



2014 Community Service Plan

St. John's Riverside Hospital, known for its' closely integrated models of care, nationally recognized services and outcomes, and strong partners is uniquely positioned to meet the health care needs of its patients and community.

BORN IN THE 19TH CENTURY

EXCELLENCE IN THE 20TH CENTURY

LEADERS IN THE 21ST CENTURY

2014 COMMUNITY SERVICE PLAN

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1. HOSPITAL MISSION STATEMENT

The St. John's Riverside Hospital (SJRH) mission statement fully encompasses our purpose and affirms our commitment to health care and those we serve. Our mission is as follows:

St. John's Riverside Hospital is dedicated to providing comprehensive medical and nursing care in a compassionate, professional, respectful and ethical manner to every patient. By offering excellence in medical care, nursing, state-of-the-art technologies, continuing education and preventive services, we are committed to improving the care we provide within each of our institutions and the quality of life in our community. We are open to new ideas, directions and initiatives that most effectively respond to community health care needs.

2. DEFINITION AND BRIEF DESCRIPTION OF THE COMMUNITY SERVED

SJRH is a 378-bed acute care community health system comprised of the following service facilities, each with independent New York State Operating Certificates:

- ◆ Andrus Pavilion – (225 beds, general medicine, surgery, obstetrics, emergency services)
- ◆ Park Care Pavilion – (141 beds, behavioral health services)
- ◆ Dobbs Ferry Pavilion – (12 beds, general medicine, surgery, emergency services).

SJRH is part of the Hudson Valley Region within Westchester County. Our Andrus and Park Care Pavilions are located in and primarily serve the city of Yonkers. The Dobbs Ferry Pavilion serves the River town communities of Hastings-on-Hudson, Ardsley, Dobbs Ferry and Irvington. The communities served by our health system are wide spread and diverse. Since 1869, St. John's has served its community by providing convenient access to high quality acute, primary and specialty care to individuals and families living in a primary service area of twelve (12) zip codes surrounding its location. The zip codes that we most commonly provide services for are: 10701, 10703, 10704, 10705, 10706, 10710, 10502, 10503, 10522, 10523, 10530 and 10533. Five zip code areas in southwest Yonkers (10701, 10703, 10704, 10705, and 10710) have been federally defined as Medically Underserved Areas.

Yonkers is New York's 4th largest city, with a population of 195,976. Yonkers and surrounding service areas are estimated for population growth from our 2010 baseline (Table 1). It is an aging industrial city with needs often overlooked in a county dominated by affluent suburbs. Yonkers borders the Bronx and shares many of New York City's urban problems. Yonkers is part of the New York High-Intensity Drug Trafficking Area.* Homelessness, unemployment, poverty, drug abuse, street crime, AIDS, and domestic violence are problems concentrated in southwest Yonkers. *The High Intensity Drug Trafficking Areas (HIDTA) program, created by Congress with the Anti-Drug Abuse Act of 1988, provides assistance to federal, state, local, and tribal law enforcement agencies operating in areas determined to be critical drug-trafficking regions of the United States. Source: <http://www.whitehouse.gov/ondcp/high-intensity-drug-trafficking-areas-program>.

Table 1

State of New York, Westchester County	Population, 2010	Population, Estimate
Yonkers (city) 1	195,976	198,449 2012
Ardley (village) 2	4,452	4,484 2011
Dobbs Ferry (village) 2	10,875	10,949 2011
Hastings-on-Hudson (village) 2	7,849	7,904 2011
Irvington (village) 2	6,420	6,468 2011

- 1 Source: United States Department of Commerce, U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, County Business Patterns, Economic Census, Survey of Business Owners, Building Permits, Census of Governments - Last Revised: Thursday, 27-Jun-2013
- 2 Source: U.S. Census Bureau, 2010 Census (Population 2010); Source: U.S. Census Bureau, Population Division (Population Estimate)

Yonkers has always been a haven for immigrants. The 2010 Census showed that **31.1%** of all Yonkers residents were foreign-born and **46%** spoke a language other than English at home. With 67,927 Hispanic residents, Yonkers, has New York's largest Hispanic community outside NYC. Many of Yonkers' Hispanics are recent immigrants with limited fluency in English. Yonkers has 40,198 African-American residents, including Haitian and Dominican immigrants. Over 100 languages are spoken in Yonkers in tight-knit ethnic enclaves ranging from Albanian to Yemeni.

Yonkers' minority communities are growing rapidly. From 2000-2010 the number of African-Americans in Yonkers rose 12.3% and Hispanics rose 33.6%. Puerto Ricans and Mexicans are the two largest Hispanic communities. Many recent Mexican immigrants are from poor rural districts where illiteracy is common. Most of Yonkers' African-Americans and Hispanics are concentrated in 17 NYSDOH high-need census tracts (1.01, 1.03, 2.01, 2.02, 2.03, 3, 4.01, 4.02, 5, 6, 10, 11.01, 11.02, 12, 13.01, 13.02, and 13.03) in southwest Yonkers. These 17 census tracts have **42%** of Yonkers total population, but **65%** of its non-Hispanic African-American population and **66%** of its Hispanic residents. This high-need area has **82,959** residents and **66,176 (80%)** are African-American and/or Hispanic including 44,821 Hispanics and 21,355 non-Hispanic African-Americans.

Minority health disparities are magnified in southwest Yonkers. The New York State Department of Health (NYSDOH) reports key health data by zip code. The zip code areas 10701 and 10705 most closely align with the 17 high-need census tracts. These two zip code areas have 73,533 residents. The NYSDOH website reports the inpatient hospitalization rate in the 10701 and 10705 zip code areas for specific conditions by race and ethnicity compared to state-wide hospitalization rates for those conditions. In both zip codes the percentages of hospital admissions for the African American and Hispanic populations exceed state-wide rates.

Southwest Yonkers has been ravaged by the triple plagues of drugs, AIDS and homelessness. Crack cocaine swept through Yonkers like a wildfire during the 1980s. Arrests relating to the sale or possession of drugs in Yonkers increased by **482%** from 1982 to 1992, while arrests for the usage of cocaine and its derivatives (*i.e.*, crack) rose **1,325%**. The influx of drugs was soon followed by a wave of homelessness and by the rapid spread of HIV/AIDS. Southwest Yonkers rapidly became and remains one of New York State's major epicenters of the HIV/AIDS epidemic. Westchester has more people living with HIV/AIDS than any other New York county outside NYC. Yonkers in turn has more people living with HIV/AIDS than any other Westchester community. Our communities of color have been disproportionately impacted by HIV/AIDS. Hispanics comprise 19.8% of Westchester's population but **26%** of its HIV/AIDS cases. African-Americans comprise 14.4% of Westchester's population but **46.2%** of its HIV/AIDS cases. Yonkers' HIV and AIDS cases are disproportionately concentrated in southwest Yonkers (zip codes 10701, 10703, and 10705).

