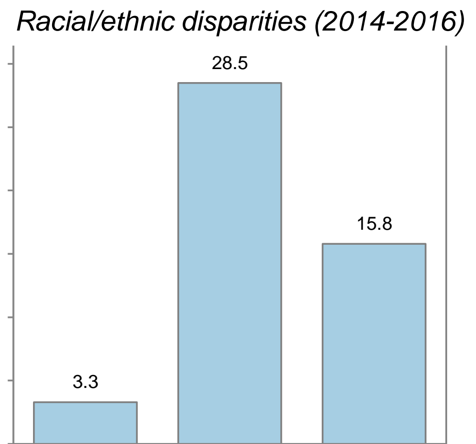
Data source: New York State Prevention Agenda Dashboard
** Indicates unreliable estimate; interpret with caution*

The HIV incidence rate is lower in Westchester County (10.4 per 100,000) than in New York State overall (16.0 per 100,000) and is below the Prevention Agenda Target (16.1 per 100,000), although it remains second highest among peer counties, only second to Richmond County. The incidence of HIV for the non-Hispanic black population and the Hispanic population were about 8.6 and 4.8 times higher than the incidence rate for the non-Hispanic white population, respectively.

Newly diagnosed HIV case rate per 100,000 population





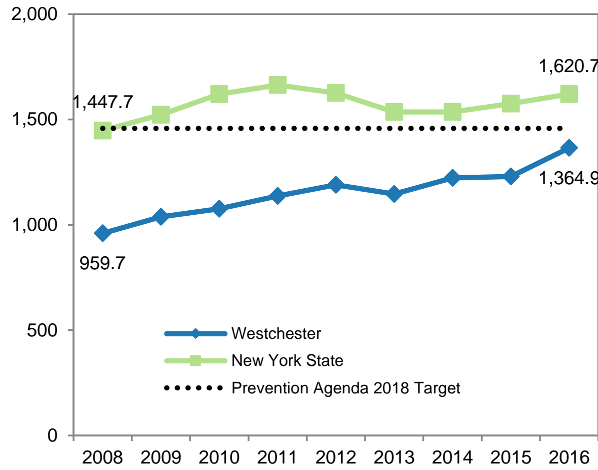


[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

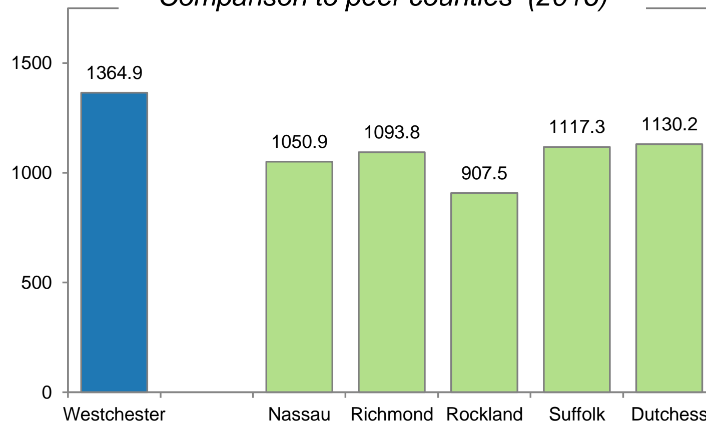
Data source: New York State Prevention Agenda Dashboard

The chlamydia rate amongst women, ages 15-44y, is lower in Westchester county (1,364.9 per 100,000) than in New York State overall (1,620.7 per 100,000), although it has increased for both over the past decade.The chlamydia rate for women ages 15-44y is highest in Westchester County when compared to its peer counties.

Chlamydia rate per 100,000 women (ages 15-44y)



Comparison to peer counties[a] (2016)

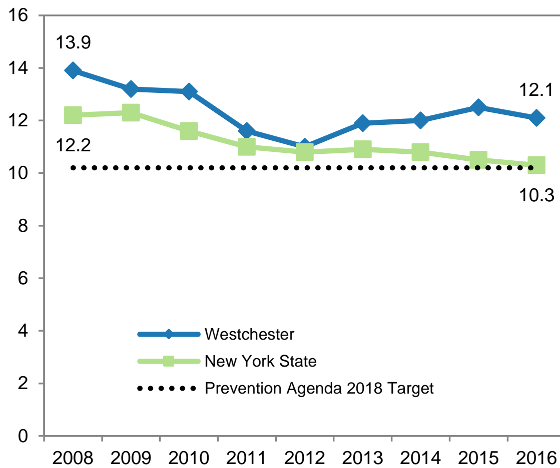


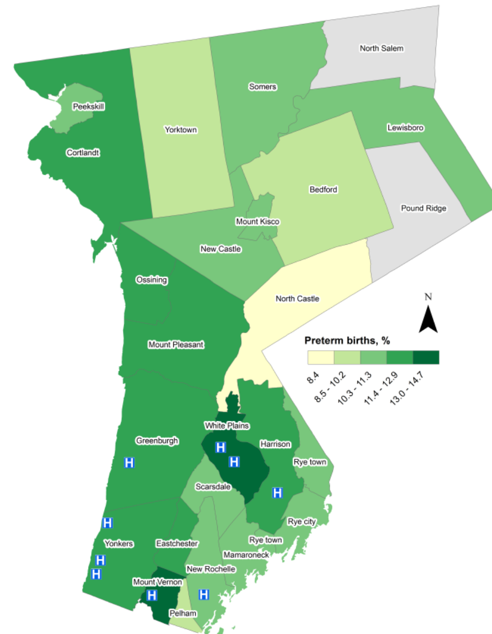
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

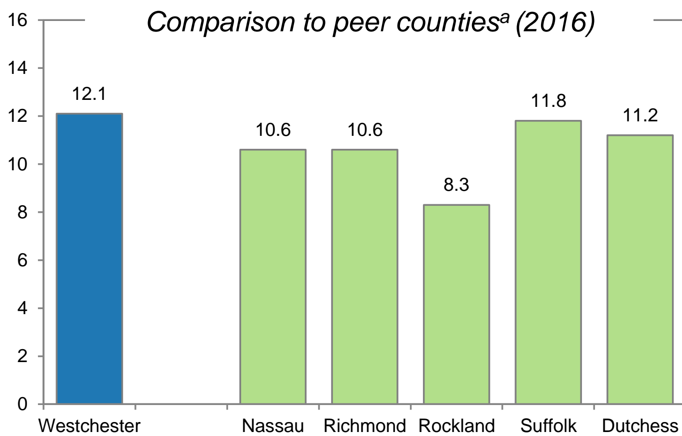
Data source: New York State Prevention Agenda Dashboard

The percent of births that are preterm is higher in Westchester County (12.1%) than in New York State overall (10.3%), the Prevention Agenda 2018 Target (10.2%) and its peer counties. The percent of births that are preterm is higher amongst the non-Hispanic black population (15.7%) than the non-Hispanic white (11.5%) and Hispanic populations (12.0%).

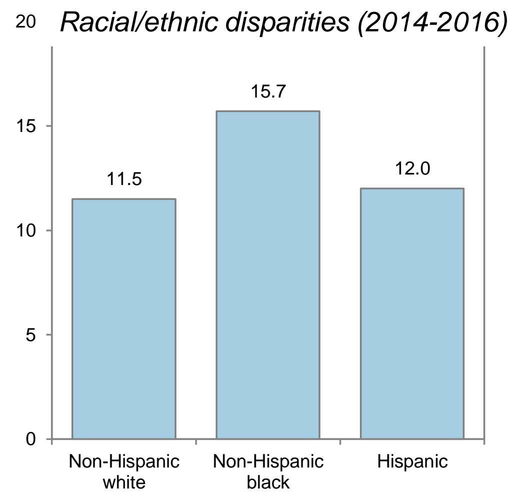
Preterm births, %







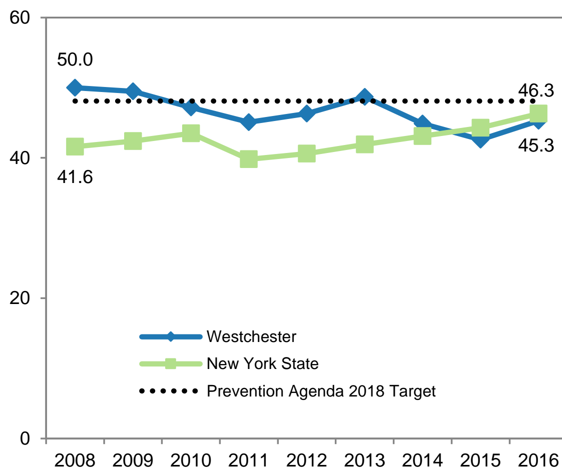
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

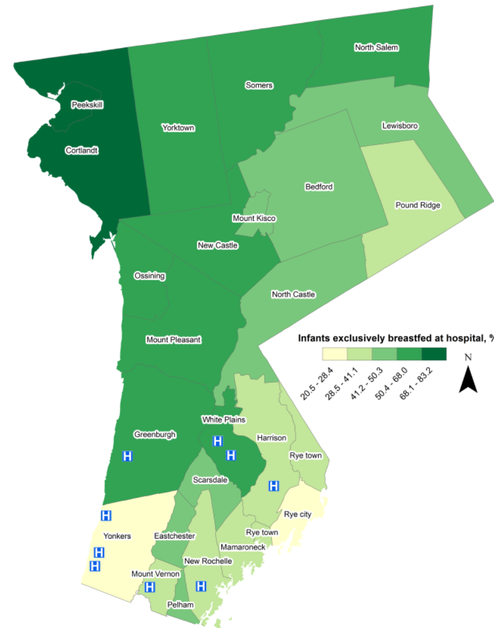


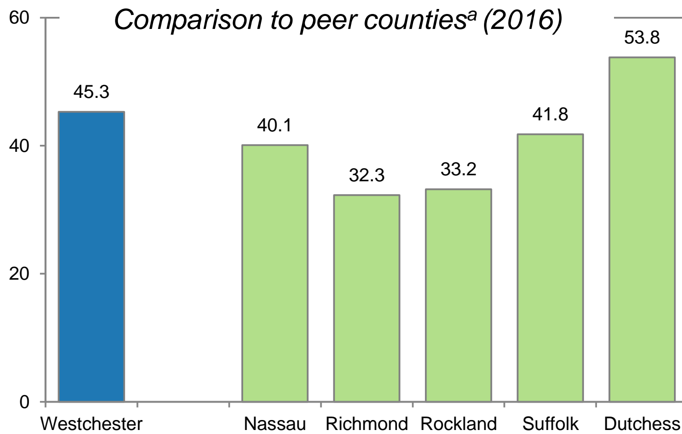
Data source: New York State Prevention Agenda Dashboard
Map is at the Minor Civil Division level and reflect data from 2013-2016
Gray area indicates unreliable estimate.

