

**MONTEFIORE HEALTH SYSTEM
MONTEFIORE NEW ROCHELLE HOSPITAL
COMMUNITY HEALTH NEEDS ASSESSMENT
AND IMPLEMENTATION STRATEGY
2015-2017**

**Montefiore Health System
Montefiore New Rochelle Hospital
Community Health Needs Assessment and Implementation Strategy 2015-17**

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COMMUNITY HEALTH NEEDS ASSESSMENT

1. Introduction

Montefiore Health System is a premier academic health system and the University Hospital for Albert Einstein College of Medicine. Combining a nationally-recognized clinical excellence with a population health perspective that focuses on the health needs of communities, Montefiore delivers coordinated, compassionate, science-driven care where, when and how patients need it most. Montefiore consists of six hospitals and an extended care facility with a total of 2,080 beds, a School of Nursing, and state-of-the-art primary and specialty care provided through a network of more than 150 locations across the region, including the largest school health program in the nation and a home health program.

Montefiore New Rochelle Hospital is a 242-bed, community-based teaching hospital offering primary, acute and emergency care to the residents of southern Westchester. Since its founding in 1892, Montefiore New Rochelle Hospital has provided for the diverse medical needs of the community and region it serves. The Hospital is part of Montefiore Health System, a premier academic medical center and the University Hospital System for Albert Einstein College of Medicine.

As of November 6, 2013, as a part of the Montefiore Health System, a premier academic medical center and the University Hospital system for Albert Einstein College of Medicine, Montefiore New Rochelle Hospital continues to provide inpatient, critical care and ambulatory services.

Montefiore New Rochelle has a number of leading-edge services and programs that have earned distinction by state and national organizations for achieving and maintaining the highest quality of care within the specialty, including:

- Designated as a Center of Excellence by the American Society of Metabolic and Bariatric Surgery
- New York State-designated Stroke Center
- New York State-designated Area Trauma Center—the only one in southern Westchester
- New York State-designated perinatal hospital with a Level 3 Neonatal Intensive Care Unit that provides state-of-the-art care for fragile newborns
- Gold Seal of Approval from The Joint Commission as a certified Center of Excellence in both hip and knee joint replacement

1a. Montefiore's Mission Statement and Strategy:

Montefiore's Mission Statement and Strategy:

In January 2009, Montefiore Medical Center completed a comprehensive review and update of its strategic plan. The process included the development and approval by its Board of Trustees of revised 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 and Equity

As part of that process, Montefiore established five Strategic Goals; setting out Montefiore's course for the decade to come:

1. Advance our partnership with the Einstein College of Medicine
2. Create notable Centers of Excellence
3. Build specialty care broadly
4. Develop a seamless delivery system with superior access, quality, safety and patient satisfaction
5. Maximize the impact of our community service

The inclusion of an explicit statement affirming Community Service as part of Montefiore's Mission Statement is not new. It has always been one of the core elements of Montefiore's mission. What has changed is the explicit reference to "advancing the health of the communities we serve", focusing on making a measurable difference in the health of those populations and communities. This is further sharpened by the inclusion as one of the five strategic goals the imperative, to "maximize the impact of our community service."

In pursuing that goal, Montefiore has tasked itself:

- To better coordinate and focus its resources on specific high prevalence/high impact problems affecting its community;
- To work internally and with community partners to identify priority health needs, and;
- To develop and implement more effective broad-based plans of action to address them, and to advance the health of the communities we serve.

The rationale behind this change was the realization that we must focus our efforts, if we are to make a real, measurable difference in the health of populations, and communities. That is essentially the same logic as underpins the state’s revised Community Service Plan process.

Historically, Montefiore has earned a reputation as a leader in the region, state and nation in providing services to its community, by developing and operating an extraordinary array of needed services to the poor and underserved, and to specific at-risk populations (eg. children, the elderly, the HIV-infected, the homeless and victims of domestic violence).

In its updated Strategy, Montefiore included a strategic goal – “Maximize the impact of our community service” – that is focused on improving performance in this critical area. It has led to the creation of a new institutional focus for community health improvement activities – the Montefiore Office of Community and Population Health, charged to

- oversee, and 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 working, together and with community partners to make a difference, to measurably improve the health of the communities we serve.

2b. Community Health Needs Assessment Submission Date

Montefiore New Rochelle Hospital's comprehensive Community Health Needs Assessment and Implementation Strategy Report submission was approved by the Community Services Committee of the Board of Trustees on November 4, 2014. The Community Health Needs Assessment and Implementation Report (CHNA & I) report was uploaded to the Montefiore website December 2014 at the URL

<http://www.montefiore.org/documents/communityservices/2014-CHNA1-NR-with-CSS-Inventory.pdf>.

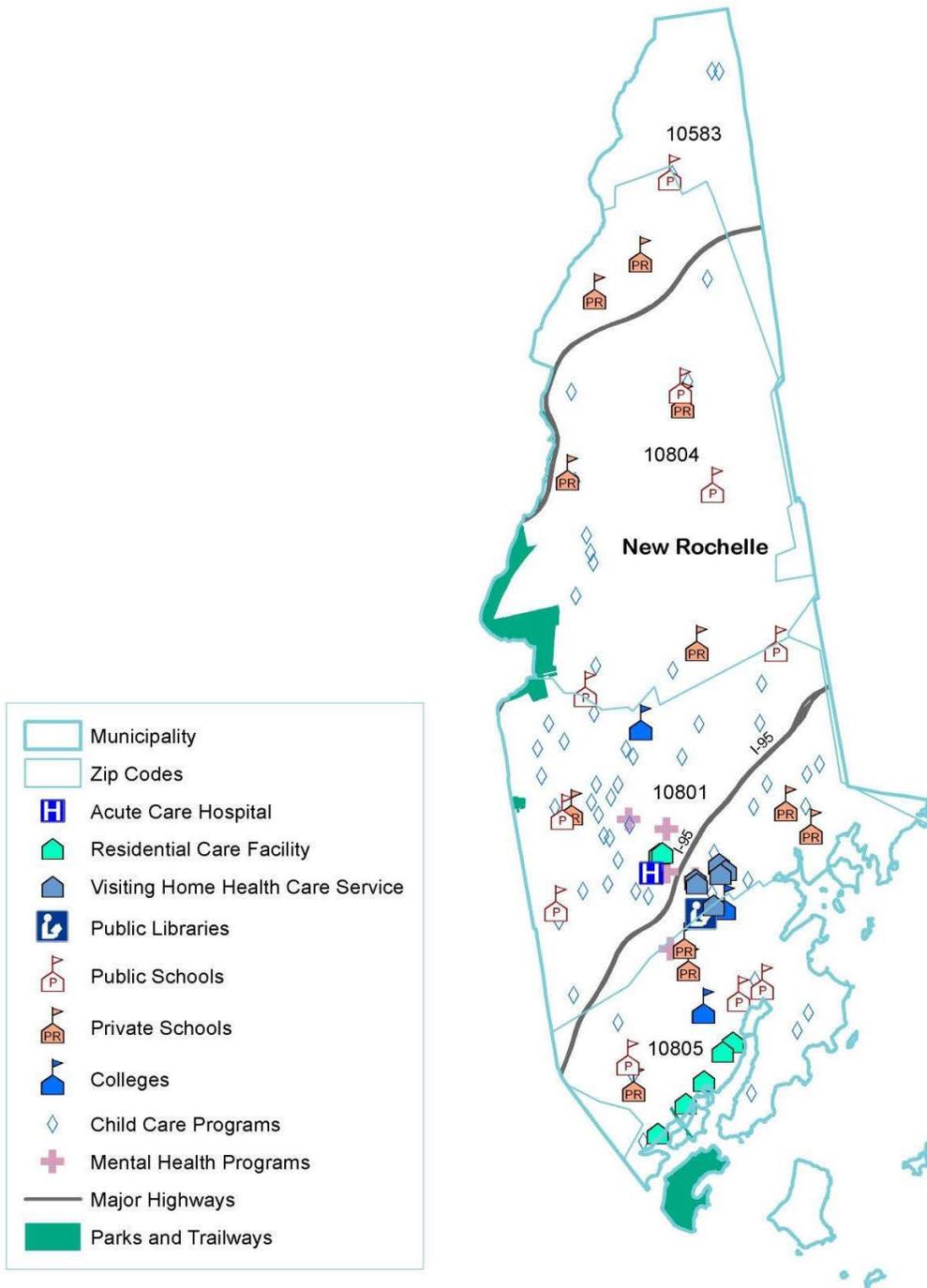
III. Definition and Description of the Community/Service Area

Montefiore New Rochelle Hospital has identified the city of New Rochelle and its surrounding towns and villages as its primary service area. Montefiore New Rochelle Hospital is the only hospital in the City of New Rochelle, which is a south eastern city in Westchester County bordered to its east by the Long Island Sound, on the west by Pelham, Pelham Manor and Eastchester, by Scarsdale to the north and east, Mamaroneck and Larchmont to the east. The city lies 2 miles (3.2 km) north of the New York City border (Pelham Bay Park in The Bronx). It is the seventh largest city in New York State. According to the United States Census Bureau, the city has a total area of 13.2 square miles (34.3 km²). The city has a rough triangle shape, approximately 10 miles (16 km) from north to south and 1.5 miles (2 km) from east to west at its widest point

The communities served by the MNRH are extremely diverse. The service area contains pockets of prosperity, where health insurance coverage is more prominent, along with many economically challenged neighborhoods whose residents are uninsured or underinsured. Most of the latter do not access healthcare routinely but rather present only in crisis through the Emergency Department.

New Rochelle is a diverse urban setting, with multiple sub-populations that evidence tremendous variation. In addition to Montefiore New Rochelle, the community is served by many independent providers including neighboring hospitals/systems, and a Federally Qualified Health Center, which has an overlapping service area. In this setting, the focus is on specific health needs of specific populations, in targeted communities, working with specific partners to address the needs of this community. The ability to apply services in a targeted fashion has been Montefiore's historical approach to developing and operating its programs of community health, and that is the approach we have taken in developing this Community Service Plan.

New Rochelle Service Area



3a. Population of New Rochelle

According to the 2013 American Community Survey of the U.S. Census, New Rochelle has approximately 78,400 residents. There are approximately 28,000 households in New Rochelle. The average household size is 2.71 people. Families made up 68% of the households; includes both married-couple families (48.9%) and single householder families (28.1% total—5.9% male, 13.2% female). Nonfamily households consist of 32% of all households in New Rochelle; includes people living alone and non-related people living under one household. 32.8% of households include one or more people under 18 years of age. 29.6% of households include one or more people 60 years of age or older.

New Rochelle is ethnically diverse. Its population is 28.5% Hispanic, 17.8% African-American, 69.6% White, 4% Asian, and 7% other. Almost one-third (26.3%) of its residents are foreign-born. Among these immigrants, more people speak only English at home than any other language. The city's immigrant communities come from diverse corners of the globe (in order of their numbers): Mexico, Colombia, Italy, Jamaica, Guatemala, Peru, Haiti, Brazil, China, and Portugal.

New Rochelle is one of Westchester County's more affluent cities. Reflecting 2013 data from the US Census Bureau's American Community Survey, 1% of New Rochelle households are on public assistance; less than the Westchester County (2.2%) and New York State (3.4%) percentages. 10.4% of New Rochelle's population lives below the poverty line and the median income is \$66,656 (compared to \$77,293 countywide). There are 12.2% of New Rochelle children living below poverty. The unemployment rate in New Rochelle is 7.5%; less than the countywide (8.4%) and statewide (9.2%) rates. 82.3% of New Rochelle residents ages 25 and older have received their high school diploma or GED; lower than both the countywide rate of 87.4 and lower than the statewide rate of 85.6%.

3b. Health Status of the City of New Rochelle

The health status of the city of New Rochelle was measured across the indicators of overall health status as well as indicators of the social, environmental, and economic determinants of health. While there are areas of improvement, New Rochelle's rates are comparable to the midline, when compared to the remainder of Westchester County.

The residents in New Rochelle have significantly high mortality rates from heart disease, cancer, stroke, and chronic lower respiratory diseases (CLRD).

Mortality Rates:

According to the New York State Department of Health's (NYSDOH) Vital Statistics of New York State report in 2011, Westchester County (which includes the city of New Rochelle) has an age-adjusted mortality rate of 713.4 per 100,000; similar to the statewide rate of 753.1. According to the Community Health Rankings in 2014, Westchester County ranked as number 3 out of 62 NY counties to have the lowest mortality rate in New York State. The leading cause of death among Westchester County residents is due to coronary heart disease (219.7 per 100,000).

Asthma & CLRD:

According to the NYSDOH, 8.7% of Westchester County adults had asthma from 2008-2009; lower than the statewide percentage of 9.7%.

According to CDC data, the percentage of Westchester County adults with asthma increased to 14% from 2011-2012; same percentage as New York State.

According to an asthma report from New York State Office of the State Comptroller, the asthma prevalence rate among Westchester County Medicaid recipients was 86.7 per 1,000 from 2008-2009. The prevalence rate increased to 98.4 per 1,000 from 2012-2013; similar to the statewide prevalence rate of 98.7.

The average (age-adjusted) rate of asthma emergency department visits per 10,000 from 2011 was 64.2 in Westchester County. In 2012, the rate of asthma emergency department visits increased to 67.4 per 10,000.

In 2010, the age-adjusted death rate due to chronic lower respiratory diseases among Westchester County residents was 24.3 per 100,000; lower than the statewide rate of 31.1. In 2011, Westchester County's death rate decreased to 23.4; remaining lower than the statewide rate of 31.2.

Heart Disease & Stroke:

The coronary heart disease mortality rate per 100,000 in Westchester County was 119.5 in 2011; similar to the 2010 rate of 117.1. The coronary heart disease hospitalization rate per 10,000 in Westchester County was 35.8 in 2011; similar to the 2010 rate of 36.4.

The cerebrovascular disease (stroke) mortality rate per 100,000 in Westchester County was 25.8 in 2011; an increase from the 2010 rate of 24.0. The stroke hospitalization rate per 10,000 in Westchester County from 2009-2011 was 22.8; similar to the statewide rate of 24.9.

The cardiovascular disease mortality rate per 100,000 in Westchester County was 199.2 in 2011; an increase from the 2010 rate of 195.5. The cardiovascular disease hospitalization rate per 10,000 in Westchester County was 133.1; similar to the 2010 rate of 135.9.

Cancer:

The mortality rate of all cancer diagnoses in Westchester County was 150.5 in 2010; similar to the statewide rate of 160.2. The type of cancer with the highest mortality rate in Westchester County is lung cancer (36.9 per 100,000; lower than the statewide rate of 41.8).

The incidence rate of all cancer diagnoses in Westchester County was 495.2 per 100,000 in 2010; similar to the statewide rate of 482.5. The type of cancer with the highest incidence rate in Westchester County is prostate cancer (22.6 per 100,000; similar to the statewide rate of 21.3).

Medically Underserved Community

Despite these challenges, the City of New Rochelle is not considered an underserved community, however the evidence of significant health disparity related to heart disease indicates that there is an unmet need in the population. The categorization for a medically underserved population is based on an index value that includes the infant mortality rate, the poverty rate, the percentage of elderly population and the primary care physician to population ratio. While the city of New Rochelle does not qualify, the nearby city of Port Chester and others along the Sound Shore, when coupled with the emerging non English speaking immigrant and migrant populations, an increased need for primary care services is becoming evident.

4. Assessment of Community Health Need

4a. Description of Process and Methods

Multiple conversations and meetings were convened internally and with external partners, including a thorough review of the data, which determined the activities that would be the focus over the CHNA implementation period. In this Community Health Needs Assessment and Implementation Report, the documentation of organizations and partners documents those individuals, groups and organizations with whom implementation activities were planned are detailed in the appendices.

Additionally, through the development of the New York State Community Service Plan Process, two local health priorities were identified within Westchester County on which all hospital organizations had agreed to participate. As the asset acquisition of Montefiore New Rochelle Hospital occurred after the development and release of the Westchester County Community Health Assessment and Improvement Plan and during a time of transition for the facility, its personnel and the community, the development of a relevant, recognized, and trusted community information solicitation process was paramount to gaining the support and trust necessary to successfully implement any identified health priorities to be implemented in the community.

In January 2013, the Westchester Department of Health Commissioner initiated a series of meetings with the acute care, specialty care and federally qualified health centers in the county to form a planning team to collectively identify two local health priorities, with at least one addressing a health disparity in support of the New York State Health Improvement Plan. Members of the pre-existing hospital entities prior to the development of Montefiore New Rochelle Hospital were present, and are still employed by MNRH to provide continuity to this process. Through this process, two New York State priority areas were chosen, beyond the process identified in the CHNA as priorities to be addressed in improving the community's health. Those are: to Prevent Chronic Disease; and to Promote Healthy Women, Infants and Children.

4.a.i Data Sources

Multiple data sources were used to support the identification and selection of the priority items, which were identified, selected, and reviewed with partners. A listing and brief summary of the data sources used to complete the secondary data analysis that were used to identify the issues of concern beyond experience and direct observation are listed below.

- i. New York State Department of Health Bronx County Indicators for Tracking Public Health Priority Areas
- ii. The Statewide Planning and Research Cooperative System (SPARCS)
- iii. NYS Community Health Indicator Reports
- iv. County Health Rankings
- v. Community Health Needs Assessment www.chna.org
- vi. CDC Sexually Transmitted Disease Surveillance Report
- vii. New York State Department of Health Annual HIV/AIDS Surveillance Report
- viii. American Community Survey

For this data collection process for New Rochelle, when City of New Rochelle data was not available, a custom area estimate for New Rochelle for the specific indicator was generated using population weighted allocations. These estimates are aggregates of each county which falls within the custom area, based on the proportion of the population from the county which also falls in the area. Population proportions are determined for each county using 2010 census block centroids. This is accomplished by dividing the summed population of the census blocks (associated with each county) which fall within the custom area by the total population of each county that intersects the custom area. In this way, when a custom area contains 50% of the area of a county, but contains 90% of its population, the figure for that county is weighted at 90% in

the custom area tabulation. This approach assumes spatial uniformity of the reported figure throughout the county. The base geography for these calculations is the county.

American Community Survey (ACS)—

Developed by the U.S. Census Bureau, the ACS is an ongoing survey that collects annual data on the major characteristics of communities throughout the U.S. The data collected is categorized into four categories: social, economic, demographic, and housing. Social characteristics include topics such as education, disability status, and health insurance status. Economic characteristics describe the income, employment status, and poverty level of U.S. communities. Demographic characteristics include age, sex, and race/ethnicity information. Housing characteristics include topics such as occupancy and vacancy, monthly rent, and household size. Approximately 3.5 million U.S. households are randomly selected to participate in the ACS each year. The 2013 data is the most recent data available at the time of this report. Questionnaires, datasets, survey results, documentation and more detailed information are available at <https://www.census.gov/acs/www/>.

Community Health Needs Assessment—

This project was developed by the Advancing the Movement organization and the Center for Applied Research and Environmental Systems (CARES) as a web-based toolkit designed to hospitals, state and local health departments, and other organizations seeking to better understand the needs and assets of their communities. County-level data retrieved from institutions such as the CDC, U.S. Census Bureau, and the Public Health Institute are formulated into customized data reports. The Full Health Indicators Report illustrates the health needs assessment profiles of U.S. counties using local demographics, socioeconomic factors, physical environment data, clinical care data, health behavior factors, and health outcomes. The 2012 data is the most recent data available at the time of this report. Detailed information on the Community Health Needs Assessment can be found at CHNA.org.

County Health Rankings—

This project is a collaboration between the Robert Johnson Foundation and the University of Wisconsin Population Health Institute. Additional data measures used in the rankings were provided by surveys and databases from other organizations such as the National Center for Health Statistics, CDC, Dartmouth Institute, U.S. Census Bureau, and U.S. Department of Agriculture. This database generates health rankings of every U.S. county and illustrates the correlations between local health outcomes, health factors, and socioeconomic factors. The county rankings are based on summary scores calculated from individual data measures. The overall Health Outcomes summary score consists of data on the county's mortality and morbidity. The overall Health Factors summary score consists of data on the county's health behaviors, clinical care, social and economic factors, and physical environment. The 2012 data is the most recent data available at the time of this report. Detailed information on the County Health Rankings can be found at <http://www.countyhealthrankings.org/our-approach>.

NYS Community Health Indicator Reports—

Reports were provided by the New York State Cancer Registry and the Behavioral Risk Factor Surveillance System (BRFSS). The NYS Cancer Registry was established in 1976 to track statewide data of all patients diagnosed with cancer. Data collected from this registry include exposure risks, stages at diagnosis, treatment information, and death rates. Each time a person is diagnosed with a tumor, the hospital(s) where that person is diagnosed and/or treated is required by the Public Health Law Section 2401 to report information about the person and tumor to the Cancer Registry within six months of patient diagnosis. The most recent year for which data on new cases and cancer deaths are available is 2011. Detailed information on the NYS Cancer Registry can be found at <http://www.health.ny.gov/statistics/cancer/registry/>. The Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide telephone surveillance system designed by the Centers for Disease Control and Prevention (CDC). BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. New York State's BRFSS sample represents the non-institutionalized adult household population, aged 18 years and older. The survey is conducted in all 50 states and U.S. territories. New York State has participated annually since 1985. Statewide representative samples are collected monthly and aggregated into yearly datasets. The 2011 data is the latest Westchester County-specific BRFSS data illustrated by the NYSDOH. Questionnaires, datasets, survey results, documentation and much more are all available at <http://www.cdc.gov/brfss/>.

New York State Department of Health's (NYSDOH) Westchester County Indicators for Tracking Public Health Priority Areas 2013-2017—

Findings are provided by various agencies such as the U.S. Census Bureau, the Center for Disease Control & Prevention (CDC), and NYSDOH programs. Detailed information provided by these agencies describe each U.S. community's entire population, including cross-tabulations of age, sex, households, families, relationship to householder, housing units, and race/ethnic groups. This NYSDOH report also includes statewide & county-specific data and the 2017 targets for numerous indicators for the five major prevention agenda areas: preventing chronic diseases; promote a healthy and safe environment; promoting healthy women, infants and children; promote mental health and prevent substance abuse; and, prevent HIV/STDs, vaccine-preventable disease and health care-associated infections. The 2012 data is the most recent data available at the time of this report. Detailed information on the NYSDOH Public Health Priority Areas report can be found at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/about.htm.

The Statewide Planning and Research Cooperative System (SPARCS)—

This comprehensive database was established in 1979 as a result of cooperation between the health care industry and government. SPARCS collects patient level data on hospital discharges, patient characteristics, diagnoses and treatments, and health care services. This database system also collects data on charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State. This database features the World Health Organization's Ninth Revision of the International Classification of Diseases (ICD-9), an official set of codes used by physicians, hospitals, and allied health workers to indicate diagnosis for all

patient encounters. The 2013 data is the most recent data available at the time of this report. The U.S. Centers for Medicare & Medicaid's DRG (Diagnosis-Related Groups) coding system is also featured in the SPARCS data. DRGs group patients by diagnosis, treatment, age, and other characteristics. Hospitals are paid a set fee for treating patients in a single DRG category. Detailed information on the SPARCS data can be found at <http://www.health.ny.gov/statistics/sparcs/>.

Westchester County Community Health Assessment & Improvement Plan 2014-2017—

The Westchester County Department of Health (WCDOH) plays a leading role in promoting health, preventing disease, and prolonging meaningful life for Westchester County residents. WCDH monitors and controls the spread of communicable diseases, monitors and regulates air and water quality, enforces the state and local sanitary code, promotes local public health activities, and assures the availability of community health services. CDH has collaborated with local hospitals and other community health partners to complete a Community Health Assessment (CHA), which describes the current health status of Westchester County residents, identifies existing gaps and health care barriers, assesses the availability and accessibility of health care services, and specifies public health priorities in the County. In addition, a Community Health Improvement Plan (CHIP) has been crafted to lay out the specific objectives, goals, and actions of the Health Department to address the public health priorities identified in the Community Health Assessment. Detailed information on this report can be found at <http://health.westchestergov.com/statistics>.

4.a.ii Collaboration and Participants

As the Community Health Needs Assessment was being developed, two simultaneous processes were evolving. First, Montefiore was charged with the development of its New York State Community Service Plan submission for the period of 2015-2017 for the New York State Health Department's Prevention Agenda. For this process, priorities were identified within Westchester County on which all hospital organizations had agreed to participate. As the asset acquisition of Montefiore New Rochelle Hospital occurred after the development and release of the Westchester County Community Health Assessment and Improvement Plan and during a time of transition for the facility, its personnel and the community, the development of a relevant, recognized, and trusted community information solicitation process was paramount to gaining the support and trust necessary to successfully implement any identified health priorities to be implemented in the community.

In January 2013, the Westchester Department of Health Commissioner initiated a series of meetings with the acute care, specialty care and federally qualified health centers in the county to form a planning team to collectively identify two local health priorities, with at least one addressing a health disparity in support of the New York State Health Improvement Plan. Members of the pre-existing hospital entities prior to the development of Montefiore New Rochelle Hospital were present, and are still employed by MNRH to provide continuity to this process. Through this process, two New York State priority areas were chosen, beyond the process identified in the CHNA as priorities to be addressed in improving the community's

health . Those are: to Prevent Chronic Disease; and to Promote Healthy Women, Infants and Children.

Second, through the Montefiore Health System’s successful application to submit as an Emerging Performing Provider System (PPS) as a part of the New York State Delivery System Reform Incentive Payment Program Application process, the decision was made to collaborate with the Hudson Valley region’s other four PPS organizations to complete one comprehensive Community Needs Assessment, resulting in the “One Region, One CNA” process. With these three similar activities occurring simultaneously, a streamlined set of data collection tools and methods were developed to gather information to inform the CAN process.

