ST. ANTHONY COMMUNITY HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT AND COMMUNITY SERVICE PLAN

2025 – 2027



St. Anthony Community Hospital
15 Maple Ave, Warwick, NY 10990

St. Anthony Community Hospital

2025 – 2027 Community Health Needs Assessment and Community Service Plan

County/Counties covered in CHNA and CSP: Orange County, New York

Participating Local Health Department(s): Orange County Health Department

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I. Introduction

St. Anthony Community Hospital ("St. Anthony's"), a member of the Westchester Medical Center Health Network (WMCHealth) in Warwick, New York, is a 60-bed hospital providing outstanding and compassionate care to residents of Orange County, New York, and New Jersey's Sussex and Passaic counties.

For over 85 years, St. Anthony's has worked to advance the health and wellbeing of the communities it serves. Our dedicated physicians, nurses, and staff are committed to delivering high-quality care to every patient – without exception. St. Anthony's is a primary resource for emergency, medical, surgical, obstetrical/gynecological and acute-care services. The comprehensive surgery program includes joint-replacement, including robotic knee-replacement, vascular, gynecological, urological, pulmonary, ophthalmic, plastic surgery, hand, foot, same-day and general surgery. The recently renovated Radiology Department now offers three-dimensional mammography. Schervier Pavilion, a 120-bed skilled-nursing facility is co-located on campus and offers short-term rehabilitative services along with long-term care.

St. Anthony's is a critical piece of the Hudson Valley Region's health care system and participates in a range of committees, community partnerships, and workgroups that aim to address regional needs and create opportunities for residents to thrive and lead healthy, fulfilling, and productive lives. As a mission-driven organization, we are committed to partnering with our communities to create a more humane world, build health equity and social justice for all, and provide exceptional value for those we serve, regardless of ability to pay.

We will continue to strive to be the leading provider of quality, compassionate and regional community health care services in the Hudson Valley. The Community Health Needs Assessment (CHNA) process is an integral part of St. Anthony's and WMCHealth's population health and community engagement efforts. The purpose of the CHNA and subsequent Community Service Plan (CSP) is to promote the evidence-based and prioritized agenda of health needs that has been co-created with community residents in support of this mission.

It should be noted that the relationship between the CSP and WMCHealth's Strategic Plan are not mutually exclusive. The CSP reflects efforts to align with both longstanding community needs and the State's initiatives to improve the social determinants of health among certain populations, while the WMCHealth Strategic Plan aims to bolster the shifting governance structure and offer a roadmap toward the long-term sustainability of the system.

About WMCHealth
WMCHealth is an 1,800-bed health care system headquartered in Valhalla, New York, with nine hospitals on seven campuses spanning 6,200 square miles of the Hudson Valley. WMCHealth employs more than 13,000 people and has nearly 3,000 attending physicians. Today, WMCHealth is the pre-eminent provider of integrated health care in the Hudson Valley, with Level 1, Level 2 and Pediatric Trauma Centers, the region's only acute care children's hospital, an academic medical center, several community hospitals, dozens of specialized institutes and centers, skilled nursing, assisted living facilities, homecare services and one of the largest mental health systems in New York State.

II. Executive Summary

As required by the New York State Department of Health (NYSDOH), St. Anthony's reaffirms its commitment to improving population health in Orange County, as presented in this 2025-2027 CHNA/CSP. Also included as part of the CHNA/CSP is St. Anthony's adopted Implementation Plan, which outlines our action plans to address the identified health needs in Orange County.

To identify the most pressing health needs in its service area, St. Anthony's collaborated with the Greater New York Hospital Association and the Mid-Hudson Region Community Health Assessment collaborative. After defining the service area, St. Anthony's collected and analyzed both secondary and primary data to understand health challenges faced by residents in their service area.

At the conclusion of the CHNA process, St. Anthony's aligned its action plans with New York's State Health Improvement Plan, more commonly known as Prevention Agenda 2025-2030, by targeting three public health prevention priorities:

Domain	Priority	Goal
Social and Community Context	Depression	Increase screening and treatment for depression to decrease prevalence.
Health Care Access and Quality	Preventive Services for Chronic Disease Prevention and Control	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases. • *With a focus on cancer*
Economic Stability	Nutrition Security	Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.

III. Community Background

Service Area Geography

St. Anthony's is located within the Village of Warwick, New York in the south-western portion of Orange County. Its primary service area is defined by federal guidelines, encompassing the smallest set of contiguous ZIP codes that account for 75% of hospital discharges.

Secondary data for this assessment were primarily drawn from the Mid-Hudson Regional Community Health Assessment, along with publicly available sources such as the New York State Community Health Indicator Reports Dashboard and the New York Behavioral Risk Factor Surveillance System. Internal hospital records were also incorporated to provide additional context. These data sources include service utilization trends, quality and safety metrics, and other operational indicators that offer a more comprehensive understanding of Good Samaritan Hospital's community impact.

