

**MONTEFIORE MEDICAL CENTER**

**MONTEFIORE – NEW ROCHELLE  
COMMUNITY SERVICE PLAN  
2015 - 2017**

**Montefiore Medical Center**  
**Montefiore – New Rochelle**  
**Community Service Plan 2015-2017**

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## **1. Mission Statement: A Longstanding Commitment, A New Focus**

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's partnership with Einstein advances clinical and translational research to accelerate the pace at which new discoveries become the treatments and therapies that benefit patients. The medical center derives its inspiration for excellence from its patients and community, and continues to be on the frontlines of developing innovative approaches to care.

### **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).

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

## **2. Definition and Description of the Community Served: Hospital Service Area**

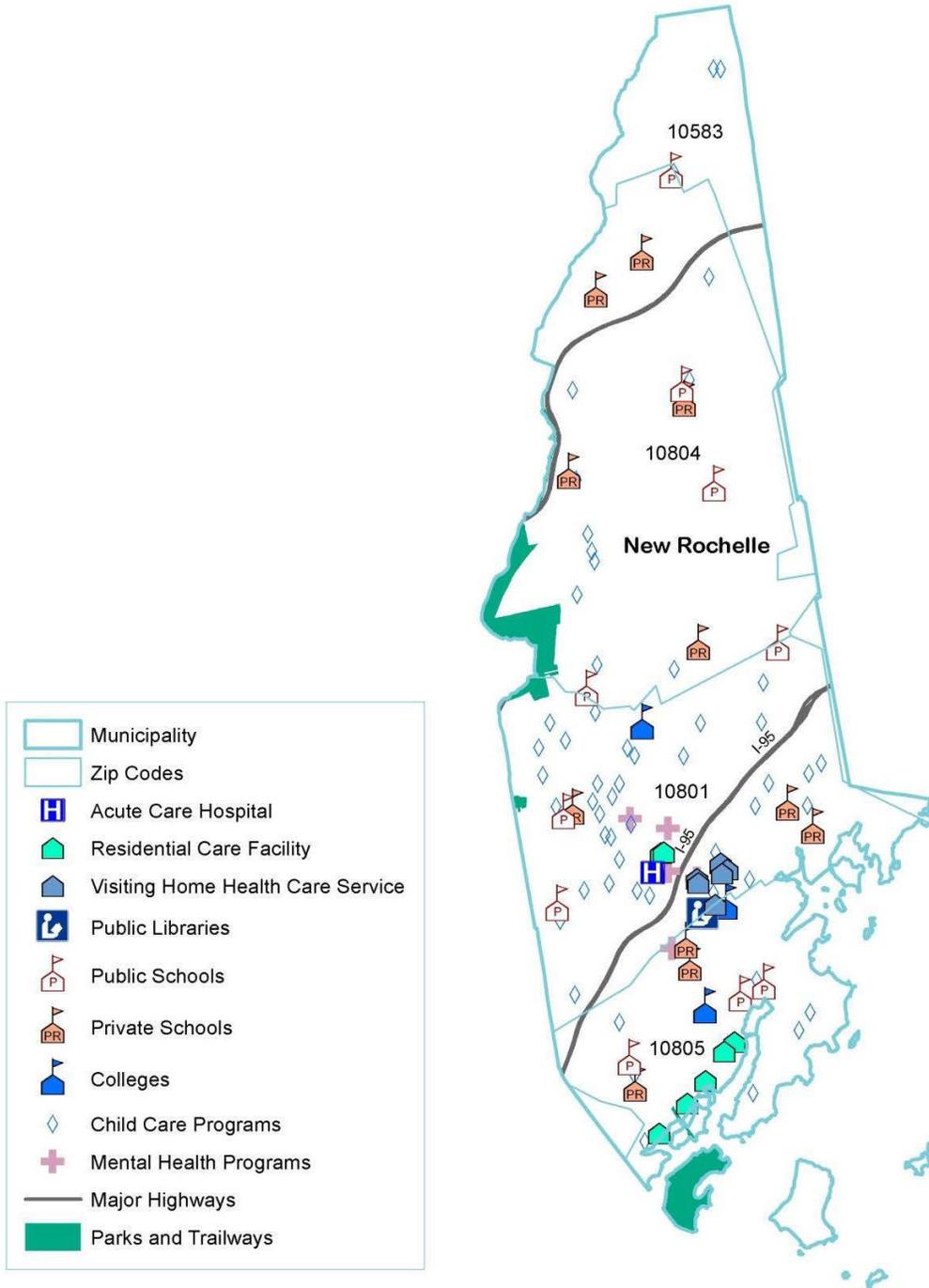
### **A. Description of Service Area**

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 km<sup>2</sup>). 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



## **B. 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%.

## **C. 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. The prevalence and/or incidence of both clinical and social determinants of health are reported from multiple sources, as detailed within the sections below. While there are areas of improvement, New Rochelle's rates are comparable to the midline, when compared to the remainder of Westchester County. When local municipality data is unavailable, County level data is provided.

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).

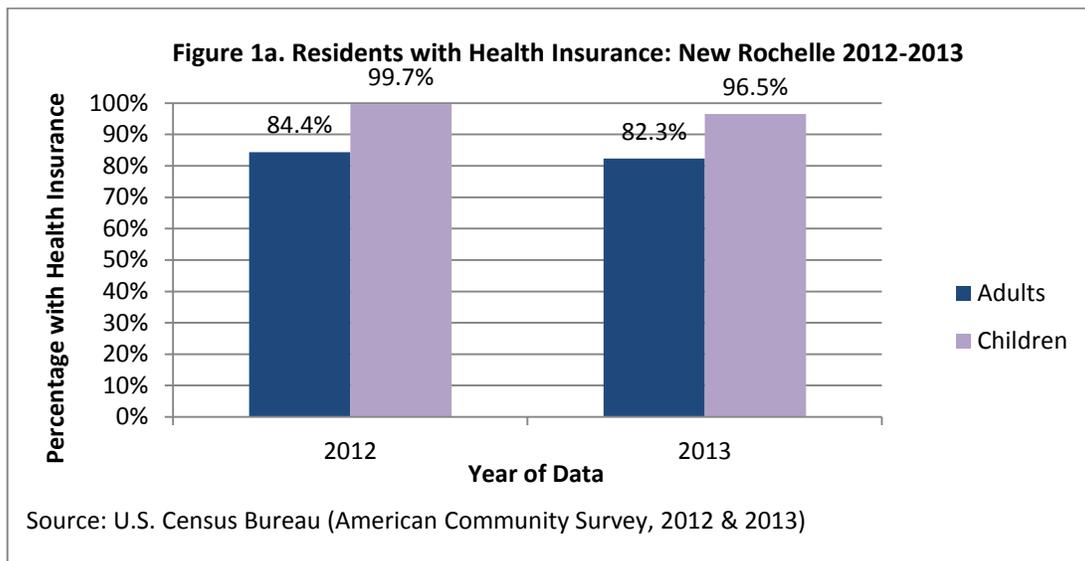
The incidence rate of all cancer diagnoses in Westchester County was 495.2 per 100,000 in 2010; similar to the statewide rate of 482.5. The type of cancer with the highest incidence rate in Westchester County is prostate cancer (22.6 per 100,000; similar to the statewide rate of 21.3).

