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NewYork-Presbyterian Hudson Valley Hospital Community Health Needs Assessment 2019-2021

December 2019

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Executive Summary

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NYP-HVH CHNA Executive Summary

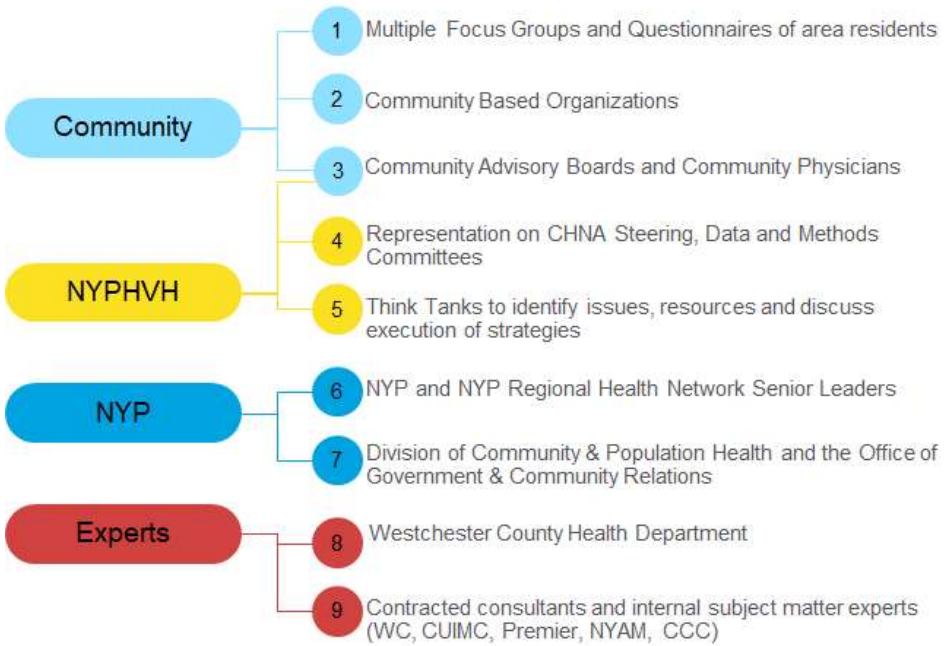
Purpose:

NewYork-Presbyterian (NYP) is deeply committed to the communities residing in the boroughs of New York City, Westchester County, and the surrounding areas. NYP delivers a range of innovative programs and services intended to educate and provide resources to prevent illness, maintain health, and improve the overall well-being of the community.

NewYork-Presbyterians Hudson Valley Hospital (NYP-HVH) has completed this Community Health Needs Assessment (CHNA) in order to update its understanding of the needs of local community members and the conditions that influence their well-being, and to assemble a three-year plan to enhance community health in areas identified as high disparity neighborhoods. The CHNA is a data tool that is used to develop a Community Service Plan (CSP) which identifies the communities of focus as well as initiatives that will be implemented to improve the health of such communities.

Governance and Engagement:

The Division of Community & Population Health and the Office of Government & Community Relations partnered to develop a standardized CHNA process to promote community awareness and hospital alignment in order to maximize the impact to those who need it most. A Steering Committee comprised of NYP leadership, which included representation from NYP-HVH, was key to providing insight, guidance, and making decisions that impacted the completion of the CHNA.



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NYP-HVH CHNA Executive Summary

Process:

NYP-HVH obtained broad community input regarding local health needs including the needs of medically underserved and low-income populations. Data collection included quantitative data for demographics, socioeconomic status, health, and social determinants as well as qualitative data from community questionnaires and focus groups. The data was analyzed to identify high disparity communities and a prioritization process was used to ensure integration with the Priority Areas of the 2019-2024 NYS Prevention Agenda. Premier, Inc. was engaged to partner with the NYP-HVH team to complete the CHNA utilizing a transparent and collaborative manner.

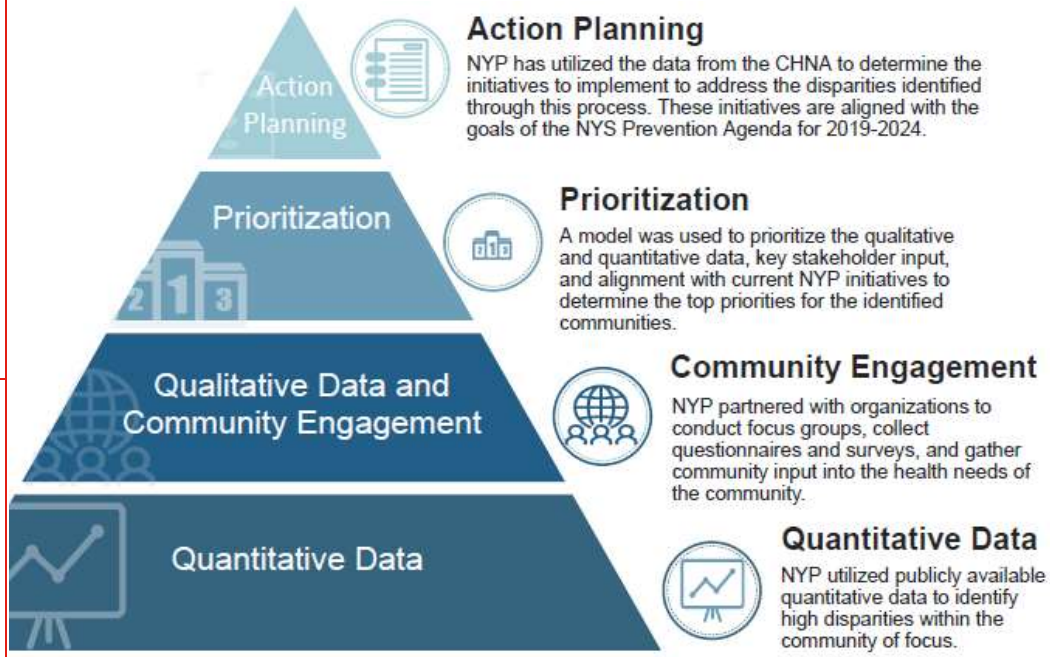
New York Prevention Agenda 2019-2024:

Vision: New York is the healthiest state for people of all ages.

Priority Areas:

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 Diseases

2019-2021 Community Focus & Planning



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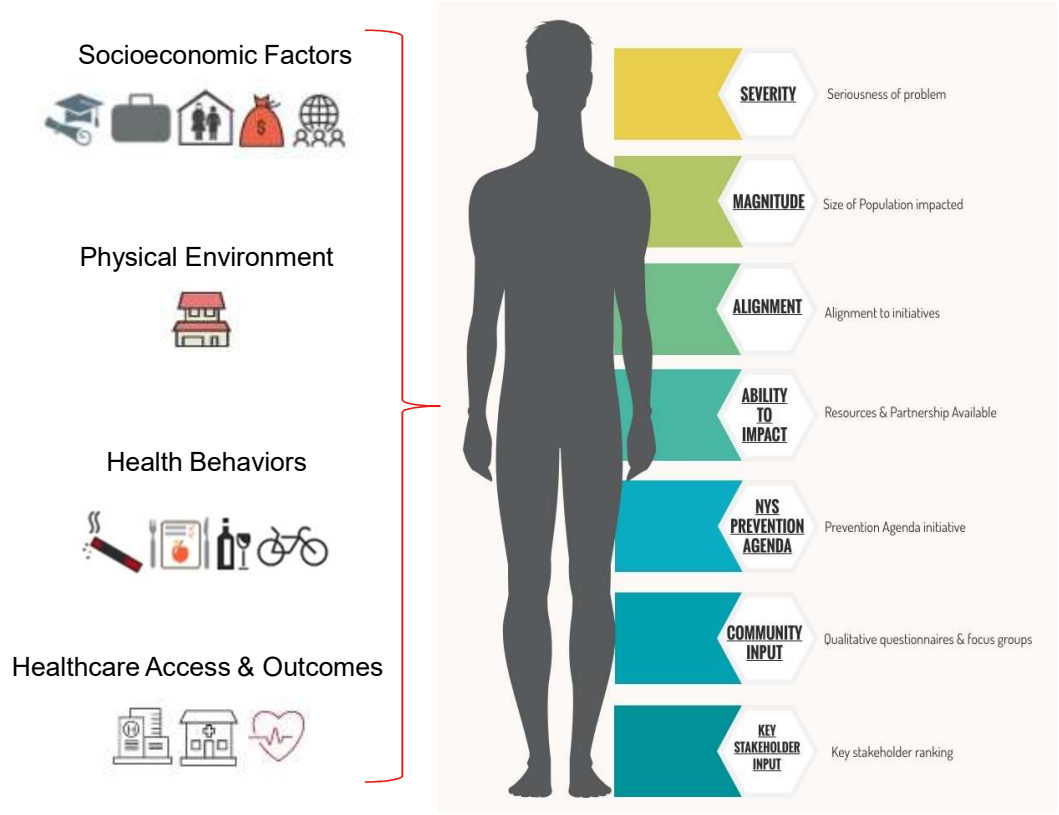
NewYork-Presbyterian Hudson Valley CHNA Executive Summary

Prioritization Method:

Premier, Inc. customized a prioritization model that utilized an approach inclusive of the Hanlon Method technique to quantify and compare indicators and identify significant community needs. The top quartile high disparity neighborhood data sets inclusive of social determinants of health, health outcomes, access, and utilization were analyzed to ensure a dynamic model for NYP-HVH. The model also included qualitative data sets to allow the voice of the community to play into the top priorities.

Representatives from NYP-HVH, NewYork-Presbyterian Hospital (NYPH), Community Advisory Boards, and clinical and operational leadership participated throughout the process. Community Health Think Tanks allowed for opportunities for participants to review summaries of quantitative and qualitative data in order to rank the top health issues. This process allowed the team to receive input as well as ensure complete understanding of the process and intent of the CHNA.



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NYP-HVH CHNA Executive Summary

Prioritized Indicators:

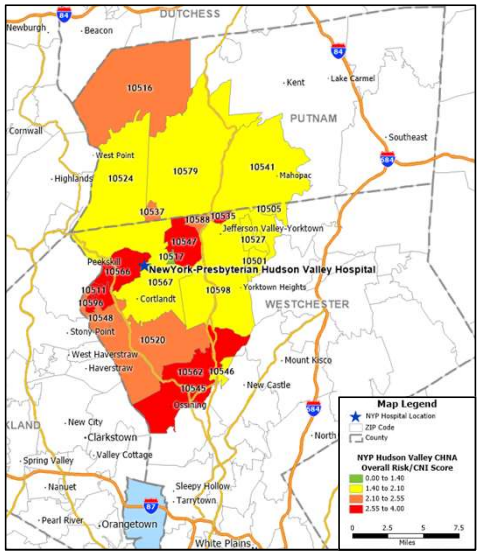
The prioritization method allowed the NYP-HVH team to narrow a vast amount of quantitative and qualitative data sets and define the highest disparity community and health indicators impacting that community. The top ten (10) indicators include:

1. Childhood Obesity
2. Obesity
3. Diabetes
4. Cancer Incidence – All Sites
5. Cancer Incidence – Breast
6. Cancer Incidence – Colon and Rectum
7. Physical Activity
8. Hospitalizations – Preventable Diabetes
9. Hospitalizations – Hypertension
10. Hospitalizations – Psychiatric

High Disparity Communities:

An analysis of community health need and risk of high resource utilization was undertaken by zip code. The Community Need Index (CNI) score is an average of five different barrier scores that measure various socio-economic indicators of each community. The results show where there is more or less need comparatively between communities.

This analysis will be used within the prioritization model to strategically place initiatives to maximize community impact.



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NewYork-Presbyterian Hudson Valley Defined Community at a Glance

POPULATION

192,346

HOUSEHOLDS

68,813

ETHNICITY

22.2%
Index: 113

Hispanic/Latino

HOME LANGUAGE*

74.9%
Index: 108

Only English

MEDIAN AGE OF HOUSEHOLDER

56
Index: 105

PRESENCE OF CHILDREN*

37.2%
Index: 117

HOUSING TENURE

Own
74.8%
Index: 142

Rent
25.2%
Index: 53

AGE OF HOUSING**

79+ years old
% Comp:**19.1** Index: 62

EDUCATIONAL ATTAINMENT: TOP 2*

23.3%
Index: 117

Bachelor's Degree

22.8%
Index: 87

High School Graduate

EDUCATION: HISPANIC/LATINO

4.5%
Index: 143

Bachelor's degree or higher

HOUSEHOLD INCOME

Median Household Income
$102,746
Index:151

Average Household Income
$138,293
Index:136

POVERTY STATUS

96.1%
Index: 108

At or above poverty

UNEMPLOYMENT RATE

5.5%
Index: 88

Percent of civilian labor force unemployed

METHOD OF TRAVEL TO WORK: TOP 2*

69.4%
Index: 132

Travel to work by **Driving Alone**

12.1%
Index: 42

Travel to work by **Public Transport**

The index is a measure of how similar or different the defined area is from the benchmark.
Benchmark is New York State.

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NYP-HVH County Data Highlights

2019 Health Issue Ranking and Data Highlights

NYSPA / NYP-HVH Issue	Quantitative Highlights	Qualitative Highlights
Healthy Women, Infants, Children	Better than state averages on selected indicators, but Westchester, 1.8, is slightly higher for preterm births, NYS 1.7%	
Well-being and Behavioral Health	There is better than average percentages of the population self reporting poor mental health, 9.0%, NYS 10.7%; Lower drug hospitalizations per 100,000 population ages 15-84, 21.1, NYS 22.6	Alcohol and drug use 1st most commonly reported health issue, 58.8%
Chronic Disease / Obesity in Children	There is about the same amount of physical activity as a percentage of the population, 76.9%, compared to NYS, 74.0% but there is more favorable, 17.8%, than the NYS average, 25.5%, percentages of adult obesity	There is opportunity to increase the number of fruits and vegetables consumed by residents, 28.5%, NYS 31.5%, but adult obesity, 17.8%, is more favorable than the NYS average, 25.5%

Focused Priorities:

The data collection and prioritization allowed NYP-HVH to identify the highest disparity of need within the communities of highest need and to align initiatives and partnerships in order to focus efforts and maximize the return to the community they serve. **Obesity, Mental Health & Substance Abuse, and Women's Health** were chosen as the top three priorities in order to develop a community service plan. The focus will not preclude NYP-HVH from initiatives not related to the focused priorities but allows the hospital to invest in new opportunities of impact. Existing hospital strategies related to cancer, hypertension, cardiovascular, etc. will continue to evolve as leading strategies.

NYP-HVH Prioritized Communities

Prioritized Communities:

Based on the data process of analytics and prioritization, NYP-HVH will target efforts in **Peekskill** to allow our teams to invest and concentrate efforts and directly impact a high need community within the three-years of the service plan.

NYP-HVH Highlights in Westchester County

Adult Obesity, Percent of Population Westchester County, 17.7% ↓ NYS, 25.5%	**Percent of preterm births among all live births** Westchester County, 1.8% ↑ NYS, 1.7%	**Self-reported binge drinking, percent of population** Westchester County, 20.7% ↑ NYS, 18.3%
Child Obesity, Percent of Population Westchester County, 13.7% NYS, 17.3%	**Rate of infant deaths (under one year old) per 1,000 live births** Westchester County, 4.6% ↕ NYS, 4.8%	**Breast Cancer Incidence** Westchester County, 478.6 ↕ NYS, 482.9

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Introduction

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Acknowledgements: Westchester County Health Planning Coalition

The Westchester County Health Planning Coalition (WCHPC), inclusive of the Westchester County Department of Health (WCDOH) and sixteen local Westchester County hospitals, formed in response to the New York State Department of Health's appeal that local health department, hospitals/hospital systems, and other community partners collectively work together to identify and address local health priorities associated with the New York State Prevention Agenda (NYSPA).

We thank this group who collaborated on several elements included within this Community Health Needs Assessment, with the ultimate goal of together advancing the health and wellness of Westchester County residents.

Acknowledgements: Community Members / Organizations

This Community Health Needs Assessment represents the culmination of work completed by multiple individuals and groups during the past year. We would like to thank our NYP leaders, staff, and physicians as well as the community members who provided their input via focus groups and questionnaires. We would especially like to thank the leadership at NYP-HVH and the organizations that hosted focus groups for the community members.

Acknowledgements: Consultants

Additionally, we recognize the collaboration of several consultants that contributed to this CHNA in partnership with NYP-HVH:

- **Premier, Inc.,** a nationally recognized healthcare consulting organization that specializes in advisory services and identifying community needs for underserved populations;
- **New York Academy of Medicine**, a New York City-based organization that addresses health challenges through innovative approaches to research, evaluation, education, policy leadership, and community engagement; and
- **Citizens' Committee for Children of New York**, a nonprofit and nonpartisan child advocacy organization that educates and mobilizes New Yorkers to make the city a better place for children.

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CITIZENS' COMMITTEE for CHILDREN
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Why a Community Health Needs Assessment?

NewYork-Presbyterian (NYP) is one of the nation's most comprehensive, integrated academic health care systems, dedicated to providing the highest quality, most compassionate care and service to patients in the New York metropolitan area, nationally, and throughout the globe. In collaboration with two renowned medical school partners, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons, NewYork-Presbyterian is consistently recognized as a leader in medical education, ground-breaking research and clinical innovation.

NYP is deeply committed to the communities residing in the boroughs of New York City, Westchester County and the surrounding areas. NYP offers a range of innovative programs and services intended to educate and provide resources to prevent illness, maintain health and improve the overall well-being of the community.

NYP-HVH has completed this Community Health Needs Assessment in order to update its understanding of the needs of local community members and the conditions that influence their well-being, and to assemble a plan to enhance community health.

NewYork-Presbyterian Hudson Valley Hospital

NewYork-Presbyterian Hudson Valley Hospital, located in Cortlandt Manor, New York, serves residents of the Hudson Valley and Westchester County. The hospital provides a wide range of inpatient and ambulatory services, with hundreds of practitioners on staff in more than 60 specialties. The hospital is home to the region's only state-of-the-art, 24-hour "no wait" emergency department, which sees more than 40,000 visits per year. The hospital's comprehensive cancer center combines chemotherapy, radiation therapy and support services all under one roof. NewYork-Presbyterian Hudson Valley Hospital has received national recognition for excellence in nursing from the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program® three consecutive times.

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CHNA Vision Statement

Our Community Health Needs Assessment will be a collaboration between NYP and the communities it serves.

It will identify significant health needs across our regions and align our hospital community benefits to improve community health over time.

Our approach will be systematic in an effort to capture current and unmet need while putting in place a process for ongoing evaluation.

Definition of Health

The definition of health historically referenced only physical health, but the definition for this CHNA is rooted in the knowledge that it is increasingly important to understand the broader components of health and well-being and how it can be impacted as well as improved.

"Health is a holistic combination of physical health (absence of sickness or pain), mental health, and wellness for which there is an individual and a community wide responsibility".

The quotes below reflect views voiced of CHNA focus group participants from the Hudson Valley area.

"Health means to me how your body feels and how your mind feels."

"I would say just pretty much your overall well-being, because it may be physical, mental, emotional. There are all different healths there."

"Health to me is overall quality from the insurance company to the doctors to the community. It's not fair for some people up here to get other medicine, and down here we get dreck…Health is overall well-being and being treated right."

"It's how you eat, but it's in moderation. It's more exercise, drinking more water, and it's being healthy overall, not only health-wise, but mental-wise. You just have to try to have a healthy lifestyle, but everybody does it in their own pace. That's how I look at health."

CHNA Governance and Collaboration

- NYP-HVH engaged in a seven-month, comprehensive, and collaborative development of this Community Health Needs Assessment (CHNA).
- Several existing NYP committees were leveraged and several newly formed to provide both governance and guidance to the process.
- NYP's CHNA Core Committee managed this process, with significant input from NYP-HVH hospital leaders, NYP's diverse team of subject matter experts, and contracted consultants.
- In addition, NYP-HVH obtained broader community input through facilitation of focus groups and administration of questionnaires to area residents – detailed later in this study.

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CHNA Process

NYP-HVH conducted its 2019 CHNA by:

1. Obtaining broad community input regarding local health needs, including the needs of medically underserved and low-income populations
2. Collecting and evaluating quantitative data for multiple indicators of demographics, socioeconomic status, health, and social determinants
3. Preparing an analysis resulting in the identification of the high disparity neighborhoods in the NYP-HVH community
4. Completing an analysis and health needs prioritization
5. Ensuring integration with the Priority Areas of the 2019-2024 New York State Prevention Agenda
6. Describing the process and methodologies utilized throughout
7. Making the CHNA results publicly available online

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Defining the NewYork-Presbyterian Hudson Valley Community

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Summary for the Defined NYP-HVH Community

Community Profile Overview

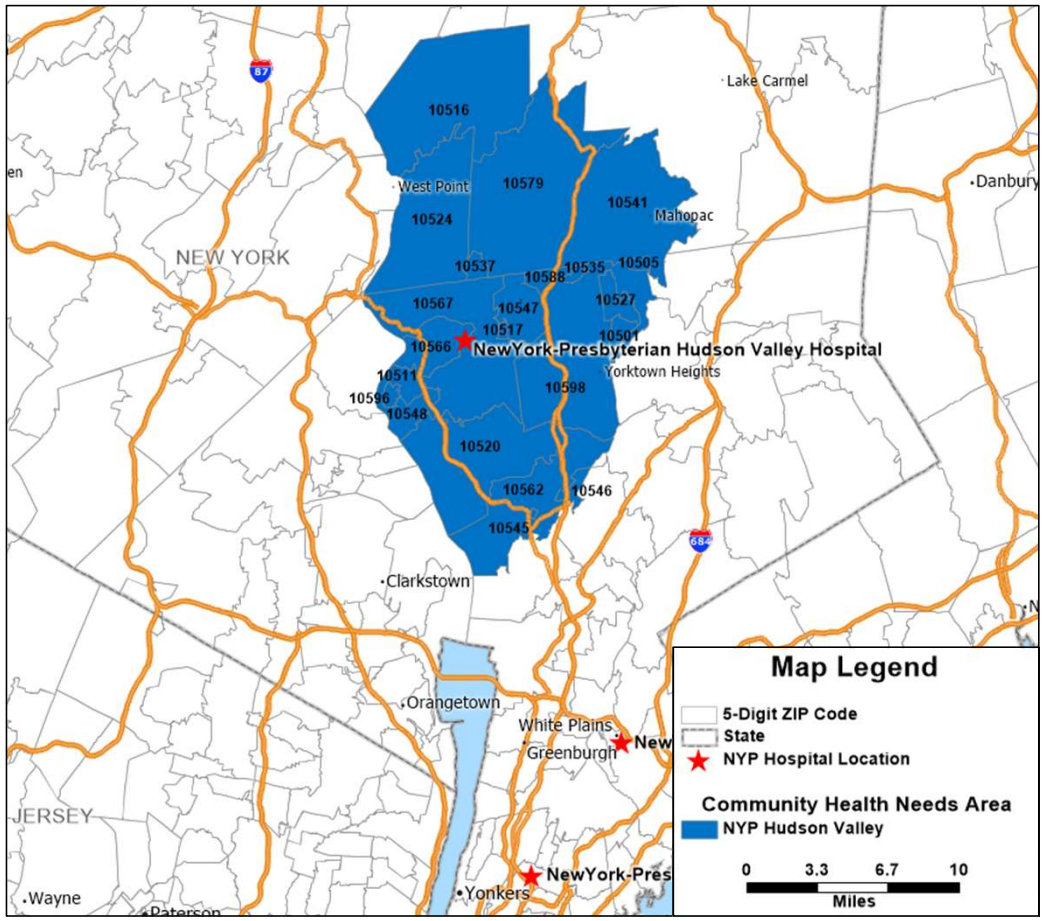
- The community definition for NYP-HVH was derived using 80% of zip codes from which NYP-HVH's patients originate and adding zip codes not among the original patient origin to create continuity in geographical boundaries. **The 22 zip code community comprises residents living in southwest Putnam and a portion of north Westchester counties.**
- The NYP-HVH community covers a geography of **approximately 192k people and it is forecasted to grow slightly faster than the state**, between 2019-2024.
- The community's age cohort profile **is slightly older** with 17.5% of the population aged 65+ compared to New York State,16.3%.
- Also, the **growth projected, for ages 65+ is higher** in the community, 18.2%, than the state, 14.4%, between 2019-2024.
- In 2019, **the community has a higher White population**, 64.3%, than the state 54.4%. The community also has a higher Hispanic population, 22.2%, than the state 19.6%.
- **Future growth is projected among Hispanics, Asian/Hawaiian/Pacific Islanders, African American, and Other** populations while the **White population is projected to decline**.
- In 2019, the **income distribution for the NYP-HVH community is more favorable** than the New York State comparison. Approximately 51.1% of the community population is in the $100,000+ bracket and the average household income, $138,293, is higher than the average of New York State, $101,507.

Summary for the Defined Hudson Valley Community, continued

Community Profile Overview, continued

- The community is **more likely to speak 'only English' at home** than the average for New York State.
- **More of the population lives in family households, 72.4%, than non-family households, 27.6%,** and the household size is larger in comparison to New York State; Also **there are 17% more children in the community** than the average for the benchmark of New York State.
- **More residents own as opposed to rent their home** in this community and **the use of public transport to travel to work is much lower** than the New York State average.
- In 2019, this **community had a 13% lower than average high school and a 17% higher than average Bachelor's degree attainment** than the New York State benchmark.
- The **unemployment rate is lower than average** for the benchmark of New York State, and **there are more white-collar workers** than the state average.
- An analysis of community health need and risk of high resource utilization was undertaken at the zip code level utilizing the Community Need Index (CNI) score developed by Dignity Health and Truven Health. The CNI is an average of five different barrier scores that measure various socioeconomic indicators of each community using the 2015 source data.
- The 22 zip codes were categorized into four quartiles. All zip codes in quartile 4 were in Westchester County, so additional analysis conducted prioritizes Westchester County.

NYP- HVH Community Definition



NewYork-Presbyterian Hudson Valley Hospital CHNA Defined Community	
ZIP Codes	
10501	10545
10505	10546
10511	10547
10516	10548
10517	10562
10520	10566
10524	10567
10527	10579
10535	10588
10537	10596
10541	10598

Sources: NYP hospital based zip code level patient origination, 80%, Maptitude

- The community definition was derived using 80% of zip codes from which NYP-HVH's patients originate, over an 18 month period (Nov 2017- Mar 2019.
- Hospital based patient data was provided by NYP's Value Institute and included inpatient admissions and outpatient visits and ancillary procedures.
- In order to create a contiguous community definition, zip codes not among the original patient origin were included to create continuity in geographical boundaries.

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Total Population Growth by Age Cohort

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NYP Hudson Valley Service Area vs. the State of New York State - Population by Age Cohort
Calendar Years 2019 to 2024

Age Cohort	Census 2010 Number	Census 2010 Percent of Total	Estimated 2019 Number	Estimated 2019 Percent of Total	Projected 2024 Number	Projected 2024 Percent of Total	Percent Change 2010 - 2024	Percent Change 2019 - 2024
NYP Hudson Valley Service Area								
0 - 14	36,239	19.4%	32,025	16.6%	30,632	15.7%	-15.5%	-4.3%
15 - 44	67,557	36.2%	68,065	35.4%	69,016	35.3%	2.2%	1.4%
45 - 64	57,280	30.7%	58,536	30.4%	56,124	28.7%	-2.0%	-4.1%
65 +	25,590	13.7%	33,720	17.5%	39,872	20.4%	55.8%	18.2%
Total	**186,666**	**100.0%**	**192,346**	**100.0%**	**195,644**	**100.0%**	4.8%	1.7%
Women 15 - 44	32,626	17.5%	32,772	17.0%	33,096	16.9%	1.4%	1.0%
Median Age		41.4		43.4		44.2	6.6%	1.8%
New York State								
0 - 14	3,531,233	18.2%	3,458,401	17.4%	3,450,628	17.1%	-2.3%	-0.2%
15 - 44	8,046,567	41.5%	7,971,497	40.1%	7,907,927	39.2%	-1.7%	-0.8%
45 - 64	5,182,359	26.7%	5,223,469	26.2%	5,121,167	25.4%	-1.2%	-2.0%
65 +	2,617,943	13.5%	3,250,309	16.3%	3,716,838	18.4%	42.0%	14.4%
Total	**19,378,102**	**100.0%**	**19,903,676**	**100.0%**	**20,196,560**	**100.0%**	4.2%	1.5%
Women 15 - 44	4,047,947	20.9%	3,985,000	20.0%	3,930,376	19.5%	-2.9%	-1.4%
Median Age		37.8		39.0		40.1	6.1%	2.7%

lley/[NYP_HudsonValley_Demographic_SAbyZIP.xlsx]Pop_Tat

Source: Nielsen, Inc.

- The NYP-HVH community serves a geography of almost 200k people and is forecast to grow slightly faster, 1.7%, than the state, 1.5%, between 2019-2024.
- The age cohort profile is similar to that of New York State but is slightly older with 17.5% of the population aged 65+ compared to 16.3%.
- Also, the growth projected, for ages 65+ is higher in the community, 18.2%, than the state, 14.4%, between 2019-2024.

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Population by Race & Ethnicity

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NYP Hudson Valley Service Area vs. the State of New York State - Ethnic Profile
Calendar Years 2019 to 2024

Ethnicity	Census 2010 Number	Census 2010 Percent of Total	Estimated 2019 Number	Estimated 2019 Percent of Total	Projected 2024 Number	Projected 2024 Percent of Total	Percent Change 2010 - 2024	Percent Change 2019 - 2024
NYP Hudson Valley Service Area								
Hispanics	33,055	17.7%	42,659	22.2%	48,366	24.7%	46.3%	13.4%
Non-Hispanics								
White	130,784	70.1%	123,754	64.3%	119,471	61.1%	-8.7%	-3.5%
African American	13,115	7.0%	13,800	7.2%	14,223	7.3%	8.4%	3.1%
American Indian/Alaskan/Aleutian	176	0.1%	182	0.1%	181	0.1%	2.8%	-0.5%
Asian/Hawaiian/Pacific Islander	6,376	3.4%	7,893	4.1%	8,796	4.5%	38.0%	11.4%
Other	3,160	1.7%	4,058	2.1%	4,607	2.4%	45.8%	13.5%
Subtotal	153,611	82.3%	149,687	77.8%	147,278	75.3%	-4.1%	-1.6%
Total	**186,666**	**100.0%**	**192,346**	**100.0%**	**195,644**	**100.0%**	4.8%	1.7%
New York State								
Hispanics	3,416,922	17.6%	3,897,754	19.6%	4,163,356	20.6%	21.8%	6.8%
Non-Hispanics								
White	11,304,247	58.3%	10,829,785	54.4%	10,574,224	52.4%	-6.5%	-2.4%
African American	2,783,857	14.4%	2,846,150	14.3%	2,864,737	14.2%	2.9%	0.7%
American Indian/Alaskan/Aleutian	53,908	0.3%	54,848	0.3%	55,436	0.3%	2.8%	1.1%
Asian/Hawaiian/Pacific Islander	1,411,514	7.3%	1,775,160	8.9%	1,984,868	9.8%	40.6%	11.8%
Other	407,654	2.1%	499,979	2.5%	553,939	2.7%	35.9%	10.8%
Subtotal	15,961,180	82.4%	16,005,922	80.4%	16,033,204	79.4%	0.5%	0.2%
Total	**19,378,102**	**100.0%**	**19,903,676**	**100.0%**	**20,196,560**	**100.0%**	4.2%	1.5%

Source: Nielsen, Inc.

- In 2019, the NYP-HVH community has a higher White population, 64.3%, than the state 54.4%.
- The community also has a higher Hispanic population, 22.2%, than the state 19.6%.
- Future growth is projected for Hispanics, Asian/Hawaiian /Pacific Islanders, African American and Other populations while the White population is projected to decline.