Demographics

The demographic composition of a community significantly influences the health status and needs of its service area, shaping the types of services required to effectively meet resident's needs.

According to the 2023 American Community Survey five-year estimates, Orange County continues to experience steady population growth and is home to 403,840 residents. Of Orange County residents, 49.9% are male, 59.2% are non-Hispanic White, 10.5% are non-Hispanic Black, 23.2% are Hispanic, and 2.8% are non-Hispanic Asian. Orange County is a mix of urban, suburban, farmland and rural areas. 24.0% of the population resides in rural areas, twice the average of New York State. Agriculture is a leading industry in Orange County and constitutes more than half of the County's open space.

Nearly 30% of Orange County residents speak a language other than English at home, primarily Spanish (15%) and other Indo-European languages (12%). The share of residents who speak English "less than very well" has climbed to 12.2%, highlighting growing language-access needs. Orange County also has a higher veteran population (5.6%) than the New York State average (3.9%).

Social Determinants of Health

Social determinants of health (SDOH) are defined as the social and physical conditions in which people are born, live, learn, work, play, worship, and age. Considerable research has shown these conditions have a significant impact on health and quality-of-life outcomes. Healthy People 2030, led by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion define SDOH in five categories: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[5] These categories align with the New York State's Prevention Agenda 2025-2030, which sets forth state and local priorities through 2030.

The following section presents key statistics for Orange County by category.

Economic Stability

Orange County faces economic challenges that directly influence health outcomes, as financial insecurity limits access to healthy food, stable housing, and preventive care.

- Approximately 5.4% of Orange County's population over the age of 16 was unemployed in 2023. This is lower than the New York State average of 6.2%.
- In Orange County, 13% of residents live in poverty, slightly lower than the New York State average of 13.7%. The distribution of poverty among racial and ethnic groups is as follows:
    - Non-Hispanic White: 7.9%
    - Non-Hispanic Black: 12.5%
    - Hispanic: 11.3%

These figures suggest structural barriers to economic mobility and addressing these gaps is foundational to improving health outcomes for residents.

Education Access and Quality

Education plays a critical role in shaping healthy behaviors, developing health literacy and clinical outcomes. Education levels in Orange County show a strong high school graduation rate of 89%, although post-secondary attainment remains uneven: 19.1% have some college, 10.3% associates degrees, 18.2% bachelor's, and 14.1% graduate degrees.

Health Care Access and Quality

In Orange County, health coverage is high with 93% of adults insured, and 2.7% of children without health insurance, suggesting systemic issues in affordability and pediatric coverage. These figures are in line with New York State averages for adults with health insurance (93.2%) and children without health insurance (2.8%).

Neighborhood and Built Environment

The environment where people live shapes their experiences including their opportunities and challenges. The county's physical environment presents significant health risks.

- Severe housing problems, including overcrowding and cost burdens, affect 21% of households
- Among economically disadvantaged residents, 6% lack access to grocery stores, limiting healthy food options,
- There are 192.4 violent crimes per 100,000 residents

Social and Community Context

Disconnected youth are teens and young adults ages 16 through 19 who are neither in school nor employed. They may face structural barriers like poverty, unstable housing, discrimination, chronic illness or caregiving responsibilities, and they tend to have higher rates of:

- Depression, anxiety, and psychological distress
- Substance use and substance use disorders
- Chronic disease later in life
- Exposure to violence or trauma

Of youth ages 16-19, 8% are disconnected from work and school, increasing vulnerability to long-term economic and health disparities. Additionally, a racial segregation index of 48 suggests entrenched structural inequities that can limit access to resources and opportunities.[1]

[1] The index is used to measure residential segregation; zero represents complete integration, while 100 is complete segregation. The index score can also represent the percentage of either non-Hispanic Black or non-Hispanic White residents who would have to move to a different geographic area in order to produce a distribution that matches that of the larger area.

Community Health Status

Data related to the health status of the community was analyzed to better understand the needs of the service area.

The following section provides key data on the health status of the Orange County community.

Physical Activity and Nutrition

Physical activity and nutrition are risk factors for many chronic conditions including type 2 diabetes, obesity, and hypertension. Within Orange County:

- Adults reporting daily consumption of at least one sugary beverage account for 21.3% of the population.
- Adults reporting daily consumption of less than one fruit and one vegetable account for 31.9% of the population.
- Participation in physical activity is low with 75.5% of adults reporting participating in physical activity in the last 30 days; the New York State average is 74.6%.

