NewYork-Presbyterian Hudson Valley Hospital

1980 Crompond Road Cortlandt Manor, New York 10567

Community Service Plan (CSP)

Implementation Plan 2019-2021

October 2019

Community Service Area:

Westchester and Putnam Counties

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Executive Summary

Introduction to Our Community Service Plan (CSP)

The NewYork-Presbyterian Hudson Valley Hospital (NYP-HVH), is a regional hospital of NewYork-Presbyterian. NYP-HVH completed a Community Health Needs Assessment (CHNA) to identify the needs of our community and develop a Community Service Plan (CSP) and detailed implementation plan. NYP-HVH is deeply committed to the communities residing in Westchester County, Putnam County, and the surrounding areas. NYP HVH 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. This summary outlines the data driven processes and priorities, partnership and collaborations, and community improvement initiatives for 2019-2021. Our priorities are aligned with the 2019-2024 New York State Prevention Agenda (NYS PA) to promote health equity with a focus on physical, mental, and social determinants of health.

Partner Involvement & Commitment

Utilizing a network approach, NYP HVH collaborated with NewYork-Presbyterian, Westchester County Health Planning Coalition (WCHPC), the Westchester County Department of Health (WCDOH), Citizen's Committee for Children of New York (CCC), Columbia University Irving Medical Center (CUIMC), Greater New York Hospital Association (GNYHA), local Community Based Organizations (CBOs), the New York Academy of Medicine (NYAM), and Weill Cornell Medical College (WCMC) to adopt a community focused process of collecting and analyzing measurable data (quantitative) and views voiced by the community (qualitative) from a variety of sources. The collaborative process ensured significant input from the key stakeholders and local community through questionnaires and focus groups conducted in several languages. This allowed the system to develop a focused implementation plan to meet the needs of those we serve.

Data Driven Priorities

NYP-HVH compiled measurable data and input from the community from numerous sources in order to analyze the health and challenges of our community. The analysis utilized county and ZIP code data for metrics and included data related to demographics, socioeconomic status,

insurance status, social determinants of health, health status, health service utilization, and the New York State Prevention Agenda. Community input sources included focus groups and community questionnaires and allowed involvement from a diverse group with respect to culture, race, language, age, gender identity, and sexual orientation. Data resources utilized include the Behavioral Risk Factor Surveillance System (BRFSS) New York State, CARES Engagement Network, Claritas, New York State Community Health Indicator Reports (CHIRs), Robert Wood Johnson County Health Rankings, State Cancer Profiles, and the United Hospital Fund.

The collected data was ranked to provide detailed insight into the communities with high disparities and was then prioritized to determine the highest health priorities for the identified communities. The prioritized process utilized both quantitative health metrics and the qualitative community input data; the results of the prioritization process provided detailed insight into the health needs and challenges of the community and allowed NYP HVH to determine which focus areas and goals, as outlined in the New York State Prevention Agenda, to focus on to address the identified needs.

Progress Improvement Tracking

NYP-HVH is committed to the successful implementation of each initiative and will utilize quality process improvement efforts to report on process and outcome measures in order to adapt each program to meet the annual expectations outlined as well as meet the needs of our community.

Community of Focus

Based on the completed data process, NYP-HVH, in partnership with local community-based organizations, will target the City of Peekskill for the Community Service Plan. The community has been identified as having high disparities, both health and social determinants of health, through the CHNA process. Additionally, Peekskill has been identified as an opportunity zone by the *Tax Cuts and Jobs Act* to incentivize private investment into economically distressed communities.

Priority Areas of Focus

The analyzed and prioritized data allowed for the identification of a community of focus as well

as priority areas to impact the health of the most vulnerable populations. NYP HVH will target efforts in Peekskill related to the prevention of (1) chronic disease, (2) promotion of healthy women, infants, and children, and (3) promotion of well-being to prevent mental health and substance abuse. To align with the constantly changing dynamics of the community, NYP-HVH has revised the focus and initiatives as compared to the 2013 – 2016 community service plan which included the prevention of chronic disease through the Healthy Heart program and reduction in obesity through improved breastfeeding rates at discharge.

NYS Prevention Agenda Priority Area & Focus	Intervention / Strategy
Prevent Chronic Disease	
Goal 1.1 Increase Access to Healthy and Affordable Foods and Beverages	• Implementation of the CHALK (Choosing Healthy & Active Lifestyles for Kids) to address food insecurities and obesity.
Promote Healthy Women, Infants, & Children	
Goal 1.2 – Reduce Maternal Mortality And Morbidity	• Implement the Healthy Steps – 2 generational approach model for improving maternal-child health in primary care and community settings by providing integrated mental health services to low-income, and uninsured pregnant women and the newborn child, and establishing co-management strategies with partner community agencies

Introduction

NewYork-Presbyterian Hudson Valley Hospital (NYP-HVH), is a regional hospital of NewYork-Presbyterian, with a long history of providing high quality health care to residents of Westchester, Putnam and Lower Dutchess Counties. A fully accredited, general, not-for-profit 128-bed hospital with a wide range of inpatient, ambulatory, and diagnostic services supported by high quality physicians and staff. In collaboration with NewYork-Presbyterian Medical Group Hudson Valley and ColumbiaDoctors, the faculty practice of Columbia University Irving Medical Center, our patients have access to 450 highly skilled and dedicated physicians who provide advanced diagnostic and treatment expertise in 62 specialties.

NYP-HVH strives for excellence, which is shown by national and regional accreditation recognition such as three consecutive Magnet achievements, Press Ganey "Guardian of Excellence Award for Patient Experience in Ambulatory Surgery", and the American Heart Association/American Stroke Association Gold Stroke Honor Roll Elite. The hospital is also certified as Baby-Friendly by Baby-Friendly USA, a joint initiative of the World Health Organization and the United Nations Children's Fund.

