Community Health Needs Assessment - Implementation Strategy Report and Community Service Plan

2025-2027

Montefiore New Rochelle

This document is submitted in accordance with the Internal Revenue Service's Form 990 Schedule H requirements.

Montefiore New Rochelle
Community Health Needs Assessment and Implementation Strategy Report 2025-2027

Cover Page

- **Identify County/Counties or service area covered in this assessment and plan**
  Montefiore New Rochelle Hospital's service area is Westchester County, New York.

- **Indication of Individual or Joint plan**
  Montefiore New Rochelle Hospital is submitting an individual plan.

- **Organization name and contact information:**
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Montefiore New Rochelle
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A. Executive Summary

Since its founding in 1892, Montefiore New Rochelle Hospital (MNR), formerly Sound Shore Medical Center, has provided for the diverse medical needs of the community and region it serves. Starting with eight beds and four nurses in 1892, the Hospital has grown to a 223-bed community-based teaching hospital offering an array of inpatient, critical care and ambulatory care services to the community. Areas of distinction at MNR include ambulatory surgery and an integrated orthopedic program that offers the full spectrum of orthopedic treatments ranging from conservative, nonsurgical treatments to complicated joint replacement surgery. The Joint Solutions Program at MNR is a recipient of the distinctive Gold Seal of Approval from the Joint Commission as a certified Center of Excellence in both hip and knee replacement. Further, MNR holds certification as a primary stroke center through Joint Commission.

In October 2021, MNR Hospital opened an expanded and reconfigured Emergency Department, a renovated and upgraded Radiology Department and a newly constructed Montefiore New Rochelle Health Center. This comprehensive campus Medical Village continues the hospital's commitment to ensure the very best, state-of-the-art care is provided to New Rochelle and its surrounding communities -- both within the hospital and outside its doors. This project significantly expanded primary and specialty care capacity as well as emergency and radiology services and availability throughout the communities served.

1. **Prevention Agenda Priorities:** Analysis of the primary and secondary data highlighted three priorities of health needs. These findings were significant across all populations surveyed and demonstrated strong alignment with the priorities of the New York State Prevention Agenda &Healthy People 2030.

   For the 2025-2027 CSP, MNR has selected three prevention agenda priorities:

   Promote Healthy Eating with a focus on increasing exclusive breastfeeding and among New York State infants.
   SMARTIE OBJECTIVE 20.1 Increase the percentage of Black, non-Hispanic infants who are exclusively breastfed in the hospital from 34.1% to 35.8%.

   Prevention Services for Chronic Disease Prevention and Control with a specific focus of reducing disparities in access and quality of evidence-based preventative and diagnostic services for chronic diseases.
   SMARTIE OBJECTIVE 32.0 Increase the percentage of adult Medicaid members aged 18 Years and older with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.

Support Nutrition Security by improving consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.
SMARTIE OBJECTIVE 3.1 Increase security in households with an annual total income of less than $25,000 from 42% to 51.1%.

2. **Data Review Process:** The process to identify the needs of the community involved the collection of both primary and secondary data. The collection of primary data from a sample of Westchester County residents was a principal element of the development of the Community Service Plan. Feedback was compiled from 3,410 respondents and identified the community concerns by municipality to support the priority selections. Additionally, a review of the data was conducted with external partners, helping to frame the development of the report. These collaborations and partnerships are described in detail in this document.

3. **Partners and Roles:** Montefiore has a long history of broad community engagement throughout southern Westchester. This ranges from ongoing community engagement and outreach by the Community Relations and Community and Population Health teams who partner with community-based and faith-based organizations, as well as participation in numerous community collaborations. Within New Rochelle, Montefiore has ongoing engagement with community serving organizations and partners that also participated in the completion of the primary data collection surveys.

   Beyond direct service, Montefiore plays a leadership role in broader public health governance. We actively participate in the Westchester County Department of Health's Hospital Planning Team and Advisory Committee meetings, helping to shape the strategic direction of regional wellness.

   Recognizing the diverse needs of the Hospital's community, MNR continues the Women, Infants, and Children (WIC) Program, which is a Federally and State funded supplemental nutrition program which seeks to improve the nutrition and health status of low-income women, infants and children in our community. MRN is also a major sponsor of Hope Community Services, the largest emergency food pantry and soup kitchen in the region.

   The CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) review, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. MNR will continue to work with its partners on existing program initiatives.

4. **Interventions & Strategies:** All interventions and process measures are detailed in the CSP 2025-2027. Interventions selected are evidenced-based and most strategies are provided per the Prevention Agenda 2025-2030 NYS Prevention Agenda.

5. **Process, Progress, and Evaluation:** The Hospital will use a comprehensive set of metrics to monitor and track the impact of our initiatives.

To Promote Healthy Eating MRN will track:

Process Measures:

- Breastfeeding Coordinator and Peer Counselor interactions with the goal of increasing by 33% each year.

Outcome Measure/Objective:

- Increase exclusive breastfeeding rates for Black non-Hispanic infants (0-6 months) against NYS Vital Records data with the goal of exceeding the NYS Prevention Agenda objective of 35.8%.

Prevention Services for Chronic Disease Prevention and Control with a specific focus of reducing disparities in access and quality of evidence-based preventative and diagnostic services for chronic diseases. MRN will monitor and track:

Process Measures:

- The percentage of patients with uncontrolled hypertension who have documented medication reconciliation and adherence review within 90 days of their most recent elevated blood pressure reading with a goal of reaching 80% compliance.

- Number of Stroke Prevention lectures given in the community and participants in attendance.

Outcome Measures/Objectives:

Increase the percentage of adult Medicaid members aged 18 years and older with Hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.

To support nutrition security by improving consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods MRN will:

Process Measures:

- Implement an enhanced diabetes management and education program. As part of this initiative, patients with poorly controlled diabetes will receive structured, routine support to improve glycemic control and overall disease management with the goal of enrolling 25% of the 134 patients with poorly controlled diabetes into a comprehensive diabetes management program delivered by a Certified Diabetes Educator (CDE).

- Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local and federal benefit programs and community-based, health-related social needs providers to address unmet needs for 100% of patients with a visit to the Montefiore New Rochelle Health Center.

Outcome Measures/Objectives:
MRN will monitor and track food security for households with an annual household income of $25,000 with the goal of meeting or exceeding the NYS Prevention Agenda goal of 51.1%.

B. Community Health Assessment (CHA)
Montefiore New Rochelle (MNR) is a 223-bed, community-based teaching hospital offering primary, acute and emergency care to the residents of southern Westchester County. Since its founding in 1892, Montefiore New Rochelle Hospital has provided for the diverse medical needs of the community and region it serves and continues to provide inpatient, critical care and ambulatory services.

Montefiore New Rochelle has a number of leading-edge services and programs that have earned distinction by state and national organizations for achieving and maintaining the highest quality of care within the specialty. Montefiore New Rochelle is a New York State-designated perinatal hospital with a Level 3 Neonatal Intensive Care Unit. MNR holds a Gold Seal of Approval from The Joint Commission as a certified Center of Excellence in both hip and knee joint replacement.

MNR is a part of the Montefiore Health System - the premier academic health system and the University Hospital for Albert Einstein College of Medicine, serving the 3.1 million people living in the New York City region and the Hudson Valley. Montefiore Health System delivers science-driven care where, when, and how patients and communities need it most, combining nationally recognized clinical excellence with expertise in accountable, value-based care that focuses on its patients, their families and the community. Montefiore's Executive Leadership and Board of Trustees sponsor the Community Health Assessment process through the Office of Community and Population Health. Montefiore's Office of Community and Population Health developed a community integrated approach which maintains ongoing relationships with community-based organizations interested in the health issues most impacting the populations of the regions we serve.

Montefiore is dedicated providing support to patients in need of financial assistance and has remained at the forefront in establishing leading-edge Financial Assistance programs for our patients. Montefiore's current program includes a multi-lingual information and counseling component. Information on Montefiore's Financial Assistance Policy can be located at http://www.montefiore.org/financial-aid-policy and is available in English and Spanish, with additional interpretations options upon request.

1. **Community Description**

Service Area:
Montefiore New Rochelle has identified Westchester County as its primary service area. Westchester County occupies 430.7 square miles and is home to over 1MM people, according

to the US Census Bureau Population Data as of 2020. Its physical environment ranges from urban centers to quiet rural landscapes. It is the 7th most populous county in New York State. In 2024, the median household income for Westchester was $99,489, the 4th highest in New York State after Nassau, Putnam and Suffolk counties and significantly higher when compared to the national median household income of $83,730, according to the United States Census Bureau Population Survey.

Westchester County is the 6th healthiest county in New York State, according to the County Health Rankings, produced by the University of Wisconsin. Residents of Westchester County have access to a number of community resources including public and private schools, open spaces, healthcare facilities, community gardens, bike lanes and much more. Despite its overall high ranking, there is considerable room to improve the health of the population in Westchester County, while also reducing health disparities for both high-need populations and those with poorer health outcomes.

Demographics:
New Rochelle

New Rochelle is the 7th largest city in New York State and the 3rd most populated city in Westchester. According to the Congressional District Health Dashboard, New Rochelle has a population of 79,726 residents. This is a 3.5% increase in population from 2010 to 2020.

In New Rochelle, there are 34,362 households, of which 20 (23%) are households with children. New Rochelle's median age is 42.8 years old, higher than the Westchester County average of 41.1 years old. New Rochelle has an ethnically diverse population. The city's population is 42% non-Hispanic white, 30.6% Hispanic, 19.4% non-Hispanic Black, 6.6% Asian and 13.4% other race.

One third (35.8%) of New Rochelle's residents are foreign-born, higher than the 26% average for Westchester County. The city's foreign-born population comes from diverse corners of the globe including Mexico, Jamaica, Guatemala, Peru, Italy, India, Colombia, Dominican Republic, Haiti and Brazil. Only 10% of the foreign-born population speaks only English at home. Nearly 40% of New Rochelle's population speaks a language in addition to English, compared the Westchester County average of 34%.

Countywide the poverty rate is 9%. In New Rochelle, it is slightly higher at 11%. According to the 2020 US Census, the median income in New Rochelle was $105,762, only slightly below the Westchester County average of $118,400. It is estimated that 11.2% of children in Westchester County live below poverty. This is significant difference from the estimated 15% of children in New Rochelle living below the poverty line. During the 2023-2024 school year, 55% of students in New Rochelle public schools qualified for free or reduced lunch.

According to the City Health Dashboard, 8.5% of New Rochelle's residents were uninsured in 2023, compared to an average of 9.7% across Westchester County. 10.2% of New Rochelle households receive food stamps/SNAP benefits. This is lower than the 19% countywide

average. New Rochelle is ranked the third populated city in Westchester County. It is estimated 6.1% of New Rochelle is unemployed, while the countywide average is only 5.6%. 51.3% of New Rochelle residents have obtained at least a bachelor's degree, higher than both the county and statewide attainment rates – 49.7% and 37.%, respectively.

2. Health Status Description

Data Sources:

The identification and selection of priority items was supported by a rigorous analysis of multiple data sources, followed by a review with our partners. The sources used for this secondary data analysis are summarized in the Supplemental Information section. This methodology ensured that our findings addressed concerns beyond the scope of direct experience and observation.

Data Collection Methods:

Primary

In 2025, Greater New York Hospital Association (GNYHA) offered member hospitals and health systems the opportunity to participate in the GNYHA Community Health Needs Assessment (CHNA) Survey Collaborative during the planning year of the New York State 2025-2030 *Prevention Agenda*. The Collaborative complemented longstanding GNYHA efforts to help members with the Community Service Plan (CSP) development and implementation process.

Hospitals are required to conduct a CHNA and develop an implementation strategy every three years. Engaging with the community to receive input on health needs is essential to the process. While not a required element of a CHNA, the collaborative survey is a part of White Plains Hospital and the Montefiore Health System CHNA and implementation strategy, known collectively as a CSP in New York State, along with other community engagement efforts and secondary data from public health departments.

GNYHA developed a health needs assessment survey with member input from community and safety net hospitals, small health systems, and large academic medical centers. Collaborative participants received from GNYHA a common survey available in 19 languages on paper and online to distribute in their communities. GNYHA hosted the survey online, collected data, analyzed results, and created custom reports for each participating hospital. Collaborative members recruited participants from their communities for the survey, with more than 16,400 community members responding.

As a participating Hospital of the CHNA Survey Collaborative we received the following resources and support before, during, and after the initiative:

- Promotional materials and marketing templates to share the survey
- Support and strategies to reach populations of focus
- Web-based survey available in 19 languages
- Bi-weekly geographic and demographic reports by Zip code or county to increase response rates

- GNYHA staff data management, cleaning, analysis, and reporting
- Comprehensive Excel codebook with health issues rankings, cleaned survey data, and raw data
- Multiple forums and office hours throughout the year and one-on-one technical assistance

Members provided input in multiple stages through a collaborative and iterative process to design the 2025 CHNA collaborative survey. GNYHA employed best practice approaches in survey design and needs assessment when developing the survey. The survey used validated questions from existing surveys such as the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System and the New York City Department of Health and Mental Hygiene's Community Health Survey. GNYHA minimized the respondent burden by keeping the survey length to a minimum.

