

Community Health Needs Assessment and Implementation Plan 2016-2018

Montefiore Mount Vernon/
Montefiore New Rochelle

Office of Community and Population Health

12/6/2016

Montefiore Mount Vernon/ Montefiore New Rochelle
Community Health Needs Assessment and Implementation Strategy 2016

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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 provides a report of the process, methods and results of a comprehensive assessment of the needs of the community served by Montefiore Mount Vernon/Montefiore New Rochelle. The Implementation Strategy further elaborates on the significant health needs of the community, describes the programs and strategies to address these significant health needs, and delineates the metrics to be used to evaluate the impact of these strategies.

The Montefiore Mount Vernon/Montefiore New Rochelle 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 on December 31, 2016.

Montefiore Health System'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, 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 lower Westchester region; 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 system.

Montefiore participates in a variety of organized partnerships and collaborative, working with other providers in Westchester County, including the Westchester County Department of Health, community-based organizations and members of the community in planning and developing initiatives aimed at improving the health of the people of Westchester County.

Definition and Description of the Community

The Lower Westchester facilities of Montefiore Mount Vernon and Montefiore New Rochelle have identified Westchester County as their primary service area. Within the cities of Mount Vernon and New Rochelle, the Montefiore facilities are the largest health service providers and it is within this geographic area that these Montefiore facilities have their community-based primary care and specialty ambulatory services. Moreover, partner Montefiore facilities in White Plains, Yonkers, and Harrison, New York allow patients to have access to a range of services extending beyond the walls of the Mount Vernon and New Rochelle facilities.

Westchester County is a large county located just to the north of New York City in the Hudson Valley; Westchester covers an area of 450 square miles (1,200 km²) and consists of 48 municipalities. The County includes urban, suburban and rural geographies. In 2015, the

estimated population of Westchester County was 976,396, up 6.6% from 915,916 in 2005. The county seat of Westchester is the city of White Plains (56,853) and other major cities include Yonkers (195,976), New Rochelle (77,062) and Mount Vernon (67,292). In 2015, the median household income for Westchester was \$86,108, 4th highest in New York State, after Nassau, Putnam and Suffolk Counties. Westchester County is the 5th healthiest county in New York State, according to the County Health Rankings, produced by the Robert Wood Johnson Foundation and University of Wisconsin. Despite its overall high ranking, there is considerable room to both improve population health and reduce health disparities in Westchester County.

The City of Mount Vernon has the highest proportion of Black/African American residents in Westchester County at 66%, with 34% of all residents being foreign born. Additionally it is the seat of Westchester County's homeless services and senior services programs housing a disproportionate number of economically challenged residents. The City of New Rochelle, while geographically larger, has an equivalently sized population, but a larger proportion of Spanish-language-only residents of Latino origin and is the anchor city for the Long Island Sound Region in Westchester County.

Assessment of Community Health Needs

The process to identify the needs of the community involved the collection of both secondary and primary data. Multiple conversations and meetings were convened internally and with external partners, and a thorough review of the data was conducted, all of which will frame the development of the Implementation Strategy. 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 sample of the Westchester county residents was an important element of the development of the Community Health Needs Assessment. Montefiore engaged with 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 Westchester 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. The priority areas selected and each of the planned interventions focus on specific priority populations and address the ethnic and cultural disparity defined in the indicators for the population served by Montefiore.

Collaborations/Partnerships

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 two Priority Areas identified with key data points highlighted are to **Prevent Chronic Disease** and to **Promote Healthy Women Infants and Children**. Within the Prevent Chronic Disease Priority Area, the two focus areas selected as **(1) Reducing Obesity in Children and Adults** and is **(2) Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings**.

In Reducing Obesity in Children and Adults, the objective is 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 (2) By 10% from 42.9% (2009) to 38.6% among adults with an annual household income of < \$25,000.

For Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings, the goal is to increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations. Within this goal, the objective is 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%.

For the second Priority Area selected, **Promote Healthy Women Infants and Children**, the goal selected is to **Reduce Premature Births**, with 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 and 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. In particular, there are programs underway (in collaboration with Hudson River Healthcare and Westchester Local Government Units (LGU) to work with bodegas on healthy snack displays and creating walking paths in parks and communities.

In addition, the Hudson Valley DSRIP PPS that Mt. Vernon and New Rochelle belong, the Montefiore Hudson Valley Collaborative (MHVC) is working on several Motivational Interviewing (MI) interventions and training programs including a software application that uses AVITARS to demonstrate the use of MI with an overweight child (interactive teaching tool) and videos demonstrating the use of Brief Action Planning with a family with an overweight child. These will be available for training clinicians throughout the Westchester area in MI for pediatric obesity self-management.

Of note, MHVC selected several projects across Domains 3 and 4 that focus on tobacco cessation and cardiovascular disease management. As part of a multi-PPS effort, Montefiore participates in a Hudson Valley Public Health Council and the Hudson Valley Regional Health Officers Network (HVHRON) to coordinate the design and deployment of public health initiatives like the recent Tobacco Cessation campaign.

Montefiore's Office of Community & Population Health has a dedicated community educator who spearheads initiatives in the city of Mt Vernon and collaborates with the Director of WIC Initiatives for events in New Rochelle. These events are focused on a variety of issues, ranging from chronic disease management and prevention, cancer screenings and promotion of healthy food consumption. Events range from farmers market walks, workshops in the community, walkathons, health fair and community-based health screens.

The Mount Vernon facility has focused its engagement across multiple health indicators (diabetes, breast, cervical, and colorectal cancers), while addressing cardiovascular disease in the older adult population. To increase screening rates for cardiovascular disease the team coordinates screening services and educational workshops to older adults at frequently occurring points of congregation, including senior centers and Naturally Occurring Retirement Communities (NORC)s . These workshops provide a gateway to engage the community in health programming that ensures that our work is targeted towards high needs/high impact activities. In 2015, we conducted over 80 community health events, including 48 screenings and 31 community workshops, reaching over 3500 residents.

Engaging local community members in our efforts enables us to employ the health care institution and the community in the activities of national health advocacy organizations, including walks, festivals, and other awareness-raising activities for health issues that impact the community.

Montefiore New Rochelle, the labor and delivery service provider for Montefiore Mount Vernon and Montefiore New Rochelle in lower Westchester is home to the designated WIC provider for the region. Monthly workshops, wellness days and fairs are provided through collaboration of WIC patient focused services and the Montefiore New Rochelle Hospital WIC Vendor Management Agency.

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

The Priority Areas selected for the 2016-2018 New York State Health Improvement Plan 2016-2018 align exactly with the priority areas referenced above - Preventing Chronic Disease and Promoting Healthy Women, Infants and Children.

These two Priority Areas have been re-selected in 2016, with the focus areas in promoting Health Women and Children to reducing premature births. This was done 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.

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 Westchester 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 low cost internet databases have entered the public sphere, such as www.auntbertha.com , www.hitesite.org , www.nowpow.com among others that have reduced the need for quickly obsolete and expensive to produce information and referral guides for community resources. 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 Bronx 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.

For more than 20 years, the Montefiore Health System has worked to provide excellent primary and specialty care to the Westchester County community and beyond, first through its community primary and specialty care sites and since 2013, it has expanded through the provision of acute care services. As the University Hospital for the Albert Einstein College of Medicine, Montefiore consists of 11 hospitals, four located in Westchester County, an extensive home healthcare agency, and an ambulatory network of nearly 200 locations throughout the region.

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 on December 31, 2016.

3a. The Populations of Mount Vernon and New Rochelle

The lower Westchester facilities of Montefiore Mount Vernon and Montefiore New Rochelle have identified the Westchester County as their primary service area. The county seat of Westchester is the city of White Plains (56,853) and other major cities include Yonkers (195,976), New Rochelle (77,062) and Mount Vernon (67,292). In 2015, the median household income for Westchester was \$86,108, 4th highest in New York State, after Nassau, Putnam and Suffolk Counties.

Westchester County is the 5th healthiest county in New York State, according to the County Health Rankings, produced by the Robert Wood Johnson Foundation and University of Wisconsin. Despite its overall high ranking, there is considerable room to improve population health in Westchester County, while also reducing health disparities as each of these cities is serving as county anchors for challenged populations.

Mount Vernon

The City of Mount Vernon has the highest proportion of Black/African American residents in Westchester County at 66%, with 34% of all residents being foreign born. Additionally it is the seat of Westchester County's homeless services and senior services programs housing a disproportionate number of economically challenged residents. According to the 2013 American Community Survey of the U.S. Census, Mount Vernon has approximately 68,000 residents within zip codes 10550, 10552, and 10553. This city is 4.4 square miles; noted as the 8th largest city and 2nd most densely populated city in New York State. This city is located north of the Bronx and bordered by Pelham, Bronxville, Eastchester, and Yonkers.

There are approximately 26,000 households in Mount Vernon. The average household size is 2.79 people. Families made up 65.6% of the households; includes both married-couple families (33.4%) and single householder families (32.2% total—3.8% male, 28.4% female). Nonfamily households consist of 34.4% of all households in Mount Vernon; includes people living alone and non-related people living under one household. 37.6% of households include one or more people under 18 years of age. 9.4% of households include one or more people 65 years of age or older.

Mount Vernon is ethnically diverse. Its population is 12.3% Hispanic, 64.7% African-American, 24.7% White, 2.1% Asian, and 5.3% other. Almost one-third (34.2%) of its residents are foreign-born. Among these immigrants, more people speak only English at home than any other language. The city's immigrant communities come from diverse corners of the globe (in order of

frequency): Jamaica, Brazil, Mexico, Dominican Republic, Portugal, the West Indies, Trinidad & Tobago, Italy, Barbados, & Guyana.

The city has one of the highest percentages of residents living below poverty in Westchester County. The poverty rate is 17.1% (compared to 9.7% countywide) and the median income is \$49,395 (compared to \$84,220 countywide). Twenty-two percent of Mount Vernon children are living below poverty; higher than the countywide percentage of 13.3%.

Seven percent of Mount Vernon households are on public assistance, twice the percentages in Westchester County (2.8%) and New York State (3.5%). Seventy-one percent of students in Mount Vernon were eligible for reduced or free lunch during the 2010-2011 school year. The Mount Vernon unemployment rate of 11.7% is one of the highest unemployment rates in Westchester County. Nearly 28% of Mount Vernon residents ages 25 and older have received a college degree; lower than countywide (46%) and statewide (34%) attainment rates.

New Rochelle

The City of New Rochelle, while geographically larger than Mount Vernon, has an equivalently sized population, but a larger proportion of Spanish language only residents of Latino origin and is the anchor city for the Long Island Sound Region in Westchester County. According to the 2013 American Community Survey of the U.S. Census, New Rochelle has approximately 78,400 residents. There are approximately 28,000 households in New Rochelle. The average household size is 2.71 people. Families made up 68% of the households; includes both married-couple families (48.9%) and single household families (28.1% total—5.9% male, 13.2% female). Nonfamily households consist of 32% of all households in New Rochelle (includes people living alone and non-related people living under one household). 32.8% of households include one or more people less than 18 years of age. 29.6% of households include one or more people 60 years of age or older.

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

New Rochelle is one of Westchester County's more affluent cities. Reflecting 2013 data from the US Census Bureau's American Community Survey, 1% of New Rochelle households are on public assistance; less than the Westchester County (2.2%) and New York State (3.4%) percentages. About 10% of New Rochelle's population lives below the poverty line and the median income is \$66,656 (compared to \$77,293 countywide). There are 12.2% of New Rochelle children living below poverty. The unemployment rate in New Rochelle is 7.5%; less than the countywide (8.4%) and statewide (9.2%) rates. Eighty-two percent of New Rochelle residents ages 25 and older have received their high school diploma or GED; lower than both the countywide rate of 87.4 and the statewide rate of 85.6%.

3b. A Snapshot of Health Disparities in Westchester County

While Westchester remains among the healthiest counties in New York State, several of its individual municipalities continue to maintain significant health gaps with portions of lower Westchester, specifically Mount Vernon, Yonkers, New Rochelle and White Plains serving as “hot spots” for asthma, HIV, and illicit drug use in the County. These areas also demonstrate excess mortality rates from heart disease, stroke, and diabetes compared to County and New York State averages.

The health status of the cities of Mount Vernon and New Rochelle were measured across the indicators of overall health status as well as indicators of the social, environmental, and economic determinants of health. While there are areas of improvement, Mount Vernon’s rates remain significantly high, when compared to the remainder of Westchester County. For the city of New Rochelle, the overall rates are comparable to the average, when compared to the remainder of Westchester County.

However, in both municipalities, the residents in Mount Vernon have significantly high mortality rates from heart disease, cancer, stroke, and chronic lower respiratory diseases (CLRD). For these conditions, available County specific rates are provided below.

Mortality Rates:

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

Asthma & Chronic Lower Respiratory Disease:

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

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

According to an asthma report from New York State Office of the State Comptroller, the asthma prevalence rate among Westchester County Medicaid recipients was 86.7 per 1,000 from 2008-

2009. The prevalence rate increased to 98.4 per 1,000 from 2012-2013; similar to the statewide prevalence rate of 98.7.

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

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

Heart Disease & Stroke:

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

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

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

Cancer:

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

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

3c. Medically Underserved Communities

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

Health Insurance:

According to the U.S. Census Bureau, from 2010-2014, 14.7% of Mount Vernon residents under 65y did not have health insurance; higher than the countywide (10.3%) and statewide (8.1%) rates.

Physician Shortage:

As of January 6, 2014, the New York State Education Department, through the Board of Regents at the request of the New York State Department of Health reaffirmed the City of Mount Vernon to be an identified Primary Care Health Professions Shortage Areas (HPSAs). These designations, Medically Underserved Area /Population (MUA) and Healthcare Provider Shortage Area (HPSA) originate from the Health Resources and Services Administration (HRSA).

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).

While all of Westchester County does not have that designation, Mount Vernon has maintained that designation for over 40 years. Despite similar challenges, the City of New Rochelle is not considered an underserved community, however the evidence of significant health disparity related to heart disease indicates that there is an unmet need in the population.

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 provides 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 engaged 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) conducted through the local Departments of Health 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. However, as the Westchester County Department of Health was engaging in a primary data collection survey process, the hospital systems of Westchester County collectively approached them to determine if it was possible to coordinate promotion, participation, referrals and engagement in electronic survey distribution process and to review the data collected to be used collaboratively as a portion of the primary data for the 2016-2018 Community Health Needs Assessment Process. An online survey was collaboratively developed and made available across the Westchester County, distributed by the Westchester County Department of Health, the Westchester County Executive's Office through www.westchestergov.com and the local Delivery System Reform Incentive Payment Program (DSRIP) Performing Provider System (PPS) providers over the summer of 2016. During this process, Westchester County compiled feedback from over 1,300 responders and identified the community concerns by municipality to support CHNA and CSP efforts of hospitals for inclusion into their Implementation Plans.

In the collaborative nature of this process Westchester County also supported the Bronx's primary data collection process through the sharing of their survey tool to identify the needs of patients that may be lost to out-of-county service leakage.

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 State Expanded Behavioral Risk Factor Surveillance System
- iii. New York State Vital Records Data
- iv. New York State Statewide Planning and Research Cooperative Systems (SPARCS)
- v. New York State Bureau of HIV/AIDS
- vi. New York State Cancer Registry
- vii. 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 State Expanded Behavioral Risk Factor Surveillance System (BRFSS): Expanded BRFSS augments the CDC BRFSS, which is conducted annually in New York State. Expanded BRFSS is a random-digit-dialed telephone survey among adults 18 years of age and older representative of the non-institutionalized civilian population with landline and cellular telephones living in New York State. The goal of Expanded BRFSS surveys is to collect county-specific data on preventive health practices, risk behaviors, injuries and preventable chronic and infectious diseases. Topics assessed by the Expanded BRFSS include tobacco use, body weight, cancer screening, and other factors linked to the leading causes of morbidity and mortality. For more information about NYS Expanded BRFSS please visit <https://www.health.ny.gov/statistics/brfss/expanded/>.

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 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. 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

The Community Engagement process for the 2016-2018 Community Service Plan was an unprecedented collaborative effort. Over the period of the previous Community Service Plan implementation, the healthcare delivery landscape shifted, previous alignments dissolved and new regional partnerships came into existence. Furthermore, the local Westchester County Department of Health's Community Health Assessment was conducted concurrently and collaboratively with the Community Health Assessments happening across the County, resulting in alignment of data being used by multiple parties. This rigorous secondary data review, complemented by the a primary data collection process (involving residents of the county in focus groups, community conversations to disseminate data and an electronic surveying process) allowed for the creation of data maps that demonstrate the County's 'hotspots' for particular indicators. Through this mapping process, each facility can see itself in relationship with the other facilities across the service areas, which has created opportunities for alignment of care.

4.a.ii.1 Partners and Organizations

Across Westchester, in addition to the local Department of Health Meeting, there is now a MHVC DSRIP aligned Collaborative with membership from Montefiore Mount Vernon, Montefiore New Rochelle, St. Joseph's Medical Center (including St. Vincent's Hospital – Westchester), St. John's Riverside Hospital, White Plains Hospital, and Burke Rehabilitation Hospital working to ensure that the CSP and DSRIP goals retain their alignment. As the CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) review, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. Montefiore will continue to work with its partners on existing program initiatives.