Westchester County has more homeless people than any other New York county outside NYC, with **1,611** people living in emergency or transitional housing as of August 1, 2013. This included 435 families and 723 children. Westchester County analyzed the communities of origin of its sheltered homeless population on April 1, 2011 and found that Yonkers accounted for **43.3%** of all homeless families and **30.5%** of all homeless childless adults in Westchester.

Our Dobbs Ferry facility is the only hospital located in the village of Dobbs Ferry, approximately 7 miles from its SJRH sister facilities in Yonkers. Its primary service areas include Dobbs Ferry, Hastings-on-Hudson, Ardsley, Irvington, Tarrytown, Elmsford, Hartsdale, Greenburgh, Yonkers, Scarsdale and White Plains. The total population of this service area is approximately 83,000. This area is defined by a population that is largely white and affluent.

3. PUBLIC PARTICIPATION

Needs Assessment – SJRH conducted its' first **Community Health Needs Assessment** (CHNA) beginning in 2012 and continuing into 2013. The area assessed was Westchester County including the targeted communities of Yonkers, Dobbs Ferry and its surrounding towns and villages. The CHNA was designed to reach broadly into the community, to identify health needs, gaps and barriers to health services. We have found that building partnerships especially in an environment of economic instability and budget deficits is critical. The collaborative process was beneficial in researching current health data, conducting health needs assessments with our communities, sharing of best practice interventions and leveraging of resources.

The St. John's Riverside Hospital CHNA was conducted by the SJRH leadership team in partnership with the Westchester County Department of Health (WCDOH) and its collaboration of health providers. Through research, data analysis, and health needs prioritization, the assessment process identified significant needs in the following New York State *Prevention Agenda 2013-2017* priority areas: Chronic Diseases Prevention;

Healthy Women, Infants, and Children; HIV Prevention; and Vaccine-Preventable Diseases. SJRH designed a three-year (2014 to 2016) **Implementation Strategy** with activities that align with our mission and strategic goals, to address these identified areas of community health need. The next Community Health Needs Assessment will be performed in 2016. With the guidance of the SJRH leadership team and identified partners; the goals, interventions and outcome measures defined in the Strategy, will be reviewed quarterly for the positive impact and improvement of the health needs of the community. The CHNA and Implementation Strategy were adopted by the SJRH Board of Trustees in December 2013. The final approved report is available to the public on the hospital's website www.riversidehealth.org.

a. Participants involved in assessing community health needs and their roles.

Leadership Team – The responsibilities of the leadership team included study and understanding of the requirements of the CHNA, initial strategic design for research and data analysis in the CHNA, prioritization of the results and preparation of the formal report.

Community Partners and Expert Input – We have found that building partnerships especially in an environment of economic instability and budget deficits is critical. The collaborative process was beneficial in collectively reviewing current health data, conducting health assessments with our communities, sharing of best practice interventions and leveraging of resources. SJRH worked with a broad range of community partners in our needs assessment and identification of priorities; they included providers such as federally qualified health centers, employers and businesses, community based organizations, regional planning organizations, governmental health agencies, housing, community based health and human service agencies, local schools and academia, policy makers, social media and consultants. We sought input through meetings, health forums, focus groups, surveys, educational sessions, written correspondence and through the hospital's community advisory board.

SJRH founded and facilitates the Healthy Yonkers Initiative (HYI), whose mission is to bring together neighborhood groups, service providers and faith communities to collectively identify and address Yonkers' health-related needs. The HYI partnership is mutually beneficial for all participants through: awareness of services, sharing of health information and data for planning purposes, program planning, implementation and evaluation of programs, coordination of outreach programs for the community, and provision of on-going outreach, and education and referrals to address relevant health issues. We recently partnered with the American Diabetes Association to enhance our employee wellness program at the hospital.

As the *only maternity service provider* in Yonkers, we provide obstetrical care to women referred from the Hudson River Health Care family practice prenatal clinic; Yonkers based St. Joseph's Medical Center; Planned Parenthood; local private obstetric physician offices and surrounding areas. Our breastfeeding initiative connects with a wide variety of local partners through the Hudson Valley Regional Perinatal Network for needs assessment, program planning and services evaluation. We participate in annual meetings and monthly webinars with the New York State Partnership for Patient Safety. St. John's works with the March of Dimes to distribute information on healthy moms, healthy pregnancies, and healthy babies. A St. John's Lactation Nurse consultant meets bi-monthly with prospective parents to provide information and education

on breastfeeding. Phone calls are made post discharge and additional in-person breastfeeding assistance sessions are provided as needed. A SJRH "Warm Line" is available 24 hours, seven days a week for breastfeeding help and other services. The following partners serve as referral sources for our patients: LaLeche International, Breastfeeding Solutions and Hudson Valley Breastfeeding.

Our HIV needs assessment included staff and clients from our HOPE Center HIV/AIDS programs, Tri-County Ryan White Part A Steering Committee, New York State Department of Health's AIDS Institute, Health Resources Services Administration, and the Tri-County Consumer Advisory Group Living Together. The HOPE Center has active planning and referral linkage agreements with the following community-based organizations and other local health-related organizations:

- Center Lane Youth Services of Westchester Jewish Community Services
- Congregations Linked in Urban Strategy to Effect Renewal (CLUSTER)
- Family Services of Westchester
- Grace Church Community Center
- Greyston Foundation
- Hospice and Palliative Care of Westchester County
- Legal Action Center
- Mt. Vernon Hospital's HIV/AIDS Treatment Center (as of November 2013 Montefiore Hospital)
- Open Door Family Medical Center, Inc. (Community Health Center)
- Planned Parenthood Hudson Peconic, Inc.
- Purchase College
- Sharing Community
- Urban League of Westchester County, Inc.
- Visiting Nurse Services in Westchester and Putnam
- Volunteers of America – Greater New York
- Westchester Medical Center

Our staff of three community outreach liaisons rotates facilities to develop closer ties between the hospital and the communities it serves, including Yonkers, Dobbs Ferry, Hastings-on-Hudson, Tarrytown, and others. On a daily basis they are working to develop community relationships to improve the health of the populations of Yonkers and the surrounding towns by determining what the needs are through local agencies, organizations, churches, schools, housing developments and community and physician offices. To attain higher levels of health and wellness, St. John's aims to be the resource to all communities by teaching, measuring case findings, and developing needed services and supports.

SJRH has consistently committed resources to reach and serve the health needs of its population. With the recent change in hospital leadership and increased commitment to population health advances, we are better positioned to make strides in health prevention and improvement. We have the ability to meet with the public, have an open dialogue, visit our primary care physician offices, and better listen to their concerns and needs. Through 2012 to 2014 we assessed the needs of our community and disseminated hospital services information by:

- Partnering with our local health department,
- Working closely with many community-based organizations, primarily through our Healthy Yonkers Initiative,
- Meeting with elected officials to seek support and advise them of our findings,
- Engaging the hospital's community advisory board, employers, businesses, local governmental organizations, health care partners, media, Yonkers Public Schools, PTA Coordinating Council, and faith-based organizations.

