



**Community Health Needs Assessment &
Implementation Plan for
Westchester County, City of Yonkers
December 2019**



Participating Local Health Department (LHD):
Westchester County Department of Health (WCDOH)
10 County Center Road, 2nd Floor, White Plains, NY 10607-1541
Attention: Ms. Renee Recchia, MPH, Acting Deputy Commissioner

Participating Health System:
Saint Joseph's Medical Center
127 South Broadway, Yonkers, New York 10701
Attention: Department of Community Outreach, Catherine Hopkins, MS, FNP-BC, AE-C

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Executive Summary

About Saint Joseph's Medical Center

Saint Joseph's Medical Center (SJMC), founded by the Sisters of Charity of New York, has served the City of Yonkers since 1888. Each year, more than 55,000 individuals are touched by Saint Joseph's and/or its St. Vincent's Westchester Division in Harrison. SJMC strives for excellence in healthcare in an atmosphere of support and shared ministry. We believe in respect and compassion for ourselves and others, excellence in service, the dignity of human life, and commitment to the community. Saint Joseph's expanded in Westchester County and New York City through its 2010 acquisition of the behavioral health services of St. Vincent's Hospital Westchester, becoming one of the largest behavioral health providers in New York State. The opening of new primary care, cardiovascular, and advanced wound care and hyperbaric medicine centers in Yonkers and an imaging center in Riverdale demonstrate Saint Joseph's continuing commitment to the community.

CHNA Methodology

To guide our community benefit and health improvement efforts, SJMC conducted a comprehensive Community Health Needs Assessment (CHNA) and developed a supporting Implementation Plan for community health improvement.

The CHNA included quantitative and qualitative research methods to determine health trends and disparities across Westchester County and the City of Yonkers. Primary study methods were used to solicit input from residents and key community stakeholders representing the broad interests of the community. Secondary study methods were used to identify and analyze statistical demographic and health trends. Specific CHNA study methods included:

- > An analysis of secondary data sources, including public health, demographic, and social measures. A comprehensive list of data references is included in Appendix A.
- > A Community Health Survey with 2,727 Westchester County residents, 452 from SJMC's primary service area, to assess perceptions of priority health issues, health risk factors, and barriers to accessing care.
- > A Community Health Summit with Westchester County health and human service providers to solicit input on community health and social needs and tactics to advance the New York State 2019-2021 Prevention Agenda.

The CHNA was conducted in a timeline to comply with IRS Tax Code 501(r) requirements to conduct a CHNA every three years as set forth by the Affordable Care Act (ACA), and in accordance with the requirements set forth by the New York State Department of Health Prevention Agenda and Community Service Plan.

Community Engagement

The 2019 CHNA was a community collaborative process, initiated with the goal of developing an assessment that is reflective of the needs of the community, including clinical and social determinants of health. SJMC partnered with the Westchester County Department of Health as

well as the Montefiore Hudson Valley Collaborative (MHVC), a group of regional hospitals and community based organizations, to gather research in support of the 2019 CHNA.

SJMC solicited and received input from persons who represent the broad interests of the community, including underserved, priority, or minority populations. Through this input we received wide perspectives on health trends, expertise about existing community resources and gaps in services, and insights about issues that contribute to health disparities.

Community Health Priorities

To work toward health equity, it is imperative to prioritize resources and activities to address the most pressing health needs within our community. Taking into account SJMC's expertise and resources, in alignment with the New York State Prevention Agenda and continuing with the initiatives originally developed in the MHVC Delivery System Reform Incentive (DSRIP) program, SJMC will focus health improvement efforts on the following priority areas for the 2020-2022 cycle:

- > Prevent Chronic Diseases with a focus on asthma
 - o Goal #1: Promote the use of evidence-based care to manage asthma.
 - o Goal #2: In the community setting, improve self-management skills for individuals with asthma.
- > Promote Well-Being and Prevent Mental and Substance Use Disorders
 - o Goal #1: Prevent opioid and other substance misuse and deaths.

The 2019 priorities are consistent with those identified in 2016, recognizing the positive impact of ongoing initiatives and continued need among residents. The focus of the priorities has changed. SJMC will focus chronic disease prevention efforts on asthma versus asthma and heart disease. SJMC has made significant investment and strides to improve asthma health in partnership with the Family Health Center and the YonkerSpectrum School Health Program, among others. SJMC has also shifted focus from behavioral healthcare coordination to expansion of substance use disorder treatment services. While behavioral healthcare initiatives will continue as part of Saint Joseph's comprehensive mental health clinic, SJMC will focus on substance use disorder in response to growing community need.

Maternal and child health needs are also a top challenge for SJMC's service area. While SJMC will not directly address these needs as part of its Implementation Plan, the medical center will continue to promote positive health outcomes in partnership with its primary care and family medicine providers. The Implementation Plan will focus on the issues that SJMC has the greatest ability to impact. SJMC has significant resource capacity and expertise in the areas of chronic disease; specifically asthma and substance use disorder prevention and treatment.

Implementation Plan Summary

SJMC's asthma initiatives align with the New York State Prevention Agenda program for evidence-based clinical- and self-management strategies. As part of the health improvement

plan, we will continue to promote medical asthma management in accordance with national guidelines, improved access and adherence to medications and devices, and expanded access to self-management interventions. We will target high-risk patients in our Family Health Center, a designated Level 3 Patient Centered Medical Home. The collective objectives and process measures for these programs are decreased asthma-related ED visits and hospitalizations, and a higher percentage of patients who have a disease management plan and receive disease self-management instruction and support.

The YonkerSpectrum School Health Program (YSHP) is a primary care school-based clinic operating in four Yonkers public schools. Since 1989, the YSHP has provided free, accessible, high quality health services to high-risk children and has become an integral component of the Yonkers healthcare delivery system. The YSHP provides a full array of primary health services, including, but not limited to, routine care of children with asthma. As part of the health improvement plan, SJMC will implement *Kickin' Asthma* and *Open Airways for Schools®* at clinic sites. These programs, developed by the American Lung Association, are among the most widely recognized asthma management tools for children in the nation, and proven-effective for decreasing asthma emergencies and raising asthma awareness among families and school personnel. The nurse practitioners who staff the clinics and administer educational programs that adhere to the National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma. Three of the nurse practitioners, as well as SJMC's medical director for ambulatory programs, are certified asthma educators.

SJMC offers the Methadone Maintenance Treatment Program, providing detoxification and methadone maintenance for patients with opiate use disorder. Individual and group counseling, annual physical examinations, testing and lab work, and primary care services are included in the program. SJMC will continue efforts to increase access and linkages to the methadone program, as well as availability of other Medication-Assisted Treatment options and Naloxone administration training. As part of its on-going efforts, SJMC will work with the New York State Office of Addiction Services and Support to enhance SJMC's programs.

SJMC is dedicated to providing trauma-informed care for patients with substance use disorder, recognizing high co-morbidity with both trauma and adverse childhood experiences. As part of the health improvement plan, SJMC will train medical staff in trauma-informed care practices, targeting inpatient and outpatient behavioral health providers in the first year of implementation. SJMC will provide similar training in partnership with community organizations, including public school staff, community residences/mental health housing, and the Healthy Yonkers Initiative.

Board Approval

The SJMC 2019 CHNA Final Report and corresponding Implementation Plan were reviewed and approved by the Board of Directors on December 9, 2019. The report and plan are available for review on the SJMC website: <https://www.saintjosephs.org/about-us>. For more information regarding the CHNA or Implementation Plan, or to submit comments or feedback, contact Catherine Hopkins, Director of Community Outreach and School Health (Catherine.Hopkins@saintjosephs.org).

Community Health Assessment

Saint Joseph's Medical Center Service Area

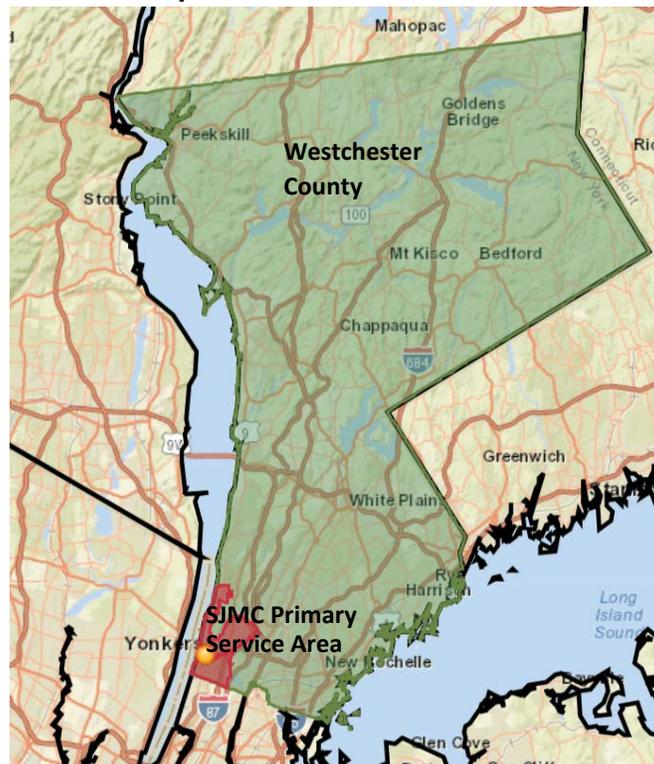
For the purpose of conducting a joint CHNA and partnering with the WCDOH, SJMC collected and analyzed data indicators for all of Westchester County. Westchester County, located just north of New York City in the Hudson Valley, spans 430.5 square land miles and 48 municipalities designated as urban, suburban, and rural geographies. The city of White Plains is the county seat. Other major cities include Yonkers, New Rochelle and Mount Vernon.

Westchester County's population grew by 3% between the 2000 and 2010 Census, from 923,459 to 949,113. The growth rate was higher than the New York State average of 2%, but lower than the national average of 10%. Westchester County is the seventh most populous county in New York State.

SJMC is located in Yonkers and serves residents of the entire city. Yonkers is 18.4 square miles with an estimated population of 200,999. The population decreased 0.06% between the 2000 and 2010 Census, but increased by approximately 3% from 2010 to 2017.

While SJMC serves all of Yonkers, their primary service area encompasses the zip codes immediately surrounding the medical center, including 10701 and 10705. The primary service area is among the most population dense areas in New York State and comprises 50% of the total Yonkers population.

Saint Joseph's Medical Center Service Area



Demographic & Socioeconomic Data

Analyses of demographic and socioeconomic data are essential in understanding health trends and determining key drivers of health status. Socioeconomic indicators play a significant role in community and individual health. Known as **social determinants of health**, they are defined as factors within the environment in which people live, work, and play that can affect health and quality of life. Social determinants of health are often the root causes of **health disparities**. Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked with social, economic, or environmental disadvantage.”

Social determinants of health are factors within the environment in which people live, work, and play that can affect health and quality of life

The following tables illustrate key demographic and socioeconomic indicators for SJMC’s primary service area and the city of Yonkers compared to all of Westchester County and New York State.

The Yonkers community is one of the most culturally and ethnically diverse in Westchester County and New York State. Approximately 31% of the Yonkers population is foreign-born and 47% of residents speak a primary language other than English, most commonly Spanish. Among foreign-born residents, 56% were born in a Latin American country. Immigrants from all over the world bring a great vitality to our community, but they challenge the Medical Center and other community service providers to understand and meet their unique health needs.

Yonkers is one of the most diverse communities in New York State; SJMC’s primary service area is even more diverse

SJMC’s primary service area population is more culturally and ethnically diverse than Yonkers overall, as well as younger. Within zip code 10705, nearly 38% of residents are foreign-born and more than half of the population is Hispanic/Latino. Residents of zip code 10701 are only slightly less diverse. The median age of residents in both zip codes is lower than Yonkers, Westchester County, and New York State. Approximately 1 in 5 residents are under age 15.

Demographic Data Indicators

	Zip Code 10701	Zip Code 10705	Yonkers	Westchester County	New York State
Gender					
Male	46.9%	48.4%	47.2%	48.4%	48.5%
Female	53.1%	51.6%	52.8%	51.6%	51.5%
Age					
Under 15	19.5%	20.4%	17.9%	18.4%	17.6%
15-24 years	13.8%	14.9%	13.2%	13.1%	13.4%
25-34 years	14.8%	15.0%	13.7%	11.4%	14.6%
35-54 years	24.9%	28.9%	27.3%	27.9%	26.5%
55-64 years	12.0%	8.9%	11.4%	13.1%	12.8%
65 years or over	14.9%	11.8%	16.4%	16.0%	15.2%
Median age	36.2	34.8	38.8	40.6	38.4

Source: US Census, American Community Survey, 2013-2017

Demographic Data Indicators cont'd

	Zip Code 10701	Zip Code 10705	Yonkers	Westchester County	New York State
Race and Ethnicity					
White	50.1%	45.9%	56.3%	65.4%	63.8%
Black or African American	26.4%	19.4%	17.8%	14.6%	15.7%
Asian	4.7%	7.5%	7.2%	5.9%	8.3%
Two or more races	3.1%	4.4%	3.8%	3.0%	3.0%
Other	15.7%	22.8%	14.9%	11.1%	9.2%
Hispanic/Latino (any race)	41.2%	52.8%	36.3%	24.0%	18.8%
Place of Birth and Language					
Foreign-born	30.6%	37.6%	30.6%	25.4%	22.7%
Primary language other than English	50.8%	59.8%	46.9%	33.3%	30.6%

Source: US Census, American Community Survey, 2013-2017

Westchester County overall has positive socioeconomic indicators, ranked second in the state for highest per capita income. Residents of Yonkers have similar socioeconomic measures to the state, but experience greater disparity when compared to Westchester County. This disparity is heightened in SJMC's primary service area, where 1 in 4 residents and 1 in 3 children live in poverty, fewer than 1 in 3 residents own their home, and 1 in 4 residents have not completed high school.

Westchester County has the second highest per capita income in the state, but 1 in 4 residents in SJMC's primary service area live in poverty

Housing affordability is a concern across Westchester County, particularly in Yonkers and SJMC's primary service area. More than 1 in 4 homeowners in Westchester County and Yonkers are cost burdened, spending 30% or more of their income on mortgage expenses. Within zip code 10701, one-third of homeowners are cost burdened. Across Westchester County, Yonkers, and the primary service area, 55% or more of renters are cost burdened. The impact of this finding is greatest in the primary service area, where nearly 70% of individuals rent their home.

Nearly 70% of primary service area residents rent their home; more than 55% are cost burdened by rent

Socioeconomic Data Indicators

	Zip Code 10701	Zip Code 10705	Yonkers	Westchester County	New York State
Economic Measures					
Median household income	\$46,519	\$49,110	\$62,399	\$89,968	\$62,765
People in poverty	25.4%	22.1%	16.4%	9.4%	15.1%
Children in poverty	38.5%	33.4%	25.3%	11.7%	21.3%
Unemployment	8.5%	10.3%	8.0%	6.5%	6.8%

Source: US Census, American Community Survey, 2013-2017

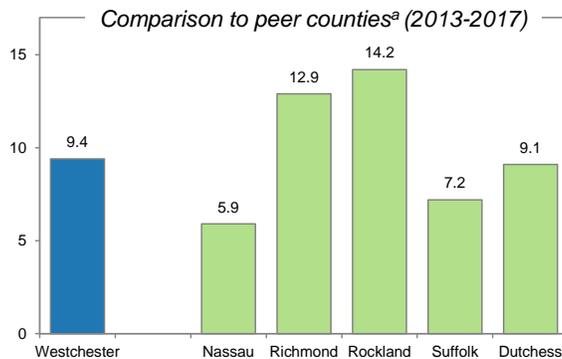
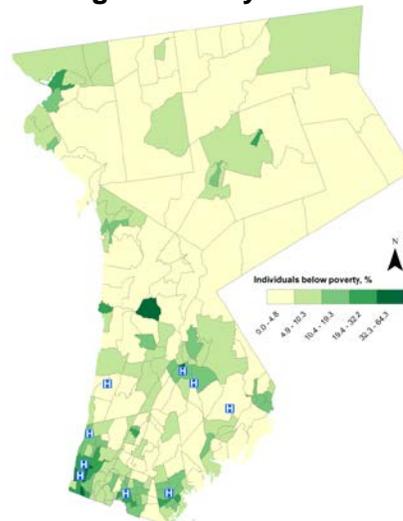
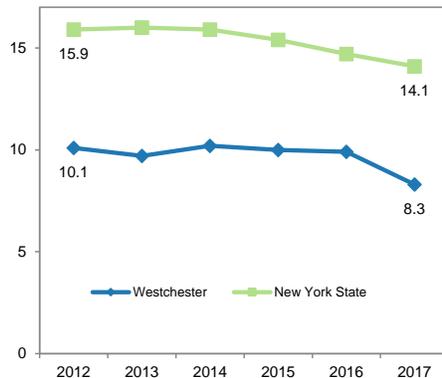
Socioeconomic Data Indicators cont'd

	Zip Code 10701	Zip Code 10705	Yonkers	Westchester County	New York State
Housing Measures					
Owner-occupied housing	31.2%	30.7%	47.3%	61.5%	54.0%
Median home value	\$339,600	\$382,400	\$380,100	\$513,300	\$293,000
Cost burdened home owners with a mortgage	32.8%	20.1%	28.2%	26.9%	20.4%
Renter-occupied housing	68.8%	69.3%	52.7%	38.5%	46.0%
Median rent	\$1,261	\$1,198	\$1,292	\$1,444	\$1,194
Cost burdened renters	58.6%	61.2%	56.5%	55.2%	53.5%
Education Measures					
No high school diploma	22.4%	25.1%	17.4%	12.5%	13.9%
Bachelor's degree or higher	27.4%	24.2%	32.6%	47.7%	35.3%

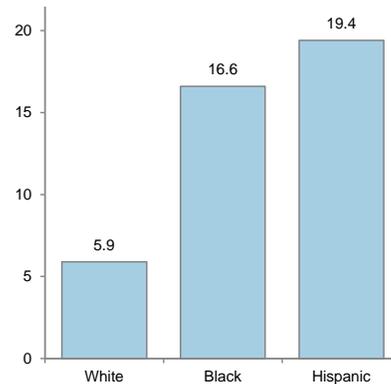
Source: US Census, American Community Survey, 2013-2017

The following data further analyzes poverty, a key indicator for socioeconomic disparity, across Westchester County and underserved populations.

Percentage of Individuals Living in Poverty



Racial/ethnic disparities^b (2013-2017)



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity. ^b The white and black population includes Hispanic individuals as data is not available by race/ethnicity separately.

Data source: American Community Survey
Map is at the census tract level and reflect data from 2013-2017.

Community Health Status Indicators

Public Health Data Analysis

Health indicators were analyzed for a number of health issues, including access to care, health risk factors, chronic disease, behavioral health, and maternal and child health. SJMC's health data focus is on county-level reporting, which is generally the most recent and most consistent data available. Data are compared to peer counties and state averages, where applicable, to provide benchmark comparisons. A comprehensive list of data sources is provided in Appendix A.

Age-adjusted rates are referenced throughout the reporting to depict a comparable burden of disease among residents. Age-adjusted rates are summary measures adjusted for differences in age distributions so that data from one year to another, or between one geographic area and another, can be compared as if the communities reflected the same age distribution.

Healthcare Access

Despite an increase over the past decade, the percent of adults with health insurance in both Westchester County (90.6%) and New York State (91.4%) are below the Prevention Agenda 2018 Target of complete coverage (100%). While most White (92.9%) and Black (88.5%) adults have health insurance, less than three-quarters (72.9%) of Hispanic adults are covered.