In Westchester County, the proportion of infants exclusively breastfed in the hospital (45.3%) has slightly decreased over the last decade, although it remains the second highest when compared to five peer counties. The proportion of infants that are exclusively breastfed in the hospital is highest for non-Hispanic white populations (58.6%), followed by Hispanic (42.0%) and non-Hispanic black populations (35.4%).

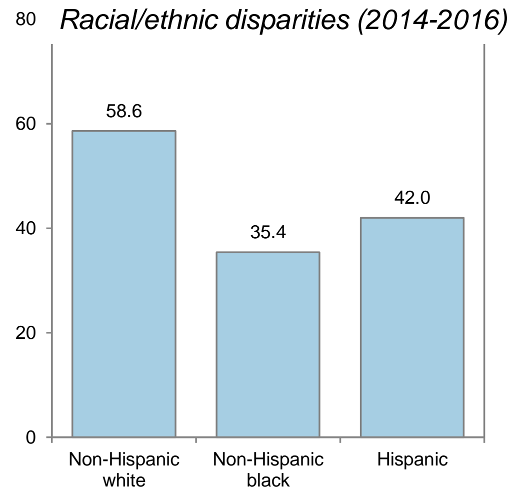
Infants exclusively breastfed in the hospital, %







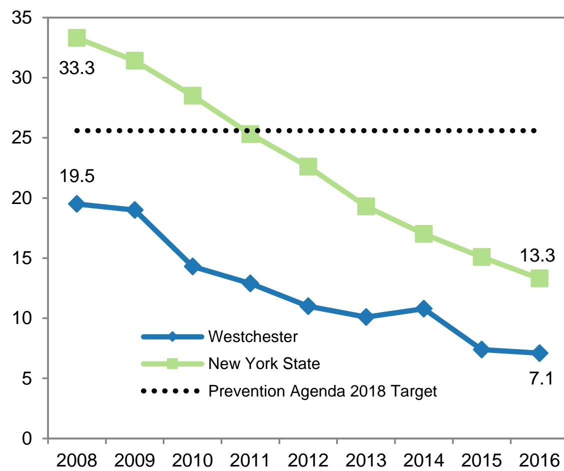
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

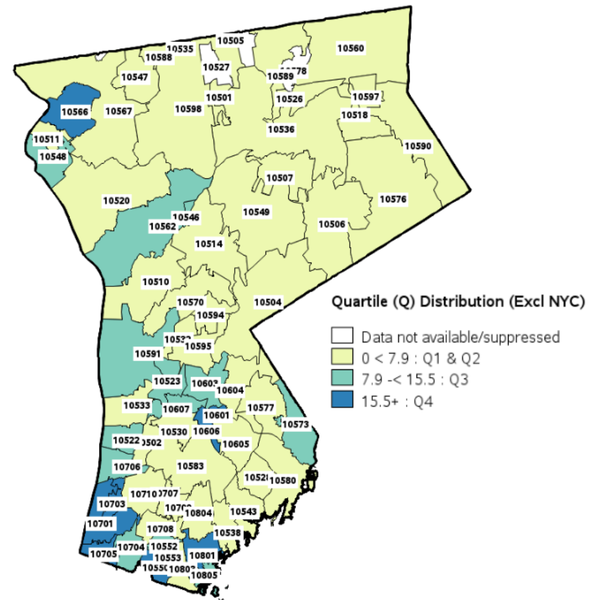


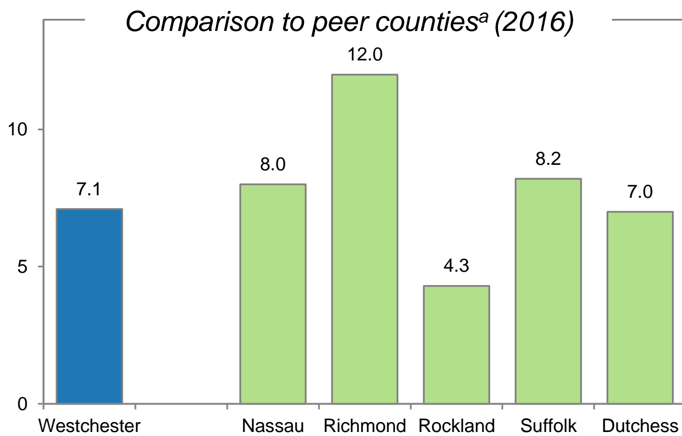
Data source: New York State Prevention Agenda Dashboard
Map is at the Minor Civil Division level and reflect data from 2013-2016

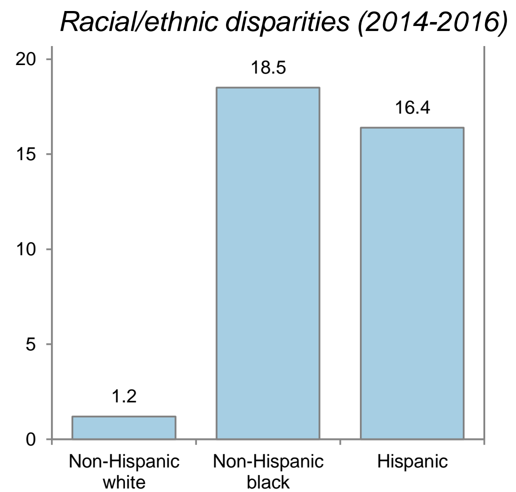
In Westchester County between 2008 and 2016, the adolescent pregnancy rate declined from 19.5 to 7.1 pregnancies per 1,000 female adolescents and remains lower than in New York State overall. The adolescent pregnancy rate is significantly higher for non-Hispanic black (18.5 per 1,000) and Hispanic (16.4 per 1,000) adolescents than non-Hispanic white adolescents (1.2 per 1,000).

Adolescent pregnancy rate per 1,000 females (aged 15-17y)







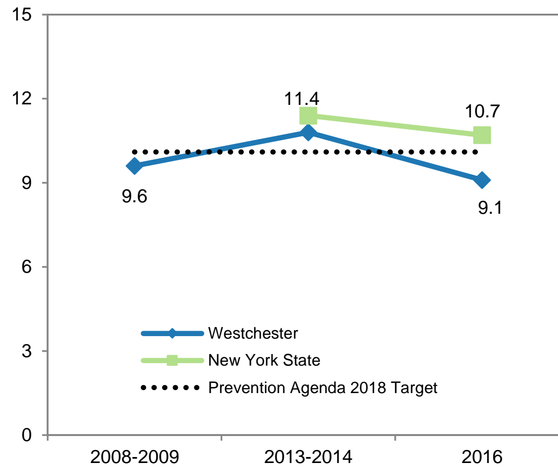


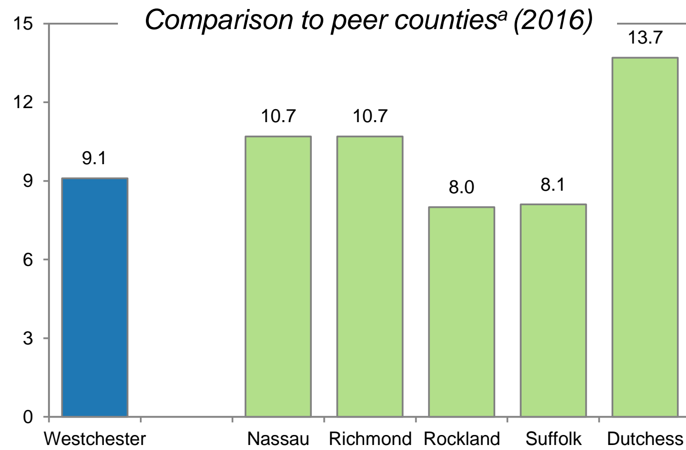
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Map is at the ZIP Code level and reflects data from 2012-2014

A smaller proportion of adults report having poor mental health for at least half of the past month in Westchester County (9.1%) than in New York State overall (10.7%), remaining below the Prevention Agenda 2018 Target. Westchester County has the third lowest proportion of adults reporting having poor mental health for at least half of the past month when compared to its five peer counties.

Adults with poor mental health for ≥14 days in the last month, %

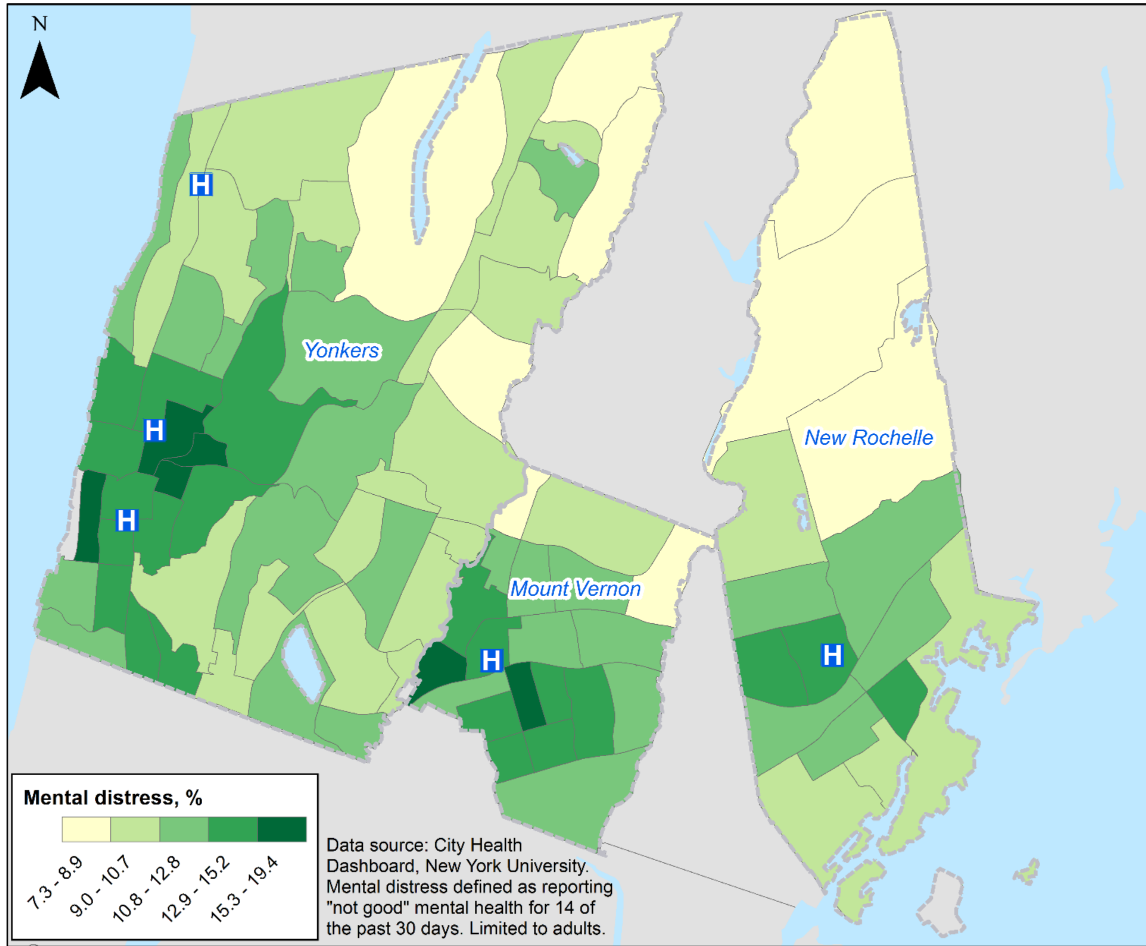




[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

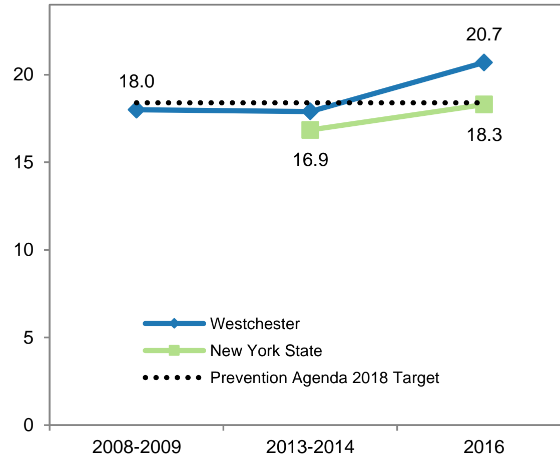
Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.