Chronic Disease

Chronic disease refers to health conditions that last one year or more, require ongoing medical care, and typically limit daily activities in some way. In New York State, chronic disease is a leading cause of disability and death.[i] Within Orange County:

- Among adults, 38.5% are obese and 7.3% have physician diagnosed diabetes.
- The percentage of adult residents with physician diagnosed high blood pressure is 29.1%.

Cancer

Cancer remains one of the leading causes of death in the United States and is often associated with premature mortality. Within Orange County:

- In 2019-2021, the lung and bronchus cancer incidence rate was 59.8 per 100,000, and the breast cancer incidence rate among females was 125.8 per 100,000.
- Colorectal cancer screening compliance among adults 50-64 years old was 61.7%, lower than the New York State value of 65.4%.
- The percentage of adolescents aged 13 years old with a complete HPV vaccine series is 24.1% which is significantly lower than the New York State average of 37.2%.

Mental Health

Mental health plays a key role in quality of life, yet mental illness is widespread, impacting roughly one in five adults.[ii] Fortunately, many mental illnesses can be managed with proper treatment and care. Within Orange County:

- Adults reporting poor mental health for 14 or more days in the last 30 days account for 10.4%; the New York State value is 13.4%.
- Adults who report having a depressive disorder account for 16.3%, which is lower than the New York State value of 17.4%.

Maternal and Infant Health

Maternal health has become a central focus for government and healthcare initiatives in recent years. Within Orange County:

- Late or absent prenatal care occurred in 6.4% of births, higher than the New York State average of 5.4%.
- The infant mortality rate is 2.9 per 1,000 live births which is lower than New York States rate of 4.2.

IV. Community-Identified Needs

Community input was collected from residents served by St. Anthony's to ensure their perspectives informed this assessment. These insights, drawn from the GNYHA CHNA Survey and key informant interviews build on the secondary data collected to create a complete view of community health needs.

GNYHA CHNA Survey

St. Anthony's participated in the GNYHA Survey Collaborative's CHNA survey which helps hospitals collect community input to better inform the health needs of their service area. St. Anthony's, a participating hospital, distributed a web-based survey tool and a paper-based tool to collect data between June and July 2025. After compiling and analyzing survey responses, GNYHA provided St. Anthony's with data specific to its defined service area.

Based on 976 responses from residents of Orange County, which encompasses approximately 403,840 residents, key insights include:

- **Respondent Demographics**
  - *Medicare population with strong health coverage:* 60% are aged 55+, including 23% aged 65–74 and 13% over 75, indicating a need for age-friendly health services and long-term care planning; 98% are insured (49% employer/union plans, 32% Medicare, 8% Medicaid), with only 2% uninsured.
  - *Highly educated and generally affluent, with pockets of economic vulnerability:* 98% graduated high school, 50% hold college degrees, 30% attended some college/technical school; 54% employed, 33% retired, 6% unable to work, 1% unemployed over a year; 55% earn over $100,000/year (22% above $200,000, 23% between $100,000–$149,000), but 10% earn less than $20,000.
  - *Predominately white, English-speaking population:* 74% identify as White, with representation from Hispanic/Latino (15%), Black/African American (11%), Asian (3%), Middle Eastern/North African (1%), and American Indian/Alaska Native (1%); 82% speak only English at home, 15% speak other languages (Spanish 11%, others include Yiddish, Chinese, French, Haitian Creole), and 4% report limited English proficiency.

- **Overall Health Status**
  - *Majority self-report good health:* In response to ranking the overall health of the people in their neighborhood, 53% answered "good", with 22% answering "fair" and 5% responding "poor".
  - *Stronger mental versus physical health status:* When asked to provide an indication of their physical and mental health, 43% said their physical health was "good" whereas 38% said their mental health was "good". Of those surveyed, a higher percentage of respondents noted their mental health was "excellent" (14%) compared to their physical health (8%).

- **SDOH**
  - *1 in 4 experience food insecurity:* When asked if they currently receive food stamps or SNAP benefits, 6% indicated that they do. To further assess food insecurity in the region, respondents were asked: 'During the past 12 months, how often did the food that you bought not last, and you didn't have enough money to get more?'. Among respondents in St. Anthony's service area, 24% answered 'Always', 'Usually', or 'Sometimes'.

- *1 in 5 experience housing insecurity:* In response to the question: 'During the last 12 months, was there a time when you were not able to pay your mortgage, rent, or utility bills?' 21% of respondents in St. Anthony's service area replied 'Yes'.

Finally, community members were presented a list of 21 health issues and asked to rank each by level of importance and satisfaction with current neighborhood services addressing that issue. Responses were scored on a 1-5 scale (1 = not at all, 2 = a little, 3 = somewhat, 4 = very, and 5 = extremely). For each health issue, an average Importance Score and Satisfaction Score were calculated ranked from highest to lowest. These scores were then compared to the overall averages and categorized as Above Average or Below Average. The health conditions were then grouped into three priority levels: Needs Attention, Maintain Efforts, and Relatively Lower Priority.

