

Community Health Needs Assessment and Implementation Report

2019-2021

White Plains Hospital

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

White Plains Hospital
Community Health Needs Assessment and Implementation Strategy Report 2019-2021

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1. Executive Summary

The Community Health Needs Assessment and Implementation Strategy Report Requirement

The Affordable Care Act requires hospitals to assess and address the health needs of the communities they serve. This Community Health Needs Assessment and Implementation Strategy Report (CHNAIR) outlines the process, methods and results of a comprehensive assessment of the needs of the community served by White Plains Hospital. The Implementation Report describes the programs and strategies to address the health needs as identified through the Community Health Needs Assessment (CHNA). White Plains Hospital's CHNAIR was approved by the Board of Directors on December 9, 2019, and was uploaded to the White Plains Hospital website on December 18, 2019.

White Plains Hospital's Community Commitment

The Hospital has a long history of reaching beyond its walls to identify and meet the needs of its community. Community services are an explicit and essential component of White Plains Hospital's mission and one of its most valued traditions. Our commitment to the community has required a multifaceted, continually evolving response, in which the unique capacities of the hospital are mobilized to improve the lives of the people and the communities we serve -- not just medically, but socially, economically and environmentally. The Hospital has been a leader in organizing and expanding community-based services that include, but are not limited to, the following integrated approaches: Community Service Plan, disease management and community outreach.

White Plains Hospital participates in a variety of organized partnerships working with other providers in Westchester County, including the Westchester County Department of Health, community-based organizations, faith-based organizations and community members to develop initiatives aimed at improving the health of the people of Westchester County.

Definition and Description of the Community

White Plains Hospital has identified Westchester County as its primary service area. Westchester County has a population of 975,321 and is approximately 430.5 square land miles. It is the 7th most populous county in New York State. The county seat is White Plains (56,404) and other major cities include Yonkers (200,999), New Rochelle (79,877) and Mount Vernon (68,671). In 2017, the median household income for Westchester was \$89,968, 4th highest in New York State, after Nassau, Putnam and Suffolk Counties.

In 2017 and 2018, Westchester County ranked as the third healthiest county in New York State, according to the County Health Rankings, produced by the University of Wisconsin. Despite its overall high ranking, there are opportunities to improve the health of our population in Westchester County, while also reducing health disparities for both high-need populations and poorer health outcomes.

Assessment of Community Health Needs

Multiple data sources were used to support the selection of the priority items that were identified and reviewed with various community partners. The partners helped disseminate the survey to their constituents to aid in the collection of primary data across Westchester County for the CHNA. Feedback was compiled from over 3,500 respondents and identified the community concerns by municipality to support CHNA and CSP efforts of hospitals for inclusion into this Implementation Report.

Additionally, conversations and meetings were convened with external partners, a thorough review of the data was conducted, all of which frame the development of the report. These collaborations and partnerships are described in detail in this document.

Collaborations/Partnerships

The Implementation Report provides information on the individuals, groups and organizations participating in activities that evolve out of the CHNA process. As the CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) review, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. White Plains Hospital will continue to work with its partners on existing program initiatives.

Prioritization of Community Health Needs

A review of results from the primary and secondary data collection process illuminated two major categories of health needs. These categories were important across the populations surveyed, reflected in the data as critical, and were in alignment with the New York State Prevention Agenda.

White Plains Hospital selected the following prevention agenda priority items: **Promote Well-Being and Prevent Mental and Substance Use Disorders**, and **Promote Healthy Women, Infants and Children**.

Within these priority areas, a commitment has been made to focus on the following two areas:

- Mental and Substance Use Disorders Prevention
- Perinatal and Infant Health

The selected priorities are fully compatible with White Plains Hospital's community health initiatives. They are supported by existing programs and staff, the community, as well as the addition of new and modified programs. Activities in support of the priorities are carried out with the input and support of our community partners.

New York State Health Improvement Plan - Implementation Plan and Measures

The Priority Areas selected for the 2019-2021 New York State Health Improvement Plan align with the priority areas referenced above. Within these two priority areas we will:

- Focus on preventing substance misuse, specifically opioid overdose deaths by increasing naloxone training, promoting prescriber education for opioid guidelines and organizing take back days.
- Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative. Engagement and referral into community based programs to support at risk mothers.

These focus areas align with other ongoing activities, including but not limited to the City of White Plains Opioid Task Force (including members from City of White Plains Department of Community and Mental Health, White Plains Police Department, and more) as well as the National Baby-Friendly Hospital Initiative.

We believe the selection of these priority areas and collaborative efforts with community partners will positively impact substance misuse and maternal child health.

2. Introduction

White Plains Hospital is a proud member of the Montefiore Health System, serving as its tertiary hub of advanced care in the Hudson Valley. The Hospital is a 292-bed not-for-profit health care organization with the primary mission of providing exceptional acute and preventive medical care to all people who live in, work in or visit Westchester County and its surrounding areas. Centers of Excellence include the Center for Cancer Care, The William & Sylvia Silberstein Neonatal & Maternity Center and The Ruth and Jerome A. Siegel Stroke Center. The Hospital's Flanzer Emergency Department is the busiest in Westchester County, with more than 60,000 patient visits a year. White Plains Hospital performs lifesaving emergency and elective angioplasty in its Joan and Alan Herfort, MD, Cardiac Catheterization Laboratory and Marie Promuto Cardiac Catheterization Laboratory. White Plains Hospital has outpatient medical facilities across Westchester, including multispecialty practices in Armonk and New Rochelle; and Scarsdale Medical Group locations in Harrison and Scarsdale. The Hospital is fully accredited by the Joint Commission and earned its recognition as a Top Performer for Key Quality Measures® in 2015 and 2013. The Hospital received Magnet® designation in 2012 and 2016 from the American Nurses Credentialing Center (ANCC). In 2014, 2016 and 2018, and 2019, White Plains Hospital received the Outstanding Patient Experience Award from Healthgrades®. For additional information, visit wphospital.org.

2a. White Plains Hospital's Mission Statement and Strategy

White Plains Hospital is a voluntary, not-for-profit health care organization with the primary mission of offering high quality, acute health care and preventive medical care to all people who live in, work in, or visit Westchester County and its surrounding areas. These exceptional services will be delivered in a caring and compassionate manner, focusing on meeting the needs of the community.

White Plains Hospital's mission extends beyond inpatient and outpatient care to include assessing and improving the health status of the local community, the professional community and the business sector. The Hospital will strive to enhance its capabilities and to deliver health care services, within the scope of its resources, in a cost-effective manner.

White Plains Hospital believes success is assured by the dedication of the people who make up the supporting constituencies: employees, physicians, licensed health care professionals, volunteers, individual supporters, businesses and civic organizations.

All care and services will be provided without regard to race, color, creed, national origin, age, sexual orientation or ability to pay.

2b. Community Health Needs Assessment Submission Date

White Plains Hospital's Community Health Needs Assessment and Implementation Report (CHNAIR) was approved by the Board of Directors on December 9, 2019. The Community Health

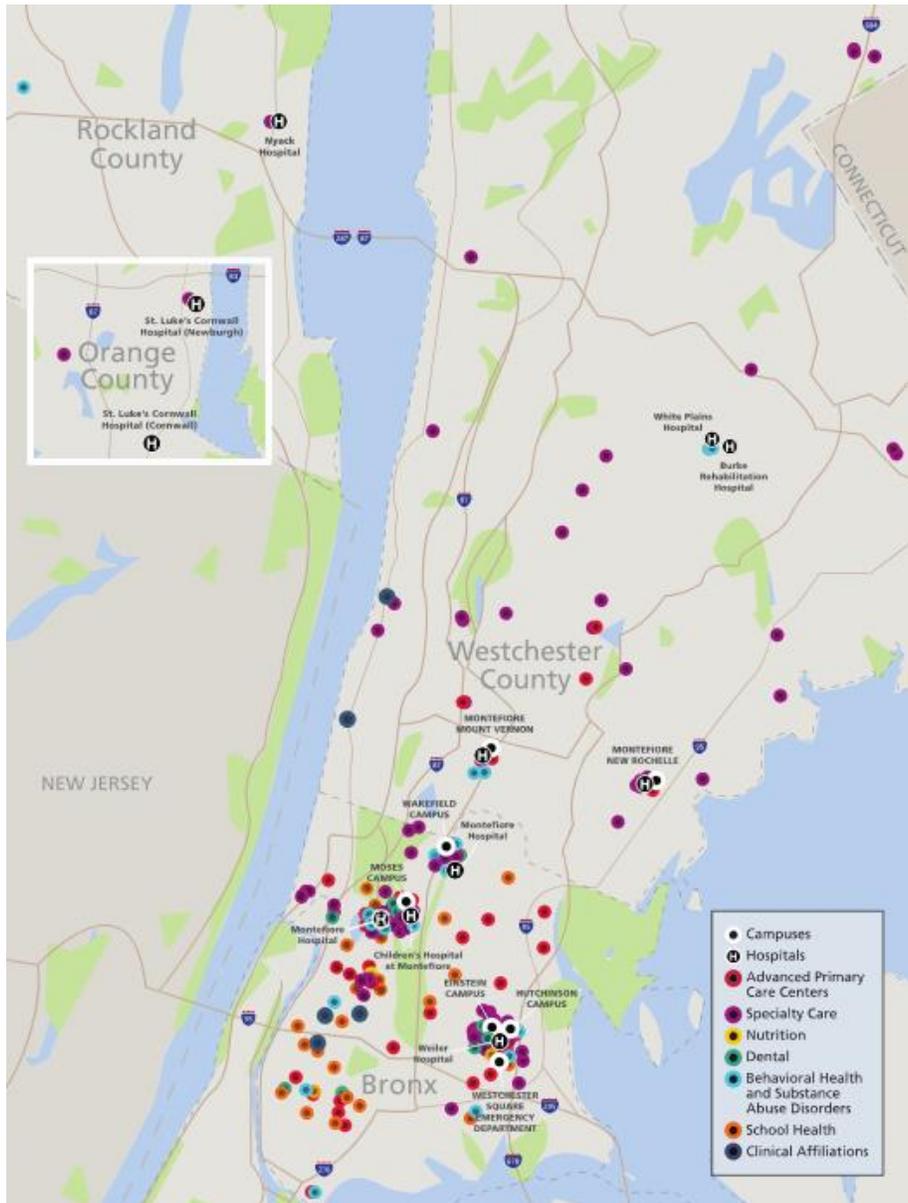
Needs Assessment and Implementation Report (CHNAIR) report was uploaded to the White Plains Hospital website on December 18, 2019.

3. Definition and Description of the Community/Service Area

White Plains Hospital has identified Westchester County as their primary service area. Westchester County has a population of 975,321 and is approximately 430.5 square land miles. It is the 7th most populous county in New York State. The county seat is White Plains (56,404) and other major cities include Yonkers (200,999), New Rochelle (79,877) and Mount Vernon (68,671). In 2017, the median household income for Westchester was \$89,968, 4th highest in New York State, after Nassau, Putnam and Suffolk counties.

Westchester County is the 3rd healthiest county in New York State, according to the County Health Rankings, produced by the University of Wisconsin. Despite its overall high ranking, there is considerable room to improve population health in Westchester County, while also reducing health disparities, as each of these cities is a hotspot for both high-need populations and poorer health outcomes.

Figure 1. Montefiore Health System Locations (White Plains Hospital sites included)



3a. The Populations of White Plains

White Plains is the county seat and the 5th most populous city in Westchester County. According to the 2017 American Community Survey, White Plains has 58,404 residents and has experienced a 10.0% increase in population between 2000 and 2017.

There are over 22,000 households in White Plains, of which 25.7% are family households with children. White Plains has a slightly younger population than Westchester County, with a median age of 38.1 years versus 40.6 years.

White Plains is also ethnically diverse. Its population is 45.1% non-Hispanic white, 33.2% Hispanic, 12.0% non-Hispanic black, 7.7% Asian/Pacific Islander and 1.8% non-Hispanic other. Almost one-third (30.8%) of its residents are foreign-born. Among the foreign-born population, more residents speak Spanish (59%) than English (13%) or another (28%) language. The city's foreign-born population come from diverse corners of the globe (in order of frequency): Mexico (21% of foreign-born), Peru (9%), Dominican Republic (7%), Colombia (6%), India (6%), China (4%), Jamaica (4%), Guatemala (4%), El Salvador (3%) and Korea (3%) and Ecuador (3%)

White Plains has the 4th largest proportion of the population that lives below the poverty level (11.9%) in the county (compared to 9.4% countywide). The median household income is \$87,550, slightly below the median household income countywide (\$89,968). Of note, 18.6% of White Plains children live below poverty, higher than the countywide percentage of 11.7%. Over half (55.7%) of students in White Plains public schools qualified for free or reduced lunch during the 2016-2017 school year.

A similar proportion of the population is publicly insured (30.3% versus 30.0% in the county) and a higher proportion are uninsured (11.7% versus 7.8% in the county). 1.5% of White Plains households are on cash public assistance, lower than the percentages in Westchester County (2.0%) and New York State (3.4%). The White Plains unemployment rate is 7.0%, which is the 5th highest in Westchester County. 50.4% of White Plains residents ages 25 and older have received at least a bachelor's degree, higher than countywide (47.7%) and statewide (35.3%) attainment rates.

3b. A Snapshot of Health Disparities in Westchester County

While Westchester County remains among the healthiest counties in New York State, several of its individual municipalities continue to have significant health gaps. Portions of lower Westchester, specifically Mount Vernon, Yonkers, New Rochelle and White Plains are "hot spots" for various health outcomes, such as asthma and preterm births in the County. Additionally, certain groups, such as some racial/ethnic minorities or those with less education, experience poorer health outcomes.

Some Westchester populations have excess mortality rates. For example, the age-adjusted mortality rate per 100,000 for the non-Hispanic black (695.1 per 100,000) and non-Hispanic white (657.0 per 100,000) populations are significantly higher than for the Hispanic population (493.2 per 100,000).

While Westchester County has an age-adjusted preventable hospitalization rate below the rate for all of New York State and the Prevention Agenda 2018 Target, there are areas and sub-populations that have excess preventable hospitalization rates. For example, the rate is 156.6

per 10,000 in ZIP Code 10601 in White Plains and 235.0 per 10,000 ZIP Code 10550 in Mount Vernon. Rates are generally elevated in the southern portion of the county, including Yonkers, Mount Vernon, the southern section of New Rochelle, and in the northern portion of the county, namely Peekskill. Further, the rate of preventable hospitalizations for the non-Hispanic black population (193.5 per 10,000) is 2.9 times higher than the rate for the non-Hispanic white population (67.4 per 10,000). The rate for the Hispanic population (56.0 per 100,000) is slightly lower than the non-Hispanic white population.

There are a multitude of reasons certain populations and geographic areas have poorer health outcomes; these reasons include, for example, differences in access to health care, quality of care, physical environments, and economic and educational opportunities, to name a few. For example, while a smaller proportion of individuals live in poverty in Westchester County than in New York State overall, those who are black (16.6%) and Hispanic (19.4%) are more likely to be living in poverty than those who are white (5.9%).

While the Prevention Agenda 2018 target for health insurance coverage among adults age 18-64 is 100%, 90% of adults are covered in Westchester County. In certain areas, such as Port Chester, a much smaller proportion of the population has health insurance (69.8%), and in other areas such as Scarsdale, almost all residents have health insurance (99.9%). Additional areas with lower health insurance coverage include White Plains, Yonkers, Mount Vernon and southern portions of New Rochelle. There are also disparities by race/ethnicity; 92.4% of the white and 88.5% of the black populations have health insurance, only 72.9% of the Hispanic population does.

Disparities are also present for other health outcomes. There is tremendous geographic variation in the rate of asthma ED visits in Westchester County. While Westchester County has a rate of 62.5 per 10,000, below the rate for New York State overall (86.2) and the Prevention Agenda 2017 Target (75.1), certain areas have much elevated rates. Specifically, the asthma ED visit rate ranges from 99.2 per 10,000 in ZIP Code 10601 in White Plains, 241.8 per 10,000 population in ZIP Code 10550 in Mount Vernon, to 5.9 per 10,000 in parts of Rye. Rates are generally elevated in Mount Vernon, southern portions of New Rochelle, Yonkers, White Plains, Ossining, and Peekskill. Education and socioeconomic status are also important determinants of health status and outcomes. In Westchester County, adults with no college education are more likely to have diabetes than adults with at least some college education (13.9 vs 7.0% respectively).

There are disparities in other health outcomes, such as maternal and child health. There is considerable geographic variation in the proportion of births that are preterm, with 13.7% of births being preterm in White Plains compared to 8.4% in North Castle, the municipality with the lowest rate. Non-Hispanic black women are more likely to have a preterm births (15.7%), as compared to the non-Hispanic white (11.5%) and Hispanic women (12.0%).

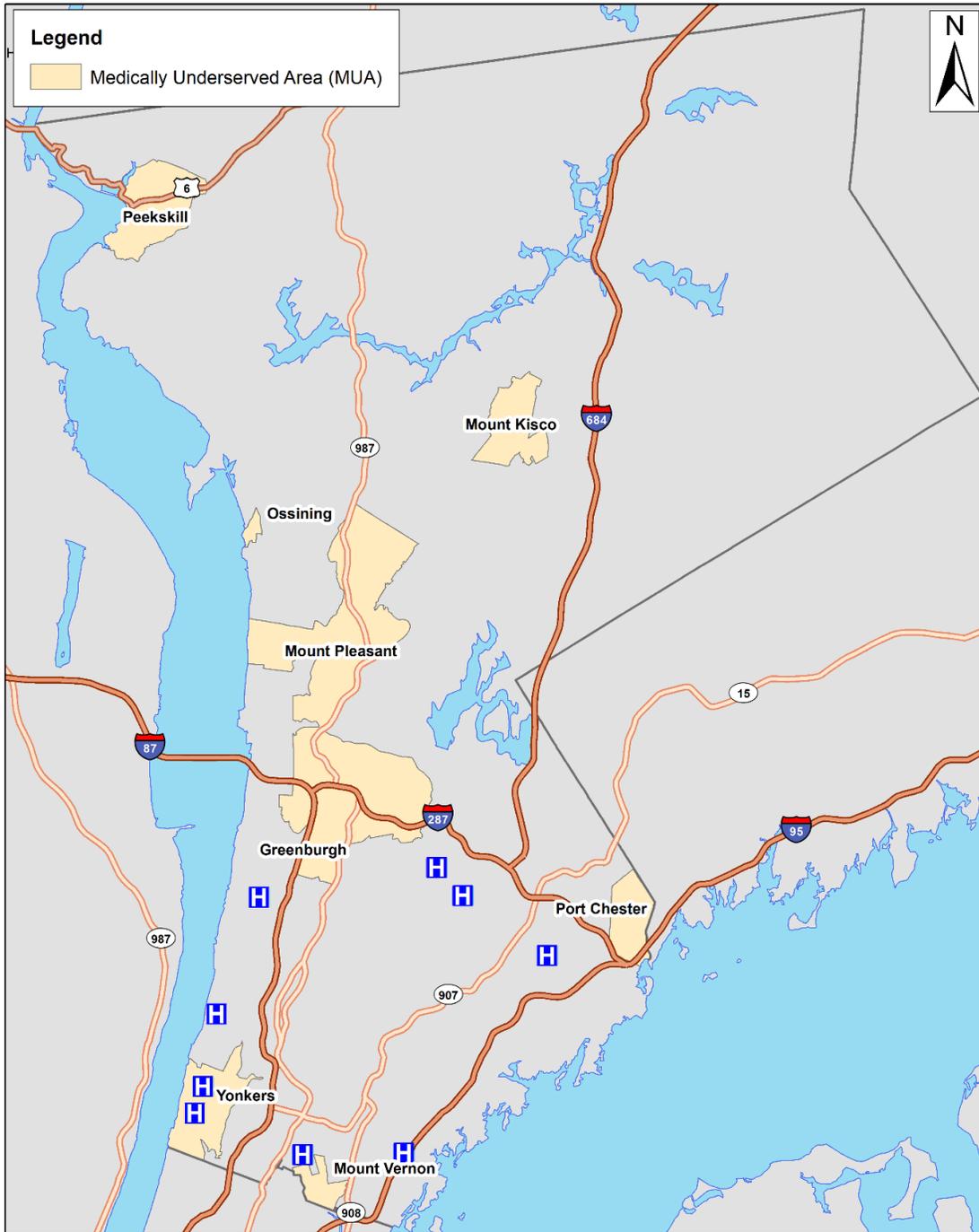
There are also disparities in the proportion of infants exclusively breastfed in the hospital. Less than half of infants are exclusively breastfed in the hospital in Westchester County, which is

below the proportion in New York State overall and the Prevention Agenda Target of 48.1%. There are also within-county geographic disparities. Specifically, proportions range from 20.5% and 28.4% in Rye and Yonkers respectively, to 83.2% in Peekskill. The proportion of infants breastfed exclusively in the hospital is lower in the southern portion of the county; 58.2% of infants are exclusively breastfed in the hospital in White Plains. Additionally, non-Hispanic white women are most likely to breastfeed exclusively in the hospital (58.6%), followed by Hispanic women (42%) and non-Hispanic black women (35.4%). There are further disparities by insurance status: 40.7% of infants whose primary payer is Medicaid were exclusively breastfed in the hospital, compared to 46.2% of infants whose primary payer is not Medicaid. Additional secondary health data is presented in Section 5.a.

3c. Medically Underserved Communities

Despite some challenges, the city of White Plains is not considered an underserved community by MUA/HPSA standards. However, the evidence of significant health disparity related to chronic disease indicates that there is an unmet need in the populations of the surrounding geographies of lower Westchester including Peekskill, Mount Kisco, Ossining, Greenburgh, Port Chester, Mount Pleasant, Yonkers and Mount Vernon, regions which are considered MUAs.

Figure 1: Medically Underserved Areas in Westchester County, NY



4. Assessment of Community Health Needs

4a. Description of Process and Methods

The process for preparing the 2019-2021 Community Health Needs Assessment was an interorganizational and community collaborative process, including the local Westchester County DOH, initiated with the goal of developing an assessment that was reflective of the needs of the community including the clinical and social determinants of health. Moreover, as the clinical service providers and social service organizations had been over sampled due to the near simultaneous compilation of reports and state/federal proposals during the period, novel collaborations with the local departments of health were engaged for the collection of primary data, while secondary data sources are noted in Section 4.a.i.

Primary Data Collection Process and Methods

In previous years, results from the CHA had been used as an important secondary data element. However, as the Westchester County Department of Health was engaging in a primary data collection survey process, the hospital systems of Westchester County collectively approached them to determine if it was possible to coordinate promotion, participation, referrals and engagement in electronic survey distribution process and to review the data collected collaboratively to be used as a portion of the primary data for the 2019-2021 Community Health Needs Assessment Process. An online survey was collaboratively developed and made available across the Westchester County, distributed by the Westchester County Department of Health, the Westchester County Executive's Office through www.westchestergov.com and the local Delivery System Reform Incentive Payment Program (DSRIP) Performing Provider System (PPS) providers over the winter and spring of 2019. During this process, Westchester County compiled feedback from over 3,500 responders and identified the community concerns by municipality to support CHNA and CSP efforts of hospitals for inclusion in their Implementation Plan Report.

4.a.i Data Sources & Analytic Notes

Multiple data sources were used to support the identification and selection of the priority items, which were identified, selected, and reviewed with partners.

Secondary Data Collection Process and Methods

A listing and brief summary of the data sources used to complete the secondary data analysis that were used to identify the issues of concern beyond experience and direct observation are listed below.

American Community Survey: The American Community Survey (ACS) replaced the Decennial Census as an ongoing survey of the United States population that is available at different geographic scales (e.g., national, state, county, census tract or census block group). ACS is a

continuous survey that addresses issues related to demographics, employment, housing, socioeconomic status, and health insurance. In the current report, data from ACS was used to identify community characteristics and evaluate the percent of families living in poverty and for mapping the percentage of adults with health insurance. For more information on ACS please visit <http://www.census.gov/programs-surveys/acs/about.html>.

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

New York State Cancer Registry: The New York State Cancer Registry was used to summarize data on new cases of breast cancer, and colorectal cancer. The Cancer Registry receives notice of all cancer diagnoses to NYS residents and classifies the cancers using established definitions. For more information on the New York State Cancer Registry please visit: <https://www.health.ny.gov/statistics/cancer/registry/>.

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

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

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

New York State Immunization Information System: The New York State Immunization Information System (NYSIIS) provides data on immunizations for all residents <19y at the county-level in the state, excluding NYC. Healthcare providers are required by law to report all

immunizations for this population to NYSIIS. This data was used to estimate the immunization status of children between 19-35 months. For more information please visit https://www.health.ny.gov/prevention/immunization/information_system/

NYS HIV Surveillance System: The NYS HIV Surveillance System, run by the AIDS Institute Bureau of HIV/AIDS Epidemiology in the New York State Department of Health, provides data on new HIV/AIDS diagnoses and other factors relating to HIV/AIDS, such as linkage to care. This report uses data on HIV incidence from this source. For more information please visit: <https://www.health.ny.gov/diseases/aids/general/about/surveillance.htm>.

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

New York State Vital Records Data: The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report, vital records data were used to examine the proportion of preterm births, proportion of infants exclusively breastfed in the hospital, the adolescent pregnancy rate, the suicide rate, and the opioid burden rate. For more information on the New York State Vital Records please visit: https://www.health.ny.gov/statistics/vital_statistics/

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

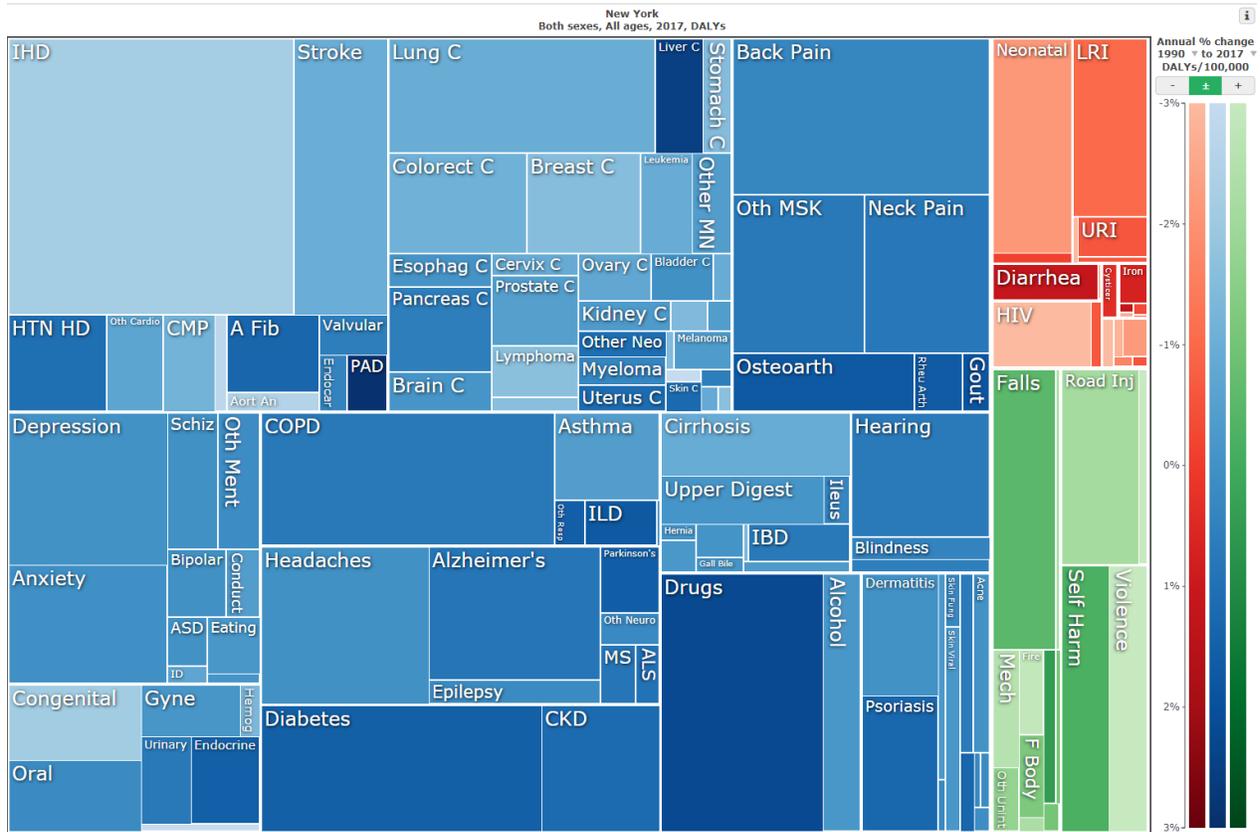
Data Tools

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

to improve population health. Data are available at: <https://vizhub.healthdata.org/gbd-compare/>

New York State Prevention Agenda Dashboard: An additional resource for data was the New York State Prevention Agenda Dashboard, which was produced by the New York State Department of Health and systematically aggregates data for the entire state and for each county for dozens of health indicators that align with the New York State Prevention Agenda. Like the Community Health Profiles, the Prevention Agenda Dashboard is not a single database, but rather a compilation of diverse databases. For more information please see: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Figure 2. Leading causes of disability adjusted life years in New York State, 2017

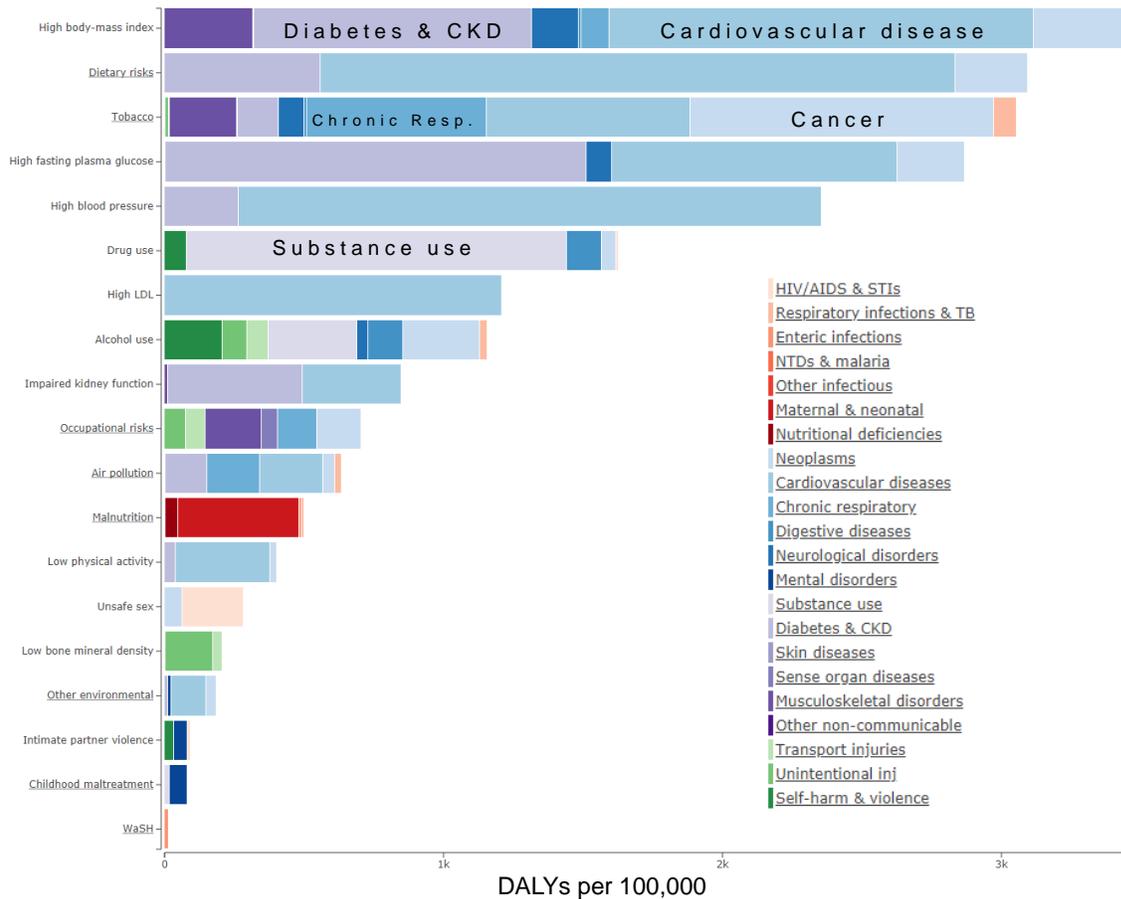


Data source: 2017 Global Burden of Disease Project.

The leading causes of ill health in New York State as measured by disability adjusted life years are ischemic heart disease (8.8%), drug use disorders (4.7%), low back pain (4.5%), chronic obstructive pulmonary disease (4.4%) and diabetes mellitus.

