On September 30, 2013 The Hospitals comprising Continuum Health Partners combined with Mount Sinai Medical Center to form the Mount Sinai Health System.

The Mount Sinai Health System is an integrated health care system providing exceptional medical care to our local and global communities. Encompassing seven hospital campuses in the New York metropolitan area, as well as a large, regional ambulatory footprint, Mount Sinai is acclaimed internationally for its excellence in research, patient care, and education across a range of specialties. The Mount Sinai Health System was created from the combination of The Mount Sinai Medical Center and Continuum Health Partners, which both agreed unanimously to combine the two entities in July 2013.

The Health System is designed to increase efficiencies and economies of scale, improve quality and outcomes, and expand access to advanced primary, specialty, and ambulatory care services throughout a wide clinical network. The System includes 2,784 full- and part-time physicians, 3,783 voluntary physicians, and 12 freestanding ambulatory surgery centers. With more than 430 full- and part-time primary care physicians, clinical teams are able to manage large populations of patients in the lowest-cost, most effective settings. The System also features a robust and continually expanding network of multispecialty services, including more than 45 ambulatory practices throughout the five boroughs of New York City, Westchester, and Long Island. It has more than 40 clinical and academic relationships with other local health care organizations, and Mount Sinai physicians can be found in more than 200 community locations throughout the New York metropolitan area. With an extraordinary array of resources for the provision of compassionate, state-of-the-art care, the Mount Sinai Health System is poised to identify and respond to the health-related needs of the diverse populations we serve.

The Mission
The mission of the Mount Sinai Health System is to provide compassionate patient care with seamless coordination and to advance medicine through unrivaled education, research, and outreach in the many diverse communities we serve.

Vision
An unrivaled academic medical center, Mount Sinai’s vision is to continue to grow and challenge convention through our pioneering spirit, scientific advancements, forward-thinking leadership, and collaborative approach to providing exceptional patient care.
History of Continuum Health Partners

In January of 1997, **Beth Israel Medical Center** and **St. Luke’s-Roosevelt Hospital Center** joined to form **Continuum Health Partners, Inc.** This entity became the parent corporation of each hospital, while each hospital continued its separate corporate identity. Both institutions had well over a century of providing care to New York’s poor and elderly, and an active tradition of community involvement, responsiveness to community needs and commitment to the improved health of the communities they served. Through the Continuum relationship, each hospital retained its own identity, its own governance structure, and its own unique relationship with its communities and its own financial independence. However, the relationship allowed the hospitals to work together in areas of mutual benefit, such as purchasing, human resource management, marketing and public affairs, government and community affairs, managed care contracting and information systems. It also, however, allowed each hospital to retain its unique and separate qualities, with separate clinical leadership. The dynamic, vibrant and community-based characteristics of each hospital were successfully retained within the relationship, distinguishing the Continuum Hospitals from many of their counterparts.

In September of 1999, **The New York Eye and Ear Infirmary** — a specialty institution with a proud 189 year tradition of service to the Lower East Side of Manhattan, became the newest member of the Continuum network.

**Recognition Of The Unique Role Of Continuum Hospitals**

The Continuum Hospitals are distinguished by the extraordinary degree to which they provide uncompensated care to their communities and serve as hospitals for New York’s poor and elderly. Each hospital has long been recognized for its role as a “safety net” hospital that serves a disproportionate number of Medicaid, low-income elderly and uninsured patients, and is distinguished by a similar inpatient payor mix that is over 60% Medicaid, Medicare and uninsured patients. As a group, the three Continuum Hospitals account for approximately 8% of the State’s Medicaid hospital expenditures.

Notwithstanding the extraordinary financial pressures faced by all NY hospitals, the Continuum Hospitals continue to expand basic services and provide health education and outreach. The Continuum Hospitals offer a wide array of hospital-sponsored community health education and screening events. The community is notified of these events and screenings by various means - mailings, advertising in local newspapers, flyers, and through mailings of various NYC Community Boards, etc. Most of these are free to those we serve. In addition, Continuum generates an extraordinarily well-used health website – [www.chpny.org](http://www.chpny.org) – offering on-line health education and physician referral. In 2012, **2,594,377** visitors browsed the Continuum website. The Continuum Hospitals provide multi-lingual educational materials for their patients and communities and markets their services in New York’s diverse ethnic communities.
Mission Statement

St. Luke's-Roosevelt Hospital Center, formed by merger in 1979, was a combination of three hospitals, each with a distinguished history of accomplishment and public service.

