“COMMUNITY STRONG”
St. John’s Riverside Hospital, known for its closely integrated models of care, nationally recognized services and outcomes, and strong partners is uniquely positioned to meet the health care needs of its patients and community.

This document, created December 1, 2019, is submitted in accordance with the Internal Revenue Service – Section 501(r).
Community Service Plan 2019 – 2021
This document is submitted as the requirement for the 2019 – 2021 Community Service Plan through the New York State Department of Health and assesses the needs for Westchester County, New York.

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This report was not completed as part of a coalition.

The St. John’s Riverside Hospital (SJRH) Community Health Needs Assessment (CHNA) process was conducted during the 2018 - 2019 period. The final Community Service Plan (CSP) and Community Health Needs Assessment/Implementation Strategy Report (CHNA/ISR) were approved by the Board of Trustees on December 9, 2019. The final approved CSP and CHNA/ISR was uploaded to the SJRH public website RiversideHealth.org on December 19, 2019, shared with community partners and a paper copy is available for public inspection upon request and without charge at the hospital facility.
Section A
Executive Summary
The Affordable Care Act requires not-for-profit hospitals to assess and address the health needs of the communities they serve through the development of a comprehensive Community Health Needs Assessment (CHNA) and Implementation Strategy (IS). St. John’s Riverside Hospital (SJRH) has considered the broad interests of its community members, analyzed health data and developed a plan to respond to the prioritized health needs identified. The SJRH CHNA provides a report of the process and results of a comprehensive assessment of the needs of its community. The SJRH IS and Community Service Plan (CSP) address the significant community health needs identified through the CHNA and outline the metrics to evaluate the impact of these initiatives. The SJRH CHNA, IS and CSP were developed based upon both Federal and New York State (NYS) guidelines. The NYS guidelines were designed to meet the Federal Healthy People 2020 goals and encompass the NYS Department of Health Prevention Agenda 2019-2024.

The Agenda is the blueprint for State and local initiatives to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disabled, and low socioeconomic groups, as well as other populations who experience them. The New York State Prevention Agenda priorities are:

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants and Children
4. Promote Well-Being and Prevent Mental and Substance Use Disorders
5. Prevent Communicable Disease

Further information regarding the Prevention Agenda can be found at the following link: https://www.health.ny.gov/prevention/prevention_agenda/2019-2014

SJRH identified and prioritized our significant health needs with consideration of the Prevention Agenda and input from the CHNA, Westchester County Department of Health (WCDOH) and Westchester County Health Planning Coalition (WCHPC), Montefiore Health Planning Teams, and members of the medically underserved, low-income, and minority population in the SJRH service area, who represent the health
interests of our community. The collection of primary data from a sample of the Westchester County residents was an important element of the development of the CHNA. SJRH, one of a number of health care participants, engaged with the WCDOH web/paper-based survey (pages 19 – 21) between January and May 2019. Over 3,500 surveys were completed with respondents requested to identify three each community and individual priority health issues/actions. The survey comprised the Primary Data Collection with queries tailored to align with the Prevention Agenda; the process included community based focus groups, grass roots distribution, collection and intra-organizational review of resident needs, service utilization and outcomes. Survey collection, methodology and data are noted on pages 18 – 31. The survey data collection process was followed by a Community Health Summit on April 5, 2019 to review/discuss the survey data. The SJRH CSP and IS are outcomes of this collaborative assessment. SJRH regularly collaborates with the Montefiore Hudson Valley Collaborative PPS. Secondary data, equally important to the assessment, was collected from multiple externally reported data sources, including but not limited to those referenced on page 44 - 47. This Community Health Improvement Plan addresses areas of two Prevention Agenda priorities we believe are of critical value to our community. Our focus initiatives require collaboration and engagement with partners to achieve successful results.

SJRH leadership assessed the organization’s resources, strengths, abilities and population served in the selection of its priorities. Partner sessions provided the opportunity for community hospitals to discuss Prevention Agenda priorities, feedback from the public needs assessment, services provided as well as gaps in service and best practices. A review of results from both primary and secondary data collection highlighted two major categories of health needs important across the populations surveyed and in alignment with the Prevention Agenda. While there were many health needs identified in the Survey,
chronic disease and substance use disorders ranked among the top themes for all races, ethnicities and age groups in the SJRH community. SJRH has selected the following Prevention Agenda priorities:

- **Priority Area:** Promote Well-Being and Prevent Mental and Substance Use Disorders
  - **Focus Area 2:** Mental and Substance Use Disorders Prevention
  - **Goal 1.2:** Prevent opioid and other substance misuse and death

- **Priority Area:** Prevent Chronic Diseases
  - **Focus Area 4:** Chronic Disease Preventive Care and Management
  - **Goal 4.1:** Increase cancer screening rates for breast cancer

The 2019 CHNA includes some findings consistent with prior assessments with community concern for attention to substance use disorders as well as prevention of diseases and is consistent with regional and nation concerns. In response, our initiatives will focus on enhancing services for the substance use disorder population via provision of Medication Assisted Treatment (MAT) and enhancing availability of breast cancer screening. Both initiatives align with the SJRH Mission and focus on services for disparate populations based on race, ethnicity and socioeconomic status.

Although lower than three of five peer counties, the opioid mortality rate tripled in Westchester County over the past decade (Figure 14). The disease of addiction requires a lifetime commitment for sobriety, this while the person experiences every day challenges which add stress to the process and/or to remain sober, resulting in relapse. Addiction has no boundaries with the social determinants of health. In addition, this disease is frequently associated with mental health disorders making it even more challenging to succeed in recovery. The use of MAT to provide FDA approved medication management of addiction in conjunction with behavioral/mental health support services has proven to help reduce one’s relapse and promote a more positive, healthy lifestyle. SJRH operates one of the largest substance use disorders services in New York State, including three outpatient rehab clinics (Mount Vernon, Greenburgh and Yonkers) and a 400 patient Opioid Clinic in Yonkers. Given our commitment to this patient population,
the identified need and the strength in our provision of addiction services, we will embark on an enhanced MAT program.

As a leader in breast cancer care, our other priority initiative is to enhance availability of breast cancer screening for females of color in our service area. Age-adjusted female breast cancer incidence rate increased in Westchester over the last several decades, above the rate for New York State (Figure 15). Given our long term participation in the Komen Grant which supports cancer screening and navigation of services for the underserved, SJRH is well positioned to provide cancer screening and individualized care. As we implement these initiatives, we will continue to collaborate with our community based colleagues to address health priorities, participate in community events and mutually exchange resource and referral information. We will partner to provide more refined data for tracking and evaluating process in goal achievement for our selected priorities. SJRH maintains a commitment to robust outreach which prioritizes health education and outreach services to the community. Efforts range from grassroots education, health screening programs, patient liaisons, physician outreach, patient concierge, care transition and support services. We continue to address community needs, provide various formal and informal supportive sources to individuals/families exhibiting healthcare challenges and participate in activities of national health advocacy such as walks, festivals, and other awareness-raising. Our internal CSP/IS Committee (page 86) will meet quarterly to evaluate successes and determine if/when revisions are required to improve outcomes. As received, community feedback will be included in these meetings. This will coincide with regular initiative reports to our organization-wide Performance Improvement Committee. Our selected initiatives are outlined on pages 32 - 39 including goals, objectives, evidence-based interventions, strategies, and activities that will continue through December 2024, including community partners and their roles and resources.
Introduction to St. John’s Riverside Hospital Mission

St. John’s Riverside Hospital, known for its closely integrated models of care, nationally recognized services and outcomes, and strong partners is uniquely positioned to meet the health care needs of its patients and community. The St. John’s Riverside Hospital Mission Statement fully encompasses our purpose and affirms our commitment to health care and those we serve. Our mission is as follows:

St. John’s Riverside Hospital is dedicated to providing comprehensive medical and nursing care in a compassionate, professional, respectful and ethical manner to every patient. By offering excellence in medical care, nursing, state-of-the-art technologies, continuing education and preventive services, we are committed to improving the care we provide within each of our institutions and the quality of life in our community. We are open to new ideas, directions and initiatives that most effectively respond to community health care needs.

Focus on Community Health

Located on the river edge in Westchester County, St. John’s Riverside Hospital (SJRH) provides medical care to the City of Yonkers and southern Westchester County. Celebrating 150 years of community care in 2019, our combined 378-bed system provides people with comprehensive preventive, diagnostic, and treatment services regardless of ability to pay.

SJRH primary service area includes the city of Yonkers, village of Dobbs Ferry and the surrounding towns and villages of Hastings-on-Hudson, Ardsley, Irvington, Tarrytown, Elmsford, Tuckahoe, Bronxville, and Scarsdale all within Westchester County, New York. Within the city of Yonkers and Dobbs Ferry, the SJRH facilities provide the largest health service in this geographic area and include community-based primary care and specialty ambulatory services. The Dobbs Ferry facility is the only hospital located in the village of Dobbs Ferry, approximately 7 miles from its SJRH sister facilities in Yonkers.

St. John’s Riverside Hospital (SJRH), part of the Hudson Valley Region, SJRH was the first hospital in Westchester County, opening its doors in 1869 as the St. John’s Invalid Home. Throughout its history of expansion, growing to three hospital campuses by 2009, and an outpatient center in 2017, SJRH has remained committed to improving the health of our community through a network that provides preventive, diagnostic, ambulatory, acute and therapeutic care. St. John’s linkages and partnerships with other health care providers and community-based organizations strengthen our reach and collaboration of comprehensive, patient-centered health care services in our region.

We have made vast investments in technology, physicians, nurses, training, and our facilities. We established a leadership role in healthcare and technology when we introduced MAKOplasty, the first orthopedic robotic system in Westchester, followed by the da Vinci robotic system and the first Hernia Center in Westchester. These offerings elevated St. John’s Riverside Hospital by offering the latest advances in surgery. Our pursuit of excellence includes renovations to several areas of the hospital which cover updated surgical operating rooms, private maternity suites and the on-going upgrade of patient rooms to private rooms. We provide a robust wound care program and Hyperbaric Therapy.
Since the establishment of The Cochran School of Nursing in 1893, St. John’s Riverside Hospital leaders have understood and respected the value of training the next generation of nursing and medical staff. In recent years, Cochran has been restructured to become more competitive and graduate high quality, competent nurses prepared for modern clinical practice. In July 2016, St. John’s Riverside Hospital implemented an Internal Medicine Residency program, followed by the implementation of an Emergency Medicine Residency in 2017, demonstrating that St. John’s Riverside Hospital is a leader in preserving quality health care for our community for generations to come.

All of these investments, along with our focused medical team, has improved quality scores across every area of patient care. We continue to be recognized by the most prestigious and respected organizations in healthcare. Our achievements include recognition in the U.S. News and World Report as Best in Orthopedics, Nephrology and Urology; Gold Plus recognition for Stroke Certification by the American Heart/Stroke Association. SJRH is accredited by the American College of Surgeons Commission on Cancer as both a Breast Center of Excellence and as a Gold Level Community Hospital Cancer Program with Outstanding Achievement. Given the size of our services, SJRH is among a select few hospitals in America with dual status. In 2015, 2016, 2017 and 2018, SJRH was privileged to receive the Women’s Choice Award from America’s Best Breast Centers. We are also accredited through the Accreditation Council for Graduate Medical Education which is the nation’s premiere medical education organization.

SJRH includes an ethnically diverse service area and is designated by New York State as a Safety Net Hospital for the regions with low income residents comprising over 40% of our patients.

It is with these world-class achievements that we are able to attract leading specialists to join our family. Progress continues and the future is bright with our commitment to the community. For more information, visit RiversideHealth.org or call 914.964.4444 or look for us on Facebook and Twitter.

**Organization Capacity**

St. John’s Riverside Hospital (SJRH), a not-for-profit, New York State Department of Health (NYSDOH) licensed 378-bed acute care community health system, operates three campuses: Andrus Pavilion (225 beds), Park Care Pavilion (141 beds), and Dobbs Ferry Pavilion (12 beds), (page 9). The Andrus Pavilion, provides emergency services, general acute and cancer care, with a full range of inpatient and outpatient services; is designated by the NYSDOH as a Stroke Center and Level II Perinatal Center, and is the only provider of maternity services in the city of Yonkers. The Andrus Pavilion also boasts a robust Wound Care Program and Hyperbaric Therapy Program.

Our Park Care Pavilion is located a few miles south of the main campus, Andrus Pavilion and has long served a special population, those afflicted with the disease of addiction. With its 141 beds, Park Care is the largest inpatient provider of detoxification and rehabilitation services in New York State and is certified by the New York State Office of Addiction Services and Supports. Park Care Behavioral Health services includes three community-based substance use disorder clinics located in Yonkers, Mount Vernon and Greenburgh and combined provided 66,031 patient visits in 2018. SJRH also operates a Methadone Clinic in the Park Care building which provides care for approximately 400 clients. While our Behavioral Health programs actively serve our immediate community, as the State’s largest inpatient provider and the primary inpatient provider for local counties, our services often extend to the surrounding counties as
needed specifically to the south. The Park Care Pavilion is also the home a NYSDOH designated AIDS Center.

