BURKE
REHABILITATION
MONTEFIORE HEALTH SYSTEM

Community Health Needs Assessment and Community Service Plan 2022 – 2024

This report covers Burke Rehabilitation Hospital and its network of outpatient locations. The contacts for this report are:

Margaret S. Smith, MBA, MPH, CHES
Assistant Vice President, Marketing & External Relations
(914) 597-2222
margaretsmith@burke.org

Grace Noone
Manager, Community Relations
(914) 597-2871
gnoone@burke.org

Burke Rehabilitation Hospital
785 Mamaroneck Avenue
White Plains, NY 10605

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Section 1: Executive Summary

Burke Rehabilitation is a not-for-profit healthcare organization devoted solely to acute physical rehabilitation. Its main campus is located in White Plains, NY. Founded in 1915, it has been a member of the Montefiore Health System since 2016. Burke operates A 150-bed hospital and also offers therapeutic care in 12 locations throughout Westchester County, the Hudson Valley, and the Bronx for those who have experienced injuries, surgery, or chronic conditions, from the simple to the very complex.

Additionally, Burke offers an ACGME-accredited residency program in Physical Medicine and Rehabilitation and fellowships in Brain Injury Medicine and Sports Medicine.

Burke's primary service area is Westchester County, NY. Westchester's population is approximately 1,000,000 over a land area of 430 square miles. Westchester is the fourth most affluent county in the state, with a median household income of $110,000. About 10% of the population lives in poverty. There are 371,736 households in Westchester County with an average of 2.67 persons per household. The median age of the population is 41.1 years. Females make up 51.2% of the population. About 89% of county residents ages 25+ are high school graduates or higher, while half have received at least a bachelor's degree. Westchester's population is 52.2% non-Hispanic white, 25.9% Hispanic, 16.7% non-Hispanic black, 2.7% two or more races, 0.1%, Native Hawaiian and other Pacific Islander alone, 6.6% Asian alone, 72.9% White alone. A quarter of county residents were born outside of the US, and one-third speak a language other than English at home.

Westchester is the seventh healthiest county in New York State, and It regularly outperforms health measures compared to State and national statistics, including premature deaths, preventable hospitalizations, rates of smoking, obesity, and hypertension. One exception is the falls rate among seniors, which is worse in Westchester County than New York State and the Hudson Valley region. Despite the generally healthy picture, health disparities are found on many measures of health, primarily among Black Non-Hispanic and Hispanic populations in the County. These disparities are most prevalent within the County where Black and Hispanic populations are over-represented compared to County averages, including the cities of Mount Vernon, Yonkers and Peekskill. About 5% of the population is not covered by health insurance.

In early 2022, Burke joined a collaborative group led by the Greater New York Hospitals Association (GNYHA) to conduct the triennial Community Health Needs Assessment (CHNA) and use the collected information to help create a Community Service Plan for the period of 2022-2024. The GNYHA

developed a validated survey instrument available in 11 languages and in both electronic and paper form. Burke fielded the survey to numerous community partners and through its network of therapy clinics as well as its campus physician practice area and at its community events. The GNYHA analyzed all the data collected and delivered reports to each participating hospital per their service area. Burke received a report for Westchester County, where 3,377 eligible individuals responded. Among other items, respondents ranked various priority health conditions for importance in their communities and for how much attention was needed to improve health for those conditions.

Armed with this data, and after examining a broad survey of secondary health data sources, Burke identified two focus areas to improve population health: reducing falls among seniors, and preventing second and subsequent heart attacks. Each of these health issues has significant impact on morbidity, mortality and healthcare costs in Westchester County. Burke's physical medicine and rehabilitation expertise uniquely positions the organization to deliver effective and well-supported programs in these two impactful areas. Falls prevention is central to its care delivery, and the organization operates a cardiac rehabilitation program. Burke also has physical resources to devote to these community health needs, including a cardiac rehabilitation facility and a fitness center.

Burke will partner with White Plains Hospital (WPH), also a member of the Montefiore Health System, to implement a three-pronged falls prevention strategy among seniors. The strategy will include community events following the algorithm of the CDC's STEADI program to screen individuals for their personal fall risk and provide referrals to HCPs to reduce risks; Grand Rounds presentations to medical staff to provide a quick screening/educational intervention in office and hospital settings; and community lectures targeting seniors to disseminate information about falls prevention.

Burke will undertake a second focused intervention to reduce secondary heart attacks. Following guidelines and best practices promulgated by the Million Hearts Program of the CDC and the American Heart Association, the intervention will focus on improving referrals to cardiac rehabilitation (CR) by

hospitals and practicing cardiologists and on increasing awareness of the significant benefits of CR among doctors who could refer patients and within the public at large, with a focus on groups with cardiac health disparities.

Section 2: Burke Rehabilitation

Burke Rehabilitation is a not-for-profit healthcare organization devoted solely to acute physical rehabilitation. Its main campus is located in White Plains, NY. Founded in 1915 through an endowment from philanthropist John Masterson Burke, it has been a member of the Montefiore Health System since 2016. Burke operates A 150-bed hospital, the only one in Westchester County dedicated solely to adult and adolescent acute rehabilitation medicine. Burke also offers therapeutic care in 12 locations throughout Westchester County, the Hudson Valley, and the Bronx for those who have experienced injuries, surgery, or chronic conditions, from the simple to the very complex.

Burke's mission is to provide the highest quality medical care and physical rehabilitation services to ensure that each patient achieves the maximum functional recovery from illness, injury or disability. Burke's vision is to lead the field as the most effective and compassionate provider of medical rehabilitation by practicing innovative treatment, pioneering clinical research and inspiring education.

Burke's inpatient and outpatient programs serve individuals who have experienced a disabling illness, traumatic injury or surgery, including stroke, spinal cord injury, traumatic brain injury, cardiopulmonary diseases, orthopedic surgery, neurological conditions and movement disorders. Rehabilitation services include physical, occupational, speech, recreational and specialty therapies, physician diagnosis and treatment, nutrition services and neuropsychology. The hospital's renowned physicians, therapists, nurses, social workers and support staff provide state-of-the-art treatment through multidisciplinary teams. All share the Burke mission to ensure that every patient makes the fullest possible recovery from illness or injury.

Burke serves patients from Westchester County, the Hudson Valley, and the Tri-State area, as well as throughout the Eastern United States and around the world.

In addition to medical rehabilitation services, Burke Rehabilitation offers community events and education, including the annual Heels & Wheels 5K Race and the Burke Adaptive Sports and Recreation Expo. Burke's robust adaptive sports program offers recreational activities for individuals of all abilities, whether former patients or members of the community, free of charge. Some of the adaptive activities offered include golf, table tennis, boxing, kayaking, water and alpine skiing, rock climbing, sailing and more.

In 2016, Burke became a teaching hospital with the establishment of a three-year Accreditation Council for Graduate Medical Education (ACGME)-accredited Physical Medicine & Rehabilitation residency program. In 2016, Burke added two fellowship programs, one in Brain Injury Medicine, and one in Sports Medicine. The residency program teaches 18 doctors across a three-year program, while the fellowships are offered for up to two doctors in each fellowship per year. These unique training experiences allow Burke to teach the next generation of rehabilitation professionals and foster the growth of leaders in the field of Physiatry.

Burke Rehabilitation Hospital is located at 785 Mamaroneck Avenue in White Plains, New York. The Burke/Montefiore outpatient physician practice is also located on the White Plains campus. Burke's network of 12 outpatient therapy sites are located at:

- Armonk (99 Business Park Drive)
- Bronx (1250 Waters Place, Tower One, 10th Floor)
- Bronx (1250 Waters Place, Tower One, 6th Floor)
- Elmsford (Montefiore Einstein Advanced Care – 555 Taxter Road, Suite 100)
- Mamaroneck (703 W. Boston Post Road)
- Purchase (3020 Westchester Avenue)

- Somers (325 Route 100, Suite 106)
- White Plains (785 Mamaroneck Avenue, Building 8 – multidisciplinary therapy)
- White Plains (785 Mamaroneck Avenue, Building 4 – musculoskeletal therapy)
- White Plains (785 Mamaroneck Avenue, Building 4 – Cardiac Rehabilitation)
- Yonkers (6 Executive Plaza, Suite 280)
- Yonkers (73 Market Street, Suite 178a)

Burke also provides a Fitness Center for community members ages 40 years and older. The Fitness Center offers personalized independent exercise programs for adults who are transitioning from Phase 2 to Phase 3 of cardiac rehabilitation or who have medical conditions where close monitoring during exercise is desirable. The Fitness Center is located on its main campus in White Plains.

Section 3: Community/Population Served

Westchester County is Burke's primary service area. As of 2020, the county had a population of 1,004,457 living on approximately 430.5 square miles. It is the 47th largest county in New York State, out of 62.

According to the 2020 United State Census, Westchester County is the 7th most populous county in New York State, with a total population of 1,004,457, an increase of 5.8% over the last full census in 2010. The county seat is White Plains (population 59,526) and other major cities include Yonkers (200,530), New Rochelle (81,587) and Mount Vernon (72,581).

According to the American Community Survey, in 2021, the median household income for Westchester was $110,705, the fourth highest in New York State, after Nassau, Putnam and Suffolk Counties. The median household income at New York State level is $63,548. Countywide, 9.6% of the population lives in poverty. Of note, 10% of county children live in poverty, lower than the statewide percentage of 20%. Approximately a third (37.3%) of students in Westchester County public schools qualified for free or reduced-price lunch during the 2018-2019 school year.

There are 371,736 households in Westchester County with an average of 2.67 persons per household. Of the family households with children, 24.5% are single-headed households. Persons under the age of five constitute 5.2% of the population. Persons under 18 years make up 21.4%, and those 65 and over are 17.8% of the population. The percentage of older adults is similar to the statewide average of 17.5%. Westchester County has a slightly older population than New York State overall, with a median age of 41.1 years versus 39 years. Females make up 51.2% of the population in Westchester.

With regard to educational levels, for the period 2016 – 2020, 88.6% of county residents ages 25+ are high school graduates or higher, while 49.7% of county residents ages 25+ have received at least a bachelor's degree, higher than the statewide (39.1%) attainment rates.

Westchester is ethnically diverse. Its population is 52.2% non-Hispanic white, 25.9% Hispanic, 16.7% non-Hispanic black, 2.7% two or more races, 0.1%, Native Hawaiian and other Pacific Islander alone, 6.6% Asian alone, 72.9% White alone. A quarter (24.6%) of county residents were born outside of the US. Those speaking a language other than English at home comprise 33.7% of the population, compared to 30% statewide average.

Among individuals under the age of 65, 5.4% are without health insurance, per the 2021 American Community Survey. This is in proportion to the 5.2 percent of the total population of New York State who are uninsured. The countywide unemployment rate is 5.2%.

Section 4: Health Needs Assessment Process

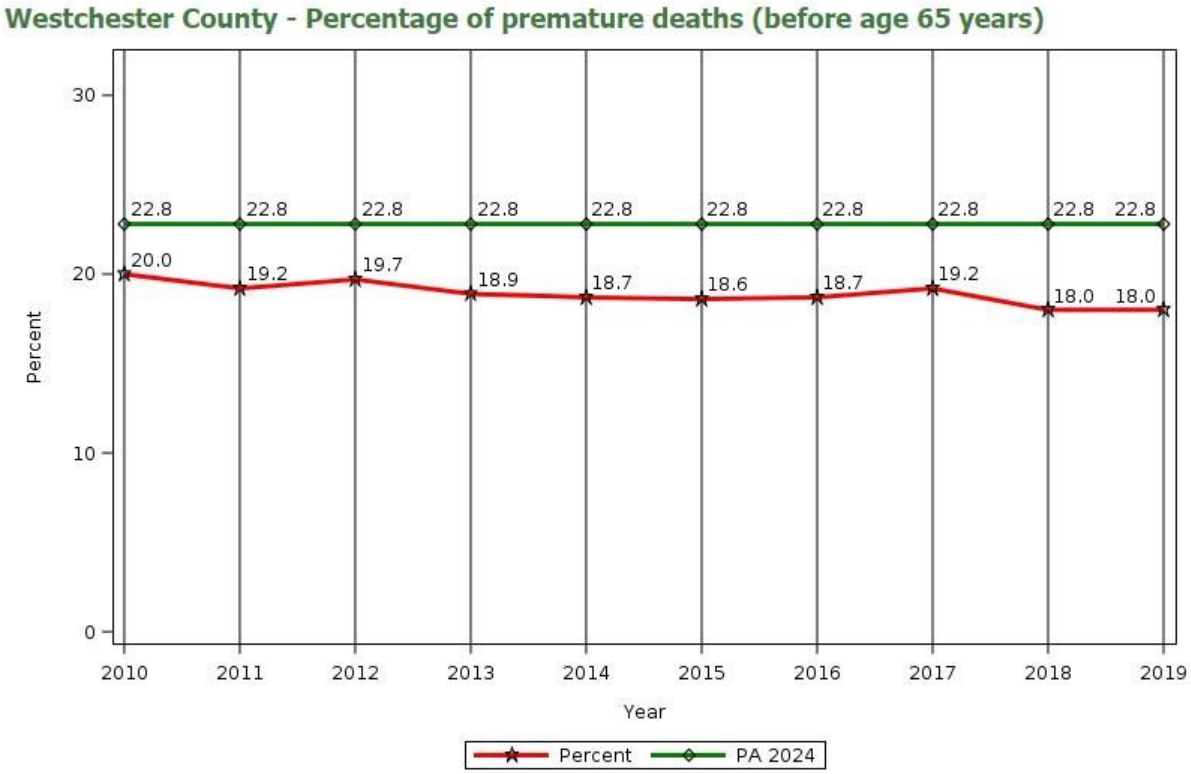
a. The Community's Health Status

Westchester County is the sixth healthiest county in New York State, according to the County Health Rankings produced by the University of Wisconsin. Westchester has fallen in rank over the past three years, as it was ranked third in 2019. Despite its overall high ranking, there are multiple areas in the county with high-need populations and poorer health outcomes.

People who die before the age of 75 can be considered to have died prematurely. In Westchester County, 4,600 years of life were lost before the age of 75 per 100,000 population, per the University of Wisconsin County Health Rankings. This compares to 6,000 for New York State, and 7,300 for the United States. In Westchester, Asians lose 2,500 years before the age of 75 per 100,000 population, in contrast to blacks, who lose 7,300 years. Hispanics and whites lose 4,300 and 4,200, respectively. The major causes of death under the age of 75 are cancer, heart disease, COVID-19, accidents, and diabetes, in descending order of importance.