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

Figure 3. Distribution of disability adjusted life years by risk factor in New York State, 2017.



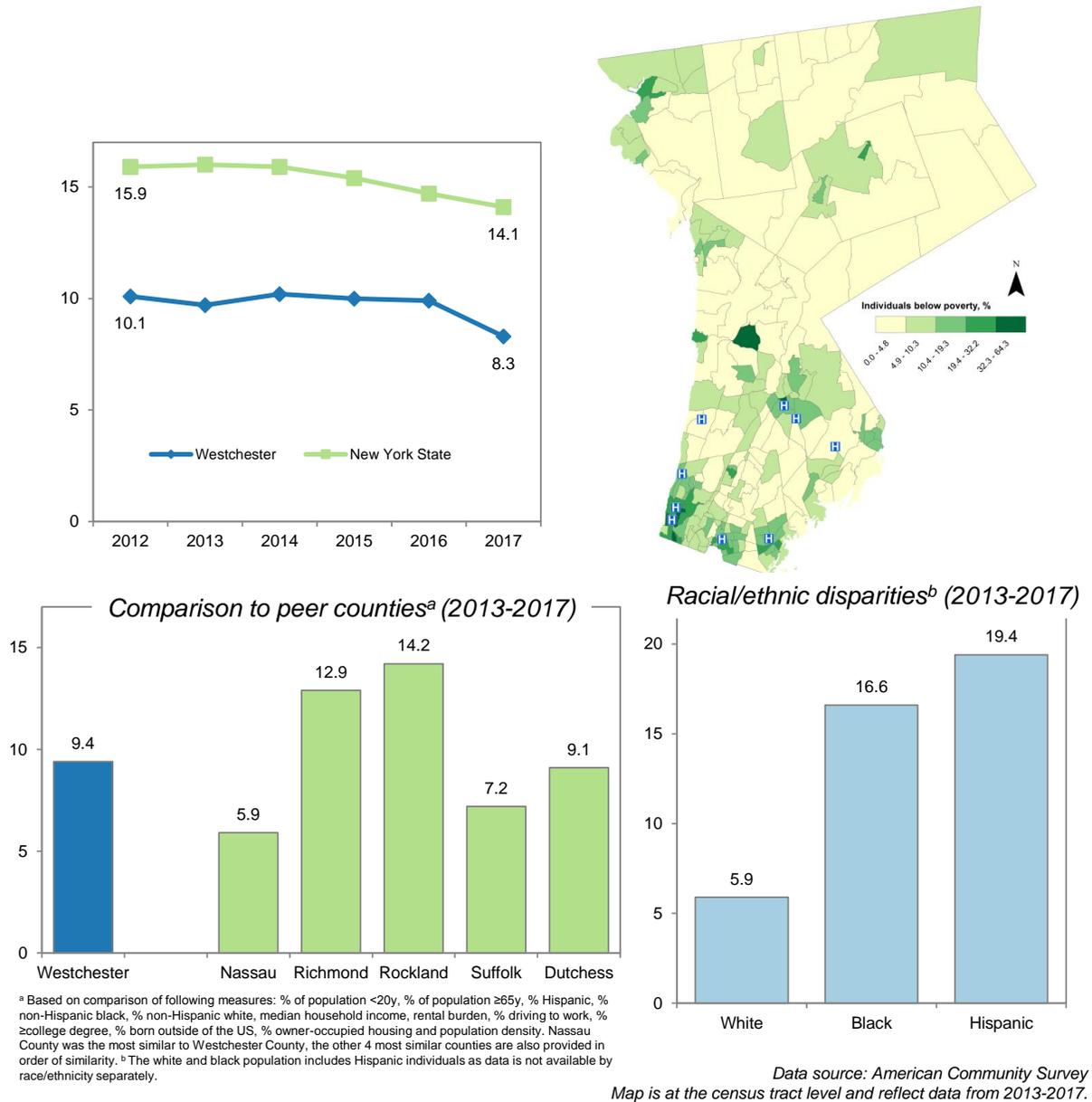
Data source: 2017 Global Burden of Disease Project

In New York State, the finest level of geographic data from the Global Burden of Disease project, elevated body mass index (BMI) is responsible for the highest proportion of disability adjusted life years (a summary measure combining fatal and non-fatal health status). Elevated BMI is responsible for excess ill health via its association with cardiovascular disease, diabetes, and some cancers.

Dietary risks are the second leading contributor to ill health, due to associations with cardiovascular disease, diabetes and some cancers. Within dietary risks (data not shown), low whole grains, high sodium, low nuts and seeds and low fruit are the leading causes of ill health. Tobacco is the third leading causes of ill health, with strong associations with many cancers, cardiovascular disease and chronic respiratory disease.

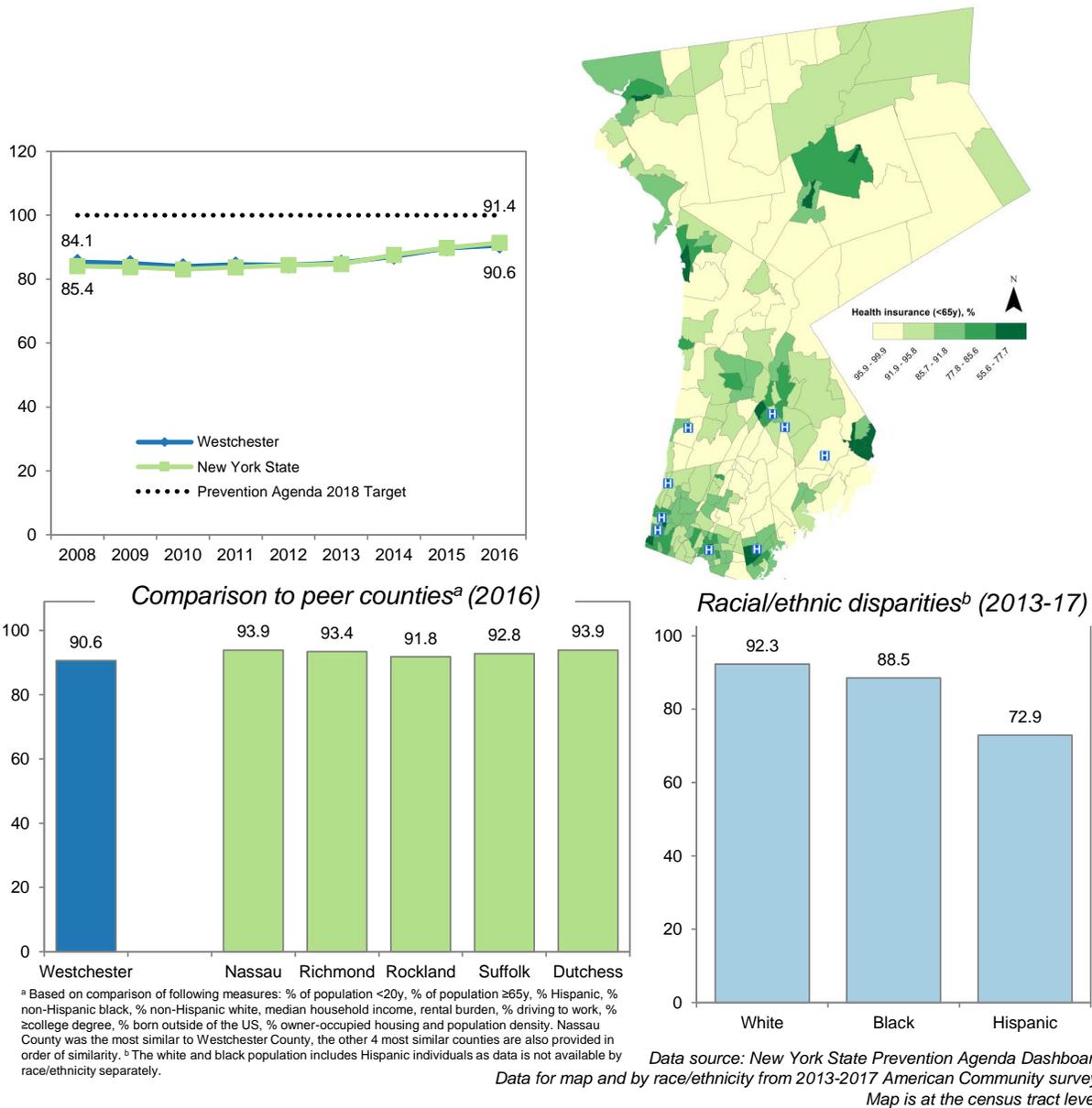
High fasting plasma glucose and high blood pressure are also leading causes of ill health. In New York State, in 2017, drug use is the sixth leading cause of disability.

Figure 4: Individuals Below Poverty, %



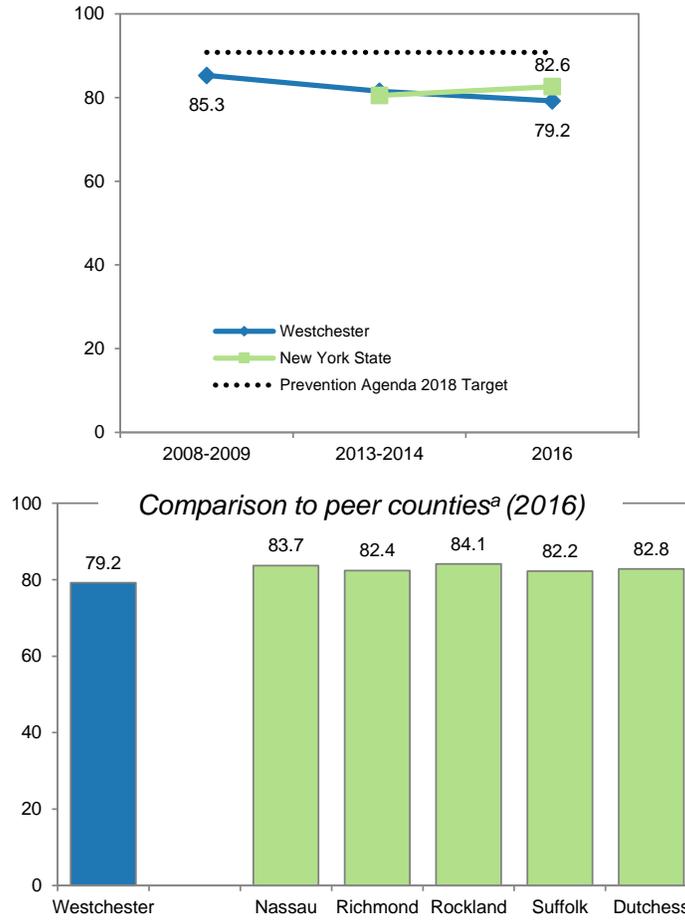
- A smaller proportion of individuals live in poverty in Westchester County compared with New York State overall (8.3 vs. 14.1%, respectively).
- Those who are black and Hispanic are more likely to be living in poverty in Westchester County than those who are white.

Figure 5: Individuals with health insurance (<65y), %



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

Figure 6: Adults (ages 18-64) with health insurance, %

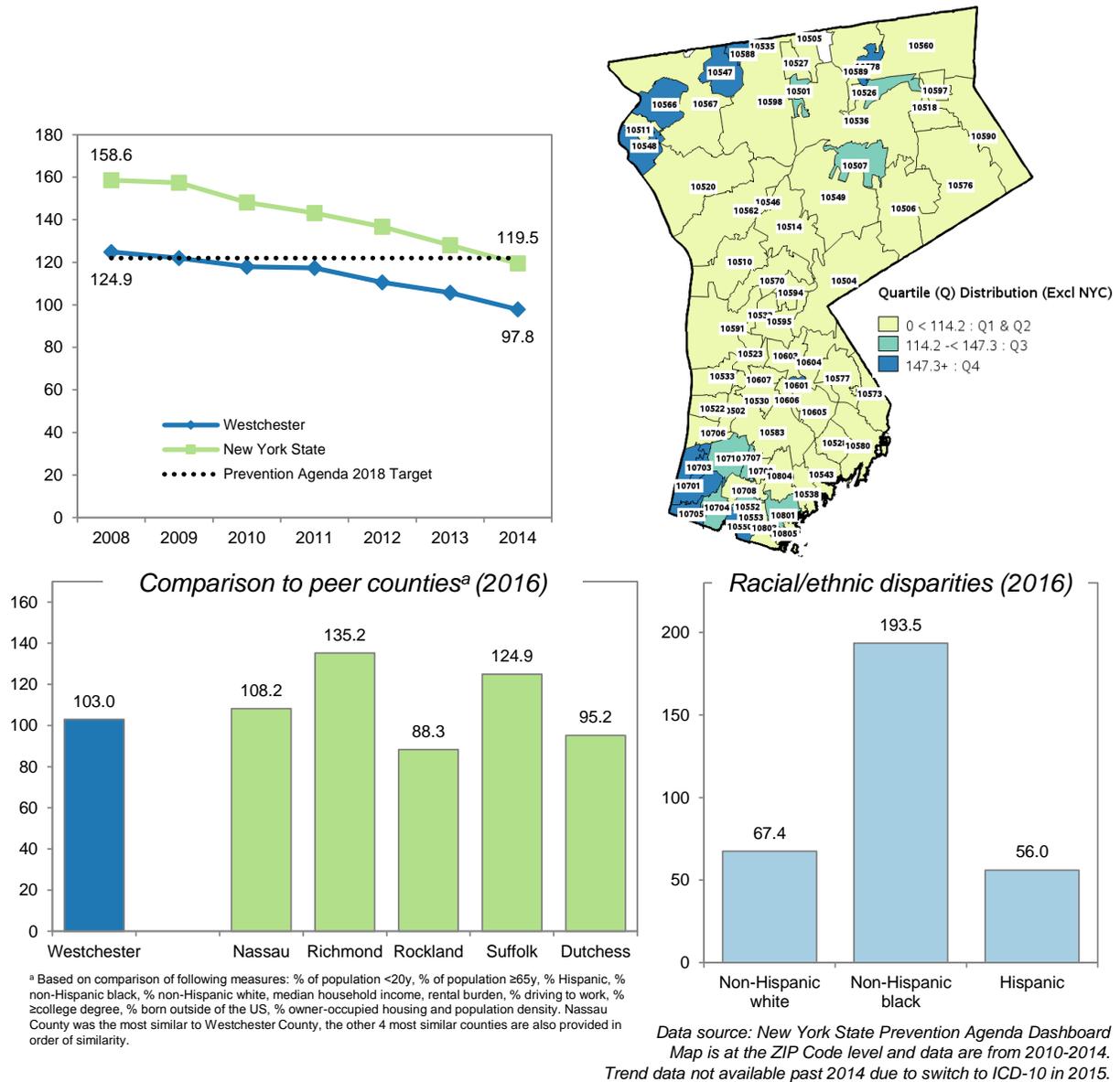


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

Data source: New York State Prevention Agenda Dashboard

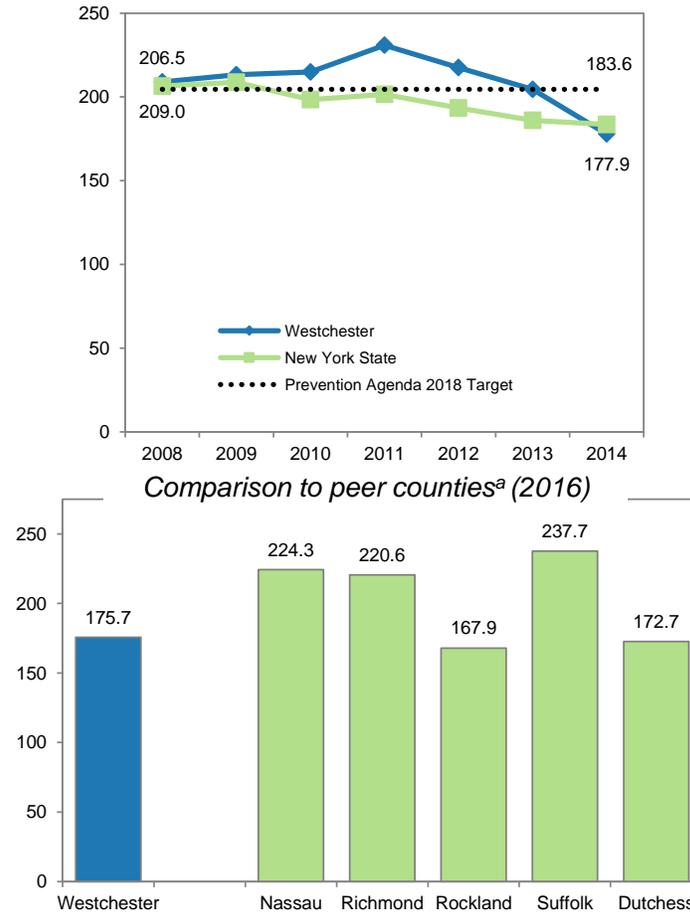
- In Westchester County, the percentage of adults with a regular healthcare provider declined from 85.3% in 2008/2009 to 79.2% in 2016.
- In comparison to its peer counties, Westchester has the lowest percentage of adults with a regular health care provider (79.2%).

Figure 7: Age-adjusted preventable hospitalization rate per 10,000 (adults age≥18y)



- The age-adjusted preventable hospitalization rate for adults has declined in both Westchester County and New York State and remains lower in Westchester County.
- The age-adjusted preventable hospitalization rate is much higher for non-Hispanic black adults (193.5 per 10,000) than non-Hispanic white and Hispanic adults (67.4 per 10,000 and 56.0 per 10,000, respectively).

Figure 8: Rate of hospitalizations due to falls per 10,000 (adults ≥65y)

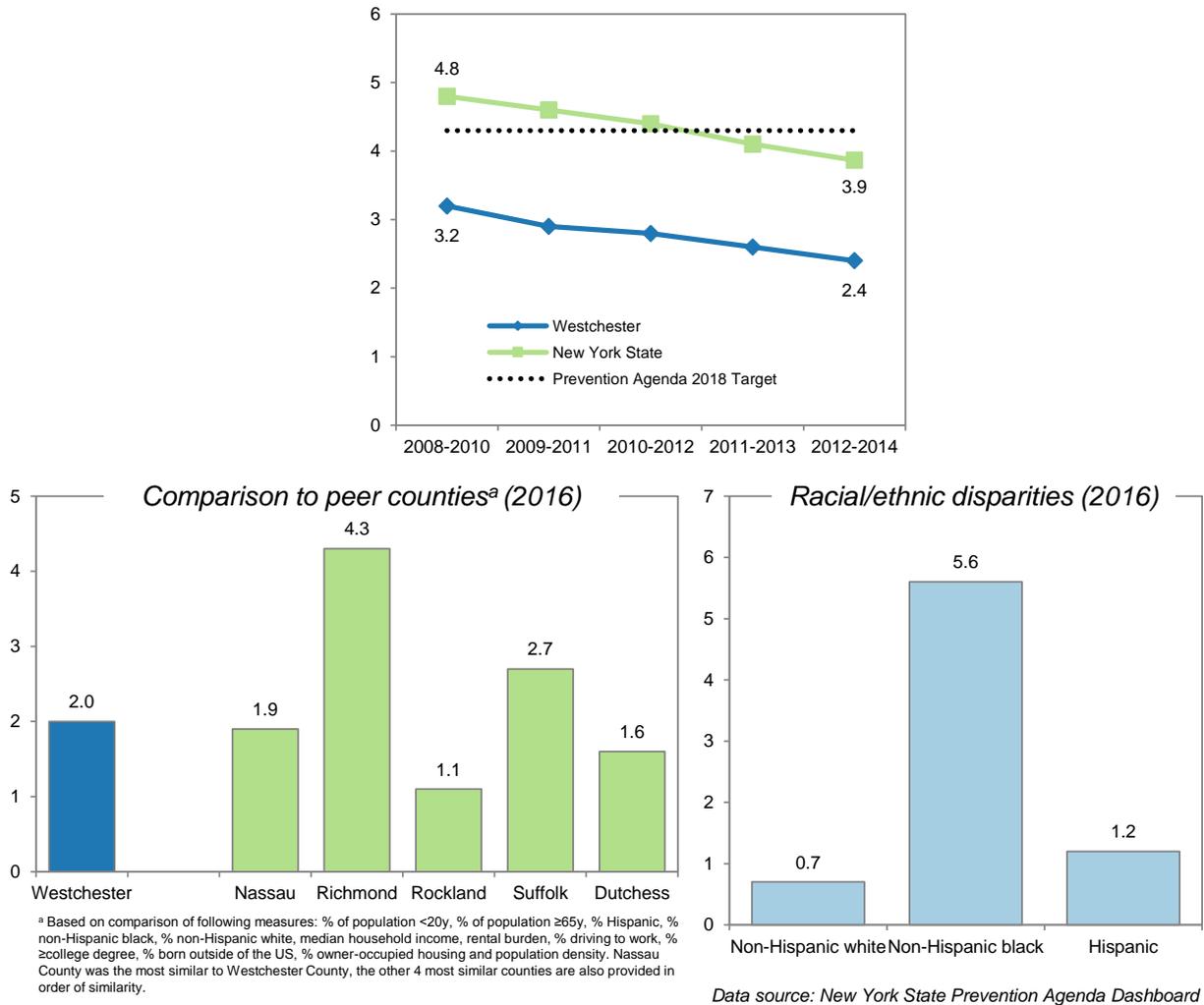


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

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

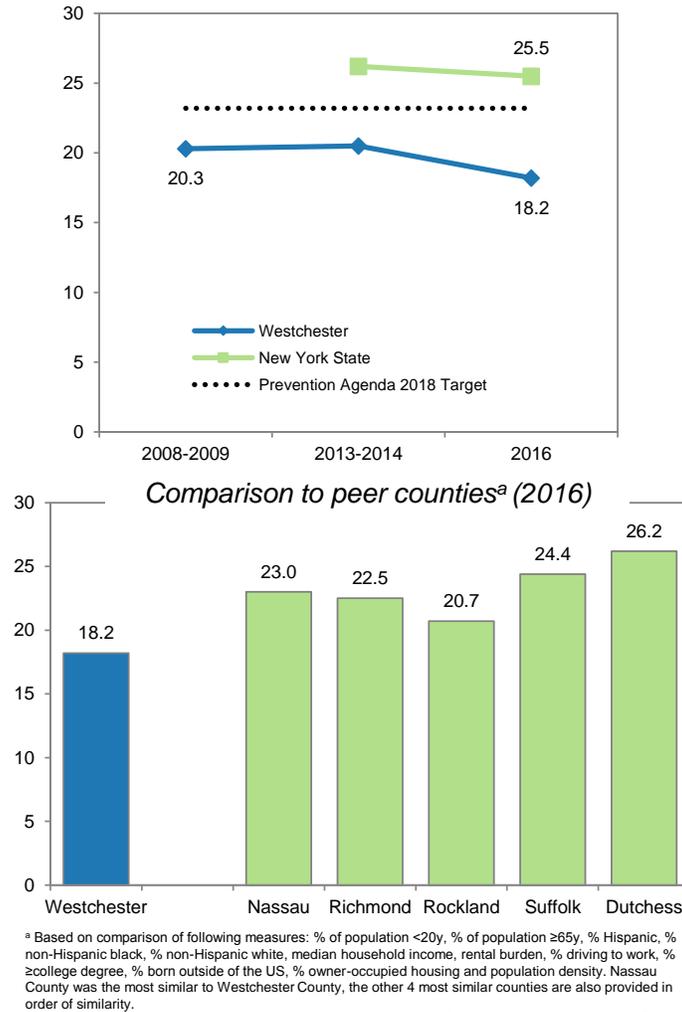
- In Westchester County and New York State overall, the fall hospitalization rate for those ≥65y is declining and is below the Prevention Agenda Target.
- In comparison to peer counties, Westchester County has a similar rate of fall hospitalizations for those ≥65y to Rockland and Dutchess counties.

Figure 9: Assault-related hospitalizations per 10,000



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

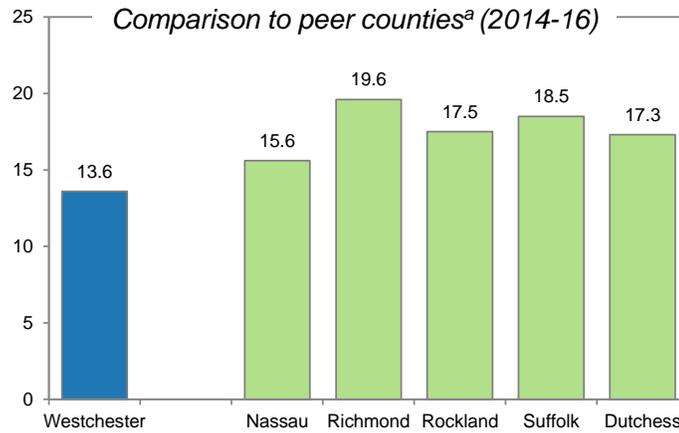
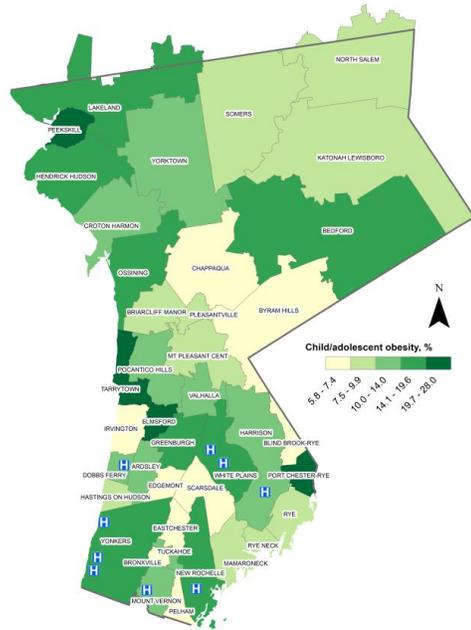
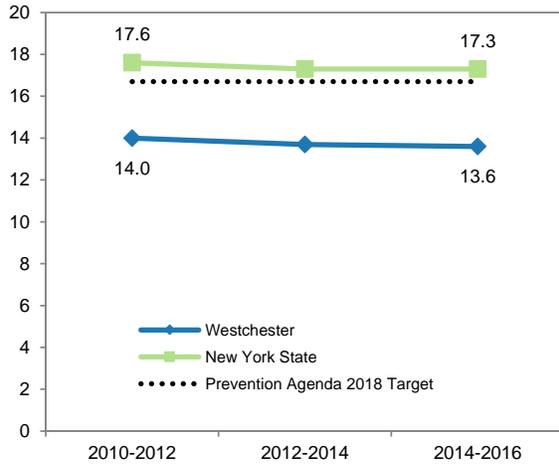
Figure 10: Adult obesity (BMI≥30), %



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

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

Figure 11: Percentage of children/adolescents who are obese

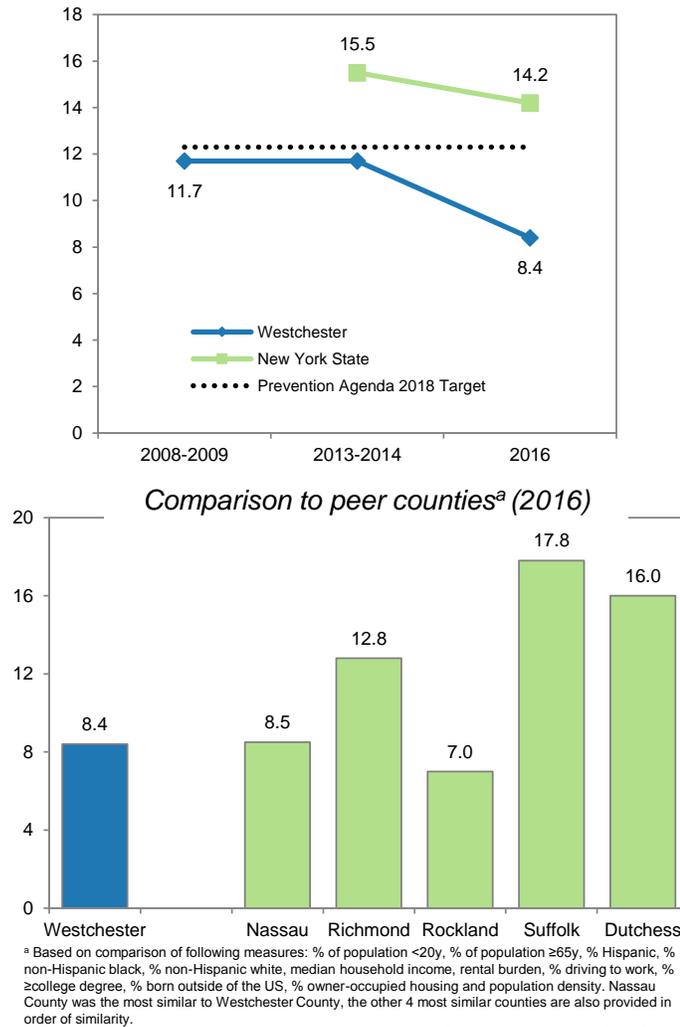


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

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

- A smaller proportion (13.6%) of children/adolescents are obese in Westchester county than in New York State overall (17.3%) and peer counties.
- Peekskill, Tarrytown, Elmsford and Port Chester-Rye school districts have the highest prevalence of child/adolescent obesity in Westchester County.

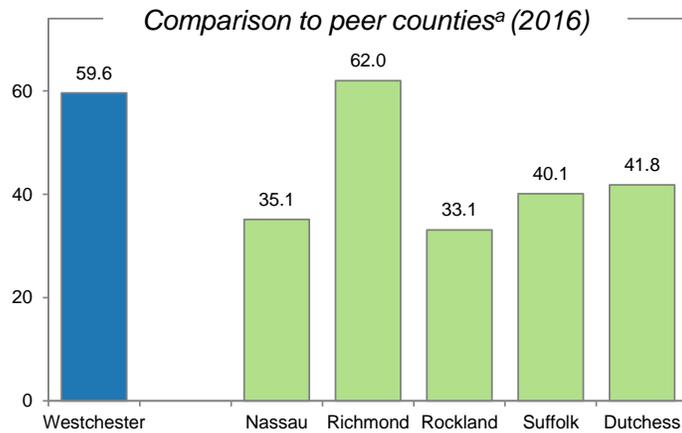
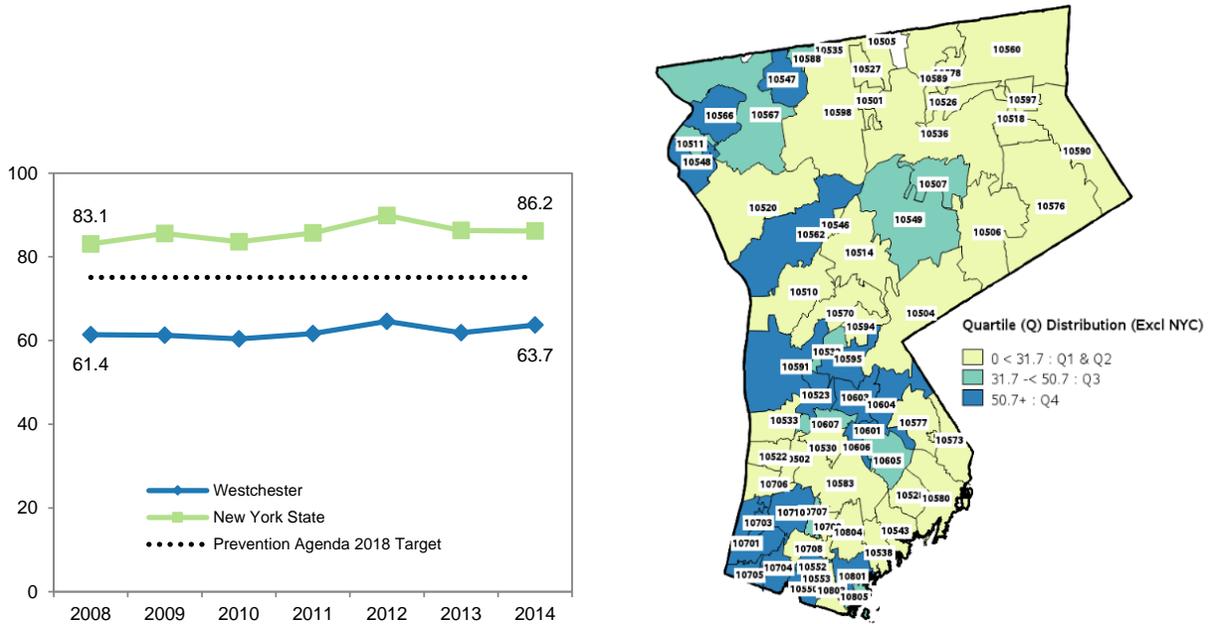
Figure 12: Adult cigarette smoking, %



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

- Between 2013/2014 and 2016, the proportion of adults that smoke cigarettes in Westchester County declined from 11.7% to 8.4%, remaining lower than in New York State overall.
- The prevalence of adult cigarette smoking is second lowest in Westchester County, just after Rockland County, compared to peer counties.