The Dobbs Ferry Pavilion, provides inpatient and primary medical care, ambulatory surgery and emergency services, and is the hub for centers of excellence in breast and orthopedic care. At SJRH, over 600 medical and allied health professionals provide a wide range of ambulatory and inpatient services; and over 250,000 individuals are served annually within our network. SJRH, governed by a voluntary twenty-six member Board of Trustees, is a safety-net hospital serving the urban, ethnically diverse and economically disadvantaged community of southwest Yonkers, New York. As a designated NYS Essential Community Provider, we serve predominantly low-income medically underserved individuals.

SJRH is a leader in community collaboration and has a long history of developing innovative approaches to care and tailoring programs to best serve the changing needs of its community. These include, but are not limited to the following: Healthy Yonkers Initiative Partnership, Disease Management Programs, Comprehensive Lay and Clinical Patient Navigation Programs, Community Health Outreach Workers and a Speaker’s Bureau. The integration of these innovative approaches supports SJRH well in its provision of services to its community.

SJRH promotes wellness in addition to treating disease and addresses needs ranging far beyond medical care. We extend this responsibility to the care of our employees and medical staff, many of whom live in the surrounding community. SJRH serves a diverse community and has been a leader in the provisions of programs that improve patient access to culturally appropriate services. Our progressive financial aid policy and robust entitlement and enrollment program through our Financial Assistance Unit supports access to care for those in need. Historically, SJRH has viewed community service and community health improvement as an integral part of its Hospital Mission, reaching out to serve the underserved.

Services to the community are an explicit and essential component of SJRH’s Mission and one of its most valued traditions. We reach beyond the walls of our campuses to identify and meet the needs of the community, not just medically, but socially, economically and environmentally. SJRH participates in a variety of organized partnerships and collaborations, working with other providers in Westchester County, including the Westchester County Department of Health, community-based organizations and members of the community in planning and developing initiatives aimed at improving the overall health of the people of Westchester County.

The communities served by our health system are widespread and diverse. SJRH provides convenient access to high quality acute, primary and specialty care to individuals and families living in a primary service area which includes but is not limited to the following areas surrounding its location: 10001, 10030, 10035, 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10458, 10459, 10460, 10463, 10465, 10466, 10467, 10469, 10473, 10502, 10522, 10523, 10533, 10550, 10583, 10591, 10701, 10703, 10704, 10705, 10706, 10707, 10708, 10710, 10801, 11212 (Figure 16). As such, it is a key emergency medical service (EMS) participant operating in its two hospitals with 50,878 emergency visits in 2018.
SJRH FACILITIES

Andrus Pavilion – 967 North Broadway, Yonkers, New York 10701
Park Care Pavilion – 2 Park Avenue, Yonkers, New York 10703
Dobbs Ferry Pavilion – 128 Ashford Avenue, Dobbs Ferry, New York 10522

PRIMARY AND SPECIALTY SERVICES

Adult Endocrinology
Ambulatory Care
Asthma and Allergic Diseases
Bariatric Surgery Center
Cancer Program, Breast Cancer Center
Dermatology
Emergency and Critical Care
Family Medicine, Internal Medicine, General Surgery
Gastroenterology
Hospitalist Program
Hyperbaric Therapy
Infectious Diseases, Nephrology
Lab
Mental Health
Neonatal
Obstetrics/Gynecology
Occupational Medicine
Orthopedics
Pulmonology/PFT, Rheumatology
Sleep Disorders / Neurosurgery / Radiology
Speech Therapy / Physical Therapy / Occupational Therapy
Stroke Center
Urgent Care
Wound Care
Section B
Community Health Assessment

Westchester County lies in the Hudson Valley slightly north of New York City and encompasses an area of 430.5 square land miles which includes urban, suburban and rural geographies over six cities, 19 towns, and 23 villages. Westchester County is the 7th most populous county in New York State with 975,321 residents. The population is 21.8% Hispanic vs. 78.2% non-Hispanic as reported in the 2010 census. The county seat of Westchester is the city of White Plains (56,404) and other major cities include Yonkers (200,999), New Rochelle (79,877) and Mount Vernon (68,671). In 2017, the median household income for Westchester was $89,968, 4th highest in New York State, after Nassau, Putnam and Suffolk Counties. Westchester County is the 3rd healthiest county in New York State, according to the County Health Rankings, produced by the University of Wisconsin.

Westchester’s overall ranking for health care improved from 2015 and remains above other Counties. However, there remains considerable opportunity to improve population health and reduce health disparities in Westchester County. Several individual municipalities continue to maintain significant health gaps/disparities, with portions of lower Westchester specifically, Yonkers, Mount Vernon, New Rochelle and White Plains serving “hot spots” for asthma, and preterm births in the County. In addition, some racial/ethnic minority groups or those with less education experience poorer health outcomes. Some of Westchester County populations experience excess mortality rates. For example, the age-adjusted mortality rate per 100,000 for the non-Hispanic black (695.1 per 100,000) and non-Hispanic white (657.0 per 100,000) populations are significantly higher than for the Hispanic population (493.2 per 100,000).

While Westchester County has an age-adjusted preventable hospitalization rate below the New York State rate as well as the 2019 - 2024 Prevention Agenda Target, there are areas and subpopulations that have excess preventable hospitalization rates. The rates are generally elevated in the southern portion of the County, which includes Yonkers. Further, the rate of preventable hospitalizations for the non-Hispanic Black population (193.5/10,000) is more than double the rate for the non-Hispanic White population (67.4/10,000). The rate for the Hispanic population (56.0/10,000) is slightly lower that the non-Hispanic White population (Figure 17).

Additional Westchester County demographics are summarized on the table on page 52 with data sourced from the Mid-Hudson Regional Community Health Assessment 2018. This data reveals 3.2% more female than male persons in the population with White, non-Hispanic persons accounting for 54.4% of the population and Black, non-Hispanic persons accounting for 13.5%. English is the primary language for 66.7% of the population with 19.8% of the population Spanish speaking; the latter statistic reflects the highest percentage of persons speaking English vs. the other Mid-Hudson region counties. Persons between the ages of 20 and 64 years old represented 58.6% of the population. The base population referenced for educational attainment is those ages 25 years and older. In Westchester County, 53.9% of the population has attained an Associate’s degree and higher as opposed to the majority of New York
State (44%) and the Mid-Hudson Region (44%). The high percentage of the population engaged in college education in Westchester is supported by an 87% High School graduation rate which is 7% higher than the New York State rate. Another factor tied to education and which affects one’s ability to maintain health is the connection teenagers and young adults (ages 16 to 24 years) feel with their community. This can be evidenced by involvement either through work and school and develops their ability to maintain a connection with resources and people to develop their skills, increase knowledge and feel a sense of purpose. Westchester County has a 10.8% rate of disconnected youth which is fourth behind Putnam (8.8%), Rockland (10%), and Dutchess (10.2%) Counties and below the New York State rate of 12.1%. This statistic is positive for Westchester to support the transition of its youth into healthy adulthood.

It is understood that economic stability is a social determinant of health. Those with stable employment tend to have stronger outcomes for both physical and mental health; it is also understood that even within employed populations, there is potential for disparity between those with high paying and low paying jobs. Income also affects nearly every other social determinant of health. Westchester County has an unemployment rate of 6.5% as noted in the Mid-Hudson Regional Community Health Assessment 2018 report. This is lower than New York State (6.8%) and the United States (6.6%). However, the rate is higher than neighboring Rockland and Putnam Counties. Consistent with the rest of New York State, education services, health care and social service agencies are the largest employers for those 16 years and older.

Per the Mid-Hudson Regional Community Health Assessment 2018 report, Westchester County falls below the New York State poverty rate of 15.1% with 9.4% of its population identified as being in poverty. Because poverty and health are closely linked, this indicates that Westchester has greater strength with the income status of its occupants.

Yonkers is the 4th largest city in New York State and the largest city in Westchester with a 2016 population estimate of 200,807 as per the U.S. Census Bureau. It is an aging industrial city with needs often overlooked in a county dominated by affluent suburbs. Based upon the 2010 U.S. Census, the highest age in population for Yonkers ranges between 25 and 54 years equaling approximately 41.5% of the population; of the entire Yonkers population, 53% are female vs. 47% male. Data referenced for the 2013 – 2017 time period from the Westchester County Department of Planning reflected nearly 75,000 households in Yonkers with the median household income noted as $62,399, considerably lower than Westchester County.

Yonkers borders the Bronx and shares many of New York City’s urban problems. St. John’s economically, culturally and ethnically diverse service area encompasses neighborhoods with large numbers of Hispanic and African-American residents, including Haitian and Dominican immigrants. Yonkers has the second highest proportion of Hispanic/Latino residents in Westchester County second only to Peekskill, per the Westchester County Department of Planning report based upon the 2010 census.
Health Challenges

There is a multitude of reasons certain populations and geographic areas have poorer health outcomes to include but not limited to differences in access to health care, quality of care, physical environments, and economic and educational opportunities to name a few. An example is that although a smaller proportion of individuals in Westchester County live in poverty vs. New York State, those who are Black (16.6%), and Hispanic (19.4%) are more likely living in poverty than White (5.9%) (Figure 19.)

The City of Yonkers has been identified as one of Westchester County’s medically underserved areas (Figure 18). In addition, Greenburgh and Mount Vernon are also identified as underserved. SJRH serves these areas, especially for substance use disorder treatment through the clinics in both towns.

Compared to New York State, a smaller proportion of individuals live in poverty in Westchester County, 14.1% vs. 8.3%. Black and Hispanic populations are more likely to experience poverty in Westchester (Figure 19).

While the 2019-2024 Prevention Agenda health insurance coverage among adults ages 18 to 24 is targeted for 100%, Westchester County overall is 90.6%. Further disparity exists in health insurance coverage by race/ethnicity as evidenced by 92.3% of White and 88.5% of Black populations are insured while 72.9% of Hispanics have coverage, all of which are below the target (Figure 20). Yonkers is included in the areas where the population experiences lower health insurance coverage. The percentage of Westchester County adults between the ages of 18 and 64 who have a regular healthcare provider declined from 85.3% in 2009 to 79.2% in 2016 and is below peer counties (Figure 21). This adds to the challenges in providing not only acute care but screening and treatment for disease.

Westchester County distributed a summation of data in the Substance Use Disorder Key Indicators (Figure 22) which reveals an increase in opioid overdose deaths between 2014 and 2016 by 6.0% based upon a rate per 100,000. Further statistics revealed a decrease in opioid emergency department visits between 2016 and 2017. This supports a need to make services more accessible for reduction of opioid use and to decrease stigma surrounding the condition so those afflicted feel comfortable seeking help.

Although lower than 3 of 5 peer counties, the opioid mortality rate tripled in Westchester County over the past decade with a rate 12/100,000. It is further noted that the rate is highest in the non-Hispanic White population (Figure 14).

Data from the New York State 2017 Global Burden of Disease Project reveals that drug use disorders are a leading cause of ill health in New York State as measured by disability adjusted life years with a 2.2% increased between 1990 and 2017. The same report notes that drug use is the sixth leading cause of disability in New York State (Figures 23 and 24).

Also noted in the Substance Use Disorder Key Indicators report is that Westchester County experienced an increase in alcohol related motor vehicle injuries and death between 2014 and 2016. This is evidenced by a rate/100,000 change from 27.7 in 2014 to 31.3 in 2016, despite a decrease in 2015. Adult binge drinking was higher in Westchester County vs. the rest of New York State by 1.6%. Despite a slight decrease in the rate per 10,000 for DWI arrests 2017 (18.1) from 2016 (20.0), the rate is still higher than 2015 (17.3) revealing efforts with substance use disorders must remain a key priority (Figure 22).
Compared to peer counties, Westchester has the largest percentage of adults reporting binge drinking in a one month reporting time (Figure 25).

Cigarette smoking is a health concern for all ages. Data reveals that the proportion of Westchester County adults who smoke cigarettes declined from 11.7% to 8.4% between 2013/2014 and 2016, and still remains lower than the New York State statistic of 14.2% (Figure 26). Interestingly, one of the highest use areas is closest to the SJRH sites (Figure 27). As per the New York State 2017 Global Burden of Disease Project, tobacco is the third leading causing of ill health and is strongly associated with many cancers, cardiovascular disease and chronic respiratory disease (Figure 23 and 24).

Mental health disorders often co-occur with substance use disorders. Despite statistics which affirm the substance use crisis, Westchester County adults who reported poor mental health for > 14 days in a month was less (9.1%) than three peer counties but higher than neighboring Rockland and Suffolk Counties (Figure 28). Interestingly, in Yonkers the highest percentage of those with mental distress (12.9 – 19.4) is noted in the area immediately surrounding the main Hospital (Figure 29).

The age-adjusted suicide death rate per 100,000 population remained stable in Westchester County between the 2008/2012 (6.3) and 2014/2016 (6.1) time frames but is still slightly above the Prevention Agenda target of 5.9. When compared to peer counties, Westchester is tied for second lowest (Figure 30).

Disparities are also present for other health outcomes. There is variation in the rate of asthma Emergency Department (ED) visits in Westchester County. While Westchester had a rate of 63.7 per 10,000 in 2014, which is below the rate for New York State overall (86.2), this County has the second highest compared to peer Counties (Figure 31). Rates are generally elevated in southern Yonkers.

As previously noted, education and socioeconomic status are important determinants of health status and outcomes. In Westchester County, adults with no college education are more likely to have diabetes than adults with some college education (13.9 vs 7.0% respectively). As per the map (Figure 32) provided by the City Health Dashboard, New York University, the areas in Yonkers immediately surrounding SJRH have the highest percentage of adults with Diabetes. Although the rate/10,000 of Diabetes associated hospitalizations increased slightly between 2008/2010 and 2012/2014 (3.7 to 4.4), the rate remained below New York State overall as well as the 2018 Prevention Agenda target. The Westchester rate is similar to peer Counties (Figure 33).

