



**Saint Joseph's  
Medical Center**

**2016 Community Health Assessment and  
Improvement Plan & Community Service Plan**



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## 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. SJMC is proud to reflect the diversity of the community in which it is located and continuously strives to respond to the ever changing healthcare needs of the communities it serves. Today's healthcare environment is one of challenge, change, and complexity, yet through collaborative efforts and unique partnerships, SJMC strives to provide quality healthcare services within our resource capabilities to serve as a leader in providing health education, support services, and care for all residents.

To better understand and address the most pressing community health needs, SJMC participated in the 2016 Westchester County Department of Health Community Health Needs Assessment (CHNA). The 2016 CHNA builds upon our 2013 CHNA and was conducted in a timeline consistent with the requirements set forth by the Affordable Care Act for non-profit hospitals and the New York State Department of Health Community Service Plan (CSP). The CHNA included SJMC's psychiatric facility, St. Vincent's Hospital, located in Harrison, New York.

The purpose of the assessment was to gather information about local health needs and health behaviors. The CHNA examined a variety of household and health statistics to create a full picture of the health across Westchester County and Yonkers. The findings help ensure that SJMC initiatives, activities and partnerships meet the needs of our communities.

## Mission Statement and Values

### Mission

Saint Joseph's Medical Center is a Catholic healthcare facility, sponsored by the Sisters of Charity of Saint Vincent de Paul of New York. We strive for excellence in healthcare in an atmosphere of support and shared ministry.

### Values

SJMC believes in:

- > Respect and compassion for ourselves and others.
- > Excellence in service
- > The dignity of human life
- > Commitment to the community

The SJMC Mission embodies the rich traditions of the followers of Saint Elizabeth Ann Seton and Saint Vincent de Paul. Their dedication to what we now call "holistic patient care" encompasses all the needs of the sick: physical, mental, and spiritual. Not only medical and nursing care, but also the education of patients so that they may prevent illness and manage chronic conditions.

## **Saint Joseph's Medical Center 2016 CHNA Cover Page**

Saint Joseph's Medical Center's New York State 2016 Community Health Needs Assessment and Implementation Plan and Community Service Plan pertain to Westchester County. SJMC's primary service area comprises zip codes 10701 and 10705. Our secondary service area includes zip codes 10703, 10704, 10710, 10474, 10463, 10470, 10466 and 10467.

The Westchester County Department of Health (WCDOH) is the participating Local Health Department for the areas that Saint Joseph's Medical Center serves. As part of the WCDOH's participation, numerous local hospitals and community-based organizations met regularly with staff of the WCDOH in support of the New York State Prevention Agenda goals. WCDOH continues, along with hospital systems, to focus on promoting health equity and reducing health disparities in Westchester's high needs neighborhoods. For this report, the WCDOH contact is:

Ms. Renee Recchia  
Acting Deputy Commissioner for Administration  
Westchester County Department of Health  
10 County Center Road, 2nd Floor  
White Plains, NY 10607-1541

The participating Hospital System is Saint Joseph's Medical Center, which encompasses Saint Joseph's Hospital, Saint Joseph's Nursing Home, and the St. Vincent's Harrison Campus which provides comprehensive behavioral health services throughout Westchester County and New York City. The contact for information that pertains to this report is:

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

# Saint Joseph's Medical Center 2016 CHNA Executive Summary

## 1. Prevention Agenda Priorities

Saint Joseph's Medical Center and its CHNA collaborative partners reviewed findings from the CHNA research to determine the highest priorities within Westchester County on which to focus community health improvement efforts. In alignment with the New York State Prevention Agenda, the partners selected the following health priorities to address during the next three year cycle:

- > Prevent Chronic Diseases
- > Promote Mental Health and Prevent Substance Abuse

In coordination with the Westchester County Health Department and in alignment with the MHVC Delivery System Reform Incentive Payment (DSRIP) program, SJMC will focus on two areas within Prevent Chronic Diseases: asthma and cardiovascular disease. SJMC is also committed to addressing Westchester County's initiative to promote mental health and prevent substance abuse. Saint Joseph's operates Saint Vincent's Hospital Westchester, the largest behavioral health provider in the county. With this expertise and long history of promoting comprehensive behavioral health, SJMC will continue to promote, support, and implement interventions and strategies to address behavioral health issues.

## 2. Emerging Health Issues

Efforts outlined in SJMC's 2013 CHNA and CSP will continue for diabetes and hypertension. A new focus on asthma and a broader focus on heart health reflects the changing needs of the community and recognition that efforts to address cardiovascular disease prevention will also positively impact diabetes rates. The 2016 CHNA indicated that behavioral health needs continue to grow across the service area. In response, SJMC will accelerate initiatives to integrate behavioral and physical health care.

## 3. Public Health Assessment Methodology

Primary research methods were used to solicit input from community members and health care providers representing the broad interests of the community. Surveys were conducted from May 16 to June 30, 2016 to assess perceptions of the most needed services, barriers to providing/receiving services, and methods to improve access to services. A profile of public health and demographic data was also created to portray the health and socioeconomic status of the community. Secondary data research was used to identify community health needs and trends across geographic areas and populations. A listing and brief summary of the data sources used to complete the analysis is included in Appendix C.

## 4. Our Partners

The 2016 assessment was an inter-organizational and 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 Health Department as part of the Montefiore Hudson Valley Collaborative (MHVC), a group of regional hospitals and community based organizations, to gather research in support of the 2016 CHNA. Following is a list of our partners:

- > Burke Rehabilitation Hospital
- > Hudson Valley Hospital
- > Lawrence Hospital
- > Montefiore Mount Vernon Hospital
- > Montefiore New Rochelle Hospital
- > Montefiore Health System
- > Northern Westchester Hospital
- > Saint John's Riverside Hospital
- > Saint Joseph's Medical Center
- > Westchester County Department of Health
- > White Plains Hospital

SJMC leadership was provided by

- > Dean Civitello, Vice President, Human Resources, Public Relations & Development
- > Catherine Hopkins, Director of Community Outreach and School Health
- > John Ohnmacht, Administrator, Radiology and Cardiology
- > Pamela Tripodi, Administrator, Family Health Center
- > Frances Casola, Senior Vice President, Operations

## 5. Community Engagement

To engage the broader community, survey tools were collaboratively developed by hospital and health department partners, and made available in paper and online format in five different languages (English, Spanish, Arabic, French Creole, and Chinese). Paper surveys were distributed in service agency and hospital waiting areas with onsite assistance provided by WCDOH staff at select locations. Online surveys were distributed via listservs provided by the WCDOH, hospitals, and community organizations. A total of 1,318 community surveys and 218 provider surveys were completed. Survey tools are included in Appendix A and B.

Saint Joseph's Medical Center 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 our sessions we share health information from the New York State and Westchester County Departments of Health and disseminate market share data.

## 6. Community Health Improvement Plan and Process Measures

SJMC developed a Community Health Improvement Plan to guide community benefit and population health improvement strategies across its service area. The plan builds upon previous health improvement activities, and where possible, aligns with the New York State Prevention Agenda. An outline of the plan is provided below. The full plan is available on pages 30-36.

### **Prevention Agenda Priority: Prevent Chronic Disease**

#### Goals:

- > To ensure all patients with asthma access to care consistent with evidence-based medicine guidelines for asthma management.
- > Support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions.

#### Specific Strategies and Process Measures:

SJMC will assemble Project Teams for asthma and cardiovascular disease based on toolkits created by the MHVC. The Project Teams will be responsible for identifying community training/educational needs and improving access to care and quality improvement. Project Team members will be assigned specific tasks and responsibilities for measuring progress.

SJMC will implement programs both internally and in the community to improve asthma and cardiovascular disease outcomes. Community-based programs will focus on building capacity to identify and self-manage conditions, targeting populations experiencing disparity. SJMC will work with providers, Medicaid Management Care Organizations, Health Homes, and community-based organizations to implement evidence-based guidelines and protocols. One program to be implemented by SJMC is the Million Hearts Campaign, an initiative co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services to improve heart disease outcomes.

Hospital staff programming will increase the number of providers who are trained in patient self-management support principles and best practices for disease diagnosis, treatment, and management. A specific strategy to be implemented by SJMC is the National Heart, Lung and Blood Institute Expert Panel Report 3 (EPR 3) guidelines for asthma management. SJMC will also increase the number of providers who deliver a Chronic Disease Self-Management Program for people with hypertension.

SJMC will develop and implement best practice protocols for the assessment and treatment of patients with asthma and cardiovascular disease and embed them in Electronic Medical Records (EMR). Records will be updated to monitor patient self-management goals and action plans, changes in disease progress, and updates from the care management team.

Process measures for monitoring progress and community impact as a result of chronic disease initiatives include:

- > Development and implementation of Asthma Action Plans that include patient monitoring of signs and symptoms and peak flow meter readings when appropriate



- > Documentation of collaboration with school nurses, teachers, school administrators, and day care centers to educate, assess, and treat school-age children with asthma
- > Embedded best practices for the diagnosis, treatment, and management of asthma in SJMC's EMR
- > Identification of asthma and cardiovascular disease Project Team members with determined tasks and responsibilities
- > Number of home/work/school environment assessments for smoking, allergenic materials, and other known asthma triggers
- > Number of patients that participate in a Chronic Disease Self-Management Program
- > Number of patients with asthma (and caregivers) participating in workshops to better manage their condition
- > Number of patients with documented self-management goals in their medical record
- > Percentage of MCOs and Health Homes actively engaged in care/treatment coordination with those patients served by SJMC
- > Percentage of primary care providers receiving training in evidence-based guidelines for asthma and cardiovascular disease diagnosis, treatment and management
- > Percentage of smokers referred to NYS Quit Line
- > Percentage of staff trained/educated in patient self-management support principles and motivational interviewing

**Prevention Agenda Priority:** Promote Mental Health and Prevent Substance Abuse

Goals:

- > Improve care coordination for behavioral health patients.
- > Increase the percentage of patients with depression whose condition is diagnosed.
- > Improve the integration of behavioral health and physical health services.

Specific Strategies and Process Measures:

In March of 2016, a full-time Social Worker was added to the Saint Joseph's Family Health Center Care Team to integrate behavioral health services within the primary care site and provide immediate therapy services. The Care Team delivery system enables providers to refer patients directly to the Social Worker via a warm handoff, lessening the stress and stigma attached with having to seek services at outside facilities.

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 Saint Joseph's community. Information sharing provides a safety net for instances when patients are not able to return to their primary care provider, or find themselves in an emergency situation.

Patients with depression are targeted for the development of a comprehensive care plan. All patients 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.

In early 2017, SJMC plans to expand the availability of Social Worker services to our nearby locations of Family Medicine and the Saint Vincent's Primary Care Clinic. By the 4th quarter of 2017, SJMC plans to enhance 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 model will allow for the treatment of more behavioral health patients and increased access to services.

Process measures for monitoring progress and community impact as a result of behavioral health initiatives include:

- > The integration of social workers into SJMC's Family Medicine and Saint Vincent's Primary Care Clinic locations
- > The number of care plans transmitted to the New York State RHIO
- > The number of patients connected with social workers and enrolled in comprehensive care plans
- > The number of patients screened for depression, and the number of patients with positive depression screenings who are referred to either a social worker or enhance mental health services
- > The number of patients who have benefited from the IMPACT model and additional services offered
- > The number of patients with documented self-management goals in their medical record
- > Tracked medical outcomes (self-management skills, health status, and ED usage) as a result of care coordination efforts

### **Board Approval and Dissemination**

The CHNA and CSP Final Report and Implementation Plan were reviewed and adopted by the SJMC Board on December 12, 2016. A copy of the Final Report and annual updates is posted on the hospital's website, <http://www.saintjosephs.org/about-us>. SJMC will also have printed copies for distribution and public inspection available at the hospital at all times.

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

# Saint Joseph’s Medical Center’s 2016 CHNA Report

## 1. Service Area

### Westchester County

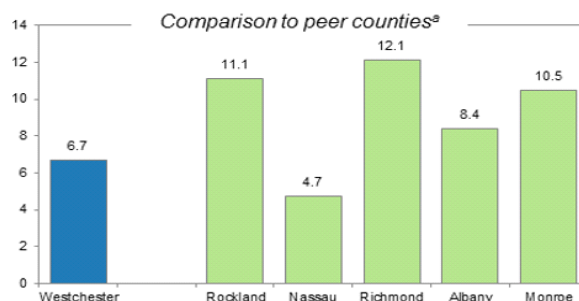
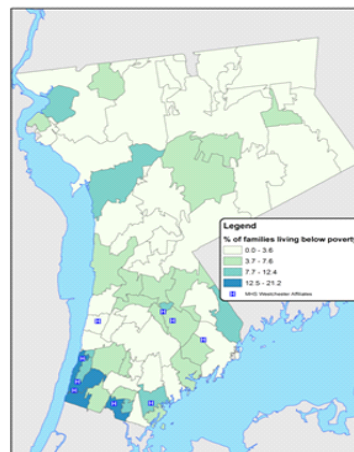
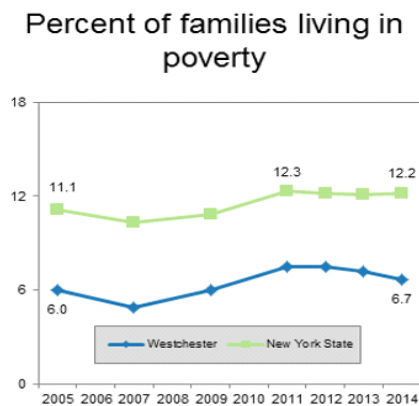
For the purpose of conducting a joint CHNA and partnering with the WCDOH, demographic and socioeconomic indicators were analyzed for all of Westchester County.

Westchester County, located just north of New York City in the Hudson Valley, spans 450 square miles and 48 municipalities designated as urban, suburban, and rural geographies. The 2015 estimated county population of 976,396 is up 6.6% from 915,916 in 2005. The county seat is the City of White Plains. Other major cities include Yonkers, New Rochelle, and Mount Vernon. The 2015 median household income for Westchester County (\$86,108) is the fourth highest in New York State after Nassau, Putnam and Suffolk Counties.

The following section highlights other socioeconomic indicators for Westchester County, as reported by the American Community Survey and New York State BRFSS.

### Poverty

- > Westchester County has half as many families living in poverty compared to the state.
- > Pockets of higher poverty are observed in some parts of Westchester County, including Yonkers and Mount Vernon.

