

2016 - 2018

# Community Health Improvement Plan



## Working to Keep Westchester Healthy

Westchester County Department of Health

## ACKNOWLEDGEMENTS

The Westchester County Department of Health (WCDH) would like to thank the members of the Westchester County Health Planning Team for their dedication and commitment.<sup>1</sup> For over eight months, the Team met frequently to develop community health surveys, review extensive data to select health priorities, and share proposed Community Health Improvement Plan (CHIP) interventions and activities.

In addition to the Planning Team, WCDH would like to thank those individuals and agencies that either completed and/or distributed surveys or provided information to the Team to inform the process.

The Westchester County Health Planning Team is committed to continuing its partnership and plans to meet on a quarterly basis to review CHIP progress and to discuss opportunities for collaboration.

**This report was prepared by Westchester County Department of Health and submitted to New York State Department of Health on December 30, 2016.**

---

<sup>1</sup> Appendix A: Detailed list of Westchester County Health Planning Team members

## TABLE OF CONTENTS

Executive Summary.....	1
Background and Purpose .....	5
Westchester County Demographics.....	6
Community Health Assessment.....	7
Community Health Surveys .....	7
Data Review Process.....	8
Community Health Improvement Plan.....	11
Communications and Engagement Strategy .....	16
2014-2017 Community Health Improvement Plan Update .....	17
Appendix A: Westchester County Health Planning Team .....	19
Appendix B: Community Health Needs Assessment: Provider Questionnaire .....	20
Appendix C: Community Health Needs Assessment: Community Questionnaire.....	22
Appendix D: Updated Prevention Agenda Dashboard.....	24
Appendix E: Health Planning Team Meetings.....	33

## EXECUTIVE SUMMARY

This report represents the 2016-2018 Community Health Improvement Plan (CHIP) for the Westchester County Department of Health and describes the health assessment and process through which the plan was developed.

In December 2013, WCDH submitted its CHA and CHIP to the New York State Department of Health (NYSDOH) for the period 2014-2017. In an effort to align with the hospital reporting period, local health departments were asked to submit an updated CHA/CHIP for the period of 2016-2018. For this cycle, WCDH built upon the successes and lessons learned from the 2014-2017 CHA/CHIP and realigned priorities to address critical health disparities. The process was guided by new data collected from needs assessment surveys of residents and community health providers in the County, and supported by data from sources such as the Prevention Agenda Dashboard and various epidemiologic profiles from the preceding plan. Working with local hospitals to form a Health Planning Team, WCDH and the hospital team members agreed to support the New York State Health Commissioner's request to align Prevention Agenda goals and implementation efforts with those in the Delivery System Reform Incentive Program (DSRIP).

Unlike many counties in New York State, Westchester County is served by a number of acute and specialty hospitals that due to their geographic location and specific hospital missions make it challenging for Westchester to select priorities that address the needs of the entire County. In addition, the healthcare landscape has dramatically changed since the preparation of the last CHIP with the formation of many new hospital mergers and affiliations that extend beyond the County.

As revealed by the needs assessment data, chronic disease persisted as the major health issue in Westchester. In addition, Mental Health and Substance Abuse appeared to be major concerns. Hospital partners found it more compelling to cultivate their current long-range initiatives in the chronic disease arena as their two main foci, but also pledged to address mental health/substance abuse alongside the WCDH.

As such, WCDH selected the following foci for the 2016-2018 CHIP:

- I. Prevent Chronic Disease: Reduce Obesity in Children and Adults
- II. Prevent Chronic Disease: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings
- III. Promote Mental Health and Prevent Substance Abuse: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Chronic disease interventions include a healthy corner store/bodega initiative, a worksite wellness program addressing nutrition and exercise, health education/promotional material campaigns, and the offering of evidence-based self-management programs. Such interventions were integrated with activities the department is currently pursuing with Hudson River HealthCare (HRHCare) through a Local Initiatives for Multi-Sector Public Health Action (Local IMPACT) grant. Interventions that address Mental Health and Substance Abuse focus on opioid overdose prevention and include medication drop boxes, take back events, and public health education including naloxone trainings. Activities were selected as extensions of current WCDH initiatives to maximize limited resources and prevent duplication of efforts. Initiatives in this plan will cover the entire County but will have special focus on six target communities:

Yonkers, New Rochelle, Mount Vernon, White Plains, Port Chester, and Peekskill. This focus will allow activities to address disparity in communities of low socioeconomic status and racial/ethnic minorities.

Westchester County Department of Health will be working with numerous partners to help execute the initiatives laid out in this plan. In addition to the partnership with HRHCare, WCDH will work with and utilize YMCA's existing program infrastructure (e.g. promotional materials, program tools) to implement the evidence-based National Diabetes Prevention Program. The WCDH will partner with a number of private businesses to provide consultations for worksite wellness and will also partner with a number of corner stores/bodegas to promote access to healthier foods and beverages.

To address opioid overdose prevention, there will be collaborations with the health professions community (e.g. schools of medicine/ pharmacy, EMS, professional organizations) and local law enforcement. Collectively, these partners will assist with the implementation of opioid abuse education and Naloxone training by offering materials, allowing workspace, and providing an audience, etc.

The WCDH will engage the broader community in addressing the overarching CHIP priorities through public event efforts within each priority area. Health promotional campaigns will be a component of interventions (i.e., promoting Healthy Corner Stores and the "Keep Healthy" initiative). Westchester County residents and health care professionals can access all "Keep Healthy" and substance abuse prevention materials on the WCDH website. Furthermore, the department will strive to keep the community engaged in health education events to

reduce non-prescription opioid use. The community is encouraged to attend advertised substance abuse prevention education and Naloxone trainings offered throughout the County.

In order to track progress and evaluate impact, the WCDH Division of Health Promotion will report activities to the Department's Planning and Evaluation Unit. Original data may be collected from either partnering organizations or directly from the Division of Health Promotion. Process measures for many activities include obtaining event and participant counts. The Division of Health Promotion will track activities as they are completed and the Planning and Evaluation Unit will periodically assess that the process measures are being met to assure intervention progress and success. The Department will work collaboratively to make sure CHIP activities are tracked, timelines are met, and specific measurable objectives are achieved.

The Westchester County Department of Health CHIP Action Plan will serve as a guide for our vision of a safe and healthy Westchester County. As such, the Department will use the *"Keep Healthy"* campaign as the overarching brand for both priorities and will work with the Westchester County Health Planning Team to ensure we are working together to Keep Westchester Healthy.

## BACKGROUND AND PURPOSE

The 2014-2017 Community Health Assessment and Improvement Plan was created as a roadmap for improving population health in Westchester County. For 2016, the NYS Department of Health charged local health departments to continue working together with hospitals to address identified community health priorities tied to the NYS Prevention Agenda 2013-2018.

The Westchester County Department of Health continues to monitor the NYS Prevention Agenda and collaborate with local public health partners to address the current health status and needs of County residents. The WCDH strives to develop interventions, programs, and initiatives to meet residents' needs and to improve health outcomes.