St. Luke's Hospital was founded in 1846, in affiliation with the Episcopal Church to “provide care for the sick poor.” Women's Hospital was established in 1855, for the “treatment of diseases peculiar to women.” Roosevelt Hospital, chartered in 1864, was dedicated to “the reception and relief of sick and diseased persons.”

From the beginning, the Hospitals have considered spiritual, moral and emotional support for their patients as integral to the important work of healing. They have been aided by the contributions of people of good will of many faiths and moral and ethical traditions in a truly ecumenical effort.

In keeping with the traditions of these hospitals, the mission of the St. Luke's-Roosevelt Hospital Center is to provide:

- Outstanding health care to meet the needs of the Hospital Center’s West Side community and the broader community of patients who utilize the services of the Hospital Center. Such care is provided without discrimination, including the care of the poor, while recognizing the limitations of the resources of the Hospital.
- Highest quality education of health professionals.
- Research to further medical knowledge and develop excellence in the delivery of health care.

Communities Served

This assessment is being submitted on behalf of St. Luke’s-Roosevelt Hospital Center

St. Luke’s and Roosevelt Hospitals offer a wide range of specialty services that cater to a large number of patients located throughout the southern portion of New York State and parts of New Jersey and Connecticut.

For purposes of this Assessment we have analyzed our Core Market.

Core Market is a smaller geography than a Primary Service Area (PSA), and provides a view of the neighborhoods in close proximity to a hospital, where the hospital’s sphere of influence is strongest.

Core Markets are defined through careful examination of the nearby neighborhoods with high market share and patient origin, and from which it is reasonable to think the hospital might serve a larger share of the residents.
Overview

Mount Sinai St. Luke's

With 523 beds, St. Luke’s Hospital serves as the principal health care provider for the West Harlem and Morningside Heights communities and operates one of Manhattan’s few Level 1 trauma services. Founded in 1847, it is home to the Al-Sabah Arrhythmia Institute, a world-class, multidisciplinary center specializing in the care and treatment of heart ailments. St. Luke’s Hospital also enjoys an outstanding reputation for services in many other medical specialties, including internal medicine, geriatrics, trauma, bariatric surgery, vascular disease, HIV/AIDS, cardiac care, physical rehabilitation, psychiatric disorders, and substance abuse. St. Luke’s Hospital also continues to expand its commitment to community-based ambulatory care and access to primary and specialty care.

The Hospital (and its designees) serves as Board members of the Morningside Area Alliance, the West Manhattan Chamber of Commerce, the Greater Harlem Chamber of Commerce, and as members of the Lincoln Square BID.

Mount Sinai Roosevelt Hospital, A Member of the Mount Sinai Health System

With 505 beds, Roosevelt Hospital is a full-service community and tertiary-care hospital with an emergency department serving Midtown and the West Side of Manhattan. Since its founding in 1871, it has placed strong emphasis on primary and specialty care. The hospital serves as the home to several renowned clinical services, including those in endovascular surgery, cancer, cardiology, and obstetrics and gynecology. Roosevelt Hospital also maintains a strong primary care presence in its surrounding neighborhoods through ambulatory and physician practices and through longstanding partnerships with some of New York’s largest federally qualified health centers, particularly the William F. Ryan Community Health Center.
### Neighborhood Information

**Neighborhood:** Central Harlem  
**Zip Codes:** 10026, 10027, 10030, 10034, 10039  
**Percentage of Patients:** 24%

### Health Indicators: Percentage of Residents Non-Age Adjusted

- **Weight:** 40.6 Overweight, 24.4 Obese
- **HPB:** 23.5 yes/ever
- **High Chol:** 19.4 yes/ever
- **Diabetes:** 09.0 yes/ever
- **Smoker:** 16.7
- **Fmr Smoker:** 14.1
- **Binge Drinker:** 24.8
- **Heavy Drinker:** No reliable data available
- **Asthma:** 10.6 ever, 1.8 currently
- **HIV Testing:** 53.9 within last 12 Mos, 24.8 more than 12 Mos, 21.3 never tested
- **Colonoscopy:** 59.9 (only 50+)
- **Flu Vaccine:** 42.4 received flu vaccine

**Self Reported Health:** (Rating Choice: Excellent, Very Good, Good, Fair or Poor)
- 31.2 Excellent:
- 33.1 Very Good:
- 24.1 Good:
- 11.6 Fair/Poor:
Neighborhood: Upper West Side Zip Codes: 10023, 10024, 10025, 10069
Percentage of Patients: 24%