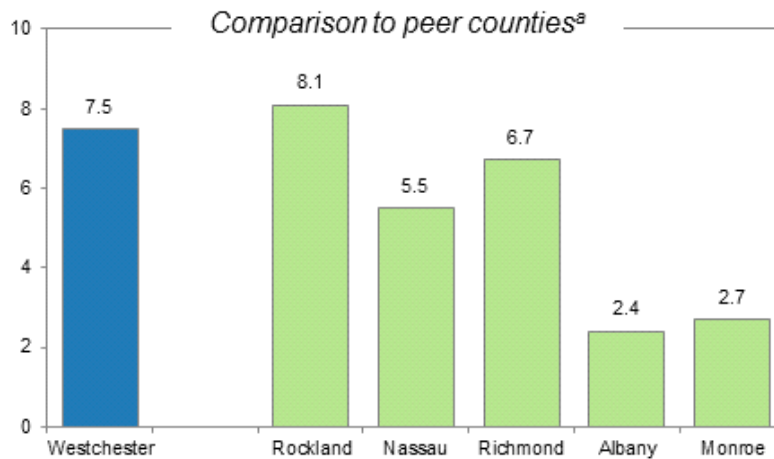
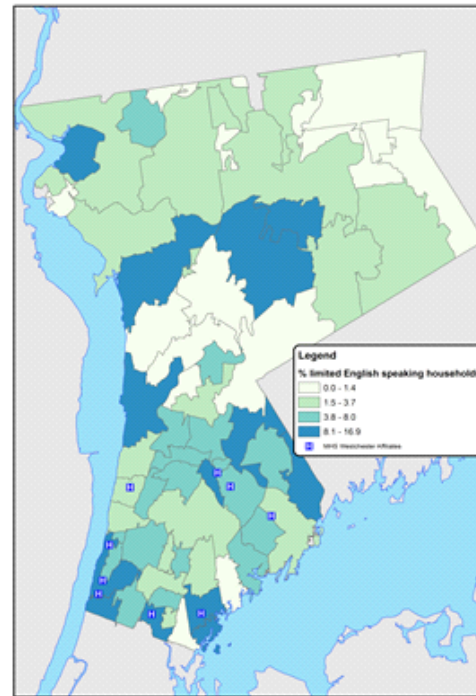
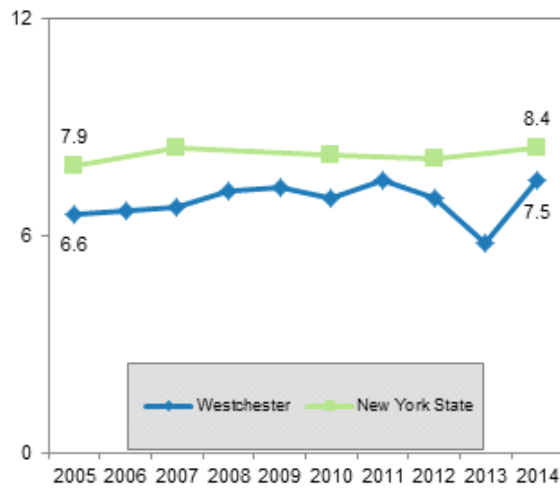


<sup>a</sup> Based on comparison of following measures: percent of population less than 20; percent of population ≥65; population density; % Hispanic; % black; % white; median household income; % college educated & % commuting alone to work. Rockland county was the most similar to Westchester County; the other 5 most similar counties are also provided in order of similarity.

### English Proficiency

- > In both New York State and Westchester County, there have been modest increases in the percentage of households that are linguistically isolated.
- > Compared to peer counties, Westchester County has the second highest proportion of households that are limited English speaking, trailing only Rockland County.
- > Pockets of linguistic isolation were observed in lower Westchester County, including Yonkers, Mount Vernon, and New Rochelle, and in Tarrytown, Ossining and Port Chester.

**Percent of households that are limited English speaking**  
(no one ≥14y speaks English only or “very well”)



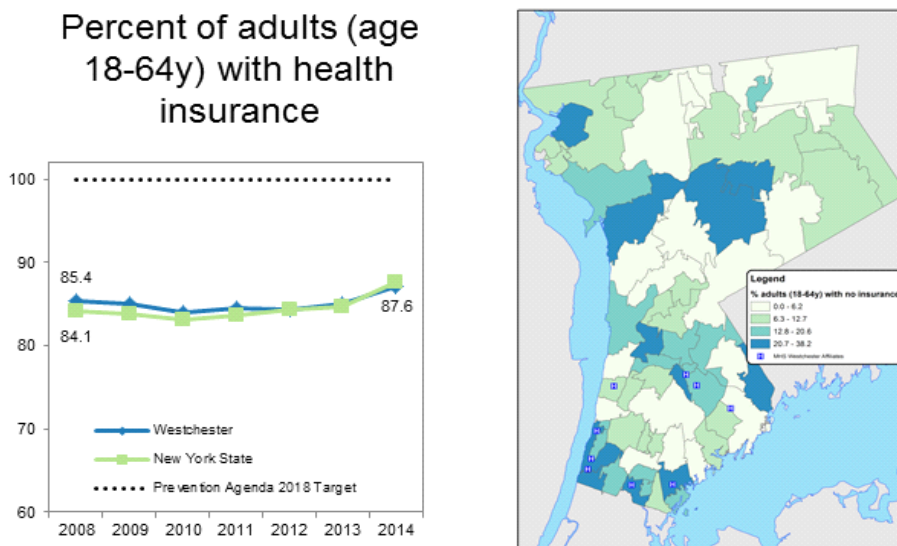
<sup>a</sup> Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

### Health Care Access

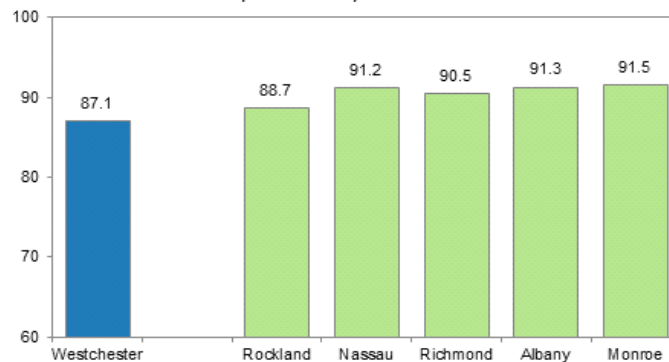
Westchester County is the fifth healthiest county in New York, according to the County Health Rankings, produced by the Robert Wood Johnson Foundation and University of Wisconsin. However, despite its overall healthy ranking, there is opportunity to improve population health and reduce health disparities in Westchester County. Portions of lower Westchester, specifically Mount Vernon, Yonkers, and New Rochelle, and White Plains were identified as having less access to health care services. They were also identified as “hot spots” for asthma, HIV, and illicit drug use, and as having higher death rates from heart disease, stroke, and diabetes compared to county and New York State averages.

### Health Insurance Coverage (Adults)

- > From 2008 to 2014, the percentage of non-elderly adults in Westchester County with health insurance increased from 85.4% to 87.6%.
- > Pockets of higher uninsured rates were observed in lower Westchester County, including Yonkers, Mount Vernon, and New Rochelle, and in White Plains, Port Chester, Peekskill, Ossining, and the Mount Kisco and Bedford Hills areas.



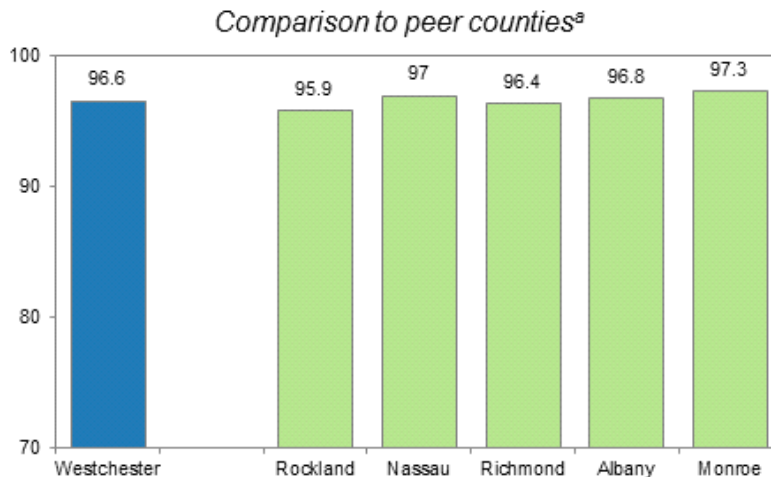
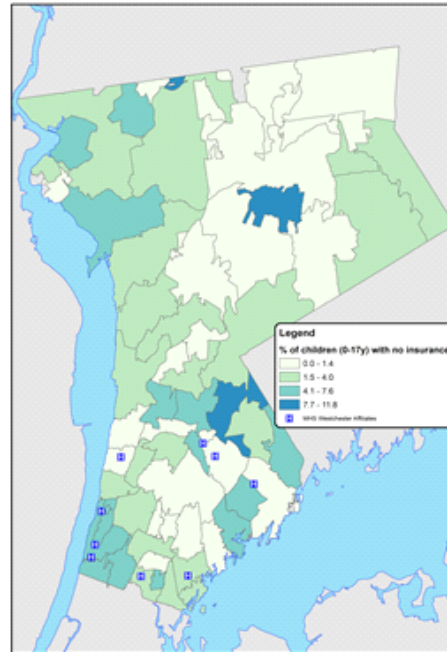
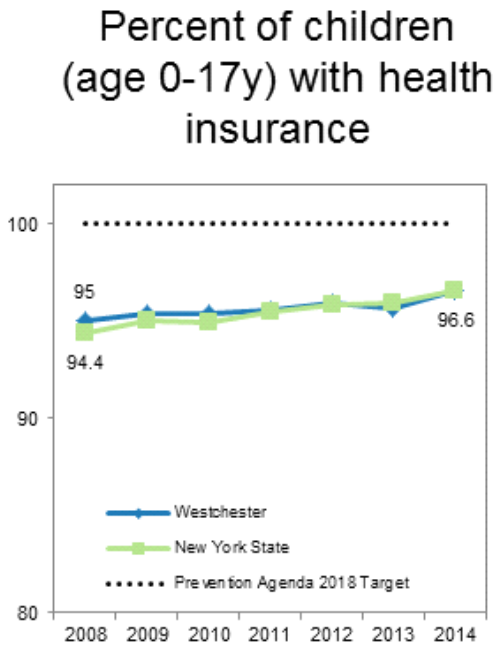
Comparison to peer counties<sup>a</sup>



<sup>a</sup> Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Health Insurance Coverage (Youth)

- > From 2008 to 2014, there was modest improvement in the percentage of children in Westchester County who have health insurance.
- > There was limited observed difference in the percentage of insured youth within Westchester County and across peer counties.

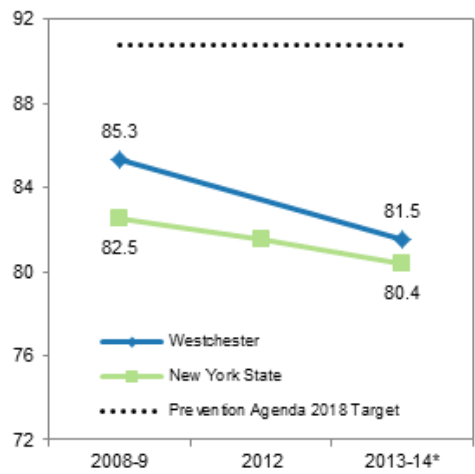


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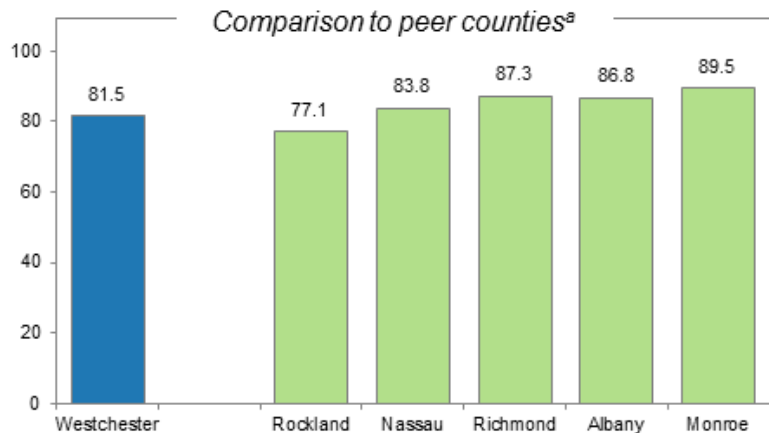
Primary Care Provider Access (Adults)

- > The proportion of adults in Westchester County with a primary care provider declined from 85.3% in 2008-2009 to 81.5% in 2013-2014. The indicator is not predicted to improve as a result of implementing the Affordable Care Act.
- > Westchester County has the second lowest percentage of adults with a primary care provider when compared to peer counties, second only to Rockland County.

Age-adjusted percent of adults with primary care provider



\* Trend may reverse after implementation of Affordable Care Act



<sup>a</sup> Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

## City of Yonkers

Yonkers is 18.4 square miles with an estimated 2015 population of 201,116. The population increased 3% from 2010. Approximately 22% of residents are under 18 years and 15% are seniors.

The Yonkers community is one of the most culturally and ethnically diverse in Westchester County and New York State. During the last two decades, a demographic shift has taken place in the city with a large influx of immigrants. Approximately 31% of the Yonkers population is foreign-born; 56% of foreign born residents were born in a Latin American country. Immigrants from all over the world bring a great vitality to our community, but they challenge the hospital and other community service providers to understand and meet their unique and complex health needs.

The following table compares the City of Yonkers to all of Westchester County and New York on key demographic and socioeconomic indicators, as well as indicators that can inhibit health care access. In addition to being a more racially and ethnically diverse population, Yonkers residents have lower educational attainment, higher poverty rates, and a higher overall uninsured rate.

