

2011 New York State One-Year Community Service Plan Update

St. John's Riverside Hospital (SJRH)

- ***Andrus Pavilion***
- ***Dobbs Ferry***
- ***ParkCare Pavilion***
- ***Malotz Skilled Nursing Pavilion***
- ***Cochran School of Nursing***

1. Mission Statement

St. John's Riverside Hospital's (SJRH) mission statement has not changed since the submission of the 2009 community service Plan (CSP).

Riverside Health Care System, Inc., 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, our institutions 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. Hospital Service Area

St. John's service area for its Andrus and ParkCare sites is ethnically diverse and encompasses neighborhoods with large numbers of Hispanic and African American residents. Approximately 80% of Yonkers women reside in the St. John's primary and secondary service areas. The 2000 US census estimates the current female population in Yonkers to be slightly over 100,000. Females under 21 years of age constitute a large percentage of the female population (31%). Yonkers has the highest proportion of Hispanic residents in Westchester County. Spanish is the dominant language although many were raised in the United States and speak English. Half of the women in Yonkers are Hispanic, followed by black women at 30% and white women at 19%. Over 40% of the population is over 45 years of age. – Southwest Yonkers (zip codes 10701, 10703, 10704 and 10705) has been federally defined as a Medically Underserved Area. - One in every five families lives in poverty, with over one third of these families headed by females. - Southwest Yonkers leads Westchester County in unemployment, high school dropouts, overcrowded housing, families in poverty, and children in poverty. - Mean and Median incomes are the lowest in the county. - Yonkers is a federally designated High Intensity Drug Trafficking Area. - The rate of poverty, teen pregnancy, lack of pre-natal care, vaccine preventable disease, Tuberculosis and HIV/AIDS in southwest Yonkers are among the highest in the region; with large numbers of recent immigrants, Hispanics with limited fluency in English and high school dropouts. - As of December 31, 2002, 1,243 cases of AIDS have been diagnosed in Yonkers (excludes pediatric and includes inmate cases). The cumulative incidence of reported AIDS cases in Yonkers is more than 2 1/2 times that

for all other areas of Westchester County combined.

The St. John's Dobbs Ferry site is the only hospital located in the Town of Greenburgh, New York. Its primary service area is comprised of the Villages of Dobbs Ferry, Hastings-on-Hudson, Ardsley, Ardsley-on-Hudson, Irvington, Tarrytown, Elmsford, Hartsdale, unincorporated areas of Greenburgh and adjacent areas of Yonkers, White Plains and Scarsdale. The total population of this service area is 168,589. This area is defined by a population that is largely white and affluent.

The primary service area used in the community service planning has not changed and no changes have occurred since the submission of the 2010 report.

3. As in the last CSP report, the community partners continue to be involved in assessing community health needs (e.g., community groups, local health departments, etc).

Some examples of how SJRH is continuing to work with community partners to assess community health needs are: the establishment of additional linkages with organizations in the river towns: - outside of Yonkers area; identification of faith-based organizations to identify opportunities to provide services for minority and uninsured populations; and establishment of a partnership with Cabrini Immigration located in Dobbs Ferry that provides services to immigrants.

4. The Prevention Agenda Priorities identified in the CSP are:

- Access to Quality Health Care**
- Chronic Disease**
- Community Preparedness**
- Mental Health and Substance Abuse**

5. These are the same priorities as in the previous 2010 CSP.

6. The goals for the selected priority areas are:

Access to Quality Health Care and Chronic Disease –

Provide access to care and treatment through a Hybrid Model of Care focused on Asthma, other COPD issues, Diabetes, Pneumonia, Hypertension and Dehydration. A patient-centered project focused on the reduction of emergency room use and integrated primary care in the emergency room, inpatient admissions for ambulatory sensitive conditions of southern Westchester County residents. It is a three-pronged program of:

1. case management of chronic conditions and
 2. improved access to breast cancer treatment for minority populations.
- Institute a primary care approach incorporated into the Dobbs Ferry emergency room service with follow-up case management in the community;
 - Prevent unnecessary admissions to the hospital and other surrounding hospitals;

- Provide more cost effective care for patients in alternative settings while focusing on the patients' chronic conditions in addition to the "health issue of the day";
- Expand the role of the emergency room as a medical assessment unit where our emergency medicine team will provide more intensive treatment in the emergency room;
- Provide a coordinated team care approach as a key element for the "Medical Home" patient-centered demonstration program.