This report highlights findings from an abbreviated community health assessment, outlines the process by which priorities were chosen, and describes the goals, objectives, and action plans for the focus areas in an updated Improvement Plan for the 2016-2018 cycle.



## WESTCHESTER COUNTY DEMOGRAPHICS

Covering an area of about 450 square miles, Westchester County is home to nearly one million people as of the 2010 Census. The County is just North of New York City, bordered on the West by the Hudson River, on the North by Putnam County, and on the East by the Long Island Sound and Connecticut’s Fairfield County. Currently, the County contains six cities and 19 towns (many include incorporated villages within the town borders). The County’s population is diverse and ever-changing, with an increasing number of various minority groups and foreign-born populations.

<b>Westchester Population</b>			976,396		<b>Place of Birth</b>		
<b>Sex</b>					US Born		
Male			472,340	48.4%	724,341		
Female			504,056	51.6%	252,055		
					74.2%		
					25.8%		
<b>Race</b>					<b>Language Spoken at Home (Ages 5+)</b>		
White			648,511	66.4%	English only		
Black			142,311	14.6%	614,055		
Asian			58,978	6.0%	66.7%		
Two or More Races			28,932	3.0%	33.3%		
Other Race			97,664	10.0%	Other Language		
					<i>(Spanish)</i>		
					<i>(Indo-European)</i>		
					<i>(Asian/Pacific Island)</i>		
					<i>(Other)</i>		
<b>Ethnicity</b>					<b>Family Structure (Households w/ Own Children &lt;18)</b>		
Hispanic or Latino			236,042	24.2%	Married-couple Family		
Non-Hispanic/ Latino			740,354	75.8%	77,550		
					74.5%		
					19,239		
					18.5%		
					7,330		
					7.0%		
<b>Age Distribution</b>					<b>Educational Attainment (Adults 25+)</b>		
0-4			55,260	5.7%	Less than High School		
5-9			60,816	6.2%	87,374		
10-14			64,243	6.6%	13.1%		
15-17			41,115	4.2%	High School/GED		
18-24			87,510	9.0%	132,206		
25-44			237,467	24.3%	19.8%		
45-64			275,972	28.2%	Some College or Associate's Degree		
65-74			81,694	8.3%	134,812		
75+			72,319	7.4%	20.2%		
					Bachelor's Degree		
					159,043		
					23.8%		
					Master's Degree or Higher		
					154,017		
					23.1%		
					<b>Median Household Income</b>		
					\$86,108		
					<b>Population Below Poverty Level</b>		
					10.0%		
					<b>Unemployment (Age 16+)</b>		
					6.0%		

Source: 2015 American Community Service (1 year estimate), US Census Bureau.

## COMMUNITY HEALTH ASSESSMENT

Building on the previous cycle, the Westchester County Health Planning Team (WCDH and county hospitals) continued to work collaboratively on this project to each complete a Community Health Improvement Plan. For over eight months, the group actively participated in monthly meetings, communicated through emails and phone calls, and contributed to each stage of the Community Health Assessment.

One of the major objectives of the Health Planning Team's collaboration was to design and conduct a community health survey to assess the current health status of Westchester County residents. The team intended for this assessment to help reevaluate existing health improvement priorities to ensure selected priorities address the most current and critical health issues.

### Community Health Surveys

The assessment was carried out with two separate surveys distributed to health providers and county residents. Surveys were made available in paper-format and online through Survey Monkey. Surveys were offered in multiple languages; WCDH translated the survey into Spanish and hospitals had the survey translated into other languages based on the needs of their respective communities. Both WCDH and hospitals were responsible for survey distribution. Paper forms for community members were placed in waiting areas of various service agencies and hospitals. In addition, WCDH had staff onsite at service locations to assist and encourage underserved populations to complete the survey. Online links for both the provider and community surveys were distributed through listservs available to the WCDH,

hospitals, and community-based organizations. A total of 1,318 community surveys and 218 provider surveys were conducted from May 16, 2016 to June 30, 2016. <sup>2, 3</sup>

The survey findings demonstrated existing gaps and health barriers, assessed the availability and accessibility of health services, and reiterated the public health priorities of Westchester County. This assessment was ultimately employed as one of the primary data sources to inform the selection of Prevention Agenda priority areas for the 2016-2018 cycle.

### **Data Review Process**

The team conducted an extensive review of health indicators contained in the NYS Prevention Agenda, supported by the Community Health Survey and Provider Health Survey results. Additional information was provided by the WCDH Planning & Evaluation (P&E) unit, including the Prevention Agenda Dashboard, DSRIP documentation, and the epidemiologic profile from the 2014-17 CHA/CHIP cycle. A variety of planning tools were presented by WCDH P&E to the Health Planning Team, including health indicator updates and a Prevention Agenda/DSRIP assessment tool for identifying overlapping system requisites. <sup>4</sup>

After the preliminary survey results became available, the Team reviewed County-level aggregate data and the County performance of each Prevention Agenda health indicator while also considering current activities/progress from the 2014-2017 cycle. Chronic Disease and Mental Health/Substance Abuse were selected as the two priority areas. Over the following months, the team met multiple times to discuss possible interventions/ programs, and

---

<sup>2</sup> Appendix B: Community Health Needs Assessment: Provider Questionnaire

<sup>3</sup> Appendix C: Community Health Needs Assessment: Community Questionnaire

<sup>4</sup> Appendix D: Prevention Agenda Dashboard

strategies to address these priorities.<sup>5</sup> Additional reports and data analyses, including those at the sub-county levels (hospital service-area specific), were provided to hospitals by WCDH P&E for a customized view with which to focus their hospital initiatives.

In addition to a thorough review of the data, the Team considered the achievability of proposed programs/interventions and whether they aligned with each agency's mission and service goals. Considering the diversity of the County's population and the number of acute and specialty hospitals serving different areas, it was a challenge for the Team to select priorities that could apply across the board.

While chronic disease continued to stand out as the major health issue in Westchester, the new survey data revealed significant concerns regarding Mental Health and Substance Abuse among Westchester communities. However, given that the survey was done through convenience sampling, other data sources were considered in decision making as well as consideration of the existing strategic priorities of the hospitals and their networks. Given these factors, it was logical to cultivate existing long-range initiatives in the chronic disease arena for the required two main foci, especially since many hospitals on the Team have already established ongoing initiatives for these areas. Moreover, it was important to also address the stark mental health/substance abuse concerns by including it as a third priority. All hospitals have pledged to support addressing mental health and substance abuse prevention alongside the WCDH while committing to two chronic disease foci for their CHIPs.

---

<sup>5</sup> Appendix E: List of Health Planning Team meetings

The Westchester County Department of Health has committed to the following foci for the 2016- 2018 cycle:

- I. Prevent Chronic Disease: Reduce Obesity in Children and Adults
- II. Prevent Chronic Disease: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings
- III. Promote Mental Health and Prevent Substance Abuse: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

## COMMUNITY HEALTH IMPROVEMENT PLAN

The following Community Health Improvement Plan aims to lay out the specific goals, objectives, and strategies of the Westchester County Department of Health to address the realigned public health priorities identified through the Community Health Assessment for the 2016-2018 cycle.

