St. Luke's Cornwall Hospital
*With you for life.*

# 2014 COMMUNITY SERVICE PLAN

## *Overview*

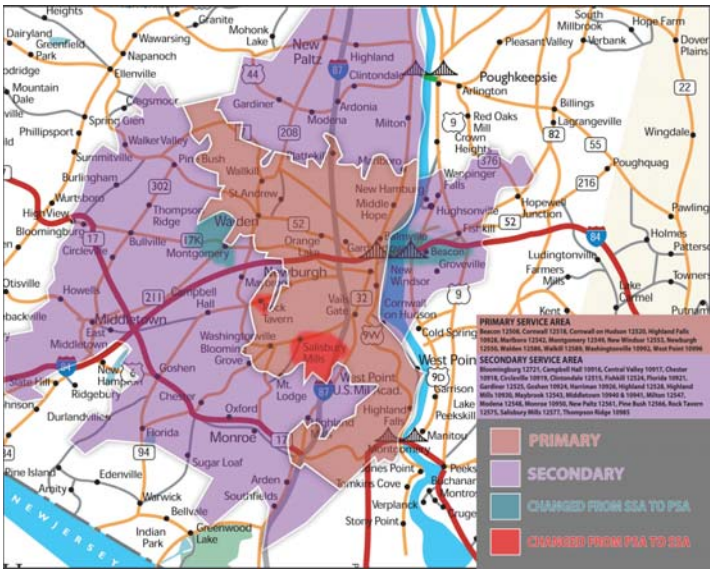
St. Luke's Cornwall Hospital (SLCH), with main campuses in Cornwall and Newburgh and offsite facilities throughout the community, is a 345-bed acute care hospital dedicated to providing for the health care needs of the community. SLCH has participated in a community health needs assessment (CHNA) and developed an implementation plan with strategies to address identified needs within the community. The assessment was conducted using survey data from the 2010-2013 Community Health Assessment from Orange County Department of Health, Demographic and Economic profile prepared by Siemens and other data sources.

The 2014 Community Service Plan outlines St. Luke's Cornwall Hospital's progress to date on the prevention areas outlined in the 2013 Community Service Plan.

## *Background*

The SLCH geographic coverage area serves a population of approximately 400,000 people. In 2013, SLCH provided healthcare services to 14,000 Medicaid patients. As a safety net provider, SLCH serves a population that has been designated as a medically underserved area (MUA). The hospital's Primary Service Area includes the City of Newburgh, the most densely populated portion of SLCH's Primary Service Area, with more than 1,500 people per square mile. St. Luke's Cornwall Hospital's market is defined by 36 neighboring zip codes mainly in Orange County and including Ulster and Dutchess counties.

SLCH is a not-for-profit community hospital that provides dedicated care to more than 250,000 patients per year. SLCH is a 345-bed acute care hospital with main campuses in Cornwall and Newburgh as well as several offsite facilities throughout the community.




## *Primary Service Area Demographic Snap Shot*

- The overall population is growing moderately between 2% to 3% through 2016; two fastest growing zip codes in the county are within 5 to 12 miles of the Hospital.
- Nearly 57.5% of the overall population is 50 years of age and older.
- $77, 421 is the average household income.
- In 2011, the estimated unemployment rate was slightly lower than New York's average at 7.9%
- In 2008, provisional data indicated that 19.7% of Orange County adults reported disabilities and 5.9% reported health problems that required the use of special equipment such as a cane, wheelchair, special bed or telephone.
- SLCH along with Community Health Centers have been working to access eligibility for Medicaid Managed Care, Child Health Plus and Family Health Plus.
- During the period of 1990-2000, approximately 9,000 immigrants established residency in Orange County, with over one-third of that number settling in the city of Newburgh, NY. The Census estimates that Orange County has experienced a 28% increase in foreign-born population from 2000-2005 compared to 16.3% nationwide.
- The Orange County Department of Health has determined that housing units within the county increased 11% from 1990-2000 to 122,754. The DOH found that the majority of housing units in the county are owner occupied- 67%.
- Overall, the perception of health is very high; 72% of respondents claim to have good or very good health.
- Nearly 50% of the population feels that they are at normal weight.
- Though the population feels as though they are at normal weight, 32% of SLCH's service area is obese and 28% is overweight.
- While the lack of access to primary care is due to financial resources or employment, 86.9% of survey respondents claim to have medical insurance.
- 81% of the population claims to be aware of no or low cost health insurance programs available to children.
- 81% of SLCH's service area does not smoke.