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

Beyond the formal structures that Montefiore established to gain input from the communities it serves, Montefiore's Office of Community and Population Health participates in a variety of informal organized partnerships and collaboratives, working with other providers in the Westchester, the Westchester County Department of Health, community-based organizations

and others, using a community level approach that involves relevant community based organizations interested in planning and developing initiatives aimed at improving the health of the residents of Westchester County.

5. Identification and Prioritization 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 Westchester County. Second, we completed an assessment of secondary data for 25 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 among Westchester County residents 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 January-September, for ICD-9 codes and one for October-December, for ICD-10 codes.

Table 1. Inpatient discharges for among Westchester residents, 2015

January-September 2015		October-December 2015	
Diagnosis	N	Diagnosis	N
Single liveborn in hospital without Cesarean section	3,899	Single liveborn infant delivered vaginally	1,241
Septicemia NOS	2,499	Sepsis organism NOS	902
Single liveborn in Hospital By Cesarean section	2,403	Single liveborn infant delivered by cesarean	697
Pneumonia Organism NOS	1,320	Pneumonia Organism NOS	374
Care involving other specified rehabilitation procedure	1,312	MTL care for scar from previous cesarean delivery	296
Previous cesarean delivery, delivered, with or without mention of antepartum condition	1,022	Non-ST elevation myocardial infarction	288
Acute Kidney Failure NOS	959	Acute Kidney Failure NOS	278
Drug Withdrawal	903	COPD w exacerbation	268
Subendocardial infarction, initial episode of care	865	Urinary tract infection site NOS	256
Urinary Tract Infection NOS	840	Acute on chronic diastolic heart failure	242
Atrial Fibrillation	765	Opioid dependence w withdrawal	237
Coronary atherosclerosis of native coronary artery	748	Post-term pregnancy	225
Post term pregnancy, delivered, with or without mention of antepartum condition	727	Acute on chronic systolic heart failure	218
Alcohol Withdrawal	718	Alcohol dependence w withdrawal uncomplicated	181
Obstructive chronic bronchitis with Exacerbation	702	MDD recurrent severe w/o psychotic features	168
Noninfectious gastroenteritis and colitis NEC & NOS	274	Unilateral primary osteoarthritis right hip	167
Hyposmolality	274	Syncope & Collapse	164
Intestinal Obstruction NOS	246	ASHD native coronary artery w unstable angina	150
Chest Pain NOS	220	Unilateral primary osteoarthritis left knee	145
Congestive Heart Failure NOS	207	1st degree perineal laceration during delivery	139

NOS = Not otherwise specified; NEC = not elsewhere classified

Table 2. Inpatient discharges for Ambulatory Care Sensitive Conditions among Westchester County residents, 2015

January-September 2015		October-December 2015	
Diagnosis	N	Diagnosis	N
Pneumonia Organism NOS	1246	Pneumonia Organism NOS	352
Urinary Tract Infection NOS	820	COPD w exacerbation	260
Obstructive chronic bronchitis with (acute) exacerbation	668	Urinary tract infection site NOS	251
Atrial Fibrillation	657	Acute on chronic diastolic heart failure	230
Leg Cellulitis	625	Acute on chronic systolic heart failure	171
Acute & Chronic Diastolic Heart Failure	594	Syncope & Collapse	158
Acute & Chronic Systolic Heart Failure	582	Cellulitis left lower limb	123
Syncope & Collapse	554	Chest Pain NEC	120
Chest Pain NEC	536	Atrial fibrillation NOS	118
Colon Diverticulitis	419	Chest Pain NOS	103
Dehydration	406	Cellulitis right lower limb	103
Chronic Obstructive Asthma with Exacerbation	335	Asthma NOS w exacerbation	98
Food/Vomit Pneumonitis	310	Noninfective gastroenteritis & colitis NOS	94
Epilepsy NOS Without mention of intractable epilepsy	292	Dehydration	92
Asthma NOS with Exacerbation	291	Paroxysmal atrial fibrillation	86
Noninfectious gastroenteritis and colitis NEC & NOS	274	Pneumonitis D/T inhalation food & vomit	84
Hyposmolality	274	Epilepsy NOS not intractable without status epilepticus	69
Intestinal Obstruction NOS	246	Intestinal obstruction NOS	68
Chest Pain NOS	220	Asthma NOS w status asthmaticus	68
Congestive Heart Failure NOS	207	Aftercare following joint replacement surgery	67

NOS = Not otherwise specified; NEC = not elsewhere classified

Table 3. Emergency Department visits among Westchester County Residents, 2015

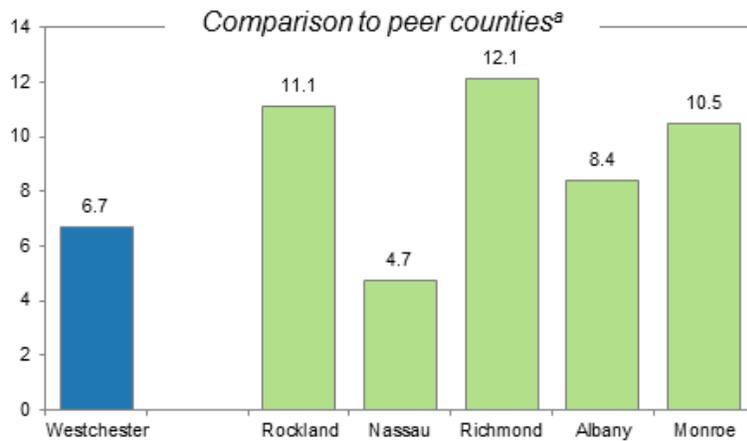
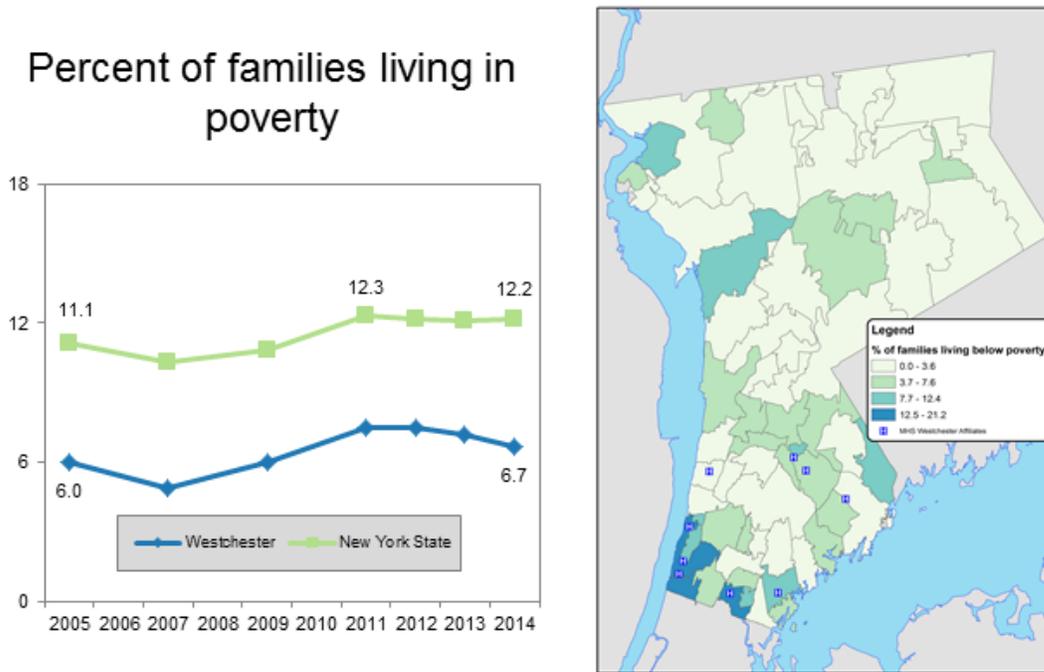
Diagnosis	N
Head Injury NOS	3781
Urinary Tract Infection NOS	3510
Noninfectious gastroenteritis and colitis NEC & NOS	3488
Acute Upper Respiratory Infection NOS	3423
Headache	3241
Chest Pain NEC	3231
Acute Pharyngitis	2997
Abdominal Pain-Site NOS	2986
Chest Pain NOS	2871
Fever NOS	2856
Open Wound Finger	2555
Alcohol Abuse-Unspecified	2500
Dizziness & Giddiness	2445
Asthma NOS with exacerbation	2444
Abdominal Pain-Site NEC	2439
Otitis Media NOS	2339
Lumbago	2259
Viral Infection NOS	2147
Syncope & Collapse	2140
Ankle Sprain NOS	2137

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

Figure 2. Percent of families living in poverty



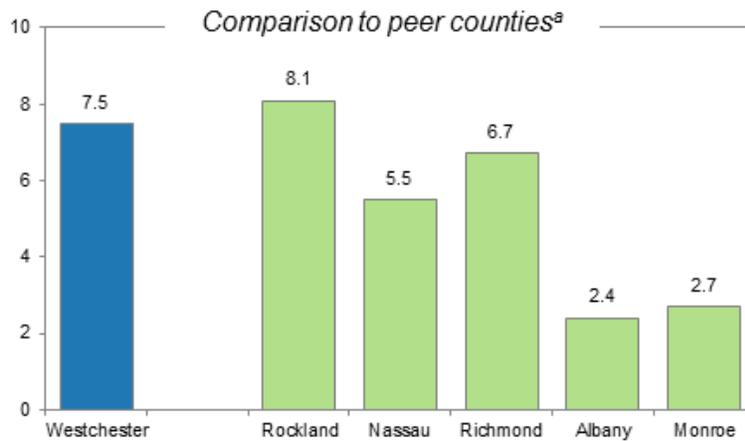
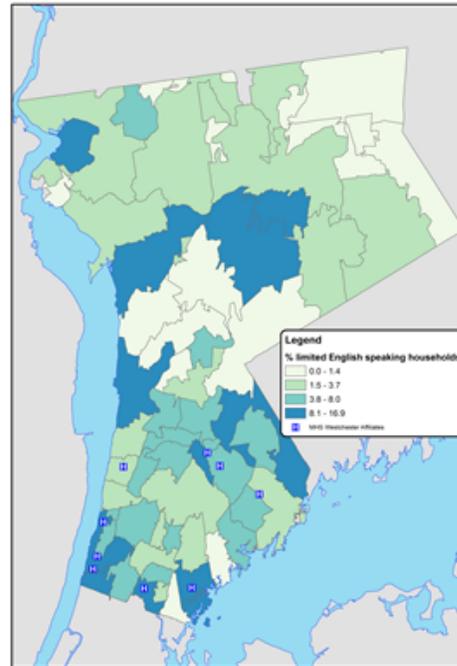
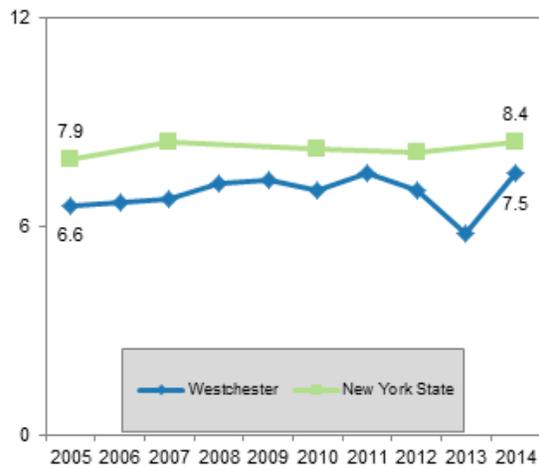
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: American Community Survey

- Westchester County has half as many families living below poverty as compared to the rest of New York State.
- Pockets of higher poverty are observed in some parts of Westchester County, including Yonkers and Mount Vernon.

Figure 3. Percent of households that are limited English speaking

Percent of households that are limited English speaking
(no one $\geq 14y$ speaks English only or "very well")



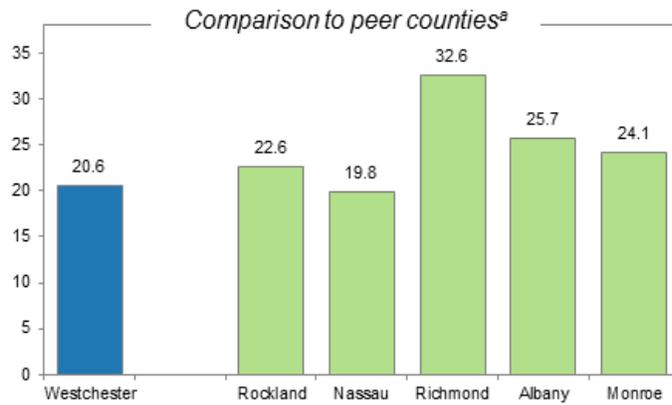
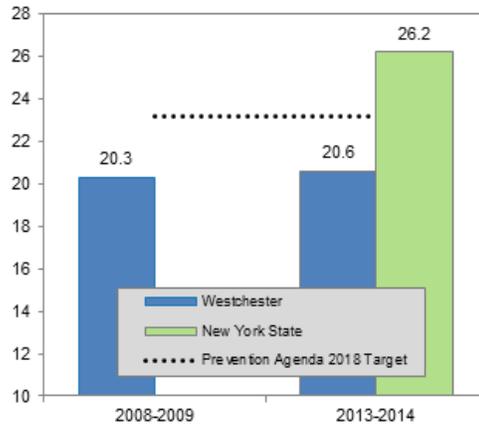
^a Based on comparison of following measures: percent of population less than 20y, percent of population $\geq 65y$, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: American Community Survey

- In both New York State and Westchester County, there have been modest increases in the percent of households that are linguistically isolated.
- Compared to peer counties, Westchester has the second highest proportion of linguistic isolation, trailing only Rockland County.
- Pockets of linguistic isolation were observed in Southern Westchester County, including Yonkers, Mount Vernon and New Rochelle, and also in Tarrytown, Ossining and Port Chester.

Figure 4. Percent of adults are who are obese

Percent of adults who are obese (BMI≥30)

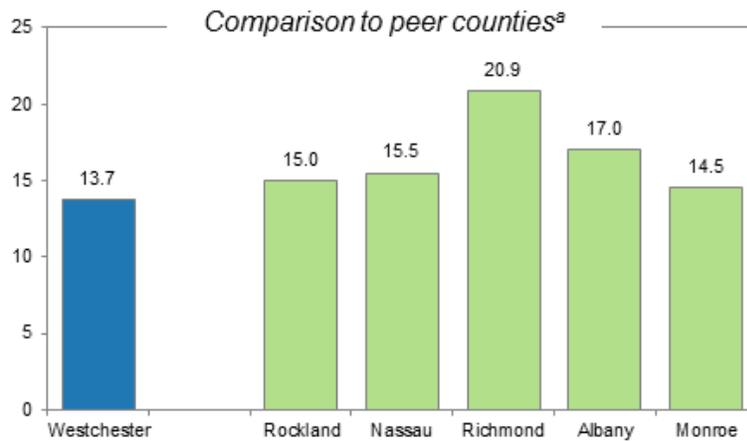
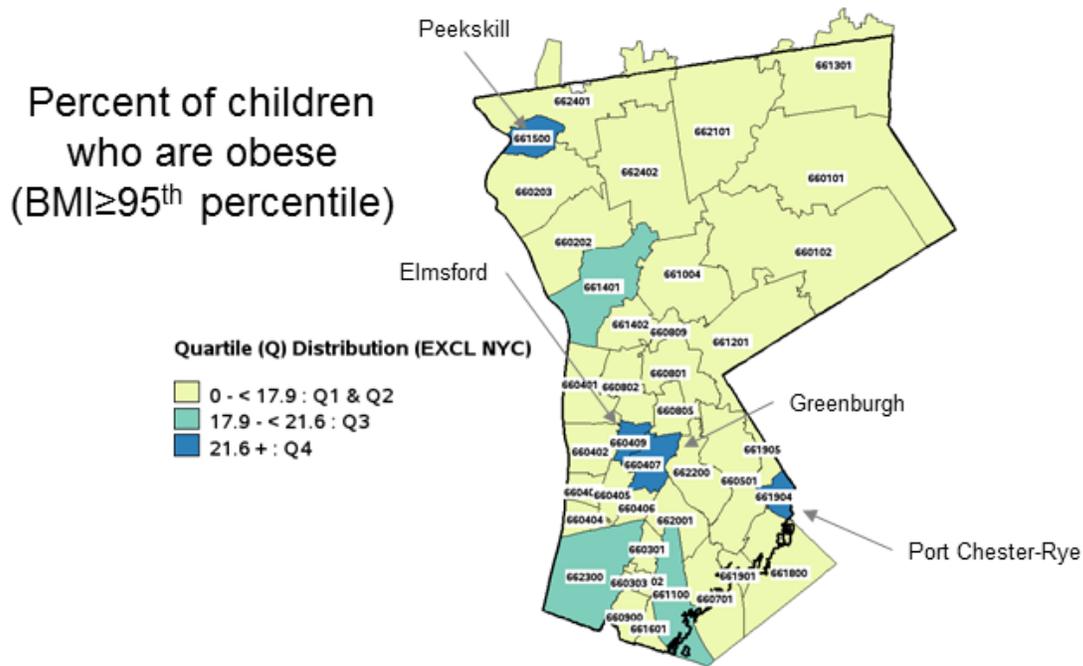


^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: New York State Expanded BRFSS

- Long-term trend data is not available, but in recent years the percent of adults in Westchester County who are obese has remained stable and well below the statewide average.
- Compared to peer counties, Westchester County has the second lowest prevalence of obesity, trailing only Nassau County.