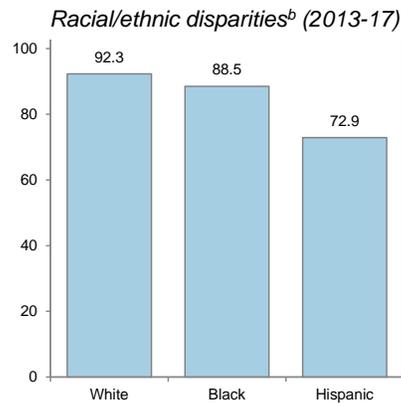
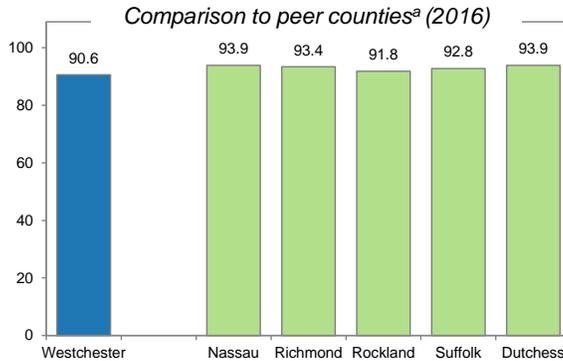
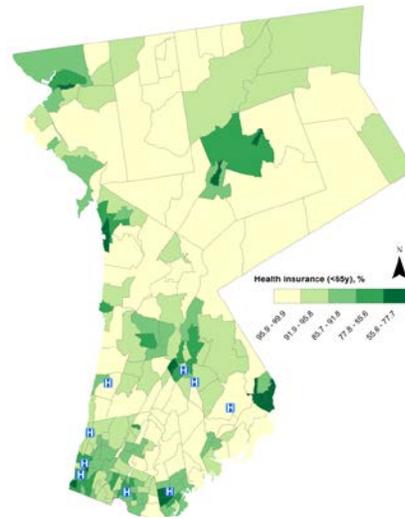
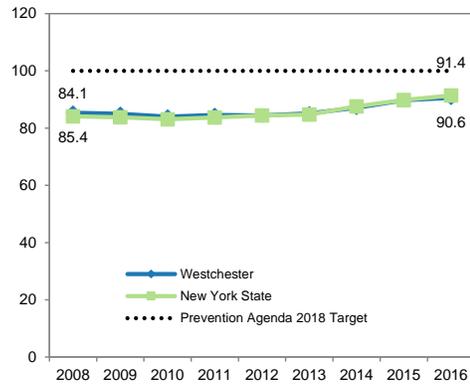
SJMC primary service area residents are less likely to have health insurance

Residents of Yonkers and SJMC's primary service area are less likely to have health insurance than their peers across Westchester County. The greatest disparity in health insurance coverage is seen among adults age 19 to 64, White residents, and foreign-born residents.

In Westchester County, the percentage of adults with a regular healthcare provider declined from 85.3% in 2008/2009 to 79.2% in 2016. In comparison to its peer counties, Westchester has the lowest percentage of adults with a regular healthcare provider.

In comparison to peer counties, Westchester County has the lowest percentage of adults with a regular primary care doctor

Percentage of Adults Age 19-64 with Health Insurance



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity. ^b The white and black population includes Hispanic individuals as data is not available by race/ethnicity separately.

Data source: New York State Prevention Agenda Dashboard
Data for map and by race/ethnicity from 2013-2017 American Community survey.
Map is at the census tract level.

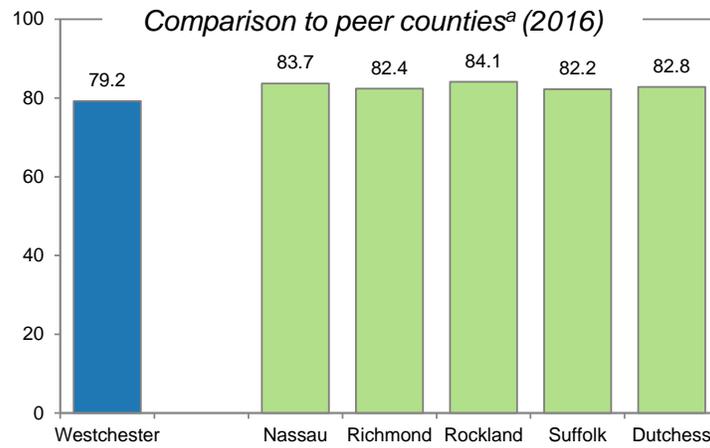
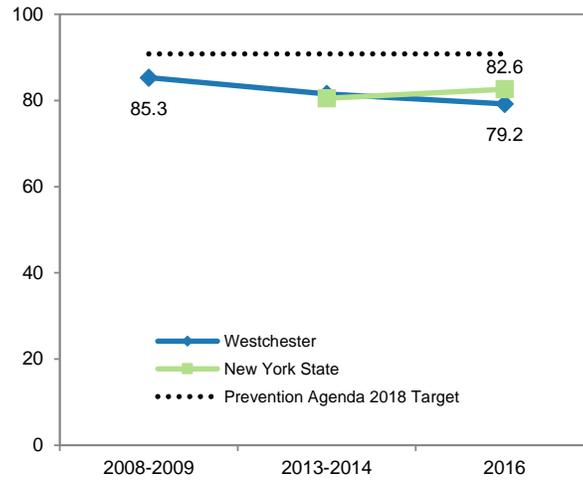
Health Insurance Coverage, 2013-2017

Red = Lower than Westchester County by ≥2 Percentage Points

	Zip Code 10701	Zip Code 10705	Yonkers	Westchester County	New York State
Total population	88.2%	85.8%	90.3%	92.2%	92.4%
Age					
Under age 19	96.5%	94.9%	96.5%	97.4%	96.9%
Age 19 to 64	82.2%	80.0%	85.8%	88.3%	89.2%
Age 65 or over	96.8%	96.2%	98.5%	99.1%	99.1%
Race and Ethnicity					
White	88.2%	86.1%	91.7%	94.9%	94.4%
Black or African American	90.5%	90.5%	91.0%	91.5%	91.4%
Asian	90.2%	93.5%	92.1%	93.3%	90.2%
Hispanic/Latino (any race)	84.0%	81.6%	85.7%	81.8%	85.4%
Place of Birth					
Foreign-born	77.9%	75.4%	81.6%	80.2%	83.8%

Source: US Census, American Community Survey, 2013-2017

Percentage of Adults with a Primary Care Provider



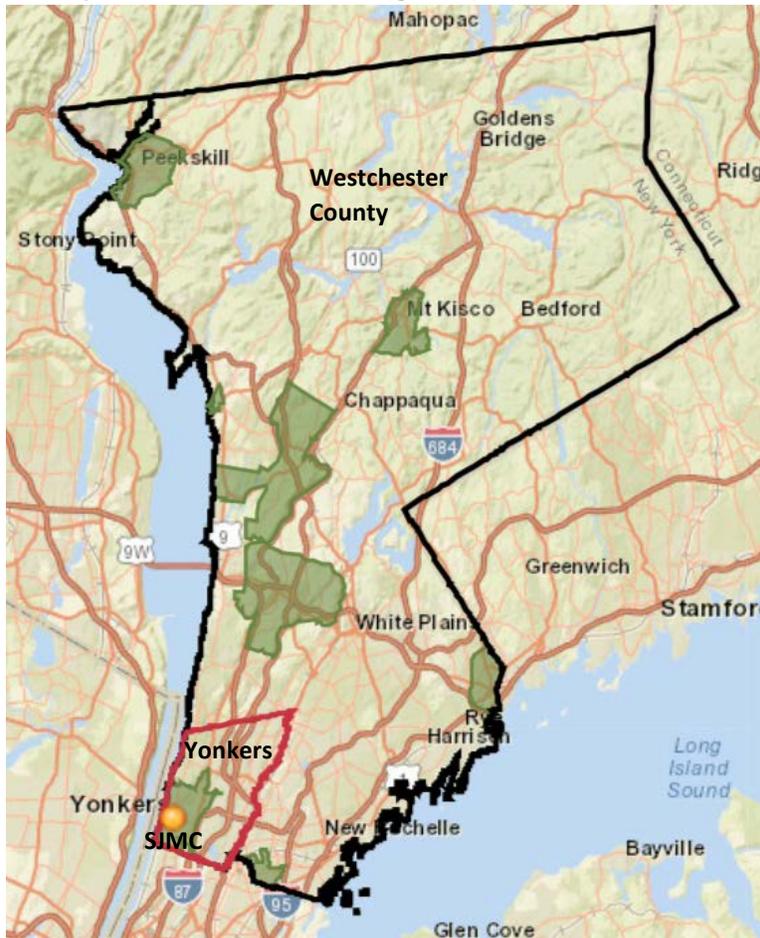
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard

The Health Resources & Services Administration (HRSA) is responsible for designating Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs). Shortage areas are determined based on a defined ratio of total health professionals to total population. MUAs identify geographic areas with a lack of access to primary care services. Nearly all of SJMC's primary service area is a designated MUA, as well as a HPSA for primary care and mental healthcare.

Nearly all of SJMC's primary service area is a MUA and HPSA for primary care and mental healthcare

Medically Underserved Areas (green) in Westchester County



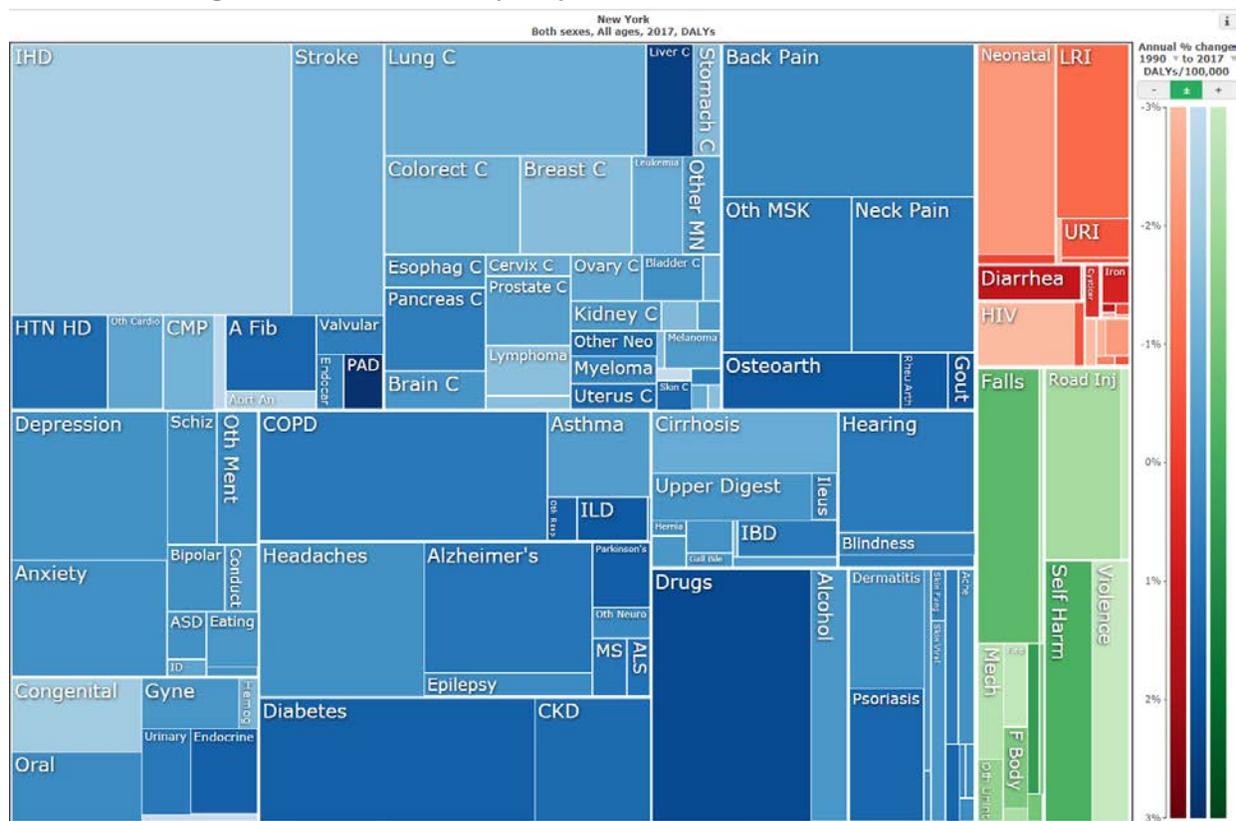
Source: Health Resources & Services Administration, 2018

Health Outcomes

The leading causes of ill health in New York State, as measured by disability adjusted life years (DALYs), are ischemic heart disease (8.8%), drug use disorders (4.7%), low back pain (4.5%), chronic obstructive pulmonary disease (4.4%), and diabetes mellitus. DALY is a measure of overall disease burden in a community, shown as the number of years lost due to ill-health, disability, or early death.

The color saturation in the graph below shows the proportionate change in DALYs from 1990 to 2017. Among leading causes of disability, the largest increases in DALYs were observed for liver cancer (+2.5%), drug use disorders (+2.2%), and osteoarthritis (+1.8%). The largest declines in DALYs were observed for HIV/AIDS (-7.4%) and tuberculosis (-5.9%).

Leading Causes of Disability Adjusted Life Years in New York State, 2017



Source: 2017 Global Burden of Disease Project

In New York State, elevated body mass index (BMI) is responsible for the highest proportion of DALYs. Elevated BMI is responsible for excess ill health via its association with cardiovascular disease, diabetes, and some cancers.

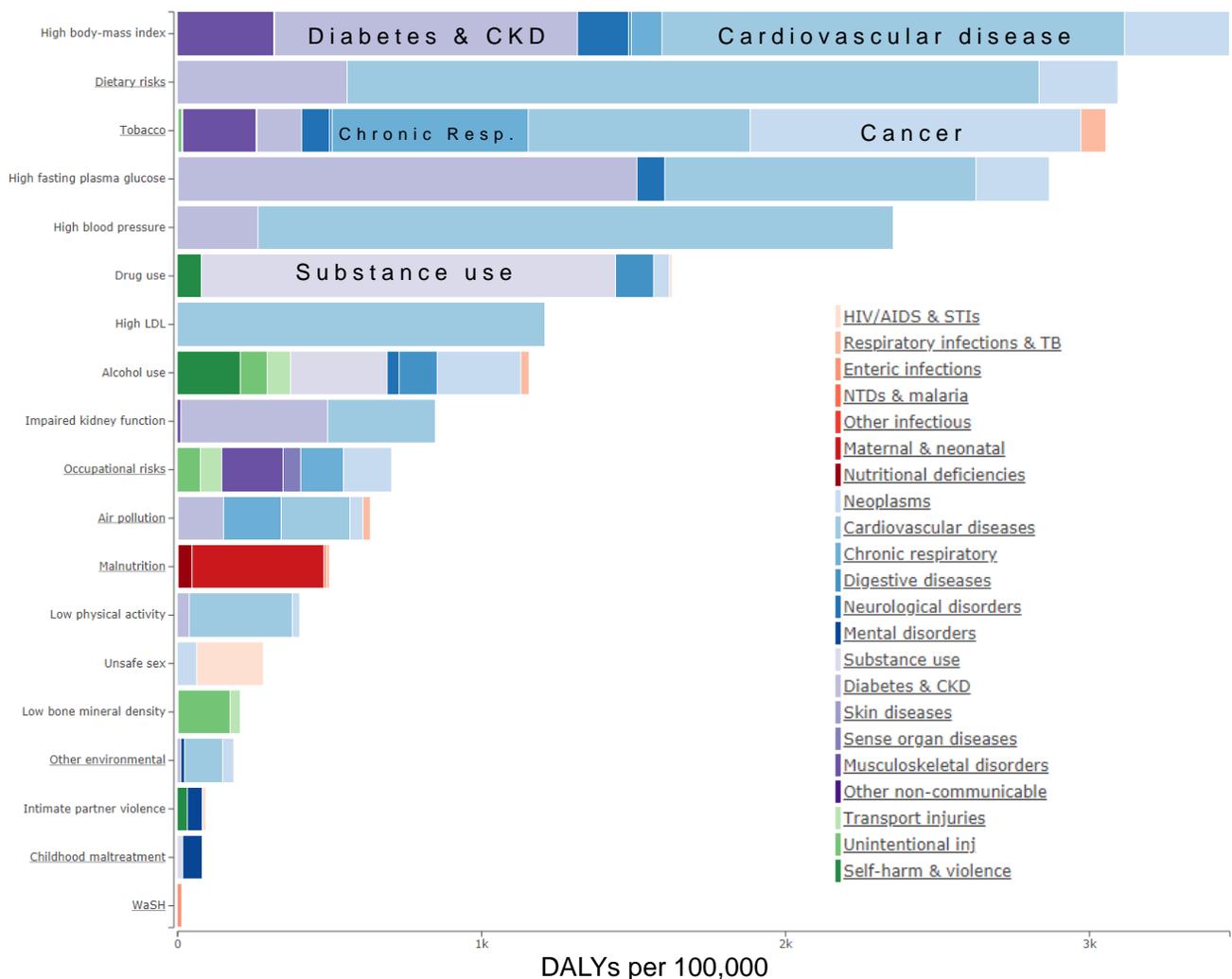
Across New York State, elevated BMI is the leading cause of years lost due to ill health, disability, or early death

Dietary risks are the second leading contributor to ill health,

and are also associated with cardiovascular disease, diabetes, and some cancers. Among dietary risks, low consumption of whole grains, nuts, seeds and fruit, and high consumption of sodium are the leading causes of ill health.

Tobacco is the third leading cause of ill health, with strong associations with many cancers, cardiovascular disease, and chronic respiratory disease. High fasting plasma glucose and high blood pressure are also leading causes of ill health, followed by drug use which is the sixth leading cause of disability in New York State.

Distribution of Disability Adjusted Life Years by Risk Factor in New York State, 2017

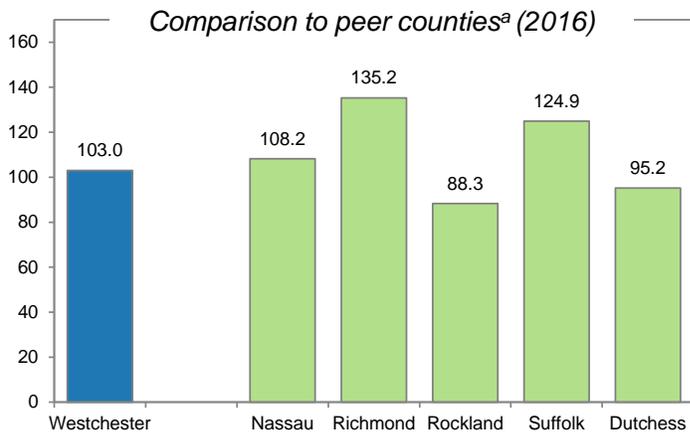
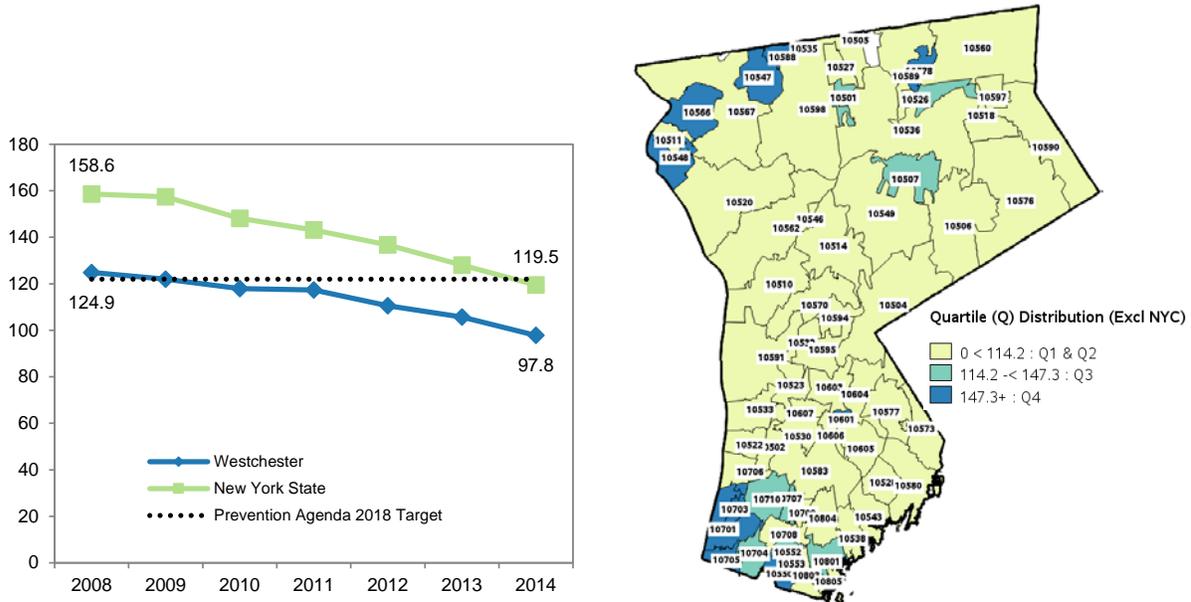


Source: 2017 Global Burden of Disease Project

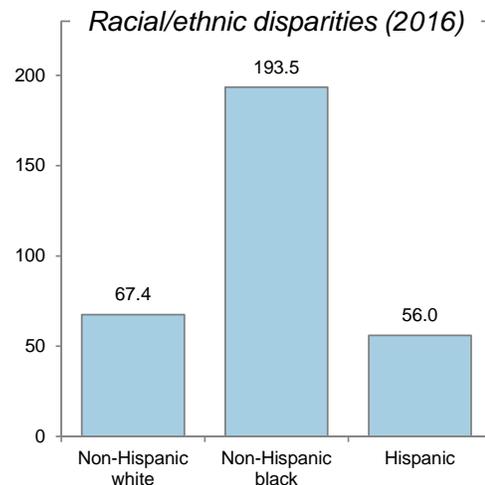
Preventable hospitalizations are hospital admissions that are preventable through access to high-quality primary care and appropriate disease management. The age-adjusted preventable hospitalization rate for adults declined in both Westchester County and New York State, and remains lower in Westchester County. The hospitalization rate is higher for non-Hispanic Black adults (193.5 per 10,000) than non-Hispanic White and Hispanic adults (67.4 per 10,000 and 56.0 per 10,000, respectively), and among residents in SJMC primary service area zip codes.