4.a.ii.1 Partners/Organizations

4.a.ii.1.a Partners/Organizations

As indicated in Section 4a, the partners listed in this section comprise 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) development, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. In Section 7, it is clearly documented that Montefiore will continue to work on the over 85 existing program initiatives, as each of those initiatives have partners, metrics, and meeting schedules.

The Montefiore Health System has significant experience in working with community advisory groups and boards. During the process of initiating the relationship with the New Rochelle community and its surrounding villages, the community group platform through the former Special Supplemental Nutrition Program for Women Infants and Children (WIC) program now a part of Montefiore New Rochelle Hospital, was utilized as a method of gathering input from key community stakeholders on the health of the community.

As the asset acquisition of Montefiore New Rochelle Hospital occurred after the development and release of the Westchester County Community Health Assessment and Improvement Plan and during a time of transition for the facility, its personnel and the community, the development of a relevant, recognized, and trusted community information solicitation process was paramount to gaining the support and trust necessary to successfully implement any identified health priorities to be implemented in the community. The Montefiore New Rochelle Hospital WIC Community Advisory Group (WIC CAG) met for this purpose.

This key stakeholder group was made of consumer participants as well as a select number of members from civic, municipal and non-governmental service providers, leaders in the business and faith communities and non-affiliated community residents. To level set the discussions, the community advisory group participated in an extensive data review session examining over 400 data categories specifically related to the indicators of overall health status as well as indicators of the social, environmental, and economic determinants of health. After significant distillation, the community group assisted in the review and prioritization of the health needs of this community, as well as the identification of key topics to be included in the comprehensive

Community Needs Assessment that was developed in Fall 2014.

This community level approach involving relevant stakeholders that in the targeted community who are interested in the particular health issues being addressed provides for a closer alignment between the community level goals of Montefiore and the health promotion/ improvement/ maintenance goals of the community.

Furthermore, Montefiore met with the Deputy Commissioner, Dr. Cheryl Archibald, and her team to gain a greater understanding of the process for the county in selecting the health priorities. The inter-organizational committee that was developed to address the identification of these health needs consisted of the following membership:

Westchester County Health Planning Team Members

Organization	Name	Title
Blythedale Children’s Hospital	Lena Cavanna	Director, Community & Media Relations
	Regina M. Kelly	Chief Planning, Govt. Relations and Compliance Officer
Burke Rehabilitation Center	Jorina Fontelera	Manager, Public Relations and External Communications
	Lenore Sirner	Assistant Administrator, Clinical Services
Hudson Valley Hospital Center	Bill Dauster	Vice President, Marketing & Development
	Victoria Hochman	Director, Marketing
	Linda LeMon	IBCLC
	Sabrina Nitkowski-Keever	Director, Maternal Child Health
	Danielle O’Malley	Coordinator, Community Relations
Lawrence Hospital Center	Alisa Holland	Manager, Marketing & Communications
	Steve Schoener	Vice President
	Tracy Wanamaker Conte	Vice President

Mount Vernon Neighborhood health Center, Inc.	Opal Dunstan	Chief Operating Officer
	Robert Kozlenko	Director, QA & Clinic
Northern Westchester Hospital	Gretchen Mullin	Associate Director, Marketing & Communications
	Maria Simonetti	Director, Community Health Education & Outreach

Open Door Family Medical Center	Grace Beltran	Director, Marketing & Community Relations
	Lindsay Farrell	President & CEO
Phelps Memorial Hospital Center	Sue Alvado	Manager, Corporate Health
	Barbara Bruno	Director, Maternal Child Health
	Mary McDermott	Vice President, Nursing
	Anne Nelson	Director, Cardiology Services
	Mary Sernatinger	Director, Marketing & Public Relations
	Lori Thomas	Grants Officer
	Eve Urban	Project Administrator
Saint Joseph's Hospital	Catherine Elser	Director, 55Plus
Sound Shore Medical	Rosemary Martino	Vice President, Clinical System Development

Center	Paul Rowland	Senior Vice President, Strategic Planning
St. John's Riverside Hospital	Cheray Burnett	Vice President
St. Vincent's Hospital Westchester	Terri Ezekiel	Director, Community Relations & Marketing
Westchester Medical Center	June Keenan	Executive Director, Center for Regional Healthcare Innovation
	Anthony Mahler	Senior Vice President, Strategic Planning
White Plains Hospital	Dawn French	Vice President, Marketing & Community Relations
	Kellie King	Assistant Director, Community Outreach

Organization	Name	Title
Westchester County Department of Health (*Staff who either participated in planning meetings and/or provided data analysis and/or other input.)	Sherlita Amler, MD	Commissioner
	Cheryl Archbald, MD	Deputy Commissioner, Community Health
	Megan Cea, MPH	Assistant Statistician
	Stan Cho, MPH	Medical Data Analyst
	Donna Dyke	Assistant Commissioner, Health for Nursing Services
	Janet Forcina	Health Care Administrator
	Rosemary James MPH, MPA	Medical Data Analyst
	Jiali Li, PhD	Director, Research & Evaluation
	Renee Recchia, MPH	Acting Deputy Commissioner of Administration

	Mila Venuti, MPA	Assistant Statistician
	Corie Weiss	Staff Nutritionist
	Carrie Aaron-Young	Director, Community Nutrition Services

Lastly, the collaboration of the ‘One Region, One CNA’ was led by the Survey Committee made up of :

- Dr. Deborah Viola, Thao Doan, Sarah Finch of Wechester Medical Center;
- Chanie Sternberg, and Michal Sperka of the Refuah Health Center;
- Craig Storrow of Health Alliance;
- Dr. Amanda Parsons and Dr. Nicole Hollingsworth of the Montefiore Health System
- Representatives of each of the respective consulting agencies, Manatt, McKinsey and, Markowitz as required.

5. Identification of Community Health Needs

The process to identify the needs of the community involved the collection of secondary and primary data. Examining a variety of factors, the following series of indicators, identified with rate, source, and comparison to New York State and national data (when available) is provided.

The primary and secondary data collection process illuminated multiple categories of health needs that were both important across the populations surveyed and reflected in the data as critical. The two being targeted over this implementation are:

1. Prevention of Chronic Disease, specifically the reduction of racial and ethnic disparities leading to premature death due to cardiovascular disease, and
2. Promotion of Healthy Women Infants and Children, specifically through increasing the proportion of infants that are breastfed.

Due to the broad scope of programs provided across the Montefiore Health System, multiple needs were identified beyond the planned focused activity of the Community Service Plan, and will be addressed through the ongoing programs across the delivery system.

The Health Status of the City of New Rochelle

The health status of the city of New Rochelle was measured across the indicators of overall health status as well as indicators of the social, environmental, and economic determinants of

health. While there are areas of improvement, New Rochelle's rates remain near countywide averages in the areas where data is available when compared to the remainder of Westchester County.

The ethnic and racial minority residents in New Rochelle however, do have significantly high mortality rates from heart disease, cancer, stroke, and chronic lower respiratory diseases (CLRD).

Mortality Rates:

According to the New York State Department of Health's (NYSDOH) Vital Statistics of New York State report in 2011, Westchester County (which includes the city of New Rochelle) has an age-adjusted mortality rate of 713.4 per 100,000; similar to the statewide rate of 753.1. According to the Community Health Rankings in 2014, Westchester County ranked as number 3 out of 62 NY counties to have the lowest mortality rate in New York State. The leading cause of death among Westchester County residents is due to coronary heart disease (219.7 per 100,000).

Asthma & CLRD:

According to the NYSDOH, 8.7% of Westchester County adults had asthma from 2008-2009; lower than the statewide percentage of 9.7%.

According to CDC data, the percentage of Westchester County adults with asthma increased to 14% from 2011-2012; same percentage as New York State.

According to an asthma report from New York State Office of the State Comptroller, the asthma prevalence rate among Westchester County Medicaid recipients was 86.7 per 1,000 from 2008-2009. The prevalence rate increased to 98.4 per 1,000 from 2012-2013; similar to the statewide prevalence rate of 98.7.

The average (age-adjusted) rate of asthma emergency department visits per 10,000 from 2011 was 64.2 in Westchester County. In 2012, the rate of asthma emergency department visits increased to 67.4 per 10,000.

In 2010, the age-adjusted death rate due to chronic lower respiratory diseases among Westchester County residents was 24.3 per 100,000; lower than the statewide rate of 31.1. In 2011, Westchester County 'sdeath rate decreased to 23.4; remaining lower than the statewide rate of 31.2.

Heart Disease & Stroke:

The coronary heart disease mortality rate per 100,000 in Westchester County was 119.5 in 2011; similar to the 2010 rate of 117.1. The coronary heart disease hospitalization rate per 10,000 in Westchester County was 35.8 in 2011; similar to the 2010 rate of 36.4.

The cerebrovascular disease (stroke) mortality rate per 100,000 in Westchester County was 25.8 in 2011; an increase from the 2010 rate of 24.0. The stroke hospitalization rate per 10,000 in Westchester County from 2009-2011 was 22.8; similar to the statewide rate of 24.9.

The cardiovascular disease mortality rate per 100,000 in Westchester County was 199.2 in 2011; an increase from the 2010 rate of 195.5. The cardiovascular disease hospitalization rate per 10,000 in Westchester County was 133.1; similar to the 2010 rate of 135.9.

Cancer:

The mortality rate of all cancer diagnoses in Westchester County was 150.5 in 2010; similar to the statewide rate of 160.2. The type of cancer with the highest mortality rate in Westchester County is lung cancer (36.9 per 100,000; lower than the statewide rate of 41.8).

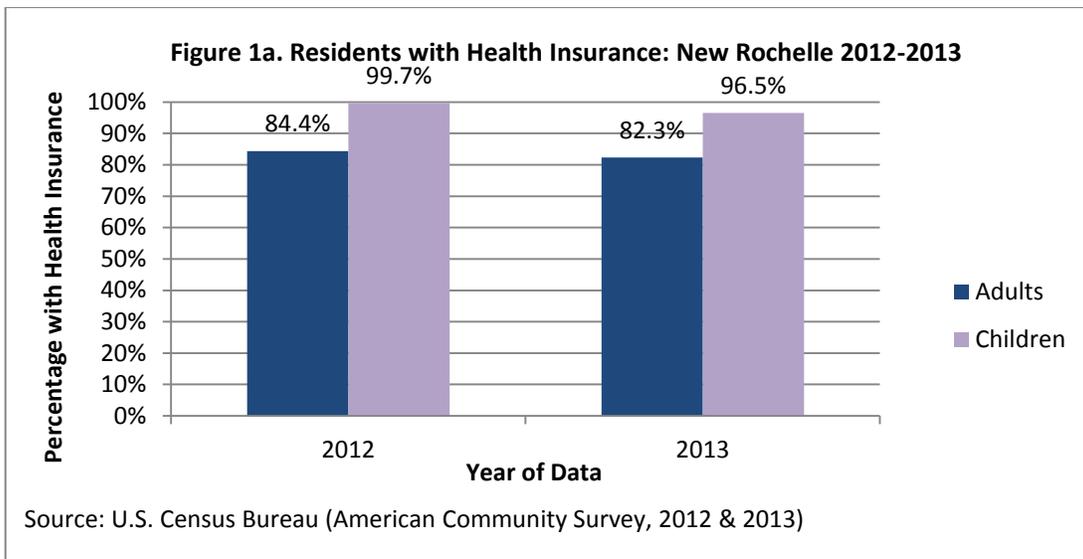
The incidence rate of all cancer diagnoses in Westchester County was 495.2 per 100,000 in 2010; similar to the statewide rate of 482.5. The type of cancer with the highest incidence rate in Westchester County is prostate cancer (22.6 per 100,000; similar to the statewide rate of 21.3).

Health Status of the City of New Rochelle: Health Indicators and Data Sources

Health Indicators

1. Access to Quality Health Services

- According to the U.S. Census Bureau, 84.4% of adults (see Figure 1a) and 99.7% of children in New Rochelle had health insurance in 2012. The percentage of New Rochelle adults with health insurance in 2012 was higher than the Westchester County percentage and similar to the New York State (NYS) percentage (see Figure 1b). The percentage among children in New Rochelle in 2012 was higher than the countywide and statewide percentages (see Figure 1c).
- In 2013, the percentage of New Rochelle residents with health insurance decreased to 82.3% for adults (see Figure 1a) and 96.5% for children. The percentage of New Rochelle adults with health insurance in 2013 was lower than the Westchester County and NYS percentages (see Figure 1b). The percentage among New Rochelle children in 2013 was lower than the countywide percentage and similar to the statewide percentage (see Figure 1c).
- From 2012-2013, New Rochelle children were more likely to have health insurance coverage than New Rochelle adults. In 2012, the percentage of New Rochelle children with health insurance was higher than the overall percentages among children in Westchester County and New York State. The percentage of New Rochelle adults and children with health insurance decreased over the years. Despite the decrease in 2013, the percentage of New Rochelle children remained higher than that of New Rochelle adults.



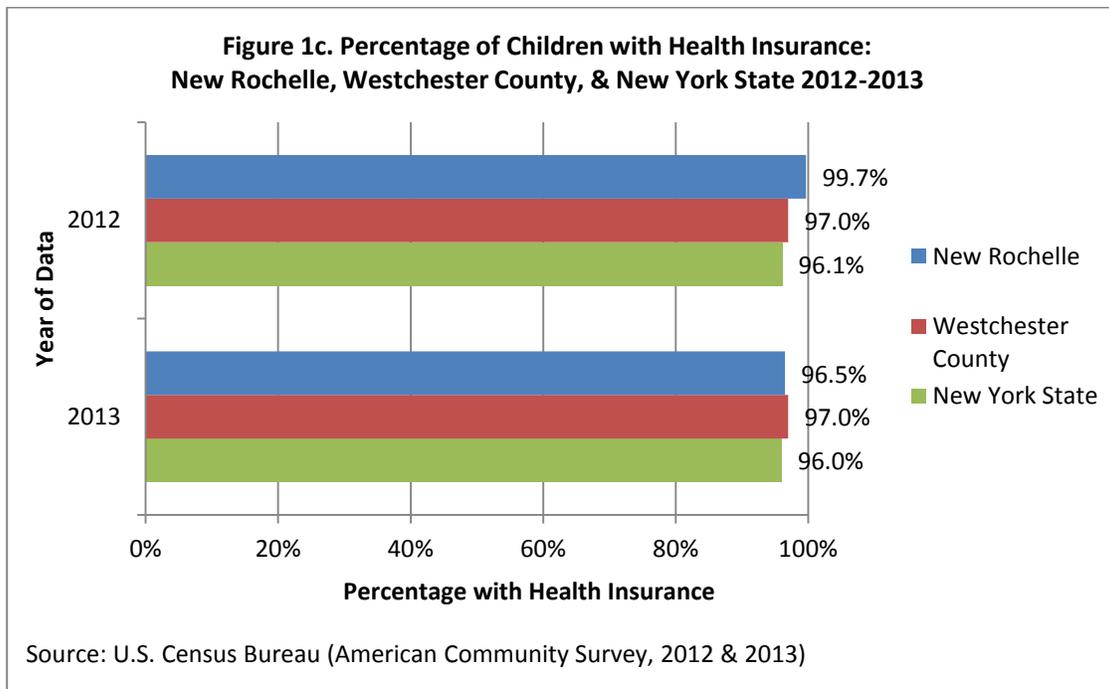
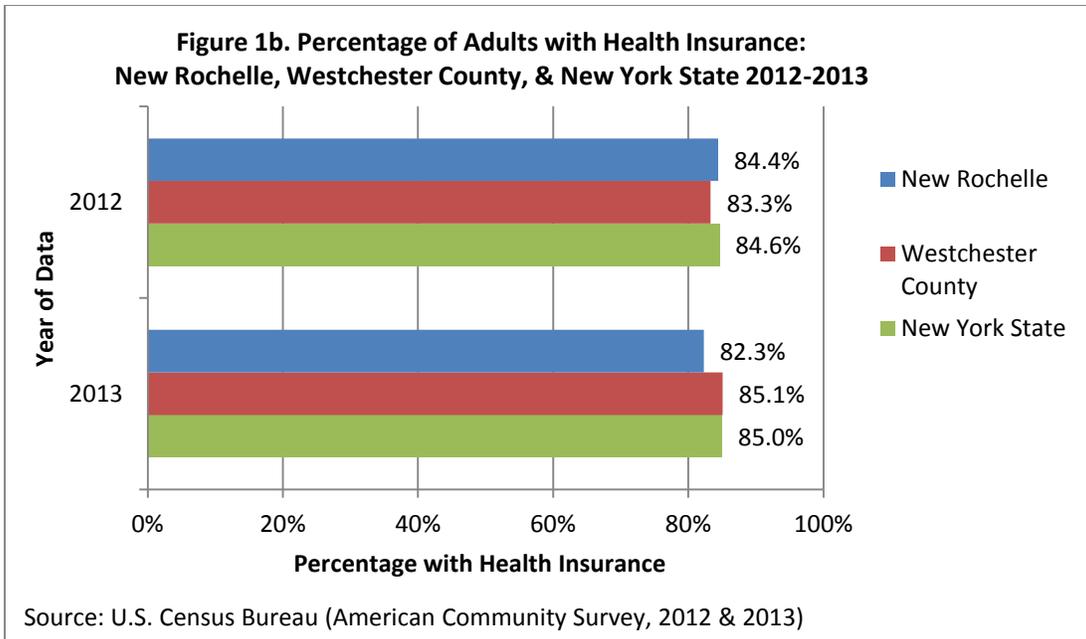


Figure 1d illustrates 20 ailments with the highest total number of patient diagnoses throughout New Rochelle (zipcodes: 10801; 10802; 10804; & 10805) from 2011-2013. The total number of patients diagnosed with each of the top 20 ailments represents hospital discharges among all New Rochelle residents. These ailments were categorized using the DRG coding system.

- From 2011-2013, Psychoses had the highest total number of inpatient diagnoses in New Rochelle.
- Among the top 20 inpatient diagnoses, Seizures without Major Complications & Comorbid Conditions had the lowest total number of inpatient diagnoses in New Rochelle from 2011-2013.
- The following diagnoses have decreased over the 2011-2013 period in the following area codes:
 - Psychoses
 - Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours with Major Complication or Comorbidity
 - Cesarean Section without Complications & Comorbid Conditions, or Major Complications & Comorbid Conditions
 - Syncope & Collapse
 - Seizures without Major Complications & Comorbid Conditions
 - Simple Pneumonia & Pleurisy with Complications & Comorbid Conditions
 - Septicemia Or Severe Sepsis without Mechanical Ventilation 96+ Hours without Major Complication or Comorbidity
- Among the top 20 inpatient diagnoses, Cellulitis without Major Complications & Comorbid Conditions; and Neonate/Newborns with Other Significant Problems increased over the 2011-2013 period.
- The following inpatient diagnoses increased in 2012 and decreased in 2013:
 - Vaginal Delivery without Complicating Diagnoses

- Alcohol/Drug Abuse or Dependence without Rehabilitation Therapy without Major Complications & Comorbid Conditions
- Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders without Major Complication or Comorbidity
- Major Joint Replacement or Reattachment Of Lower Extremity without Major Complications & Comorbid Conditions
- Cesarean Section with Complications & Comorbid Conditions, or Major Complications & Comorbid Conditions
- Heart Failure & Shock with Complications & Comorbid Conditions
- The following inpatient diagnoses decreased in 2012 and increased in 2013:
 - Miscellaneous Disorders of Nutrition, Metabolism, & Fluid/Electrolytes without Major Complication or Comorbidity
 - Kidney & Urinary Tract Infections without Major Complications & Comorbid Conditions
 - Heart Failure & Shock with Major complications & comorbid conditions
- There was no significant change in the number of inpatient diagnoses for Chest Pain; and Red Blood Cell Disorders without Major Complication or Comorbidity from 2011-2012. The number of inpatient diagnoses for these conditions decreased in 2013.
- The major health indicator themes that are described among the top 20 inpatient diagnoses in New Rochelle are:
 - Mental Diseases & Disorders
 - Maternal, Fetal, and Infant Health
 - Substance Abuse
 - Diseases & Disorders of the Digestive System
 - Respiratory Disorders
 - Circulatory System Disorders

Figure 1d. Top 20 discharges: New Rochelle, NY

Source: SPARCS

DRG	Description	2011	2012	2013
MSDRG-885	Psychoses	423	392	388
MSDRG-775	Vaginal Delivery W/O Complicating Diagnoses	321	359	316
MSDRG-897	Alcohol/Drug Abuse Or Dependence W/O Rehabilitation Therapy	207	288	124
MSDRG-871	Septicemia Or Severe Sepsis W/O Mv 96+ Hours W Mcc	237	210	204
MSDRG-766	Cesarean Section W/O Cc/Mcc	188	162	147
MSDRG-392	Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc	207	211	168
MSDRG-603	Cellulitis W/O Mcc	154	140	143
MSDRG-794	Neonate W Other Significant Problems	112	136	139
MSDRG-313	Chest Pain	156	157	116
MSDRG-312	Syncope & Collapse	110	108	101
MSDRG-470	Major Joint Replacement Or Reattachment Of Lower Extremity W/O Mcc	156	169	153
MSDRG-765	Cesarean Section W Cc/Mcc	68	85	78
MSDRG-292	Heart Failure & Shock W Cc	85	89	86
MSDRG-812	Red Blood Cell Disorders W/O Mcc	99	100	83
MSDRG-101	Seizures W/O Mcc	84	75	63
MSDRG-641	Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes W/O Mcc	95	89	103
MSDRG-690	Kidney & Urinary Tract Infections W/O Mcc	93	90	106
MSDRG-194	Simple Pneumonia & Pleurisy W Cc	96	84	79
MSDRG-872	Septicemia Or Severe Sepsis W/O Mv 96+ Hours W/O Mcc	92	80	75
MSDRG-291	Heart Failure & Shock W Mcc	76	68	83

Preventable Hospital Stays: Top 20 Inpatient Ambulatory Sensitive Discharges

Figure 1e illustrates 20 ailments with the highest total number of inpatient ambulatory sensitive discharges throughout New Rochelle from 2011-2013. The total number of patients diagnosed with each of the top 20 ailments represents sensitive ambulatory discharges among all New Rochelle residents. The top 20 ailments were categorized using the DRG coding system.

- From 2011-2013, Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders without Major Complication or Comorbidity had the highest total number of inpatient ambulatory sensitive discharges in New Rochelle.
- Among the top 20 inpatient ambulatory sensitive discharges, Diabetes without complications & comorbid conditions, or major complications & comorbid conditions had the lowest total number of inpatient diagnoses in New Rochelle from 2011-2013.
- The following ambulatory sensitive discharges have decreased over the 2011-2013 period:
 - Simple Pneumonia & Pleurisy with complications & comorbid conditions

- Cardiac arrhythmia & conduction disorders without complications & comorbid conditions, or major complications & comorbid conditions
- Simple Pneumonia & Pleurisy without Complications & Comorbid Conditions, or Major Complications & Comorbid Conditions
- Chronic Obstructive Pulmonary Disease with Major Complications & Comorbid Conditions
- The following ambulatory sensitive discharges increased in 2012 and decreased in 2013:
 - Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders without Major Complication or Comorbidity
 - Syncope & Collapse
 - Heart Failure & Shock with Complications & Comorbid Conditions
 - Heart Failure & Shock without Complications & Comorbid Conditions, or Major Complications & Comorbid Conditions
 - Chronic Obstructive Pulmonary Disease without Complications & Comorbid Conditions, or Major Complications & Comorbid Conditions
- The following ambulatory sensitive discharges decreased in 2012 and increased in 2013:
 - Cellulitis without Major Complications & Comorbid Conditions
 - Miscellaneous Disorders of Nutrition, Metabolism, & Fluid/Electrolytes without Major Complication or Comorbidity
 - Kidney & Urinary Tract Infections without Major Complication or Comorbidity
 - Heart Failure & Shock with Major Complications & Comorbid Conditions
 - Medical Back Problems without Major Complications & Comorbid Conditions
 - Chronic Obstructive Pulmonary Disease with Complications & Comorbid Conditions
- The number of ambulatory sensitive discharges increased for Signs & Symptoms without Major Complications & Comorbid Conditions from 2011-2012. There was no significant change on the number of discharges on 2013.

- The number of ambulatory sensitive discharges decreased for Bronchitis & Asthma without Complications & Comorbid Conditions, or Major Complications & Comorbid Conditions; and Diabetes without Complications & Comorbid Conditions, or Major Complications & Comorbid Conditions from 2011-2012. There was no significant change on the number of discharges on 2013.
- There was no significant change in the number of inpatient diagnoses for Chest Pain; and Seizures without Major Complications & Comorbid Conditions from 2011-2012. The number of inpatient diagnoses for these conditions decreased in 2013.
- The major health indicator themes that are described among the top 20 ambulatory sensitive discharges in New Rochelle are:
 - Diseases & Disorders of the Digestive System
 - Respiratory Disorders
 - Nutrition Disorders
 - Circulatory System Disorders
 - Heart Diseases
 - Diabetes

Figure 1e. Top 20 ambulatory sensitive discharges: New Rochelle, NY
Source: SPARCS

DRG code	Description	2011	2012	2013
MSDRG-392	Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc	209	211	168
MSDRG-603	Cellulitis W/O Mcc	154	140	144
MSDRG-313	Chest Pain	156	157	116
MSDRG-312	Syncope & Collapse	130	135	115
MSDRG-292	Heart Failure & Shock W Cc	94	102	94
MSDRG-101	Seizures W/O Mcc	101	100	82
MSDRG-641	Misc Disorders Of Nutrition, Metabolism, Fluids/Electrolytes W/O Mcc	95	89	103
MSDRG-690	Kidney & Urinary Tract Infections W/O Mcc	93	90	106
MSDRG-194	Simple Pneumonia & Pleurisy W Cc	96	85	80
MSDRG-291	Heart Failure & Shock W Mcc	85	72	89
MSDRG-203	Bronchitis & Asthma W/O Cc/Mcc	74	56	55
MSDRG-948	Signs & Symptoms W/O Mcc	42	65	66
MSDRG-310	Cardiac Arrhythmia & Conduction Disorders W/O Cc/Mcc	69	67	64
MSDRG-293	Heart Failure & Shock W/O Cc/Mcc	56	61	56
MSDRG-195	Simple Pneumonia & Pleurisy W/O Cc/Mcc	64	59	50
MSDRG-192	Chronic Obstructive Pulmonary Disease W/O Cc/Mcc	38	40	25
MSDRG-190	Chronic Obstructive Pulmonary Disease W Mcc	56	50	48
MSDRG-552	Medical Back Problems W/O Mcc	80	49	55
MSDRG-191	Chronic Obstructive Pulmonary Disease W Cc	48	31	36
MSDRG-639	Diabetes W/O Cc/Mcc	34	21	22

Figure 1f illustrate 20 ailments with the highest total number of patient diagnoses in the emergency departments of New Rochelle hospitals from 2011-2013. The total number of patients diagnosed with each of the top 20 ailments represents ED diagnoses among all New Rochelle residents. These ailments were categorized using the ICD-9 coding system.