<table>
<thead>
<tr>
<th>Health Indicators: Percentage of Residents Non-Age Adjusted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight: 29.7 Overweight 8.1 Obese</td>
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<tr>
<td>Smoker: 8.4</td>
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<td>Fmr Smoker: 23.7</td>
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<tr>
<td>Binge Drinker: 28.8</td>
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<tr>
<td>Heavy Drinker: 9.1</td>
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<tr>
<td>Asthma: 8.1 ever No reliable data available currently</td>
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<tr>
<td>HIV Testing: 27.1 Within last 12 Mos 41.7 More than 12 Mos 31.2 Never Tested</td>
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<tr>
<td>Colonoscopy: 76.9 (only 50+)</td>
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<td>Flu Vaccine: 44.2 Received flu vaccine</td>
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<tr>
<td>Self Reported Health: (Rating Choice: Excellent, Very Good, Good, Fair or Poor)</td>
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<tr>
<td>31.2 Excellent:</td>
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<tr>
<td>26.6 Very Good:</td>
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<tr>
<td>31.3 Good:</td>
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<tr>
<td>10.8 Fair/Poor:</td>
</tr>
</tbody>
</table>
Neighborhood:  ● Washington Heights  
 ● Inwood  
 Zip Codes:  10031, 10032, 10033, 10034, 10040  
 Percentage of Patients:  16%  

**Health Indicators: Percentage of Residents Non-Age Adjusted.**

<table>
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<th>Health Indicator</th>
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<td>Heavy Drinker</td>
<td>11.1</td>
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<tr>
<td>Asthma</td>
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<tr>
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<tr>
<td>Colonoscopy</td>
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<tr>
<td>Flu Vaccine</td>
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<td>Self Reported Health</td>
<td>(Rating Choice: Excellent, Very Good, Good, Fair or Poor)</td>
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<tr>
<td></td>
<td>Excellent: 19.3</td>
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<td>Fair/Poor: 25.0</td>
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<td></td>
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</table>
Neighborhood:  
- Chelsea
- Greenwich Village
- Clinton
- Soho

Percentage of Patients: 15.0

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<td>30.9 Never Tested</td>
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<tr>
<td>Colonoscopy: 60.1 (only 50+)</td>
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<tr>
<td>Flu Vaccine: 46.3 Received flu vaccine</td>
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Self Reported Health:  
(Rating Choice: Excellent, Very Good, Good, Fair or Poor)  
22.7 Excellent:  
41.3 Very Good:  
18.3 Good:  
17.8 Fair/Poor:
**Neighborhood:** Central Harlem  
**Zip Codes:** 10026, 10027, 10030, 10034, 10039  
**Percentage of Patients:** 8%

### Health Indicators: Percentage of Residents Non-Age Adjusted.

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<td>Fair/Poor:</td>
<td>11.6</td>
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Neighborhood:  
- Washington Heights  
- Inwood  
Zip Codes: 10031, 10032, 10033, 10034, 10040

Percentage of Patients: 6%

### Health Indicators: Percentage of Residents Non-Age Adjusted.

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**Self Reported Health:**  
(Rating Choice: Excellent, Very Good, Good, Fair or Poor)

- 19.3 Excellent:  
- 22.3 Very Good:  
- 33.5 Good:  
- 25.0 Fair/Poor:
Manhattan Community Board 4 was greatly affected by the closure of the St. Vincent’s Catholic Medical Center. To assess the effects of the closure, Board 4 partook in a community health needs assessment. The needs identified by studies were:

- Access to Care
- Emergency Services
- HIV/AIDS
- Substance Abuse
- In addition Community Board 4 additionally found the need for:
  - Services for seniors
According to the 2014 District Needs Statement the needs identified by studies were:

- Homeless Services including:
  - AIDS
  - Mental Health
  - Addiction

- Services for seniors:
  - In home services
  - Adult Day Programs
Manhattan Community Board 9 has not done a Community Health Assessment for 2014.

The only one found from 2011 states:

- Ambulatory Care services for prenatal care,
- Services for addicted mothers and teenagers
- Mental Health Services for youth
According to their District Needs Statement:

- Cerebral Vascular Disease
- Cancer
- Heart Disease
- HIV Related Illness
- Obesity
- Substance Abuse
- Teen Pregnancy
- Access to care for Seniors
Community Health Outreach and Education

St. Luke’s and Roosevelt Hospitals maintain a robust series of education and screening programs through our Community Health Education and Outreach Programs. For the last twenty years, this has been accomplished through the work of the Department of Government & Community Affairs and its community outreach program. The Department’s integral partnerships and inter-departmental and external collaborations have only heightened healthcare delivery and community outreach accessibility. The Hospitals are committed to the health screenings and other activities staged through their outreach efforts. They have taken specific steps to ensure that they are closely targeted to the community’s health needs.

