# 2025 Community Health Needs Assessment & Community Service Plan for City of Yonkers, Westchester County

December 2025

Saint Joseph's Medical Center


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# About Saint Joseph's Medical Center and the 2025 CHNA & CSP

Since its founding by the Sisters of Charity of St. Vincent de Paul in 1888, Saint Joseph's Medical Center (Saint Joseph's) has been meeting the healthcare needs of Yonkers and surrounding communities. Saint Joseph's is a Catholic healthcare facility. We strive for excellence in healthcare in an atmosphere of support and shared ministry.

Saint Joseph's serves our community with patient-centered quality care and offers a range of services including specialized programs in orthopedics, cardiology, family medicine, and geriatrics. Our advanced capabilities encompass emergency care, cutting-edge diagnostic imaging, and ambulatory surgery. In addition, we provide comprehensive inpatient and outpatient behavioral health services, as well as a network of primary care providers throughout Westchester County and the Bronx. Through our St. Vincent's Hospital Westchester division, we offer a comprehensive range of mental health, addiction, and residential programs serving Westchester County and New York City.

Saint Joseph's believes in respect and compassion for ourselves and others, excellence in service, the dignity of human life, and commitment to the community. In 2024 alone, Saint Joseph's invested approximately $43 million in its charitable mission, covering the cost of care for people in need, subsidizing care and services for people with low incomes and/or underserved by healthcare resources, and continuously investing in many community health initiatives.

As a trusted local healthcare leader and partner, Saint Joseph's is dedicated to understanding and addressing the most pressing health and wellness concerns for our community. Saint Joseph's conducts a Community Health Needs Assessment (CHNA) every three years to help us better serve our community by measuring the health status of residents, gathering wide community input on health concerns, and identifying opportunities to collaborate with partners.

The CHNA informs the development of Saint Joseph's Community Service Plan (CSP) to move from data to action to address identified priority health needs. The CSP serves as a guide for strategic planning and a tool by which to align community health investments with the highest needs in our community.

We invite our community partners to learn more about the CHNA and CSP and opportunities for collaboration to address identified health needs. Please visit our website or submit comments directly to Catherine Hopkins at catherine.hopkins@saintjosephs.org.

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# Executive Summary

## 2025 Community Health Needs Assessment

The goal of the CHNA was to gather data and community input to inform strategies to support a healthy and thriving region and to foster a collaborative approach for community health improvement.

### CHNA Study Objectives:

- Compile a comprehensive profile of the factors that impact health and wellbeing for residents
- Compare community health indicators with previous CHNAs to document trends and changes
- Demonstrate the impact of Social Drivers of Health; document disparities experienced by populations and communities
- Strengthen community member engagement and partnerships; engage residents in the study process
- Define three-year priority areas and develop action planning
- Develop a community resource to monitor the progress of community health initiatives

The results of the CHNA will help us identify priorities and strategies to improve health and wellbeing in Yonkers and surrounding communities and promote health for all residents. Responding to the study findings and sharing data with other community-based organizations, Saint Joseph's aims to ensure that all residents benefit from our local resources, robust social service network, and the high-quality healthcare available in our community to help residents live their healthiest lives.

### Research Partner

Saint Joseph's contracted with *Build Community* to conduct the CHNA. *Build Community* is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. An interdisciplinary team of researchers and planners, *Build Community* has worked with hundreds of healthcare and community-based organizations and their partners to reimagine policies and achieve measurable impact. Learn more about their work at buildcommunity.com.

## 2025 CHNA Leadership and Community Partnership

The 2025 CHNA was overseen by a steering committee of representatives from Saint Joseph's and conducted collaboratively with the Greater New York Hospital Association and its member hospitals. Saint Joseph's also collaborates with the City of Yonkers Mayor's Health Advisory Board to regularly assess and respond to resident health concerns. This approach ensured a comprehensive study and helped foster a platform for collective community impact.

### 2025 CHNA Steering Committee Members

The following individuals served on the CHNA steering committee as liaisons to Saint Joseph's and the communities they serve.

Catherine Hopkins, MS, FNP-BC, AE-C, Director of Employee Health Services

Lorraine Horgan, MS, Vice President – External Affairs

### Greater New York Hospital Association Partnership

In 2025, the Greater New York Hospital Association (GNYHA) offered member hospitals and health systems the opportunity to participate in the GNYHA CHNA Survey Collaborative during the planning year of the New York State 2025-2030 Prevention Agenda. The Collaborative complemented longstanding GNYHA efforts to help members with the CHNA and CSP development and implementation process.

GNYHA developed a health needs assessment survey with member input from community and safety net hospitals, small health systems, and large academic medical centers. Collaborative participants received from GNYHA a common survey available in 19 languages on paper and online to distribute in their communities. GNYHA hosted the survey online, collected data, analyzed results, and created custom reports for each participating hospital. Collaborative members recruited participants from their communities for the survey. More than 16,400 community members responded to the survey, including 3,546 community members resided in Saint Joseph's service area.

### Community Collaboration

Saint Joseph's is both a participant and convening partner for local and regional collaboratives to address unmet community needs. Saint Joseph's serves on the City of Yonkers Mayor's Health Advisory Board, where members work to create and recommend effective policies, programs, and projects in the city with regard to the health and wellbeing of its residents. Saint Joseph's regularly collaborates with the Westchester County Department of Health to address emerging needs, most recently as part of a county-wide coalition to improve colorectal cancer screening rates. Saint Joseph's is also a lead agency for the region's Social Care Network to identify and respond to health-related social needs within the clinical setting. In this and many other ways, Saint Joseph's serves as a community partner and ensures ongoing assessment and response to the community's top needs.

## 2025 CHNA Study Area

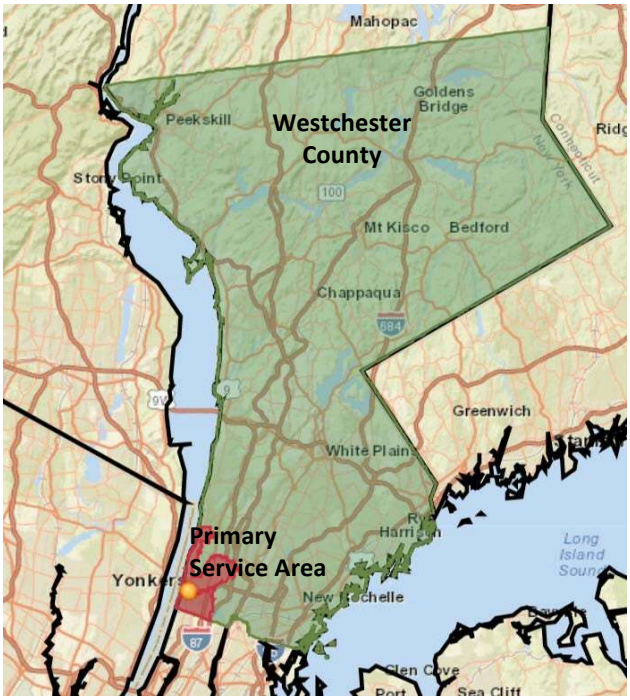
Saint Joseph's is in Yonkers in Westchester County, New York. Westchester County, located just north of New York City in the Hudson Valley, covers 500 square miles and 45 unique cities, towns, and villages designated as urban, suburban, and rural geographies. It has a population of nearly one million people.

Located along the Hudson River, Yonkers is New York State's third largest city and the largest city in Westchester County. Yonkers had an estimated 2023 population of 209,529. A city in the center of it all, Yonkers serves as the gateway between New York City and the Hudson Valley.

Yonkers is one of the most diverse cities in New York State and the region. As of 2023, approximately 32.4% of residents were born outside the United States. An estimated 46% of Yonkers households speak a primary language other than English and the school district is comprised of students hailing from 100 different cultures and nationalities. The Yonkers population is also younger with a median age of 39 years compared to a countywide median of 41.5 years. Nearly 1 in 4 residents in the zip codes surrounding Saint Joseph's are youth under the age of 18.

Saint Joseph's serves all of Yonkers and surrounding communities, but their primary service area encompasses the zip codes surrounding the medical center, including 10701 and 10705. For purposes of the CHNA, secondary data focus on all of Yonkers and Westchester County. Demographics and other available indicators for zip codes 10701 and 10705 were analyzed to determine opportunities for prioritized interventions to address health and social disparities.

**Saint Joseph's Medical Center Primary Service Area**



## Research Methods

The CHNA was conducted from March to December 2025 and included primary and secondary research methods to determine health trends and disparities.

### Primary Research and Community Engagement

Community engagement was an integral part of the CHNA. Saint Joseph's collaborated with the GNYHA and its member hospitals to participate in the GNYHA CHNA Survey Collaborative. The survey aimed to engage community residents and receive their input on health needs. GNYHA developed the survey with input from collaborating members. Collaborative members recruited participants from their communities for the survey. GNYHA hosted the survey online, collected data, analyzed results, and created custom reports for each participating hospital.

#### GNYHA Survey Collaborative

More than 16,400 community members responded to the survey, including 3,546 community members residing in Saint Joseph's service area. The survey was available in 19 languages in paper and online format. Community members qualified for the survey if they were 18 years or older and lived within any of the geographic areas identified by collaborative members as their hospital's service area.

#### Community Conversations

Saint Joseph's participated in meetings with community and hospital representatives to share CHNA data findings, gather feedback on priority health issues, and collectively define challenges and meaningful strategies for health improvement.

### Secondary Data Analysis

Secondary data, including demographic, socioeconomic, and public health indicators, were analyzed to measure key data trends and priority health issues, and to assess emerging health needs. Data were compared to New York State and/or national benchmarks and Healthy People 2030 (HP2030) goals, as available, to assess areas of strength and opportunity. Healthy People 2030 is a national initiative establishing 10-year goals for improving the health of all Americans.

#### Secondary Data Statistics

Secondary data are reported for all of Westchester County and Yonkers and by zip code, as available, to demonstrate localized health needs. The most recently available data at the time of publication is used throughout the study. Due to the time required to collect and analyze data, it is typical for the data to reflect prior years rather than the current year. A comprehensive list of secondary data sources is included in Appendix A.

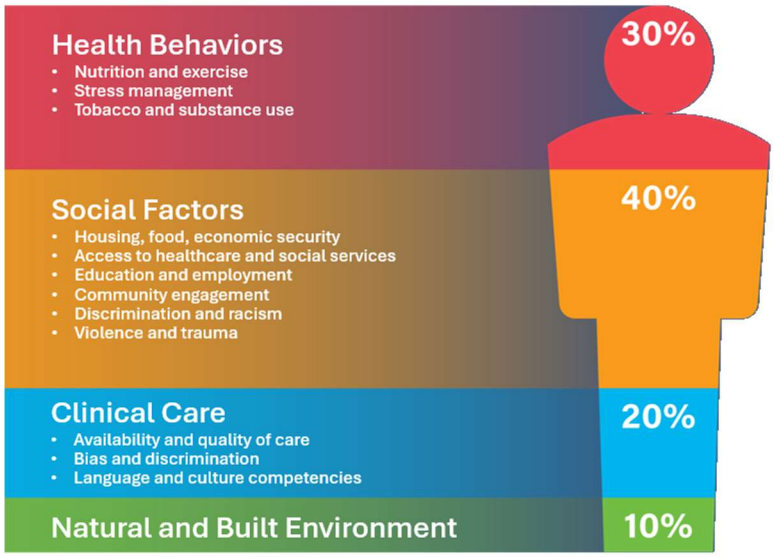
## Social Drivers of Health

*Where we live impacts choices available to us*

The CHNA was conducted to provide deeper insights into the differences in health and wellbeing experienced between groups of people in the region. We used the Social Drivers of Health (SDoH) framework to study and document income and poverty; housing and food security; early learning and education; social factors; and the environment and built community. We analyzed data across these five domains of SDoH to identify strengths and challenges in our community that impact our health and wellbeing.

*Graphic Credit: U.S. Department of Health and Human Services*


*Social Drivers of Health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.*




*50% of a person's health is determined by social factors and their environment.*

*Only 20% of health outcomes are attributed to clinical care.*

Examining data across SDoH domains helps us understand factors that influence differences in health status, access to healthcare, and outcomes between groups of people**.** These differences include higher prevalence of chronic diseases like diabetes, lack of health insurance, inability to afford essential medications, and shortened life expectancy. Advancing health for all residents means ensuring that all people in a community have the resources and care they need to achieve optimal health and wellbeing. To advance health for all, we need to look beyond the healthcare system to address "upstream" SDoH issues like education attainment, job opportunities, affordable housing, and safe environments.

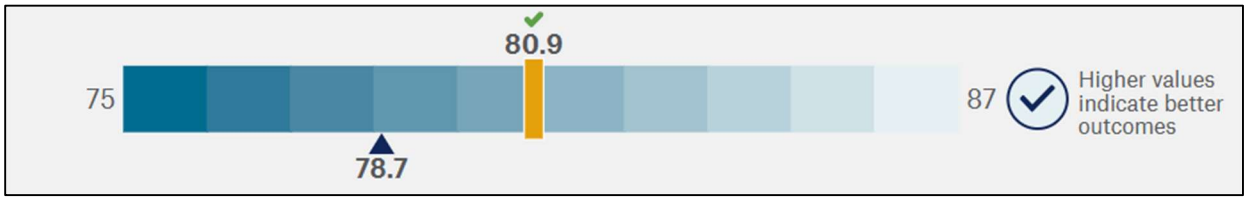
## Our Strengths and Opportunities

Yonkers is a thriving community with strong population and economic growth, revitalization efforts, and a booming housing market. The city is well connected to the region and accessible to the rest of Westchester County, New York City, and beyond via railroad stations and major highways. The waterfront district continues to grow with new housing development, restaurants, shops, and parks. Yonkers is in Westchester County, which is known for its top-notch public schools and high quality of life. It is an intellectual capital, boasting a highly educated workforce, competitive colleges and universities, Fortune 500 companies, world-changing nonprofits, and cutting-edge research centers.

Yonkers residents as a whole live longer when compared to peer cities across the nation. Average life expectancy for Yonkers residents in 2015 was about 80.9 years compared to 78.7 years across other large cities in the U.S. When compared to peer cities, Yonkers residents have fewer deaths due to chronic conditions like heart disease and cancer, report better mental health, and are more likely to have health insurance and receive routine checkups. Yonkers is considered highly walkable and well served by parks and green spaces (Source: City Health Dashboard).

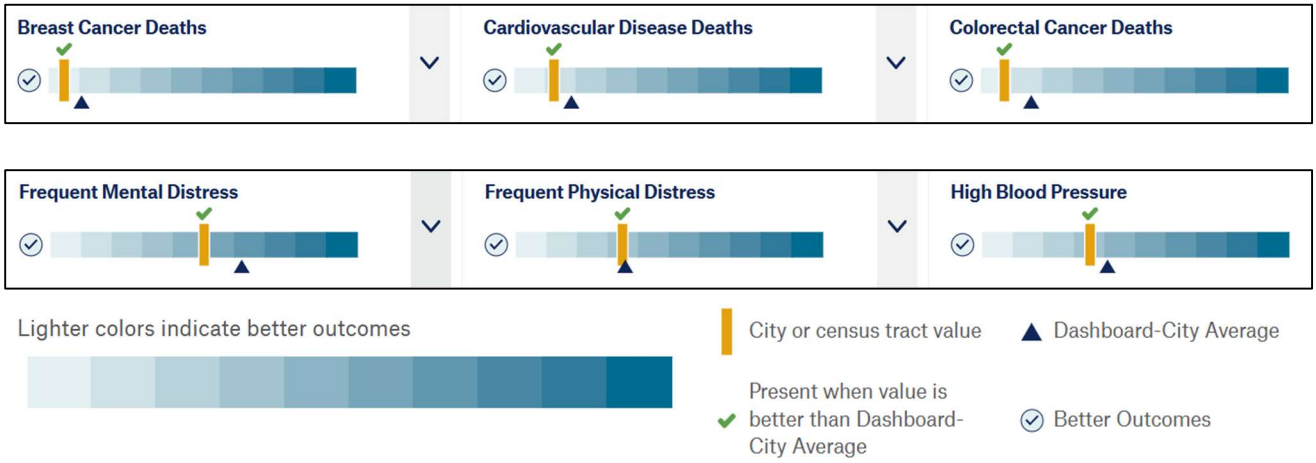
The City Health Dashboard provides data on health and the factors that influence it for over 1,200 cities and smaller communities across the U.S. It was created by the Department of Population Health at NYU Langone Health. The following graphics illustrate select City Health Dashboard findings for Yonkers compared to other cities across the nation.

**Average Life Expectancy for Yonkers Residents Compared to Other Large Cities Across the US**



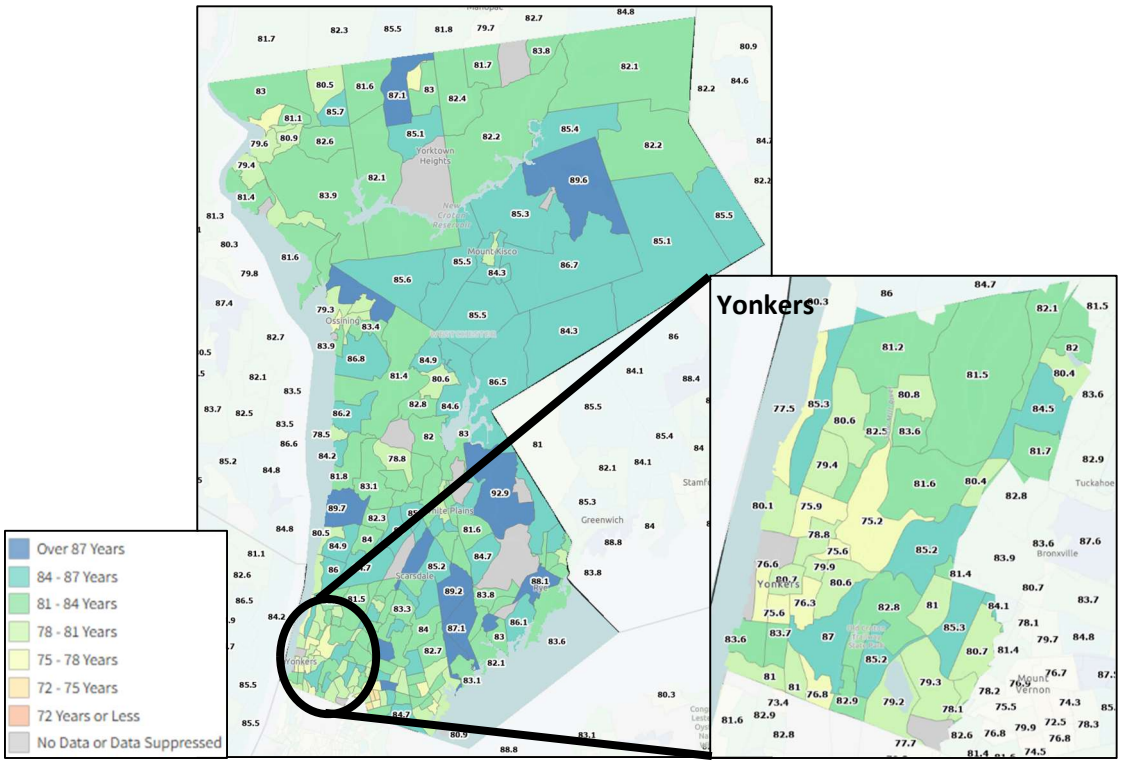

Source: City Health Dashboard

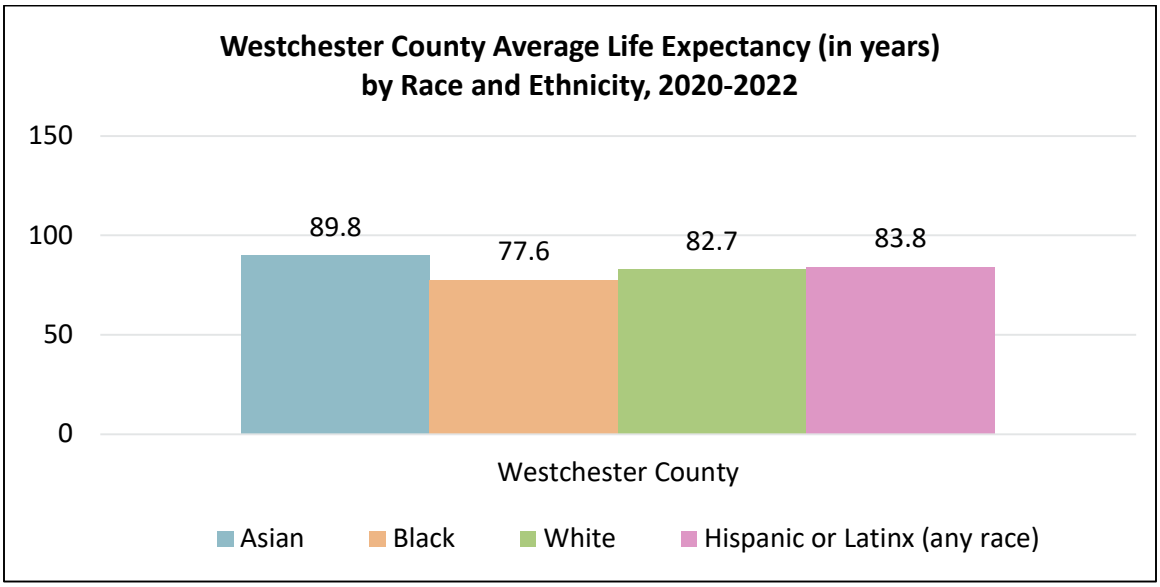
**Yonkers City Health Dashboard Select Indicators**



Using these existing strengths, communities can work together to improve health for all residents. Yonkers is a thriving community, but its prosperity and health are not shared equitably among residents. Residents of downtown Yonkers, including Saint Joseph's primary service area, may live 10-20 years less than residents of other parts of the city or county. Across Westchester County, and consistent with national trends, systemic issues of discrimination and racism have contributed to a five-year deficit in life expectancy for Black and/or African American residents compared to other population groups.

**Average Life Expectancy by Westchester County Census Tract, 2010-2015**




Source: Centers for Disease Control and Prevention

Saint Joseph's is a healthcare resource for historically underserved Yonkers residents. Yonkers is a Health Professional Shortage Area (HPSA) for primary and mental healthcare services for Medicaid-eligible populations. Medicaid is the government health coverage available to eligible people with low income. Approximately 33.9% of all Yonkers residents and 46%-48% of Saint Joseph's primary service area residents have Medicaid. Approximately 14.7% of all Yonkers residents and 18% of primary service area residents live in poverty.

Consistent with national trends, financial insecurity has increased for area residents. Across Westchester County, the percentage of food insecure residents increased from 6.6% in 2021 to 10.7% in 2023. Poverty data indicate that Yonkers residents, particularly children, are likely disproportionately affected by food insecurity. Approximately 20% of Yonkers children, including 22%-25% of children living in Saint Joseph's primary service area, live in poverty. Approximately 27%-28% of families in Saint Joseph's primary service area receive SNAP benefits compared to 9.5% of families across Westchester County. Housing prices have increased and 40.7% of Yonkers households and 45% or more of primary service area households are housing cost burdened, spending at least 30% of their income on mortgage or rent expenses alone.

Adverse socioeconomic indicators have contributed to health disparities for Yonkers residents. Approximately 10.3% of Yonkers adults have diabetes compared to 8.2% of adults across Westchester County. The rate of emergency department visits for asthma has historically been twice the county average. About 16.2% of Yonkers adults have chronically poor mental health, an increase from prior years and higher than the countywide average of 14.2%. An estimated 10.5% of Yonkers youth aged 16-19 are disconnected from the community, neither working nor in school, compared to an average of 6.7% of youth in other cities across the US. Opioid burden, defined as outpatient ED visits and hospital discharges for non-fatal opioid overdose and opioid overdose deaths, is disproportionately higher in Yonkers compared to the rest of the county.

Community health needs and opportunities for the Yonkers community are further defined in the following report. Saint Joseph's proposed response to these needs, including priority areas of focus and health improvement partnerships and programming, are outlined in the accompanying CSP.

## Community Priorities and Summary of Community Service Plan

### Determining Community Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining the issues on which to focus efforts over the next three-year cycle, Saint Joseph's collected feedback from community stakeholders and aligned its efforts with the New York State Prevention Agenda.

The Prevention Agenda is New York's State Health Improvement Plan. It is aimed at improving the health status of individuals in New York and reducing health disparities through a strong emphasis on prevention. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare.

Saint Joseph's leaders applied the following criteria to define Prevention Agenda priorities for the hospital:

- Prevalence of health disparity and number of community members affected
- Prevalence of health disparity compared to city, state, and national benchmarks
- Existing programs, resources and expertise to address issues
- Input from community partners and representatives
- Alignment with concurrent public health and social service organization initiatives

Based on the CHNA, Saint Joseph's will focus on the following Prevention Agenda priorities:


The identified priorities represent key disparities affecting area residents and are aligned with Saint Joseph's existing resources and initiatives to advance health equity. The following sections highlight evidence-based interventions, strategies, and activities being implemented by Saint Joseph's as part of its CSP to address the priority areas and associated health disparities.

### Community Service Plan Summary of Activities

Saint Joseph's is committed to meeting the holistic health and social needs of its patients and community members. Saint Joseph's implemented screenings across its clinical service lines to better identify and respond to patient's unmet health-related social needs (HRSNs). Saint Joseph's is also a lead agency for the region's Social Care Network, tasked with building a robust network of community-based organizations providing HRSN services and coordinating with health care providers. The Social Care Network is responsible for ensuring that there is a seamless, consistent, coordinated, end-to-end process for screening, navigation, and delivery of social services.

Nutrition security is among the top unmet HRSNs for Saint Joseph's patients and the broader community. In addition to supporting patient screening and connections to the Social Care Network for nutrition services, Saint Joseph's supports point of care and community-based food access. In May 2021, in partnership with Feeding Westchester, Saint Joseph's added an onsite free food pantry at the Family Health Center for patients who present with food insecurity. In 2023, the food pantry served 1,300 unique individuals. In 2024, the food pantry served 1,218 unique individuals. Feeding Westchester also operates a mobile food distribution site across the street from Saint Joseph's, delivering thousands of pounds of food to residents on a monthly basis.

Saint Joseph's is also a leader in providing affordable and supportive housing with nearly 1,500 housing units operated throughout Westchester County and New York City. Saint Joseph's Residential Services include senior housing programs for frail and low-income older adults, 24-hour supportive housing for adults with serious mental illness and other special needs, affordable apartments for individuals and families, and supported housing with rental stipends and case management services.

Saint Joseph's operates primary care school-based health centers in five Yonkers public schools. Since 1989 the centers have provided free, accessible, high quality health services to high-risk children and have become an integral component of the Yonkers healthcare delivery system. The program receives funding from the New York State Department of Health and HRSA Bureau of Primary Health, funding and in-kind services from Yonkers Public Schools, and in-kind services and financial support from Saint Joseph's.

The school-based health centers provide a full array of primary health services including, but not limited to, routine care of children with chronic conditions such as asthma, obesity, and diabetes; comprehensive histories and physical examinations; laboratory testing; immunizations; health counseling; and dental preventive services. Additional services focus on health education in areas such as managing asthma, nutrition, substance use, accident prevention, personal hygiene, growth and development, and first aid.