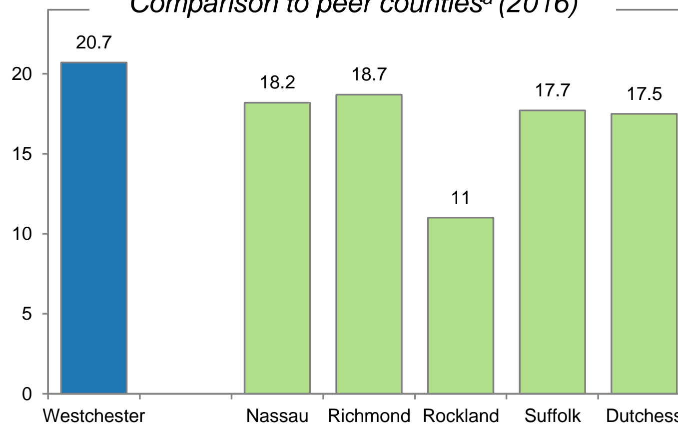
Adults with mental distress, %



Between 2013/2014 and 2016, the percent of adults binge drinking in the past month increased from 18.4% to 20.7% in Westchester County, remaining higher than in New York State overall. Westchester County has the largest percentage of adults reporting binge drinking in the past month compared to its peer counties.

Adults binge drinking during past month, age-adjusted %



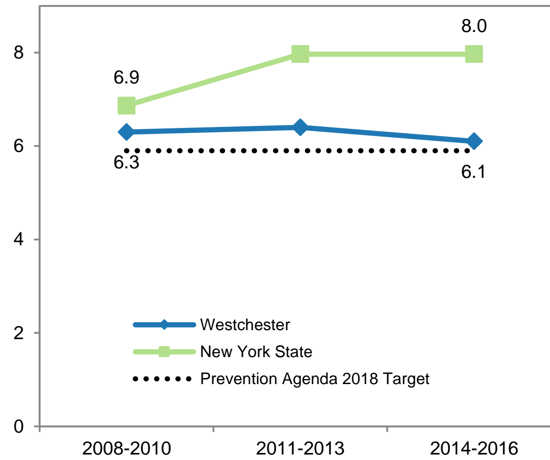


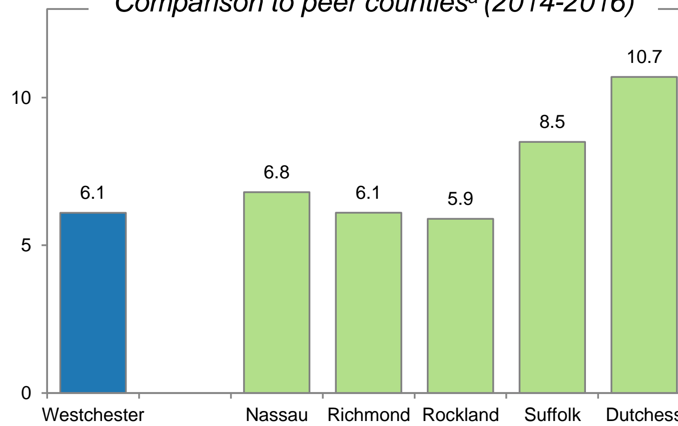
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard

The age-adjusted suicide death rate remained relatively stable between 2008/2012 and 2014/2016 in Westchester County (6.3 vs. 6.1), slightly above the Prevention Agenda 2018 Target of 5.9 per 100,000. Westchester County is tied for the second lowest age-adjusted suicide death rate when compared to 5 peer counties.

Age-adjusted suicide death rate per 100,000 population



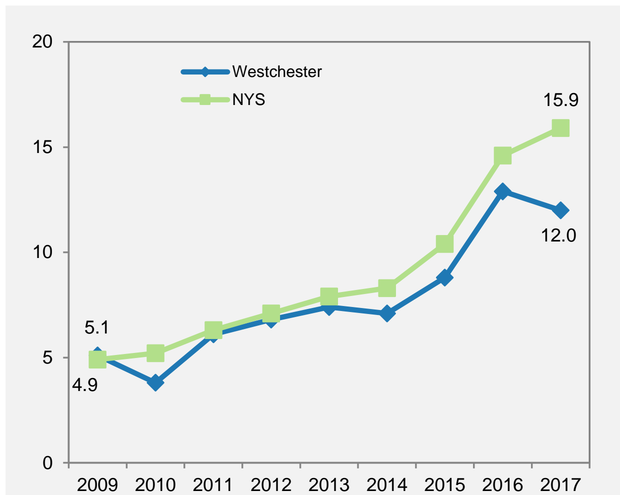


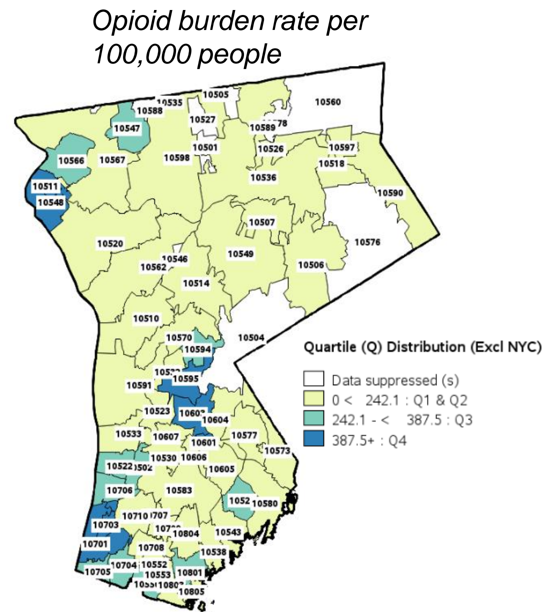
[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

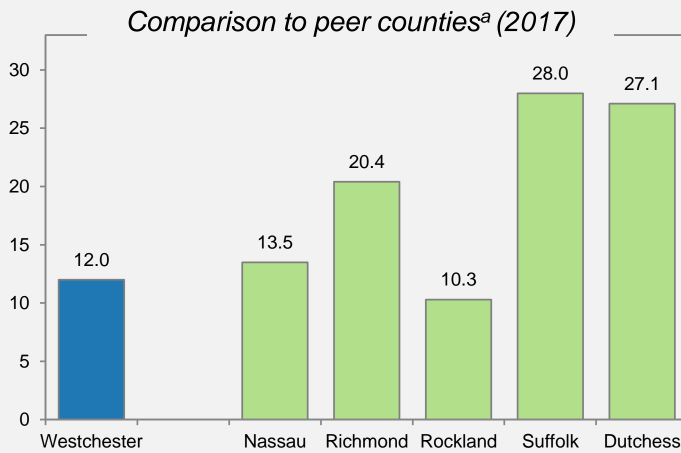
Data source: New York State Prevention Agenda Dashboard

The opioid mortality rate tripled in Westchester County over the past decade, although it is lower than in 3 of 5 of its peer counties. Those who are non-Hispanic white are more than twice as likely to die from opioids as non-Hispanic black and Hispanic populations.

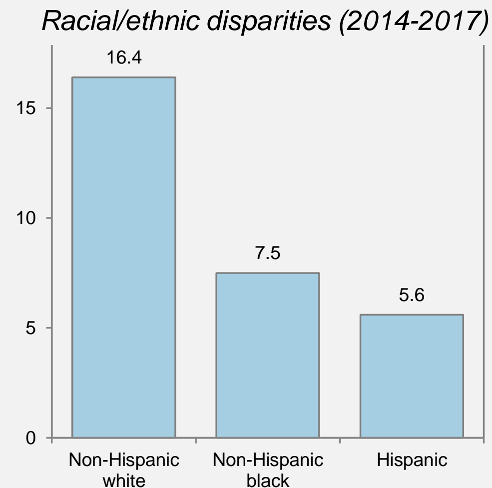
Age-adjusted opioid mortality rate per 100,000 people







[a] Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.



Data source: Mortality data from CDC WONDER, 2017
Map data is at the ZIP Code level and is from New York Opioid Data Dashboard, 2016.

Review of Key Findings

Summit Findings

Information from the Summit report was used to identify key actions. Key actions within each of the four Prevention Agenda Priority Areas were identified as follows:

> Prevent chronic disease: Support and leverage existing community resources across homes, schools, churches, CBOs, etc. to address chronic diseases.
>
> Promote a healthy and safe environment: Address currently fragmented and inconsistent education and communication.
>
> Promote healthy women, infants and children: 1) Design community awareness campaigns and messaging focused upon prenatal and infant care and, 2) Health systems need a holistic care approach that eliminates silos across the continuum.
>
> Promote well-being and prevent mental and substance use disorders: Break down silos and collaborate through forums such as the 2019 Health Summit.

Key Findings from Analysis

Despite each of these different methods and approaches to primary data collection in gathering community input, there was a consistent focus on mental health, food and nutrition, obesity and chronic disease. Obesity and its related behaviors have significant impact on chronic disease, therefore, it is intended that the programs that are detailed specifically for the reduction of obesity will also impact the prevalence of diabetes, hypertension, asthma, cancer and cardiovascular disease in Westchester County. The tables below show a breakdown of the findings based on primary data collection for the Montefiore Mount Vernon (MMV) and Montefiore New Rochelle (MNR) service areas.

