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

2025-2027

Montefiore Mount Vernon

Office of Community & Population Health

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This New York State 2025-2027 Community Health Assessment and Improvement Plan and Community Service Plan are covering Westchester County, one of the centrally located counties within the New York City metropolitan area situated in the Hudson Valley with a population of about one million people. This document is submitted as the requirement for the 2025-2027 Community Health Needs Assessment and Implementation Strategy Report for the Schedule H Requirement of the Internal Revenue Service 990 tax form and assesses the health needs for Westchester County, New York.

The participating hospitals in the health system are Montefiore Mount Vernon Hospital, a part of the Montefiore Health System, and encompasses the municipalities of the City of Mount Vernon and the county of Westchester. The contact for information that pertains to this report is:

Montefiore Mount Vernon
Quality & Regulatory Affairs Department
12 N. 7th Avenue
Mount Vernon, NY 10550

Shannon P. Wales, MSW, MPH
Director
Quality & Regulatory Affairs Department
swales@montefiore.org

Jasmin Dorado, MBA
Quality Specialist
Quality & Regulatory Affairs Department
jadorado@montefiore.org

Elizabeth Spurrell-Huss, MSW, MPH
Director, Community Health Programs
Community & Population Health
espurrel@montefiore.org

Executive Summary

The completion of a Community Health Needs Assessment and Implementation Strategy Report is a requirement of the Internal Revenue Service's 990 tax documentation requirements under the Patient Protection and Affordable Care Act (PPACA). The PPACA requires hospitals to assess and address the health needs of the communities they serve. This Community Health Needs Assessment meets the first component of these requirements, providing a report on the process, methods and results of a comprehensive assessment of the needs of the community served by Montefiore New Rochelle and Montefiore Mount Vernon. The second component encompasses the Implementation Strategy and Community Service Plan, which further discusses the significant health needs of the community, describes the programs and strategies to address these significant health needs, and delineates the metrics to be used to evaluate the impact of these strategies. The program, strategies and metrics chosen must align with priority areas outlined in the New York State Prevention Agenda 2025-2030.

The Montefiore Mount Vernon Community Health Needs Assessment (CHNA) process, secondary data, and the Community Service Plan were approved by Montefiore Board of Trustees on December 11, 2025. The Community Health Needs Assessment (CHNA) report was uploaded to the Montefiore website on December 30, 2025.

Introduction

Montefiore Mount Vernon Hospital (MMV), located in Lower Westchester County, serves a diverse urban community with significant social and economic diversity. This Community Health Needs Assessment (CHNA) was developed to identify and prioritize key health needs within the hospital's service area and to align those priorities with the New York State Prevention Agenda 2025–2030. The assessment is part of Montefiore Health System's ongoing commitment to improving community health outcomes, promoting health equity, and ensuring that all residents—regardless of income, background, or circumstance—have access to high-quality, coordinated care.

Montefiore Mount Vernon plays a vital role in addressing the health challenges of a population that experiences higher rates of chronic disease, mental health concerns, and economic instability compared to county and state averages. In partnership with local organizations, public health agencies, and community stakeholders, MMV seeks to develop sustainable strategies that address both medical and social determinants of health. The priority areas identified for 2025–2027 include economic stability, mental health disorders, and preventive services for chronic disease. These focus areas reflect the hospital's commitment to strengthening the local health infrastructure, expanding access to care, and reducing disparities that contribute to poor health outcomes.

About Montefiore Mount Vernon Hospital

Montefiore Mount Vernon is located at 12 North Seventh Avenue, Mount Vernon NY, 10550, is a licensed 121-bed hospital. As a community-based hospital, MMV has been serving the medical needs of the community and region since its founding in 1891. MMV provides emergency, inpatient, psychiatric, critical care and ambulatory services. MMV is a Joint Commission Certified Primary Stroke Center, an HIV/AIDS Center, and site of the Beale Chronic Wound Treatment and Hyperbaric Center. The Montefiore School of Nursing is located adjacent to Montefiore Mount Vernon's Campus.

MMV is 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.

Description of Population Served

Montefiore Mount Vernon has identified Westchester County as its primary service area. Montefiore is the largest health service provider in Mount Vernon and critical services include community-based primary care and specialty ambulatory services. Moreover, partner Montefiore facilities in White Plains, Yonkers, the Bronx and Harrison, New York allow patients to have access to a range of services extending beyond the walls of Mount Vernon as needed.
According to the U.S. Census Bureau, Westchester County has a population of 1,006,447 and is approximately 430.5 square miles of land. It is the 7th most populous county in New York State. The county seat of Westchester is White Plains (62,561) and other major cities include Yonkers (211,040), New Rochelle (85,512) and Mount Vernon (71,999). In 2024, the median household income for Westchester was $118,411, 3rd highest in New York State, after Nassau, and New York Counties.

From 2014-2025, Westchester County ranked 6th in Health Outcomes and 5th in Health Factors out of the 62 counties in New York State, according to the County Health Rankings, produced by the University of Wisconsin. Despite its overall high ranking, there is considerable room to improve population health in Westchester County, while also reducing health disparities, as there are cities in the county that are hotspots for both high-need populations and poorer health outcomes.

Mount Vernon is the 3rd most populated city in Westchester County. The city is 4.4 square miles and is one of the most densely populated cities in New York State. According to the 2021 American Community Survey, Mount Vernon has 73,893 residents and has experienced 7.6% population growth from 2017 - 2020. The city has the highest proportion of non-Hispanic black residents in Westchester County at 62% (compared to 14% countywide). Additionally, it is the seat of Westchester County's homeless services and senior services programs, housing a disproportionate number of lower-income residents. Mount Vernon is located just north of the Bronx and bordered by Pelham, Bronxville, Eastchester, and Yonkers.

There are about 28,286 households in Mount Vernon. Of these, about 31.5% are family households with children. The average household size in 2.47. Of the family households with children, (45.4%) are single-headed households. Mount Vernon has a median age of 37.5 years versus 42 years in Westchester County (U.S. Census Bureau, n.d.). The median household income in Mount Vernon is $82,126, lower than the median household income of $118,411 for Westchester County, and New York State ($85,820).
In 2023, 13.6% of the population reported living in poverty. Among those affected, 21% are seniors (65 and over) and 13% are children. By comparison, the poverty rate for seniors in New York State is 14.3%, and for children, it is 18.6% (Census Reporter, n.d.).

Mount Vernon's population is racially and ethnically diverse, with Black residents comprising the majority of the community. According to U.S. Census Bureau QuickFacts, 60.4% of residents identify as Black alone, compared with 16.2% who identify as White alone; 2.2% identify as Asian alone; 0.6% identify as American Indian/Alaska Native alone; and 10.0% identify as two or more races (Native Hawaiian/Other Pacific Islander alone is reported as 0.0%). In addition, 18.3% of residents identify as Hispanic or Latino (an ethnicity that can include people of any race), and 14.8% identify as White alone, not Hispanic or Latino—highlighting the importance of culturally and linguistically responsive services tailored to a predominantly Black community with a substantial Hispanic/Latino population (U.S. Census Bureau, n.d.). While 72% of the population in

Mount Vernon speak only English at home, 28% speak other languages at home including: Spanish (18%), other Indo-European languages (5.8%), Asian and Pacific Islander languages (0.1%), and other languages (4.1%). The city's foreign-born population includes individuals from Jamaica, Italy, Portugal, Haiti, the West Indies, and Brazil, among others (City-Data.com, n.d.).

