Community Health Needs Assessment and Implementation Plan

2016-2018

White Plains Hospital

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

White Plains Hospital

Community Health Needs Assessment and Implementation Strategy 2016-2018

1. Executive Summary

The Community Health Needs Assessment Requirement

The Affordable Care Act requires hospitals to assess and address the health needs of the communities they serve. This Community Health Needs Assessment provides a report of the process, methods and results of a comprehensive assessment of the needs of the community served by White Plains Hospital. The Implementation Strategy further elaborates on the significant health needs of the community, describes the programs and strategies to address these significant health needs, and delineates the metrics to be used to evaluate the impact of these strategies. The White Plains Hospital Community Health Needs Assessment (CHNA) process and secondary data was approved by the Board of Trustees on December 12, 2016. The Community Health Needs Assessment (CHNA) report was uploaded to the White Plains Hospital website on December 31, 2016.

White Plains Hospital's Community Commitment

White Plains Hospital is a leader in community and has a long history of developing innovative approaches to care and tailoring programs to best serve the changing needs of its community. These include, but are not limited to the following: Community Service Plan, Patient-Centered Medical Home, and Community Outreach. The integration of these innovative approaches supports White Plains Hospital well in its provision of services to its community.

White Plains Hospital embraces its social responsibility and defines its role broadly, promoting wellness in addition to treating disease and addressing needs ranging far beyond medical care. We extend this responsibility to the care of our employees and medical staff, many of whom live in the surrounding community.

Services to the community are an explicit and essential component of White Plains Hospital's mission and one of its most valued traditions. The medical center has a long history of reaching beyond the walls of its hospitals to identify and meet the needs of its community and has been a leader in organizing and expanding community-based services. Our commitment to the community has required a multifaceted, continually evolving response, in which the unique capacities of the hospital are mobilized to improve the lives of the people and the communities we serve -- not just medically, but socially, economically and environmentally, wherever and whenever our resources can make a difference.

For much of our history, community service at White Plains Hospital has been a vital grassroots movement. When pressing needs arose that lay beyond the purview of traditional health care, physicians, nurses, social workers, staff and community partners have stepped in to address them. These programs tackle a range of health problems in Westchester County, and with the understanding that the practice of medicine is a service to the community, we have defined community service to include those efforts at preventing disease, enhancing wellbeing and enacting social change that go beyond the traditional health system.

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

Definition and Description of the Community

Westchester County is a large county located just to the north of New York City in the Hudson Valley; Westchester covers an area of 450 square miles (1,200 km^2) and consists of 48 municipalities. The County includes urban, suburban and rural geographies. In 2015, the 5 estimated population of Westchester County was 976,396, up 6.6% from 915,916 in 2005. The county seat of Westchester is the city of White Plains (56,853) and other major cities include Yonkers (195,976), New Rochelle (77,062) and Mount Vernon (67,292). In 2015, the median household income for Westchester was $86,108, 4th highest in New York State, after Nassau, Putnam and Suffolk Counties. Westchester County is the 5th healthiest county in New York State, according to the County Health Rankings, produced by the Robert Wood Johnson Foundation and University of Wisconsin. Despite its overall high ranking, there is considerable room to both improve population health and reduce health disparities in Westchester County.

Assessment of Community Health Needs

The process to identify the needs of the community involved the collection of both secondary and primary data. Multiple conversations and meetings were convened internally and with external partners, and a thorough review of the data was conducted, all of which will frame the development of the Implementation Strategy. In this Community Health Needs Assessment, these collaborations and partnerships are described.

Multiple data sources were used to support the identification and selection of the priority items which were identified, selected, and reviewed with the partners. A listing and brief summary of the data sources used to complete the secondary data analysis that were used to identify the issues of concern beyond experience and direct observation are included in this report.

The collection of primary data from a sample of the Westchester county residents was an important element of the development of the Community Health Needs Assessment. White Plains Hospital engaged with the Westchester County Department of Health's online Community Resident and Provider Health Surveys to facilitate the implementation of the primary data collection process for the Community Health Needs Assessment for Westchester County and to assist in the facilitation of these community level connections thereby alleviating additional surveying overload.

Using data collected through these sources, the impact on the community's health by the interventions implemented can be measured and analyzed. The priority areas selected and

each of the planned interventions focus on specific priority populations and address the ethnic and cultural disparity defined in the indicators for the population served by White Plains Hospital.

Collaborations/Partnerships

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

Prioritization of Community Health Needs

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

White Plains Hospital selected the following prevention agenda priority items to **Prevent Chronic Disease** and **Promote Healthy Women, Infants and Children**.

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

1. Promote use of evidence-based care to manage chronic diseases
2. Increase screening rates for cardiovascular diseases; diabetes; and breast, cervical and colorectal cancers, especially among disparate populations.
3. Increase the proportion of babies who are breastfed in New York State

The selected priorities are fully compatible with White Plains Hospital's community health initiatives. They are supported by existing programs and staff, as well as the addition of new and modified programs. Activities in support of the priorities are carried out with the input and support of our community partners. In order to carry out the priority agenda items, White Plains Hospital focuses on several constituencies, including staff (more than 2,300 employees), patients, and the local community. In all, more than 10,000 individuals participate in Hospital related health events each year.

Measures and Identified Resources to Meet Identified Needs

Internal Resources and Measures

White Plains Hospital has a history of developing innovative approaches to care and tailoring programs to best serve the changing needs of its community. These include, but are not limited to the following: Community Service Plan, Patient-Centered Medical Home, Disease

Management Programs, and Community Outreach. The integration of these innovative approaches supports White Plains Hospital well in its provision of services to its community.

White Plains Hospital has a vast portfolio of programs and services that address a majority of the significant community health needs identified in the Community Health Needs Assessment. The breadth and depth of the programs and services vary, but each address a need identified in the community.

White Plains Hospital's Community Relations department has a dedicated person who spearheads initiatives in the city of White Plains (and surrounding areas), who collaborates with community based organizations to implement impactful programming for community members. These events are focused on a variety of issues, ranging from chronic disease management and prevention, cancer screenings and promotion of healthy food consumption. Events range from educational workshops in the community, walks/runs, health fair and community-based health screenings.

Engaging local community members in our efforts enables us to employ the health care institution and the community in the activities of national health advocacy organizations, including walks, festivals, and other awareness-raising activities for health issues that impact the community.

Montefiore New Rochelle, the labor and delivery service provider for Montefiore Mount Vernon and Montefiore New Rochelle in lower Westchester is home to the designated WIC provider for the region. Monthly workshops, wellness days and fairs are provided through collaboration of WIC patient focused services and the Montefiore New Rochelle Hospital WIC Vendor Management Agency.

Across the identified significant priority areas, numerous indicators with associated metrics are described which will be utilized to demonstrate improvements needed to provide evidence of the impact of Montefiore's efforts in addressing the health needs of its community.

New York State Health Improvement Plan - Implementation Plan and Measures

The Priority Areas selected for the 2016-2018 New York State Health Improvement Plan align with the priority areas referenced above - Preventing Chronic Disease and Promoting Healthy Women, Infants and Children.

These two Priority Areas have been selected in 2016, with the focus areas in Promote Healthy Women and Children and Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings This was done to create better alignment with the initiatives of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program. DSRIP has a very strong focus on both the prevention and management of chronic diseases, we believe that by continuing our chronic disease prevention work in our ambulatory locations and extending our reach into the community.

External Resources and Linkages

In addition to the multiple resources that have been developed at White Plains Hospital independently and through partnership with other organizations, there is an extensive set of resources that are available to meet the needs of Westchester residents which cannot be met entirely by White Plains Hospital programs and services, or that choose to utilize external organizations. In advancement since 2013, multiple free and lost cost internet databases have entered the public sphere, such as www.auntbertha.com, www.hitesite.org, www.nowpow.com among others that have reduced the need for quickly obsolete and expensive to produce information and referral guides for community resources. As White Plains Hospital is an organization that works with complex health needs and whose community faces multi-factorial crises that impact upon overall health, providing information, accessibility and review of such external resources and links provides additional information on available resources to address community needs for our community partners.

2. Introduction

White Plains Hospital (WPH) is a proud member of the Montefiore Health System, serving as its tertiary hub of advanced care in the Hudson Valley. WPH is a 292-bed not for-profit health care organization with the primary mission of providing exceptional acute and preventive medical care to all people who live in, work in or visit Westchester County and its surrounding areas. Centers of Excellence include the Center for Cancer Care, The William & Sylvia Silberstein Neonatal & Maternity Center and The Ruth and Jerome A. Siegel Stroke Center. The Hospital's Flanzer Emergency Department is the busiest in Westchester County, seeing nearly 57,000 visits a year. White Plains Hospital performs lifesaving emergency and elective angioplasty in its Joan and Alan Herfort, M.D. Cardiac Catheterization Laboratory and Marie Promuto Cardiac Catheterization Laboratory. White Plains Hospital also has outpatient medical facilities in Armonk and New Rochelle. The Hospital is fully accredited by the Joint Commission and earned its recognition as a Top Performer for Key Quality Measures® in 2015 and 2013. The Hospital is also an eleven-time winner of the Consumer Choice Award, an honor given to the nation's top hospitals by the National Research Corporation, and received Magnet® designation in 2012 from the American Nurses Credentialing Center (ANCC). In 2014 and 2016, White Plains Hospital received the Outstanding Patient Experience Award from Healthgrades®, given to only 10% of hospitals nationwide. For additional information, visit wphospital.org.

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

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

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

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

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

2b. Community Health Needs Assessment Submission Date

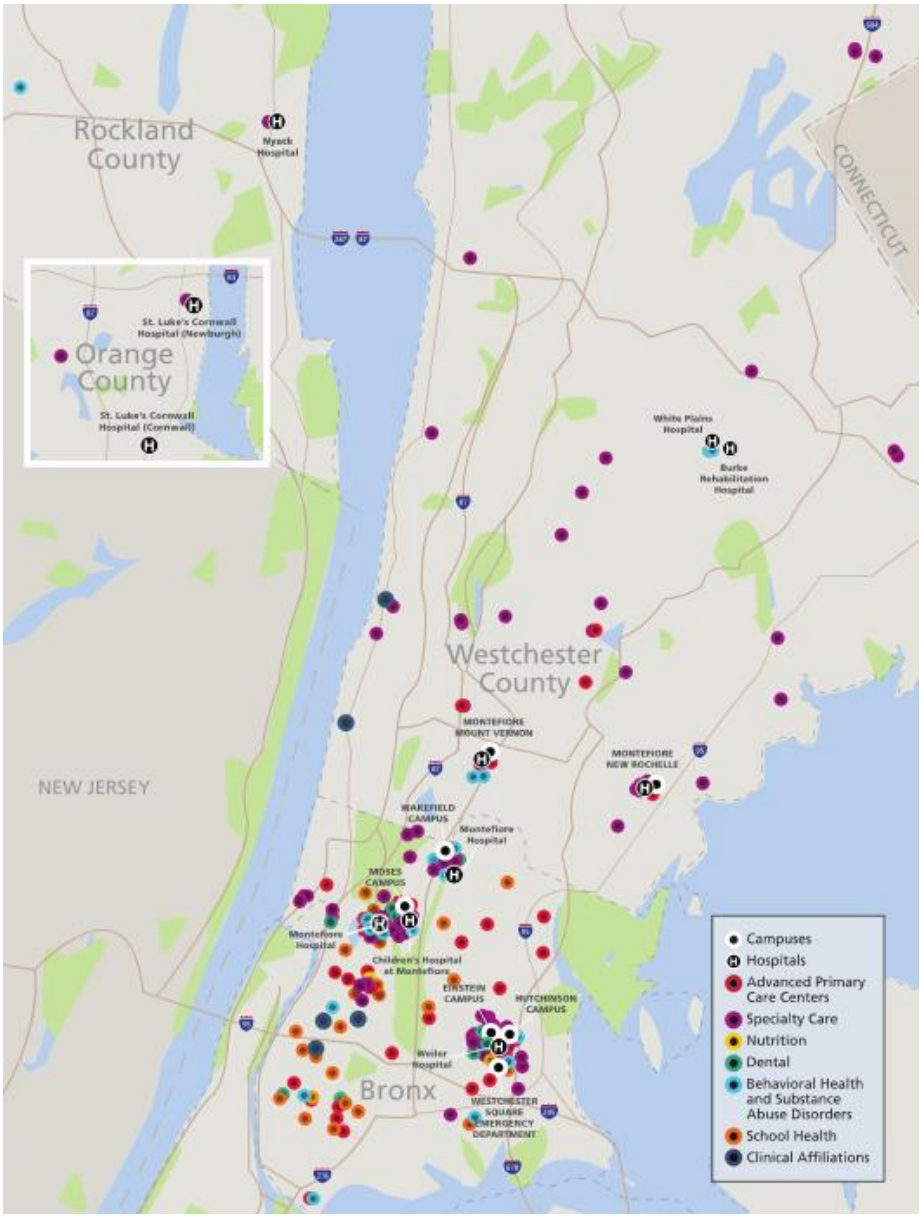
White Plains Hospital's Community Health Needs Assessment (CHNA) process and secondary data was approved by the Board of Trustees on December 12, 2016. The Community Health

Needs Assessment and Implementation Report (CHNAI&R) report was uploaded to the White Plains Hospital website on December 31, 2016.

3. Definition and Description of the Community/Service Area

Westchester County is a large county located just to the north of New York City in the Hudson Valley; Westchester covers an area of 450 square miles (1,200 km^2) and consists of 48 municipalities. The County includes urban, suburban and rural geographies. In 2015, the estimated population of Westchester County was 976,396, up 6.6% from 915,916 in 2005.

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



3a. The Populations of White Plains

White Plains Hospital has identified Westchester County as its primary service area. The county seat of Westchester is the city of White Plains (56,853) and other major cities include Yonkers (195,976), New Rochelle (77,062) and Mount Vernon (67,292). In 2015, the median household income for Westchester was $86,108, 4th highest in New York State, after Nassau, Putnam and Suffolk Counties.

Westchester County is the 5th healthiest county in New York State, according to the County Health Rankings, produced by the Robert Wood Johnson Foundation and University of Wisconsin. Despite its overall high ranking, there is considerable room to improve population health in Westchester County, while also reducing health disparities as each of these cities is serving as county anchors for challenged populations.

3b. A Snapshot of Health Disparities in Westchester County

While Westchester remains among the healthiest counties in New York State, several of its individual municipalities continue to maintain significant health gaps with portions of lower Westchester, specifically Mount Vernon, Yonkers, New Rochelle and White Plains serving as "hot spots" for asthma, HIV, and illicit drug use in the County. These areas also demonstrate excess mortality rates from heart disease, stroke, and diabetes compared to County and New York State averages.

Mortality Rates:
According to the New York State Department of Health's (NYSDOH) Vital Statistics of New York State report in 2011, Westchester County has an age-adjusted mortality rate of 713.4 per 100,000; similar to the statewide rate of 753.1. According to the Community Health Rankings in 2014, Westchester County ranked as number 3 out of 62 NY counties to have the lowest mortality rate in New York State. The leading cause of death among Westchester County residents is due to coronary heart disease (219.7 per 100,000).

Asthma & Chronic Lower Respiratory Disease:
According to the NYSDOH, 8.7% of Westchester County adults had asthma from 2008-2009; lower than the statewide percentage of 9.7%.

According to CDC data, the percentage of Westchester County adults with asthma increased to 14% from 2011-2012; same percentage as New York State.

According to an asthma report from New York State Office of the State Comptroller, the asthma prevalence rate among Westchester County Medicaid recipients was 86.7 per 1,000 from 2008-19 2009. The prevalence rate increased to 98.4 per 1,000 from 2012-2013; similar to the statewide prevalence rate of 98.7.

The average (age-adjusted) rate of asthma emergency department visits per 10,000 from 2011 was 64.2 in Westchester County. In 2012, the rate of asthma emergency department visits increased to 67.4 per 10,000.

In 2010, the age-adjusted death rate due to chronic lower respiratory diseases among Westchester County residents was 24.3 per 100,000; lower than the statewide rate of 31.1. In 2011, Westchester County's death rate decreased to 23.4; remaining lower than the statewide rate of 31.2.

Heart Disease & Stroke:

The coronary heart disease mortality rate per 100,000 in Westchester County was 119.5 in 2011; similar to the 2010 rate of 117.1. The coronary heart disease hospitalization rate per 10,000 in Westchester County was 35.8 in 2011; similar to the 2010 rate of 36.4.

The cerebrovascular disease (stroke) mortality rate per 100,000 in Westchester County was 25.8 in 2011; an increase from the 2010 rate of 24.0. The stroke hospitalization rate per 10,000 in Westchester County from 2009-2011 was 22.8; similar to the statewide rate of 24.9.

The cardiovascular disease mortality rate per 100,000 in Westchester County was 199.2 in 2011; an increase from the 2010 rate of 195.5. The cardiovascular disease hospitalization rate per 10,000 in Westchester County was 133.1; similar to the 2010 rate of 135.9.

Cancer:

The mortality rate of all cancer diagnoses in Westchester County was 150.5 in 2010; similar to the statewide rate of 160.2. The type of cancer with the highest mortality rate in Westchester County is lung cancer (36.9 per 100,000; lower than the statewide rate of 41.8).

The incidence rate of all cancer diagnoses in Westchester County was 495.2 per 100,000 in 2010; similar to the statewide rate of 482.5. The type of cancer with the highest incidence rate in Westchester County is prostate cancer (22.6 per 100,000; similar to the statewide rate of 21.3).

3c. Medically Underserved Communities

The City of White Plains has not been deemed to have a population and geography that meet the criteria as a medically underserved population and medically underserved area (with respect to its access to primary care services). However the evidence of significant health disparity related to chronic disease indicates that there is an unmet need in the populations of the surrounding geographies of lower Westchester including Yonkers and Mount Vernon, regions which are considered MUAs.

4. Assessment of Community Health Need

4a. Description of Process and Methods

The process for preparing the 2016-2018 Community Health Needs Assessment was an interorganizational and community collaborative process, initiated with the goal of developing an assessment that was reflective of the needs of the community including the clinical and social determinants of health. Moreover, as the clinical service provides and social service organizations had been over sampled due to the near simultaneous compilation of reports and state/federal proposals during the period, novel collaborations with the local departments of health were engaged for the collection of primary data, while secondary data sources are noted in Section 4.a.i.

Primary Data Collection Process and Methods

The New York State Department of Health required that the Community Health Assessments (CHA) conducted through the local Departments of Health be conducted in 2016 as opposed to 2017 when they were previously scheduled. In previous years, results from the CHA had been used as an important secondary data element. However, as the Westchester County Department of Health was engaging in a primary data collection survey process, the hospital systems of Westchester County collectively approached them to determine if it was possible to coordinate promotion, participation, referrals and engagement in electronic survey distribution process and to review the data collected to be used collaboratively as a portion of the primary data for the 2016-2018 Community Health Needs Assessment Process. An online survey was collaboratively developed and made available across the Westchester County, distributed by the Westchester County Department of Health, the Westchester County Executive's Office through www.westchestergov.com and the local Delivery System Reform Incentive Payment Program (DSRIP) Performing Provider System (PPS) providers over the summer of 2016. During this process, Westchester County compiled feedback from over 1,300 responders 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 identified, selected, and reviewed with partners.

Secondary Data Collection Process and Methods

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

Listing of Data Sources

i. American Community Survey
ii. New York State Expanded Behavioral Risk Factor Surveillance System
iii. New York State Vital Records Data
iv. New York State Statewide Planning and Research Cooperative Systems (SPARCS)
v. New York State Bureau of HIV/AIDS
vi. New York State Cancer Registry
vii. New York State Prevention Agenda Dashboard

Description of Data Sources

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 evaluate the percent of families living in poverty, the percent of households that are limited English speaking and the percentage of adults or children with health insurance. For more information on ACS please visit http://www.census.gov/programs-surveys/acs/about.html.

New York State Expanded Behavioral Risk Factor Surveillance System (BRFSS): Expanded BRFSS augments the CDC BRFSS, which is conducted annually in New York State. Expanded BRFSS is a random-digit-dialed telephone survey among adults 18 years of age and older representative of the non-institutionalized civilian population with landline and cellular telephones living in New York State. The goal of Expanded BRFSS surveys is to collect county specific data on preventive health practices, risk behaviors, injuries and preventable chronic and infectious diseases. Topics assessed by the Expanded BRFSS include tobacco use, body weight, cancer screening, and other factors linked to the leading causes of morbidity and mortality. For more information about NYS Expanded BRFSS please visit https://www.health.ny.gov/statistics/brfss/expanded/

New York State Vital Records Data: The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report vital records data were used to examine the percentage of life births that are preterm and the teen pregnancy rate. For more information on the New York State Vital Records please visit: https://www.health.ny.gov/statistics/vital_statistics/.