PRIORITY AND ACTION AREAS FOR MONTEFIORE MOUNT VERNON HOSPITAL SERVICE AREA

	Priority Area for Community	Action Area for Community	Personal Priority Area
Ranking	MMV Service Area	MMV Service Area	MMV Service Area
1	Mental Health	Affordable Housing	Food and Nutrition
2	Food and Nutrition	Mental health services	Physical activity
3	Chronic Disease screening and care	Employment opportunities	Environments that promote well-being & active lifestyles
4	Obesity	Access to healthier food	Mental health
5	Environments that promote well-being & active lifestyles	Exercise and weight loss programs	Chronic disease screening and care

PRIORITY AND ACTION AREAS FOR MONTEFIORE NEW ROCHELLE HOSPITAL SERVICE AREA

	Priority Area for Community	Action Area for Community	Personal Priority Area
Ranking	**MNR Service Area**	**MNR Service Area**	**MNR Service Area**
1	Mental Health	Affordable Housing	Food and Nutrition
2	Food and Nutrition	Mental health services	Physical activity
3	Chronic Disease screening and care	Access to healthier food	Environments that promote well-being & active lifestyles
4	Obesity	Employment opportunities	Chronic disease screening and care
5	Child & Adolescent Health	Exercise and weight loss programs	Mental health

Special Considerations

A Community Health Survey of the Hudson Valley was created and administered by Siena College Research Institute on behalf of the CHA Collaborative. The survey was conducted in all seven counties in the region. Additionally, in March and April of 2019, Members of the Local Health Department Prevention Agenda collaborative conducted 10 focus groups with health and services providers to identify the most pressing barriers and issues facing the populations they serve. The Local Health Department Prevention Agenda collaborative designed the focus groups as a supplement to the Community Health Survey acknowledging that certain populations may have been under represented in the survey participants. These populations could include but are not limited to those who speak English as a second language, those experiencing homelessness, members of the LGBTQ+ community, and children.

The goal of the focus groups was to leverage service provider knowledge of the populations they serve to identify issues effecting health, and how they intersect with each other. The Local Health Department Prevention Agenda collaborative met several times to identify and design a

survey tool that was used to collect preliminary response data before the focus groups were held. Many of the focus groups were conducted through already existing meetings and collaborative of stakeholders throughout the region. The survey tool was sent to members of these collaboratives to fill out prior to the focus groups via Survey Monkey. The data collected through these surveys was used to inform the questions asked during the in person focus groups.

IMPLEMENTATION STRATEGY REPORT

Implementation Strategy Report

For the 2019-2021 Implementation Strategy, Montefiore has elected to retain the two priority areas: Prevent Chronic Disease and Promote Healthy Women Infants and Children.

In the Comprehensive Community Services plan developed for 2016-2018, the priority areas selected are Prevent Chronic Disease and Promote Healthy Women Infants and Children. Through the projects and activities initiated during that plan, Montefiore New Rochelle and Montefiore Mount Vernon were able to contribute to the overall trend improvements in those areas for New York State. However, although Westchester County has continued to be among the top five and has shown improvements along with the rest of New York State, the rates for conditions identified in the communities of Mount Vernon and New Rochelle remains higher in most cases than the countywide and statewide averages.

Significant Needs to be Addressed

As described within the Community Description and Service Area section of this proposal, Westchester County, while gradually increasing in ethnic diversity has hotspots where populations, up to 90%, identify as a cultural/racial/ or ethnic minority. As the racial and ethnic populations have shown disparate rates of impact, in consultation and collaboration with community partners, within Prevent Chronic Diseases the focus area and goal that was selected is: Focus Area 4: Chronic Disease Preventive Care and Management, Goal 4.2 Increase early detection of cardiovascular disease, diabetes, pre-diabetes and obesity, under Objective 4.2.1: Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%. Montefiore New Rochelle and Montefiore Mount Vernon have also added a new priority area for this cycle: Prevent Communicable Diseases, with a focus on vaccine preventable diseases, specifically HPV.

Montefiore New Rochelle and Montefiore Mount Vernon have identified three Prevention Agenda Priority Areas:

1. **Preventing Chronic Disease** with a specific focus on Preventive Care and Management.

Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

2. **Promote Healthy Women Infants and Children**, Focus Area: Perinatal and Infant Health, Goal 2.2: Increase breastfeeding, Objective 2.2.1.0: Increase the percentage of infants who

are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among all infants.

3. **Prevent Communicable Diseases, Focus Area** : Vaccine Preventable Diseases

   Goal 1.1: Improve vaccination rates, Objective 1.1.2: Increase the percentage of NYS 13-year-old adolescents with a complete HPV vaccine series by 10% to 37.4%

Priority Area: Preventing Chronic Disease
Focus Area 4: Preventive care and management

Goal	**Goal 4.2 Increase early detection of cardiovascular disease, diabetes, pre-diabetes and obesity**
Outcome Objectives	Objective 4.2.1: Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%
Interventions/Strategies/ Activities	Engagement of clinical partners in the HbA1c screening protocol as outlined in HEDIS; alignment of the clinical and community based resources to address the level of patient health status (prevention, management or control).
Family of Measures	Number of patients who received a HbA1c test in last 3 years Number of people whose most recent HbA1c level indicated poor control (>.9.0 percent), was missing, or did not have a HbA1c test
Partner Roles and Resources	Provide access to a range of preventive, maintenance and self-management programs for individuals across the pre-diabetes and diabetes spectrum. Partners will also provide Technical Assistance, opportunities for neighborhood based cultural/linguistic specific classes, and opportunities for data sharing and collaboration
By When	December 31, 2021
Disparities	The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic

The next Priority Area that was selected is **Promote Healthy Women Infants and Children**, Focus Area: Perinatal and Infant Health, Goal 2.2: Increase breastfeeding, Objective 2.2.1.0: Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among all infants. In the last cycle, Montefiore New Rochelle and Montefiore Mount Vernon focused on activities to bring the hospitals closer to meeting the guidelines of the Baby Friendly Initiative. Activities from the last cycle included participation in the New York State Baby Friendly Initiative at Montefiore New Rochelle; and alignment with the infant mortality reduction initiatives and perinatal health objectives sponsored through the Mount Vernon Neighborhood Health Center, the Montefiore Medical Group Family Health and Wellness Center and Hudson River Healthcare centers. By including interventions focused on increasing breastfeeding rates, Montefiore New Rochelle/ Montefiore Mount Vernon will move closer to the tenets of the Baby Friendly Hospital Initiative.

Priority Area: Promote Healthy Women, Infants and Children
Focus Area 2: Perinatal and Infant Health

Goal	**Goal 2.2: Increase breastfeeding**
Outcome Objectives	Objective 2.2.1.0: Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among all infants
Interventions/Strategies/ Activities	Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding. Activities to include education and support for mothers to initiate and maintain breastfeeding, and education for nursing staff to support mothers with breastfeeding.
Family of Measures	Percentage of infants who are exclusively breastfed in the hospital Number of nurses that participate in breastfeeding education program
Partner Roles and Resources	Engagement and referral into appropriate programs (clinical or community) to support mothers with breastfeeding. Partner will also provide technical assistance and supportive community programming.
By When	December 31, 2021
Will Action Address Disparity	In Westchester County, the proportion of infants that were exclusively breastfed is highest for non-Hispanic white populations (58.6%), followed by Hispanic (42.0%) and non-Hispanic black populations (35.4%). The

	community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic Black or Hispanic.

Montefiore New Rochelle and Montefiore Mount Vernon have added a new priority area for this reporting cycle. The final Priority Area selected is **Prevent Communicable Diseases**, Focus Area: Vaccine Preventable Diseases, Goal 1.1: Improve vaccination rates, Objective 1.1.2: Increase the percentage of NYS 13-year-old adolescents with a complete HPV vaccine series by 10% to 37.4%. Activities for this priority area will focus on increasing the number of adolescents and teens that have completed the 2 dose series vaccine for HPV. Activities to address this priority will include partnering with clinical providers to increase rates of immunization by increasing education and advocacy on HPV vaccinations to parents of children and adolescents ages 9-13 years old. By including interventions focused on increasing breastfeeding rates, Montefiore New Rochelle and Montefiore Mount Vernon will help to address the rates of HPV-related cancers.

Priority Area: Prevent Communicable Diseases
Focus Area 1: Vaccine Preventable Diseases

Goal	**Goal 1.1: Improve vaccination rates**
Outcome Objectives	Objective 1.1.2: Increase the percentage of NYS 13-year-old adolescents with a complete HPV vaccine series by 10% to 37.4%
Interventions/Strategies/ Activities	Partner with clinical providers to increase rates of immunization by increasing education and advocacy to parents for HPV vaccination for children and adolescents ages 9-13.
Family of Measures	Percent of children and adolescents ages 9-13 years old with a complete HPV vaccine series (2 dose series)
Partner Roles and Resources	Support outreach efforts through education and advocacy on the importance of HPV vaccination with parents of children and adolescents age 9-13. Provide vaccinations
By When	December 31, 2021
Will Action Address	Based on data from NYS from 2011-2015, rates of HPV-related cancers are higher for individuals who are non-Hispanic Black, while Hispanics and non-

Disparity	Hispanic White individuals have rates closer to the average for NYS. Individuals identifying as Asian, Pacific Islander (API) and American Indians/Alaska Natives have lower rates. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic

Significant Needs Not Addressed

In addition to the multiple resources that have been developed at Montefiore independently and through partnership with other organizations there continues to be a need for community-based programs and resources that can augment Montefiore's programs and services. Below is a listing of programs and services that Montefiore provides for the communities it serves that are not the programs featured in the Implementation Strategy.

Internal Resources and Measures

Montefiore continues to engage in cross-sector partnerships with government, community organizations, hospitals, and businesses to address the health and social needs of our patient population. Below is a list of Montefiore programs that address a variety of community needs, including a brief description, the intervention measures that the program captures and the coordination of the program to the larger New York State Prevention Agenda. Some of these programs are located in Westchester County but many are located in the Bronx. The Bronx-based programs listed below accept Westchester County patients and therefore, have been included in this resource list.