Community Health Needs Assessment Process

The process for preparing for the 2025-2027 Community Health Needs Assessment and Community Service Plan was an inter-organizational and community collaborative process, initiated with the goal of developing an assessment that was reflective of the needs of the community including both clinical and social determinants of health. As part of the primary data collection process, Montefiore Health System participated in the Community Health Needs Assessment Survey Collaborative led by the Greater New York Hospital Association (GNYHA). The Community Health Needs Assessment Survey Collaborative included multiple health systems and hospitals across New York State that agreed to work with GNYHA to develop and administer an electronic and paper-based survey across service areas; with GNYHA assumed responsibility for analyzing and reporting out on the data collected. Additionally, MMV participated in the Mid-Hudson Region Community Health Assessment (CHA) Collaborative with the Westchester County Department of Health and other hospitals and health systems in Westchester County.

Community Assets and Resources

There are many assets and resources in Westchester County that support the development, implementation, and continued success of clinical and community programs to address the health needs of the communities we serve across the county. With an area of about 450 square miles, Westchester County is located just north of New York City. It is bordered on the west by the Hudson River, on the north by Putnam County, and on the east by the Long Island Sound and Connecticut's Fairfield County. Within its 48 municipalities, Westchester County can be described as predominately a mix of urban and Suburban. Comprised of 6 cities, 19 towns, and 23 villages,

Photo from City of Mount Vernon – Recreation Department

the county is home to 43 public school districts and 24 colleges and universities. Westchester County is home to the 38-member Westchester Library System, and that serves as a cultural hub in many of its cities offering a myriad of activities and events for children, adults and seniors. Westchester County also has many parks and spaces for year-round recreation, including playgrounds for children of all ages and abilities. Many of these parks regularly host family-friendly events and seasonal festivals. In addition, Mount Vernon is home to Doles Center, a vital hub for the community. The Doles Center offers an array of services from public assistance programs to senior services and activities. Westchester County is also home to many community-based organizations, hospitals, clinics, and other social service and health care providers including four hospitals that are part of Montefiore Health System.

Description of Community Health Status

While Westchester County remains among the healthiest counties in New York State, several of its individual municipalities continue to have significant health gaps. Portions of lower Westchester, specifically Mount Vernon, Yonkers, New Rochelle and White Plains are "hot spots" for various health outcomes, including asthma and preterm births in the County (Westchester County Department of Health, n.d.). Additionally, certain groups, such as some historically marginalized racial/ethnic groups or those with less education, experience poorer health outcomes. Secondary data was used to capture a snapshot of health conditions, health outcomes and health practices among the populations across the county and, in some cases, specifically for Mount Vernon to help us understand the health needs of the populations served by MMV. This data is presented in the following paragraphs.

Some Westchester populations have higher rates of premature death compared to other populations in the county. For example, the rate of premature deaths (defined as death before the age of 65) in Westchester County is 18% which is lower than the premature death rate for New York State (22.7%) and lower than the 2024 NYS Prevention Agenda target (22.8%). Unfortunately, A closer look at these numbers reveals disparities in the percentage of premature deaths by race/ethnicity. Specifically, between non-Hispanic black and non-Hispanic white population in Westchester County, where there is a difference of 19.3%. Disparities also exist between non-Hispanic white and Hispanic populations in Westchester County with a difference of 23.4%. According to the New York State Prevention Agenda, the difference in premature death between non-Hispanic black and non-Hispanic white populations has worsened compared to 2018, when the difference in percentage between the two groups was 14.5%.

While Westchester County has an age-adjusted preventable hospitalization rate below the rate for all of New York State and the Prevention Agenda 2024 Target, there are areas and sub-populations that have excess preventable hospitalization rates. For example, the rate is 226.1 per 10,000 ZIP Code 10550 in Mount Vernon. Rates are generally elevated in the southern portion of the county, including Yonkers, Mount Vernon, the southern section of New Rochelle, and in the northern portion of the county, namely Peekskill. Further, the rate of preventable hospitalizations for the non-Hispanic black population (206.7 per 10,000) is 3.3 times higher than the rate for the non-Hispanic white population (61.9 per 10,000). The rate for the Hispanic population (53.0 per 100,00) is slightly lower than the non-Hispanic white population.

There are a multitude of reasons certain populations and geographic areas have poorer health outcomes; these reasons include, for example, differences in access to health care, quality of care, physical environments, and economic and educational opportunities, to name a few. For example, while a smaller proportion of individuals live in poverty in Westchester County than in New York State overall, those who are black (14%) and Hispanic (15.1%) are more likely to be living in poverty than those who are white (5.6%).

The Prevention Agenda 2030 target for health insurance coverage among adults age 18-64 is 97%, and in Westchester County 93% of adults are covered. While the overall number of adults with health insurance coverage in Westchester County has increased since the last Community Health Needs Assessment in 2019, in certain areas, such as Port Chester, a smaller proportion of the population has health insurance (88%), and in other areas such as Scarsdale, almost all residents have health insurance (98.9%). Additional areas with lower health insurance coverage include White Plains (91.8%), Yonkers (92.6%), and Mount Vernon (89.6%). The number of adults with health insurance coverage in New Rochelle (93.5%) is slightly higher than that of Westchester County. There are also disparities by race/ethnicity; 97.6% of the white and 93% of the black populations have health insurance, followed by 90.1% of the Hispanic population.

Disparities exist for other health outcomes in Westchester County. The following paragraphs highlight a few important health conditions where data show disparate health outcomes for different populations in Westchester County with a specific focus on populations served by MMV.

Input Representing the Broad Interests of the Community

Montefiore has a long history of broad community engagement in the Mount Vernon community. This ranges from coordination of the Community Advisory Board (CAB) at MMV which meets monthly from September to June, to 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.

Montefiore plays a leadership role in a variety of critical community and public health efforts, including membership in the Westchester County Department of Health's Hospital Planning Team and Advisory Committee meetings, board membership and strategic partnership with the local Boys and Girls Club and Youth Community Outreach Program (YCOP) for youth development and activities. Participation in these efforts gives Montefiore trust-based access to the communities

we serve, which we continue to foster by participating in, and presenting at, community sponsored events, Community Board meetings and local conferences.

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

Primary Data Collection Process

The 2025-2027 CHNA was an inter-organizational and community collaborative process, initiated with the goal of providing greater insight into the health and social needs of community members residing in Westchester County. Data presented in the 2025-2027 CHNA includes both primary data as well as complementary secondary data from a wide range of sources. The method of primary data collection involved surveys of Westchester County residents that took place during the Spring and early Summer of 2025.

MMV participated in two survey collaboratives: the Greater New York Hospital Association (GNYHA) CHNA Collaborative and the Mid-Hudson Region Community Health Assessment Collaborative. The GNYHA CHNA Collaborative survey could be completed via a web-based tool (using a computer, cellphone, or other electronic device) or on paper; the paper surveys were available in ten languages, including English, Spanish, Korean, Polish, and Italian. Due to its electronic format, dissemination of the survey was widespread, with most surveys being completed electronically. The survey was disseminated through multiple distribution points including our hospitals and clinics, community-based organizations, and government partners.

For the community survey conducted as part of the GNYHA Collaborative, a total of 3,410 surveys were completed among individuals working-in or residing-in Westchester County. Participants were asked to rank twenty-one health priorities for the community, which included options such

as cancer, smoking, obesity, diabetes, maternal health care, and mental health. Additionally, participants were asked to rank their satisfaction with the current services in their neighborhood to address those 21 health conditions. The twenty-one health conditions listed in the survey were selected to match the priorities and focus areas of the New York State Prevention Agenda. The health conditions were categorized into three groups: needs attention, maintain efforts, and relatively lower priority. These categorizations were based upon consideration of scores for both importance and satisfaction ratings.

Local health departments from each county collaborated on the CHA with the goal of conducting a regional community health assessment reaching residents as a means to assess and collaborate on regional health priorities. Hospitals within Montefiore Health System located in the mid-Hudson Region continue to collaborate with our local health departments and coordinate on the assessment and implementation of programming to address identified community needs.