### Demographic and Socioeconomic Indicators

	Yonkers	Westchester County	New York State
<b>Race and Ethnicity</b>			
White Population	61.2%	66.4%	63.8%
Black/African American Population	17.0%	14.6%	15.6%
Hispanic/Latino Population (any race)	36.6%	24.2%	18.8%
<b>Educational Attainment</b>			
High school graduate or higher	83.6%	86.9%	86.0%
Bachelor's degree or higher	31.5%	46.9%	35.0%
<b>Place of Birth and Language</b>			
Foreign born	30.5%	25.8%	22.9%
Language other than English spoken at home	46.1%	33.3%	30.9%
<b>Poverty</b>			
Families	14.7%	6.7%	11.6%
Individuals	18.7%	10.0%	15.4%
Children under 18 years	30.4%	12.8%	22.0%
<b>Health Insurance Coverage</b>			
All residents	8.7%	7.1%	7.1%
Foreign born	16.9%	18.3%	15.7%

Source: American Community Survey, 2015



### Primary Service Area

SJMC serves all of Yonkers, but defines its primary service area as zip codes 10701 and 10705. The estimated population of the primary zip codes is 100,276, representing approximately 50% of the total Yonkers population. The primary service area population is more culturally and ethnically diverse than the City of Yonkers and experiences greater socioeconomic disparity (Source: American Community Survey, 2011-2015).

The area is an urban mix of high-rise apartments, older wood frame homes, and a downtown business area that contains community-based not-for-profit organizations. Zip codes 10701 and 10705 are some of the most population dense areas in New York State with a population density of 23,166 per square mile. The population density for all of Yonkers is 11,051 residents per square mile (Source: [www.city-data.com](http://www.city-data.com)).

### Demographic and Socioeconomic Indicators

	10701	10705	Yonkers
<b>Race and Ethnicity</b>			
White Population	52.5%	44.6%	58.6%
Black/African American Population	26.3%	17.9%	17.2%
Hispanic/Latino Population (any race)	42.5%	52.3%	35.5%
<b>Educational Attainment</b>			
High school graduate or higher	77.6%	75.7%	83.0%
Bachelor's degree or higher	24.0%	24.4%	31.1%
<b>Place of Birth and Language</b>			
Foreign born	31.0%	36.5%	30.6%
Language other than English spoken at home	50.5%	59.3%	46.6%
<b>Poverty</b>			
Families	21.8%	17.8%	13.4%
Individuals	25.9%	21.7%	16.7%
Children under 18 years	37.8%	31.8%	25.1%
<b>Health Insurance Coverage</b>			
All residents	14.6%	16.5%	11.8%
Foreign born	27.8%	27.2%	22.0%

Source: American Community Survey, 2011-2015

### Health Professional Shortage Areas/Medically Underserved Areas

The City of Yonkers is a mental health professional shortage area (HPSA) for all Medicaid eligible residents and all residents residing in the southwest portion of the city. The southwest portion of the city is also a designated Medically Underserved Area (MUA), determined by the U.S. Department of Health and Human Services Health Resources and Services Administration as having too few primary care providers, high infant mortality, high poverty, or a high elderly population.

## 2. Community Health Issues - Data

Primary and secondary research methods were used to illustrate and compare health trends and disparities across SJMC’s service area. Primary research solicited input from community members and health care providers representing the broad interests of the community, including experts in public health and individuals representing medically underserved, low-income, and minority populations. Secondary data identified community health needs and trends across geographic areas and populations.

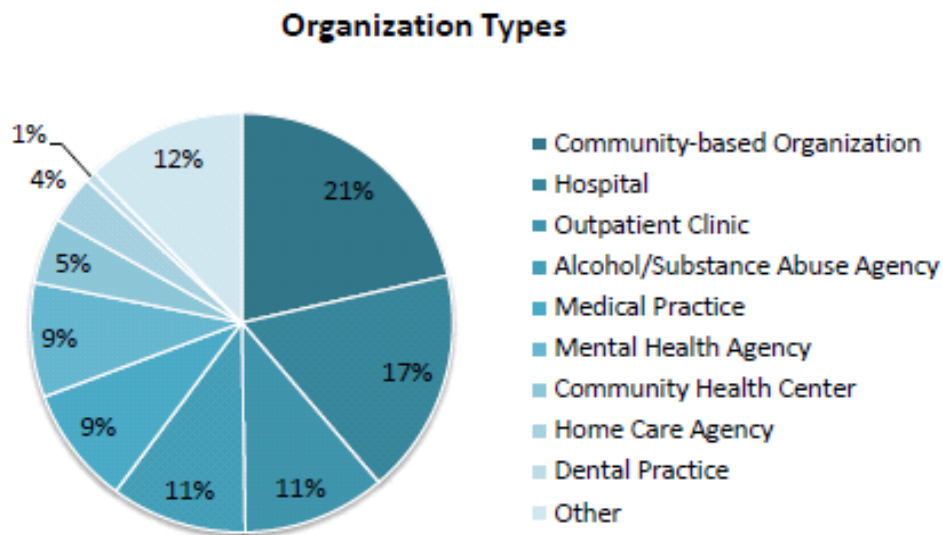
### Primary Research Findings

Community input was a significant aspect of the Community Health Needs Assessment. SJMC collaborated with the WCDOH and other county health systems to conduct surveys among both residents and health care providers. Surveys were conducted from May 16, 2016 to June 30, 2016 via paper- and online-format to assess perceptions of the most needed services, barriers to providing/receiving services, and methods to improve access to services. A total of 1,318 community resident surveys and 218 provider surveys were completed. Copies of both survey tools are available in Appendix A and B.

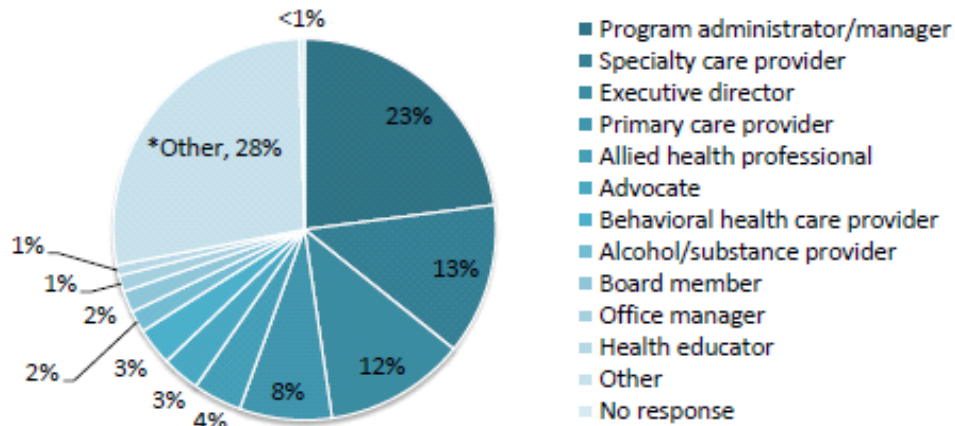
### Health Care Provider Survey

Health care providers work for diverse organizations representing the broad interests of the community. The following section highlights provider demographics and key findings for all of Westchester County.

#### Provider Demographics



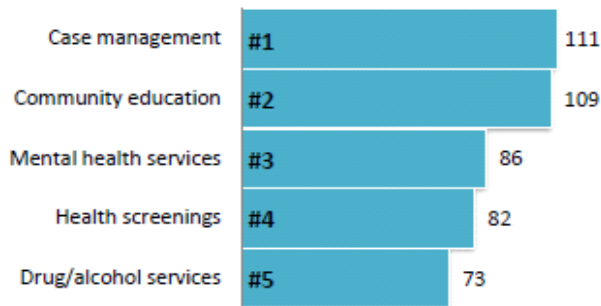
### Title or Role of Respondent within Agency



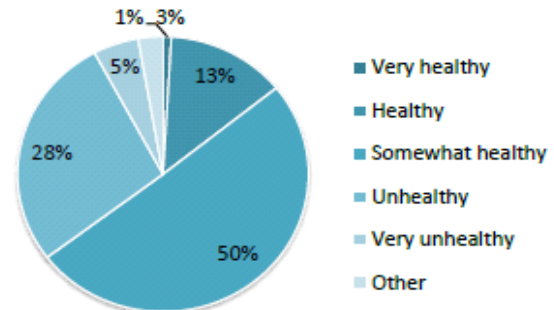
\* The qualitative "Other" free-responses were overall not applicable and not itemized in the presented results.

### Key Survey Findings

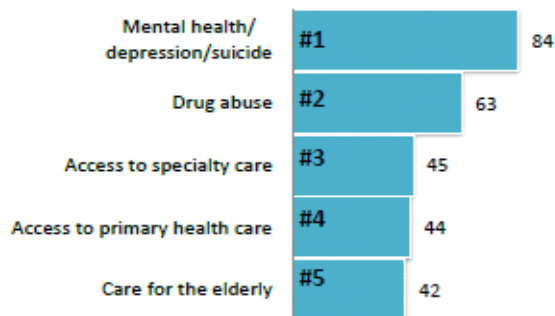
#### Top Services Provided to Community



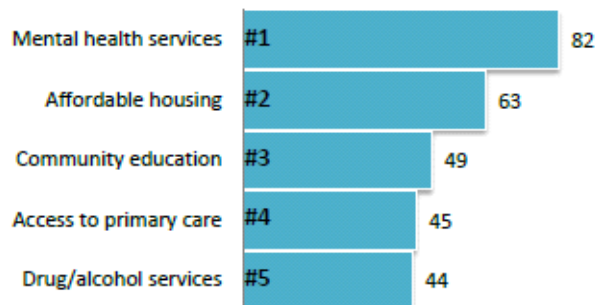
#### Perceived Health Status of Community



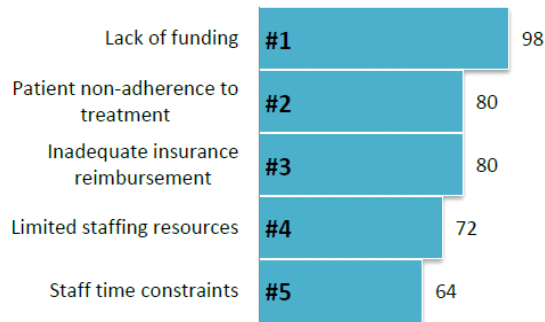
#### Top Health Concerns for Community



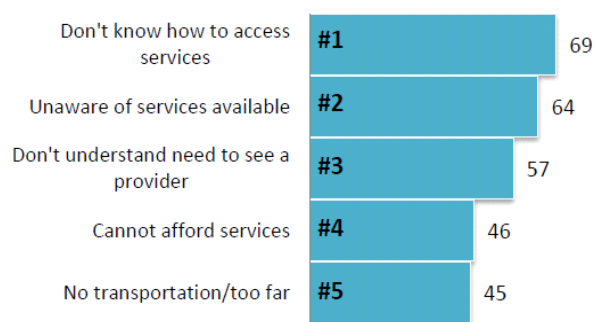
#### Programs Needed to Address Health Concerns



**Top Barriers to Providing Care**



**Top Barriers to Patients Receiving Care**



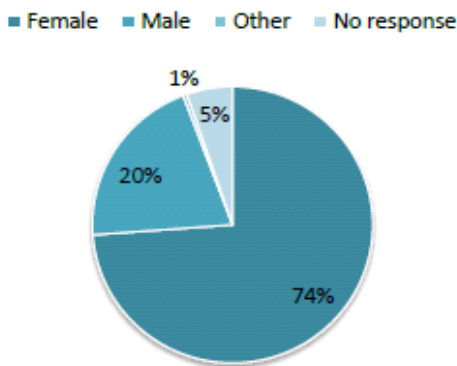
**Community Resident Health Survey**

Community resident health surveys results were reported for all of Westchester County and partner hospital service area. The following section highlights respondent demographics and key findings for the county and SJMC’s service area.

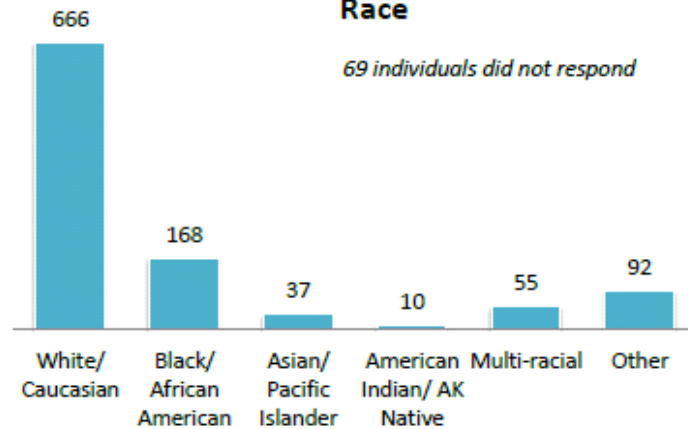
Respondent Demographics

Survey respondents were primarily female, White/Caucasian, Non-Hispanic, and between the ages of 45 and 64. Twenty-nine percent of respondents were identified as being underserved, defined as having a high school education or less and/or having Medicaid or uninsured. Surveys were conducted using convenience sampling. Convenience sampling relies on the population that is easily accessible, permitting any and all individuals to respond. As a result, the respondents are not random and do not mirror true county demographics. However, the results of the survey are valuable in identifying general areas of public health concern.