Community members could complete the survey online in a format compatible with mobile devices. Collaborative members also received copies of the survey to distribute and use for data collection in 19 languages, including English and the top 16 languages spoken among non-English speakers as designated by New York State.

Before the collaborative began, participating hospitals provided GNYHA with a list of the counties or Zip codes where the hospital would field the survey. GNYHA attributed respondents who lived in a hospital's survey service area to that hospital. Hospitals recruited members of their community to participate in the survey and entered data from paper surveys online. Each hospital received a report with data from respondents who live in that service area.

3. *Secondary Data Analysis*

The secondary data used to identify community health needs is described in our Community Service Plan and listed in our Supplemental Information section of this report. The secondary data evaluation consists of two distinct approaches. First, we used data from internal databases to examine the leading causes of inpatient hospitalization and Emergency Department visits for Montefiore New Rochelle (MRN). Second, we completed an assessment of secondary data for health indicators from several population-based data sources.

Community Engagement

MNR works actively to advance the Commissioner of Health's mission by collaborating with our community to improve population health. We continuously evaluate our present initiatives, strategic plans, and prevention agenda priorities against local needs.

Community health needs were identified through an ongoing dialogue with patients, community members, elected officials, local business leaders, and organizations, including the local Department of Health. Furthermore, we collaborate with other healthcare facilities through the Greater New York Hospital Association (GNYHA) to coordinate efforts on priority agenda items and the Community Health Needs Assessment (CHNA).

MNR remains deeply rooted in the community. Our staff (including doctors, nurses, and personnel), volunteers, and board members are committed to improving population health and regularly participate in community events and partnerships with organizations and the Westchester County Department of Health.

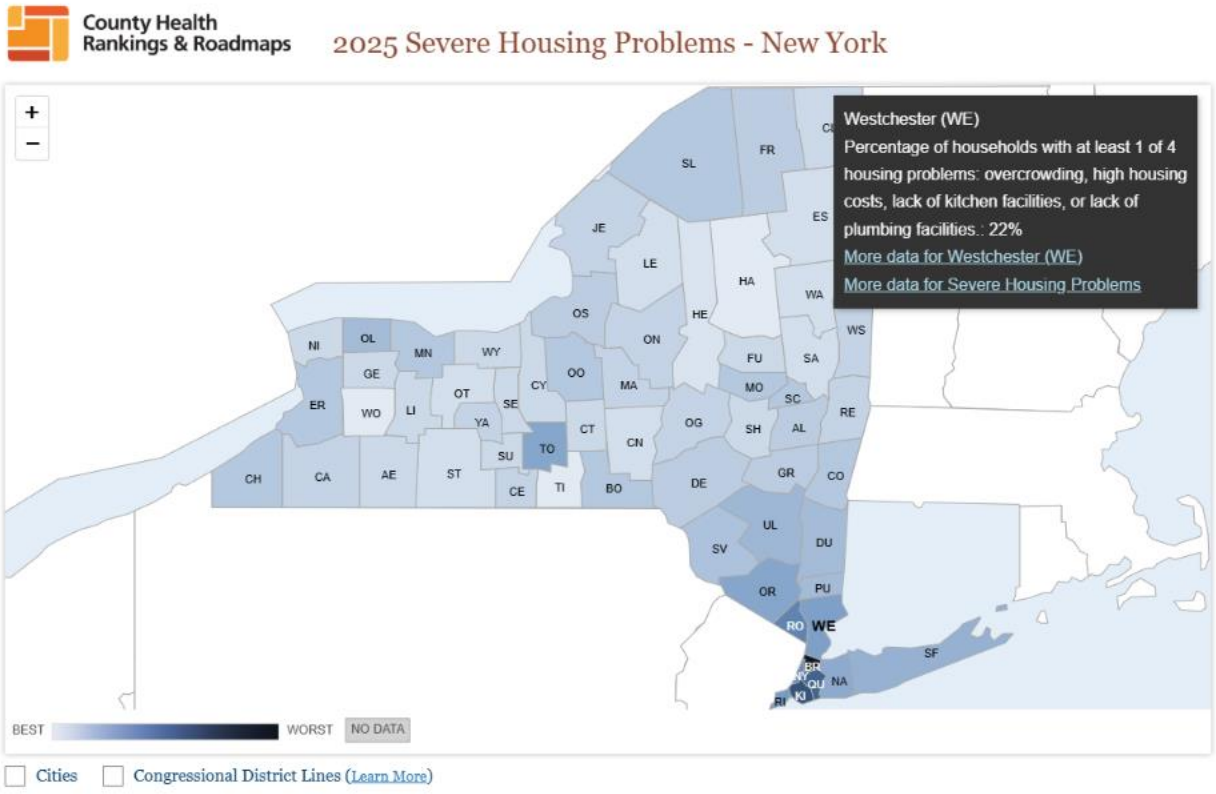
MNR partners with several city not-for-profit organizations and entities to ensure that the needs of the community are met through actively participating in community health fairs and provides education and screening for blood pressure, diabetes, and stroke. In 2025, MNR partnered with Monroe University – New Rochelle campus, and the New Rochelle Council of Community Services to provide a comprehensive health fair that invited organizations to offer resources in healthcare, child and senior services, to address food insecurity and legal matters. We continued to expand these initiatives by working with the New Rochelle Chamber of Commerce, The City of New Rochelle Youth Development and Parks and Recreation Department, and by bringing awareness to our services by partnering with the New Rochelle Council on the Arts.

This collaborative partnership and continuous communication enables the Hospital to monitor community needs. This insight is crucial for achieving community wellness goals, identifying critical gaps in care, and maintaining alignment with NYS Prevention agenda initiatives.

Relevant Health Indicators

Westchester County continues to show better than average health standings when compared to other counties in New York State, and especially when compared to average counties in the nation (see figure below).

However, there are community conditions which negatively impact Westchester County residents, such as severe housing problems as well as unemployment rates. In Westchester County 22% of households experienced housing problems, slightly below New York State at 23% but significantly higher than overall Unites States of 17%. Housing problems, defined as overcrowding, high housing costs, lack of kitchen facilities or lack of plumbing facilities all of which are deterrents when trying to maintain a healthy diet and overall lifestyle.



University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps

Health Challenges and Associated Risk Factors – Health Disparities

There are significant social and health disparities in New Rochelle, Mount Vernon and Yonkers compared to the rest of the county. These towns are home to the largest populations of homeless individuals in Westchester County:

- Mount Vernon, 14%, tied with Port Chester for highest homeless population
- Yonkers, 13%, 2nd highest homeless population
- New Rochelle, 11%, third highest homeless population

New Rochelle	Mount Vernon	Yonkers
11% (3rd highest in county)	14% (highest in county tied with Port Chester)	13% (2nd highest in county)

Homelessness is linked to poorer health outcomes. Studies have shown that homeless individuals often have limited access to healthcare, increased exposure to health risks, higher rates of mental illness/substance abuse. The chronic stress of the instability of being homeless also affects their health.

New Rochelle, Mount Vernon and Yonkers also have higher rates of diabetes, hypertension and obesity than other cities in Westchester.

Diabetes Rates – County Avg. 11.6%		
New Rochelle	**Mount Vernon**	**Yonkers**
10.4%	12.5%	11.5%

Hypertension Rates – County Avg. 31.6%		
New Rochelle	**Mount Vernon**	**Yonkers**
28.9%	34.7%	30.1%

Obesity Rates – County Avg. 26.6%		
New Rochelle	**Mount Vernon**	**Yonkers**
28%	34.1%	30.1%

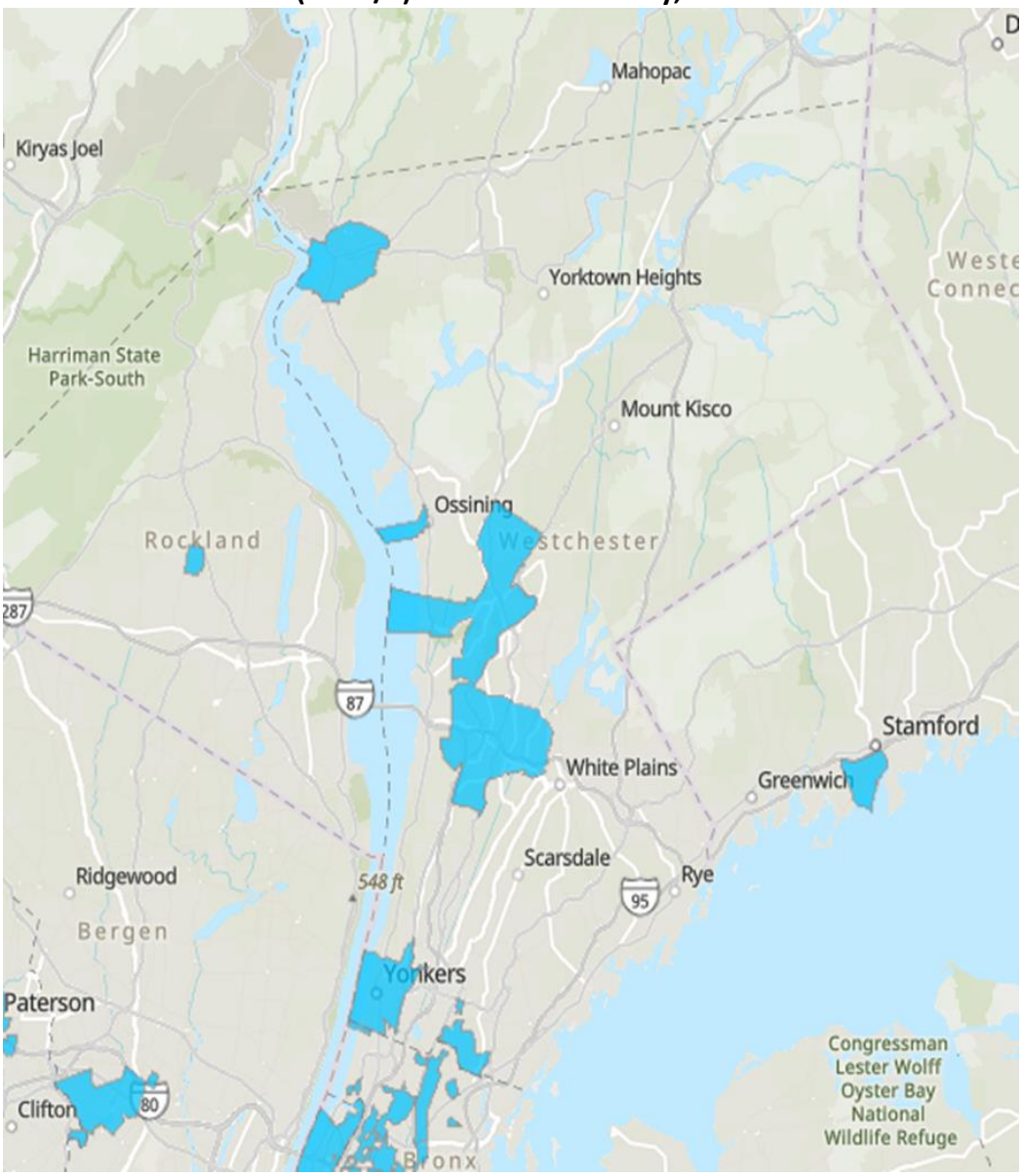
While New Rochelle and Yonkers have lower rates of diabetes and hypertension than the county average, Mount Vernon's population suffers from these diseases at a higher rate than the remainder of Westchester County. All three towns also have higher obese populations than the county average. While there are many variables that affect causes of obesity, a city may have a higher obesity rate due to a combination of social, environmental and economic factors. Obesity prevalence can vary between race and gender, however it has been found that black, non – Hispanic adults and Hispanic adults in the United States have higher obesity rates than white and Asian adults (black, non-Hispanic 45%, Hispanic 48%). It is important to note that Mount Vernon has the second highest black, non – Hispanic population in the county (62.4%). Studies have shown that black, non – Hispanic individuals are diagnosed with diabetes, hypertension and obesity at a higher rate than individuals of other races. This correlation is evidenced in Mount Vernon – they have a higher black, non – Hispanic population, and higher rates of diabetes, hypertension and obesity.

Mount Vernon and Yonkers' rates of homelessness and residents utilizing food stamps are significantly higher than the county average.

	Westchester County Average	Mount Vernon	Yonkers
Homelessness	9.00%	14% ***highest population in the county (tied with Port Chester)**	13% ***2nd highest in county**
% of Households on Food Stamps	10.00%	20.2% ***2nd highest in county**	16.70%

As demonstrated in numerous studies, individuals experiencing homelessness or relying on food assistance programs often face poorer health outcomes compared to the general population. It is therefore important to examine the relationship between disease prevalence in Mount Vernon and Yonkers and the higher proportions of residents in these communities who are experiencing homelessness or utilizing food stamps.