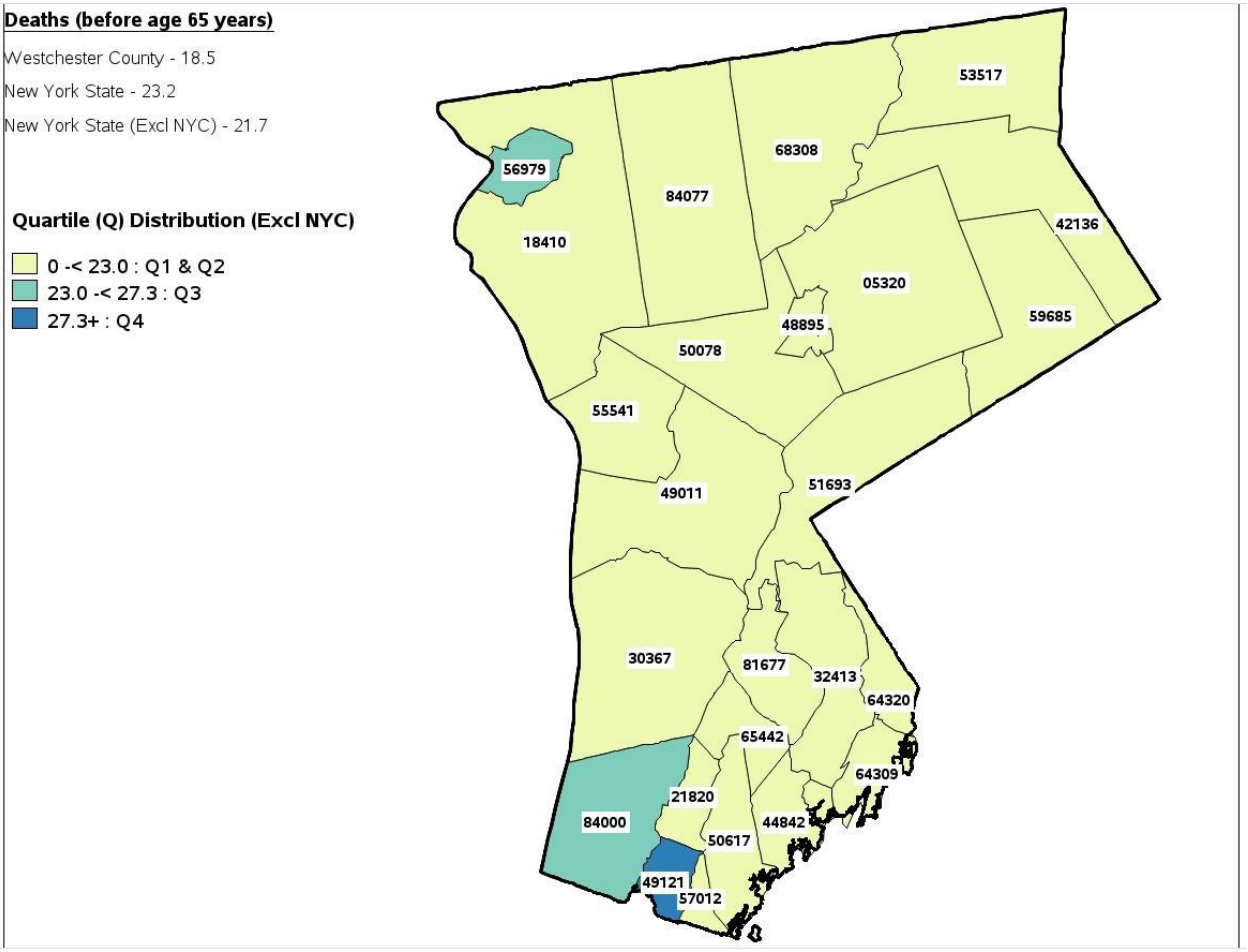
New York State classifies deaths before age 65 as premature. According to the New York State

Prevention Agenda Dashboard, with data drawn from the Vital Records as of January 2022, Westchester County has a lower rate of premature deaths than New York State, 18% versus 22%. The rate is also lower than the Prevention Agenda target set for 2024 (PA 2024).



Despite this, certain areas within Westchester County are subject to higher rates of premature death than the county as a whole. The areas of health disparity for premature death in Westchester County encompass Mount Vernon, Peekskill and Yonkers. These are areas of relatively lower income (e.g., Mount Vernon median household income is $59,291) and higher non-Hispanic Black (Mount Vernon) or Hispanic (Yonkers) population than the County as a whole.

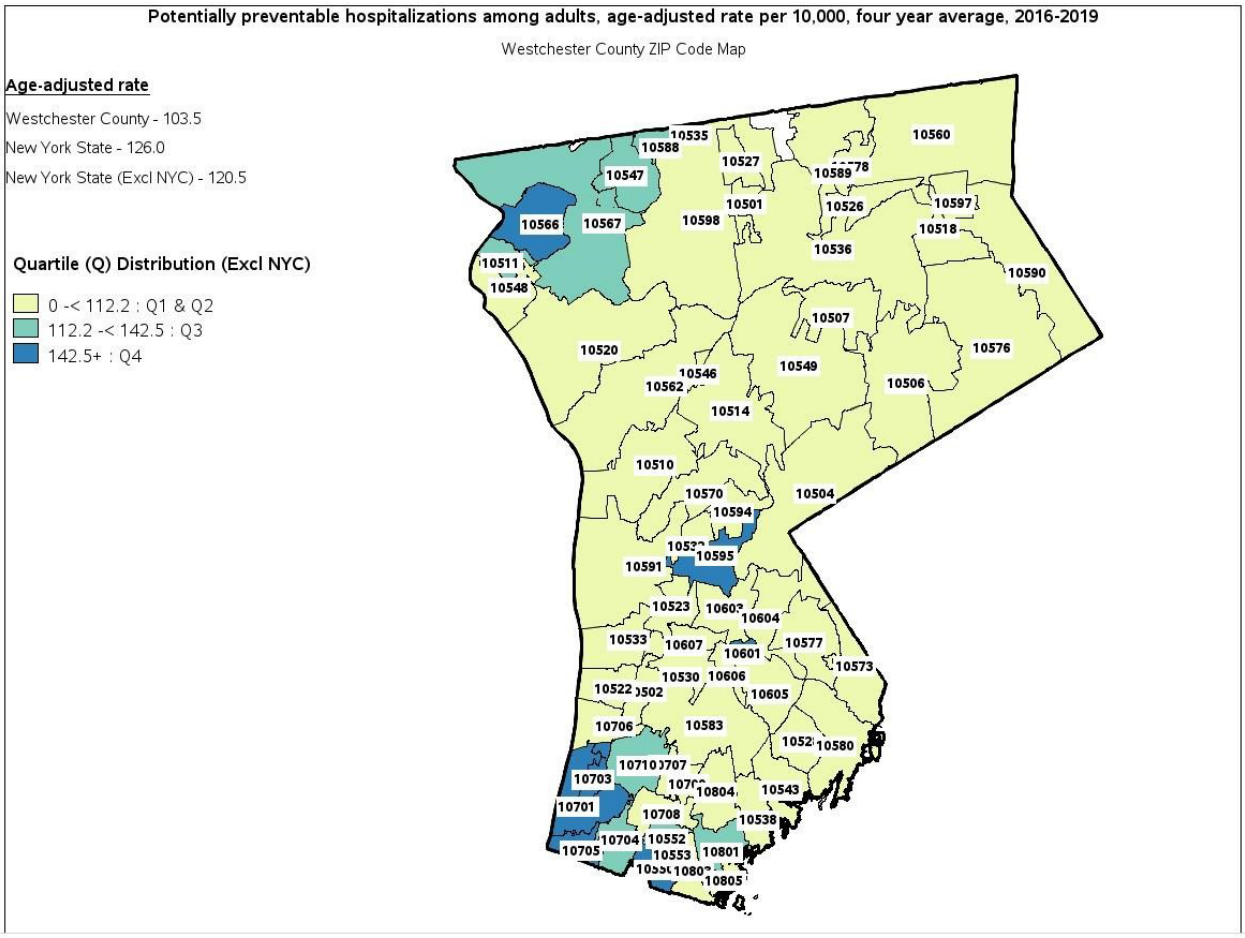
Westchester County Premature Deaths by Minor Civil Division, four-year average, 2016-2019



Premature deaths evaluated by race show that, in Westchester County, 31.9% of non-Hispanic Blacks die prematurely, and 36% of Hispanics die prematurely, compared to 12.6% of non-Hispanic Whites. In New York State, 35.8% of non-Hispanic Blacks die prematurely, and 34.5% of Hispanics die prematurely, while 18.1% of White non-Hispanics do so. Overall, people living in Westchester County suffer fewer premature deaths compared to New York State, with the exception of Hispanics, who fare somewhat worse in Westchester than in the State as a whole. Despite the relatively better outcome for premature death in Westchester County, the health disparities on this measure are quite pronounced for non-Hispanic Black and Hispanic people compared to non-Hispanic Whites.

Potentially preventable hospitalizations are also a marker of community health. According to data from SPARCS as of November 2021, reported in the New York State Prevention Agenda,

Westchester County has an age-adjusted rate of 103.5 per 10,000 adults, which is lower than the New York State rate of 126.0 and lower than the Prevention Agenda goal of 115.0. However, certain regions within the county have a much higher rate of preventable hospitalizations, including Jefferson Valley, Mount Vernon, Peekskill, Valhalla, one zip code in White Plains (10601), and Yonkers. These areas have age-adjusted rates of preventable hospitalizations ranging from 140.1 to 226.1.



Evaluating preventable hospitalizations by race shows that, in Westchester County, Black Non-Hispanics have a rate of 206.7 per 10,000 adults, Hispanics have a rate of 53.0, while White NonHispanics have a rate of 61.9 per 10,000 adults. Overall in New York State, Black non-Hispanics have a rate of 213.8 per 10,000 adults, Hispanics have a rate of 132.6, while non-Hispanic Whites show a rate of 98.0. Thus, on preventable hospitalizations, Westchester County performs better than New York State as a whole. Notwithstanding the relatively better status for preventable

hospitalizations in Westchester County, the health disparities on this measure among racial and ethnic groups are very pronounced, especially for Black Non-Hispanic people.

Conditions that can contribute to poor health, higher rates of hospitalization and premature death include high blood pressure, obesity, smoking, high cholesterol, and high blood sugar levels. The following data are taken from the Behavioral Risk Factor Surveillance System 2019 and 2020 for New York State and Westchester County.

In Westchester County, 26.6% of adults ages 18 and older have high blood pressure, while 78% of such individuals take medication to control the condition. This compares to 29.3% of New York State adults with high blood pressure, and 78.6% taking medication to control it. High blood pressure is more prevalent among Black Non-Hispanic people than other races/ethnicities and more prevalent among males and older adults. It is also associated with lower income, lower educational attainment, obesity, disability status, and diabetes.

Among Westchester adults, 21.3% are obese, compared to 26.3% in New York State. In New York State, males are more likely to be overweight than females, but males and females are equally likely to be obese. Obesity is more prevalent among Black Non-Hispanic and Hispanic people than among White Non-Hispanics. Older adults ages 65+ have lower rates of obesity than middle aged adults in New York State. People with a college education have lower rates of obesity than those with lower educational attainment. Disabled people are more likely to have obesity.

Current tobacco smokers make up 10.8% of the adult population in Westchester, and 12.0% of New York State adults. More males than females smoke, with lower education and lower income being correlated to higher rates of smoking. A greater percentage of individuals covered by Medicaid smoke than those who have other forms of health insurance. Unemployment, frequent mental distress, and disability status are factors associated with higher smoking rates.

Nearly 26% of Westchester adults on an age-adjusted basis have high cholesterol compared to

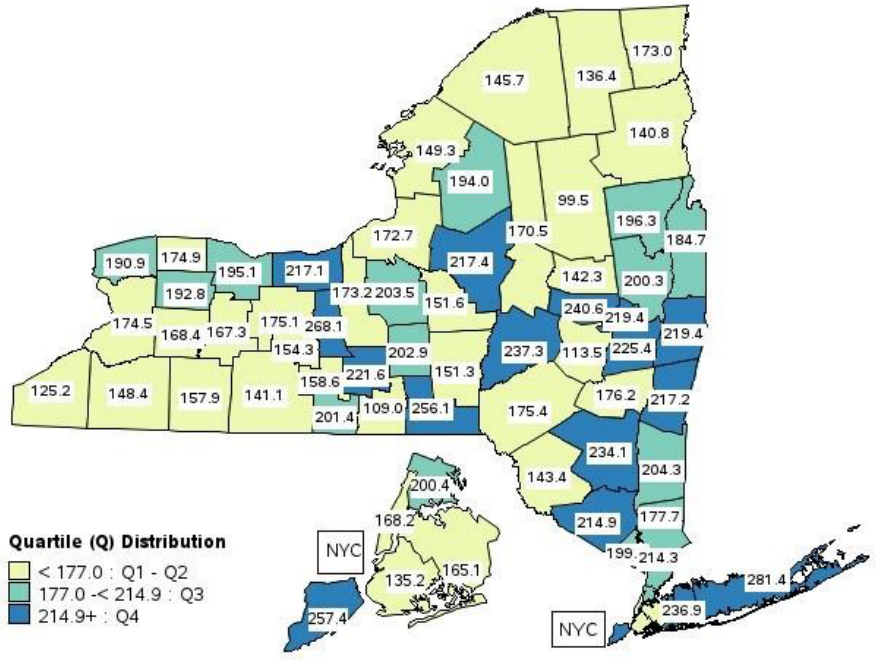
32.6% of New York State adults. High cholesterol is more prevalent among males, older adults, and White Non-Hispanic people. It is found more often in individuals with diabetes and high blood pressure.

Diabetes prevalence is 8.1% in Westchester, compared to 10.3% in New York State. Diabetes prevalence is higher among Black Non-Hispanic and Hispanic populations than among White NonHispanics. It is also higher among older adults. Lower educational attainment and income are associated with greater prevalence of diabetes, as is obesity and disability status.

Accidents and injuries also contribute to poor health outcomes. In Westchester County, hospitalizations due to falls among adults ages 65+ were 214.3 per 10,000 such individuals in 2019. This compares to the rate for the Mid-Hudson region of 208.7 and to the rate for New York State of 193.9, per SPARCS data as of February 2022. Thus, Westchester County has worse outcomes compared to regional and state experience.