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Socioeconomic Profile – Household Income

NewYork-Presbyterian
NYP Hudson Valley Service Area vs. the State of New York State - Socioeconomic Profile
Calendar Years 2019 to 2024

Socioeconomic Indicator	Census 2010	Estimated 2019	Projected 2024	Percent Change 2010 - 2024	Percent Change 2019 - 2024
NYP Hudson Valley Service Area					
Population	186,666	192,346	195,644	4.8%	1.7%
Households	62,806	68,813	70,191	11.8%	2.0%
Median Household Income	$70,885	$102,746	$109,542	54.5%	6.6%
Average Household Income	$89,866	$138,293	$148,575	65.3%	7.4%
Income Distribution					
Under $25,000	15.1%	11.0%	10.0%	-33.5%	-6.8%
$25,000 - $49,999	19.0%	14.8%	14.1%	-25.9%	-2.9%
$50,000 - $99,999	33.7%	23.1%	22.2%	-34.1%	-2.0%
$100,000 +	32.3%	51.1%	53.7%	66.5%	7.1%
	100.0%	100.0%	100.0%		
New York State					
Population	19,378,102	19,903,676	20,196,560	4.2%	1.5%
Households	7,056,878	7,584,043	7,719,346	9.4%	1.8%
Median Household Income	$43,792	$68,067	$74,555	70.2%	9.5%
Average Household Income	$61,489	$101,507	$111,343	81.1%	9.7%
Income Distribution					
Under $25,000	29.5%	19.9%	18.2%	-38.5%	-7.0%
$25,000 - $49,999	26.3%	19.0%	17.8%	-32.1%	-4.3%
$50,000 - $99,999	29.0%	26.7%	25.7%	-11.2%	-2.0%
$100,000 +	15.3%	34.4%	38.3%	151.1%	13.2%

lley/[NYP_HudsonValley_Demographic_SAbyZIP.xlsx]Household_Table

Source: Nielsen, Inc.

- In 2019, the income distribution for NYP-HVH community is more favorable than the New York State comparison.
- The community's average household income, $138,293, is higher than the average of New York State, $101,507.
- Approximately 51.1% of the community population is in the $100,000+ bracket, much more than the 34.4% for New York State.
- Also, this $100,000+ income bracket is projected to grow the fastest.

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Community Demographic Profile

POPULATION

192,346

HOUSEHOLDS

68,813

ETHNICITY

22.2%

Index: 113

Hispanic/Latino

HISPANIC ORIGIN*

68.2%

Index: 129

Non Cuban/Mexican/Puerto Rican

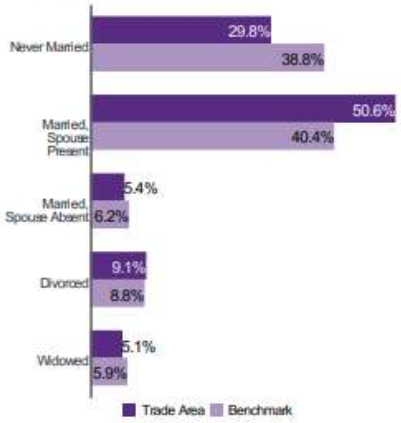
HOME LANGUAGE*

74.9%

Index: 108

Only English

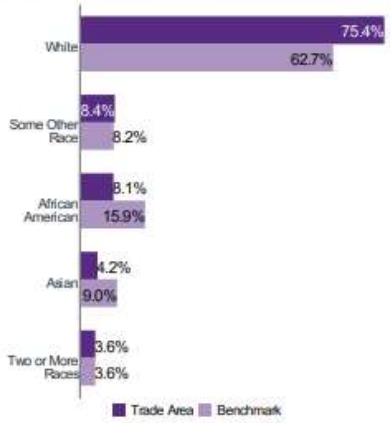
MARITAL STATUS



POPULATION BY AGE

Age	Count	%	Index
0 - 4	9,883	5.1	89
5 - 9	10,458	5.4	94
10 - 14	11,684	6.1	105
15 - 17	8,014	4.2	115
18 - 20	7,359	3.8	94
21 - 24	9,667	5.0	96
25 - 34	20,867	10.8	75
35 - 44	22,158	11.5	91
45 - 54	28,950	15.1	116
55 - 64	29,586	15.4	116
65 - 74	19,575	10.2	107
75 - 84	9,343	4.9	105
85+	4,802	2.5	113

POPULATION BY RACE**



Benchmark: New York

*Top variable chosen from percent composition ranking

**Top 5 variables chosen from percent composition ranking

Index Colors: <80 | 80 - 110 | 110+

The index is a measure of how similar or different the defined area is from the benchmark.

- In 2019, this community comprises approximately 192k people.
- Hispanic/Latino is 13% higher than the average for the benchmark of New York State.
- The population is more likely to speak only English at home than the average for the benchmark of New York State.
- There is a smaller minority population than the state average and there are more married persons than there are never married.

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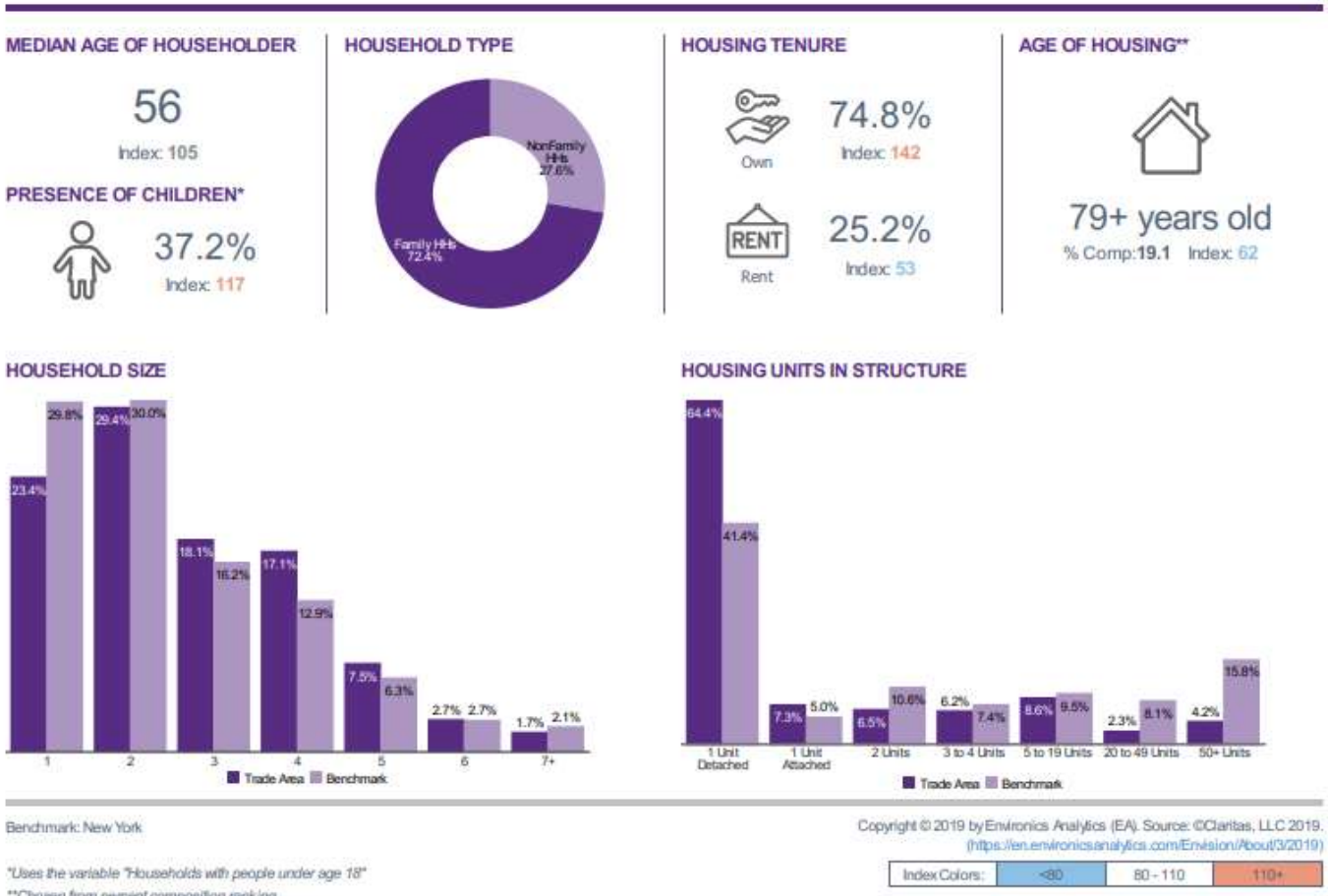
Community Household & Housing



- The median age of household, 56 years old, is 5% higher than the New York State median; yet there are 17% more children in the community than the average for the benchmark of New York State.
- More of the population lives in family households, 72.4%, than non-family households, 27.6%, and the household size is larger in comparison to New York State.
- More residents own as opposed to rent their home in this community; ownership is 42% higher than the average for the benchmark of New York State.

The index is a measure of how similar or different the defined area is from the benchmark.

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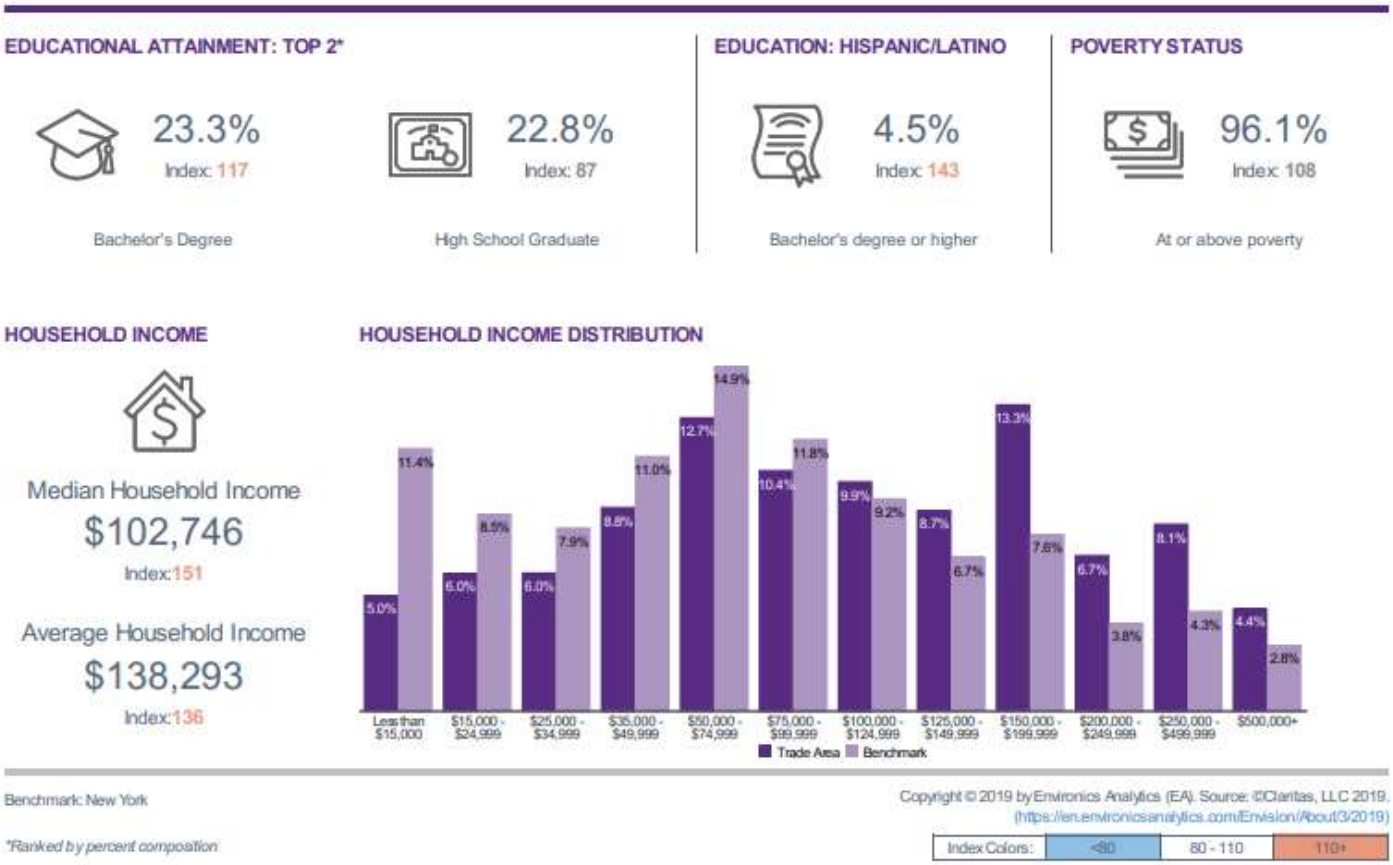
Community Education & Affluence



- In 2019, this community had a 13% lower than average high school and a 17% higher than average bachelor's degree attainment than the New York State benchmark.
- Both the community's median household income, $102,746 and average household income, $138,292, are higher than the average for the benchmark of New York State.

The index is a measure of how similar or different the defined area is from the benchmark.

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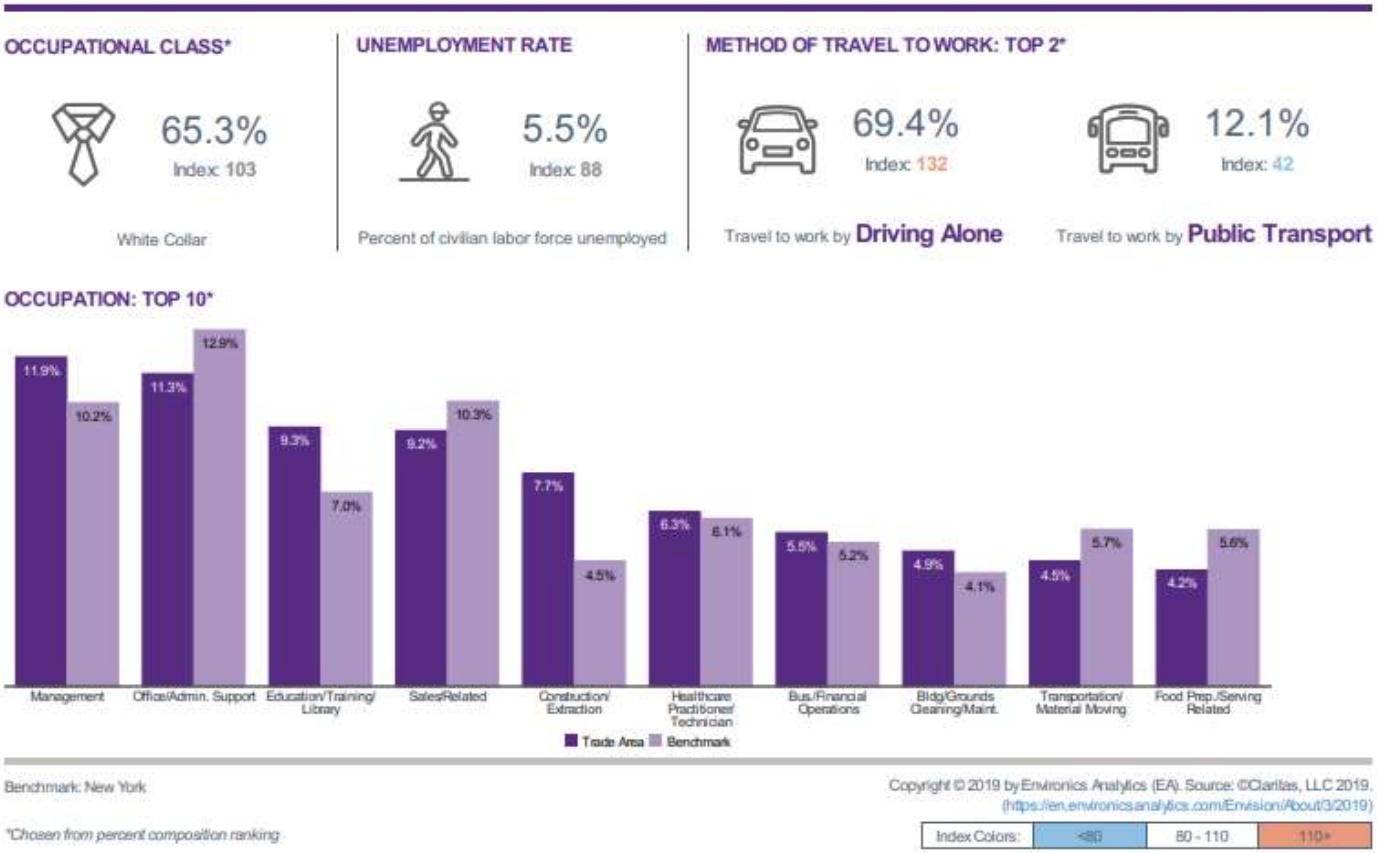
Community Employment & Occupation



The index is a measure of how similar or different the defined area is from the benchmark.

- In 2019, the community unemployment rate is lower than average for the benchmark of New York State, and there are more white collar workers than the state average.
- The population that uses public transport to travel to work is much lower than the average for the benchmark of New York State.

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AMAZING THINGS ARE HAPPENING HERE

Defining the High Disparity Communities

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NYP- HVH Communities of High Disparity Method

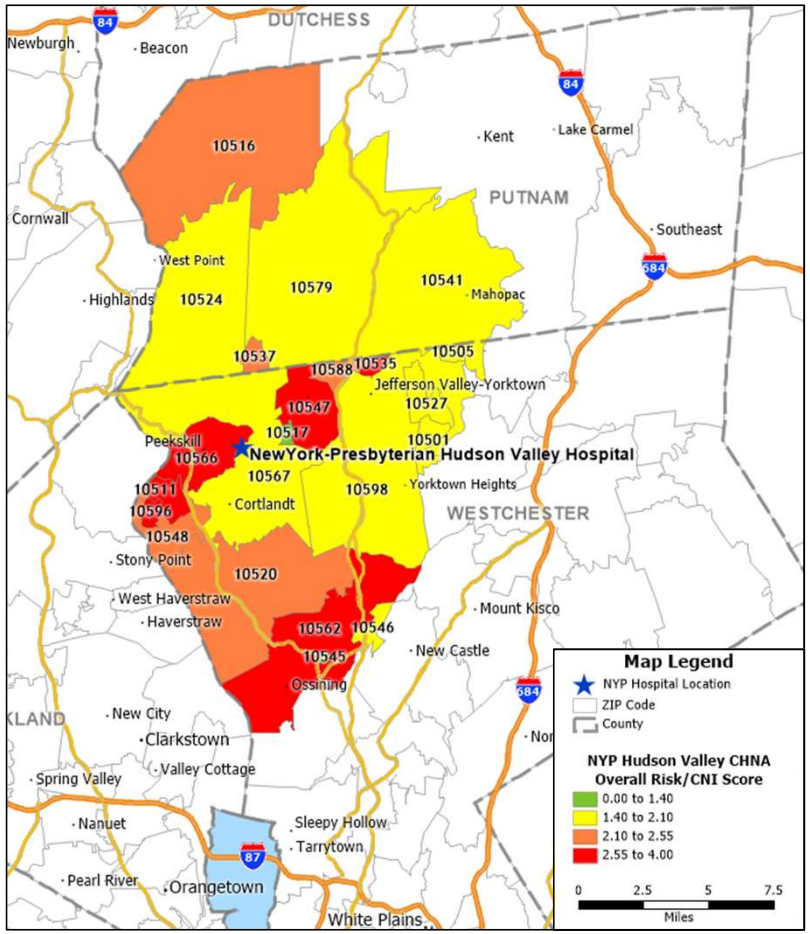
The Community Need Index (CNI) score is an average of five different barrier scores that measure various socioeconomic indicators of each community using the 2015 source data. These barriers, and the statistics that comprise them, were carefully chosen and tested individually by both Dignity Health and Truven Health:

1. Income Barrier	Percentage of households below poverty line, with head of household age 65 or more
	Percentage of families with children under 18 below poverty line
	Percentage of single female-headed families with children under 18 below poverty line
2. Cultural Barrier	Percentage of population that is minority (including Hispanic ethnicity)
	Percentage of population over age 5 that speaks English poorly or not at all
3. Education Barrier	Percentage of population over 25 without a high school diploma
4. Insurance Barrier	Percentage of population in the labor force, aged 16 or more, without employment
	Percentage of population without health insurance
5. Housing Barrier	Percentage of households renting their home

Every populated ZIP code in the United States is assigned a barrier score of 1,2,3,4, or 5 depending upon the ZIP code national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally.

For more information on the CNI score refer to http://cni.chw-interactive.org.

NYP-HVH Communities of High Disparity Analysis



- An analysis of communities with high disparities allows the NYP-HVH leadership to focus community-based efforts in order to have a high impact on the health of the community.
- An analysis of community health need and risk of high resource utilization was undertaken by zip code.
- The need score is an average of five different barrier scores that measure various socioeconomic indicators of each community.
- The results show where there is more or less need comparatively between communities.

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NYP-HVH Communities of High Disparity Analysis
Higher Disparity Quartiles 3 & 4 and Lower Disparity Quartiles 1 & 2

Zip Code	City	County	State	Overall Domain Risk/CNI Score	Quartile
10566	Peekskill	Westchester	New York	4.0	Quartile 4
10562	Ossining	Westchester	New York	3.8	Quartile 4
10596	Verplanck	Westchester	New York	3.0	Quartile 4
10547	Mohegan Lake	Westchester	New York	2.8	Quartile 4
10511	Buchanan	Westchester	New York	2.6	Quartile 4
10535	Jefferson Valley	Westchester	New York	2.6	Quartile 4
10520	Croton On Hudson	Westchester	New York	2.4	Quartile 3
10537	Lake Peekskill	Putnam	New York	2.4	Quartile 3
10548	Montrose	Westchester	New York	2.4	Quartile 3
10588	Shrub Oak	Westchester	New York	2.4	Quartile 3
10516	Cold Spring	Putnam	New York	2.2	Quartile 3
10567	Cortlandt Manor	Westchester	New York	2.0	Quartile 2
10505	Baldwin Place	Westchester	New York	1.8	Quartile 2
10579	Putnam Valley	Putnam	New York	1.8	Quartile 2
10546	Millwood	Westchester	New York	1.6	Quartile 2
10501	Amawalk	Westchester	New York	1.4	Quartile 1
10524	Garrison	Putnam	New York	1.4	Quartile 1
10527	Granite Springs	Westchester	New York	1.4	Quartile 1
10541	Mahopac	Putnam	New York	1.4	Quartile 1
10598	Yorktown Heights	Westchester	New York	1.4	Quartile 1
10517	PO Box	Westchester	New York	-	Quartile 1
10545	PO Box	Westchester	New York	-	Quartile 1

Source: http://cni.chw-interactive.org/

- Recognizing the variability among data, 11 of the 22 zip codes were identified to be of comparatively higher disparity, which could benefit from focused efforts of health improvement.
- In particular, all the zip codes in Quartile 4 are within the county of Westchester.
- The zip codes identified to have lesser disparities will also benefit from the community health improvement efforts offered broadly by NYP-HVH.

AMAZING THINGS ARE HAPPENING HERE

Assessing the Health of Westchester and Putnam Counties

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Assessing Westchester and Putnam Counties

Demographics and Socioeconomic Status

- Publicly available data were collected for Putnam and Westchester Counties.
- There is a total population of 1,083,976 in these 2 counties (91% from Westchester).
- **In aggregate, these counties are 51.4% female and slightly older**, 17.1% of the population is 65+, compared to NYC, 12.5% and NYS 16.3%.
- These **counties have a much lower minority population,** 45.5% than the NYC 67% average, but only slightly lower than the NYS 45.6% average.
- Both counties report a **smaller percent of families below poverty (2.8% for Putman 6.8% for Westchester),** this is much better than the NYS average, 11.3%.
- There is about **the same as NYS average percentages for adults aged 18-64, 87.5%, NYS 87.6%, and for children aged <19, 96.6%, NYS 96.6%, with health insurance, but a smaller percentage of the population is enrolled in Medicaid, 25.5%, NYS 38.1%.**
- There is a higher percentage of residents that speak only English at home in Putnam, 81.6%, than in Westchester, 67.0%, NYS 69.3%.
- In comparison to NYS averages **there is a smaller percentage of the population that completed High School; fewer unemployed, fewer disabled and less single parents.**
- Compared to the NYS average, there are **more people living in an Area Median Income (AMI) income band of $200,000,** and fewer **people living in an income band under $15,000.**

Assessing Westchester and Putnam Counties

Social Determinants of Health

- **There is only slightly worse 'percent of households with severe housing problems' 20.7%**, NYS 20.4% **and rent burden of 30% or more**, 40.8%, NYS 39.2%. There is **less of an issue for housing insecurity in Westchester, 33.1**%, NYS 36.4%.
- Westchester, 7.7%, and Putnam, 4.7%, each reports a **smaller percentage of the population than NYS, 11.9%, with food insecurity.**
- The Social & Environmental Safety indicators assessed **(air quality, hospitalizations for assaults and violent crimes) are more favorable than the state averages,** especially all violent crime 204.8, NYS 381.6.
- **Commute times vary, Putnam is 42 min and Westchester is 38 min.** In comparison NYC is 27 minutes and NYS 36 minutes.

Health Status

- Overall, these two counties are **more favorable than the NYS averages for maternal indicators** (maternal mortality, infant death rate, late prenatal care and teen births; However, **Westchester, 1.8%, is slightly higher than the NYS average, 1.7%, for percent of preterm births among all live births.**
- There is **opportunity to increase the number of fruits and vegetables consumed by residents**, 28.5%, NYS 31.5%, **but the percentage of the population with adult obesity, 17.8%, is more favorable than the NYS average, 25.5%.**
- **There is about the same percent of the population reporting physical activity, 76.9%, compared to NYS, 74.0%.**

Assessing Westchester and Putnam Counties

Health Status, continued

- **Premature deaths of aged less than 75 years, 34.2, NYS 40.1, the percentage of the population self-reporting good-excellent health, 2.7%, NYS 4.0%, and the percentage of the population self-reporting not getting needed medical care, 12.5%, NYS 11.5%, are less favorable** in comparison to the NYS averages.
- There is **better than average percentage of the population self-reporting poor mental health**, Putnam 8.5%, Westchester 9.1%, NYS 10.7%.
- Putnam, 21.7%, and Westchester, 20.7%, **both have a higher than average, 18.3%, percentage of the population self-reporting binge drinking**.
- There is a **better than NYS average percentage of the population with diabetes, hypertension, cardiovascular (CV) and chronic obstructive pulmonary disease (COPD).**
- There are **higher percentages of the population reporting smoking in Putnam**,**18.3%** than Westchester, 9.4%, and NYS, 14.5%.
- **Putnam also has a higher percentage of adult population on blood pressure medicine**, 68.2%, than Westchester, 53.3%, and NYS, 55.6%.
- **Putnam has a higher than average cancer incidence per 100,000 among all sites,** 519.4, NYS 482.9**, breast,** 141.0, NYS 130.7, **colorectal,** 40.9, NYS 38.9, **and lung,** 63.7, NYS 58.9.
- **Westchester has a higher than average incidence of breast,** 141.4, NYS 130.7**, and prostate,** 132.1, NYS 125.0, **cancers per 100,000.**

Assessing Westchester and Putnam Counties

Health Care Service Utilization

- Both counties **compare favorably to the NYS averages for all hospitalizations (total hospitalizations, asthma, diabetes, hypertension, pediatric asthma, drug related, falls and stroke).**
- There are **fewer than average ED visit crude rate per 100,00 population, in Putnam, 29,393, and Westchester, 33,933**, NYS 40,582.

Assessing Westchester and Putnam Counties Overview

The 22 zip codes defining the NYP-HVH community were categorized into four quartiles. **All zip codes in quartile 4 were in Westchester County, so additional analysis conducted prioritizes Westchester County.**

The following indicators have been selected to assess community health needs, to identify health disparities, to utilize in prioritizing the implementation strategies and to support health intervention planning.

- **Demographics** (population, gender, age cohort, race/ethnicity, English only spoken at home, unemployment, disability status, single parent households, etc.)
- **Socioeconomic status** (poverty, Area Median Income (AMI) eligibility for housing financial assistance)
- **Insurance status** (uninsured, Medicaid enrolled)
- **Social Determinants of Health** (housing, food insecurity, social and safety environment, transportation)
- **Indicators of health** (healthy eating and physical activity, women infant and children, well-being & mental health, chronic disease, hospitalizations, and Emergency Department utilization)

Population Profile for NYP-HVH

County	Population (Total #)	Percent of female population	Percent of male population	Percent of population ages 0-17	Percent of population ages 18-24	Percent of population ages 25-44	Percent of population ages 45-64	Percent of population ages 65+
Putnam	99,267	↓ 50.2%	49.9%	↓ 19.3%	9.2%	22.0%	32.2%	↑ 17.3%
Westchester	984,709	↑ 51.6%	48.5%	↑ 21.9%	9.4%	23.6%	28.0%	↑ 17.1%
NYP-HVH Counties	1,083,976	↑ 51.4%	48.6%	↑ 21.7%	9.4%	23.5%	28.3%	↑ 17.1%
New York City	8,354,889	52.4%	47.6%	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	19,903,676	51.4%	48.6%	21.0%	9.3%	27.1%	26.3%	16.3%

Source: Claritas

↑ Illustrates neighborhood statistic is larger than the NYS statistic

→ Illustrates neighborhood statistic is equal to the NYS statistic

↓ Ilustrates neighborhood statistic is smaller than the NYS statistic

- Age and gender composition help inform an understanding of the community and health service planning.
- In Putnam and Westchester Counties there is a total population of over 1 million.
- 51.4% of the community is female and 48.6% is male, the same as the NYS average.
- The population is slightly older, 17.1% of the population is 65+, compared to NYS, 16.3%.

	% Female	% Male
NYP-HVH Counties	51.4%	48.6%
New York City	52.4%	47.6%
New York State	51.4%	48.6%

Source: Claritas

	(0-17)	(18-24)	(25-44)	(45-64)	(65+)
NYP-HVH Counties	21.7%	9.4%	23.5%	28.3%	17.1%
New York City	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	21.0%	9.3%	27.1%	26.3%	16.3%

Source: Claritas

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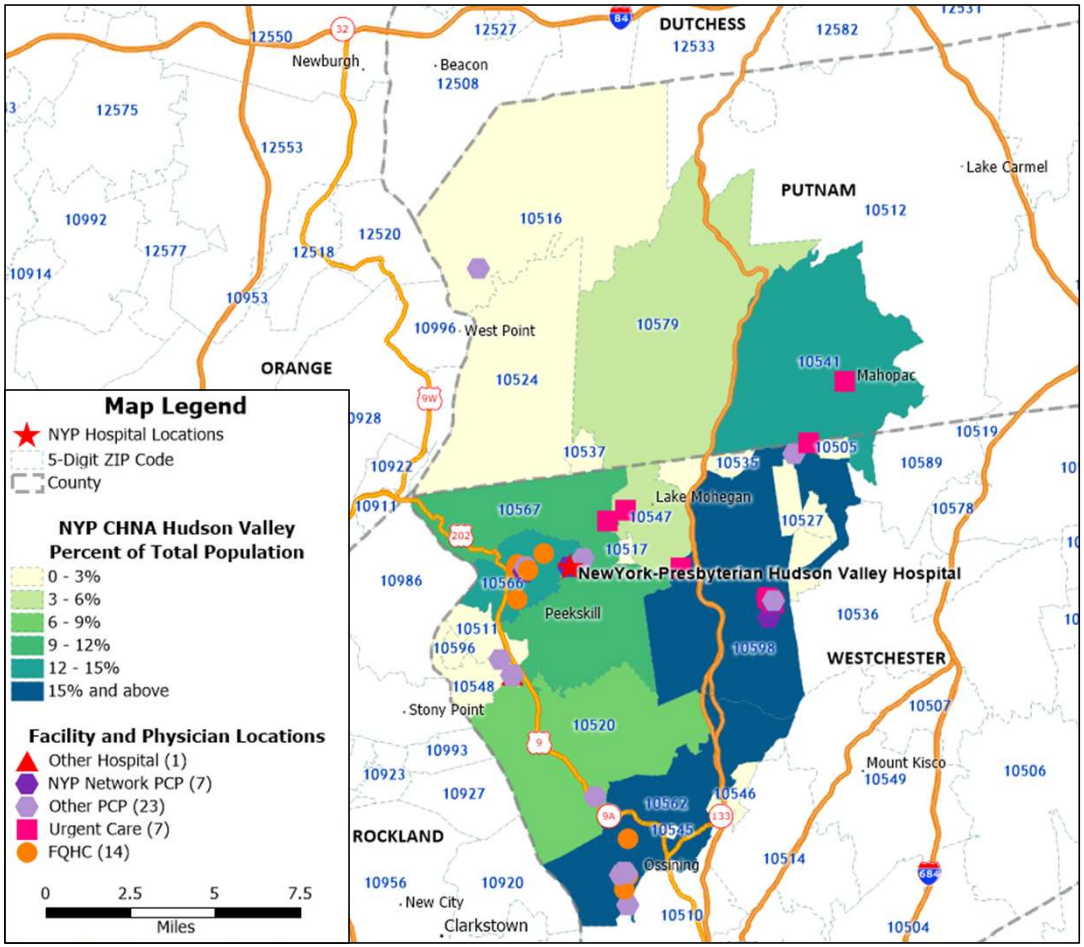
Total Population and Key Health Care Providers in the Hudson Valley Community



- Market saturation of health care providers within the surrounding areas of NYP-HVH reflects a group of Hospitals, NYP network Primary Care providers, non-NYP Primary Care providers, Urgent Care facilities, and Federally Qualified Health Centers (FQHC's) in order to reflect pockets of need to address community access issues.
- Analysis of such saturation or lack of saturation in appropriate providers allows for strategic placement of services to address community needs.