HRSA Data Warehouse, Quick Maps, Medically Underserved Areas/Populations (MUA/P)Westchester County, NY



Community Assets and Resources

Westchester County has numerous assets and resources that support the development and success of clinical and community health programs.

These assets include the 38-member Westchester Library System, which serves as a cultural hub offering varied activities for all ages, and extensive parks and recreational spaces that host year-round events and festivals, including playgrounds for children of all abilities. The county also features the Huguenot Children's Library, the only free-standing children's library in the county.

Below is a list of programs provided by Montefiore New Rochelle in conjunction with its listed partners to help address health conditions in the community. The programs below address a

variety of community needs. Included is the name of each program, a brief description, the intervention measures that the program captures and the program's connection to the larger New York State Prevention Agenda.

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Queen City Art Gallery	An exhibition space located in the Hospital, a collaboration between the Montefiore Fine Art Program and the New Rochelle Council on the Arts with the mission to heal, teach and advance the health of the community.	Increase support of families in our community and general satisfaction of patients and their caregivers.	Social and Community Context: Anxiety and Stress
Hope Community Services	Providers the community with access to healthy and nutritious foods delivered through a food pantry and soup kitchen in the region. In addition to nutritional support, this organization provides clothing, language skills, emotional support, immigration services and other daily necessities to the community.	Increase support for families in our community with essential needs to care for themselves. Decrease Food insecurity in our community.	Neighborhood & Built Environment: Access to Community Support & Services
Montefiore Health System Healthy Thanksgiving Initiative	Provides 10,000 lbs of fresh produce to local organizations, schools and not for profits	Decrease food insecurity and provide access to healthy foods to improve health.	Economic Stability: Nutrition Insecurity

Boys and Girls Club of New Rochelle Workforce Development	Provide workforce development	Onsite MNR hospital tours and activities that help reinforce employment opportunities	Economic Stability: Unemployment
YMCA Healthy Kids Day	Promote child health	Blood pressure and diabetes screenings	Healthcare Access and Quality: Preventative Services for Chronic Disease Prevention and Control
City of New Rochelle Dept of Parks and Recreation and Youth Development Workforce Development	Workforce development; Promote health	Provide education for health eating, diabetes and stroke prevention	Economic Stability: Unemployment; Healthcare Access and Quality: Preventative Services for Chronic Disease Prevention and Control
City of New Rochelle Annual City Street Fair	Street Fair and Community Health and Wellness Event	Education and health screenings	Healthcare Access and Quality: Preventative Services for Chronic Disease Prevention and Control
Joy Project	Community support program that provides winter coats to children in need.	Distribution of coats to approx. 400 children, protecting them from cold weather, reducing health risk and assisting families with financial hardship	Economic Stability: Poverty; Healthcare Access and Quality: Preventive Services
Reach Out and Read	Pediatric literacy program that integrates early childhood reading into healthcare visits.	Provides free books to children during well child visits and encourages parents to read aloud at home, supporting early	Healthcare Access and Quality: Preventative Services for Chronic Disease Prevention and Control

		literacy, language development and positive parent-child interaction	
Health Families New York- Westchester	Voluntary, evidence based prevention program promoting healthy development of children 0-5	Family support to ensure healthy relationship development between parent and child	Social and Community Context: Anxiety and Stress
914 Cares	Distribution of diverse range of assistance packages to 125 local organizations working directly in their communities	Distribution of resources to neediest addressing ability to work, success in school, overcome poverty	Economic Stability: Poverty; Unemployment
Carver Center	Community hub providing diverse services filling in gaps of essential services	Youth development, family support, education, nutrition, case management inclusive of after school programs, summer camps, food pantries	Neighborhood & Built Environment: Access to Community Support & Services
United Community Center of Westchester	Provide direct assistance focused on immediate needs to transition out of public assistance.	Supportive services, programs, advocacy to empower individuals and improve their quality of life, restore hope	Neighborhood & Built Environment: Access to Community Support & Services; Economic Stability: Poverty; Unemployment

		and achieve self-sufficiency.	
Maternal Infant Network Services	Perinatal network and non-profit with a mission to reduce infant and maternal mortality rates with local Hudson Valley community.	Support health and wellness of expectant mothers and women of reproductive age.	Healthcare Access and Quality: Access to and Use of Prenatal Care

C. Community Service Plan

1. **Major Community Health Needs:**

Approximately 16,400 community members responded to the survey in New York State, and more than 60% reached the end of the survey. Significant issues identified by community members in all Collaborative members' distributed surveys included: violence (including gun violence), stopping falls among elderly, mental health disorders (such as depression), affordable housing and homelessness prevention, and obesity in children and adults. Community members qualified for the survey if they were 18 and older and lived within any of the geographic areas identified by Collaborative members as their hospital's service area.

During the survey fielding period, GNYHA held member forums where Collaborative members shared best practices and challenges in recruiting community members for the survey. GNYHA produced biweekly geographic and demographic reports summarizing the responses in their service area, which allowed hospitals to adjust their dissemination strategy.

Following the survey's close, GNYHA provided each participant with a report that summarizes the survey responses and respondent demographics and a spreadsheet with the processed respondent-level data for their service area. This allowed participating hospitals to conduct additional analyses. GNYHA also provided technical assistance to each hospital to interpret their results and identify areas of need. GNYHA also created custom reports as requested by members.

A collaborative effort among various organizations yielded 3,410 completed services in Westchester County. Participants were surveyed on two key areas using a Likert scale with responses ranging from 1 "Not at All" to "Extremely" to measure importance of health conditions and current health services provided in the community. The health priorities for the community included options such as diabetes, women's and maternal health care, heart disease, cancer and violence (including gun violence).

The CHNA survey results and respondents' demographic data were reviewed. The geographical distribution of CHNA survey respondents spanned 71 unique ZIP codes across Westchester County. The largest grouping of respondents came from the White Plains area zip code (19%) of the surveys completed in Westchester County, followed by Yonkers (18%) and New Rochelle (9%). Demographic data noted 84% of those completing the survey did so in English and 15% completed it in Spanish, showing a significant increase in Spanish respondents (+12%). The age concentration of respondents was between 55-74, comprising 41% of the responses. Seventy-two percent of respondents were women, 26% were men and 2% identified as non-binary/another gender. The largest shift in respondent characteristics was Race and Ethnicity, showing a higher response from the Hispanic population. Forty-three percent identified as white, non-Hispanic, 30% as Hispanic, 17% as Black, non-Hispanic and 5% as Asian/Pacific Islander, non-Hispanic. Eighty-nine percent noted their sexual orientation to be straight, 6% identified as gay, lesbian or bisexual, 4% identified as other. Respondents leaned towards a higher education with 56% reported as college graduates, 21% some college or technical school and 15% high-school graduate or GED. In addition, 40% of respondents noted having an annual household income greater than $100,000 or more in the previous year while the remaining 60% reported an average household income of less than $100,000, of which 15% reported their income as less than $20,000. This information was considered when analyzing our respondents' answers regarding their health priorities.

The four leading community health conditions identified included: Violence (including gun violence), Stopping falls among the elderly, Mental Health/Depression, Obesity in children and adults and Affordable housing and homelessness prevention (see **Table 1**).

Health priorities of moderate importance and satisfaction were also summarized in the CHNA survey report from GNYHA (see **Table 2**). At the top of this list was access to healthy and nutritious foods. Women's and maternal health care also remained a continued important health priority among those surveyed, with a score of 4.19 of 5. Areas of lower health importance and higher satisfaction of services within the community are outlined (see **Table 3**).

Table 1. Top 5 Community health priorities as identified by the GNYHA Community Health Needs Assessment Survey, 2025**.**

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	4	4.26	Above Average	16	3.12	Below Average
Stopping falls among elderly	7	4.17	Above Average	18	3.11	Below Average
Mental health disorders (such as depression)	8	4.15	Above Average	21	2.98	Below Average
Obesity in children and adults	13	4.02	Above Average	23	2.93	Below Average
Affordable housing and homelessness prevention	14	4.02	Above Average	26	2.66	Below Average

Data source: GNYHA CHNA Survey Collaborative 2025

Table 2. Community health priorities 5-12, as identified by the GNYHA Community Health Needs Assessment Survey, 2025.

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Maintain Efforts						
Access to healthy/nutritious foods	1	4.33	Above Average	4	3.37	Above Average
Cancer	2	4.33	Above Average	5	3.36	Above Average
Dental care	3	4.32	Above Average	9	3.24	Above Average
Heart disease	5	4.22	Above Average	2	3.38	Above Average
Women's and maternal health care	6	4.19	Above Average	7	3.27	Above Average
Infectious diseases (COVID-19, flu, hepatitis)	9	4.13	Above Average	3	3.38	Above Average
Diabetes and high blood sugar	10	4.10	Above Average	8	3.27	Above Average
High blood pressure	11	4.10	Above Average	1	3.40	Above Average
Adolescent and child health	12	4.08	Above Average	10	3.24	Above Average

Data source: GNYHA CHNA Survey Collaborative 2025

Table 3. Community health priorities 13-21, as identified by the GNYHA Community Health Needs Assessment Survey, 2025.

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Relatively Lower Priority						
Arthritis/disease of the joints	17	3.96	Below Average	17	3.11	Below Average
Assistance with basic needs like food, shelter, and clothing	19	3.92	Below Average	19	3.07	Below Average
Access to continuing education and job training programs	20	3.84	Below Average	20	3.06	Below Average
Substance use disorder/addiction (including alcohol use disorder)	21	3.81	Below Average	22	2.95	Below Average
Job placement and employment support	22	3.78	Below Average	24	2.86	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	23	3.57	Below Average	25	2.83	Below Average
Sexually Transmitted Infections (STIs)	26	3.51	Below Average	15	3.14	Below Average
School health and wellness programs	15	3.98	Below Average	13	3.18	Above Average
Infant health	16	3.96	Below Average	6	3.31	Above Average
Asthma, breathing issues, and lung disease	18	3.95	Below Average	11	3.19	Above Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	24	3.54	Below Average	14	3.14	Above Average
Hepatitis C/liver disease	25	3.53	Below Average	12	3.18	Above Average

Data source: GNYHA CHNA Survey Collaborative 2025

3. **Developing Objectives, Interventions, and an Action Plan:**

As a part of the submission for the New York State Health Improvement Plan for 2025-2027 required by the New York State Department of Health, Montefiore New Rochelle has elected to choose the following three priority areas: Healthy Eating, Preventative Services for Chronic Disease Prevent and Nutrition Security.

Within each priority, the Hospital has selected SMARTIE objectives, evidence-based interventions, performance measures and timeframes, and are as detailed below.

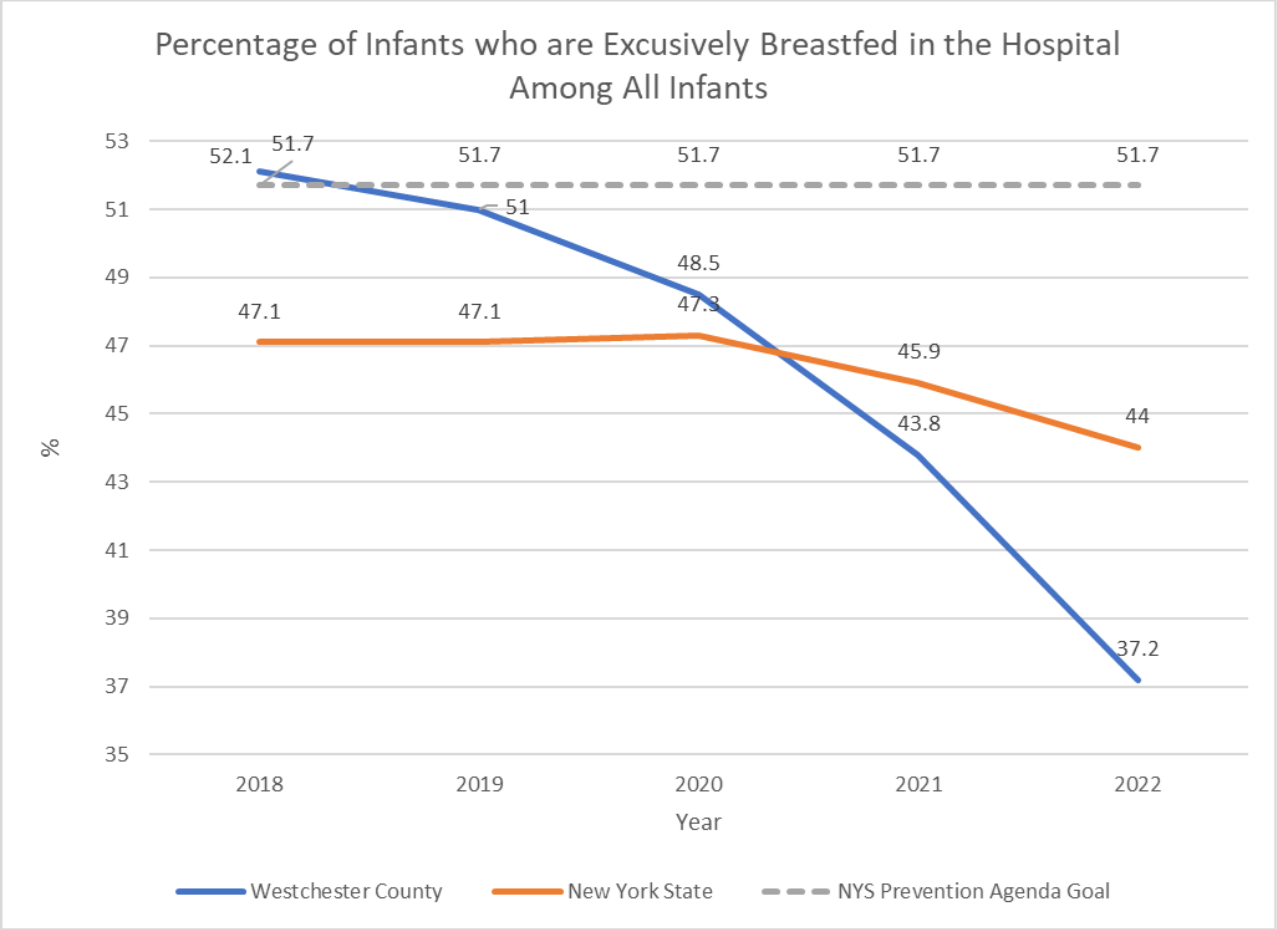
These focus areas align with other ongoing activities, including but not limited to, the breadth and scope of organizations as listed in– the Table of Programs on page 16 - 19.

