Community Health Needs Assessment and Implementation Strategy & the NYS Comprehensive Community Service Plan Report 2022-2024

White Plains Hospital

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

Community Health Needs Assessment and Implementation Strategy & the NYS Comprehensive Community Service Plan Report 2022-2024

Cover Page

1. Identify County/Counties or service area covered in this assessment and plan

White Plains Hospital's service area is Westchester County, New York.

2. Participating Local Health Department(s) (LHDs) and contact Information

Our Participating Local Health Department is The Westchester County Department of Health. For this report, the contact information is:

The Westchester County Department of Health
First Deputy Commissioner
10 County Center Road, 2nd Floor
White Plains, NY 10607-1541
Attention: Renee Recchia

3. Participating Hospital/Hospital System(s) and contact information

White Plains Hospital is a member of the Montefiore Health System. For this report, the contact information is:

White Plains Hospital
101 East Post Road
White Plains, NY 10601
Attention: Dawn French
Senior Vice President
Marketing & Community Outreach
DFrench@wphospital.org

White Plains Hospital
101 East Post Road
White Plains, NY 10601
Attention: Ashley Liberatore
Director, Community Outreach
aliberatore@wphospital.org

Montefiore Health System
Office of Community and Population Health
3 Executive Boulevard
Yonkers, NY 10701
Attention: Oni Tongo, MS, RD
Manager, Health Equity Programs
Community & Population Health
otongo1@montefiore.org

Montefiore Health System
Office of Community and Population Health
3 Executive Boulevard
Yonkers, NY 10701
Attention: Elizabeth Spurrell-Huss
Director, Health Equity Programs
Community & Population Health
espurrel@montefiore.org

4. Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals.

This is not applicable for this submission.

White Plains Hospital

Community Health Needs Assessment

and Implementation Strategy and the NYS Community Service Plan Report 2022-2024

1. Executive Summary

White Plains Hospital has a long history of collaborating with community and governmental partners to improve the health of the community members it serves. White Plains Hospital's Community Health Needs Assessment and Implementation Strategy (CHNAIR) & the NYS Comprehensive Community Service Plan (CSP) Report demonstrate our coordinated community health improvement planning and collaborative efforts to advance population health.

a. Prevention Agenda Priorities

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.

For the 2022-2024 CHNAIR & NYS CSP, White Plains Hospital has selected two prevention agenda priority items:

1) Promote a Healthy and Safe Environment with a specific focus on reducing injuries in vulnerable populations. Within this focus area, our specific goal is:

Goal 1.1 Reduce Falls Among Vulnerable Populations

2) Promote Healthy Women, Infants and Children with a specific focus on perinatal & infant health. Within this focus area, our specific goal is:

Goal 2.2 Increase Breastfeeding

Within these two priority areas we will:

- Implement strategies to prevent hospitalizations related to falls among adults 65 years or older.

- Promote and implement maternity care practices consistent with the National Baby-Friendly Hospital Initiative. Support at-risk mothers by engaging with and referring them to community-based programs.

These focus areas align with other ongoing activities, including but not limited to White Plains Hospital's Interdisciplinary Fall Prevention Taskforce, White Plains Hospital's Nursing Professional Practice Council, White Plains Hospital's Geriatric Surgery Verification Committee, White Plains Hospital's Geriatric Steering Committee, 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 community health through reduced hospitalizations due to falls and improved maternal child health.

The White Plains Hospital's CHNAIR/CSP was approved by the Board of Directors on December 12, 2022 and was uploaded to the White Plains Hospital website on December 19, 2022.

b. Changes From 2019 Priority Selection

The selected priorities both expand upon and deviate from those chosen in 2019. The first priority area, Promote a Healthy and Safe Environment, is a deviation from our original 2019 selection, Promote Mental Health and Prevent Substance Abuse. At the time, this priority area was selected to support the national and state effort of reducing mortalities related to opioid overdoses. Through a collaborative effort with the Westchester County Department of Health's Department of Community & Mental Health, this indicator has improved within Westchester County. In light of this, and our lack of behavioral health services, the Hospital decided not to continue with this effort. According to the CDC, falls are the leading cause of fatal and nonfatal injuries among adults 65 and older. This health issue was identified by our surveyed community members and was supported by data that showed the impact of this health issue within the Hospital's service area.

For our second priority, White Plains Hospital has elected to continue to build upon its efforts in Promoting Healthy Women, Infants and Children. This was one of our 2019 priority areas. Maternal health continues to be a need identified by our community and aligns with the National Baby-Friendly Initiative the Hospital is working on sustaining. We have chosen to focus on the goal of increasing the percentage of infants who are exclusively breastfed within the Hospital. Although progress has have been made in this focus area, the organization understands the importance of this goal for the health of our community and recognizes there is still work to do.

Both of our chosen priority areas 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. White Plains Hospital will be partnering with Burke Rehabilitation Hospital, also located in White Plains, NY and part of the Montefiore Health System, on the priority to Promote a Healthy and Safe Environment. Additionally, activities in support of the priorities are carried out with the input and support of our community partners.

c. Data Review Process

The process to identify the needs of the community involved the collection of both primary and secondary data. The collection of primary data from a sample of Westchester County residents was an important element of the development of the Community Service Plan. Feedback was compiled from 3,377 respondents and identified the community concerns by municipality to support the priority selections. Additionally, a thorough review of the data was conducted with external partners, helping to frame the development of the report. These collaborations and partnerships are described in detail in this document.

d. Community Engagement

As an established member of the community and a leading healthcare provider in Westchester County, White Plains Hospital plans to work collaboratively with its internal staff and external partners to serve the needs of our patient and community populations, and to meet the goals set forth in this plan to make New York State healthier. The CHNAIR/CSP provides information on the individuals, groups and organizations participating in activities that evolve out of the CHNA process. The CHNAIR and the CSP process were conducted simultaneously, and there is strong alignment between the areas of focus in this report. White Plains Hospital will continue to work with its partners on existing program initiatives.

e. Review of Evidence-Based Interventions

All implementation strategies, interventions, and process measures are detailed in the CHNAIR/CSP 2022-2024. Interventions selected are evidenced-based and most strategies are provided per the Prevention Agenda 2022-2024 Action Plans (NYS Prevention Agenda 2019-2024 New York State's Health Improvement).

Promote a Healthy and Safe Environment
WPH will partner with Burke Rehabilitation Hospital to implement a three-pronged fall prevention strategy consisting of the following:

- Provide several community events each year during the service plan period to screen individuals for their personal fall risk, educate them about their risks, and provide information to reduce their likelihood of falling.
- Host a Grand Rounds presentation annually to medical staff of WPH and Burke and to Burke Residents and Fellows presenting information on evaluating patients for falls and providing a quick screening/educational intervention in office. Provide education on de-prescribing in the elderly – Beers criteria and fall risks.
- Provide several community educational events each year targeting residents of assisted living and other congregate-living communities to disseminate information about falls and how to prevent them. These events can be conducted in-person or virtually.

Promote Healthy Women, Infants and Children
Consistent with Baby-Friendly guidelines, the Hospital will continue to participate in the interventions below:

- Follow our evidence-based breastfeeding policy
- Train all new and existing health care staff in the skills necessary to follow our policy, and require completion of annual skills labs
- Strongly encourage and support the postpartum nursing staff to become certified lactation counselors (CLC) and/or breastfeeding counselors
- Inform pregnant women about the benefits and management of breastfeeding

- Help mothers initiate breastfeeding within one hour of birth
- Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants
- Restart in-person prenatal breastfeeding classes
- Provide our outpatient Obstetrics practices with our Lactation consultation class information
- Give infants no food or drink other than breast milk, unless medically indicated
- Encourage breastfeeding for infants with low blood sugar
- Update our policy on the Management of the Newborn at Risk for Hypoglycemia to include best practices related to breastfeeding and donor milk
- Practice rooming-in. Allow mothers and infants to remain together 24 hours a day
- Encourage breastfeeding on demand
- Give no artificial nipples or pacifiers to breastfed infants
- Start to plan for the establishment of breastfeeding support groups and refer mothers to them upon discharge from the hospital
- Identify areas in need of practice improvement using patient/mother surveys

f. Tracking and Process Measures

The Hospital plans to use a variety of measures to monitor and track the impact of our initiatives. Specific to the first priority area, **Promote a Healthy and Safe Environment**, White Plains Hospital will measure:

Process Measures:

- Fall Prevention assessment and intervention strategy: Number of executed sessions, number of attendees/participants, and participants' knowledge on how to avoid falls will be tracked and assessed. Post-event phone calls will be utilized to assess adherence to fall prevention recommendations.
- Provider education: Number of executed sessions and number of attendees/participants will be tracked and assessed. Post-lecture surveys will track the percentage of improved knowledge gained from education.
- Community Education: Number of executed sessions and number of attendees/participants will be tracked and assessed.

Outcome Measure/Objective:

- Decrease the annual rate of hospitalizations due to falls among residents ages 65 and over by 5% to 173.7 per 10,000 residents within Westchester County.

Specific to the second priority area, **Promote Healthy Women, Infants and Children**, White Plains Hospital will measure:

Process Measures:

- Community Education: Number of prenatal breastfeeding executed sessions and number of attendees/participants will be tracked and assessed.
- Board-Certified Lactation Consultants post-discharge interactions with mothers will be monitored and tracked.
- Skin-to-skin contact will be monitored and tracked.
- First latch in the Labor & Delivery room will be monitored and tracked.

Outcome Measures/Objectives:

- White Plains Hospital will monitor and track its breastfeeding implementation rates against the NYS Vital Statistics 2021 data with the goal of exceeding the NYS Prevention Agenda 2024 objective of 51.7%.
- Achieve redesignation as a Baby-Friendly Hospital

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 and The William & Sylvia Silberstein Neonatal & Maternity Center. The Hospital's Flanzer Emergency Department is the busiest in Westchester County. 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 and in 2021, the Hospital formally launched its cardiac surgery program with its first-ever open-heart surgery in partnership with world-class cardiac surgeons from Montefiore Einstein. White Plains Hospital has outpatient medical facilities across Westchester, including multispecialty practices in Armonk, New Rochelle, Somers and Yorktown Heights; 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 2019. In 2022, White Plains Hospital received a 5-star rating from the Centers for Medicare and Medicaid Services (CMS) — the highest distinction offered by the federal agency. In addition, the Hospital received Magnet® designation three times, most recently in 2021 from the American Nurses Credentialing Center (ANCC). The Hospital recently received the American Heart Association's Mission: Lifeline® Gold Achievement Award for its treatment of patients who suffer severe heart attacks in its Emergency Department and Cardiac Catherization labs and its mortality rate is amongst the

lowest in the country according to the National Cardiovascular Data Registry (NCDR). The Hospital has been reaccredited by the American College of Surgeons Commission on Cancer, and by the for providing high-quality, patient-centered cancer care to their patients and the community. It has earned a three-year accreditation from the National Accreditation Program for Rectal Cancer (NAPRC), and the Hospital's Bariatric Surgical Center was reaccredited as a Comprehensive Center under the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) in 2022. White Plains Hospital has received full accreditation for its breast cancer program four times from the National Accreditation Program for Breast Centers (NAPBC) and The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) granted White Plains Hospital with two meritorious outcomes for surgical patient care in 2022. Also in 2022, the Hospital received the Outstanding Patient Experience Award from Healthgrades® for the 7th time, and in 2022 became the only Hospital in Westchester to be awarded with an A Safety Grade from the Leapfrog Group for the 8th time. For additional information, visit https://www.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. The Community Health Needs Assessment and Implementation Strategy & the NYS Community Service Plan Report Requirements

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). The Community Service Plan (CSP) is a requirement by New York State Department of Health and must be submitted every 3 years. White Plains Hospital, along with all voluntary hospitals in New York state, is required to submit a Community Service Plan every three years, with a progress update each year to the New York State Department of Health. This report summarizes White Plains Hospital's community service initiatives, including collaborations with our community partners, addressing New York State's Prevention Agenda priorities. The White Plains Hospital's CHNAIR/CSP was approved by the Board of Directors on December 12, 2022 and was uploaded to the White Plains Hospital website on December 19, 2022.

3. Definition and Description of the Community/Service Area and Summary of Assets

White Plains Hospital has identified Westchester County as its primary service area. Westchester County has a population of 997,895 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 (59,559) and other major cities include Yonkers (209,530), New Rochelle (81,587) and Mount Vernon (72,581). In 2020, the median household income for Westchester was $99,489, the 4th highest in New York State after Nassau, Putnam and Suffolk counties.

Westchester County is the 6th healthiest county in New York State, according to the County Health Rankings, produced by the University of Wisconsin. Residents of Westchester County have access to a number of community resources including public and private schools, open spaces, healthcare facilities, community gardens, bike lanes and much more. Despite its overall high ranking, there is considerable room to improve the health of the population in Westchester County, while also reducing health disparities for both high-need populations and those with poorer health outcomes.

3a. The Populations of White Plains

White Plains is the county seat and the 4th most populous city in Westchester County. According to the 2020 American Community Survey, White Plains has 59,559 residents and has experienced a 4.8% increase in population between 2010 and 2020.

There are over 23,222 households in White Plains, of which 23.5% are family households with children. White Plains has a slightly older population than Westchester County, with a median age of 42 years versus 41.1 years.

White Plains is also ethnically diverse. Its population is 46.5% non-Hispanic white, 31.6% Hispanic, 12.4% non-Hispanic black, 7.7% Asian/Pacific Islander and 1.8% non-Hispanic other. Almost one-third (31.4%) of its residents are foreign-born. Among the foreign-born population, more residents speak Spanish (45%) than English (3.2%) or another (55%) language at home. The city's foreign-born population come from diverse corners of the globe (in order of

frequency): Mexico (21.3% of foreign-born), Peru (11.5%), Dominican Republic (5.6%), Colombia (6.1%), India (5.2%), China (2.8%), Jamaica (3.9%), Guatemala (3.7%), Korea (3%), El Salvador (2.9%) and Ecuador (2.9%).

