Community Health Needs Assessment, Implementation Strategy & the NYS Comprehensive Community Service Plan Report 2025-2027

White Plains Hospital

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

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[COVER PAGE]

- **Identify County/Counties or service area covered in this assessment and plan**
  White Plains Hospital's service area is Westchester County, New York.

- **Indication of Individual or joint plan**
  - White Plains Hospital is submitting an individual plan.
  - White Plains Hospital did not engage or use any outside entity to complete this assessment and plan.

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A. Executive Summary:

White Plains Hospital has a deep, long-standing commitment to improving community health, actively collaborating with both community and governmental partners. Our coordinated approach to population health is clearly demonstrated in our Community Health Needs Assessment (CHNA) and Community Service Plan (CSP) Report. These documents highlight our efforts to advance the well-being of the community we serve.

1. **Prevention Agenda Priorities:** Analysis of the primary and secondary data highlighted three priorities of health needs.

   These findings were significant across all populations surveyed and demonstrated strong alignment with the priorities of the New York State Prevention Agenda & Healthy People 2030.

   For the 2025-2027 CSP, White Plains Hospital has selected three prevention agenda priorities:

   - **Prevention of Infant and Maternal Mortality** with a specific focus on improving health outcomes by lowering morbidity rates for infants and birthing persons.
     SMARTIE OBJECTIVE 27.1 Decrease the rate of maternal mortality among Black, non-Hispanic birthing Persons.

   - **Promote Healthy Eating** with a focus on making nutritious, culturally appropriate foods available.
     SMARTIE OBJECTIVE 19.1 Decrease the percentage of adults with an annual household income less than $50,000 who consume no fruits or vegetables daily from 31.7% to 30.1%.

   - **Prevention Services for Chronic Disease Prevention and Control** with a specific focus on reducing disparities in access and quality of evidence-based preventative and diagnostic services for chronic diseases.
     SMART OBJECTIVE 32.0 Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7% .

2. **Data Review Process:** The process to identify the needs of the community involved the collection of both primary and secondary data. The collection of primary data, from a sample of Westchester County residents, was crucial to the development of the Community Service Plan. Feedback was compiled from 3,410 respondents and identified community concerns by municipality to support the priority selections. Additionally, a

review of this data was conducted with external partners, helping to frame the development of the report. These collaborations and partnerships are described in detail in this document.

3. **Partners and Roles – Community Engagement:** As a leading healthcare provider and established community member in Westchester County, White Plains Hospital is committed to working with its staff and external partners to meet the health needs of our patients and the community. This Community Service Plan (CSP) directly outlines the individuals, groups, and organizations involved in these efforts. Developed in tandem with our Community Health Needs Assessment (CHNA), the CSP is strongly aligned with its core findings, ensuring that we continue to effectively implement existing program initiatives alongside our valued partners. The Hospital engages the Healthy Community Initiative (HCI) subcommittee, described later in this report, throughout the year and will share updates with this workgroup three times per year. In 2026, HCI will meet in February, May, and October.

4. **Interventions and Strategies:** All interventions and strategies are detailed in the CSP 2025-2027. Interventions selected are evidenced-based and most strategies are provided per the Prevention Agenda [2025-2030 NYS Prevention Agenda].

Prevention of Infant and Maternal Mortality

WPH is dedicated to safeguarding the health of expectant mothers and infants. We will continue the following key initiatives to drive equitable outcomes:

- Collaboration with the NYS Birth Equity and Inclusion Project with the aim of decreasing Primary Cesarean Section (PC02 C/S) rates for all patients and especially in black non-Hispanic mothers delivering at WPH.
- Expanding educational access by increasing the availability and accessibility of Childbirth Education.
    - Increasing number of outpatient prenatal classes, specifically Childbirth Education, expanding the class schedule and ensuring financial assistance is readily available for families facing financial hardship.
    - Create and distribute patient education materials to obstetric offices.
    - Increase the availability of virtual education available to all patients.
- Enhancing data integrity by collecting race data and abstracting 100% of the patient population.
- Nursing Education: Spinning Babies Workshops focused on educating birthing professionals on physiological birth practices, and how to work with fetal positioning to support labor progression.

Healthy Eating

To support the need for healthy and nutritious food and its correlation to the rising incidence of Type II Diabetes in adults, WPH will expand programming focused on healthy lifestyle counseling by:

- Expanding the ED-to-Home Diabetes Program by increasing the number of patients with poorly controlled diabetes enrolled in this telehealth-based initiative for coordinated follow-up care.
- Increasing number of interactions with providers who will provide counseling on healthy eating, physical activity, or weight and self-monitoring tools to manage their diabetes.

Prevention Services for Chronic Disease Prevention and Control - Hypertension
WPH will address hypertension management and education in the community, narrowing in on communities that are disproportionately affected by undiagnosed or uncontrolled hypertension. Interventions will:
- Implement a hypertension remote patient monitoring program for hypertension case management.
- Provide stroke prevention education to at-risk communities.
- Provide Blood Pressure Screening Program, with a pathway to establish follow-up care.

5. **Process, Progress, and Evaluation:** The Hospital will use a comprehensive set of metrics to monitor and track the impact of our initiatives. To ensure progress and evaluate community impact, the Hospital has established cross-functional workgroups to meet on a quarterly basis where key stakeholders will analyze performance data, identify areas for improvement, and refine intervention strategies on a quarterly basis.

Prevention of Infant and Maternal Mortality, White Plains Hospital will measure:

Process Measures:
- Primary Cesarean Section (PC02 C/S) rate of Black non-Hispanic mothers.
- Educational Access:
    - Childbirth Education Classes: Number of executed sessions and number of attendees/participants will be tracked and assessed.
    - 100% of OB/GYN providers, who deliver at the Hospital, will have access to maternal patient education.
    - Nursing Education: 100% of Labor & Delivery registered nurses to complete Spinning Babies workshop.
    - Obstetrics (OB) Navigation Program: Number of completed OB navigator interactions to increase 15% each year.

Outcome Measure/Objective:

- Decrease the rate of maternal mortality per 100,000 live births among Black, non-Hispanic birthing persons from 65.2 to 55.0.

<u>For Healthy Eating</u> with a focus on making nutritious, culturally appropriate foods available priority, WPH will track:

<u>Process Measures</u>:

- Number of patients with poorly controlled diabetes enrolled in the ED-to-Home Program, a telehealth-based initiative for coordinated follow-up care and medication optimization, with the goal of expanding patient enrollment by 5% each year.
- The number of provider interactions with the aim of counseling on healthy eating, physical activity, or weight and self-monitoring tools to manage their diabetes, with the goal of expanding interactions by 5% each year.
- Number of patients enrolled in the Food is Medicine program, which provides patients who screen for food insecurity, delivery of fresh and shelf-stable food and targeted nutrition education for a period of six months with a goal of serving 200 patients each year.

<u>Outcome Measures/Objectives:</u>

Decrease the percentage of adults with an annual household income of less than $50,000 who consume no fruits or vegetables daily from 31.7% to 30.1%.

<u>Prevention Services for Chronic Disease Prevention and Control - Hypertension</u>, the Hospital will measure:

<u>Process Measures</u>:

- Enrollment of Remote Patient Monitoring (RPM): Patients enrolled will receive coordinated follow-up care, medication reconciliation and resources with a goal of 20% enrollment of patients meeting criteria each year.
- Number of Stroke Prevention lectures given in the community and participants in attendance, with the aim of providing 4 lectures per year. A survey will be provided at the end of each lecture to gauge participant satisfaction and intent to receive follow-up care.
- Number of Blood Pressure Screenings performed and percentage of elevated screenings participants that received a plan of care.

<u>Outcome Measures/Objectives</u>:

- Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.

B. Community Health Assessment (CHA)

White Plains Hospital is a proud member of the Montefiore Health System and serves as its tertiary hub of advanced care in the Hudson Valley. The Hospital is a 292-bed not-for-profit

health care organization with the primary mission of providing exceptional acute and preventive medical care to all people who live in, work in or visit Westchester County and its surrounding areas. White Plains Hospital has outpatient medical facilities across Westchester, including multispecialty practices in Armonk, Hawthorne, Larchmont, New Rochelle, Rye Brook, Scarsdale, Somers, Yonkers and Yorktown Heights; and Scarsdale Medical Group locations in Harrison and Scarsdale.

The Hospital is fully accredited by the Joint Commission, and in 2025 received another 5-star rating from the Centers for Medicare & Medicaid Services (CMS) — the highest distinction offered by the federal agency – for the fourth consecutive year. In addition, the Hospital received its third Magnet® designation from the American Nurses Credentialing Center (ANCC), a distinction held by only two percent of hospitals in the country. White Plains Hospital has consistently received the Outstanding Patient Experience Award from Healthgrades®, and in 2025 was awarded an "A" Safety Grade from the Leapfrog Group for the 14th consecutive time. White Plains Hospital's mission extends beyond inpatient and outpatient care to include assessing and improving the health of our residents, 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 rooted in 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.

1. Community Description

Service Area:
White Plains Hospital has identified Westchester County as its primary service area Westchester County occupies 430.7 square miles and is home to over 1 million people, according to the US Census Bureau Population Data as of 2020. Its physical environment ranges from urban centers to quiet rural landscapes. It is the 7th most populous county in New York State.

In 2024, the median household income for Westchester was $99,489, the 4th highest in New York State after Nassau, Putnam and Suffolk counties and significantly higher when compared to the national medial household income of $83,730, according to the United States Census Bureau Population Survey.

Westchester County is the 6th healthiest county in New York State, according to the County Health Rankings, produced by the University of Wisconsin. Residents of Westchester County have access to a number of community resources including public and private schools, open spaces, healthcare facilities, community gardens, bike lanes and much more. Despite its overall

high ranking, there is considerable room to improve the health of the population in Westchester County, while also reducing health disparities for both high-need populations and those with poorer health outcomes.

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

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

White Plains is also ethnically diverse. Its population is 46.5% non-Hispanic white, 31.6% Hispanic, 12.4% non-Hispanic black, 7.7% Asian/Pacific Islander and 1.8% non-Hispanic other. Almost one-third (31.4%) of its residents are foreign-born. Among the foreign-born population, more residents speak Spanish (45%) than English (3.2%). The city's foreign-born population come from diverse corners of the globe (in order of frequency): Mexico (21.3% of foreign-born), Peru (11.5%), Dominican Republic (5.6%), Colombia (6.1%), India (5.2%), China (2.8%), Jamaica (3.9%), Guatemala (3.7%),Korea (3%), El Salvador (2.9%) and Ecuador (2.9%).

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

A similar proportion of the population is insured (91.8% versus 94.6% in the county) and a higher proportion are uninsured (8.2% versus 5.4% in the county). 1.5% of White Plains households are on cash public assistance, lower than the percentages in Westchester County (2.0%) and New York State (3.4%). The White Plains unemployment rate is 5.6%, which is the 5th highest in Westchester County. 51.2% of White Plains residents ages 25 and older have received at least a bachelor's degree, higher than countywide (49.7%) and statewide (37.5%) attainment rates.

2. Health Status Description

Data Sources:
The identification and selection of priority items was supported by a rigorous analysis of multiple data sources, followed by a review with our partners. The sources used for this secondary data analysis are summarized in the Supplemental Information section. This methodology ensured that our findings addressed concerns beyond the scope of direct experience and observation.

Data Collection Methods:

Primary

In 2025, Greater New York Hospital Association (GNYHA) offered member hospitals and health systems the opportunity to participate in the GNYHA Community Health Needs Assessment (CHNA) Survey Collaborative during the planning year of the New York State 2025-2030 *Prevention Agenda*. The Collaborative complemented longstanding GNYHA efforts to help members with the Community Service Plan (CSP) development and implementation process.

Hospitals are required to conduct a CHNA and develop an implementation strategy every three years. Engaging with the community to receive input on health needs is essential to the process. While not a required element of a CHNA, the collaborative survey is a part of White Plains Hospital and the Montefiore Health System CHNA and implementation strategy, known collectively as a CSP in New York State, along with other community engagement efforts and secondary data from public health departments.

GNYHA developed a health needs assessment survey with member input from community and safety net hospitals, small health systems, and large academic medical centers. Collaborative participants received from GNYHA a common survey available in 19 languages on paper and online to distribute in their communities. GNYHA hosted the survey online, collected data, analyzed results, and created custom reports for each participating hospital. Collaborative members recruited participants from their communities for the survey, with more than 16,400 community members responding.

As a participating Hospital of the CHNA Survey Collaborative, we received the following resources and support before, during, and after the initiative:

- Promotional materials and marketing templates to share the survey
- Support and strategies to reach populations of focus
- Web-based survey available in 19 languages
- Bi-weekly geographic and demographic reports by Zip code or county to increase response rates
- GNYHA staff data management, cleaning, analysis, and reporting
- Comprehensive Excel codebook with health issues rankings, cleaned survey data, and raw data
- Multiple forums and office hours throughout the year and one-on-one technical assistance

Members provided input in multiple stages through a collaborative and iterative process to design the 2025 CHNA collaborative survey. GNYHA employed best practice approaches in survey design and needs assessment when developing the survey. The survey used validated questions from existing surveys such as the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System and the New York City Department of Health and

Mental Hygiene's Community Health Survey. GNYHA minimized the respondent burden by keeping the survey length to a minimum.

Community members could complete the survey online in a format compatible with mobile devices. Collaborative members also received copies of the survey to distribute and use for data collection in 19 languages, including English and the top 16 languages spoken among non-English speakers as designated by New York State. Before the collaborative began, participating hospitals provided GNYHA with a list of the counties or Zip codes where the hospital would field the survey. GNYHA attributed respondents who lived in a hospital's survey service area to that hospital. Hospitals recruited members of their community to participate in the survey and entered data from paper surveys online. Each hospital received a report with data from respondents who live in that service area.