- From 2011-2013, Acute Upper Respiratory Infections (unspecified site) had the highest total number of ED diagnoses in New Rochelle.
- Among the top 20 ED diagnoses, Lumbago had the lowest total number of ED diagnoses in New Rochelle from 2011-2013.
- The following ED discharges have decreased over the 2011-2013 period:
 - Acute Upper Respiratory Infections (unspecified site)
 - Otitis Media (unspecified)
 - Acute Pharyngitis
 - Urinary Tract Infection (unspecified site)
 - Fever (unspecified type)
 - Headache
 - Abdominal Pain (other site)
 - Lumbago
- The number of ED discharges increased for Viral Infection (unspecified type) from 2011-2013.
- The following ED discharges increased in 2012 and decreased in 2013:
 - Other & Unspecified Noninfectious Gastroenteritis & Colitis
 - Head Injury (unspecified type)
 - Asthma NOS W Exacer (Asthma, unspecified type, with acute exacerbation)
 - Abdominal Pain (unspecified type)
 - Open Wound of Finger(s) without Mention of Complication

- Dizziness & Giddiness
- Chest Pain (unspecified type)
- (Medical) Encounter/Visit for Removal of Sutures/Stitches
- The following ED discharges decreased in 2012 and increased in 2013:
 - Chest Pain (other)
 - Acute Bronchitis
 - Ankle Sprain (unspecified type)
- The major health indicator themes that are described among the top 20 ED discharges in New Rochelle are:
 - Respiratory Disorders
 - Diseases & Disorders of the Digestive System
 - Chronic Pain Disorders
 - Infectious Diseases
 - Skin Disorders

Figure 1f. Top 20 ED diagnoses: New Rochelle, NY

Source: SPARCS

ICD-9 diagnosis code	Description	2011	2012	2013
4659	Acute URI NOS	480	438	400
3829	Otitis Media NOS	551	348	329
462	Acute Pharyngitis	449	345	285
5990	Urinary Tract INF NOS	459	375	299
78060	Fever NOS	518	261	225
5589	NonINF Gastroent NEC&NOS	366	376	324
95901	Head Injury NOS	325	444	359
49392	Asthma NOS W Exacer	260	323	301
78659	Chest Pain NEC	477	272	274
7999	Viral Infection NOS	169	359	361
7840	Headache	354	298	288
4660	Acute Bronchitis	283	239	249
78900	Abdominal Pain-Site NOS	259	342	243
8830	Open WND Finger	277	284	266
7804	Dizziness & Giddiness	235	266	215
84500	Ankle Sprain NOS	232	222	250
78900	Abdominal Pain-Site NEC	308	178	171
78650	Chest Pain NOS	129	337	231
V5832	Encount Suture Rmvl	133	155	126
7242	Lumbago	281	172	138

2. Chronic Diseases

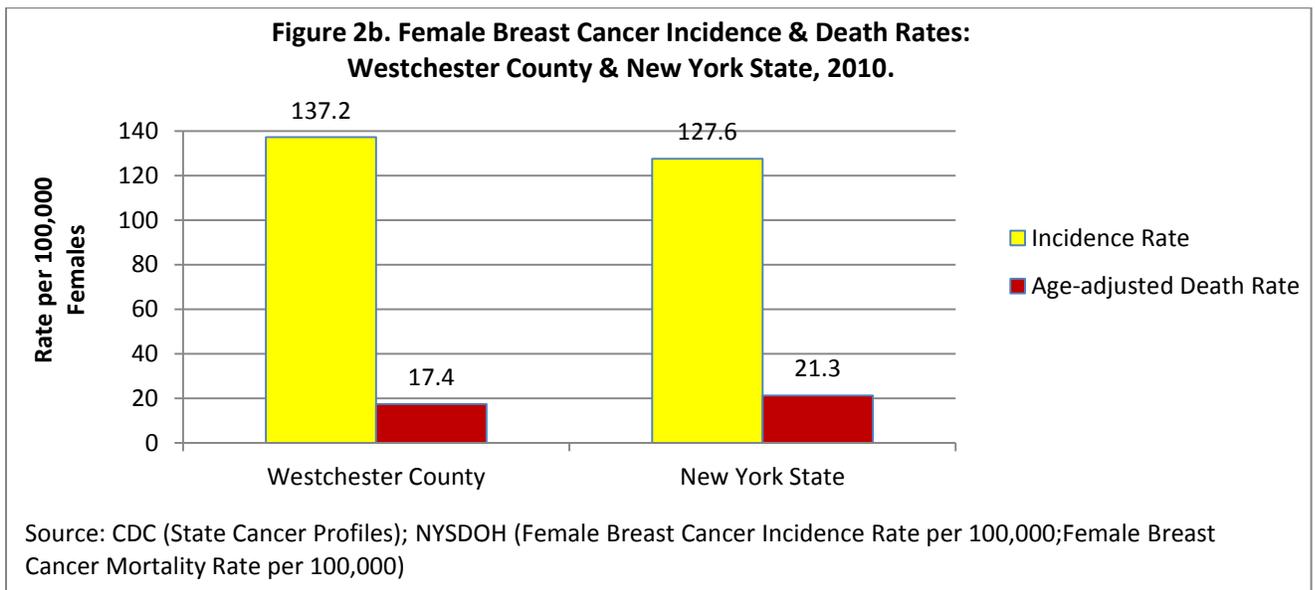
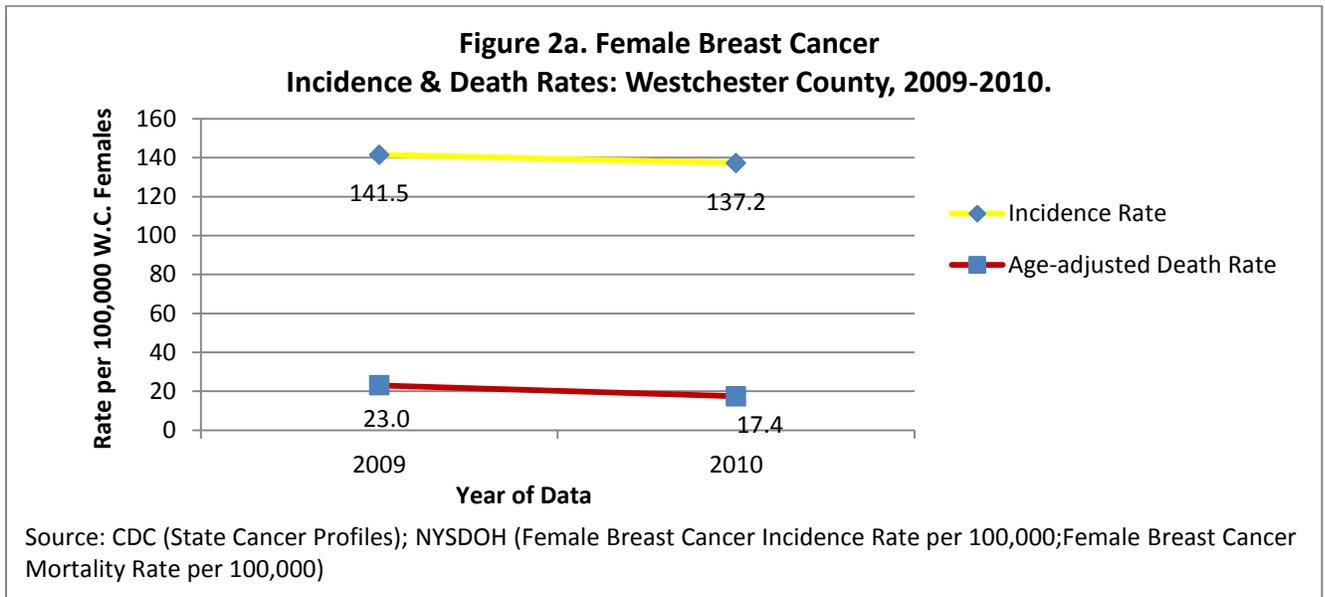
Chronic Diseases: Cancer

Breast Cancer (citywide data unavailable):

- According to the Centers for Disease Control & Prevention (CDC) and the New York State Department of Health (NYSDOH), the female breast cancer incidence rate in Westchester County was 141.5 per 100,000 females in 2009 (see Figure 2a). The Westchester County rate was higher than the statewide rate of 130.7 (see Figure 2b).
- In 2010, Westchester County's female breast cancer incidence rate decreased to 137.2; remaining higher than the statewide rate of 127.6 (see Figure 2b).
- The age-adjusted death rate due to breast cancer in Westchester County was 23.0 per 100,000 females in 2009. The death rate decreased to 17.4 per 100,000 females in 2010

(see Figure 2a). The Westchester County rate was lower than the statewide rate of 21.3 (see Figure 2b).

- Overall, Westchester County’s female breast cancer incidence and death rates have decreased in the last few years. The breast cancer death rate in Westchester County was lower than the statewide rate in 2010; however, the breast cancer incidence rate among Westchester County females remained higher than the statewide incidence rate.

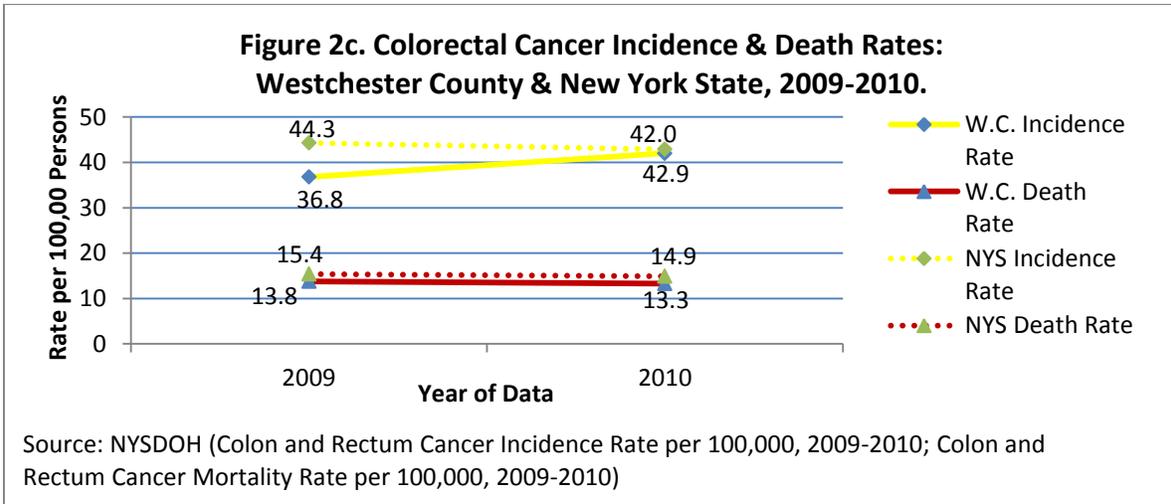


- According to the County Health Rankings data, 67.6% of Westchester County female Medicare enrollees ages 67-69 reported in 2010 that they received at least one

mammography screening over a two-year period; higher than the statewide percentage of 65.9%. In 2011, 66% received at least one mammography screening; remaining higher than the statewide percentage of 63%.

Colorectal Cancer (citywide data unavailable):

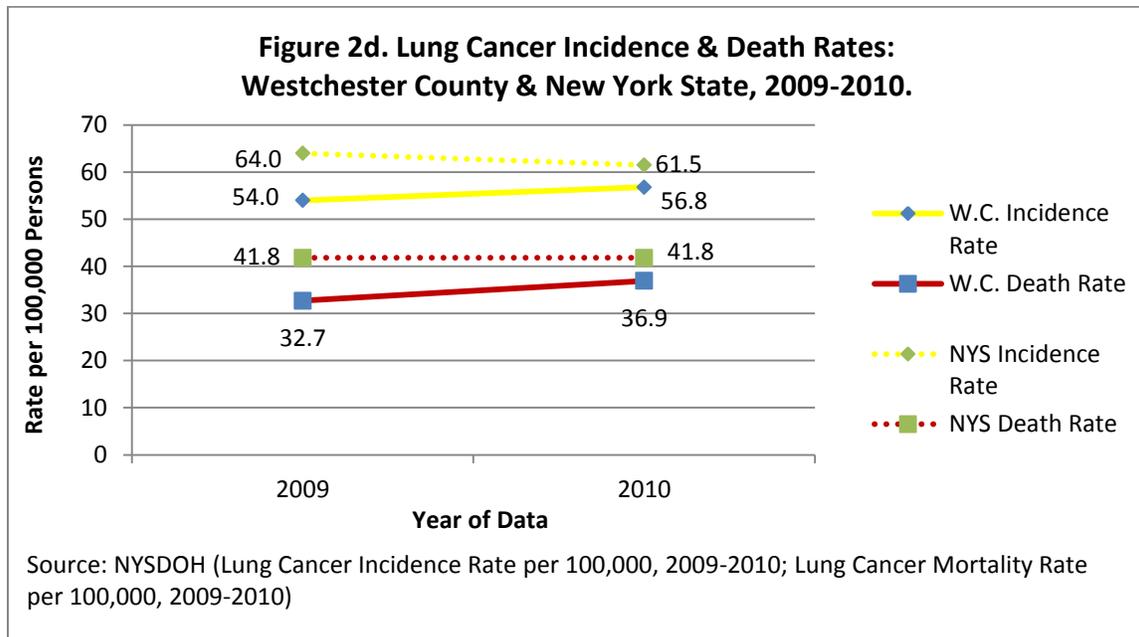
- According to the NYSDOH, the colorectal cancer incidence rate among Westchester County residents in 2009 was 36.8 per 100,000 persons; lower than the statewide rate of 44.3. In 2010, the incidence rate among Westchester County residents was 42.0; no significant difference from the statewide rate of 42.9 (see Figure 2c).
- The age-adjusted death rate due to colorectal cancer was 13.8 per 100,000 among Westchester County residents in 2009; lower than the statewide rate of 15.4. In 2010, the death rate among Westchester County residents was 13.3; remaining lower than the statewide rate of 14.9 (see Figure 2c).
- Overall, the colorectal cancer incidence rate among Westchester County residents increased over the years. Although the colorectal death rate among Westchester County residents remained lower than the statewide rate, there was no significant change in the Westchester County rate from 2009-2010.
- In 2012, 72.3% of Westchester County residents ages 50 and older had a colonoscopy in the past 10 years; higher than the statewide percentage of 65.2%.



Lung cancer (citywide data unavailable):

- According to the NYSDOH, the lung cancer incidence rate among Westchester County residents was 54.0 per 100,000 persons in 2009; lower than the statewide rate of 64.0. In 2010, the incidence rate in Westchester County increased to 56.8; lower than the statewide rate of 61.5 (see Figure 2d).

- The age-adjusted death rate due to lung cancer was 32.7 per 100,000 among Westchester County residents in 2009; lower than the statewide rate of 41.8. In 2010, the lung cancer death rate in Westchester County increased to 36.9; lower than the statewide rate of 41.8 (see Figure 2d).
- Overall, Westchester County's lung cancer incidence and death rates remained lower than the statewide rates from 2009-2010.



Prostate cancer (citywide data unavailable):

- According to the NYSDOH, the prostate cancer incidence rate among Westchester County males was 152.9 per 100,000 males in 2009; lower than the statewide rate of 161.9. In 2010, the statewide rate of 147.6 was lower than the Westchester County rate. There was no significant change in Westchester County incidence rates between 2009 and 2010.
- The age-adjusted death rate due to prostate cancer in Westchester County was 23.0 per 100,000 males in 2009; higher than the statewide rate of 20.7. In 2010, the prostate cancer death rate in Westchester County slightly decreased to 22.6; higher than the statewide rate of 21.3.
- Overall, Westchester County's prostate cancer incidence rate remained lower than the statewide rates from 2009-2010. Despite the decrease in prostate cancer death rate among Westchester County males, the Westchester County rate remained higher than the statewide death rate.

Cervical cancer (citywide data unavailable):

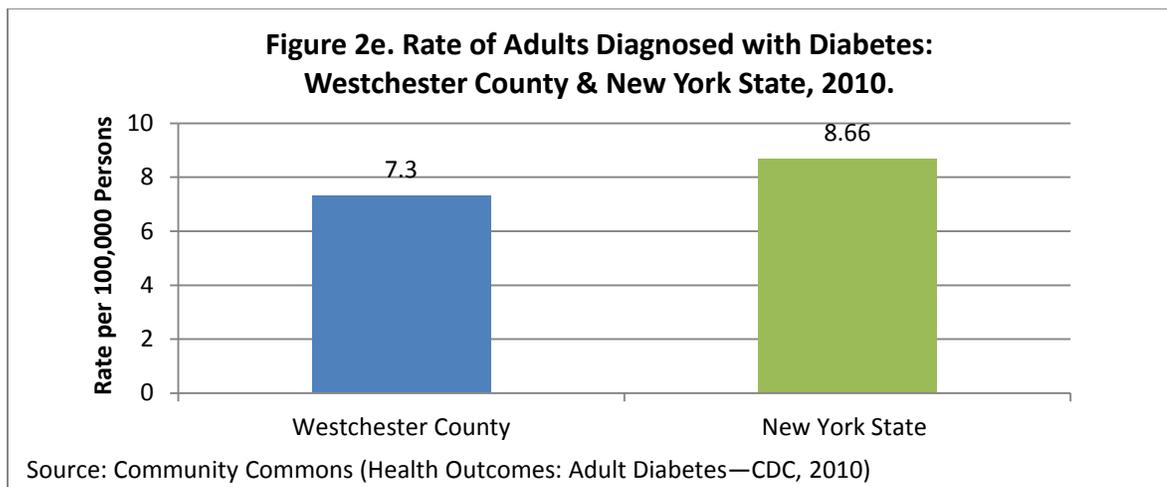
- According to the NYSDOH, the cervical cancer incidence rate among Westchester County females was 8.2 per 100,000 females in 2009; similar to the statewide rate of 8.3. In 2010, the incidence rate among Westchester County females was 6.4; lower than the statewide rate of 8.0.
- In 2009, 81.5% of Westchester County women ages 18 and older reported that they had a pap test within the past three years; similar to the statewide percentage of 81.7%.

Oral cavity and pharynx cancer (citywide data unavailable):

- According to the NYSDOH, the oral cavity and pharynx cancer incidence rate among Westchester County residents was 8.9 per 100,000 persons in 2009; lower than the statewide rate of 10.6.
- In 2010, the incidence rate in Westchester County increased to 10.5; similar to the statewide rate of 10.4.

Chronic Diseases: Diabetes (*citywide data unavailable*)

- According to 2010 CDC data, 7.3 of adults in Westchester County have been diagnosed with diabetes; lower than the statewide rate of 8.66 (see Figure 2e).



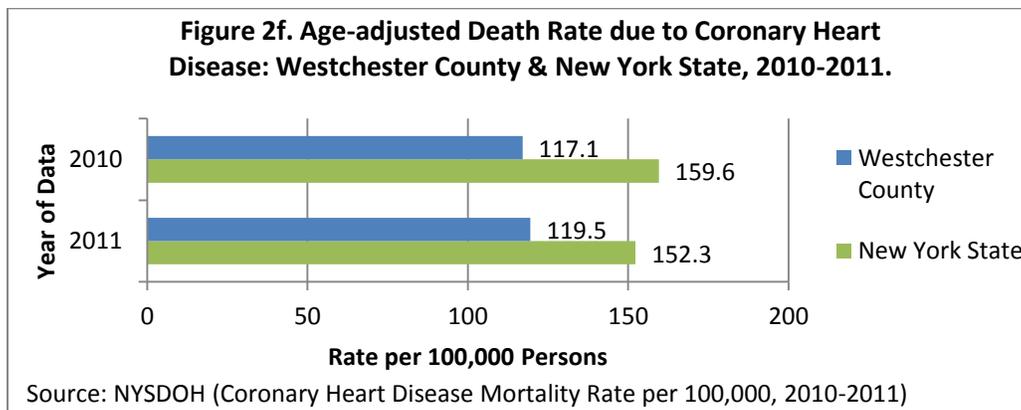
- According to the County Health Rankings data, 85% of diabetic Medicare enrollees ages 65 and older in Westchester County reported in 2010 that their blood sugar levels were screened in the past year using the HbA1c test method. 87% of enrollees reported in 2011 that they received HbA1c screening in the past year.

- The age-adjusted death rate due to diabetes was 9.7 per 100,000 among Westchester County residents in 2010; lower than the statewide rate of 16.5.
- In 2011, the age-adjusted death rate due to diabetes increased to 12.5 per 100,000 among Westchester County residents; remaining lower than the statewide rate of 17.7.

Chronic Diseases: Heart Disease and Stroke

Heart Disease (citywide data unavailable)

- According to the NYSDOH, the age-adjusted death rate due to coronary heart disease among Westchester County residents was 117.1 per 100,000 in 2010; lower than the statewide rate of 159.6.
- In 2011, the Westchester County death rate increased to 119.5 in 2010; remaining lower than the statewide rate of 152.3 (see Figure 2f).



Stroke (citywide data unavailable):

- The age-adjusted death rate due to cerebrovascular disease (stroke) was 24.0 per 100,000 Westchester County residents in 2010; lower than the statewide rate of 27.5.

- In 2011, the stroke death rate among Westchester County residents increased to 25.8; remaining lower than the statewide rate of 27.1.

High blood pressure (citywide data unavailable):

- According to the NYSDOH, 22.8% of Westchester County residents were diagnosed with high blood pressure in 2009; lower than the statewide rate of 25.7%.

High cholesterol (citywide data unavailable):

- According to the CDC, 41.6% of Westchester County adults were diagnosed with high cholesterol in 2009; higher than the statewide percentage of 39.4%.
- From 2011-2012, the percentage of adults in Westchester County with high cholesterol decreased to 31.9%; lower than the statewide rate of 38.7%.

Chronic Diseases: Respiratory Diseases (citywide data unavailable)

- According to the NYSDOH, 8.7% of Westchester County adults had asthma from 2008-2009; lower than the statewide percentage of 9.7%.
- According to CDC data, the percentage of Westchester County adults with asthma increased to 14% from 2011-2012; same percentage as New York State.
- The age-adjusted death rate due to chronic lower respiratory diseases among Westchester County residents was 24.3 per 100,000 in 2010; lower than the statewide rate of 31.1.

- In 2011, Westchester County's age-adjusted death rate due to chronic lower respiratory diseases decreased to 23.4; remaining lower than the statewide rate of 31.2.

3. Communicable Diseases and Immunizations

Pneumonia and Influenza (citywide data unavailable)

- According to CDC data from 2006-2012, 63.7% of Westchester County residents ages 65+ reported that they received a pneumonia shot in the past; lower than the statewide rate of 65.1%.
- According to the NYSDOH, 78.1% of Westchester County residents ages 65+ reported that they received a flu shot within the last year; higher than the statewide rate of 60%.

STDs & HIV/AIDS (citywide data unavailable)

- According to the CDC, the rate of chlamydia in Westchester County was 317.29 per 100,000 in 2012; lower than the statewide rate of 516.54.
- The rate of Westchester County residents living with HIV was 474.33 per 100,000 in 2010; lower than the statewide rate of 810.01.
- From 2011-2012, 46.3% of Westchester County adults were screened for HIV/AIDS.

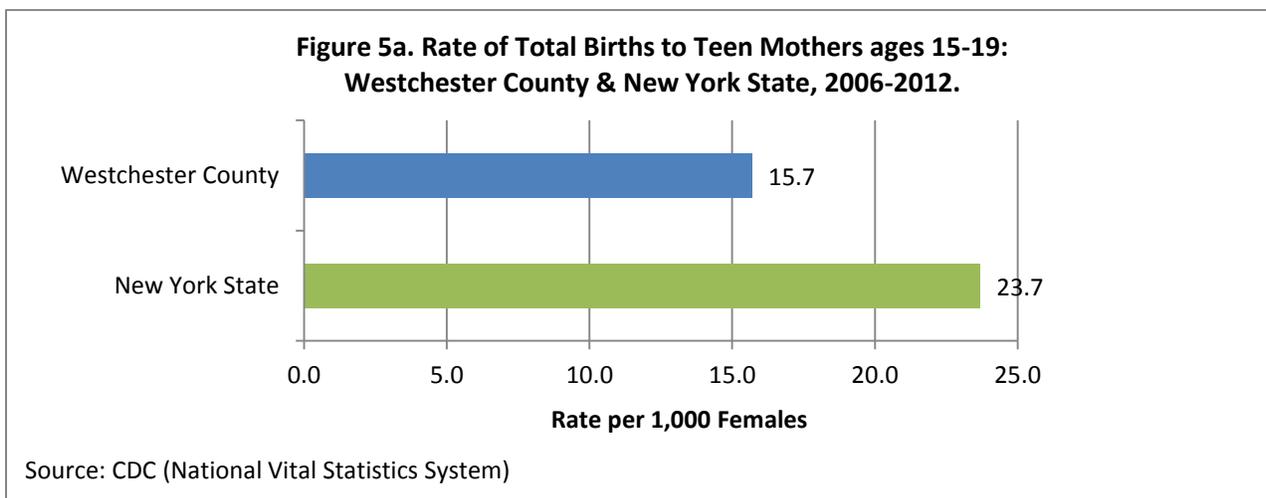
4. Disability

- According to the U.S. Census Bureau, 12.3% of New Rochelle residents are living with a disability in 2013. The New Rochelle percentage was higher than the Westchester County percentage of 9.1% and the New York State percentage of 11.2%.