## *Primary Service Area Demographic Snap Shot (continued)*

(All data has been taken from the New York State Department of Health at https://health.data.ny.gov/ and SLCH's information database)

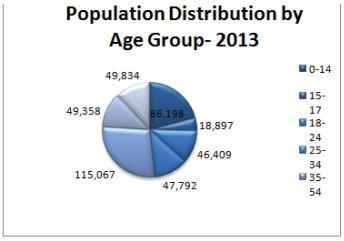
| | Service area | | | 2013 | 2018 | %Change |
|---|---|---|---|---|---|---|
| 2010 Total Population | 408,964 | | Total Male Population | 206,800 | 210,389 | 1.7% |
| 2013 Total Population | 413,555 | | Total Female Population | 206,755 | 210,474 | 1.8% |
| 2018 Total Population | 420,863 | | Females, Child Bearing Age | 80,027 | 78,775 | -1.6% |
| % Change 2013-2018 | 1.8% | | | | | |

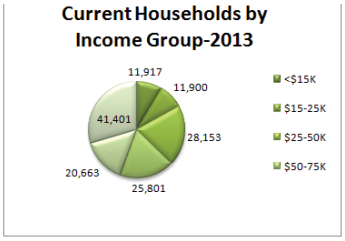
### AGE DISTRIBUTION

| Age Group | 2013 | % of Total | 2018 | % of Total | USA 2013% of Total |
|---|---|---|---|---|---|
| 0-14 | 86,198 | 20.8% | 85,028 | 20.2% | 19.6% |
| 15-17 | 18,897 | 4.6% | 18,332 | 4.4% | 4.1% |
| 18-24 | 46,409 | 11.2% | 48,092 | 11.4% | 10.0% |
| 25-34 | 47,792 | 11.6% | 51,204 | 12.2% | 13.1% |
| 35-54 | 115,067 | 27.8% | 104,771 | 24.9% | 26.9% |
| 55-64 | 49,358 | 11.9% | 55,091 | 13.1% | 12.4% |
| 65+ | 49,834 | 12.1% | 58,345 | 13.9% | 13.9% |
| Total | 413,555 | 100.0% | 420,863 | 100.0% | 100.0% |

### INCOME DISTRIBUTION

| 2013 Household Income | HH Count | % of Total | USA % of Total |
|---|---|---|---|
| <$15K | 11,917 | 8.5% | 13.8% |
| $15-25K | 11,900 | 8.5% | 11.6% |
| $25-50K | 28,153 | 20.1% | 25.3% |
| $50-75K | 25,801 | 18.5% | 18.1% |
| $75-100K | 20,663 | 14.8% | 11.7% |
| Over $100K | 41,401 | 29.6% | 19.5% |
| Total | 139,835 | 100.0% | 100.0% |



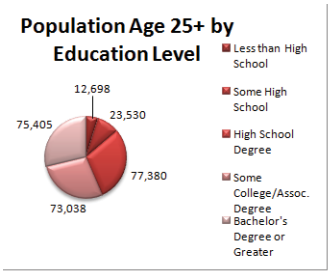


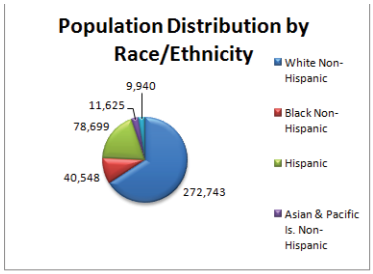

### EDUCATION LEVEL DISTRIBUTION

| 2013 Adult Education Level | Pop Age 25+ | % of Total | USA % of Total |
|---|---|---|---|
| Less than High School | 12,698 | 4.8% | 6.2% |
| Some High School | 23,530 | 9.0% | 8.4% |
| High School Degree | 77,380 | 29.5% | 28.4% |
| Some College/Assoc. Degree | 73,038 | 27.9% | 28.9% |
| Bachelor's Degree or Greater | 75,405 | 28.8% | 28.1% |
| Total | 262,051 | 100.0% | 100.0% |