Figure 5. Percent of children who are obese

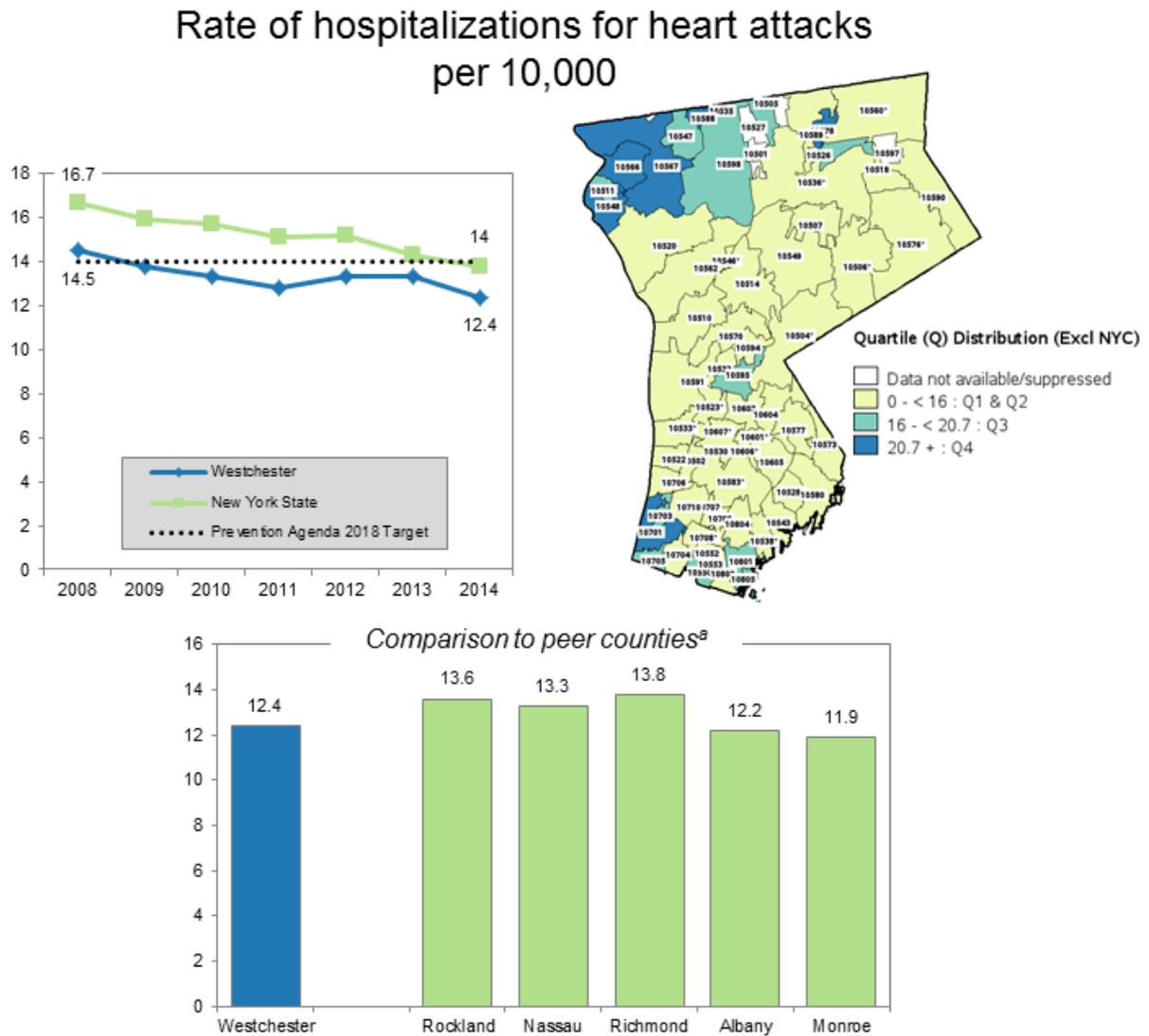


^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided. In order of similarity.

Data Source: Student Weight Status Category Reporting System (SWSCRS)

- Not shown here, childhood obesity in Westchester County has decreased from 14% in 2010-2012 to 13.7% in 2012-2014.
- Some parts of Westchester County had higher prevalence of childhood obesity than others, including Peekskill, Elmsford, Greenburgh and Port Chester-Rye.
- Compared to peer counties, Westchester County has the lowest prevalence of childhood obesity.

Figure 6. Rate of hospitalizations for heart attacks per 10,000



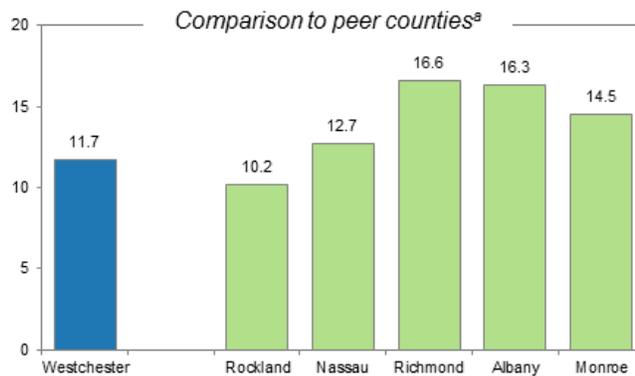
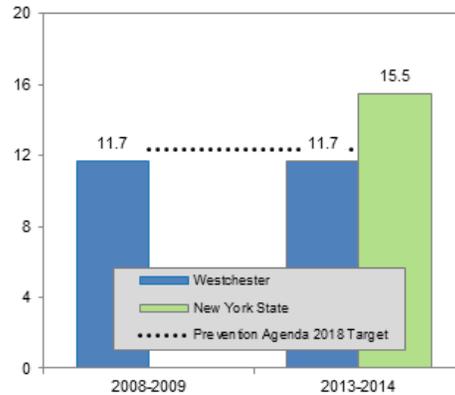
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data Source: SPARCS

- The rate of hospitalizations for heart attacks has declined in both Westchester County and New York State, with rates being substantially lower in Westchester County than New York State.
- Pockets of high rates were observed in Yonkers and Peekskill and Cortlandt Manor.
- Compared to peer counties, Westchester County has the third lowest rates of heart attack hospitalizations, trailing on Albany and Monroe counties.

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

Percent of adults who smoke cigarettes

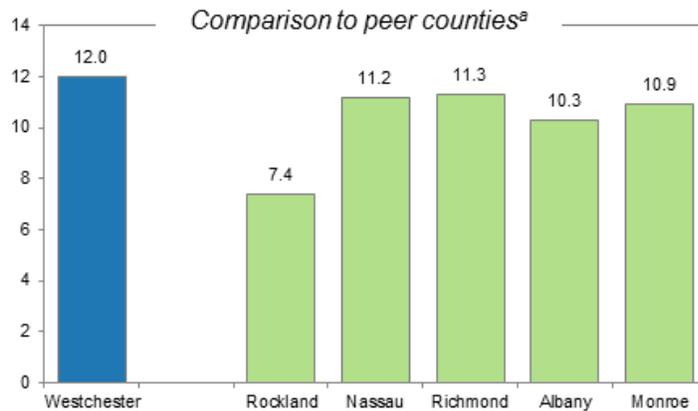
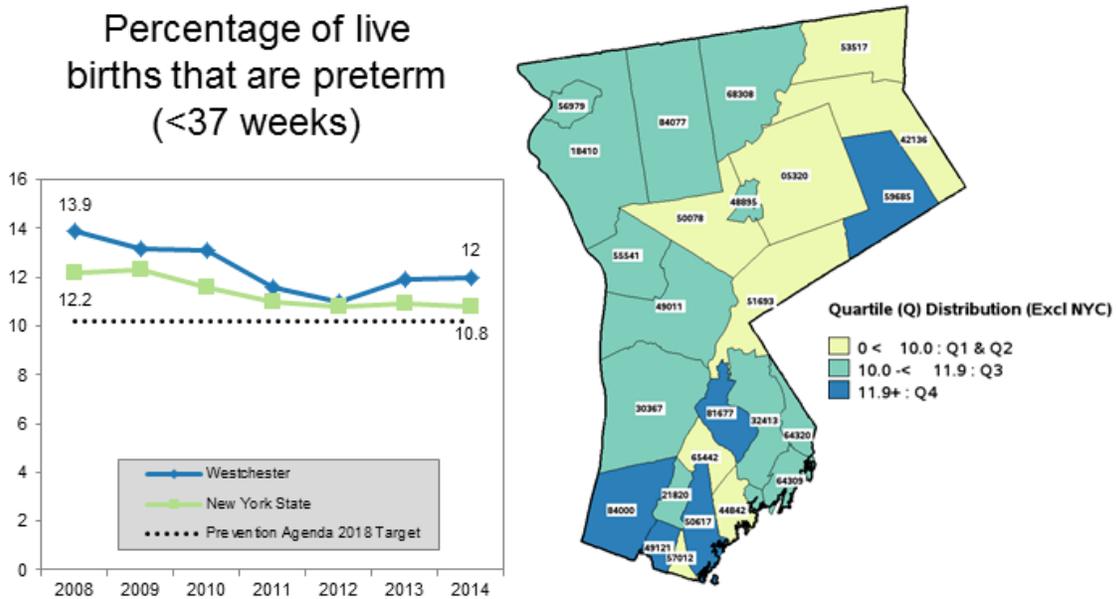


* Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: New York State Expanded BRFSS

- Long-term trend data is not available, but the percent of adults who smoke cigarettes in Westchester County has remained stable at 11.7% in recent years, well below the statewide average.
- Compared to peer counties, Westchester County has the second prevalence of cigarette smoking, trailing only Rockland County.

Figure 8. Percentage of live births that are preterm

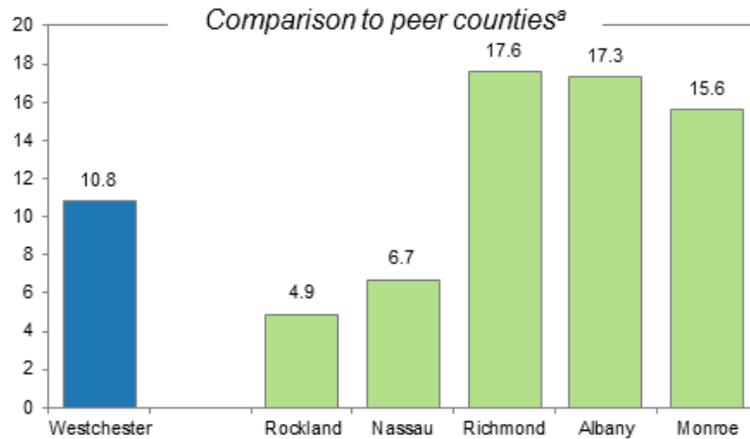
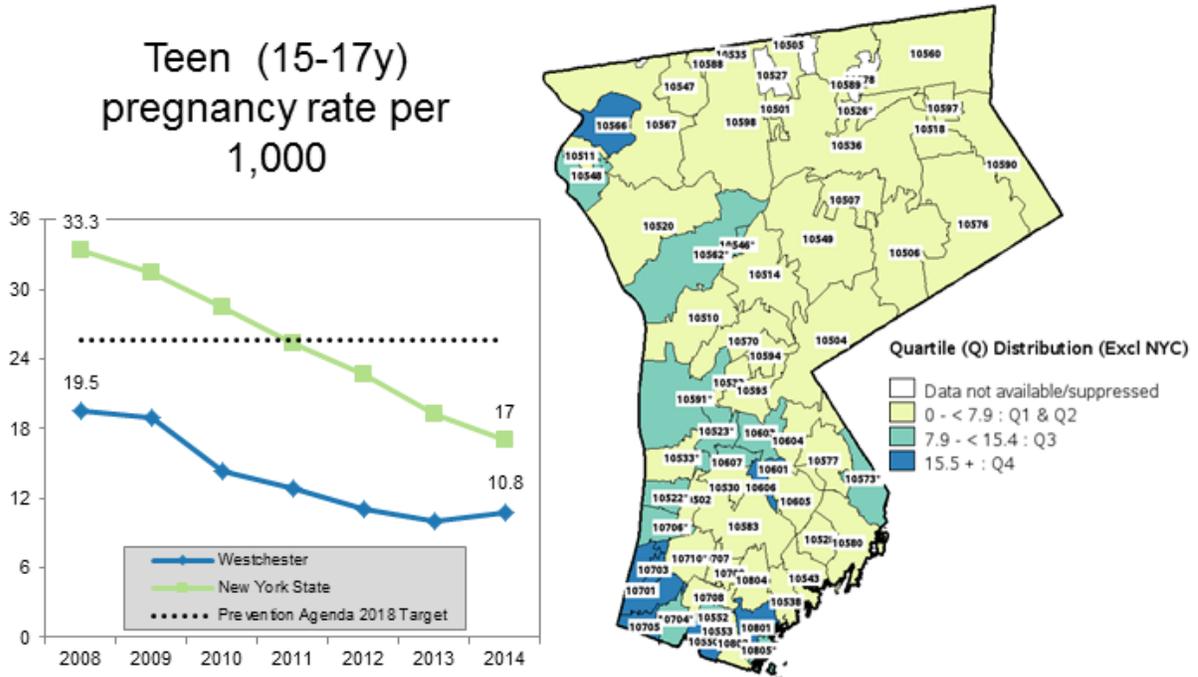


^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: New York State Vital Statistics

- While rates of preterm birth have declined in Westchester County they remain higher than the statewide average and well above the Prevention Agenda 2018 Target.
- Hotspots of preterm birth were observed in Yonkers, Mount Vernon and New Rochelle.
- Compared to peer counties, the rate of preterm birth in Westchester County was considerably higher.

Figure 9. Teen pregnancy rate



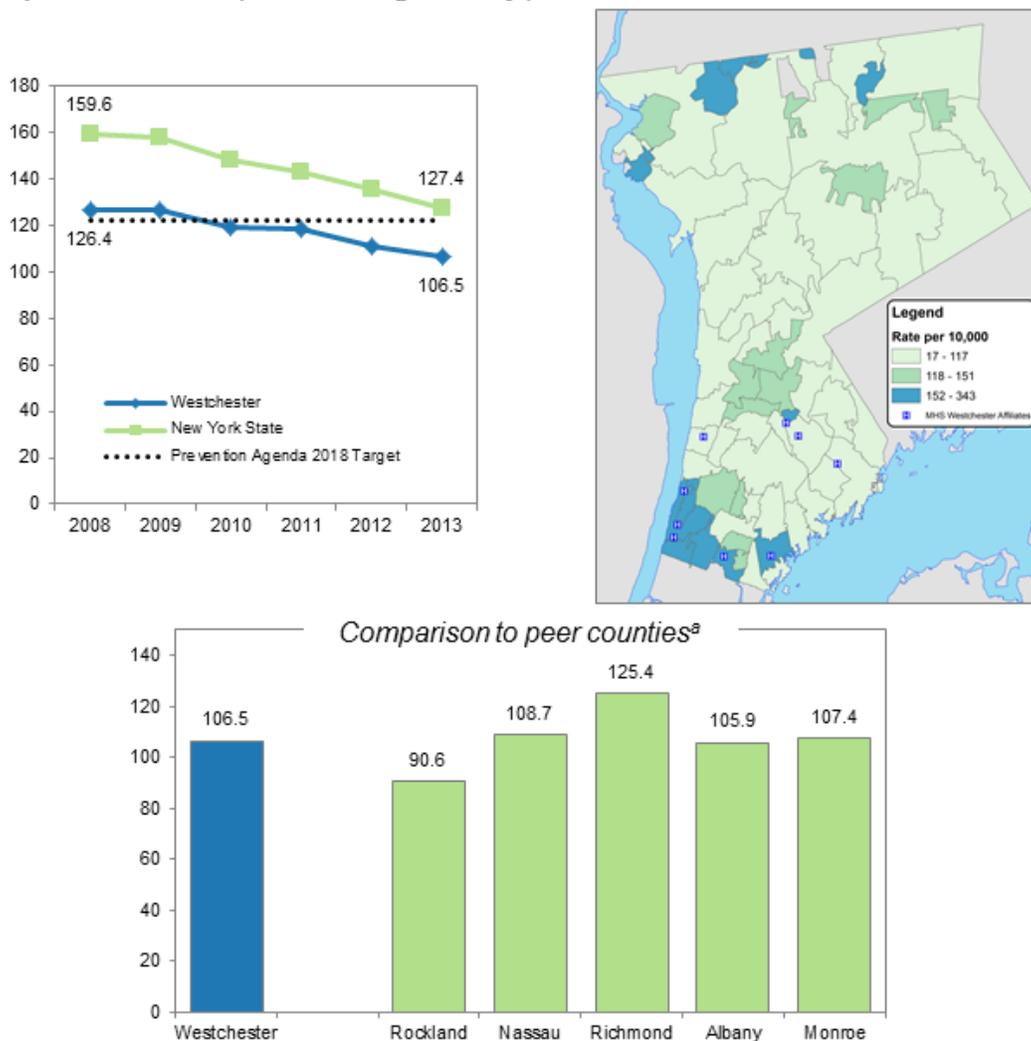
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: New York State Vital Statistics

- The rate of teen pregnancies in Westchester County decreased nearly 50% from 2008 to 2014, considerably lower than the statewide average and the Prevention Agenda 2018 Target.
- Hotspots of teen pregnancies were observed in Yonkers, Mount Vernon, New Rochelle and Peekskill.
- The teen pregnancy rate was substantially higher in Westchester County compared to Rockland and Nassau counties, but lower than Richmond (Staten Island), Albany and Monroe counties.