Preventable hospitalizations are declining, but remain higher among minority populations and SJMC's primary service area

Age-Adjusted Preventable Hospitalizations per 10,000 Adults Age 18 or Over



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.



Data source: New York State Prevention Agenda Dashboard
Map is at the ZIP Code level and data are from 2010-2014.
Trend data not available past 2014 due to switch to ICD-10 in 2015.

The following tables indicate the top 20 diagnoses among SJMC inpatient hospitalizations and emergency department treat-and-release visits for calendar year 2018. While sepsis was the top inpatient discharge diagnosis, behavioral health conditions, including alcohol-related disorders and schizoaffective disorders, were the next most common conditions, accounting for 9.9% of all discharges. Alcohol-related disorders were also the top diagnosis for emergency department treat-and-release visits, accounting for 5.2% of all visits.

Respiratory conditions were prevalent among both inpatient hospitalizations and emergency department treat-and-release visits at SJMC. Among inpatient hospitalizations, chronic obstructive pulmonary disease (COPD) was the third most common diagnosis. Among emergency department visits, asthma was the second most common diagnosis, followed by acute upper respiratory infections of multiple and unspecified sites.

Top 20 Inpatient Discharge Diagnoses at SJMC, 2018

Ranking	ICD-10 Code	Label	Number of Discharges	Percent of Total Discharges
1	A41	Other sepsis	320	7.9
2	F10	Alcohol-related disorders	232	5.8
3	F25	Schizoaffective disorders	166	4.1
4	J44	Other chronic obstructive pulmonary disease	122	3.0
5	L03	Cellulitis and acute lymphangitis	121	3.0
6	F20	Schizophrenia	112	2.8
7	F31	Bipolar disorder	108	2.7
8	E11	Type 2 diabetes mellitus	104	2.6
9	I13	Hypertensive heart and chronic kidney disease	100	2.5
10	J18	Pneumonia, unspecified organism	92	2.3
11	I11	Hypertensive heart disease	75	1.9
12	J45	Asthma	74	1.8
13	R07	Pain in throat and chest	66	1.6
14	M17	Osteoarthritis of knee	63	1.6
15	F32	Major depressive disorder, single episode	62	1.5
16	I16	Hypertensive crisis	62	1.5
17	N17	Acute kidney failure	60	1.5
18	N39	Other disorders of urinary system	58	1.4
19	R55	Syncope and collapse	57	1.4
20	G40	Epilepsy and recurrent seizures	54	1.3
	--	Other	1,918	47.6

Source: SJMC Internal Data, 2018

Top 20 Emergency Department Treat-and-Release Diagnoses at SJMC, 2018

Ranking	ICD-10 Code	Label	Number of Discharges	Percent of Total Discharges
1	F10	Alcohol-related disorders	1572	5.2
2	J45	Asthma	1003	3.3
3	J06	Acute upper respiratory infections of multiple and unspecified sites	840	2.8
4	M54	Dorsalgia	754	2.5
5	R10	Abdominal and pelvic pain	709	2.3
6	Z53	Persons encountering health services for specific procedures and treatment, not carried out	707	2.3
7	J02	Acute pharyngitis	670	2.2
8	R07	Pain in throat and chest	630	2.1
9	N39	Other disorders of urinary system	605	2.0
10	F19	Other psychoactive substance related disorders	576	1.9
11	M79	Other and unspecified soft tissue disorders, not elsewhere classified	548	1.8
12	S01	Open wound of head	473	1.6
13	S00	Superficial injury of head	443	1.5
14	S61	Open wound of wrist, hand and fingers	435	1.4
15	M25	Other joint disorder, not elsewhere classified	431	1.4
16	H66	Suppurative and unspecified otitis media	409	1.4
17	F43	Reaction to severe stress, and adjustment disorders	364	1.2
18	F41	Other anxiety disorders	347	1.1
19	J40	Bronchitis, not specified as acute or chronic	340	1.1
20	F10	Alcohol related disorders	1572	5.2
	-	Other diagnoses	18408	60.8

Source: SJMC Internal Data, 2018

Health Behaviors

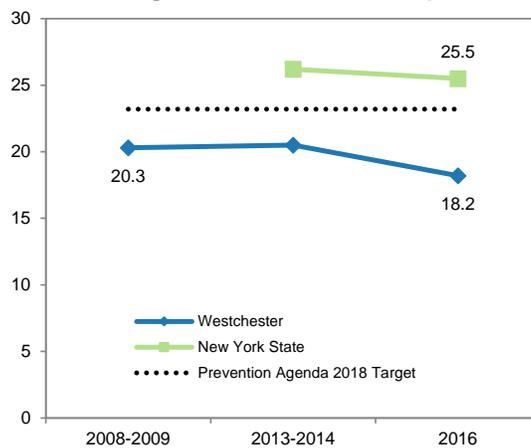
Health behaviors may increase or reduce the likelihood of disease or early death. Individual health behaviors include risk factors like smoking and obesity, or health promoting behaviors like exercise, good nutrition, and stress management. The prevalence of these health behaviors is provided below, with benchmark comparisons, as available.

Approximately one-fifth (18.2%) of adults in Westchester County are obese, which meets the Prevention Agenda 2018 Target and is lower than the New York State average overall. Westchester County has the smallest proportion of obese adults compared to its peer counties.

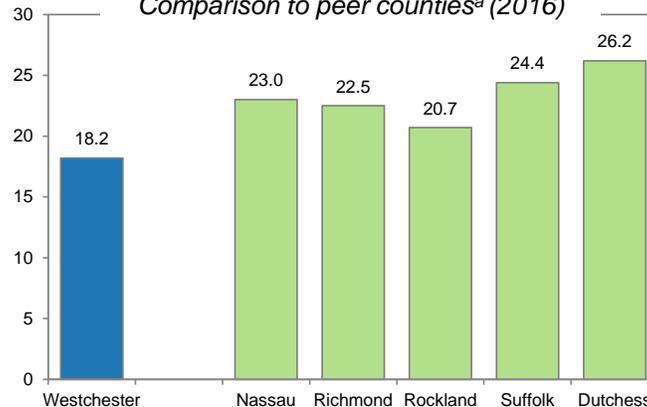
Westchester County has the lowest proportion of obese adults and youth among peer counties

Similarly, a smaller proportion (13.6%) of children/adolescents in Westchester County are obese when compared to New York State overall (17.3%) and peer counties. Childhood obesity rates in Westchester County have been stable. Peekskill, Tarrytown, Elmsford, and Port Chester-Rye school districts have the highest prevalence of child/adolescent obesity in Westchester County.

Percentage of Obese Adults (BMI ≥30)



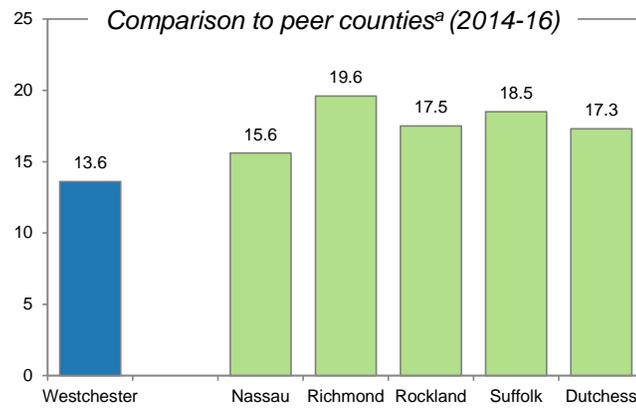
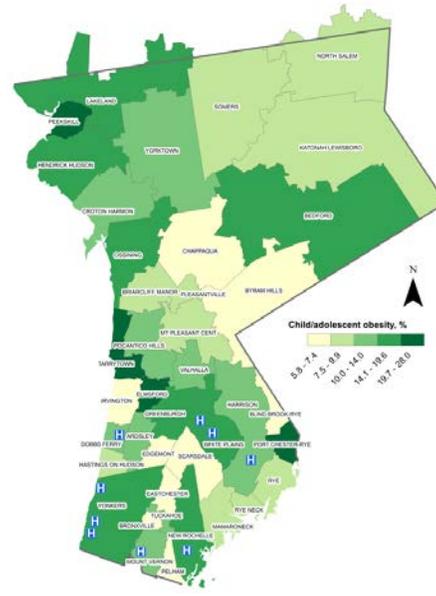
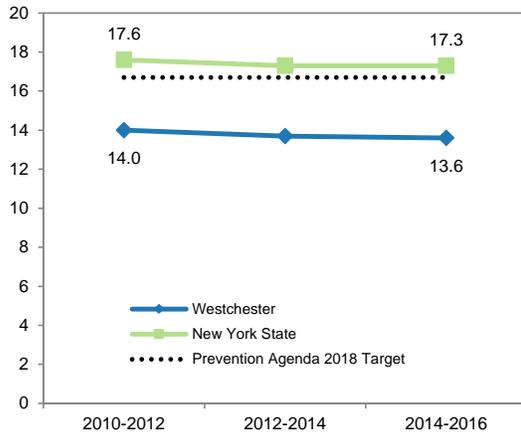
Comparison to peer counties^a (2016)



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard. 2008-2009 New York State data not available.

Percentage of Obese Children

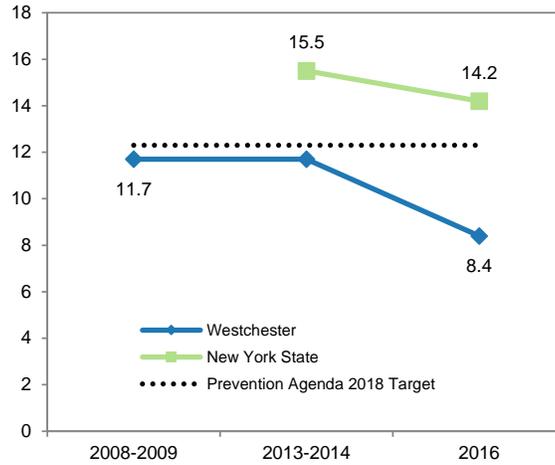


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

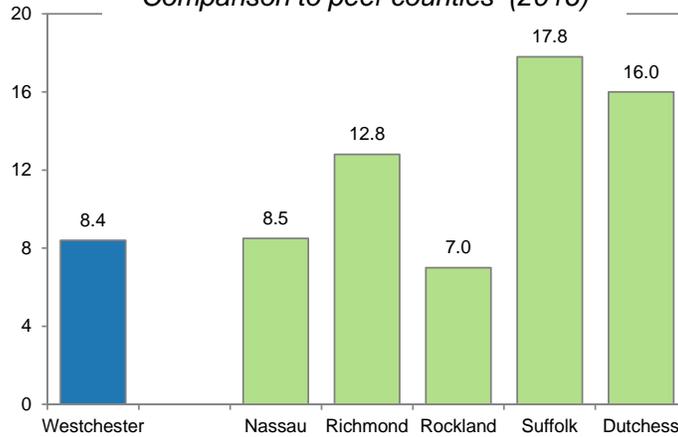
Data source: New York State Prevention Agenda Dashboard
Map is at the school district level and reflect data from 2014-2016.

Between 2013/2014 and 2016, the proportion of Westchester County adults that smoke cigarettes declined from 11.7% to 8.4%. Westchester County adults are less likely to smoke when compared to New York State overall. In comparison to peer counties, Westchester County has the second lowest percentage of adult smokers, behind Rockland County.

Percentage of Adults Smoking Cigarettes



Comparison to peer counties^a (2016)



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.

Chronic Disease

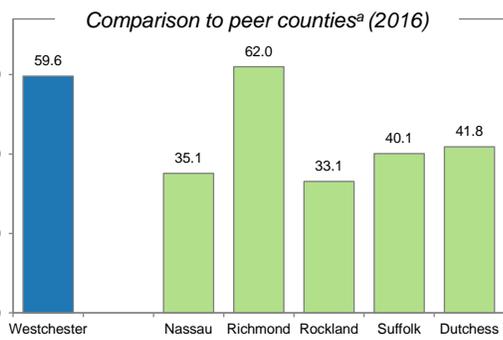
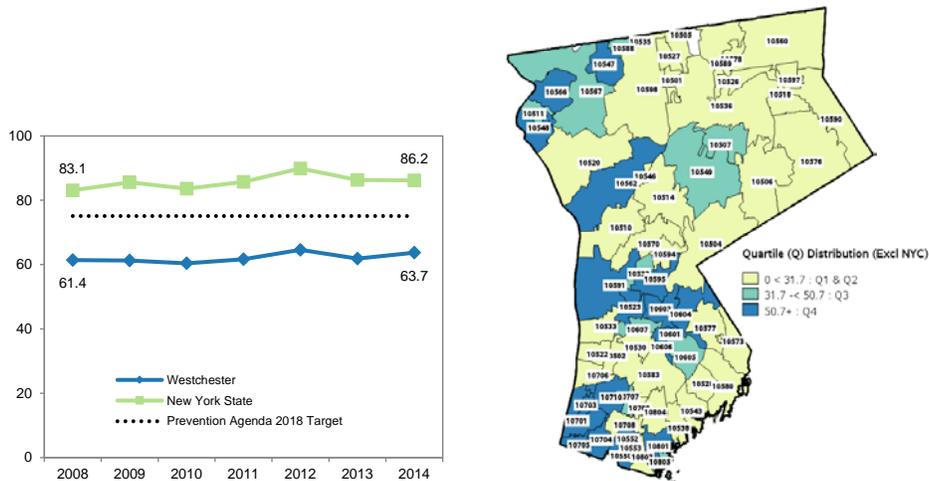
Chronic diseases are among the most prevalent and costly health conditions in the United States. More than two thirds of all deaths are caused by one or more of these five chronic diseases: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. Chronic diseases are often preventable through reduced risk behaviors, early detection of risk factors, and effective primary and community management of disease.

When effectively managed, asthma should not be the primary reason for an ED visit. Asthma-related ED visits often speak to access to care barriers, lack of primary care, and poor disease management. Westchester County has historically had fewer asthma-related ED visits than New York State overall, and meets the Prevention Agenda 2018 Target. Asthma continues to be a top concern for Westchester County though, as it has the second highest asthma-related ED visit rate among peer counties. The Westchester County rate is more than 50% higher than the rate for Rockland and Nassau counties.

Westchester County has the second highest rate of asthma-related ED visits among peer counties; SJMC primary service area zip codes have among the highest rates in the county

SJMC primary service area residents are among the highest asthma-related ED visits in Westchester County, as shown in the map below.

Asthma-Related ED Visits per 10,000 Population



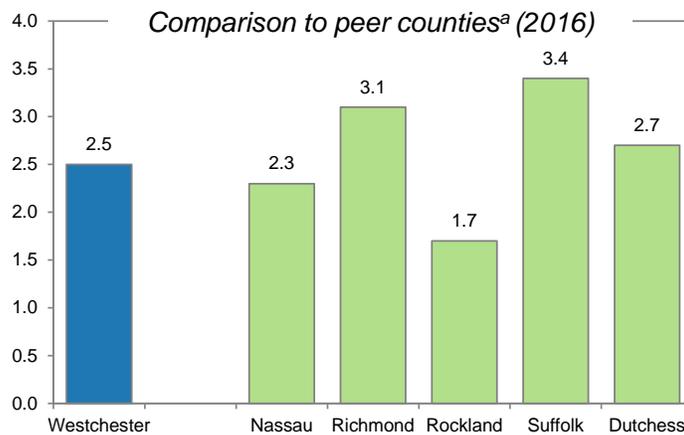
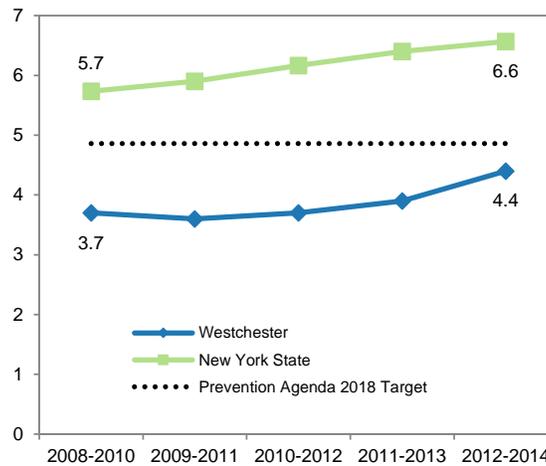
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard Map is at the ZIP Code level and data are from 2010-2014.

Between 2008/2010 and 2012/2014, the hospitalization rate for short-term complications of diabetes among Westchester County adults increased slightly from 3.7 to 4.4 per 10,000. The hospitalization rate continues to be lower than the rate for New York State overall, but nearly surpasses the Prevention Agenda 2018 Target. As of 2016, Westchester County had a similar adult hospitalization rate for short-term complications of diabetes as other peer counties.

Westchester County has a lower rate of hospitalization due to short-term complications of diabetes, but the rate is increasing

Hospitalizations for Short-Term Complications of Diabetes per 10,000 Adults Age 18 or Over



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

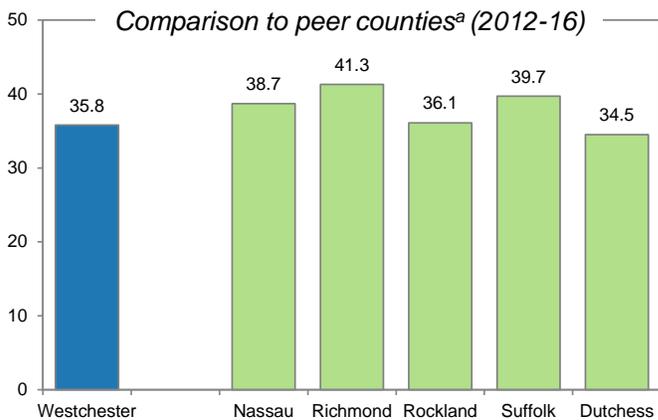
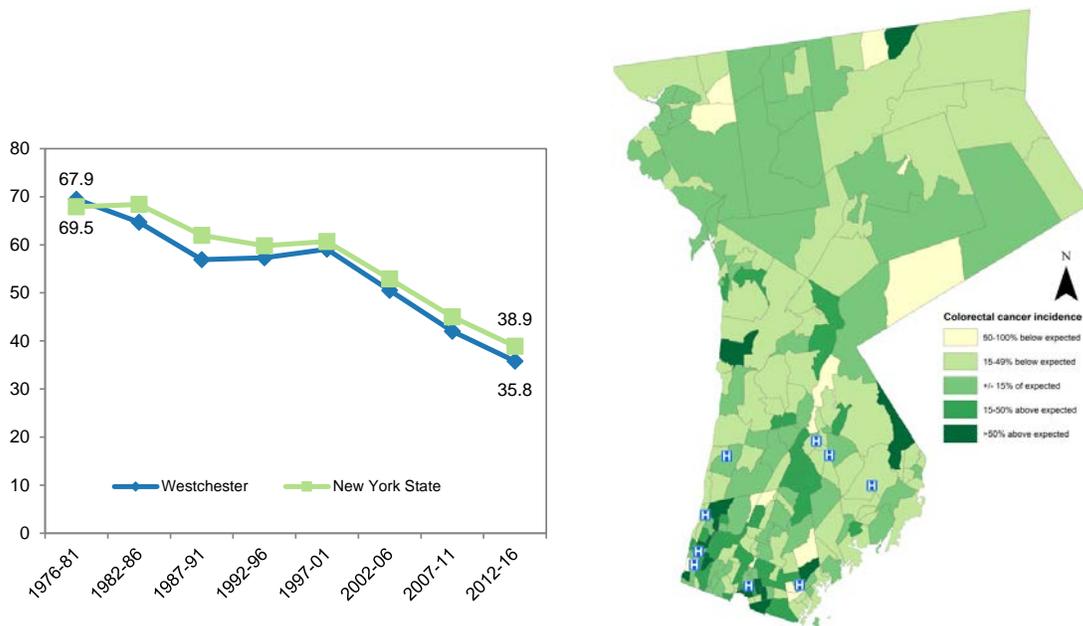
Data source: New York State Prevention Agenda Dashboard. Trend data not available past 2014 due to change in ICD coding.