- 10.8% of New Rochelle males and 13.8% of New Rochelle females have a disability.
- Age groups in New Rochelle with any disability: 1.7% under age 18; 9.5% ages 18-64; and 38.1% age 65+.
- In 2013, 12% of Whites, 15.9% of Blacks/African-Americans, and 9.7% of Hispanics/Latinos in New Rochelle had a disability. From 2008-2012, 8.5% of New Rochelle’s Asian population had a disability.

5. Family Planning & Adolescent Pregnancy (*citywide data unavailable*)

- According to CDC data from 2006-2012, the rate of total births to teen mothers ages 15-19 in Westchester County was 15.7 per 1,000; lower than the statewide rate of 23.7 (see Figure 5a).



6. Maternal, Fetal, and Infant Health

- According to CDC data from 2006-2012, 8.3% of total live births in Westchester County resulted in low infant birthweight (under 2500 grams); similar to the statewide rate of 8.2%.
- According to the WIC Breastfeeding Data Local Agency Report, the number of infants in participation from the Sound Shore Medical Center WIC Program in New Rochelle were 1847, with 69 breastfeeding exclusively, 824 partially breastfed and 954 fully formula fed in 2012.

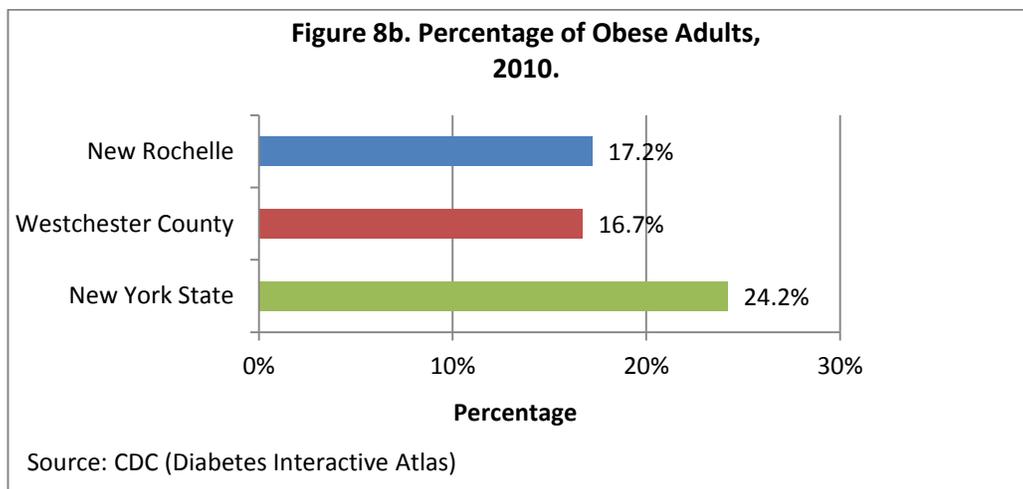
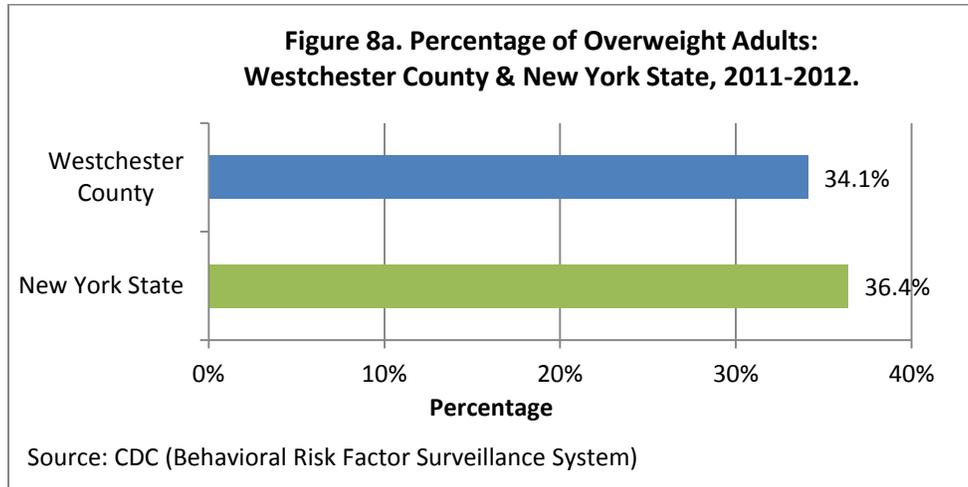
7. Mental Health and Mental Disorders (*citywide data unavailable*)

- According to CDC data from 2007-2011, the age-adjusted death rate due to suicide in Westchester County was 6.32 per 100,000; lower than the statewide rate of 7.40.

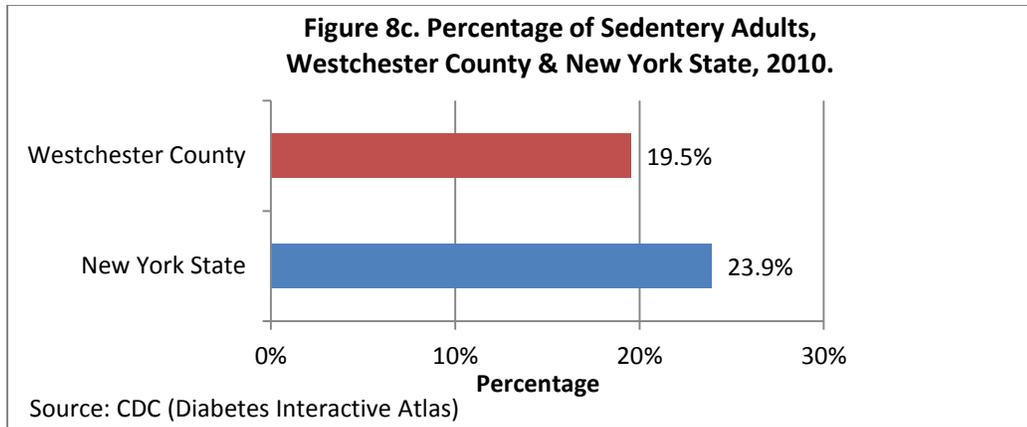
8. Nutrition, Physical Activity, and Weight

- According to the CDC, 34.1% of Westchester County adults were reported to be overweight from 2011-2012; lower than the statewide rate of 36.4% (see Figure 8a).

- In 2010, 17.2% of New Rochelle adults were reported to be obese; higher than the countywide percentage of 16.7% and lower than the statewide percentage of 24.2% (see Figure 8b).



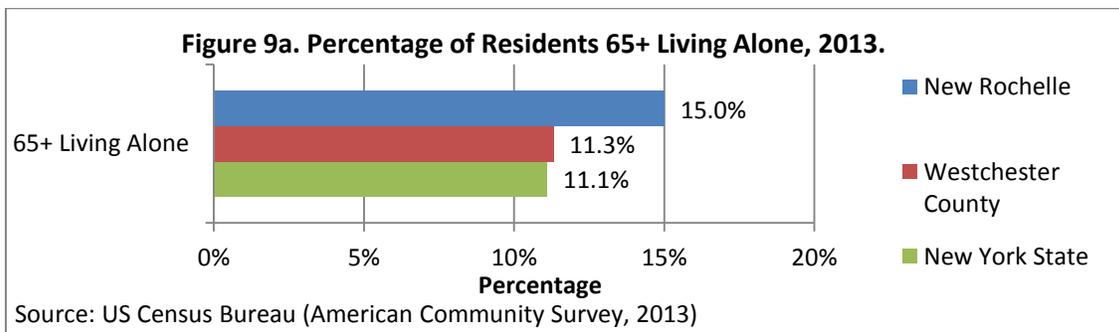
- According to the CDC, 19.5% of Westchester County adults ages 20 and older reported in 2010 that they engaged in no leisure time physical activity in the past 30 days; lower than the statewide percentage of 23.9% (see Figure 8c).



- From 2005-2009, 68.8% of Westchester County adults consumed less than 5 servings of fruits and vegetables each day; less than the statewide percentage of 73.2%.

9. Older Adults and Aging

- According to the U.S. Census Bureau, 15% of the New Rochelle population ages 65 and over reported living alone in 2013; higher than the Westchester County percentage of 11.3% and the New York State percentage of 11.1% (see Figure 9a).

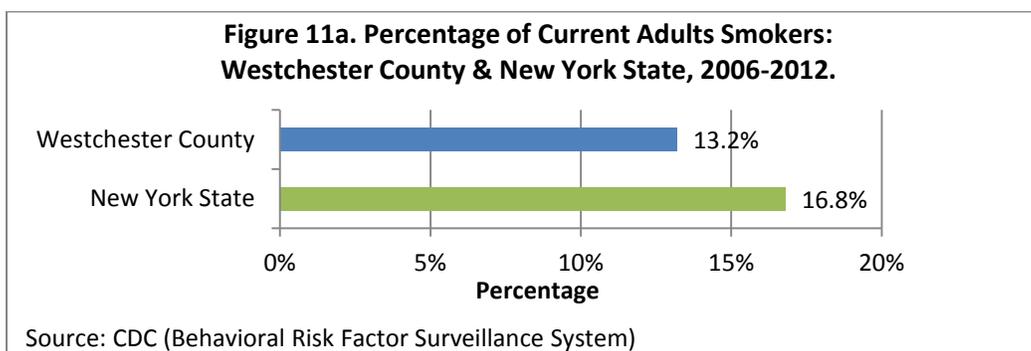


10. Injury and Violence Prevention (*citywide data unavailable*)

- The age-adjusted death rate due to unintentional injuries from 2007-2011 in Westchester County was 20.1 per 100,000; lower than the statewide rate of 25.

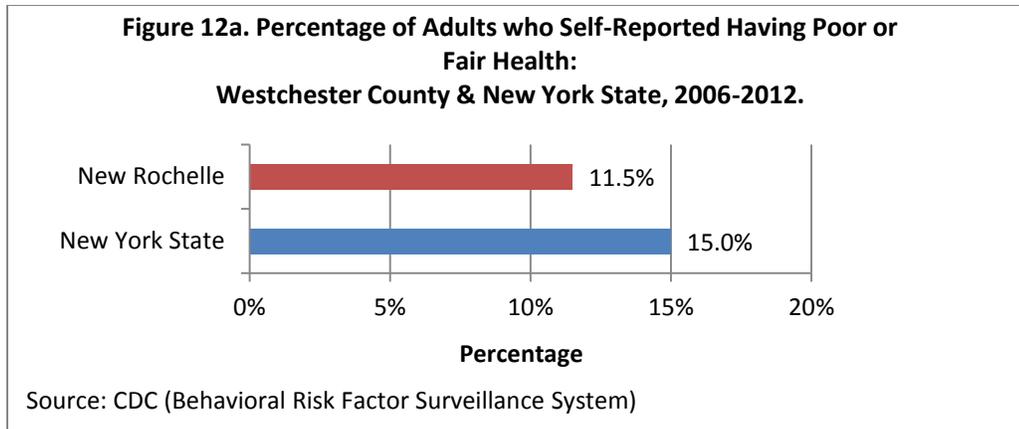
11. Substance Abuse and Tobacco Use

- According to CDC data from 2006-2012, 17.4% of New Rochelle adults ages 18 and older engaged in heavy alcohol consumption; higher than the countywide percentage of 16.1% and lower than the statewide rate of 17.5%.
- According to CDC data from 2006-2012, 13.2% of adults in Westchester County reported being current smokers; lower than the statewide percentage of 16.8% (see Figure 11a).



12. Wellness and Lifestyle (*citywide data unavailable*)

- According to CDC data from 2006-2012, 11.5% of Westchester County adults self-reported having poor or fair health; lower than the statewide percentage of 15% (see Figure 12a).

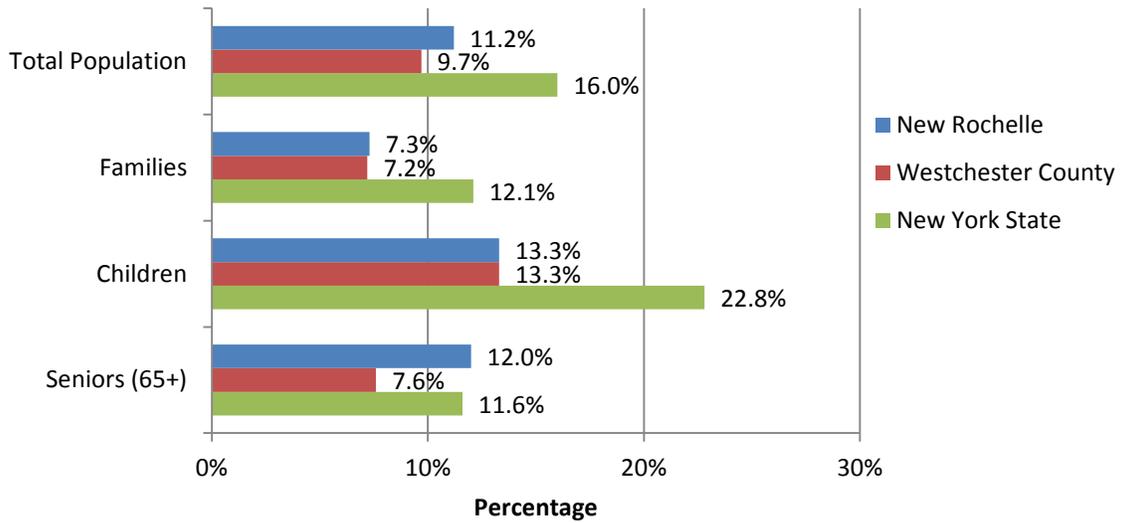


- According to CDC data from 2006-2012, 22.8% of Westchester County adults self-reported that they received insufficient social and emotional support all or most of the time; lower than statewide rate of 24%.

B. Economy

- According to the US Census Bureau (2013), 11.2% of New Rochelle residents lived below poverty level. In 2013, 7.3% of New Rochelle families, 13.3% of New Rochelle children, and 12% of New Rochelle residents ages 65 and older lived below poverty level.
- In Westchester County, 9.7% of the population lived below the poverty level in 2013. During the same year, 7.2% of families, 13.3% of children, and 7.6% of individuals ages 65 and older in Westchester County lived below poverty level.
- In New York State, 16% of the population lived below the poverty level in 2013. 12.1% of families, 22.8% of children, and 11.6% of residents ages 65 and older in New York State lived below the poverty level (see Figure 13a).

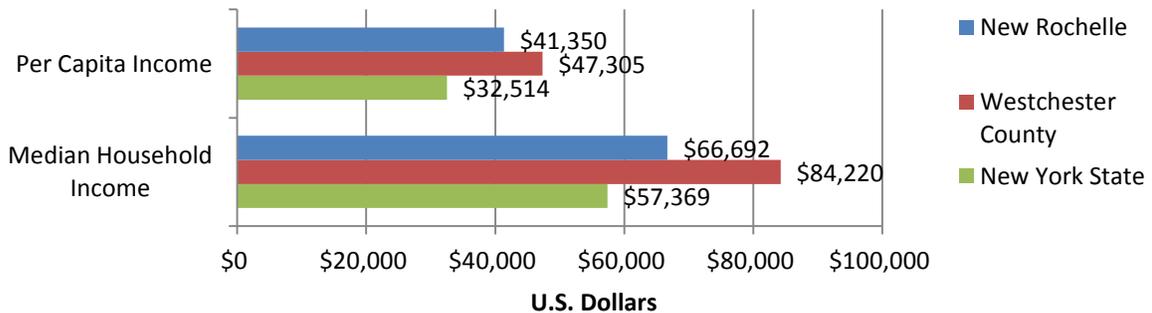
Figure 13a. Percentage of Individuals Living in Poverty, 2013.



Source: US Census Bureau (American Community Survey, 2013)

- The per capita income of people living in New Rochelle, New York in 2013 was \$41,350. In 2013, the per capita income was \$47,305 in Westchester County and \$32,514 in New York State. In 2013, the median household income in New Rochelle was \$66,692. The median household income was \$84,220 in Westchester County and \$57,369 in New York State (Figure 13b).

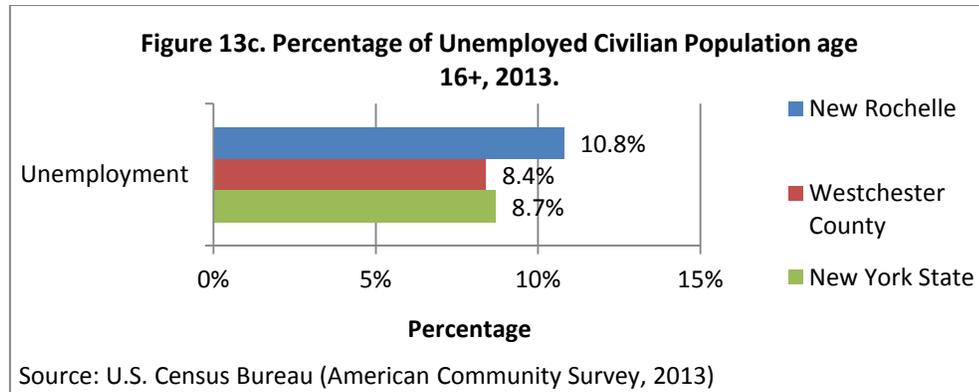
Figure 13b. Income, 2013.



Source: US Census Bureau (American Community Survey, 2013)

- In 2013, 4.3% of New Rochelle households received public assistance income. Within the same year, 2.8% of Westchester County households and 3.5% of New York State households received public assistance income.

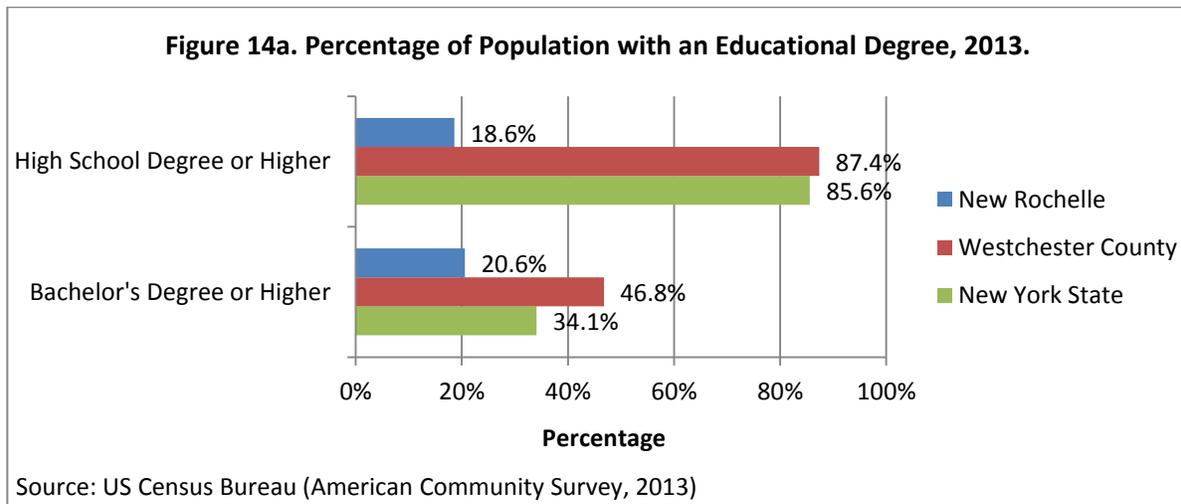
- According to the National Center for Education Statistics, 42.3% of students in New Rochelle were eligible for reduced or free lunch during the 2010-2011 school year; higher than the countywide percentage of 30.5% and statewide percentage of 32.5%.
- According to the U.S. Census Bureau, the unemployment rate in 2013 was 10.8% in New Rochelle, 8.4% in Westchester County, and 8.7% in New York State (Figure 13c).



- An estimated 53.4% of renters in New Rochelle spent 30% or more of their household income on rent in 2013. In the same year, an estimated 52% of renters in Westchester County and 50.8% of renters in New York State spent 30% or more of their household income on rent.
- In 2013, the homeowner vacancy rate was 2.1 in New Rochelle, 1.5 in Westchester County, and 1.6 in New York State.
- In 2013, 95% of occupied housing units in New Rochelle were owner-owned units. Within the same year, 92.6% of occupied housing units in Westchester County and 88.8% of occupied housing units in New York State were owner-owned units.

C. Education

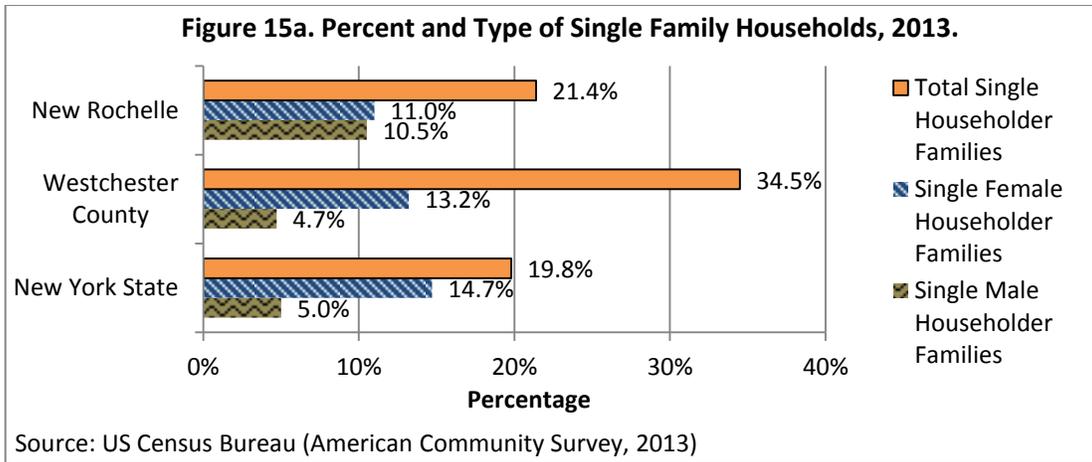
- In 2013, 18.6% of the population 25 years and over in New Rochelle had a high school degree or higher. Within the same year, 87.4% of Westchester County and 85.6% of New York State residents 25 years and over had a high school degree and higher.
- 20.6% of residents 25 years and over in New Rochelle had a bachelor's degree or higher in 2013. Within the same year, 46.8% of Westchester County and 34.1% of New York State residents 25 years and over had a bachelor's degree or higher (Figure 14a).



- From 2011-2012, the rate of ninth grade students who graduated in 4 years in New Rochelle was 82; lower than the countywide rate of 86.44 and statewide rate of 83.50.

D. Social Environment

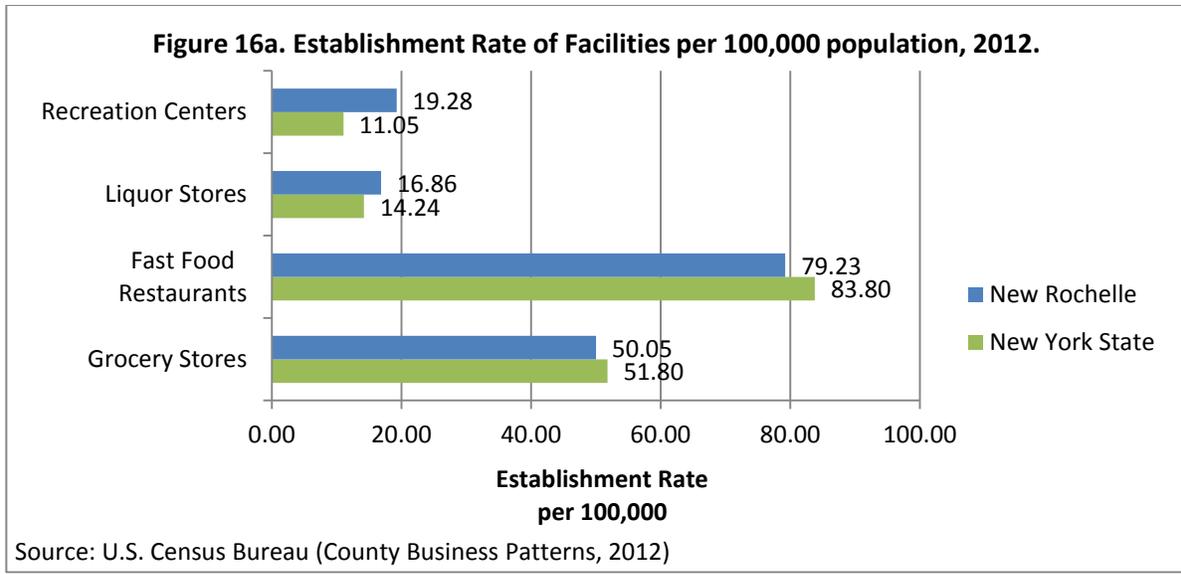
- According to the U.S. Census Bureau, there were approximately 30,000 households in New Rochelle in 2013. The average household size in New Rochelle was 2.54 people; lower than the countywide (3.42) and statewide (2.64) rates.
- Families made up 67% of the New Rochelle households; lower than the countywide percentage (69.8%) and higher than the statewide percentage (63.5%).
- Married-couple families made up 45.6% of New Rochelle households in 2013; lower than the countywide (52%) percentage and higher than the statewide (43.8%) percentage.
- Single-householder families made up 21.4% of New Rochelle households in 2013; lower than the countywide (34.5%) percentage and higher than the statewide percentage (19.8%). 10.5% of New Rochelle's households were headed by males; higher than the countywide (4.7%) and statewide (5%) percentages. 11% of New Rochelle's households were headed by females; lower than the countywide (13.2%) and statewide (14.7%) percentages.