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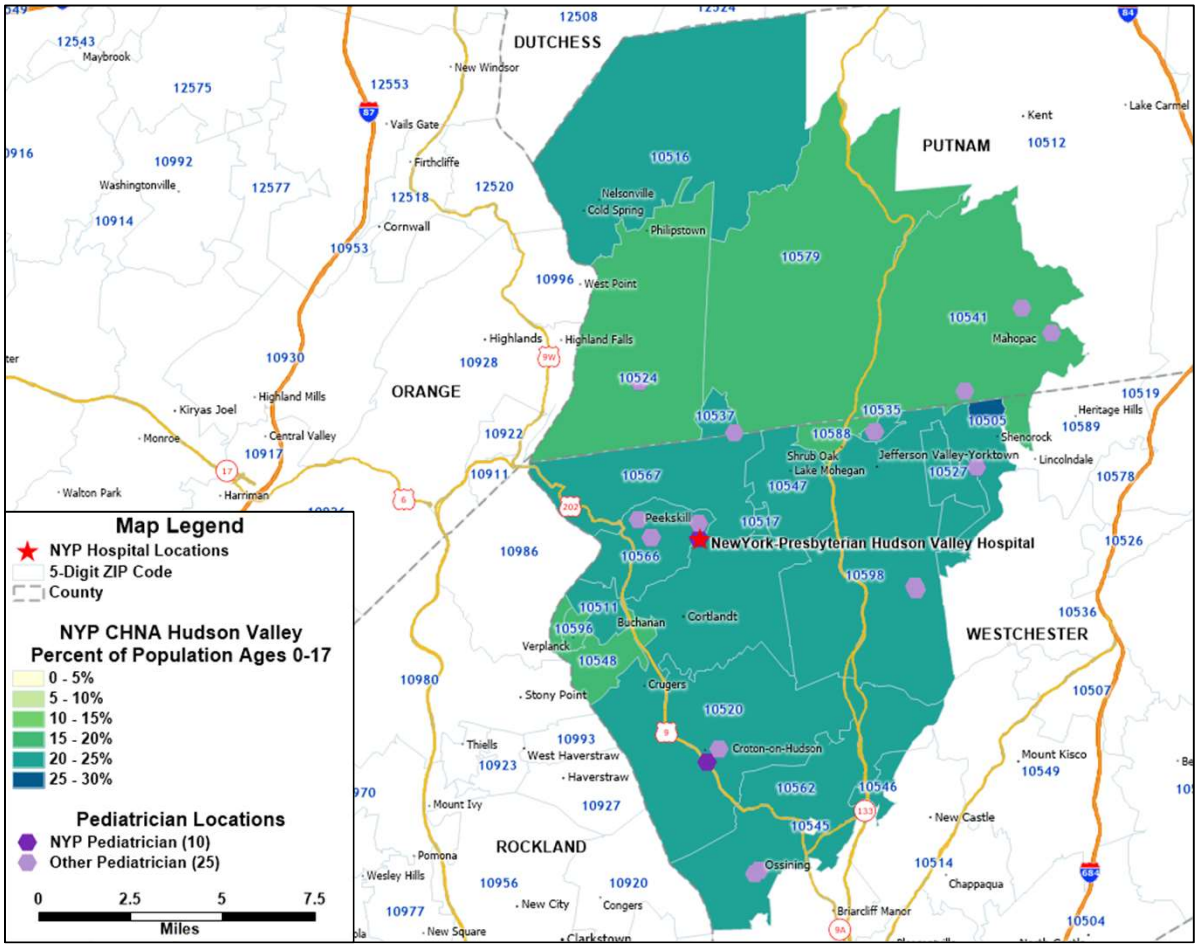
Pediatric Population and Key Health Care Providers in the Hudson Valley Community



- Community assets are outlined to reflect potential pockets of community need specific pediatric populations.
- NYP and non-NYP pediatric practices are identified to allow for identification of gaps as well as potential partnership arenas to impact the community at large.

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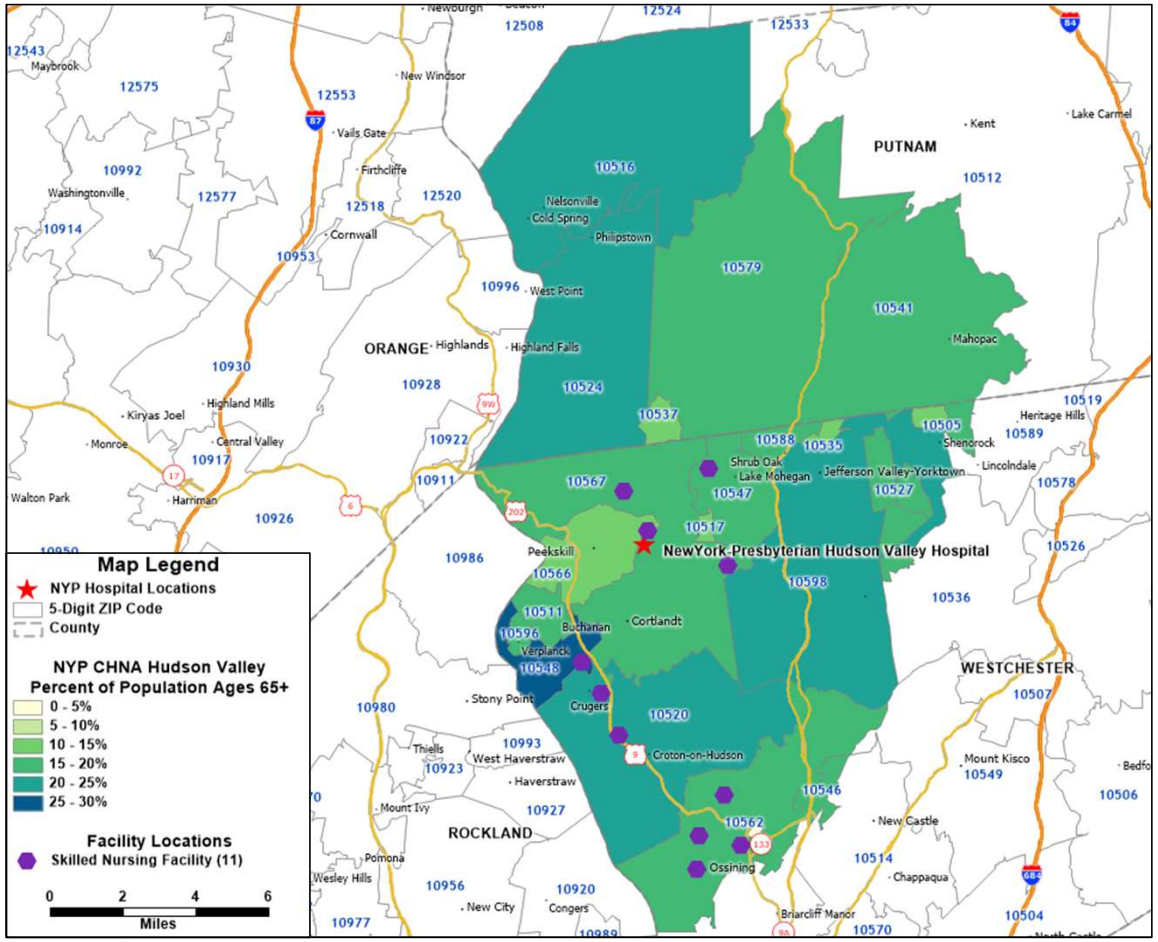
Senior Population and SNFs in the Hudson Valley Community



- Skilled Nursing Facilities are identified on the map to reflect potential access issues for concentrated senior populations.
- Communities have dispersed providers and SNF's targeting senior populations suggesting areas for focused strategies to impact long-term care and post-acute activity.

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Race / Ethnicity Profile for NYP-HVH

County	Percent of Hispanic or Latino population (any race)	Percent of White population (not Hispanic or Latino)	Percent of Black population (not Hispanic or Latino)	Percent of Asian and Pacific Islander population	Percent of all other race population
Putnam	15.4%	78.0%	2.7%	2.2%	1.7%
Westchester	25.5%	52.1%	13.6%	6.4%	2.4%
NYP-HVH Counties	24.6%	54.5%	12.6%	6.0%	2.3%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

Source: Claritas

Illustrates neighborhood statistic is larger than the NYS statistic

Illustrates neighborhood statistic is equal to the NYS statistic

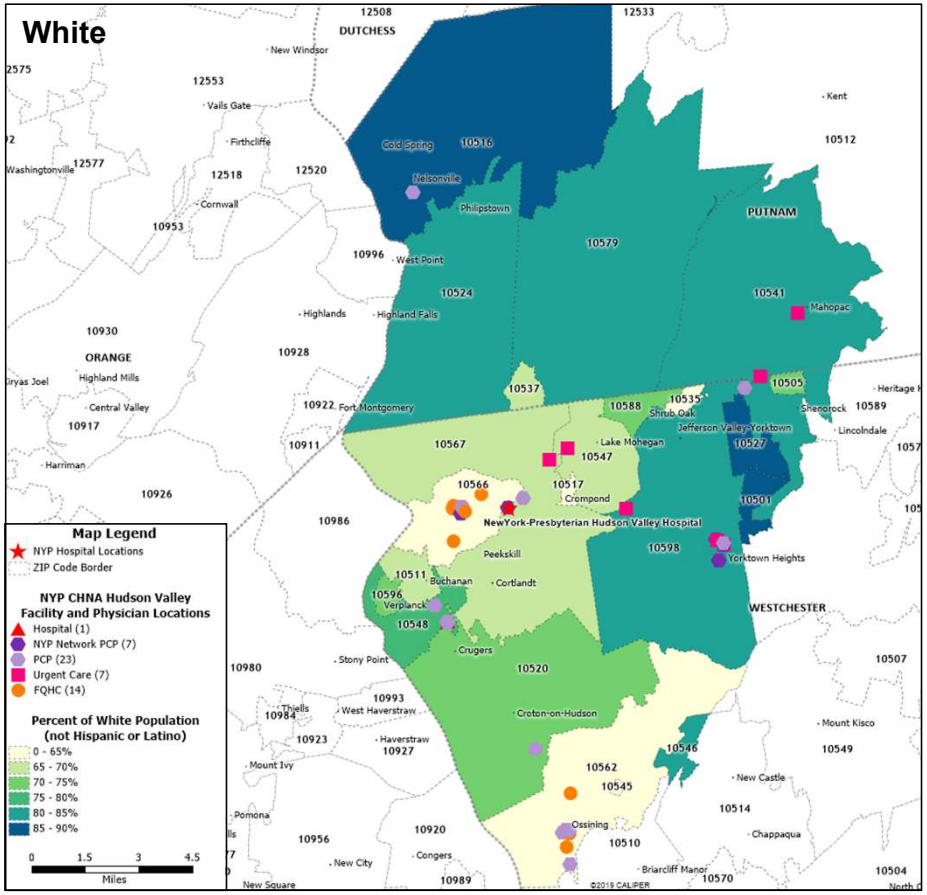
Ilustrates neighborhood statistic is smaller than the NYS statistic

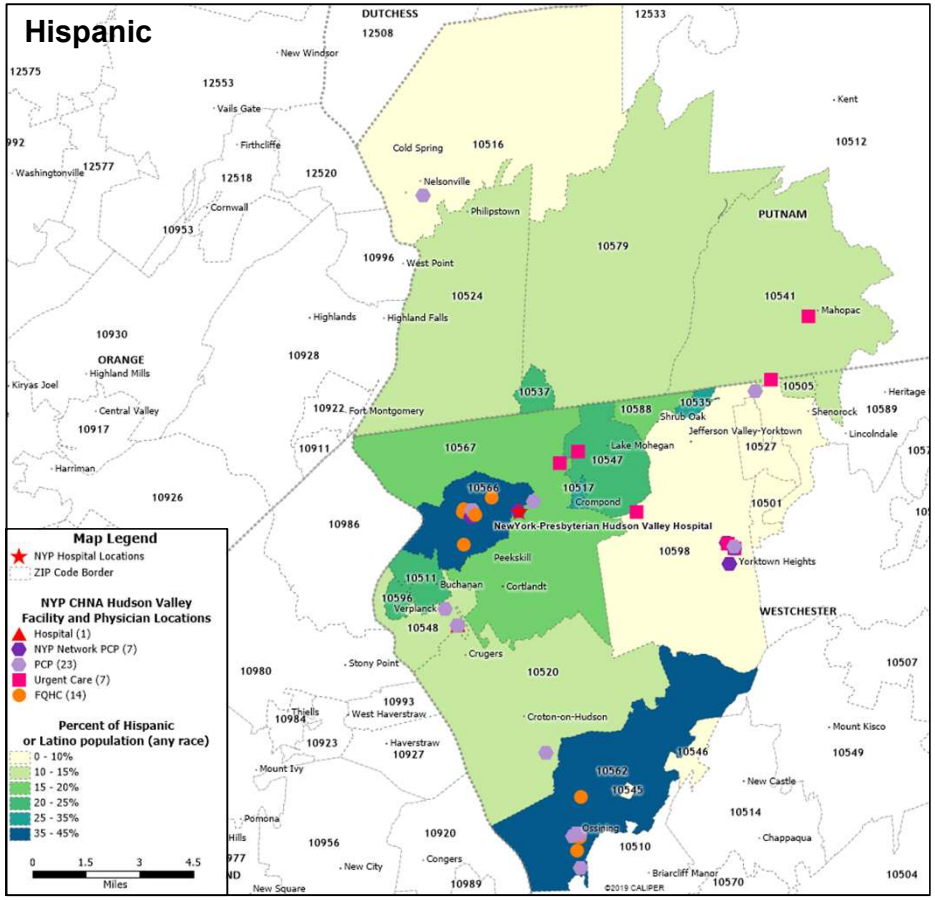
	Hispanic or Latino	White	Black	Asian / Pacific Islander	All Other
NYP-HVH Counties	24.6%	54.5%	12.6%	6.0%	2.3%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

Source: Claritas

- Race/ethnicity composition can also help inform an understanding of the community and health service needs as well as potential cultural norms to consider in outreach and care delivery.
- Overall, the two-county community is primarily White, 54.5%, Hispanic/Latino, 24.6%, and Black, 12.6%.
- The community has about the same percentage of White residents as the state, but a higher percentage of Hispanic/Latino and a slightly smaller percentage of Black residents.

Population by Race / Ethnicity and Key Health Care Providers in the Hudson Valley Community





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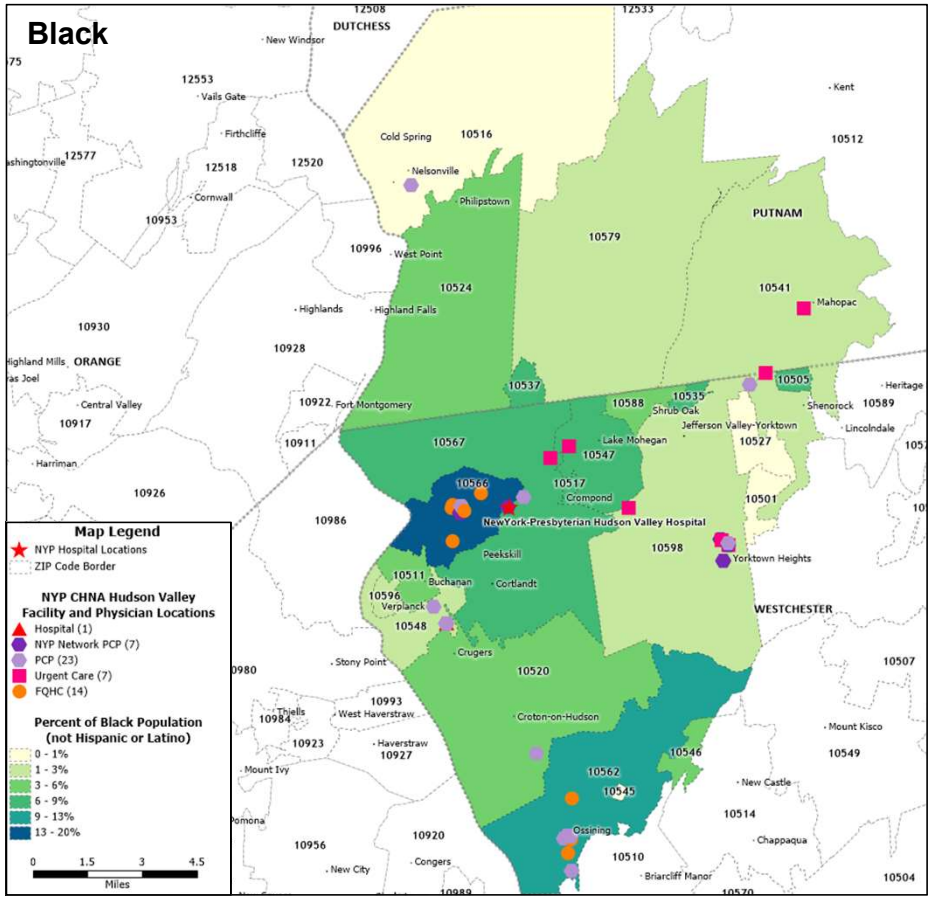
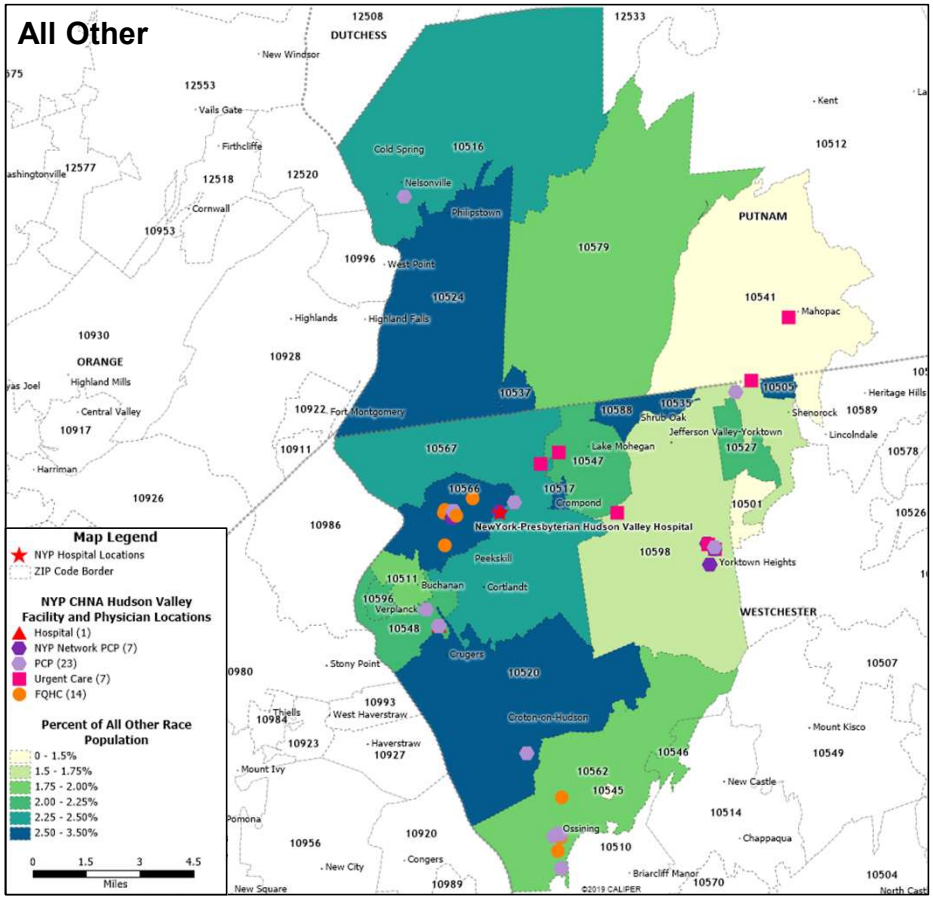
Population by Race / Ethnicity and Key Health Care Providers in the Hudson Valley Community





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Poverty & Health Insurance Profile for NYP-HVH

County	2019 Families Below Poverty	2019 Families Below Poverty with children	Percentage of adults aged 18-64 years with health insurance	Percentage of children aged <19 years with health insurance	Percent of population enrolled in Medicaid
Putnam	2.8%	2.2%	91.2%	96.7%	15.0%
Westchester	6.8%	4.6%	87.1%	96.6%	26.6%
NYP-HVH Counties	6.4%	4.4%	87.5%	96.6%	25.5%
New York City	N/A	N/A	N/A	N/A	N/A
New York State	11.3%	8.2%	87.6%	96.6%	38.1%

Source: Claritas

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- Economic factors and insurance are predictors of health outcomes and strongly influence health behavior.
- Overall, there is a more favorable percentage of families living in poverty than the NYS average.
- Individuals with insurance coverage is higher than that of the NYS average for most populations within the NYP-HVH community.
- There is less of the population enrolled in Medicaid, 25.5%, NYS 38.1%.

Other Risk Indicators

County	Speak Only English at Home	Percent Adults Age 25+ Not Completed High School	% of population ages 16+ unemployed	% of population reported disabled	% of households, single mother with children	% of households, single father with children
Putnam	81.6%	7.2%	34.9%	4.2%	5.8%	2.2%
Westchester	67.0%	12.8%	35.1%	3.8%	9.4%	2.4%
NYP-HVH Counties	68.3%	12.2%	35.1%	3.8%	9.1%	2.4%
New York City	N/A	19.9%	10.3%	10.3%	9.6%	2.3%
New York State	69.3%	13.8%	36.9%	4.9%	12.0%	3.2%

Source: Claritas; County-Level Behavioral Risk Factor Surveillance System

Illustrates neighborhood statistic is larger than the NYS statistic

Illustrates neighborhood statistic is equal to the NYS statistic

Illustrates neighborhood statistic is smaller than the NYS statistic

- While none of these are conclusive determinants alone, there evidence-based predictors of health outcome to consider including: those not graduating from high school, unemployment, disabled community members, and single parents.
- Among the health predictability indicators, High School graduation rate, unemployment, disabled and single parents, there are lower than NYS averages.

Percent of People Living within Select Income Bands (% AMI)

County	% of People Living within Income Band $200,000 or more	% of People Living within Income Band $100,000 to $199,999	% of People Living within Income Band $75,000 to $99,999	% of People Living within Income Band $50,000 to $74,999	% of People Living within Income Band $35,000 to $49,999	% of People Living within Income Band $25,000 to $34,999	% of People Living within Income Band $15,000 to $24,999	% of People Living within Income Band Under $15,000
Putnam	↑ 18.5%	↑ 33.9%	↑ 13.0%	↓ 12.4%	↓ 8.2%	↓ 5.5%	↓ 5.6%	↓ 2.9%
Westchester	↑ 21.7%	↑ 26.5%	↓ 10.0%	↓ 12.5%	↓ 8.6%	↓ 6.2%	↓ 6.4%	↓ 8.1%
NYP-HVH Counties	↑ 21.4%	↑ 27.2%	↓ 10.3%	↓ 12.5%	↓ 8.5%	↓ 6.1%	↓ 6.3%	↓ 7.7%
New York City	10.3%	21.2%	10.9%	14.7%	10.4%	7.8%	9.2%	15.4%
New York State	11.0%	23.5%	11.8%	14.9%	11.0%	7.9%	8.5%	11.4%

Source: Claritas

↑ Illustrates neighborhood statistic is larger than the NYS statistic

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↓ Ilustrates neighborhood statistic is smaller than the NYS statistic

- The Area Median Income (AMI) is the midpoint of a region's income distribution – half of families in a region earn more than the median and half earn less than the median.
- For housing policy, U.S. Department of Housing and Urban Development (HUD) sets income thresholds relative to the AMI to identify persons eligible for housing assistance.
- Compared to the NYS average, there are more people in the living in income bands of $200,000 or more and fewer living in income bands under $15,000.

Housing and Food Insecurity

County	Severe Housing Problems	Housing Insecurity	Rent burden, 30% or more	County Foreclosure Rate 2018
Putnam	16.6%	37.1%	38.1%	1.5%
Westchester	21.1%	32.7%	41.1%	0.6%
NYP-HVH Counties	20.7%	33.1%	40.8%	0.6%
New York City	N/A	N/A	54.2%	0.4%
New York State	20.4%	36.4%	39.2%	0.6%

Source: County-Level Behavioral Risk Factor Surveillance System; RWJ County Health Rankings; Cares Engagement; Office of the NYS Comptrol

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

County	Food Insecurity
Putnam	4.7
Westchester	7.7
NYP-HVH Counties	7.4
New York City	N/A
New York State	11.9

Source: RWJ County Health Rankings

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- Housing and food insecurity can impact health significantly.
- In Putnam there are less severe housing problems than NYS. However, Westchester is slightly higher than average.
- There is more housing insecurity in Putnam, 37.1% than in Westchester, 32.7%; and NYS at 36.4%.
- The rent burden of 30% or more is similar to the NYS average of 39.2%.
- Food insecurity is more favorable than NYS, 11.9%.

Social & Environmental Safety and Transportation

County	Air Quality (Annual Avg. MCG per Cubic Meter of Fine Particle Matter)	Assault Hospitalization per 100,000 Population, Age Adjusted Rate	Violent Crime
Putnam	1.2	1.0	48.4
Westchester	2.4	2.6	220.6
NYP-HVH Counties	2.3	2.5	204.8
New York City	N/A	6.2	N/A
New York State	2.5	3.8	381.6

Source: Cares Engagement; New York State Community Health Indicator Reports (CHIRS)

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Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

County	Workers who commute by any form of transportation over 60 minutes each way.
Putnam	42.0
Westchester	38.0
NYP-HVH Counties	N/A
New York City	27.0
New York State	36.0

Source: Claritas

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Indicates neighborhood statistic is less favorable than the NYS statistic by more than five perce

- Physical environment (pollution, access to safe streets & parks, etc.) plays a key role in health and well-being. Long term health factors have also evolved to include social and familial support resources.
- Air quality, 2.3, is favorable to the NYS average, 2.5.
- Assault hospitalizations and violent crimes are also favorable in comparison to NYS averages.
- There are longer than NYS average, 36 minutes, commute times to work.

Health Status Indicators: Women, Infants, and Children

County	Maternal mortality rate per 100,000 live births	Rate of infant deaths (under one year old) per 1,000 live births	Percent of live births receiving late prenatal care	Percent of preterm births among all live births	Rate of Teen Births (per 1,000 women ages 15 to 19)
Putnam	0.0	3.7	2.1%	1.4%	4.4
Westchester	9.5	4.6	4.1%	1.8%	10.8
NYP-HVH Counties	8.6	4.5	3.9%	1.8%	10.2
New York City	19.3	4.4	7.0%	9.1%	23.7
New York State	18.7	4.8	5.6%	1.7%	17.8

Source: New York State Community Health Indicator Reports (CHIRS)

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- The frequency of maternal morbidity issues have worsened over time, nationally.
- Infancy health status can impact long term health and the lack of early prenatal care can result in very costly neonatal and/or pediatric care needs.
- Overall, these two counties are more favorable than the NYS averages for these indicators.
- However, Westchester, 1.8%, is slightly higher than the NYS average, 1.7%, for preterm births.

Health Status Indicators: Healthy Eating & Physical Activity

County	Percentage of adults who ate in 24 hrs, 1+ serving fruit/veg	Percentage of adults who drink >1 sweetened beverages daily	Percentage of adults who report being obese	Child obesity, Students 95th percentile or higher	Percentage of adults w/ physical activity in last 30 days
Putnam	27.0%	22.9%	19.2%	16.0%	75.0%
Westchester	28.6%	18.5%	17.7%	13.7%	77.1%
NYP-HVH Counties	28.5%	18.9%	17.8%	13.9%	76.9%
New York City	35.1%	23.0%	22.9%	N/A	73.0%
New York State	31.5%	24.2%	25.5%	0.0%	74.0%

Source: County-Level Behavioral Risk Factor Surveillance System; New York State Community Health Indicator Reports (CHIRS)

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Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- Behaviors related to healthy eating and physical activity can directly contribute to improved health outcomes and chronic illness.
- There is opportunity to increase the number of fruits and vegetables consumed by residents, 28.5%, as compared to NYS, 31.5%.
- Adult obesity, 17.8%, is more favorable than the NYS average, 25.5%.
- There is similar amount of physical activity, 76.9%, compared to NYS, 74.0%.

Health Status Indicators: Well-Being & Mental Health

County	Percentage premature deaths (aged less than 75 years)	Percentage of adults self-report health as good-excellent	Percentage of adults not getting needed medical care	Percentage of adults self-reporting poor mental health [1]	Percentage of adults self-reporting binge drinking
Putnam	41.6	4.0%	13.5%	8.5%	21.7%
Westchester	33.4	2.6%	12.4%	9.1%	20.7%
NYP-HVH Counties	34.2	2.7%	12.5%	9.0%	20.8%
New York City	N/A	78.0%	10.0%	10.3%	17.3%
New York State	40.1	4.0%	11.5%	10.7%	18.3%

Source: County-Level Behavioral Risk Factor Surveillance System; New York State Community Health Indicator Reports (CHIRS)

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- Key indicators for the health of a community include mortality rates and self reported physical and mental health status as well as general access to needed medical care.
- Premature deaths are lower at 34.2% than that of NYS at 40.1%.
- Self reported good-excellent health shows 2.7% which is lower than the NYS reported 4.0%.
- Those reporting they are not getting needed medical care is higher than the NYS average at 12.5%.
- There is better than average self reports of poor mental health, 9.0%, NYS 10.7%.
- Putnam, 21.7%, and Westchester, 20.7%, both have a higher than average percentage of binge drinking.

Health Status Indicators: Chronic Disease

County	Percentage of adults with diabetes	Percentage of adults with hypertension	Percentage of adults reporting current smoking	Rate of new HIV diagnoses per 100,000 people
Putnam	6.9%	21.1%	18.3%	4.3
Westchester	7.6%	24.2%	9.4%	12.0
NYP-HVH Counties	7.5%	23.9%	10.2%	11.3
New York City	11.0%	28.0%	14.0%	24.0
New York State	9.5%	28.9%	14.5%	17.9

Source: County-Level Behavioral Risk Factor Surveillance System; New York State Community Health Indicator Reports (CHIRS)

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County	Percentage of adults with arthritis	Percentage of adults with CV (heart attack, coronary heart disease, or stroke)	Percentage of adults with COPD	Percentage of adults taking medication for high blood pressure
Putnam	23.4%	4.4%	4.2%	68.2
Westchester	19.7%	6.1%	3.8%	53.3
NYP-HVH Counties	20.0%	5.9%	3.8%	54.7
New York City	18.5%	6.6%	3.7%	54.7
New York State	21.8%	7.0%	4.9%	55.6

Source: County-Level Behavioral Risk Factor Surveillance System

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- Behaviors like smoking can lead to chronic diseases, which are both costly and resource intensive to manage.
- There is a better than NYS average percentage of diabetes, hypertension, cardiovascular (CV) and chronic obstructive pulmonary disease (COPD).
- There are higher percentages of smoking in Putnam ,18.3% than Westchester, 9.4%, and NYS, 14.5%.
- Putnam also has a higher percentage of adults on blood pressure medicine, 68.2%, than Westchester, 53.3%, and NYS, 55.6%.