Cardiovascular Diseases and Diabetes

African Americans and Latinos represent one of the highest-risk groups for Type 2 Diabetes and Hypertension in terms of prevalence and disease burden. The Department of Government and Community Affairs has been addressing health disparities in the underserved communities by providing innovative outreach activities offered through the Department’s Community Health Education and Outreach Programs. Last year, the department participated in more than 30 events, conferences, lectures, street festivals, cultural festivals, and other community outreach initiatives, conducting health screenings which included blood pressure, total cholesterol, HDL, and blood glucose, and prostate cancer, at churches, beauty salons, and community centers in Harlem. More than 1,200 people (predominantly African American and Latino/Hispanic) were screened and, when medically necessary, referred participants to one of St. Luke’s or Roosevelt Hospitals’ medical facilities. In addition, this department has led the Barbershop Quartet Initiative and CHOSEN Program (Church-based Health Outreach, Screening and Education Network) each serving as a vehicle for delivering screening, prevention and health education services to a largely indigent and medically underserved and underrepresented minority populations.

Childhood Obesity

The New York Obesity Research Center (TNYORC), at St. Luke’s and Roosevelt Hospital, has a strong professional education program, committed to advancing the training of physicians and scientists who take pride in serving at-risk members of our communities surrounding the Harlem. Although specific physiological and environmental factors are known to increase the risk of obesity, little is known about how these factors interact in individual children and within economically disadvantaged communities with a higher than average prevalence of obesity, such as those within SLR’s catchment area. Over the last decade, TNYORC’s has made combating the increasing childhood obesity problem a prime focus. This is in response to the growing racial and ethnic disparities, and disproportionate health outcomes, experienced in our communities. Some ways they have strived to combat this epidemic include:

- Body Composition Studies: Where they utilize their pre-eminent body composition laboratory to account for accurate non-invasive measurement of BMI.
- Food Intake Studies: where they utilize The Child Taste and Eating Lab to make nutritious food more appealing and edible to children.
• Epidemiological Studies: Where they continually design research projects that focus on areas that assess long term implications and outcomes of childhood obesity. Thereafter, they intend to utilize this research to develop new strategies for preventing and treating obesity, in the Latino and African American communities.

St. Luke’s and Roosevelt Hospital Centers have also collaborated with numerous Community-Based Organizations to ensure that the hospitals are addressing the community’s health needs. They have partnered with organizations such as:

- Abyssinian Baptist Church
- Alpha Phi Alpha Senior Citizens Center
- American Diabetes Association
- Assemblyman Danny O’Donnell’s Office
- Assemblyman Keith Wright
- Bat For A Cause
- Caanan Baptist Church
- Christian Cultural Center
- Clergy and Citizens With A Purpose
- Community School Districts #3 and #5 (Harlem)
- Duryea Presbyterian Church
- Eastchester Presbyterian Church
- Emblem Health
- Greater Harlem Chamber of Commerce
- Healthfirst Health Plan
- Iris House, Inc
- National Council of Jewish Women NY Section
- New York City Housing Authority
- New York Yankees
- Omega Psi Phi Fraternity
- St. Gregory the Great Parish
- Teacher’s College
- Touro College
- West Manhattan Chamber of Commerce

In addition, the department of Government & Community Affairs has ongoing collaboration with internal medical departments which include:

- Breast Surgery Department
- Cardiology Department
- Endocrinology Department
- H.E.A.L. Center Program
- Neurology Department
- Pediatric Department
- Psychiatry Department
- The New York Obesity Research Center
- Urology Department
- Vascular Surgery Department
- Women, Infants and Children Program (WIC)
Caring For Our Underserved Communities by Reducing Racial Health Disparities and Disproportionate Health Outcomes

St. Luke's and Roosevelt Hospitals have developed strategies for specific groups of New Yorkers to make their lives healthier and better. Each new initiative is designed to provide culturally-sensitive care, build awareness among hospital staff about the differences in diverse populations, and provide improved educational opportunities and access to quality care. The Community Health Education and Outreach Program is known for its innovative outreach initiatives, including screening hundreds of African Americans and Latinos across various socio-economic and health coverage backgrounds in Harlem and its surrounding communities. These screenings focus on cardiovascular disease and diabetes prevention and awareness. Additionally, the Hospital and its Community Health Education and Outreach Programs, address behavioral modification and disease-management by referring community members to their primary care facilities in order to manage their respective diseases.