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Adherence Intervention for Pediatric Renal Transplant	Adherence Intervention for Pediatric Renal Transplant aims to support adolescents (14-21) awaiting kidney transplant who struggle with their treatment regimens. The program uses dialectical behavior therapy, counseling, support groups and medication management with the goal of improving quality of life and general life skills.	Increase in patient adherence to renal transplant treatment regimens; Improvement in patient quality of life	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Adolescent AIDS Program	The Adolescent AIDS Program (AAP) provides comprehensive care, risk reduction services and HIV counseling to HIV-positive adolescents (13-24). The program also offers rapid and simple HIV testing and counseling to at-risk youth throughout the Bronx, especially in areas of high seroprevalence.	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Adolescent Depression and Suicide Program	Adolescent Depression and Suicide Program is a subspecialty outpatient clinic within the Dept. of Psychiatry that provides comprehensive assessments and evidence-based treatment for youth (12-18) who present with symptoms of depression, suicidal behaviors and non-suicidal self-injurious	Decrease in adolescent depression rate; Decrease in adolescent suicide and attempted suicide rates; Decrease in adolescent suicidal feelings	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	behaviors. Many patients also struggle with school, family and drug problems. The program runs lectures and workshops for school personnel, students and community members.		
AIDS Center	As a New York State Dept. of Health-designated AIDS Center, this division at Moses provides a broad array of inpatient and outpatient services to adults (22+) living with AIDS. The care model consists of an integrated team of health care professionals, including physicians, social workers, nurses, HIV counselors, dietitians, adherence counselors, researchers, mental health providers, pharmacists and	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	administrative staff.		
B'N Fit	B'N Fit is a comprehensive weight loss program for obese teens (12-21) that conducts medical, nutritional and psychosocial evaluations and refers participants to treatment for obesity-related illness. The program is offered in conjunction with a community after-school program that consists of nutrition classes, physical activity programming, parent groups, family nights and a six-week summer program.	Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Breast and Cervical Screening Event	Screening for breast exams and pap smears for women 18 years and older. Mammograms for women 40 years and older. In addition, women's health education and information is provided.	Increase in breast exams and pap smears for women 18+; Increase in mammograms for women 40+; Decrease in diagnosis of late-stage breast and cervical cancer	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Caregiver Support Center	The Caregiver Support Center is dedicated to providing support to the caregiver, a family member or friend and the primary source of care for an ill family member, in addition to medical support of clinical staff.	Increase in general satisfaction of caregiver	Promote Mental Health and Prevent Substance Abuse
Centering Pregnancy	Centering Pregnancy is a national program that	Increase in utilization of	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	provides comprehensive prenatal care in a group setting. It affords women the opportunity to spend more time with their prenatal care provider, to befriend other pregnant women and to learn about themselves, their pregnancies and their newborns. The program is offered at two MMG sites: FHC and SBHCCF--and soon to be started at CFCC.	prenatal care services; Increase in positive health outcomes for newborns and their mothers	
Centers Implementing Clinical Excellence & Restoring Opportunity (CICERO)	CICERO is an integrated HIV/AIDS and primary care program that functions at ten Montefiore primary care sites and offers treatment, educational, counseling and supportive services to HIV/AIDS patients in the primary	Increase in proportion of HIV+ individuals engaged in care	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	care setting.		
CFCC'S Breastfeeding Support	CFCC's Breastfeeding Initiative is a collaborative effort between the Depts. of Pediatric Medicine and OB/GYN that supports new mothers and trains staff to manage breastfeeding. Expectant and new mothers and their infants (0-2) are referred to a board certified pediatrician who is also a board certified lactation consultant, who provides individual consults and runs a weekly breastfeeding group clinic. The program's goal is to improve breastfeeding rates in the hospital and clinic settings and to help Montefiore become	Increase in proportion of mothers who breastfeed	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	recognized as a "baby-friendly hospital" by the WHO. Individual consults are available 3 mornings per week and the breastfeeding group clinic meets on Thursday afternoons. Annual lectures are given to pediatric residents and other staff.		
CHAM Oncology Groups	Over four 12-week sessions in 2012, up from 2 in 2011, CHAM runs four distinct support groups targeted to: teenagers with cancer, school-age children with cancer, siblings of cancer patients and parents of children undergoing cancer treatment.	Increase in patient satisfaction for oncology patients and their families	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
CHAM Sickle Cell Groups	Over a 10-week session, CHAM runs a support group targeted to school-age sick cell patients. The group gives patients an opportunity to meet others going through similar experiences and provides the chance for self-expression and positive socialization.	Increase in patient satisfaction for sickle cell patients and their families	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse
CHF Disease Management	Through primary care and care management services, the CMO seeks to decrease preventable readmissions and improve the continuity of care for the hospital's Emblem CHF patients. At-risk patients are managed through case management calls, home	Decrease in preventable readmissions for CHF patients; Increase in continuity of care for CHF patients	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	visits and the use of telehealth and telescales.		
Children's Evaluation and Rehabilitation Center (CERC)	CERC, the clinical arm of the Rose F. Kennedy University Center for Excellence in Developmental Disabilities, offer multidisciplinary evaluation and treatment to children and adults with intellectual and other disabilities, such as autism spectrum disorder, cerebral palsy, mental retardation, learning disabilities. The Center is composed of 10 teams, which focus their activities on a specific component of this population.	Increase in patient satisfaction for individuals with intellectual and other disabilities	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Colorectal Cancer Patient Navigation Program	The Colorectal Cancer Patient Navigator Program is the bridge between the community and health care. We eliminate complexity bringing together interdisciplinary teams to work towards reducing colorectal cancer rates by assessing, educating, scheduling, and guiding our patients through the screening process. Our aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-show and cancellation rates.	Increase in screening for colorectal cancer; Decrease in colorectal cancer	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Communilife Montefiore Temporary Respite Program	The program provides temporary community-based supportive housing for Montefiore inpatients that do not have a suitable living arrangement and do not need to be hospitalized. Patients who are discharged into the program facility receive case management, medication management, care coordination, entitlements services and the support they need to find suitable permanent housing.	Increase in patient satisfaction; Increase in proportion of inpatients who report having suitable living arrangements	Promote a Healthy and Safe Environment
Comprehensive Services Model, CSM	CSM is a Welfare-to-Work program for public assistance clients with substance use disorders. CSM comprehensively evaluates all clients and then case manages them	Increase in stabilization in substance abuse treatment; Increase in employment of	Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	with the goals of stabilization in substance abuse treatment and either employment or attainment of federal disability benefits, if eligible. CSM refers to state-certified substance abuse treatment programs and provides comprehensive social services.	individuals with substance abuse disorders; Increase in attainment of federal disability benefits for individuals with substance abuse disorders	
Diabetes Disease Management	Through care management services delivered telephonically, face-to-face (both one-on-one and in group settings) and through direct mail, the CMO empowers people with Type II diabetes to improve their health outcomes and quality of life.	Increase in positive health outcomes for individuals with diabetes; Increase in quality of life for individuals with diabetes	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Diabetes in Pregnancy Program	Diabetes in Pregnancy is a prenatal care program for women with pre-gestational or gestational diabetes mellitus. The program's classes explore the impact of diabetes on a patient's pregnancy, baby and family. Additionally, participants receive nutritional counseling and co-management consultation.	Increase in quality of prenatal care for diabetic women	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Diabetes Management: PROMISED	A novel approach in Diabetes Education - the **Pro**active **M**anaged **I**nformation **S**ystem for **E**ducation in **D**iabetes "PROMISED" is a 10-hour interactive educational program. The program is approved and certified by the American Diabetes Association and adheres to	Increase in management of diabetes; Increase in positive health outcomes for diabetic mothers and their newborns	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	the more recent Standards of Care and it is tailored to meet the needs of our Bronx residents. Patients are referred to PROMISED by their primary care physicians and following completion of the program they are empowered to better manage their disease. Each case is reviewed and discussed separately and the referring PCP receives a consultation letter regarding management of glycemic control, cardiovascular risk factors and comorbidities. Individual cases are presented adhering to the Health Insurance Portability and Accountability Act of 1996		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	(HIPAA)		
Dialysis Outreach	Dialysis outreach seeks to strengthen communication between Montefiore's transplant program and community physicians and to provide a seamless referral service where a physician or patients only need to make one phone call and will receive an appointment with a Montefiore Hepatologist, Nephrologist or Surgeon depending on the reason	Increase in patient satisfaction; Increase in provider satisfaction	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	for the referral. The program seeks to resolve customer service issues, help expedite the referral and evaluation process and answer any questions pertaining to transplant and Montefiore. Dialysis outreach also provides in service training for dialysis staff so that understand transplant. Additionally, the program works with the American Liver Foundation, National Kidney Foundation and Organ Donor Network on education, community events and outreach.		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
DOH Infertility Demonstration Project	The Infertility Demonstration Project is a statewide campaign that helps couples (21-44) who lack the financial resources to access In-vitro Fertilization services. Depending on total household income, the participating couple is required to pay a certain portion of fees after insurance. The Dept. of Health then pays the remaining cost. The program is particularly important for couples whose insurance does not cover the cost of medication for the IVF cycle.	Increase in access to In-vitro fertilization services	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Explainer Program	The Explainer program employs youth interns from the community to teach patients and families at CHAM how to navigate the interactive patient care system at the bedside TV. This system, called the GetwellNetwork, offers health education, TV, video, internet, gaming, and customer service to patients and their families. The interns are provided with career workshops and encouraged to pursue career opportunities in health care through skill building in resume writing, interviewing and education.	Increase in patient satisfaction	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Family Treatment/Rehabilitation	Family Treatment/Rehabilitation is an evaluation and case management program for families with identified risk of child abuse or neglect and identified psychiatric or substance use disorders. The program provides evaluation and referral for treatment, and provides case management to track participation.	Increase in quality of case management for families with identified risk of child abuse or neglect	Promote Mental Health and Prevent Substance Abuse
Farmer's Market Walks	Every Tuesday from June-November, nutritionists and health educators lead groups at various Montefiore sites to local Farmer's Markets. Participants learn about seasonal produce, discuss recipes and when available, receive "Health	Increase in healthy eating habits; Increase in fruit and vegetable consumption	Promote a Healthy and Safe Environment