We believe the selection of these priority areas and collaborative efforts with community partners will positively impact community health through reduced Emergency Department utilization, mitigation of chronic conditions, and health disparities.

Domain: Social and Community Context
Priority: Healthy Eating

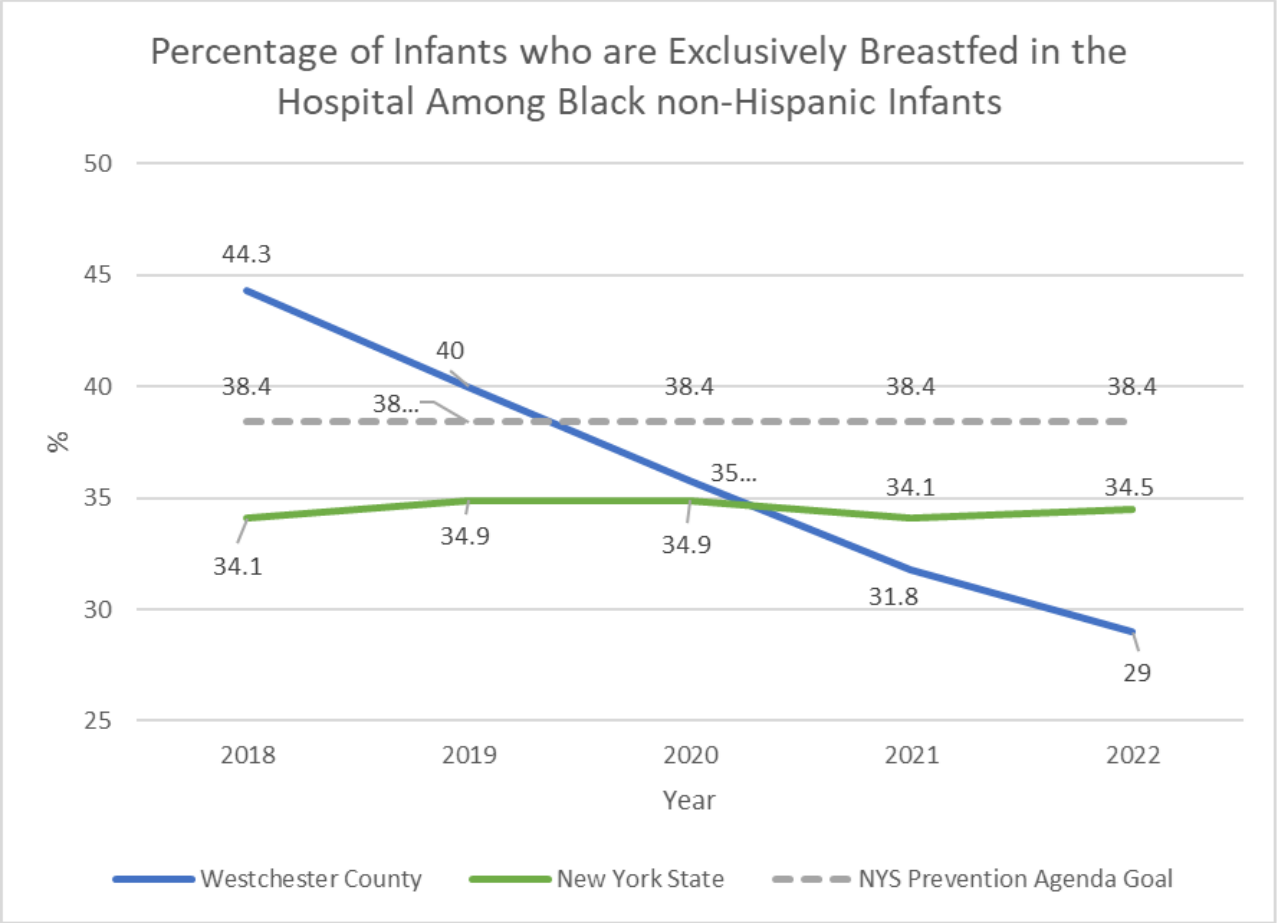
The American Academy of Pediatrics (AAP) and the World Health Organization (WHO) recommend exclusive human milk feeding for the first six months of an infant's life, followed by continued breastfeeding/chest feeding. This recommendation is highlighted as a priority in the 2025 NYS Prevention Agenda. Additionally, the WHO underscores the importance of breastfeeding as it protects infants against diarrhea and illnesses and could also have an impact on reducing the risk of obesity in childhood and adolescence.

MRN recognizes the short-and long-term benefits of breastfeeding for infant and maternal health. The data from Westchester County highlights a decline in the percentage of infants exclusively breastfeed in the Hospital, which has dropped from 52.1% in 2018, where it was meeting the NYS Prevention Agenda goal of 51.7%, down to 37.2% in 2022. In 2020 the further decline of this rate brought Westchester County below the NYS State rate, underscoring the need to implement targeted strategies and improve this health outcome for infants in the county.



Data Source: Vital Records, data as of May 2024

When looking at this data by race and ethnicity, there are further disparities and opportunities for Black, non-Hispanic infants.



The graph above displays the percentage of Black, non-Hispanic infants who were exclusively breastfed in the hospital from 2018 through 2022, comparing Westchester County with New York State and the New York State Prevention Agenda Goal. Across the five-year period Westchester County shows a steady decline in Black, non-Hispanic infants exclusively breastfed in the hospital. In 2018, the exclusive breastfeeding rate in Westchester County was 44.3%, this rate has now decreased in the most recent year reviewed to 34.5% in 2022. Westchester County and New York State have not met the New York State Prevention Agenda goal in 2020, 2021 or 2022.

Overall, the graph highlights a declining trend in Westchester County's exclusive breastfeeding rates among Black non- Hispanic infants, and a gap between the rates and the Prevention Agenda goals. There is a need for increased focus on promoting healthy infants through increasing these exclusively breastfed rates to meet the Prevention Agenda goal.

<table>
<tr><td></td><td></td></tr>
<tr><td>Goal</td><td>Promote healthy eating and make nutritious, culturally appropriate foods available.</td></tr>
<tr><td>Outcome Objectives</td><td>Increase the percentage of Black, non-Hispanic infants who are exclusively breastfed in the hospital from 34.1% to 35.8%.
<table><tr><td>Desired Outcome:</td><td>Increased exclusive breastfeeding and chest feeding among New York state infants.</td></tr><tr><td>Indictor:</td><td>Percentage of infants who are exclusively breastfed in the hospital among all infants.</td></tr><tr><td>Data Source:</td><td>New York State Vital Records</td></tr><tr><td>Subpopulation of Focus</td><td>Black, non-Hispanic birthing infants (0-6 months)</td></tr><tr><td>Baseline:</td><td>34.1% (2021)</td></tr><tr><td>Target:</td><td>35.8% (2030)</td></tr></table></td></tr>
<tr><td>Interventions</td><td>• The MNR WIC Program will provide breastfeeding promotion through breastfeeding education and support to postpartum Black-non-Hispanic women.
• Increase our monthly breast-feeding support group participation from a baseline through partnership with Healthy Families Westchester, The united Community Center of Westchester and The HOPE Community Services.</td></tr>
<tr><td>Measures & Objectives</td><td>Process Measures & Objectives
• By December 31 of 2026 & 2027, the MNR WIC Program through the oversight of our Breastfeed Coordinator and Peer Counselor Coordinator will provide additional support and breastfeeding education to our Black non-Hispanic moms by assigning Breastfeeding Peer Counselors to them to provide additional peer motivation and support. This will increase 16 contacts postpartum moving from a baseline of 12 contacts postpartum.
• By December 31 of 2026 & 2027 the monthly breast-feeding support group participation will increase from a baseline of 4 African American exclusively breastfeeding mothers to 6 mothers, increasing 33% each year.</td></tr>
</table>

	Outcome Measures & Objectives: • MNR WIC Program will monitor and track its exclusive breastfeeding rates for Black non-Hispanic infants (0-6 months) against NYS Vital Records data with the goal of exceeding the NYS Prevention Agenda objective of 35.8%.

Domain: Health Care Access and Quality

Priority: Prevention Services for Chronic Disease Prevention and Control – Hypertension
Hypertension control is crucial to reducing cardiovascular morbidity and mortality, yet achieving blood pressure control is challenging, especially in economically disadvantaged populations (Bolen S D, Koroukian S, Wright J T, et al., 2023).

As published by the AHA in 2025, hypertension is the number one preventable risk factor for cardiovascular disease and kidney disease. More recent studies have also confirmed that high blood pressure affects brain health and cognition. (AHA, New high blood pressure guideline emphasizes prevention, early treatment to reduce CVD risk, 2025). As stated in an article published by the National Library of Medicine (NIH), citing data from the 1999–2018 US National Health and Nutrition Examination Survey, more than half (56.3%) of patients with hypertension have uncontrolled blood pressure. It further states that patients with high medication adherence to antihypertensive medications are 45% more likely to achieve blood pressure control than those with medium or low adherence.

High Blood pressure is highly prevalent in NYS and in Westchester County. In New York State, an estimated 4.9 million people, or 30.5% of the adult population, have been diagnosed with high blood pressure (NYS DOH, 2023). According to Westchester County Department of Health, Community Health Data Report issued in August of 2024, Behavioral Risk Factor Surveillance System (BRFSS) is an annual nationwide telephone survey conducted by the Centers for Disease Control and Prevention (CDC).

A standardized questionnaire is used to collect prevalence data among U.S. residents 18 years and older regarding their health status, risk behaviors, and preventive practices affecting their overall health. The most prevalent health outcomes reported among Westchester County adults were high cholesterol (36%), high blood pressure (29%), and obesity (27%) (WC DOH, 2024). Self-reported adults taking medication to control high blood pressure is at 78.3%, leaving room for improvement to help manage blood pressure (WC DOH, 2024).

For Medicaid populations specifically, a statewide NYS Medicaid study looked at anti-hypertensive medication adherence, showing there is a large opportunity for improvement with nonadherence in the 40.9-46.2% range (Donghong Gao, NYS DOH; Rachael A. Austin, NYS DOH, 2024). When reviewing Medicaid adult members with hypertension data, the evidence shows a gap in many individuals not taking their medication or taking it inconsistently. Hence, improving this metric is a meaningful target.