Secondary Data Analysis
The secondary data used to identify community health needs is described in our Community Service Plan and listed in our Supplemental Information section of this report. The secondary data evaluation consists of two distinct approaches. First, we used data from internal databases to examine the leading causes of inpatient hospitalization and Emergency Department visits for White Plains Hospital. Second, we completed an assessment of secondary data for health indicators from several population-based data sources.

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

White Plains Hospital continues to be deeply rooted in the community, partnering with local organizations, elected officials, Westchester County Department of Health and other community-based organizations. The Hospital's staff (including doctors, nurses, and other personnel), volunteers and board members are committed to improving population health and regular potentiating in community events.

To further broaden engagement in the 2025 community health survey, WPH partnered with Westchester County and our *Healthy Community Initiative* Task Force, in addition to other community organizations, groups, and individuals to best understand our community's needs. The *Healthy Community Initiative's* mission is to positively impact the overall health of our community in a holistic way, working with municipal, community and private partners to create programs that focus on prevention and overall wellbeing. Task Force members include:

- Beth Bricker, City of White Plains Parks & Recreation Commissioner

- Heather Miller, Executive Director, Thomas H. Slater Center
- Frank Williams, Executive Director, White Plains Youth Bureau
- Bernard Thombs, African American Men of Westchester
- Helena Marescot, Director of Health & Wellness, Youth Bureau
- Brad Kerner, Vice President, Community Engagement and Impact, Feeding Westchester
- Deborah Hertz, Director of Strategic Programs and Quality Assurance, Lifting Up Westchester
- Reverend Erwin Lee Trollinger, President, Ministers Fellowship Council; Pastor, Calvary Baptist Church
- Judith Aucar, Executive Director, El Centro Hispano, Inc.
- Honorable Jewel Williams Johnson, Westchester Couty Board of Legislators Health Chair
- Jessy Mendez, Director of Arts Education, ArtsWestchester
- Denise Brooks, Deputy Director, White Plains Housing Authority
- Amy Ansehl, Associate Dean, School of Health Sciences and Practice, New York Medical College

The Task Force was instrumental in enabling the Hospital to gain a deeper, more actionable understanding of our community's needs and health priorities.

Through this collaborative partnership and ongoing communication, the Hospital maintains a pulse on community needs, allowing us to how to effectively address communities wellness goals, identify gaps in care, and ensure alignment with NYS Prevention agenda initiatives.

Relevant Health Indicators

Westchester County continues to show better than average health standings when compared to other counties in New York State, and especially when compared to average counties in the nation (see figure below).

Westchester County Population Health and Well-being - 2025

Diagram summarizes data released on 03/19/2025

Westchester, New York | County Health Rankings & Roadmaps

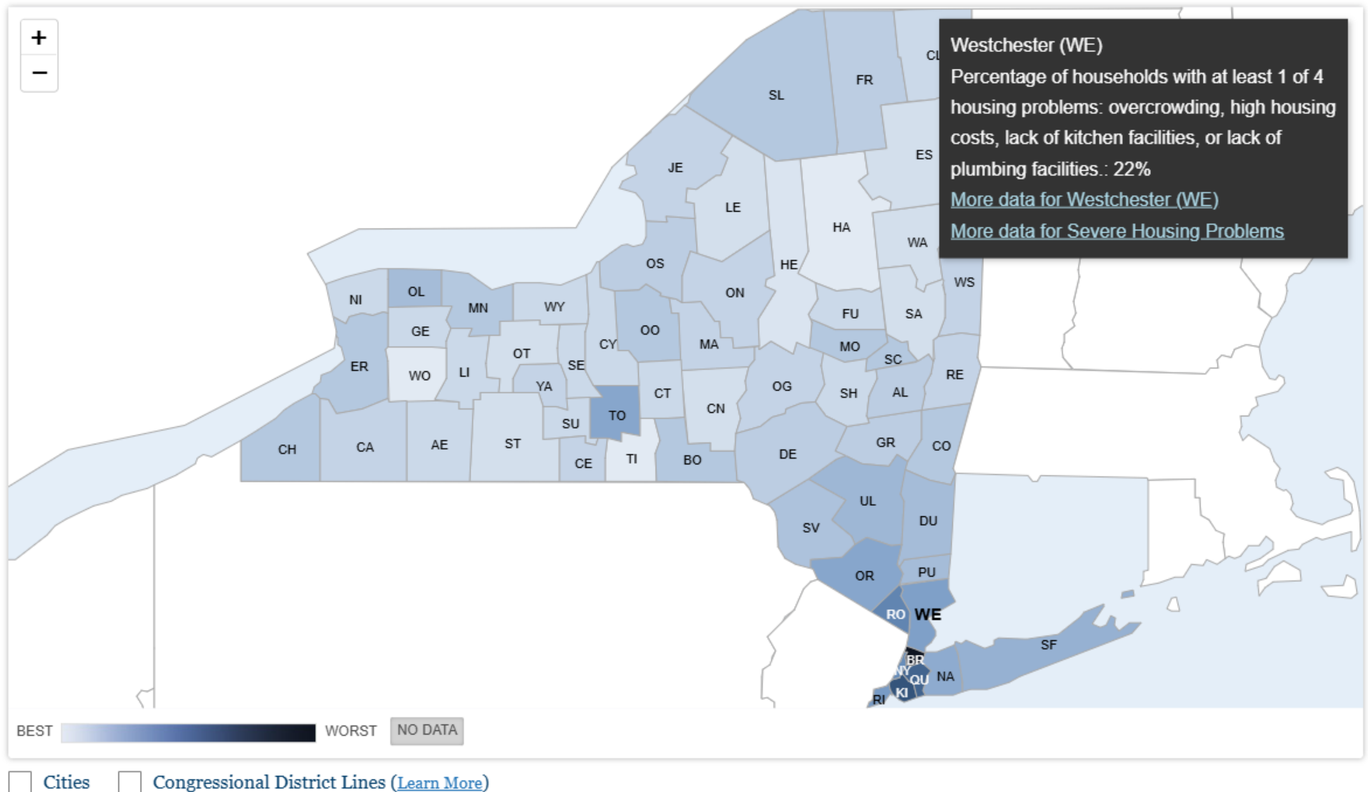
University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps

However, there are community conditions which negatively impact Westchester County residents, such as severe housing problems as well as unemployment rates. In Westchester County 22% of households experienced housing problems, slightly below New York State at 23% but significantly higher than overall Unites States of 17%. Housing problems, defined as overcrowding, high housing costs, lack of kitchen facilities or lack of plumbing facilities, all of which are deterrents when trying to maintain a healthy diet and overall lifestyle.

These environmental factors significantly perpetuate health disparities across our community, resulting in poorer health outcomes.

County Health Rankings & Roadmaps

2025 Severe Housing Problems - New York



University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps

Health Challenges and Associated Risk Factors

Some parts of Westchester County NY face elevated health risks and disparities. For example, the age-adjusted mortality rate per 100,000 is higher for non-Hispanic Black (757.4 per 100,000) and non-Hispanic White (587.9 per 100,000) populations are significantly higher than for the Hispanic population (526.4 per 100,000) than Asian/Pacific Islander population (356.9 per 100,000).

Geographic variation that translates to health outcomes also exists across the county. There is geographic variation in the percentage of children and adolescents with obesity with the top five largest percentage being Port Chester-Rye Union Free School District (26.7%), Peekskill City School District (24.2), Ossining Union Free School District (20.7), New Rochelle City School District (19.4), and Greenburg Central School District (18.6). The lowest rates are Scarsdale Union Free School District (4.3%), Edgemont Union Free School District (4.9), Blind Brook- Rye School District (5.8) Byram Hills Central School District (5.8), and Briarcliff Manor Union Free School District (6.1). City of White Plains is on the higher range with 17% of children and adolescents with obesity.

Related to Emergency Department Visits in the county, there is geographic variation in the rate of Emergency Department visits for asthma. For instance, the city of White Plains ZIP 10601 asthma emergency department visits rate per 10,000, aged 0-17 years is 77.7. This is significantly better than the rate in ZIP 10550, Mt. Vernon, which has an asthma emergency department visit rate of 146.6; comparatively to the lower end Katonah, ZIP 10536, has a rate of 10.7. There is room for improvement across the county and rates are generally elevated in the southern portion of the county.

Health Disparities

There are disparities in health geographically across Westchester County which contribute to poorer health outcomes (see map below). For example, potentially preventable hospitalizations among adults, age-adjusted rate per 10,000 in city of White Plains ZIP Code 10601 is 119.9 (2019-2022), similar to rate of 10801 New Rochelle (116.2), 10595 Valhalla (128.1) but much higher than surrounding zips in the county such as Portchester (29.1), which displays a disparity in preventable hospitalizations across the county. In addition, there is City specific data that shows in the City of White Plains 15.8% of deaths that are premature (before age 65) Vital Records, 2019-2022. This is higher than some surrounding cities, such as the town of Greenburgh (13.3%) and Mamaroneck (12.9%).

HRSA Data Warehouse, Quick Maps, Medically Underserved Areas/Populations (MUA/P)

Westchester County, NY

There are also disparities in other health outcomes, such as maternal and child health. There is considerable geographic variation in the proportion of births that are preterm, with 8.4% of births being preterm in City of White Plains compared to town of Scarsdale, the municipality with the lowest rate at 6.1%, and the highest rate at 12.4% in City of Mount Vernon.

The City of White Plains had an estimated 7.4% of the population that is less than 65 years old who were uninsured in 2023, compared to an average of 9.7% across local and surrounding zip

codes (ACS, 2023). There is a disparity in the uninsured population by Race/Ethnicity in City of White Plains Hispanic population makes up 32.9% of the City's population and has 15.9% uninsured, comparatively to 43.9% of the City's population and has 2% uninsured, Black makes up 11.4% of the population and has 5.1% uninsured, Asian makes up 8.4% of the city's population and 3.4% is uninsured, other race/ ethnicity makes up 13.1% of the population and 14.2% of this demographic is uninsured (City Health Dashboard, 2023).

Community Assets and Internal Resources:

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

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

	guiding patients through the screening process. Its aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease no-show and cancellation rates.		
Pancreatic Cancer Early Detection Program	The Pancreatic Cancer Early Detection Program is part of the Digestive Cancer Program at WPH, which applies a modern and comprehensive approach to caring for people with malignancies of the gastrointestinal tract. It features clinical research, coordination of ancillary services, and community outreach, as well as a cancer conference devoted solely to cancers of the digestive tracts.	Increase in screening for pancreatic cancer; Decrease in pancreatic cancer	Health Care Access and Quality: Prevent Chronic Diseases
Oral Head and Neck Cancer Screening Program	Screening for Oral, Head and Neck Cancer.	Increase in screening for Oral Head, and Neck Cancer; Decrease in Oral, Head and Neck Cancer	Health Care Access and Quality: Prevent Chronic Diseases
Lung Cancer Screening Program	The screening involves a brief interview with a member of the research team, a questionnaire, and a	Increase in screening for lung cancer	Health Care Access and Quality: Prevent Chronic Diseases

	low-dose CT scan. Open to individuals who are at least 50 years of age, have smoked for 20 pack years, and are currently smoking or have stopped smoking within the last 20 years.		
Internship & Volunteer Program	The Office of Volunteers recruits, hires and trains interns for the hospital, including high school, college and graduate level students.	Increase in satisfaction of interns	Neighborhood & Built Environment: Access to Community Support & Services
Exceptional Nurse Apprentice Program	The program offers graduating HS seniors (at least 18 years of age by date of application), and college students with an interest in a nursing career an opportunity to experience firsthand what it is like to be a nurse in a Magnet designated acute care hospital.	Increase access to Nursing internships roles for our community members; Increase in satisfaction of interns	Economic Stability: Unemployment
Youth Medical Pathway Programs	In partnership with a variety of community organizations and schools, the Hospital exposes students with various rewarding career paths within the healthcare sector with the goal of broadening students'	Decrease unemployment and promote equitable approaches to optimize career development.	Economic Stability

	understanding of the diverse opportunities in healthcare and inspire them to explore these vital roles.		
Project Search	In partnership with Westchester Institute for Human Development and Ability Beyond, the Hospital provides young adults (18-25) with disabilities personalized support in an intensive year of community-based career development and an internship experience.	Decrease unemployment and promote equitable approaches to optimize career development.	Economic Stability
Neighborhood Health Fair	The annual Neighborhood Health Fair offers free health screenings including: breast exams, prostate exams, HIV screening, blood pressure, podiatry, diabetes risk assessments, dental exams, and lab/blood work for cholesterol and sickle cell anemia. A variety of health information is also distributed.	Screening for various chronic health issues. Mammograms provided free of charge for those eligible.	Health Care Access and Quality: Prevent Chronic Diseases
Physician Referral Navigator	Free Physician referral service: providing callers with names of practitioners or specialists.	Increase in accessibility of health care; Increase in utilization of health services	Health Care Access and Quality: 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	Social and Community Context: Anxiety and Stress
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	Increase breastfeeding rates	Social and Community Context: Healthy Eating
Breast Cancer Patient Navigation Program	The Breast Cancer Patient Navigator is the bridge between the community and health care. We eliminate complexity by bringing together interdisciplinary teams to work towards reducing breast cancer rates by assessing, educating, scheduling, and guiding our patients through the screening process. The program's aim is to eliminate barriers and build relationships in effort to increase the screening completion rates and decrease	Increase in screening for breast cancer; Decrease in breast cancer	Health Care Access and Quality: Prevent Chronic Diseases

	no-show and cancellation rates.		
Heart Month	During the month of February, WPH hosts and participates in a series of educational sessions and health screenings for residents of Westchester County.	Increase in blood pressure screenings; Increase in cardiac health	Health Care Access and Quality: Prevent Chronic Diseases
Marketing & Community Relations Division	By functioning as the link between the community and the Hospital's resources, the Community Relations department builds relationships with community-based organizations, government agencies and elected officials within Westchester County.	Increase in community-based health interventions	Health Care Access and Quality: Prevent Chronic Diseases
Perinatal Bereavement Support Group	Provides families an opportunity to listen and/or share their experiences in a comfortable and safe environment for parents who are mourning a loss.	Increase support to parents in the community	Social and Community Context: Anxiety and Stress, Depression
Food Pharmacy	Provides individuals with food who screen positive for food insecurity when receiving care at our Family Heath Center and our Center for Cancer Care.	Decrease Food insecurity in our community	Neighborhood & Built Environment: Access to Community Support & Services

Food is Medicine	Provides individuals who have been discharged from the Hospital with an elevated A1C who screen positive for food insecurity with fresh and shelf-stable food deliveries for 6 months.	Decrease Food insecurity in our community	Neighborhood & Built Environment: Access to Community Support & Services
City of White Plains Park and Recreation – Farmers' Market	The Hospital participates by providing health education and information about services and programs.	Increase in accessibility of health care; Increase in utilization of health services	Health Care Access and Quality: Prevent Chronic Diseases
United Way 211 Program	Providers individuals with information and access to community resources such as food pantries, housing, childcare, senior services, health and mental programs and substance abuse programs.	Increase support of families in our community with essential needs to care for themselves	Neighborhood & Built Environment: Access to Community Support & Services
914 Cares Essentials Program	Provides patients of the Family Health Center and Maternal and Child Health, with essential items such as diapers, wipes, books, pack and plays, hygiene kits and more.	Increase support of families in our community with essential needs to care for themselves	Neighborhood & Built Environment: Access to Community Support & Services

C. Community Service Plan

1. Major Community Health Needs:

Approximately 16,400 community members responded to the survey in New York State, and more than 60% reached the end of the survey. Significant issues identified by community members in all Collaborative members' distributed surveys included: violence (including gun violence), stopping falls among elderly, mental health disorders (such as depression), affordable housing and homelessness prevention, and obesity in children and adults. Community members qualified for the survey if they were 18 and older and lived within any of the geographic areas identified by Collaborative members as their hospital's service area.