### Focus I

<b>PRIORITY: PREVENT CHRONIC DISEASE</b>	
<b>Focus:</b> Reduce Obesity in Children and Adults	
<b>Initiative (Brief background):</b> Although county averages are below the New York State and Prevention Agenda targets, obesity remains a problem among urban, low-SES populations and racial/ethnic minorities. It was also strongly perceived as a significant community health issue by County residents and health providers (via needs assessment survey). Initiatives targeting 6 high-needs communities in Westchester may decrease the impact of obesity in those areas.	
<b>Health Disparities Addressed:</b> According to the Medicaid redesign team subcommittee on health disparities, <u>eating 5+ fruits and vegetables daily</u> is a top 5 disparity in Health Related Behaviors; initiatives like Healthy Corner Stores/Bodegas directly address this issue, particularly in lower-SES neighborhoods.	
<b>WCDH Goal(s):</b> Create community environments that promote and support healthy food and beverage choices and physical activity; Expand the role of public and private employers in obesity prevention.	
<b>Outcome Objective(s)</b>	<b>Performance Measure(s) Source(s)</b>
By December 31, 2018, increase the number of worksites and key community institutions that adopt and/or implement nutrition standards for healthy food and beverage procurement from <u>0 to 15</u> in six target high-needs communities.	Reporting by the institution to WCDH or through contributing partners (e.g. Hudson River HealthCare, Ossining Open Door, Creating Healthy Schools & Communities Yonkers and the Hudson Community Health Alliance, etc).
By December 31, 2018, promote physical activity in <u>10</u> community venues through signage, worksite policies, social support, or joint use agreements in six target high-needs communities.	
By December 31, 2018, increase the number of small food retail venues in the community that provide access to healthier foods and beverages through greater availability, and improved pricing, promotion and placement from <u>0 to 10</u> .	Assessments and visits with participating small food retail venues by WCDH or through reporting by contributing partners (i.e. Creating Healthy Schools & Communities Yonkers and the Hudson Community Health Alliance, etc).

<b>Interventions, Strategies, and Activities</b>	<b>Process Measure(s)</b>
<p>Work with community based organizations, worksites, and hospitals in six target high need communities to develop and adopt policies toward implementing nutrition standards. Programs include:</p> <ul style="list-style-type: none"> <li>• Healthy Corner Store/Bodega Initiative: The County will work with stores to improve availability and access to healthier foods. Stores sign a letter of commitment to implement 2-3 strategies for improvement.</li> <li>• Worksite wellness program: The County will partner with worksites to adopt policies committing to healthy meeting guidelines, modifying vending machine procurement policies for healthier foods, and placing posters at point of decision locations to encourage healthy choices.</li> </ul>	<p>Number of targeted community based organizations, worksites, and hospitals that develop and adopt policies to implement nutrition standards (cafeterias, snack bars, vending)</p> <p>Number of individuals (and their demographic data if available) potentially accessing settings that have adopted policies to implement nutrition standards for healthy food and beverage procurement.</p>
<p>Work with community venues in six target high need communities to promote physical activity through signage, worksite policies, social support, and joint use agreements. Programs include:</p> <ul style="list-style-type: none"> <li>• Public signage initiative: Signage promoting physical activity i.e. on busses and at bus stops, working with County and Municipal Parks to assess/implement signage in parks, and working with community venues and worksites to create marked walking paths.</li> <li>• Worksite wellness program: The County will partner with worksites to provide resources including signage, sample policies, and messaging templates to encourage physical activity among employees. Will include a letter of commitment to outline interventions to complete designated strategies.</li> <li>• County “Keep Healthy” Campaign: WCDH created various educational and promotional materials for the public, also available to partner institutions and organizations.</li> </ul>	<p>Number and type of community venues that promote physical activity through signage, worksite policies, social support, and joint use agreements.</p> <p>Number of individuals who have access to community venues that promote physical activity through signage, worksite policies, social support, and joint use agreements.</p>
<b>Partner Role/ Partner Resources</b>	
<p>Partners in the community help us to reach those in need throughout Westchester, with a special focus on the six targeted high need communities of Yonkers, New Rochelle, Mount Vernon, White Plains, Port Chester, Peekskill. WCDH will work with a myriad of organizations and agencies, including community coalitions, hospitals, businesses, municipalities and health centers to achieve our CHIP goals.</p>	

## Focus II

<b>PRIORITY: PREVENT CHRONIC DISEASE</b>	
<b>Focus:</b> Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings	
<b>Initiative (Brief background):</b> In addition to strong perception (via needs assessment survey) as a significant community health problem by residents and health providers, the management and prevention of chronic disease will target leading causes of morbidity (hospitalizations) and mortality.	
<b>Health Disparities Addressed:</b> According to the Medicaid redesign team subcommittee on health disparities, <u>diabetes</u> is a top 5 disparity in hospitalization rates, particularly among black/African Americans and those of Hispanic ethnicity. Evidence-based initiatives like the National Diabetes Prevention Program directly target diabetes as a community issue.	
<b>WCDH Goal(s):</b> Promote evidence-based care to manage chronic diseases.	
<b>Outcome Objective(s)</b>	<b>Performance Measure(s) Source(s)</b>
By December 31, 2018, promote the use of four different evidence-based interventions to prevent and/or manage chronic disease at various sites/venues, by enrolling <u>150</u> adults into evidence-based lifestyle change programs.	Reporting by the venues to WCDH or through contributing partners (e.g. YMCA, Hudson River Health Care, Ossining Open Door, Westchester County Hospitals, Westchester County Office of Senior Programs and Services, and the Hudson Community Health Alliance, etc.)
<b>Interventions, Strategies, and Activities</b>	<b>Process Measure(s)</b>
Work with community partners to offer evidence-based self-management programs; options (for which there are trained health educators in Westchester County) include: <ul style="list-style-type: none"> <li>• National Diabetes Prevention Program</li> <li>• Chronic Disease Self-Management Program</li> <li>• Diabetes Self-Management Program</li> <li>• Health-Smart Behavior Program</li> </ul>	Number of participants at EBIs offered by WCDH and partners.  Number and type of evidence-based self-management programs (also called evidence-based interventions, or EBIs) offered by WCDH and partners.
<b>Partner Role/ Partner Resources</b>	
Partners in the community help us to reach those in need throughout Westchester, with a special focus on the six targeted high need communities of Yonkers, New Rochelle, Mount Vernon, White Plains, Port Chester, Peekskill. WCDH will work with a myriad of organizations and agencies, including community coalitions, hospitals, businesses, municipalities and health centers to achieve our CHIP goals.	