Figure 10. Age-adjusted preventable hospitalizations¹ per 10,000

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



^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

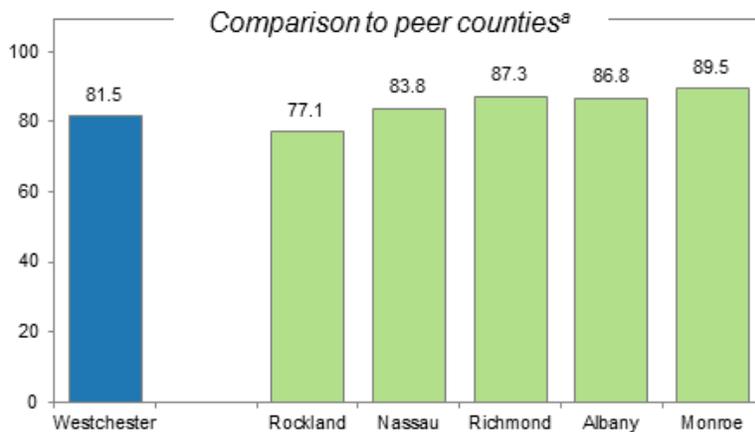
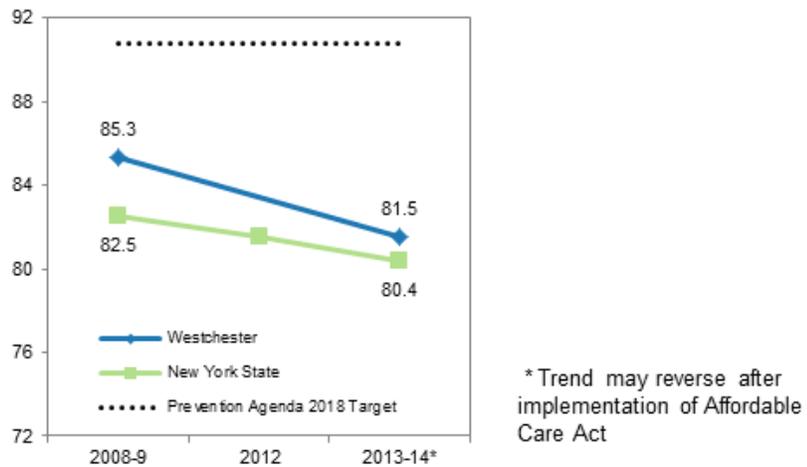
Data source: SPARCS

- In both New York State and Westchester County the rate of avoidable hospitalizations has declined. The Westchester County rate is substantially lower than both the New York State rate and the Prevention Agenda 2018 target.
- Rates of avoidable hospitalizations were elevated in parts of lower Westchester County, including Yonkers, Mount Vernon and New Rochelle.

¹ 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

Age-adjusted percent of adults with primary care provider

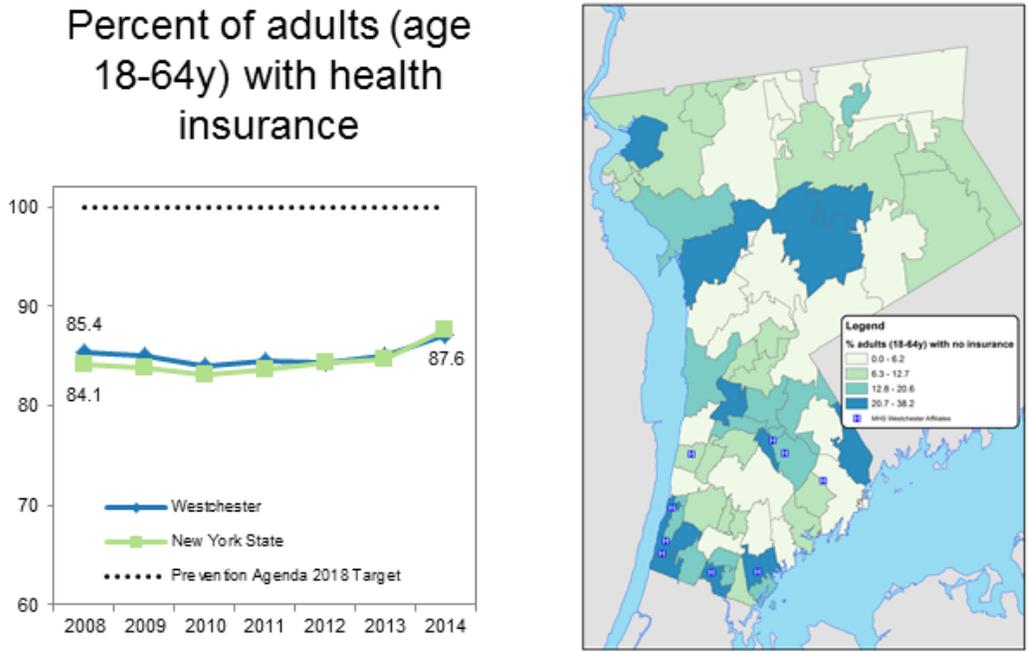


^a Based on comparison of following measures: percent of population less than 20, percent of population ≥65, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided. In order of similarity.

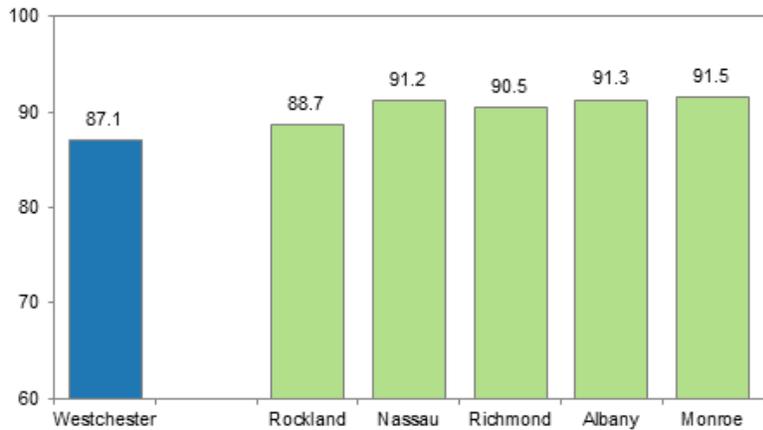
Data source: New York State Expanded BRFSS

- The proportion of adults in Westchester County with a primary care provider has declined from 85.3% in 2008-9 to 81.5% in 2013-2014. It is important to note that this data will not pick-up any dramatic uptick in access to primary care that may be attributable to implementation of the Affordable Care Act.
- Compared to peer counties, the percent of adults with a primary care provider was second lowest in Westchester County, somewhat higher than that observed in Rockland County.

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



Comparison to peer counties^a

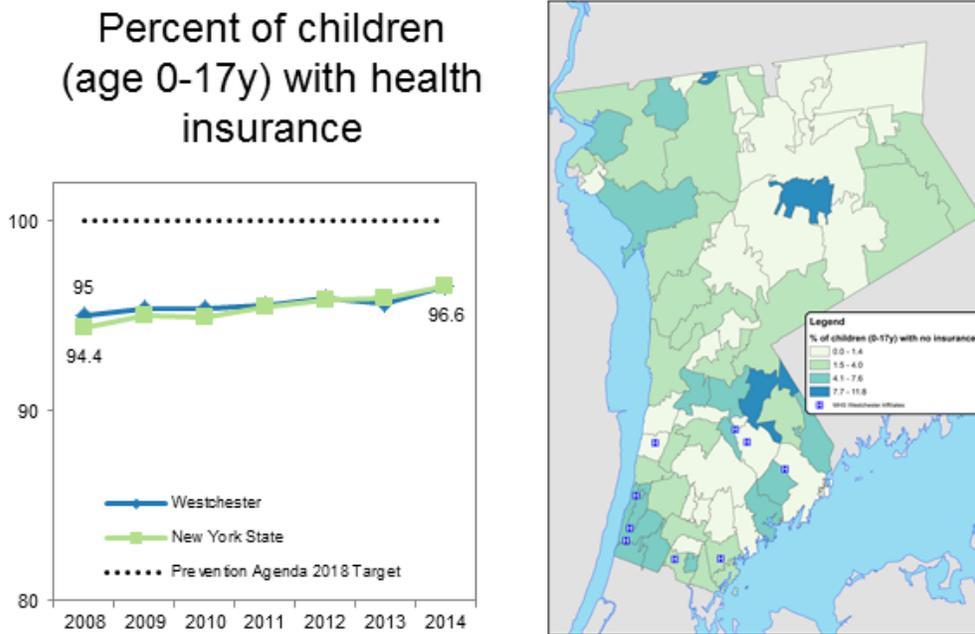


^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided. In order of similarity.

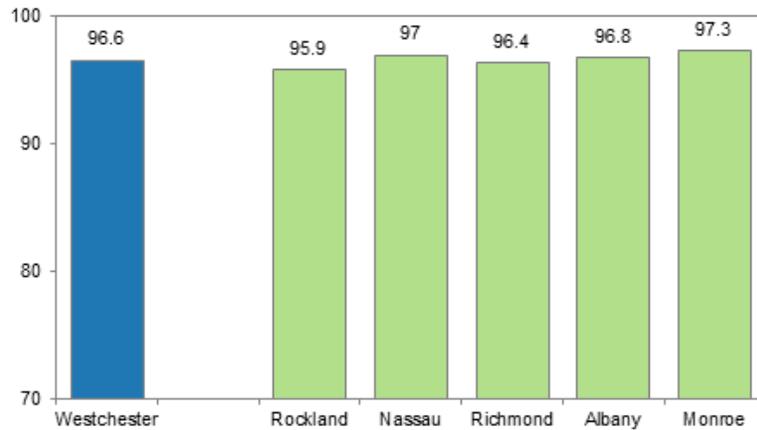
Data source: American Community Survey

- From 2008 to 2014, the percent of non-elderly adults in Westchester County with health insurance increased from 85.4% to 87.6%.
- Pockets of not having health insurance were observed in lower Westchester County, including Yonkers, Mount Vernon, New Rochelle, and also in White Plains, Port Chester, Peekskill, Ossining, and the Mt Kisco and Bedford Hills area.

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



Comparison to peer counties^a



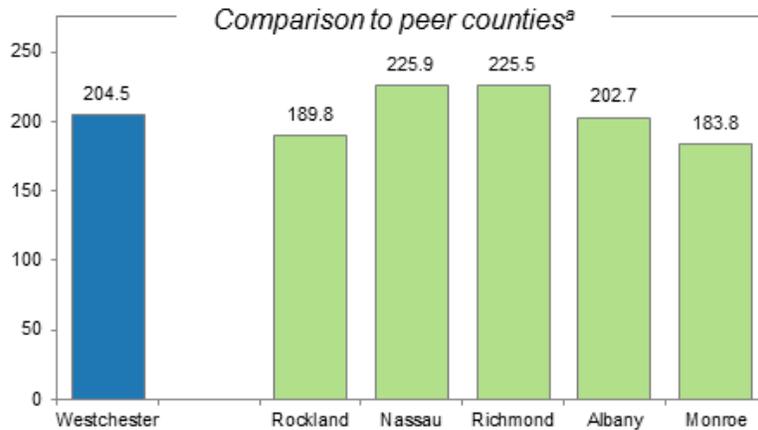
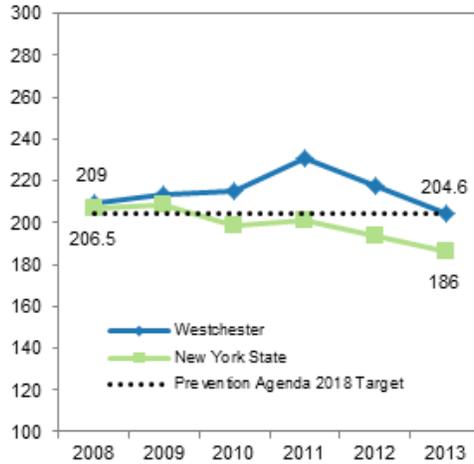
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: American Community Survey

- From 2008 to 2014, there was modest improvement in the percent of children in Westchester County with health insurance.
- There were no dramatic hotspots for not having any health insurance among children in Westchester County.
- In addition, health insurance coverage among children was very comparable across peer counties.

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

Fall-related hospitalization rate per 10,000 (adults age ≥ 65y)

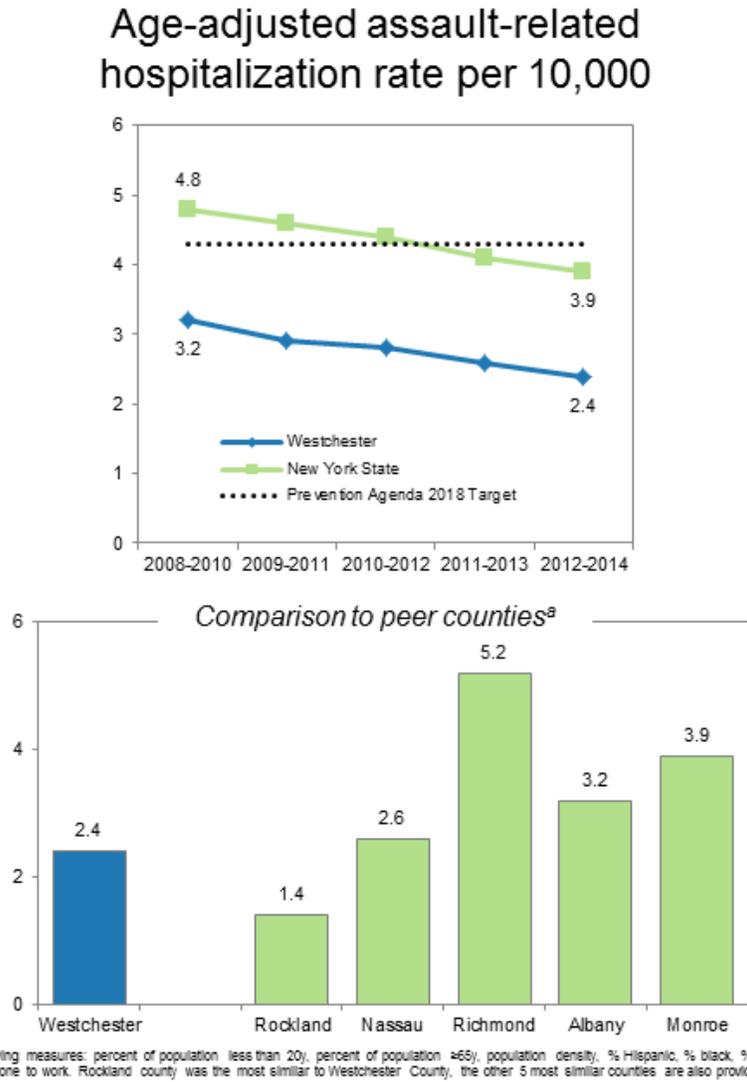


^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: SPARCS

- Between 2008-2013, fall-related hospitalizations in Westchester County increased and then decreased, and were slightly higher than New York State rates.
- Compared to peer counties, rates higher than Rockland and Monroe counties, but lower than Nassau and Richmond (Staten Island) counties.

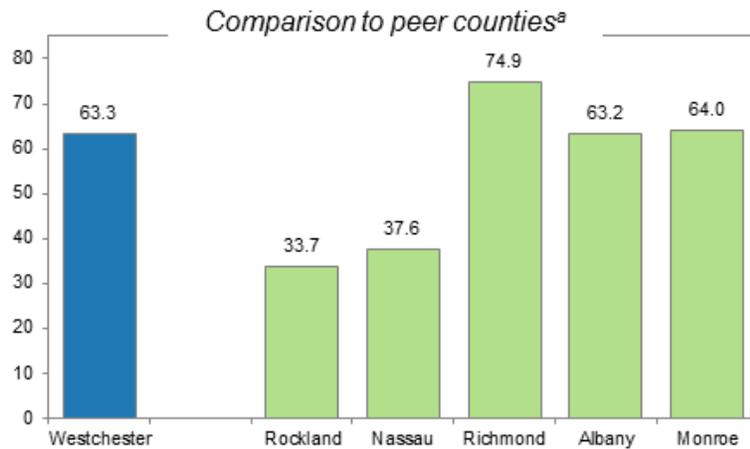
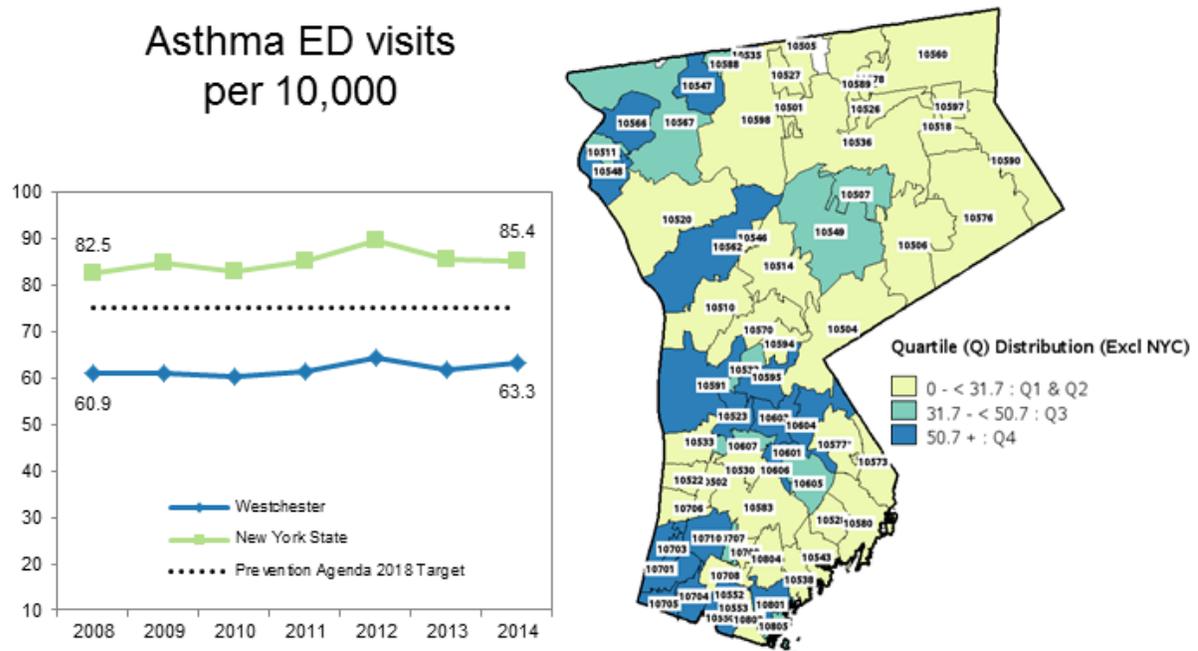
Figure 15. Age-adjusted assault-hospitalization rate per 10,000



Data source: SPARCS

- Between 2008-2013, assault-related hospitalizations in Westchester County decreased and remained well-below the statewide average and the Prevention Agenda target.
- Compared to peer counties, rates were lowest in Rockland County, followed by Westchester County.

