MONTEFIORE MEDICAL CENTER
COMMUNITY SERVICE PLAN 2014-2017

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As the University Hospital for Albert Einstein College of Medicine, Montefiore is a premier academic medical center nationally renowned for its clinical excellence, scientific discovery and commitment to its community. Recognized among the top hospitals nationally and regionally by U.S. News & World Report, Montefiore provides compassionate, patient- and family-centered care and educates the healthcare professionals of tomorrow. The Children's Hospital at Montefiore is consistently named in U.S. News' "America's Best Children's Hospitals," and is second among those in the New York metro area. With four hospitals, 1,491 beds and 90,000 annual admissions, Montefiore is an integrated health system seamlessly linked by advanced technology. State-of-the-art primary and specialty care is provided through a network of more than 140 locations across the region, including the largest school health program in the nation and a home health program. Montefiore's partnership with Einstein advances clinical and translational research to accelerate the pace at which new discoveries become the treatments and therapies that benefit patients. The medical center derives its inspiration for excellence from its patients and community, and continues to be on the frontlines of developing innovative approaches to care.

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

A. Montefiore's Mission Statement and Strategy:

In January, 2009, Montefiore Medical Center completed a comprehensive review and update of its strategic plan. That process included the development and approval by its Board of Trustees of revised statements of the medical center's Mission, Vision and Values.

Mission:
To Heal, To Teach. To Discover and to Advance the Health of the Communities We Serve.
Vision:
To be a premier academic medical center that transforms health and enriches lives.
Values:
Humanity, Innovation, Teamwork, Diversity and Equity

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

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

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

In pursuing that goal, Montefiore has tasked itself:

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

and to advance the health of the communities we serve.

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

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

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

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

The Office of Community and Population Health was established in the Fall, 2009. It is a new and important function at Montefiore, and its formation parallels other changes at Montefiore, and at Einstein, including:

- creation of a new Montefiore Office of Community Relations;
- consolidation and integration of responsibility for Health Education and Community Outreach, coupled with the re-organization of the staffing for Montefiore's eleven community advisory boards to improve their effectiveness and ability to provide meaningful input regarding how our hospitals and major ambulatory care sites and services can better serve their diverse communities; and
- improved coordination of Montefiore's community health efforts with those of Albert Einstein College of Medicine, including the Institute for Community and Collaborative Health and the Hispanic Center for Excellence.

The goals and directions of Montefiore's Office of Community and Population Health coincide with and reinforce those articulated by the State DOH in its revised approach to the Community Service Plan.

B. <u>Enhancing Community Access to Health Insurance</u>

Montefiore Medical Center has taken a proactive approach to conducting outreach and education of individuals in the community that might be eligible for health insurance coverage through the New York State of Health – New York's Health Insurance Marketplace. Montefiore's planning focused on two key constituencies – external Bronx and lower Westchester Community and internal Montefiore staff.

Externally, Montefiore's strategy was to work with our partners in the community to sponsor and execute outreach and education events throughout our catchment area. To date, Montefiore has participated in or helped to sponsor six different educational events targeting different members of the Bronx and Lower Westchester Community specifically related to the Marketplace, with more to come. Partners have included elected officials, other providers (in particular funded Navigators in the Bronx, such as Bronx Community Health Network and Community Service Society of New York), health plans, and others. In addition, Montefiore created several resources for patients that are used throughout the institution and provided at community-based events, including:

- Printed over 2,500 flyers and tri-folds on the New York State of Health, in both English and Spanish, provided at events and in physician offices and clinics for patients.
- Created a patient-facing webpage on Montefiore's internet site describing the Exchange and posting useful materials.
- Launched a series of E-Screens across all campuses which provide a snapshot of important information on the Marketplace.
- Conducted PR and press on the Exchange targeting both English and Spanish regional press outlets.

Internally, Montefiore's goals were 1) to educate associates who will have interaction with patients who may have questions; 2) to educate associates who will be a source of information for their communities. To that end, Montefiore launched a series of associated education and awareness efforts:

- Developed a seminar on the Basics of the New York State of Health.
    - This seminar has been delivered (or is scheduled to be delivered) in-person to staff across the institution at health centers, to social workers, call center employees, and other various departments upon request.
    - The presentation has been recorded in voice-over webinar format, and is to be made available online through Montefiore's intranet site for associates.
- Montefiore Intranet Site – Montefiore created an internal webpage where information about the Exchange, Navigator and In-Person Assistance programs, free internet action sites and other important information is made available to associates.
- Internal Periodicals – Articles and information were included (or will be included) in Montefiore's internal periodicals, such as Montefiore Update, Inspired Medicine, and using Montefiore's internal networking engine, Yammer.

Finally, Montefiore expects to train over 100 associates that currently are employed as Medicaid Specialists and Financial Aid specialists to become Certified Application Counselors (CAC). In doing so, these individuals will be permitted by the State to actually help patients enroll in health coverage through the Marketplace. Montefiore has also submitted paperwork to become a CAC training site, which will be an important resource for newly hired Montefiore staff as well as other community-based organizations in the Bronx and lower Westchester that also need to have staff trained.

2. Hospital Service Area

A. Description of Service Area

Montefiore has identified the Bronx as its primary service area. More than 85% of Montefiore's hospitals' discharges are residents of the Bronx, and it is within this geographic

area that Montefiore has distributed the vast majority of its community-based primary care and specialty ambulatory services.

Defining a "Hospital Service Area" for Montefiore, however, is not as straightforward as it may be for a freestanding community hospital, which is aligned with and serves a discrete geographic community. To begin with, Montefiore operates four hospitals (Moses, Weiler and Wakefield Hospitals, and the Children's Hospital at Montefiore), each of which serves as a "community hospital" for quite different communities in the Bronx.

An additional division of Montefiore is an ambulatory care facility, which includes a freestanding emergency department at Westchester Square. In addition, each hospital has a nearby specialty ambulatory care center; and serves as a referral center for the Bronx and the wider region, serving patients who need specialty ambulatory and inpatient care.

Beyond its hospital campuses, Montefiore operates a large number of in-community services sites. Montefiore operates over 25 community-based primary care centers, located in communities across the Bronx and southern Westchester. Each of these primary care centers has its own service area, providing comprehensive primary care services to a specific population drawn from its surrounding community, tailoring its services to the needs of the patients and communities it serves.

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

- Montefiore's School Health Program (MSHP) provide comprehensive primary care to a population of elementary, middle and high school students throughout the Bronx. Founded in 1983, the MSHP is the largest and most comprehensive school-based health program in the country, and a major community outreach program for children living in the Bronx. Currently, the MSHP provides a range of medical, mental health,

reproductive and health promotion services to 25,000 students who make over 80,000 visits per year.

- Together, Montefiore and Einstein operate an 11-site substance abuse treatment program that offers drug treatment and rehabilitation services and comprehensive primary care to a population of 4,500 recovering substance abusers in communities across the Bronx.
- Finally, Montefiore provides a wide array of targeted outreach services to at-risk populations within its service area, including programs serving the homeless and victims of domestic violence, as well as services to homebound and/or fragile seniors in community-based settings throughout the Bronx.

The Bronx is a large and diverse urban setting, with many sub-populations and communities that evidence tremendous variation from one to another. Those communities are served by many providers - hospitals/systems, and community health centers - with overlapping service areas. General concepts like "service area" and a "service area population" based on a simple geographic definition (e.g. a set of zip codes) are difficult to apply in a setting like the Bronx, or to a health care delivery system like Montefiore. In such a setting, one must focus on the specific health needs of specific populations, in specific communities, working with specific partners. That has been Montefiore's historical approach to developing and operating its programs of community health, and that is the approach we have taken in developing this Community Service Plan.

B. **Population of the Bronx**

According to the 2012 American Community Survey of the U.S. Census, the Bronx with 1.4 million residents is the nation's poorest urban county; the poverty rate is 31% (compared to 19.4% city-wide) and median income $32,450 (compared to $51,270 city-wide). There are 44.5% of Bronx children living below poverty, also one of the highest child poverty rates in the United States.

There are 7.37% of Bronx households on public assistance, twice the percentages in New York City (4.15%) and New York State (3.40%). There are 84.18% of Bronx students eligible for reduced-fee and free lunch programs. The Bronx unemployment rate of 11.9% is one of the highest unemployment rates in the country. Despite the high poverty and unemployment rates, 27% of Bronx residents ages 25 and older have received their high school diploma or GED, higher than citywide (24%) and statewide (26.9%) attainment rates.

The Bronx is ethnically diverse. Its population is 54.3% Hispanic, 33.2% African-American, 10.6% White, 3.7% Asian, and 3.3% Other. Almost one-third (34.7%) of its residents are foreign-born and 40.7% of the births are to foreign-born mothers. Among these immigrants, more people speak a foreign language at home (predominantly Spanish) than speak "only English." Its new immigrants come from diverse corners of the globe (in order of their numbers): Dominican Republic, Jamaica, Mexico, Ecuador, Guyana, Ghana, Honduras, Italy, Trinidad & Tobago, and Bangladesh.

The Bronx was New York City's first borough to have a majority of people of color and is the only borough with a Latino majority. Only three counties in the eastern United States have a lower portion of Non-Hispanic whites and only one has a higher proportion of Latinos. The Bronx is also the youngest county in New York State with 39.2% children and one of only five U.S. counties with more than 30% single family households.

Before HRSA's 2008 regulation changes designating Health Professions Shortage Areas (HPSAs), almost half (45%) of our population lived in federally designated HPSAs; now the Bronx is qualified as a Whole County HPSA.

C. **Health Status of the Bronx**

The Bronx has been an epicenter of the asthma, HIV, and drug epidemics and also has excess mortality rates from heart disease, stroke, and diabetes compared to city-wide and national averages. As the Bronx mortality rates remain significantly high, the number of physicians in the Bronx continues to dwindle.

Mortality Rates:

According to the New York State Department of Health's (NYSDOH) Vital Statistics of New York State report in 2011, the Bronx has a higher age-adjusted mortality rate (639.8 per 100,000) than New York City (622.7 per 100,000) as a whole. According to the Community Health Rankings in 2010, the Bronx ranks as a county with one of the highest mortality rates in New York State. From the list of 62 NY counties with the lowest to highest mortality outcome (with 1 as the lowest and 62 as the highest), the Bronx ranked at number 60. The leading cause of death among Bronx residents is due to coronary heart disease (206.1 per 100,000).

Asthma:

According to the New York City Department Of Health's (NYCDOH) Community Health Survey in 2011, 17.9% of total Bronx adults reported that they had asthma. The percentage of Bronx adults with asthma was higher than the New York City percentage of 11.9%. According to the NYSDOH, the average (age-adjusted) rate of asthma emergency department visits per 100,000 from 2008-2010 was 231.4 in the Bronx, significantly higher than the New York City rate of 131.5 and statewide rate of 87.1. The age-adjusted death rate due to chronic lower respiratory diseases among Bronx residents was 25.6 per 100,000 in 2009; higher than the New York City rate of 18.1. In 2010, the Bronx rate increased to 29.9; remaining higher than the NYC rate of 20.9.

Diabetes:

According to the NYCDOH, 13.1% of adults in the Bronx reported that they were diagnosed with diabetes in 2011. 15.2% of Bronx adults reported that they were diagnosed with diabetes in 2012. From 2011-2012, the diabetes percentage among Bronx adults remained higher than the citywide diabetes rate of 10%.

According to the NYSDOH, the average (age-adjusted) rate of diabetes hospitalization per 10,000 from 2009-2011 was 399.1 in the Bronx, significantly higher than the New York City rate of 270.5 and statewide rate of 226. The age-adjusted death rate due to diabetes was 28 per 100,000 Bronx residents in 2009; higher than the New York City rate of 19.5 and statewide rate of 16.6. In 2010, the death rate among Bronx residents decreased to 26.8. Despite the decrease in death rate due to diabetes among Bronx residents in 2010, the Bronx rate remained higher than the NYC rate of 20.2 and statewide rate of 16.6.

Health Insurance:
According to the New York State Department of Health, 19.79% of Bronx adults did not have health insurance in 2011, higher than the national rate of 15.1%. During the same year, 4.37% of Bronx children did not have health insurance, lower than the national rate of 7.5%.

Physician Shortage:
In 2013, the Health Resources and Services Administration (HRSA) considered nine population groups and eight facilities in Bronx County to be Primary Care Health Professions Shortage Areas (HPSAs). This marks an increase in the number of population groups (four in 2011 to nine in 2013) and a decrease in the number of service areas (four in 2011 to zero in 2013) and facilities (ten in 2011 to eight in 2013) considered to be HSPAs in 2011. In 2013 the following nine population groups were considered HPSAs: Medicaid Eligible—Fordham/Norwood, Medicaid Eligible—Highbride, Medicaid Eligible—Hunts Point/Mott Haven, Medicaid Eligible—Morris Heights, Medicaid Eligible—Morrisania, Medicaid Eligible—Soundview, Medicaid Eligible—Tremont, Medicaid Eligible—West Farms, Medicaid Eligible—Parkchester/Throgs Necks. In 2013, the following service areas were considered HPSAs: Highbridge, Huntspoint/Mott Have, Morris Heights, Morrisania.

3. Public Participation

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

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

The four elements are:

Partner	Role
Montefiore/ Albert Einstein College of Medicine	Coordinating community site Able to provide sample data to represent sample of the community and results of interventions within a smaller timeline
NYC District Public Health Office	Provide data, epidemiological support, access to NYCDOH programs and access to the NYCDOHMH Community Health Profiles survey
Local Community Board	Represent the interests of local community, local business and local government in the implementation of any intervention
Local Community Based Organizations	Provide direct representation of the constituency to be reached through the interventions and a base for community initiated interventions to be supported by the other coalition members

Through collaboration, this four part coalition, working in individual communities delineated by the Montefiore Medical Group primary care site located within a specific neighborhood, identifies interventions that can be worked on both collaboratively and independently to transform the community's health. Using data collected through Montefiore, the District Public Health Office and other sources, the impact on the community's health by the interventions implemented can be measured and analyzed.

4. Assessment and Selection of Health Priorities

Collaborative Process and Criteria to Identify Priorities

The process to identify at least four priorities evolved out of a series of conversations initially held between Montefiore and the New York City Department of Health as a part of identifying the Take Care New York 2016 Priorities. In reviewing the full list of items, it was very clear that many of their targeted areas, such as Healthy Eating: Active Living, Tobacco Free Living, and Children and Youth agenda items were areas that there was inter-organizational synergy. Through collaborations with large stakeholder partner groups and awareness of the status of Bronx County, as the county with the lowest ranking health status in New York State (62 out of 62), as reported in the 2013 County Health Rankings from the Robert Wood Johnson Foundation, stakeholder groups have agreed that tackling issues impacting improved nutrition, increased physical activity and tobacco-use cessation efforts would be where the greatest impact could be achieved. **Two New York State Priority areas were then chosen, to Prevent Chronic Disease and to Promote Health Women, Infants and Children.**

According to the 2012 American Community Survey of the U.S. Census, 54.3% of the population is Hispanic, 33.2% African-American, 10.6% White, 3.7% Asian, and 3.3% Other. As the borough with the smallest non-Hispanic White population in New York City, focusing on disparities is inherent in everything that Montefiore accomplishes. The priority areas selected and each of the planned interventions focus on specific priority populations and address the ethnic and cultural disparity defined in the indicators for the population served by Montefiore.

Data Sources

Multiple data sources were used to support the identification and selection of the priority items identified, selected, and reviewed with partners. The data sets that were used to identify the issues of concern beyond experience and direct observation are listed below. The comprehensive report of the tabulated Bronx data summarized for this Community Service Plan is provided in Appendix B.

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

Findings are provided by 2010 Bureau of U.S. Census data. The Census data is collected every 10 years using a detailed survey method that counts every resident throughout the U.S. Detailed information provided by the Census survey results describe each U.S. community's entire population, including cross-tabulations of age, sex, households, families, relationship to householder, housing units, and race/ethnic groups. This NYSDOH report also includes data and the 2017 targets for numerous indicators for the five major prevention agenda areas: preventing chronic diseases; promote a healthy and safe environment; promoting healthy women, infants and children; promote mental health and prevent substance abuse; and, prevent HIV/STDs, vaccine-preventable disease and health care-associated infections. The 2011 data is the most recent data available at the time of this report. Detailed information on the NYSDOH Public Health Priority Areas report can be found at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/about.htm.

The Statewide Planning and Research Cooperative System (SPARCS)

This comprehensive database was established in 1979 as a result of cooperation between the health care industry and government. SPARCS collects patient level data on hospital discharges, patient characteristics, diagnoses and treatments, and health care services. This database system also collects data on charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State. This database features the World Health Organization's Ninth Revision of the International Classification of Diseases (ICD-9), an official set of codes used by physicians, hospitals, and allied health workers to indicate diagnosis for all patient encounters. The 2012 data is the most recent data available at the time of this report. The U.S. Centers for Medicare & Medicaid's DRG (Diagnosis-Related Groups) coding system is also featured in the SPARCS data. DRGs group patients by diagnosis, treatment, age, and other characteristics. Hospitals are paid a set fee for treating patients in a single DRG category. Detailed information on the SPARCS data can be found at http://www.health.ny.gov/statistics/sparcs/.

NYS Community Health Indicator Reports

Reports were provided by the New York State Cancer Registry and the Behavioral Risk Factor Surveillance System (BRFSS). The NYS Cancer Registry was established in 1976 to track statewide data of all patients diagnosed with cancer. Data collected from this registry include exposure risks, stages at diagnosis, treatment information, and death rates. Each time a person is diagnosed with a tumor, the hospital(s) where that person is diagnosed and/or treated is required by the Public Health Law Section 2401 to report information about the person and tumor to the Cancer Registry within six months of patient diagnosis. The most recent year for which data on new cases and cancer deaths are available is 2010. Detailed information on the NYS Cancer Registry can be found at

http://www.health.ny.gov/statistics/cancer/registry/. The Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide telephone surveillance system designed by the Centers for Disease Control and Prevention (CDC). BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. New York State's BRFSS sample represents the non-institutionalized adult household population, aged 18 years and older. The survey is conducted in all 50 states and U.S. territories. New York State has participated annually since 1985. Statewide representative samples are collected monthly and aggregated into yearly datasets. Questionnaires, datasets, survey results, documentation and much more are all available at http://www.cdc.gov/brfss/. The 2010 data is the latest Bronx-specific BRFSS data illustrated by the NYSDOH.

New York City Department of Health and Hygiene (NYCDOH) Community Health Survey

The Community Health Survey (CHS) is an annual telephone survey that provides essential data used by the NYCDOH to monitor the health of New Yorkers, evaluate the outcomes of public health initiatives, and guide policy decisions. The survey provides citywide and borough-specific estimates of health indicators and risk factors. Each year, approximately 9,000 adults ages 18 and older are randomly selected to participate in the CHS. The 2012 data is the most recent data available at the time of this report. Questionnaires, datasets, survey results, documentation and much more are all available at http://www.nyc.gov/html/doh/html/data/survey.shtml.

County Health Rankings

This project is a collaboration between the Robert Johnson Foundation and the University of Wisconsin Population Health Institute. Additional data measures used in the rankings were provided by surveys and databases from other organizations such as the National Center for Health Statistics, CDC, Dartmouth Institute, U.S. Census Bureau, and U.S. Department of Agriculture. This database generates health rankings of every U.S. county and illustrates the correlations between local health outcomes, health factors, and socioeconomic factors. The county rankings are based on summary scores calculated from individual data measures. The overall Health Outcomes summary score consists of data on the county's mortality and morbidity. The overall Health Factors summary score consists of data on the county's health behaviors, clinical care, social and economic factors, and physical environment. The 2010 data is the most recent data available at the time of this report. Detailed information on the County Health Rankings can be found at http://www.countyhealthrankings.org/our-approach.

Community Health Needs Assessment

This project was developed by the Advancing the Movement organization and the Center for Applied Research and Environmental Systems (CARES) as a web-based toolkit designed to hospitals, state and local health departments, and other organizations seeking to better understand the needs and assets of their communities. County-level data retrieved from institutions such as the CDC, U.S. Census Bureau, and the Public Health Institute are formulated into customized data reports. The Full Health Indicators Report illustrates the health needs assessment profiles of U.S. counties using local demographics, socioeconomic factors, physical environment data, clinical care data, health behavior factors, and health outcomes. The 2010 data is the most recent data available at the time of this report. Detailed information on the Community Health Needs Assessment can be

found at CHNA.org.

NYC Youth Risk Behavior Survey (YRBS)

This survey is conducted through an ongoing collaboration between the New York City Department of Health and Mental Hygiene (DOHMH), the Department of Education (DOE), and the National Centers for Disease Control and Prevention (CDC). The New York City's YRBS is part of the CDC's National Youth Risk Behavior Surveillance System (YRBSS). Based on the protocol developed by CDC, the survey has been conducted in odd-numbered years since 1997 to monitor priority health risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems among youth in New York City. Students complete a self-administered, anonymous questionnaire that measures a variety of behaviors, including tobacco, alcohol and drug use, unintentional injury and violence, sexual behaviors, dietary behaviors, and physical activity. The results are representative of public high school students in grades 9 through 12. The NYC YRBS can provide prevalence data for the city as a whole, for each of the five boroughs starting in 2003, and since 2005 for three high-risk neighborhoods - the South Bronx, North and Central Brooklyn, and East and Central Harlem in Manhattan - where the DOHMH has its District Public Health Offices (DPHOs). The 2011 data is the most recent data available at the time of this report. Detailed information on the NYCDOH's YRBS can be found at http://www.nyc.gov/html/doh/html/data/youth-risk-behavior.shtml.

CDC's Sexually Transmitted Disease Surveillance

This report documents statistics and trends for sexually transmitted diseases (STDs) in the United States through 2011. This publication is intended as a reference document for policy makers, program managers, health planners, researchers, and others who are concerned with the public health implications of these diseases. The surveillance information in the latest report is based on the following sources of data: (1) notifiable disease reporting from state and local STD programs; (2) projects that monitor STD positivity and prevalence in various settings, including regional Infertility Prevention Projects, the National Job Training Program, the STD Surveillance Network, and the Gonococcal Isolate Surveillance Project; and (3) other national surveys implemented by federal and private organizations. The STD surveillance systems operated by state and local STD control programs, which provide the case report data for chlamydia, gonorrhea, and syphilis, are the data sources of many of the figures and most of the statistical tables in this publication. Detailed information on the CDC's Sexually Transmitted Disease Surveillance can be found at http://www.cdc.gov/std/stats11/default.htm.

NYSDOH's Annual HIV/AIDS Surveillance Report

The Annual Surveillance Report presents recent data on newly diagnosed HIV cases and persons living with diagnosed HIV infection in New York State. Twenty-two sets of tables are grouped by major geographic division (New York State (NYS), New York City (NYC), NYS excluding NYC, Ryan White Regions1, NYC boroughs). Most sets feature three tables on separate pages – (A) living HIV and AIDS cases, (B) new HIV diagnoses and (C) new AIDS diagnoses. The historical table (Table 1) includes HIV and AIDS diagnoses, and deaths among persons with AIDS. This report is produced by the Bureau of HIV/AIDS Epidemiology (BHAE), AIDS Institute, New York State Department of Health (NYSDOH). Access to this publication is available through the Internet at the

following address: http://www.nyhealth.gov/diseases/aids/statistics/index.htm.

American Community Survey (ACS)
Developed by the U.S. Census Bureau, the ACS is an ongoing survey that collects annual data on the major characteristics of communities throughout the U.S. The data collected is categorized into four categories: social, economic, demographic, and housing. Social characteristics include topics such as education, disability status, and health insurance status. Economic characteristics describe the income, employment status, and poverty level of U.S. communities. Demographic characteristics include age, sex, and race/ethnicity information. Housing characteristics include topics such as occupancy and vacancy, monthly rent, and household size. Approximately 3.5 million U.S households are randomly selected to participate in the ACS each year. The 2012 data is the most recent data available at the time of this report. Questionnaires, datasets, survey results, documentation and more detailed information are available at https://www.census.gov/acs/www/.

Community Engagement
For each of these priority areas, different groups were engaged. Within the Prevent Chronic Disease Priority three subsets of groups participated.

Reducing Obesity in Children and Adults
According to the NYSDOH, 68% of Bronx adults were reported to be overweight or obese between 2008 and 2009. This is higher than the reported rates in both New York City (57.9%) and New York State (59.3%). The NYCDOH Youth Risk Behavior Survey (2011) found that the Bronx had the highest rate of teen obesity of all five boroughs with 14.8% of teens reported obese. New York City has a teen obesity rate of 11.6%. The Bronx also had the highest percentage of teens that were overweight but not obese of all five boroughs, with 16.9%.

For the Priority Area - **Reducing Obesity in Children and Adults**, a new group was conceptualized in April of 2012 when Dr. Steven Safyer submitted an opinion commentary through one of the local New York City periodicals http://www.nydailynews.com/opinion/winning-obesity-battle-article-1.1056892 detailing the strategies he proposed would lead to victory in the battle over obesity. This call to action mobilized New York City Department of Health and Mental Hygiene leadership to call for a meeting and jointly in partnership with the Bronx Borough President, the Honorable Ruben Diaz Jr. and New York State Senator Gustavo Rivera - (D) 33rd District, the decision was made to gather through leaders on this issue to define and work on solutions.

Fifteen sector issue key stakeholder organizations were invited to participate in the initial meeting held on June 25, 2013. The leaders were:

Organization	**Leaders**
1. Office of the Bronx Borough President	The Honorable Ruben Diaz, Jr. Melissa Cebollero
2. New York State Senator:	The Honorable Gustavo Rivera
3. Montefiore Medical Center:	Dr. Steven Safyer, President & CEO
4. New York City Department of Health and Mental Hygiene:	Commissioner of Health, Dr. Thomas A. Farley
5. Urban Health Plan, Inc.:	Ms. Paloma Hernandez, Pres & CEO

6.	Morris Heights Health Center	Ms. Verona Greenland, MPH, Pres & CEO
7.	Health First	Pat Wang, JD, CEO
8.	1199SEIU/HCWE	George Gresham, President
9.	Furco Food Corp.	Rudy Fuertes
10.	Jerome-Gun Hill BID	Ruben Luna
11.	CTG/Bronx Borough Lead	Dr. Neil Calman
13.	Bronx Clergy Task Force	Bishop Angelo Rosario
14.	Health and Hospitals Corporation	Dr. David Stevens
15.	YMCA of NYC	Jack Lund, CEO
16.	Dept. of Education (DOE)	Lindsey Harr
17.	Greater New York Diabetes Association	
18.	New York State Health Foundation,	Jim Knickman
19.	Greater New York Hospital Assoc.	Lloyd Bishop
		Amy Osorio

This group was supplemented with staff from each of the lead organizations. At this meeting, after a presentation from the four principals and clinical experts for the New York City Department of Health and Mental hygiene and Montefiore Medical Center, this group agreed to tackle collectively and collaboratively the issues surrounding obesity in children and adults through the Bronx Campaign to Prevent and Control Obesity.

<u>Reducing Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure</u>
According to the NYCDOH Community Health Survey (2012), 15.8% of adults in the Bronx reported being current smokers as compared to 15.5% of New York City adults reported being current smokers.

As tobacco use remains the leading preventable cause of premature death in the United States, accounting for 19% of these deaths, more than obesity, infections (including HIV/AIDS), motor vehicle accidents, homicide, suicide, and drug and alcohol abuse combined, we have selected **Reducing Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure** as the second focus area**.** Montefiore will continue with its strong supportive partnership with Bronx BREATHES (**BR**onx **E**instein **A**lliance for **T**obacco **F**ree **H**ealth and **E**nvironmental **S**ervices). Bronx BREATHES was established in 2004 as the Bronx Tobacco Cessation Center and is one of nineteen designated tobacco cessation centers in New York State, funded by the New York State Department of Health Bureau of Tobacco Control. Montefiore participates in the Bronx BREATHES Monthly Staff and Partnership meeting, which is led by the Bronx BREATHES staff and its Principal Investigator, Dr. Alvin 'Hal' Strelnick, and attended by representatives of the following partner organizations:

Albert Einstein College of Medicine
American Cancer Society
Bronx Community Health Network
Bronx County Medical Society
Bronx CREED
Bronx Lebanon Hospital
Bronx Lesbian & Gay Health Resource Consortium
Bronx Psychiatric Center
Clinical Directors Network
Emblem Health Plan of New York
Health People
Jacobi Medical Center
Lehman College-Department of Nursing
Lincoln Medical and Mental Health Center
Montefiore Medical Center
Morris Heights Health Center
Morrisania Diagnostic & Treatment Center
New York City Department of Health & Mental Hygiene
North Central Bronx Hospital
NYC Coalition for a Smoke-Free City
Office of the Bronx Borough President Ruben Diaz, Jr.
Project Samaritan AIDS Services
Segundo Ruiz Belvis Diagnostic & Treatment Center
South Bronx Asthma Partnership
St. Barnabas Hospital
The Bronx Health Link
Urban Health Plan

At the last meeting of the group, on October 14, 2013, Montefiore's commitment to continue addressing tobacco related concerns as a part of its Community Service plan was roundly approved as it would continue to support the strides that the coalition has made in reducing tobacco use across multiple populations in the Bronx. These successes include:

- Provided approximately 240 smokers with Nicotine Replacement Therapy.
- Provided training on tobacco cessation in patients to 963 providers
- Reduced smoking so that from 2002 to 2008 the Bronx had reduced its adult smoking rate by 32% (from 25.2% to 17.1%, respectively), second only to much richer Manhattan (21.1% to 13.8% or a 34.6% reduction) among the five boroughs
- In 2007 and 2009 Bronx teens had the lowest smoking rate among the five boroughs (6.2% and 6.7%, respectively) and the biggest reductions since 2003 (51%). (Surveys are only conducted in odd numbered years.)
- Bronx BREATHES has helped eliminate the ethnic/racial disparities in smoking rates and nicotine replacement therapy in the Bronx.
- The Bronx also has the highest portion of physician-referred callers to the NYS Quitline among the five boroughs.
- Montefiore was the first hospital in the Bronx to achieve Silver Star designation as a part of the New York City Department of Health and Mental Hygiene's Health Hospital Initiatives Tobacco Cessation program.

<u>Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings</u>

The Bronx has New York City's highest rates of pre-diabetes, diabetes and it is suspected to have equally high rates of undiagnosed diabetes among its 1.4 million residents. Montefiore, as the University Hospital for the Albert Einstein College of Medicine was selected as one of the initial 27 clinical centers across the nation selected to participate in the original Diabetes Prevention Program (DPP) study which found that participants who lost a modest amount of weight through dietary changes and increased physical activity sharply reduced their chances of developing diabetes. Participants in the lifestyle intervention group - those receiving intensive

individual counseling and motivational support on effective diet, exercise, and behavior modification - reduced their risk of developing diabetes by 58 percent. This finding was true across all participating ethnic groups and for both men and women. Lifestyle changes worked particularly well for participants aged 60 and older, reducing their risk by 71 percent. About 5 percent of the lifestyle intervention group developed diabetes each year during the study period, compared with 11 percent of those in the placebo group. The DPP's results indicate that millions of high-risk people can delay or avoid developing Type 2 diabetes by losing weight through regular physical activity and a diet low in fat and calories. (National Diabetes Information Clearinghouse).

Montefiore has embraced implementation of the national YMCA of New York City's Diabetes Prevention Program (Y-DPP) to arrest the development of this chronic disease within our population. In partnership with the YMCA of New York City we began referring our patients into the Y's in the Bronx. Additionally, the health education staff at Montefiore has been trained by the YMCA of NYC to facilitate the Y-DPP program and as of October 2013, Montefiore has the largest group of patients enrolled and processed through the Y-DPP program as compared to any other health system in New York City. Due to this successful collaboration, we were invited to participate in the South Bronx Community Referral Task Force (SBCRT).

The SBCRT 's membership includes representatives from the following organizations as well as three private clinician practice groups:

YMCA's DPP
City Harvest
Montefiore Medical Center
Cornell Cooperative Extension
Lincoln Hospital
Bronx Health Reach
St. Simon Stock Roman Catholic Church
Hope of Israel Senior Center
Shape Up New York City
Dr. Essen
Dr. Patel
Uptown Medical Group

In agreement with this membership, Montefiore has selected Diabetes Prevention as its measure for increasing access to high quality diabetes preventive care and management in both clinical and community settings, which is a reaffirmation and expansion of the work we proposed in the 2010-2013 Community Service Plan where the organizational focus was on pediatric diabetes.

Maternal and Infant Health

As one of the largest delivery hospitals in the Bronx, while we have demonstrated a strong commitment to maternal and infant health, mothers in the Bronx continue to report lowered ongoing breastfeeding rates. Montefiore has invested to improve maternal and infant health, including a partnership with the March of Dimes to reduce rates of low birth-weight and premature births, and operation of one of the city's largest WIC programs, providing health education and nutrition support to poor mothers, infants and children. Montefiore has embraced the Latch On NYC program at each of our delivery hospitals, which has been formally endorsed

by the New York State Department of Health, Greater New York Hospital Association, Academy of Family Physicians, New York County Chapter, American Academy of Pediatrics, District II, New York State and the Society for Adolescent Health and Medicine, New York State Chapter. In partnership with the New York City Department of Health and Mental Hygiene, Montefiore is one of twenty-six hospitals participating in the partnership.

5. Three Year Plan of Action

The four areas selected by Montefiore (and the corresponding designations in the Prevention Agenda 2013-2017: New York State's Health Improvement Plan) for submission in this Community Service Plan are as follows:

Under the Priority Area – *Prevent Chronic Disease*

1. Reducing Obesity In Children and Adults
    a. Goal 1.0.1 – Reduce the percentage of children who are obese
    b. Goal 1.3 - Expand the role of healthcare and health service providers and insurers in obesity prevention

2. Reducing Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
    a. Goal 2.2.2 - Increasing the number of unique callers to the New York State Quit-Line
    b. Goal 2.2.2 - Decreasing the prevalence of cigarette smoking by adults ages 18 years and older

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

Under the Priority Area – *Promote Healthy Women Infants and Children*

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

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

Prevent Chronic Disease

Focus Area 1: Reducing Obesity in Children and Adults

In continuation of the efforts proposed in the 2010-2013 Community Service Plan, Montefiore will continue to apply its efforts to the prevention, control and dissipation of obesity in children and adults.

Goal 1.0.1 - Reduce the percentage of children who are obese

Strategic Plan:

To address the significant issue of obesity reduction in children, Montefiore has partnered with the New York City Department of Health and Mental Hygiene, the Honorable Bronx Borough President Ruben Diaz Jr., and New York State Senator, 33rd District Gustavo Rivera (D) to convene a group of strategic industry leaders across healthcare, government, retail, faith-based, community, municipal and civic groups to collectively address obesity in the borough of the Bronx. Through the formation of the Bronx Campaign to Prevent and Control Obesity, it is the

collective belief that the five agreed upon measures can advance the borough in decreasing obesity.

Goals & Objectives:
The Campaign has several key interventions that can be used by the various partners to ensure that there is a consistent message delivered across the community related to obesity. The key interventions below, which have multiple sub elements, will be used to direct the borough wide obesity prevention and reduction message. The goals presented below are a part of the larger borough-wide initiative in which Montefiore intends to contribute in meaningful ways.

Key Intervention 1: Launch health promotion and education campaigns
Key Intervention 2: Improve worksite food and physical activity environments
Goals:
- Fully adopt NYC Food Standards in 9 Bronx hospitals
- Adopt NYC Food Standards at 50 other large employers

Key Intervention 3: Increase healthy eating opportunities in retail settings
Goals:
- 350 retailers adopt Shop Healthy Bronx changes
- Have a minimum of five retail food distributors adopt Shop Healthy changes
- Distribute at least 20,000 additional Health Bucks

Key Intervention 4: Increase physical activity in schools and the community
Goals:
- Have approximately 4,000+ Bronx elementary teachers trained in classroom physical activity programs
- Work with approximately twenty affordable housing sites, schools and community groups champion and implement active design improvements

Key Intervention 5: Increase obesity-related interventions in healthcare centers
Goals:
- Increase current level of referrals and bring on board 20 additional health centers that refer to YMCA Diabetes Prevention Program (Y-DPP)
- Work with twenty health centers to promote healthy eating and active living through electronic medical records (EMR), prescriptions for prevention and more.

The diversity in the group's membership means that not every organization will work on every intervention; however there is a commitment to unify the message for Key Intervention 1.

Evidence Base:
There have been numerous studies supporting the five key interventions that have been conducted not only by the New York City Department of Health and Mental Hygiene, as well as the national Let's Move Campaign, and the efficacy of the YMCA's Diabetes prevention Program, among others.

Performance Measures and Time Frame Targets:
For the following Key Interventions, the larger organization has planned for a longer time frame than is covered through the Community Service Plan time period of 2017, for the achievement of several of these goals. However, it is our anticipation to make significant progress as indicate on these interventions for reporting through 2017.

Key Intervention 1: Launch health promotion and education campaigns
Key Intervention 2: Improve worksite food and physical activity environments
Performance Measure: Reduce Obesity in the Bronx by 10%
Key Intervention 3: Increase healthy eating opportunities in retail settings
Performance Measure: Reduce the percentage of Bronxites who consume one or more sugar sweetened beverages a day by 30%
Key Intervention 4: Increase physical activity in schools and the community
Performance Measure: Decrease the percentage of Bronxites who report no fruit or vegetable consumption by 30%
Key Intervention 5: Increase obesity-related interventions in health care centers
Performance Measure: Decrease the percentage of Bronxites who report no physical activity in the past 30 days by 15%

Goal 1.3 – Expand the role of healthcare and health service providers in obesity prevention
Strategic Plan:

As this Objective 1.3.2: increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization is closely aligned with the Priority Area Preventing Chronic Disease, Focus Area 2 - Maternal and Infant Health Goal 2.2.1 - Increase the proportion of infants born in New York State who are exclusively breastfed during the birth hospitalization, we have detailed the plan in that section, located below.

Focus Area 2: Reducing Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

Goal 2.2.2 - Increasing the number of unique callers to the New York State Quit-Line
Goal 2.2.2 - Decreasing the prevalence of cigarette smoking by adults ages 18 years and older
Strategic Plan:

Montefiore has been successful at increasing the number of unique callers to the New York State Quit-Line with our inpatient populations as we have been able to document 100% contacts for patients at discharge with provision of the New York State Quit-Line information. In 2012, this covered over 50,000 unique adult, aged over 18 lives. We have also been tremendously successful with the expansion of the smoke free campus to cover all of our locations in addition to our acute care hospitals and have remained an ardent support of supplemental nicotine replacement therapy in the community as demonstrated by Montefiore's annual distribution of NRT across the Bronx.