<table>
<tr><td></td><td></td></tr>
<tr><td>Goal</td><td>Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.</td></tr>
<tr><td>Outcome Objectives</td><td>Increase the percentage of adult Medicaid members aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.
<table><tr><td>Desired Outcome:</td><td>Increase the percentage of adults with diagnosed hypertension who consistently take prescribed antihypertensive medication, particularly among those who have been prescribed treatment but are not currently adherent.</td></tr><tr><td>Indicator:</td><td>Hypertension management (% of adults reporting medication used to manage their hypertension, aged 18 years or older.</td></tr><tr><td>Data Source:</td><td>Behavioral Risk Factor Surveillance System (BRFSS)</td></tr><tr><td>Subpopulation of Focus</td><td>Medicaid members aged 18 years and older with hypertension</td></tr><tr><td>Baseline:</td><td>66.9% (2023)</td></tr><tr><td>Target:</td><td>75.5% (2030)</td></tr></table></td></tr>
<tr><td>Interventions</td><td>MNR will enhance hypertension management in primary care by implementing medication adherence support strategies, including medication refill reminders, pharmacist-led education, and outreach to patients with gaps in medication refills or persistently elevated blood pressure readings. Clinical teams will reinforce self-monitoring with home blood pressure cuffs and ensure timely follow-up visits for treatment adjustments. This intervention will target our Medicaid population patients age 18yrs+.</td></tr>
<tr><td>Measures & Objectives</td><td>Process Measures & Objectives</td></tr>
</table>

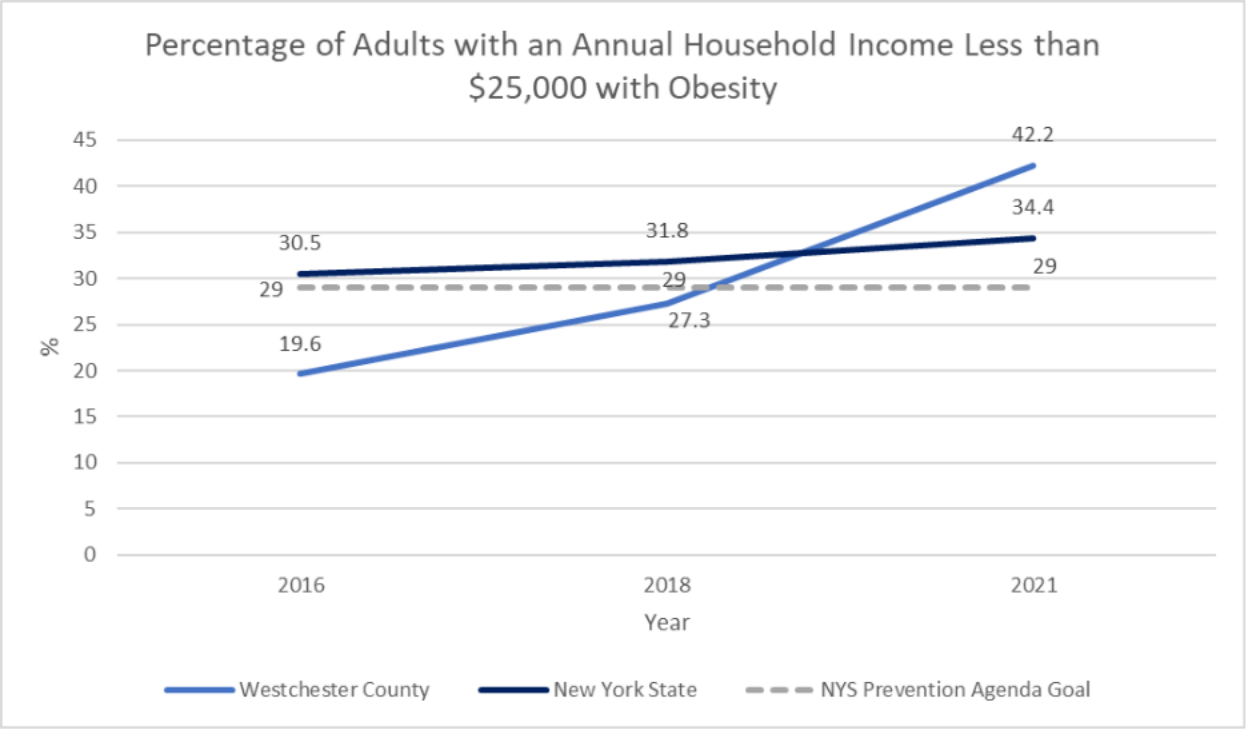
	• By December 31, 2026, 2027 MNR will implement a hypertension adherence follow-up protocol in primary care, ensuring that at least 80% of patients with uncontrolled hypertension have documented medication reconciliation and adherence review within 90 days of their most recent elevated blood pressure reading. • The Health Center will provide one stroke-prevention lecture per year in the community, with documentation of the number of lectures delivered and total participants in attendance. ***Outcome Measures & Objectives*** • MNR will monitor and report the percentage of adult Medicaid members with hypertension who are currently taking medication to manage their condition, comparing performance to BRFSS data and the New York State Prevention Agenda target of 75.5%.
Equity	Yes. The staff will devote resources to increasing the percentage of adult Medicaid members with hypertension who are currently taking medication to manage their high blood pressure.

Domain: Social and Community Context

Priority: Nutrition Security

According to the New York State 2025 Prevention Agenda, consistent access to affordable, healthy food is a key factor in reducing hunger and preventing chronic disease, especially for vulnerable populations at high risk for nutrition-related health disparities. In 2021, one in four (24.9%) of adults indicated that they were always, usually, or sometimes worried or stressed out about having enough money to buy nutritious food (NYS DOH, Food Security New York State Adults 2021).

In addition, factors such as income levels can affect nutrition security and equitable access to healthy, affordable safe, and culturally appropriate foods, in NYS Survey the prevalence of reported food insecurity was higher among adults with a household income less than $25,000 (51.9%) (NYS DOH, Food Security New York State Adults 2021). According to the American Heart Association's Fact Sheet Strengthening US Policies and Programs to Promote Equity in Nutrition Security, "Poor dietary intake is a leading contributor to the development of chronic diseases such as diabetes, cardiovascular disease, and cancer" (2022).



Data Source: NYS Behavioral Risk Factor Surveillance System, data as of October 2022

The graph displays the percentage of adults with an annual household income below $25,000 who are living with obesity, comparing Westchester County, New York State and the New York State Prevention Agenda goal overall for the years 2016, 2018 and 2021.

In 2016, Westchester County reported a significantly lower obesity rate, 19.6% compared to the statewide rate 30.5%. By 2018, both Westchester County (27.3%) and New York State (31.8%) reported increases. The largest change is 2021, where Westchester County rate climbs drastically to 42.2%, surpassing the state rate, which also increased to 34.4%. In the years reported, neither New York State nor Westchester County met the New York State Prevention Agenda goal of 29%.

Overall, the graph highlights a concerning upward trend in obesity among low- income adults, particularly in Westchester County, where the increase is substantially higher than the years before.

Feeding Westchester, a local nonprofit committed to providing food to a hunger-relief network of more than 300 partners and programs in Westchester County conducted analysis titled "The Hunger Relief Systems Analysis" in partnership with Boston Consulting Group, it is the first of its kind extensive evaluation of hunger in Westchester County. This research shows, "a more accurate picture of hunger in Westchester County, with the neighborhoods identified with the greatest unmet hunger needs are Mount Vernon, New Rochelle, Ossining and Yonkers" (2023). These areas of the region have a significant lack of affordable, healthy, and plentiful food sources. USDA defines a food desert as an area of low access to food, where at least 33% of the

population lives more than 1 mile from a supermarket or large grocery store (Michele Ver Ploeg, David Nulph and Ryan Williams, 2011). Overall, the data displays a shocking number of neighborhoods in Westchester with residents struggling with access to nutritious foods.

<table>
<tr><td></td><td></td></tr>
<tr><td>Goal</td><td>Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.</td></tr>
<tr><td>Outcome Objectives</td><td>Increase food security in households with an annual total income of less than $25,000 from 42% to 51.1%.
<table>
<tr><td>Desired Outcome:</td><td>Increase household food security.</td></tr>
<tr><td>Indictor:</td><td>Percentage of adults that were food secure in the past 12 months, aged 18 years and older.</td></tr>
<tr><td>Data Source:</td><td>Behavioral Risk Factor Surveillance System (BRFSS)</td></tr>
<tr><td>Subpopulation of Focus</td><td>Households with an annual income of less than $25,000.</td></tr>
<tr><td>Baseline:</td><td>42% (2023)</td></tr>
<tr><td>Target:</td><td>51.1% (2030)</td></tr>
</table></td></tr>
<tr><td>Interventions</td><td>Implement an enhanced diabetes management and education program. As part of this initiative, patients with poorly controlled diabetes will receive structured, routine support to improve glycemic control and overall disease management.
Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local and federal benefit programs and community-based, health-related social needs providers to address unmet needs for 100% of patients with visits to the Montefiore New Rochelle Health Center.</td></tr>
<tr><td>Measures & Objectives</td><td>Process Measures & Objectives
Implement an enhanced diabetes management and education program. As part of this initiative, patients with poorly controlled</td></tr>
</table>

	diabetes will receive structured, routine support to improve glycemic control and overall disease management with the goal of enrolling 25% of the 134 patients with poorly controlled diabetes into a comprehensive diabetes management program delivered by a Certified Diabetes Educator (CDE). • Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local and federal benefit programs and community-based, health-related social needs providers to address unmet needs for 100% of patients with visits to the Montefiore Medical Group New Rochelle Health Center. ***Outcome Measures & Objectives*** • MNR will monitor and report the percentage of adult Medicaid members with hypertension who are currently taking medication to manage their condition, comparing performance to BRFSS data and the New York State Prevention Agenda target of 75.5%.

4. **Partner Engagement:**
   Montefiore New Rochelle engages with a broad range of partners to ensure that members of the community have access to resources which address a variety of needs. These are indicated in the table on pages 16-19.

5. **Sharing Findings with the Community:**
   Montefiore New Rochelle (MNR) 2025–2027 Community Health Needs Assessment (CHNA), Implementation Strategy Report, and Community Service Plan will be made publicly available through multiple channels. The full report can be accessed online at https://www.montefiore.org/community-reports, via the Community Reports tab on the MMC website under *Montefiore Mount Vernon/Montefiore New Rochelle*.

   The report will also be shared through employee communication channels, and via email and, where appropriate with community leaders and elected officials.

D. Supplemental Information

This report is reflective of a segment of the programming offered at White Plains Hospital. Information on additional programing be found at https://www.wphospital.org/calendar/

Information on White Plains Hospital's Financial Assistance Policy can be located at https://www.wphospital.org/patients-visitors/patients/billing-information/ and is available in English and Spanish.

Summary of Secondary Data Sources & Analytic Notes

American Community Survey: The American Community Survey (ACS) replaced the Decennial Census as an ongoing survey of the United States population that is available at different geographic scales (e.g., national, state, county, census tract or census block group). ACS is a continuous survey that addresses issues related to demographics, employment, housing, socioeconomic status, and health insurance. In the current report, data from ACS was used to identify community characteristics and evaluate the percentage of families living in poverty and for mapping the percentage of adults with health insurance. For more information on ACS, please visit: About the ACS (census.gov).

US Census Bureau Small Area Health Insurance Estimates: The U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) program provides modeled, single-year estimates of insurance coverage at the county-level and by various demographic, economic and geographic characteristics. Data from this program was used to estimate insurance coverage for adults. For more information, please visit: About (census.gov)

New York State Cancer Registry: The New York State Cancer Registry was used to summarize data on new cases of breast cancer, and colorectal cancer. The Cancer Registry receives notice of all cancer diagnoses to NYS residents and classifies the cancers using established definitions. For more information on the New York State Cancer Registry, please visit: NYS Cancer Registry

NYS Expanded Behavioral Risk Factor Surveillance System (NYS Expanded BRFSS): The NYS Expanded Behavioral Risk Factor Surveillance System (NYS Expanded BRFSS) supplements the CDC BRFSS. Specifically, it provides county-level estimates of various health behaviors and outcomes. Data from the NYS Expanded BRFSS was used to estimate multiple indicators in this report, related to access to a primary care provider, poor mental health, cigarette smoking, obesity, colorectal cancer screening, flu immunization and binge drinking. For more information please visit: Expanded Behavioral Risk Factor Surveillance System (Expanded BRFSS) (ny.gov)

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

Student Weight Status Category Reporting System (SWSCRS) data: The Student Weight Status Category Reporting System provides weight status data for children and adolescents at public schools in New York State, excluding NYC at the school district, county, and region levels and by grade groups. This data was used to estimate child/adolescent obesity. For more information, please visit: Student Weight Status Data (ny.gov)

New York State Immunization Information System: The New York State Immunization Information System (NYSIIS) provides data on immunizations for all residents <19y at the county level in the state, excluding NYC. Healthcare providers are required by law to report all immunizations for this population to NYSIIS. This data was used to estimate the immunization status of children between 19-35 months. For more information, please visit: New York State Immunization Information System (NYSIIS)

NYS HIV Surveillance System: The NYS HIV Surveillance System, run by the AIDS Institute Bureau of HIV/AIDS Epidemiology in the New York State Department of Health, provides data on new HIV/AIDS diagnoses and other factors relating to HIV/AIDS, such as linkage to care. This report uses data on HIV incidence from this source. For more information, please visit: AIDS Institute (ny.gov)