Secondary Data Collection Process

In addition to the review of primary data, to capture an up-to-date high-level view of the health status of Westchester County residents, we evaluated temporal trends, differences between Westchester and peer counties and sub-county differences, when available, for more than 21 measures, including: obesity, preterm births, teen pregnancy rates, poverty, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screenings, COVID vaccination, HIV incidence, cancer incidence rates (lung, colorectal, prostate, cervical and breast), and diabetes. These data were obtained from multiple population-based datasets including the American Community Survey (formerly referred to simply as the Census), New York State Expanded Behavioral Risk Factor Surveillance System (BRFSS), New York State Statewide Planning and Research Cooperative Systems (SPARCS), New York State Vital Statistics, New York State HIV/AIDS Epidemiology Reports, and the New York State Cancer Registry. Additional data was obtained from the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard.

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Westchester County Secondary Data Sources

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

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 https://www.census.gov/programs-surveys/sahie/about.html.

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: https://www.health.ny.gov/statistics/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. https://www.health.ny.gov/statistics/brfss/expanded/

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: http://www.health.ny.gov/statistics/sparcs/.

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 https://www.health.ny.gov/prevention/obesity/statistics_and_impact/student_weight_status_data.htm

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 https://www.health.ny.gov/prevention/immunization/information_system/

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: https://www.health.ny.gov/diseases/aids/general/about/surveillance.htm.

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: https://www.health.ny.gov/diseases/aids/general/about/surveillance.htm

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, proportion of infants exclusively breastfed in the hospital, the adolescent pregnancy rate, the suicide rate, and the opioid burden rate. For more

information on the New York State Vital Records please visit:
https://www.health.ny.gov/statistics/vital_statistics/

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
https://www.cdc.gov/nchs/nvss/index.htm

Data Tools

City Health Dashboard: The City Health Dashboard is produced by the Department of Population Health at NYU Langone and the Robert F. Wagner School of Public Service at NYU, in partnership with the National Resource Network. It is funded through the Robert Wood Johnson Foundation. The dashboard aggregates data from multiple sources for the 500 largest cities in the United States, including Yonkers, Mount Vernon and New Rochelle. For more information please see:
https://www.cityhealthdashboard.com/

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 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 important areas of intervention to improve population health. Data are available at: https://vizhub.healthdata.org/gbd-compare/

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 see: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Summary of Findings from Community Health Needs Assessments

The analysis of primary and secondary data resulted in selected areas identified as areas for continued activity and future focus. Results from the survey showed that residents desired programs and interventions that address 12 health conditions – see table 1.

Needs Attention	Maintain Efforts	Relatively Lower Priority
Violence (including gun violence)	Access to healthy/nutritious foods	Arthritis/disease of the joints
Stopping falls among elderly	Cancer	Assistance with basic needs like food, shelter, and clothing
Mental health disorders (such as depression)	Dental care	Access to continuing education and job training programs
Obesity in children and adults	Heart disease	Substance use disorder/addiction (including alcohol use disorder)
Affordable housing and homelessness prevention		Job placement and employment support
		Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah

		Sexually Transmitted Infections (STIs)
		School health and wellness programs
		Infant health
		Asthma, breathing issues, and lung disease
		HIV/AIDS (Acquired Immune Deficiency Syndrome)

Table 1. List of priority health conditions identified by Westchester County residents through the 2025 Community Health Needs Survey.

Results from the community survey conducted with the GNYHA Collaborative were used to identify specific key focus areas within each of the four Prevention Agenda Priority Areas for the Community Service Plan. These were identified as follows:

- *Economic Stability* -Regular SDOH screening within healthcare settings provides a proactive approach to identifying patients facing economic instability. By assessing factors such as income, employment, and access to basic needs, hospitals can connect patients to community-based organizations and social service resources that address underlying drivers of poor health. This integrated model of care aligns with the New York State Prevention Agenda (2025–2030) priority of promoting economic stability and reducing health inequities.
- *Mental Health Disorders- Depression:* Reducing anxiety and stress through coordinated prevention and early identification strategies aligns with the New York State Prevention Agenda (2025–2030) goals of promoting well-being and resilience across populations.
- *Health Care Access and Quality – Preventive Services for Chronic Disease Prevention and Control:* Improve diagnosis of prediabetes and referrals to the National Diabetes Prevention Program (DPP) lifestyle change programs among high-burden MV adults. MMV's goal is to increase the percentage of patients referred to DPP from 10% to 30%.

This section provides a summary of findings resulting from the Community Health Needs surveys conducted through the GNYHA CHNA Survey Collaborative in Summer 2025.

GNYHA CHNA Survey Collaborative

The following section summarizes key results from the GNYHA CHNA Collaborative survey described in the previous section. The results present respondents' demographic data, COVID-related questions, and overall health assessment questions related to respondents and their neighborhoods.

In total, 3,410 individuals working or residing in Westchester County completed the survey. Among respondents, the most common languages spoken at home were English and Spanish, others included Cantonese, Mandarin, Bengali, Arabic, Russian, and Korean. It is important to note that survey participants were allowed to skip any questions they felt uncomfortable responding to. Some participants left questions blank, which may impact the data.

The anonymous survey asked respondents about --their age, gender, and education level. These demographic data are presented in Table 1. The data shows respondents of the Community Health Survey were primarily adults and older adults, between the ages of 45-74. Seventy-two percent of respondents were female while 26% were male. For education level, 56% of the respondents completed college or more.

Table 1: Socio-demographic percentages of Westchester County Community Health Survey Respondents

	Number	Percent
Age		
18 - 24	102	5%
25 - 34	200	9%
35 - 44	333	15%
45 - 54	319	15%
55 - 64	427	20%
65 - 74	452	21%
75+	330	15%
Gender Identity		
Cisgender Man	553	26%
Cisgender Woman	1,554	72%
Gender Minority	47	2%

Education		
Grades 8 (Elementary) or less	83	4%
Grades 9 through 11 (Some High School)	104	5%
Grade 12 or GED (High School Graduate)	315	15%
College 1 year to 3 years (Some college or technical school)	444	21%
College 4 years or more (College graduate)	1,191	56%
Grades 8 (Elementary) or less	83	4%

Table 2 continues the sociodemographic data of respondents, highlighting employment status, annual household income, and health insurance. The two most represented employment status of respondents were “retired” and “employed full-time for wages or salary” at 46% and 29% respectively. Just over half of respondents reported an annual household income of $100,000 or more at 34%. Overwhelming, the two most common health insurance that respondents have are “a plan purchased through an employer or union” at 39% and Medicare at 33%.

Table 2: Socio-demographic percentages of Westchester County Community Health Survey Respondents Continued

Employment Status		
Employed for wages	976	46%
Self-employed	144	7%
Out of work for 1 year or more	61	3%
Out of work for less than 1 year	64	3%
A homemaker	88	4%
A student	59	3%
Retired	610	29%
Unable to work	97	5%
Annual Household Income		
Less than $20,000	284	15%
$20,000 to $24,999	116	6%
$25,000 to $34,999	140	7%
$35,000 to $49,999	163	9%
$50,000 to $74,999	226	12%
$75,000 to $99,999	208	11%
$100,000 to $149,999	268	14%
$150,000 to $199,999	167	9%
$200,000 or more	308	16%

Health Insurance		
A plan purchased through an employer or union (including plans purchased through another person's employer)	828	39%
A private nongovernmental plan that you or another family member buys on your own	54	3%
Medicare	706	33%
Medigap	6	0%
Medicaid	264	12%
Children's Health Insurance Program (CHIP)	13	1%
Military related health care: TRICARE (CHAMPUS) /VA health care /CHAMP-VA	7	0%
Indian Health Services	1	0%
State sponsored health plan	99	5%
Other government program	32	1%
No coverage of any type	124	6%

Table 3 presents the racial and ethnic data collected from survey respondents. Forty three percent of respondents identified as White alone followed by Hispanic at 30%, Black or African American alone at 17%, and Asian alone at 5%. Of those of Hispanic/Latinx origin or ancestry, Puerto Rican, Mexican, and Colombian were the most represented respondents at 28%, 15%, and 13%.