White Plains has the 4th largest proportion of the population that lives below the poverty level (10.1%) in the county (compared to 7.6% countywide). The median household income is $96,715, slightly below the median household income countywide ($99,489). Of note, 11.7% of White Plains children live below the poverty line, higher than the countywide percentage of 11.2%. Almost half (49.0%) of students in White Plains public schools qualified for free or reduced lunch during the 2020-2021 school year.

A similar proportion of the population is insured (91.8% versus 94.6% in the county) and a higher proportion are uninsured (8.2% versus 5.4% 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 5.6%, which is the 5th highest in Westchester County. 51.2% of White Plains residents ages 25 and older have received at least a bachelor's degree, higher than countywide (49.7%) and statewide (37.5%) 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 (611.1 per 100,000) and non-Hispanic white (542.5 per 100,000) populations are significantly higher than for the Hispanic population (381.0 per 100,000) and Asian/Pacific Islander population (265.8 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 2024 Target, there are areas and sub-populations that have excess preventable hospitalization rates. For example, the rate is 152.8 per 10,000 in ZIP Code 10601 in White Plains and 226.1 per 10,000 ZIP Code 10550 in Mount Vernon. Rates are generally elevated in the southern portion of the county, including Yonkers, Mount Vernon, the southern section of New Rochelle, and in the northern portion of the county, namely Peekskill. Further, the rate of preventable hospitalizations for the non-Hispanic black population (206.7 per 10,000) is 3.3 times higher than the rate for the non-Hispanic white population (61.9 per 10,000). The rate for the Hispanic population (53.0 per 100,000) is lower than the non-Hispanic white population.

There are a multitude of reasons certain populations and geographic areas have poorer health outcomes. Differences in access to health care, quality of care, physical environments, and economic and educational opportunities are just a few factors. For example, while a smaller proportion of individuals live in poverty in Westchester County than in New York State overall, those who are black (14.0%) and Hispanic (15.1%) are more likely to be living in poverty than those who are white (5.6%).

While the Prevention Agenda 2024 target for health insurance coverage among adults age 18-64 is 97%, 93% of adults are covered in Westchester County. In certain areas, such as Port Chester, a much smaller percentage of the population has health insurance (86.3%), and in other areas such as Scarsdale, almost all residents have health insurance (98.7%). 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; 96.8% of the white and 94.1% of the black populations have health insurance, only 90% of the Hispanic population does.

Disparities are also present for other health outcomes. There is tremendous geographic variation in the rate of Emergency Department visits for asthma in Westchester County. While Westchester County has a rate of 56.0 per 10,000, below the rate for New York State overall (68.6), certain areas have more elevated rates. Specifically, the asthma Emergency Department visit rate ranges from 45.6 per 10,000 in ZIP Code 10601 in White Plains to 150.0 per 10,000 population in ZIP Code 10550 in Mount Vernon, to 9.7 per 10,000 in the town of Rye. There are also variations in the rate of fall related ED visits amongst those age 65+ in Westchester County. While Westchester County has a rate of 182.1 per 10,000, below the rate for New York State overall (180.1), certain areas, such as the City of White Plains (199.6) and the City of Yonkers (219.4) have more elevated rates. 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 12.05% of births being preterm in White Plains compared to 9.12% in North Castle, the municipality with the lowest rate. Non-Hispanic black women are more likely to have a preterm births (12.8%), as compared to the non-Hispanic white (8.2%) and Hispanic women (8.7%).

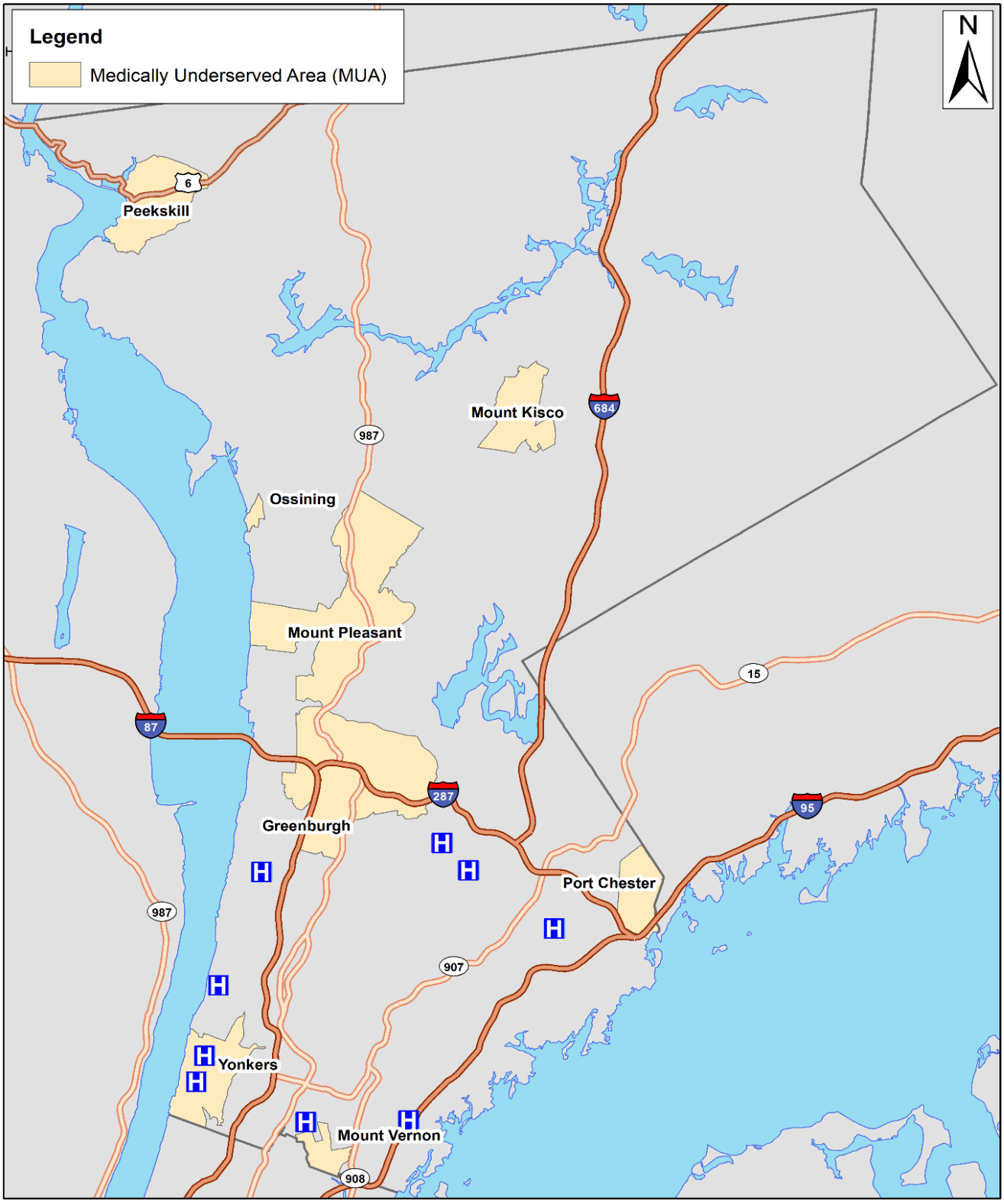
There are also disparities in the proportion of infants exclusively breastfed in the hospital. 51.0% of infants are exclusively breastfed in the hospital in Westchester County, which is below the proportion in New York State overall and the Prevention Agenda Target of 51.7%. There are also intra-county geographic disparities. Specifically, proportions range from 57.9% and 35.2% in Rye and Yonkers, respectively, to 70.3% in Peekskill. The proportion of infants breastfed exclusively in the hospital is lower in the southern portion of the county; 61.4 of infants are exclusively breastfed in the hospital that reside in the city of White Plains. Additionally, non-

Hispanic white women are most likely to breastfeed exclusively in the hospital (58.6%), followed by Hispanic women (40.6%) and non-Hispanic black women (40.0%). 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 the supplemental information portion of this report.

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 disparities 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 (See **Figure 1**)**.**

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 2022-2024 Community Health Needs Assessment and Implementation Strategy and the NYS Comprehensive Community Service Plan Report was an interorganizational and collaborative process, including participation from the community and the Greater New York Hospital Association (GNYHA). Our goal was to develop an assessment that was reflective of the needs of the community, including the clinical and social determinants of health. This process enabled us to deploy a Community Health Needs Assessment survey that was developed using best practice approaches in survey design and needs assessment. This survey was our source for our primary data collection. To complement our primary data collection, secondary data sources were compiled and reviewed to establish community health priorities in Westchester County. Secondary data sources are noted in the Supplemental Information section of this report.

Primary Data Collection Process and Methods

In early 2022, the Greater New York Hospital Association (GNYHA) offered member hospitals and health systems the opportunity to participate in the GNYHA Community Health Needs Assessment (CHNA) Survey Collaborative. The collaborative supported participating members' primary data collection efforts to meet the requirements of the Federal CHNA and the New York State Community Service Plan (CSP) by gathering information on community health needs and engaging with community members. A diverse group of GNYHA member hospitals participated in the 2022 collaborative, including community and safety net hospitals, small health systems, and large academic medical centers. GNYHA developed a health needs assessment survey with member input, made the survey available in 11 languages on paper and online, collected the data, analyzed the results, and created custom reports for each participating hospital. The members recruited participants from their communities to respond to the survey, netting 17,600 respondents. Community members qualified for the survey if they were at least 18 years old and lived within any of the geographic areas identified by the members as their hospital's service area. During this process, Westchester County compiled feedback from 3,377 respondents and identified the community concerns by municipality to support CHNA and CSP efforts of hospitals for inclusion into their Implementation Plans.

4.a.i Data Sources & Analytic Notes

Multiple data sources were used to support the identification and selection of the priority items, which were and reviewed with partners. A listing and brief summary of the data sources used to complete the secondary data analysis are listed within our Supplemental Information section of this report. These data sources were used to identify the issues of concern beyond experience and direct observation.

4.a.ii Collaborations and Partnerships

The Community Engagement process for the 2022-2024 CHNAIR/CSP 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 were developed.

White Plains Hospital serves the community of the greater White Plains area and is pleased to regularly partner with local organizations. White Plains Hospital's staff (including doctors, nurses, and other personnel), volunteers and board members all regularly contribute to and participate in community events. 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 partnerships and collaboratives, working with other providers in Westchester County, the Westchester County Department of Health, community-based organizations, and others.

Throughout the completion of the most recent community health survey, WPH engaged with our *Healthy Community Initiative* Task Force, in addition to other community organizations, groups, and individuals to best understand our community's broad interests and needs. 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:

- Heather Miller, Executive Director, Thomas H. Slater Center
- Frank Williams, Executive Director, White Plains Youth Bureau
- Mayor Thomas Roach, The City of White Plains
- Mariam Elgueta, Assistant to Mayor, City of White Plains
- Ned Corona, Director of Program Operations, YWCA
- Virgil Dantes, Director of Programs and Network Services, Feeding Westchester
- Monique Marshall, RDN, 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.
- Judith Aucar, Deputy Director, El Centro Hispano, Inc.
- Deborah Augarten, Assistant Superintendent for Special Education and Pupil Services, White Plains School District
- Kathleen Halas, Executive Director, Child Care Council of Westchester, Inc.
- Denise Brooks, Deputy Director, White Plains Housing Authority
- Megan Lucas, Regional Director, Westchester & Putnam Counties, American Heart Association
- Amy Ansehl, Associate Dean, School of Health Sciences and Practice, New York Medical College

With the assistance of this Task Force, WPH was better able to understand the varying needs and interests within our community. These collaborative partners were continually asked the following questions:

- What can we do to assist you and 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 addressing any or all of these health issues?

Additionally, many community-based organizations are involved in committees chaired by White Plains Hospital, such as the Neighborhood Health Fair Committee. These committees offer ongoing support and new perspectives on the progress of our initiatives and any new health issues that arise in our catchment areas. White Plains Hospital will continue to work with its partners on existing program initiatives.

5. Identification and Prioritization of Community Health Needs

In order to form a complete picture of our community's health needs, we conducted an assessment of secondary data, including data from population-based surveys, hospital discharges and numerous other data sources. This information supplemented our collection of primary data via a community-member survey.

5a. Secondary Data Analysis

The secondary data used to identify community health needs is described in Section 4.a.i and listed in our Supplemental Information section of this report. 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 Emergency Department visits for White Plains Hospital. Second, we completed an assessment of secondary data for health indicators from several population-based data sources.

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 numerous 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 within our supplemental information section of this report. Additionally, some of the most applicable data points coinciding with our chosen priorities are presented in this section as well.

5b. Primary Data Analysis

In keeping with the Commissioner of Health's mission, White Plains Hospital works in partnership with our community, assessing our present initiatives, strategic plans and prevention agenda priorities. Community health needs were identified through an ongoing dialogue with patients, community members, elected officials, organizations, area business leaders and our local Department of Health. In addition, the GNYHA brought together a variety of health care facilities to collaborate on the priority agenda items as well as the Community Health Needs Assessment (CHNA).

Community Survey

Overview & Methods

The CHNA collaborative survey is an abbreviated version of the 2022 GNYHA Model Community Health Needs Assessment Survey. The survey used validated questions from existing surveys such as the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (CDC BRFSS) and the New York City Department of Health and Mental Hygiene's Community Health Survey (NYC CHS). GNYHA sought to minimize respondent burden by keeping the survey length to a minimum. The CHNA was a joint effort by the GNYHA and numerous hospitals and health care agencies, who worked to develop a survey that each institution then distributed to their patients and surrounding communities. The methods were summarized in section 4.