The communications and relationships developed are the groundwork for cooperative and more sustained education and clinical guidance to improve the health of Yonkers, Dobbs Ferry and surrounding area residents.

b. Dates and a description of the outcomes of the public input process, discussion of barriers or gaps in services.

The St. John's Riverside Hospital Community Health Needs Assessment (CHNA) was designed to provide broad community input from both research and analysis of existing data. The foundation of the assessment and resulting implementation strategy was strengthened by decades of partnering with community organizations and residents. We formally collaborated with the Westchester County Department of Health (WCDOH) in the implementation of our CHNA, determination of priorities, and development of interventions.

Our CHNA revealed that the factors affecting health and access to health care resources, do not directly relate to any lack of resources in health care delivery; but instead include a host of factors which influence an individual or a families ability to access those things necessary to maintain good health or to access health services when in need. Broadly they include: poverty, employment status, adequate insurance, transportation, cultural perceptions, family stress and lack of knowledge or comfort with the current model of health care delivery.

The following sections describe methods utilized to involve the public in assessing community health needs and associated outcomes:

Planning Meetings – SJRH's public input process, discussion of findings and potential health improvement initiatives, involved the following collaborations: WCDOH's Health Planning Team and Health Summit, WCDOH Healthy Hospital's Collaborative, Healthy Yonkers Initiative, SJRH Community Advisory Committee, and the maternity and HIV partnerships.

SJRH along with other area hospitals participated in the Westchester County Department of Health's **Healthy Hospitals Collaborative Prevention Agenda Initiative** led by the County Commissioner of Health. Sessions gave the opportunity for area hospitals to discuss *Prevention Agenda* priorities, feedback from their public needs assessments, services provided and gaps in services. We were able to rotate the meetings to

participating hospitals' sites, where we had the opportunity to share community health improvement evidence-based strategies and best practices. Site tours were also provided.

Healthy Yonkers Initiative: HYI holds regular quarterly meetings. Recent meetings include:

- March 20, 2014 at St. Joseph's Medical Center
- June 19, 2014 at the Yonkers Riverfront Library
- September 18, 2014 at The Chema Center
- December 18, 2014 at St. John's Riverside Hospital

Each HYI sub-committee reports at the quarterly HYI meetings. The committees are:

- Partnership for the Elderly/Livable Communities Coalition,
- Early Childhood Initiative (ECI),
- Yonkers 55 Plus / Yonkers on the Move,
- Diabetes Initiative,
- Yonkers Public Schools, and the
- Yonkers Community Planning Council.

The meetings feature speakers who present information and facilitate discussions of community needs and resources. Recent speakers included the following representatives:

- Westchester Hispanic Coalition
- American Diabetes Association
- Westchester County Office for the Disabled
- City of Yonkers
- American Lung Association
- Yonkers YMCA's new CDC-funded Racial and Ethnic Approaches to Community Health (REACH) project called Yonkers Healthy Connections for L-Y-F-E (*Living Your Fullest Everyday*).

All other meetings and community events bring the healthcare needs of the community to the forefront of discussion multiple times during the year, and encourage participants to share their opinion on the health of our community and address any gaps in services with their constituents.

A meeting held in June 2014 between SJRH and the **Hudson Valley Regional Perinatal Network** gave the opportunity for a formal discussion of perinatal needs across the region, services provided, and discussion of barriers or gaps in service.

HIV/AIDS – Our multi-faceted HIV needs assessment process included the following activities:

- Yearly consumer satisfaction surveys (and analysis) with follow-up key informant interviews and focus groups on specific items highlighted by consumer input. The last survey was conducted in 2013. Items addressed had to do with client perception of HOPE Center services and potential areas of increased needs. Client participation in 2014 is through a random sample of HOPE's clients.
- Client participation in 6 HOPE Center Performance Improvement (PI) meetings per year. These meetings provide client input into HOPE's yearly PI plan that was developed in early 2013 and was re-designed for 2014. Goals of the PI plan are in congruence with this plan.
- Attend and participate in Ryan White Part A Steering Committee meetings per year (meetings are held monthly). This group includes participation and input from the Tri-County Consumer Advisory Group, Living Together. This group is convened by the Westchester County Department of Health. Clients in this group continue to work to achieve a better understanding of the new reimbursement strategies.
- Ongoing participation in the state and nationally funded 'in+Care' quality improvement project including clients, NY State Department of Health and HRSA, HIV/AIDS Bureau. (Monthly)
- Conference calls with HRSA HIV/AIDS Bureau. (Monthly)
- Meetings with clients regarding the "Getting to Zero" (reduction in community viral load) project. These meetings are to help clients understand the need for a reduction in the community viral loads and seek client input on ways to reach a lower community viral load. Major input had to do with clients not understanding how their individual viral load would impact the community viral load.
- Numerous educational events on the Affordable Care Act (ACA) for staff and one to one education of all clients who are now newly eligible to access Medicaid and/or NY State of Health resources. (Educating clients and guiding them through the enrollment process).
- Client participation through Treatment Adherence group and Hepatitis C group (every month, 2014). Input is obtained in both groups on client priorities for programming. Clients decided to discontinue Treatment Adherence Group in 2014.
- In 2014, ongoing client participation through the SAMHSA-funded TCE/HIV grant program. This included client satisfaction surveys and an internal evaluation.

Forums – SJRH has partnered with local New York State **Assembly member Shelley Mayer** to offer open forums to present health information and to discuss how the Affordable Care Act can best be used to support population health needs. The forums are an educational force to make people aware of the health supports available.

To further enhance our assessment of HIV needs in our area, we collaborated with the **Latino/Hispanic Health Equity Initiative**. Their organizational goal is to achieve health equity through education, collaboration and action. This regional forum plays a valuable role in engaging partners throughout New York State to address racial and ethnic health related disparities. Members of the Latino/Hispanic community and their partners discuss and identify key challenges to living healthy and addressing health issues in different regions of New York State. It provides a forum to learn directly from the Latino/Hispanic community about the issues affecting their health. The forums succeed in bringing together partners who

could collaborate and share existing resources within the Latino/Hispanic community to address issues. The information obtained through open forum discussion among key stakeholders is beneficial in designing our community action plans.

Focus Groups – The SJRH **Community Advisory Committee** has been very enthusiastic in working with the hospital to better integrate the delivery of care with the health needs of our local community. The group met on February 11 and June 17, 2014 and one meeting was devoted to review and analysis of service area demographic and hospital data; discussion of the needs of the community; and identification of community partners. Feedback was solicited in that meeting and over the course of the year. Members were encouraged to share information provided in these sessions with their community groups and businesses.

The SJRH Community Advisory Committee members represent the following: Yonkers Public Schools, Yonkers Parent Teacher Association, Yonkers Historical Society, Yonkers City Emergency Management Services, Yonkers Chamber of Commerce, local attorney, local politician, physician, local business owner, ambulance services, clergy member, neighborhood community center leader, local residents.