Expected Outcomes for Chronic Disease Care are:

Asthma -

Decrease admission rates for asthma by 5% in the first year from 2009 to 2010;
Decrease admission rates for asthma by 20 % in the second year from 2010 to 2011;
and maintain that rate throughout.

Pneumonia -

Decrease admission rates for pneumonia by 5% in the first year from 2009 to 2010;
Decrease admission rates for pneumonia by 20 % in the second year from 2010 to 2011;
and maintain that rate throughout.

Hypertension –

Decrease admission rates for hypertension by 5% in the first year from 2009 to 2010;
Decrease admission rates for hypertension by 10 % in the second year from 2010 to 2011; and maintain that rate throughout.

Dehydration –

Decrease admission rates for dehydration by 5% in the first year from 2009 to 2010;
And maintain at 15% rate thereafter throughout.

Diabetes –

Decrease admission rates for diabetes by 5% in the first year from 2009 to 2010;
And maintain at 15% rate thereafter throughout.

Community Preparedness

Community education and screenings to include: - Access to insurances and alternatives should individuals not qualify for insurance.

Outreach, Education and Information for free screenings/low cost programs, re: breast cancer, cervical screening, colon cancer, hypertension, obesity, blood pressure screenings
Children and Adult Asthma Education - Diabetes Prevention and Management including Dietary information. Expansion of our Pediatric Asthma Program into zip codes outside the Yonkers area.

Training for Community Emergency Service Providers: Community emergency services providers, including ambulance workers, will be trained in appropriate medical protocols for treatment of chronic conditions to decrease inappropriate reliance on emergency rooms; early diagnostic and emergency services will be linked to stabilize and triage patients to appropriate services.

Mental Health and Substance Abuse

Mental Health and Substance Abuse Programs available at SJRH include the Smithers Program that receives funding from several sources including the NYS Division of Probation & Correctional Alternatives, the Westchester County Department of Probation, Westchester County Department of Corrections and the Westchester County DCMH.

A Substance Abuse Prevention goal is to expand treatment programming to special populations, i.e. patients in the criminal justice system, veterans and the military.

7. The following measures are being used to track progress in SJRH selected priorities:

Access and Chronic Disease –

SJRH tracks data on the access of and treatment rendered to the low-income, minority, uninsured, and underinsured patients in this service area and provides follow-up case management. The Hybrid Model of Care focus is on the reduction of emergency room use and inpatient admissions for ambulatory sensitive conditions. The Prevention Quality Indicators (PQIs), developed by The Agency for Healthcare Research and Quality (AHRQ) are used to track outcomes by measuring the rates of reductions throughout the period. Specific reductions in emergency use and inpatient admissions were set for each of the five chronic conditions using PQI measures. SJRH collaborates with community providers and is responsible for reporting on these benchmarks demonstrating improved health outcomes community wide.

The data collection effort began with 2008 for the benchmark year for the community PQI indicators and is compared annually. The following Ambulatory Sensitive Conditions are benchmarked: • Adult Asthma Rate • Child Asthma Rate (Under 18) • Bacterial Pneumonia Admission Rate • COPD Admission Rate • Dehydration Admission Rate • Diabetes Short-term and Long-term Complications admissions rates • Hypertension Admission Rates • Uncontrolled Diabetes Admission Rate data are dependent on the quality of the Statewide Planning & Research Cooperative System (SPARCS) data available. We report findings by: age, sex race and financial payer data. The goal is to measure changes in these PQI measures during the period. Ethnicity data is not collected through the SPARCS database so that findings related to ethnicity may be more limited to information collected on patients who participate in the program. In addition to PQI indicators epidemiological and statistical trends are reported. The data is reported quarterly and includes the following: age, sex, ethnicity, race and payer source. For ambulatory procedures and inpatient admissions, we track what services are provided according to: patient demographics, diagnosis and outcomes.

For Breast Cancer, our evaluation model measures:

- our participants increased awareness, knowledge, understanding, and acceptance of the importance of prevention and treatment for breast cancer. –
- participation in screenings and monthly workshops to provide information, education and referrals.
- increased referrals for diagnostic, primary and specialty care
- increase in the number of residents that continue with referred care on an ongoing basis
- increased access to and use of available cancer resources and heightened empowerment among those that take control of their health care needs.