Our Commitment to Care is to put patients first and we strive to continuously improve to meet the needs of our community by ensuring quality of care, patient satisfaction, and innovation in healthcare processes at our facility as well as within the community.

Purpose

NYP-HVH is deeply committed to the community members residing in Westchester and Putnam Counties as well as the surrounding areas and delivers a wide-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. In addition to the medical services provided to patients, NYP-HVH offers numerous community-based activities including monthly healthy cooking classes, bi-monthly farmers market, and educational social lectures on a variety of health-related topics.

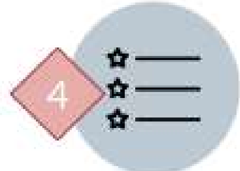
The CHNA process is undertaken every three years to determine the high need communities and health disparities that can be most positively impacted by focused interventions and initiatives supported by the NYP-HVH. The CHNA aligns with the New York State 2019-2024 Prevention Agenda priorities to improve health equity for all New Yorkers through partnerships with community organizations to address social determinants of health (SDoH) and align interventions to reduce health disparities. The alignment of regional and state-wide initiatives with the Prevention Agenda has allowed the state to improve its overall national ranking from 28th to 10th healthiest state since 2008.

NYP-HVH completed the 2019 CHNA process to update our understanding of our community and the factors that are influencing our community members' physical and mental well-being. This understanding has informed our three-year CSP to create initiatives to improve the health and well-being of local community members living in high disparity neighborhoods that we serve. The CHNA and CSP data collection and action planning process utilized by NYP-HVH was designed to ensure a comprehensive analysis of the community need.

Obtaining ***broad community input*** regarding local health including medically underserved and low-income populations

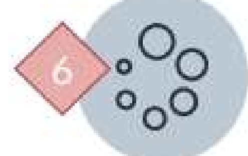
Collecting and evaluating ***quantitative data*** for multiple indicators of demographics, socioeconomic status, health, and social determinants

Preparing an analysis resulting in the ***identification of the high disparity neighborhoods*** in the NewYork-Presbyterian Hudson Valley Hospital community



Prioritizing complex health needs utilizing a comprehensive model

Ensuring ***integration with the Priority Areas of the 2019-2024 New York State Prevention Agenda***



Including the ***description of each process and methodologies*** utilized

Making the CHNA ***results publicly available*** online

Figure 1Process Overview

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 and improved. For the purpose of this document:

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.

Process & Governance

NYP-HVH engaged in a collaborative effort with NewYork-Presbyterian to create a collaborative, community focused approach to the development of the CHNA. A robust governance structure was created with representation from each campus hospital key stakeholders, community groups, and community health experts. The following committees were convened for this

process:

- ***Data Committee –*** managed the data collection and analysis process to ensure data integrity and inclusion of social determinant of health indicators and quality health indicators.
- ***Methods Committee –*** created the processes to engage community members in the CHNA process through community health needs questionnaires and in-person focus groups.
- ***Steering Committee –*** leadership engaged in oversight of the CHNA development and strategic decision making for the CHNA and CSP.

In addition to the formal committee structure, Community Health Think Tank meetings were held across the hospitals to engage key members in the planning process for the initiatives and process to operationalize each intervention. The Community Health Think Tanks are an ongoing process to engage key stakeholders in a performance improvement process and provide feedback for reporting to the system on the progress for the CSP.

Partner Engagement

NYP-HVH engaged in a multi-layered collaborative approach to conduct the 2019 CHNA process by participating with multiple partners to complete the process. One alliance was with the Westchester County Health Planning Coalition (WCHPC) which is a coalition of the Westchester County Department of Health (WCDOH) and 16 local Westchester County hospitals. WCHPC completed an analysis of quantitative and qualitative data elements as a 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 their community.

Along with the WCHPC partnership, NYP HVH partnered with NewYork-Presbyterian and collaborated with Citizens' Committee for Children of New York, Columbia University Irving Medical Center, Weill Cornell Medicine, New York Academy of Medicine (NYAM), and Greater New York Hospital Association for this CHNA process. Through such collaborations NYP-HVH was able to adopt a resource-rich community-engagement approach that involved collecting and analyzing qualitative information from the community at large and quantitative data from a variety of publicly available sources to comprehensively assess the health status of our communities. Each stakeholder added to the ongoing work by providing insight on the publicly available data for the various regions specific to the high disparity communities, while providing guidance on collecting stakeholder and community feedback and incorporating best practices for the CHNA.

Through this process, the data was refined and validated through the use of community input as well as other community assessments, such as the Westchester County Health Summit, the Westchester County survey, and the Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment.

NYP-HVH partnered with NYAM to facilitate community focus groups to attain input on the health and needs of the community at large. NYP-HVH partnered with several community-based organizations to host focus groups:

Hudson Valley Gateway Chamber of Commerce
Since 1915

- Caring for the Hungry and Homeless of Peekskill (CHHOP)
- Hudson Valley Gateway Chamber of Commerce
- HRHCare Community Health
- The Field Library in Peekskill
- Yorktown Chamber of Commerce
- Yorktown Seniors Advisory Committee

The ability to engage, analyze, and plan with our community-based partners allowed NYP-HVH to develop thorough implementation plans utilizing evidence-based criteria to identify initiative-based partnerships for 2019 – 2021.