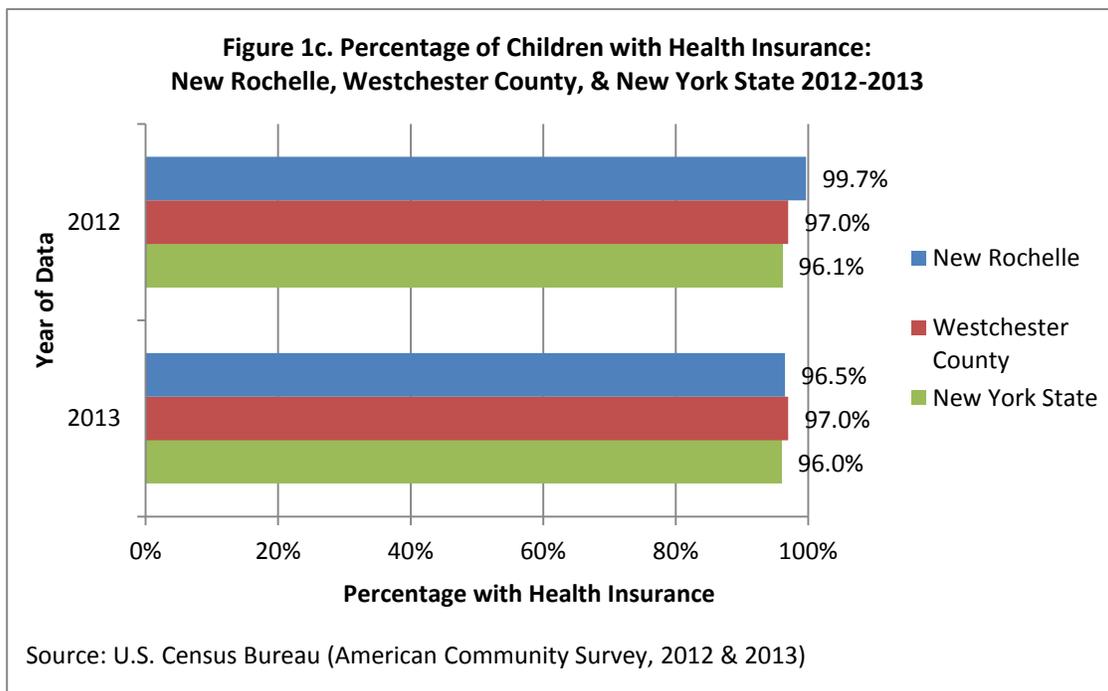
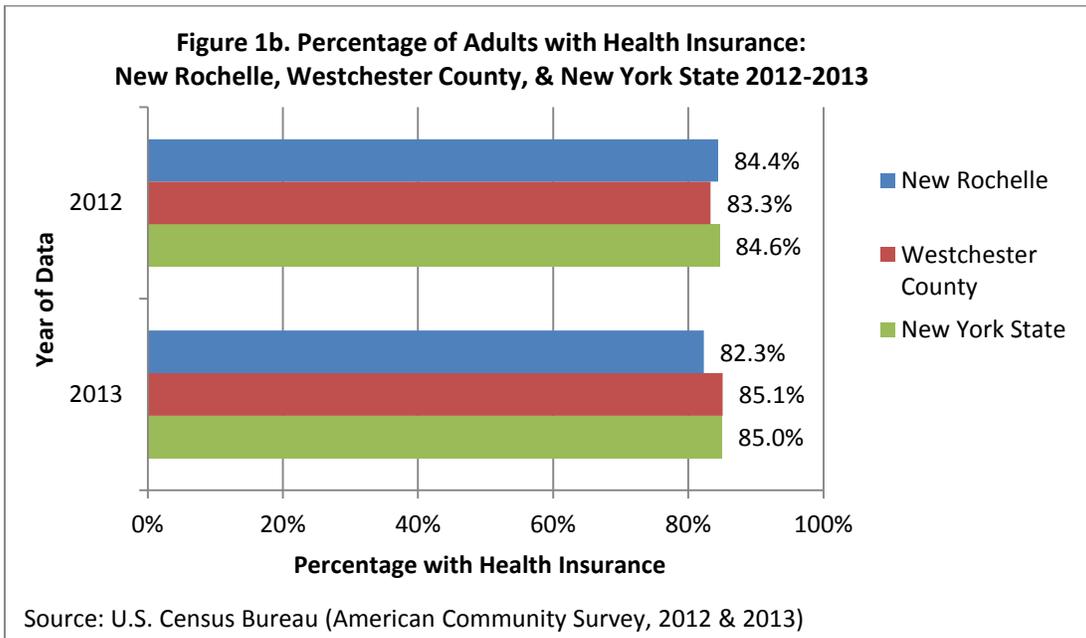
## Health Status of the City of New Rochelle: Health Indicators and Data Sources

### 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.





*Preventable Hospital Stays: Top 20 Inpatient Diagnoses*

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

### *Preventable Hospital Stays: Top 20 ED Diagnoses*

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

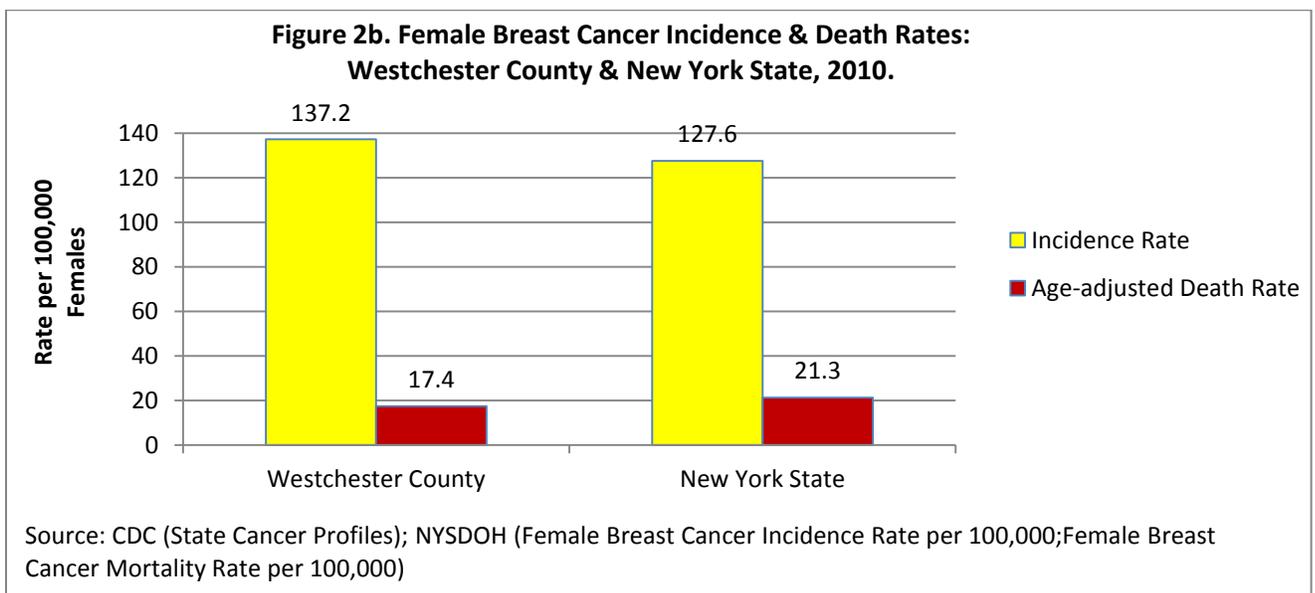
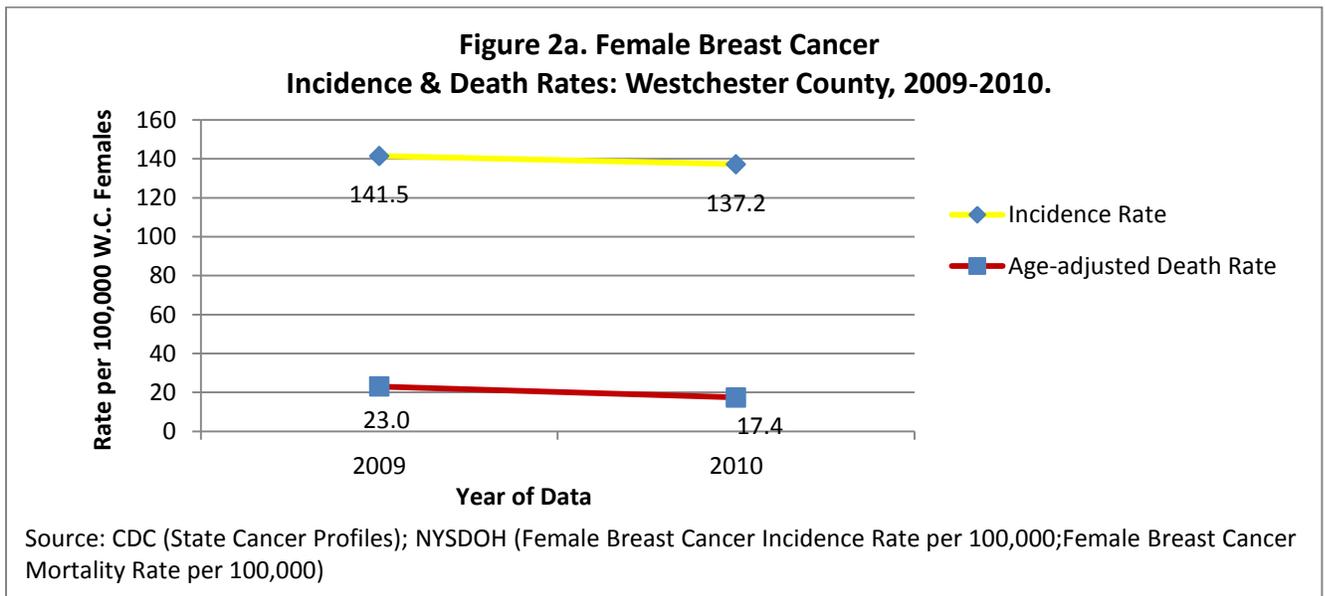
## 2. Chronic Diseases