Consistent with the state, the incidence of colorectal cancer in Westchester County declined over the past decade. The current incidence rate is slightly lower than the state rate. Among population groups in Westchester County, Hispanic residents have a lower incidence of colorectal cancer than non-Hispanic Black and non-Hispanic White residents.

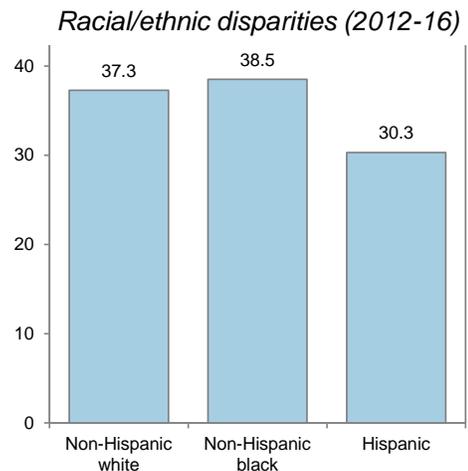
Westchester County has the highest rate of colorectal cancer screenings among peer counties, and the second lowest incidence of colorectal cancer

Lower cancer incidence rates can indicate lower screening rates and delayed detection of cancer, but Westchester County adults are more likely to receive colorectal cancer screenings than adults statewide and have the highest screening rate among peer counties. The Westchester County screening rate does not yet meet the Prevention Agenda 2018 Target.

Age-Adjusted Colorectal Cancer Incidence per 100,000

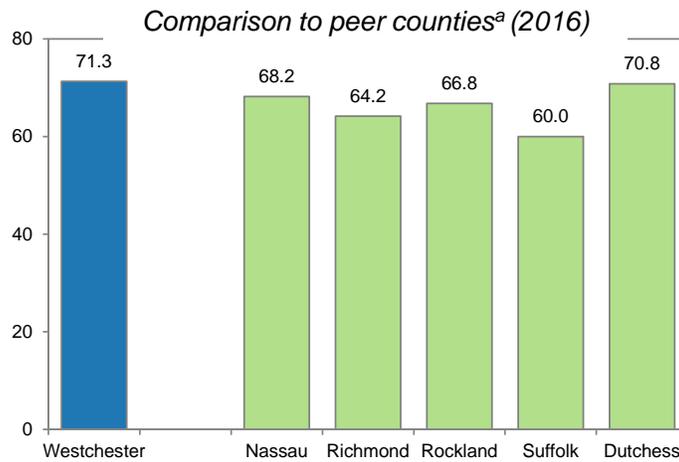
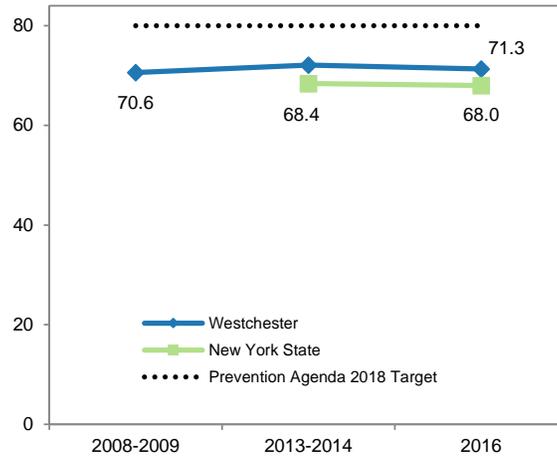


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.



Data source: New York State Cancer Registry
Map is at the census tract level and reflects data from 2010-2014.

Percentage of Adults Age 50 to 75 Years Receiving a Colorectal Cancer Screening



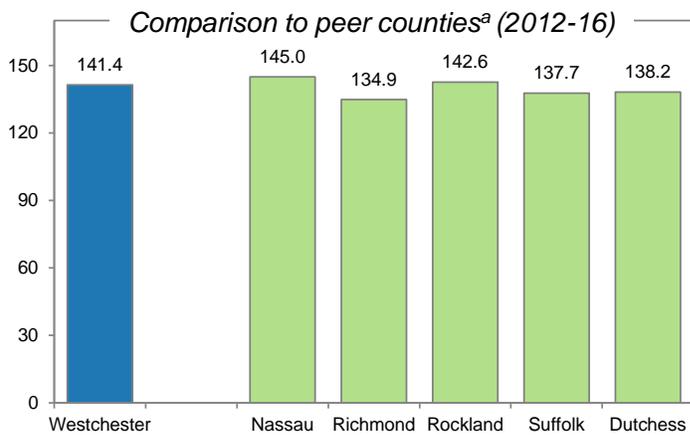
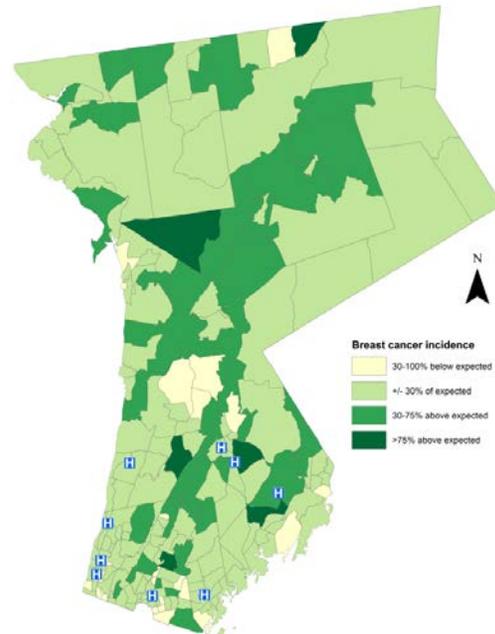
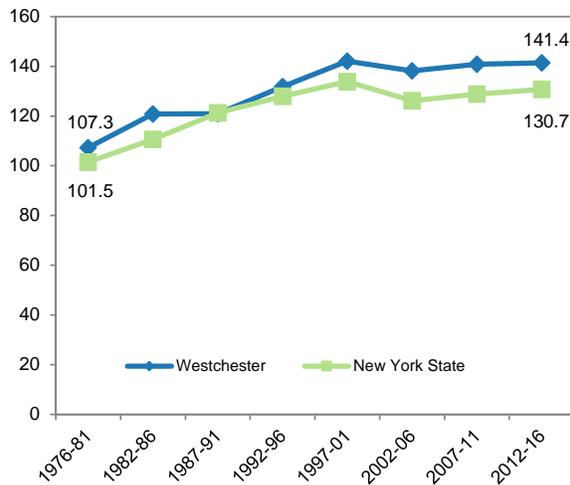
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.

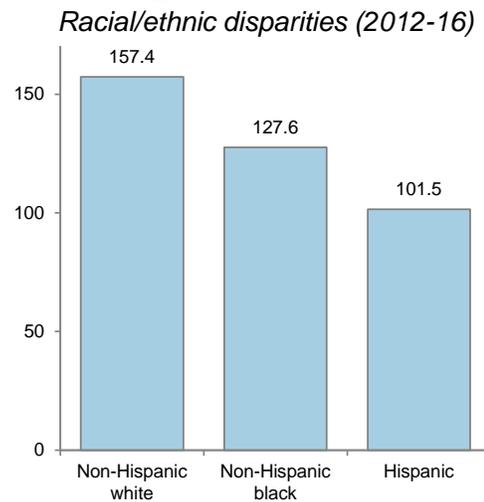
Consistent with the state, the incidence of female breast cancer in Westchester County increased over the past decade. The current Westchester County incidence rate is higher than the state rate. Among population groups in Westchester County, non-Hispanic White women have a higher incidence of breast cancer than non-Hispanic Black and Hispanic women.

Contrary to colorectal cancer trends, female breast cancer incidence is increasing in Westchester County and higher than the state

Age-Adjusted Breast Cancer Incidence per 100,000 Women



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.



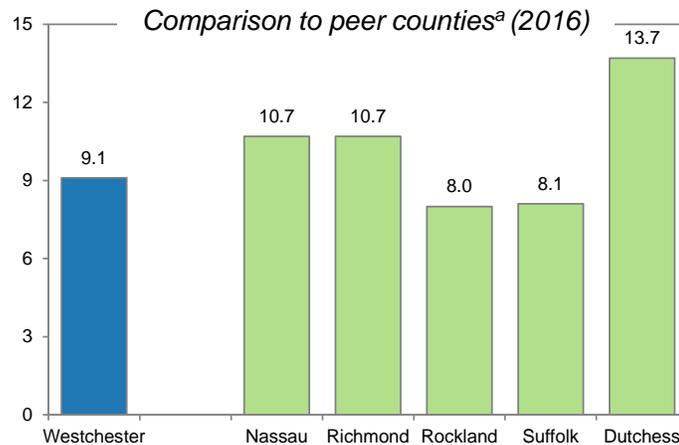
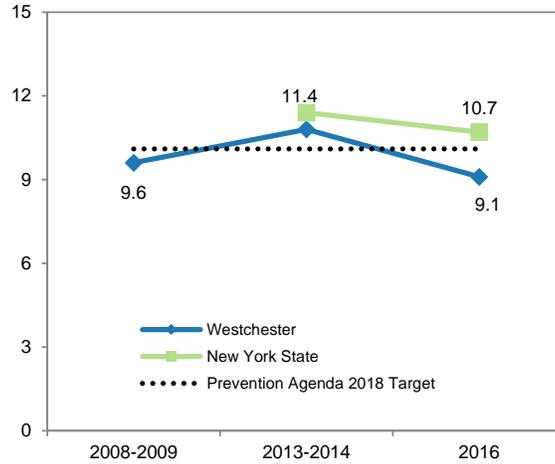
Data source: New York State Cancer Registry
Map is at the census tract level and reflects data from 2010-2014.

Mental Health and Substance Use Disorder

The proportion of Westchester County adults reporting poor mental health for at least half of the past month (9.1%) is lower than New York State overall (10.7%) and meets the Prevention Agenda 2018 Target. Westchester County has the third lowest proportion of adults reporting poor mental health for at least half of the past month when compared to its five peer counties.

Fewer adults in Westchester County report consistently poor mental health when compared to the state overall

Percentage of Adults with Poor Mental Health on 14 or More Days in the Past Month



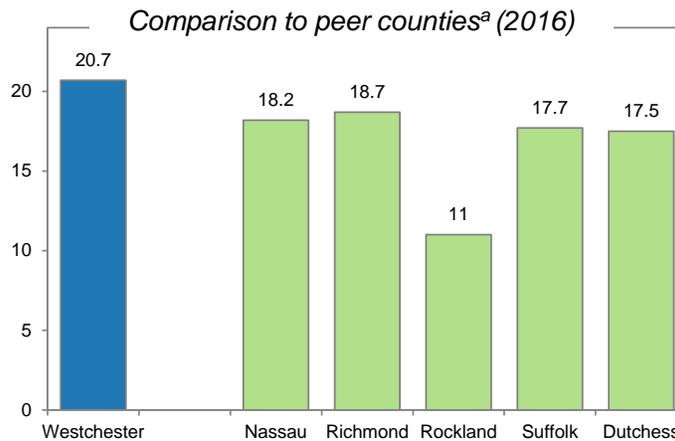
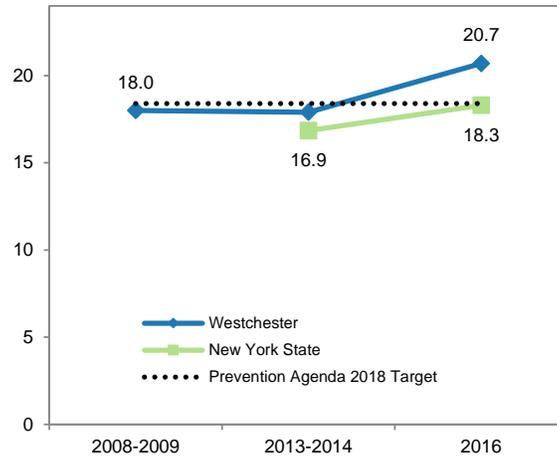
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.

Between 2013/2014 and 2016, the percentage of Westchester County adults reporting binge drinking in the past month increased from 18.4% to 20.7%, exceeding New York State overall and the Prevention Agenda 2018 Target. Westchester County has the largest percentage of adults reporting binge drinking in the past month compared to peer counties.

Westchester County has the highest percentage of adults who report binge drinking among peer counties

Age-Adjusted Percentage of Adults Binge Drinking in the Past Month



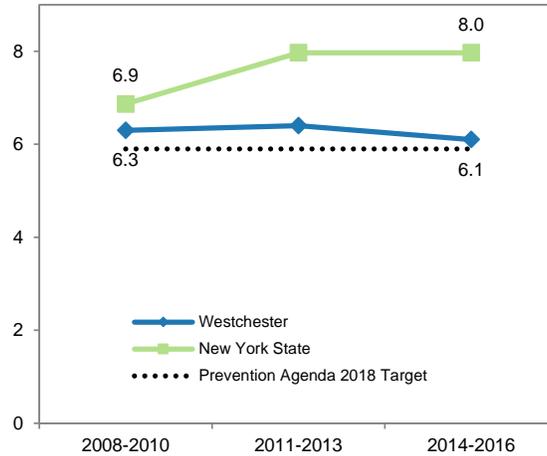
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard

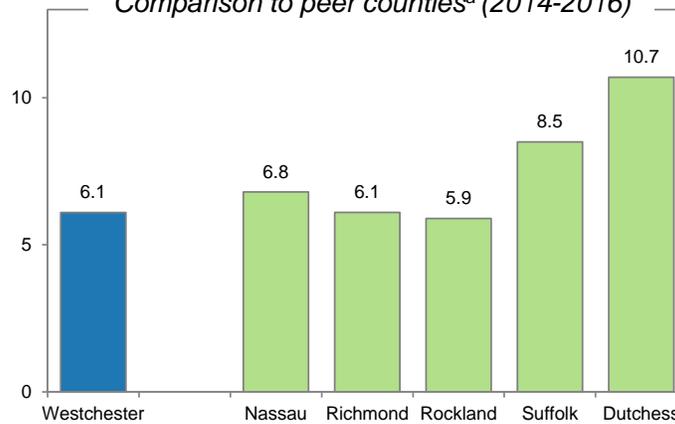
The age-adjusted suicide death rate remained relatively stable in Westchester County between 2008/2010 and 2014/2016. The current death rate nearly meets the Prevention Agenda 2018 Target of 5.9 per 100,000, and is lower than the state death rate. Westchester County, along with Richmond County, has the second lowest age-adjusted suicide death rate among peer counties.

The Westchester County suicide death rate is the second lowest among peer counties, and lower than the state

Age-Adjusted Suicide Death Rate per 100,000 Population



Comparison to peer counties^a (2014-2016)



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

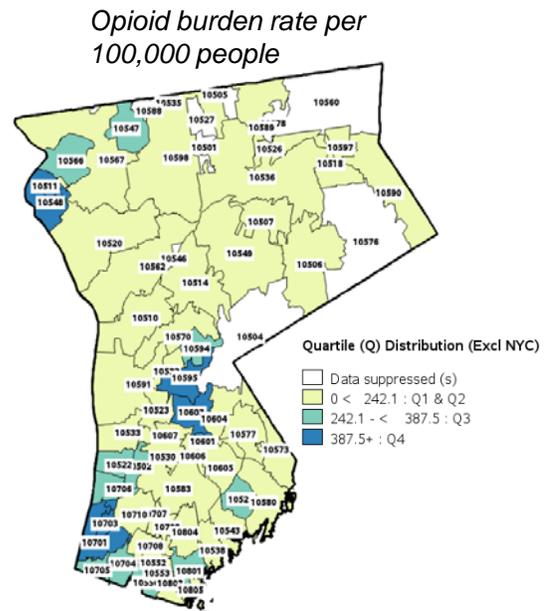
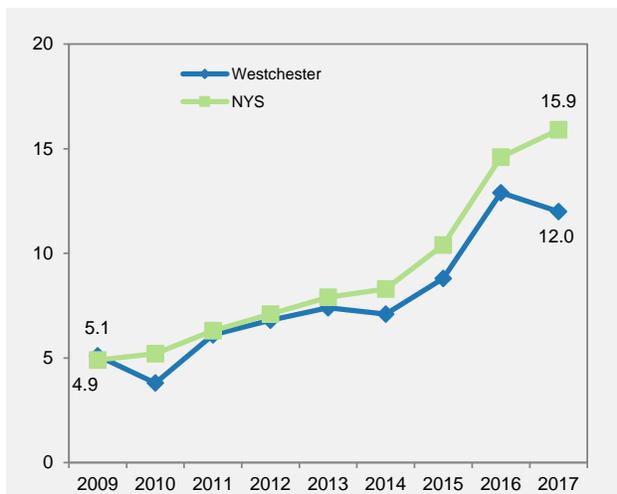
Data source: New York State Prevention Agenda Dashboard

The death rate due to opioids tripled in Westchester County over the past decade, although the current death rate is lower than the state rate and second lowest among peer counties. Non-Hispanic White residents are more than twice as likely to die from opioids as non-Hispanic Black or Hispanic populations.

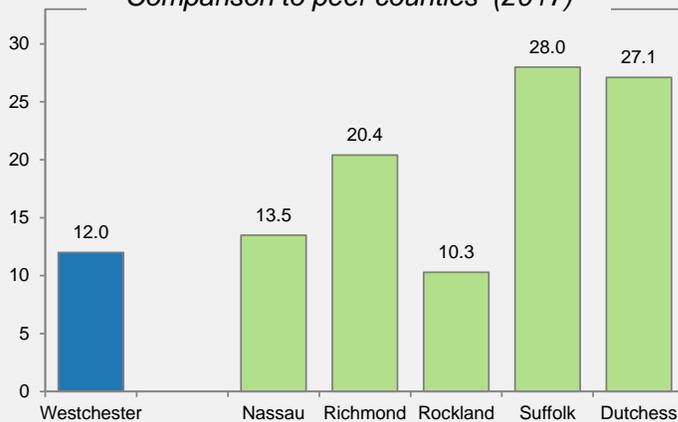
The death rate due to opioids tripled in Westchester County in the past decade; the SJMC primary service area has one of the highest death rates in the county

SJMC primary service area residents have among the highest death rates due to opioids in Westchester County, as shown in the map below.

