Community Health Needs Assessment and Implementation Plan 2016-2018

Montefiore Medical Center

Office of Community and Population Health

12/6/2016

This document is submitted as the requirement for the 2016-2018 Community Health Needs Assessment and Implementation Plan for the IRS – 990 Schedule H Requirements.

Montefiore Medical Center

Community Health Needs Assessment and Implementation Strategy 2016

1. Executive Summary

The Community Health Needs Assessment Requirement

The Affordable Care Act requires hospitals to assess and address the health needs of the communities they serve. This Community Health Needs Assessment meets the first component of these requirements, providing a report of the process, methods and results of a comprehensive assessment of the needs of the community served by Montefiore Medical Center. The second component encompasses the Implementation Strategy, which will further discuss the significant health needs of the community, describe the programs and strategies to address these significant health needs, and delineate the metrics to be used to evaluate the impact of these strategies.

Montefiore Medical Center's Community Health Needs Assessment (CHNA) process and secondary data was approved by the Community Services Committee of the Board of Trustees on December 6, 2016. The Community Health Needs Assessment (CHNA) report was uploaded to the Montefiore website December 31, 2016.

Montefiore Medical Center's Community Commitment

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

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

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

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

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

Montefiore participates in a variety of organized partnerships and collaborative, working with other providers in the Bronx, the New York City Department of Health and Mental Hygiene, community-based organizations in the Bronx and members of the community in planning and developing initiatives aimed at improving the health of the people of the Bronx.

Definition and Description of the Community

Montefiore has identified the Bronx as its primary service area. More than 85% of Montefiore's hospitals' discharges are residents of the Bronx, and it is within this geographic area that Montefiore has distributed the vast majority of its community-based primary care and specialty ambulatory services.

The Bronx has been an epicenter of the asthma, HIV, and drug epidemics and also has excess mortality rates from heart disease, stroke, and diabetes compared to city-wide and national averages. As the Bronx mortality rates remain significantly high, the number of physicians practicing in the Bronx continues to dwindle, earning the county a federal Health Professional Shortage Area (HPSA) designation.

Bronx County is New York City's first borough to have a majority of people of color and it is the only borough with a Latino majority. The Bronx is amongst the youngest counties in New York State with a median age of 33.6 and 25.3% of the population being under the age of 18 years. The Bronx has the highest proportion of single-parent headed households in the US (19.2%). Furthermore, the Bronx has qualified as a Whole County Health Professions Shortage Area (HPSA) by HRSA, since 2008, as almost half (45%) of our population is currently living in a HPSA designated geographic area.

Assessment of Community Health Needs

The process to identify the needs of the community involved the collection of secondary and primary data.

Multiple conversations and meetings were convened internally and with external partners, and a thorough review of the data was conducted, all of which will frame the development of the Implementation Strategy. In this Community Health Needs Assessment, these collaborations and partnerships are described.

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

The collection of primary data from a representative sample of the Bronx residents was an important element of the development of the Community Health Needs Assessment. The Bronx is an ethnically diverse borough with a population of 1.4 million that despite economic and environmental improvements since the 1970's continues to include numerous groups with difficulties such as low health literacy, limited income, English proficiency, and lack of insurance or insurance knowledge. To capture the voices of various sectors of Bronx community residents and workers from various perspectives, a mixed-methods approach to data collection consisting of coordinated focus groups and participation in conjunction with the New York City Department of Health and Mental Hygiene's Community Consultations process as well as multi-lingual electronic surveying directed through partnering Bronx organizations was used.

Montefiore engaged with both the New York City Department of Health and Mental Hygiene's Community Conversation process, as well as the Westchester County Department of Health's online Community Resident and Provider Health Surveys to facilitate the implementation of the primary data collection process for the Community Health Needs Assessment for Bronx County and to assist in the facilitation of these community level connections thereby alleviating additional surveying overload.

Using data collected through these sources, the impact on the community's health by the interventions implemented can be measured and analyzed. As the borough with the smallest non-Hispanic White population in New York City, focusing on disparities is inherent in everything that Montefiore accomplishes. The priority areas selected and each of the planned interventions focus on specific priority populations and address the ethnic and cultural disparities of the population served by Montefiore.

Collaborations/Partnerships

In 2014, Montefiore lead a multi-stakeholder application to the Robert Wood Johnson Foundation's Culture of Health Prize which was awarded to the Bronx in 2015 in recognition of the significant collaborative achievements the county has made in health. . However, despite these gains, the Bronx continues to have the lowest ranking in New York State, ranking 62 out of 62 in the 2016 County Health Rankings from the Robert Wood Johnson Foundation. The Culture of Health stakeholder group continues to work collaboratively to address agreed on significant health issues impacting the community and has formed a County wide coalition, the #Not 62 Coalition – The Campaign for a Healthy Bronx.

In addition to the county-wide coalition, Montefiore collaborated with the New York City Department of Health and Mental Hygiene's (NYCDOHMH) Community Consultations to prepare this CHNA. We reviewed the Take Care New York 2020 Priorities and identified points of alignment between the New York State priorities, the New York City Goals and the needs identified through the CHNA data review process. In 2016, the data collection process was expanded to include factors related to the Social Determinants of Health, which have been acknowledged to have broad reaching impact on addressing community health outcomes. The top 5 identified priorities in the Bronx (not in ranked order) were (1) Obesity, (2) High School Graduation, (3) Smoking, (4) Air Quality and (5) Child Care, which were identified from eight community meetings. Obesity received, by far, the highest average score, earning an average ranking of 17.5 out of 23, compared to high school graduation (15.1 out of 23), which was second. Obesity was the only priority identified as a top five concern in each of the eight community meetings.

In addition to this collaborative input from NYCDOHMH, Montefiore worked closely with its communities by working with a variety of community advisory boards (CABs). Montefiore participates in a variety of organized partnerships and collaboratives, working with other providers in the Bronx, and we worked extensively with representatives of the affected communities through these CABs to identify health care needs and determine the appropriate configuration of services. Beyond the formal structure that Montefiore established to gain input from the communities it serves, the medical center participates in a variety of organized

partnerships and collaboratives, working with other providers in the Bronx, the NYCDOHMH, community-based organizations in the Bronx and members of the community in planning and developing initiatives aimed at improving the health of the people of the Bronx. Montefiore has developed additional approaches to the assessment of community needs and health priorities and to the establishment of partnerships with community organizations.

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

The report provides information on the individuals, groups and organizations that are participating in the focused Implementation Plan activities that evolve out of the CHNA process. As the CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) review, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. Montefiore will continue to work with its partners on existing program initiatives.

Prioritization of Community Health Needs

A review of the results from the primary and secondary data collection process illuminated two major categories of health needs that were important across the populations surveyed, reflected in the data as critical, and in alignment with the New York State Prevention Agenda. The first of two Priority Areas identified with key data points highlighted are to **Prevent Chronic Disease** with the two focus areas selected. The first focus area is **(1) Reducing Obesity in Children and Adults**, for the targeted objective to decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day by 5% from 20.5% (2009) to 19.5% among all adults and by 10% from 42.9% (2009) to 38.6% among adults with an annual household income of < $25,000. The second focus area is (2) **Increasing Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings** with the goal of increasing screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations, with a specificc objective chosen to increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%.

The second of the two Priority Area selected is to **Promote Healthy Women Infants and Children** with the goal selected to **Reduce Premature Births**, and the targeted objective of reducing the rate of preterm birth in NYS by at least 12% to 10.2%. Additional measures correlated to high rates of preterm birth will be collected and include:

- % of adults 18 years and older who consume one or more sugary drinks per day (NYS CHS)
- % of respondents ages 18 years and older who smoke or use tobacco some days or every day (HCAPS)
- % of respondents who discussed or were recommended cessation medications (HCAPS)
- % of respondents who discussed or were provided cessation methods or strategy (HCAPS)
- % of patients with diabetes who received the following tests: A1C, cholesterol, eye exam, nephropathy (HEDIS)
- % of patients with diabetes whose most recent A1c >9% (HEDIS)
- % of patients with diabetes whose most recent LDL was <100 (HEDIS)

The disparities that we hope to reduce will largely be focused on race/ethnicity. In preparation for this we are optimizing our ability to capture this information in our electronic health record. This will enable us to assess health disparities for many of the quality measures listed above.

Measures and Identified Resources to Meet Identified Needs

Internal Resources and Measures

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

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

Across the identified significant priority areas, numerous indicators with associated metrics are described which will be utilized to demonstrate improvements needed to provide evidence of the impact of Montefiore's efforts in addressing the health needs of its community.

New York State Health Improvement Plan - Implementation Plan and Measures

As a part of the Montefiore Community Service Plan submission for the New York State Health Improvement Plan for 2016-2018, required by the New York State Department of Health, several broad focus areas in two priority areas were identified - Preventing Chronic Disease and Promoting Healthy Women, Infants and Children, in addition to the large array of services provided by Montefiore. These broad focus areas are (1) Reducing Obesity in Children and Adults through education and increasing access to high quality chronic disease preventive care and management in both clinical and community settings, and (2) Improving Maternal and Infant Health. Across these focus areas, six goals, with specific interventions, performance measures and time frames, were identified.

> **(1) Preventing Chronic Disease with a specific focus on reducing obesity in children and adults.**
>
> **(2) Promotion of Healthy Women, Infants and Children with a specific focus on Maternal and Infant Health.**

The two Priority Areas selected in 2013 have been re-selected in 2016, though one of the focus areas changed from increasing breastfeeding to reducing premature births as a way to create better alignment with the initiatives of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program. DSRIP has a very strong focus on both the prevention and management of chronic diseases and behavioral health issues (including

substance abuse), and given these are significant risk factors for premature births, we believe that by continuing our chronic disease prevention work in our clinics and extending our reach into the community, we can significantly reduce preterm births.

External Resources and Linkages

In addition to the multiple resources that have been developed at Montefiore independently and through partnership with other organizations, there is an extensive set of resources that are available to meet the needs of Bronx residents which cannot be met entirely by Montefiore programs and services, or that choose to utilize external organizations. In advancement since 2013, multiple free and lost cost internet databases have entered the public sphere, such as www.auntbertha.com , www.hitesite.org , www.nowpow.com among others that have reduced the need for quickly-obsolete and expensive-to-produce information and community resources referral guides. As Montefiore is an organization that works with complex health needs and whose community faces multi-factorial crises that impact upon overall health, providing information, accessibility and review of such external resources and links provides additional information on available resources to address community needs for our community partners.

2. Introduction

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

Montefiore Health System includes eleven hospitals, including a rehabilitation hospital, a state of the art surgical/specialty center campus "hospital without beds", a multi-county ambulatory network, a skilled nursing facility, a school of nursing, two home health agencies and the state's first freestanding emergency room. With our new member and affiliate locations in Westchester, Rockland and Orange counties, Montefiore's regional integrated delivery system now offers patients highly specialized clinical expertise close to home.

2a. Montefiore's Mission Statement and Strategy:

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

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

An update of the Strategic Planning Process was completed in January 2009 which included the 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

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

1. Advancing the partnership with the Einstein College of Medicine
2. Creating notable Centers of Excellence
3. Building specialty care broadly
4. Developing a seamless delivery system with superior access, quality, safety and patient satisfaction
5. Maximizing the impact of our community service

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

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

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

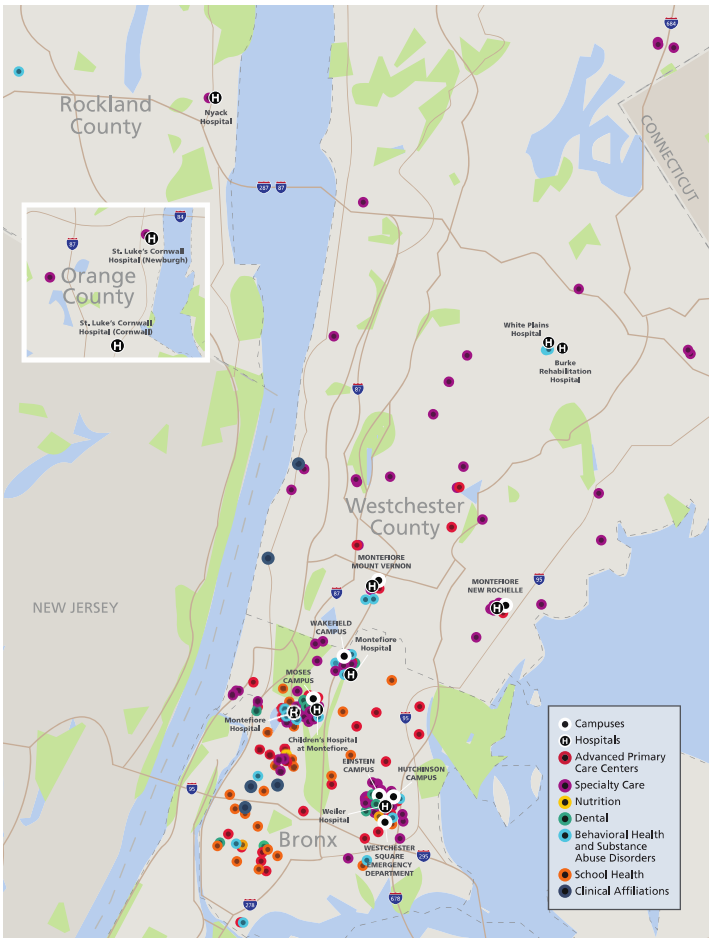
2b. Community Health Needs Assessment Submission Date

Montefiore Medical Center's Community Health Needs Assessment (CHNA) process and secondary data was approved by the Community Services Committee of the Board of Trustees on December 6, 2016. The Community Health Needs Assessment and Implementation Report (CHNAI&R) report was uploaded to the Montefiore website December 31, 2016.

Definition and Description of the Community/Service Area

For the purposes of this Community Health Needs Assessment, Bronx County is the defined Community/Service Area for this Assessment. For Montefiore Medical Center, this includes four hospital campuses (Moses/Children's Hospital at Montefiore, Einstein, Wakefield, and the Hutchinson Metro Center), as well as the freestanding Emergency Department at the Westchester Square campus and an ambulatory/specialty care network of nearly 200 locations throughout the Bronx and Westchester counties.

Figure 1. Montefiore Health System Locations



Montefiore also operates a range of programs focusing on the needs of special populations:

- Montefiore's School Health Program (MSHP) provides comprehensive primary care to a population of elementary, middle and high school students throughout the Bronx. Founded in 1983, the MSHP is the largest and most comprehensive school-based health program in the country and a major community outreach program for children living in the Bronx. Currently, the MSHP provides a range of medical, mental health, reproductive and health promotion services to 25,000 students who make over 90,000 visits per year.

- The Montefiore Substance Abuse and Treatment Program/ Division of Substance Abuse (SATP/DOSA) is an 11-site substance abuse treatment program that offers drug treatment and rehabilitation services and comprehensive primary care to a population of 4,500 recovering substance abusers in communities across the Bronx.

- Montefiore provides a wide array of targeted outreach services to at-risk populations within its service area, including programs serving the homeless and victims of domestic violence, mothers at risk of premature birth, as well as services to homebound and/or fragile seniors in community-based settings throughout the Bronx.

3. Definition and Description of the Community/Service Area

3a. The Population of the Bronx

Montefiore has identified the Bronx as its primary service area. In 2015, the population of the Bronx was 1.46 million. The Bronx is the nation's poorest urban county; in 2015, according to the American Community Survey, 27.9% of families live in poverty (compared to 16.8% citywide) and the median household income is $35,176 (compared to $51,141 in Brooklyn, 60,422 in Queens, 71,622 in Staten Island and 75,575 in Manhattan). Forty-three percent of Bronx children live below poverty; the ninth highest proportion for any county in the United States, and the highest for any urban county. The Bronx is amongst the youngest counties in New York State, with a median age of 33.6, trailing only Tompkins County and Jefferson County; 25.3% of the population is <18 years. The Bronx has the highest proportion of single-parent headed households (19.2%) among counties in the US. In 2015, Montefiore served approximately 500,000 Bronx residents, or roughly 36% of the total Bronx population.

In the Bronx, according to 2015 Census data, 35.8% of households received Supplemental Nutrition Assistance Program (SNAP, formerly referred to as food stamps) benefits, compared to 15.4% in New York State overall and 17.0% in the rest of NYC (excluding the Bronx). During the same time period 55.5% of children less than 18 years lived in a household that received some form of public assistance (including Supplemental Security Income [SSI], cash assistance or SNAP/food stamps), compared to 28.9% statewide and 32.1% in the rest of NYC.

According to the Bureau of Labor Statistics, the unemployment rate in the Bronx in 2015 was 7.7%, the highest in New York State. In 2015, 71.2% of Bronx residents ages 25 and older have received their high school diploma or GED, though this is substantially lower than citywide (81%) and statewide (86%) attainment rates.

More than 87% of Montefiore Medical Center's hospitals' discharges are residents of the Bronx, and it is within this geographic area that Montefiore has distributed the vast majority of its community-based primary care.

The Bronx is one of the most diverse counties in the nation according to the 2015 American Community Survey, 10.0% was non-Hispanic White, 29.3% non-Hispanic Black, and 55.1% were Hispanic/Latino of any race. More than one-third (35.3%) of Bronx residents in 2015 were born outside of the United States and 51.9% of births among Bronx residents were to foreign-born mothers in 2014 according to New York City Vital Statistics data. In the Bronx, more people speak a foreign language at home (predominantly Spanish [48.2%]) than speak "only English"

(39.9%). The Bronx was New York City's first borough to have a majority of people of color and is the only borough with a Latino majority. Only three counties in the eastern United States have a lower portion of Non-Hispanic whites and only one has a higher proportion of Latinos (Miami-Dade County). Its new immigrants come from diverse corners of the globe (in order of frequency): the Dominican Republic, Jamaica, Mexico, Ecuador, Guyana, Ghana, Honduras, Italy, Trinidad & Tobago, and Bangladesh. As the population in the Bronx is exceptionally diverse, improvements in the health of the general population must necessarily address ethno/cultural/race based disparities.

As over 80% of individuals served by Montefiore are represented in the above demographics, the ethnic, gender and socio-economic health disparities that are challenging the Bronx population will be encountered, acknowledged, recorded and addressed.

3b. A Snapshot of Health Disparities in the Bronx

While the Bronx has continued to improve, along with New York City, in the overall reduction of negative health outcomes, the gap between the Bronx and the other boroughs remains and it has maintained its status as the epicenter of the asthma, HIV, and drug epidemics in New York City. The County also continues to demonstrate excess mortality rates from heart disease, stroke, and diabetes compared to citywide and national averages.

Mortality Rates

In 2014, based on data from the New York City Department of Health and Mental Hygiene (NYC DOHMH), the Bronx had the highest age-adjusted all-cause mortality rates (640 per 100,000) in New York City (580 per 100,000 for all of NYC). According to the 2015 County Health Rankings from the Robert Wood Johnson Foundation, the Bronx has the 58th out of 62 highest rates of premature death, losing 7,050 years before 75 per 100,000 compared to 5,457 per 100,000 compared to New York State. The leading causes of death among Bronx residents in 2014 were coronary heart disease (194 per 100,000), cancer (152 per 100,000), influenza & pneumonia (27.3 per 100,000), chronic lower respiratory disease (23.3 per 100,000), and diabetes mellitus (22.8 per 100,000). For each of these causes of death, rates were higher in the Bronx as compared to NYC overall.

Asthma

According to the NYCDOHMH Community Health Survey in 2014, 14.2% of Bronx adult residents reported that they had been previously diagnosed with asthma. The percentage of Bronx adults with asthma was higher than the New York City percentage of 11.3%. According to the NYSDOH, in 2014, the emergency department visits per 100,000 for asthma was 274 per

100,000, more than twice that of NYC overall (134 per 100,000) and 5-times the statewide rate (85 per 100,000). The age-adjusted death rate due to chronic lower respiratory diseases among Bronx residents was 23.3 per 100,000 in 2014; higher than the New York City rate of 20.0.

Diabetes

According to the NYC DOHMH CHS in 2014, 14.0% of adults in the Bronx reported that they had previously been diagnosed with diabetes, compared to 10.7% citywide. From 2002-2014, the prevalence of diabetes among Bronx adults remained higher than the citywide prevalence. According to the NYSDOH, the average (age-adjusted) rate of hospitalizations for short-term complications of diabetes per 10,000 from 2012-2014 was 117 per 100,000 in the Bronx, significantly higher than the New York City rate of 71 and statewide rate of 65 per 100,000. The age-adjusted death rate due to diabetes was 23 per 100,000 Bronx residents in 2014; higher than the New York City rate of 19.9 per 100,000. In both the Bronx and NYC overall, the mortality rate due to diabetes declined.

Obesity

In 2014, based on data from the NYC DOHMH Community Healthy Survey, the Bronx had the highest prevalence of adult obesity (defined as body mass index≥30 kg/m^2); 30.3% compared to 24.7% citywide. The prevalence of obesity increased in the Bronx through 2012, peaking at 31.9%, stabilizing thereafter. Similar to adult obesity, the Bronx has the highest rates of obesity among children, 13.4% vs. 11.8% in the rest of New York City, though like adult obesity, the prevalence appears to be declining (down from 15.3% in 2003).

HIV/AIDS

Based on data from the New York State Department of Health in 2014, the Bronx (36.2 per 100,000) has the second highest incidence (new cases) of HIV, trailing only Manhattan (40.8 per 100,000). Despite this difference, the trends in HIV incidence in the Bronx are encouraging; they have declined approximately 59% from 2002 to 2014, from 87.4 per 100,000 to 36.2 per 100,000.

3c. Medically Underserved Communities

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

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

The Bronx has 18 MUA neighborhoods, with a combined population of 815,000. Most of these neighborhoods are located south of Interstate 95 (I-95), which is where most of the primary care HPSA designations are located. An additional six Bronx neighborhoods may also qualify for MUA designation. The Bronx has eight Primary Care HPSA designated neighborhoods (Morris Heights, Highbridge, Soundview/West Farms, Morrisania, Tremont, Parkchester/Throgs Neck, Fordham/Norwood, and Hunts Point/Mott Haven), six Mental Health HPSAs (West Central Bronx, Hunts Point/Mott Haven, Soundview, Parkchester/Throgs Neck, Kingsbridge/Riverdale, and Fordham/Norwood), and three Dental HPSAs (Central Bronx, Southwest Bronx, and Morris Heights/Fordham).