Goals & Objectives:

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

Evidence Base:

The evidence base for the expansion of smoking cessation programs especially using the New York State Tobacco Control program is substantial. Bronx BREATHES, our partner in this activity, as well as the Partnership for a Smoke Free Bronx are state and federally funded entities. The measures of these activities are constructed within the framework established by the New York City Department of Health and Mental Hygiene's Healthy Hospital Initiative and the results will be evaluated through the NC Prevention Partners, a national leader in tobacco cessation evaluation.

Performance Measures and Time Frame Targets

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

Performance Measures (Increasing Unique Callers):

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

Performance Measures (Decreasing the smoking prevalence in adults):

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

Timeframe targets:

As Montefiore is pursuing Gold Star Status, through the New York City Department of Health and Mental Hygiene's Healthy Hospital Initiative, having achieved both Bronze and Silver Star Status, this is an important activity for the hospital. We anticipate being able to attain this status by 2015, and to maintain it through 2017.

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

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

Strategic Plan:

Montefiore has selected to focus on increasing screening rates for diabetes especially among disparate populations through the increased implementation of and referral to the YMCA of New York City's Diabetes Prevention Program (Y-DPP) across Montefiore Medical Center's Montefiore Medical Group sites, while continuing participation in the South Bronx Community Referral Task collaboration to increase the number of community available sites for Y-DPP.

Goals & Objectives:

The YMCA's Diabetes Prevention Program helps those at high risk adopt and maintain healthy lifestyles and reduce their chances of developing type 2 diabetes. The goals of the program are to:

- Reduce body weight by 7%
- Gradually increase physical activity to at least 150 minutes per week

In a classroom setting conducted either in the community or in the clinical setting, a trained lifestyle coach will instruct participants on how to change their lifestyle by learning about healthy eating, physical activity and other behavior changes over the course of 16 one-hour sessions. The topics covered include nutrition, getting started with physical activity, overcoming stress, staying motivated, and others relevant to the group. After the initial 16 core sessions, monthly meetings continue for up to a year for added support to help with maintenance of the progress they have achieved. Blood glucose monitoring is a part of the clinical visit and is not

monitored specifically within the Y-DPP group. However, the patient's physician received progress reports at four weeks, nine weeks and 13 weeks to incorporate the education provided in the program into the patients overall primary care services.

Evidence Base:
The Y-DPP Community Program Implementation is supported by multiple studies including the Translating the Diabetes Prevention Program into the Community: The DEPLOY Pilot Study conducted by Ackermann et al (2008) and YMCA Model Adapting the Diabetes Prevention Program Lifestyle Intervention for Delivery in the Community by Ackerman and Marrero (2007). The YMCA Diabetes Prevention program is based on the landmark Diabetes Prevention Program funded by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC), which showed that by eating healthier, increasing physical activity and losing a small amount of weight, a person with pre-diabetes can prevent or delay the onset of type 2 diabetes by 58%.

Performance Measures and Time Frame Targets:
Performance Measures:
The performance measures associated with the implementation of the YMCA of New York City's Diabetes prevention program are as follows:

- Number of patients referred into the Y-DPP program, or other approved DPP program
- Duration of Y-DPP participation
- Percentage reaching body weight target
- Percentage reaching physical activity target
- Number of patients referred to Y-DPP that demonstrate decreases in A1c in aggregate

Time Frame Targets:
The Montefiore implementation is currently focused on six Montefiore Medical Group sites, however, in 2014, it is the intention to expand to another four Montefiore Medical Group sites and by 2017 have all sites with eligible adults referred to the program. As New York and other states are currently examining offering access to the DPP programs as a covered benefit, this timeline may be accelerated.

Promote Healthy Women Infants and Children

Focus Area 2 - Maternal and Infant Health

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

Strategic Plan & Goals
Montefiore Medical Center has committed to achieving the goals of the Baby Friendly Hospital initiative and has signed on to the New York City Department of Health's Latch-On NYC Initiative to support breastfeeding mothers and to increase the proportion of women that are achieving the World Health Organization's target rate of having the first six months of an infant's life with exclusive breastfeeding.

Initiative Objectives:
The objectives of the Latch on NYC initiative are as follows:

1. Montefiore will enforce the New York State hospital regulation to not supplement breastfeeding infants with formula feeding unless medically indicated and documented within the infants medical record

2. Provide physical restriction to infant formula by hospital staff including the tracking of infant formula distribution with the health department
3. Discontinue the distribution of free promotional formula
4. Prohibit the display and distribution of infant formula promotion materials in any hospital location.

The objectives of the Baby Friendly Hospital are:

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

Evidence Base:

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

Latch-On NYC, an initiative of the New York City Department of Health, is a local effort within the New York City CDC that has encouraged all NYC maternity hospitals to make a voluntary commitment to support mothers who choose to breastfeed by providing additional support to breastfeeding mothers and minimize practices that can interfere with that choice such as supplementing breastfeeding infants with formula, unless medically indicated or at the mother's specific request. Participating hospitals also pledge to end the distribution of promotional formula and materials during the hospital stay and at discharge. Supporting this institutional initiative is a public awareness campaign to promote the health benefits of breast milk, and to inform women of their right to receive education, encouragement and support to breastfeed their babies if they choose to do so.

When hospitals stop promoting infant formula, mothers are more likely to exclusively breastfeed their babies. The evidence supporting this initiative is strong. An evaluation of the New York City Health and Hospitals Corporation data has shown that after the Health and Hospitals Corporation (HHC) hospitals discontinued providing infant formula samples at hospital discharge and implemented other practices to support breastfeeding, the exclusive breastfeeding rate at eight weeks following delivery increased by 21%, with no change in rates for mothers delivering at non-HHC facilities.

Performance Measures and Time Frame Targets:
In 2012, over 6,300 infants were delivered at Montefiore, with over 2,400 of those infants delivered women defined as low income.

Performance Measures:

Identification of the following

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

Development of the following:

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

Time Frame Targets:
The time frame established for achievement of the baby friendly hospital designation is 2017. Achievement of the entire Latch on NYC protocol is also expected to be achieved by 2017. Montefiore has established a Breastfeeding Committee that contains an inter-organizational, interdisciplinary membership from Montefiore, Jacobi Medical Center and the Albert Einstein College of Medicine. Supplementary membership is held by the Assistant Commissioner of the Bronx District Public Health Office and the Assistant Commissioner of the Bureau of Maternal and Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene.

6. Dissemination of the Plan to the Public

The plan to disseminate the delivery of the Montefiore Medical Center 2014-2017 Community Service Plan report to the public will occur across a number of platforms:

- The Community Service Plan will be posted to the www.montefiore.org website at the specific address http://www.montefiore.org/documents/CSP2014-2017.pdf It can also be found through accessing the general www.montefiore.org site and clicking the Community Reports tab located in two areas of the face page, both under the Community tab or by scrolling to the bottom of the page where Community Reports is provided as hyperlinked text which can take a viewer directly to the report.
- The Community Service Plan will be mailed out in hard copy to members of the Montefiore Board, as well as provided to community leaders and elected officials. To facilitate this distribution, a copy of the direct link is also provided specifically to the distribution link of the Office of the Bronx Borough President, which maintains the borough's largest electronic

communication list and can provide dissemination beyond the traditional healthcare partners.

- A QR code for the link to the report will be made available for print materials to facilitate ease of access to the report. The QR code, accessible through most smart phone readers, for the site is provided below.

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

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

7. Maintaining Engagement

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

In Focus Area 1 – Reducing Obesity in Children and Adults; Goal 1.0.1 – to reduce the percentage of children who are obese, we will continue to operate through the school wellness councils and work within the 21 school based health centers that are a part of Montefiore to address educational and implementation concerns. Through the B'N Fit program, we will connect with the participants behavioral group and the parents support group to keep ongoing dialogue about obesity prevention initiatives. Data from the B'N Fit site http://montekids.org/bnfit will also be shared to inform the response to the work that is occurring.

For Goal 1-3 - increase the percentage of children and adolescents ages 3-17 years with an outpatient visit with a primary care provider or obstetrics/gynecology practitioner during the measurement year, who received appropriate assessment for weight status during the measurement year, we will work with the Bronx Community Healthcare Network's (BCHN) Quality Improvement Committee to monitor compliance with the numbers of children across healthcare providers whose weights are assessed.

For Goal 1.4 - Expand the role of public and private employers in obesity prevention, we have aligned with the national Partnership for Quality Care, whose membership includes a national labor-management partnership of twenty-one organizations to establish the benchmarks for the development of a culture of health in the workplace.

1199 SEIU United Healthcare East
Daughters of Charity Health System
Dignity Health
Greater New York Hospital Association
Group Health Cooperative
HealthPartners
Jackson Health System
Kaiser Permanente
Los Angeles County Department of Health Services
Maimonides Medical Center
Montefiore Medical Center
Partners Healthcare
Service Employees International Union
SEIU Healthcare Minnesota
SEIU Healthcare Pennsylvania
SEIU Healthcare 1199NW
SEIU United Healthcare Workers-West
SEIU Local 1991
Committee of Interns & Residents of SEIU Healthcare
Steward Health Care (formerly Caritas Christi Health System)
West Penn Allegheny Health System

Through this national benchmarking process we are able to maintain and expand the manner in which we continue to expand the role of public and private employers in obesity prevention.

In Focus Area 2 – Reducing Illness Disability and Death related to tobacco use and second hand smoke, to maintain engagement in this area, we will work with the Bronx BREATHES coalition and the Partnership for a Smoke Free Bronx to measure and document the progress on Objective 2.2.1 - increase the number of unique callers to the NYS Smokers' Quitline; Objective 2.2.2 - decrease the prevalence of cigarette smoking by adults ages 18 years and older, and Objective 2.2.3 - increase the utilization of smoking cessation benefits among smokers who are enrolled in Medicaid Managed Care. Additionally Montefiore is pursuing the established New York City Healthy Hospital Initiative Tobacco Program's Star Advancement Program which provides an additional review of the data against national tobacco cessation program initiatives. As one of the member institutions of the Healthy Hospital Initiative, we serve as a model institution for the borough.

In Focus Area 3 – Increasing Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings, Objective 3.3.1- increase the percentage of adults with arthritis, asthma, cardiovascular disease, or **diabetes** who have taken a course or class to learn how to manage their condition, to maintain this goal, we will expand our partnership with the YMCA of New York City's Diabetes Prevention Program (DPP), as well as the newly granted Diabetes Prevention Program offerings through Emblem Health, and any of the other newly arising approved DPP programs. Montefiore will continue to participate in the collaboration established through the New York City Department of Health and Mental Hygiene's South Bronx Community Referral Task Force, which provides monitoring and evaluation of data submitted through the various DPP programs across the Bronx.

The fourth area we are addressing is in the priority area Promote Healthy Women, Infants and Children. In Focus Area 1of the section – Maternal and Infant Health, Objective 2.2.1 - increase the percent of infants born in NYS who are exclusively breastfed during the birth hospitalization,

we anticipate the maintenance of this work externally through the collaboration with the Latch-On NYC partnership established through the New York City Department of Health and supported through the Greater New York Hospital Association. Within Montefiore, as we have two active campus based breastfeeding initiatives, we will continue to monitor the breastfeeding initiation compliance rates and pursue recognition as a baby friendly hospital.

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

8. Financial Aid Program

Montefiore has a charity care program which is a model program, providing outreach, enrollment assistance and charity care. Staff informs all patients receiving services who are uninsured or underinsured about the program. Information on the financial aid policy and procedures is provided to patients, in both English and Spanish, including brochures available in all the patient service areas, information posted on the intranet and internet, and information on the bills sent out to patients. When a patient requests a financial aid consultation, we set up an interview, send out an application to be completed, or interview patient at time they present if they have required documentation on hand. Montefiore assists all walk-in patients from the community with their inquiries and will complete a Medicaid application whether or not they have already been seen at one of our facilities. We believe all patients that are eligible should be guided through the application process. Our program first attempts to assist the patient in getting enrolled in a state program. We recognize that if they are enrolled they will be able to fill their prescriptions and see physicians. Montefiore has made major investments in manpower to support the patient through this process. We have staff located at all our facilities who can complete an application and send it to HRA. Our success can be measured by the number of patients who were enrolled in the Medicaid program (excluding patients enrolled in PCAP). If a patient gets enrolled in Medicaid, but the enrollment does not cover the period of time the service occurred, the payment for that treatment episode is considered charity care.

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

Appendix A – Data Sources

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

Findings are provided by 2010 Bureau of U.S. Census data. The Census data is collected every 10 years using a detailed survey method that counts every resident throughout the U.S. Detailed information provided by the Census survey results describe each U.S. community's entire population, including cross-tabulations of age, sex, households, families, relationship to householder, housing units, and race/ethnic groups. This NYSDOH report also includes data and the 2017 targets for numerous indicators for the five major prevention agenda areas: preventing chronic diseases; promote a healthy and safe environment; promoting healthy women, infants and children; promote mental health and prevent substance abuse; and, prevent HIV/STDs, vaccine-preventable disease and health care-associated infections. The 2011 data is the most recent data available at the time of this report. Detailed information on the NYSDOH Public Health Priority Areas report can be found at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/about.htm.

The Statewide Planning and Research Cooperative System (SPARCS)

This comprehensive database was established in 1979 as a result of cooperation between the health care industry and government. SPARCS collects patient level data on hospital discharges, patient characteristics, diagnoses and treatments, and health care services. This database system also collects data on charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State. This database features the World Health Organization's Ninth Revision of the International Classification of Diseases (ICD-9), an official set of codes used by physicians, hospitals, and allied health workers to indicate diagnosis for all patient encounters. The 2012 data is the most recent data available at the time of this report. The U.S. Centers for Medicare & Medicaid's DRG (Diagnosis-Related Groups) coding system is also featured in the SPARCS data. DRGs group patients by diagnosis, treatment, age, and other characteristics. Hospitals are paid a set fee for treating patients in a single DRG category. Detailed information on the SPARCS data can be found at http://www.health.ny.gov/statistics/sparcs/.

NYS Community Health Indicator Reports

Reports were provided by the New York State Cancer Registry and the Behavioral Risk Factor Surveillance System (BRFSS). The NYS Cancer Registry was established in 1976 to track statewide data of all patients diagnosed with cancer. Data collected from this registry include exposure risks, stages at diagnosis, treatment information, and death rates. Each time a person is diagnosed with a tumor, the hospital(s) where that person is diagnosed and/or treated is required by the Public Health Law Section 2401 to report information about the person and tumor to the Cancer Registry within six months of patient diagnosis. The most recent year for which data on new cases and cancer deaths are available is 2010. Detailed information on the NYS Cancer Registry can be found at http://www.health.ny.gov/statistics/cancer/registry/. The Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide telephone surveillance system designed by the Centers for Disease Control and Prevention (CDC). BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in

the population. New York State's BRFSS sample represents the non-institutionalized adult household population, aged 18 years and older. The survey is conducted in all 50 states and U.S. territories. New York State has participated annually since 1985. Statewide representative samples are collected monthly and aggregated into yearly datasets. Questionnaires, datasets, survey results, documentation and much more are all available at http://www.cdc.gov/brfss/. The 2010 data is the latest Bronx-specific BRFSS data illustrated by the NYSDOH.

New York City Department of Health and Hygiene (NYCDOH) Community Health Survey
The Community Health Survey (CHS) is an annual telephone survey that provides essential data used by the NYCDOH to monitor the health of New Yorkers, evaluate the outcomes of public health initiatives, and guide policy decisions. The survey provides citywide and borough-specific estimates of health indicators and risk factors. Each year, approximately 9,000 adults ages 18 and older are randomly selected to participate in the CHS. The 2012 data is the most recent data available at the time of this report. Questionnaires, datasets, survey results, documentation and much more are all available at http://www.nyc.gov/html/doh/html/data/survey.shtml.

County Health Rankings
This project is a collaboration between the Robert Johnson Foundation and the University of Wisconsin Population Health Institute. Additional data measures used in the rankings were provided by surveys and databases from other organizations such as the National Center for Health Statistics, CDC, Dartmouth Institute, U.S. Census Bureau, and U.S. Department of Agriculture. This database generates health rankings of every U.S. county and illustrates the correlations between local health outcomes, health factors, and socioeconomic factors. The county rankings are based on summary scores calculated from individual data measures. The overall Health Outcomes summary score consists of data on the county's mortality and morbidity. The overall Health Factors summary score consists of data on the county's health behaviors, clinical care, social and economic factors, and physical environment. The 2010 data is the most recent data available at the time of this report. Detailed information on the County Health Rankings can be found at http://www.countyhealthrankings.org/our-approach.

Community Health Needs Assessment
This project was developed by the Advancing the Movement organization and the Center for Applied Research and Environmental Systems (CARES) as a web-based toolkit designed to hospitals, state and local health departments, and other organizations seeking to better understand the needs and assets of their communities. County-level data retrieved from institutions such as the CDC, U.S. Census Bureau, and the Public Health Institute are formulated into customized data reports. The Full Health Indicators Report illustrates the health needs assessment profiles of U.S. counties using local demographics, socioeconomic factors, physical environment data, clinical care data, health behavior factors, and health outcomes. The 2010 data is the most recent data available at the time of this report. Detailed information on the Community Health Needs Assessment can be found at CHNA.org.

NYC Youth Risk Behavior Survey (YRBS)
This survey is conducted through an ongoing collaboration between the New York City Department of Health and Mental Hygiene (DOHMH), the Department of Education (DOE), and the National Centers for Disease Control and Prevention (CDC). The New York City's YRBS is

part of the CDC's National Youth Risk Behavior Surveillance System (YRBSS). Based on the protocol developed by CDC, the survey has been conducted in odd-numbered years since 1997 to monitor priority health risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems among youth in New York City. Students complete a self-administered, anonymous questionnaire that measures a variety of behaviors, including tobacco, alcohol and drug use, unintentional injury and violence, sexual behaviors, dietary behaviors, and physical activity. The results are representative of public high school students in grades 9 through 12. The NYC YRBS can provide prevalence data for the city as a whole, for each of the five boroughs starting in 2003, and since 2005 for three high-risk neighborhoods - the South Bronx, North and Central Brooklyn, and East and Central Harlem in Manhattan - where the DOHMH has its District Public Health Offices (DPHOs). The 2011 data is the most recent data available at the time of this report. Detailed information on the NYCDOH's YRBS can be found at http://www.nyc.gov/html/doh/html/data/youth-risk-behavior.shtml.

CDC's Sexually Transmitted Disease Surveillance

This report documents statistics and trends for sexually transmitted diseases (STDs) in the United States through 2011. This publication is intended as a reference document for policy makers, program managers, health planners, researchers, and others who are concerned with the public health implications of these diseases. The surveillance information in the latest report is based on the following sources of data: (1) notifiable disease reporting from state and local STD programs; (2) projects that monitor STD positivity and prevalence in various settings, including regional Infertility Prevention Projects, the National Job Training Program, the STD Surveillance Network, and the Gonococcal Isolate Surveillance Project; and (3) other national surveys implemented by federal and private organizations. The STD surveillance systems operated by state and local STD control programs, which provide the case report data for chlamydia, gonorrhea, and syphilis, are the data sources of many of the figures and most of the statistical tables in this publication. Detailed information on the CDC's Sexually Transmitted Disease Surveillance can be found at http://www.cdc.gov/std/stats11/default.htm.

NYSDOH's Annual HIV/AIDS Surveillance Report

The Annual Surveillance Report presents recent data on newly diagnosed HIV cases and persons living with diagnosed HIV infection in New York State. Twenty-two sets of tables are grouped by major geographic division (New York State (NYS), New York City (NYC), NYS excluding NYC, Ryan White Regions1, NYC boroughs). Most sets feature three tables on separate pages – (A) living HIV and AIDS cases, (B) new HIV diagnoses and (C) new AIDS diagnoses. The historical table (Table 1) includes HIV and AIDS diagnoses, and deaths among persons with AIDS. This report is produced by the Bureau of HIV/AIDS Epidemiology (BHAE), AIDS Institute, New York State Department of Health (NYSDOH). Access to this publication is available through the Internet at the following address: http://www.nyhealth.gov/diseases/aids/statistics/index.htm.

American Community Survey (ACS)

Developed by the U.S. Census Bureau, the ACS is an ongoing survey that collects annual data on the major characteristics of communities throughout the U.S. The data collected is categorized into four categories: social, economic, demographic, and housing. Social characteristics include topics such as education, disability status, and health insurance status. Economic characteristics describe the income, employment status, and poverty level of U.S. communities. Demographic

characteristics include age, sex, and race/ethnicity information. Housing characteristics include topics such as occupancy and vacancy, monthly rent, and household size. Approximately 3.5 million U.S households are randomly selected to participate in the ACS each year. The 2012 data is the most recent data available at the time of this report. Questionnaires, datasets, survey results, documentation and more detailed information are available at https://www.census.gov/acs/www/.

Appendix B: Health Indicators

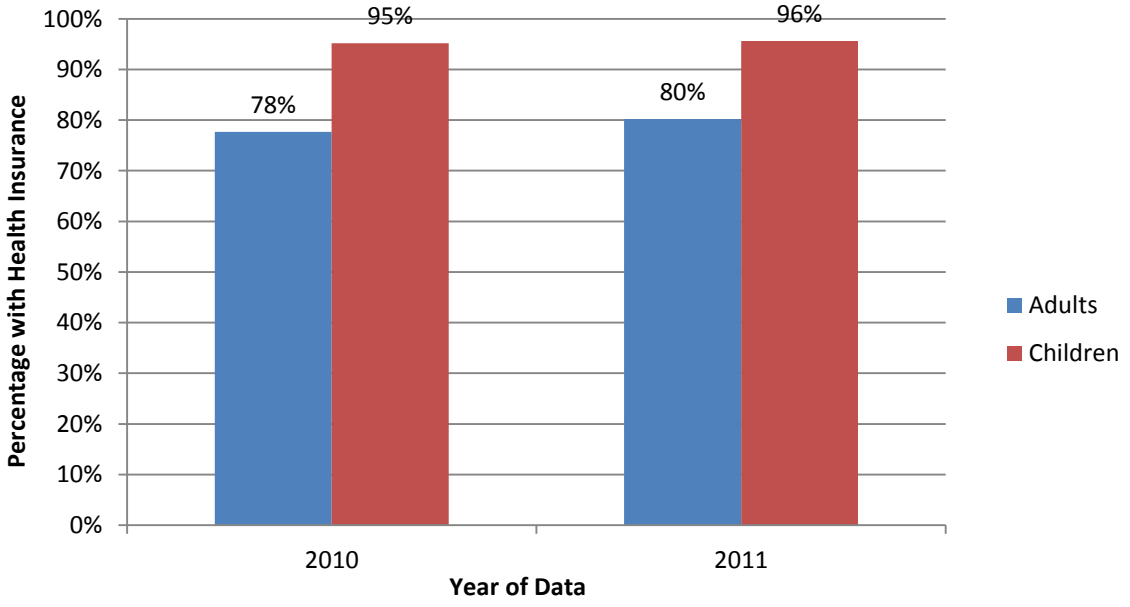
1. Access to Quality Health Services

- According to the New York State Department of Health (NYSDOH), 77.7% of adults and 95.2% of children in the Bronx had health insurance in 2010 (see Figure 1a). The percentage of Bronx adults with health insurance in 2010 was lower than the U.S. percentage of 84.5% (see Figure 1b). The percentage among Bronx children in 2010 was higher than the U.S. percentage of 92% (see Figure 1c).

- In 2011, the percentage of Bronx residents with health insurance rose to 80.21% for adults and 95.63% for children (see Figure 1a). The percentage of Bronx adults with health insurance in 2011 remained lower than the U.S. percentage of 84.9% (see Figure 1b). The percentage among Bronx children in 2011 was slightly higher than the U.S. percentage of 92.5% (see Figure 1c).

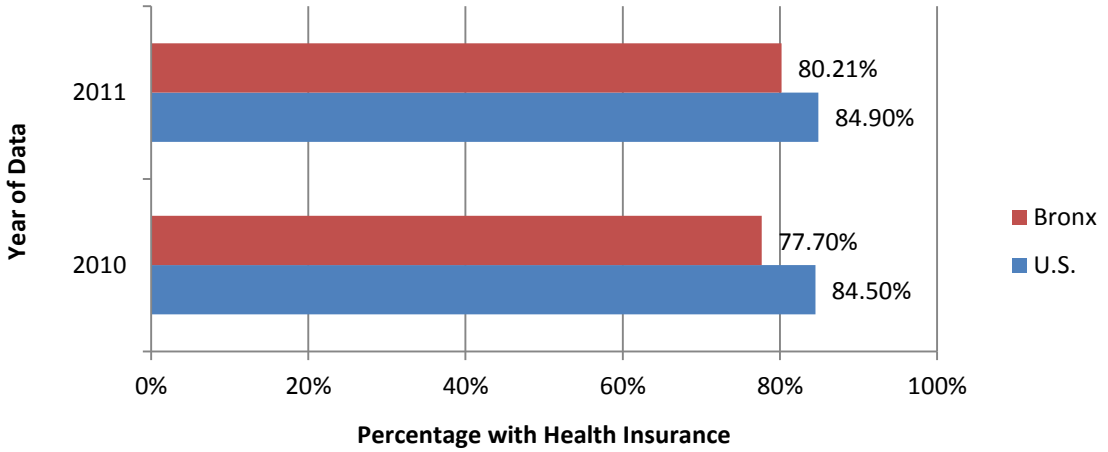
- From 2010-2011, Bronx children were more likely to have health insurance coverage than Bronx adults. The percentage of Bronx children with health insurance was higher than the overall percentage of U.S. children with health insurance. The percentage of Bronx adults with health insurance was lower than the overall percentage of U.S. adults with health insurance.

Figure 1a: Residents with Health Insurance, Bronx County 2010-2011



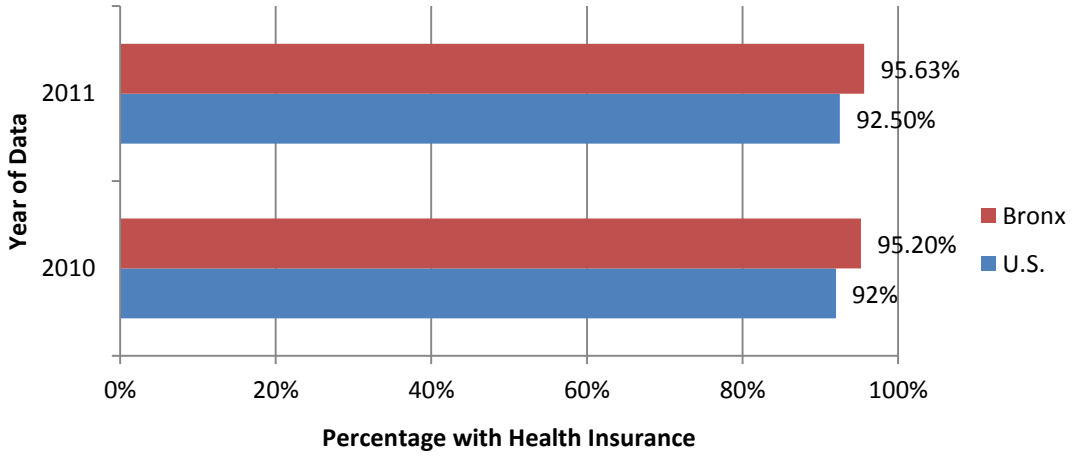
Source: NYSDOH (Bronx County Indicators for Tracking Public Health Priority Areas 2013-2017)

Figure 1b. Percentage of Adults with Health Insurance, Bronx County & U.S. 2010-2011



Source: U.S. Census Bureau (American Community Survey 2010-2011)

Figure 1c. Percentage of Children with Health Insurance, Bronx County & U.S. 2010-2011



Source: U.S. Census Bureau (American Community Survey 2010-2011)

Preventable Hospital Stays: Top 25 Inpatient Diagnoses

Figure 1b illustrates 25 ailments with the highest total number of patient diagnoses throughout the Bronx from 2010-2012. The total number of patients diagnosed with each of the top 25 ailments represents hospital discharges among all Bronx residents. These ailments were categorized using the ICD-9 coding system.

- From 2010-2012, Single LB-Hosp W/O CD (Single Live Births in Hospital without Cesarean Section) had the highest total number of inpatient diagnoses in the Bronx.

- Among the top 25 inpatient diagnoses, Opioid Dependence-Cont (Opioid type dependence, continuous) had the lowest total number of inpatient diagnoses in the Bronx in 2010. From 2011- 2012, Abn Fhr/Rhythm-Del (Abnormality in fetal heart rate or rhythm, delivered, with or without mention of antepartum condition) had the lowest number of diagnoses.

- The following diagnoses have decreased over the 2010-2012 period:
  - Single LB-Hosp W/O CD
  - Chest Pain NEC (Other Chest Pain)
  - Asthma NOS W Exacer (Asthma, unspecified type, with acute exacerbation)
  - Alcohol Withdrawal
  - Cor AS-Native Vessel (Coronary atherosclerosis of native coronary artery)
  - Syncope & Collapse
  - Chr Obstr Asth W Exacer (Chronic obstructive asthma with acute exacerbation)
  - Urinary Tract INF NOS (Urinary tract infection, site not specified)
  - Rehabilitation Px NEC (Care involving other specified rehabilitation procedure)
  - Leg Cellulitis (Cellulitis and abscess of leg, except foot)
  - OCB W Exacerbation (Obstructive chronic bronchitis with acute exacerbation)
  - HIV Disease

- The following diagnoses have increased over the 2010-2012 period:
  - Septicemia NOS (Unspecified septicemia)
  - ALC Dep NEC & NOS-Cont (Other and unspecified alcohol dependence, continuous)
  - Post Term Preg-Del (Post term pregnancy, delivered, with or without mention of antepartum condition)
  - Acute Kidney Failure NOS (Acute kidney failure, unspecified)
  - Opioid Dependence-Cont (Opioid type dependence, continuous)

- The following inpatient diagnoses increased in 2011 and decreased in 2012:
  - Pneumonia Organism NOS (Pneumonia, organism unspecified)
  - Previous Cd NOS-Del (Previous cesarean delivery, delivered, with or without mention of antepartum condition)
  - Drug Withdrawal
  - Hb-Ss Disease W Crisis (Sickle Cell Anemia disease with crisis)
  - Subend Infarct-Initial (Subendocardial infarction, initial episode of care)

- Single LB-Hospital By CD (Single Live Births in Hospital by Cesarean Section); Ac & Chr Systolic HF (Acute on chronic systolic heart failure); and Abn Fhr/Rhythm-Del were the three inpatient diagnoses to decrease in 2011 and increase in 2012.

- The major health indicator themes that are described among the top 25 inpatient diagnoses in the Bronx are:
  - Heart Disease & Stroke
  - Respiratory Diseases
  - Communicable Diseases
  - Maternal, Fetal, and Infant Health
  - Substance Abuse

Figure 1b. Inpatient top 25 diagnoses, all Bronx and ZIPs

Source: SPARCS 2010-2012

Bronx

ICD-9 diagnosis code	ICD-9 diagnosis description	2010	2011	2012
V3000	Single LB-Hosp W/O CD	14,216	13,852	13,391
V3001	Single LB-Hospital By CD	7,014	6,633	6,656
78659	Chest Pain NEC	6,678	6,256	5,354
486	Pneumonia Organism NOS	4,178	4,531	3,974
0389	Septicemia NOS	3,486	3,932	4,249
49392	Asthma NOS W Exacer	3,846	3,601	3,272
30391	ALC Dep NEC & NOS-Cont	2,769	3,167	3,364
29181	Alcohol Withdrawal	2,867	2,765	2,690
41401	Cor AS-Native Vessel	3,113	2,746	2,382
7802	Syncope & Collapse	2,636	2,610	2,335
64511	Post Term Preg-Del	2,410	2,561	2,569
65421	Previous Cd NOS-Del	2,346	2,404	2,362
49322	Chr Obstr Asth W Exacer	2,415	2,319	2,116
5990	Urinary Tract INF NOS	2,278	2,144	2,010
5849	Acute Kidney Failure NOS	2,022	2,106	2,201
V5789	Rehabilitation Px NEC	2,045	1,984	1,978
42823	Ac & Chr Systolic HF	2,093	1,910	1,965
6826	Leg Cellulitis	1,999	1,966	1,830
2920	Drug Withdrawal	1,987	2,008	1,766
49121	OCB W Exacerbation	1,876	1,787	1,779
042	HIV Disease	1,942	1,856	1,531
28262	Hb-Ss Disease w Crisis	1,641	1,719	1,665
30401	Opioid Dependence-Cont	1,377	1,651	1,728
41071	Subend Infarct-Initial	1,572	1,616	1,490
65971	Abn Fhr/Rhythm-Del	1,747	1,374	1,394

Preventable Hospital Stays: Top 20 Inpatient Ambulatory Sensitive Discharges

Figure 1c illustrates 20 ailments with the highest total number of inpatient ambulatory sensitive discharges throughout the Bronx from 2010-2012. The total number of patients diagnosed with each of the top 20 ailments represents sensitive ambulatory discharges among all Bronx residents. The top 20 ailments were categorized using the DRG coding system.

- From 2010-2011, Chest Pain had the highest total number of inpatient ambulatory sensitive discharges in the Bronx. In 2012, Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc (Esophagitis, Gastroenteritis, & miscellaneous digestive disorders without major complications & comorbid conditions) had the highest number of ambulatory sensitive discharges.
- Among the top 20 ambulatory sensitive discharges, Medical Back Problems W/O Mcc had the lowest total number of ambulatory sensitive discharges in the Bronx from 2010-2012.

- The following ambulatory sensitive discharges have decreased over the 2010-2012 period:
  - Chest Pain
  - Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc
  - Bronchitis & Asthma W Cc/Mcc (complications & comorbid conditions and major complications & comorbid conditions)
  - Heart Failure & Shock W Mcc (with major complications & comorbid conditions)
  - Cardiac Arrhythmia & Conduction Disorders W/O Cc/Mcc (without complications & comorbid conditions and major complications & comorbid conditions)
  - Diabetes W/O Cc/Mcc
  - Chronic Obstructive Pulmonary Disease W/O Cc/Mcc
  - Chronic Obstructive Pulmonary Disease W Mcc
  - Medical Back Problems W/O Mcc

- The following ambulatory sensitive discharges increased in 2011 and decreased in 2012:
  - Cellulitis W/O Mcc
  - Syncope & Collapse
  - Kidney & Urinary Tract Infections W/O Mcc
  - Simple Pneumonia & Pleurisy W Cc (with complications & comorbid conditions)
  - Heart Failure & Shock W Cc
  - Chronic Obstructive Pulmonary Disease W Cc
  - Diabetes W Cc
  - Simple Pneumonia & Pleurisy W/O Cc/Mcc

- Bronchitis & Asthma W/O Cc/Mcc; Seizures W/O Mcc; and Misc Disorders of Nutrition, Metabolism, Fluids/Electrolytes W/O Mcc were the three ambulatory sensitive discharges to decrease in 2011 and increase in 2012.

- The major health indicator themes that are described among the top 20 inpatient ambulatory sensitive discharges in the Bronx are:
  - Diabetes

- Heart Disease & Stroke
- Respiratory Diseases
- Nutrition Disorders
- Digestive Disorders

Figure 1c. Inpatient top 20 ambulatory sensitive discharges, all Bronx and ZIPs

Source: SPARCS 2010-2012

Bronx

DRG code	DRG description	2010	2011	2012
MSDRG-313	Chest Pain	7,559	7,024	6,189
MSDRG-392	Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc	6,901	6,640	6,562
MSDRG-203	Bronchitis & Asthma W/O Cc/Mcc	5,605	5,599	5,765
MSDRG-603	Cellulitis W/O Mcc	3,810	3,823	3,633
MSDRG-312	Syncope & Collapse	3,037	3,045	2,796
MSDRG-202	Bronchitis & Asthma W Cc/Mcc	2,677	2,655	2,576
MSDRG-690	Kidney & Urinary Tract Infections W/O Mcc	2,584	2,642	2,488
MSDRG-101	Seizures W/O Mcc	2,411	2,392	2,505
MSDRG-641	Misc Disorders Of Nutrition,Metabolism,Fluids/Electrolytes W/O Mcc	2,228	2,212	2,444
MSDRG-194	Simple Pneumonia & Pleurisy W Cc	1,997	2,387	2,137
MSDRG-292	Heart Failure & Shock W Cc	1,723	2,193	2,122
MSDRG-291	Heart Failure & Shock W Mcc	2,028	1,567	1,558
MSDRG-191	Chronic Obstructive Pulmonary Disease W Cc	1,539	1,735	1,725
MSDRG-638	Diabetes W Cc	1,504	1,737	1,622
MSDRG-310	Cardiac Arrhythmia & Conduction Disorders W/O Cc/Mcc	1,614	1,524	1,412
MSDRG-639	Diabetes W/O Cc/Mcc	1,713	1,406	1,293
MSDRG-192	Chronic Obstructive Pulmonary Disease W/O Cc/Mcc	1,598	1,415	1,275
MSDRG-190	Chronic Obstructive Pulmonary Disease W Mcc	1,510	1,391	1,315
MSDRG-195	Simple Pneumonia & Pleurisy W/O Cc/Mcc	1,371	1,511	1,256
MSDRG-552	Medical Back Problems W/O Mcc	1,231	1,203	1,202

Preventable Hospital Stays: Top 25 ED Diagnoses

Figure 1d illustrate 25 ailments with the highest total number of patient diagnoses in the emergency departments of Bronx hospitals from 2010-2012. The total number of patients diagnosed with each of the top 25 ailments represents ED diagnoses among all Bronx residents. These ailments were categorized using the ICD-9 coding system.

- From 2010-2011, Asthma NOS W Exacer (Asthma, unspecified type, with acute exacerbation) had the highest total number of ED diagnoses in the Bronx. In 2012, Viral

Infection NOS (unspecified viral infection) had the highest total number of ED diagnoses.

- Among the top 25 ED diagnoses, Epigastric ABD Pain (Abdominal pain, epigastric) had the lowest total number of ED diagnoses in the Bronx in 2010 and 2012. In 2011, Asthma NOS (Asthma, unspecified type, unspecified) had the lowest ED diagnoses.

- The following ED diagnoses have decreased over the 2010-2012 period:
  - Fever NOS (Fever, unspecified)
  - Acute URI NOS (Acute upper respiratory infections of unspecified site)
  - Acute Pharyngitis
  - NonINF Gastroent NEC & NOS (Other and unspecified noninfectious gastroenteritis and colitis)
  - Oth CCE Comp Preg-AP (Other current conditions classifiable elsewhere of mother, antepartum condition or complication)
  - Head Injury NOS (Head injury, unspecified)

- The ED diagnoses of Dizziness have increased over the 2010-2012 period.