Asthma burden disproportionately affects Yonkers youth. From 2016 to 2018, the rate of ED visits for asthma per 10,000 Yonkers residents aged 0-4 was 222.3 compared to a countywide rate of 135.5. In response to this need, Saint Joseph's implemented provider and community-based training on asthma management. Saint Joseph's established physician orders specific to chronic condition well visits, including asthma, to serve as a guide for nursing and provider interventions, and streamlined asthma templates in its electronic medical records to facilitate documentation of key factors for asthma management. As part of the Project BREATHE NY asthma initiative for children ages 0-18, Saint Joseph's validated its data measures for monthly reporting of asthma control and management factors. Relevant asthma protocols have also been implemented at the school-based health centers.

Substance use, misuse, and overdose mortality are persistent public health challenges for the Yonkers community. In 2024, 16.7% (3,672) of emergency department visits at Saint Joseph's involved a substance use disorder encounter, the highest proportion of any hospital in Westchester County. From 2016 to 2018, the opioid burden rate per 100,000 people was 406.7 in Yonkers compared to 234.3 countywide. Saint Joseph's outpatient addiction programs improve access to opioid treatment and

recovery services by reducing the time from first contact to assessment to active enrollment in treatment. Saint Joseph's expanded the use of medication-assisted treatment (MAT) in all of its behavioral health programs and promotes open access to MAT services, particularly following an overdose or related encounter. Rapid access to MAT provides immediate craving and overdose risk relief, as well as enhances patient engagement through a positive perception of program efficacy.

Saint Joseph's trains its medical staff in a trauma-informed approach to substance use disorder treatment. This approach is supported by compelling research evidence documenting the high co-morbidity of substance use disorder, including opioid use disorder, with both trauma and adverse childhood experiences. Trauma-informed care incorporates knowledge of patient trauma into all aspects of service delivery to achieve evidence-backed best practice outcomes.

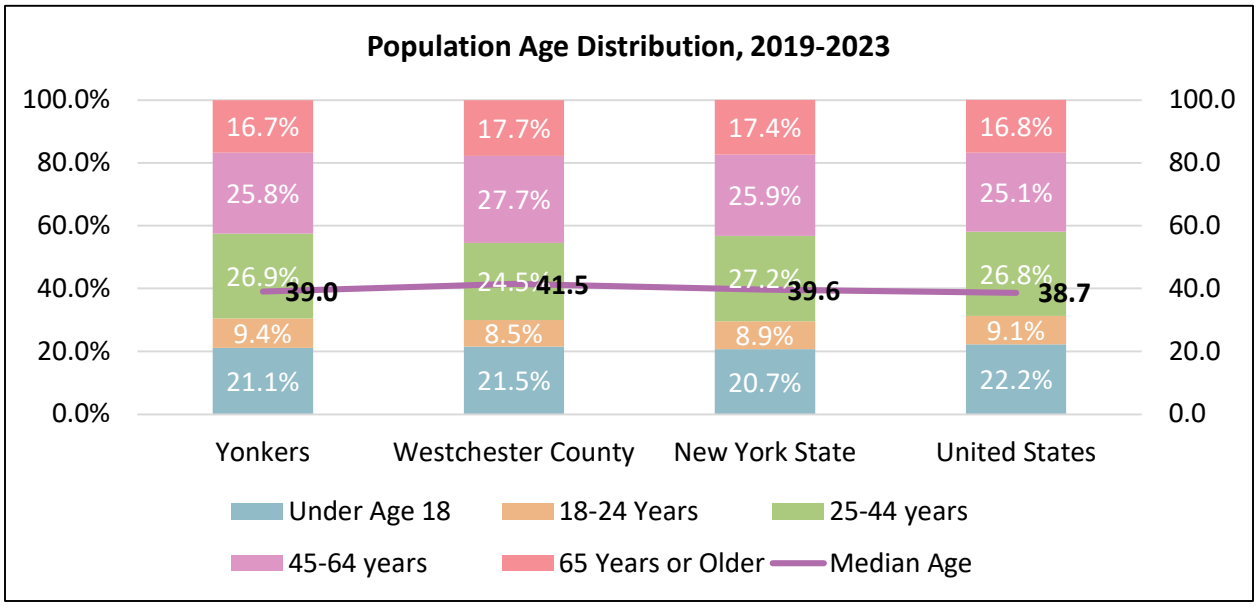
Substance use disorders and mental health concerns are often co-occurring and require a coordinated approach. Saint Joseph's Department of Psychiatry provides comprehensive outpatient and inpatient mental health services, addiction treatment programs and crisis services, and residential services. Saint Joseph's also implemented SDoH screening among patients to identify and respond to health-related social needs.

As part of its broader community strategy to address mental health and substance use disorders, Saint Joseph's provides Naloxone administration training and operates a Crisis Prevention and Response Team (CPRT). Naloxone administration training is provided to various entities including prescribers, consumers, and community-based organizations. The CPRT is designed for people experiencing a mental health crisis and can provide assessment, crisis intervention, supportive counseling, and linkages to services. The CPRT is an interdisciplinary mobile team of mental health professionals that partners with schools, law enforcement, and various health and social service agencies. The team responds to people directly in the community.

Saint Joseph's is committed to caring for the Yonkers community and beyond. The CSP is one way that Saint Joseph's tracks and monitors its health improvement work.

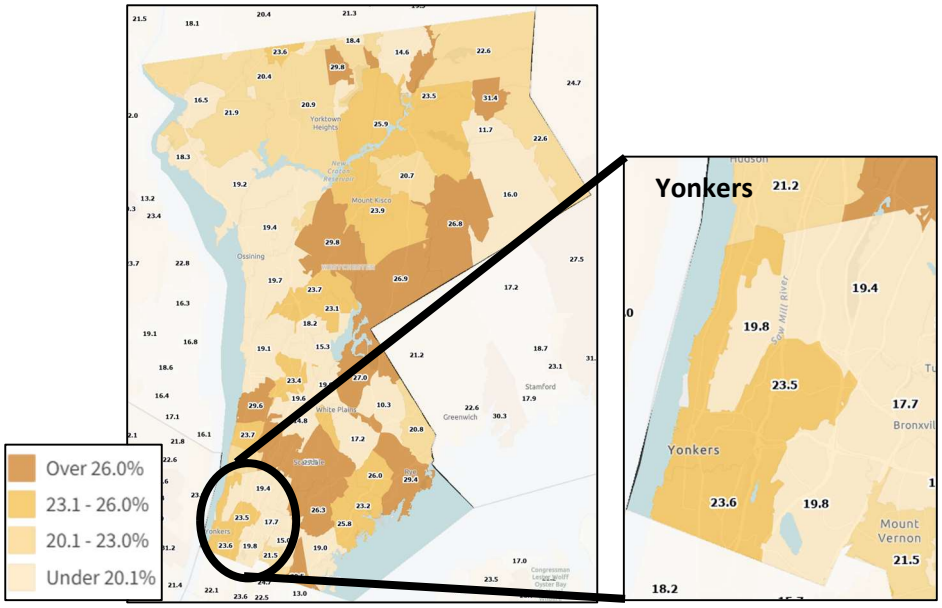
# Our Community and Residents

Yonkers had a total population of 209,529 in 2023, a slight -0.12% decline from 2022 (209,780). However, long-term trends show population growth, and at a faster rate than most other New York cities. Between the 2010 and 2020 censuses, the Yonkers population grew approximately 8%, adding about 15,600 residents. Yonkers residents are younger than residents across Westchester County with proportionally more young adults and fewer older adults. The Saint Joseph's primary service area is even younger with nearly 1 in 4 residents under the age of 18.




Source: US Census Bureau, American Community Survey

**Youth Under the Age of 18 by Westchester County Zip Code, 2019-2023**

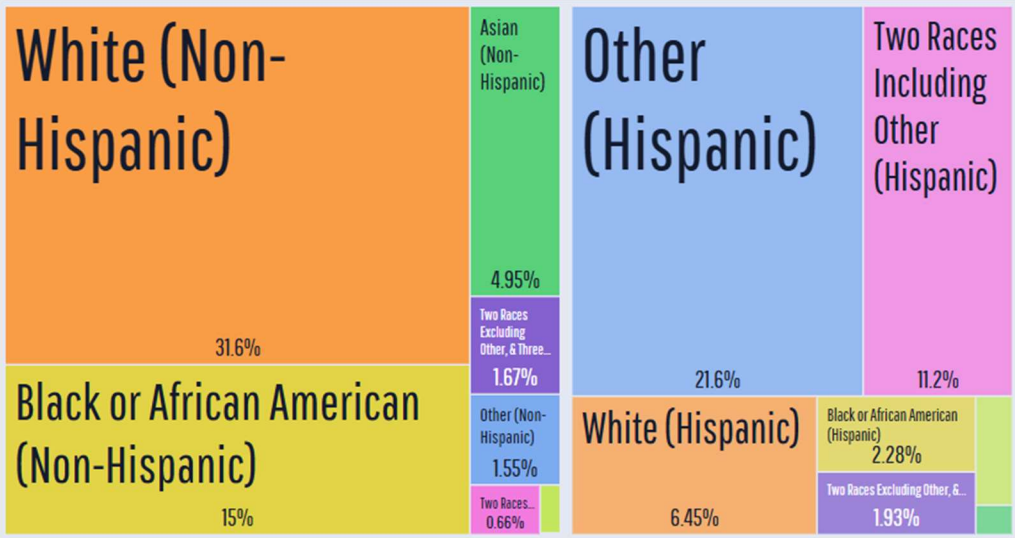



Source: US Census Bureau, American Community Survey

Yonkers benefits from population diversity and a rich variety of cultures. As of 2023, 32.4% of Yonkers residents were born outside of the U.S. The city school district is comprised of students hailing from 100 different cultures and nationalities.

The following chart shows select racial and ethnic groups represented in Yonkers as a share of the total population. Approximately 44.4% of Yonkers residents identify as Hispanic compared to 27% of all Westchester County residents. The largest population groups in Yonkers are white, non-Hispanic (31.6%); other race, Hispanic (21.6%); and Black and/or African American, non-Hispanic (15%).

**Yonkers Residents by Race and Ethnic Identity, 2019-2023**




Source: US Census Bureau, American Community Survey & Data USA

*Other Race has historically captured ethno-racially mixed individuals, as well as Latinx individuals who do not consider ethnicity as separate or distinct from race.

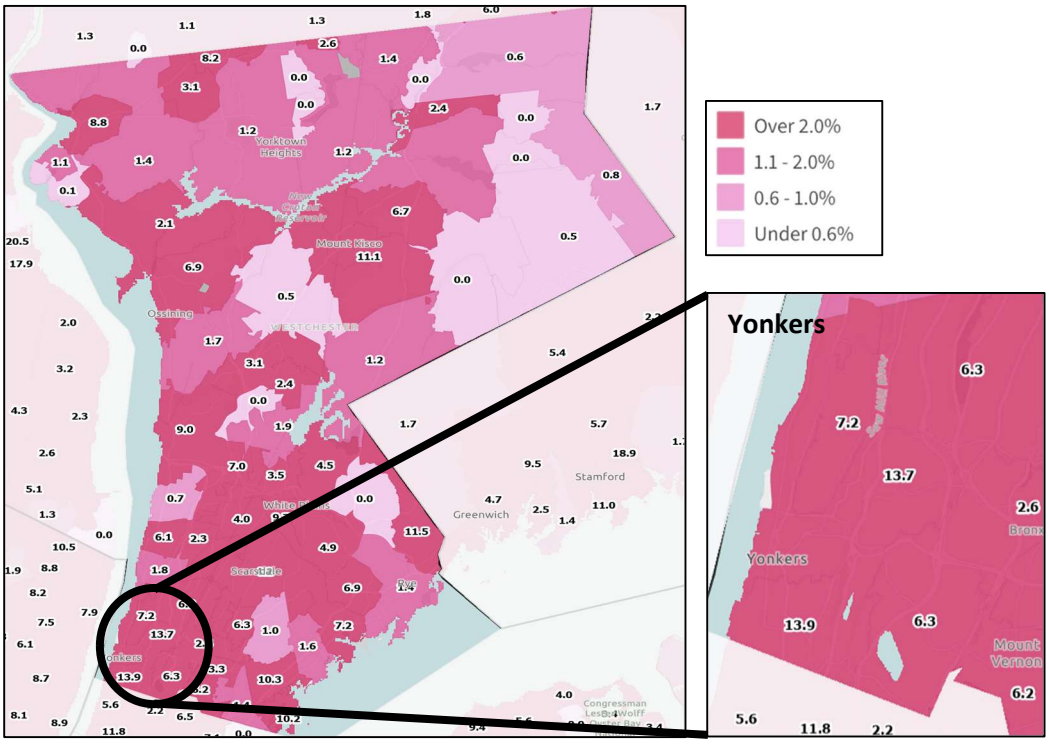
**Population Identifying as Hispanic and/or Latinx (any race), 2019-2023**

| | Percentage |
|---|---|
| Yonkers | 44.4% |
| Westchester County | 27.0% |
| New York State | 19.6% |
| United States | 19.0% |

Source: US Census Bureau, American Community Survey

An estimated 46% of Yonkers households speak a primary language other than English, double that of the national average (22%). The most common non-English language spoken in Yonkers is Spanish, although due its diverse population, a wide variety of other languages are spoken in the city. In approximately 14% of primary service area households, no one aged 14 or older speaks English at least 'very well' and another language is often spoken in the home. These households are considered linguistically isolated, and the findings inform a heightened community need for multilingual and culturally appropriate resources and workforce efforts to ensure that providers and staff reflect the diversity of residents.

**Linguistically Isolated Households by Westchester County Zip Code, 2019-2023**




Source: US Census Bureau, American Community Survey

The economy of Yonkers employs roughly 102,000 people. In 2023, the largest industries in Yonkers were Healthcare and Social Assistance, Educational Services, and Retail Trade. The most common job groups, by number of people living in Yonkers, were Office and Administrative Support Occupations, Management Occupations, and Sales and Related Occupation. The following chart illustrates the share breakdown of the primary jobs held by residents of Yonkers.

**Yonkers Residents by Employment Sector, 2019-2023**

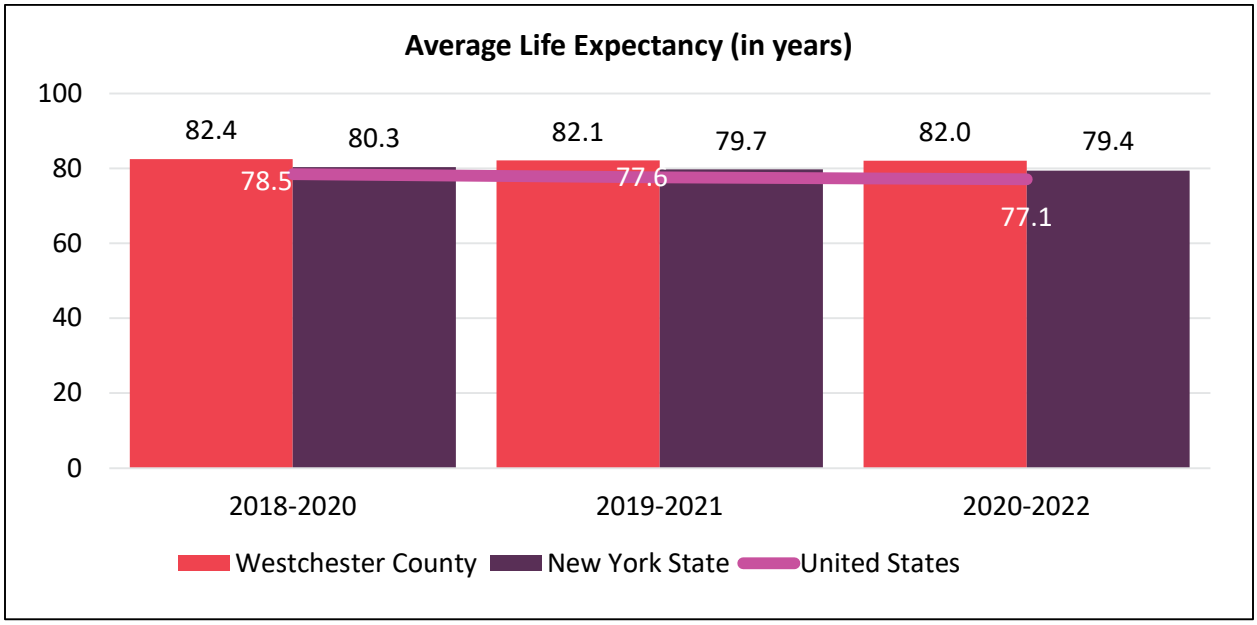

Source: US Census Bureau, American Community Survey & Data USA

# Measuring Health in Our Community

Life expectancy is a key measure of health and wellbeing within a community, often reflecting the underlying socioeconomic and environmental factors. The Social Drivers of Health framework shows that at least 50% of a person's health profile is influenced by the socioeconomic and environmental factors that they experience. Understanding the impacts and addressing the conditions in the places where people live is essential to improving health outcomes and advancing health equity.

*Life expectancy measures how long people generally live within the defined geography and is the culmination of living conditions, health status, economic security, and the overall experience of residents within a community.*

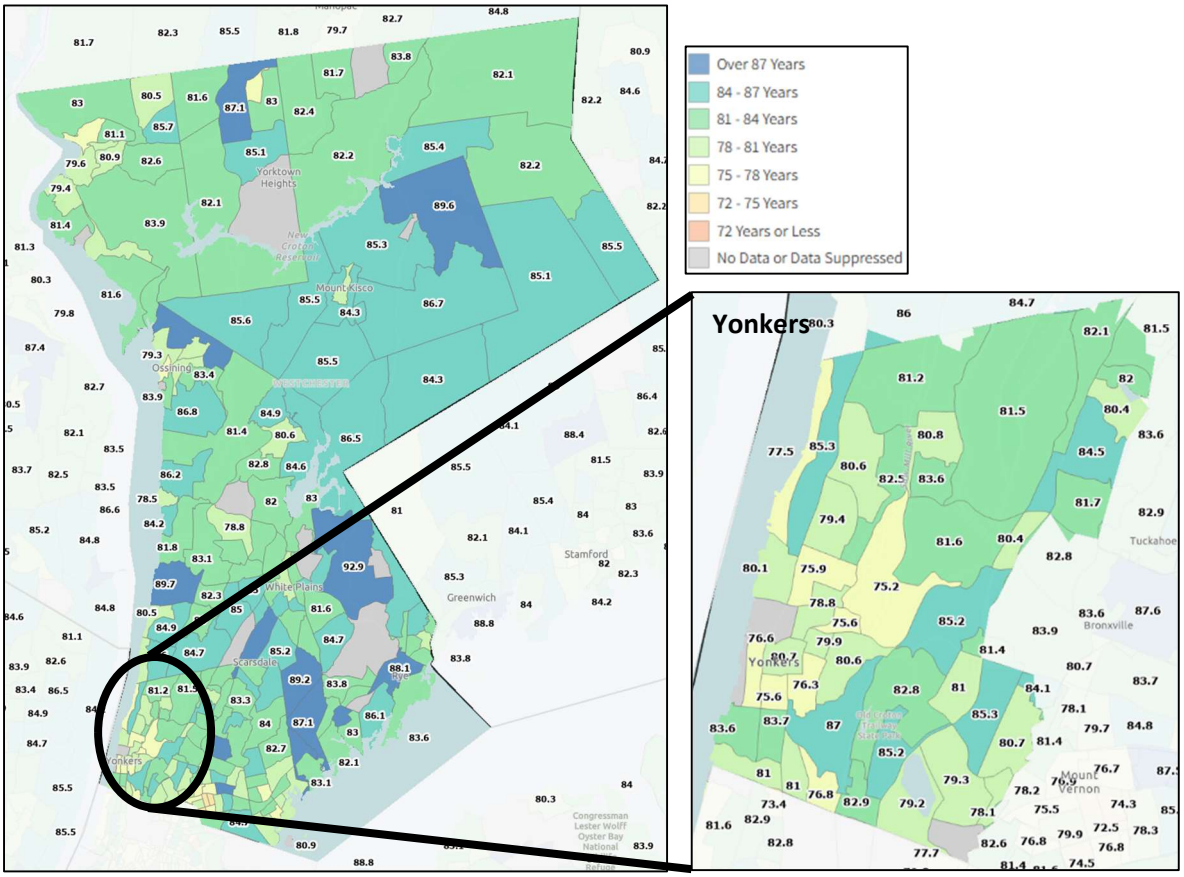
Westchester County overall reports high average life expectancy that exceeds the national average by five years. Overall higher life expectancy in Westchester County reflects strong SDoH factors, including a diverse economy, educational opportunity and attainment, rich health and social services, and access to green spaces. Note: Average life expectancy declined nationally during the COVID-19 pandemic.




Source: Centers for Disease Control and Prevention

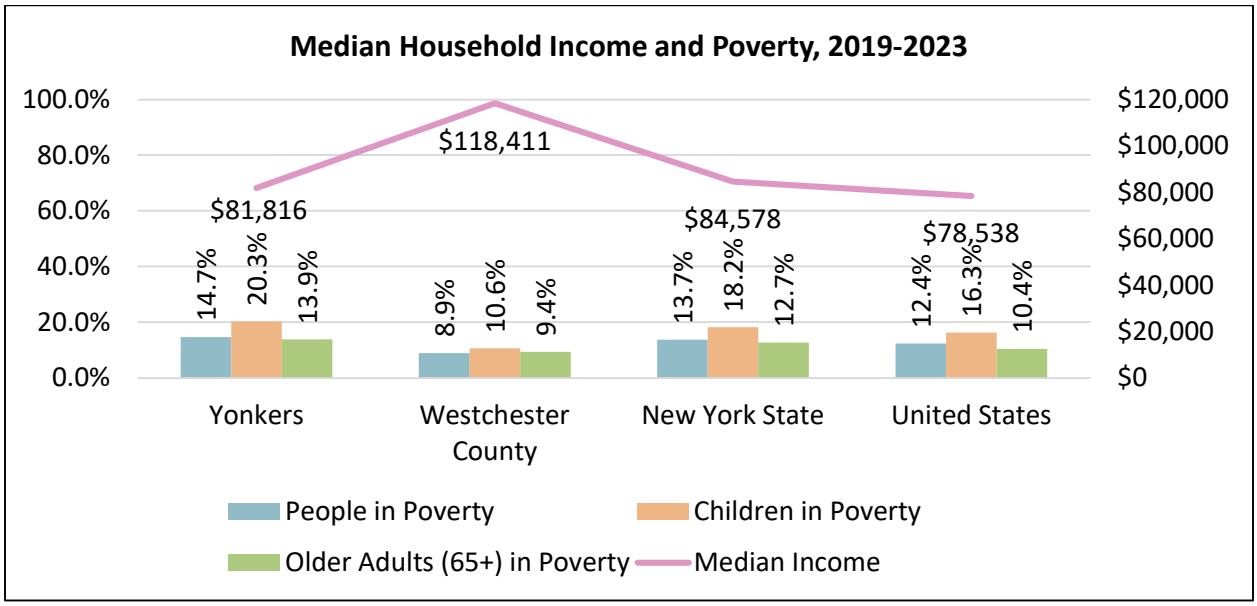
However, not all people in Westchester County share these positive outcomes. Residents of Yonkers, particularly in and around Saint Joseph's primary service area, may live 10-20 years less than residents of other parts of the city or county, reflecting the impact of SDoH and historical disparities.

**Average Life Expectancy by Westchester County Census Tract, 2010-2015**




Source: Centers for Disease Control and Prevention

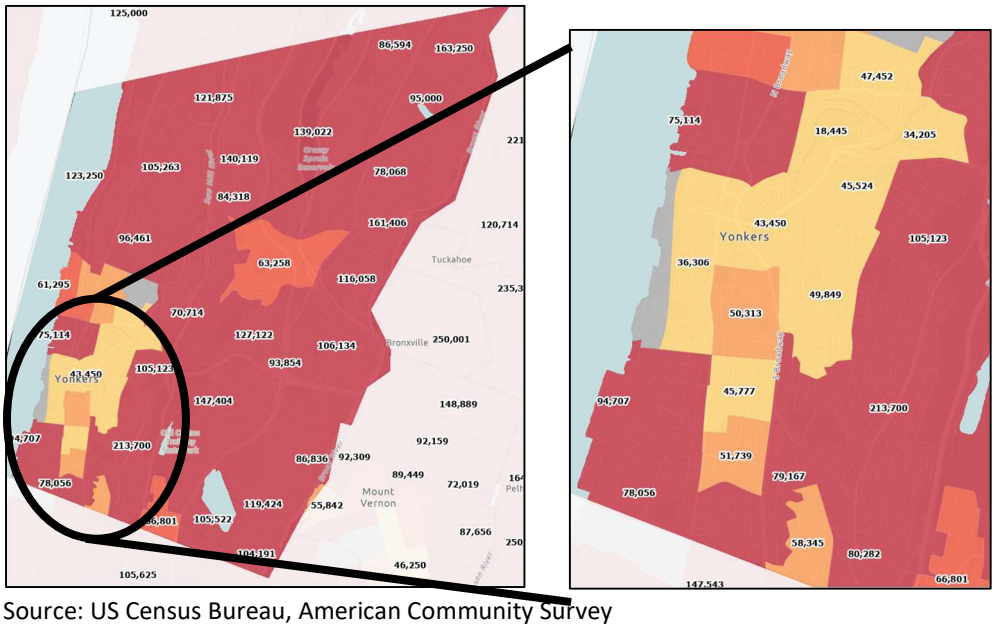
A key SDoH factor and indicator of health disparity is financial security and access to wealth. Median income has increased, and experiences of poverty have declined for Yonkers residents. However, residents continue to have lower incomes and higher poverty levels than their peers across Westchester County. Notably, 20% of Yonkers children live in poverty, double the countywide average.




Source: US Census Bureau, American Community Survey

Income and experiences of poverty vary widely across the city. The following map shows median household income by Yonkers census tract. Residents of the downtown area have median incomes less than $50,000. Within Saint Joseph's primary service area, in Census Tract 5.02, residents have a median income of less than $18,445 and 74.5% of residents live in poverty.

**Median Household Income by Yonkers Census Tract, 2019-2023**




Source: US Census Bureau, American Community Survey

The Health Resources and Services Administration Unmet Need Score (UNS) helps in allocation of resources—including primary and preventive healthcare services—across communities with higher unmet need based on social, economic, and health status. The UNS evaluates zip codes using a weighted sum of 28 health and social measures with values ranging from 0 (least need) to 100 (greatest need).

The following table shows UNS values for Saint Joseph's primary service area and select related social drivers of health indicators. Both zip codes have UNS values exceeding 50, indicating above average unmet need and community-level disparities. These disparities are reflected in indicators like financial security, educational attainment, and access to healthcare.