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Health Status Indicators: Cancer Incidence

County	Cancer Incidence - All Sites	Cancer Incidence - Breast	Cancer Incidence - Colon and Rectum	Cancer Incidence - Lung	Cancer Incidence - Prostate
Putnam	519.4	141.0	40.9	63.7	119.4
Westchester	478.6	141.4	35.8	48.4	132.1
NYP-HVH Counties	482.3	141.4	36.3	49.8	130.9
New York City	477.7	131.3	39.8	60.2	131.7
New York State	482.9	130.7	38.9	58.9	125.0

Source: State Cancer Profiles

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- The diagnosis of cancer has a tremendous impact on the physical, mental and economic well-being of an individual and their families.
- Putnam has a higher than average cancer incidence per 100,000 among all sites at 519.4 as compared to NYS at 482.9. Breast, Colorectal, and Lung cancers are all higher than the NYS averages.
- Westchester has a higher than average incidence of breast and prostate cancers per 100,000.

Health Care Service Utilization: Hospitalizations

	Hospitalizations			
County	Age-adjusted total hospitalization rate per 10,000	Age-adjusted asthma hospitalization rate per 10,000	Age-adjusted diabetes hospitalization rate per 10,000	Hypertension hospitalization rate per 10,000 - 18+ years
Putnam	902.2	7.5	15.0	2.1
Westchester	1,031.2	13.5	25.4	5.3
NYPHVH Counties	1,019.4	13.0	24.4	5.0
New York City	N/A	N/A	N/A	N/A
New York State	1,127.6	17.6	34.2	68.0

Source: New York State Community Health Indicator Reports (CHIRS)

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	Other Hospitalizations			
County	Asthma hospitalization rate per 10,000 - Aged 0-17 years	Drug-related hospitalization rate per 10,000	Age-adjusted falls hospitalization rate per 10,000	Cerebrovascular disease (stroke) hospitalization rate per 10,000
Putnam	21.4	17.1	28.6	35.2
Westchester	37.4	21.5	32.6	40.2
NYP-HVH Counties	35.9	21.1	32.2	39.7
New York City	N/A	N/A	N/A	N/A
New York State	54.0	22.6	34.0	45.6

Source: New York State Community Health Indicator Reports (CHIRS)

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- Hospitalization represents the potential need for prevention and management of chronic conditions and can lead to increased healthcare cost.
- Both counties compare favorably to the NYS averages for all hospitalizations including asthma, diabetes and hypertension hospitalizations.
- Both counties also compare favorably to the NYS averages for other hospitalizations of child asthma, drugs, falls and stroke.

Health Care Service Utilization: ED

NYC Neighborhood Tabulation Area	Emergency Dept: All Visits per 100,000 Population, Crude Rate
Putnam	29,393
Westchester	33,933
NYP-HVH Counties	33,517
New York City	46,079
New York State	40,582

Source: New York State Community Health Indicator Reports (CHIRS), note: converted CHIRS rate per 10k to per 100k

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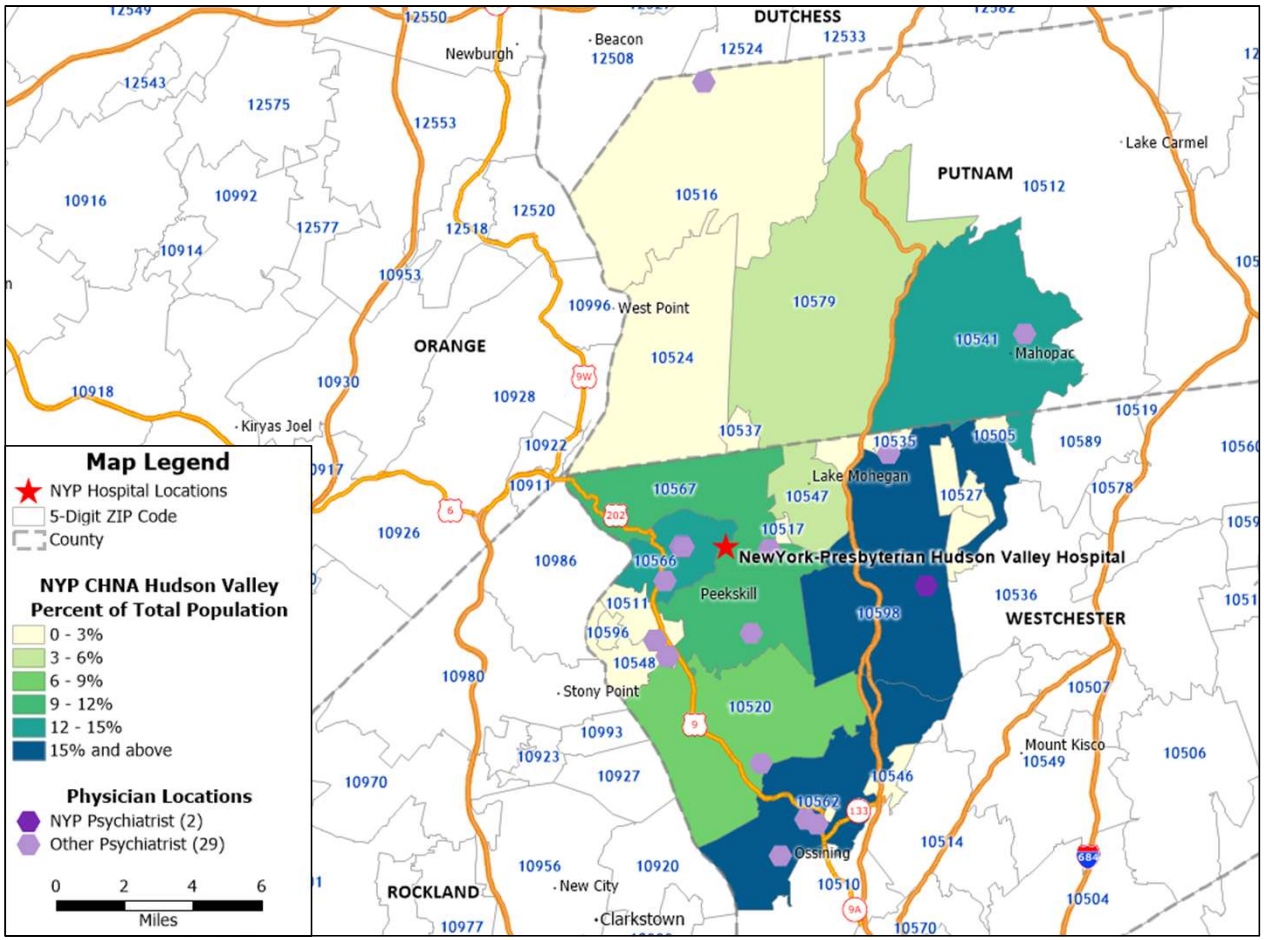
- There are fewer than average ED visits per 100,00 population, in Putnam, 29,393, and Westchester, 33,933, NYS 40,582 per 100,000 population.
- The amount of emergency department encounters can reflect ambulatory access issues within the county.

Psychiatric Hospitals and Physicians in the Hudson Valley Community



- Behavioral health providers and facilities are lacking across the service area. This is a consistent trend across the state of New York.
- Pockets of providers exist in lower quartile communities of need with opportunities for access in high need populations.

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Health Provider Assets in the NYP-HVH Community

Asset Type	Quartile 1	Quartile 2	Quartile 3	Quartile 4	Total
Short Term Acute Care Hospital	0	1	0	0	1
VA Hospital	0	0	1	0	1
Childrens Hospital	0	0	0	0	0
Long Term Acute Care Hospital	0	0	0	0	0
Rehabilitation Hospital	0	0	0	0	0
Psychiatric Hospital	0	0	0	0	0
Federally Qualified Health Center	0	0	0	14	14
Urgent Care Clinic	4	1	0	2	7
Skilled Nursing Facility	0	2	3	6	11
Facility Total	**4**	**4**	**4**	**22**	**34**
Primary Care Physicians	6	2	9	13	30
Pediatricians	14	3	5	13	35
Psychiatrists	2	2	17	10	31
Physician Total	**22**	**7**	**31**	**36**	**96**

Data Source: Definitive Health

This table represents a count only and does not imply that all providers listed accept the most vulnerable populations of Medicaid, low-income, and/or uninsured patients.

Westchester County Health Department Data Summary

The following information have been collected and **prepared by the Westchester County Health Department, specifically for the Westchester County community**, to assess community health needs, to identify health disparities, to utilize in prioritizing the implementation strategies and to support health intervention planning.

- **Demographics** (population, gender, age cohort, by race)
- **Socioeconomic status** (education, unemployment, poverty and housing insecurity)
- **Health Status** (average age at death, birth weight, premature birth, high blood pressure, select causes of death and mortality rates)
- **Health Care Service Utilization** (hospitalizations and ER visits)

Westchester County Health Department Data Summary

Demographics and Socioeconomic Status

- There are almost 1M people that reside in the Westchester County geography.
- Approximately 52% of the county is female and 48% is male.
- About 22% of the county is under the age of 18 and **18% of the population is 65+, compared to NYS at 15.4%.**
- **White Alone is the most numerous race group**, 66.1%, but Hispanics comprise 23.6% of the population and are the largest minority group, followed by Black Alone, 14.4%.
- **A strong percentage of the population has attained a High School diploma or equivalent or a College degree**. This varies by race and ethnicity, with the White population more frequently attaining a Bachelor's Degree.
- The **unemployment rate in Westchester among all populations appears higher** than the NYS percentage of labor force unemployed, 4.7, but Blacks have the highest unemployment rate at 11%.
- In **Westchester County, 18% of Hispanic and 17% of Black populations are living in poverty** (higher than the NYS average of 14.8%).
- **Hispanic populations have the highest percentage of housing insecurity**, 63.% which is more than double the percentage of White Non-Hispanic populations, 26.1% and higher than Black Non-Hispanic populations, 47.6%.

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Westchester County Health Department Data Summary

Health Status

- The average age of death is lowest for minorities, 66.3 for Hispanics and 70.8 for Blacks. **Whites live 8 to 13 years longer than Hispanics or Blacks, respectively.**
- **The top causes of death for county residents are consistently diseases of the circulatory system**.
- **Low birthweight among infants is highest for Non-Hispanic Black women,** 12.7% and Non-Hispanic Asian women, 8.8%. Hispanic women have the lowest rates of low birthweight, 6.7%, followed by Non-Hispanic White, 6.8%. The NYS percentage of low birthweight is 7.9%
- **Notably, all race/ethnicities have a higher than the average percent of premature births, but it is highest for Non-Hispanic Black women at** 15.7%. The NYS percentage of premature births with <37 weeks gestation is 8.8%.
- **Non-Hispanic Black populations also have the least favorable rates of physician diagnosed high blood pressure.**
- **Non-Hispanic Black populations have the highest rate of physician diagnosed high blood pressure**, 45.5%. The rates for White Non-Hispanics, 25.7%, and Hispanics,17.3%, are lower than the state average, 28.9%.

Westchester County Health Department Data Summary

Health Status, continued

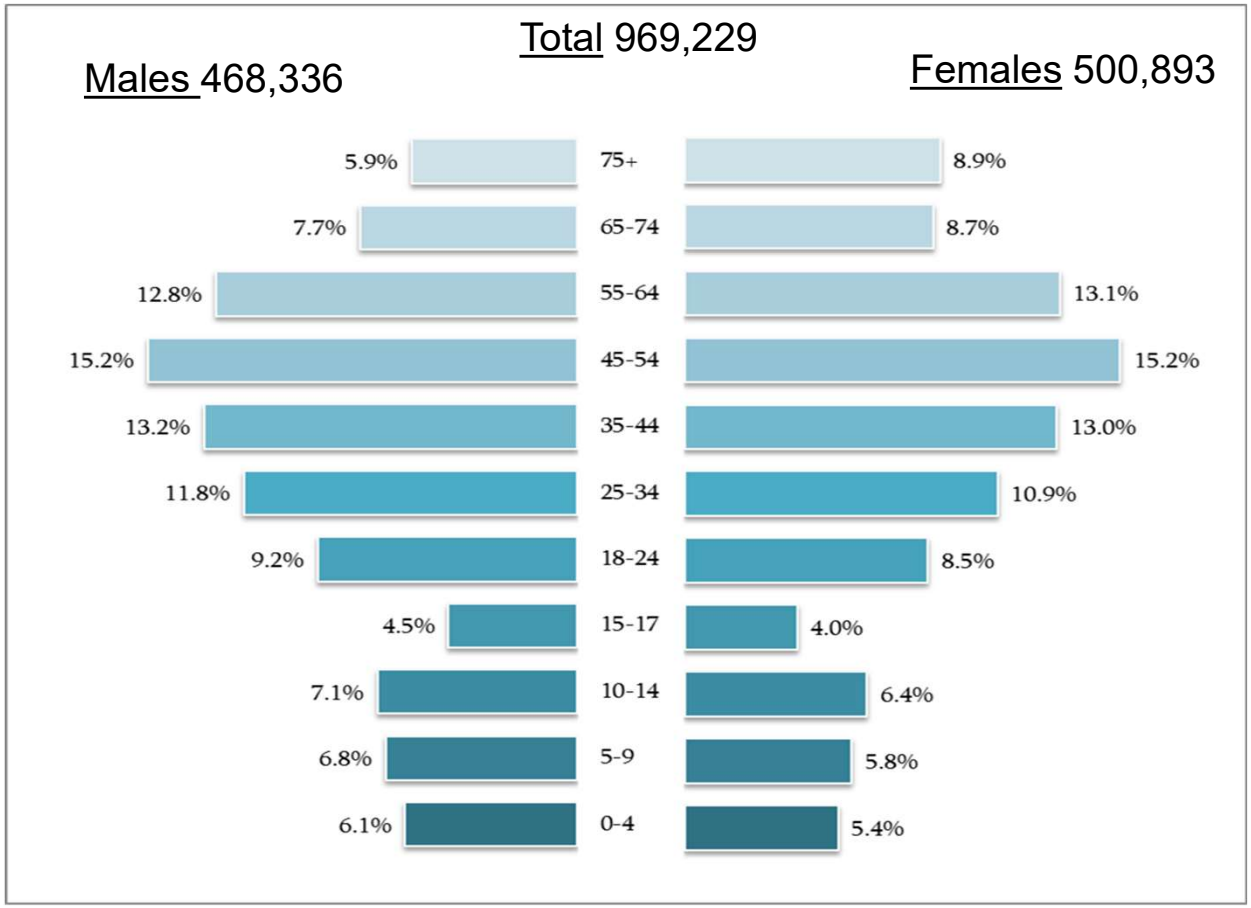
- While Non-Hispanic Black populations report **a high percentage of 1+ sugary drinks consumed daily**, Hispanic populations report the highest percentage.
- The **diabetes mortality rate among Non-Hispanic Blacks is highest, 25.3**, while the other race / ethnicities are lower than the NYS average, 17.0.
- **Black males' cancer incidence rate, 605.2, is higher than White males, 555.9 and higher than the NYS average,** 564.4. Conversely, Black females' cancer incidence rate 364.0, is lower than White females, 555.9 and both lower than the state average.
- **Black males' cancer mortality rate of 214.1 is higher than the state average**, 176.2, while White males' rate of 167.4 is slightly lower than NYS average. Black females' cancer mortality rate of 148.3 is lower than the state average, and White females' rate of 130.7 is lower still.

Westchester County Health Department Data Summary

Health Care Service Utilization

- In total, **county residents are more frequently hospitalized for circulatory system conditions** (cardiovascular issues).
  - Black populations are hospitalized most often for circulatory system conditions or mental disorders.
  - Hispanic populations are also hospitalized most often for circulatory system conditions or mental disorders, but at lower percentages than Blacks.
  - White populations are most frequently hospitalized for circulatory and digestive conditions.
- **Non-Hispanic Black populations have a significantly higher hospitalization rate**, 106.0, for heart disease than other race/ethnicities ranging 27.8 - 69.6.
- **Non-Hispanic Black populations also have higher mortality rates 202.0, for heart disease related conditions** than others in the County, but these rates are lower than the NYS cardiovascular disease mortality rate per 100,000 of 272.2.
- The **top causes, among all races/ethnicities, for ER visits are injuries and poisonings followed by respiratory issues.** However, White populations top ER visits are for injuries and poisonings followed by cardiovascular disease.

Westchester County Population
Average of 2012-2016, Age and Sex



Source: U.S. Bureau of Census via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

- Age and gender composition help inform an understanding of the community and health service planning.
- There are almost 1M people that reside in the Westchester County geography.
- Approximately, 52% of the community is female and 48% is male.
- About 22% of the population is under the age of 18 and 18% of the population is 65 or older, compared to NYS at 15.4%.

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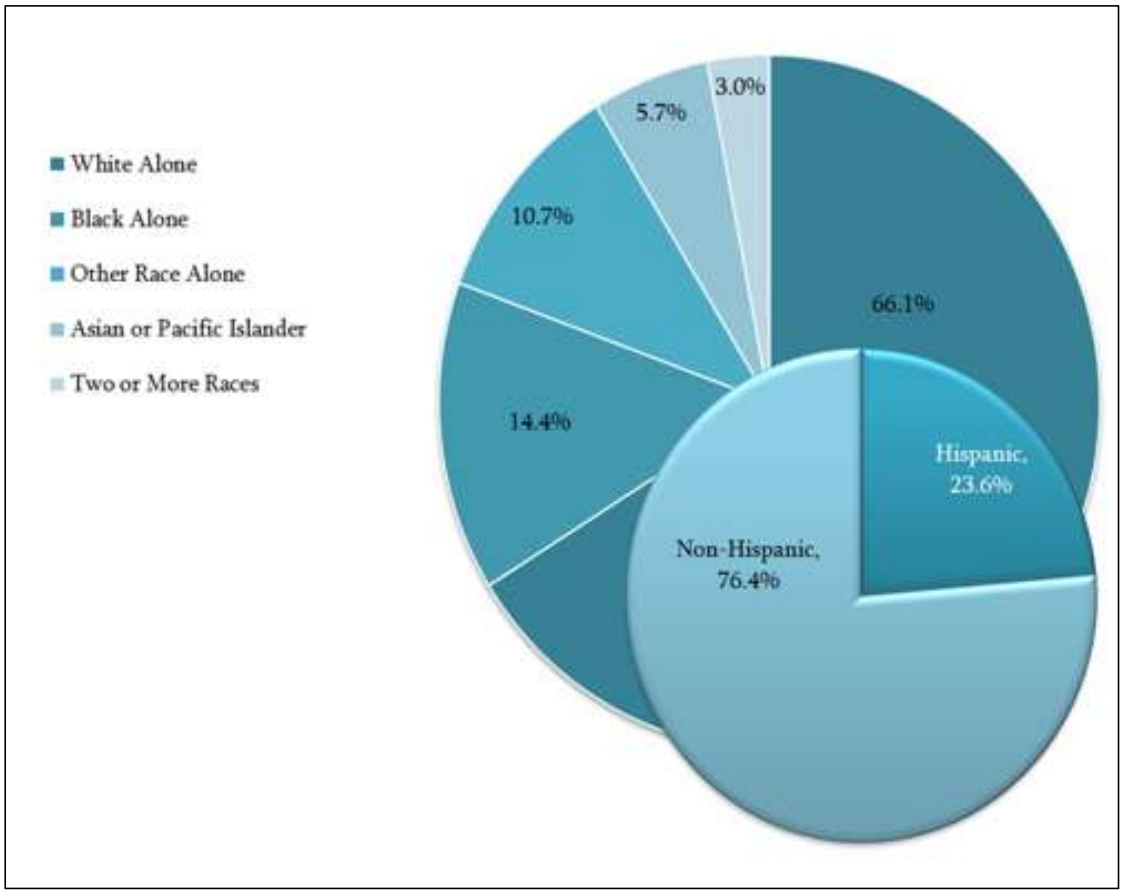
Westchester County Population
Average of 2012-2016, Race and Ethnicity



Source: U.S. Bureau of Census via the Westchester County Health Department

- Race/ethnicity composition can also help inform an understanding of the community and health service needs as well as potential cultural norms to consider in outreach and care delivery.
- White Alone is the most numerous race group at 66.1%.
- Hispanics comprise 23.6% of the population and are the largest minority group, followed by Black Alone, 14.4%.

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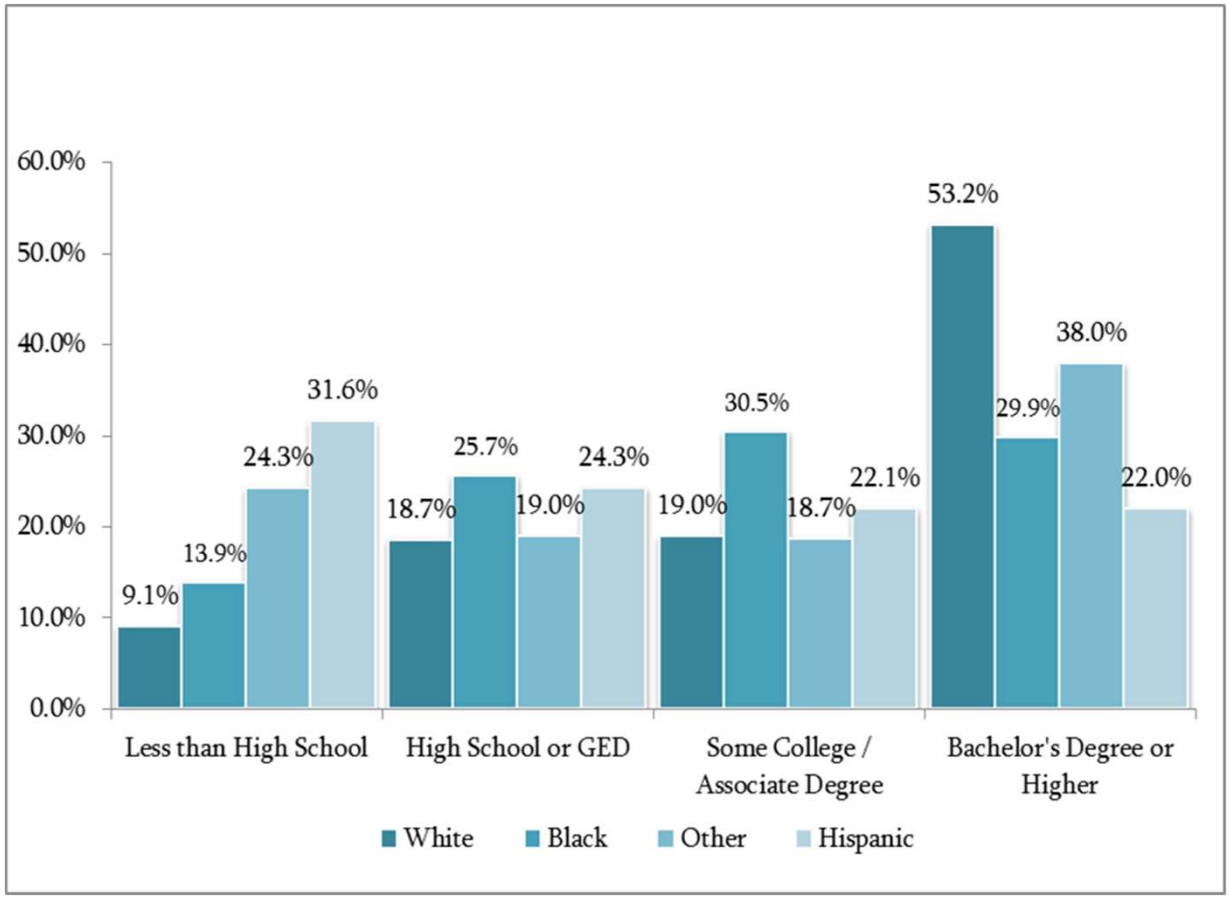
Westchester County Population
Average of 2012-2016, Race and Education



Source: U.S. Bureau of Census via the Westchester County Health Department

- While not a conclusive determinant alone, level of educational attainment is another predictor of health outcome to consider when identifying potential risks.
- A strong percentage of the population has attained a High School diploma or equivalent or a College degree.
- There is variability by race and ethnicity with the White population more frequently attaining a Bachelor's Degree.
- Hispanic persons have the highest percentage of not attaining a High School diploma.

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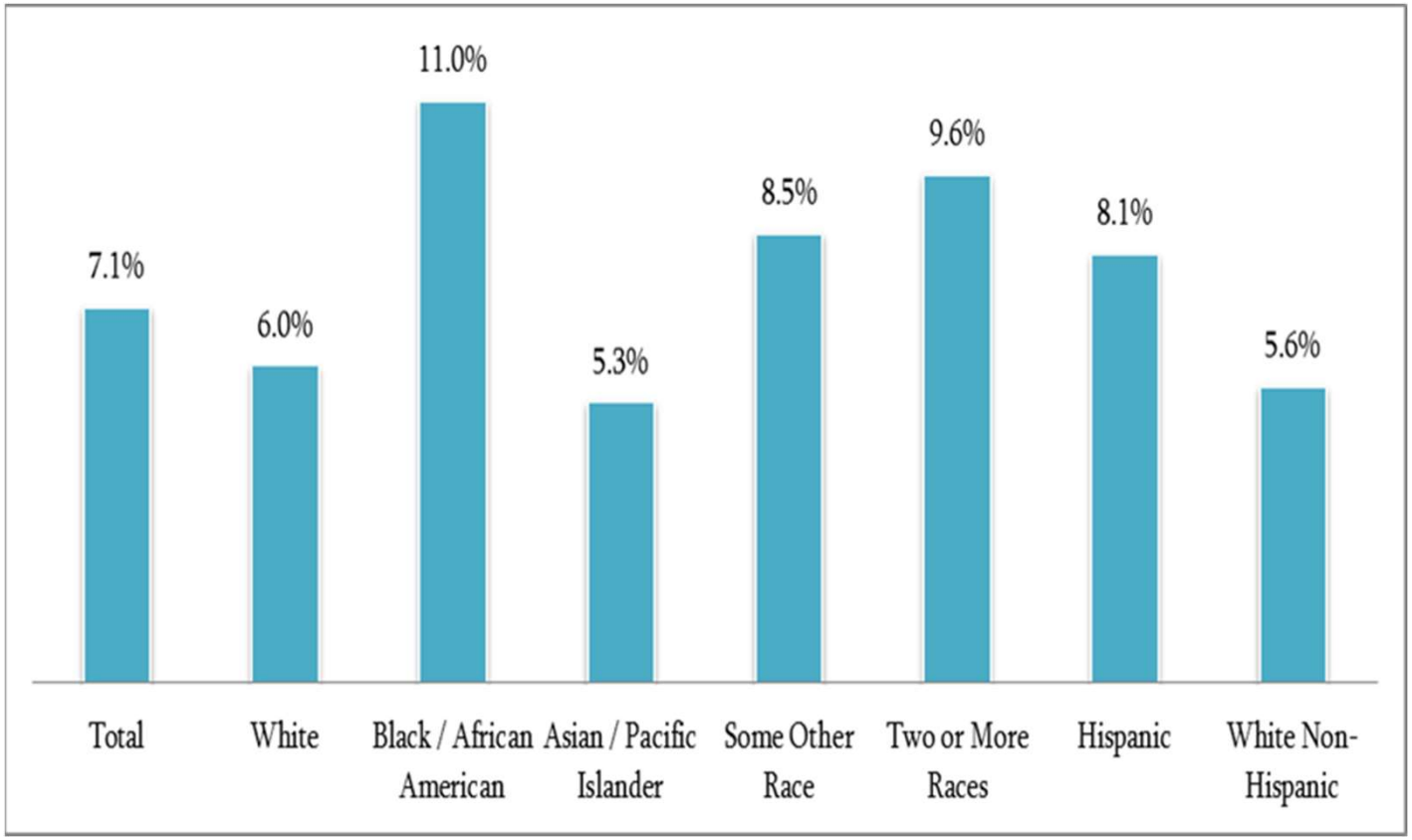
Westchester County Population
Average of 2012-2016, Race and Unemployment



- Another predictor of health outcome to consider is unemployment.
- The unemployment rate in Westchester among all populations appears higher than the NYS percentage of labor force unemployed at 4.7%.
- This varies by race and ethnicity, with Blacks having the highest unemployment rate at 11%.

Source: U.S. Bureau of Census via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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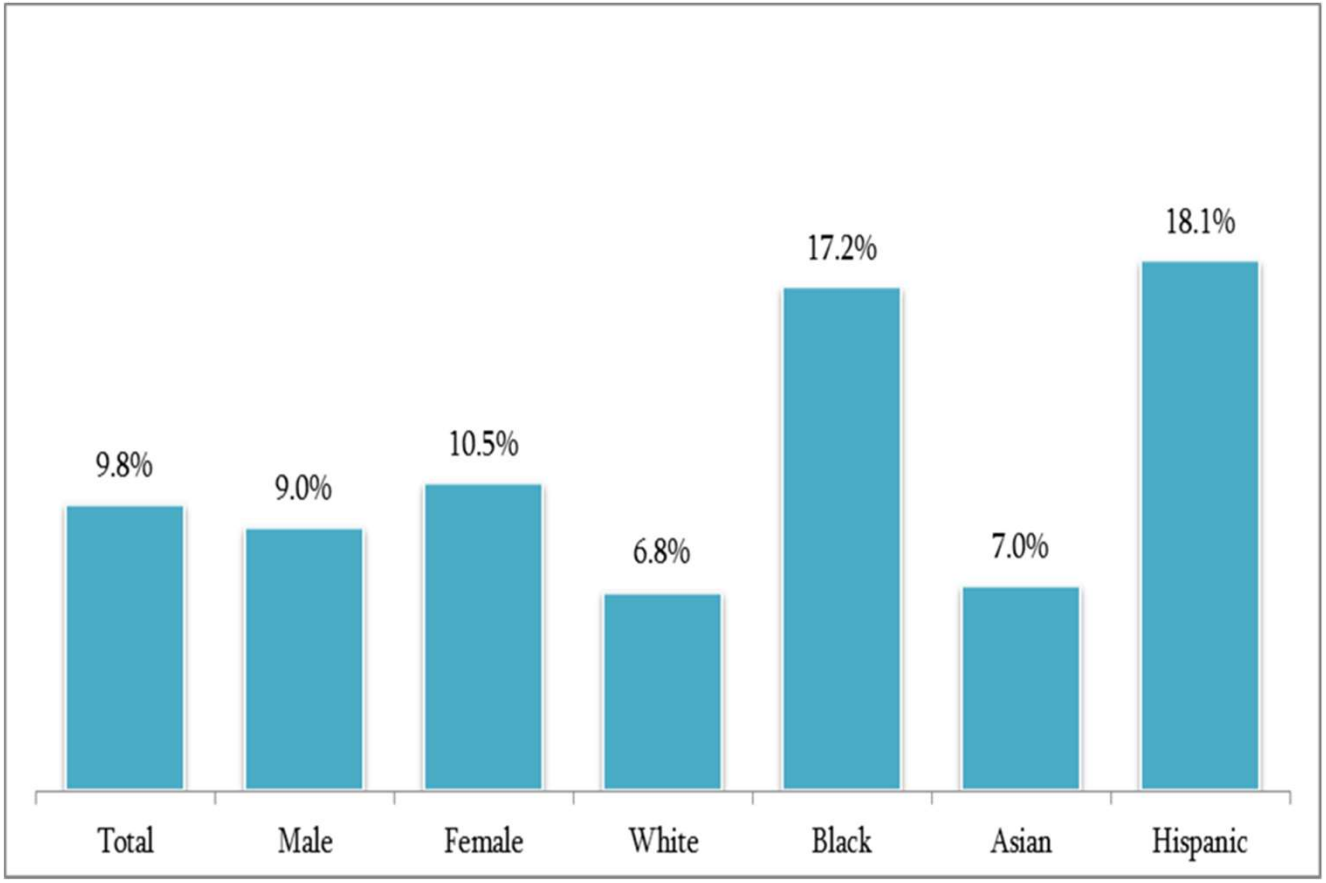
Westchester County Population
Average of 2012-2016, Race and Poverty



- Economic factors and insurance are large predictors of health outcomes and strongly influence health behavior.
- In Westchester County, 18% of Hispanic and 17% of Black populations are living in poverty.
- The NYS percentage of the population in poverty is 14.8%.