- According to the New York State Division of Criminal Justice Services, New Rochelle's violent crime was 225.7* in 2013; lower than the statewide rate of 388.4.

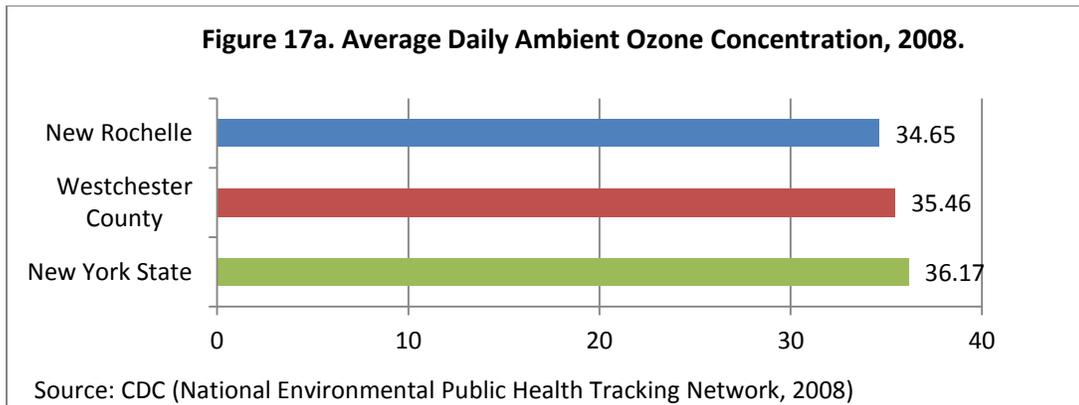
E. Built Environment

- According to the U.S. Census Bureau, there were 38 grocery stores in New Rochelle in 2012. The establishment rate for New Rochelle grocery stores was 50.05 per 100,000 population; lower than the statewide rate of 51.80 (see Figure 16a).
- In 2010, 99.7% of New Rochelle's low-income population lived less than a mile from a grocery store; higher than the countywide (98.7%) and statewide (97.5%) percentages.
- There were 61 fast food restaurants in New Rochelle in 2012. The establishment rate for fast food restaurants in New Rochelle was 79.23 per 100,000 population; lower than the statewide rate of 83.80 (see Figure 16a).
- There were 12 liquor stores in New Rochelle in 2012. The establishment rate of liquor stores in New Rochelle was 16.86 per 100,000 population; higher than the statewide rate of 14.24 (see Figure 16a).
- There were 14 recreation and fitness facilities in New Rochelle in 2012. The establishment rate of such facilities in New Rochelle was 19.28 per 100,000 population; higher than the statewide rate of 11.05 (see Figure 16a).



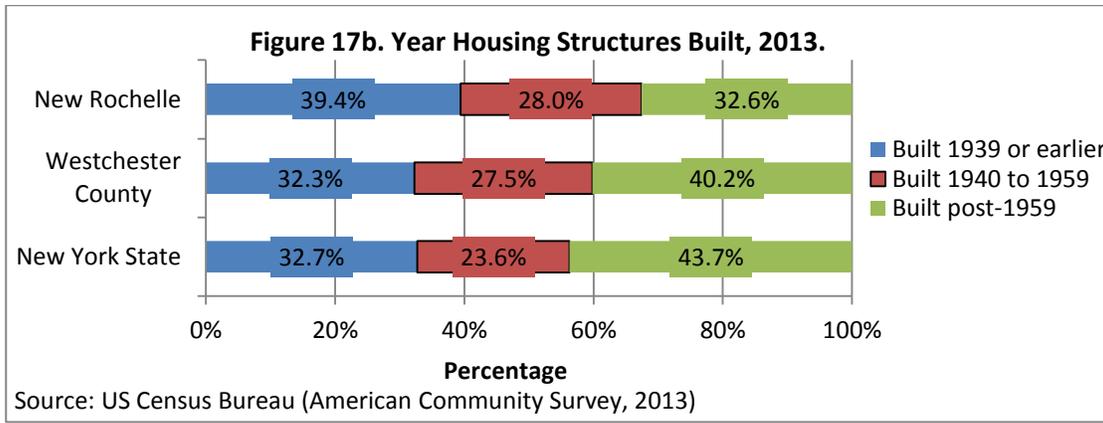
F. Environment

- According to the CDC, New Rochelle’s average daily ambient ozone concentration was 34.65 in 2008; lower than the countywide (35.46) and statewide (36.17) rates (see Figure 17a).
- New Rochelle’s number of ozone days (or days exceeding the emission standard of 75 parts per billion) was 2 in 2008; higher than the countywide rate of 1.80 days and lower than the statewide rate of 1.93 days.



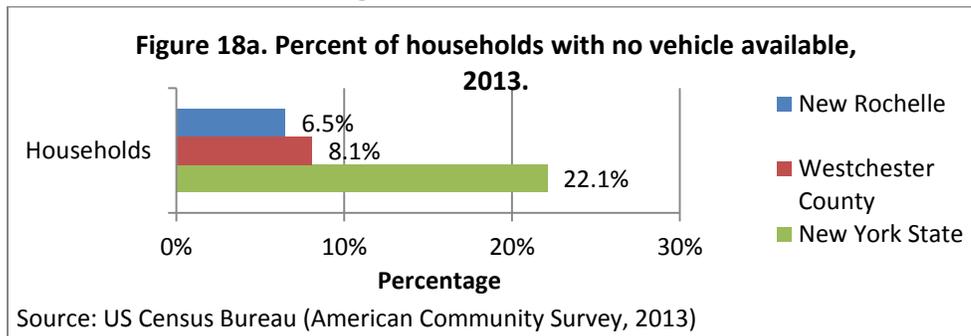
- In 2013, 39.4% of occupied housing units in New Rochelle were built in 1939 or earlier and 28% of occupied housing units were built between 1940 and 1959. In Westchester County, 32.3% of occupied housing units were built in 1939 or earlier and 27.5% were

built between 1940 and 1959. 32.7% of occupied housing units in New York State were built 1939 or earlier and 23.6% of occupied housing units were built between 1940 and 1959 (see Figure 17b).

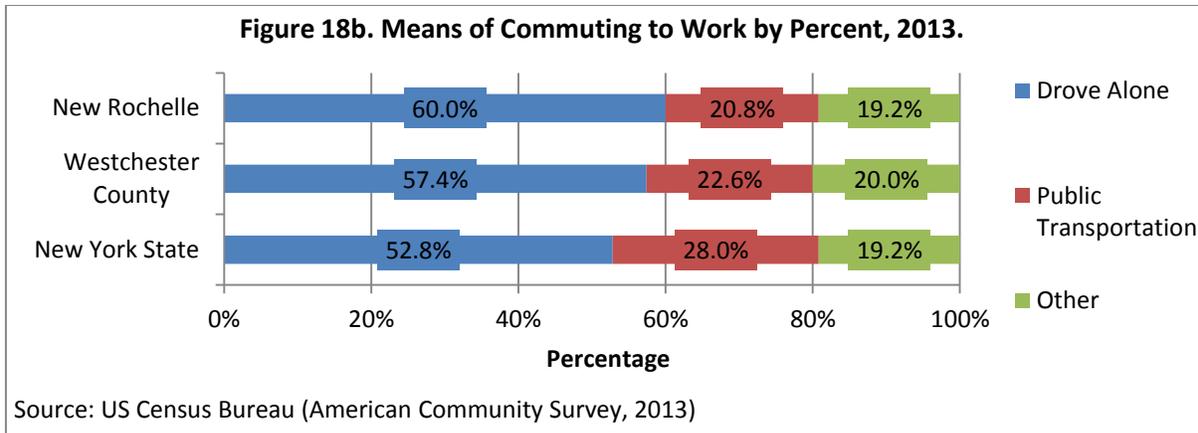


G. Transportation and Transportation Safety

- In 2013, the mean travel time to work for New Rochelle residents was 32.2 minutes. Within the same year, the mean travel time to work was 32.9 minutes in Westchester County and 32.1 minutes in New York State.
- In 2013, 6.5% of New Rochelle households had no vehicle available. In comparison, 8.1% of Westchester County households and 22.1% of New York State households had no vehicle available (see Figure 18a).



- Out of 34,797 total New Rochelle workers in 2013, 60% drove alone to work and 20.8% used public transportation. Out of 459,302 total Westchester County workers, 57.4% drove to work alone and 22.6% used public transportation. Out of 9,024,559 total New York State workers, 52.8% drove alone to work and 28% used public transportation (see Figure 18b).



- According to CDC data from 2007-2011, the age-adjusted death rate due to motor vehicle collisions in Westchester County was 3.52 per 100,000; lower than the statewide rate of 4.68.

IMPLEMENTATION STRATEGY

6. Measures and Resources to Meet Identified Needs

Montefiore is a leader in community health and has a long history of developing innovative approaches to care and tailoring programs to best serve the changing needs of its community. These include, but are not limited to the following: Community Service Plan, Community Services Strategy, Accountable Care Organization, Patient-Centered Medical Home, Disease Management Programs, and Community Outreach. The integration of these innovative approaches serves Montefiore well in its services to its community.

Montefiore has a vast portfolio of programs and services that address a majority of the significant community health needs identified in the Community Health Needs Assessment. The breadth and depth of the programs and services vary, but each address a need identified in the community.

Historically, Montefiore has earned a reputation as a leader in the region, state and nation in providing services to its community, by developing and operating an extraordinary array of needed services to the poor and underserved, and to specific at-risk populations (e.g., children, the elderly, the HIV-infected, the homeless and victims of domestic violence).

Beyond its involvement in patient care services to individuals within and (in some cases) beyond its service area, the faculty and staff at Montefiore are heavily invested in the provision of service to the wider community, through:

- the education of health professionals;
- the generation of new knowledge through basic, clinical and social sciences research;
- affecting health policy through service on a range of professional, governmental and inter-institutional boards and advisory group; and
- by involvement in programs of community service (like housing preservation) which go beyond the boundaries of health and health care.

Montefiore embraces its social responsibility and defines its role broadly, promoting wellness in addition to treating disease and addressing needs ranging far beyond medical care. We extend this responsibility to the care of our employees and medical staff, many of whom live in the surrounding community.

The population Montefiore serves is one of the most diverse in the nation. Montefiore has been an incubator for programs that improve patients' access to culturally appropriate services, and its progressive financial aid policy and robust entitlement enrollment program support access to care for those in need. Historically, Montefiore has viewed community service and community health improvement as a delivery system challenge, reaching out to serve the under-resourced.

Services to the community are an explicit and essential component of Montefiore's mission and one of its most valued traditions. The medical center has a long history of reaching beyond the walls of its hospitals to identify and meet the needs of its community and has been a national leader in organizing and expanding community-based services. Our commitment to the community has required a multifaceted, continually evolving response, in which the unique capacities of the academic medical center are mobilized to improve the lives of the people and the communities we serve -- not just medically, but socially, economically and environmentally, wherever and whenever our resources can make a difference.

For much of our history, community service at Montefiore has been a vital grassroots movement. When pressing needs arose that lay beyond the purview of traditional health care, physicians, nurses, social workers, staff and community partners have stepped in to address them. These programs tackle a remarkable range of health problems in the Bronx; from the epidemics of diabetes and obesity to high rates of teen pregnancy. They come in an equally impressive range of sizes; from an online guide to hundreds of social services to complex federally-funded agencies with hundreds of staff. With the understanding that the practice of medicine is a service to the community, we have defined community service to include those efforts at preventing disease, enhancing wellbeing and enacting social change that go beyond traditional health care and its fee-for-service reimbursement system.

Through this entrepreneurial spirit, over the past one hundred years in the Bronx, Montefiore associates have developed, independently and in collaboration with other organizations, an impressive array of programs that address many of the needs of our communities. In many cases the programs developed in the Bronx have resulted in national changes in best practices and through our relationship as the University Hospital for the Albert Einstein College of Medicine, the programs have the capacity to expand the evidence base to improve the health of communities like ours beyond our borders.

6a. Internal Resources and Measures

Below is a list of Montefiore programs that address a variety of community needs, including a brief description, the intervention measures that the program captures and the coordination of the program to the larger New York State Prevention Agenda that is also aligned with the New York City Take Care New York initiatives.

Appendix B provides an inventory of community service programs, including the target population, the health issues addressed, and outcomes.

In the section following the program list, the process for the management of community health needs not met by our programs will be provided.

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p>Adherence Intervention for Pediatric Renal Transplant</p>	<p>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.</p>	<p>Increase in patient adherence to renal transplant treatment regimens; Improvement in patient quality of life</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>
<p>Adolescent AIDS Program</p>	<p>The Adolescent AIDS Program (AAP) provides comprehensive care, risk reduction services and HIV counseling to HIV-positive adolescents (13-24). The program also offers rapid and simple HIV testing and counseling to at-risk youth throughout the Bronx, especially in areas of high seroprevalence.</p>	<p>Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>
<p>Adolescent Depression and Suicide Program</p>	<p>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</p>	<p>Decrease in adolescent depression rate; Decrease in adolescent suicide and attempted suicide rates; Decrease in adolescent suicidal feelings</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>

	struggle with school, family and drug problems. The program runs lectures and workshops for school personnel, students and community members.		
AIDS Center	As a New York State Dept. of Health-designated AIDS Center, this division at Moses provides a broad array of inpatient and outpatient services to adults (22+) living with AIDS. The care model consists of an integrated team of health care professionals, including physicians, social workers, nurses, HIV counselors, dietitians, adherence counselors, researchers, mental health providers, pharmacists and administrative staff.	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Bardonia Health Day	As part of Bardonia Health Day, Montefiore associates present Heart Healthy Education to 5 through 12 year olds on topics including exercise and healthy eating	Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
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	Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

	<p>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.</p>		
<p>Breast and Cervical Screening Event</p>	<p>Screening for breast exams and pap smears for women 18 years and older. Mammograms for women 40 years and older. In addition, women's health education and information is provided.</p>	<p>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</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>
<p>Bronx BREATHEs</p>	<p>Bronx BREATHEs is a tobacco cessation center that serves multiple health care organizations in the Bronx by giving providers training and resources to help their patients quit smoking.</p>	<p>Decrease in number of smokers</p>	<p>Prevent Chronic Diseases</p>
<p>Bronx CHAMPION</p>	<p>Bronx Community Health and Acute Medical Performance Improvement Organizational Network is a pay-for-performance project intended to improve the care of diabetes mellitus, cardiovascular disease and specific acute medical conditions for adults ages 50 years and older. The program collects and analyzes data from Internal and Family Medicine in order to generate performance</p>	<p>Increase in quality of care for individuals with diabetes; Increase in quality of care for individuals with heart disease</p>	<p>Prevent Chronic Diseases</p>

	<p>scores for providers who are then awarded financial incentives based on the quality of their care. The program was in hiatus during 2011-2012 and will resume in 2013.</p>		
<p>Bronx-CATCH, Collective Action to Transform Community Health</p>	<p>Bronx-CATCH is a partnership between Montefiore, the New York City Department of Health and Mental Hygiene, the Bronx Community Health Network, other community based organizations and agencies and local elected officials. Recognizing that population health is a local issue, the goal is to create a series of neighborhood-specific stakeholder partnerships, extending out from different Montefiore Medical Group health center sites, to support healthy behaviors and increase health-promotion resources for patients and the local community.</p>	<p>Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity</p>	<p>Prevent Chronic Diseases; Promote a Health and Safe Environment</p>
<p>Caregiver Support Center</p>	<p>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.</p>	<p>Increase in general satisfaction of caregiver</p>	<p>Promote Mental Health and Prevent Substance Abuse</p>

<p>Centering Pregnancy</p>	<p>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.</p>	<p>Increase in utilization of prenatal care services; Increase in positive health outcomes for newborns and their mothers</p>	<p>Promote Healthy Women, Infants and Children</p>
<p>Centers Implementing Clinical Excellence & Restoring Opportunity (CICERO)</p>	<p>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.</p>	<p>Increase in proportion of HIV+ individuals engaged in care</p>	<p>Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>
<p>CFCC'S Breastfeeding Support</p>	<p>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</p>	<p>Increase in proportion of mothers who breastfeed</p>	<p>Promote Healthy Women, Infants and Children</p>

	<p>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.</p>		
<p>CHAM Oncology Groups</p>	<p>Over four 12-week sessions in 2012, up from 2 in 2011, CHAM runs four distinct support groups targeted to: teenagers with cancer, school-age children with cancer, siblings of cancer patients and parents of children undergoing cancer treatment.</p>	<p>Increase in patient satisfaction for oncology patients and their families</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>
<p>CHAM Sickle Cell Groups</p>	<p>Over a 10-week session, CHAM runs a support group targeted to school-age sickle cell patients. The group gives patients an opportunity to meet others going through similar experiences and provides the chance for self-expression and positive socialization.</p>	<p>Increase in patient satisfaction for sickle cell patients and their families</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>

<p>CHF Disease Management</p>	<p>Through primary care and care management services, the CMO seeks to decrease preventable readmissions and improve the continuity of care for the hospital's Emblem CHF patients. At-risk patients are managed through case management calls, home visits and the use of telehealth and telescales.</p>	<p>Decrease in preventable readmissions for CHF patients; Increase in continuity of care for CHF patients</p>	<p>Prevent Chronic Diseases</p>
<p>Children's Evaluation and Rehabilitation Center (CERC)</p>	<p>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.</p>	<p>Increase in patient satisfaction for individuals with intellectual and other disabilities</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>
<p>Colorectal Cancer Patient Navigation Program</p>	<p>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</p>	<p>Increase in screening for colorectal cancer; Decrease in colorectal cancer</p>	<p>Prevent Chronic Diseases</p>

	screening process. Our aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-show and cancellation rates.		
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 treatment programs and provides comprehensive social	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 disorders	Promote Mental Health and Prevent Substance Abuse

	services.		
Diabetes Club	Diabetes Club is a bimonthly support group for adults with type 2 diabetes in which patients share their experiences and discuss strategies for managing their illness. The club welcomes families and friends of participants to attend meetings and to share their experiences and ideas with the group.	Increase in patient satisfaction for individuals with diabetes	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
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	Increase in quality of prenatal care for diabetic women	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

	consultation.		
Diabetes Management: PROMISED	<p>A novel approach in Diabetes Education - the Proactive Managed Information System for Education in Diabetes "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)</p>	<p>Increase in management of diabetes; Increase in positive health outcomes for diabetic mothers and their newborns</p>	<p>Prevent Chronic Diseases</p>

<p>Dialysis Outreach</p>	<p>Dialysis outreach seeks to strengthen communication between Montefiore's transplant program and community physicians and to provide a seamless referral service where a physician or patients only need to make one phone call and will receive an appointment with a Montefiore Hepatologist, Nephrologist or Surgeon depending on the reason 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.</p>	<p>Increase in patient satisfaction; Increase in provider satisfaction</p>	<p>Prevent Chronic Diseases</p>
<p>DOH Infertility Demonstration Project</p>	<p>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</p>	<p>Increase in access to In-vitro fertilization services</p>	<p>Promote Healthy Women, Infants and Children</p>

	<p>after insurance. The Dept. of Health then pays the remaining cost. The program is particularly important for couples whose insurance does not cover the cost of medication for the IVF cycle.</p>		
<p>Eat Healthy, Shop Smart</p>	<p>Eat Healthy, Shop Smart is an voucher program with an educational component that teaches cancer patients about the importance of a plant-based diet. At new patient orientation, patients are triaged for nutritional risk and offered vouchers for use at farmer's markets at both the Moses and Einstein campuses. Farmer's markets fun from May to October, pending weather limitations. The program provides financial aid to participants to purchase fruits and vegetables.</p>	<p>Increase in healthy eating habits; Increase in fruit and vegetable consumption</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment</p>
<p>Explainer Program</p>	<p>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</p>	<p>Increase in patient satisfaction</p>	<p>Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children</p>

	workshops and encouraged to pursue career opportunities in health care through skill building in resume writing, interviewing and education.		
Family Treatment/Rehabilitation	Family Treatment/Rehabilitation is an evaluation and case management program for families with identified risk of child abuse or neglect and identified psychiatric or substance use disorders. The program provides evaluation and referral for treatment, and provides case management to track participation.	Increase in quality of case management for families with identified risk of child abuse or neglect	Promote Mental Health and Prevent Substance Abuse
Farmer's Market Walks	Every Tuesday from June-November, nutritionists and health educators lead groups at various Montefiore sites to local Farmer's Markets. Participants learn about seasonal produce, discuss recipes and when available, receive "Health Bucks," a \$2 coupon to purchase a fruit or vegetable.	Increase in healthy eating habits; Increase in fruit and vegetable consumption	Promote a Healthy and Safe Environment

<p>Geriatric Ambulatory Practice</p>	<p>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.</p>	<p>Increase in patient satisfaction</p>	<p>Prevent Chronic Diseases</p>
<p>Green Cart Partnership Program</p>	<p>The Green Cart Partnership Program develops partnerships between community health centers and mobile street vendors who sell fresh produce as part of the Dept. of Health's Green Cart Program. Health center staff motivate patients to shop at Green Carts by conducting weekly cooking demonstrations that feature recipes heavy in produce. Staff also distribute information about the location of Green Carts throughout the Bronx and serve as advocates for street vendors.</p>	<p>Increase in healthy eating habits; Increase in fruit and vegetable consumption</p>	<p>Promote a Healthy and Safe Environment</p>

<p>Healing Arts</p>	<p>The Healing Arts at Montefiore is a network of programs that uses the arts, creative arts therapies, integrative medicine, and other healing approaches to enhance the quality of life, health and well-being of Montefiore’s patients, associates and community. Healing Arts programs are available in the Children’s Hospital, Oncology, Palliative Care, Rehabilitation Medicine, Psychiatry, and other departments to complement patient care by helping to reduce pain and other physical symptoms, provide comfort and enjoyment, promote self-expression, and enhance quality of life.</p>	<p>Increase in patient satisfaction and quality of life</p>	<p>Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>
<p>Healthy Living with Chronic Conditions</p>	<p>Healthy Living with Chronic Conditions is a workshop that helps patients with chronic conditions lead healthier lives. Patients who have hypertension, diabetes, arthritis, HIV/AIDS and other illnesses attend weekly sessions for six weeks where they learn to eat well, cope with stress, communicate effectively with medical providers and identify and accomplish goals.</p>	<p>Increase in patient satisfaction</p>	<p>Prevent Chronic Diseases</p>

<p>Healthy Steps</p>	<p>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.</p>	<p>Increase in patient satisfaction; Increase in pediatric access to primary care</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>
<p>Heart Center Corporate Programs</p>	<p>Corporate Programs practices provide outreach services to the communities they serve including: lectures at Phelps Memorial Hospital, free blood pressure screenings and educational seminars at local nursing homes.</p>	<p>Increase in free health screenings; Increase in educational services provided to community members</p>	<p>Prevent Chronic Diseases</p>
<p>Heart Month</p>	<p>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</p>	<p>Increase in blood pressure screenings; Increase in cardiac health</p>	<p>Prevent Chronic Diseases</p>

	<p>pressure screenings and counseling sessions at all Montefiore campuses, in senior citizen centers, local elementary schools, colleges and health centers.</p>		
<p>Hepatitis C Support Group</p>	<p>The Hepatitis C Support group is a supportive service for adults with Hepatitis C. Topics of discussion include disease management, treatment options, side effects, compliance and coping with relational and psychological impacts of disease and treatment.</p>	<p>Increase in patient satisfaction for individuals with Hepatitis C</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>
<p>Home Health Aide Employment and Training</p>	<p>Home Health Aide Employment and Training is a stimulus-funded program that helps unemployed community members obtain employment as home health aides. The program provides supportive services and case management throughout the training and employment process. Additionally, participants who complete training receive a portable certification that can be used to obtain future placements.</p>	<p>Increase in employment of community members as home health aides</p>	<p>Promote a Healthy and Safe Environment</p>

<p>HPV Vaccine Clinic</p>	<p>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 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.</p>	<p>Increase in HPV vaccination rate</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>
<p>Indochinese Mental Health Program</p>	<p>The Indochinese Mental Health clinic provides outpatient mental health services to the Bronx Southeast Asian community. The program is a collaborative effort between the Dept. of Psychiatry and the Dept. Family Medicine and is designed according to</p>	<p>Increase in mental health services available; Increase in utilization of mental health services by the Bronx Southeast Asian community</p>	<p>Promote Mental Health and Prevent Substance Abuse</p>

	<p>recommendations from the Harvard Program in Refugee Trauma. In addition to mental health services, staff coordinate patients' care with clinic physicians and link them to community resources.</p>		
<p>Information and Referral Service</p>	<p>The Information and Referral Service connects users to vital social services and resources in the Bronx. It is comprised of a walk-in/call-in site for patients, a consultation service for Montefiore staff and an internal resource manual written for social workers. The walk-in site is open to any person in need of help with entitlements, especially the chronically ill, elderly, young mothers and the very poor.</p>	<p>Increase in patient satisfaction; Increase in provider satisfaction</p>	<p>Promote a Healthy and Safe Environment</p>
<p>Inpatient Asthma Workshop DID NOT HAPPEN IN 2012 Working with Pulmonary to redefine the program for inpatient and outpatient, encouraged to measure outcomes</p>	<p>The Inpatient Asthma Workshop is an educational program at CHAM that teaches hospitalized patients and their families about asthma. Conducted by a social worker, the Workshop addresses the challenges and stressors that asthmatic children face in their communities and provides families with useful information and resources.</p>	<p>Decrease in asthma symptoms</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>

<p>Integrated Medicine and Palliative Care Team (IMPACT)</p>	<p>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 effectiveness of its interventions. IMPACT</p>	<p>Increase in patient satisfaction</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>
<p>Lead Poisoning Prevention Program</p>	<p>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,</p>	<p>Decrease in lead poisoning</p>	<p>Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children</p>