### 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).

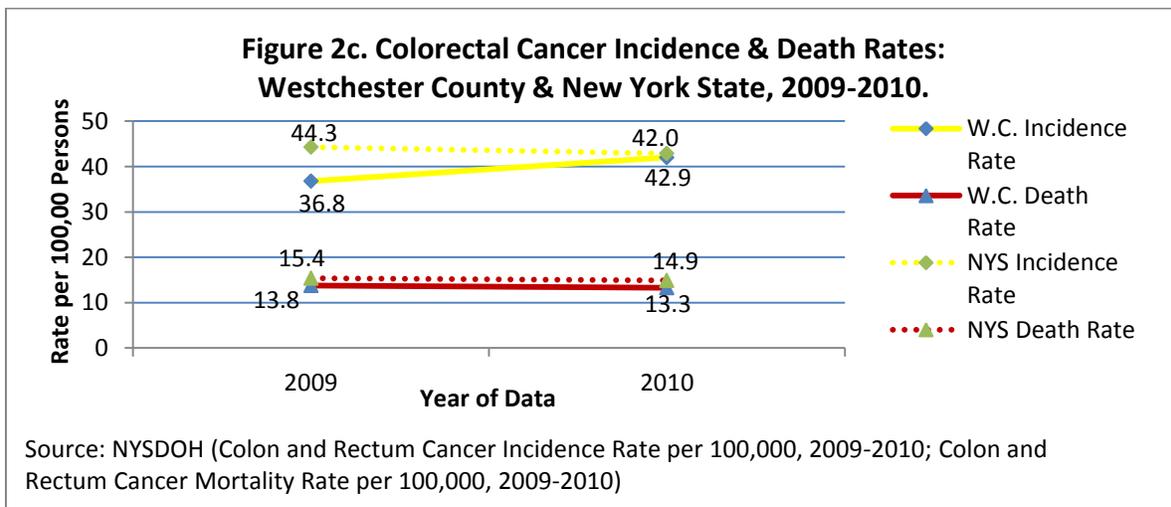
- In 2010, Westchester County’s female breast cancer incidence rate decreased to 137.2; remaining higher than the statewide rate of 127.6 (see Figure 2b).
- The age-adjusted death rate due to breast cancer in Westchester County was 23.0 per 100,000 females in 2009. The death rate decreased to 17.4 per 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%.

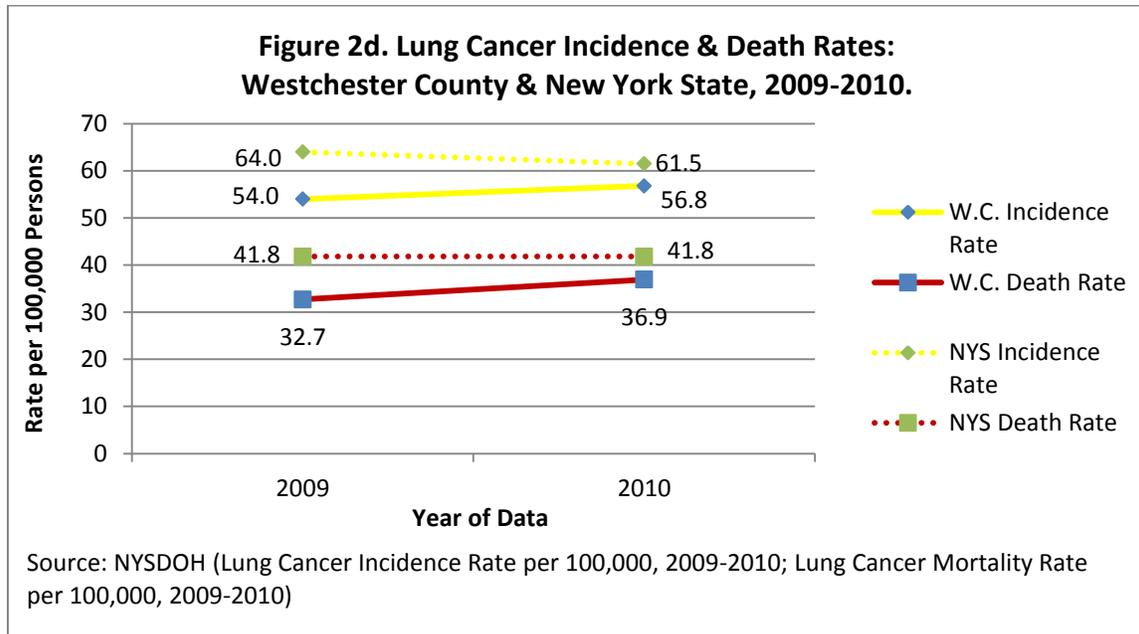


*Lung cancer (citywide data unavailable):*

- 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.

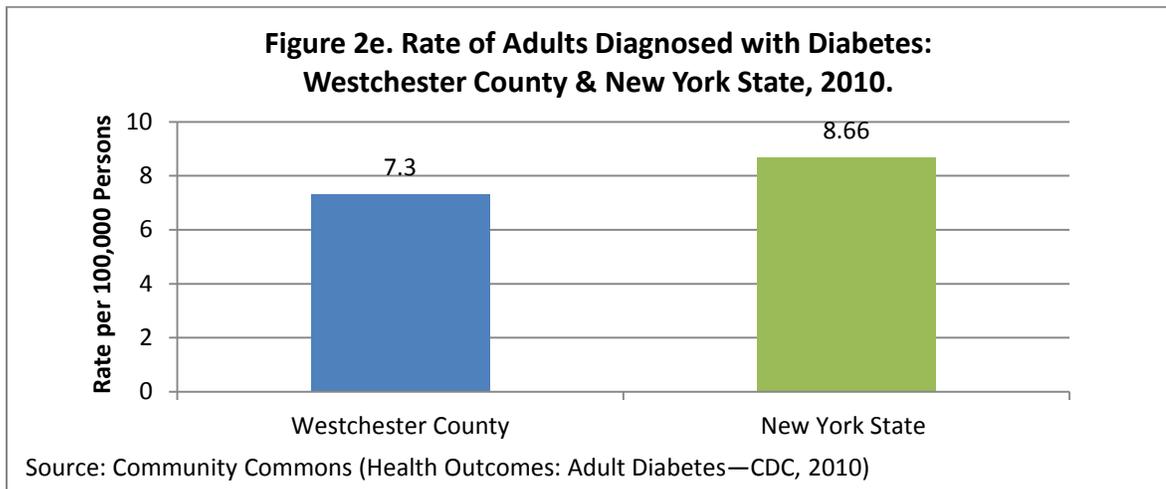
- In 2009, 81.5% of Westchester County women ages 18 and older reported that they had a pap test within the past three years; similar to the statewide percentage of 81.7%.

*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).

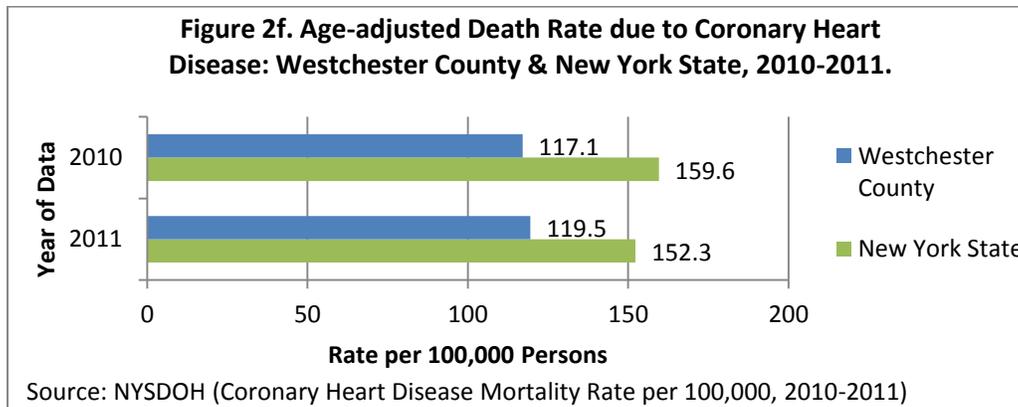


- According to the County Health Rankings data, 85% of diabetic Medicare enrollees ages 65 and older in Westchester County reported in 2010 that their blood sugar levels were screened in the past year using the HbA1c test method. 87% of enrollees reported in 2011 that they received HbA1c screening in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