### Focus III

<b>PRIORITY: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE</b>	
<b>Focus:</b> Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders	
<b>Initiative (Brief background):</b> There is a strong perception among residents and health providers (via needs assessment survey) that non-medical drug/opioid use is a significant community health problem in the County. Data from SPARCS (2010-2014) indicate a steadily increasing rate of opioid-related ED and inpatient hospital admissions every year, growing from 49.7 to 99.8 per 100k and 218.2 to 259.4 per 100k, respectively. WCDH is committed to addressing this issue.	
<b>Health Disparities Addressed:</b> According to the Medicaid redesign team subcommittee on health disparities, <u>drug-related admissions</u> are a top 5 disparity in hospitalization rates. Initiatives in Westchester County including medication lock boxes, take back programs, and community/provider education directly address the growing issue of non-medical opioid use.	
<b>WCDH Goal(s):</b> Prevent overdose deaths and the non-medical use of opioids (heroin, fentanyl, hydrocodone, methadone, morphine, oxycodone, etc.) by adults and youth.	
<b>Outcome Objective(s)</b>	<b>Performance Measure(s) Source(s)</b>
<p>Prevent opioid overdose and deaths through –</p> <ul style="list-style-type: none"> <li>• Prescriber education</li> <li>• Harm reduction, including Naloxone training</li> <li>• Community-based prevention education and supply reduction</li> </ul> <p>By December 31, 2018, WCDH will provide opioid abuse education and Naloxone training* to <u>1500</u> community members and professionals</p> <p>By December 31, 2018, WCDH will work to increase by <u>5%</u> the number of households that safely dispose of medications at the County’s Household Material Recycling Facility (H-MRF) through the promotion of/participation in medication drop off opportunities.</p>	<p>Reporting by WCDH or by partners to WCDH.</p>
<b>Interventions, Strategies, and Activities</b>	<b>Process Measure(s)</b>
<p>Interventions to address non-medical use of opioids include:</p> <ul style="list-style-type: none"> <li>• Medication drop off opportunities and events associated with Westchester County’s H-MRF</li> <li>• 38 drop boxes located at municipal police departments for safe disposal of un-used medications</li> <li>• Take-back days and events, where education may be offered concurrently.</li> <li>• Public health education events, regarding</li> </ul>	<p>Number of individuals and/or households participating in safe medication disposal programs, and medication collection poundage at the Westchester County HMRF, and through take back events, and drop box locations.</p> <p>Number of individuals and/or households educated about safe medication disposal options and</p>

<p>opioids:</p> <ul style="list-style-type: none"> <li>○ Naloxone trainings</li> <li>○ Health professional education (e.g. responsible prescribing for medical students, pharmacists, etc.)</li> <li>○ Law enforcement education (including campus safety officers, police and probation officers)</li> <li>○ Community education</li> <li>● Participation in coalitions and community partnerships regarding substance abuse and related issues</li> </ul>	<p>programs.</p> <p>Number of Naloxone trainings.</p> <p>Number of individuals participating in Naloxone trainings (include group demographic details community vs. health providers vs. law enforcement, etc.)</p> <p>Number of public awareness, outreach, and educational efforts to change attitudes, beliefs, and norms about opioid use.</p> <p>Number of coalition meetings and community partnership meetings/activities attended.</p>
<p><b>Partner Role/ Partner Resources</b></p>	
<p>Tackling the problem of non-medical opioid use and abuse requires a diverse and robust collaboration among multiple organizations and agencies. WCDH will work with numerous partners, including community groups, police departments, EMS workers/first responders, schools/colleges, mental health service providers, hospitals, pharmacists, physicians, drug use prevention coalitions, NYSDOH, and other government agencies to achieve our CHIP goals.</p>	
<p><i>*Naloxone trainings will continue to be conducted by WCDH contingent upon the receipt/availability of free Naloxone Overdose Rescue Kits from NYSDOH.</i></p>	

## COMMUNICATIONS AND ENGAGEMENT STRATEGY

The Westchester County Health Planning Team has committed to convene quarterly over the next three years, and meetings will be hosted by the Westchester County Department of Health. These meetings will allow each hospital/stakeholder to brief the larger group on their progress, successes, and challenges with implementing their interventions. The Team will also meet to identify partnership opportunities toward achieving common project objectives.

To track progress and improvement, WCDH will utilize an existing internal reporting structure between Health Promotion, which executes the interventions; and, Planning and Evaluation, which tracks and analyzes the resulting data and prepares the CHA. Activities will be reported from Health Promotion to Planning and Evaluation. The sources of the data may come from organizations who will partner with WCDH on activities or from within Health Promotion. WCDH will coordinate its evaluation efforts through internal meetings. While Planning and Evaluation will periodically assess the process measures to assure intervention progress and success, Health Promotion will internally track activities as they occur.

The WCDH's website will feature the publication of the 2016-2018 CHIP, as well as the completed Community Health Assessment that supports the selection of the CHIP priorities. In addition, the Department will inform partners about the CHIP to ensure hospitals on the Health Planning Team receive a copy of the document.

## 2014-2017 COMMUNITY HEALTH IMPROVEMENT PLAN UPDATE

Westchester County Department of Health's 2014-2017 Community Health Improvement Plan consisted of two priorities. Priority Area 1: To prevent chronic disease and reduce racial disparities by decreasing the percentage of blacks and Hispanics dying prematurely from heart related disease; and, Priority Area 2: To promote healthy women, infants and children by increasing the proportion of infants that are breastfed. In collaboration with community-based organizations and hospitals, WCDH was able to implement many activities to reduce health disparities in its target populations.

The goal to increase access to chronic disease preventive care and management was largely accomplished. WCDH staff delivered evidence-based programs in collaboration with the Rye and Yonkers YMCA. In an effort to connect underinsured or uninsured members of the community with care, and to promote chronic disease prevention strategies, WCDH established the "Keep Healthy" campaign. "Keep Healthy" brochures were disseminated at all WCHD clinics, WIC offices, health promotion events, and Health Insurance Access/Navigator events. Clinical preventive services were also established in WCDH's TB and STD clinics by taking blood pressure measurements as routine vital signs, assessing smoking status of all new patients, and referring patients to needed services.

The goal and corresponding activities to increase the proportion of infants breastfeeding was slightly modified from the initial plan. A WCDH Public Health Nurse was trained as a Certified Lactation Consultant and provided home based breastfeeding support and guidance to new mothers as needed. Westchester County Department of Health also implemented a lactation policy that promotes and supports breastfeeding among its employees. "Keep

Healthy” breastfeeding education materials were created and disseminated to residents, CBOs and on social media platforms. Collaboration with Westchester County businesses/employers to establish worksite lactation support programs proved to be challenging due to the complexity of additional policy implementation. As a result, the decision was made to discontinue this component of the activities. Additionally, untimely staff turnover and a limited budget proved to be barriers to a comprehensive achievement of this priority.

The 2014-2017 CHIP process allowed the Department to address important public health issues and served as a guide for improving the health of Westchester County residents. It also provided us with some “lessons learned” that helped us shape the 2016-2018 CHIP. Moving forward with the new CHIP cycle, the Department has decided to continue to focus on chronic disease prevention and will shift our focus from breastfeeding promotion to substance abuse prevention to align with the current needs of the community.