New York State Sexually Transmitted Disease Surveillance Data: NYS Sexually Transmitted Disease Surveillance Data are provided by the Bureau of STD Prevention and Epidemiology within the NYS Department of Health (DOH). Cases are reported by the 57 local health departments in NYC to the NYS DOH. This report uses this data to estimate rate of chlamydia in each county. For more information, please visit: Sexually Transmitted Infections Data and Statistics (ny.gov)

New York State Vital Records Data: The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report, vital records data were used to examine the proportion of preterm births, and proportion of infants exclusively breastfed in the hospital. For more information on the New York State Vital Records, please visit: Vital Statistics of New York State (ny.gov)

National Vital Statistics Surveillance System: The National Center for Health Statistics collects and disseminates national vital statistics, including births and deaths from state/local jurisdictions (e.g., state departments of health). This data source was used to estimate the opioid-related mortality rate. For more information on NVSSS, please visit: NVSS - National Vital Statistics System Homepage (cdc.gov)

Data Tools

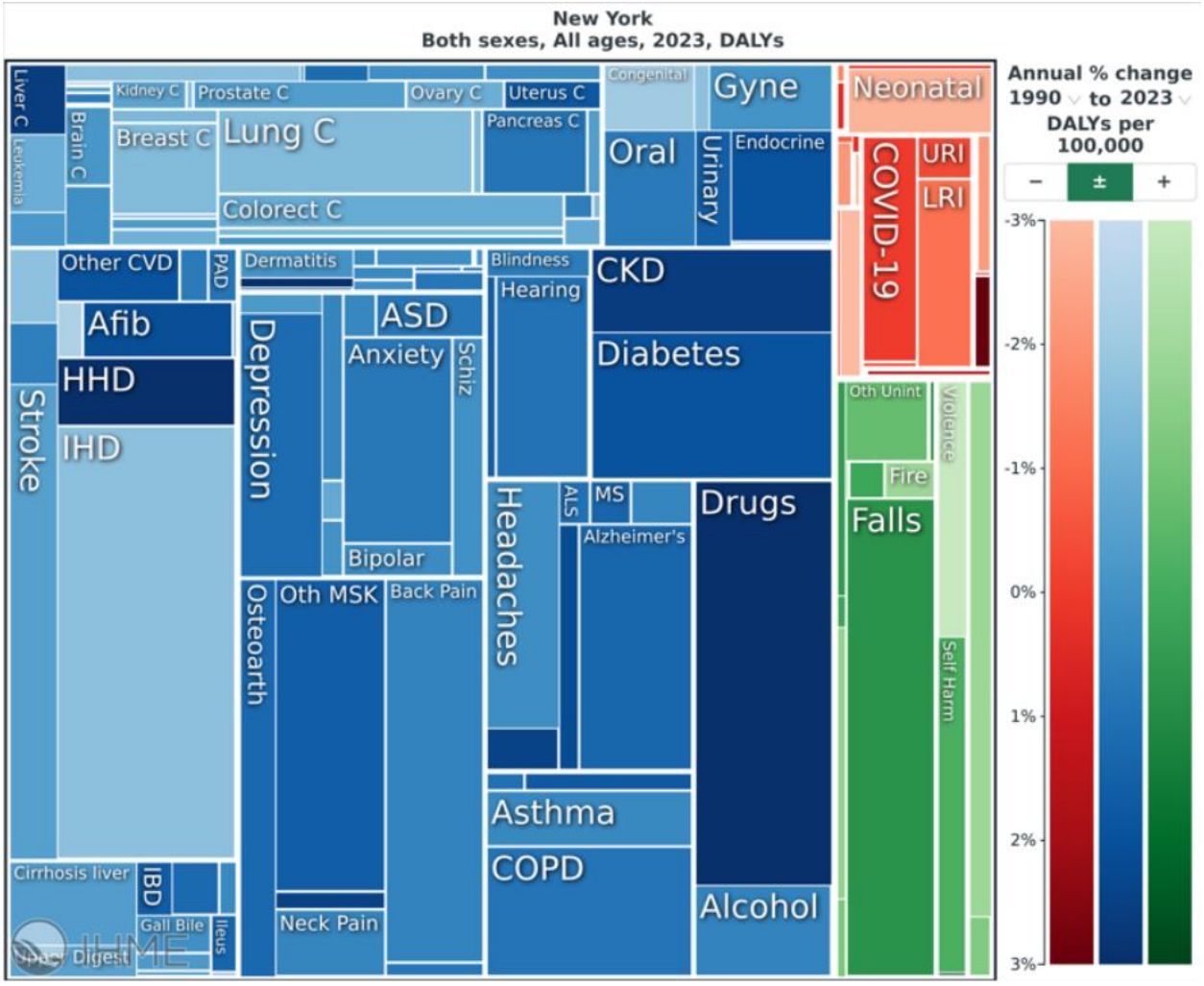
Global Burden of Disease: The Global Burden of Disease (GBD) project from the Institute of Health Metrics and Evaluation at the University of Washington uses a comprehensive risk-assessment framework to summarize the collective impact of risk factors and health outcomes on adverse health. Specifically, GBD combines many datasets to estimate disability adjusted life years (DALYs) associated with numerous outcomes and risk factors. DALYs are a summary measure of population health that combines information on fatal health events and non-fatal health states. This is an important advantage over vital statistics which do not capture the important health impact of non-fatal health states (e.g., back pain, moderate depression, or

alcohol use). GBD also allows for the estimation of DALYs attributed to specific risk factors, including body mass index, smoking, dietary risks, occupational risks, air pollution, etc. Data from the GBD is available at the global, national and state level; local estimates are not available. Despite this limitation, this information can be used to understand the most critical areas of intervention to improve population health. Data available at: [VizHub - GBD Compare (healthdata.org)]

New York State Prevention Agenda Dashboard: An additional resource for data was the New York State Prevention Agenda Dashboard, which was produced by the New York State Department of Health and systematically aggregates data for the entire state and for each county for dozens of health indicators that align with the New York State Prevention Agenda. Like the Community Health Profiles, the Prevention Agenda Dashboard is not a single database, but rather a compilation of diverse databases. For more information, please visit: [Prevention Agenda 2025-2030: New York State's Health Improvement Plan].

Secondary Data Review & Trends

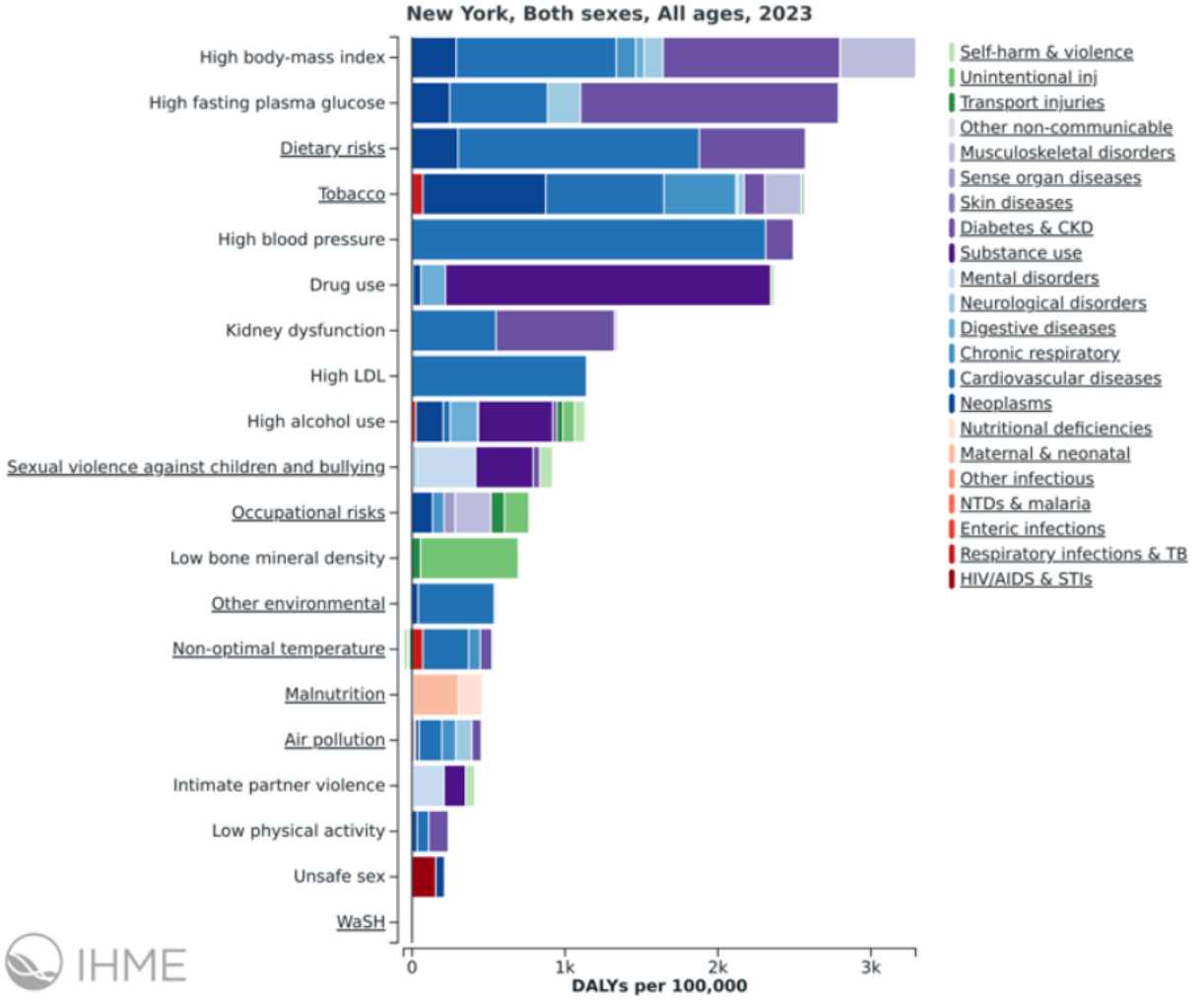
Leading causes of disability-adjusted life years in New York State, 2023



Data source: 2023 Global burden of Disease Project, Institute for Health Metrics and Evaluation.

The leading causes of ill health in New York State as measured by disability adjusted life years are ischemic heart disease (8.69%), drug use disorders (6.23%), lower back pain (4.25%), and diabetes (4%). The saturation of the graph shows the proportionate change in DALYs from 1990 to 2023.

Figure 3. Distribution of disability adjusted life years by risk factor in New York State, 2023.



Data source: 2023 Global Burden of Disease Project

In New York State, according to the finest level of geographic data from the Global Burden of Disease project, high body mass index is responsible for the highest proportion of disability adjusted life years (a summary measure combining fatal and non-fatal health status). High body mass index risks are the leading contributor to ill health, due to associations with diabetes, cardiovascular disease, and musculoskeletal disorders. High fasting glucose is the second leading cause of ill health, with strong associations with diabetes, cardiovascular, and neoplasms. The third leading cause of ill health is dietary risks, due to associations of

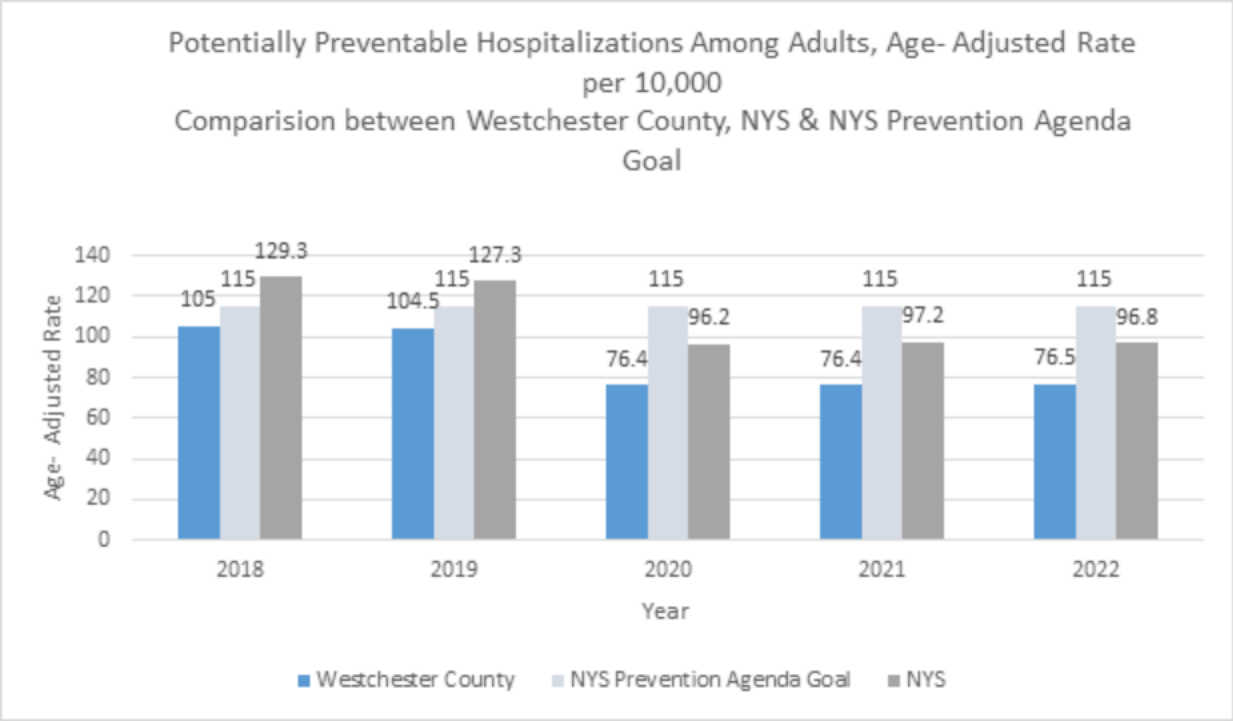
cardiovascular disease, diabetes, and neoplasms. Tabacco and high blood pressure are also causes of ill health. Within high blood pressure (data not shown) is attributed to cardiovascular disease and diabetes while Tabacco usage is associated with mainly cardiovascular diseases and neoplasms.