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

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

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

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 collects data for the entire state and for each county for dozens of health indicators that align with the New York State Prevention Agenda. The Prevention Agenda Dashboard is not a single database, but rather a compilation of diverse databases. For more information please see: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

4.a.ii Collaborations and Partnerships

The Community Engagement process for the 2016-2018 Community Service Plan was an unprecedented collaborative effort. Over the period of the previous Community Service Plan implementation, the healthcare delivery landscape shifted, previous alignments dissolved and new regional partnerships came into existence. Furthermore, the local Westchester County Department of Health's Community Health Assessment was conducted concurrently and collaboratively with the Community Health Assessments happening across the County, resulting in alignment of data being used by multiple parties. This rigorous secondary data review, complemented by the a primary data collection allowed for the creation of data maps that demonstrate the County's 'hotspots' for particular indicators. Through this mapping process, each facility can see itself in relationship with the other facilities across the service areas, which has created opportunities for alignment of care.

4.a.ii.1 Partners and Organizations

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

the CSP. White Plains Hospital will continue to work with its partners on existing program initiatives.

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

Throughout the completion of the most recent community health survey, WPH engaged with community organizations, groups, and individuals to best understand the broad interests and needs of our community. These include the following but are not limited to:

- Westchester County Department of Health
- Mayor Thomas Roach, White Plains, NY and the Office of The Mayor
- Bhavana Pahwa - MA, LCSW-R, PhD, Deputy Director, Youth Bureau, City of White Plains
- El Centro Hispano, Inc.
- White Plains YMCA & YWCA
- Thomas H. Slater Community Center

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

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

Additionally, these individuals and organizations are involved in many committees chaired by WPH (i.e. Neighborhood Health Fair Committee; ExSTEPtional Committee, etc.), so they present ongoing support and new perspectives on the progress of our initiatives and any new health issues that arise in our catchment areas.

5. Identification and Prioritization of Community Health Needs

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

5a. Secondary Data Analysis

The secondary data used to identify community health needs is described in Section 4.a.i. The secondary data evaluation consists of two distinct approaches. First, we used data from the Statewide Planning and Research Cooperative System (SPARCS) to examine the leading causes of hospitalization, avoidable hospitalizations, and ED visits for Westchester County. Second, we completed an assessment of secondary data for 25 core health indicators from several population-based data sources.

Overview of SPARCS Data for White Plains Hospital

Top 20 Inpatient Diagnoses in 2015

Table 1 summarizes the top 20 inpatient discharges among Westchester County residents using the most recently available SPARCS data. Because of the transition from ICD-9 to ICD-10 in October 2015 data are presented in two sections, one for January-September, for ICD-9 codes and one for October-December, for ICD-10 codes.

January-September 2015		October-December 2015	
Diagnosis	N	Diagnosis	N
Single liveborn in hospital without Cesarean section	3,899	Single liveborn infant delivered vaginally	1,241
Septicemia NOS	2,499	Sepsis organism NOS	902
Single liveborn in Hospital By Cesarean section	2,403	Single liveborn infant delivered by cesarean	697
Pneumonia Organism NOS	1,320	Pneumonia Organism NOS	374
Care involving other specified rehabilitation procedure	1,312	MTL care for scar from previous cesarean delivery	296
Previous cesarean delivery, delivered, with or without mention of antepartum condition	1,022	Non-ST elevation myocardial infarction	288
Acute Kidney Failure NOS	959	Acute Kidney Failure NOS	278
Drug Withdrawal	903	COPD w exacerbation	268
Subendocardial infarction, initial episode of care	865	Urinary tract infection site NOS	256
Urinary Tract Infection NOS	840	Acute on chronic diastolic heart failure	242
Atrial Fibrillation	765	Opioid dependence w withdrawal	237
Coronary atherosclerosis of native coronary artery	748	Post-term pregnancy	225
Post term pregnancy, delivered, with or without mention of antepartum condition	727	Acute on chronic systolic heart failure	218
Alcohol Withdrawal	718	Alcohol dependence w withdrawal uncomplicated	181
Obstructive chronic bronchitis with Exacerbation	702	MDD recurrent severe w/o psychotic features	168
Noninfectious gastroenteritis and colitis NEC & NOS	274	Unilateral primary osteoarthritis right hip	167
Hyposmolality	274	Syncope & Collapse	164
Intestinal Obstruction NOS	246	ASHD native coronary artery w unstable angina	150
Chest Pain NOS	220	Unilateral primary osteoarthritis left knee	145
Congestive Heart Failure NOS	207	1st degree perineal laceration during delivery	139

NOS = Not otherwise specified; NEC = not elsewhere classified

Table 2. Inpatient discharges for Ambulatory Care Sensitive Conditions among Westchester County residents, 2015

January-September 2015		October-December 2015	
Diagnosis	N	Diagnosis	N
Pneumonia Organism NOS	1246	Pneumonia Organism NOS	352
Urinary Tract Infection NOS	820	COPD w exacerbation	260
Obstructive chronic bronchitis with (acute) exacerbation	668	Urinary tract infection site NOS	251
Atrial Fibrillation	657	Acute on chronic diastolic heart failure	230
Leg Cellulitis	625	Acute on chronic systolic heart failure	171
Acute & Chronic Diastolic Heart Failure	594	Syncope & Collapse	158
Acute & Chronic Systolic Heart Failure	582	Cellulitis left lower limb	123
Syncope & Collapse	554	Chest Pain NEC	120
Chest Pain NEC	536	Atrial fibrillation NOS	118
Colon Diverticulitis	419	Chest Pain NOS	103
Dehydration	406	Cellulitis right lower limb	103
Chronic Obstructive Asthma with Exacerbation	335	Asthma NOS w exacerbation	98
Food/Vomit Pneumonitis	310	Noninfective gastroenteritis & colitis NOS	94
Epilepsy NOS Without mention of intractable epilepsy	292	Dehydration	92
Asthma NOS with Exacerbation	291	Paroxysmal atrial fibrillation	86
Noninfectious gastroenteritis and colitis NEC & NOS	274	Pneumonitis D/T inhalation food & vomit	84
Hyposmolality	274	Epilepsy NOS not intractable without status epilepticus	69
Intestinal Obstruction NOS	246	Intestinal obstruction NOS	68
Chest Pain NOS	220	Asthma NOS w status asthmaticus	68
Congestive Heart Failure NOS	207	Aftercare following joint replacement surgery	67

NOS = Not otherwise specified; NEC = not elsewhere classified

Table 3. Emergency Department visits among Westchester County Residents, 2015

Table 3. Emergency Department visits among Westchester County Residents, 2015

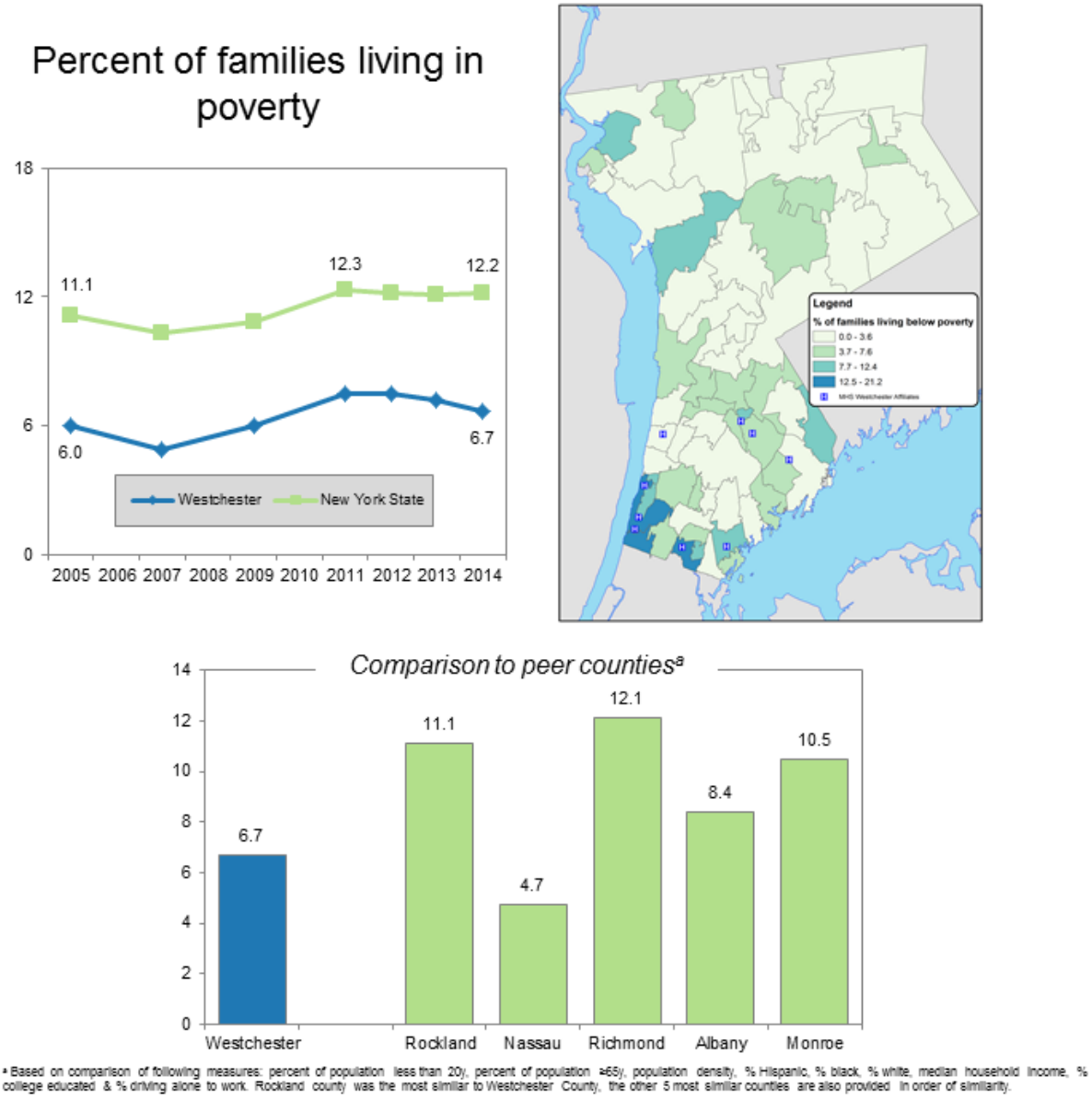
Diagnosis	N
Head Injury NOS	3781
Urinary Tract Infection NOS	3510
Noninfectious gastroenteritis and colitis NEC & NOS	3488
Acute Upper Respiratory Infection NOS	3423
Headache	3241
Chest Pain NEC	3231
Acute Pharyngitis	2997
Abdominal Pain-Site NOS	2986
Chest Pain NOS	2871
Fever NOS	2856
Open Wound Finger	2555
Alcohol Abuse-Unspecified	2500
Dizziness & Giddiness	2445
Asthma NOS with exacerbation	2444
Abdominal Pain-Site NEC	2439
Otitis Media NOS	2339
Lumbago	2259
Viral Infection NOS	2147
Syncope & Collapse	2140
Ankle Sprain NOS	2137

NOS = Not otherwise specified; NEC = not elsewhere classified

Population-Based Secondary Data Review

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

Figure 2. Percent of families living in poverty

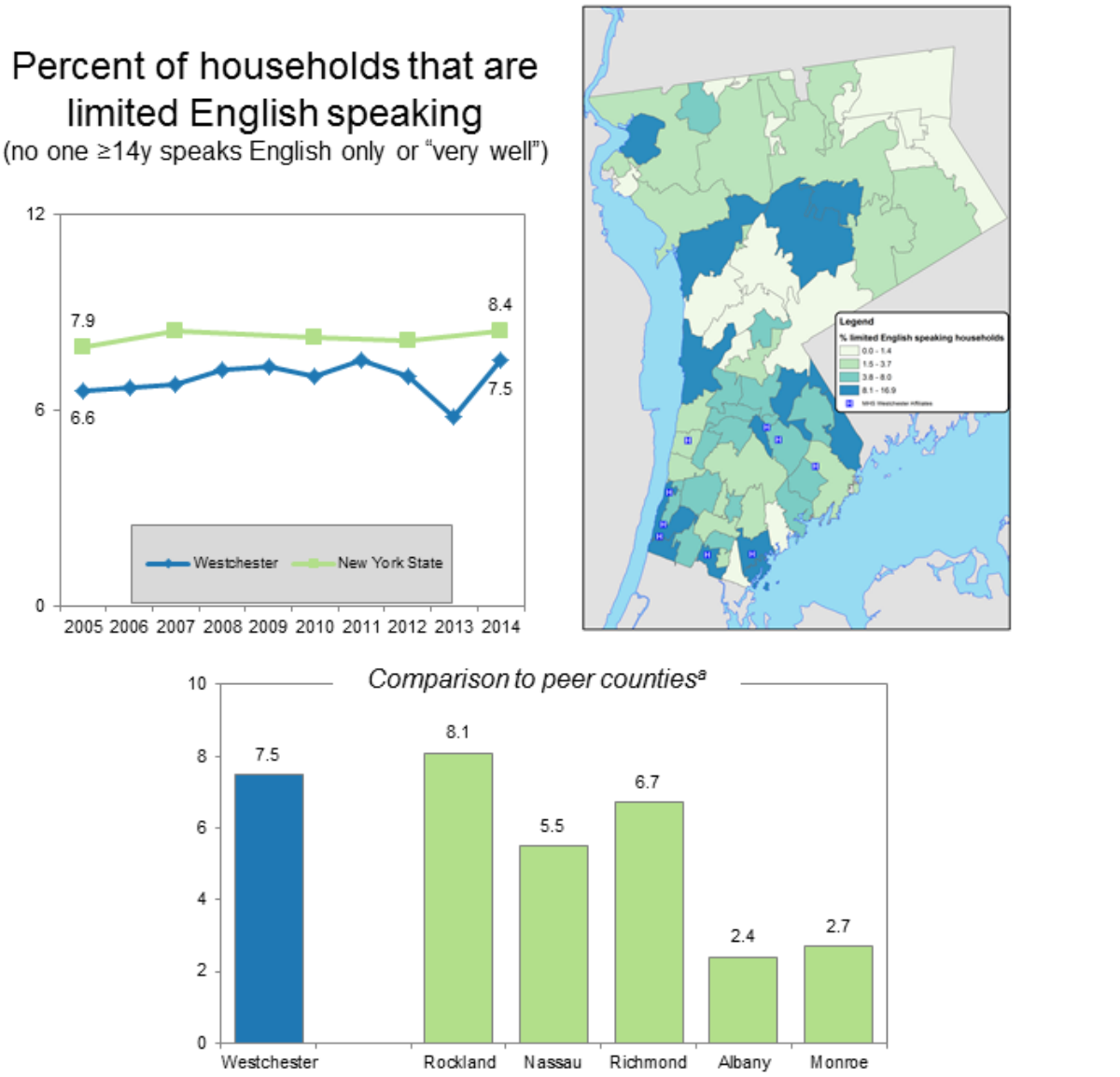


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: American Community Survey

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

Figure 3. Percent of households that are limited English speaking

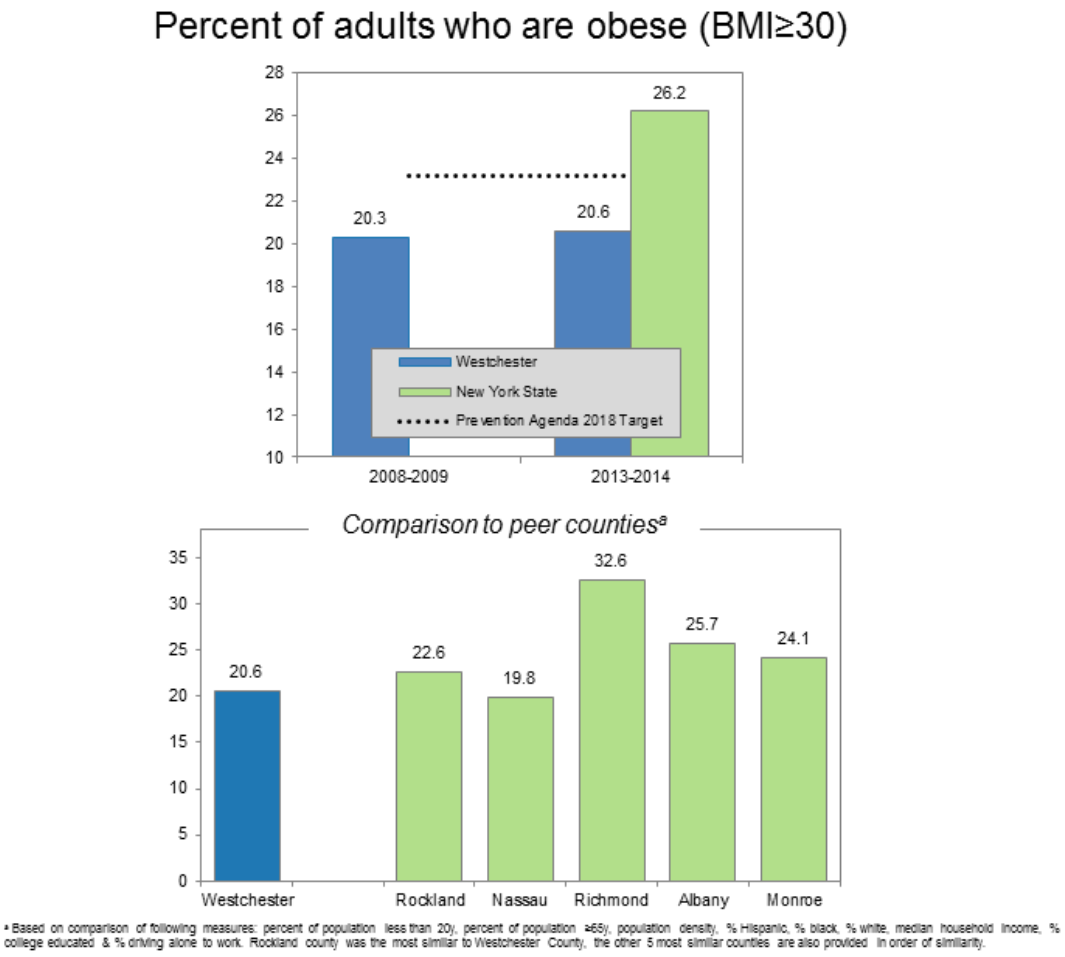


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: American Community Survey

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

Figure 4. Percent of adults are who are obese

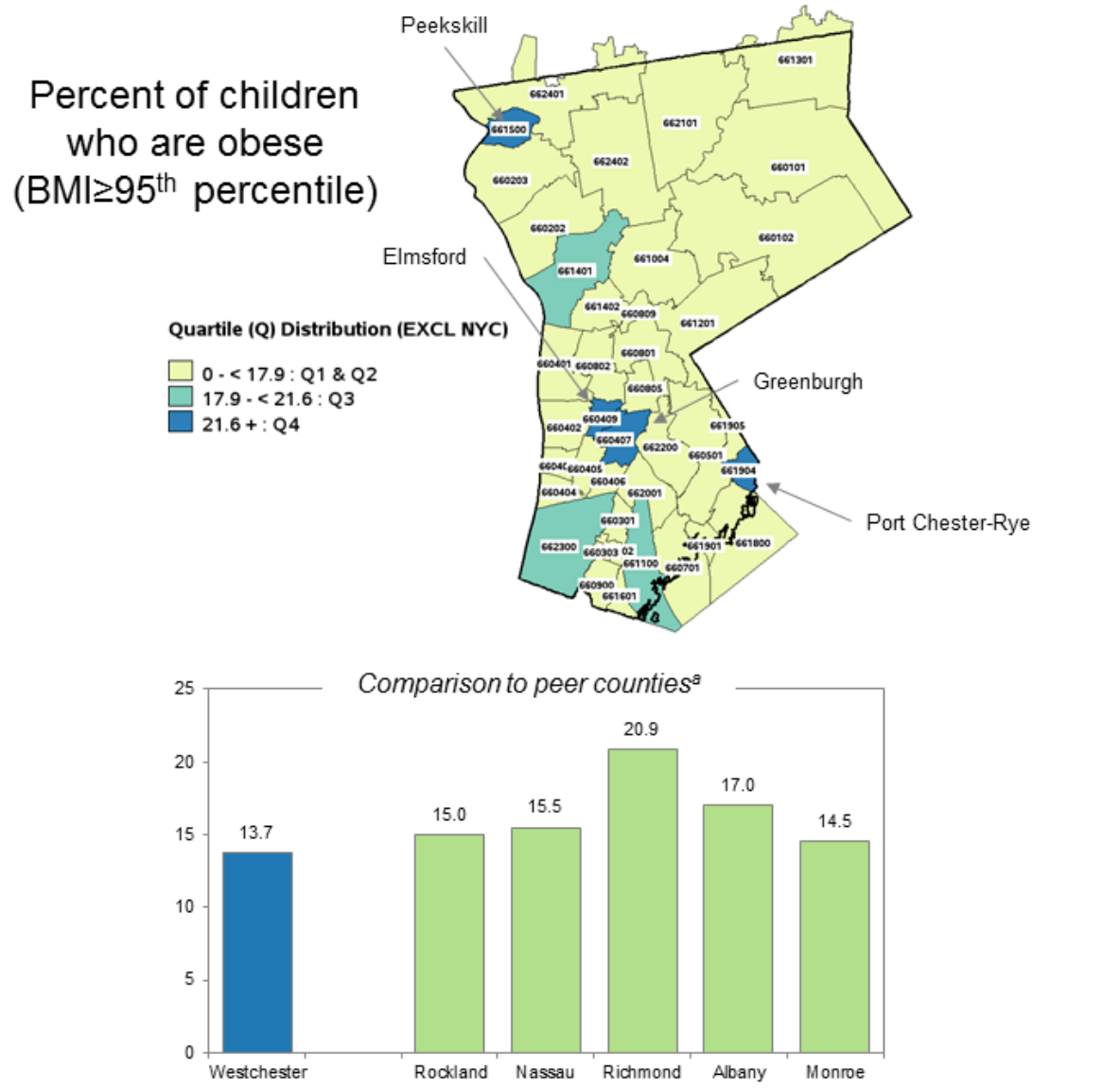


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: New York State Expanded BRFSS

- Long-term trend data is not available, but in recent years the percent of adults in Westchester County who are obese has remained stable and well below the statewide average.
- Compared to peer counties, Westchester County has the second lowest prevalence of obesity, trailing only Nassau County.