During the survey fielding period, GNYHA held member forums where Collaborative members shared best practices and challenges in recruiting community members for the survey. GNYHA produced biweekly geographic and demographic reports summarizing the responses in their service area, which allowed hospitals to adjust their dissemination strategy.

Following the survey's close, GNYHA provided each participant with a report that summarizes the survey responses and respondent demographics and a spreadsheet with the processed respondent-level data for their service area. This allowed participating hospitals to conduct additional analyses. GNYHA also provided technical assistance to each hospital to interpret their results and identify areas of need. GNYHA also created custom reports as requested by members.

A collaborative effort among various organizations yielded 3,410 completed services in Westchester County. Participants were surveyed on two key areas using a Likert scale with responses ranging from 1 "Not at All" to "Extremely" to measure importance of health conditions and current health services provided in the community. The health priorities for the community included options such as diabetes, women's and maternal health care, heart disease, cancer and violence (including gun violence).

The CHNA survey results and respondents' demographic data were reviewed internally with clinical and executive leadership as well as our Healthy Community Initiative on the following dates.

Meeting	2025 Date	Discussion Topics
Healthy Community Initiative	February 12	Planning process and timeline for Community Service Survey and CSP Planning Cycle

Healthy Community Initiative	May 8	Review of CHNA/CSP Planning Process & Timeline Discussion of NYS Prevention Agenda and Healthy People 2030
Senior Leadership Team Meeting	September 23	Overview of NYS Prevention Agenda, Healthy People 2030 Review of Community Health Survey Data
Stakeholder Committee Meetings	September 26 & 30	Review of Community Health Survey Data, secondary data
Healthy Community Initiative	October 9	Review of Community Health Survey Data, secondary data and selection of priorities

The geographical distribution of CHNA survey respondents spanned 71 unique ZIP codes across Westchester County. The largest grouping of respondents came from the White Plains area zip code (19%) of the surveys completed in Westchester County, followed by Yonkers (18%) and New Rochelle (9%). Demographic data noted 84% of those completing the survey did so in English and 15% completed it in Spanish, showing a significant increase in Spanish respondents (+12%). The age concentration of respondents was between 55-74, comprising 41% of the responses. Seventy-two percent of respondents were women, 26% were men and 2% identified as non-binary/another gender. The largest shift in respondent characteristics was Race and Ethnicity, showing a higher response from the Hispanic population. Forty-three percent identified as white, non-Hispanic, 30% as Hispanic, 17% as Black, non-Hispanic and 5% as Asian/Pacific Islander, non-Hispanic. Eighty-nine percent noted their sexual identity to be straight, 6% identified as gay, lesbian or bisexual, 4% identified as other. Respondents leaned towards a higher education with 56% reported as college graduates, 21% some college or technical school and 15% high-school graduate or GED. In addition, 40% of respondents noted having an annual household income greater than $100,000 or more in the previous year while the remaining 60% reported an average household income of less than $100,000, of which 15% reported their income as less than $20,000. This information was considered when analyzing our respondents’ answers regarding their health priorities.

The four leading community health conditions identified included: Violence (including gun violence), Stopping falls among the elderly, Mental Health/Depression, Obesity in children and adults and Affordable housing and homelessness prevention (see **Table 1**).

Health priorities of moderate importance and satisfaction were also summarized in the CHNA survey report from GNYHA (see **Table 2**). At the top of this list was access to healthy and nutritious foods. Women's and maternal health care also remained a continued important health priority among those surveyed, with a score of 4.19 of 5. Areas of lower health importance and higher satisfaction of services within the community are outlined (see **Table 3**).

Table 1. Top 5 Community health priorities as identified by the GNYHA Community Health Needs Assessment Survey, 2025**.**

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	4	4.26	Above Average	16	3.12	Below Average
Stopping falls among elderly	7	4.17	Above Average	18	3.11	Below Average
Mental health disorders (such as depression)	8	4.15	Above Average	21	2.98	Below Average
Obesity in children and adults	13	4.02	Above Average	23	2.93	Below Average
Affordable housing and homelessness prevention	14	4.02	Above Average	26	2.66	Below Average

Data source: GNYHA CHNA Survey Collaborative 2025

Table 2. Community health priorities 5-12, as identified by the GNYHA Community Health Needs Assessment Survey, 2025.

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Maintain Efforts						
Access to healthy/nutritious foods	1	4.33	Above Average	4	3.37	Above Average
Cancer	2	4.33	Above Average	5	3.36	Above Average
Dental care	3	4.32	Above Average	9	3.24	Above Average
Heart disease	5	4.22	Above Average	2	3.38	Above Average
Women's and maternal health care	6	4.19	Above Average	7	3.27	Above Average
Infectious diseases (COVID-19, flu, hepatitis)	9	4.13	Above Average	3	3.38	Above Average
Diabetes and high blood sugar	10	4.10	Above Average	8	3.27	Above Average
High blood pressure	11	4.10	Above Average	1	3.40	Above Average
Adolescent and child health	12	4.08	Above Average	10	3.24	Above Average

Data source: GNYHA CHNA Survey Collaborative 2025

Table 3. Community health priorities 13-21, as identified by the GNYHA Community Health Needs Assessment Survey, 2025.

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Relatively Lower Priority						
Arthritis/disease of the joints	17	3.96	Below Average	17	3.11	Below Average
Assistance with basic needs like food, shelter, and clothing	19	3.92	Below Average	19	3.07	Below Average
Access to continuing education and job training programs	20	3.84	Below Average	20	3.06	Below Average
Substance use disorder/addiction (including alcohol use disorder)	21	3.81	Below Average	22	2.95	Below Average
Job placement and employment support	22	3.78	Below Average	24	2.86	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	23	3.57	Below Average	25	2.83	Below Average
Sexually Transmitted Infections (STIs)	26	3.51	Below Average	15	3.14	Below Average
School health and wellness programs	15	3.98	Below Average	13	3.18	Above Average
Infant health	16	3.96	Below Average	6	3.31	Above Average
Asthma, breathing issues, and lung disease	18	3.95	Below Average	11	3.19	Above Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	24	3.54	Below Average	14	3.14	Above Average
Hepatitis C/liver disease	25	3.53	Below Average	12	3.18	Above Average

2. Prioritization Methods:

The primary data collection was important in identifying health priorities important to our community members as well as highlighting gaps in healthcare services and programming impacting the overall health of our community.

We recognize there are many factors contributing to the health and well-being of our community which extend beyond the immediate scope of this report Community Service Plan (CSP). During this cycle we will continue to expand programming and partnerships with community organizations so that we can maximize our collective impact and sustainably to improve the health and growing needs of our service area.

Mental Health/Depression was emphasized by our community members as an area of need, across Westchester County and throughout NYS. The Hospital does not currently offer mental health services, outside of our Emergency Department. However, the Hospital will continue its efforts to train community members in naloxone administration and mental health first aid.

Similarly, homelessness and affordable housing were identified as top priorities by the community. To address these social needs the Hospital will continue to support referrals to community resources through our Care Management department, staffed by licensed social workers who will ensure patients are screened prior to their discharge from the hospital.

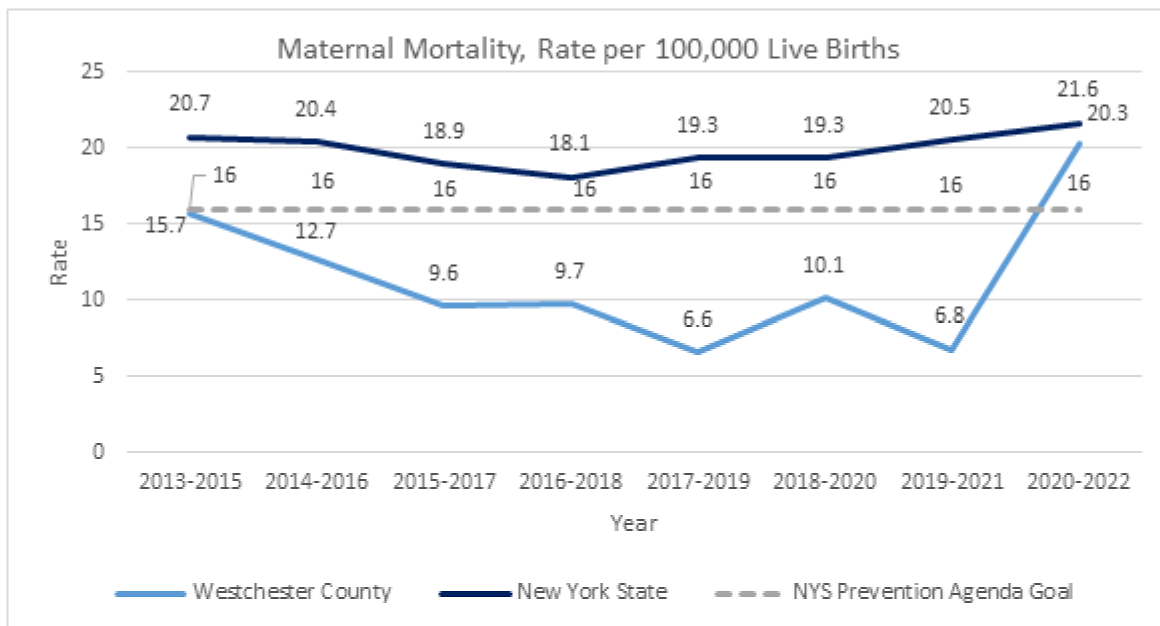
Given the scope of community needs and the Hospital's available resources, we have aligned our priority selection with our centers of excellence and existing programming. This approach maximizes efficiency, ensures we address health conditions where we can have the greatest impact, and aligns with primary data indicating where Hospitals maintain their efforts in Westchester County.

These findings and considerations led to the selection of the Hospital's prevention agenda priority areas. For the 2025-27 CHNAIR/CSP, White Plains Hospital selected to focus on the Health Care and Access domain.

Prevention of Infant and Maternal Mortality

Women's and Maternal care were recurring health priorities by respondents. In addition, our most up-to-date Maternal and Child Health (MCH) data from the Statewide Planning and Research Cooperative System (SPARCS) demonstrated opportunities for improvement within this indicator. According to SPARCS, the percentage of women aged 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy was 29.1% compared to the MCH 2024 objective of 38.1%, which is lower than NYS 2023 data showing a rate of 30.4%. In addition the percentage of Maternal mortality rate per 100,000 live births is estimated at 20.3% as of 2023 NYS Vital Statistics data, above the MCH Objective of 15.7 by 4.6%.

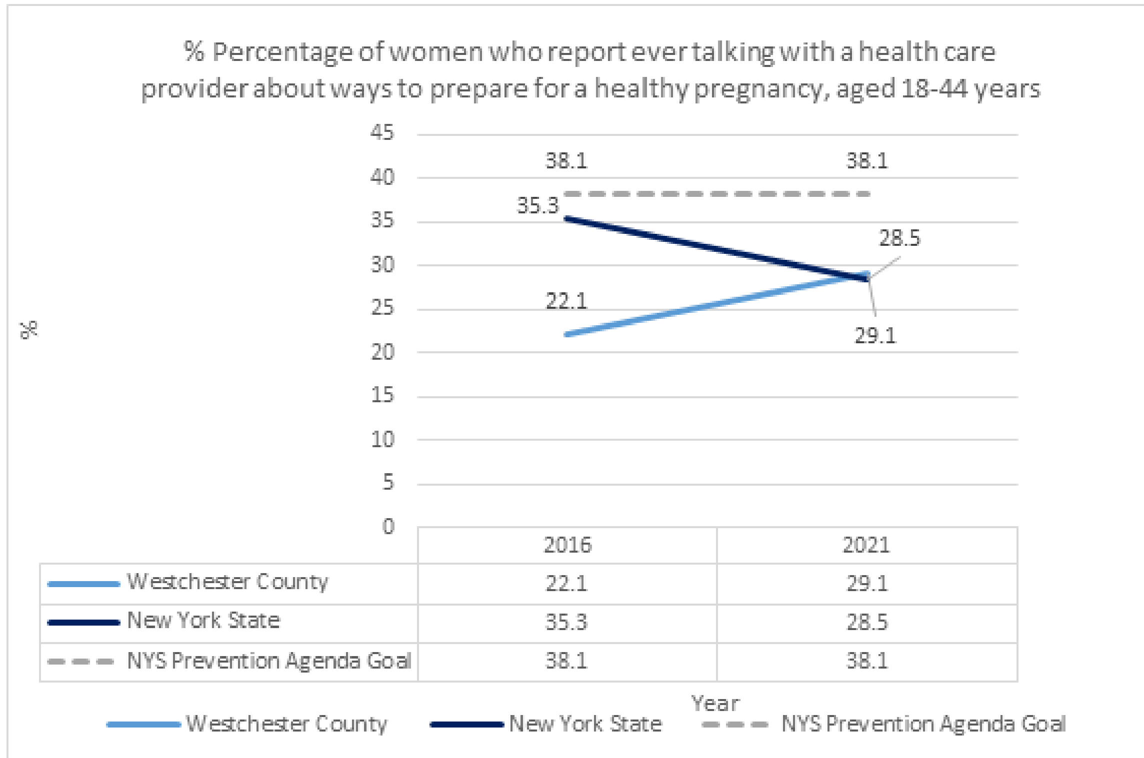
Additionally, maternal mortality rates in Westchester County are showing a concerning upwards trend in recent years, as depicted in the graph below.