Childhood and adult obesity are long standing areas of concern nationwide. Westchester County has the smallest proportions of adult persons with obesity as compared to New York State overall and peer counties (Figure 34). Obesity in children and adolescents in Westchester County is of smaller proportion (13.6%) vs. New York State overall (17.3%) (Figure 35).

Adolescent pregnancy rates/1,000 decreased dramatically from 2008 (19.5) to 2016 (7.1). Despite the decline, the rate of adolescent pregnancy is significantly higher for non-Hispanic Black (18.5/1,000) and Hispanic (16.4/1,000) than non-Hispanic White adolescents (Figure 36).

Disparity is present in maternal and child health with one example being Westchester County experiencing a 12.1% rate of preterm births vs. 10.3% in New York State with the Westchester rate above the
Prevention Agenda 2018 Target of 10.2%. This rate also exceeds peer counties and is noted to be highest in the non-Hispanic Black population (Figure 37).

It has long been understood that breast feeding is considered healthiest for mother and child; the proportion of infants exclusively breastfed in Westchester County decreased slightly in the last decade to 45.3% but still remains the second highest of peer counties. The proportion of infants exclusively breastfed in the hospital is highest for non-Hispanic White populations at 58.6% vs. Hispanic (42%) and non-Hispanic Black populations (35.4%) (Figure 37).

Timely cancer screening and treatment remain a nationwide focus. Westchester County data reveals an increase in the incidence of age-adjusted female breast cancer with a rate that is not only above the New York State rate overall but also above three peer Counties. The highest incidence is in non-Hispanic White residents (157.4/100,000) as opposed to non-Hispanic Black residents (127.6/100,000) and Hispanic residents (101.5/100,000) (Figure 39).

Colorectal cancer screening in Westchester County was higher than New York State overall (71.3% vs. 68%); however, both rates are below the Prevention Agenda target. Of note, Westchester has the highest rate compared to peer Counties (Figure 40). Evidence of the higher rate of screening is substantiated by a decline over the past few decades in the incidence of age-adjusted colorectal cancer which is 35.8% for Westchester vs. 38.9% for New York State overall and below all peer Counties except Dutchess. Rates are higher and almost equal for non-Hispanic White and non-Hispanic Black residents (37.3/100,000 & 38.5/100,000) vs. 30.3/100,000 for the Hispanic population (Figure 41).

Although below the New York State statistic, Westchester is ahead of peer Counties with regard to childhood immunizations (Figure 42). In addition, Westchester County can boast an adult flu immunization rate above the New York State rate (64.2 vs. 59.5) and above four of its five peer Counties (Figure 43). Both rates are indicators for wellness.

SJRH will continue to collaborate with all community partners on the provision of quality health care and on the initiatives selected for this Prevention Agenda period. As an active partner in the Westchester community, we participate with our health care and support service colleagues to promote healthy living and wellness. Please see pages 83 – 85 which include but are not limited to our various health partners. Also note that partners specific to the initiatives are referenced within the Community Health Improvement Plan presentation on pages 32 – 39.

As noted, SJRH was an active participant in the County-wide survey. Review of the general results of this survey revealed that respondents identified a priority health issue for the community as Chronic Disease Screening and Care which was noted as the 2nd most important issue for Westchester County. Substance Use Disorders was noted in the top 10, ranking as the 8th community priority (Figure 8). Actions for both of these priorities ranked in the top 10 for Westchester with Drug and Alcohol Treatment Services 6th and Health Screenings 8th (Figure 9).

Responses were collated for the individual priorities and Chronic Disease Screening and Care ranked 4th with Substance Use Disorders ranking 19th. Of note, respondents identified Mental Health as a priority and this ranked 5th (Figure 12). Upon review of this, it could be hypothesized that of the more than 3500
respondents, respondents did not perceive a personal/individual need for substance use disorder treatment and/or did not have personal exposure to same. However, another hypothesis could be consistent with the ongoing stigma still attached to the disease of addiction and the often co-occurring mental health issues which may be evidenced in the ranking of mental health as the collective 5th priority.

Interestingly, the data specific to SJRH service area collectively reveals respondents noted Mental Health as 1st priority, followed by Chronic Disease Screening and Care as 2nd and Substance Use Disorders as 8th for the community (Figure 11). Consistent with the larger survey of all Westchester respondents, individual priorities for the SJRH service area was noted as Chronic Disease Screening and Care as 4th, Mental Health 5th and Substance Use Disorders as 19th (Figure 12). Again, the same hypothesis may apply.

Upon review of the survey data, it was noted that respondents identified most helpful actions for the SJRH service area with Mental Health 3rd, Drug and Alcohol Treatment Services as 7th and Health Screenings as 9th (Figure 13). All of this data supports the selection of the initiatives noted within this report. While SJRH is committed to comprehensive quality care for all of its service area, given the respondents identification of the community needs as noted above as well as our strength in servicing persons with substance use disorders and our highly recognized breast cancer care programs, we determined the two initiatives outlined on pages 32 – 39 to be our focus for the Community Health Improvement Plan for this particular Prevention Agenda.

As a participant in the Westchester County Health Assessment and the subsequent County Health Summit which includes a diverse group of health care professionals and community service organizations, challenges and barriers to health care were identified. Extensive discussion ensued regarding various trends, identified challenges and proposed actions with a focus on the Prevention Agenda Priorities. A detailed report of the Health Summit (Appendix A) was distributed to all participants and will not be reiterated here. Identified challenges for our service area include, in no particular order:

- Mental health and substance use disorders remain a high concern as does the stigma surrounding these diseases.
- Geographical and affordability barriers to access of mental health care.
- Undocumented status of individuals is a barrier as these persons may be fearful and often reluctant to seek resources.
- Disparities range across race, gender and age.
- Language barriers exist.
- Lack of funding (solo efforts are more challenging to start and to resource thus requiring partnership and collaboration)
- Education is critical throughout the age spectrum to promote healthy lifestyle behaviors and must be capitalized upon.
- Economic and “safety” disparities remain throughout the county.
- Observed inconsistent and fragmented education across the community.
- Development of safe environments for persons seeking help (undocumented, family violence, mental health disorder stigmas, etc.)
- Adequate and appropriate resources across the county, but coordination is lacking.
• Health improvement requires broader approaches addressing social, economic and environmental factors.
• Importance of enhancing patient centered care and inclusivity is needed for extending care planning to family and caregivers and promoting a multidisciplinary approach in treatment.
• Ease of access will continue to impact choice and utilization.
• Need to change the financial incentive structure of public assistance to pay for healthy food options.
• Work is needed with local organizations to increase access to healthier food options.
• Jobs are needed and employers should promote health, offer childcare, and more.
• Economic status inequality exists.
• Affordable, healthy food is needed and there is a lack of green/farmers markets.
• Public transportation is limited in sections of Westchester County.
• Need in the community for more affordable housing (both permanent and transitional purposes).
• Water quality is threatened due to improper disposal of pharmaceuticals.
• Safe places are needed for all to walk, play, exercise and socially engage.

In addition, as noted in the NYS Prevention Agenda 2019 – 2024 Health Assessment/Summary of Health Issues, chronic diseases continue to be a major burden including cancer. Often people do not seek appropriate screening and/or are unaware of the opportunities to do so. This often leaves the person without care at an early stage of disease when treatment can be initiated promptly to reduce negative outcomes. As is well understood, early detection of cancer leads to more effective and successful treatment.

Also noted in the same aforementioned assessment, opioid overdose remains a serious health concern and one that contributes to declining life expectancy. As noted in Figure 44 from the NYS Prevention Agenda and sourced from CDC WONDER, in 2016 overdose deaths involving any opioid, age-adjusted rate/100,000 in New York State was 15.1 for the State overall and 11.5 in the New York City area. The latter is a close neighbor of Westchester County and as SJRH is the one of the largest inpatient substance use disorder providers in New York State, we often serve persons in our neighboring Counties. Both regionally and nationally, substance use disorders remain a prevalent health concern and require ongoing attention. Mental health and substance use are more often than not co-occurring and those who suffer from these conditions require extensive assessments to determine the primary problem in order to effectively develop a solid treatment plan that reflects patient centered care with a compassionate and non-stigmatizing approach.

These two concerns were identified by the SJRH team as priorities for our service area given the needs identified in the review of primary and secondary data resources as well as our strength in provision of both breast cancer care and substance use disorder treatment.

SJRH has the resources and expertise to assist its community with many of the challenges and will remain a willing and active partner in improving health care for the larger community.

For the last three years, St. John’s Riverside Hospital implemented a project relative to assessment of co-occurring mental health disorders as a way to assist with treating people with substance use disorders. As one of the largest providers of substance use disorder services in New York State, SJRH is well positioned
to continue to assist with the opioid crisis and build patient centered care for persons who suffer from addiction, with a focus on providing our patients with an opportunity to attain and sustain sobriety. The goal is for long term treatment. During the WCHPC Health Summit, it was acknowledged that there continues to exist stigma within the larger community regarding people suffering from substance use disorder. Participants in the Health Summit committed to breaking down silos and increasing collaboration to serve this special population. SJRH is positioned to lead this effort with the enhanced MAT program. This program will be described in more detail in the following pages but will consist of increased provision of MAT and ongoing monitoring to assess success rates and resolve barriers to success.

SJRH has demonstrated a long-standing commitment to high quality cancer care through the integration of breast health outreach, education, screening, diagnostic services, treatment, support, survivorship, research and clinical trials. As previously noted, SJRH’s cancer programs are accredited by the American College of Surgeon’s Commission on Cancer as both a Breast Center of Excellence and as a gold-level Community Hospital Cancer Program with Outstanding Achievement. This dual status has been granted to only a select few hospitals in America and we are proud to be among this group.

The SJRH Yonkers Community Breast Health Program ensures access to patient navigation, education, screening, timely follow-up for treatment and provision of support services for women in our medically underserved Yonkers community. Breast cancer rates among minority communities continue to outpace those of white women in our service area, where one out of five will develop breast cancer. Our mission is to detect the disease in its earliest stage to delay, if not prevent, its onset and avoid unnecessary testing and hospitalization.

We are a State-designated Safety Net Hospital for the region with low-income residents comprising over 40% of our patients. As per the U.S. Census Bureau (2013-2017 American Community Survey 5-year estimates) Yonkers females 35+ make up 30% of the population and 52.6% are women of color. The median household income in 2017 was $62,399 and 16.4% live in poverty.

SJRH provides opportunities for assistance for those in need without adequate means/insurance to support their health care. Our policy is posted on our website RiversideHealth.org. In this location, the viewer may learn about Hospital charges/expenses, insurances as well as gain information re: financial assistance.
Primary Data Collection

Primary data collection for the Westchester County CHNA was done collaboratively between partner institutions and the Westchester County Department of Health. Community input on health priorities in Westchester County was gathered through a community survey and an in-person summit with stakeholders. The methods are summarized below. Multiple approaches to primary data collection were used to make use of existing and cost-efficient data collection activities and to employ multiple methods at gathering community input, so no single method or group of people would receive too much weight in identifying community concerns. As aforementioned in this report, the survey queries were tailored to align with the Prevention Agenda; the process included community based focus groups, grass roots distribution, collection and intra-organizational review of resident needs, service utilization and outcomes.

Community Survey

For the community survey, a total of 3,524 surveys were completed among individuals working-in or residing-in Westchester County. Seventy-three percent of respondents were women, 26% were men and 1.0% identified as non-binary, trans female/trans woman, trans male/trans man (Figure 2). The survey was completed by a wide-range of ages (Figure 1).

- 7.9% were 18-24y
- 18.1% were 25-34y
- 17.5% were 35-44y
- 17.4% were 45-54y
- 18.3% were 55-64y
- 20.9% were ≥65y.

Thirty two percent of respondents identified as Hispanic and 43.7% identified as non-Hispanic white and 16.2% as non-Hispanic black (Figure 3). Respondents resided throughout the county, with 13% living in a White Plains ZIP Code (10601, 10603, 10604, 10605, 10606, 10607, 10608) and approximately 34.6% living in the St. John’s Riverside service area. Additional respondent demographics information is noted in Figures 1 through 7.

Participants were asked to identify the three health priorities for the community, which included options such as smoking, obesity, diabetes, mental health and access to primary care. In addition, participants were asked to identify the potential strategies that would, in their opinion, have the greatest impact on improving population health. Participants were also asked to rank their own personal health priorities. The leading community health priorities identified included mental health, chronic disease screening and care, food and nutrition, obesity and environments that promote well-being and active living (Figure 8). The leading personal health priorities were food and nutrition, physical activity, environments that promote well-being and active living, chronic disease screening and care and mental health (Figure 10). The leading strategies identified included: affordable housing, mental health services, access to healthier food, exercise and weight loss programs, employment opportunities and drug and alcohol treatment services (Figure 9).
2019 Westchester County Community Health Survey

There are many areas where the healthcare system can make efforts to improve community. We are interested in knowing the areas the healthcare system should prioritize in Westchester County, NY. Your opinion on priorities for both community health and your own personal health are of interest. Your responses are anonymous. Please only complete this survey if you are 18 years-old or older. Thank you for your participation!