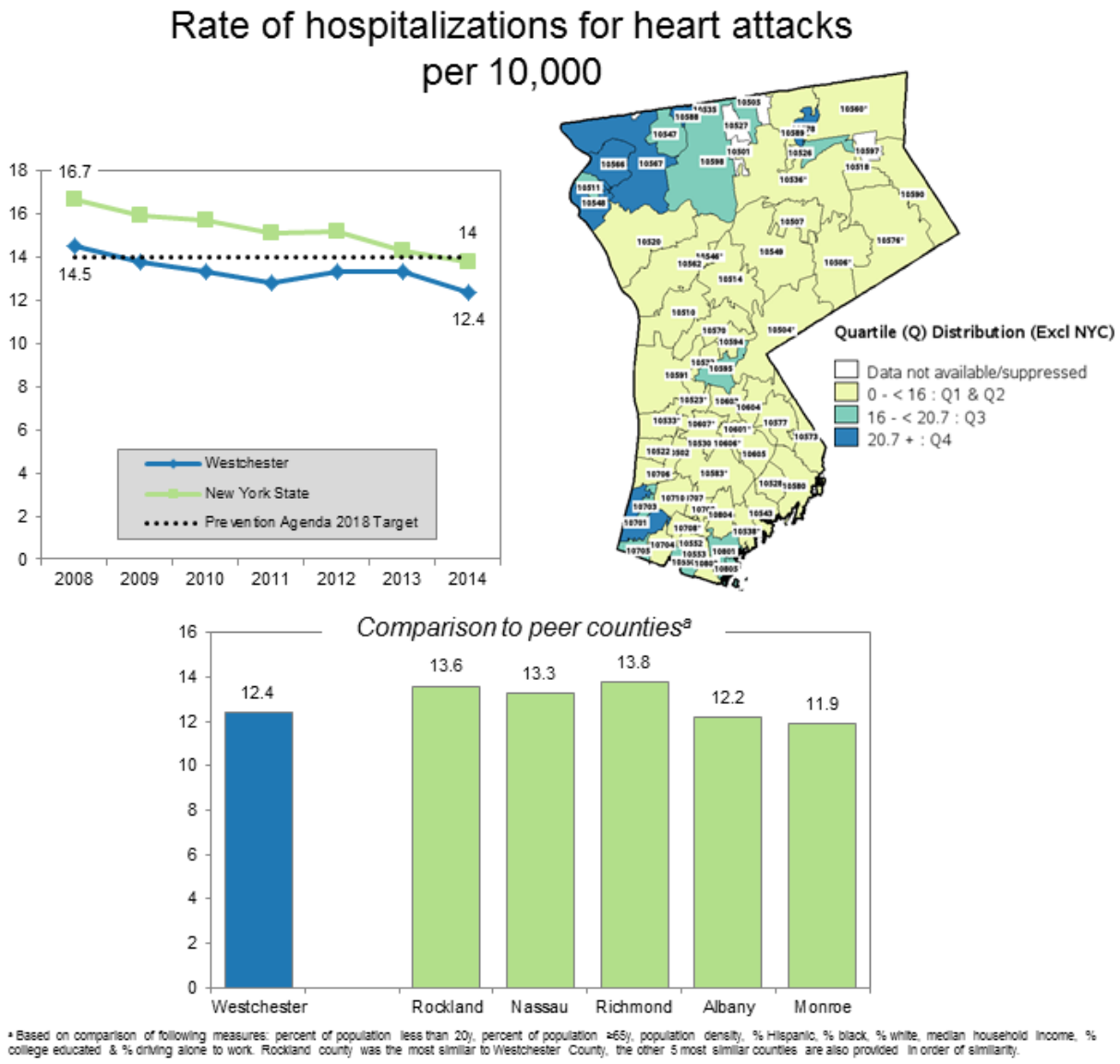
Figure 5. Percent of children who are obese



Data Source: Student Weight Status Category Reporting System (SWSCRS)

- Not shown here, childhood obesity in Westchester County has decreased from 14% in 2010-2012 to 13.7% in 2012-2014.
- Some parts of Westchester County had higher prevalence of childhood obesity than others, including Peekskill, Elmsford, Greenburgh and Port Chester-Rye.
- Compared to peer counties, Westchester County has the lowest prevalence of childhood obesity.

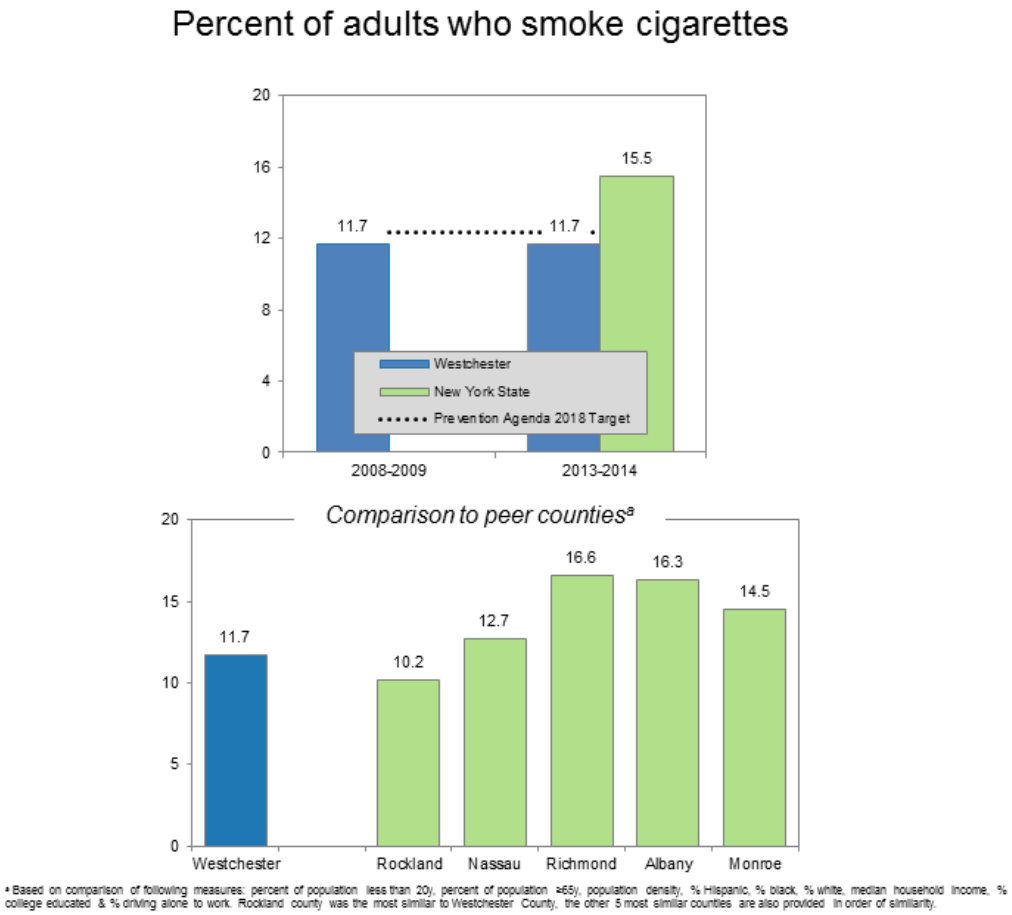
Figure 6. Rate of hospitalizations for heart attacks per 10,000



Data Source: SPARCS

- The rate of hospitalizations for heart attacks has declined in both Westchester County and New York State, with rates being substantially lower in Westchester County than New York State.
- Pockets of high rates were observed in Yonkers and Peekskill and Cortlandt Manor.
- Compared to peer counties, Westchester County has the third lowest rates of heart attack hospitalizations, trailing on Albany and Monroe counties.

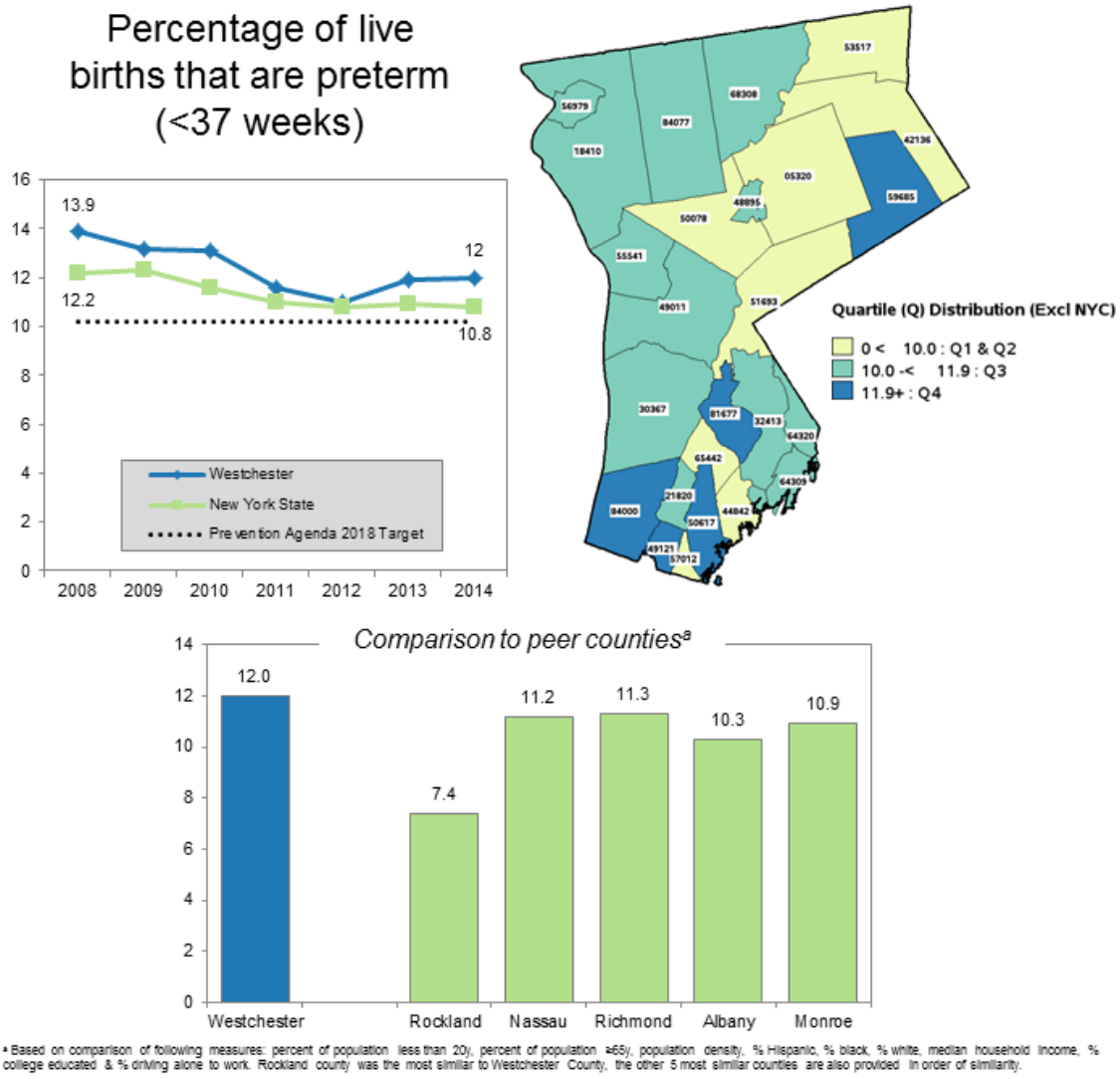
Figure 7. Age-adjusted percent of adults who currently smoke cigarettes



Data source: New York State Expanded BRFSS

- Long-term trend data is not available, but the percent of adults who smoke cigarettes in Westchester County has remained stable at 11.7% in recent years, well below the statewide average.
- Compared to peer counties, Westchester County has the second prevalence of cigarette smoking, trailing only Rockland County.

Figure 8. Percentage of live births that are preterm

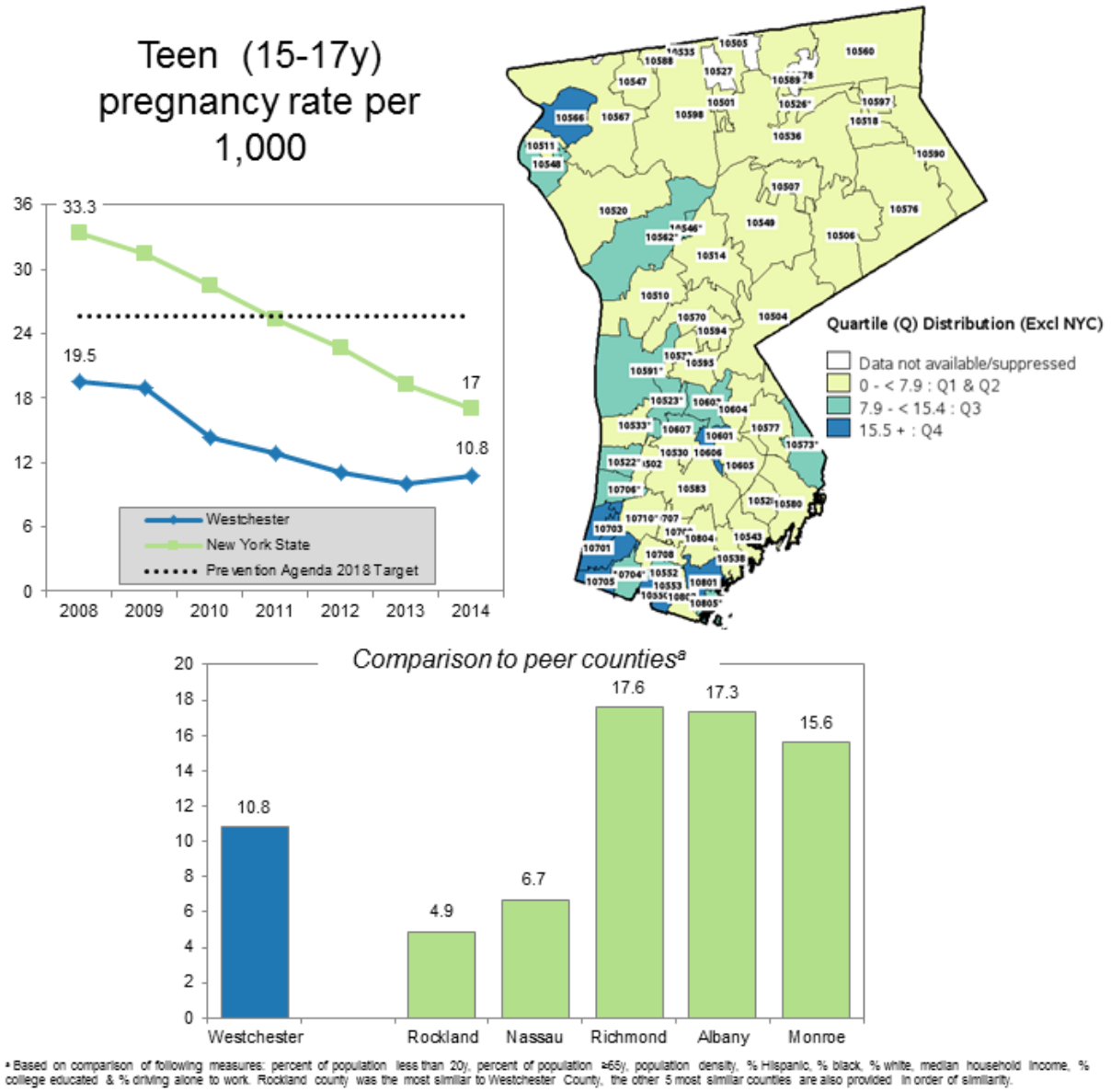


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: New York State Vital Statistics

- While rates of preterm birth have declined in Westchester County they remain higher than the statewide average and well above the Prevention Agenda 2018 Target.
- Hotspots of preterm birth were observed in Yonkers, Mount Vernon and New Rochelle.
- Compared to peer counties, the rate of preterm birth in Westchester County was considerably higher.

Figure 9. Teen pregnancy rate

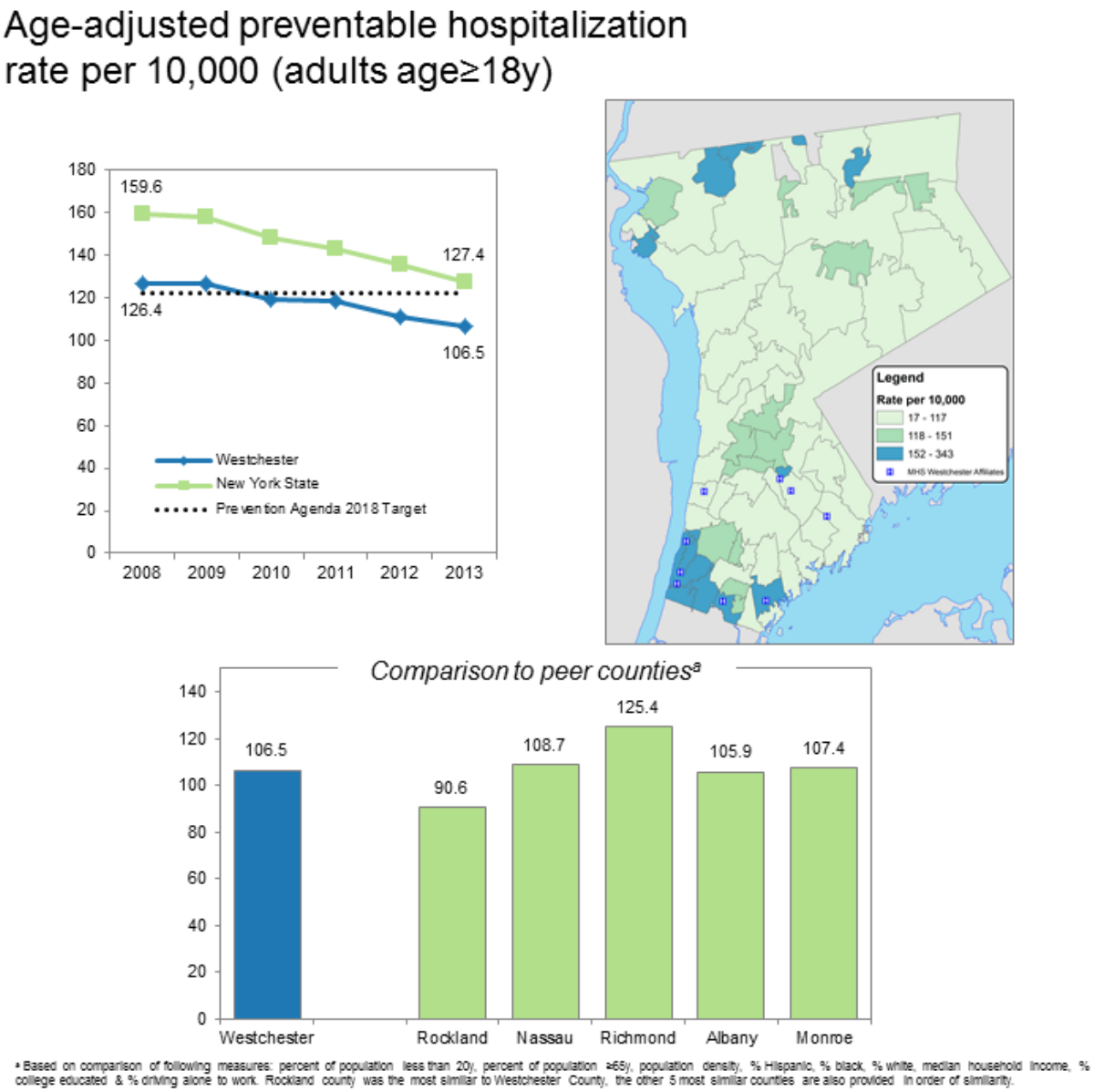


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: New York State Vital Statistics

- The rate of teen pregnancies in Westchester County decreased nearly 50% from 2008 to 2014, considerably lower than the statewide average and the Prevention Agenda 2018 Target.
- Hotspots of teen pregnancies were observed in Yonkers, Mount Vernon, New Rochelle and Peekskill.
- The teen pregnancy rate was substantially higher in Westchester County compared to Rockland and Nassau counties, but lower than Richmond (Staten Island), Albany and Monroe counties.