**Saint Joseph's Medical Center Primary Service Area Zip Codes by Unmet Need Score and Select Social Drivers of Health Indicators (Years 2019-2023)^**

| Zip Code | Total Population in Poverty | Children in Poverty | No High School Diploma | No Health Insurance | 2025 Unmet Need Score |
|---|---|---|---|---|---|
| 10701 | 18.2% | 24.8% | 19.5% | 8.6% | 58.92 |
| 10705 | 18.0% | 21.6% | 19.3% | 7.6% | 52.49 |
| Yonkers | 14.7% | 20.3% | 15.6% | 6.5% | NA |
| Westchester County | 8.9% | 10.6% | 10.6% | 5.0% | 31.63 |
| New York State | 13.7% | 18.2% | 11.9% | 5.1% | NA |

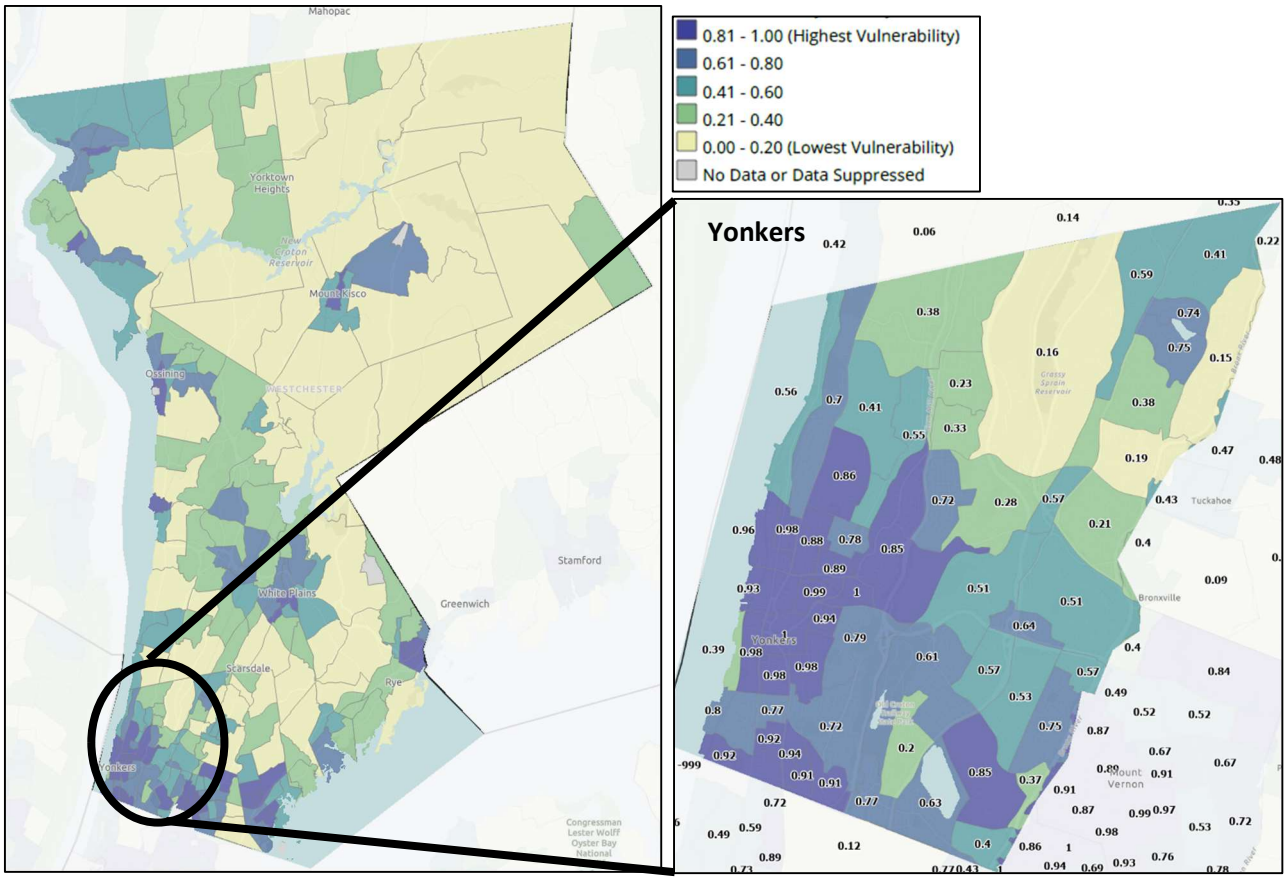
Source: Health Resources & Services Administration & US Census Bureau, American Community Survey
^Select SDoH indicators are presented to illustrate measures that influence the calculation of the Unmet Need Score.

The Social Vulnerability Index (SVI) goes a level deeper than the UNS to demonstrate vulnerability to health disparities at a census tract-level. The SVI scores census tracts on a scale from 0.0 (lowest) to 1.0 (highest) vulnerability based on factors like poverty, lack of transportation, and overcrowded housing.

*Census tracts are small geographic regions defined for the purpose of taking a census, designed to be relatively homogeneous in terms of population characteristics, economic status, and living conditions. Census tracts typically contain between 1,500 and 8,000 people.*

The SVI findings reinforce historical disparities in average life expectancy in downtown Yonkers. Most communities within these neighborhoods have SVI values of 0.9 or higher, and many communities have SVI values of 0.98 or higher out of a maximum score of 1.0. These findings suggest more negative social risk factors and opportunities for targeted intervention.

**Social Vulnerability Index by Census Tract within Yonkers, 2022**




Source: Centers for Disease Control and Prevention

# Community Health Needs

The CHNA was a comprehensive study of health and socioeconomic indicators for Yonkers and Westchester County residents. The following section highlights key health and wellbeing needs, guided by community input and perceptions of the top concerns for the region.

## Greater New York Hospital Association CHNA Survey Collaborative

In 2025, GNYHA offered member hospitals and health systems the opportunity to participate in the GNYHA CHNA Survey Collaborative. GNYHA developed a survey with input from members, using validated questions from existing surveys such as the CDC Behavioral Risk Factor Surveillance System and the New York City Department of Health and Mental Hygiene's Community Health Survey.

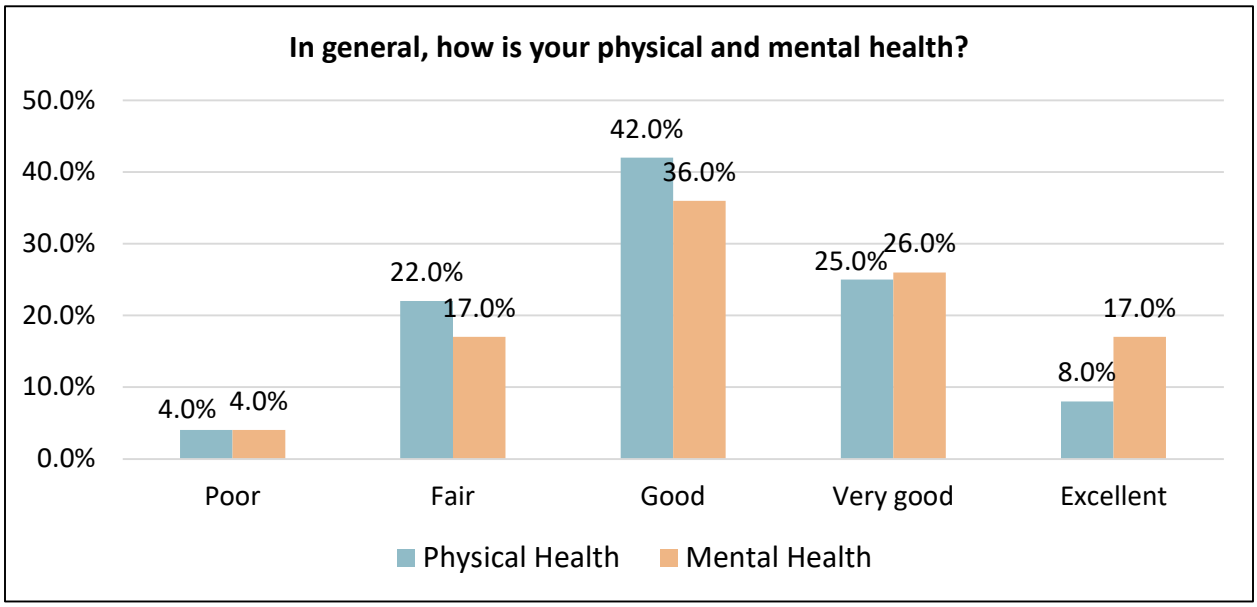
The survey was available to community members aged 18 or older. Community members could complete the survey online in a format compatible with mobile devices. Collaborative members also received copies of the survey to distribute and use for data collection in 19 languages, including English and the top 16 languages spoken among non-English speakers as designated by New York State.

Participating hospitals provided GNYHA with 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. Collaborative members recruited participants from their communities for the survey, with more than 16,400 community members responding. Of the total respondents, 3,546 community members resided in Saint Joseph's service area and 623 resided in Yonkers.

The following is a summary of survey findings with select supporting secondary data findings.

## Health Status of Survey Participants

Survey respondents were asked to rate their overall physical and mental health status. Perceptions of individual health were mixed and generally indicated opportunity for health improvement. About 30%-40% of respondents rated their physical health and/or mental health as *very good* or *excellent*, while about 20%-30% rated them as *fair* or *poor*. Approximately 40% of respondents rated their physical or mental health as *good*.




Source: GNYHA CHNA Survey Collaborative

Approximately 3% of respondents reported having Long COVID with significant activity limitations. Long COVID is a chronic condition that occurs after COVID-19 infection. Symptoms may include fatigue, brain fog, and shortness of breath, among others. Approximately 7% of respondents reported having Long COVID without significant activity limitations and 91% reported having no current Long COVID.

Survey respondents were asked to share their experience with health-related social needs including food and housing insecurity. **Nearly one-third (31%) reported having food insecurity**, stating that in the past 12 months they *always*, *usually*, or *sometimes* didn't have enough money to get more food when they needed it. Only 12% of respondents received SNAP (supplemental nutrition assistance program) benefits. **Nearly one-quarter (23%) reported having housing insecurity**, stating that in the past 12 months there was a time when they were not able to pay their mortgage, rent, or utility bills.

**Survey Participants with Health-Related Social Needs**

| | Number | Percent |
|---|---|---|
| Receiving Food Stamps or SNAP | 283 | 12% |
| Food Insecurity | 718 | 31% |
| Housing Insecurity | 548 | 23% |

Source: GNYHA CHNA Survey Collaborative

## Identified Community Needs

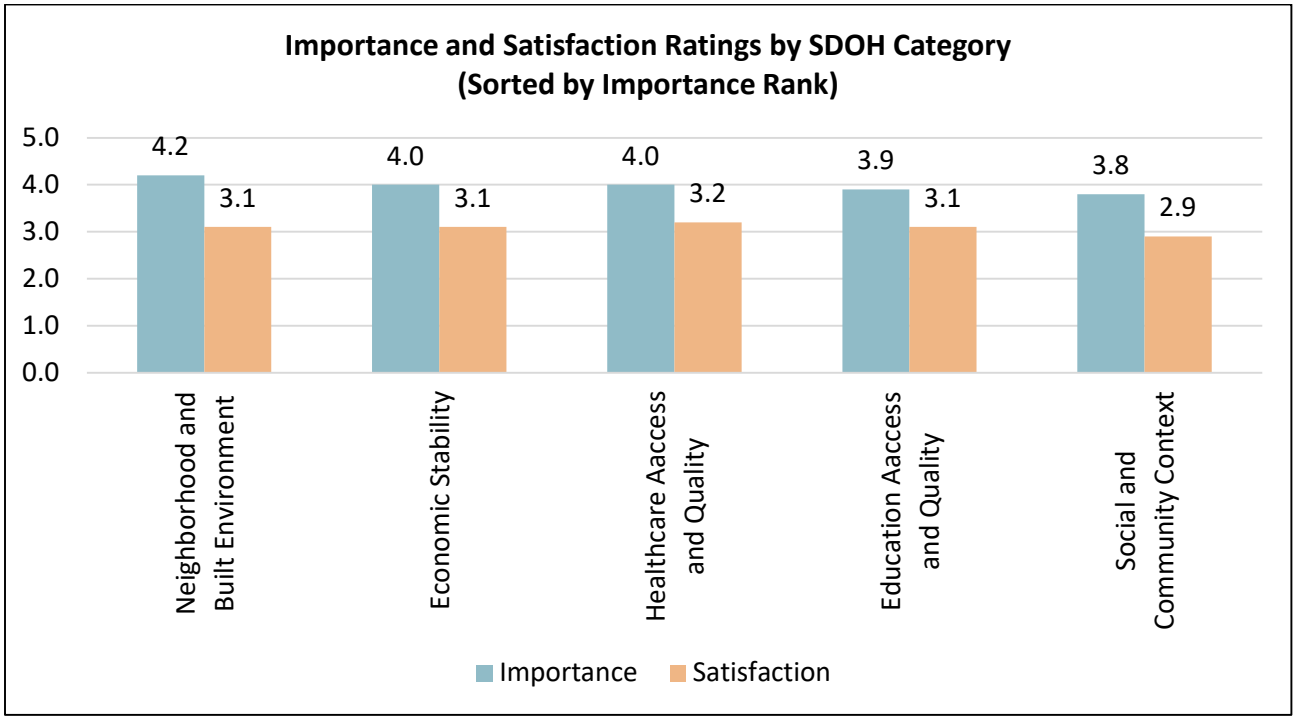
When asked to rate the overall health of the people in their neighborhood, 46% of respondents rated it as *good* and a similar proportion rated it as *very good* or *excellent* (26%) or *fair* or *poor* (28%). In follow up questions, respondents were asked to rate health and social wellbeing issues that affect people in their neighborhood.

Survey respondents were presented with 26 health and social wellbeing issues that relate to the five SDoH domains: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, and Social and Community Context. Respondents were asked to share how important the issues are to them and how satisfied they are with current services in their neighborhood. Based on their responses, issues were ranked as "Needs Attention," "Maintain Efforts," or "Relatively Lower Priority" to inform community health priorities and areas of focus for health improvement efforts.

**Health and Social Wellbeing Issues Assessed by GNYHA CHNA Survey Collaborative Participants**

| Economic Stability | Education Access and Quality | Healthcare Access and Quality | Neighborhood and Built Environment | Social and Community Context |
|---|---|---|---|---|
| • Affordable housing and homelessness prevention<br>• Access to healthy, nutritious foods<br>• Assistance with basic needs (food, shelter, and clothing)<br>• Job placement and employment support | • Access to continuing education and job training programs<br>• School health and wellness programs | • Adolescent and child health<br>• Arthritis<br>• Obesity in children and adults<br>• Cancer<br>• Dental Care<br>• Diabetes and high blood sugar<br>• Heart Disease<br>• Hepatitis C/liver disease<br>• High blood pressure<br>• HIV/AIDS<br>• Infant health<br>• Infectious diseases (COVID-19, flu, hepatitis)<br>• Sexually Transmitted Infections (STIs)<br>• Women's and maternal healthcare | • Violence (including gun violence)<br>• Stopping falls among the elderly | • Mental health disorders (such as depression)<br>• Substance use disorder/addiction (including alcohol use disorder)<br>• Cigarette smoking, tobacco use, vaping, e-cigarettes, hookah |

Health and social wellbeing issues were rated on a scale of 1 (not at all) to 5 (extremely) for both perceived importance and satisfaction with current services. When considered in aggregate, all five SDoH domains received similar importance and satisfaction scores. Issues related to Neighborhood and Built Environment were of highest importance to survey respondents, followed by Economic Stability and Healthcare Access and Quality.

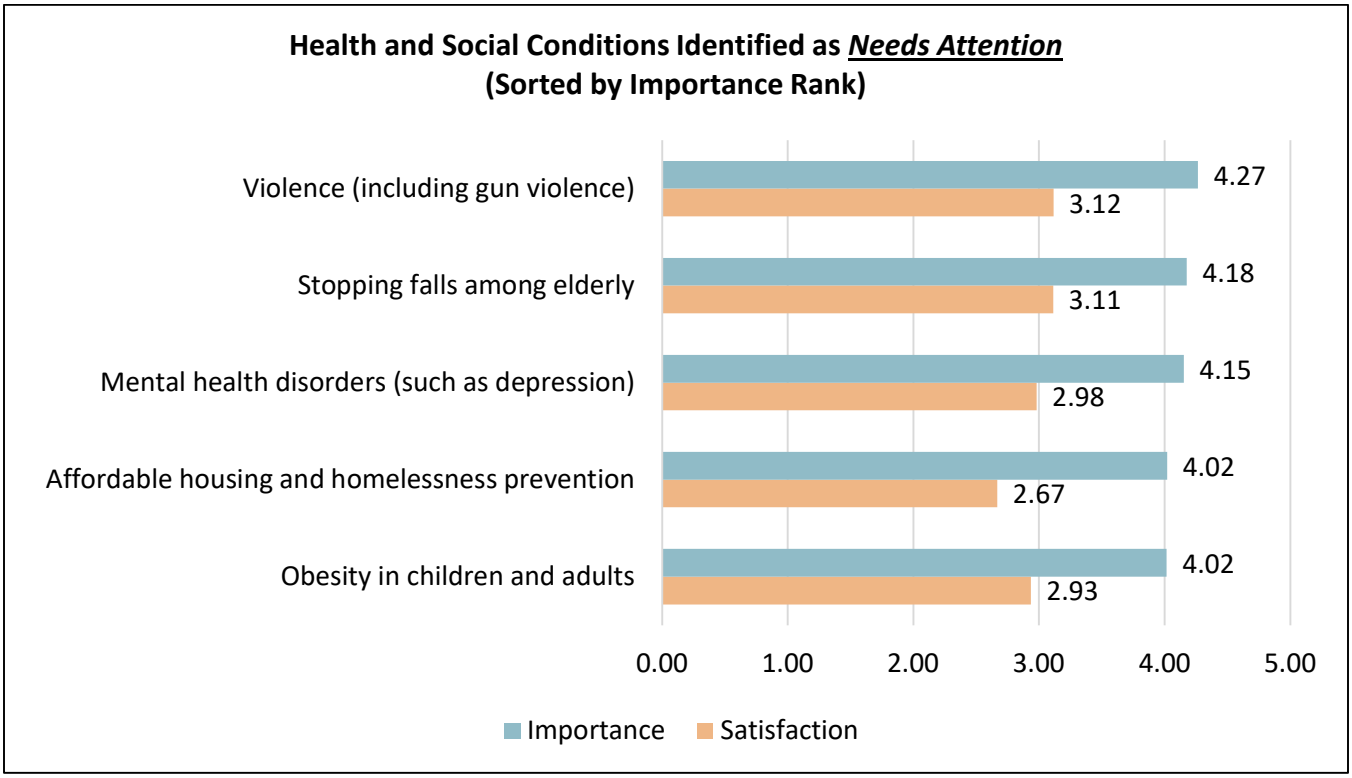



Source: GNYHA CHNA Survey Collaborative

The following graphs show rankings for each of the 26 health and social wellbeing issues comprising the five SDoH domains, grouped by "Needs Attention," "Maintain Efforts," or "Relatively Lower Priority."

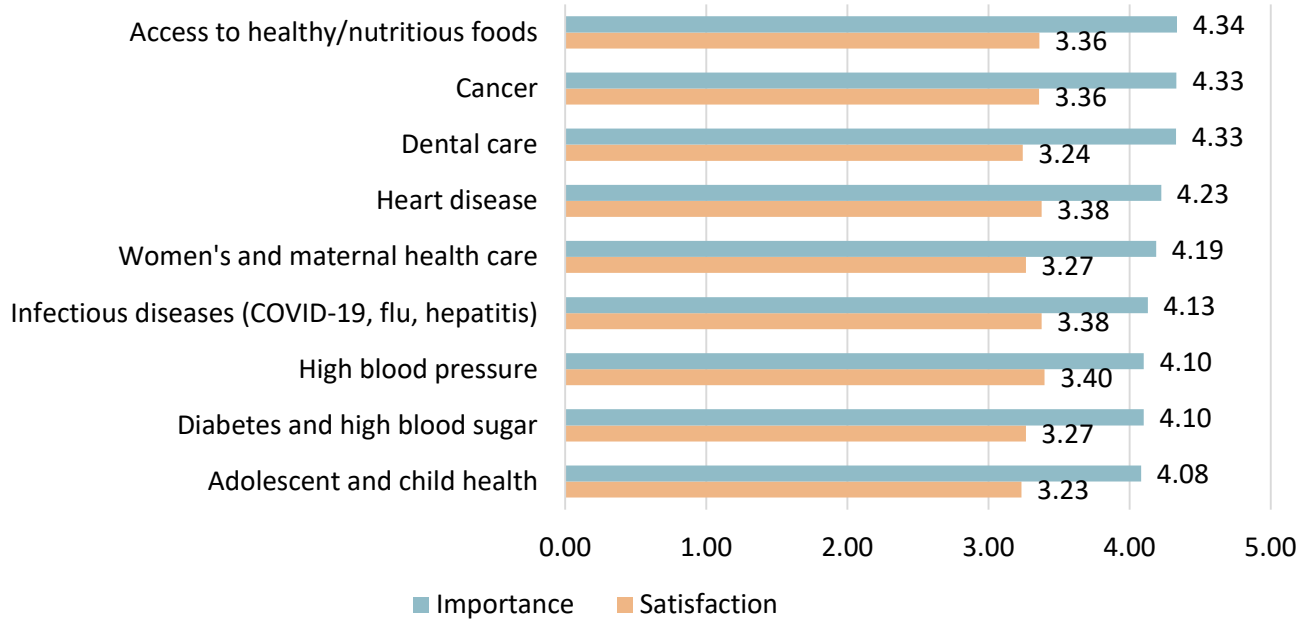
- Issues identified as "*Needs Attention*" had above average importance rankings relative to other issues and below average satisfaction rankings.
- Issues identified as "*Maintain Efforts*" had above average importance rankings relative to other issues and above average satisfaction rankings.
- Issues identified as "*Relatively Lower Priority*" had below average importance rankings relative to other issues and mixed satisfaction rankings.

These issues are further explored with supporting secondary data findings in the following sections.



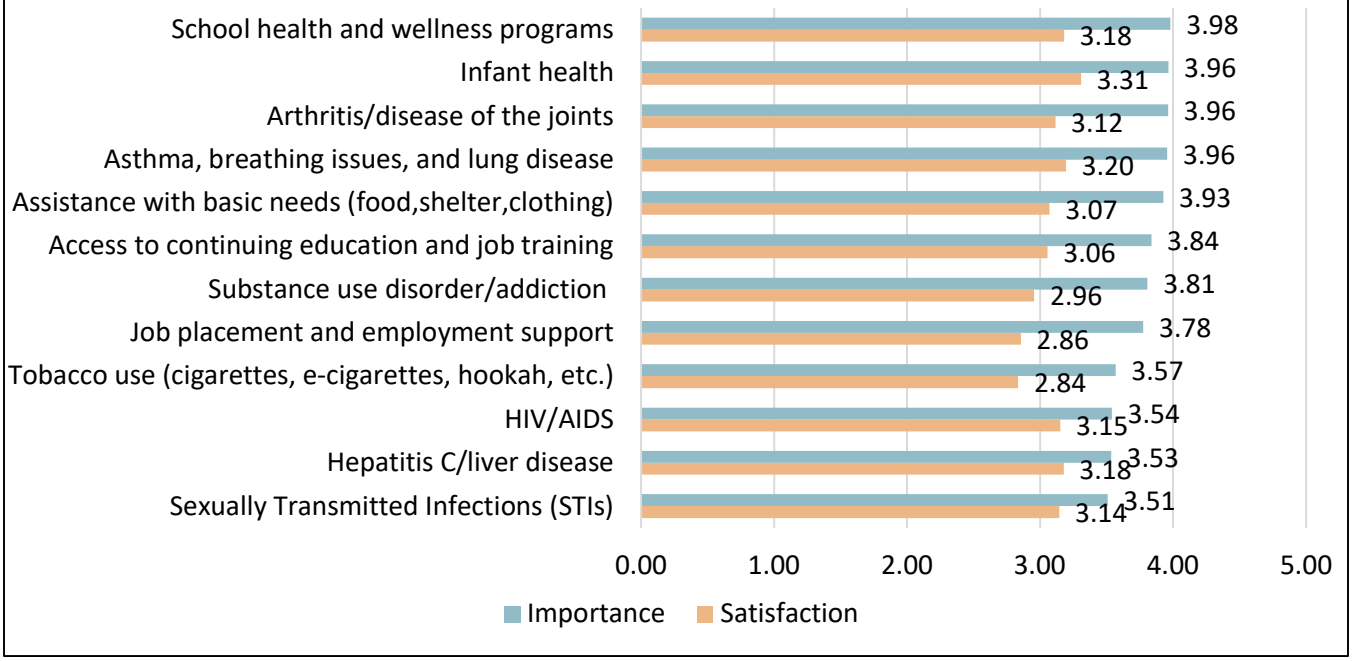

Source: GNYHA CHNA Survey Collaborative

**Health and Social Conditions Identified as *Maintain Efforts***
**(Sorted by Importance Rank)**




Source: GNYHA CHNA Survey Collaborative

**Health and Social Conditions Identified as *Relatively Lower Priority***
**(Sorted by Importance Rank)**




Source: GNYHA CHNA Survey Collaborative

## Identified Community Needs: Needs Attention

The following table displays health and social wellbeing issues identified as "Needs Attention" and their respective importance and satisfaction rankings relative to other issues.

The two issues comprising the Neighborhood and Built Environment domain, violence and stopping falls among the elderly, were important issues for survey participants and there was low satisfaction for current services to address them. Issues related to mental health disorders, affordable housing and homelessness, and obesity had slightly lower importance to survey participants but services to address them were among the least satisfactory. Affordable housing and homelessness received a satisfaction rank of 26 out of 26 total issues (least satisfied of any issue).

**Importance and Satisfaction Rankings for Health and Social Wellbeing Issues Identified as "Needs Attention"**

| | Importance Rank (From 1 Most Important to 26 Least Important) | Satisfaction Rank (From 1 Most Satisfied to 26 Least Satisfied) |
|---|---|---|
| Violence (including gun violence) | 4 | 17 |
| Stopping falls among elderly | 7 | 18 |
| Mental health disorders (such as depression) | 8 | 21 |
| Affordable housing and homelessness prevention | 13 | 26 |
| Obesity in children and adults | 14 | 23 |

Source: GNYHA CHNA Survey Collaborative

Select secondary data findings related to the identified issues are shown below to demonstrate their effect on community members.