Source: U.S. Bureau of Census via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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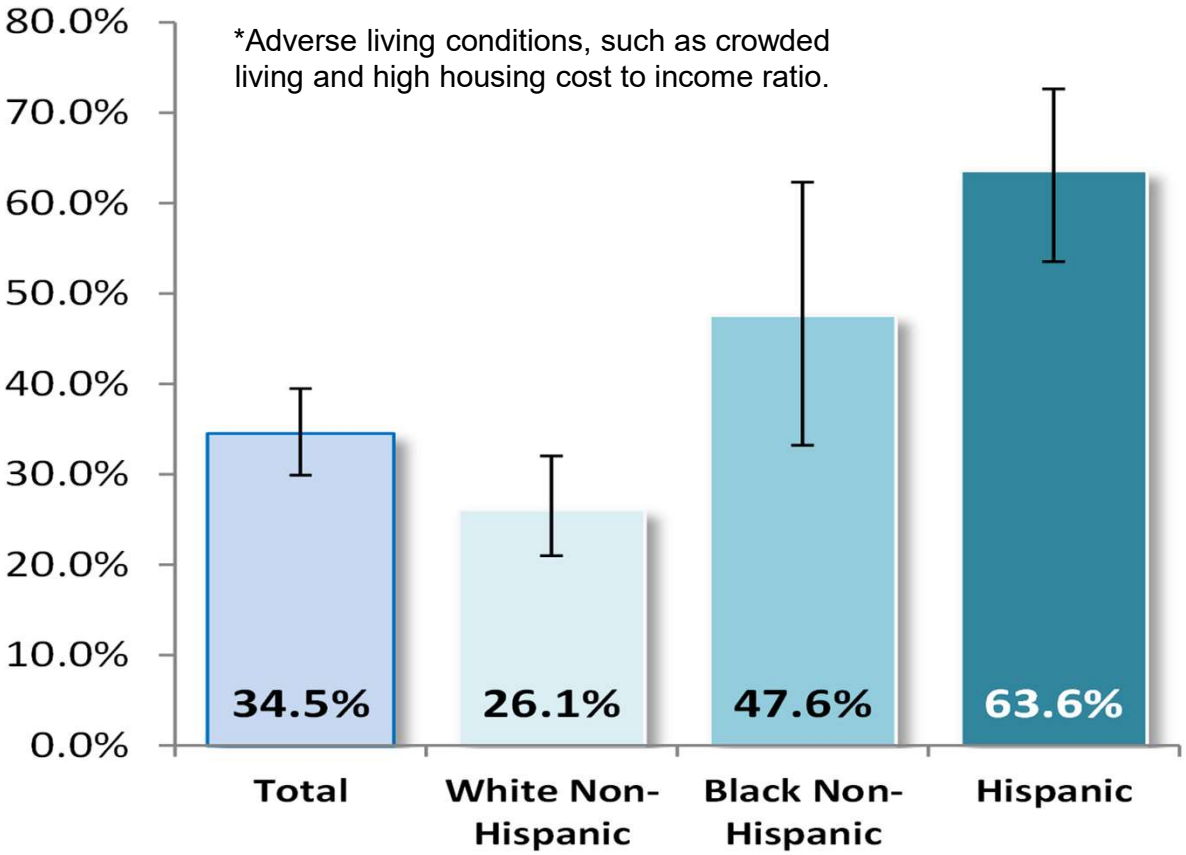
Westchester County Population
2013-2014 Race and Housing Insecurity* in the Past 12 Months



- Hispanic populations have the highest percentage of adults experiencing housing insecurity at 63.%.
- This is more than double the percentage of White Non-Hispanic populations, 26.1% and higher than Black Non-Hispanic populations, 47.6%.

Source: Westchester County Health Department

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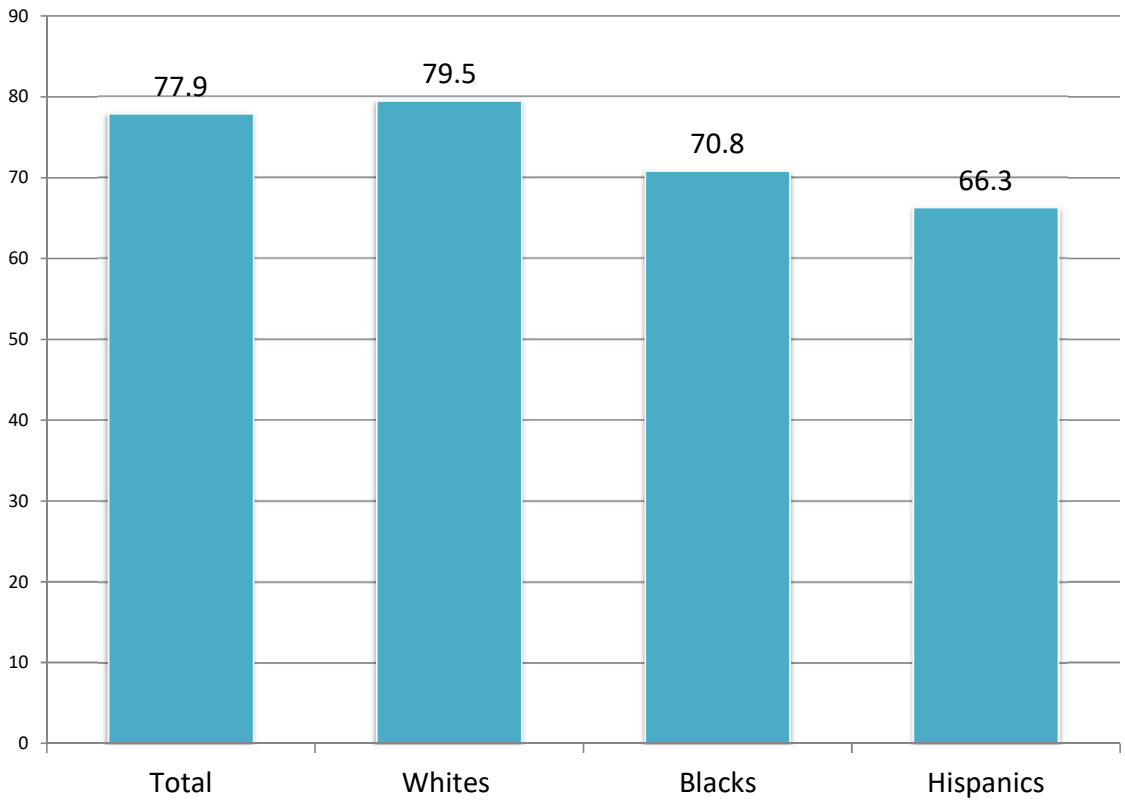
Westchester County Population
2015 Race and Average Age at Death



- Mortality rates by race and average age of death allows for the ability to identify disparities among races which can then be traced to issues related to access, socio-economic factors, insurance coverage, etc.
- The average age of death is lowest for minorities at 66.3 for Hispanics and 70.8 for Blacks.
- Whites live 8 to 13 years longer than Hispanics or Blacks, respectively.

Source: NYS Vital Statistics via the Westchester County Health Department

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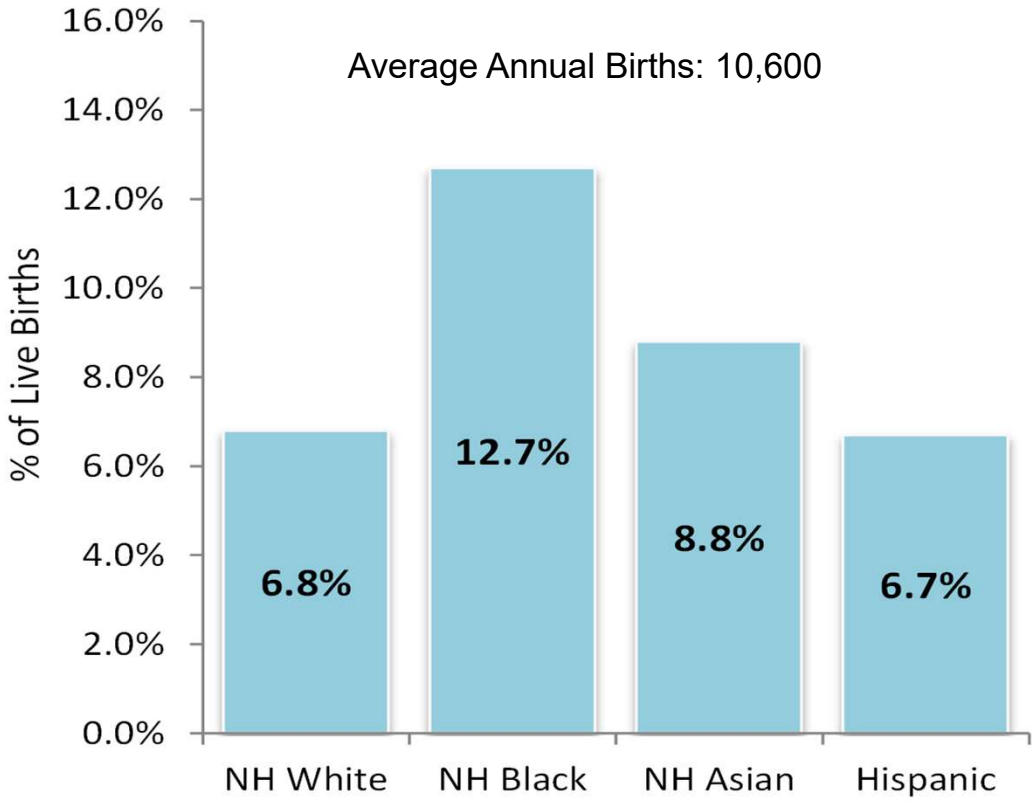
Westchester County Population
2015 Race and Top Causes of Death

	Total		White		Black		Hispanic	
	N	%	N	%	N	%	N	%
Total	6,689	100	5,556	100	832	100	401	100
Diseases of the circulatory system	2,451	36.64	2,074	37.33	272	32.69	124	30.92
Neoplasms	1,803	26.95	1,502	27.03	216	25.96	106	26.43
Diseases of the respiratory system Influenza	613	9.16	533	9.59	62	7.45	19	4.74
External causes of morbidity and mortality Accidents	290	4.34	232	4.18	40	4.81	39	9.73
Diseases of the nervous system	265	3.96	229	4.12	29	3.49	13	3.24
Certain infectious and parasitic diseases	247	3.69	180	3.24	55	6.61	18	4.49

Source: NYS Vital Statistics via the Westchester County Health Department

- The top causes of death, for County residents, are consistently diseases of the circulatory system (e.g. heart failure, hypertension, stroke, etc.).
- The number two cause of death is neoplasms (an abnormal mass of tissue that can be benign (not cancer) or malignant (cancer)).

Westchester County Population
2011-2013 Race and Births with Low Birthweight



- The health status of infancy can impact long term health.
- Low birthweight among infants is highest for Non-Hispanic Black women at12.7% and Non-Hispanic Asian women at 8.8%.
- Hispanic women have the lowest rates of low birthweight, 6.7%, followed by Non-Hispanic White, 6.8%.
- The NYS percentage of low birthweight is 7.9%

Source: NYS Vital Statistics via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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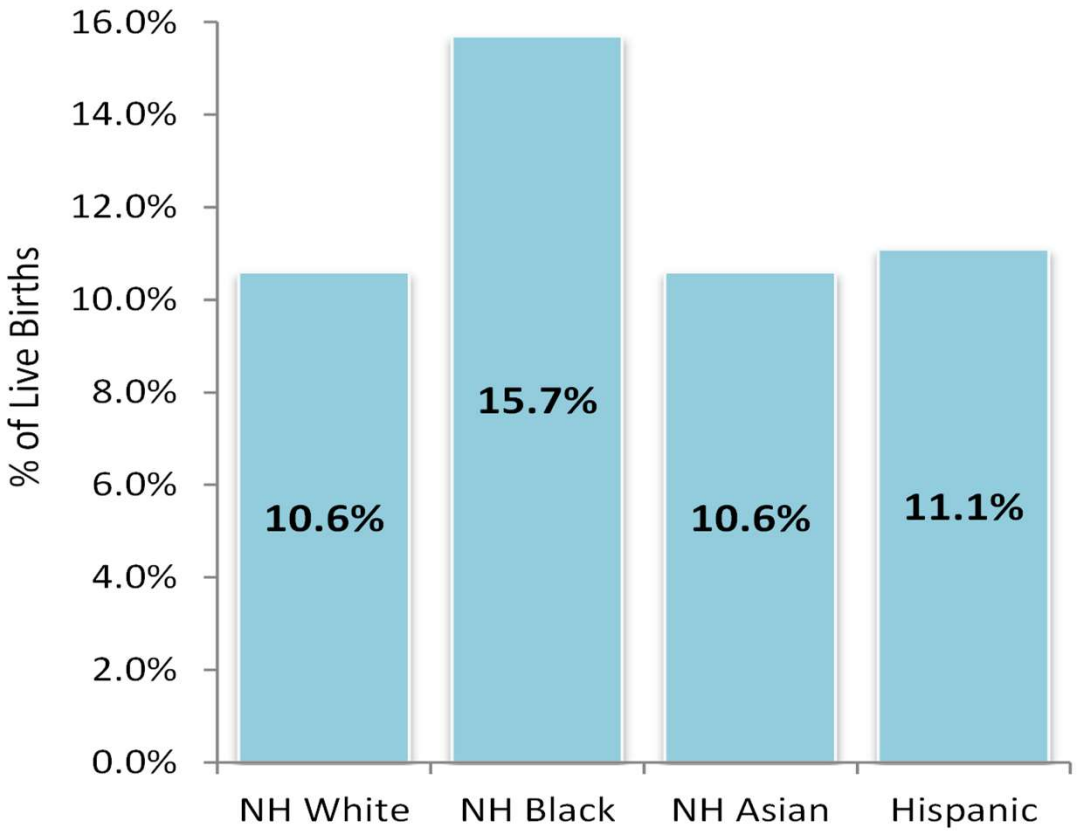
Westchester County Population
2011-2013 Race and Premature Births



- Premature births again is highest for Non-Hispanic Black women, 15.7%.
- Notably, all populations in the County are higher than the NYS percentage of premature births with <37 weeks gestation at 8.8%.

Source: NYS Vital Statistics via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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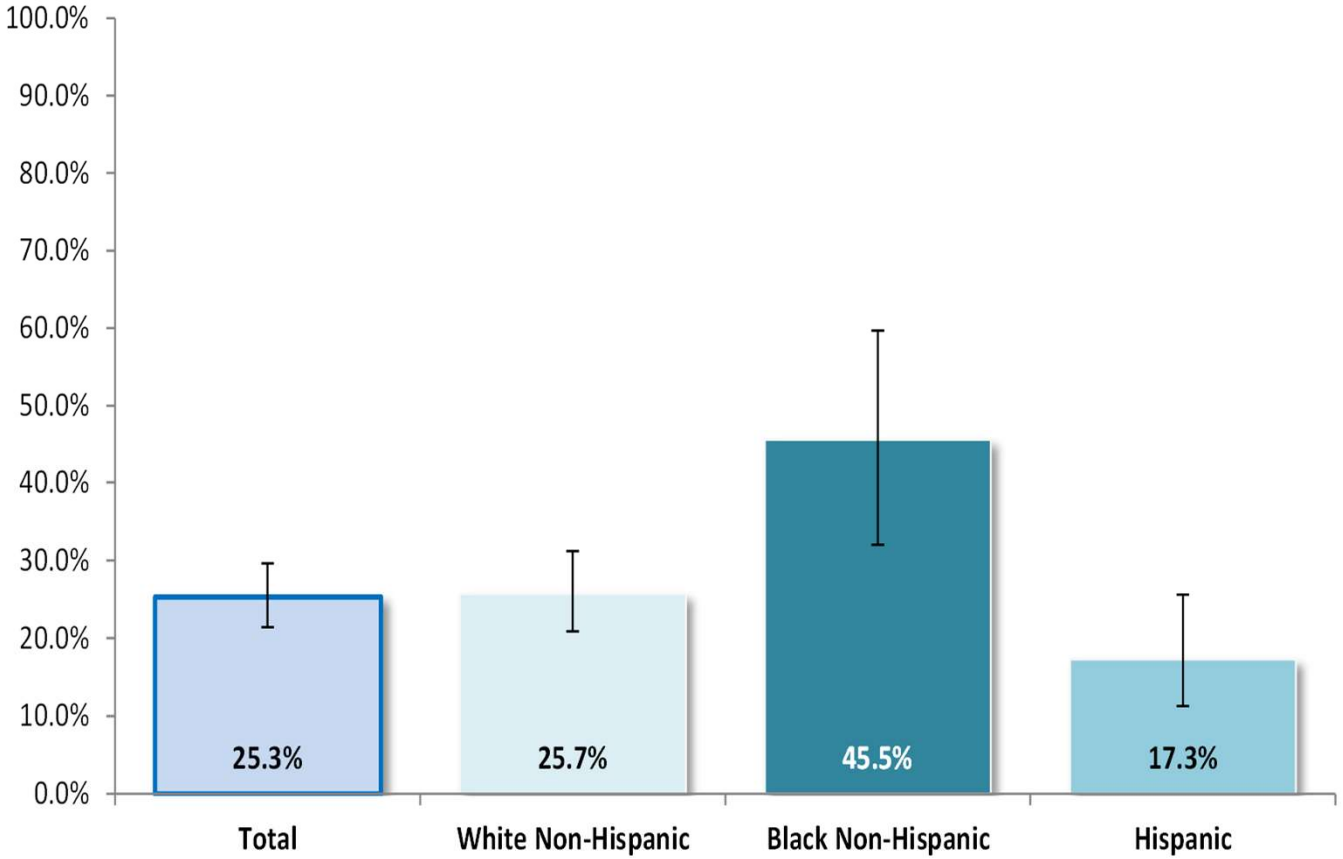
Westchester County Population
2013-2014 Race and Physician-Diagnosed High Blood Pressure



- Non-Hispanic Black populations have the highest rate of physician diagnosed high blood pressure, 45.5%.
- The NYS age-adjusted percentage of adults with physician diagnosed high blood pressure is 28.9%.
- The rates for White Non-Hispanics, 25.7%, and Hispanics,17.3%, are lower than the state average.

Source: NYS Extended BRFSS via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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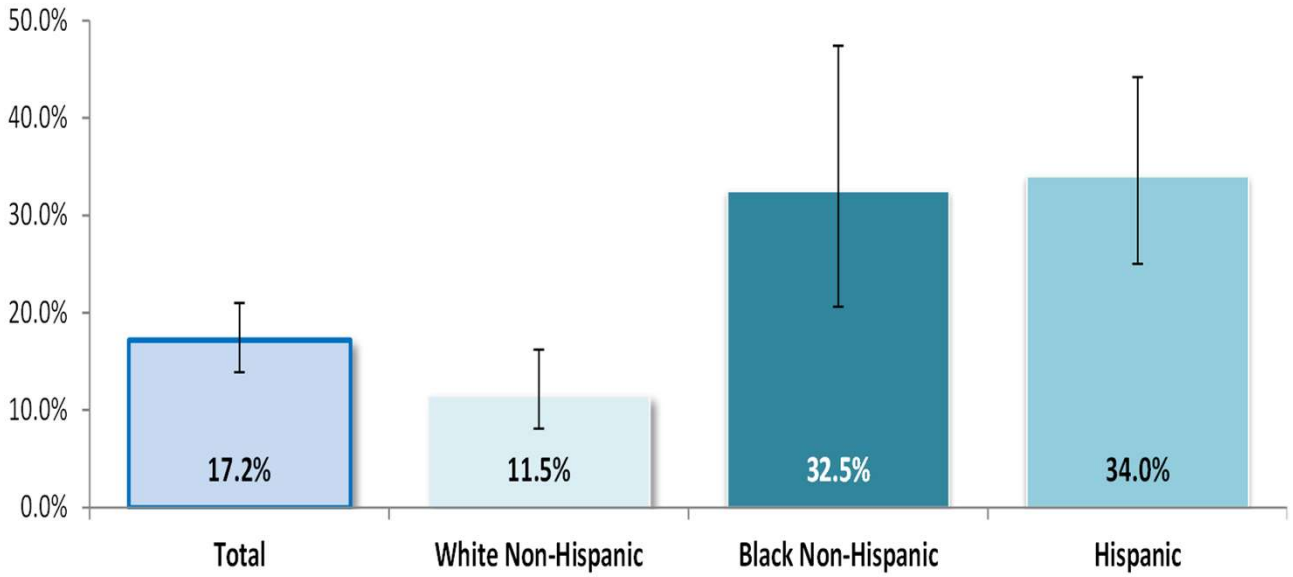
Westchester County Population
2013-2014 Race and % Adults Consuming One+ Sugary Drinks Daily



- Hispanic populations have the highest percentage of adults reported consuming one or more sugary drinks daily, 34.0%.
- Black Non-Hispanic also report a high percentage, 32.5%.

Source: NYS Extended BRFSS via the Westchester County Health Department

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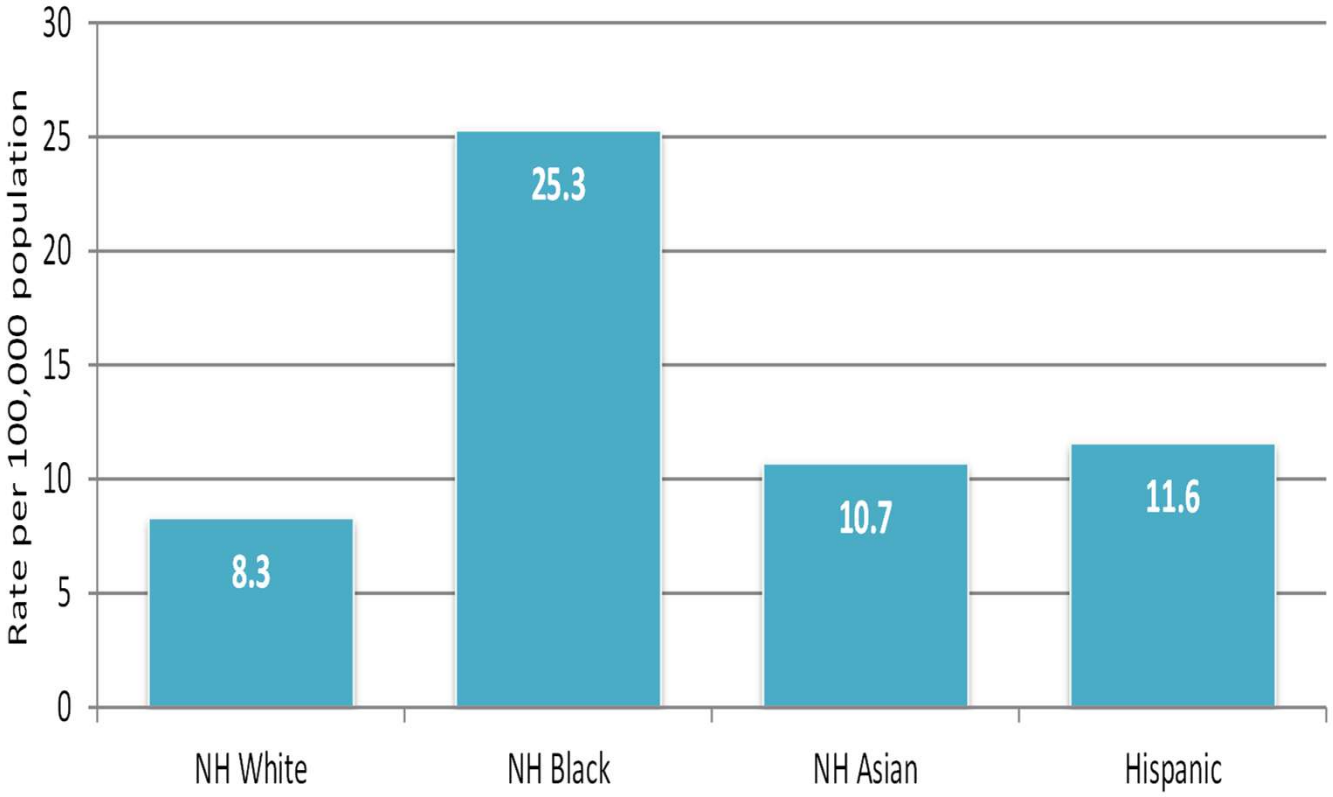
Westchester County Population
2011-2013 Race and Diabetes Mortality Rate



- The New York State age-adjusted diabetes mortality rate per 100,000 is 17.0.
- The rate among Non-Hispanic Blacks, 25.3 per 100,000, is higher than the NYS average, while the other race / ethnicities are lower.

Source: NYS Vital Statistics via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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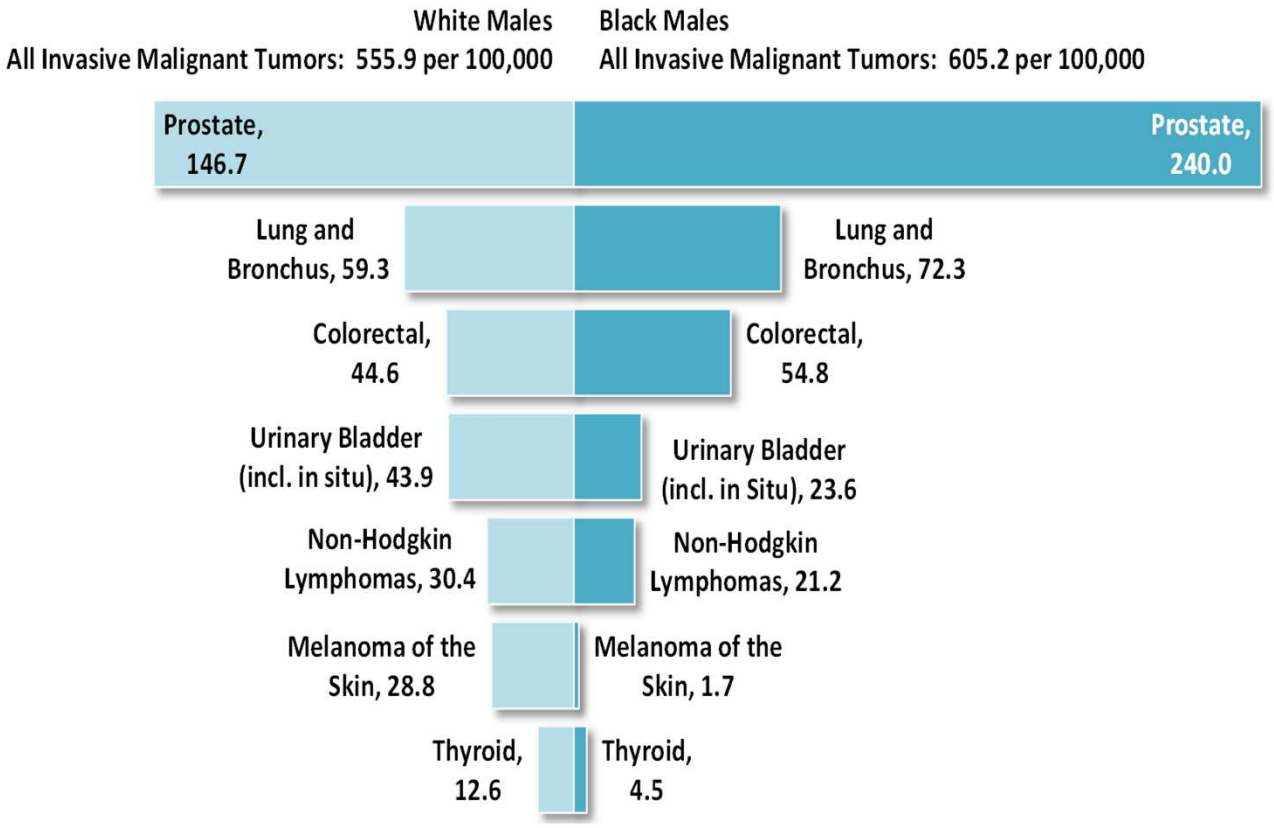
Westchester County Population
2008-2012 Race and Average Annual Incidence Rates (Males)



- The NYS total population (males and females both), all cancer incidence rate per 100,000 is 564.4.
- Black males' cancer incidence rate of 605.2 is higher than the state average, while the White males' rate of 555.9 is slightly lower than average.
- Black males have a higher incidence than White males for all malignant tumors (cancers), lung cancer, and colorectal cancer.
- White males have the higher incidence among urinary bladder, Non-Hodgkin Lymphomas, skin melanomas, and thyroid cancers.

Source: NYS Cancer Registry via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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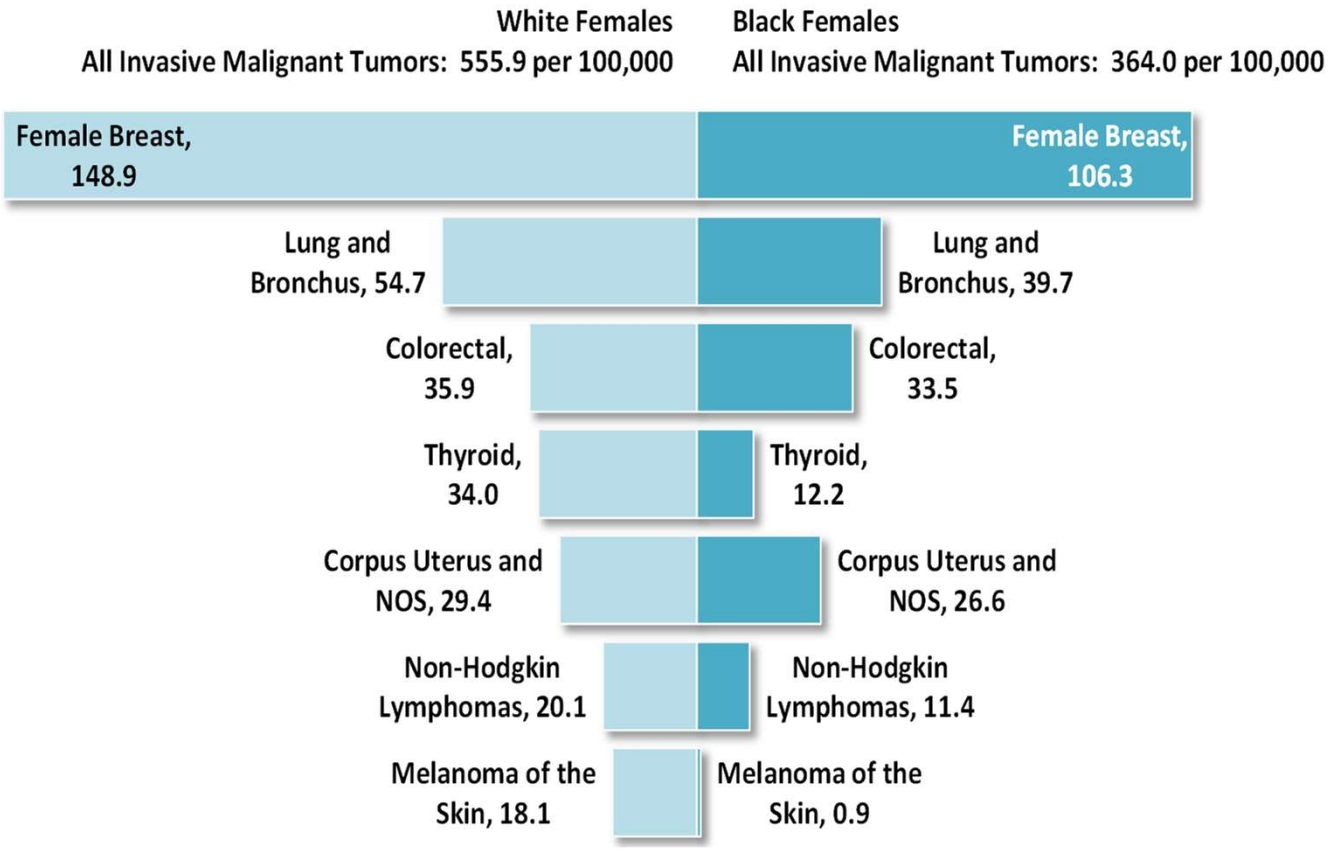
Westchester County Population
2008-2012 Race and Average Annual Incidence Rates (Females)



- The NYS total population (males and females both) all cancer incidence rate per 100,000 is 564.4.
- White females' incidence rate of 555.9 is slightly lower in comparison and Black Females is much lower than state average at 364.0.
- White females have the higher incidence among all the cancers listed here.