Hospitalizations due to falls among adults, rate per 10,000 population, aged 65+ years, 2019

Prevention Agenda 2024 Objective: 173.7



Data Source: SPARCS, data as of February 2022

Secondary data were reviewed from a number of sources to learn about the overall health of Westchester County and compare it to that of New York State. Following is a list of sources and tools that were used:

United State Census Bureau Quick Facts

This data access tool offers basic population, business and geography statistics for all states and counties and for cities and towns with a population greater than 5,000.

https://www.census.gov/programs-surveys/sis/resources/data-tools/quickfacts.html

American Community Survey:

The American Community Survey (ACS) replaced the Decennial Census as an ongoing survey of the United States population that is available at different geographic scales (e.g., national, state, county, census tract or census block group). ACS is a continuous survey that addresses issues related to demographics, employment, housing, socioeconomic status, and health insurance.

http://www.census.gov/programs-surveys/acs/about.html

New York State Prevention Agenda Dashboard:

The New York State Prevention Agenda Dashboard is produced by the New York State Department of Health and systematically aggregates data for the entire state and for each county for dozens of health indicators that align with the New York State Prevention Agenda. The Prevention Agenda Dashboard is not a single database, but rather a compilation of diverse databases.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

The County Health Rankings and Roadmaps (CH&R) is a program of the University of Wisconsin Population Health Institute. The CH&R provides data related to health behaviors, factors and outcomes to inform leaders and improve health equity. Westchester, New York | County Health Rankings & Roadmaps

Behavioral Risk Factor Surveillance System (BRFSS) 2019, 2020, New York State and Westchester County

The BRFSS is the nation's premier system of telephone surveys that collect state0level data about health risk behaviors, chronic health conditions, and use of preventive services. Data are available by state and county as well as census tract and zip code in the PLACES module.

https://chronicdata.cdc.gov/500-Cities-Places/PLACES-Local-Data-for-Better-Health-County-Data20/swc5-untb

National Center for Health Statistics, National Vital Statistics System: WISQARS injury data

This site is an interactive, online database for fatal and non-fatal injury, violent death, and cost of injury data. statistics query and reporting system. Queries can be made by fatal and non-fatal incidents, by age, gender, and race/ethnicity.

https://www.cdc.gov/injury/wisqars/index.html

CDC Interactive Atlas of Heart Disease and Stroke

This resource from the CDC offers data that is searchable by geographic area, including down to the county level, cardiac condition, health indicator, race/ethnicity, gender, and age.

https://www.cdc.gov/dhdsp/maps/atlas/index.htm

The Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive payer data reporting system that collects patient data. It originally was created in 1979 to collect information relating to patient discharge from hospitals.

https://www.health.ny.gov/statistics/sparcs/#:~:text=Statewide%20Planning%20and%20Research%20Cooperative%20System%20(SPARCS),-Overview&text=SPARCS%20is%20a%20comprehensive%20all,information%20on%20discharges%20from%20hospitals.

b. Community Engagement for Needs Assessment Process

i. Process for Engaging with the Community

In early 2022, the Greater New York Hospital Association (GNYHA) offered member hospitals and health systems the opportunity to participate in the GNYHA Community Health Needs Assessment (CHNA) Survey Collaborative. A diverse group of GNYHA member hospitals participated in the 2022 collaborative, including community and safety net hospitals, small health systems, and large academic medical centers located in Orange, Rockland, Westchester, Bronx, New York, and Nassau counties. Burke Rehabilitation Hospital accepted this offer and became part of the collaborative group. The collaborative supported participating members' primary data collection efforts to meet the requirements of the Federal CHNA and the New York State Community Service Plan (CSP) by gathering information on community health needs and engaging with community members. While not a required element of a CHNA, surveys can be part of a hospital's CHNA and CSP along with other community engagement efforts and secondary data such as surveillance data from public health departments.

GNYHA developed a health needs assessment survey with member input and made the survey available in English and the 10 most frequently spoken foreign languages in New York State, including Arabic, Bengali, Chinese, Haitian Creole, Italian, Korean, Polish, Russian, Spanish, and Yiddish. GNYHA developed the survey using best practice approaches in survey design and needs assessment. GNYHA members provided input in multiple stages through a collaborative and iterative process. The survey used validated questions from existing surveys such as the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (CDC BRFSS) and the New York City Department of Health and Mental Hygiene's Community Health Survey (NYC CHS). GNYHA sought to minimize respondent burden by keeping the survey length to a minimum. It contained 22 items that asked respondents to evaluate and rank their health needs and recent health status on a Likert scale as well as report demographic and other information. The survey was fielded as a convenience sample.

The survey was available on paper and online, including via a QR code. It was compatible with mobile devices. The survey was fielded between April 11 and June 30, 2022. Collaborative members disseminated the survey via their community partners as well as through their own clinics and medical offices, at community events and via other opportunities. Before the collaborative began, participating hospitals gave GNYHA a list of the counties or zip codes where the hospital would field the survey. GNYHA attributed respondents who lived in a hospital's survey service area to that hospital. More than 17,600 community members responded. In Westchester County, Burke's primary service area, 3,377 surveys were completed by adults ages 18 and older or about 0.43% of the eligible population.

Following the survey's close, GNYHA collected the data and analyzed the results. GNYHA provided each hospital with a report that summarized the survey responses and respondent demographics, and a spreadsheet with the processed respondent-level data for their service area, allowing for participating hospitals to conduct additional analyses.

For Westchester County, the CHNA collected responses from 3,377 residents over the age of 18. A demographic analysis of the respondents showed them to be more female, white, older and affluent than the general make-up of the County.

ii. Community Partners Involved

Burke distributed the questionnaire primarily electronically. Burke posted the QR code for the survey at all of its 12 outpatient sites and at the medical practice located on campus. Paper copies were available at each of these sites as well. Burke also fielded the survey through its community partners, all of which are located in Westchester County. The QR code was posted on the television screens in patient hospital rooms for patients to participate if desired. The questionnaire was also distributed at a community event held in May on Burke's campus as well as during adaptive sports activities. The survey link was also posted on Burke's social media pages, including Instagram, Facebook, LinkedIn, and Twitter. Paper copies were available in the lobby of the hospital for visitors to complete.

Burke's sent the electronic survey link to its community partners, who were asked to forward the questionnaire to their constituents for completion. These partners comprise a diverse array of organizations serving different age groups, social needs and areas in the County. The community-based partner organizations included:

- Westchester County Government
- Westchester County Department of Health
- The Town of Greenburgh
- The Westchester County Association
- The City of White Plains
- Rye Community Synagogue
- Rye Derby
- Pound Ridge Recreation Department
- At Home on the Sound
- Somers Chamber of Commerce
- Armonk Chamber of Commerce
- Rye Trustees
- Volunteer NY
- Larchmont Recreation Department
- Westchester Children's Association
- American Heart Association
- Childcare Council of Westchester
- RDC Center for Counseling
- United Hebrew
- Sarah Neuman-The New Jewish Home
- Westchester Community College

- Manhattanville College
- Pace University
- Purchase College

c. Assets and Resources to Address the Community Health Needs

Many of the health conditions and disparities uncovered through the health needs assessment have their roots in social determinants, such as income and educational attainment. Poor levels of social determinants are more prevalent among Black or Hispanic individuals than non-Hispanic whites, and such social determinants are frequently predictive of poorer health. Geographical barriers and the physical environment can also play a role in access to care, opportunities for physical activity, and access to nutritious food. These social and physical determinants are the target of organizations that provide services to reduce or eliminate the conditions that lead to poor health and health disparities. The following programs in Westchester County respond to such needs. This is by no means an exhaustive list, but the tables include some of the most prominent organizations serving human needs. Many of these community resources specifically address the New York State Prevention Agenda priority areas.

Organization/Program Name	**Description**	**Target Population(s)**
American Heart Association/American Stroke Association www.heart.org	Provides education, screening and events for the community related to cardiovascular disease and stroke prevention and treatment. Main focus on physical activity and nutrition.	Individuals with cardiovascular disease or stroke, or those looking to prevent these conditions

Blythedale Children's Hospital Eat Well, Be Well Program www.blythedale.org/kohls	Educates children in schools and low income individuals through classroom instruction, community events and collaborations with food pantries to teach healthy eating habits and provide access to food.	Children and low income families
Family Services of Westchester www.fsw.org	Provides early childhood services, employee assistance programs, family mental health, intergenerational home program, services for the aging, youth and veterans.	Low income and at risk populations
Feeding Westchester www.feedingwestchester.org	Provides fresh produce and healthy food options children's programs, a mobile food pantry and cooking and nutrition classes. Staff make home visits and help families utilize the SNAP program.	Low-income families, food insecure families, children and underserved communities

Blythedale Children's Hospital Eat Well, Be Well Program www.blythedale.org/kohls	Educates children in schools and low income individuals through classroom instruction, community events and collaborations with food pantries to teach healthy eating habits and provide access to food.	Children and low income families
Hope's Door www.hopesdoorny.org	Offers free individual and group counseling, emergency shelter, legal and advocacy services for victims of domestic violence.	Victims of domestic violence
Inter-Care www.inter-care.com	Outpatient individual and group counseling and treatment for individuals battling substance abuse.	Individuals abusing alcohol and other substances
Lifting Up Westchester www.liftingupwestchester.org	Helps men, women and children in need by providing food, shelter, support, mentoring and support for mental illness and substance abuse.	Low income individuals and families dealing with mental illness, homelessness, HIV/AIDS, and substance abuse
Local colleges: Westchester Community College, Purchase College - SUNY, Mercy College	Offer health services to students, health education resources and programs. Support tobacco-free lifestyle.	Students
My Sister's Place www.mspny.org	Offers individual and group counseling, emergency shelter, legal and advocacy services for victims of domestic violence and human trafficking.	Victims of domestic violence and human trafficking.
Open Door Family Medical Center www.opendoormedical.org	Offers primary care for all at affordable prices. Includes human services, prevention and wellness, medical	Individuals in need of medical services with
	condition treatment, dental, behavioral health and pharmacy services, regardless of ability to pay.	any level of (or no) financial resources.

Blythedale Children's Hospital Eat Well, Be Well Program www.blythedale.org/kohls	Educates children in schools and low income individuals through classroom instruction, community events and collaborations with food pantries to teach healthy eating habits and provide access to food.	Children and low income families
Planned Parenthood www.plannedparenthood.org	Provides affordable health services for mostly, but not exclusively, females. Services available for people with or without health insurance, including sex education, STI testing, birth control, abortion, HIV services, LGBT services, pregnancy testing and services and family planning.	Women of all ages and men, with or without health insurance, seeking reproductive or sexual healthcare services.
Pow*r Against Tobacco www.powragainsttobacco.org	Partners with local businesses and notfor-profit organizations and private citizens to reduce tobacco use.	Individuals looking to quit or prevent others' smoking
The Mental Health Association of Westchester www.mhawestchester.org	Promotes mental health through advocacy, community education and direct services.	At risk youth and families
The Sharing Community www.thesharingcommunity.org	A soup kitchen open to anyone who is hungry. Meals also provided to residents in transitional housing and men's shelters. Holiday meals on Thanksgiving and Christmas.	Homeless and hungry
NY Smoke Free https://www.nysmokefree.com/	Provides guidance, coaching and evidence-based help to quit smoking and vaping	Individuals looking to quit smoking
United Way of Westchester and Putnam www.uwwp.org	Focuses on financial stability for individuals and families Targets the root causes of poverty and provides job training and tools.	Low income families/families living in poverty
WestCOP www.westcop.org	Provides services to individuals of all ages, including nutrition, mental health, energy cost reduction, housing, financial assistance, employment and emergency shelter.	Low income and at risk populations
YWCA of White Plains and Central Westchester www.ywcawpcw.org	Provides economic empowerment, leadership development opportunities, health and wellness services and	Women, and specifically racial minority women

Blythedale Children's Hospital Eat Well, Be Well Program www.blythedale.org/kohls	Educates children in schools and low income individuals through classroom instruction, community events and collaborations with food pantries to teach healthy eating habits and provide access to food.	Children and low income families
	advocacy for racial justice, prison system reform and racial equality.	

Westchester County also provides community members with a number of civic and natural resources, including public and private schools, libraries, healthcare facilities, outdoor recreational spaces and parks, bike lanes and more that are assets for living a healthy life.

Local Government

The Westchester County local government provides a multitude of departments and offices specifically designed to help better the lives of Westchester residents. These departments are: budget, consumer protection, correction, attorney-law, emergency services, environmental facilities, finance, health, human resources, human rights, information technology, labs and research, law, mental health, parks, planning, probation, public safety, public works, senior programs and services, social services, tourism and transportation. These offices provide specific services, programs, resources and advocacy work at the county level.

Local Health Department

The Westchester County Department of Health is a strong resource for healthcare facilities as well as community members. The department provides population health resources and programming and leads policy initiatives to improve the health of all communities in the County. A list of services available from their website includes: air quality, animal disease control, asbestos, childhood lead poisoning prevention, public health emergency complaints, early intervention, flu prevention, food service establishment, prenatal care encouragement and connection, health insurance, hazardous material

response, healthy heart strategies, HIV/AIDS, home health, immunizations, individual sewage and well water supply systems, Lyme disease, petroleum bulk storage, prenatal care, preschool education, public water supply, rabies, radiological health, realty, services for children with disabilities, sexual health, smoking, solid waste, temporary residence, tick-borne diseases, tuberculosis and water quality. The Westchester County Department of Health is a strong and active resource in the community.

Healthcare Facilities

Westchester County is home to over a dozen hospitals, including tertiary care hospitals, a physical rehabilitation hospital, and psychiatric hospitals. Westchester also offers many outpatient healthcare facilities. These facilities provide care for the full range of health-related conditions. Many of these outpatient facilities are affiliated with a county hospital or hospital system. According to the County Health Rankings from the University of Wisconsin, in 2019, the ratio of primary care physicians to patients in Westchester County was 720:1. This compares to the ratio in New York State of 1,180:1 and in the United States of 1,310:1.

Community-Based Organizations

Westchester County is home to hundreds of community and faith-based organizations which are all important resources for community members. Some examples were listed in the above resource table. These organizations may provide specialized services for a particular social or human services issue, or may provide a wide range of services for a number of different populations. Referrals are made to these local organizations when Burke or another facility does not have the specialty training or resources to provide the services and care the individual needs. Many organizations are culturally targeted to reach specific populations. Some examples of services provided include advocacy for policy change, counseling and education, medical screening and treatment, legal assistance, physical goods

donations, connection to specific other resources, and enrollment in social service programs such as Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Medicaid, subsidized childcare and more. When possible, many times these organizations work with one another or the local government to extend their reach and the level of services and resources they can provide.