Data Mining & Analytics

The robust data collection and analytic process that NYP-HVH underwent for this CHNA process ensured that community needs are well represented through the development of documents and strategies. The process used quantitative and qualitative data to illustrate the health needs of the Westchester County and Putnam County communities. The quantitative data was focused at a ZIP code and county level, while the qualitative data focused on viewpoints of community members obtained through questionnaires and focus groups. Additionally, NYP-HVH utilized numerous additional data sources to provide a robust picture of the community, including the WCDOH county CHNA quantitative data analysis and survey and the needs assessment done by the HICCC.

Quantitative Data

NYP HVH utilized data sets from multiple sources to analyze community health need and risk of high disparity geography to the specific ZIP code level. The analysis utilized the ZIP code geography of 29 indicators across five domains: demographics, income, insurance, access to care and New York State Department of Health Prevention Agenda Priorities. Indicator categories included demographics, socioeconomic status, insurance status, social determinants of health, health status, and health service utilization. These were collected to assess community health needs, to identify disparities, to utilize in prioritizing the implementation strategies and to support health intervention planning (See data sources in Appendix A).

Qualitative Data

Qualitative data was gathered, validated, and refined using (1) community input from facilitation of focus groups and administration of community health need questionnaires to area residents as well as (2) leveraging other community assessments performed in the community. The community input from multiple sources allowed for a comprehensive representation of our community inclusive of multiple languages, socio-economic statuses, culture, race, age, and gender identity. Summaries of each qualitative input source are included below, and additional details can be found in the Community Health Needs Assessment at https://www.nyp.org/about-us/community-affairs/community-service-plans.

New York Academy of Medicine – Community Health Needs Questionnaires (CHNQs) & Focus Groups

NYP-HVH partnered with NYAM to conduct CHNQs and focus groups of community members. The CHNQs were administered at community events and focus groups, and offered online. Respondents from targeted demographics were represented in the response rate. NYP HVH received 153 responses to the CHNQs with 52.3% being completed in-person and 47.7% being completed online.

Additionally NYAM partnered with six community-based organizations to conduct focus groups to gain insights on health challenges, community health needs, and ways to inprove personal and community health. Participants were engaged in discussions, facilitated by NYAM, on health care, exercise, food, available services in the community, telehealth, mental health, and more. Participants were able to express their opinions on their personal experiences, resources their communities have access to, and the challenges they face.

Westchester County Community Health Survey

The WCDOH conducted a community health survey of Westchester County residents as part of its CHNA process. The survey asked residents to rank what the top priority health issues are for the community, how best to improve community health, populations that require the greatest attention, and how you describe your personal health. The survey was conducted for the entire county of Westchester, and we partnered with NYAM to conduct a sub-analysis of the ZIP codes within the NYP HVH community specifically to include in our CHNA process.

Westchester County Community Health Summit

The Westchester County Health Planning Coalition collaboratively hosted a Community Health Summit 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 NYS Prevention Agenda priority areas. Over 70 attendees across health and community-based organizations participated in the facilitated breakout sessions and an engaging gallery walk intended to promote conversation focused upon four of the NYS PA priority areas:

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.

Herbert Irving Comprehensive Care Center of Columbia University Community Health Needs Assessment

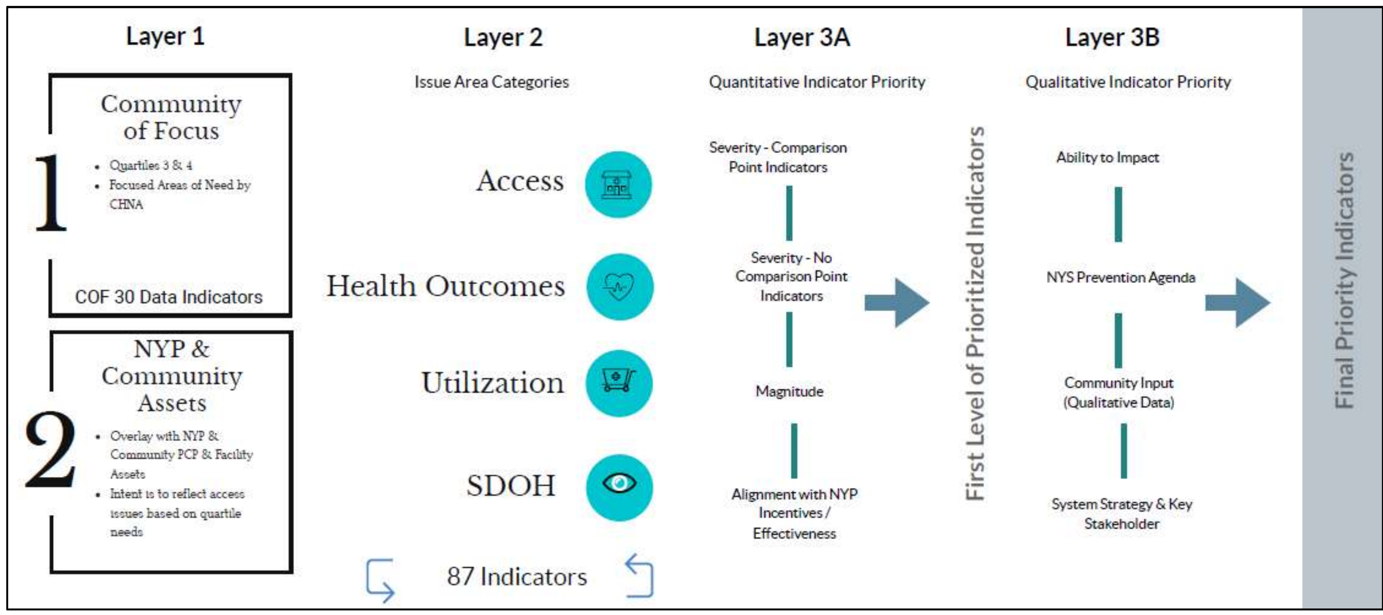
In 2018, the Herbert Irving Comprehensive Cancer Center of Columbia University conducted a Community Health Needs Assessment. The assessment, developed with 15 other National Cancer Institute funded sites across the country, was further refined with New York specific questions through collaboration with the Albert Einstein and Mount Sinai Cancer Centers. The 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 catchment area for their work comprises 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. The survey has preliminarily received 1,021 responses.