4. Assessment of Community Health Need

4a. Description of Process and Methods

The process for preparing the 2016-2018 Community Health Needs Assessment was an inter-organizational and community collaborative process, initiated with the goal of developing an assessment that was reflective of the needs of the community including the clinical and social determinants of health. Moreover, as the clinical service providers and social service organizations had been over sampled due to the near simultaneous compilation of reports and state/federal proposals during the period, novel collaborations with the local departments of health were implemented for the collection of primary data, while secondary data sources are noted in Section 4.a.i.

Primary Data Collection Process and Methods

The New York State Department of Health required that the Community Health Assessments (CHA) to be conducted by the local Departments of Health were to be conducted in 2016 as opposed to 2017 when they were previously scheduled. In previous years, results from the CHA had been used as an important secondary data element.

Three primary data collection strategies were used to triangulate the identification of community health priorities in the Bronx, including: 1) the 2014 Community Needs Assessment (CNA) conducted by the New York Academy of Medicine (NYAM), 2) the New York City Community Consultations, implemented by the New York City Department of Health and Mental Hygiene, and 3) a survey of Bronx residents implemented in collaboration with the Westchester County Department of Health to support the CSPs/CHNAs for hospitals in Westchester County. The methods and key results of each of these primary data collection activities are summarized below. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

2014 Community Needs Assessment

Montefiore participated in the 2014 Bronx-wide Community Needs Assessment (CNA) process conducted by the New York Academy of Medicine on behalf of several Bronx Delivery System Reform Incentive Payment (DSRIP) Participating Provider Systems (PPS). The NYAM CNA

included both primary and secondary data collection, with both a review of public datasets as well as community focus groups and surveys.

New York City Community Conversations

Overview & Methods

We leveraged data collected by the New York City Department of Health & Mental Hygiene (NYC DOHMH) from the Take Care New York 2020 (TCNY 2020) Community Consultations[1]. The Community Conversations were spearheaded by NYC DOHMH to support hospitals in preparing their CHNAs and CSPs.

The Community Consultations were held across New York City, with eight events held in the Bronx, corresponding roughly to Community Districts with high rates of poor health outcomes. Participants were asked to rank 23 health priorities (e.g., obesity, violence, asthma or smoking) in order of importance to their community.

In order to make the Community Consultations accessible to as many New Yorkers as possible, DOHMH staff with expertise in policy, communications, community engagement and intergovernmental affairs collaboratively selected Consultation sites based on the following criteria:

- Location within, or proximity to, neighborhoods with high rates of poor health outcomes
- Accessibility by subway or, in the case of outer neighborhoods, by other common modes of transportation
- Availability of a free or inexpensive venue meeting the following requirements
- Neutral and welcoming space
- Open during evening and/or weekend hours
- Layout accommodating to small group discussions
- AV equipment

The Community Consultation results aim to inform the development of strategies to improve population health outcomes through a focus on closing health equity gaps. This is why DOHMH prioritized outreach efforts to lay community members living in neighborhoods with high rates of poor health outcomes. DOHMH did this by using internal communication channels and leveraging outreach support from sister agencies, healthcare organizations, nonprofit organizations, city officials (elected and non-elected), and faith-based leaders. We provided grants to 11 community organizations to support our outreach efforts.

[1] More details on the TCNY 2020 Community Consultations can be found here: https://www1.nyc.gov/site/doh/health/neighborhood-health/tcny-community-consultations-results.page

Press announcements and print media

- At the launch of the Community Consultations, DOHMH targeted press outreach at large-circulation newspapers in order to raise overall awareness of the process
- Once the Consultations were ongoing, DOHMH targeted additional press outreach at local outlets, community calendars and blogs serving the neighborhoods where Consultations were being held
- DOHMH did an additional press release at the launch of Online Voting

Social media

- DOHMH promoted each Consultation and Online Voting on our website, and partners promoted select Consultations on their own websites
- DOHMH created a Facebook event page for each Consultation, with some pages created in more than one language
- DOHMH and partners additionally promoted each Consultation and Online Voting through Twitter and Facebook posts
- DOHMH paid for sponsored social media promotion targeting social media users based on their location

Dissemination of print materials (flyers, posters, postcards)

- Print materials in multiple languages were hung and disseminated in the venues hosting the Consultations and nearby public spaces
- Print materials were directly handed out to community members by staff and partners who canvassed the neighborhoods near the Consultations

Word-of-mouth

- DOHMH staff and partners spoke directly with local organizations (churches, businesses, schools, housing developments, arts organizations) and residents through street outreach conducted in the days before each Consultation
- DOHMH and partners promoted the Consultations by making announcements at local events, such as church services, school meetings, etc.
- DOHMH and partners sent out emails about the Consultations and Online Voting to lists of additional partners and lay community members

Community consultation outreach targeted participation of lay community members, with special emphasis on those who live in impoverished neighborhoods and are at high risk of poor

health. We used a combined model of in-person consultations and online consultation. We received input from 1033 New Yorkers and 207 Bronx residents (20%).

Residents were asked to select their community district of residence (in the paper ballot at Community Consultations, or in the online survey) and rank a list of indicators provided by DOHMH in order of importance (where 1 = most important). DOHMH analyzed the results using a simple point system, in which each ranking was assigned a point value from 1-23 (with the indicator ranked 1 receiving 23 points, and the indicator ranked 23 receiving 1 point). The indicators that received the most points from all participants' rankings were identified as top priorities.

Preliminary data published earlier in 2016 identified the top priorities of a given Consultation, by collectively analyzing all of the ballots completed and collected at that in-person Consultation. The final results by community district and borough presented above combine the prioritization done at the in-person consultations and the online survey. In order to identify the top priorities of a given borough, DOHMH collectively analyzed all ballots (in-person and online) on which participants had noted a community district of residence located within that borough.

Community Survey

Methods

The survey was disseminated to community based organizations and other partners in the Bronx, and data were evaluated for those working/residing in the Bronx. The survey was administered from August 2016 through October 2016 using SurveyMonkey. Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health.

4.a.i Data Sources & Analytic Notes

Multiple data sources were used to support the identification and selection of the priority items, which were identified, selected, and reviewed with partners.

Secondary Data Collection Process and Methods

A listing and brief summary of the data sources used to complete the secondary data analysis that were used to identify the issues of concern beyond experience and direct observation are listed below.

Listing of Data Sources

i. American Community Survey
ii. New York City Community Health Survey
iii. New York City Youth Behavior Risk Survey
iv. New York State Vital Records Data
v. New York State Statewide Planning and Research Cooperative Systems (SPARCS)
vi. New York State Bureau of HIV/AIDS
vii. New York State Cancer Registry
viii. New York City Community Health Profiles
ix. New York State Prevention Agenda Dashboard

Description of Data Sources

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

New York City Community Health Survey: The New York City Community Health Survey (CHS) is an annual random digit dial telephone survey of the NYC adult population. CHS is a complex survey that provides a representative sample of NYC residents. Addressing a wide range of topics, in the current report CHS data were used to estimate the percent of adults with a primary care provider, the percent of adults who are obese, the percent of adults who are current smokers, the percent of adults who received a colorectal cancer screening, and the percent of adults getting a flu immunization. For more information about CHS please visit http://www1.nyc.gov/site/doh/data/data-sets/community-health-survey.page.

New York City Youth Behavior Risk Survey: The New York City Youth Behavior Risk Survey (YRBS) is an ongoing collaboration of the New York City Department of Health & Mental Hygiene, the

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

New York State Vital Records Data: The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report vital records data were used to examine the percentage of life births that are preterm and the teen pregnancy rate. For more information on the New York State Vital Records please visit: https://www.health.ny.gov/statistics/vital_statistics/

New York State Statewide Planning and Research Cooperative Systems (SPARCS): SPARCS is the primary source of data on ED visits and inpatient hospitalizations at New York State hospitals. All inpatient admissions and ED visits at NYS hospitals are sent to SPARCS and compiled into a master database. SPARCS data was used to estimate the rates of avoidable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, asthma ED visits, hospitalizations for short-term diabetes complications, and hospitalizations for heart attacks. For more information about SPARCS please visit: http://www.health.ny.gov/statistics/sparcs/.

New York State Bureau of HIV/AIDS: Data on HIV incidence (new cases) were obtained from the NYS Bureau of HIV/AIDS, which receives reports of all new HIV diagnoses to NYS residents meeting an established case definition. For more information please visit: https://www.health.ny.gov/diseases/aids/general/statistics/.

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

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

New York State Prevention Agenda Dashboard: An additional resource for data was the New York State Prevention Agenda Dashboard, which was produced by the New York State

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

4.a.ii Collaborations and Partnerships

4.a.ii.1 Partners and Organizations

In 2014, Montefiore lead a multi-stakeholder application to the Robert Wood Johnson Foundation's Culture of Health Prize which was awarded to the Bronx in 2015 in recognition of the significant collaborative achievements the county has made in health. . However, despite these gains, the Bronx continues to have the lowest ranking in New York State, ranking 62 out of 62 in the 2016 County Health Rankings from the Robert Wood Johnson Foundation. The Culture of Health stakeholder group continues to work collaboratively to address agreed on significant health issues impacting the community, specifically diet and exercise, alcohol and drug use, sexual health, access/quality of care and air and water quality and have formed a County wide coalition, the #Not 62 Coalition – The Campaign for a Healthy Bronx.

In addition to the county-wide coalition, Montefiore collaborated with the New York City Department of Health and Mental Hygiene's (NYCDOHMH) Community Consultations to prepare this CHNA. We reviewed the Take Care New York 2020 Priorities and identified points of alignment between the New York State priorities, the New York City Goals and the needs identified through the CHNA data review process. In 2016, the data collection process was expanded to include factors related to the Social Determinants of Health, which have been acknowledged to have broad reaching impact on addressing community health outcomes. The identified priorities in the Bronx (not in ranked order) were (1) Obesity, (2) High School Graduation, (3) Smoking, (4) Air Quality and (5) Child Care which were identified as the top five priorities from the eight community meetings. Obesity received, by far, the highest average score, earning an average ranking of 17.5 out of 23, compared to high school graduation (15.1 out of 23), which was second. Obesity was the only priority identified as a top five concern in each of the eight community meetings.

In addition to this collaborative input from NYCDOHMH, Montefiore worked closely with its communities and ensured that community participation occurred by working with a variety of community advisory boards (CABs). Montefiore participates in a variety of organized

partnerships and collaboratives, working with other providers in the Bronx, and we worked extensively with representatives of the affected communities through these CABs to identify health care needs and determine the appropriate configuration of services. Beyond the formal structure that Montefiore established to gain input from the communities it serves, the medical center participates in a variety of organized partnerships and collaboratives, working with other providers in the Bronx, the NYCDOHMH, community-based organizations in the Bronx and members of the community in planning and developing initiatives aimed at improving the health of the people of the Bronx. Montefiore has developed additional approaches to the assessment of community needs and health priorities and to the establishment of partnerships with community organizations.

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

The report provides information on the individuals, groups and organizations that are participating in the focused Implementation Plan activities that evolve out of the CHNA process. As the CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) review, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. Montefiore will continue to work with its partners on existing program initiatives.

5. Identification of Community Health Needs

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

5a. Secondary Data Analysis

The secondary data used to identify community health needs is described in Section 4.a.i. The secondary data evaluation consists of two distinct approaches. First, we used data from the Statewide Planning and Research Cooperative System (SPARCS) to examine the leading causes of hospitalization, avoidable hospitalizations, and ED visits for Montefiore Medical Center hospitals. Second, we completed an assessment of secondary data for more than 20 core health indicators from several population-based data sources.

Overview of SPARCS Data for Montefiore Medical Center

Top 20 Inpatient Diagnoses in 2015

Table 1 summarizes the top 20 inpatient discharges at Montefiore Medical Center hospitals in the Bronx, this includes Moses, the Children's Hospital at Montefiore, Wakefield and Weiler, using the most recently available SPARCS data. Because of the transition from ICD-9 to ICD-10 in October 2015, data are presented in two sections, one for October-December 2015, for ICD-10 codes, and one for January-September 2015, for ICD-9 codes.

- For both time periods, single live born vaginal birth was the most common discharge code, followed by septicemia, not otherwise specified.
- Cesarean delivery was the third most common discharge, followed by chest pain and pneumonia organism.
- Other leading diagnoses were COPD with exacerbation, heart failure, syncope, urinary tract infections, kidney failure, myocardial infarction, and conditions related to sickle-cell disorders. Additional discharge codes are described in **Table 1**.

Table 1. Summary of primary discharge diagnosis codes for inpatient discharges at Montefiore Medical Center hospitals in the Bronx in 2015 among Bronx residents. Across the Montefiore, the top three diagnoses across the ICD9- to ICD 10 coding were Single Live Born Infant (Vaginal), Sepsis NOS, and Single Live Born Infant (Cesarean) in 2015. Montefiore Medical Center includes the Moses, Children's Hospital at Montefiore, Wakefield and Weiler campuses

ICD 10: October 2015-December 2015		*ICD 9: January 2015-September 2015*	
Diagnosis description	*Discharges*	*Diagnosis description*	*Discharges*
Single liveborn infant delivered vaginally	889	Single liveborn infant delivered vaginally	2953
Sepsis organism NOS	598	Septicemia NOS	2008
Single liveborn infant delivered by cesarean	447	Single liveborn infant, delivered By Cesarean	1493
Pneumonia Organism NOS	352	Chest Pain NEC	1058
Chest Pain NEC	332	Pneumonia Organism NOS	1007
COPD with exacerbation	330	Coronary atherosclerosis of native coronary artery	799
Acute on chronic systolic heart failure	274	Acute on chronic systolic heart failure	792
Syncope & collapse	264	Acute Kidney Failure NOS	713
Urinary tract infection site NOS	229	Asthma NOS with Exacerbation	700
Acute on chronic diastolic heart failure	217	Syncope & collapse	674
Acute Kidney Failure NOS	201	Morbid Obesity	614
Post-term pregnancy	183	Post term pregnancy, delivered	604
Maternal care for scar from previous cesarean delivery	181	Urinary Tract Infection NOS	599
Morbid obesity due to excess calories	159	Acute on chronic diastolic heart failure	598
ASHD native coronary artery with unstable angina	158	Chronic obstructive asthma with (acute) exacerbation	575
Asthma NOS with exacerbation	143	Previous cesarean delivery, delivered	563
Hemoglobin SS disease with crisis NOS	133	Hemoglobin SS Disease with Crisis	550
Chest Pain NOS	125	Obstructive chronic bronchitis with (acute) exacerbation	543
Non-ST elevation myocardial infarction	125	Atrial Fibrillation	498
Abnormality in fetal heart rate and rhythm complicating labor and delivery	123	Cerebral artery occlusion, unspecified with cerebral infarction	483
Total	**19,642**	**Total**	**60,355**

Data source: SPARCS 2015. Acronyms: NOS = not otherwise specified; NEC = not elsewhere classified

Top 20 Avoidable Inpatient Diagnoses in 2015 at Montefiore

Table 2. Summary of primary discharge diagnosis codes for ambulatory care sensitive condition discharges at Montefiore Medical Center hospitals in the Bronx in 2015 among Bronx residents. Across the Montefiore , the top three diagnoses across the ICD9- to ICD 10 coding were Chest Pain, Pneumonia Organism NOS and COPD with Exacerbation in the fall of 2015 and Asthma NOS with Exacerbation from January – September 2015. Montefiore Medical Center includes the Moses, Children's Hospital at Montefiore, Wakefield and Weiler campuses.

ICD 10: October 2015-December 2015		*ICD 9: January 2015-September 2015*	
Diagnosis description	*Discharges*	*Diagnosis description*	*Discharges*
Chest Pain NEC	327	Chest Pain NEC	1018
Pneumonia Organism NOS	326	Pneumonia Organism NOS	934
COPD w exacerbation	321	Asthma NOS W Exacerbation	691
Syncope & Collapse	258	Acute & Chronic Systolic Heart Failure	663
Acute on chronic systolic heart failure	234	Syncope & Collapse	654
Urinary tract infection site NOS	226	Urinary Tract INF NOS	588
Acute on chronic diastolic heart failure	199	Chronic Obstructive Asthma with Exacerbation	560
Asthma NOS w exacerbation	143	Acute & Chronic Diastolic Heart Failure	553
Chest Pain NOS	121	OCB W Exacerbation	516
Acute bronchiolitis due to respiratory syncytial virus	106	Dehydration	469
Cellulitis left lower limb	98	Asthma W Status asthmaticus	445
Acute bronchiolitis NOS	90	Leg Cellulitis	435
Dehydration	90	Atrial Fibrillation	429
Viral intestinal infection NOS	83	Viral Enteritis NOS	355
Noninfective gastroenteritis & colitis NOS	79	Epilepsy NOS W/O Interactions	285
Asthma NOS w status asthmaticus	74	Colon Diverticulitis	252
Mild persistent asthma w status asthmaticus	73	Non-infective Gastroenteritis NEC&NOS	243
Gastro-esophageal reflux disease w/o esophagitis	72	Chest Pain NOS	240
Moderate persistent asthma w status asthmaticus	70	Diabetes Mellitus, Type 2 /NOS W Manifestations NEC NSU	232
Mild intermittent asthma w status asthmaticus	70	Other cardiac Dysrhythmias	218
Total	**7,364**	**Total**	**21,875**

Data source: SPARCS 2015. Acronyms: NOS = not otherwise specified; NEC = not elsewhere classified

Top 20 ED Diagnoses

Table 3. Summary of primary discharge diagnosis code for Emergency Department (ED) visits at Montefiore Medical Center hospitals in the Bronx in 2015 among Bronx residents. Across Montefiore, the top three diagnoses across the ICD9- to ICD 10 coding were Viral Infection NOS, Acute Upper Respiratory Infection NOS and Headache. Montefiore Medical Center includes the Moses, Children's Hospital at Montefiore, Wakefield and Weiler campuses

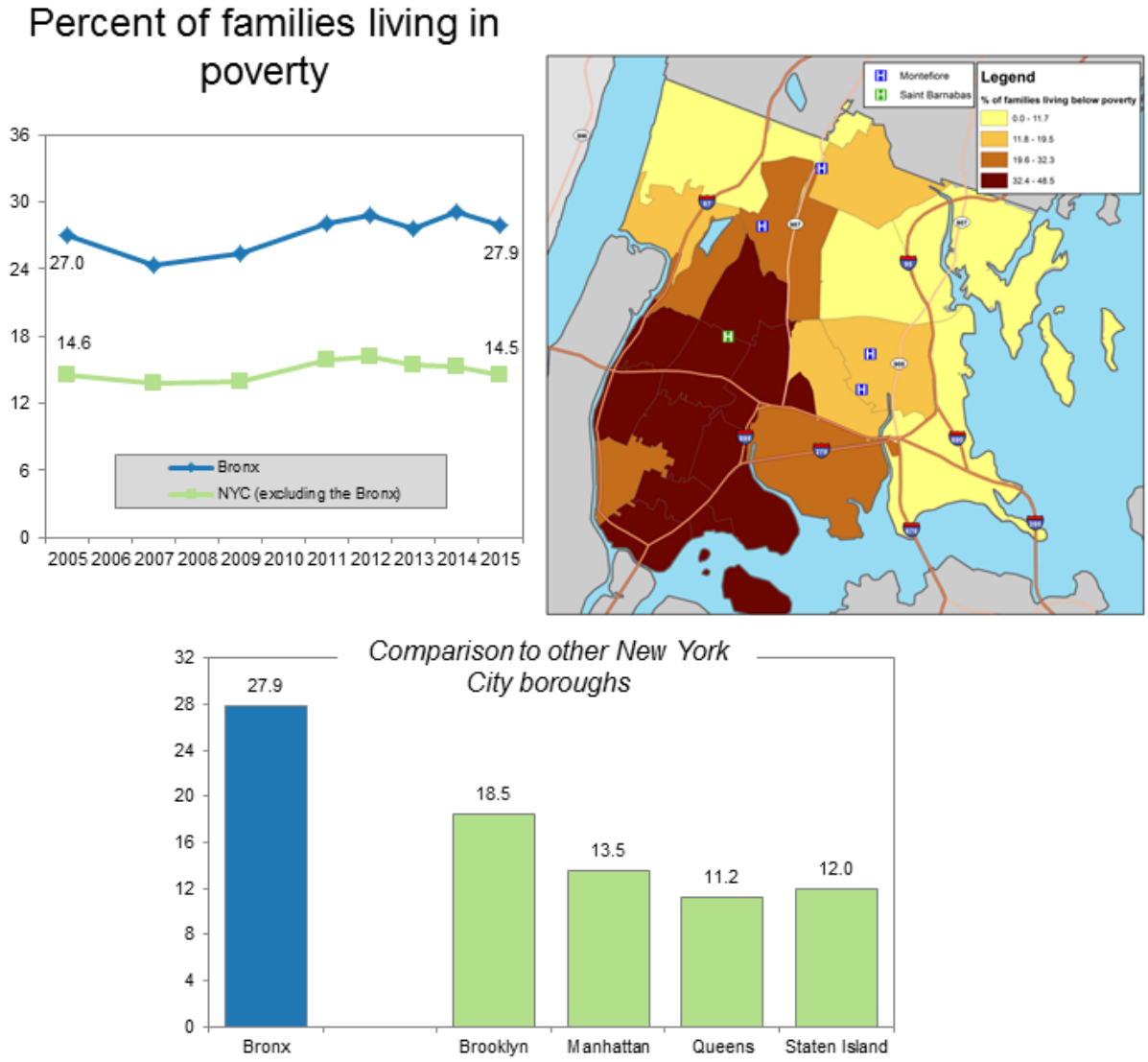
Diagnosis/Description	Number
Viral Infection NOS	4,756
Acute Upper Respiratory Infection NOS	4,531
Headache	4,071
Abdominal Pain-Site NEC	3,815
Lumbago	3,416
Non-infective Gastroenteritis NEC&NOS	3,339
Asthma NOS W Exacerbation	3,332
Acute Pharyngitis	3,000
Chest Pain NEC	2,934
Pain in Limb	2,775
Chest Pain NOS	2,671
Other specified complications of pregnancy, antepartum condition or complication	2,665
Asthma NOS	2,448
Fever NOS	2,447
Dizziness & Giddiness	2,422
Cough	2,378
Otitis Media NOS	2,181
Urinary Tract INF NOS	2,086
Strep Sore Throat	2,006
Epigastric Abdominal Pain	1,881
Total	**177,681**

Data source: SPARCS 2015. NOS = not otherwise specified; NEC = not elsewhere classified

Population-Based Secondary Data Review

To capture an up-to-date high-level view of the health status of Bronx residents, we evaluated temporal trends, differences between Bronx and the rest of New York City and sub-county differences, when available, for more than 20 measures, including: obesity, preterm births, teen pregnancy rates, poverty, linguistic isolation, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screening, HIV incidence, lung, colorectal, prostate and breast cancer incidence rates, and hospitalizations for asthma, diabetes, assaults, heart attacks and falls. These data were obtained from multiple population-based datasets including the American Community Survey (formerly referred to simply as the Census), New York City Community Health Profiles, New York State Statewide Planning and Research Cooperative Systems (SPARCS), New York State Vital Statistics, New York State HIV/AIDS Epidemiology Reports, and the New York State Cancer Registry. Additional data was obtained from the New York City Community Health Profiles and the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard. The data sources used are summarized in **Section 4.a.i** and the data themselves are presented in the following pages.