Figure 10. Age-adjusted preventable hospitalizations[1] per 10,000

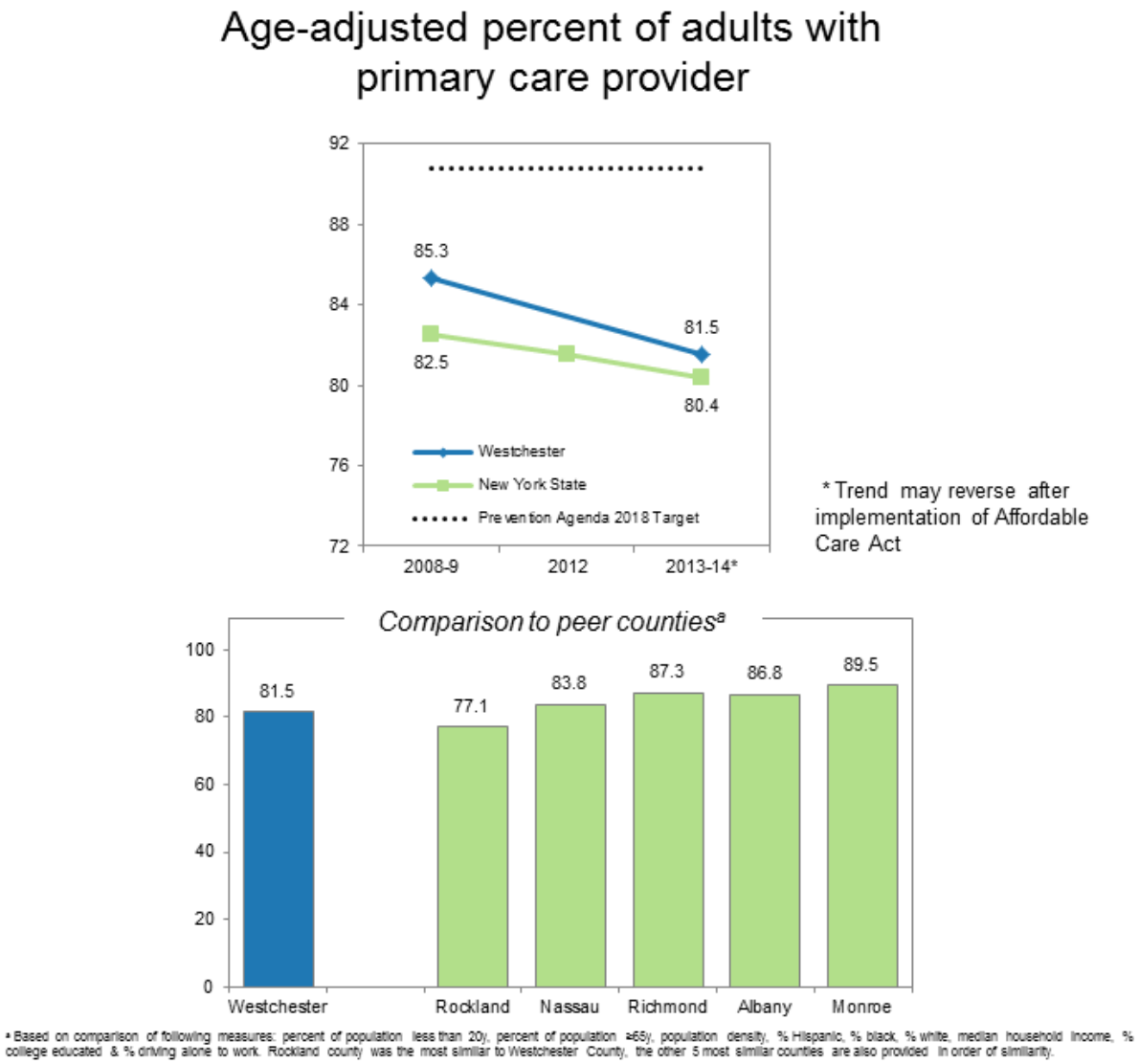


Data source: SPARCS

- In both New York State and Westchester County the rate of avoidable hospitalizations has declined. The Westchester County rate is substantially lower than both the New York State rate and the Prevention Agenda 2018 target.
- Rates of avoidable hospitalizations were elevated in parts of lower Westchester County, including Yonkers, Mount Vernon and New Rochelle.

[1] Defined as hospitalizations for the following: (1)Short-term complication of diabetes (2)Long-term complication of diabetes (3)Uncontrolled diabetes (4)Lower-extremity amputation among patients with diabetes (5)Hypertension (6)Congestive heart failure (7)Angina (8)Chronic obstructive pulmonary disease (9)Asthma (10)Dehydration (11)Bacterial pneumonia (12)Urinary tract infection.

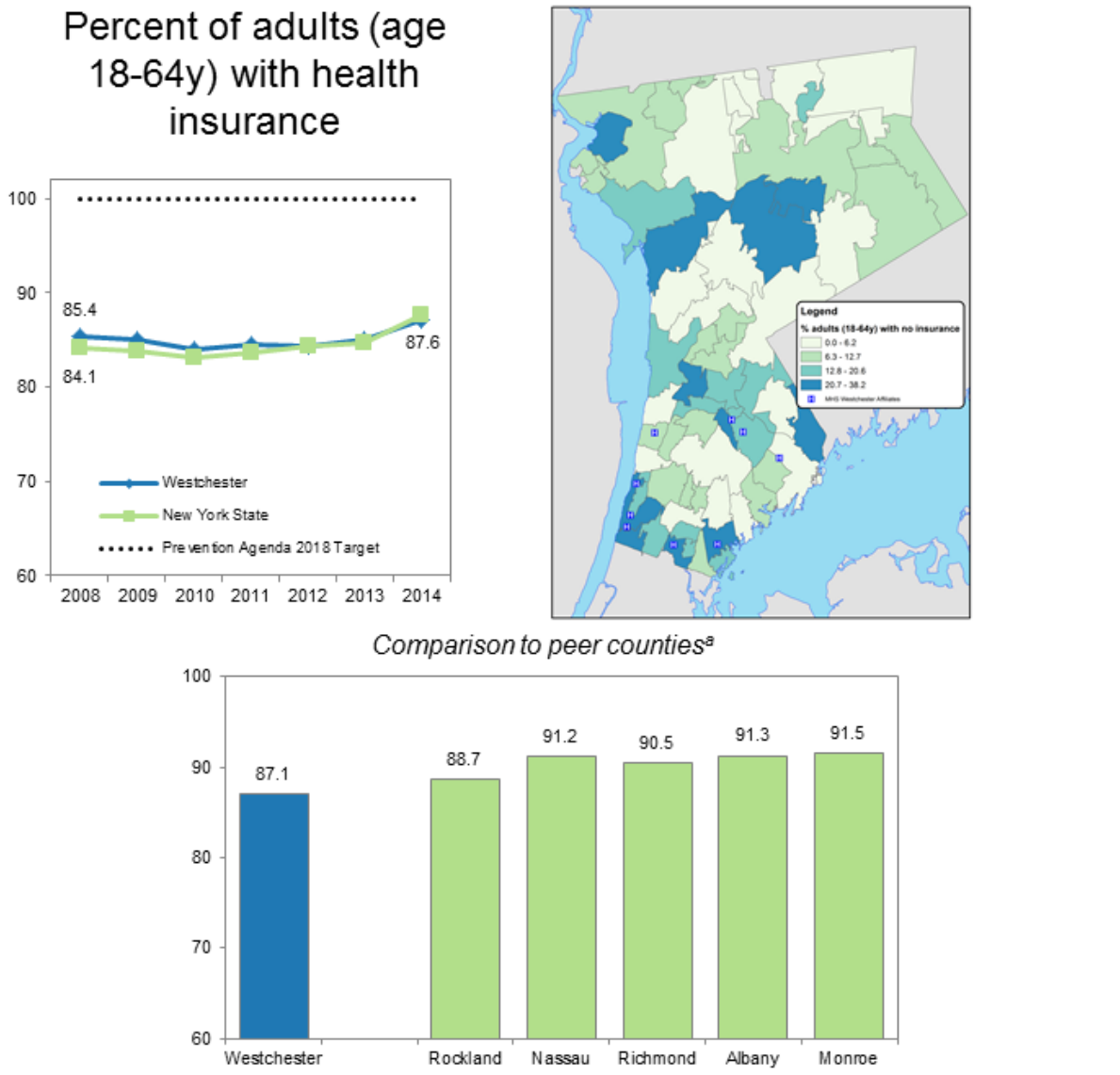
Figure 11. Age-adjusted percent of adults with a primary care provider



Data source: New York State Expanded BRFSS

- The proportion of adults in Westchester County with a primary care provider has declined from 85.3% in 2008-9 to 81.5% in 2013-2014. It is important to note that this data will not pick-up any dramatic uptick in access to primary care that may be attributable to implementation of the Affordable Care Act.
- Compared to peer counties, the percent of adults with a primary care provider was second lowest in Westchester County, somewhat higher than that observed in Rockland County.

Figure 12. Percent of adults (age 18-64y) with health insurance

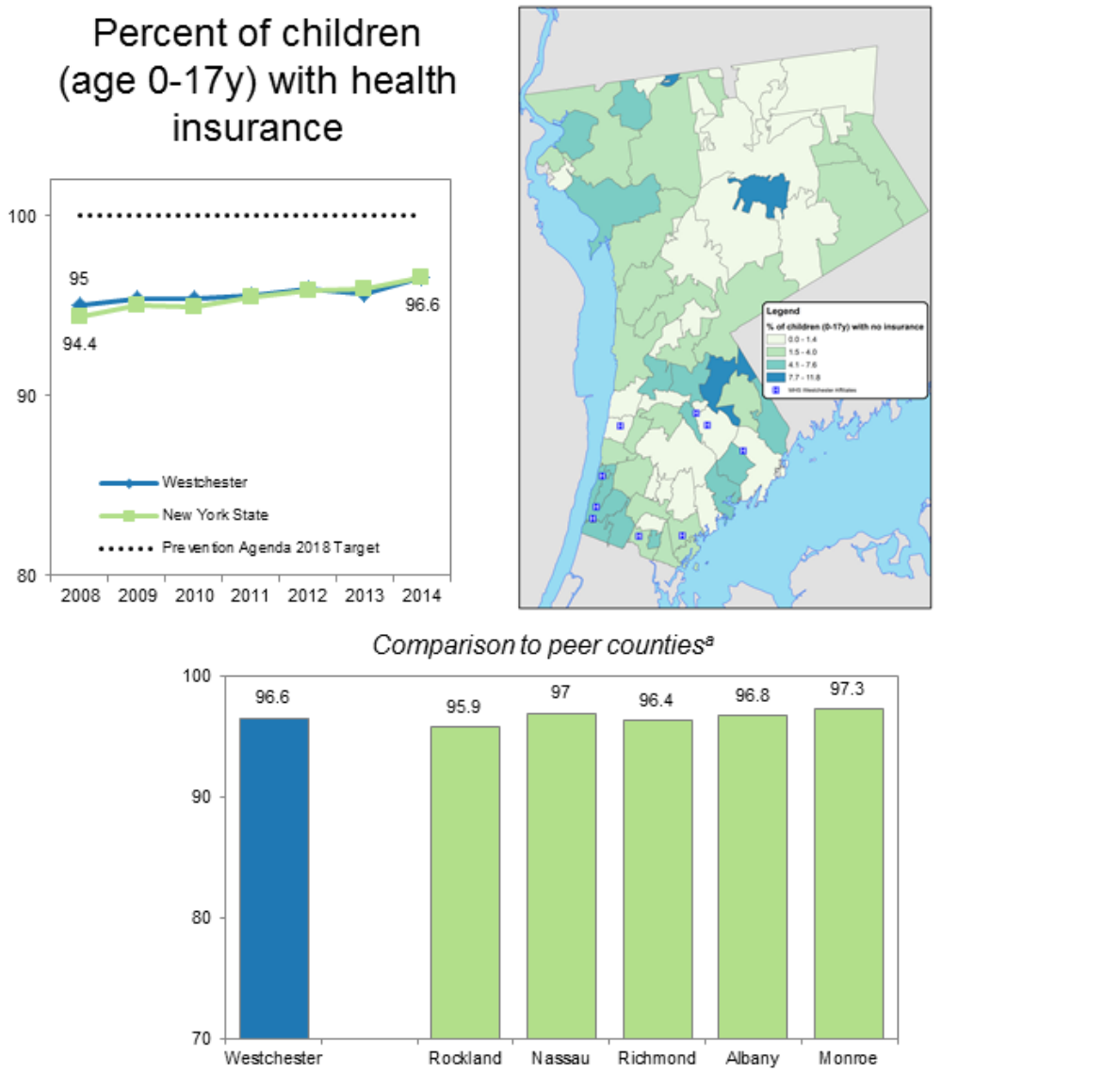


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other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

Data source: American Community Survey

- From 2008 to 2014, the percent of non-elderly adults in Westchester County with health insurance increased from 85.4% to 87.6%.
- Pockets of not having health insurance were observed in lower Westchester County, including Yonkers, Mount Vernon, New Rochelle, and also in White Plains, Port Chester, Peekskill, Ossining, and the Mt Kisco and Bedford Hills area.

Figure 13. Percent of children (age 0-17y) with health insurance

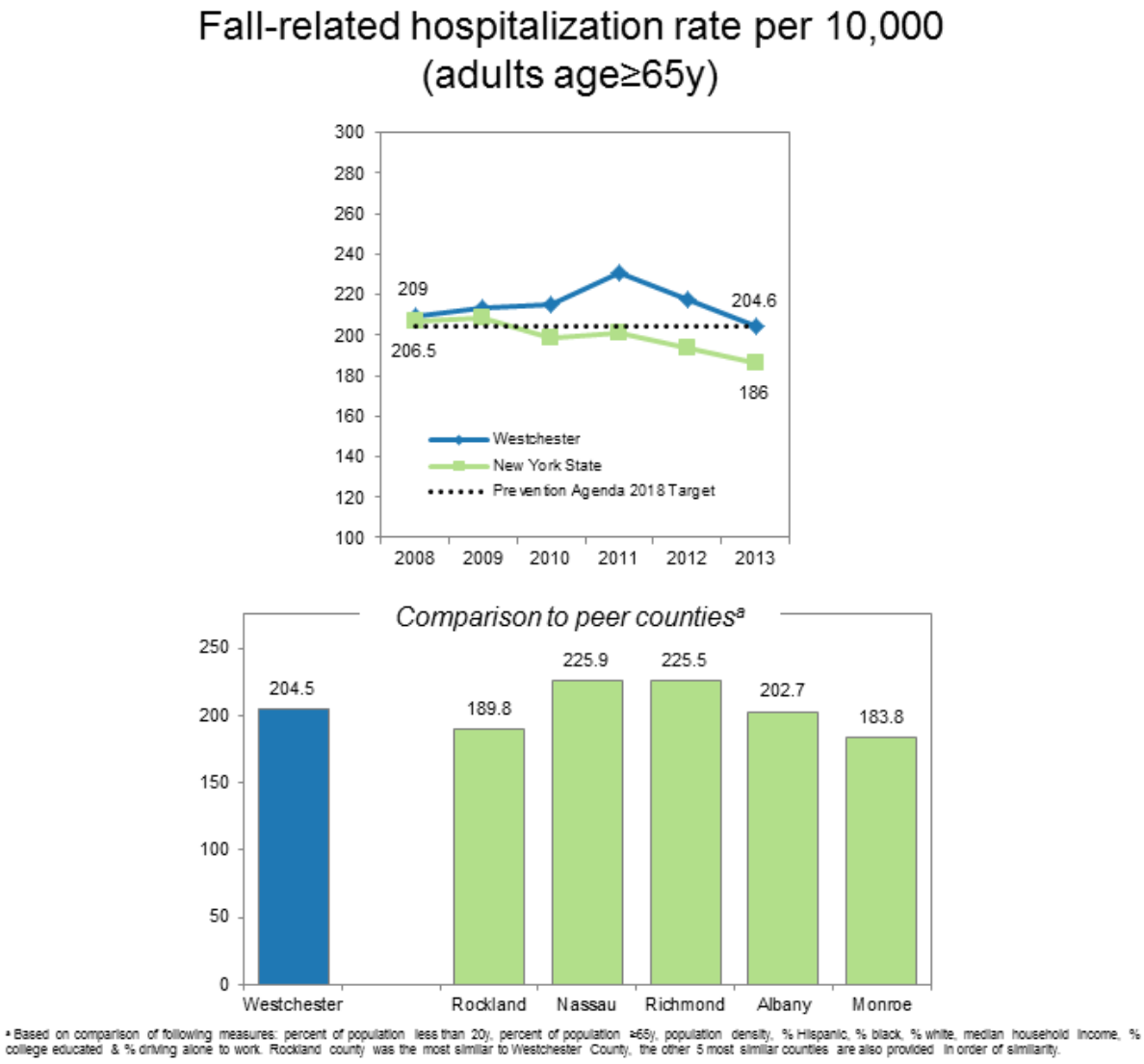


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other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

Data source: American Community Survey

- From 2008 to 2014, there was modest improvement in the percent of children in Westchester County with health insurance.
- There were no dramatic hotspots for not having any health insurance among children in Westchester County.
- In addition, health insurance coverage among children was very comparable across peer counties.

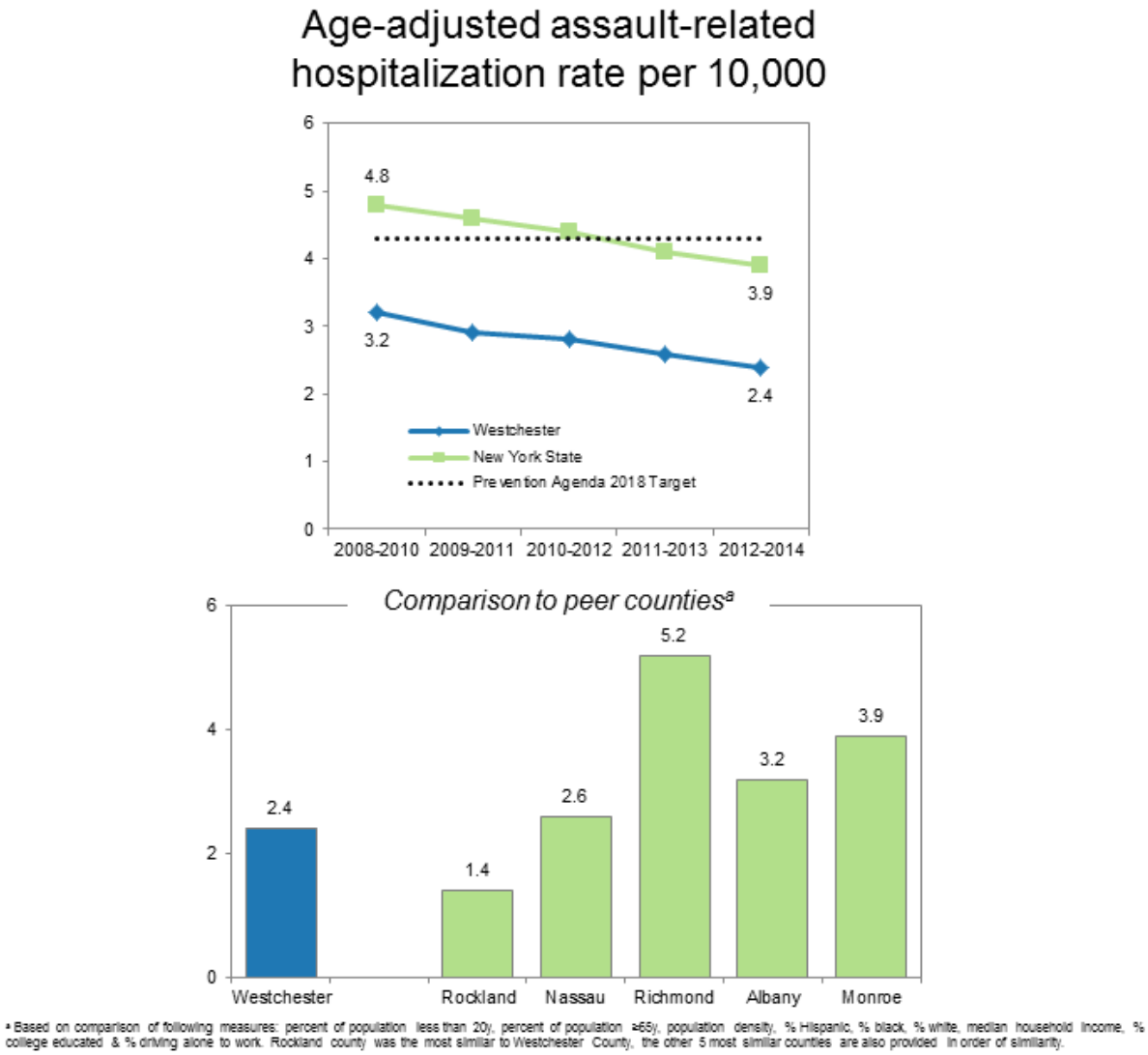
Figure 14. Fall-related hospitalization rate per 10,000



Data source: SPARCS

- Between 2008-2013, fall-related hospitalizations in Westchester County increased and then decreased, and were slightly higher than New York State rates.
- Compared to peer counties, rates higher than Rockland and Monroe counties, but lower than Nassau and Richmond (Staten Island) counties.