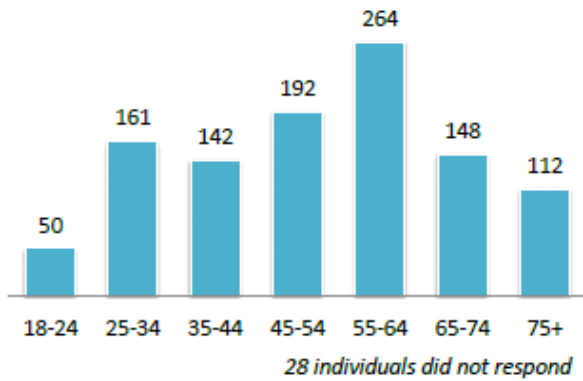
**Gender**



**Race**

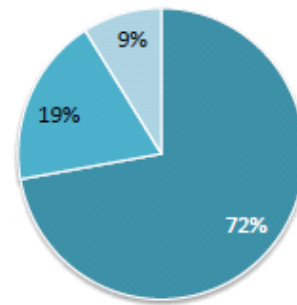


### Age Groups



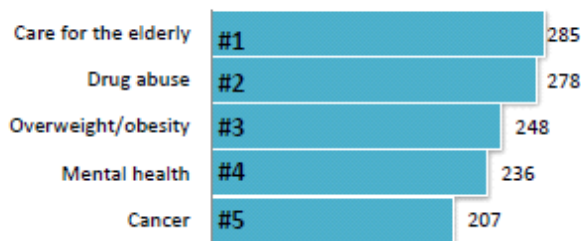
### Ethnicity: Hispanic/Latino

■ No ■ Yes ■ No response

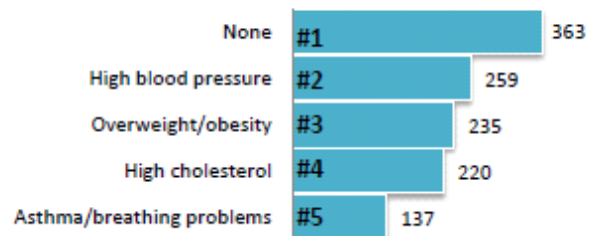


## Key Survey Findings – Westchester County

### Top Health Concerns for Community



### Existing Chronic Health Issues



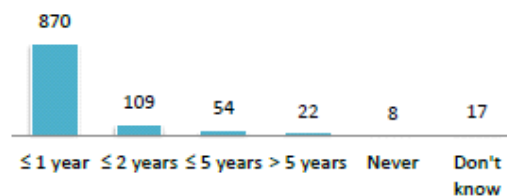
### Top Health Concerns for Self



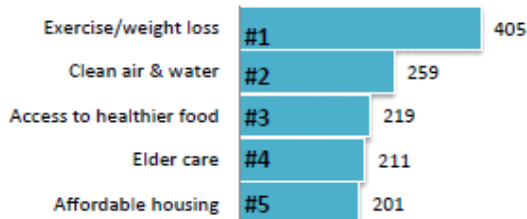
### Have Primary Care Provider



### Time Since Last Dr. Appointment



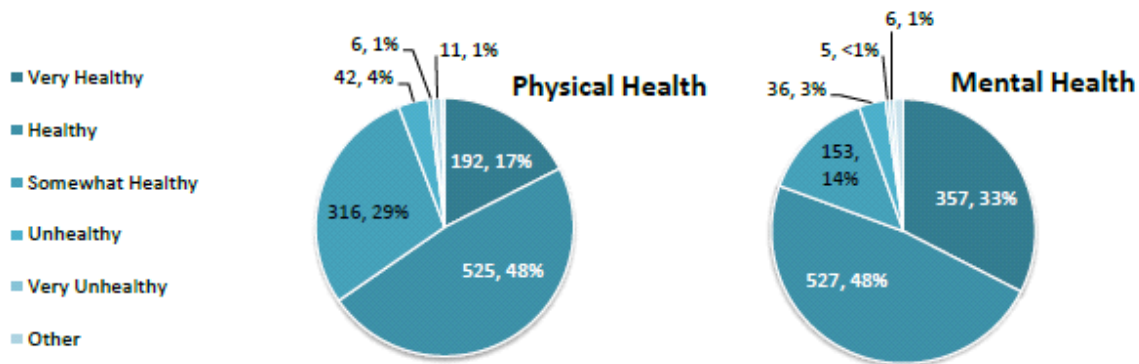
### Programs Needed to Address Concerns



### Emergency Room Use in Past Year



**Perceived Health Status:**



**Key Survey Findings – SJMC Service Area**

SJMC’s service area includes zip codes 10701, 10703, 10704, 10705, and 10710. Identified priority areas and health concerns for SJMC service area residents were consistent with those identified for the entire county, as depicted in the table below.

Ranking	Top Health Concerns for Community		Top Health Concerns for Self	
	SJMC Service Area	Westchester County	SJMC Service Area	Westchester County
1	Drug abuse	Drug abuse	Exercise/weight loss	Exercise/weight loss
2	Violence	Elder care	Clean air & water	Clean air & water
3	Obesity	Obesity	Affordable housing	Access to healthy food
4	Diabetes	Mental health	Access to healthy food	Elder care
5	Mental health	Cancer	Job opportunities	Affordable housing

**Secondary Research Findings**

**Chronic Disease**

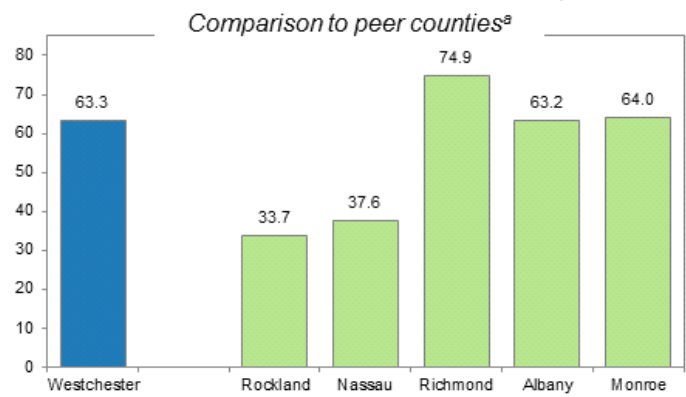
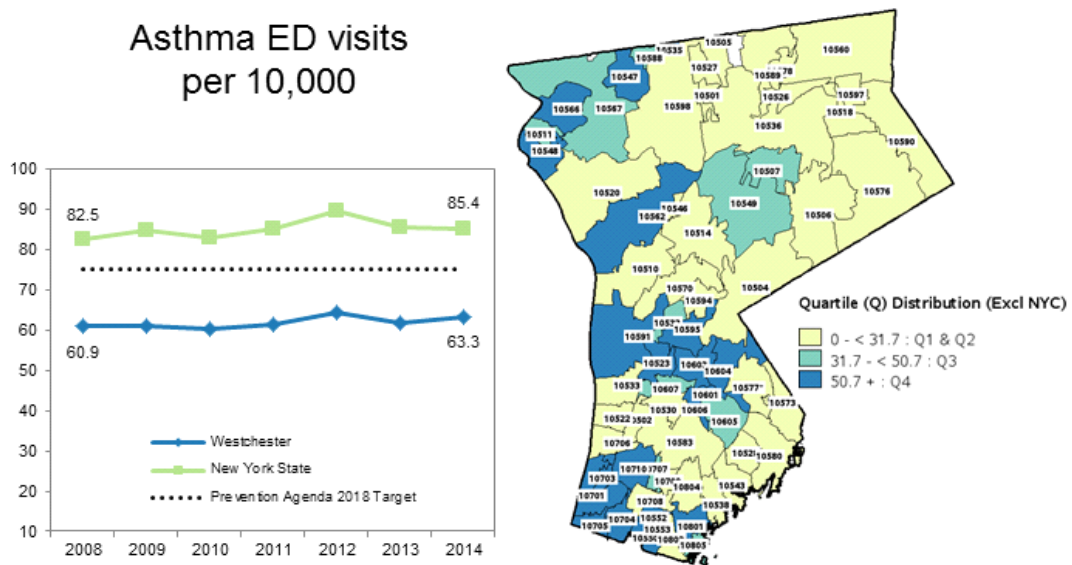
The following section highlights key findings related to chronic disease rates and health disparities for Westchester County and Yonkers. Trending and comparison data charts are provided, as available. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard.

**Asthma & Chronic Lower Respiratory Disease**

- > According to the New York State Department of Health, 8.7% of Westchester County adults had asthma in 2008-2009, which is lower than the statewide percentage of 9.7%. Updated data from the CDC for 2011-2012 found that asthma prevalence among adults increased across the state and in Westchester County to 14%.



- > The asthma prevalence rate per 1,000 among Westchester County Medicaid recipients increased from 86.7 in 2008-2009 to 98.4 in 2012-2013. The statewide prevalence rate in 2012-2013 was 98.7.
- > In 2010, the age-adjusted death rate due to chronic lower respiratory diseases among Westchester County residents was 24.3 per 100,000. In 2011, Westchester County's death rate decreased to 23.4, remaining lower than the statewide rate of 31.2.
- > The emergency department visit rate in Westchester County remained stable from 2008 to 2014 and is lower than the state rate. However, higher rates are observed in Yonkers, Mount Vernon, New Rochelle, White Plains, Tarrytown, Ossining, and Peekskill.



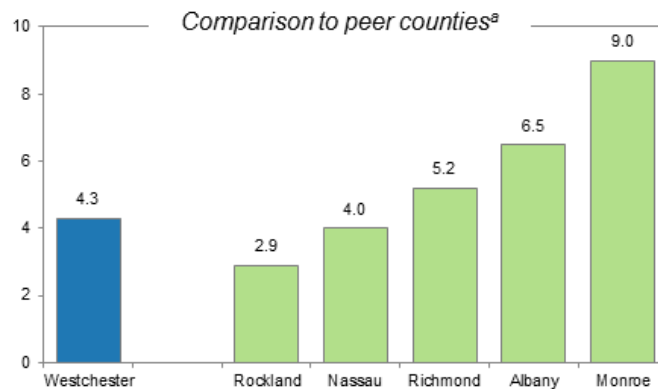
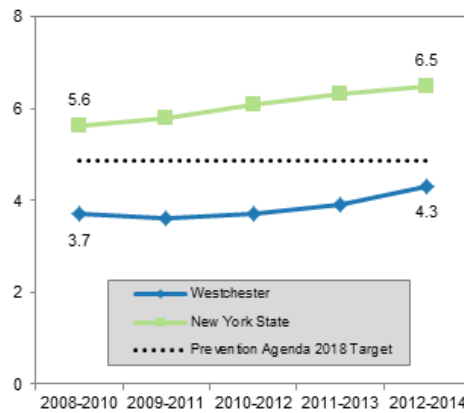
<sup>a</sup> Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.



Diabetes

- > The rate of hospitalizations for short-term complications of diabetes increased across the state and in Westchester County. The county rate is lower than the state rate, meets the Prevention Agenda 2018 target, and is the third lowest in comparison to peer counties.

Rate of hospitalizations for short-term complications of diabetes per 10,000 (adults 18+y)



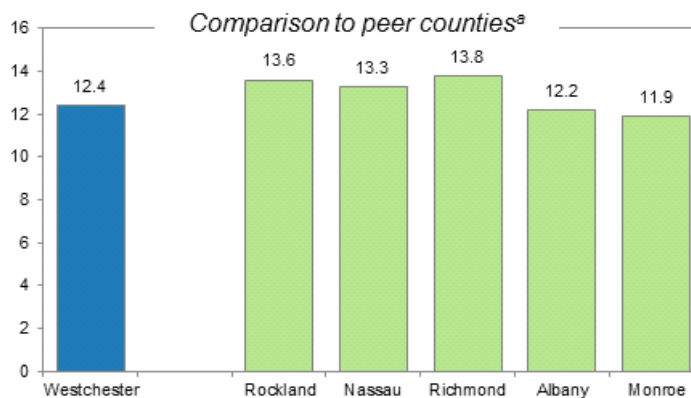
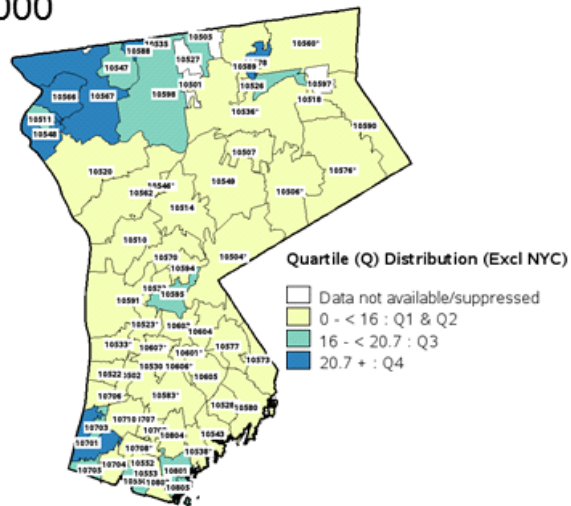
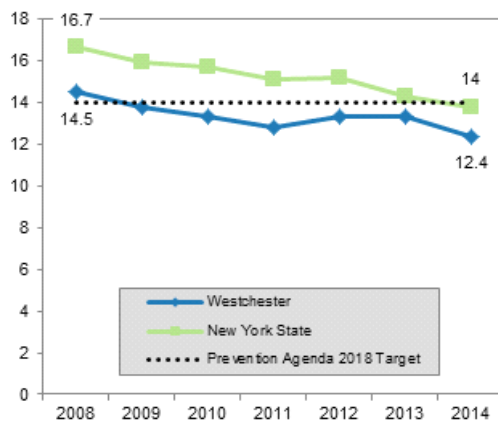
\* Based on comparison of following measures: percent of population less than 20y; percent of population ≥65y; population density; % Hispanic; % black; % white; median household income; % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Heart Disease & Stroke

- > Heart disease is the number one cause of death in Westchester County and the second leading cause of premature death (death before age 65). In 2012, heart disease accounted for 2,113 deaths or 31% of all deaths in the county. Adding in 490 deaths due to stroke and other diseases of the circulatory system, total deaths from circulatory disease were 60% higher than the next leading cause of death, cancer.
- > The Westchester County 2011 coronary heart disease death rate per 100,000 (119.5) and coronary heart disease hospitalization rate per 10,000 (35.8) remained stable from 2010 rates of 117.1 and 36.4 respectively.
- > The stroke death rate per 100,000 in Westchester County was 25.8 in 2011, an increase from the 2010 rate of 24.0. The stroke hospitalization rate per 10,000 in Westchester County in 2009-2011 was 22.8, similar to the statewide rate of 24.9.

- > Among Hudson Valley Collaborative Performing Provider System (PPS) providers, 29% of inpatient admissions and 12% of ED visits have a cardiovascular diagnosis. SJMC has one of the highest number of inpatient admissions and ED visits due to a primary cardiovascular disease diagnosis in the PPS.
- > The rate of hospitalizations for heart attacks declined across the state and in Westchester County. The current county rate is lower than the state rate, but higher rates are observed in Yonkers, Peekskill, and Cortlandt Manor.