- The following ED diagnoses increased in 2011 and decreased in 2012:
  - Viral Infection NOS
  - Headache
  - Cough
  - Pain in Limb
  - Abdominal Pain-Site NEC (Abnormal pain, other specified site)
  - Chest Pain NOS (Chest pain, unspecified)
  - Otitis Media NOS (Unspecified otitis media)
  - Lumbago
  - Nonsp Skin Eruption NEC (Rash and other nonspecific skin eruption)
  - Abdominal Pain Site-NOS (Abdominal pain, unspecified site)
  - Backache NOS (Backache, unspecified)
  - Urinary Tract INF NOS (Urinary tract infection, site not specified)
  - Chest Pain NEC (Other chest pain)

- Acute URI Mult Sites NEC (Acute upper respiratory infections of other multiple sites)
- Joint Pain-Lower Leg
- Asthma NOS
- Epigastric ABD Pain

- The ED diagnoses of Asthma NOS W Exacer have decreased in 2011 and increased in 2012.

Figure 1d. Emergency Department top 25 diagnoses, all Bronx and ZIPs

source: SPARCS 2010-2012

Bronx

ICD-9 diagnosis code	ICD-9 diagnosis description	2010	2011	2012*
49392	Asthma NOS W Exacer	17,459	17,110	12,901
07999	Viral Infection NOS	15,439	16,730	13,561
7840	Headache	15,688	16,459	11,322
78060	Fever NOS	17,087	16,882	9,497
7862	Cough	16,425	17,736	9,139
7295	Pain in Limb	13,254	15,035	9,062
78909	Abdominal Pain-Site NEC	13,660	13,995	9,372
4659	Acute URI NOS	13,972	13,691	9,261
78650	Chest Pain NOS	11,729	13,053	10,308
462	Acute Pharyngitis	13,814	12,088	9,014
3829	Otitis Media NOS	10,954	11,490	8,444
7242	Lumbago	10,855	11,376	8,068
7821	Nonsp Skin Eruption NEC	10,278	10,577	6,358
78900	Abdominal Pain-Site NOS	9,760	10,122	6,988
5589	NonINF Gastroent NEC&NOS	9,905	7,631	7,536
7245	Backache NOS	8,584	9,385	7,097
7804	Dizziness & Giddiness	8,455	8,597	6,542
5990	Urinary Tract INF NOS	6,646	6,832	6,268
78659	Chest Pain NEC	6,879	7,103	5,630
4658	Acute URI Mult Sites NEC	7,483	7,694	4,429
64893	Oth CCE Comp Preg-AP	6,898	6,604	5,211
95901	Head Injury NOS	6,949	6,801	4,948
71946	Joint Pain-Lower Leg	6,286	6,848	5,488
49390	Asthma NOS	6,313	6,366	5,039
78906	Epigastric ABD Pain	6,098	6,546	4,656

*number of diagnoses within 9 months of 2012

2. Chronic Diseases

Chronic Diseases: Cancer

Breast Cancer:

- According to the NYSDOH, the female breast cancer incidence rate in the Bronx was 109.4 per 100,000 females in 2009 and decreased to 105.6 in 2010 (see Figure 2a).

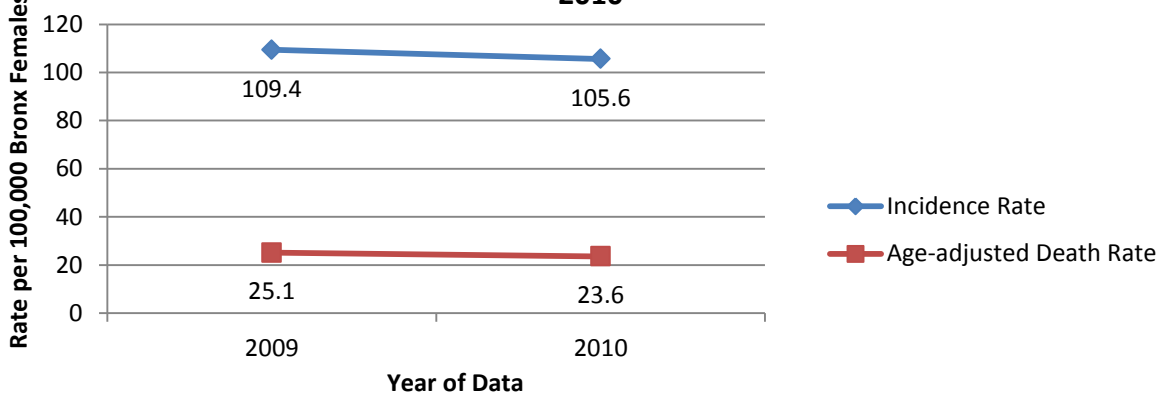
- In 2010, the Bronx's female breast cancer incidence rate remained lower than the New York City rate of 115.3 and statewide rate of 123.6 (see Figure 2b).

- The age-adjusted death rate due to breast cancer in the Bronx was 25.1 per 100,000 females in 2009. The death rate decreased to 23.6 per 100,000 females in 2010 (see Figure 2a).

- Despite the decrease in breast cancer death rate, the Bronx's death rate remained higher than the New York City rate of 20.6 and statewide rate of 21.3 in 2010 (see Figure 2b).

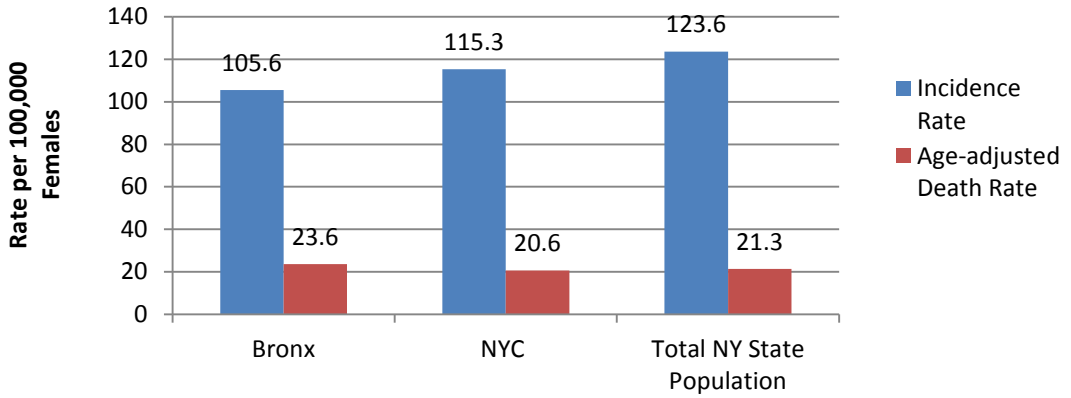
- Overall, the Bronx female breast cancer incidence and death rates have slightly decreased in the last few years. The breast cancer incidence rate in the Bronx is lower than citywide and statewide rates; however, the breast cancer death rate among Bronx females remained higher than the female breast cancer death rates in New York City and throughout New York State.

Figure 2a: Bronx Female Breast Cancer Incidence & Death Rates 2009-2010



Source: NYSDOH (Female Breast Cancer Incidence and Mortality by Year, Bronx County, 1976-2010)

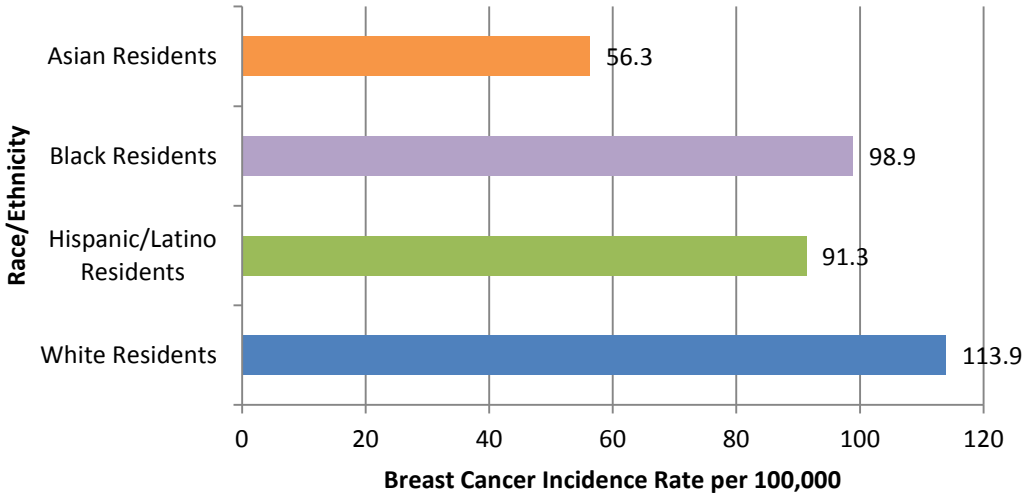
Figure 2b: Female Breast Cancer Incidence & Death Rates, New York 2010



Source: NYSDOH (Female Breast Cancer Incidence and Mortality by Year, Bronx County, 1976-2010)

- The average Bronx female breast cancer incidence rate from 2006-2010 was 113.90 for whites; 98.90 for blacks; 56.30 for Asians; and 91.30 for Hispanics/Latinos (see Figure 2c).

Figure 2c. Average Female Breast Cancer Incidence Rate per 100,000 in the Bronx from 2006-2010, by Race/Ethnicity



Source: Community Health Needs Assessment (Health Outcomes)

- According to the County Health Rankings data, 61% of Bronx female Medicare enrollees ages 67-69 reported in 2010 that they received at least one mammography screening over a two-year period. The Bronx's self-reported mammography screening percentage was lower than the statewide report of 66% in 2010.

Colorectal Cancer:

- According to the NYSDOH, the colorectal cancer incidence rate among Bronx residents in 2009 was 44.4 per 100,000 persons; higher than the citywide rate of 43.8 within the same year.

- The incidence rate among Bronx males was 52.5 per 100,000 males in 2009 and increased to 53.3 in 2010 (see Figure 2d). The incidence rate among Bronx females was 42.0 per 100,000 females in 2009 and decreased to 40.2 in 2010 (see Figure 2d).

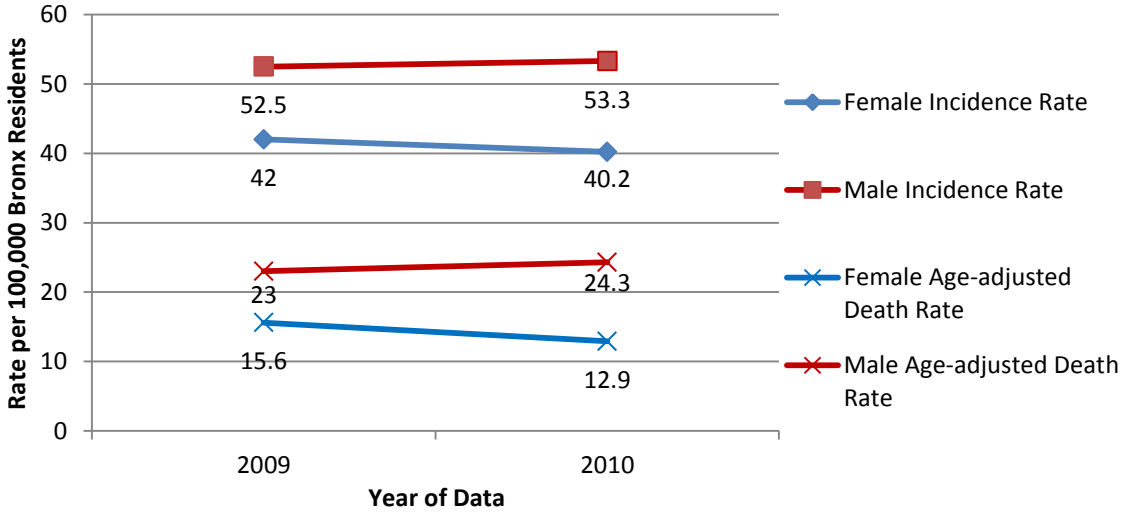
- The age-adjusted death rate due to colorectal cancer was 17.9 per 100,000 Bronx residents in 2009 (see Figure 2d); higher than the citywide rate of 15.4 within the same year.

- The age-adjusted death rate for Bronx males was 23.0 per 100,000 males in 2009. The male death rate increased to 24.3 in 2010 (see Figure 2d).

- The age-adjusted death rate of Bronx females due to colorectal cancer was 15.6 deaths per 100,000 females in 2009. The death rate for females decreased to 12.9 in 2010 (see Figure 2d).

- Overall, the incidence rate among Bronx males increased over the years as the Bronx female rate decreased. The male incidence rate was higher than the female rate in 2009 and 2010. The death rate due to colorectal cancer in the last few years was higher among Bronx males than Bronx females. The Bronx male death rate has increased over the years as the Bronx female rate decreased. Based on data reported in 2009, the colorectal cancer incidence and death rates among Bronx residents were higher than the New York City and rates.

Figure 2d: Bronx Colorectal Cancer Incidence & Death Rates 2009-2010, by Gender



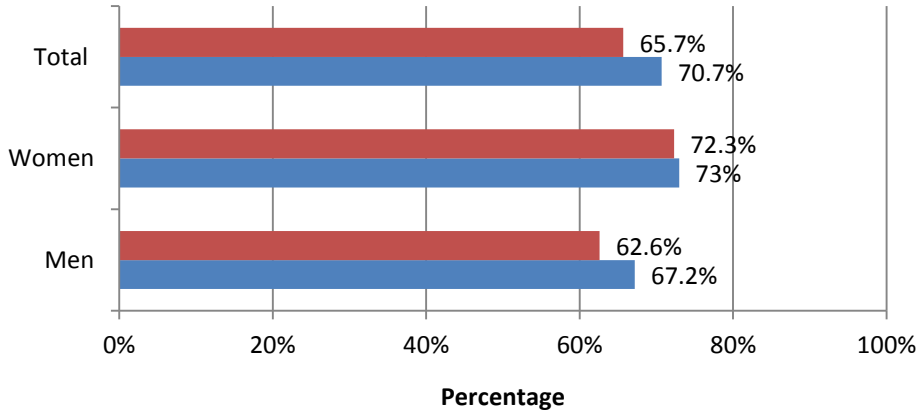
Source: NYSDOH (Colorectal Cancer Incidence and Moratlity by Year, Bronx County, 1976-2010)

- In 2011, 65.7% of Bronx residents ages 50 and older had a colonoscopy in the past 10 years. 62.6% of Bronx men and 72.3% of Bronx women had a colonoscopy in the past 10 years (see Figure 2e). The self-reported colonoscopy percentage among Bronx residents in 2011 was lower than the New York City percentage of 68.6% (see Figure 2f).

- In 2012, 70.7% of Bronx residents ages 50 and older had a colonoscopy in the past 10 years. 67.2% of Bronx men and 73.0% of Bronx women had a colonoscopy in the past 10 years (see Figure 2e). The self-reported colonoscopy percentage among Bronx residents in 2012 was higher than the New York City percentage of 68.5% (see Figure 2f).

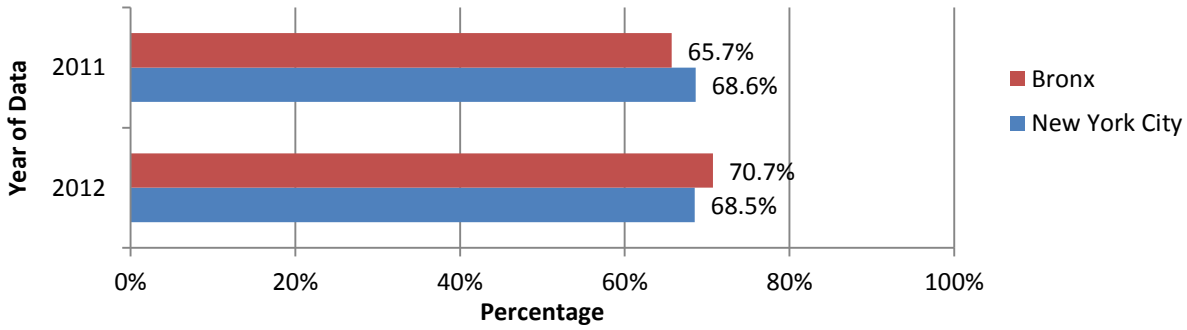
- Overall, the self-reported percentage of Bronx residents that had a colonoscopy in the past 10 years increased in the last few years. By 2012, the colonoscopy percentage among Bronx residents surpassed the New York City percentage. Within the same year, the colonoscopy percentages increased among Bronx women and Bronx men.

Figure 2e. Percentage of Bronx Residents who had a Colonoscopy in the Past 10 Years, 2011-2012



Source: NYCDOH (Community Health Survey 2011-2012)

Figure 2f. Percentage of Residents who had a Colonoscopy in the Past 10 Years, 2011-2012



Source: NYCDOH Community Health Survey 2011 and 2012

Lung cancer:

- According to the NYSDOH, the lung cancer incidence rate among Bronx residents was 51.8 per 100,000 persons in 2009; higher than the citywide rate of 50.0.

- The incidence rate among Bronx males was 68.2 per 100,000 males in 2009; higher than the New York City rate of 66.3 and lower than the statewide rate of 77.1. The Bronx rate decreased to 66.5 in 2010 (see Figure 2g); remaining higher than the NYC rate of 62.4 and lower than the statewide rate of 71.6 (see Figure 2h).

- The incidence rate among Bronx females was 44.3 per 100,000 females in 2009; higher than the New York City rate of 43 and lower than the statewide rate of 54.9. The Bronx rate decreased to 37.8 in 2010 (see Figure 2g); lower than the New York City rate of 41.1 and statewide rate of 54.6 (see Figure 2i).

- Although the incidence rates among Bronx men and women have decreased in the last few years, the incidence rate of lung cancer is significantly higher among Bronx men than Bronx women. From 2009-2010, the lung cancer incidence rates among Bronx residents remained higher than the citywide rates. In comparison to New York State data, the lung cancer incidence rates remained lower than the statewide rates.

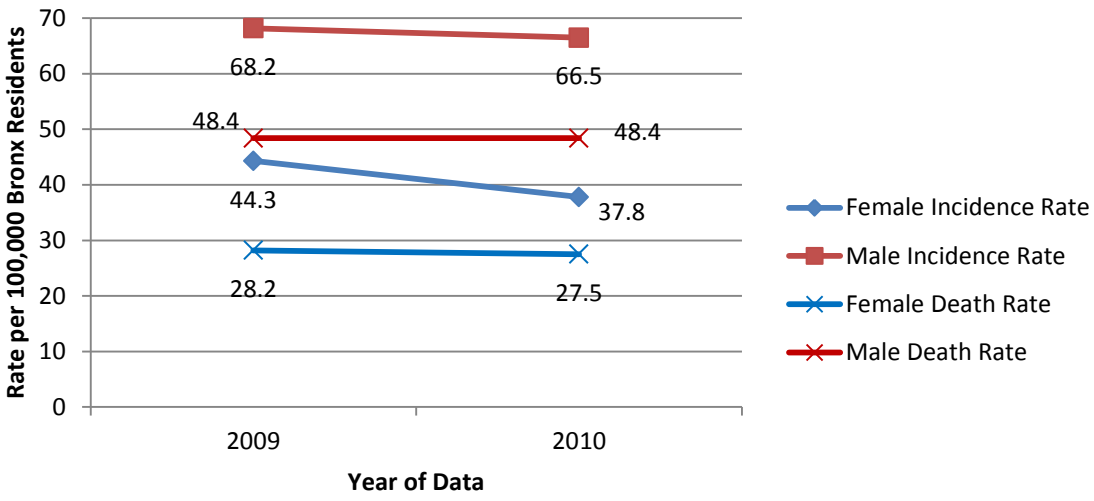
- The age-adjusted death rate due to lung cancer was 35.2 per 100,000 Bronx residents in 2009; higher than the citywide rate of 31.7.

- The age-adjusted death rate for Bronx males was 48.4 per 100,000 males in 2009 (see Figure 2g); higher than the New York City rate of 43.1 and lower than the statewide rate of 52.2. There was no significant change in lung cancer death rate among Bronx males in 2010; remaining higher than the NYC rate of 43.9 and lower than the statewide rate of 51 (see Figure 2j).

- The age-adjusted death rate for Bronx females was 28.2 per 100,000 females in 2009 (see Figure 2g); higher than the New York City rate of 26 and lower than the statewide rate of 34.5. In 2010, the death rate among Bronx females decreased to 27.5; similar to the NYC rate of 27.2 and remaining lower than the statewide rate of 35.4 (see Figure 2k).

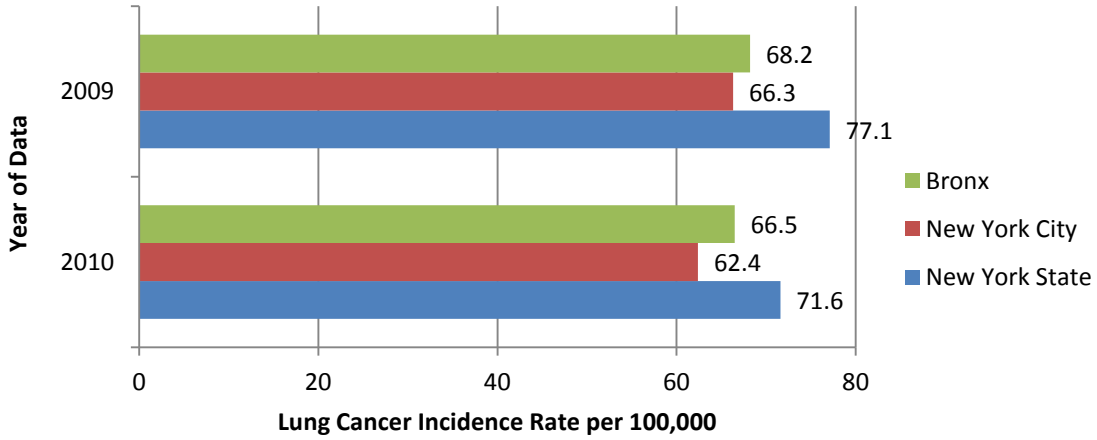
- Overall, the death rate due to lung cancer was significantly higher among Bronx males than Bronx females in 2009 and 2010. The Bronx female death rate has decreased over the years as the Bronx male rate showed no significant change. From 2009-2010, the lung cancer death rates among Bronx residents remained higher than the citywide rates. In comparison to New York State data, the lung cancer death rates remained lower than the statewide rates.

Figure 2g: Lung Cancer Incidence & Death Rates 2009-2010, Bronx Data by Gender



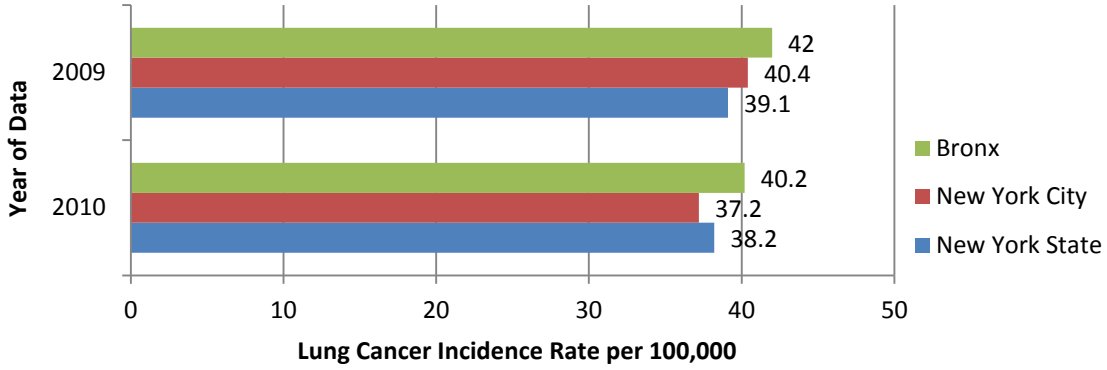
Source: NYSDOH (Lung Cancer Incidence and Mortality by Year, Bronx County, 1976-2010)

Figure 2h. Lung Cancer Incidence Rates among Males, 2009-2010



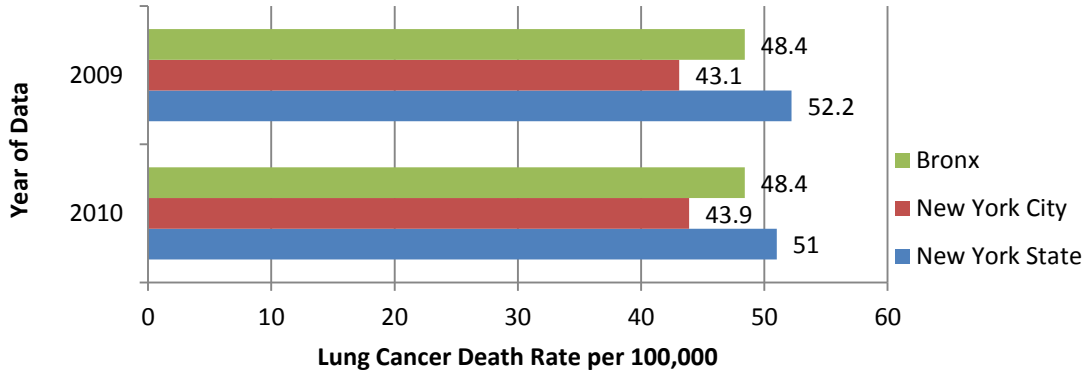
Source: NYSDOH (Cancer Registry)

Figure 2i. Lung Cancer Incidence Rates among Females, 2009-2010



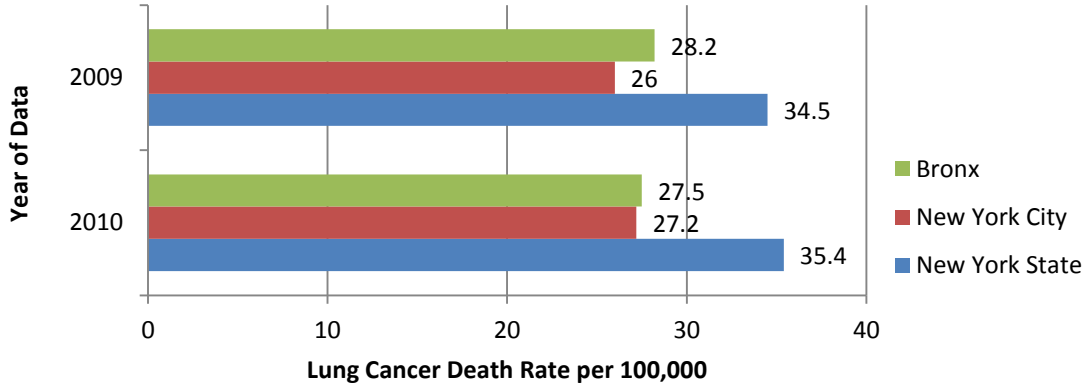
Source: NYSDOH (Cancer Registry)

Figure 2j. Lung Cancer Death Rates among Males in New York, 2009-2010



Source: NYSDOH (Cancer Registry)

Figure 2k. Lung Cancer Death Rates among Females in New York, 2009-2010



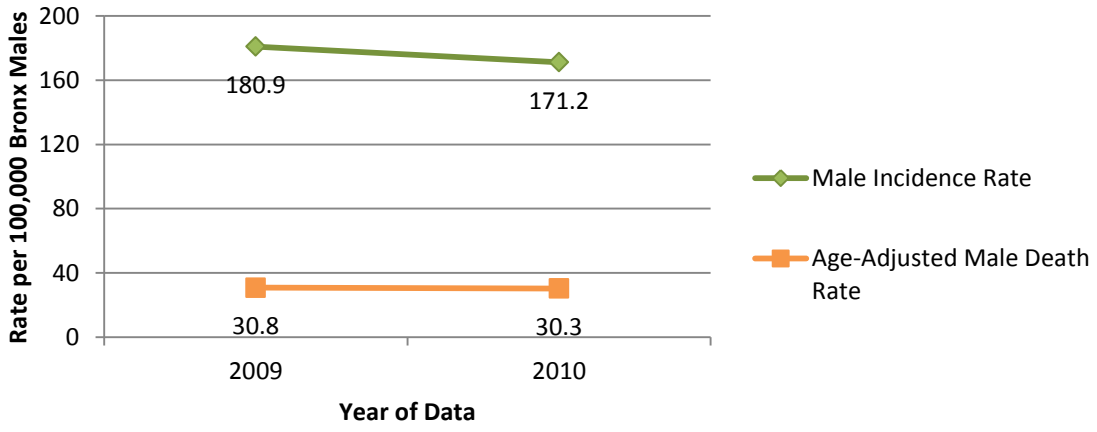
Source: NYSDOH (Cancer Registry)

Prostate cancer:

- According to the NYSDOH, the prostate cancer incidence rate among Bronx males was 180.9 per 100,000 males in 2009; higher than the New York City rate of 160.3 and statewide rate of 161.9. The incidence rate among Bronx males decreased to 171.2 in 2010 (see Figure 2l); remaining higher than the NYC rate of 144.3 and statewide rate of 147.6.

- The age-adjusted death rate due to prostate cancer in the Bronx was 30.8 per 100,000 males in 2009; higher than the New York City rate of 24.1 and statewide rate of 20.7. The Bronx death rate was 30.3 per 100,000 males in 2010; remaining higher than the NYC rate of 24.1 and statewide rate of 21.3. There was no significant change in prostate cancer death rates among Bronx males from 2009-2010 (see Figure 2l).

Figure 2l: Bronx Prostate Cancer Incidence & Death Rates 2009-2010



Source: NYSDOH Prostate Cancer Incidence and Moratlity by Year, Bronx County, 1976-2010

Cervical cancer:

- According to the NYSDOH, the cervical cancer incidence rate among Bronx females was 9.3 per 100,000 females in 2009; similar to the New York City rate of 9.5 and higher than the statewide rate of 8.3. In 2010, the incidence rate among Bronx females was 9.2; the same rate as NYC and higher than the statewide rate of 8.0. There was no significant difference in incidence rates between Bronx females and NYC females. The Bronx incidence rates remained higher than the New York State rates from 2009-2010.

- According to the Centers for Disease Control and Prevention (CDC), 82.9% of women ages 18 and older reported in 2010 that they had a pap test within the past three years.

Oral cavity and pharynx cancer:

- The oral cavity and pharynx cancer incidence rate among Bronx residents was 11.6 per 100,000 persons in 2009; higher than the NYC rate of 9.6.

- The incidence rate among Bronx males was 20.2 per 100,000 males in 2009; higher than the New York City and statewide rates of 16. In 2010, the incidence rate among Bronx males decreased to 14.5; lower than the NYC rate of 13.6 and higher than the statewide rate of 15.3.

- The incidence rate among Bronx females was 6.5 per 100,000 females in 2009; higher than the New York City rate of 5.3 and statewide rate of 6.1. In 2010, the rate among Bronx females decreased to 3.9; lower than the citywide rate of 6.1 and statewide rate of 6.5.

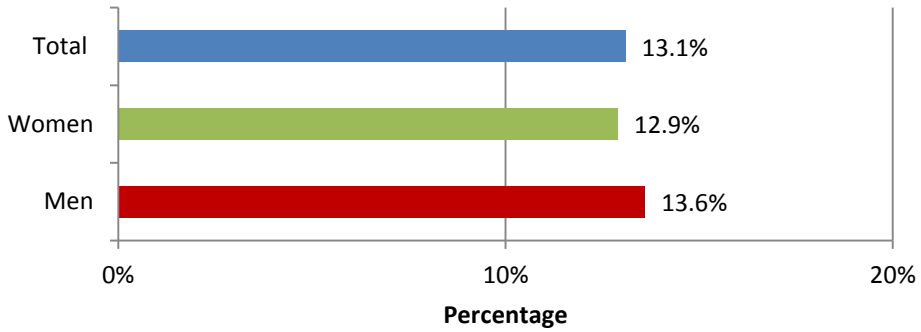
- Overall, the incidence rate of oral cavity and pharynx cancer decreased in the past few years. From 2009-2010, the Bronx male incidence rate was significantly higher than the Bronx female rate. In 2010, the incidence rates among Bronx males and Bronx females were lower than the citywide and statewide rates.

Chronic Diseases: Diabetes

- According to the NYCDOH, 13.1% of adults in the Bronx reported that they were diagnosed with diabetes in 2011. 13.6% of Bronx men and 12.9% of Bronx women reported ever being diagnosed with diabetes (see Figure 2m).

- In 2012, 15.2% of Bronx adults reported that they were diagnosed with diabetes. 13.2% of Bronx men and 16.9% of Bronx women reported ever being diagnosed with diabetes (see Figure 2m).

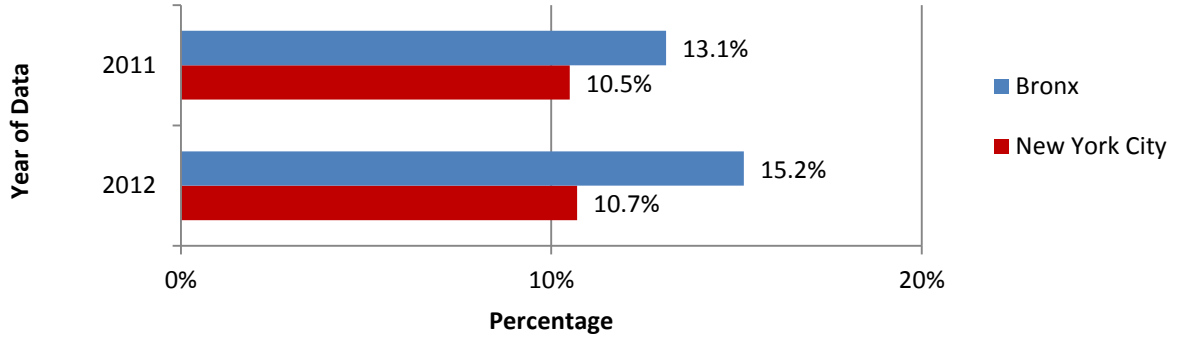
Figure 2m. Percentage of Bronx Residents Diagnosed with Diabetes



Source: NYCDOH (Community Health Survey 2011-2012)

- From 2011-2012, the diabetes percentage among Bronx residents remained higher than the citywide diabetes rate of 10% (see Figure 2n).

Figure 2n. Percentage of Residents Diagnosed with Diabetes, 2011-2012



Source: NYCDOH (Community Health Survey 2011-2012)

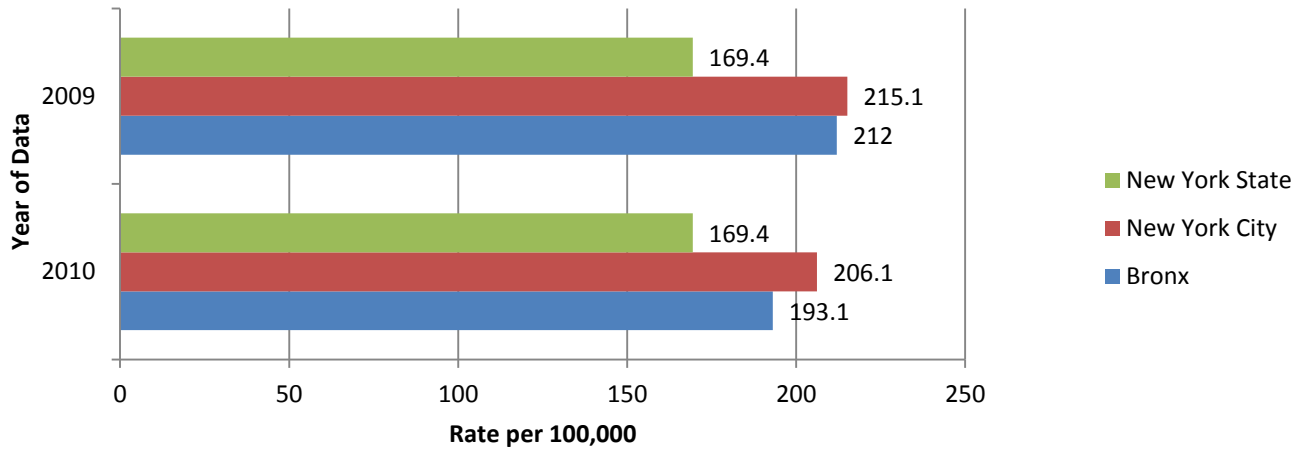
- According to the County Health Rankings data, 77% of diabetic Medicare enrollees ages 65 and older in the Bronx reported in 2009 that their blood sugar levels were screened in the past year using the HbA1c test method. 78% of enrollees reported in 2010 that they received HbA1c screening in the past year.
- The age-adjusted death rate due to diabetes was 28.0 per 100,000 Bronx residents in 2009; higher than the New York City rate of 19.5 and statewide rate of 16.6. In 2010, the death rate among Bronx residents decreased to 26.8; higher than the NYC rate of 20.2 and statewide rate of 16.6. The death rate due to diabetes among Bronx residents was higher than the citywide and statewide death rates from 2009-2010.

Chronic Diseases: Heart Disease and Stroke

Heart Disease

- According to the Community Needs Assessment and NYSDOH data, the age-adjusted death rate due to coronary heart disease among Bronx residents was 215.1 per 100,000 in 2009; higher than the New York City rate of 212 and statewide rate of 169.4. In 2010, the Bronx death rate decreased to 206.1 in 2010; remaining higher than the NYC rate of 193.1 and statewide rate of 169.4 (see Figure 2o).

Figure 2o. Age-adjusted Death Rate due to Coronary Heart Disease, 2009-2010

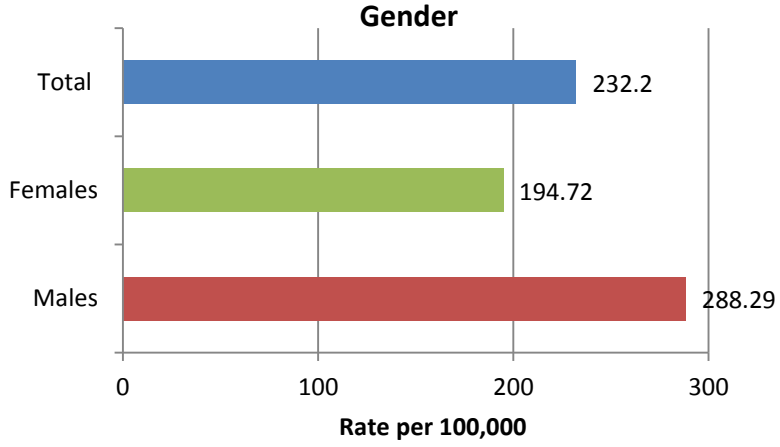


Source: Community Needs Assessment; NYSDOH

- The annual age-adjusted death rate due to coronary heart disease from 2006-2010 among Bronx residents was approximately 232.20 per 100,000 persons (see Figure 2p).