The first few questions are about the health needs of the community where you live.

What THREE areas do you see as being priority health needs in the community where you live?

- Antibiotic resistance and healthcare associated infections
- Chronic disease screening and care for conditions like asthma, diabetes, cancer and heart disease
- Food safety and chemicals in consumer products
- Hepatitis C
- Injuries, such as falls, work-injuries or traffic-injuries
- Mental health
- Outdoor air quality
- Smoking, vaping and secondhand smoke
- Substance use disorders
- Violence

- Child and adolescent health
- Environments that promote well-being and active lifestyles
- Food and nutrition
- HIV/AIDS
- Maternal and women’s health
- Newborn and infant health
- Physical activity
- Sexually transmitted diseases
- Vaccinations/immunizations
- Water quality

What THREE actions would be most helpful to improve the health of the community where you live?

- Access to dental care
- Access to primary care
- Caregiver support
- Drug & alcohol treatment services
- Health insurance enrollment
- Improving racial equality
- Quality and affordable childcare
- Services for older adults
- Violence prevention

- Access to education
- Affordable housing
- Clean air & water
- Employment opportunities
- Health screenings
- Immigrant support services
- Safe places to walk & play
- Smoking & tobacco services

- Access to healthier food
- Breastfeeding support
- Domestic violence prevention/victim support
- Exercise & weight loss programs
- Home care services
- Mental health services
- Services for LGBTQ population
- Public transportation

What population needs the greatest attention?

- Infants
- Young children
- School-aged children
- Teens
- Young adults
- Middle-aged adults
- Older adults

The rest of the survey is about you and your health needs.
What THREE areas do you see as being priority health needs for YOURSELF?

- Antibiotic resistance and healthcare associated infections
- Chronic disease screening and care for conditions like asthma, diabetes, cancer and heart disease
- Food safety and chemicals in consumer products
- Hepatitis C
- Injuries, such as falls, work-injuries or traffic-injuries
- Mental health
- Outdoor air quality
- Smoking, vaping and secondhand smoke
- Substance use disorders
- Violence
- Antibiotic resistance and healthcare associated infections
- Child and adolescent health
- Environments that promote well-being and active lifestyles
- Food and nutrition
- HIV/AIDS
- Maternal and women's health
- Newborn and infant health
- Physical activity
- Sexually transmitted diseases
- Vaccinations/immunizations
- Water quality

Would you say that in general your health is:
- Excellent
- Very good
- Good
- Fair
- Poor

Do you have somebody that you think of as your personal doctor or health care provider?
- Yes
- No

Has a doctor, nurse or other health professional told you that you had any of the following (check all that apply):
- Heart disease
- Stroke
- Asthma
- Depression/anxiety
- Skin cancer
- Cancer (not including skin cancer)
- COPD, emphysema or chronic bronchitis
- Arthritis
- Kidney disease
- Diabetes (not including during pregnancy)

Was there a time in the past year 12 months when you needed to see a doctor but could not because of the following ...?
- Cost
- Transportation
- Could not get appointment at time that worked

What type of insurance do you use to pay for your doctor or hospital bills (check all that apply):
- Your employer or a family member’s employer
- The New York State Marketplace (Exchange)
- Medicare
- Medicaid
- Military (TriCare or VA)
- COBRA
- I do not have health insurance
- Other: ___________

During the past 30 days, have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on any of the following...
- Race or ethnicity
- Gender identity
- Age
- Sexual orientation
- Perceived immigration status
- Religion
- Disability

The next set of questions will be used to describe who responds to the survey and will not be examined individually. Please remember that your responses are anonymous.

What is your current gender identity?
- Female
- Male
- Trans female/trans woman
- Trans male/Trans man
- Genderqueer/gender non-conforming
- Different identity (please state): __________________

What is your age?
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75+

What is the highest grade or year of school you completed?
- Less than high school
- High school graduate/GED
Figure 1: Age of Respondents %
Figure 2: Gender of Respondents %

- Female: 73.3%
- Male: 26.5%
- Non-binary: 0.2%

Figure 3: Race/Ethnicity of Respondents %

- Non-Hispanic White: 43.7%
- Hispanic: 31.6%
- Non-Hispanic Black: 16.2%
- Non-Hispanic Asian/Pacific: 3.4%
- Non-Hispanic Multiple: 2.1%
- Non-Hispanic Other: 2.5%
- Non-Hispanic American Indian/Alaskan: 0.4%
Figure 4: Respondent Language Spoken %

![Pie chart showing language spoken by respondents. The majority (74.8%) speaks English, followed by Spanish (19.7%) and Other (5.5%).](image)

Figure 5: Education of Respondents %

![Pie chart showing education level of respondents. The largest group (24.6%) has a College Grad degree, followed by Advanced/Pro Degree (29.5%), High School Grad/GED (18.8%), Some College/Tech School (19.3%), and Less than High School (7.7%).](image)
Figure 6: Respondent Employment Status %

- Employed: 57%
- Retired: 15.8%
- Out of Work: 9.1%
- Homemaker: 6.7%
- Self Employed: 5.4%
- Student: 4.9%
- Unable to Work: 4.1%

Figure 7: Insurance of Respondents %

- Commercial: 58.5%
- Medicare: 21.7%
- Medicaid: 16.4%
- None: 7.3%
Figure 8: Community Health Priorities Identified by the Westchester County Community Survey, 2019

- Mental health
- Chronic disease screening & care
- Food & nutrition
- Obesity
- Environments that promote well-being & active living
- Child & adolescent health
- Smoking/vaping/secondhand smoke
- Substance use disorders
- Physical activity
- Food safety & chemicals in consumer products
- Violence
- Maternal & women’s health
- Water quality
- Injuries
- Vaccinations/immunizations
- Sexually transmitted diseases
- Antibiotics resistance & healthcare associate infection
- Newborn & infant health
- Outdoor air quality
- HIV/AIDS
- Hepatitis C

Data source: Westchester County Community Survey, 2019
Figure 9: Strategies to Improve Health Among Westchester County Residents from the Westchester County Community Survey, 2019

Data source: Westchester County Community Survey, 2019
Figure 10: Individual Health Priorities Identified by the Westchester County Community Survey, 2019

Data source: Westchester County Community Survey, 2019
Figure 11: Community Health Priorities Identified by St. John’s Riverside Hospital Service Area, 2019
Figure 12: Individual Health Priorities Identified by the St. John’s Riverside Hospital Service Area, 2019
Figure 13: Strategies to Improve Health Among Residents in the St. John’s Hospital Service Area, 2019
Summit Findings

The final report from the Summit is available in Appendix A. Key actions within each of the four Prevention Agenda Priority Areas were identified as follows:

- **Prevent chronic disease**: Support and leverage existing community resources across homes, schools, churches, CBOs, etc. to address chronic diseases.
- **Promote a healthy and safe environment**: Address currently fragmented and inconsistent education and communication.
- **Promote healthy women, infants and children**: 1) Design community awareness campaigns and messaging focused upon prenatal and infant care and, 2) Health systems need a holistic care approach that eliminates silos across the continuum.
- **Promote well-being and prevent mental and substance use disorders**: Break down silos and collaborate through forums such as the 2019 Health Summit.

Key Findings from Analysis

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

This Community Health Needs Assessment, Implementation Strategy and Community Service Plan will be monitored quarterly and an update reported to the public on an annual basis.

<table>
<thead>
<tr>
<th>PRIORITY AREA: Prevent Chronic Diseases</th>
<th>Focus Area 4: Chronic Disease Preventive Care and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL: 4.1</strong></td>
<td>Increase Cancer Screening Rates (Breast Cancer)</td>
</tr>
<tr>
<td>Objective 4.1.1</td>
<td>Increase the percentage of women with an annual household income of less than $25,000 who receive breast cancer screening based on most recent guidelines.</td>
</tr>
<tr>
<td>INTERVENTIONS/STRATEGIES/ACTIVITIES:</td>
<td>1. Work with health care providers/clinics to put system in place for patient and provider screening reminders.</td>
</tr>
<tr>
<td></td>
<td>2. Conduct one-one (by phone and in person) and group education (presentation or other interactive sessions in church, home, senior center, or other setting).</td>
</tr>
<tr>
<td>PROCESS MEASURES:</td>
<td><strong>Current State:</strong> In the 2018-2019 Komen grant year, SJRH provided breast cancer screening to 340 individuals with annual household incomes less than $25,000.</td>
</tr>
<tr>
<td>(Evidence-based/Promising Practice Resources)</td>
<td><strong>Process Measures:</strong> 1. By 11/30/2020, SJRH will provide appropriate breast cancer screening to 450 individuals with household incomes less than $25,000.</td>
</tr>
<tr>
<td></td>
<td>2. By 11/30/2021, SJRH will provide appropriate breast cancer screenings to 490 individuals with household incomes less than $25,000.</td>
</tr>
<tr>
<td>PARTNER ROLE:</td>
<td>Susan G. Komen Foundation</td>
</tr>
<tr>
<td></td>
<td>American Cancer Society</td>
</tr>
<tr>
<td></td>
<td>Cancer Support Team</td>
</tr>
<tr>
<td></td>
<td>Gilda’s Club of Westchester</td>
</tr>
<tr>
<td></td>
<td>Westchester Jewish Community Services</td>
</tr>
<tr>
<td></td>
<td>Support Connection</td>
</tr>
<tr>
<td></td>
<td>Cancer Services Program of the Hudson Valley</td>
</tr>
<tr>
<td></td>
<td>Hudson River Healthcare</td>
</tr>
<tr>
<td></td>
<td>Young Women’s Christian Association</td>
</tr>
</tbody>
</table>
## PRIORITY AREA: Prevent Chronic Diseases

**Focus Area 4: Chronic Disease Preventive Care and Management**

<table>
<thead>
<tr>
<th>GOAL: 4.1 continued</th>
<th>Increase Cancer Screening Rates (Breast Cancer)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PARTNER RESOURCES:</strong></td>
<td>Susan G. Komen Foundation – ongoing grant support of navigator activities including patient reminders as well as individual and group racially and ethnically appropriate educational efforts.</td>
</tr>
<tr>
<td></td>
<td>American Cancer Society – education, prevention and early detection, community referrals, free wigs, transportation assistance, free/discount rate lodging, advocacy and patient services.</td>
</tr>
<tr>
<td></td>
<td>Cancer Support Team – provide professional nursing, social work counseling, case management and other supportive services, as well as transportation and financial assistance.</td>
</tr>
<tr>
<td></td>
<td>Gilda’s Club – innovative programs that are an essential complement to medical care, providing individual and family counseling, support groups, workshops, education, and social activities.</td>
</tr>
<tr>
<td></td>
<td>WJCS – provides services that address the emotional, practical, spiritual and caregiving needs of individuals and families facing serious and life threatening illness.</td>
</tr>
<tr>
<td></td>
<td>Support Connection – provides free, confidential support services and programs to people affected by breast and ovarian cancer.</td>
</tr>
<tr>
<td></td>
<td>Cancer Services Program of the Hudson Valley – provide free screening mammograms for insured women between 40 and 64.</td>
</tr>
<tr>
<td></td>
<td>HRHC – FQHC which provides primary care, obstetrics and gynecology services and is a core referral practice for screening and diagnostic imaging.</td>
</tr>
<tr>
<td></td>
<td>YWCA – Encore Plus Program has provided breast cancer awareness and prevention education to low-income, uninsured/underinsured and senior women.</td>
</tr>
</tbody>
</table>

**BY WHEN:**

See Process Measures sections above for goals.

**ACTION ADDRESSES DISPARITY:**

Hispanic women are disproportionately affected with breast cancer and African American women have a disproportionately higher rate of breast cancer mortality in Westchester County. The Komen Grant targets women of color for breast cancer screening and appropriate follow up to screening within an appropriate time line.

| Target: | 79.7% |
| Baseline: | 75.9% |
| Baseline Year: | 2016 |
| Data Source: | BRFSS |
| Date Level: | State (race/ethnicity, gender & region) and County |
Per the 2018 Mid-Hudson Region Community Health Assessment which sourced data from the American Cancer Society 2017 and the NYSDOH Cancer Registry, 2018, in the United States, the age-adjusted rate of breast cancer incidence in 2015 was 126.2/100,000 women. The rate for Westchester was 143.8, 4th highest in the Mid-Hudson peer group, revealing opportunity for improvement. Public awareness, screening and advanced treatment options contribute to decreased mortality rates. One of the key screening tools is mammography and is recommended for women 40 years and older. As reported in the aforementioned Mid-Hudson report, Healthy People 2020 set a target of 81.1% of the female population to receive breast cancer screening. Per current data, Westchester met this target at 84.8%; however, there are disparities experienced between women of color relating to both screening and follow up with appropriate time frames. SJRH will continue its commitment to promote breast cancer screenings and continue our commitment to the underserved in our community.

The specific evidence-based interventions/strategies/activities being implemented to address the specific priority Prevent Chronic Disease through enhanced breast cancer screening are noted below and in the aforementioned table.

1. **Work with health care providers/clinics to put system in place for patient and provider screening reminders.**

2. **Conduct one-to-one (by phone and in person) and group education (presentation or other interactive sessions in churches, homes, senior centers, or other settings).**

Both interventions are listed as evidence-based in the New York State Health Improvement Plan 2019 – 2024 (pages 44-45) based on evidence cited in the Community Guide (https://www.thecommunityguide.org/topic/cancer). Both of these interventions are currently supported by SJRH’s grant from the Susan G Komen Breast Cancer Foundation (https://ww5.komen.org/).