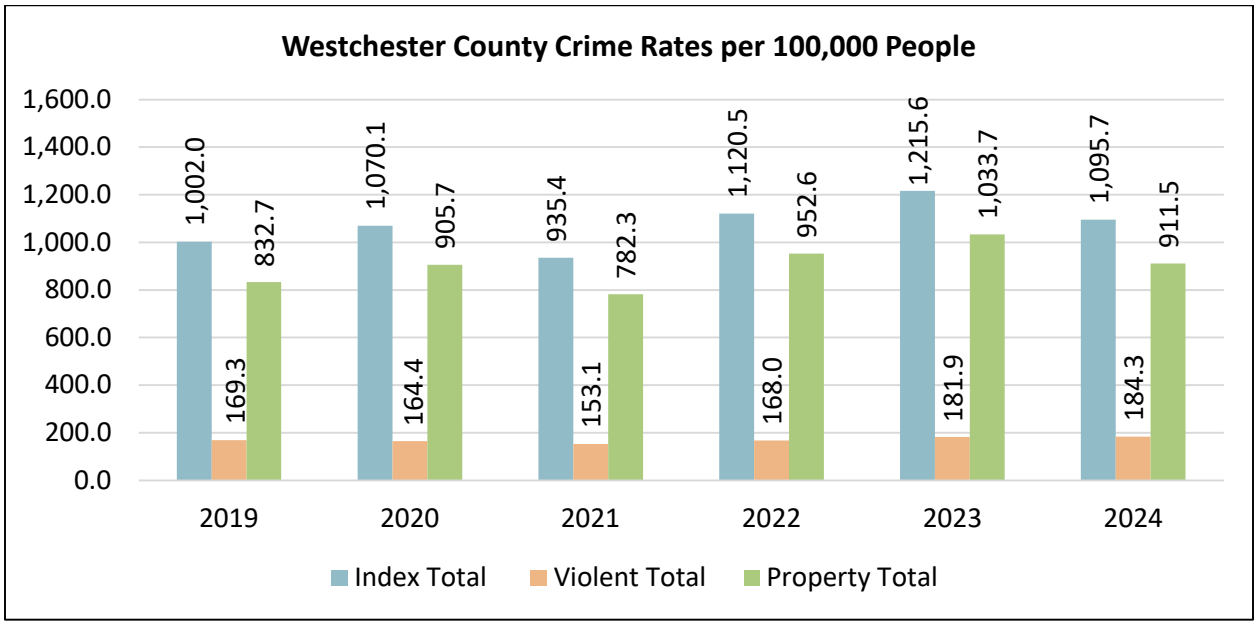
### Violence

The index crime rate is a measure of the number of crimes per 100,000 people, often based on the seven crimes the FBI considers the most serious: murder and non-negligent manslaughter, rape, robbery, aggravated assault, burglary, larceny-theft, and motor vehicle theft. These index crimes are used to calculate a general crime rate for an area.

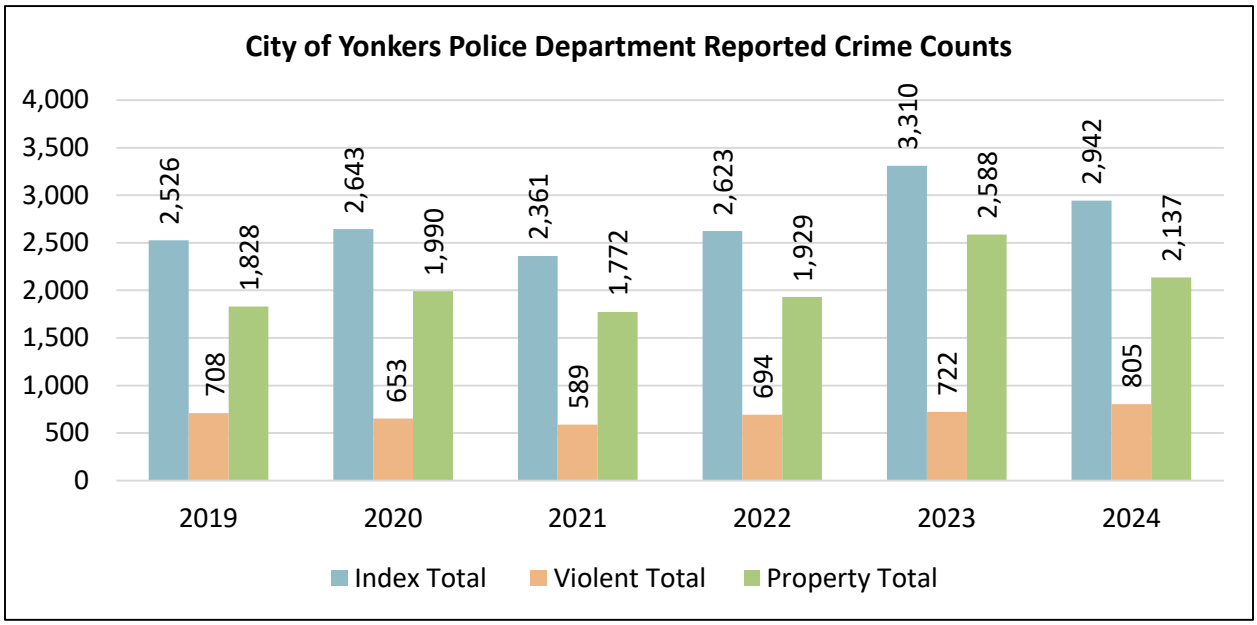
The index crime rate for New York, including New York City, declined through 2021 but increased in 2022 and 2023, reflecting in part instability and social disruption caused by the COVID-19 pandemic. Outside of New York City, property crime (burglary, larceny-theft, motor vehicle theft) largely accounted for the increase, rising from 1,199.8 property crimes per 100,000 people in 2021 to 1,489.1 in 2023.

Westchester County also saw a rise in crimes in 2022 and 2023, including both property and violent crimes. Consistent with the state, the county's total crime rate declined in 2024, although violent crimes continued to increase. A similar trend was seen in Yonkers.

New York State reports crime data by reporting agency or police department, although the data represent *counts* and are not as reliable as crime *rates*. The Yonkers City Police Department reported similar crime trends as the county and state overall with an increase in all crimes through 2023 and an increase in violent crimes through 2024.




Source: New York State Division of Criminal Justice Services



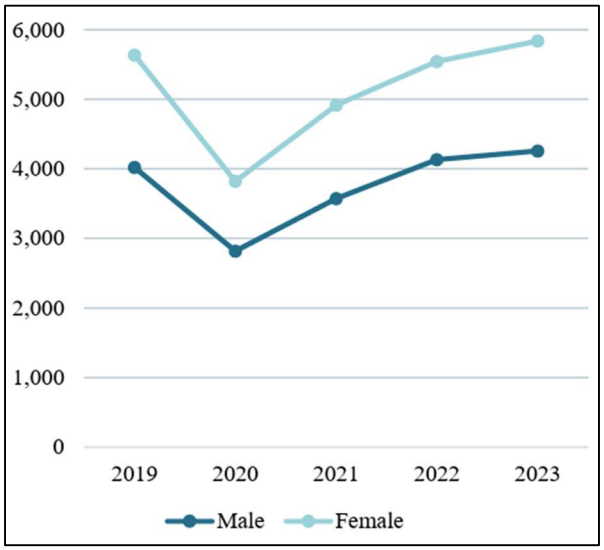

Source: New York State Division of Criminal Justice Services

## Stopping Falls among Elderly

Nearly 1 in 5 Westchester County and Yonkers residents are aged 65 or older. According to the New York State Department of Health, falls are the leading cause of injury-related deaths, hospitalizations, and emergency department visits among adults aged 65 or older.

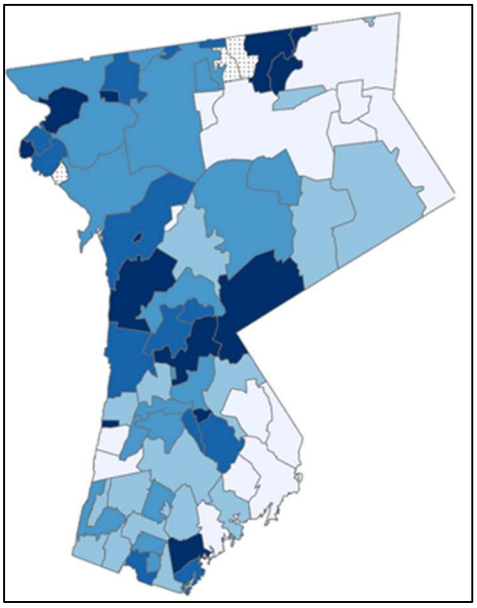
From 2019 to 2023, Westchester County adults aged 65 or older had 39,945 hospital visits due to falls. The rate of hospital visits due to falls per 100,000 older adults fell sharply in 2020 but has since increased annually. The average cost per hospital visit claim involving a fall (all ages) in 2023 was over $4,200, observing approximately a 16% average annual increase in cost from 2019 to 2023.

**Hospital Visit Rate Involving Falls per 100,000 Population Aged 65 or Older**



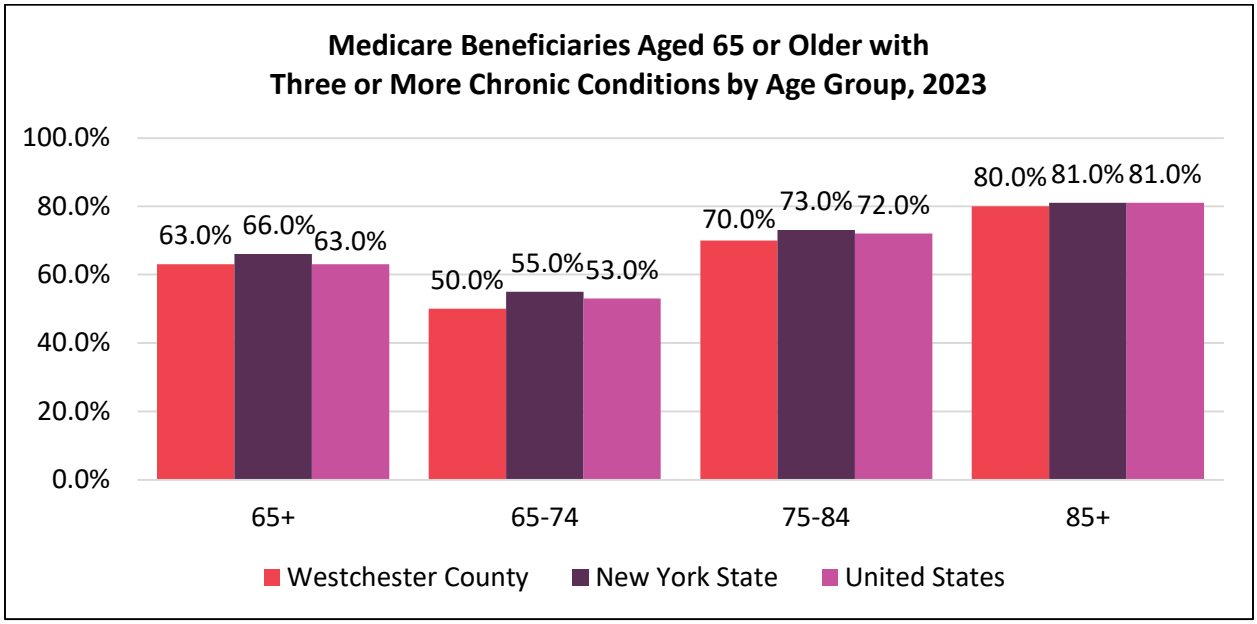

Source: Westchester County Department of Health

**Hospital Visits Involving Falls (all ages) per 100,000 Population by Zip Code, 2019-2023**



Source: Westchester County Department of Health

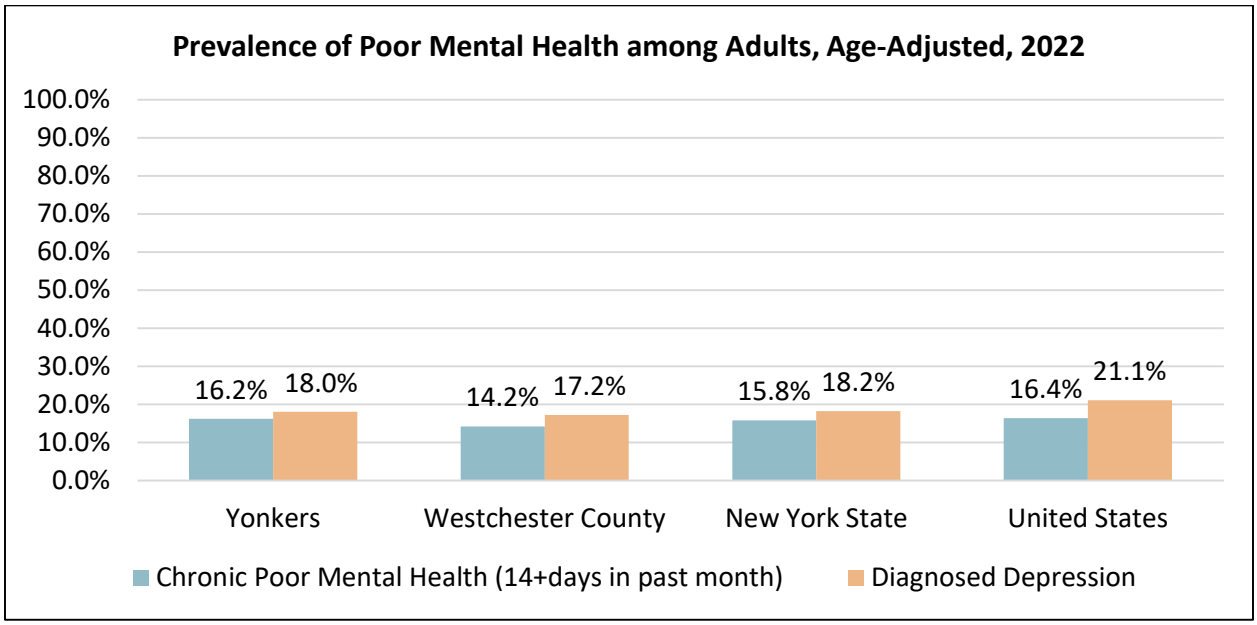
Many falls are the result of multiple risk factors working in concert, including leg weakness, disability, living alone, chronic conditions, and taking multiple medications, among others. The following graph depicts chronic disease prevalence. Approximately 63% of all Westchester County older adult Medicare beneficiaries manage three or more chronic conditions. Additionally, 28% of all Westchester County older adults and 34.4% of all Yonkers older adults live with a disability. Approximately 12.8% of Westchester County older adults and 13.3% of Yonkers older adults live alone.




Source: Centers for Medicare & Medicaid Services

## Mental Health Disorders

Poor mental health is prevalent among adults and increasing statewide and nationally. In 2022, more than 1 in 10 Westchester County and Yonkers adults reported chronic poor mental health (14 or more days of poor mental health in past month), and nearly 1 in 5 reported a diagnosed depression disorder. In Yonkers, the proportion of adults with chronic poor mental health increased more than two percentage points from 14% in 2020 to 16.2% in 2022. Westchester County saw a similar trend with an increase from 12.5% in 2020 to 14.2% in 2022. When viewed by zip code (next page), clear mental health disparities are present and generally aligned with areas placed at risk for socioeconomic barriers.

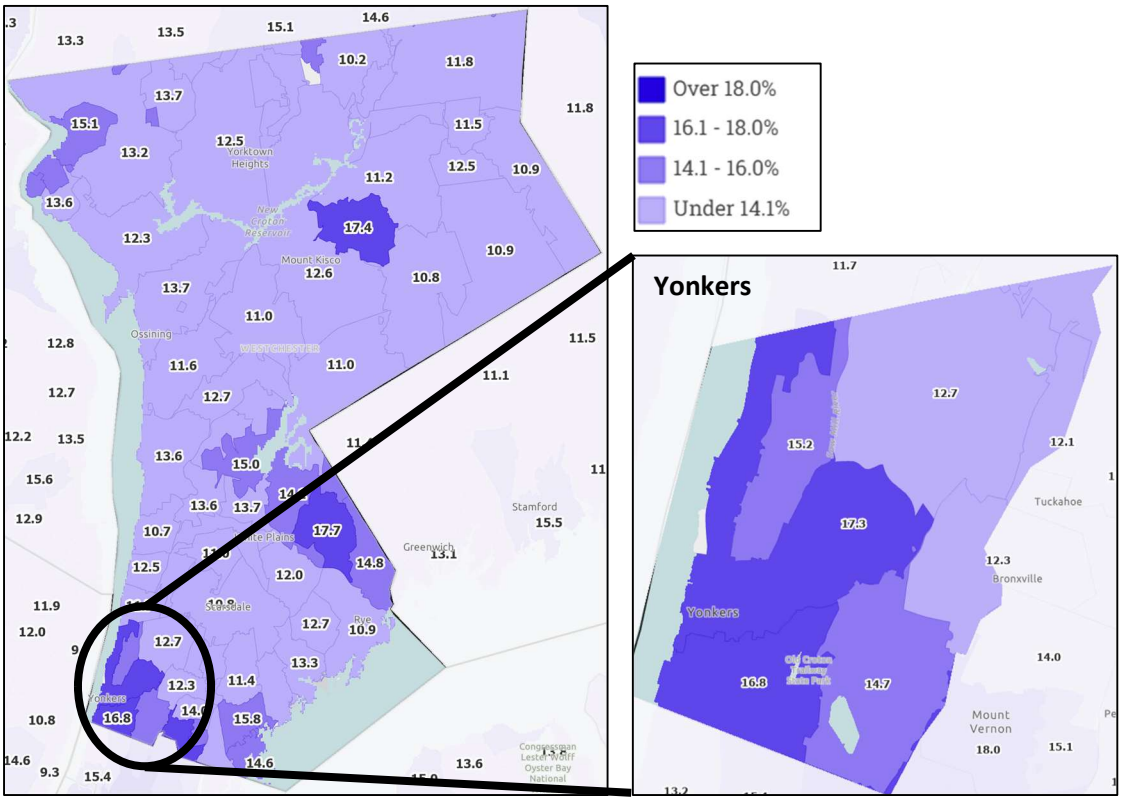



Source: Centers for Disease Control and Prevention

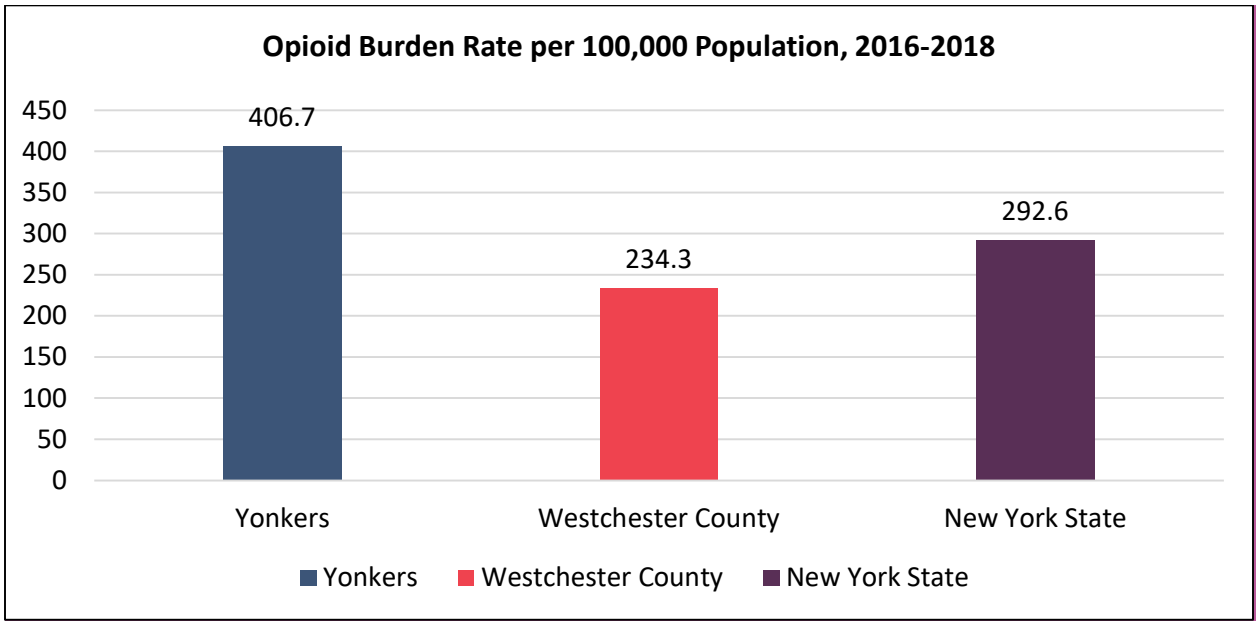
Mental health and substance use disorders are often co-occurring conditions. Yonkers has been challenged by substance use disorder, particularly opioid use disorder and the impact of the opioid epidemic. The widespread availability of prescription painkillers and illicit drugs like heroin and, increasingly, potent synthetic opioids like fentanyl, has driven the crisis. In response, the city has implemented a multi-pronged approach involving law enforcement, education, and community outreach and focused on prevention and assistance for those affected.

In 2024, 16.7% (3,672) of emergency department visits at Saint Joseph's involved a substance use disorder encounter, the highest proportion of any hospital in Westchester County. Montefiore Mount Vernon Hospital had the next highest proportion in the county at 4.9% (720). Substance use disorder encounters included those cases with alcohol, nicotine, opioids, cannabis, sedatives, cocaine, stimulants, hallucinogens, inhalants, and other psychoactive substance documented while visiting the emergency department.

**Adults with Chronic Poor Mental Health by Zip Code, Crude Percentages, 2022**



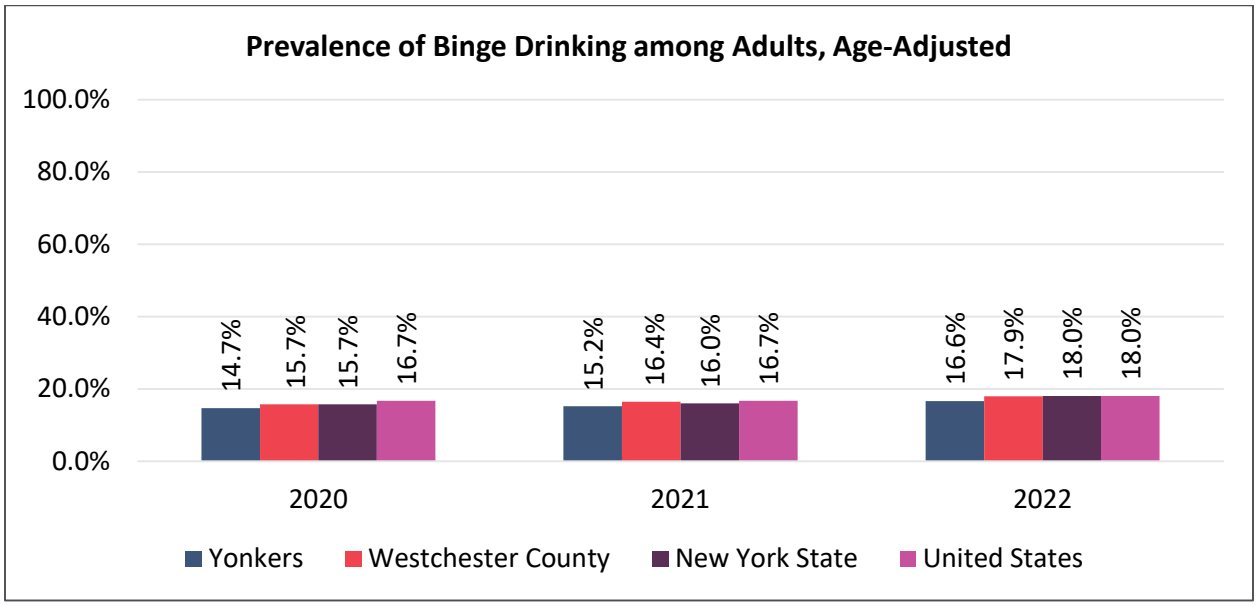

Source: Centers for Disease Control and Prevention




Source: Westchester County Department of Health

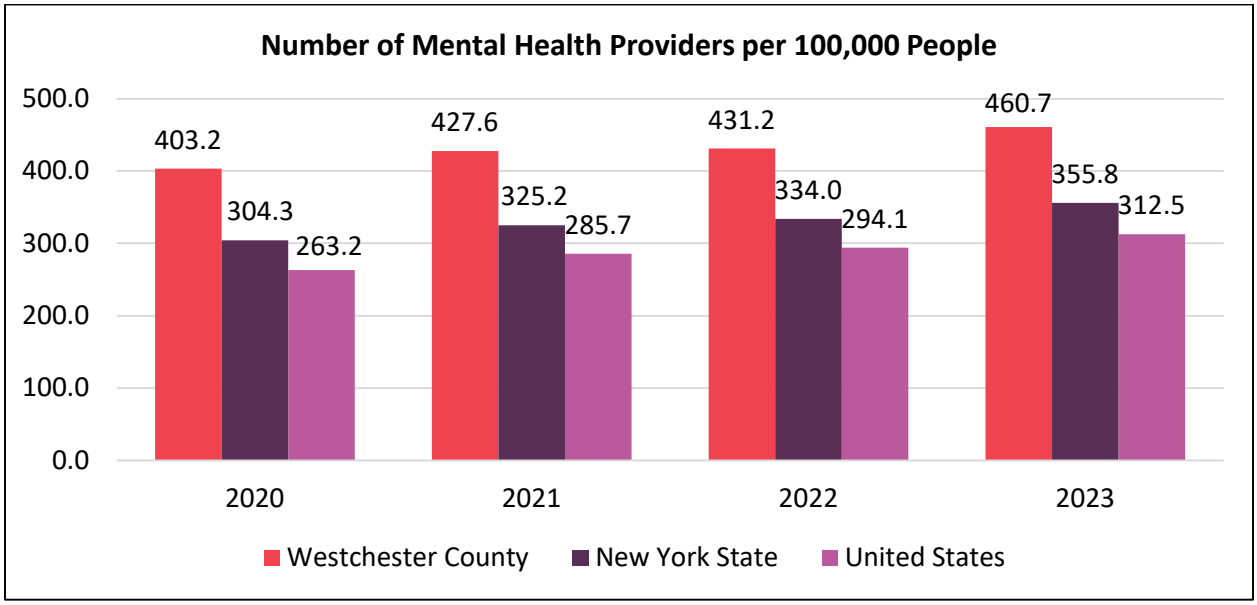
*Opioid burden includes outpatient ED visits and hospital discharges for non-fatal opioid overdose, abuse, dependence, and unspecified use; and opioid overdose deaths.

Alcohol is the most prevalent addictive substance used among adults. In 2024, among all emergency department visit encounters involving substance use disorder at Westchester County hospitals, 36% involved alcohol. Consistent with state and national trends, the proportion of Yonkers and Westchester County adults reporting excessive alcohol use, such as binge drinking, increased in recent years.




Source: Centers for Disease Control and Prevention

The availability of mental health providers has increased across Westchester County, and the county has consistently had more providers than the state and the nation. However, provider availability is not equally distributed across the county. *Yonkers is a mental healthcare HPSA for people with Medicaid*.




