Community Health Needs Assessment and Implementation Strategy Report 2019-2021

Montefiore Medical Center

Office of Community & Population Health

12/30/2019

This document is submitted as the requirement for the 2019-2021 Internal Revenue Service Community Health Needs Assessment & Implementation Strategy Report

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The Community Health Needs Assessment and Implementation Strategy Report 2019-2021 contains data representing Bronx County, the northernmost county of New York City and the third most densely populated county in the United States. This document is submitted as the requirement for the 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 the Bronx, County, New York.

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

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Executive Summary

Introduction

Montefiore Medical Center – in partnership with multiple Bronx hospital and healthcare providers, community stakeholders including the New York City Department of Health and Mental Hygiene's Bronx Health Bureau, community organizations and community residents, has conducted the 2019 Community Health Needs Assessment to identity the significant health concerns of Bronx County.

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

Community Health Needs Assessment Process and Methods

Given the complexity and diversity of the populations of the Bronx, the process to identify the needs of the community involved the collection of 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 framed the development of the Implementation Strategy.

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. As the New York City Department of Health and Mental Hygiene did not engage in a separate primary data collection process during this assessment cycle, the concern of survey fatigue was less present. The NYCDOHMH's provision of comprehensive borough specific data assisted the process of interpreting areas of need across the borough.

In addition to data provided from New York City sources, multiple additional secondary data sources were used to support the identification and selection of the priority items which were selected and reviewed with the partners.

The collection of primary data from a representative sample of Bronx residents was an important element of the development of the Community Health Needs Assessment. To capture the voices of various sectors of Bronx community residents and workers from various perspectives, a multi-lingual electronic survey directed through partnering Bronx organizations was used. Using data collected through these sources, the impact on the community's health by the interventions implemented was measured and analyzed.

Input Representing Broad Interests of the Community

The communities of the Bronx are not homogeneous. While the Bronx is New York City's youngest borough, it also has the distinction as the borough with the second largest number of languages spoken at home, as well as having New York City's smallest non-Hispanic White population. Age, ethnic and cultural diversity elements have necessitated the evaluation of disparities and inequities facing the populations we serve. The identification of priority areas selected has been enhanced through the input from the New York City Department of Health and Mental Hygiene's Bureau of Bronx Neighborhood Health.

Montefiore Medical Center facilitated strong relationships with community groups. The Montefiore Community Advisory Boards, which serve the Montefiore Medical Center Acute Care campuses in the Bronx consist of membership serving the twelve Bronx Community Boards and also represent key constituencies in those communities including local police precinct councils, large faith based organizations and major social service providers. The staff of Montefiore's Office of Community and Population Health and Montefiore's Office of Government and Community Relations also engages with the Bronx Borough President's duly appointed representatives of the official twelve Bronx Community Boards. In addition to receiving input from these regional boards and their community membership, the staff also solicits information from elected leaders through health focused legislative breakfasts which allow the sharing of secondary data with the local elected officials to receive confirmation or alternate opinion on the impacts felt by their constituencies.

Montefiore also participates with a number of coalitions, most notably the #Not 62 Coalition – The Campaign for a Healthy Bronx. In 2014, Montefiore lead a multi-stakeholder application to the Robert Wood Johnson Foundation's Culture of Health Prize which was awarded to the Bronx in 2015 in recognition of the significant collaborative achievements the county has made in health. However, despite these gains, the Bronx continues to have the lowest ranking in New York State, ranking 62 out of 62 in the 2019 County Health Rankings from the Robert Wood Johnson Foundation. As a founding member and ongoing participant of the #Not 62 Steering Committee Stakeholder Group, we, along with the over 90 partner organizations in the coalition to work collaboratively to address agreed on significant health issues impacting the community through continued its partnerships.

Transformative Feedback

With the previous community health assessments, Montefiore did not receive any written feedback; however, Montefiore was invited to explain its Community Benefit spending to a group of key community stakeholders led by the North West Bronx Community and Clergy Coalition (NWBCC). The NWBCC directly questioned the allocation of resources and recommended that resources be directed towards addressing the social determinants of health, specifically violence prevention efforts in the communities along the Jerome Avenue Corridor. This meeting led to an evaluation of available data on local violence, including shootings, and has resulted in a financial resources being identified from DSRIP and other budgeted sources to support a SBH System led violence prevention effort which is a part of SBH's Prevention Agenda efforts and in which Montefiore is a partner.

Definition and Description of the Community Service Area

Montefiore has identified the Bronx as its primary service area. In 2018, the population of the Bronx was 1.43 million. In the same year Montefiore Medical Center served approximately 460,000 Bronx residents, or about 32% of the total Bronx population. Montefiore has distributed the vast majority of its community-based primary care and specialty ambulatory services in the Bronx.

While the Bronx is the sixth smallest county in the nation (42.1 square miles), it is also the third densest county in the nation with 34,242 people per square mile. The Bronx is home to more than 1.4 million people. Bronx residents have access to a number of community resources including public and private schools, open spaces, healthcare facilities, community gardens, bike lanes and much more.

While the health status of the Bronx has improved in recent years, the gap between the Bronx and other boroughs remains and it has maintained. The Bronx remains a hotspot for excess mortality, diabetes, obesity, asthma, drugs/opioids, and HIV/AIDS in New York City. As the Bronx mortality rates remain significantly high, the number of physicians practicing in the Bronx continues to dwindle, earning the county a federal Health Professional Shortage Area (HPSA) designation. The Bronx has a long history as a medically designated underserved area or having a shortage of providers. These designations, Medically Underserved Area /Population (MUA) and Healthcare Provider Shortage Area (HPSA) originate from the Health Resources and Services Administration (HRSA).

Primary Data Collection Process

The primary data collection strategy used for Bronx County was to conduct a broadly distributed survey to identify community health priorities in the Bronx in alignment with the 2019-2024 New York State Prevention Agenda. Available in English and Spanish, on paper, web, mobile and through QR reader smart mobile ; and with translation services into other non-Limited English Proficiency (LEP) required languages on demand, over 4,000 surveys were collected in collaboration with the Westchester County Department of Health to support the CSPs/CHNAs for hospitals in Westchester County. 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.

Secondary Data Collection Process

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

Review of Key Findings

While the health status of the Bronx has improved in recent years, the gap between the Bronx and other boroughs remains and it has maintained. The Bronx remains a hotspot for excess mortality, diabetes, obesity, asthma, drugs/opioids, and HIV/AIDS in New York City. This section of the report summarizes some of the key health disparities in the Bronx.

Special Considerations

The Bronx, with its large population, remains a challenging population to assess comprehensively. Despite a multi-site, multi-methods, multi-lingual approach to survey distribution, the survey completion rate was lower than desired with 584 individuals documenting Bronx Zip codes completing the primary data collection tool of Community Health Needs Assessment survey. When compared to the American Community Survey, women and adults age 25-34 years old, are slightly over-represented in the survey, however the overall age and gender distribution of participants is comparable to the distribution of respondents. Also notable was the participation of an increased proportion of more highly educated residents than the Bronx overall, but the race/ethnicity distribution is comparable.

The survey was disproportionately completed by individuals who indicated that they spoke English, as opposed to Spanish at-home. While all of these factors represent possible gaps in information, the combination of both primary and secondary data helps to fill in some of the gaps and help identify community needs as identified through community input and the most recent available data for the county.

The 2019 Implementation Strategy Report

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

Significant Needs to be Addressed

Given the complexity of supportive services and programs provided across the Montefiore Health System and input from multiple sources as previously described, the needs selected for identification were done to ensure alignment with the New York State Prevention Agenda. The major category areas are Preventing Chronic Disease and Promote Well-Being and Prevent Mental and Substance Use Disorders. Based on the reported and documented health needs that were important across the populations surveyed and also reflected in the data as critical and in alignment

The first of two Priority Areas identified with key data points highlighted are to Prevent Chronic Diseases with two focus areas selected. The first focus area is (1) Healthy Eating and Food Security, for the targeted objectives to:

- Decrease the percentage of adults ages 18 years and older with obesity (among all adults)
- Decrease percentage of adults who consume one or more sugary drink per day (among all adults)
- Increase percentage of adults with perceived food security (among all adults)

The second focus area is (2) Preventative Care and Management with the targeted objectives of increasing the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%, and decreasing the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%).

The second of the two Priority Area selected is to Promote Well-Being and Prevent Mental and Substance Use Disorders with the goal selected to Prevent opioid overdose deaths, and the targeted objectives to:

- Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 1,00,000 population; and
- Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.1 per 1,000 population. Baseline: 35.9 per 1,000

One of the Priority Areas selected in 2016 have been re-selected in 2016, though the focus areas have expanded to include food security. This cycle's Priority Areas also includes work on mental and substance use disorders which is in alignment with the DSRIP work at Montefiore. DSRIP has a very strong focus on both the prevention and management of chronic diseases and behavioral health issues (including substance abuse). Given these are significant risk factors for the residents of the Bronx, we believe that it is important to continue our chronic disease prevention work in our clinics and extending our reach into the community.

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 Bronx 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 Bronx residents.

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 Medical Center. 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.

Montefiore Medical Center's 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

Organizational Background

Montefiore Medical Center – in partnership with multiple Bronx hospital and healthcare providers, community stakeholders including the New York City Department of Health and Mental Hygiene's Bronx Health Bureau, community organizations and community residents, has conducted the 2019 Community Health Needs Assessment for the 2019-2021 Community Service Plan to identity the significant health concerns of Bronx County.

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

Montefiore Medical Center is a part of Montefiore Health System - the premier academic health system and the University Hospital for Albert Einstein College of Medicine, serving the 3.1 million people living in the New York City region and the Hudson Valley. Montefiore Health System delivers science-driven care where, when and how patients and communities need it

most, combining nationally recognized clinical excellence with expertise in accountable, value-based care that focuses on its patients, their families and the community. 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.

This Community Service Plan is reflective of a segment of the programming offered at Montefiore Medical Center and will be made available to the public after review and approval of the Montefiore Medical Center Community Services Subcommittee, as an approved committee of the Board of Trustees on December 19, 2019.

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.

Montefiore's Mission Statement and Strategy:

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

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

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

Mission:

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

Vision:

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

Values:

Humanity, Innovation, Teamwork, Diversity, Equity and Quality

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

1. Create the "One Montefiore Einstein Experience"

2. Grow specialty and subspecialty care

3. Elevate Einstein's standing in research and education

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

5. Be a supportive pillar of community health

In the explicit affirmation of maximizing the Impact of our Community Service, Montefiore has focused on improving performance in this critical area through the development of the programmatic function areas including the Office of Community and Population Health and the Office of Community Relations which have been charged:

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

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

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

Description of 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 Bronx 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 the Bronx, 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 sources used to identify community health needs are described in this report. 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 Medical Center hospitals. 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 Medical Center, specifically the top 20 inpatient diagnoses and top 20 reasons for treat-and-release emergency department (ED) visits are included in Appendix B.

Description of Statistical Tests or Processes

To capture an up-to-date high-level view of the health status of Bronx residents, we evaluated temporal trends, differences between Bronx and the rest of New York City and sub-county differences, when available, for more than 20 measures, including: obesity, preterm births, teen pregnancy rates, poverty, linguistic isolation, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screening, HIV incidence, lung, colorectal, prostate and breast cancer incidence rates, and hospitalizations for asthma, diabetes, assaults, heart attacks and falls. These data were obtained from multiple population-based datasets including, but not limited to, the American Community Survey (formerly referred to simply as the Census), New York City Community Health Profiles, New York State Statewide Planning and Research Cooperative Systems (SPARCS), New York State Vital Statistics, New York City HIV/AIDS Annual Surveillance Statistics, and the New York State Cancer Registry. Additional data was obtained from the New York City Community Health Profiles and the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard. A listing of the data sources used to complete the secondary data analysis that was used to identify the issues of concern beyond experience and direct observation are listed below. The data sources used are summarized and the data themselves are presented in the following pages.

Listing of Data Sources

i. American Community Survey
ii. National Vital Statistics Surveillance System
iii. New York City Community Health Survey
iv. New York City Youth Behavior Risk Survey
v. New York State Vital Records Data
vi. New York State Statewide Planning and Research Cooperative Systems (SPARCS)
vii. New York City HIV/AIDS Annual Surveillance Statistics
viii. New York State Cancer Registry
ix. New York City Sexually Transmitted Disease Surveillance Data
x. Global Burden of Disease
xi. New York City Community Health Profiles
xii. New York State Prevention Agenda Dashboard

Input Representing the Broad Interests of the Community

The communities of the Bronx are not homogeneous. While the Bronx is New York City's youngest borough, it also has the distinction as the borough with the second largest number of languages spoken at home, as well as having New York City's smallest non-Hispanic White population. Age, ethnic and cultural diversity elements have necessitated the evaluation of disparities and inequities facing the populations we serve. The identification of priority areas selected has been enhanced through the input from the New York City Department of Health and Mental Hygiene's Bronx Health Bureau.

Montefiore Medical Center facilitated strong relationships with community groups. The Montefiore Community Advisory Boards, which serve the Montefiore Medical Center Acute Care campuses in the Bronx consist of membership serving the twelve Bronx Community Boards and also represent key constituencies in those communities including local police precinct councils, large faith based organizations and major social service providers. The staff of Montefiore's Office of Community and Population Health and Montefiore's Office of

Government and Community Relations also engages with the Bronx Borough President's duly appointed representatives of the official twelve Bronx Community Boards. In addition to receiving input from these regional boards and their community membership, the staff also solicits information from elected leaders through health focused legislative breakfasts which allow the sharing of secondary data with the local elected officials to receive confirmation or alternate opinion on the impacts felt by their constituencies.

Montefiore also participates with a number of coalitions, most notably the #Not 62 Coalition – The Campaign for a Healthy Bronx. In 2014, Montefiore lead a multi-stakeholder application to the Robert Wood Johnson Foundation's Culture of Health Prize which was awarded to the Bronx in 2015 in recognition of the significant collaborative achievements the county has made in health. However, despite these gains, the Bronx continues to have the lowest ranking in New York State, ranking 62 out of 62 in the 2019 County Health Rankings from the Robert Wood Johnson Foundation. As a founding member and ongoing participant of the #Not 62 Steering Committee Stakeholder Group, we, along with the over 90 partner organizations in the coalition to work collaboratively to address agreed on significant health issues impacting the community through continued its partnerships.

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

Montefiore's executive leadership and Board of Trustees support these efforts through the Office of Community and Population Health. Montefiore's Office of Community and Population Health developed a community level approach involving relevant community based organizations interested in the particular health issues being addressed. This provides for a closer alignment between the community level goals of Montefiore and the organizational goals of the community organizations. This approach is the Collective Action to Transform Community Health (CATCH) Program, which is a community level coalition bringing together aspects of the community that may have a significant impact on community health.

The report provides information on the individuals, groups and organizations that are participating in the focused Implementation Plan activities that evolve out of the CHNA process. 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.

Stakeholder, Partner and Community Feedback

With the previous community health assessments, Montefiore did not receive any written feedback; however, Montefiore was invited to explain its Community Benefit spending to a group of key community stakeholders led by the North West Bronx Community and Clergy Coalition (NWBCC). The NWBCC directly questioned the allocation of resources and recommended that resources be directed towards addressing the social determinants of health, specifically violence prevention efforts in the communities along the Jerome Avenue Corridor. This meeting led to an evaluation of available data on local violence, including shootings, and has resulted in a financial resources being identified from DSRIP and other budgeted sources to support a SBH System led violence prevention effort which is a part of SBH's Prevention Agenda efforts and in which Montefiore is a partner.

Definition/ Description of the Community Service Area

Description of the Population/ Community Served by the Hospital: The Bronx

Montefiore has identified the Bronx as its primary service area. In 2018, the population of the Bronx was 1.43 million. In the same year Montefiore Medical Center served approximately 460,000 Bronx residents, or about 32% of the total Bronx population.

The Bronx is the nation's poorest urban county; 28% of the population lives in poverty (compared to 15.9% citywide) and the median household income is $37,397 (compared to $56,942 in Brooklyn, 64,509 in Queens, 79,201 in Staten Island and 85,071 in Manhattan). About 40% of Bronx children live below poverty; the eighth highest proportion for any county in the United States, and the highest for any urban county. The Bronx is amongst the youngest counties in New York State, with a median age of 34, trailing only Tompkins and Jefferson County. The Bronx has the 4th highest proportion of single-parent headed households with children (59.5%) among US counties.

In the Bronx, 37.6% of households received Supplemental Nutrition Assistance Program (SNAP, formerly referred to as food stamps) benefits, compared to 14.9% in New York State overall and 16.5% in the rest of NYC (excluding the Bronx). Fifty-six percent of children less than 18 years lived in a household that received some form of public assistance (including Supplemental Security Income [SSI], cash assistance or SNAP/food stamps), compared to 26.9% statewide and 29.6% in the rest of NYC.

According to the Bureau of Labor Statistics, the unemployment rate in the Bronx in 2018 was 5.7%, the 2nd highest in New York State. In 2015, 71.9% of Bronx residents ages 25 and older have received their high school diploma or GED; this is substantially lower than citywide (83.7%) and statewide (86.4%) attainment rates.

The Bronx is one of the most diverse counties in the nation according, 56.2% are Hispanic/Latino of any race, 29.0% are non-Hispanic black, 9.1% are non-Hispanic white and 3.8% are non-Hispanic Asian. More than one-third (36.4%) of Bronx residents were born outside of the United States and 55.6% of births among Bronx residents were to foreign-born mothers in 2016 according to New York City Vital Statistics data. In the Bronx, more people speak a language other than English at home (60%) than speak "only English" (40.0%); 48.0% speaks Spanish at-home. The Bronx was New York City's first borough to have a majority of people of color and is the only borough with a Latino majority. Only one county in the eastern United States have a lower proportion of Non-Hispanic whites and only one has a higher proportion of Latinos (Miami-Dade County). Its foreign-born population comes from diverse corners of the globe (in order of frequency) the Dominican Republic, Jamaica, Mexico, Ghana, Ecuador, Bangladesh, Guyana, Honduras, Nigeria, Trinidad & Tobago and Italy; with no other country of origin accounting for more than 1% of the foreign-born population. As the population in the Bronx is exceptionally diverse, improvements in the health of the general population must necessarily address racial/ethnic and socioeconomic drivers of health disparities.

More than 88% of Montefiore Medical Center's inpatient and ED discharges are residents of the Bronx, and it is within this geographic area that Montefiore has distributed the entirety of acute-care facilities and the vast majority of its community-based primary care.

Unique Community Characteristics and Resources

The Bronx is the sixth smallest county in the nation with 42.1 square miles. The Bronx is also the third densest county in the nation with 34,242 people per square mile, making it home to more than 1.4 million people. Bronx County has many resources to support its population. Bronx residents have access to a number of community resources including public and private schools, open spaces, healthcare facilities, community gardens, bike lanes and much more. Below are brief descriptions.

The assets described below were assessed in 2019 through examination of resources known to Montefiore and verified through municipal sources including the New York City government webpage, www.nyc.gov which provides information on land use, municipal sites, parks, schools and other relevant community located assets, and the New York Public Library website www.nypl.org. Additionally, Montefiore has gained knowledge of local community resources through supportive databases for patient referrals through sites like www.nowpow.com and www.hitesite.org.

Hospitals and Clinics

The Bronx has a 313 healthcare facilities, including public and private hospitals, medical clinics, federally-qualified health centers (FQHCs), community health centers, and independent community based primary care providers that provide services to the community. These clinical providers include New York City's public hospital system, and providers such as Montefiore, BronxCare, and St. Barnabas Hospital that provide primary and specialty care throughout the borough.

Local Health Department

New York City has a strong local health department, the New York City Department of Health and Mental Hygiene (NYC DOHMH) that provides population health programming and leads city-wide and national policy initiatives to improve the health of local communities. Through NYC DOHMH's local Bureau of Bronx Neighborhood Healths, community members and organizations in the Bronx have access to programs, services, and spaces for planning and organizing in the Bronx.

Open Spaces

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

Public Libraries

There are 33 public libraries in the Bronx. The public library provides a range of services to the community including, and not limited to, community events and assistance with health insurance plan enrollment through the Health Insurance Marketplace.

Public and Private Schools

The Bronx has 423 public and private schools and 8 colleges/ universities. Many schools in the Bronx continue to offer services and resources to support both the education and health needs of their student population, including health and wellness programming through the NYC Department of Education and partnerships with community organizations and health systems (for example, the Montefiore School Health Program).

Community Organizations

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

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

Institutional Assets and Programs

In addition to the broad range of community accessible assets listed above, within Montefiore there are over sixty of programs led by, or implemented in partnership with Montefiore Medical Center and fifteen major externally contracted service providers that supplement the needs of the community.

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, created by Montefiore, of some of the community programs in the Bronx that address a variety of community needs, including a brief description of the services provided and the target population. This list will be shared as part of the Community Service Plan on the hospital's website. Hard copies of the report including this list of community resources will be available upon request.

Organization/ Program	Description
Part of the Solution (P.O.T.S.)	Community organization providing homeless and low-income individuals and families with case management, a community dining room and food pantry, and clothing. Social services include benefits and entitlements screening, legal services, and more.
Dr. Martin Luther King Jr. Health Center	A Not-for-profit health center providing primary and specialty medical services and dental and optical care for patients of all ages. Services also include healthy eating classes that provide information on the importance healthy eating choices and nutrition.
BronxWorks	Organization providing social services to the Bronx community. Services include housing assistance, senior services, Single Stop social services, programming for children, teens, and youth, the Homelessness Prevention Program which provides case management and essential services to at-risk individuals and families to prevent homelessness. Individuals and families receive services that help them overcome problems with public benefits, housing, health care and other issues that could impede their ability to maintain stable households. Food pantry, soup kitchen,

	WIC registration assistance
Women's Housing and Economic Development Company (WHEDCO)	Community organization offering community members crisis intervention counseling, advocacy, education, case management, health insurance screening and enrollment assistance, referrals, SingleStop social services (including benefits and entitlements screening and enrollment assistance), and legal assistance for housing, public assistance, family law, and disability issues. They also operate a food pantry.
Bronx Community Health Network	Not-for-profit organization and Federally Funded Health Center that sponsors 21 community- and school-based health centers in the Bronx. Bronx REACH CHAMPS is working to address the overall health and wellness in the Bronx with six key initiatives focused on healthy stores, worksites, schools, day cares, parks and open spaces, as well as clinical linkages.
The Institute for Family Health's COMPASS Program	Community program that provides integration and coordinates services for people living with HIV/ AIDS in order to maintain good health through a patient-centered team that coordinates clinical services and provides case management and health education as well as behavioral health services. Behavioral health services include psychotherapy, psychiatry, psychiatric evaluations, medications, and follow up, support with depression, stress, and family problems related to HIV status, and help managing relationships that may be challenged because of HIV status.
New York City Family Center	Nonprofit organization dedicated to providing comprehensive care to families, including unemployment benefits application assistance, citizenship preparation, college prep, computer classes, ESL classes, food pantry, individual counseling, legal assistance and homelessness prevention programming.
The Bronx Defenders	Not-for-profit legal organization providing Bronx residents in need with legal representation, advocacy, and referrals. They also offer social services including food stamp assistance. The Bronx Defenders staff includes attorneys, social workers, parent advocates, investigators, administrative support, and community

	organizers.
R.A.I.N.	Multi-social service agency offering a myriad of services with a focus on the provision of continuum of care that includes a range of services for seniors and people with disabilities. R.A.I.N. has twelve Bronx based and one Manhattan based full-service neighborhood senior centers, home-delivered meals to homebound elderly, transportation services, assistance with benefits and entitlements, case management and elder abuse services, and Cucina Dolores, a community-based mobile meals program for homeless and hungry persons in the South Bronx in collaboration with the Bob and Dolores Hope Foundation.
Phipps Neighborhoods	Not-for-profit developer, owner, and manager of affordable housing in New York City, providing programming and/or education on careers, support with creating resumes, case management and social workers, and SNAP registration assistance.
Argus Community- Home and Community Based Services	A program that assists individuals enrolled in Health and Recovery Plans to receive supportive services in their own home and community.
New Settlement Community Center	Not-for-profit community recreation center providing individuals with access to recreation classes and the aquatic center, as well as information and referrals for Pre-K and school-age programs.
New York Public Library	Offers a variety of services to the residents of Melrose, including tax-filing assistance, computer programs, and ESL classes.

Secondary Data Collection Plan

In addition to the review of primary data, to capture an up-to-date high-level view of the health status of Bronx residents, we evaluated temporal trends, differences between Bronx and the rest of New York City, disparities by race/ethnicity and socioeconomic status, and sub-county differences, when available, for more than 20 measures, including: poverty, having a primary care provider, having health insurance coverage, obesity (adults and children), diabetes, teen

births, preterm births, breastfeeding, flu vaccination, receipt of colonoscopy, colorectal cancer incidence, breast cancer incidence, new HIV diagnoses, chlamydia diagnoses, preventable hospitalizations, asthma hospitalizations, fall-related hospitalizations, assault hospitalizations, smoking, opioid-related mortality, depression, and suicide. The metrics were selected as they represent the continuum of risk factors and health outcomes of interest and are publicly available. These data were obtained from multiple population-based datasets including the Global Burden of Disease Project, American Community Survey, New York City Community Health Profiles, New York City Community Health Survey, New York City Youth Risk Behavior Survey, New York State Statewide Planning and Research Cooperative Systems (SPARCS), National Vital Statistics Surveillance System, New York State Vital Statistics, New York City Vital Statistics, New York City Sexually Transmitted Diseases Surveillance Data, New York City HIV/AIDS Epidemiology Reports, and the New York State Cancer Registry. Additional data was obtained from the New York City Community Health Profiles and the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard.

In addition to the secondary data previously described, we evaluated the distribution of different primary discharge diagnoses at Bronx-based Montefiore hospitals in 2019 using data from SPARCS. This data is presented in **Appendix B**.

BRONX SECONDARY DATA SOURCES

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

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

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

New York City Community Health Survey: The New York City Community Health Survey (CHS) is an annual telephone survey of approximately 10,000 NYC adults, of which about 15-20% live in the Bronx. The complex survey is conducted in English, Spanish, Russian and Chinese (Mandarin and Cantonese) and provides a representative sample of NYC adult residents. Addressing a wide range of topics, in the current report CHS data were used to estimate the percent of adults with a primary care provider, the percent of adults who are obese, the percent of adults who are current smokers, the percent of adults who received a colorectal cancer screening, and the percent of adults getting a flu immunization. For more information about CHS please visit http://www1.nyc.gov/site/doh/data/data-sets/community-health-survey.page.

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

New York State Vital Records Data: The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report, vital records data were used to examine the proportion of infants exclusively breastfed in the hospital and the opioid burden rate. For more information on the New York State Vital Records please visit: https://www.health.ny.gov/statistics/vital_statistics/

New York State Statewide Planning and Research Cooperative Systems (SPARCS): SPARCS is the primary source of data on ED visits and inpatient hospitalizations at New York State hospitals.

All inpatient admissions and ED visits at NYS hospitals are sent to SPARCS and compiled into a master database. SPARCS data was used to estimate the rates of preventable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, asthma ED visits, and the opioid burden rate . For more information about SPARCS please visit: http://www.health.ny.gov/statistics/sparcs/.

New York City HIV/AIDS Annual Surveillance Statistics: The HIV Epidemiology and Field Services Program (HEFSP), within the New York City Department of Health and Mental Hygiene, collects and manages all data on HIV infection and AIDS diagnoses in the NYC. This data source was used to estimate HIV diagnoses rates.

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

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

Data Tools and Reports

Global Burden of Disease: The Global Burden of Disease (GBD) project from the Institute of Health Metrics and Evaluation at the University of Washington uses a comprehensive risk-assessment framework to summarize the collective impact of risk factors and health outcomes on adverse health. Specifically, GBD combines many datasets to estimate disability adjusted life years (DALYs) associated numerous outcomes and risk factors. DALYs are a summary measure

of population health that combines information on fatal health events and non-fatal health states. This is an important advantage over vital statistics which do not capture the important health impact of non-fatal health states (e.g., back pain, moderate depression, or alcohol use). GBD also allows for the estimation of DALYs attributed to specific risk factors, including body mass index, smoking, dietary risks, occupational risks, air pollution, etc. Data from the GBD is available at the global, national and state-level; local-estimates are not available. Despite this limitation this information can be used to understand the most important areas of intervention to improve population health. Data are available at: https://vizhub.healthdata.org/gbd-compare/

New York City Community Health Profiles: The Community Health Profiles are produced by the New York City Department of Health & Mental Hygiene, and summarize a number of contextual, behavioral and health indicators by Community District. The Community Health Profiles are not a database, but rather a collection of data from diverse databases, including the American Community Survey, the NYC Community Health Survey, and SPARCS. For more information please visit: https://www1.nyc.gov/site/doh/data/data-publications/profiles.page

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

Primary Data Collection Plan

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

Primary Data Collection

A primary data collection strategy was used in conjunction with secondary data to identify community health priorities in the Bronx. The primary method of primary data collection was a survey of Bronx residents implemented in the Spring and early Summer of 2019. 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.

The survey was designed to be completed in less than 5 minutes and was based on a survey previously used in 2016 to assess community health needs. The survey included questions on what community members perceived to be the priority health concerns in the community where they lived. We also asked participants 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[1]. Beyond questions specifically related to community health concerns, participant demographic and health status data were collected. Copies of the English and Spanish versions of the paper survey are provided in the Appendix.

Survey participants were sought using various approaches:

- E-mails were sent to relevant list-serves with links to the survey
- Health fairs and other events staffed by Montefiore Office of Community & Population Health staff
- Surveys were disseminated at community board meetings throughout the Bronx
- Strategically disseminated by key partners including the NYC Department of Health & Mental Hygiene and St. Barnabas Health System

Paper copies were manually entered into the online survey tool and the data were analyzed by the Office of Community & Population Health.

[1] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

In total, 584 individuals completed the survey. A summary of survey participants and a comparison to the Bronx overall is presented in **Table 1**. This table helps identify what groups may be over/under-represented in the survey.