Our goal will be to increase the number of screenings provided to women in the community with annual household incomes less than $25,000. Specifically, our goal shall be to increase the number of women of color and racial/ethnic minorities receiving this service.

This initiative and the progress made will be tracked to evaluate the impact of our work. During the Komen Grant year of April 2019 – March 2020, SJRH developed a data tracking system using data harvested from our Meditech EMR to identify the number of women with Medicaid as the primary payer source who received breast cancer related services within a cascade of treatment. This data includes individuals falling within the target population who are educated regarding breast cancer, number of individuals screened for breast cancer, number who need diagnostic imaging, number who need imaging and complete the imaging, number with an abnormal finding from the imaging who require follow up, and the number of received follow up within the appropriate time frame. Data for this initiative (number who are screened) shall be harvested quarterly from the second tier of this cascade.
The Process Measures and our partners in this initiative are noted in the above table. SJRH resources include, but are not limited to Patient Navigation, Cancer Support Group, Look Good Feel Better Program. Community based resources are identified in the summary table below.

<table>
<thead>
<tr>
<th>Resource Name</th>
<th>Type of Resource</th>
<th>Services Target Population Receives</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. John’s Riverside Hospital</td>
<td>Community-based hospital</td>
<td>Patient Navigation; including scheduling of appointments, call backs and reminder letters for additional imaging and biopsies, referrals for transportation to treatment for breast cancer, support groups</td>
</tr>
<tr>
<td>Susan G. Komen Foundation</td>
<td>Foundation</td>
<td>Ongoing grant support of navigator activities including patient reminders as well as individual and group racially and ethnically appropriate educational efforts.</td>
</tr>
<tr>
<td>American Cancer Society</td>
<td>Community-based organization</td>
<td>Education, prevention and early detection, community referrals, free wigs, transportation assistance, free/discount rate lodging, advocacy and patient services.</td>
</tr>
<tr>
<td>Cancer Support Team</td>
<td>Community-based organization</td>
<td>Provide professional nursing, social work counseling, case management and other supportive services, as well as transportation and financial assistance.</td>
</tr>
<tr>
<td>Gilda’s Club</td>
<td>Community-based organization</td>
<td>Innovative programs that are an essential complement to medical care, providing individual and family counseling, support groups, workshops, education, and social activities.</td>
</tr>
<tr>
<td>WJCS</td>
<td>Community-based organization; Mental Health provider</td>
<td>Provides services that address the emotional, practical, spiritual and caregiving needs of individuals and families facing serious and life threatening illness.</td>
</tr>
<tr>
<td>Support Connection</td>
<td>Community-based organization</td>
<td>Provides free, confidential support services and programs to people affected by breast and ovarian cancer.</td>
</tr>
<tr>
<td>Cancer Services Program of the Hudson Valley</td>
<td>Community-based organization</td>
<td>Provides free screening mammograms for insured women between 40 and 64.</td>
</tr>
<tr>
<td>Hudson River Healthcare</td>
<td>Federally qualified health center.</td>
<td>FQHC which provides primary care, obstetrics and gynecology services and is a core referral practice for screening and diagnostic imaging.</td>
</tr>
<tr>
<td>YWCA-Encore Plus Program</td>
<td>Community-based organization</td>
<td>Encore Plus Program has provided breast cancer awareness and prevention education to low-income, uninsured/underinsured and senior women.</td>
</tr>
</tbody>
</table>
## PRIORITY AREA: Promote Well-Being and Prevent Mental and Substance Use Disorders
### Focus Area 2: Mental and Substance Use Disorders Prevention

<table>
<thead>
<tr>
<th>GOAL 2.2:</th>
<th>Prevent opioid and other substance misuse and death.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 2.2.2:</td>
<td>Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.8 per 1,000 population. Baseline: 36.5 per 1,000</td>
</tr>
<tr>
<td>INTERVENTIONS/STRATEGIES/ACTIVITIES:</td>
<td>Medication Assisted Treatment (MAT) is an evidence-based intervention for Opioid Use Disorder.</td>
</tr>
</tbody>
</table>
| PROCESS MEASURES: (Evidence-based/Promising Practice Resources) | Current State:  
- At SJRH, 33.5 percent of qualified outpatients\(^1\) who have an opioid use disorder diagnosis receive their first prescription for MAT during the first 30 days following assessment.  
- At SJRH, 0% of qualified inpatients\(^2\) in our detoxification services receive their first dose of Buprenorphine (or other MAT) during their inpatient stay.  

**Process Measures:**  
1. By 11/30/2020, 44% of all appropriate patients who have a diagnosis of opioid use disorder in the outpatient substance use services shall be offered and shall accept Buprenorphine treatment within 30 days of program assessment.  
2. By December 2021, 54% of all appropriate patients who have a diagnosis of opioid use disorder in the outpatient substance use services shall be offered and shall accept Buprenorphine treatment within 30 days of program assessment.  
3. By 11/30/2020, 10% of all appropriate inpatient detoxification patients who have a diagnosis of opioid use disorder shall be offered and shall accept Buprenorphine treatment during their inpatient stay.  
4. By 11/30/2021, 54% of all appropriate inpatient detoxification patients who have a diagnosis of opioid use disorder shall be offered and shall accept Buprenorphine treatment during their inpatient stay. |
| PARTNER ROLE: | MHVC  
Montefiore Health Services  
NYS State OASAS  
Westchester County Department of Community Health |

\(^1\) Those outpatients with a medically appropriate opioid use disorder who are not currently receiving treatment with another approved MAT, including Methadone.  
\(^2\) Those inpatients with a medically appropriate opioid use disorder who are not currently receiving treatment with another approved MAT, including Methadone.
### PRIORITY AREA: Promote Well-Being and Prevent Mental and Substance Use Disorders

#### Focus Area 2: Mental and Substance Use Disorders Prevention

<table>
<thead>
<tr>
<th>GOAL 2.2: continued</th>
<th>Prevent opioid and other substance misuse and death.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PARTNER RESOURCES:</strong></td>
<td>OASAS: Current guidelines on MAT. Targeted technical assistance with program development and implementation.</td>
</tr>
<tr>
<td></td>
<td>Montefiore Health Services: Technical support towards fulfillment of the goals of the CHNA and CSP.</td>
</tr>
<tr>
<td></td>
<td>Mid-Hudson Valley Collaborative (PPS): Technical support.</td>
</tr>
<tr>
<td></td>
<td>Westchester County Department of Community Mental Health: Technical support.</td>
</tr>
<tr>
<td></td>
<td>Appropriate CBOs and other outpatient providers of MAT: Referral sources for clients from inpatient units for MAT services</td>
</tr>
<tr>
<td><strong>BY WHEN:</strong></td>
<td>See Process Measures section for goals.</td>
</tr>
<tr>
<td><strong>ACTION ADDRESSES DISPARITY:</strong></td>
<td>Yes. The community services through the proposed program are generally low-income and include a high proportion of individuals who are non-Hispanic Black or Hispanic. Income &lt;$25,000 (Medicaid population).</td>
</tr>
</tbody>
</table>

---

Target:  43.8 per 1,000³
Prevention Agenda Baseline:  36.5 per 1,000⁴
SJRH Baseline:  33.5 per 100⁵
Prevention Agenda Baseline Year:  2017
SJRH Baseline Year:  Q 1, 2, & 3 2019
Data Source:  PMP Registry and SJRH PI Data
Data Level:  Westchester County and SJRH Outpatient Data

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⁵ SJRH Baseline for Q 1, 2, and 3, 2019; outpatient data
The specific evidence-based intervention/strategies/activities being implemented to address the priority *Promote Well-Being and Prevent Mental and Substance Use Disorders* through the use of Medication Assisted Treatment (MAT) is noted below and in the aforementioned table. MAT is recognized as a highly-effective evidence-based approach to treating Opioid Use Disorders (*Thomas, et al., 2014*). SJRH has offered MAT in one of its outpatient treatment programs since 2018 and as of 2019 now offers this treatment in all outpatient settings. This intervention to address the opioid use epidemic was selected because of its broad evidence-base and because it is recommended as the treatment of choice both by the New York State Office of Addiction Services and Support (OASAS) and the Substance Abuse Mental Health Services Administration (SAMHSA).

SJRH plans to begin offering MAT to inpatient detox clients in 2020.

Consistent with prior tracking, SJRH will continue to monitor progress made with this initiative. In April 2019, SJRH’s Behavioral Health Services (BHS) began to track MAT implementation in all outpatient settings. This data is reviewed quarterly in both the BHS and the Hospital’s Performance Improvement (PI) Committee meetings. Specifically, data on individuals who received an assessment indicating an opioid use disorder is harvested from St. John’s EMR (Meditech). In addition, the EMR supplies data on diagnoses, prescriptions and dates of first prescription for the various MAT options. This data is cleaned and reviewed to assure that patients are not on another form of MAT (such as Methadone). The cleaned and purged data is then used to track the percentage of clients who received MAT within 30 days of initial diagnosis within our system.

Based on the data, quarterly action plans are developed for MAT uptake and results are reviewed in the PI Committee meetings. Action plans are reviewed and results are tracked quarterly.

The Process Measures are noted in detail in the above table and summarized as follows:

- **Outpatient**: Percent of appropriate patients who have a diagnosis of opioid use disorder in the outpatient substance use services who accept Buprenorphine treatment and who receive a prescription within 30 days of assessment.
- **Inpatient**: Percent of appropriate inpatient detoxification patients who have a diagnosis of opioid use disorder who are offered and accept Buprenorphine treatment during their inpatient stay.

Our partners in this initiative are also noted in the above table.
SJRH resources include, but are not limited to:

- Behavioral Health Services and BHS Performance Improvement Committee
- BHS Inpatient Detoxification and Rehabilitation Services
- BHS Opioid Treatment Program
- BHS Outpatient Services at New Focus Center (Yonkers), Greenburgh ATS (Greenburgh/White Plains), and Archway (Mt. Vernon)
- SJRH’s Performance Improvement Committee
- Symphony Medical Group

Community based resources are identified in the summary table below.

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Services Target Populations Receives</th>
<th>Type of Resource</th>
</tr>
</thead>
</table>
| Individuals assessed as having an opioid use disorder  | • Assessment & referral to MAT  
• Provision of MAT prescriptions and monitoring  
• Provision of other counseling and substance use treatment services when client is ready. | SJRH and other substance use providers in Westchester County, NY.  
The following link allows a search for providers including individual medical practitioners offering MAT: https://webapps.oasas.ny.gov/providerDirectory/index.cfm?search_type=2 |

References:

Significant Health Needs Not Addressed in the Community Health Improvement Plan

Relative to the survey process, one gap is the number of respondents which is a very small percentage of the overall population in Westchester County. Of note, approximately 35% of the overall number of responses (3,524) were for the Yonkers service area with 1,219 respondents identified. Although this is a promising statistic for the overall survey, it is also a low statistic compared to the Yonkers census. The value of reaching more persons can only add to the community assessment. SJRH maintains an excellent and robust, community focused Public Relations and Marketing Department. The Staff in this area are continually connected to the community and working to educate regarding resources available and help develop needed services. We will continue to listen to our constituents and develop programs as opportunities present.

The SJRH CSP team worked diligently to assess both primary and secondary data. Primary data from the survey respondents identified a number of concerns for the community. The top concern raised is mental health. While SJRH provides a large substance use disorder service and it is understood that this disease often co-occurs with mental health disorders, we are not licensed as a primary care provider for mental health. We do however maintain a small staff of mental health professionals to provide service to the substance use disorder and HIV population to augment their primary treatment plans. There are a number of both inpatient and outpatient primary mental health providers in Westchester County which SJRH collaborates with and refers to. Persons may arrive to either of our acute care Emergency Departments and/or the Behavioral Health Services Patient Welcome Center for service. If during their assessment, an acute mental health concern is identified, the person will be referred to the proper level of care based upon that assessment. Given all of the above, SJRH did not embark on an initiative with primary mental health focus.

Food and Nutrition (3rd), Obesity (4th), Environments that Promote Well-Being (5th), Physical Activity (9th) and Food Safety and Chemicals in Consumer Products (10th) were also identified in the top 10 areas of concern for the community with their respective ranking noted in parenthesis. SJRH works with our patient population via inpatient and outpatient dietary consultation and we also support a bariatric program for the more seriously obese clientele. As needed, we also participate in health fairs and other programs geared toward educating the public regarding a healthy lifestyle inclusive of healthy eating. SJRH also facilitates a staff Wellness Committee which is a Management and Union collaboration to develop program for staff focused on wellness. This is a key component as it speaks to the general focus at SJRH for wellness but also many of our staff are also Westchester residents. While we are committed to enhancing the lives of our patients through the direct health care we provide and general activities targeted to educate our constituents about attaining and maintaining a healthy lifestyle, upon review of the various health issues cited we determined our robust skills sets for the initiatives selected best served our community at this time. Of note, SJRH just embarked on implementation of a blood management program geared toward the population who wish to avoid use of blood products during surgical and/or medical procedures. This program recognized a person’s choice for health care and options. Finally, through the Behavioral Health Service Line, the organization is partnering with Greyston to develop a program targeted toward providing meaningful employment opportunities to those individuals recovering from substance use disorders. Meaningful employment is a key to promoting healthy lifestyle and promoting one’s feeling of confidence and self-worth.
Smoking, vaping, second hand smoke combined ranked as 7th concern for the community. This concern was addressed in the last Community Service Plan for the prior Prevention Agenda. Outcomes of related initiatives are noted on pages 42 and 43. SJRH maintains our campuses as non-smoking and maintains a positive therapeutic approach to helping our patients become tobacco free. Patients are offered nicotine replacement therapy and other services to reduce smoking.