	<p>advocates for lead poisoned children during local and state legislative reviews and collaborates with city and private agencies in environmental intervention.</p>		
<p>LINCS Program at CHAM</p>	<p>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.</p>	<p>Increase in patient satisfaction; Increase in accessibility of primary care services available to children</p>	<p>Prevent Chronic Disease; Promote Healthy Women, Infants and Children</p>
<p>Liver Transplant Support Group</p>	<p>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,</p>	<p>Increase in patient satisfaction for liver transplant patients</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>

	disease management, and strengthening coping skills in a mutually supportive environment.		
Managed Addiction Treatment Services, MATS	MATS is a clinical care coordination program for substance abusers, which since August 1 2012 has been fully incorporated into the Bronx Accountable Healthcare Network (BAHN), the Montefiore-led, NYSDOH designated Health Home. Through clinical case management, MATS helps clients stabilize in substance abuse treatment, access other medical, behavioral health, and social services, reduce inpatient admissions and ED visits, and enhance overall health and wellness by assisting clients with engagement and adherence to outpatient clinical services.	Increase in treatment of substance abuse; Increase in accessibility of social and medical services for substance abusers	Promote Mental Health and Prevent Substance Abuse
Medical House Calls Program	Through medical home visits, the CMO helps chronically ill, at-risk geriatric and adult patients who have a history of multiple inpatient admissions and are homebound. A team of primary care physicians provide medical care. The program is also supported by social workers, outreach specialists	Increase in patient satisfaction; Increase in accessibility of primary care services	Prevent Chronic Diseases

	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.		
Medical Stabilization Unit - Detox Programs	The MSU is a 10 bed inpatient unit for the treatment of acute withdrawal symptoms from drug and/or alcohol dependency. Most patients have comorbid psychiatric disorders or complicated medical diseases exacerbated by substance use.	Increase in patient satisfaction; Decrease in relapse of patients	Promote Mental Health and Prevent Substance Abuse
Melanoma Screening	Screening for Melanoma. Event takes place at MECCC in May.	Increase in screening for Melanoma; Decrease in occurrence of Melanoma	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

<p>Montefiore School Health Program</p>	<p>MSHP is the largest and most comprehensive school-based health care network in the United States. It has 20 school-based health center sites that provide primary care, mental health, oral health and community health services to patients regardless of citizenship status and ability to pay. All sites are federally qualified or partially qualified health centers. Included in MSHP is the Healthy Kids program, comprised of an array of evidence-based prevention activities focused on increasing physical activity and healthy eating in Bronx children and their families.</p>	<p>Increase in proportion of students receiving health care</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>
<p>Mosholu Preservation Corporation (MPC)</p>	<p>MPC is a non-profit organization committed to preserving and revitalizing Bronx neighborhoods by improving housing and promoting economic and community development. It is governed by a Board of Directors made up of Montefiore trustees and management, community leaders and development experts who serve in a pro bono capacity.</p>	<p>Increase in local economy; Increase in preservation of neighborhoods</p>	<p>Promote a Healthy and Safe Environment</p>
<p>Mujeres Unidas (Spanish-Speaking Breast Cancer Support Group)</p>	<p>The Spanish-Speaking Breast Cancer Support Group provides support, educational workshops</p>	<p>Increase in patient satisfaction of Spanish-speaking</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>

	and social events for Spanish-speaking women in different stages of breast cancer.	breast cancer patients	
New Directions Recovery Center and Chemical Dependency Program - Medically Supervised Outpatient	<p>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.</p>	Decrease in alcohol and drug abuse	Promote Mental Health and Prevent Substance Abuse
New York Children's Health Project (NYCHP)	<p>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 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</p>	Increase in accessibility of health care services to homeless individuals	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

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) 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.		
<p style="text-align: center;">Office of Community Health</p>	<p>Working closely with colleagues at Montefiore, the Albert Einstein College of Medicine and partners from a wide range of institutions, governmental agencies and community-based organizations, the Office of Community Health, a part of the Department of Community & Population Health, identifies community health needs, shares information about community health services and promotes collaborative interventions. The development of the Bronx CATCH Initiative, the implementation of five community based coalitions using program implementation and evaluation, engaging Montefiore, NYCDOHMH, local community government and leading community based organizations in Williamsbridge, Fordham, West Farms, Melrose and the Prospect Avenue sections of the Bronx has been the major effort of 2012. Additionally, the Office develops effective strategies and methods to</p>	<p style="text-align: center;">Increase in accessibility to health care; Increase in community-based health interventions</p>	<p style="text-align: center;">Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>

	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
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	Prevent Chronic Diseases

		Neck Cancer	
Organ/Tissue Donor Program	The Organ/Tissue Donor Program raises awareness about organ/tissue donation and transplantation within the Montefiore and Bronx communities. Through educational initiatives and a range of recruitment activities, the program helps potential donors understand the importance of donation and encourages them to join the donor registry. The program is further responsible for ensuring that potential donor candidates are referred to the local Organ 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 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	Increase in general satisfaction of individuals who have undergone ostomy diversion	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

	one-on-one counseling.		
<p>Parent-to-Parent Support Group for Heart Transplants</p>	<p>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.</p>	<p>Increase in patient satisfaction for heart transplant patients; Increase delivery of transplant information to patients</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>

<p>Patient and Community Education</p>	<p>The Department of Community & Population Health now encompasses the previous departments of (1) Patient and Community Education, (2) Associate Wellness and (3) the Office of Community Health, which manages the population health initiatives and responds to community requests for involvement by Montefiore. This includes the development of initiatives to address important chronic disease health indicators with inter-organizational partners. The department also provides associate support for health fairs, health screenings, workshops, seminars and other events to the Bronx and lower Westchester County. It focuses on health and wellness topics of interest or major concern to the communities it serves.</p>	<p>Increase in number of health screenings and health fairs; Increase in number of educational events for the community; Decrease in chronic illness</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment</p>
<p>Phoebe H. Stein Child Life Program</p>	<p>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</p>	<p>Increase in patient satisfaction; Increase in satisfaction of patients' families</p>	<p>Promote Healthy Women, Infants and Children</p>

	procedures, teach parents to help their children cooperate with medical treatment and encourage normal growth and development.		
Pregnancy Prevention Program in School Health	The Pregnancy Prevention Program provides confidential reproductive and sexual health services, mental health services, and population based prevention and health promotion programs on the classroom, school and local community levels at nine Bronx high school campuses housing 34 schools. An example is the Reducing the Risk curriculum was introduced through ninth grade classrooms to bring a validated sex education curriculum to all ninth grade students. The program aims to decrease rates of unplanned teen pregnancy and STI transmission and to increase rates of high school graduation. Reducing the Risk is one of the first rigorously evaluated sexual education curricula to have a measurable impact upon behavior. The program is delivered the curriculum to students in the ninth grade before many become sexually	Decrease in unplanned teen pregnancy; Decrease in STI transmission in teens; Increase in high school graduation rates; Increase in sexual education programs	Promote Healthy Women, Infants and Children; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

	active.		
Project BRAVO (Bronx AIDS Volunteer Organization)	Project BRAVO is a hospital-based volunteer program managed by the AIDS Center that provides support to HIV and AIDS patients. Volunteers provide friendly visits to hospitalized patients and staff the BRAVO food pantry. Volunteers help with preparation, set up, distribution and storage of food and pantry bags as well as conduct record keeping and filing.	Decrease in number of HIV+ individuals without adequate access to food	Promote a Healthy and Safe Environment; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Project HEAL	Project HEAL is a drop-in center intended to prevent HIV infection among women in the Bronx. Services include supportive counseling, crisis intervention, individual and group-based activities, HIV testing and referrals to medical care and other social services. The project helps women develop the skills needed to	Decrease in HIV infection; Decrease in high-risk behavior; Increase in HIV testing	Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

	reduce high-risk behaviors that may lead to HIV infection.		
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. 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.	Increase in patient satisfaction of Oncology patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

<p>Regional Perinatal Center</p>	<p>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.</p>	<p>Increase in availability of critical obstetric and neonatal care</p>	<p>Promote Healthy Women, Infants and Children</p>
<p>Renal Disease Young Adult Group</p>	<p>The program runs a support group for young adults ages 18-30 years who are diagnosed with End Stage Renal Disease. The support group afford participants the opportunity to share their emotions and concerns with each other and with professional staff.</p>	<p>Increase in patient satisfaction for individuals with End Stage Renal Disease</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>
<p>Respiratory Disease Management</p>	<p>Through telephonic outreach, health coaching and home visits to higher-risk patients, the CMO aims to improve the health of patients with asthma and chronic obstructive pulmonary disease. Members who were enrolled in our population based program, by either receiving age appropriate educational mailings, or went to ER or were admitted- received an educational call to follow up on their condition.</p>	<p>Decrease in symptomatic asthma and chronic obstructive pulmonary disease</p>	<p>Prevent Chronic Diseases</p>

<p>School Re-Entry Team</p>	<p>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.</p>	<p>Increase in satisfaction of cancer and sickle cell patients</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children</p>
<p>South Bronx Health Center for Children and Families (SBHCCF)</p>	<p>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:</p> <ul style="list-style-type: none"> • Primary care for children, adolescents and adults • Women's health and prenatal care • HIV testing, counseling, and primary care • Mental health counseling • Case management • Dental care • Nutrition 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 <p>SBHC's Center for Child</p>	<p>Increase in accessibility of health care; Increase in utilization of health services</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>

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
- 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

	<p>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.</p>		
<p>Strength Through Laughter and Support Program</p>	<p>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.</p>	<p>Increase in patient satisfaction and quality of life of individuals with cancer</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>
<p>Substance Abuse Treatment Program, Methadone Program</p>	<p>The SATP consists of two opioid treatment programs for opioid-dependent adults. Both</p>	<p>Increase in access to health care services for opioid-</p>	<p>Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>

	sites provide integrated primary, mental health, HIV and substance abuse care.	dependent adults	
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 Mental Health and Prevent Substance Abuse
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

<p>The J.E. and Z.B. Butler Child Advocacy Center</p>	<p>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 conducts outreach and research.</p>	<p>Decrease in child abuse; Increase in access to care services for children who have been abused</p>	<p>Promote a Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Mental Health and Prevent Substance Abuse</p>
<p>To Your Health: Zumba Bronx</p>	<p>To Your Health: Zumba Bronx provides patients and associates of Montefiore with Zumba classes at sites throughout the Bronx. Certified instructors, many of whom are also Montefiore Health Educators, teach this form of "dance-fitness" inspired by Latin music at little or no cost to participants.</p>	<p>Increase in participants in Zumba classes; Increase in exercise; Decrease in BMI; Decrease in obesity</p>	<p>Prevent Chronic Conditions; Promote a Healthy and Safe Environment</p>

Women, Infants and Children (WIC) Program

Montefiore's WIC program is the oldest in New York State, established in 1974, and serves 13,000 women, infants and children. WIC is a supplemental nutrition program, providing supplemental food vouchers, nutrition education, breast feeding education, peer counseling and physical fitness education. Women are pre-screened for the program and receive a medical referral to the WIC program from providers, they qualify based on their income. Once they are screened, they receive counseling with a nutritional counselor. Vouchers are distributed for supermarket purchases on 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.

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

<p>Women's Heart Health Center</p>	<p>The WHHC provides screenings, appointments, monthly lectures on heart health and a weekly clinic on Tuesday afternoons to women in the Bronx. The clinic is run by two female cardiologists. Additionally, the center participates in the Yale University School of Medicine's VIRGO study, which is an NIH-funded multi-center study that examines the influence of gender on outcomes in young AMI patients. The program is currently in Year 4 of the longitudinal study.</p>	<p>Increase in screenings for cardiac disease; Increase in educational programs related to cardiac health</p>	<p>Prevent Chronic Disease; Promote Healthy Women, Infants and Children</p>
<p>Wound Healing Program</p>	<p>The Wound Healing Program provides inpatient, outpatient, nursing home and home visiting wound healing services. The program focuses on building innovative, patient-centered health services delivery systems that work for wound patients in order to provide excellence in care and to improve wound healing outcomes in the Bronx.</p>	<p>Increase in positive outcomes for wound healing patients</p>	<p>Prevent Chronic Diseases</p>

6b. New York State Health Improvement Plan - Implementation Plan and Measures

As a part of the Montefiore submission for the New York State Health Improvement Plan for 2015-2017, required by the New York State Department of Health, two broad focus areas across two priority areas - Preventing Chronic Disease and Promoting Healthy Women, Infants and Children, in addition to the large array of services provided by Montefiore were identified.

These broad focus areas are (1) Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings , (2) Reducing Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure (3), and (4) Improving Maternal and Infant Health. Across these focus areas, six goals, with specific interventions, performance measures and time frames, were identified, and are described in the next section.

Two Year Plan of Action—2015-2017

The two areas selected by Montefiore New Rochelle Hospital (and the corresponding designations in the Prevention Agenda 2014-2017: New York State's Health Improvement Plan) for submission in this Community Service Plan are as follows:

Under the Priority Area – Prevent Chronic Disease

1. Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
 - a. Goal 3.3.1 - Increasing screening rates for cardiovascular disease, diabetes, breast, cervical, and colorectal cancers especially among disparate populations

Under the Priority Area – Promote Healthy Women Infants and Children

2. Maternal and Infant Health
 - a. Goal 2.2.1 - Increase the proportion of infants born in New York State who are exclusively breastfed during the birth hospitalization

The plan of action for each focus area is described in the following sections:

Prevent Chronic Disease (Heart Disease)

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Goal 3.3.1 - Increasing screening rates for cardiovascular disease, diabetes, breast, cervical, and colorectal cancers especially among disparate populations

Strategic Plan:

Montefiore has selected to focus on reducing the racial disparities by decreasing the percentage of Blacks and Hispanics dying prematurely from heart related diseases by focusing on reducing tobacco and nicotine consumption among these populations in the Montefiore service area as tobacco and nicotine consumption is a leading causal indicator in heart related disease. The implementation of this focus area will strongly combine elements of Focus Area 2: Reducing Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.

Specifically, through the specific implementation of Goal 3.3.1 - Increasing screening rates for cardiovascular disease, diabetes, breast, cervical, and colorectal cancers especially among disparate populations, focusing specifically on cardiovascular diseases, through the mechanism of:

Goal 2.2.2 - Increasing the number of unique callers to the New York State Quit-Line

Goal 2.2.2 - Decreasing the prevalence of cigarette smoking by adults ages 18 years and older

There is a strong likelihood of positively trending toward the reduction of the racial and ethnic disparity rates in premature death from heart related disease.

Strategic Plan:

Montefiore has been successful at increasing the number of unique callers to the New York State Quit-Line with our inpatient populations as we have been able to document 100% contacts for

patients at discharge with provision of the New York State Quit-Line information. In 2012, this covered over 50,000 unique adult, aged over 18 lives. We have also been tremendously successful with the expansion of the smoke free campus to cover all of our locations in addition to our acute care hospitals and have remained an ardent support of supplemental nicotine replacement therapy in the community as demonstrated by Montefiore's annual distribution of Nicotine Replacement Therapy across the Bronx and the expansion of this practice at Montefiore New Rochelle Hospital.

Goals & Objectives:

The goal is to increase the rate of unique callers from across our ambulatory populations and within the communities that our ambulatory facilities are located in by enhancing the training of physicians and increasing the quantity and visibility of the education we provide in New Rochelle and the surrounding communities.

Evidence Base:

The evidence base for the expansion of smoking cessation programs especially using the New York State Tobacco Control program is substantial. The POWR Tobacco Cessation Program of the American Lung Association funded through the New York State Tobacco Control Program is Montefiore's partner in this activity. The measures of these activities are constructed within the framework established by the New York State Department of Health Tobacco Control Program.

Performance Measures and Time Frame Targets

The performance measures associated with the increasing of unique callers to the quit line and the decreasing of smoking prevalence in adults 18 year and older are:

Performance Measures (Increasing Unique Callers):

- Number of callers referred to the quit line as documented in the Electronic Medical Record data
- Incorporate quit line information on patient discharge information
- Receive reporting through POWR Tobacco Cessation program of referral of patients through the Fax to Quit program to enhance the number of calls/contacts with the Quitline

Performance Measures (Decreasing the smoking prevalence in adults):

- Increasing the provision of pharmaceutical Nicotine Replacement Therapy by appropriate clinical staff to individuals who desire to eliminate tobacco use.
- Increasing the prominence of advertising and traditional and social media messaging to increase the likelihood of appropriate messaging reaching individuals with appropriate readiness levels to quit smoking

Timeframe targets:

Montefiore New Rochelle Hospital, as a part of the Montefiore Health System is examining the Opt-to-Quit™ model as an enterprise wide solution to be implemented by 2017, to further enhance the existing utilization of the Fax-to-Quit hotline. Through the Opt-to-Quit platform, the facility or program establishes a patient opt-out policy that triggers the referral process and links tobacco using patients to the evidence-based services of the New York State Smokers' Quitline. The Quitline accepts referred patient information through one of the secure information exchange options; patients are contacted by the Quitline within 72 hours or as specified by the provider. All patients are offered Quitline services at initial contact. The Quitline generates a PAR back to the facility which can be accessed on demand or via electronic or fax delivery. Quitline communications with the patient are continued at 3-month intervals for up to 12 months. The purpose of the extended contact is to motivate subsequent quit attempts, encourage tobacco using or recently quit patients to use Quitline services, and to offer access to appropriate levels of support.

Promote Healthy Women Infants and Children

Focus Area 2 - Maternal and Infant Health

Goal 2.2.1 - Increase the proportion of infants born in New York State who are exclusively breastfed during the birth hospitalization

Strategic Plan & Goals

Montefiore Medical Center has committed to achieving the goals of the Baby Friendly Hospital initiative and expand this designation as an enterprise wide solution to our Westchester Hospitals. It has previously signed on to this designation for our Bronx hospitals through the New York City Department of Health's Latch-On NYC Initiative to support breastfeeding mothers and to increase the proportion of women that are achieving the World Health Organization's target rate of having the first six months of an infant's life with exclusive breastfeeding.

Initiative Objectives:

1. Montefiore will enforce the New York State hospital regulation to not supplement breastfeeding infants with formula feeding unless medically indicated and documented within the infants medical record
2. Provide physical restriction to infant formula by hospital staff including the tracking of infant formula distribution with the health department
3. Discontinue the distribution of free promotional formula
4. Prohibit the display and distribution of infant formula promotion materials in any hospital location.

The objectives of the Baby Friendly Hospital are:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast-milk, unless medically indicated.
7. Practice rooming in - allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

Evidence Base:

The Baby Friendly Hospital Initiative (BFHI) developed and launched in 1991 as a program of the World Health Organization and UNICEF is a part of the global effort to support and enable mothers to initiate breastfeeding their babies, with the recommendation for exclusively breastfeeding infants for their first six months of life. This initiative works to the care of pregnant women, new mothers and their infants in hospitals and other health providing institutions due to research and clinically reported improved lifelong outcomes in health for both

the breastfed infant and the mother. Additional information about the Baby Friendly Hospital Initiative can be found here <http://www.babyfriendlyusa.org/>.

In support of our system wide objectives, Montefiore New Rochelle support mothers who choose to breastfeed by seeking Baby Friendly Hospital Designation, providing additional support to breastfeeding mothers and minimize practices that can interfere with that choice such as supplementing breastfeeding infants with formula, unless medically indicated or at the mother's specific request. Participating hospitals also pledge to end the distribution of promotional formula and materials during the hospital stay and at discharge. Supporting this institutional initiative is a public awareness campaign to promote the health benefits of breast milk, and to inform women of their right to receive education, encouragement and support to breastfeed their babies if they choose to do so.

When hospitals stop promoting infant formula, mothers are more likely to exclusively breastfeed their babies. The evidence supporting this initiative is strong.

Performance Measures and Time Frame Targets:

In 2012, over 1,847 infants were delivered at Montefiore New Rochelle Hospital. Of these infants, for the year 2012, 38.4% were exclusively breastfed, 58.6% received supplemental feeding during the initial hospitalization and 92.8% were identified to have been fed any breast milk during the hospital stay.

Across the region, from the available WIC statistics provided as a part of the Healthy, Hunger-Free Kids Act of 2010 (the Act), Public Law 111-296 for the fiscal year (FY) 2012, breastfeeding performance measurements based on program participant data of the number of partially and fully breastfed infants for each WIC State and local agency was provided.

The WIC program at the Westchester County Department of Health, located in New Rochelle, saw 2192 infants, of which 167 were fully breastfed, 896 were partially breastfed and 1129 were fully formula fed.

Performance Measures:

Identification of the following

- Exclusion criteria
- Delivery Type

- Skin to Skin Contact
- Labor Pain Management
- Type of Infant Feeding through Hospital Stay
- Pacifier Use
- Rooming In
- Previous Breastfeeding Experience & Success (If Applicable)
- Feeding Intent
- Barriers to Breastfeeding (for non-exclusive mothers only)

Development of the following:

- Written breastfeeding policy that is routinely communicated to all health care staff.
- Train all health care staff in the skills necessary to implement this policy.
- Educational materials and messaging that inform pregnant women about the benefits and management of breastfeeding
- Initiate breastfeeding within one hour of birth.
- Lactation maintenance education during separation from infant
- Establishment of breastfeeding support groups for referral upon discharge

Time Frame Targets:

The time frame established for achievement of the baby friendly hospital designation for Montefiore New Rochelle is 2017. Achievement of the entire Latch on NYC for the Bronx hospitals, as a part of the enterprise wide implementation protocol is also expected to be achieved by 2017. Montefiore has established a Breastfeeding Committee that contains an inter-organizational, interdisciplinary membership from the three labor and delivery campuses of Montefiore (Einstein, Wakefield and New Rochelle), Jacobi Medical Center and the Albert Einstein College of Medicine. Supplementary membership is held by the Assistant Commissioner of the Bronx District Public Health Office and the Assistant Commissioner of the Bureau of Maternal and Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene and the Director of the Westchester County Special Supplemental Nutrition Program for Women Infants and Children program.

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Appendices

English Survey

We are asking people who live in the Hudson Valley to take a 10 minute survey to tell us what they think about health needs in their communities. Your opinions are very important to us and will help us understand how to better meet your health care needs. You are not required to answer all questions.

Note: The survey is completely anonymous – we are not asking for any information that can identify you. Please feel free to forward our survey link to friends and family and co-workers.

Thank you for your participation!

First, we would like to ask you some general questions.

1. What county do you live in? (check only one)

- | | | |
|--------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Dutchess | <input type="checkbox"/> Orange | <input type="checkbox"/> Putnam |
| <input type="checkbox"/> Rockland | <input type="checkbox"/> Sullivan | <input type="checkbox"/> Ulster |
| <input type="checkbox"/> Westchester | <input type="checkbox"/> Delaware | <input type="checkbox"/> Don't Know |

2. What is your zip code? ____ ____ ____ ____ ____

3. What category best describes your race?

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Other (please tell us) _____ | |

4. Are you Hispanic/Latino? Yes No

5. What is your country of birth?

United States Other (please tell us) _____

6. What is your gender?

Male Female Other _____

7. Are you currently employed?

Yes, full-time Yes, part-time No (skip to question 9)

8. If you are employed, do you work for a healthcare organization?

Yes No

9. During the past 12 months, what was your total household income before taxes, including wages and other income for everyone who lives there?

Less than \$10,000
 \$10,000 - \$19,999
 \$20,000 - \$29,999

\$30,000 - \$39,999

\$40,000 - \$49,999

\$50,000 - \$74,999

\$75,000 or more

10. What is your age?

18-24 years

25-34

35-44

45-54

55-64

65-74

75 years and older

11. Do you have any of the following types of health insurance? (check all that apply)

Medicaid

Medicare

Insurance through a private company

Other (please tell us) _____

None (skip to question 13.)

12. If you have health insurance, do you purchase your insurance through the New York State Health Exchange? Yes No

13. If you have no health insurance, are you aware of any ways that you can get health care paid for? Yes No

14. Do you have a healthcare provider for checkups and visits when you are sick?
 Yes No

Now, we would like to ask a few questions about your health.

15. How would you describe your overall health?

- Excellent
- Very good
- Good
- Fair
- Poor

16. How would you describe your overall mental health?

- Excellent
- Very good

Good

Fair

Poor

17. How long has it been since you visited a doctor for a routine physical exam or check-up?

In the past year (skip to question 19)

In the past 2 years (skip to question 19)

In the past 5 years

Five or more years ago

Never

Don't Know

18. If never or more than 2 years ago, what is the main reason(s) you did not have a routine physical exam or check-up? (check all that apply)

Cannot afford

Co-pay or deductible too high

Insurance does not cover

Too far to travel

- Did not have transportation
- Did not have the time
- Healthy/ Do not need to see a doctor
- Cannot find a doctor who speaks my language
- Health Care Provider said it was not needed
- Do not like going / Afraid to go
- Did not have childcare
- Other (please tell us) _____

19. In the past 12 months, did you have a routine dental check-up?

- Yes (skip to question 21) No

20. If no, what is the main reason(s) you did not have a routine dental check-up? (check all that apply)

- Cannot afford
- Co-pay or deductible too high
- Insurance does not cover
- Too far to travel
- Did not have transportation
- Did not have the time

- Healthy/ Do not need to see a dentist
- Dentist said it was not needed
- Cannot find a dentist who speaks my language
- Do not like going / Afraid to go
- Did not have childcare
- Other (please tell us) _____

21. In the past 12 months, did you receive care in the emergency room?

- Yes No (skip to question 23)

22. If yes, what is the main reason for your emergency room visit? Please only check one response.

- Thought problem too serious for a doctor's visit
- Health provider said to go to emergency room
- Doctor's office not open
- No other place to go

- Emergency room is closest provider
- Receive most of my care at emergency room
- Could not find a local provider who speaks my language
- Other (please tell us) _____

23. Looking at the list of health issues below, please mark the 5 that you think are the most important in the community where you live. Feel free to add one or more issues not listed here that you think should be in the top 5.