Age-Adjusted Opioid Death Rate per 100,000 Population

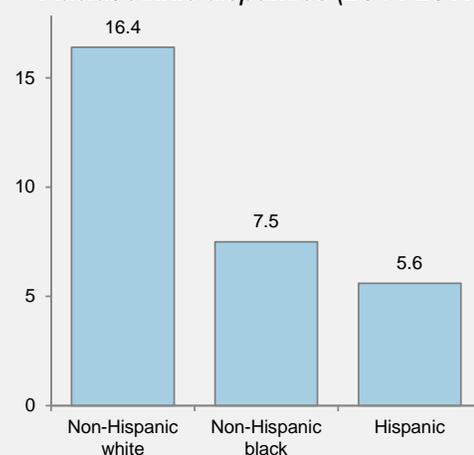


Comparison to peer counties^a (2017)



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Racial/ethnic disparities (2014-2017)



Data source: Mortality data from CDC WONDER, 2017

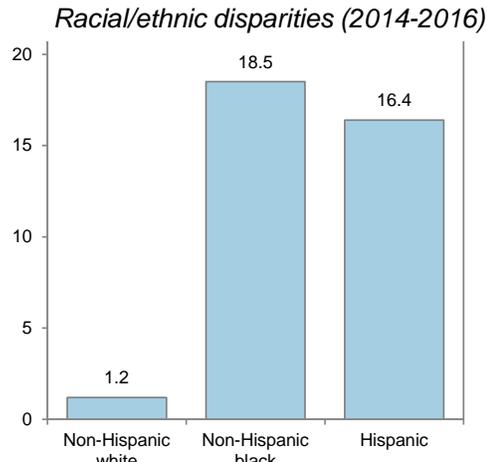
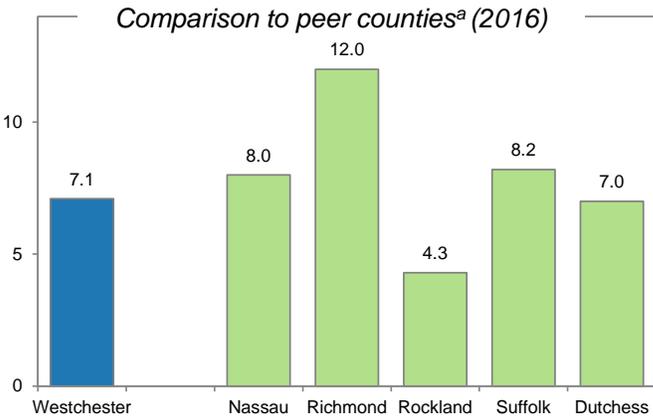
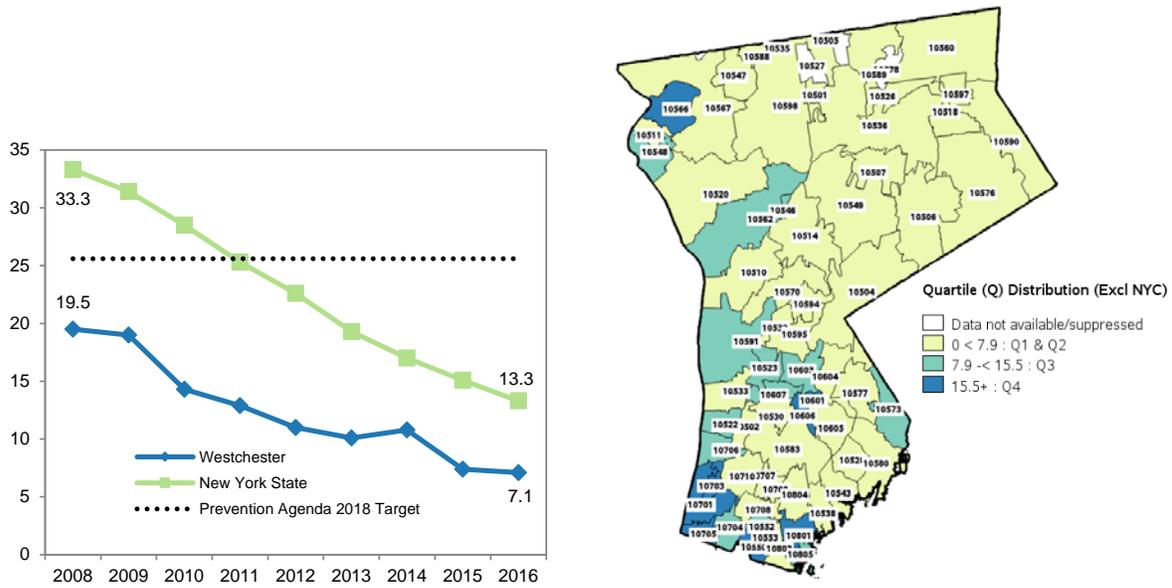
Map data is at the ZIP Code level and is from New York Opioid Data Dashboard, 2016.

Maternal and Child Health

The adolescent pregnancy rate for Westchester County declined from 2008 to 2016, is lower than the New York State rate, and meets the Prevention Agenda 2018 Target. While this finding is positive, it is not consistent across population groups. The adolescent pregnancy rate is higher for non-Hispanic Black (18.5 per 1,000) and Hispanic (16.4 per 1,000) adolescents than non-Hispanic White adolescents (1.2 per 1,000). SJMC primary service area adolescents have among the highest pregnancy rates.

Westchester County overall has a lower rate of adolescent pregnancies, but the rate is higher among minority and SJMC primary service area residents

Adolescent Pregnancy Rate per 1,000 Females Age 15 to 17



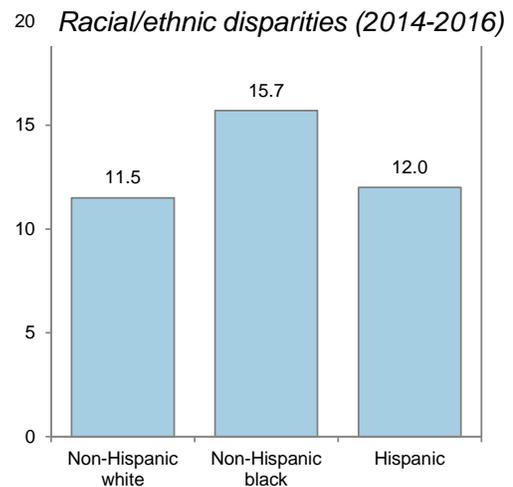
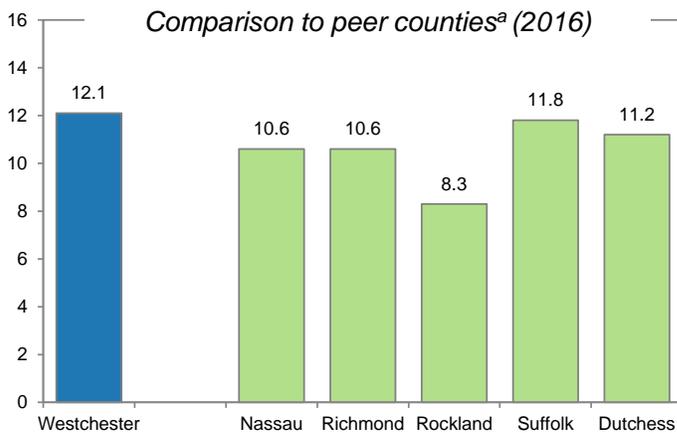
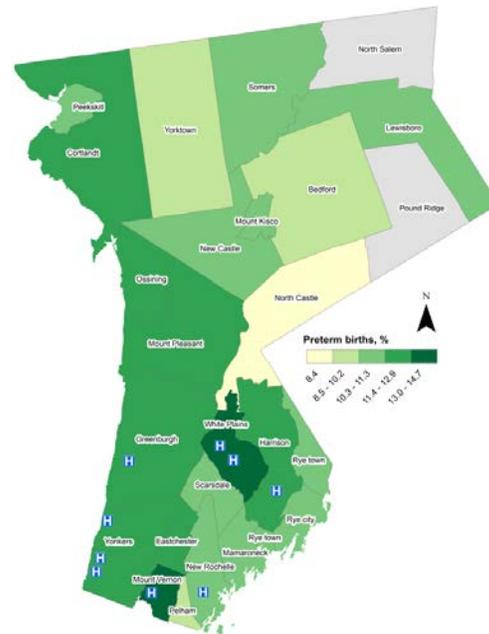
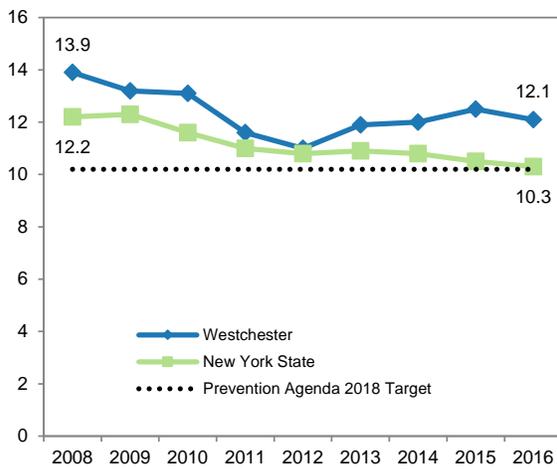
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Map is at the ZIP Code level and reflects data from 2012-2014

The percent of births that are preterm is higher in Westchester County than in New York State overall, and highest among all peer counties. The percentage does not meet the Prevention Agenda 2018 Target. The percent of births that are preterm is higher amongst the non-Hispanic Black population (15.7%) than the non-Hispanic White (11.5%) and Hispanic populations (12.0%).

Westchester County has the highest percentage of preterm births among peer counties

Percentage of Preterm Births



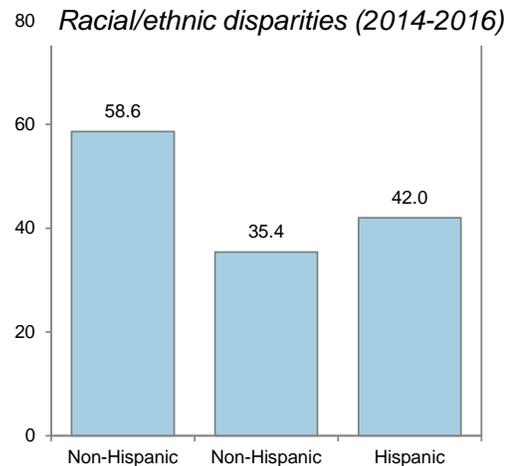
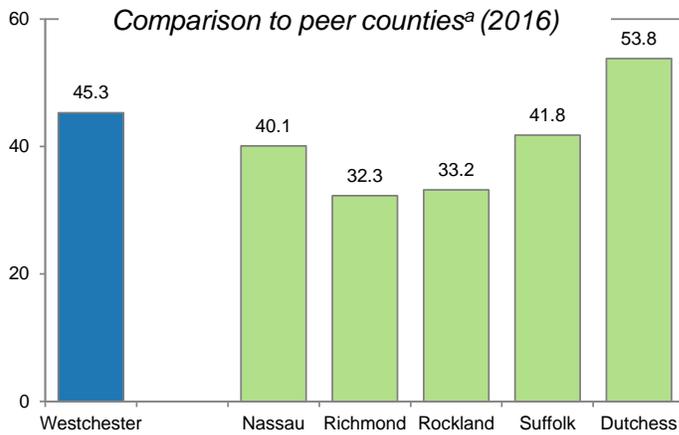
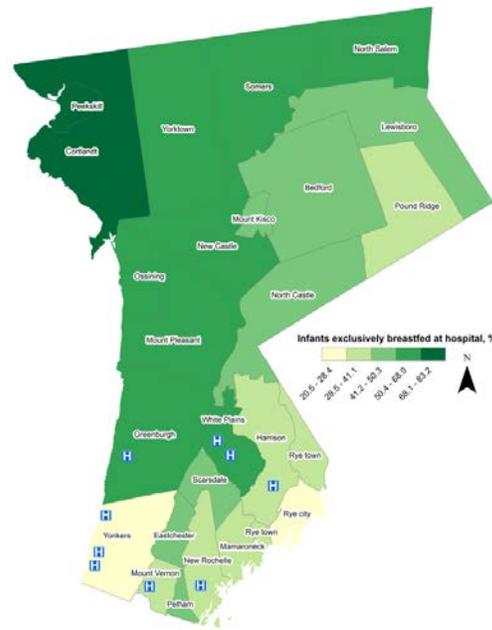
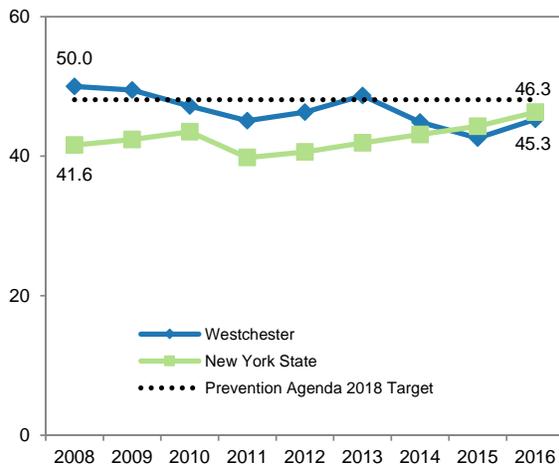
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Map is at the Minor Civil Division level and reflect data from 2013-2016
Gray area indicates unreliable estimate.

In Westchester County, the proportion of infants exclusively breastfed in the hospital (45.3%) has slightly decreased over the last decade, although it remains the second highest when compared to five peer counties. The proportion of infants that are exclusively breastfed in the hospital is higher for non-Hispanic White populations (58.6%) than Hispanic (42.0%) and non-Hispanic Black populations (35.4%). Babies born to mothers in the SJMC primary service area are among the least likely to be exclusively breastfed.

Westchester County has the second highest percentage of breastfed babies among peer counties, but the percentage is declining

Percentage of Infants Exclusively Breastfed in the Hospital



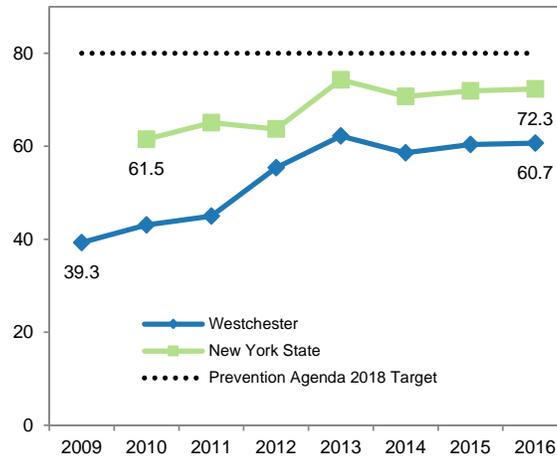
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Map is at the Minor Civil Division level and reflect data from 2013-2016

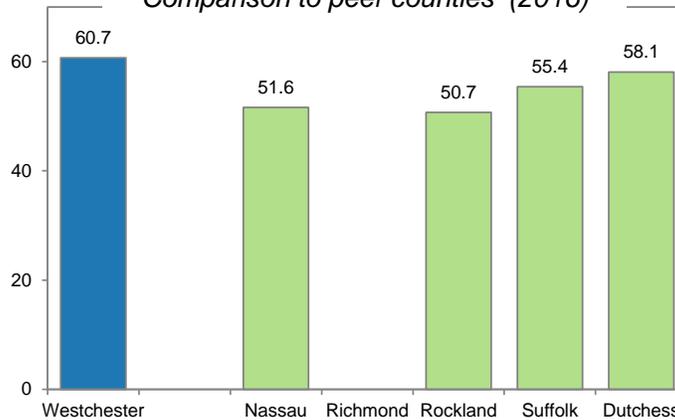
Despite an upward trend over the past decade, a smaller proportion of Westchester County children age 19 to 35 months have received their full immunizations when compared to New York State overall (60.7 vs. 72.3% respectively). Westchester County has the highest proportion of immunized children among peer counties.

Westchester County has the highest percentage of immunized children among peer counties, but the percentage is lower than the state overall

Percentage of Children Age 19-35 Months with 4:3:1:3:3:1:4 Immunization Series Coverage



Comparison to peer counties^a (2016)



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard
Richmond county data not available

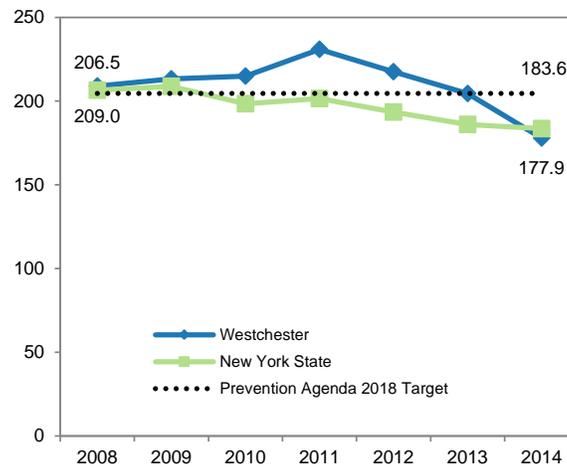
Older Adult Health

Approximately 16% of Westchester County residents are older adults age 65 or over. According to the National Council on Aging, falls are the leading cause of fatal injury and the most common cause of nonfatal trauma-related hospital admissions among older adults.

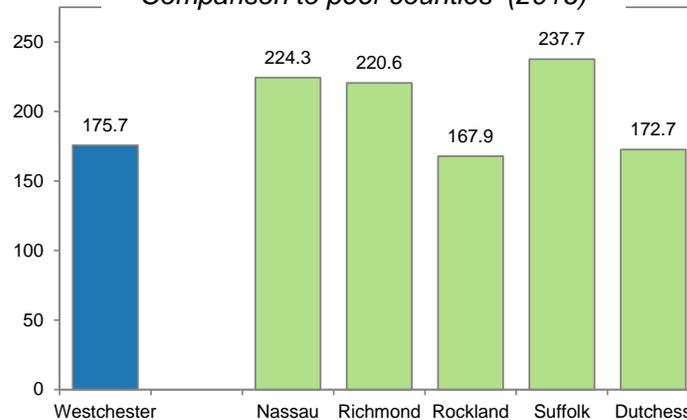
Westchester County older adults have fewer fall-related hospitalizations than peer counties, and the rate is declining

In Westchester County and New York State overall, the fall hospitalization rate among older adults is declining and lower than the Prevention Agenda 2018 Target. In comparison to peer counties, Westchester County has among the lowest rates of fall hospitalizations among older adults.

Fall Hospitalization Rate per 10,000 Adults Age 65 or Over



Comparison to peer counties^a (2016)



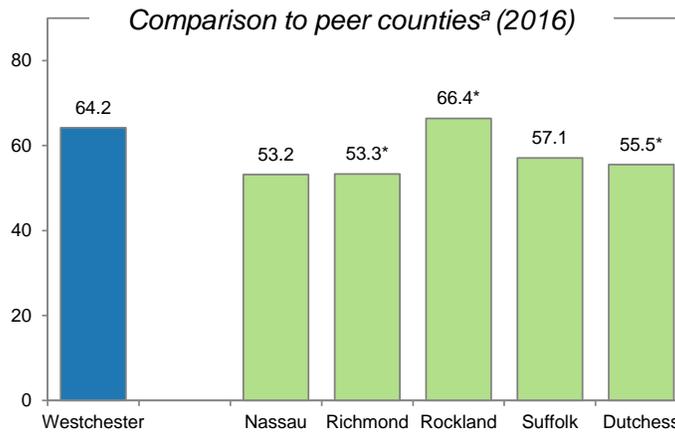
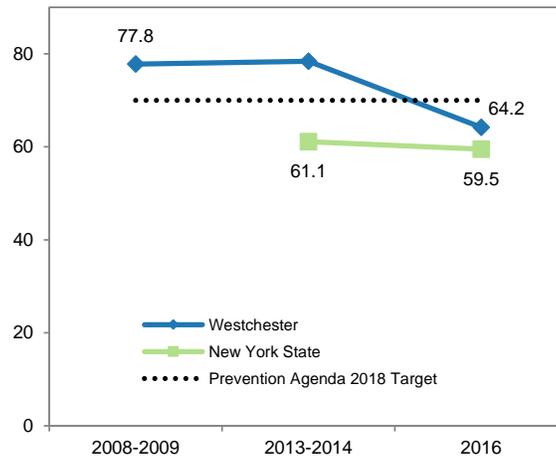
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

*Data source: New York State Prevention Agenda Dashboard
Trend data not available past 2014 due to switch to ICD-10 in 2015.*

In Westchester County, the proportion of older adults who received a flu immunization declined from 77.8% in 2008/2009 to 64.2% in 2016. The current percentage is higher than New York State overall and higher than peer counties, but does not meet the Prevention Agenda 2018 Target.