Outdoor Space

The county of Westchester has 52 sites which serve as parks, trail ways, points of interest and historical sites, public golf courses and nature preserves. Most parks are available to community members free of charge and without a park pass. Many of the parks offer equipment, children's programming, art, special programs and recreational events. Westchester County also boasts paved bicycle and pedestrian paths, hiking and mountain biking trails. County-wide, Westchester encourages children to get out and play, and all individuals to engage in safe and healthy outdoor activity, as evidenced by the outdoor infrastructure in place to facilitate activity.

Section 5: Prioritized Health Needs to be Addressed

a. Health needs uncovered through the Community Health Needs Assessment

The Community Health Needs Assessment (CHNA) enabled assessors to learn about the health needs and priorities of the community members who responded to the survey. The survey plan called for a convenience sampling of the population aged 18 and older in each hospital's catchment area. The findings included respondents' importance rankings of 21 priority health conditions, as designated by the New York State Prevention Agenda. Respondents also ranked their satisfaction about each health condition with regards to how much attention is being paid to the condition by healthcare and community-based organizations.

Respondents endorsed violence, including gun violence, mental health/depression, and stopping falls among the elderly as health conditions that need attention. These conditions were in or near the top one-third of all 21 conditions that respondents ranked for importance. Other conditions that were ranked of greater importance included:

- Dental care (#1)
- Cancer (#2)
- Access to healthy/nutritious food (#3)
- COVID-19 (#5)
- Heart Disease (#6)

Respondents felt that adequate efforts were already being made on these five health issues.

Besides the primary source information that was collected via the CHNA, Burke also looked at secondary sources of information on the health conditions of people living in Westchester County, our most important catchment area. The New York State Department of Health reports that heart disease has been the leading cause of death amongst residents of Westchester County for every year from 2010 to 2019, the last year for which the report is available. This was true for both males and females.

Cancer is the second greatest cause of death, and this was also consistent over the ten-year period and consistent across males and females. Unintentional injury, which includes falls, was ranked third for males, but seventh for females and overall was the fifth most important cause of death.

Leading Causes of All Deaths for Total Population
Selected Counties: Westchester

Top 7 Causes

		Number of deaths and age-adjusted death rate							
		Total Deaths	#1 Cause of Death	#2 Cause of Death	#3 Cause of Death	#4 Cause of Death	#5 Cause of Death	#6 Cause of Death	#7 Cause of Death
Westchester	2019	Total Deaths 7,244 524.1 per 100,000	Heart Disease 1,934 132.0 per 100,000	Cancer 1,612 121.5 per 100,000	CLRD 319 22.4 per 100,000	Cerebrovascular Disease 281 19.6 per 100,000	Unintentional Injury 265 24.3 per 100,000	Pneumonia and Influenza 176 12.0 per 100,000	Diabetes 164 12.0 per 100,000
	2018	Total Deaths 7,383 535.8 per 100,000	Heart Disease 2,038 139.1 per 100,000	Cancer 1,535 115.8 per 100,000	Cerebrovascular Disease 325 23.6 per 100,000	CLRD 320 22.4 per 100,000	Unintentional Injury 300 27.8 per 100,000	Pneumonia and Influenza 233 16.2 per 100,000	Alzheimer's Disease 160 10.2 per 100,000
	2017	Total Deaths 7,163 526.9 per 100,000	Heart Disease 2,064 143.5 per 100,000	Cancer 1,496 115.7 per 100,000	Unintentional Injury 301 27.8 per 100,000	Cerebrovascular Disease 300 21.6 per 100,000	CLRD 264 19.0 per 100,000	Pneumonia and Influenza 201 14.0 per 100,000	Alzheimer's Disease 172 11.0 per 100,000
	2016	Total Deaths 7,094 529.9 per 100,000	Heart Disease 2,091 147.7 per 100,000	Cancer 1,665 128.7 per 100,000	Unintentional Injury 306 28.3 per 100,000	Cerebrovascular Disease 294 21.5 per 100,000	CLRD 256 19.0 per 100,000	Pneumonia and Influenza 210 15.1 per 100,000	Septicemia 182 13.4 per 100,000
	2015	Total Deaths 7,025 530.7 per 100,000	Heart Disease 1,972 141.6 per 100,000	Cancer 1,618 127.6 per 100,000	Cerebrovascular Disease 302 22.4 per 100,000	CLRD 279 20.8 per 100,000	Unintentional Injury 272 25.0 per 100,000	Pneumonia and Influenza 213 15.0 per 100,000	Septicemia 172 12.5 per 100,000

CLRD: Chronic Lower Respiratory Diseases
*Rates based on fewer than 10 events in the numerator are unstable.
Note: Ranks are based on numbers of deaths, then on mortality rates. Where county's death counts and rates are tied, '(tie)' appears at the bottom of the corresponding cells, and causes are further ranked alphabetically.
If a cell is blank, then there were no deaths from any of the 25 causes used in our tables. These causes are listed in the technical notes.

Source: Vital Statistics Data as of January 2022

b. Priority Health Needs to be Addressed by the Community Service Plan

Burke has identified two areas of focus for the Community Service Plan for 2022-2024. The choice of focus area is based on:

- the Community Health Needs Assessment (CHNA) conducted in the Spring of 2022
- an evaluation of prevailing health conditions and needs utilizing various secondary sources as documented above
- discussion of priority areas with a collaborating tertiary hospital partner in our catchment area

Burke's unique healthcare knowledge and capabilities.

Burke has chosen to focus on:

- Falls prevention among seniors
- Secondary prevention of heart attacks

Burke selected these focus areas though discussion with clinical personnel at Burke and at our sister hospital in the Montefiore Health System, White Plains Hospital. We selected these areas because falls among seniors and cardiac disease and death place a heavy burden on the community, disrupting lives, causing premature deaths, and costing the national healthcare system billions of dollars each year. The impact of these health conditions is felt widely. Health disparities are observed for these conditions, disadvantaging large groups of people who suffer disproportionately. Burke's physical medicine and rehabilitation expertise uniquely positions us to deliver effective and well-supported programs in the two focus areas. Burke has deep capabilities in the field of rehabilitative medicine through our medical professionals, both Board-Certified Physical Medicine and Rehabilitation physicians and allied health professionals, and our knowledge and practice of falls prevention through our normal care practices. Additionally, we are expert in the delivery of cardiac rehabilitation through our Cardiac Rehabilitation Program, staffed by physicians and exercise physiologists. We also have physical resources to devote to addressing these community health needs, including our cardiac rehabilitation facility and our fitness center.

Burke has chosen not to focus on other areas that were ranked highly by CHNA respondents. These included dental health, violence prevention, including gun violence, and mental health/depression. Other areas that are important in the broader population include cancer and chronic lower respiratory diseases, which are major causes of death in Westchester County. Burke chose not to focus on these other areas in favor of pursuing high-value health improvements for which we have a specific and unique expertise. Other hospitals in Westchester County that are acute care community or

tertiary hospitals treat patients with a broad array of health issues. They are better equipped to focus on issues such as cancer prevention and improving mental health.

The focus areas for the current plan correspond to some of the interventions that would have been undertaken for the 2019-2021 Community Service Plan. In that plan, falls reduction was identified as a focus area, as was increasing physical activity in the population through programs in our Fitness Center. As the plan would have gotten underway, the COVID-19 pandemic struck New York. Burke, like all hospitals in our region, had to modify its operations, shut down non-essential programs, including all outpatient sites and the Fitness Center, and place all personnel in positions to meet an overwhelming demand for medical care for COVID patients. As the first wave of COVID infection hit, Burke transformed itself by setting up hospital beds in the therapy gyms to accommodate up to 90 COVID patients in residence at one time. We also acted as a safety net for rehabilitation units in other hospitals, including those in New York City and as far away as upstate New York. Those hospitals had curtailed their inpatient acute rehabilitation care in order to treat more COVID patients. Burke received the patients that were transferred to us and provided the rehabilitative care that could not be gotten elsewhere.

Since the start of the pandemic, we have cared for approximately 698 patients rehabilitating from COVID, either as a primary diagnosis or with co-morbidities. We were also a site for COVID-19 vaccine administration when the vaccines were first made available to the public. Our nurses and other personnel ran 35 vaccine clinics in the hospital. The initial clinics were run for health care professionals, whether affiliated with Burke or from other practices, such as dentistry. When the public was allowed to receive vaccination, Burke ran 23 clinics for members of the public. We advertised to the public to let residents of the County know that vaccines were available through us, seeking out underserved Black and Hispanic residents to help mitigate health disparities in these groups. We administered approximately 4,797 vaccines, of which 3,090 were given to members of the public. We continue to treat COVID-19 patients, though vaccine administration has since been moved to pharmacies and other outpatient facilities by the NYS Department of Health.

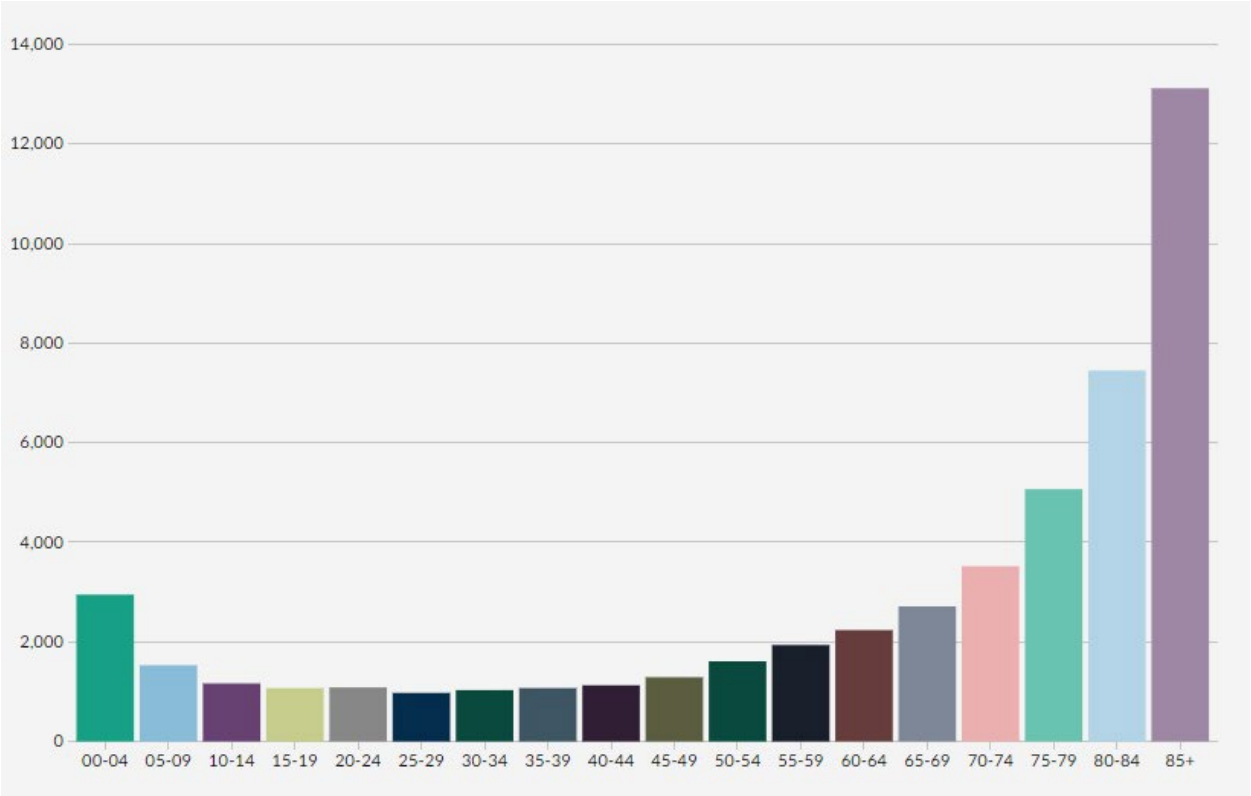
COVID-19 infection rates have now dropped from their peak levels, and hospital operations have normalized to a great extent. We intend to carry out the 2022-2024 Community Service Plan, including providing annual status reports, as written.

Focus Area One: Falls Prevention Among Seniors

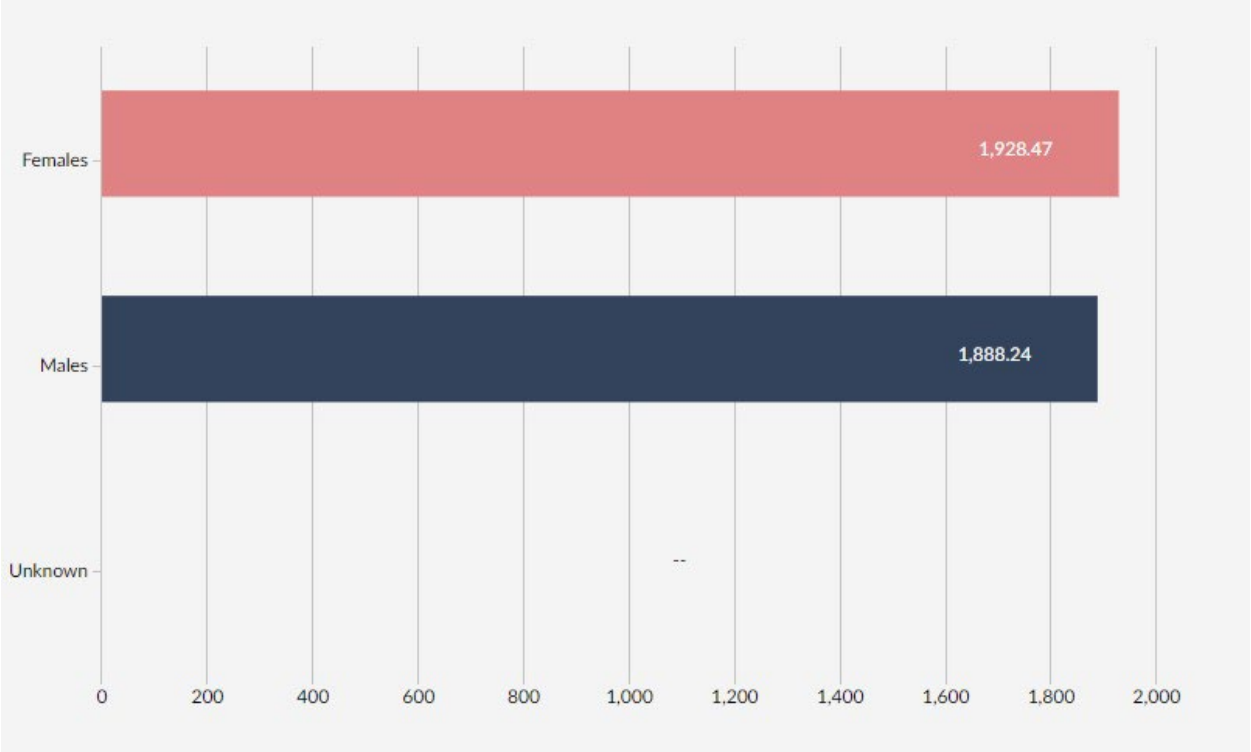
Respondents to the CHNA rated falls prevention among the elderly as a health condition that needs attention. Of 21 health conditions, it was ranked number eight in importance.