Table 3: Racial and Ethnic percentages of Westchester County Community Health Survey Respondents

Race/Ethnicity		
American Indian or Alaska Native alone	13	1%
Asian alone	103	5%
Black or African American alone	353	17%
Hispanic or Latino alone	621	30%
Middle Eastern or North African alone	15	1%
Native Hawaiian or Pacific Islander alone	3	0%
White alone	901	43%
Multiracial and/or Multiethnic	94	4%
Hispanic/Latinx Origin or Ancestry		

Puerto Rican	28%
Mexican	15%
Colombian	13%
Other South American	10%
Other Central American	8%
Dominican	7%
Ecuadorian	7%
Cuban	4%
Other	9%

Implementation Strategy Report and Community Service Plan

Through the process of completing and reviewing data obtained through the primary and secondary sources, engaging with community stakeholders and key partners and a review of resources available within the Medical Center and through its partnerships, an Implementation Strategy and Community Service Plan was developed to address the significant needs identified. This section of the report describes the strategies to be implemented by Montefiore Medical Center to address the identified needs of the population.

As stated in the Primary Data Collection section of this report, MMV used multiple strategies to gather input from community members about their health-related needs and concerns for the community. In the GYNHA CHNA Collaborative survey, we used data from a key survey question about 34 health conditions to help us identify which health needs to address in this cycle. The health conditions question in the GNYHA CHNA Collaborative survey asked respondents to rate twenty-one health conditions on both their level of importance and satisfaction with present services. The twenty-one health conditions listed in the survey were selected to match the priorities and focus areas of the New York State Prevention Agenda. The health conditions were categorized into three groups: needs attention, maintain efforts, and relatively lower priority. These categorizations were based upon consideration of scores for both importance and satisfaction ratings. The three health conditions listed in the “Needs Attention” category have relatively high ratings of importance and low ratings of satisfaction. Those in the “Maintain Efforts” category had high importance ratings paired with high satisfaction ratings. The remaining

category of “Relatively Lower Priority” contained health conditions that respondents categorized as lower in importance and medium to high satisfaction scores.

The community members identified three health conditions that need attention, nine health conditions to maintain efforts, and nine health conditions of relatively lower priority in their neighborhood (Table 1).

Needs Attention	Maintain Efforts	Relatively Lower Priority
Violence (including gun violence)	Access to healthy/nutritious foods	Arthritis/disease of the joints
Stopping falls among elderly	Cancer	Assistance with basic needs like food, shelter, and clothing
Mental health disorders (such as depression)	Dental care	Access to continuing education and job training programs
Obesity in children and adults	Heart disease	Substance use disorder/addiction (including alcohol use disorder)
Affordable housing and homelessness prevention		Job placement and employment support
		Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah
		Sexually Transmitted Infections (STIs)
		School health and wellness programs
		Infant health
		Asthma, breathing issues, and lung disease
		HIV/AIDS (Acquired Immune Deficiency Syndrome)

Table 1. List of priority health conditions identified by Westchester County residents through the 2025 Community Health Needs Survey.

The completion of a Community Health Needs Assessment and Implementation Strategy Report is a requirement of the Internal Revenue Service’s 990 tax documentation requirements under the

Patient Protection and Affordable Care Act (PPACA). The PPACA requires hospitals to assess and address the health needs of the communities they serve. This Community Health Needs Assessment meets the first component of these requirements, providing a report of the process, methods and results of a comprehensive assessment of the needs of the community served by Montefiore Mount Vernon. The second component encompasses the Implementation Strategy, which further discusses the significant health needs of the community, describes the programs and strategies to address these significant health needs and delineates the metrics to be used to evaluate the impact of these strategies. The program, strategies and metrics chosen must align with priority areas outlined in the New York State Prevention Agenda 2025-2030.

Significant Needs to Be Addressed

In the Comprehensive Community Services Plan for 2025–2027, the City of Mount Vernon identified three key priority areas: economic stability, mental health disorders, and preventive services for chronic disease. These priorities align closely with the New York State Prevention Agenda 2025–2030 and reflect the city's commitment to addressing the underlying social and systemic factors that influence health outcomes. Strengthening economic stability through regular screening for social determinants of health (SDOH) allows healthcare providers to identify residents facing financial hardship and connect them to essential community resources. Focusing on mental health, particularly in the prevention and early identification of depression supports statewide efforts to promote emotional resilience and well-being across populations. Enhancing access to preventive services for chronic disease, such as improving the diagnosis of prediabetes and expanding referrals to National Diabetes Prevention Program (DPP) lifestyle interventions, aims to reduce disease burden and improve health equity among high-risk adults. Together, these priorities represent a targeted and integrated approach to improving population health and advancing the goals of the NYS Prevention Agenda within the Mount Vernon community.

The City of Mount Vernon presents a unique and pressing set of health and social challenges that distinguish it from the broader Westchester County and New York State contexts. While located in one of the wealthiest counties in New York, Mount Vernon faces persistent disparities that align more closely with under-resourced urban areas across the state. These disparities affect

economic stability, mental health outcomes, and access to preventive healthcare services, making localized attention essential under the New York State Prevention Agenda 2025–2030.
Economic stability remains one of Mount Vernon's most significant challenges. The city's poverty rate, ranging between 14–16%, is more than double that of Westchester County's average of 6–7%, and slightly higher than the statewide rate of approximately 13%. Median household income in Mount Vernon—around $63,000—is drastically lower than Westchester County's median of about $118,000, underscoring the deep economic divide that exists within the county. Many residents experience housing cost burdens, spending more than 30% of their income on rent or mortgages, which leaves fewer resources for food, healthcare, and other essentials. Food insecurity is also rising, as evidenced by growing reliance on local food pantries and assistance programs. These economic pressures limit residents' ability to achieve stable, healthy lives and contribute to downstream health problems such as chronic disease, mental distress, and reduced preventive care utilization. In contrast, while Westchester County as a whole benefits from strong employment rates and abundant resources, inequities in job access, education, and transportation isolate communities like Mount Vernon from those opportunities. This economic instability directly contributes to the social determinants of health priorities outlined in the NYS Prevention Agenda, which emphasizes equitable access to economic and social resources as a foundation for health equity.

Mental health is another area where Mount Vernon faces disproportionate needs compared to the county and state. Rates of depression, anxiety, and stress-related disorders are higher among Mount Vernon residents, particularly among lower-income populations, seniors, and youth. Economic hardship, community violence, and the lingering effects of the COVID-19 pandemic have further intensified psychological strain. Access to mental health services is limited—many residents rely on emergency departments or primary care providers for behavioral health care instead of specialized mental health professionals. This problem is compounded by cultural stigma surrounding mental illness and a shortage of culturally competent providers in the area. In contrast, other parts of Westchester County, especially affluent northern and central suburbs, have a dense network of private practitioners and behavioral health programs. Mount Vernon's

mental health landscape demonstrates the uneven distribution of care within the county and highlights why the NYS Prevention Agenda's focus on early intervention, resilience-building, and integrated behavioral health services is particularly relevant here. Expanding access to mental health resources in Mount Vernon aligns directly with the state's goal to reduce inequities in mental and emotional well-being.