GNYHA members provided input in multiple stages through a collaborative and iterative process. GNYHA produced biweekly geographic and demographic reports summarizing the responses in their service area, which allowed hospitals to adjust their dissemination strategy.

Table 1. GNYHA Member Forum dates

March 9, 2022 & March 31, 2022	June 1, 2022
April 28, 2022	July 27, 2022
May 5, 2022	September 9, 2022

Through the combined efforts of these organizations, 3,377 surveys were completed in Westchester County. Participants were asked to rank 21 Health Conditions in importance to

them using a five-point scale from 1= “Not at all” to 5= “Extremely”. In addition, the participants had to also rank “How satisfied are you with current services in your neighborhood?” utilizing the same five-point scale. The health priorities for the community included options such as COVID-19, obesity, diabetes, mental health, and women’s and maternal health care.

Community Survey Results

The CHNA survey health priorities and respondents’ demographic data were reviewed. Respondents resided in more than 70 ZIP Codes. The largest grouping of respondents came from the White Plains area zip code, making up close to 20% of the surveys completed in Westchester County. Demographic data noted 97% of those completing the survey did so in English and 3% completed it in Spanish. Respondents tended to be older; 35% were 45-64, 28% were 65-74, and 21% were 75+. Seventy-three percent of respondents were women, 26% were men and a very small percent identified as non-binary/another gender. Seventy percent identified as white, non-Hispanic, 14% as Hispanic, 9% as Black, non-Hispanic and 4% as Asian/Pacific Islander, non-Hispanic. Of those who identified as Hispanic; 28% were Puerto Rican, the largest proportion of Hispanic respondents. Eighty-nine percent noted their sexual identity to be straight, 3% identified as gay, lesbian or bisexual, 2% identified as Other and 7% preferred not to say. Seventy-five percent noted to have graduated college and 42% were retired. In addition, 51% of respondents noted to have a annual household income greater than $100,000 or more in the previous year. This information was considered when analyzing our respondents’ answers regarding their health priorities.

Key Findings from Analysis

The three leading community health priorities identified included: Violence (including gun violence), Mental Health/Depression, and Stopping Falls among the elderly. (see **Table 2**). Mental Health/Depression, a continued concern among our community members, was also highlighted in our 2019 CHNA as being a top priority.

Health priorities of moderate importance and satisfaction were also summarized in the CHNA survey report from GNYHA (see **Table 3**). Women’s and maternal health care remained a continued important health priority among those surveyed, with a score of 4.02; with moderate satisfaction with the community services available with a score of 3.42. Areas of lower health importance and higher satisfaction of services within the community are outlined (see **Table 4**).

Priority Selection

The primary data collection provided important insight into what our community members feel are the most important health priorities and of those which health conditions need additional support with services. Within the communities White Plains Hospital serves, there are many health needs that are beyond the scope of this report. Many of the needs that are not

addressed directly by the CHNAIR/CSP are being served by existing White Plains Hospital and Montefiore Health System programs, community-based organizations, and other health care providers in the community we serve. During this cycle of our CHNAIR/CSP, we will continue to coordinate our efforts with community organizations so that we maintain an up-to-date understanding of community needs and resources, allowing us to maximize our collective impact to improve the communities health.

Stopping falls among the elderly was highlighted as a top health priority by respondents. In addition, our most up-to-date falls data from the Statewide Planning and Research Cooperative System (SPARCS) demonstrated opportunities for improvement within this indicator. According to SPARCS, the rate of hospitalization due to falls per 10,000 members of the population, aged 65 or older (2016-2018) for the city of White Plains was 199.6. This rate is significantly higher than Westchester County at 182.1, NYS at 180.1 and the NYS Prevention Agenda target of 173.7.

Violence, including gun violence, continues to be a concern throughout the country. However, our secondary data analysis revealed that the assault-related hospitalizations, rate per 10,000 members of the population in Westchester County is at 1.9; significantly below the NYS rate of 3.1 and below the NYS Prevention agenda goal of 3.0.

Mental Health/Depression was again emphasized by our community members as an area of need. This health issue was a priority focus of our 2019 CSP, specifically reducing opioid overdose deaths. Our efforts to train community members on naloxone administration and promote prescriber education for opioid guidelines were deemed successful when reviewing the overall trend improvements in this area of focus for New York State. Opioid analgesic prescription has significantly improved, but overdose deaths involving any opioids has not had a significant change. However, the organization does not have robust internal resources to help support or create new mental health services in our community at this time.

These findings and considerations led to the selection of the Hospital's prevention agenda priority areas. For the 2022-2024 CHNAIR/CSP, White Plains Hospital selected the following prevention agenda priority items: Promote a Healthy and Safe Environment and Promote Healthy Women, Infants and Children.

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

- Injuries, Violence and Occupational Health
- Perinatal & Infant Health

Table 2. Top 3 Community health priorities as identified by the GNYHA Community Health Needs Assessment Survey, 2022

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	4	4.35	Above Average	18	2.97	Below Average
Mental health/depression	7	4.14	Above Average	17	3.00	Below Average
Stopping falls among elderly	8	4.12	Above Average	14	3.18	Below Average

Data source: GNYHA CHNA Survey Collaborative 2022

Table 3. Community health priorities 4-12, as identified by the GNYHA Community Health Needs Assessment Survey,2022

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Maintain Efforts						
Dental care	1	4.43	Above Average	5	3.65	Above Average
Cancer	2	4.37	Above Average	6	3.64	Above Average
Access to healthy/nutritious foods	3	4.37	Above Average	1	3.78	Above Average
COVID-19	5	4.33	Above Average	2	3.76	Above Average
Heart disease	6	4.28	Above Average	3	3.71	Above Average
High blood pressure	9	4.10	Above Average	4	3.70	Above Average
Women's and maternal health care	10	4.02	Above Average	10	3.42	Above Average
Arthritis/disease of the joints	11	3.93	Above Average	12	3.35	Above Average
Adolescent and child health	12	3.91	Above Average	8	3.51	Above Average

Data source: GNYHA CHNA Survey Collaborative 2022

Table 4. Community health priorities 13-21, as identified by the GNYHA Community Health Needs Assessment Survey,2022

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Relatively Lower Priority						
Obesity in children and adults	14	3.79	Below Average	20	2.94	Below Average
Substance use disorder/drug addiction (including alcohol use disorder)	16	3.62	Below Average	19	2.95	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	18	3.44	Below Average	21	2.93	Below Average
Hepatitis C/liver disease	19	3.14	Below Average	13	3.27	Below Average
Sexually Transmitted Infections (STIs)	20	2.98	Below Average	15	3.04	Below Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	21	2.84	Below Average	16	3.03	Below Average
Diabetes/elevated sugar in the blood	13	3.81	Below Average	9	3.45	Above Average
Asthma/breathing problems or lung disease	15	3.72	Below Average	11	3.39	Above Average
Infant health	17	3.54	Below Average	7	3.51	Above Average

6. Measures and Identified Resources to Meet Identified Needs

6a. Implementation Strategy and Measures

As a part of the submission for the New York State Health Improvement Plan for 2022-2024 required by the New York State Department of Health, White Plains Hospital has elected to choose the following two prevention agenda priority items: **Promote a Healthy and Safe Environment and Promote Healthy Women, Infants and Children**. Within these priority areas, a commitment has been made to impact the following two focus areas: Injuries, Violence and Occupational Health 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 a Healthy and Safe Environment
Focus Area: Injuries, Violence and Occupational Health
Falls among older adults are common, preventable and can impact an individual's quality of life. In addition, falls can be costly to an individual and the community they live in. Direct costs such as medical bills, hospital and doctor fees, paired with indirect costs of long-term effects of injuries, such as disability, dependence on others, lost time at work and household duties, can have long lasting implications. In support of the NYS prevention Agenda priority Goal 1.1 and with consideration of our CHNA community members responses, White Plains Hospital, in partnership with Burke Rehabilitation Hospital, is committed to reducing falls amongst older adults in our community.

To support this goal, the WPH and Burke are planning on instituting evidence-based interventions that will:

- Provide several community events each year to screen individuals for their personal fall risk, educate them about their risks, and provide information to reduce their likelihood of falling.
- Provide prescriber education on how to evaluate patients for falls and provide a quick screening/educational intervention in office, as well as, on the importance of deprescribing in the older adult population- based on the Beers criteria.
- Host fall prevention educational lectures with our partners in the community.

Burke and WPH will work closely together to recruit participants for the fall risk screening and education intervention. The target population is people 65 and older in the service area. The events will take place in the community, at gathering places such as churches, community centers, or in adult or assisted living facilities. The collaborative group will identify sites and champions within those sites to assist with recruiting and logistics.

At the outset of the intervention, participants will be asked to complete a short, validated questionnaire about their history of falls, knowledge on avoiding falls, attitudes and beliefs

regarding falls and their ability to avoid them, and their behaviors surrounding fall avoidance. They will then be evaluated on multiple criteria, including gait, strength, balance, vision and foot problems. Co-morbidities such as osteoporosis, cardiac issues, Parkinson's Disease, and depression will be identified. Current medications and potential home hazards will also be discussed. Once these measures have been taken, the participant will receive feedback on their personal risk factors and how they can be mitigated to avoid falls. Referrals will be made as needed to programs and providers who can work with the participant on specific risk factors, such as a physical therapy or exercise program, ophthalmologist or optometrist for vision problems, a podiatrist for foot issues, an occupational therapist to evaluate home safety, and a PCP or internist to manage medications that increase fall risk. After the intervention, participants will complete a short survey to assess their increase in knowledge and self-efficacy, as well as their satisfaction with the program.

<table>
<tr><td>Goal</td><td>Goal 1.1 Reduce falls among vulnerable populations</td></tr>
<tr><td>Outcome Objectives</td><td>Objective 1.1.b. Decrease the annual rate of hospitalizations due to falls among residents ages 65 and over by 5% to 173.7 per 10,000 residents.

<table><tr><td>Target</td><td>173.7 per 10,000</td></tr><tr><td>Baseline</td><td>182.8 per 10,000</td></tr><tr><td>Baseline Year</td><td>2016</td></tr><tr><td>Data Source</td><td>NYS SPARCS Data</td></tr><tr><td>Data Level</td><td>State, County level</td></tr></table></td></tr>
<tr><td>Interventions/Strategies/Activities</td><td>Intervention 1.1.1. Connect older adults and people with disabilities with evidence-based fall prevention programs such as Tai Chi for Arthritis, Stepping On, and A Matter of Balance.

1. WPH & Burke will partner to provide several community events each year during the service plan period to screen individuals for their personal fall risk, assess these risks, and provide information and recommendations to see healthcare providers who can help them reduce their personal risk factors.

2. WPH & Burke will provide several community educational events each year</td></tr>
</table>

	targeting residents of assisted living and other congregate-living communities to disseminate information about falls and how to prevent them. These events can be conducted in person or virtually. *Intervention 1.1.2* Promote health care provider screening for fall risk among older adults and people with disabilities, and engage health care providers in identifying modifiable risk factors and developing a fall prevention plan of care. A fall prevention plan of care may include but is not limited to physical or occupational therapy, community-based programs, medication management, Vitamin D supplements, updated eyeglasses, and changes to footwear. 1. WPH & Burke will partner to provide a Grand Rounds presentation annually to medical staff of WPH and Burke and to Burke Residents and Fellows presenting information on evaluating patients for falls and providing a quick screening/educational intervention in office and hospital settings.
Measures & Objectives	*Process Measures & Objectives:* • By December 31 of each of the years 2023, 2024 and 2025, the WPH/Burke collaborative will conduct three community screening and assessment events for fall prevention. • By December 31 of each of the years 2023, 2024 and 2025, the WPH/Burke collaborative will conduct one Grand Rounds presentation for health care providers of each organization to improve understanding and increase adoption of fall screening protocols for in-office visits and for hospital stays. • By December 31 of each of the years 2023, 2024 and 2025, the WPH/Burke collaborative will conduct four lectures, either virtually or in-person, for people

	ages 65+ to educate them on risks and avoidance of falls. • By the end of each fall screening event, at least 50% of participants will demonstrate improvement in knowledge about how to avoid falls. • By the end of each falls screening event, at least 50% of participants will demonstrate an increase in their likelihood to follow recommendations to reduce their fall risk. • By the end of each fall screening event, at least 50% of participants will report that the program was helpful to them. • By the end of each fall screening event, 100% of participants with demonstrated risk will have received a recommendation for referral to an appropriate healthcare provider for follow-up. • By three months post-intervention, at least 50% of participants will report that they took at least one action to lower their fall risk. • By three months post-intervention, at least 50% of participants will report no falls since they participated in the program. • By the end of each falls prevention lecture at community sites, at least 50% of attendees will report improved knowledge to prevent falls. *Outcome Measure & Objective:* • Decrease the annual rate of hospitalizations due to falls among residents ages 65 and over by 5% to 173.7 per 10,000 residents by 2024.
Partner Role	WPH & Burke will collaborate and partner with local governmental and community-based organizations to provide a three-pronged approach to fall prevention in the community.
Partner Resources	Provide supportive community programming, visit assistance, and educational resources.

By When	December 31, 2024
Will Action Address Disparity	Yes. The staff are extremely invested in reaching the prevention agenda goal of decreasing falls among those 65 years and over.