Disparity Prioritization Process

A prioritization process was created to analyze the quantitative and qualitative data inputs collected through the CHNA process. The process had several layers in which the data was input and prioritized to arrive at the final priority indicators.

- *Layer 1* –geocoded health issues were sorted into quartiles. Issues in the 3rd and 4th quartiles (high risk areas) were then further analyze in the next layer.
- *Layer 2* – the data indicators were grouped into four categories (1) Access, (2) Health Outcomes, (3) Utilization, and (4) Social Determinants of Health.
- *Layer 3A* – the quantitative data was ranked based on three criteria: (1) severity – with a comparison to NYS or without a comparison, (2) magnitude of the population impacted, and (3) alignment with current NYP HVH initiatives.
- *Layer 3B* – the 3rd and 4th quartile (highest risk) data from layer 3A was utilized for layer 3B of the model; the qualitative data for this section was ranked based on four indicators of (1) ability to impact the indicator, (2) alignment with the NYS PA, (3) Community Input, and (4) NYP stakeholder input



Prioritized Community Needs

The data identification and prioritization process for NYP-HVH resulted in numerous indicators in the top quartile to focus efforts and identification of multiple potential initiatives to impact the

community of highest need. The prioritization model does not preclude the hospital from investing in other opportunities but does allow for a community-based strategy utilizing partners to reach the most vulnerable populations.

At a high level, the indicators in Table 1 can be grouped into the following categories:

- Women's Health / Maternal Health
- Chronic Disease & Obesity
- Mental Health & Substance Abuse
- Cancer

Table 1

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

Utilization	Emergency Dept.: All Visits	4th
Utilization	Hospitalizations: Drug	4th

Our Community At Large

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 ZIP codes to create continuity in geographical boundaries. This resulted in a total of 22 community ZIP codes in northern Westchester County and southern Putnam County.

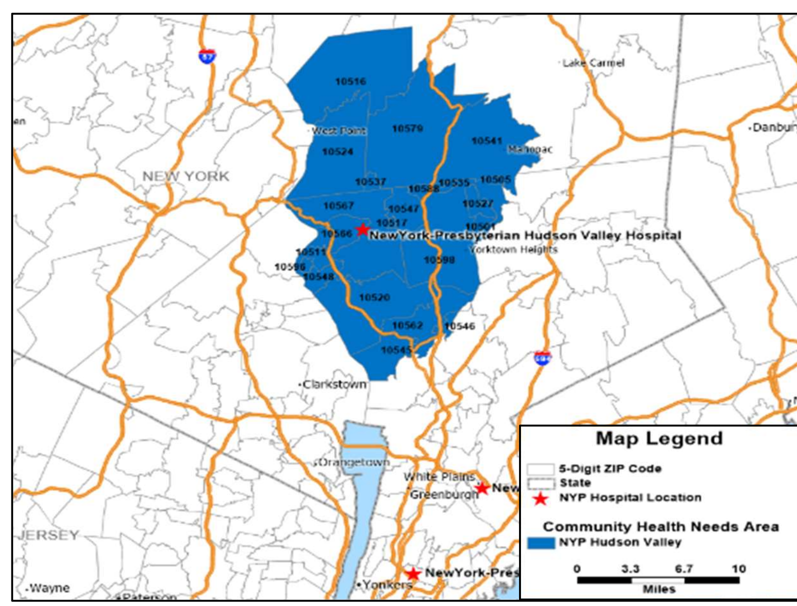


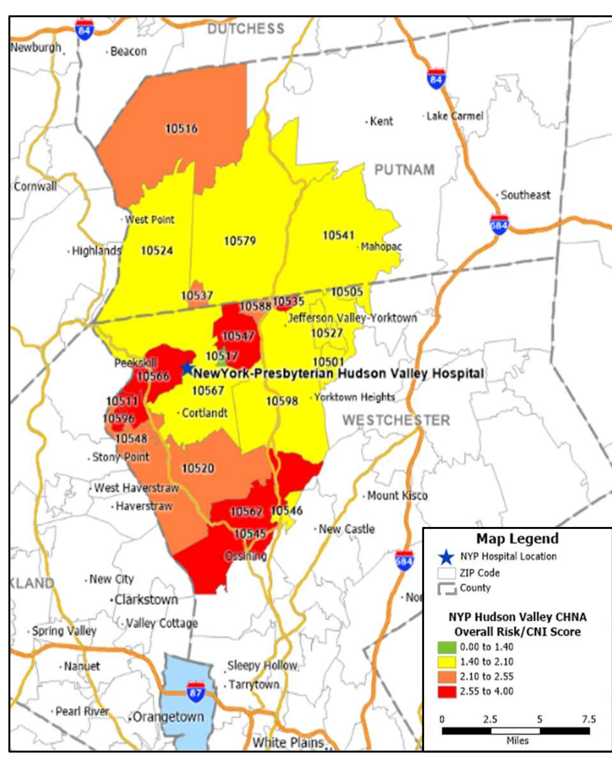
Table 2

NYP-HVH Defined Community Highlights

192k PEOPLE The defined community covers a geography of approximately 192k people	**1.7% POPULATION GROWTH** Forecasted to grow faster, 1.7%, than the state average, 1.5%, between 2019-2024	**17.5% 65+ POPULATION** Is slightly older with 17.5% of the population aged 65+ compared to 16.3% for NYS
$138,293 HOUSEHOLD INCOME The average household income, $138,293, is higher than the average of New York State, $101,507	**5.5% UNEMPLOYMENT RATE** The unemployment rate, 5.5%, is lower than the state benchmark, and there are more white-collar workers than the state average	**LOWER MINORITY POPULATION** Higher White population, 64.9%, than the state, 54.4%, higher Hispanic community at 22.2% compared to NYS, 19.6%