Source: NYS Cancer Registry via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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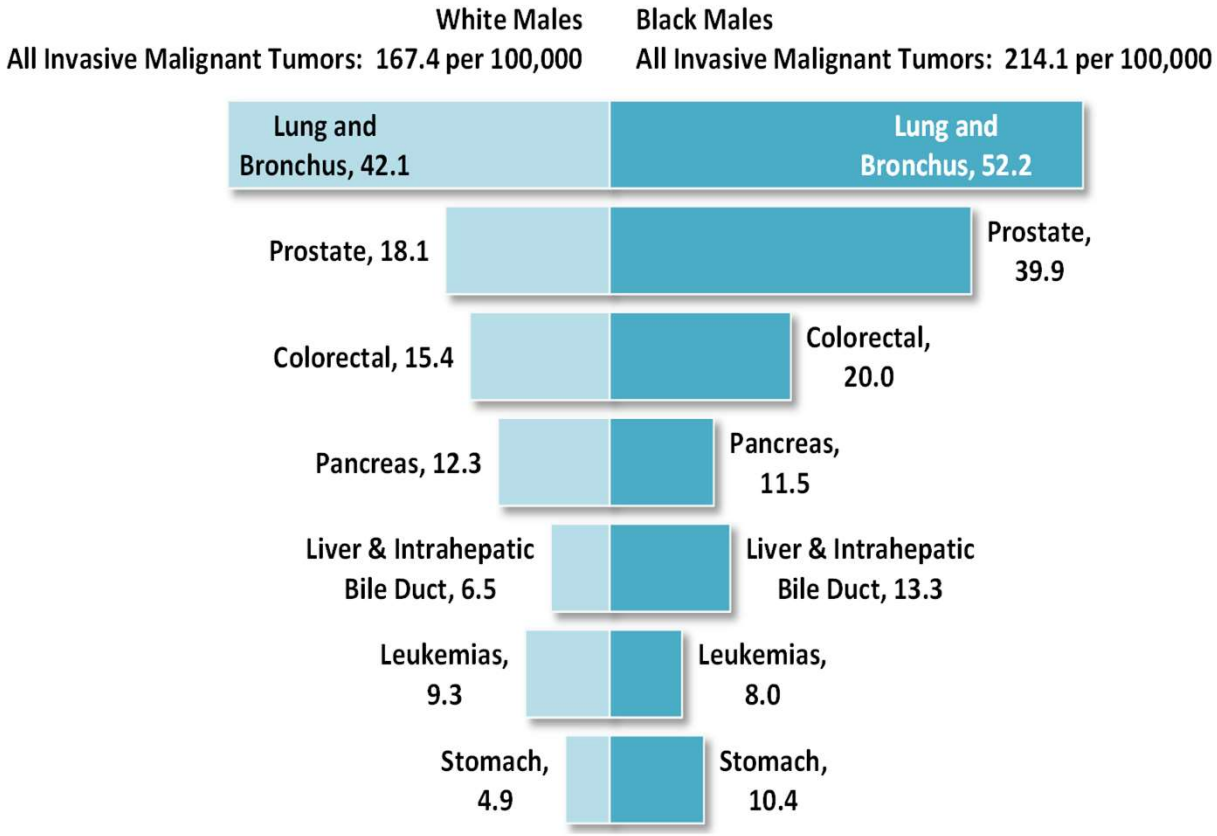
Westchester County Population
2008-2012 Race and Average Annual Mortality Rates (Males)



- The NYS total population (males and females both) all cancer mortality rate per 100,000 is 176.2.
- Black males' cancer mortality rate of 214.1 is higher than the state average, while White males' rate of 167.4 is slightly lower than average.
- Black males have a higher incidence than White males for most of these cancers, except for pancreatic cancer and leukemias.

Source: NYS Cancer Registry via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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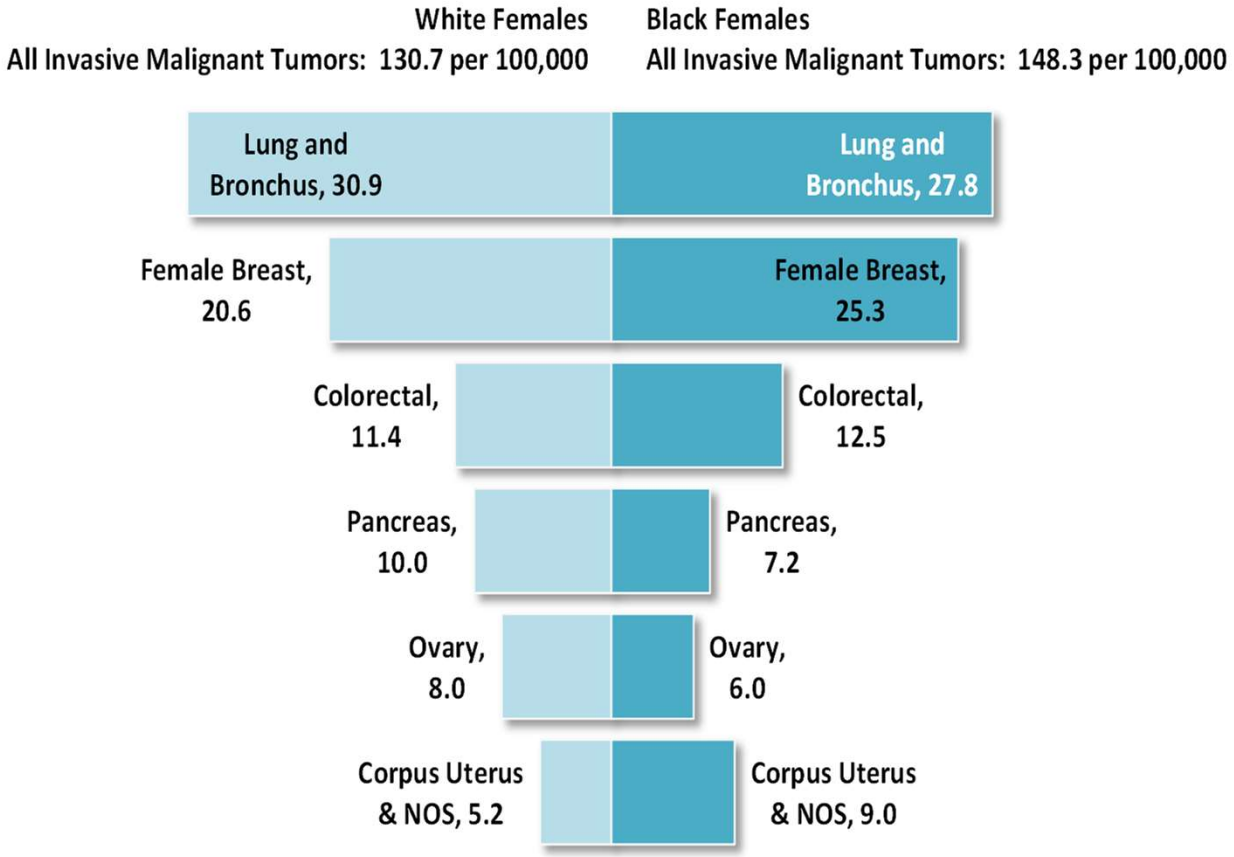
Westchester County Population
2008-2012 Race and Average Annual Mortality Rates (Females)



- The NYS total population (males and females both) all cancer mortality rate per 100,000 is 176.2.
- Black females' cancer mortality rate of 148.3 is lower than the state average, and White females' rate of 130.7 is lower still.
- White females have the higher incidence among cancers of the lung, pancreas, and ovary.
- Black females have the higher incidence among cancers of the breast, colorectal, and uterus.

Source: NYS Cancer Registry via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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Westchester County Population
2008 Race and Top Causes of Hospitalization

	Total		White		Black		Hispanic	
	N	%	N	%	N	%	N	%
Total	111,638	100.00	71,579	100.00	19,662	100.00	15,299	100.00
Circulatory System	15,570	13.95	10,877	15.20	2,550	12.97	1,179	7.71
Mental Disorders	8,881	7.96	4,626	6.46	2,461	12.52	1,136	7.43
Digestive System	8,880	7.95	6,048	8.45	1,350	6.87	1,313	8.58
Respiratory System	7,773	6.96	5,247	7.33	1,410	7.17	949	6.20
Neoplasms (including benign)	6,027	5.40	4,241	5.92	965	4.91	484	3.16
Musculoskeletal System and Connective Tissue	5,349	4.79	3,980	5.56	702	3.57	386	2.52
Injury and Poisoning	4,832	4.33	3,400	4.75	583	2.97	511	3.34
Genitourinary System	4,473	4.01	2,981	4.16	738	3.75	607	3.97

Source: NYS SPARCS via the Westchester County Health Department

- In total, county residents are more frequently hospitalized for circulatory system conditions (cardiovascular issues).
- Black populations are hospitalized most often for circulatory system conditions or mental disorders.
- Hispanic populations are also hospitalized most often for circulatory system conditions or mental disorders, but at lower percentages than Blacks.
- White populations are most frequently hospitalized for circulatory and digestive conditions.

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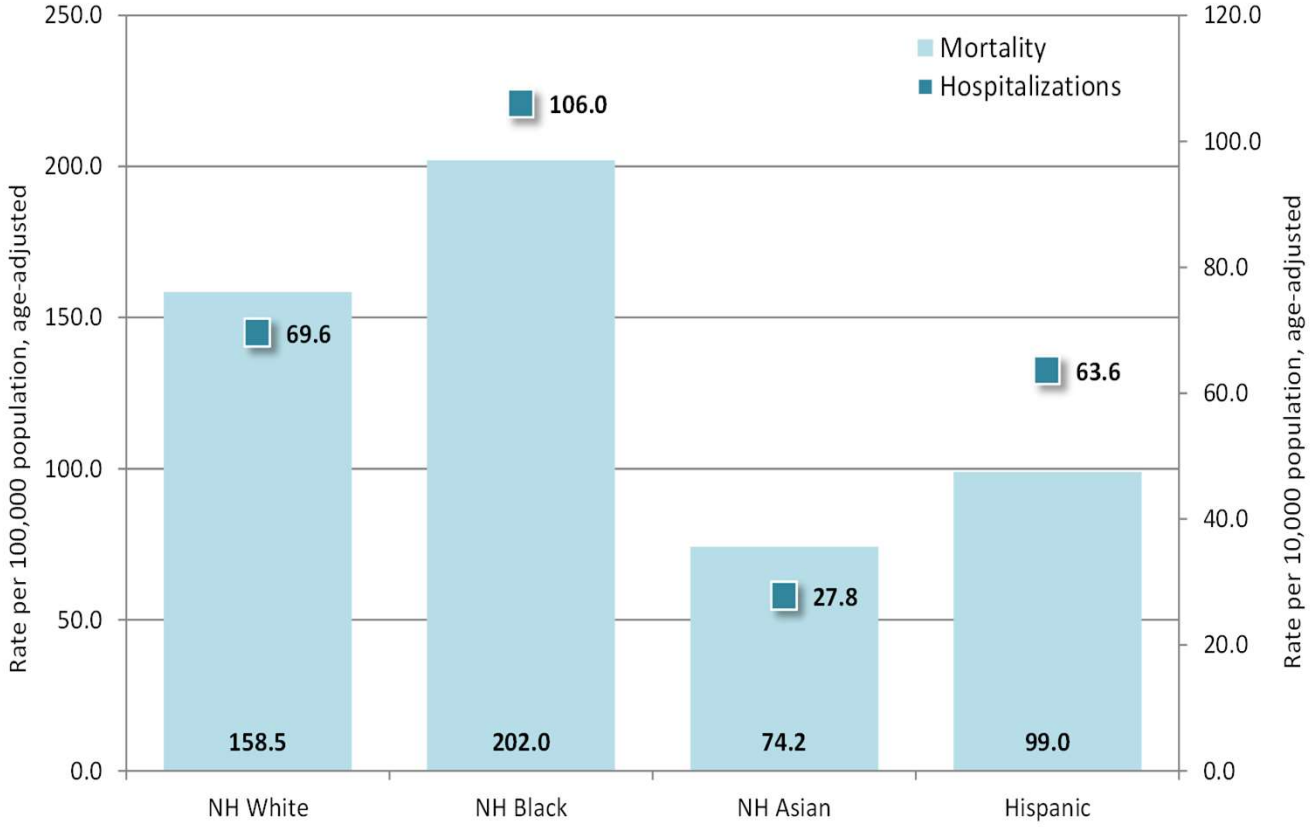
Westchester County Population
2011-2013 Race and Heart Disease Mortality and Hospitalizations



- Non-Hispanic Black populations have a significantly higher hospitalization rate of 106.0, for heart disease than other race/ ethnicities ranging from 27.8 - 69.6.
- Non-Hispanic Black populations also have higher mortality rates 202.0, for heart disease related conditions than others in the County, but these rates are lower than the NYS cardiovascular disease mortality rate per 100,000 of 272.2.

Source: NYS Vital Statistics via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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Westchester County Population
2008 Race and Top Causes of Emergency Room Visits

	Total		White		Black		Hispanic	
	N	%	N	%	N	%	N	%
Total	295,123	100.00	159,351	100.00	71,516	100.00	62,499	100.00
Injuries and poisonings	**76,071**	25.78	**45,670**	28.66	**14,980**	20.95	**14,114**	22.58
Diseases of the respiratory system	**33,486**	11.35	**15,729**	9.87	**9,820**	13.73	**8,698**	13.92
General symptoms	**27,282**	9.24	**14,726**	9.24	**6,343**	8.87	**6,689**	10.70
Diseases of the cardiovascular system	**26,910**	9.12	**16,711**	10.49	**6,095**	8.52	**3,277**	5.24
Diseases of the digestive system	**23,745**	8.05	**12,867**	8.07	**5,400**	7.55	**5,691**	9.11
Diseases of the musculoskeletal &	**19,658**	6.66	**10,147**	6.37	**5,621**	7.86	**3,686**	5.90
Mental disorders	**15,847**	5.37	**7,756**	4.87	**4,020**	5.62	**2,845**	4.55
Diseases of the urogenital system	**14,720**	4.99	**7,951**	4.99	**3,525**	4.93	**3,401**	5.44

- The top causes, among all races/ethnicities, for ER visits are injuries and poisonings followed by respiratory issues.
- White populations top ER visits are for injuries and poisonings followed by cardiovascular disease.

Source: NYS SPARCS via the Westchester County Health Department

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AMAZING THINGS ARE HAPPENING HERE

Key Health Policy Impact

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Key Health Policies Potentially Impacting the NYP-HVH Community

The health care policy environment can and does contribute to community wide health improvement or conversely to its challenges. For this study, several policies have been identified and described.

Federal Change in Public Charge Rule

Potential unfavorable impact to the willingness of residents with a green card or those who may apply for one to seek and/or access care because fear of losing citizenship status.

In August 2019, the Trump Administration announced a final rule that changes the policies used to determine whether an individual applying for admission or adjustment of status is inadmissible to the U.S. Under longstanding policy, the federal government can deny an individual entry into the U.S. or adjustment to legal permanent resident (LPR) status (i.e., a green card) if he or she is determined likely to become a public charge. Under the rule, officials will newly consider use of certain previously excluded programs, including non-emergency Medicaid for non-pregnant adults, the Supplemental Nutrition Assistance Program (SNAP), and several housing programs, in public charge determinations. The changes will create new barriers to getting a green card or immigrating to the U.S. and likely lead to decreases in participation in Medicaid and other programs among immigrant families and their primarily U.S.-born children beyond those directly affected by the new policy. Decreased participation in these programs would contribute to more uninsured individuals and negatively affect the health and financial stability of families and the growth and healthy development of their children.

Key Health Policies Potentially Impacting the NYP-HVH Community

Affordable Care Act (ACA) Challenge in Texas:

Could unfavorably impact persons, who have since 2019 been able to obtain health insurance and ACA protections.

A group of states, including Texas challenged the Affordable Care Act on the grounds that the individual mandate with no tax penalty was not a tax and therefore unconstitutional. A Federal Judge in Texas agreed with this reasoning and ruled that the individual mandate is unconstitutional without a tax penalty and that the law should be struck down.

The case is now before a Federal Appeals Court in New Orleans which could rule issue a ruling at any time. The stakes of the lawsuit are significant. If the ACA were, in fact, ruled unconstitutional, that could mean that health insurers could once again refuse coverage or otherwise discriminate against patients who have preexisting conditions. Additionally, it would mean that roughly 20 million people who obtained insurance after the ACA was implemented could lose it. The ACA also made other sweeping changes to the health care system, including: expanding Medicaid eligibility for low-income adults; requiring private insurance, Medicare, and Medicaid expansion coverage of preventive services with no cost sharing; phasing out the Medicare prescription drug “donut hole” coverage gap; establishing new national initiatives to promote public health, care quality, and delivery system reforms; and authorizing a variety of tax increases to finance these changes. All of these provisions could be overturned if the trial court’s decision is upheld.

Key Health Policies Potentially Impacting the NYP-HVH Community

1115 Waiver – Delivery System Reform Incentive Payment (DSRIP) Program – 2.0 Extension

The extension of the DSRIP program would allow health systems and networks to invest in transformative clinical initiatives to impact the Medicaid population. The discontinuation of this program could result in the removal of programs due to the ability to sustain projects and partnerships.

New York State announced they will seek a four-year 1115 Waiver extension to the current DSRIP initiative. If approved, the extension would further support clinical transformation efforts focused to the Medicaid populations associated to 25 Performing Provider Systems (PPS). New and ongoing funding would allow continued investments in programs focused on: improving quality outcomes, enhancing workforce development, addressing social determinants of health, and increasing community-based clinical network development. The extension would expand on existing activity and establish new programs.

Maternal Mortality Review Board

The review board would focus to improvement strategies for preventing future deaths and improving overall health outcomes targeting maternal populations with an emphasis to reduce racial disparities in health outcomes.

Governor Cuomo signed legislation to create a Maternal Mortality Review Board charged to review the cause of each maternal death in New York State. New York City will also have a maternal mortality review board to review cases within the five boroughs. The Boards will make recommendations to the New York State Department of Health for clinical improvement strategies to improve overall health and outcomes of this population. They will also look at ways to reduce racial disparities in health outcomes. The work of the board would aid DSRIP initiatives addressing access to care and coordination since Medicaid accounts for more than 50 percent of births within the state.

Key Health Policies Potentially Impacting the NYP-HVH Community

Ending the Epidemic

Initiative focused upon treatment persons with HIV with the goal of reducing HIV prevalence in NY.

New York State and New York City are working on a plan to the end the AIDS epidemic. The Ending the Epidemic (ETE) initiative seeks to maximize the availability of life-saving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. The overarching goal is to achieve the first ever decrease in HIV prevalence by the end of New York State by the end of 2020. Primary objectives are to: identify persons with HIV who remain undiagnosed and link them to health care services, and retain them in the care system to prevent further transmission and improve their health.

In New York City, the goal is to reduce the number of new infections in the City to fewer than 600 by 2020. This target aligns with the State's goal of reducing new statewide infections to fewer than 750 by 2020. In New York City, the four primary objectives are to: increase access to HIV prevention services; promote innovative, optimal treatment for HIV; enhance methods for tracing HIV transmission; and improve sexual health equity for all New Yorkers

Marijuana Decriminalization

The decriminalization of small amounts of marijuana, 25 grams or less, and automatic expungement of previous convictions could encourage the use of substances which could lead to other substance abuse disorders in high disparity communities.

Legislation was passed in June of 2019 to decriminalize the use of marijuana by expunging many past marijuana possession convictions and reducing the penalty for the possession of small amounts of the drug. The bill does not fully legalize the use of marijuana.

Key Health Policies Potentially Impacting the NYP-HVH Community

Elimination of religious exemptions to vaccinations for school aged children:

While this issue continues to be debated publicly, this is elimination of religion exemption is intended to increase the number of vaccinations among schoolchildren decreasing unnecessary outbreaks and potential severe illnesses and deaths.

Amid an ongoing measles outbreak, New York State enacted a new law in June to eliminate nonmedical exemptions from school vaccination requirements. The law took effect immediately. While this issue continues to be challenged in the courts, it would favorably increase the number of vaccinations among schoolchildren decreasing unnecessary outbreaks and potential severe illnesses and deaths.

New York State Ban on Flavored E-cigarettes

Emergency ban is focused upon reducing the use of vaping products by New York youth.

In September, New York State enacted an emergency ban on the sale of flavored electronic cigarettes and nicotine e-liquids. The ban is part of a growing response to combat the increase in young people using vape products, given the appeal of flavors to the youth market. There are some who have concerns that the ban will keep people smoking regular cigarettes who may have considered switching and lead to a “black market” for vaping products with untested or unknown ingredients.

Key Health Policies Potentially Impacting the NYP-HVH Community

NY State Opioid Tax

To begin to fight the opioid epidemic, the state of NY placed an excise tax on opioids sold to or within the state in order to help victims of the opioid crisis.

The tax, which went into effect July 1, 2019, is anticipated to generate $100 million in revenue for the state to allow administration to address the opioid crisis within the state of NY. The tax is based on the amount of opioid in each unit sold as well as wholesale acquisition cost and applies to whatever entity makes the first sale. The impact will be seen by manufacturers and wholesale organizations since initiation as numerous pharmaceutical manufacturers have discontinued shipments to the state.

AMAZING THINGS ARE HAPPENING HERE

Community Input

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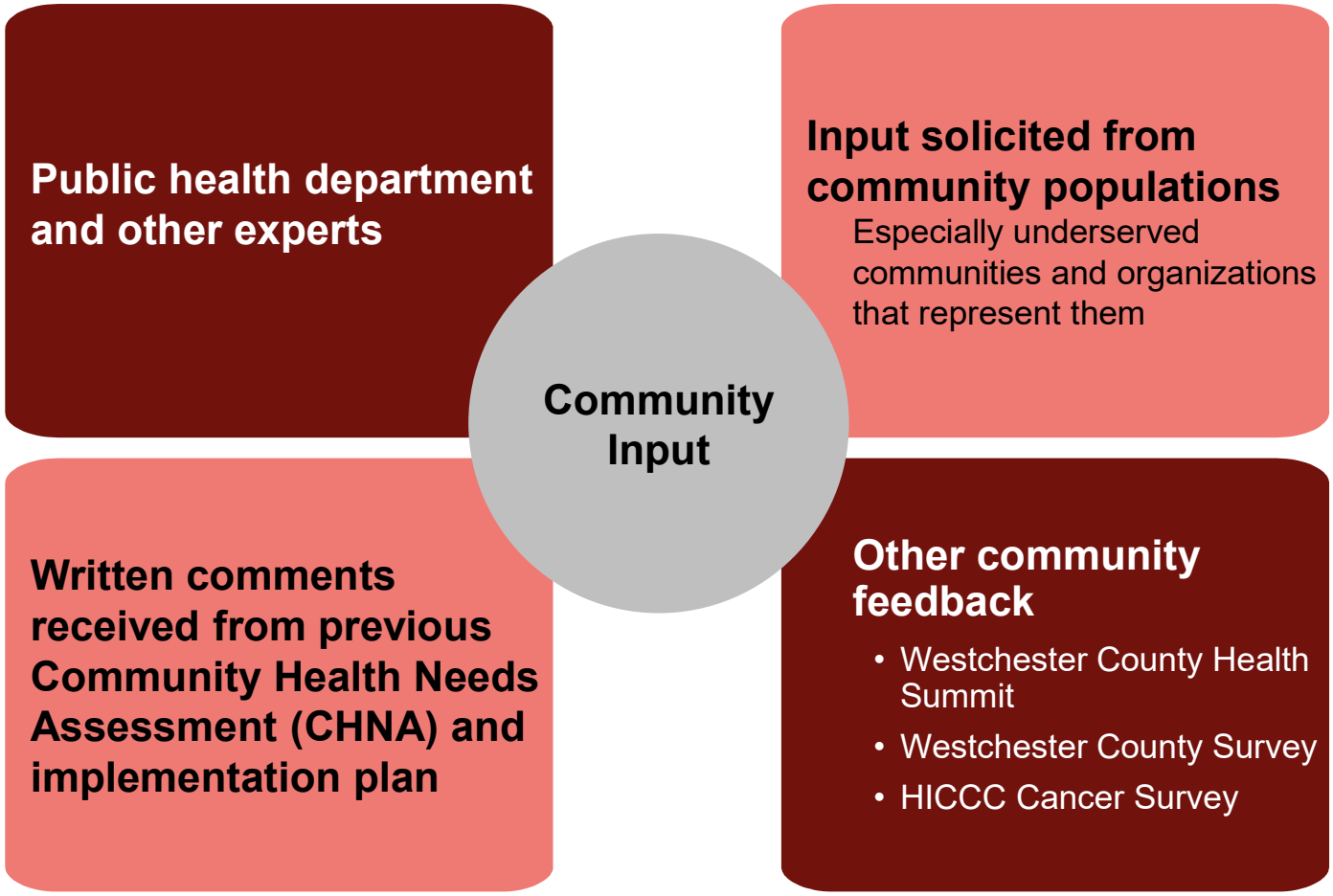
Overview of Community Input



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Public Health Department and Other Experts

In conducting the 2019 CHNA, NYP and NYP-HVH collaborated with the Westchester County Department of Health (WCDOH), Columbia University Mailman School of Public Health (CUMSPH), and Greater New York Hospital Association (GNYHA).

A notable partnership has been the Westchester County Health Planning Coalition (WCHPC), inclusive of the WCDOH and the sixteen local Westchester County Hospitals formed in response to the New York State Department of Health's appeal that each county's local health department, hospitals/hospital systems and other community partners collectively work together to identify and address local health priorities associated with the New York State Prevention Agenda (NYSPA).This group's ultimate goal is to advance the health and wellness of Westchester County residents in a collaborative manner.

Through these collaborations we were able to adopt a community-engaged approach that involved collecting and analyzing quantitative and qualitative data from a variety of publicly available sources to comprehensively assess the health status of our communities. Each stakeholder added to our ongoing work by providing insight on the publicly available data for the various regions specific to the NYP-HVH High Disparity Communities, while providing guidance on collecting stakeholder and community feedback and incorporating best practices for our CHNA.

Community Populations – Community Health Needs Questionnaire Method

The Center for Evaluation and Applied Research (CEAR) at the New York Academy of Medicine (NYAM) administered the Community Health Needs Questionnaire (CHNQ), which was developed in collaboration with the NewYork-Presbyterian CHNA Steering and Methods Committees of which the Citizens' Committee for Children in New York (CCC) was a member.

The CHNQ focused on basic demographics, health concerns (individual and community-wide), health care utilization, barriers to care, and use of NYP-HVH services. NYAM began collecting this data in June 2019, in partnership with numerous community organizations, which were identified in collaboration with NYP and represent a range of populations, e.g., older adults, immigrant and, homeless populations.

Respondents included community advisory board members and community residents, some of which were recruited using online platforms such as Craigslist.

CHNQs were self-administered or administered by NYAM staff or staff and volunteers at community organizations, who are trained and supported in questionnaire administration by NYAM staff.

The resident CHNQs were completed by NYP-HVH community residents, ages 18 and older.

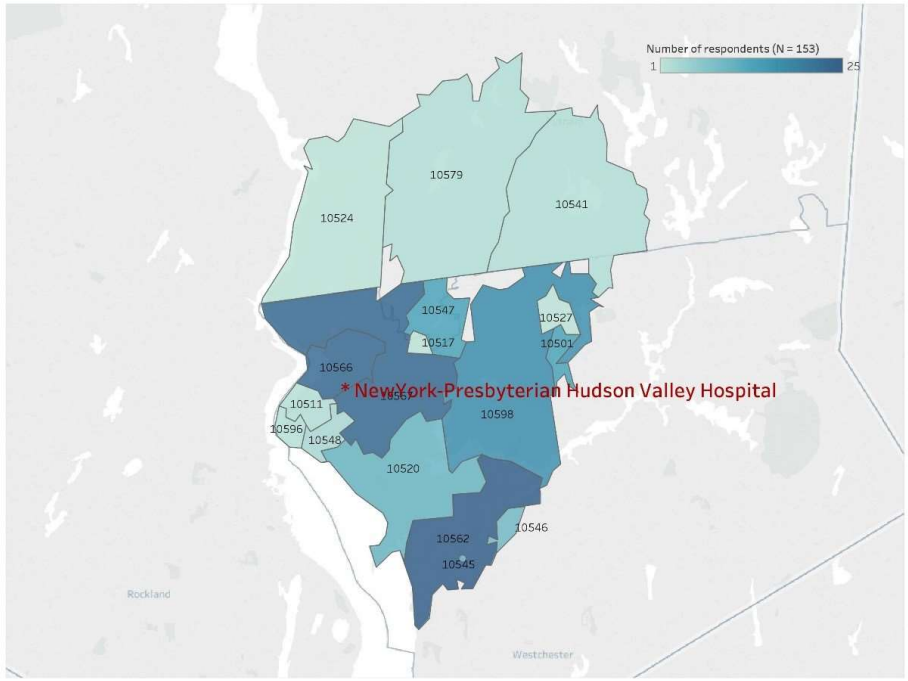
The CHNQ was translated and administered in Spanish, English, Korean, Chinese, Russian, and Haitian Creole.

Participants received a gift card valued at $10 for completing the CHNQ.

Community Populations – Community Health Needs Questionnaire Results

- 153 questionnaires were completed
  - 52.3% In person
  - 47.7% Online

Hudson Valley Community Health Needs Assessment defined region - questionnaire respondents



Most commonly reported community health issues *		N=208
Community health issue	**n**	**%**
Alcohol & drug use	90	58.8%
Tobacco use	61	39.9%
Mental health	56	36.6%
Cancer	55	35.9%
Diabetes	51	33.3%
High blood pressure	51	33.3%
Obesity	46	30.1%

* Multiple responses permitted.
Note: Responses selected fewer than 30% of the time are not presented.

Recommendations to improve community health*		N=208
Community health recommendations	**n**	**%**
Less cigarette/vaping	78	51.0%
More places for older adults to live and socialize	69	45.1%
More local jobs	53	34.6%
Less air pollution	49	32.0%
More parks and recreation centers	48	31.4%
Improved housing conditions	45	29.4%
Increased public transportation	45	29.4%
Cleaner streets	41	26.8%
Improved water quality	40	26.1%
Reduced crime	39	25.5%

*Multiple responses permitted
Note: Responses selected fewer than 24% of the time are not presented

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Community Populations – Focus Group Method

The Center for Evaluation and Applied Research (CEAR) at the New York Academy of Medicine (NYAM) developed a semi-structured focus group guide in collaboration with the NewYork-Presbyterian CHNA Steering and Methods Committees and with input from the Citizens' Committee for Children in New York (CCC) who has extensive experience related to qualitative research methods.

Facilitation of the CHNA focus groups were conducted by NYAM staff or by community based organization hosts. All were experienced in focus group facilitation and trained by NYAM on the CHNA protocol. All groups also had a trained co-facilitator, responsible for logistics and note taking.

Focus groups were recruited by community based organizations identified by the NewYork-Presbyterian CHNA Steering and Methods Committees and that agreed to host these sessions.

Each focus group was approximately ninety minutes in length. Participants completed either the full Community Health Needs Questionnaire (CHNQ) or an abridged version, focused on demographics, health status, and other individual characteristics.

Participants were informed of the voluntary nature of participation (overall and for specific questions) and that results would be reported without names or identifying characteristics. Guidelines for discussion were also presented at the start of the groups, which included, for example, the importance of hearing from all participants and the facilitator role in guiding the discussion.

All groups were audio recorded and professionally transcribed; non-English focus groups were professionally translated.

Community Populations – Focus Group Results

Greatest Health Concerns	"I feel like everybody I know right now keeps getting diagnosed with cancer. I couldn't tell you what the link is, but in this area – I mean, all over."
	"[Organic food] is so much more expensive, and just to feed a family of five, you just gotta shop your best."
	"Because there's an environmental disease to it underground, people don't talk about it. People don't talk about chemicals in the ground and the [Indian Point] nuclear plant, the stuff that big businesses are doing that are wrong. They just blame it on our social – diabetes, drugs, and keep your focus off the big issues because we've got the poor. "
Mental Health, Behavioral Health, & Drug Use	"If you go into the doctor and say I have a pain, I'm finding that the seniors are just given straightaway an opioid, oxycodone, or whatever it may be."
	"The school system is having a lot of problems with bullying, so it's like, probably people's mental health is being affected, because they have to worry about their kids going to school. Like me, I'm worried about my daughter going to kindergarten this year, and with all the bullying problems... And I think there should be programs where they teach kids, "Hey, this is not okay. This is how you stick up for people."
Social Determinants of Health	"I'm unemployed, and I've been here for two months. I find random day jobs here and there, but I'm used to working 60-hour weeks. And I'm not saying it's my fault or the town's fault. It's just there's no work here. That just is what it is. Without a car, I can only travel so far. I hop on the Metro-North in order to do my work in Beacon, but it's just – it's tough to find work out here."
	"People that live below the poverty level have greater health issues, have greater mental issues than people above, because people above get the proper treatment and care."