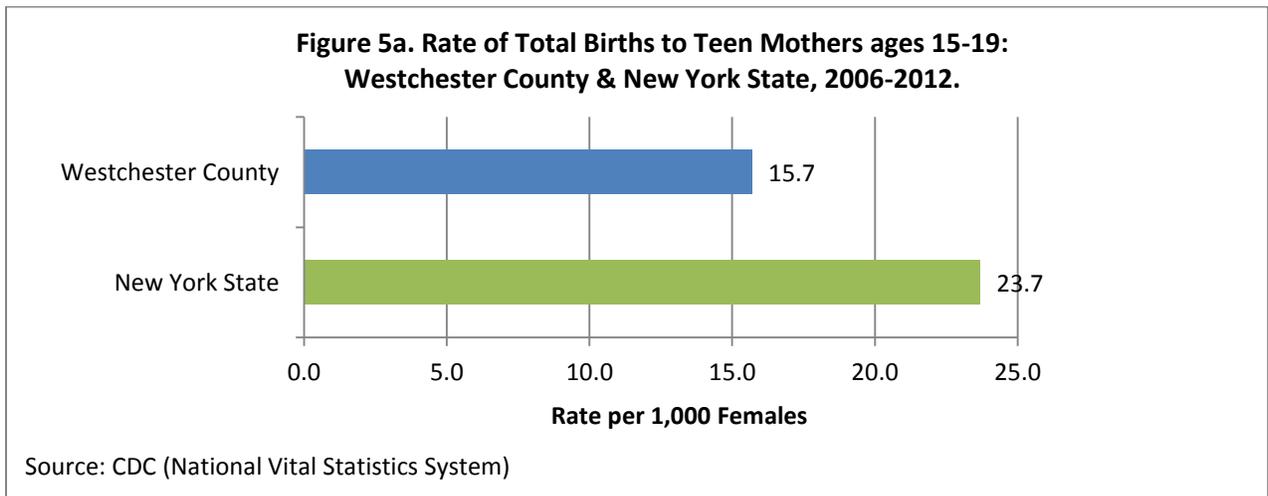
### 4. Disability

- 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

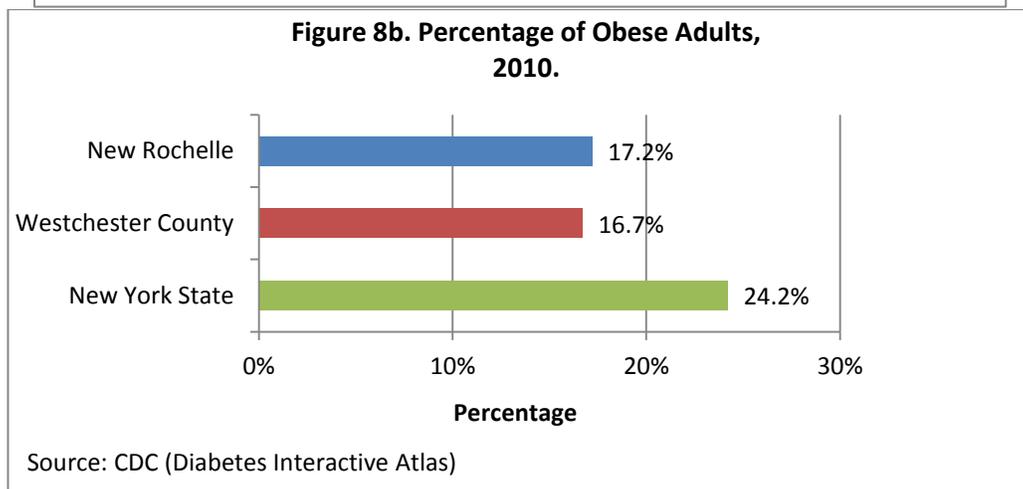
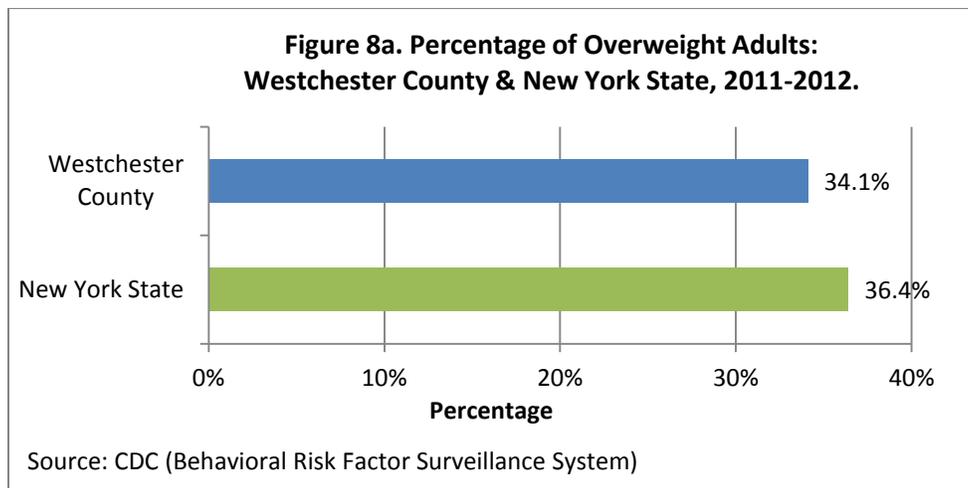
- According to CDC data from 2006-2012, 8.3% of total live births in Westchester County resulted in low infant birthweight (under 2500 grams); similar to the statewide rate of 8.2%.
- According to the WIC Breastfeeding Data Local Agency Report, the number of infants in participation from the Sound Shore 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*)

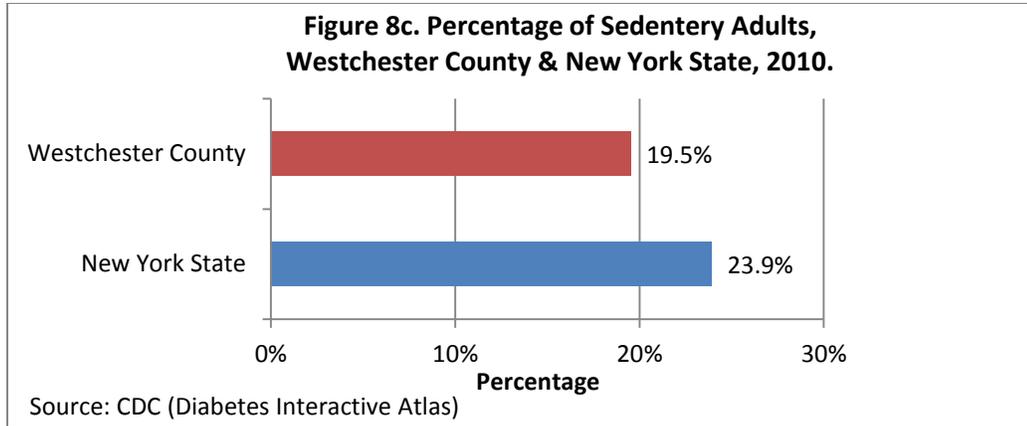
- According to CDC data from 2007-2011, the age-adjusted death rate due to suicide in Westchester County was 6.32 per 100,000; lower than the statewide rate of 7.40.

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).



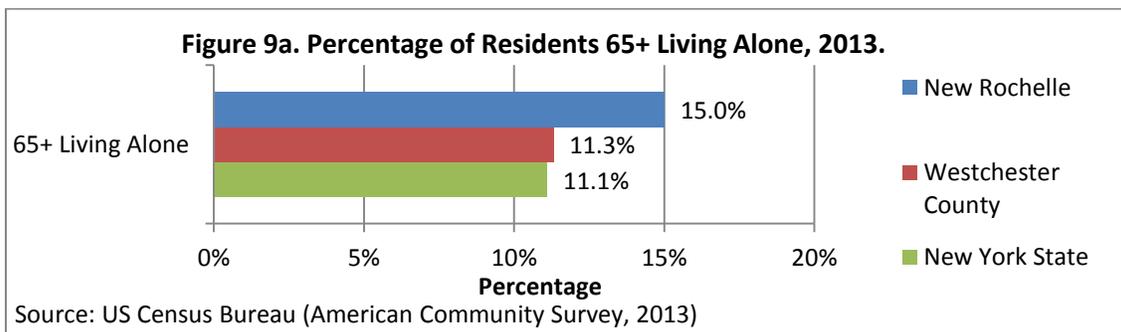
- According to the CDC, 19.5% of Westchester County adults ages 20 and older reported in 2010 that they engaged in no leisure time physical activity in the past 30 days; lower than the statewide percentage of 23.9% (see Figure 8c).