Our Community of Focus

The NYP-HVH communities of highest disparity were determined through an analysis of 29 indicators. The indicators were selected across five domains: demographics, income, insurance, access to care and New York State Department of Health Prevention Agenda Priorities. The objective of this analysis was to determine the ZIP codes where the health needs were comparatively higher within the NYP-HVH community. Through this analysis 11 of the 22 ZIP codes were identified as higher disparity and could benefit from focused community health improvement efforts. In particular, the ZIP codes in the 4th quartile (highest disparity ZIP codes, shown in red in above map) are located in Westchester County.



The highest disparity ZIP codes for NYP-HVH are shown in Table 3 along with their (explain CNI score info).

Table 3

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

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:

Barrier	Statistic
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.

Peekskill, in addition to being the community with the highest disparities, has also been designated as an Opportunity Zone under the *Tax Cuts and Jobs Act*, which allows for tax incentives for private investment into economically distressed communities. Opportunity Zones were developed to spur economic development in distressed communities throughout the country by providing tax benefits to investors who invest in such communities. Such communities were categorized as economically distressed by the federal government and provide an additional point of validation for focused interventions & commitments by providers within the community.

Westchester County Data Highlights for NYS PA Priority Areas

Prevention Agenda Priority Area	Westchester County	NY State Community Health Indicator Report Trends
Prevent Chronic Disease Focus Area 1: Healthy Eating and Food Security	**Adult Obesity, Percent of Population** Westchester County, 17.7% ↓ NYS, 25.5% **Child Obesity, Percent of Population** Westchester County, 13.7% NYS, 17.3%	Trend data suggests that there is some improvement among elementary school aged children, but among middle school and high school aged children, Obesity has worsened in Westchester County. There is no trend data for adult obesity in Westchester County.
Promote Healthy, Women, Infants and Children Focus Area 1: Maternal & Women's Health	**Percent of preterm births among all live births** Westchester County, 9.2% ↨ NYS, 8.8% **Rate of infant deaths (under one year old) per 1,000 live births** Westchester County, 4.6% ↨ NYS, 4.8%	According to CHIRS Data, the percentage of preterm births (<37 weeks gestation) has not had a significant difference from the NYS rate.
Promote Well-Being and Prevent Mental and Substance Use Disorders Focus Area 1: Promote Well-Being Focus Area 2: Prevent Mental and Substance Use Disorders	**Self-reported binge drinking, percent of population** Westchester County, 20.7% ↑ NYS, 18.3%	According to the Open Data Network binge drinking for Westchester County is increasing and was reported at 16.70% in 2015.

Community Challenges & Contributing Factors

The NYP-HVH community is slightly older, on average, with projected growth in the age 65+ population which traditionally utilizes services at a higher rate. The community has a lower than New York State average of minority population, but growth is projected among Hispanics, Asian/Hawaiian/Pacific Islanders, and African Americans while the White population is not expected to grow. The social determinants of health concerns are lower than state averages but there are still issues related to food insecurity, housing security, and behavioral risk factors such as smoking and drinking.

Health care access in the community is a challenge, along with access to mental health and substance abuse providers due to the lack of providers. Telehealth/Telemedicine resources have not been established thoroughly in the community and could provide alternative options to treatment.

Focus Groups, Community Health Needs Questionnaires, and county surveys indicated the community is concerned about substance abuse, cancer, chronic diseases, housing, and cultural diversity in healthcare. The qualitative data is summarized below.

Community Health Needs Questionnaires

NYAM received 153 CHNQs for the NYP HVH community. The top reported community health issues are summarized in Table 4.

Table 4

Mostly 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 less than 30% of the time are not presented.		

Additionally, respondents were asked to make recommendations on ways to improve community health. These are listed in Table 5.

Table 5

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 less than 24% of the time are not presented		

Focus Groups

NYAM conducted seven (7) focus groups with community members in English and Spanish in the Hudson Valley community to gain insight into participants views on health and the challenges they face personally, and what they see as obstacles in the community to achieving improved health community wide.

Greatest Health Concerns
- Asthma
- Cancer
- Diabetes
- Heart Disease
- HIV
- STDs

Social Determinants of Health
- Affordable Housing
- Affordable Healthy Food

Other
- Many travel outside the county for healthcare needs
- Limited Mental Health services
- Providers are reluctant to give pain meds when needed due to opioid crisis

Recommendations
- Improved community outreach - health fairs, educational programs, etc.
- Limited 24 hr. pharmacies
- Sensitivity training for providers on populations served

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.

I feel like the only thing in Peekskill is pizza and Chinese food to order.

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.

To me, health means being able to navigate through your life without having health issues interfere with you. That's number one. And number two, having facilities and services available to you when you do have a serious health issue and having quality services.

We can talk about disease and things, heart disease, that's another huge – especially in women, it's off the charts.