- impact on minority breast cancer treatment rates by type of services received.

8. The following update on the Plan for Action is a summary of the implementation status of SJRH's "3 – year plan", including successes and barriers in the implementation process and when applicable, indicating how and why plans have been altered as a result of stated successes and barriers.

Access to Quality Care and Chronic Disease – Our team meets monthly or more frequently, either in person or via conference call to discuss patient/project needs. We continue to be contacted directly by the Emergency Department for patients who are part of the Hybrid PQI, which facilitates initial contact while the patient is still in the Emergency Department. PQI discharge instructions were assessed and we have seen a decrease in recurrent visits/admissions for patients who are compliant with their discharge plan. However, contacting patients continues to be an issue. We specifically experience difficulty in maintaining contact with asthma patients due to the need for long term therapy and education.

The Nurse Practitioner has been successful in contacting the other PQI diagnoses. We have experienced an increase in asthma patients in the Emergency Department, but our admission rate for this diagnosis remains low.

High risk patients that were treated at Andrus and Dobbs Ferry ER sites for diabetes or a related condition were targeted. A registry was created for data collection, reporting and support. The diabetes coordinator monitored patient notifications and reminders and facilitated interventions. The ER staff was also educated in diabetes management techniques. Our pneumonia rate for the Emergency Department increased slightly during the period with no recurrences but, our admission rate remains low for this diagnosis. Pneumonia patients were treated with antibiotics promptly; patients were discharged to a safe environment which decreased unnecessary hospital admissions. A five star rating was achieved for pneumonia care. Protocols were implemented and followed to achieve our goal of treating hypertension to lower blood pressure and avoid the risk of associated complications. We upgraded a level to Bronze accreditation status for our Stoke Care Program. Decrease in patient dehydration was addressed through improved discharge planning protocols. The dehydration volume significantly decreased for Emergency Department visits and admissions, many patients had multiple co-morbidities. The Hybrid Model successes include: - Positive reaction of contacted patients, especially if they had questions about care. - Primary care physician involvement in the model. A large volume of patients who utilize the Emergency Department are affiliated with Dobbs Ferry and St. John's. We are able to have direct contact with attending physicians. Patients and primary care physicians have been pleased with the education sessions provided. Team members have had some initial contact with patients in the Emergency Department as the team is available, assisting uninsured patients in obtaining information and financial assistance in a timely manner. Team members have informed patients how to access free programs and low cost medication. We continue to make progress with referrals for Medicaid and self-pay patients referred to the Ashikari Breast Center. There have been very low reoccurrence rates for all our PQI's including Asthma during the 2010 – 2011 period.

Community Preparedness – Our community partners in the Healthy Yonkers

Initiative have reported increased health education sessions, referrals for screenings and treatment for a large number of underserved and newly arrived adults in Yonkers. Health literacy is a vital NYS Education department initiative and remains a priority for St. John. In 2010, our Director of Community Outreach and Education received the NYS Association for Continuing Education Service Award for contributions to the Yonkers Public Schools' adult health literacy program. As part of our commitment to community health, we co-lead with the City of Yonkers and participated in the Healthy Yonkers Initiative, a community wide partnership aimed at addressing community health concerns of the highest priority.

9. The following summary highlights the impact or changes that have been realized to date as a result of our collaborative plan.

Over the past year we have worked closely with other area hospitals, the Westchester County DOH, the City of Yonkers/Dobbs Ferry municipalities and other community partners to focus on preventing disease and reducing health disparities. Several ambulance corps meetings were held during the 2010 – 2011 period, with excellent attendance and participation in discussions. In the Hybrid Model - we continue to experience very low reoccurrence rates for all our PQI's however, succeeding at patient contact and follow-up despite systems we have in place, remains a challenge.

Diabetes Care – A comprehensive outpatient wound management program is available for our diabetic patients with neuropathy. In 2011, we successfully installed two hyperbaric chambers in the wound healing center. Community Preparedness - Our outreach into the community utilizing the agencies, faith-based organizations and private groups of our Healthy Yonkers Initiative (HYI) consortium, enabled us to reach over 1,500 people with health education relating to cancer, hypertension, diet and salt consumption (a Westchester County Department of Health [WCDOH] health priority). Responding to the identified needs of our community, St. John's Riverside Hospital was awarded funds to launch a Hepatitis C support group and community education program. The objective of the group is to provide peer support to those individuals undergoing treatment for Hepatitis C and to assist those contemplating treatment. We continue to work closely with Cabrini Immigration Services and the Valentine Family Practice and their clients.