The Relatively Lower Priority category includes health issues with a below average Importance Score. The Maintain Efforts category covers issues with above average scores for both the Importance Score and Satisfaction Score. The Needs Attention category includes health issues with above average Importance Scores and below average Satisfaction Scores. Table 1 highlights the health issues identified as Needs Attention and Maintain Efforts based on responses from St. Anthony's community members. The Appendix provides the complete list of results for all three categories.

Table 1. Ranking of Health Issues Categorized as "Needs Attention" and "Maintain Efforts"

Needs Attention	
Social and Community Context	Mental health disorders (such as depression)
Health Care Access and Quality	Women's and maternal health care
Economic Stability	Affordable housing and homelessness prevention
Health Care Access and Quality	Obesity in children and adults
Health Care Access and Quality	Arthritis/disease of the joints
Maintain Efforts	
Health Care Access and Quality	Cancer
Health Care Access and Quality	Dental care
Economic Stability	Access to healthy/nutritious foods
Health Care Access and Quality	Heart disease
Neighborhood and Built Environment	Violence (including gun violence)
Neighborhood and Built Environment	Stopping falls among elderly
Health Care Access and Quality	Diabetes and high blood sugar
Health Care Access and Quality	High blood pressure
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)
Health Care Access and Quality	Adolescent and child health
Health Care Access and Quality	Asthma, breathing issues, and lung disease
Education Access and Quality	School health and wellness programs

The ranked health needs outlined in Table 1 provide a snapshot of residents' health concerns and expectations. Five issues stood out as requiring increased focus: mental health disorders, women's and maternal health care, affordable housing and homelessness prevention, obesity in children and adults, and arthritis/disease of the joints.

Twelve additional issues were identified as important to maintain momentum on, including cancer, dental care, access to health/nutritious foods, and heart disease, among others. These selections suggest that while progress may be underway in these areas, continued investment is needed to ensure long-term impact. Respondents reported "Neighborhood and Built Environment" as the most important Social Determinant of Health category, and the "Health Care Access and Quality" and "Neighborhood and Built Environment" categories tied for highest satisfaction.

Key Informant Interviews

Key informants were chosen for their expertise in public health, their knowledge of local community health needs, their ability to represent the broad interest of St. Anthony's service area, and their insight into the needs of medically underserved or vulnerable populations.

Key themes from interviews conducted included:

Mental Health
Key informants emphasized the growing acuity and complexity of mental health needs in the community, particularly around postpartum depression, anxiety, and co-occurring substance use disorders. Participants also stressed the shortage of behavioral health resources and a need for enhanced screening and follow-up care across the WMCHealth.

Chronic Disease
Key informants underscored the prevalence of chronic conditions and associated risk factors throughout the community, including obesity, cancer, and elevated rates of smoking. Notably, persistent disparities exist in cancer screening, diagnosis, and outcomes across the region. These disparities are especially pronounced among immigrant and Orthodox communities, as well as individuals facing language and transportation barriers, which impact both screening and vaccination uptake.

Nutrition Security
Food insecurity is a high-priority concern across all regions served by WMCHealth, impacting chronic disease management, treatment compliance, and overall health outcomes. Despite these challenges, WMCHealth has worked to address nutrition insecurity by integrating screening and support into clinical workflows and by partnering with local community organizations to connect patients with essential resources.

V. Priority Community Health Needs

Community health needs were developed based on:

- High prevalence or incidence of health issues (e.g., rates exceeding regional averages)
- Community-identified priorities gathered through the GNYHA survey and key informant interviews
- St. Anthony's service profile and the broader WMCHealth's service profile

Health needs that appear in both primary and secondary data will form the final list of Identified Community Health Needs.

The IRS mandates hospitals to list the needs generated from this assessment in priority order. The criteria below guided the prioritization of the Identified Community Health Needs:

- Alignment with state and local priorities
- Alignment with WMCHealth's strategic plan, services, and capabilities
- Community scores and ranking
- Ability to drive measurable change and population health impact at scale

Using these criteria, the St. Anthony's community confirmed the final prioritized list of community health needs presented below:

Domain	Priority	Goal
Social and Community Context	Depression	Increase screening and treatment for depression to decrease prevalence. • *With a focus on individuals in the postpartum period*
Health Care Access and Quality	Preventive Services for Chronic Disease Prevention and Control	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases. • *With a focus on cancer*
Economic Stability	Nutrition Security	Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods. • *With a focus on low-income households*

VI. Community Assets

Orange County, New York is resource-rich with an extensive network of health and human service agencies located throughout the county. In addition to these agencies, Orange County is home to five area hospitals, hundreds of medical providers, two-year and four-year colleges, a medical school and several large Federally Qualified Health Centers. Throughout the CHNA process, these community partners assisted the Health Department to assess and prioritize health needs and many have made commitments to work towards the health goals of the county