- As shown in Figure 2p, the annual age-adjusted death rate due to coronary heart disease from 2006-2010 among Bronx males was approximately 288.29 per 100,000 males. For Bronx females, the annual death rate was approximately 194.72 per 100,000 females.

Figure 2p. Annual Age-Adjusted Death Rate due to Coronary Heart Disease from 2006-2010, Bronx Data by Gender

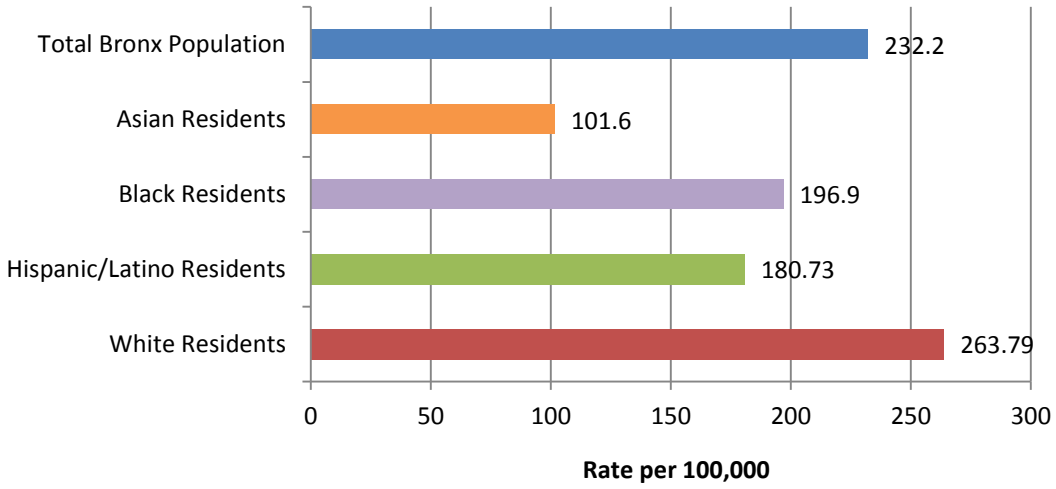


Source: Community Health Needs Assessment (Heart Disease Mortality)

- The annual age-adjusted death rate due to coronary heart disease from 2006-2010 in the Bronx was 263.79 per 100,000 for whites; 196.90 for blacks; 180.73 for Hispanics/Latinos; and 101.60 for Asians (see Figure 2q).

- The death rates due to coronary heart disease were significantly high among Bronx residents. From 2006-2010, Bronx Whites and Bronx males had the highest risk of dying from coronary heart disease (see Figure 2q).

Figure 2q. Annual Age-Adjusted Death Rate due to Coronary Heart Disease from 2006-2010, Bronx Data by Race/Ethnicity



Source: Community Needs Assessment (Heart Disease Mortality)

Stroke:

- The age-adjusted death rate due to cerebrovascular disease (stroke) was 19.4 per 100,000 Bronx residents in 2009; higher than the New York City rate of 17.6 and lower than the statewide rate of 26.7. In 2010, the death rate among Bronx residents increased to 21.6; remaining higher than the NYC rate of 19.3 and lower than the statewide rate of 26.7. From 2009-2010, the death rate among Bronx residents reminded higher than the citywide rate and lower than the statewide rate.

- The annual death rate due to stroke from 2006-2010 among Bronx males was approximately 27.83 per 100,000 males. For Bronx females, the annual death rate was approximately 21.19 per 100,000 females.

- The annual death rate due to stroke from 2006-2010 in the Bronx was 25.78 per 100,000 for whites; 22.77 for blacks; 21.61 for Hispanics/Latinos; and 17.98 for Asians.

- Overall, the death rate due to stroke among Bronx residents has increased over the years. Although the death rate among Bronx residents was higher than the citywide rate from 2009-2010, the Bronx rate remained lower than the statewide rate. Males and whites have greater stroke mortality risks than other groups in the Bronx.

High blood pressure:

- According to the NYCDOH Community Health Survey in 2011, 32.8% of Bronx adults reported that they were diagnosed with hypertension. The percentage among Bronx adults was higher than the New York City percentage of 28.9%. 30.6% of Bronx men and 34.2% of Bronx women reported that they were diagnosed with hypertension.

- In 2012, 32.9% of Bronx adults reported that they were diagnosed with hypertension. The percentage among Bronx adults was higher than the New York City percentage of 27.8%. 32.5% of Bronx men and 33% of Bronx women reported that they were diagnosed with hypertension.

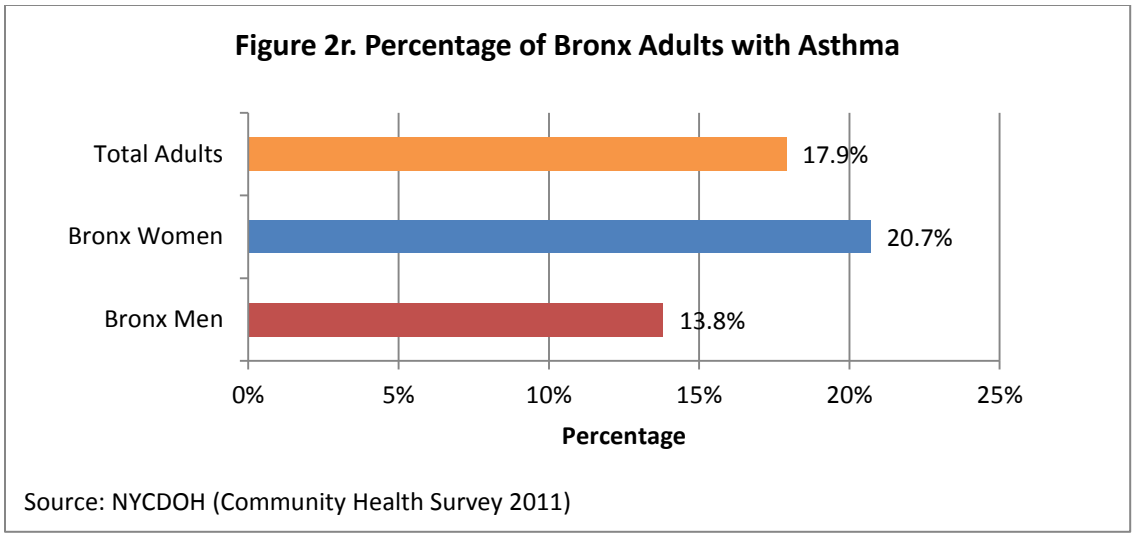
High cholesterol:

- According to the NYCDOH Community Health Survey in 2011, 31.5% of Bronx adults were told by a health professional that they had high cholesterol. The percentage among Bronx adults was higher than the New York City percentage of 30.6%. 35.1% of Bronx men and 28.1% of Bronx women were told by a health professional that they had high cholesterol.

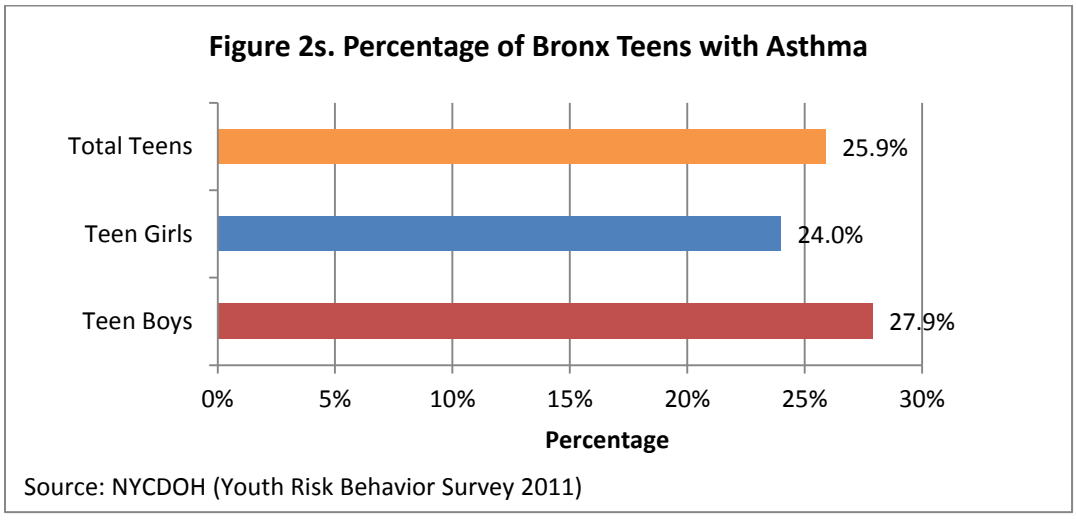
- In 2012, 32% of Bronx adults were told by a health professional that they had high cholesterol. The percentage among Bronx adults was higher than the New York City percentage of 29.1%. 34.7% of Bronx men and 29.8% of Bronx women were told by a health professional that they had high cholesterol. The Bronx rates were higher than the citywide rates.

Chronic Diseases: Respiratory Diseases

- According to the NYCDOH Community Health Survey in 2011, 17.9% of total Bronx adults, 13.8% of Bronx men, and 20.7% of Bronx women reported that they had asthma (see Figure 2r). The percentage among Bronx adults was higher than the New York City percentage of 11.9%



- 25.9% of total Bronx teens, 24.0% of Bronx teen girls, and 27.9% of Bronx teen boys have asthma (see Figure 2s).



- The age-adjusted death rate due to chronic lower respiratory diseases among Bronx residents was 25.6 in 2009; higher than the New York City rate of 18.1 and lower than the statewide rate of 31.1. In 2010, the Bronx rate increased to 29.9; remaining higher than the NYC rate of 20.9 and lower than the statewide rate in 31.1. Although the Bronx death rate was higher than the citywide rate, the death rate among Bronx residents was lower than the statewide rate from 2009-2010.

3. Communicable Diseases and Immunizations

Pneumonia and Influenza

- According to 2008-2009 NYSDOH data, 48.3% of Bronx residents ages 65+ reported that they received a pneumonia shot in the past; lower than the citywide rate of 56.2%

and statewide rate of 64.7%. 58.6% of Bronx residents ages 65+ reported that they received a flu shot within the last year; lower than the citywide rate of 73.8% and statewide rate of 75%.

- The Bronx death rate due to influenza and pneumonia was 31.3 per 100,000 persons in 2010 and decreased to 29.7 in 2011. In 2010, the death rate in the Bronx was higher than the citywide rate of 30.1. In 2011, the death rate was lower than the citywide rate of 30.2.

STDs

According to the 2010 and 2011 CDC STD Surveillance Reports:

- The incidence rate of chlamydia in the Bronx was 1,321.5 per 100,000, ranking the Bronx at 7th place among U.S. cities with the highest reported chlamydia cases in 2010. The incidence rate decreased to 1,302.2, remaining at 7th place in 2011. The 2011 incidence rate of chlamydia in the Bronx was higher than the statewide rate of 530.3 per 100,000 and the national rate of 457.6 per 100,000.

- The incidence rate of syphilis in the Bronx was 11.7 per 100,000, ranking the Bronx at 17th place among U.S. cities with the highest reported syphilis cases in 2010. The incidence rate decreased to 11.0, ranking the Bronx at 19th place in 2011. The 2011 incidence rate of syphilis in the Bronx was higher than the statewide rate of 24.7 per 100,000 and the national rate of 4.5 per 100,000.

- The incidence rate of gonorrhea in the Bronx was 236.2 per 100,000, ranking the Bronx at 11th place among U.S. cities with the highest reported gonorrhea cases in 2010. The incidence rate increased to 272.0, ranking the Bronx at 8th place in 2011. The 2011 incidence rate of gonorrhea in the Bronx was higher than the statewide rate of 106.9 per 100,000 and the national rate of 104.2 per 100,000.

- Overall, the Bronx ranks as a county with one of the highest STD incidence rates in the U.S. from 2010-2011. The gonorrhea incidence rate continued to increase over the years in the Bronx as the county's syphilis and chlamydia rates decreased. The Bronx STD rates were significantly higher than statewide and national rates in 2010-2011.

HIV/AIDS

According to the NYSDOH's Annual HIV/AIDS Surveillance Report:

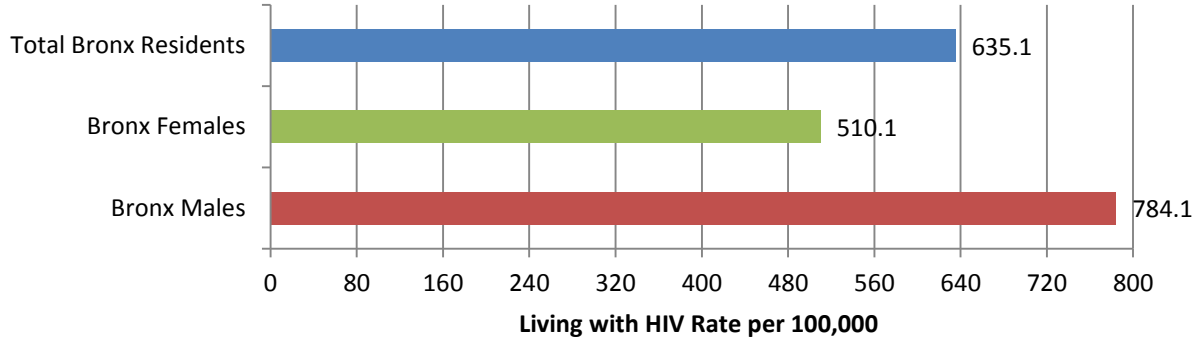
- The rate of Bronx residents living with HIV was 632.2 per 100,000 persons in 2009 and increased to 635.1 in 2010 (see Figure 3a). The rate among Bronx residents was higher than the citywide and statewide rates in 2009-2010. In 2009 the citywide rate was 449.8 per 100,000 and in 2010 the citywide rate was 471.4

per 100,000. In 2009 the statewide rate was 249.6 per 100,000 and in 2010 the statewide rate was 255.6 per 100,000 (see Figure 3b).

- The rate of Bronx males living with HIV was 766.5 per 100,000 persons in 2009 and increased to 784.1 in 2010 (see Figure 3a).

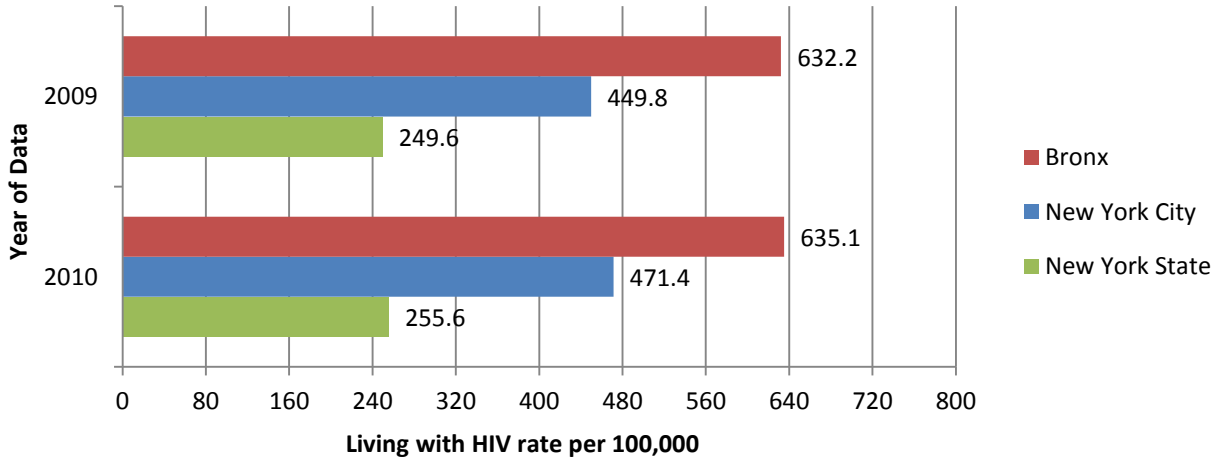
- The rate of Bronx females living with HIV was 518.7 per 100,000 persons in 2009 and decreased to 510.1 in 2010 (see Figure 3a).

Figure 3a. Rates of Bronx Residents Living with HIV from 2009-2010



Source: NYS HIV/AIDS Surveillance Annual Report; For Cases Diagnosed through Dec. 2009 and Dec. 2010

Figure 3b. Rates of New York Residents Living with HIV from 2009-2010



Source: NYS HIV/AIDS Surveillance Annual Report; For Cases Diagnosed through Dec. 2009 and Dec. 2010

- Overall, the rate of Bronx residents living with HIV increased from 2009-2010. The Bronx rate of residents living with HIV is significantly higher than the citywide and statewide rates. Among cases of Bronx residents living with HIV,

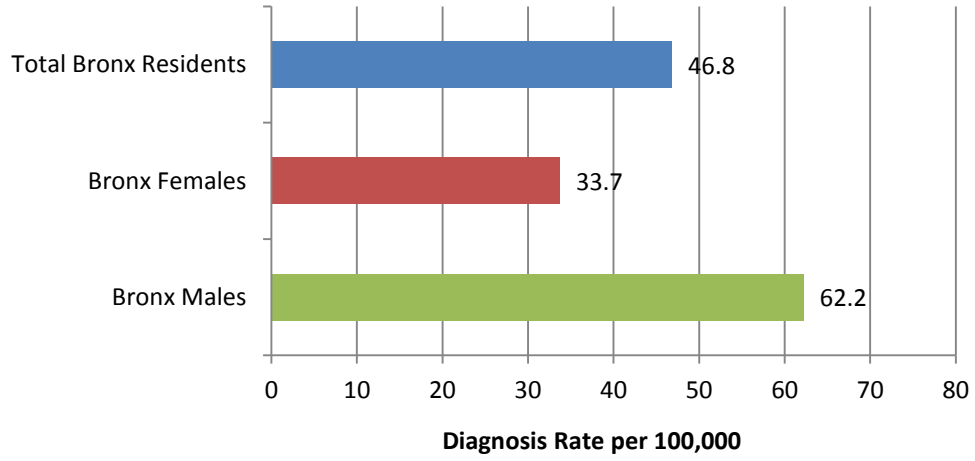
male cases of HIV are more prevalent than female cases. The Bronx female cases decreased over time as the Bronx male cases increased.

- The rate of newly diagnosed AIDS cases among Bronx residents was 52.9 per 100,000 persons in 2009 and decreased to 46.8 in 2010 (see Figure 3c). The newly diagnosed AIDS cases in the Bronx were higher than the citywide and statewide rates from 2009-2010. In 2009 the citywide rate was 32.5 per 100,000 and in 2010 it was 28.5 per 100,000. In 2009 the statewide rate was 17.6 per 100,000 and in 2010 it was 15.4 per 100,000 (see Figure 3d).

- The rate of newly diagnosed AIDS cases among Bronx males was 70.0 per 100,000 in 2009 and decreased to 62.2 in 2010 (see Figure 3c).

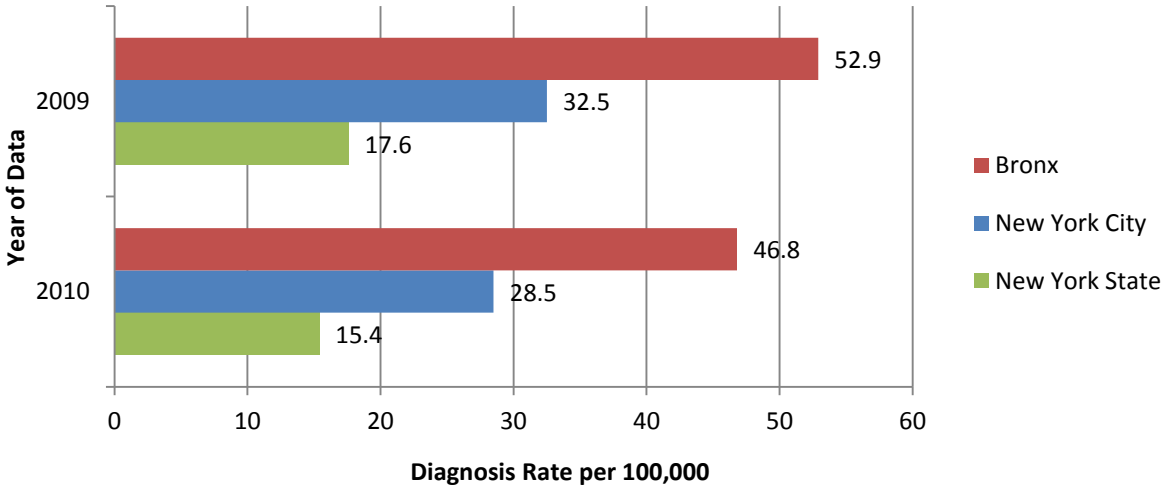
- The rate of newly diagnosed AIDS cases among Bronx females was 38.5 per 100,000 persons in 2009 and decreased to 33.7 in 2010 (see Figure 3c).

Figure 3c. Rates of Bronx Residents Newly Diagnosed with AIDS from 2009-2010



Source: NYS HIV/AIDS Surveillance Annual Report; For Cases Diagnosed through Dec. 2009 and Dec. 2010

Figure 3d. Rates of New York Residents Newly Diagnosed with AIDS from 2009-2010



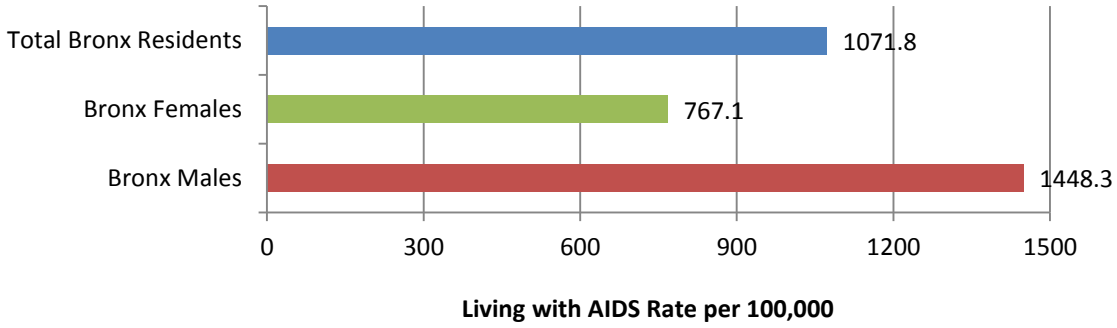
Source: NYS HIV/AIDS Surveillance Annual Report; For Cases Diagnosed through Dec. 2009 and Dec. 2010

- The rate of Bronx residents living with AIDS was 1056.3 per 100,000 persons in 2009 and increased to 1071.8 in 2010 (see Figure 3e). The rate among Bronx residents was higher than the citywide and statewide rates in 2009-2010 (see Figure 3f).

- The rate of Bronx males living with AIDS was 1429.1 per 100,000 persons in 2009 and increased to 1448.3 in 2010 (see Figure 3e).

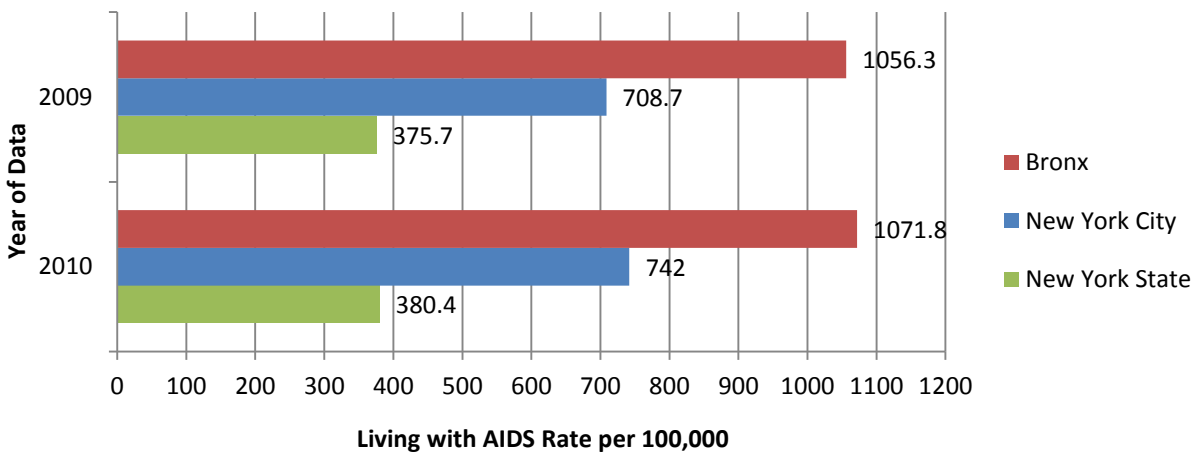
- The rate of Bronx females living with AIDS was 754.1 per 100,000 persons in 2009 and increased to 767.1 in 2010 (see Figure 3e).

Figure 3e. Rates of Bronx Residents Living with AIDS from 2009-2010



Source: NYS HIV/AIDS Surveillance Annual Report; For Cases Diagnosed through Dec. 2009 and Dec. 2010

Figure 3f. Rates of New York Residents Living with AIDS from 2009-2010



Source: NYS HIV/AIDS Surveillance Annual Report; For Cases Diagnosed through Dec. 2009 and Dec. 2010

- Overall, the rate of newly diagnosed AIDS case among Bronx residents has decreased over time. Although the Bronx diagnosis rates are decreasing, they remained higher than the citywide and statewide rates. Among newly diagnosed AIDS cases in the Bronx, new male cases of AIDS are more prevalent than new female cases. The rate of Bronx residents living with AIDS increased from 2009-2010. The Bronx rate of residents living with AIDS is significantly higher than the citywide and statewide rates. Among cases of Bronx residents living with AIDS, male cases of AIDS are more prevalent than female cases.

4. Disability

- According to 2011 U.S. Census Bureau data, 13.8% of Bronx residents are living with a disability. The Bronx percentage was higher than the statewide percentage of 10.9% and the nationwide percentage of 12.1%.

- 12.60% of Bronx males and 14.60% of Bronx females have a disability.

- Age groups in the Bronx with any disability: 5.37% under age 18; 12.50% ages 18-64; and 43.31% age 65+.

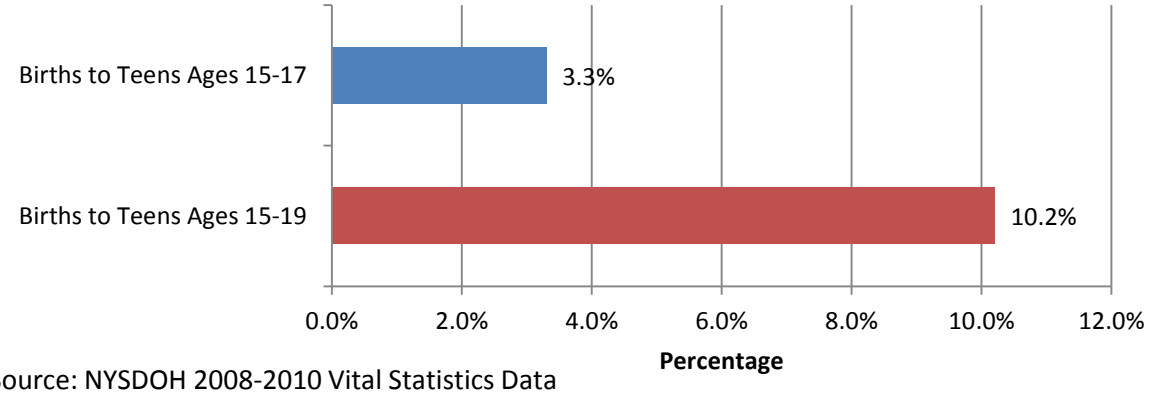
- Race/ethnic groups in the Bronx with any disability: 18.22% whites; 15.56% of Native Americans/Alaskan Natives; 13.97% Hispanics/Latinos; 13.57% blacks/African Americans; and 7.04% Asians.

5. Family Planning & Adolescent Pregnancy

- The rate of Bronx births to teens ages 15-17 was 3.6% in 2009 and decreased to 3.2% in 2010 (see Figure 5a). The Bronx percentages were higher than the citywide and statewide rates from 2009-2010. The citywide rate in 2009 was 1.9% and in 2010 was 1.8%. The statewide rate in 2009 and 2010 was 1.9% (see Figure 5b).

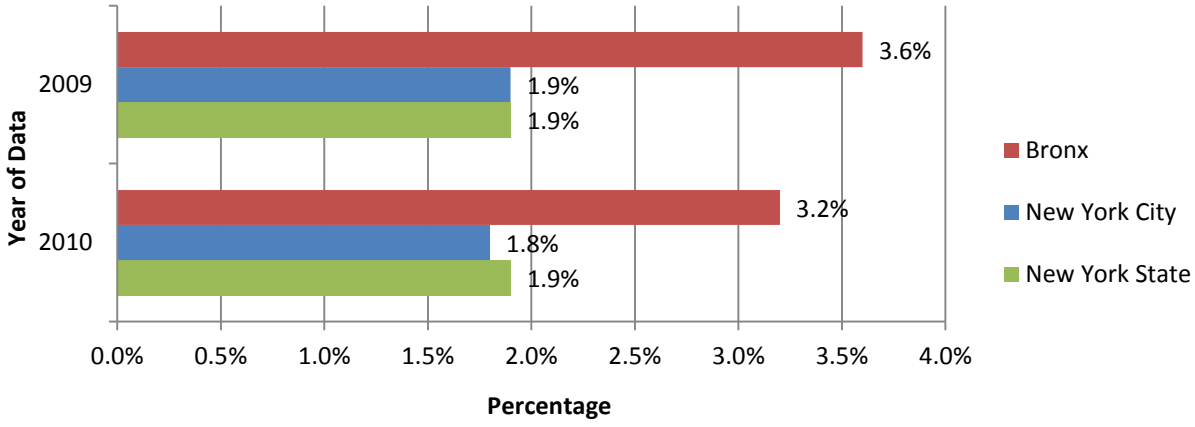
- The rate of Bronx births to teens ages 15-19 was 10.5% in 2009 and decreased to 10.0% in 2010. (see Figure 5a). The Bronx percentage was higher than citywide and statewide rates from 2009-2010. In 2009 the citywide rate was 6.2% and in 2010 it was 5.9%. In 2009 and 2010 the statewide rate was 6.6% (see Figure 5c).

Figure 5. Percentage of Bronx Births to Teens Ages 15-17 and 15-19 from 2009-2010



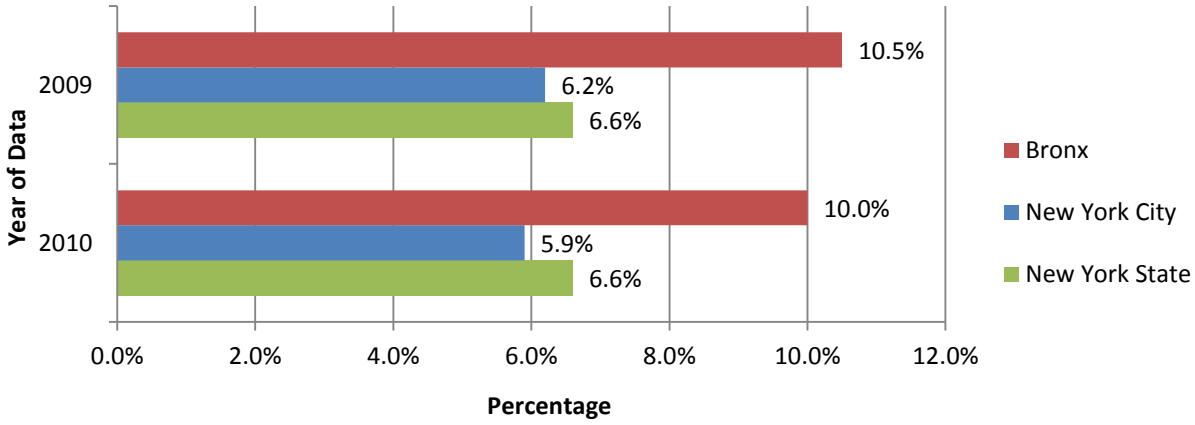
Source: NYSDOH 2008-2010 Vital Statistics Data

Figure 5b. Percentage of New York Births to Teens Ages 15-17 from 2009-2010



Source: NYSDOH 2008-2010 Vital Statistics Data

Figure 5c. Percentage of New York Births to Teens Ages 15-19 from 2009-2010



Source: NYSDOH 2008-2010 Vital Statistics Data

- According to the Community Health Needs Assessment data, the Bronx teen birth rate among females ages 15-19 from 2003-2009 was 47.50 per 1,000 births.

- Bronx teenage girls by race/ethnicity, birth rate (per 1,000 births): 14.40 whites; 42.10 blacks; 11.60 Asians; and 57.10 Hispanics/Latinos.

6. Maternal, Fetal, and Infant Health

According to the NYSDOH:

- The rate of Bronx mothers who received late or no prenatal care was 10.0% in 2009 and increased to 11.0% in 2010. The Bronx rates were higher than the citywide rates 2009-2010. In 2009 the citywide rate was 6.8% and in 2009 it was 7.3%.

- The infant mortality rate in the Bronx was 6.6 per 1,000 live births in 2009 of infants <1 year, and decreased to 5.6 in 2010. The Bronx rates were higher than the citywide and statewide rates from 2009-2010.

- The percentage of premature births <37 weeks gestation in the Bronx was 14.3% in 2009 and decreased to 12.4% in 2010. The Bronx rates were higher than the citywide and statewide rates from 2009-2010.

Low birthweight

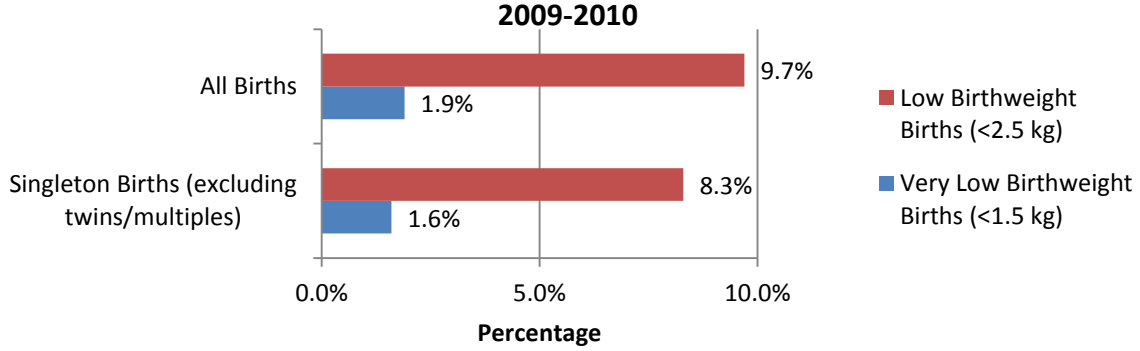
- The rate of very low birthweight (<1.5 kg) births was 1.9% births in 2009 and 2010 (see Figure 6a). The Bronx rates were higher than the citywide rate from 2009-2010, which was 1.6% (see Figure 6b).

- The rate of very low birthweight (<1.5 kg) singleton births (excluding twins/multiples) was 1.6% in 2009 and 2010 (see Figure 6a). The Bronx rates were higher than the citywide rate from 2009-2010, which was 1.2% (see Figure 6b).

- The rate of low birthweight (<2.5 kg) births was 9.9% in 2009 and decreased to 9.7% in 2010 (see Figure 6a). The Bronx rates were higher than the citywide rates 2009-2010, which were 8.7% (see Figure 6c).

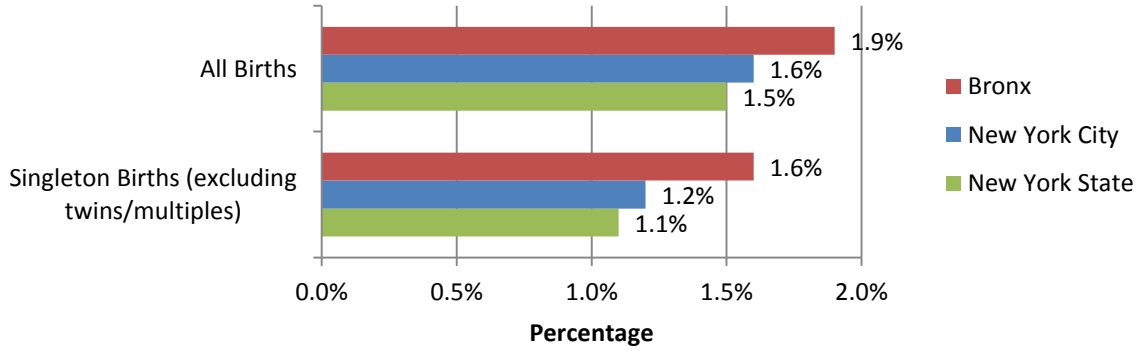
- The rate of low birthweight (<2.5 kg) singleton births (excluding twins/multiples) was 8.3% in 2009 and decreased to 8.1% in 2010 (see Figure 6a). The Bronx rates were higher than the citywide and statewide rates from 2009-2010. In 2009 and 2010 the citywide rates were 6.7%. In 2009 the statewide rate was 8.2 per 100,000 and 2010 it was 6.2 per 100,000 (see Figure 6c).