Data source: Vital Records, data as of March 2025

This line graph presents the maternal mortality rate per 100,000 live births for Westchester County, New York State, and in comparison, to the New York State Prevention Agenda Goal over several multi-year periods. In Westchester County, the maternal mortality rate began at 15.7 in 2013-2015 and declined steadily to a low of 6.6 in 2017-2019. However, after 2019, the

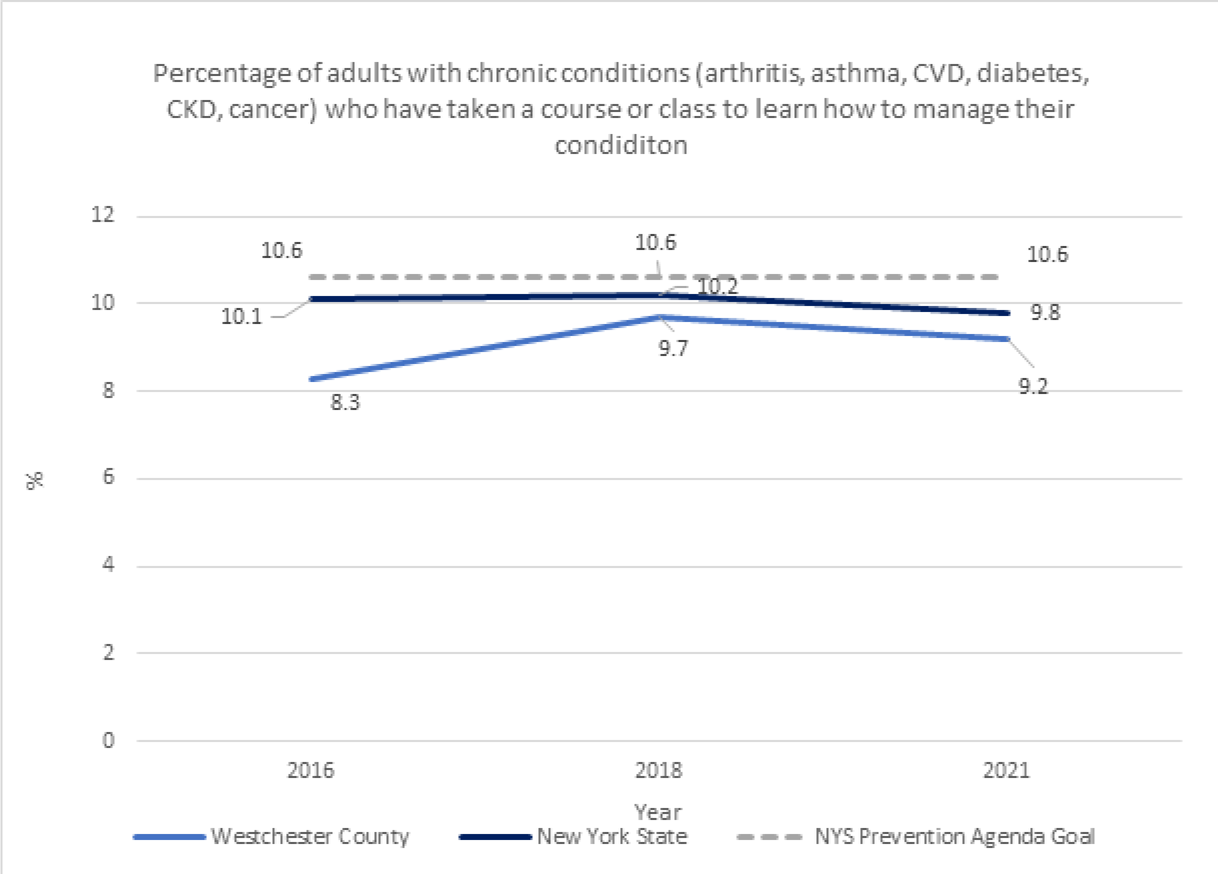
rate started to rise again, reaching 20.3 in 2020-2022, the highest rate recorded in all years shown. Overall, the data shows that maternal mortality in both Westchester County and New York State remains above the New York State Prevention Agenda Goal, with recent years (2020-2022) showing a concerning upwards trend in Westchester County. We must continue our efforts and programming aligned to reduce the rate of maternal mortality in Westchester County.



	2016	2021
Westchester County	22.1	29.1
New York State	35.3	28.5
NYS Prevention Agenda Goal	38.1	38.1

Data Source: NYS Behavioral Risk Factor Surveillance System, data as of October 2022

The graph illustrates the percentage of women aged 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy in Westchester County and New York State, and in comparison to the New York State Prevention Agenda Goal (38.1%) for the years 2016 and 2021. In 2016, Westchester County reported 22.1, which is significantly below both the state average of 35.3% and the New York State Prevention Agenda Goal 38.1%. By 2021, Westchester County improved and narrowed the gap with the state average (28.5%). Despite this improvement for Westchester County, it did not meet the 38.1% NYS Prevention Agenda Goal, highlighting the need for targeted interventions to achieve the NYS Prevention Agenda Goal.



Data source: NYS Behavioral Risk Factor Surveillance System, data as of October 2022

The line graph above illustrates the percentage of adults with chronic conditions (including arthritis, asthma, cardiovascular disease, diabetes, chronic kidney disease, and cancer) who have taken a course or class to learn how to manage their condition in Westchester County, New York State and in relation to the New York State Agenda Goal, for the years 2016, 2018, and 2021.

In 2016, 8.3% of adults with chronic conditions in Westchester County had taken a self-management course, compared to 10.1% statewide, and the NYS Prevention Agenda Goal of 10.6%. By 2018, Westchester County's percentage increased to 9.7%, moving towards closing the gap with the state average and state goal. In 2021, participation of adults in Westchester County slightly declined to 9.2%, while the statewide percentage also decreased to 9.8%, remaining below the consistent NYS Prevention Agenda goal of 10.6%.

Overall, the data shows that while both Westchester County and New York State made modest improvements from 2016 to 2018, participation in chronic disease management programs and education declined by 2021, neither met the NYS Prevention Agenda Goal during the period, showing room for improvement in our community.

Given the scope of community needs and the Hospital's available resources, we have aligned our priority selection with our centers of excellence and existing programming. This approach maximizes efficiency, ensures we address health conditions where we can have the greatest impact, and aligns with primary data indicating where Hospitals maintain their efforts in Westchester County.
These findings and considerations led to the selection of the Hospital's prevention agenda priority areas. For the 2025-27 CHNAIR/CSP:

- Prevention of Infant and Maternal Mortality
- Healthy Eating: Promote Health Eating
- Preventative Services for Chronic Disease Prevent and Control – Hypertension

3. Developing Objectives, Interventions, and an Action Plan:

As a part of the submission for the New York State Health Improvement Plan for 2025-2027 required by the New York State Department of Health, White Plains Hospital has elected to choose the following three priority areas: Prevention of Infant and Maternal Mortality, Preventative Services for Chronic Disease Prevent and Control – Hypertension and Healthy Eating.

Within each priority the Hospital has selected SMART or SMARTIE objectives, evidence-based interventions, performance measures and timeframes, and are as detailed below.

These focus areas align with other ongoing activities, including but not limited to Westchester Birth Equity Improvement Project (BEIP), Maternal and Child Health Council, White Plains Hospital Diabetes Management initiatives, White Plains Hospital's Nursing Professional Practice Council, Primary Care Council, Ambulatory Streeting Committee, Glycemic Control Committee, and collaboration with our Paramedicine program. We believe the selection of these priority areas and collaborative efforts with community partners will positively impact community health through reduced Emergency Department utilization, mitigation of chronic conditions, and health disparities among birthing women.

Domain: Health Care Access and Quality
Priority: Prevention of Infant and Maternal Mortality

White Plains Hospital is committed to continuing to integrate health equity into our mission, strategic plan, and operations. The Maternal Child Health department fosters an inclusive, supportive environment that values all birthing experiences. It strives to eliminate maternal health disparities by collecting and analyzing data, educating staff, implementing culturally responsive care, engaging with the community, and ensuring equitable access to resources for all families. The program targets all maternal patients in Westchester County and surrounding areas, specifically those delivering at White Plains Hospital.

While Cesarean Section (CS) can be a medically indicated intervention, studies have shown correlation between CS births leading to health complications for women and children. For birthing women, some of those risks are blood clots and increased risk of infection.* (OASH)

White Plains Hospital will continue various initiatives to improve health equity and maternal patient outcomes with a focus on reducing the PC-02 rate. Currently our overall PC-02 rate (34%) and the PC-02 rate for patients that self-identify as Black (52%), Multiracial (36%), and White (33%) exceed the recommended rate ($\leq$ 30).

Strategies have been implemented as part of a larger Cesarean Section Reduction Project to decrease these numbers as follows:

- Improve patient race data collection
- Abstract 100% of low-risk patients that have a Cesarean Section (NTSV), to review the medical necessity and quality of care of this patient population.
- Increase the number of Childbirth Education Classes, offering financial assistance to remove any barriers to education because of financial burdens.
- Create and distribute patient education materials to obstetric offices.
- Increase the availability of educational videos on our MCH website, and mechanisms to drive patients to our website, increasing video utilization.
- Creation of a committee to review all low-risk patients delivering via Cesarean Section at White Plains Hospital.
- NTSV Management Policy to standardize evidence-based practices.
- Standard utilization of induction of labor (IOL) algorithm and education for all staff.

In addition to our Labor & Delivery efforts to reduce PC-02, we look to involve our community by working with our community partners, such as local faith organizations, community centers, such as the Thomas H Slater Center, to help reduce health disparities in underserved communities by providing tools, resources, services and programs for success.

<table>
<tr><th colspan="2"></th></tr>
<tr><td>Goal</td><td>Improve health outcomes by lowering mortality and morbidity rate for infants and birthing persons.</td></tr>
<tr><td>Outcome Objectives</td><td>Decrease the rate of maternal mortality per 100,000 live births among Black, non-Hispanic birthing persons from 65.2 to 55.0.
<table>
<tr><td>Desired Outcome:</td><td>Decrease rate of maternal mortality.</td></tr>
<tr><td>Indicator:</td><td>Rate of maternal mortality per 100,000 live births.</td></tr>
<tr><td>Data Source:</td><td>National Vital Statistics System.</td></tr>
<tr><td>Subpopulation of Focus</td><td>Black, non-Hispanic birthing persons</td></tr>
<tr><td>Baseline:</td><td>65.2 (2017-2021)</td></tr>
<tr><td>Target:</td><td>55.0 (2030)</td></tr>
<tr><td>Implementation Partners</td><td>Westchester County Department of Health, Spinning Babies ®</td></tr>
</table></td></tr>
<tr><td>Interventions</td><td>
The Hospital will implement NTSV cesarean section reduction program, including a standardized policy.
The Hospital made the commitment to increase access to childbirth education classes, online educational videos, and literature across OB/GYN outpatient practices. Educational content covers topics such as stages of labor, positioning techniques with a focus on vaginal delivery, options for medications administered, comfort and pain management techniques, and advocacy.
The Hospital will expand pre-natal and post-natal access to our Obstetrics Navigators and Lactation Consultants, screening patients for SDoH, connecting them to community resources, and triaging care needs.
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</table>

Measures & Objectives	*Process Measures & Objectives*
	• By December 31 of 2025, 2026 & 2027, White Plains Hospital will monitor and track the PCO2 rate among, specifically stratifying PCO2 rate among Black non-Hispanic birthing mothers, with the target goal of decrease rate to less than recommended rate of 30%.
	• By December 31 of each of the years 2025, 2026, 2027, White Plains Hospital will provide:
	  o 24 in-person childbirth education classes.
	  o Execute initiatives to improve education video utilization rates by 5%.
	  o Distribute collateral to all outpatient practices, with a goal of documenting 100% of maternal patients.
	• White Plains Hospital will monitor and track obstetric navigation and lactation consultant interactions with a goal of increasing by 5% each year.
	Outcome Measures & Objectives:
	• White Plains Hospital will monitor and track its PCO2 rates against NYS Vital Statistics data with the goal of exceeding the NYS Prevention Agenda objective of 55.0%.

Will Action Address Health Equity	Yes. The staff are extremely invested in reaching the prevention agenda goal of lowering mortality and morbidity rates for infants and birthing persons.