### RACE/ETHNICITY DISTRIBUTION

| Race/Ethnicity | 2013 Pop | % of Total | USA % of Total |
|---|---|---|---|
| White Non-Hispanic | 272,743 | 66.0% | 62.3% |
| Black Non-Hispanic | 40,548 | 9.8% | 12.3% |
| Hispanic | 78,699 | 19.0% | 17.3% |
| Asian & Pacific Is. Non-Hispanic | 11,625 | 2.8% | 5.1% |
| All Others | 9,940 | 2.4% | 2.9% |
| Total | 413,555 | 100.0% | 100.0% |






## *Primary Service Area Demographic Snap Shot (continued)*

(All data has been taken from the New York State Department of Health at https://health.data.ny.gov/ and SLCH's information database)

Adults with a Disability

| Locality | n[1] | Yes %[2] | n | No % | C.I.[3] |
|---|---|---|---|---|---|
| Orange | 131 | 17.9 | 494 | 82.1 | 3.2 |
| Rockland | 110 | 16.1 | 495 | 83.9 | 3.2 |
| Westchester | 103 | 14 | 497 | 86 | 2.9 |

Key study findings for the LHV region include:

- A much higher percentage of providers than key informants indicated that the overall health and language needs of the immigrant population were being met in the target communities.
- Providers most frequently cited insufficient services for referral for mental health, dental, and legal issues.
- Providers/key informants identified housing, employment, finances and health insurance as key concerns in recent immigrants.
- Providers/key informants identified depression and alcoholism as common health issues in recent immigrants as did study immigrants.
- Only 50% of study participants had a "regular" provider and 73% had used a hospital ED in the past year.
- 50-75% of study immigrants reported their health providers spoke their language "little or not at all".
- 52.7% of study immigrants had insurance for themselves or a family member; 10.8% had no insurance for anyone in the family.
- Complementary and Alternative Medicine (CAM) use was prevalent and study immigrants expressed a lack of comfort in discussing this with their health care providers.
- Two out of five study immigrants reported a health problem and more than one-third rated their health as fair or poor.
- 25% of study immigrants reported chronic diseases, 20% infectious diseases (primarily TB), and 10% mental health issues.
- 40% of study immigrants reported their partners (mostly males) had never been to a doctor for a check-up.
- Almost half of study immigrants reported going to the doctor only when they were ill.
- Over 90% of study immigrants found it "difficult" for immigrants to live in their community.

(Data charts have been taken from the Orange County Department of Health)

## *Main Health Challenges*

According to the Orange County Department of Health, in the last 6 months, residents have seen a health care provider for the following health issues:

- Diabetes- 76% of population
- High Blood Pressure- 77% of population
- High Cholesterol- 62% of population
- Cancer or Cancer Screenings- 61% of population
- Heart Disease- 74% of population

Based on this information, SLCH has identified several health challenges that face the community of which our healthcare services extend to. Included with these challenges are associated risk factors which have been identified by the Department of Health. The main challenges are:

- Heart disease
- Cancer
- Stroke

Within these health challenges, there are other obstacles that are leading causes of these challenges including diabetes and obesity. These obstacles greatly contribute to SLCH's main health challenges. Other risk factors have a role in these diseases as well. These risk factors are listed on the next page.

**BEHAVIORAL RISK FACTORS:** The leading overall cause of death in Orange County has been linked to numerous behavioral risk factors. Individuals residing in the St. Luke's Cornwall Hospital/Newburgh communities generally have a high rate of death caused by specific behaviors including: alcohol and substance abuse, risky sexual behavior, diet and lack of activity and the lack of consistent medical care, including lack of primary and preventative care. Behavioral and Environmental risk factors account for about 70% of premature deaths in the US overall.

**ENVIRONMENTAL RISK FACTORS:** Factors such as tobacco smoke, pollutants and environmental allergens (ex. House dust mites, cat and dog dander) are environmental health risk factors associated with the challenged addressed by SLCH. These factors in addition to a lack of access to quality medical care and a lack of financial resources allow a disease to become difficult to manage on a long term basis.