Priority Area: Promoting Healthy Women, Infants and Children

Focus Area: Perinatal & Infant Health

The second prevention agenda item aligns with our previous goals, and builds upon efforts from the 2019 Community Service Plan. White Plains Hospital and the Hospital's Maternal Child Health Division understand the importance of supporting breastfeeding for the health of infants and their mothers. Hospitals are in a unique position to support breastfeeding immediately, from the first moments following birth. Breastfeeding, especially exclusive breastfeeding, is shown to reduce the risk of asthma, obesity, respiratory issues and other chronic conditions in children. For mothers, breastfeeding has been shown to reduce the risk of breast cancer, ovarian cancer, type 2 diabetes, heart disease and a multitude of other conditions. Promoting the health of the mother leads to better outcomes for a healthy newborn. The program targets all women of child-bearing age, and their infants, who live in White Plains, NY and the surrounding areas in Westchester.

White Plains Hospital's designation as a "Baby-Friendly Hospital" in January of 2022 aligns with our goal to go beyond the Hospital walls and increase breastfeeding exclusivity, understanding that breastfeeding is a choice made prior to delivery. Based on 2019 NYSDOH data, only 47.1% of NYS infants were exclusively breastfed while in the hospital. Strategies from the previous Community Service Plan cycle that have been implemented to increase these numbers are as follows:

- Hospital's Lactation team has expanded to provide 7 day/week coverage
- Lactation RNs are IBCLC (International Board-Certified Lactation Consultants)
- Approximately 70% of postpartum nurses are certified as either Certified Breastfeeding Counselors (CBC) or Certified Lactation Counselors (CLC).
- WPH no longer accepts free formula; all formula is purchased (including special needs formulas for NICU)
- No free gifts with any formula advertising are distributed to families
- Pre-Admission Nurses meet all women prior to delivery for prenatal education; Maternity Nurse Navigator added
- Lactation Clinic and Hot Line offered by Lactation Consultants
- Skin-to-skin contact >95% for eligible babies in Labor and Delivery
- No mandatory infant separation from mother; Rooming-In preferred
- Human donor milk is now available
- Community education by Maternity RNs and Lactation Nurses has resumed after halting during the pandemic.
- Hosted a Certified Breastfeeding Counselor course for NICU and L&D nurses

- Started long-term breastfeeding support group; eliminated “cut off” date for attending mothers - mothers whose babies are now 6 months or older are still able to attend. However, this was halted due to the COVID-19 pandemic.
- Baby Talk educational event for expectant families. Experts in Obstetrics, Anesthesia, Neonatology, Pediatrics and other specializations encourage families to ask questions and receive information from WPH providers on the perinatal experience. However, this was halted due to the COVID-19 pandemic.

The COVID-19 pandemic impacted healthcare in a multitude of ways. The impact was significant to the Hospital’s Maternal Child Health Division’s goal of increasing exclusively breastfed infants. Breastfeeding can be a complex process and poses its own unique challenges for a mother that are influenced by personal and environmental factors. The COVID-19 pandemic increased many of these perceived challenges due to the nature of the virus’ transmission and the efforts around slowing the spread. Visitation of family and loved ones was significantly restricted due to our efforts to keep our mothers and babies safe from exposure. In addition, in-person classes were cancelled and the organization had to pivot many of its supportive offerings to our mothers due to the changing restrictions of the pandemic. One of the interventions implemented in our 2019 plan was directed towards educating our patients on the importance of breastfeeding. We offered a Breastfeeding Basics class facilitated by an International Board-Certified Lactation Consultant (IBCLC). The two-hour class was offered once a month and discussed the following:

- The benefits of breastfeeding
- Positioning techniques
- Establishing a good milk supply
- Signs of adequate infant intake
- Pumping and going back to work
- Collection and storage of breast milk

However, these classes were partially stopped and then restarted virtually for much of our remaining community service plan cycle (2020-2022). Understanding the importance of the class to our mothers and the unique obstacles that virtual education poses for this topic, the Hospital restarted these classes in person starting in October of 2022. Moreover, the Hospital will be making efforts towards increasing the awareness of these classes with our local community Obstetrics office practices. This effort will enable the Hospital to serve more mothers in our community. The Hospital has made the commitment to increase its availability of our IBCLCs to its mothers during the post-partum period. Mothers at discharge will be provided with our IBCLCs contact information and will be encouraged to contact the IBCLCs for education and advice once home.

At this time, we are able to report the following breastfeeding statistics for all babies born at White Plains Hospital:

2021

Skin-to-skin vaginal delivery: 89.47%

Skin-to-skin C-section delivery: 50%

First latch during skin-to-skin: 52.24%

Exclusive breastmilk feeding 26.87%

In addition to our efforts to increase breastfeeding exclusivity at discharge, we look to involve our community by working with our community partners, specifically the Thomas H. Slater Center. Their goal is to improve the quality of life, and maximize the potential of the people they serve, by providing them with the tools, resources, services and programs for success. For the past 40 years, they have supported youth and adults, including the formerly incarcerated, the unemployed and underemployed. The Center serves the 450 families who reside in the Winbrook Public Housing and the City of White Plains. Prior to the pandemic, the Hospital's Lactation Team had provided education and information on the benefits of breastfeeding. The Hospital will commit to restart these efforts to help reduce health disparities in this underserved community.

Priority Area: Promoting Healthy Women, Infants and Children
Focus Area: Perinatal & Infant Health

<table>
<tr><td>Goal</td><td>Goal 2.2 Increase breastfeeding</td></tr>
<tr><td>Outcome Objectives</td><td>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><tr><td>Target</td><td>51.7</td></tr><tr><td>Baseline</td><td>47.1</td></tr><tr><td>Baseline Year</td><td>2019</td></tr><tr><td>Data Source</td><td>Vital Statistics</td></tr><tr><td>Data Level</td><td>State, Region, County</td></tr></table></td></tr>
<tr><td>Interventions/Strategies/Activities</td><td>Intervention 2.2.1: Increase access to professional support, peer support, and formal education to change behavior and outcomes.

1. The Hospital has made the commitment to increase the availability of our International Board-Certified Lactation Consultants (IBCLC) to its mothers during the post-partum period. Mothers at discharge will be provided with our IBCLCs' contact information and will</td></tr>
</table>

	be encouraged to contact them for education and advice once home. 2. The Hospital will restart our in-person prenatal breastfeeding classes, as these have been held virtually due to the COVID-19 pandemic. Additionally, efforts will be made to increase awareness of these classes through our local community Obstetrics office practices. Intervention 2.2.2: Promote and implement maternity care practices consistent with the Baby-Friendly Hospital Initiatives framework – "Ten Steps to Successful 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. Reinforce our breastfeeding policy, continually evaluate and update it when applicable, as well as routinely communicate its elements to all health care staff 2. Train all health care staff in the skills necessary to implement this policy by training new staff and requiring completion of annual skills labs 3. Inform all pregnant women about the benefits and management of breastfeeding 4. Help mothers initiate breastfeeding within one hour of birth

	5. Show mothers 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. Intervention 2.2.3: Promote and implement early skin-to-skin contact in hospitals. 1. Reinforce the importance of skin-to-skin in the Operating Room and immediately following vaginal birth. 2. Reinforce the importance of family visitation and engagement, as this was significantly restricted due to the COVID-19 pandemic.
Measures & Objectives	*Process Measures & Objectives:* • By December 31 of each of the years 2023, 2024 and 2025, White Plains Hospital will monitor and track the use of our IBCLCs' post-discharge interaction with our mothers; with the target goal of 25 monthly post-discharge interactions. • By December 31 of each of the years 2023, 2024 and 2025, White Plains Hospital will provide a minimum of four prenatal breastfeeding classes and monitor and track enrollment. • White Plains Hospital will monitor and track skin-to-skin monthly with the target goal of 75% for the year. • White Plains Hospital will monitor and track first latches in the Labor & Delivery

	room monthly with the target goal of 75% for the year. *Outcome Measures & Objectives:* • White Plains Hospital will monitor and track its breastfeeding implementation rates against the NYS Vital Statistics 2021 data with the goal of exceeding the NYS Prevention Agenda 2024 objective of 51.7%. • By December 31 of each of the years 2023, 2024 and 2025, White Plains Hospital will continue all processes required to maintain its Baby-Friendly designation.
Partner Role	Engagement and referral into appropriate programs (clinical or community) to support mothers, including non-maternity-based programs that correlate to social determinants of health that impact access to breastfeeding resources.
Partner Resources	Provide supportive community programming, visit assistance, and educational resources.
By When	December 31, 2024
Will Action Address Disparity	Yes. The staff are extremely invested in reaching the prevention agenda goals for exclusive breastfeeding rates.

6b. Internal Resources and Measures

Below is a list of programs provided by White Plains Hospital to help address health conditions in the community. In addition, being part of the Montefiore Health system, offers the Hospital access to a large variety of programs to which we can make patient referrals. The below programs address a variety of community needs, including a brief description, the intervention measures that the program captures and the programs connection to the larger New York State Prevention Agenda.

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Breast and Cervical Screening Event	Screening for breast exams and pap smears for women 21 years and older. Mammograms for women 40 years and older. In addition, women's health education and information is provided.	Increase in breast exams and pap smears for women 21+; Increase in mammograms for women 40+; Decrease in diagnosis of late-stage breast and cervical cancer	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children
Colorectal Cancer Patient Navigation Program	The Colorectal Cancer Patient Navigator Program is the bridge between the community and health care, bringing together interdisciplinary teams to work towards reducing colorectal cancer rates by assessing, educating, scheduling, and guiding patients through the screening process. Its 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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Internship & Volunteer Program	The Office of Volunteers recruits, hires and trains interns for the hospital, including high school, college and graduate level students.	Increase in satisfaction of interns	Promote a Healthy and Safe Environment
Exceptional Nurse Apprentice Program	The program offers graduating HS seniors (at least 18 years of age by date of application), and college students with an interest in a nursing career an opportunity to experience firsthand what it is like to be a nurse in a Magnet designated acute care hospital.	Increase access to Nursing internships roles for our community members; Increase in satisfaction of interns	Promote a Healthy and Safe Environment
Oral Head and Neck Cancer Screening Program	Screening for Oral, Head and Neck Cancer.	Increase in screening for Oral Head, and Neck Cancer; Decrease in Oral, Head and Neck Cancer	Prevent Chronic Diseases
Neighborhood Health Fair	The annual Neighborhood Health Fair offers 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.	Screening for various chronic health issues. Mammograms provided free of charge for those eligible.	Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections; Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Physician Referral Navigator	Free Physician referral 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; Expectant Parent Tours of our Maternity floors are also available.	Increase breastfeeding rates; Increase in positive outcomes for labor & delivery patients/mothers	Promote Healthy Women, Infants and Children

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Breast Cancer Patient Navigation Program	The Breast Cancer Patient Navigator is the bridge between the community and health care. We eliminate complexity by bringing together interdisciplinary teams to work towards reducing breast cancer rates by assessing, educating, scheduling, and guiding our patients through the screening process. The program's 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 breast cancer; Decrease in breast cancer	Prevent Chronic Diseases
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.	Increase in screening for pancreatic cancer; Decrease in pancreatic cancer	Prevent Chronic Diseases

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Heart Month	During the month of February, WPH hosts and participates in a series of educational sessions and health screenings for residents of Westchester County.	Increase in blood pressure screenings; Increase in cardiac health	Prevent Chronic Diseases
Marketing & Community Relations Division	By functioning as the link between the community and the Hospital's resources, the Community Relations department builds relationships with community-based organizations, government agencies and elected officials within Westchester County.	Increase in community-based health interventions	Promote a Healthy and Safe Environment
Community Blood Pressure Screenings	Free screenings provided to community members at no cost; occur 2x per quarter in WPH	Increase in blood pressure screenings	Prevent Chronic Disease
Lung Cancer Screening Program	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

Program Name	Description	Intervention Measures	NYS Prevention Agenda
Perinatal Bereavement 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.	Increase support to parents in the community	Promote Mental Health and Prevent Substance Abuse
Food Pharmacy	Provides individuals with food who screen positive for food insecurity when receiving care at our Family Heath Center and our Center for Cancer Care.	Decrease Food insecurity in our community	Prevent Chronic Disease

7. Supplemental Information

This report is reflective of a segment of the programming offered at White Plains Hospital. Information on additional programing be found at https://www.wphospital.org/calendar/

Information on White Plains Hospital's Financial Assistance Policy can be located at https://www.wphospital.org/patients-visitors/patients/billing-information/ and is available in English and Spanish.

Appendix A: Summary of Secondary Data Sources & Analytic Notes

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: About the ACS (census.gov).