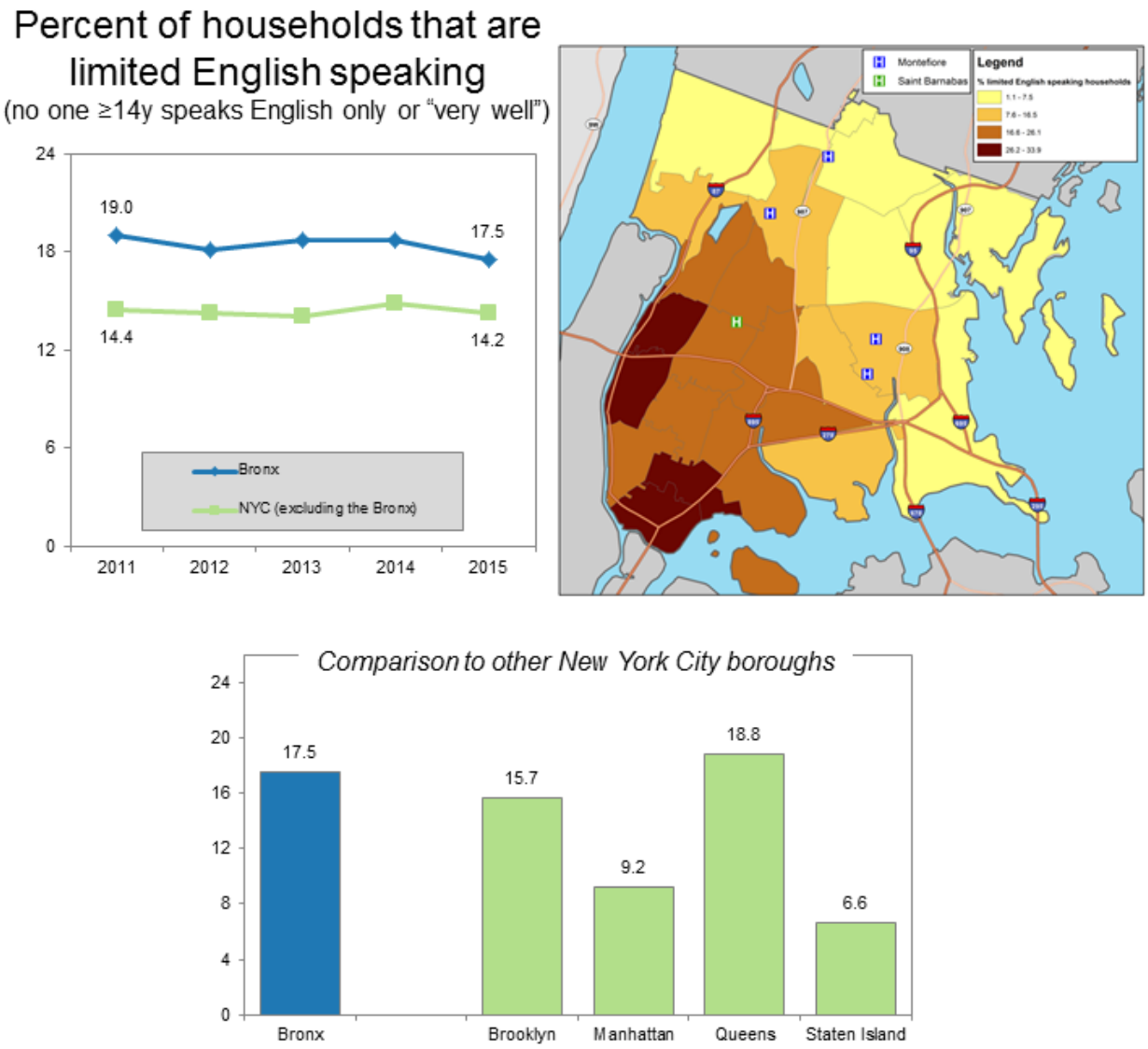
Figure 2. Percent of families living in poverty



Data source: American Community Survey

- The Bronx has the highest poverty rate of the five boroughs, and is about twice as high as the rest of New York City.
- The percent of families living in poverty in the Bronx has remained relatively stable over the past five years, after increasing slightly from 2007-2011.
- The poverty rate in the Bronx is highest in the South Bronx.

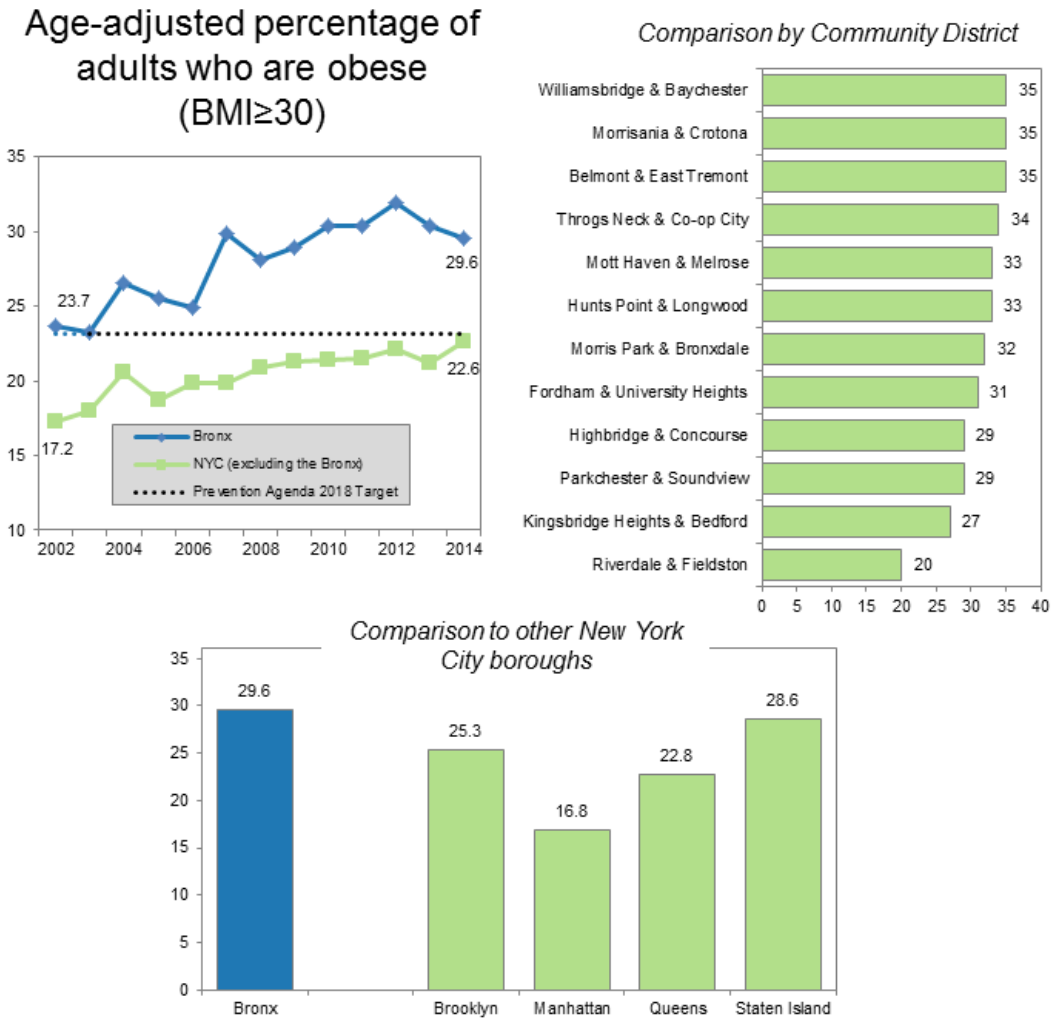
Figure 3. Percent of households that are limited English speaking



Data source: American Community Survey

- More households in the Bronx are considered limited English speaking than the rest of New York City, and percent of households that are limited English speaking is second highest of the five boroughs (following Queens).
- The percent of households that are linguistically isolated has decreased slightly from 19% in 2011 to 17.5% in 2015; across the rest of the city, the percentage has been relatively stable.
- Pockets of linguistic isolation are observed in the Mott Haven/Port Morris neighborhood and Highbridge/Morris Heights, but remain elevated in much of the South Bronx and parts the Central Bronx.

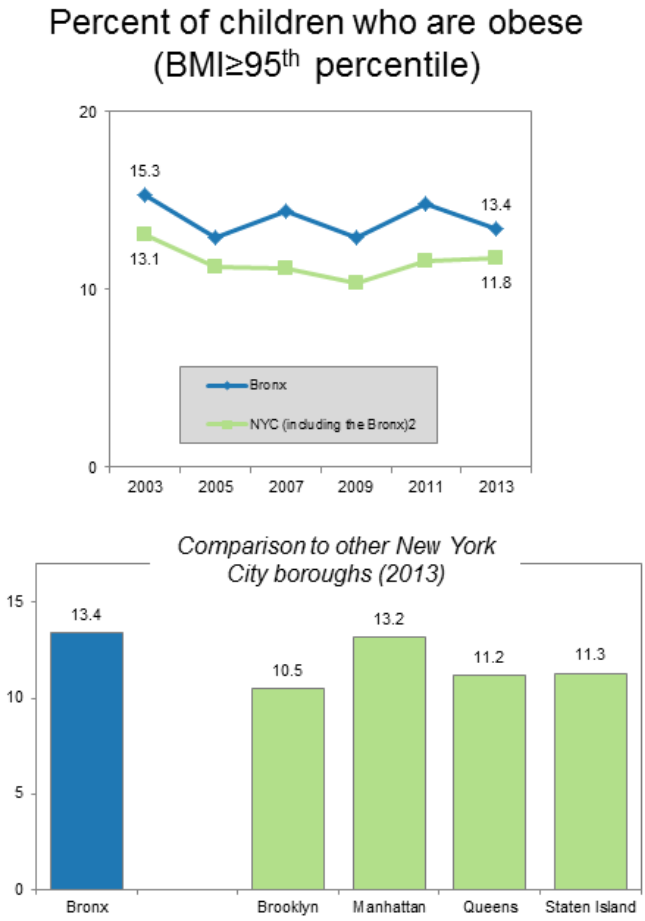
Figure 4. Age-adjusted percentage of adults who are obese



Data source: New York City Community Health Survey

- The percentage of Bronx adults who are considered obese has increased over the past 12 years from 23.7% to 29.6%, however, since 2012, this number has decreased.
- Despite stabilizing in recent years, the prevalence of obesity among Bronx adults remains 30% higher than the rest of New York City.
- The burden of obesity in the Bronx is not equally distributed; Williamsbridge & Baychester, Morrisania & Crotona, and Belmont & East Tremont have the greatest burden, while Riverdale & Fieldston and Kingsbridge Heights & Bedford have the lowest.

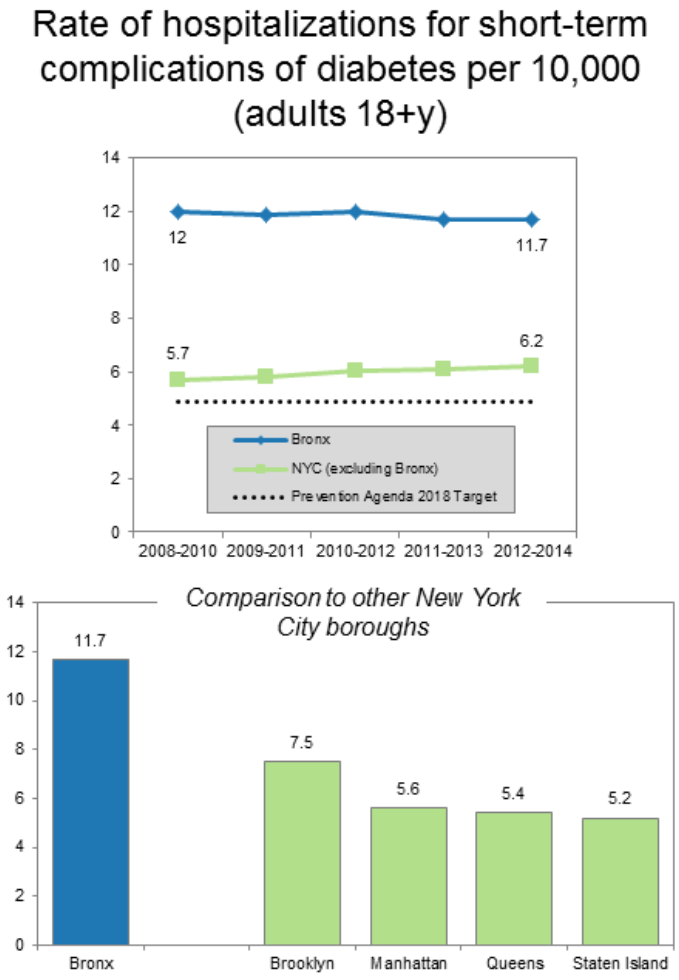
Figure 5. Percent of children who are obese



Data source: New York City Youth Behavior Risk Survey

- There is some evidence that childhood obesity, among 9th-12th graders attending public schools has declined in the Bronx and the rest of New York City.
- Despite this improvement, children in the Bronx are 13% more likely to be obese than residents of the rest of New York City.

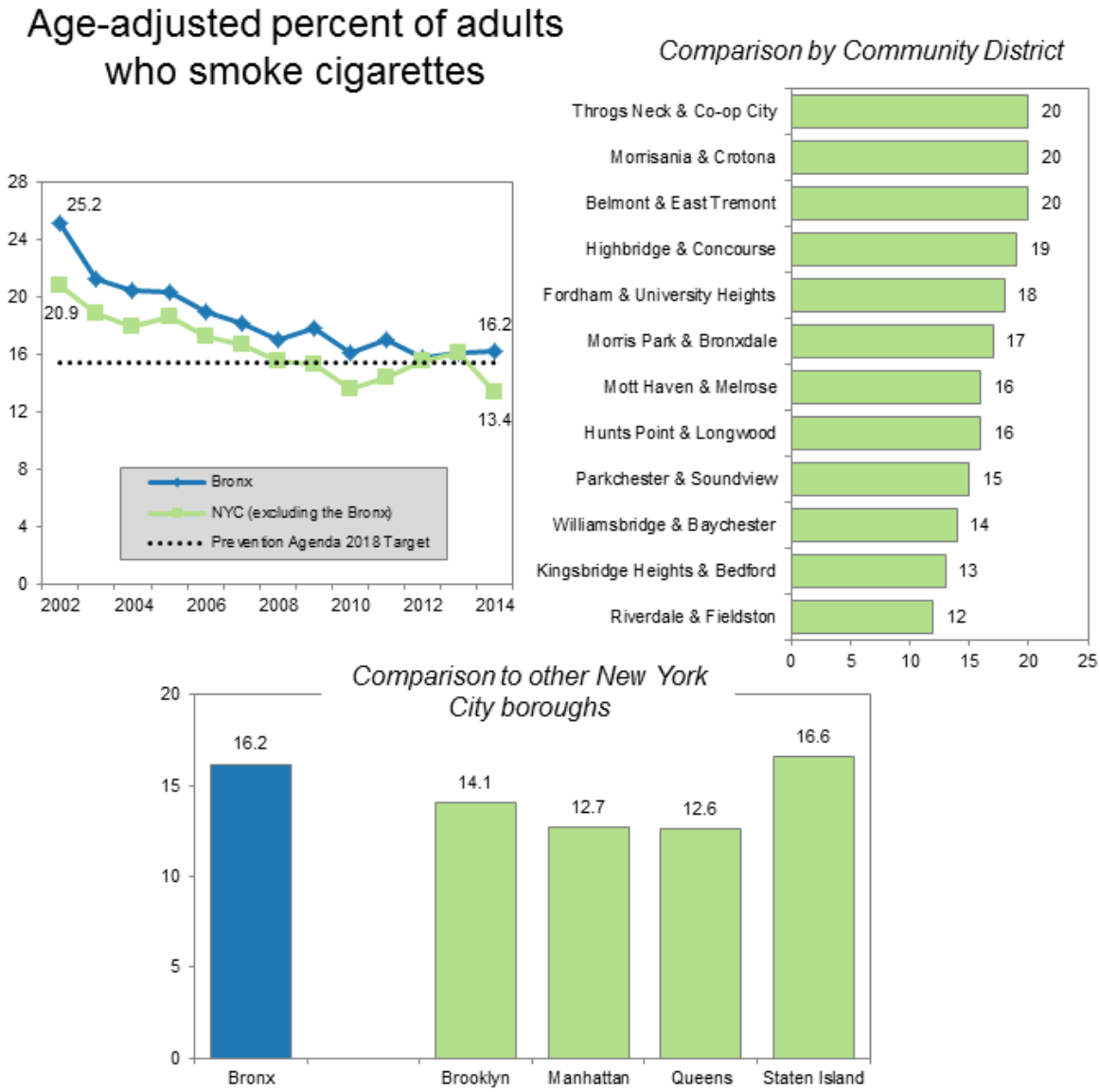
Figure 6. Rate of hospitalizations for short-term complications of diabetes per 10,000



Data source: SPARCS

- Rates of hospitalization for short-term complications of diabetes are nearly 90% higher in the Bronx as compared to the rest of New York City despite increases in the rest of New York City.

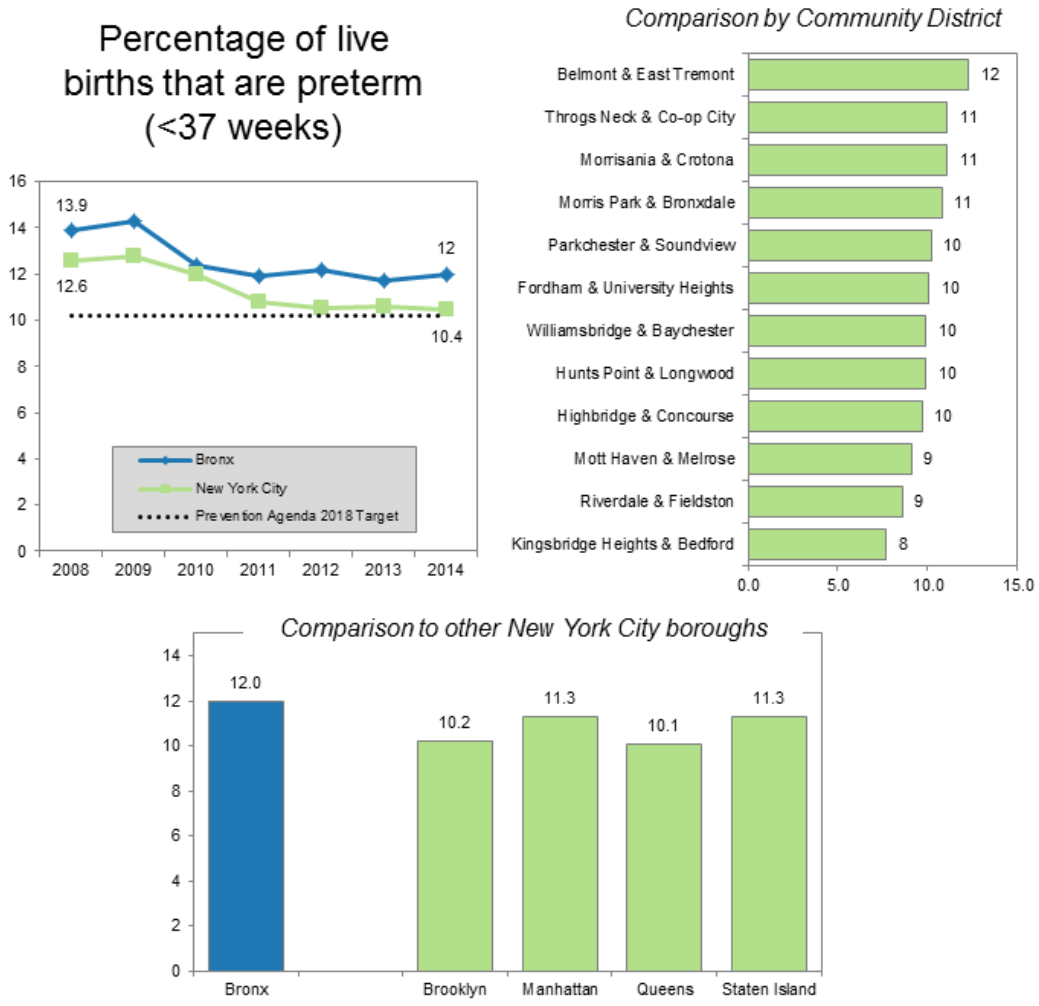
Figure 7. Age-adjusted percent of adults who currently smoke cigarettes



Data source: New York City Community Health Survey

- In both the Bronx and the rest of New York City, cigarette smoking among adults has declined, but Bronx residents continue to more likely smoke than New York City residents overall.
- Current cigarette smoking is lowest in Riverdale & Fieldston and Kingsbridge & Bedford Park and highest in Throgs Neck & Co-Op City, Morrisania & Crotona and Belmont & East Tremont.