- 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).

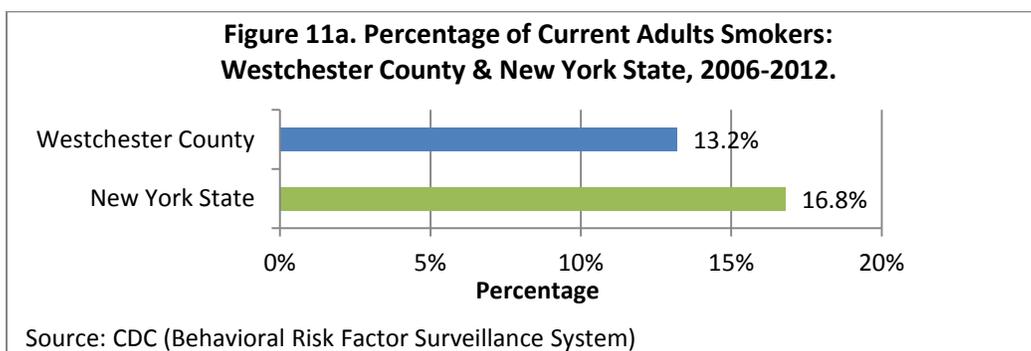


## 10. Injury and Violence Prevention (*citywide data unavailable*)

- 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.

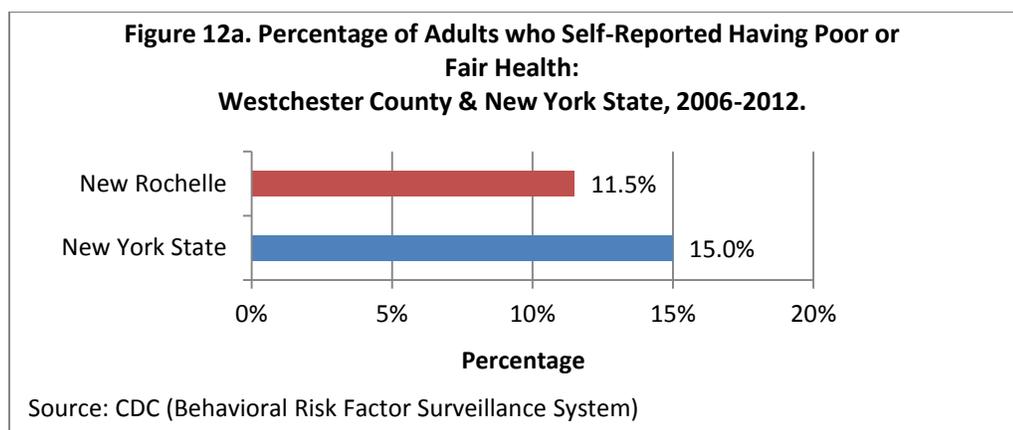
## 11. Substance Abuse and Tobacco Use

- 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*)

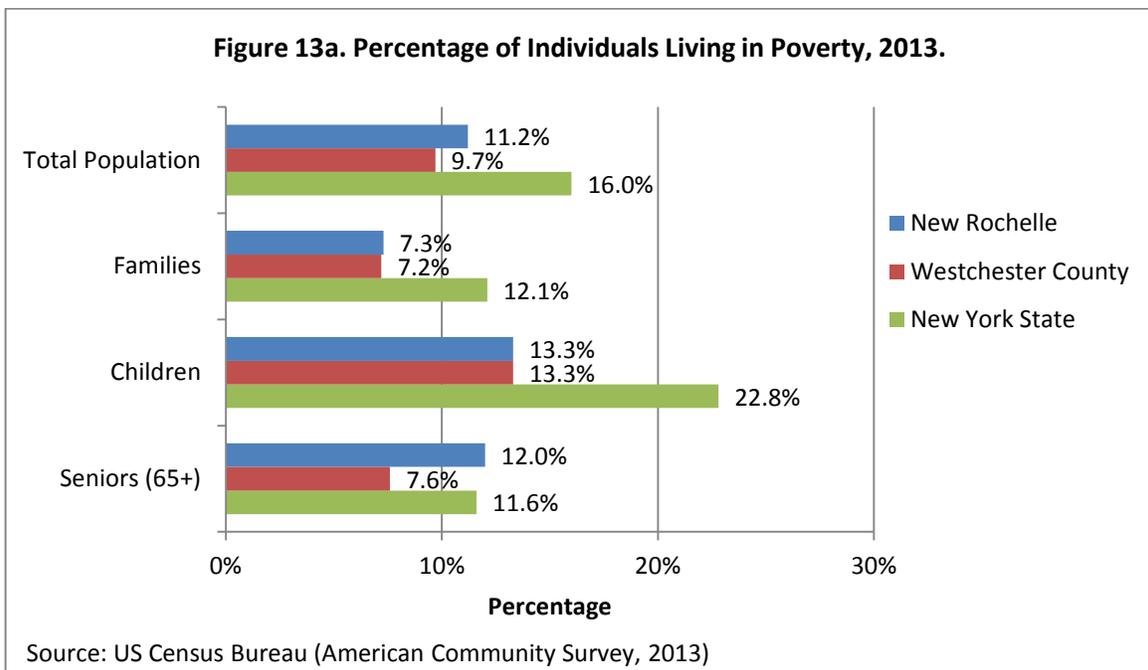
- According to CDC data from 2006-2012, 11.5% of Westchester County adults self-reported having poor or fair health; lower than the statewide percentage of 15% (see Figure 12a).



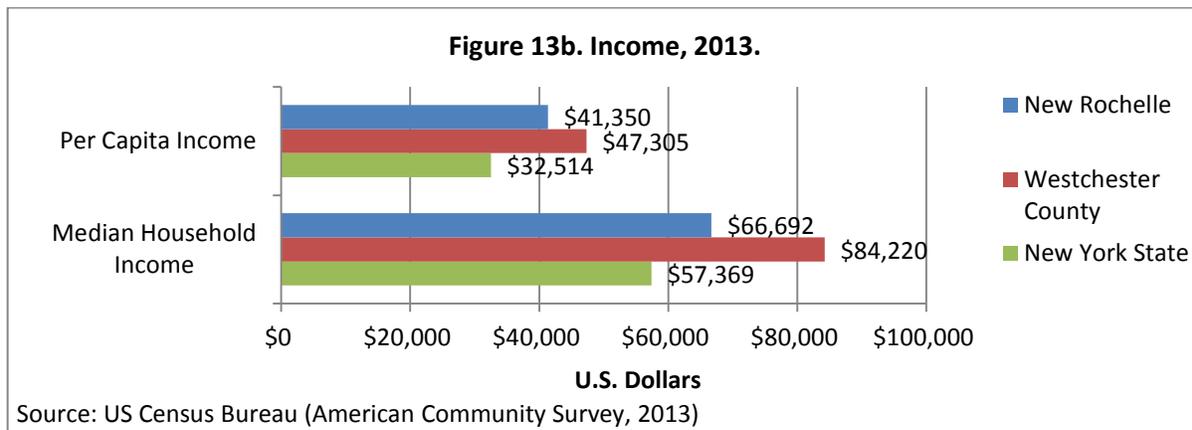
- According to CDC data from 2006-2012, 22.8% of Westchester County adults self-reported that they received insufficient social and emotional support all or most of the time; lower than statewide rate of 24%.

## B. Economy

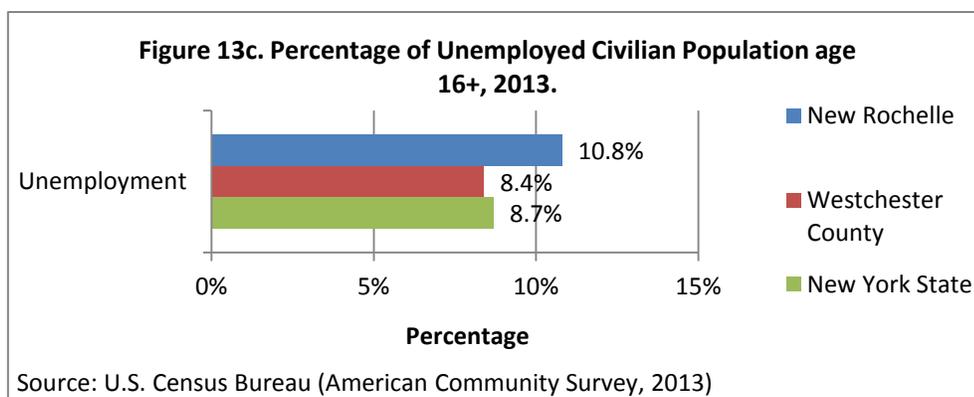
- According to the US Census Bureau (2013), 11.2% of New Rochelle residents lived below poverty level. In 2013, 7.3% of New Rochelle families, 13.3% of New Rochelle children, and 12% of New Rochelle residents ages 65 and older lived below poverty level.
- In Westchester County, 9.7% of the population 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).