In 2014, the Advisory members reviewed the *Prevention Agenda* priorities, had open discussion about health concerns within our community and made the following recommendations:

- Provide health information to the public, as broadly as possible, through disseminated information such as handouts, educational programs and health fairs,
- Focus on women and child health issues,
- Provide preventive health materials to city residents on chronic diseases such as diabetes, asthma, and heart disease,
- In addition to the areas cited, access and affordability was an underlying theme for all areas. Access to health care seems to be primarily limited by lack of insurance and higher deductibles; however, barriers to access can also be transportation, education and cultural norms. Affordability of medications is universally acknowledged as an issue. The burden of local businesses providing health insurance was mentioned. Challenges also include language, customs, lack of diversity in provider groups, the limited understanding of how the current health care system works and the concern about isolation of members of new immigrant groups emerged.

Surveys – Over 3,000 community members representing our primary and secondary service areas were identified to participate in an **online survey** using Survey Monkey, an online survey platform. The link to the survey is on our Facebook and website page. It is being promoted on each nursing unit, on the facility lobby televisions and at hospital-sponsored community events. The web-based survey consisted of ten (10) questions aimed to solicit information about the community's perception of need about health concerns and access to health services.

Data Gathering – To ensure the most accurate demographic information and community health concerns, data was gathered from numerous sources. In addition to information obtained through forums, focus groups and surveys, data analysis was conducted utilizing national, state and local community health databases.

The type of data used includes demographic, socio-economic, and health care data from a wide range of internal and external sources including:

- US Census Bureau
- Centers for Disease Control (CDC) and Prevention's Behavioral Risk Factor Surveillance System (BRFSS)
- CDC's National Center for Chronic Disease Prevention and Health Promotion
- National Center of Health Statistics
- New York State Prevention Quality Indicators
- Greater New York Hospital Association
- Westchester County Department of Health
- City of Yonkers Region Profile (Appendix L)
- St. John's Riverside Hospital Internal Data.

c. Public notification of these sessions.

SJRH sends consistent notification of sessions held through our hospital website, Facebook page, Twitter, YouTube, targeted mailings and printed materials posted throughout our three campuses. A community outreach team distributes information daily to our private practice physician offices. Notification of our patient satisfaction survey is sent by a third party provider. Our community health needs assessment survey, also available in print, is emailed to the community via Survey Monkey, and links to all surveys are posted on Facebook and the website homepage.

Our Healthy Yonkers Initiative (HYI) holds regularly scheduled quarterly meetings. The schedule of upcoming meetings is announced during the meetings, handouts are distributed, and email reminders are sent out. Agendas are used to notify committee members of topics that will be discussed at the meeting and members are welcome to propose additional items for presentation or discussion. The HYI partnership is an open forum where committee members take the opportunity to invite their clientele and other community residents that may benefit from the process. Several of the HYI subcommittees have volunteers that help to support our efforts. Their participation in other circles, i.e. the Yonkers public schools, helps us to expand and increase our reach into the local community. Notifications for 'Speakers' Bureau' events are relayed face to face during actual sessions and by select mailings to community members.

A variety of key stakeholders facilitates and publicizes HIV/AIDS planning meetings. The Westchester County Department of Health facilitates Ryan White Part A Steering Committee meetings. Living Together facilitates Tri-County Consumer Advisory Group meetings. The NY State Department of Health's AIDS Institute facilitates Quality Improvement Committee meetings.

The U.S. Department of Health and Human Service, Health Resources and Services Administration (HRSA) HIV/AIDS Bureau convenes monthly conference calls with its funded agencies. SJRH's HOPE Center conducts our annual consumer satisfaction survey, follow-up informant interviews, and focus groups. Our HOPE Center also convenes our Performance Improvement, "Getting to Zero", Treatment Adherence, and other *ad hoc* group meetings. Notifications of meetings are through flyers to all of HOPE's clients.

4. ASSESSMENT AND SELECTION OF PUBLIC HEALTH PRIORITIES

Process and Methodology – Our community's needs were identified and prioritization of those needs was established as part of a county-wide planning process facilitated by the Westchester County Department of Health's Health Planning Team. SJRH is an active participant in the Health Planning Team. Participating hospitals and health centers helped guide the CHNA process by providing community input into the design of its framework and implementation plan. The public input process encompassed the following primary collaborations: WCDOH's Healthy Hospital's Collaborative, Health Planning Team, and Health Summit; Healthy Yonkers Initiative; SJRH Community Advisory Committee, and the maternity and HIV partnerships.

SJRH, other hospitals and health centers in the county had ongoing collaboration with the WCDOH on review of data, assessment of public health needs and selection of community health improvement projects. The New York State *Prevention Agenda 2013-2017* assisted in guiding our collaboration in development of our plan around community health improvement priorities that are consistent with the population health principles embodied in Federal and State health care reform. SJRH utilized data from the following sources:

- WCDOH Planning and Evaluation health data profile of Prevention Agenda Priority Areas, Westchester County, 2013-2017,
- County Health Rankings – www.countyhealthrankings.org/,
- New York State and Westchester County Community Health Indicator Reports (CHIRS) – www.health.ny.gov/statistics/chac/indicators/.

Following review of this data and results from a myriad of community health assessments conducted by SJRH, we prioritized needs and developed a plan.

Over the past year, SJRH has experienced significant public involvement and enthusiasm, as community relationships were fortified and new ones were established with numerous health-related associations. To ensure a broad assessment of our community health needs we engaged a variety of participants including, but not limited to, the community at large through local residents participating in SJRH *Speakers Bureau* health education programs. We shared health data and sought feedback through the following SJRH groups: Community Advisory Committee, Employee Wellness Committee, Pastoral Care Committee, Radiology Advisory Committee, Physician Alignment Committee, Board of Trustees and our employees. SJRH also gathered

information from external sources by conducting public forums at the Cross County Shopping Center in Yonkers, New York and other health sessions held at select locations to address the community that represented the diverse population that we serve. St. John's Riverside Hospital receives input from the community and patients through periodic patient satisfaction surveys, sent by a third party provider. Patient experience feedback is also captured through traditional compliment and complaint letters received through administration.

The following is a description of the collaborative process with the WCDOH, review of current health data, identification and prioritization of needs for our health improvement plans.

Westchester County Department of Health – Health Planning Team

***“Working together toward a healthier Westchester”* January – October 2013**

In January 2013, St. John's Riverside Hospital along with other area hospitals and health centers partnered with the Westchester County Department of Health to work together on assessing community needs, identifying at least two local priorities, one of which should address a health disparity, and developing a plan to address the identified priorities.

To help support and coordinate this collaboration, the Westchester County Department of Health (WCDOH) invited sixteen Westchester County hospitals and health centers to attend a kick-off meeting on January 31, 2013. In addition, the three Federally Qualified Health Centers were also invited to attend. The meeting was held at the Westchester County Department of Health (10 County Center Road in White Plains).