- Out of approximately 1,200 persons that were screened, 57% were female and 43% were male.
- Fifty-eight percent of the females had abnormal glucose levels while 42% of the males also had elevated glucose levels indicative of a possible diagnosis of Diabetes Mellitus (Type 2).
- The total cholesterol blood levels were also measured, with 67% of the female participants having elevated blood levels versus 33% of the males.
- The blood pressure readings were elevated for fifty one percent of the females and 49 percent of the males screened.

After participants are screened for diabetes, hypertension, and heart disease they have an individualized consultation with a medical professional who discusses the screening results with them. Persons with abnormal results are referred to their primary care physicians for further evaluation. If a participant has a severely abnormal result, they are referred to the nearest emergency room for immediate medical attention. Participants are counseled on proper nutrition, daily exercise, the importance of medical follow-up with their primary care provider and adherence to their medications, if applicable. Departmental staff follow-up on abnormal results with a telephone call and/or a letter reminding the participant on the importance of further evaluation.

If a participant is uninsured or underinsured, they are referred to the Hospital Center’s H.E.A.L. Center finance program. The Center provides assistance in applying for public health insurance. However, if the participant is ineligible for public health insurance they are placed on the hospital’s sliding fee scale so they can receive affordable health care services.

Combating Childhood Obesity

It is estimated that 15 percent of American children are obese. Over the past twenty years, the proportion of overweight children ages 6 through 11 has more than doubled, and the rate for adolescents ages 12 through 18 has tripled. Additionally, obese children are at increased risk of developing high cholesterol, high blood pressure and Type 2 Diabetes. According to the CDC, obesity is more prevalent among African Americans and Hispanic/Latinos.
There are significant racial and ethnic disparities in obesity prevalence among U.S. children and adolescents, in comparison to studies conducted almost 20 years ago. In 2007-2008, the prevalence of obesity was significantly higher among Mexican-American adolescent boys (26.8%) than among non-Hispanic white adolescent boys (16.7%). In contrast to data extrapolated from the CDC’s National Health and Nutrition Examination Survey (NHANES III) (1988-1994) there was no significant difference in prevalence between Mexican-American and non-Hispanic white adolescent boys. Among girls in the period 2007-2008, non-Hispanic black adolescents (29.2%) were significantly more likely to be obese compared with non-Hispanic white adolescents (14.5%). Similarly, non-Hispanic black adolescent girls (16.3%) were more likely to be obese compared with non-Hispanic white adolescent girls (8.9%) in the period 1988-1994, according to the same data from NHANES III. Subsequently it is a primary focus of The New York Obesity Research Center, to reduce racial and ethnic disparities as listed below:

Between 1988-1994 and 2007-2008 the prevalence of obesity increased:
- From 11.6% to 16.7% among non-Hispanic white boys.
- From 10.7% to 19.8% among non-Hispanic black boys.
- From 14.1% to 26.8% among Mexican-American boys.

Between 1988-1994 and 2007-2008 the prevalence of obesity increased:
- From 8.9% to 14.5% among non-Hispanic white girls.
- From 16.3% to 29.2% among non-Hispanic black girls.
- From 13.4% to 17.4% among Mexican-American girls.

Since the majority of the communities we serve reflect these racial and ethnic groups, SLR is committed to counteract the burdens of pediatric obesity through community outreach in schools and neighborhoods throughout the city and state.

In addition to these programs, the Infectious Disease Control Department maintains an active program of Community Influenza Vaccination Programs at the following locations:

- Encore West
- Lincoln Synagogue
- Mount Calvary
- Notre Dame Church
- Assemblymember Rosenthal’s Office
- Schwab House
- Self Help
- St. Gregory Church
- St. John the Divine Soup Kitchen
- St. John the Divine Employees
- St. Paul’s Church
- Young Israel
Public Participation

To assess the overall health needs of the communities served by Beth Israel Medical Center data and information was collected from the following sources:

- **New York City Department of Health 2011 survey:**
  

- New York City Community Boards served by St. Luke's and Roosevelt Hospitals whose membership contain representatives of Community-Based Organizations, Employees of FHQC’s, and concerned residents. Additionally, the local community boards retrieve data from health care recipients and providers when assessing their district needs.
- William F. Ryan Health Centers / Ryan Chelsea Clinton
- Hatzolah Ambulance Service
- St. Luke's and Roosevelt Hospitals' Community Advisory Board

Assessment and Selection of Public Health Priorities

A Community Assessment Survey, conducted among St. Luke’s and Roosevelt Hospitals’ community members throughout our catchment area, cited both Cardiovascular Disease, Diabetes, and Obesity as top community health needs.