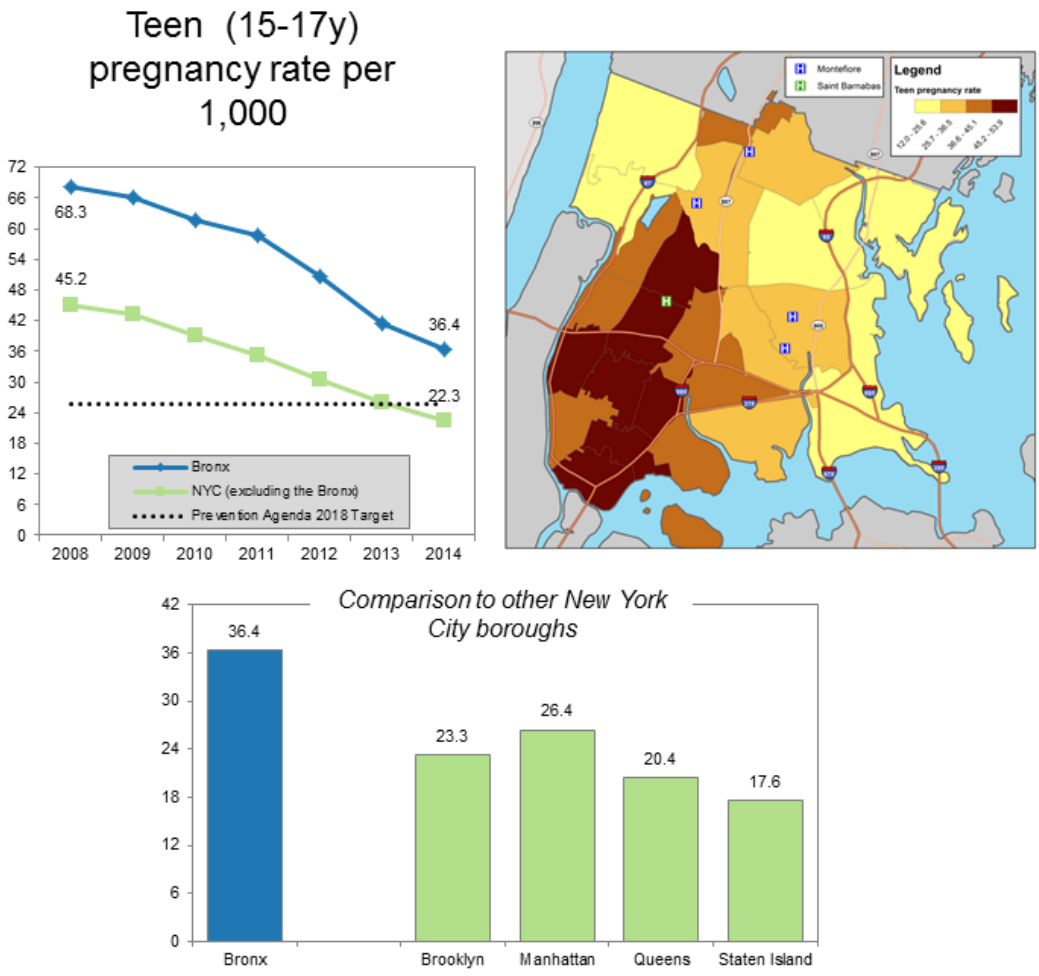
Figure8. Percentage of live births that are preterm



Data source: New York State Vital Statistics

- In both the Bronx and the rest of New York City, preterm births have declined, but Bronx residents continue to more likely experience preterm birth than New York City residents overall.

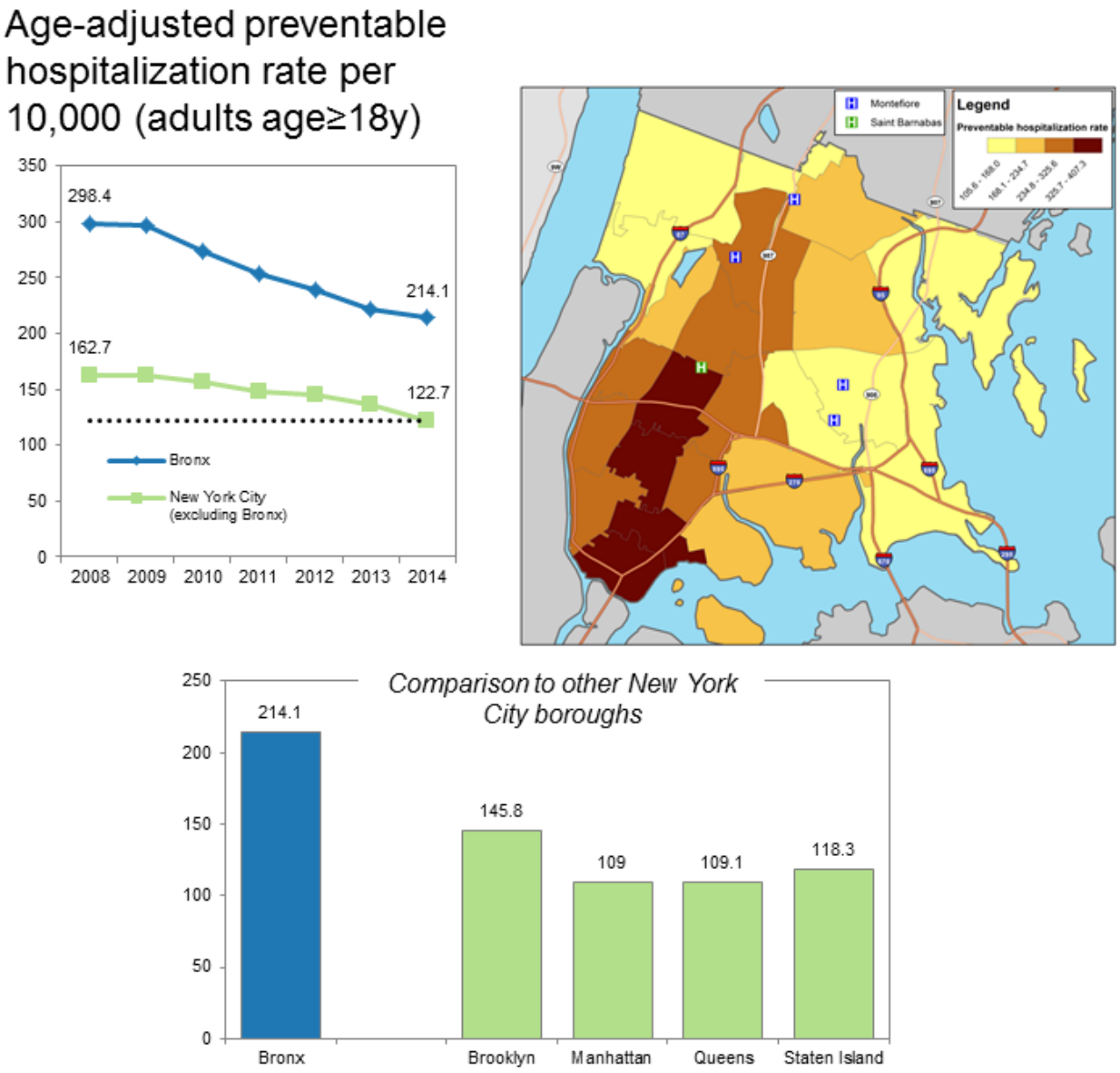
Figure 9. Teen pregnancy rate



Data source: New York State Vital Statistics

- Coinciding with the decline in preterm births, the teen pregnancy rate (and teen birth rate) has declined in both the Bronx and the rest of New York City
- Teen pregnancies remain 63% higher in the Bronx as compared to the rest of New York City.
- Teen pregnancies are most common in the South Bronx.

Figure 10. Age-adjusted preventable hospitalizations[2] per 10,000

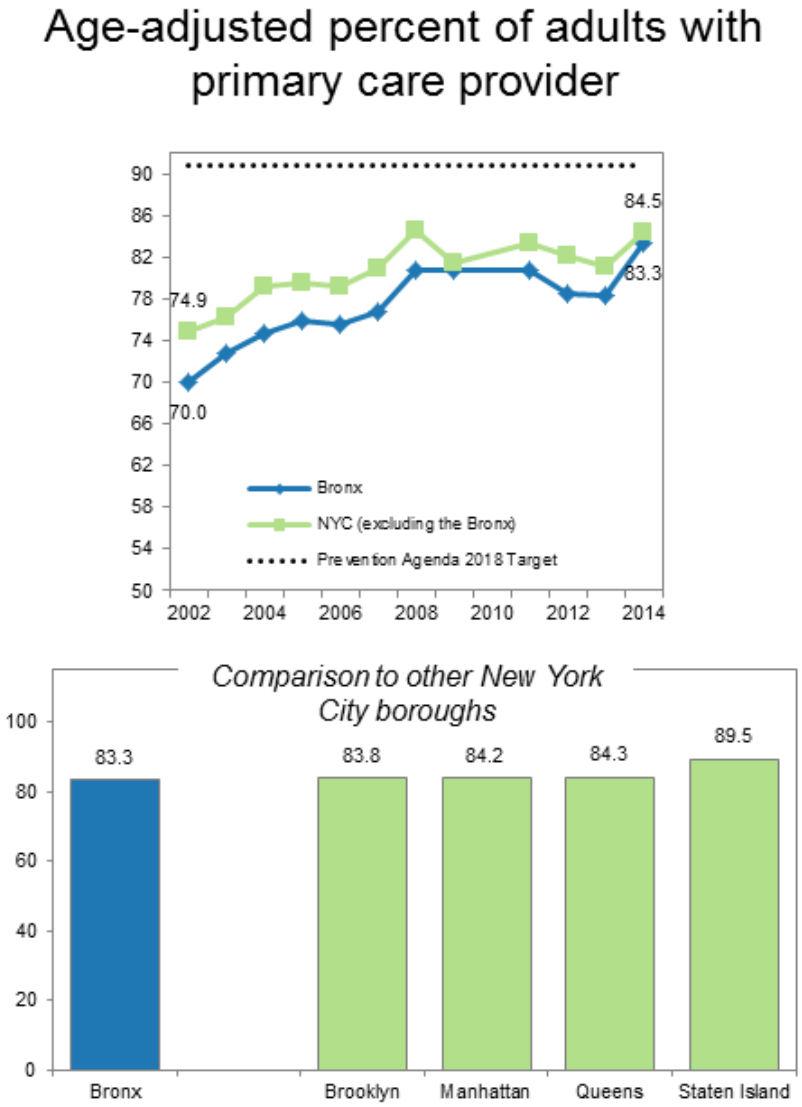


Data source: SPARCS

- The age-adjusted rate of preventable hospitalizations declined in both the Bronx and the rest of New York City, but the rate of decline appears to be greater in the Bronx (-28% compared to -25% in the rest of New York City).
- Preventable hospitalizations were most common in the South Bronx.

[2] Defined as hospitalizations for the following: (1)Short-term complication of diabetes (2)Long-term complication of diabetes (3)Uncontrolled diabetes (4)Lower-extremity amputation among patients with diabetes (5)Hypertension (6)Congestive heart failure (7)Angina (8)Chronic obstructive pulmonary disease (9)Asthma (10)Dehydration (11)Bacterial pneumonia (12)Urinary tract infection.

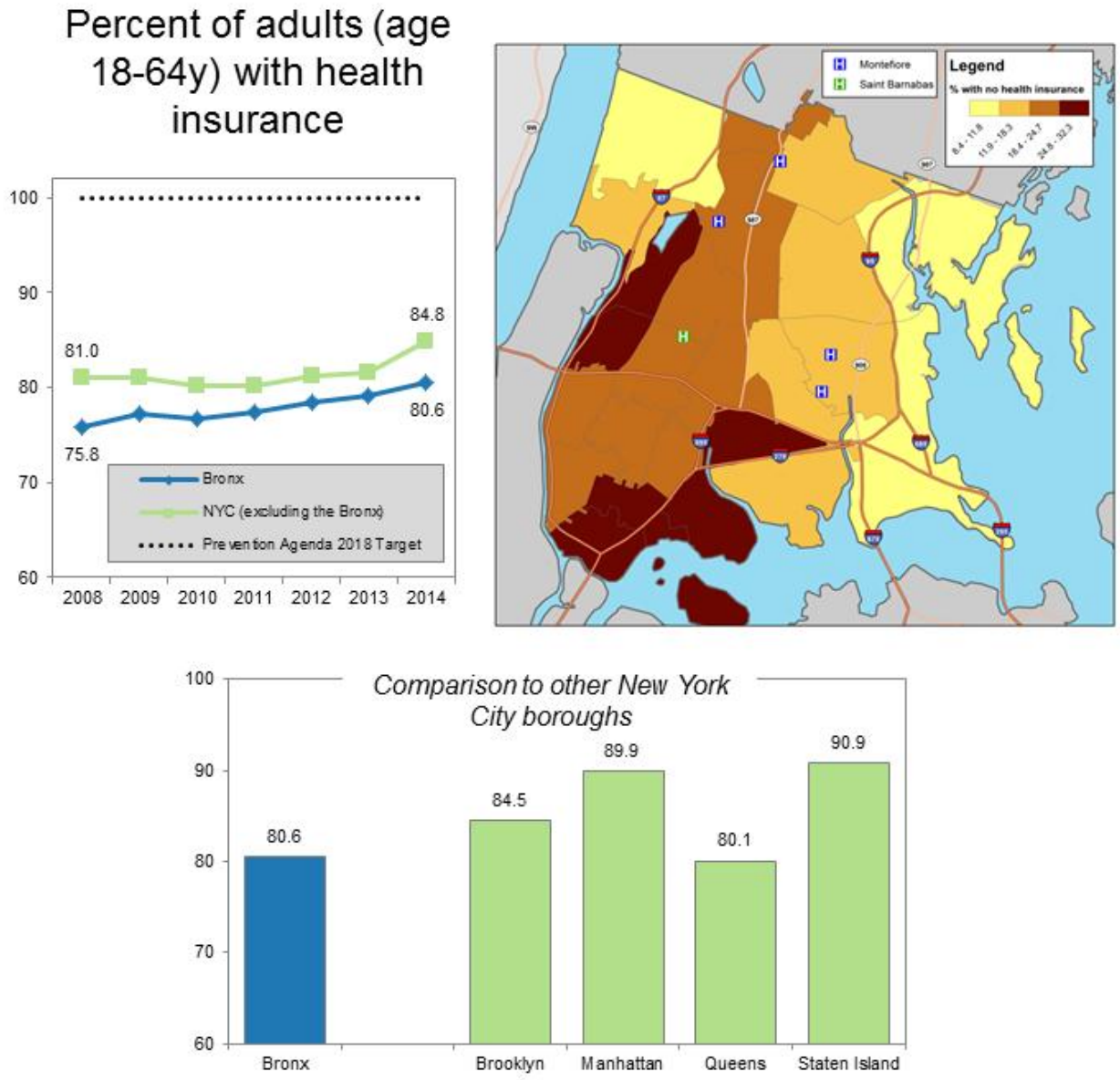
Figure 11. Age-adjusted percent of adults with a primary care provider



Data source: New York City Community Health Survey

- In both the Bronx and the rest of New York City, the percentage of adults with a primary care provider has increased.
- In the early 2000s residents of the rest of New York City were 7% more likely to have a primary care provider than Bronx residents; this disparity decreased to less than 2% by 2014.
- Despite these gains, compared to the other boroughs Bronx residents are least likely to have a primary care provider.

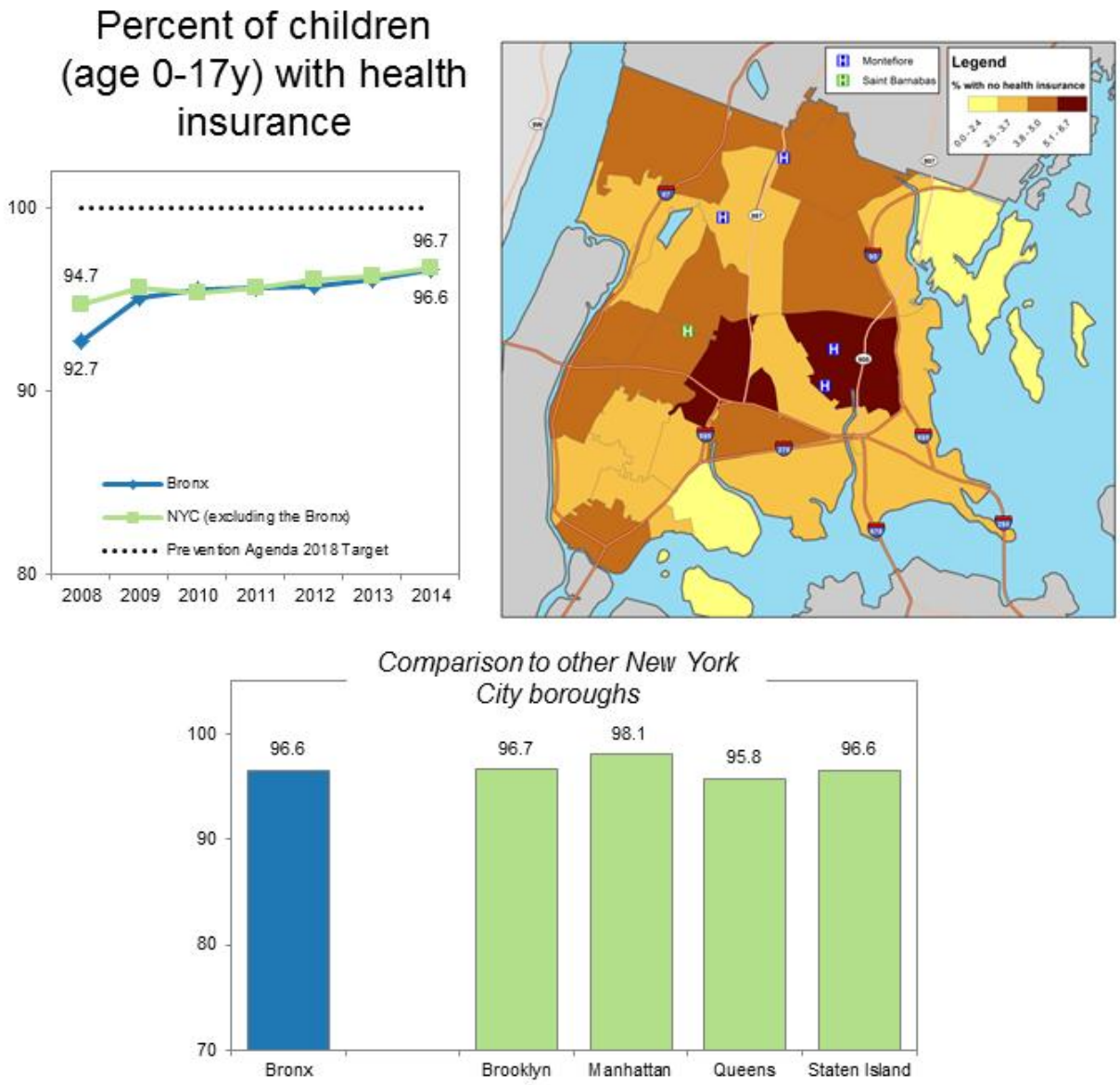
Figure 12. Percent of adults (age 18-64y) with health insurance



Data source: American Community Survey

- The percent of non-elderly adults (age 18-64y) who have health insurance increased in both the Bronx and the rest of New York City. This increase was driven in large part by Medicaid expansion and the implementation of the Affordable Care Act.
- After Queens, the Bronx has the second lowest percentage of non-elderly adults with health insurance.
- Clusters of not having insurance were observed through the middle-section of the Bronx, with hotspots observed in Mott Haven/Port Morris, Soundview and Morris Heights/University Heights.

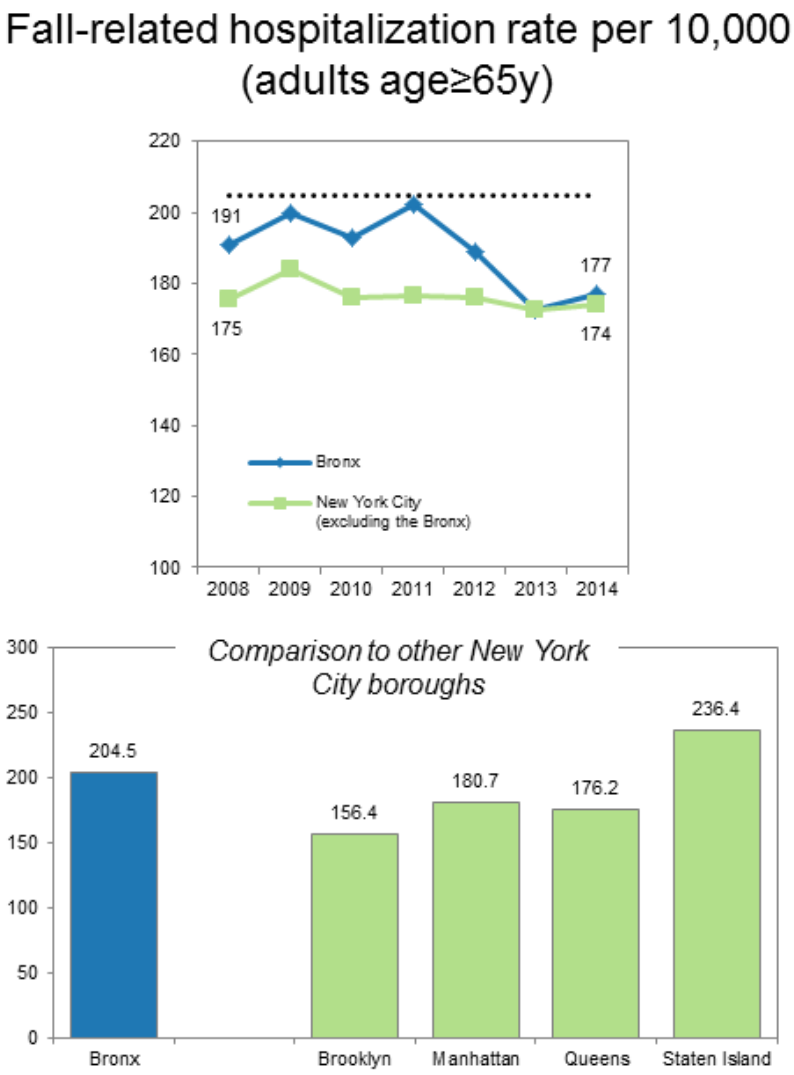
Figure 13. Percent of children (age 0-17y) with health insurance



Data source: American Community Survey

- The percent of children (age 0-17y) who have health insurance increased in both the Bronx and the rest of New York City. This increase was driven in large part by Medicaid expansion and the implementation of the Affordable Care Act.
- In 2008, residents of the rest of New York City were somewhat more likely to not have insurance as compared to Bronx residents, but this disparity completely disappeared by 2014.
- Clusters of not having insurance among children were observed in West Farms/Belmont and Morris Park/East Bronx.