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: About (census.gov)

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: NYS 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. For more information please visit: Expanded Behavioral Risk Factor Surveillance System (Expanded BRFSS) (ny.gov)

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: Statewide Planning and Research Cooperative System (ny.gov)

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: Student Weight Status Data (ny.gov)

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: New York State Immunization Information System (NYSIIS)

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: AIDS Institute (ny.gov)

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: Sexually Transmitted Infections Data and Statistics (ny.gov)

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, and proportion of infants exclusively breastfed in the hospital. For more information on the New York State Vital Records, please visit: Vital Statistics of New York State (ny.gov)

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: NVSS - National Vital Statistics System Homepage (cdc.gov)

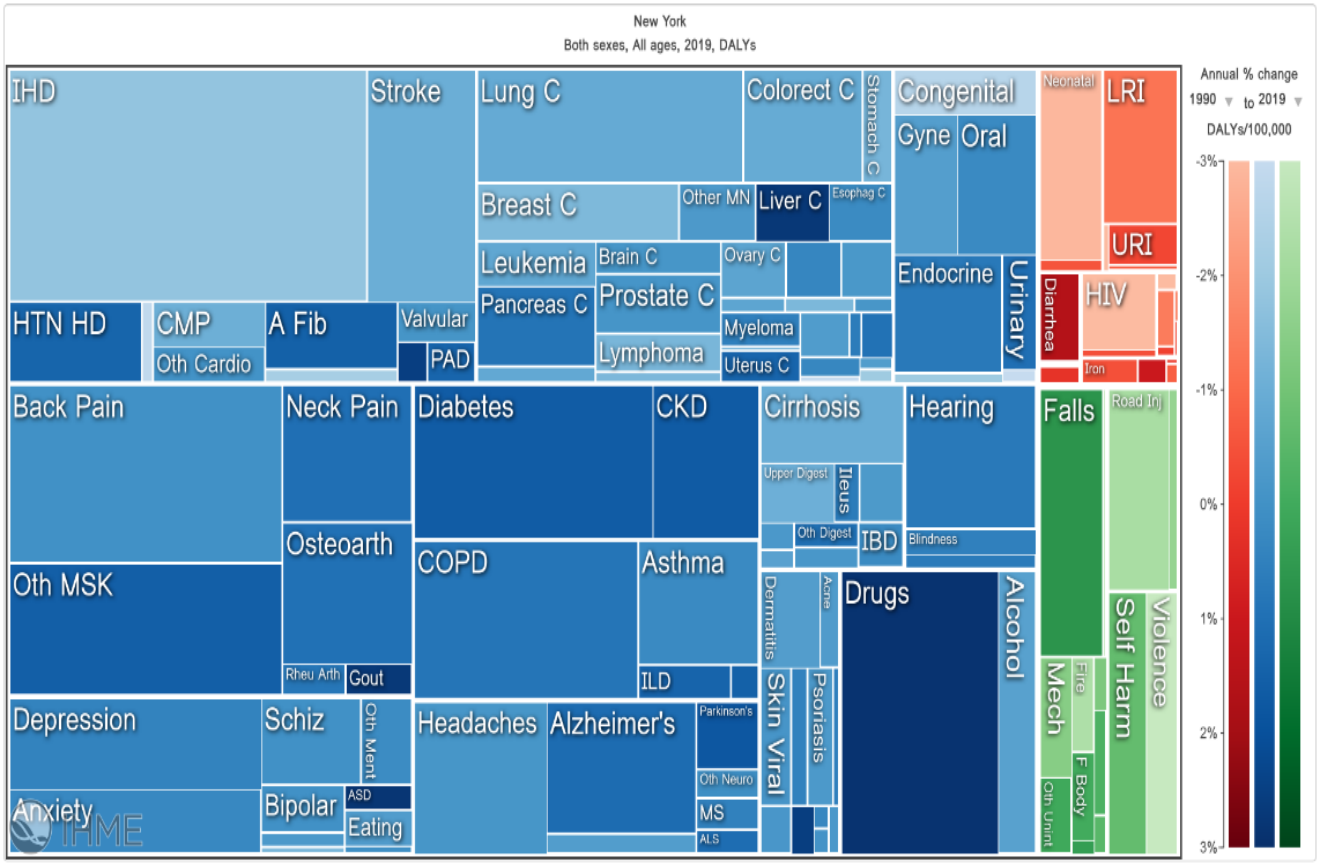
Data Tools

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 with numerous outcomes and risk factors. DALYs are a summary measure of population health that combines information on fatal health events and non-fatal health states. This is an important advantage over vital statistics which do not capture the important health impact of non-fatal health states (e.g., back pain, moderate depression, or alcohol use). GBD also allows for the estimation of DALYs attributed to specific risk factors, including body mass index, smoking, dietary risks, occupational risks, air pollution, etc. Data from the GBD is available at the global, national and state level; local estimates are not available. Despite this limitation, this information can be used to understand the most important areas of intervention to improve population health. Data available at: VizHub - GBD Compare (healthdata.org)

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 visit: Prevention Agenda 2019-2024: New York State's Health Improvement Plan (ny.gov)

Appendix B: Secondary Data Review & Trends

Figure 2. Leading causes of disability-adjusted life years in New York State, 2019

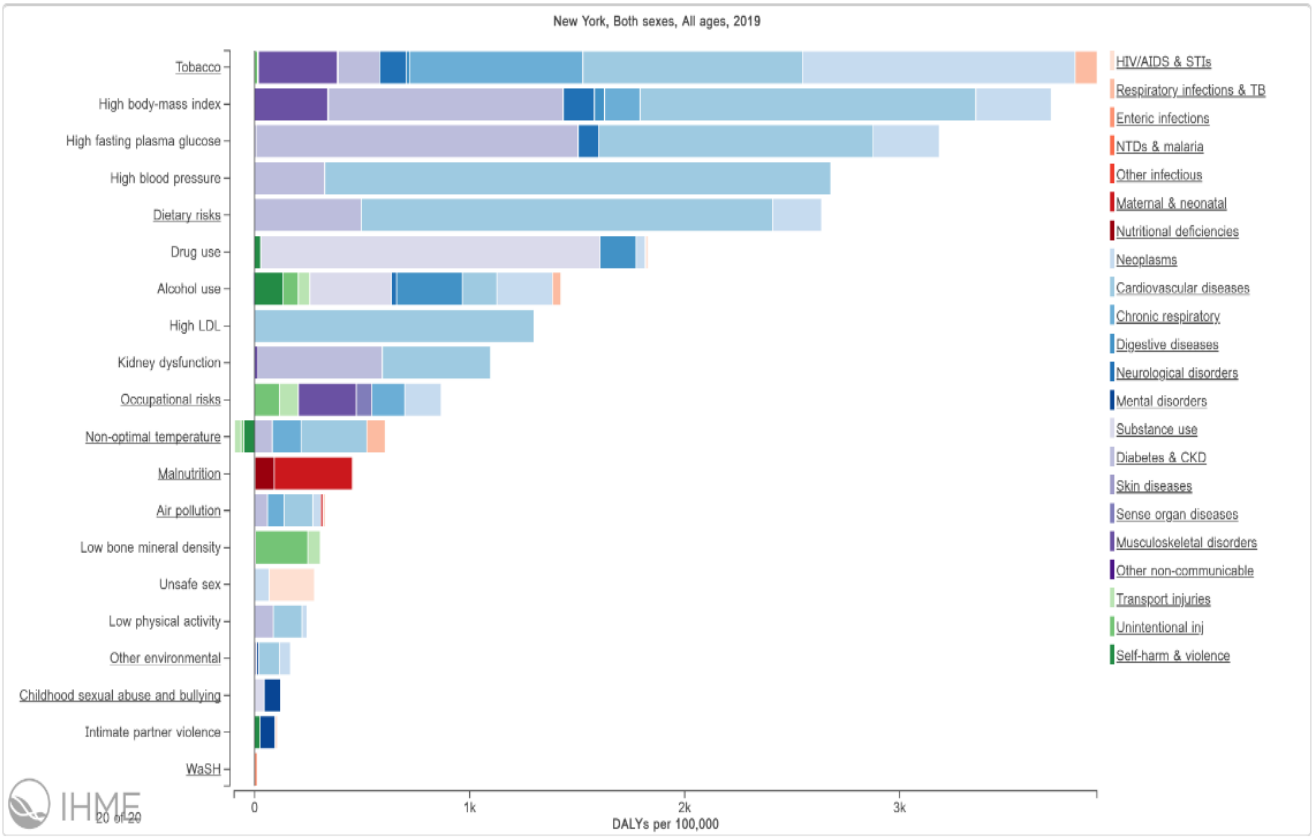


Data source: 2019 Global burden of Disease Project, Institute for Health Metrics and Evaluation.

The leading causes of ill health in New York State as measured by disability adjusted life years are ischemic heart disease (9.16%), drug use disorders (4.91%), back pain (5.35%), chronic obstructive pulmonary disease (3.94%) and diabetes mellitus (4.04%).

The saturation of the graph shows the proportionate change in DALYs from 1990 to 2019. Among leading causes of disability, the largest increases were observed for drug use disorders (+2.91%), liver cancer (+2.75%), and Endocarditis (+2.56%). Major declines were observed for HIV/AIDS (-7.03%) and sudden infant death syndrome (-7.52%).

Figure 3. Distribution of disability adjusted life years by risk factor in New York State, 2019.



Data source: 2019 Global Burden of Disease Project

In New York State, according to the finest level of geographic data from the Global Burden of Disease project, Tobacco is responsible for the highest proportion of disability adjusted life years (a summary measure combining fatal and non-fatal health status). Tobacco is responsible for excess ill health via its association with cardiovascular disease, cancers, and chronic respiratory disease.

High body-mass index risks are the second leading contributor to ill health, due to associations with cardiovascular disease, diabetes, and some cancers. High fasting glucose is the third leading causes of ill health, with strong associations with diabetes, chronic kidney disease and chronic respiratory disease.

High blood pressure and dietary risks are also leading causes of ill health. Within dietary risks (data not shown), low whole grains, high red meat, low legumes and high processed meats, high trans-fat, and high sodium are the leading causes of ill health. In New York State, in 2019, drug use continues to be the sixth leading cause of disability.

Overview of Data for White Plains Hospital

Top 20 Inpatient Diagnoses in 2021

Table 5. Top 20 inpatient discharges at White Plains Hospital, 2021

ICD-10 Code	Label	Discharges	% of total
A41.9	Sepsis, unspecified organism	1,450	6.7%
Z38.00	Single liveborn infant, delivered vaginally	1,256	5.8%
Z38.01	Single liveborn infant, delivered by cesarean	884	4.1%
U07.1	COVID-19	666	3.1%
A41.89	Other specified sepsis	505	2.3%
N17.9	Acute Kidney failure, unspecified	293	1.4%
O48.0	Post-term pregnancy	284	1.3%
N39.0	Urinary tract infection, site not specified	240	1.1%
O34.211	Maternal care for low transverse scar, previous c/section	238	1.1%
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	227	1.1%
I11.0	Hypertension heart disease with heart failure	222	1.0%
I13.0	Hypertension heart and chronic kidney disease with heart failure	198	0.9%
J18.9	Pneumonia, unspecified organism	174	0.8%
I63.9	Cerebral infarction, unspecified	139	0.6%
I16.0	Hypertension Urgency	136	0.6%
O76	Abnormality in fetal heart rate and rhythm complicating labor & delivery	128	0.6%
E86.0	Dehydration	126	0.6%
R07.89	Other chest pain	125	0.6%
O70.0	First degree perineal laceration during delivery	124	0.6%
M17.11	Unilateral primary osteoarthritis	119	0.6%
-	Other diagnoses	14,017	65%

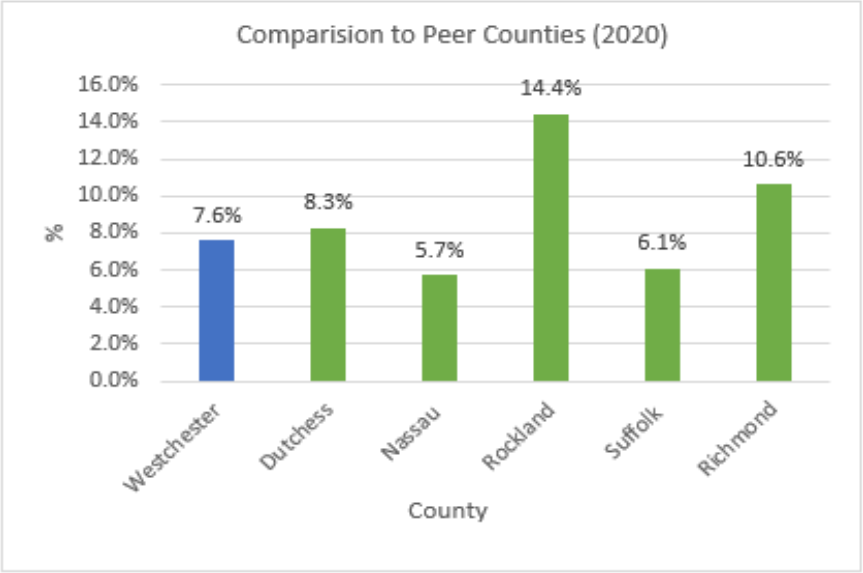
Data source: Internal Montefiore Health System data, 2021

Table 6. Top 20 reasons for treat-and-release ED visits at White Plains Hospital, 2021