Figure 15. Age-adjusted assault-hospitalization rate per 10,000

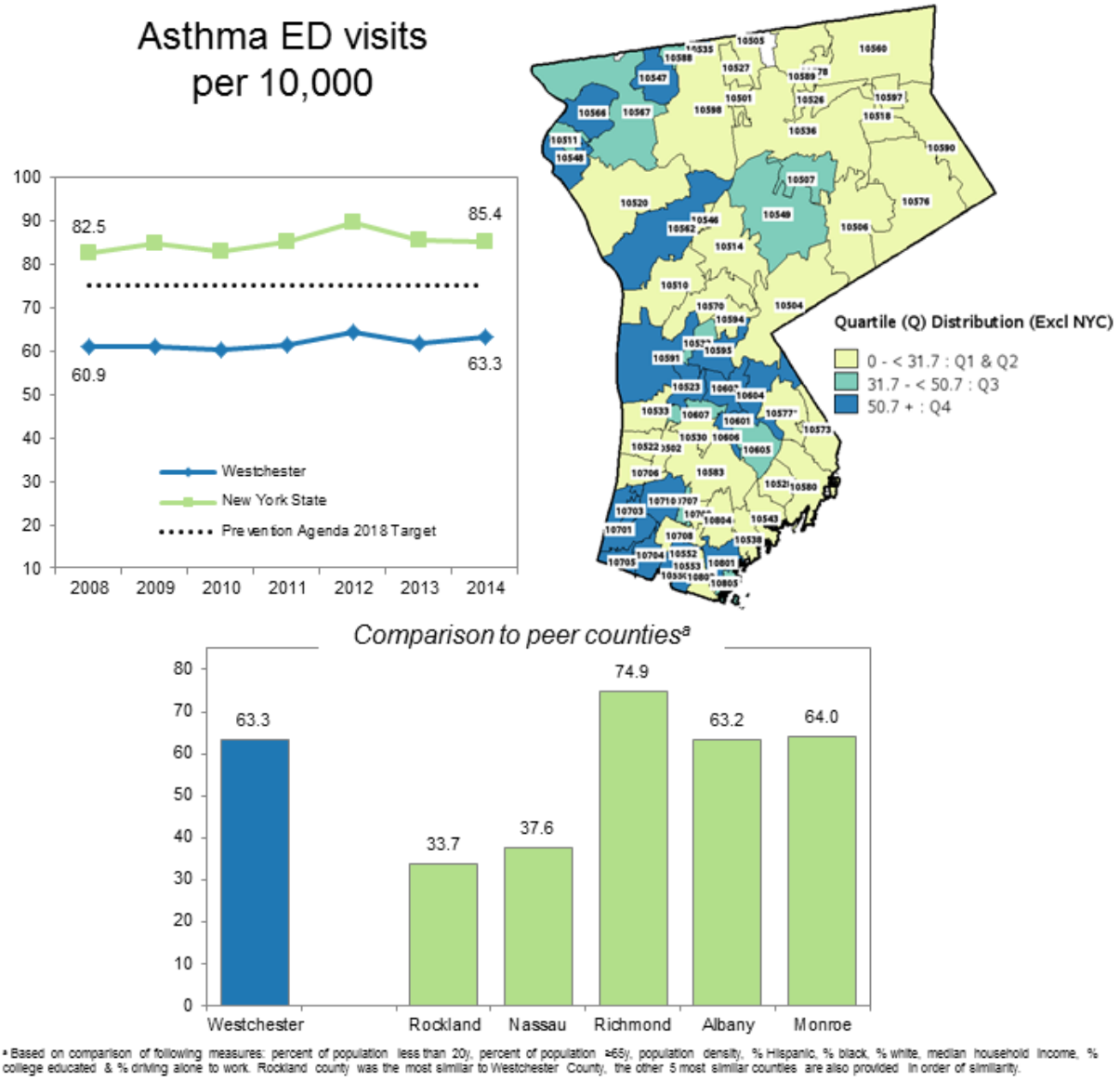


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other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

Data source: SPARCS

- Between 2008-2013, assault-related hospitalizations in Westchester County decreased and remained well-below the statewide average and the Prevention Agenda target.
- Compared to peer counties, rates were lowest in Rockland County, followed by Westchester County.

Figure 16. Asthma emergency department visits per 10,000

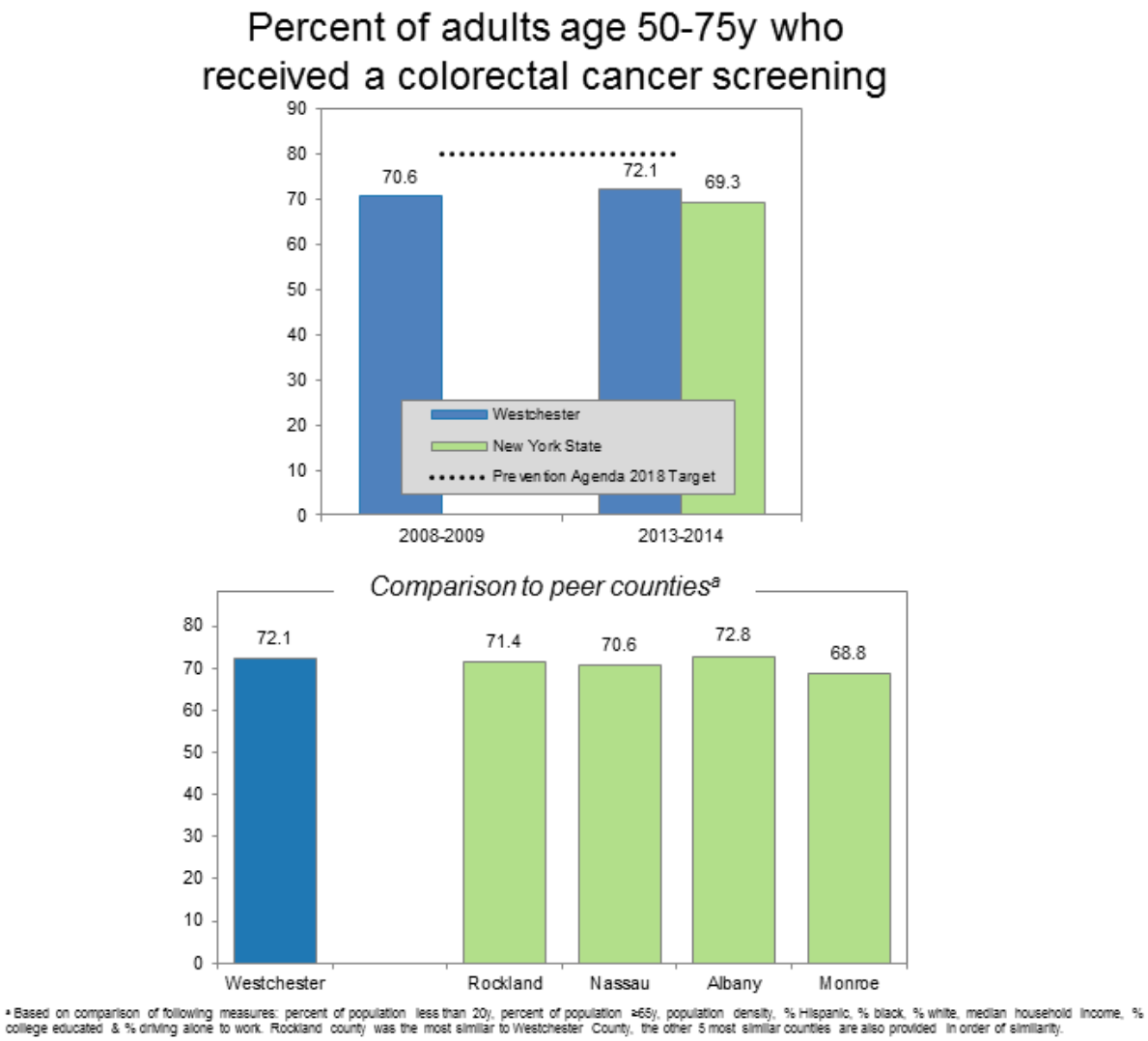


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: SPARCS

- Asthma ED rates have remained stable in Westchester County and are well below the statewide average.
- Compared to Rockland and Nassau counties, asthma ED rates in Westchester County are nearly twice as high. Rates are lower than in Richmond County (Staten Island) and comparable to the other two peer counties: Albany and Monroe counties.
- Hotspots for asthma ED visits were observed throughout Westchester County, including Yonkers, Mount Vernon, New Rochelle, White Plains, Tarrytown, Ossining, and Peekskill.

Figure 17. Percent of adults age≥50 who received a colonoscopy in the prior 10 years

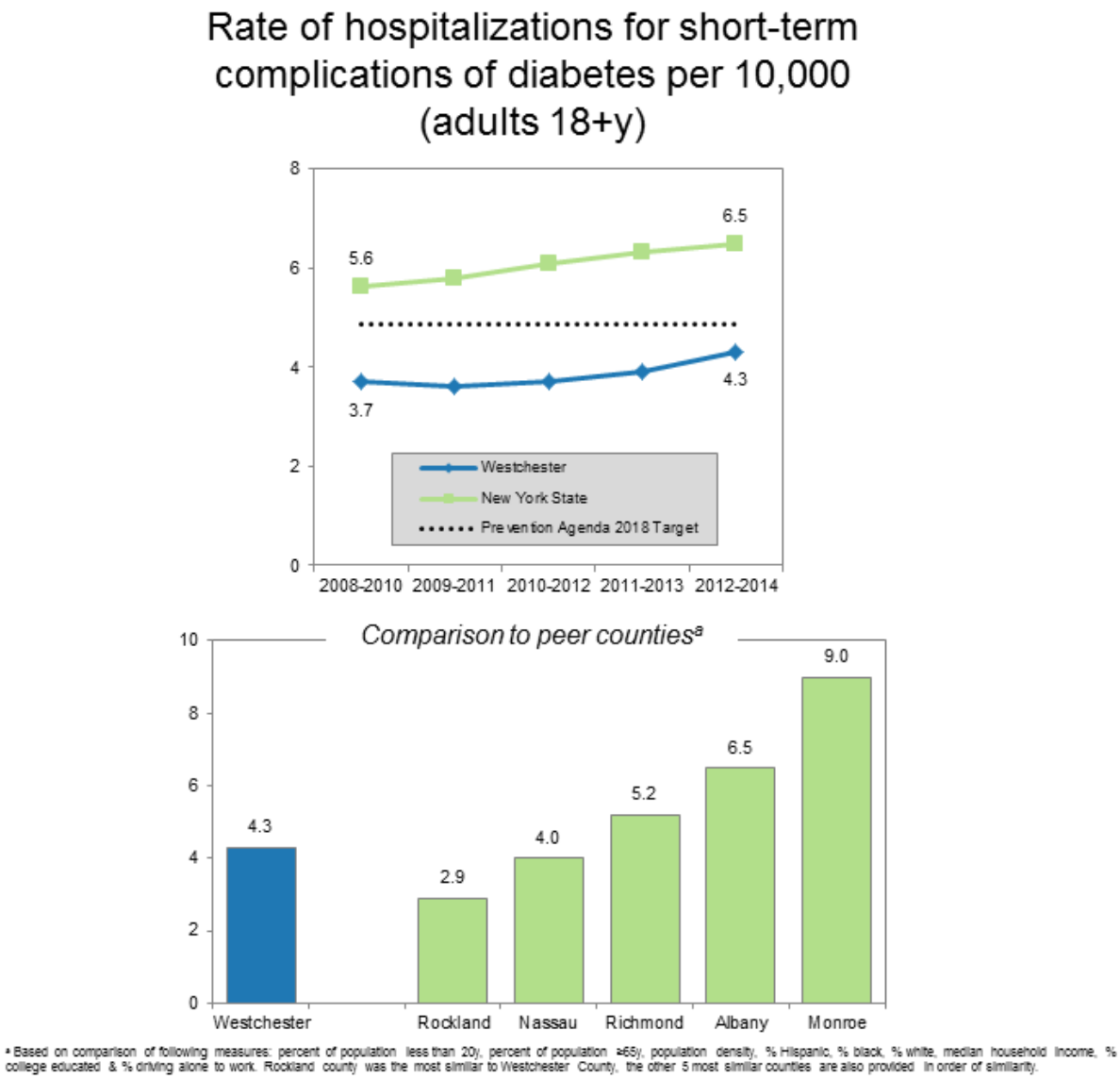


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: New York State Expanded BRFSS

- The percent of adults 50-75y who got a colonoscopy in the prior 10 years increased slightly from 2008-2009 to 2013-2014 in Westchester County.
- The proportion getting a timely colonoscopy was comparably across most peer counties, though somewhat lower in Monroe County.

Figure 18. Rate of hospitalizations for short-term complications of diabetes per 10,000

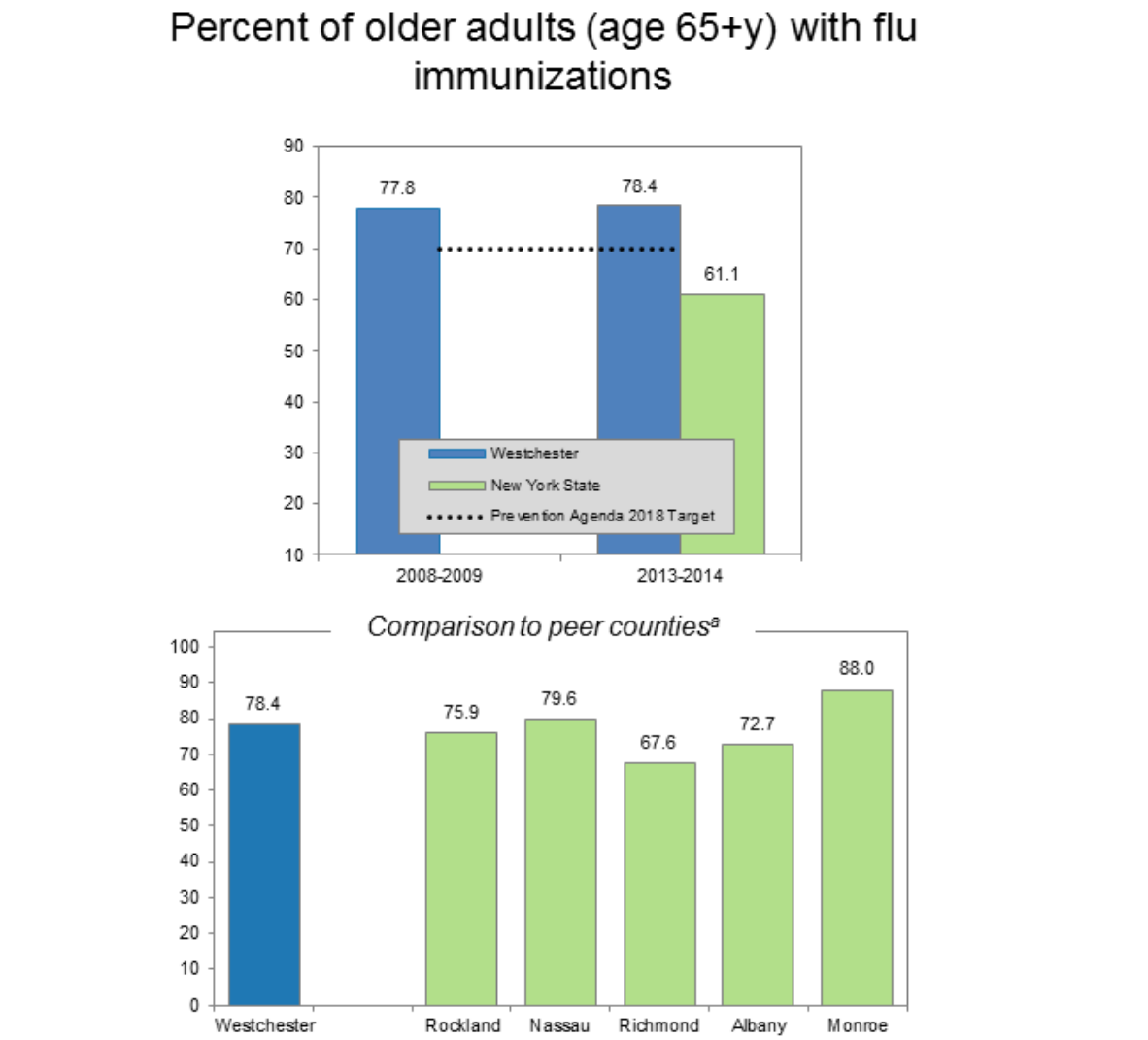


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similar to Westchester County, the other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

Data source: SPARCS

- Rates of hospitalization for short-term diabetes complications among Westchester County adults increased slightly from 2008-2010 to 2012-2014, but remained lower than the statewide rate and the Prevention Agenda target.
- Compared to peer counties, rates were worse in Westchester County compared to Rockland and Nassau County, but better than the other 3 peer counties.