Figure 13: Asthma ED visit rate per 10,000

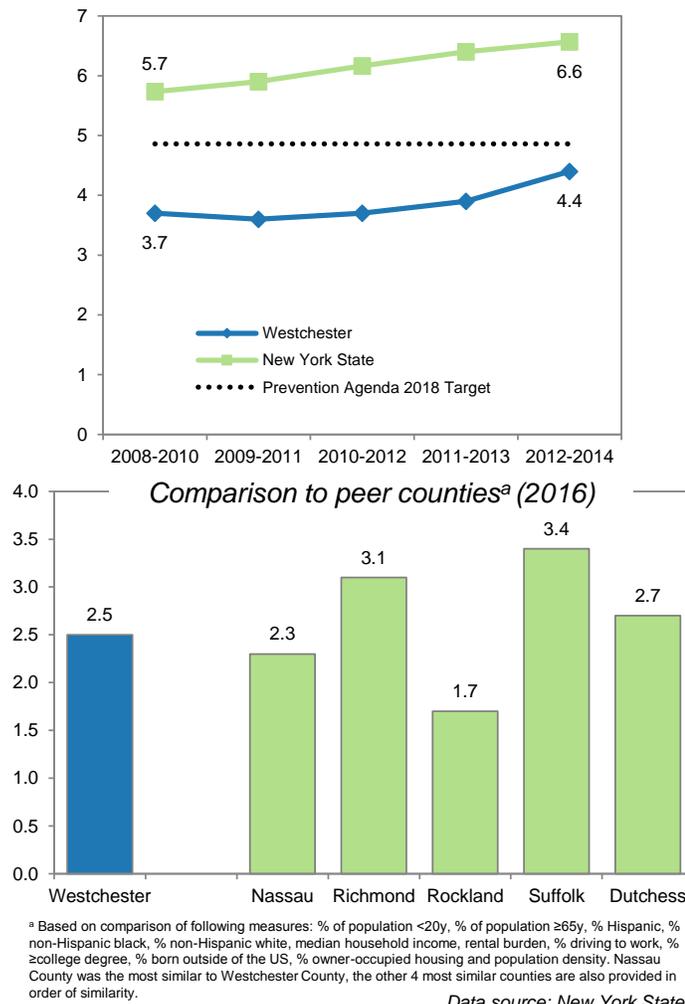


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

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

- As of 2014, the asthma ED visit rate was lower in Westchester County than in New York State overall (63.7 vs. 86.2 per 10,000) and was below the Prevention Agenda Target.
- However, Westchester County had the second highest Asthma ED visit rate when compared to its peer counties in 2016

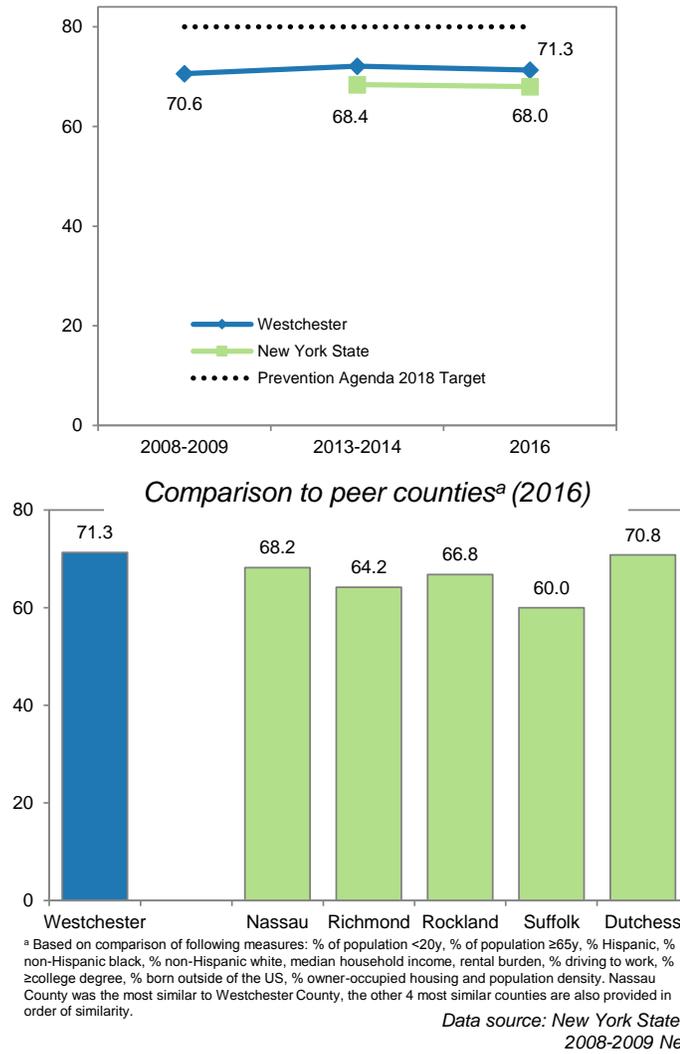
Figure 14: Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years



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

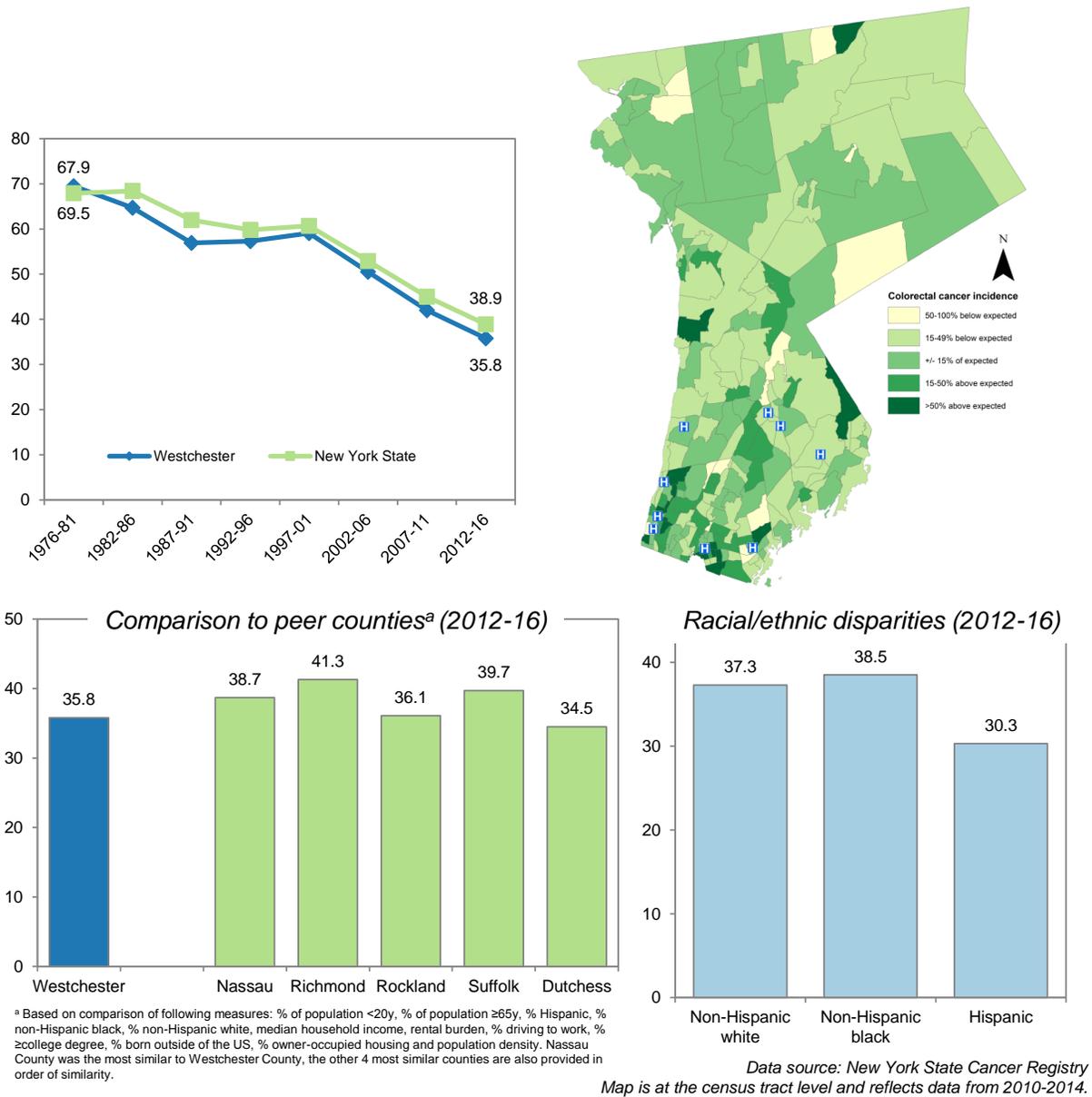
- Between 2008/2010 and 2012/2014, the adult hospitalization rate for short-term complications of diabetes increased slightly from 3.7 to 4.4 per 10,000 in Westchester County, although it remained lower than in New York State overall and the Prevention Agenda 2018 Target.
- In 2016, Westchester County had a similar adult hospitalization rate for short-term complications of diabetes when compared to 5 peer counties.

Figure 15: Adults receiving colorectal cancer screening (age 50-75y), %



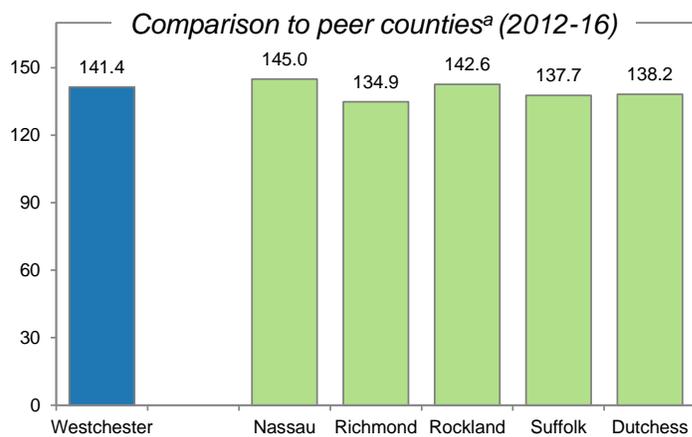
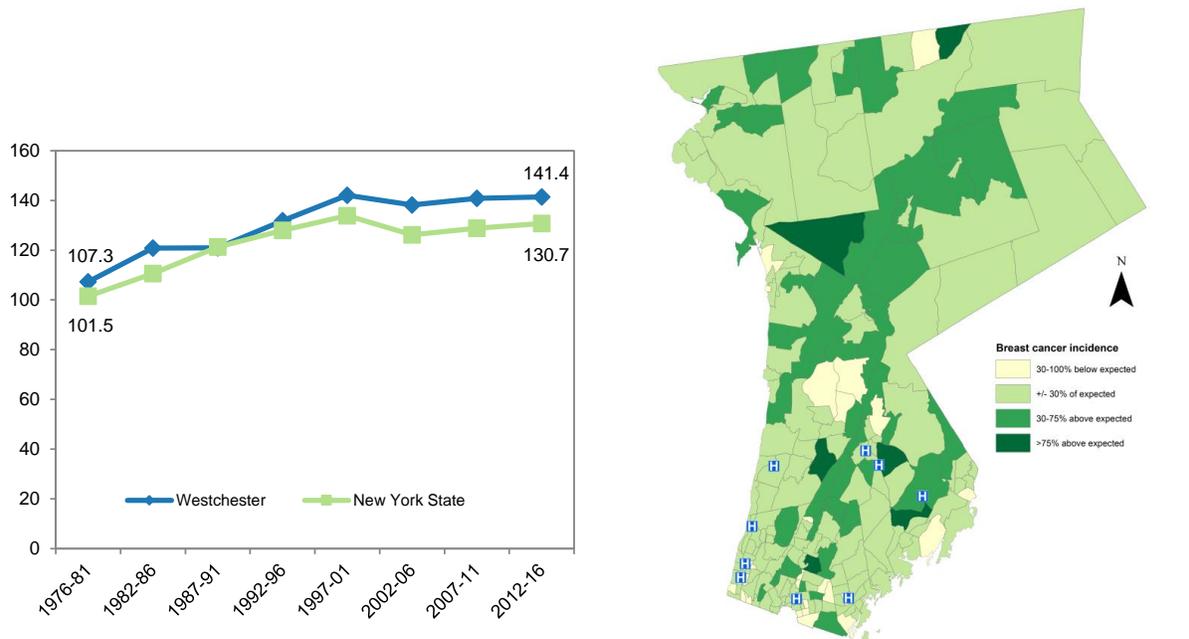
- A larger proportion of adults (ages 50-75y) received a colorectal cancer screening in Westchester County than New York State overall in 2016 (71.3% vs. 68.0%), although both remain below the Prevention Agenda 2018 Target.
- Westchester County has the largest proportion of adults (ages 50-75y) receiving a colorectal cancer screening compared to its peer counties.

Figure 16: Age-adjusted colorectal cancer incidence per 100,000

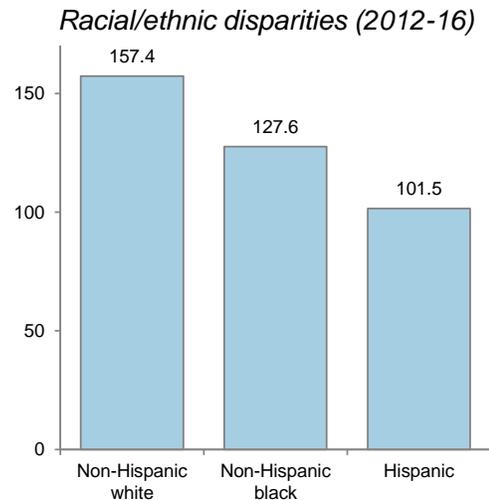


- In Westchester County, the incidence of age-adjusted colorectal cancer has declined over the past few decades and remains slightly below the incidence rate for New York State overall.
- In Westchester County, the colorectal cancer incidence rate for Hispanic residents (30.3 per 100,000) is lower than that for non-Hispanic black residents (38.5 per 100,000) and non-Hispanic white (37.3 per 100,000) residents.

Figure 17: Age-adjusted breast cancer incidence per 100,000 women



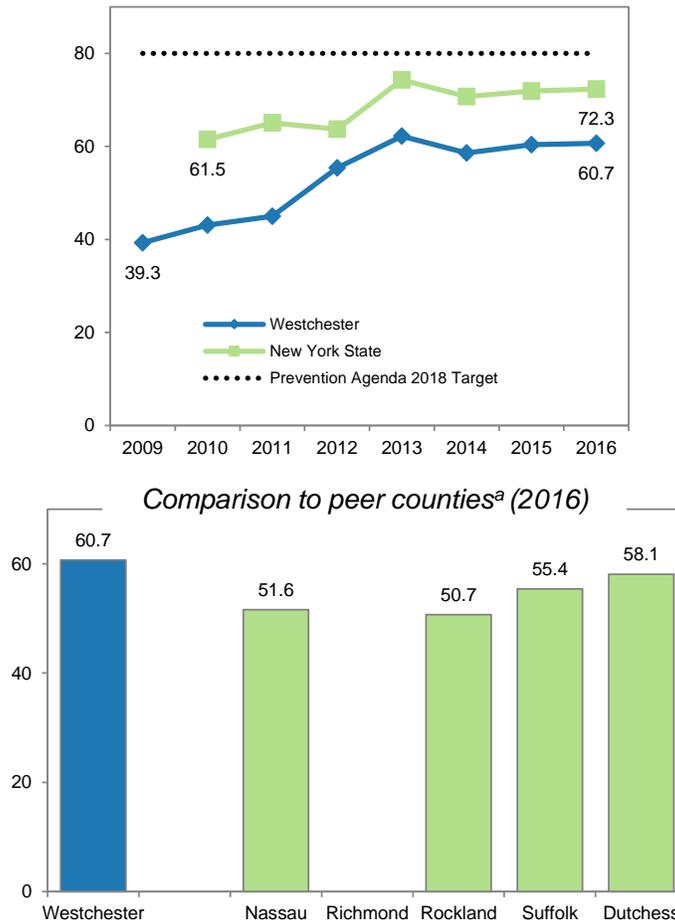
^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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



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

- The age-adjusted female breast cancer incidence rate has increased in Westchester County over the past few decades and remains above the rate for New York State overall.
- The age-adjusted female breast cancer incidence rate is highest for non-Hispanic white residents (157.4 per 100,000 women), compared with non-Hispanic black residents (127.6 per 100,000) and Hispanic residents (101.5 per 100,000).

Figure 18: Children (ages 19-35 mos) with 4:3:1:3:3:1:4 immunization series, %

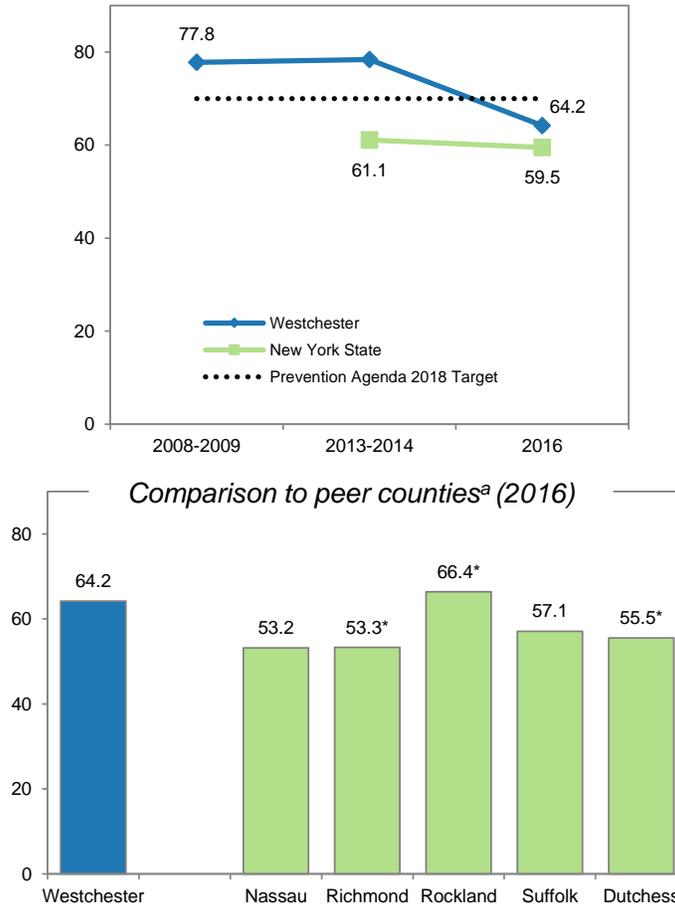


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

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

- Despite an upward trend over the past decade, a smaller proportion of children, ages 19-35 months, have received their full immunizations in Westchester County than in New York State overall (60.7 vs. 72.3% respectively).
- A larger proportion of children ages 19 to 35 months receive their full immunizations in Westchester County than in peer counties.

Figure 19: Adults (≥ 65y) with flu immunization, %

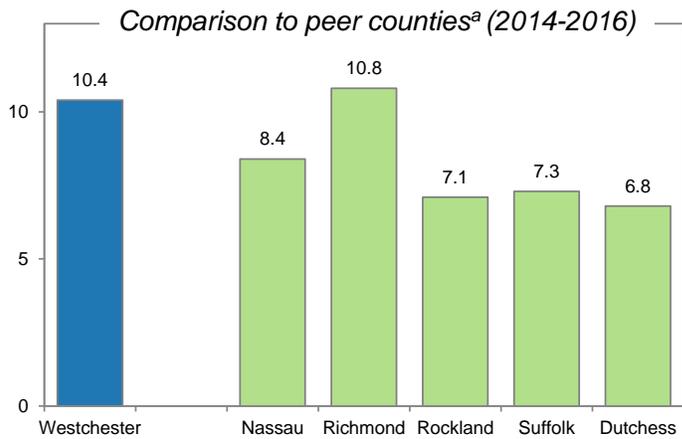
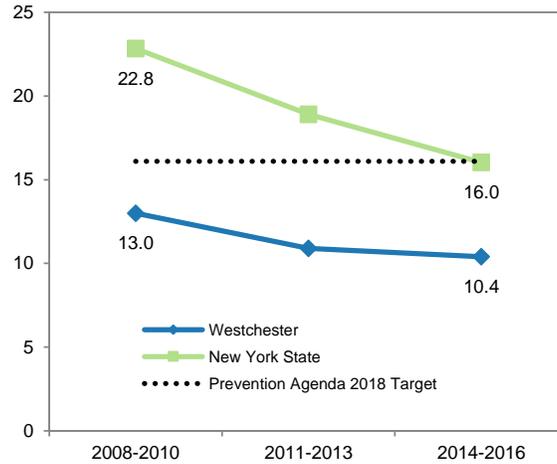


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

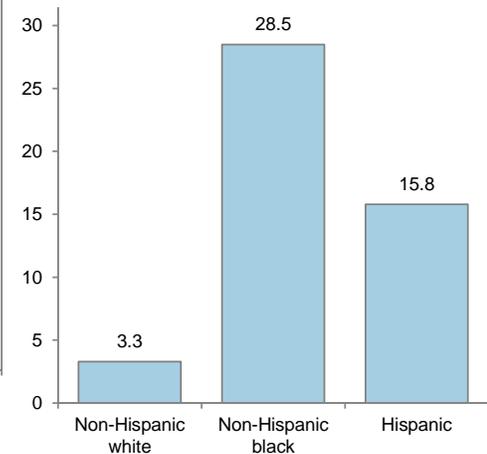
Data source: New York State Prevention Agenda Dashboard
* Indicates unreliable estimate; interpret with caution

- In Westchester County, the proportion of adults ages ≥65y who received their flu immunization declined from 77.8% in 2008/2009 to 64.2% in 2016, although it remains higher than in New York State overall (59.5%).
- Compared to peer counties, Westchester County tends to have a higher proportion of adults ≥65y who received their flu immunization in 2016.

Figure 20: Newly diagnosed HIV case rate per 100,000 population



Racial/ethnic disparities (2014-2016)

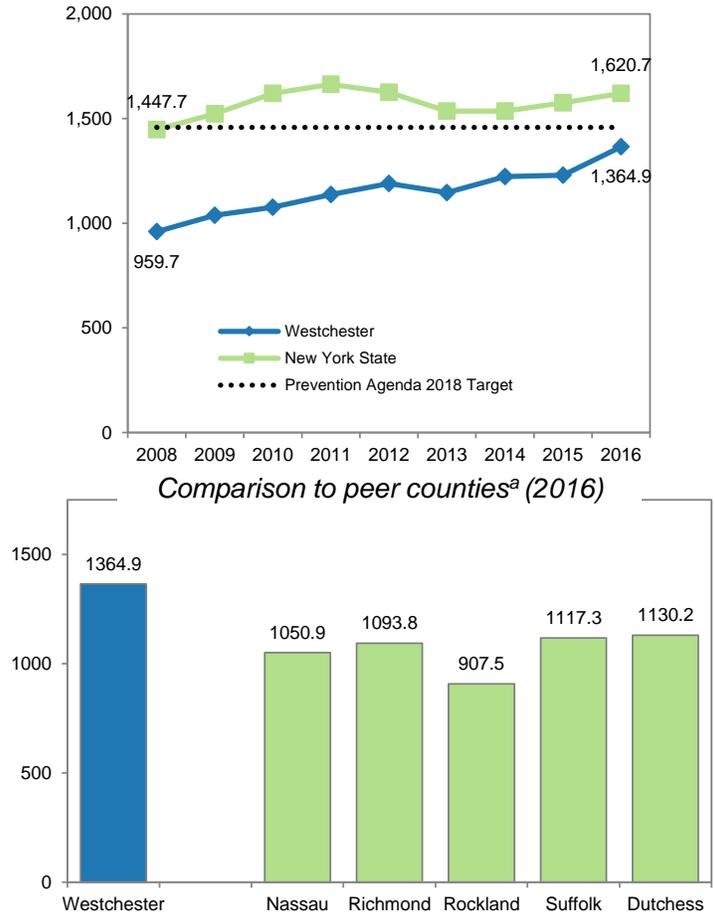


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

Data source: New York State Prevention Agenda Dashboard

- The HIV incidence rate is lower in Westchester County (10.4 per 100,000) than in New York State overall (16.0 per 100,000) and is below the Prevention Agenda Target (16.1 per 100,000), although it remains second highest among peer counties, only second to Richmond County.
- The incidence of HIV for the non-Hispanic black population and the Hispanic population were about 8.6 and 4.8 times higher than the incidence rate for the non-Hispanic white population, respectively.

Figure 21: Chlamydia rate per 100,000 women (ages 15-44y)

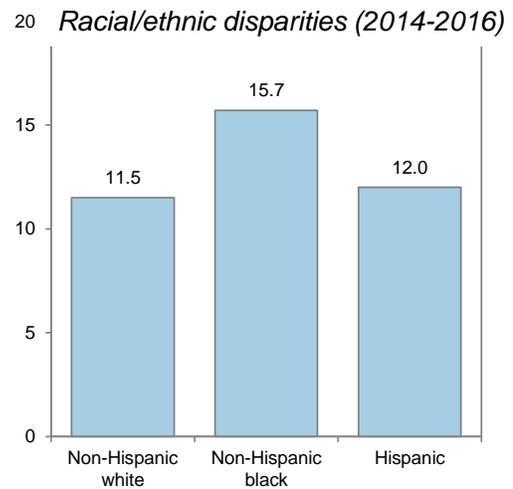
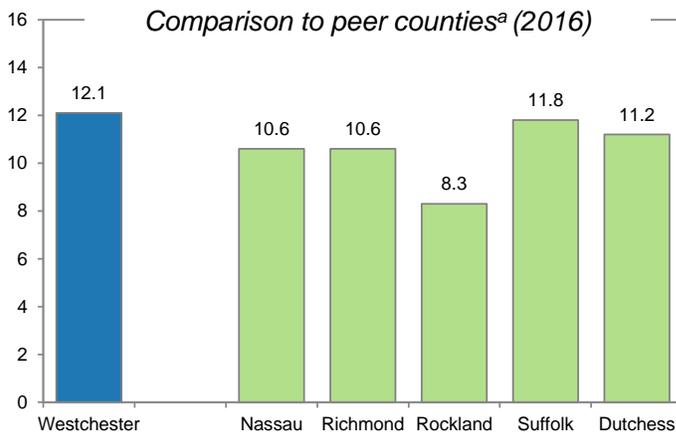
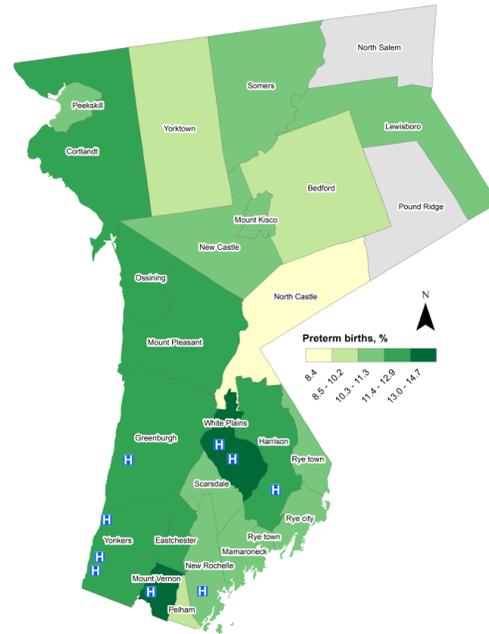
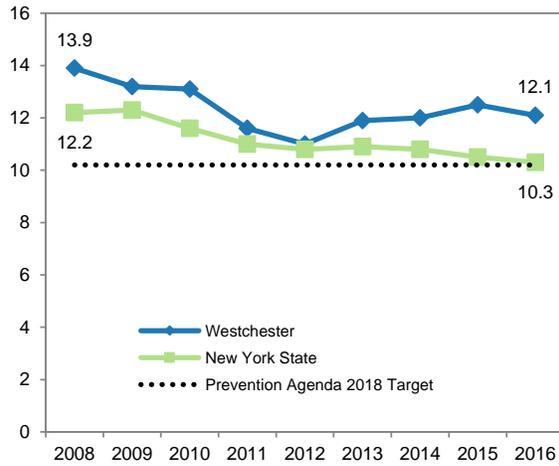


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

Data source: New York State Prevention Agenda Dashboard

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

Figure 22: Preterm births, %

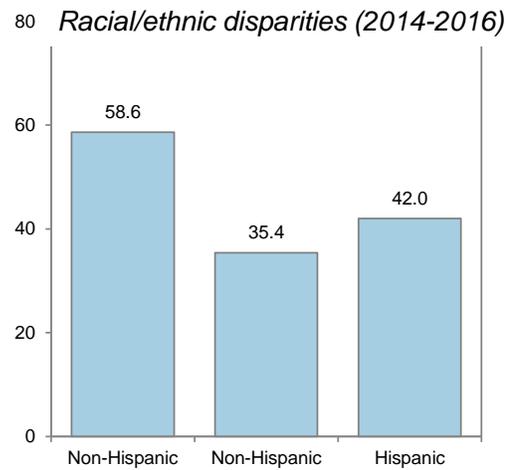
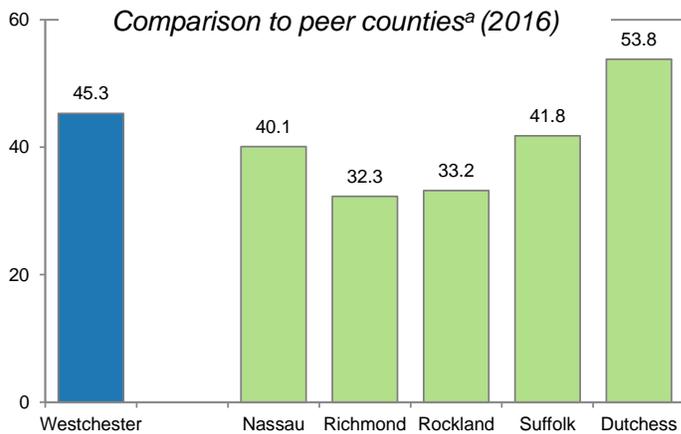
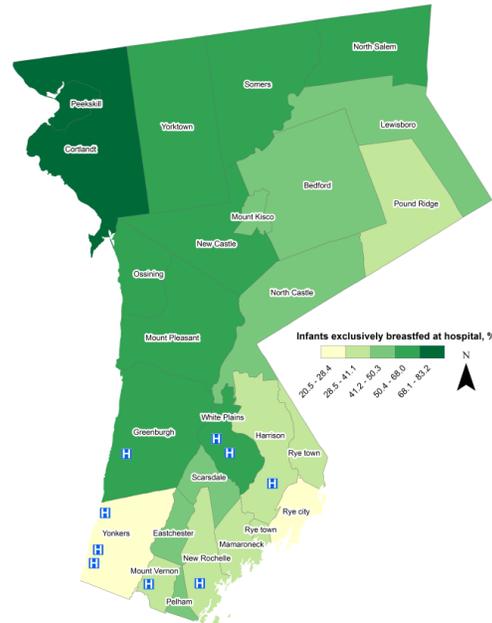
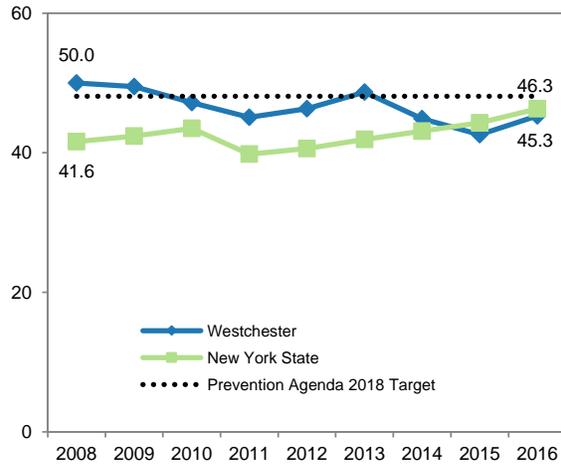


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

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

- The percent of births that are preterm is higher in Westchester County (12.1%) than in New York State overall (10.3%), the Prevention Agenda 2018 Target (10.2%) and its peer counties.
- The percent of births that are preterm is higher amongst the non-Hispanic black population (15.7%) than the non-Hispanic white (11.5%) and Hispanic populations (12.0%).