The New York City Department of Health Survey data, covering the catchment areas served by St. Luke's and Roosevelt Hospitals, showed that a majority of residents were concerned about cardiovascular disease and diabetes and childhood obesity. It further demonstrated that the more economically disadvantaged the neighborhood, the higher the incidence of both cardiovascular disease, diabetes and childhood obesity.

As both of these areas are the primary focus of the Prevention Agenda (*Priority Area 1, Focus Areas 1 and 3*), it was determined that by addressing these two health sectors, we could then be enhancing the health, well-being, and overall quality of life among our underserved and at-risk communities.

2013-2017 Prevention Agenda

**PRIORiTY #1: PREVENTING CHRONiC DISEASES**

I. **FOCUS AREA 1: Reduce Obesity in Children and Adults**

**Childhood Obesity**

Goal #1.2: Prevent childhood obesity through early child-care and schools.
Overarching Objective 1.0.1:

By December 31, 2017, reduce the percentage of children who are obese:

- By 5% from 13.1% (2010) to 12.4% among WIC children (ages 2-4 years). *(Data Source: NYS Pediatric and Pregnancy Nutrition Surveillance System [PedNSS]).* The department will continue to inform, and provide information on appropriate community health forums or events that provide services to the infant and youth populations.

- By 5% from 17.6% (2010-12) to 16.7% among public school children Statewide reported to the Student Weight Status Category Reporting system. *(Data Source: NYS Student Weight Status Category Reporting [SWSCR]) (Prevention Agenda [PA] Tracking Indicator)*

- By 5% from 20.7% (2010-11) to 19.7% among public school children in New York City represented in the NYC Fitnessgram. *(Data Source: NYC Fitnessgram) (PA Tracking Indicator)*

Interventions for Reducing Childhood Obesity for Objective #1.0.1

- Develop and implement community-led, place-based interventions targeted to address the social determinants of health in high-priority vulnerable communities.

- Reduce educational disparities by race, ethnicity, and income that underlie disparities in obesity risk factors, obesity, and obesity-related diseases.

Objective 1.2.1:

By December 31, 2017, increase the number of school districts whose competitive food policies meet or exceed the Institute of Medicine recommendations:

- *(Baseline is expected to be determined in 2012 from a collaborative NYS Department of Health/NYS Education Department project. (Data Source: NYS Education Department Local Wellness Policies, 2)*

Interventions for Reducing Childhood Obesity for Objective #1.2.1

- Increase healthy eating and physical activity agendas by fostering partnerships and collaborations with schools and our clinical setting to link health care-based efforts with community prevention activities.

- Adopt regulations and policies designed to implement standards that will support quality nutrition, increased physical activity in schools.
  - Increase staff training, community support and reinforcement of these regulations and policies.

- Develop and provide support for the implementation, monitoring and enforcement of NYS Education Department learning standards for physical education and nutrition in grades K-12.
II. FOCUS AREA 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Cardiovascular Diseases and Diabetes

Goal #3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.

Objective 3.1.4:
By December 31, 2017, increase the percentage of adults, 18 years and older, who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%. (Data Source: NYS BRFSS)

Interventions for Reducing Cardiovascular Disease and Diabetes per Goal #3.1

- Continue biometric screenings for high blood sugar or diabetes, high blood pressure, and abnormal cholesterol levels in the community. Increase health outreach in the community and among community partners.

- Utilize health communications to build public awareness and demand.

- Continue to build collaborations among community-based organizations, and faith-based sectors, independent living centers, businesses and clinicians to identify and serve underserved groups.
  - Design and implement culturally relevant programs tailored to improve access to preventive services.

- Establish training programs across the health professional spectrum, to include enhancement of patient-centered skills, disability, literacy and providers’ cultural competency.

Goal #3.3: Promote culturally relevant chronic disease self-management education.

Objective 3.3.1:
By December 31, 2017, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their chronic condition. (Data Source: BRFSS; annual measure, beginning 2013)

Interventions for Reducing Cardiovascular Disease and Diabetes per Goal #3.3

- Ensure consumer access to, and coverage for, preventive services, through referrals to our clinical and financial services which offer counseling services to consumers.
• Develop widely-accessible behavioral tools (i.e., modification and surveillance workshops, health education seminars) that educate members of the community on disease epidemiology, disease self-management and medical interventions.
  
  o Connect health care providers and community members to use lifestyle intervention professionals and specialists, (i.e. registered dietitians, exercise physiologists and social workers.