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	Bucks," a $2 coupon to purchase a fruit or vegetable.		
Geriatric Ambulatory Practice	The Geriatric Ambulatory Practice provides comprehensive primary care to very frail patients (65+). It focuses on medical and functional assessment for patients and offers consultation visits for primary care physicians who are having difficulty caring for dementia, frequent falls, osteoporosis, elder abuse and multiple chronic conditions that impact the elderly. The practice also serves as a training site for geriatric fellows, medical residents and medical students.	Increase in patient satisfaction	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Healing Arts	The Healing Arts at Montefiore is a network of programs that uses the arts, creative arts therapies, integrative medicine, and other healing approaches to enhance the quality of life, health and well-being of Montefiore's patients, associates and community. Healing Arts programs are available in the Children's Hospital, Oncology, Palliative Care, Rehabilitation Medicine, Psychiatry, and other departments to complement patient care by helping to reduce pain and other physical symptoms, provide comfort and enjoyment, promote self-expression, and enhance quality of	Increase in patient satisfaction and quality of life	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	life.		
Healthy Living with Chronic Conditions	Healthy Living with Chronic Conditions is a workshop that helps patients with chronic conditions lead healthier lives. Patients who have hypertension, diabetes, arthritis, HIV/AIDS and other illnesses attend weekly sessions for six weeks where they learn to eat well, cope with stress, communicate effectively with medical providers and identify and accomplish goals.	Increase in patient satisfaction	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Healthy Steps	Healthy Steps ensures that primary care for infants and toddlers focuses on issues of development, behavior, parental mental health and the parent-child relationship. Building on the national model, the program collocates and integrates behavioral and mental health specialists in the pediatric primary care setting. These specialists use screening tools such as maternal depression screening and child social emotional screening to determine and implement interventions that ensure successful early childhood years.	Increase in patient satisfaction; Increase in pediatric access to primary care	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Heart Month	During the month of February, The Center for Heart & Vascular Care conducts a series of educational sessions and health screenings for Montefiore associates and for residents of the Bronx. The Center conducts lectures about heart health and healthy lifestyles as well as blood pressure screenings and counseling sessions at all Montefiore campuses, in senior citizen centers, local elementary schools, colleges and health centers.	Increase in blood pressure screenings; Increase in cardiac health	Prevent Chronic Diseases
Hepatitis C Support Group	The Hepatitis C Support group is a supportive service for adults with Hepatitis C. Topics of discussion include disease	Increase in patient satisfaction for individuals with	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	management, treatment options, side effects, compliance and coping with relational and psychological impacts of disease and treatment.	Hepatitis C	
HPV Vaccine Clinic	The HPV Vaccine clinic is a stand-alone clinic open to the Montefiore community and local medical providers. It offers vaccines, education and counseling to women ages 19-26 in an effort to reduce the spread of sexually-transmitted HPV infection and the onset of cervical cancer. Before the creation of the program, many OB/GYN clinics, and providers of women's health in 19-26 year olds in the community had stopped providing the	Increase in HPV vaccination rate	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	vaccine to women in this age bracket due to insufficient Medicaid coverage and low reimbursement. The clinic also seeks to correct billing issues and allow for vaccines to be provided through sponsored programs to low income women in order to make vaccine administration cost effective. This site also offers participation in ongoing research projects as well.		
Integrated Medicine and Palliative Care Team (IMPACT)	IMPACT is an interdisciplinary service that provides integrative palliative care to for pediatric patients facing life threatening or life limiting disease, and their care givers. Services	Increase in patient satisfaction	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	include palliative and end-of-life care, pain management, mental health services, acupuncture, essential oil therapy, Reiki, yoga, massage, healing touch, nutrition and supplements, cooking classes, herbal medicine and homeopathy, among others. The team educates students and staff on palliative care and conducts research to measure the effectiveness of its interventions. It conducts research to measure to measure the effectiveness of its interventions. IMPACT		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Lead Poisoning Prevention Program	A designated NYS Resource Center for Lead Poisoning Prevention, the LPPP consists of a multidisciplinary team in medicine, research, social services, environmental investigation, and public advocacy. It serves as a referral center for the medical management of lead poisoning, links families to safe housing during home abatement procedures, provides bilingual educational workshops, advocates for lead poisoned children during local and state legislative reviews and collaborates with city and private agencies in environmental intervention.	Decrease in lead poisoning	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

Program Name	**Description**	**Intervention Measures**	**NYS Prevention Agenda**
LINCS Program at CHAM	LINCS is a medical home that provides comprehensive primary care and care coordination in outpatient, inpatient and home care settings to children (0-21) with complex, chronic and life-limiting conditions. The program incorporates a palliative care consultation service that provides ongoing care to children in community-based home hospices. Additionally, the program delivers comprehensive primary care to siblings during and after their brothers and sisters have passed away.	Increase in patient satisfaction; Increase in accessibility of primary care services available to children	Prevent Chronic Disease; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Liver Transplant Support Group	The Liver Transplant Support Group is a psycho-educational program for pre- and post-liver transplant patients and their families. Led by two social workers and a psychiatrist, the groups focus on expectations and challenges pre and post liver transplant, learning signs and symptoms of liver disease, disease management, and strengthening coping skills in a mutually supportive environment.	Increase in patient satisfaction for liver transplant patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
Medical House Calls Program	Through medical home visits, the CMO helps chronically ill, at-risk geriatric and adult patients who have a history of multiple inpatient admissions and are	Increase in patient satisfaction; Increase in accessibility of primary care	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	homebound. A team of primary care physicians provide medical care. The program is also supported by social workers, outreach specialists and nurses who collaborate to address a variety of psychosocial concerns affecting the patients medical condition. The program has the capacity to care for 750 patients.	services	
Mobile Dental Van	The Mobile Dental Van provides dental care to patients at MMC affiliated schools that do not have permanent dental services. Staffed by a dentist and a hygienist and equipped with two dental chairs, a digital X-Ray system and a billing system, the van operates	Increase in proportion of individuals receiving dental care	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	five days per week and visits schools on a rotating schedule.		
Montefiore School Health Program	MSHP is the largest and most comprehensive school-based health care network in the United States. It has 20 school-based health center sites that provide primary care, mental health, oral health and community health services to patients regardless of citizenship status and ability to pay. All sites are federally qualified or partially qualified health centers. Included in MSHP is the Healthy Kids program, comprised of an array of evidence-based prevention activities	Increase in proportion of students receiving health care	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	focused on increasing physical activity and healthy eating in Bronx children and their families.		
Mosholu Preservation Corporation (MPC)	MPC is a non-profit organization committed to preserving and revitalizing Bronx neighborhoods by improving housing and promoting economic and community development. It is governed by a Board of Directors made up of Montefiore trustees and management, community leaders and development experts who serve in a pro bono capacity.	Increase in local economy; Increase in preservation of neighborhoods	Promote a Healthy and Safe Environment