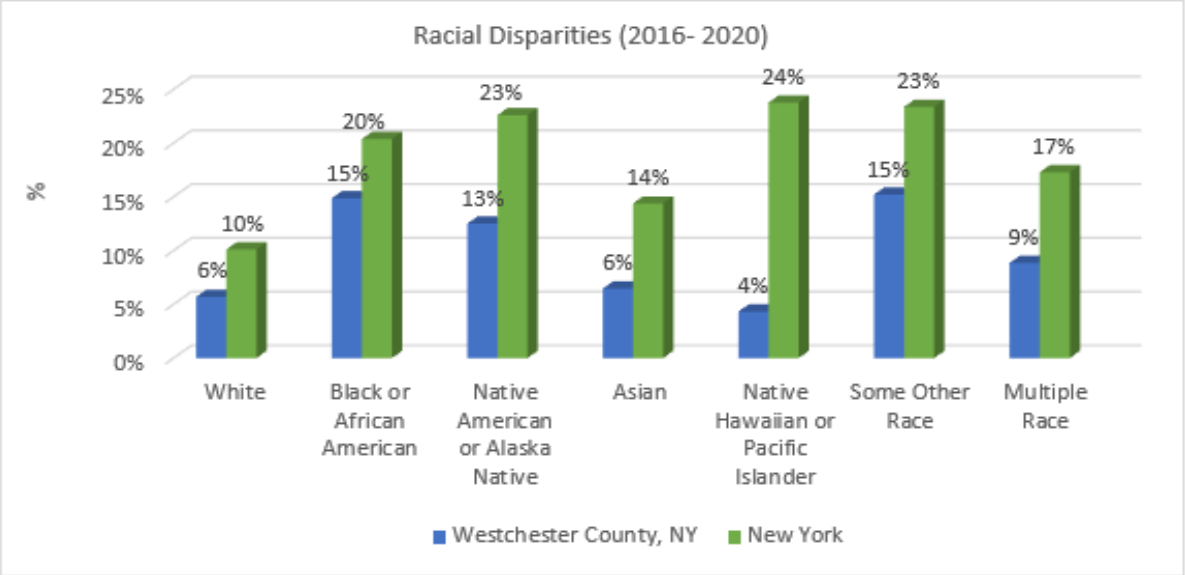
ICD-10 Code	Label	Visits	% of total
U07.1	COVID-19	2,956	6.1%
R07.89	Other chest pain	1,297	2.7%
Z20.822	Contact with and (suspected) exposure to covid-19	1,287	2.7%
R51.9	Headache, unspecified	900	1.9%
J06.9	Acute upper respiratory infection, unspecified	863	1.8%
N39.0	Urinary tract infection, site not specified	831	1.7%
R07.9	Chest pain, unspecified	827	1.7%
F10.129	Alcohol abuse with intoxication, unspecified	754	1.6%
R10.9	Unspecified abdominal pain	747	1.5%
R42	Dizziness and giddiness	735	1.5%
S09.90XA	Unspecified injury of head, initial encounter	596	1.2%
R55	Syncope and collapse	526	1.1%
J02.9	Acute pharyngitis, unspecified	493	1.0%
B34.9	Viral infection, unspecified	472	1.0%
R50.9	Fever, unspecified	472	1.0%
K52.9	Noninfective gastroenteritis and colitis, unspecified	456	0.9%
R11.2	Nausea with vomiting, unspecified	445	0.9%
R00.2	Palpitations	434	0.9%
M54.5	Low back pain	384	0.8%
I10	Essential (primary) hypertension	365	0.8%
-	Other diagnoses	32,493	67.2%

Data source: Internal Montefiore Health System data, 2021

Figure 4: All Ages in Poverty, %



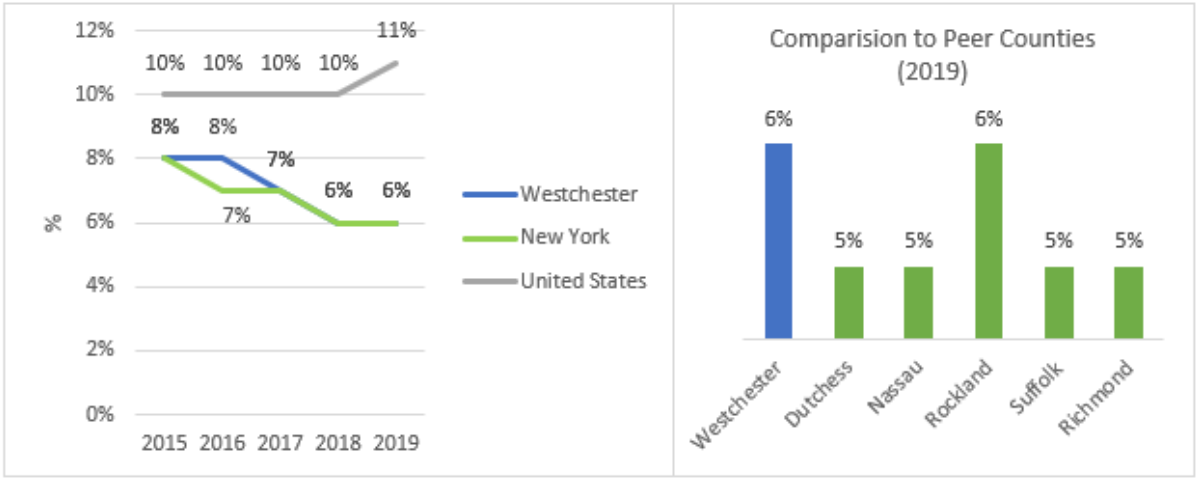
Data Source: 2020 Small Area Income and Poverty Estimates (SAIPE) data



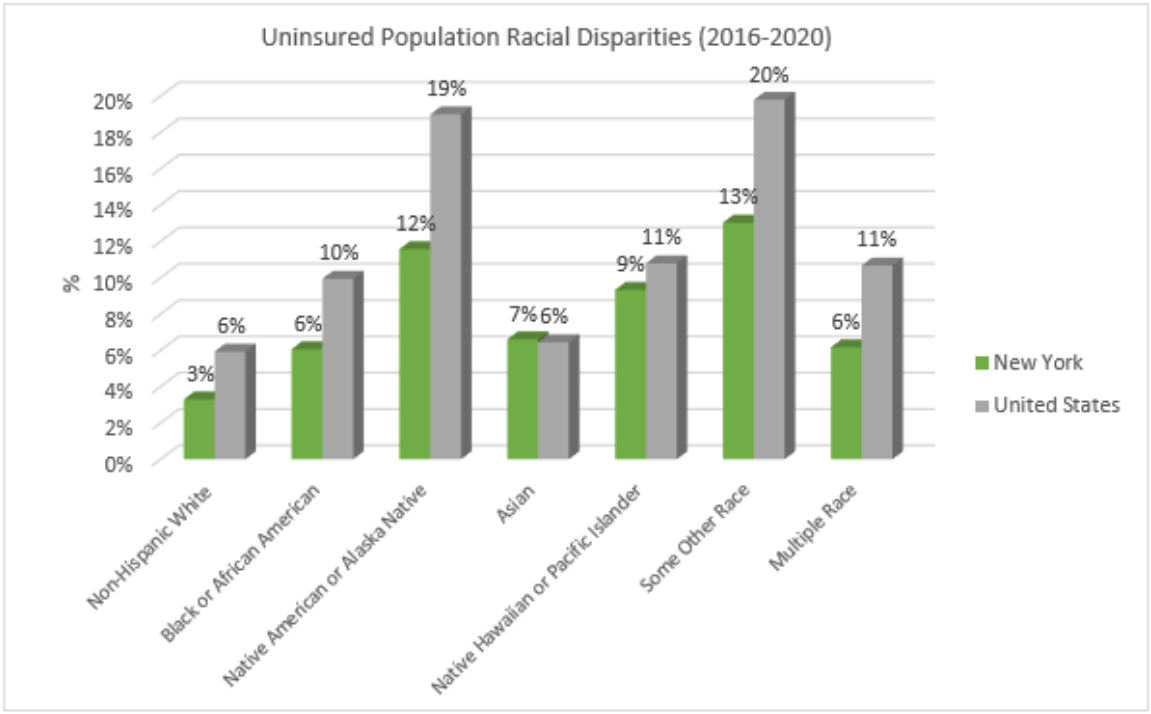
Data Source: US Census Bureau, American Community Survey (ACS). 2016-2020

- In comparison to its peer counties, Westchester County has a higher percentage of individuals in poverty than Nassau and Suffolk counties, but has less individuals in poverty than Dutchess, Richmond and Rockland counties.
- Those who identify as Black, Other Race and Native American or Alaska Native are more likely to be living in poverty in Westchester County.

Figure 5: Individuals Under Age 65 Without Health Insurance



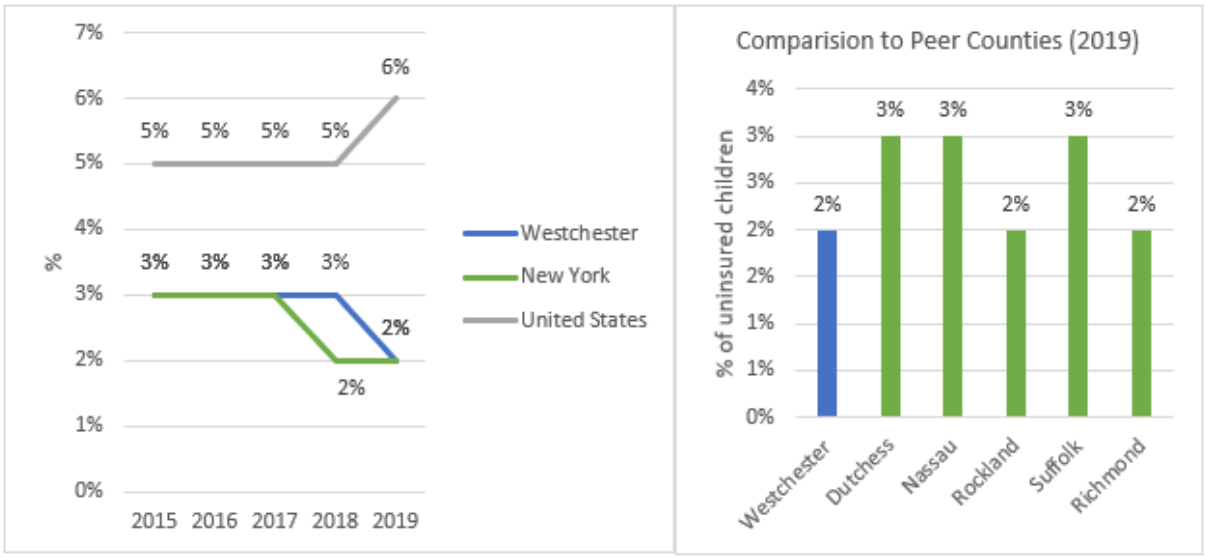
Data Source: US Census Bureau's Small Area Health Insurance Estimates (SAHIE), data from2019



Data Source: US Census Bureau, American Community Survey (ACS). 2016-2020

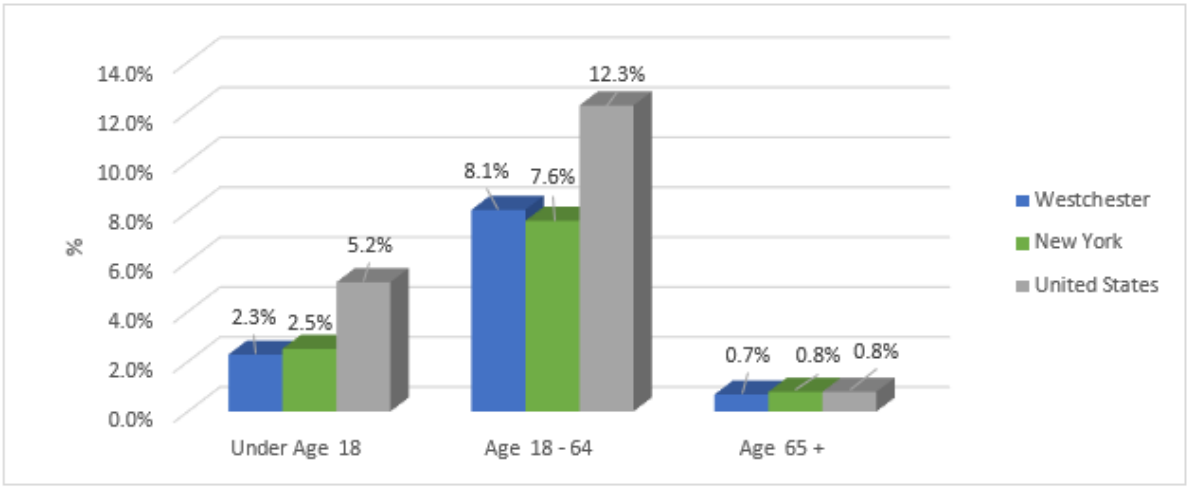
- Trending downward since 2016, in Westchester County and New York State 6% of people under the age of 65 did not have health insurance in 2019. This is lower than the uninsured rate of the United States at 11% for 2019.
- Westchester and Rockland counties both have 6% of individuals insured compared to the other peer counties which have an uninsured population of 5%.
- In New York State and United States, the uninsured population is highest in individuals that identified as “some other race” on the US Census Bureau, American Community Survey 2016-2020.

Figure 6: Uninsured Children, Age 18 and Below



Data Source: US Census Bureau's Small Area Health Insurance Estimates (SAHIE), data from 2019

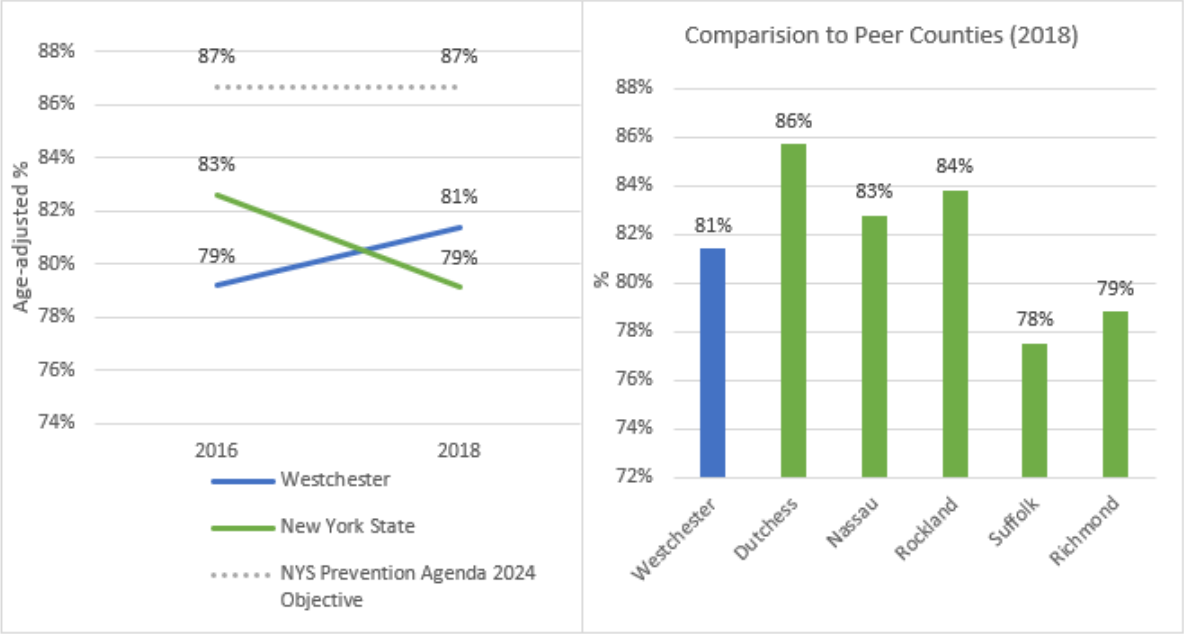
Figure 7: Age Disparities Among the Uninsured Population (2016-2020)



Data Source: US Census Bureau, American Community Survey (ACS). 2016-2020

- The uninsured population is highest amongst the 18-64 year old age group across the United States including Westchester County and New York State.