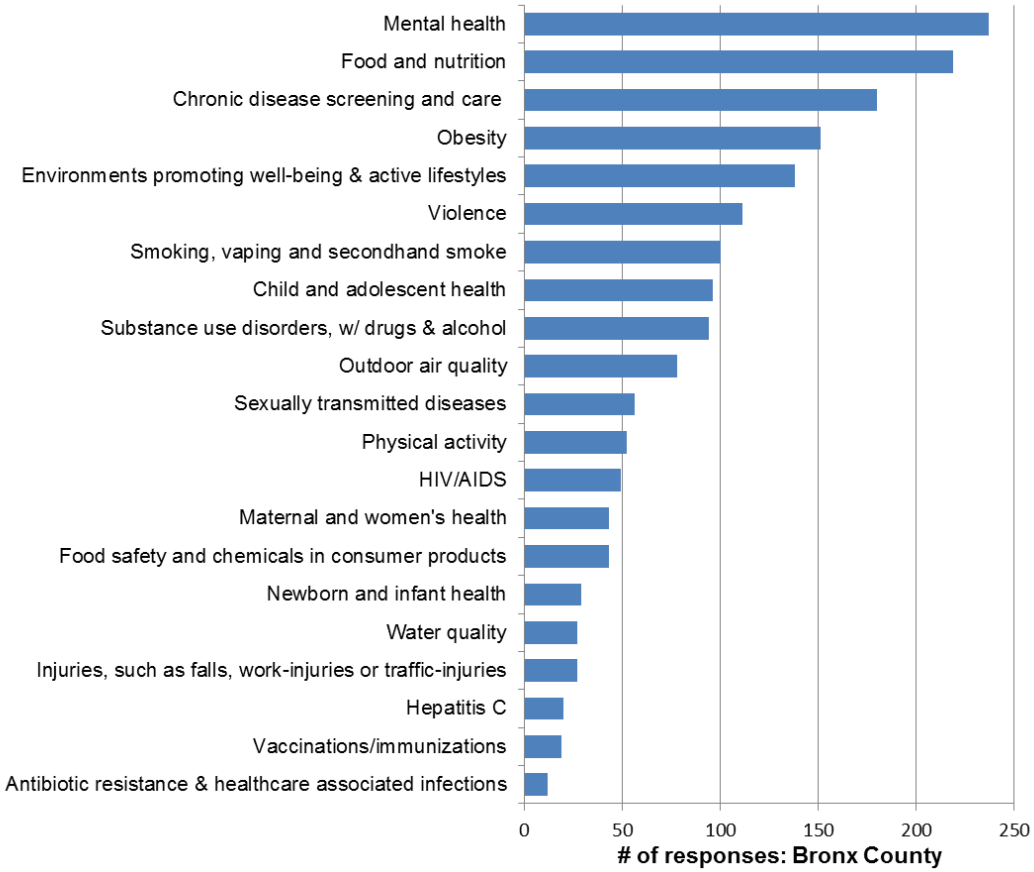
Table 1. Socio-demographic comparison of Bronx Community Health Survey and Bronx Population from the American Community Survey, 2017

	Percent (%)	
	Bronx Community Health Survey (n=584)	**Bronx Overall from American Community Survey, 2017**
Age		
18-24	8.0	10.4
25-34	29.0	16.1
35-44	17.8	12.6
45-54	13.0	12.8
55-64	14.7	10.9
65-74	12.9	7.0
75+	4.7	5.4
Sex		
Female	71.4	54.1
Male	28.6	45.9
Education		
Less than HS	4.9	27.1
HS	17.8	27.6
Some College	25.5	27.2
College or More	51.9	18.2
Race/ethnicity		
Hispanic	43.5	55.7
Non-Hispanic Black	39.1	29.4
Non-Hispanic White	8.6	9.5
Other	8.6	5.4
Primary Language Spoken At Home		
English	73.5	39.1
Spanish	16.9	48.6
Other	9.6	12.4

The survey captured an age distribution of Bronx residents that closely matches with the age distributions of Bronx County overall as measured by the American Community Survey in 2017. The table shows that adults age 25-34y are slightly over-represented in the survey (29%)

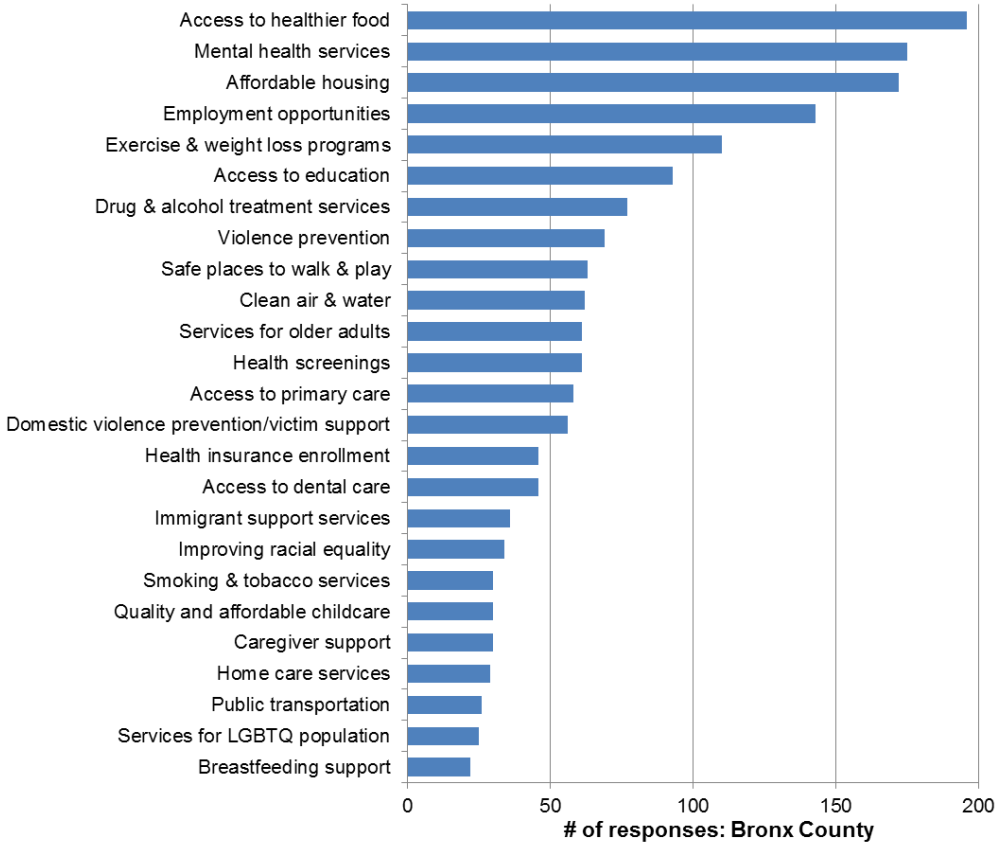
compared to the age distributions of adults age 25-34y in Bronx County as measured by the American Community Survey in 2017 at 16.1%. Survey data shows that more women completed the survey (71.4%) as compared to men (28.6). The survey also captured a higher proportion of residents with a college education or more compared to the Bronx overall; however, the race/ethnicity distribution is comparable. The survey was disproportionately completed by individuals who indicated that they spoke English, as opposed to Spanish at-home.

Community priorities in the Bronx Community Health Survey, 2019



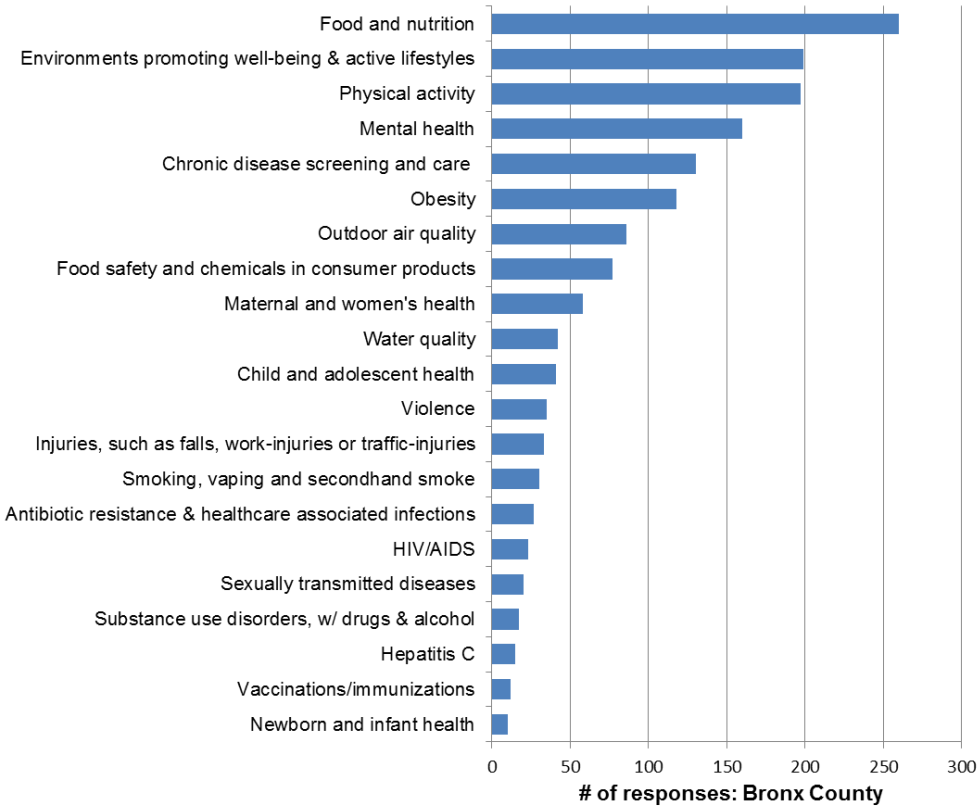
Participants were asked to identify the top 3 community health priorities out of a list of more than 20 options. This data is of critical importance to the hospital as it tells us what community members think are the priority areas. In this survey, mental health, food and nutrition, chronic disease screening and care, and obesity were the top identified priorities. Additional community priorities receiving a large number of responses included environments promoting well-being and active lifestyles, violence, and smoking (including vaping and secondhand smoke).

Most helpful actions for the community in the Bronx Community Health Survey, 2019



Participants were also asked to identify what actions or activities would be most helpful for their community. The leading responses to this question were access to healthier food, mental health services, affordable housing, employment opportunities and exercise and weight loss programs.

Individual priorities from the Bronx Community Health Survey, 2019



In addition to asking survey participants to think about community issues we also asked them to report on the priority health issues for themselves. The responses to this question differed slightly from the community concerns. Food and nutrition, environments that promote well-being and active lifestyles, physical activity, and mental health were the top priorities.

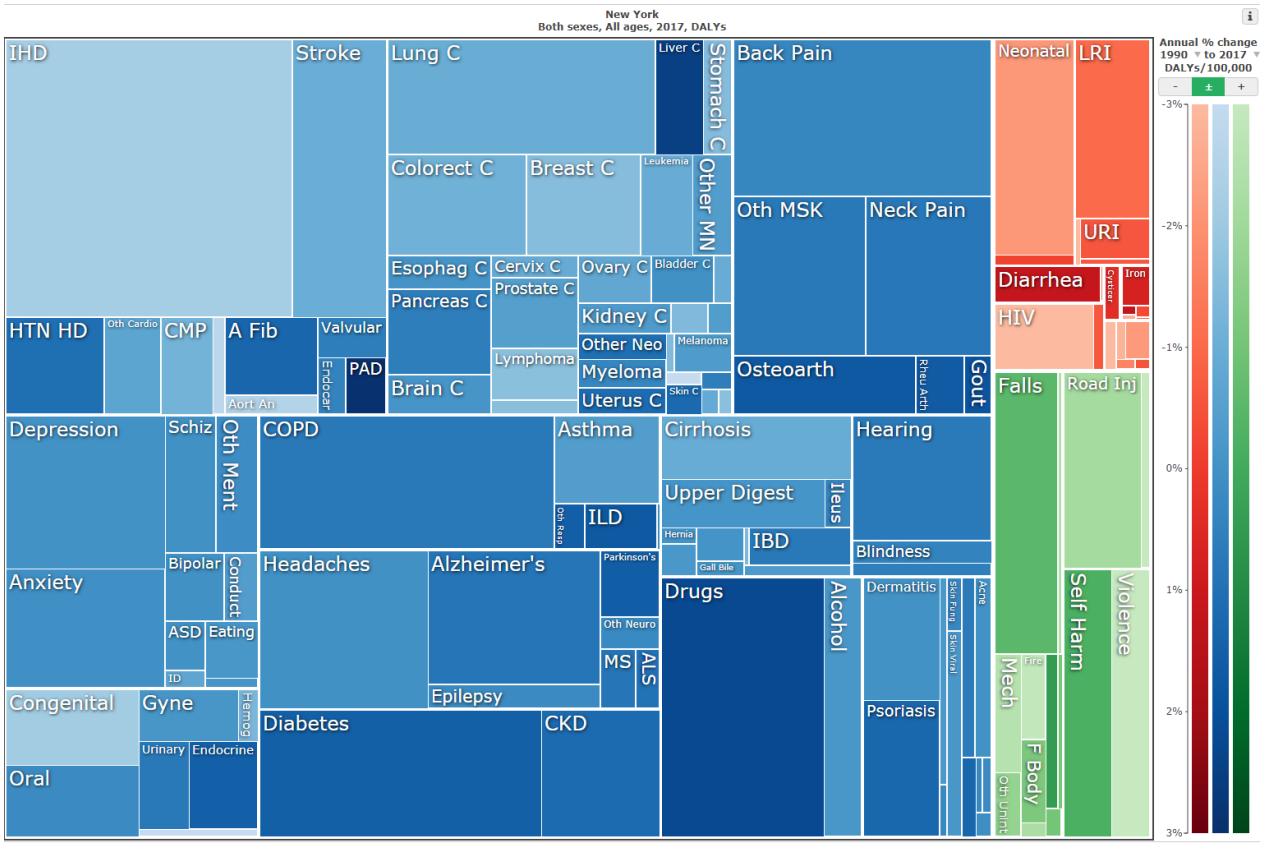
In summary, mental/behavioral health and obesity-related health issues were identified by participants as priority areas.

Presentation of Data

This section describes the secondary data collected as part of the Montefiore Medical Center 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 3** 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

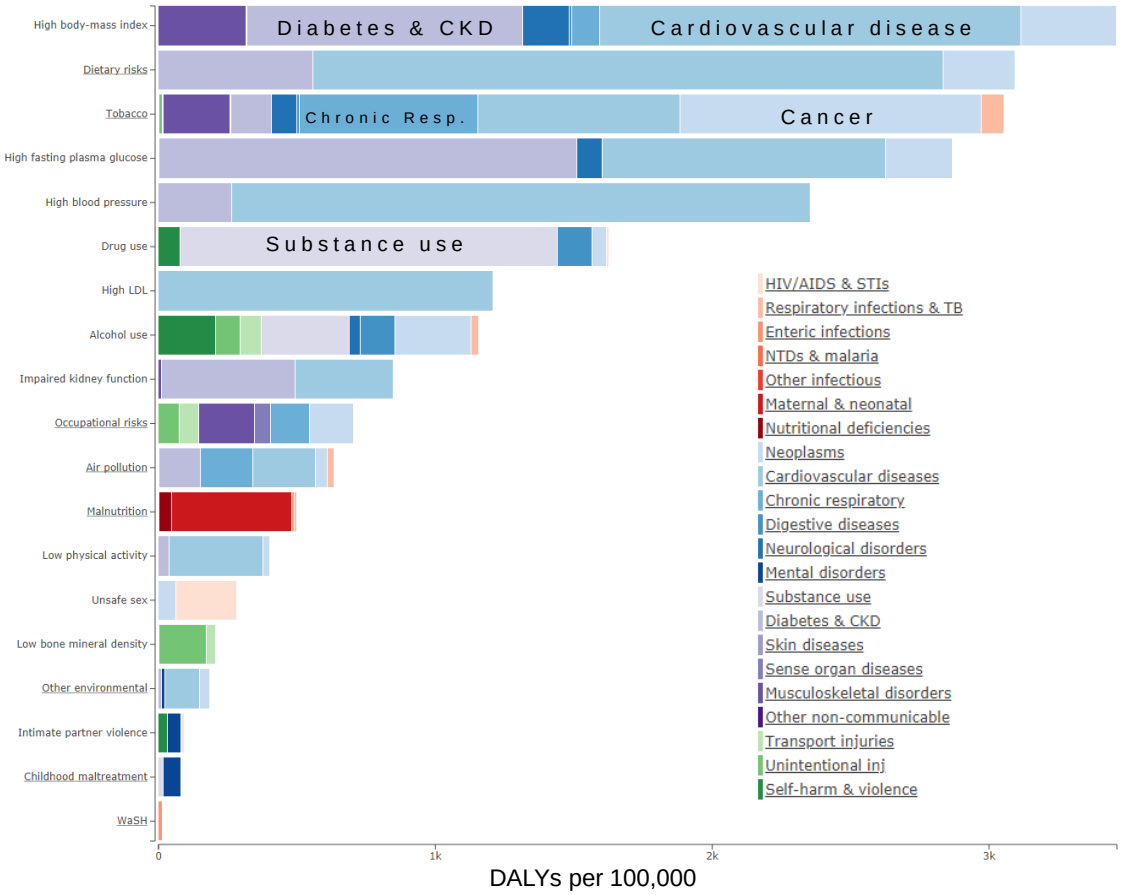


Data source: 2017 Global Burden of Disease Project.

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.

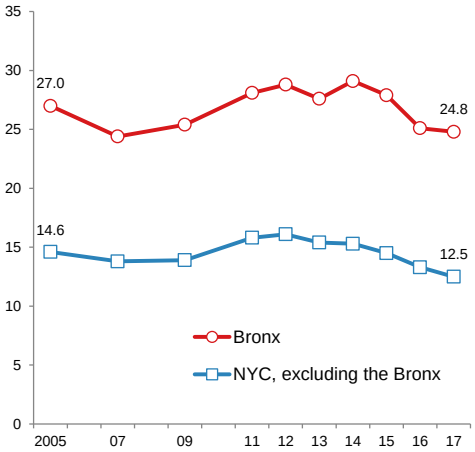
Dietary risks are the second leading contributor to ill health, due to associations with cardiovascular disease, diabetes and some cancers. Within dietary risks (data not shown), low whole grains, high sodium, low nuts and seeds and low fruit are the leading causes of ill health.

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.

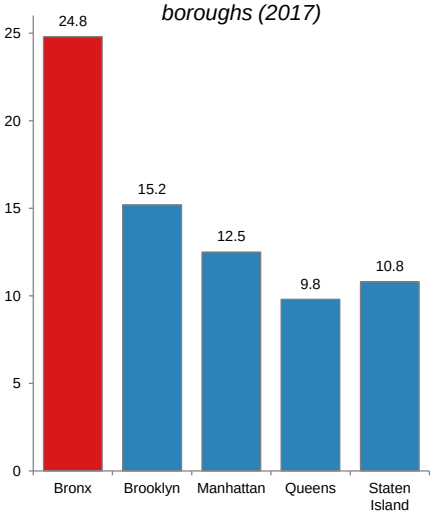
The subsequent graphs include the secondary data collected using the data sources described above. Depending on the data available data elements may include the following: trends comparing the Bronx to New York City, a comparison of values to other NYC boroughs and data on disparities by race/ethnicity 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.

In 2017, about ¼ of families in the Bronx were living in poverty, which is nearly twice the percentage of families in the rest of NYC. In the Bronx, the percentage of families living in poverty is highest among the Hispanic and non-Hispanic black populations, and in the South Bronx.

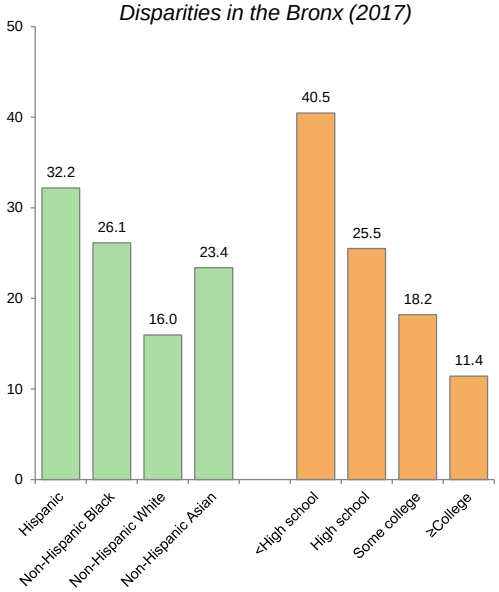
Percent of Families Living in Poverty



Comparison to NYC boroughs (2017)



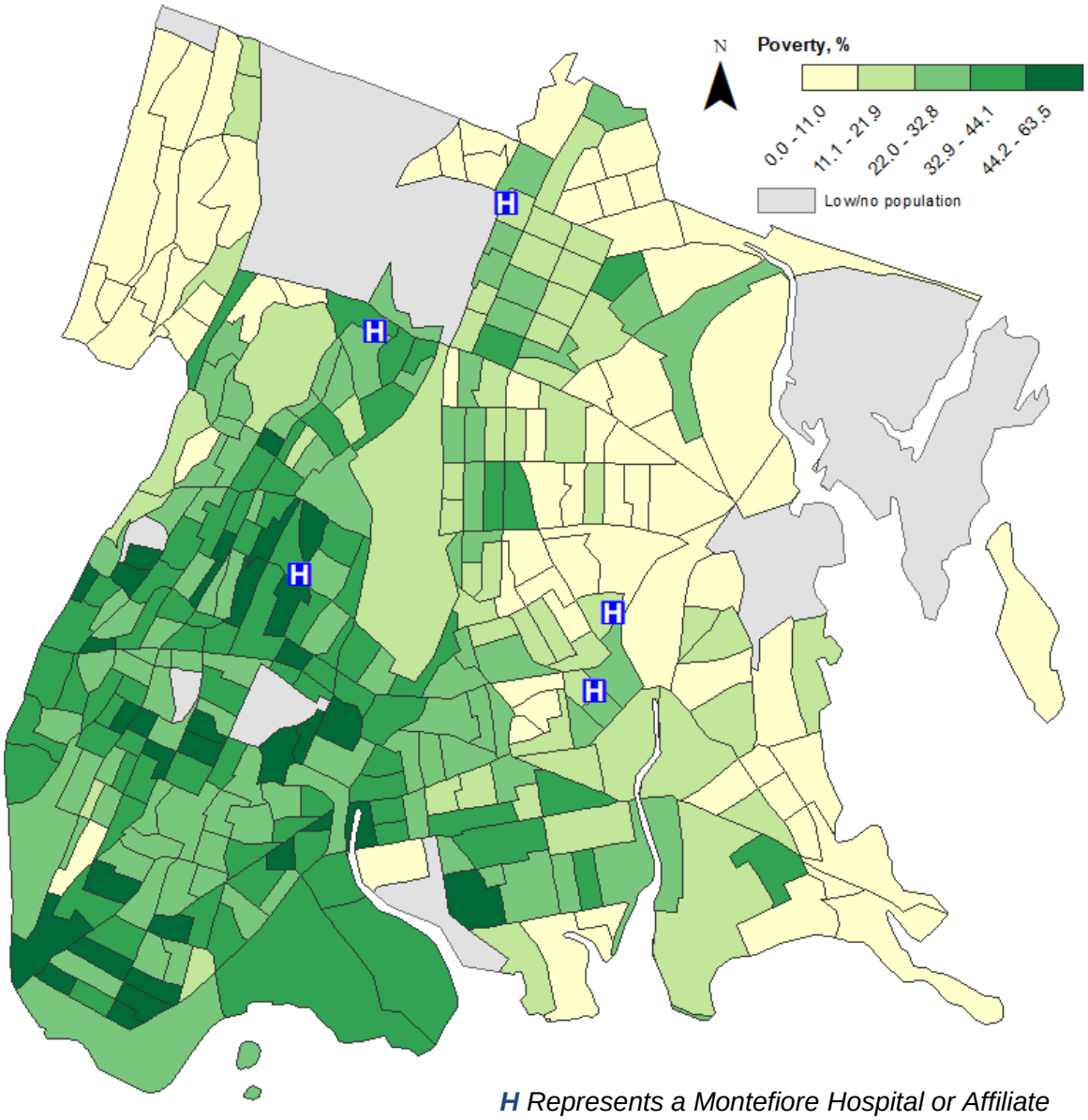
Disparities in the Bronx (2017)



Data source: American Community Survey.
Disparities data from Public Use Microdata.

Percent of Families Living in Poverty in the Bronx

Differences by Census Tract

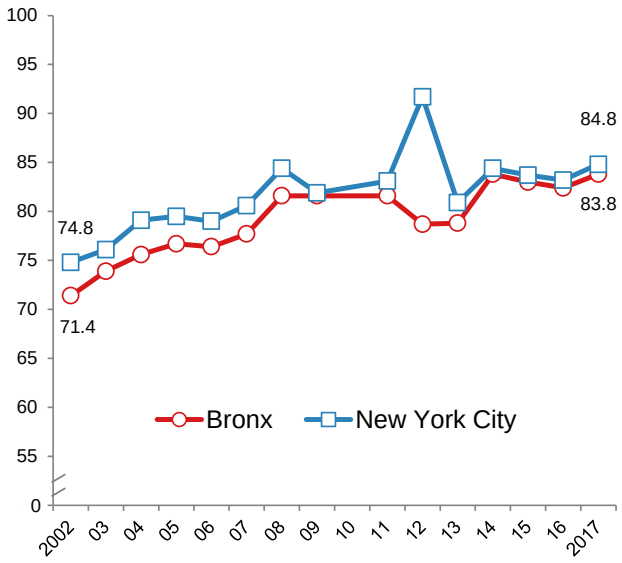


***H** Represents a Montefiore Hospital or Affiliate*

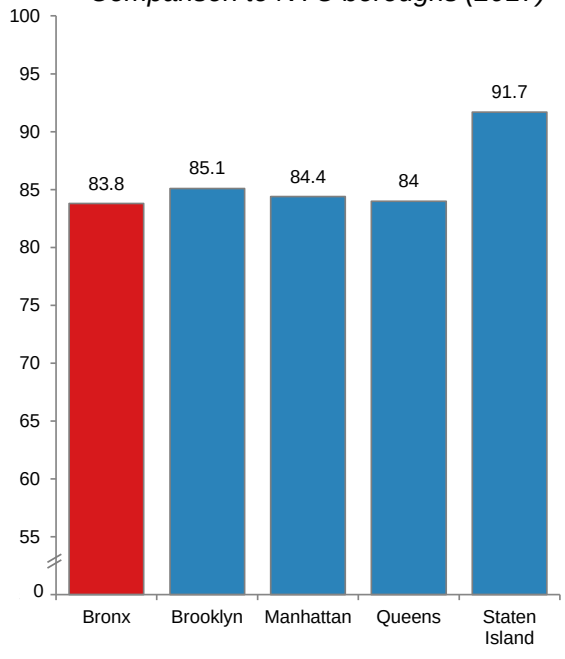
Data source: American Community Survey (2013-2017)

For nearly the last two decades, the percent of adults with a primary care provider has increased across NYC. The percent of adults with a PCP increases as level of education increases.

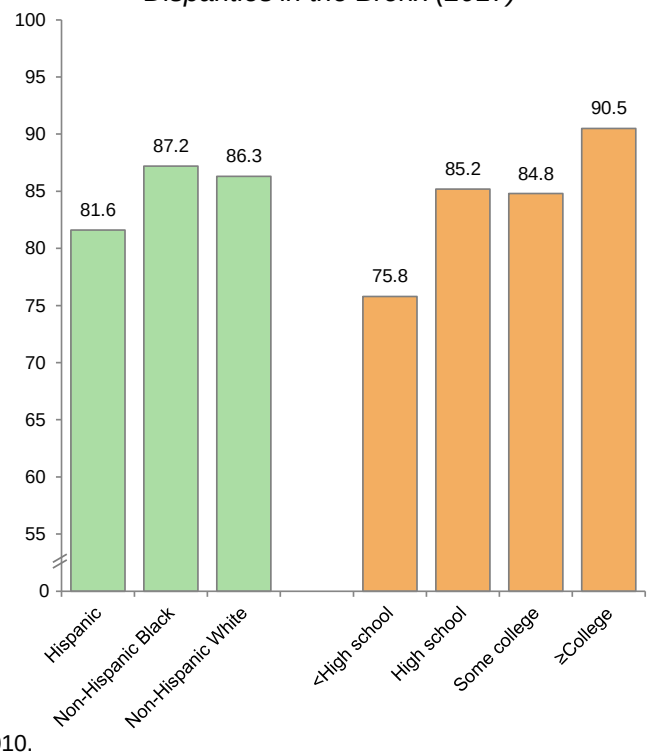
Percent of Adults who Report Having a Primary Care Provider



Comparison to NYC boroughs (2017)



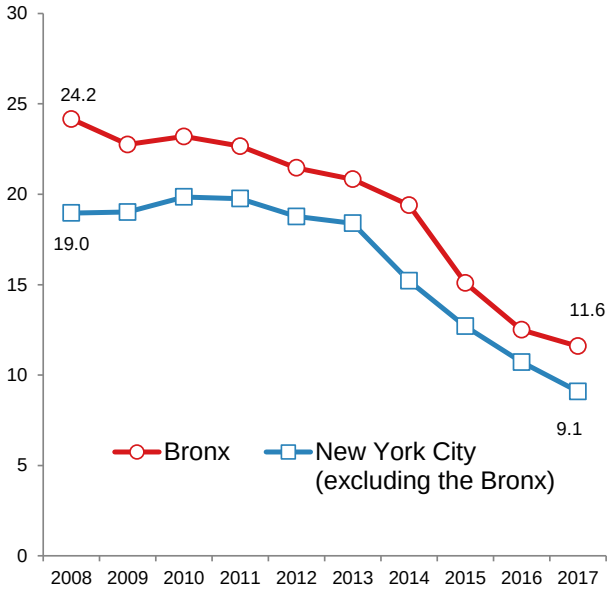
Disparities in the Bronx (2017)



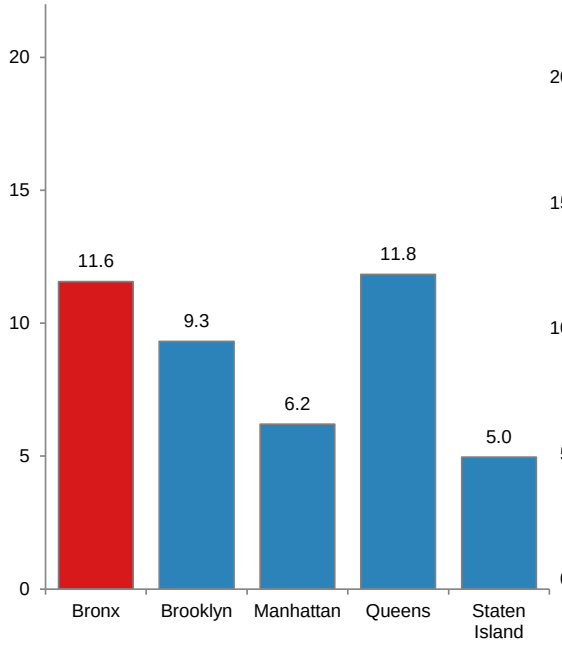
Data source: NYC Community Health Survey.
Data are age-adjusted. Trend data not available in 2010.