## APPENDIX A: WESTCHESTER COUNTY HEALTH PLANNING TEAM

Organization	Member
<b>Blythedale Children’s Hospital</b>	Lisa Petrucelli, <i>Director, Early Childhood Programs - Social Work Dept.</i>
<b>Montefiore Medical Center</b> Montefiore Mount Vernon Hospital Montefiore New Rochelle Hospital Burke Rehabilitation Hospital White Plains Hospital	Nicole Harris-Hollingsworth, <i>Assistant Vice President</i> Rosemary Martino, <i>Director, Business Development</i> Angela Cermele, <i>Manager, Special Projects</i> Marisa Iallonardo, <i>Manager, Communications</i> Eliza O’Neill, <i>Director, Communications</i> Jaime Bocchino, <i>Coordinator, Community Relations &amp; Events</i>
<b>NewYork-Presbyterian</b> NewYork-Presbyterian Hudson Valley Hospital NewYork-Presbyterian Lawrence Hospital	Patti Pelican, <i>Coordinator, Community Outreach</i> Alisa Holland, <i>Director, Marketing &amp; Communications</i>
<b>Northwell Health</b> Northern Westchester Hospital Phelps Memorial Hospital Center	Nancy Copperman, <i>Assistant Vice President, Public Health and Community Partnerships; Strategic Planning</i> Gretchen Mullin, <i>Director, Marketing &amp; Public Affairs</i> Oneida Andujar, <i>Grants Officer</i> Yeva Posner, <i>Lactation Consultant</i> Tim Wages, <i>Senior Administrative Director of Ancillary Services</i> Lisa Koch, <i>Director of Development</i> Katherine Porter, <i>Development Information Specialist</i>
<b>Saint Joseph’s Medical Center</b>	Catherine Hopkins, <i>Director, Community Outreach and School Health</i> Dean Civitello, <i>Vice President, Human Resources, Public Relations &amp; Development</i>
<b>St. John’s Riverside Hospital</b>	Cheray Burnett, <i>Vice President, Administration</i>
<b>Westchester Medical Center</b>	Deborah Marshall, <i>Vice President, Planning and Strategic Initiatives</i> Tony Mahler, <i>Senior VP Strategic Planning</i>
<b>Westchester County Department of Health</b>	Sherlita Amler MD, <i>Commissioner of Health</i> Renee Recchia, <i>Acting Deputy Commissioner, Division of Administration</i> Jiali Li, <i>Director of Research and Evaluation, Planning and Evaluation</i> Bonnie Lam, <i>Medical Data Analyst, Planning and Evaluation</i> Mila Venuti, <i>Assistant Statistician, Planning and Evaluation</i> Carrie Aaron-Young, <i>Asst. Commissioner, Division of Health Promotion</i> Heather McGill, <i>Program Administrator, Health Promotion</i> Jordan Burton, <i>CDC Public Health Associate, Health Promotion</i> Laurie Smalley, <i>Supervising Public Health Nurse, Community Health</i> Caren Halbfinger, <i>Director of Public Affairs, Administration</i>

## APPENDIX B: COMMUNITY HEALTH NEEDS ASSESSMENT: PROVIDER QUESTIONNAIRE

We want to hear your thoughts about important health issues in the community you serve. Together, the Westchester County Health Department and hospitals throughout Westchester County, NY, will use the results of this short survey and other information to help improve health programs. Thank you for your participation!

<b>Agency Name:</b>	_____
<b>Zip code of site location:</b>	_____

**Optional:**  
**Your name** \_\_\_\_\_ **Phone #** \_\_\_\_\_ **Email address** \_\_\_\_\_

How would you best describe your title/role in your agency?		
<input type="checkbox"/> Advocate	<input type="checkbox"/> Board member	<input type="checkbox"/> Office manager
<input type="checkbox"/> Alcohol/substance provider	<input type="checkbox"/> Dental provider	<input type="checkbox"/> Primary care provider
<input type="checkbox"/> Allied health professional	<input type="checkbox"/> Executive director	<input type="checkbox"/> Program administrator/manager
<input type="checkbox"/> Behavioral health care provider	<input type="checkbox"/> Health educator	<input type="checkbox"/> Specialty care provider
<input type="checkbox"/> Other (please specify): _____		

Please check the categories that best describe your agency. (Please check all that apply)		
<input type="checkbox"/> Alcohol/substance Abuse Agency	<input type="checkbox"/> Dental Practice	<input type="checkbox"/> Medical Practice
<input type="checkbox"/> Community-based Organization	<input type="checkbox"/> Home Care Agency	<input type="checkbox"/> Mental Health Agency
<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Hospital	<input type="checkbox"/> Outpatient Clinic
<input type="checkbox"/> Other (please specify): _____		

Please check the type of services provided by your agency. (Please check all that apply)		
<input type="checkbox"/> Breastfeeding support	<input type="checkbox"/> Family planning	<input type="checkbox"/> Prenatal/PCAP services
<input type="checkbox"/> Case management	<input type="checkbox"/> Food access	<input type="checkbox"/> Primary care services- adults
<input type="checkbox"/> Childcare	<input type="checkbox"/> Health insurance enrollment	<input type="checkbox"/> Primary care services- children
<input type="checkbox"/> Community education	<input type="checkbox"/> Health screenings	<input type="checkbox"/> Rehabilitation services
<input type="checkbox"/> Dental services	<input type="checkbox"/> Home care services	<input type="checkbox"/> Smoking/tobacco services
<input type="checkbox"/> Domestic violence prevention	<input type="checkbox"/> Housing	<input type="checkbox"/> Transportation
<input type="checkbox"/> Drug/alcohol services	<input type="checkbox"/> Immigrant support services	<input type="checkbox"/> Violence/bullying/gang prevention
<input type="checkbox"/> Elder care/senior services	<input type="checkbox"/> Immunization	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Exercise/ weight loss programs	<input type="checkbox"/> Mental health services	

Please check all persons served by your agency. (Check all that apply)		
<input type="checkbox"/> Adults	<input type="checkbox"/> Immigrants	<input type="checkbox"/> Seniors
<input type="checkbox"/> Children	<input type="checkbox"/> Low-income	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Disabled	<input type="checkbox"/> Uninsured	

What are the THREE biggest ongoing health concerns for the people/community you serve?		
<input type="checkbox"/> Access to immunizations	<input type="checkbox"/> Dental care	<input type="checkbox"/> Mental health/depression/ suicide
<input type="checkbox"/> Access to primary health care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutrition/eating habits
<input type="checkbox"/> Access to specialty care	<input type="checkbox"/> Disability	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Distracted driving	<input type="checkbox"/> Preventable injury/falls
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Smoking/tobacco use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Family planning/teen pregnancy	<input type="checkbox"/> Violence
<input type="checkbox"/> Care for the elderly	<input type="checkbox"/> Healthy environment	<input type="checkbox"/> Women's health
<input type="checkbox"/> Child health & wellness	<input type="checkbox"/> Heart disease/stroke	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections	