- 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).



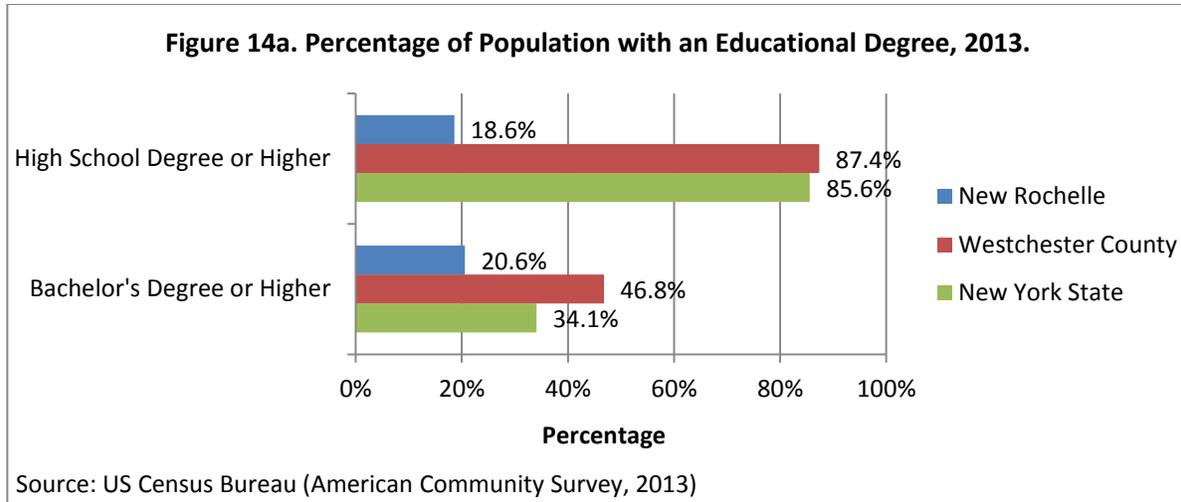
- In 2013, 4.3% of New Rochelle households received public assistance income. Within the same year, 2.8% of Westchester County households and 3.5% of New York State households received public assistance income.
- According to the National Center for Education Statistics, 42.3% of students in New Rochelle 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).

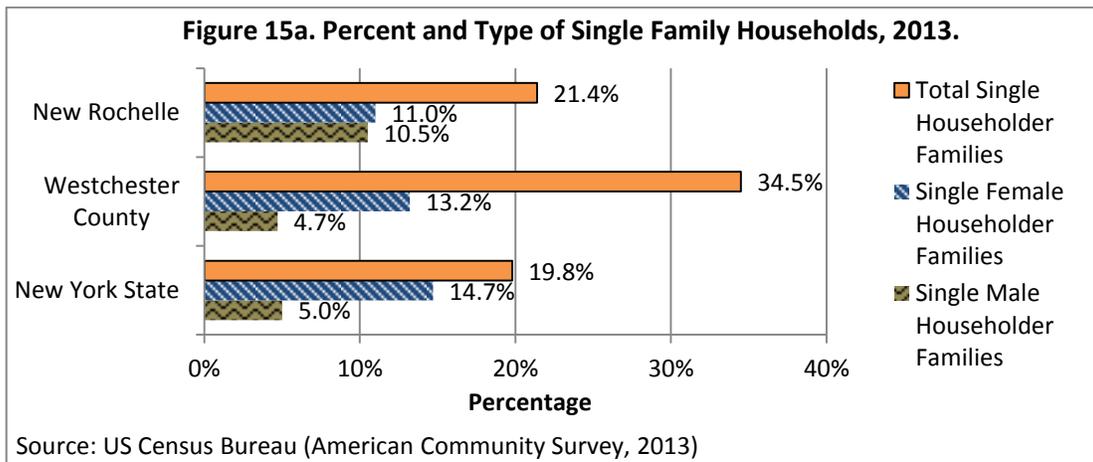


- From 2011-2012, the rate of ninth grade students who graduated in 4 years in New Rochelle was 82; lower than the countywide rate of 86.44 and statewide rate of 83.50.

### 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

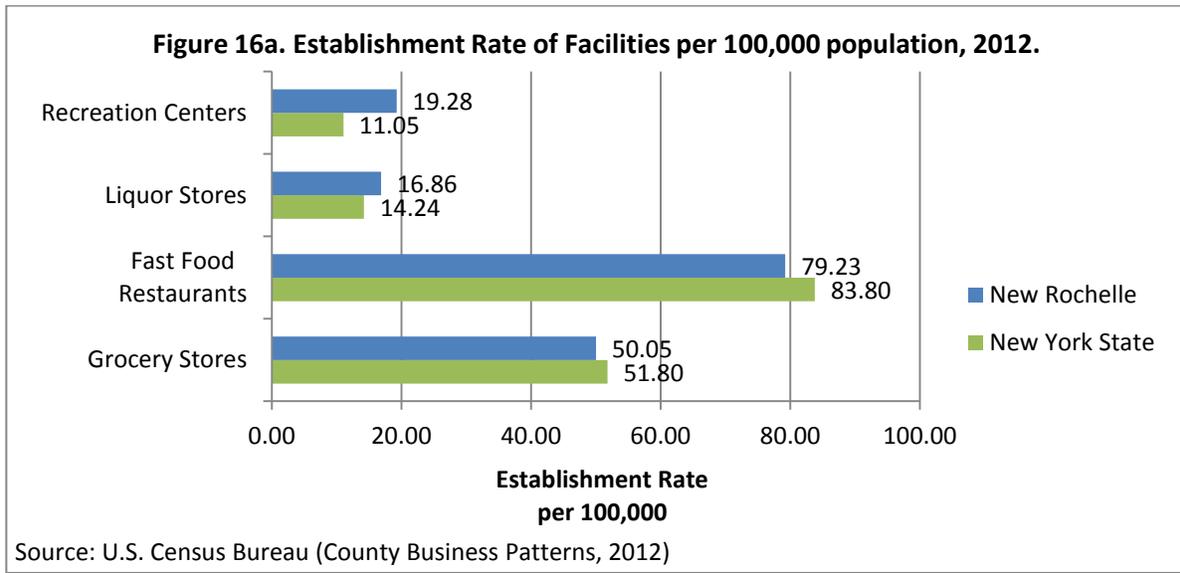
were headed by females; lower than the countywide (13.2%) and statewide (14.7%) percentages.



- 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.

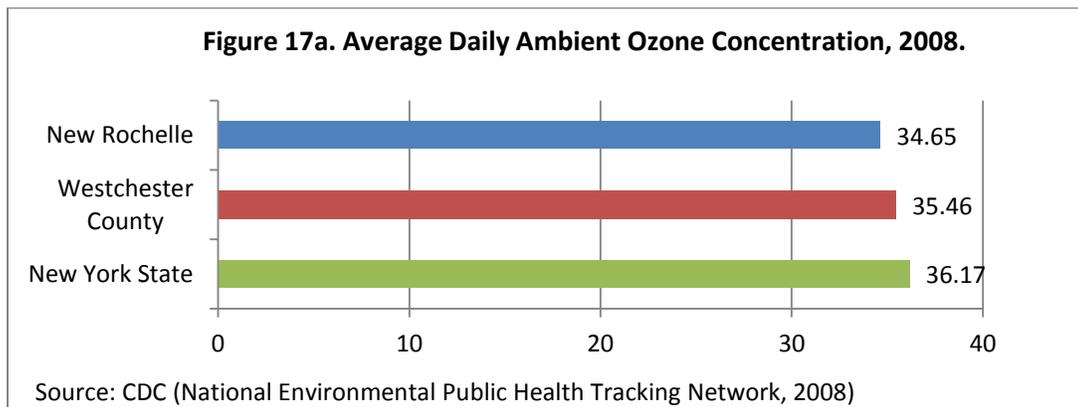
#### E. Built Environment

- 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).