### Rate of hospitalizations for heart attacks per 10,000

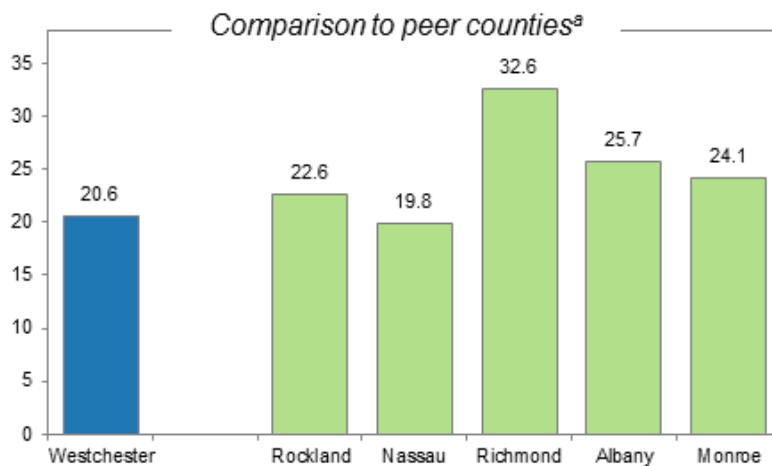
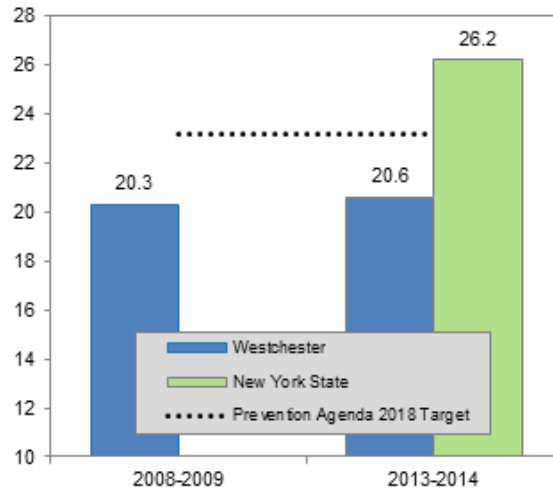


<sup>a</sup> Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Risk Factors

- > The percentage of Westchester County adults who are obese remained stable from 2008-2009 to 2013-2014. The percentage is lower than the state average and meets the 2018 Prevention Agenda target. In comparison to peer counties, Westchester County has the second lowest prevalence of obesity.
- > The percentage of Westchester County children who are obese remained stable from 2008-2009 to 2013-2014. In comparison to peer counties, Westchester County has the second lowest prevalence of obesity. However, areas within Westchester County, including Peekskill, Elmsford, Greenburgh, and Port Chester-Rye have higher rates.
- > The percentage of Westchester County adults who smoke cigarettes remained stable from 2008-2009 to 2013-2014. The percentage is lower than the state average and meets the 2018 Prevention Agenda target. In comparison to peer counties, Westchester County has the second lowest prevalence of adult smokers.

Percent of adults who are obese (BMI ≥ 30)

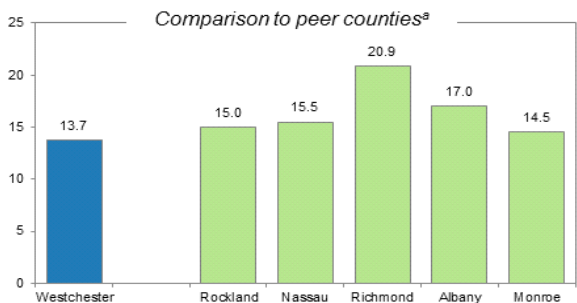


<sup>a</sup> Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Percent of children who are obese (BMI ≥ 95<sup>th</sup> percentile)

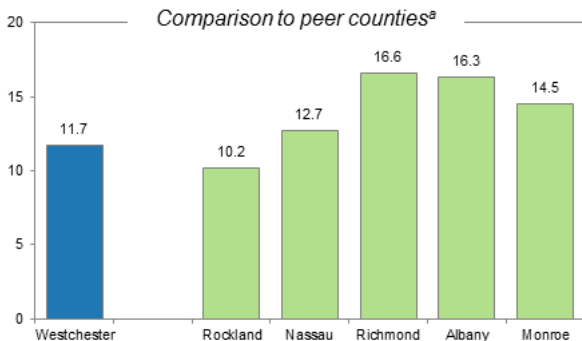
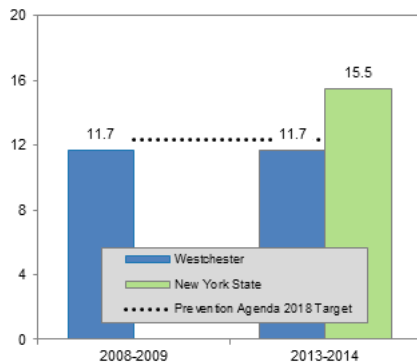
Quartile (Q) Distribution (EXCL NYC)

- 0 - < 17.9 : Q1 & Q2
- 17.9 - < 21.6 : Q3
- 21.6 + : Q4



\* Based on comparison of following measures: percent of population less than 20; percent of population ≥65; population density; % Hispanic; % black; % white; median household income; % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Percent of adults who smoke cigarettes

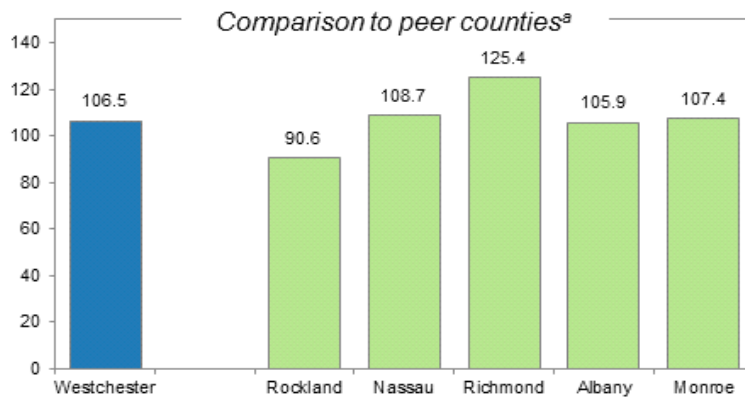
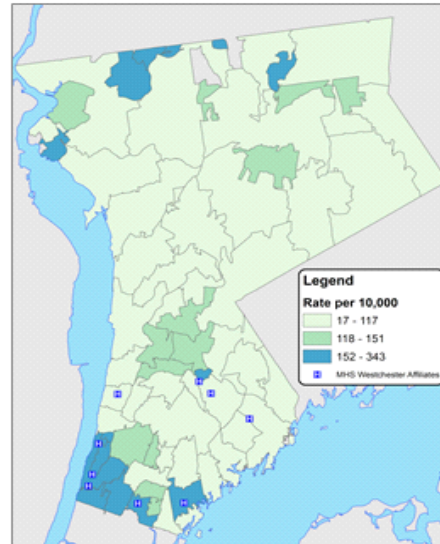
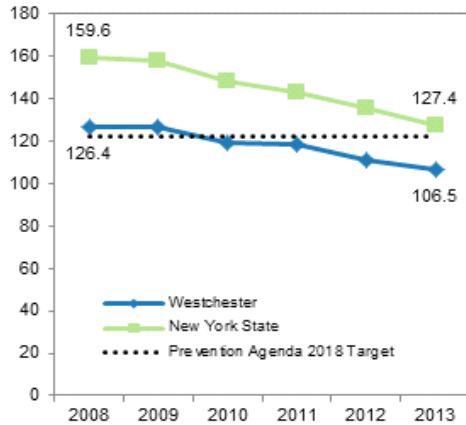


\* Based on comparison of following measures: percent of population less than 20; percent of population ≥65; population density; % Hispanic; % black; % white; median household income; % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

Preventable Hospitalizations

- > The rate of preventable hospitalizations decreased across New York and in Westchester County. The county rate is lower than the state rate and meets the Prevention Agenda 2018 target. However, rates are elevated in Yonkers, Mount Vernon, and New Rochelle.

Age-adjusted preventable hospitalization rate per 10,000 (adults age ≥ 18y)



\* Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.

## Mental Health and Substance Abuse

The following section highlights key findings related to behavioral health issues within Westchester County and Yonkers. Trending and comparison data charts are provided as available. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard.

### Binge Drinking

- > The percent of Westchester County adults who reported binge-drinking during the past month remained stable from 2008-2009 to 2013-2014 at 18%. The percentage is on par with the state rate and nearly meets the 2018 Prevention Agenda target. However, it is higher when compared to peer counties.

	Age-Adjusted Percentage of Adult Binge Drinkers (2013-2014)
Westchester	18.0%
Rockland	13.1%
Nassau	13.4%
Richmond	22.1%
Albany	16.6%
Monroe	18.8%
New York State	17.8%
2018 Prevention Agenda Target	18.4%

### Suicide

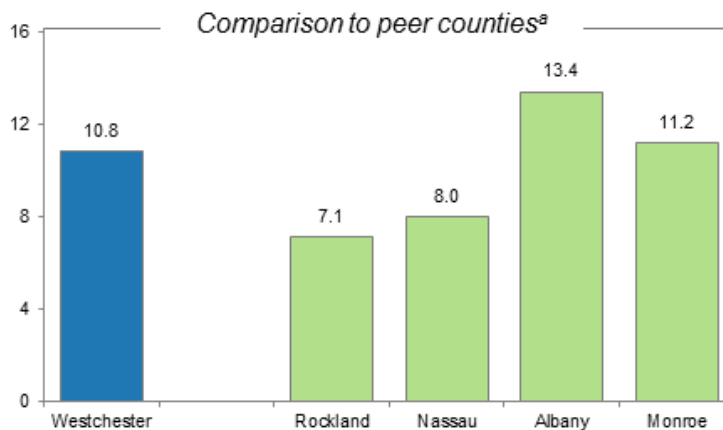
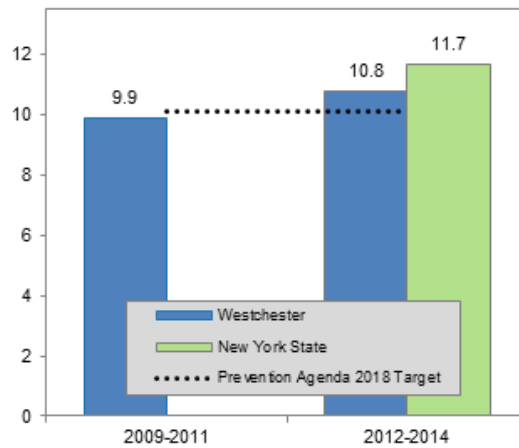
- > The Westchester County age-adjusted suicide rate per 100,000 remained stable from 2008-2010 (6.3) to 2012-2014 (6.5). The current rate is lower than the state rate, and is within reach of the 2018 Prevention Agenda target.

	Age-Adjusted Suicide Rate per 100,000 (2012-2014)
Westchester	6.5
Rockland	6.5
Nassau	6.4
Richmond	6.1
Albany	9.6
Monroe	7.9
New York State	7.9
2018 Prevention Agenda Target	5.9

Poor Mental Health Days

- > The percent of Westchester County adults who self-reported having 14 or more days of poor mental health in the past month increased slightly from 2009-2011 to 2012-2014. The current percentage is lower than the state rate, but exceeds the 2018 Prevention Agenda target.

**Age-adjusted percentage of adults with poor mental health for 14+ days in last month**



<sup>a</sup> Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other 5 most similar counties are also provided in order of similarity.



### 3. Identification of Prevention Agenda Priorities

The MHVC collaborative partners reviewed findings from the CHNA research, including input from community residents and health care providers and public health findings, to determine the highest priorities within Westchester County on which to focus community health improvement efforts. In alignment with the New York State Prevention Agenda, the partners selected the following health priorities to address during the next three year cycle:

- > Prevent Chronic Diseases
- > Promote Mental Health and Prevent Substance Abuse

In coordination with the Westchester County Health Department and in alignment with the Delivery System Reform Incentive Payment (DSRIP) program, Saint Joseph's Medical Center will focus on two areas within Prevent Chronic Diseases: asthma and cardiovascular disease.

SJMC is committed to addressing Westchester County's initiative to promote mental health and prevent substance abuse. Saint Joseph's operates Saint Vincent's Hospital Westchester, the largest behavioral health provider in Westchester County. With this expertise and long history of promoting comprehensive mental health and treating/preventing substance abuse, Saint Joseph's will continue to promote, support, and implement interventions and strategies to address behavioral health issues.

## 4. Prevention Agenda Priorities - Goals and Objectives

SJMC developed a Community Health Improvement Plan (CHIP) to guide community benefit and population health improvement strategies across its service area. The CHIP builds upon previous health improvement activities, and where possible, aligns with the New York State Prevention Agenda.

### Prevention Agenda Priority: Prevent Chronic Diseases

#### Focus Area #1: Asthma

Goal Outcome	Objective	Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity
To ensure access for all patients with asthma to care consistent with evidence-based medicine guidelines for asthma management	To reduce the number of asthma related visits to the ED	Assemble an Asthma Project Team consisting of members outlined in the Asthma Implementation Toolkit created by Montefiore Hudson Valley Collaborative (MHVC)	<ul style="list-style-type: none"> <li>&gt; Identify and list Asthma Project Team members with determined tasks and responsibilities for each team member, to include identifying training/educational needs and ensuring quality improvement</li> <li>&gt; Minutes from Project Team meetings</li> </ul>	Provide various levels of support for interventions/ strategies/ activities (e.g. set up workshops or lectures, provide data, distribute educational materials, co-sponsor health initiatives, and identify underserved populations, outliers, and high risk neighborhoods)	American Lung Association	12/31/16	Yes, based on the various disparities in the City of Yonkers, SJMC will implement specific evidenced-based interventions geared towards risk factors associated with race, ethnicity, culture, and socio-economic status.  SJMC will identify patients impacted by disparity and develop appropriate action plans to assist them (e.g. assist in securing health insurance, provide referrals to patient-centered medical homes, etc.).
	To implement evidence-based guidelines (EBG) for the diagnosis, treatment and management of asthma in adults and children	Educate providers and staff on the implementation of National Heart, Lung and Blood Institute Expert Panel Report 3 (EPR 3) for the management and treatment of asthma in the pediatric and adult population	<ul style="list-style-type: none"> <li>&gt; Percentage of primary care providers (PCPs) receiving training in EBGs (EPR 3) for asthma diagnosis, treatment and management including: asthma diagnosis; asthma severity assignment; use of Asthma Action Plans to guide patients in disease self-management; self-management support principles; and assessment of environmental triggers for pediatric and adult populations</li> </ul>		Hudson Valley Asthma Coalition		
		Educate medical personnel and staff regarding the proper use of maintenance medications based on the EPR 3 guidelines	<ul style="list-style-type: none"> <li>&gt; Embedded best practice techniques for the diagnosis, treatment and management of asthma in SJMC's EMR</li> <li>&gt; Documented changes to the workflow (if necessary) to work with a care management team</li> </ul>		Montefiore Hudson Valley Collaborative	National Heart, Blood, and Lung Institute	
					Westchester County Department of Health		

Goal Outcome	Objective	Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity	
To ensure access for all patients with asthma to care consistent with evidence-based medicine guidelines for asthma management	To implement evidence-based guidelines (EBG) for the diagnosis, treatment and management of asthma in adults and children	Educate medical personnel and staff regarding the stepwise approach to asthma management based on EPR 3 guidelines	<ul style="list-style-type: none"> <li>&gt; Percentage of staff trained/educated in patient self-management support principles</li> <li>&gt; Percentage of people with asthma with documented classification of severity and control</li> <li>&gt; Percentage of people with a classification of persistent asthma that have been prescribed inhaled corticosteroids (ICS)</li> </ul>	Provide various levels of support for interventions/ strategies/ activities (e.g. set up workshops or lectures, provide data, distribute educational materials, co-sponsor health initiatives, and identify underserved populations, outliers, and high risk neighborhoods)	American Lung Association	On-going	Yes, based on the various disparities in the City of Yonkers, SJMC will implement specific evidenced-based interventions geared towards risk factors associated with race, ethnicity, culture, and socio-economic status.	
	Decrease the percentage of adult smokers in our service areas	Embed smoking assessments and management (The 5A's) into SJMC's EHR	> Percentage of smokers referred to NYS Quit Line		National Heart, Blood, and Lung Institute			On-going
	Integrate Asthma Action Plans (AAPs) into care regimens/ medical records and ensure every patient with asthma has a written asthma action plan that is up to dated and reviewed annually	Documentation of known triggers and evidence-based methods of avoidance	> Number of home/work/school environment assessments for smoking, allergenic materials, and other known asthma triggers		Westchester County Department of Health			On-going
		Implement evidence-based asthma management guidelines (including an AAP) between PCPs, specialists, and community-based asthma programs to ensure a regional population based approach to asthma management	> Development and implementation of Asthma Action Plans that include patient monitoring of signs and symptoms and peak flow meter readings when appropriate					12/31/16
	Embed self-management goals into SJMC EHR	> Number of patients with documented self-management goals in their medical record		3/31/17	assist in securing health insurance, provide referrals to patient-centered medical homes, etc.).			