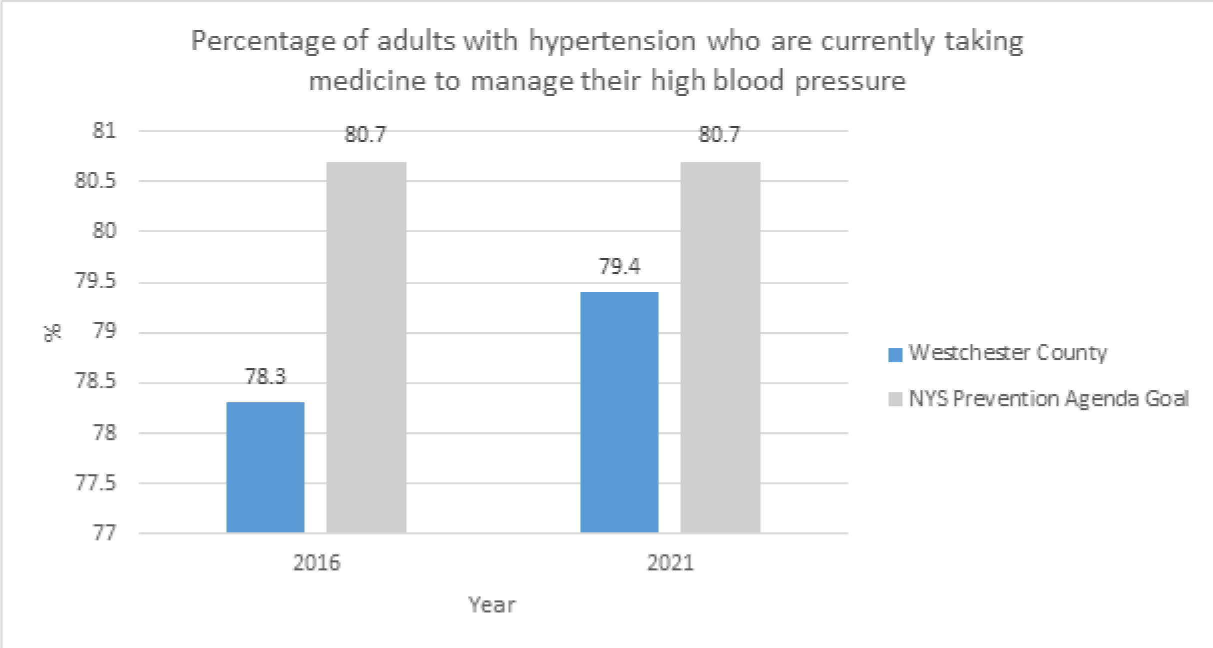
Domain: Health Care Access and Quality
Priority: Prevention Services for Chronic Disease Prevention and Control – Hypertension

Hypertension control is crucial to reducing cardiovascular morbidity and mortality, yet achieving blood pressure control is challenging, especially in economically disadvantaged populations (Bolen S D, Koroukian S, Wright J T, et al., 2023).

As published by the AHA in 2025, hypertension is the number one preventable risk factor for cardiovascular disease and kidney disease. More recent studies have also confirmed that high blood pressure affects brain health and cognition. (AHA, New high blood pressure guideline emphasizes prevention, early treatment to reduce CVD risk, 2025). As stated in an article published by the National Library of Medicine (NIH), citing data from the 1999–2018 US National Health and Nutrition Examination Survey, more than half (56.3%) of patients with hypertension have uncontrolled blood pressure. It further states that patients with high medication adherence to antihypertensive medications are 45% more likely to achieve blood pressure control than those with medium or low adherence.

High blood pressure is highly prevalent in NYS and in Westchester County. In New York State, an estimated 4.9 million people, or 30.5% of the adult population, have been diagnosed with high blood pressure (NYS DOH, 2023). According to Westchester County Department of Health, Community Health Data Report issued in August of 2024, Behavioral Risk Factor Surveillance System (BRFSS) is an annual nationwide telephone survey conducted by the Centers for Disease Control and Prevention (CDC).

A standardized questionnaire is used to collect prevalence data among U.S. residents 18 years and older regarding their health status, risk behaviors, and preventive practices affecting their overall health. The most prevalent health outcomes reported among Westchester County adults were high cholesterol (36%), high blood pressure (29%), and obesity (27%) (WC DOH, 2024). Self-reported adults taking medication to control high blood pressure is at 78.3%, leaving room for improvement to help manage blood pressure (WC DOH, 2024).



Data source: NYS Behavioral Risk Factor Surveillance System, data as of October 2022

The graph above shows the percentage of adults with hypertension who are currently taking medication to manage their high blood pressure in Westchester county compared to New York State Prevention Agenda Goal for the years 2016 and 2021. In 2016, 78.3% of adults with hypertension in Westchester County were taking medication to manage their high blood pressure in Westchester County compared to New York State (NYS) Prevention Agenda Goal for the years 2016 and 2021. In 2021, Westchester County remained 1.3 % below the NYS Prevention Agenda Goal.

Overall, the data indicates that while Westchester County made progress between 2016 and 2021 in increasing hypertension medication among adults, it still fell short of meeting the NYS Prevention Agenda Goal, showing room for improvement in medication use to help manage high blood pressure for our community.

Goal	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.

<table>
<tr>
<td>Outcome Objectives</td>
<td>Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.
<table>
<tr><td>Desired Outcome:</td><td>Increase percentage of adults with hypertension currently taking medication to manage their high blood pressure.</td></tr>
<tr><td>Indicator:</td><td>Hypertension management (% of adults reporting medication used to manage their hypertension, aged 18 years or older.</td></tr>
<tr><td>Data Area:</td><td>NYS</td></tr>
<tr><td>Subpopulation of Focus</td><td>Adults aged 18 years and older with hypertension</td></tr>
<tr><td>Baseline:</td><td>77.0% (2023)</td></tr>
<tr><td>Target:</td><td>81.7% (2030)</td></tr>
<tr><td>Implementation Partners</td><td>White Plains Community Center, Scriptology, The Thomas H. Slater Center</td></tr>
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<tr>
<td>Interventions</td>
<td>

The Hospital will launch a Remote Monitoring Program (RMP) for a subset of patients diagnosed with hypertension under the care of a WPH primary care provider. The enrollment criteria will further require patients to have two separate blood pressure readings of >140/90 in an ambulatory setting in the last calendar year. The program will focus on patient compliance with recommended care plans, monitoring and tracking blood pressure, medication adherence, and education.
The Hospital will provide stroke prevention education in communities that are disproportionately affected by a high prevalence of undiagnosed or controlled hypertension. Education will center on healthy habits for stroke prevention, stroke recognition (BE FAST), and the importance of timely emergency care.
The Hospital will continue its commitment to partnering with community and faith-based organizations by providing blood pressure readings and education. Participants will receive:

A blood pressure reading and explanation of their numbers
Education on how to effectively monitor their blood pressure
Referrals to primary care provider and specialized services

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<tr>
<td>Measures & Objectives</td>
<td>Process Measures & Objectives

By December 31, 2026, 2027 White Plains Hospital will enroll 20% of eligible patients within a 6-month period in 2026 and 2027. The Hospital will also monitor and track blood pressure readings and medication adherence among.

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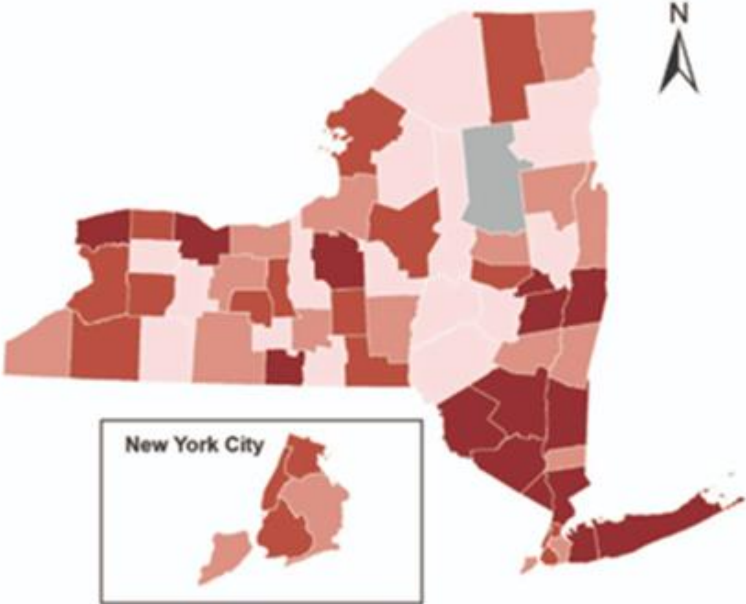
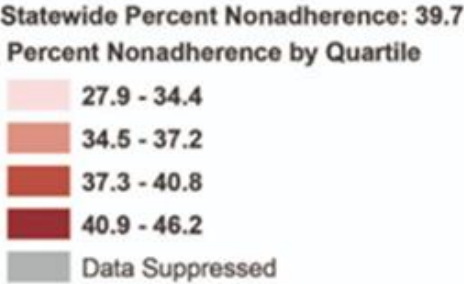
	• By December 31, 2026, 2027, White Plains Hospital will conduct 4 stroke education lectures, either virtually or in-person. • By December 31 of each of the years 2026, 2027, White Plains Hospital will conduct 150 blood pressure screenings/year. *Outcome Measures & Objectives:* • White Plains Hospital will monitor and track its medication adherence rates, among hypertensive patients, against BRFFS data with the goal of exceeding the NYS Prevention objective of 81.7%.
Will Action Address Health Equity	Yes. The staff are committed to expanding efforts and strategies to increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure.

NYS county-level Variation in RASA* nonadherence among Medicaid members in 2016.
**Renin-Angiotensin System Antagonist: RASA* is a class of drugs that block the RAS, a hormonal system that regulates blood pressure*).*



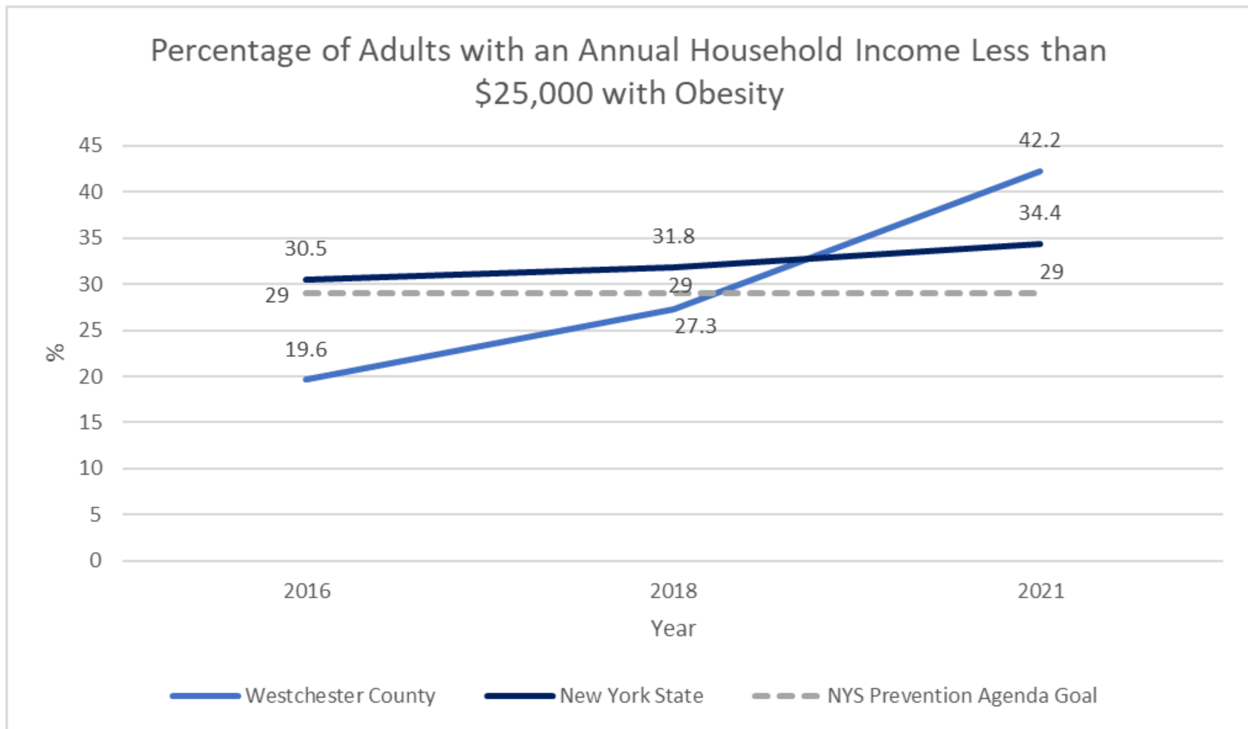


Domain: Social and Community Context
Priority: Healthy Eating

According to the New York State 2025 Prevention Agenda, consistent access to affordable, healthy food is an important factor in reducing hunger and preventing chronic disease, especially for vulnerable populations at high risk for nutrition-related health disparities. In 2021, one in four (24.9%) of adults indicated that they were always, usually, or sometimes worried or stressed out about having enough money to buy nutritious food (NYS DOH, Food Security New York State Adults 2021).

An article in the *American Journal of Clinical Nutrition* states food insecurity is associated with an increased risk of diet-related diseases including cardiovascular disease, diabetes and certain types of cancer (Food Insecurity, Neighborhood Food Environment, and Health Disparities: State of the Science, Research Gaps and Opportunities, March 2024).

The CDC further links that communities and people with lower incomes are more likely to lack convenient places that offer affordable healthier foods. When healthier foods are unavailable, people may rely on foods that are lower in nutritional value and higher in calories. (Healthy Food Environments, January 2025).