St. Anthony's has chosen specific Prevention Agenda goals based on our internal expertise, the input of our community members, resources, and the desire and commitment to improve our collective health and well-being. Recognizing no one entity can address all needs, community partners are essential to help achieve the Prevention Agenda goals. St. Anthony's works with many of the following groups within Orange County to address community needs:

Agri-Business Child Development
Access: Supports for Living
Action Towards Independence

Alcohol and Drug Awareness Council of Orange County
Alzheimer's Association, Hudson Valley Chapter
American Heart Association
Astor Services for Children & Families
Beacon School Food Access
Boys and Girls Club of Newburgh, Inc.
Catholic Charities Community Services of Orange County
Changing the OC Addiction Treatment Ecosystem
Children's Grieving Center
Cornell Cooperative Extension
Cornerstone Health Centers
Food Bank of the Hudson Valley
Jewish Family Services of Orange County
HEALing Study
Healthy Orange
Hudson River Housing, Inc.
Independent Living
Latinos Unidos
Migrant Health Services
NAMI Mid-Hudson
Nourish Newburgh – Newburgh Armory Unity Center
Orange County Office for Aging
Orange County Cancer Screening Collaborative
Orange County Crisis Call Center
Orange County Health Department
Orange County Mental Health Department
Orange County Youth Bureau
Opioid Overdose Prevention Program
Pregnant or Parenting Peoples Initiative (POPPI)
Renwick Recovery
RECAP Head Start
Sun River Healthcare
THRIVE: Advancing Mental Wellness for Youth
Welcome Orange
Union Street Community Counseling Center
United Way Dutchess-Orange Region

Impact since Last CHNA
During its last CHNA cycle, St. Anthony's identified the following as prioritized health needs:

Priority: Prevent Chronic Diseases
Goal: Increase access to healthy foods, increase food security, and increase cancer screening rates
Impact:

- Established foundational identification and referral processes to address food insecurity
- Partnered with Orange County and the Cornell Cooperative Extension to develop policies and processes to actively connect patients to SNAP and WIC programs.
- Conducted at least 50,000 food security screenings since 2022, embedding screening into routine care workflows
- Created sustainable referral pathways for patients to access nutrition assistance and preventive health resources
- Built strong community partnerships to support long-term strategies addressing SDOH.

Priority: Promote Well-Being and Prevent Mental Health and Substance Use Disorders
Goal: Reduce opioid and other substance misuse deaths through harm reduction and treatment access
Impact:

- Increased the availability of medication assisted treatment (MAT) in the Emergency Department
- Provided MAT to 50 patients since 2022, integrating treatment into acute care settings
- Expanded peer referral program, resulting in 1,519 referrals
- Distributed 1,392 Naloxone kits to patients and community members to prevent overdose deaths
- Strengthened harm reduction strategies through proactive engagement and community-based organizations

Looking Forward

WMCHealth's 2025 Community Health Needs Assessment reaffirms the System's deep and enduring commitment to the people of the Hudson Valley. The insights shared by residents, community leaders, and partner organizations have been invaluable in shaping a responsive, data-driven understanding of the region's evolving health needs. As WMCHealth advances this work, it remains steadfast in its dedication to delivering high-quality, culturally competent care that honors the diversity, lived experiences, and voices of the communities it serves. The ongoing review of health data, combined with continued engagement of stakeholders, will remain foundational to planning and decision-making, ensuring that strategies are aligned with local priorities and that progress can be measured transparently through clear, accountable indicators of success. Through this sustained partnership with the community, WMCHealth will continue to strengthen its role as a trusted regional anchor, working collaboratively to promote equity, improve outcomes, and support the long-term well-being of the Hudson Valley.

VII. Community Service Plan

WMCHealth's vital mission is to provide the highest-quality care for all residents of the Hudson Valley regardless of the ability to pay. WMCHealth will build on its long tradition of delivering the most advanced services in the region by providing a fiscally sound network that ensures access to a coordinated continuum of care for its community.

St. Anthony's CSP serves as a strategic roadmap for advancing our mission, health equity, and population health across our service area, particularly for historically underserved populations. As outlined in this plan, St. Anthony is committed to reducing disparities through targeted outreach to uninsured, underinsured, immigrant, and rural populations; translating materials and providing bilingual support; and addressing geographic barriers to care.