Program Name	Description	Intervention Measures	NYS Prevention Agenda
New Directions Recovery Center and Chemical Dependency Program - Medically Supervised Outpatient	Montefiore has two medically supervised outpatient programs. These programs treat adults with alcohol and/or drug abuse/dependence. Multidisciplinary teams at each site can also treat psychiatric disorders and address medical and psychosocial issues that may be associated with alcohol and drug use.	Decrease in alcohol and drug abuse	Promote Mental Health and Prevent Substance Abuse
New York Children's Health Project (NYCHP)	NYCHP delivers critically needed health care services to homeless families and street-involved youth at 13 sites across New York City. The families served hail from impoverished neighborhoods with few quality health care resources, and when	Increase in accessibility of health care services to homeless individuals	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	homeless they face innumerable access barriers. The program launched with one mobile medical clinic and is now one of the largest providers of health care to homeless children in New York City. NYCHP's innovative service delivery model is comprised of fully equipped mobile clinics, small clinics in shelters, and a full-time health clinic in the South Bronx. A wide array of services is provided to attend to the complex health and psychosocial needs of homeless children, adolescents and adults:• Comprehensive primary care• Asthma care (Childhood Asthma Initiative)• Women's		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	health care• Dental care• Mental health counseling, assessment, crisis intervention, and referrals• Substance abuse prevention and referrals• Case management• Emergency food assistance• Children's nutrition education and physical activity program ("Cooking, Healthy Eating, Fitness and Fun" or CHEFFs)• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call NYCHP was one the first mobile medical programs in the country to achieve Level 3 Patient Centered Medical Home (PCMH 2008) recognition from National Committee for		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	Quality Assurance (NCQA). NYCHP maintains a Community Advisory Board (CAB) comprised of consumers/patients; CAB meetings are held each quarter at a different homeless family shelter and often include members new to the system. NYCHP relies on the CAB's input to ensure the effectiveness of services and that care remains responsive to the needs of the special population served.		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Office of Community and Population Health	Working closely with colleagues at Montefiore, the Albert Einstein College of Medicine and partners from a wide range of institutions, governmental agencies and community-based organizations, the Office of Community Health, a part of the Department of Community & Population Health, identifies community health needs, shares information about community health services and promotes collaborative interventions. The Office also develops effective strategies and methods to evaluate the impact of interventions on community health needs.	Increase in accessibility to health care; Increase in community-based health interventions	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Office of Community Relations	By functioning as the link between the community and the medical center's resources, the Office of Community Relations develops positive collaborations with community-based organizations, government agencies and elected officials in the regions served by Montefiore.	Increase in community-based health interventions	Promote a Healthy and Safe Environment
Internship Program	The Office of Volunteer and Student Services and the Learning Network recruits, orients and processes interns for the medical center, including high school, college and master's level students.	Increase in satisfaction of interns	Promote a Healthy and Safe Environment
Oral Head and Neck Screening	Screening for Oral Head and Neck Cancer. Event takes place at MECCC in	Increase in screening for Oral Head and	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	April.	Neck Cancer; Decrease in Oral Head and Neck Cancer	
Organ/Tissue Donor Program	The Organ/Tissue Donor Program raises awareness about organ/tissue donation and transplantation within the Montefiore and Bronx communities. Through educational initiatives and a range of recruitment activities, the program helps potential donors understand the importance of donation and encourages them to join the donor registry. The program is further responsible for ensuring that potential donor candidates are referred to the local Organ	Increase in educational programs about organ donation; Increase in number of people who join the donor registry	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	Procurement Organization. The ultimate goal is to ensure that every person who needs an organ/tissue donation receives one		
Ostomy Support Group	The Ostomy Support Group is a supportive service for community members who have undergone any kind of Ostomy diversion, regardless of their affiliation with the hospital. Seasoned participants help new members cope with challenges in their disease process. Each group lasts for eight sessions and also functions as a referral source for the Dept. of Psychosocial Medicine at	Increase in general satisfaction of individuals who have undergone ostomy diversion	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	Einstein when members need one-on-one counseling.		
Parent-to-Parent Support Group for Heart Transplants	Our program offers an educational forum for pre and post-transplant patients (21-75). The pre transplant patients get to know the transplant team and learn how to remain an active transplant candidate. The post transplant patients learn about all the issues that affect them after a kidney transplant. The environment is supportive and the patients are around others going through the same experiences. The support group provides the	Increase in patient satisfaction for heart transplant patients; Increase delivery of transplant information to patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	opportunity for patients to share stories, information, get advice, and receive emotional and spiritual support outside the family structure. It continues to be a great success.		
Phoebe H. Stein Child Life Program	The Child Life Program minimizes the stress of hospital and outpatient visits for pediatric patients and their families through educational and supportive services. In all areas of the hospital, Child Life Specialists help children understand and prepare for their medical experiences. Specialists accompany children to the operating room or to other procedures, teach parents to help their children cooperate with medical	Increase in patient satisfaction; Increase in satisfaction of patients' families	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	treatment and encourage normal growth and development.		
Pregnancy Prevention Program in School Health	The Pregnancy Prevention Program provides confidential reproductive and sexual health services, mental health services, and population based prevention and health promotion programs on the classroom, school and local community levels at nine Bronx high school campuses housing 34 schools. An example is the Reducing the Risk curriculum was introduced through ninth grade classrooms to bring a validated sex education curriculum to all ninth	Decrease in unplanned teen pregnancy; Decrease in STI transmission in teens; Increase in high school graduation rates; Increase in sexual education programs	Promote Healthy Women, Infants and Children; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	grade students. The program aims to decrease rates of unplanned teen pregnancy and STI transmission and to increase rates of high school graduation. Reducing the Risk is one of the first rigorously evaluated sexual education curricula to have a measurable impact upon behavior. The program is delivered the curriculum to students in the ninth grade before many become sexually active.		
Prostate Cancer Screening	Montefiore Medical Center in partnership with the Daily News offering free PSA blood tests for men age 40 and over. Event runs for 4 days in	Increase in Prostate Cancer screening; Decrease in Prostate Cancer	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	June at various Montefiore sites.		
Psychosocial Oncology Program	The Psychosocial Oncology Program offers free counseling to those affected by cancer. Serving as the umbrella over a range of initiatives, the program includes Bronx Oncology Living Daily (BOLD Living) Program offering free wellness, creative arts, and mind-body workshops, a Yoga research program, Mind-Body Support Group, Be BOLD-Quit Smoking group, and BOLD Buddies. Supportive services are designed according to the interests and needs of participants. For instance, BOLD Buddies offers treatment companions	Increase in patient satisfaction of Oncology patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	and phone support to socially isolated cancer patients.		
Regional Perinatal Center	Perinatal Center, on of 18 in the state, Montefiore is a critical referral source for specialized clinical care in high risk obstetrics and neonatology. Montefiore participates in ongoing education, evaluation, data collection and quality improvement efforts with other certified hospitals and affiliates	Increase in availability of critical obstetric and neonatal care	Promote Healthy Woman, Infants and Children
Renal Disease Young Adult Group	The program runs a support group for young adults ages 18-30 years who are diagnosed with	Increase in patient satisfaction for individuals with	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	End Stage Renal Disease. The support group affords participants the opportunity to share their emotions and concerns with each other and with professional staff.	End Stage Renal Disease	
Respiratory Disease Management	Through telephonic outreach, health coaching and home visits to higher-risk patients, the CMO aims to improve the health of patients with asthma and chronic obstructive pulmonary disease. Members who were enrolled in our population based program, by either receiving age appropriate educational mailings, or went to ER or were admitted- received an educational call to follow	Decrease in symptomatic asthma and chronic obstructive pulmonary disease	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	up on their condition.		
School Re-Entry Team	The School Re-entry Team coordinates communication between the hospital and school settings in order to promote the best possible transition back to school for CHAM cancer and sickle cell patients.	Increase in satisfaction of cancer and sickle cell patients	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
South Bronx Health Center for Children and Families (SBHCCF) and the Center for Child Health Resiliency	A unique family-centered health care program, SBHC serves the Morrisania and Hunts Point-Longwood neighborhoods of the South Bronx, one of the nation's most medically underserved, at-risk communities. SBHC is a Federally Qualified Health Center (FQHC) program that offers patients access to an enhanced medical home, a model of care that addresses all of their health care needs, and includes:• Primary care for children, adolescents and adults• Women's health and prenatal care• HIV testing, counseling, and primary care• Mental health counseling• Case management• Dental care• Nutrition	Increase in accessibility of health care; Increase in utilization of health services	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	counseling• WIC referrals• Substance abuse prevention and referrals• Emergency food assistance• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call SBHC's Center for Child Health and Resiliency (CCHR), opened in 2011, is a state-of-the-art facility with a special focus on early childhood development beginning prenatally through 5 years of age. CCHR's innovative programming supports families and equips parents with the nurturing skills needed to overcome stressors detrimental to children's healthy development. SBHC also		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	offers innovative health programs on-site and in the local neighborhood that provide intensive care management, group sessions, and culturally appropriate health education:• Childhood Asthma Initiative• Starting Right, a childhood obesity initiative, nutrition education and fitness program• Diabetes Program• HIV/AIDS Program• Pregnancy Group, prenatal visits with the benefit of group support and in-depth education• Well Baby Group, pediatric visits for infants up to 2 years • Healthy Teens Initiative and access to confidential reproductive health services		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	SBHC is recognized by the National Committee for Quality Assurance (NCQA) as a Physician Practice Connections® – Patient-Centered Medical Home™ (PPC-PCMH) Program at Level 3 Recognition, the highest level available. SBHC maintains an active Community Advisory Board (CAB) comprised of public housing residents and representatives of the South Bronx community (from tenant associations, schools, community based organizations, etc.). The CAB provides invaluable feedback on future plans, service changes, community changes/events, and strategies to draw in new		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	health center patients.		
Strength Through Laughter and Support Program	Strength through Laughter and Support is an educational program that encourages participants to develop a positive attitude as they confront the challenges associated with cancer. By sharing laughter, sadness, wisdom and love in the group	Increase in patient satisfaction and quality of life of individuals with cancer	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	setting, participants find a sense of hope that helps them face the realities of living with and beyond their illness. Groups range in size from 20 to 60 participants.		
Substance Abuse Treatment Program, Methadone Program	The SATP consists of two opioid treatment programs for opioid-dependent adults. Both sites provide integrated primary, mental health, HIV and substance abuse care.	Increase in access to health care services for opioid-dependent adults	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Supporting Healthy Relationships	Supporting Healthy Relationships is an educational program for low-income Bronx couples that enhances relationships, fosters child development and provides economic benefits to its	Decrease in partner abuse; Increase in healthy relationships	Promote Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	participants. The program plays an important role in the community as research shows that parental conflict is strongly correlated to poverty.		
Suzanne Pincus Family Learning Place (FLP)	The FLP is a health information and resource center at CHAM that provides families with educational materials about child health and disease, community resources and available supportive services. The FLP's objective is to empower families to make informed decisions about their children's health care and support the principles of family-centered care. The program also assists medical providers by supplying them with	Increase in satisfaction of CHAM patients and their parents	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	materials to educate families.		
The J.E. and Z.B. Butler Child Advocacy Center	The JE&ZB Butler Child Advocacy Center (CAC), established in 1984, is the only medically based, fully accredited child advocacy center in the NYC dedicated to breaking the cycle of abuse. The CAC provides emergency medical care and psychosocial evaluations and therapy to children (0-18) who been victimized by sexual and physical abuse and/or neglect. Butler's dedicated team of doctors, social workers and psychologists also provide education and	Decrease in child abuse; Increase in access to care services for children who have been abused	Promote a Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	training of health professionals and law enforcement personnel, and conducts outreach and research.		
University Behavioral Associates	UBA is the major case management agency within Montefiore's Health Home (Bronx Accountable Health Network). UBA has an enrolled census of 4,000 (largest in NYS). And will include the Children's Health Home programs as well.		Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Women, Infants and Children (WIC) Program	Montefiore's WIC program is the oldest in New York State, established in 1974, and serves 13,000 women, infants and children. WIC is a supplemental nutrition program, providing supplemental food vouchers, nutrition education, breast feeding education, peer counseling and physical fitness education. Women are pre-screened for the program and receive a medical referral to the WIC program from providers, they qualify based on their income. Once they are screened, they receive counseling with a nutritional counselor. Vouchers are distributed for supermarket purchases on	Increase in healthy eating; Increase in consumption of fruits and vegetables; Increase in breast feeding; Increase in exercise; Decrease in BMI; Decrease in obesity	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	a monthly basis for three months' worth of fruits, vegetables, milk, eggs, juice, beans, bread, peanut butter, etc. Counselors encourage breastfeeding for new babies. At six months, new mothers receive vouchers for baby food and cereal. At 12 months, no more formula vouchers are given. Participants see a nutritionist every 3 months and qualification is verified annually. Group education, physical education and food demonstrations are given as well. Montefiore provides space and referrals.		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Wound Healing Program	The Wound Healing Program provides inpatient, outpatient, nursing home and home visiting wound healing services. The program focuses on building innovative, patient-centered health services delivery systems that work for wound patients in order to provide excellence in care and to improve wound healing outcomes in the Bronx.	Increase in positive outcomes for wound healing patients	Prevent Chronic Diseases

Web based Resources

There is an extensive set of resources that are available to meet the needs of Westchester residents which cannot be met entirely by Montefiore program and services, or that choose to utilize external organizations. Multiple free and low cost internet databases have entered 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.

Since the previous version of this report in 2016, Montefiore has begun using the internet 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 Montefiore sites have been introduced to this new online resource and work is underway to more seamlessly integrate this kind of solution into the various workflows across the ambulatory, ED and inpatient settings. As Montefiore is an organization that works with complex health needs and whose community faces multi-factorial crises that impact upon overall health, providing information, accessibility and review of such external resources and links provides additional information on available resources to address community needs for our community partners.

The use of an internet database will allow Montefiore 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. Montefiore 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 Westchester residents.

Dissemination Strategy

The plan to disseminate the delivery of the Montefiore Medical Center 2019-2021 Community Health Needs Assessment and Implementation Strategy Report to the public will occur across a number of platforms:

The Community Health Needs Assessment and Implementation Strategy Report will be posted to the www.montefiore.org website at the specific address https://www.montefiore.org/documents/communityservices/MNR-MMV-Community-Health-Needs-Report-2019-2021.org.

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 particular community interests.

The Community Health Needs Assessment and Implementation Strategy Report will be mailed sent via email to members of the Montefiore Community Advisory Boards, as well as provided to community leaders and elected officials. To facilitate this distribution, a copy of the direct link is also provided specifically to the distribution link of the Office of the Bronx Borough President, which maintains the borough's largest electronic communication list and can provide dissemination beyond the traditional healthcare partners.

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

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

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

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

Appendix

Appendix A. 2019 Westchester County Community Health Survey

2019 Westchester County Community Health Survey

There are many areas where the healthcare system can make efforts to improve community. We are interested in knowing the areas the healthcare system should prioritize in Westchester County, NY. Your opinion on priorities for both community health and your own personal health are of interest. Your responses are anonymous. Please only complete this survey if you are 18 years-old or older. Thank you for your participation!

The first few questions are about the health needs of the COMMUNITY WHERE YOU LIVE.

What THREE areas do you see as being priority health needs in the COMMUNITY WHERE YOU LIVE?	
☐ Antibiotic resistance and healthcare associated infections	☐ Child and adolescent health
☐ Chronic disease screening and care for conditions like asthma, diabetes, cancer and heart disease	☐ Environments that promote well-being and active lifestyles
☐ Food safety and chemicals in consumer products	☐ Food and nutrition
☐ Hepatitis C	☐ HIV/AIDS
☐ Injuries, such as falls, work-injuries or traffic-injuries	☐ Maternal and women's health
☐ Mental health	☐ Newborn and infant health
☐ Outdoor air quality	☐ Physical activity
☐ Smoking, vaping and secondhand smoke	☐ Sexually transmitted diseases
☐ Substance use disorders	☐ Vaccinations/immunizations
☐ Violence	☐ Water quality

What THREE actions would be most helpful to improve the health of the COMMUNITY WHERE YOU LIVE?		
☐ Access to dental care	☐ Access to education	☐ Access to healthier food
☐ Access to primary care	☐ Affordable housing	☐ Breastfeeding support
☐ Caregiver support	☐ Clean air & water	☐ Domestic violence prevention/victim support
☐ Drug & alcohol treatment services	☐ Employment opportunities	☐ Exercise & weight loss programs
☐ Health insurance enrollment	☐ Health screenings	☐ Home care services
☐ Improving racial equality	☐ Immigrant support services	☐ Mental health services
☐ Quality and affordable childcare	☐ Safe places to walk & play	☐ Services for LGBTQ population
☐ Services for older adults	☐ Smoking & tobacco services	☐ Public transportation
☐ Violence prevention		

What population needs the greatest attention?