Figure 23: Infants exclusively breastfed in the hospital, %

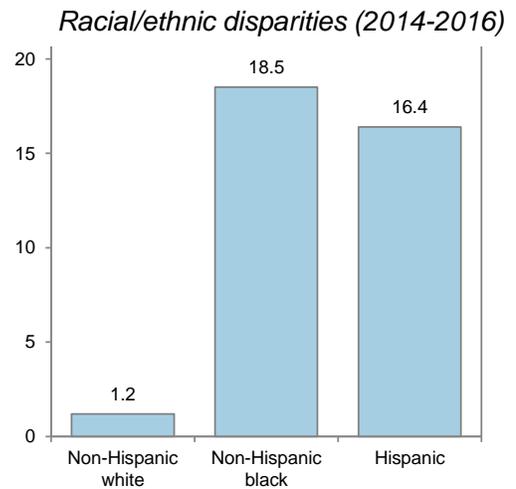
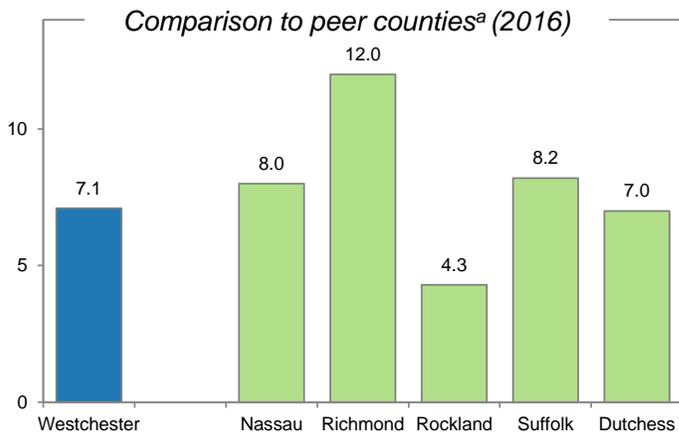
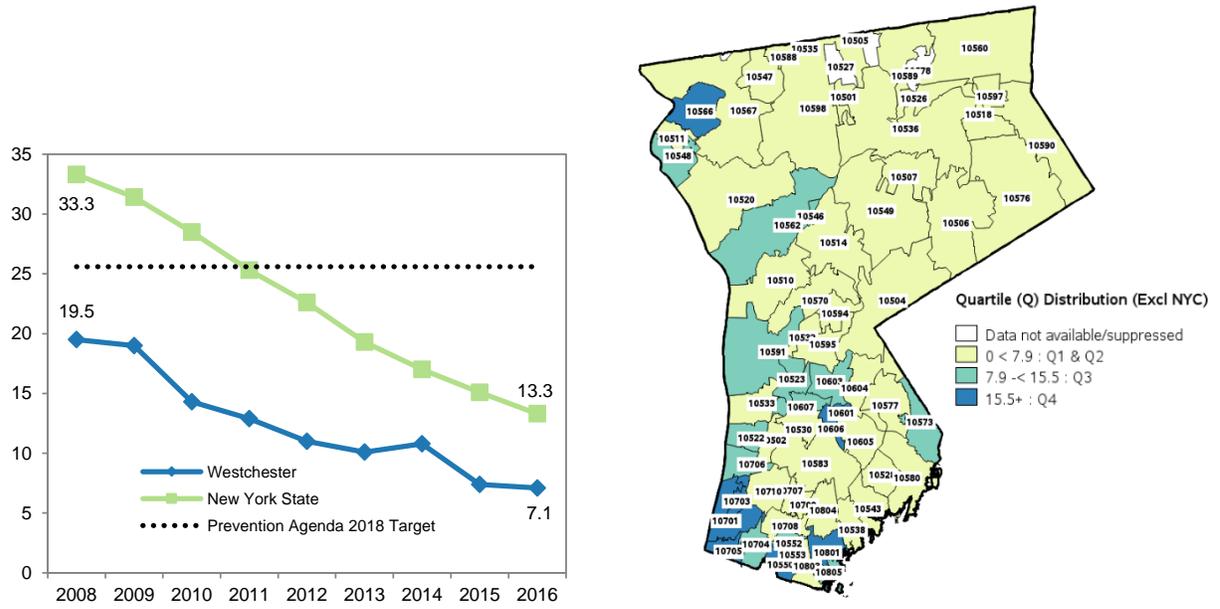


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

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

- In Westchester County, the proportion of infants exclusively breastfed in the hospital (45.3%) has slightly decreased over the last decade, although it remains the second highest when compared to five peer counties.
- The proportion of infants that are exclusively breastfed in the hospital is highest for non-Hispanic white populations (58.6%), followed by Hispanic (42.0%) and non-Hispanic black populations (35.4%).

Figure 24: Adolescent pregnancy rate per 1,000 females (aged 15-17y)

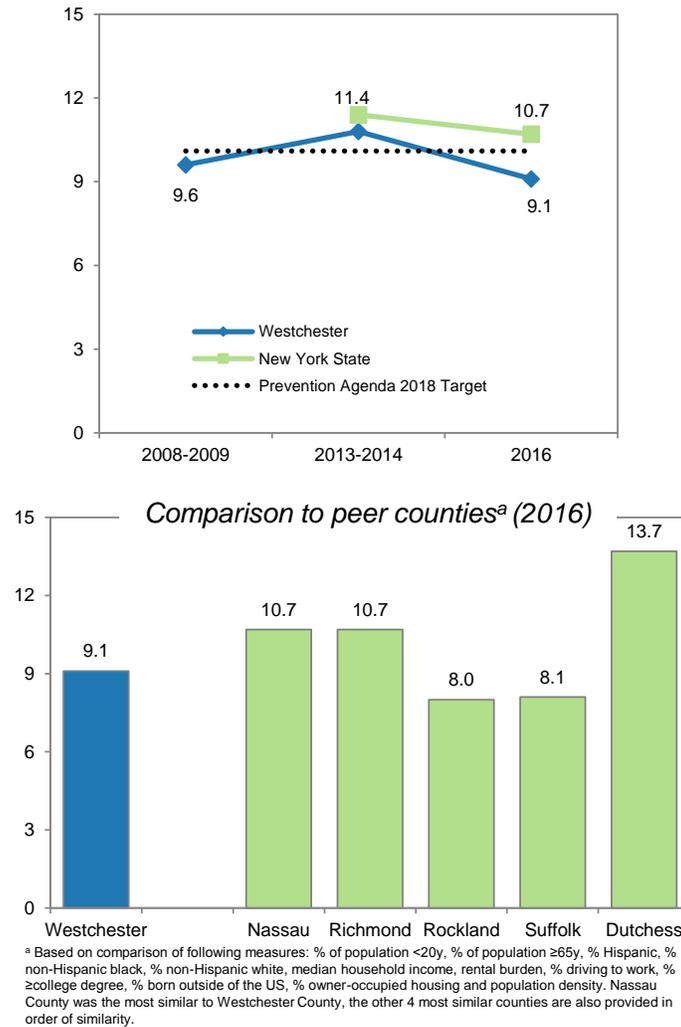


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

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

- In Westchester County between 2008 and 2016, the adolescent pregnancy rate declined from 19.5 to 7.1 pregnancies per 1,000 female adolescents and remains lower than in New York State overall.
- The adolescent pregnancy rate is significantly higher for non-Hispanic black (18.5 per 1,000) and Hispanic (16.4 per 1,000) adolescents than non-Hispanic white adolescents (1.2 per 1,000).

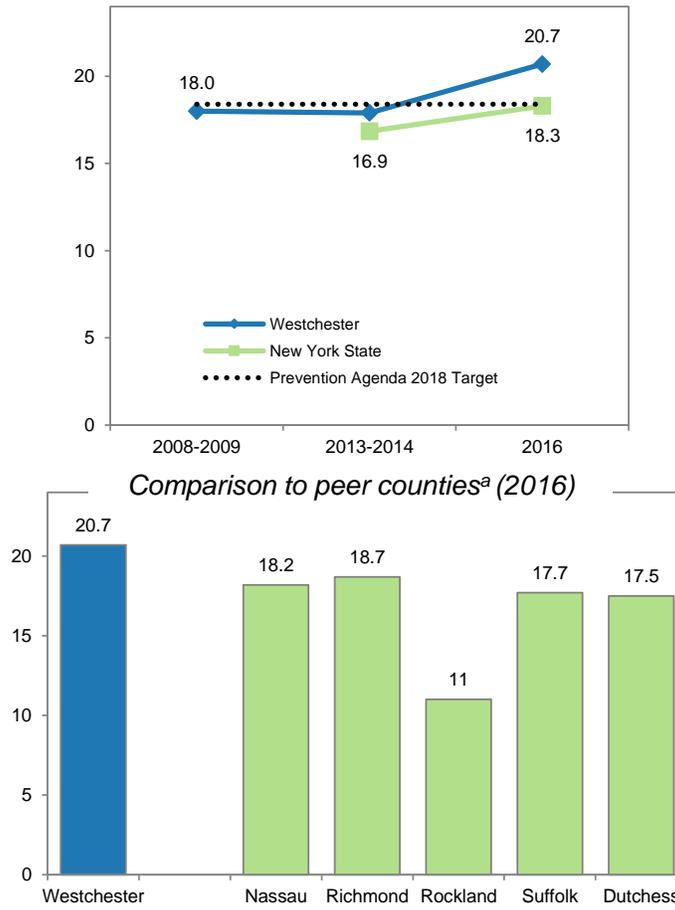
Figure 25: Adults with poor mental health for ≥ 14 days in the last month, %



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

- A smaller proportion of adults report having poor mental health for at least half of the past month in Westchester County (9.1%) than in New York State overall (10.7%), remaining below the Prevention Agenda 2018 Target.
- Westchester County has the third lowest proportion of adults reporting having poor mental health for at least half of the past month when compared to its five peer counties.

Figure 26: Adults binge drinking during past month, age-adjusted %

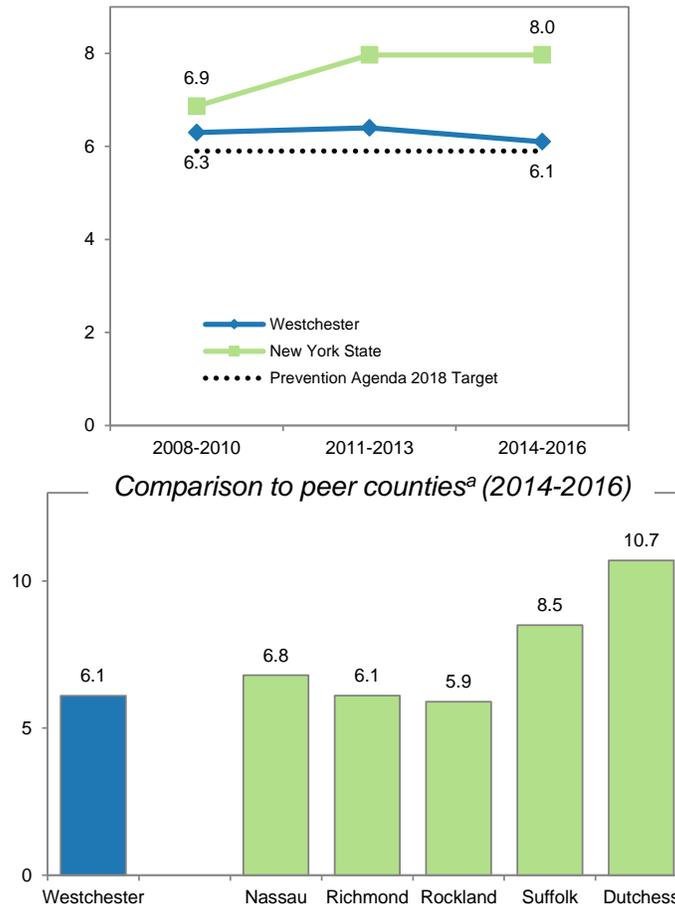


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

Data source: New York State Prevention Agenda Dashboard

- Between 2013/2014 and 2016, the percent of adults binge drinking in the past month increased from 18.4% to 20.7% in Westchester County, remaining higher than in New York State overall.
- Westchester County has the largest percentage of adults reporting binge drinking in the past month compared to its peer counties.

Figure 27: Age-adjusted suicide death rate per 100,000 population

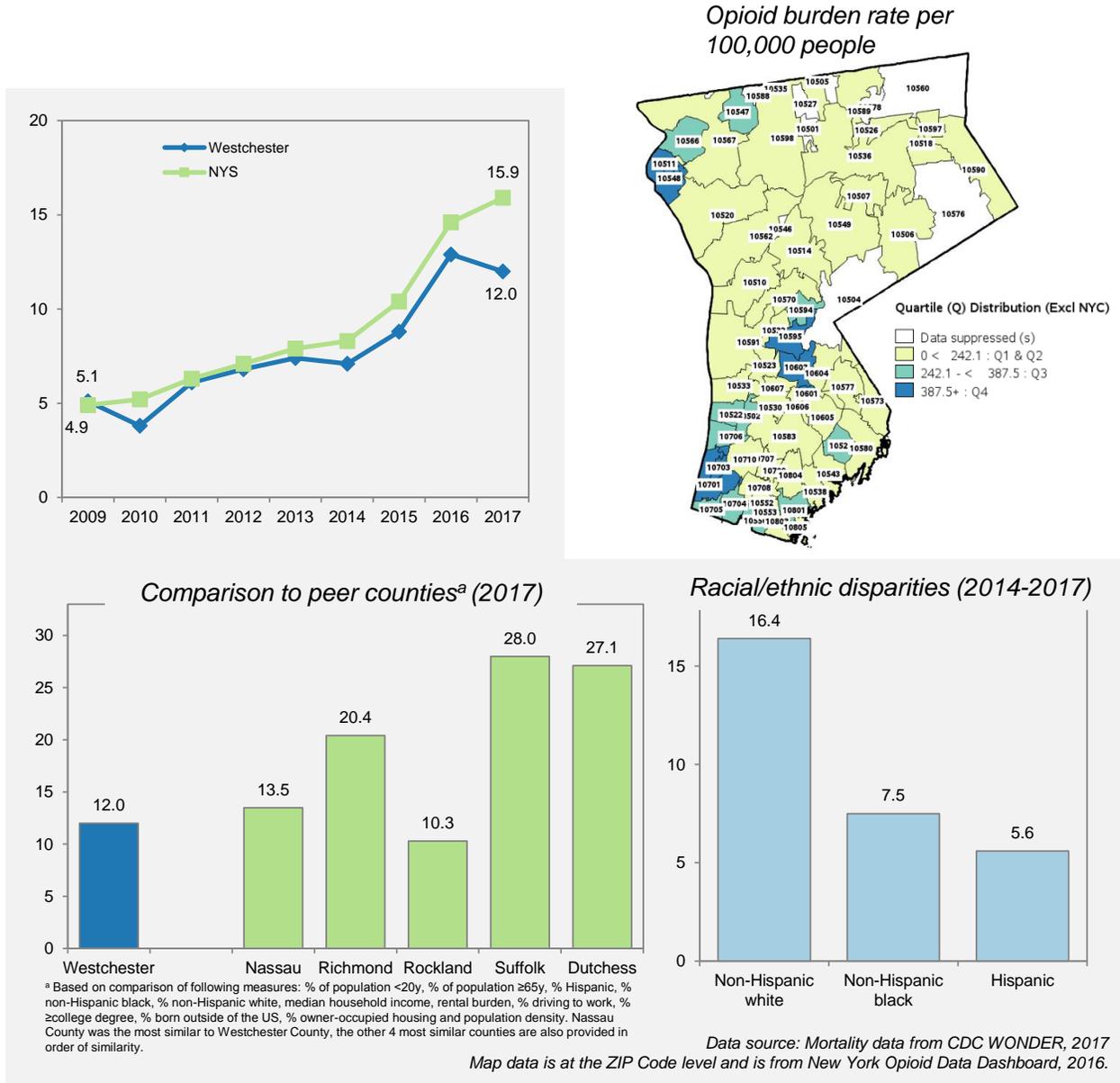


^a Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau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

Data source: New York State Prevention Agenda Dashboard

- The age-adjusted suicide death rate remained relatively stable between 2008/2012 and 2014/2016 in Westchester County (6.3 vs. 6.1), slightly above the Prevention Agenda 2018 Target of 5.9 per 100,000.
- Westchester County is tied for the second lowest age-adjusted suicide death rate when compared to 5 peer counties.

Figure 28: Age-adjusted opioid mortality rate per 100,000 people



- The opioid mortality rate tripled in Westchester County over the past decade, although it is lower than in 3 of 5 of its peer counties.
- Those who are non-Hispanic white are over twice as likely to die from opioids than non-Hispanic black and Hispanic populations.

4.a.ii Collaborations and Partnerships

The Community Engagement process for the 2019-2021 Community Service Plan was an unprecedented collaborative effort. Over the period of the previous Community Service Plan implementation, the healthcare delivery landscape shifted, previous alignments dissolved and new regional partnerships came into existence. This rigorous secondary data review, complemented by the primary data collection allowed for the creation of data maps that demonstrate the County's 'hotspots' for particular indicators. Through this mapping process, each facility can see itself in relationship with the other facilities across the service areas, which has created opportunities for alignment of care.

4.a.ii.1 Partners and Organizations

Across Westchester, in addition to the local Department of Health Meeting, there is now a MHVC DSRIP aligned Collaborative with membership from White Plains Hospital, Montefiore Mount Vernon, Montefiore New Rochelle, St. Joseph's Medical Center (including St. Vincent's Hospital – Westchester), St. John's Riverside Hospital, and Burke Rehabilitation Hospital working to ensure that the CSP and DSRIP goals retain their alignment. As the CHNA process was conducted simultaneously with the New York State Community Service Plan (CSP) review, there is strong alignment between the areas of focus in this report and the areas presented in the CSP. White Plains Hospital will continue to work with its partners on existing program initiatives.

Beyond the formal structures that White Plains Hospital established to gain input from the communities it serves, White Plains Hospital's Community Relations department participates in a variety of informal organized partnerships and collaboratives, working with other providers in Westchester County, the Westchester County Department of Health, community-based organizations and others, using an approach that involves relevant community based organizations interested in planning and developing initiatives aimed at improving the health of the residents of Westchester County.

Throughout the completion of the most recent community health survey, WPH engaged with a newly created *Healthy Community Initiative* Task Force, in addition to other community organizations, groups, and individuals to best understand the broad interests and needs of our community. The *Healthy Community Initiative's* mission is to positively impact the overall health of our community in a holistic way, working with municipal, community and private partners to create programs that focus on prevention and overall wellbeing. Task Force members include:

- Denise Brooks, Deputy Director, WP Housing Authority
- Mack Carter, Executive Director, WP Housing Authority
- Virgil Dantes, Director of Programs and Network Services, Feeding Westchester
- Ashley Hardesty, Outreach Specialist, YWCA
- Maria Imperial, Chief Executive Officer, YWCA

- Heather Miller, Executive Director, Thomas H. Slater Center
- Bhavana Pahwa, Deputy Director, White Plains Youth Bureau
- Mayor Thomas Roach, White Plains, NY and the Office of The Mayor
- Mariam Elgueta, Assistant to Mayor, City of White Plains
- Danice Tatosian, RD, Nutrition Resource Manager, Feeding Westchester
- Reverend Erwin Lee Trollinger, President, Ministers Fellowship Council; Calvary Baptist Church
- Isabel Villar, Founding Executive Director, El Centro Hispano, Inc.

Meeting with those mentioned above, WPH was better able to understand the varying needs and interests within our community. These collaborative partners are continually asked the following questions:

- What can we do to assist you & the communities you serve to achieve your wellness goals?
- Are there any unmet health-related needs?
- Explaining the current NYS prevention agenda process: Do you have populations in your organization/community that would benefit from any or all of these health issues?

Additionally, many community based organizations are involved in committees chaired by WPH, such as the Neighborhood Health Fair Committee. These committees present ongoing support and new perspectives on the progress of our initiatives and any new health issues that arise in our catchment areas.

5. Identification and Prioritization of Community Health Needs

In order to form a more complete picture of health needs we conducted an assessment of secondary data, including data from population-based surveys, hospital discharges and numerous other data sources. This information was complemented by the collection of primary data via a community-member and provider-survey.

5a. Secondary Data Analysis

The secondary data used to identify community health needs is described in Section 4.a.i. The secondary data evaluation consists of two distinct approaches. First, we used data from internal databases to examine the leading causes of inpatient hospitalization and ED visits for White Plains Hospital. Second, we completed an assessment of secondary data for ~25 core health indicators from several population-based data sources.

Overview of Data for White Plains Hospital Top 20 Inpatient Diagnoses in 2018

Table 1. Top 20 inpatient discharges at White Plains Hospital, 2018

ICD-10 Code	Label	Discharges	% of total
Z38	Liveborn infants according to place of birth and type of delivery	1,848	9.0%
A41	Other sepsis	1,478	7.2%
R07	Pain in throat and chest	477	2.3%
L03	Cellulitis and acute lymphangitis	392	1.9%
J18	Pneumonia, unspecified organism	374	1.8%
N17	Acute kidney failure	356	1.7%
I48	Atrial fibrillation and flutter	308	1.5%
N39	Other disorders of urinary system	307	1.5%
O48	Late pregnancy	299	1.5%
K80	Cholelithiasis	275	1.3%
O34	Maternal care for abnormality of pelvic organs	269	1.3%
I21	Acute myocardial infarction	259	1.3%
E11	Type 2 diabetes mellitus	253	1.2%
K57	Diverticular disease of intestine	253	1.2%
I13	Hypertensive heart and chronic kidney disease	251	1.2%
S72	Fracture of femur	243	1.2%
I63	Cerebral infarction	240	1.2%
M17	Osteoarthritis of knee	236	1.1%
I11	Hypertensive heart disease	233	1.1%
J96	Respiratory failure, not elsewhere classified	217	1.1%
-	Other diagnoses	11972	58.3%

Data source: Internal Montefiore Health System data, 2018

Table 2. Top 20 reasons for treat-and-release ED visits at White Plains Hospital, 2018

ICD-10 Code	Label	Visits	% of total
R10	Abdominal and pelvic pain	2,504	5.1%
R07	Pain in throat and chest	2,104	4.3%
M54	Dorsalgia	1,383	2.8%
S01	Open wound of head	1,271	2.6%
N39	Other disorders of urinary system	1,052	2.1%
S61	Open wound of wrist, hand and fingers	989	2.0%
F10	Alcohol related disorders	955	1.9%
M25	Other joint disorder, not elsewhere classified	952	1.9%
R51	Headache	887	1.8%
R55	Syncope and collapse	813	1.6%
M79	Other and unspecified soft tissue disorders, not elsewhere classified	808	1.6%
S09	Other and unspecified injuries of head	804	1.6%
B34	Viral infection of unspecified site	798	1.6%
R42	Dizziness and giddiness	708	1.4%
J06	Acute upper respiratory infections of multiple and unspecified sites	689	1.4%
R11	Nausea and vomiting	675	1.4%
S00	Superficial injury of head	567	1.1%
R00	Abnormalities of heart beat	554	1.1%
Z53	Persons encountering health services for specific procedures and treatment, not carried out	536	1.1%
K52	Other and unspecified noninfective gastroenteritis and colitis	526	1.1%
-	Other diagnoses	29,769	60.3%

Data source: Internal Montefiore Health System data, 2018

Population-Based Secondary Data Review

To capture an up-to-date high-level view of the health status of Westchester residents, we evaluated temporal trends, differences between Westchester County and comparator (e.g., socio-demographically similar counties) and sub-county differences, when available, for more than 20 measures, including: obesity, preterm births, teen pregnancy rates, poverty, linguistic isolation, preventable hospitalizations, access to primary care, insurance status, smoking, flu immunizations, cancer screening, HIV incidence, lung, colorectal, prostate and breast cancer incidence rates, and hospitalizations for asthma, diabetes, assaults, heart attacks and falls. This data was obtained from multiple population-based datasets including the American Community Survey (formerly referred to simply as the Census), New York State Expanded BRFSS, New York State Statewide Planning and Research Cooperative Systems (SPARCS), New York State Vital Statistics, New York State HIV/AIDS Epidemiology Reports, and the New York State Cancer Registry. Additional data was obtained from the New York State Prevention Agenda Dashboard. Whenever possible these measures aligned with those used by the New York State Prevention Agenda Dashboard. The data sources used are summarized in Section 4 and the data themselves are presented in the following pages.

b. Primary Data Analysis

Primary data collection for the Westchester County CHNA was done collaboratively between partner institutions and the Westchester County Department of Health. Community input on health priorities in Westchester County was gathered through a community survey. The methods are summarized in Section 4. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

Community Survey

Overview & Methods

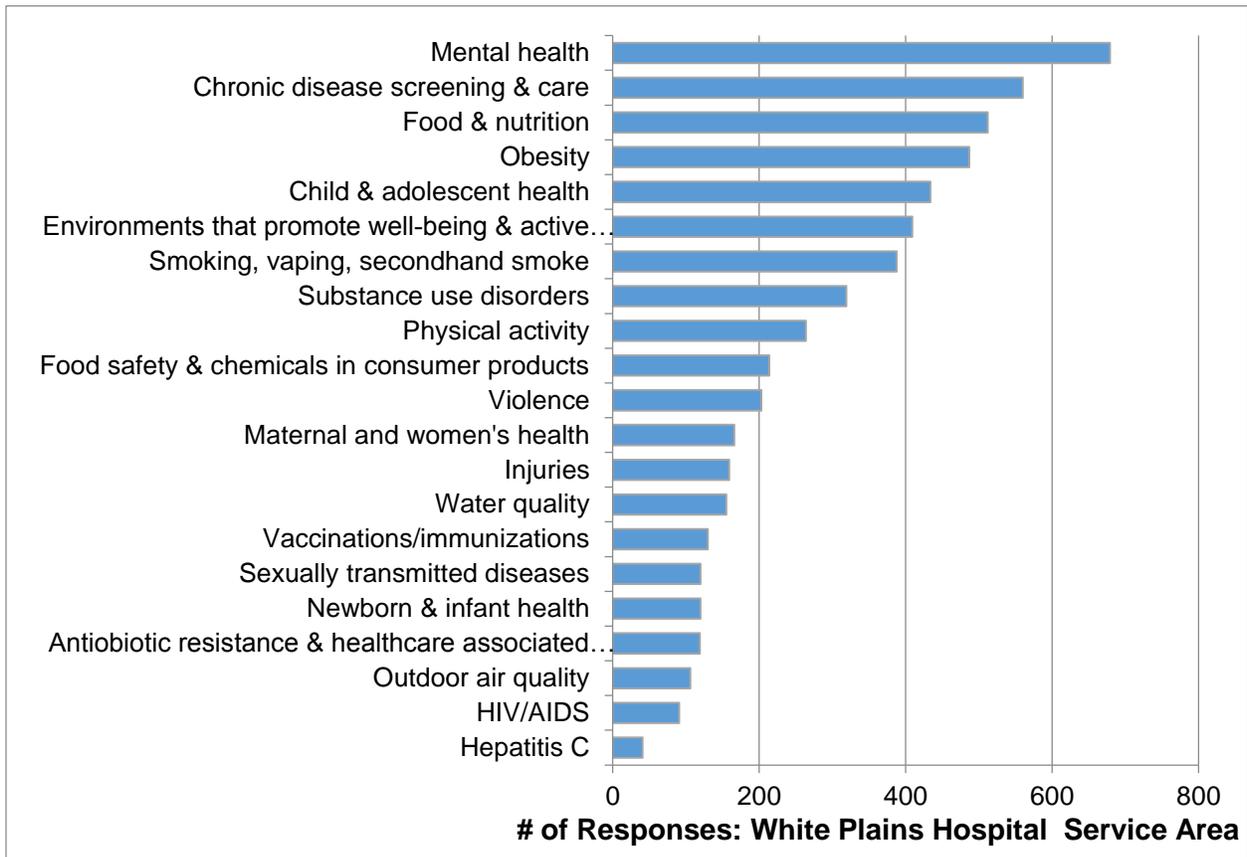
In collaboration with the Westchester County Department of Health, a community needs survey was conducted in the winter and spring of 2019. The community survey could be completed via a web-based tool (Survey Monkey) or on paper. The primary distribution of the survey was conducted through the Westchester County Department of Health's office of the Administrator and was made available through its website at the direction of the Commissioner of Health and the County Executive, which then directed it for distribution to the County's elected officials. The Montefiore Hudson Valley Collaborative also distributed the survey to its membership of over 900 hospitals, community based organizations, faith-based organizations and other social service providers. Due to its electronic format, dissemination was widespread, however paper surveys were available on request. The survey was disseminated through multiple distribution points including to hospitals, other health care providers, community-based organizations and others.

Community Survey Results

For the community survey, a total of 3,524 surveys were completed among individuals working-in or residing-in Westchester County. Seventy-eight percent of respondents were women, 21% were men and 0.5% as other, including non-conforming, non-binary and transgendered. Respondents tended to be middle-aged; 25% were 55-64y, 18% were 45-54y, 14% were 65-74y, and 13% were 35-44y. Twenty-four percent of respondents were 65y+ and 4.6% were 18-24y. Twenty-one percent of respondents were Hispanic/Latino (a), 13% were non-Hispanic Black, and 61% were non-Hispanic white. Respondents resided in more than 78 ZIP Codes. About 23.9% of respondents resided in Yonkers, 8.4% in White Plains, 5.2% in New Rochelle, 3.8% in Mount Vernon, 2.3% in Bronxville and 2% in Peekskill.

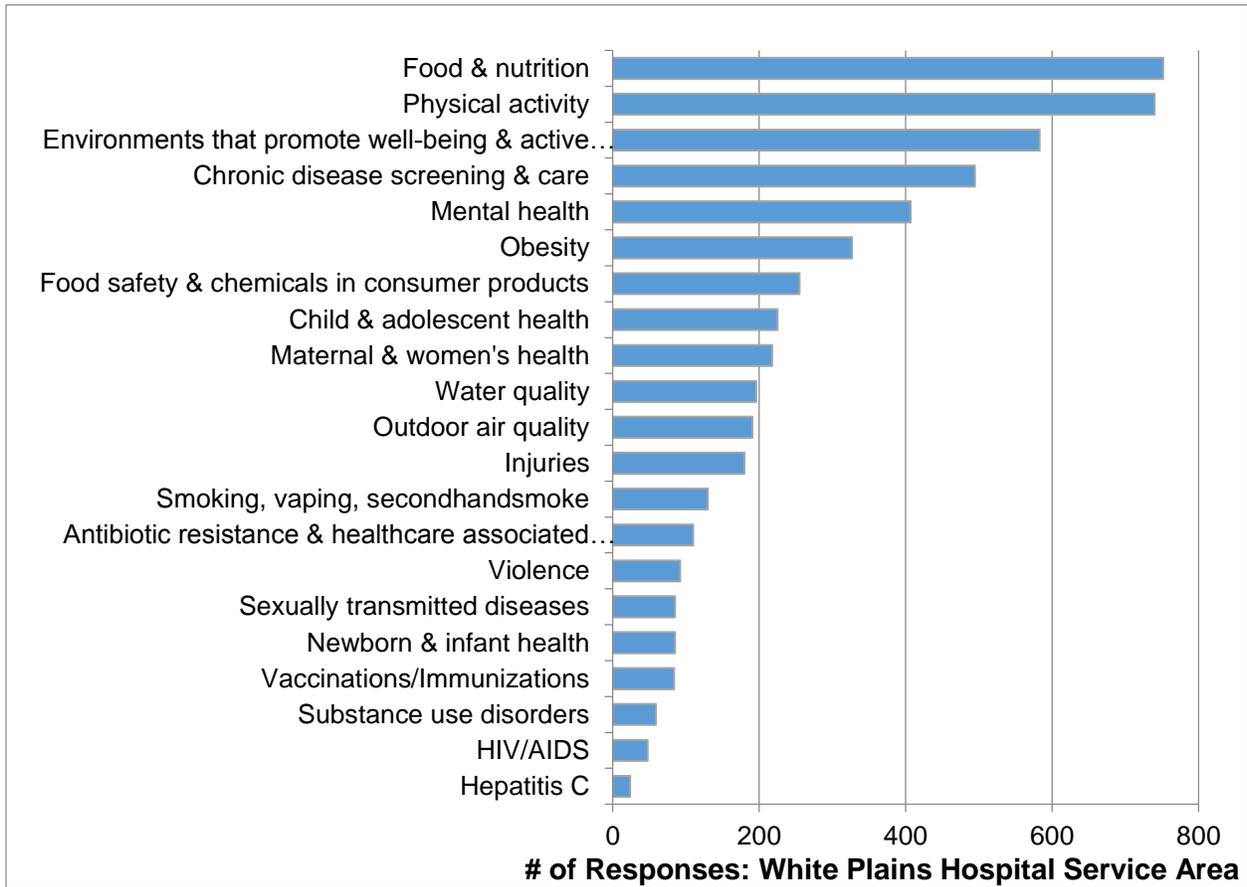
Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health. Participants were also asked to rank their own personal health priorities. The leading community health priorities identified included: mental health, chronic disease screening & care and food & nutrition (see **Figure 27**). The leading personal health priorities were food & nutrition, physical activity and environments that promote wellbeing and active lifestyles. (see **Figure 28**). The leading strategies to improve health identified include: affordable housing, mental health services and exercise/weight loss programs (see **Figure 29**).