Child and Adolescent Health ranked 6th as a community concern. SJRH is not a primary provider of child and adolescent care. Our services are limited to emergency department (ED) services where we maintain a room designed for the younger population in our Andrus ED. Patients assessed as requiring inpatient care are referred to the appropriate provider. Westchester County is home to several Hospitals which provide inpatient care to youngsters. SJRH does provide limited outpatient substance use disorder services. We also recently initiated a pediatric sleep assessment program.

Of note, our Maternal and Women’s Health program is undergoing expansion to add 24/7 Laborists to enhance patient assessment and treatment. In addition, as a key provider of maternal/child health in Westchester, we are now collaborating to assist Mount Vernon Hospital with meeting the needs of their consumers as that Hospital transitions services to primary emergency vs. acute inpatient care.

Rounding out the top 10 issues identified for the community are Chronic Disease Screening and Care and Substance Use Disorders, ranking 2nd and 8th respectively. These were the two priority focus areas selected for the Community Health Improvement Plan and are addressed within this report.

In regard to the individual surveys, most of the same issues were identified and eight of the 10 from the community also fell into the top 10 but in different order. Food and Nutrition, Physical Activity and Environments that promote well-being and active lifestyles were ranked 1st, 2nd and 3rd, respectively. While these ranked higher for the individuals, the same aforementioned reasoning applies as to why SJRH did not select these for our initiatives. Of note, as a primary acute and chronic health care provider and one that promotes healthy living, SJRH services are not best positioned to respond to these needs as a prime provider.

Water quality and outdoor air quality ranked 8th and 11th respectively and would best be addressed by public services more directly related to and skilled with those issues. While substance use disorders ranked 19th for the individual survey, hypothesis regarding this ranking are addressed earlier in this report. Given the low number of respondents and possible stigma and connection to mental health, we cannot fully determine if individuals do not in fact feel this is a need. In addition, given County, State and National statistics relative to substance use disorders as well as our strong commitment to and robust skill in providing substance use disorder treatment, we determined one of the best values we could provide was to continue to focus on this special population. Our related initiative is outlined within this report.
Evaluation: 
Impact of Initiatives to Address Significant Health Needs from the 2015-2019 CHNA

The previous CHNA identified two significant health issues through the needs assessment. These were “Prevent Chronic Disease, Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke” and “Promote Mental Health and Prevent Substance Abuse”.

**Prevent Chronic Disease, Reduce Illness, Disability and Death Related to Tobacco Use**
The goal for this area was to promote tobacco use cessation, especially among lower socioeconomic status populations and those with poor mental health; the objectives were to decrease the prevalence of cigarette smoking by adults by 12.3% and to support medical home clients by accessing evidence-based practices for smoking cessation.

The Hospital’s goal was to have 20% of clients assessed for smoking by 2017 and 40% assessed in 2018. During the 3-year cycle, SJRH implemented the 5As Assessment for smoking. By December 2016, this evidence-based assessment and intervention tool was implemented and embedded in the outpatient electronic medical record (EMR) in the main Hospital system, Meditech. It was fully implemented at SJRH’s outpatient site, HOPE Center. In 2017, 99.41% of individuals seen at HOPE Center received a 5As screen. In 2018, 502/537 individuals (93.48%) seen at HOPE Center received a 5As screen. These 537 unduplicated individuals had either Medicaid or a Medicaid Managed Care Organization as primary insurer. The slight decrease occurred because HOPE had one less Nurse Practitioner during the 2018 calendar year.

Unfortunately, the Hospital was unable to implement the 5As in its other outpatient practices because of challenges with that EMR making it impossible to embed the screen within the particular EMR.

During this cycle, the Hospital partnered with the Montefiore Hudson Valley Collaborative (the PPS) and the Hudson Valley Asthma Coalition to assist in development of the workflows and screens for this effort as part of the DSRIP initiative.

**Promote Mental Health and Prevent Substance Abuse**
The goals for this area were to identify, address, and refer to treatment individuals with a substance use disorder who had a co-occurring depressive disorder and to identify, address, and refer to treatment individuals with a substance use disorder who have co-occurring depressive disorders. The overall objective was to reduce the age-adjusted percentage of adults with poor mental health in the last month by 10% to no more than 10.1%.

These goals and objectives were to be accomplished through implementation of the PHQ-9, and the PHQ-a specifically for adolescents, an evidence-based tool to assess depressive disorders. Throughout the three years the goal was to track implementation with a goal of 80% of clients being seen in outpatient behavioral health settings of the Hospital receiving a PHQ-9.
In 2015, 0% of clients in the outpatient behavioral health services client were receiving a PHQ-9. During 2016 this tool was embedded in the electronic health record (Meditech). For 2016 the goal was for 40% of clients to receive the PHQ-9 and by 2018 80% of clients were to receive the screen. The screen was implemented at the three outpatient sites – Archway (located in Mt. Vernon), Greenburgh ATS (located in Greenburgh) and New Focus Center (located in Yonkers). The screen was also implemented in the Opioid Treatment Program in Yonkers.

In 2018 at the three sites, 1,539 unduplicated individuals were seen who had either Medicaid or a Medicaid Managed Care as their insurance. A query of the Meditech system during the review period indicated that 535/1,539 individuals (34.76%) received the PHQ-9. However, a manual chart review indicated that the electronic query was only identifying about 30% of the total number of PHQ-9s conducted during the year. If correct, this would indicate a significantly higher rate of implementation than is indicated by the electronic query, potentially exceeding the 80% goal.

In 2018 at the Opioid Treatment Program site the Program was unable to implement the screen in their electronic system. At that site, the PHQ-9 was implemented on paper and tracked in an Excel spreadsheet. 106/106 people (100%) who were assessed for intake during the period had a PHQ-9.

Although not part of the original plan, the PHQ-9 was expanded to inpatients in the behavioral health program during the 2018 calendar year. The total number of unduplicated clients with Medicaid or a Medicaid Managed Care Organization as primary insurer was estimated at 5,420. 4,674 PHQ-9s were conducted in these settings with a rate of 72.1% of behavioral health inpatients receiving this screen.

The major partner in this implementation was the Montefiore Hudson Valley Collaborative (the PPS). They provided technical support and support of the workflow development for this project.
Secondary Data Collection

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

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

**Mid-Hudson Regional Community Health Assessment 2018**

This document was written by the HealtheConnections staff and included seven counties in the Mid-Hudson Region. It was created to support partners in health across the region, including Westchester County.

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

**NYS Expanded Behavioral Risk Factor Surveillance System (NYS Expanded BRFSS):** The NYS Expanded Behavioral Risk Factor Surveillance System (NYS Expanded BRFSS) supplements the CDC BRFSS. Specifically, it provides county-level estimates of various health behaviors and outcomes. Data from the NYS Expanded BRFSS was used to estimate multiple indicators in this report, related to access to a primary care provider, poor mental health, cigarette smoking, obesity, colorectal cancer screening, flu immunization and binge drinking. [https://www.health.ny.gov/statistics/brfss/expanded/](https://www.health.ny.gov/statistics/brfss/expanded/)
New York State Statewide Planning and Research Cooperative Systems (SPARCS): SPARCS is the primary source of data on ED visits and inpatient hospitalizations at New York State hospitals. All inpatient admissions and ED visits at NYS hospitals are sent to SPARCS and compiled into a master database. SPARCS data was used to estimate the rates of preventable hospitalizations, fall-related hospitalizations, assault-related hospitalizations, asthma ED visits, hospitalizations for short-term complications of diabetes, and the opioid burden rate. For more information about SPARCS please visit: http://www.health.ny.gov/statistics/sparcs/.

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

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

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

New York State Sexually Transmitted Disease Surveillance Data: NYS Sexually Transmitted Disease Surveillance Data are provided by the Bureau of STD Prevention and Epidemiology within the NYS Department of Health (DOH). Cases are reported by the 57 local health departments in NYC to the NYS DOH. This report uses this data to estimate rate of chlamydia in each county. For more information, please visit: https://www.health.ny.gov/diseases/aids/general/about/surveillance.htm
**New York State Vital Records Data:** The New York State Vital Records is the clearinghouse for data on births and deaths for all of New York State. For the current report, vital records data were used to examine the proportion of preterm births, proportion of infants exclusively breastfed in the hospital, the adolescent pregnancy rate, the suicide rate, and the opioid burden rate. For more information on the New York State Vital Records please visit: [https://www.health.ny.gov/statistics/vital_statistics/](https://www.health.ny.gov/statistics/vital_statistics/)

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

**City Health Dashboard:** The City Health Dashboard is produced by the Department of Population Health at NYU Langone and the Robert F. Wagner School of Public Service at NYU, in partnership with the National Resource Network. It is funded through the Robert Wood Johnson Foundation. The dashboard aggregates data from multiple sources for the 500 largest cities in the United States, including Yonkers, Mount Vernon and New Rochelle. For more information please see: https://www.cityhealthdashboard.com/

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

**New York State Prevention Agenda Dashboard:** An additional resource for data was the New York State Prevention Agenda Dashboard, which was produced by the New York State Department of Health and systematically aggregates data for the entire state and for each county for dozens of health indicators that align with the New York State Prevention Agenda. Like the Community Health Profiles, the Prevention Agenda Dashboard is not a single database, but rather a compilation of diverse databases. For more information please see: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/
Figure 14: Age-adjusted opioid mortality rate per 100,000 people

- The opioid mortality rate tripled in Westchester County over the past decade, although it is lower than in 3 of 5 of its peer counties.
- Those who are non-Hispanic white are over twice as likely to die from opioids than non-Hispanic black and Hispanic populations.
Figure 15: Age-adjusted breast cancer incidence per 100,000 women

- The age-adjusted female breast cancer incidence rate has increased in Westchester County over the past few decades and remains above the rate for New York State overall.
- The age-adjusted female breast cancer incidence rate is highest for non-Hispanic white residents (157.4 per 100,000 women), compared with non-Hispanic black residents (127.6 per 100,000) and Hispanic residents (101.5 per 100,000).
**Figure 16: Westchester County Zip Codes**

<table>
<thead>
<tr>
<th>Zip Code</th>
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<th>Zip Code</th>
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Figure 17: Age-adjusted Preventable Hospitalization rate per 10,000 (adults age ≥ 18y)

- The age-adjusted preventable hospitalization rate for adults has declined in both Westchester County and New York State and remains lower in Westchester County.
- The age-adjusted preventable hospitalization rate is much higher for non-Hispanic black adults (193.5 per 10,000) than non-Hispanic white and Hispanic adults (67.4 per 10,000 and 56.0 per 10,000, respectively).
Table 1: Westchester County Demographic Data

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<tr>
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<td>503,477</td>
<td>51.6%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>530,156</td>
<td>54.4%</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>131,769</td>
<td>13.5%</td>
</tr>
<tr>
<td>Asian, non-Hispanic</td>
<td>57,004</td>
<td>5.8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>234,081</td>
<td>24%</td>
</tr>
<tr>
<td>Other, non-Hispanic</td>
<td>22,311</td>
<td>2.2%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5 Years</td>
<td>55,593</td>
<td>5.7%</td>
</tr>
<tr>
<td>5 – 19 Years</td>
<td>191,487</td>
<td>19.6%</td>
</tr>
<tr>
<td>20 – 34 Years</td>
<td>171,794</td>
<td>17.6%</td>
</tr>
<tr>
<td>35 – 64 Years</td>
<td>400,187</td>
<td>41%</td>
</tr>
<tr>
<td>&gt;65 Years</td>
<td>156,260</td>
<td>16%</td>
</tr>
<tr>
<td>Language Spoken</td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>613,330</td>
<td>66.7%</td>
</tr>
<tr>
<td>Language other than English</td>
<td>306,398</td>
<td>33.3%</td>
</tr>
<tr>
<td>Spanish</td>
<td>182,282</td>
<td>19.8%</td>
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<tr>
<td>Indo-European</td>
<td>76,129</td>
<td>8.3%</td>
</tr>
<tr>
<td>Asian &amp; Pacific Islander</td>
<td>34,056</td>
<td>3.7%</td>
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<tr>
<td>Other</td>
<td>13,931</td>
<td>1.5%</td>
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<tr>
<td>Education</td>
<td></td>
<td></td>
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<tr>
<td>&lt; HS Graduate</td>
<td>82,929</td>
<td>12.5%</td>
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<tr>
<td>HS Graduate</td>
<td>130,493</td>
<td>19.5%</td>
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<tr>
<td>College, no degree</td>
<td>94,509</td>
<td>14.1%</td>
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<tr>
<td>Associate Degree or Higher</td>
<td>360,171</td>
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<tr>
<td>Unemployment Rate</td>
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<td>6.5%</td>
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<tr>
<td>Poverty Level</td>
<td></td>
<td>9.4%</td>
</tr>
<tr>
<td>Median Household Income</td>
<td>$89,968</td>
<td></td>
</tr>
<tr>
<td>Insured &lt;65 years</td>
<td></td>
<td>90.6%</td>
</tr>
</tbody>
</table>

Source: Mid-Hudson Regional Community Health Assessment 2018
Source: New York State Prevention Agenda Dashboard
Figure 18: Medically Underserved Areas in Westchester County

Source: Westchester County Secondary Data Sources
Figure 19: Individuals below Poverty %

A smaller proportion of individuals live in poverty in Westchester County compared with New York State overall (8.3 vs. 14.1%, respectively).