- Cancer
- Heart disease
- Stroke
- Diabetes
- Obesity
- Lack of physical activity
- Asthma
- Sexually transmitted infections
- HIV
- Family planning
- Disability
- Maternal and child health
- Mental health/depression
- Substance abuse
- Tobacco use
- Injury & violence
- Lack of services for older adults
- Other (please specify): _____

24. In the past 12 months, have you or any member of your family, traveled outside your county to get health care services?

- Yes
- No (skip to question 27)

25. What service(s) did you leave your county for? (check all that apply)

- Primary Care
- Dental
- Ob/Gyn
- Family Planning
- Pediatric
- HIV/STD
- Mental Health
- Specialty
- Hospital Care
- Other (please tell us) _____

**26. What is the main reason(s) for traveling outside of your county for these services?
(check all that apply)**

- To get better quality care
- The health care provider is closer to my home / work
- No health care provider in my county

Other (please tell us) _____

27. Do you know where to go in the County for?

- Diabetes Testing Yes No
- Blood Pressure Testing Yes No
- Cholesterol Testing Yes No
- Cancer Screening Yes No
- Nutrition Education Yes No
- Weight Loss Programs Yes No
- Mental Health Services Yes No
- Substance Abuse Services Yes No
- Alcohol Abuse Services Yes No
- Family Planning Services Yes No
- Maternal and Child Health Services Yes No
- HIV Testing Yes No
- STD Testing Yes No

28. In the past 12 months, did you go for?

- Diabetes Testing Yes No
- Blood Pressure Testing Yes No
- Cholesterol Testing Yes No

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Cancer Screening | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nutrition Education | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Weight Loss Programs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mental Health | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Substance Abuse Services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol Abuse Services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Family Planning Services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Maternal and Child Health Services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV Testing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| STD Testing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

The survey is now complete. Thank you for your time.

French-Creole Survey

Nap mande moun ki rete nan Hudson Valley pou reponn kèk kesyon ki ka ede nou konnin ki sa ou panse sou sante ak lot bezwen nan kominote yo. Opinyon ou trè enpòtan pou nou e yap ede nou konprann ki jan nou ka satisfè bezwen swen medikal ou mye. Ou pa oblije reponn tout kesyon yo.

Remak: Tout kesyon yo anonim – nou pap mande ou enkenn infòmasyon ki ka identifye kiyès ou ye. Tanpri ou met santi ou lib pou voye lyen sondaj bay zanmi ou, fanmi ou, e ak kanmarad travay ou.

Mèsi anpil pou patisipasyon ou!

Premyeman, nou ta renmen mande ou kèk kesyon general.

1. Ki kote ou abite? (chwazi youn)

- | | | |
|--------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Dutchess | <input type="checkbox"/> Orange | <input type="checkbox"/> Putnam |
| <input type="checkbox"/> Rockland | <input type="checkbox"/> Sullivan | <input type="checkbox"/> Ulster |
| <input type="checkbox"/> Westchester | <input type="checkbox"/> Delaware | <input type="checkbox"/> Don't Know |

2. Ki kòd(nimero) postal ou? ____ ____ ____ ____ ____

3. Ki nasyonalite ou?

- | | |
|---|--|
| <input type="checkbox"/> Blan | <input type="checkbox"/> Nwa oswa Afriken Ameriken |
| <input type="checkbox"/> Azyatik oswa Zil Pasifik | <input type="checkbox"/> Indien d'Amériken |
| <input type="checkbox"/> Lòt (tanpri fè nou konnen) _____ | |

4. Eske ou se Panyòl? Wi Non

5. Nan ki peyi ou te pran nesesans?

Étazini oswa Lòt (tanpri fè nou konnen) _____

6. Eske ou se?

Gason Fanm Lòt _____

7. Eske wap travay?

Wi, plin tan ou tan paciel Non Si ou reponn non (ale nan kesyon nimewo 9)

8. Si wap travay, eske se pou yon òganizasyon swen sante?

Wi Non

9. Pandan dènye 12 mwa ki fek pase ya, kombyen kob antou nan kay la anvan tax, mete ansanm tout lajan pou tout moun ki rete nan kay la? Konbyen ou ka di li ye an total?

- Mwens ke \$10,000
- \$10,000 - \$19,999
- \$20,000 - \$29,999
- \$30,000 - \$39,999
- \$40,000 - \$49,999
- \$50,000 - \$74,999
- \$75,000 oswa plis

10. Ki laj ou?

- 18-24 ane
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75 ane plis

11. Ki asirans ou genyen?(chwazi youn)

- Medicaid
- Medicare
- Asirans privé
- Lòt (tanpri fè nou konnen) _____
- Pa gen(ale nan kesyon nimewo 13.)

12. Si ou gen asirans sante, eske ou te achte asirans ou nan Market echanj nan NY la?

Wi Non

13. Si ou pa gen asirans, eske ou konnen ou kapab jwenn èd pou depans medikal ou yo?

Wi Non

14. Eske ou gen yon asirans medikal ki kap peye pou swen medical ou yo si ou ta tombe malad?

Wi Non

Konye a eske ou vle reponn kek kesyon ki gin rapport ak sante ou.

15. Koman ou ta dekri sante general ou?

- Pafe
- Tre byen
- Byen
- kousi kousa
- Pa bon ditou

16. Koman ou ka dekri sante moral ou an general?

- Pafe
- Tre byen
- Byen
- Kousi kousa
- Pa bon ditou

17. Ki denye fwa ou te al kay dokté pou egzamen general?

- Ane passe (ale reponn kesyon nimero 19)
- Sa genyen 2 ane (ale reponn kesyon nimeroskip 19)
- Sa genyen 5 ane
- Sa genyen plis ke 5 ane
- Mwen pa janm ale
- Mwen pa konnin

**18. Si sa gen plis ke 2 lane, pouki rezon ki fe ou pa ale kay dokté pou yon konsiltasyon?
(chwazi tout repons ou we ki samble rezon ki empeche ou yo)**

- Mwen paka peye
- Kob pou mwen peye apre asirans la trop
- Asirans la pap peye
- Trop distans poum voyage
- Mwen pa gen mayen pou'm ale
- Mwen pa gen tan
- Mwen en bon santé / Mwen pa bezwen al we dokté
- Mwen pa kap jwen yon dokté ki pale creole
- Dokte ya di li pa necesse

- Mwen pa rinmin ale / Mwen pè ale
- Mwen pa janm we dokté depi'm te timoun
- Lot rezon (tanpri di nou) Other _____

19. Nan 12 denye mwa ki sot pase yo la, eske ou te ale we yon dantis?

- Wi (ale reponn kesyio nimerò 21)
- Non

20. Si ou reponn non, ki rezon ki enpeche'w ou al chyeke den ou? (chyeke tout sa ki semble rezon ki fe ou pa te ale)

- Ou paka peye
- Co-pay a twò wo
- Asirans pa kouvri li
- Twò lwen pou vwayaje
- Pa gen transpòtasyon
- Pa gen tan
- Mwen en bon santé / Mwen pa bezwen al we dokté
- Dokte ya di li pa necesse
- Pa ka jwenn yon doktè ki pale lang mwen
- Pa renmen ale / pè ale
- Pa t' gen gadri
- Lot (rezon tanpri di nou) _____

21. Nan 12 denye mwa ki sot pase yo eske ou te ale treté nan sal ijans?

Wi

Non (al reponn kesyon numero 23)

22. Si wi se ki rezon ki te mennen'w ou nan sal ijans la? (tcheke selman yon repons)

Kondisyon te grav, li pa te pou ofis dokté

Dokté mwen te voyem non sal dijans

Ofis dokté mwen pat ouvri

Se selman la mwen te ka ale

Se sal dijan la ki te pli pre pou mwen

Se la selman mwen resevwa swen dokté

Mwen paka jwen yon dokté ki pale menm lang avem

Lot rezon (tanpri di nou) _____

23. Gade list sa a kote wap jwen anpil kalite maladi, tanpri wa chwazi 5 nan lis la ke ou pense ki kap pi inpotan nan kominote kote wap viv la. Pap gen anken pwoblem si ou ta ajoute yon ou kelke lot maladi ke ou we ki pa mansyone nan lis la ke ou kwe ta dwe pami 5 premie yo.

- Cance
- Maladi nan ker
- ACV (maladi nan vesso sanguin nan tet)
- Maladi suc
- Obese
- Pa asse exersis
- Asthme (oppression)
- Infeccion genitale
- HIV (infeccion ki bay sida)
- Planifikasyon fanmi
- Andikape
- Soyin pandan ou ancinte
- Maladi nan tet / deprime
- Isage drog
- Isage cigaret
- Victem yon act violence
- Mank de sevice pou gran moun
- Lot rezon (tanpri patage yo avek nou): _____

24. Nan 12 denye mwa sa yo, eske ou menm ou sinon yon moun nan fanmi ou te vwayage endeyo étazini pou recevwa swen medikal?

- Wi Non (si ou reponn non, ale nan nimero 27)

25. Pouki jan de sèvis ou te oblige kite zone kote ou habite ya pou ou te al resevwa swen on lot kote (tcheke tout sa ki aplike)

- Soins de premie necesite
- Pou travay nan dent

- Soin kay ginecolog
- Planinn
- Soin pou pitit Mwen
- HIV/infeccion genital
- Maladi nan tet
- Dokte special
- Soin nan lhopital
- Lot rezon (tanpri fe nou konnin yo) _____

26. Pou ki rezon ou vwayaje deyò kote wap viv pou sèvis sa yo? (tcheke tout sa ki aplike)

- Pou jwenn pi bon kalite swen
- Doktè a pi pre lakay mwen / travay mwen
- Pa gen okenn doktè kote m ap viv
- Lòt (tanpri fè nou konnen)_____

27. Eske ou konnen koté pou ale pou jwenn sèvis sa yo kote ou viv?

- | | | |
|--------------------|-----------------------------|------------------------------|
| Egzamen maladi suc | <input type="checkbox"/> Wi | <input type="checkbox"/> Non |
| Egzamen tansyon | <input type="checkbox"/> Wi | <input type="checkbox"/> Non |
| Egzamen kolestewòl | <input type="checkbox"/> Wi | <input type="checkbox"/> Non |

Egzamen Cance	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Edikasyon nitrisyon	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Pwogram pèdi pwa	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Maladi nan tet	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Isage drog	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Abi alkòl	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Planifikasyon fanmi	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Soyin pandan ou ancinte	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
HIV (infeccion ki bay sida)	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Infeccion genitale	<input type="checkbox"/> Wi	<input type="checkbox"/> Non

28. Pandan dènye douz mwa ki fek pasé a, eske ou te ale pou fe?

Egzamen maladi suc	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Egzamen tansyon	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Egzamen kolestewòl	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Egzamen Cance	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Edikasyon nitrisyon	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Pwogram pèdi pwa	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Maladi nan tet	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Isage drog	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Abi alkòl	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Planifikasyon fanmi	<input type="checkbox"/> Wi	<input type="checkbox"/> Non
Soyin pandan ou ancinte	<input type="checkbox"/> Wi	<input type="checkbox"/> Non

Egzamen infeccion ki bay sida Wi Non

Egzamen Infeccion genitale Wi Non

Resansman an fini pou kounye a. Mèsi pou tan ou.

Portuguese Survey

Estamos solicitando aos residentes de Hudson Valley que participem de uma pesquisa de 10 minutos para nos dizer o que acham das necessidades relacionadas à saúde de suas comunidades. Sua opinião é muito importante para nós e nos ajudará a melhor atender suas necessidades de cuidados de saúde. Você não precisa responder todas as perguntas.

Observação: A pesquisa é anônima; não solicitamos informações que permitam a sua identificação. Sinta-se à vontade para encaminhar o link para nossa pesquisa aos seus amigos, parentes e colegas de trabalho.

Agradecemos sua participação!

Primeiro, gostaríamos de fazer algumas perguntas gerais.

1. Em que município você reside? (selecionar somente um)

Dutchess Orange Putnam

Rockland Sullivan Ulster

Westchester Delaware Não sei

2. Qual é o seu CEP? ____ _

3. Qual é a categoria que melhor descreve sua etnia?

- Branco Negro ou Afro-Americano
 Asiático ou de Ilhas do Pacífico Americano nativo
 Outro (especificar) _____

4. Você é hispano/latino? Sim Não

5. Em que país você nasceu?

- Estados Unidos Outro (especificar) _____

6. Qual é o seu sexo?

- Masculino Feminino Outro _____

7. Você está empregado?

- Sim, em tempo integral Sim, em meio período Não (passar para a pergunta 9)

8. Se está empregado, você trabalha para uma organização de cuidados de saúde?

- Sim Não

9. Durante os últimos 12 meses, qual foi a renda bruta total de sua família, incluindo salários e outras fontes de renda de todos os residentes de seu domicílio?

- Menos de USD 10.000
- USD 10.000 a USD 19.999
- USD 20.000 a USD 29.999
- USD 30.000 a USD 39.999
- USD 40.000 a USD 49.999
- USD 50.000 a USD 74.999
- USD 75.000 ou mais

10. Qual é a sua idade?

- 18-24 anos
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75 anos ou mais

11. Você tem algum dos seguintes tipos de seguro de saúde? (selecionar todos que se aplicarem ao seu caso)

- Medicaid
- Medicare
- Seguro por meio de uma empresa privada
- Outro (especificar) _____
- Nenhum (passar para a pergunta 13.)

12. Se tem seguro de saúde, você compra seu seguro por meio do New York State Health Exchange? Sim Não

13. Se não tem seguro de saúde, você conhece alguma maneira de conseguir pagar por cuidados de saúde? Sim Não

14. Você tem um provedor de cuidados de saúde para consultas de rotina e consultas quando está doente?
 Sim Não

Agora, gostaríamos de fazer algumas perguntas sobre sua saúde.

15. Como você descreveria sua saúde em geral?

Excelente

Muito boa

Boa

Razoável

Ruim

16. Como você descreveria sua saúde mental em geral?

- Excelente
- Muito boa
- Boa
- Razoável
- Ruim

17. Quando foi a última vez que você consultou um médico para um exame físico de rotina ou check-up?

- Há um ano (passar para a pergunta 19)
- Há dois anos (passar para a pergunta 19)
- Há cinco anos
- Há cinco anos ou mais
- Nunca
- Não sei

18. Se nunca ou há mais de dois anos, quais são os principais motivos de você não fazer um exame de rotina ou check-up? (Selecionar todas as opções que se apliquem ao seu caso)

- Não tenho como pagar
- O co-pagamento ou a franquia do seguro é muito alta
- O seguro não cobre

- Fica a uma distância muito grande
- Não tinha meio de transporte
- Não tive tempo
- Saudável/Não preciso consultar médico
- Não encontro médico que fale minha língua
- O provedor de cuidados de saúde disse que não era necessário
- Não gosto/Tenho medo
- Não tinha quem cuidasse do(s) filho(s)
- Outro (especificar) _____

19. Nos últimos 12 meses, você fez uma consulta odontológica de rotina?

- Sim (passar para a pergunta 21) Não

20. Caso negativo, quais são os principais motivos para você não ter feito uma consulta odontológica de rotina? (Selecionar todas as opções que se apliquem ao seu caso)

- Não tenho como pagar
- O co-pagamento ou a franquia do seguro é muito alta
- O seguro não cobre
- Fica a uma distância muito grande
- Não tinha meio de transporte

- Não tive tempo
- Saudável/Não preciso consultar médico
- Não encontro médico que fale minha língua
- O provedor de cuidados de saúde disse que não era necessário
- Não gosto/Tenho medo
- Não tinha quem cuidasse do(s) filho(s)
- Outro (especificar) _____

21. Nos últimos 12 meses, você recebeu atendimento de emergência?

- Sim Não (passar para a pergunta 23)

**22. Caso positivo, qual foi o principal motivo de você ter usado o serviço de emergência?
Selecione somente uma resposta.**

- Achei que o problema era grave demais para uma consulta médica
- O provedor de cuidados de saúde disse para eu ir ao serviço de emergência
- O consultório médico estava fechado
- Nenhum outro lugar aonde ir

- O serviço de emergência é o provedor que fica mais perto
- Recebo a maior parte de meu atendimento médico no serviço de emergência
- Não consegui encontrar um provedor local que falasse minha língua
- Outro (especificar) _____

23. Leia a lista de questões relacionadas à saúde abaixo e marque cinco que você acha serem as mais importantes na sua comunidade. Sinta-se à vontade para adicionar questões não listadas que você acha que deveriam estar entre as cinco principais.

- Câncer
- Doença cardíaca
- Derrame
- Diabetes
- Obesidade
- Pouca atividade física
- Asma
- Infecções sexualmente transmissíveis
- HIV
- Planejamento familiar
- Invalidez
- Saúde materna e pediátrica
- Saúde mental/depressão
- Abuso de substância
- Uso de tabaco
- Lesão e violência
- Falta de serviços para idosos
- Outro (especificar): _____

24. Nos últimos 12 meses, você ou algum membro de sua família viajou para fora do município para obter serviços de cuidados de saúde?

- Sim
- Não (passar para a pergunta 27)

25. Para obter quais serviços você viajou para fora do município? (Selecione todos os que se apliquem ao seu caso)

- Medicina geral
- Odontológico
- Obstetra/Ginecologista
- Planejamento familiar
- Pediatra
- HIV/DST
- Saúde mental
- Especialista
- Cuidado hospitalar
- Outro (especificar) _____

26. Quais são os principais motivos para viajar para fora do município para obter esses serviços? (Selecione todos os que se aplicarem ao seu caso)

- Obter cuidado de melhor qualidade
- O provedor de cuidados de saúde fica mais perto de minha casa/trabalho
- Não há provedor de cuidados de saúde no meu município
- Outro (especificar) _____

27. Você sabe aonde ir no município para receber atendimento para o seguinte?

- Exame de diabete Sim Não
- Medição de pressão sanguínea Sim Não
- Exame de colesterol Sim Não
- Triagem de câncer Sim Não
- Educação nutricional Sim Não
- Programas de perda de peso Sim Não
- Serviços de saúde mental Sim Não
- Serviços de abuso de substância Sim Não
- Serviços de abuso de álcool Sim Não
- Serviços de planejamento familiar Sim Não
- Serviços maternos/pediátricos Sim Não
- Teste de HIV Sim Não
- Teste de DST Sim Não

28. Nos últimos 12 meses, você recebeu os seguintes serviços?

- Exame de diabete Sim Não
- Medição de pressão sanguínea Sim Não
- Exame de colesterol Sim Não
- Triagem de câncer Sim Não

- Educação nutricional Sim Não
- Programas de perda de peso Sim Não
- Serviços de saúde mental Sim Não
- Serviços de abuso de substância Sim Não
- Serviços de abuso de álcool Sim Não
- Serviços de planejamento familiar Sim Não
- Serviços maternos/pediátricos Sim Não
- Teste de HIV Sim Não
- Teste de DST Sim Não

A pesquisa foi concluída. Agradecemos sua participação.

Spanish Survey

Estamos enviando a los residentes de Hudson Valley una encuesta de 10 minutos para pedirles su opinión sobre las necesidades médicas de sus respectivas comunidades. Su opinión es muy valiosa y nos ayudará a comprender mejor cómo atender a sus necesidades de salud. No tiene que responder a todas las preguntas.

Nota: Esta encuesta es totalmente anónima: no le pediremos ninguna información que pueda identificarlo. Por favor, no dude adelante el link de nuestra encuesta a sus amigos, familiares y compañeros de trabajo.

¡Gracias por participar!

En primer lugar, queremos hacerle algunas preguntas generales.

1. ¿En qué condado vive? (marque sólo uno)

- Dutchess Orange Putnam
- Rockland Sullivan Ulster
- Westchester Delaware No lo sé.

2. ¿Cuál es su código postal (*zip code*)? ____ ____ ____ ____ ____

3. ¿Cuál de estas categorías describe mejor su raza?

- Blanco Negro o afroamericano
 Asiático o isleño del Pacífico Indígena norteamericano
 Otra (por favor, diga cuál) _____

4. ¿Es usted hispano o latino? Sí No

5. ¿En qué país nació?

- Estados Unidos Otro (por favor, díganos cuál) _____

6. ¿Cuál es su sexo?

- Hombre Mujer Otro _____

7. ¿Está empleado actualmente?

- Sí, a tiempo completo Sí, a tiempo parcial No (pase a la pregunta 9)

8. Si está empleado, ¿trabaja en el sector de la salud?

Sí No

9. Durante los últimos 12 meses, ¿cuáles fueron las ganancias totales en su hogar antes de impuestos, incluyendo los salarios y otras ganancias de personas que vivan allí?

- Menos de \$10,000
- \$10,000 - \$19,999
- \$20,000 - \$29,999
- \$30,000 - \$39,999
- \$40,000 - \$49,999
- \$50,000 - \$74,999
- \$75,000 o más

10. ¿Cuántos años tiene?

- 18-24 años
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75 años o más

11. ¿Tiene alguno de los siguientes tipos de seguro de salud? (marque todos los que correspondan)

- Medicaid
- Medicare
- Seguro a través de una compañía privada
- Otro (por favor, díganos cuál) _____
- Ninguno (pase a la pregunta 13.)

12. Si tiene seguro de salud, ¿lo compró a través del New York State Health Exchange?
Sí No

13. En caso de que tenga seguro, ¿sabe si hay alguna manera de conseguir que le financien un seguro médico? Sí No

14. ¿Tiene algún proveedor de salud que le haga chequeos y a quien pueda visitar cuando esté enfermo? Sí No

Ahora vamos a hacerle algunas preguntas sobre su salud.

15. ¿Cómo describiría su estado general de salud?

- Excelente
- Muy bueno
- Bueno

Regular

Malo

16. ¿Cómo describiría su estado general de salud mental?

Excelente

Muy bueno

Bueno

Regular

Malo

17. ¿Cuánto tiempo ha pasado desde que visitó a su médico para un examen físico o chequeo rutinario?

Dentro del último año (pase a la pregunta 19)

Dentro de los últimos dos años (pase a la pregunta 19)

Dentro de los últimos cinco años

Hace cinco o más años

Nunca

No lo sé.

18. En caso de que en los últimos dos años, o nunca, se haya hecho un chequeo o un examen médico rutinario, ¿cuál o cuáles han sido las razones principales? (marque todas las casillas pertinentes)

- No puedo pagarlo.
- El copago, o el deducible, es demasiado alto.
- Mi seguro no lo cubre.
- Está demasiado lejos de mi domicilio.
- No tenía medio de transporte.
- No he tenido tiempo.
- Estoy sano / No necesito ver a un médico.
- No hay un médico disponible que hable mi idioma.
- Mi proveedor de salud me dijo que no era necesario.
- No me gusta ir al médico/ Me da miedo ir al médico.
- No tenía con quién dejar a mi(s) hijo(s).
- Otra razón (por favor, díganos cuál). _____

19. ¿Se ha hecho un chequeo dental rutinario en los últimos 12 meses?

- Sí (pase a la pregunta 21) No

20. Si ha dicho que no, ¿cuál(es) es/son la(s) razón(es) principales de no haberse hecho un chequeo dental rutinario? (marque las casillas pertinentes)

- No puedo pagarlo.
- El copago o el deducible es demasiado alto.
- Mi seguro no lo cubre.
- Está demasiado lejos de mi domicilio.
- No tenía medio de transporte.
- No he tenido tiempo.
- Estoy sano / No necesito ver a un dentista.
- No he encontrado un dentista que hable mi idioma.
- Mi proveedor de salud me dijo que no era necesario.
- No me gusta ir / Me da miedo ir.
- No tenía con quién dejar a mi(s) hijo(s).
- Otra razón (por favor, díganos cuál) _____

21. En los últimos 12 meses, ¿ha recibido asistencia en la sala de emergencias?

- Sí No (pase a la pregunta 23)

22. Si ha dicho que sí, ¿cuál fue la razón principal de su visita a la sala de emergencias? Por favor, marque una sola respuesta.

- Pensé que el problema era demasiado serio para que me atendiera mi médico.
- Mi proveedor de salud me dijo que fuera a la sala de emergencias.

- La Oficina de mi médico no estaba abierta.
- No tenía ningún otro sitio a donde ir.
- La sala de emergencias era la opción más cercana.
- Recibo casi toda mi asistencia médica en la sala de emergencias.
- No pude encontrar un proveedor cercano que hablase mi idioma.
- Otra razón (por favor, díganos cuál) _____

23. De la siguiente lista de problemas de salud, por favor, marque los 5 que usted considera más importantes para la comunidad en la que vive. Si lo desea, añada uno o más problemas de salud que, en su opinión, deberían estar entre los 5 más importantes.

- Cáncer
- Enfermedades del corazón
- Apoplejía o derrame cerebral (*stroke*)
- Diabetes
- Obesidad
- Falta de actividad física
- Asma
- Infecciones de transmisión sexual
- VIH
- Planificación familiar
- Discapacidad
- Salud materno-infantil
- Salud mental/depresión
- Abuso de sustancias
- Consumo de tabaco
- Lesiones y violencia
- Falta de servicios para adultos más mayores
- Otros problemas (por favor, diga cuáles): _____

24. Durante los últimos 12 meses, ¿ha viajado usted o algún miembro de su familia a otro condado para obtener servicios de salud?

- Sí No (pase a la pregunta 27)

25. ¿Qué tipo(s) de servicio(s) médico(s) buscó usted en el otro condado? (marque todas las casillas pertinentes)

- Asistencia médica primaria
- Salud dental
- Obstetricia/Ginecología
- Planificación familiar
- Pediatría
- VIH/STD
- Salud mental
- Especialista
- Asistencia hospitalaria
- Otro (por favor, díganos cuál) _____

26. ¿Qué razón o razones le llevaron a viajar a otro condado para obtener esos servicios? (marque todas las casillas pertinentes)

- Para obtener asistencia médica de mejor calidad
- El proveedor de salud está más cerca de mi hogar/trabajo.
- En mi condado no hay proveedores de salud.
- Otra (por favor, díganos la razón) _____

27. ¿Sabe a qué lugar del condado debe ir para cada una de las siguientes pruebas o servicios?