Figure 6a. Rates of Low Birthweight among Bronx Infants from 2009-2010



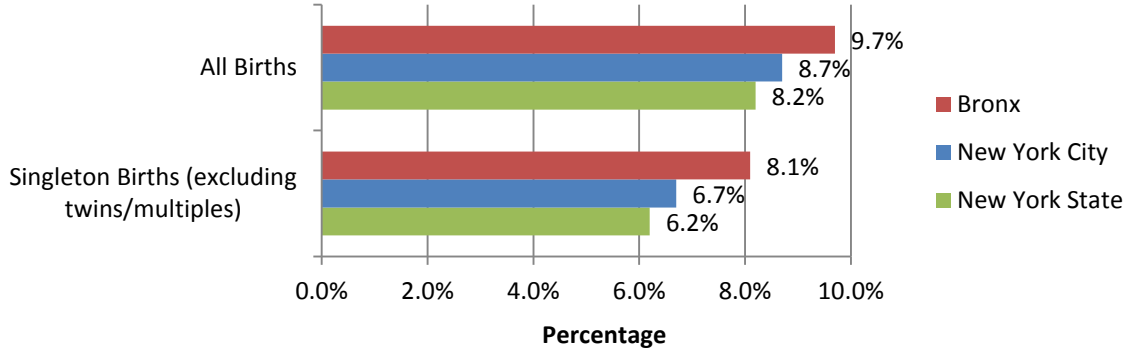
Source: NYSDOH Health Indicator Reports-Maternal and Infant Health Indicators

Figure 6b. Rates of Very Low Birthweight (<1.5 kg) among New York Infants from 2009-2010



Source: NYSDOH Health Indicator Reports-Maternal and Infant Health Indicators

Figure 6c. Rates of Low Birthweight (<2.5 kg) among New York Infants from 2009-2010

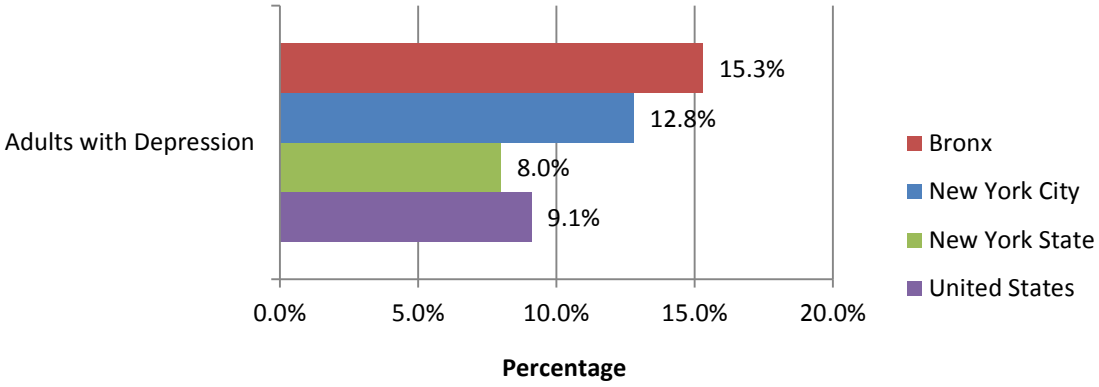


Source: NYSDOH Health Indicator Reports-Maternal and Infant Health Indicators

7. Mental Health and Mental Disorders

- According to the NYCDOH Community Health Survey (2010), 15.3% of residents in Bronx County, New York, were told by a doctor, nurse, or other health professional that they had depression, making the Bronx the borough with the second highest depression rate in New York City after Manhattan (17.5%). The overall depression rate for New York City is 12.8%. According to the CDC (2010), 8.0% of adults in New York State and 9.1% of adults in the United States suffer from depression. Thus the percentage of Bronx County residents with depression is significantly higher than city, state, and national rates of depression (Figure 7a).

Figure 7a. Percentage of Adults Suffering from Depression (2010)



Source: NYCDOH Community Health Survey 2011; CDC MMWR 2010

- From 2005-2011, the average number of poor mental health days reported by individuals in the past 30 days in the Bronx was 3.8 days. This was higher than both New York State (3.4 days) and the National Benchmark (2.3 days).

- According to the NYCDOH Community Health Survey (2012), 48.5% of Bronx County residents reported receiving mental health counseling or treatment, compared with 45.2% of New York City residents. The Bronx was the borough with the second highest percentage of residents receiving mental health counseling or treatment, after Brooklyn (54.8%).

- The NYSDOH reported that the age adjusted death rate due to suicide in 2011 was 6.41 per 100,000 in the Bronx, greater than the 5.7 per 100,000 reported in New York City.

- According to the NYCDOH Youth Risk Behavior Survey (2011), 8.9% of Bronx students had attempted suicide one or more times, making the Bronx the borough with the second highest teen suicide rate in New York City, after Brooklyn (9.5%). 8.4% of students in New York City have attempted suicide.

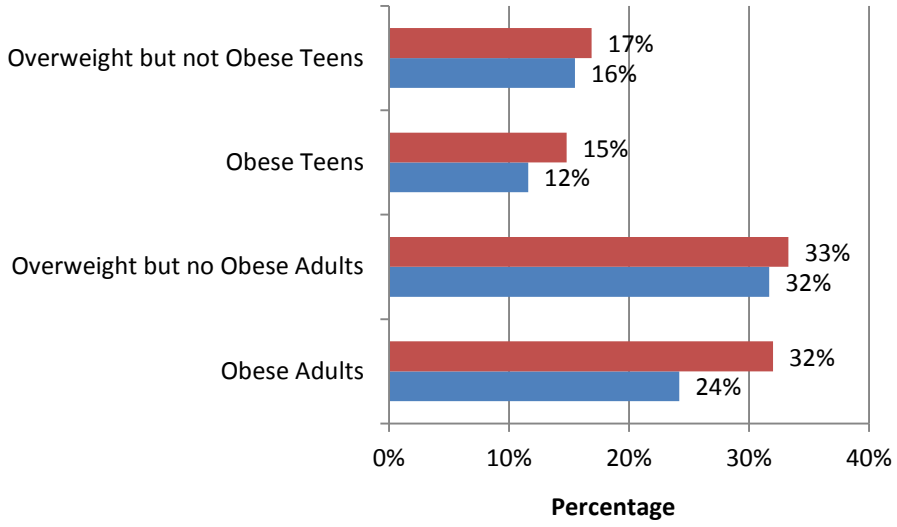
8. Nutrition, Physical Activity, and Weight

- According to the NYSDOH, 68% of Bronx adults were reported to be overweight or obese between 2008 and 2009. This is higher than the reported rates in both New York City (57.9%) and New York State (59.3%).

- As seen in Figure 8a, the NYCDOH Community Health Survey (2012) found that 32% of Bronx adults were classified as obese. This ties the Bronx with Staten Island for the borough in New York City with the highest percentage of obese adults. The overall obesity rate for New York City adults is 24.2%. 33.3% of Bronx adults were classified as overweight but not obese, making it the borough with the second highest rate of overweight adults behind Queens by 0.2%, which has a rate of 33.5%. The New York City rate for overweight but not obese adults is 31.7%.

- The NYCDOH Youth Risk Behavior Survey (2011) found that the Bronx had the highest rate of teen obesity of all five boroughs with 14.8% of teens reported obese. New York City has a teen obesity rate of 11.6%. The Bronx also had the highest percentage of teens that were overweight but not obese of all five boroughs, with 16.9%. In New York City 15.5% of teens are overweight but no obese (Figure 8a).

Figure 8a. Percentage of Overweight/Obese Adults & Teens, 2011-2012

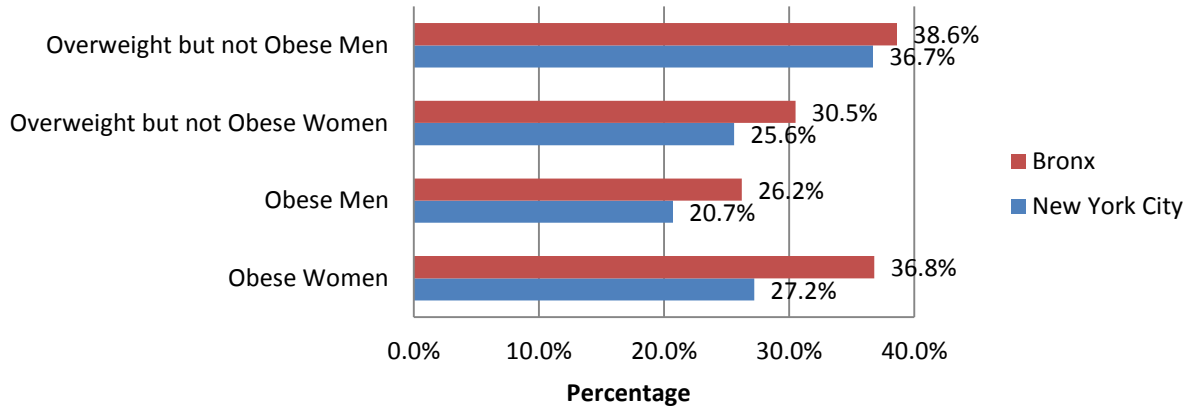


Source: NYCDOH Community Health Survey 2012; NYCDOH Youth Risk Behavior Survey, 2011

- According to the NYCDOH Community Health Survey (2012), 36.7% of Bronx men were classified as overweight but not obese, less than the New York City rate for men, which was 38.6%. The Bronx was the borough with the second lowest male overweight but not obese population. The male obesity rate in the Bronx, however, was 26.2%, making it the second most obese borough for men in New York City and significantly greater than the overall New York City male obesity rate of 20.7%.

- The percentage of women in the Bronx who were overweight but not obese was 30.5%, much higher than the New York City rate for women of 25.6%. For women, the Bronx represented the borough with the highest percentage overweight but not obese. The Bronx was also the borough with the highest female obesity rate at 36.8%, almost 10% higher than the overall New York City female obesity rate of 27.2% (Figure 8b).

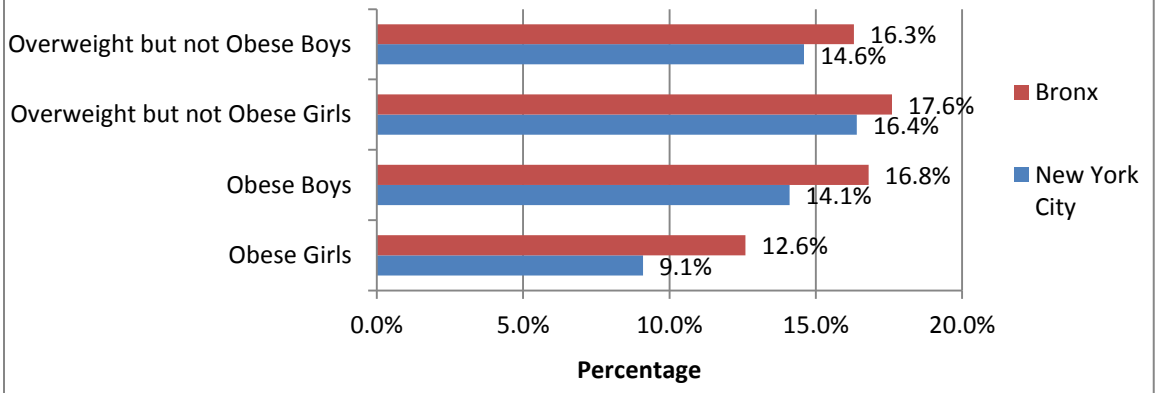
Figure 8b. Percentage of Overweight/Obese Adults by Sex, 2012



Source: NYCDOH Community Health Survey 2012

- According to the NYCDOH Youth Risk Behavior Survey (2011), 16.3% of Bronx teen boys were classified as overweight but not obese, while only 14.6% of New York City teen boys were classified as the same. The Bronx had the second largest rate of teen males who were overweight but not obese of all of the boroughs. 16.8% of Bronx teen boys were classified as obese. This was the second highest rate of all of the boroughs; only 14.1% of New York City teen boys were considered to be obese. 17.6% of Bronx teen girls were classified as overweight but not obese, greater than the 16.4% of New York City teen girls who were classified as the same and the greatest of all of the boroughs. 12.6% of teen girls were classified as obese, significantly larger than the 9.1% of New York City teen girls classified as obese and the largest of all of the boroughs (Figure 8c).

Figure 8c. Percentage of Overweight/Obese Teens by Sex, 2012

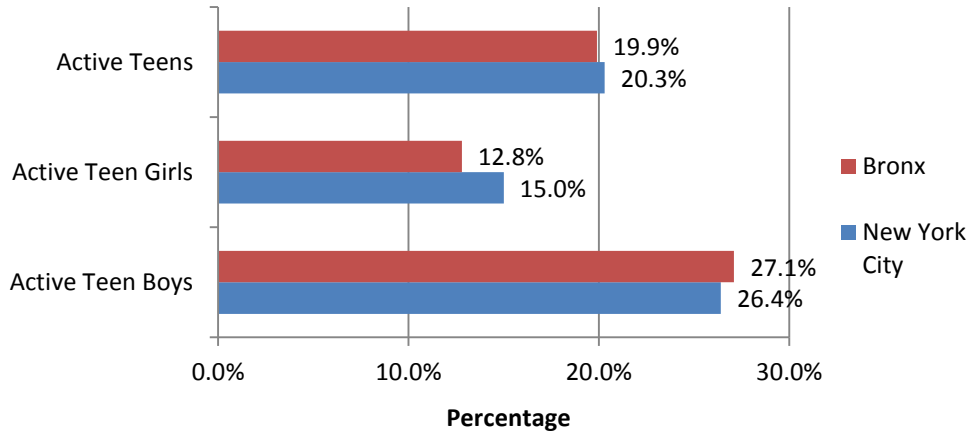


Source: NYCDOH Youth Risk Behavior Survey 2011

- The NYCDOH Youth Risk Behavior Survey (2011) found that 19.9% of Bronx teens reported engaging in physical activity for at least 60 minutes per day. This was lower

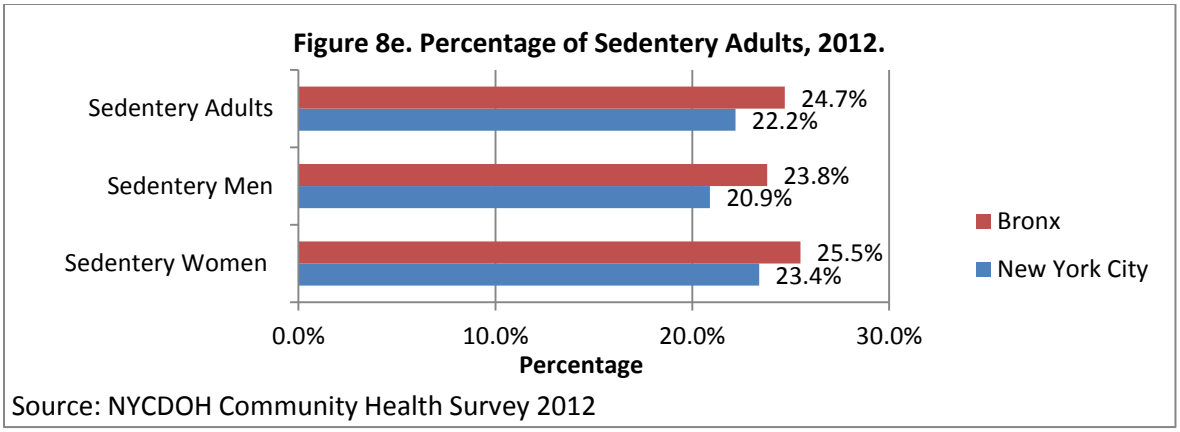
than the 20.3% of New York City teens who reported engaging in physical activity for at least 60 minutes a day. The rate of Bronx girls who engaged in physical activity was 12.8%, lower than the 15% of New York City girls who reported the same. However, at 27.1%, the rate of Bronx boys who reported engaging in physical activity was greater than the 26.4% of New York City boys who reported engaging in physical activity (Figure 8d).

Figure 8d. Percentage of Active Teens, 2011.



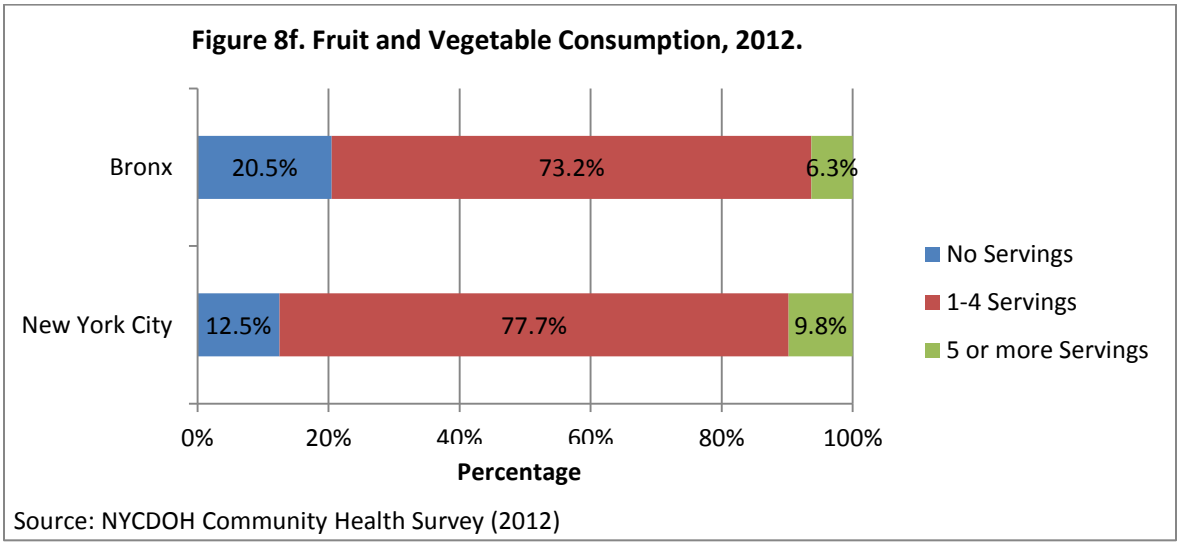
Source: NYCDOH Youth Risk Behavior Survey 2011

- The NYCDOH Community Health Survey (2012) found that the Bronx had the highest rate of adults who had not engaged in physical activity in the past 30 days of all of the boroughs at 24.7%. 22.2% of all New York City adults had not engaged in physical activity in the past 30 days. 23.8% of Bronx males had not engaged in physical activity in the past 30 days, compared with 20.9% of New York City males. 25.5% of Bronx females had not engaged in physical activity in the 30 days, compared with 23.4% of New York City females (Figure 8e).



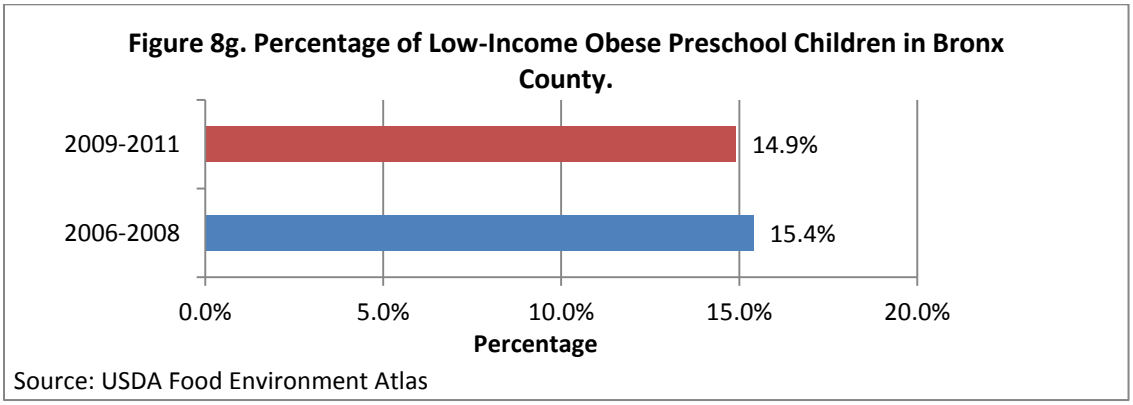
Source: NYCDOH Community Health Survey 2012

- Between 2003 and 2009, 76.5% of individuals reported consuming few fruits or vegetables. According to the NYCDOH Community Health Survey (2012), 20.5% of individuals in the Bronx consumed no servings of fruit and/or vegetables per day, 73.2% of individuals consumed 1-4 servings, and 6.3% consumed over 4 servings (see Figure 9b). The Bronx had the lowest fruit and/or vegetable consumption of all of the boroughs, with the highest percentage of individuals consuming no servings of fruit and/or vegetables per day and the lowest percentages of individuals consuming 1-4 servings and greater than 4 servings per day. For New York City, 12.5% of individuals consumed no servings of fruit and/or vegetables per day, 77.7% consumed 1-4 servings per day and 9.8% consumed greater than 4 servings per day (Figure 8f).



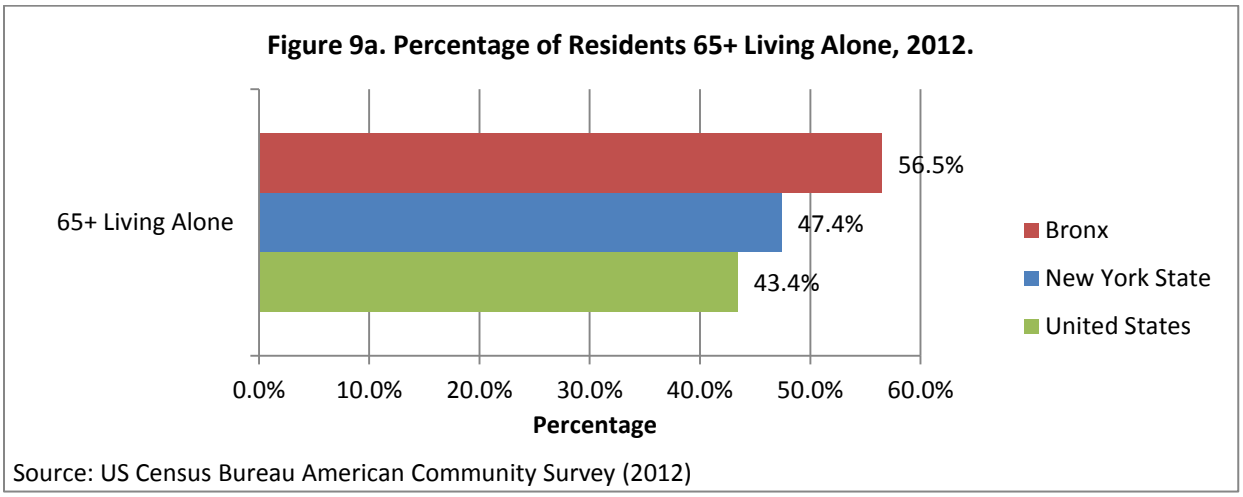
Source: NYCDOH Community Health Survey (2012)

- As shown in Figure 8c, the low-income preschool obesity rate in the Bronx was 15.4% in from 2006-2008, decreasing to 14.9% from 2009-2011. According to the CDC the low-income preschool obesity rate for New York State averaged 14.4% from 2009-2011 (Figure 8g).



9. Older Adults and Aging

- According to the U.S. Census Bureau (2012), 56.5% of the Bronx population ages 65 and over reported living alone (see Figure 9a). This is much greater than percentage of New York State residents 65+ living alone (47.4%) and the national percentage of individuals 65+ living alone (43.4%).



10. Injury and Violence Prevention
    - The age-adjusted death rate due to unintentional injuries was 19.4 per 100,000 persons in 2009 and increased to 18.8 in 2010.

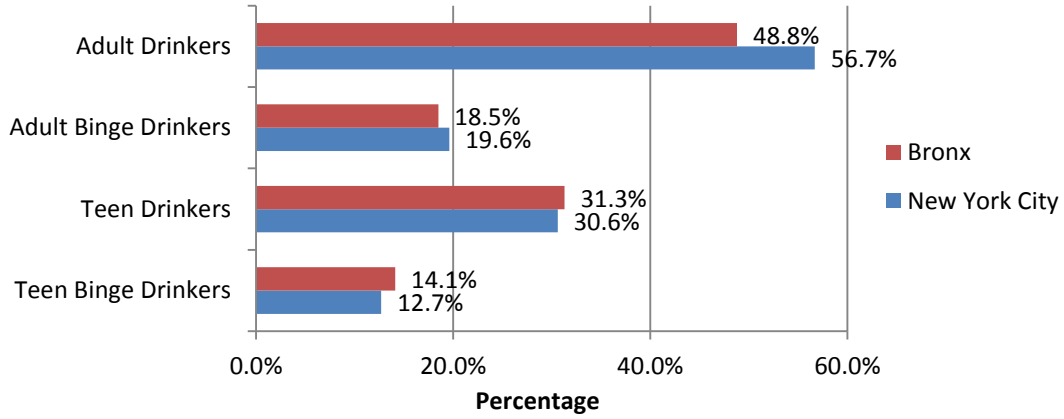
11. Substance Abuse and Tobacco Use

- The NYCDOH Community Health Survey (2012) found that 48.8% of adults in Bronx County are alcohol drinkers, less than the 56.7% of New York City adults that are alcohol

drinkers. 18.5% of Bronx County residents engaged in binge drinking, which is less than the 19.6% of New York City residents who engaged in binge drinking in 2012.

- The NYCDOH Youth Risk Behavior Survey (2011) found that 31.3% of teens in Bronx County had used alcohol in the past month, compared with 30.6% of New York City teens. Bronx County had the second highest rate of teen alcohol consumption of the five boroughs. In Bronx County, 14.1% of teens engaged in binge drinking, compared with 12.7% of New York City teens. (Figure 11a).

Figure 11a. Percentage of Drinkers and Binge Drinkers, 2011-2012.

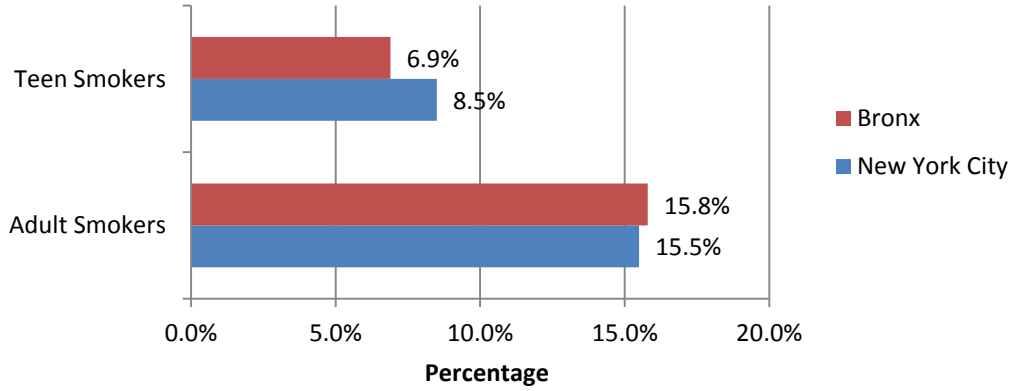


Sources: NYCDOH Community Health Survey (2012); NYCDOH Youth Risk Behavior Survey (2011)

- According to the NYCDOH Community Health Survey (2012), 15.8% of adults in the Bronx reported being current smokers. 15.5% of New York City adults reported being current smokers.

- According to the NYCDOH Youth Risk Behavior Survey (2011), 6.9% of Bronx teens reported being current smokers. This is less than the 8.5% of New York City teens who reported being current smokers. The Bronx tied with Brooklyn for the lowest percentage of teens that reported being current smokers (Figure 11b).

Figure 11b. Percentage of Smokers, 2011-2012.



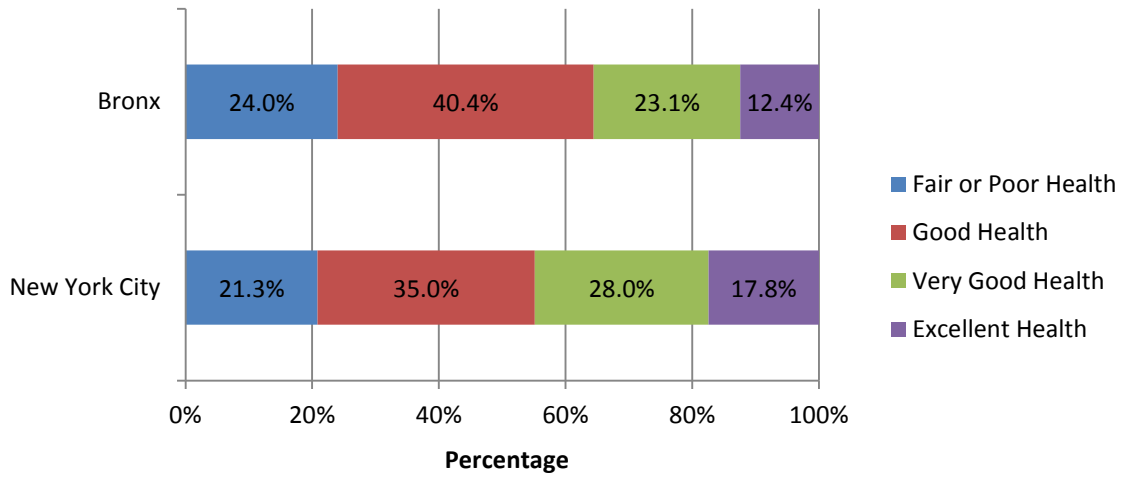
Sources: NYDOH Community Health Survey (2012); NYCDOH Youth Risk Behavior Survey (2011)

- In 2011, 17.9% of Bronx teens had used marijuana at least one time in a 30-day period, compared with 17.7% of New York City teens. 2.6% of teens reported having used methamphetamines one or more times in their lifetime, less than the 2.8% of New York City teens who had ever used methamphetamines. In Bronx County, 6.3% of teens had taken prescription pain medication without a doctor's prescription within the past 12 months. This was the lowest rate of prescription pain medication use without a prescription of all five boroughs; the New York City average was 7.3%.

12. Wellness and Lifestyle

- As shown in Figure 12a, 12.4% of Bronx residents reported in 2012 that they had excellent health; 23.1% reported being in very good health; 40.4% reported being in good health; and 24% reported being in fair or poor health. The New York City averages for self-reported health status included 17.8% in excellent health, 28% in very good health, 33% in good health, and 21.3% in fair or poor health (Figure 12a).

Figure 12a. Reported Health Status, 2012.



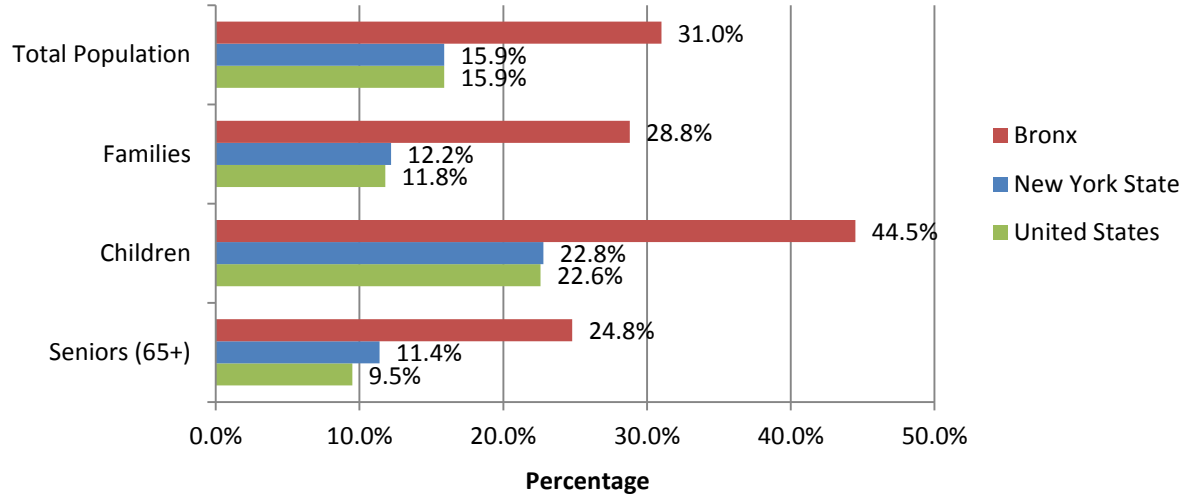
Source: NYCDOH Community Health Survey (2012)

- From 2005-2010, 34% of Bronx residents reported that they received inadequate social support. This is significantly lower than both the New York State rate (24%) and the National Benchmark (14%).

B. Economy

- According to the US Census Bureau (2012), 31% of Bronx residents lived below poverty level. In 2012, 28.8% of Bronx families, 44.5% of Bronx children, and 24.8% of Bronx residents ages 65 and older lived below poverty level. In New York State, 15.9% of the population lived below the poverty level in 2012. In 2012, 12.2% of families, 22.8% of children, and 11.4% of residents ages 65 and older lived below the poverty level. In the United States, 15.9% of the population lived below the poverty level in 2012. In 2012, 11.8% of families, 22.6% of children, and 9.5% of individuals ages 65 and older lived below poverty level (see Figure 13a).

Figure 13a. Percentage of Individuals Living in Poverty, 2012.

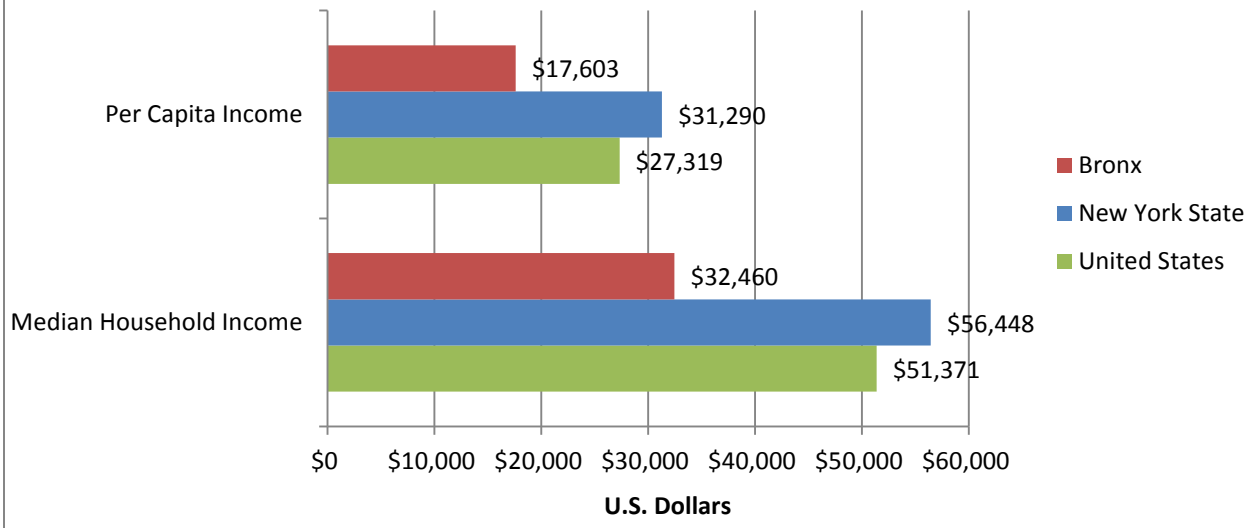


Source: US Census Bureau American Community Survey (2012)

- Out of the 1,374,278 people living in Bronx County, New York in 2012, 767,256 (55.8%) lived below 200% of poverty level. In New York State, 33% of the population lived below 200% of poverty level in 2012. In the United States, 35.1% of the population lived below 200% of poverty level in 2012.

- The per capita income of people living in Bronx County, New York in 2012 was $17,603. In 2012 the per capita income in New York State was $31,290 and in the United States was $27,319. In 2012, the median household income in the Bronx was $32,460. It was $56,448 in New York State, and $51,371 in the United States (Figure 13b).

Figure 13b. Income in 2012.



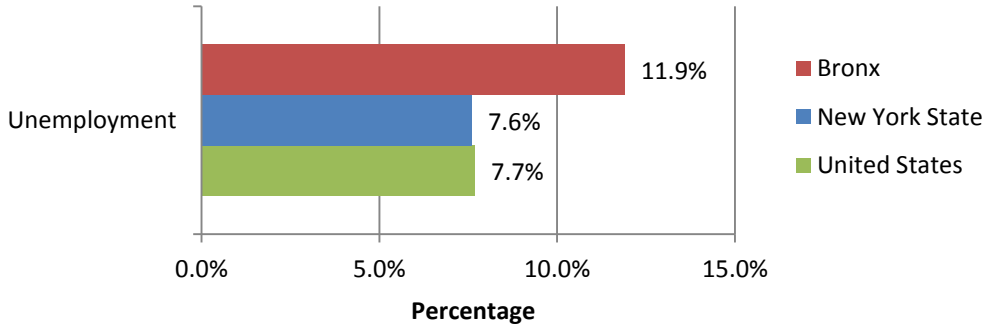
Source: US Census Bureau American Community Survey (2012)

- In 2012, 7.37% of Bronx households received public assistance income. During this time 3.39% of New York State households and 2.88% of United States households received public assistance income.

- Community Health Needs Assessment data stated that 84.18% of students in the Bronx are eligible for reduced or free lunch during the 2010-2011 school year. In New York State 48.12% of students were eligible and in the United States 48.34% were eligible.

- According to the Community Health Needs Assessment data, the unemployment rate in the Bronx as of July 2013 is at 11.90%. It is 7.60% in New York State and 7.69% In the United States (Figure 13c).

Figure 13c. Percentage of Unemployed Civilian Population age 16+, 2013.



Source: Community Health Needs Assessment (2013)

- An estimated 59.2% of renters in the Bronx spent 30% or more of their household income on rent in 2012. In the same year an estimated 50.4% of renters in New York State and 48.1% of renters in the United States spent 30% or more of their household income on rent.

- In 2012, the homeowner vacancy rate in the Bronx was 5.1%. It was 4.4% in New York State and 3.8% in the United States.

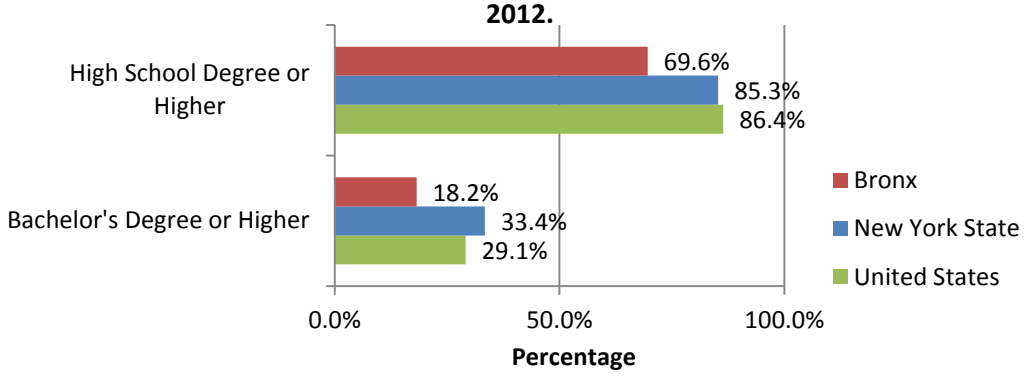
- In 2012, 19.1% of occupied housing units in the Bronx were owner-owned units. In the same year, 53.7% of occupied housing units in New York State and 63.9% of occupied housing units in the United States were owner-owned units.

- In 2010, approximately 2,516 Bronx households filed for foreclosure, a rate of 4.9 filings per 1,000 households. In New York State the foreclosure filing rate was 42 per 1,000 in 2010.

C. Education

- In 2012, 69.6% of the population 25 years and over in the Bronx had a high school degree or higher. In this same year 85.3% of New York State residents 25 years and over and 86.4% of United States residents 25 years and over had a high school degree and higher. In 2012, 18.2% of residents 25 years and over in the Bronx had a bachelor's degree or higher. In this same year 33.4% of New York State residents 25 years and over and 29.1% of United States residents 25 years and over had a bachelor's degree or higher (Figure 14a).

Figure 14a. Percentage of Population with an Educational Degree, 2012.