Substance Abuse – As a result of a stronger collaboration we realized an increase in treatment services for inpatient detoxification and rehabilitation, inpatient crisis services, outpatient treatment including day rehabilitation, methadone maintenance, adolescent and COA/COSA services, and jail based treatment services. Programs were also developed to serve specific special needs populations including the homeless, those affected by HIV/AIDS, the elderly and the dually diagnosed. Breast Cancer Care – as a result of a focused, collaborative approach during the period, we accomplished the following for our patients: (1) Received Susan G. Komen Foundation grant awards in 2009, 2010 and 2011 to support a breast health patient navigator and education and outreach activities for the underserved in our service area. (2) Avon Mammography Suite was named in recognition for the high quality of breast health services and technology. (3) Received National Accreditation for Breast Centers designation by the American College of Surgeons. (4) Won

recognition as Breast Imaging Centers of Excellence by the American College of Radiology. - A September 2011 survey is pending to certify our cancer program by the American College of Surgeons Commission on Cancer.

Responding to the needs of the community is demonstrated by the continued facilitated meetings of our Breast Cancer and Cancer Support groups. Individuals diagnosed with cancer are able to avail themselves of our Look Good Feel Better Program which provides cosmetic assistance and wigs for those in need. Breast Health Patient Navigators are at all hospital sites serving inpatient and outpatients with a continuum of health care needs and other resources.

10. SJRH has not added any new surveys since the 2010 CSP update.

The surveys currently include:

- Regular focus groups with community members to obtain the community members health questions and concerns.
- The Smithers Center distributes patient satisfaction surveys at least twice a year for clients actively involved in treatment and utilizes this information to improve the services offered in all our facilities.
- The HOPE Center Advisory Group is now the Consumer Participation Group.
- Regular forums called “Neighborhood Circles” are conducted in various Yonkers locations.
- SJRH mails surveys to the community annually.
- Informative sessions and discussions are held regularly with the employees.
- The Cochran School of Nursing holds several Information Sessions about the school’s academic program.
- All inpatients are given consumer satisfaction surveys which are reviewed and analyzed by the hospital administrators.
- Critical incidents are reported by frontline employees as a quality improvement tool.
- Counseling and testing Client surveys are administered to review and investigate any concerns identified by our customers.
- There is regular involvement in the Yonkers Chamber of commerce, the rotary, and other business organizations in our community.
- Representatives from SJRH actively participate in the Healthy Yonkers Initiative, which is a partnering organization for a multitude of community groups that form

work-groups that actively collaborate as they seek resolutions for Yonkers social and health problems; the Pastoral Care Committee; as well as social service & civic organizations. Member input and surveys are frequently utilized in these committees to determine preventive health and social priorities and plans of action.

11. **The SJRH's Community Service Plan and the yearly Updates are posted on the hospital's website as well as mailed to those who request a copy. The CSP is available to the public from the administrative offices at Andrus, ParkCare, and Dobbs Ferry pavilions and employees of St. John's can access the report via the hospital intranet. Copies can also be obtained by calling the hospital's public relations office. A public service announcement was sent to the local media outlets. The url address is: www.riversidehealth.org**

12. **A summary of the hospital's provision of financial aid in accordance with Public health law 2807 (k) (9-a), over the past year follows:**
Since the submission of the 2009 Community Service Plan the hospital has not had any significant operational or financial changes, i.e. mergers, service closures that impacted the care of the community, provision of financial assistance and/or access to health care. However, we continue to face the challenges of operating within current and proposed federal and state fiscal constraints and the directives of health reform. St. John's continues to provide comprehensive medical and nursing care to every patient, regardless of ability to pay. To accomplish this goal, SJRH makes available to all of its patients a medical care financial assistance program entitled Health Solution (the Charity Care Program). Despite the challenges of obtaining appropriate documentation we have been successful in providing financial assistance to a majority of patients who were unable to pay for all or a portion of their medical expenses incurred at the hospital and who met the eligibility guidelines established under the program.