St. Anthony is focused on advancing community health through its mission and capabilities; however, no one organization can comprehensively address all health needs in its community. Recognizing this, St. Anthony prioritized 2025–2027 initiatives based on the most prevalent health issues, community feedback from surveys and interviews, and alignment with its own and WMCHealth's service capabilities. Reasons some health needs were not selected include:

- Resource constraints
- Other facilities or organizations in the community are addressing the need
- Relative lack of expertise or competencies to effectively address the need
- A relatively low priority assigned to the need by the community

Significant health needs in the St. Anthony community that will not be addressed are:

- Affordable housing and homelessness
- Obesity and diabetes
- Arthritis/disease of the joints
- Dental care
- Heart disease
- Violence
- Stopping falls among the elderly

Over the next three years, St. Anthony will advance the NYS Prevention Agenda by implementing evidence-based strategies across our service area to address the three selected priorities as outlined below. These priorities were identified through the comprehensive CHNA process, consisting of a review of secondary data, Greater New York Hospital Association survey responses, and key informant interviews with WMCHealth leaders in mental health, chronic disease, and nutrition security.

Domain	Priority	Goal(s)
Social and Community Context	Depression	Increase early identification and treatment of postpartum depression (PPD) among birthing persons
Health Care Access and Quality	Preventive Services for Chronic Disease Prevention and Control	Improve equitable access to cancer screening and diagnostic services across all regions
		Increase HPV vaccination rates and preventive education

Economic Stability	Nutrition Security	Increase identification and support for patients experiencing food insecurity
		Increase household food security for low-income households

For each priority area identified through the comprehensive CHNA process, St. Anthony will publicly share executive summaries and progress updates via hospital and community websites, local events, and partner organizations, in accordance with NYSDOH requirements.

Priority 1. Promote Mental Health and Well-Being

Focus Area: Increase Screening and Treatment for Depression to Decrease Prevalence

Goal: Increase early identification and treatment of postpartum depression (PPD) among birthing persons

Target Population: Postpartum birthing persons across primary and secondary service areas of the Westchester Medical Center Health Network (WMCHealth) and partner hospitals

Objective:
By December 2027, achieve 100% screening for postpartum depression among all birthing persons at participating hospitals and affiliated outpatient clinics.

Intervention: Screening

- Implement universal, standardized depression screening at three key points:
  - Early prenatal care
  - Late prenatal care
  - Postpartum (using validated tools such as the Edinburgh Postnatal Depression Scale)
- Ensure screening is documented in both inpatient and outpatient settings, with electronic tracking and dashboards for real-time monitoring.

Intervention: Care Team Training and Workflows
Expand care team capacity to deliver initial treatment and follow-up for patients screening positive for PPD:

- Train OBGYNs, mid-level providers, and maternal-fetal medicine (MFM) physicians in reproductive psychiatry (e.g., through certificate programs and Project TEACH).
- Engage social workers to provide immediate support, SDOH screening, and care coordination.
- Develop a referral protocol and criteria for high-acuity cases to behavioral health specialists.

Timeline:

- By December 2025: Launch universal screening and tracking at WMCHealth's main campus; begin provider training at all sites.
- By December 2026: Expand screening and training to Good Samaritan, St. Anthony, Bon Secours, HealthAlliance, and Margaretville.
- By December 2027: Evaluate and report screening and referral compliance network-wide and by site.

Data to be Collected:

- Number and percentage of birthing persons screened for depression (inpatient and outpatient)
- Number and percentage of positive screens, stratified by severity
- Number and percentage of positive screens receiving initial treatment or referral, stratified by severity
- Demographic data (race, ethnicity, age, insurance status, SDOH needs)
- Provider training completion rates by program
- Patient follow-up and engagement rates
- SDOH screening, referral, and closed-loop referral rates

Key Partnerships:

- Westchester Medical Center OBGYN and behavioral health providers who will support screening, treatment, and training
- Social workers who will provide SDOH screening and care coordination
- Center for Women's Health Equity who will provide the reporting capabilities to track screenings and referrals
- Project TEACH who will provide training and support for mental health in maternal care

Priority 2. Preventive Services for Chronic Disease Prevention and Control

Focus Area: Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases, with a focus on cancer

Goal 1: Improve equitable access to cancer screening and diagnostic services across all regions

Objective:
Increase the percentage of adults aged 45 to 54 years who are up to date on their colorectal cancer screening based on the most recent guidelines by 10 percentage points.

Intervention: Screening

- Expand monthly cancer screening events at Good Samaritan Hospital, Saint Anthony and Bon Secours Community Hospital.
- Engage the Medical Group to increase participation in colorectal cancer screenings.

Intervention: Collaborations

- Partner with New York State Cancer Services Program to ensure uninsured and underinsured populations receive screenings when needed.
- Collaborate with federally qualified health centers (e.g., Refuah Health, Sun River Health), County Departments of Health, and other community organizations for outreach and education.
- Continue translating screening materials into multiple languages (English, Spanish, Creole, Yiddish) and utilize American Cancer Society resources for culturally and linguistically appropriate education.