New Rochelle Hospital Primary Diagnosis - 8/1/2024 Through 7/31/2025

Diagnosis Code	Primary Diagnosis Description	Cases
A41.9	Sepsis, unspecified organism	408
Z38.00	Single liveborn infant, delivered vaginally	361
Z38.01	Single liveborn infant, delivered by cesarean	154
M17.11	Unilateral primary osteoarthritis, right knee	141
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	130
N17.9	Acute kidney failure, unspecified	129
M17.12	Unilateral primary osteoarthritis, left knee	126
M17.0	Bilateral primary osteoarthritis of knee	94
M16.12	Unilateral primary osteoarthritis, left hip	80
M16.11	Unilateral primary osteoarthritis, right hip	79
O34.211	Maternal care for low transverse scar from previous cesarean delivery	74
G45.9	Transient cerebral ischemic attack, unspecified	70
O48.0	Post-term pregnancy	65
J18.9	Pneumonia, unspecified organism	65
I11.0	Hypertensive heart disease with heart failure	60
N39.0	Urinary tract infection, site not specified	58
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	51
U07.1	COVID-19	50
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	47
R55	Syncope and collapse	44

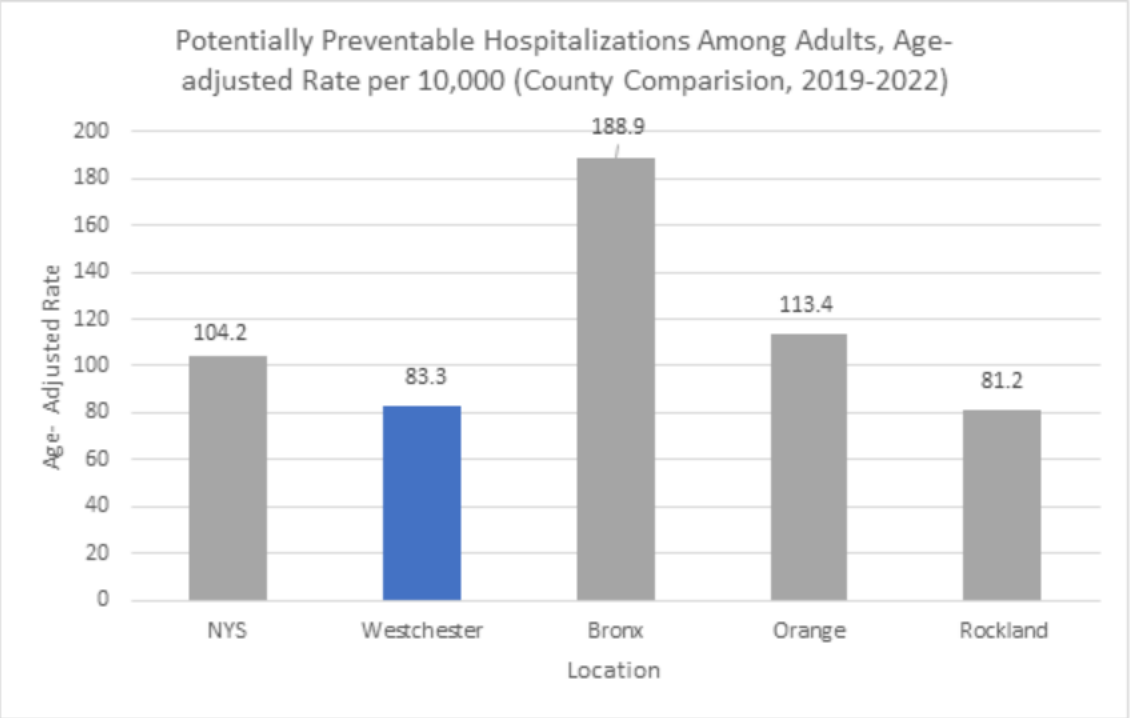
New Rochelle ED Treat and Release Primary Diagnosis - 8/1/2024 Through 7/31/2025		
Diagnosis Code	**Primary Diagnosis Description**	**Cases**
B34.9	Viral infection, unspecified	941
J10.1	Influenza due to other identified influenza virus with other respiratory manifestations	877
R07.9	Chest pain, unspecified	792
F10.129	Alcohol abuse with intoxication, unspecified	720
N39.0	Urinary tract infection, site not specified	622
K52.9	Noninfective gastroenteritis and colitis, unspecified	619
J06.9	Acute upper respiratory infection, unspecified	569
R51.9	Headache, unspecified	567
R10.9	Unspecified abdominal pain	537
R07.89	Other chest pain	519
R42	Dizziness and giddiness	481
S09.90XA	Unspecified injury of head, initial encounter	450
M54.50	Low back pain, unspecified	448
J02.0	Streptococcal pharyngitis	434
U07.1	COVID-19	360
J02.9	Acute pharyngitis, unspecified	348
R55	Syncope and collapse	330
I10	Essential (primary) hypertension	303
J40	Bronchitis, not specified as acute or chronic	281
R11.2	Nausea with vomiting, unspecified	273

Appendix:



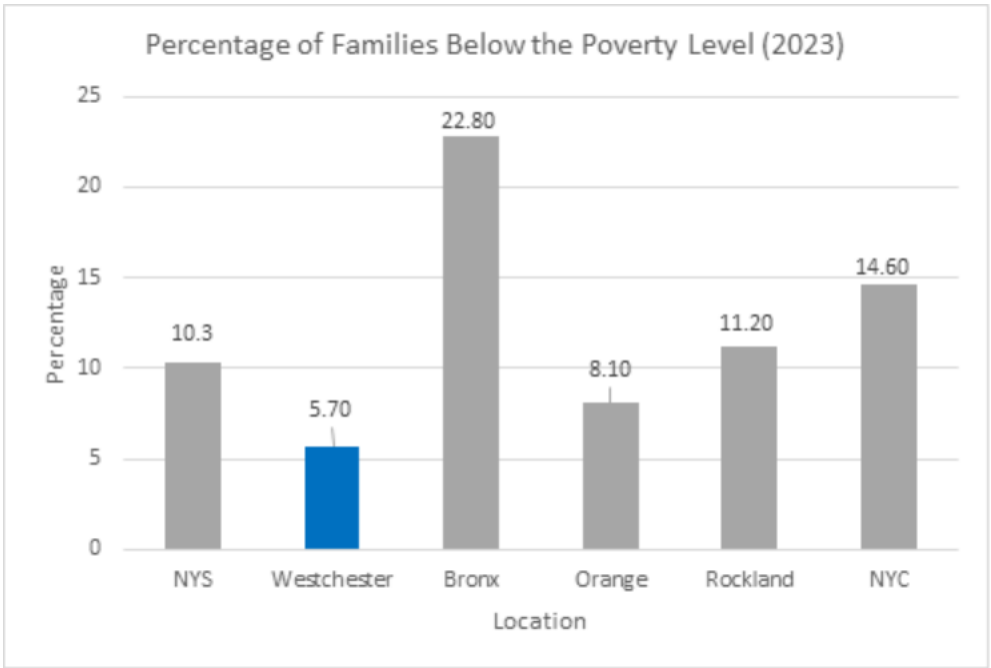
Data Source: SPARCS, Data as of July 2024

Westchester County continues to perform better than both New York State overall and the Prevention Agenda Objective for the Preventable Hospitalization Rate per 10,000 population from 2018–2022. Although the 2022 rate of 76.5 is slightly higher than the rates observed in 2020 and 2021, it still reflects a notable improvement compared with 2018, when the rate was 105.



Data Source: SPARCS, Data as of July 2024

When comparing counties from 2019–2022, Rockland County shows the strongest performance with a rate of 81.2. Westchester County follows closely with a rate of 83.3. The remaining peer counties have significantly higher rates, with Orange County at 113.4 and the Bronx at 188.9. The overall New York State rate is 104.2, which remains higher than Westchester County's rate.



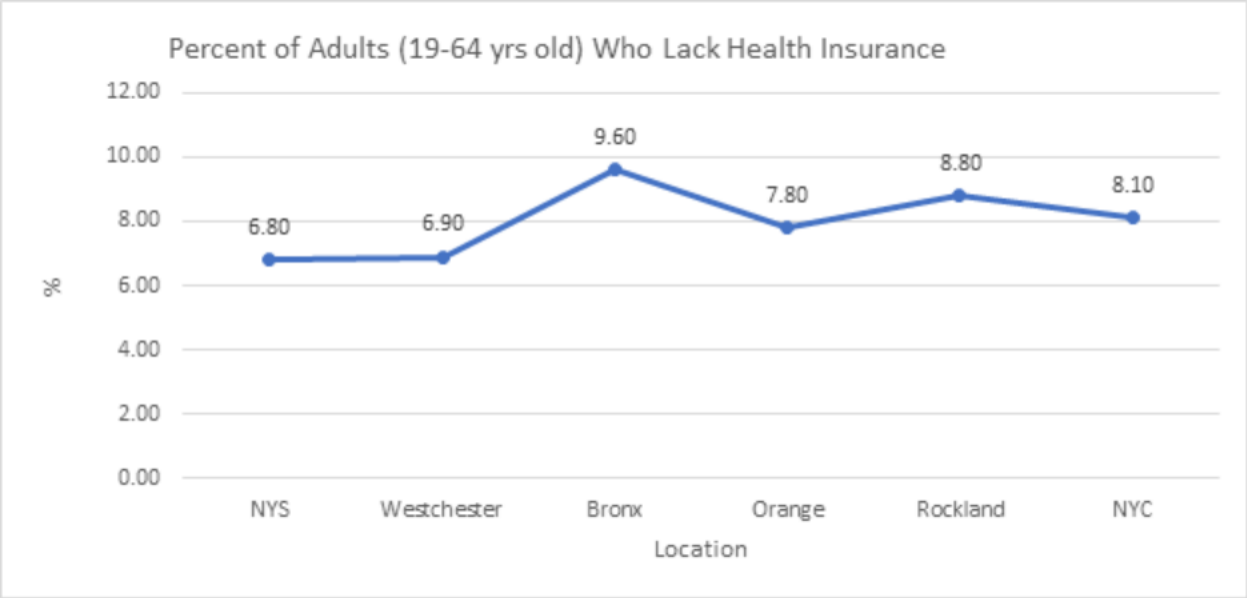
Data Source: American Community Survey/ US Census Bureau Data

When comparing poverty levels across New York State (NYS), Westchester County, Bronx County, Orange County, Rockland County, and New York City (NYC), Westchester County has the lowest percentage of families living below the poverty level at 5.7%, performing significantly better than all comparison areas. NYS has a poverty rate of 10.3% overall, nearly double that of Westchester.

The Bronx shows the highest poverty level at 22.8%, more than four times the rate in Westchester and notably higher than every other locality in the chart.

Orange County (8.1%) and Rockland County (11.2%) fall between the state average and the extremes, with Orange performing better than NYS overall but still above Westchester.