While the percent of adults who lack health insurance has been decreasing in NYC over the last decade, the Bronx still maintains a higher percent compared to the rest of NYC. In the Bronx, those with lower education and those who are Hispanic are less likely to have insurance.

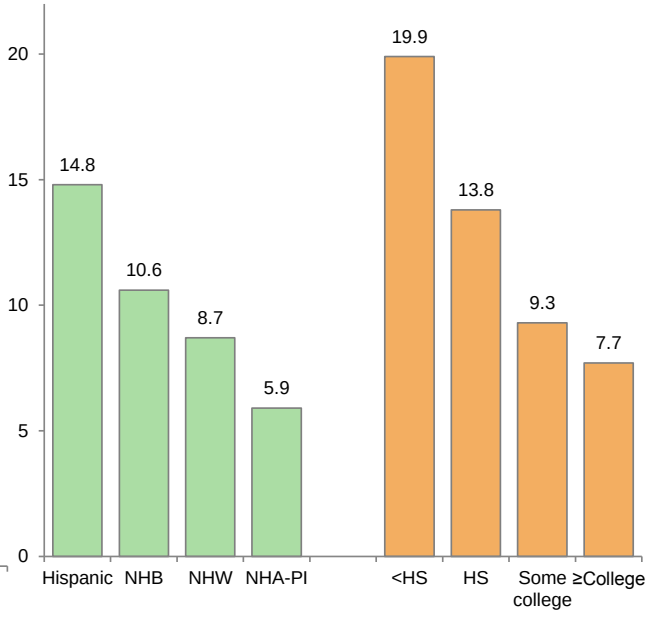
Percent of Adults (18-64y) who Lack Health Insurance



Comparison to NYC boroughs (2017)



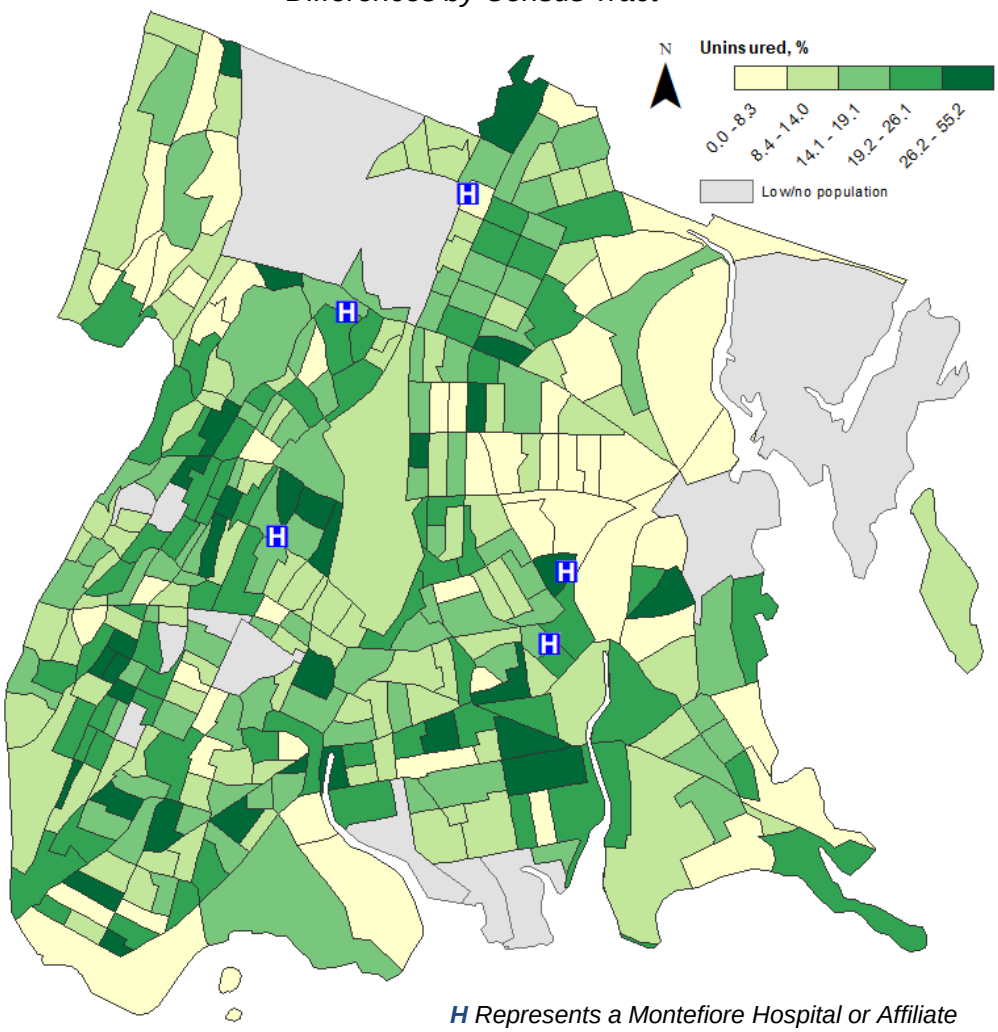
Disparities in the Bronx (2017)



Data source: American Community Survey. Disparities data from Public Use Microdata.

Percent of Adults (18-64y) who Lack Health Insurance in the Bronx

Differences by Census Tract

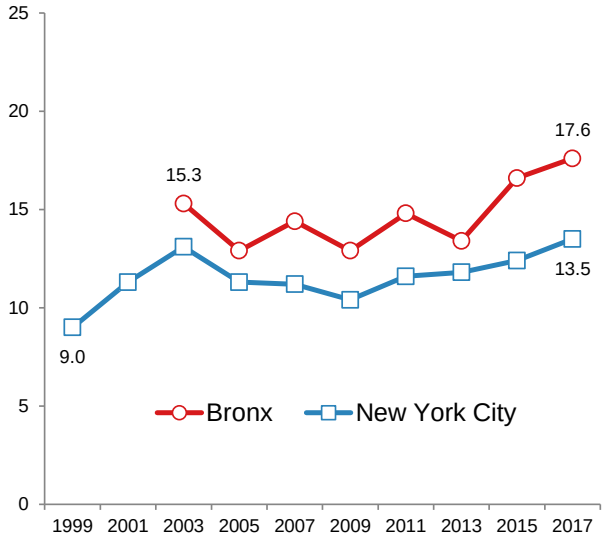


H *Represents a Montefiore Hospital or Affiliate*

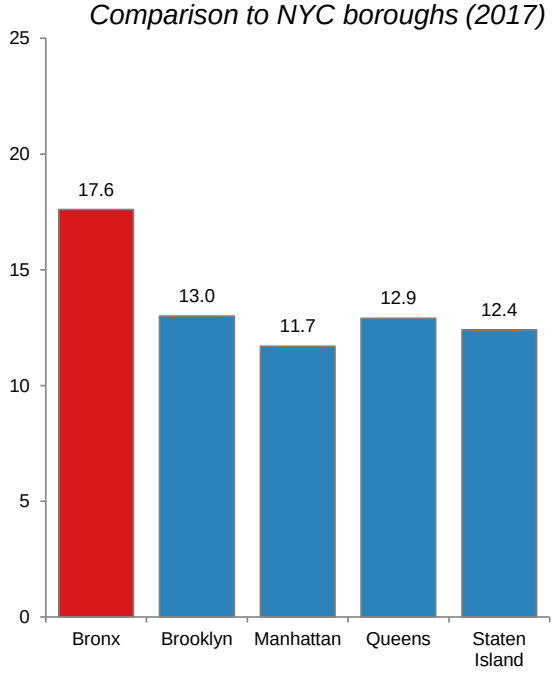
Data source: American Community Survey (2013-2017)

Overall, the percent of obese students has increased across NYC since 1999, with the Bronx having a higher percent than the rest of NYC. Males and those who are Hispanic or non-Hispanic black are more likely to be obese.

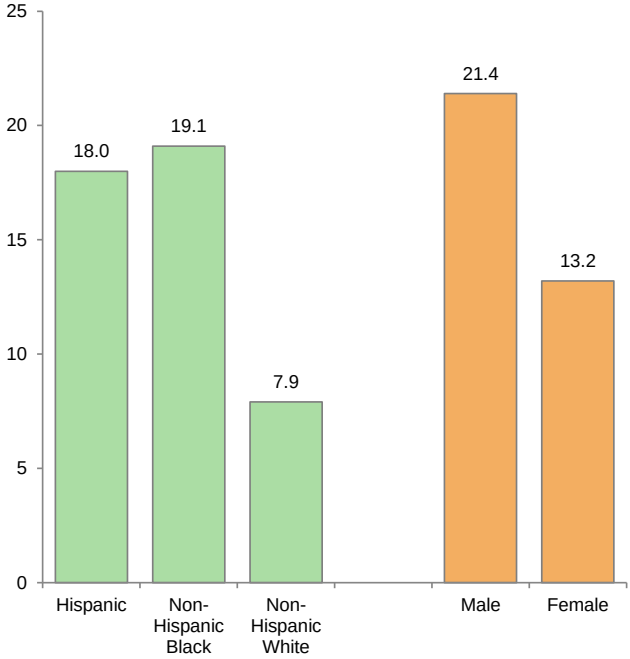
Percent of Students who are Obese



Comparison to NYC boroughs (2017)

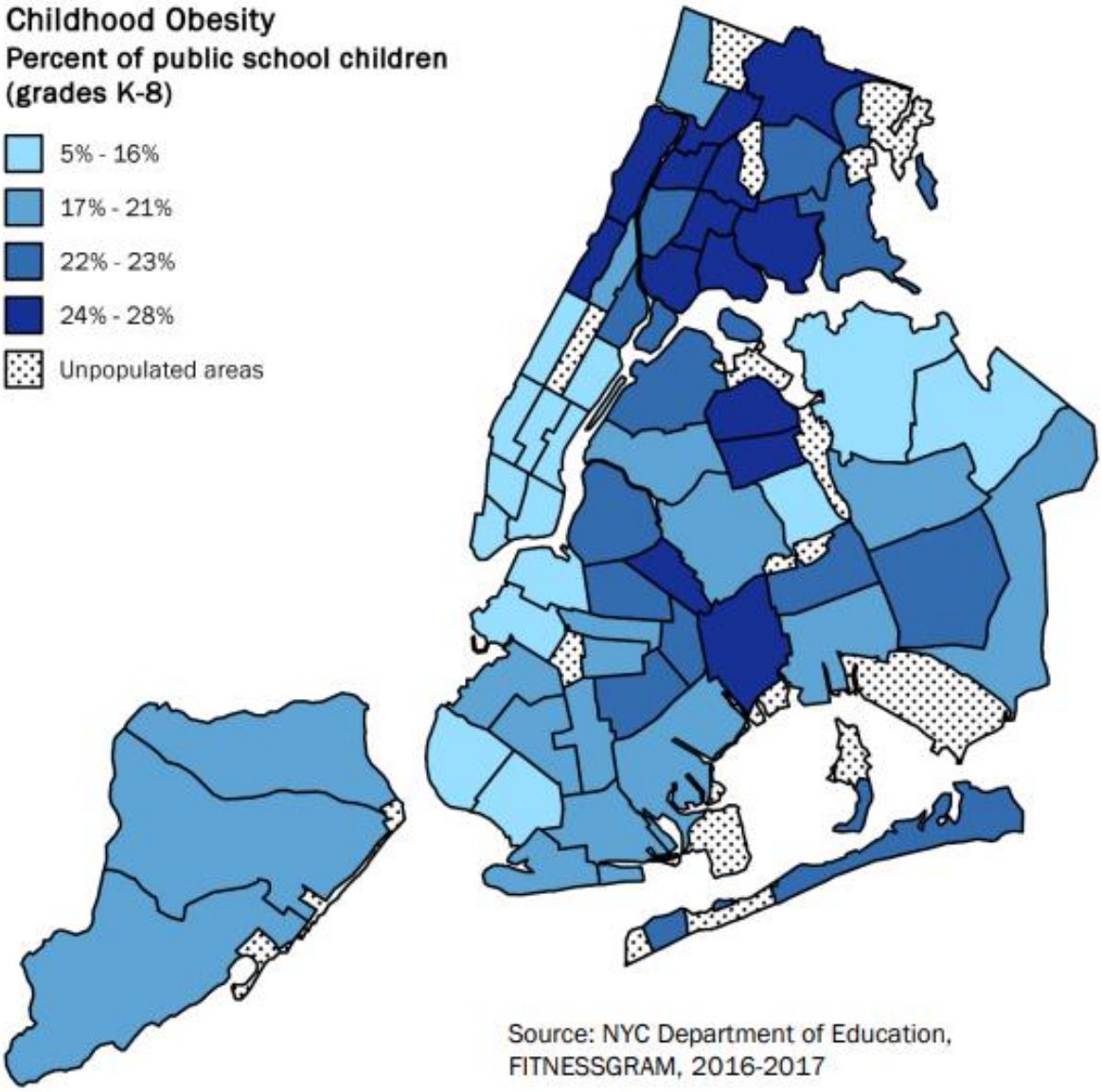


Disparities in the Bronx (2017)



Data source: NYC Youth Risk Behavior Survey. Trend data not available at borough-level before 2003.
Map data from NYC Department of Education FITNESSGRAM, 2016-2017.

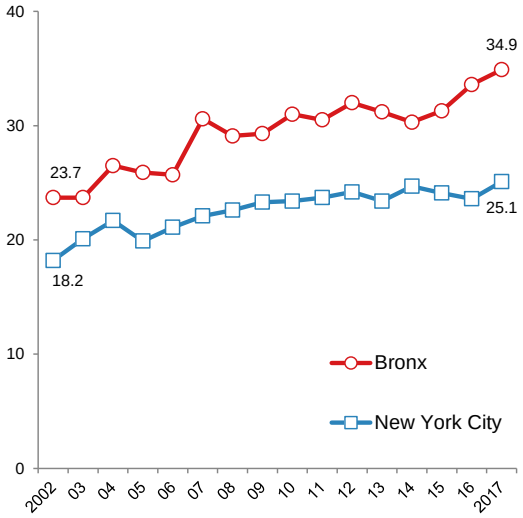
Percent of Students who are Obese



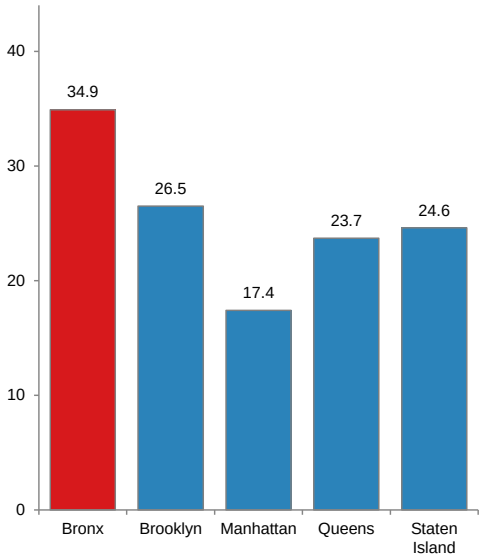
Map from New York City Community Health Profiles, 2018

In the last 15 years, there has been an increase in the proportion of adults who are obese across NYC, with the Bronx having a higher proportion compared to other boroughs. In the Bronx, the proportion of adults who are obese is higher among those who have lower education or are among the Hispanic and non-Hispanic black populations.

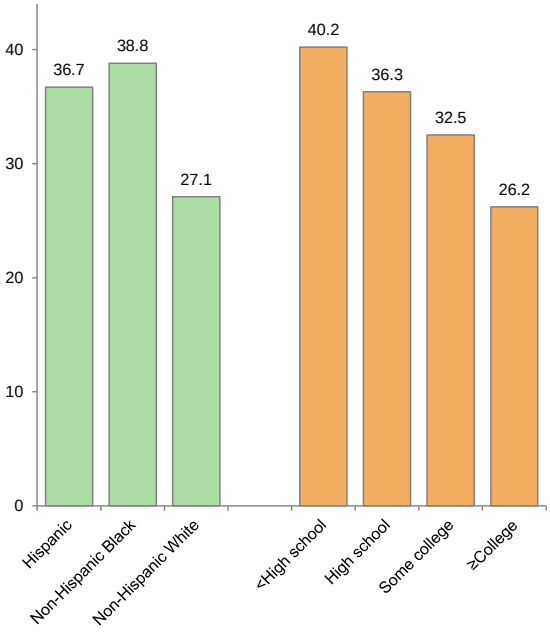
Percent of Adults who are Obese (BMI ≥ 30kg/m^2)



Comparison to NYC boroughs (2016)

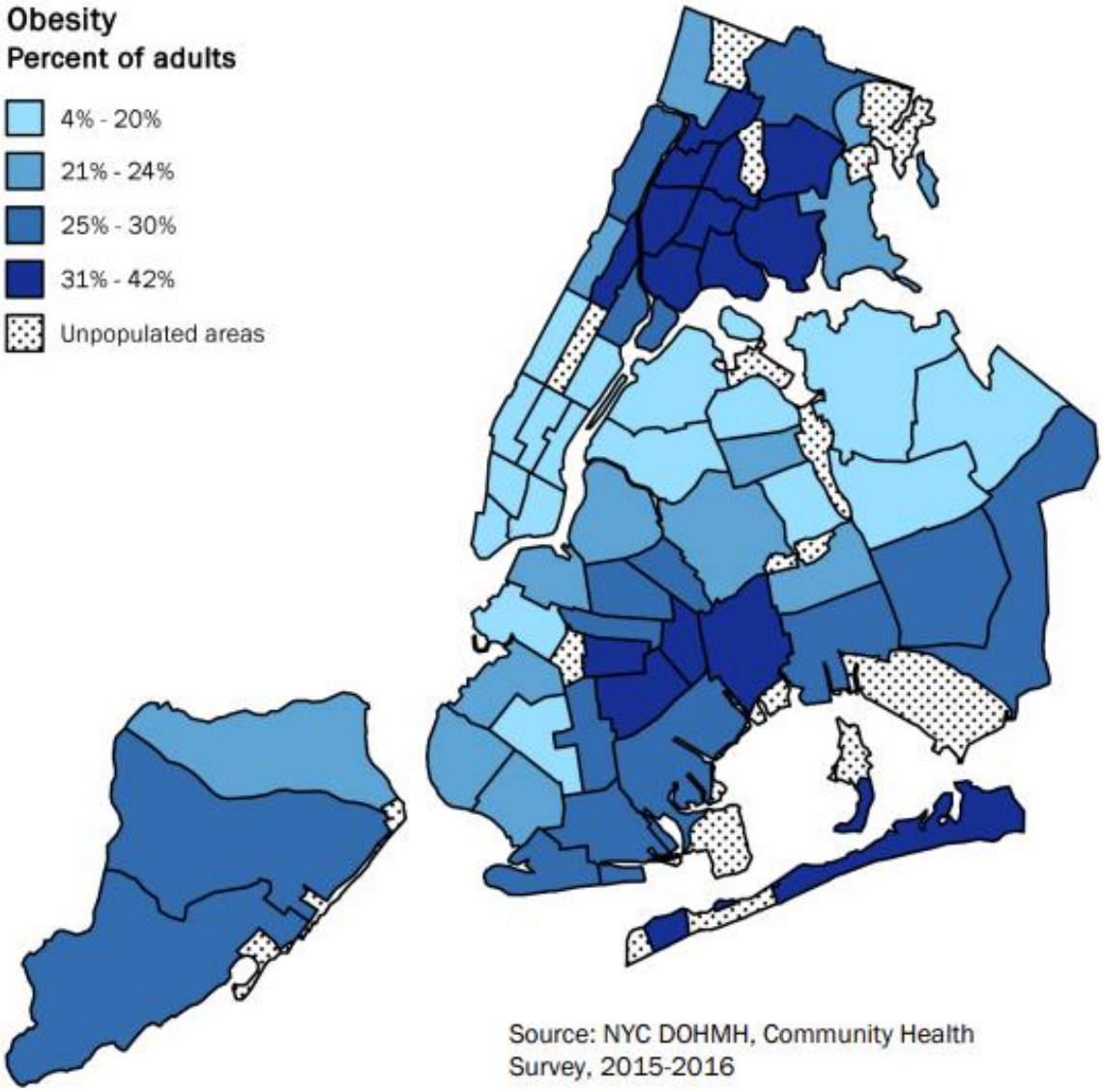


Disparities in the Bronx (2016)



Data source: NYC Community Health Survey. Data are age-adjusted.

Percent of Adults who are Obese (BMI ≥30kg/m^2)

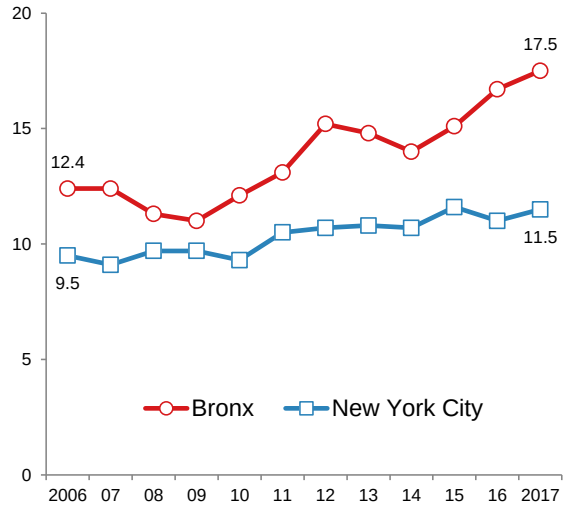


Map from New York City Community Health Profiles, 2018

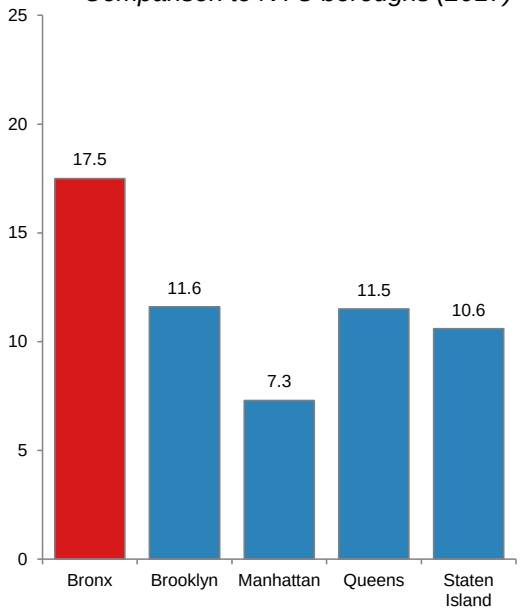
For over the last decade, there has been an increase in the percent of adults who have diabetes across NYC, with the Bronx having a higher percent compared to other boroughs. In the Bronx,

the percent of adults who have diabetes is higher among those who have less than a high school education or are Hispanic or non-Hispanic black.

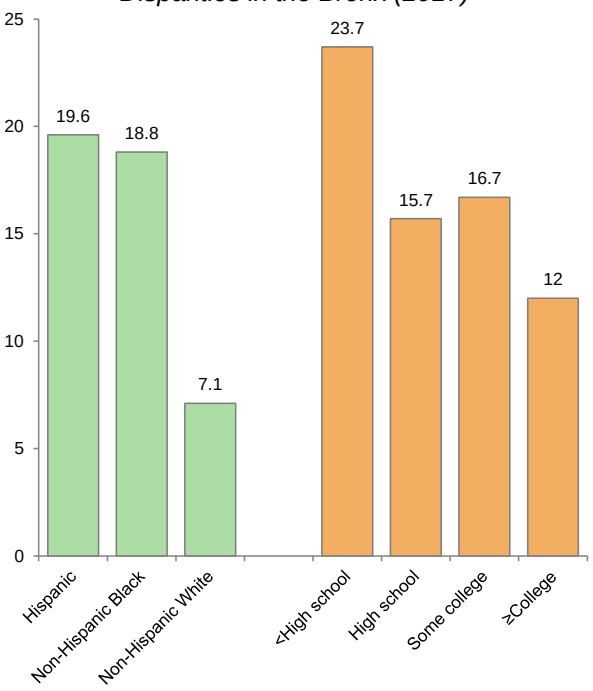
Percent of Adults who Have Been Told They Have Diabetes



Comparison to NYC boroughs (2017)

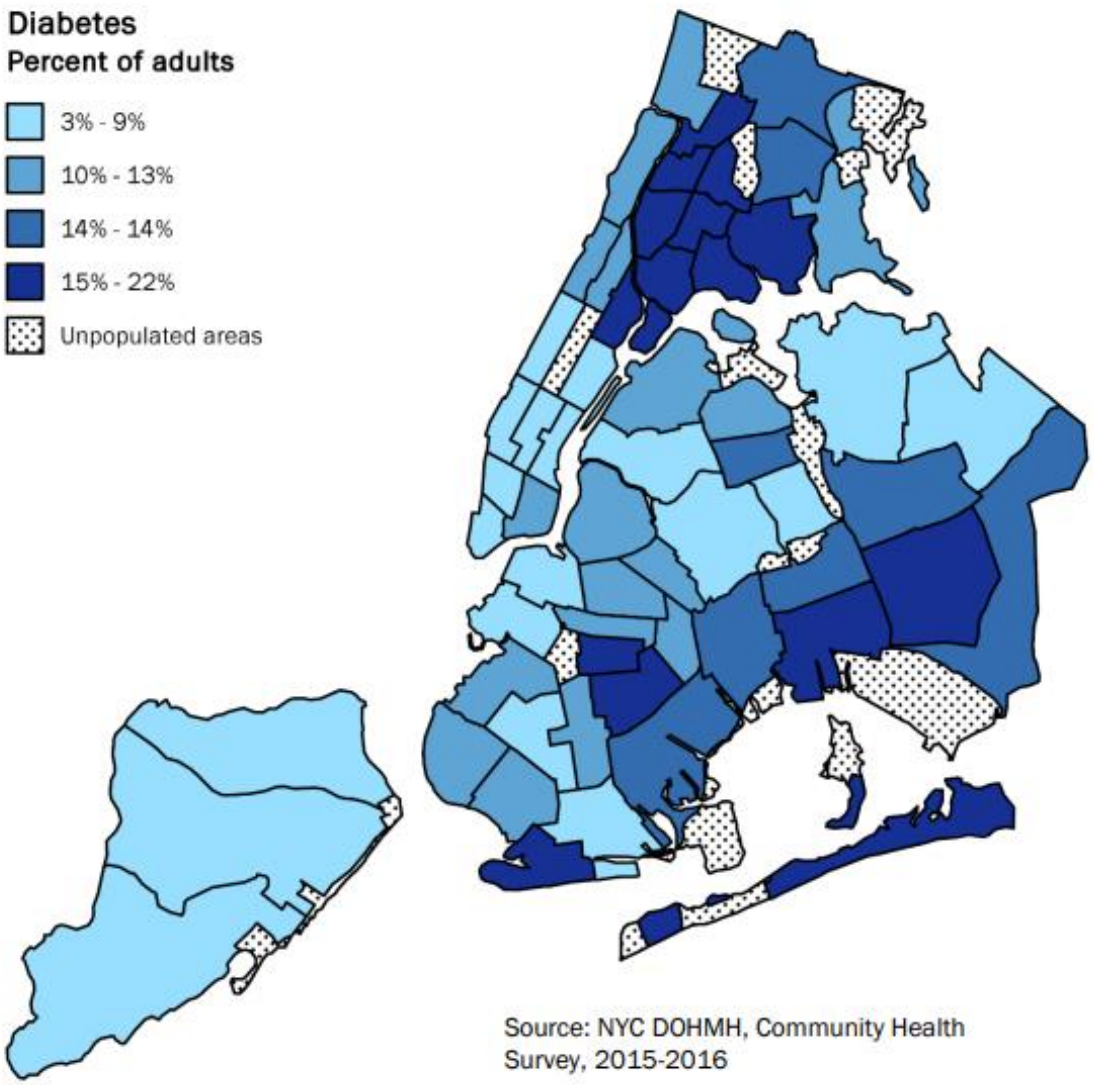


Disparities in the Bronx (2017)



Data source: NYC Community Health Survey. Data are age-adjusted.