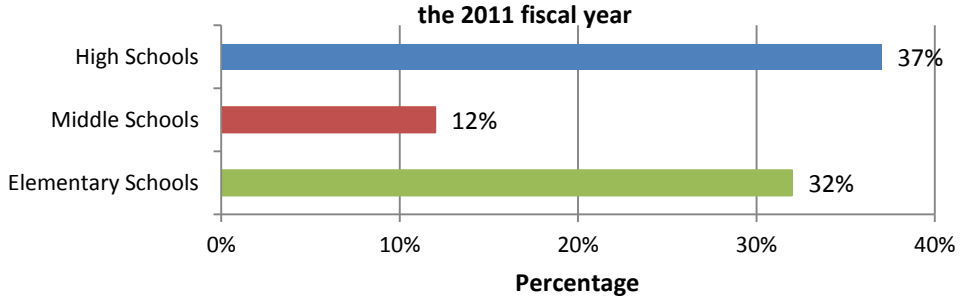


Source: US Census Bureau American Community Survey (2012)

- From 2010-2011, 58% of ninth grade students graduated in 4 years in the Bronx. During this same period, 77% of New York State ninth grade students graduated in 4 years.

- In the 2011 fiscal year in the Bronx, 32% of elementary schools, 12% of middle schools, and 37% of high schools exceeded building capacity (see Figure 14b).

14b. Percentage of school buildings that exceeded capacity in Bronx County, New York in the 2011 fiscal year

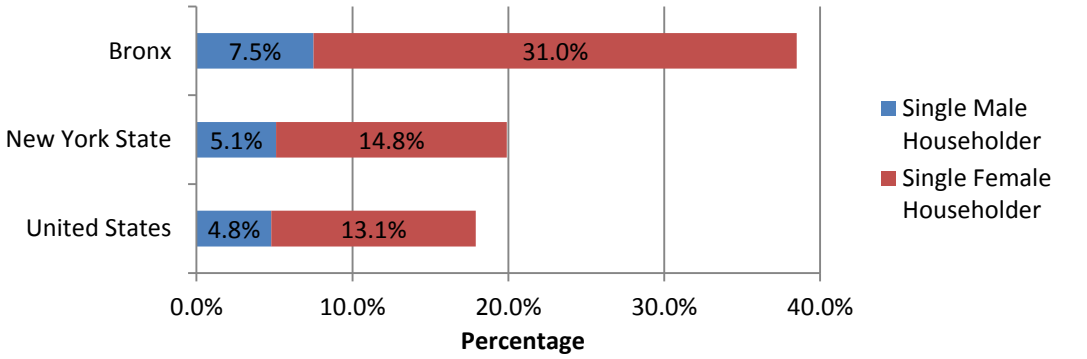


Source: NYC Department of Education-Enrollment, Capacity, and Utilization Report (2011-2012 School Year)

D. Social Environment

- Out of the 475,978 households in Bronx County, New York in 2012, an estimated 35,542 (7.5%) had a male householder with no wife present and an estimated 147,517 (31%) had a female householder with no husband present. Out of the estimated 7,238,922 households in New York State in 2012, an estimated 369,635 (5.1%) had a male householder with no wife present and an estimated 1,070,310 (14.8%) had a female householder with no husband present. Out of the estimated 115,969,540 households in the United States in 2012, an estimated 5,578,212 (4.8%) had a male householder with no wife present and an estimated 15,176,600 (13.1%) had a female householder with no husband present (Figure 15a).

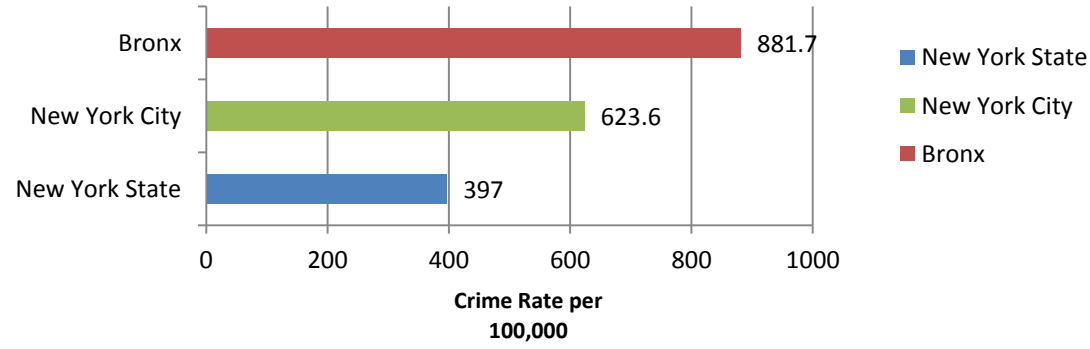
Figure 15a. Percent and Type of Single Family Households, 2012.



Source: US Census Bureau American Community Survey (2012)

- According to the NYS Division of Criminal Justice Services, the violent crime rate in the Bronx in 2011 was 881.7 per 100,000 population (see Figure 15b). In New York City it was 623.6 per 100,000 population and in New York State it was 397 per 100,000 population.

Figure 15b. Violent Crime Rate per 100,000 population, 2011.



Source: DCJS, Uniform Crim/Incident-Based Reporting Systems (2012)

E. Built Environment

- In 2011, there were 1,115 grocery stores in the Bronx and the establishment rate for grocery stores was 80.5 per 100,000 population. During this time New York State had 9,560 grocery stores with an establishment rate of 49.33 per 100,000 population and the United States had 64,366 grocery stores with an establishment rate of 20.85 per 100,000 population (Figure 16a).

- In 2010, 99.91% of the Bronx's low-income population lived less than a mile from a grocery store. During this same time 97.45% of New York State's low-income population and 93.73% of the United States' low-income population lived less than a mile from a grocery store.

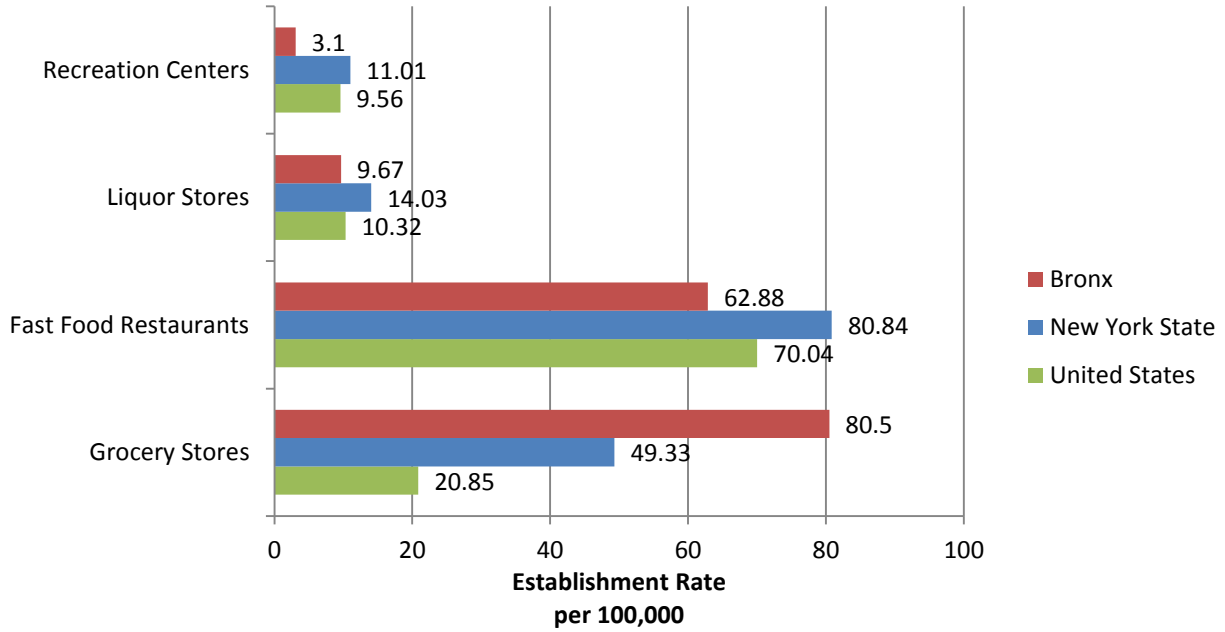
- As of April 2013, the Department of Health had identified 29 farmers' markets in the Bronx.

- In 2011 there were 871 fast food restaurants in Bronx County, New York and the establish rate was 62.88 per 100,000 population. During this same time New York State had 15,666 fast food restaurants with an establishment rate of 80.84 per 100,000 population and the United States had 216,243 fast food restaurants with an establishment rate of 70.04 per 100,000 population (Figure 16a).

- There were 134 liquor stores in Bronx County, New York in 2011 and the establishment rate of liquor stores was 9.67 per 100,000 population. In 2011 New York State had 2,719 liquor stores with an establishment rate of 14.03 per 100,000 population and the United States had 31,876 liquor stores with an establishment rate of 10.32 per 100,000 population (Figure 16a).

- In 2011 in Bronx County, New York there were 43 recreation and fitness facilities and the establishment rate of such facilities was 3.10 per 100,000 population. In 2011 New York State had 2,134 recreation and fitness facilities with an establishment rate of 11.01 per 100,000 population and the United States had 29,506 recreation and fitness facilities with an establishment rate of 9.56 per 100,000 population (Figure 16a).

Figure 16a. Establishment Rate of Facilities per 100,000 population, 2010-2011.

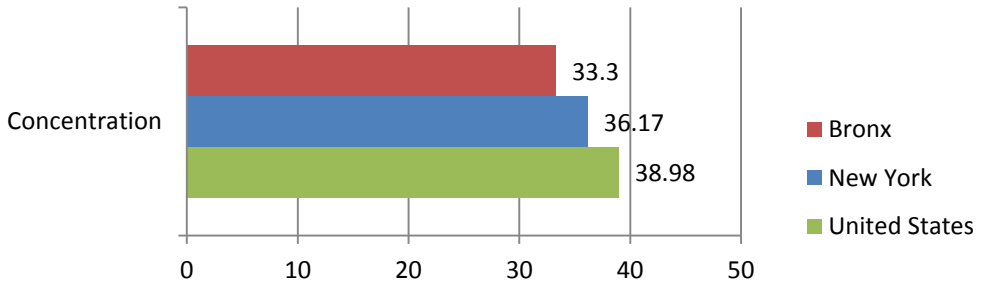


Source: Community Health Needs Assement (2013)

F. Environment

- The American Lung Association gave Bronx County, New York an ozone grade of D and reported that the weighted average of high ozone days from 2009-2011 was 2.3 days per year. In 2008 the average daily ambient ozone concentration was 33.3 in Bronx County, New York. This is lower than the rates of both New York State (36.17) and the United States (38.98) (Figure 17a).

Figure 17a. Average Daily Ambient Ozone Concentration, 2008.



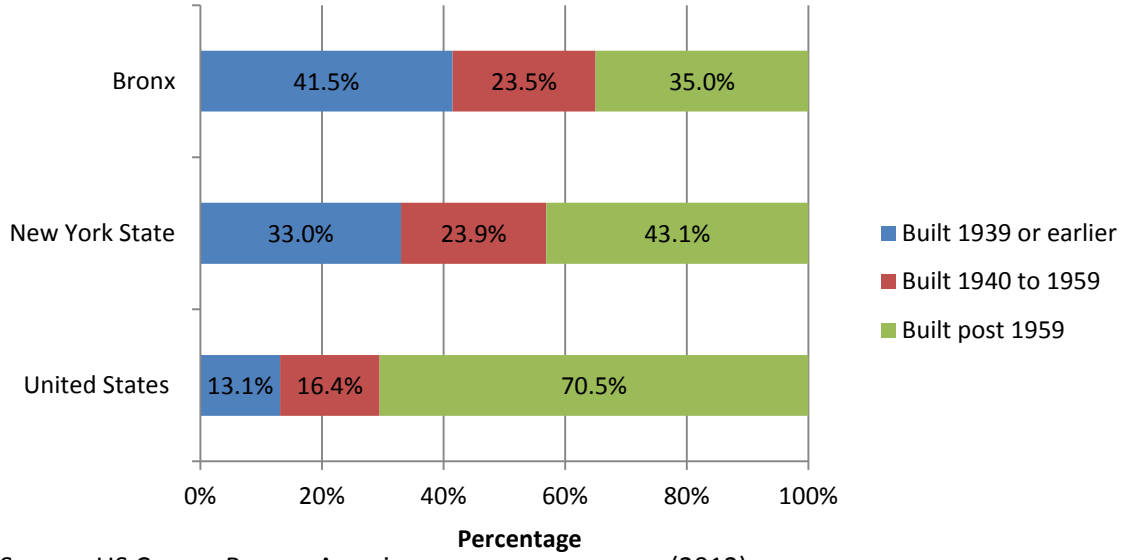
Source: Community Health Needs Assessment (2013)

- The American Lung Association gave Bronx County, New York a passing grade for annual particle pollution and noted an annual average concentration of 11.9µg/m^3 for 2009-2011. The American Lung Association gave Bronx County, New York a daily particle pollution grade of C and reported that the daily average concentration was 1.7 from 2009-2011.

- According to the U.S. Environmental Protection Agency (EPA), 1% of carcinogenic chemicals (Polycyclic Aromatic Compounds) were released into the air in the Bronx in 2011. 148lbs total of PBT (persistent, bioaccumulative, and toxic chemicals) were released on-site in the Bronx during the same year.

- In 2012, 41.5% of occupied housing units in the Bronx were built in 1939 or earlier and 23.5% of occupied housing units were built between 1940 and 1959. In New York State in 2012, 33% of occupied housing units were built in 1939 or earlier and 23.9% were built between 1940 and 1959. In 2012, 13.1% of occupied housing units in the United States were built 1939 or earlier and 16.4% of occupied housing units were built between 1940 and 1959 (Figure 17b).

Figure 17b. Year Housing Structures Built, 2012.



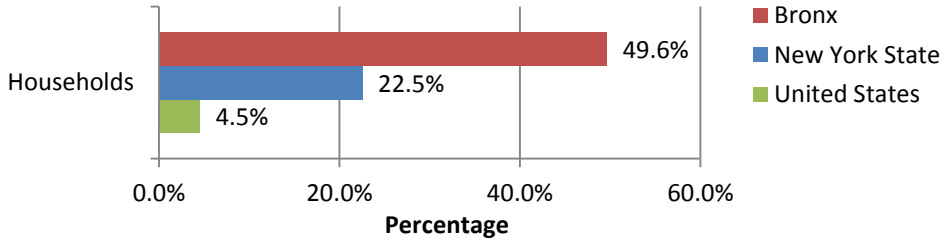
Source: US Census Bureau American Community Survey (2012)

G. Transportation and Transportation Safety

- In 2012, the mean travel time to work for Bronx residents was 42.8 minutes. In New York State, the mean travel time to work was 31.8 minutes. The national mean travel time to work was 25.7 minutes.

- In 2012 49.6% of households in the Bronx had no vehicle available. In comparison, 22.5% of New York State households and 4.5% of households in the United States had no vehicle available (Figure 18a).

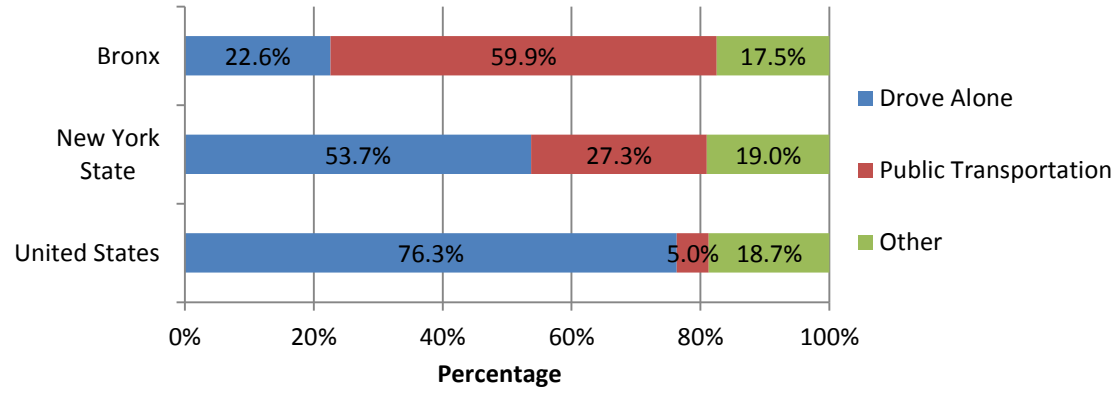
Figure 18a. Percent of households with no vehicle available, 2012.



Source: US Census Bureau American Community Survey (2012)

- In 2012 out of 526,809 total Bronx workers, 118,963 drove alone to work (22.6%) and 315,692 (59.9%) used public transportation. Out of 8,916,499 New York State workers, 4,785,225 (53.7%) drove alone to work and 2,429,897 (27.3%) used public transportation. Out of 140,862,960 national workers, 107,460,210 (76.3%) drove to work alone and 7,053,456 (5%) used public transportation (Figure 18b).

Figure 18b. Means of Commuting to Work by Percent, 2012.



Source: US Census Bureau American Community Survey (2012)

- In the Bronx, the age-adjusted death rate due to motor vehicle collisions was 4.0 per 100,000 in 2010 and decreased to 3.5 per 100,000 in 2011. In New York City the age-adjusted death rate due to motor vehicle collisions was 3.4 per 100,000 in 2010 and decreased to 3.2 per 100,000 in 2011.

Appendix C: Listing of Health Needs with Order of Magnitude/Significance

Improve Health Status and Reduce Health Disparities

Indicator	Bronx County Rate
Age-adjusted preventable hospitalizations rate per 10,000- Ages 18+ years	288.9 in 2008-2010
Percentage of adults without health insurance – Ages 18-64 years	23% in 2010; 19.79% in 2011

Prevent Chronic Diseases

Indicator	Bronx County Rate
Heart Disease Morality per 100,000	215.1 in 2009; 206.1 in 2010
Prostate Cancer Incidence	180.9 in 2009; 171.2 in 2010
Age-adjusted Death Rate, Cancer Morality per 100,000	169.50 rate from 2006-2010
Percentage of adults who are obese	30.2% in 2010-2011; 32% in 2012
Percentage of low-income preschool obesity rate	15.4% from 2006-2008; 14.9% from 2009-2011
Percentage of teens who are obese	14.8% in 2011
Percentage of individuals who reported consuming few fruits or vegetables	76.5% from 2003-2011
Percentage of adults who are sedentary	24.5% in 2011; 24.7% in 2012
Percentage of teens who do not engage in physical activity for at least 60 minutes per day	80.1% in 2011
Cervical Cancer Incidence	9.3 rate from 2009-2010
Colorectal Cancer Incidence	44.4 rate in 2009
Percentage of women ages 67-69 who did not receive a mammography over a two-year period	39% in 2010
Percentage of adults who did not receive a colonoscopy in the past 10 years– Ages 50+	34.3% in 2011; 29.3% in 2012
Teen with asthma	25.9% in 2011

Percentage of diabetic adults 65+ who did not have their blood sugar levels tested	23% in 2009; 22% in 2010
Adults with asthma	17.9% in 2011; 18.1% in 2012
Percentage of cigarette smoking among adults	17.1% in 2011; 15.8% in 2012
Adults with diabetes	13.1% in 2011; 15.2% in 2012

Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections

Indicator	Bronx County Rate
Percentage of adults ages 65+ who did not receive a pneumonia shot within the last year	51.7% in 2008-2009
Percentage of adults ages 65+ who did not receive a flu shot within the last year	41.4% in 2008-2009
Chlamydia case rate per 100,000	1,321.5 rate in 2010; 1,302.2 in 2011
Living with HIV case rate per 100,000	632.2 rate in 2009; 635.1 in 2010
Gonorrhea case rate per 100,000	236.2 rate in 2010; 272.0 in 2011
Syphillis case rate per 100,000	11.7 rate in 2010; 11.0 in 2011

Promote Healthy Women, Infants, and Children

Percent of Low Weight Births	9.9% from 2003-2009
Percentage of children without health insurance	4.8% in 2010; 4.37% in 2011

Appendix D – Supplemental Program Information

Montefiore's programs of community health services are among the nation's most extensive. Here are some examples:

Providing Primary Care to Underserved Populations

- Montefiore's network of primary care centers in the Bronx - including four (7) Federally-Qualified Health Centers (FQHC's) - provides access to high-quality primary health care services and a variety of practice-based and community outreach programs to some of the nation's poorest and most under-served communities.
- Montefiore operates one of the nation's largest programs of school-based primary care, serving over 25,000 students at 21 elementary, middle and high schools in the Bronx, providing over 80,000 health, mental health and dental visits in the latest school year. This model program – which is supported by a combination of Medicaid fee-for-service billings, grants and medical center subsidies - is able to provide services to all students in these schools, including the roughly half the students without insurance. Five of these school health clinics are designated as FQHC's.
- Montefiore provides needed health care services to homeless children and families in various locations in the Bronx and throughout New York City, through two programs, one using a fleet of mobile medical units, and a second using teams of professionals providing services within homeless shelters and assessment centers, and community-based service sites, including faith-based soup kitchens and multi-service centers.

Services to Vulnerable and At-risk Populations

- Montefiore and the Department of Pediatrics provide comprehensive care and a range of innovative programs for **high-risk children** in the Bronx, including:
  - A highly regarded prevention, counseling and treatment program for abused children and their families, based in the Child Advocacy Center.
  - A nationally recognized lead poisoning prevention, screening and treatment program serving populations at highest risk for lead poisoning. Its Safe House is a model housing program to shelter families of children with high lead levels while their dwellings are made lead free.
  - An innovative, multi-level program of care for children with and at-risk for obesity and diabetes, including initiatives in the school-based health centers, in the community-based primary care sites, and at the CHAM.
  - Health professions education programs for high school students are conducted in collaboration with area high schools.

- The medical center operates one of the nation's largest and most comprehensive programs for the diagnosis, care and ongoing management of **populations with and at-risk for HIV infection**, including**:**
  - A hospital-based, state-designated comprehensive AIDS Center (poised to celebrate its 30th year of operation in 2013) that serves 2,500 individuals with HIV/AIDS with a broad program of ambulatory and inpatient care.
  - A community-based program that serves another 1,500 persons with HIV/AIDS, operating in the medical center's primary care sites.
  - Longstanding programs focused on the prevention, early identification and ongoing care and management of children and adolescents with or at risk for HIV infection.

- An innovative program of outreach HIV primary and specialty care services, that are co-located in Montefiore's Substance Abuse Treatment Program, which serves 5,000 opiate-addicted individuals (one of the state's largest drug treatment programs, half of whom are HIV-infected) in seven drug treatment centers located throughout the Bronx. This service infrastructure has proved invaluable in mounting effective public health, diagnosis and care programs responding to the two other infectious disease epidemics that have also afflicted the borough: tuberculosis and Hepatitis-C infection.
- An AIDS volunteer program (Project BRAVO) that provides a range of supportive services (transportation, meals, visiting to homebound patients).

- Montefiore provides a wide range of on-site and outreach programs to serve the borough's **frail and at-risk elderly**, including:
  - A comprehensive, multi-disciplinary Geriatric Ambulatory Practice, including Geriatric medicine and Geriatric Psychiatry, social services, pharmacy and nutritional counseling, with service sites in the east and west Bronx.
  - An Aging and Memory Center that provides assessments, ambulatory care and home visits by Geriatric Psychiatrists.
  - The nation's largest hospital-based homecare program, providing in-home services to inner city seniors living in neighborhoods that are among the country's most disadvantaged.
  - An extensive program to identify, prevent and respond to suspected elder abuse.
  - Physician home-visit programs serving the elderly living in publicly-subsidized housing projects across the Bronx, a program mounted in partnership with the NYC Housing Authority and local community and social service agencies in "naturally-occurring retirement communities".
  - An innovative federally-funded demonstration program that uses a combination of care and case management, a physician home visiting program, home-based telemonitoring and patient/family support to manage and improve the care and health of seniors identified by CMS as their "High-Cost Beneficiaries", Medicare beneficiaries with complex medical and psychosocial needs.

- The Department of OB-GYN and Women's Health at Montefiore/Einstein is involved in a range of programs focused on the **health needs of women** in the Bronx and surrounding communities, including:
  - Partnering with NY State, NY City and local providers on the development of a regional perinatal system in the Bronx, which has among the country's highest rates of infant mortality and disability and low birth weight.
  - Provision of outreach primary care services to domestic violence shelters in the Bronx.
  - Operation of the Women's and Children's Center, a program that provides medical care, support and family counseling to women and children infected with, and/or affected by AIDS.

Responding to the unique and pressing needs of its community:

- The Montefiore-Einstein **Cancer Center** operates the Community Outreach Program, a research based cancer prevention, education, and support program that provides support and educational services to patients, families, staff, and community members facing the challenges of cancer. The Center also participates in cancer screening, cancer education and awareness, and support programs.
- Montefiore's **Community Dentistry** program provides dental services to a multitude of under-served and medically compromised patients at on-site dental facilities, one community site, and the Infectious Disease Clinic at Moses. A mobile dental van provides mobile dental services to the underserved at a variety of Montefiore primary care sites across the Bronx.
- Montefiore was recently designated by NY State as one of four **Diabetes** Centers of Excellence in the state. Montefiore has implemented a comprehensive array of programs responding to the "next epidemic" in the Bronx: the extraordinarily high and increasing rates of diabetes and obesity, and of the common cardiovascular complications and co-morbidities. Montefiore is taking a network-wide Quality Improvement approach to organizing and improving the prevention, care and management of this disease cluster, in its primary care and school-based sites, in its specialty services and hospitals.
- Finally, Montefiore has taken a leadership position in neighborhood and community development, creating and supporting the **Mosholu Preservation Corporation** (MPC). MPC, which celebrated its 30th anniversary in 2011, is a community redevelopment corporation that has successfully rehabilitated housing stock in the depressed neighborhoods in the northwest Bronx and has also been involved in a number of economic development and community development activities.

Accountable Care Act and New York Health Insurance Marketplace

Montefiore Medical Center has taken a proactive approach to conducting outreach and education of individuals in the community that might be eligible for health insurance coverage through the New York State of Health – New York's Health Insurance Marketplace. Montefiore's planning focused on two key constituencies – external Bronx and lower Westchester Community and internal Montefiore staff.

Externally, Montefiore's strategy was to work with our partners in the community to sponsor and execute outreach and education events throughout our catchment area. To date, Montefiore has participated in or helped to sponsor 6 different educational events targeting different members of the Bronx and Lower Westchester Community specifically related to the Marketplace, with more to come. Partners have included elected officials, other providers (in particular funded Navigators in the Bronx, such as Bronx Community Health Network and Community Service Society of New York), health plans, and others. In addition, Montefiore created several resources for patients that are used throughout the institution and provided at community-based events, including:

- Printed over 2500 flyers and tri-folds on the New York State of Health, in both English and Spanish, provided at events and in physician offices and clinics for patients.
- Created a patient-facing webpage on Montefiore's internet site describing the Exchange and posting useful materials.
- Launched a series of E-Screens across all campuses which provide a snapshot of important information on the Marketplace.

- Conducted PR and press on the Exchange targeting both English and Spanish regional press outlets.

Internally, Montefiore's goals were 1) to educate associates who will have interaction with patients who may have questions; 2) to educate associates who will be a source of information for their communities. To that end, Montefiore launched a series of associated education and awareness efforts:

- Developed a seminar on the Basics of the New York State of Health.
    - This seminar has been delivered (or is scheduled to be delivered) in-person to staff across the institution at health centers, to social workers, call center employees, and other various departments upon request.
    - The presentation has been recorded in voice-over webinar format, and is about to be made available online through Montefiore's intranet site for associates.
- Montefiore Intranet Site – Montefiore created an internal webpage where information about the Exchange, Navigator and In-Person Assistance programs, free internet action sites and other important information is made available to associates.
- Internal Periodicals – Articles and information were included (or will be included) in Montefiore's internal periodicals, such as Montefiore Update, Inspired Medicine, and using Montefiore's internal networking engine, Yammer.

Finally, Montefiore expects to train over 100 associates that currently are employed as Medicaid Specialists and Financial Aid specialists to become Certified Application Counselors (CAC). In doing so, these individuals will be permitted by the State to actually help patients enroll in health coverage through the Marketplace. Montefiore has also submitted paperwork to become a CAC training site, which will be an important resource for newly hired Montefiore staff as well as other community-based organizations in the Bronx and lower Westchester that also need to have staff trained.

2012 Community Service Inventory

Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

Contents

Program name:	**Bardonia Health Day**
Description:	As part of Bardonia Health Day, Montefiore associates present Heart Healthy Education to 5 through 12 year olds on topics including exercise and heathy eating
Target population:	School-aged children
Health Target:	Nutrition and Physical Activity
Location:	Community-based
Outcomes:	Montefiore has been invited back each year for the last 10 years, feedback from school organizers and teachers has been positive.
Funding:	Montefiore

Program name:	**B'N Fit**
Description:	B'N Fit is a comprehensive weight loss program for obese teens 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.
Target population:	Youth ages 12-21 years with a BMI>95th percentile for sex and age
Health Target:	Obesity, Nutrition and Physical Activity
Location:	CHAM, Mosholu Montefiore Community Center
Outcomes:	In 2012, 95 participants enrolled in the program. Of these 46% completed the program, mean baseline weight was 101 kg, 23% lost >5% of BMI, 5% gained >5% of BMI and 72% maintained their BMI. The proportion of participants consuming 2 or more vegetables per day increased from 21% at baseline to 42 % at 9 months and the proportion consuming 2 or more fruits per day increased from 26% at baseline to 47% at baseline. The proportion of participants exercising 3 or more days in the prior two week period increased from 48% at baseline to 62% at 9 months. The proportion of participants watching 2 or more hours of TV or computer games per day was unchanged at 88% at baseline and 9 months.
Funding:	Grants; reimbursements; Montefiore; HRSA: Mosholu Montefiore Community Center; Coca Cola Foundation; Fundraising such as the Annual B'N Fit Walkathon; AstraZeneca Foundation

Program name:	**Bronx-CATCH, Collective Action to Transform Community Health**
Description:	Bronx-CATCH is a partnership between Montefiore, the New York City Department of Health and Mental Hygiene, the Bronx Community Health Network, other community based organizations and agencies and local elected officials. Recognizing that population health is a local issue, the goal is to create a series of neighborhood-specific stakeholder partnerships, extending out from different Montefiore Medical Group health center sites, to support healthy behaviors and increase health-promotion resources for patients and the local community.
Target population:	Bronx residents
Health Target:	Nutrition, Physical Activity and Tobacco Prevention
Location:	Community based, MMG sites
Outcomes:	The development of the initiative and implementation of five community based coalitions using program implementation and evaluation, engaging Montefiore, NYCDOHMH, local community government and leading community based organizations in Williamsbridge, Fordham, West Farms, Melrose and the Prospect Avenue sections of the Bronx has been the major effort of 2012.
Funding:	Montefiore

Program name:	**Office of Community Health**
Description:	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. Additionally, the Office develops effective strategies and methods to evaluate the impact of interventions on community health needs.
Target population:	Bronx Community Members; Target communities of Williamsbridge, West Farms, Fordham, Melrose & Prospect Avenue Corridor
Health Target:	Community Health, Tobacco, Nutrition, Physical Activity
Location:	Community-based
Outcomes:	The Office of Community Health continues to lead Montefiore's efforts at decreasing smoking among its associates and in the communities it serves. The Office has adjusted patients electronic medical records to include a limited Community Health Survey to assess the impact of fruit & vegetable consumption, physical activity and sugar sweetened beverage consumption in the Bronx CATCH communities. The Office continues to partner with the NYC Dept. of Health to coordinate its efforts and campaigns achieving a Bronze Star for its smoking Cessation activities and a Silver Star for its hospital food based activities.
Funding:	Montefiore and 2 small grants

Program name:	**Office of Community Relations**
Description:	By functioning as the link between the community and the medical center's resources, the Office of Community Relations develops positive collaborations with community-based organizations, government agencies and elected officials in the regions served by Montefiore.
Target population:	Bronx and lower Westchester county residents; Montefiore patients and associates
Health Target:	Community Health, Tobacco, Nutrition, Physical Activity
Location:	Moses
Outcomes:	The Office of Government Relations participated in 40 community-based events in 2012 to promote smoking cessation and cardiovascular health through exercise and nutrition and obesity, diabetes, and other health related programming
Funding:	Montefiore

Program name:	**To Your Health: Zumba Bronx**
Description:	To Your Health: Zumba Bronx provides patients and associates of Montefiore with Zumba classes at sites throughout the Bronx. Certified instructors, many of whom are also Montefiore Health Educators, teach this form of "dance-fitness" inspired by Latin music at little or no cost to participants.
Target population:	All adult patients or associates of Montefiore
Health Target:	Physical Activity
Location:	Moses, MMG
Outcomes:	1,105 Montefiore Associates and patients participated in Zumba classes in 2012
Funding:	Montefiore and participant fees

Program name:	**Women, Infants and Children (WIC) Program**
Description:	Montefiore's WIC program is the oldest in New York State, established in 1974, and serves 13,000 women, infants and children annually. WIC is a supplemental nutrition program, providing supplemental food vouchers, nutrition education, breast feeding education, peer counseling and physical fitness education. 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.
Target population:	Low income women, pregnant woman, breastfeeding women, children from birth to five years old
Health Target:	Obesity and Nutrition
Location:	Westchester Square, Fordham Plaza, and 161st Street, near CHCC
Outcomes:	The WIC program serves 13,000 participants annually. Participants, both women and children, are screened for obesity, overweight, underweight, breastfeeding rate and anemia. These measures are reported to the state as part of grant requirements.
Funding:	USDA, New York State and NYC DOHMH five year grant

Program name:	**Bronx BREATHES**
Description:	Bronx BREATHES is a tobacco cessation center that serves multiple health care organizations in the Bronx by giving providers training and resources to help their patients quit smoking.
Target population:	Smoking population in the Bronx
Health Target:	Tobacco
Location:	Einstein
Outcomes:	Bronx BREATHES provides ongoing support and technical assistance in tobacco cessation services. Bronx BREATHES has played a major role in Montefiore being the first Hospital to receive the Bronze Star Hospitals as part of the NYC Tobacco-Free Hospitals campaign. The program conducted 250 visits to health care sites and in-service trainings throughout the Bronx and provided approximately 100 smokers with Nicotine Replacement Therapy. Bronx BREATHES provided training on tobacco cessation to approximately 500 providers.
Funding:	Albert Einstein School of Medicine

DIABETES PROGRAMS

Program name: **Diabetes Club**
Description: Diabetes Club is a bimonthly support group for adults with type 2 diabetes in which patients share their experiences and discuss strategies for managing their illness.
Target population: Adults ages 18 years and older with Type 2 diabetes, their family members and friends
Health Target: Diabetes
Location: Einstein, Clinical Diabetes Center
Outcomes: The Diabetes Club served 43 adult patients in 2012 and their families.
Funding: Montefiore

Program name: **Diabetes Disease Management**
Description: Through care management services delivered telephonically, face-to-face (both one-on-one and in group settings) and through direct mail, the CMO empowers people with Type II diabetes to improve their health outcomes and quality of life.
Target population: Diabetic patients ages 18 years and older
Health Target: Diabetes
Location: CMO
Outcomes: In 2012, only 9.5% of the CMO's Medicare Diabetics had A1C values over 9% (compared with a HEDIS benchmark of 18%). Commercial and Medicaid populations were also well below the HEDIS targets. LDL control exceeds HEDIS benchmarks for all lines of business - 65.8% of Medicare patients, 61% of Medicaid and 53% of the Commercial population had LDL values under 100. This exceeds HEDIS in all 3 populations.
Funding: Risk contract

Program name: **Diabetes Management: PROMISED**
Description: A novel approach in Diabetes Education - the Proactive Managed Information System for Education in Diabetes "PROMISED" is a 10-hour interactive educational program. The program is approved and certified by the American Diabetes Association and adheres to the more recent Standards of Care and it is tailored to meet the needs of our Bronx residents. Patients are referred to PROMISED by their primary care physicians and following completion of the program they are empowered to better manage their disease. Each case is reviewed and discussed separately and the referring PCP receives a consultation letter regarding management of glycemic control, cardiovascular risk factors and comorbidities.
Target population: Adults over the age of 18 years old with type 2 diabetes with medical insurance. Patients with type 1 diabetes and pregnant woman are not eligible.
Health Target: Diabetes
Location: Moses, Einstein, Clinical Diabetes Center
Outcomes: The program identifies cardiovascular risk factors and emphasizes prevention of cardiovascular complications, the major cause of death in individuals with Type 2 Diabetes. We continue to focus on and see improvement in the main outcome measures of A1C, blood pressure and low density lipoprotein (LDL) cholesterol in accordance with the American Diabetes Association recommendations. The PROMISED program which serves the Bronx population has performed equally or better than the recent cross-sectional data provided by the National Health and Nutrition Examination Surveys (NHANES) from 2007–2010.
Funding: Montefiore and reimbursements

Program name:	**Diabetes in Pregnancy Program**
Description:	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.
Target population:	Pregnant women of all ages with pre-gestational or gestational diabetes mellitus
Health Target:	Diabetes
Location:	Medical Park, FCC, Wakefield
Outcomes:	The Diabetes in Pregnancy program provided 678 visits for pregnant women at three locations throughout Montefiore in 2012. The program assesses incidence of diabetes in pregnancy at Montefiore and associated health outcomes, works to improve healthcare and outcomes for women with diabetes in pregnancy and their babies through education, home care nursing interventions and screening of risks in family members. The program also works to provide professional education and improve community awareness.
Funding:	NYS Dept. of Health and reimbursements

HEART HEALTH PROGRAMS

Program name: **CHF Disease Management**
Description: 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.
Target population: Adult EmblemHealth members; some Health First and ACO members
Health Target: Heart Health
Location: CMO
Outcomes: The program succeeds in decreasing CHF-related admissions in a chronically ill population and in maintaining costs of care related to their heart failure.
Funding: Risk contract

Program name: **Heart Center Corporate Programs**
Description: Corporate Programs practices provide outreach services to the communities they serve including: lectures at Phelps Memorial Hospital, free blood pressure screenings and educational seminars at local nursing homes.
Target population: Residents of Bronx and Westchester
Health Target: Heart Health
Location: Bronx & Westchester community based
Outcomes: Provides community outreach and education.
Funding: Montefiore

Program name: **Heart Month**
Description: During the month of February, the Montefiore Einsten Center for Heart & Vascular Care conducts a series of educational sessions and health screenings for Montefiore associates and residents of the Bronx. The Center conducts lectures about heart health and healthy lifestyles as well as blood pressure screenings and counseling sessions at all Montefiore campuses, in senior citizen centers, local elementary schools, colleges and health centers.
Target population: Montefiore associates and residents of the Bronx
Health Target: Heart Health
Location: Community-based
Outcomes: We conducted heart health screenings at each Montefiore campus for associates. Screenings were also provided at an elementary school and senior citizen center. Lectures were given in Bronx public schools, senior centers and community centers throughout the Bronx
Funding: Montefiore

Program name: **Women's Heart Health Center**
Description: The WHHC provides screenings, appointments, monthly lectures on heart health and a weekly clinic on Tuesday afternoons to women in the Bronx. The clinic is run by two female cardiologists. Additionally, the center participates in the Yale University School of Medicine's VIRGO study, which is an NIH-funded multi-center study that examines the influence of gender on outcomes in young AMI patients.
Target population: Women under the age of 55
Health Target: Heart Health
Location: Einstein/Moses/Wakefield
Outcomes: Tracks Women's Heart Health status post miocardial infarction. In terms of research, the Center is in year four of a 10 year longitudinal study.
Funding: Reimbursements

Program name:	**CHAM Oncology Groups**
Description:	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.
Target population:	School age and adolescent cancer patients, their siblings and families
Health Target:	Cancer
Location:	CHAM
Outcomes:	Patients and families have the opportunity to meet with others coping with similar experiences, improve coping mechanisms through self-expression and socialization. The group brings in experts in mindfulness, stress reduction, art therapy, nutrition and yoga.
Funding:	Montefiore; grant

Program name:	**Eat Healthy, Shop Smart**
Description:	Eat Healthy, Shop Smart is an voucher program with an educational component that teaches cancer patients about the importance of a plant-based diet. At new patient orientation, patients are triaged for nutritional risk and offered vouchers for use at farmer's markets at both the Moses and Einstein campuses. Farmer's markets run from May to October, pending weather limitations.
Target population:	Adult patients in cancer treatment
Health Target:	Cancer
Location:	Moses, Einstein
Outcomes:	Approximately 200 patients took advantage of Farmer's Market vouchers throughout 2012.
Funding:	Montefiore

Program name:	**Mujeres Unidas (Spanish-Speaking Breast Cancer Support Group)**
Description:	Mujeres Unidas provides support, educational workshops and social events for Spanish-speaking women in different stages of breast cancer.
Target population:	Spanish-speaking breast cancer patients ages 18 years and older, from the newly diagnosed to those in active treatment
Health Target:	Cancer
Location:	Montefiore Medical Park, Montefiore-Einstein Cancer Center
Outcomes:	The women involved in the group are great advocates for change and sources of positive energy. In addition to assisting each other in becoming self-advocates, participants do a lot of active recruitment to keep the group going, which speaks to the program's success. Participants are very future-oriented, helping others in the group as they go through treatment, undergo surgery, or struggle with depression.
Funding:	Susan G. Komen Race for the Cure

Program name: **Psychosocial Oncology Program**

Description: 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.