I feel like also, mental health, people are not getting the mental health [services] that they need. That's why they're probably using drugs, because I know with me, I used to smoke marijuana, because I had a lot of anxiety and depression. So, when I couldn't get the help that I needed, I would smoke marijuana.

Westchester County Community Health Summit

Attendees identified strengths and resources in the community, barriers and gaps to improvement, action items that would benefit and align with the NYS PA priority areas, and SDoH that are essential to any developing strategies. Such findings included recommendations to utilize schools and other non-traditional organizations for a delivery of resources such as education and outreach, and utilization of culturally sensitive programs to outreach to the community.

Other Community Feedback – Focus on Cancer

Due to the tremendous burden of cancer on physical, mental and economic well-being and recognizing that the senior age-cohort 65+ is disparately impacted by this disease, NYP-HVH is undertaking additional community research with a focus on cancer. This study was not complete at the time of publishing this Community Service Plan so only highlights of preliminary findings and anticipated next steps are included below:

Herbert Irving Comprehensive Care Center of Columbia University Community Health Needs Assessment

The HICCC preliminary survey results have shown:

1. Strong interest in genetic screening information across cancer patients and family members, NewYork-Presbyterian patients and the community. HICCC Community Outreach and Engagement (COE) has developed and tested in over 500 individuals a precision medicine curriculum that has been very successful in teaching complex concepts like the difference between sporadic and germline mutations. Sixty percent (60%) of the workshops were conducted in Spanish.

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 NYPH clinics.
3. The cancer screening rates are high in the NYPH and community respondents with exception of colorectal screening rates that are lower in the community.

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.

Health Care Policy Potential Impact

Health Care Policy Potential Impact

The health care policy environment can and does contribute to community-wide health improvement or conversely, to its challenges. Several policies have been identified as affecting residents of New York and the environment in which NYP operates. The NYP Government and Community Affairs team will continue to monitor and communicate changes within the health care policy environment in order to inform patient care and community-based initiatives.

Initiatives in the CSP were developed considering the following policy environment:

Federal Change in Public Charge Rule

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." Once the rule is enacted, officials will now 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.

Affordable Care Act Challenge

A group of states presented a legal challenge to the Affordable Care Act (ACA) on the grounds that the individual mandate was unconstitutional. The case is now before a Federal Appeals

Court, which could issue a ruling at any time. If the ACA were, in fact, ruled unconstitutional, that could mean 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 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 eliminated.

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

New York State has filed for an extension of its 1115 Waiver for the DSRIP initiative. If approved, the extension would further support clinical transformation efforts focused on the Medicaid population. 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.

Elimination of religious exemptions to vaccinations for school aged children

Amid an ongoing measles outbreak, New York State enacted a law in June 2019 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

In September 2019, New York State attempted to enact an emergency ban on the sale of flavored electronic cigarettes and nicotine e-liquids. This move was temporarily blocked by the courts but New York State continues to pursue a ban. The proposed 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.

Marijuana Decriminalization

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. 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.

Ending the Epidemic

New York’s Ending the Epidemic 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 in 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.

Maternal Mortality Review Board

Governor Cuomo signed legislation to create a Maternal Mortality Review Board charged to review the cause of each maternal death in New York State. 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.

Community Service Plan – Focus & Interventions

Community of Focus

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

Priority Areas of Focus

- The 2016-2018 Community Service Plan focused on addressing obesity in children and adults through breastfeeding at discharge. NYP-HVH increased the breastfeeding rate at discharge to 94% through education and support within 1 hour of birth. Our plan also addressed heart disease. Through our Healthy Heart program, participants experienced positive improvements in blood pressure and weight loss.

NYP-HVH remains committed to serving the community by providing health care services and activities that benefit our community members. The hospital is continuing breastfeeding promotion and the Healthy Heart program, along with numerous other outreach activities, which are listed in the appendix. To respond to New York State's call to identify two priorities and address disparities, we are additionally committing to the following two new initiatives which will be monitored and evaluated over the next 3 years.

The initiatives below respond to the following Prevention Agenda Priorities:

- Prevent Chronic Disease – Focus Area 1: Reduce Obesity & the Risk of Chronic Disease
- Goal 1.2 – Reduce maternal mortality and morbidity.

The 2019-2021 Community Service Plan was reviewed and approved by Executive Leadership and the Board of Trustees on December 3, 2019.

2019-2021 Community Service Plan Initiatives

Prevent Chronic Disease – *Focus Area 1: Reduce Obesity & the Risk of Chronic Disease*

Goal 1.1 - Increase access to healthy and affordable foods and beverages

Objective – Utilize a culturally sensitive process to empower organizations to focus on nutrition and physical activity, Promote wellness through community-based partnerships, and address food insecurities.

INTERVENTION EXPLAINED: Choosing healthy & active lifestyles for kids (*CHALK*) is *New York-Presbyterian's* obesity prevention program. CHALK aims to address obesity using a socio ecological model as its theoretical framework. The program will drive system and environmental changes that produce long lasting improvements around wellness in the targeted community of Peekskill. CHALK's multipronged approach as currently implemented in Washington Heights/Inwood includes:

- Mobile market (client-choice style mobile food pantry serving food insecure patients by household size, up to 200 individuals per distribution; connection to community resources, cooking demonstrations, and benefits enrollment)
- Fruit and vegetable prescription program (coupons redeemable for produce at local farmers markets for patients seen at hospital community-based primary care sites ($10/month))
- Elementary schools partnership (non-prescriptive partnership model, creation of wellness councils, implementation of wellness policies, staff professional development, nutrition education, connection to community resources and partners, built environment changes that promote healthy lifestyles).