2013-2017 Prevention Agenda

PRIORITY #1: PREVENTING CHRONIC DISEASES

I. FOCUS AREA 1: Reduce Obesity in Children and Adults

Childhood Obesity

Goal #1.2: Prevent childhood obesity through early child-care and schools.

Overarching Objective 1.0.1:

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• By 5% from 20.7% (2010-11) to 19.7% among public school children in New York City represented in the NYC Fitnessgram. (Data Source: NYC Fitnessgram) (PA Tracking Indicator)

• Interventions for Reducing Childhood Obesity for Objective #1.0.1

• Develop and implement community-led, place-based interventions targeted to address the social determinants of health in high-priority vulnerable communities.

• Reduce educational disparities by race, ethnicity, and income that underlie disparities in obesity risk factors, obesity, and obesity-related diseases.

Objective 1.2.1:

By December 31, 2017, increase the number of school districts whose competitive food policies meet or exceed the Institute of Medicine recommendations

• (Baseline is expected to be determined in 2012 from a collaborative NYS Department of Health/NYS Education Department project. (Data Source: NYS Education Department Local Wellness Policies)
Interventions for Reducing Childhood Obesity for Objective #1.2.1

- Increase healthy eating and physical activity agendas by fostering partnerships and collaborations with schools and our clinical setting to link health care-based efforts with community prevention activities.
- Adopt regulations and policies designed to implement standards that will support quality nutrition, increased physical activity in schools.
  - Increase staff training, community support and reinforcement of these regulations and policies.
- Develop and provide support for the implementation, monitoring and enforcement of NYS Education Department learning standards for physical education and nutrition in grades K-12.

II. FOCUS AREA 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Cardiovascular Diseases and Diabetes

*Goal #3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.*

*Objective 3.1.4:*  
By December 31, 2017, increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%. *(Data Source: NYS BRFSS)*

*Interventions for Reducing Cardiovascular Disease and Diabetes per Goal #3.1*

- Continue to biometric screenings for high blood sugar or diabetes, high blood pressure, and abnormal cholesterol levels in the community. Increase health outreach in the community and among community partners.
- Utilize health communications to build public awareness and demand.
- Continue to build collaborations among community-based organizations, and faith-based sectors, independent living centers, businesses and clinicians to identify and serve underserved groups.
  - Design and implement tailored culturally relevant programs to improve access to preventive services.
- Establish training programs across the health professional spectrum, to include enhancement of patient-centered skills, disability literacy and providers’ cultural competence.

*Goal #3.3: Promote culturally relevant chronic disease self-management education.*

*Objective 3.3.1:*  
By December 31, 2017, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. *(Data Source: BRFSS; annual measure, beginning 2013)*
Interventions for Reducing Cardiovascular Disease and Diabetes per Goal #3.3
- Ensure consumer access to and coverage for preventive services, through referrals to our clinical and financial services that offer counseling services to consumer.
- Develop widely accessible behavioral modification and surveillance workshops and health education seminars that educate members of the community on disease epidemiology, disease self-management and medical interventions.
  - Connect health care providers and community members to use lifestyle intervention professionals and specialists, (i.e. registered dietitians, exercise physiologists and social workers.

THREE-YEAR ACTION PLAN
On September 30, 2013, St. Luke’s-Roosevelt Hospitals (SLR) and other former Continuum Health Partner Hospitals combined with Mount Sinai Hospital, Mount Sinai Queens, and the Icahn School of Medicine at Mount Sinai to form the Mount Sinai Health System. As a member of the Mount Sinai Health System, St. Luke’s and Roosevelt hospitals remain committed to addressing the 2014-2017 Prevention Agenda’s Action Plan. However, the implementation plan and strategies for a three-year period are difficult to outline so early in process.

Increase Awareness and Interventions to Reduce Childhood Obesity:

Year One 2014:
- In the midst of the transition, MSSL and MSRH strive to develop and implement community-led, place based intervention targeted to address childhood obesity and the social determinants of health that contribute to the rise of childhood obesity in high-priority vulnerable communities (per Objective #1.0.1).
- Throughout this year, MSSL and MSRH will focus on developing programs that will strengthen and support evidence-based nutritional education in early child care settings and potentially schools. Since the community we serve is so ethnically diverse, we intend on creating nutritional programs that demonstrate healthier living, through culturally-sensitive cuisines and cooking plans.
- In order to optimize adaptation and ensure that these children and their parents are adopting a more active and nutritious lifestyle, we are establishing internal and external partnerships to fuel the aforementioned programs.