The percentage of Westchester County older adults who receive a flu shot is declining

Percentage of Older Adults Age 65 or Over with an Annual Flu Shot



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

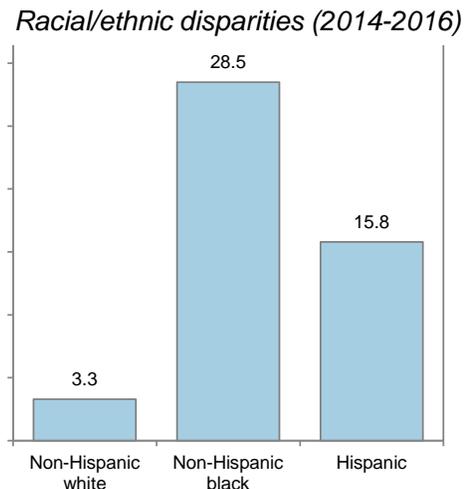
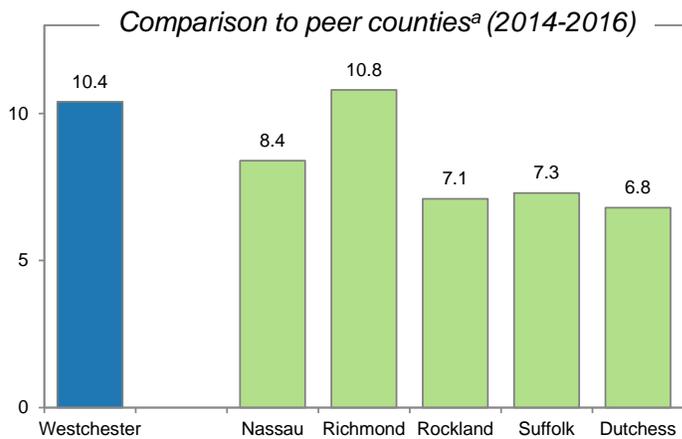
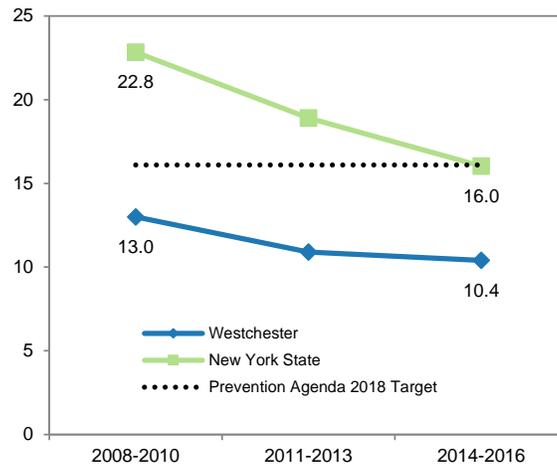
Data source: New York State Prevention Agenda Dashboard
 * Indicates unreliable estimate; interpret with caution

Sexually Transmitted Infections

The HIV incidence rate is lower in Westchester County (10.4 per 100,000) than in New York State overall (16.0 per 100,000) and meets the Prevention Agenda 2018 Target (16.1 per 100,000). However, in comparison to peer counties, Westchester County has the second highest HIV incidence rate. The incidence of HIV among the non-Hispanic Black population and Hispanic population is approximately 8.6 and 4.8 times higher than among the non-Hispanic White population, respectively.

In Westchester County, HIV incidence is 8.6 times higher among non-Hispanic Black residents versus non-Hispanic White residents

Newly Diagnosed HIV Cases per 100,000 Population



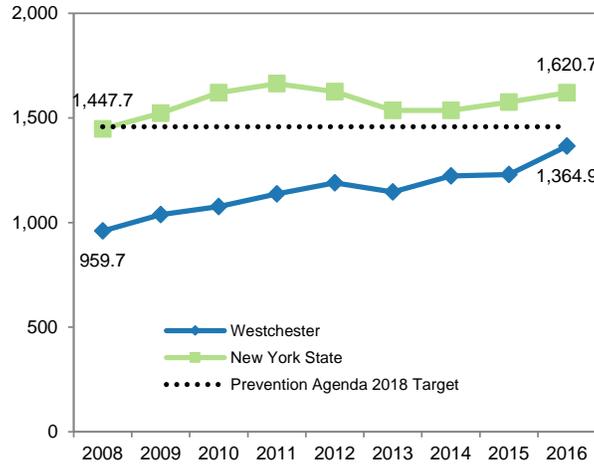
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

Data source: New York State Prevention Agenda Dashboard

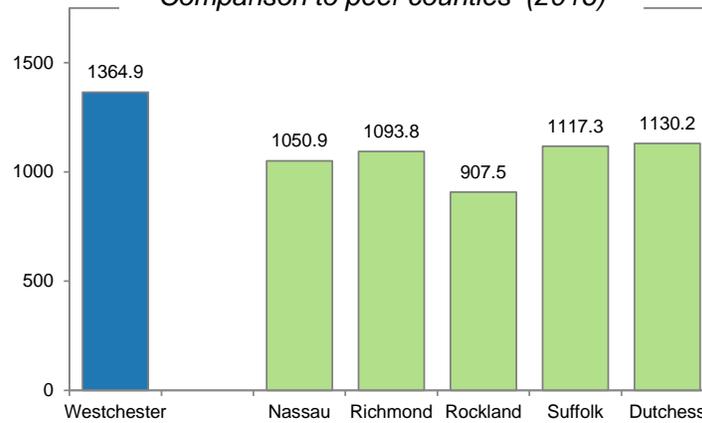
The chlamydia rate amongst women age 15 to 44 is lower in Westchester County (1,364.9 per 100,000) than in New York State overall (1,620.7 per 100,000), although the rate has increased for both geographies over the past decade. The chlamydia rate for women age 15 to 44 is highest in Westchester County when compared to peer counties.

Westchester County has the highest rate of chlamydia among women age 15 to 44 among peer counties; the rate is increasing

Chlamydia Rate per 100,000 Women Age 15 to 44



Comparison to peer counties^a (2016)



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.

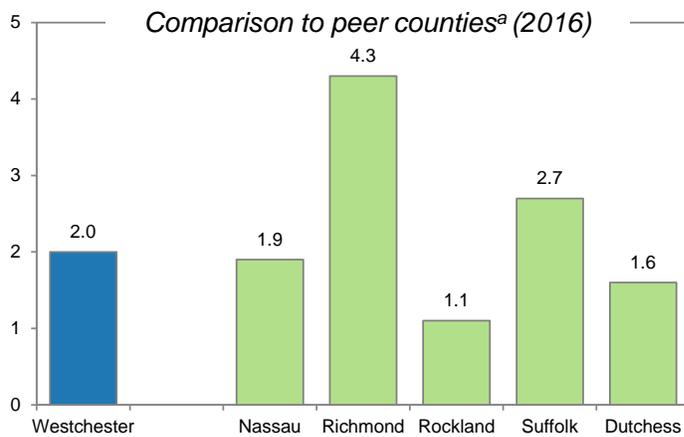
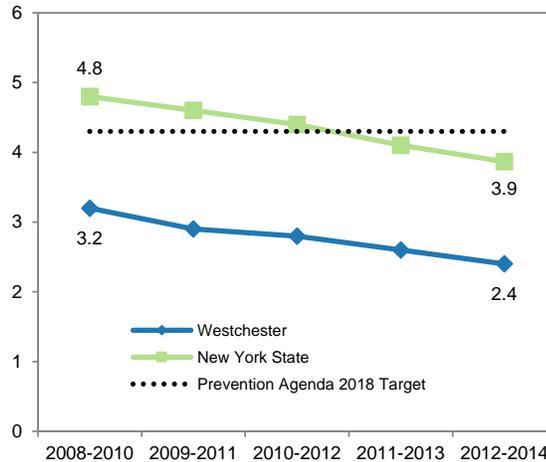
Data source: New York State Prevention Agenda Dashboard

Violence

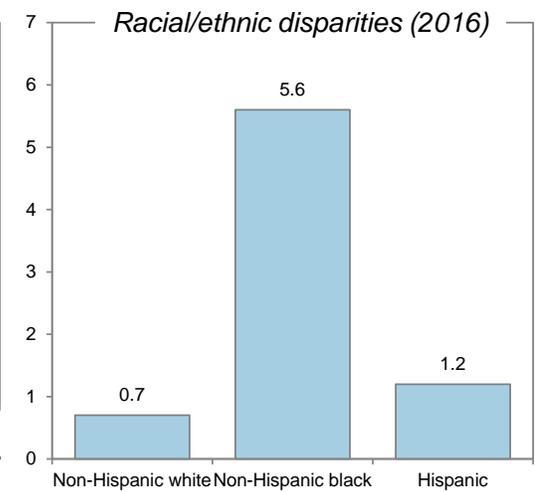
The assaulted-related hospitalization rate is more than 1.5 times lower in Westchester County (2.4 per 10,000) than in New York State overall (3.9 per 10,000). The assault-related hospitalization rate is higher for non-Hispanic Black residents (5.6 per 10,000) than non-Hispanic White (0.7 per 10,000) and Hispanic (1.2 per 10,000) residents.

Westchester County has a lower rate of assault-related hospitalizations, but the rate is higher for Black residents

Assault-Related Hospitalizations per 10,000 Population



^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.



Data source: New York State Prevention Agenda Dashboard

Community Health Survey Results

SJMC collaborated with the WCDOH and other local hospitals to conduct a Community Health Survey among Westchester County residents age 18 or over. The survey was conducted to assess perceptions of health in the community, including the top priority health issues, the most needed services, and the largest obstacles preventing access to care.

Surveys were conducted from January to March 2019 via paper- and online-format and in both English and Spanish. The surveys were distributed to a diverse range of community groups and were available in public locations, such as local libraries, hospitals, clinics, and county offices. A total of 2,727 surveys were completed.

The majority of respondents were female (73%), between the ages of 35 and 64 (53%), and White (59%). Nearly one-quarter of respondents (22%) were age 65 or over and 19% were Black/African American. Approximately 33% of respondents also identified as Hispanic or Latino. Seventy-five percent of respondents spoke English as their primary language. Spanish was the second most common language (19%). Slightly more than half of respondents (54%) were employed and had attained a college degree (55%).

The following is a summary of the findings from the Community Health Survey.

- > The top three priority health issues for Westchester County were mental health (n=1,034), chronic disease (n=846), and food and nutrition (n=737). Other top issues included obesity (n=716), environments that promote well-being & active lifestyles (n=619), and child and adolescent health (n=576).
- > The majority of survey participants rated their health as “good” (37.4%) or “very good” (32.7%). When asked to identify the top three priority health issues for themselves, participant responses were similar to the priority health issues identified for the county, with the exception of physical activity:
 - Physical activity (n=1,129)
 - Food and nutrition (n=1,111)
 - Environments that promote well-being & active lifestyles (n=911)
 - Chronic disease (n=730)
 - Mental health (n=586)
 - Obesity (n=505)
- > The top health conditions experienced by survey participants were hypertension (n=509), arthritis (n=493), and depression/anxiety (n=402).
- > The top three needed services to improve the health of Westchester County residents were affordable housing (n=794), mental health services (n=726), and exercise and weight loss programs (n=589). Other top needed services included access to healthier food (n=545), services for older adults (n=461), and drug and alcohol treatment (n=441).
- > The following populations were seen as needing the greatest attention to improve health: older adults (n=1,052), teens (n=921), and young adults (n=616).

- > While 80% of respondents had somebody that they think of as their personal doctor, many respondents identified barriers to accessing their provider, including cost (17.4%), transportation (9.1%), and inability to get an appointment (18.6%).
- > Approximately 8% of respondents did not have health insurance. Among insured individuals, the majority (53.8%) had employer-based insurance. Medicare was the second most common health insurance type (23.4%) among respondents.
- > Respondents were asked if, in the past 30 days, they felt emotionally upset as a result of how they were treated based on demographic and social characteristics. Respondents were most likely to experience this outcome based on their race or ethnicity (12.6%) and age (10.9%). Fewer respondents experienced this outcome based on their gender identity (5.8%), perceived immigration status (4.8%), disability (4.2%), religion (3.9%), or sexual orientation (2.5%).

Community Health Survey findings were considered in conjunction with public health data to determine health priorities for SJMC's service area. Community Health Survey data is valuable in informing community strengths and gaps in services, as well as wider community context for public health data findings.

Community Health Summit Summary

The Westchester County Health Planning Coalition collaboratively hosted a Community Health Summit on April 5, 2019 in White Plains, NY. The purpose of this meeting was to elicit feedback from the local community, government, and health and social service providers related to their perspective on the health and social needs of their clients with the goal of advancing the New York State Department of Health's 2019-2021 Prevention Agenda (NYSPA) to:

1. Improve the health of New Yorkers in five priority areas; and
2. Reduce health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations who experience them.

Over 70 attendees across health and community based organizations participated in the Premier facilitated breakout sessions and a Gallery Walk intended to promote conversation focused upon four of the New York State Department of Health's 2019-2021 Prevention Agenda (NYSPA) Priority Areas. A list of the represented community organizations is included in Appendix B.

1. Prevent Chronic Diseases - chronic disease continues to be a major burden including heart diseases, cancers, diabetes, and asthma
2. Promote a Healthy and Safe Environment - in the past several years, water quality has become a major issue that warrants attention and broader **environmental factors impact on health needs to be addressed.**
3. Promote Healthy Women, Infants and Children – there continue to be disparities related to infant mortality, preterm birth, and maternal mortality
4. Promote Well-being and Prevent Mental and Substance Use Disorder - opioid overdose has become a major issue over the past few years

Note: The fifth NYSPA Priority Area - Prevent Communicable Diseases – was not a focus of discussion for this specific meeting. While familiarity with the topics varied between individuals, all were engaged and focused upon identifying concerns and proposing actionable solutions.

Although the facilitated breakout sessions were convened around four very different Priority Areas, common themes emerged across these discussions:

There are many strengths and resources existing in the community.

- > Schools and many other non-traditional organizations in the county provide important settings for the delivery of resources for education, training, and other needed assistance
- > Healthcare organizations across the county were identified as expert resources and critical to coordinate and collaborate with to meet essential needs
- > Health providers and Community Based Organizations are skilled at fostering connections, building coalitions, developing networks, and collaboration (e.g. this Community Health Summit)
- > There is a solid foundation from which to integrate existing and launch new programs

Identification of barriers and gaps is the first step to improvement.

- > Begin education and training for healthy behaviors as young as possible (target children and adolescents)
- > Observed inconsistent and fragmented education across the community
- > Develop culturally specific guidance and messaging (e.g. healthy eating) that is essential for effective communication
- > Create safe environments for persons seeking help (undocumented, family violence, mental health disorder stigmas, etc.)
- > Understand and align current programs as a first step before building new programs
- > Inventory the community's current programs/assets and publish a resource directory in a centralized location that is easily accessible to residents (website, a dedicated phone line, etc.)
- > Lack of funding (solo efforts are more challenging to start and to resource thus requiring partnership and collaboration)

There are action items which could benefit all four Priority Areas.

- > Utilize social media for education, increased awareness, and communication
- > Improve transitions and coordination across entire continuum of health providers and community-based organizations
- > Embrace a person-centric language that is universal to all to increase awareness and reduce stigma, for all too common health needs (mental health, substance use disorders, reproductive health, domestic violence, etc.)
- > Include in the care planning process all categories of provider, family, and caregiver
- > Focus efforts on the basic needs, before trying to address other needs

Social Determinants of Health must be considered when developing strategies.

- > Jobs are needed and employers should promote health, offer childcare, and more
- > Economic status inequality exists
- > Affordable, healthy food is needed and there is a lack of green/farmers markets
- > Public transportation is limited across Westchester County
- > There is a need in the community for affordable housing (both permanent and transitional purposes)
- > Air quality is inconsistent, and pollutants are carried by the wind from Ohio
- > Water quality is threatened due to improper disposal of pharmaceuticals
- > Undocumented status frequently restricts outreach to resources due to fear
- > Safe places are needed for all to walk, play, exercise, and socially engage

- > Disparities range across race, gender, and age
- > Language barriers exist

The session for each prevention agenda topic allowed clinical and non-clinical providers to offer an engaged depiction of the needs of the community and included:

NYSPA #1: Prevent Chronic Diseases

- > Chronic diseases were acknowledged as primarily cancer, cardiovascular disease, and diabetes.
- > Education begins at school to create healthy choices and habits and is critical throughout the age spectrum to promote healthy lifestyle behaviors.
- > Economic and “safety” disparities remain throughout the county.
- > There are adequate and appropriate resources across the county, but coordination is lacking.

ACTION: Support and leverage existing community resources across homes, schools, churches, CBOs, etc. to address chronic diseases.

NYSPA #2: Promote a Healthy and Safe Environment

- > There is an increased recognition that health improvement requires broader approaches addressing social, economic, and environmental factors.
- > An environment of trust and culturally safe communication must exist between the community and its residents to affect change.
- > Ease of access will continue to impact choice and utilization.
- > There is need to change the financial incentive structure of public assistance to pay for healthy food options.
- > Work is needed with local organizations to increase access to healthier food options.

ACTION: Address currently fragmented and inconsistent education and communication.

NYSPA #3: Promote Healthy Women, Infants and Children

- > The health of women, infants, children, and families is fundamental to overall community health.
- > There is an abundance of existing resources, but there is a lack of coordination for a communal and publicly accessible platform.

ACTION: Design community awareness campaigns and messaging focused upon prenatal and infant care.

ACTION: Health systems need a holistic care approach that eliminates silos across the continuum.

NYSPA #4: Promote Well-being and Prevent Mental and Substance Use Disorders

- > Mental health and substance use disorder was a more popular topic than promoting well-being.
- > Inclusivity is needed for extending care planning to family and caregivers and promoting a multidisciplinary approach in treatment.
- > There are geographical and affordability barriers to accessing mental healthcare.

ACTION: Break down silos and collaborate through forums such as the 2019 Health Summit.

The results of this report were used by the Westchester County Health Planning Coalition to help drive this engaged group of community advocates' strategic plan for community health and wellness improvement via a three-year Implementation Plan.

Summary of Community Health Challenges

Westchester County is the third healthiest county in New York State, according to the 2019 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.

Several of Westchester County's municipalities continue to have significant health gaps. Portions of lower Westchester, including Yonkers and SJMC's primary service area, are "hot spots" for poorer health outcomes, such as asthma prevalence and management and overdose deaths.

Westchester County is the third healthiest county in New York State, but not all residents share equally in positive health outcomes

Black/African American and Hispanic populations, which comprise a larger proportion of the total SJMC primary service area population, experience notable disparities related to these health outcomes and others. Many of these disparities can be traced back to differences in social determinants of health, particularly poverty.

Preventable hospitalizations are an indicator of healthcare access barriers that contribute to health disparities. While the preventable hospitalization rate for adults is lower in Westchester County than New York State overall and declining, sub-populations within the county have excess hospitalization rates. Rates are generally elevated in the southern portion of the county, including Yonkers, and among minority populations. Within SJMC's primary service area zip codes, the hospitalization rate is ≥ 147.3 per 10,000 compared to the county average of 97.8 per 10,000. Among the non-Hispanic Black population, the hospitalization rate is 2.9 times higher than the rate for the non-Hispanic White population.

Preventable hospitalizations, a key indicator of healthcare access barriers, are higher in the SJMC primary service area

Residents of SJMC's primary service area experience notable barriers to accessing care. More than 1 in 10 residents in the primary service area are uninsured, higher than Westchester County and the state overall. Uninsured rates are highest among foreign-born residents (~25%) who comprise 30% or more of the population. Westchester County overall has the lowest percentage of adults with a primary care provider, and the percentage is declining. Primary care access barriers are greater in SJMC's primary service area, a majority HPSA for primary care.

Fewer SJMC primary service area residents are insured; the area is a majority HPSA for primary care

Asthma is one of the most common chronic conditions among Americans, affecting an estimated 1 in 13 people. It is the most common chronic condition among children. When effectively managed in a primary care or other outpatient setting, asthma should not be the primary reason for an ED visit. Asthma-related ED visits often speak to access to care barriers, lack of primary care, and poor disease management. While Westchester County overall has historically had fewer asthma-related ED visits compared to the state, it has the

SJMC primary service area zip codes have among the highest rates of asthma-related ED visits in the county

second highest visit rate among peer counties. SJMC primary service area zip codes have among the highest ED visit rates in the county.

Westchester County residents overall have better mental health, as indicated by self-reported mental health status and suicides rates, but substance use disorder is prevalent. Westchester County has the highest percentage of adults who report binge drinking among peer counties, and the percentage is increasing. The death rate due to opioids tripled in Westchester County over the past decade. While the county has a lower death rate than the state overall, portions of the county, including SJMC's primary service area, are disproportionately impacted. Non-Hispanic White residents are more than twice as likely to die from opioids as non-Hispanic Black or Hispanic populations.