Chronic disease prevention and access to quality healthcare also pose ongoing challenges for Mount Vernon residents. The prevalence of diabetes in Mount Vernon is estimated at 13–15%, notably higher than the county average of 10% and above the state's average of around 11%. Hypertension and cardiovascular disease rates are likewise elevated. These statistics are compounded by lower rates of preventive care utilization and late-stage diagnosis of conditions that could have been mitigated earlier through regular screening and referral programs. Despite being located near well-resourced hospitals and clinics within Westchester County, Mount Vernon residents often face logistical and financial barriers to care. Gaps in insurance coverage, limited health literacy, and transportation challenges prevent many from accessing preventive services. In response, initiatives such as increasing referrals to the National Diabetes Prevention Program (DPP) from 10% to 30% represent a measurable and evidence-based strategy to improve chronic disease outcomes in the city. This effort aligns squarely with the NYS Prevention Agenda 2025–2030 goals of expanding community-based prevention and strengthening care coordination between healthcare systems and public health organizations.

Overall, the comparison between Mount Vernon, Westchester County, and New York State reveals a pattern of concentrated disparity within a broader context of abundance. Mount Vernon's socioeconomic hardships elevate mental health burden, and lower access to preventive care stands in stark contrast to the wealth and resources that characterize most of Westchester County. The city's challenges demonstrate why localized, equity-focused strategies are essential for achieving the broader objectives of the NYS Prevention Agenda. By addressing the intertwined issues of economic instability, mental health access, and chronic disease prevention, Mount Vernon can move toward greater health equity and improved community well-being, ultimately

contributing to the state's overarching goal of reducing health disparities and promoting resilience across all populations.

Priority	*Economic Stability*
Focus Area	Poverty
Goal	➢ *SMART Goal: 4.0* Reduce the percentage of people living in poverty from 13.6% to 12.5%. o *SMART(IE) Goal: 4.1* Increase the percentage of adults, with an annual income of less than $25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 85.1% to 89.4%.
Intervention	Conduct regular screening of patients at MMV for SDOH for unmet Housing Security and Affordability for Social Determinant of Health (SDOH) factors like income and unemployment. MMV's goal is to increase the percentage of patients screened for SDOH upon inpatient admission to MMV to 50%.

Priority	*Mental Health Disorders*
Focus Area	Depression
Goal	➢ *SMART Goal:* 7.0 Decrease the percentage of adults who experience frequent mental distress from 13.4% to 12.0%. o SMART(IE) Goal: Reduce the percentage of adults with major depressive episodes from 6.7% to 5.7%.
Intervention	Integrate behavioral health into primary care by: ➢ Promoting the use of standardized screening tools such as depression screening and refer patients to behavioral health providers.

Priority	*Health Care Access and Quality*
Focus Area	Health Care Access and Quality – Preventive Services for Chronic Disease Prevention and Control
Goal	Goal 30.0 Increase the percentage of adults aged 35 years and older who had a test for high blood sugar in the past year from 78.1% to 82.4%.
Intervention	Improve diagnosis of prediabetes and referrals to the National Diabetes Prevention Program (DPP) lifestyle change programs among high-burden

MV adults. MMV's goal is to increase the percentage of patients referred to DPP from 10% to 30%.

Discussion of Interventions to Address Identified Health Needs

For the 2025-2027 Implementation Strategy, Montefiore has elected to retain the three priority areas selected from the last reporting cycle. In the Comprehensive Community Services plan developed for 2025-2027, the priority areas selected were Prevent Chronic Disease, Promote Healthy Women Infants and Children, and Prevent Communicable Diseases. Although Westchester County has continued to be among the top five in many health outcomes and has shown improvements along with the rest of New York State, the rates for conditions identified in the communities of Mount Vernon remains higher in most cases than the countywide and statewide averages. Also, as explained in the earlier section "Description of Community Health Status" there are disparate health outcomes among different populations in Westchester County. Data also shows that cities within the county also show differences in health outcomes, and in some cases, little or no improvement.

Significant Needs Not Addressed

When looking at the results from the GNYHA CHNA Collaborative Survey, three health conditions were identified by participants as needing attention. These priorities include Violence (including gun violence), dental care and affordable housing and homelessness prevention. While the programs selected for the Community Health Needs Assessment -Implementation Strategy Report and Community Service Plan do not address these health conditions, there are existing and planned programs across Montefiore Health System to address these community-identified priorities. Montefiore-Einstein Psychiatry Associates offers in-person and video therapy visits for adults and children addressing a wide range of conditions. In addition to individual, family and group mental health services, Montefiore partners with community organizations offer virtual and in-person workshops covering a range of topics related to mental health that are led by our providers. Additionally, representatives from Montefiore Health System are actively participating in the Gun Violence Prevention Collaborative led by Northwell Health and are learning from other

hospitals, local health departments and community-based organizations about existing and planned strategies to address gun violence in the state. Montefiore provides many programs and services for the communities it serves that are not the programs featured in the Community Health Needs Assessment - Implementation Strategy Report and Community Service Plan. This includes a list of over 60 programs addressing the priorities laid out in the New York State Prevention Agenda.

Since the last report in 2022, the use of a low-cost internet database has expanded in the public sphere such as Findhelp. Additionally, OCPH manages the vendor relationship with Findhelp, a community resource directory and referral platform. Findhelp is embedded in our electronic health record, Epic, which allows patient care teams to connect patients who identify social needs to community resources.

Since the previous version of this report in 2019, Montefiore has continued to expand and has a goal to scale screening and referring patients for unmet social needs. This includes the use of the electronic database platform www.findhelp.org to connect patients to needed resources, which has been a challenge for the health care sector. This online tool is a much more comprehensive and practical alternative to the home-grown referral guides that many health care providers have had to use in the past. Those were hard to keep-up-to-date and difficult to search, a problem that is largely addressed by the online version.

While MMV has elected to focus on three programs for the 2025-2027 Community Health Needs Assessment and Community Service Plan, there are multiple resources that have been developed at Montefiore independently and through partnership with other organizations. Even so, there continues to be a need for community-based programs and resources that can augment Montefiore's programs and services. There is an extensive set of resources that are available to meet the needs of Westchester residents which cannot be met entirely by Montefiore program and services, and/or are available for those that choose to use external organizations.

As described within the Community Description and Service Area section of this proposal, Westchester County, while gradually increasing in ethnic diversity, has hotspots where populations, up to 90%, identify as a cultural/racial/ or ethnic minority. As the racial and ethnic populations have shown disparate rates of impact, in consultation and collaboration with community partners, MMV have selected to work on three priority areas from the New York State Prevention Agenda: 1) Economic Stability, 2) Mental Health Disorders and 3) Prevent Chronic Diseases. The following sections include short descriptions and tables summarizing the selected Prevention Agenda Priority Areas and interventions for Montefiore Mount Vernon.

Priority Area: Economic Stability

Community feedback consistently highlighted the urgent need for support with food, housing, clothing, and financial resources. The CHNA outcomes showed that over 2,000 Westchester residents identified affordable housing and homelessness prevention as health concerns, and that over 2,200 residents were unsatisfied with current neighborhood services to address those needs.

Economic stability is a critical determinant of health, influencing an individual's ability to access housing, food, healthcare, and other essential resources. In Westchester, persistent poverty continues to drive health disparities and limit opportunities for wellness and self-sufficiency. As of 2023, **approximately 13.6% of Mount Vernon residents live below the federal poverty line,** compared to 14.2% statewide. The **median household income is $77,190 and** remains significantly lower than the New York State median of

Older adults in Mount Vernon, New York, are disproportionately affected by financial hardship. In Mount Vernon, roughly one in five residents aged sixty-five and older live below the federal poverty line, a rate significantly higher than Westchester County's overall rate. County data show that poverty is primarily concentrated among Black and Hispanic seniors, and that nearly 38% of older adults in Westchester live alone, increasing their risk for isolation and unmet needs. As housing and utility costs continue to rise and renter households across Westchester become increasingly rent-burdened, many low-income older adults in Mount Vernon struggle to keep up with rent, utilities, and other basic expenses. At the same time, Mount Vernon has been identified

as one of the county's areas with the greatest unmet hunger needs, and local reports suggest that about one in six older adults face the threat of hunger, often skipping meals or choosing less nutritious foods. Together, these ongoing challenges, such as food insecurity, high housing cost burden, and other financial pressures, contribute to chronic physical and mental health stress, social isolation, and reduced well-being, healthcare access, and poorer overall health outcomes for older adults in Mount Vernon.