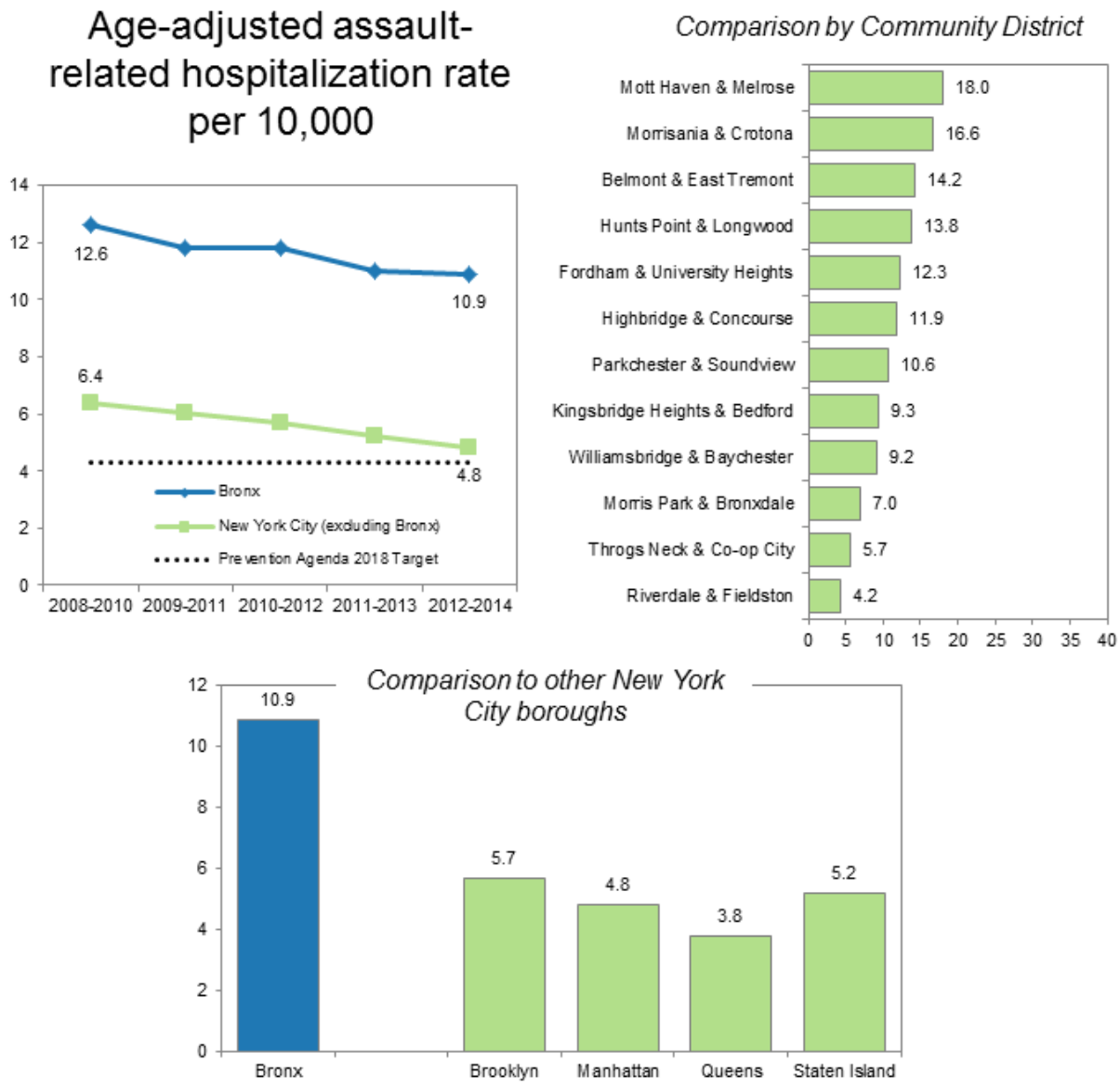
Figure 14. Fall-related hospitalization rate per 10,000



Data source: SPARCS

- Fall-related hospitalizations among older adults declined in the Bronx, while remaining relatively stable in the rest of New York City. As of 2014, there was little difference in rates comparing the Bronx to the rest of New York City.

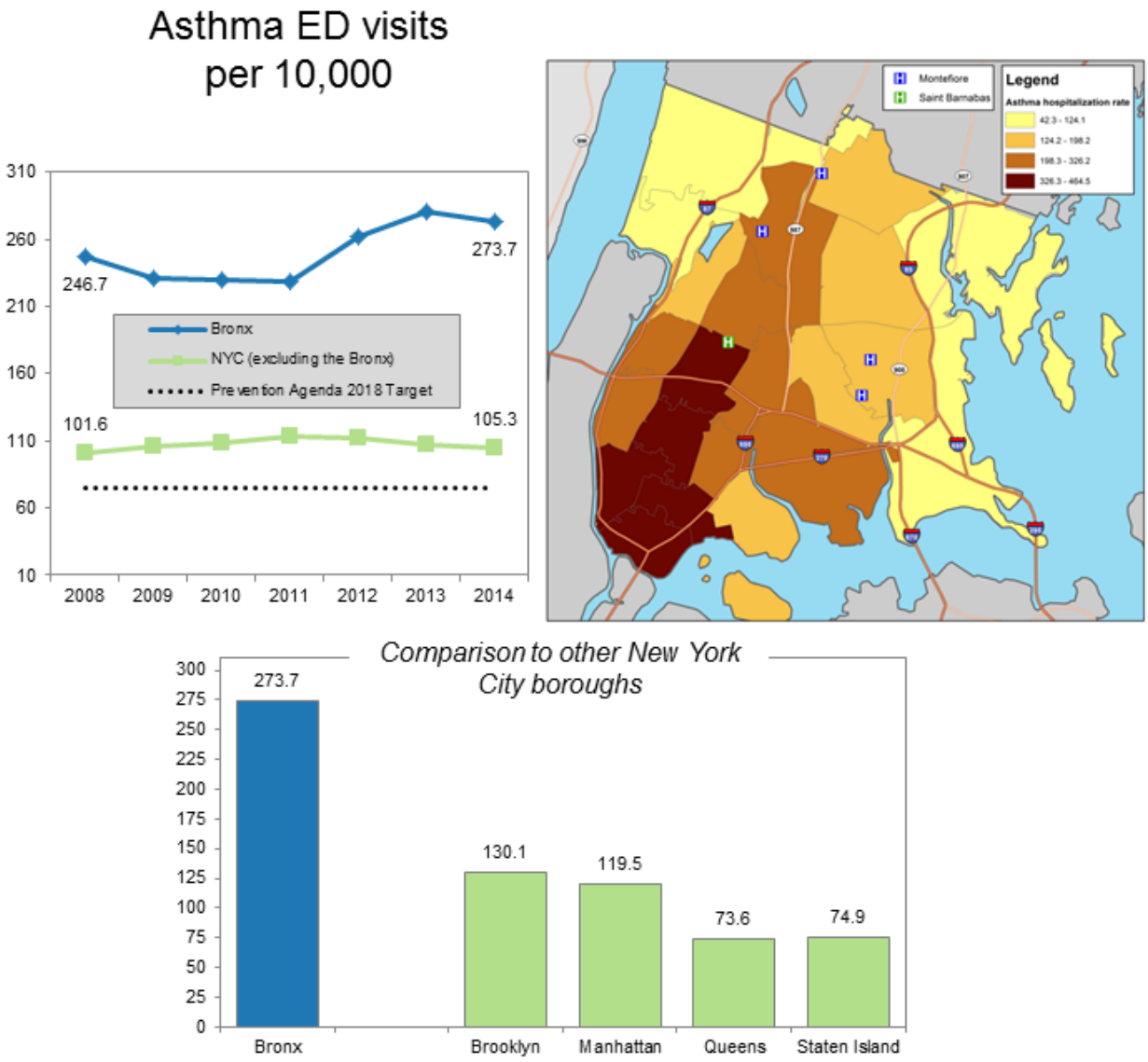
Figure 15. Age-adjusted assault-hospitalization rate per 10,000



Data source: SPARCS

- Age-adjusted assault-related hospitalizations in both the Bronx and the rest of New York City declined, but a substantial disparity remained.
- Bronx residents had more than 2.5-fold higher rates of assault-related hospitalizations than the rest of New York City and more than the Prevention Agenda 2018 Target.
- Disparities within the Bronx were also apparent; rates were highest in Mott Haven & Melrose, Morrisania & Crotona, and Belmont & East Tremont; rates were lowest in Riverdale & Fieldston and Throgs Neck & Co-Op City.

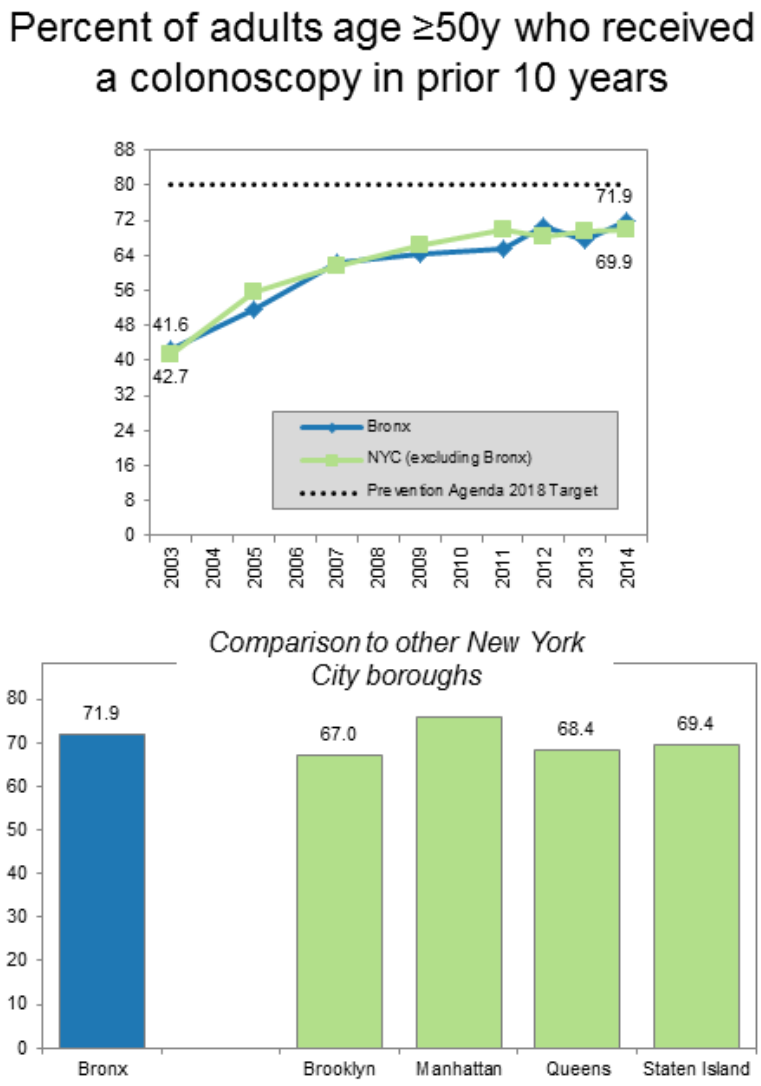
Figure 16. Asthma emergency department visits per 10,000



Data source: SPARCS

- Asthma ED visits in the Bronx were stable from 2008-2011, but increased thereafter. They remained more than 2.5-fold higher than the rest of New York City and nearly 4-fold higher than the Prevention Agenda target.
- Disparities within the Bronx were also apparent; rates were substantially higher in the South Bronx and lower in Riverdale & Fieldston and Co-Op City & Throgs Neck.

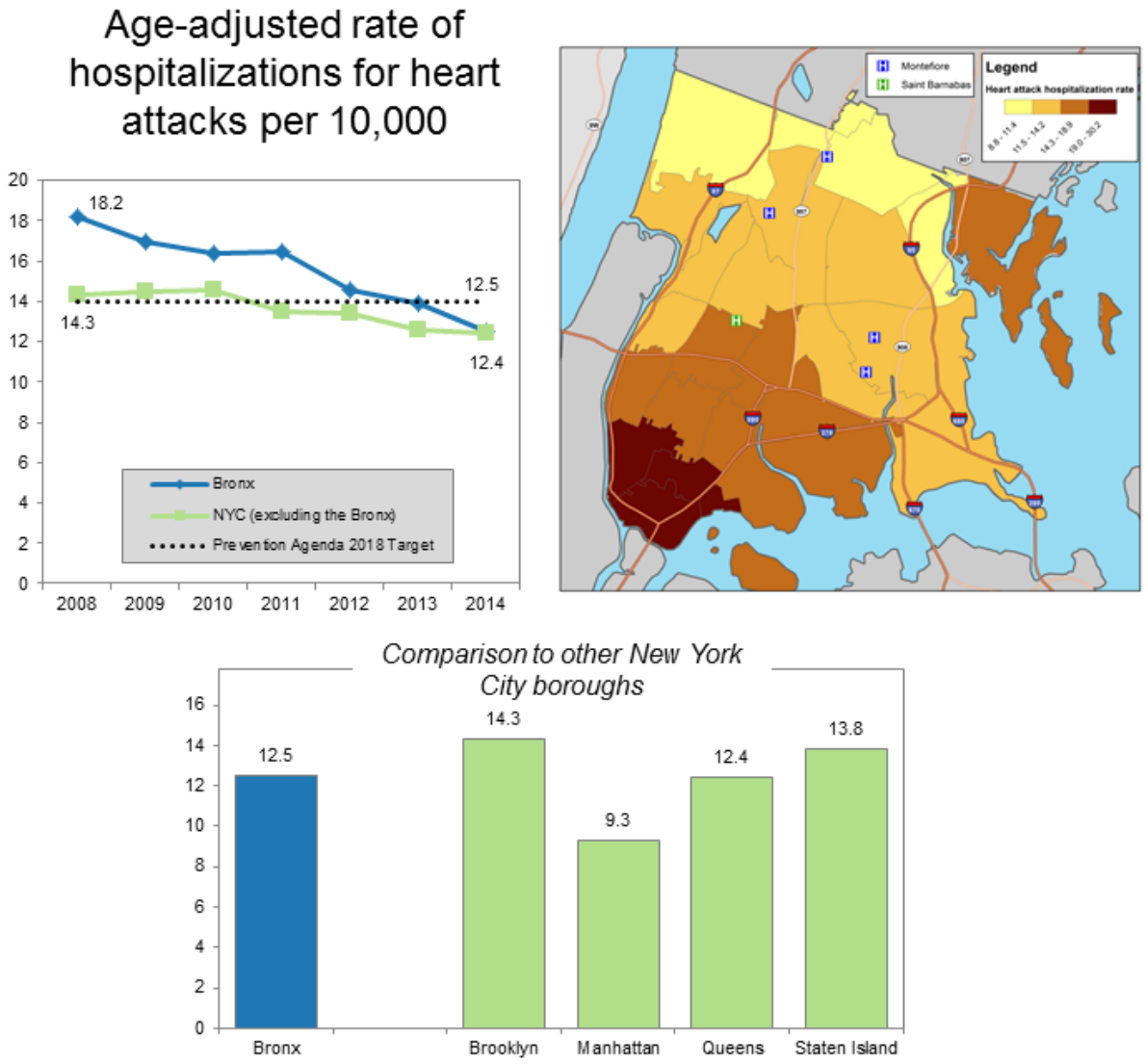
Figure 17. Percent of adults age≥50 who received a colonoscopy in the prior 10 years



Data source: New York City Community Health Survey

- In both New York City and the Bronx, rates of receiving a colonoscopy among adults age ≥50y increased, but remained below the Prevention Agenda target.
- The rate of increase has been comparable in the Bronx compared to the rest of New York City.

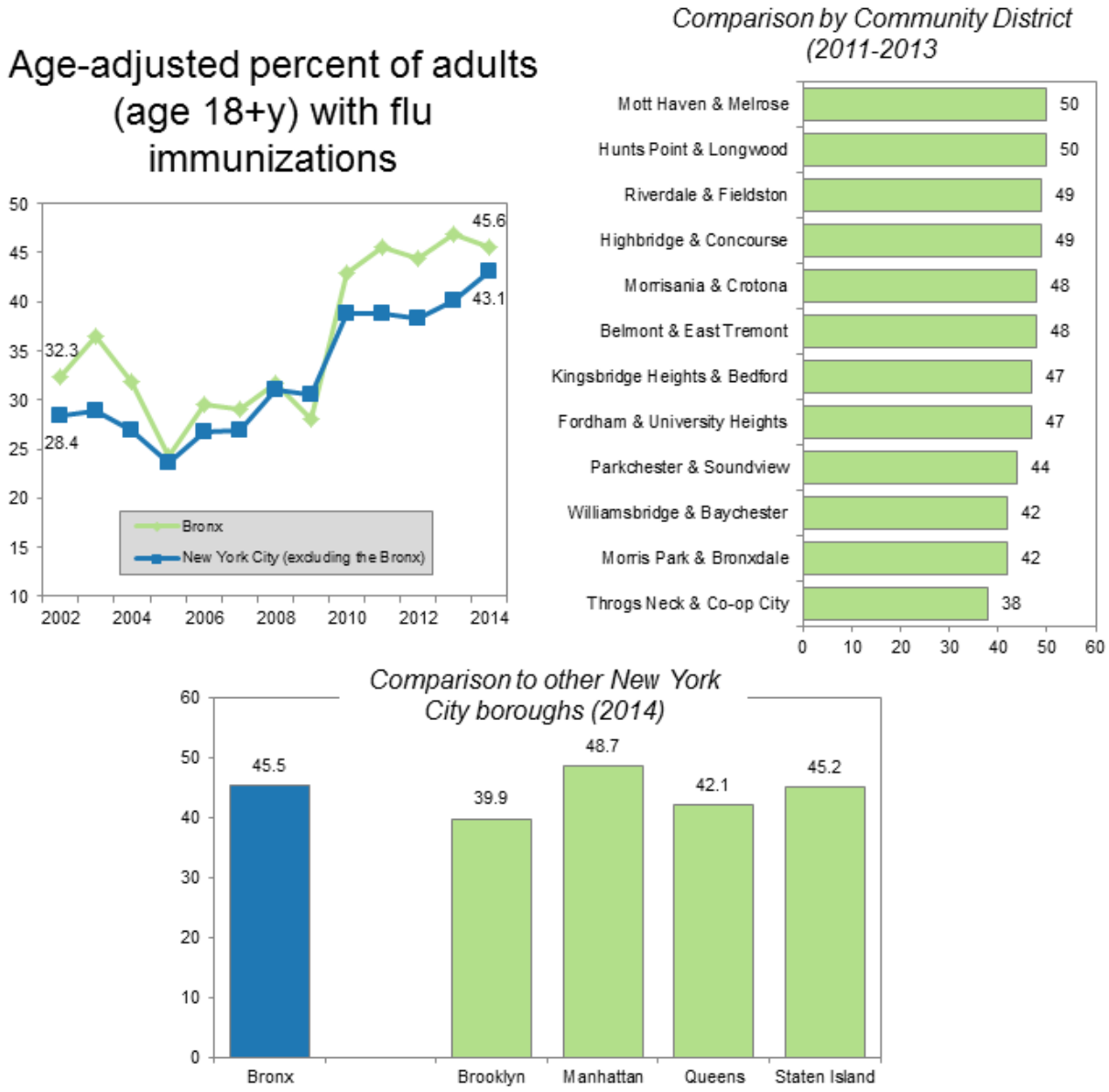
Figure 18. Age-adjusted rate of hospitalizations for heart attacks per 10,000



Data source: SPARCS

- Age-adjusted hospitalizations for heart attacks (myocardial infarction) declined substantially in the Bronx and are now comparable to rates in the rest of New York City.
- A distinct north-south gradient in heart attack hospitalizations was observed in the Bronx, with the highest rates in the South Bronx and lower rates in the North Bronx, including Riverdale, Wakefield and the Co-Op City areas.

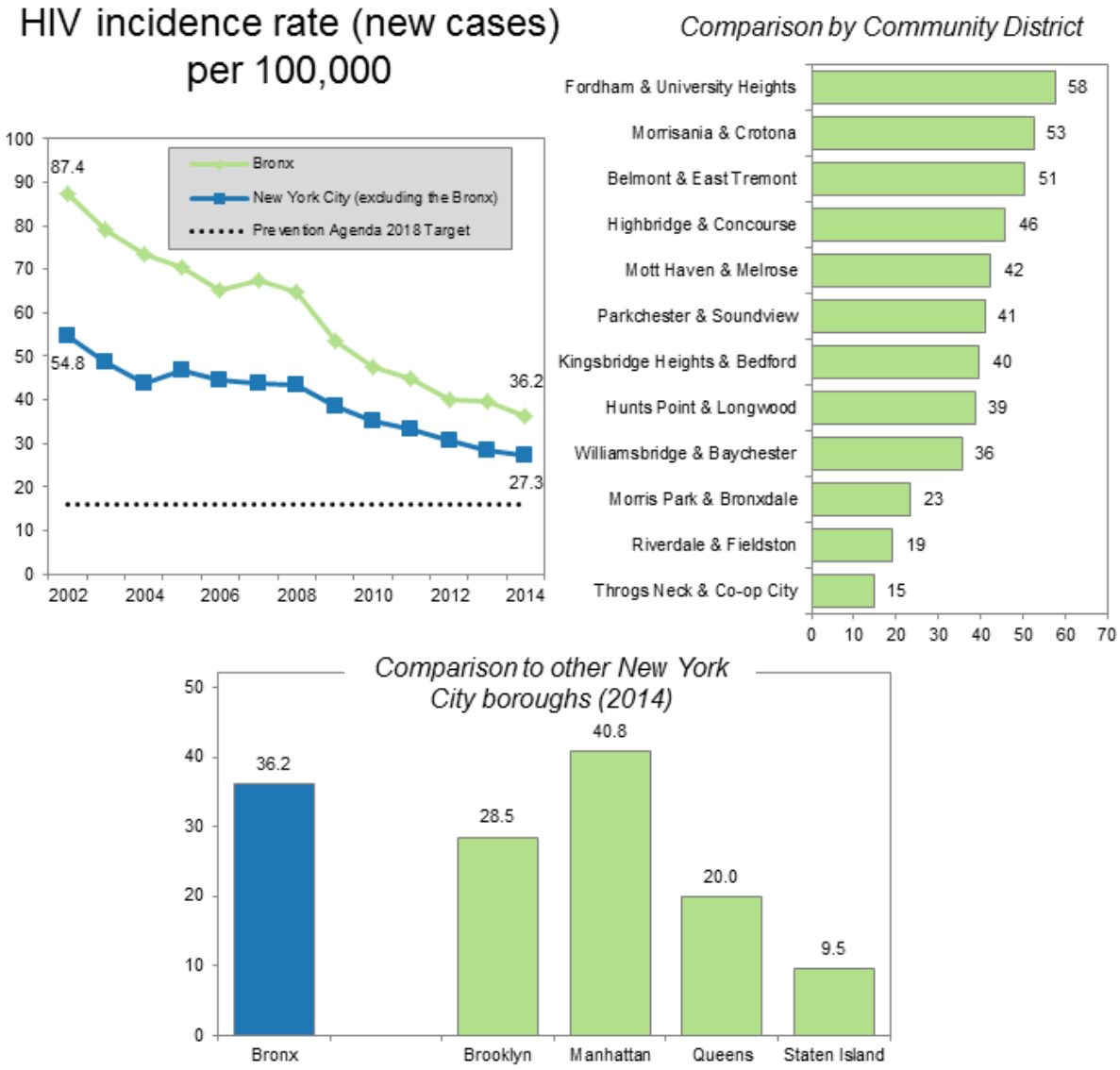
Figure 19. Age-adjusted percent of adults getting immunized for the flu



Data source: New York City Community Health Survey

- Receipt of flu immunizations among adults was relatively stable from 2002-2010 in both the Bronx and the rest of New York City, increasing thereafter.
- Bronx adults were marginally more likely to receive a flu immunization than residents of the rest of New York City.
- Uptake of flu immunizations were highest in the Mott Haven & Melrose, Hunts Point & Longwood, Riverdale & Fieldston, Highbridge & Concourse, and lowest in Throgs Neck & Co-Op City.