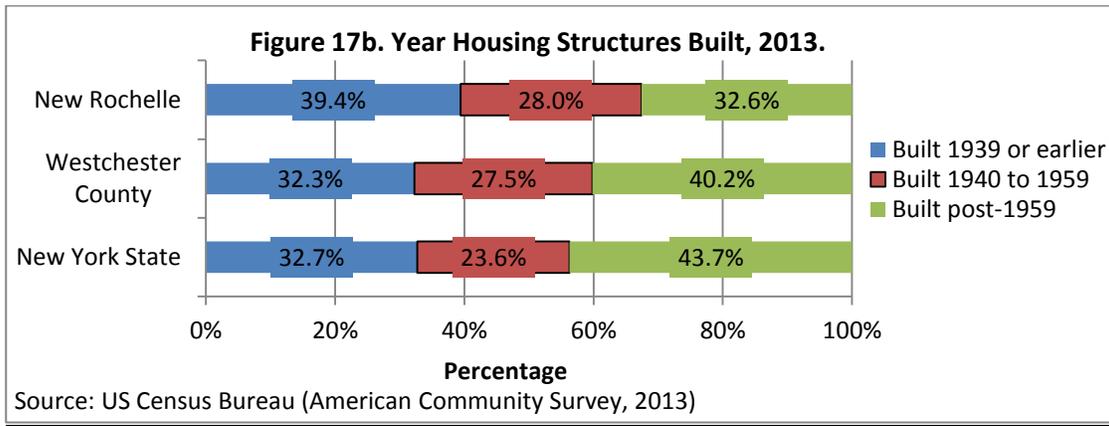


#### F. Environment

- 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.

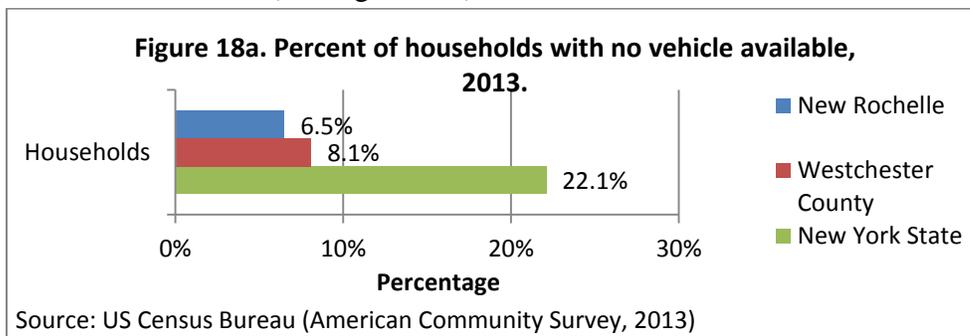


- In 2013, 39.4% of occupied housing units in New Rochelle were built in 1939 or earlier and 28% of occupied housing units were built between 1940 and 1959. In Westchester County, 32.3% of occupied housing units were built in 1939 or earlier and 27.5% were built between 1940 and 1959. 32.7% of occupied 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).

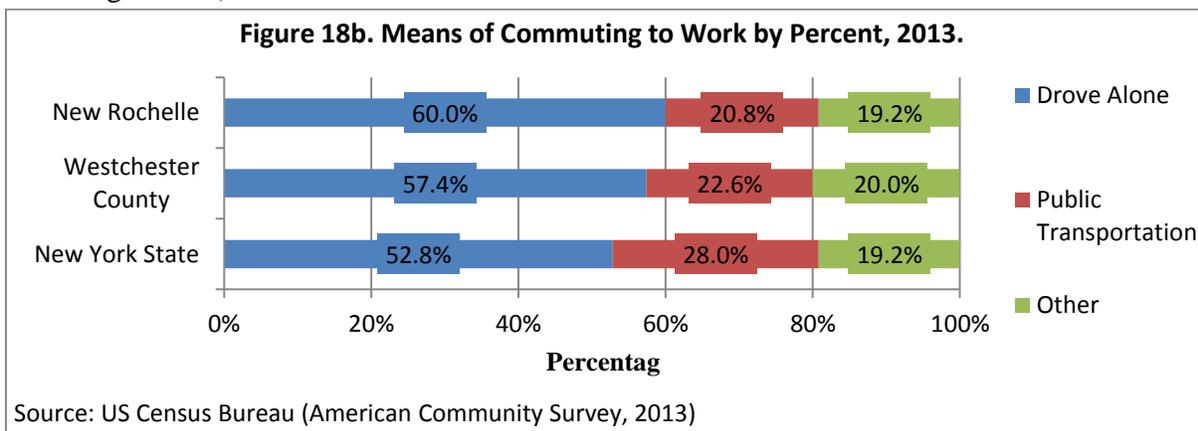


**G. Transportation and Transportation Safety**

- 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.
- 

### **3. Public Participation**

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, the community advisory group platform 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.

While a formal advisory board was being developed at Montefiore New Rochelle, Montefiore was concurrently engaged in the completion of a community health needs assessment (CHNA) as a part of its submission for the Delivery System Reform Incentive Payment Program. The CHNA for this submission was a part of a One Region – One CNA (Community needs Assessment) process for which Montefiore conducted focus groups, electron and paper surveys and community information sessions. The input from these multiple surveying opportunities was used to assist in gathering public input on the health concerns across New Rochelle and the region.

In addition to this process, Montefiore New Rochelle Hospital participates in a variety of organized partnerships and collaboratives, working with other health service providers and community-based organizations and members of the community in planning and developing initiatives aimed at improving the health of the people in New Rochelle and the surrounding region. Montefiore New Rochelle Hospital also works closely with county leadership across the Westchester County Departments of Health, of Senior Programs and Services, of Social Services and of Mental Health, and has developed collaborative approaches to the assessment of community needs and health priorities and to the establishment of partnerships with community organizations.

Through the sharing of primary and secondary data collected by Montefiore and through its collaborations with other regional partners, the impact on the community's health by the interventions implemented can be measured and analyzed.

In Section 4, Assessment and Selection of Health Priorities, the participants from the County Health department, as well as the membership from Local acute and specialty hospitals, as well as the three local Federally Qualified Health Centers are listed.

**4. Assessment and Selection of Health Priorities**

**Collaborative Process and Criteria to Identify Priorities**

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.

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.

Beginning in January 2013, the Westchester Department of Health Commissioner initiated a series of meeting 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. Several of the members of the pre-existing hospital entities prior to the development of Montefiore New Rochelle Hospital (formerly known as Sound Shore Medical Center) were present, and are still employed by MNRH to provide continuity to this process.

**Westchester County Health Planning Team Members**

<b>Organization</b>	<b>Name</b>	<b>Title</b>
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
New Rochelle 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 Center	Rosemary Martino	Vice President, Clinical System Development
	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

<b>Organization</b>	<b>Name</b>	<b>Title</b>
Westchester County Department of Health  (*Staff who either participated in planning meetings and/or	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

provided data analysis and/or other input.)	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

After a careful consideration of the available data and discussions across the stakeholder group, two priorities were identified that applied to all the agencies and to the County. These were:

1. Prevent Chronic Disease: Reduce Racial Disparities by Decreasing the Percentage of Blacks and Hispanics Dying Prematurely from Heart Related Diseases, and
2. Promote Healthy Women, Infants and Children: Increase the proportion of infants that are Breastfed.

Through localized collaborations with large stakeholder groups and awareness of the health and healthcare status of New Rochelle, being in a county that ranks 7<sup>th</sup> for health outcomes, 5<sup>th</sup> for health factors risk and 1<sup>st</sup> for health behaviors of 62 counties in the RWJ Foundation health rankings, the disparities in the city of New Rochelle, as compared to the county indicate that that decreasing premature death rates among Blacks & Hispanics due to heart-related diseases and increasing breastfeeding rates would have a significant impact on New Rochelle’s community health status.

**Targeted Interventions for New Rochelle**

**Reducing Racial Disparities in Heart Related Diseases**

Through the county wide process initiated in January 2013, the identified ratio of the percentage of Non-Hispanic Black to non-Hispanic White deaths due to diseases of the heart was 2.61 to 1. For Hispanics to Non-Hispanic White it was 3.35 to 1 across Westchester County. These disparities persisted when examining average age at death by race and ethnicity from the period 2008-2010 with the county wide average age being 77.2, with the non-Hispanic white rate existing at 79.9 and the non-Hispanic Black and Hispanic rates at 69.1 and 62.6 years respectively. With the percentages of premature deaths as a percentage of all deaths for the county presenting as a remarkable 46.9% for the Hispanic population and 36.8% for the non-

Hispanic Black population as compared to only 14.8% for the non-Hispanic White population, reducing racial disparities in heart related diseases was identified as a priority.