At the first meeting Sherlita Amler, MD, Westchester County Commissioner of Health, welcomed all participants to the meeting. WCDOH provided a brief team overview of the prior planning process and the new requirements for both the health department and the hospitals specific to the development of community health assessments and community health improvement plans. The Health Planning Team supported working collaboratively on this project and during the past ten months we demonstrated our commitment by attendance at monthly meetings, participating in two conference calls and hosting a Health Summit entitled “Working Together Toward a Healthier Westchester”. In addition, the team has shared information, resources and updates through email and phone calls.

The team met monthly and conducted an extensive review of all the health indicators contained in the Prevention Agenda. For each indicator, the team reviewed whether the County was below, meeting or exceeding the state established targets/goals, the estimated number of people affected by each indicator (when available), the County's overall ranking for the indicator compared to other New York Counties, and the performance range within the State. The team often requested the Westchester County Department of Health to provide additional reports/analysis, including data at a sub-County level to allow a more complete understanding of the problem.

The team developed an agency profile that was distributed to community partners. The profile requested each agency to provide general agency information, such as hours of operations, office locations and service areas, as well as to include current activities, training and policies in place to support the selected priorities and any new activities planned. The team also invited community partners to a half-day summit that was devoted to sharing current activities/programs and to discuss what could be done to address the selected health priorities.

Identification of four (4) major goals in three (3) prevention priority areas for our Plan:

SJRH collated and summarized the results from the WCDOH Health Planning Team, community forums, focus groups, and surveys. Several major areas emerged as strong community needs and were presented to the SJRH Leadership Team and Community Advisory Committee for review, comment and prioritization. After presentation and discussion of key areas, participants were encouraged to rank each identified area based upon two criteria: 1. The importance or impact that areas had on community need and 2. How strongly the area correlated with SJRH strengths as a health care system. Hence, two additional priorities were chosen as part of our plan, prevention of HIV and Hepatitis C Virus (HCV) due to the occurrence and intensity of these diseases in our service area. The prevalence of HIV/AIDS in Yonkers, NY, primarily southwest Yonkers, has one of the highest rates of HIV infection in NY State and within our HIV population approximately 30%* are dually diagnosed with Hepatitis C (*HOPE Center statistical data, 2012).

Priority 1: Prevent Chronic Diseases

- Focus Area: Increase access to high-quality chronic disease preventive care and management in both clinical and community settings
 - **Goal # 1: Promote culturally relevant chronic disease self-management education.**

Priority Area 2: Promote Healthy Women, Infants, and Children

- Focus Area: Maternal and Infant Health
 - **Goal # 2: Increase the proportion of babies who are breastfed.**

Priority Area 3: Prevent HIV, STDs, Vaccine-Preventable Diseases, and Health Care-Associated Infections

- Focus Area: Human Immunodeficiency Virus (HIV)
 - **Goal # 3: Increase early access to and retention in HIV care.**
- Focus Area: Hepatitis C Virus (HCV)
 - **Goal # 4: Increase and coordinate HCV prevention and treatment capacity.**

In addition to a thorough review of the data, the priorities selected included consideration of priorities that were attainable and that aligned with each agency's mission and service area. With the diversity and the number of hospitals in the County, it was quite challenging for the team to select its priorities especially when for a number of indicators the data revealed only certain parts of the County being impacted.

After careful deliberation and discussions, the following two priorities were selected:

1. Increasing Breastfeeding
(Focus Area: Promote Healthy Women, Infants and Children)
2. Decreasing the Percentage of Blacks and Hispanics Dying Prematurely from Heart-related deaths
(Focus Area: Prevent Chronic Disease)

Southwest Yonkers and Westchester County data were compared for the purpose of addressing the needs in our service area.

Percentage of Infants Who Were Exclusively Breastfed in the Hospital after Birth by Region, Westchester County, 2008-2010. Southwest Yonkers had 34.6 percent of infants who were exclusively breastfed in the hospital as compared to 54.2 percent of infants in Westchester County.

Percentage of Premature* Deaths by Region, Westchester County, 2008-2010. Southwest Yonkers (Y) 22.9% as compared to Westchester County (W) 20.0%; White Y 18.2 vs. W 16.3; Black Y 45.4 vs. W 36.7; Hispanic Y 49.6 vs. W 46.9 and Asian/Other Y 44.0 vs. W 40.3.

Annual Average of Premature Deaths, 2008-2010, Percentage of Premature Deaths by race. Total WC 22.0, White 16.3, Hispanic 46.9, Black 36.7 and Other 40.3. (Average age of death 77.2, 79.1, 62.6, 69.1, 65.9 respectively). *Premature as defined less than 65 years of age.

More than 50% of respondents to the ***SJRH Community Health Needs Assessment Survey*** administered via Survey Monkey (November 2013) indicated chronic diseases as the most important health issue facing our community today.

The team developed an agency profile that was distributed to community partners. The profile requested each agency to provide general agency information, such as hours of operations, office locations and service areas, as well as to include current activities, training and policies in place to support the selected priorities and any new activities planned. The team also invited community partners to a half-day summit that was devoted to sharing current activities/programs and to discuss what could be done to address the selected health priorities.

Two additional priorities were chosen as part of our plan, prevention of HIV and HCV due to the occurrence and intensity of these diseases in our service area. The prevalence of HIV/AIDS in Yonkers, NY, primarily southwest Yonkers, has one of the highest rates of HIV infection in NY State and within our HIV population approximately 30%* are dually diagnosed with Hepatitis C (**HOPE Center statistical data, 2012*).

5. THREE YEAR PLAN OF ACTION

Priority Areas, Goals and Interventions

PRIORITY 1: PREVENT CHRONIC DISEASES

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

GOAL #1: Promote culturally relevant chronic disease self-management education.

The SJRH CARE TRANSITION COACH PROGRAM was introduced in 2012 to reduce recidivism and facilitate transition from in-patient stays at Andrus Pavilion to home for patients with chronic medical condition. This patient-centered and home visiting program addresses the needs of the patients who are not provided sufficient primary care options in our medically underserved area of Yonkers. Nurses and Case Managers, in collaboration with the Care Transition Coach who is a Spanish speaking registered nurse, identifies patients who would benefit from the program. The program is the first and only one in Westchester County. It is a co-jointly implemented program between the Visiting Nurse Association of Hudson Valley and St. John's Riverside Hospital. There is no charge for patient participation in the program.

The role of the coach is to "steer" the patient to be more self confident and better able to manage their own health care, become self advocates with their healthcare provider, provide self-care and capably make decisions about their own health care needs. The role of the coach is to develop self confidence and awareness of one's health status and any changes in that status so as to make informed self-care decisions and manage health status more effectively. The coaching program also helps patients communicate more effectively with their healthcare providers and will increase satisfaction with care received as well as avoid returns to the Emergency Department (ED) that are not needed.