Year Two 2015:
- MSSL and MSRH will increase healthful eating and physical activity agendas by fostering partnerships and collaborations with schools, academia, policy makers, elected officials and our clinical setting to link health care based efforts with community prevention activities (per Objective #1.2.1).
• The Department of Government & Community Affairs outreach will host health workshops and discussions at local schools to address healthcare accessibility, health literacy, nutrition and physical activity to an audience of parents, educators and students.

• Furthermore, MSSL and MSRH will be hosting health fairs at schools for students and their families, in addition to conducting free health screenings for parents.

• Ultimately, by the end of YR2 the hospitals plan to utilize these interventions to further reduce health education disparities by race, ethnic and income that underlie disparity in obesity risk factors, obesity, and obesity-related diseases (per Objective #1.0.1).

**Year Three 2016:**

• Implement and support community-led obesity prevention activities, by adopting regulations and policies designed to implement standards that will support quality nutrition and physical activity in schools (per Objective #1.2.1).

• Develop and provide support for implementation, monitoring and enforcement of NYS Education Department learning standards for physical education and nutrition in grades K-12 (per Objective #1.2.1).

Additionally, Mount Sinai St. Luke’s and Mount Sinai Roosevelt will be supporting a grant from Bank Street College to enhance awareness of nutrition and other factors related to childhood obesity. One school will be assigned to us from West Harlem and East Harlem.

**Increase Screening Rates and Community Education for Diabetes and Cardiovascular Diseases:**

**Year One 2014:**

• Continue to build collaborations among community-based organization, faith-based sectors, independent living centers, businesses, and clinicians to identify and serve underserved groups (per Objective #3.1.4).

• Continue biometric screening for high blood sugar or diabetes, high blood pressure, and abnormal cholesterol levels in the community (per Objective #3.1.4).

• Utilize health communication to build public awareness and demand for prevention (per Objective #3.3.1 and Objective #3.1.4).

**Year Two 2015:**

• Ensure consumer access to and coverage for preventative services, through referrals to our hospitals’ clinical and financial services to offer counseling to consumer and reduce healthcare inaccessibility.
- Increase health outreach and screenings in the community and among community partners (per Objective # 3.1.4).

- Design and implement tailored culturally relevant programs to improve access to preventative services (per Objective # 3.3.1).
  1. Establish training programs across the health professional spectrum, to include enhancement of patient-centered skills, disability-literacy, and provider’s cultural competence.

**Year Three 2016:**

- Develop and organize widely accessible behavioral modification and surveillance workshops/programs, and health education seminars that educate members of the community on disease epidemiology, disease self-management and medical interventions (per Objective # 3.3.1).
  - Encourage health care providers and community members to use lifestyle intervention professionals and specialists, (i.e. registered dietitians, exercise physiologists, and social workers, etc.)
  - Emblem Health/Stanford University: Living with Chronic Diseases Workshops: This program teaches techniques that not only help cope with condition such as arthritis, diabetes, hypertensions, or heart and lung disease, but also renews participants’ sense of well-being, healthiness, and quality of life. Through these workshops, participants learn to understand symptoms, the importance of relaxation, the ability to accomplish goals, the significance of self-confidence, and how to replenish and improve their overall energy. Workshops bring 12-20 individuals from the community together, to meet for 2.5 hours weekly. These meetings are led by trained, engaging peer leaders.

**Dissemination of Plan to Public**

The Community Service Plan will be available through hard copy through the department of Government and Community Affairs, and online at [www.wehealny.org](http://www.wehealny.org)

**Brief Description of Process Use to Maintain Engagement with Local Partners**

In order to tackle the above health needs and concerns, and successfully induce healthful behavioral changes within these community settings, Mount Sinai St. Luke’s and Mount Sinai Roosevelt recognize the significance of partnering with community-based organization, faith-based organizations, schools and local businesses. Some of the organizations we have partnered with in the past are listed below:
In addition, the department of Community Affairs & Government Affairs has ongoing collaborations with internal departments which include:

- Breast Surgery Department
- Cardiology Department
- Endocrinology Department
- H.E.A.L. Center Program
- Neurology Department
- Pediatric Department
- Psychiatry Department
- The New York Obesity Research Center
- Urology Department
- Vascular Surgery Department
- Women, Infants and Children Program (WIC)

In the past these collaborative efforts have successfully led to heightened health education and disease awareness.
For Additional Information, Contact:

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