Source: Centers for Medicare and Medicaid Services

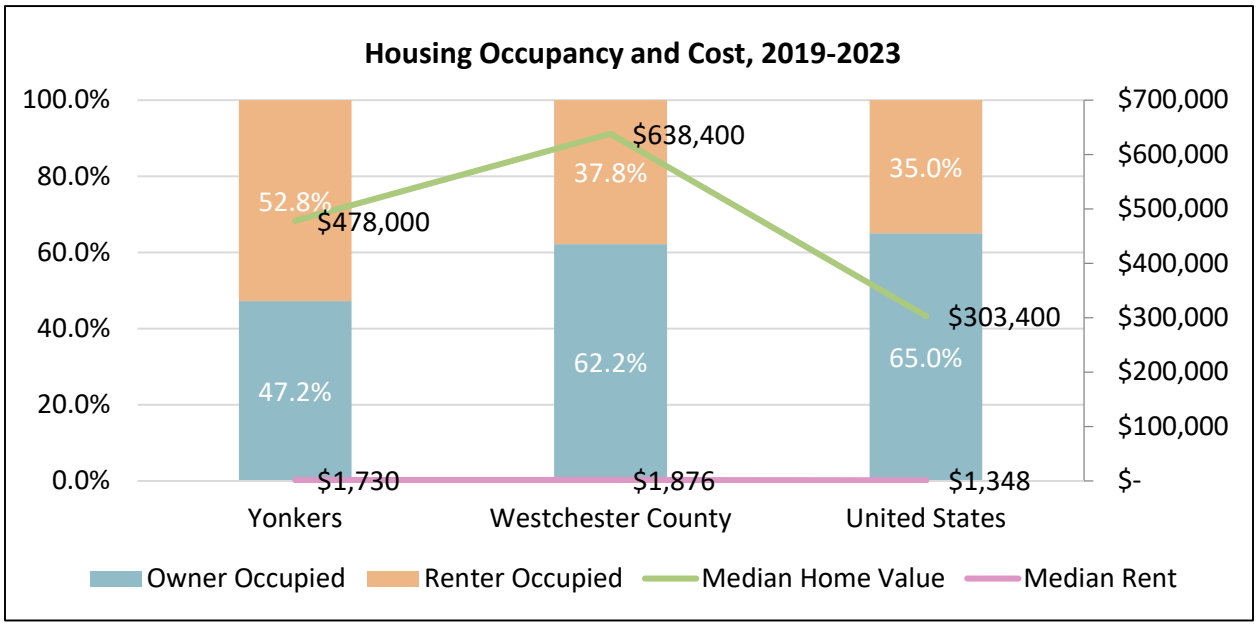
*Mental health providers include those specializing in psychiatry, psychology, mental health, addiction or substance use disorders, or counselling.

### Affordable Housing and Homelessness Prevention

Housing is expensive in Westchester County and Yonkers. The median home value in Westchester County in 2023 was $638,400, 2.1 times higher than the national average of $303,400; the Yonkers median property value was $478,000, 1.58 times higher than the national average. Between 2022 and 2023 the median home value increased 3.13% across Westchester County and 4.71% in Yonkers.

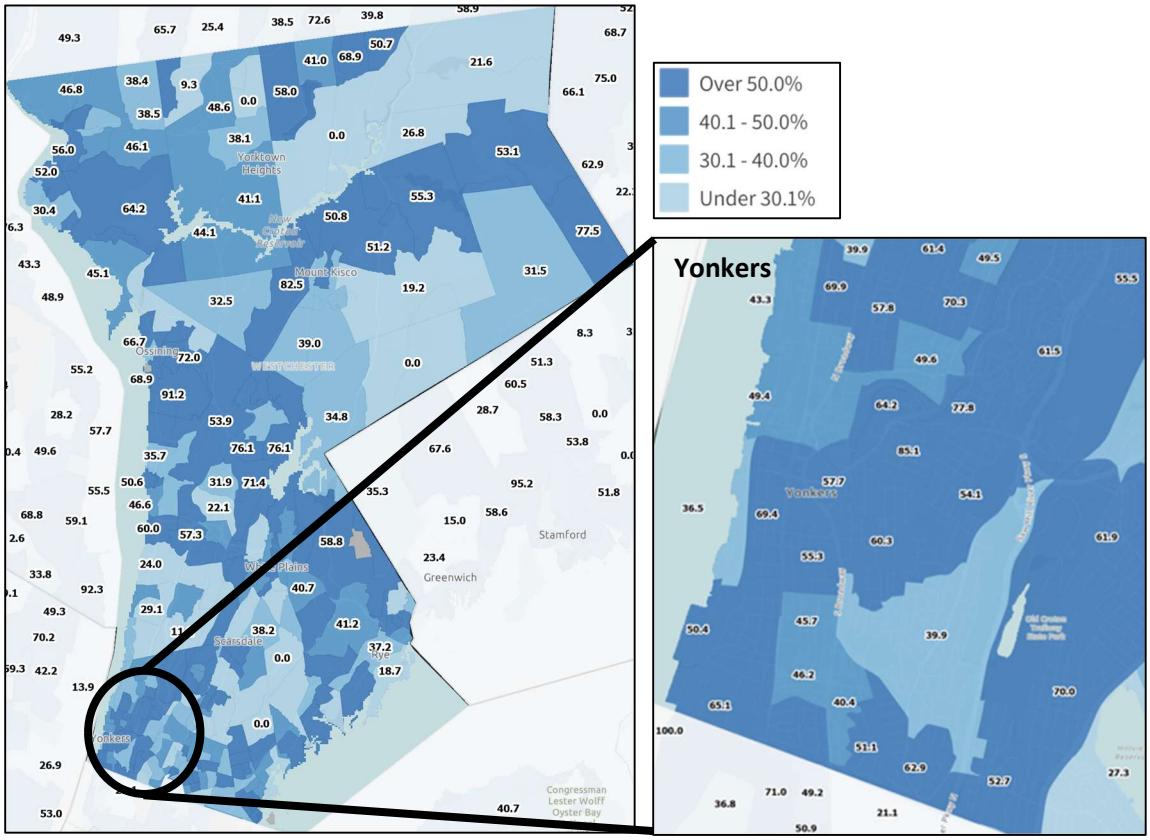
Approximately 36% of all Westchester County households and 40.7% of Yonkers households are cost burdened by rent or mortgage expenses, meaning they spend more than 30% of their combined income on housing alone. Households that are housing cost burdened have fewer resources to spend on other basic needs, such as food and utilities.

Westchester County and Yonkers residents are less likely to own their home than their peers nationally. In Yonkers, more than half (52.8%) of households rent their home. Nationally, renters are more likely to experience housing cost burden. In Yonkers, 54.4% of renters spend 30% or more of their income on rent alone.




Source: US Census Bureau, American Community Survey

**Percentage of Cost Burdened Renters by Census Tract, 2019-2023**




Source: US Census Bureau, American Community Survey

The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness required by the US Department of Housing and Urban Development for communities that participate in its Continuum of Care (CoC) program. The count is usually conducted in late January each year.

The Yonkers, Mount Vernon/Westchester County CoC serves the region, and in 2025, identified 1,730 unhoused people, including 647 children. The number of unhoused people increased 31% since 2023. Homelessness does not affect all people equally, reflecting longstanding disparities in economic stability and mobility and historical inequities. While Black and/or African American people make up roughly 14% of the Westchester County population, they make up 54% of people experiencing homelessness.

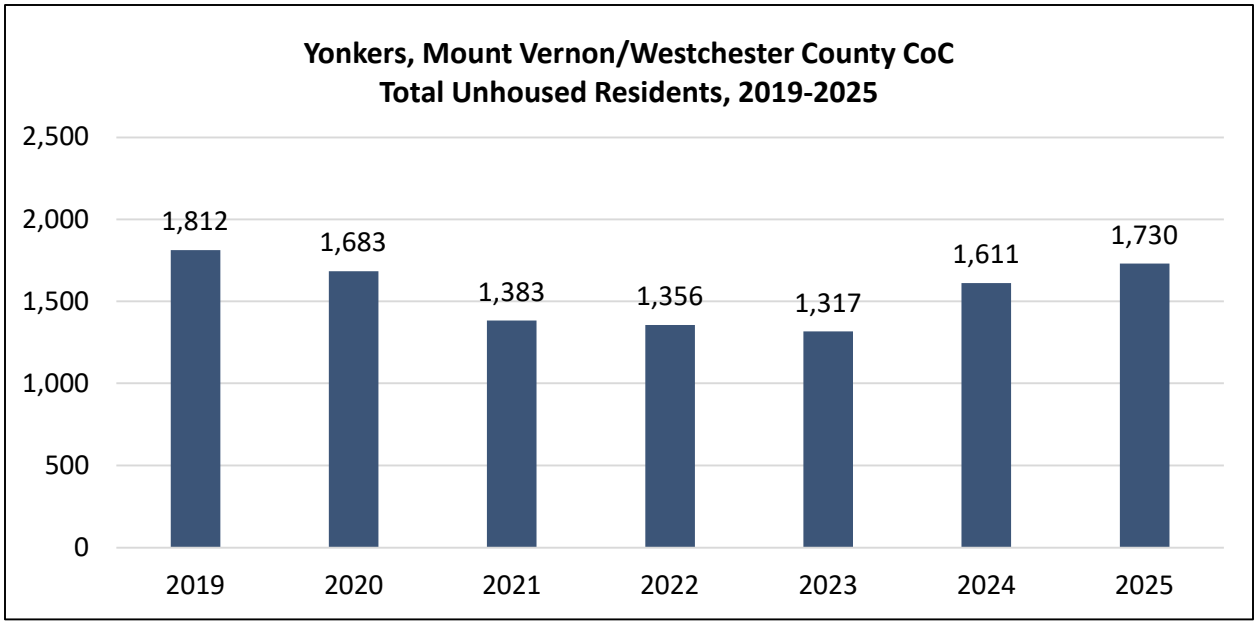
PIT count data for the Yonkers, Mount Vernon/Westchester County CoC are shown on the next page.

**Point-in-Time Homeless Count, 2025**

| | Yonkers, Mount Vernon/ Westchester County CoC |
|---|---|
| Number of unhoused residents | 1,730 |
| Number of unhoused children | 647 |
| Number of unhoused residents over 55 years old | 246 |
| Number of veterans | 23 |
| Number of people fleeing domestic or sexual violence (adults only) | 89 |
| Chronically Unhoused | 133 |
| Race/Ethnicity | |
| White | 135 |
| Black/African American | 931 |
| Multiple Race | 302 |
| Hispanic/Latinx Only | 357 |
| Other Race* | 5 |
| Number of unhoused residents with a: | |
| Mental health (severe and persistent) | 306 |
| Chronic substance use disorder | 136 |

Source: US Department of Housing and Urban Development

*Other Race includes: American Indian, Alaska Native or Indigenous; Asian or Asian American; Middle Eastern or North African; Native Hawaiian or Pacific Islander



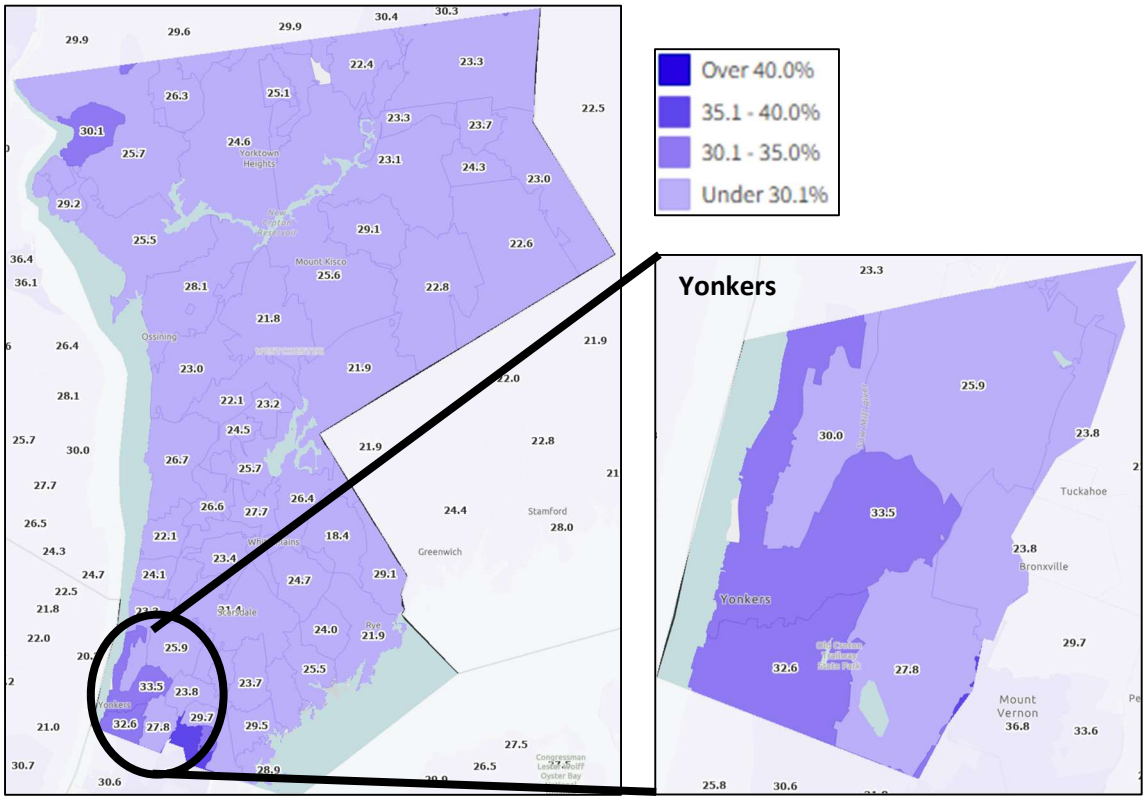

Source: US Department of Housing and Urban Development

## Obesity

Obesity is a complex chronic disease caused by a combination of genetic, metabolic, and behavioral factors. It is strongly associated with an individual's socioeconomic and community experience, including availability of and access to affordable nutritious foods and recreation opportunities and time and resources to participate in a healthy lifestyle.

In 2022, 26.6% of Westchester County adults and 30.3% of Yonkers adults had obesity compared to 33.4% of adults nationwide. The proportion of adults with obesity has been variable year-over-year but generally increased within the last five years.

**Adults with Obesity by Zip Code, Crude Percentages, 2022**




Source: Centers for Disease Control and Prevention

## Identified Community Needs: Maintain Efforts

The following table displays health and social wellbeing issues identified as "Maintain Efforts" and their respective importance and satisfaction rankings relative to other issues.

Access to healthy/nutritious foods was the most important issue for survey participants (ranked #1) and current services to address it were generally perceived as satisfactory. Issues related to chronic disease, access to healthcare, and adolescent and child health were also among the most important issues for participants with general satisfaction in current services. These shared perceptions indicate both high community need and support for existing community resources and improvement efforts.

**Importance and Satisfaction Rankings for Health and Social Wellbeing Issues Identified as "Maintain Efforts"**

| | Importance Rank (From 1 Most Important to 26 Least Important) | Satisfaction Rank (From 1 Most Satisfied to 26 Least Satisfied) |
|---|---|---|
| Access to healthy/nutritious foods | 1 | 4 |
| Cancer | 2 | 5 |
| Dental care | 3 | 9 |
| Heart disease | 5 | 3 |
| Women's and maternal healthcare | 6 | 7 |
| Infectious diseases (COVID-19, flu, hepatitis) | 9 | 2 |
| High blood pressure | 10 | 1 |
| Diabetes and high blood sugar | 11 | 8 |
| Adolescent and child health | 12 | 10 |

Source: GNYHA CHNA Survey Collaborative

Select secondary data findings related to the identified issues are shown below to demonstrate their effect on community members.

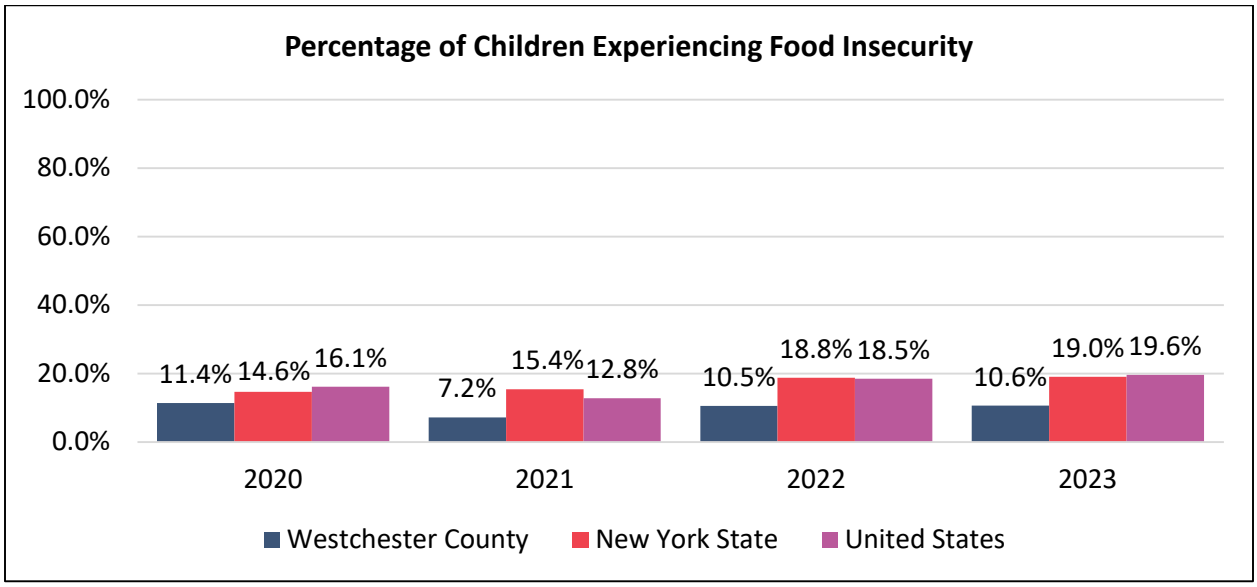
### Access to Healthy/Nutritious Foods

At the root of health disparities for area residents are socioeconomic experiences or social drivers of health. The recent rise in costs of living has further degraded these experiences and challenged people to meet their basic needs and maintain their health.

Experiences of food insecurity have increased for Westchester County, the state, and the nation. Across Westchester County, the percentage of all food insecure residents increased from 6.6% in 2021 to 10.7% in 2023. The percentage of food insecure children increased from 7.2% in 2021 to 10.6% in 2023.

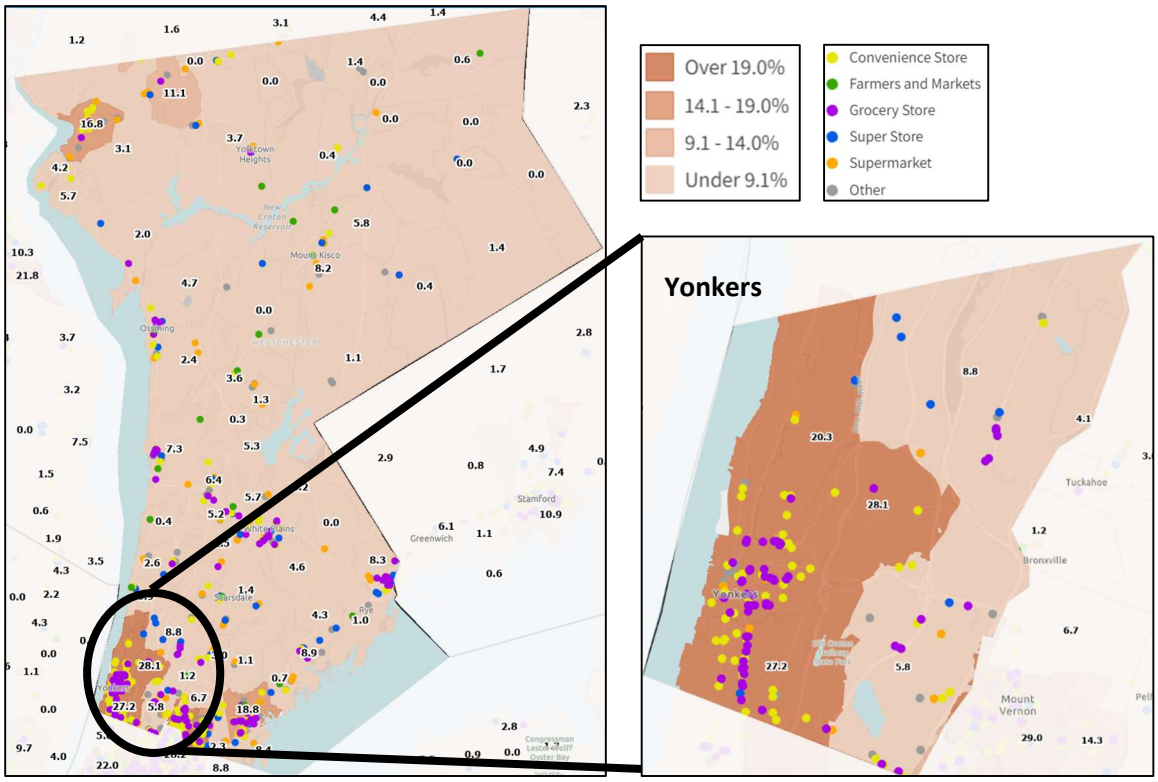
Westchester County residents are less likely to experience food insecurity than their peers statewide and nationally, but experiences vary widely by community. Poverty data indicate that Yonkers residents, particularly children, are likely disproportionately affected by food insecurity. Approximately 15% of

Yonkers residents and 20% of Yonkers children live in poverty. When viewed by zip code, as many as 28% of families in Yonkers receive SNAP benefits compared to 9.5% of families across Westchester County. The recent government shutdown affecting the distribution of SNAP benefits, as well as anticipated federal funding cuts to SNAP in 2027, have far-reaching impact on Yonkers residents.




Source: Feeding America

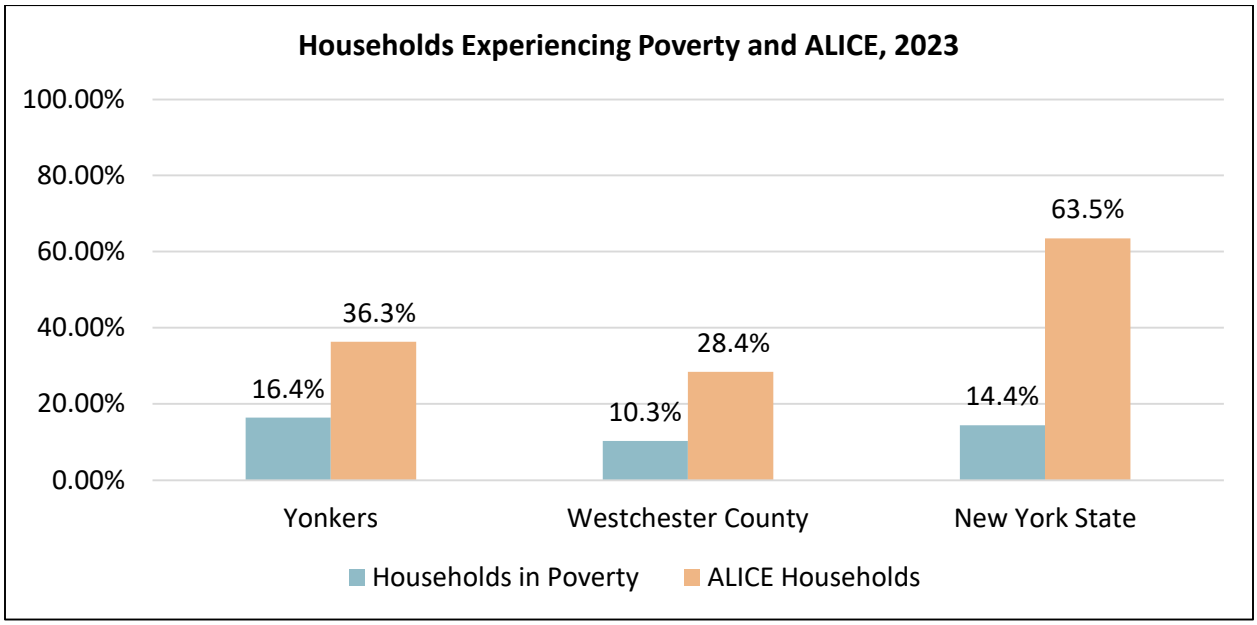
**Households Receiving SNAP Benefits by Zip Code, 2022 & SNAP-Authorized Retailers by Store Type, 2025**




Source: US Census Bureau, American Community Survey & US Department of Agriculture

Another indicator of growing financial insecurity among residents and the need for community access to healthy and nutritious foods is the proportion of households that are ALICE. ALICE stands for **Asset Limited Income Constrained Employed** and represents the growing number of families that have income above the federal poverty level, but below the threshold necessary to meet all basic needs. ALICE households are working households that can't afford all the basics of housing, childcare, food, transportation, healthcare and technology.

While the number of people living at or below the poverty level has declined, the number of ALICE households has increased nationwide, corresponding with rising costs of living. Approximately one-quarter of households in Westchester County and one-third of households in Yonkers are ALICE. When combined with households living in poverty, more than 50% of households in Yonkers may experience financial hardship.




Source: United for ALICE

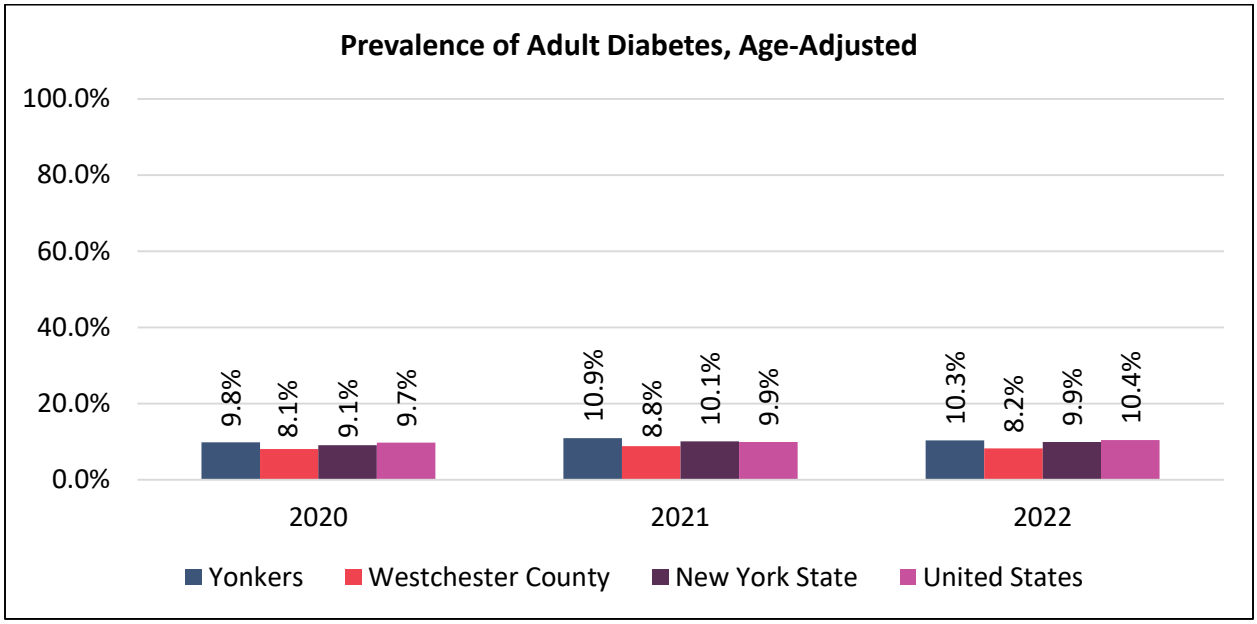
## Chronic Disease and Access to Healthcare

Chronic conditions are the leading causes of morbidity and mortality for Americans. Chronic conditions like diabetes, heart disease, and cancer were identified as important issues for GNYHA survey participants and are among the most common chronic conditions affecting adults nationally.