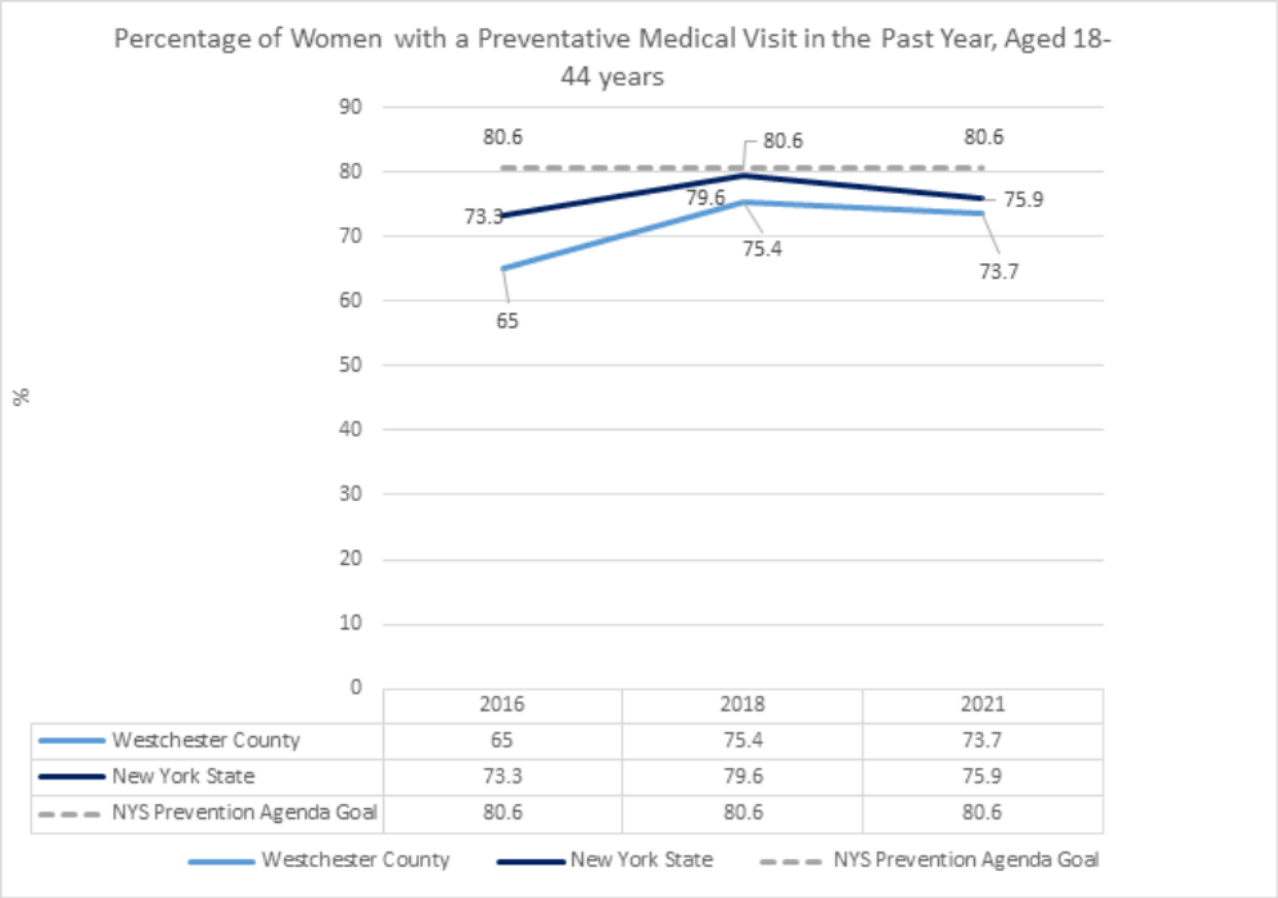
Overall, the graph highlights Westchester County's relatively strong socioeconomic standing compared with both neighboring counties and statewide figures, while showing disparities, particularly the higher poverty rate in the Bronx.



Data Source: American Community Survey/US Census Bureau Data; S2701Selected Characteristics of Health Insurance Coverage in the United States

Westchester County has a relatively low uninsured rate at 6.9%, similar to the NYS average of 6.8%. Among all locations compared, the Bronx has the highest percentage of uninsured adults at 9.6%, standing out as the most vulnerable area in terms of health insurance coverage. Orange County (7.8%), Rockland County (8.8%), and NYC (8.1%) all report uninsured rates above both the state and Westchester levels. Rockland and NYC in particular show moderately elevated levels compared with Westchester.

Overall, Westchester County is performing slightly better than the state average and better than all neighboring comparison areas, with the Bronx experiencing the greatest challenges in adult health insurance coverage.



Data Source: NYS Behavioral Risk Factor Surveillance System, data as of October 2022

In 2016, Westchester County reported 65% of women aged 18-44 years who had a preventative medical visit in the past year in Westchester County, which was significantly below both the state average of 73.3% and the NYS Prevention Agenda Goal of 80.6%. By 2018, Westchester County improved to 75.4%, narrowing the gap with New York State, which peaked at 79.6% approaching the New York State Prevention Agenda goal. However, in 2021, both regions experienced declines, with Westchester County dropping slightly to 73.7% and New York State 75.9%, moving further away from the target of 80.6% set by the New York State Prevention Agenda.

Despite overall improvement since 2016, neither Westchester County nor New York State achieved the 80.6% goal, and the recent downward trend suggests a need for efforts to maintain and increase preventative care utilization.

GNYHA 2022 Community Health Survey (English)

2025 Community Health Survey

We want to improve the health services we offer to people who live in your neighborhood. The information you give us will be used to improve health services for people like yourself.

Completing the survey is voluntary. We will keep your answers private. If you are not comfortable answering a question, leave it blank.

We value your input. Thank you very much for your help.

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1 Are you 18 years of age or older?

- ○ Yes
- ○ No → Thank you very much, but we are only asking this survey of people who are ages 18 and older.

2 We want people from all different neighborhoods to take part in this survey. Please tell us the zip code where you live so we can identify your neighborhood.

Zip code: _____

IF YOU PROVIDED A ZIP CODE, PLEASE GO TO QUESTION 6. YOU DO NOT NEED TO ANSWER THESE QUESTIONS.

3 Do you live in New York City?

- ○ Yes
- ○ No → Skip to 5

4 If you live in New York City, please select the borough where you live:

- ○ The Bronx → Go on to page 3
- ○ Brooklyn → Go on to page 3
- ○ Manhattan → Go on to page 3
- ○ Queens → Go on to page 3
- ○ Staten Island → Go on to page 3
- ○ I do not live in New York City → Answer 5

5 If you do not live in New York City, please tell us the county where you live:

- ○ Albany County
- ○ Allegany County
- ○ Broome County
- ○ Cattaraugus County
- ○ Cayuga County
- ○ Chautauqua County
- ○ Chemung County
- ○ Chenango County
- ○ Clinton County
- ○ Columbia County
- ○ Cortland County
- ○ Delaware County
- ○ Dutchess County
- ○ Erie County
- ○ Essex County
- ○ Franklin County
- ○ Fulton County
- ○ Genesee County
- ○ Greene County
- ○ Hamilton County
- ○ Herkimer County
- ○ Jefferson County
- ○ Madison County
- ○ Monroe County
- ○ Montgomery County
- ○ Nassau County
- ○ Niagara County
- ○ Oneida County
- ○ Onondaga County
- ○ Ontario County
- ○ Orange County
- ○ Orleans County
- ○ Oswego County
- ○ Otsego County
- ○ Putnam County
- ○ Rensselaer County
- ○ Rockland County
- ○ Saratoga County
- ○ Schenectady County
- ○ Schoharie County
- ○ Schuyler County
- ○ Seneca County
- ○ St. Lawrence County
- ○ Steuben County
- ○ Tioga County
- ○ Tompkins County
- ○ Ulster County
- ○ Warren County
- ○ Washington County
- ○ Wayne County
- ○ Westchester County
- ○ Wyoming County
- ○ Yates County
- ○ Other_____

- ○ Lewis County
- ○ Livingston County
- ○ Suffolk County
- ○ Sullivan County

Health Status

6 In general, how is the overall health of the people of your neighborhood?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

7 In general, how is your physical health?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

8 In general, how is your mental health?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

9 **For each of the following, please tell us: How important is each of the following to you and how satisfied are you with the current services in your neighborhood to address each issue?**

		How important is this issue to you?						How satisfied are you with current services?					
		Not at all	A little	Somewhat	Very	Extremely	Don't know	Not at all	A little	Somewhat	Very	Extremely	Don't know
1	Access to continuing education and job training programs	○	○	○	○	○	○	○	○	○	○	○	○
2	Access to healthy/nutritious foods	○	○	○	○	○	○	○	○	○	○	○	○
3	Adolescent and child health	○	○	○	○	○	○	○	○	○	○	○	○
4	Affordable housing and homelessness prevention	○	○	○	○	○	○	○	○	○	○	○	○
5	Arthritis/disease of the joints	○	○	○	○	○	○	○	○	○	○	○	○
6	Assistance with basic needs like food, shelter, and clothing	○	○	○	○	○	○	○	○	○	○	○	○
7	Asthma, breathing issues, and lung disease	○	○	○	○	○	○	○	○	○	○	○	○
8	Cancer	○	○	○	○	○	○	○	○	○	○	○	○
9	Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah	○	○	○	○	○	○	○	○	○	○	○	○
10	Infectious diseases (COVID-19, flu, hepatitis)	○	○	○	○	○	○	○	○	○	○	○	○
11	Dental care	○	○	○	○	○	○	○	○	○	○	○	○
12	Diabetes and high blood sugar	○	○	○	○	○	○	○	○	○	○	○	○
13	Heart disease	○	○	○	○	○	○	○	○	○	○	○	○
14	Hepatitis C/liver disease	○	○	○	○	○	○	○	○	○	○	○	○
15	High blood pressure	○	○	○	○	○	○	○	○	○	○	○	○
16	HIV/AIDS (Acquired Immune Deficiency Syndrome)	○	○	○	○	○	○	○	○	○	○	○	○
17	Infant health	○	○	○	○	○	○	○	○	○	○	○	○
18	Job placement and employment support	○	○	○	○	○	○	○	○	○	○	○	○
19	Mental health disorders (such as depression)	○	○	○	○	○	○	○	○	○	○	○	○
20	Obesity in children and adults	○	○	○	○	○	○	○	○	○	○	○	○
21	School health and wellness programs	○	○	○	○	○	○	○	○	○	○	○	○
22	Sexually Transmitted Infections (STIs)	○	○	○	○	○	○	○	○	○	○	○	○
23	Stopping falls among elderly	○	○	○	○	○	○	○	○	○	○	○	○
24	Substance use disorder/ addiction (including alcohol use disorder)	○	○	○	○	○	○	○	○	○	○	○	○
25	Violence (including gun violence)	○	○	○	○	○	○	○	○	○	○	○	○
26	Women's and maternal health care	○	○	○	○	○	○	○	○	○	○	○	○

Long-term COVID Effects

10 **Have you ever tested positive for COVID-19 (using a rapid point-of-care test, self-test, or laboratory test) or been told by a doctor or other health care provider that you have or had COVID-19?**

- ○ Yes
- ○ No [Skip to question 13]

11 **Do you currently have symptoms lasting 3 months or longer that you did not have prior to having coronavirus or COVID-19?**

- ○ Yes
- ○ No [Skip to question 13]

12 **Do these long-term symptoms reduce your ability to carry out day-to-day activities compared with the time before you had COVID-19?**

- ○ Yes, a lot
- ○ Yes, a little
- ○ Not at all

Social Determinants of Health

13 **During the past 12 months, have you received food stamps, also called SNAP, the Supplemental Nutrition Assistance Program on an EBT card?**

- ○ Yes
- ○ No

14 **During the past 12 months how often did the food that you bought not last, and you didn't have money to get more?**

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

15 **During the last 12 months, was there a time when you were not able to pay your mortgage, rent or utility bills?**

- ○ Yes
- ○ No

Health Care Access

16 What is the current source of your primary health insurance (the one you use most often)?

- ○ A plan purchased through an employer or union (including plans purchased through another person's employer)
- ○ A private nongovernmental plan that you or another family member buys on your own
- ○ Medicare
- ○ Medigap
- ○ Medicaid
- ○ Children's Health Insurance Program (CHIP)
- ○ Military related health care: TRICARE (CHAMPUS) /VA health care /CHAMP-VA
- ○ Indian Health Services
- ○ State sponsored health plan
- ○ Other government program
- ○ No coverage of any type

Demographic Information

17 What is your race and/or ethnicity? (Select all that apply)

- □ American Indian or Alaska Native
  For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
- □ Asian
  For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.
- □ Black or African American
  For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
- □ Hispanic or Latino
  For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.
- □ Middle Eastern or North African
  For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.
- □ Native Hawaiian or Pacific Islander
  For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
- □ White
  For example, English, German, Irish, Italian, Polish, Scottish, etc.

18 Do you speak a language other than English at home?

- ○ Yes
- ○ No [Skip to question 21]

19 What is this language? (Select all that apply)

- ☐ Spanish
- ☐ Arabic
- ☐ Bengali
- ☐ Burmese
- ☐ Chinese
- ☐ French
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Nepali
- ☐ Polish
- ☐ Russian
- ☐ Urdu
- ☐ Yiddish
- ☐ Other

20 How well do you speak English?

- ○ Very well
- ○ Well
- ○ Not well
- ○ Not at all

21 Which of the following best represents how you think of yourself?

- ○ Gay or lesbian
- ○ Straight, that is not gay or lesbian
- ○ Bisexual
- ○ I use a different term

22 How do you currently describe yourself? (Select all that apply)

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term

23 Are you transgender?

- ○ Yes
- ○ No

- ○ $150,000 to $199,999
- ○ $200,000 or more

This is the end of the survey. Thank you very much for your help.