Figure 19. Percent of older adults getting immunized for the flu

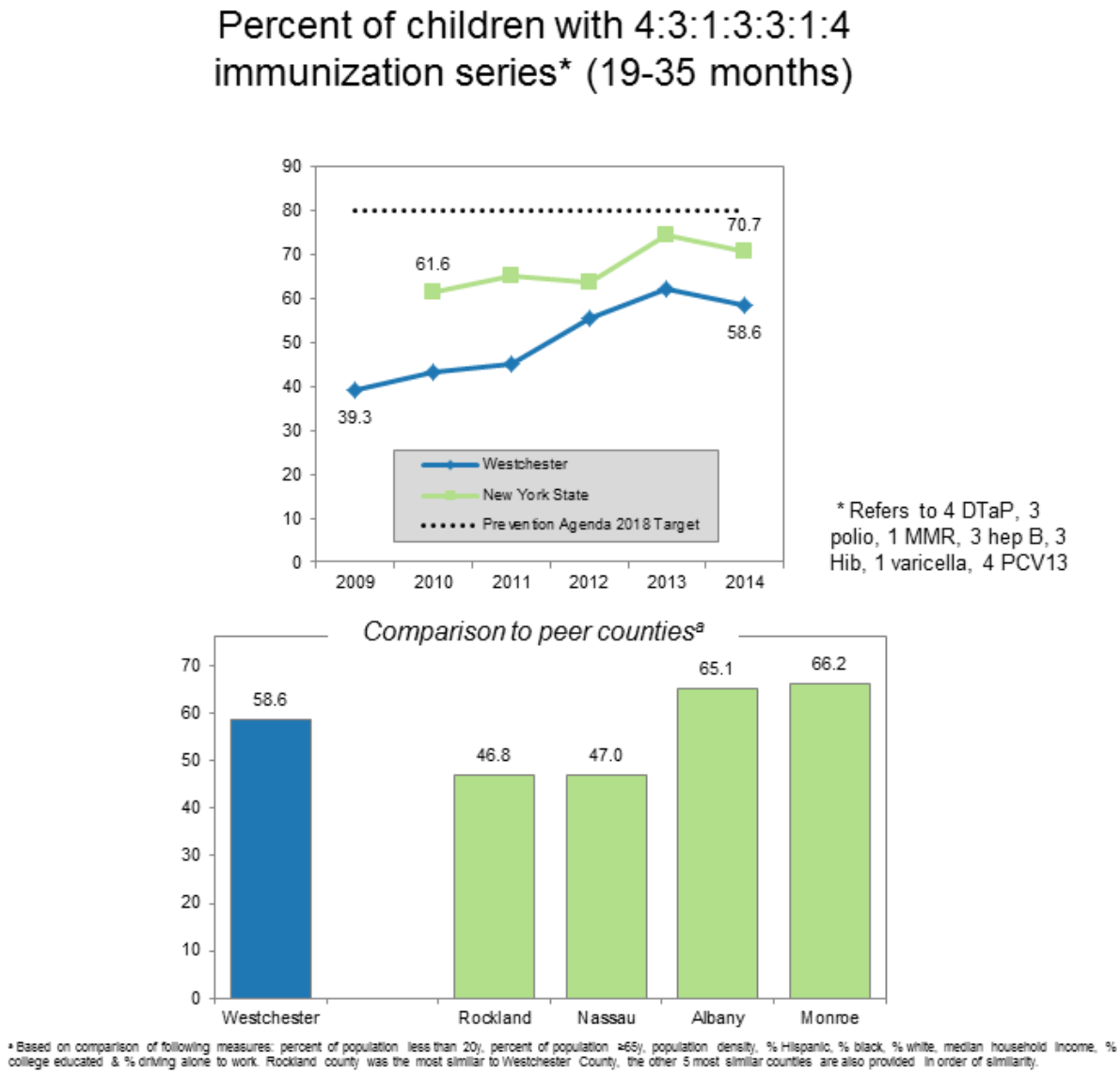


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hilspanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: New York State Expanded BRFSS

- A modest increase in the percent of older adults getting a flu shot was observed in Westchester County, with the percentage being substantially higher than the rest of New York State.
- Compared to peer counties, rates were generally comparably, but were higher than Richmond (Staten Island) and Albany counties.

Figure 20. Percent of children getting 4:3:1:3:3:1:4 immunization series[2]

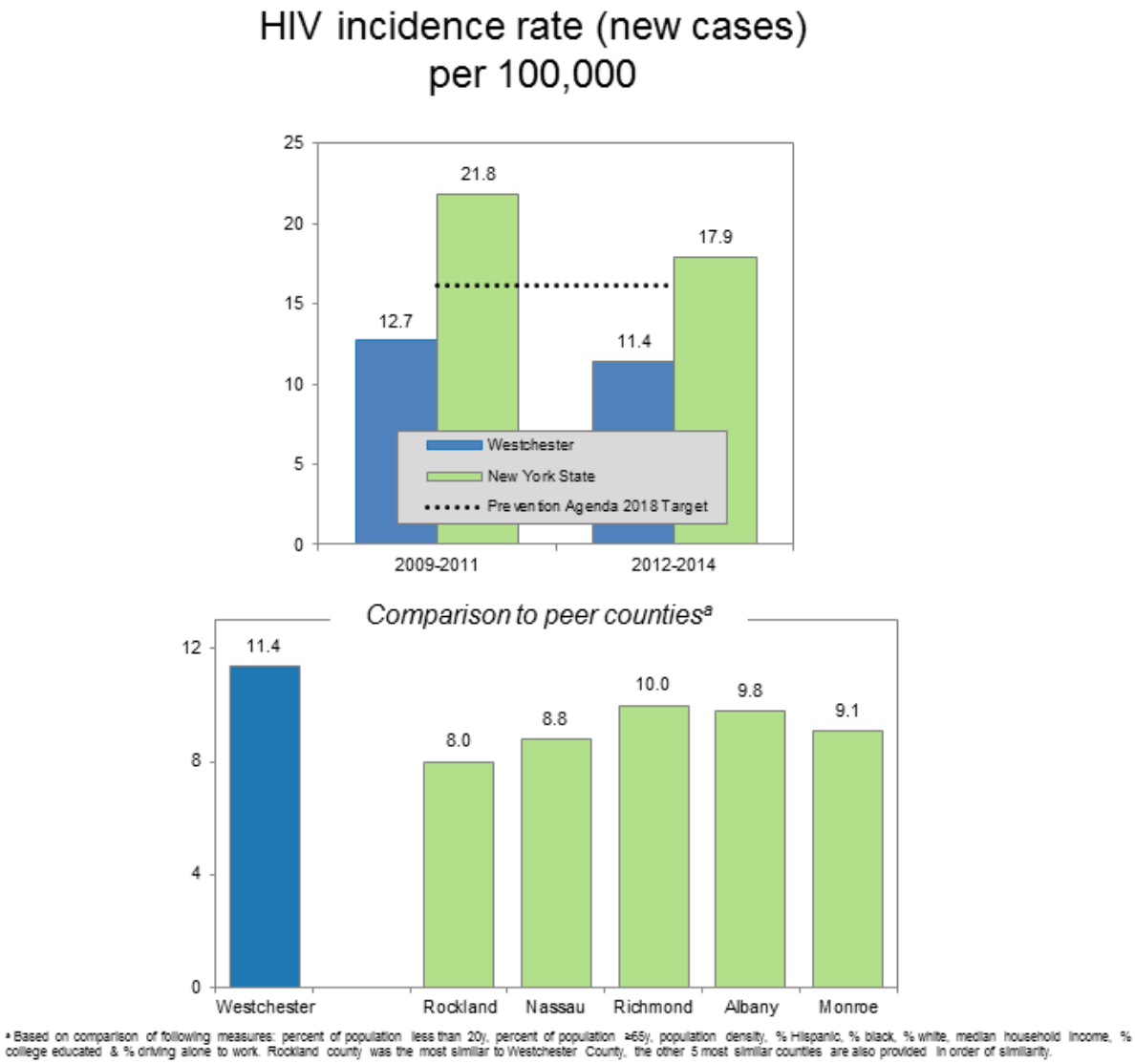


Data source: NYS Immunization Information System

- The percent of young children covered by the 4:3:1:3:3:1:4 immunizations series increased in Westchester County but remained lower than the statewide average and the Prevention Agenda target.
- Compared to peer counties, coverage rates were higher than Rockland and Nassau counties, but lower than Albany and Monroe counties.

[2] The percentage of children (aged 19-35 months) who received their 4:3:1:3:3:1:4 immunization series (4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13).

Figure 21. HIV incidence rate per 100,000

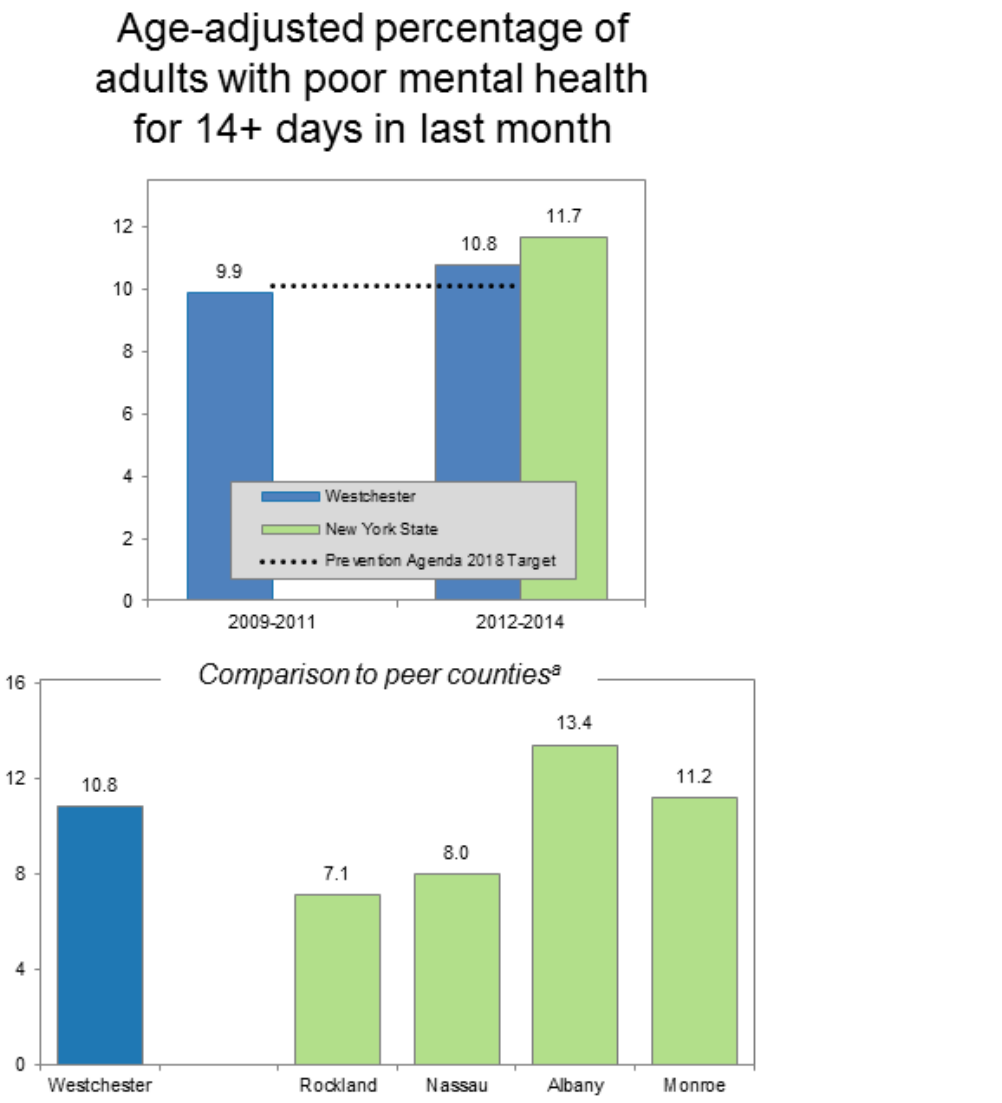


[a] Based on comparison of following measures: percent of population less than 20y, percent of population ≥65y, population density, % Hispanic, % black, % white, median household income, % college educated & % driving alone to work. Rockland county was the most similiar to Westchester County, the other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

Data source: New York State HIV/AIDS Epidemiology Reports

- The incidence of HIV in Westchester County is substantially lower than the statewide rate and has modestly declined from 2009-2011 to 2012-2014.
- The incidence rate in Westchester County was higher than all peer counties.

Figure 22. Age-adjusted percent of adults with 14 or more poor mental health days in past month



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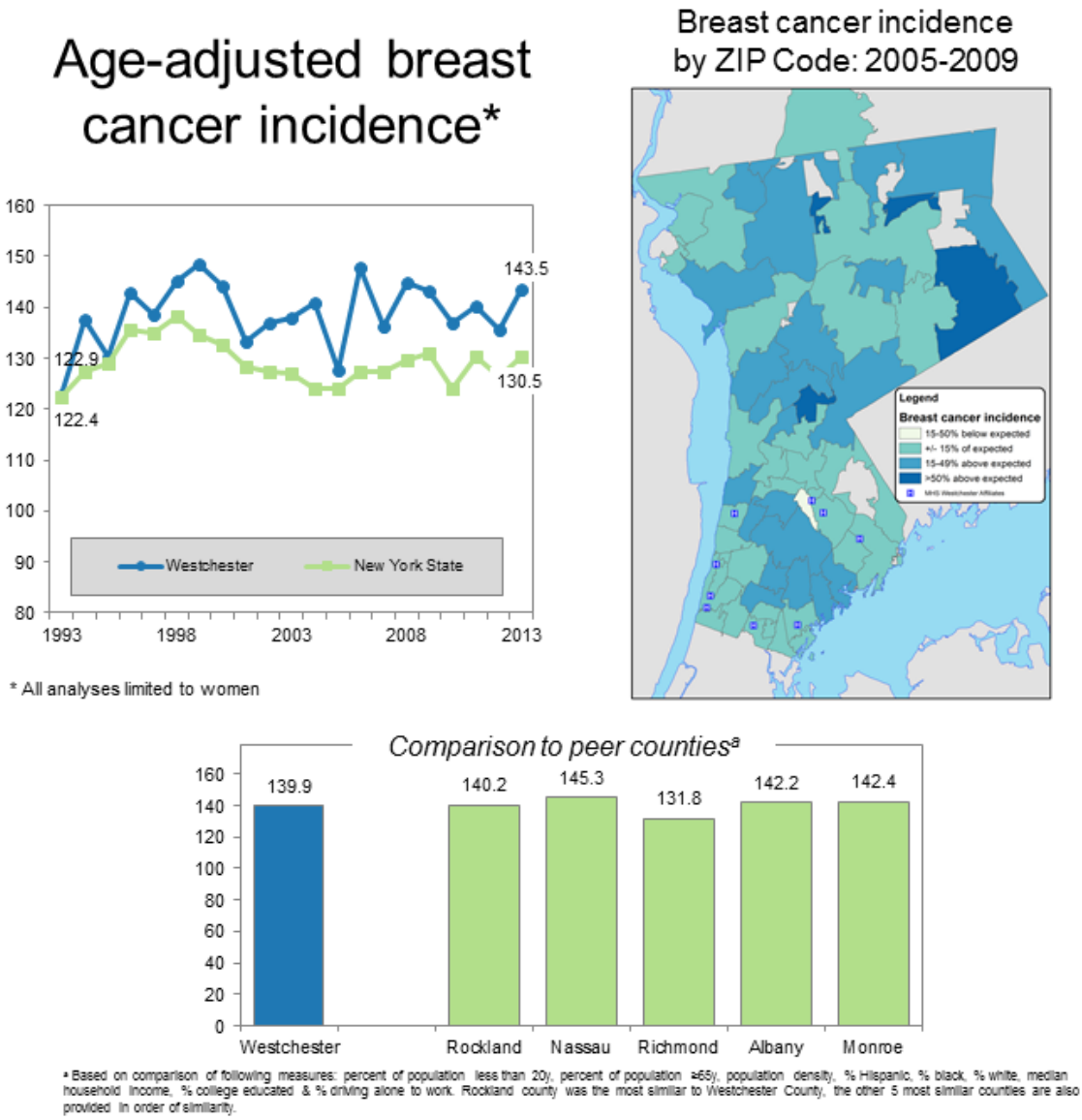
Data source: New York State Expanded BRFSS

- The percent of Westchester County adults with more than 14+ days of poor mental health in the past month increase marginally from 2009-2011 to 2012-2014, but remained lower than the statewide percent.
- Compared to peer counties, the percent in Westchester County is higher than Rockland and Nassau, but lower than Albany and Monroe counties.

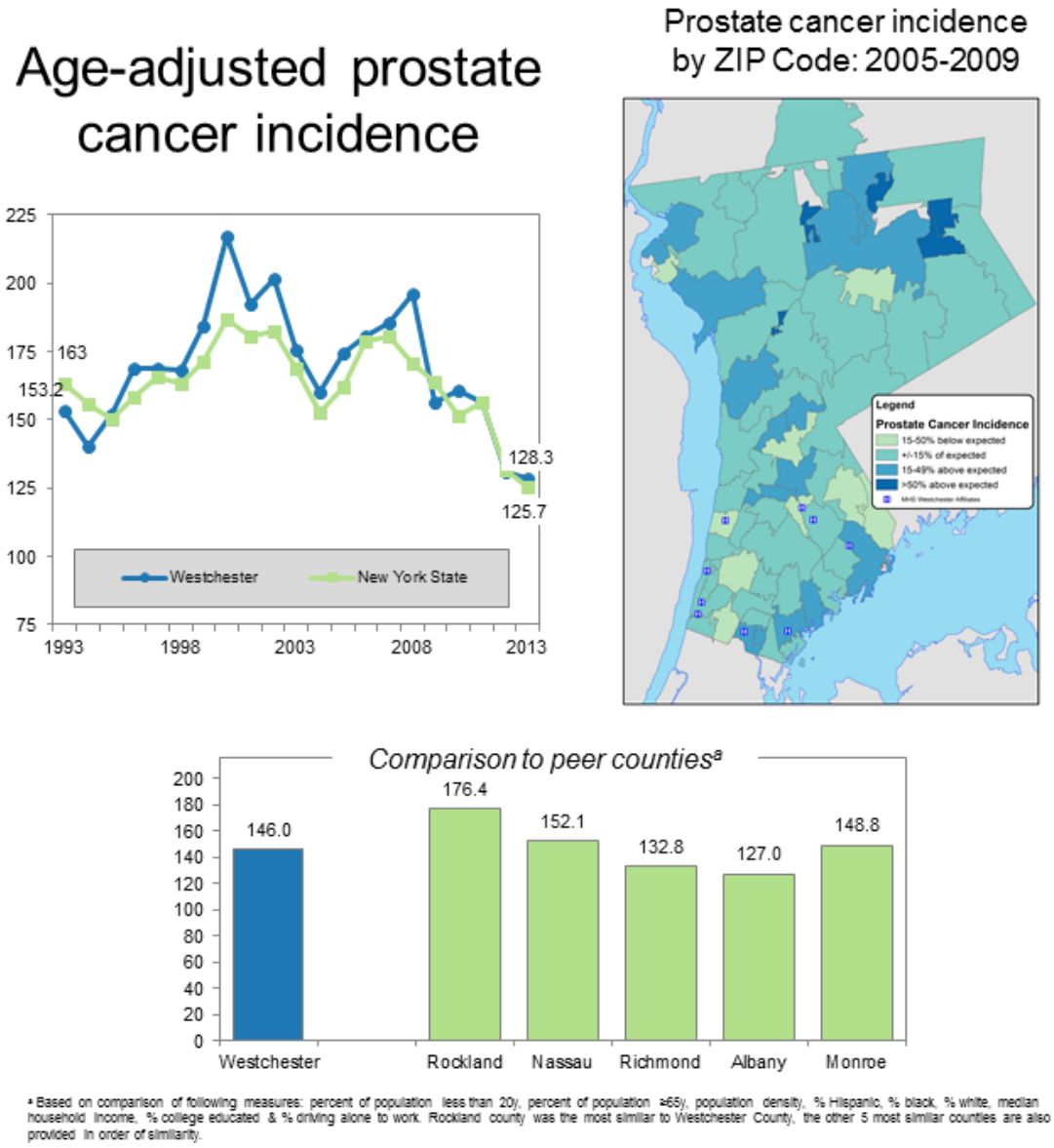
Figure 23. Age-adjusted breast cancer incidence, among women only



Data source: New York State Cancer Registry

- The age-adjusted incidence of breast cancer in Westchester County is higher compared to New York State overall and rates in Westchester County have increased slightly from 1993 to 2013.
- Modestly elevated breast cancer incidence rates were observed in some parts of Westchester County, including Larchmont, Eastchester, Bronxville, Scarsdale, Irvington, Thornwood, Pound Ridge, Goldens Bridge and Amawalk.