Interventions:

- Patients with chronic diseases such as Congestive Heart Failure (CHF), Cardiac Disease, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, and Renal Disease, who have frequent re-hospitalizations or are at risk for such, will be referred to the transition coach. Includes the caregivers for patients with dementia.

The Coaching of the patients and family members is based on the Coleman Transition Intervention. Coaching begins in the hospital setting. Once the patient is discharged, the Care Transition Coach will make 1-2 home visits, usually within 24-48 hours after discharge and 1-2 weekly telephone calls for 30 days.

- Coach will focus on key factors to preventing readmission: Medication Reconciliation---compare discharge instructions with prescriptions and drugs at home; Personal Health Record---provide and teach use of booklet where patients can keep medical information and medication lists in one place; Physician Visit Within Seven Days---schedule appointment for the patient and prepare list of questions; Red Flags---teach patient to identify early warning signs that indicate need for follow-up with MD with a focus to avoid re-admission.
- Measure rate of recidivism to the Emergency Department including recidivism for Acute Myocardial Infarction (AMI), CHF and Pneumonia.
- Measure readmission rate for those that refused the service.
- Analyze barriers to the success of self-management.

Objective 1:

SJRH Care Transition Coach to assess an additional 75 patients, discharged from the inpatient setting to home, to provide culturally relevant chronic disease self-management patient education sessions (An additional 20 in 2014, 25 in 2015, and 30 in 2016) – Baseline 2012: 144 patients educated.

2014, additional (5) patients to be assessed per quarter through the SJRH Care Transition Coach Program.

Outcome: (2013 = 170 patient encounters) (2014 = 241 patient encounters - an additional (17) patients per quarter from 2013).

Improvements/Action Plan: In-hospital or other setting visits prior to home visit - Assistance to enhance follow-up care and communication with Primary Care Physician - Addressing Patients on Coumadin - Nurse Education and Follow-up - Program Marketing - Improve Meditech Access - Provide on-site Space for Coach - Improve Discharge Medication List - Increase Staff Education re: Care Transitions - Increase Patient Acceptance Rate.

Challenges: Palliative Care and Home Health Agency connections.

PRIORITY 2: PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

FOCUS: Maternal and Infant Health

GOAL #2: Increase the proportion of NYS babies who are breastfed.

According to the Office on Women's Health, U.S. Department of Health and Human Services, breastfeeding is essential to a child's development. Breast milk is rich in nutrients and changes as a baby matures. Babies that are breastfed receive the necessary hormones and antibodies that fight off long term illness. It has been proven that formula-fed babies have a higher risk of ear infections, asthma, obesity, Type 2 diabetes and other diseases. (Source: <http://www.womenshealth.gov/breastfeeding/why-breastfeeding-is-important/index.html>).

Objective 1:

Increase the percentage of SJRH-born infants breastfed in the hospital by 10% to 64% (By 2% in 2014, 4% in 2015, 4% in 2016) – Baseline 2012: 54%.

Outcome: January – December 2014 = 60% (An additional 6% from 2012).

Objective 2:

Reduce disparity by 3% by 2016: Ratio of Black and Ratio of Hispanic to White percentage of infants exclusively breastfed in the hospital (By 1% in 2014, 1% in 2015, 1% in 2016) – Baseline 2012: Black 14%, Hispanic 10%, White 20%. Disparity gap: Black 6%, Hispanic 10%.

Outcome: To be updated with data from the 2015 NYS Annual Report.

Improvements/Action Plan: Distributed Breastfeeding Bill of Rights upon Admission - Promoted Skin to Skin & Breastfeeding in Labor & Delivery - Encouraged Rooming-In - Continued practice of NOT placing pacifiers & bottles in Cribs of Breastfed Babies - Removal of magazines that contain formula coupons or advertisements - Enhanced Follow-up Phone Call Protocol - Developed internal report to track exclusive Breastfeeding by Race - Partnered with NYS "Great Beginnings NY" Campaign - Participate in NYC & WCDOH Initiatives.

Challenges: WIC restriction of formula and other supplies if mother states that she is breastfeeding. Data measure for exclusive breast feeding is not acceptable if the mother uses formula (1) or more times while in the hospital.

The SJRH Health System encourages mothers to breastfeed their infants. In 2012 we made progress, increasing the number of new mothers who did breastfeed their infants at least some of the time from 44% in 2011 to 54% in 2012. We are focused on reducing racial disparities in the *breast-only* feeding rate. Table 2 shows that our

African-American patients in 2011 and 2012 were less likely to give their children the health benefits of exclusively breastfeeding as compared to White patients. Hispanic patients exclusively breastfeeding from 2011 to 2012 decreased by 50%. In 2011 the percentage of Black mothers at SJRH who breast-fed solely was 11% as compared to whites at 22%, 2012 14% as compared to 20% and Hispanic mothers only 10% as compared to 20% of White mothers.

Table 2: Feeding type by Race at St. John's Riverside Hospital (Source: EBC)

		Raw Numbers						Percentages		
		Breast Milk Only	Formula Only	Breast Milk and Formula	Total			Breast Milk Only	Formula Only	Breast Milk and Formula
2011	Black	37	181	127	345	2011	Black	11%	52%	37%
	White	73	141	118	332		White	22%	42%	36%
	Hispanic	178	224	411	813		Hispanic	22%	28%	51%
	Other	14	29	42	85		Other	16%	34%	49%
	Year Total	302	575	698	1575		Year Total	19%	37%	44%
2012	Black	43	114	144	301	2012	Black	14%	38%	48%
	White	57	100	123	280		White	20%	36%	44%
	Hispanic	77	233	449	759		Hispanic	10%	31%	59%
	Other	9	25	56	90		Other	10%	28%	62%
	Year Total	186	472	772	1430		Year Total	13%	33%	54%

**PRIORITY 3: PREVENT HIV, STDs, VACCINE-PREVENTABLE DISEASES, AND HEALTH CARE-
ASSOCIATED INFECTIONS**

FOCUS: Human Immunodeficiency Virus (HIV)

GOAL #3: Increase early access to and retention in HIV care at SJRH.

St. John's Riverside Hospital is the only NY State Designated AIDS Center in Yonkers and provides Yonkers' only dedicated and comprehensive HIV-related primary care services. Our program currently provides 334 HIV-positive individuals with a comprehensive array of services including primary HIV-related health care, comprehensive care management/care coordination, dental care, treatment adherence services, and psychiatric and social work services.

Objective 1:

Increase the number of return people: who are lost to follow-up and return to HIV-related primary care; who know their HIV status and enter care at the HOPE Center; who are newly diagnosed and enter care for the first time at the HOPE Center by 15 to 71 during the period 2014-2016 (additional 5 in 2014, 5 in 2015, and 5 in 2016) – Baseline 2012: 56.

In 2014, increase # of return people; lost to follow-up and return to HIV-related primary care; that know their status and enter care at the HOPE Center by (5) - 15/Qtr.

Outcome: 2014 = 64, an additional (9) people.