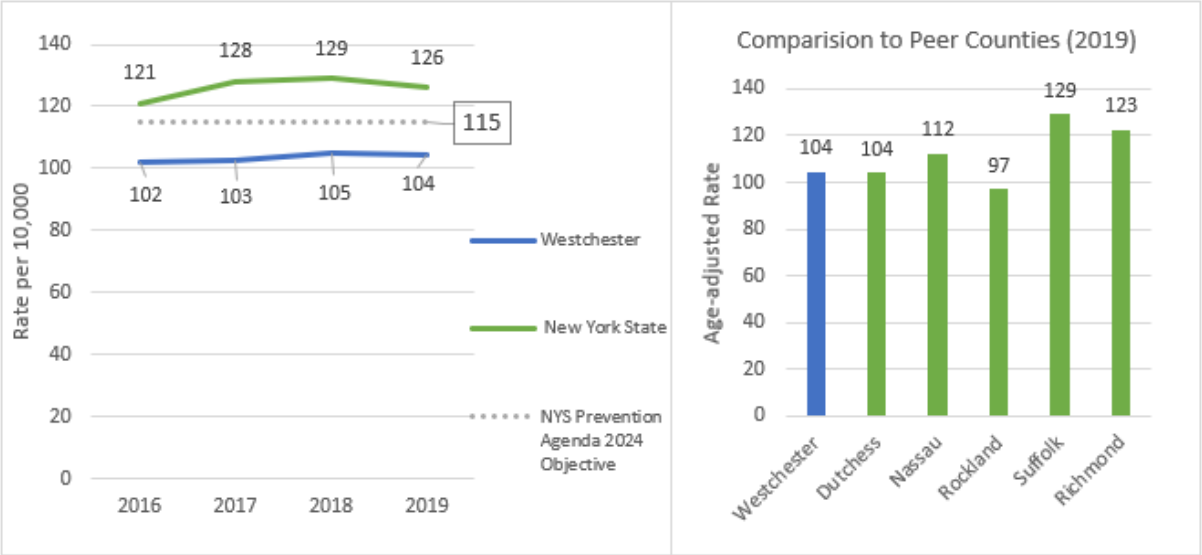
Figure 8: Adults Who Have a Regular Health Care Provider



Data Source: NYS Behavioral Risk Factor Surveillance System (BRFSS), data as of August 2020

- Westchester County adults are more likely to have a regular health care provider (81%) than New York State (79%), although this is still below the New York State Prevention Agenda 2024 Objective of 87%.
- Dutchess, Rockland, Nassau counties are all reporting a higher percentage of adults with a regular health care provider than Westchester County. However, none of the peer counties have meet the New York State Prevention Agenda 2024 Objective of 87% as of 2018.

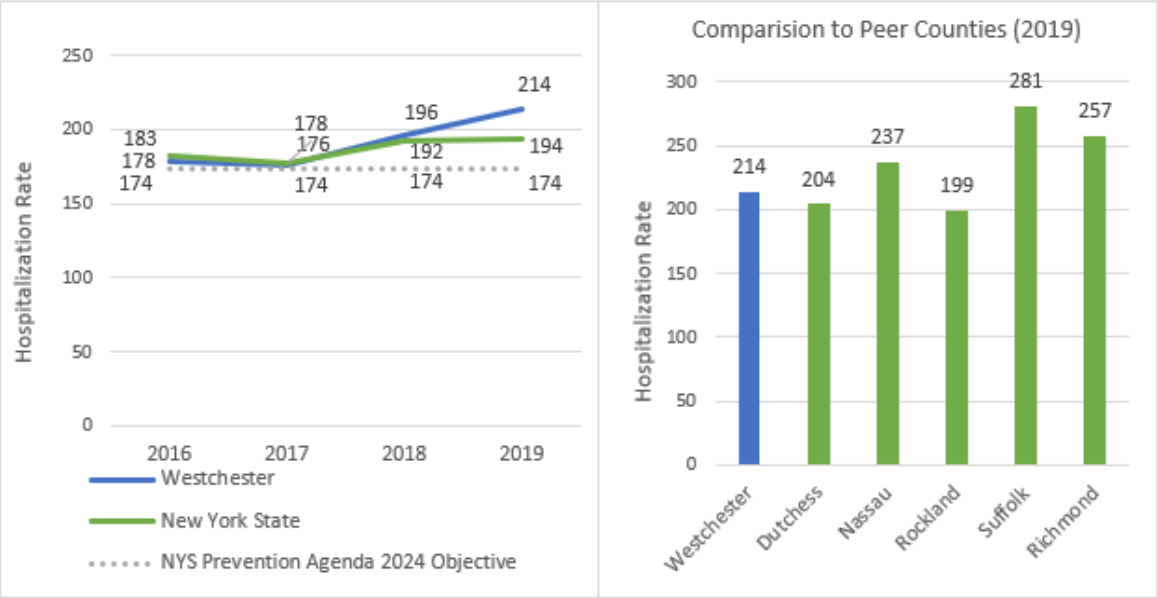
Figure 9: Age-adjusted Preventable Hospitalization Rate per 10,000 (Adults above 18 years)



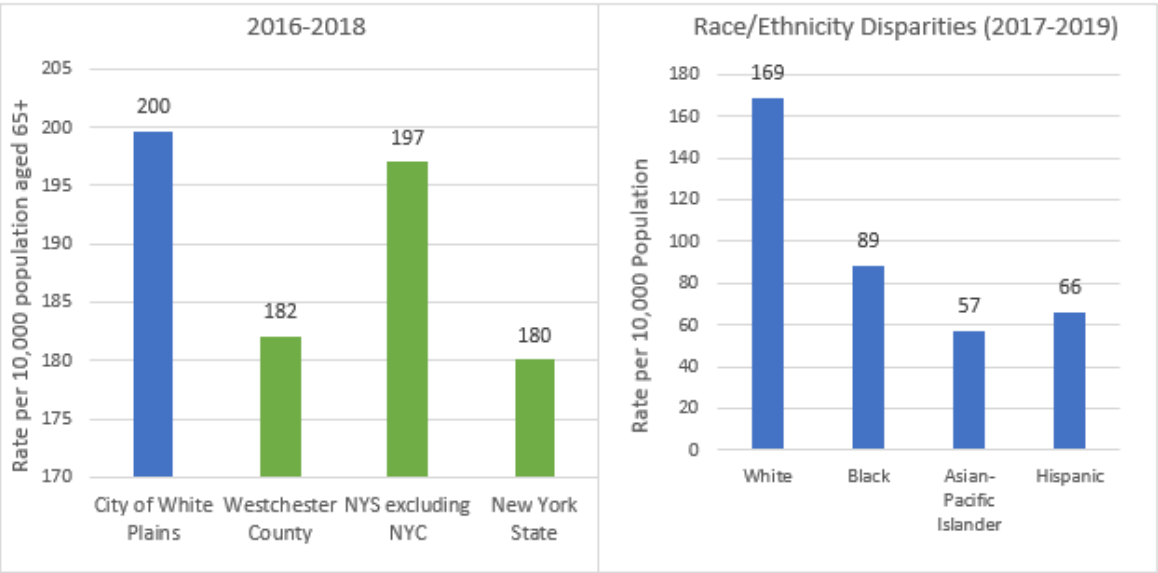
Data Source: Statewide Planning and Research Cooperative System (SPARCS), data as of November 2021

- Westchester County is performing better than the New York State Prevention Agenda 2024 Objective for Preventable Hospitalization Rate per 10,000.

Figure 10: Hospitalizations Due to Falls Among Adults, Rate per 10,000 Population, Aged 65+



Data Source: Statewide Planning and Research Cooperative System (SPARCS), data as of February 2022

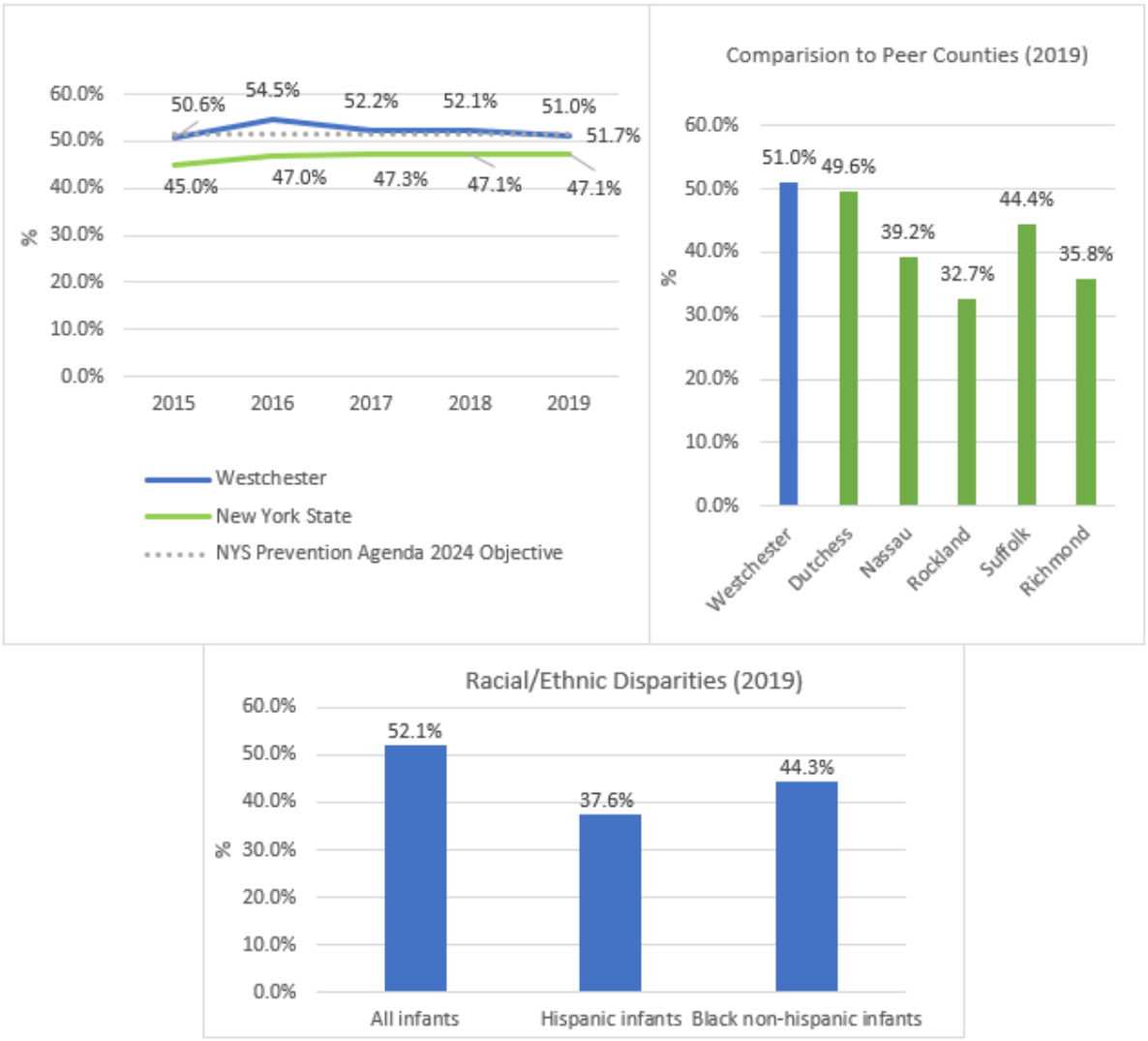


Data Source: *Left Graph* Statewide Planning and Research Cooperative System (SPARCS), data 2016-2018

Right Graph Statewide Planning and Research Cooperative System (SPARCS), data 2017-2019

- Westchester has a higher hospitalization rate due to falls than New York State and the New York State Prevention Agenda 2024 Objective. This rate is trending upwards since 2017. The City of White Plains has a higher rate of hospitalization (200) than the county (182).
- In comparison to peer counties, Westchester County, with a rate of 214, is ranking behind Dutchess (204) and Rockland (199) Counties, which have lower rate of hospitalization in 2019.
- White individuals are more likely to be hospitalized due to a fall than other races.