Community Populations – Focus Group Results

Housing	"I think one of the issues is that in the Yorktown area, in the five hamlets, there's not enough affordable – and I don't mean affordable by low-income or anything by that means. That, as well, but what I'm talking about is just a place where, if you're retiring, and you don't have children any more, and you don't need a big house, and you're looking at downsizing."
	"Especially in Westchester County, coupled with the transportation; if you do find something, it's far. It's not accessible. It's small in space. That causes depression. They're not building enough. They make agreements with the federal government, and then when it falls back to the county to fill the affordable housing, they leave them in the system hanging"
Transportation	"Well, transportation really is a big issue. Like Cortlandt, there's not even sidewalks. At least Peekskill you can go on a sidewalk. Cortlandt, you're taking your life in your hands to try to walk up Croton Avenue."
	"I think a lot of these go hand-in-hand with loneliness, not being able to drive, not being able to socialize with people, because for some reason or another they are forgotten in those homes."
Food, Nutrition, and Physical Activity	"I feel like the only thing in Peekskill is pizza and Chinese food to order."
	"There's a lot of seniors that – not that they can't afford it, but they just live alone. They don't wanna cook. "
	"Like he said, in the winter, there's not enough free gyms we can go to exercise when it's freezing."

Community Populations – Focus Group Results

Healthcare Use	"One thing, I think the one thing our community is especially fortunate to have is Hudson Valley Hospital. Right there. I don't think realty agents tell people that, but if you're in Putnam County, you may have to travel a distance to get to a hospital. For us in Cortlandt and Peekskill – so, having a hospital in our backyard is a definite positive that a lot of communities – especially as you go farther north, distances increase. So, I think it's great that we have the hospital here."
	"I like doctors that don't make you feel like they've gotta get on with your appointment because somebody's waiting. Fortunately, my experience is – the doctors I go to pretty much give me the time and attention."
Health Information Sources	"I will say that I have not gone, but Phelps hospital is always sending me stuff about their classes and their group – they even have some group – mental health groups that you can just walk into. And I know that Presbyterian does it, but I would like to see – hear more about it, through their magazine or whatever their literature is."
Perspectives on Telehealth	"I would rather go in, because I'm like, I have to ask a million questions when I go to the doctor. So, if I'm at home, I'm gonna be distracted, and then I'm probably not gonna think about it."
	"I think that medicine has to get more personal again. And I don't see how that – I know it's convenient, my kids use it with my grandson. You know, they'll call – I don't even know what it is. Dial-A-Doc, I have no idea, but I think that you need that physical contact."
	"I think right now, all of us have a smart phone or close to a smart phone. So, the ability to do it, I don't think, is limiting as much anymore. Everyone Facetimes, our children. "

Community Populations – Focus Group Results

Social and Supportive Services

"[This organization] is about the only place where you can stop and go and get somebody that cares for you about medical, about food, food stamps, the social worker."

"I like doctors that don't make you feel like they've gotta get on with your appointment because somebody's waiting. Fortunately, my experience is – the doctors I go to pretty much give me the time and attention."

Participant Recommendations

"Could they partner with the school districts and do something? To make them aware, teach them young that these services are available. Set up a little booth outside of the cafeteria and serve good foods."

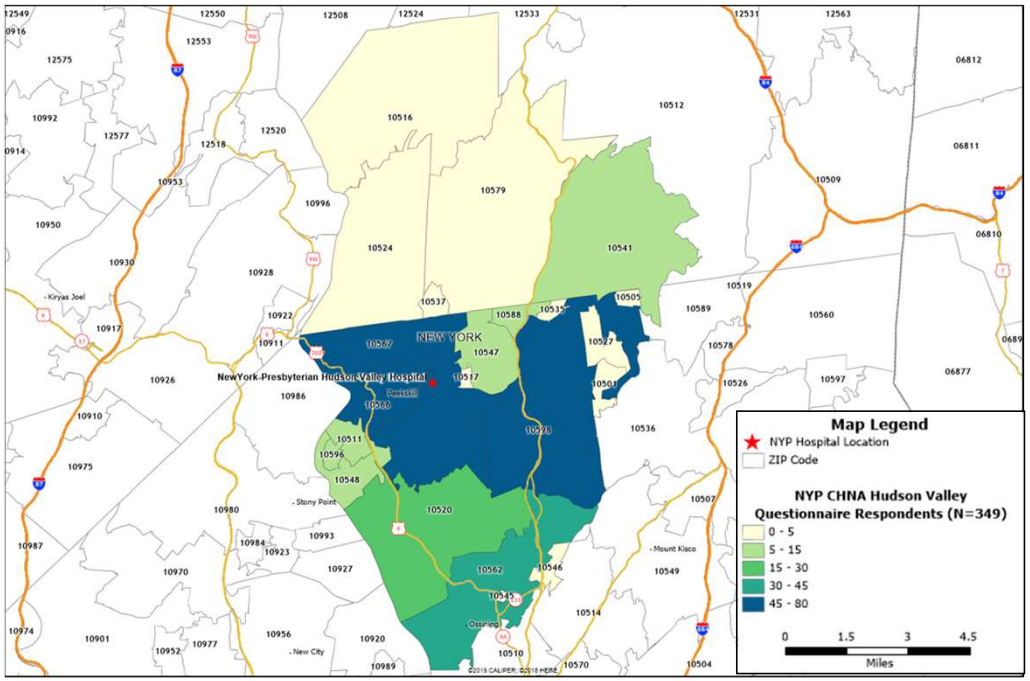
"More parenting classes… There are certain things, like brushing your kid's teeth, what the risks are of not doing it. Certain things that are parenting that they should give a booklet or something to everybody in the community."

"At the shelter they kick the homeless out at like six o'clock in the morning. And the only place to really go is in front of the library, or the riverfront is right there. And then they have to wait until I think eleven o'clock or something until they can eat again. And it's like, for elderly, if they're homeless, they're gonna have to wait in the cold. Sometimes it's cold out, and especially at that time, there should be an area, like – I don't know, a certain housing area where they can maybe just – there are couches, or maybe not couches, but chairs and a little TV or something, so that they can – because people just assume that homeless people are on drugs, or they put themselves there. Sometimes it's like, the circumstances put them there."

"I don't know if this is systematic, but they need to do something about the home health aide system, because it's just – it's ridiculous… Not only are they not well-trained, they pay them nothing... So, there are not a lot of motivated, caring people who do it."

Westchester County Survey – Analysis for NYP-HVH Defined Community

This analysis is based on a subset of the Westchester County survey for the Hudson Valley CHNA community. Westchester County completed 3,524 surveys and 349 respondents reside within the Hudson Valley community.



Priority Health Issues in the community where I live*		
Mental health	151	43.3%
Chronic disease screening & care	114	32.7%
Obesity	104	29.8%
Substance use disorders	95	27.2%
Food and nutrition	81	23.2%
Environments that promote well-being & active lifestyles	75	21.5%
Smoking, vaping and secondhand smoke	61	17.5%
Physical activity	56	16.0%
Child and adolescent health	49	14.0%
Food safety and chemicals in consumer products	42	12.0%
Injuries, such as falls, work or traffic injuries	36	10.3%
Water quality	35	10.0%
Vaccinations/immunizations	30	8.6%
Maternal and women's health	27	7.7%
Antibiotic resistance & healthcare associated infections	25	7.2%
Outdoor air quality	21	6.0%
Violence	19	5.4%
Newborn and infant health	10	2.9%
Sexually transmitted diseases	8	2.3%
HIV/AIDS	5	1.4%
Hepatitis C	2	0.6%

Westchester County Survey – Analysis for NYP-HVH Defined Community

Helpful Actions to Improve Community Health (n=349)		
Mental health services	107	30.7%
Affordable housing	87	24.9%
Exercise & weight loss programs	84	24.1%
Services for older adults	78	22.3%
Drug & alcohol treatment services	73	20.9%
Access to healthier food	51	14.6%
Health screenings	47	13.5%
Safe places to walk & play	47	13.5%
Home care services	46	13.2%
Caregiver support	44	12.6%
Employment opportunities	39	11.2%
Access to primary care	38	10.9%
Access to dental care	37	10.6%
Clean air & water	36	10.3%
Public transportation	36	10.3%
Quality and affordable childcare	32	9.2%
Immigration support services	27	7.7%
Access to education	23	6.6%
Health insurance enrollment	22	6.3%
Improving racial equality	22	6.3%
Domestic violence prevention/victim support	21	6.0%
Smoking & tobacco services	19	5.4%
Violence prevention	14	4.0%
Services for LGBTQ population	8	2.3%
Breastfeeding support	2	0.6%

Population that needs the greatest attention*	n	%
Older adults	165	47.3%
Teens	89	25.5%
Young adults	84	24.1%
School-aged children	50	14.3%
Middle-aged adults	45	12.9%
Young children	35	10.0%
Infants	18	5.2%
Other specific groups	9	2.6%
*multiple responses permitted		

Summary: Westchester County Community Health Summit

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

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

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

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

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Summary: Westchester County Community Health Summit, continued

While familiarity with the topics varied between individuals, all were engaged and focused upon identifying concerns and proposing actionable solutions. Although the facilitated breakout sessions were convened around four very different Priority Areas, common themes emerged across these discussions:

There are many strengths & resources existing in the community.

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

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

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

Summary: Westchester County Community Health Summit, continued

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

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

Social Determinants of Health must be considered when developing strategies.

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

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Summary: Westchester County Community Health Summit, continued

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

NYSPA #1: Prevent Chronic Diseases

- Chronic diseases were acknowledged as primarily cancer, cardiovascular disease and diabetes.
- Education begins at school to create healthy choices and habits and is critical throughout the age spectrum to promote healthy lifestyle behaviors.
- Economic and "safety" disparities remain throughout the county.
- There are adequate and appropriate resources across the county, but coordination is lacking.
- **ACTION:** Support and leverage existing community resources across homes, schools, churches, CBOs, etc. to address chronic diseases.

NYSPA #2: Promote a Healthy and Safe Environment

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

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Summary: Westchester County Community Health Summit, continued

NYSPA #3: Promote Healthy Women, Infants and Children

- The health of women, infants, children and families is fundamental to overall community health.
- There is an abundance of existing resources, but there is a lack of coordination for a communal and publicly accessible platform.
- **ACTION:** Design community awareness campaigns and messaging focused upon prenatal and infant care.
- **ACTION:** Health systems need a holistic care approach that eliminates silos across the continuum.

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

- Mental health and substance use disorder was a more popular topic than promoting well-being.
- Inclusivity is needed for extending care planning to family and caregivers and promoting a multidisciplinary approach in treatment.
- There are geographical and affordability barriers to access of mental health care.
- **ACTION:** Break down silos and collaborate through forums such as the 2019 Health Summit.

The results of this report will be used by the Westchester County Health Planning Coalition to help drive this engaged group of community advocates' strategic plan for community health and wellness improvement via a three year community service plan. A full copy of the Westchester County Community Health Summit report may be obtained by emailing a request to community@nyp.org.

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Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment

Herbert Irving Comprehensive Cancer Center (HICCC) Community Outreach and Engagement (COE) mission is to reduce the cancer burden and cancer health disparities in the HICCC Catchment Area (CA).

- This is accomplished through outreach, promoting and facilitating research, and engaging community partners and stakeholders in developing and delivering community education, access to services, research, and policy initiatives relevant to the CA.
- The CA is composed of the **five New York City boroughs, Westchester and Rockland Counties in New York, and Bergen County in New Jersey.** Distinct features of the CA include a highly diverse population across race, ethnicity and socioeconomic status, with significant representation of individuals who are (1) of Hispanic ethnicity, (2) foreign-born, and/or (3) living below the federal poverty line.

Assessment Background:

- In 2018, the HICCC received a CCSG supplement (P30CA013696-44S7) to conduct a community health needs assessment. The assessment, developed with 15 other National Cancer Institute (NCI) funded sites across the country, was further refined with NYC-specific questions through collaboration with Albert Einstein and Mount Sinai Cancer Centers. The resulting **survey includes questions related to healthcare access and barriers, screening behaviors, social determinants of health, demographics, HPV and hepatitis screening and vaccination, tobacco use, medication use, alcohol use, physical activity, environmental exposures, cancer family history, survivorship, and views and attitudes toward genetic testing and clinical trials.**
- The **goal of the data collection (n=1,250) is to augment the available data** (publicly available data as well as research databases in two major ways: 1) quantify whether there are unmet primary and secondary (screening) prevention needs of the HICCC patients and their family members; and 2) capture additional data constructs and ascertain the needs of populations that may be underrepresented in state and national surveys. The study design will also provide valuable data on the utility of a family-based approach to prevention not previously attempted by Cancer Centers.

Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment

Methods:

- The survey is being administered to patients from HICCC oncology clinics and NYPH ambulatory care network (ACN) clinics, and at community sites including housing shelters in the Bronx through collaboration with COE community partners. Family members of patients are being surveyed too, as many residents in the CA reside within multi-generational households.
- Eligible HICCC cancer patients were identified through the HICCC's Database Shared Resource (DBSR). Patients were contacted via e-mail to participate in the online survey, and they each received four e-mail reminders. When they clicked the survey link, they were directed to a Qualtrics form to complete an online consent. After agreeing to participate, they completed a 35-minute online survey. At the end of the survey, participants were asked if they were willing to share the survey with any family members. All participants and family members who completed the survey and provided mailing addresses received a $10 Target gift card which was sent to their home.
- Data collection for HICCC cancer patients began in May. In the summer of 2019, permission was granted to send surveys to ACN patients and recently the first round of contact with ACN patients was initiated. In addition to surveying patients through the HICCC and ACN, surveys have been conducted in the community in collaboration with community partners. The community health needs assessment is expected to be completed by December 31, 2019.

Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment

Summary of Preliminary Analyses

Selected Key Metrics	HICCC (n=634)	ACN (n=235)	Community (n=152)	Total (n=1021)
Demographics	(%)	(%)	(%)	(%)
Age - Mean	52.1	41.8	42.6	48.2
Hispanic	27.6	70.2	73	44.2
Foreign-born	22.7	29.4	50	28.3
Below Poverty Level	18.5	48.9	37.5	28.3
Primary Prevention Summary				
Overweight (BMI 25-29)	29.7	13.6	27.6	25.7
Obese (BMI ≥30)	27.3	25.5	31.6	27.5
Physically Active	50.6	48.1	51.3	50.1
Current Smoker	1.7	4.3	5.3	2.8
Use of alternate tobacco products (hookah, vape, etc.)	7.9	20.4	1.7	11.3
With Cancer Family History	46.5	32.8	17.8	39.1
Interested in Genetic Testing	67.7	76.2	59.2	68.4
Ever Been Screened for Cancer				
Mammography (n=349)	95.6	90.7	85.7	93.1
Colonoscopy (n=460)	92	84.2	60.3	86.7
Stool Test (n=460)	32.5	27.6	15.5	29.6
Pap Test (n=670)	90.6	86	70.7	86.4
Healthcare Access				
Has Healthcare Coverage	91.2	92.3	69.7	88.2
In Past 12 Months Needed a Doctor but Couldn't Go because of Cost	10.3	11.9	15.1	11.3
Social Determinants				
Number of People in Household – Mean	2.8	3.1	2.9	2.9
Living in Stable Housing in Past 2 Months	92.6	89.4	73.7	89
Worries about Unstable Housing in Next 2 Months	8.5	16.2	15.1	11.3
Easy to buy healthy foods in neighborhood	83.3	80.4	71.1	80.8
≤High School Education	15	21.7	48.7	21.5

Preliminary Analyses Support:

1) Strong interest in genetic screening information across cancer patients and family members, NYPH ambulatory care network (ACN) patients and the community. Herbert Irving Comprehensive Cancer Center (HICCC) Community Outreach and Engagement (COE) has developed and tested in over 500 individuals (60% of the workshops conducted in Spanish) a precision medicine curriculum that has been very successful in teaching complex concepts like the difference between sporadic and germline mutations.
2) Even though there is a low report of current cigarette smoking, there is a high report of alternative tobacco products (hookah, vape, etc.), as high as 20% in patients from ACN clinics.
3) The cancer screening rates are high in the ACN and community respondents with exception of colorectal screening rates that are lower in the community.

Next Steps:

- After completion of the target enrollment, a full data analyses will be conducted to examine differences across sources of respondents as well as differences based on demographics including race/ethnicity, age, geographic location, and socioeconomic status.

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Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment

This table summarizes the ongoing relevant screening, cancer vaccination, and risk factor data in the HICCC Catchment Area (CA).

Cancer screening and risk factor data in the HICCC CA

		Neighborhoods in NCA				*HICCC CA by County*							
	US (ref)	WH/I	South Bronx	Central Harlem	UWS	Manhattan	Bronx	Westchester	Brooklyn	Queens	Rockland	Staten Island	Bergen
Mammography	78.3	87	76.7	61	70.2	78.6	84	84.8	79.8	81	72	75.1	81.4
Cervical Cancer	81.3	87.9	86.3	87.5	91.5	79.3	80.5	79	81.3	79.6	79.1	86.4	85.3
Colorectal Cancer	69.8	72.1	62.4	78.7	76.5	67.7	71.5	71.3	68.4	61.3	66.8	64.2	64.5
HPV Vaccination (boys and girls)	48.6	72	78	67	52	63	70	23.3*	43	52	9.3*	27	†
Fruit and Vegetable	82	81	83	84	92	90	83	71.4	86	89	74.1	90	†
Any Physical Activity	76.9	77	65	73	83	81	70	77.1	72	70	73.5	75	48.2
Legend		-74.90%	Lower than the US rate				No difference from US rate				Higher than the US rate		110%
Obesity	30.2	26	34	34	10	15	32	17.7	27	22	20.7	25	19.3
Binge Drinking	16.9	24	12	17	19	25	14	20.7	15	15	11	18	14.7
Current Smoker	16.4	13	15	10	10	13	14	9.4	14	14	6.6	16	10.8
Sugary Beverages	32.1	23	34	29	12	17	34	18.5	24	22	23.1	26	†
Legend		-66.90%	Lower than the US rate				No difference from US rate				Higher than the US rate		47.90%

*Girls only; †Data not available

Sources: County Screening: NYC Epi Query 2014 (mammography), 2017 (cervical and colorectal) (https://a816-healthpsi.nyc.gov/epiquery/CHS/CHSXIndex.html); County Risk Factors: NYC DOHMH Community Profiles 2018 (https://www1.nyc.gov/site/doh/data/data-publications/profiles.page); County Screening Rates: NY BRFSS 2016 (https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n/data), NJ BRFSS 2015-2017 (https://www-doh.state.nj.us/doh-shad/indicator/view/BrstMamExam.County.html); Rockland and Westchester HPV Vaccination Rates: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/indicator_map.htm; County Risk Factors: NYC DOHMH Community Profiles 2018, NY BRFSS 2016, NJ BRFSS 2015-2017; National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13–17 Years — United States, 2018. MMWR. 2019; Vol 68/No. 33; HPV rates matched to NYC data time frame (2017).

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Written Comments on Most Recently Adopted CHNA and Implementation Strategy

NYP-HVH has not received written comments regarding its 2016-2018 Community Health Needs Assessment nor its 2016-2018 Community Service Plan.

Your feedback on this report is welcomed. You may send written comments to or request more information on this 2019 Community Health Needs Assessment at community@nyp.org.

AMAZING THINGS ARE HAPPENING HERE

Prioritization of Significant Health Needs

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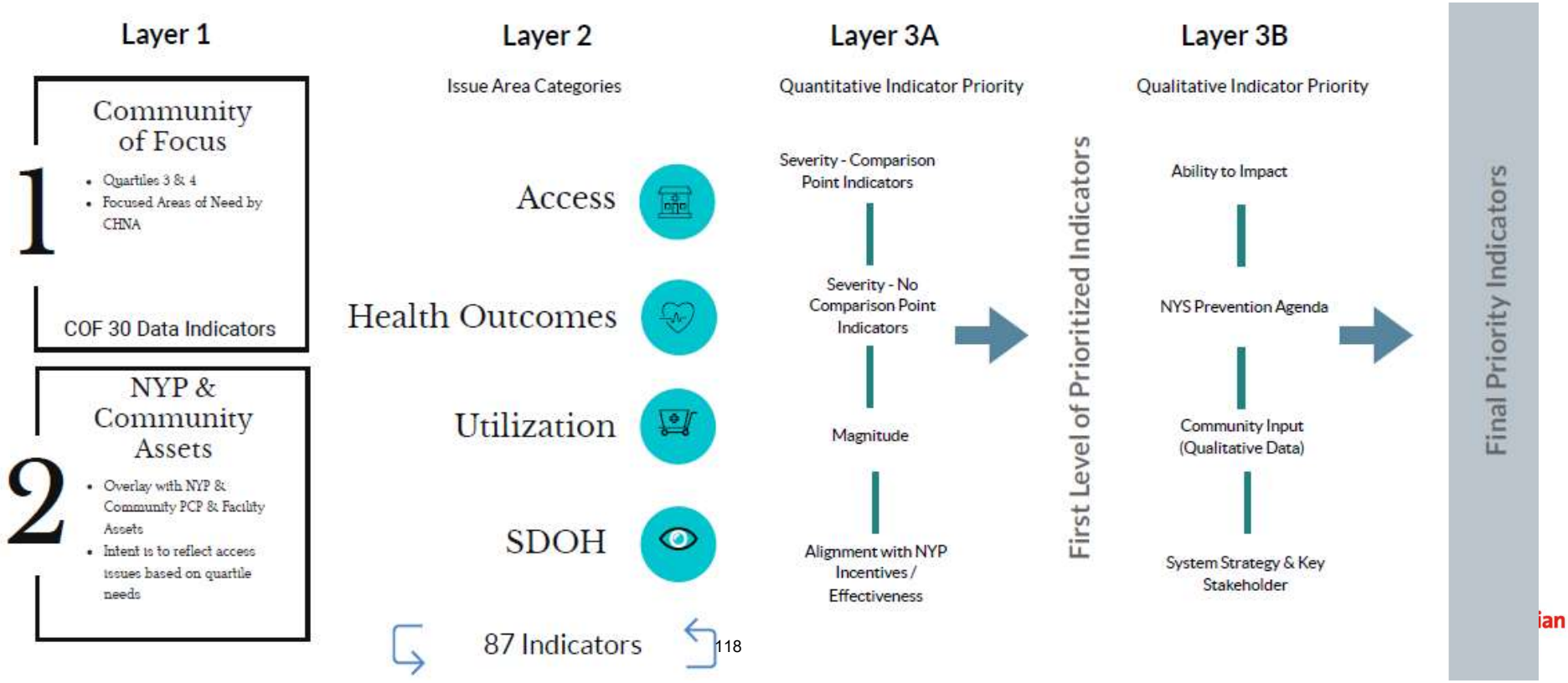
Prioritization of Significant Health Needs – Overview of Method

The prioritization method allowed the NYP-HVH team to narrow a vast amount of quantitative and qualitative data sets and define the highest disparity community and health indicators impacting that community. The model utilizes a layered approach based on the Hanlon method to incorporate the quantitative and qualitative data as well as the alignment with system initiatives and resources and key stakeholder input.



Prioritization of Significant Health Needs – Overview of Method

Full Model with Ranking and Weighting

		Prioritization Category	Definition	Type	1 - LOW	2 - MODERATE	3 - HIGH	Weight
Layer 1	**Layer 2**	**Layer 3**						**Priority Value**
		Layer A - Identify Significant Health Needs Step #1						
Community of Focus - COF Indicators Define Areas of Need	Issue Area Categories Access Health Outcomes Utilization SDOH	Severity - Comparison Point Indicators	Seriousness of Problem Variance to Local or State Comparison Point	Objective - Data Pre-Populated	Comparison Variance to be determined upon indicator analysis (range)	Comparison Variance to be determined upon indicator analysis (range)	Comparison Variance to be determined upon indicator analysis (range)	30%
		Severity - Non Comparison Point Indicators	Seriousness of Problem Key Stakeholder Perception of Serverity	Subjective - Key Stakeholder Input	Hanlon Method 0 - Not Serious 1 - 2 - Relatively Not Serious	Hanlon Method 3 - 4 - Moderatley Serious 5 - 6 - Serious	Hanlon Method 7 - 8 - Relatively Serious 9 - 10 - Very Serious	5%
		Magnitude	Size of Problem Amount of Population Impacted	Objective - Data Pre-Populated	Hanlon Method 1 - 4 .1% - .99%	Hanlon Method 5 or 6 1% - 9.99%	Hanlon Method 7 - 10 > 10% of population	40%
		Alignment with NYP Initiatives / Effectiveness of Initiatives to Need	Alignment of NYP Active Initiatives & the Effectiveness of Initiatives	Objective - Initiative Tracker & Population Health Think Tank Meeting #2	Hanlon Method 0 -< 5% effective 1 - 2 - 5% - 20% effective	Hanlon Method 3 - 4 - 20% - 40% effective 5 - 6 - 40% - 60% effective	Hanlon Method 7 - 8 - 60% - 80% effective 9 - 10 - 80% - 100% effective	25%
		Layer B - Identify Significant Health Needs Step #2						
		Availability to Impact / Available New Resources of Funding / People / Process	Resources Available & Funding Availability Community Partnership Impact Patient Compliance Impact	Subjective - Key Stakeholder Input Population Health Think Tank Meeting #2	Hanlon Method 0 -< 5% potential 1 - 2 - 5% - 20% potential	Hanlon Method 3 - 4 - 20% - 40% potential 5 - 6 - 40% - 60% potential	Hanlon Method 7 - 8 - 60% - 80% potential 9 - 10 - 80% - 100% potential	10%
		NYS Prevention Agenda	Prevention Agenda Initiative	Objective - Data Pre-Populated	Not on Prevention Agenda & Not on Previous CSP	On Prevention Agenda & Not on Previous CSP	On Prevention Agenda & On previous CSP	40%
		Community Input (Focus Groups & Surveys)	NYAM Key Findings Summaries from Focus Groups & Surveys	Objective - Data Pre-Populated	Pending NYAM Summaries Occurrence Count for focus group & surveys			40%
		System Strategy & Key Stakeholder Input	System & Key Stakeholder Subjective Input	Subjective - Key Stakeholder Input Population Health Think Tank Meeting #2	0 - 10 Score by Leader & Rank Ordering in Category			10%

Prioritization of Significant Health Needs - Results

The data identification and prioritization process resulted in numerous indicators falling into the 4th quartile. At a high level, these indicators can generally be grouped into:

1. Women's Health
2. Obesity / Diabetes
3. Mental Health & Substance Abuse
4. Cancer

These indicators will be used to inform the CSP strategy for NYP-HVH. The focus will not preclude NYP-HVH from initiatives not related to the focused priorities but allows NYP-HVH to invest in new opportunities of impact. Existing hospital strategies related to cancer, hypertension, cardiovascular, etc. will continue to evolve as leading strategies.

CATEGORY	INDICATORS	ISSUE SCORE	QUARTILE
Health Outcomes	Childhood Obesity	3	4th
Health Outcomes	Obesity	3	4th
Health Outcomes	Diabetes	3	4th
Health Outcomes	Cancer Incidence - All Sites*	3	4th
Health Outcomes	Cancer Incidence - Breast*	3	4th
Health Outcomes	Cancer Incidence - Colon and Rectum*	3	4th
Health Outcomes	Physical Activity	3	4th
Utilization	Hospitalizations: Preventable Diabetes*	3	4th
Utilization	Hospitalizations: Preventable Hypertension*	3	4th
Utilization	Hospitalizations: Psychiatric*	3	4th
Health Outcomes	Percentage of adults with diagnosed high blood pressure taking high blood pressure medication	2.9	4th
Health Outcomes	Percentage of adults with poor mental health for 14 or more days in the last month	2.6	4th
Health Outcomes	Cancer Incidence - Prostate*	2.5	4th
Access	Late Or No Prenatal Care	2.2	4th
SDoH	Binge Drinking*	2.1	4th
Health Outcomes	Cancer Incidence - Lung*	2.1	4th
Health Outcomes	Self-Reported Health	2	4th
SDoH	Sugary Drink Consumption*	2	4th
Utilization	Emergency Dept.: All Visits*	2	4th
Utilization	Hospitalizations: Drug*	2	4th

Westchester County Health Planning Coalition Selected Priorities

The Westchester County Health Planning Coalition (WCHPC), inclusive of the Westchester County Department of Health (WCDOH) and the sixteen local Westchester County Hospitals, formed in response to the New York State Department of Health's appeal that each county's local health department, hospitals/hospital systems and other community partners collectively work together to identify and address local health priorities associated with the New York State Prevention Agenda (NYSPA).

Together they selected the below planned areas of focus for the next 3 years:

1. Prevent Chronic Diseases
2. Promote Well-Being and Prevent Mental and Substance Abuse Disorder

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Previously Conducted CHNA

NewYork-Presbyterian
Hudson Valley Hospital

NYP-HVH Impact Evaluation of 2016 Implementation Strategy

Based on a Community Health Needs Assessment collaboration with the Westchester County Department of Health and Westchester County Hospitals the following priorities were selected for the 2016-2018 Community Service Plan:

1. Increase access to high quality chronic disease preventative care and management in both clinical and community settings.
2. Reduce obesity in children and adults.

NYP-HVH Impact Evaluation of 2016 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Prevent Chronic Diseases: Promote use of evidenced based care to manage chronic diseases by increasing participation of adult minority population at risk of heart disease due to a previous heart attack, or other cardiac issues or predisposition due to heredity, high blood pressure, diabetes or being overweight in a self-management course to learn the importance of heart healthy meal planning and the benefits of exercise.	• Expand nutrition and culinary literacy to positively impact everyday meal planning; improve confidence in healthy heart meal planning; improve mindful eating; provide increased access to wholesome foods in 100% of class participants. • Increase intake of fruits and vegetables to 3 or more services per day and decrease intake of sugar and sodium in 75% of participants. 50% of group will have increased exercise to 3 days per week; will demonstrate weight loss between 0-10lbs. And decrease blood pressure within 10mm/Hg (either systolic or diastolic); and no increase in BMI.	• Enrollment at no charge to the Healthy Heart Program – two 5-month programs to include: 10 free Healthy Heart Cooking Classes; education to understand the nutrition labels; mindful eating techniques; increase nutrition literacy; fitness membership to Wellness Center; bi-monthly farmers' market on campus.	Yes, from 2016 to 2018, NYP-HVH addressed the objectives of Priority/Focus Area #1. A total of 78 individuals from minority backgrounds were served with heart health education and resources.	- Demonstrating the impact of the program were the attitudinal shifts toward nutrition and exercise to support cardiovascular health and overall well-being. Findings verify improved confidence in healthy heart meal planning; improved mindful eating' increased intake of fruits and vegetables; decreased intake of sodium and sugar, and increase in exercise. - The program had positive effects on blood pressure and weight loss. - The program was supported not only by NYP-HVH cardiologists, but referrals also increased for patients of internal medicine practitioners. - Upon completion of the program, participants had continued access to healthy cooking classes at the hospital's Teaching Kitchen as well as informational sessions/community lectures held throughout the year on-site, at the hospital.

NYP-HVH Impact Evaluation of 2016 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Prevent Chronic Diseases: Expand the role of healthcare and health service providers in obesity prevention by increasing breastfeeding at discharge to 90%; implementing and maintaining maternity care practices consistent with the World Health Organization's Ten Steps to Successful Breastfeeding.	• Increase breastfeeding at discharge to 90%.	• Have a written breastfeeding (BF) policy that is routinely communicated to health care staff; train health care staff in the skills necessary to implement BF policy; BF education and promotion of al BF within 1 hour of birth; teach how to breastfeed and maintain lactation even if separated from infant; provide breastmilk unless otherwise medically indicated; practice rooming-in; encourage BF on demand; give no pacifiers or artificial nipples to BF infants; establish and promote BF support groups; establish annual OB/GYN and pediatric physician educational lecture on the benefits of BF as it relates to reducing obesity.	Yes, from 2016 through October 2018, NYP-HVH achieved the goals of Priority/Focus Area #2, and increased breastfeeding rates at discharge to 94%. This exceeded the Prevention Agenda goal of 90%. In comparison, the New York state-wide prevention agenda goals in 2018 for breastfeeding rates at discharge was 48.1%.	- NYP-HVH expanded its role in obesity prevention by training all Obstetrical Services staff on the benefits of breastfeeding and by providing breastfeeding education and support to mothers within one hour of birth; teaching mothers how to maintain lactation; and encouraging breastfeeding on demand. - The hospital will maintain its focus on the importance of breastfeeding, while respecting the right of each patient to choose. Breastfeeding education and a bi-monthly Breastfeeding Support Group continues to be held at NYP-HVH. - NYP-HVH remains certified as a "Baby Friendly" hospital. - In addition, NYP-HVH OB/GYN nurses are Magnet nurses, recognized for their clinical excellence, best practices and innovation. Research shows that Magnet hospitals have better outcomes.