Figure 16. Asthma emergency department visits per 10,000



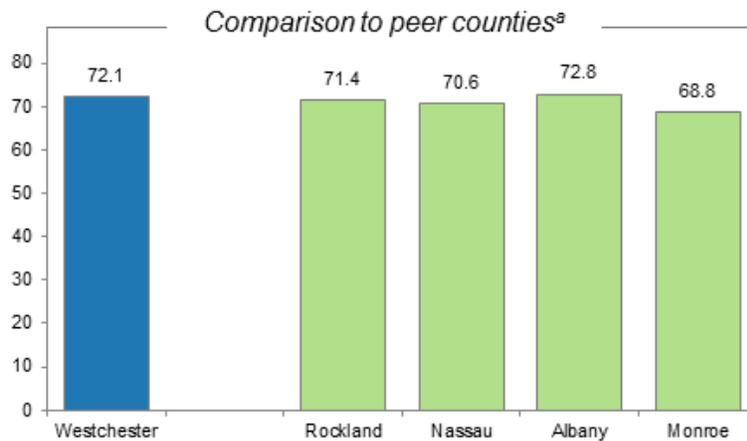
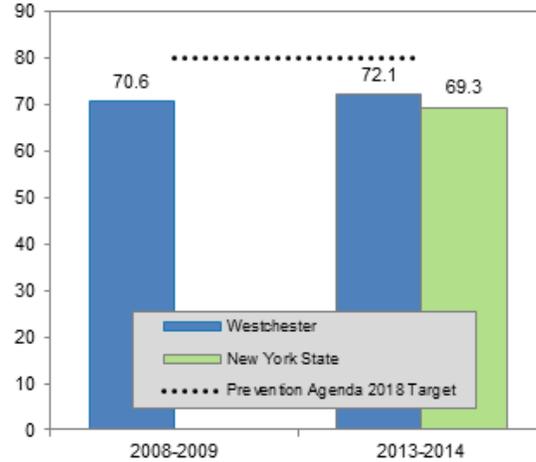
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: SPARCS

- Asthma ED rates have remained stable in Westchester County and are well below the statewide average.
- Compared to Rockland and Nassau counties, asthma ED rates in Westchester County are nearly twice as high. Rates are lower than in Richmond County (Staten Island) and comparable to the other two peer counties: Albany and Monroe counties.
- Hotspots for asthma ED visits were observed throughout Westchester County, including Yonkers, Mount Vernon, New Rochelle, White Plains, Tarrytown, Ossining, and Peekskill.

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

Percent of adults age 50-75y who received a colorectal cancer screening



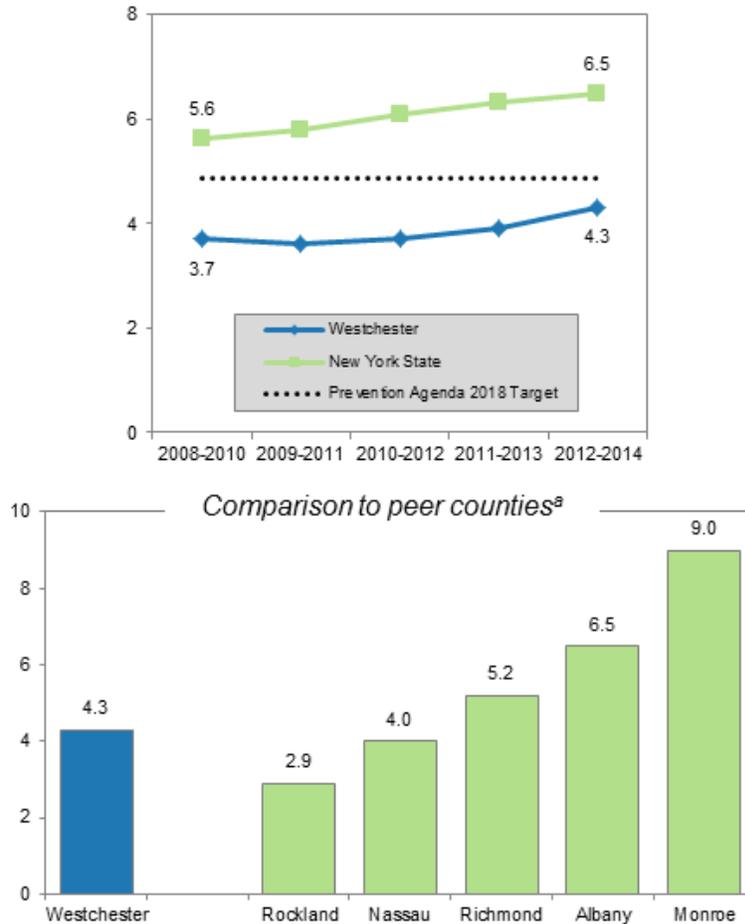
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided. In order of similarity.

Data source: New York State Expanded BRFSS

- The percent of adults 50-75y who got a colonoscopy in the prior 10 years increased slightly from 2008-2009 to 2013-2014 in Westchester County.
- The proportion getting a timely colonoscopy was comparably across most peer counties, though somewhat lower in Monroe County.

Figure 18. Rate of hospitalizations for short-term complications of diabetes per 10,000

Rate of hospitalizations for short-term complications of diabetes per 10,000 (adults 18+y)



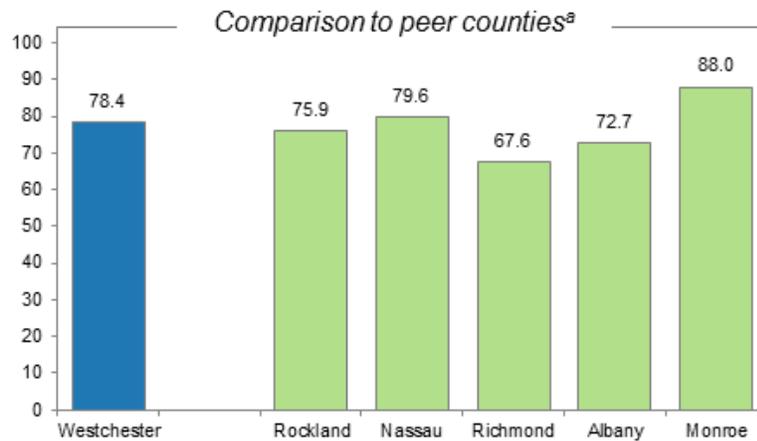
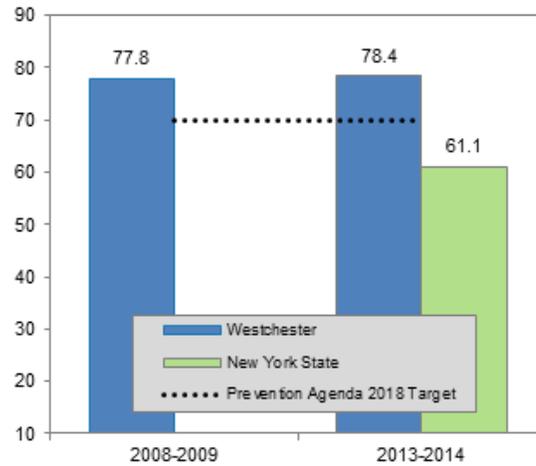
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided. In order of similarity.

Data source: SPARCS

- Rates of hospitalization for short-term diabetes complications among Westchester County adults increased slightly from 2008-2010 to 2012-2014, but remained lower than the statewide rate and the Prevention Agenda target.
- Compared to peer counties, rates were worse in Westchester County compared to Rockland and Nassau County, but better than the other 3 peer counties.

Figure 19. Percent of older adults getting immunized for the flu

Percent of older adults (age 65+y) with flu immunizations



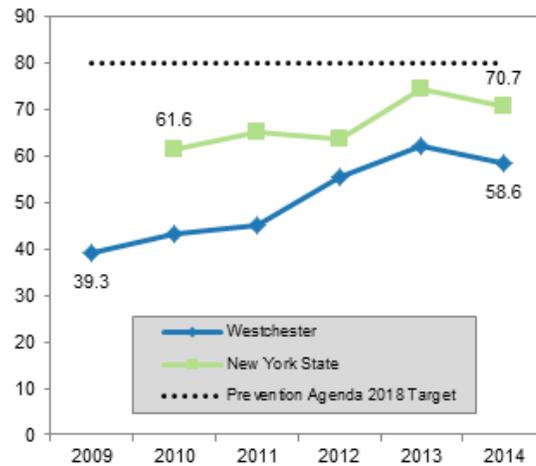
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: New York State Expanded BRFSS

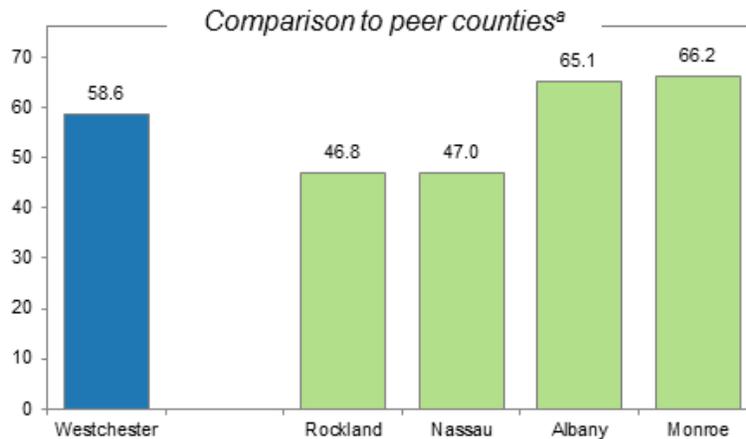
- A modest increase in the percent of older adults getting a flu shot was observed in Westchester County, with the percentage being substantially higher than the rest of New York State.
- Compared to peer counties, rates were generally comparably, but were higher than Richmond (Staten Island) and Albany counties.

Figure 20. Percent of children getting 4:3:1:3:3:1:4 immunization series²

Percent of children with 4:3:1:3:3:1:4 immunization series* (19-35 months)



* Refers to 4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13



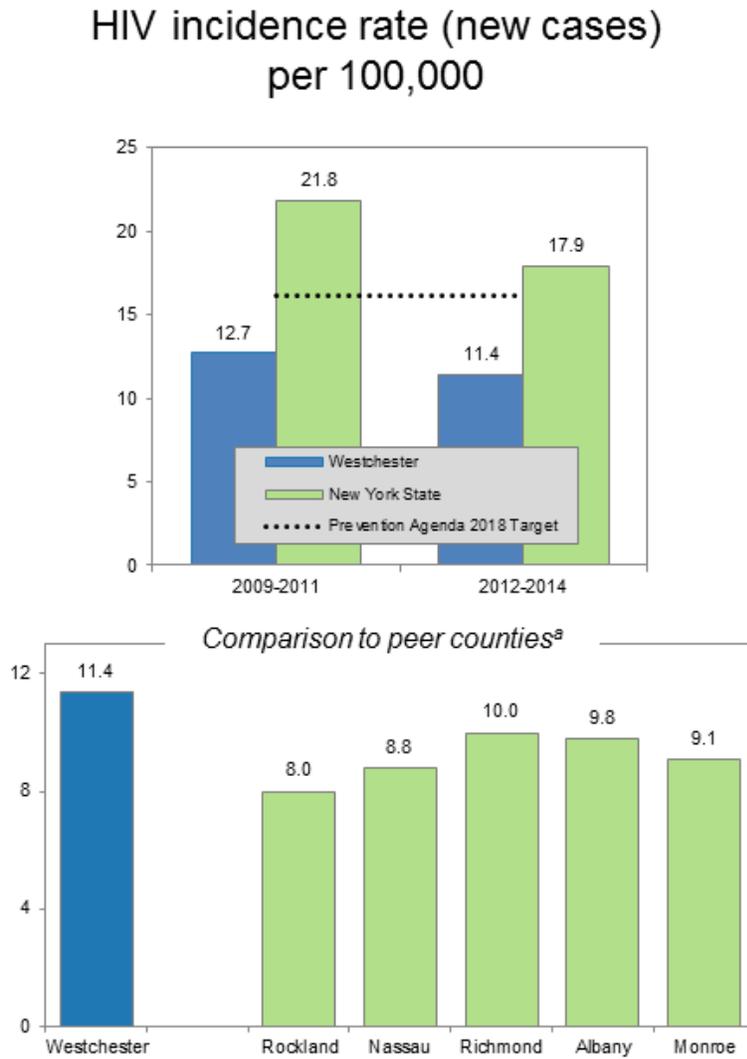
^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: NYS Immunization Information System

- The percent of young children covered by the 4:3:1:3:3:1:4 immunizations series increased in Westchester County but remained lower than the statewide average and the Prevention Agenda target.
- Compared to peer counties, coverage rates were higher than Rockland and Nassau counties, but lower than Albany and Monroe counties.

² The percentage of children (aged 19-35 months) who received their 4:3:1:3:3:1:4 immunization series (4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13).

Figure 21. HIV incidence rate per 100,000



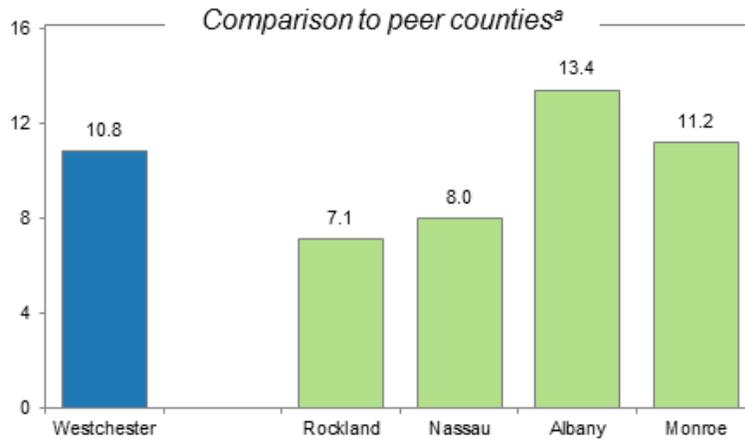
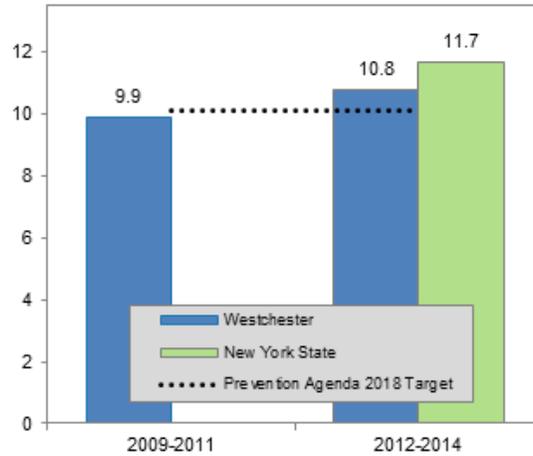
^a Based on comparison of following measures: percent of population less than 20, percent of population ≥65, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: New York State HIV/AIDS Epidemiology Reports

- The incidence of HIV in Westchester County is substantially lower than the statewide rate and has modestly declined from 2009-2011 to 2012-2014.
- The incidence rate in Westchester County was higher than all peer counties.