Figure 27. Community health priorities as identified by the Westchester County Community Survey, 2019



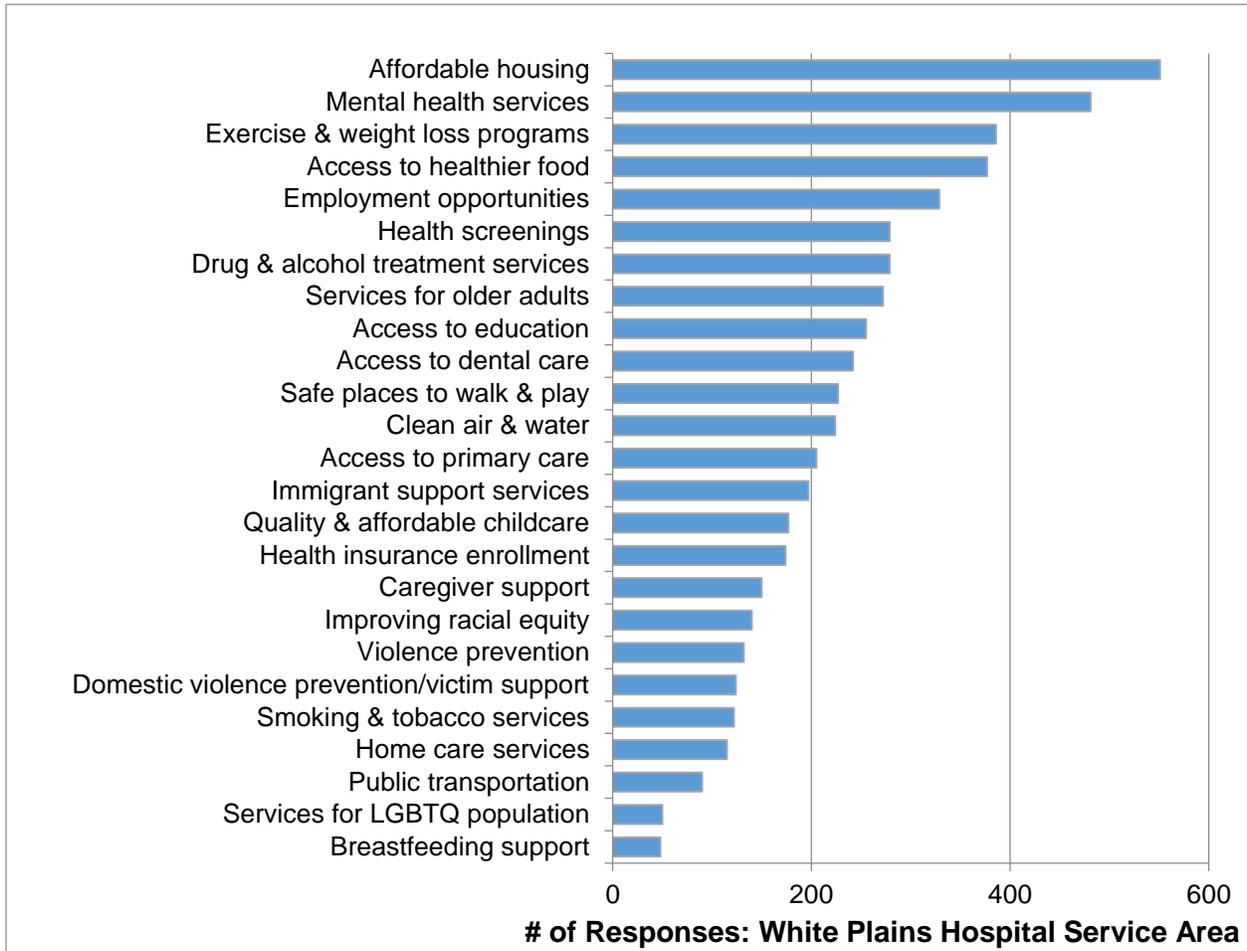
Data source: Westchester County Community Survey, 2019

Figure 28. Personal health priorities as identified by the Westchester County Community Survey, 2019



Data source: Westchester County Community Survey, 2019

Figure 29. Strategies to improve health among Westchester County residents from the Westchester County Community Survey, 2019



Data source: Westchester County Community Survey, 2019

Key Findings from Analysis

Despite each of these different methods and approaches to primary data collection in gathering community input, there was a consistent focus on mental health, food and nutrition and child and adolescent health. These findings led to the selection of the Hospital’s prevention agenda priority areas.

6. Potential Measures and Identified Resources to Meet Identified Needs

6a. *Internal Resources and Measures*

Below is a list of programs provided by Montefiore Health System, of which White Plains Hospital is a part of. These programs address a variety of community needs, including a brief description, the intervention measures that the program captures and the coordination of the program to the larger New York State Prevention Agenda. Some of these programs are located in Westchester County but many are located in the Bronx. The Bronx-based programs listed below accept Westchester County patients and therefore, have been included in this resource list.

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Adherence Intervention for Pediatric Renal Transplant	Adherence Intervention for Pediatric Renal Transplant aims to support adolescents (14-21) awaiting kidney transplant who struggle with their treatment regimens. The program uses dialectical behavior therapy, counseling, support groups and medication management with the goal of improving quality of life and general life skills.	Increase in patient adherence to renal transplant treatment regimens; Improvement in patient quality of life	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

<p>Adolescent AIDS Program</p>	<p>The Adolescent AIDS Program (AAP) provides comprehensive care, risk reduction services and HIV counseling to HIV-positive adolescents (13-24). The program also offers rapid and simple HIV testing and counseling to at-risk youth throughout the Bronx, especially in areas of high seroprevalence.</p>	<p>Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>
<p>Adolescent Depression and Suicide Program</p>	<p>Adolescent Depression and Suicide Program is a subspecialty outpatient clinic within the Dept. of Psychiatry that provides comprehensive assessments and evidence-based treatment for youth (12-18) who present with symptoms of depression, suicidal behaviors and non-suicidal self-injurious behaviors. Many patients also struggle with school, family and drug problems. The program</p>	<p>Decrease in adolescent depression rate; Decrease in adolescent suicide and attempted suicide rates; Decrease in adolescent suicidal feelings</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>

	runs lectures and workshops for school personnel, students and community members.		
AIDS Center	As a New York State Dept. of Health-designated AIDS Center, this division at Moses provides a broad array of inpatient and outpatient services to adults (22+) living with AIDS. The care model consists of an integrated team of health care professionals, including physicians, social workers, nurses, HIV counselors, dietitians, adherence counselors, researchers, mental health providers, pharmacists and administrative staff.	Decrease in high-risk behavior; Increase in HIV testing; Increase in linkage to treatment and care for HIV+ individuals	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

<p>B'N Fit</p>	<p>B'N Fit is a comprehensive weight loss program for obese teens (12-21) that conducts medical, nutritional and psychosocial evaluations and refers participants to treatment for obesity-related illness. The program is offered in conjunction with a community after-school program that consists of nutrition classes, physical activity programming, parent groups, family nights and a six-week summer program.</p>	<p>Increase in healthy eating habits; Increase in physical activity; Decrease in BMI; Decrease in obesity</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>
<p>Breast and Cervical Screening Event</p>	<p>Screening for breast exams and pap smears for women 18 years and older. Mammograms for women 40 years and older. In addition, women's health education and information is provided.</p>	<p>Increase in breast exams and pap smears for women 18+; Increase in mammograms for women 40+; Decrease in diagnosis of late-stage breast and cervical cancer</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>

Caregiver Support Center	The Caregiver Support Center is dedicated to providing support to the caregiver, a family member or friend and the primary source of care for an ill family member, in addition to medical support of clinical staff.	Increase in general satisfaction of caregiver	Promote Mental Health and Prevent Substance Abuse
Centering Pregnancy	Centering Pregnancy is a national program that provides comprehensive prenatal care in a group setting. It affords women the opportunity to spend more time with their prenatal care provider, to befriend other pregnant women and to learn about themselves, their pregnancies and their newborns. The program is offered at two MMG sites: FHC and SBHCCF--and soon to be started at CFCC.	Increase in utilization of prenatal care services; Increase in positive health outcomes for newborns and their mothers	Promote Healthy Women, Infants and Children
Centers Implementing Clinical Excellence & Restoring Opportunity (CICERO)	CICERO is an integrated HIV/AIDS and primary care program that functions at ten	Increase in proportion of HIV+ individuals engaged in care	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

	<p>Montefiore primary care sites and offers treatment, educational, counseling and supportive services to HIV/AIDS patients in the primary care setting.</p>		
<p>CFCC'S Breastfeeding Support</p>	<p>CFCC's Breastfeeding Initiative is a collaborative effort between the Depts. of Pediatric Medicine and OB/GYN that supports new mothers and trains staff to manage breastfeeding. Expectant and new mothers and their infants (0-2) are referred to a board certified pediatrician who is also a board certified lactation consultant, who provides individual consults and runs a weekly breastfeeding group clinic. The program's goal is to improve breastfeeding rates in the hospital and clinic settings and to help</p>	<p>Increase in proportion of mothers who breastfeed</p>	<p>Promote Healthy Women, Infants and Children</p>

	<p>Montefiore become recognized as a “baby-friendly hospital” by the WHO. Individual consults are available 3 mornings per week and the breastfeeding group clinic meets on Thursday afternoons. Annual lectures are given to pediatric residents and other staff.</p>		
CHAM Oncology Groups	<p>Over four 12-week sessions in 2012, up from 2 in 2011, CHAM runs four distinct support groups targeted to: teenagers with cancer, school-age children with cancer, siblings of cancer patients and parents of children undergoing cancer treatment.</p>	<p>Increase in patient satisfaction for oncology patients and their families</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>
CHAM Sickle Cell Groups	<p>Over a 10-week session, CHAM runs a support group targeted to school-age sickle cell patients. The group gives patients an opportunity to meet others going through</p>	<p>Increase in patient satisfaction for sickle cell patients and their families</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>

	similar experiences and provides the chance for self-expression and positive socialization.		
CHF Disease Management	Through primary care and care management services, the CMO seeks to decrease preventable readmissions and improve the continuity of care for the hospital's Emblem CHF patients. At-risk patients are managed through case management calls, home visits and the use of telehealth and telescales.	Decrease in preventable readmissions for CHF patients; Increase in continuity of care for CHF patients	Prevent Chronic Diseases
Children's Evaluation and Rehabilitation Center (CERC)	CERC, the clinical arm of the Rose F. Kennedy University Center for Excellence in Developmental Disabilities, offer multidisciplinary evaluation and treatment to children and adults with intellectual and other disabilities, such as autism spectrum disorder, cerebral palsy,	Increase in patient satisfaction for individuals with intellectual and other disabilities	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

	mental retardation, learning disabilities. The Center is composed of 10 teams, which focus their activities on a specific component of this population.		
Colorectal Cancer Patient Navigation Program	The Colorectal Cancer Patient Navigator Program is the bridge between the community and health care. We eliminate complexity bringing together interdisciplinary teams to work towards reducing colorectal cancer rates by assessing, educating, scheduling, and guiding our patients through the screening process. Our aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-show and cancellation rates.	Increase in screening for colorectal cancer; Decrease in colorectal cancer	Prevent Chronic Diseases

<p>Communitlife Montefiore Temporary Respite Program</p>	<p>The program provides temporary community-based supportive housing for Montefiore inpatients that do not have a suitable living arrangement and do not need to be hospitalized. Patients who are discharged into the program facility receive case management, medication management, care coordination, entitlements services and the support they need to find suitable permanent housing.</p>	<p>Increase in patient satisfaction; Increase in proportion of inpatients who report having suitable living arrangements</p>	<p>Promote a Healthy and Safe Environment</p>
<p>Comprehensive Services Model, CSM</p>	<p>CSM is a Welfare-to-Work program for public assistance clients with substance use disorders. CSM comprehensively evaluates all clients and then case manages them with the goals of stabilization in substance abuse treatment and either employment or attainment of federal</p>	<p>Increase in stabilization in substance abuse treatment; Increase in employment of individuals with substance abuse disorders; Increase in attainment of federal disability</p>	<p>Promote Mental Health and Prevent Substance Abuse</p>

	disability benefits, if eligible. CSM refers to state-certified substance abuse treatment programs and provides comprehensive social services.	benefits for individuals with substance abuse disorders	
Diabetes Disease Management	Through care management services delivered telephonically, face-to-face (both one-on-one and in group settings) and through direct mail, the CMO empowers people with Type II diabetes to improve their health outcomes and quality of life.	Increase in positive health outcomes for individuals with diabetes; Increase in quality of life for individuals with diabetes	Prevent Chronic Diseases
Diabetes in Pregnancy Program	Diabetes in Pregnancy is a prenatal care program for women with pre-gestational or gestational diabetes mellitus. The program's classes explore the impact of diabetes on a patient's pregnancy, baby and family. Additionally, participants receive nutritional counseling	Increase in quality of prenatal care for diabetic women	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

	and co-management consultation.		
Diabetes Management: PROMISED	A novel approach in Diabetes Education - the Proactive Managed Information System for Education in Diabetes "PROMISED" is a 10-hour interactive educational program. The program is approved and certified by the American Diabetes Association and adheres to the more recent Standards of Care and it is tailored to meet the needs of our Bronx residents. Patients are referred to PROMISED by their primary care physicians and following completion of the program they are empowered to better manage their disease. Each case is reviewed and discussed separately and the referring PCP receives a consultation	Increase in management of diabetes; Increase in positive health outcomes for diabetic mothers and their newborns	Prevent Chronic Diseases

	letter regarding management of glycemic control, cardiovascular risk factors and comorbidities. Individual cases are presented adhering to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)		
Dialysis Outreach	Dialysis outreach seeks to strengthen communication between Montefiore's transplant program and community physicians and to provide a seamless referral service where a physician or patients only need to make one phone call and will receive an appointment with a Montefiore Hepatologist, Nephrologist or Surgeon depending on the reason for the referral. The program seeks to resolve customer service issues, help expedite the	Increase in patient satisfaction; Increase in provider satisfaction	Prevent Chronic Diseases

	<p>referral and evaluation process and answer any questions pertaining to transplant and Montefiore. Dialysis outreach also provides in service training for dialysis staff so that understand transplant. Additionally, the program works with the American Liver Foundation, National Kidney Foundation and Organ Donor Network on education, community events and outreach.</p>		
<p>DOH Infertility Demonstration Project</p>	<p>The Infertility Demonstration Project is a statewide campaign that helps couples (21-44) who lack the financial resources to access In-vitro Fertilization services. Depending on total household income, the participating couple is required to pay a certain portion of fees after insurance. The Dept. of Health then pays</p>	<p>Increase in access to In-vitro fertilization services</p>	<p>Promote Healthy Women, Infants and Children</p>

	the remaining cost. The program is particularly important for couples whose insurance does not cover the cost of medication for the IVF cycle.		
Explainer Program	The Explainer program employs youth interns from the community to teach patients and families at CHAM how to navigate the interactive patient care system at the bedside TV. This system, called the GetwellNetwork, offers health education, TV, video, internet, gaming, and customer service to patients and their families. The interns are provided with career workshops and encouraged to pursue career opportunities in health care through skill building in resume writing, interviewing and education.	Increase in patient satisfaction	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

<p>Family Treatment/Rehabilitation</p>	<p>Family Treatment/Rehabilitation is an evaluation and case management program for families with identified risk of child abuse or neglect and identified psychiatric or substance use disorders. The program provides evaluation and referral for treatment, and provides case management to track participation.</p>	<p>Increase in quality of case management for families with identified risk of child abuse or neglect</p>	<p>Promote Mental Health and Prevent Substance Abuse</p>
<p>Farmer's Market Walks</p>	<p>Every Tuesday from June-November, nutritionists and health educators lead groups at various Montefiore sites to local Farmer's Markets. Participants learn about seasonal produce, discuss recipes and when available, receive "Health Bucks," a \$2 coupon to purchase a fruit or vegetable.</p>	<p>Increase in healthy eating habits; Increase in fruit and vegetable consumption</p>	<p>Promote a Healthy and Safe Environment</p>

<p>Geriatric Ambulatory Practice</p>	<p>The Geriatric Ambulatory Practice provides comprehensive primary care to very frail patients (65+). It focuses on medical and functional assessment for patients and offers consultation visits for primary care physicians who are having difficulty caring for dementia, frequent falls, osteoporosis, elder abuse and multiple chronic conditions that impact the elderly. The practice also serves as a training site for geriatric fellows, medical residents and medical students.</p>	<p>Increase in patient satisfaction</p>	<p>Prevent Chronic Diseases</p>
<p>Healing Arts</p>	<p>The Healing Arts at Montefiore is a network of programs that uses the arts, creative arts therapies, integrative medicine, and other healing approaches to enhance the quality of life, health and well-being of Montefiore's</p>	<p>Increase in patient satisfaction and quality of life</p>	<p>Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>

	<p>patients, associates and community. Healing Arts programs are available in the Children’s Hospital, Oncology, Palliative Care, Rehabilitation Medicine, Psychiatry, and other departments to complement patient care by helping to reduce pain and other physical symptoms, provide comfort and enjoyment, promote self-expression, and enhance quality of life.</p>		
<p>Healthy Living with Chronic Conditions</p>	<p>Healthy Living with Chronic Conditions is a workshop that helps patients with chronic conditions lead healthier lives. Patients who have hypertension, diabetes, arthritis, HIV/AIDS and other illnesses attend weekly sessions for six weeks where they learn to eat well, cope with stress, communicate effectively with medical</p>	<p>Increase in patient satisfaction</p>	<p>Prevent Chronic Diseases</p>

	providers and identify and accomplish goals.		
Healthy Steps	Healthy Steps ensures that primary care for infants and toddlers focuses on issues of development, behavior, parental mental health and the parent-child relationship. Building on the national model, the program collocates and integrates behavioral and mental health specialists in the pediatric primary care setting. These specialists use screening tools such as maternal depression screening and child social emotional screening to determine and implement interventions that ensure successful early childhood years.	Increase in patient satisfaction; Increase in pediatric access to primary care	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

<p>Heart Month</p>	<p>During the month of February, The Center for Heart & Vascular Care conducts a series of educational sessions and health screenings for Montefiore associates and for residents of the Bronx. The Center conducts lectures about heart health and healthy lifestyles as well as blood pressure screenings and counseling sessions at all Montefiore campuses, in senior citizen centers, local elementary schools, colleges and health centers.</p>	<p>Increase in blood pressure screenings; Increase in cardiac health</p>	<p>Prevent Chronic Diseases</p>
<p>Hepatitis C Support Group</p>	<p>The Hepatitis C Support group is a supportive service for adults with Hepatitis C. Topics of discussion include disease management, treatment options, side effects, compliance and coping with relational and psychological impacts of disease and treatment.</p>	<p>Increase in patient satisfaction for individuals with Hepatitis C</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>

<p>HPV Vaccine Clinic</p>	<p>The HPV Vaccine clinic is a stand-alone clinic open to the Montefiore community and local medical providers. It offers vaccines, education and counseling to women ages 19-26 in an effort to reduce the spread of sexually-transmitted HPV infection and the onset of cervical cancer. Before the creation of the program, many OB/GYN clinics, and providers of women's health in 19-26 year olds in the community had stopped providing the vaccine to women in this age bracket due to insufficient Medicaid coverage and low reimbursement. The clinic also seeks to correct billing issues and allow for vaccines to be provided through sponsored programs to low income women in</p>	<p>Increase in HPV vaccination rate</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>
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	<p>order to make vaccine administration cost effective. This site also offers participation in ongoing research projects as well.</p>		
<p>Integrated Medicine and Palliative Care Team (IMPACT)</p>	<p>IMPACT is an interdisciplinary service that provides integrative palliative care to for pediatric patients facing life threatening or life limiting disease, and their care givers. Services include palliative and end-of-life care, pain management, mental health services, acupuncture, essential oil therapy, Reiki, yoga, massage, healing touch, nutrition and supplements, cooking classes, herbal medicine and homeopathy, among others. The team</p>	<p>Increase in patient satisfaction</p>	<p>Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>

	educates students and staff on palliative care and conducts research to measure the effectiveness of its interventions. It conducts research to measure to measure the effectiveness of its interventions. IMPACT		
Lead Poisoning Prevention Program	A designated NYS Resource Center for Lead Poisoning Prevention, the LPPP consists of a multidisciplinary team in medicine, research, social services, environmental investigation, and public advocacy. It serves as a referral center for the medical management of lead poisoning, links families to safe housing during home abatement procedures, provides bilingual educational workshops, advocates for lead poisoned children during local and state legislative reviews	Decrease in lead poisoning	Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

	and collaborates with city and private agencies in environmental intervention.		
LINCS Program at CHAM	<p>LINCS is a medical home that provides comprehensive primary care and care coordination in outpatient, inpatient and home care settings to children (0-21) with complex, chronic and life-limiting conditions. The program incorporates a palliative care consultation service that provides ongoing care to children in community-based home hospices. Additionally, the program delivers comprehensive primary care to siblings during and after their brothers and sisters have passed away.</p>	<p>Increase in patient satisfaction; Increase in accessibility of primary care services available to children</p>	<p>Prevent Chronic Disease; Promote Healthy Women, Infants and Children</p>

<p>Liver Transplant Support Group</p>	<p>The Liver Transplant Support Group is a psycho- educational program for pre- and post-liver transplant patients and their families. Led by two social workers and a psychiatrist, the groups focus on expectations and challenges pre and post liver transplant, learning signs and symptoms of liver disease, disease management, and strengthening coping skills in a mutually supportive environment.</p>	<p>Increase in patient satisfaction for liver transplant patients</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>
<p>Medical House Calls Program</p>	<p>Through medical home visits, the CMO helps chronically ill, at-risk geriatric and adult patients who have a history of multiple inpatient admissions and are homebound. A team of primary care physicians provide medical care. The program is also</p>	<p>Increase in patient satisfaction; Increase in accessibility of primary care services</p>	<p>Prevent Chronic Diseases</p>

	supported by social workers, outreach specialists and nurses who collaborate to address a variety of psychosocial concerns affecting the patients medical condition. The program has the capacity to care for 750 patients.		
Mobile Dental Van	The Mobile Dental Van provides dental care to patients at MMC affiliated schools that do not have permanent dental services. Staffed by a dentist and a hygienist and equipped with two dental chairs, a digital X-Ray system and a billing system, the van operates five days per week and visits schools on a rotating schedule.	Increase in proportion of individuals receiving dental care	Prevent Chronic Diseases

<p>Montefiore School Health Program</p>	<p>MSHP is the largest and most comprehensive school-based health care network in the United States. It has 20 school-based health center sites that provide primary care, mental health, oral health and community health services to patients regardless of citizenship status and ability to pay. All sites are federally qualified or partially qualified health centers. Included in MSHP is the Healthy Kids program, comprised of an array of evidence-based prevention activities focused on increasing physical activity and healthy eating in Bronx children and their families.</p>	<p>Increase in proportion of students receiving health care</p>	<p>Prevent Chronic Diseases; Promote Healthy Women, Infants and Children</p>
<p>Mosholu Preservation Corporation (MPC)</p>	<p>MPC is a non-profit organization committed to preserving and revitalizing Bronx neighborhoods by improving housing and</p>	<p>Increase in local economy; Increase in preservation of neighborhoods</p>	<p>Promote a Healthy and Safe Environment</p>

	<p>promoting economic and community development. It is governed by a Board of Directors made up of Montefiore trustees and management, community leaders and development experts who serve in a pro bono capacity.</p>		
<p>New Directions Recovery Center and Chemical Dependency Program - Medically Supervised Outpatient</p>	<p>Montefiore has two medically supervised outpatient programs. These programs treat adults with alcohol and/or drug abuse/dependence. Multidisciplinary teams at each site can also treat psychiatric disorders and address medical and psychosocial issues that may be associated with alcohol and drug use.</p>	<p>Decrease in alcohol and drug abuse</p>	<p>Promote Mental Health and Prevent Substance Abuse</p>
<p>New York Children's Health Project (NYCHP)</p>	<p>NYCHP delivers critically needed health care services to homeless families and street-involved youth at 13 sites across New York City.</p>	<p>Increase in accessibility of health care services to homeless individuals</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse</p>

	<p>The families served hail from impoverished neighborhoods with few quality health care resources, and when homeless they face innumerable access barriers. The program launched with one mobile medical clinic and is now one of the largest providers of health care to homeless children in New York City. NYCHP's innovative service delivery model is comprised of fully equipped mobile clinics, small clinics in shelters, and a full-time health clinic in the South Bronx. A wide array of services is provided to attend to the complex health and psychosocial needs of homeless children, adolescents and adults:</p> <ul style="list-style-type: none"> • Comprehensive primary care • Asthma care (Childhood Asthma Initiative) • Women's 		
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	<p>health care• Dental care• Mental health counseling, assessment, crisis intervention, and referrals• Substance abuse prevention and referrals• Case management• Emergency food assistance• Children’s nutrition education and physical activity program (“Cooking, Healthy Eating, Fitness and Fun” or CHEFFs)• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call</p> <p>NYCHP was one the first mobile medical programs in the country to achieve Level 3 Patient Centered Medical Home (PCMH 2008) recognition from National Committee for Quality Assurance (NCQA). NYCHP maintains a Community</p>		
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	<p>Advisory Board (CAB) comprised of consumers/patients; CAB meetings are held each quarter at a different homeless family shelter and often include members new to the system. NYCHP relies on the CAB's input to ensure the effectiveness of services and that care remains responsive to the needs of the special population served.</p>		
<p>Office of Community and Population Health</p>	<p>Working closely with colleagues at Montefiore, the Albert Einstein College of Medicine and partners from a wide range of institutions, governmental agencies and community-based organizations, the Office of Community Health, a part of the Department of Community & Population Health, identifies community health needs, shares</p>	<p>Increase in accessibility to health care; Increase in community-based health interventions</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>

	information about community health services and promotes collaborative interventions. The Office also develops effective strategies and methods to evaluate the impact of interventions on community health needs.		
Office of Community Relations	By functioning as the link between the community and the medical center's resources, the Office of Community Relations develops positive collaborations with community-based organizations, government agencies and elected officials in the regions served by Montefiore.	Increase in community-based health interventions	Promote a Healthy and Safe Environment
Internship Program	The Office of Volunteer and Student Services and the Learning Network recruits, orients and	Increase in satisfaction of interns	Promote a Healthy and Safe Environment

	processes interns for the medical center, including high school, college and master's level students.		
Oral Head and Neck Screening	Screening for Oral Head and Neck Cancer. Event takes place at MECCC and WPH in April.	Increase in screening for Oral Head and Neck Cancer; Decrease in Oral Head and Neck Cancer	Prevent Chronic Diseases
Organ/Tissue Donor Program	The Organ/Tissue Donor Program raises awareness about organ/tissue donation and transplantation within the Montefiore and Bronx communities. Through educational initiatives and a range of recruitment activities, the program helps potential donors understand the importance of donation and encourages them to join the donor registry. The program is further responsible for ensuring that potential donor candidates are referred	Increase in educational programs about organ donation; Increase in number of people who join the donor registry	Prevent Chronic Diseases

	to the local Organ Procurement Organization. The ultimate goal is to ensure that every person who needs an organ/tissue donation receives one		
Ostomy Support Group	The Ostomy Support Group is a supportive service for community members who have undergone any kind of Ostomy diversion, regardless of their affiliation with the hospital. Seasoned participants help new members cope with challenges in their disease process. Each group lasts for eight sessions and also functions as a referral source for the Dept. of Psychosocial Medicine at Einstein when members need one-on-one counseling.	Increase in general satisfaction of individuals who have undergone ostomy diversion	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

<p>Parent-to-Parent Support Group for Heart Transplants</p>	<p>Our program offers an educational forum for pre and post-transplant patients (21-75). The pre transplant patients get to know the transplant team and learn how to remain an active transplant candidate. The post transplant patients learn about all the issues that affect them after a kidney transplant. The environment is supportive and the patients are around others going through the same experiences. The support group provides the opportunity for patients to share stories, information, get advice, and receive emotional and spiritual support outside the family structure. It continues to be a great success.</p>	<p>Increase in patient satisfaction for heart transplant patients; Increase delivery of transplant information to patients</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>
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<p>Phoebe H. Stein Child Life Program</p>	<p>The Child Life Program minimizes the stress of hospital and outpatient visits for pediatric patients and their families through educational and supportive services. In all areas of the hospital, Child Life Specialists help children understand and prepare for their medical experiences. Specialists accompany children to the operating room or to other procedures, teach parents to help their children cooperate with medical treatment and encourage normal growth and development.</p>	<p>Increase in patient satisfaction; Increase in satisfaction of patients' families</p>	<p>Promote Healthy Women, Infants and Children</p>
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<p>Pregnancy Prevention Program in School Health</p>	<p>The Pregnancy Prevention Program provides confidential reproductive and sexual health services, mental health services, and population based prevention and health promotion programs on the classroom, school and local community levels at nine Bronx high school campuses housing 34 schools. An example is the Reducing the Risk curriculum was introduced through ninth grade classrooms to bring a validated sex education curriculum to all ninth grade students. The program aims to decrease rates of unplanned teen pregnancy and STI transmission and to increase rates of high school graduation. Reducing the Risk is one of the first rigorously evaluated sexual</p>	<p>Decrease in unplanned teen pregnancy; Decrease in STI transmission in teens; Increase in high school graduation rates; Increase in sexual education programs</p>	<p>Promote Healthy Women, Infants and Children; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>
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	education curricula to have a measurable impact upon behavior. The program is delivered the curriculum to students in the ninth grade before many become sexually active.		
Prostate Cancer Screening	Montefiore Medical Center in partnership with the Daily News offering free PSA blood tests for men age 40 and over. Event runs for 4 days in June at various Montefiore sites.	Increase in Prostate Cancer screening; Decrease in Prostate Cancer	Prevent Chronic Diseases
Psychosocial Oncology Program	The Psychosocial Oncology Program offers free counseling to those affected by cancer. Serving as the umbrella over a range of initiatives, the program includes Bronx Oncology Living Daily (BOLD Living) Program offering free wellness, creative arts,	Increase in patient satisfaction of Oncology patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

	<p>and mind-body workshops, a Yoga research program, Mind-Body Support Group, Be BOLD-Quit Smoking group, and BOLD Buddies. Supportive services are designed according to the interests and needs of participants. For instance, BOLD Buddies offers treatment companions and phone support to socially isolated cancer patients.</p>		
Regional Perinatal Center	<p>Perinatal Center, one of 18 in the state, Montefiore is a critical referral source for specialized clinical care in high risk obstetrics and neonatology. Montefiore participates in ongoing education, evaluation, data collection and quality improvement efforts with other certified hospitals and affiliates</p>	<p>Increase in availability of critical obstetric and neonatal care</p>	<p>Promote Healthy Woman, Infants and Children</p>

<p>Renal Disease Young Adult Group</p>	<p>The program runs a support group for young adults ages 18-30 years who are diagnosed with End Stage Renal Disease. The support group affords participants the opportunity to share their emotions and concerns with each other and with professional staff.</p>	<p>Increase in patient satisfaction for individuals with End Stage Renal Disease</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>
<p>Respiratory Disease Management</p>	<p>Through telephonic outreach, health coaching and home visits to higher-risk patients, the CMO aims to improve the health of patients with asthma and chronic obstructive pulmonary disease. Members who were enrolled in our population based program, by either receiving age appropriate educational mailings, or went to ER or were admitted-received an educational</p>	<p>Decrease in symptomatic asthma and chronic obstructive pulmonary disease</p>	<p>Prevent Chronic Diseases</p>

	call to follow up on their condition.		
School Re-Entry Team	The School Re-entry Team coordinates communication between the hospital and school settings in order to promote the best possible transition back to school for CHAM cancer and sickle cell patients.	Increase in satisfaction of cancer and sickle cell patients	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children