Improvements/Action Plan:

- Continued existing linkage agreements and outreach efforts to community partners to ensure that HOPE continues as the primary referral source for HIV-related primary care in Yonkers, NY, particularly the zip codes of 10701, 10703 and 10705.
- Instituted more use of social media, particularly Facebook, to enhance at-risk community's knowledge of the resource.
- In keeping with the goals of the Department of Health and Human Service's HIV/AIDS Bureau, continue HOPE Center's existing efforts to outreach and provide early intake into HIV primary care for individuals newly diagnosed with the virus and continue to use the Ryan White Part C funded resources to re-engage any clients who are lost to follow up.

Objective 2:

Increase percentage of newly enrolled HIV patients attending all appointments during the 12-month period by 4% to 92% by 2016 (By 2% in 2014, 1% in 2015 and 1% in 2016) – Baseline October 2013: 88% (National average is 60% and Top 10% of performers nationally average 100%).

Outcome:

2014 New Patient Retention Data

- Final retention rate for Segment 1 / January 1, 2014 – April 30, 2014 = 93% (30/32)
(Exceeded 2014 target by 3%).
 - 5/1/14 – 8/31/14 - N=17, 100% (17/17) have attended appointments during the 2nd trimester.
 - 9/1/14 -12/31/14 –N=15, 87% (13/15) have attended appointments during the 3rd trimester.

Improvements /Action Plan:

- Provided the first appointment to all HIV positive clients within less than five days of the person's first contact with the HOPE Center.
- Continued existing Ryan White Part C funded retention in-care efforts and ensure appointment success throughout the first year.
- Tracked all new/reopened patients for the first year in care and ensure appointment success throughout this first year.

Objective 3:

Increase percentage of clients receiving HIV primary care services through HOPE Center who obtain viral load suppression by 5% to 81% in 2016 (By 2% in 2014, 1% in 2015 and 2% in 2016) – Baseline as of October 2013: 76% (National average is 25%; Hudson Valley Avg. 41%).

Outcome: Exceeded 2014 target by 2% = 78%

Improvements/ Action Plan: Increased linkage agreements and outreach efforts. HOPE Facebook page created Qtr. 4 of 2013, As of March'14 – 76 'Likes'; Total reach 113 people.

Interventions:

- Provide targeted medication adherence support services to all clients who are beginning or changing medication regimens. Continue access to grant funding to ensure that such services are available.
- Continue to implement the "Getting to Zero" initiative within HOPE Center to build client knowledge of and support for efforts to increase medication adherence.

- Utilize the opportunities presented through the Affordable Care Act to assist uninsured and eligible HIV-positive clients to obtain insurance services through Medicaid, Medicare or the New York State Department of Health portal. Provide opportunities for and enroll all clients who qualify for medical insurances (including Medicaid) to access these resources so that there are no interruptions of coverage that impacts their access to medications.
- Continue to obtain Ryan White Parts A, B and C funding to support the hospital's ability to provide this comprehensive continuum of HIV care, including early intervention services. Continue to seek other funding sources for services to immigrants who are not yet qualified to access insurance coverage through Medicaid or other insurance products.
- Continue to seek and obtain at least \$976,000 in HIV-related grant funding per year to provide a continuum of HIV-related care services for people in Yonkers, N.Y.
- Continue to meet all grant goals and objectives (programmatic and fiscal) in order to assure good standing on all federal, state and county grants.
- Apply for new opportunities for direct care HIV-related funding as these become available.

**PRIORITY 3: PREVENT HIV, STDs, VACCINE-PREVENTABLE DISEASES, AND
HEALTH CARE-ASSOCIATED INFECTIONS**

FOCUS: Hepatitis C Virus (HCV)

GOAL #4: Increase and coordinate HCV prevention and treatment capacity.

Objective:

Beginning in 2014, offer Hepatitis C testing to patients (born between 1945 and 1965) receiving treatment in SJRH's Emergency Department (25% in 2014, 100% in 2015, 100%, in 2016 *) – Baseline: 2013 '0'. *Performance rates are dependent on timing of the New York State statute.

Outcome: 2013 = 852 Hep C screenings. 2014 Annualized = 1425 (January – August 2014 = 950).

Improvements/Action Plan: WCDOH referral link for HOPE Center follow-up care & treatment of patients with reactive rapid and confirmatory Hep C tests. Continued staff education.

Interventions:

- Implement NYS-mandated* Hepatitis C testing in the SJRH Emergency Department by 2014.
- Analyze the feasibility of delivering quality, state of the art Hepatitis C treatment for mono-infected clients at the hospital's HOPE Center by July 2014. (Note: HOPE Center currently has a state grant for the treatment of those living with HIV and Hepatitis C. If not feasible, to begin the treatment of those who live only with Hepatitis C, we will set up a referral network of providers of this treatment by July 2014).
- For those receiving Hepatitis C treatment at HOPE Center, continue the existing linkage with community agencies offering linkage to expanded access to insurance under the Affordable Care Act to enhance public access to Hepatitis C treatment, including the new, highly-effective medications.

Recent Legislation: State of New York | Executive Chamber Andrew M. Cuomo | Governor
For Immediate Release: September 16, 2014

GOVERNOR CUOMO SIGNS BILL EXPANDING ACCESS TO HEPATITIS C TESTING

Governor Andrew M. Cuomo today signed into law a bill that increases access to hepatitis C, or HCV, tests by allowing physicians and nurse practitioners to authorize registered nurses, when appropriate, to administer the test to a patient without the need for a patient-specific order. This is an expansion of a law signed by Governor Cuomo last year requiring hospitals, clinics and physician offices to offer HCV testing to all persons born between 1945 and 1965 who are receiving in-patient or primary care services.

"This new law knocks down unnecessary barriers that reduced opportunities for testing and for people to get the help they need," Governor Cuomo said. "Simply put, the sooner a person is diagnosed with hepatitis C, the sooner treatment can begin, and I encourage all those who may be at risk to get tested as soon as they can."

Currently, a registered nurse may offer the hepatitis C test but cannot administer the test without an order from a physician or nurse practitioner for the specific patient to receive a test. The new process – administering the test under non-patient specific orders – is the same that currently exists for administering certain immunizations, the treatment of immunization-related anaphylaxis, tuberculosis tests and HIV tests. This new law, (A9124-A, S6871), builds on existing practice that aims to identify all New Yorkers who are infected with the virus so that they can seek proper treatment by removing a significant barrier to receiving an HCV test.

Senator Kemp Hannon, sponsor of the bill, said, “This legislation builds off a law enacted last year which required Baby Boomers, born between 1945 and 1965, to be offered hepatitis C testing. The bill being signed today will ensure better access to this testing for those most at risk. Authorizing non-patient specific orders for hep-C tests removes existing barriers and allows more health care professionals to administer the test. I commend the Governor for signing this legislation into law.”