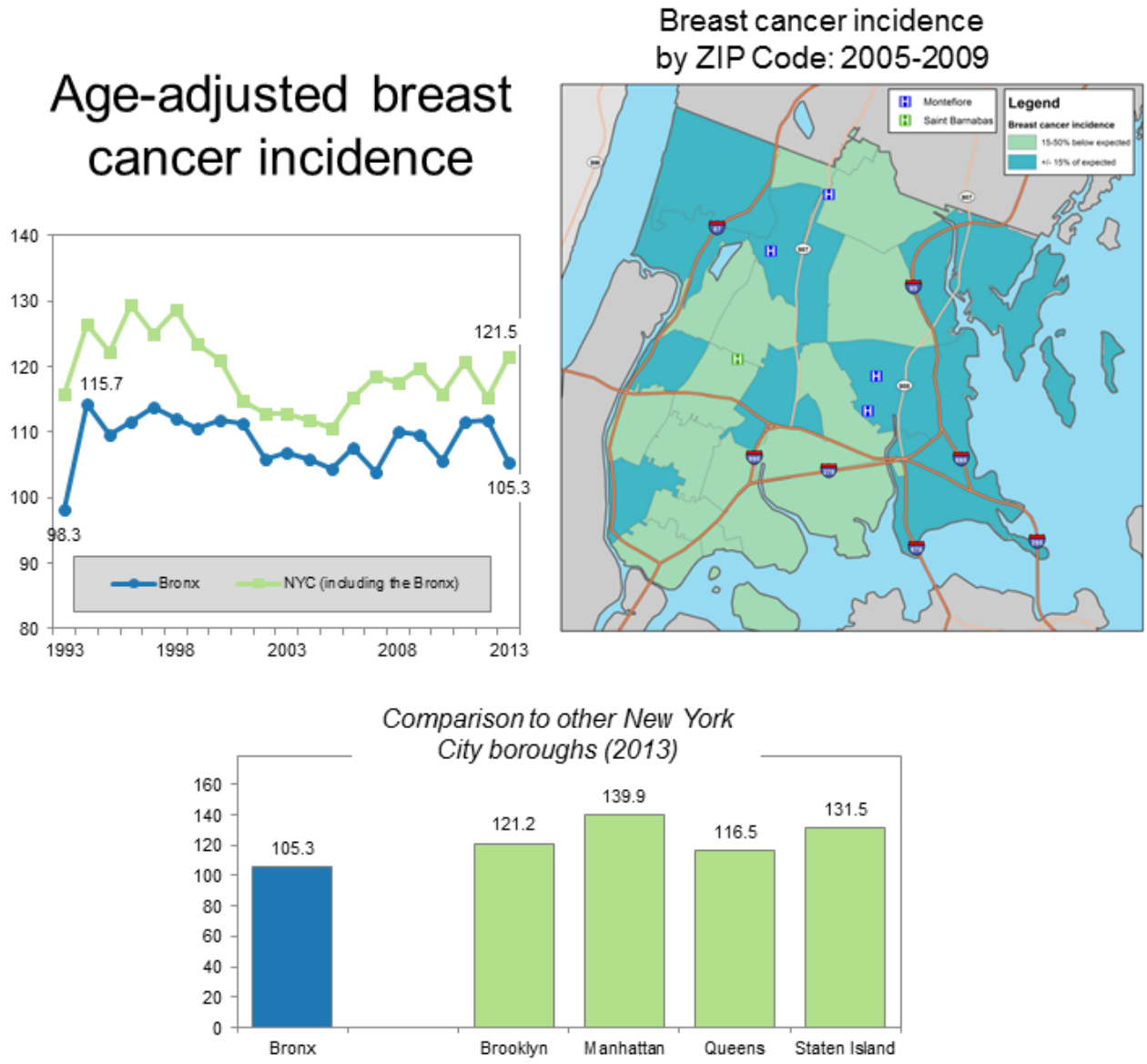
Figure 120. HIV incidence rate per 100,000



Data source: New York State HIV/AIDS Epidemiology Reports

- Incidence rates of HIV in the Bronx have declined more than 59% compared to 50% in the rest of New York City.
- The Bronx has the second highest incidence rate of HIV compared to the other New York City boroughs, trailing only Manhattan.
- Rates of HIV varied 3.9-fold within the Bronx by Community District; rates were highest in Fordham & University Heights and lowest in Throgs Neck & Co-Op City.

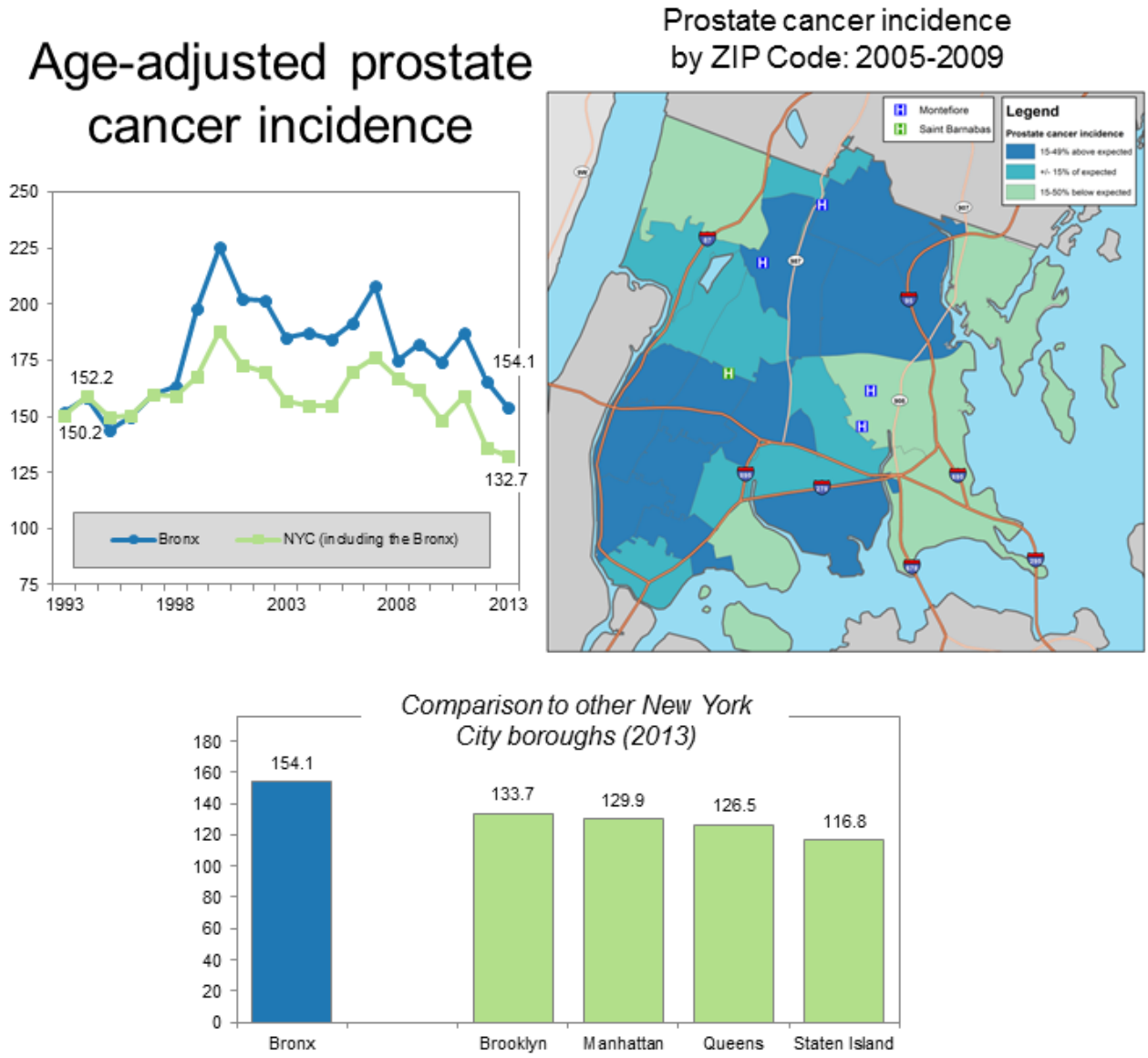
Figure 21. Age-adjusted breast cancer incidence, among women only



Data source: New York State Cancer Registry

- Breast cancer incidence declined through the 1990s, but remained stable thereafter.
- Compared to the rest of New York City, breast cancer incidence rates were lowest in the Bronx.
- There was no evidence of breast cancer incidence hotspots by ZIP Code; no ZIP Code had a higher than expected rate of breast cancer.

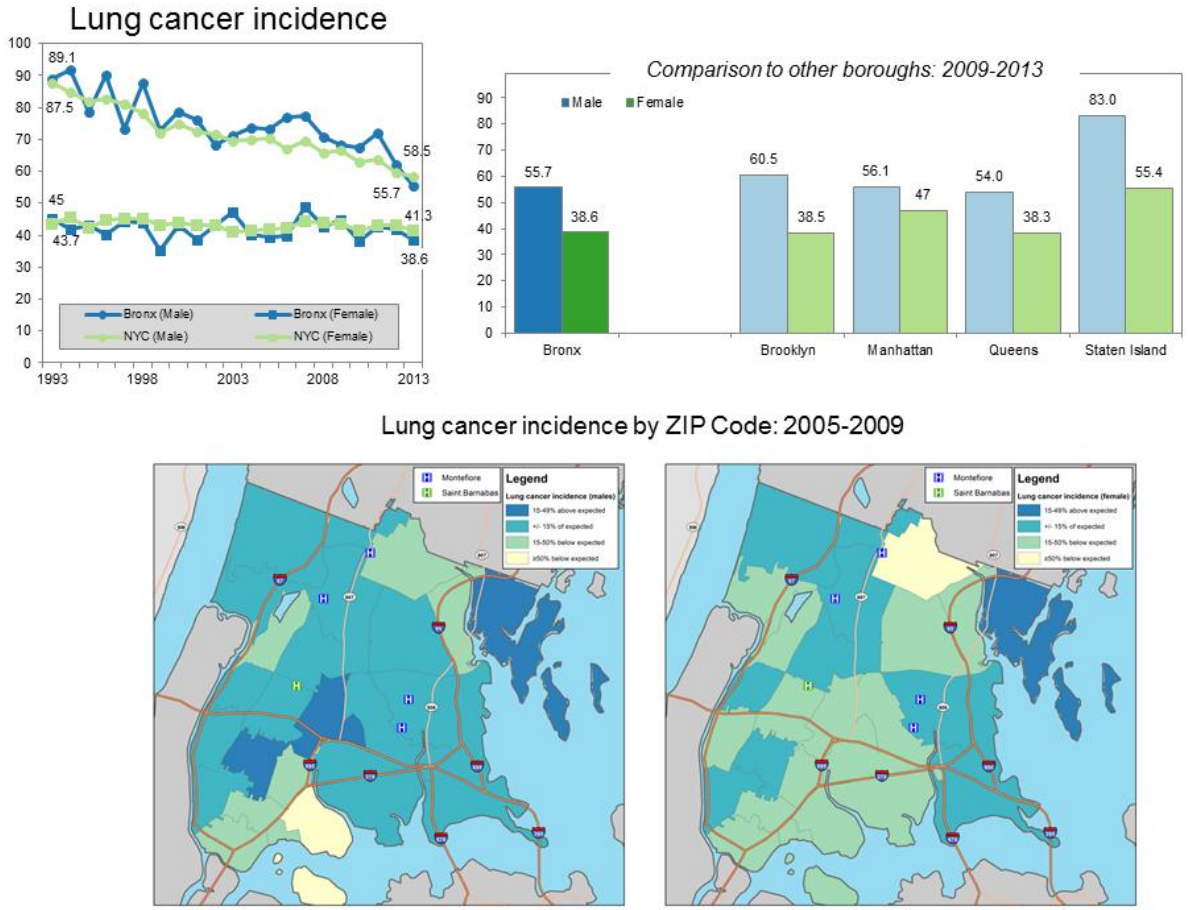
Figure 22. Age-adjusted prostate cancer incidence, among men only



Data source: New York State Cancer Registry

- Among Bronx men, rates of prostate cancer increased through the 1990s, in large part due to the widespread implementation of PSA screening, which resulted in detecting many more prostate cancers, but decreased from the early 2000s.
- Prostate cancer rates in the Bronx were higher than the rest of New York City, and 12 ZIP Codes had higher than expected prostate cancer rates.

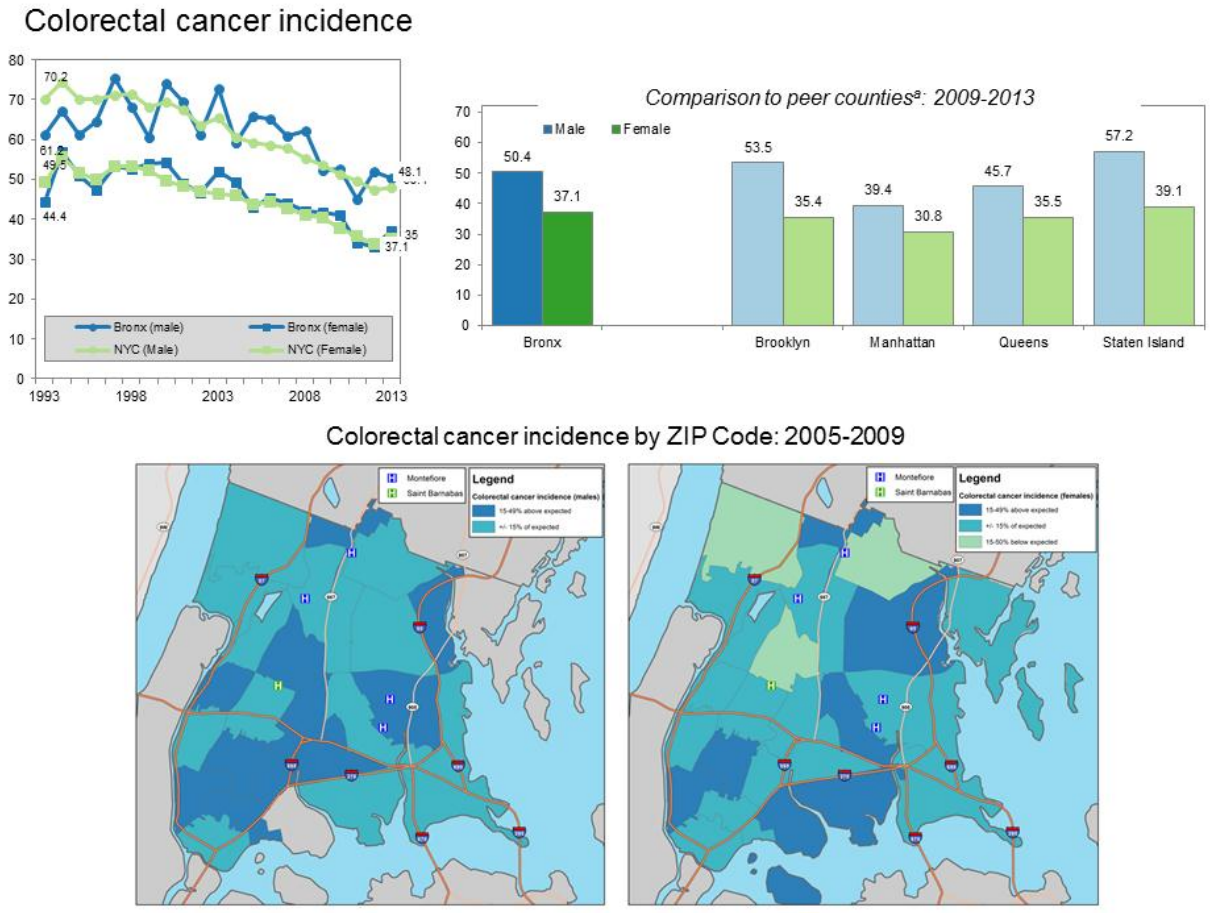
Figure 23. Age-adjusted lung cancer incidence



Data source: New York State Cancer Registry

- Among men in both the Bronx and New York City, rates of lung cancer declined, but they remained stable among women.
- Rates of lung cancer incidence were comparable in the Bronx to other New York City boroughs, with the exception of Staten Island, which has considerably elevated rates.
- For men, areas of elevated incidence were observed in West Farms, Morrisania and City Island. For women, only City Island had elevated rates.

Figure 24. Age-adjusted colorectal cancer incidence



Data source: New York State Cancer Registry

- Colorectal cancer incidence rates, among both men and women, have declined in the Bronx and the rest of New York City.
- Rates were generally comparable across boroughs, though Manhattan had substantially lower rates.

5b. Primary Data Analysis

Three primary data collection strategies were used to triangulate the identification of community health priorities in the Bronx, including: 1) the 2014 Community Needs Assessment (CNA) conducted by the New York Academy of Medicine (NYAM), 2) the New York City Community Consultations, implemented by the New York City Department of Health and Mental Hygiene, and 3) a survey of Bronx residents implemented in collaboration with the Westchester County Department of Health to support the CSPs/CHNAs for hospitals in Westchester County. The methods and key results of each of these primary data collection activities are summarized below. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

2014 Community Needs Assessment

Results

Feedback from the community members was that they were primarily concerned with diabetes, obesity, cancer, cardiovascular disease, asthma, violence and behavioral health issues. Community members connected these issues most closely with housing insecurity, unsafe environments and poor access to healthy foods.

New York City Community Conversations

Results

At eight events held in the Bronx, 43% of respondents identified as Hispanic, 32% as Black, 9% as White, 2% as Asian, 1% as American Indian or Alaskan Native, and 11% as other. Ninety-four percent (94%) identified English as their preferred language and 6% preferred Spanish. Sixty-two percent of participants were female, 27% were men, 1% identified as transgender, 1% as fluid, 1% other, and 9% declined to respond. For the Bronx overall, obesity, high school graduation, smoking, air quality and child care were the top five priorities identified from eight community meetings. Obesity received, by far, the highest average score, earning an average ranking of 17.5 out of 23, compared to high school graduation (15.1 out of 23), which was second (see **Figure 24**). Obesity was the only priority identified as a top five concern in each of the eight community meetings).

Figure 25. Relative rankings of top five priorities identified at Bronx Community Consultations

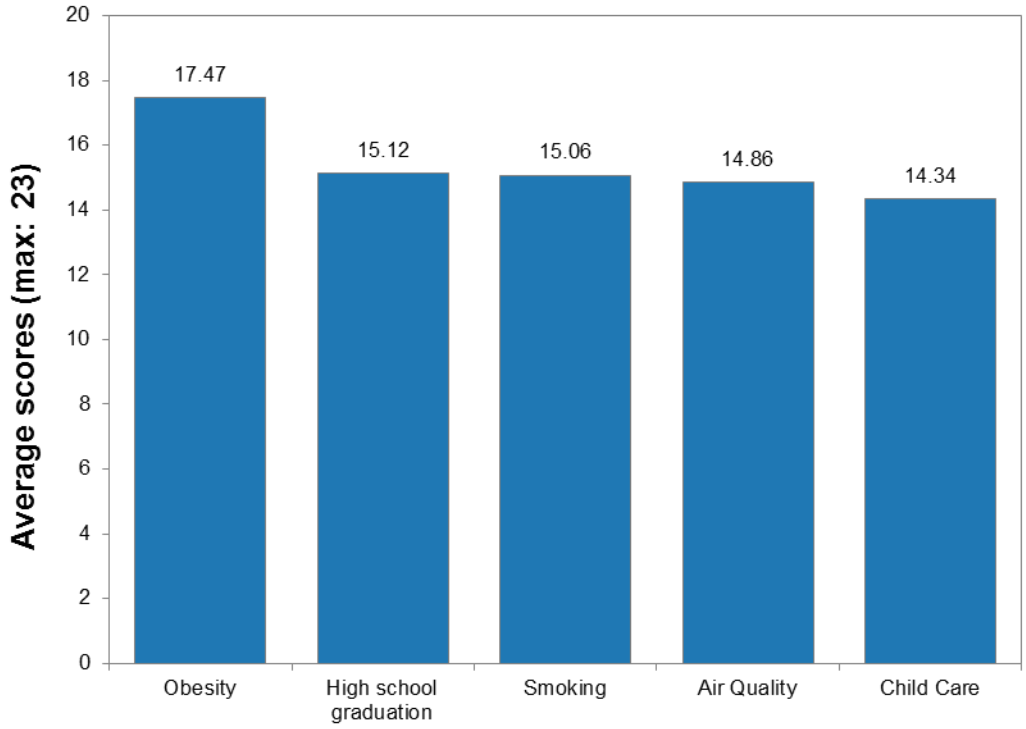


Table 4 describes the priorities identified at each Community Consultation.