Figure 24. Age-adjusted prostate cancer incidence, among men only



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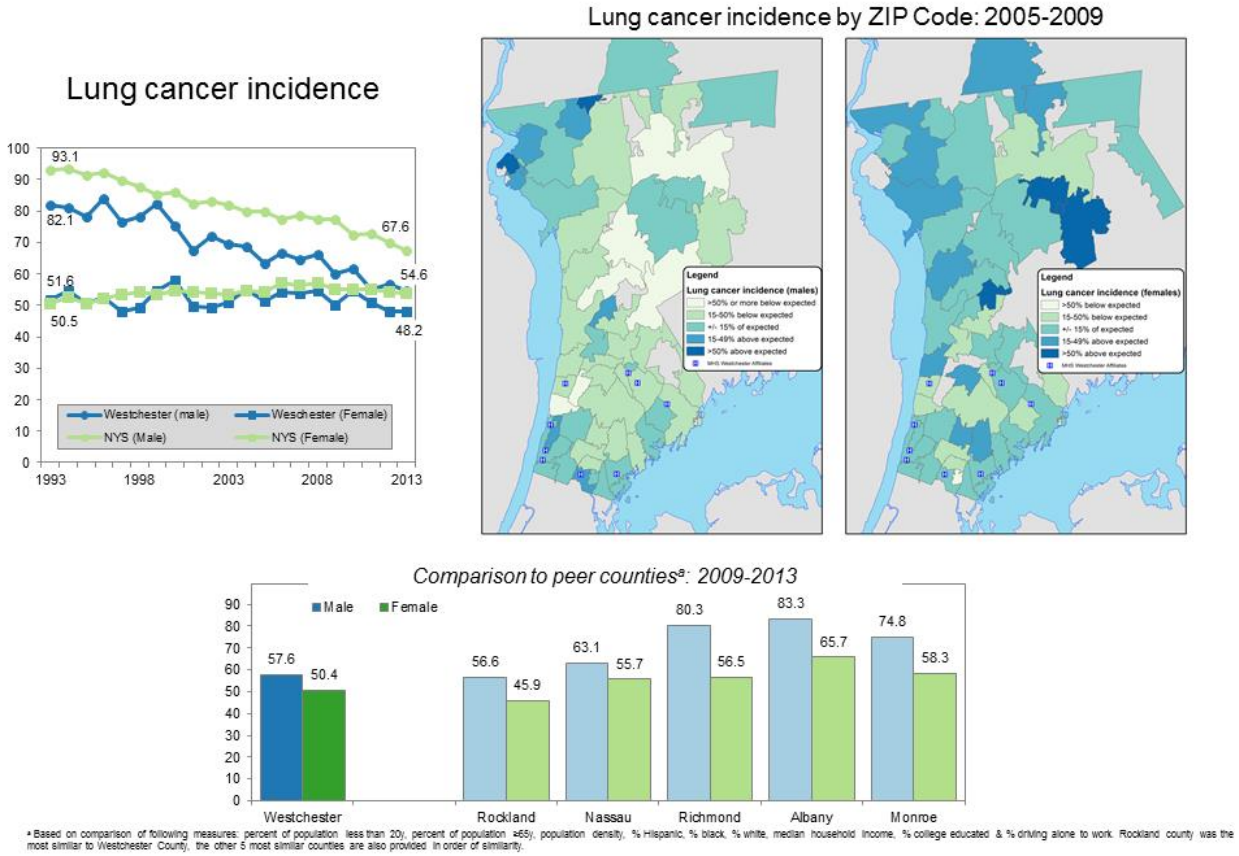
Data source: New York State Cancer Registry

- Among men in both Westchester County and New York State prostate cancer rates increased through the 1990s and then declined, in large part to rapid uptake of PSA screening.
- Modestly elevated breast cancer incidence rates were observed in some parts of Westchester County, including Larchmont, Eastchester, Bronxville, Scarsdale, Irvington, Thornwood, Pound Ridge, Goldens Bridge and Amawalk.

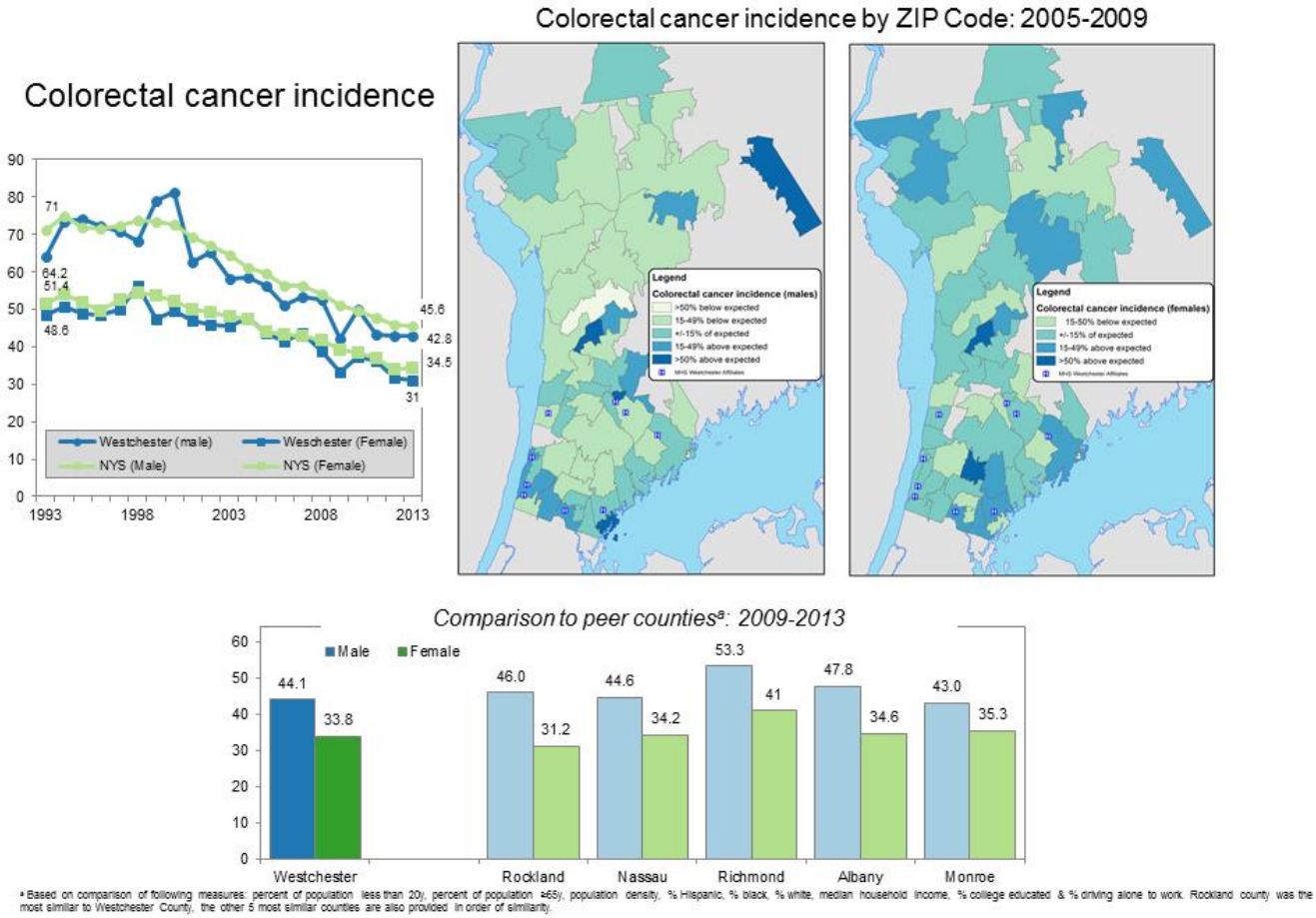
Figure 25. Age-adjusted lung cancer incidence



Data source: New York State Cancer Registry

- Among men in Westchester County lung cancer incidence has declined. It has remained stable among women. Among men, rates in Westchester County were lower than New York State, while rates among women were similar to New York State rates.

Figure 26. Age-adjusted colorectal cancer incidence



Data source: New York State Cancer Registry

- For both men and women, colorectal cancer incidence rates have declined in Westchester County and in New York State.
- Rates in Westchester County were comparable to peer counties with the exception of Richmond County (Staten Island), which had higher rates.

5b. Primary Data Analysis

Primary data collection for the Westchester County CHNA was done collaboratively between partner institutions and the Westchester County Department of Health. Two approaches were used to gather community input on community health priorities in Westchester County: 1) a community survey and, 2) a provider survey. The methods are summarized in **Section 4**. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns.

Community & Provider Survey

Overview & Methods

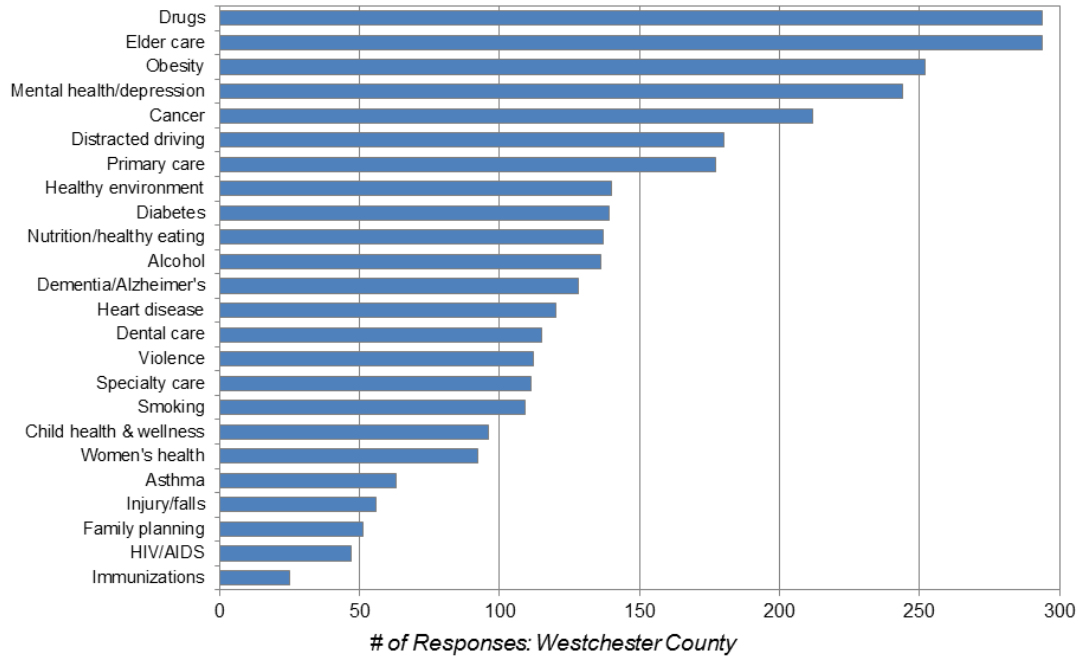
In collaboration with the Westchester County Department of Health, a community needs survey was conducted in the summer of 2016. Two versions of the survey were implemented, one for community members at-large and another for health care providers and community-based organizations (herein referred to as the provider survey). The community survey could be completed via a web-based tool (Survey Monkey) or on paper, with paper surveys available in six languages (English, Spanish, Chinese, Arabic, and French). The provider survey could be completed online. The primary distribution of the survey was conducted through the Westchester County Department of Health's office of the Administrator and was made available through its website at the direction of the Commissioner of Health and the County Executive, which then directed it for distribution to the County's elected officials. The Montefiore Hudson Valley Collaborative also distributed the survey to its membership of over 900 hospitals, community based organizations, faith-based organizations and other social service providers. Due to its electronic format, dissemination was widespread, however limited quantities of paper surveys were available on request. The survey was disseminated through multiple distribution points including to hospitals, other health care providers, community-based organizations and others.

Community Survey Results

For the community survey, a total of 1125 surveys were completed among individuals working-in or residing-in Westchester County. Seventy-eight percent of respondents were women, 21% were men and 0.5% as other, including non-conforming, non-binary and transgendered. Respondents tended to be middle-aged; 25% were 55-64y, 18% were 45-54y, 14% were 65-74y, and 13% were 35-44y. Twenty-four percent of respondents were 65y+ and 4.6% were 18-24y. Twenty-one percent of respondents were Hispanic/Latino (a), 13% were non-Hispanic Black, and 61% were non-Hispanic white. Respondents resided in more than 78 ZIP Codes. About 23.9% of respondents resided in Yonkers, 8.4% in White Plains, 5.2% in New Rochelle, 3.8% in Mount Vernon, 2.3% in Bronxville and 2% in Peekskill.

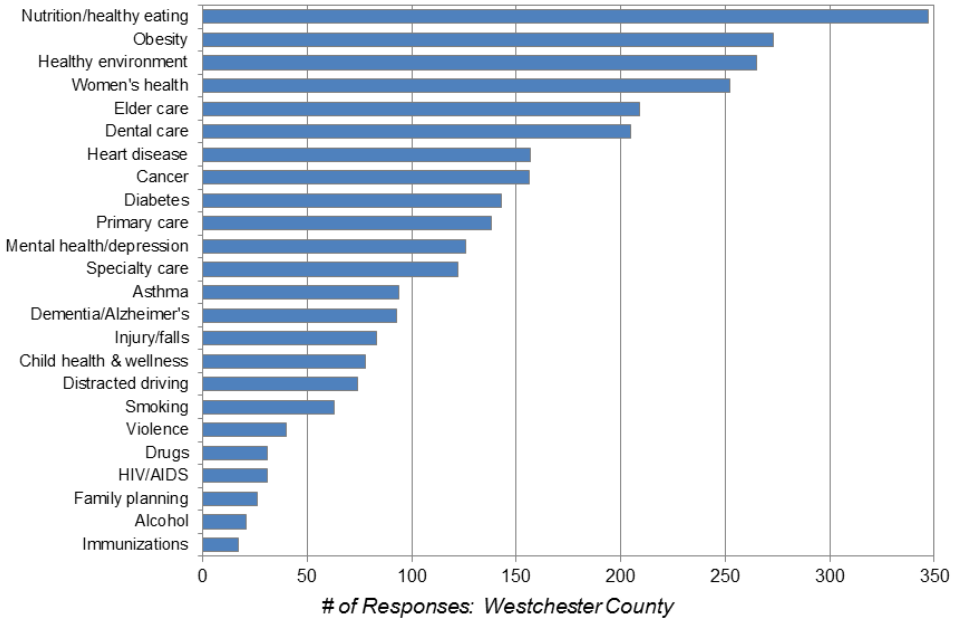
Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health. Participants were also asked to rank their own personal health priorities. The leading community health strategies identified included: drugs/drug abuse, elder care, obesity, mental health/depression and cancer (see **Figure 27**). The leading personal health priorities were nutrition/healthy eating, obesity, healthy environment, women's health and elder care (see **Figure 28**). The leading strategies identified included: exercise/weight loss programs, clean air & water, access to healthy food, elder care and affordable housing (see **Figure 29**).

Figure 27. Community health priorities as identified by the Westchester County Community Survey, 2016



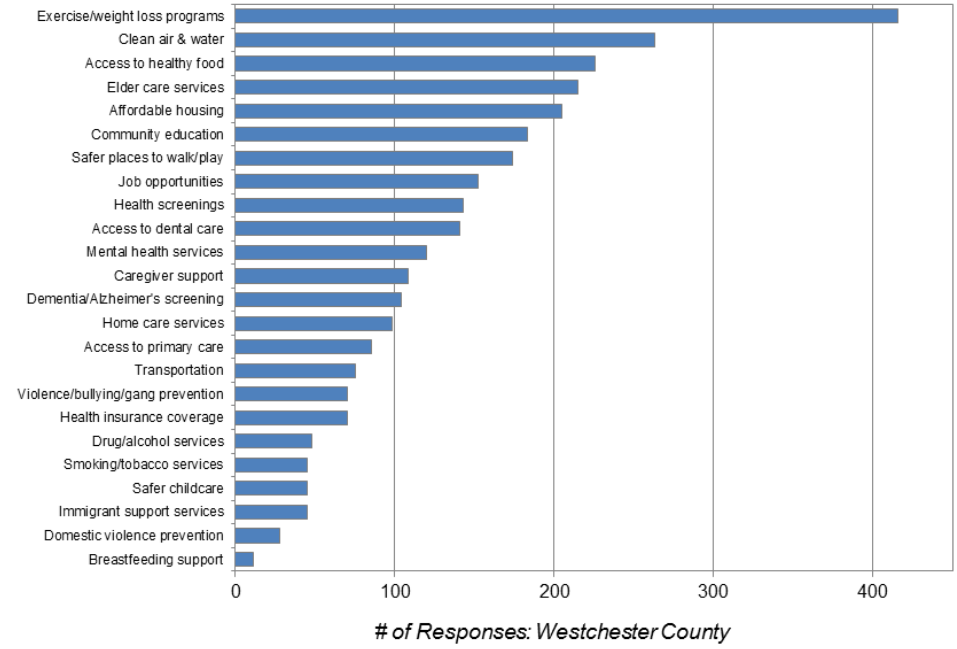
Data source: Westchester County Community Survey, 2016

Figure 28. Personal health priorities as identified by the Westchester County Community Survey, 2016



Data source: Westchester County Community Survey, 2016

Figure 29. Strategies to improve health among Westchester County residents from the Westchester County Community Survey, 2016



Data source: Westchester County Community Survey, 2016

Provider Survey Results

The provider survey was completed by 218 individuals. The leading community health priorities identified were mental health, drugs/drug abuse, access to specialty care, access to primary care, and elder care. Unlike the community surveys, obesity ranked 8th, as opposed to 3rd. Providers ranked access to both primary and specialty care more highly than community members, but both groups ranked drugs/drug abuse, mental health and elder care near the top.

Key Findings from Analysis

Despite each of these different methods and approaches to primary data collection in gathering community input, there was a consistent focus on obesity and related behaviors and outcomes among the main community health concerns. Obesity and its related behaviors have significant impact on chronic disease, therefore, it is intended that the programs that are detailed specifically for the reduction of obesity will also impact the prevalence of diabetes, hypertension, asthma, cancer and cardiovascular disease in Westchester County.

6. Potential Measures and Identified Resources to Meet Identified Needs

6a. Internal Resources and Measures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HPV Vaccine Clinic	The HPV Vaccine clinic is a stand-alone clinic open to the Montefiore community and local medical providers. It offers vaccines, education and counseling to women ages 19-26 in an effort to reduce the spread of sexually-transmitted HPV infection and the onset of cervical cancer. Before the creation of the program, many OB/GYN clinics, and providers of women's health in 19-26 year olds in the community had stopped providing the vaccine to women in this age bracket due to insufficient Medicaid coverage and low reimbursement. The clinic also seeks to correct billing issues and allow for vaccines to be provided through sponsored programs to low income women in	Increase in HPV vaccination rate	Prevent Chronic Diseases; Promote Healthy Women, Infants and Children

	order to make vaccine administration cost effective. This site also offers participation in ongoing research projects as well.		
Integrated Medicine and Palliative Care Team (IMPACT)	IMPACT is an interdisciplinary service that provides integrative palliative care to for pediatric patients facing life threatening or life limiting disease, and their care givers. Services include palliative and end-of-life care, pain management, mental health services, acupuncture, essential oil therapy, Reiki, yoga, massage, healing touch, nutrition and supplements, cooking classes, herbal medicine and homeopathy, among others. The team	Increase in patient satisfaction	Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse

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

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

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

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

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

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

	City. The families served hail from impoverished neighborhoods with few quality health care resources, and when homeless they face innumerable access barriers. The program launched with one mobile medical clinic and is now one of the largest providers of health care to homeless children in New York City. NYCHP's innovative service delivery model is comprised of fully equipped mobile clinics, small clinics in shelters, and a full-time health clinic in the South Bronx. A wide array of services is provided to attend to the complex health and psychosocial needs of homeless children, adolescents and adults:• Comprehensive primary care• Asthma care (Childhood Asthma Initiative)• Women's		

	health care• Dental care• Mental health counseling, assessment, crisis intervention, and referrals• Substance abuse prevention and referrals• Case management• Emergency food assistance• Children's nutrition education and physical activity program ("Cooking, Healthy Eating, Fitness and Fun" or CHEFFs)• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call NYCHP was one the first mobile medical programs in the country to achieve Level 3 Patient Centered Medical Home (PCMH 2008) recognition from National Committee for Quality Assurance (NCQA). NYCHP maintains a Community		

	Advisory Board (CAB) comprised of consumers/patients; CAB meetings are held each quarter at a different homeless family shelter and often include members new to the system. NYCHP relies on the CAB's input to ensure the effectiveness of services and that care remains responsive to the needs of the special population served.		
Office of Community and Population Health	Working closely with colleagues at Montefiore, the Albert Einstein College of Medicine and partners from a wide range of institutions, governmental agencies and community-based organizations, the Office of Community Health, a part of the Department of Community & Population Health, identifies community health needs, shares	Increase in accessibility to health care; Increase in community-based health interventions	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

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

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

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

Parent-to-Parent Support Group for Heart Transplants	Our program offers an educational forum for pre and post-transplant patients (21-75). The pre transplant patients get to know the transplant team and learn how to remain an active transplant candidate. The post transplant patients learn about all the issues that affect them after a kidney transplant. The environment is supportive and the patients are around others going through the same experiences. The support group provides the opportunity for patients to share stories, information, get advice, and receive emotional and spiritual support outside the family structure. It continues to be a great success.	Increase in patient satisfaction for heart transplant patients; Increase delivery of transplant information to patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

Phoebe H. Stein Child Life Program	The Child Life Program minimizes the stress of hospital and outpatient visits for pediatric patients and their families through educational and supportive services. In all areas of the hospital, Child Life Specialists help children understand and prepare for their medical experiences. Specialists accompany children to the operating room or to other procedures, teach parents to help their children cooperate with medical treatment and encourage normal growth and development.	Increase in patient satisfaction; Increase in satisfaction of patients' families	Promote Healthy Women, Infants and Children