**SOCIOECONOMIC FACTORS:** According to Healthy People 2010, NYSDOH, socioeconomic status, particularly poverty, appears to be an important contributing factor to asthma illness, disability and death. In 2008-2009, an EBRFSS was conducted for Orange County. This indicated that a total of 19.2% of those who participated were uninsured. There was a higher rate of uninsured males (22.7% as opposed to 15.6% of females). Those between the ages of 18-34 had the highest rate of all, with 31.7% uninsured. The lack of insurance in a community proves for a higher risk of mismanagement of a chronic disease.

**POLICY ENVIRONMENT** ***(smoke free parks, menu labeling, zoning for walkable communities, etc.):*** A variety of programs and organizations work to provide health information to the community. Of these programs include, Healthy Neighborhoods Program, which provides public health services to specific geographic areas identified with a high rate of environmental health needs and Healthy Orange which has implemented several worksite wellness programs which focus on healthier eating and physical activity. Events for the programs include walking events and clubs.

According to the New York State Department of Health, Chronic diseases are among the leading causes of death, disability and rising health care costs in New York State. They account for approximately 70 percent of all deaths in NYS and affect the quality of life for millions of New Yorkers, causing major limitations in daily living for about one in ten residents. Additionally, the rate of chronic diseases is rising steadily, increasing from 24 percent in 2001 to 28 percent in 2006, and in 2009 to 58 percent.

Due to the long duration and generally slow progression of chronic diseases such as cancer, diabetes, heart disease, stroke and asthma, consistent delivery of high-quality chronic disease preventative care and management proves to be the main challenge in relation to chronic diseases.
Though chronic diseases are among the most prevalent in NYS, they are often the most preventable. The World Health Organization has estimated that if the major risk factors for chronic disease were eliminated, at least 80 percent of all heart disease, stroke and type-2 diabetes would be prevented, and more than 40 percent of cancer cases would be avoided.

***The area of which SLCH will focus on for the Preventing Chronic Diseases Action Plan will be:***

- Increase access to high-quality chronic disease preventive care and management in clinical and community settings.

## *Summary of the Assets and Resources that Can Be Utilized to Address Health Issues*

SLCH has identified several resources that will be used to aid in addressing the health issues stated above. The resources that will be implemented include:

- SLCH Community engagement efforts for heart disease include thirteen engagements. Those events include medical staff speaking engagements, blood pressure screenings, conferences, and EMS respondent speaking engagements.
- SLCH is very active within the preventative cancer spectrum and annually carries the responsibility for providing; four breast screenings, one prostate screening, two colon screenings, two smoking cessation education, and two skin cancer screenings.
- SLCH provides two educational sessions per year about stroke and one general program on stroke.
- SLCH provides three programs regarding diabetes and educational information about healthy eating, diabetes prevention as well as obesity prevention.
- SLCH offers other programs including fall prevention, health maintenance screenings, information on Lyme disease, advancements in physical therapy, neck and back injuries, orthopedic emergencies, nutrition, etc.

## *Documents and Sources Used to Conduct the Assessment*

- Orange County Department of Health Assessment 2010-2013
- Orange County Department of Health Assessment results-2012, accessed on October 1, 2013
- Data pulled from SLCH data files, accessed on October 1, 2013
- Information gathered from the new York State Department of Health at ny.health.gov, accessed on October 9, 2013

**Partners for the assessment include:**

- Orange County Department of Health
- Orange County Regional Medical Center
- Bon Secours Charity Health System

**Methods to seek community input included:**

- Community/town forums and meetings
- Medical education seminars
- Physician presentations
- Health screening events

## *Prevention Agenda Area #1*
## *Prevent Chronic Diseases*

**Focus Area:** Increase access to high quality chronic disease preventative care and management in clinical and community settings.

Our focus has been to decrease exacerbation of chronic diseases and preventing unnecessary hospitalization. We have been able to reduce readmission by 5% in 2014, through work that has been completed in our Care Transitions Program. With this program, high risk patients (COPD, CHF and Diabetes) are managed by members of our team. The Coleman Model of Care is used with each patient, ensuring that they receive the proper follow up care when discharged from the hospital. Our team works closely to continue to manage the patient's needs in the community, ultimately preventing them from returning to the hospital for chronic illness. Our overall readmission rate is still around 12%. There is much work to be done to continue to enhance this program and reduce overall readmission rates at St. Luke's Cornwall Hospital, ensuring that our patients receive the right care in the right setting.