Those who are black and Hispanic are more likely to be living in poverty in Westchester County than those who are white.
Figure 20:  Individuals with Health Insurance (< 65y) %

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

* Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity. *The white and black population includes Hispanic individuals as data is not available by race/ethnicity separately.

Data source: New York State Prevention Agenda Dashboard
Data for map and by race/ethnicity from 2013-2017 American Community survey.
Map is at the census tract level.
Figure 21: Adults who have Regular Health Care Provider %

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

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

Data source: New York State Prevention Agenda Dashboard
Figure 22: Westchester County Substance Use Disorder Key Indicators (part 1)

WESTCHESTER COUNTY SUBSTANCE USE DISORDER KEY INDICATORS

OPIOID AND OTHER DRUG INDICATORS

Rest of State (ROS) = New York State excluding New York City

Opioid Deaths

In 2016 there were 126 opioid overdose deaths in Westchester County

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 100,000 (Westchester)</th>
<th>Rate per 100,000 (ROS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>6.9</td>
<td>10.2</td>
</tr>
<tr>
<td>2015</td>
<td>8.7</td>
<td>13.2</td>
</tr>
<tr>
<td>2016</td>
<td>12.9</td>
<td>18.2</td>
</tr>
</tbody>
</table>

- In 2016, the Westchester County opioid overdose death rate was lower than the Rest of State.
- Between 2014 and 2016, Westchester County saw an increase in opioid overdose deaths.

Opioid Emergency Department (ED) Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Opioid ED Visits (Westchester)</th>
<th>Rate per 100,000 (Westchester)</th>
<th>Rate per 100,000 (ROS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>260</td>
<td>26.7</td>
<td>74.9</td>
</tr>
<tr>
<td>2017</td>
<td>248</td>
<td>25.4</td>
<td>64.4</td>
</tr>
</tbody>
</table>

- In 2017, the Westchester County opioid ED visit rate was lower than the Rest of State.
- Between 2016 and 2017, Westchester County saw a decrease in opioid ED visits.

Neonatal Abstinence Syndrome (NAS)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of NAS Discharges (Westchester)</th>
<th>Rate per 1,000 (Westchester)</th>
<th>Rate per 1,000 (ROS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>49</td>
<td>5.7</td>
<td>16.0</td>
</tr>
</tbody>
</table>

- In 2016, the Westchester County NAS rate was lower than the Rest of State.

Drug Arrests (Felony and Misdemeanor)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Drug Arrests (Westchester)</th>
<th>Rate per 10,000 (Westchester)</th>
<th>Rate per 10,000 (ROS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1,719</td>
<td>17.8</td>
<td>24.8</td>
</tr>
<tr>
<td>2016</td>
<td>1,792</td>
<td>18.3</td>
<td>26.9</td>
</tr>
<tr>
<td>2017</td>
<td>1,725</td>
<td>17.6</td>
<td>29.2</td>
</tr>
</tbody>
</table>

- In 2017, the Westchester County Drug Arrest rate was lower than the Rest of State.
- Between 2015 and 2017, Westchester County remained stable in the number and rate of drug arrests.
Figure 22: Westchester County Substance Use Disorder Key Indicators (part 2)

### ALCOHOL INDICATORS

#### Alcohol Related Motor Vehicle Injuries and Deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Related Motor Vehicle Injuries and Deaths (Westchester)</td>
<td>269</td>
<td>208</td>
<td>305</td>
</tr>
<tr>
<td>Rate per 100,000 (Westchester)</td>
<td>27.7</td>
<td>21.3</td>
<td>31.3</td>
</tr>
<tr>
<td>Rate per 100,000 (ROS)</td>
<td>39.7</td>
<td>38.0</td>
<td>38.8</td>
</tr>
</tbody>
</table>

- In 2016, the Westchester County Alcohol Related Motor Vehicle Injuries and Death rate was lower than the Rest of State.
- Between 2014 and 2016, Westchester County saw an increase in Alcohol Related Motor Vehicle Injuries and Deaths.

#### Cirrhosis Deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cirrhosis Deaths (Westchester)</td>
<td>54</td>
<td>54</td>
<td>56</td>
</tr>
<tr>
<td>Rate per 100,000 (Westchester)</td>
<td>5.6</td>
<td>5.5</td>
<td>5.7</td>
</tr>
<tr>
<td>Rate per 100,000 (ROS)</td>
<td>8.8</td>
<td>8.9</td>
<td>10.1</td>
</tr>
</tbody>
</table>

- In 2016, the Westchester County Cirrhosis Death rate was lower than the Rest of State.
- Between 2014 and 2016, Westchester County saw an increase in the number and rate of Cirrhosis Deaths.

#### Age-Adjusted Adult Binge Drinking

<table>
<thead>
<tr>
<th>Location</th>
<th>Age-Adjusted Adult Binge Drinking %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westchester County</td>
<td>20.7%</td>
</tr>
<tr>
<td>Rest of State</td>
<td>19.1%</td>
</tr>
</tbody>
</table>

- The rate of Adult Binge Drinking is higher in Westchester County than the Rest of State.

#### Driving While Intoxicated (DWI) Arrests

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of DWI Arrests (Westchester)</td>
<td>1,693</td>
<td>1,956</td>
<td>1,778</td>
</tr>
<tr>
<td>Rate per 10,000 (Westchester)</td>
<td>17.3</td>
<td>20.0</td>
<td>18.1</td>
</tr>
<tr>
<td>Rate per 10,000 (ROS)</td>
<td>28.8</td>
<td>28.6</td>
<td>27.6</td>
</tr>
</tbody>
</table>

- In 2017, the Westchester County DWI Arrest rate was lower than the Rest of State.
- Between 2015 and 2017, Westchester County saw an increase in the number and rate of DWI arrests.
Figure 23: Leading causes of disability adjusted life years in New York State 2017

Data source: 2017 Global Burden of Disease Project.

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

The saturation of the graph shows the proportionate change in DALYs from 1990 to 2017. Among leading causes of disability, the largest increases were observed for liver cancer (+2.5%), drug use disorders (+2.2%) and osteoarthritis (+1.8%). Major declines were observed for HIV/AIDS (-7.4%) and tuberculosis (-5.9%).
Figure 24: Distribution of disability adjusted life years by risk factor in New York State 2017

Data source: 2017 Global Burden of Disease Project.

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

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

Tobacco is the third leading causes of ill health, with strong associations with many cancers, cardiovascular disease and chronic respiratory disease. High fasting plasma glucose and high blood pressure are also leading causes of ill health.

In New York State, in 2017, drug use is the sixth leading cause of disability.
Figure 25: Adults binge drinking during past month, age-adjusted %

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

Data source: New York State Prevention Agenda Dashboard

* Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.
Between 2013/2014 and 2016, the proportion of adults that smoke cigarettes in Westchester County declined from 11.7% to 8.4%, remaining lower than in New York State overall.

The prevalence of adult cigarette smoking is second lowest in Westchester County, just after Rockland County, compared to peer counties.
Figure 27: Adult Cigarette Smoking %

Data source: City Health Dashboard, New York University. Limited to adults.
Figure 28: Adults with Poor Mental Health for ≥ 14 days in the last month %

- A smaller proportion of adults report having poor mental health for at least half of the past month in Westchester County (9.1%) than in New York State overall (10.7%), remaining below the Prevention Agenda 2018 Target.
- Westchester County has the third lowest proportion of adults reporting having poor mental health for at least half of the past month when compared to its five peer counties.
Figure 29: Adults with Mental Distress %

[Map showing the percentage of adults with mental distress in various areas, with color coding and labels for Yonkers, New Rochelle, and Mount Vernon.]
Figure 30: Age-adjusted suicide death rate per 100,000 population

The age-adjusted suicide death rate remained relatively stable between 2008/2012 and 2014/2016 in Westchester County (6.3 vs. 6.1), slightly above the Prevention Agenda 2018 Target of 5.9 per 100,000.

Westchester County is tied for the second lowest age-adjusted suicide death rate when compared to 5 peer counties.

Data source: New York State Prevention Agenda Dashboard

* Based on comparison of following measures: % of population <20y, % of population ≥65y, % Hispanic, % non-Hispanic black, % non-Hispanic white, median household income, rental burden, % driving to work, % ≥college degree, % born outside of the US, % owner-occupied housing and population density. Nassau County was the most similar to Westchester County, the other 4 most similar counties are also provided in order of similarity.
Figure 31: Asthma ED Visit Rate per 10,000

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

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

Data source: New York State Prevention Agenda Dashboard
Map is at the ZIP Code level and data are from 2010-2014.
Figure 32: Adults with Diabetes %

Data source: City Health Dashboard, New York University. Limited to adults.
Figure 33: Rate of hospitalizations for short-term complications of Diabetes per 10,000 Ages 18+ years

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

Data source: New York State Prevention Agenda Dashboard. Trend data not available past 2014 due to change in ICD coding.
Figure 34: Adult Obesity (BMI ≥ 30) %

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

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

Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.
Figure 35: Percentage of Children/Adolescents who are Obese

- A smaller proportion (13.6%) of children/adolescents are obese in Westchester county than in New York State overall (17.3%) and peer counties.
- Peekskill, Tarrytown, Elmsford and Port Chester-Rye school districts have the highest prevalence of child/adolescent obesity in Westchester County.
Figure 36: Adolescent Pregnancy Rate per 1,000 females (aged 15 – 17 years)

- In Westchester County between 2008 and 2016, the adolescent pregnancy rate declined from 19.5 to 7.1 pregnancies per 1,000 female adolescents and remains lower than in New York State overall.
- The adolescent pregnancy rate is significantly higher for non-Hispanic black (18.5 per 1,000) and Hispanic (16.4 per 1,000) adolescents than non-Hispanic white adolescents (1.2 per 1,000).
Figure 37: Preterm Births %

- The percent of births that are preterm is higher in Westchester County (12.1%) than in New York State overall (10.3%), the Prevention Agenda 2018 Target (10.2%) and its peer counties.
- The percent of births that are preterm is higher amongst the non-Hispanic black population (15.7%) than the non-Hispanic white (11.5%) and Hispanic populations (12.0%).
Figure 38: Infants Exclusively Breastfed in the Hospital %

- In Westchester County, the proportion of infants exclusively breastfed in the hospital (45.3%) has slightly decreased over the last decade, although it remains the second highest when compared to five peer counties.
- The proportion of infants that are exclusively breastfed in the hospital is highest for non-Hispanic white populations (58.6%), followed by Hispanic (42.0%) and non-Hispanic black populations (35.4%).
The age-adjusted female breast cancer incidence rate has increased in Westchester County over the past few decades and remains above the rate for New York State overall.

The age-adjusted female breast cancer incidence rate is highest for non-Hispanic white residents (157.4 per 100,000 women), compared with non-Hispanic black residents (127.6 per 100,000) and Hispanic residents (101.5 per 100,000).
Figure 40: Adults Receiving Colorectal Cancer Screening (age 50 - 75 years) %

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

Data source: New York State Prevention Agenda Dashboard.
2008-2009 New York State data not available.
**Figure 41:** Age-adjusted Colorectal Cancer Incidence per 100,000

- In Westchester County, the incidence of age-adjusted colorectal cancer has declined over the past few decades and remains slightly below the incidence rate for New York State overall.
- In Westchester County, the colorectal cancer incidence rate for Hispanic residents (30.3 per 100,000) is lower than that for non-Hispanic black residents (38.5 per 100,000) and non-Hispanic white (37.3 per 100,000) residents.
Figure 42: Children (ages 19 – 35 months) with 4:3:1:3:3:1:4 Immunization Series %

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

A larger proportion of children ages 19 to 35 months receive their full immunizations in Westchester County than in peer counties.

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

Data source: New York State Prevention Agenda Dashboard

Richmond county data not available
Figure 43: Adults (≥65 years) with Flu Immunizations %

- In Westchester County, the proportion of adults ages ≥65y who received their flu immunization declined from 77.8% in 2008/2009 to 64.2% in 2016, although it remains higher than in New York State overall (59.5%).
- Compared to peer counties, Westchester County tends to have a higher proportion of adults ≥65y who received their flu immunization in 2016.
Figure 44: Overdose Deaths Involving Any Opioid
Report Adoption and Publication

The final Community Service Plan, Community Health Needs Assessment and Implementation Strategy Reports were approved by the St. John’s Riverside Hospital Board of Trustees on December 9, 2019 and will be appended to the Hospital website by December 30, 2019.

A press release is sent to all local media for publication, that the reports are available for the public to review. All administrative offices are provided a copy of the reports to produce upon request.