Table 4. Bronx Community District Priorities

Community and Selected Priorities
Hunts Point and Longwood (CD 2)
(Including Hunts Point and Longwood)
1. Obesity*
2. High School Graduation*
3. Smoking*
4. Air Quality*
5. Child Care*
Morrisania and Crotona (CD 3)
(Including Claremont, Crotona Park East, Melrose and Morrisania)
1. High School Graduation*
2. Obesity*
3. Violence
4. Physical Activity
5. Child Care*
Highbridge and Concourse (CD 4)
(Including Concourse, Concourse Village, East Concourse, Highbridge, Mount Eden and West Concourse)
1. Obesity*
2. High School Graduation*
3. Violence
4. Air Quality*
5. Physical Activity
Fordham and University Heights (CD 5)
(Including Morris Heights, Mount Hope, South Fordham and University Heights)
1. Obesity*
2. Controlled High Blood Pressure
3. Smoking*
4. High School Graduation*
5. Physical Activity
Belmont and East Tremont (CD 6)

Community and Selected Priorities

(Including Bathgate, Belmont, Bronx Park South, East Tremont and West Farms)

1. High School Graduation*

2. Obesity*
3. Unmet Mental Health Need
4. Child Care*
5. Drug Overdose Deaths
Riverdale and Fieldston (CD 8)

(Including Fieldston, Kingsbridge, Marble Hill, Riverdale, Spuyten Duyvil and Van Cortlandt Village)

1. Obesity*

2. Physical Activity
3. Unmet Mental Health Need
4. Air Quality*
5. Controlled High Blood Pressure

* Indicates priority selected as top five in the Bronx.

Community Survey

Overview

Lastly, in collaboration with the Westchester County Department of Health, with whom we were collaborating on data collection for Westchester County, we fielded a web-based survey assessing community health concerns.

Methods

The survey was disseminated to community based organizations and other partners in the Bronx, and data were evaluated for those working/residing in the Bronx. The survey was administered from August 2016 through October 2016 using SurveyMonkey. Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health.

Results

The survey was completed by 127 participants. Twenty-nine percent of participants were 45-54y, 19% were 35-44y and 23% were 55-64y. Sixty-nine percent of participants were women

and 31% were men. Thirty-three percent identified themselves as being Hispanic, 36% as non-Hispanic white and 20% as non-Hispanic black.

Among 127 participants, obesity, diabetes, drug abuse, nutrition and mental health as the five most important community health priorities in the Bronx. The five priorities with the greatest potential to improve population health were exercise/weight loss programs, access to healthy foods, affordable housing, community education and clean air & water.

Key Findings from Analysis

Despite each of these different methods and approaches to primary data collection in gathering community input, there was a consistent focus on obesity and related behaviors and outcomes as the main community health concerns. Obesity and its related behaviors have significant impact on chronic disease, therefore, it is intended that the programs that are detailed specifically for the reduction of obesity will also impact the prevalence of diabetes, hypertension, asthma and cardiovascular disease in Bronx County.

6. Measures and Identified Resources to Meet Identified Needs

6a. Internal Resources and Measures

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Adherence Intervention for Pediatric Renal Transplant	Adherence Intervention for Pediatric Renal Transplant aims to support adolescents (14-21) awaiting kidney transplant who struggle with their treatment regimens. The program uses dialectical behavior therapy, counseling, support groups and medication management with the goal of improving quality of life and general life skills.	Increase in patient adherence to renal transplant treatment regimens; Improvement in patient quality of life	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Adolescent AIDS Program	The Adolescent AIDS Program (AAP) provides comprehensive care, risk reduction services and HIV counseling to HIV-positive adolescents (13-24). The	Decrease in high-risk behavior; Increase in HIV testing; Increase in	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	program also offers rapid and simple HIV testing and counseling to at-risk youth throughout the Bronx, especially in areas of high seroprevalence.	linkage to treatment and care for HIV+ individuals	
Adolescent Depression and Suicide Program	Adolescent Depression and Suicide Program is a subspecialty outpatient clinic within the Dept. of Psychiatry that provides comprehensive assessments and evidence-based treatment for youth (12-18) who present with symptoms of depression, suicidal behaviors and non-suicidal self-injurious behaviors. Many patients also struggle with school, family and drug problems. The program runs lectures and workshops for school personnel, students and community members.	Decrease in adolescent depression rate; Decrease in adolescent suicide and attempted suicide rates; Decrease in adolescent suicidal feelings	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
AIDS Center	As a New York State Dept. of Health-designated AIDS Center, this division at Moses provides a broad array of inpatient and outpatient services to adults (22+) living with AIDS. The care model consists of an integrated team of health care professionals, including physicians, social workers, nurses, HIV counselors, dietitians, adherence counselors, researchers, mental health providers, pharmacists and administrative staff.	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
B'N Fit	B'N Fit is a comprehensive weight loss program for obese teens (12-21) that conducts medical, nutritional and psychosocial evaluations and refers participants to treatment for obesity-related illness. The program is offered in conjunction with a	Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

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

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
CFCC'S Breastfeeding Support	CFCC's Breastfeeding Initiative is a collaborative effort between the Depts. of Pediatric Medicine and OB/GYN that supports new mothers and trains staff to manage breastfeeding. Expectant and new mothers and their infants (0-2) are referred to a board certified pediatrician who is also a board certified lactation consultant, who provides individual consults and runs a weekly breastfeeding group clinic. The program's goal is to improve breastfeeding rates in the hospital and clinic settings and to help Montefiore become recognized as a “baby-friendly hospital” by the WHO. Individual consults are available 3 mornings per week and the breastfeeding group clinic meets on Thursday	Increase in proportion of mothers who breastfeed	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	afternoons. Annual lectures are given to pediatric residents and other staff.		
CHAM Oncology Groups	Over four 12-week sessions in 2012, up from 2 in 2011, CHAM runs four distinct support groups targeted to: teenagers with cancer, school-age children with cancer, siblings of cancer patients and parents of children undergoing cancer treatment.	Increase in patient satisfaction for oncology patients and their families	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse
CHAM Sickle Cell Groups	Over a 10-week session, CHAM runs a support group targeted to school-	Increase in patient satisfaction for sickle cell patients and	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	age sick cell patients. The group gives patients an opportunity to meet others going through similar experiences and provides the chance for self-expression and positive socialization.	their families	
CHF Disease Management	Through primary care and care management services, the CMO seeks to decrease preventable readmissions and improve the continuity of care for the hospital's Emblem CHF patients. At-risk patients are managed through case management calls, home visits and the use of telehealth and telescales.	Decrease in preventable readmissions for CHF patients; Increase in continuity of care for CHF patients	Prevent Chronic Diseases
Children's Evaluation and Rehabilitation Center (CERC)	CERC, the clinical arm of the Rose F. Kennedy University Center for Excellence in Developmental Disabilities, offer multidisciplinary evaluation and treatment to children and adults with	Increase in patient satisfaction for individuals with intellectual and other disabilities	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	intellectual and other disabilities, such as autism spectrum disorder, cerebral palsy, mental retardation, learning disabilities. The Center is composed of 10 teams, which focus their activities on a specific component of this population.		
Colorectal Cancer Patient Navigation Program	The Colorectal Cancer Patient Navigator Program is the bridge between the community and health care. We eliminate complexity bringing together interdisciplinary teams to work towards reducing colorectal cancer rates by assessing, educating, scheduling, and guiding our patients through the screening process. Our aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-show and	Increase in screening for colorectal cancer; Decrease in colorectal cancer	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	cancellation rates.		
Communilife Montefiore Temporary Respite Program	The program provides temporary community-based supportive housing for Montefiore inpatients who do not have a suitable living arrangement and do not need to be hospitalized. Patients who are discharged into the program facility receive case management, medication management, care coordination, entitlements services and the support they need to find suitable permanent housing.	Increase in patient satisfaction; Increase in proportion of inpatients who report having suitable living arrangements	Promote a Healthy and Safe Environment

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Comprehensive Services Model, CSM	CSM is a Welfare-to-Work program for public assistance clients with substance use disorders. CSM comprehensively evaluates all clients and then case manages them with the goals of stabilization in substance abuse treatment and either employment or attainment of federal disability benefits, if eligible. CSM refers to state-certified substance abuse treatment programs and provides comprehensive social services.	Increase in stabilization in substance abuse treatment; Increase in employment of individuals with substance abuse disorders; Increase in attainment of federal disability benefits for individuals with substance abuse disorders	Promote Mental Health and Prevent Substance Abuse
Diabetes Disease Management	Through care management services delivered telephonically, face-to-face (both one-on-one and in group settings) and through direct mail, the CMO empowers people with Type II diabetes to improve their health outcomes and quality of	Increase in positive health outcomes for individuals with diabetes; Increase in quality of life for individuals with diabetes	Prevent Chronic Diseases

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	of Care and it is tailored to meet the needs of our Bronx residents. Patients are referred to PROMISED by their primary care physicians and following completion of the program they are empowered to better manage their disease. Each case is reviewed and discussed separately and the referring PCP receives a consultation letter regarding management of glycemic control, cardiovascular risk factors and comorbidities. Individual cases are presented adhering to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)		
Dialysis Outreach	Dialysis outreach seeks to strengthen communication between Montefiore's transplant program and community physicians and	Increase in patient satisfaction; Increase in provider	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	to provide a seamless referral service where a physician or patients only need to make one phone call and will receive an appointment with a Montefiore Hepatologist, Nephrologist or Surgeon depending on the reason for the referral. The program seeks to resolve customer service issues, help expedite the referral and evaluation process and answer any questions pertaining to transplant and Montefiore. Dialysis outreach also provides in service training for dialysis staff so that understand transplant. Additionally, the program works with the American Liver Foundation, National Kidney Foundation and Organ Donor Network on education, community events and outreach.	satisfaction	

Program Name	Description	Intervention Measures	NYS Prevention Agenda
DOH Infertility Demonstration Project	The Infertility Demonstration Project is a statewide campaign that helps couples (21-44) who lack the financial resources to access In-vitro Fertilization services. Depending on total household income, the participating couple is required to pay a certain portion of fees after insurance. The Dept. of Health then pays the remaining cost. The program is particularly important for couples whose insurance does not cover the cost of medication for the IVF cycle.	Increase in access to In-vitro fertilization services	Promote Healthy Women, Infants and Children
Explainer Program	The Explainer program employs youth interns from the community to teach patients and families at CHAM how to navigate the interactive patient care system at the bedside TV. This system, called the	Increase in patient satisfaction	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	GetwellNetwork, offers health education, TV, video, internet, gaming, and customer service to patients and their families. The interns are provided with career workshops and encouraged to pursue career opportunities in health care through skill building in resume writing, interviewing and education.		
Family Treatment/Rehabilitation	Family Treatment/Rehabilitation is an evaluation and case management program for families with identified risk of child abuse or neglect and identified psychiatric or substance use disorders. The program provides evaluation and referral for treatment, and provides case management to track participation.	Increase in quality of case management for families with identified risk of child abuse or neglect	Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Farmer's Market Walks	Every Tuesday from June-November, nutritionists and health educators lead groups at various Montefiore sites to local Farmer's Markets. Participants learn about seasonal produce, discuss recipes and when available, receive "Health Bucks," a $2 coupon to purchase a fruit or vegetable.	Increase in healthy eating habits; Increase in fruit and vegetable consumption	Promote a Healthy and Safe Environment
Geriatric Ambulatory Practice	The Geriatric Ambulatory Practice provides comprehensive primary care to very frail patients (65+). It focuses on medical and functional assessment for patients and offers consultation visits for primary care physicians who are having difficulty caring for dementia, frequent falls, osteoporosis, elder abuse and multiple chronic conditions that impact the elderly. The practice also	Increase in patient satisfaction	Prevent Chronic Diseases

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

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Healthy Steps	Healthy Steps ensures that primary care for infants and toddlers focuses on issues of development, behavior, parental mental health and the parent-child relationship. Building on the national model, the program collocates and integrates behavioral and mental health specialists in the pediatric primary care setting. These specialists use screening tools such as maternal depression screening and child social emotional screening to determine and implement interventions that ensure successful early childhood years.	Increase in patient satisfaction; Increase in pediatric access to primary care	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse
Heart Month	During the month of February, The Center for Heart & Vascular Care conducts a series of educational sessions and health screenings for Montefiore associates and for residents of the Bronx.	Increase in blood pressure screenings; Increase in cardiac health	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	The Center conducts lectures about heart health and healthy lifestyles as well as blood pressure screenings and counseling sessions at all Montefiore campuses, in senior citizen centers, local elementary schools, colleges and health centers.		
Hepatitis C Support Group	The Hepatitis C Support group is a supportive service for adults with Hepatitis C. Topics of discussion include disease management, treatment options, side effects, compliance and coping with relational and psychological impacts of disease and treatment.	Increase in patient satisfaction for individuals with Hepatitis C	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
HPV Vaccine Clinic	The HPV Vaccine clinic is a stand-alone clinic open to the Montefiore community and local medical providers. It offers vaccines, education and counseling to women ages 19-26 in an effort to reduce the spread of sexually-transmitted HPV infection and the onset of cervical cancer. Before the creation of the program, many OB/GYN clinics, and providers of women's health in 19-26 year olds in the community had stopped providing the vaccine to women in this age bracket due to insufficient Medicaid coverage and low reimbursement. The clinic also seeks to correct billing issues and allow for vaccines to be provided through sponsored programs to low income women in order to make	Increase in HPV vaccination rate	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	vaccine administration cost effective. This site also offers participation in ongoing research projects as well.		
Integrated Medicine and Palliative Care Team (IMPACT)	IMPACT is an interdisciplinary service that provides integrative palliative care to for pediatric patients facing life threatening or life limiting disease, and their care givers. Services include palliative and end-of-life care, pain management, mental health services,	Increase in patient satisfaction	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	acupuncture, essential oil therapy, reiki, yoga, massage, healing touch, nutrition and supplements, cooking classes, herbal medicine and homeopathy, among others. The team educates students and staff on palliative care and conducts research to measure the effectiveness of its interventions. It conducts research to measure to measure the effectiveness of its interventions. IMPACT		
Lead Poisoning Prevention Program	A designated NYS Resource Center for Lead Poisoning Prevention, the LPPP consists of a multidisciplinary team in medicine, research, social services, environmental investigation, and public advocacy. It serves as a referral center for the medical management of lead poisoning, links	Decrease in lead poisoning	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	families to safe housing during home abatement procedures, provides bilingual educational workshops, advocates for lead poisoned children during local and state legislative reviews and collaborates with city and private agencies in environmental intervention.		
LINCS Program at CHAM	LINCS is a medical home that provides comprehensive primary care and care coordination in outpatient, inpatient and home care settings to children (0-21) with complex, chronic and life-limiting conditions. The program incorporates a palliative care consultation service that provides ongoing care to children in community-based home hospices. Additionally, the program delivers comprehensive primary	Increase in patient satisfaction; Increase in accessibility of primary care services available to children	Prevent Chronic Disease; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	care to siblings during and after their brothers and sisters have passed away.		
Liver Transplant Support Group	The Liver Transplant Support Group is a psycho-educational program for pre- and post-liver transplant patients and their families. Led by two social workers and a psychiatrist, the groups focus on expectations and challenges pre and post liver transplant, learning signs and symptoms of liver disease, disease management, and strengthening coping skills in a mutually supportive environment.	Increase in patient satisfaction for liver transplant patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Medical House Calls Program	Through medical home visits, the CMO helps chronically ill, at-risk geriatric and adult patients who have a history of multiple inpatient admissions and are homebound. A team of primary care physicians provide medical care. The program is also supported by social workers, outreach specialists and nurses who collaborate to address a variety of psychosocial concerns affecting the patients medical condition. The program has the capacity to care for 750 patients.	Increase in patient satisfaction; Increase in accessibility of primary care services	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Mobile Dental Van	The Mobile Dental Van provides dental care to patients at MMC affiliated schools that do not have permanent dental services. Staffed by a dentist and a hygienist and equipped with two dental chairs, a digital X-Ray system and a billing system, the van operates five days per week and visits schools on a rotating schedule.	Increase in proportion of individuals receiving dental care	Prevent Chronic Diseases
Montefiore School Health Program	MSHP is the largest and most comprehensive school-based health care network in the United States. It has 20 school-based health center sites that provide primary care, mental health, oral health and community health services to patients regardless of citizenship	Increase in proportion of students receiving health care	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	status and ability to pay. All sites are federally qualified or partially qualified health centers. Included in MSHP is the Healthy Kids program, comprised of an array of evidence-based prevention activities focused on increasing physical activity and healthy eating in Bronx children and their families.		
Mosholu Preservation Corporation (MPC)	MPC is a non-profit organization committed to preserving and revitalizing Bronx neighborhoods by improving housing and promoting economic and community development. It is governed by a Board of Directors made up of Montefiore trustees and management, community leaders and development experts who serve in a pro bono capacity.	Increase in local economy; Increase in preservation of neighborhoods	Promote a Healthy and Safe Environment

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	one of the largest providers of health care to homeless children in New York City. NYCHP's innovative service delivery model is comprised of fully equipped mobile clinics, small clinics in shelters, and a full-time health clinic in the South Bronx. A wide array of services is provided to attend to the complex health and psychosocial needs of homeless children, adolescents and adults:• Comprehensive primary care• Asthma care (Childhood Asthma Initiative)• Women's health care• Dental care• Mental health counseling, assessment, crisis intervention, and referrals• Substance abuse prevention and referrals• Case management• Emergency food assistance• Children's		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	nutrition education and physical activity program ("Cooking, Healthy Eating, Fitness and Fun" or CHEFFs)• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call NYCHP was one the first mobile medical programs in the country to achieve Level 3 Patient Centered Medical Home (PCMH 2008) recognition from National Committee for Quality Assurance (NCQA). NYCHP maintains a Community Advisory Board (CAB) comprised of consumers/patients; CAB meetings are held each quarter at a different homeless family shelter and often include members new to the system. NYCHP relies on the CAB's input to ensure the effectiveness of		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	services and that care remains responsive to the needs of the special population served.		
Office of Community and Population Health	Working closely with colleagues at Montefiore, the Albert Einstein College of Medicine and partners from a wide range of institutions, governmental agencies and community-based organizations, the Office of Community Health, a part of the Department of Community & Population Health, identifies community health needs, shares information about community health services and promotes collaborative interventions. OCPH also runs the Health Education program which provides one-on-one and group health coaching in 15 of the primary care sites.	Increase in accessibility to health care; Increase in community-based health interventions	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	Additionally, the Office develops effective strategies and methods to evaluate the impact of interventions on community health needs.		
Office of Community Relations	By functioning as the link between the community and the medical center's resources, the Office of Community Relations develops positive collaborations with community-based organizations, government agencies and elected officials in the regions served by Montefiore.	Increase in community-based health interventions	Promote a Healthy and Safe Environment

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Internship Program	The Office of Volunteer and Student Services and the Learning Network recruits, orients and processes interns for the medical center, including high school, college and master's level students.	Increase in satisfaction of interns	Promote a Healthy and Safe Environment
Oral Head and Neck Screening	Screening for Oral Head and Neck Cancer. Event takes place at MECCC in April.	Increase in screening for Oral Head and Neck Cancer; Decrease in Oral Head and Neck Cancer	Prevent Chronic Diseases
Organ/Tissue Donor Program	The Organ/Tissue Donor Program raises awareness about organ/tissue donation and transplantation within the Montefiore and Bronx communities. Through educational initiatives and a range of recruitment activities, the program helps potential donors understand the importance of donation and encourages them to	Increase in educational programs about organ donation; Increase in number of people who join the donor registry	Prevent Chronic Diseases

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

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

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

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	education curricula to have a measurable impact upon behavior. The program is delivered the curriculum to students in the ninth grade before many become sexually active.		
Prostate Cancer Screening	Montefiore Medical Center in partnership with the Daily News offering free PSA blood tests for men age 40 and over. Event runs for 4 days in June at various Montefiore sites.	Increase in Prostate Cancer screening; Decrease in Prostate Cancer	Prevent Chronic Diseases

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Regional Perinatal Center	As a NYS Dept. of Health designated Regional Perinatal Center, one of 18 in the state, Montefiore is a critical referral source for specialized clinical care in high risk obstetrics and neonatology. Montefiore participates in ongoing education, evaluation, data collection and quality improvement efforts with other certified hospitals and affiliates.	Increase in availability of critical obstetric and neonatal care	Promote Healthy Women, Infants and Children
Renal Disease Young Adult Group	The program runs a support group for young adults ages 18-30 years who are diagnosed with End Stage Renal Disease. The support group afford participants the opportunity to share their emotions and concerns with each other and with professional staff.	Increase in patient satisfaction for individuals with End Stage Renal Disease	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Respiratory Disease Management	Through telephonic outreach, health coaching and home visits to higher-risk patients, the CMO aims to improve the health of patients with asthma and chronic obstructive pulmonary disease. Members who were enrolled in our population based program, by either receiving age appropriate educational mailings, or went to ER or were admitted- received an educational call to follow up on their condition.	Decrease in symptomatic asthma and chronic obstructive pulmonary disease	Prevent Chronic Diseases
School Re-Entry Team	The School Re-entry Team coordinates communication between the hospital and school settings in order to promote the best possible transition back to school for CHAM cancer and sickle cell patients.	Increase in satisfaction of cancer and sickle cell patients	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	assistance• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call SBHC's Center for Child Health and Resiliency (CCHR), opened in 2011, is a state-of-the-art facility with a special focus on early childhood development beginning prenatally through 5 years of age. CCHR's innovative programming supports families and equips parents with the nurturing skills needed to overcome stressors detrimental to children's healthy development. SBHC also offers innovative health programs on-site and in the local neighborhood that provide intensive care management, group sessions, and culturally appropriate health education:• Childhood		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	Asthma Initiative• Starting Right, a childhood obesity initiative, nutrition education and fitness program• Diabetes Program• HIV/AIDS Program• Pregnancy Group, prenatal visits with the benefit of group support and in-depth education• Well Baby Group, pediatric visits for infants up to 2 years • Healthy Teens Initiative and access to confidential reproductive health services SBHC is recognized by the National Committee for Quality Assurance (NCQA) as a Physician Practice Connections® – Patient-Centered Medical Home™ (PPC-PCMH) Program at Level 3 Recognition, the highest level available. SBHC maintains an active Community Advisory Board (CAB) comprised of		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	public housing residents and representatives of the South Bronx community (from tenant associations, schools, community based organizations, etc.). The CAB provides invaluable feedback on future plans, service changes, community changes/events, and strategies to draw in new health center patients.		
Strength Through Laughter and Support Program	Strength through Laughter and Support is an educational program that encourages participants to develop a positive attitude as they confront the challenges associated with cancer. By sharing laughter, sadness, wisdom and love in the group setting, participants find a	Increase in patient satisfaction and quality of life of individuals with cancer	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Suzanne Pincus Family Learning Place (FLP)	The FLP is a health information and resource center at CHAM that provides families with educational materials about child health and disease, community resources and available supportive services. The FLP's objective is to empower families to make informed decisions about their children's health care and support the principles of family-centered care. The program also assists medical providers by supplying them with materials to educate families.	Increase in satisfaction of CHAM patients and their parents	Promote Healthy Women, Infants and Children
The J.E. and Z.B. Butler Child Advocacy Center	The JE&ZB Butler Child Advocacy Center(CAC) , established in 1984, is the only medically based, fully accredited child advocacy center in the NYC dedicated to breaking the cycle of abuse. The CAC provides emergency	Decrease in child abuse; Increase in access to care services for children who have been abused	Promote a Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	medical care and psychosocial evaluations and therapy to children (0-18) who been victimized by sexual and physical abuse and/or neglect. Butler's dedicated team of doctors, social workers and psychologists also provide education and training of health professionals and law enforcement personnel, and conducts outreach and research.		
University Behavioral Associates	UBA is the major case management agency within Montefiore's Health Home (Bronx Accountable Health Network). UBA has an enrolled census of 4,000 (largest in NYS). And will include the Children's Health Home programsas well.		Promote Mental Health and Prevent Substance Abuse

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	butter, etc. Counselors encourage breastfeeding for new babies, at six months, new mothers receive vouchers for baby food and cereal. At 12 months, no more formula vouchers are given. Participants see a nutritionist every 3 months and qualification is verified annually. Group education, physical education and food demonstrations are given as well. Montefiore provides space and referrals.		