Falls are amongst the most common reasons older individuals visit hospital emergency rooms. According to the CDC, nationally approximately 36 million adults ages 65+ fell in 2018, which comprises 28% of that population. Data for the following three graphs are taken from the NEISS All Injury Program operated by the Consumer Product Safety Commission for numbers of injuries, and the Bureau of Census for population estimates. The graphs are published by the CDC on its WISQARS website for nonfatal and fatal injuries.

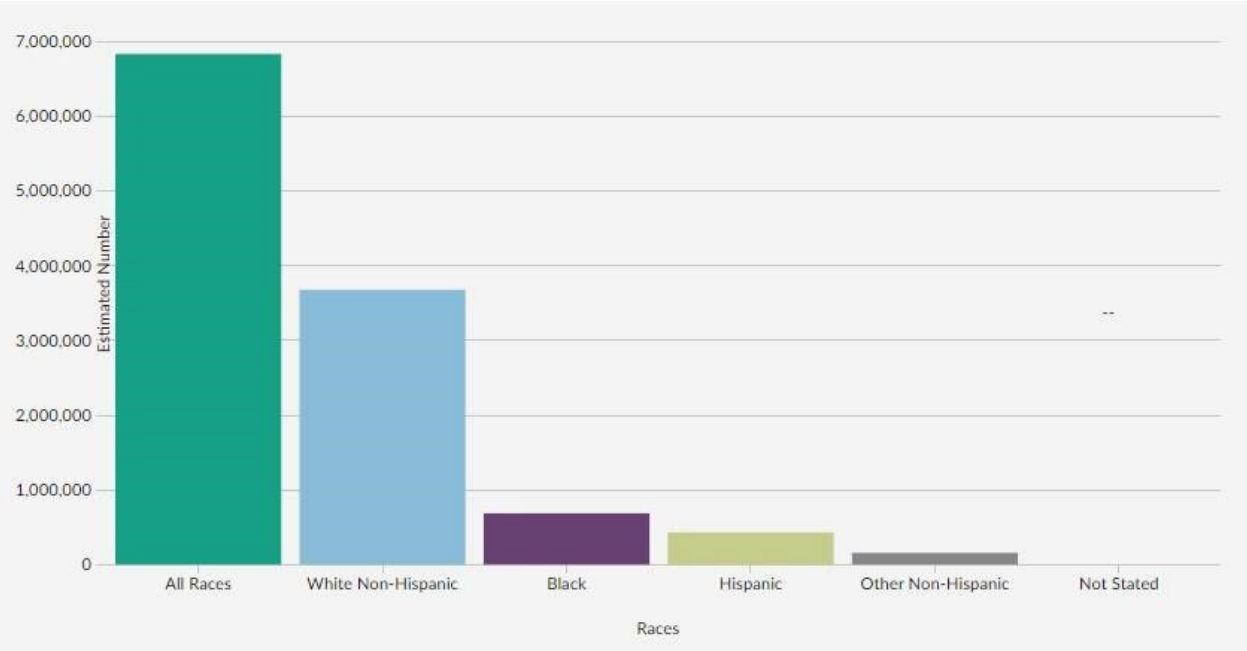
Non-Fatal Falls by Age, Crude Rate per 10,000, 2020



Non-Fatal Falls by Gender, Age-Adjusted Rate per 10,000, 2020



Non-Fatal Falls by Race, Estimated Number, 2020



2020, United States
Unintentional Fall Deaths and Rates per 100,000
All Races, Both Sexes, Ages 65 to 85+
ICD-10 Codes: W00-W19

Race	Sex	Number of Deaths	Population	Crude Rate
White	Males	16,078	21,156,615	76.00
	Females	17,783	25,716,469	69.15
		33,861	**46,873,084**	**72.24**
Black	Males	792	2,226,543	35.57
	Females	704	3,254,723	21.63
		1,496	**5,481,266**	**27.29**
Am Indian/AK Native	Males	86	213,209	40.34
	Females	86	259,577	33.13
		172	**472,786**	**36.38**
Asian/Pac Islander	Males	505	1,225,141	41.22
	Females	474	1,607,088	29.49
		979	**2,832,229**	**34.57**
		36,508	**55,659,365**	**65.59**

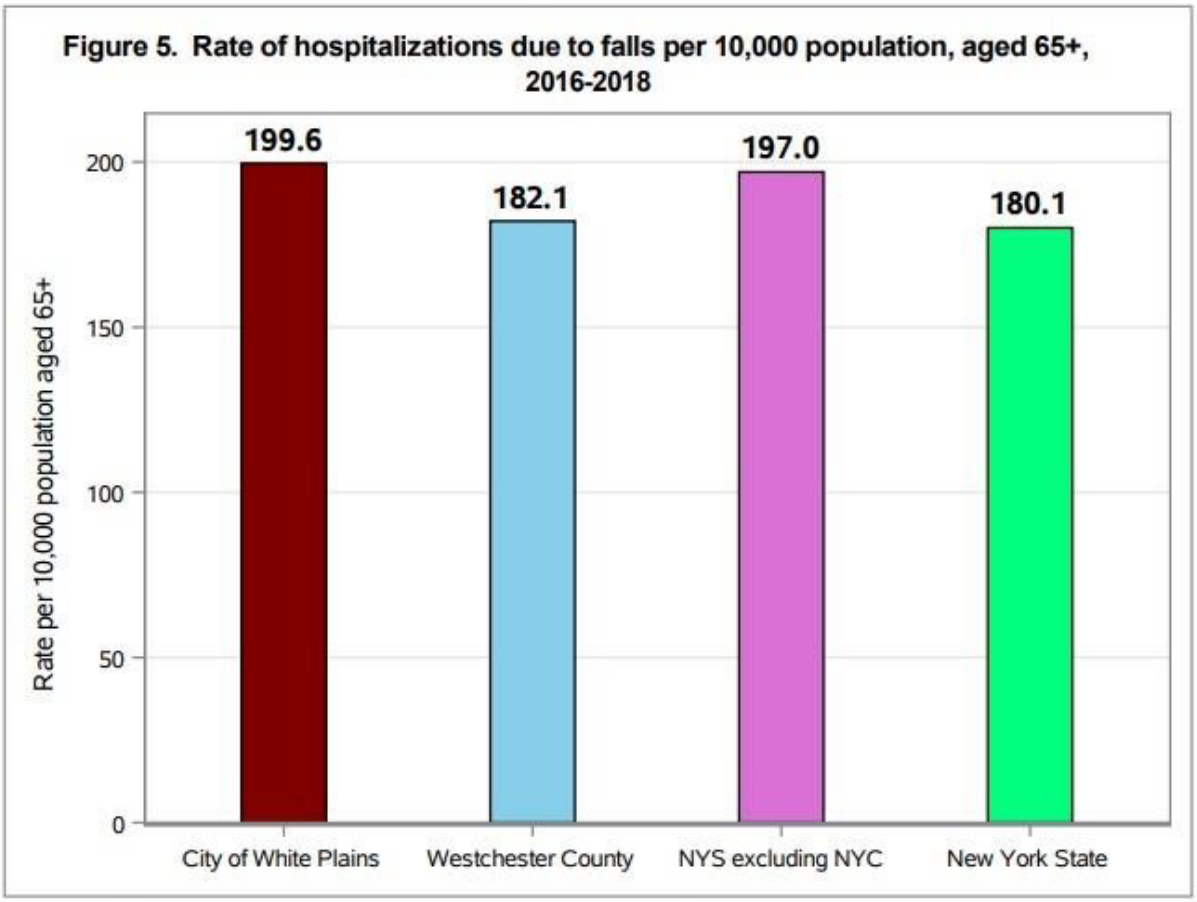
Produced by: National Center for Injury Prevention and Control, CDC
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

These graphs and table depicting national data demonstrate dramatically that the rate of falls begins to rise in late middle age and that it rises precipitously with advancing age. Females sustain more falls than males. It is difficult to ascertain differences based on race/ethnicity for non-fatal falls, since the data on falls by race include many data points where race was not stated. The data for fatal falls show a health disparity for Whites, where the crude rates are substantially higher than for other racial/ethnic

groups. However, this could be due to non-Whites dying earlier than Whites and from other causes, leaving more longer-lived whites to die from falls.

In New York State, the rate of falls in the elderly was 25.9% in 2018, about equal to the national rate. Falls lead to injuries requiring medical treatment in more than one-third of the cases. Falls are the leading cause of injury-related death among older adults. The age-adjusted rate of death due to falls in the United States was 64 per 100,000 adults ages 65+ in 2018, and this rate is rising. The age-adjusted rate of death due to falls in New York State was lower at 43 per 100,000 older adults.

SPARCS data for the years 2016 – 2018 show New York State had a rate of hospitalization due to falls among the elderly of 180.1 per 10,000. Westchester County has essentially the same rate of hospitalization due to falls among people 65+. The City of White Plains has a higher rate of hospitalization due to falls among the elderly, 199.6 per 10,000.



Source: Statewide Planning and Research Cooperative System (SPARCS)

The cost of falls is significant. Estimates from the CDC peg the cost of care for non-fatal injuries at $50 billion annually, while costs related to fatal falls run to $754 million. New York State bears the thirdhighest costs of care due to falls, exceeded only by California and Florida.

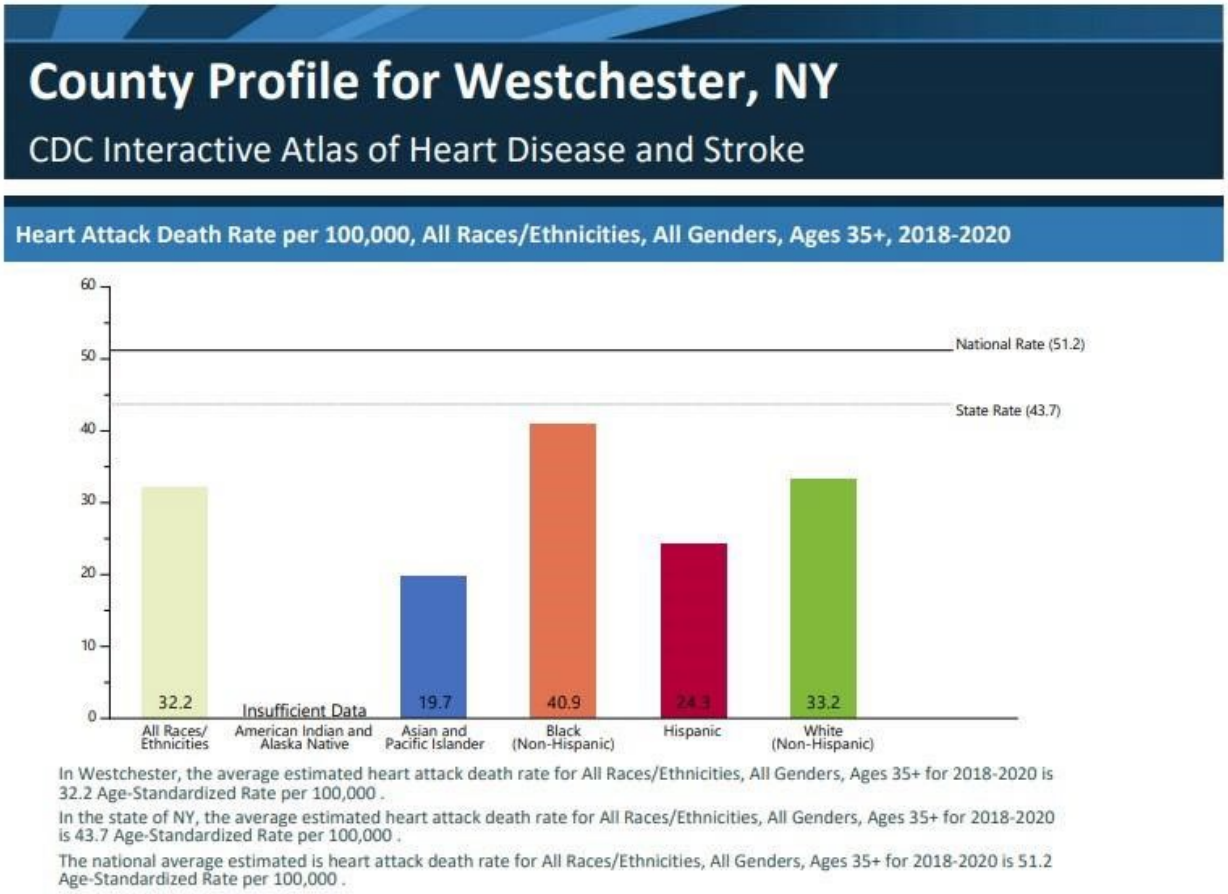
- ***Focus Area Two: Secondary Prevention of Heart Attacks***

The second focus area selected by Burke is heart disease, specifically, the secondary prevention of heart attacks. CHNA survey respondents ranked heart disease sixth of 21 health conditions in importance to them. Respondents also indicated that efforts should be maintained in preventing and treating heart disease, suggesting that this is an intermediate priority for this group of respondents.

Heart disease is the number one killer nationally for most racial and ethnic groups in the US. The American Heart Association reports in a 2022 update that about 805,000 individuals experience a heart attack annually. Of these, about 200,000 are subsequent heart attacks in individuals who had already sustained a heart attack.