**What THREE things would be most helpful to improve the health concerns of the community you serve?**

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

**How would you rate the health of the people/community you serve?**

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> Very healthy | <input type="checkbox"/> Somewhat healthy | <input type="checkbox"/> Very unhealthy                |
| <input type="checkbox"/> Healthy      | <input type="checkbox"/> Unhealthy        | <input type="checkbox"/> Other (please specify): _____ |

**What are the THREE most significant barriers impacting YOUR ABILITY to provide services to your patients/clients?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cultural competency issues         | <input type="checkbox"/> Limited or lack of access to specialists       | <input type="checkbox"/> Patient non-adherence to treatment |
| <input type="checkbox"/> High no-show rate                  | <input type="checkbox"/> Limited space and/or equipment                 | <input type="checkbox"/> Staff time constrains              |
| <input type="checkbox"/> Inadequate insurance reimbursement | <input type="checkbox"/> Limited staffing resources                     | <input type="checkbox"/> Other (please specify): _____      |
| <input type="checkbox"/> Lack of funding                    | <input type="checkbox"/> Patient cannot afford prescription medications |   |
| <input type="checkbox"/> Limited bi-lingual staff           |   |   |

**For the patients/clients you serve, what are the top THREE barriers impacting YOUR CLIENTS' ability to access your services?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> There are no issues               | <input type="checkbox"/> Don't understand need to see a provider | <input type="checkbox"/> Lack of/or limited staff who speak their language |
| <input type="checkbox"/> Cannot afford services            | <input type="checkbox"/> Inconvenient hours                      | <input type="checkbox"/> No transportation/too far                         |
| <input type="checkbox"/> Co-pay/deductible too high        | <input type="checkbox"/> Insurance does not cover service        | <input type="checkbox"/> No childcare                                      |
| <input type="checkbox"/> Cultural/religious beliefs        | <input type="checkbox"/> Lack of time                            | <input type="checkbox"/> No insurance                                      |
| <input type="checkbox"/> Don't know how to access services | <input type="checkbox"/> Lack of/or limited staff/service        | <input type="checkbox"/> Unaware of services available                     |
| <input type="checkbox"/> Don't like going/afraid to go     |  | <input type="checkbox"/> Other (please specify): _____                     |

**Where do community members you serve get most of their health information? (Check all that apply)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Community-based organization | <input type="checkbox"/> Internet               | <input type="checkbox"/> School/college                         |
| <input type="checkbox"/> Doctor/Health professional   | <input type="checkbox"/> Library                | <input type="checkbox"/> Social media (Facebook, Twitter, etc.) |
| <input type="checkbox"/> Family or friends            | <input type="checkbox"/> Newspaper/magazine     | <input type="checkbox"/> Television                             |
| <input type="checkbox"/> Health department            | <input type="checkbox"/> Radio                  | <input type="checkbox"/> Worksite                               |
| <input type="checkbox"/> Hospital                     | <input type="checkbox"/> Religious organization | <input type="checkbox"/> Other (please specify): _____          |

- Can we contact you so you can tell us more about your ideas regarding health problems in Westchester County and what should be done about them?**
- Yes \_\_\_\_\_
- No \_\_\_\_\_



## APPENDIX C: COMMUNITY HEALTH NEEDS ASSESSMENT: COMMUNITY QUESTIONNAIRE






We want to hear your thoughts about important health issues in your community. Together, the Westchester County Health Department and hospitals throughout Westchester County, NY, will use the results of this short survey and other information to help improve health programs in your community. Your responses are completely anonymous. Thank you for your participation!








<b>What are the THREE biggest ongoing health concerns for the COMMUNITY WHERE YOU LIVE?</b>		
<input type="checkbox"/> Access to immunizations	<input type="checkbox"/> Dental care	<input type="checkbox"/> Mental health/depression/suicide
<input type="checkbox"/> Access to primary health care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutrition/eating habits
<input type="checkbox"/> Access to specialty care	<input type="checkbox"/> Disability	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Distracted driving	<input type="checkbox"/> Preventable injury/falls
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Smoking/tobacco use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Family planning/teen pregnancy	<input type="checkbox"/> Violence
<input type="checkbox"/> Care for the elderly	<input type="checkbox"/> Healthy environment	<input type="checkbox"/> Women's health
<input type="checkbox"/> Child health & wellness	<input type="checkbox"/> Heart disease/stroke	<input type="checkbox"/> Other ( <i>please specify</i> ): _____
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections	
<b>What are the THREE biggest ongoing health concerns for YOURSELF?</b>		
<input type="checkbox"/> Access to immunizations	<input type="checkbox"/> Dental care	<input type="checkbox"/> Mental health/depression/suicide
<input type="checkbox"/> Access to primary health care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutrition/eating habits
<input type="checkbox"/> Access to specialty care	<input type="checkbox"/> Disability	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Distracted driving	<input type="checkbox"/> Preventable injury/falls
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Smoking/tobacco use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Family planning/teen pregnancy	<input type="checkbox"/> Violence
<input type="checkbox"/> Care for the elderly	<input type="checkbox"/> Healthy environment	<input type="checkbox"/> Women's health
<input type="checkbox"/> Child health & wellness	<input type="checkbox"/> Heart disease/stroke	<input type="checkbox"/> Other ( <i>please specify</i> ): _____
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections	
<b>What THREE things would be most helpful to improve YOUR health concerns?</b>		
<input type="checkbox"/> Access to dental care	<input type="checkbox"/> Domestic violence prevention	<input type="checkbox"/> Mental health services
<input type="checkbox"/> Access to healthier food	<input type="checkbox"/> Drug/alcohol services	<input type="checkbox"/> Safer childcare options
<input type="checkbox"/> Access to primary care	<input type="checkbox"/> Elder care services	<input type="checkbox"/> Safer places to walk/play
<input type="checkbox"/> Affordable housing	<input type="checkbox"/> Exercise/weight loss programs	<input type="checkbox"/> Smoking/tobacco services
<input type="checkbox"/> Breastfeeding support	<input type="checkbox"/> Health Insurance enrollment	<input type="checkbox"/> Transportation
<input type="checkbox"/> Caregiver support	<input type="checkbox"/> Health screenings	<input type="checkbox"/> Violence/bullying/gang prevention
<input type="checkbox"/> Clean air & water	<input type="checkbox"/> Home care services	<input type="checkbox"/> Other ( <i>please specify</i> ): _____
<input type="checkbox"/> Community education	<input type="checkbox"/> Immigrant support services	
<input type="checkbox"/> Dementia/Alzheimer's screening	<input type="checkbox"/> Job opportunities	
<b>How would you describe your overall health?</b>		
<input type="checkbox"/> Very healthy	<input type="checkbox"/> Somewhat healthy	<input type="checkbox"/> Very unhealthy
<input type="checkbox"/> Healthy	<input type="checkbox"/> Unhealthy	<input type="checkbox"/> Other ( <i>please specify</i> ): _____
<b>How would you describe your overall mental health?</b>		
<input type="checkbox"/> Very healthy	<input type="checkbox"/> Somewhat healthy	<input type="checkbox"/> Very unhealthy
<input type="checkbox"/> Healthy	<input type="checkbox"/> Unhealthy	<input type="checkbox"/> Other ( <i>please specify</i> ): _____
<b>Do you suffer from any chronic health conditions (<i>check all that apply</i>)?</b>		
<input type="checkbox"/> None	<input type="checkbox"/> Disability	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug/alcohol abuse	<input type="checkbox"/> Memory issues
<input type="checkbox"/> Auto-immune disease	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mental health
<input type="checkbox"/> Cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Other ( <i>please specify</i> ): _____