Figure 22. Age-adjusted percent of adults with 14 or more poor mental health days in past month

Age-adjusted percentage of adults with poor mental health for 14+ days in last month

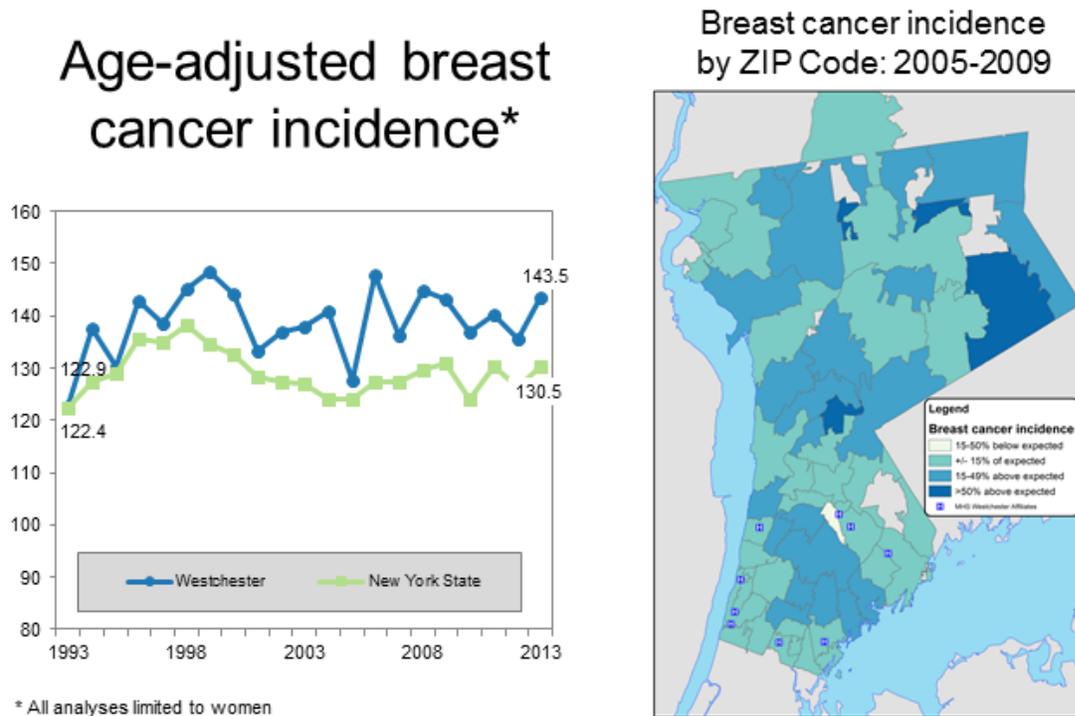


^a Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

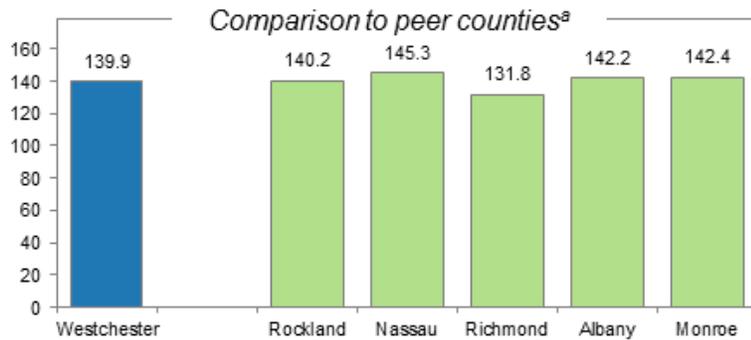
Data source: New York State Expanded BRFSS

- The percent of Westchester County adults with more than 14+ days of poor mental health in the past month increase marginally from 2009-2011 to 2012-2014, but remained lower than the statewide percent.
- Compared to peer counties, the percent in Westchester County is higher than Rockland and Nassau, but lower than Albany and Monroe counties.

Figure 23. Age-adjusted breast cancer incidence, among women only



* All analyses limited to women

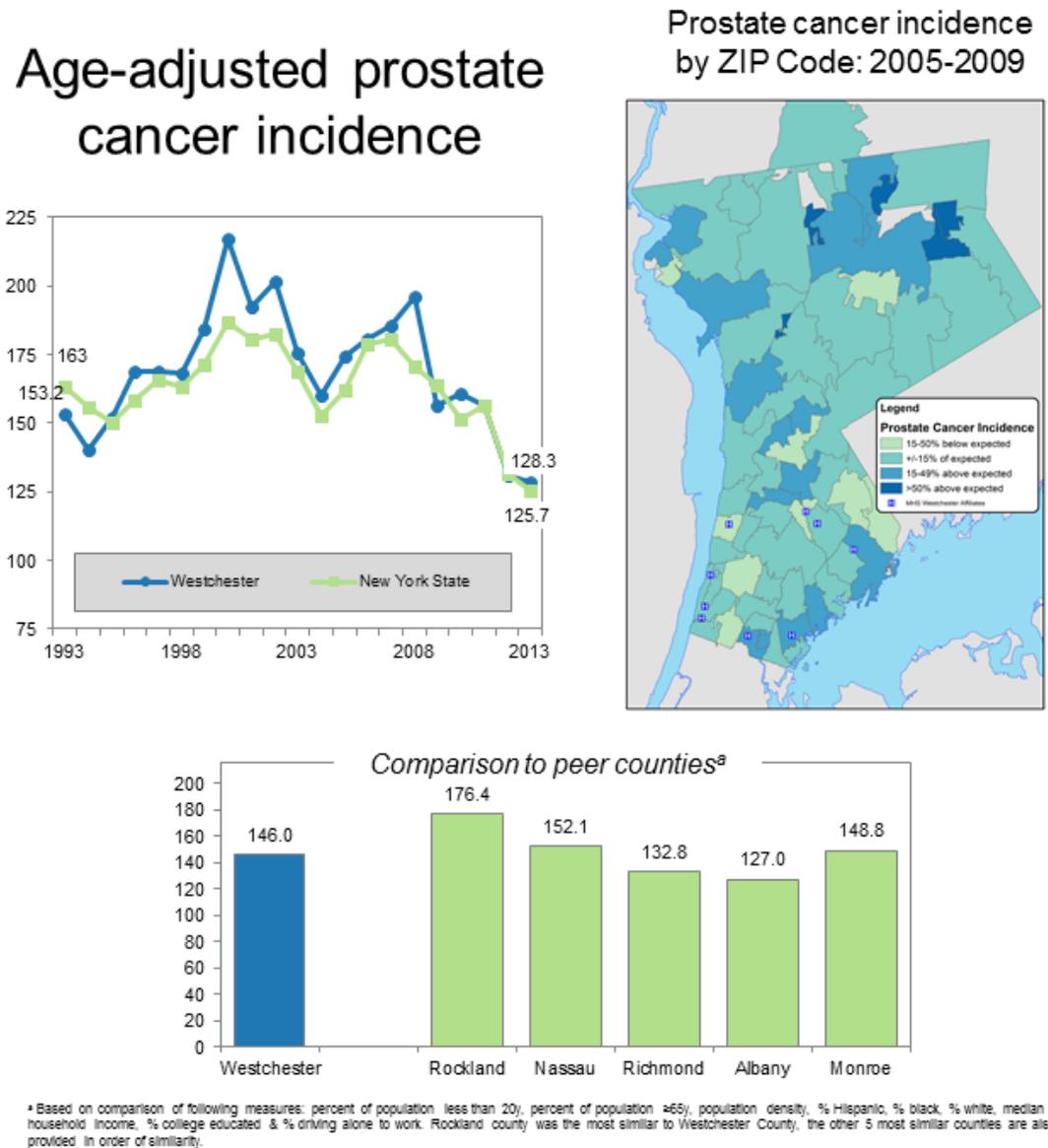


^a Based on comparison of following measures: percent of population less than 20, percent of population ≥65, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Data source: New York State Cancer Registry

- The age-adjusted incidence of breast cancer in Westchester County is higher compared to New York State overall and rates in Westchester County have increased slightly from 1993 to 2013.
- Modestly elevated breast cancer incidence rates were observed in some parts of Westchester County, including Larchmont, Eastchester, Bronxville, Scarsdale, Irvington, Thornwood, Pound Ridge, Goldens Bridge and Amawalk.

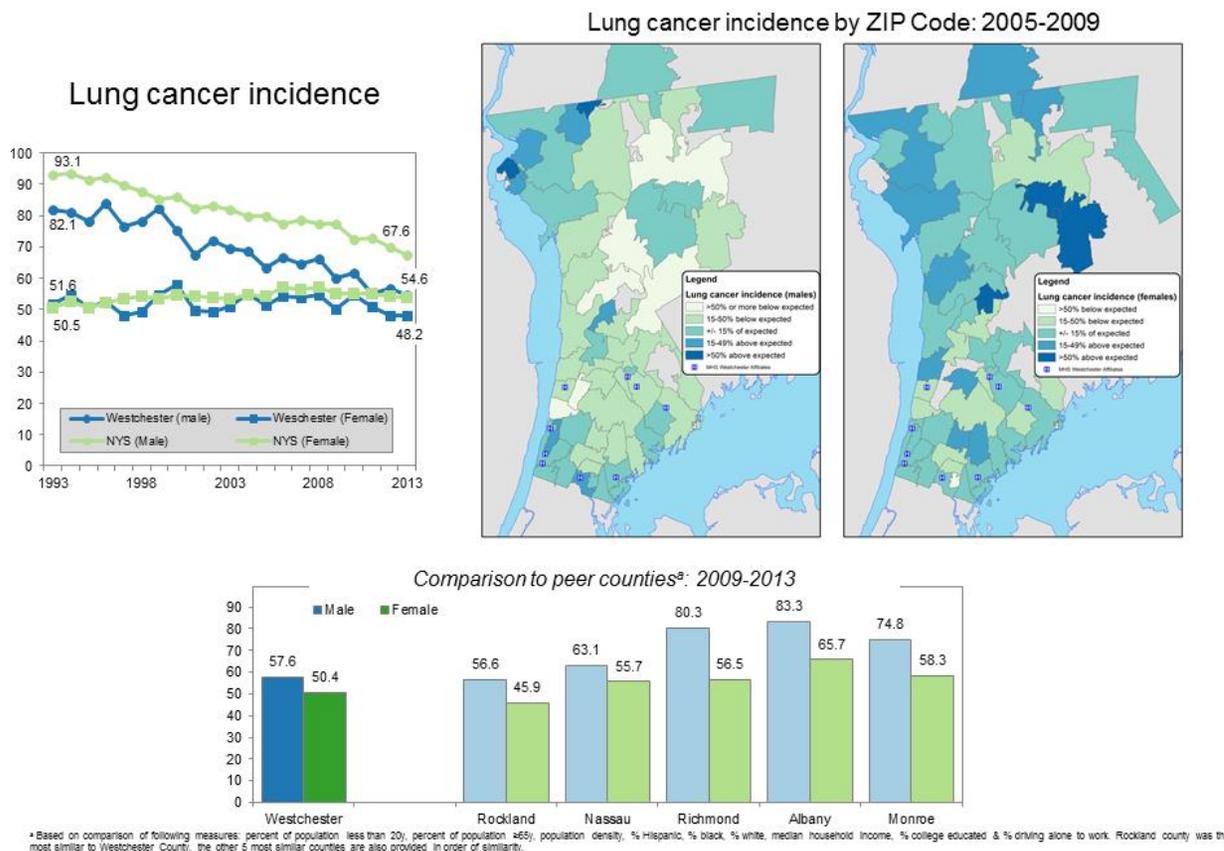
Figure 24. Age-adjusted prostate cancer incidence, among men only



Data source: New York State Cancer Registry

- Among men in both Westchester County and New York State prostate cancer rates increased through the 1990s and then declined, in large part to rapid uptake of PSA screening.
- Modestly elevated breast cancer incidence rates were observed in some parts of Westchester County, including Larchmont, Eastchester, Bronxville, Scarsdale, Irvington, Thornwood, Pound Ridge, Goldens Bridge and Amawalk.

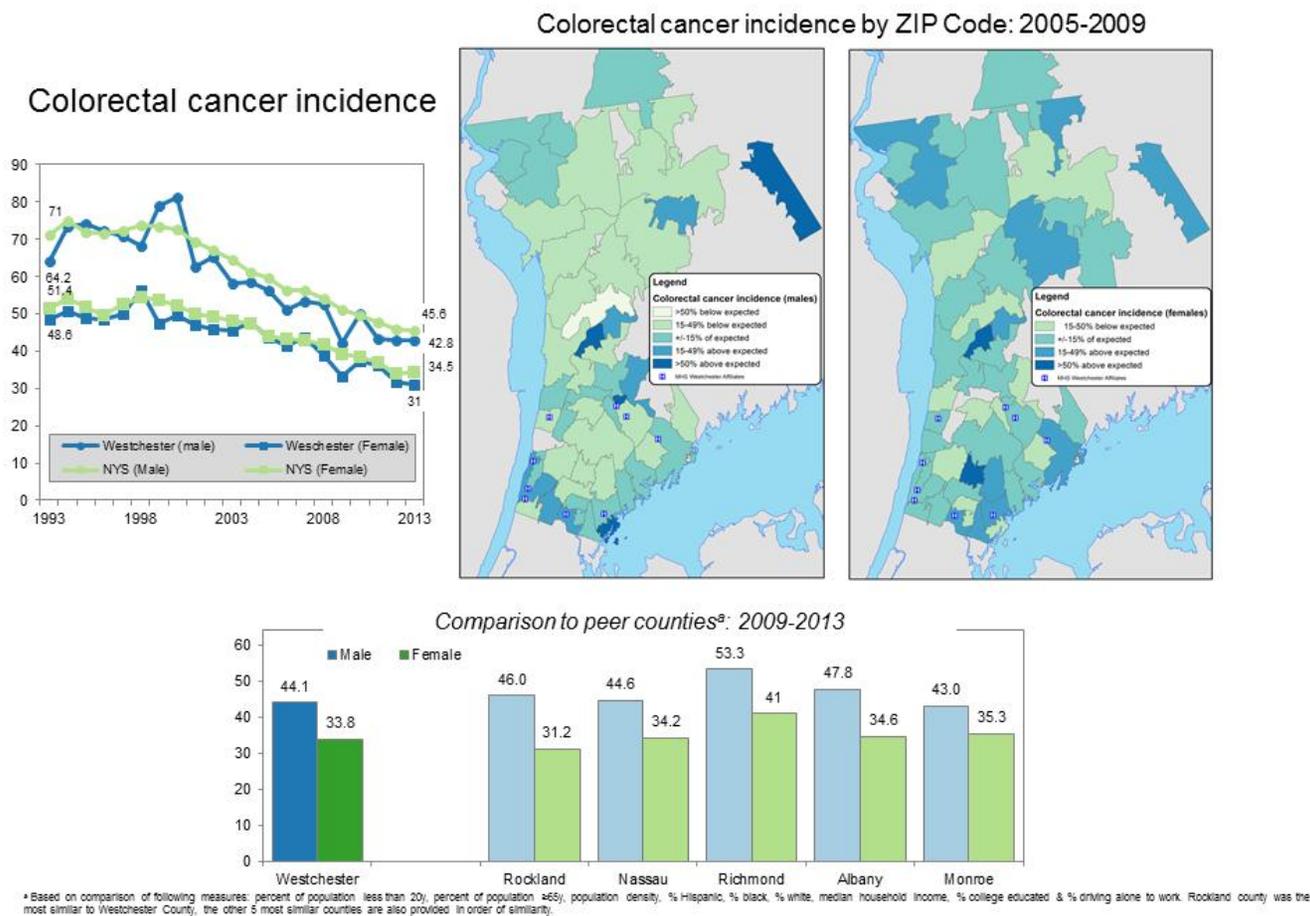
Figure 25. Age-adjusted lung cancer incidence



Data source: New York State Cancer Registry

- Among men in Westchester County lung cancer incidence has declined. It has remained stable among women. Among men, rates in Westchester County were lower than New York State, while rates among women were similar to New York State rates.

Figure 26. Age-adjusted colorectal cancer incidence



Data source: New York State Cancer Registry

- For both men and women, colorectal cancer incidence rates have declined in Westchester County and in New York State.
- Rates in Westchester County were comparable to peer counties with the exception of Richmond County (Staten Island), which had higher rates.

5b. Primary Data Analysis

Primary data collection for the Westchester County CHNA was done collaboratively between partner institutions and the Westchester County Department of Health. Two approaches were used to gather community input on community health priorities in Westchester County: 1) a community survey and, 2) a provider survey. The methods are summarized in **Section 4**. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

Community & Provider Survey

Overview & Methods

In collaboration with the Westchester County Department of Health, a community needs survey was conducted in the summer of 2016. Two versions of the survey were implemented, one for community members at-large and another for health care providers and community-based organizations (herein referred to as the provider survey). The community survey could be completed via a web-based tool (SurveyMonkey) or on paper, with paper surveys available in 6 languages (English, Spanish, Chinese, Arabic, and French). The provider survey could be completed online. The primary distribution of the survey was conducted through the Westchester County Department of Health's office of the Administrator and was made available through its website at the direction of the Commissioner of Health and the County Executive, which then directed it for distribution to the County's elected officials. The Montefiore Hudson Valley Collaborative also distributed the survey to its membership of over 900 hospitals, community based organizations, faith-based organizations and other social service providers. Due to its electronic format, dissemination was widespread, however limited quantities of paper surveys were available on request. The survey was disseminated through multiple distribution points including to hospitals, other health care providers, community-based organizations and others.