In Westchester County, the heart attack death rate for individuals ages 35+ was 32.2 per 100,000 population for the period 2018-2020. Black Non-Hispanic individuals had a higher rate, at 40.9, as did White Non-Hispanics, 33.2. Asian/Pacific Islanders and Hispanic individuals had lower rates, 19.7 and 24.3, respectively. This compares favorably to New York State, where the heart attack death rate was 43.7 for all races and ethnicities, 48.4 for Black Non-Hispanic, and 47.2 for White Non-Hispanic. Statewide, other racial/ethnic groups had lower rates. Westchester had the fourth lowest rate of heart attack deaths in this age group and in this period in the State of New York. Nationally, the rate of heart attack deaths was 51.2 for all races/ethnicities, 60.0 for Black Non-Hispanic, and 53 for White NonHispanic. All other racial/ethnic groups were lower than the national average. Thus, Westchester County had better health outcomes with regard to heart attack deaths than New York State and the nation, even among various racial/ethnic groups, including Black Non-Hispanic and White Non-Hispanic.

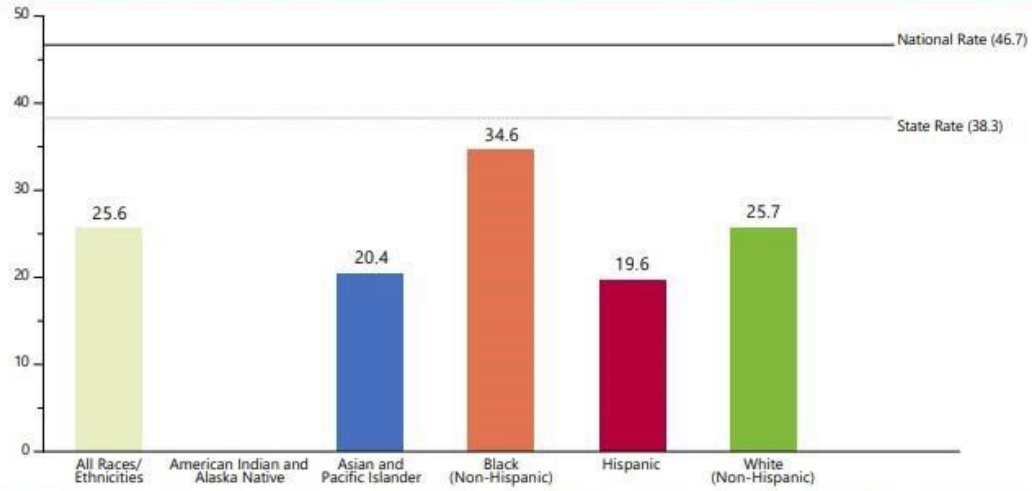
However, significant health disparities exist between racial/ethnic groups and genders within Westchester County, and it is important to put additional focus on Black Non-Hispanics, both women and men, and White Non-Hispanic men when developing health interventions to reduce the rate of second and subsequent heart attacks.



County Profile for Westchester, NY

CDC Interactive Atlas of Heart Disease and Stroke

Heart Attack Death Rate per 100,000, Black (Non-Hispanic), Women, Ages 35+, 2018-2020



In Westchester, the average estimated heart attack death rate for Black (Non-Hispanic), Women, Ages 35+ for 2018-2020 is 25.6 Age-Standardized Rate per 100,000 .

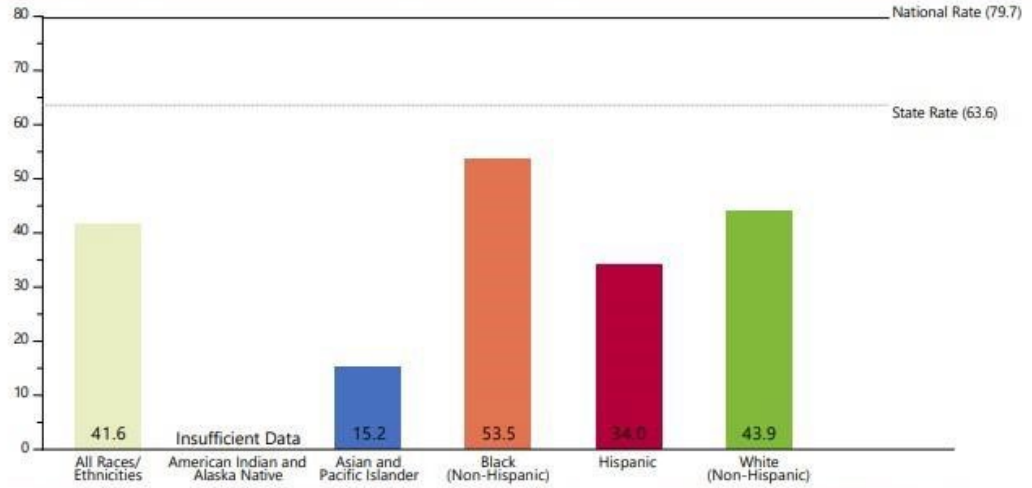
In the state of NY, the average estimated heart attack death rate for Black (Non-Hispanic), Women, Ages 35+ for 2018-2020 is 38.3 Age-Standardized Rate per 100,000 .

The national average estimated is heart attack death rate for Black (Non-Hispanic), Women, Ages 35+ for 2018-2020 is 46.7 Age-Standardized Rate per 100,000 .

County Profile for Westchester, NY

CDC Interactive Atlas of Heart Disease and Stroke

Heart Attack Death Rate per 100,000, Black (Non-Hispanic), Men, Ages 35+, 2018-2020



In Westchester, the average estimated heart attack death rate for Black (Non-Hispanic), Men, Ages 35+ for 2018-2020 is 41.6 Age-Standardized Rate per 100,000 .

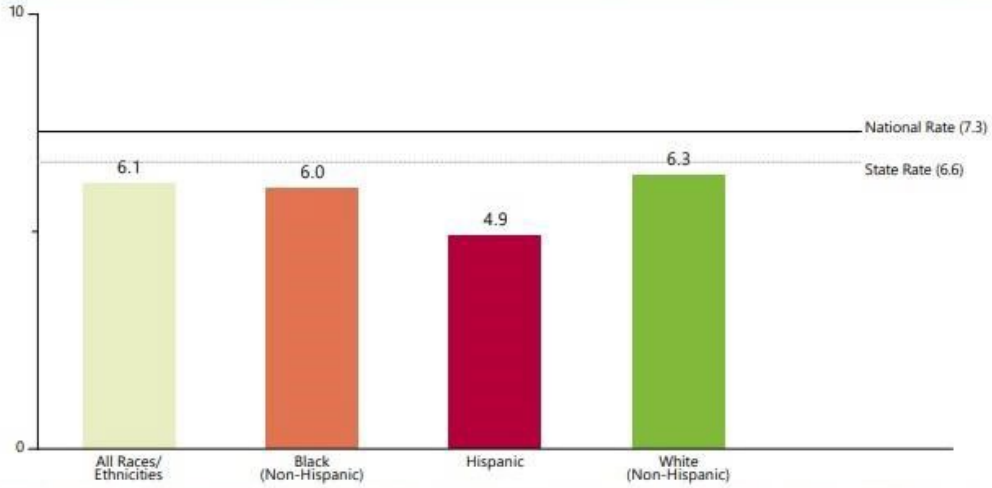
In the state of NY, the average estimated heart attack death rate for Black (Non-Hispanic), Men, Ages 35+ for 2018-2020 is 63.6 Age-Standardized Rate per 100,000 .

The national average estimated is heart attack death rate for Black (Non-Hispanic), Men, Ages 35+ for 2018-2020 is 79.7 Age-Standardized Rate per 100,000 .

County Profile for Westchester, NY

CDC Interactive Atlas of Heart Disease and Stroke

Heart Attack Hospitalization Rate per 1,000 Medicare Beneficiaries, All Races/Ethnicities, All Genders, Ages 65+, 2017-2019



In Westchester, the average estimated heart attack hospitalization rate for All Races/Ethnicities, All Genders, Ages 65+ for is 6.1 Age-Standardized Rate per 1,000 Beneficiaries .

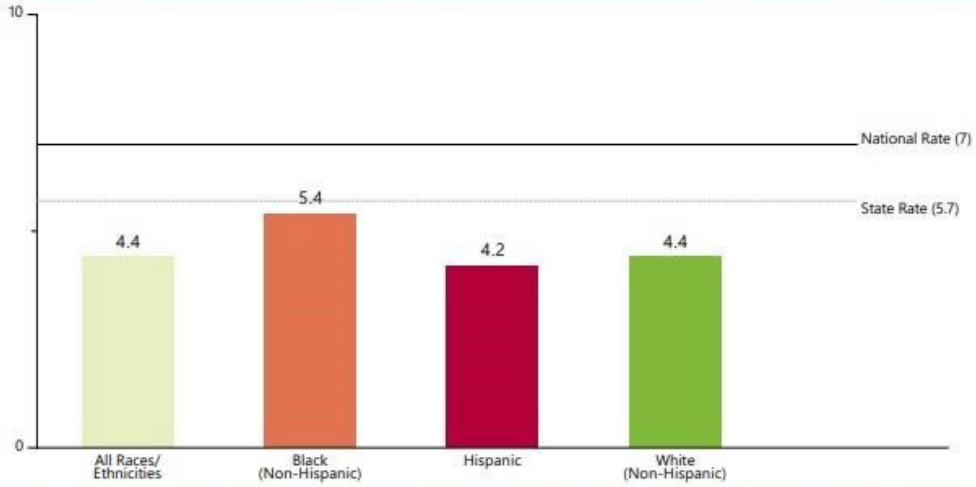
In the state of NY, the average estimated heart attack hospitalization rate for All Races/Ethnicities, All Genders, Ages 65+ for is 6.6 Age-Standardized Rate per 1,000 Beneficiaries .

The national average estimated is heart attack hospitalization rate for All Races/Ethnicities, All Genders, Ages 65+ for is 7.3 Age-Standardized Rate per 1,000 Beneficiaries .

County Profile for Westchester, NY

CDC Interactive Atlas of Heart Disease and Stroke

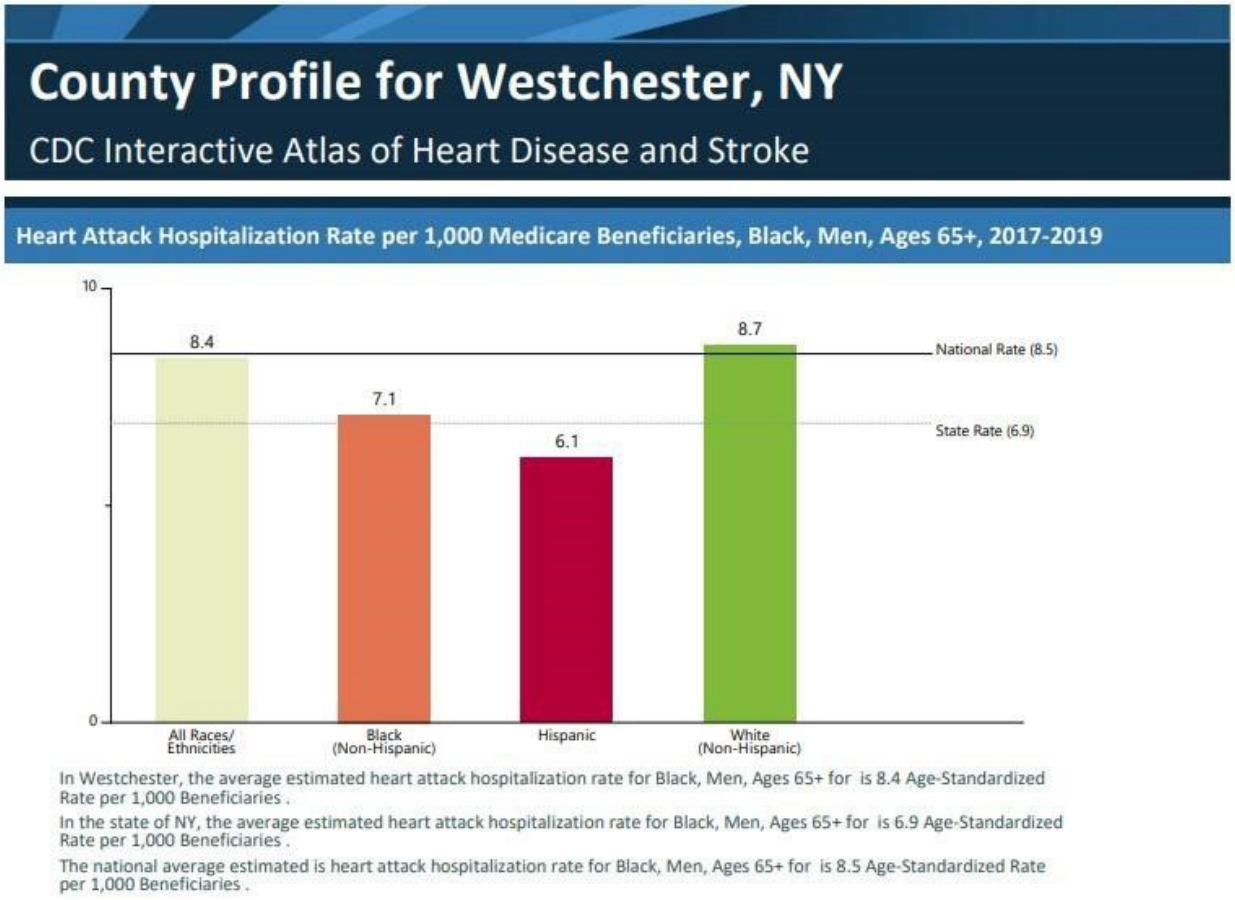
Heart Attack Hospitalization Rate per 1,000 Medicare Beneficiaries, Black, Women, Ages 65+, 2017-2019



In Westchester, the average estimated heart attack hospitalization rate for Black, Women, Ages 65+ for is 4.4 Age-Standardized Rate per 1,000 Beneficiaries .

In the state of NY, the average estimated heart attack hospitalization rate for Black, Women, Ages 65+ for is 5.7 Age-Standardized Rate per 1,000 Beneficiaries .

The national average estimated is heart attack hospitalization rate for Black, Women, Ages 65+ for is 7.0 Age-Standardized Rate per 1,000 Beneficiaries .



Looking at the heart attack hospitalization rate in men ages 65+, the rates show worse outcomes for Westchester residents as a whole, and especially for White non-Hispanics, and to a lesser extent for Black non-Hispanics, than for New York State, and even nationally.