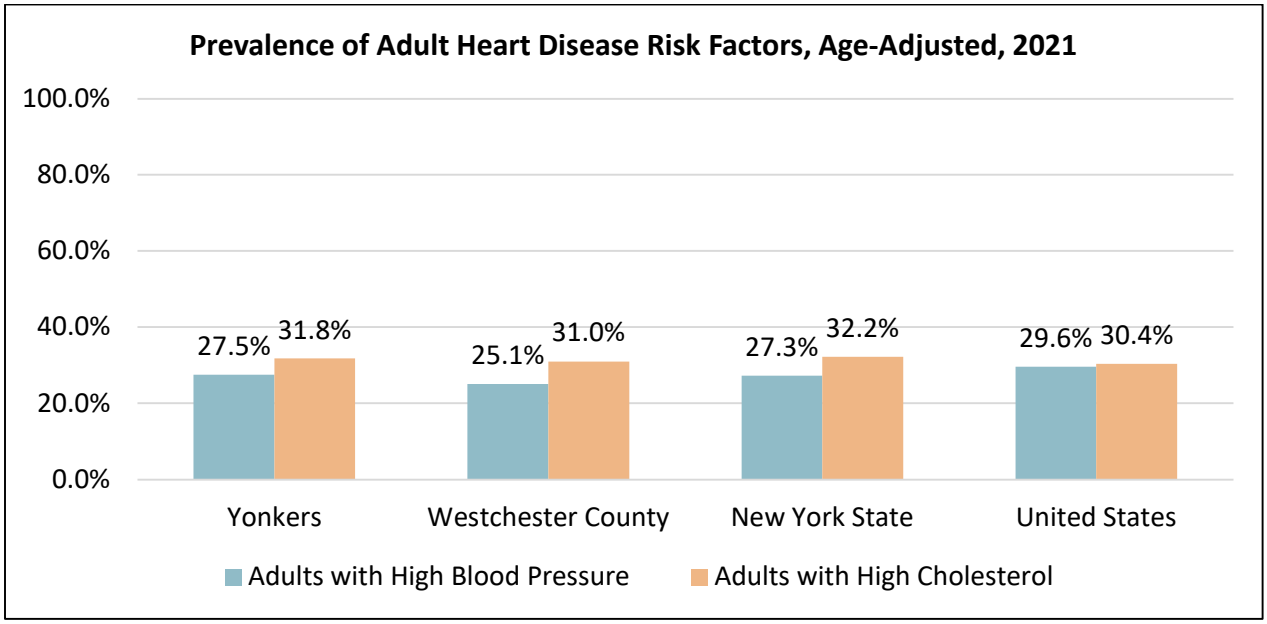
Consistent with the state and the nation, approximately 1 in 10 Westchester County and Yonkers adults have been diagnosed with diabetes, with slightly higher prevalence in Yonkers compared to the rest of the county. Diabetes prevalence was generally stable from 2020 to 2022.

Heart disease is more prevalent among adults. Across Westchester County and Yonkers, approximately 1 in 4 adults have high blood pressure and 1 in 3 adults have high cholesterol.

Viewing chronic disease data by zip code informs the need for localized prevention and intervention efforts. Within Saint Joseph's primary service area, nearly 13% of adults have been diagnosed with diabetes.

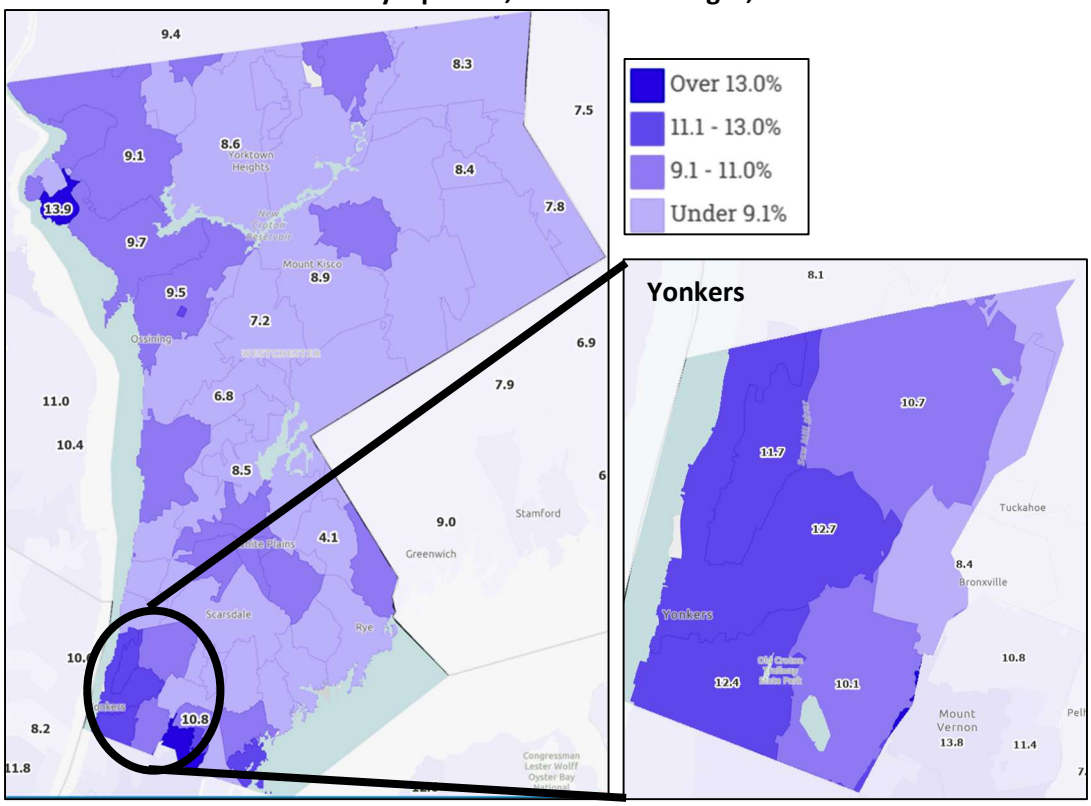



Source: Centers for Disease Control and Prevention




Source: Centers for Disease Control and Prevention

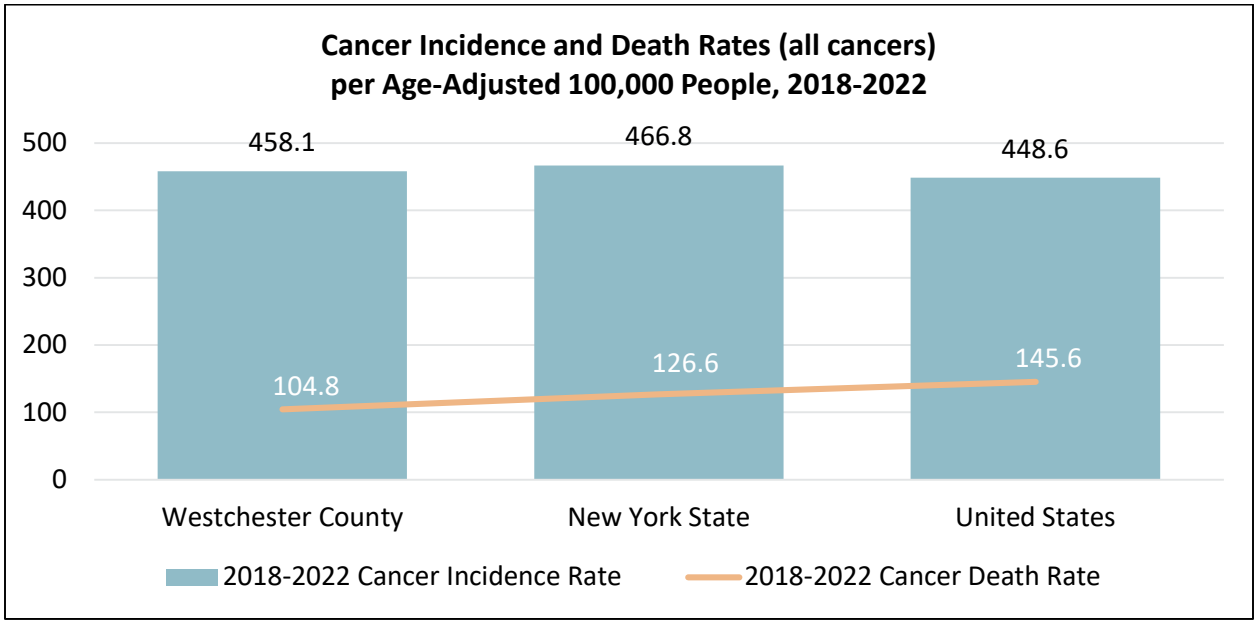
**Adults with Diabetes by Zip Code, Crude Percentages, 2022**




Source: Centers for Disease Control and Prevention

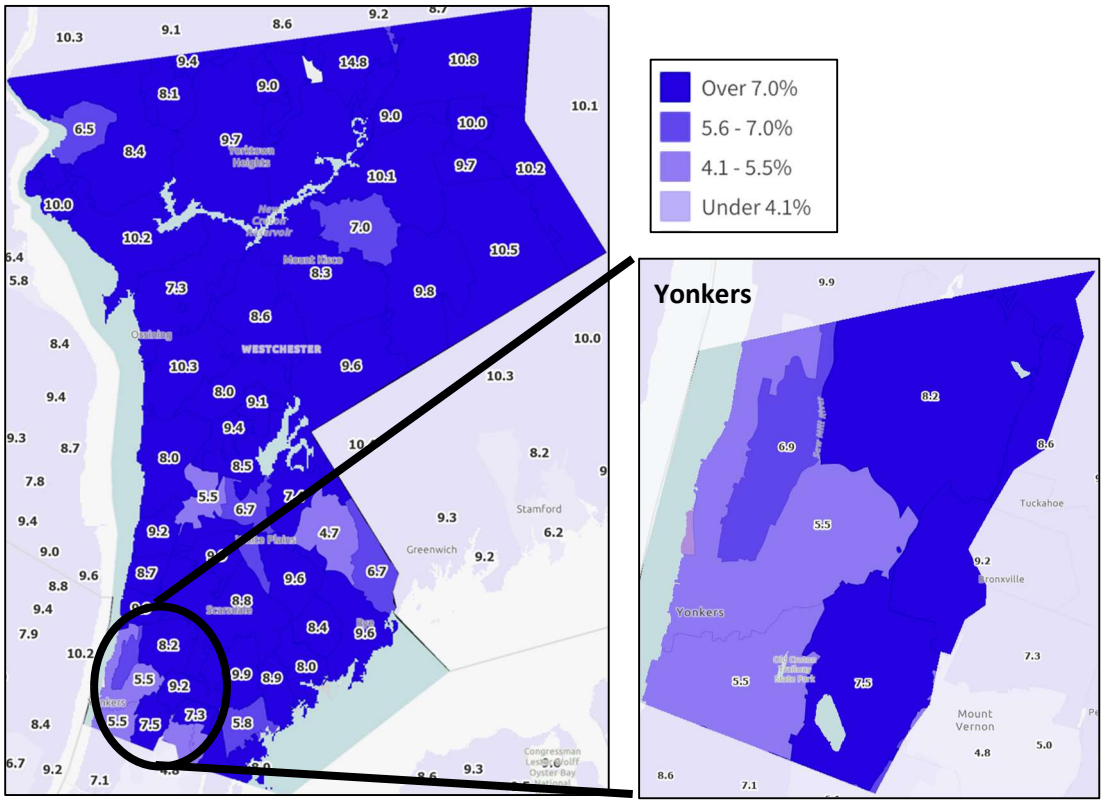
Westchester County has lower cancer incidence and death rates than the state. Across the county, an estimated 6.1% of adults have been diagnosed with cancer, including 5.8% of Yonkers adults.

Yonkers residents are generally less likely to have been diagnosed with cancer than residents across Westchester County, however, they are also slightly less likely to be screened for cancer which may contribute to lower reported prevalence and later stage diagnosis and treatment. Approximately 79% of Yonkers women aged 50-74 received a mammogram in 2022 compared to 81% of Westchester County women. Approximately 60.6% of Yonkers adults aged 50-75 received a colon cancer screening in 2022 compared to 63.4% of Westchester County adults.

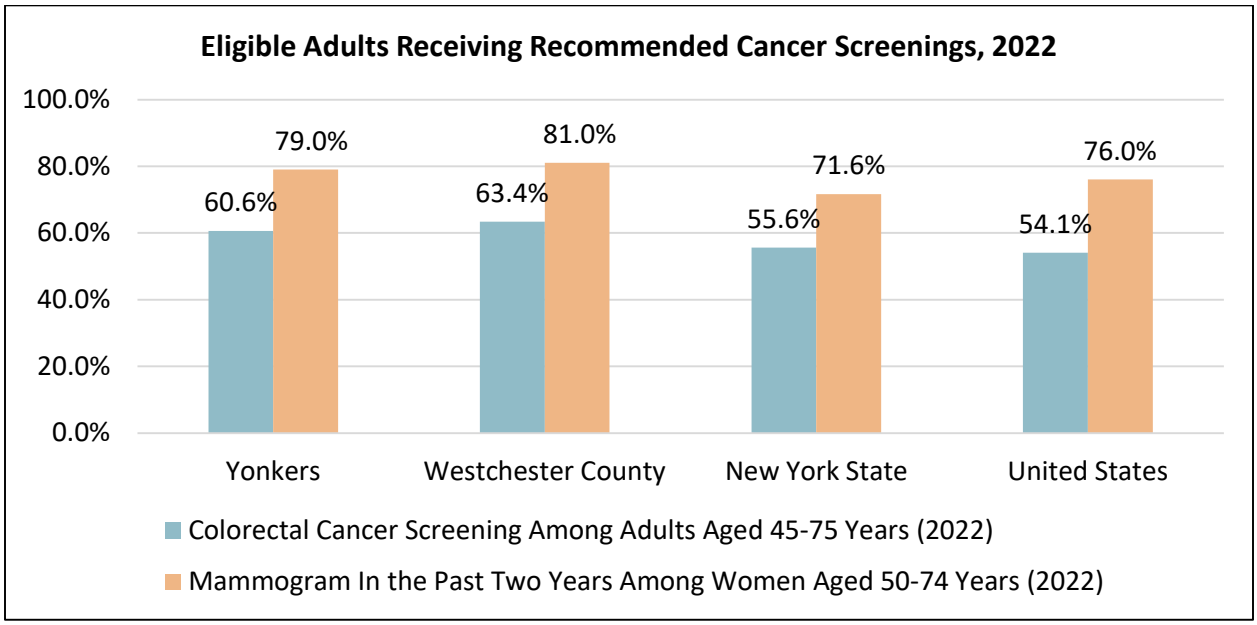



Source: Centers for Disease Control and Prevention & New York State Department of Health

**Adults with Cancer (non-skin) or Melanoma by Zip Code, Crude Percentages, 2022**

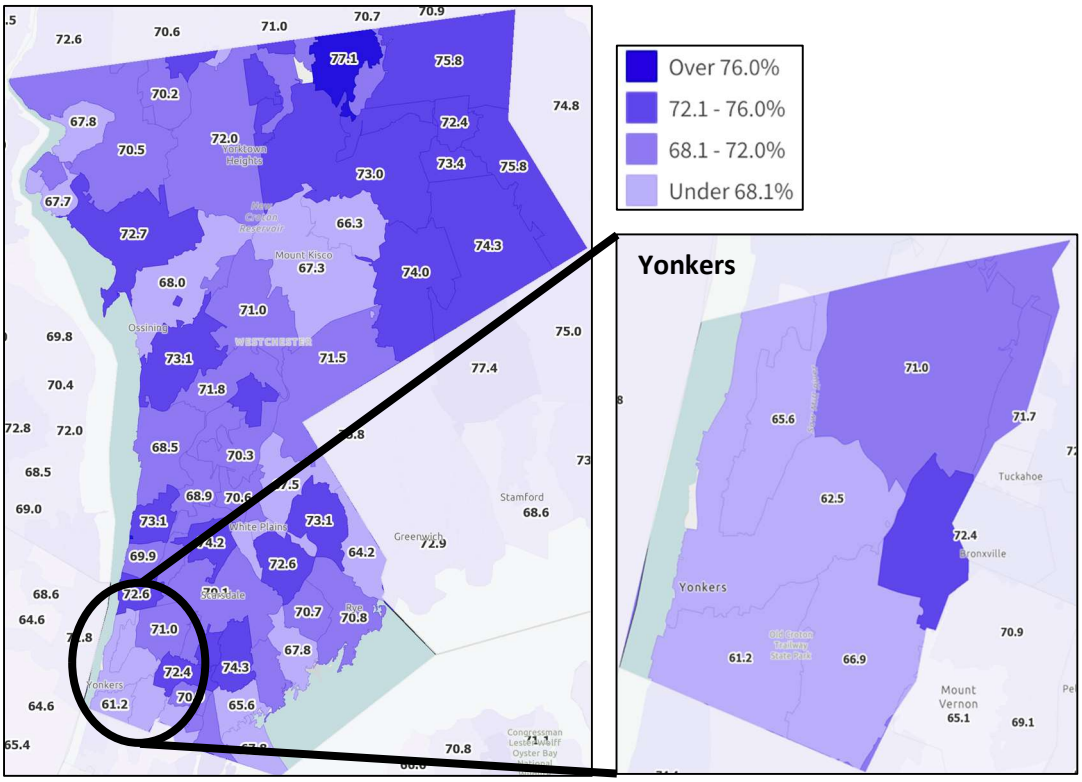



Source: Centers for Disease Control and Prevention



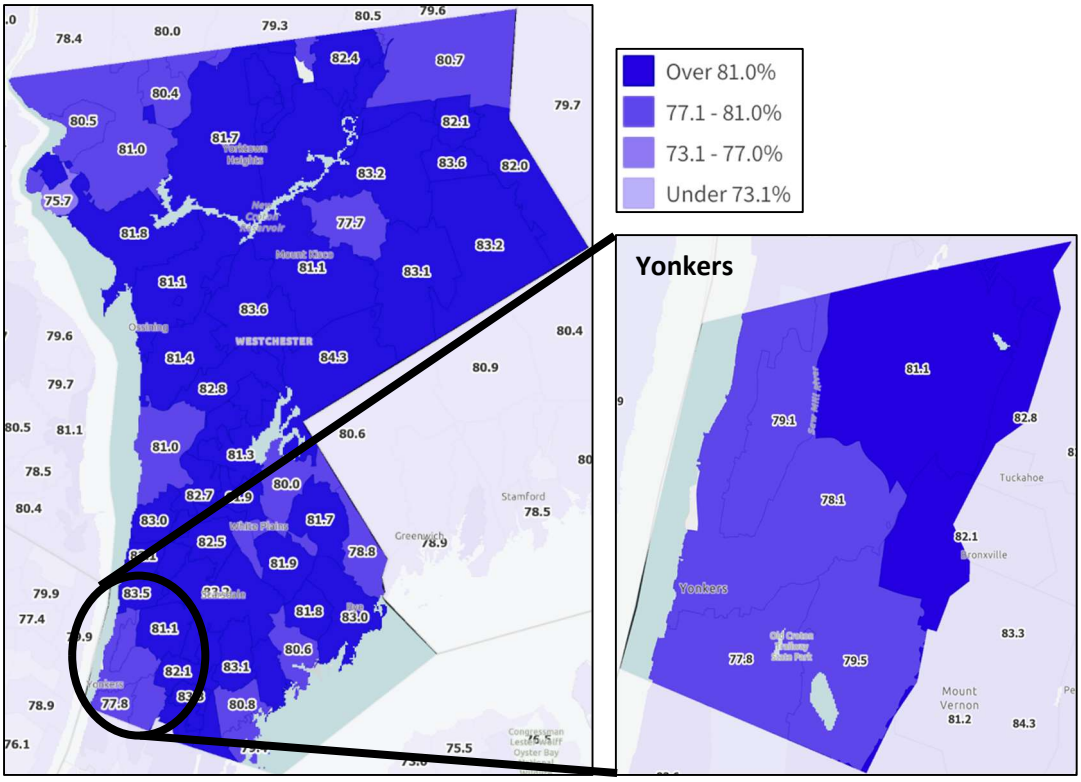

Source: Centers for Disease Control and Prevention

**Colorectal Cancer Screening Among Adults 45-75 Years by Zip Code, Crude Percentages, 2022**




Source: Centers for Disease Control and Prevention

**Mammogram in the Past 2 Years Among Women 50-74 Years by Zip Code, Crude Percentages, 2022**

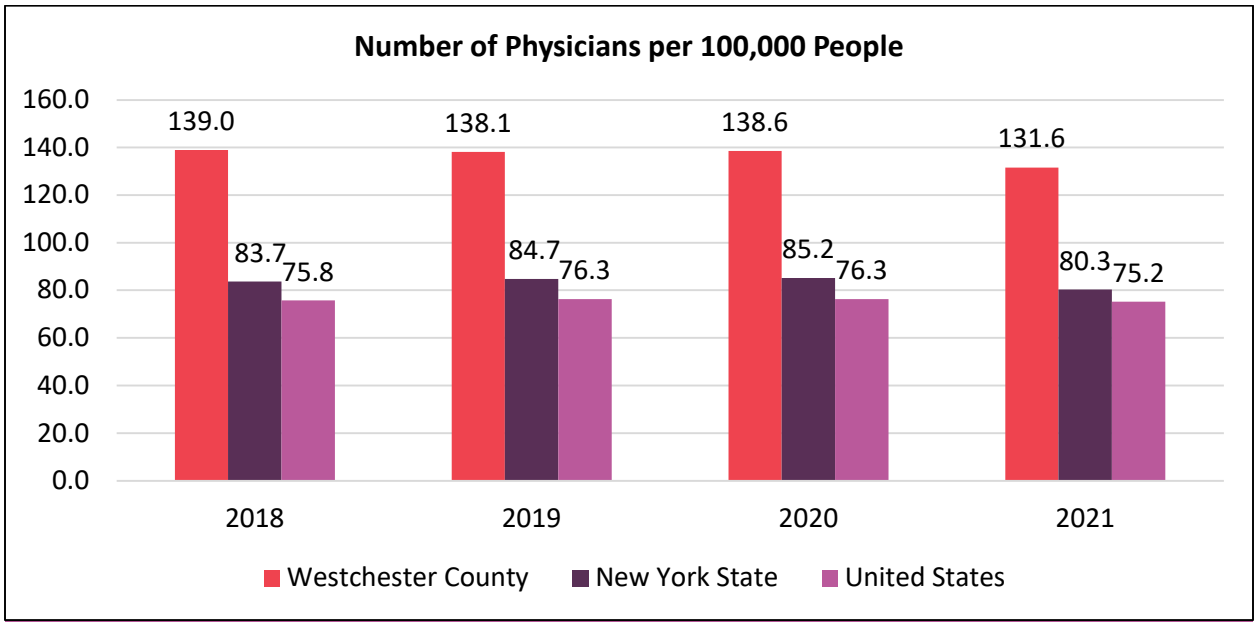



Source: Centers for Disease Control and Prevention

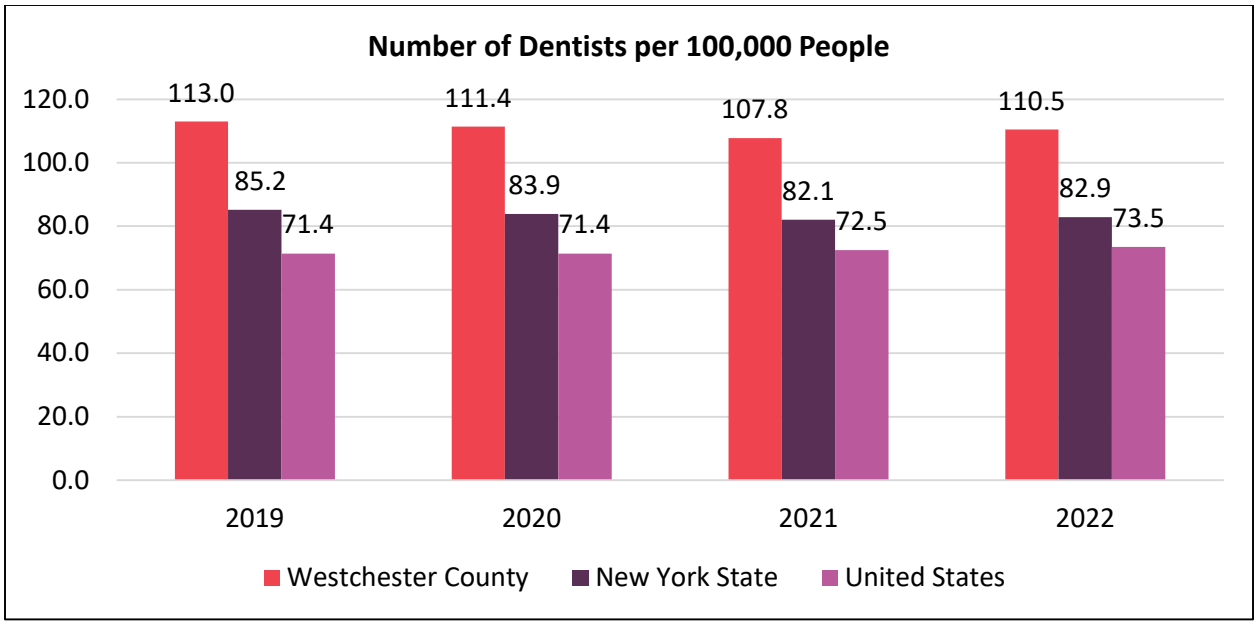
Access to timely and appropriate healthcare services is essential for prevention and management of chronic health conditions. Overall, Westchester County is well served by healthcare services. Availability of primary care physicians and dentists per 100,000 people in Westchester County has been consistently above state and national levels. However, availability of healthcare services is not equally distributed across the county. *Yonkers is a primary care HPSA for people with Medicaid health insurance*. In 2023, 33.9% of all Yonkers residents and 46%-48% of Saint Joseph's primary service area residents had Medicaid.

Medicaid is the government health coverage available to eligible people with low income. Medicare is also a government health coverage program focused on older adults and people with disabilities. Saint Joseph's is a primary healthcare resource for people with Medicaid and Medicare insurance. In 2024, Medicaid and Medicare patients made up 82% of all admitted patients and 68% of all outpatients provided with care.

Dental care is also more limited for Yonkers residents. Approximately 60.7% of Yonkers adults receive routine dental care compared to 68% of adults across Westchester County. In Saint Joseph's primary service area, approximately 55% of adults receive routine dental care.