Regular SDOH screening within healthcare settings provides a proactive approach to identifying patients facing economic instability. By assessing factors such as income, employment, and access to basic needs, hospitals can connect patients to community-based organizations and social service resources that address underlying drivers of poor health. This integrated model of care aligns with the **New York State Prevention Agenda (2025–2030)** priority of promoting economic stability and reducing health inequities.

By systematically identifying and addressing poverty-related needs, this initiative supports measurable progress toward reducing poverty rates, addressing inequities, and improving the quality of life across Bronx communities. The implementation of SDOH screening will not only help achieve the stated goals but also strengthen collaboration between healthcare and community partners to advance population health outcomes.

Priority Area	Domain 1: Economic Stability
Focus Area	Housing Stability and Affordability
Smart Goal	*4.0* Reduce the percentage of people living in poverty from 13.6% to 12.5%.
SMART(IE) Goal	*4.1* Increase the percentage of adults, with an annual income of less than $25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 85.1% to 89.4%.
Interventions/Strategies/ Activities	Conduct regular screening of patients at MMV for SDOH for unmet Housing Security and Affordability for Social Determinant of Health (SDOH) factors like income and unemployment. MMV's goal is to increase the percentage

	of patients screened for SDOH upon inpatient admission to MMV to 50%.
Measures	Participation among community organizations in health assessments, track progress on data collection and collection methods
Partner(s)	Hospital and Patients
Disparities	Socioeconomic disparity is directly linked to adverse health outcomes, negatively affecting physical and socioemotional health as well as educational development. NYS's poverty rate remains around 14%, slightly above the national average of 11.1%.2 Poverty rates among older adults in NYS are significantly higher than those of the general population, highlighting the unique challenges faced by seniors in maintaining financial sustainability. These findings highlight a persistent issue within the state, prompting ongoing efforts to address the root causes and provide support to those living in poverty to lift them out of these conditions. Data from New York University's City Health Dashboard shows that in 2019 9.8% of adults aged 18years and older in New Rochelle reported having diabetes. In Mount Vernon, 12.7% of adults reported having diabetes. Additionally, in previously reported data between 2008/2010 and 2012/2014, the adult hospitalization rate for short-term complications of diabetes increased slightly from 3.7 to 4.4 per 10,000 in Westchester County. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic Black or Hispanic-populations that have been identified as having a higher risk for diabetes.

Priority Area: Mental Health Disorders

Mental health emerged as one of the top concerns in the 2025 Community Health Survey. Westchester residents identified depression, anxiety, and stress as leading health issues, with limited access to affordable behavioral health care. Social stigma, economic strain, and provider shortages further compound these challenges.

In Westchester, where economic hardship and social stressors are widespread, the burden of anxiety and stress is particularly acute. Approximately one in five adults in low-income households (earning less than $25,000 annually) report frequent mental distress, nearly double the rate of the general adult population. Economic instability, food insecurity, high rent burden, unemployment, and exposure to community violence contribute to ongoing psychological strain among residents.

The social determinants of health, particularly income, housing stability, and access to healthcare, play a critical role in shaping mental health outcomes. Individuals experiencing poverty are more likely to encounter chronic stress, limited access to mental health services, and barriers to preventive care. This link underscores the need to integrate mental health screening, early intervention, and resource referral into healthcare and community settings.

Reducing anxiety and stress through coordinated prevention and early identification strategies aligns with the New York State Prevention Agenda (2025–2030) goals of promoting well-being and resilience across populations.

Priority	Mental Health Disorders
Focus Area	Depression
Smart Goal	7.0 Decrease the percentage of adults who experience frequent mental distress from 13.4% to 12.0%.
SMART(IE) Goal	Reduce the percentage of adults with major depressive episodes from 6.7% to 5.7%.

Interventions/Strategies/ Activities	Integrate behavioral health into primary care by: ➢ Promoting the use of standardized screening tools such as depression screening and refer patients to behavioral health providers.
Measures	Participation rate among organizations of focus, number of people screened, number of successful referrals made to needed services as a result of screening
Partner(s)	Hospital and patients
Disparities	According to the New York State Department of Health, mental disorders are both common and disabling, with more than one in 5 individuals in NYS experiencing symptoms of a mental disorder annually. Notably, one in ten adults and children face mental health challenges severe enough to impair their daily functioning in work, family, and school settings. The prevalence of depression varies across different groups. For individuals in Black, Indigenous, and People of Color (BIPOC) communities, there is an increased risk of Post Traumatic Stress Disorder (PTSD), depression, and substance use due to chronic experiences of stress, threats, and violent events that occur in direct relation to race and aspects of identity. Data from the NYS Prevention Agenda Dashboard shows that in Westchester County, the percentage of infants who were breastfed was 52.5%. The percentage of infants breastfed in Westchester County overall was higher than that in New Rochelle (50%) and Mount Vernon (42.4%). Also, in Westchester County, the proportion of infants that were exclusively breastfed is highest for non-Hispanic white populations (57.4%), followed by Hispanic (35.7%) and non-Hispanic black populations (34.9%). The numbers for Hispanic and non-Hispanic black populations decreased since the last report. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic Black or Hispanic

Priority Area: Health Care Access and Quality

Preventative Services for Chronic Disease and Prevention and Control

Preventive screenings are an important line of defense in identifying and treating chronic conditions like diabetes. The 2024 New York State Prevention Agenda objective for the percentage of adults 45 years older who have been tested for high blood sugar is 71.7%. In Westchester County, 51.4% of adults have tested high blood sugar in the past 3 years compared to 47.5% in New York State. Unfortunately, in Westchester County, this measure has reduced from 67.3% in 2016. In New York State, this measure has also decreased from previous years - 67.2% in 2019 and 63.8% in 2018.

Education and socioeconomic status are also important determinants of health status and outcomes. In New York State, those with some post-high school education (63.4%) and college graduates (62.7%) are more likely to have had a test for high blood sugar or diabetes within the past three years, compared to high school graduates/ GED (58.1%) and those who have not completed high school (52.6%). Additionally, according to the Centers for Disease Control and Prevention (CDC) Places Project Data, 12.1% of adults in Mount Vernon reported having diabetes, compared to 10.1% in Westchester County and 10.1% in New York State.

Priority Area	Health Care Access and Quality
Smart Goal	Goal 30.0: Improve high blood sugar testing rates
SMART(IE) Goal	30.0 Increase the percentage of adults aged 35 years and older who had a test for high blood sugar in the past year from 78.1% to 82.4%.
Interventions/Strategies/ Activities	Improve diagnosis of prediabetes and referrals to the National Diabetes Prevention Program (DPP) lifestyle change programs among high-burden MV adults. MMV's goal is to increase the percentage of patients referred to DPP from 10% to 30%.

Measures	Increased number of participants in Lifestyle Change Program
Partner(s)	Providers and patients
Disparities	In NYS, chronic diseases such as heart disease, stroke, cancer, chronic obstructive pulmonary disease, diabetes, and obesity are the leading causes of disability and death. They have a significant burden and fundamentally reduce one's overall quality of life, causing 6 out of 10 deaths. Social and structural inequities lead to stark racial and ethnic disparities and disproportionately impact the most vulnerable populations, including people of color. The prevalence of diabetes and obesity among Black non-Hispanic and Hispanic adults is also greater.