Target population: Anyone impacted by cancer in the Bronx and Westchester

Health Target: Cancer

Location: Moses, Montefiore Medical Park, community-based

Outcomes: The program improves the quality of life for patients who are diagnosed with cancer by helping to manage the emotional impact of cancer diagnosis, treatment, survivorship and end-of-life.

Funding: Montefiore; Avon Foundation grant; Komen Greater NYC grant; Entertainment Industry Foundation-Revlon Run/Walk grant; Mt. Sinai Legacy grant

Program name: **School Re-Entry Team**

Description: 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.

Target population: Parents and school-age children with cancer or sickle cell

Health Target: Cancer

Location: CHAM

Outcomes: Every Pediatric Hematology patient's family receives training on how to ease the transition back to school for patients, including their child's legal rights upon re-entry to school, how to get social support in school and how to combat bullying. Upon request, the School Re-Entry Team will work with their child's school to improve transition, in 2012, the team worked with 10 schools. The team also conducted 7 in class presentations on behalf of patients. Feedback from patients, teachers and administrators is positive and broadens their understanding of the special needs of patients returning to school.

Funding: Montefiore

Program name: **Strength Through Laughter and Support Program**

Description: Strength through Laughter and Support is an educational program that encourages participants to develop a positive attitude as they confront the challenges associated with cancer. By sharing laughter, sadness, wisdom and love in the group setting, participants find a sense of hope that helps them face the realities of living with and beyond their illness. Groups range in size from 20 to 60 participants.

Target population: Cancer patients in and beyond treatment and their loved ones

Health Target: Cancer

Location: Montefiore Medical Park

Outcomes: Patients who completed their treatment continue to attend groups in order to support.

Funding: Montefiore

Program name: **Oral Head and Neck Screening**
Description: Annual screening event for oral, head and neck cancer is held every April at the Montefiore Einstein Center for Cancer Care.
Target population: Open to all ages
Health Target: Cancer
Location: Montefiore Einstein Center for Cancer Care
Outcomes: In 2012, approximately 10-20 participants were screened.
Funding: Montefiore

Program name: **Melanoma Screening**
Description: Annual screening event for melanoma is held every May at the Montefiore Einstein Center for Cancer Care.
Target population: Open to all ages
Health Target: Cancer
Location: Montefiore Einstein Center for Cancer Care
Outcomes:
Funding: Montefiore

Program name: **Prostate Cancer Screening**
Description: Montefiore Medical Center in partnership with the Daily News offers free PSA blood tests for men age 40 and over. The event runs for 4 days in June at various Montefiore sites.
Target population: Men 40 years and older
Health Target: Cancer
Location: MMP MECCC Wakefield, Moses
Outcomes: 485 participants were seen at the various Montefiore sites
Funding: Montefiore; grant

Program name: **Breast and Cervical Screening Event**
Description: Screening event provides breast exams and pap smears for women 18 years and older. Mammograms for women 40 years and older. In addition, womens health education and information is provided.
Target population: Women 18 years and older
Health Target: Cancer
Location: Wakefield
Outcomes: In 2012, 41 mammograms and 39 pap smears were provided as part of the event.
Funding: Montefiore; grant

Program name:	**Colorectal Cancer Patient Navigation Program**
Description:	The Colorectal Cancer Patient Navigator Program provides a bridge between the community and health care. The program brings together interdisciplinary teams to reduce colorectal cancer rates by assessing, educating, scheduling, and guiding our patients through the screening process. The aim is to eliminate barriers and build relationships in an effort to increase the screening completion rates and decrease no-show and cancellation rates.
Target population:	Eligible patients; adults ages 50 years and older, 45 years and older if of African American decent, or 10 years before a first degree relative was diagnosed with colorectal cancer
Health Target:	Cancer
Location:	Moses
Outcomes:	The program has succeeded in eliminating barriers and building relationships in effort to increase the screening completion rates and decrease no-show and cancellation rates. In 2012, the program was able to assess, schedule, and navigate over 3,000 patients within Montefiore.
Funding:	NYC Dept. of Health

Program name: **The J.E. and Z.B. Butler Child Advocacy Center**

Description: The Child Advocacy Center (CAC), established in 1984, is the only medically based, fully accredited child advocacy center in NYC. The CAC provides emergency medical care and psychosocial evaluations and therapy to children who have 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 conduct outreach and research.

Target population: Children ages 0-18 years

Health Target: Child Health

Location: Moses Campus and community based

Outcomes: Since its inception, the CAC has evaluated over 30,000 children who have been victims of child sexual and physical abuse. The mission of the CAC is to reduce trauma and maximize safety for children and families and to improve the prosecution rate for offenders.

Funding: Federal and State funding, private donations, and 3rd party payments

Program name: **Phoebe H. Stein Child Life Program**

Description: The Child Life Program minimizes the stress of hospital and outpatient visits for pediatric patients and their families through educational and supportive services. In all areas of the hospital, Child Life Specialists help children understand and prepare for their medical experiences. Specialists accompany children to the operating room or to other procedures, teach parents to help their children cooperate with medical treatment and encourage normal growth and development.

Target population: Children, adolescent and young adult patients ages 0-21

Health Target: Child Health

Location: CHAM, Einstein

Outcomes: In 2012, a new position was created for the radiology department. Feedback from clinical staff in that area confirms that the presence of child life services to support patients during radiological procedures has improved outcomes and throughput. Less patients require sedation, images are improved for diagnostic use, and less staffing is needed to gain compliance during interventions. Research opportunities are being developed to study these observations.

Funding: Montefiore; grants

Program name: **Suzanne Pincus Family Learning Place (FLP)**

Description: 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 staff 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.

Target population: Adults, children, families, staff and community members

Health Target: Child Health

Location: CHAM, Family Care Center

Outcomes: The program promotes improved health literacy, empowerment and decreased parent/caregiver alienation by providing parent-to-parent networking opportunities and family support events. The program has experienced an upward trend, serving more people every year.

Funding: Montefiore

Program name:	**Healing Arts**
Description:	The Healing Arts at Montefiore is a network of programs that uses the arts, creative arts therapies, integrative medicine, and other healing approaches to enhance the quality of life, health and well-being of Montefiore's patients, associates and community. Healing Arts programs are available in the Children's Hospital, Oncology, Palliative Care, Rehabilitation Medicine, Psychiatry, and other departments to complement patient care by helping to reduce pain and other physical symptoms, provide comfort and enjoyment, promote self-expression, and enhance quality of life.
Target population:	Patients and associates of Montefiore
Health Target:	Child Health, Cancer, Palliative Care, Rehabilitation Medicine, Psychiatry
Location:	Moses, Einstein, Wakefield
Outcomes:	Studies show that activities such as painting, writing, storytelling, and playing and listening to music can help relieve stress, reduce pain, enhance quality of life, promote self-expression, and even improve patient satisfaction and outcomes.
Funding:	Montefiore

Program name:	**Healthy Living with Chronic Conditions**
Description:	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.
Target population:	Any patient with a chronic health condition
Health Target:	Chronic Conditions
Location:	MMG sites
Outcomes:	Research indicates that workshops reduce health care expenditures, lead to more appropriate utilization of health care resources and produce measureable improvements in patient outcomes and quality of life across different disease and patient populations.
Funding:	EmblemHealth and Montefiore

Program name:	**Hepatitis C Support Group**
Description:	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.
Target population:	Adults age 18 and older with Hepatitis C at any stage of treatment
Health Target:	Chronic Conditions
Location:	Moses
Outcomes:	A total of approximately 40-50 patients have attended at least one group. A core group of approximately 10-15 patients attend regularly.
Funding:	Montefiore

Program name:	**LINCS Program at CHAM**
Description:	LINCS is a medical home that provides comprehensive primary care and care coordination in outpatient, inpatient and home care settings to children 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.
Target population:	Children ages 0-21 years in the Bronx
Health Target:	Chronic Conditions
Location:	CHAM
Outcomes:	Of the 250-300 patients served in 2010 and 2011: 6 died, all expectedly, 1 at home; 63 were technology dependent (GT, trach, vent, or IV at home, CNS shunts excluded); the program continues to care for 8 patients whose siblings passed away from 2004-2012 and 7 siblings of children with active palliative care needs
Funding:	Montefiore

Program name:	**Ostomy Support Group**
Description:	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 when members need one-on-one counseling.
Target population:	Adults ages 18 years and older who have had any kind of ostomy diversion
Health Target:	Chronic Conditions
Location:	Medical Park
Outcomes:	In 2012, the Ostomy Support Group aided 64 patients as they acclimated to use of ostomy diversion.
Funding:	Montefiore

Program name:	**Wound Healing Program**
Description:	The Wound Healing Program provides inpatient, outpatient, nursing home and home visiting wound healing services. The program focuses on building innovative, patient-centered health services delivery systems that work for wound patients in order to provide excellence in care and to improve wound healing outcomes in the Bronx.
Target population:	Patients of all ages with chronic wounds, especially the frail, disabled, elderly or people with complex, chronic diseases
Health Target:	Chronic Conditions
Location:	Moses, CHAM, Wakefield, MMG, community-based
Outcomes:	Increased rate and speed of wound healing; reduction of diabetic amputations; reduction in severe complications and/or progression of pressure ulcers; reduction in hospital-acquired pressure ulcers; improved access for disabled patients
Funding:	Reimbursements

Program name: **Communilife Montefiore Temporary Respite Program**

Description: The program provides temporary community-based supportive housing for Montefiore inpatients who do not have a suitable living arrangement and do not need to be hospitalized. Patients who are discharged into the program facility receive case management, medication management, care coordination, entitlement services and the support they need to find suitable permanent housing.

Target population: Unstably housed Montefiore patients who are often too sick to live in the shelter system but well enough to recover in a respite situation

Health Target: Community Health

Location: Community-based

Outcomes: The Communilife Respite program aided 11 people during 2012, age range 23-74. The length of stay for those discharged ranged from 3 to 166 days. Of those in the program, 2 patients were placed in nursing homes, 2 remain in respite, 2 with family, 3 with friends, 1 assisted living, and 1 self-discharged. In addition to placing patients in more appropriate care settings, longer inappropriate hospital stays and unncessary readmissions are avoided and availability of beds is improved.

Funding: Montefiore

Program name: **Mosholu Preservation Corporation (MPC)**

Description: 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.

Target population: Bronx residents

Health Target: Community Health

Location: Community-based

Outcomes: MPC manages the Jerome Gunhill Business Improvement District, comprised of 250 small businesses. The Corporation also publishes a free community newspaper, the Norwood News. MPC works with the New York City Parks Department to improve green spaces in the Bronx, conducts graffiti removal initiatives and provides 170 units of affordable housing to residents of the Norwood community. In addition, MPC conducts economic and community development initiatives in several business districts in the north Bronx.

Funding: Income from MPC's real estate portfolio; federal, state, and local grants and contracts

Program name: **Patient and Community Education**

Description: Patient and community educatio is part of the Department of Community & Population Health, which manages the population health initiatives and responds to community requests for involvement by Montefiore. This includes the development of initiatives to address important chronic disease health indicators with inter-organizational partners. The department also provides associate support for health fairs, health screenings, workshops, seminars and other events to the Bronx and lower Westchester County.

Target population: All populations in Bronx and Lower Westchester

Health Target: Community Health

Location: Wakefield and Moses Campuses

Outcomes: Community & Population Health arranged for 13,977 individual visits in the clinical setting. The team participated in 161 events external to the clinical setting with an estimated impact of 14,000 community touches and 1,062 screenings performed.

Funding: Montefiore

Program name: **Adolescent AIDS Program**
Description: The Adolescent AIDS Program (AAP) provides comprehensive care, risk reduction services and HIV counseling to HIV-positive adolescents. The program also offers rapid and simple HIV testing and counseling to at-risk youth throughout the Bronx, especially in areas of high seroprevalence.
Target population: Adolescents and young adults ages 13-24 years
Health Target: HIV/AIDS
Location: Moses
Outcomes: In 2012 there were 48 new enrollments of HIV-infected patients into care at AAP. As of 2012, the AAP has provided care to 573 HIV-infected youth since its foundation. For the second straight year in 2012 the AAP provided HIV counseling and testing to more than 1,000 youth through the program outreach efforts and identified 5 new HIV-positive youth. Four of them engaged in care upon diagnosis.
Funding: Grants from CDC, NYS DOH, NIH, HRSA and Gilead Sciences

Program name: **AIDS Center**
Description: As a New York State Dept. of Health-designated AIDS Center, Montefiore provides a broad array of inpatient and outpatient services to adults 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.
Target population: HIV positive adults ages 22 years and older
Health Target: HIV/AIDS
Location: Moses
Outcomes: The program exceeded its 2012 targets by testing almost 10,000 persons in the Montefiore system (9,664). Sixty-five persons were identified with HIV infection and linked to care.
Funding: Federal, state and city grants; reimbursements; Montefiore

Program name: **Centers Implementing Clinical Excellence & Restoring Opportunity (CICERO)**
Description: 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.
Target population: HIV-positive adults ages 18 years and older
Health Target: HIV/AIDS
Location: MMG 2
Outcomes: 84% of patients are on antiretroviral medications and of those 79% have undetectable viral loads.
Funding: Federal grants; Medicaid reimbursements

Program name: **Project BRAVO (Bronx AIDS Volunteer Organization)**
Description: Project BRAVO is a hospital-based volunteer program managed by the AIDS Center that provides support to HIV and AIDS patients. Volunteers provide friendly visits to hospitalized patients and staff the BRAVO food pantry. Volunteers help with preparation, set up, distribution and storage of food and pantry bags as well as conduct record keeping and filing.
Target population: HIV-positive adults ages 18 years and older living in the Bronx
Health Target: HIV/AIDS
Location: Community-based
Outcomes: In 2012, the program provided 4,552 pantry bags to households, feeding approximately 14,508 family members. Since the program's inception in 1986, BRAVO has recruited, assigned and supervised over 500 volunteers.
Funding: Grants: HPNAP Operational Support/Food, TEFAP, EFSP

Program name:	**Project HEAL**
Description:	Project HEAL is a drop-in center intended to prevent HIV infection among women in the Bronx. Services include supportive counseling, crisis intervention, individual and group-based activities, HIV testing and referrals to medical care and other social services. The project helps women develop the skills needed to reduce high-risk behaviors that may lead to HIV infection.
Target population:	Women ages 18 years and older in the Bronx
Health Target:	HIV/AIDS
Location:	Community-based
Outcomes:	Project HEAL provided 287 scheduled and drop in visits for clients in 2012. Of those patients served, 96% have remained HIV-negative. 90% of women joined Project HEAL as a direct result of community outreach. 90% of women who enroll choose to be tested for HIV immediately.
Funding:	Grants from the NYC Dept. of Health AIDS Institute; Montefiore

Program name: **Indochinese Mental Health Program**

Description: The Indochinese Mental Health clinic provides outpatient mental health services to the Bronx Southeast Asian community. The program is a collaborative effort between the Dept. of Psychiatry and the Dept. Family Medicine and is designed according to recommendations from the Harvard Program in Refugee Trauma. Staff also coordinate patients' care with clinic physicians and link them to community resources.

Target population: Southeast Asian community in the Bronx, especially Cambodian and Vietnamese refugees

Health Target: Mental and Behavioral Health

Location: FHC

Outcomes: The part-time clinic program integrates a social worker, family health worker and psychiatrist to work with patients and families to stabilize mental health issues and develop individual mental health goals. For Thai patients, the family health work speaks Khmer while the Montefiore language line is used for Vietnamese patients. In 2012, the program served 75 patients, while an additional 10 Cambodian patients were seen for case management.

Funding: Reimbursement and Montefiore

Program name: **Adolescent Depression and Suicide Program**

Description: 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 who present with symptoms of depression, suicidal behaviors and non-suicidal self-injurious behaviors. Many patients also struggle with school, family and drug problems. The program runs lectures and workshops for school personnel, students and community members.

Target population: Youth ages 12-18 years

Health Target: Mental and Behavioral Health

Location: Moses

Outcomes: The Adolescent DBT Program reduces suicidal and non-suicidal self-injurious behaviors in addition to emergency room and inpatient hospitalizations, depression, substance use, anxiety, borderline personality disorder symptoms, and increases emotional and behavioral control, improved school engagement, social and global adjustment, and better outpatient retention. Moreover, adolescents who participate in our Coping with Depression Course for Adolescents have reported improvement in their mood, behavior and relationships.

Funding: Reimbursements; Einstein Young Investigator Award; donations

Program name: **Children's Evaluation and Rehabilitation Center (CERC)**

Description: CERC, the clinical arm of the Rose F. Kennedy University Center for Excellence in Developmental Disabilities, offers 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.

Target population: Any person who has intellectual or other disabilities.

Health Target: Mental and Behavioral Health

Location: Einstein

Outcomes: The Center's goal is to improve the quality of life for individuals with disabilities and their families. Each year, through 55,000 visits, CERC cares for approximately 7,500 individuals and their families.

Funding: US DHHS grant, HRSA Grant

Program name: **Comprehensive Services Model, CSM**

Description: CSM is a Welfare-to-Work program for public assistance clients with substance use disorders. CSM evaluates all clients and then offers case management 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.

Target population: Adult substance abusers in the Bronx who receive public assistance

Health Target: Mental and Behavioral Health

Location: Wakefield Campus

Outcomes: In 2012, CSM evaluated over 2,000 public assistance clients: 375 participants obtained competitive employment, 60% of whom remained employed for more than 6 months and another 20% of whom did not return to public assistance. An additional 75 clients received federal disability benefits. Over 1,000 CSM clients attended substance abuse treatment for 3 months or more, half of whom remained in treatment for more than 6 months.

Funding: Contract with the NYC Human Resources Administration

Program name: **Healthy Steps**

Description: 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.

Target population: Infants and toddlers up to age 3 years and their parents

Health Target: Mental and Behavioral Health

Location: FCC, CFCC

Outcomes: For 2012, 300 children were screened along with 100 mothers per month. Approximately 500 families were enrolled in the intensive services part of the program. 40 residents and medical students were educated in Healthy Steps curriculum.

Funding: Grants

Program name: **Managed Addiction Treatment Services, MATS**

Description: MATS is a clinical care coordination program for substance abusers, which since August 2012 has been fully incorporated into the Bronx Accountable Healthcare Network (BAHN), the Montefiore-led, NYSDOH designated Health Home. Through clinical case management, MATS helps clients stabilize in substance abuse treatment, access other medical, behavioral health, and social services, reduce inpatient admissions and ED visits, and enhance overall health and wellness by assisting clients with engagement and adherence to outpatient clinical services.

Target population: Adult Medicaid beneficiaries residing in the Bronx with multiple, chronic medical, behavioral health, and/or chemical dependency problems.

Health Target: Mental and Behavioral Health

Location: Community-based

Outcomes: In previous years, 30 participants per year have obtained competitive employment; 85-90% of participants remain in substance abuse treatment at 30, 90 and 180 days; and the program realized Medicaid cost savings of 56% on average for total enrollment, which represents 5 times the program budget. Outcome metrics under the DOH Health Home are still in development.

Funding: Medicaid

Program name: **Substance Abuse Treatment Program, Methadone Program**
Description: The SATP consists of two opioid treatment programs for opioid-dependent adults. Both sites provide integrated primary, mental health, HIV and substance abuse care.
Target population: Adults ages 18 years and older
Health Target: Mental and Behavioral Health
Location: Moses
Outcomes: Retention in care continuously exceeds the State's targets. One year retention in care is 75% program-wide, whereas the State target is 55% retention. Additionally, 75-80% of patients who obtained care for at least 3 months discontinued their opiate use, exceeding our program target of 70% abstinence.
Funding: Reimbursements; Grant Funding; NYS Office of Alcohol and Substance Abuse Services

Program name: **Medical Stabilization Unit - Detox Programs**
Description: The MSU is a 10 bed inpatient unit for the treatment of acute withdrawal symptoms from drug and/or alcohol dependency. Most patients have comorbid psychiatric disorders or complicated medical diseases exacerbated by substance use.
Target population: Adults ages 18 years and older
Health Target: Mental and Behavioral Health
Location: Wakefield
Outcomes: 75% of patients complete detoxification protocols and are referred for aftercare.
Funding: Reimbursements

Program name: **New Directions Recovery Center and Chemical Dependency Program - Medically Supervised Outpatient**
Description: 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.
Target population: Adults ages 18 years and older
Health Target: Mental and Behavioral Health
Location: Moses and Wakefield
Outcomes: 57-71% of all patients discharged from the program have discontinued all substance use. 37-54% of patients discharged from the program have either maintained their full time employment status or improved their employment status.
Funding: Reimbursements; Grant Funding; NYS Office of Alcohol and Substance Abuse Services

Program name:	**Supporting Healthy Relationships**
Description:	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.
Target population:	Low-income Bronx couples with one or more children (or couples expecting a child)
Health Target:	Mental and Behavioral Health
Location:	Community-based
Outcomes:	SHR has engaged 1460 couples. Over 75% of participating couples completed the core 24-hour relationship education series. Participants agreed that the curriculum led to improvements in their relationships: in communication (95%) and their overall relationships with their spouses (93%).
Funding:	Contract with the US Dept. of Health & Human Services

Program name:	**Caregiver Support Program**
Description:	The Caregiver Support Program 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.
Target population:	Patient caregivers and clinical staff
Health Target:	Mental and Behavioral Health
Location:	Moses
Outcomes:	Since opening in April 2011, the Caregiver Program has provided support and assistance to 1,500 caregivers. Staff and volunteers work to address the emotional and physical toll of being a caregiver as well as connect caregivers to resources within Montefiore. 15 dedicated volunteers, all retired professionals, have worked for the program since the start of services.
Funding:	Montefiore; donations

Program name:	**Integrated Medicine and Palliative Care Team (IMPACT)**
Description:	IMPACT is an interdisciplinary service that provides integrative palliative care to for pediatric patients facing life threatening or life limiting disease, and their care givers. Services include palliative and end-of-life care, pain management, mental health services, acupuncture, essential oil therapy, reiki, yoga, massage, healing touch, nutrition and supplements, cooking classes, herbal medicine and homeopathy, among others. The team educates students and staff on palliative care and conducts research to measure the effectiveness of its interventions.
Target population:	Pediatric patients and caregivers seen at CHAM (in or outpatient) identified as having palliative care needs and others by special request
Health Target:	Palliative Care
Location:	CHAM
Outcomes:	IMPACT published a study showing that yoga can decrease pain and anxiety in patients with cancer and sickle cell anemia and is planning publication of work illustrating the problem of staff burnout in pediatric oncology. Our internal data shows an increase of expected deaths in the home with hospice and a decrease in in expected cancer related deaths in PICU. This relates directly to children spending more time at home in their last months than in the hospital under the care of IMPACT and community based home care or hospice.
Funding:	NIH grant; ACIR grant; private philanthropy; reimbursements; Montefiore

Program name:	**Geriatric Ambulatory Practice**
Description:	The Geriatric Ambulatory Practice provides comprehensive primary care to very frail patients.
Target population:	Adults ages 65 years and older from the Bronx and lower Westchester
Health Target:	Primary and Preventive Care
Location:	MMG
Outcomes:	The practice focuses on medical and functional assessment for patients and offers consultation visits for primary care physicians who are having difficulty caring for dementia, frequent falls, osteoporosis, elder abuse and multiple chronic conditions that impact the elderly. The practice also serves as a training site for geriatric fellows, medical residents and medical students.
Funding:	Grants and reimbursements

Program name:	**Lead Poisoning Prevention Program**
Description:	A designated NYS Resource Center for Lead Poisoning Prevention, the LPPP consists of a multidisciplinary team in medicine, research, social services, environmental investigation, and public advocacy. It serves as a referral center for the medical management of lead poisoning, links families to safe housing during home abatement procedures, provides bilingual educational workshops, advocates for lead poisoned children during local and state legislative reviews and collaborates with city and private agencies in environmental intervention.
Target population:	Children and pregnant women with elevated blood-lead levels
Health Target:	Primary and Preventive Care
Location:	CHAM, community based
Outcomes:	In 2012 the LPPP conducted weekly clinics for the treatment and management of Lead Poisoning with visits numbering 649, provided in-hospital chelation for 6 patients with high lead level (plus 5 out-patient cases) and consulted on 16 hospitalizations in the NYS region for which the LPPP is a NYS Regional Resource Center. The program also ran 50,000 lead tests in the Montefiore in-house lead lab, cared for 47 children and 29 adults in the residential Lead Safe House and offered 241 lead poisoning prevention outreach events in high-risk communities, reaching 2,500 families. Additionally, the LPPP provided 523 consultations to medical providers and 504 to local DOHs.
Funding:	NYS Dept. of Health; reimbursements; Montefiore

Program name: **Medical House Calls Program**

Description: Through medical home visits, the CMO helps chronically ill, at-risk geriatric and adult patients who have a history of multiple inpatient admissions and are homebound. A team of primary care physicians provide medical care. The program is also supported by social workers, outreach specialists and nurses who collaborate to address a variety of psychosocial concerns affecting the patients medical condition. The program has the capacity to care for 750 patients.

Target population: Chronically ill, at-risk homebound adults and older adults

Health Target: Primary and Preventive Care

Location: MMG - Fordham

Outcomes: An abstract/poster submitted to the American Geriatric Society in December 2012 covered a sample of 143 patients with diabetes enrolled in the House Call program for which admissions declined by 19% from year 1 to year 2 in the program; emergency room visits declined by 10% from year 1 to year 2; and the average costs per patient per year were reduced from $26,750 in year 1 to $25,436 in year 2, a 5% reduction (p = .009). For the past two years the program has maintained an overall program rating of "Good" or "Very Good" by over 90% of respondents to its patient/caregiver satisfaction survey. Our social work score increased from 88% in 2011 to 89% in 2012.

Funding: Montefiore Home Care Agency, Visiting Nurse Service of NY and other home care and hospice agencies. Community service providers to homebound patients.

Program name: **Mobile Dental Van**

Description: 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.

Target population: Children in the Bronx

Health Target: Primary and Preventive Care

Location: MMG, community-based

Outcomes: The Mobile Dental Van has increased oral health awareness among children in the Bronx and improved their oral health outcomes using sealants, cleanings and fluoride treatment.

Funding: Reimbursements, grants

Program name: **Montefiore School Health Program**

Description: 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.

Target population: Children from K-12 who go to school in the Bronx

Health Target: Primary and Preventive Care

Location: Community-based

Outcomes: MSHP has more than 29,000 children registered at 20 sites throughout the Bronx, including 5 elementary schools, 3 elementary/middle schools, 2 middle schools, 3 middle/high schools and 7 high schools. Among the program's achievements in 2012, it saw a 50% reduction in hospitalizations and ER visits related to asthma, reduced consumption by 4.6 billion calories and 422 grams of fat per year in NYC schools, had 50% of students receiving mental health services successfully complete their recommended treatment plans, achieve 50% reduction in positive pregnancy test rates over the last five years and ensure that 100% of 3rd graders received sealant on eligible molars, compared to 13% in the Bronx.

Funding: Montefiore, Reimbursements, Grants - NYS Office of Mental Health, NYS DOH, HCRA

Program name: **New York Children's Health Project (NYCHP)**

Description: NYCHP delivers critically needed health care services to homeless families and street-involved youth at 13 sites across New York City. The families served are 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 psychosocial needs of homeless children, adolescents and adults.

Target population: Homeless children and families; street-involved youth

Health Target: Primary and Preventive Care

Location: Community-based

Outcomes: In 2012, 80% of homeless children were fully immunized by age 2. 26% of homeless women ages 24-64 years had received a pap test within the 3 year period. 56% of homeless children had a BMI percentile documented and counseling for nutrition/physical activity by NYCHP. 71% of adults had a BMI and follow-up plan, if over/under weight. 96% of adults were queried for tobacco use, while 97% of tobacco users were advised to quit. 93% of persistent asthmatics were prescribed acceptable therapy. 62% of hypertensive patients had controlled blood pressure. 36% of diabetics exhibited poor glucose control (HbA1C > 9) , while 32% exhibited good glucose control (HbA1C < 7).

Funding: Federal FQHC funding, patient revenue, Children's Health Fund; Montefiore

Program name:	**South Bronx Health Center for Children and Families (SBHCCF)**
Description:	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. 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. SBHC is recognized by the National Committee for Quality Assurance (NCQA) as a Physician Practice Connections® – Patient-Centered Medical Home™ (PPC-PCMH) Program at Level 3 Recognition, the highest level available. SBHC maintains an active Community Advisory Board (CAB) comprised of public housing residents and representatives of the South Bronx community (from tenant associations, schools, community based organizations, etc.).
Target population:	Any Bronx resident from infants to the elderly; focus on low-income and public housing residents
Health Target:	Primary and Preventive Care
Location:	Community-based
Outcomes:	In 2012, 97% of children were fully immunized by age 2. 86% of women ages 24-64 years had received a pap test within the 3 year period. 71% of children had a BMI percentile documented and counseling for nutrition/ physical activity. 71% of adults had a BMI and follow-up plan, if over/under weight. 100% of adults were queried for tobacco use, while 99% of tobacco users were advised to quit. 96% of persistent asthmatics were prescribed acceptable therapy. 70% of hypertensive patients had controlled blood pressure. Only 23% of diabetics exhibited poor glucose control (HbA1C > 9), while an impressive 46% exhibited good glucose control (HbA1C < 7).
Funding:	Federally funded as FQHC; patient revenue; Children's Health Fund; Montefiore

Program name: **Centering Pregnancy**

Description: 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.

Target population: Any pregnant woman in the Bronx

Health Target: Reproductive Health

Location: MMG - FHC and SBHCCF

Outcomes: Montefiore was the first organization in NYC to adopt the Centering Pregnancy model. Data from the national program indicate that Centering Pregnancy improves pregnancy outcomes. Groups of 7-10 women are started every 1-2 months.

Funding: Montefiore

Program name: **DOH Infertility Demonstration Project**

Description: The Infertility Demonstration Project is a statewide campaign that helps couples 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.

Target population: Individuals ages 21-44 years old; couples must be married or in serious relationships; commercial insurance is required

Health Target: Reproductive Health

Location: Institute for Reproductive Medicine and Health

Outcomes: Since its inception in 2003, the program has seen 272 participants and 113 live births, with 6 patients in 2012.

Funding: NYS Dept. of Health

Program name: **Regional Perinatal Center**

Description: As a NYS Dept. of Health designated Regional Perinatal Center, one of 18 in the state, Montefiore is a critical referral source for specialized clinical care in high risk obstetrics and neonatology. Montefiore participates in ongoing education, evaluation, data collection and quality improvement efforts with other certified hospitals and affiliates.

Target population: Pregnant women and their babies in the Bronx and lower Westchester County

Health Target: Reproductive Health

Location: Einstein and Wakefield

Outcomes: Montefiore's RPC received 46 newborn transports, 17 maternal and maternal-fetal transfers from NYS hospitals, conducted 15 on-site comprehensive perinatal quality assurance/quality improvement site visits with affiliates 5 of which resulted in quality of care improvement recommendation or action, held 2 conferences, and gave 5 educational presentations not including 13 pediatric grand rounds and 16 obstetrics grand rounds.

Funding: NYS Dept. of Health; Montefiore

Program name: **Pregnancy Prevention Program in School Health**

Description: 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. Includes Reducing the Risk curriculum targeted at ninth grade students to decrease rates of unplanned teen pregnancy and STI transmission and increase graduation rates.

Target population: High school students at specific School Based Health Center sites in Bronx

Health Target: Reproductive Health

Location: Community Based at Bronx high school campuses

Outcomes: From 2005 to 2009, the Pregnancy Prevention Program succeeded in increasing pregnancy tests at its Walton High School site from 350 to 475 per year (50% increase) and decreasing positive pregnancy test results from 40 to 27 per year (33% decrease). The same results were produced at Roosevelt High School over a two year period from 2010 to 2011 with positive pregnancy tests going from 30 to 14% based on 1,328 tests done in 2010 and 1,614 tests done in 2011.

Funding: Montefiore; Reimbursements; Grants - NYC Dept. of Health and Mental Hygiene; NYS DOH; HCRA; HRSA - BPHC

Program name: **HPV Vaccine Clinic**

Description: The HPV Vaccine clinic is a stand-alone clinic open to the Montefiore community and local medical providers. It offers vaccines, education and counseling to women ages 19-26 in an effort to reduce the spread of sexually-transmitted HPV infection and the onset of cervical cancer. Before the creation of the program, many OB/GYN clinics, and providers of women's health in 19-26 year olds in the community had stopped providing the vaccine to women in this age bracket due to insufficient Medicaid coverage and low reimbursement. The clinic also seeks to correct billing issues and allow for vaccines to be provided through sponsored programs to low income women in order to make vaccine administration cost effective. This site also offers participation in ongoing research projects as well.

Target population: Women ages 19-26

Health Target: Reproductive Health

Location: Montefiore-Einstein Institute for Women's Health

Outcomes: The clinic has a 90% compliance rate for completion of the full three-dose series of the vaccine. Comparatively, the CDC reports that 60% of patients stop treatment after receiving the first dose of the vaccine.

Funding: Private donation; reimbursements; Montefiore

Program name: **CFCC'S Breastfeeding Support**

Description: 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 are referred to a board certified pediatrician who is also a board certified lactation consultant, who provides individual consults and runs a weekly breastfeeding group clinic. The program's goal is to improve breastfeeding rates in the hospital and clinic settings and to help Montefiore become recognized as a "baby-friendly hospital" by the WHO. Individual consults are available 3 mornings per week and the breastfeeding group clinic meets on Thursday afternoons. Annual lectures are given to pediatric residents and other staff.

Target population: Expectant and new mothers of any age and their nursing infants ages 0-2 years or older.

Health Target: Reproductive Health and Well Child Care

Location: CFCC

Outcomes: Informal data collected indicate that mothers who attend individual and/or group sessions continue breastfeeding for longer than they would have if they had not received this support.

Funding: Breastfeeding Committee of Montefiore; Montefiore WIC.

RESPIRATORY HEALTH PROGRAM

Program name:	**Respiratory Disease Management**
Description:	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.
Target population:	Children and adult Emblem members with asthma and COPD; community education sessions are open to Montefiore community
Health Target:	Respiratory Health
Location:	CMO
Outcomes:	The program was successful at lowering Emergency Department visits, health costs, admission and ED visit rates. Asthma patients in the Respiratory program (>6 months) showed a lower ED visits/1000 (958.8) than those who were not in the program (1,312.6); 2012 COPD patients in the Respiratory Program (>6 months) costs ($19,461 PMPY)less than the members who were not in the program ($24,957 PMPY); lower IP admission/1000 rates (801.6 vs 1086.3), as well as ED visits rates (493.5 vs. 796.1)
Funding:	Risk contract

SOCIAL SERVICES PROGRAM

Program name:	**Information and Referral Service**
Description:	The Information and Referral Service connects users to vital social services and resources in the Bronx. It is comprised of a walk-in/call-in site for patients, a consultation service for Montefiore staff and an internal resource manual written for social workers. The walk-in site is open to any person in need of help with entitlements, especially the chronically ill, elderly, young mothers and the very poor.
Target population:	All patients
Health Target:	Social Services
Location:	Moses
Outcomes:	Since 1991, the I & R's resource manual - the Montefiore Manual for Human Service Advocates - has been updated regularly and since 2007, it has been available on the Montefiore Intranet. In 2001, the program received the Suzanne Pincus award for outstanding service to women in need. The main three services requested are housing, food and medical insurance.
Funding:	Montefiore; grants

Program name: **Adherence Intervention for Pediatric Renal Transplant**

Description: Adherence Intervention for Pediatric Renal Transplant aims to support adolescents 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.

Target population: Adolescents ages 14-21 awaiting transplant

Health Target: Transplant

Location: CHAM

Outcomes: All participants achieved improved adherence to their medical care and most have been successfully transplanted. Participants also report decreased levels of depression. The program published an abstract in the April 2012 American Journal of Kidney Diseases.

Funding: Montefiore

Program name: **Dialysis Outreach**

Description: Dialysis outreach seeks to strengthen communication between Montefiore's transplant program and community physicians, 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.

Target population: Montefiore patients, their families, community members, and providers

Health Target: Transplant

Location: Moses

Outcomes: Routine visits to 20 dialysis units throughout the year. Established a hub at 970 North Broadway in Yonkers for monthly outreach to evaluate patients. As a result, more patients have access to transplant services. By bringing educational materials and providing support to patients, the dialysis outreach program expands treatment options for individual patients, who may be reluctant about transplant.