Assemblyman Kenneth Zebrowski, sponsor of the bill, said, “New York continues to lead the nation in fighting this silent epidemic. With one out of 30 baby boomers potentially infected, getting people tested is critical. In order for new treatments to be effective, they must be started before the disease progresses. This bill will streamline the hepatitis C testing process, ensuring that New Yorkers are afforded treatment as early as possible. I want to thank Governor Cuomo for his collaboration; signing this bill today continues our aggressive fight to eradicate this disease.”

More information on hepatitis C testing, including a directory of testing locations throughout New York State, is available

HERE<https://www.health.ny.gov/diseases/communicable/hepatitis/hepatitis_c/rapid_antibody_testing/>.

6. DISSEMINATION OF THE PLAN TO THE PUBLIC

The Community Service Plan (CSP) will be reviewed by leadership and posted to the hospital's website by March 15, 2015 for public access. The Community Health Needs Assessment (CHNA) and Implementation Strategy were approved by the St. John's Riverside Hospital Board of Trustees on December 9, 2013. The approved report was appended to the hospital website by December 31, 2013. A press release is sent to all local media for publication that the CSP report is available for the public to review. All administrative offices are given a copy of the reports to produce upon request. The community will learn about it in our print newsletter, “Riverside”. The employees and physicians receive notification through their email newsletters with a link to connect them to our website. This year, we will be posting the link on Facebook and will be establishing a companion electronic newsletter for the community where that link will be made available. Employees can access the report through the hospital intranet. Copies can also be obtained by calling the hospital's public relations office.

The implementation strategy as outlined to address and respond to the community will be executed as part of the hospital leadership's strategic planning process and goals development through 2016.

7. MAINTAINING ENGAGEMENT

St. John's Riverside Hospital is committed to the ongoing assessment of our community health needs, maintaining engagement with its community partners and implementation of health priorities initiative through the followings methods.

SJRH sends consistent notification of health education sessions, forums, and planning meetings held through our hospital website, Facebook page, Twitter, YouTube, targeted mailings and printed materials posted throughout our three main campuses. A community outreach team distributes information daily to our private practice physician offices. Notification of our patient satisfaction survey is sent by a third party provider. Our community health needs assessment survey, also available in print, is emailed to the community via Survey Monkey, and links to all surveys are posted on Facebook and the website homepage. Notifications for *Speakers' Bureau* events are relayed face to face during actual sessions and by select mailings to community members.

Our Healthy Yonkers Initiative (HYI) holds regularly scheduled monthly meetings. The schedule of upcoming meetings is announced during the meetings, handouts are distributed, and email reminders are sent out. Agendas are used to notify committee members of topics that will be discussed at the meeting and members are welcome to propose additional items for presentation or discussion. The HYI partnership is an open forum where committee members take the opportunity to invite their clientele and other community residents that may benefit from the discussion. Several of the HYI subcommittees have volunteers that help to support our efforts. Their participation in other circles, i.e. the Yonkers public schools, helps us to expand and increase our reach into the local community.

A variety of key stakeholders facilitates and publicizes HIV/AIDS planning meetings. The Westchester County Department of Health facilitates Ryan White Part A Steering Committee meetings. *Living Together* facilitates Tri-County Consumer Advisory Group meetings. The NYS Department of Health's AIDS Institute facilitates Quality Improvement Committee meetings.

The U.S. Department of Health and Human Service, Health Resources and Services Administration (HRSA) HIV/AIDS Bureau convenes monthly conference calls with its funded agencies. SJRH's HOPE Center conducts our annual consumer satisfaction survey, follow-up informant interviews, and focus groups. Our HOPE Center also convenes our Performance Improvement, "Getting to Zero", Treatment Adherence, and other *ad hoc* group meetings. Notifications of meetings are through flyers to all of HOPE's clients.

SJRH's strategy to achieve these goals is to make appropriate resource allocation decisions so that institutional resources are expended in certain identified directions. With the combined efforts of the hospital, the community, and its leadership, finances for needed healthcare services can be provided to the population.

As part of its ongoing commitment to addressing the identified health priorities, the WCDOH Health Planning Team is planning to continue meeting to review progress in implementing the improvement plans developed by each agency, to work together, when applicable, on planned activities, to discuss barriers to implementation and consider new strategies that could be adopted. The Team is also planning to regularly convene the attendees from the health summit to provide input and support on project implementation.

SJRH will maintain its' close ties to our local partners by continuing to be actively involved in the following local planning and coordinating groups:

- Westchester County Department of Health's Health Planning Team,
- Healthy Yonkers Initiative,
- Tri-County Ryan White Part A Steering Committee,
- NYS Department of Health's AIDS Institute Quality Improvement Committee,
- U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) HIV/AIDS Bureau,
- Tri-County Consumer Advisory Group (Living Together),
- Hudson Valley Regional Perinatal Network, and the
- Community Planning Council of Yonkers.

We are enthusiastic about and fully support a major new collaboration in Yonkers that specifically focuses on overcoming racial and ethnic health disparities. Earlier this year the Yonkers Family YMCA was one of 14 YMCAs in the nation chosen by YMCA-USA to implement a CDC-funded Racial and Ethnic Approaches to Community Health (REACH) project designed to reduce health disparities in Yonkers' African-Americans and Hispanics communities.

Yonkers' REACH program, called Yonkers Healthy Connections for L-Y-F-E, is being led by the Yonkers Family YMCA and the City of Yonkers. There has been a powerful surge of community support for this effort and over 60 organizations already have agreed to participate. SJRH will be actively participating in this REACH program. We will work with its key leaders in our newly formed Community Outreach Advisory Committee focused on addressing the health needs of the minority population. It includes the woman who organized and leads Yonkers REACH. She's the YMCA CEO, a young Black minister, a countywide leader in minority health, and a powerhouse organizer. It also includes REACH's lead African-American and Hispanic Health Coaches as well as the African-American female CEOs of two of Yonkers' leading minority-controlled agencies, the Yonkers Community Action Program and the YWCA of Yonkers.

Our Community Outreach Advisory Committee also includes the African-American woman who serves as Coordinator of Residential Programs for the Municipal Housing Authority for the City of Yonkers (MHACY). MHACY is Yonkers' largest housing provider for low and moderate income families. It is the second largest public housing authority in the New York metropolitan area, second only to New York City itself. MHACY has 19 developments with 2,047 conventional public housing apartments and a Section 8 Program with an additional 2,600 scattered-site apartments.

St. John's has ongoing partnerships and collaborations at the community level to assist with the identification of local health priorities and the planning and implementation of strategies for local health improvement. These

alliances will contribute to improving the health status of our service area and reducing health disparities through increased emphasis on prevention. SJRH community representatives will be instrumental in serving as leaders to effectively engage community members in community action planning activities and identify potential diverse individuals and stakeholders, that will work together to address health related disparities in the region.

SJRH will establish a hospital committee which will meet quarterly and assume responsibility for the implementation and execution of this plan, including, but not limited to: monitoring and evaluating data, activities, and outcomes; identifying/recruiting critical stakeholders to participate on the committee; and reviewing existing and new evidenced-based interventions that could be adopted.