☐ Infants ☐ Young children ☐ School-aged children ☐ Teens ☐ Young adults ☐ Middle-aged adults ☐ Older adults

The rest of the survey is about YOU and YOUR health needs.

What THREE areas do you see as being priority health needs for YOURSELF?	
☐ Antibiotic resistance and healthcare associated infections	☐ Child and adolescent health
☐ Chronic disease screening and care for conditions like asthma, diabetes, cancer and heart disease	☐ Environments that promote well-being and active lifestyles
☐ Food safety and chemicals in consumer products	☐ Food and nutrition
☐ Hepatitis C	☐ HIV/AIDS
☐ Injuries, such as falls, work-injuries or traffic-injuries	☐ Maternal and women's health
☐ Mental health	☐ Newborn and infant health
☐ Outdoor air quality	☐ Physical activity
☐ Smoking, vaping and secondhand smoke	☐ Sexually transmitted diseases
☐ Substance use disorders	☐ Vaccinations/immunizations
☐ Violence	☐ Water quality

Would you say that in general your health is:	☐ Excellent	☐ Very good	☐ Good	☐ Fair	☐ Poor

Do you have somebody that you think of as your personal doctor or health care provider?	☐ Yes	☐ No

Has a doctor, nurse or other health professional told you that you had any of the following (check all that apply)?			
☐ Heart disease	☐ Stroke	☐ Asthma	☐ Depression/anxiety
☐ Skin cancer	☐ Cancer (not including skin cancer)	☐ COPD, emphysema or chronic bronchitis	
☐ Arthritis	☐ Kidney disease	☐ Diabetes (not including during pregnancy)	

Was there a time in the past year 12 months when you needed to see a doctor but could not because of the following ...?								
..Cost	☐ Yes	☐ No	..Transportation	☐ Yes	☐ No	..Could not get appointment at time that worked	☐ Yes	☐ No

What type of insurance do you use to pay for your doctor or hospital bills (check all that apply)?			
☐ Your employer or a family member's employer	☐ The New York State Marketplace (Exchange)	☐ Medicare	☐ Medicaid
☐ Military (TriCare or VA)	☐ COBRA	☐ I do not have health insurance	☐ Other: ___________

During the past 30 days, have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on any of the following...								
...Race or ethnicity	☐ Yes	☐ No	...Gender identity	☐ Yes	☐ No	...Age	☐ Yes	☐ No
...Sexual orientation	☐ Yes	☐ No	...Perceived immigration status	☐ Yes	☐ No	...Religion	☐ Yes	☐ No
...Disability	☐ Yes	☐ No						

The next set of questions will be used to describe who responds to the survey and will not be examined individually. Please remember that your responses are anonymous.

What is your current gender identity?	☐ Female ☐ Male ☐ Trans female/trans woman ☐ Trans male/Trans man ☐ Genderqueer/gender non-conforming ☐ Different identity (please state): _________________
What is your age?	☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75+

What is the highest grade or year of school you completed?	☐ Less than high school	☐ High school graduate/GED
☐ Some college or technical school	☐ College graduate	☐ Advanced or professional degree

What is the ZIP Code where you currently live?	_ _ _ _ _	Are you of Hispanic or Latino/a origin?	☐ Yes ☐ No

Which one the following best describes your race?		
☐ White	☐ Black or African American	☐ Asian/Pacific Islander
☐ American Indian/ Alaska Native	☐ Multi-racial	☐ Other : ___________________

Are you currently...? (CDC categories)	☐ Employed for wages	☐ Self employed	☐ Out of work
☐ A homemaker	☐ Student	☐ Retired	☐ Unable to work

What is the primary language spoken in your home?						
☐ English	☐ Spanish	☐ Italian	☐ Portuguese	☐ Chinese	☐ French	☐ Other: _________________

Appendix B. Top 20 Inpatient Discharges and Top 20 Reasons for Treat-and Release Emergency Department (ED) Visits for Montefiore Mount Vernon

Table 1. Top 20 inpatient discharges at Montefiore Mt. Vernon Hospital, 2018

ICD-10 Code	Label	Discharges	% of total
E11	Type 2 diabetes mellitus	156	4.6%
A41	Other sepsis	152	4.5%
F20	Schizophrenia	111	3.3%
R55	Syncope and collapse	98	2.9%
I13	Hypertensive heart and chronic kidney disease	96	2.8%
R07	Pain in throat and chest	92	2.7%
F25	Schizoaffective disorders	87	2.6%
J44	Other chronic obstructive pulmonary disease	79	2.3%
J45	Asthma	70	2.1%
F31	Bipolar disorder	65	1.9%
L03	Cellulitis and acute lymphangitis	63	1.9%
F32	Major depressive disorder, single episode	56	1.6%
G40	Epilepsy and recurrent seizures	52	1.5%
F10	Alcohol related disorders	49	1.4%
J18	Pneumonia, unspecified organism	48	1.4%
I63	Cerebral infarction	46	1.4%
I11	Hypertensive heart disease	43	1.3%
E87	Other disorders of fluid, electrolyte and acid-base balance	42	1.2%
I82	Other venous embolism and thrombosis	41	1.2%

D57	Sickle-cell disorders	39	1.1%
-	Other diagnoses	1918	56.4%

Data source: Internal Montefiore Health System data, 2018

Summary of the primary discharge diagnoses codes for inpatient discharges at Montefiore Mount Vernon hospital in 2019 among Westchester County residents. Across Montefiore Mount Vernon, the top three diagnoses across the ICD-10 coding were Type 2 Diabetes Mellitus, Sepsis, and Schizophrenia.

Table 2. Top 20 reasons for treat-and-release ED visits at Montefiore Mt. Vernon Hospital, 2018

ICD-10 Code	Label	Visits	% of total
R07	Pain in throat and chest	779	4.0%
M54	Dorsalgia	768	3.9%
M25	Other joint disorder, not elsewhere classified	710	3.6%
R10	Abdominal and pelvic pain	709	3.6%
J45	Asthma	509	2.6%
Z53	Persons encountering health services for specific procedures and treatment, not carried out	502	2.6%
J06	Acute upper respiratory infections of multiple and unspecified sites	437	2.2%
M79	Other and unspecified soft tissue disorders, not elsewhere classified	416	2.1%
F10	Alcohol related disorders	381	2.0%
R05	Cough	341	1.8%
S01	Open wound of head	335	1.7%
S61	Open wound of wrist, hand and fingers	323	1.7%
R51	Headache	320	1.6%
J02	Acute pharyngitis	318	1.6%
R11	Nausea and vomiting	300	1.5%
N39	Other disorders of urinary system	280	1.4%
E11	Type 2 diabetes mellitus	231	1.2%
R42	Dizziness and giddiness	230	1.2%
R06	Abnormalities of breathing	223	1.1%

Z76	Persons encountering health services in other circumstances	218	1.1%
-	Other diagnoses	11,123	57.2%

Data source: Internal Montefiore Health System data, 2018

Summary of primary treat-and-release Emergency Department (ED) visits at Montefiore Mount Vernon hospital in 2019 among Westchester County residents. Across Montefiore Mount Vernon, the top three diagnoses across the ICD-10 codes were Pain in Throat and Chest, Dorsalgia, and Other Throat Disorder.

Appendix C. Top 20 Inpatient Discharges and Top 20 Reasons for Treat-and Release Emergency Department (ED) Visits for Montefiore New Rochelle

Table 3. Top 20 inpatient discharges at Montefiore New Rochelle Hospital, 2018

ICD-10 Code	Label	Discharges	% of total
Z38	Liveborn infants according to place of birth and type of delivery	860	12.0%
A41	Other sepsis	389	5.4%
M17	Osteoarthritis of knee	270	3.8%
I13	Hypertensive heart and chronic kidney disease	141	2.0%
E11	Type 2 diabetes mellitus	140	1.9%
O34	Maternal care for abnormality of pelvic organs	139	1.9%
N17	Acute kidney failure	138	1.9%
M16	Osteoarthritis of hip	118	1.6%
J44	Other chronic obstructive pulmonary disease	117	1.6%

O48	Late pregnancy	107	1.5%
I63	Cerebral infarction	104	1.4%
I11	Hypertensive heart disease	101	1.4%
L03	Cellulitis and acute lymphangitis	99	1.4%
J96	Respiratory failure, not elsewhere classified	97	1.4%
J18	Pneumonia, unspecified organism	94	1.3%
K56	Paralytic ileus and intestinal obstruction without hernia	93	1.3%
K92	Other diseases of digestive system	81	1.1%
K57	Diverticular disease of intestine	80	1.1%
I21	Acute myocardial infarction	79	1.1%
F10	Alcohol related disorders	77	1.1%
-	Other diagnoses	3,856	53.7%

Data Source: Internal Montefiore Health System data, 2018

Summary of the primary discharge diagnoses codes for inpatient discharges at Montefiore New Rochelle hospital in 2019 among Westchester County residents. Across Montefiore New Rochelle, the top three diagnoses across the ICD-10 coding were Liveborn Infant, Other Sepsis, and Osteoarthritis of the knee.

Table 4. Top 20 reasons for treat-and-release ED visits at Montefiore New Rochelle Hospital, 2018

ICD-10 Code	Label	Visits	% of total
R07	Pain in throat and chest	1269	3.7%
R10	Abdominal and pelvic pain	1145	3.4%
J06	Acute upper respiratory infections of multiple and unspecified sites	947	2.8%
M54	Dorsalgia	926	2.7%
S61	Open wound of wrist, hand and fingers	807	2.4%
F10	Alcohol related disorders	719	2.1%
M25	Other joint disorder, not elsewhere classified	713	2.1%
J02	Acute pharyngitis	690	2.0%
S01	Open wound of head	653	1.9%
M79	Other and unspecified soft tissue disorders, not elsewhere classified	626	1.8%
O26	Maternal care for other conditions predominantly related to pregnancy	611	1.8%
N39	Other disorders of urinary system	607	1.8%
R11	Nausea and vomiting	604	1.8%
J45	Asthma	582	1.7%
R05	Cough	572	1.7%
R42	Dizziness and giddiness	505	1.5%
R50	Fever of other and unknown origin	486	1.4%
Z00	Encounter for general examination without complaint, suspected or reported diagnosis	473	1.4%

S09	Other and unspecified injuries of head	467	1.4%
R51	Headache	465	1.4%
-	Other diagnoses	20,003	59.1%

Data source: Internal Montefiore Health System data, 2018

Summary of primary treat-and-release Emergency Department (ED) visits at Montefiore New Rochelle hospital in 2019 among Westchester County residents. Across Montefiore New Rochelle, the top three diagnoses across the ICD-10 codes were Pain in Throat and Chest, Abdominal and pelvic pain, and Acute upper respiratory infections of multiple and unspecified sites.