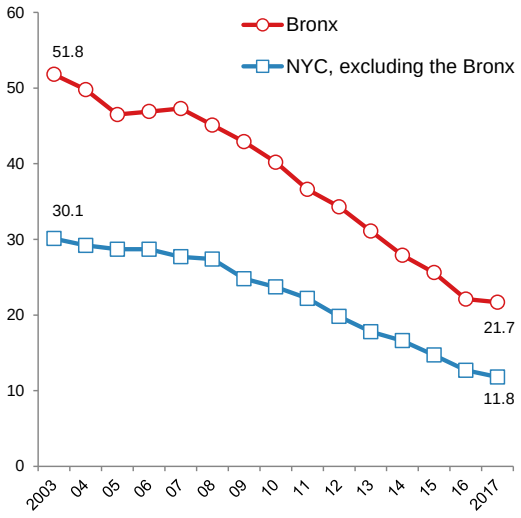
Percent of Adults who Have Been Told That They Have Diabetes



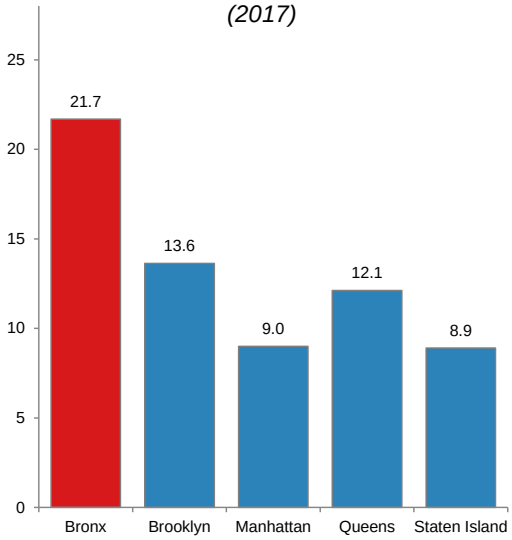
Map from New York City Community Health Profiles, 2018

Overall, the teen birth rate in NYC has been decreasing in recent years, but the Bronx still has a higher rate than other boroughs. In the Bronx, the non-Hispanic white population has lower teen birth rates.

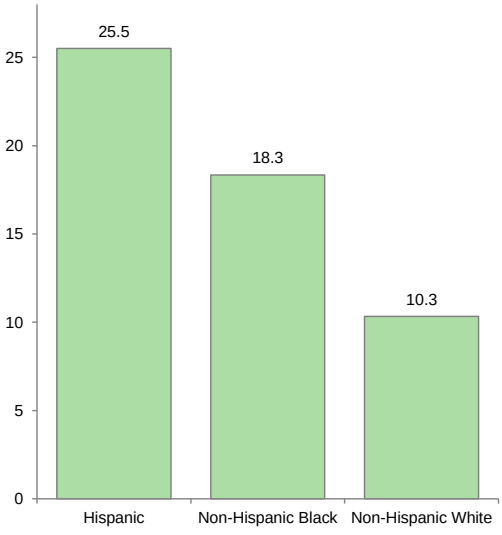
Teen Birth Rate (15-19y) per 10,000



Comparison to NYC boroughs (2017)

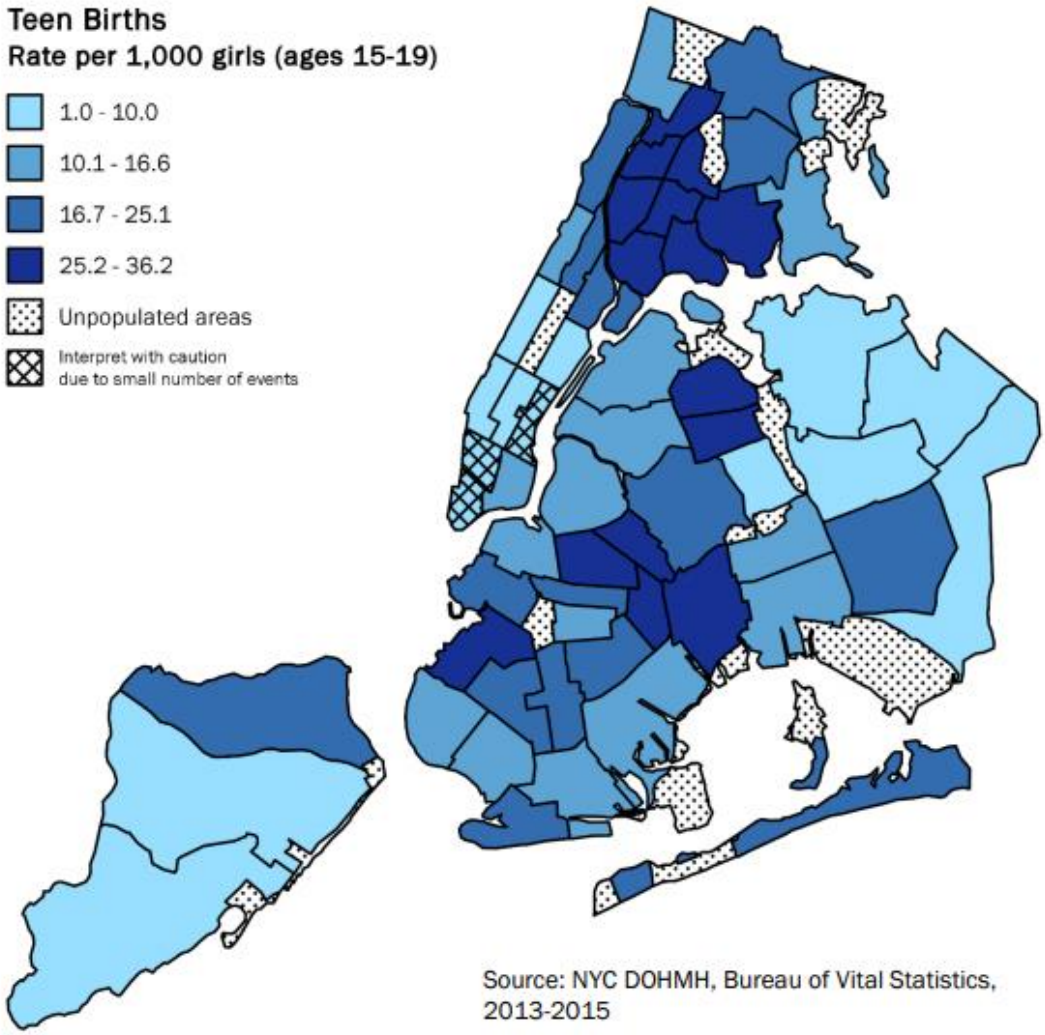


Disparities in the Bronx (2017)



Data source: National Vital Statistics Surveillance System and National Center for Health Statistics Population Estimates.

Teen Birth Rate (15-19y) per 1,000

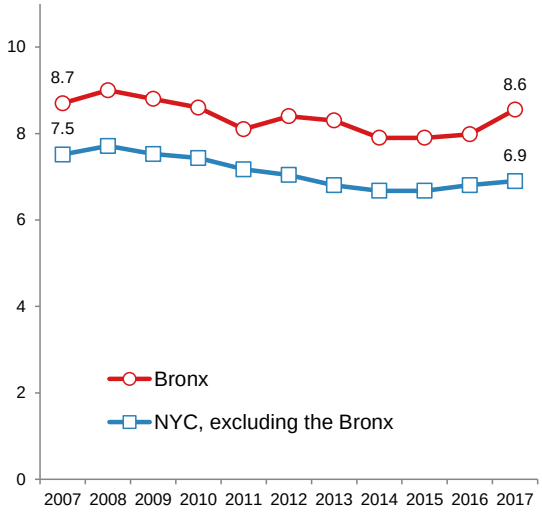


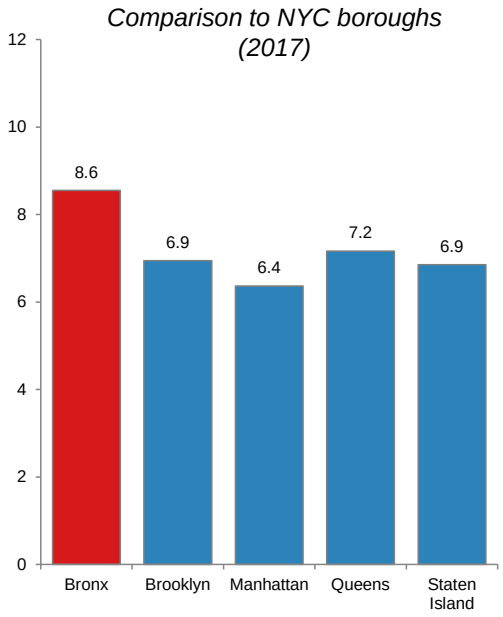
Map from New York City Community Health Profiles, 2018

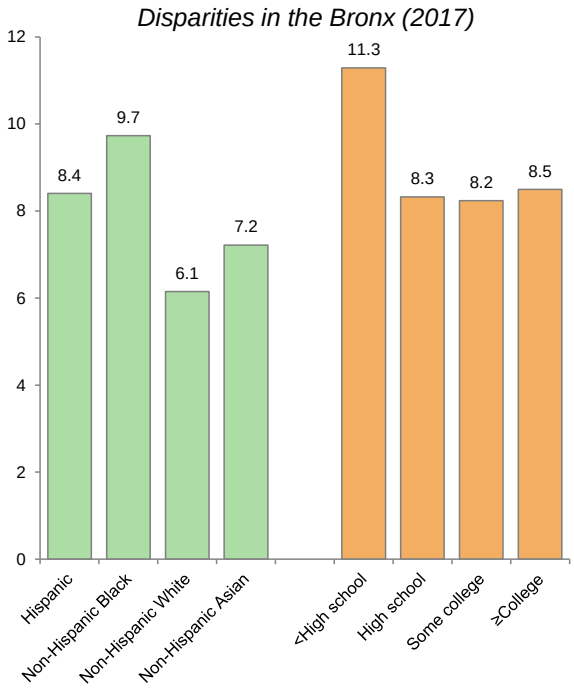
The proportion of births that are preterm in the Bronx has remained relatively unchanged from 2007 to 2017, although it remains higher than in any other borough. In the Bronx, the

proportion of preterm births is highest among those with less than a high school education and the non-Hispanic black population.

Proportion of Births that are Preterm (<37 weeks)

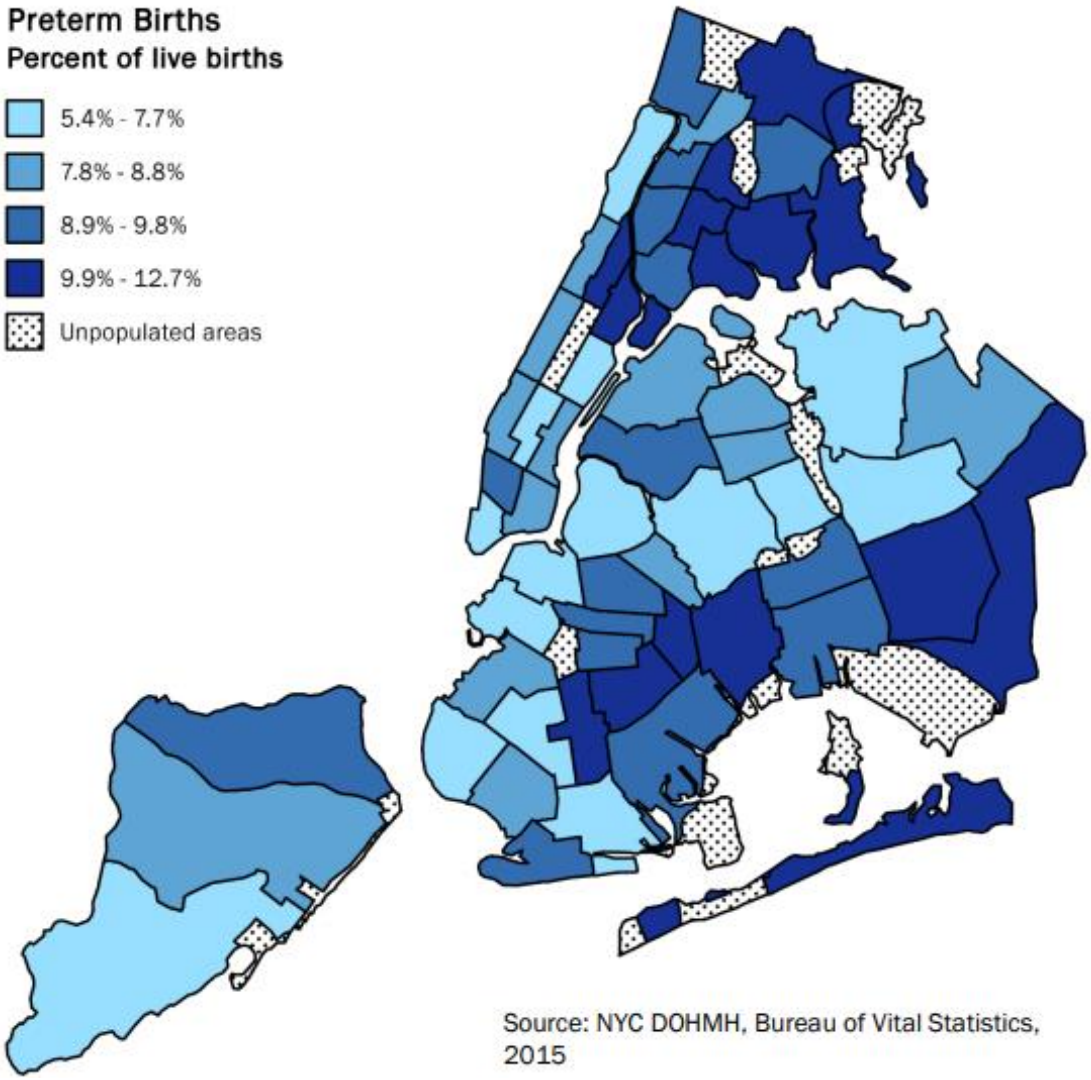






Data source: National Vital Statistics Surveillance System. Data are limited to single-births.

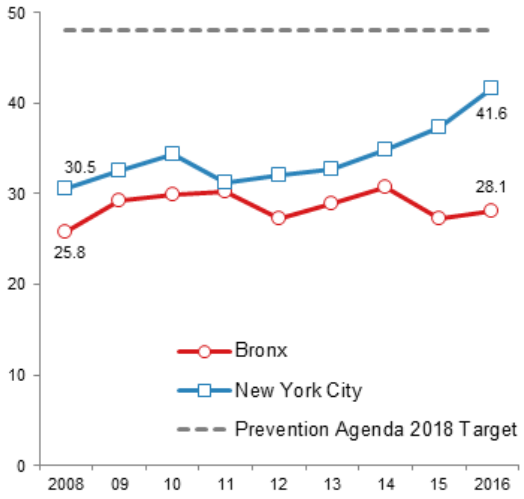
Percent of Births that are Preterm (<37weeks) Map

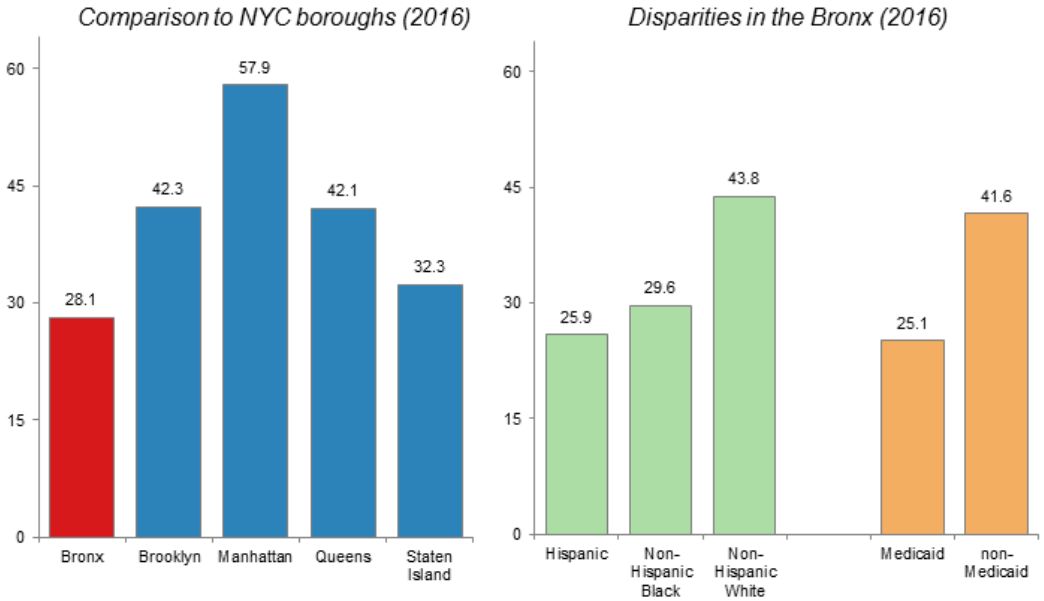


Map from New York City Community Health Profiles, 2018. Analysis not limited to single births.

While the proportion of infants exclusively breastfed in the hospital has been increasing in NYC, the proportion breastfed in the Bronx remains lower. The proportion of infants exclusively breastfed in the hospital has been increasing in NYC from 2008 to 2016, but it still falls below the PA 2018 goal. In the Bronx, the proportion of infants exclusively breastfed in the hospital is lowest among those who are Hispanic, non-Hispanic Black or have Medicaid.

Proportion of Infants Exclusively Breastfed in the Hospital

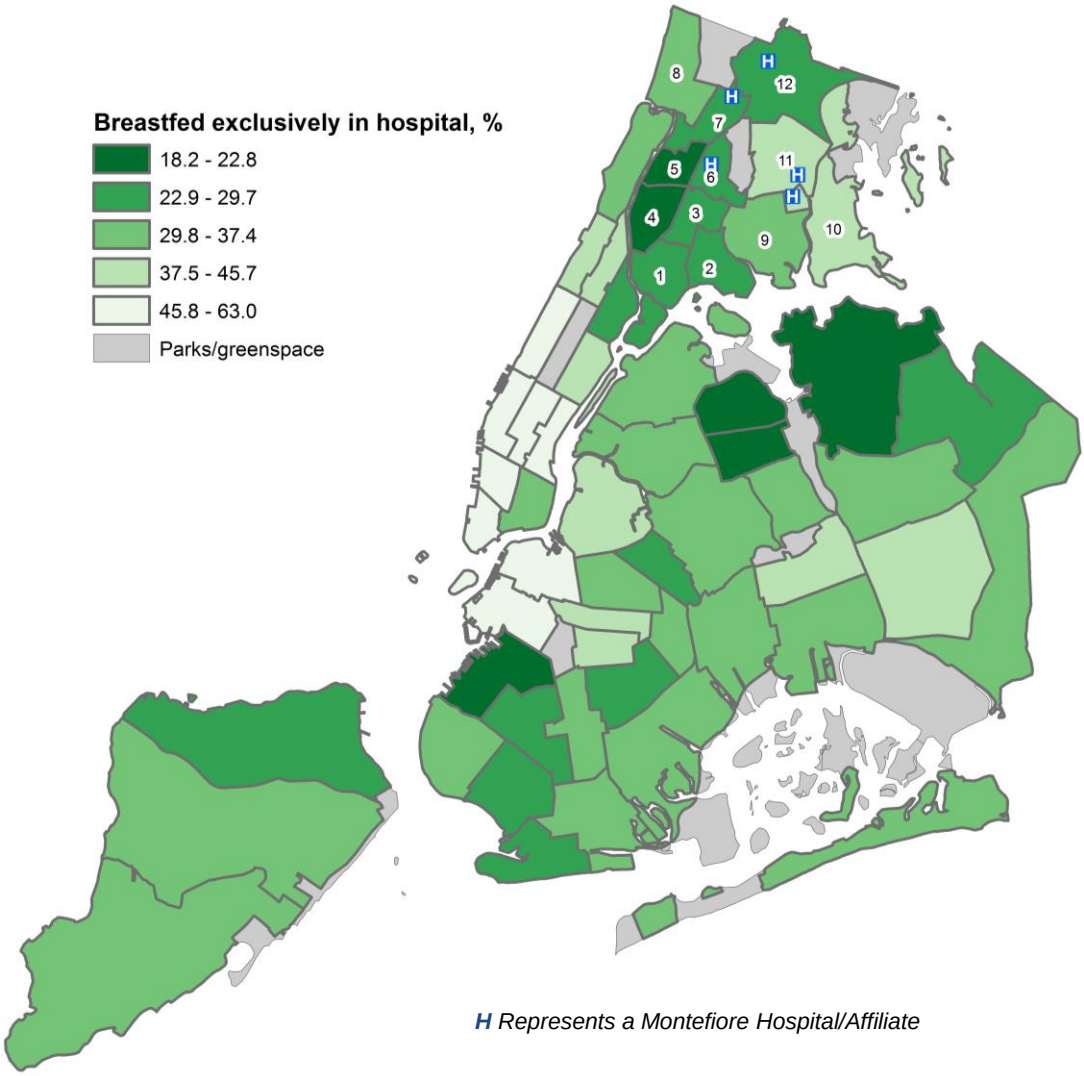




Data source: New York State Vital Statistics

Percent of Infants Exclusively Breastfed in the Hospital Map

Differences by Community District (2013-2016)

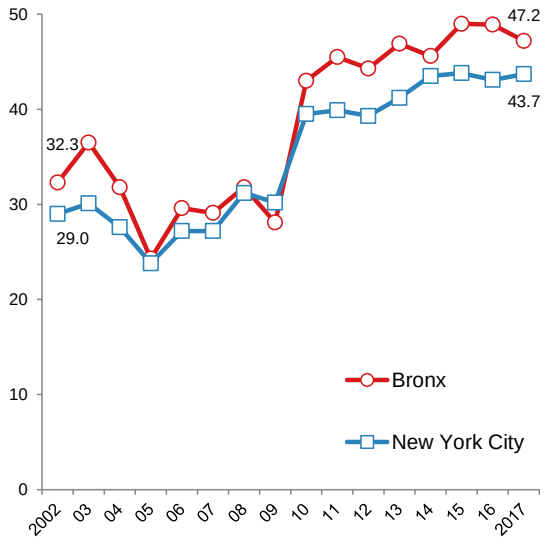


H *Represents a Montefiore Hospital/Affiliate*

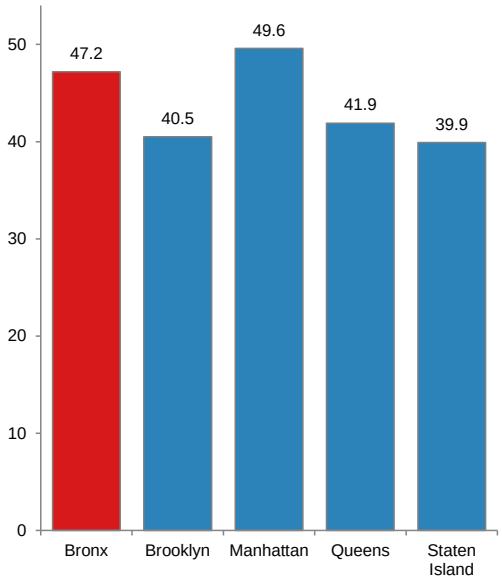
Data source: New York State Vital Statistics (2013-2016)

There was a decrease in the proportion of adults who received the flu vaccination from 2003 to 2005, but the trend has been increasing over all, with the proportion in the Bronx being second highest after Manhattan. The proportion of adults receiving the flu vaccine in the Bronx is lowest among the non-Hispanic black population, with little to no different based on education.

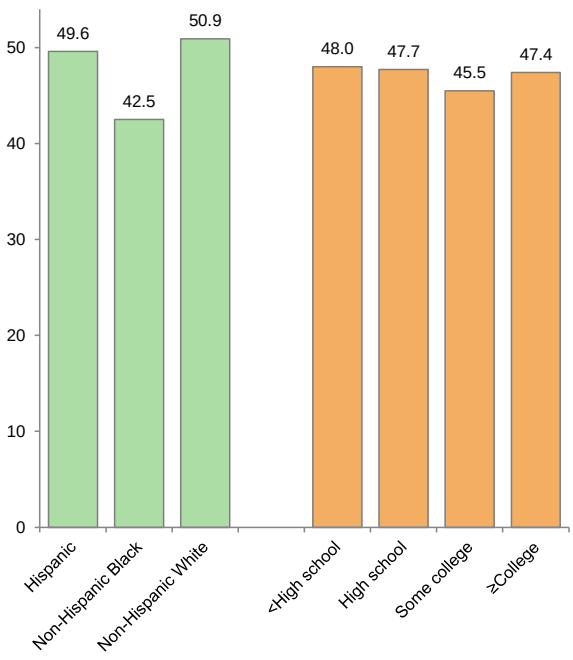
Proportion of Adults Receiving a Flu Vaccination in the Past Year



Comparison to NYC boroughs (2016)

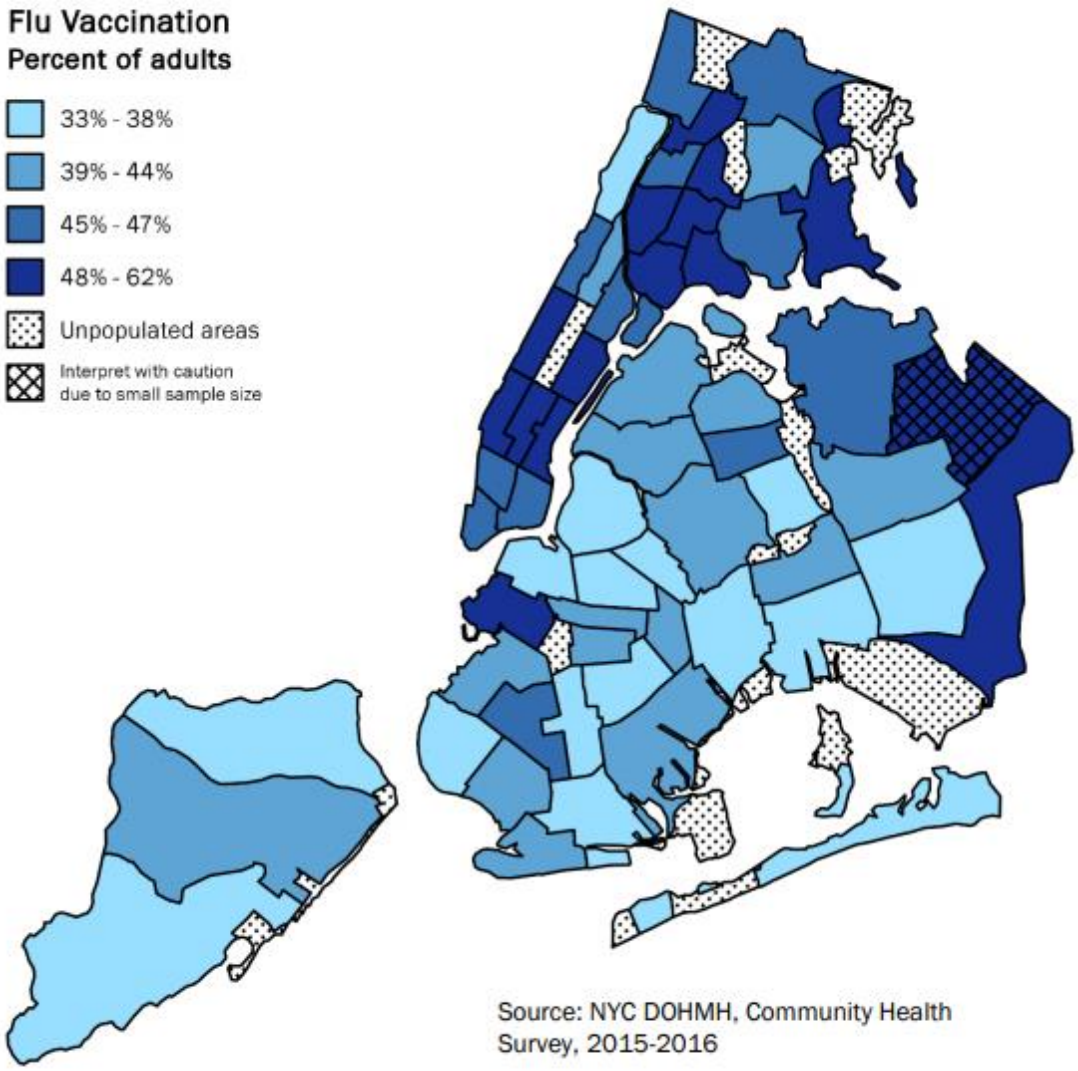


Disparities in the Bronx (2016)



Data source: NYC Community Health Survey.
Data are age-adjusted.

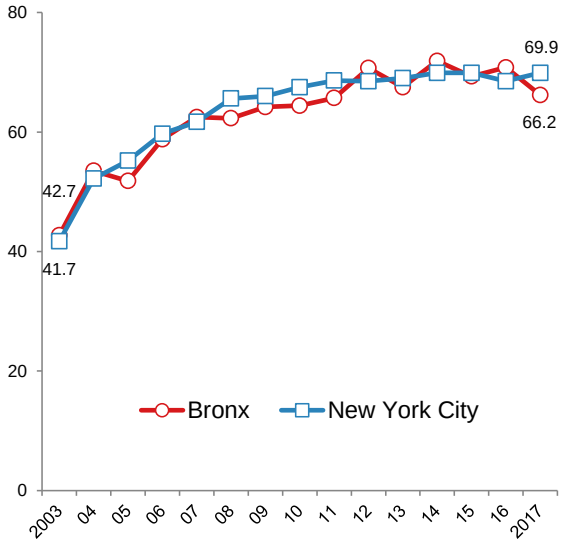
Percent of Adults Receiving a Flu Vaccination in the Past Year



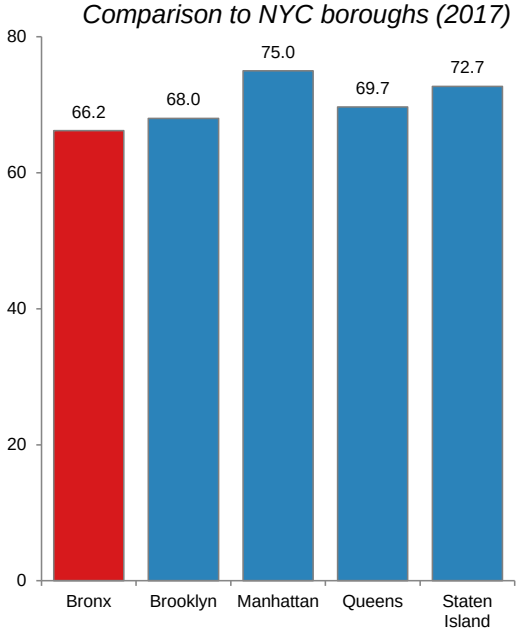
Map from New York City Community Health Profiles, 2018

The percent of adults who have had a colonoscopy in the last 10 years has increased in NYC but the Bronx has the lowest percent compared to other boroughs. In the Bronx, those with at least some college education are more likely to have had a colonoscopy in the last 10 years.