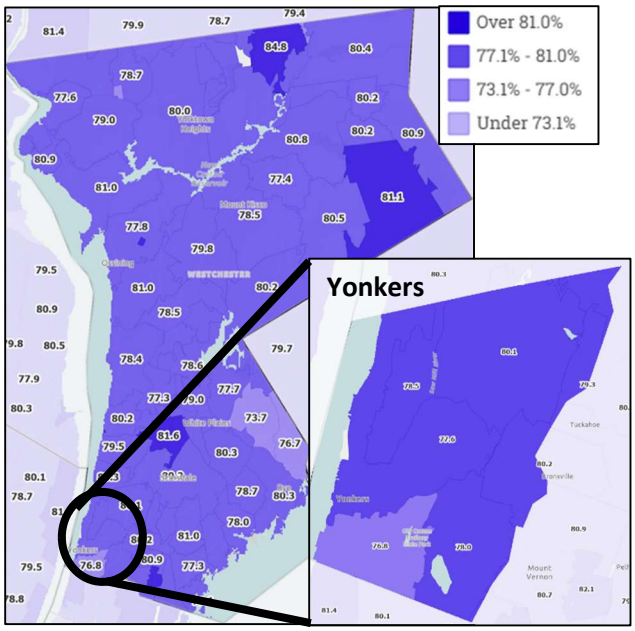



Source: Health Resources and Services Administration and Centers for Medicare & Medicaid Services

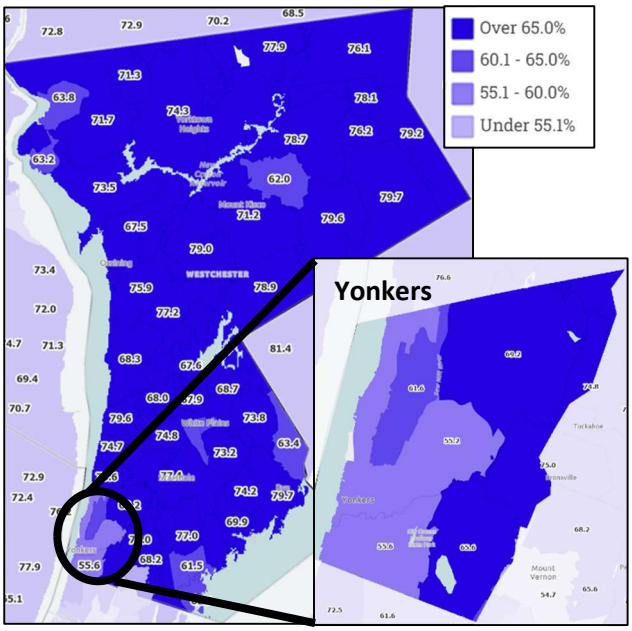



Source: Health Resources & Services Administration and Centers for Medicare & Medicaid Services

**Adults with a Primary Care Visit Within the Past Year by Zip Code, Crude Percentages, 2022**




**Adults with a Dental Care Visit Within the Past Year by Zip Code, Crude Percentages, 2022**




Source: Centers for Disease Control and Prevention

## Maternal Care

Westchester County and Yonkers had fewer births than the state and nation in 2021, and consistent with national trends, the birth rate has declined in recent years. In Yonkers, the birth rate per 1,000 people declined from 10.4 in 2017 to 7.4 in 2021.

**All Births and Birth Rate per 1,000 Population, 2021**

| | Count | Birth Rate per 1,000 |
|---|---|---|
| Yonkers | 1,477 | 7.4 |
| Westchester County | 8,310 | 8.6 |
| New York State | 209, 947 | 10.6 |
| United States | 3,664,292 | 11.0 |

Source: Centers for Disease Control & Prevention and Westchester County Department of Health

Access to adequate prenatal care can have significant positive effects on maternal and infant health outcomes. Among pregnant people in Westchester County and Yonkers with known prenatal care status, approximately one-quarter received late or no prenatal care in 2021.

Access to prenatal care has been variable year-over-year but generally declined in recent years. The proportion of pregnant people in Westchester County receiving late or no prenatal care increased from 17.7% in 2019 to 23.2% in 2021. A similar trend was seen in Yonkers with an increase from 23.9% in 2019 to 27.2% in 2021.

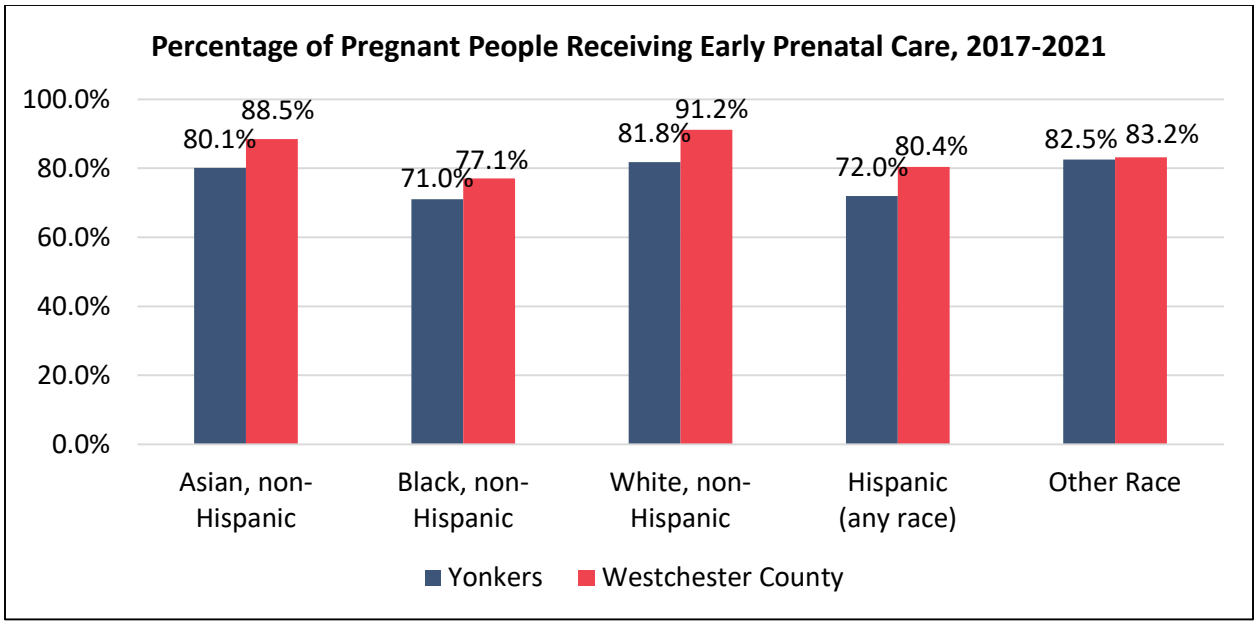
There are existing disparities in maternal and infant health outcomes between population groups, with populations of color receiving less prenatal care and experiencing more negative birth outcomes. Across Westchester County, the proportion of Black and/or African American pregnant people receiving late or no prenatal care is more than double the percentage for white people. Black and/or African American birthing people are more likely to experience maternal morbidity, conditions that cause significant health consequences during pregnancy or childbirth. Between 2017 and 2021, 0.19% of Black and/or African American birthing people in Westchester County and 0.45% in Yonkers experienced eclampsia, seizures during pregnancy or postpartum, compared to 0.05%-0.08% of other population groups.

**Maternal and Infant Health Indicators, 2021**

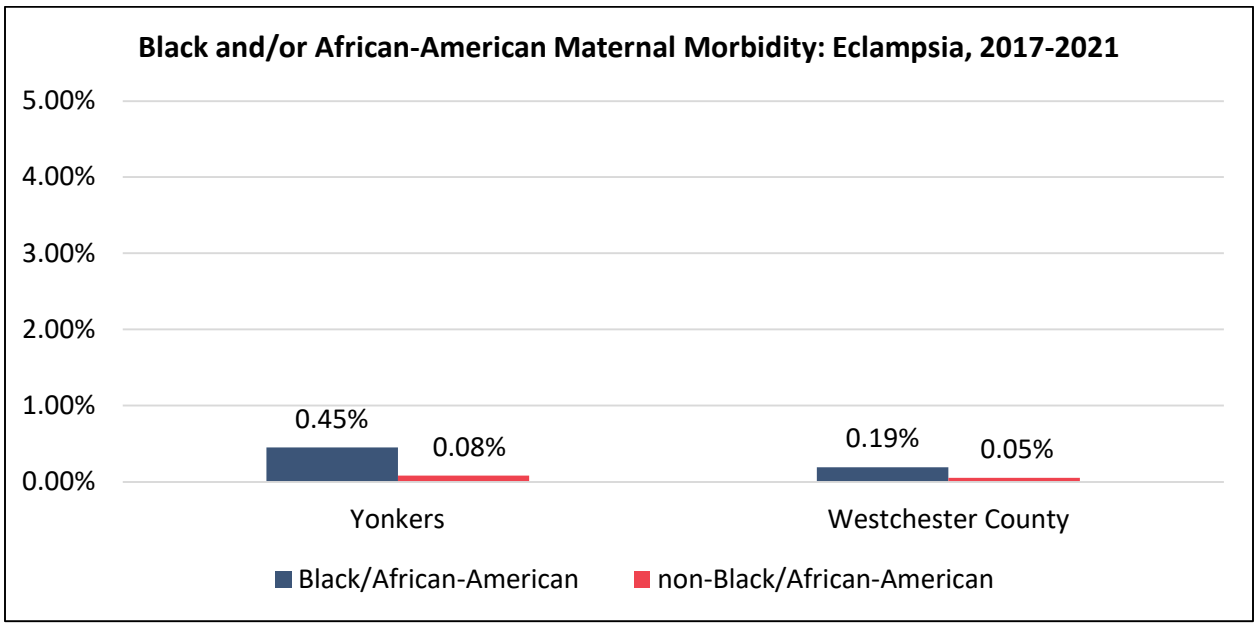
| | Late or No Prenatal Care* | Preterm Births | Low Birth Weight Births |
|---|---|---|---|
| Yonkers | 27.2% | 9.7% | 9.5% |
| Westchester County | 23.2% | 9.2% | 8.0% |
| New York State | 19.4% | 9.1% | 8.3% |
| United States | NA | 10.5% | 8.5% |
| HP2030 Goal | NA | 9.4% | NA |

Source: Centers for Disease Control & Prevention and Westchester County Department of Health

*Delayed or no prenatal care is defined as prenatal care begun at the second or third trimester, or no prenatal care throughout pregnancy. Those cases with incomplete information on prenatal care are excluded.




Source: Westchester County Department of Health



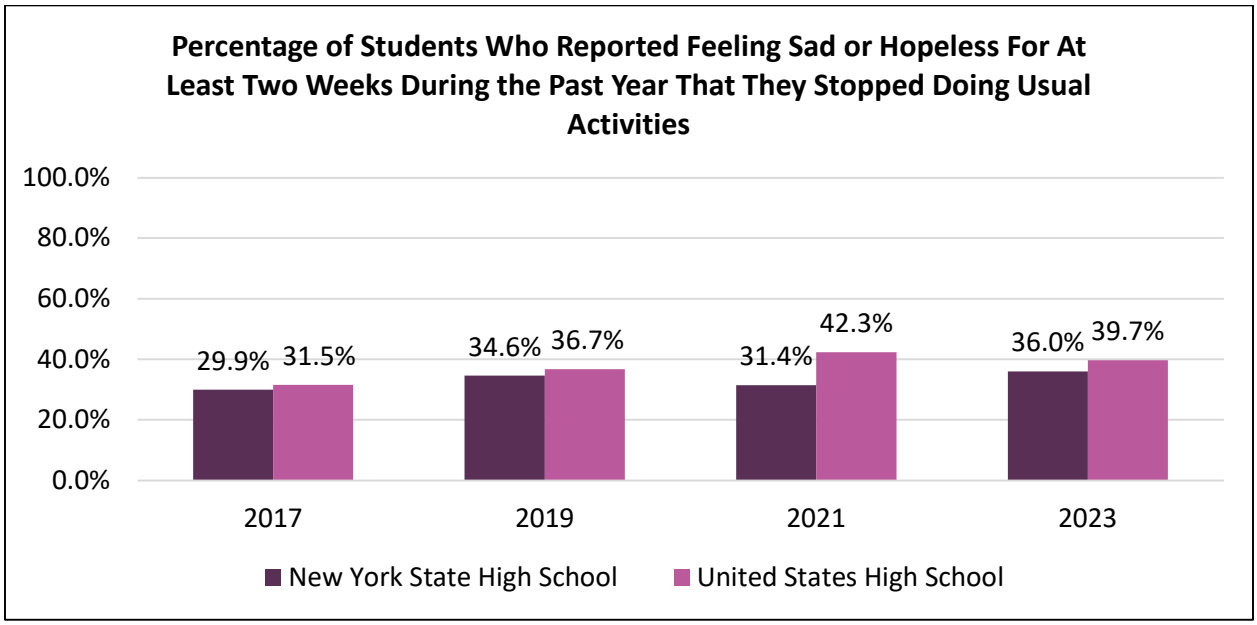

Source: Westchester County Department of Health

## Adolescent and Child Health

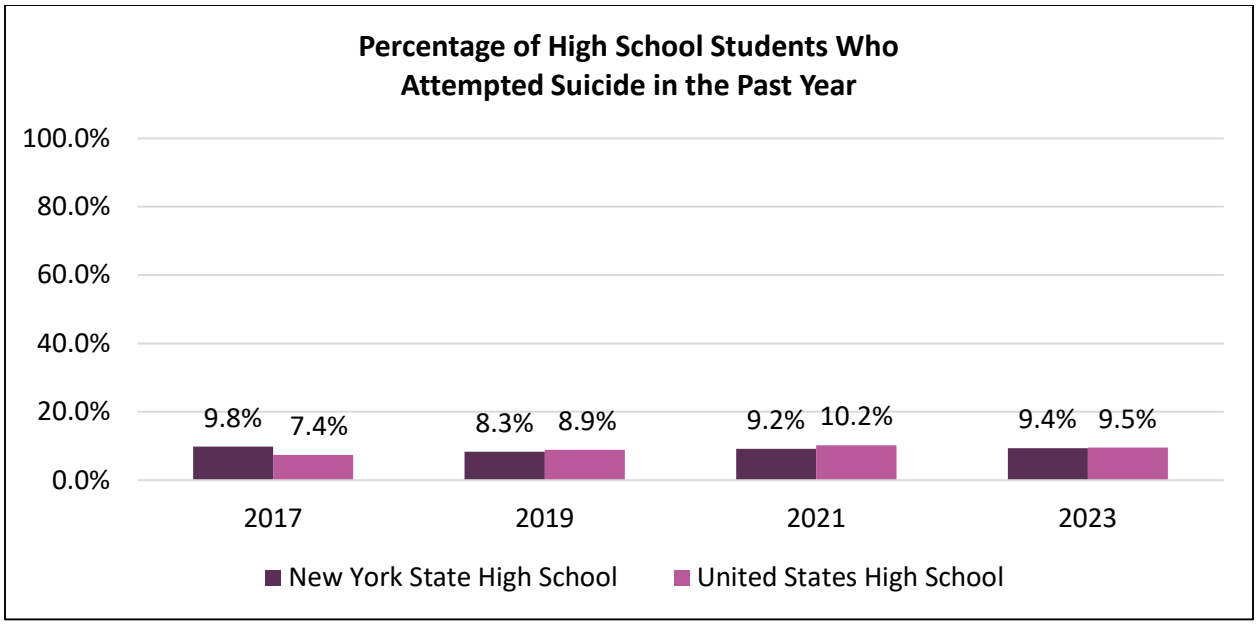
Youth behavioral health concerns have been on the rise nationally, stemming from COVID-19 impacts (e.g., isolation, developmental delays), family stress due to rising costs of living, and social media use, among other factors.

In 2023, 36% of all New York (excluding New York City) high school students reported feeling consistently sad or depressed, a slightly lower proportion than the nation overall (39.7%). The proportion of New York high school students reporting an attempted suicide has been on the rise since 2019, increasing from 8.3% to 9.4%.

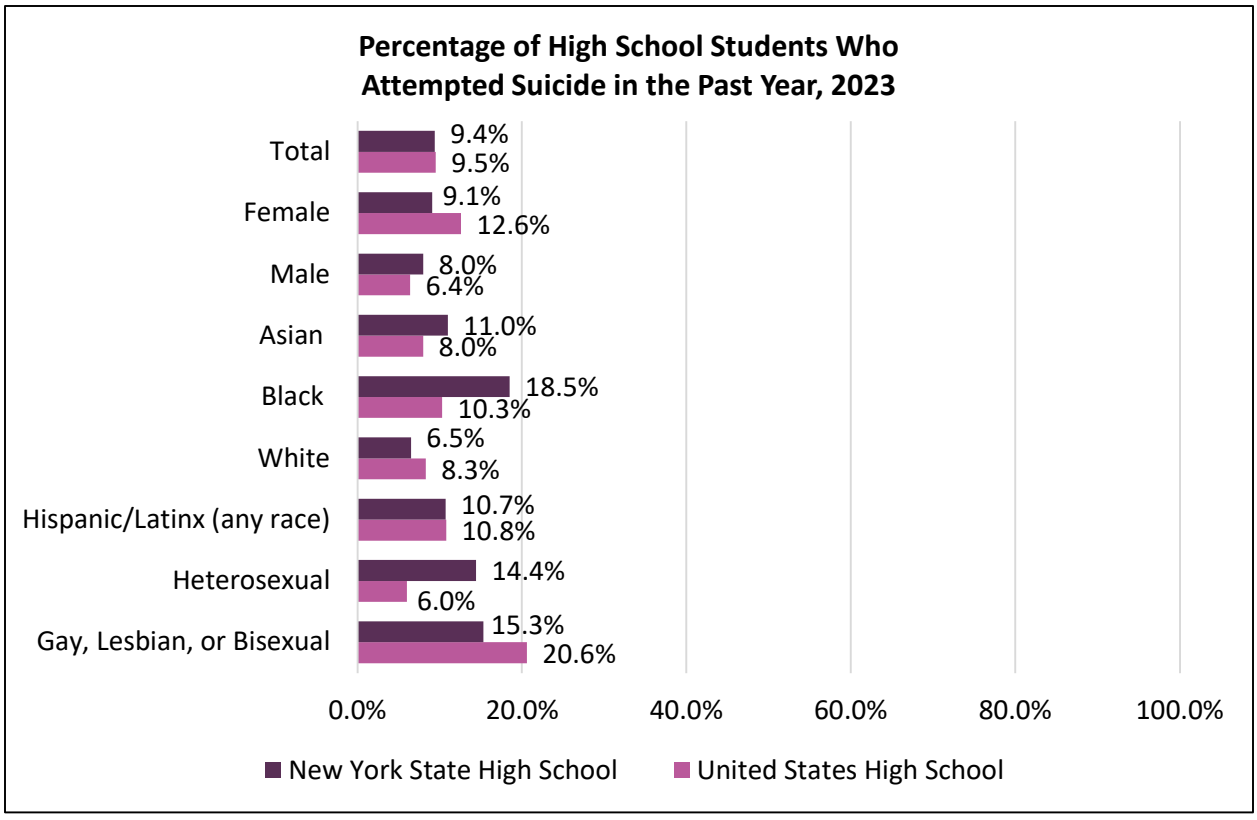
Experiences of mental distress disproportionately affect students historically placed at risk, including students of color and those who identify as LGBTQ+. Notably, in New York, students identifying as Black and/or African American were nearly three times more likely to report a suicide attempt than students identifying as white.




Source: Centers for Disease Control and Prevention
*New York State data excludes New York City.

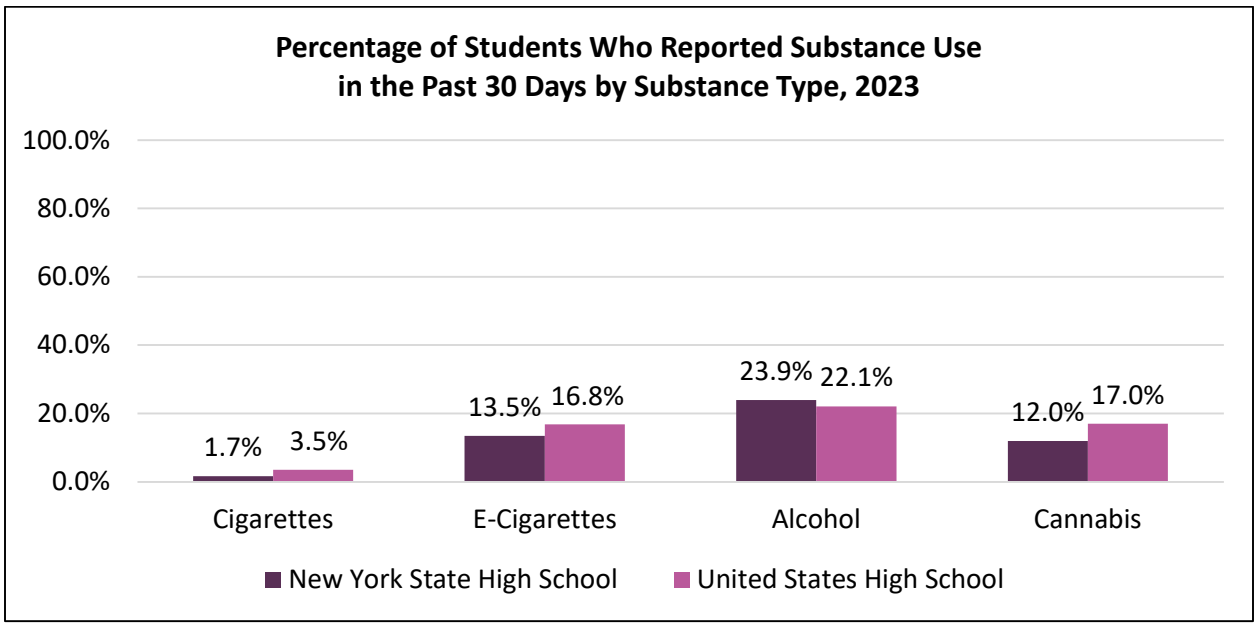



Source: Centers for Disease Control and Prevention
*New York State data excludes New York City.




Source: Centers for Disease Control and Prevention
*New York State data excludes New York City.

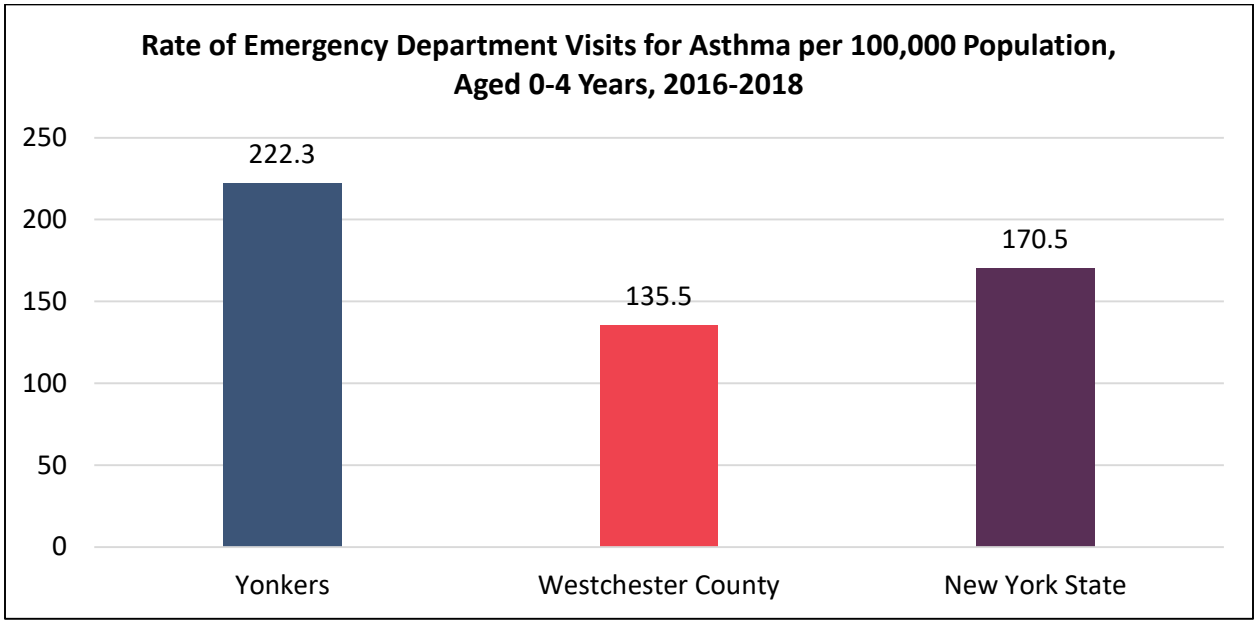
New York high school students are less likely to use substances like cigarettes, e-cigarettes, and cannabis when compared to their peers nationwide. They are slightly more likely to report alcohol use with nearly 1 in 4 students reporting use in the past 30 days. Substance use among New York students has generally declined, excluding a slight increase in students using alcohol from 2021 (21.7%) to 2023 (23.9%).




Source: Centers for Disease Control and Prevention
*New York State data excludes New York City.

A historic concern for Yonkers children, and an area of focus for Saint Joseph's, has been asthma prevalence and management. From 2016 to 2018, the number of emergency department visits due to asthma for Yonkers children aged 0-4 was more than 60% higher than the rest of the county.

There is no single cause of asthma, but environmental factors and exposure to allergens are contributors and primary considerations for Yonkers' health improvement efforts. A 2024 report by the Westchester County Department of Health found that more than 25,000 housing units in Yonkers were built before 1980 and more than 5,000 housing units are overcrowded by residents. Older homes are linked to asthma because they often have conditions like mold, dust mites, and poor ventilation, which are common asthma triggers. Overcrowded housing is linked to asthma through increased exposure to indoor asthma triggers. Additionally, smoking is more prevalent among Yonkers adults (12.5%) compared to the county overall (9.3%).




Source: Westchester County Department of Health

## Identified Community Needs: Relatively Lower Priority

The following table displays health and social wellbeing issues identified as "Relatively Lower Priority" and their respective importance and satisfaction rankings relative to other issues.

Issues identified as "Relatively Lower Priority" had below average importance for survey participants (rankings of 15 to 26 out of 26 issues). Issues related to school health and wellness, infant health, respiratory concerns, HIV/AIDS, hepatitis C, and STIs also received above average satisfaction ratings, meaning they were of low importance and existing services to meet them were seen as sufficient.

Other issues related to arthritis, assistance with basic needs, continuing education and job training, substance use disorder, employment support, and tobacco use had below average importance for survey participants, as well as below average satisfaction in current services. This finding may indicate that while survey participants were not as affected by these issues, they perceived broader community need to address them. Nearly all these issues were related to other issues identified as higher priority, including the health of older adults, financial security and access to housing and food, respiratory health, and mental health. Secondary data findings for these issues were presented in prior sections.

**Importance and Satisfaction Rankings for Health and Social Wellbeing Issues Identified as "Relatively Lower Priority"**

| | Importance Rank (From 1 Most Important to 26 Least Important) | Satisfaction Rank (From 1 Most Satisfied to 26 Least Satisfied) |
|---|---|---|
| Arthritis/disease of the joints | 17 | 16 |
| Assistance with basic needs like food, shelter, and clothing | 19 | 19 |
| Access to continuing education and job training programs | 20 | 20 |
| Substance use disorder/addiction (including alcohol use disorder) | 21 | 22 |
| Job placement and employment support | 22 | 24 |
| Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah | 23 | 25 |
| School health and wellness programs | 15 | 12 |
| Infant health | 16 | 6 |
| Asthma, breathing issues, and lung disease | 18 | 11 |
| HIV/AIDS (Acquired Immune Deficiency Syndrome) | 24 | 14 |
| Hepatitis C/liver disease | 25 | 13 |
| Sexually Transmitted Infections (STIs) | 26 | 15 |

Source: GNYHA CHNA Survey Collaborative

# Community Assets to Address Identified Health Priorities

Community assets and resources, including organizations, people, policies, and physical spaces, elevate quality of life for residents. Identifying the assets that exist in Yonkers and Westchester County is an important component of the CHNA, both to mobilize and employ resources to address identified health issues, as well as to address existing gaps in services.