- | | | |
|-------------------------------------|-----------------------------|-----------------------------|
| Pruebas de diabetes | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Pruebas de presión arterial | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Pruebas de colesterol | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Pruebas de cáncer | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Educación nutricional | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Programas para perder peso | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Servicios de salud mental | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Servicios de abuso de sustancias | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Servicios de abuso del alcohol | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Servicios de planificación familiar | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Servicios de salud materno-infantil | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Pruebas de VIH | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Pruebas de ETS* | <input type="checkbox"/> Sí | <input type="checkbox"/> No |

28. ¿Cuál(es) de las siguientes se ha hecho/ha utilizado en los últimos 12 meses?

- | | | |
|-----------------------------|-----------------------------|-----------------------------|
| Pruebas de diabetes | <input type="checkbox"/> Sí | <input type="checkbox"/> No |
| Pruebas de presión arterial | <input type="checkbox"/> Sí | <input type="checkbox"/> No |

Pruebas de colesterol	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Pruebas de cáncer	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Educación nutricional	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Programas para perder peso	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Servicios de salud mental	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Servicios de abuso de sustancias	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Servicios de abuso de alcohol	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Servicios de planificación familiar	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Servicios de salud materno-infantil	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Pruebas de VIH	<input type="checkbox"/> Sí	<input type="checkbox"/> No
Pruebas de ETS*	<input type="checkbox"/> Sí	<input type="checkbox"/> No

***Enfermedades de transmisión sexual**

Ya ha terminado la encuesta. Gracias por su tiempo.

Yiddish Survey

בס"ד

מיר בעטן איינזאמלן פון די האדסאן וועלי, אנטוויילצונעמן אין א צען מינוטיגע סורוועי אפשאצונג, כדי אונז צו אינפארמירן זייערע געדאנקען איבער די געזונטהייט באדערפעניש פונעם באפעלקערונג.

אייער מיינונגען איז זייער וויכטיג און וועט אונז העלפן פארשטיין וויאזוי מען קען בעסער צושטעלן געזונטהייט באהאנדלונג.

איר מוזט נישט ענטפערן אויף אלע פראגעס.

אכטונג: די סורוועי איז גענצליך אנאנימוס, מיר פרעגן נישט קיין אינפארמאציע וואס קען אייך אידענטעפיצירן, ביטע פילט פריי מיטצוטיילן דעם סורוועי מיט אייערע פאמיליע און פריינט.

א גרויסן דאנק פאר אייערע באטיילונג!

צום ערשט ביטע ענטפערט עטליכע אלגעמיינע פראגן:

1. אין וועלכע קאונטי וואוינט איר? (צייכנט נאר איינס)

- | | | |
|--------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> דאטשעס | <input type="checkbox"/> ארענדזש | <input type="checkbox"/> פוטנאם |
| <input type="checkbox"/> ראקלענד | <input type="checkbox"/> סאליווען | <input type="checkbox"/> אלסטער |
| <input type="checkbox"/> וועסטשעסטער | <input type="checkbox"/> דעלעווער | <input type="checkbox"/> איך ווייס נישט |

2. וואס איז אייער זיפ קאוד? _____

3. וואס איז אייער ראסע?

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Other (please tell us) _____ | |

4. אין וועלכע לאנד זענט איר געבוירן? _____

5. איר זענט א מאן פרוי?

6. האט איר ארבעט?

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> פולע שטונדן | <input type="checkbox"/> יא, טיילווייזע ארבעט | <input type="checkbox"/> ניין (גיי צו פראגע 8) |
|--------------------------------------|---|--|

7. ארבעט איר פאר א געזונטהייט קעיר ארגעניזאציע?

- | | |
|-----------------------------|--------------------------------|
| <input type="checkbox"/> יא | <input type="checkbox"/> ניין. |
|-----------------------------|--------------------------------|

8. איבער די לעצטע 12 מאנאטן, וואס איז אייער טאטאלע הויזגעזונט איינקונפט – בעפאר אראפנעמען שטייערן, אריינגערעכנט אלע איינקונפט פון יעדער וואס וואוינט ביי אייך?

- אונטער צען טויזענט דולר
- צען ביז צוואנציג טויזענט דולר
- צוואנציג ביז דרייסיג טויזענט דולר
- דרייסיג ביז פערציג טויזענט דולר
- פערציג ביז פופציג טויזענט דולר
- פופציג ביז פינעף און זיבעציג טויזענט דולר
- פינעף און זיבעציג טויזענט דולר אדער מער

9. ווי אלט זענט איר?

- 18-24 יאר
- 25-34 יאר
- 35-44 יאר
- 45-54 יאר
- 55-64 יאר
- 65-74 יאר
- 75 יאר און עלטער

10. האט איר איינע פון די פאלגענדע העלט אינשורענס? (צייכן אלע פאסיגע)

- מעדיקעיד
- מעדיקעיר
- פארזיכערונג דורך א פריוואטע קאמפאני
- אנדערע (ביטע שרייב ארויס) _____
- גארנישט (גיי צו פראגע 12)

11. האט איר געקויפט אייער אינשורענס דורך די ניו יארק סטעיט העלט עקסטשעינדזש?

- יא ניין

12. אויב איר האט נישט קיין העלט אינשורענס, זענט איר באקאנט מיט וועגן וואס איר קענט ווערן באצאלט פאר געזונטהייט באהאנדלונג?

- יא ניין

13. האט איר א דאקטער וואס איר גייט צו פאר אינטערזיכונג ווען איר זענט קראנק?

יא ניין

יעצט ביטע ענטפערט עטליכע פראגעס איבער אייער געזונט:

14. וויאזוי וואלט איר אראפגעלייגט אייער אלגעמיינע געזונט צושטאנד?

אויסערגעווענליך גוט
זייער גוט
גוט
מעסיג
שוואך

15. וויאזוי וואלט איר אראפגעלייגט אייער מענטל געזונט צושטאנד?

אויסערגעווענליך גוט
זייער גוט
גוט
מעסיג
שוואך

16. ווי לאנג איז שוין פאריבער זינט איר זענט געווען ביים דאקטער פאר א געווענליכע פיזישע אינטערזיכונג?

אין די לעצטע יאר (גיי צו פראגע 18)
אין די לעצטע צוויי יאר (גיי צו פראגע 18)
אין די לעצטע פינעף יאר
מער פון פינעף יאר
קיינמאל נישט געווען ביים דאקטער
איך ווייס נישט

17. אויב זענט איר נישט געווען ביים דאקטער די לעצטע צוויי יאר אדער מער, וואס איז די הויפט סיבה דערפון?

(צייכן אן אלע פאסיגע אנטווארט)

איך קען זיך נישט ערלויבן צו באצאלן
די צוצאלונג וואס די פארזיכערונג פירמע דעקט נישט, איז צו הויך

- מיינ אינשורענס דעקט דאס נישט
- צו ווייט אנצוקומען
- איך האב נישט קיין טראנספארטאציע מיטל אנצוקומען
- איך האב נישט קיין צייט
- איך בין געזונט און דארף נישט אנקומען צו קיין דאקטער
- איך קען נישט געפונען א פאסיגע דאקטער וואס רעדט מיין שפראך
- די דאקטער האט געזאגט אז עס פעלט נישט אויס
- איך האב נישט ליב/איך פארקט זיך צו גיין צום דאקטער.
- איך האב נישט ווער עס זאל אכט געבן אויף די קינדער.
- אנדערע אורזאך (ביטע ארויסשרייבן) _____

18. האט איר געהאט א דענטאל אינטערזיכונג אויף די ציין אין די לעצטע צוועלעף מאנאטן? יא (גיי צו פראגע 20) ניין

19. וואס איז די הויפט אורזאך אז איר האט נישט באזוכט ביים דענטיסט (צייכן אן אלע פאסיגע אנטווארט)

- איך קען זיך נישט ערלויבן צו באצאלן
- די צוצאלונג וואס די פארזיכערונג פירמע דעקט נישט, איז צו הויך
- מיינ אינשורענס דעקט דאס נישט
- צו ווייט אנצוקומען
- איך האב נישט קיין טראנספארטאציע מיטל אנצוקומען
- איך האב נישט קיין צייט
- איך בין געזונט און דארף נישט אנקומען צו קיין דאקטער
- די דאקטער האט געזאגט אז עס פעלט נישט אויס
- איך קען נישט געפונען א פאסיגע דאקטער וואס רעדט מיין שפראך
- איך האב נישט ליב/איך פארקט זיך צו גיין צום דאקטער.
- איך האב נישט ווער עס זאל אכט געבן אויף די קינדער.
- אנדערע אורזאך (ביטע ארויסשרייבן) _____

20. זענט איר באהאנדלט געווארן אין עמורדזשענס רום אין די לעצט צוועלעף מאנאטן?

יא ניין (גיי צו פראגע 22)

21. אויב יא, וואס איז געווען די הויפט אורזאך פאר'ן באזוך? (ביטע ענטפער נאר איינס)

איך האב געמיינט אז די פראבלעם איז צו ערנסט פאר א געווענליכע דאקטער.

- די דאקטער האט געהייסן גיין צום עמורדזשענסי רום.
- די דאקטער'ס אפיס איז געווען פארמאכט.
- איך האב נישט געהאט קיין צווייטע פלאץ ווי צו גיין.
- די עמורדזשענסי רום איז די נענסטע פלאץ פאר באהאנדלונג.
- איך באקום מערסטנס פון מיינע באהאנדלונגען אין עמורדזשענסי רום.
- איך האב נישט געפונען קיין דאקטער וואס קען מיין שפראך.
- אנדערע אורזאך (ביטע ארויסשרייבן) _____.

22. ביטע צייכן אן וואס זענען די פינעף הויפט וויכטיגע געזונטהייט אנגעלעגנהייטן פון די באפעלקערונג ווי איר וואוינט, איר קענט אויך צולייגן עפעס וואס שטייט נישט דא אויסגערעכנט, אבער איר פילט אז עס איז פון די פינעף וויכטיגסטע.

- קענסער.
- הארץ קראנקהייט.
- סטראוק.
- דייעביטיס, צוקער קרארנהייט.
- איבערוואג.
- ווייניג פיזישע אקטיוויטעטן.
- אסטמע, אטעמען שוועריגקייטן.
- STI.
- HIV.
- לאנגטערמינעגע פאמיליע פלענער.
- דיסעביליטי.
- עלטערן און קינד געזונטהייט.
- מענטאל העלט, דיפרסיע.
- סובסטענץ אביוז.
- רייכערן.
- געשעדיגט ווערן און ווילדקייט.
- פעלערהאפטיגקייט און צושטעלן סערוויס פאר עלטערע מענטשן.
- אנדערע, (ביטע ארויסשרייבן) _____.

23. זענט איר אדער א פאמיליע מיטגליד ארויסגעפארן פון אייער קאונטי (COUNTY) צו באקומען געזונטהייט באהאנדלונג, אין די לעצטע צוועלעף מאנאטן?

ניין (גיי צו פראגע 26) יא

24. פאר וועלכע באהאנדלונג זענט איר ארויסגעפארן פון אייער קאונטי (COUNTY) פאר? (צייכן אלע פאסיגע אנטווארט)

- געווענליכע דאקטער.
- ציינער.
- OB GYN .
- פאמיליע פלאנירונג.
- קינדער געווענליכע דאקטער (פידיעטרישאן).
- HIV STD .
- מענטאל העלט.
- ספעציעליסטן.
- שפיטאל באהאנדלונג.
- אנדערע, (ביטע ארויסשרייבן) _____.

25. וואס איז די הויפט אורזאך אז איר זענט ארויסגעפארן פון אייער קאונטי (COUNTY) צוליב דעם? (צייכן אלע פאסיגע אנטווארט)

- צו באקומען א בעסערע קוואליטעט באהאנדלונג.
- דער דאקטער איז נענטער צו מיין היים/ארבעט.
- עס איז נישט פארהאן דער באהאנדלונג אין מיין קאונטי (COUNTY).
- אנדערע אורזאך (ביטע ארויסשרייבן) _____.

26. וויסט איר ווי צו גיין אין אייער קאונטי פאר די פאלגענדע?

- | | | | | |
|--------------------------|--------------------------|----|--------------------------|------|
| דייעביטיס, צוקער טעסטינג | <input type="checkbox"/> | יא | <input type="checkbox"/> | ניין |
| בלוט דרוק טעסטינג | <input type="checkbox"/> | יא | <input type="checkbox"/> | ניין |
| קאלעסטעראל טעסטינג | <input type="checkbox"/> | יא | <input type="checkbox"/> | ניין |
| קענסער אינטערזיכונג | <input type="checkbox"/> | יא | <input type="checkbox"/> | ניין |
| נוטרישען עדיוקאציע | <input type="checkbox"/> | יא | <input type="checkbox"/> | ניין |
| פארלירן וואג פראגראמען | <input type="checkbox"/> | יא | <input type="checkbox"/> | ניין |
| מענטאל העלט סערוויס | <input type="checkbox"/> | יא | <input type="checkbox"/> | ניין |
| סובסטאנץ אביוז סערוויס | <input type="checkbox"/> | יא | <input type="checkbox"/> | ניין |

	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	אלקאהאל אביוז סערוויס
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	פעמילי פלענונג סערוויס
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	מעטערנעל און טשיילד העלט סערוויס
ביין <input type="checkbox"/>	<input type="checkbox"/>	יא <input type="checkbox"/>		HIV טעסטינג
ביין <input type="checkbox"/>	<input type="checkbox"/>	יא <input type="checkbox"/>		STD טעסטינג

27. זענט איר געגאנגען אין די לעצטע צוועלעף מאנאטן פאר די פאלגענדע?

	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	דיעביטיס, צוקער טעסטינג
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	בלוט דרוק טעסטינג
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	קאלעסטעראל טעסטינג
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	קענסער אינטערזיכונג
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	נוטרישען עדיוקאציע
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	פארלירן וואג פראגראמען
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	מענטאל העלט סערוויס
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	סובסטאנץ אביוז סערוויס
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	אלקאהאל אביוז סערוויס
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	פעמילי פלענונג סערוויס
	<input type="checkbox"/>	יא <input type="checkbox"/>	ביין <input type="checkbox"/>	מעטערנעל און טשיילד העלט סערוויס
ביין <input type="checkbox"/>	<input type="checkbox"/>	יא <input type="checkbox"/>		HIV טעסטינג
ביין <input type="checkbox"/>	<input type="checkbox"/>	יא <input type="checkbox"/>		STD טעסטינג

איר האט געענדיגט די סורוועי פראגעס.

א דאנק פאר אייער צייט.

Solicitation for CHNA Survey
Hudson Valley Residents Invited to Participate in Community Needs Assessment Survey

September 12, 2014

Contact:
(INSERT CONTACT INFORMATION HERE)

Residents of New York's Westchester, Rockland, Putnam, Orange, Sullivan, Ulster and Dutchess counties are invited to take a short survey about their health and the services they use. The survey is anonymous, will take less than 10 minutes to complete and is available online. Participants are encouraged to share the survey link and information about the survey with friends, family and other residents of the Hudson Valley.

The goal of this survey is to learn more about the health care needs of the community so future healthcare needs and services are identified and planned. Results of the community survey will be available in October.

The survey is being administered through a collaborative effort between the Center for Regional Healthcare Innovation at Westchester Medical Center, Montefiore Medical Center, Refuah Health Center, and HealthAlliance of Hudson Valley Performing Provider Systems (PPS).

Click [here](#) to take the survey

About the Participants

The Center for Regional Healthcare Innovation at Westchester Medical Center, Montefiore Medical Center, Refuah Health Center, and HealthAlliance of Hudson Valley Performing Provider Systems (PPS), are partnerships of regional care providers who will collaborate to create integrated healthcare systems outlined in the Governor's Delivery System Reform Incentive Payment (DSRIP) Program. Each PPS is one of the 42 'Emerging PPSs' selected by New York State to participate in the DSRIP program. PPSs include practitioners from all sectors of healthcare including hospitals, physician-based practices, nursing homes, Federally Qualified Health Centers, behavioral health providers, health homes, and community-based organizations.

To learn more about the Performing Provider Systems, click [here](#)

To learn more about New York State's DSRIP project, click [here](#)

To learn more about the Community Needs Assessment process, click [here](#)

Focus Group Discussion Guide

DISCUSSION GUIDE V.1

HUDSON VALLEY HEALTHCARE

FOCUS GROUPS

I. WARM-UP (5-10 MINUTES)

1. Facility explanation/group rules.
2. Purpose of group –The purpose of our discussion tonight is to understand what your healthcare needs are, what works for you and what doesn't, what resources you use and what would be ideal for your needs now and in the future. We will focus on Primary Care, Specialty Care and Behavioral/Mental Health Care.
3. Introduction: **[NAME, HOUSEHOLD COMPOSITION (WHO YOU LIVE WITH INCLUDING PARENTS, ROOMMATES, ETC.), MARITAL STATUS, AGE OF CHILDREN]** Three words your friends/family would use to describe you. Do you have health insurance or not-including private-from employer or self, military, Medicare, Medicaid etc.?

II. CURRENT PERCEPTIONS (60 MINUTES)

1. We are going to be talking about healthcare today. **[HOLD UP A CARD THAT SAYS “HEALTH”; WRITE DOWN]** What are the first three thoughts, feelings, emotions that come to mind when I say “health”? Debrief. Why do you say that?
2. **[HEALTH NEEDS/OBJECTIVES]** Now thinking about you//your family today, how do you feel about your own health? The health of your family? What illness or healthcare events are you most concerned about? **[LIST]** Why? Is that for you or another family member? What specific illnesses do you or other family members deal with on a regular basis-both physical health including specialty care and mental health issues?
3. What factors contribute to your health? What are you/your family doing to stay healthy/maintain your health, if anything?
4. **[HOLD UP A CARD THAT SAYS “HEALTHCARE”; WRITE DOWN]** What are the first three thoughts, feelings, emotions that come to mind when I say “healthcare”? Why/when do you use healthcare? What benefits are important to you when it comes to healthcare resources? **[LIST]** **(FOR EACH BENEFIT PROBE WHY THAT IS IMPORTANT TO THEM)**
5. What healthcare and community resources do you and your family use? How do you feel about these resources; do they provide you with the benefits that you are looking for or not? Describe. Do you have a primary care physician or group practice that you use or not? If not what do you use? Why is that? How well or not does that work for you?

6. **[PROBE IN DEPTH ON THE FOLLOWING BENEFITS:AVAILABILITY, ACCESSIBILITY, AFFORDABILITY, ACCEPTABILITY AND QUALITY]** When I say “Quality” as it relates to healthcare and community resources (related to healthcare), what are the first 3 thoughts feelings and emotions that come to mind? Debrief. What does “quality healthcare” mean to you? What are all the characteristics of a quality healthcare system? **[LIST]** How well do your healthcare resources deliver on quality? What could they do better? **[REPEAT FOR EACH BENEFIT]**
7. When it comes to local healthcare for you and your family what specific concerns do you have about the healthcare in this region? Why is that a concern? **[PROBE/ LISTEN FOR COST CONCERNS, ACCESS TO HEALTHCARE, ACCEPTABILITY, QUALITY, OTHER-LIST]** I have a magic wand **[WAVE WAND]** What do you wish they offered but do not? What would motivate you to use these services?
8. If you are not originally from this area or did not grow up here how is the healthcare here similar/different? **[CULTURAL ISSUES]**
9. **[ETHNIC/CULTURAL NEEDS, WHO SERVES THEM, WHERE, HOW LEARN ABOUT,EFFECTIVENESS, UNMET NEEDS/GAPS]** Now think about your community...Are there unique health needs or issues that are particular to your community? How are these needs addressed-by whom, where? How do you learn about these providers of care in your community? How well or not do you think healthcare resources/community resources address these issues? What’s missing? What’s missing? Who makes the health decisions in your home? How?
10. **[COPING W/O INSURANCE-G-1&G2]** For those of you without insurance or limited health insurance, where do you go if you need urgent medical care? Non urgent medical care? Behavioral Issues/mental health issues? How do you decide where and when to go? Why do you go there? What works? What doesn’t work? Is most frustrating? How do you pay for services if you don’t have insurance? What works best for you? Doesn’t work? What would work better? Are there any community centers you go to get primary care for free?
11. **[BARRIERS TO ACCESS SERVICES]** Earlier I mentioned that we were here because we want to learn more about your healthcare needs what works and what does not work. Now we are going to focus on what doesn’t work and what are the barriers that you face when trying to access healthcare services. Let’s list all the barriers we face and how to overcome these barriers:**[LIST-PROBE IF NOT MENTIONED ACCESSIBILITY FOR YOU/FAMILY-TRANSPORTATION, LANGUAGE ISSUES; CONVENIENCE-HOURS OF OPERATION; AFFORDABILITY- DOESN’T TAKE MY INSURANCE/ HAVE NO INSURANCE/SLIDING SCALE/MEDICAID / UNCOMPENSATED CARE; QUALITY PERCEPTIONS- NOT CONFIDENT IN OUTCOME/CARE;RELUCTANCE TO SEEK CARE-STIGMA/PROVIDER MISTRUST]** Are the barriers the same or different for Primary Care versus Mental Health Issues, versus Specialty care or not? If not what is different?
12. How if at all do you work around these barriers? How does this make you feel? What would work better?

III. PERCEPTIONS OF THE IDEAL (35 MINUTES)

1. **[WAVE WAND]** I am now going to morph you into a community leadership team and your task is to create the Ideal –well- organized, accessible, affordable, convenient, high quality

healthcare system for your community. I want you to create a list of what it would look like-what elements are most important, what services would they provide etc.? Focus on Primary Care. Debrief. What specific elements were important-what services? Why is that important to you and your family? What benefit does it provide? What would it do for your life? How would it make you feel? How would expect to find out/learn about these services/elements?

2. How does this compare to the healthcare resources in your community? What should they add to their resources? Is there anything that they currently offer that you would eliminate? Why is that? Would you replace it with something else or not? What/why? What benefit would that provide?
3. Now how would this be the same or different for Specialty Care? **[LIST ADDITIONAL ELEMENTS/SERVICES]** Why are these important? What would it do for your life? How would it make you feel? How would you expect to learn about this?
4. How does this compare to what the community currently offers? What should they add? Is there anything they should eliminate? What if anything would replace it? What benefit would that provide?**[REPEAT Q3&4 FOR BEHAVIORAL/MENTAL HEALTH SERVICES]**

IV. Smoking Cessation and Other Healthy Behaviors (15 MINUTES)

1. How many of you smoke cigarettes? How many of you have tried to quit? What was the motivation? What did you do? How did you find out about that? What ultimately happened? What do you think was needed to help you stop, if anything?
2. How many of you used to smoke but quit? What was the motivation? What did you do? How did you hear about it? Why do you think it worked? What did stopping mean to you? Your family? What advice would you give to those who were not as successful as you were?
3. If you were going to convince people to quit smoking how would you go about it? Where would they get information about this service/program? What would you tell them? How would you communicate with them? (Traditional media, Social Media, via a Doctor/PA/NP, Community groups etc.) Why do you think that would work? For those who smoke, what would work best for you?
4. How would you deter people from starting to smoke or restarting to smoke? What do you think would work? Why?
5. What if anything could the community do to help people to stop smoking or deter them from starting? **[PROBE IF NOT MENTIONED: MEDIA CAMPAIGNS, -WHERE; LIMIT SALES WITH STRITER POLICIES; MOR SMOKE FREE ZONES; BETTER ACCESS TO NICOTINE REPLACEMENT THERAPIES AND SUPPORT GROUPS ETC.]** What if anything could the medical community do to better help people stop smoking or to influence the community to deter people from smoking?
6. Changing gears-What if anything are you doing to stay healthy?**[LIST]** What preventative care measures do you take if any? Why is that? How can the community encourage more people to do these things? What creative measures can be taken to keep the community healthier?
5. **[PARTING SHOTS]** What final words of advice would you give your community's healthcare system to do the best job for you and your family? To promote a healthier lifestyle

THANK RESPONDENTS FOR THEIR TIME AND VALUABLE INFORMATION

Palm Cards in English and Spanish



We want to improve the way we deliver healthcare, but first we need your feedback. Help us make it better by taking this quick survey!

visit: tiny.cc/make-it-better

Or scan the QR code below

This survey is being administered by the Center for Regional Healthcare Innovation at Westchester Medical Center, Montefiore Medical Center, Refuah Health Center, and the HealthAlliance of the Hudson Valley
 Contact us: crhi@wcmc.com

You can use your smart phone's QR reader app to scan the QR code (right) to be taken directly to the survey. Don't have a QR reader app? Go to the App Store or Google Play and download a QR reader app. It's easy and fun.



SurveyCard-4x9_04C.indd 1



Queremos mejorar la manera en que brindamos atención médica, pero primero necesitamos sus comentarios. ¡Ayúdenos a mejorar respondiendo esta encuesta rápida!

visita: tiny.cc/make-it-better

O escanear el código QR a continuación

Esta encuesta es administrada por el Center for Regional Healthcare Innovation en Westchester Medical Center, Montefiore Medical Center, Refuah Health Center y HealthAlliance en Hudson Valley.
 Comuníquese con nosotros: crhi@wcmc.com

Usted puede utilizar QR de su teléfono inteligente aplicación de lector para escanear el código QR (derecha) para ser llevados directamente a la encuesta. No tener una aplicación de lector QR? Ir a la App Tienda o Google Play y descargar Aplicación de lector QR. Es fácil y divertido.



9/18/14 4:38 PM SurveyCard-4x9_04C.indd 2

9/18/14 4:38 PM

Posters in English and Spanish



**Help us improve
the way we deliver healthcare
in the Hudson Valley**

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