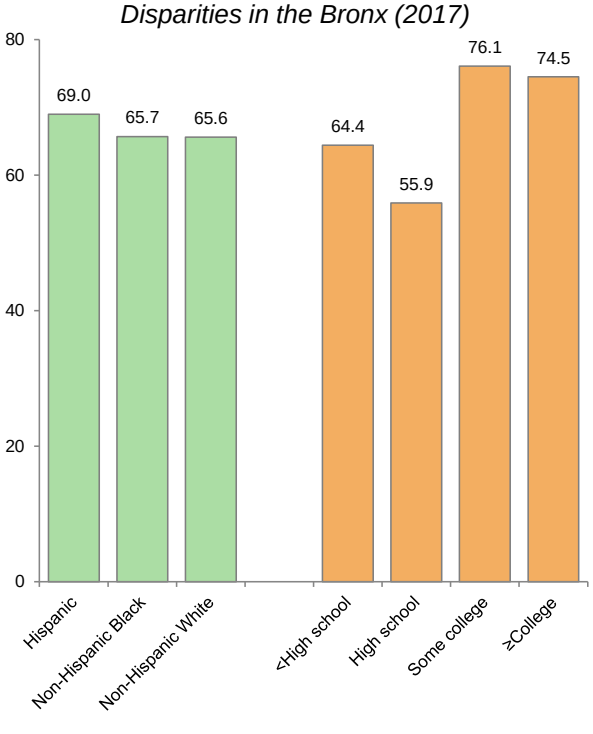
Percent of Adults Who Have Had a Colonoscopy in the Last 10 years



Comparison to NYC boroughs (2017)



Disparities in the Bronx (2017)

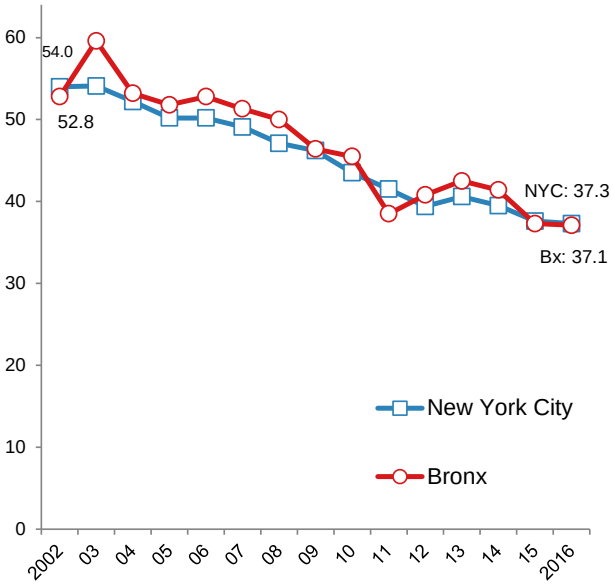


Data source: NYC Community Health Survey.
Data are age-adjusted.

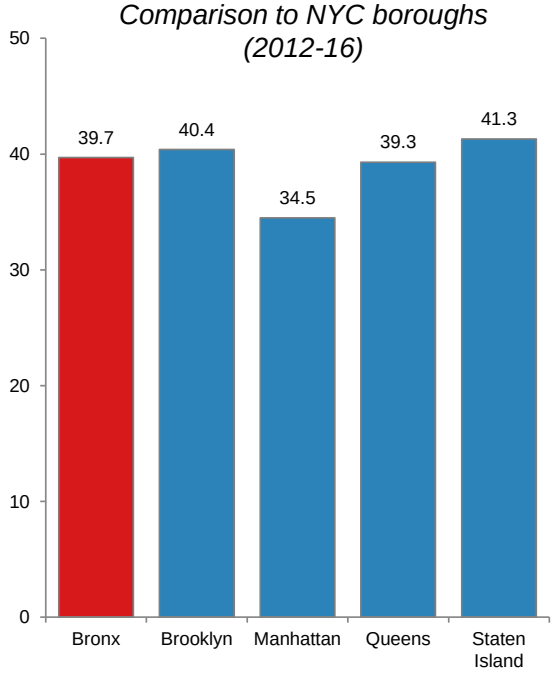
The incidence of colorectal cancer has decreased across NYC as a whole in the last two decades.

The incidence of colorectal cancer is higher among men and the non-Hispanic white population.

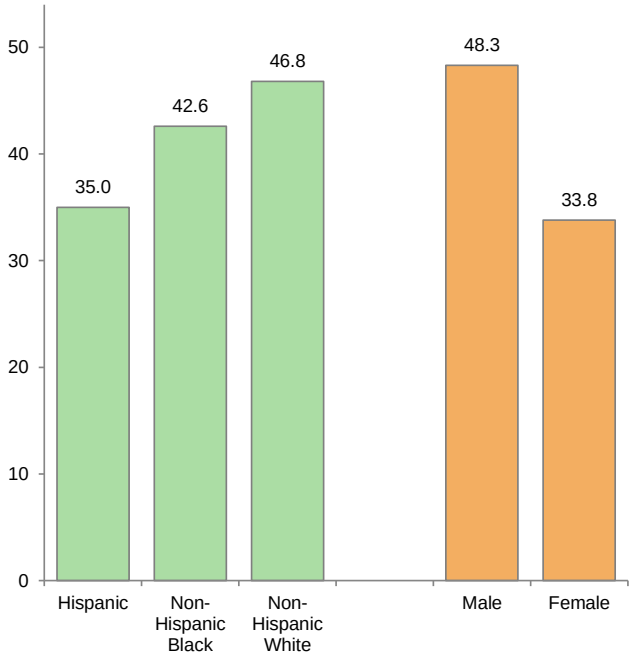
Colorectal Cancer Incidence per 100,000



Comparison to NYC boroughs (2012-16)



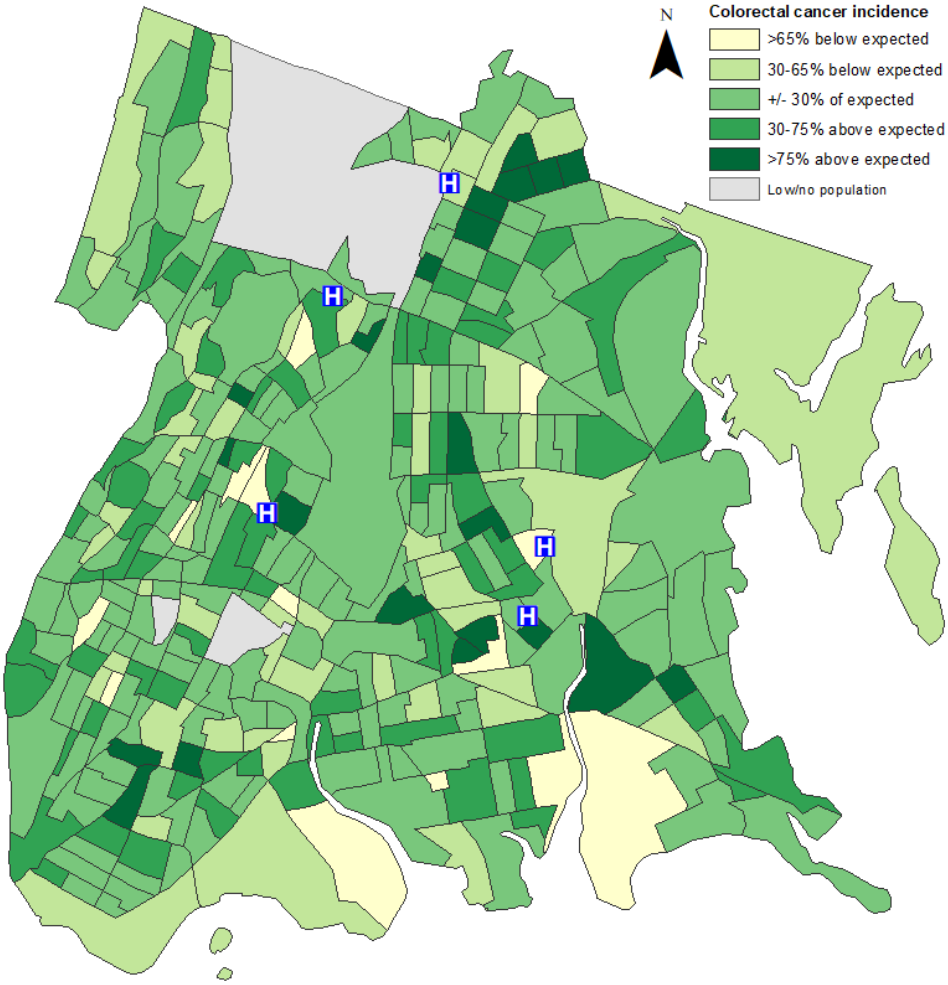
Disparities in the Bronx (2012-16)



Data source: New York State Cancer Registry.
Data are age-adjusted.

Colorectal Cancer Incidence in the Bronx

Differences by Census Tract

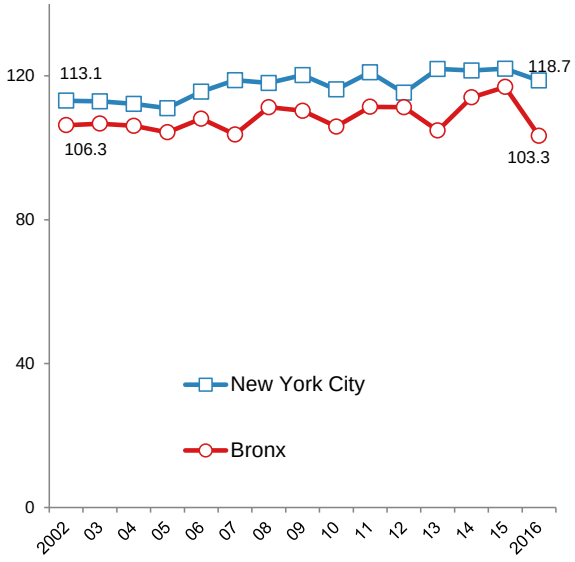


***H** Represents a Montefiore Hospital/Affiliate*

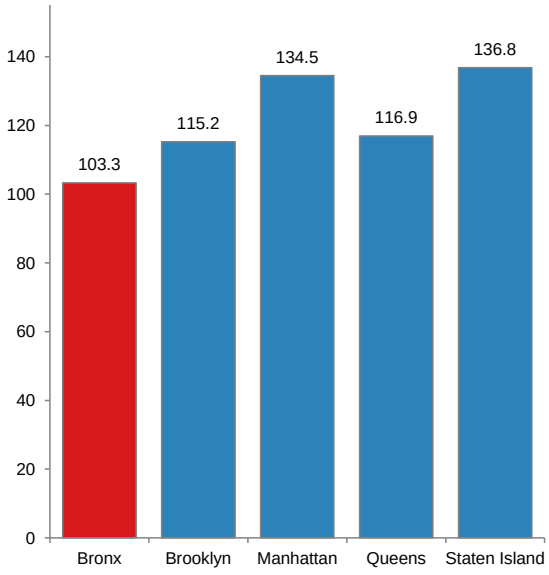
Data source: New York State Cancer Registry, 2010-2014. Data are age- and sex-adjusted.

For over the last decade, the incidence of breast cancer has remained relatively unchanged in the Bronx and NYC, with the incidence in the Bronx being lower than in any other borough. In the Bronx, the incidence of breast cancer is lowest among the Hispanic population.

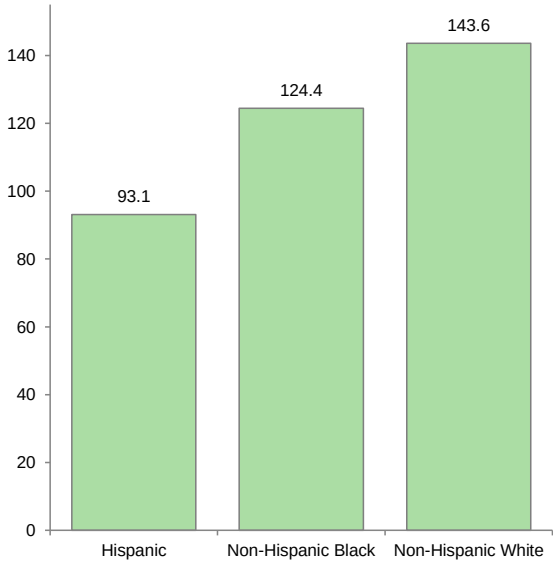
Breast Cancer Incidence per 100,000 Female



Comparison to NYC boroughs



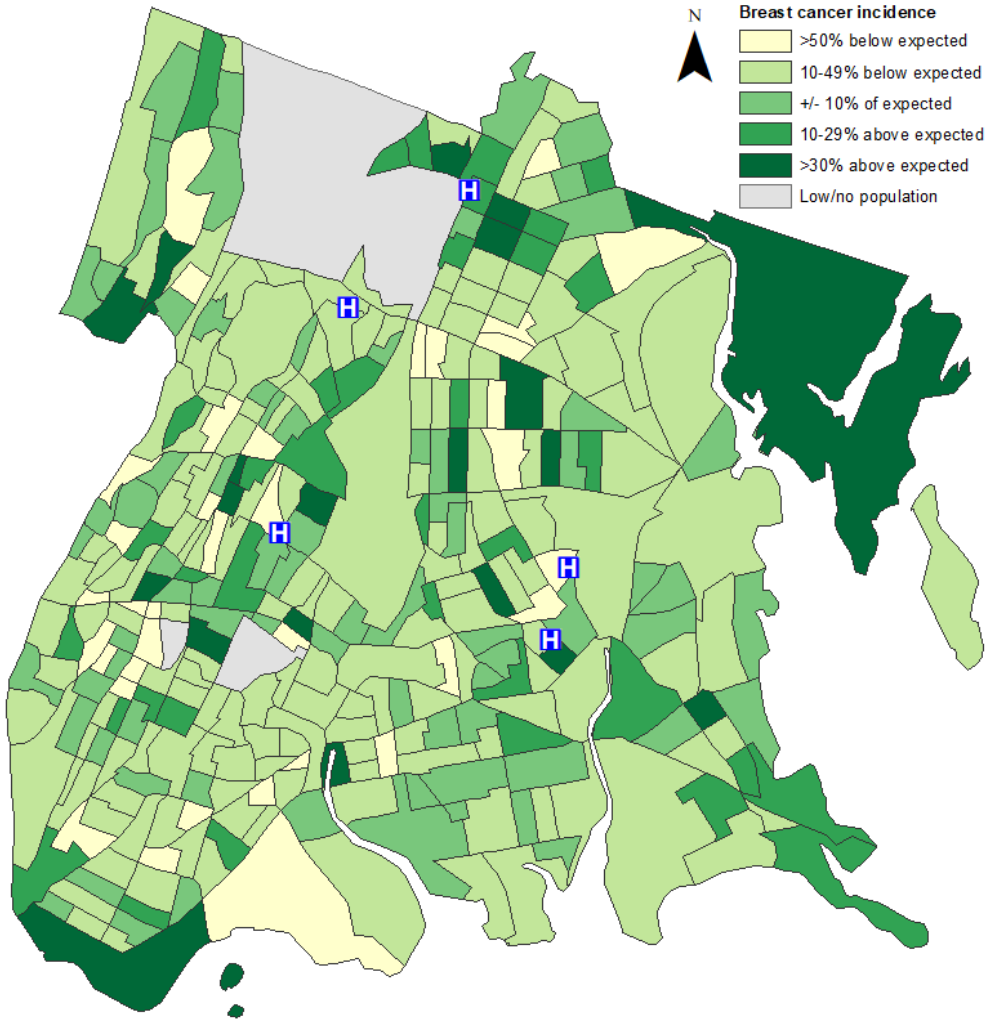
Disparities in the Bronx (2012-16)



Data source: New York State Cancer Registry.
Data are age-adjusted.

Breast Cancer Incidence in the Bronx

Differences by Census Tract

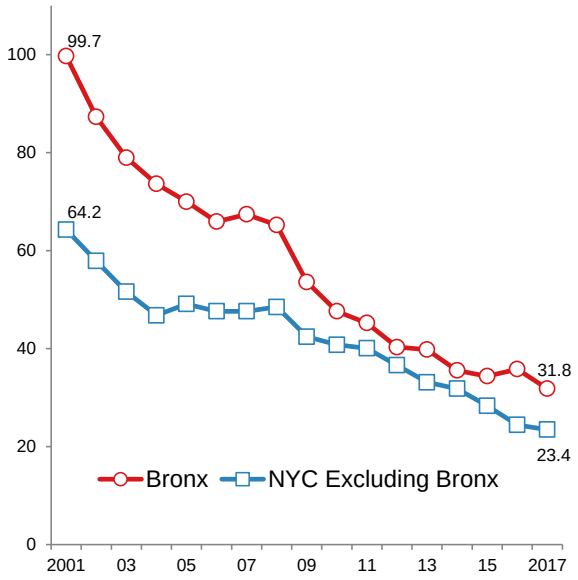


H *Represents a Montefiore Hospital/Affiliate*

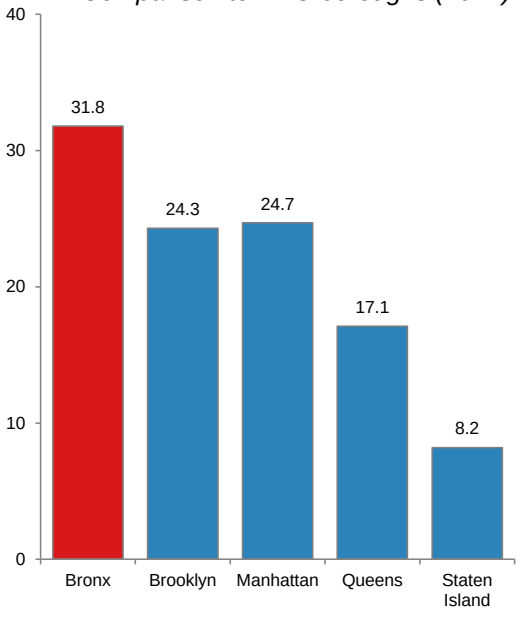
Data source: New York State Cancer Registry, 2010-2014. Data are age-adjusted.

The rate of HIV diagnoses has decreased for the Bronx by 68.1% from 2001 to 2017, but it's still higher compared to the other NYC boroughs. In the Bronx, the rate of HIV diagnoses is much higher among males and those who are non-Hispanic black.

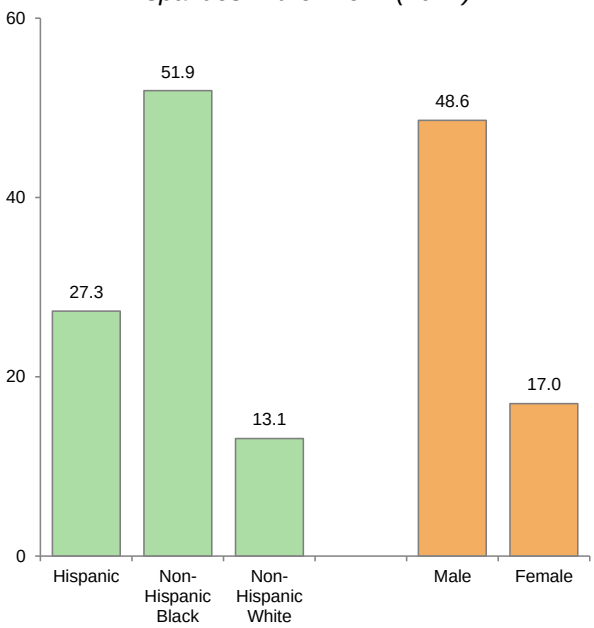
Rate of HIV Diagnoses per 100,000



Comparison to NYC boroughs (2017)

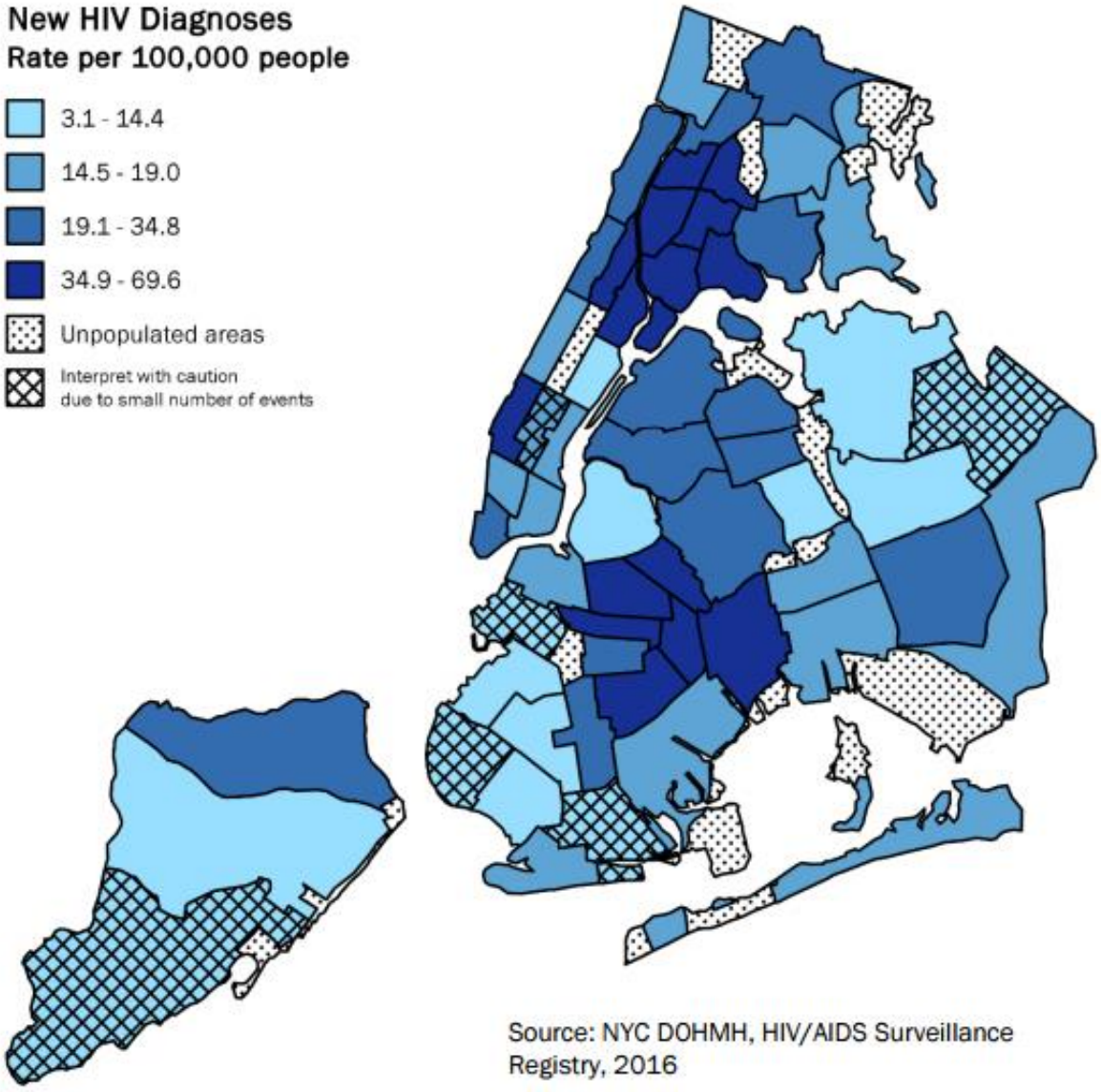


Disparities in the Bronx (2017)



Data source: NYC HIV/AIDS Annual Surveillance Statistics, 2017.

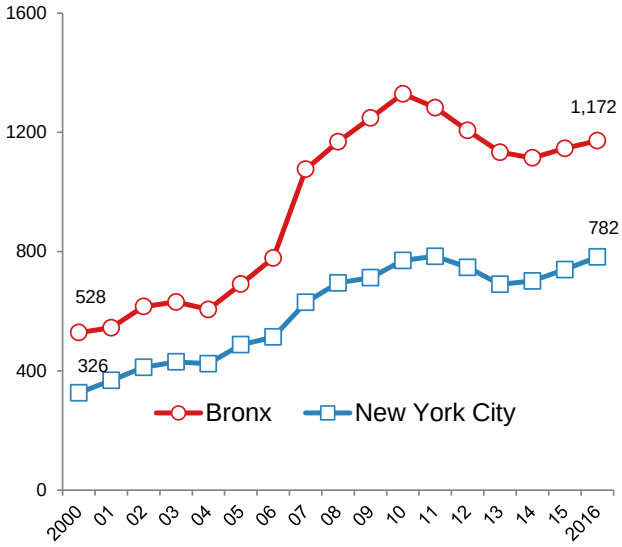
Rate of HIV Diagnoses per 100,000



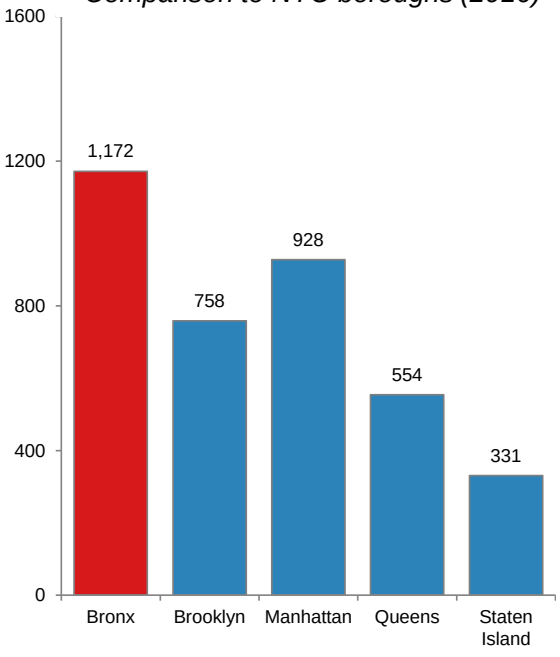
Map from New York City Community Health Profiles, 2018

From 2000 to 2016, the rate of chlamydia has been increasing in NYC, with the rate in the Bronx remaining higher compared to other NYC boroughs. In the Bronx, the rate of chlamydia is higher among females and those who are non-Hispanic black.

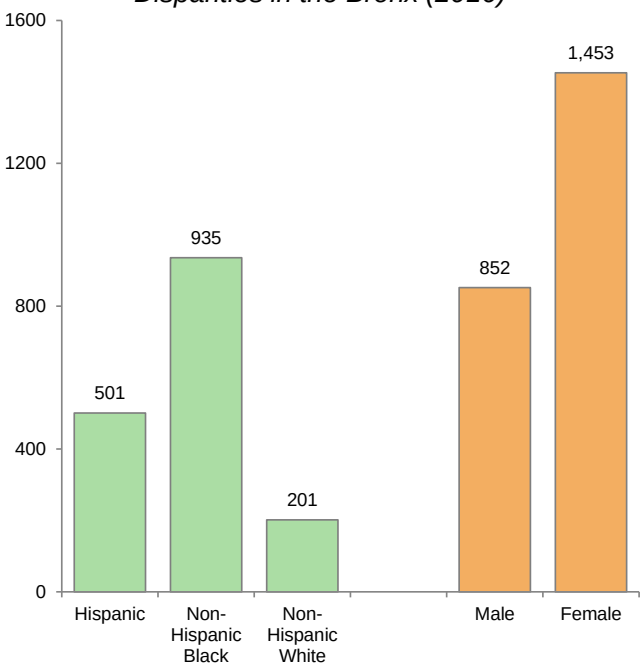
Rate of Chlamydia per 100,000



Comparison to NYC boroughs (2016)



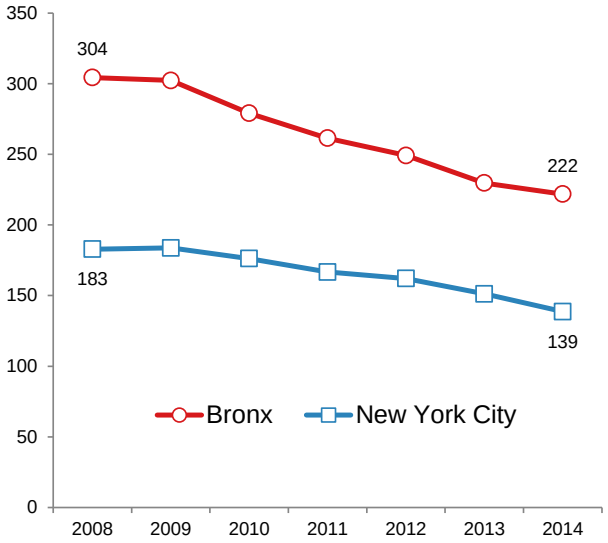
Disparities in the Bronx (2016)



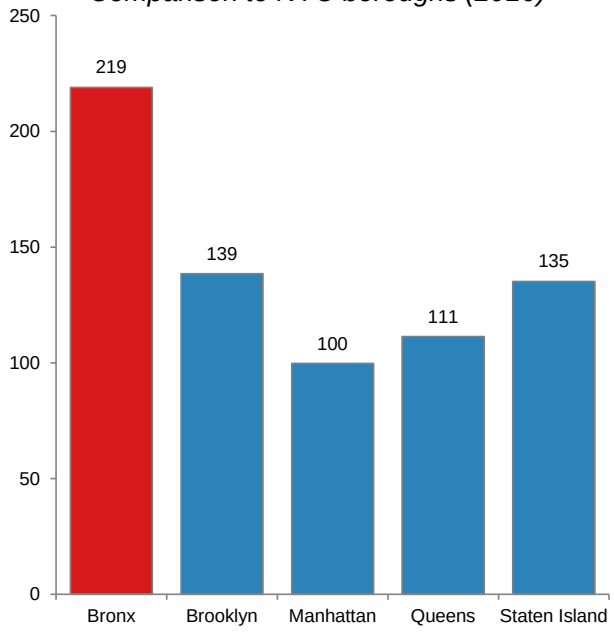
Data source: NYC Sexually Transmitted Diseases Surveillance Data.