The community will be informed regarding access in our print newsletter, “Riverside”. In addition, our Public Relations Department will share information with the community through other social media to include but not limited to:

Facebook.com/StJohnsRiversideHospital

Youtube.com/user/RHCSsjrh

Twitter.com/SJRHtoday

Instagram.com/stjohnsriversidehospital

SJRH employees, physicians and community partners will also receive notification through their email newsletters with a link to connect to our website RiversideHealth.org. Employees can access the report through the Hospital intranet and copies can be obtained upon request from the Hospital’s Public Relations Department.
Community Health Needs Assessment Survey Notice

<table>
<thead>
<tr>
<th>St. John’s Riverside Hospital Community Health Needs Assessment Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under State and Federal Guidelines, SJRH is required to complete a Community Health Needs Assessment.</td>
</tr>
</tbody>
</table>

The data collected will be used for a Comprehensive Community Service Strategy and Plan that will indicate the top two priorities that the hospital will focus on through 2024.

For more information on the Community Health Needs Assessment, please call the Public Relations & Marketing Office at 914-798-8990.

The information is being used to determine community health needs. Personal health information will be kept confidential.
Westchester County Health Care Planning Coalition 2018

As part of the CHNA process, SJRH collaborates with our provider colleagues and participated in the Westchester County Health Planning Coalition which includes but is not limited to the following providers:

- Burke Rehabilitation Hospital
- Blythedale Children’s Hospital
- Montefiore Health System
- New York Presbyterian
- Northern Westchester Hospital
- Phelps Hospital
- Saint Joseph’s Medical Center
- White Plains Hospital

These and other providers noted below were active participants in developing and implementing the Westchester County survey this year. In addition, members participated in the April 2019 Health Summit.

- African American Men of Westchester
- American Heart Association
- American Lung Association
- ANDRUS
- Arms Acres & Conifer Park
- Blind Brook Community Coalition
- Blythedale Children’s Hospital
- Brannan Solutions Group Burke Rehabilitation Center Caritas of Port Chester, Inc.
- Child Care Council of Westchester
- Family Ties of Westchester
- Feeding Westchester
- Hudson River Health Care Independent Living, Inc.
- Inter-Care, Ltd
- John A. Coleman School
- Leukemia Lymphoma Society
- Lexington Center for Recovery
- Lifting Up Westchester
- Lower Hudson Valley Perinatal Network
- Montefiore Mount Vernon & New Rochelle Hospitals
- Mount Vernon Neighborhood Health Center
- Neighbors Link
- Northwell Phelps & Northern Westchester
- Hospitals
- NYC Poison Control Center
- New York Medical College
- New York Presbyterian Hudson Valley &
- Lawrence Hospitals
- Open Door Family Medical Center
- Peekskill Youth Bureau
- Rivertowns Pediatrics PC
- Rye YMCA
- St. Christopher’s Inn
- St. John’s Riverside Hospital
- St. Joseph’s Hospital
- Student Assistance Services
- Sunshine Children’s Home and Rehab Center
- The LOFT LGBT Community Center
- The Mental Health Association of Westchester
- The Sharing Community
- United Way 2-1-1
- Urban League of Westchester
- Volunteers of America Greater New York
- Westchester Children’s Association
- Westchester Chiropractic and Wellness

**Westchester County Health Planning Coalition - Meeting Dates**

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<td>March 16</td>
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<td>May 16</td>
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<tr>
<td>October 12</td>
<td>May 10</td>
</tr>
<tr>
<td>November 8</td>
<td>July 22</td>
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<tr>
<td></td>
<td>September 20</td>
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Healthy Yonkers Initiative (HYI) Partners

- American Cancer Society
- American Heart Association
- Cabrini Immigrant Services
- City of Yonkers
- Community Planning Council of Yonkers
- Congregations Linked in Urban Strategy To Effect Renewal (CLUSTER)
- Elderly Pharmaceutical Insurance Coverage program (EPIC)
- Family Service Society of Yonkers
- Family Services of Westchester
- Good Shepard Presbyterian Church
- Greyston Foundation
- Hebrew Home for the Aged Blind/Elder Serve
- Hudson River Health Care
- Hudson River Immigrant Services/American Diabetes Association
- Nepperhan Community Center
- Office of the County Executive Invest in Kids Urban Youth Initiative
- Prime Home Healthcare
- Regency Extended Care Center/Sprain Brook Manor Rehabilitation
- Sharing Community
- Saint Joseph’s Medical Center
- United Way
- Visiting Nurse Service of the Hudson Valley
- Visiting Nurse Service of New York
- Visiting Nurse Services of Westchester/Westchester Children’s Association
- Westchester County Department of Health / Social Services
- WestHab
- Yonkers Chamber of Commerce/Yonkers Municipal Housing Authority
- Yonkers Community Action Program (YCAP)
- Yonkers Community Action Program/Yonkers YMCA and YWCA,
- Yonkers Office for the Aging
- Yonkers Office for the Aging at the Peter Chema Center/Yonkers Public Library
- Yonkers Police Department - Heroin Enforcement Response Team Program (H.E.A.R.T.)
- Yonkers Public Schools Parents As Partners
## St. John's Riverside Hospital Community Service Plan Committee

<table>
<thead>
<tr>
<th>REPRESENTATIVES</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Antonecchia, MD</td>
<td>Vice President and Chief Medical Officer</td>
</tr>
<tr>
<td>Gladys Attanasio</td>
<td>Assistant VP, Revenue Cycle</td>
</tr>
<tr>
<td>Eileen Campbell, MBA, RN</td>
<td>Project Specialist</td>
</tr>
<tr>
<td>Tara M. Curtin-Paloka, MSN, RN</td>
<td>Vice President and Chief Nursing Officer</td>
</tr>
<tr>
<td>Dennis Keane</td>
<td>Vice President and Chief Financial Officer</td>
</tr>
<tr>
<td>Nancy Magliocca, MS, RN</td>
<td>Associate Vice President, Regulatory Affairs</td>
</tr>
<tr>
<td>Denise Mananas, MA</td>
<td>Senior Director of Marketing and Public Relations</td>
</tr>
<tr>
<td>Shari Rosenberg</td>
<td>Oncology Patient Services Manager</td>
</tr>
<tr>
<td>Kay Scott, PhD, LCSW-R, CASAC</td>
<td>Associate Vice President, Behavioral Health Services</td>
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</table>
Top Discharge Diagnosis Review

As requested as part of our data review, we collated the Top 20 Inpatient Discharge Diagnoses and the Top 20 ED Discharge Diagnoses. Tables below reflect this summary.

As expected given the fact that SJRH maintains one of our three facilities to provide services to those afflicted with Substance Use Disorder, our top two diagnoses are related to the that population. This further substantiates our first initiative for increasing MAT therapy.

It is understood that screening for breast cancer would not be noted within this data as it occurs on an outpatient basis.

Table A: Top 20 Inpatient Discharges at St. John’s Riverside Hospital, January-September 2019

<table>
<thead>
<tr>
<th>Label</th>
<th>Diagnosis</th>
<th>Discharges</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10</td>
<td>Alcohol related disorders</td>
<td>4208</td>
<td>28.3%</td>
</tr>
<tr>
<td>F11</td>
<td>Opioid related disorders</td>
<td>2121</td>
<td>14.3%</td>
</tr>
<tr>
<td>Z38</td>
<td>Liveborn infants according to place of birth and type of delivery</td>
<td>869</td>
<td>5.8%</td>
</tr>
<tr>
<td>A41</td>
<td>Other sepsis</td>
<td>555</td>
<td>3.7%</td>
</tr>
<tr>
<td>L13</td>
<td>Hypertensive heart and chronic kidney disease</td>
<td>248</td>
<td>1.7%</td>
</tr>
<tr>
<td>N17</td>
<td>Acute kidney failure</td>
<td>246</td>
<td>1.7%</td>
</tr>
<tr>
<td>E11</td>
<td>Type 2 diabetes mellitus</td>
<td>211</td>
<td>1.4%</td>
</tr>
<tr>
<td>L03</td>
<td>Cellulitis and acute lymphangitis</td>
<td>188</td>
<td>1.3%</td>
</tr>
<tr>
<td>J44</td>
<td>Other chronic obstructive pulmonary disease</td>
<td>165</td>
<td>1.1%</td>
</tr>
<tr>
<td>N39</td>
<td>Other disorders of urinary system</td>
<td>165</td>
<td>1.1%</td>
</tr>
<tr>
<td>F14</td>
<td>Cocaine related disorders</td>
<td>160</td>
<td>1.1%</td>
</tr>
<tr>
<td>O34</td>
<td>Maternal care for abnormality of pelvic organs</td>
<td>153</td>
<td>1.0%</td>
</tr>
<tr>
<td>O48</td>
<td>Late pregnancy</td>
<td>153</td>
<td>1.0%</td>
</tr>
<tr>
<td>L11</td>
<td>Hypertensive heart disease</td>
<td>144</td>
<td>1.0%</td>
</tr>
<tr>
<td>M17</td>
<td>Osteoarthritis of knee</td>
<td>141</td>
<td>0.9%</td>
</tr>
<tr>
<td>J18</td>
<td>Pneumonia, unspecified organism</td>
<td>138</td>
<td>0.9%</td>
</tr>
<tr>
<td>I63</td>
<td>Cerebral infarction</td>
<td>122</td>
<td>0.8%</td>
</tr>
<tr>
<td>F13</td>
<td>Sedative, hypnotic, or anxiolytic related disorders</td>
<td>120</td>
<td>0.8%</td>
</tr>
<tr>
<td>O70</td>
<td>Perineal laceration during delivery</td>
<td>117</td>
<td>0.8%</td>
</tr>
<tr>
<td>J96</td>
<td>Respiratory failure, not elsewhere classified</td>
<td>107</td>
<td>0.7%</td>
</tr>
<tr>
<td>-</td>
<td>Other Diagnoses</td>
<td>4532</td>
<td>30.5%</td>
</tr>
</tbody>
</table>

*Data source: St. John’s Riverside Internal Data*

- For inpatient discharges, 28.3% were for alcohol related disorders and 14.3% were for opioid related disorders, which aligns with St. John’s Riverside Hospital’s focus on treating substance-use disorders.
- The third leading diagnosis for inpatient discharges was having a liveborn infant.
Abdominal and pelvic pain, dorsalgia, and acute respiratory infections were the leading diagnoses for treat-and-release ED visits at St. John’s Riverside Hospital in 2019.

Other notable diagnoses include pain in throat and chest and maternal care for conditions related to pregnancy.

It is worth noting that the top 20 broad diagnosis categories accounted for only 42.7% of total diagnoses.

Table B: Top 20 ED Discharges at St. John’s Riverside Hospital, January-September 2019

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Label</th>
<th>Discharges</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>R10</td>
<td>Abdominal and pelvic pain</td>
<td>1303</td>
<td>4.4%</td>
</tr>
<tr>
<td>M54</td>
<td>Dorsalgia (Back pain)</td>
<td>1124</td>
<td>3.8%</td>
</tr>
<tr>
<td>J06</td>
<td>Acute upper respiratory infections of multiple and unspecified sites</td>
<td>1104</td>
<td>3.7%</td>
</tr>
<tr>
<td>R07</td>
<td>Pain in throat and chest</td>
<td>1052</td>
<td>3.6%</td>
</tr>
<tr>
<td>O26</td>
<td>Maternal care for other conditions predominantly related to pregnancy</td>
<td>929</td>
<td>3.2%</td>
</tr>
<tr>
<td>J02</td>
<td>Acute pharyngitis (Sore throat)</td>
<td>800</td>
<td>2.7%</td>
</tr>
<tr>
<td>M25</td>
<td>Other joint disorder, not elsewhere classified</td>
<td>713</td>
<td>2.4%</td>
</tr>
<tr>
<td>R51</td>
<td>Headache</td>
<td>506</td>
<td>1.7%</td>
</tr>
<tr>
<td>M79</td>
<td>Other and unspecified soft tissue disorders, not elsewhere classified</td>
<td>487</td>
<td>1.7%</td>
</tr>
<tr>
<td>S01</td>
<td>Open wound of head</td>
<td>473</td>
<td>1.6%</td>
</tr>
<tr>
<td>S61</td>
<td>Open wound of wrist, hand and fingers</td>
<td>470</td>
<td>1.6%</td>
</tr>
<tr>
<td>Z48</td>
<td>Encounter for other postprocedural aftercare</td>
<td>469</td>
<td>1.6%</td>
</tr>
<tr>
<td>J45</td>
<td>Asthma</td>
<td>457</td>
<td>1.6%</td>
</tr>
<tr>
<td>R11</td>
<td>Nausea and vomiting</td>
<td>457</td>
<td>1.6%</td>
</tr>
<tr>
<td>K52</td>
<td>Other and unspecified noninfective gastroenteritis and colitis</td>
<td>429</td>
<td>1.5%</td>
</tr>
<tr>
<td>N39</td>
<td>Other disorders of urinary system</td>
<td>415</td>
<td>1.4%</td>
</tr>
<tr>
<td>S09</td>
<td>Other and unspecified injuries of head</td>
<td>374</td>
<td>1.3%</td>
</tr>
<tr>
<td>S93</td>
<td>Dislocation and sprain of joints and ligaments at ankle, foot and toe level</td>
<td>367</td>
<td>1.2%</td>
</tr>
<tr>
<td>L03</td>
<td>Cellulitis and acute lymphangitis</td>
<td>338</td>
<td>1.1%</td>
</tr>
<tr>
<td>H66</td>
<td>Suppurative and unspecified otitis media (Ear infection)</td>
<td>317</td>
<td>1.1%</td>
</tr>
<tr>
<td>-</td>
<td>Other Diagnoses</td>
<td>16870</td>
<td>57.3%</td>
</tr>
</tbody>
</table>

Data source: St. John’s Riverside Internal Data