EVIDENCE-BASE:

1. **Mobile Market And Fruit And Vegetable Prescription Programs:**

Food insecurity is associated with poor health status (aha, 2017). Accordingly, CHALK's mobile market and fruit and vegetable prescription programs join health systems nationwide in developing best practices to address social determinants of health. Promedica, an early adopter in Toledo, Ohio, launched food pharmacy, nutrition consultation, and meal distribution programs that resulted in decreased emergency room utilization and increased primary care

appointments, while reducing hospital readmissions by 53% (aha, 2017). Health-system led food pantries are an important resource for immigrant families in NYC who are less likely to access government programs (Gany et al, 2015). Obese, low income participants in fruit and vegetable prescription programs have experienced greater reductions in BMI compared to a control group (Cavanah et al, 2016). This and other food insecurity initiatives can contribute to obesity-prevention (Chen Cheung et al, 2015). Rolling out initiatives in partnership with community leaders is recommended by the American academy of pediatrics toward reducing racial disparities in obesity (Trent et al, 2019). The Mobile Market is operated by Westside Campaign Against Hunger (WSCAH), together NYP and WSCAH will partner to implement the Mobile Market in Peekskill, New York.

American Hospital Association. (2017). *Social Determinants Of Health Series: Food Insecurity And The Role Of Hospitals.* Http://Www.Hpoe.Org/Reports-Hpoe/2017/Determinants-Health-Food-Insecurity-Role-Of-Hospitals.Pdf

Cavanagh, M., Jurkowski, J., Bozlak, C., Et Al. (2016). Veggie Rx: An Outcome Evaluation Of A Healthy Food Incentive Programme. *Public Health Nutrition, 20(14),* 2636-2641.

Chen Cheung, H., Shen, A., Oo, S, Et Al. (2015). Food Insecurity And Body Mass Index: A Longitudinal Mixed Methods Study, Chelsea, Massachusetts, 2009-2013. *Preventing Chronic Disease: Public Health Research, Practice And Policy, Cdc, 12,* 150001.

Gany, F., Lee, T., Loeb, R., Ramiraz, J., Et Al. (2015). Use Of Hospital-Based Food Pantries Among Low-Income Urban Cancer Patients. *Journal Of Community Health, 40(6)*, 1193-1200.

Trent, M., Doodley, D.G., Dougé, J. (2019). American Academy Of Pediatrics Policy Statement: The Impact Of Racism On Child And Adolescent Health. *Pediatrics, 144(2)*.

2. Elementary Schools Partnership:

CHALK’s existing elementary school partnerships in northern Manhattan have increased access to healthy lifestyles for students and their families. The CHALK model strengthens school-based wellness councils and policy implementation, increases physical activity and nutrition programing, and connects stakeholders with community partners to support sustained success post-partnership (Jarpe-Ratner et al, 2013; Rausch et al, 2015).

Jarpe-Ratner E, Zamula A, Meyer D, Nieto A, McCord M. (2013). The Healthy Schools Healthy Families Program–Physical Activity Integration Into Elementary Schools In New York City. *Journal Of Community Medicine And Health Education, 3*, 194.

Rausch J C, Berger-Jenkins E, Nieto A, McCord, M & Meyer, D. (2015). Effect Of A School-Based Intervention On Parents' Nutrition And Exercise Knowledge, Attitudes, And Behaviors. *American Journal Of Health Education, 46(1)*, 33-39.

PERFORMANCE MEASURES:

- **Mobile market:** decrease food insecurity prevalence among patients participating in the program (5% decrease over 12 months); increase access to emergency food in underserved neighborhoods (10,000-20,000 lbs food distributed over 12 monthly distributions, reaching approximately 100-150 individuals per distribution); increase connection to external emergency food resources (30-50 households connected with local food pantries via optional site visit and maps customized by patient ZIP code)
- **Fruit and vegetable prescription program:** increase access to healthy and local produce (30-50 prescriptions redeemed by patients for fruit and vegetable coupons per season May-Nov, access to $10,000 in fruit and vegetable coupons redeemable for produce at farmers markets); increase fruit and vegetable prescription and coupon redemption (70% coupons redeemed for fresh fruits and vegetables per season)
- **Elementary schools partnerships:** increased participation in school wellness councils (25% increase over 12 month), development and adherence to wellness policy (25% increase in action items led by non-chalk members over 4 years); improve built environment (successful completion of at least one built environment improvement project per partnership); increase school capacity through connection to resources and CBO partners (3 key resource or partnership connections made each year).

PERFORMANCE MEASURES AND TIME TARGETS 2019-2021

- Recruit program coordinator to support expansion
- Partner with NYP CHALK team to train new staff on program strategy, partnership model, implementation and evaluation tools
- Finalize identification of community partners
- Build relationships between clinicians, school administrators, farmers markets, and community-based partners to co-design program rollout (one-on-one meetings and focus groups)
- With community input, identify programs to be tailored and implemented at each campus from pre-set menu of options: mobile market, fruit and vegetable prescription program, and school partnerships.

- Ongoing program evaluation and quality improvement

Mobile Market and Fruit & Vegetable Prescription Programs:

- Establish initial sites for mobile market and fruit & vegetable prescription programs (partner with local food pantries and farmers markets)
- Onsite planning and recruitment to launch selected program(s)
- Engage key stakeholders to compile feedback on initial rollout, co-design program improvements
- Identify sites and champions to facilitate continued program expansion
- Continue to assess and improve implementation strategy in collaboration with partners

School Partnership:

- Identify potential school partners and assess organizational readiness. Launch one partnership in September 2020; complete baseline school assessment.
- Continue engagement with current school partners.