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Appendix

NewYork-Presbyterian
Hudson Valley Hospital

Assessment Data, Defined Community at a Glance Indicators

Indicator	Source	Geographic Area	Period
Total Population Growth by Age Cohort	Nielsen	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Population by Race & Ethnicity	Nielsen	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Socioeconomic Profile – Household Income	Nielsen	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Population	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Households	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Ethnicity – Hispanic/Latino	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Hispanic Origin – Non Cuban/Mexican/Puerto Rican	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Home Language	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Marital Status	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Population by Age	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Population by Race	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Median Age of Householder	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Presence of Children	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Household Type	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Housing Tenure	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Age of Housing	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Household Size	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Housing Units in Structure	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated

Assessment Data, Defined Community at a Glance Indicators

Indicator	Source	Geographic Area	Period
Education Attainment	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Education: Hispanic/Latino	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Poverty Status	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Household Income; Median and Average	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Household Income Distribution	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Occupational Class	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Unemployment Rate	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Method of Travel to Work	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Occupation	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Demographics	Population (Total #)	Claritas	ZIP	2019, Estimated
Demographics	Percent of female population	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 0-17	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 18-24	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 25-44	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 45-64	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 65 and older	Claritas	ZIP	2019, Estimated
Demographics	Percent of Hispanic or Latino population (of any race)	Claritas	ZIP	2019, Estimated
Demographics	Percent of White population (not Hispanic or Latino)	Claritas	ZIP	2019, Estimated
Demographics	Percent of Black population (not Hispanic or Latino)	Claritas	ZIP	2019, Estimated
Demographics	Percent of Asian and Pacific Islander population	Claritas	ZIP	2019, Estimated
Demographics	Percent of all other race population	Claritas	ZIP	2019, Estimated
Demographics	Families below poverty	Claritas	ZIP	2019, Estimated
Demographics	Families below poverty with children	Claritas	ZIP	2019, Estimated
Socioeconomics	Percentage of adults aged 18-64 years with health insurance	New York State Community Health Indicator Reports (CHIRS)	County	2016
Socioeconomics	Percentage of children <19 years with health insurance	New York State Community Health Indicator Reports (CHIRS)	County	2016
Socioeconomics	Percent of population enrolled in Medicaid	UHFNYC	County	2011-2015, ACS Estimate

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Socioeconomics	Speak only English at home	Claritas	ZIP	2019, Estimated
Socioeconomics	Percent of adults ages 25+ not completed high school	Claritas	ZIP	2019, Estimated
Socioeconomics	Percent of population ages 16+ unemployed	Claritas	ZIP	2019, Estimated
Socioeconomics	Percent of total population reported disabled	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Socioeconomics	% of household, single mother with children	Claritas	ZIP	2019, Estimated
Socioeconomics	% of household, single father with children	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $200,000 or more	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $100,000 to $199,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $75,000 to $99,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $50,000 to $74,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $35,000 to $49,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $25,000 to $34,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $15,000 to $24,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band Under $15,000	Claritas	ZIP	2019, Estimated

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Housing	Severe Housing Problems	Robert Wood Johnson County Health Rankings State Cancer Profiles; ACS	County	2013-2017
Housing	Housing Insecurity	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Housing	Rent burden, 30% or more	Cares Engagement; ACS	County	2013-2017
Food & Nutrition	Food Insecurity	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Social & Environmental Safety	Air Quality (Annual Average MCG per Cubic Meter of Fine Particle Matter)	Cares Engagement; CDC	County	2012
Social & Environmental Safety	Assault Hospitalizations per 100,000 population, age adjusted rate	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Social & Environmental Safety	Violent Crime	Cares Engagement; FBI	County	2019
Transportation	Workers who commute by any form of transportation over 60 minutes away	Claritas	ZIP	2019, Estimated
Health Status: Healthy Eating & Physical Activity	Percentage of adults who ate in 24 hours, 1+ servings of fruit/vegetables	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Healthy Eating & Physical Activity	Percentage of adults who drink >1 sweetened beverages daily	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Healthy Eating & Physical Activity	Percentage of adults who report being obese	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Healthy Eating & Physical Activity	Childhood obesity, students 95th percentile or higher	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Healthy Eating & Physical Activity	Percentage of adults with physical activity in last 30 days	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Health Status: Women, Infants & Children	Maternal mortality rate per 100,000 live births	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Women, Infants & Children	Rate of infant deaths (under 1 year old) per 1,000 live births	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Women, Infants & Children	Percent of live births receiving late prenatal care	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Women, Infants & Children	Percent of preterm births among all live births	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Women, Infants & Children	Rate of teen births per 1,000 women ages 15-19	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental health	Percent of premature deaths (aged less than 75 years)	Cares Engagement; CHR	County	2015-2017
Health Status: Well-Being & Mental health	Percentage of adults that self-report health as good-excellent	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental health	Percentage of Adults not getting needed medical care	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental health	Percentage of adults self-reporting poor mental health	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental health	Percentage of adults self-reporting binge drinking	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults with diabetes	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults with hypertension	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults reporting current smoking	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Rate of new HIV diagnoses per 100,000 people	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Health Status: Chronic Disease	Percentage of adults with arthritis	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults with cardiovascular disease (heart attack, coronary heart disease, or stroke)	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percent of adults with COPD	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults taking medication for high blood pressure	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Cancer	Cancer incidence – all sites, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Status: Cancer	Cancer incidence – breast, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Status: Cancer	Cancer incidence – rectum, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Status: Cancer	Cancer incidence – lung, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Status: Cancer	Cancer incidence – prostate, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Utilization	Hospitalizations: All, age adjusted rate per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Asthma, age adjusted rate per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Diabetes, age adjusted rate per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Hypertension, per 10,000 ages 18+	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Asthma, per 10,000 aged 0-17	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Drug related, per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Falls, age adjusted rate per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Cardiovascular disease (stroke), per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014

Assessment Data, Health Provider Assets in the High Disparity Communities, Non-NYC

Category	Indicator	Source	Geographic Area	Period
Health Provider Assets	Facility - Hospital, Federally Qualified Health Center, Skilled Nursing Facility, and Urgent Care	Definitive Healthcare	Street Address	2019
Health Provider Assets	Physicians	Definitive Healthcare	Street Address	2019

Gaps Limiting Ability to Assess the Community Health Needs

A number of data sources, including state, county, and local resources were examined as part of this CHNA. One limitation of this study is that some data sources were not available for geographic boundaries at these localized levels (e.g., Neighborhood Tabulation Area).

Additionally, data publicly available was not always collected on an annual basis, meaning that some data indicators are several years old. In consideration of these limitations, the process of identifying health needs was based on both the quantitative and qualitative analyses.

Mental health and substance use indicators are limited due to privacy requirements creating challenges for assessing disparities. Similar self-reported statistics are estimated to be underreported due to the stigma of these.

Hanlon Prioritization Method Pros and Cons

The Hanlon Method for Prioritizing Health Problems, utilized in this study, is a well-respected technique which objectively takes into consideration explicitly defined criteria and feasibility factors. Though a complex method, the Hanlon Method can be used with any size group and is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values.

- **PROS:** the PEARL component can be a useful feature as it offers relatively quantitative answers that are appealing for many.
  - **P**ropriety – Is a program for the health problem suitable?
  - **E**conomics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
  - **A**cceptability – Will a community accept the program? Is it wanted?
  - **R**esources – Is funding available or potentially available for program?
  - **L**egality – Do current laws allow program activities to be implemented?

  Eliminate any health problems which receive an answer of "No" to any of these PEARL factors or proceed with corrective action to ensure that potential health priorities meet all five of the feasibility factors.

- **CONS:** The process offers the lowest priorities for those issues where the solution requires additional resources or legal changes which may be problematic. Very complicated.

Source: https://www.cdc.gov/nphpsp/documents/Prioritization%20section%20from%20APEXPH%20in%20Practice.pdf

New York State Department of Health Prevention Agenda 2019-2024

Priority Area: Prevent Chronic Diseases	Focus Area 1: Healthy Eating and Food Security Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 1.1: Increase access to healthy and affordable foods and beverages
	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
	Goal 1.3: Increase food security
	Focus Area 2: Physical Activity Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
	Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
	Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
	Focus Area 3: Tobacco Prevention
	Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults
	Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability
	Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
	Focus Area 4: Preventive Care and Management
	Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
	Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
	Goal 4.3: Promote the use of evidence-based care to manage chronic diseases
	Goal 4.4: Improve self-management skills for individuals with chronic conditions

New York State Department of Health Prevention Agenda 2019-2024

Priority Area: Promote a Healthy and Safe Environment	Focus Area 1: Injuries, Violence and Occupational Health
	Goal 1.1: Reduce falls among vulnerable populations
	Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations
	Goal 1.3: Reduce occupational injuries and illness
	Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists
	Focus Area 2: Outdoor Air Quality
	Goal 2.1: Reduce exposure to outdoor air pollutants
	Focus Area 3: Built and Indoor Environments
	Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
	Goal 3.2: Promote healthy home and school environments
	Focus Area 4: Water Quality
	Goal 4.1: Protect water sources and ensure quality drinking water
	Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
	Focus Area 5: Food and Consumer Products
	Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
	Goal 5.2: Improve food safety management

New York State Department of Health Prevention Agenda 2019-2024

Priority Area: Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women's Health
	Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age
	Goal 1.2: Reduce maternal mortality and morbidity
	Focus Area 2: Perinatal & Infant Health
	Goal 2.1: Reduce infant mortality and morbidity
	Goal 2.2: Increase breastfeeding
	Focus Area 3: Child & Adolescent Health
	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships
	Goal 3.2: Increase supports for children and youth with special health care needs
	Goal 3.3: Reduce dental caries among children
	Focus Area 4: Cross Cutting Healthy Women, Infants, & Children
	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being
	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
	Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages
	Focus Area 2: Prevent Mental and Substance Use Disorders
	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults
	Goal 2.2: Prevent opioid and other substance misuse and deaths
	Goal 2.3: Prevent and address adverse childhood experiences (ACEs)
	Goal 2.4: Reduce the prevalence of major depressive disorders
	Goal 2.5: Prevent suicides
	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population

New York State Department of Health Prevention Agenda 2019-2024

Priority Area: Prevent Communicable Diseases	Focus Area 1: Vaccine-Preventable Diseases
	Goal 1.1: Improve vaccination rates
	Goal 1.2: Reduce vaccination coverage disparities
	Focus Area 2: Human Immunodeficiency Virus (HIV)
	Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)
	Goal 2.2: Increase viral suppression
	Focus Area 3: Sexually Transmitted Infections (STIs)
	Goal 3.1: Reduce the annual rate of growth for STIs
	Focus Area 4: Hepatitis C Virus (HCV)
	Goal 4.1: Increase the number of persons treated for HCV
	Goal 4.2: Reduce the number of new HCV cases among people who inject drugs
	Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections
	Goal 5.1: Improve infection control in healthcare facilities
	Goal 5.2: Reduce infections caused by multidrug resistant organisms and C. difficile
	Goal 5.3: Reduce inappropriate antibiotic use

Community Populations – Westchester County Survey Demographics

Participant demographics (N=349)		
Age	n	%
18-24	7	2.0%
25-34	32	9.2%
35-44	40	11.5%
45-54	62	17.8%
55-64	69	19.8%
65-74	81	23.2%
75+	50	14.3%
Gender identity		
Female	251	71.9%
Male	89	25.5%
Education		
Advanced or professional degree	106	30.4%
College graduate	101	28.9%
Some college or technical school	71	20.3%
High school graduate or GED	49	14.0%
Less than high school	7	2.0%
Hispanic or Latino origin	40	11.5%
Race/ethnicity		
White	279	79.9%
Black or African American	25	7.2%
Asian or Pacific Islander	6	1.7%
Multi-racial	4	1.1%
American Indian or Alaskan Native	1	0.3%
Other	14	4.0%

Participant demographics (N=349)		
Employment*	n	%
Employed	191	54.7%
Retired	114	32.7%
Self-employed	14	4.0%
Homemaker	9	2.6%
Out of work	7	2.0%
Student	5	1.4%
Unable to work	3	0.9%
Other	4	1.1%
What is the primary language you speak at home?		
English	317	90.8%
Spanish	11	3.2%
French	1	0.3%
Italian	1	0.3%
Portuguese	1	0.3%
Other	9	2.6%

* multiple responses permitted
Percentages may not add up to 100 due to missing responses

Community Populations – Questionnaire Demographics

Hudson Valley questionnaire participant demographics (N=153)	n	%
Age		
18-25	10	6.5%
26-35	55	35.9%
36-45	19	12.4%
46-55	15	9.8%
56-65	19	12.4%
66-75	20	13.1%
76-85	13	8.5%
86 +	2	1.3%
Gender		
Female	75	49.7%
Male	75	49.7%
Gender non-binary	1	0.7%
Sexual orientation		
Heterosexual or straight	123	87.9%
Asexual	6	4.3%
Bisexual	4	2.9%
Gay or lesbian	3	2.1%
Self-described	3	2.1%
Queer	1	0.7%
Race/ethnicity *		
White	93	60.8%
Latino or Hispanic	32	20.9%
Black or African American	15	9.8%
Asian or Asian American	5	3.3%
American Indian or Alaskan Native	3	2.0%
Other	2	1.3%
Born in the U.S.	131	87.3%
How well do you speak English?		
Very well	144	96.0%
Well	5	3.3%
Not well	1	0.7%
Not at all	0	0.0%
Education completed		
Grades < 8	1	0.7%
Grades 9-11	4	2.7%
HS Diploma or GED	19	12.7%
Some college	36	24.0%
College graduate	90	60.0%
Employment *		
Working	102	66.7%
Not working	21	13.7%
Retired	19	12.4%
Volunteer	13	8.5%
Homemaker/Caregiver	5	3.3%
Student	4	2.6%
Other	3	2.0%
Type of health insurance *		
Medicare	64	41.8%
Private/commercial	53	34.6%
Medicaid	38	24.8%
Uninsured	11	7.2%
VA	2	1.3%
Don't know	2	1.3%

* Multiple responses permitted

Community Populations – Focus Group Demographics

Hudson Valley Focus Group Participant Demographics (N=39)		
	n	%
Gender		
Female	23	59.0%
Male	15	38.5%
Missing	1	2.6%
Sexual Orientation		
Heterosexual or straight	26	66.7%
Asexual	4	10.3%
Bisexual	2	5.1%
Self-described	1	2.6%
Missing	6	15.4%
Race/Ethnicity*		
White	26	66.7%
Black or African American	10	25.6%
Hispanic or Latino	4	10.3%
Missing	2	5.1%
Born in the US		
Yes	31	79.5%
How well do you speak English?		
Very well	36	92.3%
Well	2	5.1%
Missing	1	2.6%
Primary language spoken at home		
English	35	89.7%
Spanish	1	2.6%
Missing	3	7.7%

Hudson Valley Focus Group Participant Demographics (N=39)		
Highest level of education completed		
College 4 years or more (Bachelor's, JD/MD/PhD)	17	43.6%
Grade 12 or GED (High school graduate)	10	25.6%
College 1 -3 years (some college, or technical school, associate's degree)	7	17.9%
Grades 9-11 (Some high school)	4	10.3%
Missing	1	2.6%
Insurance Status*		
Private insurance	19	48.7%
Medicaid	10	25.6%
Medicare	10	25.6%
Uninsured	3	7.7%
VA insurance	3	7.7%
Employment status*		
Working	15	38.5%
Not working	10	25.6%
Retired	8	20.5%
Volunteer	4	10.3%
Homemaker/caregiver	2	5.1%
Other	6	15.4%

2019 CHNA NewYork-Presbyterian Focus Group Guide

1. To start, we'd like to hear a little about you, including how long you have lived in this community and one thing you like about it.
2. We're interested in hearing from you about health, so before we get into our more detailed questions, we want to hear from you first about how you define the term. Briefly, what does the word "health" mean to you?
3. What do you think are the greatest health issues for people in this community? (e.g., particularly common illnesses or problems)
    a. Why do you think [x health issue(s) mentioned] is so common here? (prompt if needed: age of the population, diet, lifestyle, pollution, other environmental factors)
4. [If not mentioned] Are there any particular mental health issues that people in this community face, including depression, anxiety, trauma, or stress?
    a. Why do you think [x mental health-related issue(s) mentioned] is/are significant here?
5. [If not mentioned in Q4] Is drug and alcohol use an issue in this community? Why or why not? What kind of services are available for people struggling with drug or alcohol use?

Now we're going to ask a little more about you and daily life in this community.

6. Can you tell us about the kind of food that you generally eat?
    a. How concerned are you about eating healthy? Why?
    b. How easy or hard is it to buy, eat and serve healthy food around here? Where do you go for food?
    c. What might make it easier to eat healthy?

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7. How easy or hard is it for people to exercise in this community? This includes things like walking, sports (like soccer and basketball), yoga, and other kinds of physical activity?
    a. Do you exercise?
    b. For those of you who do, what kind of exercise do you do and how often? Why?
    c. For those of you who don't, why not?
    d. How big a priority is exercise in this community? Can you explain?
    e. What might encourage people to exercise more than they do?
8. Health is more than just medical care and many things can affect health, including housing, transportation, employment, stress in daily life, etc. Does this idea ring true to you? Why or why not?
9. Are there any particular challenges, like the ones I just mentioned, that people in this community face (i.e., housing, transportation, employment, stress in daily life, etc.)?
    a. What about challenges related to housing?
    b. Transportation?
    c. Paying for food?
    d. Employment?
    e. Any others?
10. Are there things about this community that affect health in a positive way, for ex. good housing or access to healthy food?
11. What kinds of services exist in this community to help people deal with the challenges that we just discussed (If needed: like housing, transportation, employment)? Can you explain?
    a. What kinds of organizations do people look to for help with these challenges? Why?
    b. What about faith-based organizations like churches or mosques? Others?
    c. If you've ever used services like these, how helpful were they? Why/why not?

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Now I'd like to talk about healthcare.

12. Where do people here (in this room) go for health care?
    a. How did you choose where you go?
    b. How do you like it – what's good about it? What's bad?
    c. Do you schedule an annual check-up?
13. Who do people here talk to if they are feeling sad or anxious and need help with that? [Probe if necessary: a therapist? Someone at a community based organization? A religious leader? A friend or family member?]
    a. How willing are people to seek help for these kinds of issues?
    b. What might encourage people to get help for these types of issues?
14. How well do you think the services that are available for people dealing with stress, anxiety, depression or other mental health challenges serve the mental health needs of this community?
    a. Are there enough services? Not enough?
    b. Are there ways the services available could be better? Or are they fine as they are?
15. Overall, how easy or difficult do you think it is for you and others you know to get health care?
    a. What specifically makes it easy—or difficult—to get health care in this community?
    b. Is cost of services an issue?
    c. Is insurance an issue?
    d. Is language – or provider sensitivity an issue?
16. If you were able to talk to a doctor via telephone or computer (like a videochat) when you were sick, instead of going in to see the doctor in person, how likely would you be to use that service?
    a. Why or why not? [Prompt if needed: is it about your level of comfort using tech for this kind of thing? Or about your ability to access this kind of technology?

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This final set of questions are about some additional health related programs and resources.

17. If you want to learn about health – things like diabetes prevention, blood pressure or cancer screening, etc.—what kind of information is available to people in your community, if any?
    a. Who provides this information? How do they do that?
    b. Have you ever seen or gotten information like this being provided by a local hospital?
        i. If so, what was it about?
        ii. Did you attend? Why or why not?
    c. Who generally attends these programs—or looks for this kind of information?
18. What other kinds of programs exist in this community to help people stay healthy? This could be things like WIC, free exercise classes, or community health workers, for example.
    a. Has anyone used these programs?
    b. How helpful are they, in your opinion?
    c. What kind of programs do you think there could be more of?
19. Has anyone ever used a service like this? If yes, what did you think?
19. As we mentioned in the beginning of the group, the purpose of this conversation is to help NewYork-Presbyterian think about ways they can support the health of this community including things they do outside their walls. Are there any things we haven't talked about that you think NewYork-Presbyterian could do to help improve the health of the community?
20. Before we close, do you have any other comments about health or health care here – anything we haven't discussed?
21. Do you have any questions for us?

Thank you!

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2019 NewYork-Presbyterian Community Health Needs Questionnaire

The New York Academy of Medicine is conducting this survey as part of a community health needs assessment for NewYork-Presbyterian (NYP), a network of hospitals and providers across New York City and Westchester. The purpose of this survey is to identify health issues that are important in your community. The information that you provide will help NYP to develop health services and programs. This survey is voluntary and you can skip individual questions. All your responses will be kept private.

Eligibility

1. How old are you?

- ☐ <18 [Thank you, unfortunately, you are not eligible for the survey]
- ☐ 18 - 25
- ☐ 26 – 35
- ☐ 36 – 45
- ☐ 46 – 55
- ☐ 56 – 65
- ☐ 66 – 75
- ☐ 76 – 85
- ☐ 86+

2. Where do you live?

- ☐ Bronx
- ☐ Brooklyn
- ☐ Manhattan
- ☐ Queens
- ☐ Staten Island
- ☐ Westchester
- ☐ Other, please specify: _____

3. What is your zip code? ___

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2019 NewYork-Presbyterian Community Health Needs Questionnaire

Health issues in your community

4. Overall, how would you rate the health of the people in the community where you live?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

5. What do you think are the biggest health concerns in your community? (Check all that apply)

- ❑ Adolescent health
- ❑ Alcohol and drug use
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Exercise/physical activity
- ❑ Falls among older adults
- ❑ Heart disease
- ❑ Hepatitis C
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Maternal and child health
- ❑ Mental health (e.g., depression, suicide)
- ❑ Nutrition
- ❑ Obesity
- ❑ Sexually transmitted infections
- ❑ Sickle cell anemia
- ❑ Teen pregnancy
- ❑ Tobacco use
- ❑ Vaccinations
- ❑ Violence
- ❑ Other, please specify:

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2019 NewYork-Presbyterian Community Health Needs Questionnaire

6. Many things outside of medical care can impact daily health where you live. What are the top changes that you believe would improve the health of the residents of your community the most? (Check all that apply)

- ☐ Cleaner streets
- ☐ Improved housing conditions
- ☐ Improved water quality
- ☐ Increased number of places where older adults can live and socialize
- ☐ Increased public transportation
- ☐ Lead paint removal
- ☐ Mold removal
- ☐ More local jobs
- ☐ More parks and recreation centers
- ☐ Reduced air pollution
- ☐ Reduced cigarette/vaping smoke
- ☐ Reduced crime
- ☐ Reduced speeding on neighborhood streets
- ☐ Reduced traffic on neighborhood streets
- ☐ Reduction in homelessness
- ☐ Other: _____

Personal health and health care use

7. In general, would you say your health is…?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

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8. Has a doctor or other medical professional ever told you that you have any of the following . . .

	Yes	No
a. Arthritis	☐	☐
b. Asthma	☐	☐
c. Cancer (including skin cancer)	☐	☐
d. Chronic pain	☐	☐
e. COPD, emphysema or chronic bronchitis	☐	☐
f. Depression or anxiety	☐	☐
g. Diabetes	☐	☐
h. Drug or alcohol addiction	☐	☐
i. Heart disease	☐	☐
j. Hepatitis C	☐	☐
k. High blood pressure	☐	☐
l. High cholesterol	☐	☐
m. HIV/AIDS	☐	☐
n. Kidney disease	☐	☐
o. Obesity	☐	☐
p. Osteoporosis	☐	☐
q. Sexually transmitted diseases	☐	☐
r. Sickle cell anemia	☐	☐
Other:	☐	☐

2019 NewYork-Presbyterian Community Health Needs Questionnaire

9. Do you currently have health insurance?

- ☐ Yes
- ☐ No (Skip to Q10)
- ☐ Don't know (Skip to Q10)

9a. If yes, what type (Check all that apply)

- ☐ Medicaid
- ☐ Medicare
- ☐ Private/commercial
- ☐ VA
- ☐ Not sure what kind

10. Where do you most often go for health care? (Check one)

- ☐ Alternative care (e.g., herbalist, acupuncturist)
- ☐ Community health center
- ☐ Doctor's office
- ☐ Emergency room
- ☐ Hospital-based practice
- ☐ I don't go anywhere (skip to Q11)
- ☐ Pharmacy
- ☐ Spiritual healer or leader
- ☐ Urgent care
- ☐ Other, please specify:_____

10a. Is the place you go to part of NewYork-Presbyterian?

- ☐ Yes
- ☐ No
- ☐ Don't know

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2019 NewYork-Presbyterian Community Health Needs Questionnaire

11. Was there a time in the past 12 months when you needed health care or health services but did not get it?

- ☐ Yes
- ☐ No (Skip to Q12)
- ☐ Don't know (Skip to Q12)

11a. Why didn't you get the care? (Check all that apply)

- ☐ Concerned about language or translation issues
- ☐ Couldn't get an appointment soon enough or at the right time
- ☐ Didn't have transportation
- ☐ Didn't know where to go
- ☐ Didn't realize I needed to see doctor
- ☐ Don't have a doctor
- ☐ Don't like to go
- ☐ Goes against my religious/cultural beliefs
- ☐ Had other responsibilities (e.g. work, childcare)
- ☐ High cost of care (e.g. co-pay, deductible)
- ☐ I thought I wouldn't get good care
- ☐ Not insured
- ☐ Other, please specify:_____

12. During the past 12 months, how many times have you gotten care in a hospital emergency room (ER)?

- ☐ None (Skip to Q13)
- ☐ 1 time
- ☐ 2 or more times
- ☐ Don't know

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12a. Why did you choose to go to the ER? (Check all that apply)

- ☐ Didn't have insurance
- ☐ Didn't have transportation to doctor's office or clinic
- ☐ Doctor's office or clinic wasn't open
- ☐ Doctor told me to go to the ER
- ☐ Don't know
- ☐ Get most of my care at the ER
- ☐ Problem too serious for a doctor's office or clinic
- ☐ Other, please specify:_____

Hospital Services

13. Have you received medical care at any of the following NYP hospitals in the last 12 months? (Check all that apply)

- ☐ Gracie Square Hospital
- ☐ NYP Allen Hospital
- ☐ NYP Brooklyn Methodist Hospital
- ☐ NYP Columbia University Medical Center
- ☐ NYP David H. Koch Center
- ☐ NYP Hudson Valley Hospital
- ☐ NYP Komansky Children's Hospital
- ☐ NYP Lawrence Hospital
- ☐ NYP Lower Manhattan Hospital
- ☐ NYP Morgan Stanley Children's Hospital
- ☐ NYP Och Spine Hospital
- ☐ NYP Queens
- ☐ NYP Weill Cornell Medical Center
- ☐ NYP Westchester Division
- ☐ Other, please specify:_____
- ☐ No (Skip to Q14)

13a. Which services did you use? (Check all that apply)

- ☐ Adolescent health
- ☐ Birthing/Maternity
- ☐ Dental care
- ☐ Emergency department
- ☐ Heart/Cardiology care
- ☐ Pediatrics care
- ☐ Primary care (e.g. internal medicine)
- ☐ Radiology/Imaging
- ☐ Surgery
- ☐ Women's health
- ☐ Other, please specify:_____

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13b. Have you participated in any of these programs in the last 12 months?

	Yes		No	
Ask appropriate follow-up for each item below (e.g., if "yes," ask if useful); Skip patterns will be used for each question.	I found it to be useful	I did not find it useful	However, I am interested	Not interested
i. Community fitness and nutrition programs (e.g. weight loss and cooking programs)				
ii. Community health education events and lectures				
iii. Community health screening (e.g. blood pressure, diabetes)				
iv. Community support groups				
v. LGBT support services				
vi. Mental health and family counseling				
vii. Quit smoking programs				
viii. Other, please specify:				

2019 NewYork-Presbyterian Community Health Needs Questionnaire

Information and Activities

14. Where do you get most of your health information? (Check all that apply)

- ☐ Books
- ☐ Community based organization
- ☐ Doctor or health care provider
- ☐ Family or friends
- ☐ Health department
- ☐ Health fairs
- ☐ Health insurance plan
- ☐ Internet
- ☐ Library
- ☐ Newspapers or magazines
- ☐ Radio
- ☐ Religious organizations (e.g., church, temple)
- ☐ School
- ☐ Television
- ☐ Workplace
- ☐ Other, specify: ____
- ☐ Don't know

15. Which of the following do you use to communicate with your healthcare provider? (Check all that apply)

- ☐ Email
- ☐ In-person
- ☐ Online provider portal (e.g., MyChart)
- ☐ Telephone
- ☐ Text messaging
- ☐ Video conferencing (e.g., FaceTime, Skype)
- ☐ Other, specify: _____

16. Do you regularly go to or participate in any of the following? (Check all that apply)

- ☐ Community center
- ☐ Gym or recreational center
- ☐ Library
- ☐ Local park & arts/cultural organization
- ☐ Neighborhood association (e.g., tenant association)
- ☐ Other community organizations
- ☐ Religious organization (e.g., church, temple)
- ☐ School
- ☐ Senior center
- ☐ Other, specify:
- ☐ None

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2019 NewYork-Presbyterian Community Health Needs Questionnaire

Demographics

17. What is your gender?

☐ Female ☐ Male ☐ Prefer to self-describe:_

☐ Gender non-binary ☐ Transgender

18. What is your sexual orientation?

☐ Asexual ☐ Gay, or lesbian ☐ Queer
☐ Bisexual ☐ Heterosexual or straight ☐ Prefer to self-describe:_

19. What is your race or ethnicity? (Check all that apply)

☐ American Indian or Alaskan Native ☐ Hispanic or Latino
☐ Asian or Asian American ☐ White
☐ Black or African American ☐ Other, please specify: _____

20. Were you born outside of the U.S.?

☐ Yes ☐ No (Skip to Q21)

20a. In what country were you born? _____

22. How well do you speak English?

☐ Very well ☐ Well ☐ Not well ☐ Not at all

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23. Do you prefer to get health care in a language other than English?

☐ Yes ☐ No (skip to Q24)

23a. Which language? _____

24. Where do you currently live or stay?

☐ Assisted living
☐ Group home
☐ Homeless, living in a shelter
☐ Homeless, living on the street
☐ Nursing/long term care
☐ Own an apartment/house
☐ Rent an apartment/house
☐ Staying with friends/family
☐ Three-quarter housing/Halfway house
☐ Other, please specify:____

25. What is the highest level of education you completed? (Check one)

☐ Never attended school or only attended kindergarten
☐ Grades 1 through 8 (Elementary)
☐ Grades 9 through 11 (Some high school)
☐ Grade 12 or GED (High school graduate)
☐ College 1 year to 3 years (Some college or Technical school, Associate's degree)
☐ College 4 years or more (i.e. Bachelor's, JD/MD/PhD)
☐ Other, please specify: _____

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26. What is your employment status (Check all that apply)?

- ☐ Homemaker/caregiver
- ☐ Not working
- ☐ Student
- ☐ Volunteer
- ☐ Working
- ☐ Other, please specify:_____

27. How many people are part of your household, including yourself, children and adults? __

28. During the past 30 days, have you felt angry, sad or frustrated as a result of how you were treated based on any of the following?

- ☐ Age
- ☐ Disability
- ☐ Economic status
- ☐ English language skills
- ☐ Gender
- ☐ Perceived immigration status
- ☐ Race/ethnicity
- ☐ Religion
- ☐ Sexual orientation
- ☐ Other, please specify: _
- ☐ No

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29. Would you be interested in participating in a focus group on health or receiving the survey results in the future? Your contact information will be maintained separately from your survey responses (Check all that apply)

- ☐ Yes, I am interested in participating in a focus group.
- ☐ Yes, I am interested in receiving the survey results.
- ☐ No, I am not interested in either. (Skip to end of survey)

29a. Please provide your contact information below

Name: _____

Email: _____

Phone Number: _____

Thank you for helping us better understand the health needs of your community!

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Hudson Valley Hospital

AMAZING THINGS ARE HAPPENING HERE

Thank You

Your feedback on this report is welcomed. You may send written comments to or request more information on this 2019 Community Health Needs Assessment at community@nyp.org.

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