Asthma

There is tremendous geographic variation in the rate of asthma ED visits for people aged 0-17 years in Westchester County. While Westchester County has a rate of 88.9 per 10,000, below the rate for New York State overall (99.9) and the Prevention Agenda 2024 Target (131.1), certain areas have much elevated rates. Specifically, the asthma ED visit rate ranges from 247.3 per 10,000 population in ZIP Code 10550 in Mount Vernon, to 13.5 per 10,000 in parts of Rye. Rates are generally elevated in Mount Vernon, southern portions of New Rochelle, Yonkers, White Plains, Ossining, and Peekskill.

Cancer

There are several types of high-risk HPV linked to cancer. HPV is linked to cervical cancers, anal cancers, oropharyngeal cancers, vaginal cancers, vulvar cancers, and penile cancers. The CDC estimates that about 37,300 cases of cancer are caused by HPV each year.

An average of 2,821 residents in New York State were diagnosed with an HPV-related cancer each year between 2015 – 2019, with about 59% of cases in women, and about 41% in men. Incidence

rates in New York State for all HPV-related cancers combined were higher or Black non-Hispanic women (15.3) compared to Hispanic women (14.3), White non-Hispanic women (13.7), and other non-Hispanic women (9.7). Among men in the state, total HPV-related cancer incidence was higher for White non-Hispanic men (11.4), followed by Hispanic men (9.5), Black non-Hispanic men (8.9), and other non-Hispanic men (3.2). To protect against cancers caused by HPV, CDC recommends two doses of HPV vaccine for boys and girls who receive their first dose before age 15, and three doses for older teens and young adults who start the vaccine series at ages 15 through 26 and for immunocompromised persons.

Medically Underserved/HPSA Designation Status

Medically Underserved Area (MUA) and Medically Underserved Population (MUP) designations identify geographic areas and populations with a lack of access to primary care services. MUAs have a shortage of primary care health services for residents within a geographic area (for example, a whole county, urban census tracts, or civil divisions). MUPs have a shortage of primary care health services for a specific population subset within an established geographic area. Shortage designation identifies an area, population, or facility experiencing a shortage of health care services, including primary, dental or mental health care providers. These groups may face economic, cultural, or linguistic barriers to health care.

An Index of Medical Underservice (IMU) score is calculated. An IMU score ranges between 0 (highest need) and 100 (lowest need). In order to qualify as an MUA the score must be less than or equal to 62.0. Areas with limited health care professionals experience hindered health care access, creating longer wait times and delayed care and diagnosis.

In New York State, Westchester and Orange Counties have the highest number of MUAs and MUPs. The city of Mount Vernon was deemed to have a geography that meets the criteria as a medically underserved area, with respect to its access to primary care services. Despite some

Medically Underserved Areas and Medically Underserved Population (MUP)			
County	**Area Name**	**Designation Type**	**IMU* Score**
Dutchess	Low Income - Poughkeepsie	MUP Low Income	59.2
Dutchess	Migrant & Seasonal Farm Worker - East Dutchess	MUP Low Income	44.8
Orange	Orange Service Area (02397 - Newburgh)	Medically Underserved Area	55.5
Orange	Village of Kiryas Joel Service Area	Medically Underserved Area	45.0
Orange	Village of Walden Service Area	Medically Underserved Area	60.8
Orange	Low Income - Middletown Service Area	MUP Low Income	58.2
Rockland	Village of New Square Service Area	Medically Underserved Area	45.5
Rockland	Low Income - Haverstraw	MUP Low Income	61.6
Sullivan	Low Income - Monticello	MUP Low Income	61.4
Sullivan	Low-income - Western Sullivan Service Area	MUP Low Income	59.3
Sullivan and Ulster	Low Income - Wawarsing/ Fallsburg S Area	MUP Low Income	61.8
Ulster	Plattekill Town - County	Medically Underserved Area	58.8
Westchester	Westchester Service Area (02394 - Yonkers)	Medically Underserved Area	41.2
Westchester	Westchester Service Area (02395 - Mount Vernon)	Medically Underserved Area	54.0
Westchester	Westchester Service Area (02399 - Elmsford)	Medically Underserved Area	61.6
Westchester	Westchester Service Area (02400 - Peekskill)	Medically Underserved Area	58.8

Note: IMU = Index of Medical Underservice*
Source: HRSA Data Warehouse, 2021

challenges, the City of New Rochelle is not considered an underserved community by MUA/HPSA standards.

Table 2. List of Medically Underserved Areas and Medically Underserved Populations in the mid-Hudson Region of New York State.

In addition to the multiple resources that have been developed at Montefiore independently and through partnership with other organizations, there continues to be a need for community-based programs and resources that can augment Montefiore's programs and services.

There is an extensive set of resources that are available to meet the needs of Westchester residents which cannot be met entirely by Montefiore program and services, and/or are available for those that choose to use external organizations. The use of multiple free and low-cost internet databases has expanded in the public sphere such as Findhelp among others that have reduced the need for quickly obsolete and expensive-to-produce information and community resources referral guides.

Since the previous version of this report in 2022, Montefiore has continued to expand and has a goal to scale screening and refer patients for unmet social needs. This includes the use of the

electronic database platform www.findhelp.com to connect patients to needed resources, which has been a challenge for the health care sector. This online tool is a much more comprehensive and practical alternative to the home-grown referral guides that many health care providers have had to use in the past. Those were hard to keep-up-to-date and difficult to search, a problem that is largely addressed by the online version.

Many Montefiore sites have been introduced to this online resource and teams continue the work to integrate this kind of solution more seamlessly into the various workflows across the ambulatory, ED and inpatient settings. As Montefiore is an organization that works with complex health needs and whose community faces multi-factorial structural barriers that impact overall health, providing information, accessibility and review of such external resources and links, allows Montefiore to better address patients' social needs and build on the work of community-based organizations in serving the community.

The use of an internet database will allow Montefiore to connect patients to important community resources provided outside of the health system by many of our community partners to address community needs such as housing (quality and affordability), transportation, employment, and education. Montefiore recognizes the importance of addressing these needs, as part of our approach to addressing the social determinants of health and are utilizing our strong community partnerships to continue to provide services for Westchester residents.

Dissemination Plan

The plan to disseminate the delivery of the Montefiore Medical Center 2025-2027 Community Health Needs Assessment and Implementation Strategy Report, and Community Service Plan to the public will occur across several platforms. The Community Health Needs Assessment-Implementation Strategy Report and Community Service Plan Report will be posted to the www.montefiore.org website at the address: https://www.montefiore.org/community-reports.

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. Physical copies of the report will be available at the main entrances for each of the acute care facilities at the Security Desk. Appropriate staff will also provide community presentations to discuss the findings of the report and their relationship to community interests.

The report will be sent via email to members of the Montefiore Community Advisory Boards, 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 Mayor.

A QR code for the link to the report will be made available for print materials to facilitate ease of access to the report.
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 Health Needs Assessment and Community Service Plan has been distributed as technological advances allow for broader distribution.

Adoption of Report by Governing Board

The Montefiore Mount Vernon Community Health Needs Assessment (CHNA) process, secondary data, and the Community Service Plan was approved by Montefiore Board of Trustees on

December 3, 2025. The Community Health Needs Assessment (CHNA) report was uploaded to the Montefiore website on December 31, 2025.

Many Montefiore sites have been introduced to this online resource, and teams continue the work to integrate this kind of solution more seamlessly into the various workflows across the ambulatory, ED and inpatient settings. As Montefiore is an organization that works with complex health needs and whose community faces multi-factorial structural barriers that impact overall health, providing information, accessibility and review of such external resources and links, allows Montefiore to better address patients' social needs and build on the work of community-based organizations in serving the community.

Appendix

GNYHA CHNA Collaborative Survey

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 PAGE 3. 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

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
- ○ Lewis County
- ○ Livingston 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
- ○ Suffolk County
- ○ Sullivan County
- ○ Tioga County
- ○ Tompkins County
- ○ Ulster County
- ○ Warren County
- ○ Washington County
- ○ Wayne County
- ○ Westchester County
- ○ Wyoming County
- ○ Yates County

- ○ Other_____

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 health issue?