The rate of preventable hospitalizations among adults has decreased in NYC in the last decade, with the rate in the Bronx remaining higher than other NYC boroughs. In the Bronx, the rate of preventable hospitalizations in adults is highest among the non-Hispanic black population.

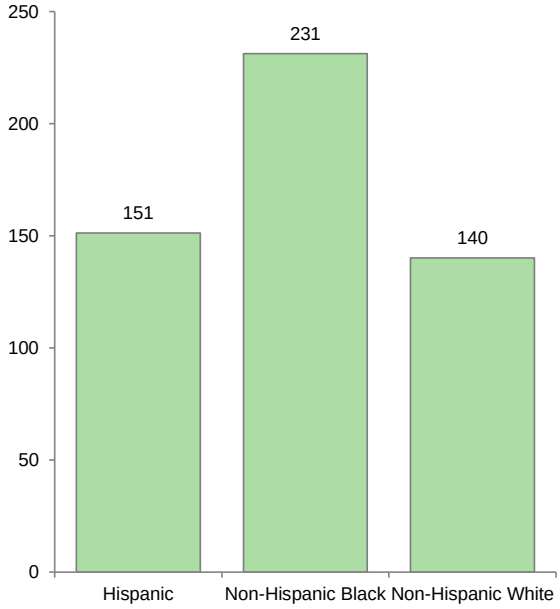
Preventable Hospitalizations Rate per 100,000 Adults



Comparison to NYC boroughs (2016)

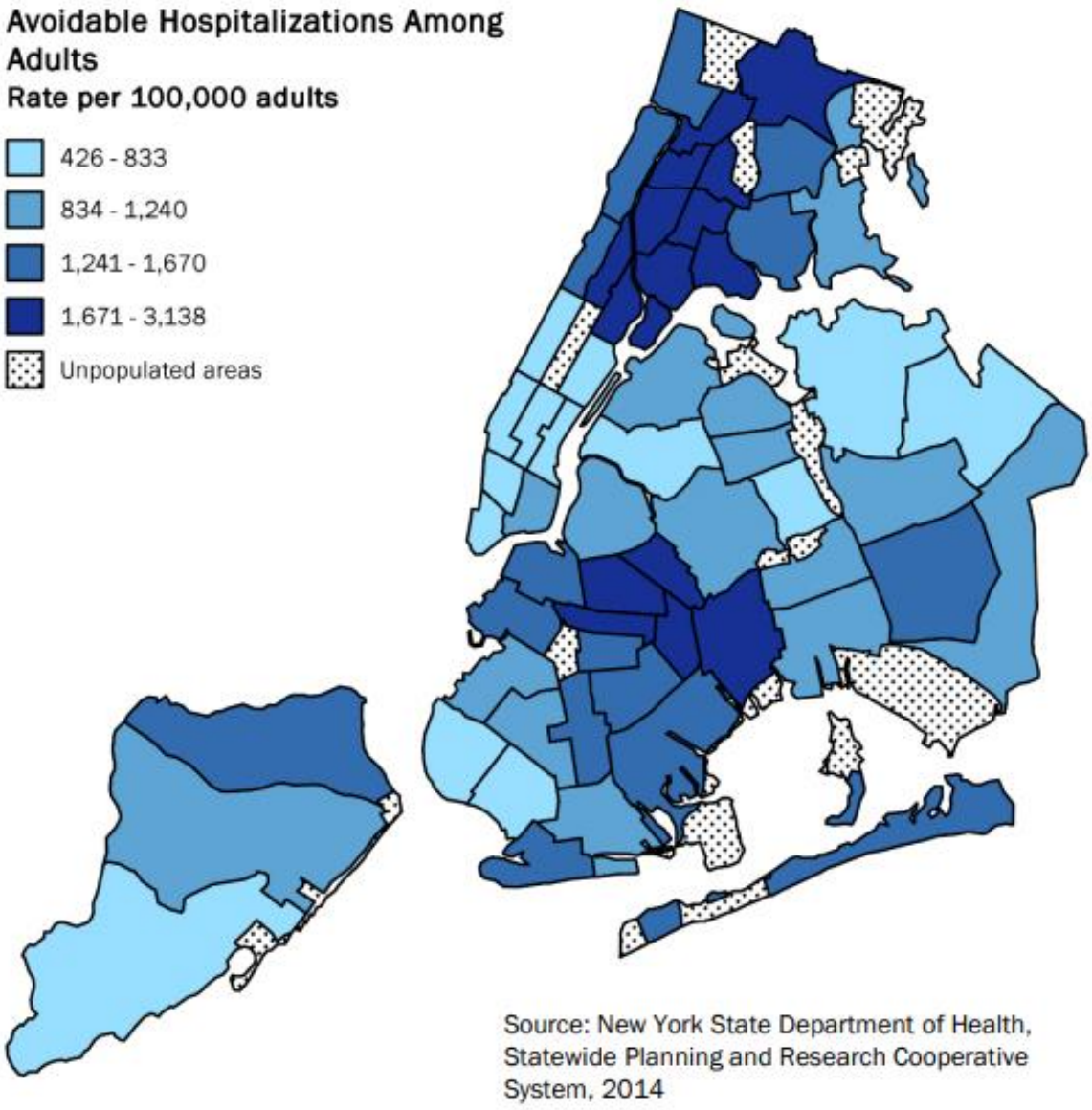


Disparities in the Bronx (2016)



Data source: Statewide Planning and Research Cooperative System (SPARCS). Trend data not available past 2014 due to switch to ICD-10 in 2015. Data are age-adjusted.

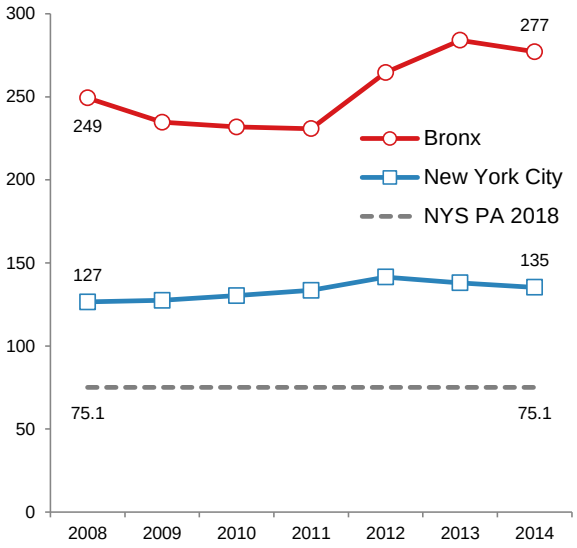
Preventable Hospitalizations Rate per 100,000 Adults



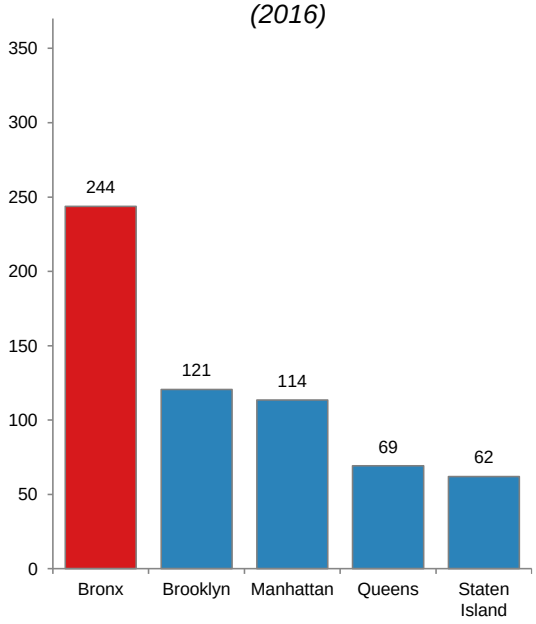
Map from New York City Community Health Profiles, 2018

The rate of asthma hospitalizations is greater in the South Bronx where the percentage of poverty is higher. The rate of asthma hospitalizations for the Bronx has increased in the last decade and remains at least two times higher than the rest of the NYC boroughs.

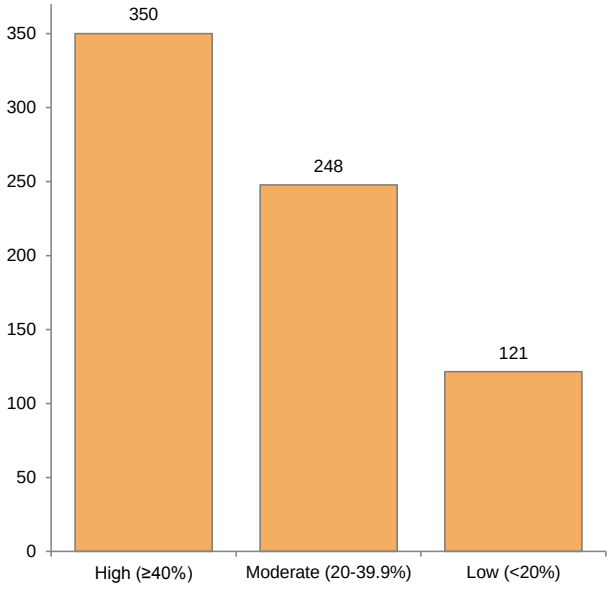
Asthma Hospitalizations per 10,000



Comparison to NYC boroughs (2016)



Disparities in the Bronx (2010-2014)

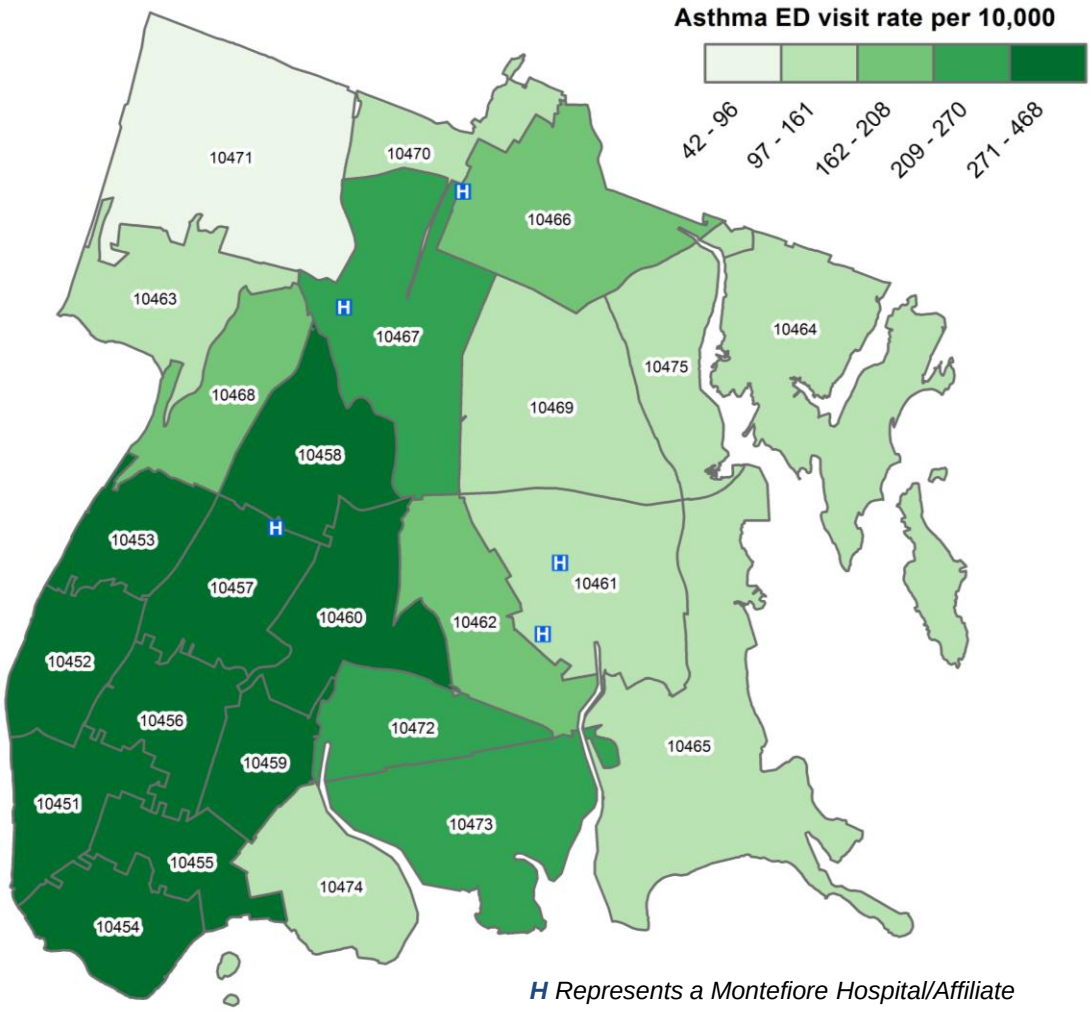


ZIP Code poverty (%)

Data source: New York State Statewide Planning and Research Cooperative System. Trend data not available past 2014 due to switch to ICD-10 in 2015. Data not age-adjusted.

Asthma Hospitalizations per 10,000 in the Bronx

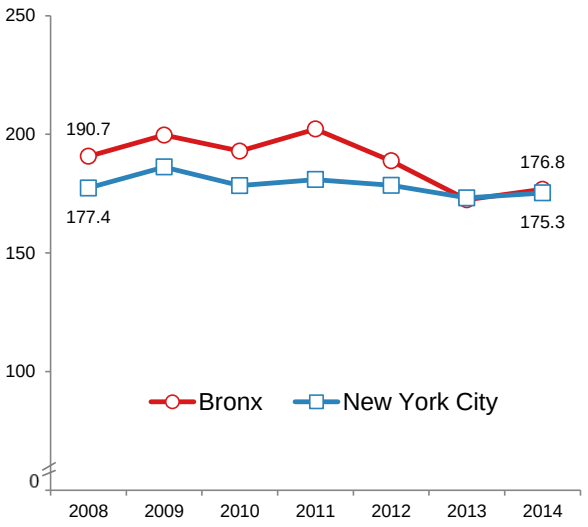
Differences by ZIP code



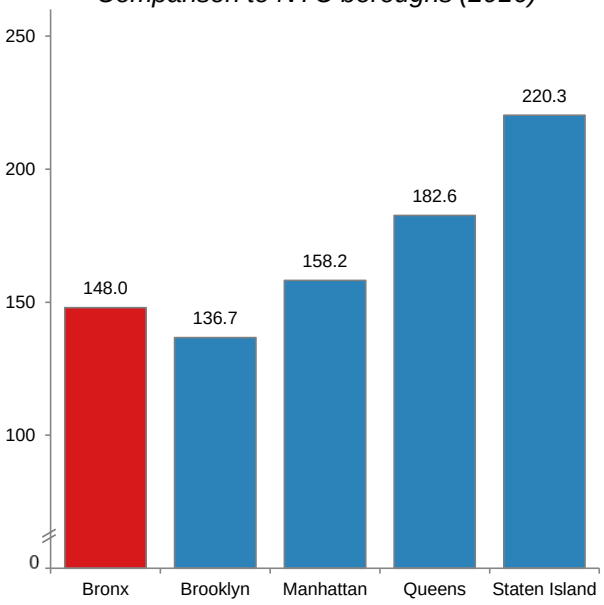
Data source: New York State Statewide Planning and Research Cooperative System, 2010-2014

The rate of hospitalizations due to falls has been decreasing in the Bronx for the last decade while the rates have remained relatively unchanged in NYC as a whole. In 2016, the Bronx had the second lowest rate of hospitalizations due to falls.

Rate of Hospitalizations Due to Falls per 10,000 Adults Aged 65+



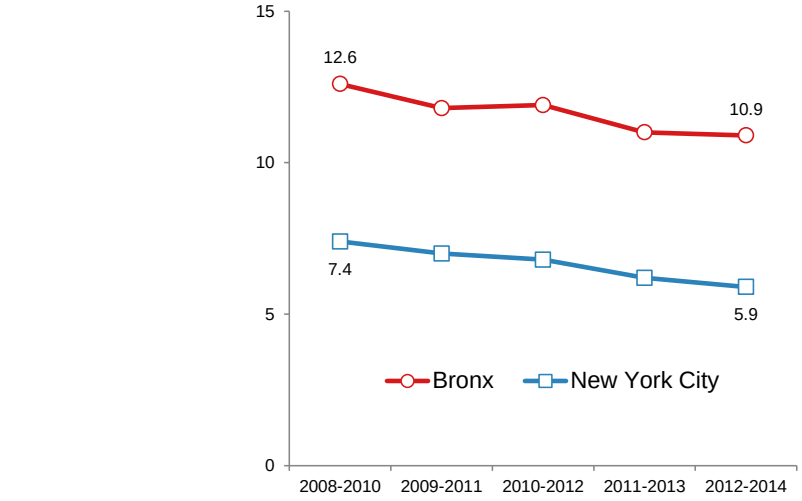
Comparison to NYC boroughs (2016)

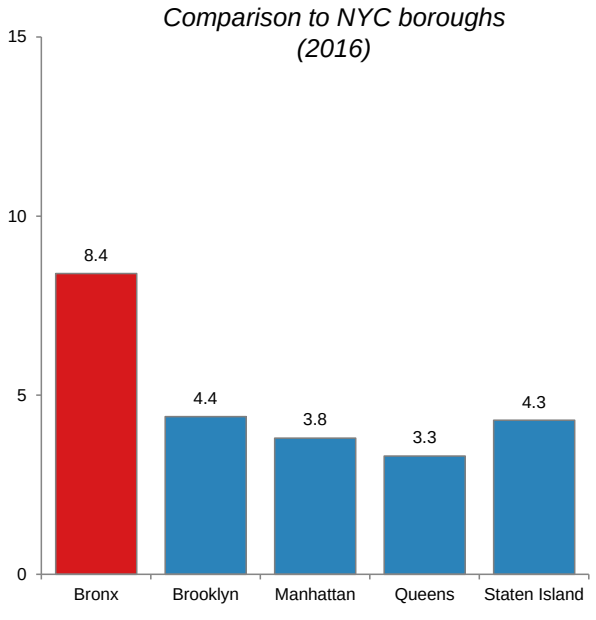


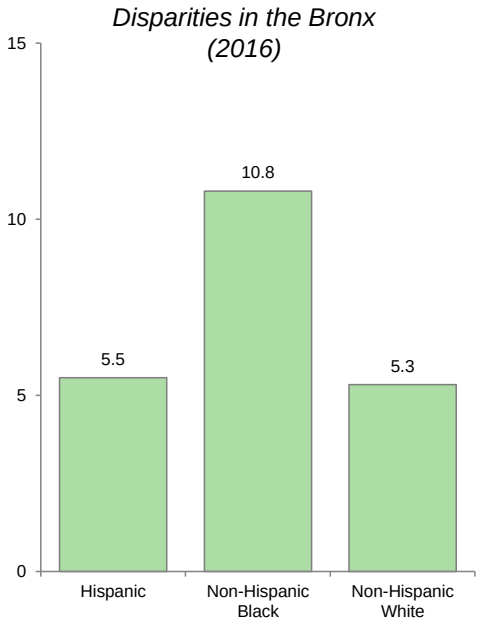
Data source: Statewide Planning and Research Cooperative System (SPARCS). Trend data not available past 2014 due to switch to ICD-10 in 2015.

While the rate of assault-related hospitalizations has decreased in the Bronx and across NYC, it remains highest in the Bronx compared to other boroughs. In the Bronx, the rate of assault-related hospitalizations is about two times higher among those who are non-Hispanic black compared to the Hispanic or non-Hispanic white populations.

Assault-Related Hospitalizations Rate per 10,000



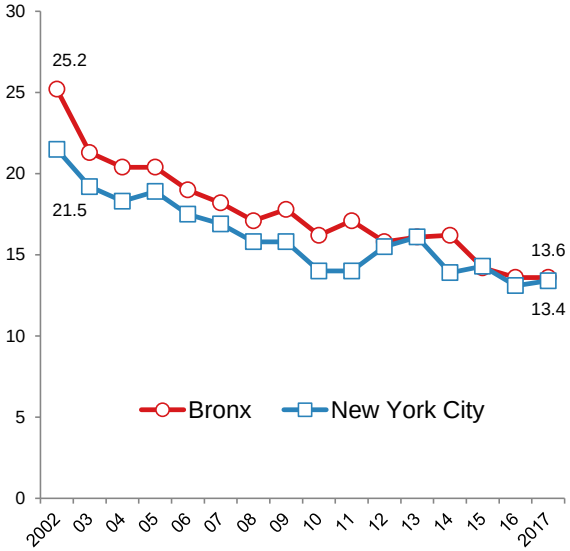




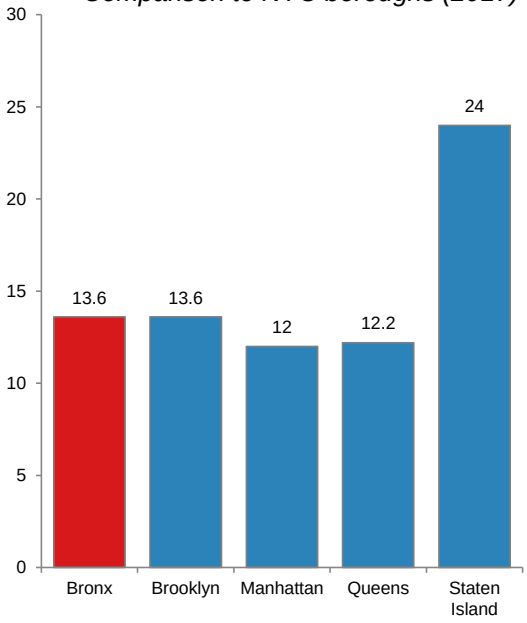
Data source: Statewide Planning and Research Cooperative System (SPARCS). Trend data not available past 2014 due to switch to ICD-10 in 2015.

The percent of adults who are current smokers has decreased in the Bronx and NYC overall for the last two decades. In the Bronx, the percent of adults who are current smokers decreases as level of education increases.

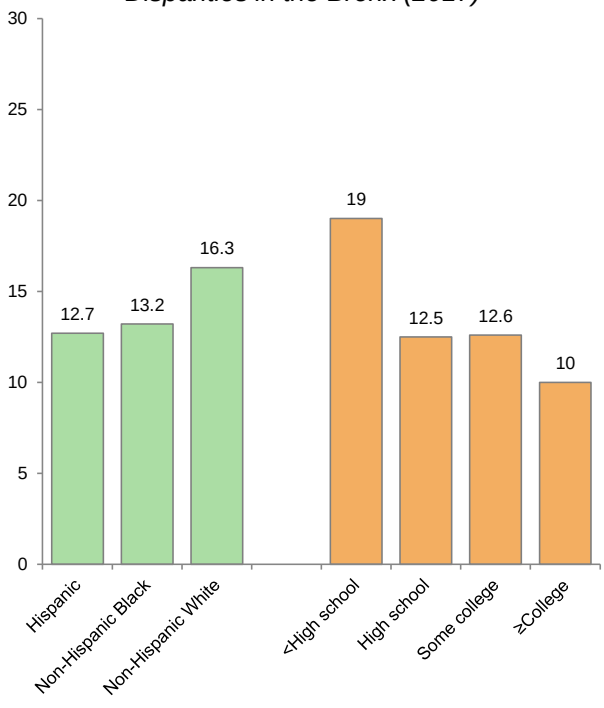
Percent of Adults Who Are Current Smokers



Comparison to NYC boroughs (2017)

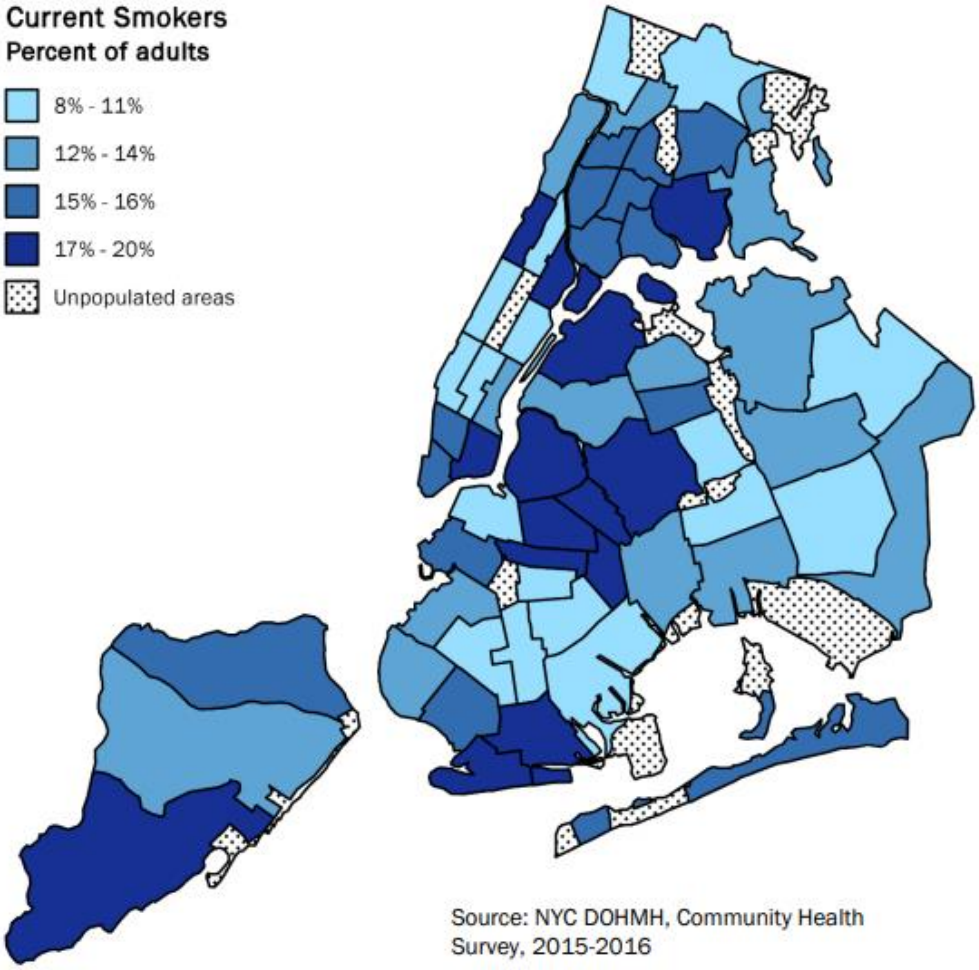


Disparities in the Bronx (2017)



Data source: NYC Community Health Survey.
Data are age-adjusted.

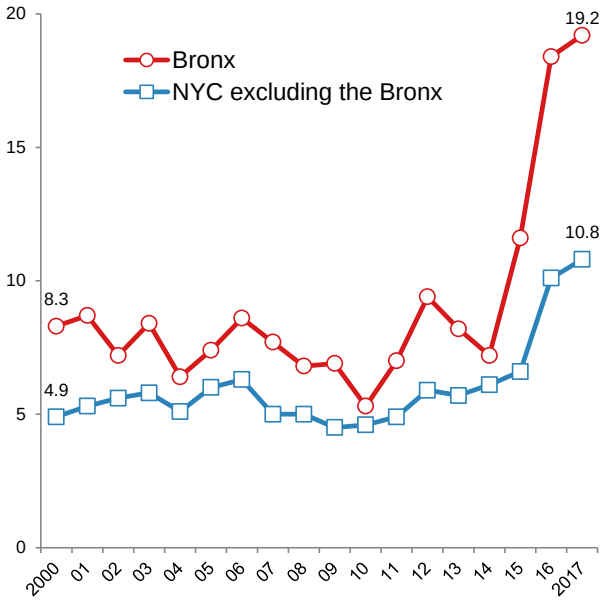
Percent of Adults Who Are Current Smokers



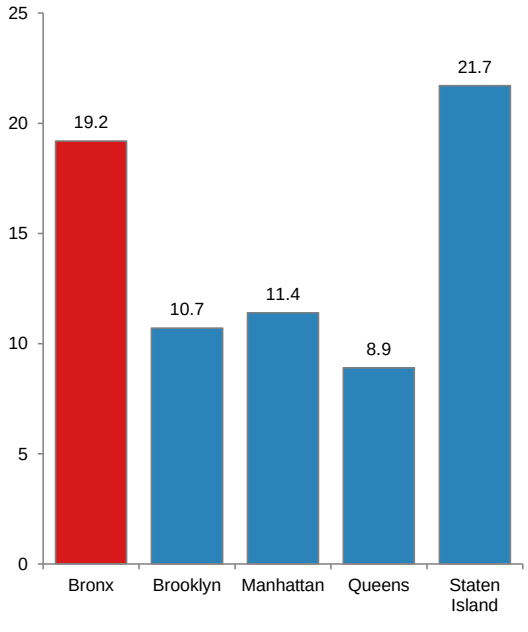
Map from New York City Community Health Profiles, 2018

From 2000 to 2017 the rate of opioid mortality has increased in the NYC, with the rates in the Bronx being second highest after Staten Island. In the Bronx, the opioid related mortality rate is highest among males and the non-Hispanic white population.