IMPLEMENTATION PARTNER(S):

- West Side Campaign Against Hunger
- Westchester County Department of Health
- Additional partnerships*

*CHALK is built on a responsive partnership model that couples capacity building support for grassroots community-based organizations with targeted resource connection, bridging local organizations, farmers markets, schools, NYP clinical teams, and patients. In year 1, program staff will conduct a community assets assessment in each target community to identify potential partners, service providers, and collaborators. Partnerships with 5-10 of these organizations (host sites, healthy food suppliers, and resource providers) will begin in year 2.

Promote Healthy Women, Infants and Children **–** *Focus Area 1: Maternal & Women's Health*

Goal 1.2 – Reduce Maternal Mortality And Morbidity.

Objective: This program aims to reduce racial, ethnic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.

INTERVENTION EXPLAINED:

Our overarching goal is to develop a two-generation approach for improving maternal-child health in primary care and community settings by providing integrated mental health services to low-income and uninsured pregnant women and the newborn child, and establishing co-management strategies with partner community agencies. We will implement an enhanced healthy steps model using telehealth to meet mothers in their home environment and integrate community health workers to ensure that families can successfully navigate the medical and social service system. Healthy steps is an evidence-based national primary care model that aims to improve the health and well-being of mothers and their newborns. In the area surrounding the targeted community of Peekskill, we will participate in an existing community agency consortium whose focus is on maternal-child health in order to implement prevention strategies at a population level.

PERFORMANCE MEASURES:

Maternal Health: Decrease no show rates for postpartum checkups, increase rates of depression screenings, treatment and follow up for maternal depression, increase rate of contraception used in postpartum period, and reduce unmet caregiver health care and social service needs.

Infant Health: Increase rates of breastfeeding, improve adherence to child well visits, increase connection and reception of early intervention services rates of developmental screening at 9-months.

PERFORMANCE MEASURES AND TIME TARGETS 2019-2021:

- Create a continuum of care between pediatrics, women's health, and behavioral health by identifying a champion in each area and creating system-level links among all disciplines
- Create a risk stratification approach and associated bundles of care that include biomedical and psychosocial criteria
- Implement the enhanced healthy steps model with telehealth and community health workers
- Identify partner community social service agencies and federal qualified health centers and implement a co-management strategy for individuals with highest needs.
- Train and equip additional sites regarding two-generation approach for healthy steps model with telehealth.
- Tailor risk stratification and established model to needs of each site. Identify staffing gaps to support expansion.
- Identify and build connection with local community partners capitalizing on telehealth technology so that there is service equity and access regardless of location.
- Streamlined referral network between NYP-HVH and community partners.
- Training and equipping community partners on the healthy steps model positive parenting, parenting stress, parental support, birth readiness, breastfeeding and nutrition.
- Providing comprehensive tiered levels of care across NYP and community partners from prevention to high levels of treatment.

IMPLEMENTATION PARTNER(S):

- Columbia Doctors
- Weil Cornell Medicine
- Westchester County Department of Health
- More local partnerships to be identified

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Initiative Progress Tracking

Progress tracking will be maintained by the NYP HVH leadership team. Findings will be used as a quality performance improvement process to refine processes and program developmental efforts to ensure needs of the population are met. The updates will then to be used to compile an annual report to meet both the state and federal expectations of reporting.

Assets & Resources

NYP-HVH recognizes there are existing assets, resources, and partners which may be leveraged for both expertise and economies of scale to deploy initiatives collaboratively for the benefit of community health improvement. Several notable assets/resources follow.

Table 6

Asset Name	Brief Description
Young Chefs Teaching Kitchen	NYP-HVH Chef Peter X. Kelly Teaching Kitchen. The Teaching Kitchen is part of a larger initiative at the hospital called Harvest for Health aimed at using healthful eating as a way to prevent chronic disease and promote health.
Cheryl R. Lindenbaum Comprehensive Cancer Center	Center devoted to high quality, full range of comprehensive cancer care in a CoC credentialed Cancer Center and NAPBC Breast Center with dedicated staff who are highly trained and specialized.
Silver Lining Healthy Aging Fair	Annual fair with resources for the aging population
Baby Friendly	Initiatives with support groups both before and after delivery to support Breast Feeding. Lactation specialists work in OB and in the community.
Westchester County Department of Health	Participation in the Community Health Coalition
NYP Hudson Valley Hospital Magnet Nurses	Magnet Recognition from the American Nurses Credentialing Center (ANCC) is the highest and most prestigious distinction a healthcare organization can receive for nursing excellence, innovation, and high-quality patient care.
Hudson River Health Care	FQHC that provides coordinated medical, dental, and behavioral health care services

Website Availability

The Community Health Needs Assessment and Community Service Plan can be found on the NYP-HVH website at https://www.nyp.org/about-us/community-affairs/community-service-plans.

Appendix

Quantitative Data Sources

Data Source	Data Period	Publicly Available Website
Behavioral Risk Factor Surveillance System (BRFSS)	2016	https://www.cdc.gov/brfss/index.html
CARES Engagement	Varies by indicator 2013-2019	https://engagementnetwork.org
Claritas	2019	N/A
New York State Community Health Indicator Reports	Varies by indicator 2011-2017	https://www.health.ny.gov/statistics/chac/indicators/
Nielsen	2019	N/A
RWJ County Health Rankings	2013-2017	https://www.countyhealthrankings.org
State Cancer Profiles	2018	https://statecancerprofiles.cancer.gov/
United Hospital Fund	2011-2015, ACS Estimate	https://uhfnyc.org/publications/publication/new-york-counties-by-population-medicaid-enrollment-and-enrollment-rates-table