Intervention: Care Coordination and Provider Awareness

- Strengthen integration between primary care and oncology, ensuring patients are connected to a PCP and referred for appropriate screenings.
- Educate primary care providers about available screening services and referral protocols.
- Address EMR gaps to improve documentation and tracking of screening rates.

Timeline:
- By December 2025: Launch expanded screening events and outreach, begin EMR improvements, establish baseline screening rates
- By December 2026: Increase provider education and community partnerships and continue expanded screening events
- By December 2027: Evaluate and report change in colorectal cancer screenings

Data to be Collected:
- Number and percentage of eligible adults screened for colorectal cancer (by site)
- Demographic data (race, ethnicity, language, insurance status, geography)
- Number of outreach events and materials distributed
- PCP connection rates and referral rates
- EMR documentation and tracking improvements

Key Partnerships:
- Westchester Medical Center oncology providers and Medical Groups who will support screening and treatment
- Regional FQHCs and local Department of Health to provide community outreach and education
- New York State Cancer Services Program who will ensure uninsured and underinsured populations receive screenings

Goal 2: Increase HPV vaccination rates and preventive education

Target Population: Adolescents

Objective:
By December 2027, increase the percentage of 13-year-old adolescents with a complete Human Papillomavirus (HPV) vaccine series by 10 percentage points, with targeted outreach to communities with low uptake

Intervention: Targeted Outreach
- Track and promote HPV vaccination through GYN services and pediatric care.
- Partner with schools, community organizations, and local health departments for education and outreach.
- Address cultural and religious barriers to vaccination through tailored messaging and community engagement.

Timeline:
- By December 2025: Establish baseline vaccination rates and launch outreach campaigns.
- By December 2026: Expand partnerships and education efforts.
- By December 2027: Evaluate and report change in vaccination rates.

Data to be Collected:

- HPV vaccination rates (by age, site, and demographic group)
- Number of outreach events and educational materials distributed
- Community feedback and engagement metrics

Key Partnerships:

- Westchester Medical Center GYN and pediatric providers who will support vaccination efforts

Priority 3. Nutrition Security

Focus Area: Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods

Goal 1: Increase identification and support for patients experiencing food insecurity

Objective:
By December 2027, achieve 100% screening for food insecurity among all patients admitted to participating hospitals and outpatient clinics, with robust tracking and referral systems.

Intervention 1: Workflows

- Implement universal food insecurity screening as part of the SDOH assessment during nursing triage and case management.
- Use EMR (e.g., Cerner) to track screening responses and referrals, with regular reporting and data review.

Intervention 2: Care Team Training and Awareness

- Educate staff on sensitive, effective ways to ask SDOH questions to improve patient comfort and accuracy of responses.
- Provide ongoing training for nursing, case management, and care coordination teams.
- Consider integrating new evidence-based care team roles (e.g., diabetes educators).
- Expand use of remote patient monitoring capabilities.

Timeline:

- December 2025: Expand screening to all sites and care teams, reinforced by regular staff education and EMR tracking.
- December 2026: Monitor progress, and address gaps.
- December 2027: Evaluate and report screening and referral tracking.

Data to be Collected:

- Number and percentage of patients screened for food insecurity
- Number and percentage of positive screens
- Number and percentage of positive screens receiving referrals
- Demographic data (race, ethnicity, insurance status, geography)
- Staff training completion rates

Key Partnerships

- Social work, discharge planning teams, and nursing staff who can screen patients for food insecurity needs
- WMC IT teams who can support EMR advancement

Goal 2: Increase household food security for low-income households

Target Population: Households with an annual total income of less than $25,000

Objective: Increase food security in households with an annual total income of less than $25,000 by 10 percentage points.

Intervention 3: Food Supply

- Formalize partnerships with local food banks, food pantries (e.g., People's Place, Catholic Charities), and community-based organizations for direct referrals and resource sharing
- Develop on-site food support (e.g., food bags, fridge space for pantry partners, regular food supply rotation).
- Train patients to use food delivery apps (e.g., Instacart, DoorDash), especially for those experiencing mobility or transportation barriers.

Intervention 4: State and County Resources

- Collaborate with county agencies (DSS, Office for the Aging, SNAP, WIC) to provide on-site benefits enrollment support for eligible patients.
- Explore partnerships with home care agencies to extend food insecurity support post-discharge.
- Explore Medicaid funding and reimbursement mechanisms to support nutrition services such as on-site nutritionists/dieticians, diabetes educators, food prescriptions, remote patient monitoring, etc.

Timeline:

- December 2025: Map existing and potential partnerships and referral pathways; pilot on-site food support.
- December 2026: Expand formal partnerships and on-site enrollment support.
- December 2027: Evaluate and report referral success rates.