	How important is this issue to you?						How satisfied are you with current services?					
	Don't know	Not at all	A little	Somewhat	Very	Extremely	Don't know	Not at all	A little	Somewhat	Very	Extremely
1 Access to healthy/nutritious foods	○	○	○	○	○	○	○	○	○	○	○	○
2 Adolescent and child health	○	○	○	○	○	○	○	○	○	○	○	○
3 Arthritis/disease of the joints	○	○	○	○	○	○	○	○	○	○	○	○
4 Asthma/breathing problems or lung disease	○	○	○	○	○	○	○	○	○	○	○	○
5 Cancer	○	○	○	○	○	○	○	○	○	○	○	○
6 Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah	○	○	○	○	○	○	○	○	○	○	○	○
7 COVID-19	○	○	○	○	○	○	○	○	○	○	○	○
8 Dental care	○	○	○	○	○	○	○	○	○	○	○	○
9 Diabetes/elevated sugar in the blood	○	○	○	○	○	○	○	○	○	○	○	○
10 Heart disease	○	○	○	○	○	○	○	○	○	○	○	○
11 Hepatitis C/liver disease	○	○	○	○	○	○	○	○	○	○	○	○
12 High blood pressure	○	○	○	○	○	○	○	○	○	○	○	○
13 HIV/AIDS (Acquired Immune Deficiency Syndrome)	○	○	○	○	○	○	○	○	○	○	○	○
14 Infant health	○	○	○	○	○	○	○	○	○	○	○	○
15 Mental health/depression	○	○	○	○	○	○	○	○	○	○	○	○
16 Obesity in children and adults	○	○	○	○	○	○	○	○	○	○	○	○
17 Sexually Transmitted Infections (STIs)	○	○	○	○	○	○	○	○	○	○	○	○
18 Stopping falls among elderly	○	○	○	○	○	○	○	○	○	○	○	○
19 Substance use disorder/drug addiction (including alcohol use disorder)	○	○	○	○	○	○	○	○	○	○	○	○
20 Violence (including gun violence)	○	○	○	○	○	○	○	○	○	○	○	○
21 Women's and maternal health care	○	○	○	○	○	○	○	○	○	○	○	○

10 **What are your COVID-19 needs?** (Select all that apply)

- ☐ At-home COVID-19 tests
- ☐ Boosters for COVID-19
- ☐ In-person testing for COVID-19 (e.g., doctor's office, pharmacy, mobile van)
- ☐ Personal protective equipment (e.g., masks, hand sanitizer, face shields, gloves)
- ☐ Treatment for COVID-19
- ☐ Reliable source(s) of information on COVID-19
- ☐ COVID-19 vaccination

11 In the last 12 months, was there a time when you needed medical care in-person but did not get it for any reason?

- ○ Yes
- ○ No → Skip to 13

12 For which of the following reasons could you not get medical care in-person the last 12 months? (Select all that apply)

- ☐ I could not afford the cost of care (e.g., copay, deductible)
- ☐ I did not have health insurance
- ☐ There were no available appointments, or I couldn't get an appointment soon enough
- ☐ I could not get through on the telephone to make the appointment
- ☐ Once I got there the wait was too long to see the doctor
- ☐ I did not have transportation
- ☐ I did not have childcare
- ☐ Because of COVID-19
- ☐ Other
- ☐ None of the above

13 In the last 12 months, was there a time when you needed medical care by video or phone but could not get it for any reason?

- ○ Yes
- ○ No → Skip to 15

14 **For which of the following reasons could you not get medical care by video or phone in the last 12 months?** (Select all that apply)

- ☐ I could not afford the cost of care (e.g., copay, deductible)
- ☐ I did not have health insurance
- ☐ There were no available appointments, or I couldn't get an appointment soon enough
- ☐ I could not get through on the telephone to make the appointment
- ☐ I did not have a computer, phone, or other device to use for the visit
- ☐ I did not know how to see the doctor by video or phone
- ☐ I did not have internet
- ☐ I did not have data or minutes in my phone plan to use for a visit
- ☐ I did not have a private place to have my appointment
- ☐ Other
- ☐ None of the above

15 **In the last 12 months, have you experienced any of the following?** (Select all that apply)

- ○ Anxiety or depression
- ○ Difficulty paying your rent/mortgage
- ○ Difficulty paying utilities or other monthly bills
- ○ Increased household expenses
- ○ Increased medical expenses
- ○ Hunger or skipped meals because you did not have enough money to buy food
- ○ None of these

16 **What type of health insurance do you use to pay for your doctor or hospital bills? Is it insurance through:**

- ○ A plan purchased through an employer or union (including plans purchased through another person's employer)
- ○ A plan that you or another family member buys on your own
- ○ Medicare
- ○ Medicaid or other state program
- ○ TRICARE (formerly CHAMPUS), VA, or Military
- ○ Alaska Native, Indian Health Service, Tribal Health Services
- ○ Some other source
- ○ I do not have any kind of health insurance coverage

17 What is your age?

_____

18 Are you…

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Another gender
- ○ Prefer not to say

19 Do you describe yourself as…

- ○ Lesbian or Gay
- ○ Straight, that is not Gay
- ○ Bisexual
- ○ Other
- ○ Prefer not to say

20 Are you Hispanic or Latino/Latina/Latinx?

- ○ No
- ○ Yes → Answer 21

21 Which group best represents your Hispanic or Latino/Latina/Latinx origin or ancestry?

- ○ Puerto Rican
- ○ Dominican
- ○ Mexican
- ○ Ecuadorian
- ○ Colombian
- ○ Cuban
- ○ Other Central American
- ○ Other South American
- ○ Other

22 **Which one or more of the following would you say is your race?** (Select all that apply)

- ☐ White
- ☐ Black or Black American → Answer 23

  23 **Some people in addition to being Black, have a certain heritage or ancestry. Do you identify with any of these?** (Select all that apply)

  - ☐ African American
  - ☐ Caribbean or West Indian
  - ☐ A recent immigrant or the child of recent immigrants from Africa
  - ☐ Other
- ☐ Asian → Answer 24

  24 Please tell me which group best represents your Asian heritage or ancestry?

  - ☐ Chinese
  - ☐ Asian Indian
  - ☐ Filipino
  - ☐ Korean
  - ☐ Japanese
  - ☐ Vietnamese
  - ☐ Other
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian, Native, First Nations, Indigenous Peoples of the Americas, or Alaska Native
- ☐ Other

25 What is the highest grade or year of school that you have completed?

- ○ Grades 8 (Elementary) or less
- ○ Grades 9 through 11 (Some High School)
- ○ Grade 12 or GED (High School Graduate)
- ○ Some college or technical school
- ○ College graduate or more

26 Including yourself, how many people usually live or stay in your home or apartment?

_____person(s)

27 What is the primary language you speak at home?

- ○ English
- ○ Spanish
- ○ Mandarin
- ○ Cantonese
- ○ Russian
- ○ Yiddish
- ○ Bengali
- ○ Korean
- ○ Haitian Creole
- ○ Italian
- ○ Arabic
- ○ Other

28 What is your current employment status? Select the category that best describes you.

- ○ Employed full-time for wages or salary
- ○ Employed part-time for wages or salary
- ○ Self-employed
- ○ Out of work for 1 year or more
- ○ Out of work for less than 1 year
- ○ A homemaker
- ○ A student
- ○ Retired
- ○ Unable to work

29 **What is your household's annual household income from all sources, before taxes, in the last year?** By household income we mean the combined income from everyone living in the household including even roommates or those on disability income.

- ○ Less than $20,000
- ○ $20,000 to $29,999
- ○ $30,000 to $49,999
- ○ $50,000 to $59,999
- ○ $60,000 to $74,999
- ○ $75,000 to $99,999
- ○ $100,000 or more

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