St. Luke's Cornwall Hospital has partnered with many organizations within our community for this initiative. The SLCH Care Transitions Team is very much a collaborative effort with our community partners, including the following:

a. Community health centers/federally qualified health centers
b. Health insurance plans
c. Government or community based-organizations-Housing
d. Government or community based organizations- Mental and Behavioral Health (including substance abuse)
e. Government or community based organizations- Social Services
f. Government or community based organizations- Transportation
g. Local coalition

In 2014, SLCH also developed the "Population Health Coalition," a partnership with more than 25 local organizations all focused on improving the health of the population served. The group meets quarterly to discuss how we can best collaborate on this initiative. Through the Population Health Coalition we are also reaching out to local schools and faith based organizations in the community. As part of the Care Transitions Program, we are also working with local home health agencies and certified nursing facilities. We are also working with the Office of the Aging to help transition our patients back into the community. They will check on patients and provide support as needed. Other partners include meals on wheels, ensuring that patients have enough food so they can still afford their necessary medications. We have also worked with patients to help them qualify for health insurance to afford their medications.

The overall engagement and excitement of all of our community partners is very high. Some of the areas we've noted great progress to date in include:

a. Identifying burden/problem to be addressed
b. Educating the community about the problem
c. Defining target population
d. Establishing clear implementation plan/timeline based on progress.

We've clearly identified that while we have numerous community programs geared towards the prevention of chronic diseases, communication is a challenge. We are working together on how to best spread the word on the resources available. One of the main challenges we face currently is developing data and disseminating results broadly through a variety of methods. St. Luke's Cornwall Hospital is looking into developing a Data Repository to house all of this information.

## *Prevention Agenda Area #2*
## *Promote Healthy Women, Infants & Children*

**Target population:** SLCH's Newburgh campus is located in the City of Newburgh, NY. In a study completed by Westchester Medical Center, the Hudson Valley (Orange County in particular) compared to the State of New York, indicates expectant mothers receive significantly less prenatal care within the first trimester. The study also suggests the infant mortality rate (per 1,000 births) is 0.6% higher in Orange County at 5.7% than the state average of 5.1%. This clearly identifies prenatal care as an area of improvement within the scope of our community health initiatives. SLCH has had 7,850 pregnancy related in-patients October 1, 2013 – September 30, 2014. 1,660 of those patients were admitted into the hospital for birthing reasons. 1,735 visits were of undisclosed reasons pertaining to pregnancy (pre/post-birth). 5% of the babies born here have been admitted into the SLCH Neo-Natal Intensive Care Unit (NICU).

The Birthing Center at SLCH works closely with two medical groups in the community: The Greater Hudson Valley Family Health Center and Crystal Run Healthcare. In addition, we also have a new lactation specialist who has joined our team. She works closely with all of our Birthing Center patients, and will be essential in improving this program.

St. Luke's Cornwall Hospital, in conjunction with our community partners began putting together the implementation plan for promoting healthy women, infants in children in 2014. We have engaged both medical groups who deliver at SLCH, to seek their guidance and input on how we can best improve this program at our community hospital. This will be a collective effort.

## *Progress to Date*

St. Luke's Cornwall Hospital has chosen to address the following disparities within this prevention area:

- Race/ethnicity
- Age
- Income/SES
- Education
- Geography

The goals and implementation plan for this prevention area are in the process of being finalized in 2014. We will begin tracking this in 2015. This priority area was identified after the 2013 community service plan was completed. The members of St. Luke's Cornwall Hospital staff are working closely with our community partners to ensure that programs and initiatives are put into place, and will be on track to meet targeted goals for 2015 now that an implementation plan has been put into place.

Through collaborations with various healthcare organizations and community organizations, SLCH will communicate with expectant parents and with the community at large. This pilot program will be communicated through public relations outreach, our credentialed obstetricians and with two initial community organization partners, The Boys & Girl Club of Newburgh and the Newburgh Armory Unity Center. After a successful pilot program, the collaborative efforts will grow to include, but is not limited to: Newburgh Enlarged City School District, the City of Newburgh, Newburgh Armory Unity Center, Mount Saint Mary College, Safe Harbors of the Hudson, SUNY Orange, the Boys and Girls Club of Newburgh, local ministries and other surrounding municipalities.