<p>South Bronx Health Center for Children and Families (SBHCCF) and the Center for Child Health Resiliency</p>	<p>A unique family-centered health care program, SBHC serves the Morrisania and Hunts Point-Longwood neighborhoods of the South Bronx, one of the nation's most medically underserved, at-risk communities. SBHC is a Federally Qualified Health Center (FQHC) program that offers patients access to an enhanced medical home, a model of care that addresses all of their health care needs, and includes:</p> <ul style="list-style-type: none"> • Primary care for children, adolescents and adults • Women's health and prenatal care • HIV testing, counseling, and primary care • Mental health counseling • Case management • Dental care • Nutrition counseling • WIC referrals • Substance abuse prevention and 	<p>Increase in accessibility of health care; Increase in utilization of health services</p>	<p>Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections</p>
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	<p>referrals• Emergency food assistance• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call</p> <p>SBHC’s Center for Child Health and Resiliency (CCHR), opened in 2011, is a state-of-the-art facility with a special focus on early childhood development beginning prenatally through 5 years of age. CCHR’s innovative programming supports families and equips parents with the nurturing skills needed to overcome stressors detrimental to children's healthy development. SBHC also offers innovative health programs on-site and in the local neighborhood that provide intensive care management, group sessions, and culturally</p>		
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	<p>appropriate health education:• Childhood Asthma Initiative• Starting Right, a childhood obesity initiative, nutrition education and fitness program• Diabetes Program• HIV/AIDS Program• Pregnancy Group, prenatal visits with the benefit of group support and in-depth education• Well Baby Group, pediatric visits for infants up to 2 years • Healthy Teens Initiative and access to confidential reproductive health services</p> <p>SBHC is recognized by the National Committee for Quality Assurance (NCQA) as a Physician Practice Connections® – Patient-Centered Medical Home™ (PPC-PCMH) Program at Level 3 Recognition, the highest level available. SBHC maintains an active</p>		
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	<p>Community Advisory Board (CAB) comprised of public housing residents and representatives of the South Bronx community (from tenant associations, schools, community based organizations, etc.). The CAB provides invaluable feedback on future plans, service changes, community changes/events, and strategies to draw in new health center patients.</p>		
<p>Strength Through Laughter and Support Program</p>	<p>Strength through Laughter and Support is an educational program that encourages participants to develop a positive attitude as they confront the challenges associated with cancer. By sharing laughter, sadness, wisdom and love in the group setting, participants find a sense of hope that helps them face the realities of living</p>	<p>Increase in patient satisfaction and quality of life of individuals with cancer</p>	<p>Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse</p>

	with and beyond their illness. Groups range in size from 20 to 60 participants.		
Substance Abuse Treatment Program, Methadone Program	The SATP consists of two opioid treatment programs for opioid-dependent adults. Both sites provide integrated primary, mental health, HIV and substance abuse care.	Increase in access to health care services for opioid-dependent adults	Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections
Supporting Healthy Relationships	Supporting Healthy Relationships is an educational program for low-income Bronx couples that enhances relationships, fosters child development and provides economic benefits to its participants. The program plays an important role in the community as research shows that parental conflict is strongly correlated to poverty.	Decrease in partner abuse; Increase in healthy relationships	Promote Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Mental Health and Prevent Substance Abuse

<p>Suzanne Pincus Family Learning Place (FLP)</p>	<p>The FLP is a health information and resource center at CHAM that provides families with educational materials about child health and disease, community resources and available supportive services. The FLP's objective is to empower families to make informed decisions about their children's health care and support the principles of family-centered care. The program also assists medical providers by supplying them with materials to educate families.</p>	<p>Increase in satisfaction of CHAM patients and their parents</p>	<p>Promote Healthy Women, Infants and Children</p>
<p>The J.E. and Z.B. Butler Child Advocacy Center</p>	<p>The JE&ZB Butler Child Advocacy Center (CAC), established in 1984, is the only medically based, fully accredited child advocacy center in the NYC dedicated to breaking the cycle of abuse. The CAC provides emergency medical care</p>	<p>Decrease in child abuse; Increase in access to care services for children who have been abused</p>	<p>Promote a Healthy Women, Infants and Children; Promote a Healthy and Safe Environment; Promote Mental Health and Prevent Substance Abuse</p>

	and psychosocial evaluations and therapy to children (0-18) who been victimized by sexual and physical abuse and/or neglect. Butler's dedicated team of doctors, social workers and psychologists also provide education and training of health professionals and law enforcement personnel, and conducts outreach and research.		
University Behavioral Associates	UBA is the major case management agency within Montefiore's Health Home (Bronx Accountable Health Network). UBA has an enrolled census of 4,000 (largest in NYS). And will include the Children's Health Home programs as well.		Promote Mental Health and Prevent Substance Abuse

<p>Women, Infants and Children (WIC) Program</p>	<p>Montefiore's WIC program is the oldest in New York State, established in 1974, and serves 13,000 women, infants and children. WIC is a supplemental nutrition program, providing supplemental food vouchers, nutrition education, breast feeding education, peer counseling and physical fitness education. Women are pre-screened for the program and receive a medical referral to the WIC program from providers, they qualify based on their income. Once they are screened, they receive counseling with a nutritional counselor. Vouchers are distributed for supermarket purchases on a monthly basis for three months' worth of fruits, vegetables, milk, eggs, juice, beans, bread,</p>	<p>Increase in healthy eating; Increase in consumption of fruits and vegetables; Increase in breast feeding; Increase in exercise; Decrease in BMI; Decrease in obesity</p>	<p>Promote Healthy Women, Infants and Children</p>
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	<p>peanut butter, etc. Counselors encourage breastfeeding for new babies. At six months, new mothers receive vouchers for baby food and cereal. At 12 months, no more formula vouchers are given. Participants see a nutritionist every 3 months and qualification is verified annually. Group education, physical education and food demonstrations are given as well. Montefiore provides space and referrals.</p>		
Wound Healing Program	<p>The Wound Healing Program provides inpatient, outpatient, nursing home and home visiting wound healing services. The program focuses on building innovative, patient-centered health services delivery systems that work for wound patients in order to provide</p>	<p>Increase in positive outcomes for wound healing patients</p>	<p>Prevent Chronic Diseases</p>

	excellence in care and to improve wound healing outcomes in the Bronx.		
ExSTEptional Physical Activity Program	The ExSteptional Challenge at WPH engages community members to a stepping challenge that promotes health through walking. Walking is the perfect, low impact exercise ideal for all ages. A minimum of 150 minutes of moderate physical activity per week is recommended for optimal health. The ExSteptional Challenge makes walking fun by turning it into a communal activity with a competitive element. Pedometers and health education are free of charge for all participants.	Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases

<p>Neighborhood Health Fair</p>	<p>For over 42 years, the annual Neighborhood Health Fair is held with free health screenings including: breast exams, prostate exams, HIV screening, blood pressure, podiatry, diabetes risk assessments, dental exams, and lab/blood work for cholesterol and sickle cell anemia. A variety of health information is also distributed.</p>	<p>Screening for various chronic health issues. Mammograms provided free of charge for those eligible.</p>	<p>Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections; Prevent Chronic Diseases</p>
<p>Refuge of Hope Health Fair</p>	<p>The annual Community Health and Wellness Fair in partnership with the Refuge of Hope Church in New Rochelle hosts services including: breast cancer screening and information on other cancers, blood pressure screening, diabetes risk assessments and nutrition information, and vision exams.</p>	<p>Screening for various chronic health issues. Mammograms provided free of charge for those eligible.</p>	<p>Prevent Chronic Diseases</p>

Physician Referral Navigator	Physician referral service: free service providing callers with names of practitioners or specialists.	Increase in accessibility of health care; Increase in utilization of health services	Prevent Chronic diseases
Caregiver Support Group	The Caregiver Support Center is dedicated to providing support to the caregiver, a family member or friend and the primary source of care for an ill family member, in addition to medical support of clinical staff.	Increase in general satisfaction of caregiver	Promote Mental Health and Prevent Substance Abuse
Maternity Classes	Expectant parent courses are open to the public and offer the following: Breastfeeding Support Group, an ongoing group for prenatal and postnatal women led by nurses/certified lactation educators; Childbirth Classes: Lamaze taught by independent & certified instructors; Parenting and Infant Care Classes; Sibling Preparation Courses;	Increase breastfeeding rates; Increase in positive outcomes for labor & delivery patients/mothers	Promote Healthy Woman, Infants and Children

	<p>Prenatal Exercise Classes, including prenatal yoga, mommy and me yoga; Expectant Parent Tours of our Maternity floors are also available.</p>		
<p>Breast Cancer Patient Navigation Program</p>	<p>The Breast Cancer Patient Navigator is the bridge between the community and health care. We eliminate complexity bringing together interdisciplinary teams to work towards reducing breast cancer rates by assessing, educating, scheduling, and guiding our patients through the screening process. Our aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-</p>	<p>Increase in screening for breast cancer; Decrease in breast cancer</p>	<p>Prevent Chronic Diseases</p>

	show and cancellation rates.		
Pancreatic Cancer Early Detection Program	The Pancreatic Cancer Early Detection Program is part of the Digestive Cancer Program at WPH, which applies a modern and comprehensive approach to caring for people with malignancies of the gastrointestinal tract. It features clinical research, coordination of ancillary services, and community outreach, as well as a cancer conference devoted solely to cancers of the digestive tracts. It has an emphasis on early detection, cutting edge advances, and professional	Increase in screening for pancreatic cancer; Decrease in pancreatic cancer	Prevent Chronic Diseases

	collaboration between doctors and nurses.		
Diabetes Disease Management	Through care management services delivered telephonically, face-to-face (both one-on-one and in group settings) and through direct mail, the CMO empowers people with Type II diabetes to improve their health outcomes and quality of life.	Increase in positive health outcomes for individuals with diabetes; Increase in quality of life for individuals with diabetes	Prevent Chronic Diseases

<p>Heart Month</p>	<p>During the month of February, The Center for Heart & Vascular Care conducts a series of educational sessions and health screenings for Montefiore associates and for residents of the Bronx. The Center conducts lectures about heart health and healthy lifestyles as well as blood pressure screenings and counseling sessions at all Montefiore campuses, in senior citizen centers, local elementary schools, colleges and health centers.</p>	<p>Increase in blood pressure screenings; Increase in cardiac health</p>	<p>Prevent Chronic Diseases</p>
<p>Office of Community Relations</p>	<p>By functioning as the link between the community and the medical center's resources, the Office of Community Relations develops positive collaborations with community-based organizations, government agencies and elected officials in</p>	<p>Increase in community-based health interventions</p>	<p>Promote a Healthy and Safe Environment</p>

	the regions served by Montefiore.		
Community Blood Pressure Screenings	Free screenings provided to community members at no cost; occur 1x per month in WPH	Increase in blood pressure screenings;	Prevent Chronic Disease
Lung Cancer Screening	The screening involves a brief interview with a member of the research team, a questionnaire, and a low-dose CT scan. Open to individuals who are at least 50 years of age, have smoked for 20 pack years, and are currently smoking or have stopped smoking within the last 20 years.	Increase in screening for lung cancer	Prevent Chronic Disease

<p>Perinatal Bereavement Support Group</p>	<p>Support group provides families an opportunity to listen and/or share their experiences in a comfortable and safe environment for parents who are mourning a loss.</p>	<p>Increase support to parents in community</p>	<p>Promote Mental Health and Prevent Substance Abuse</p>
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6b. New York State Health Improvement Plan – Implementation Plan and Measures

As a part of the submission for the New York State Health Improvement Plan for 2019-2021, required by the New York State Department of Health, White Plains Hospital has elected to choose the following two prevention agenda priority items: Promote Well-Being and Prevent Mental and Substance Use Disorders and Promote Healthy Women, Infants and Children. Within these priority areas, a commitment has been made to impact the following two focus areas: Mental and Substance Use Disorders Prevention and Perinatal & Infant Health. Across these focus areas, goals, with specific interventions, performance measures and time frames, were identified, and are described below.

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

Focus Area: *Mental and Substance Use Disorders Prevention*

Goal	Goal #2.2: Prevent opioid and other substance misuse and deaths
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Outcome Objectives

Objective 2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population

By December 31, 2021

Target	14.0 per 100,000
Baseline	15.1 per 100,000
Baseline Year	2016
Data Source	CDC WONDER
Data Level	County

Interventions/Strategies/Activities

2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers

2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations

In support of the Westchester County DOH, White Plains Hospital is committed to impacting the opioid epidemic present in our community and nation. In order to impact

Goal

Goal #2.2: Prevent opioid and other substance misuse and deaths

the above two goals, the Hospital is planning on conducting naloxone administration training sessions as well as providing awareness and education in provider and community settings.

Naloxone is an opioid antagonist that can quickly and safely reverse the potentially fatal effects of an opioid overdose. Evidence-based strategies have shown that targeted distribution programs help to train and equip individuals who are most likely to encounter or witness an overdose. Effective approaches include equipping first responders, educating the community as well as community distribution programs.

Despite the high prevalence of mental health and substance use problems, many community members go without treatment, partly due to the lack of a proper diagnosis. The implementation of an evidence-based screening tool has shown to be effective in diagnosing at-risk individuals. The Hospital plans to implement CAGE-AID to screen patients.

The Hospital plans to educate clinicians through a variety of methods:

- Offer educational resources through practice outreach and committee participation
- Data transparency with clinicians about their prescribing practices; continual chart review, counseling and action taken as needed

Process Measures

Naloxone training: Number of executed session and number of attendees/participants will be tracked and assessed.

CAGE-AID screening: Number of prescribers that utilize screening tool; measured through EMR.

Prescriber transparency/education: Offer resources to clinicians on opioid related topics, such as proper prescribing protocols, alternative pain management options, and resources for the community. Conduct minimum of quarterly chart reviews to monitor possibly

Goal	Goal #2.2: Prevent opioid and other substance misuse and deaths
	high prescriber activity, followed by counseling from medical leadership if needed.
Partner Role	Work with Westchester County Department of Health's Department of Community & Mental Health to host naloxone training sessions. Help provide resources to clinicians and community members.
Partner Resources	Provide speaker for training sessions; direct community members to appropriate services.
By When	December 31, 2021
Will Action Address Disparity	Yes. The proposed programs are proven to effectively combat opioid misuse and educate providers and community members.
Priority Area: Promoting Healthy Women, Infants and Children	
Focus Area: Perinatal & Infant Health	

Goal	Goal 2.2 Increase breastfeeding										
Outcome Objectives	Objective 2.2.1.0: Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among all infants										
	<table border="1"> <tr> <td>Target</td> <td>51.7</td> </tr> <tr> <td>Baseline</td> <td>47.0</td> </tr> <tr> <td>Baseline Year</td> <td>2016</td> </tr> <tr> <td>Data Source</td> <td>Vital Statistics</td> </tr> <tr> <td>Data Level</td> <td>State, Region, County</td> </tr> </table>	Target	51.7	Baseline	47.0	Baseline Year	2016	Data Source	Vital Statistics	Data Level	State, Region, County
Target	51.7										
Baseline	47.0										
Baseline Year	2016										
Data Source	Vital Statistics										
Data Level	State, Region, County										
Interventions/Strategies/Activities	Intervention 2.2.2: Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding.										

Goal

Goal 2.2 Increase breastfeeding

The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding.

Consistent with Baby Friendly guidelines, the hospital continues to encourage exclusive breastfeeding practices through the following steps:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff
2. Train all health care staff in the skills necessary to implement this policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Help moms initiate breastfeeding within one hour of birth
5. Show moms how to breastfeed and how to maintain lactation even if they are separated from their infants
6. Give infants no food or drink other than breast milk, unless medically indicated
7. Practice rooming-in. Allow mothers and infants to remain together 24 hours a day
8. Encourage breastfeeding on demand
9. Give no artificial nipples or pacifiers to breastfed infants
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

Process Measures

White Plains Hospital will evaluate its breastfeeding implementation rates against Vital Statistics 2016 target (51.7%).

Partner Role

Engagement and referral into appropriate programs (clinical or community) to support mothers at risk for preterm delivery, including non-maternity based

Goal	Goal 2.2 Increase breastfeeding
	<p>programs that correlate to social determinants of health that impact prematurity and access to breastfeeding resources.</p>
Partner Resources	<p>Provide supportive community programming, visit assistance, and educational resources.</p>
By When	<p>December 31, 2021</p>
Will Action Address Disparity	<p>Yes. The staff are extremely invested in reaching the prevention agenda goals for exclusive breastfeeding rates.</p>

7. **Appendix**

7.a.i. Westchester County Consumer Survey Flyer



WESTCHESTER COUNTY CARES

Take our brief survey. Tell us what health issues are important to you and your community.*

English survey

<https://www.surveymonkey.com/r/2019WCHealthSurvey>



Point your smartphone camera at the QR code for a direct link to the survey.

Español survey

<https://es.surveymonkey.com/r/2019WCHESPANOL>



Point your smartphone camera at the QR code for a direct link to the survey.

*Residents must be 18 years of age or older to take the survey.

 Westchester
gov.com

George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

7.a.ii. Westchester County Consumer Survey - English



2019 WESTCHESTER COUNTY COMMUNITY HEALTH SURVEY		
<p>There are many areas where the healthcare system can make efforts to improve the community. We are interested to hear your thoughts on what issues should be a priority in your community and for your personal health. The Health Department and hospitals in Westchester County will use the results to help improve health programs. Please take a few minutes to fill out this survey if you are 18 years or older. Your responses are anonymous. Please return your finished responses to <i>Elissa Cestone, Department of Health, 10 County Center Road, 2nd Floor, White Plains, NY 10607. Phone #: 914-995-7499. email:ec9@westchestergov.com</i></p> <p>You may also take the survey online at: https://www.surveymonkey.com/r/2019WCHealthSurvey</p> <p>Thank you for your participation!</p>		
The first few questions are about the health needs of the COMMUNITY WHERE YOU LIVE.		
What THREE areas do you see as being priority health issues in the COMMUNITY WHERE YOU LIVE?		
<input type="checkbox"/> Antibiotic resistance and healthcare associated infections	<input type="checkbox"/> Mental health	
<input type="checkbox"/> Child and adolescent health	<input type="checkbox"/> Newborn and infant health	
<input type="checkbox"/> Chronic disease screening and care for conditions like asthma, diabetes, cancer and heart disease	<input type="checkbox"/> Obesity	
<input type="checkbox"/> Environments that promote well-being & active lifestyles	<input type="checkbox"/> Outdoor air quality	
<input type="checkbox"/> Food and nutrition	<input type="checkbox"/> Physical activity	
<input type="checkbox"/> Food safety and chemicals in consumer products	<input type="checkbox"/> Sexually transmitted diseases	
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Smoking, vaping, and secondhand smoke	
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Substance use disorders	
<input type="checkbox"/> Injuries, such as falls, work-injuries, or traffic-injuries	<input type="checkbox"/> Vaccinations/immunizations	
<input type="checkbox"/> Maternal and women's health	<input type="checkbox"/> Violence	
	<input type="checkbox"/> Water quality	
What THREE actions would be most helpful to improve the health of the COMMUNITY WHERE YOU LIVE?		
<input type="checkbox"/> Access to dental care	<input type="checkbox"/> Domestic violence prevention/victim support	<input type="checkbox"/> Mental health services
<input type="checkbox"/> Access to education	<input type="checkbox"/> Employment opportunities	<input type="checkbox"/> Public transportation
<input type="checkbox"/> Access to healthier food	<input type="checkbox"/> Exercise & weight loss programs	<input type="checkbox"/> Quality and affordable childcare
<input type="checkbox"/> Access to primary care	<input type="checkbox"/> Health insurance enrollment	<input type="checkbox"/> Safe places to walk & play
<input type="checkbox"/> Affordable housing	<input type="checkbox"/> Health screenings	<input type="checkbox"/> Services for LGBTQ population
<input type="checkbox"/> Breastfeeding support	<input type="checkbox"/> Home care services	<input type="checkbox"/> Services for older adults
<input type="checkbox"/> Caregiver support	<input type="checkbox"/> Immigrant support services	<input type="checkbox"/> Smoking & tobacco services
<input type="checkbox"/> Clean air & water	<input type="checkbox"/> Improving racial equality	<input type="checkbox"/> Violence prevention
<input type="checkbox"/> Drug & alcohol treatment services		<input type="checkbox"/> Other _____
What population needs the greatest attention?		
<input type="checkbox"/> Infants	<input type="checkbox"/> Teens	<input type="checkbox"/> Older adults
<input type="checkbox"/> Young children	<input type="checkbox"/> Young adults	<input type="checkbox"/> Other specific groups _____
<input type="checkbox"/> School-age children	<input type="checkbox"/> Middle-aged adults	
The rest of the survey is about YOU and YOUR health needs		
What THREE areas do you see as being priority health issues for YOURSELF?		
<input type="checkbox"/> Antibiotic resistance and healthcare associated infections	<input type="checkbox"/> Mental health	
<input type="checkbox"/> Child and adolescent health	<input type="checkbox"/> Newborn and infant health	
<input type="checkbox"/> Chronic disease screening and care for conditions like asthma, diabetes, cancer and heart disease	<input type="checkbox"/> Obesity	
<input type="checkbox"/> Environments that promote well-being & active lifestyles	<input type="checkbox"/> Outdoor air quality	
<input type="checkbox"/> Food and nutrition	<input type="checkbox"/> Physical activity	
<input type="checkbox"/> Food safety and chemicals in consumer products	<input type="checkbox"/> Sexually transmitted diseases	
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Smoking, vaping, and secondhand smoke	
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Substance use disorders	
<input type="checkbox"/> Injuries, such as falls, work-injuries, or traffic-injuries	<input type="checkbox"/> Vaccinations/immunizations	
<input type="checkbox"/> Maternal and women's health	<input type="checkbox"/> Violence	
	<input type="checkbox"/> Water quality	

Would you say that in general your health is:		
<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Poor
<input type="checkbox"/> Very good	<input type="checkbox"/> Fair	
Do you have somebody that you think of as your personal doctor or health care provider?		
		<input type="checkbox"/> Yes _____
		<input type="checkbox"/> No _____
Has a doctor, nurse or other health professional told you that you had any of the following (check all that apply)?		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> COPD, emphysema, or chronic bronchitis	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Cancer (excluding skin cancer)	<input type="checkbox"/> Diabetes (excluding during pregnancy)	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Skin cancer		<input type="checkbox"/> Other _____
Was there a time in the past 12 months when you needed to see a doctor but could not because of the following?		
Cost	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Unable to get an appointment
		<input type="checkbox"/> Yes <input type="checkbox"/> No
What type of insurance do you use to pay for your doctor or hospital bills (check all that apply)?		
<input type="checkbox"/> Your employer or a family member's employer	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other _____
<input type="checkbox"/> The New York State Marketplace (Exchange/Obamacare)	<input type="checkbox"/> Medicaid	<input type="checkbox"/> I don't have health insurance
	<input type="checkbox"/> Military (TriCare or VA)	
	<input type="checkbox"/> COBRA	
During the past 30 days, have you felt emotionally upset, for example, angry, sad, or frustrated, as a result of how you were treated based on any of the following...		
Age	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual orientation
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Gender Identity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Perceived immigration status
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Race/Ethnicity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Religion
		<input type="checkbox"/> Yes <input type="checkbox"/> No
The next set of questions will be used to describe who responds to the survey and will not be examined individually. Please remember that your responses are anonymous.		
What is your current gender identity?		
<input type="checkbox"/> Female	<input type="checkbox"/> Trans female/Trans woman	<input type="checkbox"/> Gender not listed (please state): _____
<input type="checkbox"/> Male	<input type="checkbox"/> Trans male/Trans man	
<input type="checkbox"/> Non-binary person/Gender non-conforming		
What is your age?		
<input type="checkbox"/> 18-24	<input type="checkbox"/> 45-54	<input type="checkbox"/> 75+
<input type="checkbox"/> 25-34	<input type="checkbox"/> 55-64	
<input type="checkbox"/> 35-44	<input type="checkbox"/> 65-74	
What is the highest grade or year of school you completed?		
<input type="checkbox"/> Less than high school	<input type="checkbox"/> Some college or technical school	<input type="checkbox"/> Advanced or professional degree
<input type="checkbox"/> High school grad/GED	<input type="checkbox"/> College graduate	
What is the ZIP Code where you currently live?		
<input type="text"/>		
Are you of Hispanic or Latino origin?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Which one the following best describes your race?		
<input type="checkbox"/> White	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Multi-racial
<input type="checkbox"/> Black/African American	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Other _____
Are you currently?		
<input type="checkbox"/> Employed	<input type="checkbox"/> A homemaker	<input type="checkbox"/> Unable to work
<input type="checkbox"/> Self employed	<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Out of work	<input type="checkbox"/> Retired	
What is the primary language spoken in your home?		
<input type="checkbox"/> English	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Other _____
<input type="checkbox"/> Spanish	<input type="checkbox"/> Chinese	
<input type="checkbox"/> Italian	<input type="checkbox"/> French	

7.a.iii. Westchester County Consumer Survey – Spanish



ENCUESTA COMUNITARIA DE SALUD DEL CONDADO DE WESTCHESTER 2019

Hay muchas áreas donde el sistema de salud puede hacer esfuerzos para mejorar la comunidad. Estamos interesados en escuchar su opinión sobre qué asuntos deben ser una prioridad en su comunidad y para su salud personal. El Departamento de Salud y los hospitales del Condado de Westchester usarán los resultados para ayudar a mejorar los programas de salud. Por favor tome unos pocos minutos para llenar esta encuesta si tiene 18 años o más. Sus respuestas serán confidenciales.

Si prefiere tomar esta encuesta en línea, por favor siga este enlace: <https://www.surveymonkey.com/r/2019WCHESPANOL>

¡Gracias por su participación!

Las primeras preguntas son sobre las necesidades de salud de la COMUNIDAD DONDE USTED VIVE.

¿Cuáles son las TRES áreas que usted considera como temas de salud prioritarios en la COMUNIDAD DONDE VIVE?

- | | |
|--|--|
| <input type="checkbox"/> Resistencia a antibióticos e infecciones asociadas al cuidado de la salud | <input type="checkbox"/> Salud mental |
| <input type="checkbox"/> Salud de niños y adolescentes | <input type="checkbox"/> Salud de recién nacidos y infantes |
| <input type="checkbox"/> Exámenes de enfermedades crónicas y cuidado de condiciones como asma, diabetes, cáncer y enfermedades del corazón | <input type="checkbox"/> Obesidad |
| <input type="checkbox"/> Ambientes que promuevan el bienestar y estilos de vida activa | <input type="checkbox"/> Calidad del aire exterior |
| <input type="checkbox"/> Alimentación y nutrición | <input type="checkbox"/> Actividad física |
| <input type="checkbox"/> Seguridad alimenticia y químicos en productos de consumo | <input type="checkbox"/> Enfermedades de transmisión sexual |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Fumar, cigarrillos electrónicos, y humo de segunda mano |
| <input type="checkbox"/> VIH/SIDA | <input type="checkbox"/> Trastornos por uso de sustancias |
| <input type="checkbox"/> Lesiones, como caídas, accidentes laborales, o accidentes de tráfico | <input type="checkbox"/> Vacunas/inmunizaciones |
| <input type="checkbox"/> Salud materna y de la mujer | <input type="checkbox"/> Violencia |
| | <input type="checkbox"/> Calidad del agua |

¿Cuáles son las TRES acciones más útiles para mejorar la salud de la COMUNIDAD DONDE VIVE?

- | | | |
|---|---|--|
| <input type="checkbox"/> Acceso al cuidado dental | <input type="checkbox"/> Prevención de violencia doméstica/ apoyo para víctimas | <input type="checkbox"/> Servicios de salud mental |
| <input type="checkbox"/> Acceso a la educación | <input type="checkbox"/> Oportunidades de empleo | <input type="checkbox"/> Transporte público |
| <input type="checkbox"/> Acceso a alimentos más saludables | <input type="checkbox"/> Programas de ejercicio y pérdida de peso | <input type="checkbox"/> Cuidado infantil de calidad y accesible |
| <input type="checkbox"/> Acceso al cuidado primario | <input type="checkbox"/> Inscripción en seguros de salud | <input type="checkbox"/> Lugares seguros para caminar y jugar |
| <input type="checkbox"/> Vivienda accesible | <input type="checkbox"/> Exámenes de salud | <input type="checkbox"/> Servicios para la población LGBTQ |
| <input type="checkbox"/> Apoyo a la lactancia materna | <input type="checkbox"/> Servicios de cuidado en el hogar | <input type="checkbox"/> Servicios para adultos mayores |
| <input type="checkbox"/> Apoyo del cuidador | <input type="checkbox"/> Servicio de ayuda al inmigrante | <input type="checkbox"/> Servicios para fumadores y tabaco |
| <input type="checkbox"/> Aire y agua limpios | <input type="checkbox"/> Mejoramiento de la igualdad racial | <input type="checkbox"/> Prevención de violencia |
| <input type="checkbox"/> Servicio y tratamiento para alcohol y drogas | | <input type="checkbox"/> Otros _____ |

¿Qué población cree usted que necesita mayor atención?

- | | | |
|--|--|--|
| <input type="checkbox"/> Infantes | <input type="checkbox"/> Adolescentes | <input type="checkbox"/> Adultos mayores |
| <input type="checkbox"/> Niños jóvenes | <input type="checkbox"/> Jóvenes adultos | <input type="checkbox"/> Otro grupo específico _____ |
| <input type="checkbox"/> Niños en edad escolar | <input type="checkbox"/> Adultos de mediana edad | |

El resto de la encuesta es sobre USTED y SUS necesidades de salud

¿Cuáles son las TRES áreas que considera como temas de salud prioritarios para su salud?

- | | |
|--|--|
| <input type="checkbox"/> Resistencia a antibióticos e infecciones asociadas al cuidado de la salud | <input type="checkbox"/> Salud mental |
| <input type="checkbox"/> Salud de niños y adolescentes | <input type="checkbox"/> Salud de recién nacidos y infantes |
| <input type="checkbox"/> Exámenes de enfermedades crónicas y cuidado de condiciones como asma, diabetes, cáncer y enfermedades del corazón | <input type="checkbox"/> Obesidad |
| <input type="checkbox"/> Ambientes que promuevan el bienestar y estilos de vida activa | <input type="checkbox"/> Calidad del aire exterior |
| <input type="checkbox"/> Alimentación y nutrición | <input type="checkbox"/> Actividad física |
| <input type="checkbox"/> Seguridad alimenticia y químicos en productos de consumo | <input type="checkbox"/> Enfermedades de transmisión sexual |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Fumar, cigarrillos electrónicos, y humo de segunda mano |
| <input type="checkbox"/> VIH/SIDA | <input type="checkbox"/> Trastornos por uso de sustancias |
| <input type="checkbox"/> Lesiones, como caídas, accidentes laborales, o accidentes de tráfico | <input type="checkbox"/> Vacunas/inmunizaciones |
| <input type="checkbox"/> Salud materna y de la mujer | <input type="checkbox"/> Violencia |
| | <input type="checkbox"/> Calidad del agua |

Como considera su salud?		
<input type="checkbox"/> Excelente	<input type="checkbox"/> Buena	<input type="checkbox"/> Pobre
<input type="checkbox"/> Muy Buena	<input type="checkbox"/> Normal	
¿Tiene a alguien que usted considere como su médico personal?		<input type="checkbox"/> Sí _____ <input type="checkbox"/> No _____
¿Algún doctor, enfermera u otro profesional de salud le ha dicho que padece de alguna de las siguientes enfermedades? (marque todas las que apliquen)		
<input type="checkbox"/> Artritis	<input type="checkbox"/> COPD, enfisema, o bronquitis crónica	<input type="checkbox"/> Enfermedades del corazón
<input type="checkbox"/> Asma	<input type="checkbox"/> Depresión/ansiedad	<input type="checkbox"/> Enfermedades del riñón
<input type="checkbox"/> Cáncer (excluyendo el cáncer de piel)	<input type="checkbox"/> Diabetes (excluyendo durante el embarazo)	<input type="checkbox"/> Hipertensión
<input type="checkbox"/> Cáncer de piel		<input type="checkbox"/> Otro _____
¿Hubo algún momento en los últimos 12 meses cuando necesitó ver a un doctor pero no pudo a causa de los siguientes?		
Dinero	<input type="checkbox"/> Sí <input type="checkbox"/> No	Transporte
		<input type="checkbox"/> Sí <input type="checkbox"/> No
		No pudo hacer una cita
		<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Qué tipo de seguro usa para pagar a su doctor o las facturas del hospital (marque todas las que apliquen)?		
<input type="checkbox"/> Su empleador o el empleador de un familiar	<input type="checkbox"/> Medicare	<input type="checkbox"/> Otro _____
<input type="checkbox"/> Seguro del Estado de Nueva York (Intercambio/Obamacare)	<input type="checkbox"/> Medicaid	<input type="checkbox"/> No tengo seguro de salud
	<input type="checkbox"/> Militar (TriCare o VA)	
	<input type="checkbox"/> COBRA	
Durante los últimos 30 días, se ha sentido emocionalmente molesto, por ejemplo, enojado, triste, o frustrado, como resultado de cómo fue tratado en base a los siguientes...		
Edad	<input type="checkbox"/> Sí <input type="checkbox"/> No	Orientación sexual
		<input type="checkbox"/> Sí <input type="checkbox"/> No
Identidad de género	<input type="checkbox"/> Sí <input type="checkbox"/> No	Percepción de estado migratorio
		<input type="checkbox"/> Sí <input type="checkbox"/> No
Raza/Etnicidad	<input type="checkbox"/> Sí <input type="checkbox"/> No	Religión
		<input type="checkbox"/> Sí <input type="checkbox"/> No
Discapacidad		
		<input type="checkbox"/> Sí <input type="checkbox"/> No
		Otro
		<input type="checkbox"/> Sí <input type="checkbox"/> No
Por favor recuerde que sus respuestas son confidenciales, El siguiente grupo de preguntas serán usadas para describir mejor quién responde a la encuesta y no serán examinadas individualmente.		
¿Cuál es su identidad de género?		
<input type="checkbox"/> Mujer	<input type="checkbox"/> Mujer transgénero	<input type="checkbox"/> Género no listado (por favor declare): _____
<input type="checkbox"/> Hombre	<input type="checkbox"/> Hombre transgénero	
<input type="checkbox"/> Género no binario/Género unconforme		
¿Cuál es su edad?		
<input type="checkbox"/> 18-24	<input type="checkbox"/> 45-54	<input type="checkbox"/> 75+
<input type="checkbox"/> 25-34	<input type="checkbox"/> 55-64	
<input type="checkbox"/> 35-44	<input type="checkbox"/> 65-74	
¿Cuál es su más alto grado de estudio o año de escuela que completó?		
<input type="checkbox"/> Menos que la secundaria	<input type="checkbox"/> Algo de universidad o escuela técnica	<input type="checkbox"/> Título profesional o avanzado
<input type="checkbox"/> Graduado de secundaria/GED	<input type="checkbox"/> Graduado de universidad	
¿Cuál es el Código postal donde usted vive actualmente?		
<input type="text"/>		
¿Usted es de origen Hispano o Latino?		
<input type="checkbox"/> Sí <input type="checkbox"/> No		
¿Cuál de las siguientes describe mejor su raza?		
<input type="checkbox"/> Blanco	<input type="checkbox"/> Asiático/Isleño del Pacífico	<input type="checkbox"/> Multiracial
<input type="checkbox"/> Negro/Afro Americano	<input type="checkbox"/> Nativo Americano/Nativo de Alaska	<input type="checkbox"/> Otro _____
¿Está usted actualmente?		
<input type="checkbox"/> Empleado	<input type="checkbox"/> Cuida del hogar	<input type="checkbox"/> No puede trabajar
<input type="checkbox"/> Auto empleado	<input type="checkbox"/> Estudiante	<input type="checkbox"/> Otro _____
<input type="checkbox"/> Sin trabajo	<input type="checkbox"/> Jubilado	
¿Cuál es el lenguaje predominante que se habla en su casa?		
<input type="checkbox"/> Inglés	<input type="checkbox"/> Portugués	<input type="checkbox"/> Otro _____
<input type="checkbox"/> Español	<input type="checkbox"/> Chino	
<input type="checkbox"/> Italiano	<input type="checkbox"/> Francés	

Westchester County 2019 Health Summit Report

APRIL 5, 2019



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EXECUTIVE SUMMARY

The Westchester County Health Planning Coalition collaboratively hosted a Community Health Summit on April 5, 2019 in White Plains, NY. The purpose of this meeting was to elicit feedback from the local community, government and health and social service providers related to their perspective on the health and social needs of their clients with the goal of advancing the New York State Department of Health's 2019-2024 Prevention Agenda (NYSPA) to:

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

Over 70 attendees across health and community based organizations participated in the Premier facilitated breakout sessions and a Gallery Walk intended to promote conversation focused upon four of the New York State Department of Health's 2019-2024 Prevention Agenda (NYSPA):

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

While familiarity with the topics varied between individuals, all were engaged and focused upon identifying concerns and proposing actionable solutions.