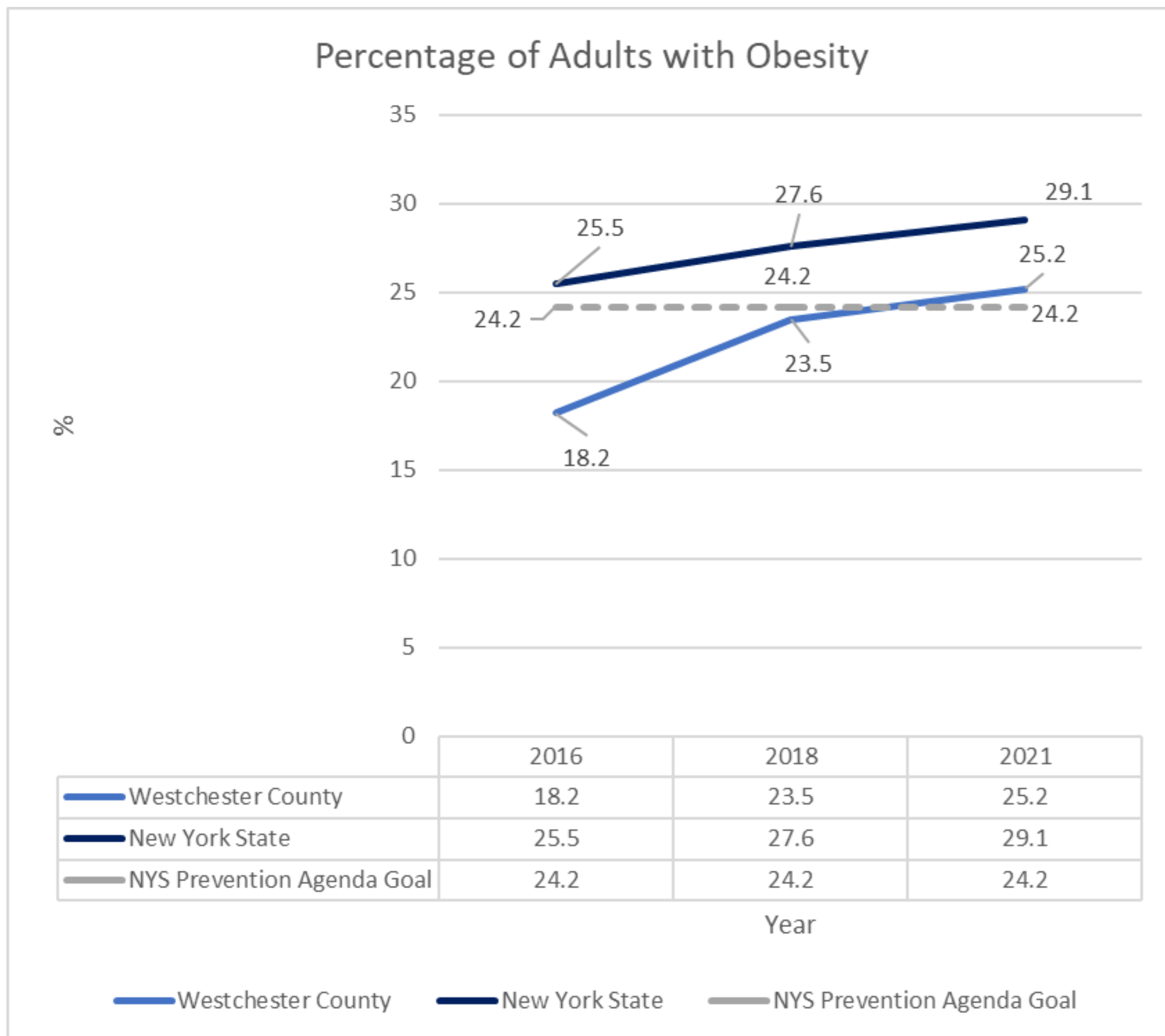


Data Source: NYS Behavioral Risk Factor Surveillance System, data as of October 2022

The graph displays the percentage of adults with an annual household income below $25,000 who are living with obesity, comparing Westchester County, New York State and the New York State Prevention Agenda goal overall for the years 2016, 2018 and 2021.

In 2016, Westchester County reported a significantly lower obesity rate, 19.6% compared to the statewide rate 30.5%. By 2018, both Westchester County (27.3%) and New York State (31.8%) reported increases. The largest change is 2021, where Westchester County rate climbs drastically to 42.2%, surpassing the state rate, which also increased to 34.4%. In the years reported, neither New York State or Westchester County met the New York State Prevention Agenda goal of 29%.

Overall, the graph highlights a concerning upward trend in obesity among low- income adults, particularly in Westchester County, where the increase is substantially higher than the years before.



	2016	2018	2021
Westchester County	18.2	23.5	25.2
New York State	25.5	27.6	29.1
NYS Prevention Agenda Goal	24.2	24.2	24.2

Data Source: NYS Behavioral Risk Factor Surveillance System, data as of October 2022

This graph shows the percentage of adults with obesity in Westchester County compared to New York State and the New York Prevention Agenda Goal for the years 2016, 2018 and 2021. In 2016, Westchester County rate was 18.2%, which is lower than both the statewide rate and

the prevention agenda target of 24.2%. By 2018, obesity rates increased in both Westchester County (23.5%), and New York State increased to (27.6%). Westchester County remained under the goal. By 2021, Westchester County's obesity rate rose to 25.2% slightly above the New York State Prevention Agenda Goal of 24.2%.

Overall, the graph highlights the persistent and rising obesity levels among adults in both Westchester County and New York State. For the first time since 2016, Westchester County is no longer under the prevention agenda goal, sparking a need for more focused efforts and programming to help combat this health issue in our community.

<table>
<tr><th></th><th></th></tr>
<tr><td>Goal</td><td>Promote healthy eating and make nutritious, culturally appropriate foods available.</td></tr>
<tr><td>Outcome Objectives</td><td>Decrease the percentage of adults with an annual household income of less than $50,000 who consume no fruits or vegetables daily from 31.7% to 30.1%.
<table>
<tr><td>Desired Outcome:</td><td>Increased consumption of nutritious foods recommended by the dietary guidelines.</td></tr>
<tr><td>Indicator:</td><td>Percentage of adults who consumed fewer than one fruit and fewer than one vegetable daily (no fruits or vegetables) aged 18 years and older.</td></tr>
<tr><td>Data Source:</td><td>Behavioral Risk Factor Surveillance System (BRFSS)</td></tr>
<tr><td>Subpopulation of Focus</td><td>Adults in households earn less than $50,000 per year.</td></tr>
<tr><td>Baseline:</td><td>31.7% (2023)</td></tr>
<tr><td>Target:</td><td>30.1% (2030)</td></tr>
<tr><td>Implementation Partners</td><td>Feeding Westchester</td></tr>
</table>
</td></tr>
<tr><td>Interventions</td><td>• Expanding the ED-to-Home Diabetes Program by increasing the number of patients with poorly controlled diabetes enrolled in this telehealth-based initiative for coordinated follow-up care.
• Increasing number of interactions with providers who will provide counseling on healthy eating, physical activity, or weight and self-monitoring tools to manage their diabetes.
• Building on the Food is Medicine program, enrolling larger cohorts of patients each year.</td></tr>
</table>

Measures & Objectives	*Process Measures & Objectives* • Number of patients with poorly controlled diabetes enrolled in the ED-to-Home Program, a telehealth-based initiative for coordinated follow-up care and medication optimization, with the goal of expanding patient enrollment by 5% each year. • The number of provider interactions with the aim of counseling on healthy eating, physical activity, or weight and self-monitoring tools to manage their diabetes, with the goal of expanding interactions by 5% each year. • Number of patients enrolled in the Food is Medicine program, which provides patients who screen for food insecurity, delivery of fresh and shelf-stable food and targeted nutrition education for a period of six months with a goal of serving 200 patients each year. *Outcome Measures & Objectives:* • White Plains Hospital will monitor and track patients who receive education on healthy eating within the Diabetes Management Cohort with the goal of exceeding the NYS Prevention objective of 30.1%.
Will Action Address Health Equity	Yes. The staff will devote resources to decrease the percentage of adults with an annual household income of less than $50,000 who consume no fruits or vegetables daily.

4. **Partner Engagement:** White Plains Hospital will monitor prevention agenda progress throughout this cycle through our *Healthy Community Initiative*, which brings together non-profit, community organizations and leaders three times per year. In addition, the Hospital will continue to monitor measures and objectives through quarterly meetings with stakeholders.

5. **Sharing Findings with the Community:**
The Affordable Care Act requires hospitals to assess and address the health needs of the communities they serve. This Community Health Needs Assessment and Implementation Strategy Report (CHNAIR) outlines the process, methods and results of a comprehensive assessment of the needs of the community served by White Plains Hospital. The Implementation Report describes the programs and strategies to address the health needs as identified through the Community Health Needs Assessment (CHNA). The Community Service Plan (CSP) is a requirement by New York State Department of Health and must be submitted every 3 years. White Plains Hospital, along with all voluntary hospitals in New York state, is required to submit a Community Service Plan every three years, with a progress update each year to the New York State Department of Health. This report summarizes White Plains Hospital's community service initiatives, including collaborations with our community partners, addressing New York State's Prevention Agenda and Healthy People 2030.

The White Plains Hospital’s CHNA/CSP was approved by the Board of Directors on December 8, 2025 and was uploaded to the White Plains Hospital website (www.wphospial.org//health-resources/community-health-wellness) on December 12, 2025.

D. Supplemental Information

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

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

Summary of Secondary Data Sources & Analytic Notes

American Community Survey: The American Community Survey (ACS) replaced the Decennial Census as an ongoing survey of the United States population that is available at different geographic scales (e.g., national, state, county, census tract or census block group). ACS is a continuous survey that addresses issues related to demographics, employment, housing, socioeconomic status, and health insurance. In the current report, data from ACS was used to identify community characteristics and evaluate the percent of families living in poverty and for mapping the percentage of adults with health insurance. For more information on ACS, please visit: About the ACS (census.gov).

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

New York State Cancer Registry: The New York State Cancer Registry was used to summarize data on new cases of breast cancer, and colorectal cancer. The Cancer Registry receives notice of all cancer diagnoses to NYS residents and classifies the cancers using established definitions. For more information on the New York State Cancer Registry, please visit: NYS Cancer Registry

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

New York State Statewide Planning and Research Cooperative Systems (SPARCS): SPARCS is the primary source of data on ED visits and inpatient hospitalizations at New York State hospitals. All inpatient admissions and ED visits at NYS hospitals are sent to SPARCS and compiled into a master database. SPARCS data was used to estimate the rates of preventable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, asthma ED visits,

hospitalizations for short-term complications of diabetes, and the opioid burden rate. For more information about SPARCS, please visit: Statewide Planning and Research Cooperative System (ny.gov)

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

New York State Immunization Information System: The New York State Immunization Information System (NYSIIS) provides data on immunizations for all residents <19y at the county level in the state, excluding NYC. Healthcare providers are required by law to report all immunizations for this population to NYSIIS. This data was used to estimate the immunization status of children between 19-35 months. For more information, please visit: New York State Immunization Information System (NYSIIS)

NYS HIV Surveillance System: The NYS HIV Surveillance System, run by the AIDS Institute Bureau of HIV/AIDS Epidemiology in the New York State Department of Health, provides data on new HIV/AIDS diagnoses and other factors relating to HIV/AIDS, such as linkage to care. This report uses data on HIV incidence from this source. For more information, please visit: AIDS Institute (ny.gov)

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

New York State Vital Records Data: The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report, vital records data were used to examine the proportion of preterm births, and proportion of infants exclusively breastfed in the hospital. For more information on the New York State Vital Records, please visit: Vital Statistics of New York State (ny.gov)

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

Data Tools

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

New York State Prevention Agenda Dashboard: An additional resource for data was the New York State Prevention Agenda Dashboard, which was produced by the New York State Department of Health and systematically aggregates data for the entire state and for each county for dozens of health indicators that align with the New York State Prevention Agenda. Like the Community Health Profiles, the Prevention Agenda Dashboard is not a single database, but rather a compilation of diverse databases. For more information, please visit: Prevention Agenda 2025-2030: New York State's Health Improvement Plan.

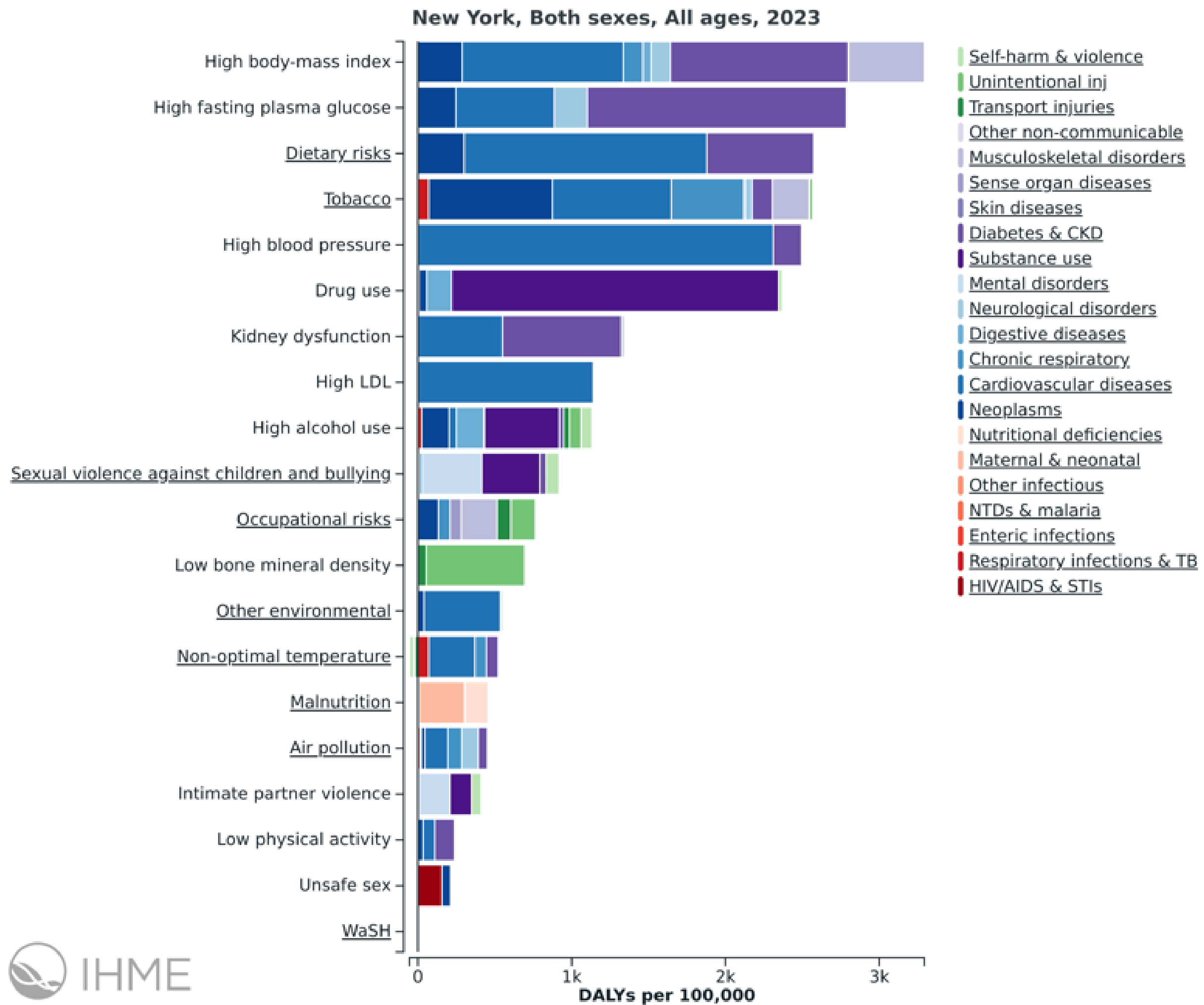
Secondary Data Review & Trends

Leading causes of disability-adjusted life years in New York State, 2023

Data source: 2023 Global burden of Disease Project, Institute for Health Metrics and Evaluation.