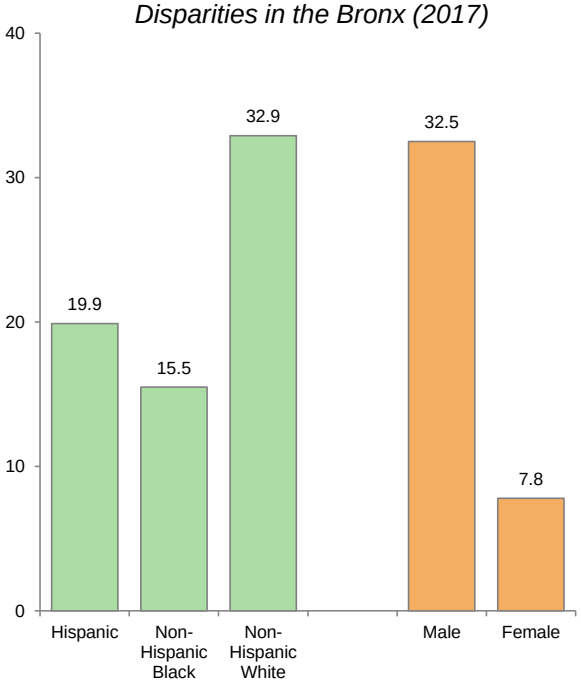
Opioid-Related Mortality per 100,000



Comparison to NYC boroughs (2017)



Disparities in the Bronx (2017)

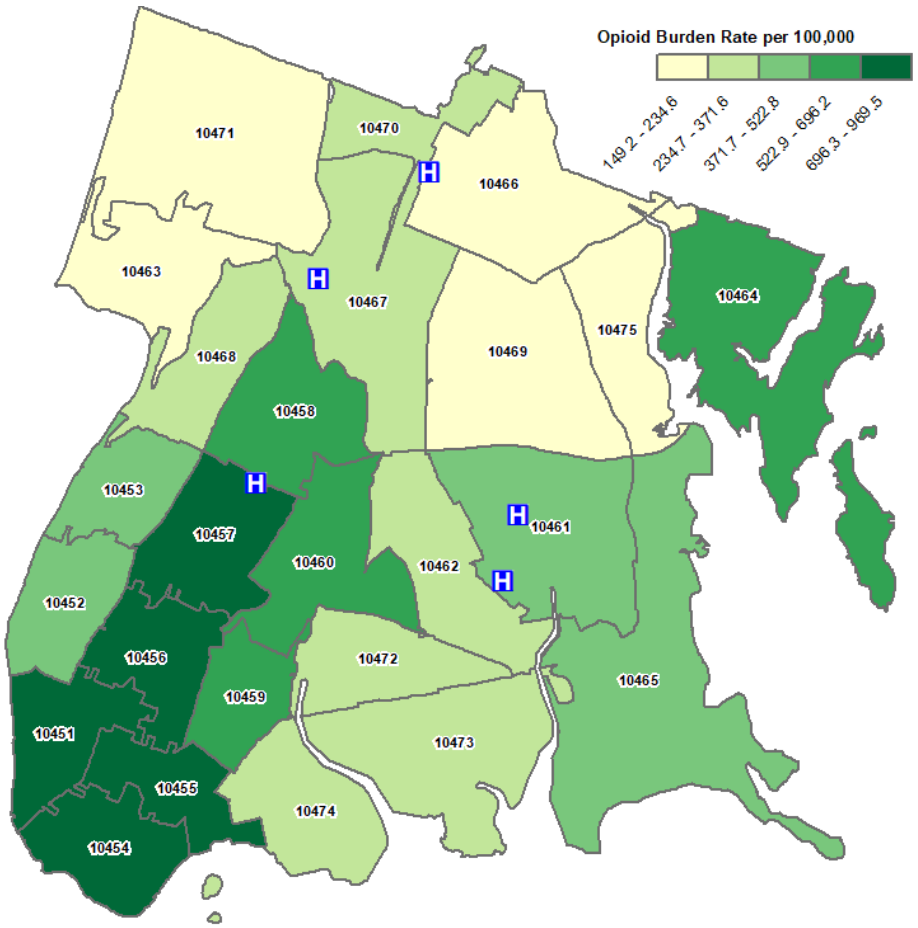


Data source: National Vital Statistics Surveillance System.

This map shows data for the opioid burden rate for the Bronx in 2016, which was highest in areas of the South Bronx.

Opioid Burden rate per 100,000 in the Bronx

Opioid Burden Rate per 100,000, 2016

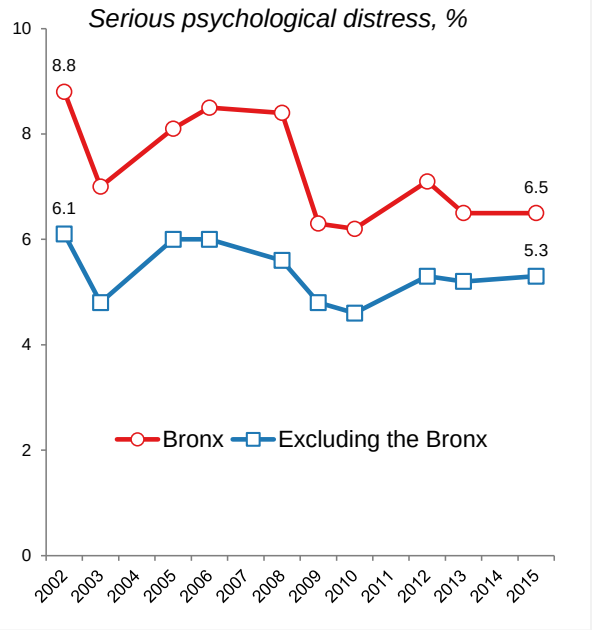


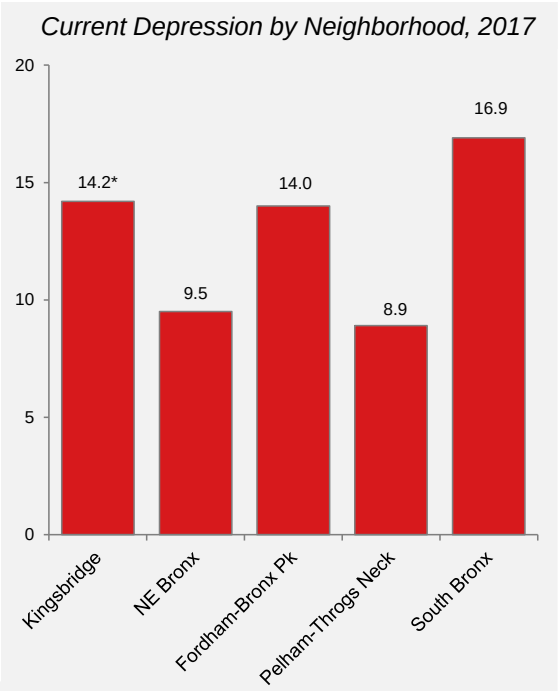
H *Represents a Montefiore Hospital/Affiliate*

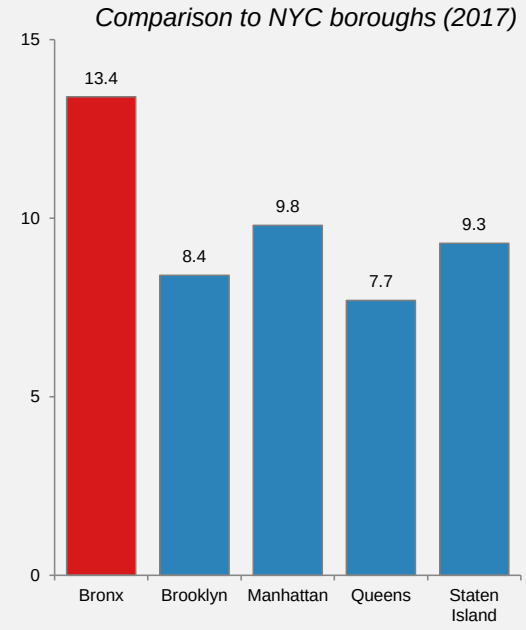
Data source: New York State Opioid Dashboard. The opioid burden combines data from SPARCS and vital statistics.

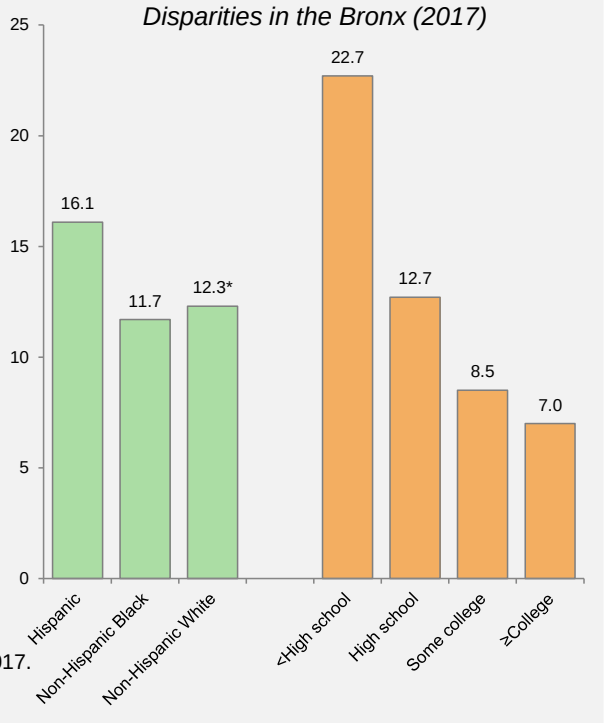
The Bronx has a higher percent of current depression compared to other NYC boroughs, with prevalence decreasing as education level increases.

Percentage of Current Depression





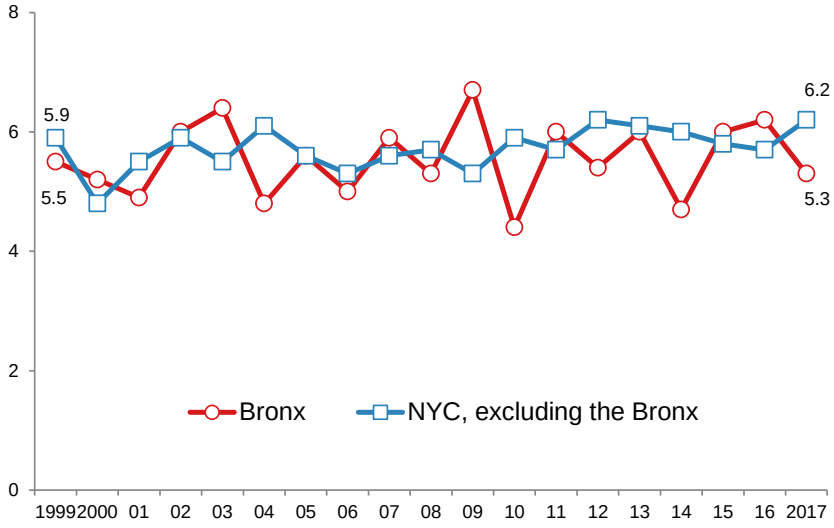




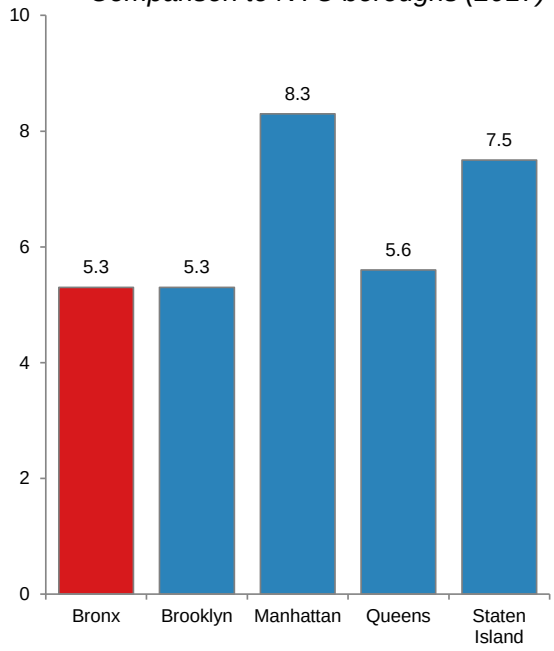
Data source: New York City Community Health Survey 2017.
Results are age-adjusted.
*Small sample size; interpret with caution.

The suicide mortality rate in the Bronx has remained steady from 1999 to 2017. In the Bronx, the suicide mortality rate is highest among males and the non-Hispanic white population

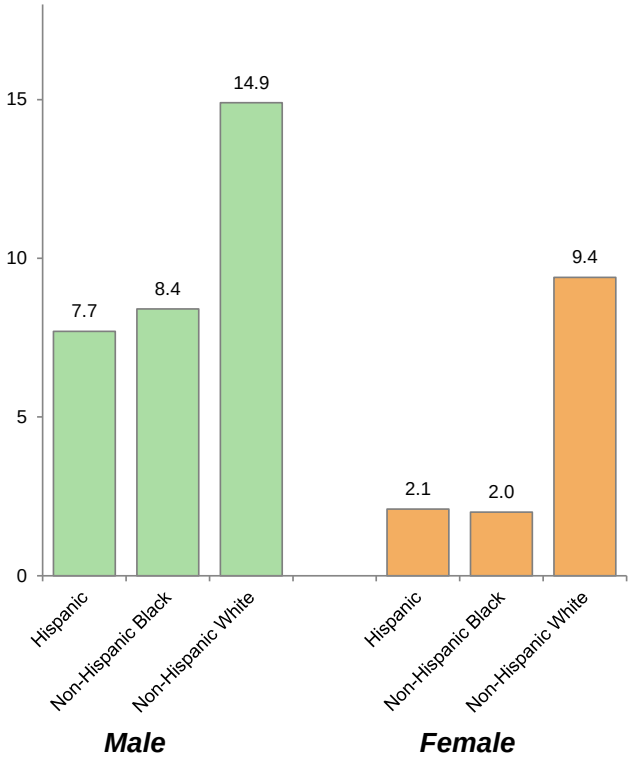
Suicide Mortality Rate per 100,000



Comparison to NYC boroughs (2017)



Disparities in the Bronx (2014-17)



Data source: National Vital Statistics Surveillance System. Data are age-adjusted.

Review of Key Findings

A Snapshot of Health Disparities in the Bronx

While the health status of the Bronx has improved in recent years, the gap between the Bronx and other boroughs remains and it has maintained. The Bronx remains a hotspot for excess mortality, diabetes, obesity, asthma, drugs/opioids, and HIV/AIDS in New York City. This section summarizes some of the key health disparities in the Bronx. Detailed secondary data is provided in **Section 7**.

Mortality Rates & Causes of Death. From 1999 through 2017, the age-adjusted mortality rate in the Bronx declined 33.8% (from 956.8 to 637.4 per 100,000). Despite this improvement, the Bronx has a higher age-adjusted mortality rate is 20.5% higher than the rest of New York City. The age-adjusted <75y mortality rate (e.g., premature mortality) is 38.7% higher in the Bronx than the rest of NYC. The leading causes of death in the Bronx are heart disease (185.2 per 100,000), cancer (136.5), unintentional injuries (37.1), influenza/pneumonia (29.2), stroke (25.4), diabetes (22.9) and chronic lower respiratory disease (22.3). About 64.2% of unintentional injury deaths are related to drug/alcohol overdose. The most common causes of cancer death include lung cancer, colorectal cancer, blood cancer/leukemia, breast cancer and pancreatic cancer.

Compared to the rest of New York City, the Bronx has excess mortality rate (e.g., >50% higher than the rest of the city) for the following causes: viral hepatitis, anemias, HIV/AIDS, essential hypertension and hypertensive kidney disease, septicemia, influenza and pneumonia, unintentional injuries, assault/homicide and chronic liver disease and cirrhosis.

Diabetes. According to the NYC DOHMH Community Health Survey in 2017, 17.5% of adults in the Bronx reported that they had previously been diagnosed with diabetes, compared to 11.5% citywide. From 2002-2017, the prevalence of diabetes among Bronx adults increased 119%. The prevalence of diabetes is significantly higher among Latino and non-Hispanic black residents of the Bronx, as well as those with less education. According to the NYSDOH, the average (age-

adjusted) rate of hospitalizations for short-term complications of diabetes per 10,000 in 2016 was 65 per 100,000 in the Bronx, significantly higher than the New York City rate of 39 and statewide rate of 40 per 100,000.

Obesity. In 2017, based on data from the NYC DOHMH Community Healthy Survey, the Bronx had the highest prevalence of adult obesity (defined as body mass index≥30 kg/m^2); 34.9% compared to 25.1% citywide. The prevalence of obesity increased 47.3% in the Bronx since 2002. Unlike the rest of the city, the upward trend in the obesity prevalence in the Bronx has not stabilized. Similar to adult obesity, the Bronx has the highest rates of obesity among children, 17.6% vs. 13.5% in the rest of New York City; the prevalence does not appear to be declining over time.

Asthma. According to the NYCDOHMH Community Health Survey in 2017, 17.0% of Bronx adult residents reported that they had been previously diagnosed with asthma (13.4% citywide). According to the NYSDOH, in 2016, the emergency department visits per 100,000 for asthma was 243.8 per 10,000, more than twice that of NYC overall (122.9 per 10,000) and 5-times the statewide rate (42 per 100,000). Asthma ED visits are significantly elevated in all parts of the Bronx with the exception of the 10471, 10464, 10463, 10470 and 10465 ZIP Codes. Rates are particularly high in the South Bronx (ZIP Codes 10454, 10451 and 10455).

Drugs & Opioids. In 1999, the age-adjusted mortality rate due to accidental drug overdoses was 10.4 per 100,000. By 2017, this had by 122% (23.1 per 100,000), making it a leading cause of death among Bronx residents. The death rate due to drug overdose is now comparable to that of diabetes or chronic lower respiratory disease. The Bronx has amongst the highest opioid burden (a measure that combines non-fatal and fatal overdose data) rates in New York State of 465.7 per 100,000 compared to 290 per 100,000 in New York City and 300.3 per 100,000 statewide.

HIV/AIDS. Based on data from the New York City Department of Health in 2017, the Bronx (31.8 per 100,000) has highest incidence (new cases) of HIV in New York City. Despite this difference, the trends in HIV incidence in the Bronx are encouraging; they have declined approximately 68% from 2002 to 2014, from 99.7 per 100,000 to 31.8 per 100,000.

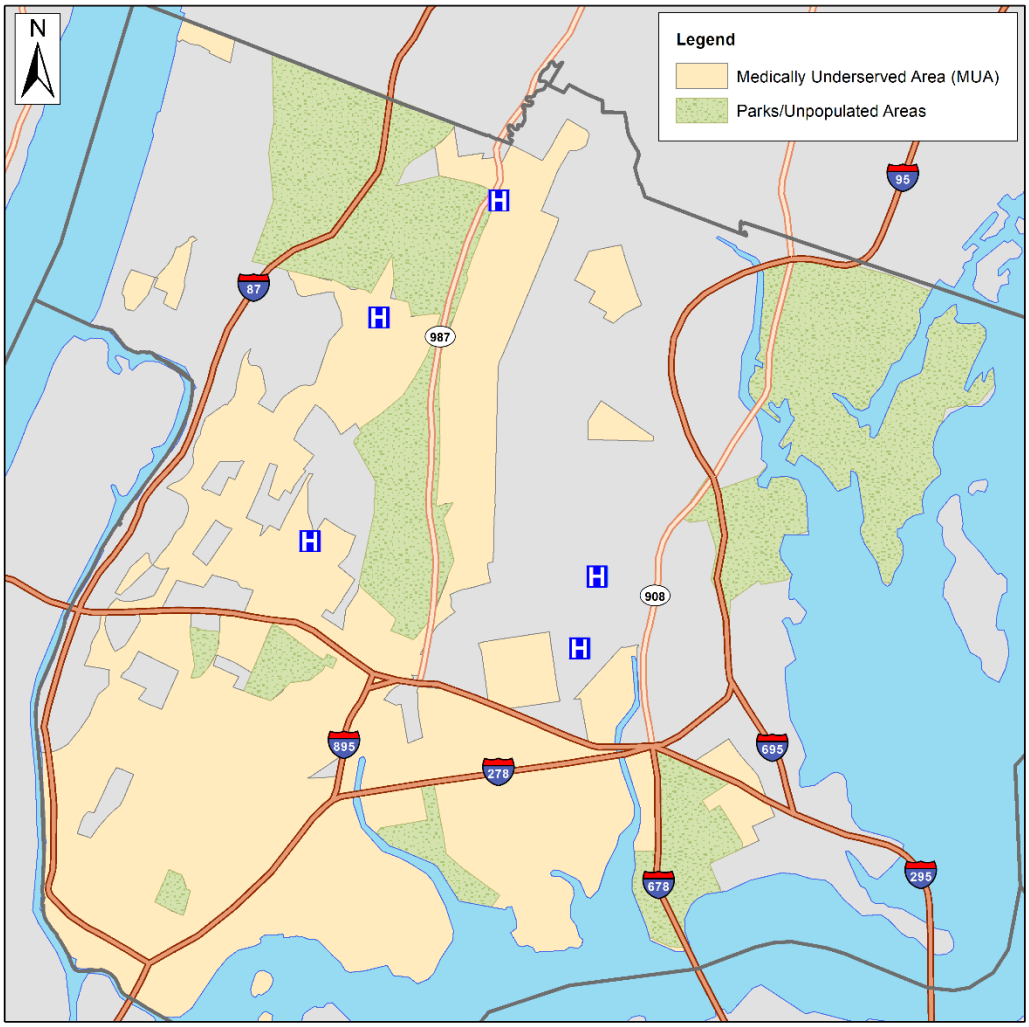
Medically Underserved Communities

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

The MUA designation applied to a neighborhood or collection of census tracts is based on four factors: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The HPSA designation is for a collection of census tracts that has been designated as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care (HRSA).

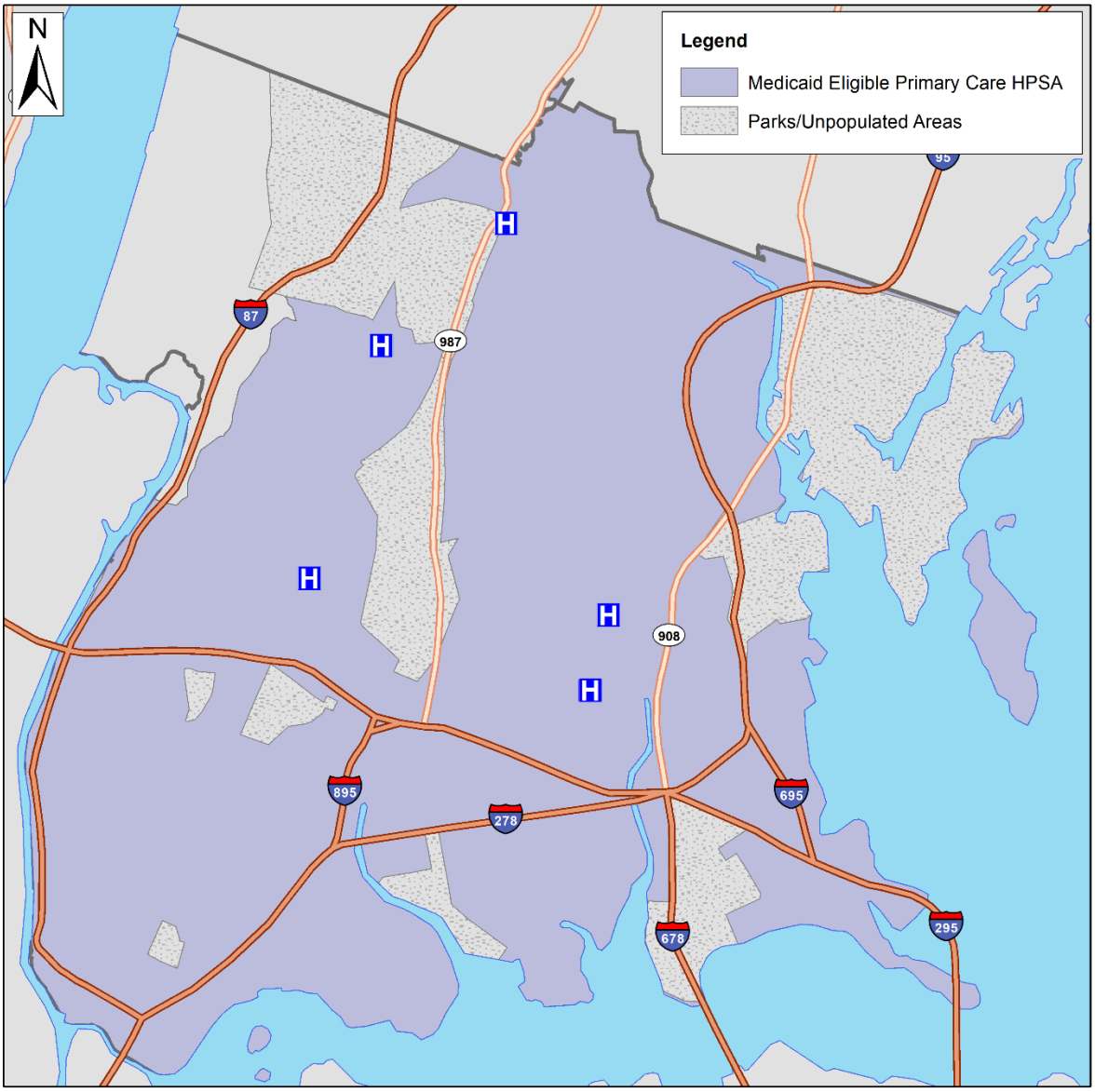
The Bronx has 18 MUA neighborhoods, with a combined population of 898,781 or 63.1% of the county population (see **Figure 1**). The Bronx has six Medicaid Primary Care HPSA designated neighborhoods (Pelham, Crotona, Northeast Bronx, High Bridge, Fordham, Hunts Point), which cover 93.7% of the county population (see **Figure 2**). The Bronx also has six Medicaid eligible mental health HPSAs (Pelham, Crotona, High Bridge, Fordham, Hunts Point, Riverdale), covering 84.2% of the Bronx population.

Figure 1. Map of Medically Underserved Areas (MUA) in the Bronx



Data source: Health Services Research Administration, 2019

Figure 2. Map of primary care health professional shortage areas in the Bronx



Data source: Health Services Research Administration, 2019

Discussion of Health Challenges

In order to identify community health needs Montefiore conducted an assessment of secondary data, including data from population-based surveys, hospital discharges and numerous other data sources. Montefiore worked collaboratively with its partners to gather extensive primary data on community health priorities using various methods and approaches.

The exact priorities identified through each of these approaches varied somewhat; however, the top community health priorities identified included 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).

Additionally Montefiore recognizes that where people live, work, learn, play, and worship have a great impact on health outcomes. Health risks and outcomes, functioning, and quality of life are impacted by the presence or lack of community resources and assets to support a population to grow and thrive, including access to healthcare, housing, education, employment and the built environment. The summary of the population in the Bronx included in this section provides a snapshot of the health disparities in the Bronx and demonstrates the continued need for collaboration with local partners.

This data shows that the health status of Bronx residents has improved in recent years; however, there remains to be a gap between the Bronx and other boroughs when looking at health outcomes across New York City. In the Bronx, many residents continue to struggle with poverty (28%) and unemployment (5.7%) with the Bronx being the poorest urban county in the United States and having the second highest unemployment rate in New York State.

Through the implementation of a social determinant of health screener in inpatient and outpatient settings, Montefiore continues to invest in ways to better learn about the challenges faced by our patient population both in and outside of the hospital. Patients identified a number of challenges through the social determinants of health screener including, but not limited to, housing, childcare, food access, healthcare transportation, safety, and legal help. Montefiore continues to explore the use of an electronic database/platform to provide personalized referrals connecting patients to community resources based on the information shared in through the social determinant of health screener. Through strong partnerships with local community organizations, Montefiore is seeking to improve the existing referral system to better connect patients to programming that addresses the specific needs of our population.

Summary List of Specified Community Needs

Based on results from the community surveys, Montefiore identified the top 5 priority and action areas for Montefiore Medical Center service area of Bronx County. The table below compares the top 5 priority and action areas by ranking.

Ranking	Priority Area for	Action Area for	Personal Priority Area

	Community	Community	
1	Mental Health	Access to Healthier Food	Food and Nutrition
2	Food and Nutrition	Mental Health Services	Environments That Promote Well-being & Active Lifestyles
3	Chronic Disease Screening And Care	Affordable Housing	Physical Activity
4	Obesity	Employment Opportunities	Mental Health
5	Environments That Promote Well-being & Active Lifestyles	Exercise And Weight Loss Programs	Chronic Disease Screening And Care

Using the primary data from the community survey in combination with the secondary data collected as part of this process, Montefiore identified the priority areas listed below for the Bronx.

- Obesity
- Diabetes
- Mental health
- Substance use disorders
- Asthma
- Hypertension
- Violence
- HIV/AIDS

Special Considerations

The Bronx, with its large population, remains a challenging population to assess comprehensively. Despite a multi-site, multi-methods, multi-lingual approach to survey distribution, the survey completion rate was lower than desired with 584 individuals documenting Bronx Zip codes completing the primary data collection tool of Community Health Needs Assessment survey. When compared to the American Community Survey, women and adults age 25-34 years old, are slightly over-represented in the survey, however the overall age and gender distribution of participants is comparable to the distribution of respondents. Also notable was the participation of an increased proportion of more highly educated residents than the Bronx overall, but the race/ethnicity distribution is comparable.

The survey was disproportionately completed by individuals who indicated that they spoke English, as opposed to Spanish at-home. While all of these factors represent possible gaps in information, the combination of both primary and secondary data helps to fill in some of the gaps and help identify community needs as identified through community input and the most recent available data for the county.

Implementation Strategy Report

Implementation Strategy Report

The overall health of Bronx County, along with other counties in New York State, has continued to improve, which has helped New York State to rise in health status from a ranking of 40th out of 50 states in 2009 to 12th out 50 states in 2018. Within New York State, the relative ranking of the Bronx has improved for (1) length of life and (2) health behaviors. Even with this overall improvement, Bronx County still ranks 62nd (last) of all counties in New York State in overall health due to remaining among the poorest performers for the other four domains: clinical care, quality of life, social and economic factors and physical environment, according to the Robert Wood Johnson County Health rankings.