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

There are many strengths & resources existing in the community.

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

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

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

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

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

Social Determinants of Health must be considered when developing strategies.

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

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

NYSPA #1: Prevent Chronic Diseases

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

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

NYSPA #2: Promote a Healthy and Safe Environment

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

ACTION: Address currently fragmented and inconsistent education and communication.

NYSPA #3: Promote Healthy Women, Infants and Children

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

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

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

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

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

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

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

The sections that follow include an overview of the event planners, participants and methodology as well as detailed findings for each NYSPA topic area.

INTRODUCTION

Community Health Summit Planners, Purpose and Participants

The Westchester County Department of Health (WCDOH) and the sixteen local Westchester County Hospitals, known as the Westchester County Health Planning Coalition (WCHPC), collaboratively hosted a Community Health Summit (the “Summit”) on April 5, 2019 in White Plains, NY. The WCHPC was formed in response to the New York State Department of Health’s (NYSDOH) appeal that each county’s local health department, hospitals/hospital systems and other community partners collectively work together to identify and address local health priorities associated with the New York State Prevention Agenda (NYSPA). Their ultimate goal is advancing the health and wellness of Westchester County residents.

The purpose of the Summit was to convene local community, government and health and social service providers with the objective of discussing community health and social needs related to the NYSPA. This report will be integrated into a Community Health Needs Assessment (CHNA) that is required by the NYSDOH and is an element in the Community Health Improvement Plan (CHIP), which all local health departments must develop.

This report provides a summary of opinions shared by attendees at the Summit. These opinions are not intended to represent the community hospitals nor the WCDOH.

The following organizations participated in this event:

African American Men of Westchester	Leukemia Lymphoma Society
American Heart Association	Lexington Center for Recovery
American Lung Association	Lifting Up Westchester
ANDRUS	Lower Hudson Valley Perinatal Network
Arms Acres & Conifer Park	Montefiore Mount Vernon & New Rochelle Hospitals
Blind Brook Community Coalition	Mount Vernon Neighborhood Health Center
Blythedale Children’s Hospital	Neighbors Link
Brannan Solutions Group	Northwell Phelps & Northern Westchester Hospitals
Burke Rehabilitation Center	NYC Poison Control Center
Caritas of Port Chester, Inc.	New York Medical College
Child Care council of Westchester	New York Presbyterian Hudson Valley & Lawrence Hospitals
Family Ties of Westchester	Open Door Family Medical Center
Feeding Westchester	Peekskill Youth Bureau
Hudson River Health Care	Rivertowns Pediatrics PC
Independent Living, Inc.	Rye YMCA
Inter-Care, Ltd	
John A. Coleman School	

New York State Department of Health’s Prevention Agenda (NYSPA)

The NYSPA is the blueprint for state and local action to 1) improve the health of New Yorkers in five priority areas; and 2) reduce health disparities for racial, ethnic, disability and low socioeconomic groups, as well as other populations who experience them. The prevention agenda was utilized as the event framework for discussions during the Summit.

 PREVENT CHRONIC DISEASE	 PROMOTE A HEALTHY AND SAFE ENVIRONMENT	 HEALTHY WOMEN, INFANTS AND CHILDREN	 PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDER	 PREVENT COMMUNICABLE DISEASE
<ul style="list-style-type: none"> • Healthy eating and food security • Physical activity • Tobacco prevention • Preventive care and management 	<ul style="list-style-type: none"> • Injuries, violence and occupational health • Outdoor air quality • Build and indoor environment • Water quality • Food and consumer products 	<ul style="list-style-type: none"> • Maternal & women’s health • Perinatal & infant health • Child & adolescent health • Cross cutting healthy women, infants & children 	<ul style="list-style-type: none"> • Promote well-being • Prevent mental and substance use disorders 	<ul style="list-style-type: none"> • Vaccine-preventable diseases • Human immunodeficiency virus (HIV) • Sexually transmitted infections (STIs) • Hepatitis C virus • Antibiotic resistance and healthcare associated infections

Source: New York State Department of Health

Please refer to Appendix A for the full list of NYSPA Priority Areas, Focus Areas and Goals.

For additional information on the NYSPA please visit the NYS Department of Health website and/or https://www.health.ny.gov/prevention/prevention_agenda/2019-2024.

Methodology

Topic Areas of Identified Community Need

The Westchester County Department of Health administered a 2019 Community Health Survey between January 29, 2019 and March 31, 2019, in English and Spanish, asking County residents 18 and older to assess their own health as well as the health of their community. This anonymous online and paper survey sought to identify the top priority health issues for Westchester residents and their community, the most needed services and the largest obstacles that prevent access to care.

Final responses numbered over 3,500 but based upon the preliminary results of the survey the four Priority Areas listed below were selected for discussion at the Westchester County 2019 Health Summit.

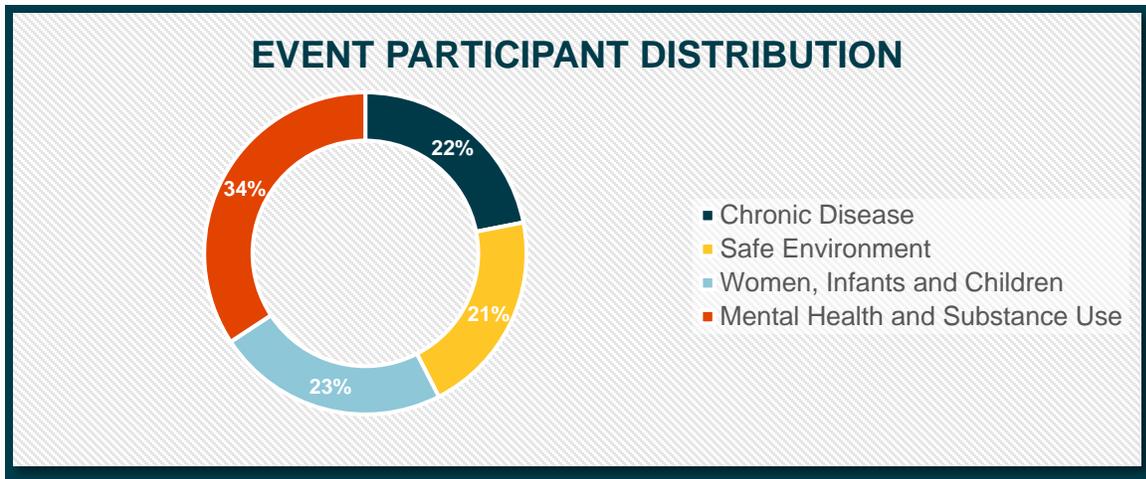
1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants and Children
4. Promote Well-being and Prevent Mental and Substance Use Disorder

The fifth NYSPA Priority Area - Prevent Communicable Diseases – was not a focus of discussion for this specific meeting.

Registration

Electronic invitations were widely distributed by all Westchester County Health Planning Coalition members (the Westchester County Department of Health and the local Westchester County Hospitals). Please refer to Appendix B for the event invitation.

So that there would be a balanced number of attendees in each discussion group, members were asked to pre-register and to self-report their preference in rank-order among the four NYSPA Priority Areas. There were 81 final pre-registrants and approximately 67 sign-ins the day of the event – April 5, 2019. The self-assigned distribution by prevention agenda priority follows.



Source: Westchester County Department of Health

Facilitation

Premier, Inc. was engaged to facilitate the breakout sessions and Gallery Walk at the direction of event planners representative of the Westchester County Department of Health, Montefiore Health System, New York Presbyterian Healthcare System and Northwell, Inc. Premier partnered with the event planners to design the strategy for the meeting inclusive of breakout sessions and a Gallery Walk. Breakout sessions were recommended in order to obtain open conversation & feedback and allow an opportunity for each participant to speak in smaller convened groups. A Gallery Walk was included to ensure that all participants could be involved in the discussions for all the Priority Areas and offer additive input into the process.

Premier is a provider-driven healthcare performance improvement company uniting an alliance of approximately 4,000 U.S. hospitals and more than 165,000 other provider organizations. Premier operates a nationally recognized healthcare consulting organization, co-innovating solutions with its members to reduce costs, improve quality and produce better patient outcomes. Premier's mission is simple: To improve the health of communities.

Event Activities

Attendees were assigned to a single breakout session corresponding to one of the four NYSPA Priority Areas based upon their pre-registered self-selected preference. Four facilitators from Premier were engaged to lead each of the four one-hour breakout sessions, using the below questions to guide discussions.

1. Describe the 3-5 year goal for health improvement, for this priority area.
2. What are the top issues and barriers to achieving this goal?
3. Are there specific populations impacted more than others?
4. What initiatives/interventions are needed to address the issues and barriers?
5. What community resources are available to support this goal?

Social determinants of health and health inequalities were incorporated into all discussions at the request of Westchester County Health Department leaders.

The four breakout sessions were conducted in English only, and were not recorded so that participants would not feel either inhibited or intimidated in discussion. Notes memorializing conversations were captured on flip charts within each breakout session.

After a short break, attendees were asked to participate in a “Gallery Walk” exercise. Attendees rotated through each of the other three breakout rooms in succession. The facilitator in each room gave an initial summary of the baseline group’s discussions. Participants were then asked to provide additional input and perspectives to the topics and questions previously recorded, building upon the discussions that had already taken place. The objective of the Gallery Walk was to create generative discussions around the topics with reinforcing as well as additive input. Conversations were added to the flip charts. Gallery Walks occurred in 20-minute discussions, totaling 60 minutes. By the time the gallery walk was completed, each attendee had the opportunity to engage in dialogs for all four NYSPA Priority Areas across one 60-minute breakout session and three 20-minute Gallery Walk rotations.

Please refer to Appendix C for the event agenda.

CONCLUSIONS BY PRIORITY AREA

In the pages that follow are the takeaways, key ideas and essential elements of the combined discussions held within each of the four breakout sessions and from the additional feedback provided by all attendees of other sessions during the Gallery Walk activity. These reflect the concepts and action items which received the most discussion and where there was greater consensus around specific subjects and ideas expressed. Please refer to Appendix D for the complete notes collected within each of these four areas.

The graphic below includes the top 24 words most frequently used during the Summit.



PRIORITY AREA 1: PREVENT CHRONIC DISEASES

- Focus Area 1: Healthy Eating and Food Security
- Focus Area 2: Physical Activity
- Focus Area 3: Tobacco Prevention
- Focus Area 4: Preventive Care and Management

The “Prevent Chronic Disease” breakout group referred to the sub-goals identified for each of the four Focus Areas in this Priority Area (as outlined in the Introduction above) as specified in the New York State Prevention Agenda 2019 – 2024. These are considered the three-to-five-year goals for the Priority Area.

Focus Areas 1 and 2 in this Priority Area have the same Overarching Goal: **“Reduce obesity and the risk of chronic illness”**.

Chronic diseases were acknowledged as primarily cancer, cardiovascular disease and diabetes. The group discussed a study reported by USA Today in the April 4, 2019 edition entitled “Global Burden of Disease Analysis” published in The Lancet. The peer reviewed study suggests that one in five deaths worldwide (approximately 11 million) are linked to unhealthy eating habits. This study affirms what many have thought for several years – that “poor diet is responsible for more deaths than any other risk factor in the world” according to the study’s author, Dr. Christopher Murray of the University of Washington. The deaths included about 10 million from cardiovascular disease, 913,000 from cancer and almost 339,000 from Type 2 diabetes. The study was funded by the Bill and Melinda Gates Foundation.

Discussion commenced by asking each participant to identify the most important issues that should be top priorities for achieving the stated goals. These ideas were shared and reinforced by other group members, and this continued throughout the session for each of the question areas discussed. Overall conclusions are stated as follows:

Conclusion – Home focused educational efforts with support initiatives from schools and other entities are crucial for improvement. A clear conclusion from discussions among all participants engaging in the discussion in this session is that home and school focused efforts to create healthy behaviors, choices and habits among children beginning at early ages are at the base of creating a generation of health-aware children. Education and developing good habits at a very early age is acknowledged as essential regarding healthy food choices, increased physical activity and

“Schools are the best resource outside of the home for providing youths with access to healthy, balanced, “attractive” meals and snacks...”

-Retreat Participant

personal care priorities. Education for people of all ages is important (especially parents of youth), and a balanced effort among all community resources is essential to create consistent messaging and provide behavior-reinforcing support that will result in improved life conditions, well-being and personal satisfaction.

Conclusion – Align conflicting economic incentives. Economic realities and implications were acknowledged as paramount to address in the quest to prevent chronic diseases in the County. This includes economic and behavioral aspects of shopping, including advertising and “quick fixes” associated with convenience stores, fast food availability and ease of access and lack of healthy food options generally, and specifically in colder weather seasons. Product placement on store shelves and at check-out of unhealthy food items puts young consumers in conflict with immediate gratification versus realizing long-term benefits of avoiding obesity, chronic diseases (e.g., diabetes, heart disease, stroke) and poor nutrition.

Conclusion – Encourage healthy lifestyle choices through constant awareness of basic indicators. Another takeaway and key action item identified and endorsed wholeheartedly by participants was to initiate a campaign that encourages everyone (especially men) to know their “golden three numbers.” That is, every male over age 21 knows their cholesterol level, blood pressure numbers, and blood sugar levels, updated every year. Awareness of these three numbers as “entry level” measures of health status would be a non-threatening way of consistently monitoring basic health indicators that will influence decisions over time that can preserve and enhance health, wellness and personal life satisfaction.

Conclusion – Safety is paramount for community well-being. The community needs “safe” groups, spaces and places for children, adults, women and others that are safe havens for activity, refuge and recovery. These exist in some areas; however, there is a need to expand and promote these resources more broadly throughout the County. (Note: The safe spaces concept should extend to undocumented individuals as well.)

Conclusion – Maximize existing resources through coordinated efforts. Participants agreed that adequate and appropriate resources exist across the County to address the four focus areas of concern. What is lacking is coordination across all entities concerned with prevention, health maintenance, wellness, disease detection, diagnosis and treatment (outpatient, inpatient, post-acute and home care). This includes CBOs (Community Benefit Organizations), who were acknowledged as essential resources already in place throughout the County and should be more proactively and assertively included and engaged as cooperative partners in addressing access issues related to nutrition, food choices, diet, education, physical activity and other capabilities and resources. It was recommended that in preventive care efforts that the “Stanford Chronic Disease Program” should be used as a model for chronic disease related behavior change (specifically targets diabetes prevention). This is an evidence-based program, and Medicare payment should be explored for SCDP participation.

Conclusion – Tobacco prevention and elimination will be difficult and require consistent education and awareness efforts. Youth are being targeted and enticed by advertising, easy

access, a “cool” factor among peers and examples of adults. Electronic cigarettes, electronic vaping, juuls, flavored products and other gateway means of attraction and addiction are pervasive. These elements will require consistent education and awareness-building efforts to combat.

Top Action(s) Discussed

Participants in each of the four sessions (baseline group and Gallery Walk groups) from all the various organizations represented strongly emphasized the need to support and leverage existing community resources as a top priority and seek collaboration in support of education efforts in homes, schools, churches, CBOs and other appropriate settings:

“It’s never too early to educate individuals regarding good health behaviors and choices.”
-Retreat Participant

“We often start too late in teaching children good health and wellness behaviors.”
-Retreat Participant

- Schools and many other non-traditional healthcare organizations in the County provide important settings for the delivery of resources for education, training and other needed assistance. School efforts should be more uniform, coordinated and supported.
 - More effective collaboration is needed among schools, public health entities, hospitals, and other health and wellness organizations across the continuum of health/wellness interests and should be proactively pursued and supported.
 - Local companies and employers should be engaged (and actively reached out to) to identify and cooperatively support solutions in balanced, unified efforts; they need to be reinforced that it is in their interests to be involved in these efforts.
-
- Ensure that education curriculums reinforce short- and long-term benefits and value of healthy decisions (around nutrition, obesity prevention, tobacco use, etc.)
 - Teaching good financial skills (debt prevention and resource management) must be integrated with teaching health and wellness behaviors
 - Use social media much more effectively and intensively to meet children “at their interest level”
 - Address issues that impact healthy food and physical activity such as education, home, schools, transportation, finances, access to healthy food, safety and structural realities



PRIORITY AREA 2: PROMOTE A HEALTHY AND SAFE ENVIRONMENT

- Focus Area 1: Injuries, Violence, and Occupational Health
- Focus Area 2: Outdoor Air Quality
- Focus Area 3: Built and Indoor Environments
- Focus Area 4: Water Quality
- Focus Area 5: Food and Consumer Products

Efforts to improve health traditionally focus on the health care system as the key driver of health and health outcomes. However, there has been increased recognition that improving health and achieving health equity requires broader approaches that address social, economic and environmental factors that influence health. Although Westchester County is perceived to be one of the wealthiest counties in the United States, a portion of this community's residents still struggle with having their basic needs met on a daily basis. Approximately 10 percent of the County's residents live below the federal poverty level, and there are affordable housing units in every municipality except two.⁴ To this end, retreat participants recognized the importance of strengthening relationships across local organizations with the objective of collaboratively addressing the five focus areas to minimize inequities across the County.

Conclusion – Culture will continue to influence the process, and communication and education must be delivered in a way that is understandable and meaningful to our diverse communities. Culture will continue to be a large influence on health, and the degree to which individuals seek assistance for services and/or issues related to their health and wellness. Residents hesitate to use available services due to their citizenship status, lack of trust and/or fear of eviction due to multi-family dwelling. While opportunities exist to leverage programs that are already in place, it is important to note that a culturally sensitive education and communication plan will be needed to establish a relationship of trust with these residents; a balanced effort among all community resources is essential to creating consistent messaging and providing behavior-reinforcing support that will result in improved life conditions. Further, the populations served rely upon a variety of different languages and communication channels. For example, elderly patients rely upon information received from their physician's office, radio or television, while younger populations rely upon social media platforms. Examples of challenges faced by the community, as well as programs that are already in place to address these challenges, are provided below.

⁴ Westchester County Department of Planning

- According to the Office of the Surgeon General, the leading *preventable* causes of death, disease and disability are asthma, lead poisoning, deaths in house fires, falls on stairs and from windows, burns and scald injuries and drowning in bathtubs and pools. Further, indoor radon is the second-leading cause of lung cancer in the United States. The Surgeon General has taken a proactive role in helping Americans protect themselves from health hazards in their homes, where we spend 85 percent to 95 percent of our time – especially in communities that lack ample and accessible green space.⁵ Specific to Westchester County, programs are in place in portions of the County (e.g., Healthy Neighborhoods Program in Yonkers) that focus on improving home safety. However, the success of these programs is often tempered due to cultural barriers, as many residents forego assistance in fear of deportation or eviction.
- Frail and elderly individuals are at-risk for a variety of challenges, including health conditions related to poor air quality, fall-related injuries and poor air quality, and addressing these issues was identified as high importance among retreat attendees. Opportunities exist to collaborate with the community’s healthcare organizations to:
 - Assure that the appropriate communication vehicles are utilized to alert these populations when an issue arises (e.g., alerts from physician office related to poor air quality).
 - Utilize screening tools to accurately identify individuals that are at-risk for a fall-related injury (e.g., Does the screening tool ask the question, “Have you ever fallen before?”).
 - Develop a coordinated approach for home assessments that provides education to families and caregivers and involves them in an effective manner to mitigate the risk of falls. Best practices should be leveraged from existing programs, including the Stepping On Program, Matters of Balance Program, among others.
- Dietary habits and choices develop early, with culture and society playing a critical role in shaping a person’s diet.
 - Research suggests that children learn eating behaviors by observing the eating habits of others, and opportunities exist to provide healthy eating education in elementary schools through consistent, coordinated programs.
 - Further, there is great need to develop a coordinated, culturally sensitive healthy eating education program to emphasize health and wellness, and address the high prevalence of obesity and chronic diseases (e.g., diabetes, high blood pressure, cholesterol) across

“The Healthy Neighborhoods Program in Yonkers has so much potential. But a lot of residents won’t answer the door when they show up for a free inspection of their home. They are afraid they will get deported or evicted because there are generations living together in such small apartments.”

-Retreat Participant

⁵ Office of the Surgeon General. Healthy Homes Reports and Publications. Accessed on May 14, 2019. <https://www.hhs.gov/surgeongeneral/reports-and-publications/healthy-homes/index.html>

minority populations (e.g., Latinos). This program should include education on: 1) the importance of breastfeeding to impact newborn health and wellness; 2) nutritional value and benefits of food, inclusive of an inventory of food items that would serve as healthier alternatives to traditional food staples (e.g., white rice, tortillas) that these residents are accustomed to.

Conclusion – Access will continue to impact choice and utilization. Portions of Westchester County are challenged with limited green space, outdoor walkways, and public transportation and poor air and water quality. Consequently, residents often select options that are easier to access, such as selecting fast food located within a few blocks versus taking multiple bus transfers to a grocery store, or disposing of medications at home versus at designated drop boxes.

- Access to healthy food options for frail and/or vulnerable populations was noted as a critical need by retreat participants. There is a need to leverage existing programs that are currently offered on a limited basis (e.g., Meals on Wheels for senior citizens), and expand these offerings more broadly to vulnerable populations throughout the County.

“Some of my patients have to take multiple bus transfers to get to a grocery store. With small children and a baby, it is just so hard for them to get fresh food.”

-Retreat Participant

- Water quality is directly linked to the appropriate disposal of prescription medications. Designated drop boxes are available at the Health Department, as well as local police stations, hospitals, and pharmacies. However, these locations are not always easily accessible by residents, particularly by those who rely on public transportation. Further, some residents are not comfortable going to police stations due to their immigration status, criminal history or other related factors. There is a need to collaborate with local healthcare organizations to provide patients with education regarding the appropriate disposal of medication (e.g., include as part of discharge instructions from hospital), and the importance of adhering to this process.

Conclusion – Financial incentives must be aligned to promote healthy behaviors. Retreat participants acknowledged that financial incentives directly influence healthy behaviors. Portions of the County are designated as food swamps or food deserts with little access to

“I used to work across the street from a women’s shelter. Every day, I would see kids go to the deli next door to get breakfast. And they would come out with chips and soda, because their SNAP cards would not pay for healthier options like egg whites or fresh fruit.”

-Retreat Participant

farmers markets, thereby resulting in limited access to healthy food options. This challenge, combined with the fact that public assistance programs (e.g., food stamps) will provide financial reimbursement for processed, unhealthy food options and not fresh, healthy foods, results in poor eating habits that directly impact the health and wellness of the County’s residents. The Health Department had previously received a grant to partner with selected convenience stores on an initiative that would

promote healthier food options (e.g., convenient placement and visible pricing for healthier food options), and retreat participants indicated that this program was met with success. There is a need to deploy a multi-factorial approach that involves: 1) changing the financial incentive structure so that public assistance pays for healthy food options; and 2) working with local organizations to increase access to healthier food options.

Conclusion – An environment of trust must exist between the community and its residents to affect change. In addition to experiencing health inequities, lower income populations are often at a greater risk for work-related injuries and domestic violence. These populations often have lower levels of education and therefore work in manual labor positions. Often these individuals forego care when experiencing a work-related injury due to the potential loss of income associated with missed days of work. Further, these residents forego care completely due to fear associated with a domestic violence incident or their immigration status. Retreat participants noted a need to collaborate with community health organizations to:

- Develop a coordinated occupational health program that is designed to treat these populations and avoid prolonged workplace-related injuries
- Create a culture of trust and safe environments for these individuals to seek care

Top Action(s) Discussed

Participants across the numerous organizations represented identified the need to address education and communication which is currently fragmented and inconsistent.

- With education being fragmented and inconsistent across the county, participants suggested partnering with local healthcare providers to assure that a consistent system is in place to alert vulnerable populations when air quality is poor. Additionally, in response to inconsistent nutrition education across school sites participants promote beginning education earlier with young students and expanding awareness and education through collaboration with local organizations (e.g., local coalitions, town halls) and via social media.
- Tailoring education to specific population cohorts was also discussed. For example, including ethnic-specific healthy food options as part of education, as well as guidance on healthy food preparation is a must.
- Participants also recognized that there are programs already in place that have a demonstrated impact on healthy food choices. These programs should be expanded (e.g. Meals on Wheels for seniors and local initiative to stock vending machines with healthier food options).



PRIORITY AREA 3: PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

- Focus Area 1: Maternal & Women’s Health
- Focus Area 2: Perinatal & Infant Health
- Focus Area 3: Child & Adolescent Health
- Focus Area 4: Cross Cutting Healthy Women, Infants, & Children

Participants in this facilitated discussion session strongly emphasized that the health of women, infants, children, and their families is fundamental to overall community health. This priority area

“There needs to be stronger community campaigns and messaging on prenatal care.”
-Retreat Participant

“Encourage addressing early entry into pre-natal care.”
-Retreat Participant

also aligns directly with the Maternal and Child Health Services Block Grant (Title V) Program, whose mission is to improve the health and well-being of the nation’s mothers, infants, children and youth, including children and youth with special care needs, and their families. Addressing the significant needs of New York State’s families requires strong partnerships and collaboration on the state and community level. The need to support and leverage existing community resources and collaboration with community based organizations is a top priority to improve the well-being of mothers, infants and children.

Conclusion – Education and awareness should have a broad audience and focus. Participants identified community campaigns and messaging focused on prenatal care and the various infant factors to be a necessary key action item. Not only educating and increasing awareness to the maternal community but also encouraging men to know their role in and embrace public health efforts to promote the health of women, infants, and children over the life course.

Disparities exist that could benefit from education and awareness. Between 2011-2013, the percentage of live births with low birthweight were higher among Non-Hispanic African American mothers, 12.7%, and Non-Hispanic Asian mothers, 8.8% than Non-Hispanic White mothers, 6.8%. Hispanic mothers reported the lowest percentage at 6.7%. During this same time, Non-Hispanic African American mothers also had premature births at a higher percentage, 15.7%, than other mothers – Hispanic, 11.1%, Non-Hispanic White, 10.6% and Non-Hispanic Asian, 10.6%.⁶

Conclusion – Aggregate and collate existing resources through coordinated effort. Participants agreed that the Westchester community has an abundance of resources that exist

⁶ 2019-2024 NYS Prevention Agenda and Westchester County Community Health Assessment

across the County to address their areas of concern. However, the information sources are scattered and there needs to be one source of truth or directory that integrates all existing resources that is easily accessible to the public so that individuals are aware of what is available to them and what they are eligible for. There needs to be a coordinated effort to develop a single platform to house all resources available for the community.

Top Action(s) Discussed

Discussions touched upon each of the four Prevention Agenda focus areas for promoting healthy women, infants and children, but less individually and more often as a collective concern. However, participants identified that while there are notable community collaborations there are still disparities and room to improve processes community wide.

- Participants agreed that it was necessary to provide consistent education to increase awareness among multiple factors that impact health. Specific to the Priority Area, cultural barriers and related disparities for low birthweight, breastfeeding and safe sleep practices should be addressed.
- The attendees discussed how the health system needs a more holistic care approach that eliminate care silos. Specifically, the community needs better systemness, connections, care coordination, handoffs and transition among different care providers and institutions.

“We need to offer and recommend that young mothers have access to caregiver support groups, parenting classes within the community centers...i.e. Mommy and Me groups.”

-Retreat Participant



PRIORITY AREA 4: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDER

- Focus Area 1: Promote Well Being
- Focus Area 2: Prevent Mental & Substance Use Disorder

“The community is skilled at fostering connections, building coalitions, developing networks and collaboration.”

-Retreat Participant

Mental health and substance use disorder was a popular topic amongst the session participants. While doing introductions, it was evident those in attendance were very engaged, representing a wide variety of community organizations and areas of expertise. The number one opportunity from the group discussion was the importance of beginning

to break down silos and connect the dot across existing community programs through forums such as the 2019 Health Summit. There was agreement that these are important topics to discuss “and mental health affects all populations in Westchester County”, but also recognition that the wider community perceives an associated stigma to mental health and substance use disorder that serves as a challenge to improve.

Conclusion – Be patient-centered and include caregivers in the care planning / treatment process.

Often the care planning process only includes the patient and does not include the role of the caregiver for the patient seeing treatment. Understanding the capacity of the caregiver is essential in building a treatment plan that is realistic and sustainable. Increasing awareness, developing ‘no-stigma’ messaging and providing consistent education about prevention are required when developing a care plan. In addition, focusing on meeting the basic needs for the patients, families and caregivers should be prioritized, before identifying treatment plans that are otherwise not possible. All providers who are part of the care team should be included in the conversation and endorse the care/treatment plan.

“It’s important to use a language that is patient-centered and universal to all.”

-Retreat Participant

Conclusion – Treating co-occurring disorders is complex and requires a multidisciplinary approach to promote optimal outcomes.

Mental health can sometimes fall to the back-burner due to other social determinate barriers. Early detection, prevention and treatment are key areas of focus when identifying and treating mental health and substance use disorder. Long-term treatment with a focus on sustainability, not just meeting the immediate need, is a much-needed paradigm shift for healthcare providers. One participant discussed the importance of

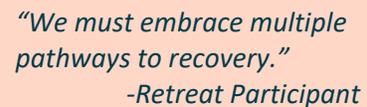
“Identify trauma and build resilience”

-Retreat Participant

treating all substances together, not replacing one substance for another, which sparked a series of additional conversations with the other stakeholders.