Westchester County experiences notable disparities in maternal and child health outcomes. While the adolescent pregnancy rate for Westchester County declined and is lower than the New York State rate, it is not consistent across population groups. The pregnancy rate is higher for non-Hispanic Black and Hispanic adolescents than non-Hispanic White adolescents. SJMC primary service area adolescents have among the highest pregnancy rates. The percentage of preterm births, while declining, is higher than the state overall and highest among minority populations. The proportion of infants exclusively breastfed in the hospital is decreasing, although it remains the second highest when compared to five peer counties. Babies born to mothers of color and mothers residing in the SJMC primary service area are among the least likely to be breastfed.

Mothers and babies in SJMC's primary service area experience poorer birth outcomes than their peers across the county and state

While maternal and child health disparities are a top challenge for Yonkers and SJMC's primary service area, SJMC will not specifically address these needs as part of the Implementation Plan, choosing to focus on the issues that the medical center has the greatest ability to impact. SJMC has significant resource capacity and expertise in the areas of chronic disease, specifically asthma, and substance use disorder prevention and treatment. SJMC will continue to promote positive maternal and child health outcomes in partnership with its primary care and family medicine providers.

Available Assets and Resources to Address Identified Health Issues

Community assets and resources, including organizations, people, policies, and physical spaces, elevate the quality of life of residents. Identifying the assets that exist within Yonkers is an important component of the CHNA, both to mobilize and employ resources to address identified health issues, as well as to address existing gaps.

The following section highlights available assets and resources within Yonkers to address the priorities to Prevent Chronic Diseases and Promote Well-Being and Prevent Mental and Substance Use Disorders, with specific focus on asthma and substance misuse and death. The list is not intended to be all encompassing of the providers and services available to residents.

Priority Need: Prevent Chronic Diseases, Focus on Asthma

Available Assets and Resources:

- > Community Partnerships:
 - [Hudson Valley Asthma Coalition](#): A partnership with healthcare practices, hospitals, schools, child care centers, and other community settings to enhance capacity to offer state-of-the-art, evidence-based asthma education and treatment.
 - Montefiore Hudson Valley Collaborative Asthma Management Guidelines: Focused on provider engagement, workflow improvements and development of infrastructure to address four primary goals:
 - Implementation of evidence-based guidelines (EBG) into primary care
 - Integration of Asthma Action Plans (AAPs) into care regimens/medical records
 - Treatment and care coordination across the care continuum
 - Use of EBGs and care coordination across the continuum to improve asthma management and reduce ED utilization/inpatient visits due to asthma
 - [YonkerSpectrum School Health Program](#), a primary care school-based clinic operating in four Yonkers public schools: Martin Luther King, Jr., Academy, Eugenio Maria de Hostos Microsociety, Rosemarie Ann Siragusa School, and Cesar E. Chavez School. The program provides free, accessible, high quality health services to high-risk children, focusing on children with asthma.

- > National Asthma Resources:
 - American Academy of Allergy Asthma and Immunology (AAAAI)
 - American Lung Association
 - Asthma and Allergy Foundation of America
 - Asthma Community Network
 - Asthma Community Network Webinars
 - Centers for Disease Control and Prevention
 - 6 I18 Initiative: Accelerating Evidence into Action

- Centers for Medicare and Medicaid Services Office of Minority Health: Asthma Data Snapshot
- Environmental Protection Agency (EPA)
- Healthy People 2020-Respiratory Diseases
- National Heart, Lung, and Blood Institute
- > New York State Department of Health [Asthma Resources and Publications](#)
 - New York's Action Against Asthma to expand the availability of comprehensive asthma control services and improve the quality of life for New Yorkers with asthma
 - Clinical Resources, including asthma action plans and management guides
 - Clinical Quality Improvement guides
 - Environmental Resources
 - Asthma Self-Management Education Resources
 - School Resources

Priority Need: Prevent Mental and Substance Use Disorders, Focus on Preventing Substance Misuse and Death

Available Assets and Resources:

- > Community Partnerships:
 - Montefiore Health System, Inc.- Department of Psychiatry
 - [Behavioral Health Integration Project](#), providing a model for integrated mental health and substance abuse with primary care services to ensure coordination of care.
 - Westchester Department of Community Mental Health
 - [Behavioral Health Crisis Stabilization Services](#), aimed at improving the community's response to behavioral health crises to drive outcomes around follow-up treatment and avoidable ED visits and hospitalizations.
- > National Substance Use Disorder Resources:
 - [Agency for Healthcare Research and Quality](#)
 - [American Society of Addiction Medicine](#)
 - [Substance Abuse and Mental Health Services Administration \(SAMHSA\)'s National Registry of Evidence-based Programs and Practices](#)
 - [SAMHSA TIP 63: Medications for Opioid Use Disorder](#)
 - [National Institute on Drug Abuse, Principles of Drug Addiction Treatment](#)
- > New York State Department of Health
 - [Buprenorphine Resources](#)
 - [The Office of Alcohol and Substance Abuse Services \(OASAS\)](#)
 - [Opioid Overdose Prevention Program](#)

- [OASAS Addiction Medications](#)
- > Saint Joseph's Medical Center
 - Crisis Prevention and Response Team, responding to community members to provide assessment, crisis intervention, supportive counseling, and linkages to services and follow up.
 - Department of Psychiatry, offering comprehensive outpatient and inpatient mental health services, addiction treatment programs and crisis services, and residential services.
 - Community Outreach, providing training on Narcan administration.
- > Westchester County Department of Health
 - [Community Opioid Overdose Training](#)
 - [Needles and Syringes Disposal program](#)
 - [Safe Medication Disposal](#)

Evaluation of Impact from 2017-2019 CHNA Implementation Plan

In 2016, SJMC completed a CHNA and developed a supporting three-year Implementation Plan for community health improvement. Guided by the findings from the 2016 CHNA, and in alignment with the New York State Prevention Agenda and the MHVC DSRIP program, SJMC selected the following health priorities to address in our 2017-2019 Implementation Plan:

- Prevent chronic diseases, focus on asthma and cardiovascular disease
- Promote mental health and prevent substance abuse

The following is a summary of the programs and services sponsored by SJMC to address the health priorities identified by the 2016 CHNA.

Prevent Chronic Diseases

Saint Joseph's Family Health Center

The Family Health Center provides comprehensive asthma treatment services. Once a patient is diagnosed with asthma, an Asthma Action Plan (AAP) is developed with the patient and a written plan is provided. As part of their on-going treatment and education, patients are referred to the Center's asthma clinic where they receive detailed education and instruction. The education and instruction includes such topics as medication use, personalizing treatment plans, environmental triggers, and the latest research.

YonkerSpectrum School Health Program

The YonkerSpectrum School Health Program (YSHP) is a primary care school-based clinic operating in Yonkers public schools. Since 1989 the YSHP has provided free, accessible, high quality health services to high-risk children and has become an integral component of the Yonkers health care delivery system. The program receives funding from the New York State Department of Health, HRSA Bureau of Primary Health; in-kind services and financial support from SJMC; and in-kind services from the Yonkers Public Schools.

The YSHP provides a full array of primary health services, including, but not limited to routine care of children with chronic conditions such as asthma, obesity and diabetes; comprehensive histories and physical examinations; laboratory testing; immunizations; health counseling; and dental preventive services. Additional services focus on health education in areas such as managing asthma, nutrition, substance abuse, accident prevention, personal hygiene, normal growth and development, and first aid.

The electronic medical record (EMR) system utilized in the school-based clinics contains a Screenings/Interventions/Assessments section that serves to score and document the Asthma Control Test (ACT) for age groups 4-11 and 12 and up. The ACT is administered at each visit and the score is documented. Every patient identified as having asthma also has a documented AAP that is reviewed and updated at least every 6 months. Asthma education provided to patients and families includes a self-management program, comprised of a home environmental

assessment questionnaire, trigger identification and reduction, medication use, and medical follow-up to reduce school absenteeism, avoidable emergency room visits, and hospital care. All asthma patients are offered an influenza vaccine if applicable.

Continuity of care is assured during non-school hours, holidays, weekends, and vacations through Saint Joseph's Family Health Center. The nurse practitioners can be reached 24 hours a day, seven days a week and are credentialed to see patients at the Family Health Center. Emergency telephone contact with the collaborating or covering physician is available on a 24-hour basis through the primary care back up system developed for the Family Health Center. The procedure is outlined in the brochure that parents receive when they enroll in YSHP.

Million Hearts® Campaign

Saint Joseph's Medical Center is proud to be a Million Hearts® partner. As a partner, we have committed to aligning our organization with the Million Hearts® evidence-based strategies to prevent cardiovascular events. Since joining the campaign, SJMC has taken the following actions to advance the goals of Million Hearts®:

- Made healthy food and beverage options available to patients, visitors, and staff.
- Implemented comprehensive smoke-free policies to reduce tobacco use and secondhand smoke exposure.
- Initiated automatic referrals for eligible patients to cardiac rehab.

Smoking Cessation

SJMC continued its smoke and tobacco free campus policies. The Harrison campus is now smoke free and patients and clients in all programs are assessed for smoking dependence. Education, smoking cessation groups, and access to nicotine replacement therapies are offered. Employees who smoke are encouraged to discuss smoking cessation options with their primary care physician or learn about quitting through the New York State Smokers' Quit Line.

Screenings, education, smoking cessation groups, and access to nicotine replacement therapies are also offered at numerous SJMC's outpatient programs throughout Westchester County and New York City.

Promote Mental Health and Prevent Substance Abuse

Crisis Prevention and Response Team

SJMC's Department of Psychiatry provides comprehensive outpatient and inpatient mental health services, addiction treatment programs and crisis services, and residential services. For those experiencing a mental health crisis, SJMC also offers a Crisis Prevention and Response Team (CPRT), which can provide assessment, crisis intervention, supportive counseling, and linkages to services and follow up. The CPRT is an interdisciplinary mobile team of mental health professionals that partners with schools, law enforcement, and various health and social service agencies. The team responds to people directly in the community.

The CPRT's goal is to help people avoid crises and to prevent emergency room visits and hospitalizations. When necessary, the team helps individuals access community resources that

serve as alternatives to hospitalization. When there is truly no alternative to hospitalization, the team offers support in arranging admission.

The Crisis Team expanded its mobile service to Saturday and initiated Sunday phone coverage. The team received approximately 4,500 calls in 2018, leading to about 1,300 patient contacts. As part of its services, the team offers “bridge visits” for county providers, providing follow up with clients at high risk for readmission and/or who need assistance connecting to care. The team made approximately 250 bridge visits in 2018.

Integrated Behavioral and Physical Health Services

Throughout SJMC there is a focused effort to evolve a collaborative model to integrate primary care and behavioral health. Examples of this focus across SJMC facilities include the following.

The main site for the Family Health Center employs a full-time social worker to integrate behavioral health services within the primary care setting and provide immediate therapy services. Providers are able to refer patients directly to the Social Worker via a warm handoff, lessening patient stress and stigma. The Social Worker works with individuals and families to address both health and social issues. A detailed and comprehensive care plan is developed, inclusive of all Care Team members. The plan is transmitted to the New York State RHIO, a regional database that can be accessed by providers outside of the SJMC community. Information sharing provides a safety net for when patients are not able to return to their primary care provider or find themselves in an emergency situation.

In 2017, SJMC expanded the availability of Social Worker services to our nearby locations of Family Medicine and the Saint Vincent’s Primary Care Clinic and enhanced behavioral integration by adopting a model known as IMPACT. The model expands the Care Team with the addition of another Social Worker, a Depression Manager, and a Psychiatrist to consult with the primary care team. The IMPACT model was continued in 2018 and allowed for the treatment of more behavioral health patients and increased access to services.

Patients at Saint Joseph’s Family Health Center are periodically screened for depression using approved evidence-based screening tools. Patients with a positive initial screening receive follow-up screening to determine the extent of their depression. The patient is then connected to a Social Worker for more intensive mental health services and programs as necessary. Patients with depression are targeted for the development of a comprehensive care plan. The number of screenings has increased each year over the last three (3) years.

SJMC works to maintain relationships and coordinate care between its addiction treatment program in Yonkers (Positive Direction), the Health Home Care Coordination Program, and the Mental Health Clinic, which treats Family Health Center patients needing more intensive services. There is also a focused effort to link behavioral health patients of St. Vincent’s Hospital Westchester and the Residential Services Program to primary care services.

Our Brooklyn/Queens Opioid Treatment Centers (OTCs) have partnered with AbbVie pharmaceuticals to successfully treat over 120 HEP C patients across all four OTC locations. They have also encouraged coordination of care by utilizing SJMC'S Special Care Coordinators to integrate services and maintain care follow up.

A "wellness" tab was piloted in the St. Vincent's EMR system to track patients' physical health and ensure that they are screened for diabetes and heart disease, both of which are prevalent in patients with serious mental illness.

Addressing the Opioid Epidemic

Outpatient addiction programs focused on reducing the time from first contact to assessment to active enrollment in treatment. The focus is driven by SJMC's goal to engage individuals in need of treatment as quickly as possible to improve success rates. SJMC has expanded the use of medication-assisted treatment (MAT), especially SUBOXONE, in all of its behavioral health programs in response to the opioid epidemic.

More than 40 training sessions (reaching approximately 1,000 people) were given in 2018 on the use of Naloxone Overdose Rescue Kits (Narcan). The sessions were attended by school staff, providers, and a variety of community organizations.

Approximately 50 substance abuse education and prevention programs were offered throughout Westchester County for schools, parents, and community groups on topics such as vaping, identifying drug paraphernalia, bullying, and strategies to deal with child substance use.

Addressing Social Determinants of Health

SJMC undertook the following initiatives to improve social determinants of health indicators for patients and community members.

- In 2018, behavioral health services introduced a "social determinants of health" screening into its standard assessment. The questionnaire addresses non-clinical patient challenges, including economic stability, housing, education, and social supports. When issues are identified, treatment providers attempt to address them through health home care coordination and other resources.
- Health Home Care Coordination Programs in Westchester County and NYC were expanded to provide services to over 1,300 high need individuals. The programs work closely to address housing needs and other social determinants of health, as well as support linkages to medical and behavioral health treatment.
- The "Bridge Home" project was developed in collaboration with the NYC Department of Homeless Services and the Staten Island Performing Provider System. Through this project, our Residential Services staff have placed eight families from the NYC shelter system into permanent supported housing. Residential Services expanded its supported housing units in the Bronx (20 units), and opened the Sr. Jane Manor apartments to include 19 units of licensed mental health housing on Staten Island.

- SJMC began construction and renovation of 160 mixed housing units in Yonkers. Fifty-nine of these units are affordable housing for families and seniors; the remaining 101 units will be available for the frail elderly and those requiring supportive case management for mental health issues. SJMC anticipates finalizing capital financing and commencing construction on these projects as follows:
 - The School Street housing project is under construction in Yonkers. The project will consist of an 80-unit apartment building with 48 units of supportive housing for individuals with special needs and 32 units of affordable housing for families.
 - Mary the Queen Convent located on Vark Street is being rehabilitated into housing units. The project will include a 67-unit apartment building with 47 units of supportive housing for the frail elderly population. The remaining 27 units will be affordable housing for seniors from the Yonkers community.

Saint Joseph's is committed to optimizing its efforts to improve the health outcomes of those it serves. Our Physicians, Nurses, Technologists and support staff are some of the most highly trained and experienced professionals, who are dedicated to our mission of providing the highest quality of healthcare. We look forward to continued success with our prevention initiatives and the ongoing support of our community.

2019-2021 Implementation Plan for Community Health Improvement

Prioritization Process and Identified Priorities

SJMC leadership reviewed findings from the CHNA research, including public health and socio-economic measures and input received from residents and Community Health Summit participants, to determine priority health needs and where to focus community health improvement efforts. Leadership representatives considered the 2019 CHNA research findings, as well as existing community and hospital services, programs, and areas of expertise. Discussion culminated in the identification of the following priorities to be addressed during the next three-year cycle. The priorities are aligned with the New York State Prevention Agenda and Montefiore Hudson Valley Collaborative initiatives.

- > Priority Area: Prevent Chronic Diseases
 - Focus Area: Preventive Care and Management (Asthma)
 - Goal #1: Promote the use of evidence-based care to manage chronic diseases.
 - Goal #2: Improve self-management skills for individuals with chronic conditions.
- > Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders
 - Focus Area: Prevent Mental and Substance Use Disorders
 - Goal: Prevent opioid and other substance misuse and deaths.

The rationale and criteria used to select this priority included:

- > Scope: How many people are affected?
 - Is the issue widespread or affecting few individuals?
 - Are there inequities or disparities among residents?
- > Severity: How critical is the issue?
 - What is the cost or burden of the issue on the community?
 - Are there negative outcomes or harm caused?
- > Ability to Impact: Can we achieve the desired outcome?
 - Are there known practices to address the issue?
 - Are resources readily available?
 - Can we measure short-, medium-, or long-term outcomes?
- > Community Readiness: Is the community prepared to take action?
 - Are there supportive leaders or policy makers?
 - What is the prevailing attitude of the community toward the issue?
 - Do we have community capacity to take on the issue?

The CHNA research findings and stakeholder feedback support the priorities to be addressed by SJMC during the next three-year cycle. Additional national findings are reported below to further support the identified health needs.

Focus Area: Preventive Care and Management (Asthma)

Scope:

The American Lung Association conducts research on asthma trends and burden. The following excerpt from the Association's [website](#) highlights the national impact of asthma.

Asthma Mortality (2016)

- In 2016, 3,518 people died from asthma. The asthma death rate decreased 41 percent from 1.7 per 100,000 population in 1999 to 1.0 in 2016, although progress has slowed since 2007.
- In 2016, 61 percent of asthma deaths were in women, and the asthma death rate was 32 percent higher among women than men.
- The asthma death rate was 2.8 times greater among Blacks than Whites in 2016.
- Both the number and rate of deaths from asthma are much greater among older age groups, but have been decreasing.

Lifetime Asthma Prevalence (2017)

- In 2017, 42.7 million Americans (13.3 percent) had ever been diagnosed with asthma by a healthcare professional. This was an increase of 46 percent from 9.1 percent in 1999.
- Children ages 5-17 years had the highest lifetime prevalence rates (15.7) compared to other groups.
- Females were about 12 percent more likely than males to ever have been diagnosed with asthma.
- Blacks are more likely than other races and ethnicities to be diagnosed with asthma over their lifetime. In 2017 they had the highest lifetime prevalence rate at 15.2 %

Severity:

The American Lung Association reported the following findings related to asthma hospitalizations and emergency department visits:

- In 2014, there were 339,890 hospitalizations with asthma listed as the primary cause, or 141.0 per 100,000 people.
- The asthma hospitalization rate decreased at an average of 1.3 points per year from 1993 to 2014, which was statistically significant at 21% overall.
- In 2014, there were 1.956 million emergency room visits with asthma listed as the primary complaint, or 613.3 per 100,000 people.
- The asthma emergency department visit rate increased at an average rate of 8.2 points per year from 2006 to 2014, which was statistically significant or 10 percent overall.

The American Thoracic Society estimated that from 2008 to 2013, asthma accounted for \$81.9 billion each year in total economic costs, including \$50.3 billion in healthcare costs, \$29 billion in mortality-related costs, and \$3.0 billion in missed school and work days.

The effects of asthma fall disproportionately on minority populations, particularly children. These individuals have higher rates of poor asthma outcomes, including hospitalizations and deaths,

due to greater exposure to environmental allergens and access to care barriers. Minority populations are the primary patient population for SJMC school- and community-based clinics. SJMC's health improvement plan is focused on improving their asthma-related outcomes.

Ability to Impact:

SJMC's goals to improve asthma outcomes can be effectively and efficiently realized through enhanced medical practices and protocols. Our key to success is the ongoing education of medical staff, patients, and families, and adherence to established evidence-based care for asthma. We employ certified Asthma Educators, including one physician and three nurse practitioners, who will lead these initiatives and leverage staff and resources across the medical center. The Asthma Educators will be supported by the personnel and material resources of the SJMC Ambulatory Care Division and the YonkerSpectrum School Health Program. Progress will be routinely monitored and measured in partnership with SJMC's Patient Care Committee and Board of Trustees, and program enhancements will be made as necessary.