Goal Outcome	Objective	Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity
To ensure access for all patients with asthma to care consistent with evidence-based medicine guidelines for asthma management	Coordinate treatment across the care continuum	Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR connectivity	> Percentage of signed contracts indicating agreement to adhere to the national guidelines for asthma treatment and management	Provide various levels of support for interventions/ strategies/ activities (e.g. set up workshops or lectures, provide data, distribute educational materials, co-sponsor health initiatives, and identify underserved populations, outliers, and high risk neighborhoods)	American Lung Association	On-going	Yes, based on the various disparities in the City of Yonkers, SJMC will implement specific evidenced-based interventions geared towards risk factors associated with race, ethnicity, culture, and socio-economic status.  SJMC will identify patients impacted by disparity and develop appropriate action plans to assist them (e.g. assist in securing health insurance, provide referrals to patient-centered medical homes, etc.).
		Build capacity to educate patients, families, and school personnel about asthma	> Number of patients with asthma (and caregivers) participating in workshops on how to properly use peak flow meters, inhalers, spacers, and/or holding chambers, and tracked outcomes from participation		Hudson Valley Asthma Coalition		
		Collaborate, when possible, with school nurses, teachers, administrators, and day care center personnel to assure appropriate education, assessment, and treatment for school-age children with asthma	> Documentation of collaboration with school nurses, teachers, school administrators, and day care centers > Number of individuals participating in educational programs and tracked outcomes based on participation		Montefiore Hudson Valley Collaborative	On-going	
		Ensure coordination with Medicaid Management Care Organizations (MCOs) and Health Homes to coordinate services for affected populations	> Percentage of MCOs and Health Homes actively engaged in care/treatment coordination with those patients served by SJMC		National Heart, Blood, and Lung Institute  New York State Department of Health		
		Use SJMC's EHR or other technical platforms to track all patients engaged in the project	> Percentage of departments and providers utilizing technical platforms to track patients engaged in project		Westchester County Department of Health		
						On-going	

### Focus Area #2: Cardiovascular Disease

Goal Outcome	Objective	Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity
Improve cardiovascular health in our region through implementation of Million Hearts Campaign strategies	To reduce hospital admissions for CV disease by 25%	Assemble a Hypertension Project Team consisting of members outlined in the Cardiovascular Toolkit created by Montefiore Hudson Valley Collaborative (MHVC)	<ul style="list-style-type: none"> <li>&gt; List of participants on Hypertension Project Team with determined tasks and responsibilities for each team member, to include identifying training/ educational needs and ensuring quality improvement</li> <li>&gt; Minutes from Project Team meetings</li> </ul>	Provide various levels of support for interventions/ strategies/ activities (e.g. set up workshops or lectures, provide data, distribute educational materials, co-sponsor health initiatives, and identify underserved populations, outliers, and high risk neighborhoods)	American Heart Association  Centers for Disease Control and Prevention	On-going	Yes, based on the various disparities in the City of Yonkers, SJMC will implement specific evidenced-based interventions geared towards risk factors associated with race, ethnicity, culture, and socio-economic status.  SJMC will identify patients impacted by disparity and develop appropriate action plans to assist them (e.g. assist in securing health insurance, provide referrals to patient-centered medical homes, etc.).
Integrate evidence-based strategies for cardiovascular disease management into clinical practice	Identify and treat undiagnosed hypertensive patients	Educate providers on the implementation of evidence-based guidelines (EBG) for the management and treatment of hypertension in the adult population with particular emphasis on Blacks, Hispanics, and other underserved populations	<ul style="list-style-type: none"> <li>&gt; Percentage of PCPs receiving training in: current evidence-based guidelines for hypertension management, aspirin use, and cholesterol management; best practice techniques for measuring blood pressure accurately; Million Hearts Campaign Strategies; and documented changes to the workflow (if necessary) to work with a care management team</li> </ul>		Million Hearts Campaign  Montefiore Hudson Valley Collaborative	On-going	
Improve medication adherence by providing once-a-day medications when appropriate					MVP Health Care  National Heart, Blood, and Lung Institute		
Develop and implement evidence-based clinical treatment protocols for heart disease (high blood pressure, cholesterol, aspirin use)	Reduce morbidity and mortality associated with hypertension in the community we serve	Identify and increase the number of partners that deliver Chronic Disease Self - Management Program (CDSMP) to people with hypertension	<ul style="list-style-type: none"> <li>&gt; Percentage of staff that have been trained in motivational interviewing and patient self-management and support principles to support this project</li> <li>&gt; Number of patients that participate in a CDSMP</li> </ul>		New York State Department of Health	3/31/17	
		Develop and implement protocols for home blood pressure monitoring with follow up support	<ul style="list-style-type: none"> <li>&gt; Percentage of patients with documented monthly blood pressure measures to determine effectiveness of prescribed medications and lifestyle changes</li> </ul>		Westchester County Department of Health	12/31/16	

Goal Outcome	Objective	Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity
Develop and implement evidence-based clinical treatment protocols for heart disease (high blood pressure, cholesterol, aspirin use)	Reduce morbidity and mortality associated with hypertension in the community we serve	Embed Chronic Disease Self-Management Goals into SJMC EHR	> Number of patients with documented self-management goals (diet, exercise, medication management, nutrition etc.) in the medical record	Provide various levels of support for interventions/ strategies/ activities (e.g. set up workshops or lectures, provide data, distribute educational materials, co-sponsor health initiatives, and identify underserved populations, outliers, and high risk neighborhoods)	American Heart Association	On-going	Yes, based on the various disparities in the City of Yonkers, SJMC will implement specific evidenced-based interventions geared towards risk factors associated with race, ethnicity, culture, and socio-economic status.
		Ensure coordination with Medicaid Management Care Organizations (MCOs) and Health Homes to coordinate services for affected populations	> Percentage of MCOs and Health Homes actively engaged in care/treatment coordination with those patients served by SJMC		Centers for Disease Control and Prevention	On-going	
		Establish agreements with providers to adhere to national guidelines for hypertension diagnosis and management, protocols for access to cardiovascular specialists and EHR connectivity	> Percentage of signed contracts indicating agreement to adhere to the national guidelines for asthma treatment and management		Million Hearts Campaign	On-going	
		Use SJMC EHR or other technical platforms to track all patients engaged in the project	> Percentage of departments and providers utilizing technical platforms to track patients engaged in project		Montefiore Hudson Valley Collaborative		
	Decrease the percentage of adult smokers in our service areas	Embed smoking assessments and management (The 5A's) into SJMC's EHR	> Percentage of smokers referred to NYS Quit Line		National Heart, Blood, and Lung Institute	On-going	SJMC will identify patients impacted by disparity and develop appropriate action plans to assist them (e.g. assist in securing health insurance, provide referrals to patient-centered medical homes, etc.).
	Increase community awareness of risk factors associated with hypertension	Develop culturally/racially sensitive marketing strategies (e.g. website, PSAs, news media, community-based organizations, etc.)	> Number of marketing strategies deployed in the community and number of residents reached by marketing efforts (as applicable)		New York State Department of Health	On-going	
					Westchester County Department of Health		

## Prevention Agenda Priority: Promote Mental Health and Prevent Substance Abuse

Goal Outcome	Objective	Interventions/ Strategies/ Activities	Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity
Improve care coordination for behavioral health patients	Decrease ED visits due to substance and alcohol abuse	Provide behavioral health self-management tools to enable patients to have more control over their health care	<ul style="list-style-type: none"> <li>&gt; Number of patients connected with social workers and enrolled in comprehensive care plans</li> <li>&gt; Tracked medical outcomes (self-management skills, health status, and ED usage) as a result of care coordination efforts</li> <li>&gt; Number of care plans transmitted to the New York State RHIO</li> </ul>	Provide various levels of support for interventions/ strategies/ activities (e.g. set up workshops or lectures, provide data, distribute educational materials, co-sponsor health initiatives, and identify underserved populations, outliers, and high risk neighborhoods)	Montefiore Hudson Valley Collaborative  New York State Department of Health  Primary Care Development Corporation (PCDC)  Washington University	On-going	Yes, based on the various disparities in the City of Yonkers, SJMC will implement specific evidenced-based interventions geared towards risk factors associated with race, ethnicity, culture, and socio-economic status.  SJMC will identify patients impacted by disparity and develop appropriate action plans to assist them (e.g. assist in securing health insurance, provide referrals to patient-centered medical homes, etc.).
	Decrease ED usage for issues exacerbated by depression or other mental health issues	Utilize social workers to develop comprehensive care plans, inclusive of all Care Team members, that address health and social needs (currently available at Saint Joseph's Family Health Center)  Collaborate with the New York State RHIO regional database to share patient care plans across health systems and providers		Primary Care Development Corporation to facilitate the successful integration of mental health services into primary health care	Westchester County Department of Health		
	Increase patient participation in behavioral health goal setting	Embed self-management goals into SJMC EHR	<ul style="list-style-type: none"> <li>&gt; Number of patients with documented self-management goals in their medical record</li> </ul>	SJMC will utilize the Washington University Mental Health Integration Program (MHIP) Toolkit to screen and treat mental health issues. The Toolkit integrates mental health screening and treatment in a Collaborative Care Model. The Toolkit also includes a registry that SJMC will use to input and track patients with mental health issues.			
Increase the percentage of patients with depression whose condition is diagnosed	Increase depression screening rates among patients	Implement periodic evidence-based depression screening among all patients with follow-up screening and care as needed	<ul style="list-style-type: none"> <li>&gt; Number of patients screened for depression</li> <li>&gt; Number of patients with positive depression screenings who are referred to either a social worker or enhanced mental health services</li> </ul>			On-going	



Goal Outcome	Objective	Interventions/ Strategies/ Activities	> Process Measures	Partner Role	Partner Resources	By When	Will Action Address Disparity
Improve the integration of behavioral health and physical health services	Decrease the wait time for behavioral health services by providing same day access	Expand the availability of social worker services to SJMC's Family Medicine and Saint Vincent's Primary Care Clinic locations to provide immediate therapy services	<ul style="list-style-type: none"> <li>&gt; Integration of social workers into SJMC's Family Medicine and Saint Vincent's Primary Care Clinic locations</li> <li>&gt; Number of patients connected with social workers and enrolled in comprehensive care plans</li> </ul>	Provide various levels of support for interventions/ strategies/ activities (e.g. set up workshops or lectures, provide data, distribute educational materials, co-sponsor health initiatives, and identify underserved populations, outliers, and high risk neighborhoods)	<p>Montefiore Hudson Valley Collaborative</p> <p>New York State Department of Health</p> <p>Primary Care Development Corporation (PCDC)</p> <p>Washington University</p> <p>Westchester County Department of Health</p>	On-going	<p>Yes, based on the various disparities in the City of Yonkers, SJMC will implement specific evidenced-based interventions geared towards risk factors associated with race, ethnicity, culture, and socio-economic status.</p> <p>SJMC will identify patients impacted by disparity and develop appropriate action plans to assist them (e.g. assist in securing health insurance, provide referrals to patient-centered medical homes, etc.).</p>
	Increase the number of patients with behavioral health conditions who are treated	Implement the IMPACT model, expanding the behavioral health Care Team to include a social worker, depression manager, and a psychiatrist to consult with primary care providers and increase access to behavioral health services	> Number of patients who have benefited from the IMPACT model and additional services offered	<p>Primary Care Development Corporation to facilitate the successful integration of mental health services into primary health care</p> <p>SJMC will utilize the Washington University Mental Health Integration Program (MHIP) Toolkit to screen and treat mental health issues. The Toolkit integrates mental health screening and treatment in a Collaborative Care Model. The Toolkit also includes a registry that SJMC will use to input and track patients with mental health issues.</p>	<p>Washington University</p> <p>Westchester County Department of Health</p>	On-going	

## 5. Roles of Collaborative Partners

Saint Joseph's Medical Center will continue its partnerships with the Westchester County Department of Health and the Montefiore Hudson Valley Collaborative, and continue to utilize the resources of various organizations (e.g. local and regional community-based organizations (CBOs), Centers for Disease Control and Prevention, American Heart Association, etc.) to maintain engagement with local and national partners. As appropriate, SJMC will also serve as a resource for providers, CBOs, local businesses, schools, etc. for the priority agenda items set forth by the WCDOH and MHVC. SJMC's Project Teams will develop regularly scheduled meetings to periodically review process measures and goal/objective outcomes to track progress and make any changes/corrections to our Prevention Agenda priorities.