<b>Do you have a health care provider for checkups and visits:</b>		<input type="checkbox"/> Yes _____
		<input type="checkbox"/> No _____
<b>How long has it been since you visited a health care provider for a routine physical exam or checkup?</b>		
<input type="checkbox"/> In the past year	<input type="checkbox"/> In the past five years	<input type="checkbox"/> Never
<input type="checkbox"/> In the past two years	<input type="checkbox"/> Five or more years ago	<input type="checkbox"/> Don't know
<b>What THREE things prevent YOU from getting medical care from a health care provider?</b>		
<input type="checkbox"/> Nothing prevents me from getting medical care	<input type="checkbox"/> Cultural/religious beliefs	<input type="checkbox"/> Insurance does not cover service
<input type="checkbox"/> Cannot afford	<input type="checkbox"/> Don't know how to find providers	<input type="checkbox"/> No transportation/too far
<input type="checkbox"/> Cannot find a health provider who speaks my language	<input type="checkbox"/> Don't like going/afraid to go	<input type="checkbox"/> No childcare
<input type="checkbox"/> Co-pay/deductible too high	<input type="checkbox"/> Don't see the benefit	<input type="checkbox"/> No insurance
	<input type="checkbox"/> I have no time	<input type="checkbox"/> Other (please specify): _____
	<input type="checkbox"/> Inconvenient office hours	
<b>In the past 12 months, did you receive care in the emergency room?</b>		<input type="checkbox"/> Yes _____
		<input type="checkbox"/> No _____
<b>If yes, what is the ONE main reason for your emergency room visit?</b>		
<input type="checkbox"/> Could not find a local health provider who speaks my language	<input type="checkbox"/> Health provider said go to emergency room	<input type="checkbox"/> Thought problem too serious for a doctor's visit
<input type="checkbox"/> Doctor's office not open	<input type="checkbox"/> No other place to go	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Emergency room is the closest provider	<input type="checkbox"/> Receive most of my care at emergency room	
<b>Where do you and your family get most of your health information? (check all that apply)</b>		
<input type="checkbox"/> Community-based organization	<input type="checkbox"/> Internet	<input type="checkbox"/> School/college
<input type="checkbox"/> Doctor/Health professional	<input type="checkbox"/> Library	<input type="checkbox"/> Social media (Facebook, Twitter, etc.)
<input type="checkbox"/> Family or friends	<input type="checkbox"/> Newspaper/magazine	<input type="checkbox"/> Television
<input type="checkbox"/> Health department	<input type="checkbox"/> Radio	<input type="checkbox"/> Worksite
<input type="checkbox"/> Hospital	<input type="checkbox"/> Religious organization	<input type="checkbox"/> Other (please specify): _____
<b>For statistical purposes only (your responses are anonymous), please complete the following:</b>		
<b>I identify as:</b>		<b>What is your age:</b>
<input type="checkbox"/> Male	<input type="checkbox"/> 18-24	<input type="checkbox"/> 55-64
<input type="checkbox"/> Female	<input type="checkbox"/> 25-34	<input type="checkbox"/> 65-74
<input type="checkbox"/> Other	<input type="checkbox"/> 35-44	<input type="checkbox"/> 75+
	<input type="checkbox"/> 45-54	
<b>Zip code where I live</b> _____	<b>Town/city where I live</b> _____	
<b>Are you Hispanic or Latino?</b>		<input type="checkbox"/> Yes
		<input type="checkbox"/> No
<b>What category best describes your race?</b>		
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Multi-racial
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Other
<b>What is the primary language you speak?</b>		
<input type="checkbox"/> English	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Tagalog
<input type="checkbox"/> Spanish	<input type="checkbox"/> French	<input type="checkbox"/> Korean
<input type="checkbox"/> Italian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other (please specify): _____
<b>What is your highest level of education?</b>		
<input type="checkbox"/> Less than high school	<input type="checkbox"/> Some college	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> High school grad/GED	<input type="checkbox"/> College graduate	
<input type="checkbox"/> Technical school	<input type="checkbox"/> Advanced degree	
<b>What is your current employment status</b>		
<input type="checkbox"/> Employed	<input type="checkbox"/> Student	<input type="checkbox"/> Retired
<input type="checkbox"/> Not employed	<input type="checkbox"/> Military	<input type="checkbox"/> Other (please specify): _____
<b>Do you have any of the following types of health insurance?</b>		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private insurance	<input type="checkbox"/> None/no insurance
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Tri-Care	<input type="checkbox"/> Other (please specify): _____




## APPENDIX D: UPDATED PREVENTION AGENDA DASHBOARD








### Westchester County – Prevention Agenda Indicators 2013-2018 (Dashboard accessed March-April 2016)











Improve Health Status and Reduce Health Disparities					
Indicator	Prevention Agenda (PA) Indicator	Data Years	Rate Ratio/ Percentage	Indicator Performance	Met 2018 PA Objective?
1	Percentage of premature deaths (before age 65 years)	2013	18.9%	No Significant Change	Yes
1.1	Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics	2011-2013	2.25	 Improved	No
1.2	Premature deaths: Ratio of Hispanics to White non-Hispanics	2011-2013	2.91	 Improved	No
2	Age-adjusted preventable hospitalizations rate per 10,000 – Age 18+	2013	106.5	 Improved	Yes
2.1	Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics	2011-2013	2.36	 Worsened	No
2.2	Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics	2011-2013	1.35	 Worsened	Yes
3	Percentage of adults (aged 18-64) with health insurance	2013	85.1%	No Significant Change	No
4	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2013-2014	81.5%	No Significant Change	No

Promote a Healthy and Safe Environment					
Indicator	Prevention Agenda (PA) Indicator	Data Years	Rate Ratio/ Percentage	Indicator Performance	Met 2018 PA Objective?
5	Rate of hospitalizations due to falls per 10,000 - Aged 65+ years	2013	204.5	 Improved	Yes
6	Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years	2013	466.6	 Improved	No
7	Assault-related hospitalization rate per 10,000	2011-2013	2.6	 Improved	Yes
7.1	Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics	2011-2013	6.59	 Improved	Yes
7.2	Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics	2011-2013	2.65	 Improved	Yes
7.3	Assault-related hospitalization: Ratio of low income ZIP codes to non-low income ZIP codes	2011-2013	2.89	 Improved	Yes
8	Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years	2013	19.7	No Significant Change	Yes
9	Percentage of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge	2014	70.1%	 Improved	Yes