Pregnancy Prevention Program in School Health	The Pregnancy Prevention Program provides confidential reproductive and sexual health services, mental health services, and population based prevention and health promotion programs on the classroom, school and local community levels at nine Bronx high school campuses housing 34 schools. An example is the Reducing the Risk curriculum was introduced through ninth grade classrooms to bring a validated sex education curriculum to all ninth grade students. The program aims to decrease rates of unplanned teen pregnancy and STI transmission and to increase rates of high school graduation. Reducing the Risk is one of the first rigorously evaluated sexual	Decrease in unplanned teen pregnancy; Decrease in STI transmission in teens; Increase in high school graduation rates; Increase in sexual education programs	Promote Healthy Women, Infants and Children; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

	education curricula to have a measurable impact upon behavior. The program is delivered the curriculum to students in the ninth grade before many become sexually active.		
Prostate Cancer Screening	Montefiore Medical Center in partnership with the Daily News offering free PSA blood tests for men age 40 and over. Event runs for 4 days in June at various Montefiore sites.	Increase in Prostate Cancer screening; Decrease in Prostate Cancer	Prevent Chronic Diseases
Psychosocial Oncology Program	The Psychosocial Oncology Program offers free counseling to those affected by cancer. Serving as the umbrella over a range of initiatives, the program includes Bronx Oncology Living Daily (BOLD Living) Program offering free wellness, creative arts,	Increase in patient satisfaction of Oncology patients	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

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

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

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

South Bronx Health Center for Children and Families (SBHCCF) and the Center for Child Health Resiliency	A unique family-centered health care program, SBHC serves the Morrisania and Hunts Point-Longwood neighborhoods of the South Bronx, one of the nation's most medically underserved, at-risk communities. SBHC is a Federally Qualified Health Center (FQHC) program that offers patients access to an enhanced medical home, a model of care that addresses all of their health care needs, and includes:• Primary care for children, adolescents and adults• Women's health and prenatal care• HIV testing, counseling, and primary care• Mental health counseling• Case management• Dental care• Nutrition counseling• WIC referrals• Substance abuse prevention and	Increase in accessibility of health care; Increase in utilization of health services	Prevent Chronic Diseases; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants and Children; Promote Mental Health and Prevent Substance Abuse; Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

	referrals• Emergency food assistance• Specialty care referral management & transportation assistance• Access 24/7 to medical providers on call SBHC's Center for Child Health and Resiliency (CCHR), opened in 2011, is a state-of-the-art facility with a special focus on early childhood development beginning prenatally through 5 years of age. CCHR's innovative programming supports families and equips parents with the nurturing skills needed to overcome stressors detrimental to children's healthy development. SBHC also offers innovative health programs on-site and in the local neighborhood that provide intensive care management, group sessions, and culturally		

	appropriate health education:• Childhood Asthma Initiative• Starting Right, a childhood obesity initiative, nutrition education and fitness program• Diabetes Program• HIV/AIDS Program• Pregnancy Group, prenatal visits with the benefit of group support and in-depth education• Well Baby Group, pediatric visits for infants up to 2 years • Healthy Teens Initiative and access to confidential reproductive health services SBHC is recognized by the National Committee for Quality Assurance (NCQA) as a Physician Practice Connections® – Patient-Centered Medical Home™ (PPC-PCMH) Program at Level 3 Recognition, the highest level available. SBHC maintains an active		

	Community Advisory Board (CAB) comprised of public housing residents and representatives of the South Bronx community (from tenant associations, schools, community based organizations, etc.). The CAB provides invaluable feedback on future plans, service changes, community changes/events, and strategies to draw in new health center patients.		
Strength Through Laughter and Support Program	Strength through Laughter and Support is an educational program that encourages participants to develop a positive attitude as they confront the challenges associated with cancer. By sharing laughter, sadness, wisdom and love in the group setting, participants find a sense of hope that helps them face the realities of living	Increase in patient satisfaction and quality of life of individuals with cancer	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

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

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

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

Women, Infants and Children (WIC) Program	Montefiore's WIC program is the oldest in New York State, established in 1974, and serves 13,000 women, infants and children. WIC is a supplemental nutrition program, providing supplemental food vouchers, nutrition education, breast feeding education, peer counseling and physical fitness education. Women are pre-screened for the program and receive a medical referral to the WIC program from providers, they qualify based on their income. Once they are screened, they receive counseling with a nutritional counselor. Vouchers are distributed for supermarket purchases on a monthly basis for three months' worth of fruits, vegetables, milk, eggs, juice, beans, bread,	Increase in healthy eating; Increase in consumption of fruits and vegetables; Increase in breast feeding; Increase in exercise; Decrease in BMI; Decrease in obesity	Promote Healthy Women, Infants and Children

	peanut butter, etc. Counselors encourage breastfeeding for new babies. At six months, new mothers receive vouchers for baby food and cereal. At 12 months, no more formula vouchers are given. Participants see a nutritionist every 3 months and qualification is verified annually. Group education, physical education and food demonstrations are given as well. Montefiore provides space and referrals.		
Wound Healing Program	The Wound Healing Program provides inpatient, outpatient, nursing home and home visiting wound healing services. The program focuses on building innovative, patient-centered health services delivery systems that work for wound patients in order to provide	Increase in positive outcomes for wound healing patients	Prevent Chronic Diseases

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

Neighborhood Health Fair	For over 35 years, the annual Neighborhood Health Fair is held with free health screenings including: breast exams, prostate exams, HIV screening, blood pressure, podiatry, diabetes risk assessments, dental exams, and lab/blood work for cholesterol and sickle cell anemia. A variety of health information is also distributed.	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
Refuge of Hope Health Fair	The annual Community Health and Wellness Fair in partnership with the Refuge of Hope Church in New Rochelle hosts services including: breast cancer screening and information on other cancers, blood pressure screening, diabetes risk assessments and nutrition information, and vision exams.	Screening for various chronic health issues. Mammograms provided free of charge for those eligible.	Prevent Chronic Diseases

Mall Walkers Program	Mall Walkers Program: A free, supervised walking program that meets three times per week at the local Galleria mall, and includes informative presentations plus free blood pressure screenings. Approximately 50 walkers participate in the program each week.	Increase in physical activity; Decrease in BMI; Decrease in obesity	Prevent Chronic Diseases
Physician Referral Service	Physician referral service: free 24-hour multi-lingual service providing callers with names of primary care 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; Prenatal Exercise Classes, including prenatal yoga, mommy and me yoga; Expectant Parent Tours of our Maternity floors are also available.	Increase breastfeeding rates; Increase in positive outcomes for labor & delivery patients/mothers	Promote Healthy Woman, Infants and Children
Breast Cancer Patient Navigation Program	The Breast Cancer Patient Navigator is the bridge between the community and health care. We eliminate complexity bringing together interdisciplinary teams to work towards reducing breast cancer rates by assessing,	Increase in screening for breast cancer; Decrease in breast cancer	Prevent Chronic Diseases

	educating, scheduling, and guiding our patients through the screening process. Our aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-show and cancellation rates.		
Pancreatic Cancer Early Detection Program	The Pancreatic Cancer Early Detection Program is part of the Digestive Cancer Program at WPH, which applies a modern and comprehensive approach to caring for people with malignancies of the gastrointestinal tract. It features clinical research, coordination of ancillary services, and community outreach, as well as a cancer conference devoted solely to cancers of the digestive tracts. It has an emphasis on early detection, cutting edge advances, and	Increase in screening for pancreatic cancer; Decrease in pancreatic cancer	Prevent Chronic Diseases

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

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

	the regions served by Montefiore.		
Oral Head and Neck Screening	Screening for Oral Head and Neck Cancer. Event takes place at MECCC and WPH in April.	Increase in screening for Oral Head and Neck Cancer; Decrease in Oral Head and Neck Cancer	Prevent Chronic Diseases
Ostomy Support Group	The Ostomy Support Group is a supportive service for community members who have undergone any kind of Ostomy diversion, regardless of their affiliation with the hospital. Seasoned participants help new members cope with challenges in their disease process. Each group lasts for eight sessions and also functions as a referral source for the Dept. of	Increase in general satisfaction of individuals who have undergone ostomy diversion	Prevent Chronic Diseases; Promote Mental Health and Prevent Substance Abuse

	Psychosocial Medicine at Einstein when members need one-on-one counseling.		

6b. New York State Health Improvement Plan – Implementation Plan and Measures

As a part of the submission for the New York State Health Improvement Plan for 2016-2018, required by the New York State Department of Health, White Plains Hospital has elected to retain these two priority areas, Prevent Chronic Disease and Promote Healthy Women Infants and Children and has selected three broad focus areas in which to implement programs. These broad focus areas are (1) Promote use of evidence-based care to manage chronic diseases, (2) Increase screening rates for cardiovascular diseases; diabetes; and breast, cervical and colorectal cancers, especially among disparate populations., and under the priority Promote Healthy Women Infants and Children the goal of (3) Increase the proportion of babies who are breastfed in New York State was selected. Across these focus areas, goals, with specific interventions, performance measures and time frames, were identified, and are described below.

Priority Area: Preventing Chronic Disease
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Goal	Goal #3.2: Promote Use of Evidence-Based Care to Manage Chronic Diseases Implementation of evidence-based Medicine Guidelines for Asthma Management
Outcome Objectives	Objective 3.2.1: By December 31, 2018, reduce the asthma emergency department visit rate: • By 28% from 218.3 per 10,000 (2007-2009) to 156.9 per 10,000 for residents ages 0-4 years. • By 20% from 81.6 per 10,000 (2007-2009) to 65.4 per 10,000 for residents ages 5-64 years. • By 29% from 31.4 per 10,000 (2007-2009) to 22.3 per 10,000 for residents ages 65 years and older. • By 10% from 83.4 per 10,000 (2007-2009) to 75.1 per 10,000 for residents of all ages. (Data Source: SPARCS) (PA Tracking Indicator; Health Disparities Indicator)

Goal	Goal #3.2: Promote Use of Evidence-Based Care to Manage Chronic Diseases Implementation of evidence-based Medicine Guidelines for Asthma Management
Interventions/Strategies/ Activities	Increase the proportion of patients completing asthma action plans at the Family Health Center with ongoing data collection and monitoring of all asthmatic patients through the electronic medical record (EMR). Implement protocol for Emergency Department providers and healthcare team members (including the RN, Tech, and Respiratory Therapist) to implement the use of an asthma action plan with each asthmatic patient presenting in the ED. The evidenced-based guidelines will be followed to ensure a decrease in asthma-related emergency department visits and admissions. The healthcare team will utilize the asthma action plan to review medications and their dosages for both the patients' current attack and daily/long-term control. The other portion of the plan that is not pictured is a "Trigger Tracker Tool" to help assist patients during their self-evaluations.
Process Measures	Number of participants trained by respiratory team and/or Family Health Center practitioners. Increase in number of youth/adults/perinatal patients informed on Asthma Action Plan.
Partner Role	Work with El Centro Hispano (ECH) to increase participation by community residents in screenings as a trusted community stakeholder. Coordination with ECH and other local CBOs to address cost related concerns for patients to ensure they engage in care.
Partner Resources	Local CBOs: Access to community members (youth/seniors/WIC participants). Access to municipal and civic leadership to advance educational objectives
By When	December 31, 2018
Will Action Address Disparity	Yes. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic.

Priority Area: Preventing Chronic Disease
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Goal	Goal #3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.
Outcome Objectives	Objective 3.1.3: By December 31, 2018, increase the percentage of adults (50-75 years) who receive a colorectal cancer screening based on the most recent guidelines (blood stool test in the past year or a sigmoidoscopy in the past 5 years and a blood stool test in the past 3 years or a colonoscopy in the past 10 years: • By 5% from 68.0% (2010) to 71.4%. In November 2015, a revised target of 80% was set for 2018. • By 10% from 59.4% to 65.4% for adults with an income <$25,000. (Data Source: NYS BRFSS) (Data Availability: state, county), HP 2020 (C-16) target: 70.5% (all adults)
Interventions/Strategies/ Activities	Screening: The Hospital aligns uninsured/underinsured/ineligible patients to the Cancer Services program to support coverage for evidence-based cancer screening exams in ways that are age and gender appropriate, and that take into consideration individual risk/benefit – to detect certain cancers at an early stage, when management or treatment has the best chance for a positive outcome. Health Promotion and Education: The Hospital actively educates and informs the communities it serves about cancer prevention, screening, clinical trials, quality care, and survivorship. WPH promotes engagement and participation in healthy community initiatives. White Plains Hospital organizes screening and prevention programs throughout the year in the community at large.
Process Measures	Number of events held, number of participants; engagement rates with the American Cancer Society and the Colon Cancer Foundation.

Goal	Goal #3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.
Partner Role	Partners provide educational materials, provide educational support and linkage to national programs for patients and their families beyond hospital services.
Partner Resources	Local CBOs: Access to educational materials and national resources. Access to linguistic materials specific to disease conditions.
By When	December 31, 2018
Will Action Address Disparity	Yes. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic.

Priority Area: Promoting Healthy Women, Infants and Children
Focus Area: Focus Area 1 - Maternal and Infant Health

Goal	Goal #2: Increase the proportion of NYS babies who are breastfed.
Outcome Objectives	Objective 2-1: By December 31, 2018, increase the percent of infants born in NYS who are exclusively breastfed by at least 10% to 48.1%. Percentage of infants exclusively breastfed in the hospital: All infants • (Target: 48.1%; Baseline: 43.7%; Year: 2010 • Source: NYSDOH Vital Records • Data Availability: State, county) Ratio of Black non-Hispanic to White non-Hispanic infants exclusively breastfed in the hospital • (Target: 0.57; Baseline: 0.52; Year: 2010 • Source: NYS Vital Records • Data Availability: State, county) Ratio of Hispanic to White non-Hispanic percentage of infants exclusively breastfed in the hospital

Goal	Goal #2: Increase the proportion of NYS babies who are breastfed.
	• (Target: 0.64; Baseline: 0.58; Year: 2010 • Source: NYS Vital Records Data Availability: State, county) Ratio of Medicaid to non-Medicaid percentage of infants exclusively breastfed in the hospital • Target: 0.66; Baseline: 0.60; Year: 2010 Source: NYS Vital Records Data Availability: State, county)
Interventions/Strategies/ Activities	White Plains Hospital is engaging in the certification process for the New York State Baby Friendly Initiative; alignment with the infant mortality reduction initiatives and perinatal health objectives sponsored through the Greenburg Health Practice of the Mount Vernon Neighborhood Health Center.
Process Measures	White Plains Hospital will evaluate its breastfeeding implementation rates against the standard established by the WIC Breastfeeding Data Local Agency Report. Will be collected and tracked to monitor trending over the CSP Period.
Partner Role	Engagement and referral into appropriate programs (clinical or community) to support mothers at risk for preterm delivery, including non-maternity based programs that correlate to social determinants of health that impact prematurity.
Partner Resources	Technical assistance, supportive community programming, visit assistance.
By When	December 31, 2018
Will Action Address Disparity	Yes. The community serviced through the proposed program is generally low-income and includes a high proportion of individuals who are non-Hispanic black or Hispanic.

6c. External Resources and Linkages

In addition to the multiple resources that have been developed at White Plains Hospital independently and through partnership with other organizations, (described in Section 7a), there is an extensive need for community-based programs and resources that that can augment the Hospital's programs and services. Knowing how to access those resources is a particular challenge for the health care sector. However, since the previous version of this report in 2013,

multiple free and lost cost online search tools have been developed, such as www.auntbertha.com , www.hitesite.org , www.nowpow.com among others. These are a much more comprehensive and practical alternative to the home-grown referral guides that many health care providers have had to use in the past. Those were hard to keep-up-to-date and difficult to search, a problem that is largely addressed by the online versions. . Many White Plains Hospital sites have been introduced to these new online resources and work is underway to more seamlessly integrate this kind of solution into the various workflows across the ambulatory, ED and inpatient settings.

7. Appendix

Westchester County Provider Survey and Consumer Survey
Electronic versions of the Westchester County Provider and Consumer Survey was provided and distributed in five languages (English, Spanish, Arabic, French Creole, and Chinese).

The provider survey was designed to provide reflective comparative insight to the questions being asked of consumers of service.

Westchester gov.com

Robert P. Astorino, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

WESTCHESTER COUNTY COMMUNITY HEALTH SURVEY

We want to hear your thoughts about important health issues in your community. Together, the Westchester County Health Department and hospitals throughout Westchester County, NY, will use the results of this short survey and other information to help improve health programs in your community. Your responses are completely anonymous. You may also take the survey at https://www.surveymonkey.com/r/CommunityHlthSurvey2016 if you prefer. Thank you for your participation!

What are the THREE biggest ongoing health concerns for the COMMUNITY WHERE YOU LIVE?

- ☐ Access to immunizations
- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other *(please specify)* : _____

What are the THREE biggest ongoing health concerns for YOURSELF?

- ☐ Access to immunizations
- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other *(please specify)* : _____

What THREE things would be most helpful to improve YOUR health concerns?

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

How would you describe your overall health?

- ☐ Very healthy
- ☐ Healthy
- ☐ Somewhat healthy
- ☐ Unhealthy
- ☐ Very unhealthy
- ☐ Other *(please specify)* : _____

How would you describe your overall mental health?

- ☐ Very healthy
- ☐ Healthy
- ☐ Somewhat healthy
- ☐ Unhealthy
- ☐ Very unhealthy
- ☐ Other *(please specify)* : _____

Do you suffer from any chronic health conditions (*check all that apply*)

- ☐ None
- ☐ Asthma/breathing problems
- ☐ Auto-immune disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Disability
- ☐ Drug/alcohol abuse
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Memory issues
- ☐ Mental health
- ☐ Overweight/obesity
- ☐ Other *(please specify)* : _____

Do you have a health care provider for checkups and visits:		☐ Yes _____ ☐ No _____
How long has it been since you visited a health care provider for a routine physical exam or checkup?		
☐ In the past year	☐ In the past five years	☐ Never
☐ In the past two years	☐ Five or more years ago	☐ Don't know
What THREE things prevent YOU from getting medical care from a health care provider?		
☐ Nothing prevents me from getting medical care	☐ Cultural/religious beliefs	☐ Insurance does not cover service
	☐ Don't know how to find providers	☐ No transportation/too far
☐ Cannot afford	☐ Don't like going/afraid to go	☐ No childcare
☐ Cannot find a health provider who speaks my language	☐ Don't see the benefit	☐ No insurance
	☐ I have no time	☐ Other *(please specify)* : _____
☐ Co-pay/deductible too high	☐ Inconvenient office hours	
In the past 12 months, did you receive care in the emergency room?		☐ Yes _____ ☐ No _____
If yes, what is the ONE main reason for your emergency room visit?		
☐ Could not find a local health provider who speaks my language	☐ Health provider said go to emergency room	☐ Thought problem too serious for a doctor's visit
☐ Doctor's office not open	☐ No other place to go	☐ Other *(please specify)* : _____
☐ Emergency room is the closest provider	☐ Receive most of my care at emergency room	
Where do you and your family get most of your health information? (*check all that apply*)		
☐ Community-based organization	☐ Internet	☐ School/college
☐ Doctor/Health professional	☐ Library	☐ Social media (Facebook, Twitter, etc.)
☐ Family or friends	☐ Newspaper/magazine	☐ Television
☐ Health department	☐ Radio	☐ Worksite
☐ Hospital	☐ Religious organization	☐ Other *(please specify)* : _____

For statistical purposes only (your responses are anonymous), please complete the following:		
I identify as:	**What is your age:**	
☐ Male	☐ 18-24	☐ 55-64
☐ Female	☐ 25-34	☐ 65-74
☐ Other	☐ 35-44	☐ 75+
	☐ 45-54	
Zip code where I live _____	**Town/city where I live** _____	
Are you Hispanic or Latino?	☐ Yes	☐ No
What category best describes your race?		
☐ White/Caucasian	☐ American Indian/Alaskan Native	☐ Multi-racial
☐ Black/African American	☐ Asian/Pacific Islander	☐ Other
What is the primary language you speak?		
☐ English	☐ Portuguese	☐ Tagalog
☐ Spanish	☐ French	☐ Korean
☐ Italian	☐ Chinese	☐ Other *(please specify)* : _____
What is your highest level of education?		
☐ Less than high school	☐ Some college	☐ Other *(please specify)* : _____
☐ High school grad/GED	☐ College graduate	
☐ Technical school	☐ Advanced degree	
What is your current employment status		
☐ Employed	☐ Student	☐ Retired
☐ Not employed	☐ Military	☐ Other *(please specify)* : _____
Do you have any of the following types of health insurance?		
☐ Medicare	☐ Private insurance	☐ None/no insurance
☐ Medicaid	☐ Tri-Care	☐ Other *(please specify)* : _____

Please return the survey by June 20, 2016 .
Email: bqlc@westchestergov.com Fax: 914-813-4303.
Mail: Bonnie Lam, Department of Health, 10 County Center Road, 2nd Floor, White Plains, NY 10607-1541