In all of our discussions, there has been great enthusiasm around enhancing the services provided to women, infants and children not only enhancing the patient experience when they are in the hospital, but also ensuring they are receiving the necessary resources and education in the community.

St. Luke's Cornwall Hospital will work closely with our community partners and staff to ensure that the needs of our community our met through this initiative.

## *In Summary*

It is important to note that throughout the last 12 months, as health care delivery continues to change and with the Delivery System Reform Incentive Payment Program beginning, St. Luke's Cornwall Hospital's partner list as noted in the 2013 Community Service Plan has largely expanded. Throughout 2014, we have teamed up with Skilled Nursing Facilities, Home Health Agencies, Federally Qualified Health Centers such as the Greater Hudson Valley Family Health Center as well as many other community providers to ensure that our patients are receiving the best care, in the most appropriate setting at the lowest possible cost.

In July 2012, the Care Transitions Coalition was formed at St. Luke's Cornwall Hospital with several other community providers. This coalition's focus remains: to provide seamless transitions for post-hospital management, enhance communication among providers, improve processes and outcomes in order to reduce preventable hospitalizations and preventable admissions, as well as avoid unnecessary emergency department utilization.

The SLCH Care Transitions Program was initiated in March 2014. In the first six months of the program 227 patients were enrolled in the program. This program currently encompasses three Care Transition RNs, one Health Coach, and an administrative assistant. The population that has been focused on to date for this program includes Congestive Heart Failure, Diabetes, COPD, and End Stage Renal Disease patients. Our team works with patients to transition them either to their home or a subacute facility, refer to other agencies, as well as intervene in the areas of medication reconciliation, Primary Care Physician referral and insurance exchange.

Of the 227 patients enrolled in the Care Transitions program, 11 (4.8%) were subsequently readmitted within 30 days to SLCH during this time frame. These 11 patients account for 19 hospital readmissions during this period (one of the patients is extremely non-compliant with all plan of care elements, and was readmitted 8 times).

In addition to the Care Transitions Program, SLCH has also implemented a strong focus on community health and the coordination between the hospital and community providers. In May 2014, the Community Health Coalition was created to bridge the gap between community health and education efforts occurring within St. Luke's Cornwall Hospital and our partnering organizations in the community. From this coalition, two subgroups were formed: Chronic Disease Prevention and a Data Repository group that would focus on the collection and distribution of data to serve as a resource for both patients and providers. In December 2014, it was realized that the combined synergy of the Care Transitions Coalition and the Community Health Coalition, to form a Population Health Coalition would enhance efforts and provide a stronger reach. To date, the Population Health Coalition has close to 100 members, all focused on working together to best coordinate care and improve the overall health of the population we all serve.

Throughout the year, SLCH has provided more than 65 educational series, lectures and screenings to the community, reaching more than 15,000 people in the community. We partnered with West Point Athletics to expand our reach with community education, providing information and blood pressure screenings throughout the 2014 football season.