Promoting community support and social acceptance increases well-being. Stigma and prejudice may be reduced by multi-faceted interventions that include education, media campaigns, personal contacts, peer services, protest and advocacy and policy and legislative changes.⁷

Conclusion – Despite an array of community resources available, access to affordable mental health care remains a barrier. In some areas of the community there are affordable mental health providers that do not require insurance but are not readily accessible. In other areas of the community, there is limited or no access to mental healthcare, some of which are very costly. Some organizations have qualified field personnel, which could be leveraged, but additional resources are needed to scale the services. Better integration of mental health services into primary care offices is an area that could be leveraged to increase the availability of mental health services. There are multiple community partners that form a solid foundation from which to integrate existing and launch new programs.



“We must embrace multiple pathways to recovery.”
-Retreat Participant

Adverse Childhood Experiences and many mental, emotional, behavioral (MEB) disorders, such as substance abuse and depression, have lifelong effects that include high psychosocial and economic costs for people, their families, schools and communities. The financial costs nationally in terms of treatment services and lost productivity are estimated at \$467 billion in 2012, and \$442 billion for misuse of prescription drugs, illicit drugs and alcohol.⁸

Top Action(s) Discussed

Discussions around this Priority Area were broad, but focused around the idea of inclusivity.

- The participants agreed that mental health affects all populations in Westchester County and that a ‘no-stigma’ education for the community at large is needed. The stigma of mental or substance abuse disorders continues to be a barrier to seeking care and promoting and encouraging early detection, intervention, prevention and treatment is necessary.
- An inventory of existing community assets should be created and made widely available and services should be integrated across organizations. Partners for health improvement collaboration must include schools, faith-based organizations and civic organizations.

⁷ Contributing Causes of Health Challenges and 2019-2024 NYS Prevention Agenda

⁸ 2019-2024 NYS Prevention Agenda

https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/nys_pa.pdf

- Clinicians themselves must be engaged and partnerships with primary care providers should be strengthened. Expand family members and other caregivers in patient care plans and treatment plans. Healthcare organizations have a role in making improvements too. Participants highlighted the need to provide medication reconciliation 72-hours post ED discharge, promote early intervention while patient is admitted and improve transitional homes and finding appropriate housing post-hospitalization.

Appendix A: New York State Prevention Agenda Priorities, Focus Areas and Goals

PRIORITY AREA: PREVENT CHRONIC DISEASES
<p>Focus Area 1: Healthy Eating and Food Security</p> <p>Overarching Goal: Reduce obesity and the risk of chronic diseases</p> <ul style="list-style-type: none"> Goal 1.1: Increase access to healthy and affordable foods and beverages Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices Goal 1.3: Increase food security
<p>Focus Area 2: Physical Activity</p> <p>Overarching Goal: Reduce obesity and the risk of chronic diseases</p> <ul style="list-style-type: none"> Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
<p>Focus Area 3: Tobacco Prevention</p> <ul style="list-style-type: none"> Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
<p>Focus Area 4: Preventive Care and Management</p> <ul style="list-style-type: none"> Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity Goal 4.3: Promote the use of evidence-based care to manage chronic diseases Goal 4.4: Improve self-management skills for individuals with chronic conditions
PRIORITY AREA: PROMOTE A HEALTHY AND SAFE ENVIRONMENT
<p>Focus Area 1: Injuries, Violence and Occupational Health</p> <ul style="list-style-type: none"> Goal 1.1: Reduce falls among vulnerable populations Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations Goal 1.3: Reduce occupational injuries and illness Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists
<p>Focus Area 2: Outdoor Air Quality</p> <ul style="list-style-type: none"> Goal 2.1: Reduce exposure to outdoor air pollutants
<p>Focus Area 3: Built and Indoor Environments</p> <ul style="list-style-type: none"> Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change Goal 3.2: Promote healthy home and school environments
<p>Focus Area 4: Water Quality</p> <ul style="list-style-type: none"> Goal 4.1: Protect water sources and ensure quality drinking water

Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water

Focus Area 5: Food and Consumer Products

Goal 5.1: Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure

Goal 5.2: Improve food safety management

PRIORITY AREA: PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

Focus Area 1: Maternal & Women’s Health

Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age

Goal 1.2: Reduce maternal mortality and morbidity

Focus Area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity

Goal 2.2: Increase breastfeeding

Focus Area 3: Child & Adolescent Health

Goal 3.1: Support and enhance children and adolescents’ social-emotional development and relationships

Goal 3.2: Increase supports for children and youth with special health care needs

Goal 3.3: Reduce dental caries among children

Focus Area 4: Cross Cutting Healthy Women, Infants, & Children

Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

PRIORITY AREA: PROMOTE WELL- BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Focus Area 1: Promote Well-Being

Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan

Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages

Focus Area 2: Prevent Mental and Substance Use Disorders

Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults

Goal 2.2: Prevent opioid and other substance misuse and deaths

Goal 2.3: Prevent and address adverse childhood experiences (ACEs)

Goal 2.4: Reduce the prevalence of major depressive disorders

Goal 2.5: Prevent suicides

Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population

PRIORITY AREA: PREVENT COMMUNICABLE DISEASES

Focus Area 1: Vaccine-Preventable Diseases

Goal 1.1: Improve vaccination rates

Goal 1.2: Reduce vaccination coverage disparities

Focus Area 2: Human Immunodeficiency Virus (HIV)

Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)

Goal 2.2: Increase viral suppression

Focus Area 3: Sexually Transmitted Infections (STIs)

Goal 3.1: Reduce the annual rate of growth for STIs

Focus Area 4: Hepatitis C Virus (HCV)

Goal 4.1: Increase the number of persons treated for HCV

Goal 4.2: Reduce the number of new HCV cases among people who inject drugs

Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections

Goal 5.1: Improve infection control in healthcare facilities

Goal 5.2: Reduce infections caused by multidrug resistant organisms and C. difficile

Goal 5.3: Reduce inappropriate antibiotic use

Source: New York State Department of Health

Appendix B: Westchester County 2019 Health Summit Invite

Come Join Us

Help shape Westchester's three year
health priorities and goals

2019 Health Summit

April 5, 2019

*Westchester County Center
White Plains, N.Y.*

8:30 a.m. to 1:00 p.m.

Advanced registration required

<https://tinyurl.com/WestchesterHealthSummit>

 Northern Westchester Hospital
Northwell Health

 NewYork-
Presbyterian **DOING MORE**

 Phelps Hospital
Northwell Health

 **BURKE**
Rehabilitation Hospital
Northwell Health

 Saint Joseph's
Medical Center

 **WP**
White Plains
Hospital

 **ST. JOHN'S**
RIVERSIDE
HOSPITAL

 Blythedale
Children's Hospital

 Westchester
gov.com

Appendix C: Westchester County 2019 Health Summit Agenda

Westchester County 2019 Health Summit

Location: Westchester County Center, White Plains

Date: April 5, 2019

Time: 9:00 am - 1:00 pm

Agenda Items

8:30 am - 9:00 am	Registration & Continental Breakfast	
9:00 am - 9:15 am	Welcome, Introductions & Objectives	Sherlita Amler, MD Westchester Health Commissioner
9:15 am - 9:55 am	State of the County: Accomplishments, Data, Outcomes & Expectations of Summit	Renee Recchia WCDH, Acting Deputy Commissioner for Administration
9:55 am - 10:00 am	Outline Breakout Process & Gallery Walk Process	Premier
10:00 am - 10:10 am	County Executive Remarks	George Latimer Westchester County Executive
10:15 am - 11:15 am	Concurrent Breakout Sessions: Prevent Mental & Substance Use Disorders Promote a Healthy & Safe Environment Prevent Chronic Diseases Promote Healthy Women, Infants & Children	Room C Room E Room F Room G
11:15 am - 11:25 am	Break	
11:25 am - 12:30 pm	Gallery Walk	Premier
12:30 pm - 1:00 pm	Recap Overall Findings & Outline Next Steps	Premier & WCDH
1:00 pm	Adjourn	



Appendix D: Facilitated Breakout Session Notes

Priority Area 1: Prevent Chronic Diseases

Focus Area 1: Healthy Eating and Food Security

Focus Area 2: Physical Activity

Focus Area 3: Tobacco Prevention

Focus Area 4: Preventive Care and Management

STRENGTHS & RESOURCES

- Schools are the best resource outside of the home for providing youth's access to healthy, balanced, "attractive" meals and snacks that incentivize and support healthy food choices and alternatives
 - Menu varieties built around healthy options
 - Ensure that children receive education about diet, nutrition, and benefits of making healthy food choices
 - Health literacy and education programs to reinforce healthy behaviors
- Schools have significant existing infrastructure and resources outside of the home for providing preventive education around tobacco use (including combustible tobacco and electronic vaping products)
- CBOs (Community Benefit Organizations) are in place in many locations throughout the County and should be more assertively engaged as cooperative partners in addressing access issues related to nutrition, food choices, diet, education and physical activity
- Several walking clubs are currently available in surrounding communities; we need to find ways to support, promote, and encourage participation in these formal and informal groups to increase the level of physical activity of the community
 - Encourage and support the formation of new groups in neighborhoods and communities
- The community needs "Safe" groups, spaces and places for children, adults, and women are areas that are safe havens for activity, refuge and recovery. These exist in some areas; however there is a need to look to expand and promote these resources more broadly
 - The safety spaces concept should extend to undocumented individuals as well
- Existing comprehensive private and public healthcare infrastructure and resources are available through area hospitals, ambulatory and diagnostic settings, emergency services, clinics, physician services, pre- and post-acute, behavioral health, therapeutic, exercise, wellness and many others across the continuum of care.
 - There is a perceived opportunity to better coordinate resources to provide increased access to coordinated quality healthcare in the community at every level of care need (e.g., prevention, diagnostic, screening, inpatient, outpatient, telehealth, others)

- This perceived need extends to preventive care and management resources and services including screening, testing, care management, and improved self-management skills
- Evidence-based information and practices ensure that decisions made about health promotion, intervention, and care management programs is evidence-based in order to yield optimal outcomes
- Start engaging, at a higher level, the companies and employers in the community to help promote healthy eating, food access, and physical activity among their employees and families
 - Encourage companies to provide incentives to their employees and families to engage in more health oriented and promoting activities
 - Incentivize companies to become more involved in promoting healthy lifestyles and choices for their employees as well as in the broader community as responsible corporate citizens

OPPORTUNITIES & GAPS

- There is a need to find better ways to leverage schools in order to:
 - Effectively address ACEs (Adverse Childhood Experiences) - traumatized children
 - Teach better self-care practices
 - Build upon parent and home support activities
 - Teach parents to be more assertive and accountable for providing home-based support around good habits (teach by example)
- There is opportunity to find ways to teach, support, and reinforce “replacement behaviors” as part of change management to develop and maintain healthy lifestyles and practices
 - Learning and adopting new habits
 - Maintaining good behavior
- “We often start too late in teaching children good behaviors.” Take advantage of opportunities to teach youth healthy behaviors from very young ages, as has been successfully done in other areas:
 - Children’s car seat use
 - Seat belt use, all ages
 - DARE program
 - Others
- Examine and address social determinants of health that impact healthy food and exercise choices (education, home, schools, transportation, finances, access to healthy food, safety, structural realities others)
- “We know the “what,” we must discover the best “how” in addressing these issues in coordinated, integrated ways, across all types of interventions, care settings, and resources

ACTION ITEMS / SOLUTIONS

- Ensure that school curriculums reinforce healthy decisions
 - Learn from the DARE program to create tobacco-free children; and to incent and reinforce healthy food choices
- Use social media to meet children “at their interest level”
 - Have “youth speak to youth” for positive and effective peer messaging
- Use the “Stanford Chronic Disease Program” as a model for chronic disease related behavior change (specifically targets diabetes prevention); this is an evidence-based program
 - Explore payment from Medicare related to SCDP participation
- Create campaigns around every adult knowing their important up-to-date basic health screening “measures” (e.g., blood pressure, cholesterol level, blood sugar levels)
- Begin education at a young age regarding health and financial skills (including obesity prevention, debt prevention and resource management)
- Standardize health messages across all schools in the County
- Ensure better and more effective collaboration among schools, public health entities, hospitals, and other health and wellness organizations
- Take measures to ensure healthy and affordable food option access especially in poor areas
- Create positive ways to “activate” people to take responsibility for their own health and choices
- Teach children “cause and effect,” and be honest with them regarding health, diet, fitness, smoking, vaping, and other harmful activities
- Ensure that communities create and maintain safe places to walk, play, exercise, dance, and engage in other health lifestyle activities
 - Help patients advocate for themselves

POTENTIAL BARRIERS

- For profit companies continue to derive revenue from unhealthy products of all types
- There is product placement of unhealthy products that attract attention and promises instant gratification (e.g., unhealthy foods at eye level, near check-out stands, on sale, enticing packaging)
- There is a lack of funding support around initiatives for individual organizations don’t have sufficient funding to solve problems on their own. There needs to be a combined effort of multiple interested parties needed to create critical mass of resources in order to start making a difference
- There is opportunity to help address how to encourage individuals to make healthy lifestyle choices as a priority in their lives
- Undocumented individuals are fearful and often reluctant to step forward to access resources that are available
- There is a lack in green markets and farmers markets throughout the year

Priority Area 2: Promote a Healthy and Safe Environment

Focus Area 1: Injuries, Violence, and Occupational Health

Focus Area 2: Outdoor Air Quality

Focus Area 3: Built and Indoor Environments

Focus Area 4: Water Quality

Focus Area 5: Food and Consumer Products

STRENGTHS & RESOURCES

Focus Area 1: Injuries, Violence, and Occupational Health

- Screening tools should be leveraged to identify potential victims of domestic violence:
 - Ask the question “Do you feel safe at home?”
- There are opportunities to leverage existing resources to reduce the risk of falls across frail and elderly populations in Westchester County
 - Personal emergency response systems
 - Home assessments should include the question “have you ever fallen before?”
- Community-based programs are in place that can be leveraged to address injuries, violence, and occupational health needs:
 - Stepping On Program
 - Matters of Balance Program
 - Safe Kids Program (childhood injury program)
 - Caregiver education and outreach programs

Focus Area 2: Outdoor Air Quality

- Local organizations currently provide education on the following; however, retreat participants noted that education is fragmented and not consistent across the County
 - Detriment of idling cars
 - Use of clean energy
 - Access to public transportation resources
 - Alternative options for transportation (e.g., bicycles) to promote physical activity and health
- Vulnerable populations are alerted by healthcare providers and other local organizations when air quality is poor. However, this communication is also fragmented and inconsistent
- There are American Lung Association programs in place that are dedicated to supporting healthy lungs and clean air within safe boundaries

- Publishes an annual State of the Air report that analyzes data from official air quality monitors to easily compare and understand the air quality in local communities, and what can be done to help improve air quality
- Community-based organizations leverage the American Lung Association's Freedom From Smoking® program to promote smoke-free lives across Westchester County

Focus Area 3: Built and Indoor Environments

- Healthy Neighborhoods Program is designed to reduce housing-related illness and injury. It is funded by a grant from the New York State Department of Health and is offered in currently only offered in Yonkers. The program offers free home safety assessments by health department staff to residents in Yonkers. The goals of the Healthy Neighborhoods Program include:
 - Increase Radon Testing
 - Prevent Indoor Air Pollution/Reduce Asthma Triggers
 - Prevent Lead Poisoning
 - Prevent Home Fire Hazards
 - Decrease Environmental Health Hazards in the Home
- Complete Streets Policy in Yonkers incorporates active transportation into the planning, design and operation of all future City streets projects, whether new construction, reconstruction, rehabilitation or pavement maintenance. This policy is premised upon the fact that active transportation attempts to better integrate physical activity through increased emphasis on walking, bicycling, and public transportation. Active transportation improves public health, reduces traffic congestion, enhances air quality, and supports local economic development
 - Complete streets are streets that are planned, designed, operated, and maintained to enable safe access for all users, and upon which pedestrians, bicyclists, transit users, persons with disabilities, and motorists of all ages and abilities are able to safely move along and across
- Housing Authorities are increasingly focusing on resident safety
- Local organizations are increasingly offering to collect residential HVAC filters and test air quality

Focus Area 4: Water Quality

- Health Department, police stations, hospitals, and pharmacies have disposal sites for prescription drugs in place
- Healthy Neighborhoods Program provides a resource to test water quality; however, limitations exist since this program is exclusively based in Yonkers

Focus Area 5: Food and Consumer Products

- Breastfeeding continues to be the preferred nutrition for newborns/infants
- Meals on Wheels provides healthy meal options to senior residents (limited access)
- Health Department had previously received a grant to partner with selected convenience stores on an initiative that would promote healthier food options. The grant has ended, but some convenience stores have continued this initiative's efforts (e.g., convenient placement of healthier food options)
- An initiative is underway to stock vending machines with healthy food options
- Education on healthy food choices is provided in schools; however, education is inconsistent across all school sites and opportunities exist to begin this education earlier in childhood to enforce healthy behaviors

OPPORTUNITIES & GAPS

Focus Area 1: Injuries, Violence, and Occupational Health

- Injuries, violence, and occupational health needs have a widespread impact on health status, and physical and mental health
 - Individuals engaged in manual labor have high rates of workplace-related injuries
 - Higher rates of domestic violence exist in cities, particularly in lower-income households
 - Falls represent a widespread health concern for frail and elderly populations. Opportunities exist to assure that these individuals have appropriate resources at home to prevent falls

Focus Area 2: Outdoor Air Quality

- What is considered to be high quality air?
- Portions of the community have high concentrations of air pollutants due to:
 - Construction in high development/growth areas
 - Tobacco use continues to be a challenge outdoors
 - Pollutants from Ohio-based factories are carried by the wind, impacting air quality in portions of Westchester County

Focus Area 3: Built and Indoor Environments

- Opportunities exist to expand safe places to walk and play. Many areas lack safe places to walk, bike lanes, and ample green space. This has resulted in both children and adults spending more time indoors
- Residential safety is a widespread concern, specific to:
 - Air quality/cleanliness (e.g., HVAC filter changes, presence of asbestos)
 - Lead poisoning
 - Fire and carbon monoxide safety
 - Rodent infestations

Focus Area 4: Water Quality

- Health status (e.g., breast cancer incidence) is directly linked to water quality. Opportunities exist to improve water quality through appropriate disposal of pharmaceutical drugs

Focus Area 5: Food and Consumer Products

- Access to affordable, healthy food is limited across selected portions of the County
 - Presence of food deserts and food swamps
- Education on healthy eating must be tailored to specific population cohorts (e.g., cookie cutter approach does not apply to all)
 - Include ethnic-specific healthy food options as part of education, as well as guidance on healthy food preparation
 - Education must start during childhood years (e.g., schools, etc.) before poor eating habits are adopted
- There is opportunity to reinforce the importance of breastfeeding for newborns/infants

ACTION ITEMS / SOLUTIONS

Focus Area 1: Injuries, Violence, and Occupational Health

- Leverage community-based programs that are already in place to address injuries, violence, and occupational health needs:
 - Stepping On Program
 - Matters of Balance Program
 - Safe Kids Program (childhood injury program)
 - Caregiver education and outreach programs
- Collaborate with healthcare organizations (e.g., hospitals, others) to:
 - Assure that assessments include the appropriate questions (e.g., Do you feel safe at home? Have you ever fallen before?)
 - Apply evidence-based programs that will reduce the risk of falls, and mitigate workplace injuries

Focus Area 2: Outdoor Air Quality

- Expand outdoor tobacco-free spaces and access to smoking cessation programs
- Collaborate with local organizations to assure that consistent education is provided on the following:
 - Detriment of idling cars
 - Use of clean energy
 - Access to public transportation resources

- Alternative options for transportation (e.g., bicycles) to promote physical activity and health
- Partner with local healthcare providers to assure that a consistent system is in place to alert vulnerable populations when air quality is poor
- Expand awareness and education through:
 - Collaboration with local organizations (e.g., local coalitions, town halls)
 - Social media

Focus Area 3: Built and Indoor Environments

- Explore opportunities to expand Healthy Neighborhoods Program beyond Yonkers to other locations in Westchester County
- Expand awareness and education through:
 - Collaboration with local organizations (e.g., local coalitions, town halls)
 - Social media

Focus Area 4: Water Quality

- Partner with local hospitals to assure that education on appropriate disposal of pharmaceuticals is provided as part of the patient's discharge instructions
- Educate community-based health workers on the importance of appropriate medication disposal so that they can educate patients on this topic. For example, retreat participants suggested that this be included in NARCAN training
- Assess opportunities to expand access to medication disposal sites that are conveniently located for residents:
 - Collaborate with local hospital pharmacies to increase awareness of drop boxes
 - Through mobile solutions (e.g., mobile van with oversight/sponsorship by police)
- Expand awareness and education through:
 - Collaboration with local organizations (e.g., local coalitions, town halls)
 - Social media

Focus Area 5: Food and Consumer Products

- Partner with hospitals and local healthcare organizations to continue providing education that emphasizes the nutritional importance of breastfeeding on newborns/infants
- Expand culture-specific (e.g., Hispanic) education/programs on health eating
 - What does fat free really mean on a labeled product?
- Provide education in schools on healthy eating across Westchester County
- Expand programs already in place that have a demonstrated impact on healthy food choices
 - Continue to work with corner stores to display healthier food options at affordable prices
 - Expand access for seniors to Meals on Wheels

- Expand initiative to stock vending machines with healthier food options
- Expand awareness and education through:
 - Collaboration with local organizations (e.g., local coalitions, town halls)
 - Social media

POTENTIAL BARRIERS

- Undocumented status of individuals is a barrier (people are often reluctant to step forward to access resources out of fear)
- There is a lack of funding around initiatives and individual organizations do not have sufficient funding to solve problems alone.
 - There needs to be a combined effort of multiple interested parties to create critical mass of resources to begin to make a difference
- There is a lack of awareness and education of importance, and the understanding that resources are available to residents to address these issues
- There is limited public transportation is available in pockets across Westchester County
- Existence of multi-family dwelling will temper utilization of community resources that assure safe indoor environments due to fear of eviction and/or rent increases
- Denial and the impact of cultural influences
 - Some ethnic cohorts prefer not to acknowledge challenges and/or seek assistance from public and/or community-based organizations
 - Culture greatly influences diet and food choices
- Pharmaceutical disposal sites must be in secure, monitored locations
 - Complex collection and disposal process make it difficult to expand/add more disposal sites. Access and convenience for residents will be paramount to increase compliance with appropriate disposal
 - Residents may be reluctant to dispose of pharmaceuticals at police stations
 - These secure resources are difficult to access for home-bound patients, or individuals with limited access to transportation
- There is opportunity in frequency of testing (e.g., air, water), and adherence to a regular testing schedule that will assure that quality is within normal ranges
- The presence of uncontrollable external forces (e.g., pollutants carried by wind from Ohio-based factories) continue to be a barrier
- Healthy food is expensive; however, access to affordable and conveniently located healthy food is a challenge
 - Presence of food deserts and food swamps across the County make it difficult to access affordable, healthy food options
- There is product placement of unhealthy products that attracts attention, promises instant gratification (e.g., unhealthy foods at eye level, near check-out stands, on sale, enticing packaging)
- There is a lack of green markets and farmers markets throughout the year, combined with the fact that many foods have pollutants and there is a need for increased access to organic food options

- Existence of profit-making companies that derive revenue from unhealthful products of all types (e.g., branding as family friendly does not necessarily mean that it is healthy)
- Food stamps and Electronic Benefit Transfer (EBT) cards do not always provide funding for healthy food options (e.g., will pay for chips but not egg whites at deli)
- How can we address and help individuals make healthy lifestyle and food choices as a priority in their lives?

Priority Area 3: Promote Healthy Women, Infants and Children

Focus Area 1: Maternal & Women's Health

Focus Area 2: Perinatal & Infant Health

Focus Area 3: Child & Adolescent Health

Focus Area 4: Cross Cutting Healthy Women, Infants, & Children

STRENGTHS & RESOURCES

- There is a collective passion for promoting health women, infants and children in the community
 - Community resiliency
- There are permanent housing options available to single women
 - Collaboration with mental health and other community health partners to provide co-location services.
- There are workshops with community-based organizations to collaborate with providers to address social determinants of health
- The IMPLICIT Pregnancy model of improving prenatal care provides education and promotes regular visits to their health care provider throughout the patient's duration of pregnancy
 - Group prenatal care support for pregnancy care
- There are Mobile Health Centers available with Behavioral Health collaboration
- John A. Coleman School / Elizabeth Seton Pediatric Center is a great resource
 - Approved and funded by NYS Dept. of Health offering early childhood and special education services in center-based and community settings to children from over 40 school districts in Westchester, Putnam and the Bronx.
 - White Plains Campus
 - Yonkers Campus
- Providers and local health agency meet to collaborate regularly
 - Regular meetings with county health department and hospitals
- There are various state programs and coalitions currently available to eligible individuals
 - Health Department Navigator Program
 - Health insurance access
 - Women, Infant and Children (WIC) and coalitions
 - Great resource for people who are eligible, enrolled and are aware about it

- Education and promotion of healthy diet
- Some organizations have a “Sliding fee scale” in place to meet the needs of the uninsured or underinsured
- Some additional community assets are:
 - Integrate free health clinics within the local schools
 - Free distribution of feminine products within the schools
 - Working to address the unfunded mandate

OPPORTUNITIES & GAPS

- There is a gap in meeting basic needs for patients, families and caregivers (Social Determinants of Health)
 - Affordable housing, jobs, food insecurity, transportation
- There are significant patient population among the underinsured and those who lack health insurance
 - Financial literacy
 - Undocumented individuals
- There is opportunity around biases, mis-information, and addressing racism
 - Implicit bias and racial disparities
- There are disparities in behavioral health among children
 - Often extremely difficult to get adolescents placed when inpatient is needed
- There is opportunity around breast cancer screening for African American women due to the higher death rate than Caucasian women
- Increase in the aging population and caring for young children continues to be an issue
 - Young mothers at work or unable to look after their own children
- There is opportunity to address abuse, substance abuse and domestic violence
 - Stigma with regards to the opioid epidemic which is also creating stigma for women in particular
- There are lack of resources and access to specialty physicians, mental health, and primary care (pediatrics)
- There are cultural barriers and disparities such as:
 - Low birthweight
 - Breastfeeding
 - Safe sleep practices
- There is a high mortality rate among African American women
- There is a need for screening and early intervention for all women, maternal, infants, children and adolescents
 - Early detection, intervention, prevention, and continued care throughout the lifespan
- Technology can also be a barrier as more young mothers leverage their phones and IT as an escape and the potential impacts this may have on the child
- There are silos in providing care, and there needs to be a more holistic care approach
 - Need better systemness, connections, care coordination, handoffs, transition among different care providers and institutions

- Access
 - Increasing service hours and access; lack of time with physician
 - Transportation for young teens/adolescents
 - E.g.: going to and from work
- There's opportunity with regards to cost of care and lack of or under funding of programs

ACTION ITEMS / SOLUTIONS

Maternal, Perinatal & Infant Health

- Offer caregivers and baby friendly programs and classes at local community centers
 - Recommend young mothers have access support groups, parenting classes, mommy & me group
 - Addressing early entry into pre-natal care
 - Post-partum & home visits
- Promote community campaigns and messaging on prenatal care (maternal, weight gain, blood pressure, blood sugar) and infant factors:
 - Sleep durations
 - Weight gains
 - Breastfeeding
- Promote breastfeeding programs offered through local hospitals
- Ensure that all eligible individuals are enrolled in the special supplemental nutrition program for Women, Infants, and children (WIC) and Supplemental Nutrition Assistance Program (SNAP)
 - Help patients advocate for themselves

Awareness & Education

- Provide, gather and maintain a resource directory (211)
 - Develop a single platform with integrated information
 - Healthify
 - Nowpow
 - 211
 - Cross-pollination of resources among local health agencies and local community-based organizations
- Develop an early literacy program targeting children and adolescents
- Provide consistent education to increase awareness
 - Use faith-based institutions, local schools, agencies, and community-based organizations for outreach and education
- Promote peer-educators and counseling services to engage, empower, and promote breastfeeding
- Utilize child mental health and substance use screenings
 - Deploy screenings for early detection, intervention, and referrals

Person-Centered Care & Provider Engagement

- Provide volunteer clinics to allow providers to offer access and treatment
 - Partner with providers to develop a direct primary care program that is not restricted to insurance
 - Faith-based institutions & community-based organizations opening their facilities to allow for patients to see and receive care
 - This allows clinicians to go out directly to the community and overall more affordable with lower overhead costs

Priority Area 4: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 1: Promote Well Being

Focus Area 2: Prevent Mental & Substance Use Disorder

STRENGTHS & RESOURCES

- There is a collective passion for mental health and substance use disorder
- There are culturally and linguistically diverse services and expertise
- There are evidence-based treatments and philosophy to care
- The community is skilled at fostering connections, building coalitions, developing networks and collaboration
 - Drug free coalitions (new & existing)
- There are multiple community care partners
 - Solid foundation from which to integrate existing and launch new programs
 - Awareness, education, continuum of care, outreach/prevention
 - Home & community-based services
 - Drop boxes throughout the county
- There is integration of mental health into primary care
 - Integration of BH / PCP and SUD treatment
- Qualified field personnel can be scaled with additional support
- Provide education to the community that reduces the stigma associated with mental health

OPPORTUNITIES & GAPS

- There is a need to meet the basic needs for people, families and caregivers (Social Determinants of Health)
 - Affordable housing, jobs, food
- There is a limited focus on 'family and caregivers' and not just the person seeking treatment
- Promote and encourage early detection, intervention, prevention and treatment

- Opportunities with identification through the school system (guidance counselors)
- There is opportunity around treating co-occurring disorders
 - Adverse childhood events (ACEs)
 - Pediatric psychiatric care (inpatient and outpatient)
- Mental health tends to fall to the ‘back-burner’
- Promote fostering better relationships with faith-based organizations and civic organizations
- Create access to affordable mental health care and providers:
 - Providers available who are affordable (i.e. those that do not take insurance) but they’re difficult to locate
 - In some areas limited or no providers and many who are very costly
 - Barriers to providers ‘accepting’ certain patients
- Develop better engagement with providers
- Provide medication reconciliation 72-hours post ED discharge
- Promote early intervention while patient is admitted
- Improve transitional homes and finding appropriate housing post-hospitalization
 - Short term options sometimes available
 - Longer term options more challenging to secure (i.e. after 21 days)
 - Some communities with no short-term resources available
- Push to legalize recreational marijuana based on current opioid epidemic will intensify the issues and create challenges long term; limited or no evidence on medical marijuana treatment
- Push for immigration reform
 - Undocumented population fearful to identify and receive services / legal barriers
- There is a lack of agencies providing therapies for Spanish speaking demographics; long wait times to gain access

ACTION ITEMS / SOLUTIONS

Population Segmentation:

- Solutions should be inclusive - “Mental health affects **ALL** populations in Westchester County”
 - Mental health
 - Co-occurring
 - Substance Abuse Disorder
- Specifically address these sub-populations (if required to select):
 - Minorities
 - Undocumented
 - Families (not just the person seeking active treatment)

Awareness & Education:

- Employ a language that is person-centered and universal to all
 - No-stigma messaging
- Increase awareness
- Provide education and outreach broadly
- Deploy screenings for early detection
- Provide consistent education about prevention
 - Use county buildings and schools for outreach and education
- Utilize child mental health and substance use screenings

Communication & Collaboration Across Existing Community Assets:

- Connect the dots – break down silos vertically and horizontally within/across organizations through forums like the Summit
- Engage civic, community and faith-based organizations
 - Deploy reliable outreach strategies
 - Partner together to identify resources
 - Leverage resources such as 211
 - Strengthen wrap-around services
 - Address inconsistency among available community resources
 - Deploy crisis intervention at police departments
- Inform community about available services
 - Focus on homeless shelters
- Explore education and partnerships with schools
 - Target guidance counselors for education to help with early-identification
- Create partnerships with primary care providers
- Market to the private sector
- Leverage existing initiatives such as Trauma informed Care (TIC)

Person-Centered Care:

- Focus long-term treatment on sustainability
- Include family/caregivers in the treatment and care planning
- Treat all substances together
- Enhance focus on long-term treatment
- Offer group visits
- Identify trauma and build resilience

Provider Engagement and Treatment:

- Include providers in the conversation
- Partner with PCPs and providers to assist with endorsing the conversation
- Determine strategies to utilize ICD-10 codes to allow providers (primary care and specialty care) to bills for services; incentive alignment
- Embrace multiple pathways to recovery

- Enhance transitional housing availability

Resources & Team Development:

- Secure and livable wages for field staff
- Provide staff support / professional development & education
 - Training on psychological disorders available
- Provide appropriate funds (on the federal level) to address issues
- Allocate funds to focus on prevention services