## Westchester County Assets

Westchester County has a rich supply of assets and resources that support the health and wellbeing of its residents. Some examples include:

- Ample green spaces as well as County and State parks providing about 98% of the population with access to outdoor recreation and exercise opportunities
- Extensive healthcare systems, including hospitals, federally qualified health centers, urgent care centers, and laboratories, operating within the county and providing timely and state-of-art direct healthcare
- A large number of colleges and universities located within the county providing opportunities for health and other education
- The extensive Bee-Line bus system serving over 27 million passengers annually, providing transportation services to over 65% of all Westchester County residents and workplaces with walking distance to a Bee-Line bus route, making the bus both close and convenient
- A variety of community organizations, task forces, coalitions, and other agencies working on providing direct services as well as policy and structural change within the county

## Yonkers Assets

Yonkers is also home to rich public infrastructure and resources that benefit its residents:

- Public Schools: 40
- Colleges: 4 colleges and 2 Seminaries
- Parks and Recreation: Over 80 parks and playgrounds, 57 ball fields, 24 tennis courts, 16 senior citizen centers, skating rink, rifle and pistol range, indoor pool, and four community centers
- Golf Courses: 2 (Dunwoodie and Sprain Lake)
- Libraries: 3 branches (Larkin Plaza, Will, Crestwood)
- Museum/Planetarium: Hudson River Museum/Andrus Planetarium
- Media: 1 daily newspaper, 2 weekly newspapers, and 2 Municipal Access Channels
- Rail Service: Metro North Commuter Railroad/Metropolitan Transportation Authority
- Bus Service: 20 Routes
- Airports: 4 within a 20- to 40-minute radius

## Health and Social Service Support

### United Way's 211 Helpline

United Way's 211 Helpline offers health and human services information, referral, assessment, and crisis support to help callers find the assistance they need to address the everyday challenges of living, as well as those that develop during times of disaster and other community emergencies. 211 is a confidential and comprehensive service that has enabled government and not-for-profit agencies to realize concrete cost savings as well as increased customer service to residents throughout the service area.

One can call United Way's 2-1-1 from any type of telephone throughout the area to speak with a professionally trained, paid call specialist 24 hours, 7 days a week. Translation services are available in over 200 languages. In addition, the database that is utilized to refer callers is always available to the public at www.211hudsonvalley.org

### Westchester County Department of Social Services

The mission of the Westchester County Department of Social Services is to empower its customers to become independent and to ensure the health, safety, and protection of vulnerable adults and children. The department betters the lives of hundreds of thousands of county residents each year, providing help with food, housing, medical services, day care, child support, eviction prevention, home energy costs, protective and preventive services for vulnerable children and adults, temporary assistance to help people gain self-sufficiency through employment, and through securing support and care for children.

More information can be found at the department website: https://socialservices.westchestergov.com/ or by visiting offices at 131 Warburton Avenue, Yonkers, NY 10701.

## Saint Joseph's Medical Center Services

With a commitment to patient-centered quality care, Saint Joseph's offers a range of services, including specialized programs in orthopedics, cardiology, family medicine, and geriatrics. Advanced capabilities encompass emergency care, cutting-edge diagnostic imaging, and ambulatory surgery. In addition, Saint Joseph's provides comprehensive inpatient and outpatient behavioral health services, as well as a network of primary care providers throughout Westchester and the Bronx. Through the St. Vincent's Hospital Westchester division, Saint Joseph's offers a comprehensive range of mental health, addiction, and residential programs serving Westchester and New York City. The following select services are available to address the identified CHNA priority areas.

- Pediatrics
- Primary Care
- Residential Services
- Saint Joseph's Family Health Center (incl. onsite food pantry)
- Saint Joseph's Mental Health and Addiction Recovery Services
- Saint Vincent's Mental Health and Addiction Recovery Services
- School-Based Health Centers

# Our Response to The Community's Needs

In 2022, Saint Joseph's conducted a similar CHNA and developed a supporting three-year Community Service Plan (CSP) to address identified priority health areas. Based on the 2022 CHNA findings, Saint Joseph's leadership identified two priority areas:

- Prevent Chronic Diseases, Focus Area: Preventive care and management
- Promote Well-Being and Prevent Mental and Substance Use Disorders

Saint Joseph's invested in internal population health management strategies and partnered with diverse community agencies across the region to fund programs and initiatives aimed at addressing the identified priority areas. The system measured contributions and community impact from these investments, as outlined in the following section.

## Evaluation of Impact

### Preventive Care: Health-Related Social Needs

Saint Joseph's is committed to meeting the holistic health and social needs of its patients and community members. Saint Joseph's implemented screenings across its clinical service lines to better identify and respond to patient's unmet health-related social needs (HRSNs). Saint Joseph's is also a lead agency for the region's Social Care Network, tasked with building a robust network of community-based organizations providing HRSN services and coordinating with health care providers. The Social Care Network is responsible for ensuring that there is a seamless, consistent, coordinated, end-to-end process for screening, navigation, and delivery of social services.

Nutrition security is among the top unmet HRSNs for Saint Joseph's patients and the broader community. In addition to supporting patient screening and connections to the Social Care Network for nutrition services, Saint Joseph's supports point of care and community-based food access. In May 2021, in partnership with Feeding Westchester, Saint Joseph's added an onsite free food pantry at the Family Health Center for patients who present with food insecurity. In 2023, the food pantry served 1,300 unique individuals. In 2024, the food pantry served 1,218 unique individuals, representing a total of 727 households. Saint Joseph's also coordinates delivery of meals and other basic needs to patients, including Thanksgiving dinner and winter coats.

Feeding Westchester also operates a mobile food distribution site across the street from Saint Joseph's, delivering thousands of pounds of food to residents on a monthly basis. Volunteer students from Saint Joseph's partner, the Charter School of Educational Excellence, and staff from Saint Joseph's Hospital and the Family Health Center distribute bags of nutritious food to those presenting with food insecurity.

Housing stability and affordability is also a top unmet HRSNs for Saint Joseph's patients and the broader community. Saint Joseph's is a leader in providing affordable and supportive housing with nearly 1,500 housing units operated throughout Westchester County and New York City. Saint Joseph's Residential Services include senior housing programs for frail and low-income older adults, 24-hour supportive housing for adults with serious mental illness and other special needs, affordable apartments for

individuals and families, and supported housing with rental stipends and case management services.

In 2024, Saint Joseph's celebrated its newest residential program with the opening of an Intensive Crisis Residence at St. Vincent's, the first facility of its kind in the region. The Paul Residence is named in memory of Daphne and Jay Paul who were very generous supporters of St. Vincent's and most recently of this project. Other support for the construction of the residence included the St. Vincent's Auxiliary and the New York State Office of Mental Health.

Located on the campus of St. Vincent's Hospital Westchester, the new facility is a voluntary short-term, residential treatment service designed as an alternative to hospitalization for adults (over 18 years old) who are currently experiencing a psychiatric crisis. The residence includes 15 private rooms and indoor and outdoor community spaces for the residents. Staffing includes 24/7 on-site nursing; on-site and on-call Psychiatrists; Licensed Mental Health Clinicians; Peer Specialists; and Case Managers.

In 2018, Saint Joseph's behavioral health services also introduced HRSNs screening into its standard assessment. When issues are identified, treatment providers work to address them through Health Home Care Coordination Programs and other resources. The programs work closely to address HRSNs, as well as support linkages to medical and behavioral health treatment.

### Preventive Care: School-Based Health Centers

Saint Joseph's operates primary care school-based health centers (SBHCs) in five Yonkers public schools, serving students from pre-k to 8th grade. The newest SBHC opened in March 2025 at the Justice Sonia Sotomayor Community School.

Since 1989 the centers have provided free, accessible, high quality health services to high-risk children and have become an integral component of the Yonkers healthcare delivery system. The program receives funding from the New York State Department of Health and HRSA Bureau of Primary Health, funding and in-kind services from Yonkers Public Schools, and in-kind services and financial support from Saint Joseph's.

The SBHCs provide a full array of primary health services including, but not limited to, routine care of children with chronic conditions such as asthma, obesity, and diabetes; comprehensive histories and physical examinations; laboratory testing; immunizations; health counseling; and dental preventive services. Additional services focus on health education in areas such as managing asthma, nutrition, substance use, accident prevention, personal hygiene, growth and development, and first aid.

Continuity of care at the SBHCs is assured during non-school hours, holidays, weekends, and vacations through Saint Joseph's Family Health Center. Emergency telephone contact with the collaborating or covering physician is available on a 24-hour basis. This integration has resulted in better health outcomes and increased access to care for area youth.

### Preventive Care: Tobacco Cessation

The Saint Joseph's Yonkers and Harrison campuses are both smoke and tobacco free, and all patients and clients are assessed for smoking dependence. Education, smoking cessation groups, and access to nicotine replacement therapies are offered. Employees who smoke are encouraged to discuss smoking cessation options with their primary care physician or learn about quitting through the New York State Smokers' Quit Line. Smoking cessation resources are also offered at numerous Saint Joseph's outpatient programs throughout Westchester County and New York City.

### Preventive Care: Screenings

Recognizing the significant gap in colorectal cancer screening among residents, Saint Joseph's worked with its primary care providers and staff to utilize tools within its electronic health record system to identify patients near due or overdue for screening, with the goal of increasing the percentage of screenings in eligible adults by 5%-10%. Saint Joseph's conducted extensive chart review for verification and improved tracking of patients due for screening. With these measures, Saint Joseph's saw a rise from 30% screening at the end of the 3rd quarter in 2023 to 43% of eligible patients screened by the end of 2024.

In 2025, Saint Joseph's partnered with the Westchester County Department of Health in a county-wide coalition to improve screening rates. In 2024, Saint Joseph's partnered with community health plans and Exact Sciences to host a screening awareness event at the Family Health Center. The event featured information on screening modalities, as well as demonstrations of the proper packing of a Cologuard kit. Presentations were also provided by medical students from NYMC. The presentations and material were presented in the patient waiting area to help further educate patients on the change in screening age as well as the importance of routine and timely screening.

### Disease Management: Asthma

Saint Joseph's implemented provider and community-based training on asthma management to improve disease outcomes. Saint Joseph's established physician orders specific to chronic condition well visits, including asthma, to serve as a guide for nursing and provider interventions. Saint Joseph's streamlined asthma templates in its electronic medical records to facilitate documentation of key factors, including smoking cessation, Asthma Control Test, the Asthma Action Plan, and assessment of triggers. In April 2022, the SBHCs joined the project with specific education goals in the school setting, including inhaler technique, medication compliance, and environmental exposures.

Asthma burden disproportionately affects Yonkers' youth. As part of the Project BREATHE NY asthma initiative for children ages 0-18, Saint Joseph's validated its data measures for monthly tracking and reporting of asthma outcomes, including severity classification, documentation of control, persistent asthma and prescribed medication, and Asthma Action Plan. Relevant asthma protocols were implemented at the school-based health centers.

### Mental and Substance Use Disorders: Early Intervention

All individuals referred to Saint Joseph's are screened for depression and suicide risk. The PHQ-2 and the PHQ-9 are used to screen patients for depression. The SAFE-T and C-SSRS screen individuals for suicide risk. Individuals in any Saint Joseph's program identified at acute risk by these validated tools are admitted to inpatient or outpatient behavioral health services.

All patients at risk of suicide develop safety plans with their therapists. The safety plans include who the patient would call and what actions they would take were they to become acutely suicidal. All suicide attempts are investigated by the program and reviewed in monthly meetings to ensure that preventive measures were taken for patients at risk and to determine if corrective action plans are necessary. They are also reported up to the Saint Joseph's Board's Quality Improvement Committee.

### Mental and Substance Use Disorders: Crisis Intervention

Saint Joseph's Department of Psychiatry provides comprehensive outpatient and inpatient mental health services, addiction treatment programs and crisis services, and residential services. As part of its broader community strategy to address mental health and substance use disorders, Saint Joseph's provides Naloxone administration training and distributions, leads the county's 988 suicide crisis line and 911 mental health diversion program, and operates a Crisis Prevention and Response Team.

Naloxone administration training is provided to various entities including prescribers, consumers, and community-based organizations. More than 260 training sessions (reaching over 3,600 people) were provided from 2022-2025 on the use of Naloxone Overdose Rescue Kits (Narcan). More than 3,650 Naloxone Rescue Kits were distributed to community members from 2022-2025. Substance use disorder education and prevention programs were also offered throughout Westchester County. These programs reached schools, parents, and community groups on topics such as vaping, identifying drug paraphernalia, bullying, and strategies to address child substance use.

When the new 988 crisis line was introduced nationally, Saint Joseph's was asked to cover the service for Westchester County callers. In 2024, Saint Joseph's added technology to assist in covering the 988 responses on a 24/7 basis with trained staff and volunteers. The outcomes for 2024 attest to the growing awareness and the great need for these services:

- In 2023, 8,191 calls were received. Of those, 482 callers needed follow-up contacts which included links to needed services.
- In 2024, 17,478 calls were received. Of those, 890 callers needed follow-up contacts which included links to needed services.

Saint Joseph's also operates Westchester County's Crisis Prevention and Response Team (CPRT). The CPRT is designed for people experiencing a mental health crisis and can provide assessment, crisis intervention, supportive counseling, and linkages to services. The CPRT is an interdisciplinary mobile team of mental health professionals that partners with schools, law enforcement, and various health and social service agencies. The CPRT's goal is to help people avoid crises and to prevent emergency room visits and hospitalizations. As part of its services, the team offers "bridge visits" for area providers, providing follow up with clients at high risk for readmission or who need assistance connecting to care.

CPRT Outcomes

- In 2023, the team had 5,465 calls. These calls resulted in 1,219 contact visits in the community.
- In 2024, the team had 5,776 calls. These calls resulted in 1,186 contact visits in the community.
- In 2023, the team had 319 bridge visits
- In 2024, the team had 356 bridge visits.

Saint Joseph's worked closely with Westchester County's Project Alliance to develop capacity for the 911 Diversion Program. The goal of the program is to divert mental health-related 911 calls to CPRT. Implementation efforts included numerous outreach meetings and training with the over 40 police departments in Westchester County to divert appropriate cases that required mental health professional intervention and reduce incidents related to police response. Program outcomes highlight its success. In 2023, there were 89 911 mental health-related calls with follow-up contact to 13 individuals and families. In 2024, the number of calls was reduced to 49 calls with only six follow-up contacts required. This reduction tied to the introduction of more crisis services within the police departments and to the greater use of 988 by individuals and families in the community.

### Mental and Substance Use Disorders: Opioid Treatment and Recovery

Saint Joseph's outpatient addiction programs improve access to opioid treatment and recovery services by reducing the time from first contact to assessment to active enrollment in treatment. Saint Joseph's has expanded the use of medication-assisted treatment (MAT) in all its behavioral health programs and promotes open access to MAT services, particularly following an overdose or related encounter. Rapid access to MAT provides immediate craving and overdose risk relief, as well as enhances patient engagement through a positive perception of program efficacy. This results in increased average length of stay in treatment, which is correlated with improved patient outcomes.

Saint Joseph's trains its medical staff in a trauma-informed approach to substance use disorder treatment. This approach is supported by compelling research evidence documenting the high co-morbidity of substance use disorder, including opioid use disorder, with both trauma and adverse childhood experiences. Trauma-informed care incorporates knowledge of patient trauma into all aspects of service delivery to achieve evidence-backed best practice outcomes.

Substance use disorders and mental health concerns are often co-occurring and require a coordinated approach. Saint Joseph's Department of Psychiatry provides comprehensive outpatient and inpatient mental health services, addiction treatment programs and crisis services, and residential services. Saint Joseph's also implemented SDoH screening among patients to identify and respond to HRSNs.

Other project goals and accomplishments:

- 100% Saint Joseph's /SVH Behavioral Health programs trained and stocked with Naloxone
- 70-92% of substance use disorder patients assessed within 5 days in 2025 (Target 70%)
- 70-90% of substance use disorder patients admitted within 7 days in 2025 (Target 70%)
- 85-95% of opioid use disorder patients on Medication-Assisted Treatment in 2025 (Target 75%)
- 100% of substance use disorder staff trained on Trauma Informed Care in 2022-2025
- Trauma Informed Care training video available on hospital-wide Intranet for all MH staff
- Shatterproof-Atlas program satisfaction rates were 4.5 (New York Average = 4.0)

# 2022-2024 Community Service Plan

## Prioritization Process and Identified Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining the issues on which to focus efforts over the next three-year cycle, Saint Joseph's collected feedback from community stakeholders and aligned its efforts with the New York State Prevention Agenda.

The Prevention Agenda is New York's State Health Improvement Plan. It is aimed at improving the health status of individuals in New York and reducing health disparities through a strong emphasis on prevention. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare.

Saint Joseph's leaders applied the following criteria to define Prevention Agenda priorities for the hospital:

- Prevalence of health disparity and number of community members affected
- Prevalence of health disparity compared to city, state, and national benchmarks
- Existing programs, resources and expertise to address issues
- Input from community partners and representatives
- Alignment with concurrent public health and social service organization initiatives

Based on the CHNA, Saint Joseph's will focus on the following Prevention Agenda priorities:


The identified priorities represent key disparities affecting area residents and are aligned with Saint Joseph's existing resources and initiatives to advance health equity. The following sections highlight evidence-based interventions, strategies, and activities being implemented by Saint Joseph's as part of its CSP to address the priority areas and associated health disparities.

## Saint Joseph Medical Center's 2026-2028 Community Service Plan

The 2026-2028 CSP builds upon previous health improvement activities, while advancing new opportunities that recognize emerging health challenges and a focus on health equity. The following is a summary of Saint Joseph's 2026-2028 CSP, outlining goals, objectives, strategies, and process measures for addressing the identified priority areas.

### Priority Area: Nutrition Security

**Goal:** Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.

**Objectives:**

- Improve the process for screening and tracking patient health-related social needs (HRSNs) to achieve 100% screening at each patient encounter.
- Strengthen referral pathways to the Social Care Network and processes for tracking service delivery to ensure patients with HRSNs receive needed services.

| Intervention | Population of Focus | Anticipated Impact |
|---|---|---|
| Provide standardized screening for unmet nutrition security needs to improve overall access | Saint Joseph's patients and clients | • Percentage of patients screened for HRSNs at each encounter |
| Refer food insecure individuals to state, local, and federal benefit programs and community-based providers to address unmet needs | Saint Joseph's patients and clients | • Percentage of patients with identified HRSNs referred to the Social Care Network |
| In partnership with Feeding Westchester, provide point of care food for Family Health Center patients identified with food insecurity | Saint Joseph's Family Health Center patients | • Number of patients served by point of care food resources |
| In partnership with Feeding Westchester, provide mobile food distribution for community members with food insecurity | Saint Joseph's service area | • Amount of food distributed to community members |
| Provide staff training to promote awareness of HRSNs and effective screening practices | Saint Joseph's staff | • Number of staff trained |
| Anticipated Resources: | | |
| ▪ Social Care Networks<br>▪ Care Management Teams<br>▪ IT Infrastructure<br>▪ Staff Education (HRSNs, Screening Practices) | | |

### Priority Area: Housing Stability and Affordability

**Goal:** Foster reliable and equitable access to safe, affordable, and secure housing options.

**Objectives:**

- Expand short-term and permanent housing options for people with housing insecurity or experiencing homelessness.
- Improve housing security for populations placed at risk, including frail and low-income older adults, adults with serious mental illness and/or substance use disorder, and individuals and families with low incomes.

| Intervention | Population of Focus | Anticipated Impact |
|---|---|---|
| Provide standardized screening for unmet housing security and affordability needs to improve overall access | All Saint Joseph's patients and clients | • Percentage of patients screened for HRSNs |
| Refer housing insecure individuals to state, local, and federal benefit programs and community-based providers to address unmet needs | All Saint Joseph's patients and clients | • Percentage of patients with identified HRSNs referred to the Social Care Network |
| Maintain and expand a full continuum of residential and housing options to meet the needs of the community | People placed at risk for housing insecurity by socioeconomic and health barriers | • Number of people housed by Residential Services<br>• Expansion of Residential Services offerings |
| Provide employment and vocational services to provide meaningful, gainful employment for residential services clients | People unable to attain or maintain employment due to psychiatric disability | • Financial security for Residential Services clients |
| Serve as a participant or convening partner for local and regional housing collaboratives to address unmet needs | Saint Joseph's service area | • New clients referred for Residential Services |
| Anticipated Resources: | | |
| ▪ Residential Services<br>▪ Care Management Teams<br>▪ Social Care Networks<br>▪ Rainbow Environmental Services Employment and Vocational Services<br>▪ IT Infrastructure<br>▪ Staff Education (HRSNs, Screening Practices) | | |

### Priority Area: Preventive Services for Chronic Disease Prevention and Control

**Goal:** Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.

**Objectives:**

- Increase the percentage of youth served by Saint Joseph's primary care services that receive recommended preventive care and screenings.
- Improve disease management outcomes for youth served by Saint Joseph's primary care services with asthma, obesity, and diabetes.

| Intervention | Population of Focus | Anticipated Impact |
|---|---|---|
| Operate primary care school-based health centers and provide free health services to children without a regular source of care | School-based health center patients | • Number of students served by school-based health centers<br>• Number of students receiving recommended preventive care services and screenings |
| Provide comprehensive health services, counseling, education, and disease management for students served by school-based health centers and identified with chronic disease | School-based health center patients | • Number of students identified with chronic disease<br>• Number of students with chronic disease showing improved disease management outcomes |
| Improve tracking and delivery of well-child visits and age-appropriate developmental screenings to promote health and early support services | Saint Joseph's youth primary care patients | • Number of youth up-to-date on recommended visits and services<br>• Early identification of needs and appropriate referrals |
| Implement standardized asthma templates in electronic medical records to assess and document asthma control techniques, management, and potential triggers | Saint Joseph's patients with asthma (incl. school-based health centers) | • Number of patients with asthma with documented control |
| Implement processes and procedures to track and report asthma outcomes for children aged 0-18 with asthma | Saint Joseph's patients with asthma (incl. school-based health centers) | • Number of patients with asthma with documented control |
| Anticipated Resources: | | |
| ▪ School-Based Health Centers Staffing and Funding<br>▪ IT Infrastructure<br>▪ Medical Professionals Time and Training | | |

### Priority Area: Preventive Services for Chronic Disease Prevention and Control

**Goal:** Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.

**Objectives:**

- Increase the percentage of eligible Saint Joseph's primary care patients who receive recommended colorectal cancer screenings to at least 50%.
- Increase community education for and access to preventive screenings and services.

| Intervention | Population of Focus | Anticipated Impact |
|---|---|---|
| Use electronic health record tools to identify patients near due or overdue for colorectal cancer screening and to conduct patient awareness campaigns | Saint Joseph's primary care patients | • Number of eligible adults who receive colorectal cancer screening |
| Collaborate with local coalitions and community agencies to improve colorectal cancer awareness and screening practices | Community residents, populations placed at risk | • Participation in local collaboratives for collective action<br>• Change in community screening practices |
| Conduct quarterly educational waiting room presentations to increase awareness of the importance of colorectal cancer screening | Saint Joseph's patients | • Change in knowledge, awareness, or receipt of cancer screening among individuals reached through education |
| Anticipated Resources: | | |
| ▪ Community Investments in Education and Preventive Services<br>▪ IT Infrastructure<br>▪ Medical Professionals and students | | |

### Priority Area: Suicide

**Goal:** Prevent suicides.

**Objectives:**

- Conduct 100% screening of Saint Joseph's patients for depression and suicide risk.
- Reduce emergency department visits and hospitalizations due to mental health crisis.
- Reduce police response to mental health crises and increase diversions to appropriate mental health services.

| Intervention | Population of Focus | Anticipated Impact |
|---|---|---|
| Conduct validated screenings for all Saint Joseph's patients for depression and suicide risk | All Saint Joseph's patients | • Identification of patients with high risk for suicide and receiving follow-up care |
| Develop safety plans for all patients at risk of suicide | Saint Joseph's patients with suicide risk | • Number of at-risk patients with a documented safety plan |
| Provide leadership and staffing for Westchester County's 24/7 988 suicide and crisis lifeline | All Westchester County residents | • Number of 988 calls<br>• Number of follow-up calls and engagement with services |
| Operate a mobile and interdisciplinary Crisis Prevention and Response Team (CPRT) to provide community-based assessment and intervention for people experiencing a mental health crisis | People experiencing a mental health crisis | • Number of CPRT calls and follow-up contact in the community |
| Support Westchester County's 911 Diversion Program to divert mental health-related 911 calls to CPRT | People experiencing a mental health crisis | • Reduction in 911 mental health-related calls and police response<br>• Number of CPRT calls and follow-up contact in the community |
| Address substance use disorder comorbidities through Naloxone training and distribution, community-based education, rapid access to MAT, and trauma-informed care training for all staff | People with substance use disorder comorbidities | • Number of community groups with Naloxone training<br>• Rapid access to substance use disorder treatment<br>• Support and expansion for the use of MAT |
| Anticipated Resources: | | |
| ▪ 988 lifeline staffing and investment<br>▪ CPRT staffing and investment<br>▪ 911 Diversion Program training for police departments<br>▪ Saint Joseph's Department of Psychiatry<br>▪ Intensive Crisis Residence | | |

## Health Needs Not Identified and/or Addressed by CSP

The CHNA also identified meeting the needs of the aging population and violence as top community health needs. While not named priorities within the CHNA, Saint Joseph's is committed to addressing these areas either directly or in collaboration with community partners.

Saint Joseph's considers the needs of older adults as part of its broader strategy to improve chronic disease prevention and control and in its efforts to identify and respond to the unique HRSNs of older adults. Saint Joseph's also works closely with its Residential Services senior housing programs to support the health and wellbeing of older adults placed at risk for health and social disparities. Senior housing programs are located in close proximity to Saint Joseph's Medical Center, providing older adults with easier access to health services.

Community violence is multifaceted because it is influenced by a complex interplay of social, economic, and structural factors, such as poverty, lack of access to quality housing and education, and historical injustices. These underlying issues create environments where violence is more likely to occur, and the effects of violence—including trauma, fear, and economic disruption—can have a ripple effect on entire communities. Saint Joseph's is working to address some of these underlying issues as part of its community health strategy. Saint Joseph's will also continue to collaborate with organizations that work on this issue and evaluate how it can support these partners.

## Partner Engagement

Saint Joseph's continues to collaborate in addressing community needs through the Mayor's Health Advisory Board and participation in various local and regional coalitions. Saint Joseph's is also a lead agency for the region's Social Care Network, tasked with building a robust network of community-based organizations providing HRSN services and coordinating with health care providers.

In this and many other ways, Saint Joseph's serves as a community partner and ensures ongoing assessment and response to the community's top needs.

## CHNA and CSP Communication Plan

Saint Joseph's made the CHNA and CSP available on its website. Saint Joseph's will maintain a printed copy of the CHNA and CSP at the hospital for public inspection upon request.

# Board Approval and Next Steps

Saint Joseph's would like to thank our community partners that provided guidance, expertise, and ongoing collaboration to inform the 2025 CHNA and CSP and help improve the health and well-being of the region.

We are committed to advancing health initiatives and community collaboration to support key health needs identified in the CHNA. The 2025 CHNA and CSP report was presented to the Saint Joseph's Board of Trustees and approved in December 2025. Following the board's approval, the CHNA and CSP report was published and accessible to the public via Saint Joseph's website at https://saintjosephs.org/about/community-health-needs-assessment-chna/.

We invite our community partners to learn more about the CHNA and CSP and opportunities for collaboration to address identified health needs. Please visit our website or submit comments directly to Catherine Hopkins at catherine.hopkins@saintjosephs.org.

# Appendix A: Public Health Secondary Data References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