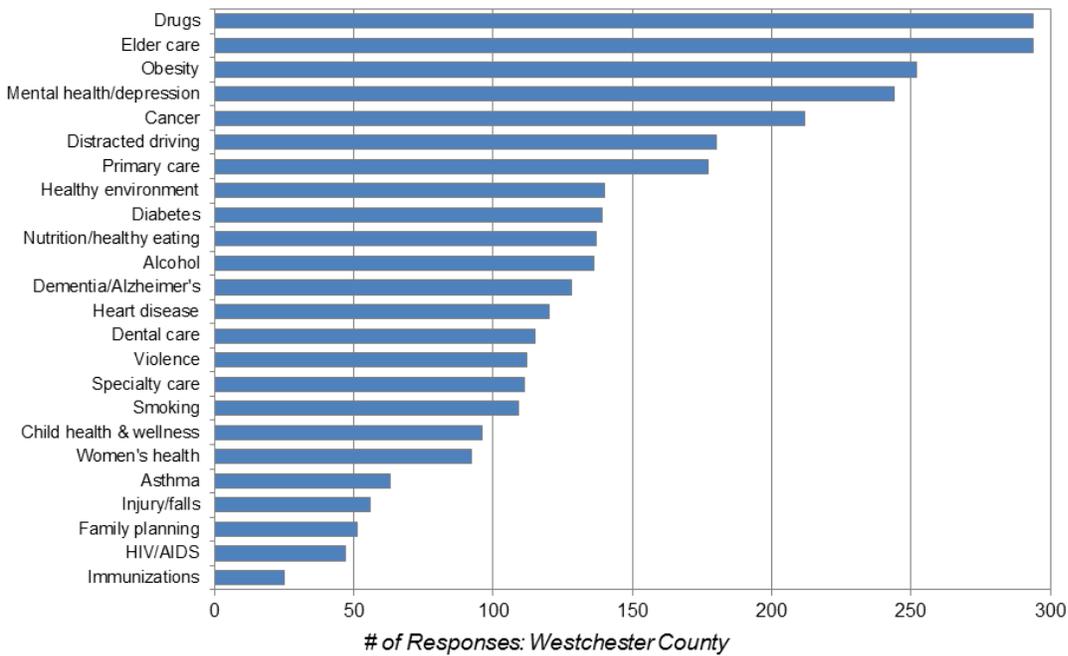
Community Survey Results

For the community survey, a total of 1125 surveys were completed among individuals working-in or residing-in Westchester County. Seventy-eight percent of respondents were women, 21% were men and 0.5% as other, including non-conforming, non-binary and transgendered. Respondents tended to be middle-aged; 25% were 55-64y, 18% were 45-54y, 14% were 65-74y, and 13% were 35-44y. Twenty-four percent of respondents were 65y+ and 4.6% were 18-24y. Twenty-one percent of respondents were Hispanic/Latino (a), 13% were non-Hispanic Black, and 61% were non-Hispanic white. Respondents resided in more than 78 ZIP Codes. About

23.9% of respondents resided in Yonkers, 8.4% in White Plains, 5.2% in New Rochelle, 3.8% in Mount Vernon, 2.3% in Bronxville and 2% in Peekskill.

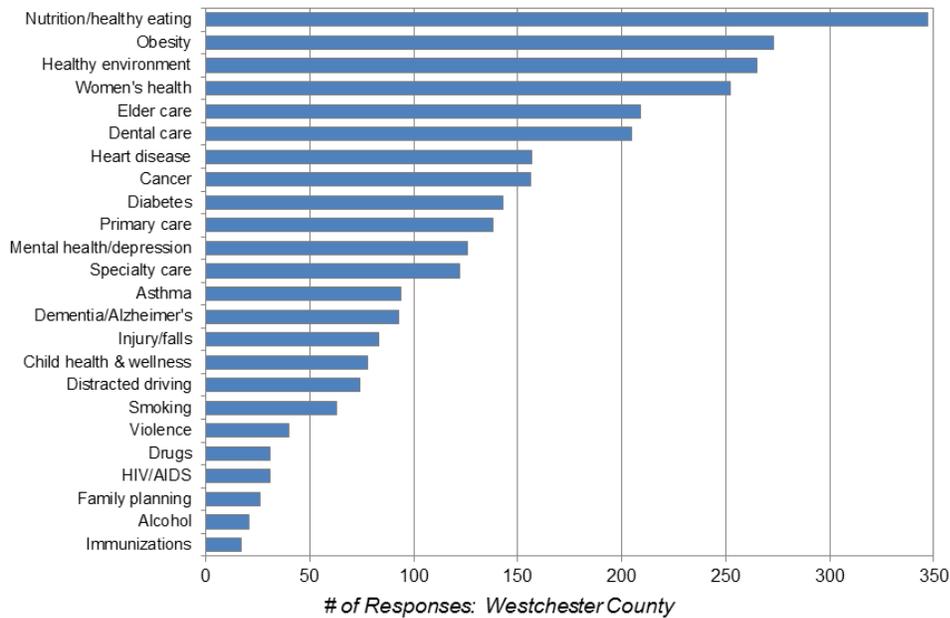
Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health. Participants were also asked to rank their own personal health priorities. The leading community health strategies identified included: drugs/drug abuse, elder care, obesity, mental health/depression and cancer (see **Figure 27**). The leading personal health priorities were nutrition/healthy eating, obesity, healthy environment, women’s health and elder care (see **Figure 28**). The leading strategies identified included: exercise/weight loss programs, clean air & water, access to healthy food, elder care and affordable housing (see **Figure 29**).

Figure 27. Community health priorities as identified by the Westchester County Community Survey, 2016



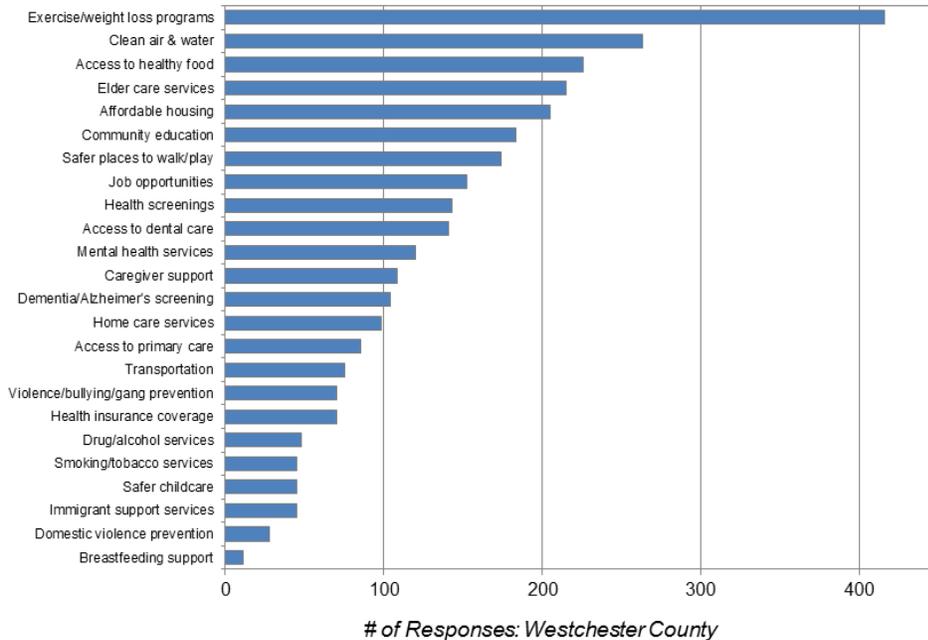
Data source: Westchester County Community Survey, 2016

Figure 28. Personal health priorities as identified by the Westchester County Community Survey, 2016



Data source: Westchester County Community Survey, 2016

Figure 29. Strategies to improve health among Westchester County residents from the Westchester County Community Survey, 2016



Data source: Westchester County Community Survey, 2016

Provider Survey Results

The provider survey was completed by 218 individuals. The leading community health priorities identified were mental health, drugs/drug abuse, access to specialty care, access to primary care, and elder care. Unlike the community surveys, obesity ranked 8th, as opposed to 3rd. Providers ranked access to both primary and specialty care more highly than community members, but both groups ranked drugs/drug abuse, mental health and elder care near the top.

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 among 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, cancer and cardiovascular disease in Westchester County.

6. Potential 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. Some of these programs are located in Westchester County but many are located in the Bronx. The Bronx-based programs listed below accept Westchester County patients and therefore, have been included in this resource list.

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Adolescent AIDS Program	The Adolescent AIDS Program (AAP) provides comprehensive care, risk reduction services and HIV counseling to HIV-positive adolescents (13-24). The program also offers rapid and simple HIV testing and counseling to at-risk youth throughout the Bronx, especially in areas of high seroprevalence.	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Adolescent Depression and Suicide Program	Adolescent Depression and Suicide Program is a subspecialty outpatient clinic within the Dept. of Psychiatry that provides comprehensive assessments and evidence-based treatment for youth (12-18) who present with symptoms of depression, suicidal behaviors and non-suicidal self-injurious behaviors. Many patients also struggle with school, family and drug problems. The program runs lectures and workshops for school	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
	personnel, students and community members.		
AIDS Center	As a New York State Dept. of Health-designated AIDS Center, this division at Moses provides a broad array of inpatient and outpatient services to adults (22+) living with AIDS. The care model consists of an integrated team of health care professionals, including physicians, social workers, nurses, HIV counselors, dietitians, adherence counselors, researchers, mental health providers, pharmacists and administrative staff.	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

Program Name	Description	Intervention Measures	NYS Prevention Agenda
B'N Fit	B'N Fit is a comprehensive weight loss program for obese teens (12-21) that conducts medical, nutritional and psychosocial evaluations and refers participants to treatment for obesity-related illness. The program is offered in conjunction with a community after-school program that consists of nutrition classes, physical activity programming, parent groups, family nights and a six-week summer program.	Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Breast and Cervical Screening Event	Screening for breast exams and pap smears for women 18 years and older. Mammograms for women 40 years and older. In addition, 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	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
		cervical cancer	
Caregiver Support Center	The Caregiver Support Center is dedicated to providing support to the caregiver, a family member or friend and the primary source of care for an ill family member, in addition to medical support of clinical staff.	Increase in general satisfaction of caregiver	Promote Mental Health and Prevent Substance Abuse
Centering Pregnancy	Centering Pregnancy is a national program that 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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p>Centers Implementing Clinical Excellence & Restoring Opportunity (CICERO)</p>	<p>CICERO is an integrated HIV/AIDS and primary care program that functions at ten Montefiore primary care sites and offers treatment, educational, counseling and supportive services to HIV/AIDS patients in the primary care setting.</p>	<p>Increase in proportion of HIV+ individuals engaged in care</p>	<p>Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>
<p>CFCC'S Breastfeeding Support</p>	<p>CFCC's Breastfeeding Initiative is a collaborative effort between the Depts. of Pediatric Medicine and OB/GYN that supports new mothers and trains staff to manage breastfeeding. Expectant and new mothers and their infants (0-2) are referred to a board certified pediatrician who is also a board certified lactation consultant, who provides individual consults and runs a weekly breastfeeding group clinic. The program's goal is to improve breastfeeding</p>	<p>Increase in proportion of mothers who breastfeed</p>	<p>Promote Healthy Women, Infants and Children</p>

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

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p>Children's Evaluation and Rehabilitation Center (CERC)</p>	<p>CERC, the clinical arm of the Rose F. Kennedy University Center for Excellence in Developmental Disabilities, offer multidisciplinary evaluation and treatment to children and adults with intellectual and other disabilities, such as autism spectrum disorder, cerebral palsy, mental retardation, learning disabilities. The Center is composed of 10 teams, which focus their activities on a specific component of this population.</p>	<p>Increase in patient satisfaction for individuals with intellectual and other disabilities</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>
<p>Colorectal Cancer Patient Navigation Program</p>	<p>The Colorectal Cancer Patient Navigator Program is the bridge between the community and health care. We eliminate complexity bringing together interdisciplinary teams to work towards reducing colorectal cancer rates by assessing,</p>	<p>Increase in screening for colorectal cancer; Decrease in colorectal cancer</p>	<p>Prevent Chronic Diseases</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	educating, scheduling, and guiding our patients through the screening process. Our aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-show and cancellation rates.		
Communilife Montefiore Temporary Respite Program	The program provides temporary community-based supportive housing for Montefiore inpatients that do not have a suitable living arrangement and do not need to be hospitalized. Patients who are discharged into the program facility receive case management, medication management, care coordination, entitlements services and the support they need to find suitable permanent housing.	Increase in patient satisfaction; Increase in proportion of inpatients who report having suitable living arrangements	Promote a Healthy and Safe Environment

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p align="center">Comprehensive Services Model, CSM</p>	<p>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.</p>	<p>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</p>	<p align="center">Promote Mental Health and Prevent Substance Abuse</p>
<p align="center">Diabetes Disease Management</p>	<p>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</p>	<p>Increase in positive health outcomes for individuals with diabetes; Increase in quality of life for individuals with diabetes</p>	<p align="center">Prevent Chronic Diseases</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	life.		
<p align="center">Diabetes in Pregnancy Program</p>	<p>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.</p>	<p align="center">Increase in quality of prenatal care for diabetic women</p>	<p align="center">Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>
<p align="center">Diabetes Management: PROMISED</p>	<p>A novel approach in Diabetes Education - the Proactive Managed Information System for Education in Diabetes "PROMISED" is a 10-hour interactive educational program. The program is approved and certified by the American Diabetes Association and adheres to the more recent Standards</p>	<p align="center">Increase in management of diabetes; Increase in positive health outcomes for diabetic mothers and their newborns</p>	<p align="center">Prevent Chronic Diseases</p>

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

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

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>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.</p>		
<p>Family Treatment/Rehabilitation</p>	<p>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.</p>	<p>Increase in quality of case management for families with identified risk of child abuse or neglect</p>	<p>Promote Mental Health and Prevent Substance Abuse</p>

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>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.</p>		
<p>Hepatitis C Support Group</p>	<p>The Hepatitis C Support group is a supportive service for adults with Hepatitis C. Topics of discussion include disease management, treatment options, side effects, compliance and coping with relational and psychological impacts of disease and treatment.</p>	<p>Increase in patient satisfaction for individuals with Hepatitis C</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>

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

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>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 the effectiveness of its interventions. IMPACT</p>		
<p>Lead Poisoning Prevention Program</p>	<p>A designated NYS Resource Center for Lead Poisoning Prevention, the LPPP consists of a multidisciplinary team in medicine, research, social services, environmental investigation, and public advocacy. It serves as a referral center for the medical management of lead poisoning, links families to safe housing during home abatement procedures, provides bilingual educational workshops, advocates for</p>	<p>Decrease in lead poisoning</p>	<p>Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children</p>

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

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>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.</p>		
<p>Mobile Dental Van</p>	<p>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.</p>	<p>Increase in proportion of individuals receiving dental care</p>	<p>Prevent Chronic Diseases</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p>Montefiore School Health Program</p>	<p>MSHP is the largest and most comprehensive school-based health care network in the United States. It has 20 school-based health center sites that provide primary care, mental health, oral health and community health services to patients regardless of citizenship status and ability to pay. All sites are federally qualified or partially qualified health centers. Included in MSHP is the Healthy Kids program, comprised of an array of evidence-based prevention activities focused on increasing physical activity and healthy eating in Bronx children and their families.</p>	<p>Increase in proportion of students receiving health care</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p>Mosholu Preservation Corporation (MPC)</p>	<p>MPC is a non-profit organization committed to preserving and revitalizing Bronx neighborhoods by improving housing and promoting economic and community development. It is governed by a Board of Directors made up of Montefiore trustees and management, community leaders and development experts who serve in a pro bono capacity.</p>	<p>Increase in local economy; Increase in preservation of neighborhoods</p>	<p>Promote a Healthy and Safe Environment</p>
<p>New Directions Recovery Center and Chemical Dependency Program - Medically Supervised Outpatient</p>	<p>Montefiore has two medically supervised outpatient programs. These programs treat adults with alcohol and/or drug abuse/dependence. Multidisciplinary teams at each site can also treat psychiatric disorders and address medical and psychosocial issues that may be associated with alcohol and drug use.</p>	<p>Decrease in alcohol and drug abuse</p>	<p>Promote Mental Health and Prevent Substance Abuse</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p>New York Children's Health Project (NYCHP)</p>	<p>NYCHP delivers critically needed health care services to homeless families and street-involved youth at 13 sites across New York City. The families served hail from impoverished neighborhoods with few quality health care resources, and when homeless they face innumerable access barriers. The program launched with one mobile medical clinic and is now one of the largest providers of health care to homeless children in New York City. NYCHP's innovative service delivery model is comprised of fully equipped mobile clinics, small clinics in shelters, and a full-time health clinic in the South Bronx. A wide array of services is provided to attend to the complex health and</p>	<p>Increase in accessibility of health care services to homeless individuals</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>psychosocial needs of homeless children, adolescents and adults:</p> <ul style="list-style-type: none"> • Comprehensive primary care • Asthma care (Childhood Asthma Initiative) • Women’s health care • Dental care • Mental health counseling, assessment, crisis intervention, and referrals • Substance abuse prevention and referrals • Case management • Emergency food assistance • Children’s nutrition education and physical activity program (“Cooking, Healthy Eating, Fitness and Fun” or CHEFFs) • Specialty care referral management & transportation assistance • Access 24/7 to medical providers on call <p>NYCHP was one the first mobile medical programs in the country to achieve Level 3 Patient Centered</p>		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>Medical Home (PCMH 2008) recognition from National Committee for Quality Assurance (NCQA). NYCHP maintains a Community Advisory Board (CAB) comprised of consumers/patients; CAB meetings are held each quarter at a different homeless family shelter and often include members new to the system. NYCHP relies on the CAB's input to ensure the effectiveness of services and that care remains responsive to the needs of the special population served.</p>		