One of the most significant correlates to heart related diseases is smoking. Cigarette smoking accounts for about one-fifth of all deaths from heart disease in the United States. Smokers have a two- to fourfold increase in coronary artery disease and about a 70 percent higher death rate from coronary artery disease than do nonsmokers. Smoking is a major risk factor for heart disease. Smoking and tobacco use are significant risk factors for a variety of chronic disorders. According to the American Heart Association, cigarette smoking is the most important preventable cause of premature death in the United States, accounting for 440,000 of the more than 2.4 million annual deaths. As such, Montefiore New Rochelle Hospital will engage the POWR Tobacco Cessation Program of the American Lung Association funded through the New York State Tobacco Control Program as a means to address the disparities in premature deaths from heart related diseases.

### Maternal and Infant Health

As one of the largest delivery hospitals in the Bronx and southern Westchester County region, while we have demonstrated a strong commitment to maternal and infant health, mothers in the Bronx and Westchester County continue to report lowered ongoing breastfeeding rates. Montefiore has invested to improve maternal and infant health, including a partnership with the March of Dimes to reduce rates of low birth-weight and premature births, and operation of one of the city's largest WIC programs, providing health education and nutrition support to poor mothers, infants and children. Montefiore has embraced the Latch On NYC program at each of our Bronx delivery hospitals, which has been formally endorsed by the New York State Department of Health, Greater New York Hospital Association, Academy of Family Physicians, New York County Chapter, American Academy of Pediatrics, District II, New York State and the Society for Adolescent Health and Medicine, New York State Chapter. For Montefiore New Rochelle Hospital, movement toward the baby Friendly Hospital designation is the next step in the promotion of health infants and families in the region.

## **5. Two Year Plan of Action—2014-2017**

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 will support the Montefiore New Rochelle commitment to support mothers who choose to breastfeed by 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 New Rochelle Neighborhood Health Center saw a total of 648 infants of which 21 were fully breastfed, 278 were partially breastfed and 349 were fully formula fed. 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 is 2017. Achievement of the entire Latch on NYC protocol is also expected to be achieved by 2017. Montefiore has established a Breastfeeding Committee that contains an inter-organizational, interdisciplinary membership from Montefiore, 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.

## **6. Dissemination of the Plan to the Public**

The plan to disseminate the delivery of the Montefiore Medical Center 2015-2017 Community Service Plan report to the public will occur across a number of platforms:

- The Community Service Plan will be posted to the [www.montefiore.org](http://www.montefiore.org) website at the specific address <http://www.montefiore.org/documents/CSP2015-2017/nr.pdf> It can also be found through accessing the general [www.montefiore.org](http://www.montefiore.org) site and clicking the Community Reports tab located in two areas of the face page, both under the Community tab or by scrolling to the bottom of the page where Community Reports is provided as hyperlinked text which can take a viewer directly to the report.

- The Community Service Plan will be mailed out in hard copy to members of the Montefiore Board, as well as provided to community leaders and elected officials. To facilitate this distribution, a copy of the direct link is also provided specifically to the distribution link of the Mayor of the City of New Rochelle, which maintains the city's largest electronic communication list and can provide dissemination beyond the traditional healthcare partners. Additionally a link will be posted on the city's website at [www.newrochelleny.com](http://www.newrochelleny.com) .
- A QR code for the link to the report will be made available for print materials to facilitate ease of access to the report. The QR code, accessible through most smart phone readers, for the site is provided below.



- Montefiore will announce through its multiple social media platforms the availability of the Community Service Plan which will be available through the following feeds:
  - Facebook: <https://www.facebook.com/montefioremedicalcenter>
  - Twitter: <https://mobile.twitter.com/MontefioreNYC>
  - YouTube: <http://www.youtube.com/user/MontefioreMedCenter>

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

## **7. Maintaining Engagement**

As Montefiore has selected multiple areas in which to address health priorities, the plan for each group is differentiated below and each group will operate on a separate schedule. To take advantage of our core activities, Montefiore has in place standing advisory boards that address operational concerns in both the Acute and Ambulatory Care environments that review and inform, from a community perspective, on the implementation of these activities. There are also

multiple formal committees operated by Montefiore, and in which Montefiore is a participant or coalition member that serve as opportunities for ongoing engagement.

In Focus Area 3 – Increasing Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings, Goal 3.3.1 - Increasing screening rates for cardiovascular disease, especially among disparate populations, Montefiore expand its screening of patients at risk for cardiovascular disease and will enhance its relationship with the POWR Tobacco Cessation Program of the American Lung Association funded through the New York State Tobacco Control Program, which serves Westchester, Putnam, Orange and Rockland, to address the needs of patients and the community that current tobacco/nicotine consumers to avert the negative impacts of these products generated by long term use.

Through the incorporation of Focus Area 2 – Reducing Illness Disability and Death related to tobacco use and second hand smoke in addressing causes of premature death from heart related diseases, we will measure and document the progress on Objective 2.2.1 - increase the number of unique callers to the NYS Smokers' Quitline; Objective 2.2.2 - decrease the prevalence of cigarette smoking by adults ages 18 years and older, and Objective 2.2.3 - increase the utilization of smoking cessation benefits among smokers who are enrolled in Medicaid Managed Care. Additionally Montefiore is pursuing expanding the integration of the Fax to Quit Program into the Opt-to Quit model.

The second area that Montefiore – New Rochelle is addressing is under the priority area *Promote Healthy Women, Infants and Children*. In Focus Area 1 of the section – Maternal and Infant Health, Objective 2.2.1 - increase the percent of infants born in NYS who are exclusively breastfed during the birth hospitalization, we anticipate the maintenance of this work externally through the collaboration with our enterprise wide solutions for breastfeeding with the adaptation of the Baby Friendly Hospital Designation. Within Montefiore, as we have three active campus based breastfeeding initiatives, we will continue to monitor the breastfeeding initiation compliance rates and pursue recognition as a baby friendly hospital.

Through the various collaborations for the multiple initiatives that we are undertaking, each has both an internal committee structure to monitor compliance with our own patient populations and an external committee structure to provide a comparative analysis of our institutional progress against borough-wide and/or citywide rates and present opportunities to track our progress and make mid-course corrections as appropriate.

## **8. Financial Aid Program**

Montefiore has a charity care program which is a model program, providing outreach, enrollment assistance and charity care. Staff informs all patients receiving services who are uninsured or underinsured about the program. Information on the financial aid policy and procedures is provided to patients, in both English and Spanish, including brochures available in all the patient service areas, information posted on the intranet and internet, and information on the bills sent out to patients. When a patient requests a financial aid consultation, we set up an interview, send out an application to be completed, or interview patient at time they present if they have required documentation on hand. Montefiore assists all walk-in patients from the community with their inquiries and will complete a Medicaid application whether or not they have already been seen at one of our facilities. We believe all patients that are eligible should be guided through the application process.

Our program first attempts to assist the patient in getting enrolled in a state program. We recognize that if they are enrolled they will be able to fill their prescriptions and see physicians. Montefiore has made major investments in manpower to support the patient through this process. We have staff located at all our facilities that can complete an application and send it to HRA. Our success can be measured by the number of patients who were enrolled in the Medicaid program (excluding patients enrolled in PCAP). If a patient gets enrolled in Medicaid, but the enrollment does not cover the period of time the service occurred, the payment for that treatment episode is considered charity care.

We believe our approach to financial aid for patients improves the access to care and the quality of care because patients will not be hesitant to see their primary care physician and in turn reduces the use of the emergency room for their non-emergent care. We believe that this has been our greatest success. The financial aid program has also provided patients with access to a primary care provider, since there are no longer concerns about insurance coverage. This ultimately has a positive effect throughout our community.

## APPENDIX A: Data Sources Definitions

### Data Sources

The development of the community service plan resulted from an extensive review of available secondary and primary data sources documenting health status in both the municipality of New Rochelle as well as Westchester County. Multiple secondary data sources utilized to inform the community and key stakeholders to justify the identification and selection of the priority items. The data sets that were used to identify the issues of concern beyond experience and direct observation are listed below.

#### *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](http://CHNA.org).

Custom area estimates for New Rochelle are generated for this indicator 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.

#### *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>.

Custom area estimates for New Rochelle are generated for this indicator 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.

#### *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/>.

Custom area estimates for New Rochelle are generated for this indicator 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.

*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](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/about.htm).

Custom area estimates for New Rochelle are generated for this indicator 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.

*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/>.

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