10	Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home	2009-2013	38.5%	 Improved	No
11	Percentage of population with low-income and low access to a supermarket or large grocery store	2010	1.27%	No Updated Data	Yes
12	Percentage of homes in Healthy Neighborhoods Program that have fewer asthma triggers during the home revisits	2010-2013	0.00%	 Worsened	--
13	Percentage of residents served by community water systems with optimally fluoridated water	2014	83.5%	 Worsened	Yes



Prevent Chronic Diseases					
Indicator	Prevention Agenda (PA) Indicator	Data Years	Rate Ratio/ Percentage	Indicator Performance	Met 2018 PA Objective?
14	Percentage of adults who are obese	2013-2014	20.6%	No Significant Change	Yes
15	Percentage of children and adolescents who are obese	2013-2014	13.7%	 Improved	Yes
16	Percentage of cigarette smoking among adults	2013-2014	11.7%	No Significant Change	Yes
17	Percentage of adults who received a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	2013-2014	72.1%	No Significant Change	No
18	Asthma emergency department visit rate per 10,000 population	2013	61.7	No Significant Change	Yes
19	Asthma emergency department visit rate per 10,000 - Aged 0-4 years	2013	145.4	No Significant Change	Yes
20	Age-adjusted heart attack hospitalization rate per 10,000	2013	13.2	No Significant Change	Yes
21	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	2011-2013	1.25	 Improved	Yes
22	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	2011-2013	3.9	 Worsened	Yes


Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections					
Indicator	Prevention Agenda (PA) Indicator	Data Years	Rate Ratio/ Percentage	Indicator Performance	Met 2018 PA Objective?
23	Percentage of children with 4:3:1:3:3:1:4 immunization series - Aged 19-35 months	2013	62.2%	 Improved	No
24	Percentage of adolescent females with 3 or more doses of HPV immunization - Aged 13-17 years	2013	27.4%	 Improved	No
25	Percentage of adults with flu immunization - Aged 65+ years <sup>b</sup>	2013-2014	78.4%	No Significant Change	Yes
26	Newly diagnosed HIV case rate per 100,000	2011-2013	11.6	 Improved	Yes
26.1	Difference in rates (Black and White) of newly diagnosed HIV cases	2011-2013	29.9	 Improved	Yes
26.2	Difference in rates (Hispanic and White) of newly diagnosed HIV cases	2011-2013	11.2	 Improved	Yes
27	Gonorrhea case rate per 100,000 women - Aged 15-44 years	2013	116.8	 Improved	Yes
28	Gonorrhea case rate per 100,000 men - Aged 15-44 years	2013	104.6	 Improved	Yes
29	Chlamydia case rate per 100,000 women - Aged 15-44 years	2013	1,145.90	No Significant Change	Yes
30	Primary and secondary syphilis case rate per 100,000 men	2013	8.1	No Significant Change	Yes
31	Primary and secondary syphilis case rate per 100,000 women	2013	0.4*	No Significant Change	Yes

Promote Healthy Women, Infants, and Children					
Indicator	Prevention Agenda (PA) Indicator	Data Years	Rate Ratio/ Percentage	Indicator Performance	Met 2018 PA Objective?
32	Percentage of preterm births	2013	11.9%	 Worsened	No
32.1	Premature births: Ratio of Black non-Hispanics to White non-Hispanics	2011-2013	1.48	 Worsened	No
32.2	Premature births: Ratio of Hispanics to White non-Hispanics	2011-2013	1.05	 Improved	Yes
32.3	Premature births: Ratio of Medicaid births to non-Medicaid births	2011-2013	1.04	 Improved	No
33	Percentage of infants exclusively breastfed in the hospital	2013	48.7%	 Improved	Yes
33.1	Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics	2011-2013	0.75	 Improved	Yes
33.2	Exclusively breastfed: Ratio of Hispanics to White non-Hispanics	2011-2013	0.99	 Worsened	Yes
33.3	Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births	2011-2013	0.93	 Worsened	Yes
34	Maternal mortality rate per 100,000 births	2011-2013	12.6*	 Improved	Yes
35	Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs	2013	71.5%	 Improved	No



35.1	Percentage of children aged 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs	2013	85.4%	No Significant Change	No
35.2	Percentage of children aged 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs	2013	83.5%	 Improved	No
35.3	Percentage of children aged 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs	2013	62.7%	 Improved	No
36	Percentage of children (aged under 19 years) with health insurance	2013	95.7%	No Significant Change	No
37	Percentage of third-grade children with evidence of untreated tooth decay	2009-2011	10.1%	No Updated Data	Yes
37.1	Tooth decay: Ratio of low-income children to non-low income children	2009-2011	4.78+	No Updated Data	No
38	Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	2013	10.1	No Significant Change	Yes
38.1	Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics	2011-2013	12.8	 Worsened	No

38.2	Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics	2011-2013	8.61	 Improved	No
39	Percentage of unintended pregnancy among live births	2013	23.7%	No Significant Change	Yes
39.1	Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic	2013	4.13	No Significant Change	No
39.2	Unintended pregnancy: Ratio of Hispanics to White non-Hispanics	2013	3.21	No Significant Change	No
39.3	Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births	2013	2.34	No Significant Change	No
40	Percentage of women (aged 18-64) with health insurance	2013	87.5%	No Significant Change	No
41	Percentage of live births that occur within 24 months of a previous pregnancy	2013	14.7%	 Improved	Yes

Promote Mental Health and Prevent Substance Abuse					
Indicator	Prevention Agenda (PA) Indicator	Data Years	Rate Ratio/ Percentage	Indicator Performance	Met 2018 PA Objective?
42	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	2013-2014	10.8%	No Significant Change	No
43	Age-adjusted percentage of adult binge drinking during the past month	2013-2014	18.0%	No Significant Change	Yes
44	Age-adjusted suicide death rate per 100,000	2011-2013	6.4	 Improved	No

## APPENDIX E: HEALTH PLANNING TEAM MEETINGS

The Health Planning Team met on the following days for the associated undertakings:

### April 8, 2016

- Provided introduction and discussed Prevention Agenda package, including:
  - The various components of CHA and CHIP, timeframes, and deadlines
  - Comparisons of the original 2013-2017 and the revised 2013-2018 NYS Prevention Agenda, the 2013-18 Prevention Agenda and DSRIP domains; the new NYSDOH goals; and WC data from the NYSDOH dashboard prepared by WCDH P&E as reference

### April 21, 2016

- Working meeting to revise and discuss survey questions with draft assembled by WCDH P&E based on successful sample surveys and planning team ideas

### May 6, 2016

- Finalized the community health and provider surveys in paper and online formats

### June 24, 2016

- WCDH P&E presented planning team with preliminary survey results

### July 8, 2016

- WCDH shared the final online survey results with the WC planning team
- Preliminarily selected two priority areas based on information provided

### July 27, 2016

- WCDH P&E summarized and shared partners' organizational commitments to suggested priority areas

- Planning team discussed priority areas

**September 16, 2016**

- WCDH compiled and shared partners' plans regarding Focus Areas and Goals for informational purposes and to encourage collaboration

**November 18, 2016**

- Team convened to share interventions, and discuss opportunities for partnership and community engagement