**2014 Community Engagement**
**Master List**

| Stroke Education: | Requirements= 2 public education engagements per year | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date** | **Speaker** | **Affiliation** | **Topic** | **Audience** | **Location** | **# of people** | **Notes:** |
| 21-May | Beverly Keefer | Clinical Staff | Stroke: Signs, Symptoms | MSMC Women's Group | MSMC- Powell Ave, Newburgh | 20 | |
| 21-Aug | Beverly Keefer | Clinical Staff | Stroke: Signs, Symptoms | Marasco Senior Center | Marasco Senior Center- 555 Union Avenue, New Windsor | 15 | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **Cardiac Education:** | ***Requirements= none*** | | | | | | |
| 5-Feb | Beverly Keefer | Clinical Staff | Blood Pressure Screening | Community/Visitors | SLCH Newburgh Campus | 35 | |
| 12-Feb | Beverly Keefer | Clinical Staff | Blood Pressure Screening | Community/Visitors | SLCH Newburgh Campus | 25 | |
| 19-Feb | Beverly Keefer | Clinical Staff | Blood Pressure Screening | Community/Visitors | SLCH Newburgh Campus | 30 | |
| 26-Feb | Beverly Keefer | Clinical Staff | Blood Pressure Screening | Community/Visitors | SLCH Newburgh Campus | 15 | |
| 19-Feb | Beverly Keefer | Clinical Staff | Matters of the Heart | Women | Union Avenue Fitness Ctr. 565 Union Ave New Windsor | 10 | |
| 24-Feb | Beverly Keefer | Clinical Staff | Matters of the Heart | Community | Newburgh Recreation Center | 20 | Tri County Heart Walk |
| 3-May | Cardiac Team/Various | Clinical Staff | General Cardiac Health | Community | Harriman State Park | 100+ | |
| 5-Aug | Beverly Keefer | Clinical Staff | Blood Pressure Screening | Marasco Senior Center | Marasco Senior Center- 555 Union Avenue, New Windsor | 15 | |
| 6-Sep | ED Nurses | Clinical Staff | Blood Pressure Screening | Army Football | Michie Stadium, West Point, NY | 10,000+ | |
| 1-Nov | Dr. Mehud Patel/Beverly Keefer | Clinical Staff | General Cardiac Health | Army Football | Michie Stadium, West Point, NY | 10,000+ | |
| | | | | | | | |
| **Cancer Education:** | ***Requirements= Four breast screenings, 1 prostate screening, 2 colon screenings, 2 smoking cessation education, 2 skin cancer screenings*** | | | | | | |
| 21-Jan | Nora McCarthy | Nursing Staff | Breast Screenings/education | Community | Newburgh campus | 10 | |
| 4-Feb | Nora McCarthy | Nursing Staff | Breast Screenings/educati | Community | Newburgh campus | 10 | |
| 11-Feb | Nora McCarthy | Nursing Staff | Breast Screenings/ed | Community | Newburgh campus | 10 | |
| 18-Feb | Nora McCarthy | Nursing Staff | Breast Screenings/ed | Community | Newburgh campus | 10 | |
| 25-Feb | Nora McCarthy | Nursing Staff | Breast Screenings/ed | Community | Newburgh campus | 10 | |
| 6-Oct | Nora McCarthy | Nursing Staff | Self-Exam Education | Marasco Senior Center | Marasco Senior Center- 555 Union Avenue, New Windsor | 10 | |
| 25-Oct | Nora McCarthy | Nursing Staff | Breat Cancer Awareness | Army Volleyball | Gillis Field House-West Point, NY | 200+ | |
| ***Ortho Education*** | ***Requirements=*** | | | | | | |
| 12-Jun | Tracey Horan and Marco from OSM | Clinical Staff | Arthritis | Monroe Seniors | Monroe, NY | 85 | |
| 14-Aug | Dr. Kenneth Rauschenbach | Medical Staff | Arthritis | Cornwall Commun | Cornwall campus | | |
| 17-Sep | Dr. Kenneth Rauschenbach | Medical Staff | Concussion/Injury Prevention | Section IX Coaches | Valley Central High School | 20 | |
| 11-Oct | TBD/Tracey Horan | Medical Staff | General Orthopedics | Army Football | Michie Stadium-West Point, NY | 10,000+ | |
| **Men's Health** | | | | | | | |
| 20-Aug | Dr. Praneeth Vemulapalli | Medical Staff | OAB/Nocturia | Community | Howland Public Library-313 Main St, Beacon | 12 | |
| 13-Sep | Various Physicians | Medical Staff | Men's & Family Health Fair | Community | Newburgh Campus | | |
| 25-Sep | Dr. Jaspreet Singh | Medical Staff | Prostate Cancer | Marasco Senior Center | Marasco Senior Center- 555 Union Avenue, New Windsor | 15 | |
| 15-Nov | Dr. Jaspreet Singh/Dr. Praneeth Vemulapalli | Medical Staff | Prostate Cancer Awareness | Army Hockey | Tate Rink-West Point, NY | 1,500+ | |
| | | | | | | | |
| **Other:** | | | | | | | |
| 22-Nov | Wendy Cedar | Nutrition Staff | General Nutrition | Army Football | Michie Stadium- West Point, NY | 10,000+ | |