Section 6: Implementation Strategies

a. Falls Prevention in Seniors

Burke will partner with White Plains Hospital (WPH) to implement a three-pronged falls prevention strategy. Burke and WPH are both members of the Montefiore Health System. WPH is located within two miles of Burke, and the organizations cover similar catchment areas. As a tertiary care hospital, WPH is very active in the community and maintains numerous relationships with community organizations for the purpose of promoting health and welfare. Burke and WPH will collaborate on the

falls prevention intervention in order to leverage the strengths of each organization and have greater impact on reducing falls among seniors. The collaboration will undertake the following interventions:

i. Three community events each year during the service plan period to screen individuals for their personal fall risk, assess their risks, and provide information and recommendations to see healthcare providers who can help them reduce their personal risk factors. This intervention will follow the STEADI algorithm of the CDC's National Center for Injury Prevention and Control.
ii. Grand Rounds presentation annually to medical staff of WPH and Burke and to Burke residents and fellows presenting information on evaluating patients for falls and providing a quick screening/educational intervention in office and hospital settings iii. Four community educational events each year targeting residents of assisted living and other congregate-living communities to disseminate information about falls and how to prevent them. These events can be conducted in person or virtually.

Burke and WPH will work closely together to recruit participating community-based organizations and their membership for the falls risk screening and education intervention. The population to be reached is people in the service area who are age 65 or older. Areas with significant health disparities, such as Mount Vernon, Yonkers, and Peekskill, will be prioritized. The events will take place in the community, at gathering places such as churches, community centers, or in adult or assisted living facilities. The collaborative group will identify sites and champions within those sites to assist with recruiting and logistics.

At the outset of the intervention, participants will be asked to complete a validated questionnaire to identify their risk for falls, history of falls, knowledge to avoid falls, and their behaviors surrounding falls avoidance. They will then be assessed on multiple criteria, including gait, strength,

balance, vision and foot problems. Medications that may increase falls risk, potential home hazards, and co-morbidities such as osteoporosis, cardiac issues, Parkinson's Disease, or depression will be identified. Upon completion of the assessment, the participant will receive feedback on their personal risk factors and how they can be mitigated to avoid falls. Recommendations will be made for referrals to providers who can help participants reduce their risk. These include physical therapy or exercise program (e.g., Tai Chi), ophthalmologist or optometrist for vision problems, podiatrist for foot issues, and PCP or internist to manage medications that increase fall risk. Information pamphlets from the CDC will also be provided. After the intervention, participants will complete a short survey assessing their increase in knowledge, intention to follow the recommendations for referrals, and their satisfaction with the program. Participants will be contacted three months post-intervention to assess their adherence to the recommendations and their experience of falls in the post-intervention period.

Burke will provide the assessment tools and surveys. Burke will also provide physical therapists and medical residents to conduct the evaluation and provide individualized fall risk profiles and recommendations to participants. WPH will identify and recruit the sites, provide some therapists for the evaluations, analyze the post intervention surveys and conduct the three-month post-intervention phone calls.

Logic Model for Falls Risk Screening and Assessment Events

Inputs	Activities	Outputs	Outcomes	Impact (Longterm outcomes)
Health professionals to conduct screening	Falls risk assessment via SPPB, ABC	Results of falls risk assessment questionnaire	Increase in knowledge about personal risks for falling	Decrease in annual ED visits due to falls among people 65+
Volunteers at community sites	Vision screening	Results of vision screening	Increase in intention to follow referral(s) to HCP to reduce risk	

Inputs	Activities	Outputs	Outcomes	Impact (Longterm outcomes)
Questionnaires for screening: SPPB and ABC	Assessment of gait, muscle strength, balance, feet/footwear, home hazards, medications, comorbidities	Results from assessment of gait, muscle strength, balance, feet, home hazards, medication, comorbidities	Referrals to appropriate HCPs as determined by screening	
Paper screening forms and pencils	Individual counseling to convey risks, and education and referrals to prevent falls	Information from post-intervention survey	At three-month follow-up, participants report following at least one recommendation they received to lower their falls risk	
Materials for vision screening	Pre-intervention survey on falls risk, history of falls, knowledge to avoid falls	Information from 3-month followup regarding recommendations and falls experience	Participants report no falls in the three-month follow-up period	
Information pamphlets from CDC for consumers on mitigating falls risks	Post-intervention survey on knowledge improvement, likelihood to follow up, and satisfaction	Report of pre and post survey results to stakeholders		
	with the intervention			
Community sites to conduct the intervention	Analysis of pre and post surveys	Report of 3month follow-up to stakeholders		
Checklist of recommendations for participants' needs based on screening results	Phone call at 3 months to assess for follow-up activity and falls since intervention			

Inputs	Activities	Outputs	Outcomes	Impact (Longterm outcomes)
Post-screening survey instrument on knowledge improvement, intention to follow recommendations, satisfaction, etc.				
Evaluator to compile and analyze the pre and post surveys				
Staff to conduct 3month follow-up phone call				
Script for followup phone call				

Goal: Reduce falls among people ages 65+ that result in hospital visits.

P**rocess objectives**:

- By December 31 of each of the years 2023, 2024 and 2025, the Burke/WPH collaborative will conduct three community screening and assessment events for falls prevention, with each event serving a minimum of 20 people.
- By December 31 of each of the years 2023, 2024 and 2025, the Burke/WPH collaborative will conduct one grand rounds presentation for health care providers of each organization to improve understanding and increase adoption of falls screening protocols for in-office visits and for hospital stays.
- By December 31 of each of the years 2023, 2024 and 2025, the Burke/WPH collaborative will conduct four lectures, either virtually or in-person, for people ages 65+

to educate them on risks and avoidance of falls. Each event will serve a minimum of 20 people.

Outcome objectives:

- By the end of each falls screening event, 50% of participants will demonstrate improvement in knowledge about how to avoid falls.
- By the end of the each falls screening event, 35% of participants will demonstrate an increase in their likelihood to follow recommendations to reduce their falls risk ○ By the end of each falls screening event, 50% of participants will report that the program was helpful to them.
- By the end of each falls screening event, 100% of participants with demonstrated risk will have received a recommendation for referral to an appropriate healthcare provider for follow-up.
- By three months post intervention, 50% of participants will report that they took at least one action to lower their falls risk ○ By three months post-intervention, 50% of participants will report no falls since they participated in the program ○ By the end of each falls prevention lecture at community sites, at least 50% of attendees will report improved knowledge to prevent falls.

Measures:

- The number of people who received the falls screening and education intervention ○ The percent of participants who report more knowledge after the intervention
- The percent of participants who report greater likelihood to follow recommendations to reduce falls risk ○ The number of people who were recommended for additional healthcare per identified

risks ○ The percent of respondents who reported not falling in the past three months ○ The number of HCPs who attended the Grand Rounds lecture ○ The percent of all targeted HCPs who attended the Grand Rounds lecture ○ The number of people who attended falls prevention lectures ○ The percent of participants who attended falls prevention lectures who reported greater knowledge after the lecture ○ The percent of people who attended falls prevention lectures who were satisfied or very satisfied with the program

b. Preventing Subsequent Heart Attacks

Burke will undertake a multi-pronged intervention to increase utilization of cardiac rehabilitation (CR), with the outcome goal of reducing the incidence of subsequent heart attacks in the population served. Individuals who have sustained a heart attack are at higher risk for experiencing another event, and they are a priority population, per the Million Hearts program of the CDC.

CR is considered the best therapy after a heart attack for preventing additional events, equally effective if not better than medication alone. The evidence for its efficacy in preventing additional heart attacks and lowering mortality overall is very high, and it is a Class 1a recommendation of the American Heart Association and the American College of Cardiology. The benefits are felt by all races and genders. However, too few people receive this therapy. Only about 20 - 30% of those who are eligible enroll in a program, and a substantial proportion of those do not complete the full program and therefore do not receive its full benefits. Women and minorities utilize CR even less than males and white individuals.

Traditionally, patients have known little about cardiac rehabilitation. They may get a referral from their cardiologist but not understand the significant positive impact it can have on their health and quality of life. Or, their cardiologist may not make a referral, or may not impress upon the patient the importance of caring for themselves through CR. A systematic review showed that a patient's physician can have a meaningful impact on the decision to enroll in a CR program. (Ghisi GL, Polyzotis P, Oh P, et al. Physician Factors Affecting Cardiac Rehabilitation Referral and Patient Enrollment: A Systematic

Review. *Clin. Cardiol*. 2013;36(6):323-335.)

Additionally, the interactions and steps taken at the acute care hospital where the patient receives cardiac care appear to be the most important factors for predicting the rate of referral to CR, according to a 2015 study. (Aragam KG, Dadi D, Neely ML. et al. Gaps in Referral in Cardiac Rehabilitation of Patients Undergoing Percutaneous Coronary Intervention in the United States. J Am Coll Cardiol, 2015;65(1):2079-2088.)

The intervention will follow the recommendations of the Million Hearts 2027 program, an initiative of the CDC and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). This is a national, evidence-based initiative begun in 2012 and renewed in 2017 and 2022 to prevent 1,000,000 heart attacks and strokes over the ensuing five-year period. CR is one recommended strategy for doing so. For CR, the goal is to reach 70% participation by eligible patients. The following strategies are endorsed by the Million Hearts program as effective in meeting the Millions Hearts goal.

i. Increase referrals of eligible patients to CR from inpatient settings, cardiologists, PCPs and other providers ii. Improve the percentage of referred patients who become enrolled patients

iii. Improve retention of patients in CR to complete the full program iv. Increase awareness of CR and its benefits among the public and potential patients

The first three strategies are complex and involve mobilizing people and resources both within and outside Burke as well as setting up new procedures and data collection strategies. Burke will focus first on increasing referrals to CR, as studies show that success here has the biggest impact on improving the delivery of CR services. (Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative - PMC (nih.gov). In subsequent years of the Community Service Plan, Burke will extend its efforts to improve the percent of referred patients

who enroll and improve retention of patients in CR. Meanwhile, increasing awareness of CR and its benefits among the public is a feasible strategy for early adoption.

This first strategy will be carried out via two avenues: increasing referrals directly from the acute care hospital setting, and increasing referrals from cardiology practices by physicians, nurse practitioners, and physician assistants during outpatient visits with eligible patients.

Logic Model for Increasing Cardiac Rehabilitation Referrals

Inputs	Activities	Outputs	Outcomes	Impact (long-term outcomes)
People at Burke to engage on the CR project	Develop team at Burke to spearhead the intervention	Agreement between Burke & WPH to work together to increase referrals	Increase in automatic referrals to CR from WPH inpatient units	Reduction in hospital readmission for subsequent cardiac events
People at WPH to engage on the CR project	Engage key members of White Plains Hospital to create buy-in on improving CR referrals from inpatient	New Epic order sets created to include CR for all eligible patients	Increase in referrals to CR from cardiology practices	Reduction in mortality due to cardiac events and other causes
PowerPoint slide decks for presentations to	Incorporate referral to CR into Epic order sets for	New forms and discharge		Reduction in healthcare costs
WPH and cardiology practices	eligible hospitalized pts.	instructions for patients		associated with cardiac events
Possible IT resources for reporting	Incorporate referral to CR in discharge checklists and patient forms	Buy-in from outpatient cardiology practices to increase referrals to CR		Increase in quality life years

Inputs	Activities	Outputs	Outcomes	Impact (long-term outcomes)
	Outreach to outpatient cardiology practices to inform and develop buy-in for automatic CR referral for eligible pts	Report to stakeholders on levels of CR referrals over time		
	Develop metrics to measure baseline referrals & improvements in referrals by Dx and by provider			
	Collect data on referral rates, including total population eligible to be referred and number referred			

Logic Model for Increasing Awareness of Cardiac Rehabilitation among Patients, Families & Providers

Inputs	**Activities**	**Outputs**	**Outcomes**	**Impact**
Content creators at Burke	Post on social media outlets about CR	Collection of social media posts	Greater awareness of importance of referral to CR among physicians	Increase in utilization of CR
Content from trusted sources (CDC, etc.)	Place blog posts on website	Library of blog posts on CR posted to website	Greater intention to refer to CR by providers	
Digital PSAs/ads to raise awareness	Film patient stories and post on website and YouTube	Collection of patient stories on website and YouTube	Greater awareness of CR among underserved groups	
Slide deck presentation to lay audience about CR benefits	Create digital ads to raise	Digital ads to raise awareness of CR services among physicians and the public	Patients request CR prescription from their doctors	

Inputs	Activities	Outputs	Outcomes	Impact
	awareness among referring physicians			
Volunteers to help organize presentation to community groups	Presentations to underserved community groups about CR benefits	Information from pre- and postintervention surveys		
Pre-intervention survey on knowledge, attitudes	Pre-intervention survey of participants at community presentations	Report to stakeholders on intervention		
Post-intervention survey on knowledge, attitudes and satisfaction with program	Post-intervention survey of participants at community presentations			

Goal: Increase the utilization of cardiac rehabilitation services, especially among underserved groups.

Process Objectives:

- By the end of February, 2023, Burke will establish a team from medicine, cardiac rehabilitation, outpatient department, and administration to carry out the CR strategy ○ By the end of March 2023, Burke will identify the individuals from White Plains Hospital with whom to work for the purposes of establishing automatic referral to CR via Epic order sets. These individuals could include the Cardiac Catheterization Lab Medical Director, the Director(s) of the hospitalist team, the Chief Medical Information Officer, quality improvement staff, and others
- By the end of June, Burke will have met at least two times with White Plains Hospital physicians and staff to develop buy in and a plan to increase utilization of CR via automatic referral through

Epic order sets ○ By the end of June, 2023, Burke will have accessed or developed baseline data to inform and evaluate its efforts to improve utilization of CR.

- By the end of 2023, Burke will deliver information to 10 hospitalists and physicians in three cardiology practices about the important role they play in influencing patients to participate in and adhere to a CR program.
- By the end of 2023, Burke will have posted on social media and its website at least 10 items aimed at consumers and physicians to raise awareness of the benefits of CR

Outcome Objectives:

- By the end of 2023, order sets will be established in Epic for each qualifying diagnosis so that White Plains Hospital can automatically refer eligible cardiac patients to CR from the inpatient unit unless the physician documents an appropriate contraindication ○ By the end of 2023, 15% of eligible patients in WPH will have their first CR appointment set up prior to discharge from the hospital

Measures:

- Baseline number of referrals to CR from WPH for 2022 ○ Baseline number of referrals to CR from cardiology practices/cardiologists in Westchester

County in 2022 ○ Number of patients discharged from WPH with an eligible diagnosis for CR in 2023 ○ Percent of patients discharged from WPH with an eligible dx who were referred to CR in 2023 ○ Number of eligible patients discharged from WPH who had a CR appointment prior to discharge ○ Percent of eligible patients discharged from WPH who had a CR appointment prior to discharge ○ Number of referrals to Burke CR from White Plains Hospital in 2023 ○ Number of referrals to Burke CR from cardiology practices in 2023 ○ Readmission rate to WPH for eligible cardiac patients who participated in CR and those who did not.