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	develops positive collaborations with community-based organizations, government agencies and elected officials in the regions served by Montefiore.		
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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p align="center">Organ/Tissue Donor Program</p>	<p>The Organ/Tissue Donor Program raises awareness about organ/tissue donation and transplantation within the Montefiore and Bronx communities. Through educational initiatives and a range of recruitment activities, the program helps potential donors understand the importance of donation and encourages them to join the donor registry. The program is further responsible for ensuring that potential donor candidates are referred to the local Organ Procurement Organization. The ultimate goal is to ensure that every person who needs an organ/tissue donation receives one</p>	<p>Increase in educational programs about organ donation; Increase in number of people who join the donor registry</p>	<p align="center">Prevent Chronic Diseases</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Ostomy Support Group	The Ostomy Support Group is a supportive service for community members who have undergone any kind of Ostomy diversion, regardless of their affiliation with the hospital. Seasoned participants help new members cope with challenges in their disease process. Each group lasts for eight sessions and also functions as a referral source for the Dept. of Psychosocial Medicine at Einstein when members need one-on-one counseling.	Increase in general satisfaction of individuals who have undergone ostomy diversion	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
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	Increase in patient satisfaction for heart transplant patients; Increase delivery of transplant information to	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>transplant patients learn about all the issues that affect them after a kidney transplant. The environment is supportive and the patients are around others going through the same experiences. The support group provides the opportunity for patients to share stories, information, get advice, and receive emotional and spiritual support outside the family structure. It continues to be a great success.</p>	<p>patients</p>	
<p>Phoebe H. Stein Child Life Program</p>	<p>The Child Life Program minimizes the stress of hospital and outpatient visits for pediatric patients and their families through educational and supportive services. In all areas of the hospital, Child Life Specialists help children understand and prepare for their medical experiences. Specialists</p>	<p>Increase in patient satisfaction; Increase in satisfaction of patients' families</p>	<p>Promote Healthy Women, Infants and Children</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>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.</p>		
<p>Pregnancy Prevention Program in School Health</p>	<p>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</p>	<p>Decrease in unplanned teen pregnancy; Decrease in STI transmission in teens; Increase in high school graduation rates; Increase in sexual education programs</p>	<p>Promote Healthy Women, Infants and Children; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>rates of unplanned teen pregnancy and STI transmission and to increase rates of high school graduation. Reducing the Risk is one of the first rigorously evaluated sexual education curricula to have a measurable impact upon behavior. The program is delivered the curriculum to students in the ninth grade before many become sexually active.</p>		
<p>Prostate Cancer Screening</p>	<p>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.</p>	<p>Increase in Prostate Cancer screening; Decrease in Prostate Cancer</p>	<p>Prevent Chronic Diseases</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p>Psychosocial Oncology Program</p>	<p>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.</p>	<p>Increase in patient satisfaction of Oncology patients</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Regional Perinatal Center	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 Woman, Infants and Children
Renal Disease Young Adult Group	The program runs a support group for young adults ages 18-30 years who are diagnosed with End Stage Renal Disease. The support group affords 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
<p align="center">South Bronx Health Center for Children and Families (SBHCCF) and the Center for Child Health Resiliency</p>	<p>A unique family-centered health care program, SBHC serves the Morrisania and Hunts Point-Longwood neighborhoods of the South Bronx, one of the nation’s most medically underserved, at-risk communities. SBHC is a Federally Qualified Health Center (FQHC) program that offers patients access to an enhanced medical home, a model of care that addresses all of their health care needs, and includes:</p> <ul style="list-style-type: none"> • Primary care for children, adolescents and adults • Women’s health and prenatal care • HIV testing, counseling, and primary care • Mental health counseling • Case management • Dental care • Nutrition counseling • WIC referrals • Substance abuse prevention and referrals • Emergency food 	<p>Increase in accessibility of health care; Increase in utilization of health services</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>assistance• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call</p> <p>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</p>		

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>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</p> <p>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</p>		

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

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
<p>Suzanne Pincus Family Learning Place (FLP)</p>	<p>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.</p>	<p>Increase in satisfaction of CHAM patients and their parents</p>	<p>Promote Healthy Women, Infants and Children</p>
<p>The J.E. and Z.B. Butler Child Advocacy Center</p>	<p>The JE&ZB Butler Child Advocacy Center (CAC), established in 1984, is the only medically based, fully accredited child advocacy center in the NYC dedicated to breaking the cycle of abuse. The CAC provides emergency</p>	<p>Decrease in child abuse; Increase in access to care services for children who have been abused</p>	<p>Promote a Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Mental Health and Prevent Substance Abuse</p>

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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
<p>Women, Infants and Children (WIC) Program</p>	<p>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</p>	<p>Increase in healthy eating; Increase in consumption of fruits and vegetables; Increase in breast feeding; Increase in exercise; Decrease in BMI; Decrease in obesity</p>	<p>Promote Healthy Women, Infants and Children</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	<p>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.</p>		
<p>Wound Healing Program</p>	<p>The Wound Healing Program provides inpatient, outpatient, nursing home and home visiting wound healing services. The program focuses on building innovative, patient-centered health services delivery systems that work for wound patients in</p>	<p>Increase in positive outcomes for wound healing patients</p>	<p>Prevent Chronic Diseases</p>

Program Name	Description	Intervention Measures	NYS Prevention Agenda
	order to provide excellence in care and to improve wound healing outcomes in the Bronx.		

6b. 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	<p>Objective 1.1.1:</p> <p>By December 31, 2018, decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day:</p> <p>By 5% from 20.5% (2009) to 19.5% among all adults.</p> <p>By 10% from 42.9% (2009) to 38.6% among adults with an annual household income of <\$25,000.</p> <p>(Data source: NYS BRFSS) (Health Disparities Indicator)</p>

Goal	Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.
Interventions/Strategies/ Activities	<p>Increase the proportion of community engagements focused on the reduction of sugar sweetened beverage consumption in the older adult population (seniors), among youth serving organizations and across perinatal services recipients in the WIC Program.</p> <p>Disseminate “Rethink Your Drink” boards across the Health System 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 Bronx based Montefiore Healthy Store Initiative (MHSI) staff. In working with the above identified populations, the community education staff, WIC Patient Services and Montefiore New Rochelle Hospital WIC Vendor Management Agency will integrate the “Rethink Your Drink” boards into patient and vendor education and training services.</p> <p>Increase the availability and frequency of health education services on food at local farmers markets.</p>
Process Measures	Number of boards disseminated at Montefiore sites; number of youth/adults/perinatal patients educated by peers on sugar content in commonly purchased sugary drinks; number of vendors reporting increased willingness to carry non SSBs at their locations.
Partner Role	CBO’s will assist in engaging youth to make “Rethink Your Drink” boards; WIC participant sites will integrate the SS education boards into their patient education services; Collaboration with local mayor’s offices on Farmer’s Market availability and participant engagement.
Partner Resources	Local CBOs: Access to community members (youth/seniors/WIC participants). Access to municipal and civic leadership to advance educational objectives
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.

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 improving the rates of screening, care, management and control of diabetes.

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	<p>Objective 3.1.4:</p> <p>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%.</p> <p>(Data Source: NYS BRFSS)</p>				
Interventions/Strategies/ Activities	<p>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.</p> <p>Increase community based screening rates for cardiovascular disease among older adults at frequently occurring points of congregation, including senior centers and Naturally Occurring Retirement Communities (NORC)s.</p>				
Process Measures	Data source	HEDIS Measure #	Description	Denominator	Target
Project 3.c.i Comprehensive Diabetes screening – All Four Tests (HbA1c, lipid profile, dilated eye	HEDIS 2015	0055, 0062, 0057	Number of people who received at least one of each of the following tests:	Number of people ages 18 to 75 with diabetes	62.5%

exam, nephropathy monitor)			HbA1c test, cholesterol screening test, diabetes eye exam, and Medicaid attention for nephropathy		
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	<p>Objective 1-1</p> <p>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%)</p>
Interventions/Strategies/ Activities	<p>Participation in the New York State Baby Friendly Initiative at Montefiore New Rochelle; alignment with the infant mortality reduction initiatives and perinatal health objectives sponsored through the Mount Vernon Neighborhood Health Center, the Montefiore Medical Group Family Health and Wellness Center and Hudson River Healthcare centers.</p>
Process Measures	<p>Within the DSRIP framework in Domain 4, references to the NYS Prevention Agenda identifying measures related to the:</p> <p>(1) Overall Percentage of preterm births,</p> <p>(2) the Percentage of preterm births – Ratio of Black non-Hispanics to White non-Hispanics,</p> <p>(3) the percentage of preterm births – Ratio of Hispanics to White</p>

	<p>non-Hispanics and</p> <p>(4) Percentage of preterm births – Ratio of Medicaid births to non-Medicaid births</p> <p>Will be collected and tracked to monitor trending over the CSP Period.</p>
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.
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 Westchester County Department of Health. Montefiore, through a review of the primary data collected through the Westchester DOH survey, in comparison to the review of available secondary data 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 low 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**

Westchester County Provider Survey and Consumer Survey

Electronic versions of the Westchester County Provider and Consumer 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.

WESTCHESTER COUNTY COMMUNITY HEALTH SURVEY

We want to hear your thoughts about important health issues in your community. Together, the Westchester County Health Department and hospitals throughout Westchester 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. You may also take the survey at <https://www.surveymonkey.com/r/CommunityHlthSurvey2016> if you prefer. Thank you for your participation!

What are the THREE biggest ongoing health concerns for the COMMUNITY WHERE YOU LIVE?		
<input type="checkbox"/> Access to immunizations	<input type="checkbox"/> Dental care	<input type="checkbox"/> Mental health/depression/suicide
<input type="checkbox"/> Access to primary health care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutrition/eating habits
<input type="checkbox"/> Access to specialty care	<input type="checkbox"/> Disability	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Distracted driving	<input type="checkbox"/> Preventable injury/falls
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Smoking/tobacco use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Family planning/teen pregnancy	<input type="checkbox"/> Violence
<input type="checkbox"/> Care for the elderly	<input type="checkbox"/> Healthy environment	<input type="checkbox"/> Women's health
<input type="checkbox"/> Child health & wellness	<input type="checkbox"/> Heart disease/stroke	<input type="checkbox"/> Other (please specify) : _____
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections	
What are the THREE biggest ongoing health concerns for YOURSELF?		
<input type="checkbox"/> Access to immunizations	<input type="checkbox"/> Dental care	<input type="checkbox"/> Mental health/depression/suicide
<input type="checkbox"/> Access to primary health care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutrition/eating habits
<input type="checkbox"/> Access to specialty care	<input type="checkbox"/> Disability	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Distracted driving	<input type="checkbox"/> Preventable injury/falls
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Smoking/tobacco use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Family planning/teen pregnancy	<input type="checkbox"/> Violence
<input type="checkbox"/> Care for the elderly	<input type="checkbox"/> Healthy environment	<input type="checkbox"/> Women's health
<input type="checkbox"/> Child health & wellness	<input type="checkbox"/> Heart disease/stroke	<input type="checkbox"/> Other (please specify) : _____
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections	
What THREE things would be most helpful to improve YOUR health concerns?		
<input type="checkbox"/> Access to dental care	<input type="checkbox"/> Domestic violence prevention	<input type="checkbox"/> Mental health services
<input type="checkbox"/> Access to healthier food	<input type="checkbox"/> Drug/alcohol services	<input type="checkbox"/> Safer childcare options
<input type="checkbox"/> Access to primary care	<input type="checkbox"/> Elder care services	<input type="checkbox"/> Safer places to walk/play
<input type="checkbox"/> Affordable housing	<input type="checkbox"/> Exercise/weight loss programs	<input type="checkbox"/> Smoking/tobacco services
<input type="checkbox"/> Breastfeeding support	<input type="checkbox"/> Health Insurance enrollment	<input type="checkbox"/> Transportation
<input type="checkbox"/> Caregiver support	<input type="checkbox"/> Health screenings	<input type="checkbox"/> Violence/bullying/gang prevention
<input type="checkbox"/> Clean air & water	<input type="checkbox"/> Home care services	<input type="checkbox"/> Other (please specify) : _____
<input type="checkbox"/> Community education	<input type="checkbox"/> Immigrant support services	
<input type="checkbox"/> Dementia/Alzheimer's screening	<input type="checkbox"/> Job opportunities	
How would you describe your overall health?		
<input type="checkbox"/> Very healthy	<input type="checkbox"/> Somewhat healthy	<input type="checkbox"/> Very unhealthy
<input type="checkbox"/> Healthy	<input type="checkbox"/> Unhealthy	<input type="checkbox"/> Other (please specify) : _____
How would you describe your overall mental health?		
<input type="checkbox"/> Very healthy	<input type="checkbox"/> Somewhat healthy	<input type="checkbox"/> Very unhealthy
<input type="checkbox"/> Healthy	<input type="checkbox"/> Unhealthy	<input type="checkbox"/> Other (please specify) : _____
Do you suffer from any chronic health conditions (check all that apply)		
<input type="checkbox"/> None	<input type="checkbox"/> Disability	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug/alcohol abuse	<input type="checkbox"/> Memory issues
<input type="checkbox"/> Auto-immune disease	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mental health
<input type="checkbox"/> Cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Other (please specify) : _____

Do you have a health care provider for checkups and visits:		<input type="checkbox"/> Yes _____
		<input type="checkbox"/> No _____
How long has it been since you visited a health care provider for a routine physical exam or checkup?		
<input type="checkbox"/> In the past year	<input type="checkbox"/> In the past five years	<input type="checkbox"/> Never
<input type="checkbox"/> In the past two years	<input type="checkbox"/> Five or more years ago	<input type="checkbox"/> Don't know
What THREE things prevent YOU from getting medical care from a health care provider?		
<input type="checkbox"/> Nothing prevents me from getting medical care	<input type="checkbox"/> Cultural/religious beliefs	<input type="checkbox"/> Insurance does not cover service
<input type="checkbox"/> Cannot afford	<input type="checkbox"/> Don't know how to find providers	<input type="checkbox"/> No transportation/too far
<input type="checkbox"/> Cannot find a health provider who speaks my language	<input type="checkbox"/> Don't like going/afraid to go	<input type="checkbox"/> No childcare
<input type="checkbox"/> Co-pay/deductible too high	<input type="checkbox"/> Don't see the benefit	<input type="checkbox"/> No insurance
	<input type="checkbox"/> I have no time	<input type="checkbox"/> Other (please specify): _____
	<input type="checkbox"/> Inconvenient office hours	
In the past 12 months, did you receive care in the emergency room?		<input type="checkbox"/> Yes _____
		<input type="checkbox"/> No _____
If yes, what is the ONE main reason for your emergency room visit?		
<input type="checkbox"/> Could not find a local health provider who speaks my language	<input type="checkbox"/> Health provider said go to emergency room	<input type="checkbox"/> Thought problem too serious for a doctor's visit
<input type="checkbox"/> Doctor's office not open	<input type="checkbox"/> No other place to go	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Emergency room is the closest provider	<input type="checkbox"/> Receive most of my care at emergency room	
Where do you and your family get most of your health information? (check all that apply)		
<input type="checkbox"/> Community-based organization	<input type="checkbox"/> Internet	<input type="checkbox"/> School/college
<input type="checkbox"/> Doctor/Health professional	<input type="checkbox"/> Library	<input type="checkbox"/> Social media (Facebook, Twitter, etc.)
<input type="checkbox"/> Family or friends	<input type="checkbox"/> Newspaper/magazine	<input type="checkbox"/> Television
<input type="checkbox"/> Health department	<input type="checkbox"/> Radio	<input type="checkbox"/> Worksite
<input type="checkbox"/> Hospital	<input type="checkbox"/> Religious organization	<input type="checkbox"/> Other (please specify): _____
For statistical purposes only (your responses are anonymous), please complete the following:		
I identify as:		What is your age:
<input type="checkbox"/> Male	<input type="checkbox"/> 18-24	<input type="checkbox"/> 55-64
<input type="checkbox"/> Female	<input type="checkbox"/> 25-34	<input type="checkbox"/> 65-74
<input type="checkbox"/> Other	<input type="checkbox"/> 35-44	<input type="checkbox"/> 75+
	<input type="checkbox"/> 45-54	
Zip code where I live _____	Town/city where I live _____	
Are you Hispanic or Latino?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What category best describes your race?		
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Multi-racial
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Other
What is the primary language you speak?		
<input type="checkbox"/> English	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Tagalog
<input type="checkbox"/> Spanish	<input type="checkbox"/> French	<input type="checkbox"/> Korean
<input type="checkbox"/> Italian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other (please specify): _____
What is your highest level of education?		
<input type="checkbox"/> Less than high school	<input type="checkbox"/> Some college	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> High school grad/GED	<input type="checkbox"/> College graduate	
<input type="checkbox"/> Technical school	<input type="checkbox"/> Advanced degree	
What is your current employment status		
<input type="checkbox"/> Employed	<input type="checkbox"/> Student	<input type="checkbox"/> Retired
<input type="checkbox"/> Not employed	<input type="checkbox"/> Military	<input type="checkbox"/> Other (please specify): _____
Do you have any of the following types of health insurance?		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private insurance	<input type="checkbox"/> None/no insurance
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Tri-Care	<input type="checkbox"/> Other (please specify): _____

Please return the survey by June 20, 2016.

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