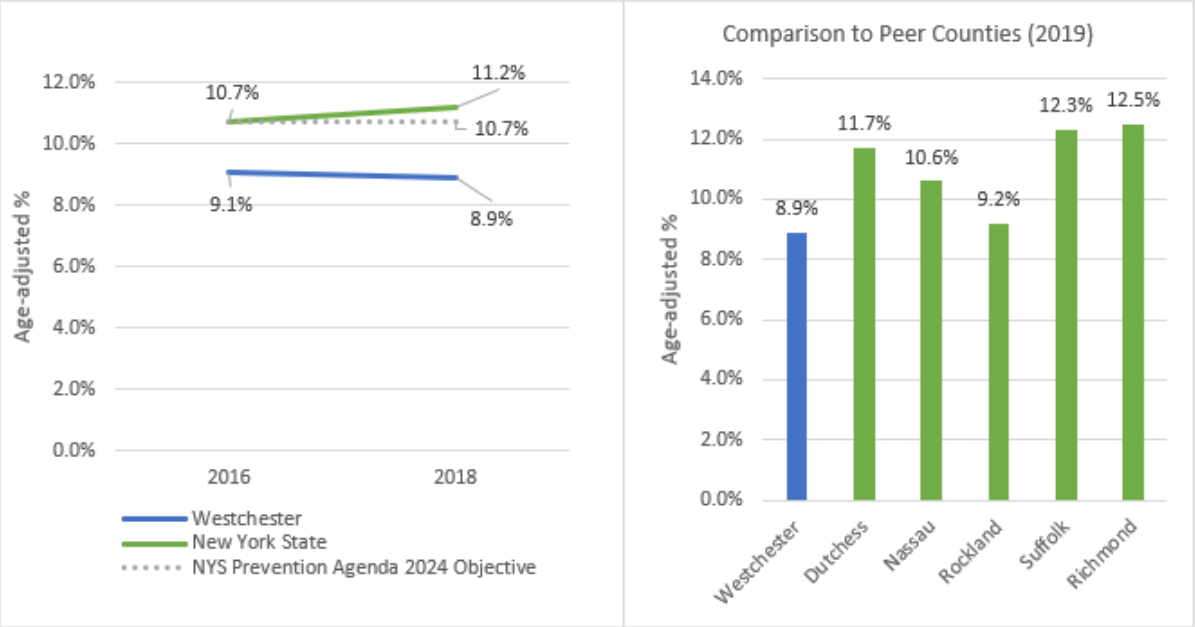
Figure 11: Infants who Exclusively Breastfed in the Hospital Among all Infants, %



Data Source: New York State Bureau of Vital Records, data as of November 2021

- Westchester County has a larger population of infants that are exclusively breastfed in the hospital as compared to all infants than the State of New York. Westchester is performing higher than many of the peer counties for this health objective.
- Although performing well compared to peer counties, Westchester County is trending downward since 2016.
- In Westchester County, Hispanic and Black (non-Hispanic) infants are less likely to be breastfed than other infants.

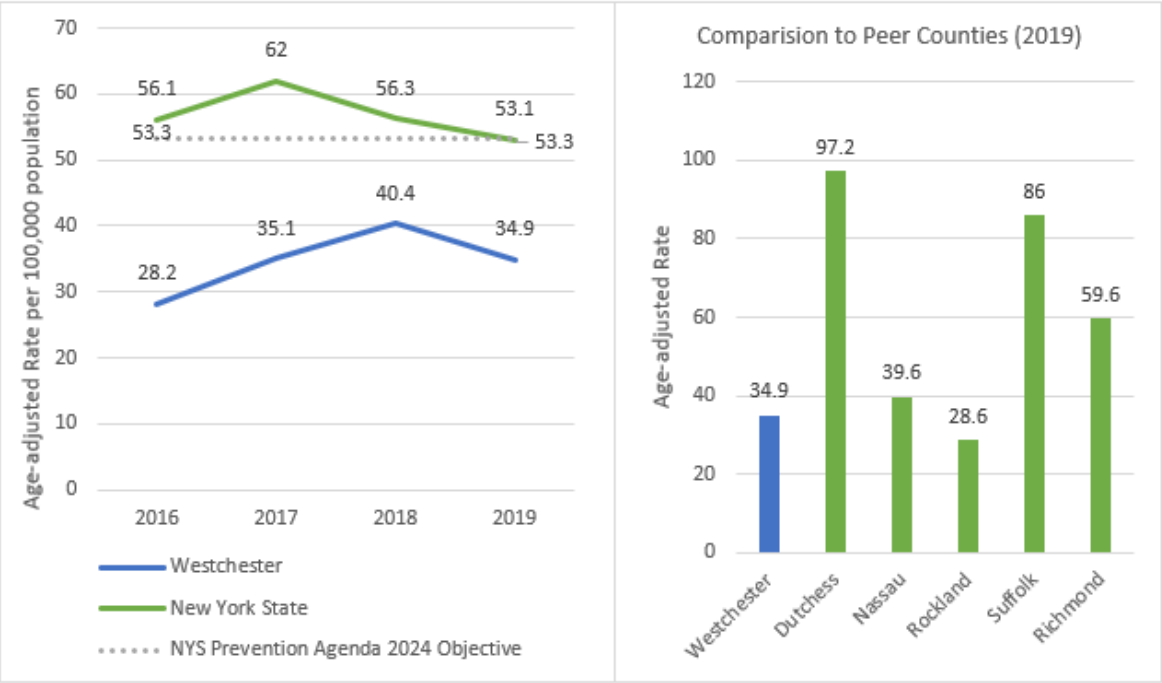
Figure 12: Frequent Mental Distress During the Past Month Among Adults, Age-adjusted %



Data Source: NYS Behavioral Risk Factor Surveillance System (BRFSS), data as of August 2020

- Westchester County adults are less likely to have frequent mental distress during the past month (8.9%) than New York State (11.2%). The county is performing better than the New York State Prevention Agenda 2024 Objective of 10.7%.
- In comparison to peer counties, Westchester has the lowest reported percentage of adults with frequent mental distress during the past month.

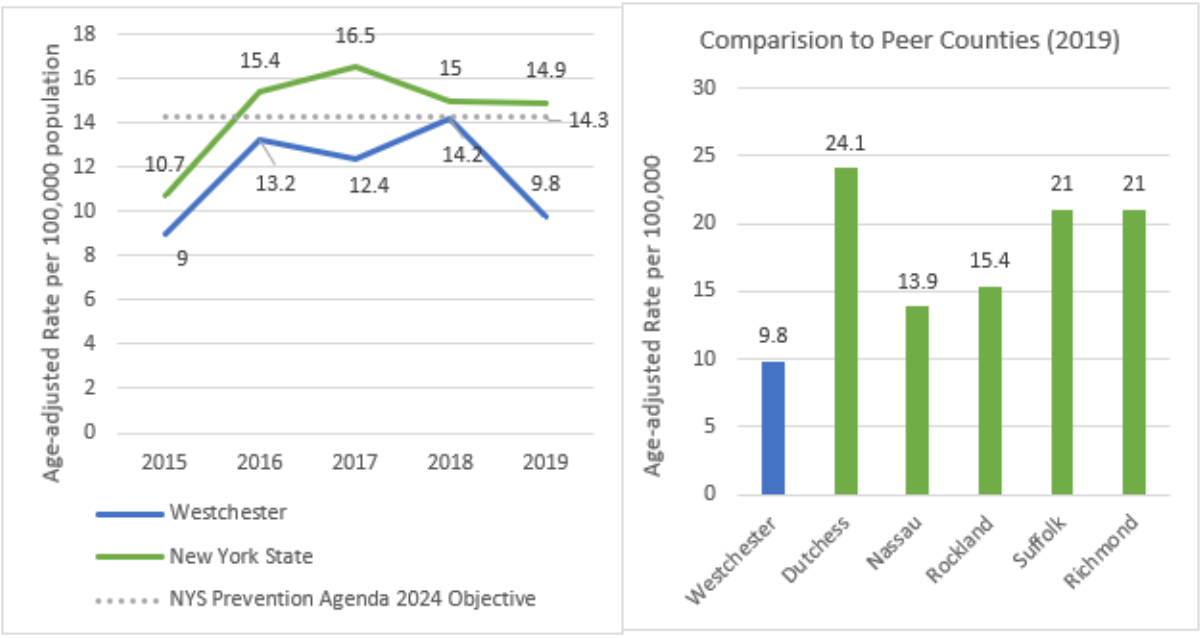
Figure 13: Emergency Department Visits (including outpatients and admitted patients) Involving any Opioid Overdose, Age-adjusted Rate per 100,000 Population



Data Source: Statewide Planning and Research Cooperative System (SPARCS), data as of November 2021

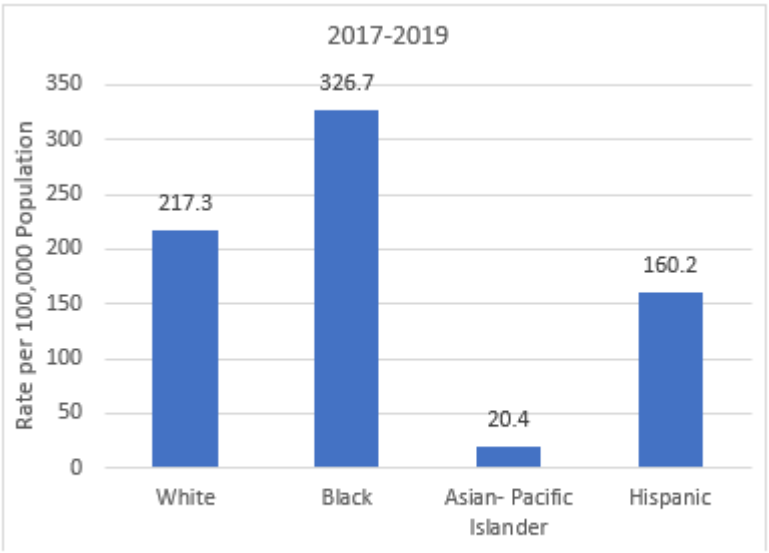
- Westchester County has a lower rate of Emergency Department visits that involve any opioid overdose than New York State and is performing better than the New York State Prevention Agenda 2024 Objective.
- Westchester County ranks better than four out of five peer counties.

Figure 14: Overdose Deaths Involving any Opioids, Age-adjusted Rate per 100,000 Population



Data Source: New York State Bureau of Vital Records, data as of November 2021

Figure 16: Opioid Burden (overdose deaths, non-fatal outpatient ED visits & hospital discharges involving opioid abuse, poisoning, dependence, unspecified use) by Race/Ethnicity



Data Source: Statewide Planning and Research Cooperative System (SPARCS), data 2017-2019

- Westchester County has a lower rate of overdose deaths involving any opioids than New York State and is performing better than the New York State 2024 Objective, and all peer counties in 2019.
- Opioid Burden is highest amongst the Black and White populations comparative to Hispanic and Asian- Pacific Islander poulations.

7.c.i. White Plains Hospital Community Health Needs Assessment Survey Flyer (English)

7.c.ii. White Plains Hospital Community Health Needs Assessment Survey Flyer (Spanish)

7.c.iii. GNYHA 2022 Community Health Survey (English)

2022 Community Health Survey

We want to improve the health services we offer to people who live in your neighborhood. The information you give us will be used to improve health services for people like yourself.

Completing the survey is voluntary. We will keep your answers private. If you are not comfortable answering a question, leave it blank.

We value your input. Thank you very much for your help.

---

1 **Are you 18 years of age or older?**

- ○ Yes
- ○ No → Thank you very much, but we are only asking this survey of people who are ages 18 and older.

2 **We want people from all different neighborhoods to take part in this survey. Please tell us the zip code where you live so we can identify your neighborhood.**

Zip code: _____

IF YOU PROVIDED A ZIP CODE, PLEASE GO TO PAGE 3. YOU DO NOT NEED TO ANSWER THESE QUESTIONS.

3 **Do you live in New York City?**

- O Yes
- O No → Skip to 5

4 **If you live in New York City, please select the borough where you live:**

- O The Bronx → Go on to page 3
- O Brooklyn → Go on to page 3
- O Manhattan → Go on to page 3
- O Queens → Go on to page 3
- O Staten Island → Go on to page 3

5 **If you do not live in New York City, please tell us the county where you live:**

- O Albany County
- O Allegany County
- O Broome County
- O Cattaraugus County
- O Cayuga County
- O Chautauqua County
- O Chemung County
- O Chenango County
- O Clinton County
- O Columbia County
- O Cortland County
- O Delaware County
- O Dutchess County
- O Erie County
- O Essex County
- O Franklin County
- O Fulton County
- O Genesee County
- O Greene County
- O Hamilton County
- O Herkimer County
- O Jefferson County
- O Lewis County
- O Livingston County
- O Madison County
- O Monroe County
- O Montgomery County
- O Nassau County
- O Niagara County
- O Oneida County
- O Onondaga County
- O Ontario County
- O Orange County
- O Orleans County
- O Oswego County
- O Otsego County
- O Putnam County
- O Rensselaer County
- O Rockland County
- O Saratoga County
- O Schenectady County
- O Schoharie County
- O Schuyler County
- O Seneca County
- O St. Lawrence County
- O Steuben County
- O Suffolk County
- O Sullivan County
- O Tioga County
- O Tompkins County
- O Ulster County
- O Warren County
- O Washington County
- O Wayne County
- O Westchester County
- O Wyoming County
- O Yates County
- O Other_____

6 In general, how is the overall health of the people of your neighborhood?

- O Poor
- O Fair
- O Good
- O Very good
- O Excellent

7 In general, how is your physical health?

- O Poor
- O Fair
- O Good
- O Very good
- O Excellent

8 In general, how is your mental health?

- O Poor
- O Fair
- O Good
- O Very good
- O Excellent

9 For each of the following, please tell us: How important is each of the following to you and how satisfied are you with the current services in your neighborhood to address each health issue?

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

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

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

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

- ○ Yes
- ○ No → Skip to 13

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

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

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

- ○ Yes
- ○ No → Skip to 15

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

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

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

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

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

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

17 **What is your age?**

_____

18 **Are you…**

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

19 **Do you describe yourself as…**

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

20 **Are you Hispanic or Latino/Latina/Latinx?**

- ○ No
- ○ Yes → Answer 21

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

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

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

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

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

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

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

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

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

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

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

_____ person(s)

27 **What is the primary language you speak at home?**

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

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

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

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

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

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

9