- Changes in medical risk factors for CR patients from baseline commencement of CR program to completion/drop out ○ Cholesterol ○ Blood pressure ○ Weight ○ Blood sugar

Section 7: Sharing the Report with the Public

Burke will share the triennial plan and annual updates on the community health interventions with key internal stakeholders and contributors to the plan, including its Board of Trustees and senior leadership team. Annual updates will be reviewed to ensure that Burke is on target with the goals set forth in this report, or to adjust interventions or strategies as needed. Community members will also be encouraged to provide feedback on Burke's Community Service Plan by contacting Burke through its External Relations email.

The dissemination of this report will include a digital copy available on Burke's website at: https://www.burke.org/about/communityhealth. Burke will announce its availability and provide a link to the report on its social media channels:

- Facebook: www.facebook.com/burkerehab/
- Twitter: www.twitter.com/burke_rehab
- LinkedIn: www.linkedin.com/company/burke-rehabilitation-hospital
- Instagram: www.instagram.com/burke_rehab/

The Community Service Plan will be available in hard copy at the security desk of Burke's hospital lobby and in the Marsal Caregiver Center. A cover sheet will include contact information for Burke's Marketing Department, should someone wish to receive a hard copy which they can remove from Burke.

Section 8: Adoption of Report

This report was produced by the Marketing and External Relations Department of Burke Rehabilitation

Hospital, and reviewed and approved by Burke's Executive Director and Chief Medical Officer on December 8, 2022. This report was reviewed by the Chair of the Burke Rehabilitation Hospital Board of Trustees and approved on December 9, 2022.

Appendices

Appendix A

Importance and Satisfaction Ratings

GNYHA CHNA Survey Collaborative 2022
Importance and Satisfaction Ratings
Westchester County

Health Condition	Importance Rank*	Importance Score^	Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	4	4.35	Above Average	18	2.97	Below Average
Mental health/depression	7	4.14	Above Average	17	3.00	Below Average
Stopping falls among elderly	8	4.12	Above Average	14	3.18	Below Average
Maintain Efforts						
Dental care	1	4.43	Above Average	5	3.65	Above Average
Cancer	2	4.37	Above Average	6	3.64	Above Average
Access to healthy/nutritious foods	3	4.37	Above Average	1	3.78	Above Average
COVID-19	5	4.33	Above Average	2	3.76	Above Average
Heart disease	6	4.28	Above Average	3	3.71	Above Average
High blood pressure	9	4.10	Above Average	4	3.70	Above Average
Women's and maternal health care	10	4.02	Above Average	10	3.42	Above Average
Arthritis/disease of the joints	11	3.93	Above Average	12	3.35	Above Average
Adolescent and child health	12	3.91	Above Average	8	3.51	Above Average
Relatively Lower Priority						
Obesity in children and adults	14	3.79	Below Average	20	2.94	Below Average
disorder)	16	3.62	Below Average	19	2.95	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	18	3.44	Below Average	21	2.93	Below Average
Hepatitis C/liver disease	19	3.14	Below Average	13	3.27	Below Average
Sexually Transmitted Infections (STIs)	20	2.98	Below Average	15	3.04	Below Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	21	2.84	Below Average	16	3.03	Below Average
Diabetes/elevated sugar in the blood	13	3.81	Below Average	9	3.45	Above Average
Asthma/breathing problems or lung disease	15	3.72	Below Average	11	3.39	Above Average
Infant health	17	3.54	Below Average	7	3.51	Above Average

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1="Not at all" to 5="Extremely"

Appendix B

Question Results

GNYHA CHNA Survey Collaborative 2022

Question Results

Westchester County

Question	Number	Percent
Total Sample		
Total Number of Qualified Respondents^	3,377	100%
At-home COVID-19 tests	1,304	56%
Reliable source(s) of information on COVID-19	1,105	47%
Boosters for COVID-19	1,053	45%
In-person testing for COVID-19 (e.g., doctor's office, pharmacy, mobile van)	983	42%
Personal protective equipment (e.g., masks, hand sanitizer, face shields, gloves)	875	37%
Treatment for COVID-19	778	33%
COVID-19 vaccination	636	27%
Missing	1,036	.
In the last 12 months, was there a time when you needed medical care in-person but did not get it?		
Yes	387	17%
No	1,899	83%
Missing	1,091	.
For which of the following reasons could you not get medical care in-person the last 12 months?*		
There were no available appointments, or I couldn't get an appointment soon enough	241	63%
I could not get through on the telephone to make the appointment	117	31%
Because of COVID-19	100	26%
Once I got there the wait was too long to see the doctor	59	15%
I could not afford the cost of care (e.g., copay, deductible)	51	13%
I did not have transportation	24	6%
I did not have health insurance	23	6%
I did not have childcare	9	2%

Once I got there the wait was too long to see the doctor	59	15%
Other	58	15%
None of the above	25	7%
Missing	4	.

In the last 12 months, was there a time when you needed medical care by video or phone but could not get it?

Yes	149	7%
No	2,132	93%
Missing	1,096	.

For which of the following reasons could you not get medical care by video or phone in the last 12 months?*

There were no available appointments, or I couldn't get an appointment	62	42%
I could not get through on the telephone to make the appointment	50	34%
I did not know how to see the doctor by video or phone	21	14%
I did not have a computer, phone, or other device to use for the visit	11	7%
I did not have internet	9	6%
I could not afford the cost of care (e.g., copay, deductible)	7	5%
I did not have a private place to have my appointment	7	5%
I did not have health insurance	4	3%
I did not have data or minutes in my phone plan to use for a visit	4	3%
Other	36	24%
None of the above	18	12%

In the last 12 months, have you experienced any of the following?*

Increased household expenses	1,126	49%
Anxiety or depression	912	40%
Increased medical expenses	659	29%
Difficulty paying utilities or other monthly bills	248	11%
Difficulty paying your rent/mortgage	181	8%
Hunger or skipped meals because you did not have enough money to buy food	68	3%

Difficulty paying utilities or other monthly bills	248	11%
None of the above	637	28%
Missing	1,090	.
In general, how is the overall health of the people of your neighborhood?		
Poor	39	1%
Fair	368	11%
Good	1,611	50%
Very good	1,037	32%
Excellent	198	6%
Missing	124	.
In general, how is your physical health?		
Poor	70	2%
Fair	534	16%
Good	1,369	41%
Very good	1,031	31%
Excellent	357	11%
Missing	16	.
In general, how is your mental health?		
Poor	73	2%
Fair	441	13%
Good	1,155	34%
Very good	1,047	31%
Excellent	646	19%
Missing	15	.

^A qualified respondent is ages 18+ and living within the service area

*Percentages may not add up to 100% because respondents could choose more than one option

Difficulty paying utilities or other monthly bills	248	11%

Appendix C

Respondent Demographics

GNYHA CHNA Survey Collaborative 2022
Respondent Demographics
Westchester County

Question	Number	Percent
Total Sample		
Total Number of Qualified Respondents^	3,377	100%
Survey Language		
English	3,261	97%
Spanish	112	3%
Korean	2	0%
Italian	1	0%
Polish	1	0%
What is the primary language you speak at home?		
English	2,009	92%
Spanish	130	6%
Cantonese	3	0%
Mandarin	2	0%
Bengali	2	0%
Arabic	2	0%
Russian	1	0%
Korean	1	0%
Other	35	2%
Missing	1,192	.
Age		

18 - 24	25	1%
25 - 29	43	2%
30 - 44	228	12%
45 - 64	636	35%
65 - 74	507	28%
75+	389	21%
Missing	1,549	.

Gender

Female	1,605	73%
Male	567	26%
Non-binary, another gender	5	0%
Prefer not to say	31	1%
Missing	1,169	.

Sexual Identity

Straight, that is not Gay	1,920	89%
Gay, Lesbian, or Bisexual	59	3%
Other	34	2%
Prefer not to say	149	7%
Missing	1,215	.

Race/Ethnicity

Gender		
White, non-Hispanic	1,526	70%
Hispanic	301	14%
Black, non-Hispanic	201	9%
Asian/Pacific Islander,non-Hispanic	96	4%
North African/Middle Eastern, non-Hispanic	12	1%
Other,non-Hispanic	51	2%
Missing	1,190	.

Hispanic/Latinx Origin or Ancestry		
Puerto Rican	82	28%
Mexican	44	15%
Colombian	38	13%
Other South American	28	10%
Other Central American	24	8%
Dominican	20	7%
Ecuadorian	19	7%
Cuban	12	4%
Other	25	9%
Missing	9	.

Some people in addition to being Black, have a certain heritage or ancestry. Do you identify with any of these?*		
African American	136	60%
A recent immigrant or the child of recent immigrants from Africa	102	31%
Caribbean or West Indian	67	30%

Gender		
Asian Heritage or Ancestry		
Asian Indian	39	39%
Chinese	29	29%
Filipino	20	20%
Korean	6	6%
Japanese	3	3%
Other	4	4%
Missing	1	.
Number of people who usually live or stay in this home/apartment		
1 person	499	24%
2 people	927	44%
3 people	289	14%
4 people	234	11%
5 or more people	173	8%
Missing	1,255	.
Highest grade or year of school completed		
Less than high school	43	2%
High school graduate	153	7%
Some college/technical school	347	16%
College graduate	1,626	75%
Missing	1,208	.
What is your current employment status?		
Retired	915	42%
Employed full-time for wages or salary	759	35%

Asian Indian	39	39%
Employed part-time for wages or salary	177	8%
Self-employed	133	6%
A homemaker	56	3%
Unable to work	50	2%
Unemployed for 1 year or more	49	2%
Unemployed for less than 1 year	22	1%
A student	13	1%
Missing	1,203	.

What is your household's annual household income from all sources, before taxes, in the last year?

Less than $20,000	109	6%
$20,000 to $29,999	92	5%
$30,000 to $49,999	164	9%
$50,000 to $59,999	130	7%
$60,000 to $74,999	176	9%
$75,000 to $99,999	242	13%
$100,000 or more	965	51%
Missing	1,499	.

What type of health insurance do you use to pay for your doctor or hospital bills?

A plan purchased through an employer or union	982	44%
Medicare	957	43%
Medicaid or other state program	125	6%
A plan that you or another family member buys on your own	75	3%
TRICARE (formerly CHAMPUS), VA, or Military	3	0%
Some other source	46	2%
I do not have any kind of health insurance coverage	42	2%

Asian Indian	39	39%
Missing	1,147	.

^A qualified respondent is ages 18+ and living within the service area

*Percentages may not add up to 100% because respondents could choose more than one option

Appendix D

Respondents by Zip Code

GNYHA CHNA Survey Collaborative 2022
Respondents by Zip Code
Westchester County

State	Zip Code	City	Number	Percent
New York	10605	WHITE PLAINS	238	7%
New York	10583	SCARSDALE	228	7%
New York	10530	HARTSDALE	140	4%
New York	10603	WHITE PLAINS	127	4%
New York	10701	YONKERS	120	4%
New York	10606	WHITE PLAINS	119	4%
New York	10573	PORT CHESTER	118	3%
New York	10801	NEW ROCHELLE	113	3%
New York	10562	OSSINING	109	3%
New York	10601	WHITE PLAINS	105	3%
New York	10591	TARRYTOWN	97	3%
New York	10804	NEW ROCHELLE	95	3%
New York	10710	YONKERS	90	3%
New York	10708	BRONXVILLE	72	2%
New York	10543	MAMARONECK	69	2%
New York	10598	YORKTOWN HEIGHTS	67	2%
New York	10805	NEW ROCHELLE	61	2%
New York	10704	YONKERS	59	2%
New York	10522	DOBBS FERRY	57	2%
New York	10604	WEST HARRISON	57	2%
New York	10705	YONKERS	53	2%
New York	10520	CROTON ON HUDSON	51	2%
New York	10607	WHITE PLAINS	51	2%
New York	10703	YONKERS	51	2%
New York	10552	MOUNT VERNON	48	1%
New York	10538	LARCHMONT	47	1%
New York	10570	PLEASANTVILLE	47	1%

GNYHA CHNA Survey Collaborative 2022
Respondents by Zip Code
Westchester County

New York	10707	TUCKAHOE	47	1%
New York	10528	HARRISON	45	1%
New York	10709	EASTCHESTER	45	1%
New York	10533	IRVINGTON	44	1%
New York	10523	ELMSFORD	42	1%
New York	10510	BRIARCLIFF MANOR	41	1%
New York	10589	SOMERS	41	1%
New York	10706	HASTINGS ON HUDSON	40	1%
New York	10550	MOUNT VERNON	37	1%
New York	10536	KATONAH	36	1%
New York	10566	PEEKSKILL	33	1%
New York	10580	RYE	33	1%
New York	10803	PELHAM	33	1%
New York	10504	ARMONK	30	1%
New York	10595	VALHALLA	30	1%
New York	10502	ARDSLEY	29	1%
New York	10532	HAWTHORNE	28	1%
New York	10549	MOUNT KISCO	27	1%
New York	10514	CHAPPAQUA	21	1%
New York	10567	CORTLANDT MANOR	21	1%
New York	10577	PURCHASE	21	1%
New York	10594	THORNWOOD	20	1%
New York	10553	MOUNT VERNON	18	1%
New York	10590	SOUTH SALEM	15	0%
New York	10547	MOHEGAN LAKE	14	0%
New York	10560	NORTH SALEM	13	0%
New York	10576	POUND RIDGE	13	0%
New York	10506	BEDFORD	10	0%
New York	10511	BUCHANAN	8	0%
New York	10507	BEDFORD HILLS	6	0%
New York	10526	GOLDENS BRIDGE	5	0%

New York	10709	EASTCHESTER	45	1%
New York	10548	MONTROSE	5	0%
New York	10501	AMAWALK	4	0%
New York	10518	CROSS RIVER	4	0%
New York	10527	GRANITE SPRINGS	4	0%
New York	10546	MILLWOOD	4	0%
New York	10588	SHRUB OAK	4	0%
New York	10596	VERPLANCK	4	0%
New York	10503	ARDSLEY ON HUDSON	3	0%
New York	10602	WHITE PLAINS	3	0%
New York	10540	LINCOLNDALE	2	0%
New York	10517	CROMPOND	1	0%
New York	10535	JEFFERSON VALLEY	1	0%
New York	10545	MARYKNOLL	1	0%
New York	10587	SHENOROCK	1	0%
New York	10597	WACCABUC	1	0%