SJMC will allocate the necessary resources (staff, financial, etc.) to maintain and enhance its engagement with various partners. This on-going process will align the goals and objectives of the Medical Center's CSP with the dynamic needs of the community it serves in order to optimize healthcare outcomes pertaining to its prevention initiatives.

## 6. Dissemination of the Report

The Community Health Needs Assessment and Community Service Plan Final Report and Implementation Plan were reviewed and adopted by the SJMC Board on December 12, 2016. SJMC will disseminate a written summary of the reports to the public on an annual basis. The reports as well as pertinent information (programs, schedules, financial data, financial assistance, announcements and updates) will be maintained and continuously updated on the Hospital's website (<http://www.saintjosephs.org/about-us>). SJMC will also have a public inspection copy available at the hospital at all times.

SJMC will utilize the local media to promote prevention initiatives and feature articles on health, as well as actively work with our partners to optimize communication to the community. Saint Joseph's Medical Center will re-convene key stakeholder meetings on a regular basis (no less than twice a year).

For more information regarding the Community Health Needs Assessment/Community Service 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 health care costs, robust community partnerships, and an overall enhanced quality of life.

## 7. Evaluation of Impact from the 2013 Community Health Improvement Plan

In 2013, SJMC completed a community health needs assessment and developed a supporting three year implementation plan to address the identified New York State Prevention Agenda priority of chronic disease. SJMC initiated the following strategies to address the priority area.

### Prevention Agenda Priority: Prevent Chronic Disease

**2013 Goal:** Effective health promotion, prevention and self-management to improve the health and wellness of Yonkers residents with emphasis on diabetes and hypertension.

#### 2013 Objectives

- > Increase community awareness about the risks, prevention and management of diabetes and hypertension
- > Increase the number of adults with diabetes and/or hypertension who have been offered and participate in culturally relevant chronic disease self-management education to learn how to manage their condition
- > Track and follow up on HbA1c testing, lipid profile, dilated eye exam, nephropathy monitoring, foot exam, BMI, and BP monitoring

#### Community Impact

Saint Joseph's Medical Center's 2013-2016 Community Health Improvement Plan focused on improving self-management for the chronic diseases diabetes and hypertension, which have a high prevalence and impact on the community we serve. With the efforts of our Clinical Staff, Administration, Local Health Department, and various Community-Based Organization Partners, SJMC's various initiatives were successful in raising awareness and improving health outcomes of both our patients and the residents of Yonkers who are affected by these chronic diseases.

Over the three year period (2013-2016), the Medical Center's prevention agenda activities reached over 5,000 people in the Yonkers Community. In addition, programs on hypertension and diabetes were provided to Medical Center employees of which over 650 are residents of the City of Yonkers. Recognizing the challenges people encounter in maintaining healthy lifestyles and adhering to their medical management programs, the Medical Center focused on introducing creative and culturally-sensitive methods to improve participation and maintain compliance in self-managing chronic diseases.

To improve clinical outcomes for SJMC's Family Health Center's adult patients with diabetes and/or hypertension we introduced the following initiatives:

- > Improved compliance with scheduled visits through a new personal notification system and direct follow-up with patients by designated Family Health Center Staff. To support this initiative a new employee classification, "Patient Care Representative," was created to better track patients' compliance with scheduled appointments, follow up with referrals to specialists, and ensure tests and results are completed and available in an optimal timeframe.

- > Recognizing that a large portion of our patient population's primary language is Spanish, the Medical Center began requiring all newly hired staff at its Ambulatory sites to be bilingual (English/Spanish) in order to improve communication and be sensitive to the cultural issues impacting a large portion of our patient population.
- > Home visits by medical staff to patients from our Family Health Center to ensure they are getting needed care when they are unable to leave their homes.
- > Introduction and maintenance of standard protocols for patients with hypertension/diabetes to include, but not limited to:
  - Blood Pressure taken and shared with patient
  - Patient/Provider medication review
  - Weight/dietary intake and assessment
  - Periodic foot exams
- > Routine measurement and tracking of patients on the following measures:
  - Reduction of their HghA1C3 Levels
  - Reduction of their Blood Pressure
  - Self-reporting on better management/compliance of patients' medical management plans
- > Referrals for appropriate specialty clinicians (e.g. Cardiologists, Ophthalmologists, Podiatrists, Registered Dietitians, etc.) within a set schedule as defined by the treating provider for patients with elevated blood sugar/HgbA1C3, elevated blood pressure, or other complications.

A program that was extremely successful in improving diabetes outcomes for Family Health Center patients was an educational program provided in partnership with the Visiting Nurse Services of New York City. The six-week program focused on diet, exercise, environment, stress management and adherence to treatment plans to improve diabetes self-management. The program enrolled 60 patients from SJMC's Family Health Center with an average attendance rate of 89%. Over 55 participants successfully completed the program and most are still being medically managed by the Family Health Center's Clinical Staff. Bilingual (English/Spanish) instructors were provided.

To increase education and awareness and improve health behaviors related to chronic diseases among Yonkers residents, SJMC offered the following programs that were free and open to the public:

- > Asthma lectures hosted in the SJMC Solarium, addressing signs and symptoms and commonly believed myths
- > *Open Airways*, a five session program presented in several Yonkers public schools in partnership with the Hudson Valley Asthma Coalition and the Gorton High School Medical Magnet Program

- > Presentations in both English and Spanish to adult learners at the Vive School, Riverdale Avenue, Yonkers:
  - *Asthma: Signs, Symptoms, and Treatment*
  - *Hypertension: Life Style Changes to Improve Your Risk of Developing High Blood Pressure*
  - *Emergencies: When to Go and When to Wait*
  - *Health Insurance Options in Westchester County*
  - *Affordable Health Care When You Do Not Have Health Insurance*
  
- > Senior health fairs sponsored by Mayor Michael Spano, providing one-on-one interaction and instruction on issues of asthma, flu vaccines, stroke, hypertension, and diabetes
  
- > Eight stroke presentations (*Spot a Stroke F.A.S.T.* and *Let's Talk About Stroke*) were offered in senior citizen/low-income housing throughout Yonkers.

Through our initiative to improve self-management for diabetes and hypertension, SJMC realized the need to provide other services throughout the City of Yonkers to improve the health of its people. One such service has been to provide flu vaccinations to various sectors of our community, including religious organizations, senior citizen housing complexes, municipal workers, and other community-based organizations. Recognizing the importance of this service, the Medical Center has provided the vaccinations at no charge.

Saint Joseph's Medical Center conducted outreach in the City of Yonkers, based on the 2013-2016 Implementation Plan, to optimize the health and well-being of its residents. SJMC disseminated information on its Community Service Plan and associated activities through the Medical Center's website. SJMC also maintained its goal of communicating activities as widely as possible by promoting them through the local media and actively working with community partners to improve communication to residents.

## 8. Changes Impacting Community Health/Provision of Charity Care/Access to Services

The Medical Center introduced/established the following programs to expand its services and address financial disparities/issues in the various communities it serves:

### **Saint Joseph's Family Medicine and Urgent Care Center**

415 South Broadway, Yonkers, NY 10705

Saint Joseph's opened a primary care practice in 2013 to address healthcare needs of a culturally diverse and economically challenged population in the City of Yonkers. The practice treats patients from pediatrics to geriatrics and is staffed by bilingual (English/Spanish) employees. Recognizing the financial challenges of this patient population, the practice provides services on a sliding fee scale based on the uninsured patients' ability to pay.

### **Cardiovascular Center**

530 Yonkers Ave, Yonkers, NY 10704

The CVC opened in mid-2014 offering Cardiology Services on an outpatient basis to both private patients of the Cardiology practice and referred patients from our FHC and the surrounding community. Staffed by Board Certified Cardiologist from the Saint Joseph's Medical PC and both NYS Licensed and Certified staff; the CVC is open Monday through Friday from 9 a.m. to 5 p.m. In addition to providing routine and emergent appointments, the CVC provides cardiac diagnostic testing including nuclear imaging and non-nuclear stress testing, echocardiography, nuclear cardiac imaging, Holter monitoring, EKGs, and vascular ultrasound. The Center accepts most private and public insurances and works with patients that are uninsured on a sliding fee scale for their diagnostic testing. Over the past year we have added an additional Board Certified Cardiologist to provide additional appointments. The volume continues to grow on a steady basis at the CVC as we look to provide quality cardiology services to the people of Yonkers and the North Bronx.

### **Saint Joseph's Imaging – Riverdale**

30150 Corlear Ave, Bronx, NY 10463

The Imaging Center opened in March 2014 offering a full line of outpatient imaging services on both a scheduled and walk-in basis to the physicians and citizens living in the Riverdale section of the Bronx. The Center, which is staffed by Board Certified Radiologists and radiology staff that is licensed by NYS and certified by the ARRT, offers general x-ray services along with mammography, MRI, ultrasound, and DEXA. Services are offered on both a routine and urgent basis with results being faxed to the referring physician within hours of the completion of the exam. The Center accepts most insurances and will work with uninsured or under-insured patients on a sliding fee scale basis. The Center is open Monday through Friday from 9 a.m. to 5 p.m.

**Westchester County's Crisis Prevention Response Team**

The St. Vincent's division of Saint Joseph's Medical Center has been operating Westchester County's Crisis Prevention Response Team (CPRT) since December 2011. Funded through the Westchester County, and the NYS Office of Mental Health, CPRT provides mobile crisis behavioral health services to residents through Westchester County, Monday through Saturday, 9 a.m. to 9 p.m. In keeping with Saint Joseph's long-standing commitment to provide comprehensive behavioral health services, the program will expand to seven days per week in 2017 in order to meet the increasing needs of vulnerable population. Comprised of seven full time clinicians, including a psychiatrist and licensed clinical social workers, CPRT provides crisis prevention counseling, evaluation, and referrals to adults, adolescents and children, especially to those who are underserved and not connected to services. Approximately 50% of CPRT services are provided to residents of Yonkers.



## Appendix A: Westchester County Provider Questionnaire

Westchester County Provider Questionnaire		
<p>We want to hear your thoughts about important health issues in the community you serve. Together, the Westchester County Health Department and hospitals throughout Westchester County, NY, will use the results of this short survey and other information to help improve health programs. Thank you for your participation!</p>		
<b>Agency Name:</b> _____ <b>Zip code of site location:</b> _____		
<b>Optional:</b> Your name _____ Phone # _____ Email address _____		
<b>How would you best describe your title/role in your agency?</b>		
<input type="checkbox"/> Advocate <input type="checkbox"/> Board member <input type="checkbox"/> Office manager <input type="checkbox"/> Alcohol/substance provider <input type="checkbox"/> Dental provider <input type="checkbox"/> Primary care provider <input type="checkbox"/> Allied health professional <input type="checkbox"/> Executive director <input type="checkbox"/> Program administrator/manager <input type="checkbox"/> Behavioral health care provider <input type="checkbox"/> Health educator <input type="checkbox"/> Specialty care provider <input type="checkbox"/> Other (please specify): _____		
<b>Please check the categories that best describe your agency. (Please check all that apply)</b>		
<input type="checkbox"/> Alcohol/substance Abuse Agency <input type="checkbox"/> Dental Practice <input type="checkbox"/> Medical Practice <input type="checkbox"/> Community-based Organization <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Mental Health Agency <input type="checkbox"/> Community Health Center <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Other (please specify): _____		
<b>Please check the type of services provided by your agency. (Please check all that apply)</b>		
<input type="checkbox"/> Breastfeeding support <input type="checkbox"/> Family planning <input type="checkbox"/> Prenatal/PCAP services <input type="checkbox"/> Case management <input type="checkbox"/> Food access <input type="checkbox"/> Primary care services- adults <input type="checkbox"/> Childcare <input type="checkbox"/> Health insurance enrollment <input type="checkbox"/> Primary care services- children <input type="checkbox"/> Community education <input type="checkbox"/> Health screenings <input type="checkbox"/> Rehabilitation services <input type="checkbox"/> Dental services <input type="checkbox"/> Home care services <input type="checkbox"/> Smoking/tobacco services <input type="checkbox"/> Domestic violence prevention <input type="checkbox"/> Housing <input type="checkbox"/> Transportation <input type="checkbox"/> Drug/alcohol services <input type="checkbox"/> Immigrant support services <input type="checkbox"/> Violence/bullying/gang prevention <input type="checkbox"/> Elder care/senior services <input type="checkbox"/> Immunization <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Exercise/ weight loss programs <input type="checkbox"/> Mental health services		
<b>Please check all persons served by your agency. (Check all that apply)</b>		
<input type="checkbox"/> Adults <input type="checkbox"/> Immigrants <input type="checkbox"/> Seniors <input type="checkbox"/> Children <input type="checkbox"/> Low-income <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Disabled <input type="checkbox"/> Uninsured		
<b>What are the THREE biggest ongoing health concerns for the people/community you serve?</b>		
<input type="checkbox"/> Access to immunizations <input type="checkbox"/> Dental care <input type="checkbox"/> Mental health/depression/ suicide <input type="checkbox"/> Access to primary health care <input type="checkbox"/> Diabetes <input type="checkbox"/> Nutrition/eating habits <input type="checkbox"/> Access to specialty care <input type="checkbox"/> Disability <input type="checkbox"/> Overweight/obesity <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Distracted driving <input type="checkbox"/> Preventable injury/falls <input type="checkbox"/> Asthma/breathing problems <input type="checkbox"/> Drug abuse <input type="checkbox"/> Smoking/tobacco use <input type="checkbox"/> Cancer <input type="checkbox"/> Family planning/teen pregnancy <input type="checkbox"/> Violence <input type="checkbox"/> Care for the elderly <input type="checkbox"/> Healthy environment <input type="checkbox"/> Women's health <input type="checkbox"/> Child health & wellness <input type="checkbox"/> Heart disease/stroke <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Dementia/Alzheimer's <input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections		