Given the complexity of supportive services and programs provided across the Montefiore Health System and input from multiple sources as previously described, the needs selected for identification were done to ensure alignment with the New York State Prevention Agenda. The major category areas are **Preventing Chronic Disease** and **Promote Well-Being and Prevent Mental and Substance Use Disorders**. Based on the reported and documented health needs that were important across the populations surveyed and also reflected in the data as critical and in alignment

Significant Needs to Be Addressed

The first of two Priority Areas identified with key data points highlighted are to **Prevent Chronic Diseases** with two focus areas selected. The first focus area is **(1) Healthy Eating and Food Security**, for the targeted objectives to:

- Decrease the percentage of adults ages 18 years and older with obesity (among all adults)
- Decrease percentage of adults who consume one or more sugary drink per day (among all adults)
- Increase percentage of adults with perceived food security (among all adults)

The second focus area is **(2) Preventative Care and Management** with the targeted objectives of increasing the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%, and decreasing the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%).

The second of the two Priority Area selected is to **Promote Well-Being and Prevent Mental and Substance Use Disorders** with the goal selected to **Prevent opioid overdose deaths**, and the targeted objectives to:

- Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 1,00,000 population; and

- Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.1 per 1,000 population. Baseline: 35.9 per 1,000

One of the Priority Areas selected in 2016 have been re-selected in 2016, though the focus areas have expanded to include food security. This cycle's Priority Areas also includes work on mental and substance use disorders which is in alignment with the DSRIP work at Montefiore. DSRIP has a very strong focus on both the prevention and management of chronic diseases and behavioral health issues (including substance abuse). Given these are significant risk factors for the residents of the Bronx, we believe that it is important to continue our chronic disease prevention work in our clinics and extending our reach into the community

Through the process of completing and reviewing data obtained through the primary and secondary sources, engaging with community stakeholders and key partners and a review of resources available within the Medical Center and through its partnerships, an Implementation Strategy was developed to address the significant needs identified. Below is a description of the priority areas, focus areas, and goals selected for this cycle of the Community Health Needs Assessment.

Priority Area: Prevent Chronic Disease

Focus Area: Healthy eating and food security

Goal	Goal 1.1: Increase access to healthy and affordable foods and beverages
Outcome Objectives	Objective 1.4 By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity (among all adults)
Interventions	The Montefiore Healthy Store Initiative (MHSI) engages bodega owners in increasing supply and promotion of healthier food and beverage options. MHSI also engages local groups around advocacy for improved food access and provides nutrition education and technical assistance to drive demand for healthier food and beverage options.
Family of Measures	Currently, ten (10) bodegas are participating in the Montefiore Healthy Store Initiative and we will implement activities to increase participation in the this program through programming to raise awareness and demand for healthier food and beverage options, and partnering with community organizations to work with bodegas in

	their neighborhoods. Family of measures will include: • Number of community-based organizations that partner with MHSI for training and technical assistance to adopt a local bodega • Number of bodegas participating in the Montefiore Healthy Store Initiative (MHSI).
Implementation Partner	MHSI will continue to work with local bodegas to promote and provide healthier food and beverage options for the community. MHSI will also work closely with community-based organizations to provide them with the support and training needed to identify and partner with bodegas in their community to increase access to healthier foods and beverages.
Partner Role(s) and Resources	Bodega owners will approve supply and promotion of healthier food and beverage products. Additionally, the Healthy Beverage Zone, an effort of the #Not62 Campaign for a Healthier Bronx will assist in connecting the MHSI with local CBO's. This work is done in partnership with the Montefiore WIC vendor training program which can provide additional access to, and engagement from, bodega owners.
By When	December 31, 2021
Will Action Address Disparity	Yes. In Bronx County the percentage of adults with obesity is 34.9%, higher than the state's baseline of 25.5%. Montefiore will continue to work to reduce this number and bring us closer to the state target of 24.2% through our community and clinical programming. Montefiore Medical Center serves an ethnically diverse and income challenged community.

Priority Area: Prevent Chronic Disease

Focus Area: Healthy eating and food security

Goal	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices

Outcome Objectives	Objective 1.7: Decrease percentage of adults who consume one or more sugary drink per day (among all adults)
Interventions	The Montefiore Healthy Store Initiative (MHSI) will disseminate "Rethink Your Drink" boards across the Health System (including ambulatory care, substance abuse treatment programs, and school health sites) to serve as a tool for educating patients and the community (including parent groups, community centers, advocacy groups, tenant groups and service agencies) about the amount of sugar present in commonly bought juices, sodas, and other flavored drinks. MHSI works with youth groups at local community based organizations (CBO's) and the Montefiore School Health Program to create "Rethink Your Drink" boards, as part of the MHSI's effort to increase the demand for zero and low calorie beverages at local stores.
Family of Measures	In the Bronx, 31% of adults report drinking 1 or more sugary drinks per day on average, based on data from the Community Health Survey. This number shows a decrease in sugary drink consumption, although it is still above the state's baseline of 23.2%. Montefiore will continue to work toward decreasing this number in the Bronx to bring the Bronx closer to the state's target of 22%. Family of measures will include: • Number of boards disseminated at Montefiore sites • Number of adults educated on sugar content in commonly purchased sugary drinks
Implementation Partner	MHSI will work with community-based organizations to provide them with the support and training needed to identify and partner with bodegas in their community to increase access to healthier foods and beverages.
Partner Role(s) and Resources	Local community-based organizations
By When	December 31, 2021
Will Action Address Disparity	Yes. Although sugary drink consumption has declined throughout New York City, it remains highest in the Bronx with younger adults, non-Hispanic black adults and adults with less education being more likely to consume sugary drinks. Montefiore Medical Center serves an ethnically diverse and income challenged community.

To better identify and understand patient needs and opportunities for intervention, Montefiore has implemented a social determinants of health screening tool to better understand the health challenges faced by our patient population. The screener will be administered in outpatient and inpatient settings to assess patients for social needs, including food insecurity. Patients with an identified need will receive referrals to community resources both at Montefiore and local community-based organizations that are partnering with Montefiore. Referrals will be provided via a community resource directory/referral tool that will connect patients to appropriate resources. Additionally, continued outreach and trainings will be offered to providers to train on proper use of the online resource directory, and to increase implementation of the screening. Information gathered through the screener will be used to design and implement future programming to address identified barriers to care.

Priority Area: Prevent Chronic Disease

Focus Area: Healthy eating and food security

Goal	Goal 1.3: Increase food security
Outcome Objectives	Objective 1.13: Increase percentage of adults with perceived food security (among all adults)
Interventions	Implement social determinants of health screener in outpatient and inpatient settings to screen for social needs, including food insecurity, and use community resource directory/referral tool to connect patients to appropriate resources.
Family of Measures	At Montefiore, more than 47,000 people have been screened through a social determinant of health screener. Data from the screener shows that 5.4% of patients screened reported food insecurity as a barrier. Family of measures will include: • Number of patients screened for social needs • Number of patient referrals to community resources to address food insecurity.
Implementation Partner	MHSI will work with community-based organizations to provide them with the support and training needed to identify and partner with bodegas in their community to increase access to healthier foods and beverages.
Partner Role(s) and	Local community-based organizations

Resources	
By When	December 31, 2021
Will Action Address Disparity	Yes. Montefiore Medical Center serves an ethnically diverse and income challenged community.

Priority Area: Prevent Chronic Disease

Focus Area: 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	Engagement of clinical partners in the HbA1c screening protocol as outlined in HEDIS; alignment of clinical and community based resources to address the level of patient health status (prevention, management or control). Increased screening and intervention is also being promoted across the ambulatory setting through the programs associated with DSRIP.
Family of Measures	Family of Measures to include: • Number of people who received an HbA1c test • Number of people whose most recent HbA1c level indicated poor control (>9.0 percent), was missing or did not have a HbA1c test • Number of people whose most recent level of bad cholesterol was below the recommended level, was missing, or did not have an LDL-c test
Implementation Partner	Clinical providers
Partner Role(s) and Resources	Partners will provide access to a range of preventive, maintenance and self-management programs for individuals across the pre-diabetes and diabetes spectrum. Partners will provide Technical Assistance, opportunities for neighborhood based cultural/linguistic specific classes, and

	opportunities for data sharing and collaboration
By When	December 31, 2021
Will Action Address Disparity	Yes. Overall, a higher percentage of adults in the Bronx have diabetes compared to other boroughs, with a higher percentage in adults who are Hispanic or non-Hispanic black. Montefiore Medical Center serves an ethnically diverse and income challenged community.

Within the Priority Area Prevent Chronic Diseases is the Focus Area: Preventive Care and Management. Increasing rates for the screening of diabetes, especially among disparate populations, is priority in increasing the rates of screening, care, management and control of diabetes. In addition to expanding the opportunities for clinical evaluation of diabetic Bronx residents, Montefiore is actively engaged with the National Diabetes Prevention Program from the CDC and is pursuing certification through the Centers for Disease Control (CDC) through the implementation of the Montefiore Diabetes Prevention Program.

Priority Area: Prevent Chronic Disease

Focus Area: Preventive Care and Management

Goal	Goal 4.3: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and pre-diabetes and obesity
Outcome Objectives	Objective 4.3.1: Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%)
Interventions	Based on the evidence-based National Diabetes Prevention Program by the CDC, Montefiore's Diabetes Prevention Program (MDPP) helps those at high risk of developing diabetes make lifestyle changes in order to delay disease onset.
Family of Measures	Family of Measures to include: • Number of people enrolled in Montefiore's Diabetes Prevention Program (MDPP) • Number of individuals who complete MDPP
Implementation Partner	Clinical providers

Partner Role(s) and Resources	Providers will screen patients for diabetes and refer patients who identify as pre-diabetic into the Montefiore Diabetes Prevention Program.
By When	December 31, 2021
Will Action Address Disparity	Yes. Overall, a higher percentage of adults in the Bronx have diabetes compared to other boroughs, with a higher percentage in adults who are Hispanic or non-Hispanic black. 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 Medical Center serves an ethnically diverse and income challenged community.

Additionally, Montefiore has chosen to include programming to address substance use disorders as this continues to be a growing need in the community. The next Priority Area that was selected is Promote Well-Being and Prevent Mental and Substance Use Disorders. Under Focus Area: Prevent Mental and Substance User Disorders, Goal 2.2 Prevent opioid overdose deaths, we selected two objectives: Objective 2.2.1: Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 1,00,000 population; and Objective 2.2.2: Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.1 per 1,000 population. Baseline: 35.9 per 1,000.

Montefiore's well-being promotion and mental health and substance use prevention strategy includes several prongs. The first is Montefiore's opioid overdose prevention education which targets medical providers, at-risk patients, community members and community-based organizations to increase access to information and resources. These activities will be implemented with the goal of reducing overdose deaths in the Bronx. The second prong of our strategy is provider education and support for providers through opioid management trainings, electronic consults, assessments for patients prescribed long-term opioids, and integration of opioid use disorder treatment programs into primary care clinics. Montefiore will partner with community-based organizations, emergency rooms, and hospitals for referrals.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area: Prevent Mental and Substance User Disorders

Goal	Goal 2.2 Prevent opioid overdose deaths
Outcome Objectives	Objective 2.2.1: Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 1,00,000 population
Interventions	Using the SAMHSA guidelines, Montefiore seeks to: • Train medical providers and staff to provide opioid overdose prevention education and naloxone take-home kits for at-risk patients at Montefiore Medical Group primary care clinics. • Provide free opioid overdose prevention education and naloxone take-home kits for community based organizations and community members who interface with Montefiore Medical Center. • Integrate opioid overdose prevention education and naloxone distribution in Montefiore's mental health and substance use treatment programs.
Family of Measures	Family of Measures to include: • Percent increase in trainees attending opioid overdose prevention/naloxone trainings hosted at clinical and community settings • Number of people that received opioid overdose prevention/naloxone trainings • Number of naloxone take-home kits distributed
Implementation Partner	Community-based organizations
Partner Role(s) and Resources	MMC partners with community based organizations to provide trainings and kits, and identify new partnerships and training opportunities.
By When	December 31, 2021
Will Action Address Disparity	Yes. Based on data from the NYC Department of Health and Mental Hygiene, rates of overdose deaths in New York City were highest among Bronx residents (a rate of 34.1 per 100,000 residents), compared with all other New York City boroughs. Latino New Yorkers had largest number of overdose deaths in 2018 (206 overdose deaths) compared with non-Latino White and non-Latino Black New Yorkers. Montefiore Medical Center serves an ethnically diverse and income challenged community.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area: Prevent Mental and Substance User Disorders

Goal	Goal 2.2 Prevent opioid overdose deaths
Outcome Objectives	Objective 2.2.2: Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.1 per 1,000 population. Baseline: 35.9 per 1,000
Interventions	Using the SAMHSA guidelines, Montefiore seeks to: • Integrate the opioid use disorder treatment programs at Montefiore's primary care clinics, and train Montefiore's medical and behavioral health providers in opioid use disorder treatment, including hosting annual buprenorphine waiver trainings. • Provide assessments for patients who are prescribed long-term opioids in order to identify and target patients with possible opioid use disorder. • Support providers through opioid management "e-consult" in order to address provider questions about patients at risk for or diagnosed with opioid use disorders. • Montefiore will also partner with community based organizations, emergency rooms, and hospitals for patient referrals.
Family of Measures	Family of Measures to include: • Percent increase in buprenorphine trainings provided to primary care providers. • Number of buprenorphine waiver trainings conducted for providers at Montefiore. • Number of people who attend buprenorphine waiver trainings • Number of patient referrals from community based organizations, emergency rooms, and hospitals to substance use treatment programs
Implementation Partner	Community-based organizations
Partner Role(s) and Resources	MMC partners with community based organizations, emergency rooms, and hospitals to accept patient referrals and to provide training and support to providers and health systems
By When	December 31, 2021

Will Action Address Disparity	Yes. While data from the NYC Department of Health and Mental Hygiene (DOHMH) shows that rates of overdose deaths in New York City were highest among Bronx residents (a rate of 34.1 per 100,000 residents), data from DOHMH also shows that the Bronx has the second lowest percentage of buprenorphine prescriptions in 2016 at 18%. Montefiore Medical Center serves an ethnically diverse and income challenged community.

Each of the two selected Priority Areas has received support from the New York City Department of Health and Mental Hygiene's citywide offices as well as support from the local Bureau of Bronx Neighborhood Health. Montefiore, St. Barnabas, and other hospital based and community health partners participated in monthly workgroup meetings where priority areas were selected and resources and measures to support selected priorities were discussed.

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

The interventions identified in the Community Service Plan do not include all of the many activities taking place across Montefiore Medical Center or the Montefiore Health System. There are a large number of programs led by, or implemented in partnership with Montefiore Medical Center.

Included below is a list of some of the Montefiore programs that address a variety of community needs, including those highlighted in the Community Health Needs Assessment. The list includes a brief description of the program, the intervention measures that the program captures and the coordination of the program to the larger New York State Prevention Agenda.

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
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	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 Well-Being and Prevent Mental and Substance Use Disorders; Prevent Communicable Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	seroprevalence.		
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 behaviors. Many patients also struggle with school, family and drug problems. The program runs lectures and workshops for school personnel, students and community members.	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 Well-Being and Prevent Mental and Substance Use Disorders
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,	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Well-Being and Prevent Mental and Substance Use Disorders; Prevent Communicable Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	mental health providers, pharmacists and 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
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, womens 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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
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 Well-Being and Prevent Mental and Substance Use Disorders
Centering Pregnancy	Centering Pregnancy is a national program that 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.	Increase in utilization of prenatal care services; Increase in positive health outcomes for newborns and their mothers	Promote Healthy Women, Infants and Children
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 care setting.	Increase in proportion of HIV+ individuals engaged in care	Promote Well-Being and Prevent Mental and Substance Use Disorders; Prevent Communicable Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
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 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.	Increase in proportion of mothers who breastfeed	Promote Healthy Women, Infants and Children
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	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
	patients are managed through case management calls, home 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 Well-Being and Prevent Mental and Substance Use Disorders
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	Increase in screening for colorectal cancer; Decrease in colorectal cancer	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	completion rates and decrease no-show and cancellation rates.		
Communilife Montefiore Temporary Respite Program	The program provides temporary community-based supportive housing for Montefiore inpatients who 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 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	Increase in stabilization in substance abuse treatment; Increase in employment of individuals with substance abuse disorders; Increase in attainment of federal disability benefits for individuals with substance abuse	Promote Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	treatment programs and provides comprehensive social services.	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
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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
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 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 (HIPAA)	Increase in management of diabetes; Increase in positive health outcomes for diabetic mothers and their newborns	Prevent Chronic Diseases
Dialysis Outreach	Dialysis outreach seeks to strengthen communication between Montefiore's transplant program and community physicians and to provide a	Increase in patient satisfaction; Increase in provider satisfaction	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	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 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.		
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	Increase in access to In-vitro fertilization services	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	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.		
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
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	Increase in quality of case management for families with identified risk of child abuse or neglect	Promote Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	evaluation and referral for treatment, and provides case management to track participation.		
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
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,	Increase in patient satisfaction and quality of life	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	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 life.		
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 Well-Being and Prevent Mental and Substance Use Disorders

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
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 vaccine to women in this age bracket due to insufficient Medicaid coverage and low	Increase in HPV vaccination rate	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	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 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	Increase in patient satisfaction	Promote Healthy Women, Infants and Children; Promote Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	effectiveness of its interventions. IMPACT		
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
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 Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
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 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.	Increase in patient satisfaction; Increase in accessibility of primary care services	Prevent Chronic Diseases
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 five days per week and visits schools on a rotating schedule.	Increase in proportion of individuals receiving dental care	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Montefiore School Health Program	MSHP is the largest and most comprehensive school-based health care network in the United States. It has 27 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 focused on increasing physical activity and healthy eating in Bronx children and their families.	Increase in proportion of students receiving health care	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Mosholu Preservation Corporation (MPC)	Mosholu Preservation Corporation (MPC) is a non-profit corporation of Montefiore Health System that is committed to preserving and revitalizing its host neighborhoods and its host communities by creating and maintaining quality, affordable housing, stimulating economic investment through workforce development and small business support and community development through aesthetic	Increase in local economy; Increase in preservation of neighborhoods	Promote a Healthy and Safe Environment

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	improvement. MPC is governed by a board of directors that are made up of Montefiore Health System trustees and management, community leaders, and development experts who serve in a pro bono capacity.		
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 Well-Being and Prevent Mental and Substance Use Disorders
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 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	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 Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	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 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)		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	recognition from National Committee for 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.		
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. OCPH also runs the Health Education program which provides one-on-one and group	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 Well-Being and Prevent Mental and Substance Use Disorders; Prevent Communicable Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	health coaching in 15 of the primary care sites. Additionally, the Office develops effective strategies and methods to evaluate the impact of interventions on community health needs.		
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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Oral Head and Neck Screening	Screening for Oral Head and Neck Cancer. Event takes place at MECCC in April.	Increase in screening for Oral Head and Neck Cancer; Decrease in Oral Head and Neck Cancer	Prevent Chronic Diseases
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 Procurement Organization. The ultimate goal is to ensure that every person who needs an organ/tissue donation receives one	Increase in educational programs about organ donation; Increase in number of people who join the donor registry	Prevent Chronic Diseases
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	Increase in general satisfaction of individuals who have undergone ostomy diversion	Prevent Chronic Diseases; Promote Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	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 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 effect 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 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.	Increase in patient satisfaction for heart transplant patients; Increase delivery of transplant information to patients	Prevent Chronic Diseases; Promote Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
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 treatment and encourage normal growth and development.	Increase in patient satisfaction; Increase in satisfaction of patients' families	Promote Healthy Women, Infants and Children
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 grade students. The program aims	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 Communicable Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	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 June at various Montefiore sites.	Increase in Prostate Cancer screening; Decrease in Prostate Cancer	Prevent Chronic Diseases
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.	Increase in patient satisfaction of Oncology patients	Prevent Chronic Diseases; Promote Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	Supportive services are designed according to the interests and needs of participants. For instance, BOLD Buddies offers treatment companions and phone support to socially isolated cancer patients.		
Regional Perinatal Center	As a NYS Dept. of Health designated Regional Perinatal Center, one 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 Women, Infants and Children
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	Decrease in symptomatic asthma and chronic obstructive pulmonary disease	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	educational mailings, or went to ER or were admitted- received an educational call to follow 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
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•	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 Well-Being and Prevent Mental and Substance Use Disorders; Prevent Communicable Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	Mental health counseling• Case management• Dental care• Nutrition 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 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 Name	Description	Intervention Measures	NYS Prevention Agenda
	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 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 health center patients.		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
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 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.	Increase in patient satisfaction and quality of life of individuals with cancer	Prevent Chronic Diseases; Promote Well-Being and Prevent Mental and Substance Use Disorders
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 Well-Being and Prevent Mental and Substance Use Disorders; Prevent Communicable Diseases
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 participants. The program plays an important role in the community as research shows that parental conflict is strongly correlated to poverty.	Decrease in partner abuse; Increase in healthy relationships	Promote Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
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 materials to educate families.	Increase in satisfaction of CHAM patients and their parents	Promote Healthy Women, Infants and Children
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 training of health professionals and law enforcement personnel, 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 Well-Being and Prevent Mental and Substance Use Disorders

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	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 Well-Being and Prevent Mental and Substance Use Disorders
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	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
	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 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.		
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	Increase in positive outcomes for wound healing patients	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	services delivery systems that work for wound patients in order to provide excellence in care and to improve wound healing outcomes in the Bronx.		

Web based Resources

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 Bronx 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 Bronx 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/MMC-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. Bronx County Community Health Survey

Montefiore DOING MORE SBH Health System BRONX

2019 BRONX COUNTY COMMUNITY HEALTH SURVEY

There are many areas where the healthcare system can make efforts to improve the community. We are interested to hear your thoughts on what issues should be a priority in your community and for your personal health. Montefiore Health SYstem and St. Barnabas Health System will use the results to help improve health programs. Please take a few minutes to fill out this survey if you are 18 years or older. Your responses are anonymous. Please return your finished responses to the ***Office of Community & Population Health, 3514 Dekalb Ave, Bronx, NY 10467. email: communityhealth@montefiore.org***

You may also take the survey online at: https://www.surveymonkey.com/r/BX_CHS_2019

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 issues 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 & active lifestyles
- ☐ Food and nutrition
- ☐ Food safety and chemicals in consumer products
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Injuries, such as falls, work-injuries, or traffic-injuries
- ☐ Maternal and women's health
- ☐ Mental health
- ☐ Newborn and infant health
- ☐ Obesity
- ☐ Outdoor air quality
- ☐ Physical activity
- ☐ Sexually transmitted diseases
- ☐ Smoking, vaping, and secondhand smoke
- ☐ 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
- ☐ Drug & alcohol treatment services
- ☐ Domestic violence prevention/victim support
- ☐ Employment opportunities
- ☐ Exercise & weight loss programs
- ☐ Health insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Improving racial equality
- ☐ Mental health services
- ☐ Public transportation
- ☐ Quality and affordable childcare
- ☐ Safe places to walk & play
- ☐ Services for LGBTQ population
- ☐ Services for older adults
- ☐ Smoking & tobacco services
- ☐ Violence prevention
- ☐ Other _____

What population needs the greatest attention?

- ☐ Infants
- ☐ Young children
- ☐ School-age children
- ☐ Teens
- ☐ Young adults
- ☐ Middle-aged adults
- ☐ Older adults
- ☐ Other specific groups _____

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

What THREE areas do you see as being priority health issues 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 & active lifestyles
- ☐ Food and nutrition
- ☐ Food safety and chemicals in consumer products
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Injuries, such as falls, work-injuries, or traffic-injuries
- ☐ Maternal and women's health
- ☐ Mental health
- ☐ Newborn and infant health
- ☐ Obesity
- ☐ Outdoor air quality
- ☐ Physical activity
- ☐ Sexually transmitted diseases
- ☐ Smoking, vaping, and secondhand smoke
- ☐ Substance use disorders
- ☐ Vaccinations/immunizations
- ☐ Violence
- ☐ Water quality

Would you say that in general your health is:		
☐ Excellent	☐ Good	☐ Poor
☐ Very good	☐ Fair	
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)?		
☐ Arthritis	☐ COPD, emphysema, or chronic bronchitis	☐ Heart disease
☐ Asthma		☐ Kidney disease
☐ Cancer (excluding skin cancer)	☐ Depression/anxiety	☐ Hypertension
☐ Skin cancer	☐ Diabetes (excluding during pregnancy	
Was there a time in the past 12 months when you needed to see a doctor but could not because of the following?		
Cost ☐ Yes ☐ No	**Transportion** ☐ Yes ☐ No	**Unable to get an appointment** ☐ 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	☐ Medicare	☐ Other _____
	☐ Medicaid	☐ I don't have health insurance
☐ The New York State Marketplace (Exchange/Obamacare)	☐ Military (TriCare or VA)	
	☐ COBRA	
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…		
Age ☐ Yes ☐ No	**Sexual orientation** ☐ Yes ☐ No	**Disability** ☐ Yes ☐ No
Gender identity ☐ Yes ☐ No	**Perceived immigration status** ☐ Yes ☐ No	**Other** ☐ Yes ☐ No
Race/Ethnicity ☐ Yes ☐ No	**Religion** ☐ 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	☐ Trans female/Trans woman	☐ Gender not listed (please state):
☐ Male	☐ Trans male/Trans man	_____
☐ Non-binary person/Gender non-conforming		
What is your age?		
☐ 18-24	☐ 45-54	☐ 75+
☐ 25-34	☐ 55-64	
☐ 35-44	☐ 65-74	
What is the highest grade or year of school you completed?		
☐ Less than high school	☐ Some college or technical school	☐ Advanced or professional degree
☐ High school grad/GED	☐ College graduate	
What is the ZIP Code where you currently live?	_ _ _ _ _	
Are you of Hispanic or Latino origin?	☐ Yes	☐ No
Which one the following best describes your race?		
☐ White	☐ Asian/Pacific Islander	☐ Multi-racial
☐ Black/African American	☐ American Indian/Alaskan Native	☐ Other _____
Are you currently?		
☐ Employed	☐ A homemaker	☐ Unable to work
☐ Self employed	☐ Student	☐ Other _____
☐ Out of work	☐ Retired	
What is the primary language spoken in your home?		
☐ English	☐ Spanish	
☐ Kru, Ibo, or Yoruba	☐ French	☐ Italian
☐ Bengali	☐ Albanian	☐ Mande
☐ Arabic	☐ French	☐ Other _____

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

Table 1. Top 20 inpatient discharges at Montefiore Medical Center, 2019

ICD-10 Code	Label	Discharges	% of total
Z38	Liveborn infants according to place of birth and type of delivery	4,009	5.5%
A41	Other sepsis	3,937	5.4%
E11	Type 2 diabetes mellitus	1,942	2.7%
R07	Pain in throat and chest	1,644	2.3%
I13	Hypertensive heart and chronic kidney disease	1,593	2.2%
J45	Asthma	1,396	1.9%
I25	Chronic ischemic heart disease	1,385	1.9%
I48	Atrial fibrillation and flutter	1,087	1.5%
I63	Cerebral infarction	1,023	1.4%
J44	Other chronic obstructive pulmonary disease	989	1.4%
M17	Osteoarthritis of knee	976	1.3%
R55	Syncope and collapse	929	1.3%
D57	Sickle-cell disorders	912	1.3%
N17	Acute kidney failure	864	1.2%
G40	Epilepsy and recurrent seizures	844	1.2%
E66	Overweight and obesity	828	1.1%
J18	Pneumonia, unspecified organism	825	1.1%
I11	Hypertensive heart disease	818	1.1%
I21	Acute myocardial infarction	793	1.1%
L03	Cellulitis and acute lymphangitis	782	1.1%
-	Other diagnoses	45,320	62.5%

Data source: Internal Montefiore Health System data, 2019 (Jan-October 15, 2019)

Summary of the primary discharge diagnoses codes for inpatient discharges at Montefiore Medical Center hospitals in the Bronx in 2019 among Bronx residents. Across Montefiore, the top three diagnoses across the ICD-10 coding were Liveborn infant, Sepsis, and Type 2 Diabetes Mellitus. Montefiore Medical Center includes the Moses, Children's Hospital at Montefiore, Wakefield and Weiler campuses.

Table 2. Top 20 reasons for treat-and-release ED visits at Montefiore Medical Center, 2019

ICD-10 Code	Label	Visits	% of total
R07	Pain in throat and chest	12,151	6.4%
R10	Abdominal and pelvic pain	9,914	5.2%
M54	Dorsalgia	8,213	4.3%
M25	Other joint disorder, not elsewhere classified	5,885	3.1%
J06	Acute upper respiratory infections of multiple and unspecified sites	5,507	2.9%
J02	Acute pharyngitis	4,920	2.6%
J45	Asthma	4,690	2.5%
R51	Headache	4,561	2.4%
M79	Other and unspecified soft tissue disorders, not elsewhere classified	4,042	2.1%
R42	Dizziness and giddiness	4,001	2.1%
B34	Ultrasonography	3,913	2.1%
K52	Other and unspecified noninfective gastroenteritis and colitis	3,369	1.8%
S01	Open wound of head	2,665	1.4%
N39	Other disorders of urinary system	2,500	1.3%
O26	Maternal care for other conditions predominantly related to pregnancy	2,288	1.2%
F10	Alcohol related disorders	2,266	1.2%
J10	Influenza due to other identified influenza virus	2,182	1.2%
S61	Open wound of wrist, hand and fingers	2,170	1.1%
S00	Superficial injury of head	2,120	1.1%
R05	Cough	2,086	1.1%
-	Other diagnoses	100,243	52.8%

Data source: Internal Montefiore Health System data, 2019 (Jan-October 15, 2019

Summary of primary treat-and-release Emergency Department (ED) visits at Montefiore Medical Center hospitals in the Bronx in 2019 among Bronx residents. Across Montefiore, the top three diagnoses across the ICD-10 codes were Throat and Chest Pain, Abdominal and Pelvic Pain, and Dorsalgia. Montefiore Medical Center includes the Moses, Children's Hospital at Montefiore, Wakefield and Weiler campuses.