Data to be Collected:

- Number of patients referred to food resources
- Number of patients successfully connected/enrolled in SNAP, WIC, etc.
- Number of food bags or pantry supplies distributed
- Number of home care agency collaborations
- Patient feedback and satisfaction

Key Partnerships

- Social work, discharge planning teams, and nursing staff who can identify patients with food needs
- Local food banks, food pantries, and community-based organizations for food access

- County agencies for support enrolling patients in programs such as SNAP and WIC for food access

Appendices

Appendix A. CHA/CHIP/CSP Self-Assessment Checklist

Local Health Department/Hospital Name: St. Anthony Community Hospital
Service County: Orange County
Date of Submission:

Required Components	Met	Not Met	Page #
Cover page that includes a list of participating organizations, service area, type of plan (joint vs. individual), and contact details	✓		1-2
Table of Contents reflecting all sections and subsections	✓		3
Executive Summary as outlined in the guidance	✓		4-5
Community Health Assessment (CHA)			
Describe service area and reflect the demographic profile of population	✓		5-6
Describe socioeconomic, educational, and environmental factors that affect health	✓		6-7
Provide an overview of the population's health and identity factors that contribute to health status and health challenges	✓		8
Assemble and analyze secondary data and whenever possible primary data to describe the health status of the community	✓		6-11
Compile and analyze trend data to describe changes in community health status and in factors affecting health	✓		6-8
Use scientific methods for collecting and analyzing data	✓		6-8
Compare selected local data with data from other jurisdictions (e.g., local to state, local to local)	✓		6-8
Provide evidence of community collaboration in planning and conducting the assessment	✓		9-11
Identify leading community health problems	✓		11-12
Identify population groups at risk for health problems	✓		11-12
Identify existing and needed health assets and resources	✓		12-13
Community Health Improvement Plan (CHIP)/Community Service Plan (CSP)			
Workplan Template:			
Utilize CHA findings to identify priorities	✓		15-20
Follow workplan template instructions to select priorities, objectives, interventions, and measures	✓		15-20
Submit Workplan in Excel format	✓		N/A

CHIP/CSP Narrative:			
Describe the process and criteria used to identify priorities based on the findings of the community health assessment	✓		12
Describe the community engagement process that was used to select the new priorities	✓		9-12
Justify unaddressed health needs	✓		15
Select at least three priorities from the Prevention Agenda list. At least one priority should include social determinants of health factors such as Poverty, Unemployment, Nutrition Security, Housing Stability and Affordability, etc.	✓		15-20
Develop objectives, interventions, and an action plan	✓		15-20
Describe the process for monitoring plan progress with community partners and making mid-course corrections	✓		15-20
Briefly describe plans for disseminating CHA/CHIP/CSP reports to the public	✓		16
Submission: Send the documents to prevention@health.ny.gov on or before December 31, 2025			
Additional Comments:			
OLHS USE ONLY: Date received: Date of initial review: Reviewer(s): Date of emailing feedback:			

Appendix B. 2025 GNYHA Community Health Needs Assessment Collaborative, Orange County, Importance and Satisfaction Rankings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^
Need Attention			
Social and Community Context	Mental health disorders (such as depression)	6	4.08
Health Care Access and Quality	Women's and maternal health care	8	4.04
Economic Stability	Affordable housing and homelessness prevention	11	3.98
Health Care Access and Quality	Obesity in children and adults	12	3.97

Health Care Access and Quality	Arthritis/disease of the joints	15	3.94
Maintain Efforts			
Health Care Access and Quality	Cancer	1	4.40
Health Care Access and Quality	Dental care	2	4.34
Economic Stability	Access to healthy/nutritious foods	3	4.32
Health Care Access and Quality	Heart disease	4	4.25
Neighborhood and Built Environment	Violence (including gun violence)	5	4.19
Neighborhood and Built Environment	Stopping falls among elderly	7	4.06
Health Care Access and Quality	Diabetes and high blood sugar	9	4.03
Health Care Access and Quality	High blood pressure	10	3.99
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	13	3.95
Health Care Access and Quality	Adolescent and child health	14	3.95
Health Care Access and Quality	Asthma, breathing issues, and lung disease	16	3.94
Education Access and Quality	School health and wellness programs	17	3.89
Relatively Lower Priority			
Education Access and Quality	Access to continuing education and job training programs	18	3.86
Economic Stability	Assistance with basic needs like food, shelter, and clothing	20	3.83
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	21	3.73
Economic Stability	Job placement and employment support	22	3.66

Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	23	3.45
Health Care Access and Quality	Hepatitis C/liver disease	24	3.23
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	25	3.12
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	26	3.07
Health Care Access and Quality	Infant health	19	3.83

*How important is this issue to you?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

[i] "Chronic Diseases and Conditions". New York State Department of Health. Available here.
[ii] "Mental Health By the Numbers". National Alliance on Mental Illness. Available here.