Westchester County Provider Questionnaire

**What THREE things would be most helpful to improve the health concerns of the community you serve?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Access to dental care          | <input type="checkbox"/> Domestic violence prevention  | <input type="checkbox"/> Mental health services            |
| <input type="checkbox"/> Access to healthier food       | <input type="checkbox"/> Drug/alcohol services         | <input type="checkbox"/> Safer childcare options           |
| <input type="checkbox"/> Access to primary care         | <input type="checkbox"/> Elder care services           | <input type="checkbox"/> Safer places to walk/play         |
| <input type="checkbox"/> Affordable housing             | <input type="checkbox"/> Exercise/weight loss programs | <input type="checkbox"/> Smoking/tobacco services          |
| <input type="checkbox"/> Breastfeeding support          | <input type="checkbox"/> Health Insurance enrollment   | <input type="checkbox"/> Transportation                    |
| <input type="checkbox"/> Caregiver support              | <input type="checkbox"/> Health screenings             | <input type="checkbox"/> Violence/bullying/gang prevention |
| <input type="checkbox"/> Clean air & water              | <input type="checkbox"/> Home care services            | <input type="checkbox"/> Other (please specify) : _____    |
| <input type="checkbox"/> Community education            | <input type="checkbox"/> Immigrant support services    |  |
| <input type="checkbox"/> Dementia/Alzheimer's screening | <input type="checkbox"/> Job opportunities             |  |

**How would you rate the health of the people/community you serve?**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Very healthy | <input type="checkbox"/> Somewhat healthy | <input type="checkbox"/> Very unhealthy                 |
| <input type="checkbox"/> Healthy      | <input type="checkbox"/> Unhealthy        | <input type="checkbox"/> Other (please specify) : _____ |

**What are the THREE most significant barriers impacting YOUR ABILITY to provide services to your patients/clients?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cultural competency issues         | <input type="checkbox"/> Limited or lack of access to specialists       | <input type="checkbox"/> Patient non-adherence to treatment |
| <input type="checkbox"/> High no-show rate                  | <input type="checkbox"/> Limited space and/or equipment                 | <input type="checkbox"/> Staff time constrains              |
| <input type="checkbox"/> Inadequate insurance reimbursement | <input type="checkbox"/> Limited staffing resources                     | <input type="checkbox"/> Other (please specify) : _____     |
| <input type="checkbox"/> Lack of funding                    | <input type="checkbox"/> Patient cannot afford prescription medications |   |
| <input type="checkbox"/> Limited bi-lingual staff           |   |   |

**For the patients/clients you serve, what are the top THREE barriers impacting YOUR CLIENTS' ability to access your services?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> There are no issues               | <input type="checkbox"/> Don't understand need to see a provider | <input type="checkbox"/> Lack of/or limited staff who speak their language |
| <input type="checkbox"/> Cannot afford services            | <input type="checkbox"/> Inconvenient hours                      | <input type="checkbox"/> No transportation/too far                         |
| <input type="checkbox"/> Co-pay/deductible too high        | <input type="checkbox"/> Insurance does not cover service        | <input type="checkbox"/> No childcare                                      |
| <input type="checkbox"/> Cultural/religious beliefs        | <input type="checkbox"/> Lack of time                            | <input type="checkbox"/> No insurance                                      |
| <input type="checkbox"/> Don't know how to access services | <input type="checkbox"/> Lack of/or limited staff/service        | <input type="checkbox"/> Unaware of services available                     |
| <input type="checkbox"/> Don't like going/afraid to go     |  | <input type="checkbox"/> Other (please specify) : _____                    |

**Where do community members you serve get most of their health information? (Check all that apply)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Community-based organization | <input type="checkbox"/> Internet               | <input type="checkbox"/> School/college                         |
| <input type="checkbox"/> Doctor/Health professional   | <input type="checkbox"/> Library                | <input type="checkbox"/> Social media (Facebook, Twitter, etc.) |
| <input type="checkbox"/> Family or friends            | <input type="checkbox"/> Newspaper/magazine     | <input type="checkbox"/> Television                             |
| <input type="checkbox"/> Health department            | <input type="checkbox"/> Radio                  | <input type="checkbox"/> Worksite                               |
| <input type="checkbox"/> Hospital                     | <input type="checkbox"/> Religious organization | <input type="checkbox"/> Other (please specify) : _____         |

Can we contact you so you can tell us more about your ideas regarding health problems in Westchester County and what should be done about them?

Yes \_\_\_\_\_

No \_\_\_\_\_

# Appendix B: Westchester County Community Health Questionnaire

Westchester County Community Health Questionnaire		
<p>We want to hear your thoughts about important health issues in your community. Together, the Westchester County Health Department and hospitals throughout Westchester County, NY, will use the results of this short survey and other information to help improve health programs in your community. Your responses are completely anonymous. Thank you for your participation!</p>		
<b>What are the THREE biggest ongoing health concerns for the COMMUNITY WHERE YOU LIVE?</b>		
<input type="checkbox"/> Access to immunizations	<input type="checkbox"/> Dental care	<input type="checkbox"/> Mental health/depression/suicide
<input type="checkbox"/> Access to primary health care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutrition/eating habits
<input type="checkbox"/> Access to specialty care	<input type="checkbox"/> Disability	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Distracted driving	<input type="checkbox"/> Preventable injury/falls
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Smoking/tobacco use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Family planning/teen pregnancy	<input type="checkbox"/> Violence
<input type="checkbox"/> Care for the elderly	<input type="checkbox"/> Healthy environment	<input type="checkbox"/> Women's health
<input type="checkbox"/> Child health & wellness	<input type="checkbox"/> Heart disease/stroke	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections	
<b>What are the THREE biggest ongoing health concerns for YOURSELF?</b>		
<input type="checkbox"/> Access to immunizations	<input type="checkbox"/> Dental care	<input type="checkbox"/> Mental health/depression/suicide
<input type="checkbox"/> Access to primary health care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutrition/eating habits
<input type="checkbox"/> Access to specialty care	<input type="checkbox"/> Disability	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Distracted driving	<input type="checkbox"/> Preventable injury/falls
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Smoking/tobacco use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Family planning/teen pregnancy	<input type="checkbox"/> Violence
<input type="checkbox"/> Care for the elderly	<input type="checkbox"/> Healthy environment	<input type="checkbox"/> Women's health
<input type="checkbox"/> Child health & wellness	<input type="checkbox"/> Heart disease/stroke	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections	
<b>What THREE things would be most helpful to improve YOUR health concerns?</b>		
<input type="checkbox"/> Access to dental care	<input type="checkbox"/> Domestic violence prevention	<input type="checkbox"/> Mental health services
<input type="checkbox"/> Access to healthier food	<input type="checkbox"/> Drug/alcohol services	<input type="checkbox"/> Safer childcare options
<input type="checkbox"/> Access to primary care	<input type="checkbox"/> Elder care services	<input type="checkbox"/> Safer places to walk/play
<input type="checkbox"/> Affordable housing	<input type="checkbox"/> Exercise/weight loss programs	<input type="checkbox"/> Smoking/tobacco services
<input type="checkbox"/> Breastfeeding support	<input type="checkbox"/> Health Insurance enrollment	<input type="checkbox"/> Transportation
<input type="checkbox"/> Caregiver support	<input type="checkbox"/> Health screenings	<input type="checkbox"/> Violence/bullying/gang prevention
<input type="checkbox"/> Clean air & water	<input type="checkbox"/> Home care services	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Community education	<input type="checkbox"/> Immigrant support services	
<input type="checkbox"/> Dementia/Alzheimer's screening	<input type="checkbox"/> Job opportunities	
<b>How would you describe your overall health?</b>		
<input type="checkbox"/> Very healthy	<input type="checkbox"/> Somewhat healthy	<input type="checkbox"/> Very unhealthy
<input type="checkbox"/> Healthy	<input type="checkbox"/> Unhealthy	<input type="checkbox"/> Other (please specify): _____
<b>How would you describe your overall mental health?</b>		
<input type="checkbox"/> Very healthy	<input type="checkbox"/> Somewhat healthy	<input type="checkbox"/> Very unhealthy
<input type="checkbox"/> Healthy	<input type="checkbox"/> Unhealthy	<input type="checkbox"/> Other (please specify): _____
<b>Do you suffer from any chronic health conditions (check all that apply)</b>		
<input type="checkbox"/> None	<input type="checkbox"/> Disability	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug/alcohol abuse	<input type="checkbox"/> Memory issues
<input type="checkbox"/> Auto-immune disease	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mental health
<input type="checkbox"/> Cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Other (please specify): _____



## Westchester County Community Health Questionnaire

<b>Do you have a health care provider for checkups and visits:</b>		<input type="checkbox"/> Yes _____
		<input type="checkbox"/> No _____
<b>How long has it been since you visited a health care provider for a routine physical exam or checkup?</b>		
<input type="checkbox"/> In the past year	<input type="checkbox"/> In the past five years	<input type="checkbox"/> Never
<input type="checkbox"/> In the past two years	<input type="checkbox"/> Five or more years ago	<input type="checkbox"/> Don't know
<b>What THREE things prevent YOU from getting medical care from a health care provider?</b>		
<input type="checkbox"/> Nothing prevents me from getting medical care	<input type="checkbox"/> Cultural/religious beliefs	<input type="checkbox"/> Insurance does not cover service
<input type="checkbox"/> Cannot afford	<input type="checkbox"/> Don't know how to find providers	<input type="checkbox"/> No transportation/too far
<input type="checkbox"/> Cannot find a health provider who speaks my language	<input type="checkbox"/> Don't like going/afraid to go	<input type="checkbox"/> No childcare
<input type="checkbox"/> Co-pay/deductible too high	<input type="checkbox"/> Don't see the benefit	<input type="checkbox"/> No insurance
	<input type="checkbox"/> I have no time	<input type="checkbox"/> Other (please specify): _____
	<input type="checkbox"/> Inconvenient office hours	
<b>In the past 12 months, did you receive care in the emergency room?</b>		<input type="checkbox"/> Yes _____
		<input type="checkbox"/> No _____
<b>If yes, what is the ONE main reason for your emergency room visit?</b>		
<input type="checkbox"/> Could not find a local health provider who speaks my language	<input type="checkbox"/> Health provider said go to emergency room	<input type="checkbox"/> Thought problem too serious for a doctor's visit
<input type="checkbox"/> Doctor's office not open	<input type="checkbox"/> No other place to go	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Emergency room is the closest provider	<input type="checkbox"/> Receive most of my care at emergency room	
<b>Where do you and your family get most of your health information? (check all that apply)</b>		
<input type="checkbox"/> Community-based organization	<input type="checkbox"/> Internet	<input type="checkbox"/> School/college
<input type="checkbox"/> Doctor/Health professional	<input type="checkbox"/> Library	<input type="checkbox"/> Social media (Facebook, Twitter, etc.)
<input type="checkbox"/> Family or friends	<input type="checkbox"/> Newspaper/magazine	<input type="checkbox"/> Television
<input type="checkbox"/> Health department	<input type="checkbox"/> Radio	<input type="checkbox"/> Worksite
<input type="checkbox"/> Hospital	<input type="checkbox"/> Religious organization	<input type="checkbox"/> Other (please specify): _____
<b>For statistical purposes only (your responses are anonymous), please complete the following:</b>		
<b>I identify as:</b>		<b>What is your age:</b>
<input type="checkbox"/> Male	<input type="checkbox"/> 18-24	<input type="checkbox"/> 55-64
<input type="checkbox"/> Female	<input type="checkbox"/> 25-34	<input type="checkbox"/> 65-74
<input type="checkbox"/> Other	<input type="checkbox"/> 35-44	<input type="checkbox"/> 75+
	<input type="checkbox"/> 45-54	
<b>Zip code where I live</b> _____	<b>Town/city where I live</b> _____	
<b>Are you Hispanic or Latino?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What category best describes your race?</b>		
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Multi-racial
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Other
<b>What is the primary language you speak?</b>		
<input type="checkbox"/> English	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Tagalog
<input type="checkbox"/> Spanish	<input type="checkbox"/> French	<input type="checkbox"/> Korean
<input type="checkbox"/> Italian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other (please specify): _____
<b>What is your highest level of education?</b>		
<input type="checkbox"/> Less than high school	<input type="checkbox"/> Some college	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> High school grad/GED	<input type="checkbox"/> College graduate	
<input type="checkbox"/> Technical school	<input type="checkbox"/> Advanced degree	
<b>What is your current employment status</b>		
<input type="checkbox"/> Employed	<input type="checkbox"/> Student	<input type="checkbox"/> Retired
<input type="checkbox"/> Not employed	<input type="checkbox"/> Military	<input type="checkbox"/> Other (please specify): _____
<b>Do you have any of the following types of health insurance?</b>		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private insurance	<input type="checkbox"/> None/no insurance
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Tri-Care	<input type="checkbox"/> Other (please specify): _____

## Appendix C: Public Health Data References

American Community Survey: The American Community Survey (ACS) is an ongoing survey of the United States population conducted by the United States Census Bureau. ACS addresses issues related to demographics and socioeconomic indicators. For more information on ACS please visit: <http://www.census.gov/programs-surveys/acs/about.html>.

New York State Expanded Behavioral Risk Factor Surveillance System (BRFSS): The BRFSS is an annual random-digit-dialed telephone survey conducted among the non-institutionalized civilian population 18 years of age and older. BRFSS analyzes county-specific data on preventive health practices, risk behaviors, injuries, and preventable diseases. For more information about BRFSS please visit: <https://www.health.ny.gov/statistics/brfss/expanded/>.

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 more information on the New York State Vital Records please visit: [https://www.health.ny.gov/statistics/vital\\_statistics/](https://www.health.ny.gov/statistics/vital_statistics/).

New York State Statewide Planning and Research Cooperative Systems (SPARCS): SPARCS is the primary source of data for ED visits and inpatient hospitalizations at New York State hospitals. SPARCS data was used to estimate the rates of avoidable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, asthma ED visits, hospitalizations for short-term diabetes complications, and hospitalizations for heart attacks. For more information about SPARCS please visit: <http://www.health.ny.gov/statistics/sparcs/>.

New York State Bureau of HIV/AIDS: Data on HIV incidence (new cases) were obtained from the NYS Bureau of HIV/AIDS, which receives reports of all new HIV diagnoses for NYS residents meeting an established case definition. For more information please visit: <https://www.health.ny.gov/diseases/aids/general/statistics/>.

New York State Cancer Registry: The New York State Cancer Registry was used to summarize data on new cases of breast cancer, prostate cancer, lung cancer and colorectal cancer. For more information on the New York State Cancer Registry please visit: <https://www.health.ny.gov/statistics/cancer/registry/>.

New York State Prevention Agenda Dashboard: The New York State Prevention Agenda Dashboard, produced by the State Department of Health, is a data clearinghouse for health indicators that align with the New York State Prevention Agenda. For more information please see: [http://www.health.ny.gov/prevention/prevention\\_agenda/2013-2017/](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/).