Community Readiness

SJMC will continue to work closely with various community organizations and leaders (e.g. city government, schools, faith based organizations, senior housing, etc.) to successfully implement asthma initiatives. SJMC is an active partner in community events, such as street fairs, health fairs, and sporting events. We will continue to have a presence at all of these events to distribute asthma information and promote available asthma management education services.

Focus Area: Prevent Mental and Substance Use Disorders (Opioid Use Disorder)

Scope:

According to the National Institute of Drug Abuse, "Every day, more than 130 people in the United States die after overdosing on opioids. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement."

The National Institute of Drug Abuse reports the following opioid crisis facts:

- Roughly 21 to 29 % of patients prescribed opioids for chronic pain misuse them.
- Between 8 and 12 % develop an opioid use disorder.
- An estimated 4 to 6 % who misuse prescription opioids transition to heroin. About 80 % of people who use heroin first misused prescription opioids.
- Opioid overdoses increased 30 % from July 2016 through September 2017 in 52 areas in 45 states.
- The Midwestern region saw opioid overdoses increase 70 % from July 2016 through September 2017
- Opioid overdoses in large cities increased by 54 % in 16 states.

The opioid crisis has had further impact on the community, including increased incidence of neonatal abstinence syndrome due to exposure to opioids in the womb, and spread of infectious diseases including HIV and hepatitis C due to injection drug use.

The impact and consequence of the opioid crisis is prevalent throughout SJMC's service area, affecting all people regardless of race, color, or socioeconomic factors. Widespread impact has contributed to decreased stigma as residents view opioid use disorder as a true disease and community issue.

Severity:

The opioid crisis has had tragic consequences for our service area, both economically and for the quality of life of residents. The financial stress caused by drug misuse and associated deaths has placed a tremendous burden on community resources, including first responders, educational systems, and law enforcement, among others. The human experienced suffering due to the opioid crisis will continue to have a lasting impact for generations.

Ability to Impact:

SJMC will leverage its existing programs and practices, including education and training, crisis intervention, counseling, and other evidence-based care to improve health outcomes. SJMC's primary focus and resource allocation will be delivered through our extensive behavioral health system of care. As with the asthma initiatives, progress will be routinely monitored and measured to ensure on-going success and to make changes and enhancements as necessary. SJMC's strategies to address the opioid crisis align with many of the strategy areas outlined by the U.S. Department of Health and Human Services (HHS), including:

1. Improving access to treatment and recovery services
2. Promoting use of overdose-reversing drugs
3. Strengthening our understanding of the epidemic through better public health surveillance

Community Readiness:

SJMC's community service areas have embraced initiatives to address the opioid crisis, and are collaborating with us to enhance efforts and achieve desired outcomes. Leaders in our community, including government entities, businesses, faith-based organizations, and others, have pledged their support for these efforts. Community residents have made tremendous strides in adopting a positive, proactive approach to decrease the stigma associated with mental and substance use disorders and reduce its overall impact. With our combined efforts, we have the necessary resources and vision to effectively reduce the devastating impact of this crisis.

Saint Joseph's Medical Center 2019-2021 Implementation Plan

SJMC developed an Implementation Plan to guide their community benefit activities across their service area. As determined through the prioritization process, SJMC will devote resources and expertise to address chronic disease, with a focus on asthma, and mental health and substance use, with a focus on preventing substance misuse and death. Eliminating health disparities will continue to be a cross-cutting strategy for SJMC.

The Implementation Plan builds upon previous health improvement activities, while recognizing new health needs and a changing healthcare delivery environment identified in the 2019 CHNA.

Priority Area: Prevent Chronic Diseases

Focus Area: Preventive Care and Management (Asthma)

Goals:

- > Promote the use of evidence-based care to manage asthma.
- > In the community setting, improve self-management skills for individuals with asthma.

Objectives:

- > Decrease the number of asthma-related ED visits and hospitalizations.
- > Increase the %age of adults with asthma who have taken a course or class to learn how to manage their condition.
- > Increase the %age of children (0-17) and adults (18+) with asthma who were ever given an asthma action plan by a doctor or health professional.

Health Disparity Addressed: Westchester County has historically had fewer asthma-related ED visits than New York State overall, but it has the second highest asthma-related ED visit rate in comparison to peer counties. Within Westchester County, SJMC primary service area zip codes have among the highest ED visit rates at ≥ 50.7 per 10,000 population. Asthma was the second most common diagnosis among SJMC ED treat-and-release visits in 2018. The service area population is diverse and many residents experience greater access to care barriers that contribute to preventable ED visits.

Implementation Plan:

SJMC will provide educational programs for Yonkers public school children with asthma in partnership with the YonkerSpectrum School Health Program school-based health clinics (SBHCs). The children served by these clinics have historically had higher incidence of asthma and asthma-related ED visits. The two programs to be offered, *Kickin' Asthma* and *Open Airways for Schools®*, were developed by the American Lung Association.

Kickin' Asthma is an asthma management program for children age 11 to 16 (grades 6-10) that educates and empowers them through a fun and interactive approach. *Kickin' Asthma* includes different learning techniques suitable for teen-aged kids and highlights self-management practices, such as recognizing triggers and proper medication use. In addition to improving asthma self-management skills, *Kickin' Asthma* increases asthma awareness among school personnel and decreases emergency room visits.

Kickin' Asthma is designed to be a convenient "out of the box" program. The program includes four sessions, each 45-minutes long, making them compatible with, or just a bit shorter than, the length of a typical school period. Each session has sections that are optional, to allow the instructor the flexibility to make time adjustments. It also, includes an optional follow-up session three months after the fourth session, to check-in and conduct a follow-up evaluation.

Open Airways for Schools® is designed for elementary school children age 8 to 11 to learn how to better manage their own asthma. The program educates and empowers children through a fun and interactive approach that teaches children how to detect the warning signs of asthma, avoid their triggers, and make decisions about their health.

Open Airways for Schools® is the most widely recognized asthma management program for children in the nation, and a proven-effective way to improve asthma self-management skills, decrease asthma emergencies, and raise asthma awareness among families and school personnel.

The SJMC nurse practitioners at each of the school-based health clinics will be responsible for organizing, enrolling, and presenting the two programs. Patients and family members will also be instructed on asthma self-management, with access to one-on-one physician education and a series of onsite group workshops. These workshops will be presented in both English and Spanish by certified asthma educators.

Asthma management education will be provided to SJMC clinical staff members. The faculty of SJMC's Family Residency Program, in collaboration with the Hudson Valley Asthma Coalition (HVAC), will provide educational opportunities based on the National Asthma Education and Prevention Program Guidelines for Diagnosis and Management of Asthma. In past years, Dr. Sankaran Krishnan, MD, MPH has been instrumental in lecturing the family medicine residents on topics such as treating and managing young patients with asthma. Dr. Krishnan is an Associate Program Director of the Pediatric Pulmonology Training Program and Director of Research at the Children's Environmental Health Center of the Hudson Valley.

As part of previous health improvement plans, SJMC, in collaboration with HVAC, offered family medicine residents and nurse practitioners the opportunity to participate in clinical sessions with Dr. Krishnan's team. The purpose of the program was to provide primary care providers the opportunity to learn about asthma care and management under the observation and guidance of pulmonologists. These opportunities were highly recommended by its participants and will be revisited by SJMC in year-3 of the current health improvement plan.

Detailed Implementation Plan:

Interventions/Strategies	Process Measures	Community Partners and Roles
<p>Conduct <i>Kickin' Asthma</i> and <i>Open Airways for Schools®</i> in Yonkers Public Schools that sponsor school based clinics</p>	<ul style="list-style-type: none"> • Number of <i>Kickin' Asthma</i> and <i>Open Airways for Schools®</i> programs conducted • Number of children referred to and participating in <i>Kickin' Asthma</i> or <i>Open Airways for Schools®</i> • Number of asthma-related ED visits among children participating in <i>programs</i> 	<ul style="list-style-type: none"> • Hudson Valley Asthma Coalition (HVAC): Inform evidence-based asthma education and treatment standards, as well as provide educational materials, including curriculum for the school-based asthma program, in-services, and supplies (e.g. spacers, mattress covers) • New York State Department of Health: Provide templates for asthma action plans and self-management education resources • YonkerSpectrum School Health Program: Implement evidence-based guidelines for asthma management, and conduct in-school programs such as <i>Kickin' Asthma</i> and <i>Open Airways for Schools®</i> • Yonkers Public Schools: Provide support for asthma learning activities, including assistance with parental consent, space for classes, and promotion for program attendance
<p>Promote evidence-based medical management in accordance with national guidelines</p>	<ul style="list-style-type: none"> • Implementation of policies/practices to promote guideline-concordant asthma care • Number of patients with policies and practices in place • Number of Family Health Center and St. Joseph's Family Practice Clinic patients with an Asthma Action Plan • Number of patients with an up to date Asthma Action Plan (at least yearly or upon changes of medical regime) • Number of children enrolled in SBHCs that have an up to date Asthma Action Plan • Number of children enrolled in SBHCs that have their asthma defined by severity and control • Number of children with asthma that had an Asthma Control Test within the last year • Number of children that have documented triggers and avoidance techniques in their patient record • Number of SBHCs using the NYSDOH Guide for Asthma Management in Schools 	
<p>Promote strategies that improve access and adherence to asthma medications and devices</p>	<ul style="list-style-type: none"> • Implementation of policies/practices to encourage self-management behaviors, including adherence to medication • Number of children with persistent asthma that have been prescribed an inhaled corticosteroid 	

Detailed Implementation Plan cont'd:

Interventions/Strategies	Process Measures	Community Partners and Roles
<p>Expand access to home-based multi-trigger, multicomponent visits by licensed professionals or qualified lay health workers to provide targeted, intensive asthma self-management education and to reduce home asthma triggers for individuals whose asthma is not well-controlled with NAEPP Guidelines' medical management and asthma self-management education (ASME)</p>	<ul style="list-style-type: none"> • Identification of partner community based organizations (e.g. Visiting Nurse Association) with trained staff to provide asthma management home visits • Implementation of policies/practices for referring patients with asthma to home-based services • Number of patients referred to home-based services • Number of home environmental assessments performed • Number of providers trained on NAEPP Guidelines including ASME and home-based interventions 	<p>See previous.</p>
<p>Expand access to evidence-based self-management interventions for individuals with asthma, whose condition(s) is not well-controlled with guidelines-based medical management alone</p>	<ul style="list-style-type: none"> • Implementation of policies/practices for identifying and referring patients to evidence-based self-management education programs (EBSMPs) • Number and type of EBSMPs in community settings • Number of patients referred to and participating in EBSMPs • %age of patients who complete EBSMPs 	

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders**Focus Area: Prevent Mental and Substance Use Disorders**

Goal: Prevent opioid and other substance misuse and deaths.

Objectives:

- > Reduce overdose deaths involving any opioid.
- > Increase the Buprenorphine prescribing rate for substance use disorder.

Health Disparity Addressed: The death rate due to opioids tripled in Westchester County over the past decade. While the county has a lower death rate than the state overall, portions of the county, including SJMC's primary service area, are disproportionately impacted. Non-Hispanic White residents are more than twice as likely to die from opioids as non-Hispanic Black or Hispanic populations.

Implementation Plan:

SJMC adopted a comprehensive strategic plan to prevent mental and substance use disorders, with the goal of reducing opioid and other substance misuse and deaths. The first component of the plan is to provide Naloxone administration training to various entities (prescribers, pharmacists and consumers), including a diverse group of Community Based Organizations (CBOs). These CBOs will include, but are not limited to, the following Yonkers and Westchester County agencies:

- > CLUSTER, Inc.
- > Family Services Society of Westchester
- > Family Services Society of Yonkers
- > Healthy Yonkers Initiative
- > Nepperhan Community Center
- > Victims Assistance Services
- > VIVE School (adult education program)
- > Westhab
- > YMCA of Yonkers
- > Yonkers Chamber of Commerce
- > Yonkers Community Center
- > Yonkers Municipal Housing A
- > YWCA of Yonkers

SJMC will aim to provide training to a minimum of 30 CBOs and 500 individuals throughout the region with a minimum of 50% of the CBOs and individuals coming from SJMC's primary service areas. In addition, SJMC clinicians including physicians, pharmacists, medical residents, nurses, social workers, counselors, and other related staff will receive the training. This widespread and multi-layered training initiative is intended to optimize resources at SJMC, as well as those throughout Yonkers and its surrounding communities, in order to reduce opioid overdose-related deaths.

SJMC will work to increase availability, access, and linkages to Medication-Assisted Treatment (MAT) services, including Buprenorphine. Reducing or eliminating the barriers to entry for

substance use disorder treatment, including MAT, are expected to contribute to a reduction in opioid-related deaths. SJMC will aim to promote open access to MAT services, particularly following an overdose or related encounter, maximizing patient motivation to receive treatment during this time. Rapid access to MAT provides immediate craving and overdose risk relief, as well as enhances patient engagement through a positive perception of program efficacy. This results in increased average length of stay in treatment, which is correlated with improved patient outcomes.

SJMC will also work to increase the number of medical staff trained in a trauma-informed approach to substance use disorder treatment. There is compelling research evidence documenting the high co-morbidity of substance use disorder, including opioid use disorder, with both trauma and adverse childhood experiences. Trauma Informed Care (“TIC”) takes into account knowledge of patient trauma, and incorporates this knowledge into all aspects of service delivery. It informs practitioners of the need to link substance use disorder patients to appropriate trauma care to achieve evidence-backed best practice outcomes.

Detailed Implementation Plan:

Interventions/Strategies	Process Measures	Community Partners and Role
Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	<ul style="list-style-type: none"> • Number of Naloxone administration trainings offered • Number of SJMC clinicians trained in Naloxone administration • Number of CBOs and residents trained in Naloxone administration • Number of Naloxone kits distributed 	<ul style="list-style-type: none"> • Community Based Organizations and SJMC clinicians: Attend and host training sessions and promote Naloxone availability
Increase availability of and access and linkages to medication-assisted treatment (MAT), including Buprenorphine	<ul style="list-style-type: none"> • Number of providers prescribing MAT • % of patients assessed for MAT within 5 days of initial contact • % of patients admitted to MAT within 7 days of initial contact 	<ul style="list-style-type: none"> • Montefiore Hudson Valley Collaborative: Identify and implement models for behavioral health integration and crisis stabilization
Increase access to Trauma-Informed Care for the treatment of substance use disorders, including opioid dependence	<ul style="list-style-type: none"> • % of staff trained in TIC: <ul style="list-style-type: none"> ○ Year 1 Targets: Saint Joseph’s and St. Vincent’s Westchester substance use disorder and mental health inpatient and outpatient providers and select Saint Joseph’s and St. Vincent’s Westchester medical providers • Number of community partners trained in TIC (to be provided by Community Outreach Director) <ul style="list-style-type: none"> ○ Year 2-3 Targets: Public school staff; Community residences/ mental health housing staff; Healthy Yonkers Initiative; Others to be determined 	<ul style="list-style-type: none"> • New York State Department of Health, Office of Alcoholism and Substance Abuse Services (OASAS): Provide treatment and training resources • New York State Department of Health: Provide Opioid Overdose Prevention Program Naloxone resources • Westchester County Department of Health: Provide Naloxone training programs

Community and Partner Engagement

SJMC continues to collaborate in addressing community needs through the Healthy Yonkers Initiative (HYI) established in 1998 by the City of Yonkers and St. John's Hospital. The Healthy Yonkers Initiative is a partnership of over fifty community-based organizations, local health and city departments, schools, businesses, faith-based institutions, and individuals in the City of Yonkers. These community partners are involved in the assessment of community health needs in our primary service area, the City of Yonkers, and its surrounding communities. St Joseph's has actively participated and supported HYI since its inception. The community partners continue to meet quarterly, rotating venues among the members. During these sessions, SJMC shares health information from the New York State and Westchester County Departments of Health and disseminate market share data.

Report Dissemination Plan

The SJMC 2019 CHNA Final Report and corresponding Implementation Plan were reviewed and approved by the Board of Directors on December 9, 2019. The reports, as well as pertinent information (programs, schedules, financial data, financial assistance, announcements, and updates), will be maintained on SJMC's website, <http://www.saintjosephs.org/about-us>. SJMC will also have a public inspection copy available at the hospital at all times, and will utilize the local media to promote prevention initiatives and feature articles on health. We will actively work with our partners to optimize communication to the community.

For more information regarding the Community Health Needs Assessment/Implementation Plan, or to submit comments or feedback, contact Catherine Hopkins, Director of Community Outreach and School Health (Catherine.Hopkins@saintjosephs.org).

SJMC is committed to the residents it serves and the neighborhoods they live in. Healthy communities lead to lower healthcare costs, robust community partnerships, and an overall enhanced quality of life.

Appendix A: Public Health Secondary Data References

1. 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 % of families living in poverty and for mapping the %age of adults with health insurance. For more information on ACS please visit <http://www.census.gov/programs-surveys/acs/about.html>.
2. 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>
3. 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/>.
4. 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/>
5. 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/>.

6. 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
7. 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/
8. 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 linkages 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>.
9. 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 the rate of chlamydia in each county. For more information, please visit: <https://www.health.ny.gov/diseases/aids/general/about/surveillance.htm>
10. 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/

11. 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 NVSS please visit <https://www.cdc.gov/nchs/nvss/index.htm>
12. Global Burden of Disease: The Global Burden of Disease (GBD) project from the Institute of Health Metrics and Evaluation at the University of Washington uses a comprehensive risk-assessment framework to summarize the collective impact of risk factors and health outcomes on adverse health. Specifically, GBD combines many datasets to estimate disability adjusted life years (DALYs) associated with numerous outcomes and risk factors. DALYs are a summary measure of population health that combines information on fatal health events and non-fatal health states. This is an important advantage over vital statistics which do not capture the important health impact of non-fatal health states (e.g., back pain, moderate depression, or alcohol use). GBD also allows for the estimation of DALYs attributed to specific risk factors, including body mass index, smoking, dietary risks, occupational risks, air pollution, etc. Data from the GBD is available at the global, national, and state-level; local-estimates are not available. Despite this limitation this information can be used to understand the most important areas of intervention to improve population health. Data are available at: <https://vizhub.healthdata.org/gbd-compare/>
13. 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/

Appendix B: Community Health Summit Participants

The following organizations participated in this event:

- African American Men of Westchester
- American Heart Association
- American Lung Association
- ANDRUS
- Arms Acres & Conifer Park
- Blind Brook Community Coalition
- Blythedale Children's Hospital
- Brannan Solutions Group
- Burke Rehabilitation Center
- Caritas of Port Chester, Inc.
- Child Care Council of Westchester
- Family Ties of Westchester
- Feeding Westchester
- Hudson River Health Care
- Independent Living, Inc.
- Inter-Care, Ltd
- John A. Coleman School
- Leukemia Lymphoma Society
- Lexington Center for Recovery
- Lifting Up Westchester
- Lower Hudson Valley Perinatal Network
- Montefiore Mount Vernon & New Rochelle Hospitals
- Mount Vernon Neighborhood Health Center
- Neighbors Link
- Northwell Phelps & Northern Westchester Hospitals
- NYC Poison Control Center
- New York Medical College
- New York Presbyterian Hudson Valley & Lawrence Hospitals
- Open Door Family Medical Center
- Peekskill Youth Bureau
- Rivertowns Pediatrics PC
- Rye YMCA
- St. Christopher's Inn
- St. John's Riverside Hospital
- St. Joseph's Hospital
- Student Assistance Services
- Sunshine Children's Home and Rehab Center
- The LOFT LGBT Community Center
- The Mental Health Association of Westchester
- The Sharing Community
- United Way 2-1-1
- Urban League of Westchester
- Volunteers of America Greater New York
- Westchester Children's Association
- Westchester Chiropractic and Wellness
- Westchester County Board of Health
- Westchester County Department of Health
- Westchester County Department of Community Mental Health
- Westchester County Department of Senior Programs and Services
- Westchester Medical Center Health PPS and Network
- WestCOP
- White Plains Hospital
- White Plains Youth Bureau
- Westchester Jewish Community Services
- Yonkers Office for the Aging
- YWCA of White Plains & Central Westchester