The leading causes of ill health in New York State as measured by disability adjusted life years are ischemic heart disease (8.69%), drug use disorders (6.23%), lower back pain (4.25%), and diabetes (4%). The saturation of the graph shows the proportionate change in DALYs from 1990 to 2023.

Figure 3. Distribution of disability adjusted life years by risk factor in New York State, 2023.



Data source: 2023 Global Burden of Disease Project

In New York State, according to the finest level of geographic data from the Global Burden of Disease project, high body mass index is responsible for the highest proportion of disability adjusted life years (a summary measure combining fatal and non-fatal health status). High body-mass index risks are the leading contributor to ill health, due to associations with diabetes, cardiovascular disease, and musculoskeletal disorders. High fasting glucose is the second leading cause of ill health, with strong associations with diabetes, cardiovascular, and neoplasms. The third leading cause of ill health is dietary risks, due to associations of cardiovascular disease, diabetes, and neoplasms. Tabacco and high blood pressure are also causes of ill health. Within high blood pressure (data not shown) is attributed to cardiovascular disease and diabetes while Tabacco usage is associated with mainly cardiovascular diseases and neoplasms.

Overview of Data for White Plains Hospital
Top 20 Inpatient Diagnoses in 2024

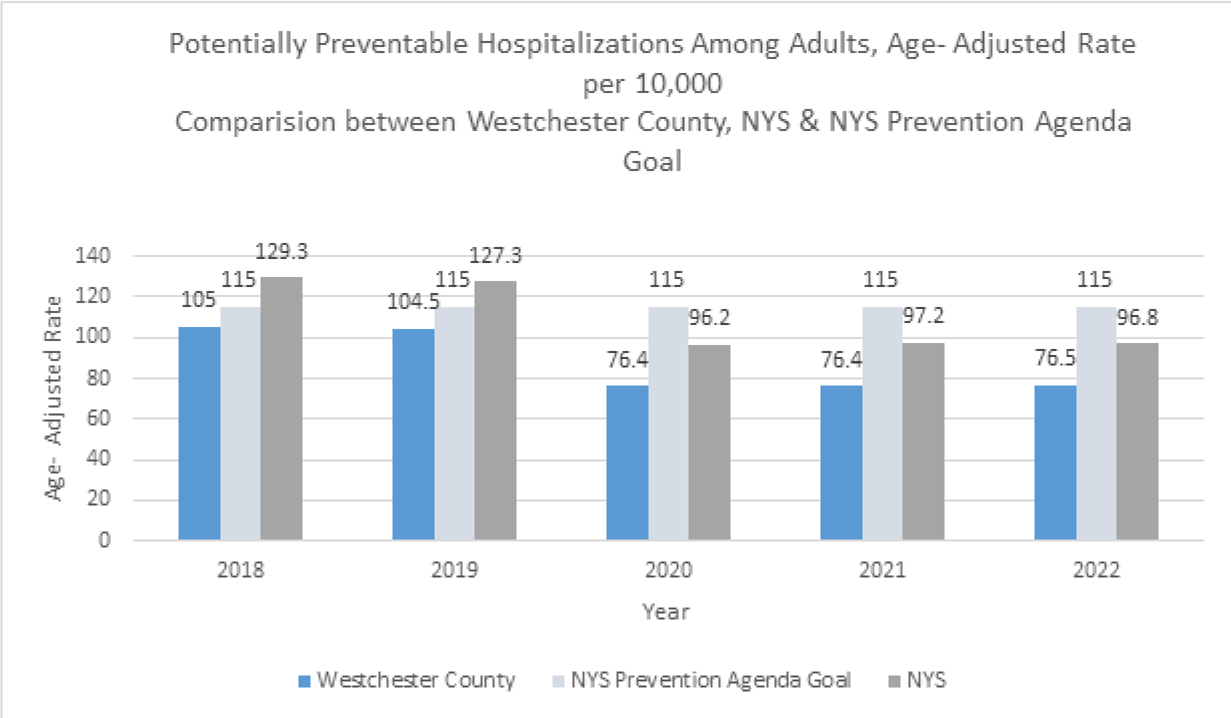
Top 20 inpatient discharges at White Plains Hospital, 2024

ICD-10 Code	Label	Discharges	% of Total
A41.9	Sepsis, unspecified organism	1,880	7.4%
Z38.00	Single liveborn infant, delivered vaginally	1,261	5.0%
Z38.01	Single liveborn infant, delivered by cesarean	955	3.8%
O48.0	Post-term pregnancy	425	1.7%
A41.89	Other specified sepsis	421	1.7%
N39.0	Urinary tract infection, site not specified	348	1.4%
O34.211	Maternal care for low transverse scar from previous cesarean delivery	337	1.3%
N17.9	Acute kidney failure, unspecified	335	1.3%
A41.51	Sepsis due to Escherichia coli (e. coli)	276	1.1%
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	272	1.1%

Top 20 reasons for treat-and-release ED visits at White Plains Hospital, 2024

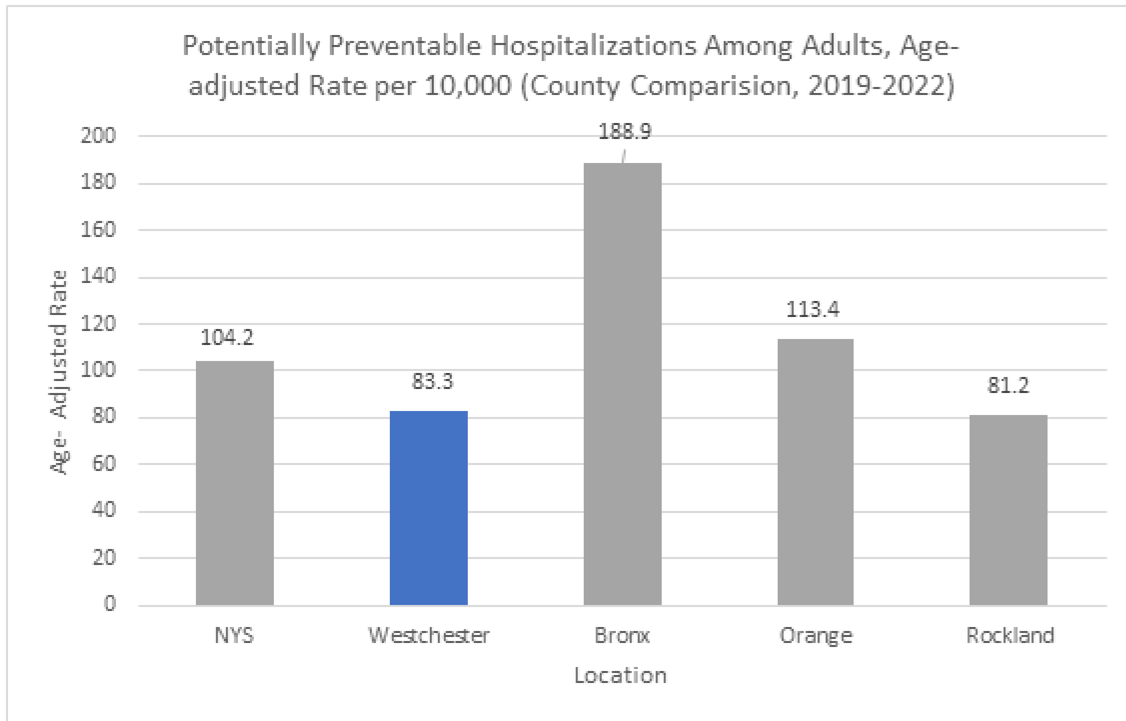
ICD-10 Code	Label	Discharges	% of Total
R07.89	Other chest pain	2,052	3.2%
R51.9	Headache, unspecified	1,504	2.4%
R07.9	Chest pain, unspecified	1,425	2.2%
R10.9	Unspecified abdominal pain	1,217	1.9%
R42	Dizziness and giddiness	1,114	1.7%
N39.0	Urinary tract infection, site not specified	1,083	1.7%
S09.90XA	Unspecified injury of head, initial encounter	1,066	1.7%
K52.9	Noninfective gastroenteritis and colitis, unspecified	1,053	1.7%
M54.50	Low back pain, unspecified	1,026	1.6%
F10.129	Alcohol abuse with intoxication, unspecified	1,003	1.6%

E. Appendix:



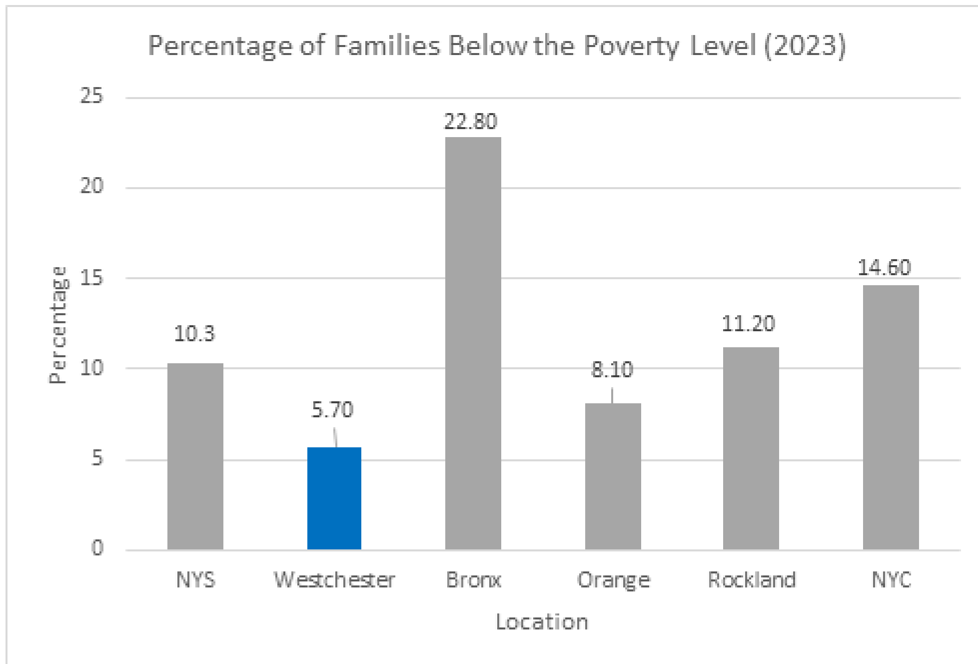
Data Source: SPARCS, Data as of July 2024

Westchester County continues to perform better than both New York State overall and the Prevention Agenda Objective for the Preventable Hospitalization Rate per 10,000 population from 2018–2022. Although the 2022 rate of 76.5 is slightly higher than the rates observed in 2020 and 2021, it still reflects a notable improvement compared with 2018, when the rate was 105.



Data Source: SPARCS, Data as of July 2024

When comparing counties from 2019–2022, Rockland County shows the strongest performance with a rate of 81.2. Westchester County follows closely with a rate of 83.3. The remaining peer counties have significantly higher rates, with Orange County at 113.4 and the Bronx at 188.9. The overall New York State rate is 104.2, which remains higher than Westchester County's rate.



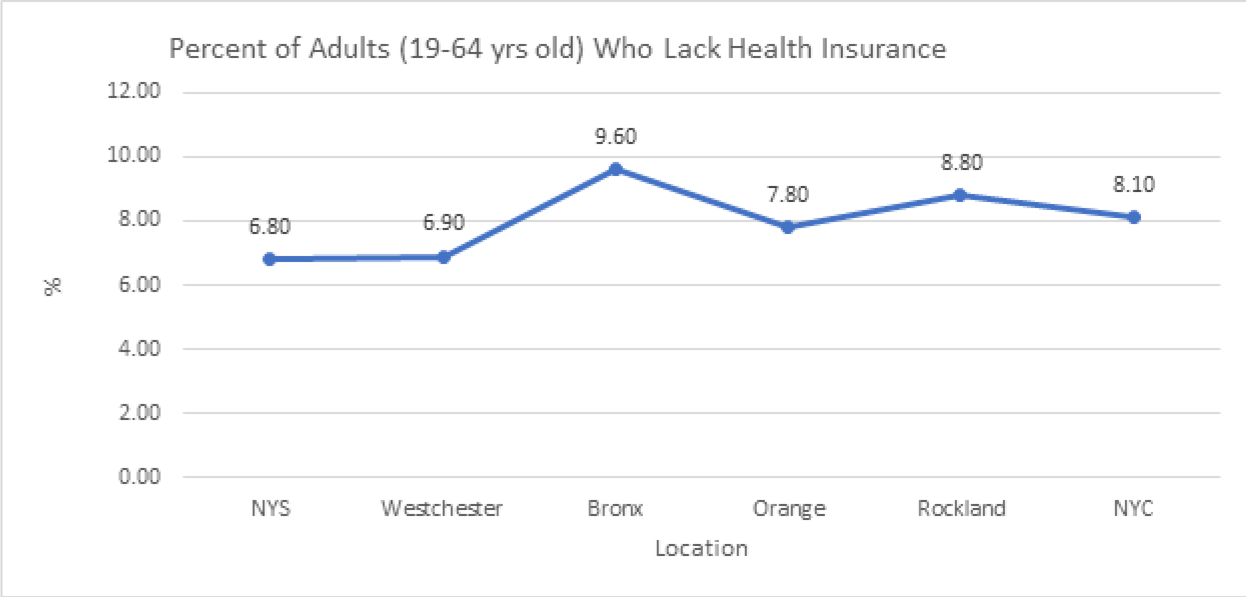
Data Source: American Community Survey/ US Census Bureau Data

When comparing poverty levels across New York State (NYS), Westchester County, Bronx County, Orange County, Rockland County, and New York City (NYC), Westchester County has the lowest percentage of families living below the poverty level at 5.7%, performing significantly better than all comparison areas. NYS overall has a poverty rate of 10.3%, nearly double that of Westchester.