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

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

In the Comprehensive Community Services plan developed for 2013-2017, the priority areas selected were **Prevent Chronic Disease** and **Promote Healthy Women Infants and Children**. Through the projects and activities initiated during that plan, Montefiore Medical Center was able to contribute to the overall trend improvements in those areas for New York State. However, although Bronx County has shown improvements along with the rest of New York State, the rates for conditions identified in these areas remains higher in most cases than the Citywide and Statewide averages.

As a part of the submission for the New York State Health Improvement Plan for 2016-2018, required by the New York State Department of Health, Montefiore has elected to retain these two priority areas, Prevent Chronic Disease and Promote Healthy Women Infants and Children and has selected three broad focus areas in which to implement programs. These broad focus areas are (1) Reducing Obesity in Children and Adults, (2) Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings, and (3) Improving Maternal and Infant Health. Across these focus areas, five goals, with specific interventions, performance measures and time frames, were identified, and are described below.

Priority Area: Preventing Chronic Disease
Focus Area: Reduce Obesity in Children and Adults

Goal	Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.
Outcome Objectives	Objective 1.1.1: By December 31, 2018, decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day: By 5% from 20.5% (2009) to 19.5% among all adults. By 10% from 42.9% (2009) to 38.6% among adults with an annual household income of <$25,000. (Data source: NYS BRFSS) (Health Disparities Indicator)
Interventions/Strategies/ Activities	Disseminate “Rethink Your Drink” boards across the Health System (including ambulatory care, substance abuse treatment programs, and school health sites) to serve as a tool for educating patients and the community about the amount of sugar present in commonly bought juices, sodas, and other flavored drinks. This work is supported by the Montefiore Healthy Store Initiative (MHSI) staff in partnership with youth groups at local community based organizations (CBO’s) and the Montefiore School Health. who create the boards and then use them to educate peers. They

Goal	Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.
	are part of the MHSI's effort to increase the demand for zero and low calorie beverages at local stores. Through MHSI, engage bodega owners in increasing supply and promotion of zero and low calorie beverages. This work with done in partnership with the Montefiore WIC vendor training program which can provide additional access to, and engagement from, bodega owners. Additional programs that will address obesity include the B'N Fit Program which addresses obesity in adolescent patients through group education and physical activity. Support from the onsite health education staff at the Montefiore Medical group sites will support this goal as well.
Process Measures	Number of boards disseminated at Montefiore sites; number of youth educated by peers on sugar content in commonly purchased sugary drinks; Number of bodegas participating in MHSI
Partner Role	CBO's and School Health sites will assist in engaging youth to make "Rethink Your Drink" boards; Bodega owners approve supply and promotion of products. The Healthy Beverage Zone, an effort of the #Not62 Campaign for a Healthier Bronx will assist in connecting the MHSI with local CBO's. Bronx Health REACH CHAMPS: provide funding for materials for "Rethink Your Drink" boards WIC vendor training program: will provide the MHSI team the ability to conduct presentations before or after WIC vendor trainings Additional programs that will address obesity through small group work within their programs include B'N Fit, Health Education, Montefiore Diabetes Prevention Program and collaborative work done by the #Not 62 Campaign Partners in the Bodega Initiative and the Healthy Beverage Zone.
Partner Resources	Local CBOs/Montefiore School Health Program: Access to community members/youth Healthy Beverage Zone committee: technical assistance and relationship building Bronx REACH CHAMPS: funding
By When	December 31, 2018
Will Action Address	Yes. The community serviced through the proposed program is

Goal	Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.
Disparity	generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic.

Also within Priority Area **Preventing Chronic Disease** is the Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings. In alignment with the Community Needs Assessment that was performed in preparation of the 2014 implementation of the Delivery System Reform Incentive Payment (DSRIP) program as well as the secondary data reporting, increasing the rates for the screening of diabetes, especially among disparate populations is a priority in improvingthe care, management and control of diabetes. In addition to expanding the opportunities for clinical evaluation of diabetic Bronx residents, there are a number of other activities focused on diabetes management, including an active engagement with the National Diabetes Prevention Program from the CDC and managed through a variety of organizations and government agencies including support for smaller faith based and community based organizations through the New York City Department of Health and Mental Hygiene, collaborating with organizations that have elected for an independent relationship with the Quality and Technical Assistance Center of NY (QTAC-NY), and Montefiore's independent pursuit of certification through the Centers for Disease Control (CDC) through the implementation of the Montefiore Diabetes Prevention Program.

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

Goal	Goal #3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.
Outcome Objectives	Objective 3.1.4: By December 31, 2018, increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%. (Data Source: NYS BRFSS)
Interventions/Strategies/ Activities	Engagement of clinical partners in the HbA1c screening protocol as outlined in HEDIS; alignment of clinical and community based resources to address the level of patient health status (prevention, management or control). Increased screening and intervention is also being promoted across the ambulatory setting through the programs associated with DSRIP.

Process Measures	*Data source*	*HEDIS Measure #*	*Description*	*Denominator*	*Target*
Project 3.c.i Comprehensive Diabetes screening – All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor)	HEDIS 2015	0055, 0062, 0057	Number of people who received at least one of each of the following tests: HbA1c test, cholesterol screening test, diabetes eye exam, and Medicaid attention for nephropathy	Number of people ages 18 to 75 with diabetes	62.5%
Project 3.c.i Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±	HEDIS 2015	59	Number of people whose most recent HbA1c level indicated poor control (>9.0 percent), was missing or did not have a HbA1c test	Number of people ages 18 to 75 with diabetes	23.2%
Project 3.c.i Comprehensive diabetes care - LDL-c control (<100mg/dL)	HEDIS 2014	64	Number of people whose most recent level of bad cholesterol was below the recommended level (LDL-C <100 mg/dL), was missing or did not have a LDL-c test	Number of people ages 18 to 75 with diabetes	51.3%
Partner Role	Provide Access to a range of preventive, maintenance and self-management programs for individuals across the pre-diabetes and diabetes spectrum.				
Partner Resources	Partners will provide Technical Assistance, opportunities for neighborhood based cultural/linguistic specific classes, and opportunities for data sharing and collaboration				
By When	December 31, 2018				
Will Action Address Disparity	Yes. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic				

The next Priority Area that was selected is **Promote Healthy Women Infants and Children**, Focus Area: Maternal and Infant Health, Goal 1 Reduce Premature Births, Objective 1.1 - reduce the rate of preterm birth in NYS by at least 12% to 10.2%.

The election of the importance of continuing these efforts comes from the coalition of programs and organizations working in this area, which include membership from local Head Start and child care centers, family resource centers, birthing centers, hospitals and clinics, immigrants and refugee centers, and substance abuse treatment programs. Organizational support was derived through the well-established partnership networks including the Bronx Community Healthcare Network, The Bronx Health Link , which currently directs referrals through the Perinatal Information Network and collaboration and coordination with the Department of Social Services, the Department of Family Medicine and the Department of OB/GYN, and outpatient/inpatient social workers at Montefiore, the Montefiore School Health Program and as well as mental health agencies in the county.

Priority Area: Promoting Healthy Women, Infants and Children
Focus Area: Maternal and Infant Health

Goal	Goal #1: Reduce Premature Births
Outcome Objectives	Objective 1-1 By December 31, 2018, reduce the rate of preterm birth in NYS by at least 12% to 10.2%. (This target is in alignment with the national ASTHO/March of Dimes target of 17.9% improvement by 2020 to achieve a national preterm birth rate of 9.6%)
Interventions/Strategies/ Activities	Engagement with Maternal Infant and Early Childhood Home Visiting Initiative (MIECHV)/Nurse Family Partnership ®, participation in the New York State Baby Friendly Initiative, and or Centering Pregnancy Program
Process Measures	Within the DSRIP framework in Domain 4, references to the NYS Prevention Agenda identifying measures related to the: (1) Overall Percentage of preterm births, (2) the Percentage of preterm births – Ratio of Black non-Hispanics to White non-Hispanics, (3) the percentage of preterm births – Ratio of Hispanics to White non-Hispanics and (4) Percentage of preterm births – Ratio of Medicaid births to non-Medicaid births will be collected and tracked to monitor trending over the CSP Period.
Partner Role	Engagement and referral into appropriate programs (clinical or community) to support mothers at risk for preterm delivery, including non-maternity based programs that correlate to social determinants of health that impact prematurity.
Partner Resources	Technical assistance, supportive community programming, visit

	assistance. Community Health Worker services
By When	December 31, 2018
Will Action Address Disparity	Yes. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic

Each of the two selected Priority Areas has received support from the New York City Department of Health and Mental Hygiene's citywide offices as well as support from the local Bronx Neighborhood Health Action Center. Montefiore, St. Barnabas, and other hospital based and community health partners participated in a series of Take Care New York #TCNY2020 Community Consultations that were led by the New York City department of Health and Mental Hygiene. Of the eight community consultations that were held in Bronx County in the neighborhoods of East Tremont (2) , Pelham Parkway, Soundview, Riverdale, Hunts Point, Mott Haven and Highbridge, every community selected Obesity as one of their top five areas of concern and through these efforts, the New York City Department of Health and Mental Hygiene, in the re-designation of the District Public Health Offices into the Neighborhood Health Action Centers, for the Bronx, East/Central Harlem and Brooklyn, have united on three common themes (1) Nutrition and Physical Activity, (2) Teen Sexual Health and (3) Maternal Health as the focus of their borough specific operations. This exhaustive process has confirmed that there is alignment with both of the Priorities selected through the data review and primary data collection processes across multiple stakeholders.

6c. External Resources and Linkages

In addition to the multiple resources that have been developed at Montefiore independently and through partnership with other organizations(described in Section 7a), there is an extensive need for community-based programs and resources that that can augment Montefiore's programs and services. Knowing how to access those resources is a particular challenge for the health care sector. However, since the previous version of this report in 2013, multiple free and lost cost online search tools have been developed, such as www.auntbertha.com , www.hitesite.org , www.nowpow.com among others. These are a much more comprehensive and practical alternative to the home-grown referral guides that many health care providers have had to use in the past. Those were hard to keep-up-to-date and difficult to search, a problem that is largely addressed by the online versions. Many Montefiore sites have been introduced to these new online resources and work is underway to more seamlessly integrate this kind of solution into the various workflows across the ambulatory, ED and inpatient settings.

7. Appendix

Bronx County Provider Survey and Consumer Survey
An electronic version of the Bronx Partners for Healthy Communities Survey was provided and distributed in five languages (English, Spanish, Arabic, French Creole, and Chinese).

The provider survey was designed to provide reflective comparative insight to the questions being asked of consumers of service.

BRONX PARTNERS FOR HEALTHY COMMUNITIES

BRONX COUNTY COMMUNITY HEALTH SURVEY

We want to hear your thoughts about important health issues in your community. Together, the organizations within the Bronx Partners for Healthy Communities and hospitals throughout Bronx County, NY will use the results of this short survey and other information to help improve health programs in your community. Your responses are completely anonymous. Thank you for your participation!

What are the THREE biggest ongoing health concerns for the COMMUNITY WHERE YOU LIVE?

- ☐ Access to immunizations
- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other *(please specify)* : _____

What are the THREE biggest ongoing health concerns for YOURSELF?

- ☐ Access to immunizations
- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other *(please specify)* : _____

What THREE things would be most helpful to improve YOUR health concerns?

- ☐ Access to dental care
- ☐ Access to healthier food
- ☐ Access to primary care
- ☐ Affordable housing
- ☐ Breastfeeding support
- ☐ Caregiver support
- ☐ Clean air & water
- ☐ Community education
- ☐ Dementia/Alzheimer's screening
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care services
- ☐ Exercise/weight loss programs
- ☐ Health Insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Job opportunities
- ☐ Mental health services
- ☐ Safer childcare options
- ☐ Safer places to walk/play
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other *(please specify)* : _____

How would you describe your overall health?

- ☐ Very healthy
- ☐ Healthy
- ☐ Somewhat healthy
- ☐ Unhealthy
- ☐ Very unhealthy
- ☐ Other *(please specify)* : _____

How would you describe your overall mental health?

- ☐ Very healthy
- ☐ Healthy
- ☐ Somewhat healthy
- ☐ Unhealthy
- ☐ Very unhealthy
- ☐ Other *(please specify)* : _____

Do you suffer from any chronic health conditions (*check all that apply*)

- ☐ None
- ☐ Asthma/breathing problems
- ☐ Auto-immune disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Disability
- ☐ Drug/alcohol abuse
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Memory issues
- ☐ Mental health
- ☐ Overweight/obesity
- ☐ Other *(please specify)* : _____

Do you have a health care provider for checkups and visits:		☐ Yes _____ ☐ No _____
How long has it been since you visited a health care provider for a routine physical exam or checkup?		
☐ In the past year	☐ In the past five years	☐ Never
☐ In the past two years	☐ Five or more years ago	☐ Don't know
What THREE things prevent YOU from getting medical care from a health care provider?		
☐ Nothing prevents me from getting medical care	☐ Cultural/religious beliefs	☐ Insurance does not cover service
	☐ Don't know how to find providers	☐ No transportation/too far
☐ Cannot afford	☐ Don't like going/afraid to go	☐ No childcare
☐ Cannot find a health provider who speaks my language	☐ Don't see the benefit	☐ No insurance
	☐ I have no time	☐ Other *(please specify)* : _____
☐ Co-pay/deductible too high	☐ Inconvenient office hours	
In the past 12 months, did you receive care in the emergency room?		☐ Yes _____ ☐ No _____
If yes, what is the ONE main reason for your emergency room visit?		
☐ Could not find a local health provider who speaks my language	☐ Health provider said go to emergency room	☐ Thought problem too serious for a doctor's visit
☐ Doctor's office not open	☐ No other place to go	☐ Other *(please specify)* : _____
☐ Emergency room is the closest provider	☐ Receive most of my care at emergency room	
Where do you and your family get most of your health information? (*check all that apply*)		
☐ Community-based organization	☐ Internet	☐ School/college
☐ Doctor/Health professional	☐ Library	☐ Social media (Facebook, Twitter, etc.)
☐ Family or friends	☐ Newspaper/magazine	☐ Television
☐ Health department	☐ Radio	☐ Worksite
☐ Hospital	☐ Religious organization	☐ Other *(please specify)* : _____

For statistical purposes only (your responses are anonymous), please complete the following:		
I identify as:	**What is your age:**	
☐ Male	☐ 18-24	☐ 55-64
☐ Female	☐ 25-34	☐ 65-74
☐ Other	☐ 35-44	☐ 75+
	☐ 45-54	
Zip code where I live _____	**Town/city where I live** _____	
Are you Hispanic or Latino?	☐ Yes	☐ No
What category best describes your race?		
☐ White/Caucasian	☐ American Indian/Alaskan Native	☐ Multi-racial
☐ Black/African American	☐ Asian/Pacific Islander	☐ Other
What is the primary language you speak?		
☐ English	☐ Portuguese	☐ Tagalog
☐ Spanish	☐ French	☐ Korean
☐ Italian	☐ Chinese	☐ Other *(please specify)* : _____
What is your highest level of education?		
☐ Less than high school	☐ Some college	☐ Other *(please specify)* : _____
☐ High school grad/GED	☐ College graduate	
☐ Technical school	☐ Advanced degree	
What is your current employment status		
☐ Employed	☐ Student	☐ Retired
☐ Not employed	☐ Military	☐ Other *(please specify)* : _____
Do you have any of the following types of health insurance?		
☐ Medicare	☐ Private insurance	☐ None/no insurance
☐ Medicaid	☐ Tri-Care	☐ Other *(please specify)* : _____

Please return the survey by ***September 30, 2016*** *.*
Email: bqlc@westchestergov.com Fax: 914-813-4303.
Mail: Bonnie Lam, Department of Health, 10 County Center Road, 2nd Floor, White Plains, NY 10607-1541

BRONX PARTNERS FOR HEALTHY COMMUNITIES

BRONX COUNTY PROVIDER SURVEY

We want to hear your thoughts about important health issues in the community you serve. Together the organizations within the Bronx Partners for Healthy Communities and hospitals throughout Bronx County, NY, will use the results of this short survey and other information to help improve health programs. Thank you for your participation!

Agency Name: _____
Zip code of site location: _____

Optional:
Your name _____ **Phone #** _____ **Email address** _____

How would you best describe your title/role in your agency?

- ☐ Advocate
- ☐ Alcohol/substance provider
- ☐ Allied health professional
- ☐ Behavioral health care provider
- ☐ Board member
- ☐ Dental provider
- ☐ Executive director
- ☐ Health educator
- ☐ Office manager
- ☐ Primary care provider
- ☐ Program administrator/manager
- ☐ Specialty care provider
- ☐ Other *(please specify)* : _____

Please check the categories that best describe your agency. *(Please check all that apply)*

- ☐ Alcohol/substance Abuse Agency
- ☐ Community-based Organization
- ☐ Community Health Center
- ☐ Dental Practice
- ☐ Home Care Agency
- ☐ Hospital
- ☐ Medical Practice
- ☐ Mental Health Agency
- ☐ Outpatient Clinic
- ☐ Other *(please specify)* : _____

Please check the type of services provided by your agency. *(Please check all that apply)*

- ☐ Breastfeeding support
- ☐ Case management
- ☐ Childcare
- ☐ Community education
- ☐ Dental services
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care/senior services
- ☐ Exercise/ weight loss programs
- ☐ Family planning
- ☐ Food access
- ☐ Health insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Housing
- ☐ Immigrant support services
- ☐ Immunization
- ☐ Mental health services
- ☐ Prenatal/PCAP services
- ☐ Primary care services- adults
- ☐ Primary care services- children
- ☐ Rehabilitation services
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other *(please specify)* : _____

Please check all persons served by your agency. *(Check all that apply)*

- ☐ Adults
- ☐ Children
- ☐ Disabled
- ☐ Immigrants
- ☐ Low-income
- ☐ Uninsured
- ☐ Seniors
- ☐ Other *(please specify)* : _____

What are the THREE biggest ongoing health concerns for the people/community you serve?

- ☐ Access to immunizations
- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/ suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other *(please specify)* : _____

What THREE things would be most helpful to improve the health concerns of the community you serve?

- ☐ Access to dental care
- ☐ Access to healthier food
- ☐ Access to primary care
- ☐ Affordable housing
- ☐ Breastfeeding support
- ☐ Caregiver support
- ☐ Clean air & water
- ☐ Community education
- ☐ Dementia/Alzheimer's screening
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care services
- ☐ Exercise/weight loss programs
- ☐ Health Insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Job opportunities
- ☐ Mental health services
- ☐ Safer childcare options
- ☐ Safer places to walk/play
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other *(please specify)* : _____

How would you rate the health of the people/community you serve?

- ☐ Very healthy
- ☐ Healthy
- ☐ Somewhat healthy
- ☐ Unhealthy
- ☐ Very unhealthy
- ☐ Other *(please specify)* : _____

What are the THREE most significant barriers impacting YOUR ABILITY to provide services to your patients/clients?

- ☐ Cultural competency issues
- ☐ High no-show rate
- ☐ Inadequate insurance reimbursement
- ☐ Lack of funding
- ☐ Limited bi-lingual staff
- ☐ Limited or lack of access to specialists
- ☐ Limited space and/or equipment
- ☐ Limited staffing resources
- ☐ Patient cannot afford prescription medications
- ☐ Patient non-adherence to treatment
- ☐ Staff time contrains
- ☐ Other *(please specify)* : _____

For the patients/clients you serve, what are the top THREE barriers impacting YOUR CLIENTS' ability to access your services?

- ☐ There are no issues
- ☐ Cannot afford services
- ☐ Co-pay/deductible too high
- ☐ Cultural/religious beliefs
- ☐ Don't know how to access services
- ☐ Don't like going/afraid to go
- ☐ Don't understand need to see a provider
- ☐ Inconvenient hours
- ☐ Insurance does not cover service
- ☐ Lack of time
- ☐ Lack of/or limited staff/service
- ☐ Lack of/or limited staff who speak their language
- ☐ No transportation/too far
- ☐ No childcare
- ☐ No insurance
- ☐ Unaware of services available
- ☐ Other *(please specify)* : _____

Where do community members you serve get most of their health information? *(Check all that apply)*

- ☐ Community-based organization
- ☐ Doctor/Health professional
- ☐ Family or friends
- ☐ Health department
- ☐ Hospital
- ☐ Internet
- ☐ Library
- ☐ Newspaper/magazine
- ☐ Radio
- ☐ Religious organization
- ☐ School/college
- ☐ Social media (Facebook, Twitter, etc.)
- ☐ Television
- ☐ Worksite
- ☐ Other *(please specify)* : _____

Please return the survey by ***September 30, 2016*** *.*

Email: bqlc@westchestergov.com Fax: 914-813-4303.

Mail: Bonnie Lam, Department of Health, 10 County Center Road, 2nd Floor, White Plains, NY 10607-1541

Can we contact you so you can tell us more about your ideas regarding health problems in Bronx County and what should be done about them?

- ☐ Yes _____
- ☐ No _____