Funding: Montefiore

Program name: **Liver Transplant Support Group**

Description: 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.

Target population: Adult patients ages 18 years and older and their families who are on the waiting list for liver transplant or have received a liver transplant

Health Target: Transplant

Location: Moses

Outcomes: Due to positive verbal feedback from patients, the support group will continue to hold monthly meetings.

Funding: Montefiore

Program name: **Organ/Tissue Donor Program**

Description: The Organ/Tissue Donor Program raises awareness about organ/tissue donation and transplantation within the Montefiore and Bronx communities.

Target population: Montefiore patients, associates and Bronx residents

Health Target: Transplant

Location: Moses

Outcomes: In 2012, Montefiore recovered organs from 11 donors – 9 at the Moses Campus, 2 at Wakefield and 2 at Weiler – an additional 2 consented donors were evaluated and medically ruled out. From these, 15 kidneys, 10 livers, 2 hearts, 1 intestine and 1 pancreas were recovered and transplanted. Tissue, including bone, corneas, skin and heart valves, were recovered from 8 tissue donors. In addition, the program held or attended 53 community events, including health fairs, college campus fairs and information fairs at houses of worship. In 2012, 33 hospital education sessions were held plus 3 major National Organ Donor Awareness days: April Donate Life, National Minority Donor Awareness Day and Donor Sabbath Day in November. The National Minority Organ Donor Awareness Day was held in May 2012 on the West Gardens with over 120 associates in attendance. Lastly, over 950 new associates attending New Associate Orientation were in service with the organ donation message and encouraged to sign onto the New York State Donate Life Registry.

Funding: Montefiore

Program name: **Parent-to-Parent Support Group for Heart Transplants**

Description: Educational forum for pre and post transplant patients. The pre transplant patients get to know the transplant team and learn how to remain an active transplant candidate. The post transplant patients learn about post transplant issues. The group provides the opportunity for patients to share stories, information, get advice, and receive emotional and spiritual support outside the family structure.

Target population: Montefiore patients, 21-75 years of age

Health Target: Transplant

Location: Moses

Outcomes: Program evaluations are overwhelmingly positive with patients requesting more than one support group meeting a month. Our program interventions have increased patient compliance with tests and procedures, calls to transplant coordinators and donor coordinator, social workers, financial advisor and registered dietitian. Patient satisfaction has increased as well as the demand for more interaction with the transplant team.

Funding: Montefiore

Program name: **Renal Disease Young Adult Group**

Description: The program runs a support group for young adults ages 18-30 years who are diagnosed with End Stage Renal Disease. The support group afford participants the opportunity to share their emotions and concerns with each other and with professional staff.

Target population: Young adults 18-30 years of age

Health Target: Transplant

Location: Moses

Outcomes: Program was held 4 times, with attendance varying from 4-14 participants. Young people between the ages of 18-30, either transplant or dialysis patients, to offer support from other young patients. Encourages management and adjustment to major illness in a young population.

Funding: Montefiore

Program name: **Explainer Program**

Description: The Explainer Program employs youth interns from the community to teach patients and families at CHAM how to navigate the interactive patient care system at the bedside TV. This system, called the GetwellNetwork, offers health education, TV, video, internet, gaming, and customer service to patients and their families. The interns are provided with career workshops and encouraged to pursue career opportunities in health care through skill building in resume writing, interviewing and education.

Target population: Available to all CHAM inpatients and outpatients in dialysis, the hem/oncology clinic, day hospital and Pediatric ED; community members ages 16-24

Health Target: Workforce Development

Location: CHAM

Outcomes: Over eleven years, 80 youth interns have been employed as Explainers. All have achieved high school diplomas and continued on to college. 45 are currently employed while the rest complete college. 4 completed graduate programs. 24 entered careers in the healthcare field. In 2012, Montefiore added 2 new Explainers for 20 total active Explainers in the program.

Funding: Montefiore; grants

Program name: **Home Health Aide Employment and Training**

Description: Home Health Aide Employment and Training is a stimulus-funded program that helps unemployed community members obtain employment as home health aides. The program provides supportive services and case management throughout the training and employment process. Additionally, participants who complete training receive a portable certification that can be used to obtain future placements.

Target population: Unemployed adults ages 18 years and older in the Bronx

Health Target: Workforce Development

Location: Community-based

Outcomes: 95% of those who completed training and became certified achieved competitive employment and the employment retention rate at 180 days was 70% .

Funding: Contract with the U.S. Dept. of Labor

Program name: **Internship Program**

Description: The Office of Volunteer and Student Services and the Learning Network recruit, orient and process interns for the medical center, including high school, college and graduate level students.

Target population: Students in the Bronx and New York region

Health Target: Workforce Development

Location: Moses, Einstein, Wakefield

Outcomes: In 2012, Montefiore had 1,937 students and interns including: 76 high school interns , 1,599 college interns and students, 188 graduate interns and 74 student enrolled in special events or projects, including community based work or independent research work. Internships provide valuable, and sometimes required, hands-on learning experiences for students.

Funding: Montefiore

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Appendix F - Community Service Programs

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Adherence Intervention for Pediatric Renal Transplant	Adherence Intervention for Pediatric Renal Transplant aims to support adolescents (14-21) awaiting kidney transplant who struggle with their treatment regimens. The program uses dialectical behavior therapy, counseling, support groups and medication management with the goal of improving quality of life and general life skills.	Increase in patient adherence to renal transplant treatment regimens; Improvement in patient quality of life	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Adolescent AIDS Program	The Adolescent AIDS Program (AAP) provides comprehensive care, risk reduction services and HIV counseling to HIV-positive adolescents (13-24). The program also offers rapid and simple HIV testing and counseling to at-risk youth throughout the Bronx, especially in areas of high 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 personnel, students and community members.	Decrease in adolescent depression rate; Decrease in adolescent suicide and attempted suicide rates; Decrease in adolescent suicidal feelings	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse Action Plan
AIDS Center	As a New York State Dept. of Health-designated AIDS Center, this division at Moses provides a broad array of inpatient and outpatient services to adults (22+) living with AIDS. The care model consists of an integrated team of health care professionals, including physicians, social workers, nurses, HIV counselors, dietitians, adherence counselors, researchers, mental health providers, pharmacists and administrative staff.	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Bardonia Health Day	As part of Bardonia Health Day, Montefiore associates present Heart Healthy Education to 5 through 12 year olds on topics including exercise and healthy eating	Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
B'N Fit	B'N Fit is a comprehensive weight loss program for obese teens (12-21) that conducts medical, nutritional and psychosocial evaluations and refers participants to treatment for obesity-related illness. The program is offered in 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 cervical cancer	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Bronx BREATHES	Bronx BREATHES is a tobacco cessation center that serves multiple health care organizations in the Bronx by giving providers training and resources to help their patients quit smoking.	Decrease in number of smokers	Prevent Chronic Diseases
Bronx CHAMPION	Bronx Community Health and Acute Medical Performance Improvement Organizational Network is a pay-for-performance project intended to improve the care of diabetes mellitus, cardiovascular disease and specific acute medical conditions for adults ages 50 years and older. The program collects and analyzes data from Internal and Family Medicine in order to generate performance scores for providers who are then awarded financial incentives based on the quality of their care. The program was in hiatus during 2011-2012 and will resume in 2013.	Increase in quality of care for individuals with diabetes; Increase in quality of care for individuals with heart disease	Prevent Chronic Diseases

Appendix F - Community Service Programs

Bronx-CATCH, Collective Action to Transform Community Health	Bronx-CATCH is a partnership between Montefiore, the New York City Department of Health and Mental Hygiene, the Bronx Community Health Network, other community based organizations and agencies and local elected officials. Recognizing that population health is a local issue, the goal is to create a series of neighborhood-specific stakeholder partnerships, extending out from different Montefiore Medical Group health center sites, to support healthy behaviors and increase health-promotion resources for patients and the local community.	Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases; Promote a Health and Safe Environment
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 Action Plan
Centering Pregnancy	Centering Pregnancy is a national program that provides comprehensive prenatal care in a group setting. It affords women the opportunity to spend more time with their prenatal care provider, to befriend other pregnant women and to learn about themselves, their pregnancies and their newborns. The program is offered at two MMG sites: FHC and SBHCCF--and soon to be started at CFCC.	Increase in utilization of prenatal care services; Increase in positive health outcomes for newborns and their mothers	Promote Healthy Women, Infants and Children
Centers Implementing Clinical Excellence & Restoring Opportunity (CICERO)	CICERO is an integrated HIV/AIDS and primary care program that functions at ten Montefiore primary care sites and offers treatment, educational, counseling and supportive services to HIV/AIDS patients in the primary care setting.	Increase in proportion of HIV+ individuals engaged in care	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
CFCC'S Breastfeeding Support	CFCC's Breastfeeding Initiative is a collaborative effort between the Depts. of Pediatric Medicine and OB/GYN that supports new mothers and trains staff to manage breastfeeding. Expectant and new mothers and their infants (0-2) are referred to a board certified pediatrician who is also a board certified lactation consultant, who provides individual consults and runs a weekly breastfeeding group clinic. The program's goal is to improve breastfeeding rates in the hospital and clinic settings and to help Montefiore become recognized as a "baby-friendly hospital" by the WHO. Individual consults are available 3 mornings per week and the breastfeeding group clinic meets on Thursday afternoons. Annual lectures are given to pediatric residents and other staff.	Increase in proportion of mothers who breastfeed	Promote Healthy Women, Infants and Children
CHAM Oncology Groups	Over four 12-week sessions in 2012, up from 2 in 2011, CHAM runs four distinct support groups targeted to: teenagers with cancer, school-age children with cancer, siblings of cancer patients and parents of children undergoing cancer treatment.	Increase in patient satisfaction for oncology patients and their families	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse
CHAM Sickle Cell Groups	Over a 10-week session, CHAM runs a support group targeted to school-age sick cell patients. The group gives patients an opportunity to meet others going through similar experiences and provides the chance for self-expression and positive socialization.	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
Children's Evaluation and Rehabilitation Center (CERC)	CERC, the clinical arm of the Rose F. Kennedy University Center for Excellence in Developmental Disabilities, offer multidisciplinary evaluation and treatment to children and adults with intellectual and other disabilities, such as autism spectrum disorder, cerebral palsy, mental retardation, learning disabilities. The Center is composed of 10 teams, which focus their activities on a specific component of this population.	Increase in patient satisfaction for individuals with intellectual and other disabilities	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse Action Plan

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Colorectal Cancer Patient Navigation Program	The Colorectal Cancer Patient Navigator Program is the bridge between the community and health care. We eliminate complexity bringing together interdisciplinary teams to work towards reducing colorectal cancer rates by assessing, educating, scheduling, and guiding our patients through the screening process. Our aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-show and cancellation rates.	Increase in screening for colorectal cancer; Decrease in colorectal cancer	Prevent Chronic Diseases
Communilife Montefiore Temporary Respite Program	The program provides temporary community-based supportive housing for Montefiore inpatients who do not have a suitable living arrangement and do not need to be hospitalized. Patients who are discharged into the program facility receive case management, medication management, care coordination, entitlements services and the support they need to find suitable permanent housing.	Increase in patient satisfaction; Increase in proportion of inpatients who report having suitable living arrangements	Promote a Healthy and Safe Environment
Comprehensive Services Model, CSM	CSM is a Welfare-to-Work program for public assistance clients with substance use disorders. CSM comprehensively evaluates all clients and then case manages them with the goals of stabilization in substance abuse treatment and either employment or attainment of federal disability benefits, if eligible. CSM refers to state-certified substance abuse treatment programs and provides comprehensive social services.	Increase in stabilization in substance abuse treatment; Increase in employment of individuals with substance abuse disorders; Increase in attainment of federal disability benefits for individuals with substance abuse disorders	Promote Mental Health and Prevent Substance Abuse Action Plan
Diabetes Club	Diabetes Club is a bimonthly support group for adults with type 2 diabetes in which patients share their experiences and discuss strategies for managing their illness. The club welcomes families and friends of participants to attend meetings and to share their experiences and ideas with the group.	Increase in patient satisfaction for individuals with diabetes	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
Diabetes Disease Management	Through care management services delivered telephonically, face-to-face (both one-on-one and in group settings) and through direct mail, the CMO empowers people with Type II diabetes to improve their health outcomes and quality of life.	Increase in positive health outcomes for individuals with diabetes; Increase in quality of life for individuals with diabetes	Prevent Chronic Diseases
Diabetes in Pregnancy Program	Diabetes in Pregnancy is a prenatal care program for women with pre-gestational or gestational diabetes mellitus. The program's classes explore the impact of diabetes on a patient's pregnancy, baby and family. Additionally, participants receive nutritional counseling and co-management consultation.	Increase in quality of prenatal care for diabetic women	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Diabetes Management: PROMISED	A novel approach in Diabetes Education - the **Pro**active **M**anaged **I**nformation **S**ystem for **E**ducation in **Di**abetes "PROMISED" is a 10-hour interactive educational program. The program is approved and certified by the American Diabetes Association and adheres to the more recent Standards of Care and it is tailored to meet the needs of our Bronx residents. Patients are referred to PROMISED by their primary care physicians and following completion of the program they are empowered to better manage their disease. Each case is reviewed and discussed separately and the referring PCP receives a consultation letter regarding management of glycemic control, cardiovascular risk factors and comorbidities. Individual cases are presented adhering to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Increase in management of diabetes; Increase in positive health outcomes for diabetic mothers and their newborns	Prevent Chronic Diseases

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Dialysis Outreach	Dialysis outreach seeks to strengthen communication between Montefiore's transplant program and community physicians and to provide a seamless referral service where a physician or patients only need to make one phone call and will receive an appointment with a Montefiore Hepatologist, Nephrologist or Surgeon depending on the reason for the referral. The program seeks to resolve customer service issues, help expedite the referral and evaluation process and answer any questions pertaining to transplant and Montefiore. Dialysis outreach also provides in service training for dialysis staff so that understand transplant. Additionally, the program works with the American Liver Foundation, National Kidney Foundation and Organ Donor Network on education, community events and outreach.	Increase in patient satisfaction; Increase in provider satisfaction	Prevent Chronic Diseases
DOH Infertility Demonstration Project	The Infertility Demonstration Project is a statewide campaign that helps couples (21-44) who lack the financial resources to access In-vitro Fertilization services. Depending on total household income, the participating couple is required to pay a certain portion of fees after insurance. The Dept. of Health then pays the remaining cost. The program is particularly important for couples whose insurance does not cover the cost of medication for the IVF cycle.	Increase in access to In-vitro fertilization services	Promote Healthy Women, Infants and Children
Eat Healthy, Shop Smart	Eat Healthy, Shop Smart is an voucher program with an educational component that teaches cancer patients about the importance of a plant-based diet. At new patient orientation, patients are triaged for nutritional risk and offered vouchers for use at farmer's markets at both the Moses and Einstein campuses. Farmer's markets fun from May to October, pending weather limitations. The program provides financial aid to participants to purchase fruits and vegetables.	Increase in healthy eating habits; Increase in fruit and vegetable consumption	Prevent Chronic Diseases; Promote a Healthy and Safe Environment
Explainer Program	The Explainer program employs youth interns from the community to teach patients and families at CHAM how to navigate the interactive patient care system at the bedside TV. This system, called the GetwellNetwork, offers health education, TV, video, internet, gaming, and customer service to patients and their families. The interns are provided with career workshops and encouraged to pursue career opportunities in health care through skill building in resume writing, interviewing and education.	Increase in patient satisfaction	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children
Family Treatment/Rehabilitation	Family Treatment/Rehabilitation is an evaluation and case management program for families with identified risk of child abuse or neglect and identified psychiatric or substance use disorders. The program provides evaluation and referral for treatment, and provides case management to track participation.	Increase in quality of case management for families with identified risk of child abuse or neglect	Promote Mental Health and Prevent Substance Abuse Action Plan
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 serves as a training site for geriatric fellows, medical residents and medical students.	Increase in patient satisfaction	Prevent Chronic Diseases

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Green Cart Partnership Program	The Green Cart Partnership Program develops partnerships between community health centers and mobile street vendors who sell fresh produce as part of the Dept. of Health's Green Cart Program. Health center staff motivate patients to shop at Green Carts by conducting weekly cooking demonstrations that feature recipes heavy in produce. Staff also distribute information about the location of Green Carts throughout the Bronx and serve as advocates for street vendors.	Increase in healthy eating habits; Increase in fruit and vegetable consumption	Promote a Healthy and Safe Environment
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 comfort and enjoyment, promote self-expression, and enhance quality of life.	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
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
Healthy Steps	Healthy Steps ensures that primary care for infants and toddlers focuses on issues of development, behavior, parental mental health and the parent-child relationship. Building on the national model, the program collocates and integrates behavioral and mental health specialists in the pediatric primary care setting. These specialists use screening tools such as maternal depression screening and child social emotional screening to determine and implement interventions that ensure successful early childhood years.	Increase in patient satisfaction; Increase in pediatric access to primary care	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse
Heart Center Corporate Programs	Corporate Programs practices provide outreach services to the communities they serve including: lectures at Phelps Memorial Hospital, free blood pressure screenings and educational seminars at local nursing homes.	Increase in free health screenings; Increase in educational services provided to community members	Prevent Chronic Diseases
Heart Month	During the month of February, The Center for Heart & Vascular Care conducts a series of educational sessions and health screenings for Montefiore associates and for residents of the Bronx. The Center conducts lectures about heart health and healthy lifestyles as well as blood pressure screenings and counseling sessions at all Montefiore campuses, in senior citizen centers, local elementary schools, colleges and health centers.	Increase in blood pressure screenings; Increase in cardiac health	Prevent Chronic Diseases
Hepatitis C Support Group	The Hepatitis C Support group is a supportive service for adults with Hepatitis C. Topics of discussion include disease management, treatment options, side effects, compliance and coping with relational and psychological impacts of disease and treatment.	Increase in patient satisfaction for individuals with Hepatitis C	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
Home Health Aide Employment and Training	Home Health Aide Employment and Training is a stimulus-funded program that helps unemployed community members obtain employment as home health aides. The program provides supportive services and case management throughout the training and employment process. Additionally, participants who complete training receive a portable certification that can be used to obtain future placements.	Increase in employment of community members as home health aides	Promote a Healthy and Safe Environment

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HPV Vaccine Clinic	The HPV Vaccine clinic is a stand-alone clinic open to the Montefiore community and local medical providers. It offers vaccines, education and counseling to women ages 19-26 in an effort to reduce the spread of sexually-transmitted HPV infection and the onset of cervical cancer. Before the creation of the program, many OB/GYN clinics, and providers of women's health in 19-26 year olds in the community had stopped providing the vaccine to women in this age bracket due to insufficient Medicaid coverage and low reimbursement. The clinic also seeks to correct billing issues and allow for vaccines to be provided through sponsored programs to low income women in order to make vaccine administration cost effective. This site also offers participation in ongoing research projects as well.	Increase in HPV vaccination rate	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Indochinese Mental Health Program	The Indochinese Mental Health clinic provides outpatient mental health services to the Bronx Southeast Asian community. The program is a collaborative effort between the Dept. of Psychiatry and the Dept. Family Medicine and is designed according to recommendations from the Harvard Program in Refugee Trauma. In addition to mental health services, staff coordinate patients' care with clinic physicians and link them to community resources.	Increase in mental health services available; Increase in utilization of mental health services by the Bronx Southeast Asian community	Promote Mental Health and Prevent Substance Abuse Action Plan
Information and Referral Service	The Information and Referral Service connects users to vital social services and resources in the Bronx. It is comprised of a walk-in/call-in site for patients, a consultation service for Montefiore staff and an internal resource manual written for social workers. The walk-in site is open to any person in need of help with entitlements, especially the chronically ill, elderly, young mothers and the very poor.	Increase in patient satisfaction; Increase in provider satisfaction	Promote a Healthy and Safe Environment
Inpatient Asthma Workshop DID NOT HAPPEN IN 2012 Working with Pulmonary to redefine the program for inpatient and outpatient, encouraged to measure outcomes	The Inpatient Asthma Workshop is an educational program at CHAM that teaches hospitalized patients and their families about asthma. Conducted by a social worker, the Workshop addresses the challenges and stressors that asthmatic children face in their communities and provides families with useful information and resources.	Decrease in asthma symptoms	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Integrated Medicine and Palliative Care Team (IMPACT)	IMPACT is an interdisciplinary service that provides integrative palliative care to for pediatric patients facing life threatening or life limiting disease, and their care givers. Services include palliative and end-of-life care, pain management, mental health services, acupuncture, essential oil therapy, reiki, yoga, massage, healing touch, nutrition and supplements, cooking classes, herbal medicine and homeopathy, among others. The team educates students and staff on palliative care and conducts research to measure the effectiveness of its interventions. It conducts research to measure to measure the effectiveness of its interventions. IMPACT	Increase in patient satisfaction	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse
Lead Poisoning Prevention Program	A designated NYS Resource Center for Lead Poisoning Prevention, the LPPP consists of a multidisciplinary team in medicine, research, social services, environmental investigation, and public advocacy. It serves as a referral center for the medical management of lead poisoning, links families to safe housing during home abatement procedures, provides bilingual educational workshops, advocates for lead poisoned children during local and state legislative reviews and collaborates with city and private agencies in environmental intervention.	Decrease in lead poisoning	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

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LINCS Program at CHAM	LINCS is a medical home that provides comprehensive primary care and care coordination in outpatient, inpatient and home care settings to children (0-21) with complex, chronic and life-limiting conditions. The program incorporates a palliative care consultation service that provides ongoing care to children in community-based home hospices. Additionally, the program delivers comprehensive primary care to siblings during and after their brothers and sisters have passed away.	Increase in patient satisfaction; Increase in accessibility of primary care services available to children	Prevent Chronic Disease; Promote Healthy Women, Infants and Children
Liver Transplant Support Group	The Liver Transplant Support Group is a psycho- educational program for pre- and post-liver transplant patients and their families. Led by two social workers and a psychiatrist, the groups focus on expectations and challenges pre and post liver transplant, learning signs and symptoms of liver disease, disease management, and strengthening coping skills in a mutually supportive environment.	Increase in patient satisfaction for liver transplant patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
Managed Addiction Treatment Services, MATS	MATS is a clinical care coordination program for substance abusers, which since August 1 2012 has been fully incorporated into the Bronx Accountable Healthcare Network (BAHN), the Montefiore-led, NYSDOH designated Health Home. Through clinical case management, MATS helps clients stabilize in substance abuse treatment, access other medical, behavioral health, and social services, reduce inpatient admissions and ED visits, and enhance overall health and wellness by assisting clients with engagement and adherence to outpatient clinical services.	Increase in treatment of substance abuse; Increase in accessibility of social and medical services for substance abusers	Promote Mental Health and Prevent Substance Abuse Action Plan
Medical House Calls Program	Through medical home visits, the CMO helps chronically ill, at-risk geriatric and adult patients who have a history of multiple inpatient admissions and are homebound. A team of primary care physicians provide medical care. The program is also supported by social workers, outreach specialists and nurses who collaborate to address a variety of psychosocial concerns affecting the patients medical condition. The program has the capacity to care for 750 patients.	Increase in patient satisfaction; Increase in accessibility of primary care services	Prevent Chronic Diseases
Medical Stabilization Unit - Detox Programs	The MSU is a 10 bed inpatient unit for the treatment of acute withdrawal symptoms from drug and/or alcohol dependency. Most patients have comorbid psychiatric disorders or complicated medical diseases exacerbated by substance use.	Increase in patient satisfaction; Decrease in relapse of patients	Promote Mental Health and Prevent Substance Abuse
Melanoma Screening	Screening for Melanoma. Event takes place at MECCC in May.	Increase in screening for Melanoma; Decrease in occurrence of Melanoma	Prevent Chronic Diseases
Mobile Dental Van	The Mobile Dental Van provides dental care to patients at MMC affiliated schools that do not have permanent dental services. Staffed by a dentist and a hygienist and equipped with two dental chairs, a digital X-Ray system and a billing system, the van operates five days per week and visits schools on a rotating schedule.	Increase in proportion of individuals receiving dental care	Prevent Chronic Diseases
Montefiore School Health Program	MSHP is the largest and most comprehensive school-based health care network in the United States. It has 20 school-based health center sites that provide primary care, mental health, oral health and community health services to patients regardless of citizenship status and ability to pay. All sites are federally qualified or partially qualified health centers. Included in MSHP is the Healthy Kids program, comprised of an array of evidence-based prevention activities focused on increasing physical activity and healthy eating in Bronx children and their families.	Increase in proportion of students receiving health care	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

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Mosholu Preservation Corporation (MPC)	MPC is a non-profit organization committed to preserving and revitalizing Bronx neighborhoods by improving housing and promoting economic and community development. It is governed by a Board of Directors made up of Montefiore trustees and management, community leaders and development experts who serve in a pro bono capacity.	Increase in local economy; Increase in preservation of neighborhoods	Promote a Healthy and Safe Environment
Mujeres Unidas (Spanish-Speaking Breast Cancer Support Group)	The Spanish-Speaking Breast Cancer Support Group provides support, educational workshops and social events for Spanish-speaking women in different stages of breast cancer.	Increase in patient satisfaction of Spanish-speaking breast cancer patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
New Directions Recovery Center and Chemical Dependency Program - Medically Supervised Outpatient	Montefiore has two medically supervised outpatient programs. These programs treat adults with alcohol and/or drug abuse/dependence. Multidisciplinary teams at each site can also treat psychiatric disorders and address medical and psychosocial issues that may be associated with alcohol and drug use.	Decrease in alcohol and drug abuse	Promote Mental Health and Prevent Substance Abuse
New York Children's Health Project (NYCHP)	NYCHP delivers critically needed health care services to homeless families and street-involved youth at 13 sites across New York City. The families served hail from impoverished neighborhoods with few quality health care resources, and when homeless they face innumerable access barriers. The program launched with one mobile medical clinic and is now one of the largest providers of health care to homeless children in New York City. NYCHP's innovative service delivery model is comprised of fully equipped mobile clinics, small clinics in shelters, and a full-time health clinic in the South Bronx. A wide array of services is provided to attend to the complex health and psychosocial needs of homeless children, adolescents and adults: • Comprehensive primary care • Asthma care (Childhood Asthma Initiative) • Women's health care • Dental care • Mental health counseling, assessment, crisis intervention, and referrals • Substance abuse prevention and referrals • Case management • Emergency food assistance • Children's nutrition education and physical activity program ("Cooking, Healthy Eating, Fitness and Fun" or CHEFFs) • Specialty care referral management & transportation assistance • Access 24/7 to medical providers on call NYCHP was one the first mobile medical programs in the country to achieve Level 3 Patient Centered Medical Home (PCMH 2008) recognition from National Committee for Quality Assurance (NCQA). NYCHP maintains a Community Advisory Board (CAB) comprised of consumers/patients; CAB meetings are held each quarter at a different homeless family shelter and often include members new to the system.	Increase in accessibility of health care services to homeless individuals	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

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Office of Community Health	Working closely with colleagues at Montefiore, the Albert Einstein College of Medicine and partners from a wide range of institutions, governmental agencies and community-based organizations, the Office of Community Health, a part of the Department of Community & Population Health, identifies community health needs, shares information about community health services and promotes collaborative interventions. The development of the Bronx CATCH Initiative, the implementation of five community based coalitions using program implementation and evaluation, engaging Montefiore, NYCDOHMH, local community government and leading community based organizations in Williamsbridge, Fordham, West Farms, Melrose and the Prospect Avenue sections of the Bronx has been the major effort of 2012. Additionally, the Office develops effective strategies and methods to evaluate the impact of interventions on community health needs.	Increase in accessibility to health care; Increase in community-based health interventions	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Office of Community Relations	By functioning as the link between the community and the medical center's resources, the Office of Community Relations develops positive collaborations with community-based organizations, government agencies and elected officials in the regions served by Montefiore.	Increase in community-based health interventions	Promote a Healthy and Safe Environment
Internship Program	The Office of Volunteer and Student Services and the Learning Network recruits, orients and processes interns for the medical center, including high school, college and master's level students.	Increase in satisfaction of interns	**Promote a Healthy and Safe Environment**
Oral Head and Neck Screening	Screening for Oral Head and Neck Cancer. Event takes place at MECCC in April.	Increase in screening for Oral Head and Neck Cancer; Decrease in Oral Head and Neck Cancer	Prevent Chronic Diseases
Organ/Tissue Donor Program	The Organ/Tissue Donor Program raises awareness about organ/tissue donation and transplantation within the Montefiore and Bronx communities. Through educational initiatives and a range of recruitment activities, the program helps potential donors understand the importance of donation and encourages them to join the donor registry. The program is further responsible for ensuring that potential donor candidates are referred to the local Organ Procurement Organization. The ultimate goal is to ensure that every person who needs an organ/tissue donation receives one	Increase in educational programs about organ donation; Increase in number of people who join the donor registry	Prevent Chronic Diseases
Ostomy Support Group	The Ostomy Support Group is a supportive service for community members who have undergone any kind of ostomy diversion, regardless of their affiliation with the hospital. Seasoned participants 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 transplant patients learn about all the issues that effect them after a kidney transplant. The environment is supportive and the patients are around others going through the same experiences. The support group provides the opportunity for patients to share stories, information, get advice, and receive emotional and spiritual support outside the family structure. It continues to be a great success.	Increase in patient satisfaction for heart transplant patients; Increase delivery of transplant information to patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

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Patient and Community Education	The Department of Community & Population Health now encompasses the previous departments of (1) Patient and Community Education, (2) Associate Wellness and (3) the Office of Community Health, which manages the population health initiatives and responds to community requests for involvement by Montefiore. This includes the development of initiatives to address important chronic disease health indicators with inter-organizational partners. The department also provides associate support for health fairs, health screenings, workshops, seminars and other events to the Bronx and lower Westchester County. It focuses on health and wellness topics of interest or major concern to the communities it serves.	Increase in number of health screenings and health fairs; Increase in number of educational events for the community; Decrease in chronic illness	Prevent Chronic Diseases; Promote a Healthy and Safe Environment
Phoebe H. Stein Child Life Program	The Child Life Program minimizes the stress of hospital and outpatient visits for pediatric patients and their families through educational and supportive services. In all areas of the hospital, Child Life Specialists help children understand and prepare for their medical experiences. Specialists accompany children to the operating room or to other procedures, teach parents to help their children cooperate with medical treatment and encourage normal growth and development.	Increase in patient satisfaction; Increase in satisfaction of patients' families	Promote Healthy Women, Infants and Children
Pregnancy Prevention Program in School Health	The Pregnancy Prevention Program provides confidential reproductive and sexual health services, mental health services, and population based prevention and health promotion programs on the classroom, school and local community levels at nine Bronx high school campuses housing 34 schools. An example is the Reducing the Risk curriculum was introduced through ninth grade classrooms to bring a validated sex education curriculum to all ninth grade students. The program aims to decrease rates of unplanned teen pregnancy and STI transmission and to increase rates of high school graduation. Reducing the Risk is one of the first rigorously evaluated sexual education curricula to have a measurable impact upon behavior. The program is delivered the curriculum to students in the ninth grade before many become sexually active.	Decrease in unplanned teen pregnancy; Decrease in STI transmission in teens; Increase in high school graduation rates; Increase in sexual education programs	Promote Healthy Women, Infants and Children; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Project BRAVO (Bronx AIDS Volunteer Organization)	Project BRAVO is a hospital-based volunteer program managed by the AIDS Center that provides support to HIV and AIDS patients. Volunteers provide friendly visits to hospitalized patients and staff the BRAVO food pantry. Volunteers help with preparation, set up, distribution and storage of food and pantry bags as well as conduct record keeping and filing.	Decrease in number of HIV+ individuals without adequate access to food	Promote a Healthy and Safe Environment; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Project HEAL	Project HEAL is a drop-in center intended to prevent HIV infection among women in the Bronx. Services include supportive counseling, crisis intervention, individual and group-based activities, HIV testing and referrals to medical care and other social services. The project helps women develop the skills needed to reduce high-risk behaviors that may lead to HIV infection.	Decrease in HIV infection; Decrease in high-risk behavior; Increase in HIV testing	Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Prostate Cancer Screening	Montefiore Medical Center in partnership with the Daily News offering free PSA blood tests for men age 40 and over. Event runs for 4 days in June at various Montefiore sites.	Increase in Prostate Cancer screening; Decrease in Prostate Cancer	Prevent Chronic Diseases

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Psychosocial Oncology Program	The Psychosocial Oncology Program offers free counseling to those affected by cancer. Serving as the umbrella over a range of initiatives, the program includes Bronx Oncology Living Daily (BOLD Living) Program offering free wellness, creative arts, and mind-body workshops, a Yoga research program, Mind-Body Support Group, Be BOLD-Quit Smoking group, and BOLD Buddies. Supportive services are designed according to the interests and needs of participants. For instance, BOLD Buddies offers treatment companions and phone support to socially isolated cancer patients.	Increase in patient satisfaction of Oncology patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
Regional Perinatal Center	As a NYS Dept. of Health designated Regional Perinatal Center, one of 18 in the state, Montefiore is a critical referral source for specialized clinical care in high risk obstetrics and neonatology. Montefiore participates in ongoing education, evaluation, data collection and quality improvement efforts with other certified hospitals and affiliates.	Increase in availability of critical obstetric and neonatal care	Promote Healthy Women, Infants and Children
Renal Disease Young Adult Group	The program runs a support group for young adults ages 18-30 years who are diagnosed with End Stage Renal Disease. The support group afford participants the opportunity to share their emotions and concerns with each other and with professional staff.	Increase in patient satisfaction for individuals with End Stage Renal Disease	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
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

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South Bronx Health Center for Children and Families (SBHCCF)	A unique family-centered health care program, SBHC serves the Morrisania and Hunts Point-Longwood neighborhoods of the South Bronx, one of the nation's most medically underserved, at-risk communities. SBHC is a Federally Qualified Health Center (FQHC) program that offers patients access to an enhanced medical home, a model of care that addresses all of their health care needs, and includes: • Primary care for children, adolescents and adults • Women's health and prenatal care • HIV testing, counseling, and primary care • Mental health counseling • Case management • Dental care • Nutrition counseling • WIC referrals • Substance abuse prevention and referrals • Emergency food assistance • Specialty care referral management & transportation assistance • Access 24/7 to medical providers on call SBHC's Center for Child Health and Resiliency (CCHR), opened in 2011, is a state-of-the-art facility with a special focus on early childhood development beginning prenatally through 5 years of age. CCHR's innovative programming supports families and equips parents with the nurturing skills needed to overcome stressors detrimental to children's healthy development. SBHC also offers innovative health programs on-site and in the local neighborhood that provide intensive care management, group sessions, and culturally appropriate health education: • Childhood Asthma Initiative • Starting Right, a childhood obesity initiative, nutrition education and fitness program	Increase in accessibility of health care; Increase in utilization of health services	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Strength Through Laughter and Support Program	Strength through Laughter and Support is an educational program that encourages participants to develop a positive attitude as they confront the challenges associated with cancer. By sharing laughter, sadness, wisdom and love in the group setting, participants find a sense of hope that helps them face the realities of living with and beyond their illness. Groups range in size from 20 to 60 participants.	Increase in patient satisfaction and quality of life of individuals with cancer	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse
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
Suzanne Pincus Family Learning Place (FLP)	The FLP is a health information and resource center at CHAM that provides families with educational materials about child health and disease, community resources and available supportive services. The FLP's objective is to empower families to make informed decisions about their children's health care and support the principles of family-centered care. The program also assists medical providers by supplying them with materials to educate families.	Increase in satisfaction of CHAM patients and their parents	Promote Healthy Women, Infants and Children

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The J.E. and Z.B. Butler Child Advocacy Center	The JE&ZB Butler Child Advocacy Center(CAC) , established in 1984, is the only medically based, fully accredited child advocacy center in the NYC dedicated to breaking the cycle of abuse. The CAC provides emergency medical care and psychosocial evaluations and therapy to children (0-18) who been victimized by sexual and physical abuse and/or neglect. Butler's dedicated team of doctors, social workers and psychologists also provide education and training of health professionals and law enforcement personnel, and conducts outreach and research.	Decrease in child abuse; Increase in access to care services for children who have been abused	Promote a Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Mental Health and Prevent Substance Abuse
To Your Health: Zumba Bronx	To Your Health: Zumba Bronx provides patients and associates of Montefiore with Zumba classes at sites throughout the Bronx. Certified instructors, many of whom are also Montefiore Health Educators, teach this form of "dance-fitness" inspired by Latin music at little or no cost to participants.	Increase in participants in Zumba classes; Increase in exercise; Decrease in BMI; Decrease in obesity	Prevent Chronic Conditions; Promote a Healthy and Safe Environment
Women, Infants and Children (WIC) Program	Montefiore's WIC program is the oldest in New York State, established in 1974, and serves 13,000 women, infants and children. WIC is a supplemental nutrition program, providing supplemental food vouchers, nutrition education, breast feeding education, peer counseling and physical fitness education. Women are pre-screened for the program and receive a medical referral to the WIC program from providers, they qualify based on their income. Once they are screened, they receive counseling with a nutritional counselor. Vouchers are distributed for supermarket purchases on a monthly basis for three months worth of fruits, vegetables, milk, eggs, juice, beans, bread, peanut butter, etc. Counselors encourage breastfeeding for new babies, at six months, new mothers receive vouchers for baby food and cereal. At 12 months, no more formula vouchers are given. Participants see a nutritionist every 3 months and qualification is verified annually. Group education, physical education and food demonstrations are given as well. Montefiore provides space and referrals.	Increase in healthy eating; Increase in consumption of fruits and vegetables; Increase in breast feeding; Increase in exercise; Decrease in BMI; Decrease in obesity	Promote Healthy Women, Infants and Children
Women's Heart Health Center	The WHHC provides screenings, appointments, monthly lectures on heart health and a weekly clinic on Tuesday afternoons to women in the Bronx. The clinic is run by two female cardiologists. Additionally, the center participates in the Yale University School of Medicine's VIRGO study, which is an NIH-funded multi-center study that examines the influence of gender on outcomes in young AMI patients. The program is currently in Year 4 of the longitudinal study.	Increase in screenings for cardiac disease; Increase in educational programs related to cardiac health	Prevent Chronic Disease; Promote Healthy Women, Infants and Children
Wound Healing Program	The Wound Healing Program provides inpatient, outpatient, nursing home and home visiting wound healing services. The program focuses on building innovative, patient-centered health services delivery systems that work for wound patients in order to provide excellence in care and to improve wound healing outcomes in the Bronx.	Increase in positive outcomes for wound healing patients	Prevent Chronic Diseases

Appendix G: Data References

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