The Bronx shows the highest poverty level at 22.8%, more than four times the rate in Westchester and notably higher than every other locality in the chart.

Orange County (8.1%) and Rockland County (11.2%) fall between the state average and the extremes, with Orange performing better than NYS overall but still above Westchester.

Overall, the graph highlights Westchester County’s relatively strong socioeconomic standing compared with both neighboring counties and statewide figures, while showing disparities, particularly the higher poverty rate in the Bronx.

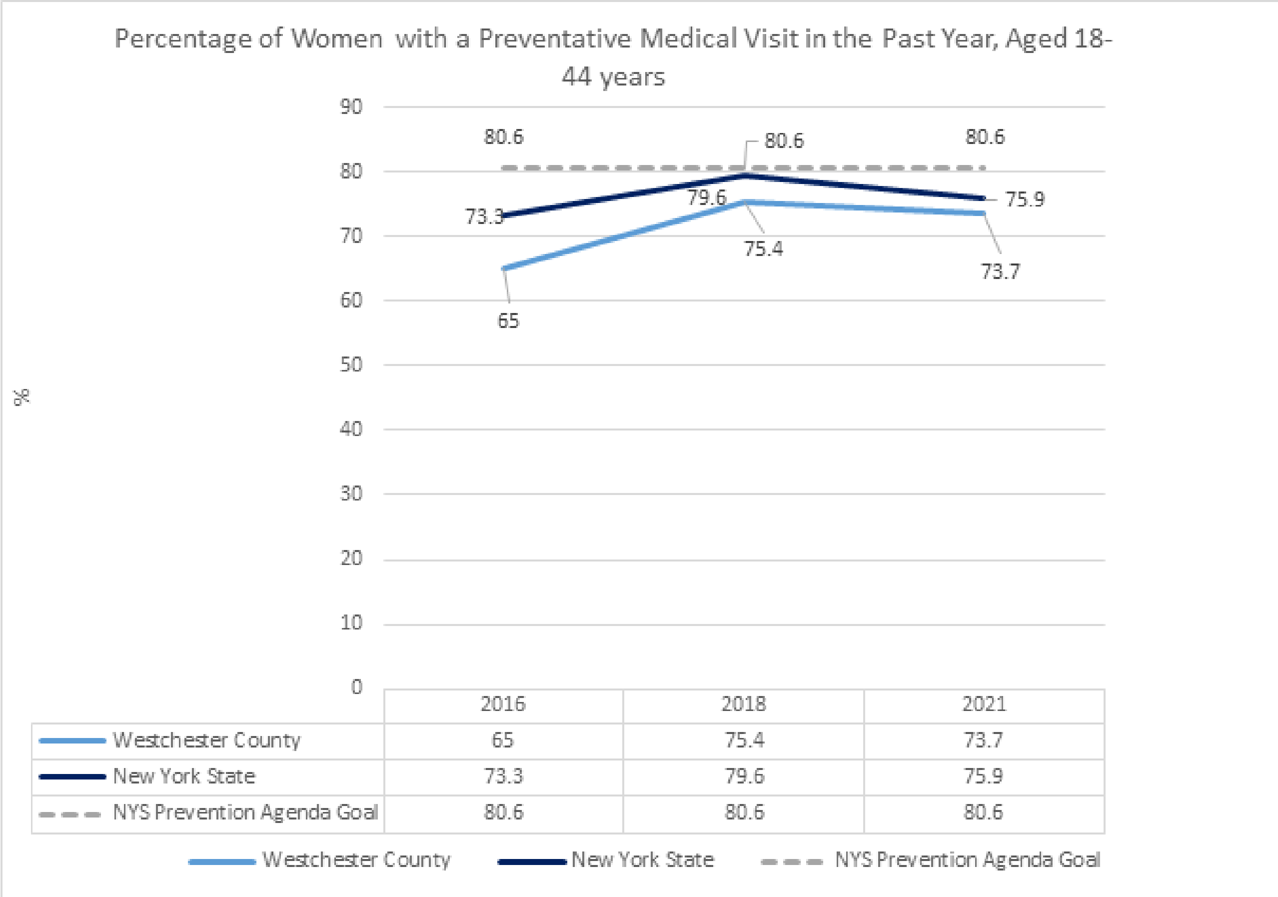


Data Source: American Community Survey/US Census Bureau Data; S2701Selected Characteristics of Health Insurance Coverage in the United States

Westchester County has a relatively low uninsured rate at 6.9%, very similar to the NYS average of 6.8%. Among all locations compared, the Bronx has the highest percentage of uninsured adults at 9.6%, standing out as the most vulnerable area in terms of health insurance coverage.

Orange County (7.8%), Rockland County (8.8%), and NYC (8.1%) all report uninsured rates above both the state and Westchester levels. Rockland and NYC in particular show moderately elevated levels compared with Westchester.

Overall, Westchester County is performing slightly better than the state average and better than all neighboring comparison areas, with the Bronx experiencing the greatest challenges in adult health insurance coverage.



	2016	2018	2021
Westchester County	65	75.4	73.7
New York State	73.3	79.6	75.9
NYS Prevention Agenda Goal	80.6	80.6	80.6

Data Source: NYS Behavioral Risk Factor Surveillance System, data as of October 2022

In 2016, Westchester County reported 65% of women aged 18-44 years who had a preventative medical visit in the past year in Westchester County, which was significantly below both the state average of 73.3% and the NYS Prevention Agenda Goal of 80.6%. By 2018, Westchester County improved to 75.4%, narrowing the gap with New York State, which peaked at 79.6% approaching the New York State Prevention Agenda goal. However, in 2021, both regions experienced declines, with Westchester County dropping slightly to 73.7% and New York State 75.9%, moving further away from the target of 80.6% set by the New York State Prevention Agenda.

Despite overall improvement since 2016, neither Westchester County or New York State achieved the 80.6% goal, and the recent downward trend suggests a need for efforts to maintain and increase preventative care utilization.

White Plains Hospital Community Health Needs Assessment Survey Flyer (English)

What Does Our Community Need to Stay Healthy?

Take our survey by July 31st.

Let us know: Scan the QR code or visit https://www.gnyhasurveys.org/CHNA

Thank you for helping keep our community healthy.

GNYHA 2022 Community Health Survey (English)

2025 Community Health Survey

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

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

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

---

1 Are you 18 years of age or older?

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

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

Zip code: ________________

IF YOU PROVIDED A ZIP CODE, PLEASE GO TO QUESTION 6. YOU DO NOT NEED TO ANSWER THESE QUESTIONS.

3 Do you live in New York City?

- ○ Yes
- ○ No → Skip to 5

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

- ○ The Bronx → Go on to page 3
- ○ Brooklyn → Go on to page 3
- ○ Manhattan → Go on to page 3
- ○ Queens → Go on to page 3
- ○ Staten Island → Go on to page 3
- ○ I do not live in New York City → Answer 5

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

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

- Lewis County
- Livingston County
- Suffolk County
- Sullivan County

Health Status

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

- Poor
- Fair
- Good
- Very good
- Excellent

7 In general, how is your physical health?

- Poor
- Fair
- Good
- Very good
- Excellent

8 In general, how is your mental health?

- Poor
- Fair
- Good
- Very good
- Excellent

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

		How important is this issue to you?						How satisfied are you with current services?					
		Not at all	A little	Somewhat	Very	Extremely	Don't know	Not at all	A little	Somewhat	Very	Extremely	Don't know
1	Access to continuing education and job training programs	○	○	○	○	○	○	○	○	○	○	○	○
2	Access to healthy/nutritious foods	○	○	○	○	○	○	○	○	○	○	○	○
3	Adolescent and child health	○	○	○	○	○	○	○	○	○	○	○	○
4	Affordable housing and homelessness prevention	○	○	○	○	○	○	○	○	○	○	○	○
5	Arthritis/disease of the joints	○	○	○	○	○	○	○	○	○	○	○	○
6	Assistance with basic needs like food, shelter, and clothing	○	○	○	○	○	○	○	○	○	○	○	○
7	Asthma, breathing issues, and lung disease	○	○	○	○	○	○	○	○	○	○	○	○
8	Cancer	○	○	○	○	○	○	○	○	○	○	○	○
9	Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah	○	○	○	○	○	○	○	○	○	○	○	○
10	Infectious diseases (COVID-19, flu, hepatitis)	○	○	○	○	○	○	○	○	○	○	○	○
11	Dental care	○	○	○	○	○	○	○	○	○	○	○	○
12	Diabetes and high blood sugar	○	○	○	○	○	○	○	○	○	○	○	○
13	Heart disease	○	○	○	○	○	○	○	○	○	○	○	○
14	Hepatitis C/liver disease	○	○	○	○	○	○	○	○	○	○	○	○
15	High blood pressure	○	○	○	○	○	○	○	○	○	○	○	○
16	HIV/AIDS (Acquired Immune Deficiency Syndrome)	○	○	○	○	○	○	○	○	○	○	○	○
17	Infant health	○	○	○	○	○	○	○	○	○	○	○	○
18	Job placement and employment support	○	○	○	○	○	○	○	○	○	○	○	○
19	Mental health disorders (such as depression)	○	○	○	○	○	○	○	○	○	○	○	○
20	Obesity in children and adults	○	○	○	○	○	○	○	○	○	○	○	○
21	School health and wellness programs	○	○	○	○	○	○	○	○	○	○	○	○
22	Sexually Transmitted Infections (STIs)	○	○	○	○	○	○	○	○	○	○	○	○
23	Stopping falls among elderly	○	○	○	○	○	○	○	○	○	○	○	○
24	Substance use disorder/ addiction (including alcohol use disorder)	○	○	○	○	○	○	○	○	○	○	○	○
25	Violence (including gun violence)	○	○	○	○	○	○	○	○	○	○	○	○
26	Women's and maternal health care	○	○	○	○	○	○	○	○	○	○	○	○

Long-term COVID Effects

10 **Have you ever tested positive for COVID-19 (using a rapid point-of-care test, self-test, or laboratory test) or been told by a doctor or other health care provider that you have or had COVID-19?**

- ○ Yes
- ○ No [Skip to question 13]

11 **Do you currently have symptoms lasting 3 months or longer that you did not have prior to having coronavirus or COVID-19?**

- ○ Yes
- ○ No [Skip to question 13]

12 **Do these long-term symptoms reduce your ability to carry out day-to-day activities compared with the time before you had COVID-19?**

- ○ Yes, a lot
- ○ Yes, a little
- ○ Not at all

Social Determinants of Health

13 **During the past 12 months, have you received food stamps, also called SNAP, the Supplemental Nutrition Assistance Program on an EBT card?**

- ○ Yes
- ○ No

14 **During the past 12 months how often did the food that you bought not last, and you didn't have money to get more?**

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

15 **During the last 12 months, was there a time when you were not able to pay your mortgage, rent or utility bills?**

- ○ Yes
- ○ No

Health Care Access

16 What is the current source of your primary health insurance (the one you use most often)?

- ○ A plan purchased through an employer or union (including plans purchased through another person's employer)
- ○ A private nongovernmental plan that you or another family member buys on your own
- ○ Medicare
- ○ Medigap
- ○ Medicaid
- ○ Children's Health Insurance Program (CHIP)
- ○ Military related health care: TRICARE (CHAMPUS) /VA health care /CHAMP-VA
- ○ Indian Health Services
- ○ State sponsored health plan
- ○ Other government program
- ○ No coverage of any type

Demographic Information

17 What is your race and/or ethnicity? (Select all that apply)

- ☐ American Indian or Alaska Native
  For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
- ☐ Asian
  For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.
- ☐ Black or African American
  For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
- ☐ Hispanic or Latino
  For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.
- ☐ Middle Eastern or North African
  For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.
- ☐ Native Hawaiian or Pacific Islander
  For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
- ☐ White
  For example, English, German, Irish, Italian, Polish, Scottish, etc.

18 Do you speak a language other than English at home?

- ○ Yes
- ○ No [Skip to question 21]

19 What is this language? (Select all that apply)

- ☐ Spanish
- ☐ Arabic
- ☐ Bengali
- ☐ Burmese
- ☐ Chinese
- ☐ French
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Nepali
- ☐ Polish
- ☐ Russian
- ☐ Urdu
- ☐ Yiddish
- ☐ Other

20 How well do you speak English?

- ○ Very well
- ○ Well
- ○ Not well
- ○ Not at all

21 Which of the following best represents how you think of yourself?

- ○ Gay or lesbian
- ○ Straight, that is not gay or lesbian
- ○ Bisexual
- ○ I use a different term

22 How do you currently describe yourself? (Select all that apply)

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term

23 Are you transgender?

- ○ Yes
- ○ No

- $150,000 to $199,999
- $200,000 or more

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